Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD MEETING
Wednesday 29th June 2011
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
9.30	1.	Apologies	Dr J Hickey	
	2.	Declarations of Interest	Dr J Hickey	
	3.	Draft minutes of meeting held on 27th April 2011	Dr J Hickey	**1**
	4.	Matters arising	Dr J Hickey	
9.40	5.	Chief Executive's Report	Dr G McSorley	**Verbal**
Clinical Quality & Safety				
9.50	6.	Delivering Safer Care	Dr S Swart/Mrs J Bradley	**Presentation**
10.10	7.	Infection Prevention Report	Mrs F Barnes	**2**
Operational Assurance				
10.20	8.	Performance report	Mrs C Allen	**3**
10.30	9.	Finance report	Mr A Foster	**4**
10.40	10.	HR Report	Ms C Wilkinson	**5**
Strategic				
10.50	11.	Quality Account	Dr S Swart	**6**
10.55	12.	Acute Services Review	Mr C Pallot	**7**
11.05	13.	Annual Plan 2011/12	Mr C Pallot	**8**
11.10	14.	Corporate Objectives 2011/12	Mr C Pallot	**9**
11.15	15.	Any Other Business		
	16.	**Date & time of next meeting** 9.30am Wednesday 28th September 2011, Boardroom, NGH		
		CONFIDENTIAL ISSUES To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Dr J Hickey	

Minutes of the Public Trust Board Meeting held on
Wednesday 27th April 2011 at 9.30am
Boardroom, Danetre Community Hospital

Present:	Dr J Hickey	Chairman
	Mr P Farenden	Interim Chief Executive
	Mr C Abolins	Director of Facilities & Capital Development
	Ms N Aggarwal-Singh	Non-Executive Director
	Mrs C Allen	Director of Operations
	Mr C Astbury	Non-Executive Director
	Mrs F Barnes	Interim Director of Nursing
	Mr J Drury	Director of Finance
	Mr B Noble	Non-executive Director
	Mr C Pallot	Director of Planning & Performance
	Mr N Robertson	Non-executive Director
	Dr S Swart	Medical Director
	Ms C Wilkinson	Director of HR
	Mr P Zeidler	Non-executive Director
In attendance:	Ms S Rudd	Company Secretary
	Mr M Essery	Shadow Lead Governor
	Ms M McVicar	Shadow Governor
	Mr F Evans	Shadow Governor
	Mr A Pritchett	Friends of Danetre
	Mr N Spoors	Chronicle & Echo
	Mr D Wenham	Member of Public
	Mr P Murphy	Member of Public
Apologies:	Mr G Kershaw	Associate Non-executive Director
	Mr D Savage	Shadow Governor

TB 11/12 01 **Declarations of Interest**

No interests in items on the agenda or additions to the Register of Interests were declared.

TB 11/12 02 **Minutes of the meeting held on 23rd February 2011**

The minutes of the previous meeting were approved as a true record.

TB 11/12 03 **Matters Arising**

There were no matters arising

TB 11/12 04 **Chief Executive's Report**

Mr Farenden presented his report and was pleased to confirm that once again the Trust had met all its statutory and key performance targets. This had been achieved against a backdrop of increasing demand and is a tribute to all staff.

The Trust has been nominated by the PCT as the preferred centre for Vascular

Surgery and is a reflection of the direction of travel of the Trust. It reaffirms the commitment and aspiration of operating as a District General Hospital plus.

Rising activity is a significant challenge and presents a risk to our plans to reduce bed capacity. It is important that the Trust continues with its transformation plans across all the workstreams.

Dr Hickey asked Mrs Allen about the non-elective demand in April, which has been high for the last two years but not previously. Mrs Allen agreed that activity was high and is similar this year to last year and that for the three years prior some slight increases were seen and also some reductions. Dr Hickey asked if the demand management schemes put in place by the PCT were having an effect. Mrs Allen replied that schemes were in their infancy for example the Community Care scheme. A slight impact is being seen however it is difficult to assess the impact of individual schemes in the face of rising demand. We are looking to see if we can identify a particular pattern. Mr Farenden commented that Trusts around us are experiencing similar patterns.

Mr Robertson asked if we have knowledge of how many patients who could have been discharged but are still in the hospital. Mrs Allen replied that 50-60 patients at any one time are awaiting for a care package.

Mr Robertson asked if there was a sense of urgency in other organisations, Dr Swart agreed that there is but it is difficult in the face of rising demand.

This year's national in-patient survey results were released on 21 April by the Care Quality Commission and action plans will be developed linked to themes of the survey. Key areas to focus on are dignity and respect for the patient and also the nutritional needs of patients across the hospital.

A pause in the legislative process of the Health Bill through Parliament was announced by Andrew Lansley. He has invited organisations, public and staff to respond to the listening exercise 4 key themes.

Mrs Astbury asked if we are promoting this exercise. Dr Hickey replied that it was being promoted on our website and intranet and that staff are being made aware. Dr Swart commented that the feedback period is short but the higher the response rate the more effective the exercise will be.

The Trust has achieved all its performance targets for the year and Dr Hickey noted that, with regard to healthcare acquired infections, our levels 3 years ago were much higher and these had been reduced to 3 in the year. CDiff has also substantially reduced, staff should be congratulated on their work to achieve this outcome.. Mr Farenden agreed and said it was particularly good given the levels of activity within the organisation.

Maternity services at NGH have achieved CNST level 2 assessment. This is an excellent achievement showing quality of service and has related financial benefits.

Haematology building work continues on track and the appeal continues to be successfully supported. Mr Abolins reported that a donation has been received from Constance Travis Foundation of £100,000k, taking the amount raised so far to over £500,000. The Board requested Mr Abolins write to the Foundation expressing their thanks.

Community beds at Danetre Hospital and the Minor Illness Minor Injury Unit (MiAMI) are now being managed by NGH. Mrs Allen noted that the transition had

been smooth and the team are working hard to ensure the ward feels part of NGH. We are also working hard with MiAMI ensure better links between them and A&E.

Dr Hickey asked Mr Pritchett of the Friends of Danetre if there were any concerns. Mr Pritchett replied that there were none. He receives frequent letters with donations from relatives and concerns were raised about the change of management. He was pleased to say that most had been unfounded although there is still a concern about a change of ethos of the ward here, locally it is held in high regard. Dr Hickey agreed that the facilities at Danetre are second to none and reaffirmed NGH's commitment to this site.

Mr Essery commented that he and Robin Kelso are shadow governors for Daventry and offered their services as liaison.

Mr Zeidler asked about the Trust scorecard noting that length of stay appears to be an upward trend, are we confident this will be reversed. Mrs Allen said that it is difficult to identify the reasons for the increase and obviously difficulties were experienced over the winter period. We have most control of elective length of stay and have undertaken significant work for patients to come in as day cases.. For non-elective rates, over the winter period patients seen were much sicker which impacts on length of stay. The position is reviewed weekly by specialty and sub-specialty. The transformation programme is looking at 10 pathways of care which we feel will reduce length of stay considerably.

The Board **noted** the report.

TB 10/12 05 **Infection Prevention Report**

Mrs Barnes presented her report noting that the end of year cases were 2 MRSA bacteraemias and 48 cases of CDiff which is a good performance.

During March Creaton ward had an increase in MRSA colonisation. A number of professionally led meetings were held to discuss actions and these support meeting continue. The cause is uncertain and a review of high level dust has been carried out. Work is ongoing with Estates and there has been an increase in the number of cleaning schedules.

Mr Fred Evans, Shadow Governor, noted that the hotel services focus group that he chairs is scheduled to visiting the ward and will assess cleanliness.

One MRSA bacteraemia, against our trajectory of three, has been identified in a patient. A root cause analysis is being undertaken tomorrow to learn from the event.

Mrs Allen asked about e-coli, this is a new measure and do we currently collect the data. Mrs Barnes replied that it has not been collected before as it tends to be a disease more familiar in the community. There is uncertainy across acute trusts as to how will collect the data.

The Board **noted** the report.

TB 11/12 06 **Care and Compassion Report**

Mrs Barnes presented the report noting that the Health Service Ombudsman published a report in February 2011 drawing on the experience of 10 families in relation to care in a hospital or community setting, particularly people over the age of 65.

The paper looks at the report and compares ourselves with the incidents that

occurred. The themes identified are how older people were not respected, lack of dignity and professionals not engaging. There are also concerns about call bells and not assisted feeding.

We have reviewed our complaints received and, in comparison to report, we have a 16% of complaints against the 18% in report.

Our areas of concern were communication and nursing care, dignity and falls. The report contains an action plan that links directly to instances in the report and also identified the assurances we have in place to ensure that the experiences of the patients documented would not be repeated here. This plan has been reported to Nursing and Midwifery Board to ensure a consistent approach to monitoring the report.

Mr Noble noted that the report concentrates on over 65s. Mrs Barnes noted initiatives are for all ages not just over 65.

Dr Swart said that the national emphasis is that we must not ignore people because of their age and that there is tension about beaucrocacy and paperwork versus care. This theme comes through in complaints and conversations.

Mr Abolins said we are planning to increase the number of volunteers. He has met with the WRVS and they are keen to assist in the process of care.

Mrs Aggarwal-Singh asked if the staff are being made aware of these findings. Mrs Barnes said that they are, the initial report has been circulated across the nursing and midwifery staff, together with the plans and gap analysis.

The Board noted the contents of the Ombudsman's report and **supported** the actions in place.

TB 11/12 07 **Performance Report**

Mrs Allen presented her report and noted that it was a real accolade that we have successfully achieved all the year end standards. We now need to look forward to the new standards being introduced. The traditional 4-hour transit time performance for patients attending A&E has been replaced with eight clinical indicators. Five of these area considered to be headline and are detailed in report. Dr Hickey asked how we collect this new information and Mrs Allen replied that the software has been amended to reflect these new indicators.

We have been reviewing our progress against the standards in shadow form and we have put plans in place to achieve them. These plans are locally and clnically led.

The approach to monitoring referral to treatment waits has changed from monitoring the percentage of patients whose referral to treatment time was less than 18 weeks to monitoring the 95th percentile time waited for completed admitted and non-admitted pathways. This is to ensure that you monitor the tail of patients waiting. We started looking at this in January and there will be some challenges in small specialties.

The Board **noted** the report.

TB 11/12 08 **Finance Report**

Mr Drury presented his report and noted the year to date surplus of £1.1m, subject to external audit. The Trust has achieved the statutory break even duty having achieved a surplus in each of the previous three financial years. The Trust has also

achieved its capital cost absorption duty of 3.5%.

The Trust did not exceed the agreed capital resource limit for the year, expenditure of £9.7m against a limit of £10.m. The under spend will be carried forward to 11/12. The Trust also achieved a £23k surplus against the external financing limit target.

The better payment policy code was not achieved, with similar levels to 2009/10. Overall the percentage was impacted in the first quarter due to cashflow issues.

There is £3.8m cash in bank, which is £1.5m higher than last year and which will help us during the first quarter of this year.

The Cost Improvement Plan was an overall target of £12m with £10.5m delivered.

With regard to Workforce there has been an overall increase of 92 staff, 68 of which are nursing posts. The numbers of managerial and administrative whole time equivalent staff fell during the year.

Stock levels have increased by £0.5m, year on year and NHS debtors have fallen by 1.3m. This is due to an agreement with the PCT to pay debtors in year. There is significant capital creditors at year end which relates to schemes agreed during the month and to be paid in April.

Mr Zeidler asked about the managerial and administrative staff, are we sure that we are not using bank and agency for administrative tasks. Mr Drury replied we have consistent levels to last year.

Dr Hickey asked why stock levels are increasing. Mr Drury said stock levels are adjusted through income and expenditure partly due to change in the mix of drugs. Dr Hickey asked if we have proper stock controls in place. Mr Drury said do not have controls in place but that these are not improving. The Pharmacy stock system is due for replacement and will provide an opportunity.

Mr Robertson asked about locum Consultants, significant progress has been made but there are still issues with the numbers of junior doctor vacancies. The position has not deteriorated from last year.

Mr Noble asked if agency expenditure was still a problem in April. Mrs Allen replied that when we see high levels of urgent care cases we have to open beds at short notice which will have an effect on agency spend.

Mr Robertson commented on the areas that have performed well with regard to their CIPs. Mrs Allen said general medicine has made significant progress and the new Directorate Manager has really got involved in understanding the finances. There is a strong management team in place.

The Board **noted** the report.

TB 11/12 09 **HR Report**

Ms Wilkinson presented her report and noted that our recruitment timeline has been benchmarked against other trusts and compares favourably. The length of time to recruit will increase by 3 weeks due to redeployment of staff within the region.

The E-rostering project is on schedule and the reports are proving useful to ascertain establishment on wards against bank and agency requirements.

Return to work monitoring continues to improve with some areas achieving 100%.

Sickness absence in February was 3.99%, reducing from 4.67% in January. The Sickness absence policy is having a positive effect along with the proactive approach by HR business partners.

Mr Noble asked about the 3 week increase in recruitment time. Ms Wilkinson replied that the regional framework for people at risk means that the internal regional procedures must have been exhausted before vacancies can be advertised externally.

The Board **noted** the report.

TB 11/12 10 **Staff Survey**

Ms Wilkinson presented her report and noted that a sample of 850 staff had been surveyed with a 49% response rate, compared to the average for acute trusts of 52%. Last year the Trust response rate was 47% therefore a small increase has been seen.

We have improved in a number of areas but there is still work to be done to achieve the Employer of Choice badge. The Capita report measures results against 3 themes and the trust scored well on staff satisfaction.

The Trust needs to continue with the action plans put in place, including individual Directorate action plans. The key findings show that we need to improve communication, improve appraisal and personal development plan rates, increase staff involvement and engagement and address issues of bullying and harassment.

We have held a number of workshops on bullying and harassment and launching a campaign across the Trust with a revised policy put in place.

Dr Swart commented that many of the issues identified could be covered by good appraisal systems, people need to be taught about being valued in appraisals.

Ms Wilkinson noted that we are also conducting pulse surveys based on areas of concern, using identical questions to the sruvey and those results will be prepared for July.

The Board **noted** the report.

TB 11/12 11 **Year End Report on Personal Development Reviews**

Ms Wilkinson presented the year end report on personal development reviews/plans. There has been an increase in the numbers of staff who have had an appraisal/personal development review, with nine areas showing achievement exceeding the 80% target. The overall percentage of staff who have had an appraisal/development review is 64.58%.

Mr Zeidler said that appraisals are obviously a key area and the Board spent a lot of time at the meeting in January reviewing plans and there was a view that we would achieve the 80% target overall. What are we going to do that is different. Ms Wilkinson agreed that it was disappointing that the overall target was not met but there have been significant by managers with increased training being carried out trust wide.

The Board requested a follow up paper on appraisal and PDP action plans to the May meeting.

The Board **noted** the report.

Action: Ms Wilkinson to present appraisal and PDP action plans to May meeting.

TB 11/12 12 Any Other Business

Dr Hickey expressed his thanks to Mr Farenden during his time as interim chief executive and asked that these be recorded.

TB 11/12 13 Date and Time of Next Meeting

Wednesday, 29th June 2011, Boardroom

Actions arising

TB 11/12 11	Appraisal and PDP action plans to May meeting.	CW	May 2011
TB 10/11 42	Provision of updates on e-rostering implementation, and inclusion of E-rostering into Capital Plan	CW	June 2011

BOARD SUMMARY SHEET	
Title	Monthly Infection Prevention Performance Report
Submitted by	Fiona Barnes, Interim Director of Nursing
Prepared by	Nina Fraser, Deputy Director of Nursing
Date of meeting	29th June 2011
Corporate Objectives Addressed	To develop and embed measures for quality and clinical outcomes to achieve the highest standards

SUMMARY OF CRITICAL POINTS
Monthly update on reportable HCAIs

PATIENT IMPACT
High – review of incidents and trend analysis of HCAIs is paramount to improving patient safety and quality of care.

STAFF IMPACT
High – review of incidents and trend analysis of HCAIs is paramount to improving patient safety and quality of care and also impacts on staff safety and wellbeing.

FINANCIAL IMPACT
Will be identified as required

EQUALITY AND DIVERSITY IMPACT
Applicable to all

LEGAL IMPLICATIONS
The Board has a statutory obligation to ensure appropriate infection prevention and control mechanisms are in place.

RISK ASSESSMENT
Failure to review infection prevention and control would be considered to be high risk.

RECOMMENDATION
The Board is asked to consider the content of this report.

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.

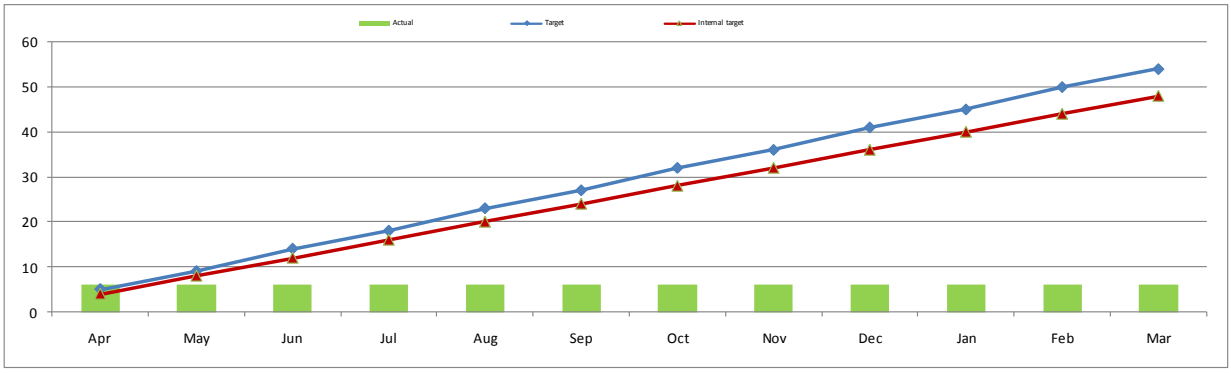
MRSA Bacteraemia (Appendix 1)
The Trusts trajectory for MRSA bacteraemias in 2011/12 is 3 cases. In May there was no >48hrs MRSA bacteraemia.

The Trust is measured on the number of MRSA bacteraemia cases per 10,000 bed days. Last year the number of bed days was based on a fixed bed base of 575. This year the bed base will reflect the actual bed base for the month which will vary from 575. The post-48 hour MRSA bacteraemia cases per 10,000 bed days year to date are 0.28.

MRSA Colonisation (Appendix 2)
During May there were 16<48hrs and 2>48hrs cases of MRSA colonisation. Internal patient verified data identifies 99% compliance for the screening of elective admissions during May. The compliance rate for emergency screening was 96% in May.

MSSA Bacteraemia (Meticillin Sensitive *Staphylococcus Aureus*)
During May there were 3 <48hrs and no >48hrs MSSA bacteraemias.

***Clostridium difficile* (*C diff*, Appendix 3)**
The Trust has a trajectory of 54 C. diff. cases with an internal stretch ceiling of 48 cases. During May the Trust identified 2 <3 day and 2 >3 day cases of C. diff. which equates to a cumulative of 0. 23 /1,000 bed day's year to date.



Escherichia coli (E Coli)
As part of the Governments plans to improve its information on HCAI the Trust will be reporting E coli bacteraemias on the Health Protection Agency's data capture system. This will begin in June 2011.

Surgical Site Infection Surveillance Scheme
The Surgical Site Infection Surveillance programme is nationally co-ordinated by the Health Protection Agency (HPA). Over 150 hospitals in England participate in the programme and the HPA ensure that a standard approach to data collection, analysis and interpretation is undertaken. Throughout the year the Trust has a programme of surgical procedures that are audited in line with the HPA guidance. On a quarterly basis the Trust submits data to the HPA and following 3-4 months the data is returned allowing the Trust to 'benchmark' our data with the national picture.

Surgical Site Surveillance of fractured neck of femur repairs

Current Year's Results to date
Although the HPA report will take some time to be generated the interim results for April and May are:

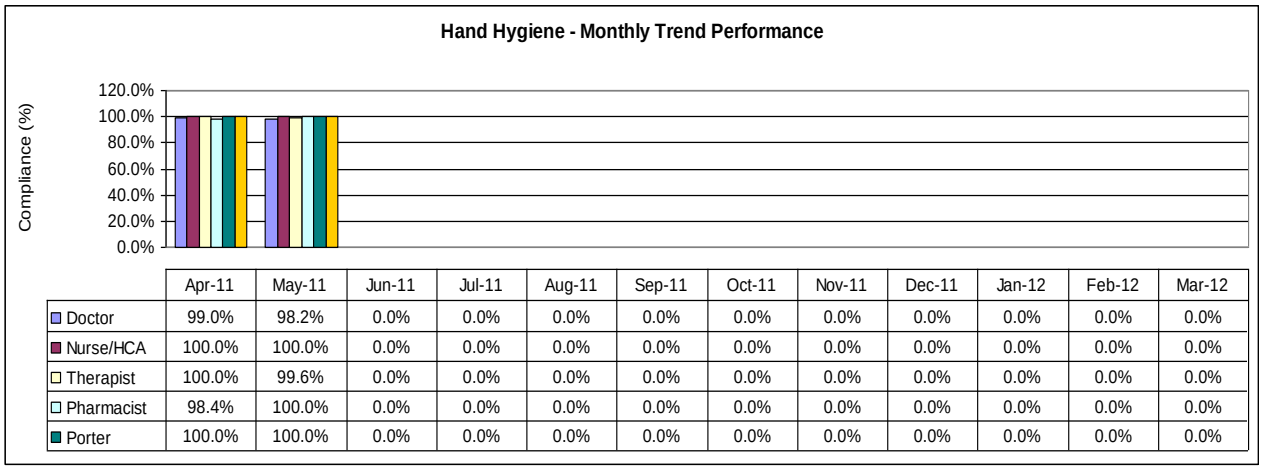
- In April 2011 out of the 24 operations to repair fractured neck of femurs (#NOF) there was 1 infection.
- In May 2011 there were 0 infections resulting from 22 operations to repair #NOF's.

It is proposed that the Surgical Site Infection Surveillance programme will continue to audit fractured neck of femurs throughout the year, and reported to the Clinical Quality and Effectiveness Group (CQEG).

Key Actions
A surgical site care bundle has been developed to support the issues identified from the previous quarters' results which include:

- Orthopaedic Consultant supervision in theatre
- The introduction of opsite dressings post operatively
- Octenisan antimicrobial body wash and nasal mupirocin 2% (bactroban) decolonisation treatment for all patients admitted to the ward

Hand Hygiene Audit
Information from the Hand Hygiene Observational Tool (HHOT) shows that in May the overall compliance for hand hygiene was 99.5%.



	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Doctor	99.0%	98.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Nurse/HCA	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Therapist	100.0%	99.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Pharmacist	98.4%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Porter	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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

Fiona Barnes
Interim Director of Nursing, Midwifery & Patient Services
DIPC

Appendix 1

MRSA Bacteraemia Incidence by Ward

MRSA Bact	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		
Ward	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	Trust Total 2011-12
Hawthorn																									0
Willow																									0
Collingtree 23hr																									0
ITU		1																							1
HDU																									0
A & E																									0
Abington																									0
Cedar																									0
Becket																									0
SingleHurst																									0
Knightley																									0
Gossett																									0
Disney																									0
Paddington																									0
Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer																									0
Sturtridge																									0
Allebone																									0
Benham																									0
Creaton																									0
Dryden																									0
EAU																									0
Eleanor																									0
Victoria																									0
Rowan																									0
Finedan																									0
Compton																									0
Brampton																									0
Holcot																									0
Althorp																									0
Talbot Butler																									0
Trust Total 2011-12	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1

Appendix 2

MRSA Colonisation Incidence by Ward

MRSA ISOLATES	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		
Ward	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	Trust Total 2011-12
Hawthorn																									0
Willow				1																					1
Collingtree																									0
ITU	1																								1
HDU																									0
A & E			1																						1
Abington		1	1	1																					3
Cedar																									0
Becket																									0
SingleHurst																									0
Knightley																									0
Gossett																									0
Disney																									0
Paddington	1		2																						3
Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer	1																								1
Sturtridge																									0
Allebone	5		6																						11
Benham																									0
Creaton		5																							5
Dryden																									0
EAU	10		4																						14
Eleanor																									0
Victoria																									0
Rowan	1		2																						3
Finedon		1																							1
Compton																									0
Brampton																									0
Holcot																									0
Althorp																									0
Talbot Butler	1																								1
Trust Total 2011-12	20	7	16	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	45

Appendix 3

Clostridium Difficile Incidence by Ward

CDT	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Trust Total
Ward	<3day	>3 da	<3da	>3 da	<3da	>3 day	<3da	>3 da	<3da	>3 da	<3da	>3 da	<3da	>3 da	<3da	>3 da	<3da	>3 da	<3da	>3 da	<3da	>3 da	<3da	>3 da	2011-12
Hawthorn		2																							2
Willow																									0
Collingtree																									0
ITU																									0
HDU																									0
A & E																									0
Abington																									0
Cedar																									0
Becket																									0
SingleHurst																									0
Knightley																									0
Gossett																									0
Disney																									0
Paddington																									0
Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer			1																						1
Sturtridge																									0
Allebone			1																						1
Benham		1																							1
Creaton		1		1																					2
Dryden																									0
EAU	2																								2
Eleanor																									0
Victoria		1																							1
Rowan		1																							1
Finedon				1																					1
Compton																									0
Brampton																									0
Holcot																									0
Althorp																									0
Talbot Butler																									0
Trust Total 2011-12	2	6	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12

TRUST BOARD GROUP SUMMARY SHEET	
Title: -	Performance Report
Submitted by: -	Christine Allen, Director of Operations
Date of meeting: -	29th June 2011
Corporate Objectives Addressed: -	

SUMMARY OF CRITICAL POINTS: -

This report sets out the key areas of performance for Northampton General Hospital NHS Trust for Month 2 **(May 2011)**.

Areas of performance to note are:

- A&E Clinical Indicators
- Cancer Standards:
  - 2 week wait for breast referrals
  - 62 days from GP referral to start of first treatment
- Stroke indicators

PATIENT IMPACT: -

N/A.

STAFF IMPACT: -

N/A.

FINANCIAL IMPACT: -

N/A.

RISK ASSESSMENT: -

N/A.

EQUALITY & DIVERSITY IMPACT ASSESSMENT: -

N/A.

RECOMMENDATION: -

Trust Board are asked to note the contents of this report.

Northampton General Hospital NHS
NHS Trust

PERFORMANCE REPORT – MAY 2011

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for **Month 2** (May 2011). The report is based on the NHS Performance Framework - Service Performance Standards and Targets.

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

2. SERVICE PERFORMANCE

Indicator	Monthly Target	Apr-11	May-11	YTD	Monthly Delivery	YTD Delivery
VTE Risk Assessment	90.0%	88.7%	90.1%	90.1%		
Methicillin resistant Staphylococcus Aureus (MRSA) bacteraemia	0.25	1	0	1		
Methicillin sensitive Staphylococcus Aureus (MSSA)		1		1		
Rates of Clostridium difficile	4.5	6	2	8		
RTT waits (95th percentile measures)						
- *admitted 95th percentile*	23 Weeks	17.64	17.51	na		
- *non-admitted 95th percentile*	18.3 Weeks	12.52	13.45	na		
- *incomplete 95th percentile*	28 Weeks	20.28	19.00	na		
RTT (Median wait measures)						
- *admitted median wait time*	11.1 Weeks	7.20	7.81	na		
- *non-admitted median wait time*	6.6 Weeks	3.97	5.34	na		
- *Incomplete median wait time*	7.2 Weeks	4.96	19.00	na		
Percentage of Patients seen within 18 weeks across all speciality groups						
Admitted	90%	97%	97%	na		
Non-admitted	95%	98%	98%	na		
Percentage of Patients seen within 18 weeks for direct access audiology treatment	90%	100%	100%	na		
A & E quality indicators						
- *unplanned re-attendance rate*	>1% and <5%	5.50%	3.70%	na		
- *total time spent in A & E (Admitted Patients)*	95th Percentile=<4 Hrs	05:13:00	05:32:00	na		
	Longest Wait =<6 Hrs	09:21:00	13:32:00	na		
- *total time spent in A & E (Non-Admitted Patients)*	95th Percentile=<4 Hrs	03:54:00	03:52:00	na		
	Longest Wait =<6 Hrs	10:27:00	14:47:00	na		
- *left department without being seen*	=<5%	0.2%	0.3%	na		
- *time to initial assessment (95th percentile < 15mins)*	=<15mins	00:49:00	00:48:00	na		
- *time to initial assessment (100% < 20mins)*	100%	81.99%	83.06%	na		
- *time to treatment in department (median)*	=<1 Hrs	00:56:00	00:52:00	na		
Cancer Wait Times						
2 week GP referral to 1st outpatient	93%	97.60%	93.80%	95.69%		
2 week GP referral to 1st outpatient - breast symptoms	93%	94.70%	82.80%	89.29%		
31 Day	96%	99.30%	98.00%	98.60%		
31 day second or subsequent treatment - surgery	94%	100.00%	100.00%	100.00%		
31 day second or subsequent treatment - drug	98%	98.30%	100.00%	99.09%		
31 day second or subsequent treatment - radiotherapy	94%	99.00%	97.60%	98.36%		
62 day referral to treatment from screening	85%	94.70%	100.00%	97.50%		
62 day referral to treatment from hospital specialist	85%	92.90%	85.20%	89.09%		
62 days urgent referral to treatment of all cancers	85%	90.40%	80.00%	85.42%		
Stroke Indicators						
Proportion of people who have a TIA who are scanned and treated within 24 hours	60%	80.00%	65.00%	72.50%		
Proportion of people who spend at least 90% of their time on a stroke unit	80%	78.69%	80.43%	79.44%		

2.1 A&E Clinical Indicators

During May 2011 the Trust did not meet the following A&E indicators:

- Total time in the A&E Department for admitted patients
- Maximum time spent in A&E for admitted and non-admitted patients.
- Time to initial assessment.

2.1.1 Total Time in the A&E Department

In May, the 95th percentile for admitted patients for the time waiting in A&E was 5 hours 32 minutes against a standard of 4 hours and the longest wait was 13 hours 32 minutes.

For non admitted patients the 95th percentile within 4 hours was achieved, however, the longest wait was 14 hours and 47 minutes.

2.1.2 Time to Initial Assessment

- The indicator for the 95th percentile of time from arrival at A&E to full initial assessment for patients brought in by emergency is 15 minutes. In May the Trust achieved 48 minutes.
- 100% of patients brought in by emergency is 15 minutes. In May the Trust achieved 48 minutes.

A Task and Finish Group has been set up, led by the Lead A&E Consultant, who are reviewing actions to ensure progress towards all indicators in line with the action plan, actions include:

- The introduction of team nursing, including reconfiguration of the nursing establishment.
- Improved recording of time of observations.
- Alert to a Senior Doctor at 45 minutes if the treatment plan has not commenced.
- Review of the Nurse Consultant post to provide additional senior decision making for patient assessment.
- Discussion with the DH Intensive Support Team to further develop improved care models.
- Set up of an Urgent Care Board to improve patient flow, which will support the delivery of the A&E indicators.

2.2 Cancer Waiting Times

2.2.1 2 Week Wait Breast Referrals

During May 2011, the Trust achieved 82.8% of non symptomatic breast referrals being seen within 2 weeks against the standard of 93%. 11 patients were not seen within 2 weeks. This was a result of patient choice and a reduction in clinics available.

A recovery plan has been developed and to date 100% of patients referred in June have an appointment within 2 weeks of referral. The following actions have been implemented:

- Additional capacity in place.
- Revised escalation process in place.
- Alert on the GP referral to Pathfinder to inform GPs of the correct referral pathway for asymptomatic patients.

Achievement of the standard for quarter 1 will be dependent on the number of referrals received and the above actions have been put in place to ensure the standard is achieved consistently.

2.2.2 62 Days from Urgent GP Referral to Start of Treatment

During May, the Trust treated 80% of patients within 62 days of their urgent referral against a standard of 85%. 15 patients were not treated within target and these were across the following tumour sites:

- Lower GI
- Gynaecology
- Lung
- Urology
- Upper GI
- Head and Neck

Delays were a result of loss of capacity due to leave and bank holidays, patient choice to defer appointments, complex diagnostic pathways and delays in referrals from referring trusts.

All of the patient pathways have been reviewed and further actions have been put in place to ensure all referrals between tumour sites and between Trusts are tracked to prevent any unnecessary delays.

The year to date performance is 85.42% and the Trust is on target to achieve the standard for quarter 1.

2.3 Stroke Indicators

During 2011/12, the Trust will be monitored against the following indicators quarterly:

2.3.1 Number of Patients who have had a Stroke and spend at least 90% of their time on a Stroke Unit

During May the Trust achieved the standard of 80% of patients spending at least 90% of their time on a Stroke Unit. The quarter to date performance however, is just under this target at 79.4%. The Directorate and Stroke Team are continuing to work with colleagues at KGH to ensure timely repatriation of patients to improve flow through the Stroke Unit. The Directorate are also developing the Early Supported Discharge service in the community to increase rehabilitation capacity and enable appropriate and timely discharge from both NGH and KGH.

2.3.2 Number of Patients who have a TIA are to be scanned within 24 hours

During May the Trust achieved the standard of 60%. 65% of patients were scanned within 24 hours and the quarter to date performance is 72.5%.

3.0 RECOMMENDATIONS

Trust Board is asked to discuss and debate any issues arising from this report.

Appendix 1: Performance Indicators - Balanced Scorecard

Indicator	Monthly Target	Apr-11	May-11	YTD	Monthly Delivery	YTD Delivery
VTE Risk Assessment	90.0%	88.7%	90.1%	90.1%		
Methicillin resistant Staphylococcus Aureus (MRSA) bacteraemia	0.25	1	0	1		
Methicillin sensitive Staphylococcus Aureus (MSSA)		1		1		
Rates of Clostridium difficile	4.5	6	2	8		
RTT waits (95th percentile measures)						
- *admitted 95th percentile*	23 Weeks	17.64	17.51	na		
- *non-admitted 95th percentile*	18.3 Weeks	12.52	13.45	na		
- *incomplete 95th percentile*	28 Weeks	20.28	19.00	na		
RTT (Median wait measures)						
- *admitted median wait time*	11.1 Weeks	7.20	7.81	na		
- *non-admitted median wait time*	6.6 Weeks	3.97	5.34	na		
- *Incomplete median wait time*	7.2 Weeks	4.96	19.00	na		
Percentage of Patients seen within 18 weeks across all speciality groups						
Admitted	90%	97%	97%	na		
Non-admitted	95%	98%	98%	na		
Percentage of Patients seen within 18 weeks for direct access audiology treatment	90%	100%	100%	na		
A & E quality indicators						
- *unplanned re-attendance rate*	>1% and <5%	5.50%	3.70%	na		
- *total time spent in A & E (Admitted Patients)*	95th Percentile=<4 Hrs	05:13:00	05:32:00	na		
	Longest Wait =<6 Hrs	09:21:00	13:32:00	na		
- *total time spent in A & E (Non-Admitted Patients)*	95th Percentile=<4 Hrs	03:54:00	03:52:00	na		
	Longest Wait =<6 Hrs	10:27:00	14:47:00	na		
- *left department without being seen*	=<5%	0.2%	0.3%	na		
- *time to initial assessment (95th percentile < 15mins)*	=<15mins	00:49:00	00:48:00	na		
- *time to initial assessment (100% < 20mins)*	100%	81.99%	83.06%	na		
- *time to treatment in department (median)*	=<1 Hrs	00:56:00	00:52:00	na		
- *percentage of A& E attendances for cellulitis and DVT that end in admission*						
- *number of admissions for cellulitis and DVT per head of weighted population*						
- *percentage of patients reviewed by an emergency medicine consultant prior to discharge*						
- *A & E service experience*						
Cancellation of Elective surgery for non-clinical reasons either pre or post admission	6%	5.03%	5.03%	5.03%		
Length of Stay						
Non-Elective	4.3	4.15	4.33	na		
Elective	3.21	3.99	3.40	na		
Total	4.08	4.12	4.20	na		
Cancelled Operations not rebooked within 28 days	0%	0%	0%	0%		
Delayed transfers of care	4%					
Number of diagnostic waits > 6 weeks	0	0	0	0		
Cancer Wait Times						
2 week GP referral to 1st outpatient	93%	97.60%	93.80%	95.69%		
2 week GP referral to 1st outpatient - breast symptoms	93%	94.70%	82.80%	89.29%		
31 Day	96%	99.30%	98.00%	98.60%		
31 day second or subsequent treatment - surgery	94%	100.00%	100.00%	100.00%		
31 day second or subsequent treatment - drug	98%	98.30%	100.00%	99.09%		
31 day second or subsequent treatment - radiotherapy	94%	99.00%	97.60%	98.36%		
62 day referral to treatment from screening	85%	94.70%	100.00%	97.50%		
62 day referral to treatment from hospital specialist	85%	92.90%	85.20%	89.09%		
62 days urgent referral to treatment of all cancers	85%	90.40%	80.00%	85.42%		
Stroke Indicators						
Proportion of people who have a TIA who are scanned and treated within 24 hours	60%	80.00%	65.00%	72.50%		
Proportion of people who spend at least 90% of their time on a stroke unit	80%	78.69%	80.43%	79.44%		
Activity vs. Plan						
Elective	0%	-5%	-6%	-5%		
DC	0%	-22%	-4%	-14%		
Non-Elective	0%	16%	12%	-81%		
OP 1sts	0%	-27%		-27%		
Op Procs	0%	167%		167%		
New to Follow Up Ratios						
GP Referrals	0%	-16%	-2%	-9%		
Day Case Rates	81%	83%	84%	83%		
Sleeping Accommodation Breach	0	0	0	0		

BOARD SUMMARY SHEET	
Title	Finance Report to the Board – June 2011/12
Submitted by	Mr J Drury, Director of Finance
Date of meeting	30th June 2011
Corporate Objectives Addressed	Financial Duties / Financial Strategy

SUMMARY OF CRITICAL POINTS

Breakeven Financial Duty.
The Income and Expenditure performance of the Trust at month 2 shows a deficit of £1,019k.

Capital Resource Limit (CRL)
The Capital Resource Limit (CRL) for 2011/12 totals £13.178m with a further £1.5m from donations. Total capital expenditure of £0.6m has been incurred at month 2.

External Financing Limit (EFL)
The Trust's planned External Financing Limit is £347k reflecting a PDC receipt in respect of the TCS asset transfer.

Capital Cost Absorption Rate
The Trust is required to achieve a capital cost absorption rate of 3.5%. Planned dividend repayments are forecast to achieve this duty.

Better Payment Practice Code (BPPC)
The position for May shows 96% compliance by volume and 67% compliance by value. Target is for 95% compliance.

PATIENT IMPACT

STAFF IMPACT

FINANCIAL IMPACT
Risk identified to achieving SHA control surplus target of £0.5m due to CIP gap.

EQUALITY AND DIVERSITY IMPACT

LEGAL IMPLICATIONS

RISK ASSESSMENT
This paper references to the BAF as follows:

- 33 Failure to produce adequate LTFM
- 40 Compliance with Prompt Payment Policy

RECOMMENDATION
The Board is asked to note the financial position for period ended May 2011.

Finance Report

May (Month 2) 2011-12

Summary

- The I&E position for May is a deficit of £1,019k compared to a planned position of £1,025K deficit.

Key Issues

- Elective Income £1m below plan YTD.
- Non-Elective activity 14% (£1.5m) above plan subject to £586k MRET adjustment (MRET plan £51k at M2).

Risks

- Non Elective pressures leading to inability to fully implement bed reduction plan (£0.1m impact) and reduction in elective activity.
- Cashflow likely to be an issue by end of Quarter 1.
- Unidentified CIP Gap of £2.2m (prior to contingency and mitigations).
- Business case to secure funding for Transformation / reorganisation costs to be approved by SHA.
- Adequacy of readmissions provision pending receipt of actual data.

1.0 Overview

I&E Position	£000's	
In-month I/E	(148)	£148k defict in May
Forecast YTD	500	£0.5m Forecast surplus (original)
Actual Year to date I/E	(1,019)	£1,019k deficit for year to date
FIMS Plan (Year to date)	(1,025)	£1.0m deficit for year to date
PCT SLA Income Variance	(441)	Below plan for YTD
Full Year I&E Forecast	500	Forecast I&E surplus

EBITDA Performance	£000's	
Trust	269FAV	£269k ahead of plan

Cost Improvement Schemes	£000's	
In month delivery	487	CIPs achieved in May
Year to date delivery	970	CIPs achieved to Year to date
Year to Go	16,830	CIPS to be delivered
Full Year Forecast	17,800	Including mitigating items

Directorate EBITDA Performance	£000's	
Medicine	(76)ADV	Variance to plan
Surgery	(688)ADV	Variance to plan
Anaesthesia	87FAV	Variance to plan
T&O	109FAV	Variance to plan
Head & Neck	(409)ADV	Variance to plan
O&G	240FAV	Variance to plan
Child Health	29FAV	Variance to plan
Pathology	(44)ADV	Variance to plan
Radiology	214FAV	Variance to plan
Oncology	(226)ADV	Variance to plan
Hospital support	414FAV	Variance to plan
Facilities	229FAV	Variance to plan
Other / Reserves	130FAV	Variance to plan

Capital	£000's	
Year to date expenditure	601	Capital expenditure for period
Forecast as % of plan	18%	18% of plan committed to date

SoFP (movement in year)	£000's	
Non-current assets	(144)	In-year depreciation plus Capex
Current assets	28	Reduction in cash offest by incr. in debtors
Current Liabilities	74	Reduction in creditors offset by accruals

Cash	£000's	
In month movement	(2,428)	Decrease over April
In Year movement	(2,745)	Decrease over March 2011
Debtors Balance > 30 days	1,413	Total outstanding over 30 days
BPPC (by volume) YTD	96%	Target 95% paid in 30 days

KPIs		
Financial Risk Rating (Shadow)	2	Surplus plan low
EBITDA	100.7%	101% achievement of plan
Liquidity (days cover)	16.4	Incl. unused WCF of £17m
Surplus Margin	-2.6%	Due to low level of surplus overall
Pay / Income	67.9%	Pay 68% of Income for YTD

SLA Income (Appendix 3)

- EL & Daycase income £1m below plan. NEL £1.5m above plan before MRET adjustment of £558k.
- OPROCS £473k above plan.

Other Clinical Income

- Private Patient Income £106k below plan. RTA / CRU income £68k above plan.

Income Generation

- £219k above plan due to new R&D allocation (£60k YTD) and drugs sales £106k above plan.

Pay Expenditure (Appendix 5)

- £319k below plan. Increased run rate in May due to additional pay week and TCS phase 1 costs.
- Victoria ward closed 16th June.

Non-Pay Expenditure (Appendix 7)

- £17k below plan for YTD. Drugs £169k above plan for YTD partly offset by sales to other NHS bodies (income).

CIP (See Transformation Update)

2.0 Executive Summary

Activity (Appendix 4)

- DC 14% below plan. EL 13% below plan. NEL 14 % above plan. OPROCS 135% above plan. WIP high.

Workforce (Appendix 5)

- 3992 WTE worked compared to budget of 4139 WTE. (Down 12 WTE on worked WTE Month 1).

Cashflow (Appendix 9)

- Cash balance reduced by £2,745k since 31st March. Increased NHS debtors due to £1m invoice for transformation programme costs and delays in payment for new TCS services

SoFP (Appendix 8)

- Net current assets increased by £0.5m.

Capital Expenditure (Appendix 12)

- Low level of expenditure for period to May with 18% of plan committed at month 2.

Shadow Monitor FRR (Appendix 13)

- Indicative score of 2 led by low EBITDA and YTD deficit.

Forecast

- The forecast I&E position remains to deliver the £0.5m control total surplus agreed with the SHA.

3.0 Conclusions & Actions

Conclusions

- 1 NEL pressures significant in April and May leading to bed pressures.
- 2 Underlying pay cost consistent with March
- 3 CIP delivery broadly on plan for identified schemes but £2.2m of schemes remain unidentified.

Actions

- 1 Plan to restore Elective & Daycase activity to plan to be developed and implemented by Directorates.
- 2 Formal Escalation of NEL activity position to PCT in accordance with provisions of contract.
- 3 Business Case to secure share of 2% Strategic Reserve to fund Transformation Programme and severance costs submitted and approved by PCT. SHA approval now required.
- 4 Actions to mitigate CIP gap to be progressed (see Transformation report).

Finance Report

Appendices

Year to Date

- £1,019k deficit compared to plan position of £1,025k giving rise to favourable variance to plan of £6k.
- EBITDA improvement achieves 101% of plan.

Current Month

- SLA income £46k below plan.
- Recovery in other clinical income (£38k adverse).
- Assumption that income will be received from PCT to fund costs of Transformation Programme. £850k accrued to date but subject to agreement with PCT.
- Additional R&D income accrued £60k YTD.
- Reduction in TCS overheads of £52k YTD.

Forecast

- £0.5m planned surplus required by year end.

Appendix 1 I&E Position

I&E Summary	Plan 2011/12 £000's	YTD Actual £000's	YTD Plan £000's	Variance to plan £000's		Forecast EOY
SLA Clinical Income	204,123	33,481	33,922	(441) Adv	1	204,123
Other Clinical Income	2,622	391	429	(38) Adv		2,622
Other Income	25,793	4,949	4,730	219 Fav		25,793
Total Income	**232,538**	**38,822**	**39,081**	**(260) Adv**		**232,538**
Pay Costs	(159,314)	(26,361)	(26,680)	319 Fav		(159,314)
Non-Pay Costs	(68,532)	(11,124)	(11,141)	17 Fav		(68,532)
CIPs	12,745	0	551	(551) Adv		12,745
Reserves	(2,268)	0	(483)	483 Fav		(2,268)
Total Costs	**(217,368)**	**(37,485)**	**(37,753)**	**269 Fav**	2	**(217,368)**
EBITDA	**15,170**	**1,337**	**1,328**	**9 Fav**		**15,170**
Depreciation	(10,550)	(1,666)	(1,666)	0 Fav		(10,550)
Amortisation	(10)	(2)	(2)	0 Fav		(10)
Impairment of Fixed Assets	0	0	0	-		0
Net Interest	40	3	7	(4) Adv		40
Dividend	(4,150)	(691)	(692)	1 Fav		(4,150)
Surplus / (Deficit)	**500**	**(1,019)**	**(1,025)**	**6 Fav**		**500**
Normalised	**0**	**0**	**0**	**-**		**0**

Notes

1. MRET adjustment £0.6m
2. Cost Run Rate below plan (incl. CIPs)

Income

•Income on plan in May.

Pay

- Run rate increased due to 5 weekly pay and addition of TCS Phase 1 Transfer (MiAMI & Danetre Ward).

Non-Pay

- Non-Pay run rate increasing in May but below plan.

Reserves

- No accruals made against reserves.

Capital Charges

- Depreciation estimated pending Q1 asset additions.

Appendix 1.1 I&E Run Rate

3 Month Run Rate £000's	March		April		May		Av. YTD
	Actual	Plan	Actual	Plan	Actual	Plan	
SLA Clinical Income	18,712	17,589	16,323	16,717	17,159	17,205	16,741
Other Clinical Income	404	247	149	214	241	215	195
Other Income	2,666	1,887	2,213	2,244	2,736	2,486	2,475
Total Income	**21,782**	**19,722**	**18,685**	**19,176**	**20,136**	**19,906**	**19,411**
Pay Costs	(12,978)	(12,489)	(12,993)	(13,304)	(13,368)	(13,376)	(13,180)
Non-Pay Costs	(6,565)	(5,055)	(5,384)	(5,314)	(5,740)	(5,827)	(5,562)
CIPs	-	165	-	258	-	292	-
Reserves	-	(257)	-	(242)	-	(242)	-
Total Costs	**(19,543)**	**(17,636)**	**(18,377)**	**(18,601)**	**(19,107)**	**(19,152)**	**(18,742)**
EBITDA	**2,240**	**2,086**	**308**	**574**	**1,029**	**753**	**669**
Depreciation	(800)	(837)	(833)	(833)	(833)	(833)	(833)
Amortisation	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Impairment of Fixed Assets	-	-	-	-	-	-	-
Net Interest	6	1	1	3	2	3	1
Dividend	(338)	(354)	(345)	(346)	(345)	(346)	(345)
Surplus / (Deficit)	**1,108**	**895**	**(870)**	**(602)**	**(148)**	**(423)**	**(509)**

Appendix 2 Directorate Performance

Trading Summary £	General Surgery		Anaes & CC		T & O		Head & Neck		Child Health		Obs & Gynae		General Medicine		Pathology		Radiology		Oncology		Hospital Support		Facilities	
	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var
	1																							
SLA Income	3,794	(589) Adv	1,444	72 Fav	3,494	236 Fav	2,872	(404) Adv	2,241	(111) Adv	4,258	158 Fav	9,394	245 Fav	1,042	(53) Adv	628	81 Fav	3,682	(203) Adv	0	(0) Adv	0	3 Fav
Other Clinical Income	29	(3) Adv	0	(0) Adv	143	46 Fav	9	(0) Adv	2	2 Fav	3	(13) Adv	137	25 Fav	20	(2) Adv	67	(9) Adv	8	(42) Adv	14	(1) Adv	0	-
Other Income	194	(1) Adv	162	4 Fav	95	(12) Adv	248	(18) Adv	142	1 Fav	125	(10) Adv	423	(1) Adv	272	(101) Adv	48	(2) Adv	229	18 Fav	2,180	195 Fav	620	67 Fav
Total Income	4,018	(594) Adv	1,606	76 Fav	3,732	269 Fav	3,128	(423) Adv	2,386	(108) Adv	4,386	136 Fav	9,953	270 Fav	1,335	(155) Adv	743	71 Fav	3,918	(226) Adv	2,194	194 Fav	620	70 Fav
Pay	(2,724)	(39) Adv	(1,729)	5 Fav	(1,708)	(20) Adv	(1,392)	(13) Adv	(1,910)	72 Fav	(2,613)	14 Fav	(6,000)	(92) Adv	(1,303)	105 Fav	(1,052)	50 Fav	(1,631)	(20) Adv	(2,920)	243 Fav	(1,379)	15 Fav
Non-Pay	(744)	(96) Adv	(234)	(20) Adv	(708)	(74) Adv	(553)	(2) Adv	(211)	28 Fav	(336)	(29) Adv	(1,486)	24 Fav	(1,134)	(37) Adv	(300)	45 Fav	(1,191)	57 Fav	(3,004)	(38) Adv	(1,211)	143 Fav
CIP's	0	-	0	-	0	-	0	-	0	-	0	-	0	(0) Adv	0	-	0	-	0	(14) Adv	0	(5) Adv	0	0 Fav
Reserves	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-
Indirect Costs	(381)	41 Fav	823	26 Fav	(793)	(67) Adv	(586)	29 Fav	90	37 Fav	(286)	120 Fav	(1,725)	(277) Adv	1,356	43 Fav	1,077	49 Fav	(180)	(22) Adv	421	20 Fav	184	1 Fav
Overheads	(852)	(0) Adv	(244)	(0) Adv	(614)	(0) Adv	(577)	(0) Adv	(427)	(0) Adv	(983)	(0) Adv	(1,433)	(0) Adv	(245)	(0) Adv	(304)	-	(418)	(0) Adv	4,086	0 Fav	2,010	0 Fav
Total Costs	(4,701)	(94) Adv	(1,385)	11 Fav	(3,823)	(161) Adv	(3,107)	14 Fav	(2,458)	137 Fav	(4,218)	104 Fav	(10,644)	(346) Adv	(1,325)	110 Fav	(579)	144 Fav	(3,420)	0 Fav	(1,417)	220 Fav	(396)	159 Fav
EBITDA	(683)	(688) Adv	221	87 Fav	(91)	109 Fav	21	(409) Adv	(72)	29 Fav	168	240 Fav	(691)	(76) Adv	10	(44) Adv	164	214 Fav	499	(226) Adv	777	414 Fav	224	229 Fav
EBITDA %	-17.0%		13.8%		-2.4%		0.7%		-3.0%		3.8%		-6.9%		0.7%		22.0%		12.7%		35.4%		36.1%	
Depreciation	(148)	0 Fav	(33)	3 Fav	(77)	(1) Adv	(65)	1 Fav	(60)	1 Fav	(106)	0 Fav	(258)	0 Fav	(79)	(1) Adv	(247)	(1) Adv	(228)	10 Fav	(338)	(0) Adv	(27)	(0) Adv
Amortisation	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-
Impairments	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-
Net Interest	0	(1) Adv	0	(0) Adv	0	(1) Adv	0	(0) Adv	0	(0) Adv	0	(1) Adv	1	(1) Adv	0	-	0	-	0	(0) Adv	0	-	0	-
Dividend	(64)	0 Fav	(12)	0 Fav	(56)	0 Fav	(64)	0 Fav	(46)	0 Fav	(52)	0 Fav	(137)	0 Fav	(85)	0 Fav	(81)	0 Fav	(88)	0 Fav	(4)	0 Fav	(2)	0 Fav
Surplus / (Deficit)	(896)	(688) Adv	176	90 Fav	(223)	107 Fav	(109)	(408) Adv	(177)	30 Fav	10	240 Fav	(1,085)	(77) Adv	(154)	(45) Adv	(164)	213 Fav	183	(216) Adv	434	414 Fav	194	229 Fav

SLA Income

- Daycase and EL income £1,044k below plan. NEL income £1.5m above plan but offset by £586k MRET adjustment.
- OPROCS £473k above plan for YTD.
- WIP £422k increase since March 11.

TCS

- Activity for MiAMI attendances to be verified with PCT. Income accrued to plan.

Provisions

- Readmissions accrued to plan £458k subject to validation process.
- New to follow outpatient provision of £298k subject to review of exclusions per SLA contract.
- Uncoded activity estimated at £129k

Estimated SLA Provisions £000's	April	May	YTD
Uncoded spells		-127	-127
Planned procedures not carried out	36	36	72
Orthotics			0
Contract Challenges	30	30	60
SUS to SLAM			0
Readmissions (30 days)	229	229	458
Casemix			0
New to Follow Up	155	143	298
Total Provisions	**450**	**311**	**761**
Contract Compliance	-23		-23
Net Total Provisions	**427**	**311**	**738**

Appendix 3 SLA Income

SLA Income by PoD £000's	Plan 2011-12	YTD Actual	YTD Plan	Variance to plan	%
Day Case	26,933	4,127	4,812	(685) Adv	(14.2%)
Elective Inpatients	18,175	2,938	3,297	(359) Adv	(10.9%)
Non Elective	66,988	12,331	10,787	1,544 Fav	14.3%
Outpatient First Attendances	12,851	1,719	2,103	(384) Adv	(18.3%)
Outpatient Follow Up Attendances	11,750	1,690	1,922	(232) Adv	(12.1%)
Outpatient First - NCL	1,657	248	297	(49) Adv	(16.5%)
Outpatient Follow Up - NCL	2,568	371	459	(88) Adv	(19.1%)
Outpatient Procedures	3,484	840	367	473 Fav	128.8%
A&E	6,469	1,196	1,081	115 Fav	10.6%
GP Direct Access Radiology	1,955	357	295	62 Fav	21.0%
Unbundled Chemotherapy PSD	2,171	333	327	6 Fav	1.7%
Pathology	5,296	875	885	(11) Adv	(1.2%)
Excluded Medicines	9,580	1,483	1,601	(118) Adv	(7.3%)
Audiology	867	145	145	-	
Critical Care & HDU	6,622	1,053	1,107	(54) Adv	(4.9%)
Childrens Services	7,133	1,189	1,189	-	
Community Midwives	3,579	597	597	-	
Radiotherapy	4,225	739	706	33 Fav	4.7%
Breast Screening	1,389	231	231	-	
Limb Centre	887	147	148	(1) Adv	(0.3%)
TCS	3,710	618	618	-	
Other Block Contracts	6,453	680	802	(122) Adv	(15.2%)
MRET	-51	-586	-9	(578) Adv	6734.8%
CQUIN	2,920	365	487	(122) Adv	(25.0%)
ARMD	898	139	135	4 Fav	3.0%
Other	-22	-24	265	(289) Adv	(109.0%)
Productivity CIP / Overperformance	427		71	(71) Adv	(100.0%)
Partially Completed Spells		422		422 Fav	100.0%
ACMF Provisions	-4,756	-738	-793	55 Fav	100.0%
Total SLA Clinical Income	**204,161**	**33,485**	**33,933**	**(449) Adv**	**(1.3%)**

SLA Activity

- Based on discharges to date
- Daycases 14% (22%) behind plan
- EL 13% (15%) behind plan
- NEL 14 % (16%) above plan.
- New and follow up Outpatients below plan
- OPROCS 135% above plan.

Appendix 4 Activity

Activity	Plan 2011-12	YTD Actual	YTD Plan	Variance to plan	%
Daycase	41,403	6,167	7,146	-979	-14%
Elective Inpatients	7,140	1,127	1,295	-168	-13%
Non Elective	39,769	7,357	6,443	914	14%
Cons New Outpatients	79,025	10,367	12,900	-2,533	-20%
Cons Follow Up Outpatients	127,645	18,252	20,676	-2,424	-12%
NCL New Outpatient	22,351	3,344	4,005	-661	-16%
NCL Follow up Outpatients	72,562	10,555	12,955	-2,400	-19%
Outpatient Procedures	22,437	5,725	2,433	3,292	135%
A&E Attendances	78,596	13,518	13,135	383	3%

Notes to Pay Expenditure

- £13.4m cost in May (£12.9m April).

Temporary Staffing

- £202k expenditure on Medical Locums in May.
- Agency Nursing increase of £240k in May.
- Bank Nurse costs reduced by £16k month on month.

Variances to Plan

- Substantive Nursing Qualified £872k favourable.
- Managerial Staff £217k favourable.
- Estates £34k adverse to plan.

Appendix 5 Pay Expenditure

Staff Group £000's	March		April		May		Av. YTD
	Actual	Plan	Actual	Plan	Actual	Plan	
Senior Medical Staff	2,198	2,233	2,213	2,313	2,201	2,310	2,207
Junior Medical Staff	1,218	1,299	1,180	1,304	1,169	1,304	1,175
Recharges Expenditure	33	30	34	27	36	27	35
Recharges Income	(171)	(87)	(120)	(74)	(103)	(74)	(111)
Medical Locums (Agency - Senior)	260	74	40	20	50	(5)	45
Medical Locums (Agency - Junior)	(109)	-	179	8	152	8	166
Total Medical Staff	**3,429**	**3,549**	**3,527**	**3,598**	**3,505**	**3,571**	**3,516**
Nursing Staff - Qualified (Band 5 +)	3,851	4,144	3,778	4,294	3,906	4,262	3,842
Nursing Staff Unqualified	636	723	697	753	691	753	694
Recharges Expenditure	-	-	-	-	-	-	-
Recharges Income	(205)	(68)	(63)	(81)	(81)	(81)	(72)
Bank Staff - Nursing	424	(0)	431	-	415	-	423
Agency Staff - Senior Nursing	306	-	72	-	147	-	110
Agency Staff - Junior Nursing	48	-	25	-	93	-	59
Total Nursing Staff	**5,060**	**4,799**	**4,940**	**4,965**	**5,171**	**4,933**	**5,055**
Managerial Staff	683	761	645	780	674	755	659
Salary Recharges - Managers	(1)	1	-	1	-	1	-
Recharges Expenditure - Managers	(2)	-	-	(3)	(4)	(3)	(2)
Recharges Income - Managers	(1)	1	1	1	1	1	1
Administration Staff	1,223	1,336	1,239	1,381	1,247	1,376	1,243
Recharges Expenditure - Admin. Staff	-	-	(0)	-	0	-	-
Recharges Income - Admin. Staff	(20)	(12)	(20)	(14)	(20)	(14)	(20)
Bank Staff - Admin	121	4	95	5	104	5	99
Agency Staff - Admin	6	1	17	-	(2)	-	8
Total Managerial & Admin	**2,008**	**2,092**	**1,977**	**2,151**	**2,000**	**2,122**	**1,988**
Other Clinical Staff	787	841	795	886	804	885	800
Scientific & Technical Staff	1,001	1,077	1,016	1,109	1,034	1,109	1,025
Estates Staff	72	70	91	79	102	79	96
All other Staff	554	597	594	654	691	759	643
Salary Recharges Expenditure - Other Staff	4	-	3	-	14	-	9
Salary Recharges Income - Other Staff	(49)	1	(47)	(38)	(58)	(38)	(53)
Agency Staff - Other	113	(92)	97	1	104	1	101
Total Other	**2,481**	**2,495**	**2,549**	**2,690**	**2,692**	**2,794**	**2,620**
CIPS	-	(404)	-	(23)	-	35	-
Additional Activity	-	-	-	-	-	-	-
Vacancy Factor	-	(42)	-	(78)	-	(78)	-
Total Cost Challenges	**-**	**(446)**	**-**	**(101)**	**-**	**(43)**	**-**
Total Pay Expenditure	**12,978**	**12,489**	**12,993**	**13,304**	**13,368**	**13,376**	**13,180**

Summary

•3992 WTE worked compared to budget of 4139 WTE. Contracted WTE total 3839 WTE.

Temporary Staffing April

•16 WTE Medical Locums.
•129 WTE Bank Nurses.
• 46 WTE Agency Nurses.

Variances from Plan (Worked v Budget)

• Junior Doctors 24WTE below plan
•Qualified Nurses 147 WTE below plan
•Managerial Staff 22WTE below plan
• Administration 78 WTE below plan offset by 60 WTE bank and agency staff.

Appendix 6 Workforce

Staff Type:	Worked Mth 12 WTE 2010/11	Worked Mth 1 WTE 2011/12	Worked Mth 2 WTE 2011/12	WTE Budget 2011/12 M1	Contracted Mth 2 WTE 2011/12
Senior Medical Staff	189.98	191.47	193.40	203.39	190.01
Junior Medical Staff	244.97	235.11	234.86	259.11	248.43
Salary Recharges Expenditure - Medical Staff	2.89	3.42	3.42	4.44	0.00
Salary Recharges Income - Medical Staff	0.00	-9.41	-8.75	-9.25	0.00
Medical Locums (Agency - Senior)	6.04	2.13	2.08	0.84	0.00
Medical Locums (Agency - Junior)	8.53	15.20	16.11	0.00	0.00
Total Medical Staff	**452.41**	**437.92**	**441.12**	**458.53**	**438.44**
Nursing Staff - Qualified (Band 5 +)	1111.66	1135.89	1151.73	1298.25	1192.73
Nursing Staff Unqualified	362.43	392.67	367.56	417.91	383.44
Salary Recharges Expenditure - Nursing Staff	0.00	0.00	0.00	0.00	0.00
Salary Recharges Income - Nursing Staff	-0.18	-20.89	-15.04	-19.91	0.00
Bank Staff - Nursing	144.62	137.62	129.45	0.00	7.80
Agency Staff - Senior Nursing	32.93	17.65	24.09	0.00	0.00
Agency Staff - Junior Nursing	17.79	13.12	21.55	0.00	0.00
Total Nursing Staff	**1669.25**	**1676.06**	**1679.34**	**1696.25**	**1583.97**
Managerial Staff	152.36	146.64	144.88	167.28	151.29
Salary Recharges Expenditure - Managers	0.00	0.00	0.00	0.00	0.00
Salary Recharges Income - Managers	0.00	0.00	-0.50	0.00	0.00
Agency Staff - Management	0.00	0.00	0.00	0.00	0.00
Administration Staff	644.96	650.97	650.35	728.07	689.44
Salary Recharges Expenditure - Admin Staff	0.00	0.00	0.00	0.00	0.00
Salary Recharges Income - Admin Staff	-1.00	-6.92	-4.63	-6.01	0.00
Bank Staff - Admin	76.81	60.62	60.57	0.60	0.00
Agency Staff - Admin	3.31	4.95	0.53	0.00	0.00
Total Managerial & Admin	**876.44**	**856.26**	**851.20**	**889.94**	**840.72**
Other Clinical Staff	238.05	240.93	241.45	277.05	240.96
Scientific & Technical Staff	355.72	360.41	358.99	384.43	377.65
Estates Staff	28.33	33.53	33.06	33.19	30.00
All other Staff	368.36	373.49	369.48	406.82	326.88
Salary Recharges Expenditure - Other Staff	0.50	0.50	0.00	0.00	0.00
Salary Recharges Income - Other Staff	0.00	-0.90	0.00	-2.72	0.00
Agency Staff - Other	28.41	25.86	17.81	0.00	0.00
Total Other	**1019.37**	**1033.82**	**1020.79**	**1098.77**	**975.49**
CIPS	0.00	0.00	0.00	-4.30	0.00
Additional Activity	0.00	0.00	0.00	0.00	0.00
Vacancy Factor	0.00	0.00	0.00	0.00	0.00
Total Cost Challenges	**0.00**	**0.00**	**0.00**	**-4.30**	**0.00**
Total Worked WTE	**4017.47**	**4004.06**	**3992.45**	**4139.19**	**3838.63**

Summary

•£17k favourable compared to plan, primarily due to costs of Transformation project. (External funding requested from PCT).

Clinical

• £204k adverse to plan mainly due to Medicines overspend £169k. (partly offset by income).

Non-Clinical

• £218k favourable variance against plan.

•Energy & Rates £67k and TCS overheads £52k underspent.

Other

•Bed replacement programme likely to impact later in the financial year.

Appendix 7 Non-Pay Expenditure

Non-Pay £000's	March		April		May	
	Actual	Plan	Actual	Plan	Actual	Plan
Clinical Non Pay - Fixed						
Equipment Hire	84	51	60	47	25	47
Equipment Maintenance	157	235	237	238	191	238
Clinical Non Pay - Fixed Total	**241**	**286**	**297**	**285**	**216**	**285**
Clinical Non Pay - Variable						
Prosthesis	183	137	132	95	133	106
Patient & Surgical Appliances	226	155	162	125	193	139
Patient Clothing & Travel	15	9	13	10	16	11
Lab Equipment Consumables	579	279	348	382	458	424
Blood	120	139	109	118	144	131
Medicines	1,811	1,571	1,492	1,405	1,648	1,566
Medical & Surgical Items	1,089	888	672	737	779	823
Dressings	70	52	67	46	64	51
Medical Gases	16	17	16	15	11	16
X-Ray Consumables	8	13	3	(0)	3	0
Clinical Non Pay - Variable Total	**4,117**	**3,259**	**3,013**	**2,932**	**3,449**	**3,269**
Clinical Non Pay - Total	**4,358**	**3,545**	**3,310**	**3,217**	**3,665**	**3,554**
Non Clinical Non Pay - Fixed						
Building & Engineering Equipment	386	195	230	276	189	276
Cleaning Equipment	47	35	54	37	41	37
Energy & Utilities	187	218	169	195	126	167
Rates	(180)	66	67	67	61	67
Printing & Stationery	117	44	67	51	63	49
Computer Equipment & Maintenance	94	96	105	111	105	111
Communications	74	56	53	59	67	57
Office Equipment	70	48	16	51	17	51
Non Pay CIP's	-	(274)	-	(39)	-	(15)
Other Fee's	128	86	51	50	70	49
Losses & Compensations	248	28	23	22	58	22
CNST	414	426	418	418	418	418
Consultancy Fee's	63	50	376	352	457	536
Training	117	66	45	70	41	70
Travel & Benefits	114	83	85	93	73	93
Staff Advertising	32	5	39	5	7	5
Non Clinical Non Pay - Fixed Total	**1,913**	**1,230**	**1,800**	**1,818**	**1,793**	**1,994**
Non Clinical Non Pay - Variable						
Patient Provisions	105	93	75	91	84	91
Patient Linen	90	74	83	77	81	77
Non Clinical Non Pay - Variable Total	195	167	158	169	165	169
Non Clinical Non Pay - Total	**2,108**	**1,397**	**1,958**	**1,987**	**1,958**	**2,162**
Expenditure SLAs:						
N PCT Services	55	50	63	57	63	57
NHT Transport	11	11	11	11	11	11
Library Facilities - Northamptonshire PCT	11	10	11	10	11	10
Two Shires - Ambulances	(8)	9	-	-	-	-
ECR	-	0	-	0	-	0
Oxford - Ambulances	-	-	-	-	-	-
Danetre Facilities	30	33	32	32	32	32
Sub-Total Non-Pay	**6,565**	**5,055**	**5,384**	**5,314**	**5,740**	**5,827**

Non Current Assets

- Increase of £606k due to revaluation and capital additions.
- Revaluation exercise to be undertaken in year by DV.

Current Assets

- Increase of £0.5m in month led by debtors increase (mainly NHS).

Current Liabilities

- Small Increase in liabilities due to accruals and PDC dividend.

Reserves

- IFRS adjustment removing Donation reserve.
- Update for TCS asset transfers awaited.

Appendix 8 Statement of Financial Position

	Balance at 31-Mar-11	Current Month Opening Balance	Current Month Closing Balance	Current Month Movement	Forecast end of year Closing Balance	Forecast end of year Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	133,062	133,062	133,062		133,062	
IN YEAR REVALUATIONS			829	829	977	977
IN YEAR MOVEMENTS		84	693	609	11,473	11,473
LESS DEPRECIATION		(834)	(1,666)	(832)	(10,560)	(10,560)
NET BOOK VALUE	**133,062**	**132,312**	**132,918**	**606**	**134,952**	**1,890**
CURRENT ASSETS						
INVENTORIES	4,555	4,541	4,623	82	4,562	7
RECEIVABLES						
NHS DEBTORS	4,812	4,360	6,247	1,887	4,812	
OTHER TRADE DEBTORS	1,295	1,056	1,081	25	1,295	
DEBTOR IMPAIRMENTS PROVISION	(166)	(166)	(166)		(166)	
CAPITAL RECEIVABLES	118	61	186	125	118	
NON NHS OTHER DEBTORS	345	394	629	235	345	
COMPENSATION DEBTORS (RTA)	2,483	2,446	2,528	82	2,483	
OTHER RECEIVABLES	817	563	863	300	817	
IRRECOVERABLE PROVISION	(253)	(254)	(254)		(253)	
PREPAYMENTS & ACCRUALS	686	1,529	1,728	199	686	
	10,137	**9,989**	**12,842**	**2,853**	**10,137**	
CASH	3,867	3,550	1,122	(2,428)	3,861	(6)
NET CURRENT ASSETS	**18,559**	**18,080**	**18,587**	**507**	**18,560**	**1**
CURRENT LIABILITIES						
NHS	4,177	3,571	3,512	59	4,180	(3)
TRADE CREDITORS REVENUE	3,528	2,726	2,958	(232)	3,580	(52)
TRADE CREDITORS FIXED ASSETS	2,401	1,310	470	840	2,401	
TAX AND NI OWED	3,275	3,359	3,443	(84)	3,275	
NHS PENSIONS AGENCY	1,831	1,741	1,780	(39)	1,831	
OTHER CREDITORS	301	318	444	(126)	301	
SHORT TERM LOANS	488	488	488		394	94
ACCRUALS AND DEFERRED INCOME	2,679	4,571	5,118	(547)	2,679	
PDC DIVIDEND DUE		329	674	(345)		
STAFF BENEFITS ACCRUAL	1,440	1,440	1,440		1,440	
PROVISIONS	380	274	247	27	380	
PROVISIONS over 1 year	310	310	310		310	
NET CURRENT LIABILITIES	**20,810**	**20,437**	**20,884**	**(447)**	**20,771**	**39**
TOTAL NET ASSETS	**130,811**	**129,955**	**130,621**	**666**	**132,741**	**1,930**
FINANCED BY						
PDC CAPITAL	99,635	99,635	99,635		100,088	453
REVALUATION RESERVE	28,713	28,713	29,542	829	29,690	977
DONATED ASSET RESERVE						
I & E ACCOUNT BALANCE	2463	2,463	2,463		2,463	
I & E CURRENT YEAR		-856	-1019	-435	500	500
FINANCING TOTAL	**130,811**	**129,955**	**130,621**	**394**	**132,741**	**1,930**

In month

- Reduction of £2.745m in cash balance since March.
- £2.6m payment of capital invoices.
- Creditors include £691k PDC accrual (PDC payable in Sep/Mar).
- £2.7m increase in debtors (mainly NHS).

Appendix 9 Cashflow

TRUST SUMMARY CASH FLOW STATEMENT MONTH 2 2011/12	Year to Date £000	Previous Year £000	Full Year Forecast £000
OPERATING ACTIVITIES			
EBITDA	1,336	14,739	15,170
NON CASH ADJUSTMENTS			
DONATED ASSET RESERVE MOVEMENTS	0	(654)	0
UNWINDING OF DISCOUNTS & RATE CHANGE		1	16
WORKING CAPITAL MOVEMENTS			
(INCREASE) / DECREASE IN INVENTORY	(36)	(563)	(7)
(INCREASE) / DECREASE IN RECEIVABLES	(2,705)	448	0
INCREASE / (DECREASE) IN CREDITORS	1,314	635	(39)
NET INFLOW	(123)	14,606	15,140
SERVICING OF FINANCE			
PDC DIVIDEND	0	(4,236)	(4,150)
INTEREST RECEIVABLE	3	36	16
INTEREST PAYABLE		0	0
NET FINANCING COSTS	3	(4,200)	(4,134)
CAPITAL EXPENDITURE			
PAYMENTS TO ACQUIRE FIXED ASSETS	2,625	8,891	11,465
BOOK VALUE OF ASSETS SOLD	0	0	
NET CAPITAL EXPENDITURE	2,625	8,891	11,465
NET CASH OUTFLOW BEFORE FINANCING	(2,745)	1,515	(459)
FINANCING			
PDC CAPITAL RECEIVED	0		453
PDC CAPITAL REPAID	0		0
FORMAL DoH LOAN REPAYMENT	0		0
CASH INFLOW FROM FINANCING	0		0
INCREASE (DECREASE) IN CASH	(2,745)	1,515	(6)

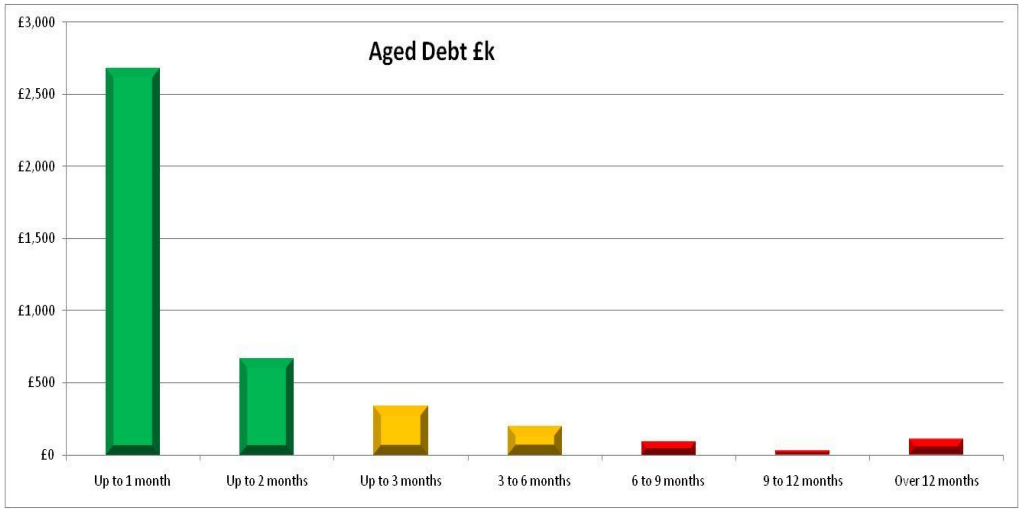
Appendix 10 Debtors

In month

- Increase of £1.9m in outstanding balances. £1m invoiced to NHSN for transformation programme support.

Problem Debtors

- CRIPPS (1 further payment received)
- Overseas Patient (provided in full at 10-11 year end)
- MKNHSFT – Oncology Services



Top 10 Debtors over £10k by value:	Description	Value £	Date due:
Cripps Social Club	SLA 10/11	84,148.00	11/04/2011
Patient K	Overseas Visitor	52,332.00	17/12/2010
Milton Keynes General Hospital	Oncology Services Oct-Dec 10	51,608.19	24/01/2011
Milton Keynes General Hospital	Oncology Services Jan-Mar 11	51,608.19	01/04/2011
Cripps Social Club	SLA Apr 09 to Sept 10	42,073.95	11/10/2010
Cripps Social Club	SLA Oct 09 - Mar 10	42,073.95	24/03/2010
BMI Three Shires	Pathology Tests Dec 10	33,035.84	22/03/2011
INHealth	PET Scans	24,685.87	25/04/2011
U H Health	Practice Educator recharge	24,094.00	16/04/2011
BMI Three Shires	Pathology Tests	21,395.61	16/04/2011

Top 10 Debtors over 2mths by age:	Description	Value £	Date due:
Cripps Social Club	SLA Apr 09 -Sept 09	42,073.95	11/10/2009
Cripps Social Club	SLA Oct 09 - Mar 09	42,073.95	24/03/2010
Patient K	Overseas visitor	52,332.00	17/12/2010
Milton Keynes General Hospital	Oncology services recharge	51,608.19	24/11/2011
NHS Northamptonshire	Medicines supplied	15,385.99	18/02/2011
Peterborough PCT	NCA Episodes Jan 11	11,873.00	22/03/2011
BM Three Shires	Pathology tests Dec 10	21,177.19	22/03/2011
BM Three Shires	Pathology tests Nov 10	33,035.84	22/03/2011
Milton Keynes General Hospital	Oncology services recharge	51,608.19	01/04/2011
Cripps Social Club	SLA 2010/11	84,148.00	11/04/2011

Aged Debtors	01.04.11 £'000	M1 £'000	M2 £'000	YTD Change £'000
Up to 1 month	1,604	1,097	2,675	1,071
Up to 2 months	210	523	664	454
Up to 3 months	280	100	336	56
3 to 6 months	249	202	194	-55
6 to 9 months	50	54	89	39
9 to 12 months	12	24	25	13
Over 12 months	146	146	105	-41
Total	**2,551**	**2,146**	**4,088**	**1,537**

Balances

- Reduction of £2.4m over March balance.

BPPC Compliance (95% target)

- Achieving target compliance with 96% by volume.
- Low level of NHS compliance

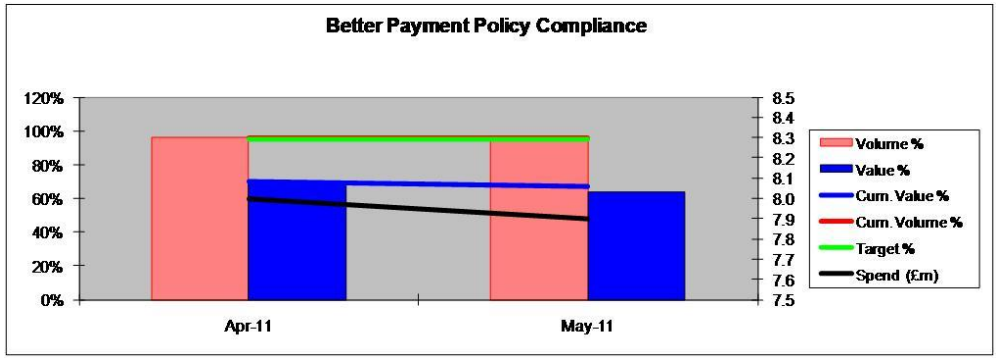
Top Ten Creditors by Invoice Value	Value £
NHS SUPPLY CHAIN	184,712
NORTHAMPTONSHIRE PROVIDER SERVICES NHS	177,858
NHS SUPPLY CHAIN	131,247
NHS SUPPLY CHAIN	128,304
NHS SUPPLY CHAIN	127,487
NHS BLOOD AND TRANSPLANT	120,411
NHS SUPPLY CHAIN	114,471
NHS SUPPLY CHAIN	111,780
NHS SUPPLY CHAIN	111,750
J TOMLINSON LIMITED	111,186

Top Ten Creditors by Account	Value £
NHS SUPPLY CHAIN	1,304,613
NHS BLOOD AND TRANSPLANT	365,698
NHS SUPPLY CHAIN	350,679
NORTHAMPTONSHIRE PROVIDER SERVICES NHS	289,652
NHSBSA PRESCRIPTION PRICING DIVISION	227,430
NHS NORTHAMPTONSHIRE	215,416
GILEAD SCIENCES LTD	167,746
ROCHE PRODUCTS LIMITED	160,831
SIEMENS PLC	138,399
NOVARTIS PHARMACEUTICALS UK LIMITED	133,628

Top Ten Creditors by Age of Invoice	Value £	Date due:
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	820	14/03/2010
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	1,709	14/03/2010
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	511	08/04/2010
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	1,629	19/06/2010
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	1,425	24/07/2010
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	1,629	29/08/2010
SIEMENS PLC	93,648	02/09/2010
AMO UK LTD	216	25/09/2010
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	87	07/10/2010
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	1,323	07/10/2010

Appendix 11 Creditors

Aged Creditors	01.04.10 £'000	NHS £'000	Trade £'000	Capital £'000	Total £'000
Up to 1 month	4,298	377	1,334	206	1,917
Up to 2 months	1,165	867	108		974
Up to 3 months	483	932	-6	0	926
Over 3 Months	790	473	20	-1	492
Total	**6,737**	**2,649**	**1,455**	**205**	**4,309**



	NHS			Non-NHS			Total		
	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%
Value £	780,147	2,781,746	28%	9,806,854	13,032,244	75%	10,587,001	15,813,990	67%
Volume	263	377	70%	9,636	9,985	97%	9,899	10,362	96%

Capital Schemes – notes

- Replacement Breast Screening mobile & trailer and static machine is final year of business case.
- Emergency Care and Mortuary schemes are currently being evaluated.
- Transformation Project approved digital dictation scheme, switchboard, E-fin / E-procurement update to date.
- The Macmillan scheme is due for completion in November, with Trust contribution due from October and go live January 2012.
- A TCS transfer relating to assets at Danetre is included at £473k and a CRL transfer will be agreed with the SHA .
- Plan includes a contingency of £739k. This will be flexed depending on the level of depreciation forecast for the year.
- Current EOY forecast is £12.439m (i.e. an underspend of £0.739m).
- Full year depreciation forecast is currently £10.550m, this includes what was previously donated element of £0.56m.

Appendix 12 Capital Expenditure

Category	Annual Budget 2011/12 £000's	Year to Date as at Month 2 Actual Spend £000's	Year to Date as at Month 2 Plan Achieved £000's	Year to Date as at Month 2 Actual Committed £000's	Year to Date as at Month 2 Plan Achieved £000's
Breast Screening Business Case	600	309	51%	492	82%
Emergency Care	500	0	0%	55	11%
Transformation Project	1,100	0	0%	0	0%
Mortuary Refurbishment	400	0	0%	0	0%
Macmillan (Trust)	450	0	0%	160	36%
Macmillan (Non Trust)	1,410	125	9%	1,405	100%
MESC	1,191	48	4%	207	17%
Estates	3,603	128	4%	673	19%
IT	2,541	105	4%	466	18%
Other	1,384	12	1%	69	5%
Total - Capital Plan	**13,178**	**726**	**6%**	**3,526**	**27%**
Less Charitable Funds	-1,510	-125	8%	-1,405	93%
Total - CRL	**11,669**	**601**	**5%**	**2,121**	**18%**

Notes to YTD Score

- Overall Score of 2 May (2in April).
- Low EBITDA (3.4%) achievement reducing a score overall.
- ROA score driven by YTD deficit.
- Deficit gives rise to a score of 1 for surplus Margin.
- Liquidity days cover includes £17m working capital facility.
- Overriding rules may apply.
- Note: Monitor review on a quarterly basis.

Appendix 13 Shadow Monitor Financial Risk Rating

Financial Criteria	Metric	Weight %	May	Shadow Rating	YTD Score
Achievement of Plan	EBITDA Achieved (% of plan)	10%	101%	5	0.50
Underlying Performance	EBITDA Margin %	25%	3.4%	2	0.50
Financial Efficiency	Return on Assets	20%	-0.25%	2	0.40
Financial Efficiency	I&E Surplus Margin	20%	-2.6%	1	0.20
Liquidity	Liquidity Ratio (Days cover)	25%	16.41	3	0.75
Weighted Average		100%			2

	< Good >		Score	< Bad >	
Metric	5	4	3	2	1
EBITDA Achieved (% of plan)	100	85	70	50	<50
EBITDA Margin %	11	9	5	1	<1
Return on Assets	6	5	3	-2	<-2
I&E Surplus Margin	3	2	1	-2	<-2
Liquidity Ratio (Days cover)	60	25	15	10	<10

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title	HR REPORT
Submitted by	Chanelle Wilkinson Director of HR & Organisational Development
Date of meeting	29 June 2011
Corporate Objectives Addressed	Objective 5

SUMMARY OF CRITICAL POINTS

This is the monthly HR report for June 2011and focuses on the following topics:-

- HR Update – Back Office Review
- E-Rostering Update
- Return to Work Monitoring
- HR Caseload Activity
- Workforce Trends – Key Performance Indicators

PATIENT IMPACT - All

STAFF IMPACT - All

FINANCIAL IMPACT- Potential

EQUALITY AND DIVERSITY IMPACT - None

LEGAL IMPLICATIONS - None

RISK ASSESSMENT - : Managing workforce risk is a key part of the Trust's risk assessment programme.

RECOMMENDATION
The Board is asked to note the contents of this report.

1. HR DIRECTORATE UPDATE

This report provides a brief overview of the return to work monitoring between December 2011 and April 2011 and an update on the HR caseload activity undertaken in May 2011. In addition, the report provides an update on the e-rostering project and a summary of the Trust's HR Key Performance Indicators for April 2011.

Furthermore, a Back Office Review of the HR functions commenced in May 2011 and a data collection exercise has been carried out. Ernst and Young are in the process of using the information collected from the HR teams to analyse and compare with data collected from other organisations. In addition, a 'Voice of the Customer' survey on the department has been distributed to among others, Directorate Managers, Executives and Clinical Directors for comments. An initial presentation of the findings took place on 17 June 2011.

2. E-ROSTERING UPDATE

The e-rostering project remains on schedule and to date there are 897 nurses and HCAs rostered on the system, with a further 511 non-clinical staff also rostered. In total, this represents 20 wards and 29 departments live and inter-facing with ESR.

There are 13 wards and 2 departments using employee on-line which means that they can enter work and annual leave requests onto the system for authorisation by their manager.

It is anticipated that the Trinity bank system which is integral to the e-rostering system will go live in November 2011. The implementation meetings will commence on 29 June 2011 with a view to start the planning process for this integration.

3. RETURN TO WORK MONITORING

The table below summarises the results by directorate of the percentage number of return to work interviews completed against the number of staff who were recorded as having been off work and returned between the months of December 2010 and April 2011 due to sickness absence.

Directorate	Dec 2010 (%)	Jan 2011 (%)	Feb 2011 (%)	March 2011 (%)	April 2011 (%)
Medicine	54.6%	76%	62.2%	64.4%	79.8%
Surgery	81%	94%	88%	86%	93%
Anaesthetics	84%	81%	72%	93%	71%
T&O	91.8%	80.8%	81%	100%	87.5%
Head & Neck	97.6%	95.7%	100%	77%	93.75%
Child Health	37%	40%	63%	39%	85%
Obs & Gynae	65%	72%	83%	68%	68%
Oncology	25%	59%	58%	28.6%	49%
Pathology	85%	87%	93%	94%	83%
Radiology	100%	82%	100%	83%	100%
Pharmacy	94%	94%	100%	100%	100%

Therapies	100%	100%	100%	100%	100%
Facilities	90%	68%	90%	94%	87%
Hospital Support	76%	87%	66%	81%	61%

There has been significant improvement this month in the percentage numbers of return to work interviews held in Child Health, with Surgery, Head and Neck and Medicine also showing improvements. Although Oncology figures have increased from 28.6% to 49% work continues in the directorate to make further improvements.

The areas where there has been deterioration include Hospital Support, Anaesthetics and Trauma and Orthopaedics. Investigations will be carried out by the HR Business Partners and where necessary escalated to the Directorate Managers or relevant Heads of Department.

In addition, to put the return to work percentages into perspective, the table below breaks down the numbers of staff off sick during the months of March 2011 and April 2011 and the numbers of staff who received a return to work interview.

Directorate	March 2011 (%)	Numbers of staff off sick in March 2011	Numbers of Return to work interviews carried out in March	April 2011 (%)	Numbers of staff off sick in April 2011	Numbers of Return to work interviews carried out in April
Medicine	64.4%	160	103	79.8%	119	95
Surgery	86%	57	49	93%	43	40
Anaesthetics	93%	14	13	71%	7	5
T&O	100%	56	56	87.5%	40	35
Head & Neck	77%	22	17	93.75%	16	15
Child Health	39%	46	18	85%	20	17
Obs & Gynae	68%	57	39	68%	56	38
Oncology	28.6%	49	14	49%	14	6
Pathology	94%	33	31	83%	30	25
Radiology	83%	18	15	100%	4	4
Pharmacy	100%	15	15	100%	8	8
Therapies	100%	19	19	100%	11	11
Facilities Hospital Support	94% 81%	47 68	44 55	87% 61%	44 46	27 40

4. HR CASEWORK

The table below identifies the active formal HR case work across the Trust up to the end of May 2011.

Type	Open Cases February 2011	Open Cases March 2011	Open Cases April 2011	Open Cases May 2011
Capability	5	6	8	11
Conduct	15	17	20	20
Harassment	5			

& Bullying Grievances		6	7	4
Grievances other than Harassment and Bullying	7	7	0	2
Sickness	66	55	48	56
Employment Tribunals	2	2	1	2
Suspension	2	2	2	3
Other	13	10	10	10
TOTAL	**115**	**105**	**96**	**108**

The table above shows that during the month of May 2011 there has been an increase in the number of capability cases. This is as a result of the HR Business Partner in Medicine actively working with managers on performance issues within the directorate.

A number of harassment and bullying cases have been resolved this month including those that were being dealt with in accordance with the Dignity at Work Policy. It must be noted that the Dignity at Work Policy is no longer in operation as this month the Trust's Harassment and Bullying Policy and the Grievance Procedure have been approved and are now on the intranet. These policies and procedures are now the mechanism for dealing with harassment and bullying cases.

The 'other' category which largely equates to organisational change does not reflect the work that is being carried out in relation to transformation.

5. WORKFORCE TRENDS – Key Performance Indicators (KPIs)

This section of the report identifies the key themes emerging from the Human Resources KPI report for April 2011 and identifies trends against Trust targets. A summary of the key actions taken to meet targets is as follows:

NHS Information Centre Sickness Absence Benchmarks

The NHS Information Centre for Health and Social Care sickness absence statistics are produced quarterly so that NHS organisations can identify appropriate benchmarks for sickness absence within their own Trusts.

The most recent publication (Table 1) relates to sickness absence over the 3 month period of October to Dec 2010***** and shows sickness absence rates by National, Regional and Acute Trusts.

The table shows that Northampton General Hospital's average for this period was below both the National and Regional average sickness absence rates and fared well against other Acute Trusts in the region.

Table 1	**Oct 2010**	**Nov 2010**	**Dec 2010**	****Oct-Dec 2010 Average**
National	**4.20%**	**4.37%**	**4.83%**	**4.47%**

East Midlands Region	**4.42%**	**4.58%**	**5.07%**	**4.69%**
Acute Trusts	**3.92%**	**4.07%**	**4.54%**	**4.18%**
Derby Hospitals NHS Foundation Trust	4.25%	4.36%	4.69%	4.43%
Kettering General Hospital NHS Foundation Trust	3.67%	4.19%	4.20%	4.02%
Leicestershire Partnership NHS Trust	5.30%	5.71%	6.12%	5.71%
Lincolnshire Partnership NHS Foundation Trust	4.55%	4.83%	5.31%	4.89%
Lincolnshire Teaching PCT	4.96%	4.95%	5.34%	5.08%
Northampton General Hospital NHS Trust	**3.76%**	**4.29%**	**5.11%**	**4.38%**
Northamptonshire Healthcare NHS Foundation Trust	5.33%	5.52%	4.76%	5.20%
Northamptonshire Teaching PCT	4.46%	5.04%	4.94%	4.81%
Nottingham City PCT	4.27%	3.79%	4.31%	4.12%
Nottingham University Hospitals NHS Trust	3.99%	4.11%	4.57%	4.22%
Nottinghamshire County Teaching PCT	4.57%	4.75%	5.74%	5.02%
Nottinghamshire Healthcare NHS Trust	5.43%	5.38%	6.08%	5.63%
Sherwood Forest Hospitals NHS Foundation Trust	4.67%	4.60%	4.69%	4.65%
United Lincolnshire Hospitals NHS Trust	5.15%	5.21%	5.50%	5.29%
University Hospitals of Leicester NHST	3.66%	3.77%	4.50%	3.98%

***Source:** NHS Information Centre for Health and Social Care – Processed using data taken from the Electronic Staff Record (ESR) Data Warehouse.

****The average sickness absence rate is calculated as an average rate for the 3 month period.

Please note: When comparing Table 1 data to the Trust's sickness absence data in Appendix A any variance is due to the timing of reporting.

Total Trust Sickness Absence – April 2011 - Appendix A and B

For the fourth consecutive month the total sickness absence rate for all staff has decreased falling from 3.71% in March 2011 to 3.58% in April 2011. Short term sickness absence continues to decrease falling from 2.02% in March 2011 to 1.86% in April. Long term sickness absence has increased slightly by 0.03% in April 2011, accounting for 1.72% of the total sickness absence. Ward based sickness absence for Band 5 and above has decreased by 0.66% to 4.49%.

The year on year comparison of the Directorate's total sickness absence (appendix B) shows that for 2010/11 it has remained consistently lower in than the previous year and for 2011/12 to date, it continues to be lower than the previous year standing 0.08% above Trust target.

Total Sickness Absence by Directorate – April 2011

Table 2 below shows total sickness absence rates by Directorate between February 2011 and April 2011. The table provides evidence that for April 2011, there were decreases within 9 Directorates.

The most significant decrease within the 3 month period was 2.57% within Anaesthetics.

Table 2

Directorate	Total Sickness Absence February 2011 (%)	Total Sickness Absence March 2011 (%)	Total Sickness Absence April 2011 (%)
Medicine	4.85	4.31	4.06
Surgery	3.09	2.65	3.84
Anaesthetics	4.80	3.32	2.23
T&O	3.71	5.14	5.10
Head & Neck	4.41	4.21	2.91
Child Health	3.53	3.57	4.19
Obs & Gynae	3.98	3.95	4.47
Oncology	4.32	3.72	2.23
Pathology	4.51	3.11	2.77
Radiology	2.68	2.65	1.34
Pharmacy	1.70	1.86	1.97
Therapies	2.54	3.22	2.45
Facilities	4.69	4.52	4.53
Hospital Supp.	3.52	3.00	2.55

The HR Business Partners continue to target areas of concern and the summary in the section below provides more detail of the reasons for concern and the actions that have or will be taken**.**

Summary by Directorates – April 2011

Short term and long term sickness absence is measured separately. Please note that the summary below has taken into account the information in both Table 2 and Table 3 and for the purpose of this section of the report, ward sickness absence includes all staff working in ward areas.

Table 3

Directorate	Short Term March 2011 (%)	Short Term April 2011 (%)	Long Term March 2011 (%)	Long Term April 2011 (%)
Medicine	2.52	2.20	1.79	1.86
Surgery	1.87	2.34	0.78	1.50
Anaesthetics	2.34	1.27	0.98	0.96
T&O	3.29	2.94	1.85	2.16
Head & Neck	2.44	1.74	1.77	1.17
Child Health	1.74	2.09	1.83	2.10
Obs & Gynae	1.03	1.92	2.92	2.55
Oncology	1.93	1.10	1.79	1.13
Pathology	1.41	1.55	1.70	1.22
Radiology	1.03	0.58	1.62	0.76
Pharmacy	1.06	1.16	0.80	0.81
Therapies	3.22	0.94	0.00	1.51
Facilities	1.93	1.56	2.59	2.97
Hospital Supp.	2.01	1.54	0.99	1.01

Key Points to note from the Sickness Absence Reports

Sickness absence data continues to improve and has become more reliable through ESR and national data collection by the NHS Information Centre for Health and Social Care. The challenge for line managers with the HR Business Partners is to use the data to tackle sickness absence and improve health and wellbeing.

In line with the NHS Information Centre for Health and Social Care sickness absence reporting, the percentage of sickness absence by staff group is shown in Table 4 below.

Table 4

Staff Group	Total Sickness Absence February 2011 (%)	Total Sickness Absence March 2011 (%)	Total Sickness Absence April 2011 (%)
Prof. Scientific & Technical	1.50%	1.65%	2.29%
Additional Clinical Services	5.45%	4.20%	5.46%
Admin. & Clerical	4.30%	3.53%	3.20%
Allied Health Professionals	2.95%	1.82%	1.63%
Estates & Ancillary	4.74%	4.48%	4.60%
Healthcare Scientists	0.70%	2.00%	0.52%
Medical & Dental	2.19%	3.04%	1.83%
Nursing & Midwifery Registered	4.18%	4.19%	3.62%

Staff Turnover April 2011 – Appendix C

The cumulative staff turnover rate (leavers) decreased from March 2011 to April 2011 from 7.41% to 7.33%.

The internal turnover rate has increased slightly from 19.65% in March 2011 to 21.87% in April 2011. The significant increase in the cumulative internal turnover rate continues to remain as a result of the high number of staff being moved or allocated to new cost codes within ESR.

Turnover by Directorates April 2011 – Appendix D

Table 4 below details the actual turnover rate (Headcount %) for April 2011 by Directorate.

Table 4

Directorate	Feb 11 (%)	Mar 11 (%)	Apr 11 (%)
Medicine	6.55	5.52	5.05
Surgery	7.96	7.44	7.62
Anaesthetics	3.45	3.42	4.73
T&O	8.16	6.05	5.40
Head & Neck	9.15	9.03	9.03

Child Health	8.42	7.80	8.78
Obs & Gynae	7.91	7.80	8.14
Oncology	9.17	8.40	8.75
Pathology	11.43	11.90	11.43
Radiology	4.76	4.67	5.33
Therapies	10.00	10.96	10.81
Facilities	9.70	9.42	9.01
Pharmacy	5.45	5.50	3.70
Hospital Support	12.50	12.47	11.90
Trust Total	**8.28**	**7.77**	**7.67**

*Please note the formula for staff turnover is the number of leavers in the year divided by average total staff in the year.

Number of Staff in Post - April 2011

The number of staff in post, excluding bank staff, has increased from 4,435 in March 2011 to 4,496 in April 2011. This figure is based on the number of staff with primary posts.

Full Time Equivalents April 2011 - Appendix E

The workforce full time equivalents increased from 3,723 in March 2011 to 3,763 in April 2011.

Temporary Staffing Costs April 2011- Appendices F and G

Bank expenditure for April 2011 was £525,369, a decrease of £19,674 on the previous month. Nursing and administrative & clerical agency expenditure has also decreased; expenditure for April 2011 was £114,287, an decrease of £245,052 on the previous month. The combined bank and agency spend for both staff groups in April 2011 decrease by £264,726 on the previous month.

The total agency expenditure (to include medical locums) for April 2011, was £432,228, a decrease of £190,059 on the previous month.

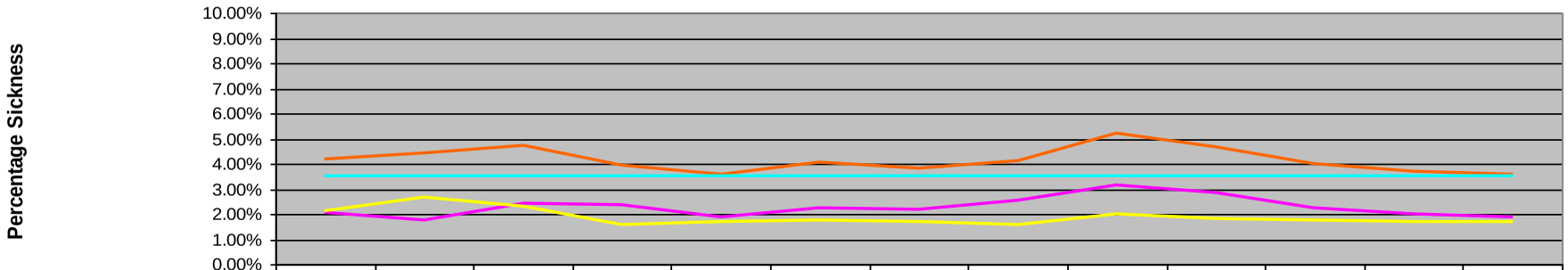
In April 2011 the total number of bookings received decreased by 1,767 compared with the previous month. The bank shift fill rate for April 2011 was 86% which continues to be above the Trust target of 80%. In total 5,509 bookings were received, 3,824 were filled by bank and 906 were filled by agency. The number of agency filled bookings has decreased by 380 compared with the previous month.

The total temporary workforce costs as a percentage of total workforce costs has reduced from 6.21% in March 2011 to 5.15% in April 2011, comprising of Nursing 3.16%, Medical Locums 1.32% and Admin and Clerical 0.67%.

Chanelle Wilkinson
Director of Human Resources
June 2011

Appendix A

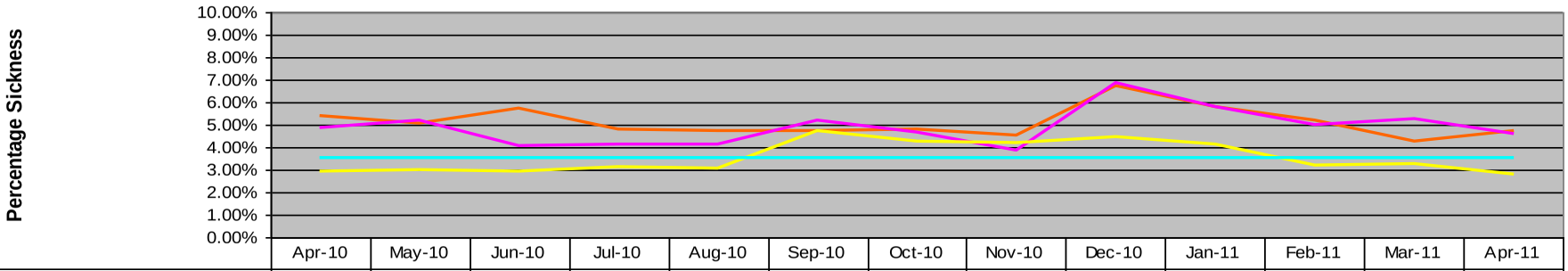
Trust Actual Sickness Absence Rate April 2010 - April 2011



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11
All Staff	4.18%	4.40%	4.74%	3.96%	3.55%	4.04%	3.81%	4.13%	5.20%	4.67%	3.99%	3.71%	3.58%
All Staff - Short Term	2.05%	1.73%	2.45%	2.38%	1.87%	2.27%	2.16%	2.53%	3.18%	2.83%	2.25%	2.02%	1.86%
All Staff - Long Term	2.13%	2.67%	2.29%	1.59%	1.69%	1.78%	1.68%	1.60%	2.02%	1.84%	1.74%	1.69%	1.72%
Trust Target	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%

CIPD Annual Absence Management Survey 2009 Quotes Public Sector Sickness rate at an average of 9.7 days per employee
Sickness Absence is calculated by the Proportion of the FTE Days Lost to Sickness expressed as a %

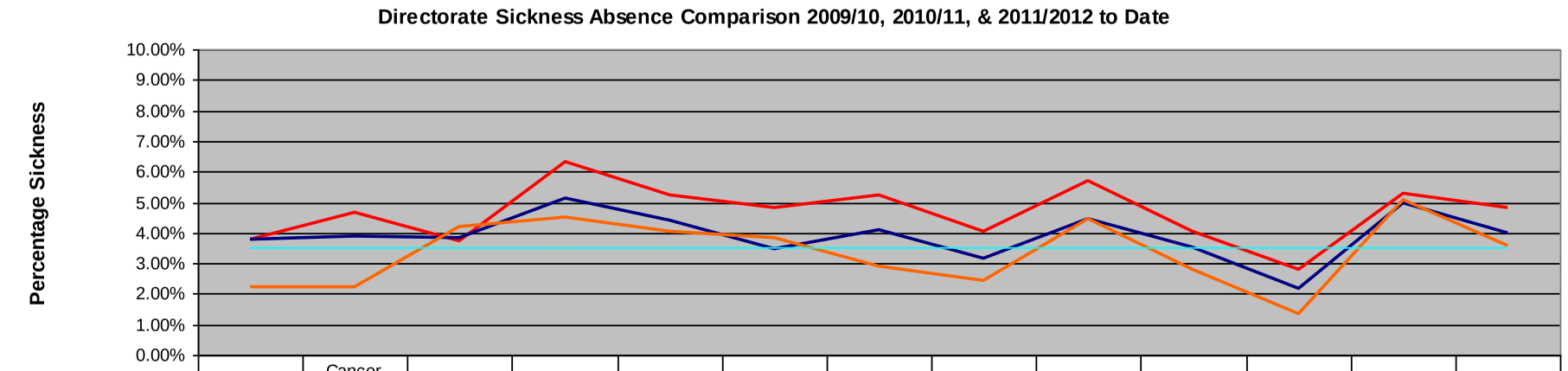
Trust Actual Sickness Absence Rate April 2010 - April 2011



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11
Bands 1 - 4	5.42%	5.06%	5.72%	4.80%	4.76%	4.74%	4.82%	4.55%	6.71%	5.82%	5.22%	4.30%	4.72%
Ward Staff - Band 5 & Above only	4.88%	5.23%	4.07%	4.14%	4.16%	5.20%	4.67%	3.89%	6.85%	5.77%	4.99%	5.25%	4.59%
All Staff - Band 5 & Above only	2.94%	3.03%	2.97%	3.15%	3.06%	4.71%	4.25%	4.17%	4.49%	4.12%	3.18%	3.30%	2.77%
Trust Target	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%

CIPD Annual Absence Management Survey 2009 Quotes Public Sector Sickness rate at an average of 9.7 days per employee
Sickness Absence is calculated by the Proportion of the FTE Days Lost to Sickness expressed as a %

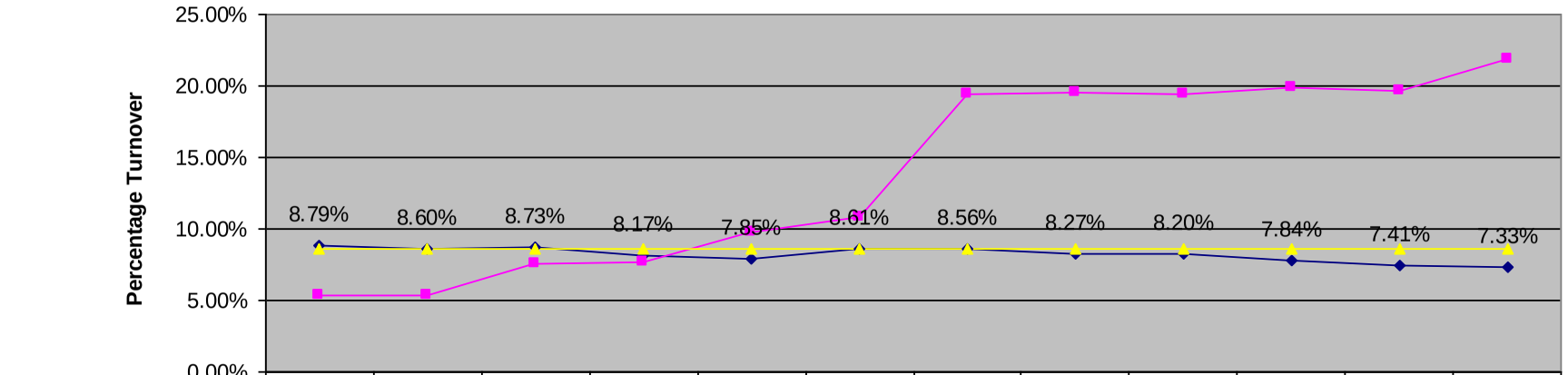
Appendix B



	Anaes & CC	Cancer Services	Child Health	Facilities	Gen Med	Gen Surg	Head & Neck	Hosp Supp	Obs & Gyn	Pathology	Radiology	T&O	NGH
2009/10	3.80%	4.66%	3.75%	6.32%	5.22%	4.84%	5.26%	4.03%	5.69%	4.05%	2.78%	5.26%	4.79%
2010/11	3.80%	3.88%	3.86%	5.14%	4.38%	3.48%	4.10%	3.18%	4.44%	3.50%	2.16%	4.97%	3.99%
2011/2012 to date	2.23%	2.23%	4.19%	4.53%	4.06%	3.83%	2.91%	2.43%	4.47%	2.78%	1.35%	5.10%	3.58%
Target	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%

Sickness Absence is Calculated by the Proportion of the FTE Days Lost to Sickness expressed as a %
Figures shown for Financial Year 09/10 and Financial Year 10/11 to Date

Appendix C



	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11
Staff turnover*	8.79%	8.60%	8.73%	8.17%	7.85%	8.61%	8.56%	8.27%	8.20%	7.84%	7.41%	7.33%
Internal Turnover**	5.30%	5.30%	7.59%	7.71%	9.72%	10.81%	19.46%	19.55%	19.37%	19.93%	19.65%	21.87%
Public Sector Avg***	8.60%	8.60%	8.60%	8.60%	8.60%	8.60%	8.60%	8.60%	8.60%	8.60%	8.60%	8.60%

Staff Turnover is calculated as the total number of people leaving the Trust divided by the average number of Staff in Post over a 12 month period
**** Internal Turnover is calculated as the total number of staff transfers internal divided by the average number of Staff in Post over a 12 month period**
***** Public Sector Information taken from the CIPD Annual Survey Report 2010**

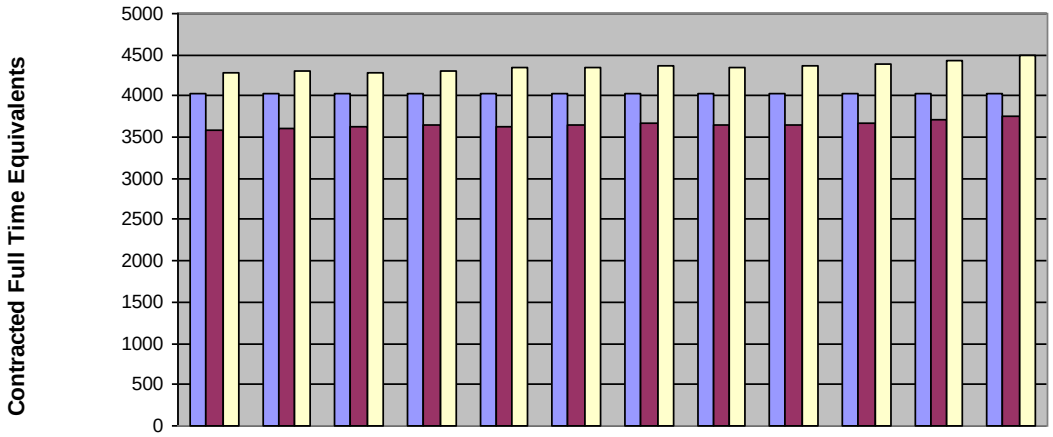
Appendix D

Summary of Turnover (Leavers) by Directorate (Permanent Positions, Cumulative over 12 Months)

Turnover (Leavers) (Permanent positions, Cumulative over 12 Months)	**Headcount** (Av. over 12 Months)	**FTE** (Av. over 12 Months)	**Starters** (Headcount)	**Starters** (FTE)	**Leavers** (Headcount)	**Leavers** (FTE)	**LTR** (Headcount %)	**LTR** (FTE %)
Medicine	832	662.11	150	121.87	42	30.79	5.05%	**4.65%**
Surgery	407	341.86	50	38.53	31	26.15	7.62%	**7.65%**
Anaesthetics	148	129.82	18	17.23	7	5.59	4.73%	**4.30%**
Trauma & Orthopaedic	278	233.34	36	28.91	15	11.11	5.40%	**4.76%**
Head & Neck	144	121.13	8	5.36	13	11.07	9.03%	**9.14%**
Child Health	296	231.84	20	15.30	26	18.67	8.78%	**8.05%**
Obs & Gynae	442	348.25	63	44.87	36	26.56	8.14%	**7.63%**
Oncology	240	202.16	15	11.60	21	15.97	8.75%	**7.90%**
Pathology	210	175.15	17	16.07	24	17.89	11.43%	**10.21%**
Radiology	150	127.66	5	4.20	8	6.59	5.33%	**5.16%**
Therapies	74	63.52	7	6.48	8	7.72	10.81%	**12.16%**
Facilities	333	281.17	29	21.91	30	24.35	9.01%	**8.66%**
Pharmacy	108	89.47	9	8.31	4	2.53	3.70%	**2.83%**
Hospital Support	378	321.04	30	24.82	45	39.03	11.90%	**12.16%**

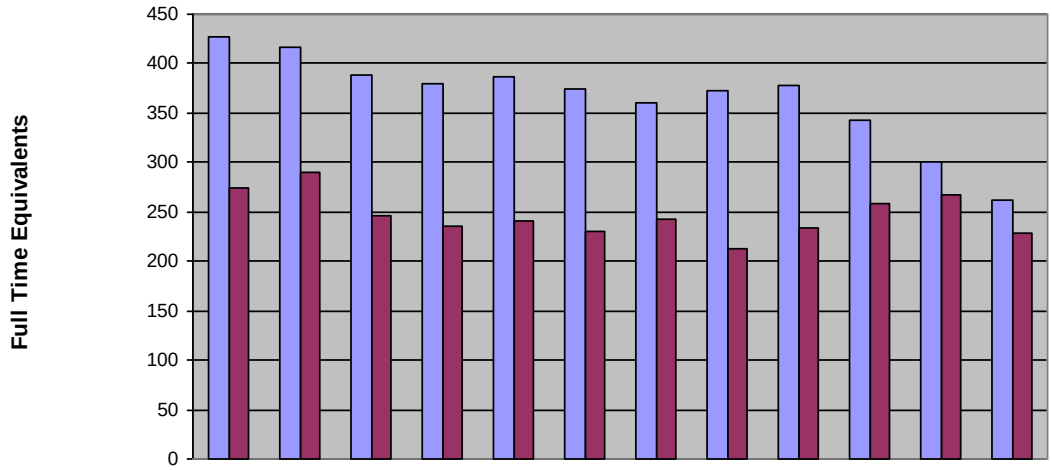
Appendix E

Comparison - Funded Establishment versus Contracted Full Time Equivalents
May 2010 - April 2011



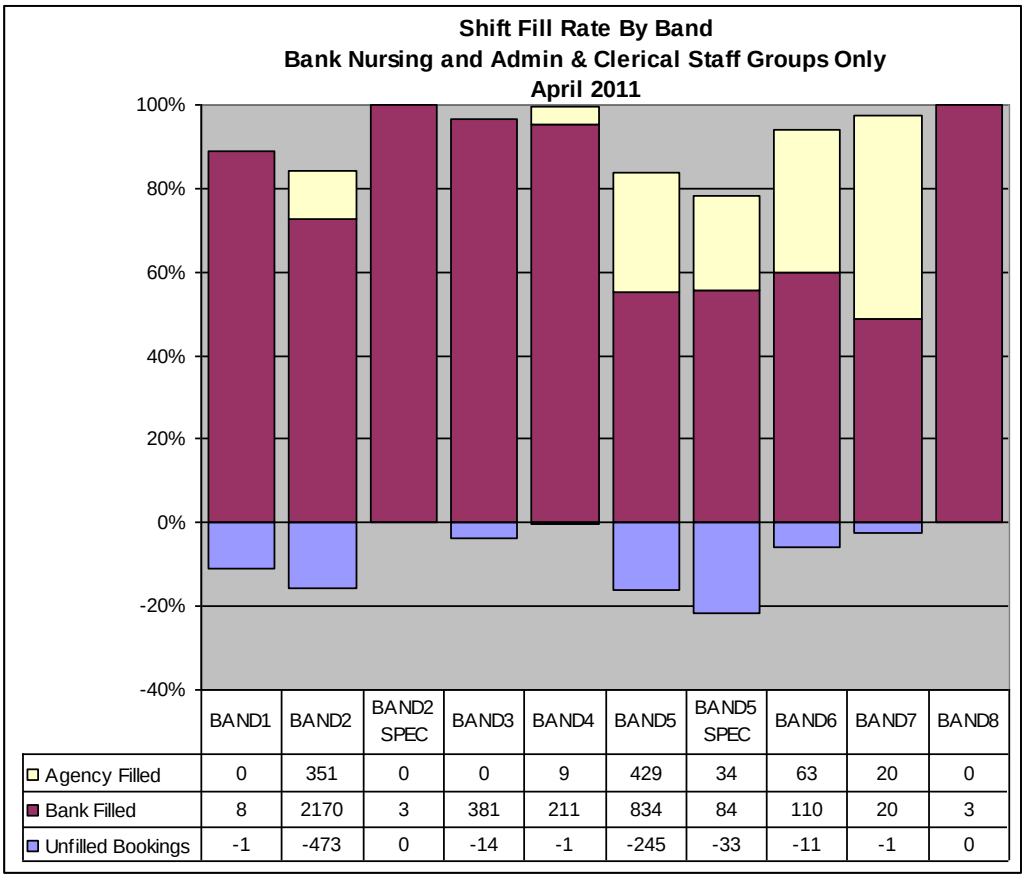
	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11
Funded Full Time Equivalent	4024	4024	4024	4024	4024	4024	4024	4024	4024	4024	4024	4024
Actual Full Time Equivalent	3597	3608	3636	3644	3637	3650	3664	3652	3647	3681	3723	3763
Headcount	4293	4310	4285	4295	4338	4351	4365	4353	4358	4393	4435	4496

Comparison - Vacancy Levels versus Bank & Agency Use
May 2010 - April 2011



	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11
Vacancy Full Time Equivalent	427	416	388	380	387	374	360	372	377	343	301	261
Bank & Agency Full Time Equivalent	275	290	246	235	241	231	242	213	233	258	268	228

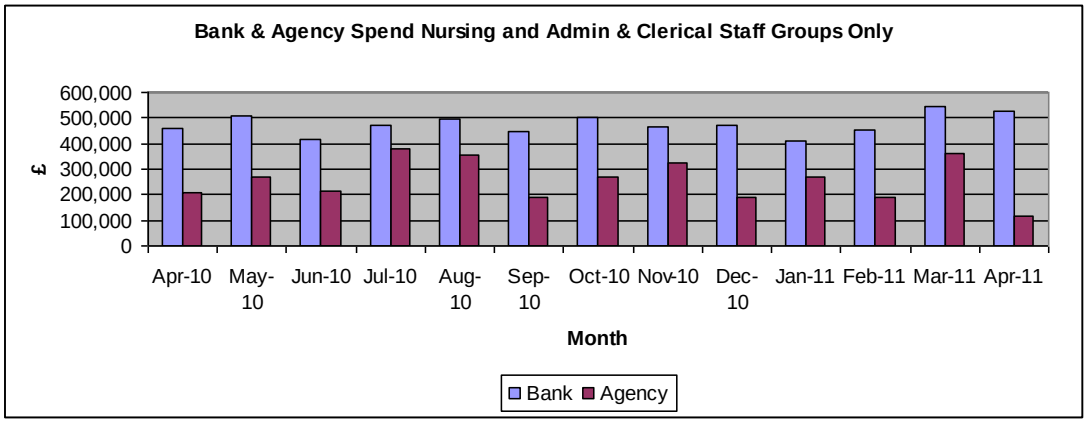
Appendix F

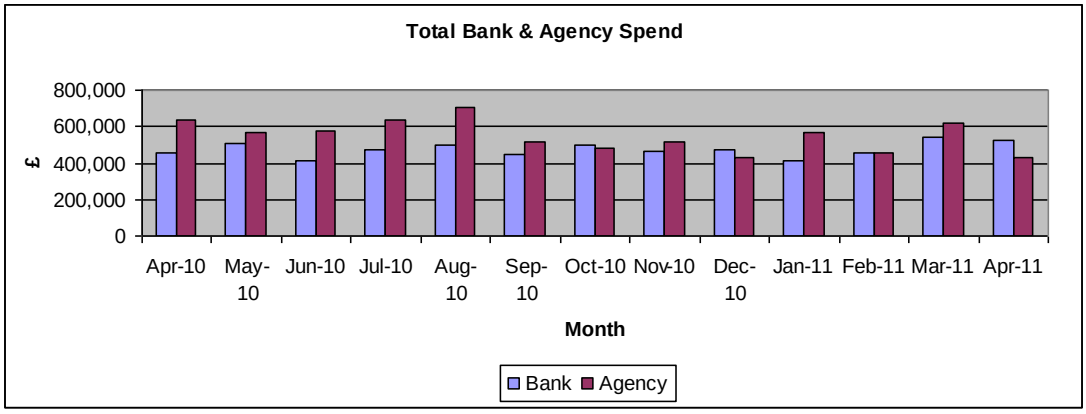


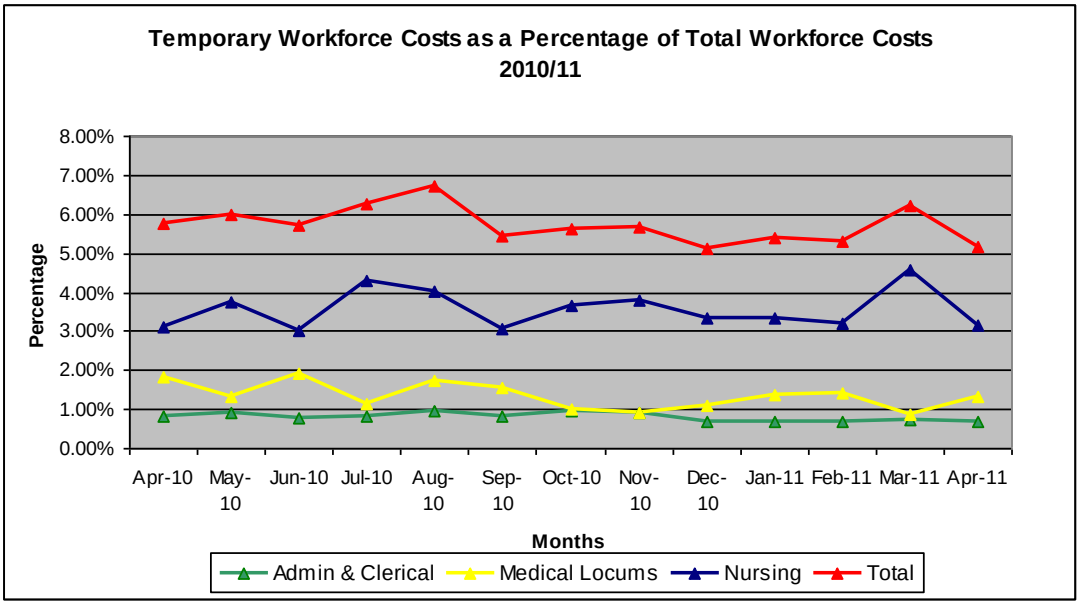
	BAND1	BAND2	BAND2 SPEC	BAND3	BAND4	BAND5	BAND5 SPEC	BAND6	BAND7	BAND8
Agency Filled	0	351	0	0	9	429	34	63	20	0
Bank Filled	8	2170	3	381	211	834	84	110	20	3
Unfilled Bookings	-1	-473	0	-14	-1	-245	-33	-11	-1	0

Booking Grade	Total Bookings	Unfilled Bookings	Bank Filled	Bank Filled Hours	Agency Filled	Agency Filled Hours	Fill Rate
BAND1	9	-1	8	45	0	0	89%
BAND2	2994	-473	2170	15978	351	2577.15	84%
BAND2SPEC	3	0	3	15	0	0	100%
BAND3	395	-14	381	2589.5	0	0	96%
BAND4	221	-1	211	1494	9	68	100%
BAND5	1508	-245	834	6994.5	429	3373	84%
BAND5SPEC	151	-33	84	707	34	347	78%
BAND6	184	-11	110	917.25	63	484.45	94%
BAND7	41	-1	20	166	20	150	98%
BAND8	3	0	3	22.5	0	0	0%
Totals:	**5509**	**-779**	**3824**	**28928.75**	**906**	**6999.6**	**86%**

Appendix G


Bank & Agency Spend Nursing and Admin & Clerical Staff Groups Only
£
600,000
500,000
400,000
300,000
200,000
100,000
0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
Month
Bank
Agency


Total Bank & Agency Spend
£
800,000
600,000
400,000
200,000
0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
Month
Bank
Agency


Temporary Workforce Costs as a Percentage of Total Workforce Costs 2010/11
Percentage
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
Months
Admin & Clerical
Medical Locums
Nursing
Total

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title	Quality Account- final report
Submitted by	Dr Sonia Swart, Medical Director
Prepared by	Nina Fraser, Deputy Director of Nursing
Date of meeting	29th June 2011
Corporate Objectives Addressed	Improve Clinical Quality and Safety

SUMMARY OF CRITICAL POINTS

Quality Accounts are annual reports to the public that give details about the quality of services that are delivered and outline the priorities and plans for improvement. At the Board meeting in May 2011 the Board approved the draft Quality Accounts to be sent to the PCT, LINks and OSC for comment.

This year non- FT NHS Trusts are involved in a third party assurance dry run. As part of the dry run the Trust is required to provide the auditors with the attached signed Statement of Director Responsibilities in respect of the 2010-11 Quality Account.

PATIENT IMPACT

Achieving high quality care for patients remains a priority and this account will be available to patients on the NHS choices website as well as our own Trust website.

STAFF IMPACT

The Quality Account provides an opportunity for staff to understand the importance of the improvements identified and to engage in identifying further areas for improvement.

FINANCIAL IMPACT

The ability to continually drive forward quality is increasingly important and will also affect NGH income.

EQUALITY & DIVERSITY

This report may need to be made accessible for hard to reach groups.

LEGAL IMPLICATIONS

The Quality Account is mandatory.

RECOMMENDATIONS

The directors are asked to confirm to the best of their knowledge and belief they have complied with the requirements listed overleaf in preparing the Quality Account.

The Chairman and Chief Executive are asked to sign the attached document to verify this.

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.
By order of the Board
NB: sign and date in any colour ink except black

.....Date.....Chairman

.....Date.....Chief Executive

BOARD SUMMARY SHEET	
Title	Acute Services Reconfiguration
Submitted by	Chris Pallot, Director of Planning and Performance
Date of meeting	29 June 2011
Corporate Objectives Addressed	

SUMMARY OF CRITICAL POINTS

The paper describes the process that is being adopted for the Acute Services Reconfiguration across five acute hospitals in the Milton Keynes, Northamptonshire, Bedford and Luton clusters and the associated timescales. It focuses on the deliverables associated with phase one of the programme and provides details of the organisation that has been appointed to facilitate the review.

PATIENT IMPACT - The outcomes of the review will have an impact on patient services across the region which as of yet are undefined

STAFF IMPACT - There could be an impact on staff in any of the five Trusts associated with the review should services be moved either to or from one of the hospitals.

FINANCIAL IMPACT – The aim of the review is to use clinical evidence to support service change which will drive financial savings. The aim is to support the QIPP challenge across the clusters and therefore there will be considerable savings anticipated by commissioners.

EQUALITY AND DIVERSITY IMPACT – N/A at this time

LEGAL IMPLICATIONS - To be defined

RISK ASSESSMENT - : N/A

RECOMMENDATION

The Board are recommended to: -

- Note the substantial workload commitment of entering into the review
- Commit to the review, noting that a key first deliverable is the production of an overall programme plan

ACUTE SERVICES RECONFIGURATION PROGRAMME

BACKGROUND

South East Midlands (SEM) is a natural community of over 1.6m people, expected to rise to 2.2m by 2031. SEM is made up of the two Clusters of Milton Keynes, Northamptonshire and Bedfordshire Luton, crossing two SHAs, and is largely coterminous with the new South East Midlands Local Enterprise Partnership (SEMLEP).

The principle of conducting a review of healthcare services currently provided in acute hospitals across this geography; was first discussed and agreed in the summer of 2009. A small review started in November 2010 when all key stakeholders across Northamptonshire, Milton Keynes and Bedfordshire, agreed to review a number of individual specialties where there was potential to improve clinical quality and/or cost efficiency through reconfiguration across the sites. It would be fair to say that little service change took place as a result of this review.

It is now clear that these specialty reviews need to be set in the context of a larger vision across South East Midlands and as part of a more co-ordinated approach to reconfiguration of acute care that includes GP Commissioning plans for local and sub-regional services.

There is general recognition that the existing model for acute services is not going to work in the future; a new approach is needed that meets National and Local quality and safety requirements and responds head-on to the financial challenge facing the NHS. Currently there is duplication of services across these five hospitals and limited provision of more specialised and time-dependent services that this size of population could support. There is limited co-ordinated response to commissioner's plans to develop services in the Community and in Primary Care.

DELIVERABLES

The key output will be an agreed clinical strategy for acute services across South East Midlands with recommendations for the configuration of services that are cognisant of existing QIPP plans, GP Commissioner aspiration's and hospital CIPs, and are based on National and International evidence and best practice. The strategy will include: -

1. Clarity for all partners on the clinical and financial **Case for Change** based on local analysis and using National and International evidence

2. Documented clarity on **commitment to change among partners** and their Boards with an understanding of what that change might look like

3. A **robust programme design** that will deliver the required change at pace

4. A shared clinical vision and an identified **range of service models** that could address the case for change and a shortlist of potentially viable solutions

5. Engagement strategy resulting in excellent **engagement with clinicians, the public and other key stakeholders**

6. Accessible comprehensive **analysis of the SEM acute position** (quality, financial and activity) and the tools to enable SEM partners to continue the analysis themselves

7. Identification of **opportunities for short-term change** (quick wins) between organisations that will deliver improvement (clinical and/or financial) within a year, and a prioritised list of further opportunities

8. Identification on the **optimal configuration of the programme and a business case** for resources to support the programme going forward, identifying the potential to fund the programme from new savings

NGH has been actively engaged within the process and has stressed the need to identify upfront, the barriers to any ASR and the requirement to remove these to ensure service reconfiguration can actually be delivered. A specific requirement of the programme design is:-

> *'Working with providers and commissioners to identify the barriers to service reconfiguration and their mitigating actions, thereby enabling a binding agreement between all partners that ensures buy-in and commitment from the start'*

APPOINTMENT OF AN EXTERNAL PARTNER TO LEAD THE PROGRAMME

NHSN has acted as the lead for the procurement of consultancy support to manage the development of the programme. The programme is split into distinct phases with the first being a 6-week period to design the entire programme.

The briefing given to potential partners stated that the key role of the consultancy partner is to facilitate and support the partnership to work together to design the whole programme and the governance and infrastructure, ensuring that the programme is owned by all members of the partnership and that programme delivery is enabled by the Commissioners and led by the Acute Trusts. This will involve: -

- Working with partners to secure their agreement of a robust governance and engagement process, which supports the key principle for the Programme to be Commissioner Enabled and Provider Led

- Co-ordinating the design of an effective clinical engagement process across the partnership, building on existing mechanisms

- Building on existing arrangements, co-ordinating the design of a wider stakeholder engagement strategy (including OSCs), an integrated and effective patient and public engagement strategy and a partnership engagement strategy, incorporating other critical partners such as Community Providers and the Ambulance Services

- Supporting the definition and understanding of what success looks like for all partners and the public, and building that into a critical success factors framework

- Facilitating the development of a transparent option appraisal and clear agreed decision-making process

- Supporting the partners to develop the full design of the whole programme, including the phasing

- Working with Providers and Commissioners to identify the barriers to change, and their mitigating actions thereby enabling a binding agreement between all partners that ensures buy-in and commitment from the start

- Exploring the balance of a well planned health system to maintain high quality services and avoid sudden unplanned service collapses and ensuring choice and competition are effectively supported to achieve market led solutions

- Working with the partners to understand whether this large complex programme is best delivered as a single process or as two, and if two, what configuration that should be (cluster or alternative geographic) and how they will work consistently together

- Identifying opportunities for funding the programme in the future from earlier savings within the health system

The partner would also be responsible for working with partners to identify a shared clinical vision and case for change, and producing a range of feasible clinical models for South East Midlands that will be used to stimulate discussion and development of options through Phase Two. This will involve: -

- Reviewing, affirming and consistently collating existing work and what we already know - QIPP Plans, previous ASR, Commissioning Intentions and identifying gaps

- Identifying best value services for a range of population sizes (i.e. 50k, 100k, 1m, 2m) and what that means for local hospitals (based on National Clinical Guidelines and National Benchmarked unit cost)

- Working with Commissioners to define the size and scope of hospital based provision that they wish to commission

- Working with providers and commissioners to identify where there are deficiencies in current services that could be resolved across the five hospitals

- Identifying what reconfiguration or service change should be planned and developed across the whole area, or by partnerships of 2 or 3 hospitals, or what should be done very locally - all based on patient flows or optimal service provision for the public

- Identifying a range of service models that could address the case for change and then an agreed shortlist of potentially viable solutions

- Identifying a range of best-practice service models (including networks, joint ventures) and how those could apply to different specialities

- Prioritising areas that would benefit from change (quick wins) and establishing the most appropriate phased timetable for the rest of the programme

- Developing the key principles to ensure financial sustainability for all organisations and building those into the programme processes, including possible gain-sharing among Commissioners and Providers

THE SUCCESSFUL PARTNER

As a result of the procurement process led by NHSN, KPMG have been appointed as the partner for phase one of the ASR programme. The initial 6-week period of work commenced on 20 June 2011.

TIMESCALES

The timescales associated with the programme are as follows: -

Phase 1

June – July 2011. Deliver clinical strategy with recommendations for reconfiguration and financial implications

August – September 2011. Agreement on recommendations for consultation through governance arrangements

Phase 2

September 2011. Gateway reviews

October – November 2011. Public consultation

December 2011. Outcome of Consultation through Governance arrangements

January – February 2012. Finalise implementation roadmap

Phase 3

April 2012. Early services changes take effect

2014 – All service change and reconfiguration completed

GOVERNANCE

The ASR Programme will be managed through a Programme Board led by the Acute Trusts with full engagement of GP Commissioners, Public Representatives and other stakeholders.

The Programme Board will make recommendations jointly to the two Clusters.

As Cluster structures are finalised, the final governance arrangements for the ASR will become clearer.

RECOMMENDATIONS

The Board are recommended to: -

- Note the substantial workload commitment of entering into the review
- Commit to the review, noting that a key first deliverable is the production of an overall programme plan

Chris Pallot
Director of Planning and Performance
20 June 2011

TRUST BOARD SUMMARY SHEET	
Title: -	Annual Plan 2011/12
Submitted by: -	Chris Pallot, Director of Planning and Performance
Date of meeting: -	29th June 2011
Corporate Objectives Addressed: -	The annual plan lists the corporate objectives for 2011/12 aligned with the contents of the Trusts Integrated Business Plan

SUMMARY OF CRITICAL POINTS: -

This report sets out the Trust's Annual Plan for 2011/12.

NHS Foundation Trusts are required to produce an Annual Plan to cover the following: -

- Chief Executives statement on delivery against the previous year's objectives
- Annual Plan Commentary
- Membership Report
- Financial Projections
- Forward Planning Information

The Annual Plan will be examined as part of the Due Diligence process for our Foundation Trust application but as importantly, will be a reference point for all Directorates as they deliver their objectives during 2011/12

PATIENT IMPACT: -

The aims and objectives of the Plan are directly linked to improving the quality and delivery of all patient level services

STAFF IMPACT: -

Workforce implications arising out of this plan are included in Trust wide and Directorate workforce plans

FINANCIAL IMPACT: -

Delivery of the objectives within the plan will directly impact upon the financial plan for 2011/12. Detailed financial projections are listed within the document

RISK ASSESSMENT: -

N/A

EQUALITY & DIVERSITY IMPACT ASSESSMENT: -

N/A

RECOMMENDATION: -

Trust Board Members are asked to approve the Annual Plan for 2011/12

Northampton General Hospital NHS
NHS Trust

ANNUAL PLAN

2011/12

8

June 2011

Table of Contents

1. PAST YEAR PERFORMANCE

1.1 Chief Executive's Summary of the Past Year

2010/11 was another successful year at Northampton General Hospital, but not without its challenges. With the hard work and support of all staff, volunteers and members, the Trust sustained performance and built on the progress made in previous years.

During the past year NGH created a strong platform on which to move forward. There are significant challenges in the coming year with the impact of a transformation programme that will secure long-term stability for NGH and support the NHS Foundation Trust application.

During 2010/11 there was an unprecedented demand for acute services, with adverse winter weather and the outbreak of swine flu. Despite this, for the second year running, Northampton General Hospital achieved all its key targets, and for the fifth year delivered a financial surplus.

Throughout the year the Trust continued to meet the overall target to treat all patients within 18 weeks of referral. This has been achieved in parallel to delivering a range of other key performance targets, notably the work undertaken to drive down healthcare associated infections, which remains a key focus. As a direct result, the number of hospital acquired infections also reduced significantly, with just 2 more than 48 hours MRSA bacteraemia reports during the year, and Clostridium Difficile infections were down by more than half to 48. The Trust met all of the targets associated with our cancer services which we provide across Northamptonshire and Milton Keynes.

This is a period of greater financial pressures and uncertainty which requires the Trust to reduce its cost base by £30m over the next two financial years. This target must be met whilst at the same time maintaining and enhancing clinical services and providing high quality patient care, against a background where the demand for our services continues to grow.

To achieve this there will have to be flexible, innovative and creative working. Work began on a Trust-wide Transformation Programme during the early part of 2010. This programme will deliver £30m of savings over the next two years. A challenge of this magnitude requires robust processes to support the work needed, which will involve looking at every aspect of our services. The aim continues to be to deliver services in the most efficient and cost-effective way, whilst at the same time ensuring the provision of quality and safe services rightly expected from NGH.

1.2 Summary of Quality Outcomes

In 2010, the Trust published its first Annual Quality Accounts, which set out the 4 quality priorities for 2010/11 and described what had been achieved during the previous 12 months. Since then the Trust has approved its first quality strategy which sets out the vision for quality, the roles and responsibilities of each staff member working both clinically and not in clinical settings and how the Board will gain assurance that the Trust is achieving its aims. The Trust defines quality as encompassing patient safety, clinical effectiveness and patient experience, and over the last year has made good progress in using national, regional and local quality indicators to engage the organisation in improving quality in each of these areas.

The quality priorities for 2010/11 were: -

- Improving the experience for all patients by focusing on essential care in every ward
- Improving the effectiveness, safety and patient experience for the Trust's Stroke Services
- Improving the prevention of blood clots through implementation of best practice for risk assessment and prescription of clot preventing drugs according to NICE guidance
- Reducing all infections including MRSA, C- Difficile and surgical site infections

The Trust Board received quarterly updates on each of these priorities throughout the year and the final achievements are published in this year's quality accounts.

Quality priorities for 2011/12

In order to involve and consult with key stakeholders about this year's quality priorities a 'long list' of seven was identified by reviewing the Trust's performance over the last year; national or regional priorities; and from horizon scanning.

The 'long list' was discussed and consulted on extensively with staff, patients and the public, and around 200 responses to the consultation were received. A final list of four quality priorities was identified and was approved by the Board in March 2011.

The quality priorities for 2011/12 are: -

- Making sure that patients receive the right care, in the right place, at the right time
- Improving the patient experience for vulnerable adults (incorporating essential elements of nursing care)
- Improving patient safety through junior doctor engagement
- Improving patient outcomes and speeding up a patient's recovery after surgery through the enhanced recovery programme

1.3 Summary of Past and Future Financial Performance

Table 1 - Historical and Projected Finance Performance

	09/10	10/11	11/12	12/13	13/14	14/15	15/16
	£m	£m	£m	£m	£m	£m	£m
Income	**227.8**	**236.3**	**231.8**	**230.7**	**231.2**	**234.1**	**236.2**
Costs	**(211.5)**	**(221.6)**	**(216.6)**	**(216.4)**	**(215.9)**	**(216.5)**	**(218.2)**
EBITDA	**16.3**	**14.7**	**15.2**	**14.3**	**15.3**	**17.7**	**18**
EBITDA %	**7%**	**6%**	**7%**	**6%**	**7%**	**8%**	**8%**
Net surplus / (deficit)	**(5.0)**	**1.1**	**0.5**	**0.9**	**1.9**	**4**	**4.5**
Net surplus / (deficit) %	**-2%**	**0%**	**0%**	**0%**	**1%**	**2%**	**2%**
Normalised surplus / (deficit)	**2.0**	**1.1**	**0.5**	**0.9**	**1.9**	**4.5**	**5**
Cash at bank	**2.4**	**3.8**	**3.8**	**5**	**3.1**	**3.6**	**4**
Forecast risk rating	**N/A**	**3**	**3**	**3**	**3**	**4**	**4**

1.4 Performance

During 2010/11, the Trust has successfully met all our financial obligations, reduced the length of waits and met all our key performance targets. The following summarises our year end position against the national standards.

Table 2 - Key Performance Target

Performance Indicator	Monitoring	Standard	Year end
Four-hour maximum wait in A&E from arrival to admission, transfer or discharge	YTD	98%	
Cancelled ops-breaches of 28 days readmission guarantee as % of cancelled ops	YTD	5.00%	
MRSA	YTD	6	
C Diff	YTD	98	
18 weeks RTT-admitted	Quarter	90%	
18 weeks RTT-non- admitted	Quarter	95%	
Achievement of standards in all specialties	Quarter	0	
2 week GP referral to 1st outpatient	YTD	93%	
2 week GP referral to 1st outpatient-breast symptoms	YTD	93%	
31 day second or subsequent treatment-surgery	YTD	94%	
31 day second or subsequent treatment-drug	YTD	98%	
31 day second or subsequent treatment-radiotherapy	YTD	96%	
62 day referral to treatment from screening	YTD	90%	
62 day referral to treatment from hospital specialist	YTD	85%	
62 days urgent referral to treatment of all cancers	YTD	85%	
Reperfusion: Primary Angioplasty (PPCI)	YTD	75%	
Reperfusion: Thrombolysis	YTD	68%	
2 week RACP	YTD	98%	
Delayed transfer of care	Total in period	3.50%	
Patients that have spent more than 90% of their stay in hospital on a stroke unit	2008-09	60%	

2. FUTURE BUSINESS PLANS

2.1 Overall Vision

Our vision is to deliver the safest, most clinically effective acute services in the country based on the needs of our patients. These services may be delivered from our acute hospital, community hospital site or by our staff in the community. We recognise the financial climate in which the NHS operates will become much more challenging. It is highly likely that with reduced growth from central funds, competition between providers will accelerate.

Our strategic aims and objectives support our vision and are to:

- Maintain and enhance our position as the local provider of choice through patient-centred services
- Increase our ability to provide more specialist and tertiary services in Northampton in order to provide more care to the local population as well as increase contribution to the Trust's finances
- Enhance secondary care services in excellent facilities beyond the hospital sites and offering services closer to patients' homes making NGH more attractive to patients who elect to choose their provider of care
- Ensure our long term financial viability through improving the clinical quality, productivity and efficiency of services

2.2 Strategic Overview

The Trust recognises the current economic climate and future commissioner intentions for models of care closer to home and the impact of both of these on service delivery and service developments.

In order to support the strategic planning process, the Assurance Framework and Risk Register have been reviewed using the following tools to analyse and identify any potential risks; PEST: a review of the political, economic, social and technological factors impacting on service delivery and a SWOT: a review of the Trust's strengths, opportunities, weaknesses and threats.

A detailed Trust-wide analysis has also taken place with Directorates using their own PEST analyses to identify issues that are more specific to the Directorate. Statutory and regulatory requirements have also been taken into account. The table below summarises the organisation's PEST Analysis.

Table 3 – PEST Analysis

Political	• 'Free choice' and greater freedoms to market services and the impact of the competition commission • Implications of the NHS Constitution • Implications of the Healthcare Bill 2009 and the Healthcare Act 2008 • World Class Commissioning Assurance • Impact of Acute Services Review • Medical Revalidation • Single Equality Bill
Economic	• Current economic downturn • Payment by Results (PBR) changes to tariff • Impact of 2011/12 tariff and PBR rules • Increased choice, co-operation and competition • Reduced growth in central funding for healthcare • Transforming Community Services (TCS) • Financial impact of education and training reforms
Socio-cultural	• Demographic/population change • Frequency & accuracy of demographic data • Rising public expectations and increase in consumerism • Public concerns about health care acquired infections (HCIA) • Public Health campaigns and screening • Workforce supply and age profile of workforce • NHS Carbon Reduction Strategy
Technological	• Development of information systems and the implications of the National Programme for IT (NPfIT) • New drugs & medical technologies • NICE and improving outcomes guidance dictating the need for changes to service models • Technological innovation enabling service redesign and cost reduction

2.3 Corporate Objectives

The Corporate Objectives for 2011/12 are outlined below; the emphasis throughout this year will be on delivering greater efficiencies, improved clinical outcomes and developing services closer to home.

- To improve the clinical quality of patient care focusing on safe, effective treatment that is patient centred

- To develop an effective, efficient and flexible workforce to support the changing environment

- Develop a revised Business Strategy, reflected in our Integrated Business Plan to obtain Secretary of State approval for NGH to become a Foundation Trust by July 2012

- To develop a strategic partnership with Nene Commissioning and other Commissioners and enhanced working relationships with all local GPs

- Develop critical clinical care pathways to deliver effective integrated care as part of the Acute Services Review

- To agree a revised Estate Strategy in the context of the Trusts Service Strategy, Transformation Programme and the Acute Services Review, which explores alternative funding mechanisms and is completed in line with the FT Application Timetable

- To develop, implement and sustain transformation in the way we deliver our services in order to maintain quality and deliver c£18million reduction in cost base by the end of 2011/12

- To implement effective service-line management across the organisation by 31 December 2011, and to develop underpinning business processes that deliver increased managerial control

2.4. Key Measures of Success

To improve the clinical quality of patient care focusing on safe, effective treatment that is patient centred

Safety

- Increase safety incident reporting in line with peer average
- Decrease harm events (falls, pressure ulcers, medication safety measures as per Quality Accounts)
- Increase staff ownership of safety issues

Effective Patient Centred Treatment

- Support enhanced recovery
- Right bed, right care
- Patient experience additional focus on vulnerable/dementia patients.
- Reduce hospital mortality
- Full Compliance with CQUIN Measures

To develop an effective, efficient and flexible workforce to support the changing environment

- Increased performance against all key HR Performance Indicators
- Workforce changes and workforce savings achieved in line with Trust Performance and Financial Plans
- Highly skilled & knowledgeable workforce capable of supporting the transformation and emerging strategies of the Trust
- Talent management & succession planning implemented
- Developing a culture and environment where the workforce can excel and the Trust becomes an employer of choice. (Staff Survey)

Develop a revised Business Strategy, reflected in our Integrated Business Plan to obtain Secretary of State approval for NGH to become a Foundation Trust by July 2012

- Final IBP that reflects Business Strategy and outcomes of Acute Services Review

To develop a strategic partnership with Nene Commissioning and other Commissioners and enhanced working relationships with all local GPs

- Jointly agreed clinical pathways commissioned & jointly owned
- Regular discussion forum with Clinical leaders & GP's, plus clinical specialty & GP discussion

Develop critical clinical care pathways to deliver effective integrated care as part of the Acute Services Review

- Agreed distribution of services supported by referral pathways with agreed clinical outcome measures

To agree a revised Estate Strategy in the context of the Trusts Service Strategy, Transformation Programme and the Acute Services Review, which explores alternative funding mechanisms and is completed in line with the FT Application Timetable

- Revised medium to long-term Estate Strategy that reflects Service Plans and Strategic Priorities
- Revised 5 Year Capital Investment Plan that is affordable
- Fit for purpose and appropriately sized estate to deliver Trust activity
- Revised strategy approved by Trust Board and incorporated into IBP

To develop, implement and sustain transformation in the way we deliver our services in order to maintain quality and deliver c£18million reduction in cost base by the end of 2011/12

- Transformation Programme delivery reducing cost base by £18 million

To implement effective service line management across the Organisation by 31 December 2011 and to develop underpinning business processes that deliver increased managerial control

- 2010/11 reference costs submitted using SLR System
- Report suite in place 2011/12
- Shadow budgeting process using HRG cost and activity

3. SERVICE DEVELOPMENTS

The Trust's Integrated Business Plan (IBP) outlined a number of service developments that would contribute to the delivery of the strategic objectives. Each directorate has identified detailed service development plans for 2011/12 through individual Directorate Annual Plans.

3.1 Stroke Services	
Contribution to the Overall Vision	**Key Actions and Delivery Risks**
• The continued development of the	• Continued implementation of the

Northamptonshire Primary Stroke Centre at NGH will contribute to the Trust vision to 'Increase our ability to provide more specialist and tertiary services in Northampton in order to provide more care to the local population as well as increase contribution to the Trust's finances'	NGH Primary Stroke Centre • Ongoing awareness raising and training to local GPs of the service • Development of Early Supported Discharge (ESD) Community Services Stroke Rehabilitation Team • Offer Primary Stroke Services to the population served by MKFT to ensure the shortest travel time to appropriate care for their population • 24/7 Stroke Co-ordinator available to ensure direct access to stroke assessment beds and full imaging requirements • 24/7 thrombolysis, with out of hours cover by stroke physician on call or telemedicine link to comprehensive Stroke Centre Stroke Physician • Appointment of 2 additional Consultant Stroke Physicians • Continued repatriation processes for cross-border or North Northamptonshire residents to return to their closest hospital post acute phase
Key resource requirements • 2 additional Consultant Stroke Physicians • ESD Community Services Stroke Rehabilitation Team	**Measures of progress** • Locum consultant in place-July 2011 • Additional consultant in place December 2011 • 24/7 Thrombolysis-October 2011 • ESD Team in place-December 2012

3.2 Vascular Services	
Contribution to the Overall Vision • The implementation of the Northamptonshire Vascular Service with the surgical site located at NGH will contribute to the Trust vision to 'Increase our ability to provide more specialist and tertiary services in Northampton in order to provide more care to the local population as well as increase contribution to the Trust's finances'	**Key Actions and Delivery Risks** • Implement AAA screening by April 2012 as part of round 3 of the National AAA screening programme • Agree and implement plans to transfer all elective and non-elective arterial surgery for Northamptonshire to NGH by Jan 2012 • Transfer all non-elective admission for Northamptonshire to NGH by January 2012 • Develop 24/7 Vascular Surgeon and Interventional Radiology rotas • Key risk to implementation is the requirement to ensure viable 24/7 general surgical rotas across NGH and KGH
Key Resource Requirements • Internal business case developed • County wide project implementation process to ensure delivery of service	**Measures of Progress** • Approval for AAA screening service-expected July 2011 • Job planning and 24/7 rotas agreed

	January 2012 • Transfer of elective and non-elective surgery - January 2012

3.3 Transforming Community Services (TCS)	
Contribution to the Overall Vision • The transfer of the following services to NGH as part of Transforming Community Services: Danetre Hospital, MIAMI, Corby and Isebrook community beds, will contribute to the Trust vision to 'Enhance secondary care services in excellent facilities beyond the hospital sites and offering services closer to patients homes'	**Key Actions and Delivery Risks** • Transfer of MIAMI • Transfer of Danetre Community Hospital • Transfer of Corby community beds • Transfer of Isebrook community beds • NGH will operate these services through an agreement with Northamptonshire Partnership NHSFT who will take on the buildings associated with these services under the proposed TCS arrangements
Key Resource Requirements • Full business cases have been developed and approved by Trust Board	**Measures of Progress** • Increased provision of activity at Danetre hospital

3.4 Commissioning of Beds from Avery Healthcare	
Contribution to the Overall Vision • The commissioning of beds from Avery Healthcare will contribute to the Trust vision to 'Enhance secondary care services in excellent facilities beyond the hospital sites and offering services closer to patients homes'	**Key Actions and Delivery Risks** • Increase appropriate capacity to care for this specific client-group - 22 beds • Ensure appropriate facilities dedicated to the care of this client group • Reduce activity on the main site leading to capacity reduction • Redeploy staff to maximise reduction in agency costs • Realise benefits from the innovative approach to the partnership such as NGH services being offered to Avery (e.g. clinical waste, infection control, pharmacy)
Key Resource Requirements • A business case has been signed-off by the Hospital Management Group and Trust Board	**Measures of Progress** • Reduced capacity and cost on the acute site - end of quarter1 • Improved patient experience in a brand new; purpose built facility-end of quarter 1

3.5 Community Elderly Care Services (CECS)	
Contribution to the Overall Vision • The proposed Community Elderly Care Service (CECS) is an integral element of the health economy's	**Key Actions and Delivery Risks** The CECS programme combines a range of projects which are interdependent and requires the simultaneous development

demand management strategy, which will address acute service pressure particularly in the area of emergency admissions, and manage and redirect care where appropriate to the community • This will contribute to the Trust vision to 'Ensure our long term financial viability through improving the clinical quality, productivity and efficiency of services'	of all projects to optimise success. The projects currently underpinning the programme include the following areas: - • Deployment and integration into ICT of specialist Consultant Geriatricians and Psycho-geriatricians • Expansion of Intermediate Care Teams (ICT) • Reclassification of Specialist Care Centre (SCC) Beds including the development of 4 outreach teams attached to each SCC funded through re-investment of released resources Links to Dementia Strategy • Development of Chronic Disease Management (CDM) model for diabetes and COPD • Investigation into the development of a community based assessment unit for frail, elderly patients • Assignment of community bed stock through Transforming Community Services (TCS) • Countywide Falls review and resultant service change • Re-design of rehabilitation / re-enablement services and resultant service change The key risk is that the reduction in admissions fail to materialise
Key Resource Requirements • NGH will support a Specialist Consultant Geriatrician • A full business case to include the impact of the reductions of bed requirements has been approved by Trust Board	**Measures of Progress** • Reduced capacity and cost on the acute site - end of quarter 2 • Reduced number of A&E referrals- end of quarter 2 • Reduced length of stay - end of quarter 2

4. SUMMARY OF FINANCIAL FORECAST

The forecast financial information set out below demonstrates how the Trust will deliver its strategy and vision over the next five years. This will involve investment in service developments that are EBITDA enhancing. Further, the Trust will move forward in the development of its estate through the commencement of a building programme to provide new modern ward facilities through the utilisation of long-term borrowing. This is recognised by the Trust as one of the key benefits of becoming a Foundation Trust.

4.1 Income and Expenditure

The table below sets out the income and expenditure account for NGH for the five years ending 31 March 2016.

Table 4 - Forecast Income and Expenditure Accounts

	10/11 Actual £m	11/12 Projected £m	12/13 Projected £m	13/14 Projected £m	14/15 Projected £m	15/16 Projected £m	CAGR %
NHS Clinical Income	208.4	205.4	203.7	203.6	206	207.4	0.41%
Non NHS Clinical Income	2.7	2.7	2.8	2.8	2.9	2.9	-1.32%
Other Income	25.0	23.6	24.2	24.7	25.3	25.8	3.33%
Total Income	236.1	231.8	230.7	231.2	234.1	236.2	0.69%
Pay Costs	(154.5)	(149.4)	(145.0)	(142.0)	(139.7)	(138.3)	-1.60%
Non pay Costs	(67.2)	(62.2)	(71.4)	(73.9)	(76.8)	(79.9)	4.21%
EBITDA	14.4	15.2	14.3	15.3	17.7	18	2.13%
EBITDA %	6%	8%	6%	7%	8%	8%	
Depreciation	(9.4)	(10.30	(9.2)	(9.1)	(9.4)	(9.2)	-1.60%
Impairments	-	-	-	-	-	-	-
Net interest receivable / (payable)	-	-	-	(0.1)	(0.1)	(0.1)	-
PDC Dividend	(4.2)	(4.1)	(4.1)	(4.1)	(4.1)	(4.2)	
Net Surplus	1.1	0.5	0.9	1.9	4	4.5	17.6%

Service developments relating to Stroke and Trauma and Orthopaedic accounts for income growth of £1.0m at current prices in 2010/11, and £3.9m in 2012/13.

The figures above include the full effect of the Danetre and MiAMI TCS transfer; excludes Corby and Isebrook.

Other clinical income and other income are forecast to remain flat over the five year period.

Pay costs decrease by £6m over the period drive primarily by pay inflation offset by headcount reduction. The additional cost of incremental drift is expected to reduce from its current level of 1.0% to 0.4% as employees reach the top of bandings.

The plan is prepared on the basis that Trust restructuring costs will be funded by drawing on PCT strategic reserves.

Non-pay costs increase during the model reflecting higher volume price increases offset by procurement and Clinical Negligence Scheme for Trusts (CNST) savings.

In order to achieve the forecast surplus, cost reduction savings are required as follows.

Table 5 - Cost Improvement Programme to 2015

CIP	2011/12		2012/13		2013/14		2014/15		2015/16	
	%	£m	%	£m	%	£m	%	£m	%	£m
Recurrent	6.5	15.0	4.0	9.1	3.8	9.3	3.6	7.9	2.4	5.3
Non recurrent	0.0	2.0	0.3	0.5	0.7	1.2	0.4	1.0	0.4	1.0

4.2 Balance Sheet

The balance sheets of Northampton General Hospital NHS Trust for the period covered by the projections are set out in the table below.

Table 6- Forecast Balance Sheet

	10/11 Actual £m	11/12 Projected £m	12/13 Projected £m	13/14 Projected £m	14/15 Projected £m	15/16 Projected £m
Non Current Assets	133.0	134.4	137.5	140.4	145.8	150.6
Current Assets (excluding cash)	14.7	13.7	13.6	15.1	15.3	15.4
Cash	3.9	3.8	5	3.1	3.6	4
Current Liabilities	(20.1)	(18.7)	(19.8)	(20.1)	(20.4)	(20.7)
Loans & Leases	(0.4)	(0.3)	(2.6)	(2.9)	(4.6)	(5.1)
Provision for Liabilities and Charges	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)
Total Assets Employed	130.8	132.6	133.5	135.3	139.4	143.9
Taxpayers Equity						
PDC	99.6	100.1	100.1	100.1	100.1	100.1
I&E Reserve	(3.8)	(3.6)	(2.7)	(0.8)	3.2	7.7
Revaluation Reserve	28.7	28.9	29.2	29.6	30.0	30.3
Donated Asset Reserve	6.3	7.3	6.8	6.5	6.1	5.8
Total Funds Employed	130.8	132.6	133.5	135.3	139.4	143.9

4.3 Cash Flow

The cash flow statements for Northampton General Hospital NHS Trust for the period covered by the projections are set out in the table below.

Table 7 - Forecast Cash flow

	10/11 Outturn £m	11/12 Projected £m	12/13 Projected £m	13/14 Projected £m	14/15 Projected £m	15/16 Projected £m
EBITDA	14.4	15.2	14.3	15.3	17.7	18
Operating Cash Flow	14.3	14.5	11.8	13.6	17.3	17.8
Capital Expenditure	(8.9)	(10.7)	(8.1)	(10.5)	(11.8)	(12.3)
Cash Flow before Financing	5.4	3.8	6	3.1	5.6	5.6
Net Interest (paid) / reserved	-	-	-	(0.1)	(0.2)	(0.2)
Drawdown of Loans	0.5	-	-			-
Repayment of Loans and lease Principal	(0.1)	(0.1)	(0.7)	(0.8)	(0.9)	(0.9)
Dividends paid	(4.2)	(4.1)	(4.1)	(4.1)	(4.1)	(4.2)
Net Cash outflow / inflow	1.5	0	1.2	(1.9)	0.5	0.4

4.4 Capital Investment Strategy

In full support of our objectives to enhance our position as local provider of choice and meeting patients' needs in an excellent environment the Trust has established a five year capital strategy and has made a commitment to investing in medical equipment, IT and the estate of Northampton General Hospital NHS Trust. The Trust has considered how this may be funded and how the benefits of Foundation Trust status may be realised. The guidelines that the Trust has developed in determining the capital programme are set out below.

- Business cases for all capital developments are required and must fit with the Trust's overall strategic direction and delivery of its corporate objectives
- Business cases will be required to demonstrate and realise benefits to contribute towards improving the bottom line of the Trust
- Backlog and maintenance expenditure on the Trust estate will be funded from internally generated cash
- External funding under the Prudential Borrowing Limit will be considered where term borrowing is considered appropriate and provides a better match of the costs and risks of the asset to the economic life

The capital plan was reviewed in light of the strategic aims of the Trust and schemes prioritised based on their ability to assist the Trust in meeting its strategy. The following table lists specific schemes being developed to respond to the strategy outlined previously in the business plan.

Table 8 - Specific Schemes linked to Strategic Aims

Strategic Aim	Scheme Details
Maintain and enhance position as local provider of choice	Upgrading existing linear accelerator with IGRT and CT Scanner in line with recommendations of NRAG report
Excellent Environment	Replacement of Radiology equipment to improve efficiency of Radiology activity
Increase Specialist and Tertiary Services	Commissioning of linear accelerator on Milton Keynes NHS Foundation Trust site to move care closer to patient home
Increase Specialist and Tertiary Services	Investment in breast screening to respond to requirement to change from analogue to digital and to earn additional income through the increase in the age bandings identified for screening. Included within this plan is a mobile scanner and consideration of a location off-site meeting objective of care closer to home
Excellent Environment	Replacement of ageing ward blocks to improve environment and quality of care by moving away from older ward blocks
Long-term Financial viability	Increase in expenditure on Information Technology

The current investment programme for the five years ending 31March 2016 is set out in the table below.

Table 9 - Forecast Capital Expenditure

At current prices	11/12 Forecast £m	12/13 Forecast £m	13/14 Forecast £m	14/15 Forecast £m	15/16 Forecast £m
Radiotherapy - upgrade		-	-	-	-
Radiology - Breast Screening	0.6	0.1	-	-	-
Replacement Ward Building		0.1	3.2	3.0	1.6
Outpatient Services	-		-	0.2	1.0
Emergency Care	0.5	-	-	-	-
Ward Reconfiguration				-	-
Transformation Schemes	1.1	0.6			
Offsite Development	0.1	0.1	0.1	0.1	0.1
Maternity Services	-	-	-	0.8	1.5
Haematology Development	0.5	-	-	-	-
Medical Equipment	1.0	1.0	1.0	1.0	1.0

At current prices	11/12 Forecast £m	12/13 Forecast £m	13/14 Forecast £m	14/15 Forecast £m	15/16 Forecast £m
Information Technology	2.3	2.5	2.0	1.8	1.8
Estates - Backlog	2.0	2.1	2.0	2.2	2.3
Estates - Statutory	0.8	0.7	0.7	0.6	0.6
Estates - non maintenance	1.3	0.7	0.7	1.0	0.9
Total	**10.3**	**7.9**	**9.7**	**10.7**	**10.8**

This will be financed by

Table 10 - Capital-Financing Strategy

	11/12 Projected £m	12/13 Projected £m	13/14 Projected £m	14/15 Projected £m	15/16 Projected £m
Retained Depreciation	10.0	9.9	10.2	10.7	10.8
Borrowing	-	-			-
Cash from Retained Earnings	0.3	0	-		
Cash		(2.0)	(0.5)	(0.9)	
TOTAL	**10.3**	**7.9**	**9.7**	**10.7**	**10.8**

5. MEMBERSHIP REPORT

5.1 Foundation Trust Application Timeline

The Trust will submit its application to the Department of Health in July 2012, which will give time for the Transformation Programme to deliver many of the savings that are required to ensure the Trust is financially stable.

In recent months the Trust has signed the tripartite agreement along with the Strategic Health Authority and Department of Health to confirm this timescale.

During the intervening period the Trust will concentrate on a number of actions that are critical to the success of our application; these include.

- Clinical Excellence
- Stakeholder Engagement
- Membership Involvement
- Board Development
- Development of a Financially Stable Organisation

Our aim is that all of these actions will ensure the organisation has the best possible chance of success during the rigorous assessment process.

5.2 Membership Size and Movements

Table 11 – Membership Analysis

Public Constituency	Last Year (10/11)	This Year (11/12) Estimated
At year start (April 1)	3358	3922
New Members	667	1000
Members leaving	31	60
At year end (March 31)	3922	4862
Staff Constituency*	**Last Year (10/11)**	**This Year (11/12) Estimated**
At year end (March 31)	3819	3819

5.3 Analysis of Current Membership**

Table 12 – Current Membership

Public Constituency	Number of Members	Eligible Membership***
Age (years):		
16-25	86	87,400
26-45	318	199,000
46-65	696	185,500
65 +	1002	106,100
Ethnicity**	**Number of Members**	**Eligible Membership**
White	1957	549,700
Mixed	10	6,900
Asian	43	11,500
Black	65	6,900
Other	23	2,900
Gender	**Number of Members**	**Eligible Membership**
Male	660	283,200
Female	945	294,700

* Staff are members via the opt-out process
**Where the information has been provided by the member
***Calculated using the population of Northamptonshire

5.4 Membership Commentary

Public members are recruited on an opt-in basis and are aged 16 and over. They are recruited from the following localities.

Members are either members of the public living within the catchment area of Northampton and Daventry and South Northants, or are service users and their families and carers from the wider area listed below.

- Northampton
- Daventry and South Northamptonshire
- East Northamptonshire and the surrounding areas (where we offer specialist services – e.g. cancer, stroke)

Staff members are recruited on an opt-out basis. All staff members either are employed under a contract of employment by the Trust for a 12-month contract or have been continuously employed by the Trust for at least 12 months. Staff members are divided into four classes.

- Medical and Dental Practitioners.
- Nursing, Midwifery
- Allied Professional
- Non-Clinical.

Members are recruited utilising the following methods.

- Invitation by letter.
- Post boxes and flyers around the Trust.
- Recruitment events.
- Recruitment through governors.
- Recruitment at governor led events.

5.5 Future Membership

The membership changes consistently and the member recruitment targets have developed to consider this. The aim is to have a membership of 8,500 by September 2011, with 4500 public members. This will be achieved by:

- Public recruitment events. This has a limited success in recruiting members who remain engaged. Public face-to-face recruitment has worked best when undertaken at events which are health focused, or the recruitment is on the hospital site. The most successful method of recruitment is through letters sent to discharged patients, or to patients attending outpatients

- Governor-led recruitment events. Governor surgeries within libraries have been set up as a way of allowing the Governors to have face-to-face contact with their member constituents. This is still at the early stages, but we plan to build upon this

- Young people engagement and communication. Events held at Northampton College, in conjunction with other NHS organisations. A presentation will be rolled out to sixth forms within Northamptonshire to raise awareness of careers within the NHS, and the benefits of becoming a member of an NHS Trust

- Co-operating with other local NHS organisations to share knowledge and ideas, joint recruitment events. This has been very successful in both recruitment and engagement of members

- Setting up a local network with other membership offices. Two networks are running, both local to Northamptonshire and from the East Midlands SHA area

6. CONCLUSION

During 2011/12 the Trust will continue to develop and embed the Trust-wide Transformation Programme in order to deliver £30m of savings over the next two years. The Trust will develop a revised Business Strategy that reflects transformation programme and the outcome of the Acute Services Review.

The Trust will work towards becoming a Foundation Trust by July 2012.

BOARD SUMMARY SHEET	
Title	Draft Corporate Objectives 2011/12
Submitted by	Chris Pallot, Director of Planning & Performance
Date of meeting	29 June 2011
Corporate Objectives Addressed	

SUMMARY OF CRITICAL POINTS

Following the May 2011 Board Meeting and the Board Workshop, the draft objectives agreed have now been further developed to ensure they are SMART. They support the delivery of our goals and will be assessed on a regular basis to monitor progress and achievement.

PATIENT IMPACT -

STAFF IMPACT -

FINANCIAL IMPACT

EQUALITY AND DIVERSITY IMPACT -

LEGAL IMPLICATIONS -

RISK ASSESSMENT - :

RECOMMENDATION

The Board are asked to review and agree the proposed objectives.

CORPORATE OBJECTIVES 2011/12

Objectives	Measures of success	Timescale	Monitoring	Current Position
1. To improve the clinical quality of patient care focusing on safe, effective treatment that is patient centred.	**Safety** ➢ Increase safety incident reporting in line with peer average. ➢ Decrease harm events (falls, pressure ulcers, medication safety measures as per Quality Accounts). ➢ Increase staff ownership of safety issues. **Effective Patient Centred Treatment** ➢ Support enhanced recovery. ➢ Right bed, right care. ➢ Patient experience additional focus on vulnerable/dementia patients. ➢ Reduce hospital mortality. ➢ Full Compliance with CQUIN Measures.	➢ March 2012. ➢ March 2012 ➢ Ongoing ➢ March 2012. ➢ Monthly to CQEG and HMG. ➢ Monthly MD sign off of achievement in accordance with Quality Schedule. ➢ In accordance with Quality Schedule.	➢ Quarterly monitoring reporting to CQEG. ➢ Quarterly CQEG, HGC, Trust Board. ➢ Patient Safety Board. ➢ Quarterly Quality Accounts. ➢ Quarterly Patient Safety Clinical Quality & Governance progress report. ➢ HMG, CQEG, Quarterly Quality Review Meeting with PCT. ➢ Quarterly Patient Safety CQEG Progress Report, Quarterly Review with PCT.	

Objectives	Measures of success	Timescale	Monitoring	Current Position
2. To develop an effective, efficient and flexible workforce to support the changing environment.	➢ Increased performance against all key HR Performance Indicators. ➢ Workforce changes and workforce savings achieved in line with Trust Performance and Financial Plans. ➢ Highly skilled & knowledgeable workforce capable of supporting the transformation and emerging strategies of the Trust. ➢ Talent management & succession planning implemented ➢ Developing a culture and environment where the workforce can excel and the Trust becomes an employer of choice. (Staff Survey)	➢ March 2012. ➢ In line with Trust Performance Timeline. ➢ September 2011. ➢ September 2011. ➢ On-going.	➢ Trust Board (monthly) CQEG (mandatory training) DMs/HR Forum. ➢ HR Forum Trust Board/Trust Performance. ➢ HR Forum, Monthly Workforce Development Board, Trust Board (6 monthly). ➢ As above. ➢ HR Forum Monthly, HMG, Trust Board (6 monthly).	
3. Develop a revised Business Strategy, reflected in our Integrated Business Plan to obtain Secretary of State approval for NGH to become a Foundation Trust by July 2012.	➢ Completed final IBP that reflects Business Strategy and outcomes of Acute Services Review.	➢ July 2011.	➢ HMG & Trust Board.	

Objectives	Measures of success	Timescale	Monitoring	Current Position
4. To develop a strategic partnership with Nene Commissioning and other Commissioners and enhanced working relationships with all local GPs .	➢ Jointly agreed clinical pathways commissioned & jointly owned. ➢ Regular discussion forum with Clinical leaders & GP's, plus clinical specialty & GP discussion.	➢ Work programme developed by December 2011.	➢ HMG & Trust Board.	
5. Develop critical clinical care pathways to deliver effective integrated care as part of the Acute Services Review.	➢ Agreed distribution of services supported by referral pathways with agreed clinical outcome measures.	➢ December 2011.	➢ HMG & Trust Board.	
6. To agree a revised Estate Strategy in the context of the Trusts Service Strategy, Transformation Programme and the Acute Services Review, which explores alternative funding mechanisms and is completed in line with the FT Application Timetable.	➢ Revised medium to long term Estate Strategy that reflects Service Plans and Strategic Priorities. ➢ Revised 5 Year Capital Investment Plan that is affordable. ➢ Fit for purpose and appropriately sized estate to deliver Trust activity. ➢ Revised strategy approved by Trust Board and incorporated into IBP.	➢ Approval by Trust Board February 2012.	➢ Estates Planning & Development Group. ➢ Capital Committee. ➢ Finance & Performance Committee. ➢ Estate KPI's.	

Objectives	Measures of success	Timescale	Monitoring	Current Position
7. To develop, implement and sustain transformation in the way we deliver our services in order to maintain quality and deliver c£18million reduction in cost base by the end of 2011/12.	➢ Transformation Programme delivery reducing cost base by £18 million.	➢ March 2012.	➢ Transformation Delivery Group, HMG, Trust Board.	
8. To implement effective service line management across the organisation by 31 December 2011 and to develop underpinning business processes that deliver increased managerial control.	➢ 2010/11 reference costs submitted using SLR System. ➢ Report suite in place 2011/12. ➢ Shadow budgeting process using HRG cost and activity.	➢ 31 July 2011. ➢ 30 September 2011. ➢ 31 March 2012.	➢ Project Board, HMG Trust Board.	

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD MEETING
Wednesday 29th June 2011
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
9.30	1.	Apologies	Dr J Hickey	
	2.	Declarations of Interest	Dr J Hickey	
	3.	Draft minutes of meeting held on 27th April 2011	Dr J Hickey	**1**
	4.	Matters arising	Dr J Hickey	
9.40	5.	Chief Executive's Report	Dr G McSorley	**Verbal**
Clinical Quality & Safety				
9.50	6.	Delivering Safer Care	Dr S Swart/Mrs J Bradley	**Presentation**
10.10	7.	Infection Prevention Report	Mrs F Barnes	**2**
Operational Assurance				
10.20	8.	Performance report	Mrs C Allen	**3**
10.30	9.	Finance report	Mr A Foster	**4**
10.40	10.	HR Report	Ms C Wilkinson	**5**
Strategic				
10.50	11.	Quality Account	Dr S Swart	**6**
10.55	12.	Acute Services Review	Mr C Pallot	**7**
11.05	13.	Annual Plan 2011/12	Mr C Pallot	**8**
11.10	14.	Corporate Objectives 2011/12	Mr C Pallot	**9**
11.15	15.	Any Other Business		
	16.	**Date & time of next meeting** 9.30am Wednesday 28th September 2011, Boardroom, NGH		
		CONFIDENTIAL ISSUES To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Dr J Hickey	