Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD MEETING
Wednesday 28th September 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 29h June 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.	CQC Registration and Declaration	Mrs F Barnes	**2**
10.00	7.	Quality and Patient Experience Report	Mrs F Barnes	**3**
10.10	8.	Infection Prevention Report	Mrs F Barnes	**4**
10.20	9.	Infection Prevention Annual Report	Mrs F Barnes	**5**
10.25	10.	Medical Director's Patient Safety Report	Dr S Swart	**6**
Operational Assurance				
10.35	11.	Annual Security Report	Mr C Abolins	**7**
10.45	12.	McMillan Scheme Update	Mr C Abolins	**8**
10.50	13.	Performance report	Mrs C Allen	**9**
11.00	14.	Finance report	Mr J Drury	**10**
11.10	15.	HR Report	Ms C Wilkinson	**11**
Strategic				
11.20	16.	Acute Services Review Update	Dr S Swart	**12**
11.25	17.	Recruitment of Chair	Dr J Hickey	**13**
11.30	18.	Any Other Business		
11.30	19.	**Date & time of next meeting** 9.30am Wednesday 30th November 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 29th June 2011 at 9.30am
Boardroom, Northampton General Hospital

Present:	Dr J Hickey	Chairman
	Dr G McSorley	Chief Executive
	Mrs 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 G Kershaw	Associate Non-executive Director
	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 Human Resources
	Mr P Zeidler	Non-executive Director
In attendance:	Mr A Foster	Deputy Director of Finance
	Ms S Rudd	Company Secretary
	Mr M Essery	Shadow Lead Governor
	Ms M McVicar	Shadow Governor
	Mr F Evans	Shadow Governor
	Mr R Kelso	Shadow Governor
	Mr N Spoors	Chronicle & Echo
Apologies:	Mr C Abolins	Director of Facilities & Capital Development
	Mr J Drury	Director of Finance
	Mr D Savage	Shadow Governor

TB 11/12 14 Declarations of Interest

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

TB 11/12 15 Minutes of the meeting held on 27th April 2011

The minutes of the previous meeting were approved subject to the following:

- noting that 'Mrs' Astbury should read 'Mr'.
- TB 11/12 08, 9th paragraph, addition of 'the position' after 'not improving'

TB 11/12 16 Matters Arising

Dr Hickey introduced Dr Gerry McSorley, who has now taken up his position as Chief Executive of the Trust.

Mr Fred Evans, shadow governor, noted that a meeting of the Hotel Services focus group has been held. A visit to Finedon Ward had been undertaken and was found to be in excellent condition, clean and the patients were happy with the food they have been receiving.

TB 11/12 17 Delivering Safer Care

Mrs Jane Bradley presented 'Delivering Safer Care' to the Board noting that patient safety is everyone's business. Progress should be visible and measurable. Mrs Bradley discussed the initiatives throughout the Trust which include the patient safety strategy group, junior doctor's patient safety forum, quality indicator scorecards and ongoing patient safety training programmes.

New initiatives for 2011 include prevention of death from VTE, ward safety champions, Patient Safety Board, surviving sepsis - action box and audit and the enhanced recovery programme.

Mrs Bradley commented that it is important that we engage all staff, that Trust board support is essential and that we continually work to develop safer systems and to ensure that every member of staff understands their role in delivering safer care.

Dr Hickey noted that he was impressed with the emphasis that is put on patient safety within the organisation and then asked about the response of staff to the initiatives. Dr Swart replied that it is important to talk to staff about the issues and things to be done. The challenge is to use the input to redesign systems so that the only way to do things is the safe way. Redesign of systems is not easy, we frequently need to reset and update goals in line with the external and political environment. It is a continual journey.

Mrs McVicar, shadow governor, asked if, when undertaking a test, for example thrombolysis, do staff tell the patient what they are doing as if this happens you enhance their experience. Dr Swart replied that we have booklets for each area that explain what is happening, messages are also on the bedside televisions and there is information on the safety board i.e. this is what we're doing to help you not get blood clots.

Dr Hickey asked if it was a concern that there are too many initiatives therefore diluting the focus. Dr Swart replied that many initiatives are embedded in normal practice; which is clearly set out in the safety strategy.

The Board **noted** the report and thanked Mrs Bradley

TB 10/12 18 **Chief Executive's Report**

Dr McSorley provided an update on the Government reform plans and noted that the Government proposals had been paused and a forum was provided for observations on the changes. The NHS Confederation has published an analysis of the Government's revisions to the bill highlighting issues that the NHS Confederation believes require review.

A number of items have been confirmed. PCTs have now clustered and Northamptonshire and Milton Keynes are now a single cluster. SHAs will now cluster during transition phase although we do not know yet what this will look like for us in the East Midlands. We are likely to find out in early July.

The NHS Commissioning Board will assume its functions and SHAs and PCTs will be abolished. The timeline for achievement of Foundation Trust status of April 2014 has been amended so that where there are substantial sensible reasons then extra time will be provided. The timetable for implementation has slightly altered, and we expect further clarification over the coming months.

Dr McSorley noted that the performance and finance reports both reference continued high levels of activity and discussion of the Acute Services Review will take place later in the meeting as it has now formally commenced under the

sponsorship of the PCTs.

The Board **noted** the report.

TB 11/12 19 **Infection Prevention Report**

Dr Swart presented the infection prevention report in Mrs Barnes absence. The Trust is within its trajectories for healthcare associated infections however the targets are challenging and continued focus is required. There were no post 48hrs MRSA bacteraemias in May, with the post 48 hours cases per 10,0000 bed days year to date is 0.28. During May there were 16 pre 48 hours and 2 post 48 hours cases of MRSA colonisation and no post 48 hours cases of MSSA bacteraemia.

The surgical site surveillance scheme is a national programme coordinated by the Health Protection Agency. The Trust submits data on a quarterly basis which allows us to benchmark our data with the national picture. The interim results for surgical site surveillance of fractured neck of femur repairs are 1 infection from 24 operations in April and zero infections from 22 operations in May. The approach that has been taken for MRSA and C Diff is being extended to surgical site infections.

Dr Hickey reminded the meeting of the progress made over the years in relation to healthcare associated infections and that the Board adopted a zero tolerance policy.

(Mrs Barnes joined the meeting)

Dr Hickey queried the 100% compliance with hand hygiene audits. Mrs Barnes replied that our Patient and Public Involvement infection prevention group have been reviewing the hand hygiene audits.

Dr Hickey asked about the Health Protection Authority, and when will we see the results of our data submission. Mrs Barnes replied that data is submitted at the end of the quarter and it usually takes three to four months to collate and return.

Dr Hickey asked about the actions being taken regarding surgical site infections and Dr Swart replied that improvements need to be made. A surgical site care bundle has been developed and, if applied on every occasion, will reduce the likelihood of infection.

Dr Hickey asked about MRSA colonisation by ward, and if Creaton is still on special measures. Mrs Barnes replied that we continue to monitor the position each month.

The Board **noted** the report.

TB 11/12 20 **Performance Report**

Mrs Allen presented her report and noted that the new A&E indicators are very complex and challenging for any organisation and that plans are in place to meet these new standards.

During May the Trust did not meet the indicators for Total time in the A&E department for admitted patients, maximum time spent in A&E for admitted and non admitted patients and Time to initial assessment.

Actions are being taken to ensure progress towards all indicators in line with the action plan. The actions include reconfiguring of the nursing establishment and the introduction of team nursing, alert to a senior Doctor at 45 minutes if the treatment

plan has not commenced and the set up of an Urgent Care Board to improve patient flow.

Mr Zeidler noted that the longest wait was 13 hours but that this was not waiting for treatment and it would be helpful to clarify wording. Mrs Allen replied that the wait is for the entire stay for treatment.

Mr Robertson noted that we are constrained by volume and bed blocking and asked what is being done about the system processes. Mrs Allen replied that within our Health Economy we have had long discussions through the integrated care board looking at treatment for frail, elderly patients. Current schemes are having an impact, although fairly small at the moment. With regards to social care, additional funding has been provided to enable that flow. There are some recommendations that the Intensive Support Team will make around the wider health economy and Mrs Allen can discuss them through the Integrated Care Board.

Dr Hickey asked if planning for winter pressures has commenced and Mrs Allen replied that it has, the first workshop was held last week.

Two week wait breast referrals standard, the Trust achieved 82.8% against the standard of 93%. 11 patients were not seen within two weeks. This was due to patient choice and also our capacity. Actions are in place to achieve the standard for the quarter with additional capacity being put in place. There is a revised escalation process in place and we are providing better information for GPs. The Trust is on target to deliver the standard for the quarter.

80% of patients were treated within 62 days from urgent referral to start of treatment, against the standard of 85%. 15 patients were not treated within target. All patient pathways have been reviewed and further actions put in place and the Trust is on target to achieve the standard for the quarter.

The standard of 80% of patients spending at least 90% of their time on a stroke unit was achieved, however work continues to ensure that the standard is achieved for the quarter. An Early Supported Discharge service in the community is being developed to increase rehabilitation capacity.

The Board **noted** the report.

TB 11/12 21 **Finance Report**

Mr Foster presented the finance reported and noted a £1,019k deficit against a planned position of £1,025k deficit, a £6k favourable variance.

Non elective activity is £1.5m above plan and is subject to an MRET adjustment of £586k for the first two months of the financial year. Two hundred spells were uncoded and have been subsequently validated leading to a £730k MRET adjustment. Elective activity is being impacted due to the non elective pressures.

Costs are £270k favourable against plan, and include CIP targets. There seems to be less non-elective pressure in June and this has allowed us to commence our bed closure programme.

There has been an overall reduction in WTE workforce in April and May, including the effects of the transfer of community services.

The Better Payment Practice Code shows 96% compliance by volume and 67% compliance by value. The target is for 95% compliance. The cash balance has

reduced by £2,745k since the end of March and there are increased debtors due to the costs of the Transformation programme and delays in payment for the new TCS services.

With regard to Directorate performance, the impact on performance in Surgery can be seen due to the non elective pressures. More forward looking information will be provided to the next meeting, however the Trust is still on target to achieve £0.5m surplus.

Mr Noble commented that three directorates are worse than budget in just 2 months with high numbers of agency and locum staff. Mrs Allen replied that agency numbers are high as, during the month we were still opening escalation areas which account for these numbers. Dr McSorley commented that we would expect the closure of Victoria and Compton wards to have an impact on these figures.

Mr Zeidler asked about the MRET challenges, there is £0.5m variance to plan in the first 2 months, what assurances are we receiving from the PCT about reducing demand. Dr McSorley said that in light of the month two numbers we will be discussing at a meeting being held shortly and we can demonstrate that the impact of schemes is not sufficient so far. The meeting will be operational and will look at schemes in detail.

Dr Hickey asked that, for the non-elective demand, are they all patients that need to be in an acute hospital. Dr Swart replied that work has been ongoing with the ambulance service, but broadly speaking if patients attend A&E we do not admit if they can go elsewhere in the system and we are working with supporting care homes etc.

Mr Fred Evans, shadow governor, enquired about the debt for Cripps being reduced by half. Mr Foster replied that they have paid the first instalment of their repayment plan.

The Board **noted** the report.

TB 11/12 22 **HR Report**

Ms Wilkinson presented her report and noted that the e-rostering project remains on schedule, with 20 wards and 29 departments live and interfacing with ESR.

Mr Zeidler noted that although it is early days, what is the anecdotal feedback. Ms Wilkinson replied that it is still early in the process and not fully implemented. Once it is then staff will have to actively respond to the reporting if their roster looks unbalanced. The system provides significant live information which helps with managing the rosters.

Mr Robertson enquired about the back office review and Ms Wilkinson replied that a first outline of observations will be presented to the Transformation Delivery Group next week.

Mr Zeidler noted that it is encouraging to see a reduction in temporary staff costs, even with pressures seen, and asked if we understand how this has been achieved. Ms Wilkinson replied that it is a combination of factors including the reduction in sickness absence.

Dr McSorley asked about the WTE figures, 3,723 in the HR report and 3,982 in finance report. Mr Foster replied that the finance figures include both WTE and temporary staff whereas the HR figure does not.

Fred Evans noted that pharmacy should be recognised for their 100% achievement of attendance at return to work interviews.

The Board **noted** the report.

TB 11/12 23 **Quality Account**

Dr Swart presented the quality account report noting that these are annual reports to the public that give details about the quality of services delivered and outline the priorities and plans for improvement. The Board approved the draft quality account to be sent to stakeholders for comment in May 2011.

The Directors are required to sign a Statement of Director Responsibilities and it was noted that a dry run third party assurance process has been undertaken.

The Board **approved** the signature of the statement and congratulated staff on the work that has been undertaken.

It was noted that the accounts will not be externally printed to save costs, and will be available on the NHS Choices website and the Trust website from tomorrow.

TB 11/12 24 **Acute Services Review**

Mr Pallot presented the report noting that it follows on from previous verbal updates to the Board. The contents of the paper include the deliverables for the programme and the methods to be used to engage stakeholders.

First phase has been to design the programme and develop the engagement strategy with clinicians, the public and other key stakeholders. It is anticipated that a further report to the board will be made in September. The programme has some initial deliverables however it is clear that the majority of the recommendations will not be put in place until 2013.

Mr Robertson asked about the governance of the programme and if it includes NHS Northamptonshire and Milton Keynes. Mr Pallot replied that it does, the programme is 'Commissioner enabled, Provider led'. Dr McSorley noted that the Chief Executives of the PCTs are sponsors and that they are accountable with a common responsibility.

Mr Robertson asked if this is in parallel to the QIPP initiatives, for example real estate. Dr McSorley replied that there clearly needs to be an interaction between the streams. Mr Robertson asked what assurance process is there in place for the directors in this organisation that this is going forward. Dr McSorley replied that the Chief Executive, Medical Director and the Director of Planning and Performance have significant involvement in all elements of the work.

Mr Noble enquired about the funding and Mr Pallot replied that there is no requirement for us to fund, but that there will be significant management time required.

Dr Hickey asked how this will impact our ability to put together a Long Term Financial Model and Dr McSorley replied that it should assist us. Early conversations with KPMG indicate we should gain a greater degree of confidence, provided we scope it properly.

The Board noted the report and **resolved** that the Trust is committed to participating and contributing to the review and ensuring that the scope and focus is appropriate.

Action: Acute Services Review update to September meeting

TB 11/12 25 **Annual Plan 2011/12**

Mrs Allen presented the Trust annual plan for 2011/12, which covers the Trust's delivery against the previous year's objectives, the Trust membership report, financial projections and forward planning information. Mrs Allen noted that the PEST analysis will need to be updated to reflect some of the changes that we are currently seeing.

Mr Robertson noted that the Board is undertaking a workshop session next month on the board assurance framework following approval of the corporate objectives.

The Board **approved** the report.

TB 11/12 26 **Corporate Objectives 2011/12**

The board noted the final version of the Trust corporate objectives, ensuring that they are measurable.

Dr Hickey requested quarterly reporting on progress against achievement and to ensure that sufficient time for discussion is allocated.

The Board **approved** the corporate objectives

Action: Ms S Rudd to note quarterly agenda item

TB 11/12 27 **Any Other Business**

There being no further business the meeting was declared closed.

Date and Time of Next Meeting
Wednesday, 28th September 2011, Boardroom, NGH

Actions arising

TB 11/12 24	Acute Services Review update	CP	September 2011
TB 11/11 46	Note quarterly agenda item for corporate objectives	SR	November 2011

TRUST BOARD SUMMARY SHEET	
Title	Care Quality Commission – Registration and Declaration
Submitted by	Fiona Barnes, Interim Director of Patient, Nursing and Midwifery Services.
Prepared by	Roz Young. Interim Head of Governance
Date of meeting	28th September 2011
Corporate Objectives Addressed	To improve clinical quality and safety

SUMMARY OF CRITICAL POINTS

- Northampton General Hospital is registered with the Care Quality Commission (CQC) and its services were inspected in June 2011.
- The CQC reviewed evidence of compliance on 8 of the 16 outcomes and determined that at this stage 3 required a more depth review.
- Following the on-site inspection the CQC identified a minor concern in Outcome 4 shown in their report which is enclosed.
- The Board and Non-Executive Directors must assure themselves that NGH are maintaining compliance with the 16 essential standards for Quality and Safety and they do this through a bi-annual confirm and challenge with outcome leads.

PATIENT IMPACT

The CQC Essential Standards for Quality and Safety are designed to ensure that the healthcare delivered at NGH is safe and effective for the population we serve.

STAFF IMPACT

Compliance with the CQC Essential Standards for Quality and Safety ensures that staff have the training, education and support they need to do their job effectively.

FINANCIAL IMPACT

There is an annual registration fee of 85K, requested in June 2011 to cover the 2011/12 registration fees. This is a 40K increase from the estimated fees and is a result of the CQC redefining how the fees would be calculated. They have now decided fees will be based on turnover rather than bed base.

EQUALITY AND DIVERSITY IMPACT

Compliance with the Quality and Safety standards will enable NGH to deliver healthcare that meets the needs of the community we serve and that no act or omission is detrimental to a diverse group of staff or population.

LEGAL IMPLICATIONS

It is a legal requirement to register with the CQC. Failure to remain registered and monitor compliance at Board level may result in enforcement action being taken by the CQC.

RISK ASSESSMENT

The Trust is at risk of having conditions attached to the registration and possible enforcement action being taken if there is a failure to demonstrate ongoing compliance with the CQC Essential Standards for Quality and Safety.

RECOMMENDATION

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

Introduction
Northampton General Hospital Trust (NGH) recognise that providing a safe and effective service is of paramount importance. The Executive and Non-Executive Directors have undertaken a series of confirm and challenge meetings to monitor ongoing compliance. This report summarises the outcome of those meetings. In addition NGH were requested by the Care Quality Commission, to submit a Provider Compliance Assessment Report (PCA) for eight of the sixteen Essential Standards for Quality and Safety. The outcome of this was reported to Board in June 2011.

CQC Inspection
The CQC reviewed the trusts evidence of compliance on 8 of the 16 outcomes and determined that at this stage 3 outcomes required a more in depth review; these were Outcome 4, 7 and 16. They carried out a visit on 29 June 2011, 30 June 2011, 4 July 2011, checked the provider's records, talked to staff, reviewed information from stakeholders and talked to people who use services.
The CQC inspection identified no concerns for outcome 7 and 16 and one area of minor concern in outcome 4;
Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights.
Patients who are able to communicate easily get the care and attention they need. The quality of care experienced by patients less able to communicate their needs may be compromised by the lack of information about the way they communicate their needs.

The full report can be found in appendix 1. NGH were requested to submit an action plan to identify how we would resolve these issues achieving compliance. This was submitted on the 23rd August and ongoing compliance will be monitored by the HGC.

NGH Internal Confirm and Challenge Meetings
A series of confirm and challenge meetings took place between May and July 2011 for each of the 16 Essential Standards for Quality and Safety. The purpose of the meeting was to gain ongoing assurance of compliance with each standard and also to ensure that there are detailed action plans in place to resolve any areas that require improvement.

At the meeting the Executive, Non Executive Director, Quality Assurance Manager (or representative) and Corporate lead/s for each outcome were all present (later referred to as the team) and the following reports were reviewed;

- A report for each outcome provided by the lead/s providing an overview of the outcome and the list of evidence available.
- A directorate clinical governance framework report was cross-referenced to the Essential Standards.
- A status report which indicated when the last update was provided on performance accelerator by the lead/s.

To inform the confirm and challenge process the team also used the;

- CQC Judgment Framework
- Quality and Risk Profile (QRP)
- CQC Inspection reports from other trusts.

The QRP provided the team with greater understanding of how they should judge compliance and risk. Following each meeting, actions were recorded by the Quality Assurance Manager and will be uploaded onto performance accelerator where progress will be monitored. Actions have progressed since the confirm and challenge process was undertaken, thereby providing further assurance that work is continuing at a pace expected in relation to the serious nature of CQC compliance.

The outcome of the 'confirm and challenge' meetings is that NGH has maintained compliance with the 16 Essential Standards for Quality and Safety. However there were elements within the standards that the team require further action for assurance purposes which will be reviewed as part of the next confirm & challenge meeting.

Next Steps

1. The Lead for each outcome has developed a detailed action plan for any area requiring improvement
2. The next Confirm and Challenge meetings are planned to commence November 2011.

Recommendation

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

Review of compliance

Northampton General Hospital NHS Trust Northampton General Hospital	
Region:	East Midlands
Location address:	Cliftonville Northampton Northamptonshire NN1 5BD
Type of service:	Acute services with overnight beds Rehabilitation services
Date of Publication:	August 2011
Overview of the service:	Northampton General Hospital NHS Trust provides healthcare services from locations that cover the Northampton and Daventry area along with the south of Northamptonshire. Northampton General Hospital is an acute hospital located in the centre of Northampton. The hospital provides all major specialities which includes a 24 hour accident and emergency service.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Northampton General Hospital was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 29 June 2011, carried out a visit on 30 June 2011, carried out a visit on 4 July 2011, checked the provider's records, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We spoke with patients using the service on 10 wards over a period of two and a half days and received a lot of positive comments about the care and treatment that people were receiving.

Patients told us that nurses and health care assistants treat them with respect and remember to close the bed area curtains to preserve their privacy and dignity. They also told us that when they are taken to other departments in the hospital for treatment or tests and are not fully clothed, then staff make sure that they are covered with a blanket.

Patients were positive about the care and treatment that they were receiving. The comments included; "The doctors know what they were doing", "Although staff are very busy, patients get the help and care that they need", "We cannot fault the care and attention", "Staff are kind and caring".

Patients told us that patients who need help with their meals get it. One patient said that it was unpleasant to have the meal that they had been unable to eat left in front of them when they were feeling unwell and would like staff to take it away a bit quicker.

Patients told us that it can sometimes be difficult for them and their relatives to get the information that they need. One relative had been particularly distressed as they were unable to find out why the patient had not returned from theatre when expected. A patient also told us that they had experienced difficulties and a long delay in getting the medication they needed when they were discharged from hospital. They thought this may be as a result of poor communication between departments.

However another patient told us that they had found communication to be very good. They told us that their planned operation had been cancelled, but they were satisfied that they had received a very good explanation why the operation could not go ahead as planned.

What we found about the standards we reviewed and how well Northampton General Hospital was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

Patients who are able to communicate easily get the care and attention they need. The quality of care experienced by patients less able to communicate their needs may be compromised by the lack of information about the way they communicate their needs.

Outcome 07: People should be protected from abuse and staff should respect their human rights

Allegations of abuse are taken seriously and appropriate action is taken by staff to ensure patients are protected from harm.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The assessment and monitoring of the quality of care and treatment involves staff at all levels. The trust has identified the need to learn from incidents and is demonstrating that it is taking action to improve the quality of care and treatment that patients receive.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We visited 10 wards over a period of two and a half days and spoke with patients, some of their family members and staff providing care. We looked at a sample of care records and observed interactions between staff and patients. The wards we visited included those specialising in surgery, medicine, trauma and orthopaedics, head and neck and oncology.

Patients made a lot of positive comments to us about their care and treatment. For example, one patient said that they had been dealt with promptly on arrival in the accident and emergency department and had confidence in the doctors who they described as "knowing what they were doing". Other comments which summarise the views of patients and visitors included "Although staff are very busy, patients get the help and care that they need", "We cannot fault the care and attention".

We observed staff supporting patients with meals and drinks and providing them with reassurance. On one ward we spoke with someone who was reluctant to have a meal because they had difficulty managing to eat it without help. A member of staff provided the support they needed to enable this patient to enjoy their meal.

Two patients told us that initially they had received care on the emergency assessment unit and that this unit was particularly busy and noisy with new admissions and "staff coming and going throughout the night". We explored this further by speaking with patients on the emergency assessment unit. Their comments were summarised by someone who said that the 'noise' was unavoidable as new patients were constantly

being admitted to the ward, some of whom were confused or distressed.

Two carers accompanying a patient who was unable to speak with us said that they were happy with the medical care and treatment being provided. They told us that staff were helpful and kind. The carers told us that they were there to support the patient's mental health needs while they were in hospital.

Some patients told us that they were given good information about their care and treatment and any changes to this. For example one patient told us that their original planned operation had been cancelled because someone else needed an emergency operation. They were told enough information to understand and accept the reasons why their operation had been cancelled.

In contrast we spoke with a patient who told us that their relative had not been able to find out why their operation had taken longer than expected. The relative told us that they had been very anxious and distressed as a result, and that they thought staff could have been more helpful in keeping them better informed.

One patient told us that on their recent admission to hospital the arrangements for their discharge had been poor. In the morning they were transferred from the ward to the discharge lounge to wait for their pain relief medication. Staff were unable to tell them when their medication would be available. It was eventually agreed that they could go home and a relative agreed to return for their medication later. We were told it was around 8pm before the medication was ready to be picked up.

Other evidence
Over three days we observed and spoke with staff responsible for patient care and treatment. We spoke with health care assistants, nursing staff, pharmacy staff, and physiotherapists. We also spoke with members of the discharge team, managers, doctors and a consultant, all of whom came across as being committed to patient care and making improvements.

We saw staff on the wards responding appropriately and promptly to patients and visitors.

A consultant told us about improvements that had recently been made to senior staff rotas. These changes meant that a consultant was now available and carrying out ward rounds for longer periods throughout the day.

There was a system in place for nursing staff to quickly identify risks to patients through the use of readily identifiable symbols which are displayed on boards above each bed. The risks identified included, for example, not eating or drinking enough, developing pressure ulcers or blood clots, or being prone to falls.

Specialist equipment such as pressure mattresses were in place for patients suffering from, or at risk of, developing pressure ulcers. Staff knew they needed to reposition patients regularly to minimise the risk and we saw records confirming when this was done. However some records we saw relating to the use of pressure mattresses were not consistently dated. This meant that it was difficult to establish when the equipment was first used.

We found that nursing staff knew who they needed to help with eating and drinking. A symbol above the bed of patients needing such help was an additional prompt to staff that assistance was needed. This information is also recorded on the patient's plan of care, which is completed on admission to the ward.

Staff explained that meal times are 'protected'. This means that all staff on the ward can devote their time to those patients who need help at mealtimes. Routine ward rounds, for example, do not take place during the protected period. Patients told us they liked this system and that it worked well. It meant they could enjoy their meal in relative peace and get the help they needed if they had difficulty in managing their food or drink.

Staff acknowledged that there are times when there are unavoidable mealtime interruptions. For example, someone had to go for a necessary medical scan during the protected mealtime. We were told that arrangements were made for them to have their meal later on.

On one ward we noted that the hostess served patients with their plated meals, including those who were identified as needing help. In one case we observed that a meal was left on someone's table before a staff member was free to help them. Although the meal was served covered with a lid to keep the food warm there did not appear to be a facility for leaving meals in a hot cabinet if staff are unavailable for more than a few minutes. In this instance, however, the patient did not have to wait long before a staff member arrived to help.

We visited another ward at the end of the meal time period and found that several patients were left with unfinished meals in front of them. They had been assessed as being able to manage their meals independently. We were told that there was nothing wrong with the food; they just did not feel well enough to finish their meal. One patient commented that it was not very pleasant to have the remains of his meal left in front of him, especially when he felt unwell. The matron for that ward confirmed that she would address this issue.

For patients identified as being at nutritional risk we found that their food and fluid intake was being monitored and recorded. We also observed that patients had access to regular drinks and that staff were helping where necessary and recording this on a fluid intake chart. However we did find an overnight gap in one patient's records which we raised with the nurse in charge, who told us this would be looked into. We also spoke with this patient's relative who visited twice a day. She said staff were always encouraging her mother to drink and that she had seen them record the amount drunk on a sheet kept attached to the bed frame. When we re-checked this patient's records the following day we found they were being appropriately completed throughout the 24hr period.

Where patients had been transferred from an assessment ward to another ward in the hospital, we found that a new assessment of risk was carried out on admission to the new ward. This process provided the necessary up to date information staff needed to manage any identified risks so that the patient's care could be safely managed.

We found that wards differ in the way information is recorded, for example making use of different forms to record the same information. We found it initially confusing, and staff moving between wards also told us this makes their job more difficult, especially if

they need to absorb information quickly and know what is going on in the a ward they may be unfamiliar with. One patient commented that from what he saw going on around him staff had to contend with 'lots of paper' to find out what other disciplines were currently saying and doing when it came to ensuring consistency of treatment. We were told by senior managers, however, that records are being standardised across all wards so that each discipline involved in a patient's treatment will be better informed about their colleagues' involvement.

We looked at the records for two patients with a learning disability to see how the hospital manages patients with special needs. Information about the patient that would serve to guide staff, such as 'communicates through signs and gestures', or 'patient does not normally speak but responds to conversation', appeared insufficient. We saw no documented evidence that an effort was made to expand upon these simple general comments about how the patient would communicate with staff.

We observed one patient trying to catch the attention of staff by using signs and gestures. When we drew a staff member's attention to this she made every effort to establish what they needed, and then helped them with a drink. We discussed with the staff member the fact that the patient was continuing to use the same signs and gestures, she commented that they had been doing this earlier in the day and didn't think it was anything to be concerned about. Due to the lack of information in the patient's records about how they communicate their basic needs such as thirst, hunger and pain and the fact that the patient continued to try and attract attention through signs and gestures, we raised this with a nurse. The nurse confirmed that she would check on the patient and contact the care home where this patient lives, for more detailed information about how they communicate.

Staff also told us that they can access support and advice about caring for patients with a learning disability through a part time specialist learning disability nurse, although this nurse only worked two days a week. Senior staff told us that they had an action plan in place to increase staff support to learning disability advice and as such had increased the hours of the learning disability nurse.

We found that additional arrangements had been made to support someone with dementia on one of the assessment wards. We were told that the patient had been very confused and distressed and their behaviours were putting other patients at risk. We heard the staff member talking with the patient in a calm and soothing manner. We also spoke with a visiting relative of another patient with dementia. They told us they were happy with the care being provided, although they commented that staff were very busy and they wondered how much time they would have to provide reassurance and comfort to someone who had no relatives or regular visitors.

Staff told us that they were due to have some dementia care training which they felt would help them to support patients with dementia better while in hospital. We discussed this with one of the matrons who confirmed that specific wards had been identified as priorities for this training.

Our judgement
Patients who are able to communicate easily get the care and attention they need. The quality of care experienced by patients less able to communicate their needs may be compromised by the lack of information about the way they communicate their needs.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
When we spoke with patients on the wards they told us staff were kind, were mindful of their dignity when helping them with personal care and showed them respect.

In 2010 we conducted a survey of adults receiving in-patient treatment at the hospital. We found that the number of patients at Northampton General Hospital who said they felt threatened by other patients or visitors in comparison with other hospitals was much worse than expected. However, during our current visits to the wards we did not meet anyone who had been or felt threatened, but staff did tell us that precautionary arrangements had been made for someone to have one to one support from staff throughout the day. This was put in place because the previous day some patients on the ward had felt threatened by this patient's unpredictable behaviour and that staff needed to take action to minimise risk and reassure other patients on the ward that they were being protected from harm or discomfort.

Other evidence
As part of our review we asked for some information to be sent to us about how this outcome area was being met. The trust's response acknowledges that more work is needed to be done to make sure the hospital is fully compliant with this outcome area.

Some of the actions that the trust has already identified include providing more trainers in matters of safeguarding, and reviewing and where necessary revising existing safeguarding policies as lessons are learned. The trust has also identified that it needs to provide more accessible information to the public about safeguarding. Senior

managers told us that pertinent information about safeguarding incidents is escalated to executive level within the trust.

We spoke with health care assistants and nursing staff, including bank and agency staff, and asked them about their knowledge of safeguarding procedures within the hospital. They were all aware of their responsibilities for reporting any incidents of abuse or concerns they may have about poor care or treatment. With the exception of one agency worker all staff knew the name of the trust's safeguarding lead and how to contact her. However the agency worker was clear about her responsibility to report any concerns to the person in charge of the ward.

Staff told us that they receive training they need to protect patients from abuse and one member of staff told us that they had been given some extra responsibilities for increasing awareness of safeguarding amongst colleagues.

As part of our review we asked Northamptonshire County Council (NCC) safeguarding team if they had any information about how the trust responds to safeguarding. They told us that they are currently investigating some safeguarding concerns that have been raised by people outside the hospital. They felt that the number of safeguarding referrals they receive from the hospital about allegations or incidents that have occurred in the hospital is relatively low.

Senior managers told us that there had been an increase in safeguarding incidents recently, which had concerned them. Although the reasons for the recent increase in the number of safeguarding incidents is not clear, we found that staff do know what to do if they have concerns. Senior managers made it clear that they are taking the matter seriously and will ensure that appropriate action is taken in all cases.

One particular case is currently being investigated by the hospital under their serious untoward incident procedures. The trust are working with Northamptonshire County Council's (NCC) safeguarding team to review and revise their procedures to ensure that the expectations and reporting procedures are more compatible. Senior managers within the trust have responded quickly and positively to questions that were raised and have developed revised draft procedures for further discussion with NCC.

Although the investigations referred to above have not yet been completed, early indications are that staff need further training about the Mental Capacity Act 2005 and its practical application. We were told this is being actively addressed by the trust. For example, information supplied by the trust before we visited told us that their Mental Capacity Act policy was reviewed in June 2011 and had been amended. It also identified that training has been identified as mandatory for specific staff groups. A senior manager told us that recent Mental Capacity Act training for consultants and nursing staff has already taken place. Staff we spoke with also confirmed that they were to receive more training in this area.

Part of ensuring that patients are adequately safeguarded is ensuring that decisions about their care and treatment are made with consideration to their mental capacity and whether decisions should involve anyone else to advocate on their behalf. We found a 'Do Not Resuscitate' form on the file of someone with mental health needs. From the way the form had been completed we were unclear whether the patient had been assessed as having capacity and whether anyone else had been, or should have been,

involved in the decision making. The patient was too unwell for us to ask them about this and staff told us that it had been a clinical decision. On discussion with the ward sister she confirmed that she would follow this up to ensure that the correct people were involved in such an important decision. We also raised this issue with senior managers in order to ensure that this is covered in the planned training.

During our visits we identified a sample of incidents that had been reported to the National Patient Safety Association and asked for further information about the actions taken. We found that appropriate action had been taken to protect patients, although senior managers had identified one incident that had not been reported through the trust's safeguarding vulnerable adult procedures as it should have been. They took immediate action to rectify this. In addition they provided reassurances that they would review how incident reports are screened to ensure that procedures are consistently followed in future.

Our judgement
Allegations of abuse are taken seriously and appropriate action is taken by staff to ensure patients are protected from harm.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
Patients told us that they are asked for their views about their care and treatment during their stay in hospital. They are asked to answer a set of questions generated on a hand held electronic device which is left with a sample of patients. This is referred to as a patient tracker system and provides senior managers with an overview of patients' experiences on the wards.

One patient told us that they liked the fact that they could make comments about their care without feeling rushed or pressured to answer. Another told us that they felt it was important to tell someone about things that had gone wrong so that improvements could be made, but that they did not want to make a fuss when they were feeling unwell.

Other evidence
Before we visited the hospital we received information from the trust about how they assess and monitor the quality of their care and services. This information told us that there are several groups within the hospital who are responsible for quality. These include the Clinical Quality and Effectiveness Group and Healthcare Governance Committee who submit reports to the trust board every three months and also submit monthly minutes.

The Medical Director and Director of Nursing and Midwifery take lead responsibility for the assessment and monitoring of the service and submitting reports on quality matters to the trust board. There is also an Operations Director who is responsible for providing

confirmation and challenge of the evidence of quality assurance bi-annually.

Trust board meeting agendas and minutes show that quality matters are discussed at board level. For example on 29 June 2011 the board were to approve the final Quality Account report for 2011/12. This is an important report which is made public and which the directors are required by law to prepare each year. It reports on progress over the previous year and sets priorities for the coming year. At the trust board meeting four quality priorities were set for 2011/12, based on improving patient care and making sure that patients receive the right care.

One of the priorities for improvement in 2011/12 is improving the patient experience for vulnerable adults. We are aware that there have been some complaints and safeguarding investigations about the care of vulnerable patients. Choosing this as a key priority indicates that this information has been escalated to board level and taken into account in the plans for improvement.

We wanted to see what happens when something does go wrong and whether improvements are made as a result. A senior manager provided us with a copy of an action plan that had been developed following a safeguarding vulnerable adult referral. The plan confirmed that the matter had been taken seriously; it acknowledged the problem and clearly identified the actions that were to be taken to make improvements and the timescales that they would be achieved by. Some actions had already been taken with some initial training sessions, and ward staff told us that they were aware that they were to have more training. They also told us that they were aware of some recent safeguarding concerns and the need to understand their responsibilities.

Our discussions with senior managers identified that they recognise the importance of learning from incidents and quickly identifying improvements that can be made. This was demonstrated through discussion about the above safeguarding case.

In November 2010 a report on discharge arrangements was produced by the Local Involvement Network (LINk). The LINk is a group made up of individuals and community groups who work together to improve healthcare and social care services. The report findings included issues about poor communication, transport not being arranged and medication not being ready. We also know that complaints and safeguarding referrals have been made about the discharge from hospital. We spoke with a manager in the discharge team about what action is being taken in respect of concerns relating to discharge. We were told that the need to separate complaints and have a more focused approach to addressing the problems has been acknowledged. A group has been set up and is due to meet the first week in July 2011 to identify actions that need to be taken to improve patient experiences of discharge.

When we spoke with nursing staff on the wards we could see that from the point of admission they were starting to look at arrangements for discharge. We spoke with a member of staff in the discharge lounge (which is now closed), someone from the hospital discharge team and also a pharmacy technician on the ward. Our discussions with these people identified that timely actions and good communication by different departments is critical to the safe patient discharge. A thorough analysis of complaints is a key factor in identifying what went wrong and where improvements can be made. We found a case where a person believed there had been a significant delay in pharmacy preparing medication, when in fact the delay was in the doctor writing the

prescription.

Staff were aware of patient comments that had been made through the 'experience tracker' (an electronic device used by patients to comment on their care and treatment) and of some of the concerns that had been raised about patient care. This is important in helping to improve practice. For example a ward sister was aware that there had been several concerns raised about noise on her ward, and told us that although the concerns related to noise from patients she was working with staff to try and reduce noise levels as much as possible. Although not always possible, on the day of our visit a very confused patient had been allocated a side room to reduce their distress and noise levels for others.

We found that an audit system had been implemented on the wards to assess the quality and safety of care, treatment and support that patients were receiving. A matron explained further improvements were to be made to the audit tool so that it was more focussed on checking the quality of information within assessments and care plans. She was also keen to ensure that it captured the actual care and treatment being provided, rather than just checking the relevant documents were in place.

Senior staff told us that new record keeping documentation is to be launched in September as a result of a review which had taken place. Staff told us that the review found a difference in practice on wards in relation to where information such as clinical and nursing notes were stored within patients' files, and also in signing records such as fluid charts. We also found that this could be confusing. For people working across different wards there was the potential for important information to be missed, which then may impact on the care that someone receives.

We were assured by senior staff that staff would receive training as part of the implementation of the new record keeping system. This will include improving the quality of information in the records. One particular area that we identified was a need to improve the information about communication for patients with no verbal communication.

The trust has had three mortality outlier alerts since September 2010. Mortality outliers identify an unexpected number of deaths of patients after being admitted to hospital for a particular condition or procedure, when compared with figures for other trusts. The trust was required to investigate these cases and provide us with information about their investigation. Following this, one of the cases has been closed as the trust was able to provide us with assurances about their actions. We have requested further information in another case, and in respect of the third we are reviewing the response.

Our judgement
The assessment and monitoring of the quality of care and treatment involves staff at all levels. The trust has identified the need to learn from incidents and is demonstrating that it is taking action to improve the quality of care and treatment that patients receive.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: The quality of care experienced by patients less able to communicate their needs may be compromised by the lack of information about the way they communicate their needs.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within 14 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA

TRUST BOARD SUMMARY SHEET	
Title	Quality and Patient Experience Report
Submitted by	Fiona Barnes, Interim Director of Nursing, Midwifery and Patient Services
Written by	Keren Salt, Governance Facilitator, Patient Experience
Date of meeting	28th September 2011
Corporate Objectives Addressed	To improve clinical quality and safety

SUMMARY OF CRITICAL POINTS

This report provides a summary of some of the quality and patient experience initiatives within the Trust and includes the Quality Priorities for Nursing and Midwifery 2011/12, the Clinical Governance Review Scheme (CGRS) and an update on the Patient Experience Tracker.

PATIENT IMPACT

The Nursing and Midwifery Quality Priorities demonstrate our commitment to key areas of patient care. The CGRS provides us with a method to review that compliance levels across the Trust are those that are expected by our patients, in that they are safe and effective for the population we serve.

STAFF IMPACT

The implementation of the Quality Priorities will give staff the opportunity to enhance the overall patient experience within their own area. The CGRS will facilitate the development of activities which increase our compliance levels at an operational level and provides a further opportunity to embed the CQC Essential Standards of Quality and Safety. The Patient Experience Tracker will enable us to monitor the progress of our improvement plan.

FINANCIAL IMPACT

Failure to achieve compliance with the CQC essential standards at Directorate level could result in financial penalties for the Trust.

EQUALITY AND DIVERSITY IMPACT

The CGRS assesses whether staff deliver healthcare that meets the needs of the community we serve and that no act or omission is detrimental to a diverse group of staff or population.

LEGAL IMPLICATIONS

It is a legal requirement for NGH to monitor compliance with the CQC essential standards and this is monitored at Board Level. The CGRS ensures there is also accountability for compliance throughout the organisation.

RISK ASSESSMENT

Failure to demonstrate ongoing compliance with the CQC Essential Standards for Quality and Safety will put the Trust services at risk of having conditions attached to the registration and possible enforcement action being taken.

RECOMMENDATION

The Board is asked to note the contents of this report and support the next steps as outlined in the report.

Quality Priorities for Nursing and Midwifery 2011/12

Introduction:
In order to identify improvement priorities for Nursing and Midwifery a review was undertaken to consider our current progress with the High Impact Actions (HIA's) and clarify other programme/project work streams to improve the Patient Experience at Northampton General Hospital.

Background:
Over the past year there has been progress made against the High Impact Actions across the Trust. However, it was felt that there were a number of fundamental Patient Experience projects that should be part of the future Priorities for Nursing & Midwifery to dovetail with the High Impact Actions.

A scoping exercise was undertaken to consider a number of other data sets, reports and initiatives from national, regional & local sources that were not part of the HIA's work stream. The following information sources and reports were triangulated as part of the review.

- NGH Quality Accounts
- Safety Express/ Thermometer
- CQUINs
- Master dashboard
- Head Nurse Quality indicators
- Peer review
- National In-patient survey
- CQC National review of dignity & nutrition
- CQC NGH visit - Outcome 4
- Care and Compassion report

Undertaking this review allowed us to identify which areas required the greatest focus and the following Quality Priorities for Nursing and Midwifery 2011/12 were identified:

1. Falls Prevention
2. Nutrition and Hydration
3. Dignity and Respect (to include dementia)
4. Patient Experience (to include communication)
5. Safeguarding of Vulnerable Adults.

Progress to date:
Each Quality Priority has an Improvement Lead and Sponsor. Over the past 6 weeks, using the Institutes of Healthcare Improvement improvements methodology, there have been extensive pilots of individual interventions grouped together to represent a care bundle. For example the Falls Prevention care bundle includes:

- Updated Falls Care Plan
- Standardised symbol to identify an individual who is at risk of falling
- Standardised the clinical handover
- Training on medication that increase the risk of falls for pharmacists
- Enhanced Patient Care Round

The Quality Priorities were launched in September for a 'staggered' implementation during October 2011. An update will be provided to the Trust Board in three months to report the progress of the Nursing and Midwifery Quality Priorities.

Clinical Governance Review Scheme Progress Report

Introduction:
In February 2011, the Trust Board supported the ongoing development of the Clinical Governance Review Scheme (CGRS) as a support mechanism to the 'Confirm and Challenge' process that was already in place to provide assurance that the Care Quality Commission (CQC) standards are being routinely achieved. This report describes the outcomes of Phase 1 CGRS visits, the actions that have been put in place to address the issues identified and gives an overview of the Phase 2 visits.

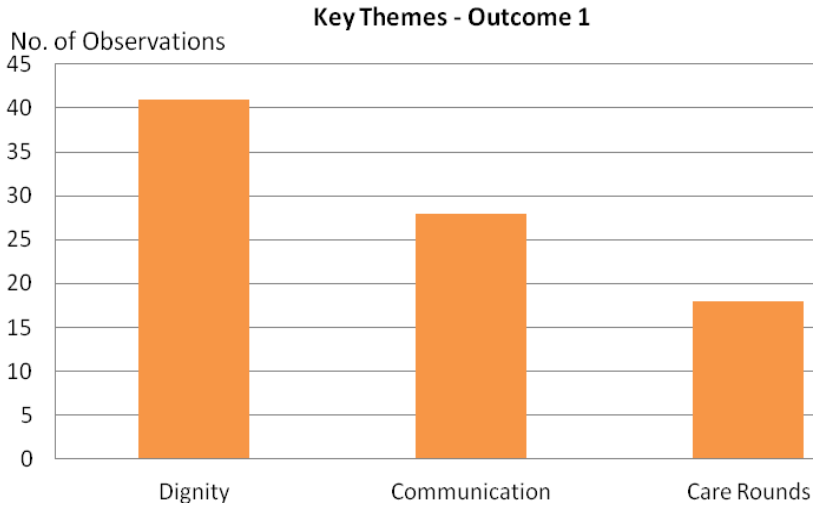
Background:
A total of 33 wards were visited which included all inpatient wards and the day surgery units at Northampton General Hospital and Danetre Hospital. The following CQC outcome standards were reviewed:
Outcome 1 – Dignity and Involvement
Outcome 5 – Nutrition
Outcome 12/13/14 – Staffing and Training
Outcome 16 – Quality of Services

Thematic Analysis
The following themes were identified from the wards and departments visited, each outcome is listed individually.

Outcome 1- Dignity and Involvement
Approximately 205 observations were made for this outcome. Some of the examples of positive practice in this outcome included:

- Patients being dressed appropriately according to their choice;
- Use of curtain around beds during care/treatment interventions;
- Some really good examples of patient information boards;
- Staff wearing correct uniform and ID badges;
- Friendliness and co-operation of staff.

The top three 'Key Themes' to be addressed, i.e. the three areas with the highest number of negative observations are identified in the table below:



The table below describes how we are addressing each of these key themes:

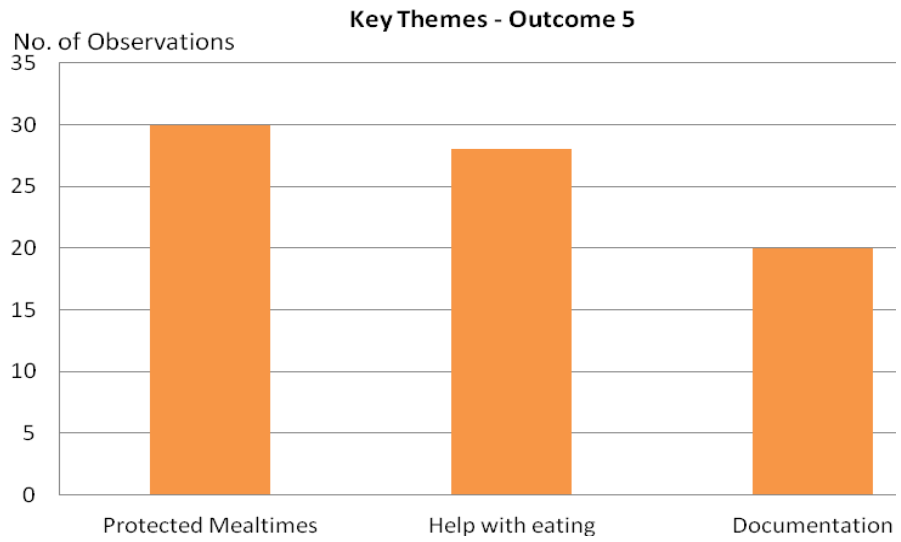
Key Theme	Actions to Address
Dignity - Quality Priority 3	Interventions include: • Development of a care bundle with five interventions, including lights and call bells to night mode and ward doors closed at night. • Improvement plan – self assessment for each ward to address the factors causing noise at night • CGRS action plans and follow up phase 2 visits
Communication - Quality Priority 4	Interventions include: • Patient Orientation Checklist • Patient Orientation Booklet • Orientation Posters • CGRS action plans and follow up phase 2 visits
Care Rounds	CGRS action plans and follow up phase 2 visits

Outcome 5 – Nutrition

Approximately 96 observations were made for this outcome. Some of the examples of positive practice in this outcome included:

- Where protected mealtimes are in operation, patients can eat their meals uninterrupted;
- Other staff (such as therapists, porters) being asked to leave wards at mealtimes;
- Nutritional assessment tool in use to identify those patients at highest nutritional risk enabling a focus from the nursing staff;
- Multidisciplinary approach to nutritional assessment;
- Friendliness of staff during mealtimes, both when meals were being distributed and whilst patients were eating.

The top three 'Key Themes' to be addressed, i.e. the three areas with the highest number of negative observations are identified in the table below:



The table below describes how we are addressing each of these key themes:

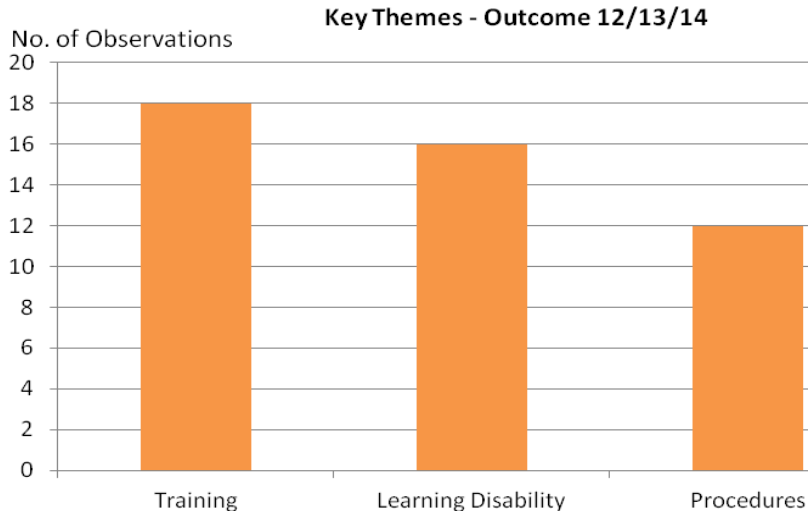
Key Theme	Actions to Address
Protected Mealtimes - Quality Priority 2	Interventions include: • Implementing Protected Mealtimes across all areas except paediatrics and Maternity – included in care bundle • Closer links with Friends of Northampton and WRVS to support Protected Mealtimes
Help with eating - Quality Priority 2	Interventions include: • Red tray system to highlight to all which patients require assisted feeding • Magnet system to highlight patients that require assisted feeding and special diets • A pilot project to train staff to provide enhanced care for patients with swallowing difficulty
Documentation - Quality Priority 2	Interventions include: • Weigh days to ensure that all patients are weighed at the appropriate time and is recorded in the notes

Outcome 12/13/14 – Staffing and Training

Approximately 45 observations were made for this outcome. Some of the examples of positive practice in this outcome included:

- Staff working well together as teams;
- Staff carrying out daily tasks and engaging actively with patients;
- Staff being able to raise any issues of concern around quality and feeling that these issues would be dealt with;
- Staff giving patients priority over everything else – including excusing themselves from review teams to go and attend to patients;
- Treatment being carried out in a timely manner, without rushing patients.

The top three 'Key Themes' to be addressed, i.e. the three areas with the highest number of negative observations are identified in the table below:



The table below describes how we are addressing each of these key themes:

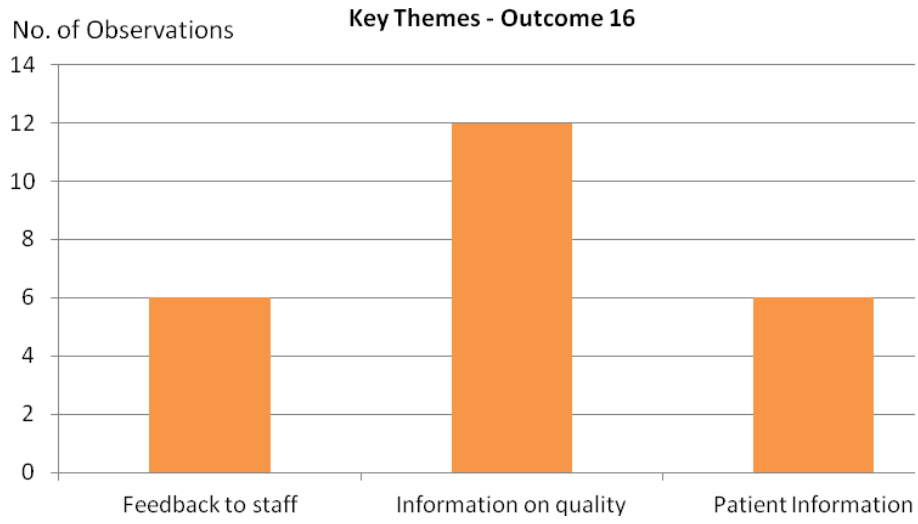
Key Theme	Actions to Address
Training	NHSLA programme: • Undertaking gap analysis of policy vs training needs analysis • CGRS action plans and follow up phase 2 visits
Learning Disability - Quality Priority 5	Interventions include: • A&E grab sheet & pathway • Competency workbook • Trust core assessment • Hospital passport
Procedures	CGRS action plans and follow up phase 2 visit

Outcome 16 – Quality of Service

The assessment of this outcome was added into the reviews much later in the process. Approximately 23 observations were made for this outcome. Some of the examples of positive practice in this outcome included:

- Staff talking to patients about their safety and welfare;
- Care plans being appropriately updated when treatment regimens are changed;
- Risk assessments being completed appropriately with patients.

The top three 'Key Themes' to be addressed, i.e. the three areas with the highest number of negative observations are identified in the table below:



The table below describes how we are addressing each of these key themes:

Key Theme	Actions to Address
Feedback to staff	CGRS action plans and follow up phase 2 visits
Information on quality	Review of monitoring information to ensure relevance, value and awareness as part of the Quality Priorities work CGRS action plans and follow up phase 2 visits
Patient Information	Interventions include:

- Quality Priorities 1,4 and 5	CGRS action plans and follow up phase 2 visits

Ward Follow Up
A report was provided to every ward following the CGRS visit, detailing the judgement made for each outcome, areas of good practice and any areas of concern. Action plans were then developed by the ward sisters and head nurses, and these will be used as the basis for the Phase 2 CGRS visits, during which implementation of these actions will be reviewed.

Next Steps
CGRS Phase 2 will commence at the end of September and continue through until Christmas 2011. The focus and methodology for the next phase has changed slightly from that used in Phase 1. Each ward has been prioritised according to the outcome of the Phase 1 visits, highest priority being given to those with 'major concerns'. Action plans that were developed at ward level will be reviewed to assess implementation progress and where appropriate attainment levels will be adjusted. Phase 2 will also present the opportunity to review standards of practice against any other CQC essential standards, where required and indeed implementation progress to the Quality Priorities for Nursing and Midwifery 2011/12.

Patient Experience Tracker Update

Introduction:

The Patient Experience Tracker (PET) is used to gain a real-time understanding of Patient Experience. The following table describes some of the activity currently being undertaken with PET. This work links to the activities being undertaken through the Quality Priorities for Nursing and Midwifery and the CGRS and is one of the ways we are monitoring patient experience.

Theme	Action
PET Contract	• A review of the PET contract has been undertaken and this has been renewed for a further 6 months only. • An options appraisal has been undertaken to allow the Trust to explore the market with a view to replacing the current system. • The Patient Experience lead is working closely with the Purchasing Department to ensure that we adhere to procurement guidelines
Underperforming areas on National Inpatient Survey 2010	There were 10 underperforming areas which included, for example, noise at night, sharing sleeping area with the opposite sex and getting enough help with eating meals. These 10 questions form the basis of the new PET questions. We will start collecting data on the first set of these questions w/c 19 September 2011. Improvement is expected in these areas due to the focus of attention through the Quality Priorities for Nursing and Midwifery and CGRS action plans. Patients sleeping in same sex accommodation initiatives have now been completed, these include: • Single sex assessment areas • Single sex escalation area for MDSU • New curtain in MDSU separating patients • Single same sex lists for Endoscopy • Extra bathroom facilities for patients on Dryden and Talbot Butler • New signage for bathroom facilities • New bathrooms (Pods) in some wards
CQUIN – Patient Experience	A further PET set of questions covers the 5 patient experience questions for CQUIN. Data collection for these questions has already commenced (w/c 12.9.11).

Recommendation

Trust Board is asked to note the contents of the paper and support the activities being undertaken to improve the overall Patient Experience.

Northampton General Hospital NHS
NHS Trust

TRUST 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	28th September 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.

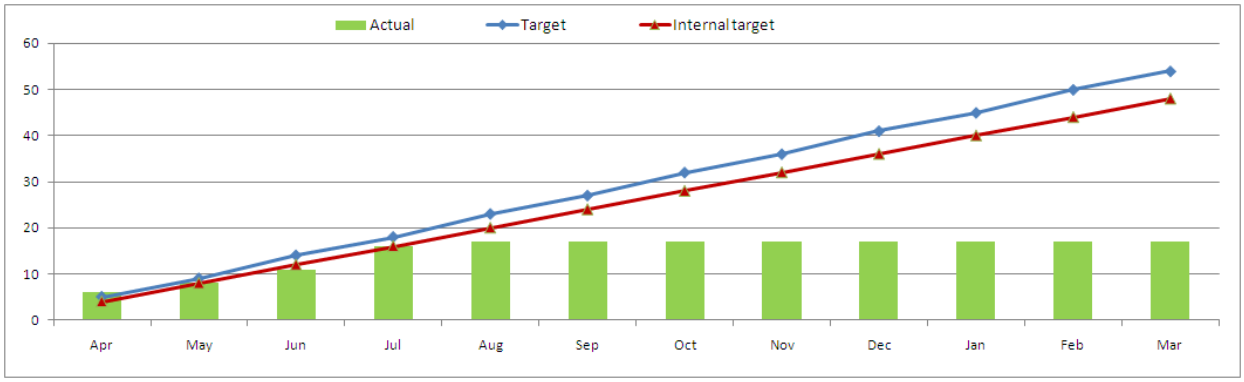
MRSA Bacteraemia (Appendix 1)
The Trusts trajectory for MRSA bacteraemia in 2011/12 is 3 cases. In July and August there were no >48hrs MRSA bacteraemia.

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 **0.11**.

MRSA Colonisation (Appendix 2)
During July there were 15 <48hrs and 1 >48hrs cases of MRSA colonisation and in August there were 22 <48hrs and 4 >48hrs cases of MRSA colonisation. Internal patient verified data identifies 99.6% compliance for the screening of elective admissions during July and 99.4% compliance for the screening of elective admissions during August. The compliance rate for emergency screening was 98.3% in July and the compliance rate for emergency screening was 98.6% in August.

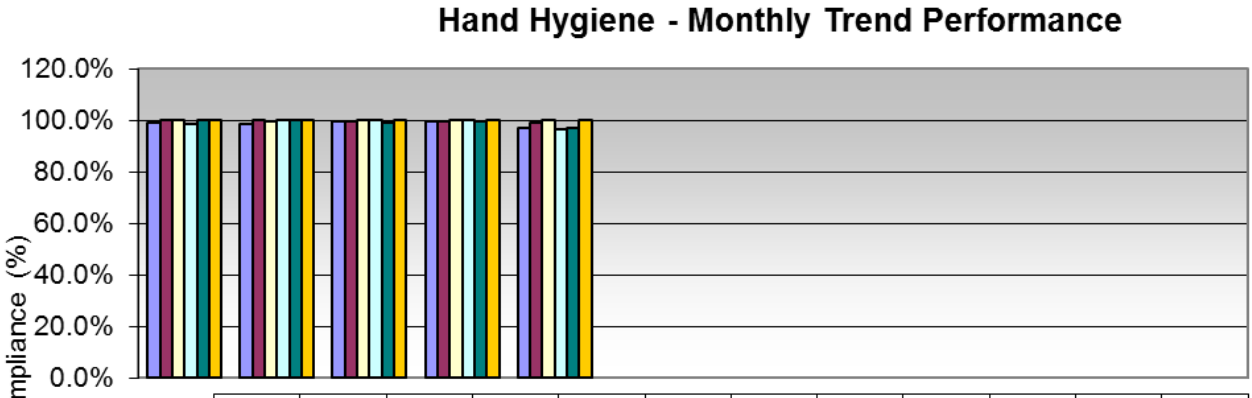
MSSA Bacteraemia (Meticillin Sensitive *Staphylococcus Aureus*)
During July there was 2 cases <48hrs and 2 cases >48hrs MSSA bacteraemia.
During August there were 4 <48hrs and 1 >48hrs MSSA bacteraemia.

***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 July the Trust identified 3<3 day and 5 >3 day cases of C. diff. which equates to a cumulative of **0. 22** /1,000 bed day's year to date. During August the Trust identified 0 <3 day and 1>3 day cases of C. diff. which equates to a cumulative of **0.19** /1,000 bed day's year to date. Total year to date of 17 cases.



Escherichia coli (E Coli)
As part of the Governments plans to improve its information on HCAI the Trust is reporting E coli bacteraemias on the Health Protection Agency's data capture system. In July 2011 there were 8 cases <48 hrs and 3 cases >48hrs E. coli bacteraemia. In August 2011 there were 7 cases <48 hrs and 1 case >48hrs E. coli bacteraemia.

Hand Hygiene Audit
Information from the Hand Hygiene Observational Tool (HHOT) shows that in July the overall compliance for hand hygiene was 99.5 %. In August the overall compliance for hand hygiene was 98.4%.



	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%	99.4%	99.4%	97.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Nurse/HCA	100.0%	100.0%	99.7%	99.3%	99.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Therapist	100.0%	99.6%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Pharmacist	98.4%	100.0%	100.0%	100.0%	96.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Porter	100.0%	100.0%	99.0%	99.3%	97.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Phlebotomist	100.0%	100.0%	100.0%	100.0%	100.0%	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

4

Appendix 1

MRSA Bacteraemia Incidence by Ward

MRSA Bact	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Trust Total 2011 -12
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	
Hawthorn																									0
Willow																									0
Collingtree 23hr																									0
ITU		1																							1
HDU																									0
A & E	1																								1
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							1		1																2
Benham																									0
Creaton																									0
Dryden																									0
EAU																									0
Eleanor																									0
Victoria																									0
Hazelwood (Community)																									0
Danetre (Community)																									0
Corby (Community)																									0
Rowan																									0
Finedan																									0
Compton																									0
Brampton																									0
Holcot																									0
Althorp																									0
Talbot Butler																									0
Trust Total 2011-12	1	1	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4

Appendix 2 **MRSA Colonisation Incidence by Ward**

MRSA ISOLATES	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Trust Total 2011-12
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	
Hawthorn									1																1
Willow				1			2																		3
Collingtree																									0
ITU	1								1																2
HDU																									0
A & E			1				1																		2
Abington		1	1	1						1															4
Cedar					1																				1
Becket								1																	1
SingleHurst																									0
Knightley						1			1																2
Gossett																									0
Disney																									0
Paddington	1		2																						3
Balmoral										1															1
Robert Watson																									0
Sandringham																									0
Spencer	1																								1
Sturtridge																									0
Allebone	5		6		7		4		9																31
Benham																									0
Creaton		5				1	1			1															8
Dryden						1			2																3
EAU	10		4		6	1	5		6																32
Eleanor						1			2	1															4
Victoria																									0
Hazelwood (Community)																									0
Danetre (Community)																									0
Corby (Community)																									0
Rowan	1		2				1																		4
Finedon		1																							1
Compton						2																			2
Brampton						2																			2
Holcot																									0
Althorp																									0
Talbot Butler	1						1																		2
Trust Total 2011-12	20	7	16	2	14	9	15	1	22	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	110

Appendix 3 **Clostridium Difficile Incidence by Ward**

CDT	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Trust Total 2011-12
Ward	<3	>3	<3	>3	<3	>3	<3	>3	<3	>3	<3	>3	<3	>3	<3	>3	<3	>3	<3	>3	<3	>3	<3	>3	
Hawthorn		2						1																	3
Willow							1			1															2
Collingtree																									0
ITU																									0
HDU							1																		1
A & E																									0
Abington								1																	1
Cedar																									0
Becket																									0
SingleHurst																									0
Knightley																									0
Gossett																									0
Disney																									0
Paddington																									0
Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer			1			1																			2
Sturtridge																									0
Allebone			1																						1
Benham		1																							1
Creaton		1		1																					2
Dryden																									0
EAU	2				1	1																			4
Eleanor																									0
Victoria		1																							1
Hazelwood (Community)								1																	1
Danetre (Community)																									0
Corby (Community)																									0
Rowan		1																							1
Finedon				1																					1
Compton								2																	2
Brampton																									0
Holcot																									0
Althorp						1																			1
Talbot Butler							1																		1
Trust Total 2011-12	2	6	2	2	1	3	3	5	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25

TRUST BOARD SUMMARY SHEET	
Title	Infection Prevention & Control Annual Report
Submitted by	Fiona Barnes
Date of meeting	28th September 2011
Corporate Objectives Addressed	To develop and embed measures for quality and clinical outcomes to achieve the highest standards

SUMMARY OF CRITICAL POINTS
The Infection Prevention and Control Annual Report outlines a summary of the key infection prevention and control initiatives and activities of the Trust for the year April 2010 to March 2011 (10/11).

PATIENT IMPACT
High – Provides an overview of Infection Prevention and Control measures that have been put in place to improve patient safety and quality of care.

STAFF IMPACT
High – Provides an overview of Infection Prevention and Control measures that have been put in place to improve 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 approve this report.

Northampton General Hospital NHS
NHS Trust

`

Infection Prevention

&

Control

Annual Report

April 2010 to March 2011

Director of Infection Prevention

CONTENTS

1.0 Executive Summary

This report outlines a summary of the key infection prevention and control initiatives and activities of Northampton General Hospital (NGH) for the year April 2010 to March 2011 (10/11). It also provides an assessment of performance against national targets for the year.

Infection prevention and control lies at the heart of the Trust Strategy, NGH is committed to delivering the safest, most clinically effective, patient focussed services that we can. During the reporting year the Trust adopted a 'zero tolerance' approach to all avoidable infections, which became the driving force for all staff to be fully engaged with the concept of infection prevention. Our ongoing challenge is to sustain the momentum and improve still further.

The national strategic framework on which the infection prevention and control agenda at NGH is based upon has remained consistent during 2010/11, supporting the Trust to be compliant with the Health Act 2006 - Code of Practice for the Prevention and Control of Healthcare Associated Infections revised January 2008 (Department of Health), and the Care Quality Commission (CQC,) which was established by the Health Act (DH, 2008).

Infection prevention and control has increased in significance and prominence and rightly this shows no signs of diminishing. The Operating Framework for 2010/11 continues to place preventing Healthcare Associated Infections (HCAIs) high on the NHS agenda. This is supported by the Care Quality Commissions focus on infection prevention standards as a basic requirement of registration for healthcare providers, and the ongoing inspections against the Code of Practice for the prevention and control.

Key Achievements

There has been continuing focus on reducing both MRSA bacteraemia rates and *Clostridium difficile* rates, monitored by the Health Protection Agency (HPA). This report identifies how the Trust has continued to exceed its target reductions in both MRSA blood stream infections and *Clostridium difficile* infection.

- The number of post 48hr MRSA bacteraemia infections during 2010/11 was 2 compared with 3 in 2009/10, presenting a significant reduction of 33%.

- Screening for MRSA has continued within NGH, with elective screening maintained at 99% compliance. Emergency screening during 10/11 and currently stands at 95% compliance.

- The number of *Clostridium difficile* infections was 48 compared to 98 cases in 09/10, showing a reduction in cases of 49%. This is an improvement in performance and remaining well below the contract ceiling.

- Continued progress has been made with the DH 'Saving Lives' (2005) programme across the Trust to ensure compliance with the requirements of the 'High Impact Interventions' (HII), with all staff held to account for the clinical care they provide. The profile of good hand hygiene practice has been a priority with compliance rates continuously improving. The introduction of the 'Matron's Dashboard' has proved a successful tool in firmly embedding the culture of accountability and securing improvements in infection prevention. New and updated HIIs are added as these are developed.

Healthcare Governance Committee (HGC) is a sub-committee of the Trust Board. The Matron's Dashboard was reviewed with Matrons invited to discuss their results. The ongoing promotion of 'Ward to Board' and clinical accountability in relation to infection prevention has been further developed and updated with Executive Directors and the Trust Chairman undertaking 'Infection Prevention Inspections' in all ward areas, truly embedding the ethos that infection prevention is everyone's business.

However, the improved performance in relation to infection prevention and control within the Trust is no reason for complacency. The Infection Prevention and Control Team will continue to raise awareness of specific issues surrounding HCAIs with both our staff and local population, and to promote and monitor clinical practice to minimise the risk of HCAIs for patients who have their care at NGH.

2.0 Background

The Infection Prevention and Control Team (IPCT) provide infection prevention and control services for Northampton General NHS Hospital Trust. This report relates to infection prevention and control within the Trust and provides a summary of the work undertaken by the IPCT.

The Trust continues to base its infection prevention and control agenda on the national strategic framework, identified through the following documents:

- *Winning ways* (DH 2003),
- *A matron's charter: an action plan for cleaner hospitals* (DH 2004),
- *The National specifications for cleanliness in the NHS: a framework for setting and measuring performance outcomes (NPSA 2007).*
- *Saving Lives: A delivery programme to reduce healthcare associated infection (HCAI) including MRSA* (DH 2007).
- *The Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Health Care Associated Infections* (DH 2008),
- *Board to ward how to embed a culture of HCAI prevention in acute trusts* (DH 2008)
- *Safe, Clean, Care*:- reducing infections and saving lives(DOH 2008)
- The Operating Framework for 2010/11

The Trust is required to meet the duties of the Hygiene Code, NHS Litigation Authority (NHSLA) and the Care Quality Commission (CQC) standards.

3.0 Infection Prevention and Control Arrangements

The IPCT consists of the following:

- Director of Infection Prevention and Control (DIPC): Director of Nursing, Midwifery and Patient Services
- Deputy Director of Infection prevention and Control (DDIPC) Deputy Director of Nursing
- Consultant Microbiologist
- Lead Infection Prevention Nurse (Band 8A)
- Infection Prevention Nurse (IPC qualified): 2 WTE (Band 7)
- Infection Prevention Nurse: 3 WTE (Band 6)
- Administrative/Surveillance support: 1 WTE (Band 3)

The Infection Prevention and Control Department has a budget to cover all nursing and administrative staff costs.

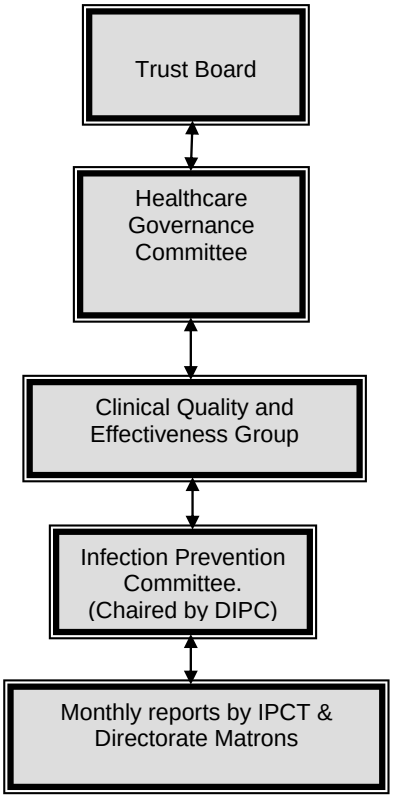
The Infection Prevention and Control Department includes microbiology, virology, wound surveillance, and epidemiology. The IPCT works with pharmacy, facilities, directorate matrons, ward sisters, infection prevention and control link staff and sterile services.

The core service includes an infection prevention and control advisory service, active infection prevention work, education and training throughout the organisation, audit, policy formulation and advice, surveillance, epidemiology, outbreak and control management.

In common with many other trusts, the workload of the core infection prevention and control team increased within the period under review. Examples of this include the requirement for training of all staff in infection prevention and control and hand hygiene. Another is in the reports (verbal and written) to demonstrate performance and compliance with guidance, standards, targets or reporting frameworks. The addition of a further infection prevention nurse has greatly supported the team to achieve this workload.

The Infection Prevention and Control Team Objectives 2010/11 have been led by the IPCT and all areas of work have been achieved, many with ongoing work as part of the continuous improvement cycle.

Infection Prevention and Control Governance and Reporting Arrangements at NGH



4.0 Governance

During this period, Trust wide improvements were made in the governance structure. There was also an emphasis on clinical engagement and participation in risk, safety and quality. This included ownership of infection prevention and control issues by all staff supported at all levels from board to ward.

The work undertaken during this period reflected Trust priorities and the Infection Prevention and Control Annual programme and objectives.

4.1 DIPC Reporting to the Board

The DIPC reports to the Trust Board on a monthly basis, including monthly surveillance figures and any matters by exception. The DIPC meets frequently with the Consultant Microbiologist and Lead Infection Prevention Nurse as well as quarterly meeting the IPCT.

4.2 Infection Prevention and Control Committee

The Infection Prevention and Control Committee (IPCC) is chaired by the DIPC and meets monthly. The membership has been reviewed to ensure all staff groups are represented and participating, with the terms of reference updated. Decontamination and sterile services also report through the IPCC. The IPCC reports to the Clinical Quality and Effectiveness Group. From a compliance point of view a shadow governor/patient representative attends as an observer.

4.3 Healthcare Governance Committee (HGC)

The HGC, formally the IHGC is a sub committee of the Trust Board and reviews areas of concern arising from the IPCC or CQEG by exception.

4.4 Links to Clinical Governance and Patient Safety

The Infection Prevention Team reports the Trust position in relation to infection prevention and control to the Clinical Quality and Effectiveness Group (CQEG) on a monthly basis. The Directorates include their monthly infection prevention data within their own quarterly reports to CQEG. Learning from MRSA bacteraemia infections is reported through the Patient Safety Learning Forum to representatives from all Directorates for dissemination to Directorate Governance Groups.

4.5 Northamptonshire Health Economy HCAI Group

The DIPC, Consultant Microbiologist and members of the IPCT are active members of the local health economy group. This group is in existence to drive forward the Northamptonshire approach to infection prevention and control working together to ensure the quality of patient experience throughout the county is of equal good quality.

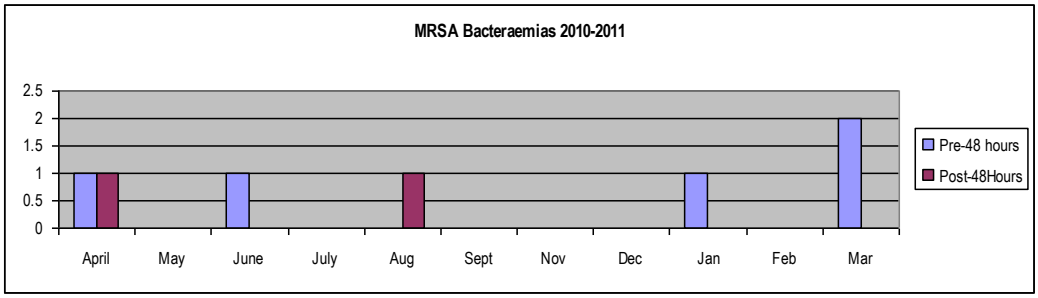
5.0 National and Local Surveillance

The IPCT and Infection Prevention and Control Department undertake the following national and local surveillance:

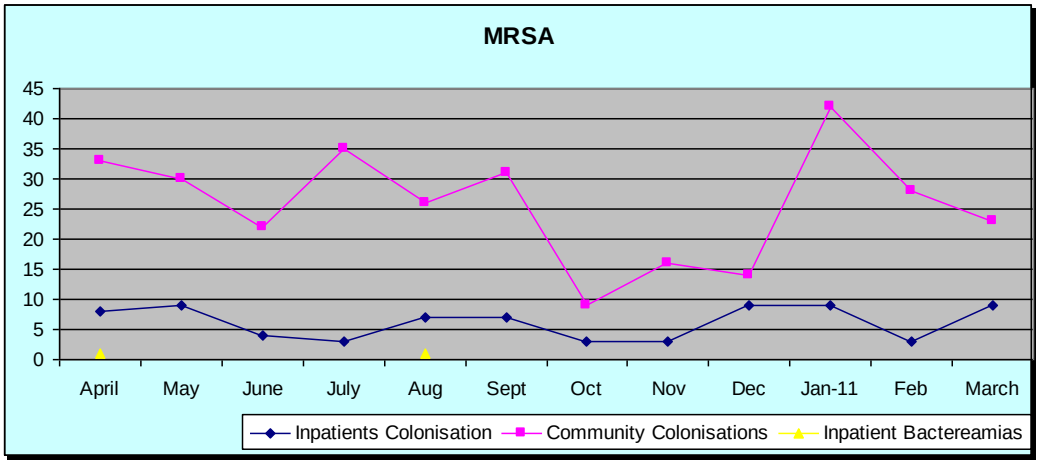
- National MRSA bacteraemia reporting
- National MSSA bacteraemia reporting
- National *Clostridium difficile* reporting
- National Glycopeptide Resistant Enterococci reporting
- Surgical site infection reporting
- Local surveillance of all ‘Alert’ organisms and an extensive surgical site surveillance programme.

5.1 MRSA bacteraemia

There has been a year on year decrease in the number of MRSA bacteraemia in the Trust. The ceiling for this year was 6 post cases. The Trust was attributed 2 post 48 hour cases in total. This is shown in the graph below:



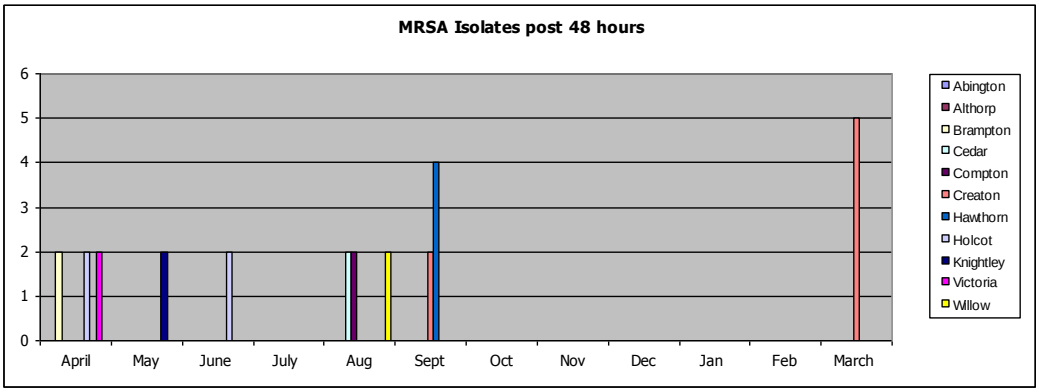
Patients newly identified with MRSA Infection and Colonisation



The Trust continues to work with the PCT and the Whole Health Economy in continuing to promote excellent HCAI policy and practice.

The IPCT identified a range of 'special measures' (Appendix 3) which were implemented on any ward that had 2 or more incidences of colonised new patients with MRSA or *Clostridium difficile* in a 28-day period. The graph below reflects the wards that have been on special measures for MRSA colonisation.

Wards that have 2 or more incidences of MRSA colonisation



5.2 MRSA Screening

NGH achieved compliance with the requirements for all elective patients to be screened for MRSA colonisation, under the reporting methodology advocated by the DH.

The overall compliance for the year for electives was 99% (patient specific verified data) and the overall compliance for non electives was 95%. Efforts continue to achieve greater compliance.

5.3 MSSA bacteraemia

There is a mandatory requirement for all NHS acute trusts to report Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia from the 1st January 2011.This reflects the zero tolerance approach that the Government has made clear that the NHS should adopt for all Healthcare Associated Infections (HCAIs), while recognising that not all MSSA bacteraemia are HCAIs. Over the past few years, the NHS has made significant progress in reducing MRSA bloodstream and *C. difficile* infections. This is a significant achievement and a remarkable turnaround from where the Trust was five years ago. It is believed that the introduction of mandatory surveillance for MSSA is timely and appropriate to help establish the extent to which these are healthcare associated. The availability of a robust and accurate picture of the scale of MSSA infections, nationally and locally, will also support patients in making meaningful choices about their healthcare.

The trust records MSSA bacteraemia cases separately on the web-based system, as they do already for MRSA bacteraemia and the Chief Executive will sign-off on the 15th of the month. The first MSSA Chief Executive sign-off for the January mandatory data was the 15 February 2011.

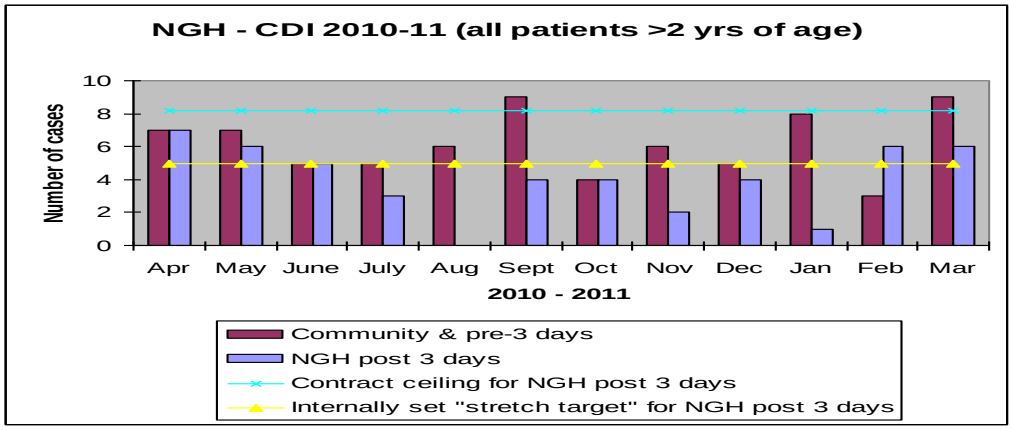
Further information will be made available in due course regarding plans for the frequency of the publication of this data.

The Trust is determining trends and themes of pre and post admission MSSA bacteraemias at NGH. This commenced from 1st January 2011. There were two instances of post 48 hour MSSA bacteraemias in total up to the end of February 2011.

With a look back at post 48 hour admission MSSA bacteraemias from April 2010 to December 2011 we have identified areas related to long-term central venous access devices, surgical site or soft tissue infections and *Staphylococcus aureus* urinary tract infections leading to urosepsis. An action plan has been instigated and is reviewed at the Infection Prevention Committee.

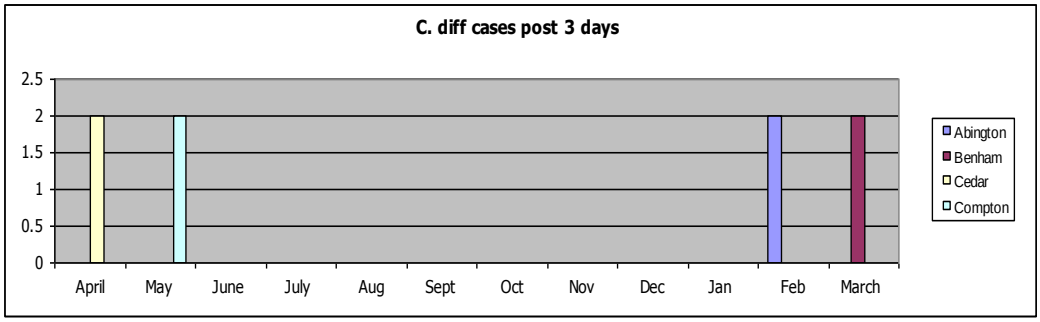
5.4 Clostridium difficile

The 2010 – 2011 ceiling for cases of *Clostridium difficile* associated diarrhoea (CDAD) was 98 by the PCT contract with an internal target of 60 set by the Trust Board. The Trust had 48 CDAD cases (post 3 days) attributed to the Trust during 10/11.



Special Measure actions were implemented for wards that have two or more incidences of *Clostridium difficile* in a 28-day period. The graph below reflects the wards that have been on special measures for CDAD.

Wards that have 2 or more incidences of Clostridium difficile



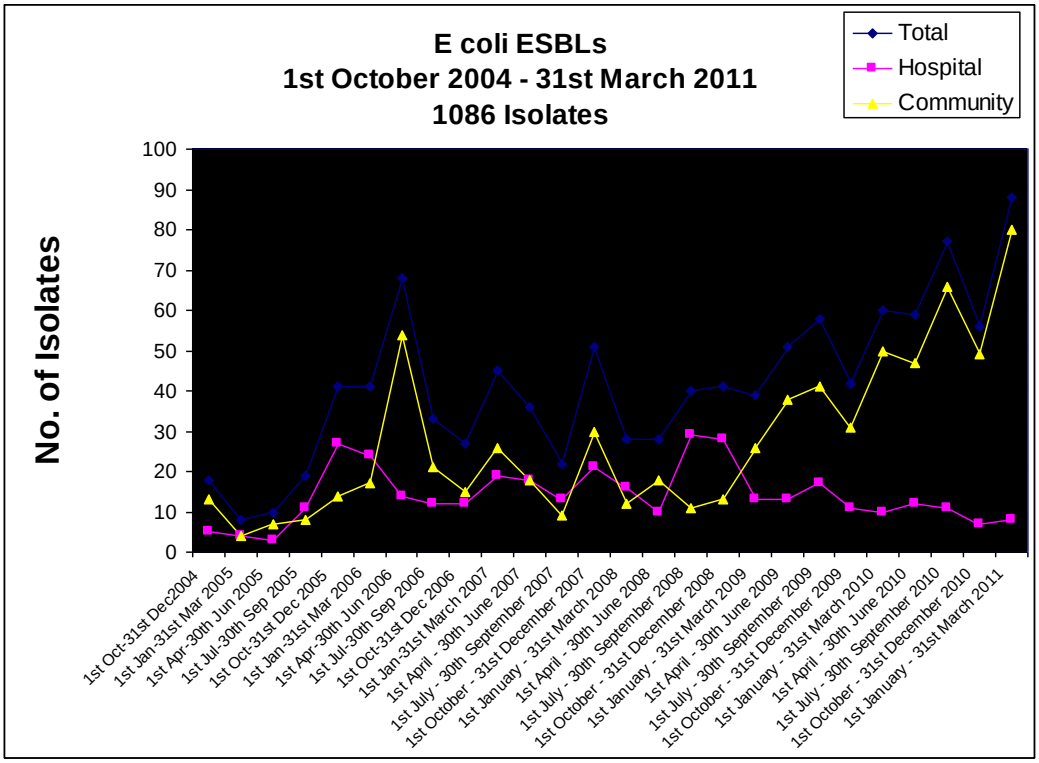
The weekly walk round, is a round to review all inpatients with *Clostridium difficile* within Northampton General Hospital, including the review of the antibiotic management of these patients. This was expanded in August 2010 to include a Consultant Gastroenterologist, Consultant Microbiologist, a member of the Infection Prevention and Control Team and the Antimicrobial Pharmacist.

5.5 Local Surveillance of ESBLs

A local surveillance system to monitor the numbers of infections with ESBL (Extended-Spectrum Beta-Lactamase) producing coliform in the south of the county has been established based on reports generated by the laboratory.

ESBL (Extended-Spectrum Beta-Lactamase)-producing *E coli* are antibiotic-resistant strains of *E coli* commonly causing urinary tract infections.

This information is being used locally to determine empiric antibiotic choice for the treatment of patients with serious urosepsis



5.6 Glycopeptide Resistant Enterococci

Enterococci are normally found within the gut. Although a common cause of urinary tract infections, enterococci can occasionally cause serious infections such as endocarditis. In immunocompromised patients, for example haemodialysis patients and haematology patients, especially those with intravascular lines, enterococci may cause a bacteraemia. Glycopeptide resistant enterocci are resistant to glycopeptides antibiotics such as Vancomycin and Teicoplanin. In addition to the ESBL (Extended Spectrum Beta Lactamase) surveillance the Trust also reports GRE reported to the HPA and has done since 2003.

6.0 Outbreaks

6.1 Norovirus

An outbreak of Norovirus affected 2 wards (Allebone and Eleanor – Hyper Acute Stroke Unit with 12 beds) in December 2010 and lasted for a period of 7 days. In total, there were 13 patients affected, approximately 19 staff members reported to Occupational Health and 41 bed days lost. There were 2 visitors who were symptomatic with diarrhoea and vomiting who had visited patients at the start of the outbreak. 4 out of the 5 specimens were identified as Norovirus positive.

A second outbreak of Norovirus was identified on Collingtree and Cedar ward in January 2011. The outbreak lasted for a period of 12 days**.** In total there were 27 patients affected, approximately 11 staff members and approximately 36 bed days lost. The pathology laboratory used testing to confirm positive Norovirus.

A third outbreak of Norovirus was identified in March 2011. This involved Creaton, Compton, Holcot, Dryden and Benham. The outbreak lasted for a period of 26 days. The pathology laboratory used testing to confirm positive Norovirus.

A major outbreak of Norovirus outbreak was declared with these incidents being managed through the Major Outbreak Code of Practice for Control of Communicable Diseases (NGH, 2008) and the Major Outbreak Group was convened chaired by the Director of Nursing (Director of Infection Prevention).

7.0 Antimicrobial Stewardship

7.1 Compliance to Trust antibiotic policy, September 2010

This Point Prevalence Audit was performed by Clinical Pharmacists on all wards at the Trust excluding Singlehurst, Barratt Maternity Home [maternity], 37 Camelot Way, Paediatrics and Theatres over a one day period (22nd September 2010). The aim was to audit antimicrobial prescribing at the Trust and compliance to the Trusts Antibiotic Policy.

This is in response to the **HCAI Performance Monitoring Framework Core Duty 10**: *Duty to adhere to policies and protocols applicable to infection prevention and control;* Core sub duty [10j] which expects a rolling programme of policy audit (prescribing etc), revision and update.

In addition the document **Saving Lives: Antimicrobial prescribing A summary of best practice, DH (2006)** states that the Antimicrobial policy should be compliance audited and has set out standards for prescribing.

Descriptor	Number	Proportion	Comments
Total number of patients seen	**494 patients**		The average number seen as per previous audits: 500 patients.
Number of Patients on Antibiotics	**111 patients**	**22.5%**	The median number of patients receiving antibiotics as per previous audits is 25.9% therefore a lower number noted in this audit.
Total Number of Antibiotics prescribed.	**141 antibiotics**	**0.29 per patient**	The average proportion of antibiotics prescribed per patient seen as per previous audits is 0.35 therefore lower in this audit.
Number adhered to the policy	**141 prescriptions**	**100%**	All prescriptions audited were found to comply with the Trusts antibiotic policy or guided by microbiology advice. The average compliance rate as per previous audits is **97.2%.**
Number of intravenous (IV) prescriptions	**75 prescriptions**	**53.2%**	The number of patients on IV antibiotics in this audit is lower compared to the average percentage from previous audits (54.8%).
Number of oral (PO) prescriptions	**66 prescriptions**	**46.8%**	Previous audits show an average of 44.8% of patients on oral antibiotics.
Average duration of administration of	**3 days**		The duration of administration for IV antibiotics is lower then the

IV antibiotics			average of 4.23 days from previous audits.
Average duration of administration of PO antibiotics.	**2.65 days**		Antimicrobials should be prescribed for a maximum of seven days.[1] Therefore the duration of treatment with oral antibiotics was within the recommended duration.
Duration of antibiotic administration stated on prescription chart.	**75 prescriptions**	**53%**	All these were within the recommended durations stated in the Trust Antimicrobial Guidelines.
IV to oral switch.	**7 prescriptions**	**9.3%**	The antimicrobial policy encourages the conversion of IV to Oral antibiotics promptly. The average duration of administration of IV antibiotics prior to switching to oral was 3.5 days.

1. Anon (2006). **Saving Lives reducing infection, delivering clean and safe care: Antimicrobial prescribing: A summary of best practice,** DoH. http://www.clean-safe-care.nhs.uk/toolfiles/104_281812ANT_antimicrobial_pres.pdf

7.2 Missed doses audit, November 2010

National Patient Safety Agency issued a Rapid Response Report NPSA/2010/RRR009: Reducing harm from omitted and delayed medicines in hospital. [1] Omission and delay of medicinal doses frequently occur for a variety of reasons.[1] It is important to recognise that harm can arise from the omission or delay of critical medicines even though only a small percentage of omitted and delayed medicines may cause harm or have the potential to cause harm.[1] In hospitals this can happen as a result of errors during the prescribing, dispensing, supply or administration of the medicines.[1]

Result

This audit was carried out at NGH for the 24 hour preceding Wednesday 31st November on all wards except paediatrics (due to resource issues).

A total of 400 antimicrobial doses were given within the preceding 24 hour period (3.57 doses per patient) and of these 20 were the first prescribed dose.

There were a total of 39 omitted doses (10% of all prescribed doses) which includes 5 omissions of the first prescribed dose (13% of all omitted doses). The reasons for omissions were as follows; Patient away: 1 (3%), Blank: 18 (46%), Refused: 6 (15%), No Route: 5 (13%), Not Available: 7 (18%) and other: 2 (5%).

Of the 7 doses annotated as drug not being available (4 prescriptions), an antibiotic was found on the ward for 1 prescription. From the 18 blank doses 4 had been given but the chart not signed however for the rest it could not be ascertained if the dose had been given or not.

There were 4 prescriptions where the last dose had been delayed. From these, 3 doses had been delayed by 1 hour and for 1 prescription this delay was 8 hours.

Actions are:

- Increased awareness of omissions via the Pharmacy Medicines Management Training day.
- Share audit results via the Trusts corporate screen saver highlighting the importance of giving antibiotics promptly and on time and prescribing this appropriately.
- Raising awareness during Junior Dr training on antibiotics.

- Ensuring awareness of the importance of ordering antibiotics from pharmacy promptly and for the pharmacy dispensary to supply these as a matter of urgency.
- Inclusion of antibiotics in the critical list for pharmacy medicines that need dispensing urgently.
- Review of antibiotic stock in the Pharmacy Emergency drug cupboard and on wards to ensure availability out of hours.
- Raising awareness amongst nursing staff via directorate nurses and incorporation via directorate training of the importance of prompt antibiotic administration.

7.3 Training initiatives

A member of the IPT trained Nurses on Antimicrobial Stewardship at the Infection Prevention Study day on November 25th 2010.

7.4 Antibiotic campaigns

The IPT promoted the European Antibiotic Awareness Day on 18th November by using a presentation on the Trust's corporate screen saver to encourage prudent antibiotic use in the community and in hospitals.

7.5 Raising national awareness in Influenza management

It is almost two years since the first cases of infection with influenza A virus subtype H1N1 (i.e. 'swine flu') hit the headlines. During this time, various different measures have been put in place to prevent infection in vulnerable individuals and to treat those who have been seriously affected, both nationally and at local levels.

Antimicrobial pharmacists have played a key role in ensuring that, as far as possible, antiviral medicines and flu vaccines have been available when and where needed. Drawing on the procedures and practices adopted at Northampton General Hospital NHS Trust, and although advice about preparedness to combat flu frequently changes, it was hoped a published article might be useful to pharmacists nationally charged with managing supply chain processes in what remains of this flu season and beyond.

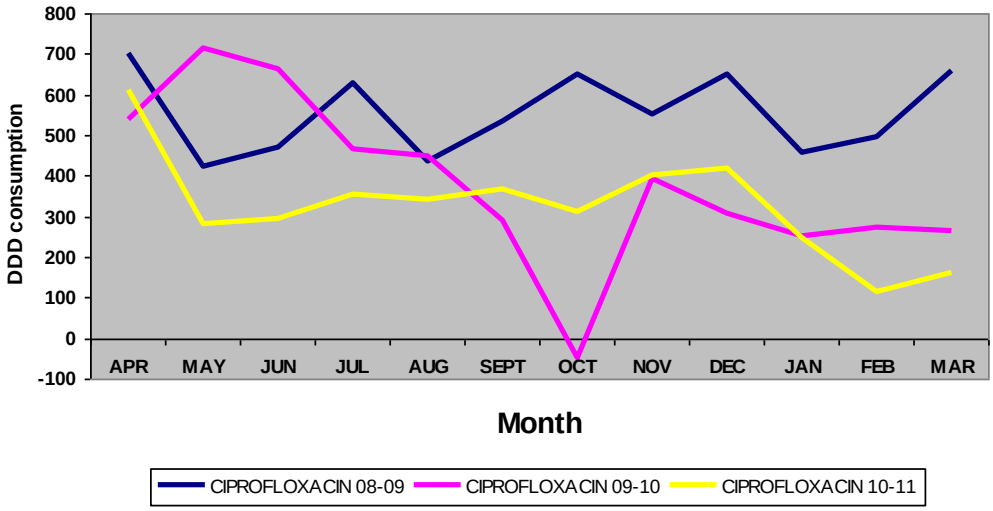
Sadak M (2011). H1N1 influenza — managing the medicines supply chain, *The British Journal of Clinical Pharmacy*; 3: 55-56. http://www.clinicalpharmacy.org.uk/

7.6 Monitoring antimicrobial consumption

This is measured at NGH using the WHO standard DDD (Daily Defined Dose) data. This enables us to track usage of all antibiotics including those that can predispose patients to C.Diff.

The usage of Ciprofloxacin (Quinilone antibiotic) which can predispose patients to *Clostridium difficile* has reduced at the Trust through active policing and monitoring. The decision to prescribe Ciprofloxacin for inpatients is required to be approved by the Consultant Microbiologists before dispensing by pharmacy. The graph below shows the usage measured by daily defined doses (DDD). The huge negative reduction in October 2009 is as a result of stock being withdrawn from all the wards at NGH except ITU.

DDD consumption for Ciprofloxacin 2008 - 2011



8.0 Saving Lives

The Trust has taken significant steps in embedding the Saving Lives programme into daily activities of clinical care. The overall aim of Saving Lives is to ensure that all staff recognise how they can contribute to reducing infection rates and adopt best practice to achieve this. High impact interventions are used to reduce the risk of healthcare associated infection. Each of these interventions has a simple evidence based tool that reinforces the actions that clinical staff must undertake 'every time' for key procedures in order to significantly reduce infection. The aim is to increase the reliability of clinical processes and reduce unwarranted variation in care delivery.

An internal Saving Lives forum was introduced by the IPCT. The forum meets every 6 weeks and provides an opportunity to network together, to share good practice and solve any problems.

8.1 Matrons Dashboard

The Matrons are required to populate an Infection Prevention compliance chart each month with the percentages from the high impact interventions within Saving Lives. The results are RAG rated and fed back at the IPCC, receiving constructive challenge from the DIPC. Areas that are non compliant are raised by exception to the HGC to report actions being undertaken to resolve any issues.

9.0 Diarrhoea Study Day

The Infection Prevention Team held their first study day on November 25th 2011 at the Cripps Postgraduate Centre.

The theme of the day was diarrhoea with excellent lectures around the theme of diarrhoea incorporating the management and treatment of the *Clostridium difficile* and the "Winter Curse" Norovirus.

Over 50 members of staff mainly infection prevention link nurses attended the event. Sue Hardy, Director of Nursing, Midwifery & Patient Services & Director of Infection Prevention and Control gave the welcome address.

Speakers included Dr A Bentley, Consultant Microbiologist, Mohamed Sadak Anti microbial pharmacist, Wendy Foster Specialist Infection Prevention Practitioner and Andrea O'Connor operations Manager Microbiology. Guest speakers included Dr J Harris from the HPA and Pam Howe Lead Infection Prevention & Control nurse from Kettering.

The evaluation forms provided valuable feed-back, stating it was "very informative, increased their knowledge and understanding", "most enjoyable & well organised" "I think the study day was excellent".

10.0 Ward to Board

To support the on-going HCAI agenda across the Trust all Executive Directors and the Trust Chairman participate in an 'Infection Prevention Inspection' on a monthly basis. This 'inspection', facilitated by the IPCT involves visiting clinical areas with a similar inspection programme to the CQC visit. Each of the Executive Directors visits 2/3 areas and audits the clinical area against set criteria. Data from the visits is collated by the IPCT for the monthly IPCC to review. Common themes being (1) high level dust, which has been addressed by providing specialist equipment for domestic staff to access high level areas, e.g. curtain frames; and (2) cleaning of patient toilets, which has been facilitated by having toilet cleaning schedules completed x 3 per day and these are placed on the doors of the patient's toilets. Respective wards and action plans are provided and actioned accordingly. The audit results are also reviewed monthly at the Infection Prevention and Control Committee.

11.0 The 2010/11 IPCT Annual Plan

The IPCT Annual Plan which can be found in Appendix A provides an overview of the commitment to prevention and control of infection by the IPCT within the clinical directorates. The Infection Prevention and Control audit is a vital component of robust infection prevention and control service. The objectives of the audits are to inform the Trust of their level of compliance to national IPC standards, local policies and procedures and allow improvements to be made based upon findings. It also identifies target areas for training.
The plan was achieved except for one area regarding the further development of an ESBL (Extended Spectrum Beta Lactamase) database. The department was not successful with the anticipated web based surveillance application, ICNet.

Infection Prevention Audits April 2010- March 2011

The following audits were undertaken during the year:

Audit	Overall Hospital Score	Key Actions taken
Sharps	**93%**	Temporary closure not used when bins are not in use, Sharps bins overfull. Bins not assembled correctly. All of the audit results are fed back verbally to the nurse in charge at the time of the audit and a report sent subsequently requiring an action plan to address the findings. The results are also reviewed at the IPC.
Environment	**94%**	High dust, dusty bed frames dusty fans. This had been addressed as documented above, as with all audits. Domestics have also been trained in utilising a special piece of equipment for cleaning easy access high level dust If not easy access – Estates to be contacted with job reference number raised.
Personal Protective Equipment (PPE)	**98%**	Facemasks and eye protection ordered for the wards where this was not available. Doctor reminded to wear gloves as a single use item.
Linen	**96%**	The areas were made aware of the importance of not overfilling linen bags from an infection prevention view point but also from a health and safety perspective.
Waste	**93%**	Not all waste bins were visibly clean and many of the bins were found to be rusty which makes them difficult to be cleaned effectively Procurement with infection Prevention are planning to review new bins across the organisation.
Isolation	**99%**	No isolation sign outside of 1 room this was fed back at the time of the audit and actioned.
Total Hospital Compliance	**95.5%**	

12.0Training and Education

The minimum training compliance was 85% for this period within the Trust and IPCT achieved 72% for infection prevention and control. The IPCT provide the following education and training sessions:

12.1 Induction training

Induction prevention and control training is provided to all new staff during induction training. This session covers a basic awareness of standard precautions including hand washing, MRSA, *Clostridium difficile,* cleaning, safe handling and disposal of sharps, management of sharps injuries and the transmission of infection. Induction training is also provided for junior doctors.

12.2 Mandatory Update training

Infection prevention and control has been included in the mandatory training programme. The main objectives of this training is to provide an update for all staff on current infection control issues, national guidance and the importance of hand hygiene and standard precautions.

12.3 Infection Prevention Lectures provided to the University of Northampton

Over this year three lectures have been provided to the University of Northampton 56 first year pre-registration student nurses and paramedics.

12.4 Ward and Department Based Training

Numerous ad hoc training sessions have been provided to staff in their work place. These have been either requested by the ward and department staff or as a result of audit or special measures.

13.0 Pandemic flu training and fit mask testing

The IPCT continued training with regards to swine flu and fit testing Personal Protective Equipment (FFP3) masks. The sessions included a power point presentation, and fit testing of disposable FFP3 masks. This highlighted the poor fit of the disposable FFP3 masks. The decision was taken to fit test staff working in high risk areas with their personal, wipe cleanable FFP3 mask.

14.0 Infection Prevention Annual Programme For Surgical Site Surveillance 2010/11 (Appendix 3)

Since 2004, all NHS hospitals where orthopaedic procedures are performed are required to carry out a minimum of three months surveillance of surgical site infections. This information is reported to the Health Protection Agency who analyse the data and provide reports for local hospitals and produce a national report.

Table to show NGH's surgical site surveillance results in comparison to the national programme

Quarter	Surgical Site under surveillance	NGH rates	National rates	Directorate action plans
Apr-June 2010	Total Hip Replacements	**1.1%**	**1.1%**	No actions required.
July-Sept 2010	Total abdominal hysterectomies	**3.7% (post discharge)**	**2.7%**	To be re-audited Apr-June 2011
	Limb amputations	**6.7% (Inpatients)**	**6.4%**	To be re-audited Oct – Dec 2011
Oct-Dec 2010	Caesarean sections	**325 operations 5.2%**		Awaiting final report. Re-auditing Jul-Sep 2011.
	Repair of Neck of Femurs	**3.4%(in patients)**	**1.9%**	Re-audited Jan-Mar 2011. Introduced care bundle.
Jan-Mar 2011	Total Knee Replacements (by NORTH team)	**2.3%**	**1.3%**	Reviewed one infection by consultant and are contacting HPA for removal of this one which will reduce the NGH rate.
	Repair of Neck of Femurs	**3.1%**	**1.9%**	Continuous SSIS by IPT and directorate auditing care bundle.

15.0 Hospital cleaning

The Patient Environmental Action Group (PEAT) and the IPCT has been present on previous visits and the team continued to achieve acceptable scores in the majority of the assessment process.

Monthly cleaning audits are performed in all directorates with the table below providing a monthly average and overall average at the end of the year.

20010/2011

Month	%
April	97
May	96
June	97
July	98
August	96
September	92
October	95
November	92
December	97
January	97
February	97
March	98
Average	96

16.0 NHS Institute for Innovation and Improvement

The NHS Institute for Innovation and Improvement (NHSI) recognise that whilst HCAI's have been significantly reduced, many patients still remain anxious about the prospect of a stay in hospital because they are concerned about HCAI's.

NGH was approached to work with the NHSI to support the development of a media campaign to address the concerns of the population. One of the key actions from this was the setting up of an Infection Prevention Sub Group, Institute of Innovation HCAI Tackling Infections Focus Group.

Members of the group are Matrons, IPCT, Preoperative Assessment Sister, Communications and a patient representative. The group meets quarterly.

Issues that are being reviewed and actioned are:

- To raise awareness of the Institute of Innovation HCAI tackling Infections website, there will be 5 new plasma screens later this year displaying messages re the importance of cleanliness within an acute hospital setting. This is planned for July.
- NGH to adopt the information from the Institute of Innovation.
- To become familiar with the Institute of innovation HCAI tackling Infection PR Tool Kit. This may also feature on the plasma screens.
- Myth busting to increase patients awareness to patients and staff about infections. This is still in progress.
- To raise awareness of the Institute of innovation HCAI tackling Infections work book for nurses. This is to be taken to the Infection Prevention practice teaching sessions.
- The members of the patient's focus group are to become ambassadors for utilising the foaming sanitiser outside of departments and ward areas. The members of this group had their CRB checks completed and will be ready to perform their first audit this will be actioned at the next meeting 6th July 2011.

- To make NGH MRSA leaflets more eye catching. This is still in progress

Actions are being reported back to the IPC and this work continues in 2011/12.

17.0 Decontamination Arrangements

Sterile Service Unit
The Sterile Service department processed nearly 20,000 trays during April 10 to March 2011 including Instrument Trays, Procedure Packs and individual Medical Devices with a non-conformance rating of under 0.5%

The Sterile Service Department demonstrates compliance with ISO EN13485/2003 where manufacturers of medical devices have to provide evidence that Decontamination Technicians are trained to a national standard. The Sterile Service Department implemented the NVQ level 3 qualification in decontamination during May 2010 following this two technicians have already successfully completed the course, a further 4 are nearing completion.

The department has also undergone building works to divide the: 'Inspection and Packing Room' with a wall, creating a steriliser loading area. This has greatly improved the air handling of the room ensuring positive air pressure is maintained at all times. Following on from this work two new sterilisers were replaced without disruption to the manufacturing process and a further two are being delivered in May 2011.

As from 1st April 2011 the Medical Equipment Library which manages and re-processes specialised mattresses and other medical equipment such as infusion pumps is now part of the Sterile Service Department. This will ensure the highest levels of decontamination are maintained whilst delivering efficiency savings to the Trust.

The introduction of a Decontamination Group commenced in February 2011, which has replaced the Endoscopy Scope Users Group and the Sterile Services Liaison Group. The Decontamination Group includes representatives from ENT, Endoscopy, Infection Prevention Control, Sterile Services and Theatres. The purpose of the group is to ensure decontamination procedures are standardized across the Trust, the group reports into the Medical Devices Committee.

Endoscopy
The Endoscopy decontamination room saw the installation and commissioning of two specialised filtered scope storage cabinets which allow for safe storage of flexible endoscopes for up to 76 hours. This has greatly reduced the need to re-process scopes after a three hour usable window, saving money and time. Two Endoscopy technicians have also completed their NVQ level 3 qualifications.

Trust Creutzfeldt - Jakob disease (CJD) Policy
The newly ratified Creutzfeldt - Jakob disease policy is now available via the Trust's intranet. The policy provides guidance on prevention, control and management of TSE (CJD, vCJD) infections and is relevant to all clinical staff of Northampton general Hospital.

Appendix A - Infection Prevention and Control Team Annual Programme of Work April 2010 – March 2011

Standard	Action point	Lead/ Responsible person(s)	Implementation Programme	Evidence Required	Review/ Monitor	Review Monitor date
CQC 1- Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them **CQC 3**- Provide suitable accurate information on infections to service users and their visitors **CQC- 5-** Ensure that people who have or develop an infection are identified promptly and receive appropriate treatment and care to reduce the risk of passing the infection to other people **CQC- 6** Ensure that all staff and those employed to provide care in all settings are	• Board level agreement regarding responsibility for minimising HCAI • Surveillance of "alert organisms" & Surgical Site Infections • Infection Prevention and control Annual plan, incorporating annual plan of work • Provide suitable and sufficient assessment risks to patients	DIPC, Lead IPN,	• Daily Surveillance of alert organisms • Maintenance and development of ICNet(future) • Mandatory surveillance MRSA Bacteraemia and C-diff in collaboration with HPA, Other alert organisms i.e. ESBLs , PVL • Maintenance of IPCT data bases • Develop the annual audit plan to include audit of specific IPC policies • Specific IPC documentation for in-patient areas include actions and risk assessments • Monitor elective screening compliance • Maintenance of MRSA screening compliance. • Report SI's and provide support for directorates to investigate with Root Cause Analysis • To continue to develop emergency screening.	• Advice to wards/clinical areas via daily ward visits, telephone enquiries and advice on treatment management • Face to face discussions with ward staff on identification of positive Alert Organism • Monthly graphs/charts to Information and Contracting. • Monthly reports Heads of Nursing, Clinical leads, Monthly reports to HMB and Trust Board via IPCC and HCGC minutes. • Achieving of Trust National and locally agreed targets for MRSA bacteraemia and *Clostridium difficile* • Feedback from Region via quarterly reports	Daily Monthly Monthly Monthly Quarterly	Monthly IPC

fully involved in the process of preventing and controlling infections **CQC- 7** Provide or secure adequate isolation facilities **CQC- 8** Secure adequate access to laboratory support as appropriate **NHS LA Standard 4** – The organisation has an approved documentation process for managing risks associated with infection prevention and control that is implemented and monitored **NHS LA Standard 2 – Criterion 8 Hand Hygiene** The organisation has an approved documented process for ensuring delivery of effective hand hygiene to all permanent staff groups that is implemented and monitored	within healthcare settings • Surgical Site Surveillance		• Maintenance of compliance with patients checklist and audit 2 monthly • Mandatory hips & knees undertaken by Orthopaedic teams with support from IPCT as requested). • To continue to develop SSS via a rolling programme via HPA Colindale – Vascular, Large Bowel. Hysterectomy and develop new surveillance including Caesarean section • Surveillance and management of outbreaks of Infection, e.g. Clusters of MRSA colonisation or clinical specimens, *Clostridium difficile,* Norovirus outbreaks requiring closure of wards and impacting on Trust business	• Feedback to directorate Leads via Surveillance nurse as reports received from HPA • Daily meetings, as required, during outbreaks of infection, reporting to CE, Director of Nursing, PCT and SHA • Advice to medical staff re: antibiotic treatment via Microbiologists • Advice to wards regarding appropriate isolation and nursing practice • Advice to Heads of Nursing, on-call managers and Site Management Team as appropriate as per Policy for Outbreaks of Infection	Monthly Daily	

CQC 2- *Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections* Towards Cleaner Hospitals **CQC- 6** Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections **CQC- 9** Have and adhere to policies, designed for the individuals care and provider organisations, that will help and control infections **NHS LA Standard 4** – The organisation has an approved documentation process for managing risks associated with infection prevention and control that is implemented and monitored		DIPC, Lead IPCN, Lead for Facilities, Lead for Estates	***Programme of Audit*** Environmental Use of IPS/DH Audit tool to develop database, maintain safe environment. Collaborative working with Facilities to deliver a robust audit programme to monitor and maintain compliance with national Cleaning standards ***Practice*** • Point Prevalence- Urinary catheters - 6 monthly • **MRSA IPCP audit – compliance with Policy** • MRSA screening Point prevalence monitoring of compliance in admission and high risk areas • **Isolation- Compliance with Policy** • Time to isolation audit? • Hand hygiene monthly by each ward within Saving Lives audit programme • Special measures • Ad hoc following outbreaks of clusters of infection • 3 monthly audits by link nurses regarding PPEs and Cleanliness of patient equipment • Monthly Saving Lives audit *Clostridium Difficile*	• Feed back to Head of Nursing and ward managers via IPCC • Provide infection prevention and control advice • Ensure support of Ward managers and More involvement of link nurses • Plan audits in advance to ensure link nurse availability • Emphasise realistic action plans. • Re-audit within a realistic time-frame • Review of audit tool and care plan • From clinical areas and Leads – use findings to direct education • Further Audits will be added as required.	Monthly, Quarterly, six monthly and annually	Monthly IPC
CQC 4 – Provide suitable accurate information on infections to any person concerned with providing further support or		DIPC, Lead IPN,	***Clostridium Difficile Associated Diarrhoea) –*** • *Daily Laboratory based surveillance*	• Achieving of trust and nationally decided target • Advice to wards regarding appropriate management including isolation and nursing	Monthly	Monthly ICC

nursing/medical care in a timely fashion **CQC- 5-** Ensure that people who have or develop an infection are identified promptly and receive appropriate treatment and care to reduce the risk of passing the infection to other people **CQC- 6** Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections **CQC- 7** Provide or secure adequate isolation facilities			• Mandatory reporting of all CDT on HPA HCAI web based surveillance system • Reporting of CDT deaths or SI's on STEIS • Identification of Hotspots (2 or more positives in one ward area within 28 days) • RCA all positive Cdiff specs >3 days • RCA all MRSA bacteraemias <48hrs for Trust learning	practice • Advice to medical staff re: antibiotic treatment via Microbiologists • Monthly graphs to HN and ward Managers • Monthly reports Heads of Nursing, Directorate leads, Monthly reports to HMB and Trust Board via IPCC	Monthly Monthly	
CQC- 9 Have and adhere to policies, designed for the individuals care and provider organisations, that will help and control infections **NHS LA Standard 4** – The organisation has an approved documentation process for managing risks associated with infection prevention and control that is implemented and monitored		DIPC, Lead IPCN,	• Review and update policies in line with National Guidance Review. All policies updated and endorsed by Infection Prevention and Control Committee • Review each policy as necessary • Collaboration with other specialists e.g. Occupational Health Department, Site Management, Facilities and Estates Leads • Distribute policies to all wards & Departments within the Trust & Associated Trusts • Policies available on Intranet Web Page **Provision of policies for**	All new and updated policies will be ratified by Infection Prevention and Control Committee prior to Trust ratification at the Quality Governance Board	Monthly	Monthly IPCC

			individual organisms will include • MRSA • *Clostridium Difficile* • GRE • Gram Negative infections including ESBLs and Acinetobacter • Tuberculosis • Meningococcal infections • Viral Haemorrhagic Fever • CJD			
CQC- 10 Ensure, so far as is reasonably practicable, that care workers are free of and protected from exposure to infections that can be caught at work and that all staff are suitable educated in the prevention and control of infection associated with the provision of health and Social care **NHS LA Standard 4 – Criterion 9** The organisation has an approved documentation process for managing risks associated with infection prevention and control that is implemented and monitored **NHS LA Standard 2 – Criterion 8 Hand Hygiene** The organisation has an approved documented process for ensuring delivery of effective hand hygiene to all permanent staff groups that is		DIPC, Lead IPCN,	**Provision of Education for all staff** **Mandatory** Monthly induction Monthly refresher (x2) **Infection Prevention and Control Link nurses** 6 meetings - monthly Jan – March and July – Sept **As requested** Housekeepers, Porters, Radiographers, Physiotherapists, Phlebotomists Occupational Therapists, Estates Staff, Hospital Volunteers Teach on the IV study days, Ward Sisters / HCA's/Aseptic technique **Monthly** Obstetrics NICU Paediatrics **Night Staff sessions** 1night shift every 6 months. **Hand Hygiene** Ad hoc by directorate IPCT	• Monitoring of attendance at mandatory sessions by Staff Development via OLM • Monitor ad hoc attendance by IPCT • Audit practice to evaluate learning and application • Education and Feedback of Practice Audits to address issues/ review guidelines. Inform and participate in establishing evidence to support good Infection Control Practice trust wide. • Liaise with Directorate Practice Development Nurses. Training and Development Department, and Clinical Development Nurse • Continue liaison with		Monthly ICC

implemented and monitored			leads and following ht Spots or outbreaks of Infection Cascade hand hygiene trainers Target Medical Staff **<u>Alert Organisms</u>** Ad hoc by IPCT leads, cascade trainers and following special measures or outbreaks of Infection Target Medical Staff **Nursing and Midwifery Students** As requested from University Northampton First year students allocated one day with infection prevention.	University College Northampton		
CQC- 6 Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections **NHS LA Standard 2 – Criterion 8 Hand Hygiene** The organisation has an approved documented process for ensuring delivery of effective hand hygiene to all permanent staff groups that is implemented and monitored		DIPC, Lead IPCN, Director of HR, Lead for Facilities and Estates.	Collaborative working with other Departments within the Trust and External to the Trust Involving attendance at Trust wide and External meetings • 6 weekly meetings with estates and IPT • Regular meetings with OH working together on common policies, discuss staff and infection prevention policies. • IPCT nominated representative to attend directorate governance meeting. • Health Economy HCAI Group, Led by Commissioning PCT • Nursing Advisory Board • Practice Development Forum • Estates issues – collaboration with Preventative Maintenance Programme, Advice re	• Raise awareness with Directorate Managers and Clinical Directors • Raise awareness via Link Nurses, Ward Managers and Directorate Head Nurses • Raise awareness of purchasing issues with wards • Liaise with wards via housekeepers • Feedback of PEAT assessment to wards, etc	Monthly via Infection Prevention and Control Committee.	Monthly ICC

			future builds/improvements • Procurement Group working with the Materials management and Supplies Department. Participation in product reviews • Decontamination group • Water management Group • Audit and assurance Group – re Cleaning Specifications and Standards lead Facilities • Participation in PEAT self-assessment. • Health and Safety Group • Northamptonshire Clinical Investigatory Group	• Monitoring process changes following RCA on a county wide basis		

This programme of work will be significantly influenced and added to by tasks assigned to Infection Prevention and Control Team as situations arise.

Audit of this programme is on going by the IPCT.

This programme to be reviewed annually or as indicated from feedback.

Monitoring is on the Performance Accelerator (PA) in accordance with Governance compliance with the Care Quality Commission (CQC). This is updated monthly by the Infection Prevention Team (IPT).

Northampton General Hospital NHS
NHS Trust

TRUST BOARD SUMMARY SHEET	
Title	Medical Director's Patient Safety Update
Submitted by	Dr Sonia Swart, Medical Director
Prepared by	Dr Sonia Swart
Date of meeting	28th September 2011
Corporate Objectives Addressed	To improve the clinical quality of patient care focusing on safe, effective treatment that is patient centred

SUMMARY OF CRITICAL POINTS

This report provides an update on some key areas of significance with respect to the implementation of the NGH Patient Safety Strategy

PATIENT IMPACT

High quality care for patients remains a priority. Patient Safety is a key component of that quality and patients need to understand what this means.

STAFF IMPACT

There is a risk of poor staff morale relating to failure to deliver high quality care and failure to provide safe care is an important part of this. All staff need to be engaged in safety initiatives.

FINANCIAL IMPACT

Patient safety indicators are likely to be linked to payments either through the CQUIN framework or through other contracting mechanisms

EQUALITY & DIVERSITY

N/A

LEGAL IMPLICATIONS

Trust Boards are mandated to examine quality and safety across a range of services

RECOMMENDATIONS

Board members are asked to note the contents of this report and debate the issues raised. They are also asked to continue to support the work required to improve patient safety.

Progress against the Trust's Patient Safety Strategy

Background:

The Trust has been working to improve the quality of care and safety of patients in a sustained way for a number of years. There have been a variety of projects and many of these have resulted in ways of working that are now embedded in normal practice.

In practice, patient safety work is a continuum and must be constantly refreshed in the light of new evidence or practice and in the light of changing priorities.

The Trust's vision for safety is that systems and processes should be in place to ensure that every member of staff understands their role in patient safety and works towards that goal every day

As part of this vision there is a commitment to ensuring that progress is visible for staff and patient to view and that the Trust is able to demonstrate a reduction in both harm events and death rates.

This report provides an update on a selection of some of the projects in place over the last 6 months

1. Patient Safety Board

This is a multidisciplinary board which meets bi monthly to receive presentations with respect to key projects. The presentations to date have been extremely stimulating and this has proved an effective way of stimulating interest across the staff groups.

2. Junior Doctors Patient Safety Board

This was a new initiative past year and has proved very successful. The most junior doctors in the Trust have been involved in a series of projects and initiatives to improve patient care at ward level. They have been able to present their findings regionally and hopefully soon nationally and have helped us to build a culture of Trust wide junior doctor audits. Last year the doctors left a developed project for implementation which has been taken forward as the Surviving Sepsis campaign and will be contributed to by the new junior doctor safety board. They will also be developing their own projects one of which will be chosen for next years ' Aspiring to Excellence ' programme aimed at the doctors of tomorrow.

3. Surviving Sepsis

This campaign came out of the Junior Doctors Safety Board and is now a Trust wide project to improve the recognition and treatment of patients with infection. This project has strong multidisciplinary leadership and will help to focus staff on a key safety issue. There will be an ongoing audit of the compliance with the current sepsis guidelines and the mortality rates from all forms of sepsis will be tracked carefully.

4. Aspiring to Excellence

This years 3 week course for final year medical students was based around last years junior doctor project 'Surviving Sepsis' and involved many lead clinicians across the Trust in helping to launch the ' Sepsis Box'. The innovative approach to patient safety teaching for medical students is to be developed into a formal module that can be used by other Medical Schools with the help of the prize money that was

awarded to Jane Bradley who was the Regional Safety Innovation Prize winner for this project.

5. Improving Discharge Medication and Reducing Harm from Medication

The regular audit of medication charts, the design of new medication charts and the focus on ensuring reporting of medication incidents has led to increased focus in this area. It is difficult to design an effective measure of medication harm, as in the first instance, a focus in this area results in an increased reporting of incidents but the formation of the medication safety group and involvement of junior doctors is likely to improve matters. Increased education and awareness with respect of high risk medications is also in place.

6. Prevention of Blood Clots

Although the Trust has attained the standard of over 90% of patients receiving a risk assessment for VTE, there is still work to do in this area and the Trust is developing a campaign of communication to improve matters in this high risk area. The Thrombosis committee continues to monitor progress and there is an active regional group led by the NGH MD which is also ensuring that we retain focus on this area. There is a process whereby the notes are examined for every patient who develops a blood clot within 3 months of a hospital discharge. In the last 6 months all of these patients had been treated with drugs to prevent blood clots.

7. Communicating Safety Issues with Staff and Patients

The Trust has developed a generic patient safety leaflet which is aimed at patients and which will mirror the content of the Safety Boards which will be visible on every ward. The focus of the Boards and the leaflet will be to engage the patient in the safety agenda and explain what the staffs are doing to ensure their safety. This booklet is needed because it puts all the key safety messages in one place. One of the problems with patient information is that there is so much of it. This should make it easier for patients to understand and will also help the staff. The same format is to be used as screensavers on the patient televisions where there will be video messages from our own staff regarding safety issues and including some public health issues such as smoking. A copy of the leaflet is included in the Board papers. The content has been designed with the help of patient and staff groups.

8. Electronic Handover

Handover of care is a key patient safety issue. The Trust has developed an electronic handover tool which can be used to highlight patients that need an intervention from the team taking over care. This tool is currently being used in some areas and will be rolled out across the Trust. This is currently used for medical handover but a combined nursing medical handover tool would be possible and probably desirable. The current tool complements the physical handover process where patients are discussed at the handover to the night team.

9. Recognising the Deteriorating patient

The current patient safety clinical leads were appointed to address the issues raised by a number of reports highlighting issues in hospital where there was a failure to recognise the acutely ill or deteriorating patient. At that time the recording of observations and warning scores was very poor. Although this has now improved significantly there are still improvements required in order to ensure that every patient has accurate observations preformed at the right frequency and that worrying results

are appropriately escalated and acted on. This is the subject of a refreshed approach which will be launched along with a revised scoring system which is likely to be a national mandate. The Trust is currently investigating an automated wireless tracking device used to record and calculate observations and nursing assessments which can be used by both medical and nursing staff to ensure that the necessary actions from all observations that indicate a deteriorating patient are acted on.

10. Patient Safety Week (September 12-18)

During this week a series of screensavers highlighted the above initiatives and some other key safety/quality initiatives in the trust such as Enhanced Recovery. The message on the screens was 'It Starts With Me'. This was part of the message to staff that they all have a role in patient safety.

This is an update to provide the Board with assurance that significant emphasis in place on projects aimed at improving patient safety and increasing the awareness amongst staff and patients who need to be partners in these initiatives.

Dr Sonia Swart
Medical Director
September 2011

TRUST BOARD SUMMARY SHEET	
Title	Annual Security Report
Submitted by	Charles Abolins, Director of Facilities and Capital Development
Date of meeting	28 September 2011
Corporate objectives addressed	
SUMMARY OF CRITICAL POINTS This report highlights security activities during 2010/11 and outlines in particular the data and trends relating to security incidents. The paper also provides information on security improvements during the past year and planned initiatives for 2011/12	
PATIENT IMPACT Reducing the risk to both staff and patients through a proactive approach to security.	
STAFF IMPACT Training of staff in conflict resolution and heightening awareness of security risks.	
FINANCIAL IMPACT The cost to the Trust of theft and criminal damage was estimated at £2000 during 10/11	
EQUALITY & DIVERSITY IMPACT	
LEGAL IMPLICATIONS	
RISK ASSESSMENT	
RECOMMENDATION The Trust Board are asked to note the content of the report and to support the proposed improvements and initiatives for the current year.	

Northampton General Hospital NHS
NHS Trust

Security Management Review
2010-2011

2010-2011 SECURITY MANAGEMENT REVIEW
REPORT TO THE TRUST BOARD

1.0 Executive Summary

20010/11 has again been a challenging year for the Trusts Security Department. The report shows that criminal activity, physical assaults and verbal abuse are a daily occurrence. In total there were **343** reported incidents either to security or reported through the Trusts Datix reporting system. This is a slight reduction on last years reported figure of **350.** There has been a significant shift in reported activity this year.

There were **33** reported crimes/thefts, a **66%** reduction on the previous financial year.

Reported physical assaults via Datix increased by **56%.** This is disappointing to report as for the last two years there has been a steady decrease.

Reported verbal, aggressive and harassment incidents total remains consistent with last year.

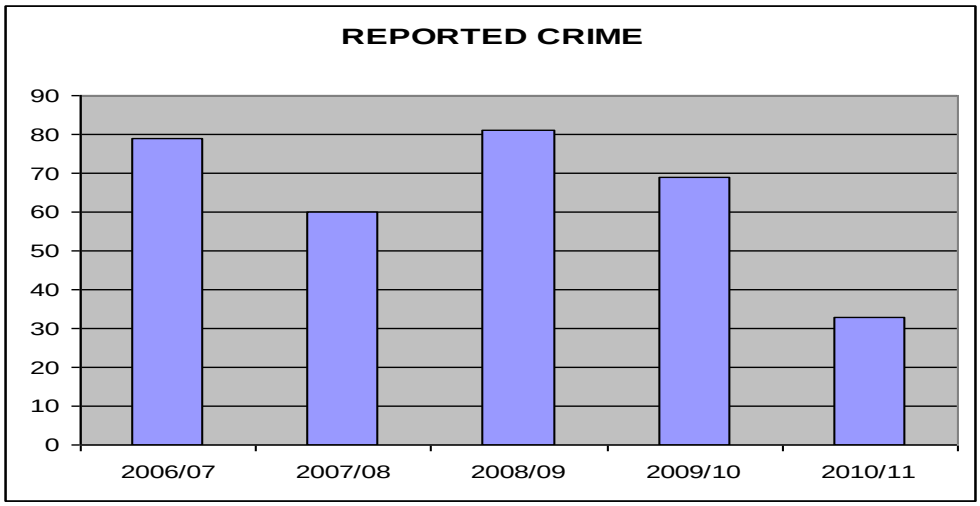
2.0 Introduction and Background

In December 2003 the Secretary of State launched the Security Management Strategy " A Professional Approach to the Management of Security in the NHS" This can be downloaded at www.nhsprotect.nhs.uk The Security Management Services has been rebranded from April 2011 and forms part of the NHS Business Service Authority.

Since 2003 the Trust has actively worked with the SMS in providing statistical data around physical assaults, this has helped SMS identify the scale of violence against all NHS staff. The Trust also reports on how many staff attend conflict resolution courses, this again allows for better publicising of the training being provided within the NHS The Trust has also shaped its security policies around guidance given by SMS.

The Facilities Directorate provides an in-house Security team which consists of 10 officers. The Security Department provides security 24/7 and ideally with a minimum of 2 officers on a shift. In addition Portering staff provides support and back up to Security all of whom are in direct radio contact with each other. Security will attend routine calls as well as emergency calls such as fire alarms, intruder alarms and incidents in progress.

2.1 Reported Crime Incidents 10/11 and comparative data.
The Security Department routinely collect data on incidents which are used to identify problem areas and assist in determining the most effective counter measures and initiatives.



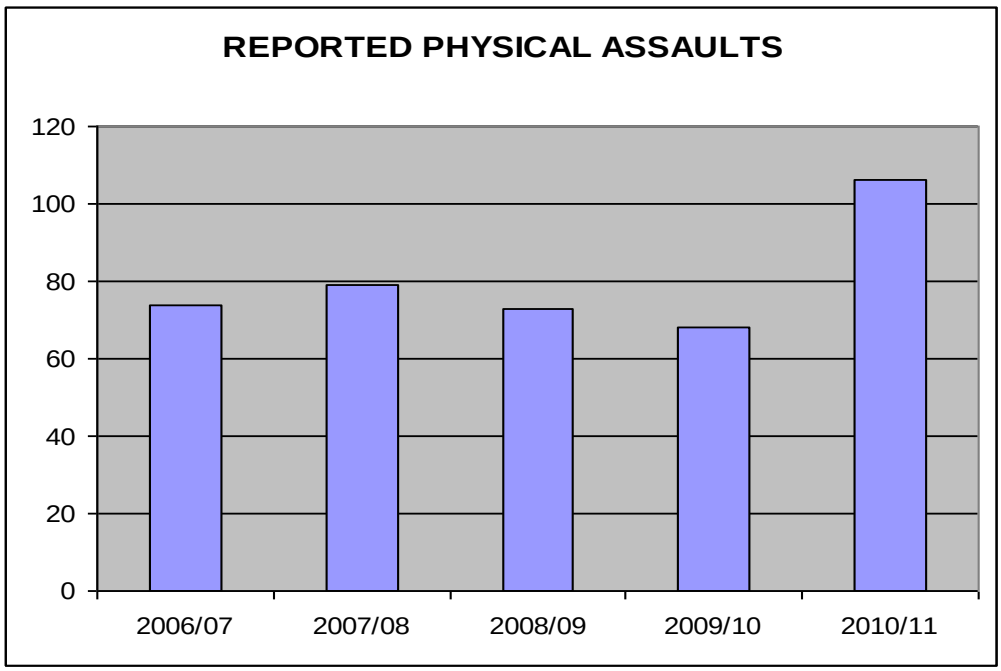
2.2 Data summary breakdown

- **66%** decrease in reported crime compared with last year's figures. This is encouraging to report and is hopefully attributed to the proactive approach being taken by staff in protecting the Trusts and their own property.
- **48%** of reported crime to security was theft of cash, and credit cards from staff. **5** incidents related directly to cash held in departments being stolen. **11** Incidents reported related directly to staff including **5** incidents where credit cards were stolen from separate offices and 4 successful attempts were made by the perpetrators in obtaining cash from bank and building societies. This is serious criminal activity and currently forms part of a national investigation by NHS Protect and the police. A large organised gang has been identified and a number of suspects are on remand or wanted. Our Security Department and a member of staff were vigilant enough on the last occasion to identify a suspect, follow them to an awaiting car and obtain the registration number. CCTV was also reviewed and a suspect was identified and CCTV stills obtained. All this information has been passed onto the police.
- **1** vehicle related crime was reported which is a significant drop from last years reported figure of **10**. When you consider the vehicle activity on site 24/7 our local police have reported that this site is not a targeted area due to probably the amount of CCTV sited across all main car parks.
- **1** reported theft of patient money which again is a significant reduction, as last years reported figure was **10**.
- The cost to the Trust of theft and criminal damage to equipment and property during the past 12 months has been is estimated at **£2000**. This includes £1750 in cash and £250 worth of criminal damage. The £250 for criminal damage has been recovered as the offender was arrested after the incident and convicted.
- **5** reported incidents of vending machines being damaged/ broken into with on occasion's cashbox/loose money taken, this is a reduction from the **9** reported last year. These incidents have been linked to one individual suspect who was arrested following the fifth occasion through good CCTV

evidence which showed the suspect breaking into the vending machine. The suspect is currently awaiting conviction. The CCTV was installed after the previous break-ins so has proved its worth, with no further break-ins in Area K.

2.3 Physical, Verbal Abuse, Aggressive and Harassment Incidents Data
This information is compiled from the Risk Management Departments Sentinel and Datix reporting systems

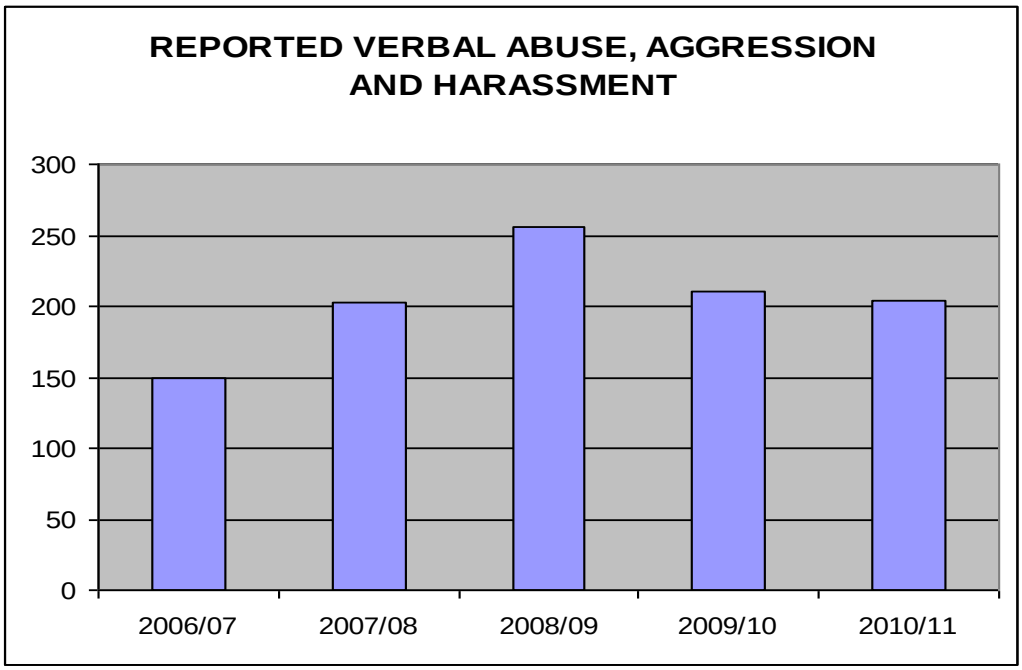
NHS PROTECT definition of physical assault: *"the intentional application of force against the person of another without lawful justification resulting in physical injury or personal discomfort"*



- **56%** increase in physical assault reported incidents, this significant increase maybe attributed to staff awareness regarding when to report an incident as a physical assault through conflict resolution training and easier access to reporting through Datix. It should be noted that the majority of physical assaults are low level types where scratching, pinching and flailing arms and legs connecting to staff being the descriptions used via Datix.
- **1133** staff attended the half day non intervention conflict resolution course during the year.
- There continues to be reportable incidents whereby physical assaults have been attributed to the mental state of a patient, dementia or detoxing. . With the increase in this type of patient the Trust needs to ensure it has suitably trained staff to manage these patients and the environment needs to be appropriate for the patient. Currently a restraint policy has been developed and is under review. The policy states that trained teams intervene when restraint is deemed appropriate for a patient based on risk assessment. Directorates need to ensure their staff are appropriately trained if physical intervention is needed in the best interests of the patient. Security officers will attend to support and protect clinical staff.

- Last years report stated that there was an assault on a qualified nurse working in A+E which resulted in the patient being charged for aggravated bodily harm and that the police were investigating and preparing a report for the Crown Prosecution Service. The offender was convicted in November 2010 and sentenced to 15 months in prison. This was reported in the Chronicle and Echo which helps demonstrate that the Trust will prosecute when staff are assaulted.

NHS PROTECT definition of verbal abuse, aggression and harassment: *"the use of inappropriate words or behaviour causing distress and/or constituting harassment"*



- There has been a slight decrease in reported verbal abuse, aggressive and harassment incidents for a second year. This decrease may be attributed to the ongoing conflict resolution training which trains staff on how to recognise and defuse potential situations.

4.0 Achievements During 10-11

- As part of the ongoing CCTV strategy additional cameras have been installed within the hospital corridors. These include the ground floor administration corridors at Billing Road Entrance and corridor main junctions. There are currently **71** cameras covering the Trust and are networked to authorised personal computers within the Security Department.
- The St Crispin's Safer Community Team's mobile unit was on site on four occasions. Staff and visitors were encouraged to meet with our local police officers.
- Regular meetings continue to take place between the Trusts LSMS, Security staff and the police; the sharing of intelligence is a regular feature.
- The Security Department continues to be a part of the Northampton Retail Crime Initiative, which meets regularly to share intelligence on criminal activity and informed of all persons who are under Anti Social Behaviour Orders (ASBOs). The security Department hold a file with photos of

persons on current ASBOs. This is a useful document as security officers are familiar with these faces and report to the police if seen on Trust property. By entering Trust property they are in breach of their conditions of movement unless attending for a hospital appointment or to seek urgent medical attention and this breach is arrestable.

- There has been full rollout of the 65 lone worker devices for community midwives.
- Hospital Watch has been re-established and is a good vehicle for sharing information and advise across all Directorates.
- Both the Security Policy and Protecting Staff policy have been revised and ratified and are available on the intranet.

5.0 Conclusion

It is encouraging to see a continual down turn on criminal activity on site, however we must not loose sight of the fact that the Trust is accessible to the public and that the opportunity to commit a theft will always remain. Reducing the opportunity will continue to be a driving factor in providing a safe and secure environment.

It is disappointing to report an increase in reported physical assaults. The majority of assaults staff are facing continue to be from confused ward based patients. With the increased attendance on the CRT courses staff should be better prepared in dealing with difficult situations.

The Trust does need to consider interventional training to help staff deal with mental health and confused patients who may or may not lack capacity. The perception of seeing uniformed officers handling vulnerable patients should be reviewed and appropriately trained clinical staff take the lead.

The reporting of verbal abuse incidents has also decreased which again is encouraging however no member of the public has the right to abuse Trust staff. Managers should ensure that the Protecting Staff Policy guidance is followed and that patients and visitors are made aware that this is unacceptable behaviour and that the Trust will initiate a range of sanctions against individuals who act in this way towards staff. This should include documented evidence using the policy template letters informing patients of their actions. This may help reduce the risk if they were to be readmitted.

.

6.0 Initiatives Planned for 11/12

- To continue to improve follow ups with police when a crime has been committed to get feedback on outcome or on how an ongoing investigation is progressing.
- To continue to improve CCTV coverage, the emphasis will be to enhance external coverage, particularly in current blind spot areas. A site survey has been carried out to identify areas.
- To achieve NHSLA level 2 in security environment the Trusts Security Policy states that risk assessments are to be carried out by Directorate Managers to identify that buildings and areas are able to be secured in the event of an untoward incident. This will help identify that the Trust can carry out a full Lockdown of the site and or partial Lockdown if required in a specific area and that the Trust can demonstrate it is protecting its staff and property.
- To agree a memorandum of understanding between the Trust and Local Prison Services for prisoner escort and bedwatch function on Trust site. A

concordat between the National Offender Management Service and NHS PROTECT is in place, local arrangements need to reflect appropriate activity and monitoring of prisoners attending NGH for treatment.

- To investigate the feasibility of a dedicated security control room staffed 24/7 monitoring CCTV and alarm systems to further improve response times and detection rates.
- To review and introduce improved corporate signage and literature for staff and visitors informing them of security measures in place and how to report security incidents. Currently there are a range of information posters and signage at various entrances to the hospital.

A Watkins
Local Security Management Specialist

Northampton General Hospital NHS
NHS Trust

TRUST BOARD SUMMARY SHEET	
Title	Update Report on the Development of the Haematology Outpatient Department (Macmillan Scheme)
Submitted by	Charles Abolins, Director of Facilities and Capital Development
Date of meeting	28th September 2011
Corporate Objectives Addressed	

SUMMARY OF CRITICAL POINTS

- The contractor is making good progress with the development
- The scheme remains within budget
- The go live date of February 2012 will be achieved
- The Macmillan appeal has exceeded the half way mark

PATIENT IMPACT

STAFF IMPACT

FINANCIAL IMPACT

EQUALITY AND DIVERSITY IMPACT

LEGAL IMPLICATIONS

RISK ASSESSMENT

RECOMMENDATION
The Board are asked to note the content of the update report

8

MACMILLAN APPEAL
EXTENSION AND IMPROVEMENTS TO THE HAEMATOLOGY DEPARTMENT

UPDATE REPORT
28th SEPTEMBER 2011

Macmillan Scheme

1. Progress

It is estimated that the contract works are some two weeks behind programme. It is anticipated that practical completion will be mid December 2011. Due to flexibility in the commissioning programme this does not impinge on the proposed go live date of February 2012.

The externals are complete and the area is fully watertight. The 'first fix' electrical, plumbing and woodwork installations are complete and the contractors are currently finishing partition work and plastering internal walls.

Having recently inspected the site it is already evident that the internal space created is vastly superior to the old department and will significantly improve the patient experience and working environment for staff.

2. Commissioning

A commissioning programme has now been developed and circulated to all members of the Commissioning group for comment and further information.

The ordering of Furniture and Equipment is currently being organised and programmed accordingly with the commissioning programme.

There will be a full Project/Commissioning meeting held in October ahead of practical completion.

3. Finance

All elements of the project are still under their allotted budgets.

Currently there are still some construction issues under negotiation, however taking risk items into consideration the scheme is still well within budget. The main contract budget is still running with an uncommitted contingency of £91K which should cover any further unknowns.

4. Fund Raising

To date the Macmillan fundraising has reached over £750,000 which exceeds the half way point of the appeal.

Charles Abolins
Director of Facilities and Capital Development

Northampton General Hospital NHS
NHS Trust

TRUST BOARD SUMMARY SHEET	
Title: -	Performance Report
Submitted by: -	Christine Allen - Director of Operations
Date of meeting: -	28th September 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 5 **(August 2011)**.

The Trust did not achieve the following standards for August 2011:

- 62 day from urgent referral to start of cancer treatment
- 31 day from decision to treat to start of first treatment for subsequent cancer treatment

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 is asked to note the contents of this report.

Northampton General Hospital NHS
NHS Trust

PERFORMANCE REPORT – AUGUST 2011

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for **Month 5** (August 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

Technical Guidance Reference	Indicator	Monthly Target	Apr-11	May-11	Jun-11	Q1	Jul-11	Aug-11	Q2 to date
HQU05,06, 07	**RTT waits (95th percentile measures)**								
	- *admitted 95th percentile*	23 Weeks							
	- *non-admitted 95th percentile*	18.3 Weeks							
	- *incomplete 95th percentile*	28 Weeks							
SQU24,25, 26	**RTT (Median wait measures)**								
	- *admitted median wait time*	11.1 Weeks							
	- *non-admitted median wait time*	6.6 Weeks							
	- *Incomplete median wait time*	7.2 Weeks							
	Percentage of Patients seen within 18 weeks across all speciality groups								
	Admitted	90%							
	Non-admitted	95%							
	Percentage of Patients seen within 18 weeks for direct access audiology treatment	90%							
HQU09,10, 11,12,13	**A & E quality indicators**								
	- *unplanned re-attendance rate*	>1% and <5%							
	- *total time spent in A & E (Admitted Patients)*	95th Percentile=<4 Hrs							
		Longest Wait =<6 Hrs							
	- *total time spent in A & E (Non-Admitted Patients)*	95th Percentile=<4 Hrs							
		Longest Wait =<6 Hrs							
	- *left department without being seen*	=<5%							
	- *time to initial assessment (95th percentile < 15mins)*	=<15mins							
	- *time to initial assessment (100% < 20mins)*	100%							
	- *time to treatment in department (median)*	=<1 Hrs							
	Number of diagnostic waits > 6 weeks	0							
	Cancer Wait Times								
	2 week GP referral to 1st outpatient	93%							
	2 week GP referral to 1st outpatient - breast symptoms	93%							
	31 Day	96%							
	31 day second or subsequent treatment - surgery	94%							
	31 day second or subsequent treatment - drug	98%							
	31 day second or subsequent treatment - radiotherapy	94%							
	62 day referral to treatment from screening	85%							
	62 day referral to treatment from hospital specialist	85%							
	62 days urgent referral to treatment of all cancers	85%							
	Stroke Indicators								
VSA14_06	*Proportion of people who have a TIA who are scanned and treated within 24 hours*	60%							
VSA14_03	*Proportion of people who spend at least 90% of their time on a stroke unit*	80%							

2.1 August Performance

The Trust achieved all standards for August; the only exception was two of the Cancer Standards. The Trust continued to achieve all the 18 Week Standards for median waits and the 95th percentile, as well as continuing to meet the standard of 90% of admitted and 95% of non-admitted patients treated within 18 weeks across all specialties.

The Trust achieved the A&E Standards grouped for timeliness and patient impact, as well as achieving 95% of patients treated within 4 hours.

2.2 Cancer Standards

2.2.1 62 Days from Urgent GP Referral

During August, the Trust treated 79% of patients within 62 days of their urgent referral just exceeding the standard of 85%. 13 patients were not treated within 62 days and the small number of patients treated during the month has affected the overall position.

Breaches have been as a result of complex diagnostic pathways in Upper and Lower GI. There has been an increase in the number of Urology breaches due to complex pathways and patient's choice to defer treatment. A plan is now in place to more closely monitor this standard to ensure the achievement of this standard for quarter two.

2.2.2 31 Day Consultant Upgrade for Surgery

During August, the Trust achieved 92.3% against the standard of 94%. Two patients were not treated within time as a result of additional test required prior to surgery and elective capacity for colorectal surgery. The Trust is expected to achieve the standard for quarter two.

2.3 A&E Clinical Indicators

In addition to the five headline measures, Trusts are still monitored for the total time spent in A&E. 95% of patients are to spend a maximum of 4 hours in A&E. The Trust achieved the standard and 97.2% patients were treated within 4 hours.

2.3.1 Total Time in the A&E Department

In August, the 95th percentile for admitted patients for the time waiting in A&E was 4 hours and 37 minutes compared to 5 hours and 47 minutes in July. For non admitted patients the 95th percentile was within 4 hours at 3 hours 40 minutes.

2.3.2 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 August the Trust achieved 31 minutes.

2.3.3 Longest Wait

The longest wait for admitted patients was 12 hours and 3 minutes, an increase from the longest wait in July of 11 hours and 2mins. The longest wait seen in August reflects the time taken to stabilise a critically ill patient waiting for transfer out of the hospital.

For non-admitted patients, the longest wait has remained stable at 11 hours and 38 minutes, in July it was 11 hours and 31 minutes.

3.0 RECOMMENDATIONS

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

BOARD SUMMARY SHEET	
Title	Finance Report to the Board – August 2011/12
Submitted by	Mr J Drury, Director of Finance
Date of meeting	28th September 2011
Corporate Objectives Addressed	Financial Duties / Financial Strategy

SUMMARY OF CRITICAL POINTS

Breakeven Financial Duty.
The I&E position for August is a deficit of £2,092k compared to a planned position of £1,687K deficit.

Capital Resource Limit (CRL)
The Capital Resource Limit (CRL) for 2011/12 totals £11.6m with a further £1.5m from donations. Total capital expenditure of £3.38m has been incurred at month 5.

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 August shows 95% compliance by volume and 79% 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 August 2011.

Finance Report

August (M5) FY 2011-12

1.0 Overview

Summary

- The I&E position for August is a deficit of £2,092k compared to a planned position of £1,687K deficit.

Key Issues

- Elective Income £1.6m below plan YTD.
- Non-Elective activity 13% (£4.7m) above plan subject to £1.9m MRET adjustment (MRET plan £21k at M5).

Risks

- Non Elective pressures leading to inability to fully implement bed reduction plan, however Compton Ward closed at end of month.
- Significant CIP schemes require HR consultation in autumn.
- Cash balance restored but aged creditor balance increasing.
- Mitigating actions of £5m to be delivered in second half of year.
- Business case to secure funding for Transformation / reorganisation costs to be approved by SHA. Business case resubmitted to NHSN to amend proposed use of funds.
- Adequacy of readmissions and maternity provision pending receipt of actual data.

I&E Position	£000's	
In-month I/E	(922)	£922k deficit in August.
Reprofile plan (YTD)	(1,933)	YTD Forecast (August reprofile)
Actual Year to date I/E	(2,090)	£2.09m deficit for year to date
FIMS Plan (Year to date)	(1,687)	£1.7m deficit for year to date
PCT SLA Income Variance	26	On plan
Full Year I&E Forecast	500	Forecast I&E surplus

EBITDA Performance	£000's	
Trust	(460)ADV	£460k behind plan

Cost Improvement Schemes	£000's	
In month delivery	873	
Year to date delivery	5,034	Includes YTD mitigating actions
Year to Go	12,766	CIPS to be delivered
Full Year Forecast	17,800	Including mitigating items

Directorate EBITDA Performance	£000's	
Medicine	809FAV	Variance to plan
Surgery	(1,194)ADV	Variance to plan
Anaesthesia	282FAV	Variance to plan
T&O	364FAV	Variance to plan
Head & Neck	(946)ADV	Variance to plan
O&G	545FAV	Variance to plan
Child Health	(67)ADV	Variance to plan
Pathology	(70)ADV	Variance to plan
Radiology	514FAV	Variance to plan
Oncology	(78)ADV	Variance to plan
Hospital support	914FAV	Variance to plan
Facilities	223FAV	Variance to plan
Other / Reserves	(1,602)ADV	Variance to plan

Capital	£000's	
Year to date expenditure	3,381	Capital expenditure for period
Forecast as % of plan	43%	43% of plan committed to date

SoFP (movement in year)	£000's	
Non-current assets	174	In-year depreciation plus Capex
Current assets	3,446	NHS debtors
Current Liabilities	5,040	Increase in creditors , accruals & dividend

Cash	£000's	
In month movement	1,858	Increase over July
In Year movement	(475)	Decrease over March 2011
Debtors Balance > 30 days	1,413	Total outstanding over 30 days
BPPC (by volume) YTD	95%	Target 95% paid in 30 days

KPIs		
Financial Risk Rating (Shadow)	2	Surplus plan low
EBITDA	89.2%	93% achievement of plan
Liquidity (days cover)	13.8	Incl. unused WCF of £17m
Surplus Margin	-2.1%	Due to low level of surplus overall
Pay / Income	66.5%	Pay 67% of Income for YTD

SLA Income (Appendix 3)

- EL & Daycase income £1.6m (£1.7m July) below plan. NEL £4.7m above plan before MRET adjustment of £1.9m.
- OPROCS £1m above plan.

Other Clinical Income

- Private Patient Income £39k below plan. RTA / CRU income £67k above plan.

Income Generation

- £307k above plan due to new R&D allocation (£100k YTD) and external drug sales £116k above plan.

Pay Expenditure (Appendix 5)

- £366k below plan.

Non-Pay Expenditure (Appendix 7)

- £684k above plan for YTD. Drugs, surgical appliances , Prosthesis and stationery expenditure above plan.

CIP (See Transformation Update)

2.0 Executive Summary

Activity (Appendix 4)

- DC 10% below plan. EL 9% below plan. NEL 13 % above plan. OPROCS 93% above plan. Significant WIP reduction in August.

Workforce (Appendix 5)

- 4,051 WTE worked compared to budget of 4,205 WTE. (Worked WTE flat to M4.)

Cashflow (Appendix 9)

- Cash balance restored but creditors > 30 days total £3.7m

SoFP (Appendix 8)

- £0.9m reduction in net assets.

Capital Expenditure (Appendix 12)

- £3.4m of expenditure for period to August with 43% of plan committed at month 5.

Shadow Monitor FRR (Appendix 13)

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

Forecast

- A range of mitigating actions is set out at appendix 14 to address the I&E forecast position and ensure delivery of the £0.5m control total surplus agreed with the SHA.

3.0 Conclusions & Actions

Conclusions

- NEL pressures significant in first five months, however reduction in ageing of WIP noted in August.
- Baseline Forecast I&E position of £4.6m deficit at month 5 requires additional actions to deliver financial targets.
- 81 WTE reduction since March (excluding impact of second phase of TCS (no redundancies to date).
- CIP delivery broadly on plan for identified schemes but £5.0m of mitigating actions required to bridge forecast I&E position.

Actions

- Plan to restore Elective & Daycase activity to plan implemented by Directorates.
- NEL activity position escalated to PCT in July in accordance with provisions of contract.
- 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, however change to use of funds submitted,
- Cashflow strategy set out in September F&P Committee paper. Recommendation to be sought for approval by Board.
- Actions to mitigate CIP gap to be progressed (see Appendix 14 and Transformation report).

Finance Report

Appendices

Year to Date

- £2,090k deficit compared to plan position of £1,687k giving rise to an adverse variance to plan of £403k.
- EBITDA achieves 89% of plan.

Current Month

- SLA income on plan.
- Recovery in other clinical income (£307k fav).
- Income received from PCT to fund costs of Transformation Programme. £1.5m accrued to date.
- Additional R&D income accrued £100k 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	207,739	86,567	86,541	26 Fav	207,739
Other Clinical Income	2,622	1,114	1,087	27 Fav	2,622
Other Income	25,250	11,829	11,522	307 Fav	25,250
Total Income	**235,610**	**99,510**	**99,150**	**360 Fav**	**235,610**
Pay Costs	(160,457)	(66,213)	(66,579)	366 Fav	(160,457)
Non-Pay Costs	(67,837)	(29,507)	(28,823)	(684) Adv	(67,837)
CIPs	9,849	0	1,258	(1,258) Adv	9,849
Reserves	(1,994)	0	(755)	755 Fav	(1,994)
Total Costs	**(220,440)**	**(95,720)**	**(94,899)**	**(821) Adv**	**(220,440)**
EBITDA	**15,170**	**3,790**	**4,251**	**(460) Adv**	**15,170**
Depreciation	(10,550)	(4,117)	(4,221)	104 Fav	(10,550)
Amortisation	(10)	(4)	(4)	0 Fav	(10)
Impairment of Fixed Assets	0	0	0	-	0
Net Interest	40	11	17	(6) Adv	40
Dividend	(4,150)	(1,770)	(1,729)	(41) Adv	(4,150)
Surplus / (Deficit)	**500**	**(2,090)**	**(1,687)**	**(403) Adv**	**500**

Notes

1. MRET adjustment £1.9m at M5.
2. FIMs plan for deficit of £1.687m YTD.
3. August reprofile £1.933m deficit YTD.

Income

- Income above plan in August driven by NEL activity but daycase variance improved by £140k.

Pay

- WTE consistent with June and July allowing for TCS phase 2 transfer. July sees introduction of annual leave accrual (£180k benefit).

Non-Pay

- Non-Pay run rate consistent

Reserves

- No accruals made against reserves

Capital Charges

- Depreciation estimated pending Q2 asset additions.

Appendix 1.1 I&E Run Rate

3 Month Run Rate £000's	June		July		August	
	Actual	Plan	Actual	Plan	Actual	Plan
SLA Clinical Income	17,562	17,806	17,919	17,463	17,605	17,349
Other Clinical Income	311	220	240	219	172	220
Other Income	2,394	2,507	2,417	2,308	2,069	1,977
Total Income	**20,267**	**20,533**	**20,575**	**19,990**	**19,847**	**19,546**
Pay Costs	(13,180)	(13,052)	(13,228)	(13,401)	(13,444)	(13,446)
Non-Pay Costs	(6,137)	(5,967)	(6,155)	(5,926)	(6,091)	(5,811)
CIPs	-	(18)	-	371	-	355
Reserves	-	(206)	-	200	-	(422)
Total Costs	**(19,317)**	**(19,243)**	**(19,384)**	**(18,757)**	**(19,535)**	**(19,324)**
EBITDA	**950**	**1,290**	**1,191**	**1,233**	**312**	**222**
Depreciation	(787)	(833)	(818)	(861)	(846)	(861)
Amortisation	(1)	(1)	(1)	(1)	(1)	(1)
Impairment of Fixed Assets	-	-	-	-	-	-
Net Interest	2	3	4	3	2	3
Dividend	(345)	(346)	(345)	(346)	(389)	(346)
Surplus / (Deficit)	**(181)**	**114**	**31**	**29**	**(922)**	**(983)**

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
SLA Income	10,035	(898) Adv	3,693	245 Fav	8,974	702 Fav	7,364	(981) Adv	5,654	(299) Adv	10,607	257 Fav	25,918	1,974 Fav	2,716	(28) Adv	1,683	253 Fav	9,707	(149) Adv	-	(1) Adv	-	7 Fav
Other Clinical Income	75	(19) Adv	0	(1) Adv	300	56 Fav	21	(1) Adv	4	3 Fav	22	(16) Adv	312	34 Fav	51	(5) Adv	166	(23) Adv	74	(49) Adv	70	29 Fav	-	-
Other Income	522	33 Fav	408	13 Fav	262	11 Fav	678	13 Fav	357	5 Fav	273	(64) Adv	1,053	(5) Adv	638	(45) Adv	99	(26) Adv	550	23 Fav	4,912	(7) Adv	1,520	132 Fav
Total Income	10,632	(884) Adv	4,101	257 Fav	9,536	769 Fav	8,064	(969) Adv	6,015	(291) Adv	10,902	177 Fav	27,283	2,002 Fav	3,405	(77) Adv	1,948	205 Fav	10,330	(175) Adv	4,982	21 Fav	1,520	138 Fav
Pay	(6,780)	(148) Adv	(4,384)	(49) Adv	(4,103)	(57) Adv	(3,532)	(108) Adv	(4,765)	157 Fav	(6,527)	42 Fav	(15,631)	(355) Adv	(3,276)	112 Fav	(2,633)	117 Fav	(3,907)	(15) Adv	(7,447)	668 Fav	(3,408)	1 Fav
Non-Pay	(1,955)	(243) Adv	(637)	(67) Adv	(1,934)	(328) Adv	(1,451)	12 Fav	(631)	1 Fav	(857)	(44) Adv	(4,409)	25 Fav	(2,860)	(82) Adv	(744)	112 Fav	(3,410)	91 Fav	(7,180)	220 Fav	(3,363)	111 Fav
CIP's	-	-	-	-	-	-	-	-	-	-	-	-	-	(0) Adv	-	-	-	-	-	(35) Adv	-	(13) Adv	-	0 Fav
Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Indirect Costs	(1,008)	81 Fav	2,301	141 Fav	(2,007)	(19) Adv	(1,614)	120 Fav	205	66 Fav	(746)	371 Fav	(4,744)	(863) Adv	3,538	(23) Adv	2,868	80 Fav	(370)	56 Fav	1,107	18 Fav	469	(27) Adv
Overheads	(2,130)	(0) Adv	(610)	(0) Adv	(1,534)	(0) Adv	(1,442)	(0) Adv	(1,067)	(0) Adv	(2,457)	(0) Adv	(3,596)	(0) Adv	(613)	(0) Adv	(760)	-	(1,189)	(0) Adv	10,370	0 Fav	5,026	0 Fav
Total Costs	(11,873)	(310) Adv	(3,330)	25 Fav	(9,578)	(405) Adv	(8,038)	24 Fav	(6,258)	224 Fav	(10,586)	369 Fav	(28,380)	(1,192) Adv	(3,210)	7 Fav	(1,269)	309 Fav	(8,876)	97 Fav	(3,149)	893 Fav	(1,276)	85 Fav
EBITDA	**(1,241)**	**(1,194) Adv**	**771**	**282 Fav**	**(42)**	**364 Fav**	**26**	**(946) Adv**	**(244)**	**(67) Adv**	**316**	**545 Fav**	**(1,098)**	**809 Fav**	**194**	**(70) Adv**	**680**	**514 Fav**	**1,454**	**(78) Adv**	**1,833**	**914 Fav**	**244**	**223 Fav**
EBITDA %	**-11.7%**		**18.8%**		**-0.4%**		**0.3%**		**-4.1%**		**2.9%**		**-4.0%**		**5.7%**		**34.9%**		**14.1%**		**36.8%**		**16.1%**	
Depreciation	(356)	14 Fav	(79)	9 Fav	(185)	7 Fav	(157)	8 Fav	(142)	9 Fav	(259)	10 Fav	(625)	25 Fav	(194)	5 Fav	(621)	5 Fav	(562)	36 Fav	(869)	0 Fav	(67)	0 Fav
Amortisation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Net Interest	2	(1) Adv	0	(0) Adv	2	(1) Adv	1	(1) Adv	0	(0) Adv	2	(1) Adv	3	(2) Adv	-	-	-	-	1	(0) Adv	-	-	-	-
Dividend	(165)	(4) Adv	(30)	(1) Adv	(142)	(3) Adv	(165)	(4) Adv	(117)	(3) Adv	(133)	(3) Adv	(350)	(8) Adv	(217)	(5) Adv	(208)	(5) Adv	(227)	(5) Adv	(11)	(0) Adv	(5)	(0) Adv
Surplus / (Deficit)	**(1,760)**	**(1,184) Adv**	**661**	**290 Fav**	**(367)**	**367 Fav**	**(295)**	**(942) Adv**	**(503)**	**(61) Adv**	**(75)**	**551 Fav**	**(2,070)**	**824 Fav**	**(216)**	**(71) Adv**	**(149)**	**514 Fav**	**666**	**(47) Adv**	**953**	**915 Fav**	**172**	**223 Fav**

SLA Income

- Daycase and EL income £1.6m below plan. NEL income £4.7m above plan but offset by £1.9m MRET adjustment.
- OPROCS £1m above plan for YTD.
- WIP £0.6m decrease since March 11.

TCS

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

Provisions

- Readmissions accrued at £625k for YTD subject to validation process.
- New to follow outpatient provision of £657k subject to review of exclusions per SLA contract.
- August – accrual for non-payment for first £1m of over performance.

Appendix 3 SLA Income

SLA Income by PoD £000's	YTD Plan	YTD Actual	Variance to plan	%
DC	11,870	10,701	(1,169) Adv	(10.9%)
EL	8,050	7,615	(436) Adv	(5.7%)
NEL	27,189	31,908	4,719 Fav	14.8%
MRET	-21	-1,905	(1,884) Adv	98.9%
OPFA	5,565	4,555	(1,010) Adv	(22.2%)
OPFUP	5,092	4,471	(621) Adv	(13.9%)
OPFASPNCL	709	708	(1) Adv	(0.2%)
OPFUPSPNCL	1,098	947	(151) Adv	(16.0%)
OPPROC	1,185	2,195	1,010 Fav	46.0%
Excluded Medicines	4,016	4,076	60 Fav	1.5%
Childrens Services	2,972	2,972	-	
Critical care & HDU	2,776	2,756	(20) Adv	(0.7%)
A&E - PbR	2,712	3,088	376 Fav	12.2%
TCS	2,354	2,390	36 Fav	1.5%
Pathology	2,220	2,294	74 Fav	3.2%
Radiotherapy	1,771	1,814	43 Fav	2.4%
Community Midwives	1,491	1,491	-	
Unbundled Chemotherapy PSD	887	844	(43) Adv	(5.2%)
GPDA Radiology	799	916	117 Fav	12.7%
Stroke	673	60	(613) Adv	(1020.6%)
Breast Screening	579	579	-	
Ante-natal Pathology	505	396	(109) Adv	(27.6%)
Limb Centre	370	379	10 Fav	2.5%
Audiology	361	361	-	
Cancer MDT Meetings	277	277	-	
Excluded Devices	264	277	13 Fav	4.6%
Myoviews	208		(208) Adv	#DIV/0!
Anti-Coagulation	139	139	-	
Brachytherapy	127	149	22 Fav	14.7%
Downs Screening	96	96	-	
Other Bblock / CPC	421	887	466 Fav	52.6%
ARMD	367	389	21 Fav	5.5%
Other	-582	-1,257	(675) Adv	53.7%
Grand Total	**86,541**	**86,567**	**26 Fav**	**0.0%**

Appendix 4 Activity

SLA Activity

- Based on discharges to date
- Daycases 10%behind plan
- EL 9% behind plan
- NEL 13 % above plan.
- New and follow up Outpatients below plan
- OPROCS 93% above plan.

Activity	Plan 2011-12	YTD Actual	YTD Plan	Variance to plan	%
Daycase	41,403	15,890	17,651	-1,761	-10%
Elective Inpatients	7,140	2,879	3,165	-286	-9%
Non Elective	39,769	18,354	16,228	2,126	13%
Cons New Outpatients	79,025	27,403	34,139	-6,736	-20%
Cons Follow Up Outpatients	127,645	48,411	54,804	-6,393	-12%
NCL New Outpatient	22,351	9,444	9,561	-117	-1%
NCL Follow up Outpatients	72,562	27,168	31,013	-3,845	-12%
Outpatient Procedures	22,437	15,027	7,794	7,233	93%
A&E Attendances	78,596	34,101	32,946	1,155	4%

Notes to Pay Expenditure

- £13.4m cost in August (£13.2m June and July).

Temporary Staffing

- £285k expenditure on Medical Locums in August (£195k July).
- Agency Nursing reduction of £97k month on month.
- Bank Nurse costs reduced by £12k month on month.

YTD Variances to Plan

- Substantive Nursing Qualified £1.97m favourable.
- Junior Medical £654k favourable to plan.
- Managerial Staff £444k favourable.
- Estates £66k adverse to plan.

Appendix 5 Pay Expenditure

Staff Group £000's	June		July		August	
	Actual	Plan	Actual	Plan	Actual	Plan
Senior Medical Staff	2,173	2,283	2,171	2,325	2,183	2,325
Junior Medical Staff	1,161	1,303	1,153	1,297	1,184	1,297
Salary Recharge Exp. - Medical Staff	63	27	111	27	74	27
Salary Recharge Inc. - Medical Staff	(153)	(74)	(127)	(74)	(132)	(91)
Capitalised Salary - Medstaff	-	-	-	-	-	-
Medstaff WLI & ADH's	95	5	71	5	83	21
Agency Medstaff (Senior)	66	8	69	8	123	8
Agency Medstaff (Junior)	148	8	125	8	163	8
Total Medical Staff	**3,553**	**3,560**	**3,575**	**3,596**	**3,676**	**3,595**
Nursing Staff - Qualified (Band 5 +)	4,000	4,190	3,766	4,316	3,995	4,352
Nursing Staff Unqualified	690	736	699	825	714	808
Salary Recharge Exp. - Nursing Staff	-	-	-	-	8	2
Salary Recharge Inc. - Nursing Staff	(72)	(81)	(89)	(81)	(62)	(81)
Capitalised Salary - Nursing	(23)	-	(8)	-	(4)	-
Bank Staff - Nursing	262	-	361	-	349	-
Agency Staff - Senior Nursing	124	-	166	-	115	-
Agency Staff - Junior Nursing	62	-	109	-	63	-
Total Nursing Staff	**5,042**	**4,845**	**5,004**	**5,060**	**5,177**	**5,080**
Managerial Staff	737	773	688	770	699	796
Salary Recharge Exp. - Managers	13	1	(13)	1	-	1
Salary Recharge Inc. - Managers	(14)	(3)	(9)	(3)	(7)	(3)
Capitalised Salary - Managers	(29)	-	(9)	-	(9)	-
Agency Staff - Management	5	1	5	1	6	1
Administration Staff	1,228	1,377	1,241	1,385	1,227	1,366
Salary Recharge Exp. - Admin Staff	-	-	-	-	-	-
Salary Recharge Inc. - Admin Staff	(30)	(14)	(20)	(14)	(9)	(14)
Capitalised Salary - Admin	-	-	-	-	-	-
Bank Staff - Admin	103	5	140	5	118	26
Agency Staff - Admin	15	-	19	-	6	-
Total Managerial & Admin	**2,029**	**2,139**	**2,042**	**2,145**	**2,032**	**2,174**
Other Clinical Staff	804	881	814	901	801	901
Scientific & Technical Staff	1,015	1,068	1,012	1,050	1,024	1,090
Estates Staff	88	79	96	79	87	79
All other Staff	598	653	678	736	593	642
Salary Recharge Exp. - Other Staff	7	-	31	10	40	57
Salary Recharge Inc. - Other Staff	(49)	(46)	(51)	(45)	(49)	(42)
Capitalised Salary - Other Staff	-	-	-	-	-	-
Bank & Agency Staff - Other	94	4	27	2	62	2
Total Other	**2,556**	**2,641**	**2,608**	**2,733**	**2,558**	**2,730**
CIPS	-	(55)	-	(55)	-	(55)
Additional Activity	-	-	-	-	-	-
Vacancy Factor	-	(78)	-	(78)	-	(78)
Total Cost Challenges	**-**	**(134)**	**-**	**(133)**	**-**	**(133)**
Total Pay Expenditure	**13,180**	**13,052**	**13,228**	**13,401**	**13,444**	**13,446**

Summary

•4051 WTE worked compared to budget of 4205 WTE. Contracted WTE total 3846 WTE.

Temporary Staffing August

•18 WTE Medical Locums. (15 WTE July).
•142 WTE Bank Nurses. (124 WTE July).
• 50 WTE Agency Nurses. (57 WTE July).

Variances from Plan (Worked v Budget)

• Junior Doctors 8WTE below plan
•Qualified Nurses 106 WTE below plan
•Managerial Staff 20WTE below plan
• Administration 85 WTE below plan offset by 74 WTE bank and agency staff.

Appendix 6 Workforce

Staff Type:	Worked Mth 5 WTE 2011/12	WTE Budget 2011/12 M1	Contracted Mth 5 WTE 2011/12
Senior Medical Staff	194.04	204.30	193.51
Junior Medical Staff	245.16	257.81	265.68
Salary Recharges Expenditure - Medical Staff	6.08	4.44	0.00
Salary Recharges Income - Medical Staff	-11.58	-9.25	0.00
Medical Locums (Agency - Senior)	6.72	0.84	0.00
Medical Locums (Agency - Junior)	10.79	0.00	0.00
Total Medical Staff	**451.21**	**458.14**	**459.19**
Nursing Staff - Qualified (Band 5 +)	1174.20	1319.58	1213.36
Nursing Staff Unqualified	379.12	436.19	392.53
Salary Recharges Expenditure - Nursing Staff	0.60	1.00	0.00
Salary Recharges Income - Nursing Staff	-23.54	-19.91	0.00
Bank Staff - Nursing	142.71	0.00	8.84
Agency Staff - Senior Nursing	22.51	0.00	0.00
Agency Staff - Junior Nursing	27.99	0.00	0.00
Total Nursing Staff	**1723.59**	**1736.86**	**1614.73**
Managerial Staff	147.44	170.49	150.24
Salary Recharges Expenditure - Managers	0.00	0.00	0.00
Salary Recharges Income - Managers	-1.05	0.00	0.00
Agency Staff - Management	2.00	0.00	0.00
Administration Staff	641.57	729.43	644.06
Salary Recharges Expenditure - Admin Staff	0.00	0.00	0.00
Salary Recharges Income - Admin Staff	-6.13	-6.01	0.00
Bank Staff - Admin	73.04	1.13	0.00
Agency Staff - Admin	1.15	0.00	0.00
Total Managerial & Admin	**858.02**	**895.04**	**794.30**
Other Clinical Staff	245.14	284.40	245.46
Scientific & Technical Staff	355.74	393.01	374.88
Estates Staff	32.45	33.19	29.00
All other Staff	371.83	405.66	329.00
Salary Recharges Expenditure - Other Staff	1.00	5.00	0.00
Salary Recharges Income - Other Staff	-3.60	-2.72	0.00
Agency Staff - Other	15.88	0.00	0.00
Total Other	**1018.44**	**1118.54**	**978.35**
CIPS	0.00	-3.16	0.00
Additional Activity	0.00	0.00	0.00
Vacancy Factor	0.00	0.00	0.00
Total Cost Challenges	**0.00**	**-3.16**	**0.00**
Total Worked WTE	**4051.26**	**4205.42**	**3846.56**

Summary

•£684k adverse compared to plan, primarily due to Prosthesis ,surgical appliances Medicines and printing & stationary costs.

Clinical

• £305k adverse to plan mainly due to Medicines overspend £97k and surgical appliances £187k. (both partly offset by income) and Prosthesis £163k.

Non-Clinical

• £337k adverse variance against plan.

Other

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

Appendix 7 Non-Pay Expenditure

Non-Pay £000's	June		July		August	
	Actual	Plan	Actual	Plan	Actual	Plan
Clinical Non Pay - Fixed						
Equipment Hire	91	47	66	47	62	47
Equipment Maintenance	290	231	189	236	251	261
Clinical Non Pay - Fixed Total	**382**	**278**	**254**	**283**	**313**	**308**
Clinical Non Pay - Variable						
Prosthesis	186	117	145	111	112	117
Patient & Surgical Appliances	123	153	191	143	228	150
Patient Clothing & Travel	14	12	14	12	16	12
Lab Equipment Consumables	441	467	427	310	437	437
Blood	112	144	125	138	106	144
Medicines	1,736	1,816	1,689	1,684	1,770	1,766
Medical & Surgical Items	895	909	895	874	887	983
Dressings	69	57	66	54	64	57
Medical Gases	23	18	18	17	18	18
X-Ray Consumables	2	1	(6)	1	1	1
Clinical Non Pay - Variable Total	**3,601**	**3,694**	**3,564**	**3,344**	**3,639**	**3,686**
Clinical Non Pay - Total	**3,983**	**3,972**	**3,819**	**3,627**	**3,953**	**3,993**
Non Clinical Non Pay - Fixed						
Building & Engineering Equipment	225	276	267	356	324	356
Cleaning Equipment	58	37	52	37	48	37
Energy & Utilities	208	167	231	167	188	167
Rates	65	67	55	67	66	67
Printing & Stationery	71	50	87	57	82	57
Computer Equipment & Maintenance	110	111	104	111	115	138
Communications	80	58	74	58	69	59
Office Equipment	18	51	15	51	15	51
Non Pay CIP's	-	(334)	-	(156)	-	(162)
Other Fee's	123	86	143	126	130	110
Losses & Compensations	33	22	24	22	92	22
CNST	418	418	418	418	418	418
Consultancy Fee's	326	538	435	538	113	41
Training	44	70	74	70	67	79
Travel & Benefits	73	94	72	93	89	93
Staff Advertising	1	5	-	5	53	5
Non Clinical Non Pay - Fixed Total	**1,855**	**1,715**	**2,052**	**2,020**	**1,870**	**1,539**
Non Clinical Non Pay - Variable						
Patient Provisions	100	91	84	91	105	91
Patient Linen	82	77	85	77	97	77
Non Clinical Non Pay - Variable Total	183	169	168	169	202	169
			-	-	-	-
Non Clinical Non Pay - Total	**2,037**	**1,884**	**2,220**	**2,189**	**2,072**	**1,707**
Expenditure SLAs:						
N PCT Services	63	57	63	57	15	57
NHT Transport	11	11	11	11	9	11
Library Facilities - Northamptonshire PCT	11	10	11	10	11	10
Two Shires - Ambulances	-	-	-	-	-	-
ECR	-	0	-	0	-	0
Oxford - Ambulances	-	-	-	-	-	-
Danetre Facilities	32	32	32	32	32	32
Sub-Total Non-Pay	**6,137**	**5,967**	**6,155**	**5,926**	**6,091**	**5,811**

Non Current Assets

- Reduction of £20k in month due to net of capital additions less depreciation for period.
- Revaluation exercise to be undertaken in year by DV.

Current Assets

- Increase of £0.7m in month led by £1.8m increase in cash balance and reduction in debtors (mainly NHS) and pre-payments.
- Increase in cash balance month on month of £1.8m.

Current Liabilities

- Increase of £1,6m in month due to NHS creditors £0.4m, Trade £1.0m and capital creditors £0.7m.
- £1.754m accrual for PDC dividend (payable September).
- Staff benefits accrual reduced by £180k (annual leave provision).

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		960	945	(15)	997	997
IN YEAR MOVEMENTS		2,508	3,346	838	11,473	11,473
LESS DEPRECIATION		(3,274)	(4,117)	(843)	(10,560)	(10,560)
NET BOOK VALUE	**133,062**	**133,256**	**133,236**	**(20)**	**134,972**	**1,910**
CURRENT ASSETS						
INVENTORIES	4,555	4,595	4,506	(89)	4,562	7
RECEIVABLES						
NHS DEBTORS	4,812	8,414	7,676	(738)	4,812	
OTHER TRADE DEBTORS	1,295	921	1,025	104	(166)	(1,461)
DEBTOR IMPAIRMENTS PROVISION	(166)	(166)	(166)		686	852
CAPITAL RECEIVABLES	118	276	493	217	118	
NON NHS OTHER DEBTORS	345	402	173	(229)	345	
COMPENSATION DEBTORS (RTA)	2,483	2,587	2,495	(92)	1,295	(1,188)
OTHER RECEIVABLES	817	591	501	(90)	817	
IRRECOVERABLE PROVISION	(253)	(254)	(254)		(253)	
PREPAYMENTS & ACCRUALS	686	2,421	2,164	(257)	2,483	1,797
	10,137	**15,192**	**14,107**	**(1,085)**	**10,137**	
CASH	3,867	1,534	3,392	1,858	3,861	(6)
NET CURRENT ASSETS	**18,559**	**21,321**	**22,005**	**684**	**18,560**	**1**
CURRENT LIABILITIES						
NHS	4,177	3,819	4,228	(409)	4,180	(3)
TRADE CREDITORS REVENUE	3,528	3,240	4,180	(940)	3,580	(52)
TRADE CREDITORS FIXED ASSETS	2,401	1,549	2,204	(655)	2,244	157
TAX AND NI OWED	3,275	3,414	3,344	70	3,275	
NHS PENSIONS AGENCY	1,831	1,782	1,784	(2)	1,831	
OTHER CREDITORS	301	453	455	(2)	301	
SHORT TERM LOANS	488	488	488		571	(83)
ACCRUALS AND DEFERRED INCOME	2,679	6,354	5,629	725	2,679	
PDC DIVIDEND DUE		1,365	1,754	(389)		
STAFF BENEFITS ACCRUAL	1,440	1,260	1,260		1,440	
PROVISIONS	380	230	214	16	380	
PROVISIONS over 1 year	310	310	310		310	
NET CURRENT LIABILITIES	**20,810**	**24,264**	**25,850**	**(1,586)**	**20,791**	**19**
TOTAL NET ASSETS	**130,811**	**130,313**	**129,391**	**(922)**	**132,741**	**1,930**
FINANCED BY						
PDC CAPITAL	99,635	99,635	99,635		100,088	453
REVALUATION RESERVE	28,713	29,383	29,383		29,690	977
DONATED ASSET RESERVE						
I & E ACCOUNT BALANCE	2463	2,463	2,463		2,463	
I & E CURRENT YEAR		(1,168)	(2,090)	(922)	500	500
FINANCING TOTAL	**130,811**	**130,313**	**129,391**	**(922)**	**132,741**	**1,930**

Appendix 9 Cashflow

MONTHLY CASHFLOW	Annual £000s	ACTUAL Q1 £000s	JUL £000s	AUG £000s	FORECAST SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS											
SLA Base Payments	202,016	49,638	16,351	17,599	16,918	16,918	16,918	16,918	16,918	16,918	16,918
SLA Variable inc Over Performanc	287			287							
SHA Payments (SIFT etc)	8,859	2,083	751	741	796	723	723	723	723	723	873
Other NHS Income	15,686	3,460	3,035	1,526	1,895	795	795	795	795	795	1,795
PP / Other (Specific > £250k)	2,230	658	294	305	276	264	433				
PP / Other	10,656	2,467	1,044	773	900	900	900	972	900	900	900
Salix Capital Loan	202							202			
EFL / PDC											
Temporary Borrowing						4,000				-4,000	
Interest Receivable	26	6	4	2	2	2	2	2	2	2	2
TOTAL RECEIPTS	239,963	58,312	21,479	21,233	20,787	23,602	19,771	19,612	19,338	15,338	20,488
PAYMENTS											
Salaries and wages	153,702	38,532	12,882	13,073	13,045	12,725	12,700	12,595	12,725	12,700	12,725
Trade Creditors	54,886	15,712	4,249	4,869	5,000	5,000	3,950	4,950	3,950	3,950	3,256
NHS Creditors	15,081	4,601	2,792	784	1,517	1,317	917	917	917	917	400
Capital Expenditure	11,872	2,894	454	652	1,307	1,418	1,076	1,043	1,285	996	747
PDC Dividend	4,233				2,108						2,125
Repayment of Loans											
Repayment of Salix loan	159				70						90
TOTAL PAYMENTS	239,933	61,739	20,377	19,378	23,047	20,460	18,643	19,505	18,877	18,563	19,343
Actual month balance	30	-3,427	1,103	1,855	-2,260	3,142	1,128	107	461	-3,225	1,146
Balance brought forward	3,831	8,462	404	1,507	3,362	1,102	4,244	5,372	5,479	5,940	2,715
Balance carried forward	3,861	5,035	1,507	3,362	1,102	4,244	5,372	5,479	5,940	2,715	3,861

Notes to cashflow

- Cash balance restored from Q1 low of £404k to £3.4m at end of August.
- Analysis highlights ongoing need for Temporary borrowing. Creditors > 30 days amount to £3.7m at 31.8.11
- H1 PDC Dividend successfully paid in September.
- SLA payment for September received in 1st week.

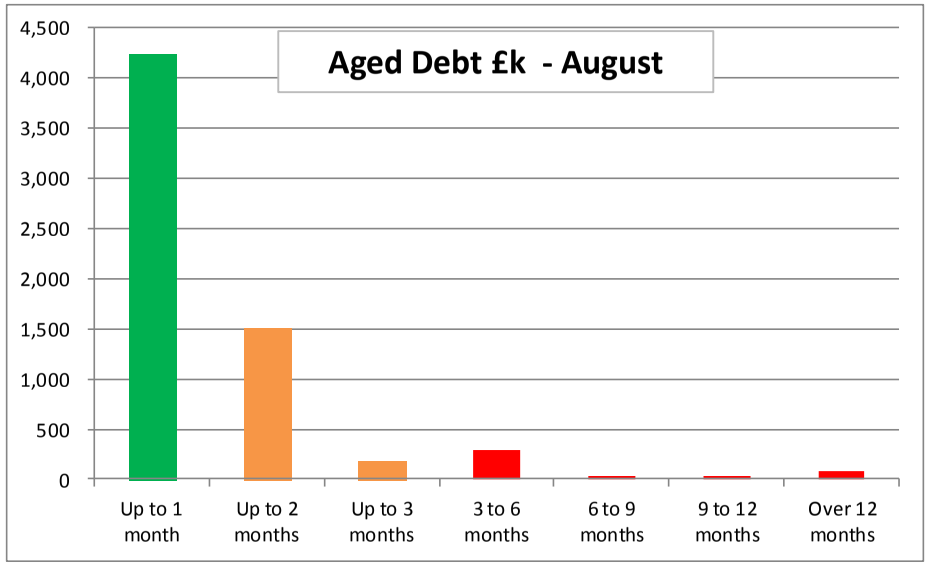
Appendix 10 Debtors

In month

- Increase of £3.8m in outstanding balances since April includes £2.6m of MPET invoices raised in August covering period to December 11.
- Underlying reduction of £1.2m month on month.

Problem Debtors

- CRIPPS



Aged Debtors	01.04.10	April	May	June	July	August	YTD Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Up to 1 month	1,604	1,097	2,675	2,168	3,103	4,239	2,635
Up to 2 months	210	523	664	1,696	478	1,512	1,302
Up to 3 months	280	100	336	388	320	172	-108
3 to 6 months	249	202	194	259	349	286	37
6 to 9 months	50	54	89	140	154	32	-18
9 to 12 months	12	24	25	24	24	26	14
Over 12 months	146	146	105	61	66	75	-71
Total	**2,551**	**2,146**	**4,088**	**4,736**	**4,494**	**6,342**	**3,791**

Appendix 11 Creditors

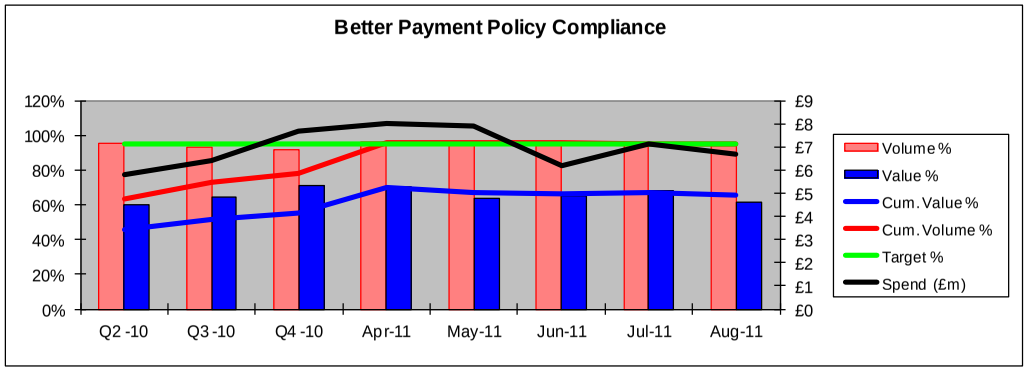
Balances

- Increase of Reduction of £0.9m over March balance of which £3.7m > 30days.

BPPC Compliance (95% target)

- Achieving target compliance with 95% by volume.
- Low level of NHS compliance

	NHS			Non-NHS			Total		
	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%
Value £	1,237,909	5,771,005	21%	22,273,803	29,937,697	74%	23,511,712	29,937,697	79%
Volume	661	885	75%	23,110	24,097	96%	23,771	24,982	95%



Aged Creditors	01.04.10 £'000	NHS £'000	Trade £'000	Capital £'000	Total £'000
Up to 1 month	4,298	677	2,685	588	3,950
Up to 2 months	1,165	846	803	409	2,058
Up to 3 months	483	890	44	0	934
Over 3 Months	790	709	-1	-1	707
Total	**6,737**	**3,122**	**3,531**	**996**	**7,649**

Notes to Capital Schemes

- Emergency Care and Mortuary schemes are currently being determined.
- Transformation Project approved digital dictation scheme, switchboard, E-fin / E-procurement update to date.
- A TCS transfer relating to assets at Danetre is included at £452k and a CRL transfer will be agreed with the SHA.
- We await SHA / DH guidance following the policy change in treating donated assets.
- Current EOY forecast is £11.326 million i.e. an underspend of £1.836 million.
- Full year depreciation forecast is currently £10.342 million (was £10.504 million), following Month 5 review this includes what was previously donated element of £0.560 million.

Appendix 12 Capital Expenditure

Category	Annual Budget 2011/12 £000's	Year to Date as at Month 5 Actual Spend £000's	Year to Date as at Month 5 Plan Achieved £000's	Year to Date as at Month 5 Actual Committed £000's	Year to Date as at Month 5 Plan Achieved £000's
Breast Screening Business Case	535	514	96%	522	98%
Emergency Care	500	2	0%	27	5%
Transformation Project	567	31	5%	96	17%
Mortuary Refurbishment	400	0	0%	0	0%
Macmillan (Trust)	450	0	0%	160	36%
Macmillan (Non Trust)	1,410	679	48%	1,454	103%
MESC	1,034	630	61%	743	72%
Estates	3,333	877	26%	1,448	43%
IT	2,365	851	36%	1,363	58%
Other	2,568	526	20%	732	29%
Total - Capital Plan	**13,162**	**4,110**	**31%**	**6,546**	**50%**
Less Charitable Funds	-1,534	-729	48%	-1,505	98%
Total - CRL	**11,627**	**3,381**	**29%**	**5,041**	**43%**

Notes to YTD Score

- Overall Score of 2 for August.
- Low EBITDA (3.8%) achievement reducing score overall.
- ROA score driven by YTD deficit.
- Deficit gives rise to a score of 1 for surplus margin.
- Liquidity days of 13.81 cover includes £17m working capital facility.
- Liquidity cover -14days (Score of 1 excl. WCF).
- Overriding rules may apply.
- Note: Monitor review on a quarterly basis.

Appendix 13 Shadow Monitor Financial Risk Rating

Financial Criteria	Metric	Weight %	Aug	Shadow Rating
Achievement of Plan	EBITDA Achieved (% of plan)	10%	89%	4
Underlying Performance	EBITDA Margin %	25%	3.8%	2
Financial Efficiency	Return on Assets	20%	-0.25%	2
Financial Efficiency	I&E Surplus Margin	20%	-2.1%	1
Liquidity	Liquidity Ratio (Days cover)	25%	13.81	2
Weighted Average		100%		

	< 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

TRUST BOARD SUMMARY SHEET	
Title	HR Report
Submitted by	Chanelle Wilkinson, Director of Human Resources and Organisational Development
Date of meeting	September 2011
Corporate Objectives Addressed	To develop an effective, efficient and flexible workforce to support the changing environment

SUMMARY OF CRITICAL POINTS

Workforce Capacity and Temporary Workforce

The report identifies an increase in budgeted workforce establishment and contracted substantive workforce which is due to the transfer of staff from the community. In addition, the temporary utilised workforce has fluctuated since April 2011 but there is an overall increase to July 2011. This can be attributed to the normal seasonal increase in individuals taking annual leave due to the summer holidays and can also be reflected in the increase in sickness absence from June 2011 to July 2011.

Sickness Absence

Sickness absence increased from 3.70% in June 2011 to 4.22% in July 2011, of this 1.98% can be attributed to long term sickness absence in July 2011. Although this was a small increase from June (1.56%) the percentage is still below the Trust target of 2% for long term sickness absence. However, the short term sickness rate is above the Trust target of 1.4% and in July 2011 was 2.25%. The HR Business Partners have been tasked to work with the Managers in the Departments where there are concerns. In general, year on year the sickness absence rates have decreased since 2009/10.

Staff Turnover

Staff turnover has declined to 7.05% which is below the Trust target of 8%. This may be attributed to the current economic climate and uncertainty in the job market.

Staff Appraisal

Appraisal activity has increased to 40% in June 2011 and increased by a further 20.3% to 60.3% in July 2011 (it must be noted that this takes into account future bookings to year end). It is envisaged that the percentage of completed appraisals will increase during Q3 and Q4 as most appraisals were completed in those quarters in 2010/11. In future the HR Business Partners will be advising Managers to bring forward appraisals to fit into the financial cycle and in line with the Corporate Objectives.

Mandatory Training

On the basis that mandatory training continues at the same rate as has been completed between April 2011 and July 2011, 84.4% of staff will be trained in all subjects by the financial year end.

PATIENT IMPACT – Low

STAFF IMPACT - Medium

FINANCIAL IMPACT - High

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 content of this report.

TRUST BOARD SUMMARY SHEET	
Title	Acute Services Review
Submitted by	Dr Sonia Swart, Medical Director
Prepared by	Dr Sonia Swart
Date of meeting	28th September 2011
Corporate Objectives Addressed	To improve the clinical quality of patient care focusing on safe, effective treatment that is patient centred

SUMMARY OF CRITICAL POINTS

- This report provides an update on the Acute Services Review approved in principle by the Board in November 2009 and formally launched in January 2011 and then redesigned and relaunched in Summer 2011.
- The Board is asked to note the report and discuss the strategic implications

PATIENT IMPACT

High quality care for patients remains a priority. Strategic Planning for Acute Care is essential if standards are to be maintained in the face of the changing economic and political environment.

STAFF IMPACT

Staffing specialist services and providing access to specialist services on a 24 hour basis is an increasing challenge which requires collaboration between adjacent hospitals and primary care partners.

FINANCIAL IMPACT

Economic viability is more likely to be sustained if services are reconfigured carefully with the aim of maintaining stability on hospital sites

EQUALITY & DIVERSITY

N/A

LEGAL IMPLICATIONS

RECOMMENDATIONS

Board Members are asked to note the contents of this report and discuss the implications

The South East Midlands Acute Services Review (ASR)

Background

In 2009 the Trust Board considered an opportunity for improved collaboration across NHS health and social care organisations in the Milton Keynes and South Midlands (MKSM) Population Growth Area, working together to reduce duplication, improve patient experience and quality through the reconfiguration and development of locally based services, supported by centres of clinical excellence for specialist in-patient care.

This work was based on the premise that it is possible to conceive that various configurations of acute services across MKSM might provide an effective infrastructure for care in the 21st century, ranging from local hospitals in each major community with some but not all specialist services provided from each local hospital site, to local hospitals supported by a single multi-speciality specialist site.

The Trust Board approved support for the project to support the joint planning of specialist acute services through the MKSM programme management approach, accountable to the MKSM Health and Social Care Group and Chief Executives of each of the constituent NHS Organisations. This then relaunched as the Acute Service Review (ASR) following confirmation of the case for change in the Autumn of 2010.

The project brief and the scope of the original ASR was shared and supported by NHS Bedfordshire PEC and Board, Nene Commissioning and NHS Northamptonshire, Milton Keynes GP Commissioners and Board and the Chief Executive Officers of the Acute Trusts in Bedford, Milton Keynes, Northampton and Kettering.

In April 2011 the commissioners made the decision to change the focus of the review in 2 regards. Firstly the review was to be extended in scope and secondly the number of partners was to be increased.

As a result of various deliberations a new Acute Services Review was started in June 2011 with the support of KPMG. This review is now commissioned by the 2 PCT clusters Luton/Bedfordshire and Milton Keynes/Northamptonshire and involves 5 Acute Provider Trusts (Northampton, Kettering, Milton Keynes, Bedford and Luton and Dunstable) and 6 Clinical Commissioning Consortia, 3 Ambulance Trusts. In addition 4 Community providers, 5 local authorities and 3 ambulance Trusts are involved.

The Board is provided with this programme summary as an update and in order to stimulate debate with respect to understanding this methodology to support planning for future services in the context of shifting boundaries of SHAs and PCTs and the emerging commissioning groups.

Summary of the ASR Programme Brief (Appendix 1)

The aim of the programme is to improve the health, access and quality of services delivered across the South East Midlands to support the improved outcomes for the population who access services. This will be facilitated through a phased programme following the OGC Gateway review stages

The deliverables will be:

- a clinically led and agreed clinical strategy based on national and international best practice that takes into account existing QIPP plans and GP commissioner aspirations
- a set of recommendations and a full business case for future configuration of acute services across South East Midlands agreed by the thirteen partner organisations and consulted on with the wider stakeholders and the public
- an implementation plan, process and necessary support to deliver the agreed recommendations over the agreed timeframe
- high quality and sustainable acute services for the population

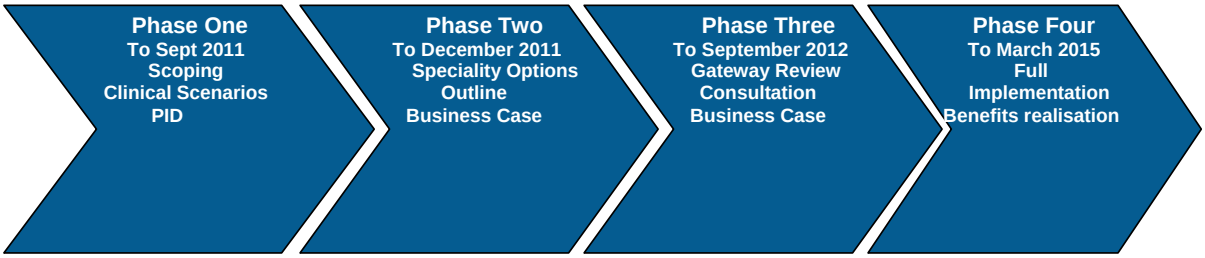
Phase One

Phase One is the initial preparatory phase and will run from 20 June 2011 to 19 September 2011.

KPMG have been engaged to, work as part of a joint programme team to support the delivery of the phase.

The deliverables at the end of Phase One will provide partner organisations with an objective view of the case for change, strategic outline of potential service configurations to consider and develop in Phase Two as well as identify a mitigation strategy to the potential barriers to change.

Key Activities and Outline Timescales (final phasing to be agreed end of Phase One)



Phase One	
June – mid September 2011	Appoint external consultant partner – KPMG appointed 20th June 2011 See Annex 1 for detailed timing and governance arrangements for Phase One. Identify clinical leaders including the associated supporting structure

Phase Two	
October – December 2011 **3 months**	Produce recommended clinical strategy with options for reconfiguration of services across SEM, financial implications and proposed implementation plan, including options for early changes Pre-engagement with staff, stakeholders, patients and the public to scope the recommendation for consultation Early service changes proposed from April 2012 to be highlighted, agreed and consulted on as required Gain Board agreement on recommendations for early service changes, and consultation through the production of a Outline Business Case
Phase Three	
January 2012	Gateway Reviews
February – June 2012	Public Consultation for longer term changes Implement April 2012 changes Review proposals and gain Board sign off for first stage of implementation plans
July – September 2012	Development of the Full Business Case for the agreed scenario and Board sign off from each partner organisation and Programme Board
Phase Four	
October 2012	Continue implementing early service changes
March 2014	Majority of service changes complete
March 2015	All service change and reconfiguration completed during 2014/15 in line with QIPP Plans

Governance

The Programme is managed through a Programme Board made up of the Accountable Officers of the thirteen partner organisations, accountable to the Cluster Boards and the five Acute Trust Boards. A Steering Group provides local Director level leadership and wide stakeholder engagement and ensure the programme works with pace and momentum.
Clinical and professional leadership is provided through a Clinical Reference Group which will explore and develop clinical solutions and make recommendations on service change to the Steering Group.

Commissioners, in conjunction with providers will set the vision and expectations for acute service provision across South East Midlands and the providers will work together to develop the proposals and implementation plans to ensure this is delivered.

Progress to Date

The various Boards have met and debated the issues and there was a one day event in September designed to consolidate and confirm the positions of the Acute Trusts prior to a planned 2 day event in October which is known as U-Collaborate.

The purpose of this event will be to engage a wider stakeholder group to confirm and build a majority consensus on the case for change, to reach agreement on the key services which must be provided on every hospital site, to consider some key specialist services which need to be provided but not on every site and to develop a work programme to further define the service models with milestones and ownership.

The progress to date has been slow due to confusion arising from lack of clarity concerning process and some lack of clarity concerning the commissioning mandate.

Indications to date are that this work will receive high level support from the new SHA and that the PCT cluster and clinical commissioners will develop a clear view concerning further steps within a short timeframe.

Meanwhile NGH is well represented at all the levels of meetings and there is good clinical engagement in the design of the event, in the Clinical Reference Group work and at Steering Board level.

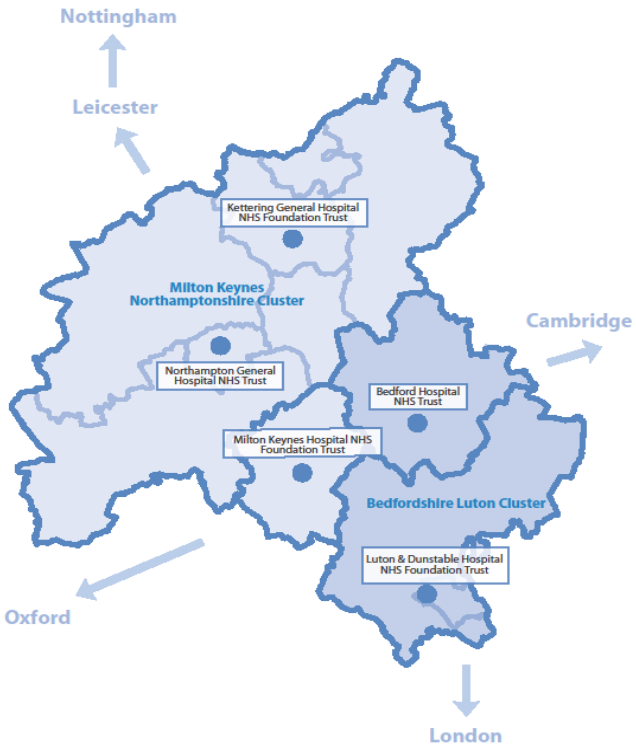
The Board is asked to recognise the strategic importance of the review and discuss the risks associated with it

Sonia Swart
Medical Director

September 2011

Appendix 1

South East Midlands Acute Services Review


Nottingham
Leicester
Kettering General Hospital NHS Foundation Trust
Milton Keynes Northamptonshire Cluster
Cambridge
Northampton General Hospital NHS Trust
Bedford Hospital NHS Trust
Milton Keynes Hospital NHS Foundation Trust
Bedfordshire Luton Cluster
Luton & Dunstable Hospital NHS Foundation Trust
Oxford
London

Document Version Control			
Acute Services Review **Programme Brief**			
Version	**Date**	**Author**	**Change**
V1	09.05.11	N Bell	
V2	18.05.11	N Bell/J Waite	
V2a	18.05.11	Sent to Provider Commissioner Forum for Comments	Taking comments into account and ITQ deliverables
V3	08.06.11	N Bell	Adapted following comments from Nick Hicks, Prov/Comm Forum on 4th July 2011 and KPMG
V4	06.07.11	N Bell	Adapted following discussion at Steering Group
V5	19.07.11	N Bell	
Final	22.07.11	N.Bell	Comments from St Grp incorporated

Document Distribution	
Approval	**Comment**
Final version issued on 22nd July as the agreed Programme Brief. Partners to discuss this with Boards in a way that best meets the needs of the organisation	

Table of Contents

1. Purpose of this document

This document sets out the ambition and drive for excellence that the Acute Service Review Programme (referred to as the Programme) seeks to achieve for the local population through the transformation of the services currently provided in an acute hospital setting.

It is envisaged that this will be a phased programme of work running from the initial scoping phase (Phase One) in June 2011 through to the achievement of improved patient outcomes by March 2015.

This document contains the current understanding of how the programme will work, however it is recognised that through the scoping phase this may change as the potential scenarios and the scale of the transformation emerge.

By the end of Phase One[1] this document will be developed into a Project Initiation Document (PID) the key elements of which will include:

- the agreed case for change
- the potential scenarios and underpinning evidence
- the design and phasing of the future programme

The PID will then be agreed through the Programme Board and signed off by the Cluster Boards and each of the five acute Trust Boards at the September meetings.

2. Executive Summary

This document sets out the ambition and drive for excellence that the Acute Service Review Programme seeks to achieve for the local population through a collaborative partnership of commissioners and providers. The thirteen NHS partners are working together, with wider stakeholders and public and patient representatives, to review care currently provided in an acute hospital setting for the population, develop a clinical vision and reconfigure local services to improve clinical quality and outcomes for patients, value for money and accessibility for the local population.

The aim of the Programme is to deliver excellent quality and outcomes for the population and ensure clinical and financial sustainability of the health economy. This will be clinically led and undertaken through a phased programme, running to 2014/15.

The Programme will be managed through a Programme Board made up of the Accountable Officers of the thirteen partner organisations, accountable to the Cluster Boards and the five Acute Trust Boards. A Steering Group will provide local Director level leadership and wide stakeholder engagement and ensure the programme works with pace and momentum.

Clinical and professional leadership will be provided through a Clinical Reference Group which will explore and develop clinical solutions and make recommendations on service change to the Steering Group.

Patient engagement in the ASR programme process is essential, and action will be taken to ensure that the programme builds on existing work to enable wider engagement.

[1] Phase One is the initial scoping phase that will design the future programme and develop the range of clinical scenarios to be progressed through the remaining phases. This will be a clinically led process and will focus on building a consensus on the potential scenarios and the future of the programme. Phase One runs from 20 June to 19 September 2011

3. Introduction

South East Midlands (SEM) is a community of over 1.6m people, which previously spanned 3 Strategic Health Authority boundaries (South Central, East of England and East Midlands). It is widely recognised that this administrative divide resulted in little or no formal strategic planning for the population and has led to duplication of services and inefficiency within local health services. The population is predicted to rise to 2.2m by 2031 with a need to treat more patients within a constrained financial envelope.

There is, therefore a need to look across the SEM health economy to develop a model of care that works collaboratively across the partners to improve efficiency and effectiveness, increase quality and improve clinical outcomes for patients. This is an opportunity to transform care for the local population, learn from the best and reconfigure services to deliver excellent quality and outcomes. SEM is made up of two NHS PCT Clusters; Milton Keynes and Northamptonshire and Bedfordshire Luton, and is largely coterminous with the South East Midlands Local Enterprise Partnership (SEMLEP).

The principle of conducting a review of acute healthcare services across this geography was first discussed and agreed in the summer of 2009. A small review started in November 2010 when 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 was identified that the current pattern of hospital provision is unsustainable into the future particularly given the research regarding the affect of critical mass on patient outcomes for complex procedures. Going forward it is evident that these specialty reviews need to be set in the context of a larger vision for acute services across South East Midlands and as part of a more co-ordinated approach to an agreed clinical strategy for acute care that includes GP Commissioning plans for local and sub-regional services.

The aim of the programme is to achieve excellent services for patients through the implementation of ambitious and innovative clinical solutions across South East Midlands. This will be undertaken through a phased programme which will be clinically led and based on evidence and best practice. This phased approach will follow the OGC[2] Gateway stages to ensure the clinical and financial viability of the options has been fully considered and to support the agreement through individual Trust Boards.

4. Organisations involved

There are two commissioning clusters (Milton Keynes Northamptonshire and Bedfordshire Luton) working together, between them they spend £2.3billion a year. Just over £1bn is spent on acute services of which £870m is spent on the five local hospitals (38%of total spend). There is an identified financial challenge from health economy QIPP plans[3] of approximately £500m by 2015/16 for the South East Midlands health economies, including a potential gap of £200m on hospital based care. The level of change required to deliver this can only be achieved through a collaborative transformational programme involving all the key partner and wider stakeholder organisations. There are thirteen NHS partner organisations identified as part of the Programme (outlined below) and additional NHS and non-NHS stakeholders within the local authority, community health services, ambulance trusts and beyond.

The two PCT Clusters of Milton Keynes Northamptonshire and Bedfordshire Luton:

[2] Office of Government Commerce (now part of the Efficiency and Reform Group within the Cabinet Office) gateway stages from Strategic Business Case (PID in this case); Outline Business Case to Full Business Case and Benefits Realisation Plan

[3] QIPP Plans – Quality Innovation Productivity and Prevention plans developed in each PCT

PCT	Population coverage	Funding
NHS Northants	720,000	£1,001m
NHS Beds	431,000	£615m
NHS MK	260,000	£371m
NHS Luton	215,000	£314m
Totals	**1,626,000**	**£2,301m**

Five Acute Trusts:

Acute Trust	Beds	Staff	Turnover
Northampton General Hospital	822	4,000	£236m
Luton & Dunstable Foundation Trust	600	3,500	£200m
Kettering Foundation Trust	550	3,000	£170m
Milton Keynes Foundation Trust	540	2,600	£152m
Bedford General Hospital	410	2,100	£147m
Totals	**2,700**	**14,800**	**£879m**

And six GP Commissioning Consortia:

GP Commissioning Consortia	Population coverage
Nene Commissioning **(**covering most of Northamptonshire - except Corby)	653,000
Corby GP Commissioning	67,000
Bedfordshire Clinical Commissioning	431,000
Premier MK	130,000
GP Healthcare MK	130,000

Luton Health Commissioners	215,000
Totals	**1,626,000**

These thirteen NHS partners are working together to review all care currently provided in an acute hospital setting for the population, and transform local services to improve clinical quality and outcomes for patients, value for money and accessibility for the local population. Other key stakeholders engaged in the programme are:

Five Local Authorities:

Local Authority	**Population coverage**
Northamptonshire County Council	720,000
Milton Keynes Unitary Council	260,000
Bedford Borough Unitary Council	153,000
Central Bedfordshire Unitary Council	278,000
Luton Unitary Council	215,000
Totals	**1,626,000**

Four Community Providers:

Community Service Provider	**Population covered within SEM**
Northamptonshire Healthcare Foundation Trust	720,000
Milton Keynes Community Service	260,000
South east Essex Partnership Trust (Bedfordshir	431,000
Cambridgeshire Community Services Trust (Luton)	215,000
Totals	**1,626,000**

Three Ambulance Services Trusts:

Ambulance Trust	**Population covered within SEM**
East Midlands Ambulance Trust	720,000
South Central Ambulance Trust	260,000

East of England Ambulance Trust	646,000
Totals	**1,626,000**

5. Aim and Outcomes of the ASR Programme

The aim of the Programme is to deliver excellent quality and outcomes for the population and ensure clinical and financial sustainability of the health economy.

The Programme will be undertaken in a way that specifically addresses the four service reconfiguration criteria outlined in the Secretary of State's letter of 20 May 2010.

- The review will be clearly based on **clinical evidence**
- **Patient and public engagement** will be a feature throughout the review
- **GPs** will be engaged throughout
- **Patient Choice** will be a key driver for this review

6. Benefits

The intended benefits for the programme as a whole are:

- An overall **improvement in the quality of service** available to the population of South East Midlands
- Achievement of national and local acute **clinical and quality requirements**
- **Improved health outcomes** for the population
- **Improved accessibility** for patients to high quality local services
- **More efficient and effective hospital based care** across all hospitals accessed by the population both within and outside the five acute trust partners)
- A **sustainable healthcare system**

7. Scope of the Programme

The Programme will consider all of the acute services currently commissioned from or provided within an acute hospital setting for the population of the two PCT Clusters. This includes both routine acute and specialist care currently provided outside of the area and (where quality and cost effectiveness can be maintained or improved) services that are currently provided in acute settings that might be better provided in primary care, community or, social care.

Out of the scope of this programme are:

- Services commissioned by the National Commissioning Group (NCG)
- Mental Health Services
- Primary and community based services **other than** where hospital services are better provided in association with community services

Although focused on services currently provided in an acute setting commissioners will, where necessary consider all their resources in order to support the objectives of the programme.

8. Principles

The fundamental design principles that underpin the Programme are:

- A significant clinical presence will be retained on all existing DGH sites
- Health interests of the population will take precedence over the interests of institutions
- The process will be open and transparent with the public and their representatives and staff involved from the beginning
- The process will be clinically led and evidence based

- Recognition that decisions and changes made as a result of the Programme will need to ensure safe, sustainable, affordable services for the population for the foreseeable future

9. Behaviours

The way partners engage in the Programme should underpin these principles. This will include:

- Being open and honest
- Keeping to agreements
- Being open minded and not driven by organisational interests
- Focusing on the delivery of excellence for all patients
- Being ambitious for the population as a whole

10. Criteria against which scenarios will be assessed

Potential scenarios will initially be assessed against the criterion used by the Independent Reconfiguration Panel (IRP). Additional criteria may be added following structured discussion with patient representative groups and with the Programme Board, Steering Group and Clinical Reference Group.

The IRPs role is to provide expert advice to Ministers on:

- proposed NHS reconfigurations or significant service change
- options for NHS reconfigurations or significant service change

In providing this advice the Panel consider whether proposals will provide **safe, sustainable and accessible services for the local population**, taking account of:

- clinical and service quality
- the current or likely impact of patients choices and rigour of public involvement and consultation processes
- the views and future referral needs of local GPs who commission services, the wider configuration of the NHS and other services locally, including likely future plans
- other national policies, including guidance on NHS Service change

any other issues Ministers direct in relation to service reconfigurations generally or specific reconfigurations in particular

11. Deliverables of the Programme

The aim of the programme is to improve the health, access and quality of services delivered across the South East Midlands to support the improved outcomes for the population who access services. This will be facilitated through a phased programme following the OGC Gateway review stages (see footnote on p5 for further details).

The deliverables will be:

- a clinically led and agreed clinical strategy based on national and international best practice that takes into account existing QIPP plans and GP commissioner aspirations
- a set of recommendations and a full business case for future configuration of acute services across South East Midlands agreed by the thirteen partner organisations and consulted on with the wider stakeholders and the public
- an implementation plan, process and necessary support to deliver the agreed recommendations over the agreed timeframe
- high quality and sustainable acute services for the population

Phase One
Phase One is the initial preparatory phase and will run from 20 June 2011 to 19 September 2011. KPMG have been engaged to, work as part of a joint programme team to support the delivery of the phase. Many of the deliverables from Phase One will be collated in to a single Project Initiation Document (PID) to provide the basis for the programme going forward.

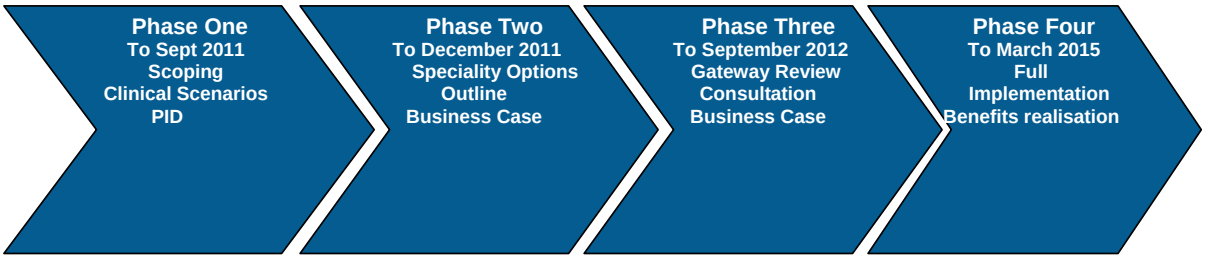
The deliverables at the end of Phase One will provide partner organisations with an objective view of the case for change, strategic outline of potential service configurations to consider and develop in Phase Two as well as identify a mitigation strategy to the potential barriers to change.

Specific deliverables for Phase One have been agreed as:

- Clarity for all partners on the clinical and financial **Case for Change** based on an **analysis of the baseline position** (quality, finance and activity), including the potential for improvement based on local analysis and using national and international evidence
- Clear documented **commitment to change among partners** and their Boards with an understanding of what that change might look like
- A **programme design and configuration** that will progress the remainder of the review in a robust and pragmatic way with phasing, timescales and actions capable of being achieved
- A shared clinical ambition and an identified **range of high level viable clinical scenarios**[4] to address the case for change
- An engagement plan for excellent **engagement with clinicians, the public** and other key stakeholders
- The establishment of a **clinical leadership model** to drive the remaining phases of the programme
- A **finance and activity tool** to enable the modelling of different scenarios for Phase Two and beyond
- Identification of widely agreed **barriers to change** and plans to address these
- **A resourcing plan** agreed by the Programme Board, to support the programme going forward, identifying any potential to fund the programme from new savings

Where appropriate these Phase One deliverables will be prepared in the format of a Project Initiation Document for formal sign off by the individual Trust Boards as well as through the agreed governance structure which includes patient representatives.

12. Key Activities and Outline Timescales (final phasing to be agreed end of Phase One)



[4] Clinical scenarios are identified as potential high level service configuration (non-organisational) based on evidence and best practice such as critical mass requirements.

Phase One	
June – mid September 2011	Appoint external consultant partner – KPMG appointed 20th June 2011 See Annex 1 for detailed timing and governance arrangements for Phase One. Identify clinical leaders including the associated supporting structure
Phase Two	
October – December 2011 **3 months**	Produce recommended clinical strategy with options for reconfiguration of services across SEM, financial implications and proposed implementation plan, including options for early changes Pre-engagement with staff, stakeholders, patients and the public to scope the recommendation for consultation Early service changes proposed from April 2012 to be highlighted, agreed and consulted on as required Gain Board agreement on recommendations for early service changes, and consultation through the production of a Outline Business Case
Phase Three	
January 2012	Gateway Reviews
February – June 2012	Public Consultation for longer term changes Implement April 2012 changes Review proposals and gain Board sign off for first stage of implementation plans
July – September 2012	Development of the Full Business Case for the agreed scenario and Board sign off from each partner organisation and Programme Board
Phase Four	
October 2012	Continue implementing early service changes
March 2014	Majority of service changes complete
March 2015	All service change and reconfiguration completed during 2014/15 in line with QIPP Plans

13. Governance

The Programme will be managed through a Programme Board made up of the Accountable Officers of the thirteen partner organisations, accountable to the Cluster Boards and the five Acute Trust Boards. A Steering Group will provide local Director level leadership and wide stakeholder engagement and ensure the programme works with pace and momentum.

Clinical and professional leadership will be provided through a Clinical Reference Group which will explore and develop clinical solutions and make recommendations on service change to the Steering Group.

Commissioners, in conjunction with providers will set the vision and expectations for acute service provision across South East Midlands and the providers will work together to develop the proposals and implementation plans to ensure this is delivered.

Corporate support functions will be engaged in activity throughout the Programme including Finance, HR, Information, Communications etc

Clinical, public and patient engagement will be continuous throughout the Programme.

Annex 1 outlines the detailed governance arrangements for Phase One. Final governance arrangements for the ongoing Programme will be agreed by the end of Phase One and incorporated into the Project Initiation Document.

14. Resources Required

The Executive Lead for the ASR in the NMK Cluster (Dr Nick Hicks) will act as the Senior Responsible Officer (SRO) for the Programme and will work closely with the identified Executive Lead for the ASR in the Beds Luton Cluster (Simon Wood). Together they will ensure the Programme is appropriately strategically aligned and focused, and is effectively supported to deliver success.

Resources required delivering Phase One of the programme:

- A small dedicated internal NHS team (interim, future to be agreed as part of the resourcing plan going forward)
- Additional manpower to be allocated from commissioners and providers including community, patient representation, social care and ambulance trusts as required
- Internal Clinical Leadership
- External consultant partner (KPMG were appointed through a competitive process) to support with Phase one. Phase One costs will be funded by the Clusters.

A proposal on resourcing and funding the programme for Phase Two and beyond will be developed by the SRO and presented to the Steering Group in early August for discussion and comment. A recommended proposal from the Steering Group will then go to the Programme Board at the end of August.

15. Identified Risks

Risk No	Date	Description of Risk	Mitigation of Risk	RAG
1	5.5.11	As a result of the breadth of stakeholder/institution involvement required for success, there is a risk that one or more partners or stakeholders will not remain committed and therefore outcomes will not be delivered.	Clear sign up from all partners to the principles, aim and objectives of the programme is required at the start. The external consultants will work with all 13 partners to create an agreement during Phase One.	
2	5.5.11	As a result of the breadth /diversity of stakeholder /institutional involvement providers and commissioners may have conflicting opinions of the ASR and its intended outcomes. This may lead to disengagement of partners at a crucial point in the process.	The agreement being worked on during Phase One, which all organisations Boards should sign up to, should significantly reduce this risk. Also a clear governance structure needs to be agreed, with concord about how final decisions will be reached and by whom.	
3	5.5.11	As a result of internal financial pressures and the pace of change, there is a risk that insufficient funding will be made available to support the ASR. This will result in the review and implementation not taking place.	Clarity on resources and who contributes what should be finalised at the end of Phase One	
4	5.5.11	The principle has been established that this process will be commissioner enabled and provider led , but the lack of clarity about what this means could lead to disagreement between the key	Clarifying the purpose, scope and phasing of the review, and the term “commissioner enabled and provider led” during Phase One should reduce this risk.	

		partners and inability to agree recommendations.		
5	5.5.11	The speed required to undertake this review could lead to a very internally focussed process and there is a risk of making mistakes others across the wider NHS have already made and found solutions to.	Bringing learning from other Reviews, locally, nationally and internationally should be a key role of external consultants and a continual challenge on Programme Board agendas	
6	4.7.11	The speed required to undertake Phase One of the review could result in insufficient data from either Acutes or PCTs being available to model potential changes	Ensure data requirements are highlighted early and shared with Acutes and PCTs and that Director level support is engaged in the organisations to encourage speedy turnaround and mitigate barriers	
7	5.5.11	Due to the high profile of the ASR there is a risk of political interference or lack of political support to make the difficult decisions.	Development of a clear and comprehensive stakeholder management plan, clearly identifying a process for working with MPs and local councillors to ensure they are fully engaged throughout.	
8	5.5.11	As a result of the volume of work to be undertaken in a tight timescale, there is a risk the capacity and capability required by the ASR programme team may be unavailable	Need to have a clear resources plan agreed at the start, using external skills where necessary to bolster internal skills availability	
9	10.5.11	It is possible that key players and stakeholders may change over the course of the programme leading to a loss of knowledge and drive for the programme at individual organisation level	Ensure that the profile of the programme is high enough in organisations to ensure nominated successors.	
10	5.5.11	There is a risk of compromising the clinical credibility of solutions and delivery of outcomes if clinical engagement is both insufficient and ineffective.	Engagement with clinicians throughout the programme needs to be planned. We need to be clear about what clinical engagement means and provide time for clinicians to engage. Evidence based options appraisal and a clear decision making process will enable clinicians to feel more engaged.	
11	6.7.11	Changes in NHS policy and the reform agenda could put the objectives at risk	Ensure the patient is at the centre of the scenarios developed. Ensure all policy and reform is considered as part of the development of scenarios	
12	6.7.11	Availability of key partners and stakeholders for meetings especially in the phase one could impact on the collaborative nature of the programme	Partners to prioritise diaries as far as possible. PMO to send out dates as far in advance as possible. Arrange conference calls where face to face meetings are not possible	
13	6.7.11	As the programme develops there is a risk of adverse media interest / public opinion	Need a robust, proactive communications plan in place to manage the media and ensure wide ranging engagement with Links and the public Ensure good links between all partner Communications leads to help respond quickly to issues as they arise.	
14	19.7.11	There could be a risk to community and social care organisations from recommendations of the programme and visa versa	LAs and Community Services should be actively engaged in developing recommendations through the CRG and the Steering Group.	

16. Identified Issues

ID no	Date	Issue	Action required	RAG
1	5.5.11	Need to be clear about what resources are required and get agreement about funding at an early stage.	Ensure a resourcing plan is developed and agreed by all partners – July 2011	
2	5.5.11	The uncertainty of the involvement and participation of Luton & Dunstable Hospital and Luton GP Commissioners, this needs to be clarified.	Work with Luton stakeholders to understand their need for and commitment to the process.	
3	5.5.11	Communications and engagement support will be crucial from the start of the programme. Need to be clear about how the 13 communications/departments will work together.	Create the Communications sub group with comms leads from all organisations at an early stage and develop an agreed plan.	
4	5.5.11	Recognition of the difficulties of releasing clinicians from clinical work – usually takes 6 week.	Plan as far in advance as we can to give clinicians as much notice as possible.	
5	11.5.11	Lack of availability of information and data to support decision making	Utilise what we already have, and identify gaps. Ensure everyone is committed to provide timely data.	
6	11.5.11	Benefits and outcomes need to be identified and agreed to ensure full organisational buy-in	This will be done as part of Phase One.	
7	4.7.11	Board level engagement will be crucial throughout – regular documentation needs to be produced for agreement at Board meetings	Programme Brief to go to all Boards followed by regular briefings. Consider NEDS briefings	

17. Stakeholder Engagement

Effective communications across the complex web of stakeholders will be a key and crucial feature of this project. A stakeholder map will be developed along with a communication plan to ensure consistency of communication to all stakeholders.

Key Stakeholders will include:

- Patients and the wider public (to be addressed with input from the Joint Links Group)
- PCT and Cluster Boards
- Clinical Commissioning Consortia
- Acute Trust Boards
- Local Authorities and elected members
- Community Services Providers
- Ambulance Trusts
- SHAs (East Midlands and East of England)
- Trust Medical Directors
- Clinicians across primary, acute and tertiary care
- Specialist Commissioning Groups (East Midlands, East of England and South Central)
- Clinical Networks (
- MPs (17 across the area)
- Overview and Scrutiny Committees
- Health and Wellbeing Boards
- Workforce planning groups

- Royal Colleges
- Local Media

Patient engagement in the ASR programme process is essential, and action will be taken to ensure that we build on existing work to enable wider engagement.

Initial briefings have been circulated to partners and stakeholders regarding the programme update. The governance structure includes a wide range of stakeholders particularly the Steering Group including social care, ambulance trusts, patient representatives and community providers to ensure a wider engagement.

Engagement will increase in phase 2 as the strategic scenarios are development culminating in a formal consultation period.

ANNEX 1

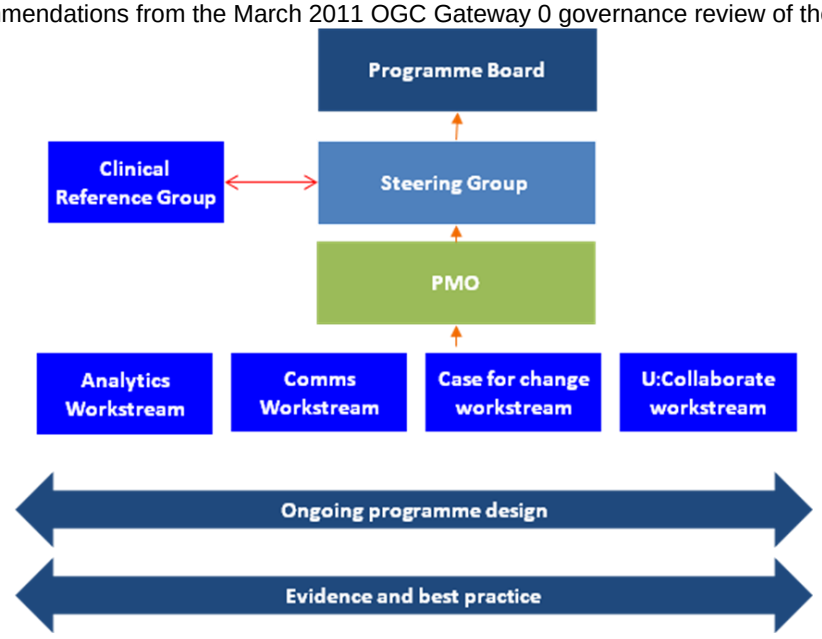
South East Midlands Acute Service Review Phase One - Governance Arrangements

Context

This paper seeks to set out the proposed phase one governance arrangements for the South East Midlands Acute Service Review.
The complex multi-faceted nature of the programme means that strong governance arrangements are required in order to manage the potential risks and ensure the timely delivery of the phases. There are thirteen partner organisations as well as a wider group of stakeholders such as the local authorities, ambulance trusts, Links, third sector and community provider organisations.

Proposed programme governance structure

The proposed governance structure as outlined is designed to set the pace and support the decision-making for the initial phase of the programme.
An output for phase one will be an ongoing governance structure for phase two and beyond.
The proposed governance arrangements for the programme also take into consideration the recommendations from the March 2011 OGC Gateway 0 governance review of the earlier SEM ASR



Phase One Governance meetings – role, membership and frequency

The aim of this structure is to support the clinicians to develop the potential strategic scenarios based on clinical quality and viability through the Clinical Reference Group (CRG). These are then presented to the wider Steering Group (SG) for a whole systems approach to their further development.

The recommendations from the Steering Group and will be presented to the Programme Board (PB) for ratification. The Medical Directors of the acute trusts attend both the CRG and the SG and provide consistency. The chair of the CRG and both SROs are on the Steering Group and Programme Board ensuring consistent messaging and clinical leadership. The meetings dates as outlined below demonstrate this flow.

	Role	Membership	Meeting Frequency
Programme Board	• To provide overarching leadership for the programme at cluster level • Decision making forum • To have final sign off on all outputs/ deliverables/ key decision making • Link to Health and Wellbeing Board / Overview and Scrutiny as appropriate	• Co- Chair - Cluster Chief Executives • Acute Trust CEOs • Clinical Commissioning Groups CEOs • Chair of the Clinical Reference Group • Cluster SROs	**14 July** – progress call On phase 1 governance **19th July –** Pre-U:Collaborate workshop to test emerging case for change and potential clinical scenarios **25th August** – agree U:Collaborate design, materials etc **7-8th September –** U:Collaborate workshop **19th September** – Post U:Collaborate Sign off phase one deliverables
Steering Group	• To provide local leadership and representation of the key stakeholders • To progress the programme outputs • To provide advice and challenge to the option formulation and ensure quality • To provide pace and momentum	• Co-Chair - Programme SROs for both clusters • Lead Director for each acute trust • Medical Director for each acute trust • All six Clinical Commissioning Group reps(management) • Chair of CRG • Lead from each Local Authority • 2 x LiNKs representative • Lead from each community services provider	**19th July** Inaugural meeting to agree principles and programme of work followed by pre-U:Coll workshop to test emerging case for change and potential clinical scenarios **12th August** Meeting to review progress, future resourcing, barriers to change **24th August -** discussion and agreement of the U:Collaborative material and contributors **7 -8th September –** U:Collaborate workshop **16th September -** **–** agree final U:Collaborate scenarios to be presented at Programme Board

Clinical Reference Group	• To provide clinical and professional leadership • To consider the evidence of best practice • To consider the clinical options for the health economy • To represent the services, staff and patients across the health and social care economy • Recommend to SG and Programme Board the approval of programme options and outputs	• Chair - nominated from within the group • Five acute trust Medical Directors • Five acute trust Directors of Nursing • GP representation from 6 Clinical Commissioning Groups • 2 x LiNKs representatives • Lead from each Local Authority • Lead from each Ambulance Trust • Lead from each Community Services • Additional Trust nominated leads to be Clinical Champions to act as a conduit between the CRG and the trust clinicians	**13th July –** Inaugural meeting to develop the principles and potential hypotheses to contribute to the development of the case for change. Followed by a dinner. **19th July –** Pre-U:Collaborate workshop to test emerging case for change and potential clinical scenarios **26th July –** Progress output from the pre-U:Collaborate workshop and commence the material design **10th August -** development of U:Collaborative clinical scenarios and material **23rd August -** agree final U:Collaborate material and contributors for discussion at Steering Group (24th August) and sign off at Programme Board (25th August) **7 -8th September –** U:Collaborate workshop **w/c 10th September– subgroup -** agree final scenarios to be discussed at Steering Group (14th Sept)
Patient and Public Engagement	• To provide the patient perspective • To communicate the progress of the programme to relevant patient groups • To support communication with relevant public and patient groups and advise which groups are appropriate	• 2 Links reps on the Steering Group • 2 Links reps on the Clinical Reference Group • 1 Links rep in the Communications Group • Ad hoc and planned meetings with patient groups • Overview and Scrutiny leads • Health and Well Being Boards	• Meeting schedules as per the Steering Group and Clinical Reference Group • Fortnightly Communications Leads meeting • Ad hoc and planned meetings with patient groups as and when required
Programme Office	• To provide Directorship and support to the programme	• Senior Responsible Officer • Programme Director • Project Manager	• As and when required minimum weekly

	• To manage the workstreams output • To keep the pace and momentum • To ensure the governance of the programme • To produce the evidence/ resource/ data analytics etc to drive the programme • To organise stakeholder events • To manage the reporting and comms to stakeholders	• External advisory support • Administration • Communication Lead	
Workstreams	• Analytics • Communications • Case for change • U:Collaborate • Evidence – national/ international best practice	• Information/ Finance/ Data Analytics Leads • Communications Leads (each Trust) • Clinical Leads from the CRG	• Fortnightly Communications Leads meeting

Phase One Timetable – programme key activities/ deliverables

Week 0 w/c 20 June 2011

Actions

- Contracting
- Kick off the programme
  - programme plan
  - information request list
  - stakeholder map
  - risk log
  - communications plan
  - case for change approach agreed
  - agree workstreams and weekly reporting structure
  - agree branding
- Meetings with Chief Executives of the acute trusts
- 1:1 meetings and Governance meetings arranged

Outputs – Programme plan and proposed programme governance structure

Week 1 w/c 27 June 2011

Actions

- 1:1 interviews with key stakeholders
- Develop criteria for inclusion in the programme brief for comment
- Data gathering and gather evidence for the case for change

- Agree U:Collaborate invitation list and send out invites
- Populate standardised position statement template
- Preparation and agree content and agendas for all governance meetings for w/c 4 July 2011

Outputs - Programme governance briefing paper
Programme governance meetings arranged

Week 2 w/c 4 July 2011

Actions

- Provider and Commissioner Forum
- Agree governance structure
- Continue 1:1 interviews with key stakeholders
- Continue to develop the case for change
- Data gathering

Outputs - Provider/ Commissioner Forum
Agreed phase one governance structure including commitment to change from all of the partner organisations
First draft of the case for change
Produce revised programme brief

Week 3 w/c 11 July 2011

Actions

- Initial draft of case for change
- Development of catalogue of evidence of best practice
- Steering Group meeting
- Clinical Reference Group meeting
- Prepare for pre U:Collaborate workshop
- Build the analytical model (subject to data received from acute trusts by 8th July 2011)

Outputs - Inaugural Clinical Reference Group meeting
Initial case for change for discussion
Initial draft of catalogue of the evidence of best practice

Week 4 w/c 18 July 2011

Actions

- Pre U:Collaborate workshop held – test material and modelling output (subject to the data being received from the acute trusts by 8th July 2011) and discuss potential barriers to change
- Finalise narrative for the case for change and range of clinical scenarios based on the outcome of the workshop
- Prepare U:Collaborate format and agree materials to be produced over the summer break

Outputs - Inaugural Steering Group meeting
Pre-U:Collaborative workshop to test:

- case for change
- modelling outputs (subject to acute trust data availability)
- evidence of best practice
- range of clinical scenarios for U:Collaborate
-

Summer break – 22th July – 2nd September 2011

Actions

- Develop U:Collaborate materials
- Programme Board, Steering Group and Clinical Reference Group meetings

Week 5 w/c 5th September 2011

Actions/ Outputs

- U:Collaborate event (2 days)

Week 6 w/c 12th September 2011

Actions

- U:Collaborate event work product produced
- Refine the range of clinical scenarios from the workshop
- Development of a phased programme plan
- Develop the phase two structure for the Clinical Reference Group including associated recruitment processes and funding mechanisms
- Finalise potential future programme funding mechanisms

Outputs - No outputs

Week 7 w/c 19th September 2011

Action: Programme Board

Northampton General Hospital NHS
NHS Trust

Chair of Northampton General Hospital NHS Trust

Information pack for applicants

Reference no: EM0959

Closing date: 12 noon on 25 October 2011

Interviews: 17 November 2011 tbc

Appointments Commission

Regulated by The Commissioner for Public Appointments

Contents

Dear Applicant

Thank you for your interest in this post and your time spent reading this information pack.

Northampton General Hospital NHS Trust is seeking to submit a Foundation Trust application to the Department of Health on 1 July 2012 and will be at the cutting edge of the Government's commitment to the decentralisation of public services and the creation of a patient- led NHS. The role of the Chair will be critical if that vision is to become a reality. This is your opportunity to make this happen.

As a member of the selection panel I can perhaps help you by telling you what we will be looking for in the successful candidate. The most important qualities will be leadership and personal reputation. You will need this if you are to encourage the staff and people from many diverse communities across the Northamptonshire area to share your vision for healthcare services.

To provide effective leadership to Northampton General Hospital NHS Trust you will need to be able to call on high level of skills and experience you will bring from leading other large and complex organisations. Finally, you will need to demonstrate commitment and conviction. The NHS is one of the most important institutions in this country. It needs and deserves 100% dedication from those who work within it.

An application form is enclosed with the information pack. I do hope you are excited by the challenges this opportunity presents and that you will be inspired to apply.

Sarah Boulton
Chair, Midlands and East

Kaye Burnett
Vice Chair (East Midlands)

Overview

Key dates:

Closing date:	12 noon on 25th October 2011
Interviews held on:	17th November 2011
Appointment start date:	December 2011 TBC

Qualities required: Applicants applications will need to demonstrate that they have the necessary experience, and will need to show that they have:

- experience of leading an organisation with a significant budget and of comparable complexity;
- a considerable reputation within your field whether public, private or voluntary sector.
- a portfolio of high level governance and organisational skills including strategic planning, financial management, risk management, organisation performance management and service development in a regulated environment;
- experience of building alliances and working relationships with a range of stakeholders

If you are shortlisted for interview, you will also need to show that you have the competencies required to be effective in this demanding leadership role

Eligibility: Preference will be given to applicants who live in, or have strong connections with the Northamptonshire area.

Remuneration: £20,896 per annum

In the event of Northampton General Hospital NHS Trust achieving Foundation Trust status, the Chair's remuneration may be reviewed (NHS Foundation Trust Chairs typically receive £35,000-60,000 per annum).

Time commitment: Up to 3½ days per week (including some evening engagements)

Key contacts: For an informal and confidential discussion with the Chief Executive of the Trust, Dr Gerry McSorley, regarding the role please contact Vicki Burgess, PA to the Chair, on 01604 545457 prior to the closing date. This will play no part in the selection process.

For information regarding the selection process, please contact: Leslie Horn on 0113 394 6746
Appointments Commission
Blenheim House, Duncombe St, Leeds, LS1 4PL
Email: leslie.horn@appointments.org.uk.

Please quote reference EM0959 on all correspondence.

About Northampton General Hospital NHS Trust

Northampton General Hospital NHS Trust has provided the following profile of the Trust, its services and its plans for the future.

Northampton General Hospital NHS Trust (NGH) provides services from four main sites and a number of smaller facilities. The largest hospital site is based in Northampton town centre providing a full range of acute services; the other hospital sites are in Daventry,Wellingborough and Corby providing further acute services and community beds. They serve agrowing population which is currently around 370,000 inhabitants. The Trust is also an accredited Cancer Centre delivering cancer services to a wider population of 880,000 from Northamptonshire, North Buckinghamshire and South Leicestershire.

The Trust has recognised that the landscape for the provision of acute healthcare is changing rapidly and so has focussed its recent developments on increasing its tertiary and specialist services capacity on the main Northampton site as well as providing more care to the local community especially through the hospital facilities in Daventry.

Tertiary and specialist service development has included cancer, renal inpatient provision and cardiology services in the Heart Centre. In 2010/11, the Trust was nominated by the PCT as the County Stroke Centre and in March 2011 as the centre for major vascular surgery in Northamptonshire. This has broadened the portfolio of the Trust and the Trust is engaged in the process of integrating these services with existing operations with a view to maximising clinical quality and earnings potential through high quality, patient centred care.

Danetre Hospital is a NHS Northamptonshire (NHSN) owned facility providing both acute and community services. NGH lease part of the hospital from NHSN in order to provide outpatient, diagnostic and day surgery services to this important area of the local population.Community beds at Isebrook Hospital in Wellingborough and Corby Community Hospital transferred to NGH under the Transforming Community Services initiative in July 2011.
The trust aims to grow their reputation as the hospital of choice by offering more services closer to the patient‟s home through developing more tertiary and specialist services and by offering more outreach services.

The Trust employs circa 3,628 WTE members of staff, a headcount of 4,310 People (as at November 2010). The trust has an annual income of around £233m (2010/11).

Vision

The trust's vision is to deliver the safest, most clinically effective acute services in the country based on the needs of the patient. These services may be delivered from one of the acute hospitals or by staff in the community. The trust recognises that the financial climate that the NHS operates in is going to become much more challenging over the coming years. Also, that it is highly likely that with reduced growth from central funds that competition between providers will accelerate.

Strategic objectives

Northampton General Hospital NHS Trust has set out in its Strategic Plan an ambitious programme of work to deliver the high-quality, value-for-money health services that the people of Northamptonshire needs. To do this, it will:

- Maintain and enhance their position as the local provider of choice through patient centred services.

- Increase their 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 their long term financial viability through improving the clinical quality, productivity and efficiency of services.

The future

- The trust view is that attaining NHS Foundation Trust status will help them to realise their vision by:

- Making and implementing business decisions more quickly by operating more efficiently within a clearer financial regime.

- Using Foundation Trust freedoms to enhance the quality of the environment for patients and staff.

- Improving services through the involvement of an active staff and public membership and effective Governors Council.

- Enhancing strategic planning and accountability by integrating the views of the wider stakeholders and Governors.

- Supporting the organisation through effectively negotiated legally binding contracts.

- Operating within a clear and enhanced governance system and constitutional arrangements.

NHS Foundation Trusts are managed by a Board of Directors which is accountable to patients, staff and the local public.

The Foundation Trust board will continue to be made up of Executive and Non-executive Directors. The Chair of the Board of Directors will continue be a non-executive and will also chair the Council of Governors. The Foundation Trust Chair will therefore play an important role in ensuring effective communication between these two groups.

In accordance with legislation, transitional arrangements will apply for the current trust board to form the new Board of Directors of the new NHS Foundation Trust to ensure that there is no disruption to the effective operation of the hospitals.

Further details

More information about Northampton General Hospital NHS Trust, such as business plans, annual reports and further information about services, is available on the website: http://www.northamptongeneral.nhs.uk/Home.aspx

The role and responsibilities of the Chair

The Chair is accountable to the Secretary of State, through the Strategic Health Authority Chair and the Appointments Commission for giving leadership to the NHS trust board and delivering value for money for NHS resources in terms of quality of service and financial balance.

As Chair, you will:

- Provide leadership to the board, the Trust, the other non-executives, the Chief Executive and executive directors; and ensure the effectiveness of the board in all aspects of its role and agenda; including directing the organisation towards achieving the Government's objective of all trusts achieving Foundation Trust status;
- Ensure the provision of accurate, timely and clear information to the board and directors to meet statutory requirements;
- Ensure effective communication with the board, staff, patients & the public in a changing healthcare environment;
- Arrange the regular evaluation of the performance of the board, its committees and individual non-executives, directors, and the Chief Executive;
- Plan and conduct board meetings, with the Chief Executive. Facilitate the effective contribution of non-executive directors and ensure constructive relations within the organisation and between executive and non-executive directors. Share and use relevant expertise of all members of the board.

In particular the Chair will:

- Pro-actively direct and manage the development of major board decisions ensuring that 'due process' has been applied at all stages of decision making and full and complete consideration has been given to all options during the process;
- Hold the Chief Executive to account for the effective management and delivery of the organisation's strategic aims and objectives;
- Ensure that the board develops and oversees strategies, which will result in tangible improvements to the health of the population and clinical services;
- Ensure that the board establishes clear objectives to deliver agreed strategies and regularly review performance against these objectives;
- Ensure that the board maintains its responsibility for the effective governance of the organisation by making the best use of resources including the development of effective risk and performance management processes;
- Ensure that the board, and the organisation, observe the Secretary of State's policies and priorities, including the requirements of the Codes of Conduct and Accountability;
- Be aware of relevant, regulatory and Central Government policies;
- Play a key role in building strong partnerships with Local Authority, local health economy, and other stakeholders in the community and nationally, including regulators such as Monitor and the Healthcare Commission. In the future, this will include developing an effective board of Governors and promoting harmonious relations with the board;

- Ensure that the interests of all stakeholders, and influence of all advisers, are fairly balanced;
- Provide the leadership needed by the Board to shape the organisation; develop a culture which supports the values of the NHS, and ensure the organisation values diversity in its workforce and demonstrates equality of opportunity in its treatment of staff and patients and in all aspects of its business;
- Be an ambassador for the Trust with national, regional and local bodies; be knowledgeable and aware of local issues, and recognise the Trusts role as a major local employer;
- Where necessary, assist in the appointment of executives and non-executives and ensure systems of support and appraisal.

Qualities required for the role

You will need to demonstrate that you have:

- experience of leading an organisation with a significant budget and of comparable complexity;
- a considerable reputation within their field whether public, private or voluntary sector;
- a portfolio of high level governance and organisational skills including strategic planning, financial management, risk management, organisation performance management and service development in a regulated environment;
- experience of building alliances and working relationships with a range of stakeholders.

Preference will be given to applicants who live in the Northamptonshire area. If you are shortlisted for interview, you will also need to show that you have the competencies required to be effective in this demanding leadership role. These are:

Patient and community focus	high level of commitment to patients, carers and the community and to tackling health inequalities in disadvantaged groups
Self belief and drive	the motivation to improve NHS performance and the confidence to take on challenges
Intellectual flexibility	the ability to be creative, make sense of complexity and clarify it for other people
Strategic direction	the ability to develop a clear vision and enthuse others
Holding to account	the willingness to be held to account for board performance and the ability to hold the Chief Executive and non-executives to account
Team working	the ability to take on a personal leadership role and build an effective team
Effective influencing and communication	a high level of ability to gain support and influence, political acumen

Diversity and equality of opportunity

We welcome applications from all sections of the community and from people with diverse experience and backgrounds.

On appointment

Remuneration

The remuneration for this post is £20,896 per annum. It will require the successful candidate to devote up to 3½ days a week on NHS duties, which may include some time commitment during the evening.

This is taxable under Schedule E and subject to Class 1 NI contributions. It is not pensionable. Chairs are also eligible to claim allowances, at rates set centrally, for travel and subsistence costs incurred necessarily on NHS business.

- ***Warning: Impact of appointment on people in receipt of benefits.*** *Your appointment may have an effect on your entitlement to benefits. If you are in receipt of benefits you should seek advice from the Benefits Agency.*

Period of appointment – The successful candidate will be appointed for up to 4 years. After this you may be considered for a further term, subject to consistently good performance and the needs of the organisation.

This post is a public appointment and not a job and is therefore not subject to the provisions of employment law except where discrimination is alleged. Options open to a person with a complaint such as this whether directly employed or not, include an employment tribunal.

Training and development

The Appointments Commission provides induction training for all new Chairs and non-executives as soon as they are appointed. Induction continues throughout their first year in post. More information about the Induction Programme is available from: www.appointments.org.uk/Home/OurServices/TrainingandInduction. The next date for the Chairs residential induction event is in Leeds in January 2012 at a date and venue to be confirmed.

Strategic Health Authorities are responsible for Chair and non executive ongoing training and support as part of a programme of leadership development.

Standards in public life

You will be expected to demonstrate high standards of corporate and personal conduct. All successful candidates will be asked to subscribe to the "Codes of Conduct and Accountability for NHS boards" which can be found on our website www.appointments.org.uk/Home/Appointees/TermsandConditions

You should note particularly the requirement to declare any conflict of interest that arises in the course of board business and the need to declare any relevant business interests, positions of authority or other connections with commercial, public or voluntary bodies. These will be published in the organisation's annual report with details of all board members' remuneration from NHS sources.

Applicants must also confirm that they understand the standards of probity required by public appointees outlined in the "Seven Principles of Public Life". These principles are attached at Appendix 2. More information about these can be found on the website of the Commissioner for Public Appointments at www.publicappointmentscommissioner.org

Disqualification for appointment

Not everybody is eligible to be appointed to an NHS body. All appointments are governed by legislation which details the circumstances in which individuals may be disqualified. They do vary, but you may not serve as a Chair if, at the same time, you are:

- ***a Chair or non-executive of another NHS body*** including other Strategic Health Authorities, Primary Care Trusts and NHS trusts. There are exceptions relating to those serving on some Special Health Authorities.
- ***holding an officer appointment in the NHS*** including honorary or unpaid medical or dental posts. There are one or two exceptions in prescribed circumstances.
- ***a practising Healthcare professional*** including practising GPs, General Dental Practitioners and their employees and people who have been removed from or suspended from a list of Part II practitioners, in some circumstances.
- ***an MP or MEP*** or a candidate for election.
- ***other circumstances***
    - People who have received a prison sentence or suspended sentence of 3 months or more in the last 5 years;
    - People who are the subject of a bankruptcy restrictions order or interim order;
    - Anyone who has been dismissed (except by redundancy) by any NHS body;
    - In certain circumstances, those who have had an earlier term of appointment terminated;
    - Anyone who is under a disqualification order under the Company Directors Disqualification Act 1986;
    - Anyone who has been removed from trusteeship of a charity.

As a general principle, the Appointments Commission will not appoint serving Civil Servants within the Department of Health, or members/employees of the Care Quality Commission. Further advice about disqualification for appointment can be given by contacting the Appointments Commission on info@appointments.org.uk or Leslie Horn on 0113 394 6746.

How to apply

How to apply

All applicants are required to complete the Chair application form. This is now available online by visiting our website www.appointments.org.uk and searching for the vacancy reference EM0959. Alternative formats such as, braille, large print and tape versions of this information pack and the application forms are available from the Appointments Commission by e-mailing info@appointments.org.uk or by calling Leslie Horn on 0113 394 6746 quoting the appropriate reference number.

The Appointments Commission must receive your completed application form **before the closing date for applications.** Alternative format applications can be returned to:

Leslie Horn
Appointments Officer
The Appointments Commission
Blenheim House
Duncombe Street
LEEDS
LS1 4PL

Online applications will be acknowledged by email, usually within an hour of submitting your application. If you submit a paper copy of the application, or one in an alternative format, and would like us to confirm that we have received your application, please put your name, address and a stamp on the acknowledgement card included in the hard copy information pack and return it with your application form. All applicants will be contacted again after the closing date.

Your personal information

Your personal information will be held in accordance with the Data Protection Act 1998. You will not receive unsolicited paper or electronic mail as a result of sending us any personal information using this website. No personal information will be passed on to third parties for commercial purposes.

When we ask you for personal information, we promise we will:

- only ask for what we need, and not collect too much or irrelevant information
- ensure you know why we need it
- protect it and insofar as is possible, make sure nobody has access to it who shouldn't
- ensure you know what choice you have about giving us information
- make sure we don't keep it longer than necessary
- only use your information for the purposes you have authorised

We ask that you:

- give us accurate information
- tell us as soon as possible of any changes
- tell us as soon as possible if you notice mistakes in the information we hold about you

If you apply for a post we will share some of the information you provide with the members of the selection panel for the post to which you apply so that your application form and CV can be assessed to see whether you have the expertise required for the post you have applied. These individuals will usually be identified in the information pack. The monitoring information you provide is not used in the

selection process and will not be shared with the selection panel assessing your application.

Selection panel members acting as our agents will always be instructed to protect your information in line with the requirements of the Appointments Commission Information Security Policy and the Data Protection Act 1998. Where we do need to contact a third party there will be a contract in place to ensure that your personal information is protected.

The Commissioner for Public Appointments regulates and monitors appointments to public bodies to ensure procedures are fair. The Appointments Commission is required by the Commissioner for Public Appointments to retain information about the people who apply for public appointments within his remit, and make this information available to his for audit purposes, if requested to do so. Information you provide in your application may therefore be made available to the Commissioner for Public Appointments and the Commissioner's auditors on a confidential basis in order to help fulfil the Commissioner's formal complaints investigation role and for audit purposes.

Information management

Information that you provide via this website may be used for statistical analysis by the Appointments Commission but it will not be used in a way that enables you to be identified.

The Appointments Commissions Data Protection Policy in relation to the information we collect is set out below:

- We will hold personal details about those who register for a personal online account for a period of up to two years, after which we will ask you if you wish to continue to subscribe
- If you submit an application form, your form and any supporting documentation will be retained for up to two years after the closing date for applications
- Any other information relating to an application held electronically, which includes your contact details and monitoring information you provided, will be held for up to 2 years after the closing date for applications

If at any time you wish your personal information to be removed from our records please contact the Appointments Commission.

Further information about our privacy policy statement is available on our website www.appointments.org.uk/Home/Privacy.

Dealing with your concerns - For queries about your application, please telephone Leslie Horn on 0113 394 6746 or leslie.horn@appointments.org.uk

Once we receive your application

We will process your application as quickly as possible and will keep you informed at key stages. On average it takes around nine weeks from advertisement to appointment.

After the closing date for applications:

- We will rely only the information you provide on your application form and CV to assess whether you have the experience required at the appropriate

level. These criteria are identified in the "Qualities required for the role" section

- The selection panel will be chaired by Gareth Hadley one of our Appointments Commissioners, the other 2 panel members will be, Kaye Burnett and an Independent Public Appointments Assessor
- The panel will have decided the candidates who will be invited for interview, taking account of the evidence provided on your application
- We will write to let you know whether or not you will be interviewed. **Due to the volume of applications we receive, we are unfortunately only able to provide feedback to individuals shortlisted for interview**
- If invited to interview, the panel will question you about your experience and expertise and ask specific questions to find whether you meet the specified competencies
- If, in the view of the panel, you have the skills and experience and have demonstrated the competencies required, and you are the best candidate, you will be recommended for appointment
- The Appointments Commission's Health and Social Care Appointments Committee will consider the interview panel recommendations and make the final decision on the appointment
- If you are successful, you will receive a letter from the Chair of the Appointments Commission inviting you to serve

For queries about your application, please contact Leslie Horn on 0113 394 6746 or leslie.horn@appointments.org.uk.

How to complain

We aim to process all applications as quickly as possible and to treat all applicants with courtesy. If you are unhappy with the way your application has been handled, we would like to hear from you.

Please contact: Anne Watts CBE
Chair
Appointments Commission
Blenheim House
Duncombe Street
Leeds, LS1 4PL

Please quote the reference number on the front of this pack in all correspondence.

We will reply to your complaint within 20 days. If, after receiving our response you are still not satisfied, you may contact the Commissioner for Public Appointments.

The Commissioner for Public Appointments' aim is to ensure that the public appointments within his remit are made on merit after a fair, open and transparent process. One aspect of the Commissioner's role is to investigate complaints about the public appointments processes within his remit.

If you want more information about the Commissioner's complaints policy and the way in which complaints are investigated, please follow the link below to the document "Your Guide to Making a Complaint about a Public Appointments Process".
https://www.publicappointmentscommissioner.org/web-resources/resources/61a5ce86e17.pdf">Your Guide to Making a Complaint about a Public Appointments Process.