Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD MEETING
Wednesday 7th December 2011
9.30 am Room 1, Training & Development Centre,
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 28h September 2011	Dr J Hickey	**1**
	4.	Matters arising	Dr J Hickey	
9.35	5.	Chief Executive's Report	Dr G McSorley	**2**
Clinical Quality & Safety				
9.45	6.	Medical Director's Patient Safety Report/SHMI Update	Dr S Swart	**3**
10.00	7.	Infection Prevention Report	Mrs F Barnes	**4**
10.05	8.	NHSLA Assessment	Mrs F Barnes	**5**
Operational Assurance				
10.10	9.	Performance report	Mrs C Allen	**6**
10.20	10.	Finance report	Mr J Drury	**7**
10.30	11.	HR Report	Mrs A Chown	**8**
Strategic				
10.40	12.	Transformation Programme Update	Mrs C Allen	**9**
10.50	13.	Acute Services Review SEM Phase 1 Completion & Phase 2 Proposals	Dr G McSorley	**10**
10.55	14.	Corporate Objectives Progress Update	Dr G McSorley	**11**
11.00	15.	Any Other Business		
	16.	**Date & time of next meeting** 9.30am Wednesday 29th February 2012, 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 28th September 2011 at 9.30am
Boardroom, Northampton General Hospital

Present:	Dr J Hickey	Chairman
	Dr G McSorley	Chief Executive
	Mr C Abolins	Director of Facilities & Capital Development
	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 J Drury	Director of Finance
	Mr G Kershaw	Associate Non-executive Director
	Mr B Noble	Non-executive Director
	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:	Mrs K Spellman	Head of Planning & Performance
	Ms S Rudd	Company Secretary
	Mr M Essery	Shadow Lead Governor
	Mr F Evans	Shadow Governor
	Mr R Kelso	Shadow Governor
	Mr N Spoors	Chronicle & Echo
Apologies:	Mr C Pallot	Director of Planning & Performance
	Mr D Savage	Shadow Governor

TB 11/12 28 **Declarations of Interest**

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

TB 11/12 29 **Minutes of the meeting held on 29th June 2011**

The minutes of the previous meeting were approved subject to referring to QIPP 'demand management initiatives' in TB 11/12 24, 4th paragraph.

TB 11/12 30 **Chief Executive's Report**

Dr McSorley discussed the next stage of planned Government reform coming into force over the weekend. Three SHA's are coming together in a Cluster and from this weekend the Trust will be in the Midlands and East SHA. The executive team to lead that area are currently being appointed. Sir Neil McKay has been appointed as Chief Executive and will be visiting the Trust on 18th October.

TB 11/12 31 **CQC Registration and Declaration**

Mrs Barnes presented her report providing an update to the work undertaken since the visit by the CQC and the internal confirm and challenge meetings held to monitor ongoing compliance with the sixteen Essential Standards for Quality and Safety.

Eight of sixteen outcomes were reviewed as part of the visit with supporting

information sent to the CQC. The CQC visited 10 wards over 3 days, reviewing outcomes 4, 7 and16.

A minor area of concern was identified for outcome 4 relating to communication with patients who were unable to communicate themselves. The CQC report is included with the papers and actions identified will be monitored through the Healthcare Governance Committee.

Confirm and challenge meetings are undertaken to gain ongoing assurance of compliance with each standard and this process will commence again in November.

Dr Hickey asked about the confirm and challenge meetings and if we feel that they are robust and achieve their objectives. Dr Swart replied that they are an opportunity to review and examine the current position, the meetings have improved but they need to maintain focus.

Mrs Wilkinson commented that the process has been rigorous and worthwhile and from an HR perspective has been a very useful exercise. Mr Robertson agreed that the facilitation has improved. Mr Kershaw noted that he finds them very informative, with good quality of information, depth and analysis.

Mr Drury asked if there are any lessons we can use going forward. Mrs Barnes replied that verbal feedback from the CQC was that our documentation was very good, but recognising earlier points, we need to ensure that there is an understanding of the depth of the standards. There is no doubt that the organisation has undergone a learning process but what we have is on a par with what the CQC would expect.

Mrs Aggarwal-Singh asked about internal processes. Mrs Barnes replied that there are two main processes, confirm and challenge and the Clinical Governance Review Scheme (CGRS). The CGRS is very practical and involves a group of staff who are not familiar with an area looking outcomes in a practical sense, mirroring the CQC inspection process.

The Board **noted** the report and **supported** the ongoing actions.

TB 10/12 32 **Quality and Patient Experience Report**

Mrs Barnes presented her report which provides an overview of some of the quality and patient experience initiatives within the Trust.

A review of progress against High Impact Actions and other work streams took place to identify improvement priorities for Nursing and Midwifery. A number of information sources, both regional and national, were triangulated as part of the review. Five priorities were identified as detailed in the report and the Board will receive quarterly updates on outcomes and progress.

Clinical Governance Review Scheme
The report provides an overview of the outcomes of key areas and allows us to benchmark ourselves and identify actions required. Phase 2 will commence at the end of September and each ward has been prioritised based on the outcome of the phase 1 visits.

Patient Experience Tracker Update
The PET is a handheld device where patients answer 5 key questions and we then use this data to benchmark ourselves against the Department of Health outcomes. New questions are being asked from week commencing 19 September and are

based on the underperforming areas on the National Inpatient Survey 2010.

Mrs Allen asked about the monitoring of progress and Mrs Barnes noted that each action identified has a lead, is monitored through the Nursing and Midwifery Board, confirm and challenge meetings, the clinical governance review schemes and also the Clinical Quality and Effectiveness Group.

Dr Hickey asked if the CGRS visits were taken seriously within the organisation. Mrs Barnes replied that initially there was awkwardness at assessing colleagues but that this has now progressed. The clinical areas themselves have said they have found the process beneficial and helps to give a true understanding of what the standards mean on the 'shop floor'. Dr Hickey if the community wards at Wellingborough and Isebrook were included. Mrs Barnes replied that they were not part of the first phase but will be included in the process that commences in October.

Mr Evans, Shadow Governor, asked if the PET was used on all wards. Mrs Barnes replied that they are used on all wards and that it has been a challenge to standardise the questions and the methodology.

Action: Mrs Barnes to provide an update to the Board on a quarterly basis.

TB 11/12 33 **Infection Prevention Report**

Mrs Barnes presented the monthly infection prevention report. There were no post 48hours MRSA bacteraemia cases in July and August and MRSA colonisation continues to be monitored. There was 1 post 48hours MSSA case in August and a Root Cause Analysis (RCA) has been undertaken, allowing clinicians to review the care provided to understand themes and lessons.

There were 5 cases of clostridium difficile (CDiff) in July and 1 in August. At the time of writing the total cases year to date is 17 and all have a RCA carried out for themes.

Dr Hickey commented that it is important to remember how far this Trust has progressed and shows what can be achieved with focus on infection prevention. It is important however to prevent complacency. Mrs Barnes noted that there are strict processes in place and a very active infection prevention team.

Mr Robertson agreed that the current infection prevention position is an achievement particularly against the background of the increase in activity and complexity of cases.

The Board **noted** the report.

TB 11/12 34 **Infection Prevention Annual Report**

Mrs Barnes presented the report on the work of the infection prevention team on an annual basis. Infection prevention is reported to the Board on a monthly basis however it is helpful to provide a summary of the key initiatives and activities undertaken.

Mr Noble asked how the performance of this Trust compares to others. Mrs Barnes replied that the Healthcare Governance Committee Chairman had asked for benchmarking information which had been provided to the Committee. The Trust is in the upper quartile for both MRSA and CDiff.

Dr Hickey commented on the antimicrobial stewardship and the excellent adherence to policy. Mrs Barnes noted that there is a specialist pharmacist in place

who is very active in the infection prevention group and takes this work forward.

The Board **noted** the annual report.

TB 11/12 35 Medical Director's Patient Safety Report

Dr Swart presented her report on key areas of significance in implementation of the NGH Patient Safety Strategy. The Surviving Sepsis campaign is an important trust wide project to improve recognition and treatment of patients with infection. The campaign came out of the Junior Doctors Safety Board and helps staff to focus on this issue. This is an issue for all Trusts as patients need rapid treatment. A Sepsis Box is now on the wards with everything in them to treat an infective episode. The aim is to reduce the time from identification to antibiotics. There will be an ongoing audit of compliance with the sepsis guidelines and at the end of the campaign the work will then be embedded into normal practice.

The Trust was the Regional Safety Innovation prize winner for this project, led by Jane Bradley. The prize money will allow development of a formal module to be rolled out to other Trusts. Dr Hickey noted that the WRVS helped financially with production of the boxes and recorded the thanks of the Board.

A Patient Safety Booklet has been developed and will be launched within the Trust next week. The leaflet aims to engage patients in understanding what we do and why to ensure their safety. The format is also being used on screensavers on the patient televisions and will hopefully help with communication on the wards about safety issues.

Dr Hickey asked if Dr Swart thought that the information may scare patients. Dr Swart replied that there has been extensive patient input into the content. Mr Evans, shadow governor, commented that the booklet will be very useful for patients who are admitted. Dr Swart noted that the booklet will be available in pre operative assessment and that testing is taking place as to where best to put it so that patients are not overloaded with information.

The Trust has achieved the standard of 90% of patients assessed for prevention of blood clots and we have improved our assessment and paperwork. There is still work to do and a communication campaign is being developed. Patients that develop a blood clot within 3 months of leaving hospital are being reviewed and of the 9 cases that Dr Swart reviewed, all had received a risk assessment and had received appropriate treatment. Focus is now on ensuring we recomplete a risk assessment every time the condition of a patient changes.

Dr Hickey asked about handover and Dr Swart noted that an electronic handover tool has been developed. The tool is being used in some areas so that when handover takes place there is a task list so that the incoming team can see at a glance the tasks that need to be done and whose responsibility they are. The tool is currently used for medical handover but a combined nursing medical tool would be possible. The IT relationship is important and we are also exploring wireless technology that records the whereabouts of patients in the Trust. The technology can also flag up the deteriorating patient based on observations.

Dr Kelso, shadow governor, asked if it is possible to tag wristbands as to where the patient is located. Dr Swart replied that at the moment we are looking at which bay the patient is in. The real time management of where the patient is will be valuable, emergency admissions etc. There is a cost attached and we need to work in partnership with the IT companies.

TB 11/12 36 Annual Security Report

Mr Abolins presented his report on security activities during 2010/11 and noted that overall, incidents remain similar to last year. This is a positive report and there has been a decrease in crime incidents which is encouraging. Staff have taken a responsible attitude to looking after their own assets.

The programme of improving CCTV detection has continued and we continue to liaise closely with the police.

Less positive is the increase in physical assaults on staff and are often due to the types of patients seen with dementia or detoxing etc. They are low level assaults and relate to the conditions of the patients. Conflict resolution training has been undertaken and also the training of staff to manage these patients appropriately. A restraint policy has been developed and is under review.

In November last year there was a serious assault on a qualified nurse and the perpetrator was convicted and is serving time in prison. It is important for staff to know that they are being supported.

Ongoing proactive initiatives are planned for 11/12 as detailed in the report.

Mr Essery asked about the situation with regard to CCTV at Danetre. Mr Abolins replied that we do not have security involvement there, but incidents are now being reported to us.

Mr Evans noted that hospital watch has been re established. Mr Abolins said that this is a mini version of community watch. A group of staff meet on a regular basis to discuss incidents and how they may be mitigated and also to encourage reporting.

The Board **noted** and **supported** the ongoing initiatives.

TB 11/12 37 **MacMillan Scheme Update**

Mr Abolins presented an update as to progress on the development of the Haematology Outpatient department. An artists impression of the build is included in the report. Good progress is being made, the build is a couple of weeks behind schedule but this will not affect the go live date of February next year. The patients will be pleased with facility as will staff and will be a first class function.

Dr Swart commented that she was delighted the project was finally happening. The previous facility was extremely cramped with a high footfall. It was not the right environment for patients and MacMillan is very good at creating the patient environment.

Mr Abolins noted that that funding has exceeded the half way mark and there has been significant support from Chronicle and Echo. Mr Spoors from the Chronicle and Echo announced a 10k run being held on Sunday for the cause and he would appreciate the support

The Board **noted** the progress made.

TB 11/12 38 **Performance Report**

Mrs Allen presented her report noting that in August there were 2 areas of concern.

62 day from urgent referral to start of cancer treatment – 79% of patients were treated with 63 days against the standards of 85%. A small number were not treated within the timeframe, affecting the overall position. The breaches were as a result of complex diagnostic pathways and a plan is now in place to closely monitor

the standard to ensure achievement for quarter 2.

31 day Consultant upgrade for Surgery – the Trust achieved 92.3% against the standard of 94%. Additional tests were required for two patients and were therefore not treated in the time. Each patient is being actively monitored and the standard should be achieved for quarter 2.

A&E standard of 95% of patients to wait a maximum of 4 hours in A&E was achieved. The longest wait for admitted patients was 12 hours and 3 minutes and reflects one patient being stabilised for transfer to Oxford.

Dr McSorley said the comparative factor with other Trusts is important and it would be helpful to see some information. Mrs Allen replied that we are performing comparatively well in relation to our peer group.

Dr Hickey commented that the performance of this Trust is good considering the non elective pressures being seen.

The Board **noted** the report.

TB 11/12 39 **Finance Report**

Mr Drury presented his report noting that the I&E position for August is a deficit of £2,092k compared to a planned position of £1,687k deficit, principally due to the non elective activity and the impact of not being able to fully implement the bed reduction plan. It was noted however that Compton was closed at the end of August.

In August the Trust performed a stock take of the Transformation Programme and reassessed delivery and a reprofile of Trust plan. The stock take showed that the Trust needed to identify additional cost saving of £5m. These have been identified but additional schemes are required for headroom.

There is a risk to achievement of the £0.5m planned surplus but progress is being made on discussions with the SHA and PCT regarding the MRET adjustment. There are also significant numbers of CIP schemes over the coming months that require consultation and the Trust is preparing for that process.

The PDC dividend has been paid and to fund, creditors have been stretched to £3.7m greater than 30 days. However, the Better Payment Practice Code has been maintained on performance by volume, and for value we have maintained non NHS creditors.

Capital expenditure reduction was proposed and we are on track to deliver that. Headcount, if exclude TCS, has reduced by 80WTE by way of vacancy controls. Mrs Allen noted that there is a group that meets weekly and reviews each vacancy with a view to utilising staff within the Trust.

Mr Evans asked about the invoices to Cripps and Mr Drury noted that they have paid £84k in this financial year and are now 3 invoices outstanding.

Dr Kelso asked about non pay costs against plan and the variance. Mr Drury replied that this relates to phasing of the budget and when invoices are received. The variance should even out. Mr Drury noted that the position is monitored carefully through the Finance & Performance Committee.

The Board **noted** the report.

TB 11/12 40 **HR Report**

Ms Wilkinson presented her report noting that short term sickness absence requires focus as is above the Trust target of 1.4%. The HR business partners are working with managers in departments where there are concerns. Long term sickness absence remains below target and in general sickness absence rates have decreased since 2009/10.

Staff turnover has declined which is not surprising in the current climate. Appraisal activity has increased however most appraisals take place in the last quarter of year. We aim to bring this forward and are working with managers to do just that.

Mandatory Training is anticipated to achieve 84.4% of staff trained at year end provided we maintain capacity and run rate.

Board **noted** the report.

TB 11/12 41 **Acute Services Review Update**

Dr Swart presented the report outlining the background to the review and a summary of the ASR programme brief.

Five Acute trusts are participating, Luton/Bedford/Milton Keynes/Northampton/ Kettering. The review is looking at services across the population of 1.8m.

The first phase will end in October with an event that ensures all parties understand the need for change and the specialist services which need to be provided. It will also consider some key specialist services that need to be provided but not on every site. This is a complex piece of work in which we are actively involved and represented at all levels of meetings with good clinical engagement.

It is important we work in partnership with other hospitals and PCTs and we are now at the point where everyone understands that change is needed. Dr Swart commented that to achieve standards we need to cooperate, for example staff working across sites. Specialist units must be accessible to patients across the system and it is difficult to do this in a structured way. There is a significant amount of time and commitment required for the Trust.

Mr Robertson noted that the progress to date has been slow arising from lack of clarity concerning process and the commissioning mandate and asked about accountability. Dr Swart replied that the Commissioners, in conjunction with the providers will set the vision and expectations for acute service provision and the programme is managed through a programme management board made up of accountable officers from the participating organisations . Delivery dates have been reframed and Dr McSorley said that part of the delay is to generate a better understanding of what the Commissioners will feed into the process.

Mr Zeidler said that we would all share Mr Robertson's concern and asked if we are clear as a Trust what we need to do to protect the services of the Trust and build the appropriate relationships. Dr McSorley replied that throughout phase 1 there has been engagement but we are also very clear that the challenge is the focus on a better outcome for patients. At beginning of the process colleagues were in different SHAs and now there is only one SHA. Sir Neil McKay is taking a particular interest in this issue and there is growing clarity that people want to see these five trusts working closely together. Quarterly updates or more frequently if required will be provided to the Board.

The Board **noted** the report.

Action: Quarterly update on ASR progress

TB 11/12 42 **Recruitment of Chair**

Dr Hickey noted that he has decided not to apply for a second term as Chairman of the Trust when his current term expires on 31 October 2011. Due to increasing outside commitments he is no longer able to devote the time required to the role. The position is being advertised by the Appointments Commission and Dr Hickey has agreed to extend his commitment to the end of December when a new appointment should have been made.

TB 11/12 43 **Any Other Business**

There being no further business the meeting was declared closed.

Date and Time of Next Meeting

Wednesday, 7th December 2011, Room 1 Training & Development Centre

Actions arising

TB 11/11 26	Note quarterly agenda item for corporate objectives	SR	November 2011
TB 11/11 32	Nursing & Midwifery priorties update to the Board on a quarterly basis.	FB	February 2012
TB 11/11 41	Acute Services Review quarterly update to Board	GM	February 2012

BOARD SUMMARY SHEET	
Title	Chief Executive's Report
Submitted by	Dr Gerry McSorley – Chief Executive
Date of meeting	7th December 2011
Corporate Objectives Addressed	
SUMMARY OF CRITICAL POINTS	
PATIENT IMPACT	
STAFF IMPACT	
FINANCIAL IMPACT	
EQUALITY AND DIVERSITY IMPACT	
LEGAL IMPLICATIONS	
RISK ASSESSMENT	
RECOMMENDATION The Board is asked to note the report.	

Operating Framework for the NHS 2012/13

The Government has published the Operating Framework for the NHS in 2012/13. Hard copies will be available for the meeting. It is important to note that this document needs to be seen alongside the technical guidance note, as yet unpublished, but which may have significant implications for how the Operating Framework is implemented. The technical guidance should be published by Christmas.

Performance monitoring by the new SHA

As the new SHA comes into effect it has been announced that all non Foundation provider Trusts will be subject to a similar performance management regime by the SHA as Monitor undertakes for FTs. We are awaiting the detail of this but it is likely that the Board will be required to self-certify the Trust's performance on a range of issues on a monthly basis. If performance is not within acceptable ranges then an escalation process will be invoked. This will match the Monitor framework for FTs.

Acute services Review

Papers later on the agenda bring the Board up to date on the current position on this topic.

BOARD SUMMARY SHEET	
Title	Medical Director's Patient Safety Report - HSMR update
Submitted by	Dr S Swart
Prepared by	Dr K N Robinson and Dr S Swart
Date of meeting	7th December 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

Progress has been made in various clinical and non-clinical areas to ensure that information is accurate, and clinical concerns are addressed.

PATIENT IMPACT

High quality care for patients remains a priority. Patients will be able to view quality indicators in the public domain and commissioners will increasingly commission on the basis of quality.

STAFF IMPACT

There is a risk of poor staff morale relating to failure to deliver high quality care and poor record keeping and coding will only accentuate this problem and make it difficult to ensure that staff understand exactly what their role in improving care is.

FINANCIAL IMPACT

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

LEGAL IMPLICATIONS

Trust Boards are mandated to examine quality across a range of services and failure to provide requisite quality standards will result in the risk of litigation.

RECOMMENDATION

Board members are asked to note the contents of this report and debate the issues raised and consider whether sufficient emphasis and resource is in place to ensure the required improvement in standards. They are also asked to continue to support the work required to improve documentation and clinical coding and to support clinical audit as required to examine all issues of concern.

Mortality, HSMR and Clinical Coding Review Project 2011 - 12 and Review of Current Mortality and Safety Data provided by Dr Foster

Introduction

This paper is a follow up to that submitted to the Board on 26th October 2011 and focuses specifically on areas noted to be at risk that were highlighted for action.

Since the last Board meeting there has been a significant amount of progress in agreeing the key areas of focus for mortality reviews. There has also been progress towards a more structured review process for data relating to both clinical coding and clinical care with improved partnership working arrangements agreed between clinicians, coders, information analysts and Dr Foster information systems.

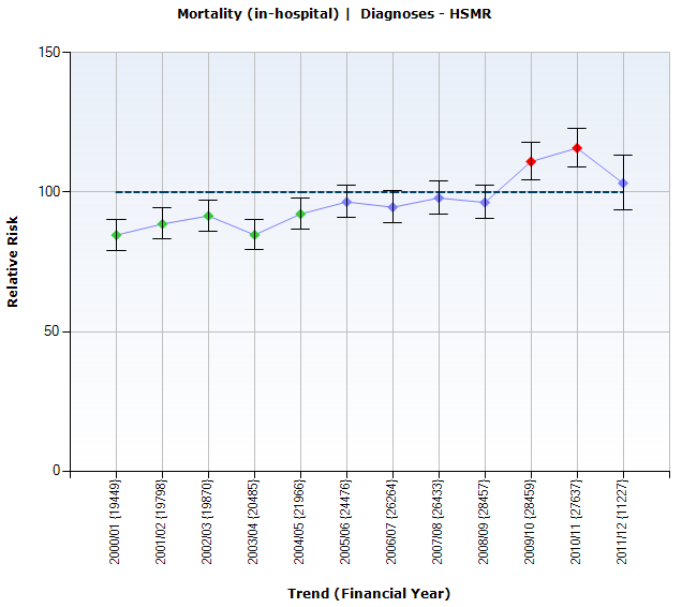
This has been put in place to supplement the regular scrutiny of mortality data which has been going on for many years.

The Board should note the considerable investment of clinical time required to ensure that appropriate attention is given to investigation of mortality concerns.

This issue remains of key reputational importance for the Trust.

HSMR [NGH]

Trend (Financial Year)	Spells	Superspells	% of all	Deaths	%	Expected	%	RR	Low	High
ALL	275329	274521	100.0 %	11658	4.2 %	12201.9	4.4 %	95.5	93.8	97.3
2000/01	19508	19449	7.1 %	904	4.6 %	1068.1	5.5 %	84.6	79.2	90.3
2001/02	19868	19798	7.2 %	981	5.0 %	1107.2	5.6 %	88.6	83.1	94.3
2002/03	19949	19870	7.2 %	1020	5.1 %	1114.8	5.6 %	91.5	86.0	97.3
2003/04	20557	20485	7.5 %	973	4.7 %	1148.9	5.6 %	84.7	79.5	90.2
2004/05	22039	21966	8.0 %	1060	4.8 %	1149.8	5.2 %	92.2	86.7	97.9
2005/06	24541	24476	8.9 %	1069	4.4 %	1107.4	4.5 %	96.5	90.8	102.5
2006/07	26319	26264	9.6 %	1014	3.9 %	1071.6	4.1 %	94.6	88.9	100.6
2007/08	26522	26433	9.6 %	1032	3.9 %	1053.8	4.0 %	97.9	92.1	104.1
2008/09	28529	28457	10.4 %	1039	3.7 %	1078.7	3.8 %	96.3	90.6	102.4
2009/10	28525	28459	10.4 %	1072	3.8 %	965.8	3.4 %	111.0	104.4	117.8
2010/11	27695	27637	10.1 %	1056	3.8 %	911.6	3.3 %	115.8	109.0	123.0
2011/12	11277	11227	4.1 %	438	3.9 %	424.2	3.8 %	103.3	93.8	113.4



Current Position NGH

HSMR for 2011-12 [data to end August 2011] has reduced slightly since the previous month [**103.8** to **103.3**]. If this were rebased as per Dr Foster methodology the number would be around 110 for the period from April 2011 – August 2011 which represents an improving position from that reported for the year end 2010 - 11 which has been reported in the Dr Foster Good Hospital Guide at 116.

It has been agreed that every week al deaths in the preceding week will be reviewed by Dr Robinson and Dr Swart with a team of senior coders to ensure that coded information is accurate and comprehensive. This process has started and a standard operating procedure is being agreed. Case notes will then be subject to a review of care using a detailed and structured audit tool. This is currently under development and it is intended that a multidisciplinary team of consultants will be trained to use this and produce composite data which will measure standards of care objectively. Where care management problems are identified these will be fed back to the relevant consultant in charge of the case. All consultants will in any case receive feedback on the death of any patient under their care. A weekly challenge meeting will be set up to share learning and discuss issues. The methodology for this is likely to evolve but will include principles such as those adopted by the National Confidential Enquiry system which Dr Robinson is very familiar with.

There has been significant buy in to the process by coders and from consultant volunteers from a wide range of specialities. This is a measure of the degree of clinical engagement with this very important issue

The impact of the community hospitals [offering palliative and end-of-life care, and also rehabilitation] which have recently become part of the acute trust has yet to become clear. It is likely that a specific process will be required to ensure that all the issues relating to coding at these sites has a specific lead and focus.

Table 2 - NGH compared to other Hospitals in the East Midlands [HSMR]

Peer (SHA)	Spells	Superspells	% of all	Deaths	%	Expected	%	RR	Low	High
ALL	343229	334815	100.0 %	14772	4.4 %	14125.0	4.2 %	104.6	102.9	106.3
University Hospitals Of Leicester NHS Trust	70025	68651	20.5 %	2668	3.9 %	2650.5	3.9 %	100.7	96.9	104.6
Nottingham University Hospitals NHS Trust	68806	66531	19.9 %	2727	4.1 %	2771.2	4.2 %	98.4	94.7	102.2
United Lincolnshire Hospitals NHS Trust	54341	54067	16.1 %	2539	4.7 %	2236.1	4.1 %	113.5	109.2	118.1
Derby Hospitals NHS Foundation Trust	43969	43677	13.0 %	1817	4.2 %	1806.9	4.1 %	100.6	96.0	105.3
Northampton General Hospital NHS Trust	27239	27080	8.1 %	1082	4.0 %	966.8	3.6 %	111.9	105.3	118.8
Kettering General Hospital NHS Foundation Trust	23941	23787	7.1 %	1016	4.3 %	1004.0	4.2 %	101.2	95.1	107.6
Sherwood Forest Hospitals NHS Foundation Trust	22570	22302	6.7 %	1169	5.2 %	1075.0	4.8 %	108.7	102.6	115.2
Chesterfield Royal Hospital NHS Foundation Trust	21902	21647	6.5 %	1110	5.1 %	1021.8	4.7 %	108.6	102.3	115.2

Although the rolling year HSMR to end August remains significantly high, it is no longer the highest in the SHA, having fallen substantially from **116** to **111.9.**

Areas for action

At present the key areas of concern are as follows:

1. Respiratory tract illnesses:

Review of patients with ***aspiration*** **pneumonia** has revealed significant coding anomalies which are being addressed with the coding department. There were no significant causes for concern regarding clinical care.

An alert from CQC concerning mortality rates amongst **elderly patients with pneumonia** is being addressed through audit of 30 cases who died in the year to August 2011. [Dr KN Robinson and Dr L Jameson]. Information to date suggests that coding is correct. The full report is awaited and will be reported to the CQC in December.

A review using 'process mapping' of selected patients with pneumonia is being undertaken by Dr J Wilkinson, Consultant Intensivist. Dr Wilkinson and Jane Bradley have also developed 2 tools to assist in the management of these patients. Firstly a poster and diagnosis pathway clarifying the diagnostic criteria for the different types of pneumonia has been produced (**Appendix 1A & B)** and will be displayed on the wards. Secondly a Pneumonia Care Bundle sticker to ensure a standardised treatment of pneumonia and for use as an audit tool has been agreed and is now ready for use (**Appendix 2**)

Respiratory physicians are addressing the documentation in the medical notes to ensure that pneumonia diagnoses are appropriately described. This has been led by Dr Andrew Jeffrey as the senior respiratory physician who provided input to the pneumonia poster and who has worked with Jane Bradley to pilot a ward round checklist sticker which will come into use from end of November. This will formally focus medical staff on ensuring that a working diagnosis is entered in the notes (**Appendix 3**).

Additional support in confirming accurate diagnosis is being provided by radiology and microbiology.

Improving care of all patients with infective conditions ['sepsis'] is being addressed through a series of Trustwide projects involving staff of all disciplines and grades.

CHKS are assisting with detailed data analysis and identification of unusual variation in casemix.

2. Cardiac diseases:

A review of coding and care of patients who died with a diagnosis of with **acute myocardial infarction** is being led by Dr Jon Timperley, Consultant Cardiologist. SMR for the rolling year is **127.4** [**111.7** for 2011-12]. MINAP process and outcome data for NGH suggests that the management of MI at NGH is good.

Further analysis, by the Heart Failure team led by Dr David Sprigings, of patients who die following admission with **heart failure** has identified significant coding anomalies to be addressed with coding dept, which is likely to reduce the SMR to below statistical significance. Analysis with support from Dr Foster has identified a low number of admissions with this diagnosis [Table 3]. East Midlands SHA data also shows that Northamptonshire has the lowest mortality from HF in the SHA. It is therefore possible that the strong community heart failure service is reducing avoidable admissions and that the casemix of those admitted with heart failure is skewed in severity, explaining the high mortality. Further work will be required to ensure that data regarding community services and overall mortality for the population is adequately captured.

Review of care of all deaths from Heart Failure will also be undertaken to provide assurance that poor care is not contributing to the raised SMR

Table 3 - NGH compared to other Hospitals in the East Midlands [Heart Failure]

Peer (SHA)	Spells	Superspells	% of all	Deaths	%	Expected	%	RR	Low	High
ALL	5037	4937	100.0 %	780	15.8 %	746.8	15.1 %	104.4	97.2	112.0
University Hospitals Of Leicester NHS Trust	1191	1180	23.9 %	175	14.8 %	189.9	16.1 %	92.2	79.0	106.9
United Lincolnshire Hospitals NHS Trust	856	852	17.3 %	137	16.1 %	124.9	14.7 %	109.7	92.1	129.7
Nottingham University Hospitals NHS Trust	848	827	16.8 %	114	13.8 %	122.4	14.8 %	93.2	76.9	111.9
Derby Hospitals NHS Foundation Trust	564	559	11.3 %	94	16.8 %	86.6	15.5 %	108.6	87.8	132.9
Sherwood Forest Hospitals NHS Foundation Trust	425	422	8.5 %	65	15.4 %	59.3	14.1 %	109.6	84.6	139.7
Kettering General Hospital NHS Foundation Trust	334	334	6.8 %	49	14.7 %	41.3	12.4 %	118.6	87.7	156.8
Chesterfield Royal Hospital NHS Foundation Trust	312	307	6.2 %	49	16.0 %	43.1	14.0 %	113.6	84.1	150.2
Northampton General Hospital NHS Trust	292	289	5.9 %	60	20.8 %	40.0	13.8 %	150.1	114.6	193.2

3. Hip fracture

A multidisciplinary audit of all deaths following admission with hip fracture in 2011 is underway and an interim report is now available for April-Sept 2011, as planned following an CQC mortality alert concerning patients with this condition. Concerns have been identified in 2 areas: availability of specialist medical support ['orthogeriatrics'] and involvement of senior T&O surgeons in perioperative care. An action plan is under development, and a detailed prospective audit of all such cases is ongoing and will be presented at a meeting led by the Medical Director and Director of Patient & Nursing Services. Clinicians are being supported by Dr Foster in reviewing their data.

Currently poor data quality for 2011-12 prevents the accurate calculation of mortality in this diagnosis group, but it is likely that mortality is falling.

4. Specialist services: stroke and renal failure

The stroke team continue to review all deaths to confirm coding accuracy and review standards of care. SMR [rolling year] is currently **105.8** [**101.9** 2011-12].

A review of deaths from patients admitted with renal failure has been received from Dr Pickering and an action plan is awaited. SMR [rolling year] is **126.7** [**140.4** 2011-12]

Summary of progress so far

All diagnoses of concern have now been subject to scrutiny by specialists in that area. Information translation problems [medical notes and coding] have been found in all areas. Work is underway to rectify this, through engagement between coders and clinicians and initiatives to improve the clarity of the notes.

Simultaneous review of care has been undertaken in all areas, and concerns have been identified in the management of elderly patients with pneumonia and hip fractures.

Understanding high hospital mortality rates from cardiac disease is more complex in the presence of independent information which suggests that outcomes in the whole health economy are within the normal range - or better. There may be similar issues with respect to mortality from Chronic Obstructive Pulmonary Disease where we have an effective community team preventing all but the most serious admissions. Contacts with the East Midlands Quality Observatory have been made to look at this issue.

Mortality from stroke is improving but should be routinely monitored in view of the acute stroke service.

Mortality from acute renal failure requires further examination.

The Trust is fortunate to have agreed some further assistance from an international expert in patient safety who will be working with us in a workshop environment in early December to help to energise key clinical and managerial staff to assist in the very challenging work required to resolve our issues relating to Hospital Standardised Mortality Ratios.

Dr K N Robinson – Associate Medical Director, Clinical Governance

Dr Sonia Swart – Medical Director

Appendices:-

1. A - Pneumonia Diagnosis Poster

   B – Diagnosis Pathway

2. Pneumonia Care Bundle Sticker
3. Ward Round Checklist Sticker

APPENDIX – 1 A - Poster

LRTI

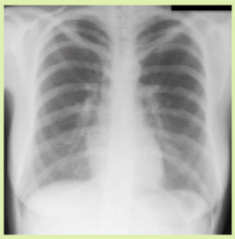
Getting the diagnosis right

There are fairly precise criteria that distinguish acute bronchitis from broncho-pneumonia and lobar pneumonia. They matter.
Acute-bronchitis is very common in the community but relatively rare in hospital. It does not cause death
Lobar pneumonia is the least common and carries a **14% predicted mortality**. It often occurs in otherwise fit young people.
Broncho-pneumonia is common and carries a **58% predicted mortality**, mostly because it is associated with debilitation from other diseases.

Please record the right diagnosis! ***Place a pneumonia care bundle sticker in the notes***

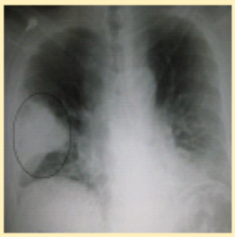
Acute-bronchitis

Cough with purulent sputum, frequently expiratory crackles and a **normal chest Xray.**



Lobar Pneumonia

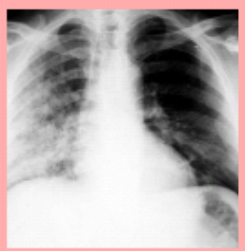
Cough, fever, possible delirium, bronchial breathing and possible expiratory crackles. Sputum production is unusual in the early stages. Elevated or suppressed WBC. **Confluent consolidation on chest Xray (or CT) involving at least one whole lung segment.** (remember to check behind the heart shadow)



Mortality 14%

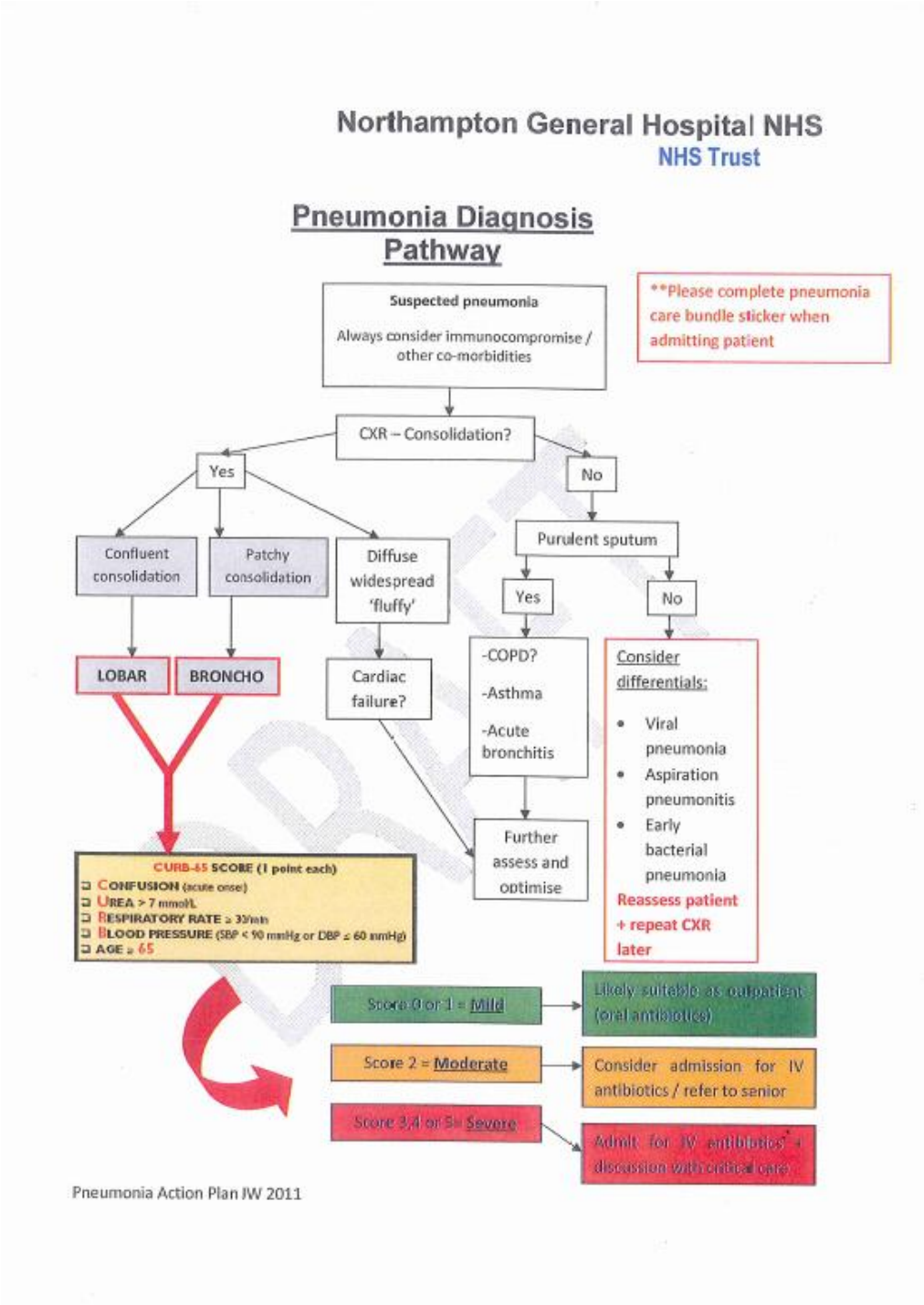
Broncho-pneumonia

Cough, purulent sputum and expiratory crackles. Should have systemic evidence of infection – e.g. raised WBC and usually fever.
Patchy consolidation on chest Xray.



Mortality 58%

APPENDIX 1 B – Diagnosis Pathway



APPENDIX 2 – Pneumonia Care Bundle

Pneumonia Care Bundle

1. Working diagnosis		Broncho ☐ Lobar ☐ Acute bronchitis ☐
2. Clinical evidence for pneumonia		Cough ☐ ↑WCC ☐ Purulent sputum ☐ Fever ☐ CRP ☐ Clinical signs ☐
3. CURB-65 pneumonia score		Mortality implication / Management
Confusion	☐ YES +1	0-1 Low risk: consider outpatient treatment / oral antibiotics.
Urea>19mg/dL	☐ YES +1	2 Moderate risk: consider inpatient treatment or as outpatient with close follow up. Discuss with a senior clinician.
RR >30	☐ YES +1	3 Severe risk: admit, discuss with senior clinician + consider critical care review.
Systolic BP <90 or Diastolic ≤60	☐ YES +1	4 or 5 Highest risk: admit patient, discussion with a senior clinician + critical care review / HDU or ITU admission.
Age >65	☐ YES +1	
CURB-65 Score ➡	☐	
Time .... :		
4. Appropriate antibiotics administered within 1 hour of CURB-65		☐
5. Gas exchange – take ABG, record result and prescribe desired oxygen concentration		
O_2 saturation .....% On air ☐ On O_2 ☐ PaO_2 ..... $PaCO_2$ ..... Target O_2 saturation 88-92% ☐ 94-98% ☐		
6. MANAGEMENT PLAN	Level of review needed	Observation frequency needed
EWS ➡ ☐	Critical care outreach requested ☐	4 hourly obs ☐
Follow hospital escalation policy as per EWS. Senior review of all patients scoring 3 or more.	ST3 or above review request ☐	2 hourly obs ☐
	Consultant review request ☐	1 hourly obs ☐
	ITU review requested ☐	HDU / ITU admission ☐
Time .... : .... GMC No:	** 2 or more SIRS criteria? ➡ Trigger sepsis box and complete 'sepsis 6' ☐	

Affix Addressograph Here

Signed .....

GMC: .....

Ward .....

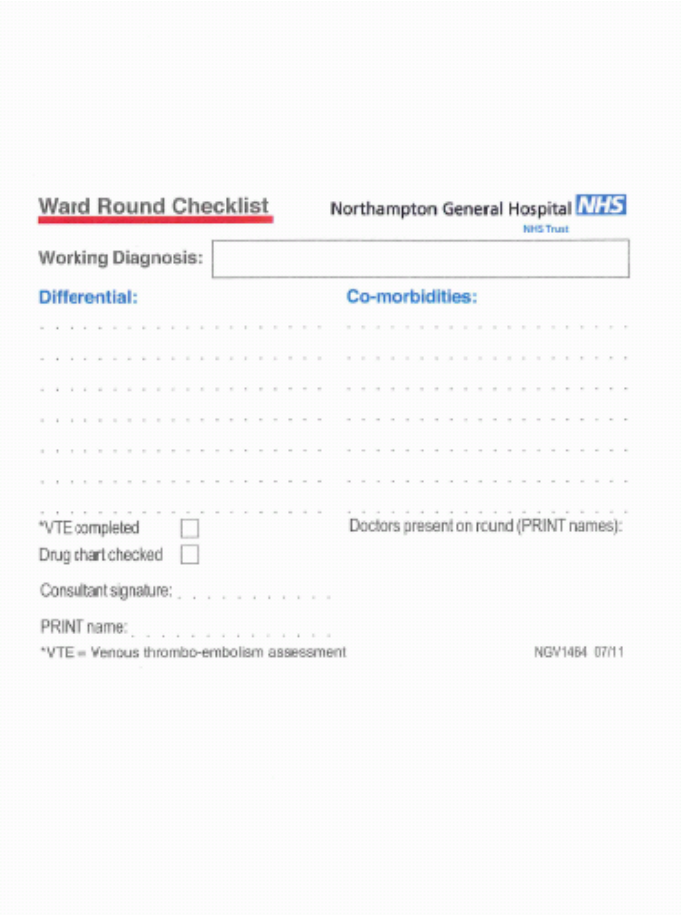
Time .....

Remove this care bundle sticker, place in notes and retain back section for audit purposes

NGV1525

Northampton General Hospital NHS
NHS Trust

APPENDIX 3 – Ward Round Checklist Sticker



Ward Round Checklist

Northampton General Hospital NHS
NHS Trust

Working Diagnosis:

Differential:

Co-morbidities:

*VTE completed ☐

Drug chart checked ☐

Doctors present on round (PRINT names):

Consultant signature:

PRINT name:

*VTE = Venous thrombo-embolism assessment

NGV1464 07/11

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	7 December 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.

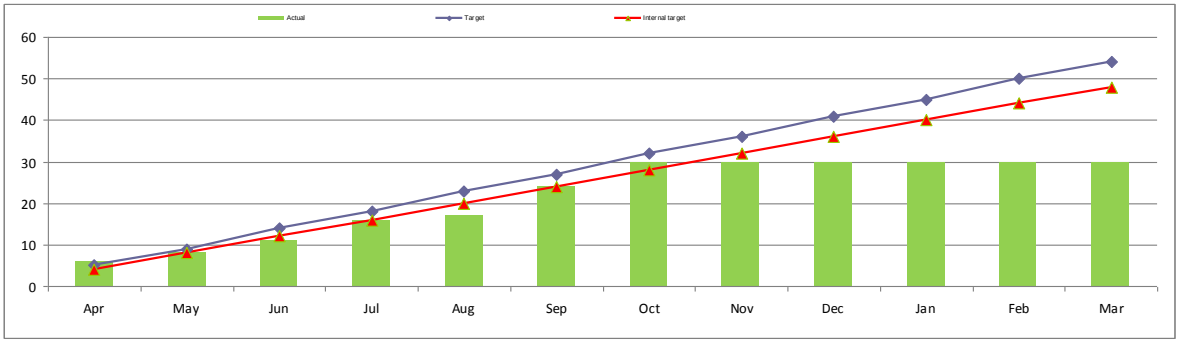
MRSA Bacteraemia (Appendix 1)
The Trusts trajectory for MRSA bacteraemia in 2011/12 is 3 cases. In October there were no >48hrs MRSA bacteraemia.

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 year to date are 0.08/10,000 bed days.

MRSA Colonisation (Appendix 2)
During October there were 10 <48hrs and 4 >48hrs cases of MRSA colonisation. Internal patient verified data identifies 99.4% compliance for the screening of elective admissions during October. The compliance rate for emergency screening was 97.3% in October.

MSSA Bacteraemia (Meticillin Sensitive *Staphylococcus Aureus*)
During October there were 3 cases <48hrs and 1 case >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 October the Trust identified 3<3 day and 6>3 day cases of C. diff. which equates to a cumulative of .24/1,000 bed day's year to date. The graph below shows that the Trust is just over its month 7 stretch target but within our trajectory.



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 from June 2011. There is still a great deal to learn about the epidemiology, antibiotic resistance patterns and risk factors for these organisms. In October there were 5 cases <48 hrs and 3 cases >48hrs E. coli bacteraemia. The rates remain the same with the majority originating from the community.

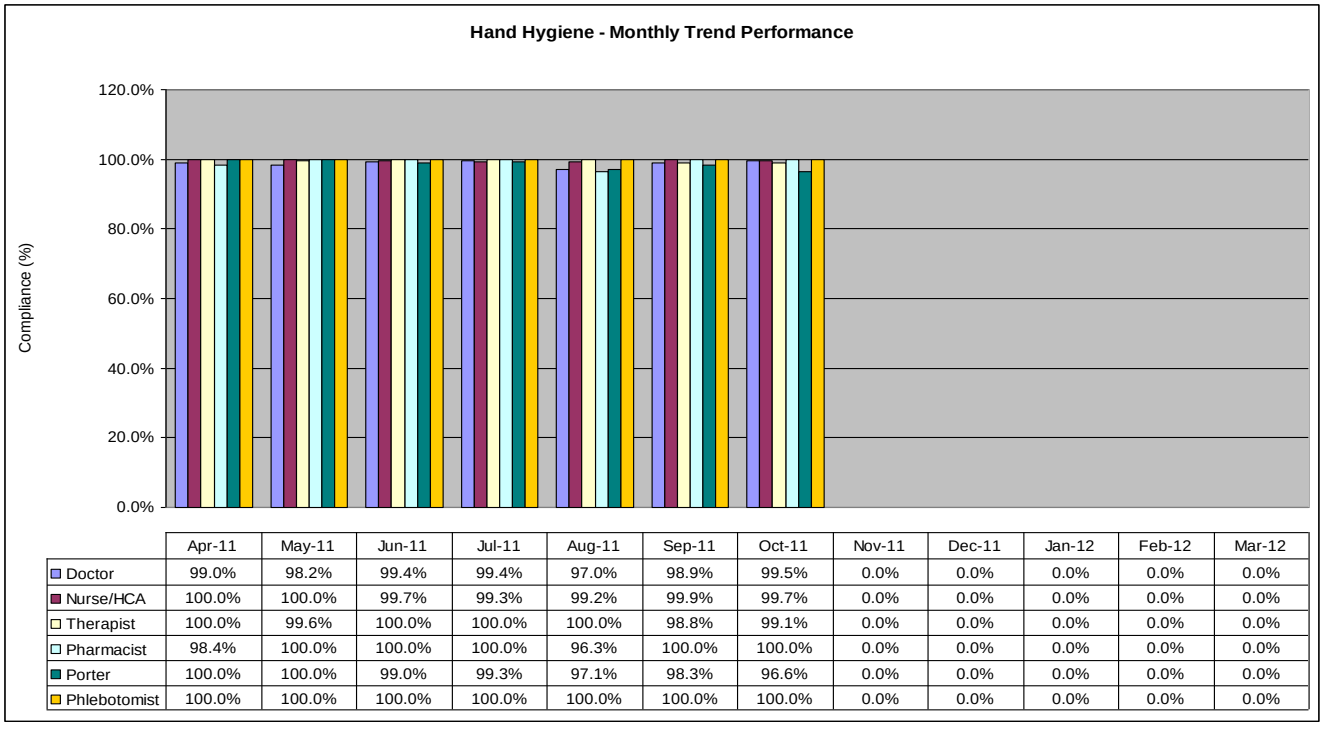
Surgical Site Infection Surveillance Scheme (SSIS)
The Trust takes part in national surgical site surveillance scheme of over 150 hospitals in England so that it can measure the rates of surgical wound infection and be sure that patients are given the highest possible standard of care. The national programme is coordinated by the Health Protection Agency (HPA).

Background
The national Surgical Site Infection Surveillance programme is continuing to audit this category throughout the year and reports are generated quarterly.

Current October Results to date
Interim results for October only are:

- Out of the 32 operations to open reduction of internal fixation for long bones (ORIF) there were no infections.
- There was 1 infection resulting from 24 operations to repair #NOF's.

Hand Hygiene Audit
Information from the Hand Hygiene Observational Tool (HHOT) shows that in October the overall compliance for hand hygiene was 99.3%.



	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%	98.9%	99.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Nurse/HCA	100.0%	100.0%	99.7%	99.3%	99.2%	99.9%	99.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Therapist	100.0%	99.6%	100.0%	100.0%	100.0%	98.8%	99.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Pharmacist	98.4%	100.0%	100.0%	100.0%	96.3%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Porter	100.0%	100.0%	99.0%	99.3%	97.1%	98.3%	96.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Phlebotomist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Recommendation

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

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

Appendix 1 **MRSA Bacteraemia Incidence by Ward**

MRSA Bact	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		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
Finedon																									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												1
Willow				1			2																		3
Collingtree																									0
ITU	1								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		1														2
Gossett																									0
Disney																									0
Paddington	1		2										1												3
Balmoral										1															1
Robert Watson																									0
Sandringham																									0
Spencer	1																								1
Sturtridge																									0
Allebone	5		6		7		4		9		7		4												31
Benham																									0
Creaton		5				1	1			1				1											8
Dryden						1			2																3
EAU	10		4		6	1	5		6		10		2												32
Eleanor						1			2	1	1														4
Victoria																									0
Hazelwood (Community)														1											0
Danetre (Community)														1											0
Corby (Community)																									0
Rowan	1		2				1																		4
Finedon		1											1												1
Compton						2																			2
Brampton						2								1											2
Holcot																									0
Althorp																									0
Talbot Butler	1						1																		2
Trust Total 2011-12	20	7	16	2	14	9	15	1	22	4	19	0	10	4	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				1	1												4
Willow							1			1		1													2
Collingtree																									0
ITU												1													0
HDU							1							1											1
A & E																									0
Abington								1				1													2
Cedar																									0
Becket																									0
SingleHurst																									0
Knightley														1											1
Gossett																									0
Disney																									0
Paddington																									0
Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer			1			1																			1
Sturtridge																									0
Allebone			1								3		1												0
Benham		1										1		1											3
Creaton		1		1										1											3
Dryden																									0
EAU	2				1	1					3		1												1
Eleanor																									0
Victoria		1																							1
Hazelwood (Community)								1																	1
Danetre (Community)														1											1
Corby (Community)																									0
Rowan		1												1											2
Finedon				1																					1
Compton								2																	2
Brampton																									0
Holcot												1													1
Althorp						1																			1
Talbot Butler							1					1													1
Trust Total 2011-12	2	6	2	2	1	3	3	5	0	1	6	7	3	6	0	0	0	0	0	0	0	0	0	0	30

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title	NHS Litigation Authority (NHSLA) Risk Management Standards – Level 1 Assessment
Submitted by	Fiona Barnes, Interim Director of Nursing
Prepared by	Keren Salt, Quality Assurance Manager (Interim)
Date of meeting	7 December 2011
Corporate Objectives Addressed	Compliance with NHSLA Risk Management Standards.

SUMMARY OF CRITICAL POINTS

This report provides the Trust Board with details of the Trust's recent NHSLA Risk Management Standards Level 1 Assessment which was undertaken on 10 and 11 November 2011.

PATIENT IMPACT

High quality care for patients remains a priority. Patients can view the NHSLA assessment report on the NHSLA website once it has been published.

STAFF IMPACT

Staff morale is key to the success of the organisation, achievement of a level 1 assessment is a positive outcome which in turn positively affects staff.

FINANCIAL IMPACT

The achievement of Level 1 of the NHSLA's Risk Management standards improves the Trust's governance ratings with CQC and provides a 10% discount (approx. £100,000) on our NHSLA contributions.

LEGAL IMPLICATIONS

The Trust Board is mandated to examine quality across a range of services and failure to achieve requisite quality standards could heighten the risk of litigation.

RECOMMENDATION

The Trust Board is asked to note the content of this report and support the actions identified in 'next steps'.

1.0 Introduction

The Trust was recently successful at achieving Level 1 of the NHS Litigation Authority (NHSLA) Risk Management Standards 2011/12. This report provides the Trust Board with an overview of that assessment.

2.0 Summary

Organisation assessed	Northampton General Hospital NHS Trust
Services assessed	All services
Date of last assessment	12th November 2009
Assessment date	10th November and 11th November 2011
Date next assessment due	7th November 2013
Standards assessed	*NHSLA Risk Management Standards for NHS Trusts Providing Acute Services 2011*
Level prior to assessment	Level 1
Level applied for	Level 1
Level achieved	Level 1
Discount awarded	10%

The organisation was assessed against five standards each containing ten criteria giving a total of 50 criteria. In order to gain compliance at Level 1 the organisation was required to pass at least 40 of these criteria, with a minimum of seven criteria being passed in each individual standard. The organisation scored as follows:

Governance	10/10 Compliant
Competent & Capable Workforce	10/10 Compliant
Safe Environment	9/10 Compliant
Clinical Care	10/10 Compliant
Learning from Experience	10/10 Compliant

OVERALL COMPLIANCE 49/50 Compliant

Detailed scores from the Assessor have been provided to the Trust corresponding to the evidence that was reviewed as part of the assessment to demonstrate Level 1 compliance.

Prior to formal assessment the organisation was encouraged to conduct a self assessment. The organisation's self-assessment results are depicted below and plotted against the actual assessment results.

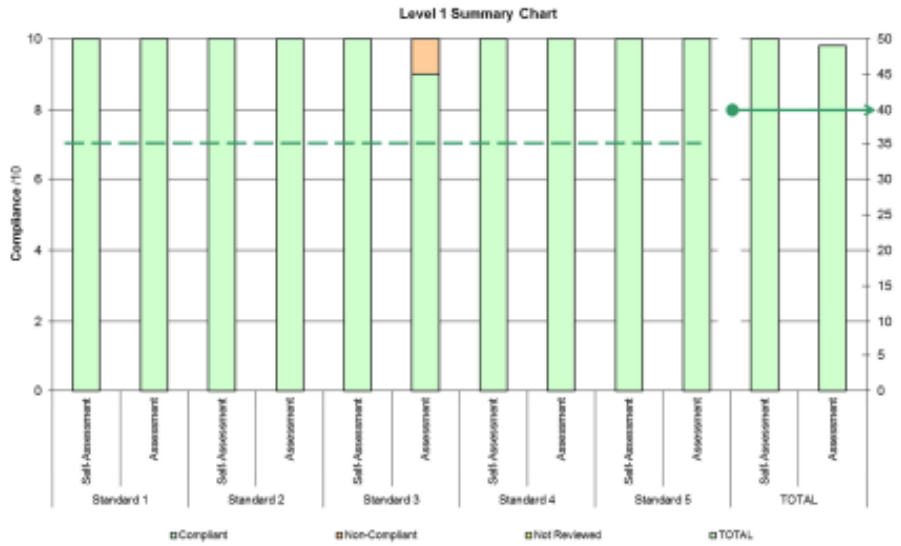


Chart 1: Comparison of the organisation's self-assessment to actual assessment outcome

The one area in which the Trust did not receive compliance was the *Security of Premises and Assets Policy* (version 5.7, October 2010) which did not reflect in policy the current working arrangements. Staff were able to verbalise the process. The policy has now been amended and re-published.

Other areas for improvement were identified within the report and these will be addressed through the implementation of the action plan to take the organisation to level 2.

3.0 Next Steps

The full NHSLA report details the further steps the Trust now needs to take to enhance compliance to the Level 1 requirements, these will inform the action planning for level 2.

A feedback session will be provided to all relevant staff to inform them of the results.

A task and finish group will be established to drive the organisation forward to achieving a level 2.

It is the Trust's intention to improve its NHSLA rating to a level 2. This can only be achieved once measureable standards have been put in place in all of the associated policies and monitored for a minimum of 12 months. It is therefore suggested that the earliest the Trust could undergo a level 2 assessment would be February 2013.

4.0 Monitoring Arrangements

Trust Board can be assured that the Clinical Quality and Effectiveness group (CQEG) will receive quarterly reports on the Trust's progress in preparation for a level 2 assessment.

5.0 Recommendation

The Trust Board is asked to note the content of this report and support the actions identified in 'next steps'.

TRUST BOARD SUMMARY SHEET	
Title: -	Performance Report
Submitted by: -	Christine Allen - Director of Operations
Date of meeting: -	7th December 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 7 **(October 2011)**.

The Trust achieved all the minimum performance standards for October 2011, with the exception of:

- 62 day from urgent referral to start of cancer treatment
- 4 hour transit time in A&E

PATIENT IMPACT: -

Patients waiting over the maximum waiting times

STAFF IMPACT: -

Greater pressure on staffing as activity has increased

FINANCIAL IMPACT: -

N/A

RISK ASSESSMENT: -

N/A

EQUALITY & DIVERSITY IMPACT ASSESSMENT: -

N/A

RECOMMENDATION: -

Trust Board is asked to discuss the contents of this report.

PERFORMANCE REPORT – OCTOBER 2011

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for **Month 7** (October 2011). The report is based on the NHS Performance Framework - Service Performance Standards and Targets.

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

2. SERVICE PERFORMANCE

Indicator	Monthly Target	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	YTD	Monthly Delivery	YTD Delivery
RTT waits (95th percentile measures)											
- *admitted 95th percentile*	23 Weeks								na		
- *non-admitted 95th percentile*	18.3 Weeks								na		
- *incomplete 95th percentile*	28 Weeks								na		
RTT (Median wait measures)											
- *admitted median wait time*	11.1 Weeks								na		
- *non-admitted median wait time*	6.6 Weeks								na		
- *Incomplete median wait time*	7.2 Weeks								na		
Percentage of Patients seen within 18 weeks across all speciality groups											
Admitted	90%								na		
Non-admitted	95%								na		
Percentage of Patients seen within 18 weeks for direct access audiology treatment	90%								na		
A & E quality indicators											
4 hour maximum wait in A&E from arrival to admission, transfer or discharge	95%										
- *unplanned re-attendance rate*	>1% and <5%								na		
- *total time spent in A & E (Admitted Patients)*	95th Percentile=<4 Hrs								na		
	Longest Wait =<6 Hrs								na		
- *total time spent in A & E (Non-Admitted Patients)*	95th Percentile=<4 Hrs								na		
	Longest Wait =<6 Hrs								na		
- *left department without being seen*	=<5%								na		
- *time to initial assessment (95th percentile < 15mins)*	=<15mins								na		
- *time to initial assessment (100% < 20mins)*	100%								na		
- *time to treatment in department (median)*	=<1 Hrs								na		
Number of diagnostic waits > 6 weeks	0								0		
Cancer Wait Times											
2 week GP referral to 1st outpatient	93%								95.55%		
2 week GP referral to 1st outpatient - breast symptoms	93%								96.67%		
31 Day	96%								98.66%		
31 day second or subsequent treatment - surgery	94%								98.51%		
31 day second or subsequent treatment - drug	98%								99.57%		
31 day second or subsequent treatment - radiotherapy	94%								97.61%		
62 day referral to treatment from screening	85%								95.33%		
62 day referral to treatment from hospital specialist	85%								91.50%		
62 days urgent referral to treatment of all cancers	85%								85.05%		
Stroke Indicators											
Proportion of people who have a TIA who are scanned and treated within 24 hours	60%								72.67%		
Proportion of people who spend at least 90% of their time on a stroke unit	80%								86.29%		

2.1 October Performance

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 all admitted and 95% of non-admitted patients treated within 18 weeks.

The Trust achieved the key stroke indicators with over 80% of stroke patients spending at least 90% of their stay on the stroke wards and over 60% of patients with a TIA having their scan within 24 hours.

The Trust continues to exceed the national standard of all diagnostic tests carried out with 6 weeks of request. During October all diagnostic tests were carried out within 4 weeks of request.

The Trust achieved all of the cancer standards with the exception of the 62 day standard from urgent GP referral to the first definitive treatment for suspected cancer referrals.

The Trust achieved the minimum A&E standards grouped for timeliness and patient impact however did not achieve transit time of 95% of patients treated within 4 hours. During October 93.1% of patients were treated within 4 hours against the standard of 95%.

2.2 Cancer Standards

62 days from urgent GP referral

This target is monitored on a quarterly rather than a monthly basis, the Trust achieved the quarter two target for 62 days from urgent referral to first definitive treatment, however has not achieved the required level in October, achieving 80.2% against the standard of 85%. This continues to be a challenging standard and significant improvement is required throughout December to ensure that the standard for quarter 3 is delivered.

A recovery plan has been developed and progress against this is being measured on a weekly basis.

2.3 A&E Clinical Indicators

During October the Trust achieved 93.19% of patients spending a maximum of 4 hours in A&E against the standard of 95%.

The Trust achieved the minimum standards for timeliness and patient experience however the following standards continue not to be achieved;

- Total Time in the A&E Department
- Time to Initial Assessment
- Longest Wait

The Trust has been working with the Intensive Support Team and a recovery plan has been developed, progress against this is monitored an weekly basis. The recovery plan has also been submitted to the PCT.

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 – October 2011/12
Submitted by	Mr J Drury, Director of Finance
Date of meeting	7th December 2011
Corporate Objectives Addressed	Financial Duties / Financial Strategy

SUMMARY OF CRITICAL POINTS

Breakeven Financial Duty.
The I&E position for October is a deficit of £1,855k compared to a planned position of £390K deficit. This is an improvement on the previous month.

Capital Resource Limit (CRL)
The Capital Resource Limit (CRL) for 2011/12 totals £11.5m with a further £1.57m from donations. Total capital expenditure of £4.3m has been incurred at month 7.

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 October shows 91% compliance by volume and 61% 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 NEL and CIP risk.

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 October 2011.

TRUST BOARD SUMMARY SHEET	
Title	HR REPORT
Submitted by	Andrea Chown, Deputy Director of HR
Date of meeting	1st December 2011
Corporate Objectives Addressed	To develop an effective, efficient and flexible workforce to support the changing environment

SUMMARY OF CRITICAL POINTS

This is the monthly HR report for November 2011 which focuses on September 2011 and the following topics :-

- **Workforce Capacity**

Substantive workforce capacity decreased by 5.71 FTE to 3,806.73 which is 332.84 FTE below the plan for the month. This is primarily due to vacancies not being recruited to which is in line with the Trust Transformation Programme.

- **Temporary Workforce**

Temporary workforce capacity remains above the planned temporary FTE. There continues to be a high dependency on temporary staff to provide one to one care (specialling) for patients. There are 23 substantive Band 2 FTEs in the recruitment pipeline to support the one-to-one care. Temporary staff continue to be utilised to provide cover for vacancies being held which is in line with the Trust Transformation Programme.

- **Staff Sickness Absence**

The Total Sickness Absence Rate has increased by 0.1% to 4.0%. Short term sickness remains above Trust target and work is ongoing in all Directorates to decrease short term sickness absence levels.

- **Staff Turnover**

Turnover (leavers) has increased 0.2% on the month to 7.30%, which remains below the Trust target of 8%.

- **Mandatory Training**

The Mandatory Training Activity Forecast shows a decrease in activity. If the mandatory training leads continue to train the same numbers of staff that they have done between April 2011 and August 2011, 76.4% 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 discuss and support the ongoing actions.

Finance Report

October (M7) FY 2011-12

Summary

•The I&E position for October is a deficit of £1,855k (September £2,248k) compared to a planned position of £390K deficit.

Key Issues

•Elective Income £2.0m (£1.8m September) below plan YTD.

•Non-Elective activity 14% £5.3m (£5.3m September) above plan subject to £2.3m MRET adjustment (MRET plan £30k at M7).

Risks

•Non Elective pressures have required bed rebasing leading to inability to fully implement and sustain bed closure plan. Seven additional Avery beds purchased.

•Significant CIP schemes requiring extended Staff Side consultation in Q3.

•Cash balance decreased with constraints on ability to meet overdue creditor demand in November.

•Mitigating actions of £5m to be delivered H2 but requirement to identify additional actions.

•PCT affordability giving rise to risk in agreeing adequate forecast outturn for SLA income.

•Business case to secure funding for Transformation / reorganisation costs remains outstanding.

• Delays in agreeing Q1 SLA reconciliation process with NHSN.

•Adequacy of readmissions and maternity provision pending receipt of actual data.

1.0 Overview

I&E Position	£000's	
In-month I/E	541	£541k surplus in October.
Reprofile plan (YTD)	(1,052)	YTD Forecast (August reprofile)
Actual Year to date I/E	(1,855)	£1.855m deficit for year to date
FIMS Plan (Year to date)	(390)	£0.4m deficit plan for year to date
PCT SLA Income Variance	432	£432k above plan
Full Year I&E Forecast	500	Forecast I&E surplus

EBITDA Performance	£000's	
Trust	(1,415)ADV	£1.4m behind plan

Cost Improvement Schemes	£000's	
In month delivery	1,558	CIPs delivered in October
Year to date delivery	8,188	Includes YTD mitigating actions
Year to Go	9,123	CIPS to be delivered
Full Year Forecast LTF	17,311	Including mitigating items

Directorate EBITDA Performance	£000's	
Medicine	709FAV	Variance to plan
Surgery	(1,586)ADV	Variance to plan
Anaesthesia	(198)ADV	Variance to plan
T&O	313FAV	Variance to plan
Head & Neck	(1,120)ADV	Variance to plan
O&G	545FAV	Variance to plan
Child Health	(116)ADV	Variance to plan
Pathology	(172)ADV	Variance to plan
Radiology	750FAV	Variance to plan
Oncology	(449)ADV	Variance to plan
Hospital support	1,142FAV	Variance to plan
Facilities	207FAV	Variance to plan
Other / Reserves	(1,440)ADV	Variance to plan

Capital	£000's	
Year to date expenditure	4,322	Capital expenditure for period
Committed as % of plan	51%	% of plan committed for YTD

SoFP (movement in year)	£000's	
Non-current assets	302	Revaluations
Current assets	1,906	NHS debtors
Current Liabilities	3,392	Increase in deferred income

Cash	£000's	
In month movement	(1,075)	Decrease over September
In Year movement	(3,137)	Decrease over March 2011
Debtors Balance > 30 days	2,891	Total outstanding over 30 days
BPPC (by volume) YTD	91%	Target 95% paid in 30 days

KPIs		
Financial Risk Rating (Shadow)	2	Low surplus level
EBITDA	81.8%	82% achievement of plan
Liquidity (days cover)	-13.8	Incl. unused WCF of £17m
Surplus Margin	-1.3%	Due to low level of surplus overall
Pay / Income	65.8%	Pay 66% of Income for YTD

SLA Income (Appendix 3)

- The Trust is performing above plan overall by £0.4m (0.4%). Within this performance provision has been made for Readmissions £2.64m based on the PCT's Q1 assessment and contract challenges of £1.48m. MRET has been reduced for Stroke and Readmissions numbers.
- OPROCS £1.4m above plan.

Other Clinical Income

- Private Patient income is £13k below plan with RTA and CRU £16k ahead of plan for the YTD.

Income Generation

- £1.8m above plan due to recognition of Macmillan donation (£978k), R&D income and other income generation schemes.

Pay Expenditure (Appendix 5)

- £186k adverse (0.2%).

Non-Pay Expenditure (Appendix 7)

- £2,201k above plan for YTD. Drugs, surgical appliances and Prosthesis expenditure above plan.

CIP (See Transformation Update)

- £8.2m delivered for YTD. Behind plan for Beds and Elective income recovery .

2.0 Executive Summary

Activity (Appendix 4)

- DC 9% below plan. EL 9% below plan. NEL 11 % above plan. OPROCS 83% above plan.

Workforce (Appendix 5)

- 4032 WTE (4033 WTE September) worked compared to budget of 4124 WTE

Cashflow (Appendix 9)

- Cash balance reduced and creditors > 90 days total £7.0m (£5.3m September).

SoFP (Appendix 8)

- £1.18m reduction in net assets since March.

Capital Expenditure (Appendix 12)

- £4.3m of expenditure for period to September with 51% of plan committed at month 7.

Shadow Monitor FRR (Appendix 13)

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

Forecast

- A review of the forecast outturn position is currently being assessed and the outcome will be reported to the December Board meeting and shared with the SHA.

3.0 Conclusions & Actions

Conclusions

- The Trust has put measures in place to respond to the significant NEL pressures through a rebasing of the bed stock and the purchase of an additional seven Avery beds.
- CIP programme delivering broadly to plan overall but inherent risks to delivery an d need to formalise funding of reorganisation costs with PCT. Several key mitigating actions have been delivered in October.
- The CIP run rate requirement increases in Q3.
- Non-pay expenditure significantly above plan and controls are being implemented for H2.

Actions

- Forecast outturn position to be updated and expected SLA income position to be reviewed and agreed with NHSN.
- Additional mitigating actions to be discussed and agreed by Executive Team as a means to securing delivery of the SHA control total of £0.5m surplus by the financial year end.
- Review of strategic options to alleviate cashflow difficulties to be agreed with SHA.

Finance Report

Appendices

Year to Date

- £1,855k deficit compared to plan position of £390k giving rise to an adverse variance to plan of £1,486k.
- EBITDA achieves 79% of plan.

Current Month

- SLA income £660k above plan includes £97k increase in WIP month on month.
- Other income includes recognition of £978k donation for Macmillan scheme in October.
- Income received from PCT to fund costs of Transformation Programme. £1.8m accrued to date.
- Additional R&D income accrued £475k YTD.

Forecast

- £0.5m planned surplus required by year end.
- August reprofile exercise £1.052m deficit at month 7.
- Reforecast exercise underway in November.

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
SLA Clinical Income	207,751	122,655	122,223	432 Fav
Other Clinical Income	2,581	1,508	1,505	3 Fav
Other Income	25,478	17,386	15,579	1,806 Fav
Total Income	**235,809**	**141,549**	**139,307**	**2,242 Fav**
Pay Costs	(158,646)	(93,076)	(92,891)	(186) Adv
Non-Pay Costs	(67,480)	(42,098)	(39,897)	(2,201) Adv
CIPs	6,714	0	2,021	(2,021) Adv
Reserves	(1,227)	0	(549)	549 Fav
Total Costs	**(220,639)**	**(135,174)**	**(131,315)**	**(3,859) Adv**
EBITDA	**15,170**	**6,375**	**7,992**	**(1,617) Adv**
Depreciation	(10,550)	(5,761)	(5,979)	217 Fav
Amortisation	(10)	(6)	(6)	0 Fav
Impairment of Fixed Assets	0	0	0	-
Net Interest	40	16	23	(7) Adv
Dividend	(4,150)	(2,479)	(2,421)	(58) Adv
Surplus / (Deficit)	**500**	**(1,855)**	**(390)**	**(1,465) Adv**

Notes

1. MRET adjustment £2.3m at M7.
2. FIMs plan for deficit of £0.39m YTD.
3. Reprofile £1.052m deficit YTD.

Income

- Income above below plan in October driven by NEL activity, increase in WIP and restatement of MRET baseline for stroke services.

Pay

- Worked WTE consistent with September. Overall pay bill £37k lower month on month. £57k reduction in bank and agency expenditure.

Non-Pay

- Non-Pay run rate increased in October.

Reserves

- No accruals made against reserves

Capital Charges

- Further reduction in forecast depreciation charge pending Q2 asset additions.

Appendix 1.1 I&E Run Rate

3 Month Run Rate £000's	August		September		October	
	Actual	Plan	Actual	Plan	Actual	Plan
SLA Clinical Income	17,605	17,349	17,713	17,967	18,375	17,715
Other Clinical Income	172	220	243	220	151	199
Other Income	2,069	1,977	2,585	1,971	2,972	2,086
Total Income	**19,847**	**19,546**	**20,540**	**20,158**	**21,498**	**20,000**
Pay Costs	(13,444)	(13,450)	(13,450)	(13,152)	(13,413)	(13,156)
Non-Pay Costs	(6,091)	(5,811)	(6,273)	(5,667)	(6,318)	(5,407)
CIPs	-	355	-	617	-	146
Reserves	-	(422)	-	(194)	-	355
Total Costs	**(19,535)**	**(19,328)**	**(19,723)**	**(18,395)**	**(19,731)**	**(18,063)**
EBITDA	**312**	**218**	**817**	**1,762**	**1,767**	**1,937**
Depreciation	(846)	(861)	(772)	(861)	(873)	(897)
Amortisation	(1)	(1)	(1)	(1)	(1)	(1)
Impairment of Fixed Assets	-	-	-	-	-	-
Net Interest	2	3	4	3	1	3
Dividend	(389)	(346)	(354)	(346)	(354)	(346)
Surplus / (Deficit)	**(922)**	**(987)**	**(306)**	**558**	**541**	**697**

Appendix 2 Directorate Performance

Trading Summary £	General Surgery		Anaes & CC		T & O		Head & Neck		Child Health	
	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var
Total Income	14,910	(1,251) Adv	5,202	(177) Adv	13,166	747 Fav	11,406	(1,242) Adv	8,498	(370) Adv
Pay	(9,480)	(237) Adv	(6,180)	(112) Adv	(5,725)	(105) Adv	(4,891)	(141) Adv	(6,623)	236 Fav
Non-Pay	(2,750)	(276) Adv	(858)	(51) Adv	(2,677)	(384) Adv	(2,075)	(7) Adv	(938)	(46) Adv
Other Expenditure	(4,358)	177 Fav	2,378	142 Fav	(4,939)	54 Fav	(4,233)	270 Fav	(1,232)	64 Fav
EBITDA	**(1,678)**	**(1,586) Adv**	**542**	**(198) Adv**	**(174)**	**313 Fav**	**207**	**(1,120) Adv**	**(295)**	**(116) Adv**
EBITDA %	**-11.3%**		**10.4%**		**-1.3%**		**1.8%**		**-3.5%**	
ITDA	(718)	21 Fav	(154)	12 Fav	(450)	10 Fav	(447)	10 Fav	(358)	14 Fav
Surplus / (Deficit)	**(2,396)**	**(1,565) Adv**	**388**	**(186) Adv**	**(625)**	**323 Fav**	**(240)**	**(1,109) Adv**	**(653)**	**(102) Adv**

Trading Summary £	Obs & Gynae		General Medicine		Pathology		Radiology		Oncology	
	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var
Total Income	15,212	139 Fav	39,169	3,031 Fav	4,751	(121) Adv	2,826	371 Fav	14,355	(392) Adv
Pay	(9,128)	44 Fav	(22,152)	(808) Adv	(4,596)	130 Fav	(3,702)	147 Fav	(5,492)	(44) Adv
Non-Pay	(1,212)	(63) Adv	(6,545)	(361) Adv	(4,012)	(73) Adv	(1,074)	112 Fav	(4,892)	(5) Adv
Other Expenditure	(4,615)	425 Fav	(11,716)	(1,153) Adv	4,129	(108) Adv	3,044	120 Fav	(2,232)	(8) Adv
EBITDA	**256**	**545 Fav**	**(1,243)**	**709 Fav**	**272**	**(172) Adv**	**1,095**	**750 Fav**	**1,740**	**(449) Adv**
EBITDA %	**1.7%**		**-3.2%**		**5.7%**		**38.7%**		**12.1%**	
ITDA	(543)	14 Fav	(1,349)	37 Fav	(572)	4 Fav	(1,167)	4 Fav	(1,099)	50 Fav
Surplus / (Deficit)	**(286)**	**559 Fav**	**(2,592)**	**746 Fav**	**(300)**	**(168) Adv**	**(73)**	**755 Fav**	**640**	**(398) Adv**

Trading Summary £	Hospital Support		Facilities		Central		TOTAL	
	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var
Total Income	6,859	597 Fav	2,194	152 Fav	3,000	756 Fav	141,549	2,242 Fav
Pay	(10,507)	821 Fav	(4,780)	1 Fav	180	(118) Adv	(93,076)	(186) Adv
Non-Pay	(9,941)	(266) Adv	(4,870)	96 Fav	(255)	(875) Adv	(42,098)	(2,201) Adv
Other Expenditure	16,068	(10) Adv	7,706	(41) Adv	-	(1,203) Adv	0	(1,271) Adv
EBITDA	**2,479**	**1,142 Fav**	**249**	**207 Fav**	**2,925**	**(1,440) Adv**	**6,375**	**(1,415) Adv**
EBITDA %	**36.1%**		**11.4%**		**97.5%**		**4.5%**	
ITDA	(1,267)	1 Fav	(100)	1 Fav	(6)	(28) Adv	(8,230)	152 Fav
Surplus / (Deficit)	**1,213**	**1,143 Fav**	**150**	**209 Fav**	**2,919**	**(1,468) Adv**	**(1,855)**	**(1,263) Adv**

SLA Income

- Daycase and EL income £2.0m below plan. NEL income £5.3m above plan but offset by £2.6m emergency readmissions assumption. This level of readmissions provision leads to non-elective being outside the MRET threshold.
- OPROCS £1.4m above plan for YTD.
- WIP £0.8m decrease since March 11.
- CQUIN accrued at 75% pending achievement of measures.

TCS

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

Provisions

- Readmissions accrued at £2,640k for YTD subject to validation process.
- New to follow outpatient provision of £553k after review of exclusions per SLA contract.
- £167k accrual for non-payment for first £1m of over performance (NHSN only).

Estimated SLA Provisions £'s	YTD
Casemix Provision	
New 2 FUP	552,772
Readmissions	2,640,124
Coding issues	60,000
SUS/SLAM	232,363
WA14Z	178,953
Over performance (first £1m)	166,667
NCA Adjustments	-296,103
Beds PCT Challenges	2,095
Bucks PCT Challenges	7,441
MKPCT Challenges	10,957
FNOF	1,856
Not Responsible Commissioner (NHSN Challenges)	256,321
Inpatient Duplicates	933
LPTs	52,243
Total	**3,866,623**

Appendix 3 SLA Income

SLA Income by PoD £000's	YTD Plan	YTD Actual	Variance to plan	%
DC	16,437	14,983	(1,454) Adv	(8.8%)
EL	11,370	10,789	(580) Adv	(5.1%)
NEL	38,626	43,966	5,341 Fav	13.8%
OPFA	7,780	6,379	(1,401) Adv	(18.0%)
OPFUP	7,118	6,403	(715) Adv	(10.0%)
OPFASPNCL	985	1,030	45 Fav	4.5%
OPFUPSPNCL	1,526	1,321	(205) Adv	(13.4%)
OPPROC	1,816	3,189	1,373 Fav	75.6%
Excluded Medicines	5,617	5,810	193 Fav	3.4%
A&E - PbR	3,793	4,432	640 Fav	16.9%
Childrens Services	4,161	4,161	-	
TCS	3,751	3,821	69 Fav	1.8%
Critical care & HDU	3,883	3,771	(112) Adv	(2.9%)
Pathology	3,105	3,197	92 Fav	3.0%
Radiotherapy	2,477	2,528	51 Fav	2.1%
Community Midwives	2,088	2,088	-	
GPDA Radiology	1,133	1,333	200 Fav	17.6%
Unbundled Chemotherapy PSD	1,258	1,214	(44) Adv	(3.5%)
Breast Screening	810	810	-	
Ante-natal Pathology	708	557	(150) Adv	(21.2%)
Limb Centre	518	527	10 Fav	1.9%
Audiology	506	506	-	
Excluded Devices	370	468	98 Fav	26.6%
Other Block	2,977	2,153	(823) Adv	(27.7%)
MRET	-30		30 Fav	(100.0%)
ARMD	520	589	69 Fav	13.2%
Provisions	-2,774	-3,867	(1,092) Adv	39.4%
CQUIN	1,703	1,309	(394) Adv	(23.1%)
WIP	-13	-814	(801) Adv	6242.9%
NHSN contract adjustment	0		0 Fav	100.0%
Grand Total	**122,217**	**122,655**	**438 Fav**	**0.4%**

SLA Activity

- Based on discharges to date
- Daycases 9 % behind plan.(10% September).
- EL 9% behind plan (7% September).
- NEL 11% above plan. (12% September).
- New and follow up Outpatients below plan
- OPROCS 83% above plan.

Appendix 4 Activity

Activity	Plan 2011-12	YTD Actual	YTD Plan	Variance to plan	%
Daycase	41,403	23,049	25,222	-2,173	-9%
Elective Inpatients	7,140	4,075	4,463	-388	-9%
Non Elective	39,769	25,459	23,026	2,433	11%
Cons New Outpatients	79,025	38,536	47,772	-9,236	-19%
Cons Follow Up Outpatients	127,645	70,611	77,203	-6,592	-9%
NCL New Outpatient	22,351	13,806	13,286	520	4%
NCL Follow up Outpatients	72,562	38,132	43,110	-4,978	-12%
Outpatient Procedures	22,437	21,774	11,869	9,905	83%
A&E Attendances	78,596	48,409	46,081	2,328	5%

Notes to Pay Expenditure

- £13.41m cost in October (£13.45m September).

Temporary Staffing

- £184k expenditure on Medical Locums in October (£275k September; £285k August).
- Agency Nursing increase of £10k month on month.
- Bank costs increased by £27k to £494k in month of which £127k relates to administration staff.

YTD Variances to Plan

- Substantive Nursing Qualified £2.4m (8%) favourable.
- Junior Medical £765k (8%) favourable to plan but offset by £1m agency locum expenditure.
- Managerial Staff £542k (10%) favourable.
- Estates £93k (17%) adverse to plan.

Appendix 5 Pay Expenditure

Staff Group £000's	August		September		October	
	Actual	Plan	Actual	Plan	Actual	Plan
Senior Medical Staff	2,183	2,325	2,157	2,325	2,184	2,286
Junior Medical Staff	1,184	1,297	1,272	1,297	1,243	1,329
Salary Recharge Exp. - Medical Staff	74	27	47	27	69	27
Salary Recharge Inc. - Medical Staff	(132)	(91)	(137)	(77)	(142)	(77)
Capitalised Salary - Medstaff	-	-	-	-	-	-
Medstaff WLI & ADH's	83	21	72	3	62	3
Agency Medstaff (Senior)	123	8	119	8	95	8
Agency Medstaff (Junior)	163	8	155	8	89	8
Total Medical Staff	**3,676**	**3,595**	**3,685**	**3,590**	**3,599**	**3,582**
Nursing Staff - Qualified (Band 5 +)	3,995	4,342	3,931	4,170	3,923	4,147
Nursing Staff Unqualified	714	823	689	757	705	775
Salary Recharge Exp. - Nursing Staff	8	2	0	2	9	3
Salary Recharge Inc. - Nursing Staff	(62)	(81)	(49)	(62)	(101)	(78)
Capitalised Salary - Nursing	(4)	-	(4)	-	(4)	-
Bank Staff - Nursing	349	-	364	-	368	-
Agency Staff - Senior Nursing	115	-	145	-	177	-
Agency Staff - Junior Nursing	63	-	67	-	45	-
Total Nursing Staff	**5,177**	**5,084**	**5,144**	**4,866**	**5,122**	**4,846**
Managerial Staff	699	796	722	775	706	750
Salary Recharge Exp. - Managers	-	1	-	1	-	1
Salary Recharge Inc. - Managers	(7)	(3)	(7)	(3)	(7)	(3)
Capitalised Salary - Managers	(9)	-	(9)	-	(9)	-
Agency Staff - Management	6	1	5	1	1	1
Administration Staff	1,227	1,366	1,231	1,372	1,210	1,348
Salary Recharge Exp. - Admin Staff	-	-	-	-	-	-
Salary Recharge Inc. - Admin Staff	(9)	(14)	(15)	(14)	(17)	(14)
Capitalised Salary - Admin	-	-	-	-	-	-
Bank Staff - Admin	118	26	104	6	127	6
Agency Staff - Admin	6	-	13	-	6	-
Total Managerial & Admin	**2,032**	**2,174**	**2,044**	**2,138**	**2,017**	**2,089**
Other Clinical Staff	801	901	831	878	846	877
Scientific & Technical Staff	1,024	1,090	1,028	1,091	1,043	1,085
Estates Staff	87	79	96	79	91	79
All other Staff	593	642	595	649	689	729
Salary Recharge Exp. - Other Staff	40	57	8	33	(5)	33
Salary Recharge Inc. - Other Staff	(49)	(42)	(51)	(42)	(89)	(42)
Capitalised Salary - Other Staff	-	-	-	-	-	-
Bank & Agency Staff - Other	62	2	70	1	100	2
Total Other	**2,558**	**2,730**	**2,577**	**2,690**	**2,675**	**2,764**
CIPS	-	(55)	-	(55)	-	(47)
Additional Activity	-	-	-	-	-	-
Vacancy Factor	-	(78)	-	(78)	-	(78)
Total Cost Challenges	**-**	**(133)**	**-**	**(133)**	**-**	**(125)**
Total Pay Expenditure	**13,444**	**13,450**	**13,450**	**13,152**	**13,413**	**13,156**

Summary

•4032 WTE (4033 WTE September) worked compared to budget of 4124 WTE. Contracted WTE total 3829 WTE.

Temporary Staffing August

•12 WTE Medical Locums. (16 WTE September).
•129 WTE Bank Nurses. (131 WTE September).
• 62 WTE Agency Nurses. (53 WTE September).

Variances from Plan (Worked v Budget)

• Junior Doctors 10 WTE below plan
•Qualified Nurses 107 WTE below plan
•Managerial Staff 23WTE below plan
• Administration 94 WTE below plan offset by 59 WTE bank and agency staff.

Appendix 6 Workforce

Staff Type:	Worked Mth 7 WTE 2011/12	WTE Budget 2011/12 M1	Contracted Mth 7 WTE 2011/12
Senior Medical Staff	194.43	202.74	194.31
Junior Medical Staff	249.25	258.76	264.11
Salary Recharges Expenditure - Medical Staff	6.83	4.44	0.00
Salary Recharges Income - Medical Staff	-13.82	-9.25	0.00
Medical Locums (Agency - Senior)	5.77	0.84	0.00
Medical Locums (Agency - Junior)	6.57	0.00	0.00
Total Medical Staff	**449.03**	**457.53**	**458.41**
Nursing Staff - Qualified (Band 5 +)	1165.05	1272.52	1197.21
Nursing Staff Unqualified	381.92	421.24	395.74
Salary Recharges Expenditure - Nursing Staff	1.50	0.50	0.00
Salary Recharges Income - Nursing Staff	-26.89	-19.91	0.00
Bank Staff - Nursing	128.65	0.00	10.28
Agency Staff - Senior Nursing	27.84	0.00	0.00
Agency Staff - Junior Nursing	34.43	0.00	0.00
Total Nursing Staff	**1712.50**	**1674.35**	**1603.23**
Managerial Staff	146.71	169.49	150.18
Salary Recharges Expenditure - Managers	0.00	0.00	0.00
Salary Recharges Income - Managers	-1.05	0.00	0.00
Agency Staff - Management	0.00	0.00	0.00
Administration Staff	630.53	724.16	624.20
Salary Recharges Expenditure - Admin Staff	0.00	0.00	0.00
Salary Recharges Income - Admin Staff	-6.38	-6.01	0.00
Bank Staff - Admin	58.95	1.13	0.00
Agency Staff - Admin	1.80	0.00	0.00
Total Managerial & Admin	**830.56**	**888.77**	**774.38**
Other Clinical Staff	256.82	283.49	254.67
Scientific & Technical Staff	357.50	386.50	385.66
Estates Staff	29.68	33.19	26.00
All other Staff	374.55	400.83	327.10
Salary Recharges Expenditure - Other Staff	9.25	5.00	0.00
Salary Recharges Income - Other Staff	-3.60	-2.72	0.00
Agency Staff - Other	15.42	0.00	0.00
Total Other	**1039.62**	**1106.29**	**993.43**
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	**4031.71**	**4123.78**	**3829.45**

Summary

•£2,201k adverse compared to plan, primarily due to Prosthesis ,Surgical Appliances, Medicines and Equipment Hire.

Clinical

• £768k (2.9%) adverse to plan mainly due to Medicines overspend £267k and surgical appliances £247k. (both partly offset by income) and Prosthesis £285k driven by increased elective workload in T&O. Equipment hire £167k adverse to plan.

Non-Clinical

• £1,472k (11%) adverse variance against plan due to Printing & Stationery £85k, Communications and Legal Fees £152k and Consultancy Fess £282k.

Other

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

• Building and Engineering equipment and schemes £207k underspent.

Appendix 7 Non-Pay Expenditure

Non-Pay £000's	August		September		October	
	Actual	Plan	Actual	Plan	Actual	Plan
Clinical Non Pay - Fixed						
Equipment Hire	62	47	121	47	71	47
Equipment Maintenance	251	261	339	235	232	220
Clinical Non Pay - Fixed Total	**313**	**308**	**460**	**282**	**303**	**267**
Clinical Non Pay - Variable						
Prosthesis	112	117	183	117	168	111
Patient & Surgical Appliances	228	150	207	150	118	116
Patient Clothing & Travel	16	12	13	10	14	11
Lab Equipment Consumables	437	437	355	433	385	415
Blood	106	144	137	144	131	138
Medicines	1,770	1,766	1,757	1,748	1,839	1,678
Medical & Surgical Items	887	983	917	921	933	1,003
Dressings	64	57	69	55	66	53
Medical Gases	18	18	18	18	16	17
X-Ray Consumables	1	1	1	1	-	1
Clinical Non Pay - Variable Total	**3,639**	**3,686**	**3,657**	**3,597**	**3,671**	**3,543**
Clinical Non Pay - Total	**3,953**	**3,993**	**4,116**	**3,880**	**3,974**	**3,810**
Non Clinical Non Pay - Fixed						
Building & Engineering Equipment	324	356	287	356	307	142
Cleaning Equipment	48	37	51	37	57	37
Energy & Utilities	188	167	161	167	211	171
Rates	66	67	66	67	66	67
Printing & Stationery	82	57	66	57	96	129
Computer Equipment & Maintenance	115	138	112	116	113	116
Communications	69	59	69	58	84	68
Office Equipment	15	51	14	50	27	(98)
Non Pay CIP's	-	(162)	-	(159)	-	(158)
Other Fee's	130	110	154	110	44	196
Losses & Compensations	92	22	26	22	48	22
CNST	418	418	418	418	418	418
Consultancy Fee's	113	41	377	41	284	41
Training	67	79	47	72	54	72
Travel & Benefits	89	93	65	92	256	91
Staff Advertising	53	5	(8)	5	9	5
Non Clinical Non Pay - Fixed Total	**1,870**	**1,539**	**1,906**	**1,510**	**2,074**	**1,320**
Non Clinical Non Pay - Variable						
Patient Provisions	105	91	73	91	83	90
Patient Linen	97	77	82	76	82	77
Non Clinical Non Pay - Variable Total	202	169	154	167	165	167
			-	-	-	-
Non Clinical Non Pay - Total	**2,072**	**1,707**	**2,060**	**1,677**	**2,239**	**1,487**
Expenditure SLAs:						
N PCT Services	15	57	53	57	53	57
NHT Transport	9	11	0	11	8	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	**6,091**	**5,811**	**6,273**	**5,667**	**6,318**	**5,407**

Non Current Assets

- Increase of £102k in month due to net of capital additions less depreciation and revaluations for period.
- Revaluation exercise to be undertaken in year by DV. Indication that building indices will rise.
- Awaiting final valuation report for Macmillan Cancer Centre new build (donated).

Current Assets

- Increase of £0.47m in month led by £1.0m reduction in cash balance and an increase in NHS debtors.

Current Liabilities

- Increase of £170k in month.
- Staff benefits accrual reduced by £180k since April (annual leave provision).

Reserves

- IFRS adjustment removing Donation reserve.
- Update for TCS asset transfers awaiting PDC transfer from NHSN.

Appendix 8 Statement of Financial Position

	Balance at 31-Mar-11	Current Month Opening Balance	Closing Balance	Movement	Forecast end of year Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	133,062	133,062	133,062		133,062	
IN YEAR REVALUATIONS		1,320	666	(654)	997	997
IN YEAR MOVEMENTS		3,768	5,397	1,629	11,473	11,473
LESS DEPRECIATION		(4,888)	(5,761)	(873)	(10,560)	(10,560)
NET BOOK VALUE	**133,062**	**133,262**	**133,364**	**102**	**134,972**	**1,910**
CURRENT ASSETS						
INVENTORIES	4,555	4,518	4,616	98	4,562	7
RECEIVABLES						
NHS DEBTORS	4,812	7,508	8,963	1,455	4,812	
OTHER TRADE DEBTORS	1,295	1,052	982	(70)	1,295	
DEBTOR IMPAIRMENTS PROVISION	(166)	(166)	(166)		(166)	
CAPITAL RECEIVABLES	118	324	324		118	
NON NHS OTHER DEBTORS	345	193	306	113	345	
COMPENSATION DEBTORS (RTA)	2,483	2,499	2,479	(20)	2,483	
OTHER RECEIVABLES	817	472	520	48	817	
IRRECOVERABLE PROVISION	(253)	(254)	(254)		(253)	
PREPAYMENTS & ACCRUALS	686	2,055	1,965	(90)	686	
	10,137	**13,683**	**15,119**	**1,436**	**10,137**	
CASH	3,867	1,805	730	(1,075)	3,861	(6)
NET CURRENT ASSETS	**18,559**	**20,006**	**20,465**	**459**	**18,560**	**1**
CURRENT LIABILITIES						
NHS	4,177	4,697	5,143	(446)	4,180	(3)
TRADE CREDITORS REVENUE	3,528	2,940	4,446	(1,506)	3,580	(52)
TRADE CREDITORS FIXED ASSETS	2,401	2,142	1,608	534	2,244	157
TAX AND NI OWED	3,275	3,403	3,370	33	3,275	
NHS PENSIONS AGENCY	1,831	1,772	1,814	(42)	1,831	
OTHER CREDITORS	301	338	580	(242)	301	
SHORT TERM LOANS	488	418	418		571	(83)
ACCRUALS AND DEFERRED INCOME	2,679	6,557	4,734	1,823	2,679	
PDC DIVIDEND DUE			354	(354)		
STAFF BENEFITS ACCRUAL	1,440	1,259	1,259		1,440	
PROVISIONS	380	178	146	32	316	
PROVISIONS over 1 year	310	330	330		374	
NET CURRENT LIABILITIES	**20,810**	**24,034**	**24,202**	**(168)**	**20,791**	**19**
TOTAL NET ASSETS	**130,811**	**129,234**	**129,627**	**393**	**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	2,464	2,464		2,463	
I & E CURRENT YEAR		(2,248)	(1,855)	393	500	500
FINANCING TOTAL	**130,811**	**129,234**	**129,627**	**393**	**132,741**	**1,930**

Appendix 9 Cashflow

MONTHLY CASHFLOW	Annual £000s	APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
		ACTUAL							FORECAST				
RECEIPTS													
SLA Base Payments	201,896	16,407	16,313	16,919	16,351	17,599	17,580	16,097	16,979	16,913	16,913	16,913	16,913
SLA Variable inc Over Performanc	287					287							
SHA Payments (SIFT etc)	8,955	676	657	750	751	741	744	731	832	748	748	748	828
Other NHS Income	18,119	1,681	757	1,023	3,035	1,526	2,114	1,108	1,480	1,200	1,200	1,200	1,795
PP / Other (Specific > £250k)	1,857	368		290	294	305	276		324				
PP / Other	10,997	892	667	908	1,044	773	1,143	838	900	1,024	1,009	900	900
Salix Capital Loan	202									46	60	96	
EFL / PDC													
Temporary Borrowing													
Interest Receivable	27	2	2	2	4	2	4	1	2	2	2	2	2
TOTAL RECEIPTS	242,340	20,025	18,396	19,892	21,479	21,233	21,861	18,775	20,517	19,933	19,932	19,859	20,438
PAYMENTS													
Salaries and wages	155,890	12,677	12,787	13,068	12,882	13,073	13,108	13,136	13,130	13,130	13,075	12,900	12,925
Trade Creditors	54,313	5,132	4,534	6,045	4,092	4,869	6,010	4,362	4,906	4,150	3,950	3,950	2,312
NHS Creditors	16,608	1,423	2,187	991	2,792	784	1,329	1,432	1,417	1,417	1,117	1,117	600
Capital Expenditure	11,103	1,084	1,337	473	610	652	825	932	1,181	1,257	1,059	890	803
PDC Dividend	4,233						2,108						2,125
Repayment of Loans													
Repayment of Salix loan	164						70						95
TOTAL PAYMENTS	242,311	20,316	20,845	20,578	20,377	19,378	23,448	19,862	20,634	19,954	19,201	18,857	18,859
Actual month balance	29	-291	-2,449	-687	1,103	1,855	-1,587	-1,087	-117	-21	731	1,002	1,579
Balance brought forward	3,831	3,831	3,540	1,091	404	1,507	3,362	1,775	688	571	549	1,280	2,282
Balance carried forward	**3,861**	**3,540**	**1,091**	**404**	**1,507**	**3,362**	**1,775**	**688**	**571**	**549**	**1,280**	**2,282**	**3,861**

Notes to cashflow

- Forecast meets EFL and H2 dividend payment but achieved by a reduction of creditor payments in March.
- H1 PDC Dividend (£2.1m) successfully paid in September.
- Outstanding creditor balance increasing and difficulties meeting all overdue invoices in November.
- Excludes costs of reorganisation and associated PCT income (to be confirmed by NHSN.

Appendix 10 Debtors

In month

- Increase of £2.3m in outstanding balances since April includes £1.4m of MPET invoices raised in August covering period to December 11.
- Underlying reduction of £124k month on month.

Problem Debtors

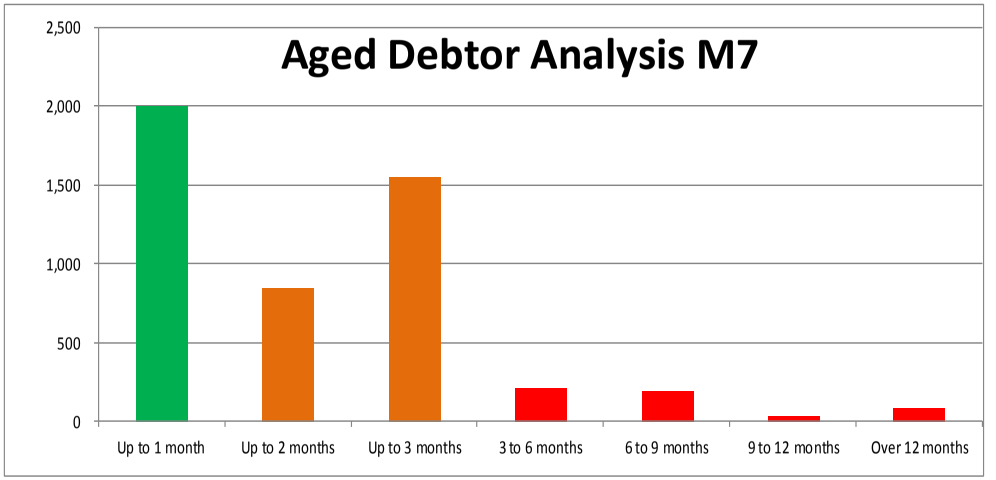
- CRIPPS

Top 10 Debtors over £10k over 2mths by value:

	Description	Value £	Date due:
Cripps Social Club	SLA 201/11	84,148.00	11/04/2011
Cripps Social Club	SLA 1.1.09 -31.3.10	42,073.95	24/03/2010
University Hospitals Leic	Medicine recharge Qtr1	41,917.51	19/09/2011
Depuy	T&O Clinical Fellow	40,000.00	26/09/2011
University Hospitals Leic	SLA Qtr 1	39,887.75	30/09/2011
InHealth	PET Scans	24,685.87	25/04/2011
University of Hertfordshire	Practice Educator recharge	24,094.00	19/08/2011
University Hospitals Leic	Radiology recharge 1st Qtr	21,355.00	16/04/2011
Oxfordshire PCT	Mth 4 Performance	18,930.00	17/09/2011
NHS Northamptonshire	Alcohol Liaison Nurse	18,005.64	29/08/2011

Top 10 Debtors over £10k over 2mths by age:

	Description	Value £	Date due:
Cripps Social Club	SLA Oct 09 - Mar 09	42,073.95	24/03/2010
Cripps Social Club	SLA 1.4.10 - 31.3.10	84,148.00	11/04/2011
University Hospitals Leic	Radiology recharge	21,355.00	16/04/2011
InHealth	PET Scans	24,685.87	25/04/2011
Bedfordshire PCT	Chemotherapy medicines	13,750.05	30/07/2011
Kettering General Hospital	Dr Tan Recharge	12,954.00	30/07/2011
University of Hertfordshire	Practice Educator recharge	24,094.00	19/08/2011
NHS Northamptonshire	LAC Physical Health	11,514.00	19/08/2011
Roche Diagnostics	NGH Pump Service	15,914.00	28/08/2011
NHS Northamptonshire	Alcohol Liaison Nurse	18,005.64	29/08/2011



Aged Debtors	01.04.10	April	May	June	July	August	September	October	YTD Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Up to 1 month	1,604	1,097	2,675	2,168	3,103	4,239	1,683	2,001	397
Up to 2 months	210	523	664	1,696	478	1,512	2,652	843	633
Up to 3 months	280	100	336	388	320	172	202	1,544	1,264
3 to 6 months	249	202	194	259	349	286	183	205	-44
6 to 9 months	50	54	89	140	154	32	194	192	142
9 to 12 months	12	24	25	24	24	26	26	28	16
Over 12 months	146	146	105	61	66	75	76	79	-67
Total	**2,551**	**2,146**	**4,088**	**4,736**	**4,494**	**6,342**	**5,016**	**4,892**	**2,341**

Appendix 11 Creditors

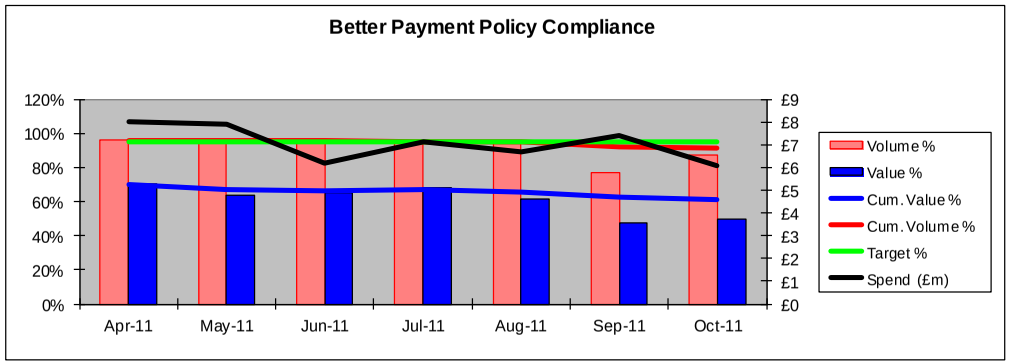
Balances

- Increase of £2.0m over March balance.
- £7.0 > 90days.

BPPC Compliance (95% target)

- 4% below target compliance with 91% 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 £	1,406,220	7,474,982	**19%**	28,683,859	41,761,569	**69%**	30,090,079	49,236,551	**61%**
Volume	891	1,209	**74%**	30,952	33,683	**92%**	31,843	34,892	**91%**



Top 10 by age	Invoice Value £	Due Date
SIEMENS PLC	93,647.50	02/09/2010
OXFORD RADCLIFFE HOSPITAL NHS TRUST	5,576.55	15/01/2011
NHS NORTHAMPTONSHIRE	52,774.00	20/01/2011
NHS NORTHAMPTONSHIRE	26,387.00	09/02/2011
NORTHAMPTONSHIRE PROVIDER SERVICES NHS	177,858.00	06/03/2011
NHS NORTHAMPTONSHIRE	57,094.37	01/04/2011
OXFORD RADCLIFFE HOSPITAL NHS TRUST	5,576.55	10/04/2011
NHSBSA PRESCRIPTION PRICING DIVISION	75,910.48	11/05/2011
SIEMENS PLC	1,169.13	08/06/2011
MEDIA FOR MYCOBACTERIA LTD	19.22	12/06/2011

Top 10 by account	Account Balance £
NHS SUPPLY CHAIN	986,763.60
GILEAD SCIENCES LTD	514,208.91
ROCHE PRODUCTS LIMITED	478,174.35
NORTHAMPTONSHIRE HEALTHCARE NHSFT	472,412.64
NHSBSA PRESCRIPTION PRICING DIVISION	455,338.41
NORTHAMPTONSHIRE PROVIDER SERVICES NHS	413,865.12
NHS BLOOD AND TRANSPLANT	368,438.04
ERNST & YOUNG LLP	344,911.20
J TOMLINSON LIMITED	323,692.36
NOVARTIS PHARMACEUTICALS UK LIMITED	288,348.57

Aged Creditors	01.04.10 £'000	NHS £'000	Trade £'000	Capital £'000	Total £'000
Up to 1 month	4,298		88	3	90
Up to 2 months	1,165	1	642	24	667
Up to 3 months	483	126	808	67	1,001
Over 3 Months	790	3,529	2,663	824	7,015
Total	**6,737**	**3,656**	**4,201**	**917**	**8,774**

Note:
Phased payment profile agreed with NHS Supply Chain to achieve reduction to 60 day terms . Trust on track to deliver.

Notes to Capital Schemes

- Replacement Breast Screening mobile & trailer and static machine is final year of business case.
- Emergency Care and Mortuary schemes have now started work on site.
- Transformation Projects include digital dictation, switchboard and E-fin / E-procurement upgrades.
- The Macmillan scheme is due for completion by December to include Trust contribution for F&E.
- A TCS transfer relating to assets at Danetre is included at £452k and a CRL transfer will be agreed with the SHA.
- Contingency of £1,612k of which £560k related to donated depreciation for which SHA / DH policy guidance is awaited.
- Current EOY forecast is £11.451m (underspend of £1.625m).
- Full year depreciation forecast is currently £10.218m including previously donated element of £0.56m.

Appendix 12 Capital Expenditure

Category	Annual Budget 2011/12 £000's	Year to Date as at Month 7 Actual Spend £000's	Year to Date as at Month 7 Plan Achieved £000's	Year to Date as at Month 7 Actual Committed £000's	Year to Date as at Month 7 Plan Achieved £000's
Breast Screening Business Case	535	522	98%	522	98%
Emergency Care	768	68	9%	136	18%
Transformation Project	578	50	9%	117	20%
Mortuary Refurbishment	400	13	3%	237	59%
Macmillan (Trust)	450	0	0%	160	36%
Macmillan (Non Trust)	1,410	1,004	71%	1,784	127%
MESC	1,034	833	81%	851	82%
Estates	3,203	1,093	34%	1,719	54%
IT	2,354	1,139	48%	1,519	65%
Other	2,344	702	30%	743	32%
Total - Capital Plan	**13,075**	**5,425**	**41%**	**7,788**	**60%**
Less Charitable Funds	-1,572	-1,103	70%	-1,883	120%
Total - CRL	**11,503**	**4,322**	**38%**	**5,905**	**51%**

Notes to YTD Score

- Overall Score of 2 for October.
- EBITDA (4.5%) achievement reducing score overall.
- ROA score driven by YTD deficit.
- Deficit gives rise to a score of 2 for surplus margin.
- Liquidity days of 13.76 cover includes £17m working capital facility.
- Liquidity cover -14.4days (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 %	Oct	Shadow Rating	YTD Score
Achievement of Plan	EBITDA Achieved (% of plan)	10%	80%	3	0.30
Underlying Performance	EBITDA Margin %	25%	4.5%	2	0.50
Financial Efficiency	Return on Assets	20%	-3.34%	1	0.20
Financial Efficiency	I&E Surplus Margin	20%	-1.3%	2	0.40
Liquidity	Liquidity Ratio (Days cover)	25%	13.76	2	0.50
Weighted Average		100%			2

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

Workstream Savings

Progress	Total savings of £8.2m have been recorded for the year to date. This includes £1.8m in relation to funding for EY fees and £0.5m of additional R&D income.
Two schemes are off Track in October	The following schemes have red rated post cash delivery compared to the agreed plan. Beds - £64k (Spencer /Knightly delays) IBRs – £123k (T&O elective activity reduced in October).
There is an increase in the target rate of delivery from October	The required rate of savings for Theatres, Outpatients ,Beds and Procurement all increase from October.

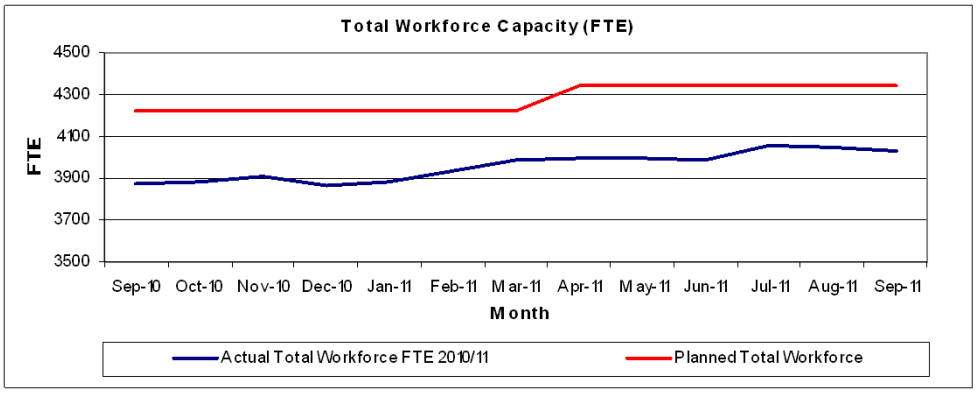
Workstream	**Plan**	**LTF M7**	**YTD Plan**	**YTD Actual**	**October Red Rated**	**October Delivered**
	£k	**£k**	**£k**	**£k**	**£k**	**£k**
Theatres	399	259	136	129		26
Beds	1,299	1,234	397	157	64	92
Outpatients	210	129	10	57	-47	57
Pharmacy	702	717	431	455		63
Procurement	1,300	1,100	622	630		95
Controls	4,485	4,126	909	946	-135	308
Non Clinical	218	125	12	-	-9	
Estates	60	17	10	10		10
IBRs	1,924	1,772	892	785	123	61
Diagnostics	345	304	142	130	9	26
Reorganisation	70	39	-	-		
Back Office	50	-	-	-		
Medical Productivity	50	-	-	-		
2% CIPs	4,789	4,789	2,671	2,614	-81	465
Total	**15,899**	**14,611**	**6,232**	**5,913**	**-76**	**1,203**
Existing Mitigations	**2,700**	**2,700**	**2,275**	**2,275**		**355**
Total CIP Delivery	**18,599**	**17,311**	**8,507**	**8,188**	**-76**	**1,558**

1 Workforce Capacity – Full Time Equivalent (FTE) Staff

1.1 In September 2011, total workforce capacity (i.e. substantive staff plus temporary capacity) decreased by 21.01 FTE, to 4,028.96 FTE, which is 317.03 FTE below the planned total workforce as shown below in Figure 1. Please note the transfer of community services in July 2011 included 64.2 FTE. Further details are shown in Appendix 1 & 2.

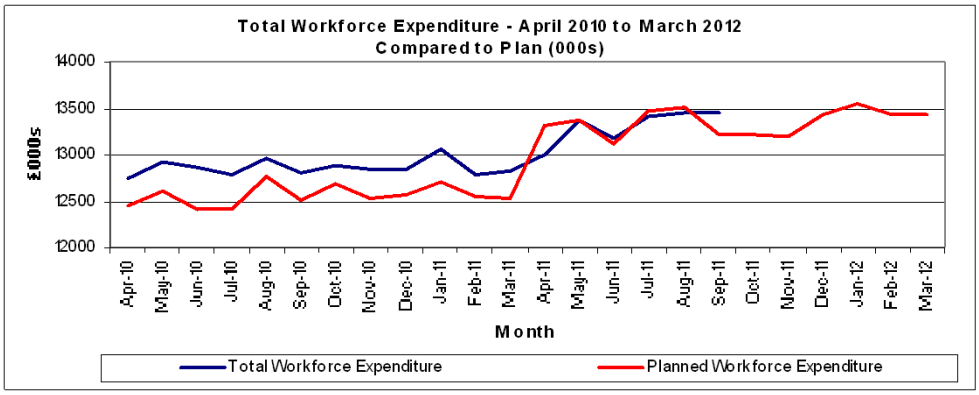
[NB. Planned total workforce = funded establishment + 5% planned temporary workforce capacity].

Figure 1



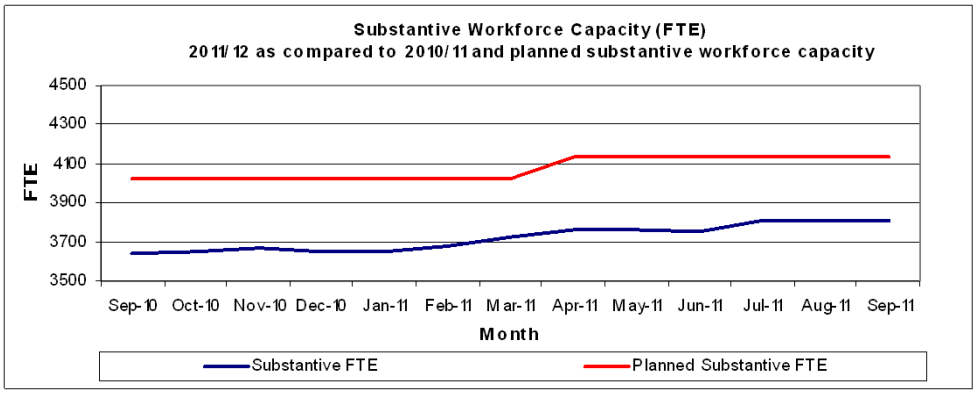
1.2 The total workforce expenditure (all pay elements) increased by £6k to £13.450m in September 2011, which is £238k above the planned total workforce expenditure, as detailed in figure 2 below.

Figure 2



1.3 Substantive workforce capacity decreased by 5.71 FTE to 3,806.72 FTE in September 2011, which is 332.84 FTE below plan for September 2011, as shown in Figure 3. This remains primarily due to vacancies not being recruited to due to the Trust Transformation Programme. Please note the FTE increase in July 2011 takes into account the transfer of community services to include 25.43 FTE from Corby and 38.77 FTE from Isebrooke.

Figure 3



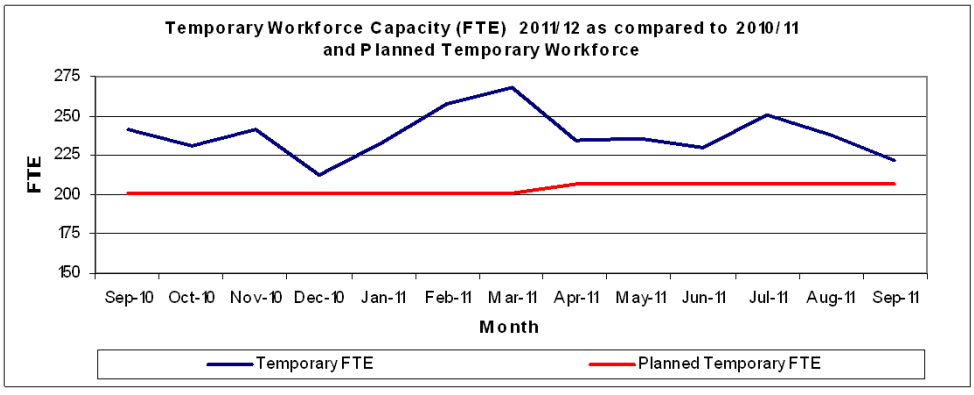
1.4 Temporary workforce capacity - total bank & agency hours recorded on the Trust Central Bank System (excluding medical locums), converted to an indicative FTE) remains above the planned temporary FTE but has decreased by 15.3 FTE to 222.2 FTE in September 2011, which is 15.25 FTE above planned position, as shown in Figure 4 below.

In total the Temporary Workforce Rate decreased from 5.9% in August 2011 to 5.5% in September 2011.

The highest Temporary Workforce Rate is within Head & Neck, despite a decrease from 9.3% in August 2011 to 8.9% in September 2011. Within Medicine there remains a high dependency on temporary staff to provide one to one care (specialling) for patients.

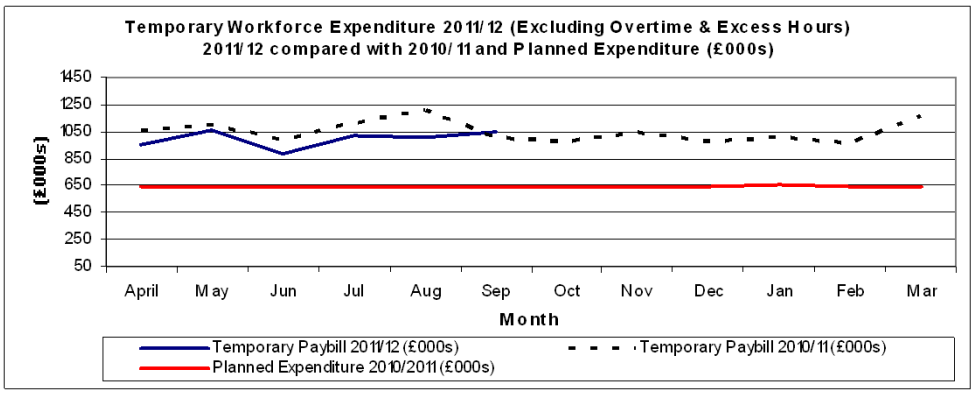
The highest increase in the Temporary Workforce Rate was within T & O with a variance of 1.4% on the previous month, rising from 6.1% to 7.5% in September 2011. The majority of bank and agency cover is for short term sickness. In addition, taking into account the Trust Transformation Programmes, there are also vacancies within T & O that have not been recruited to and have been covered by bank and agency staff.

Figure 4



1.5 Temporary workforce expenditure (i.e. combined bank, agency and locum) increased in September 2011 by £37.631k to £1.042.907m, as shown below in Figure 5. Bank and Agency Nursing Costs increased by £49.308 in August 2011 to £576.173k in September 2011.

Figure 5

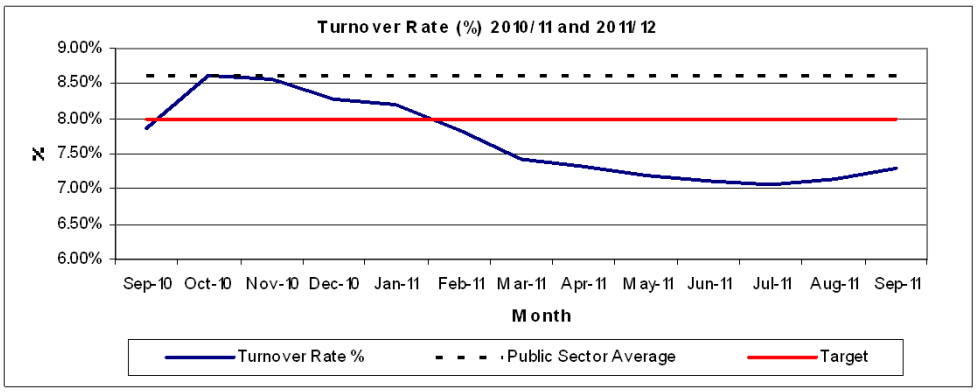


2 Workforce Performance

2.1 Turnover (leavers) has increased slightly by 0.2% to 7.30% in September 2011, which is below Trust target of 8%, as shown in Figure 6 below. Turnover is measured over a rolling 12 month period.

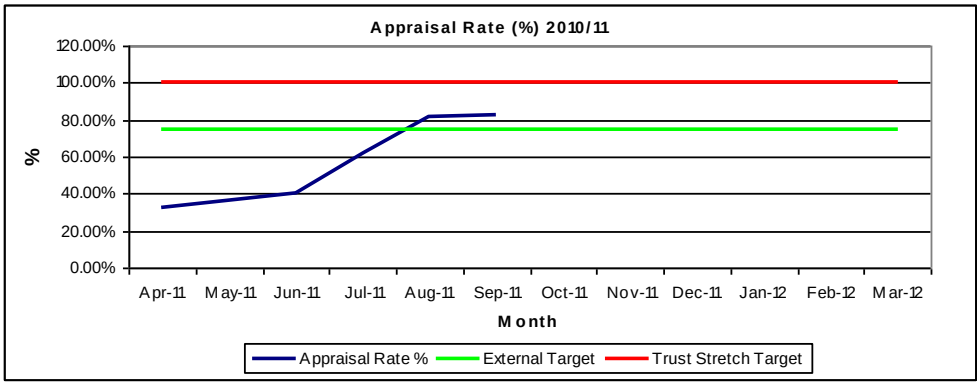
[NB. The formula for staff turnover is the number of leavers in the year divided by average total staff in the year].

Figure 6



2.2 Appraisal Compliance has increased to 83% in September 2011, as demonstrated in figure 7 (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 in the trend for 2010/11. The HR Business Partners continue to advise Managers to bring forward appraisals to fit into the financial cycle and in line with the Corporate Objectives.

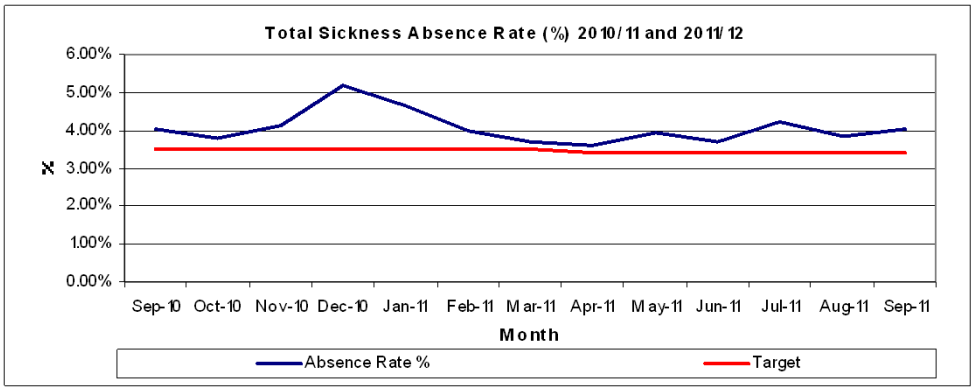
Figure 7



2.3 Total Sickness Absence Rate has increased by 0.1% to 4.0% in September 2011, as detailed in Figure 8 below. The Trust target in 2011/12 is 3.4%.

[NB. Sickness Absence data is calculated by the proportion of FTE days lost to sickness expressed as a %].

Figure 8



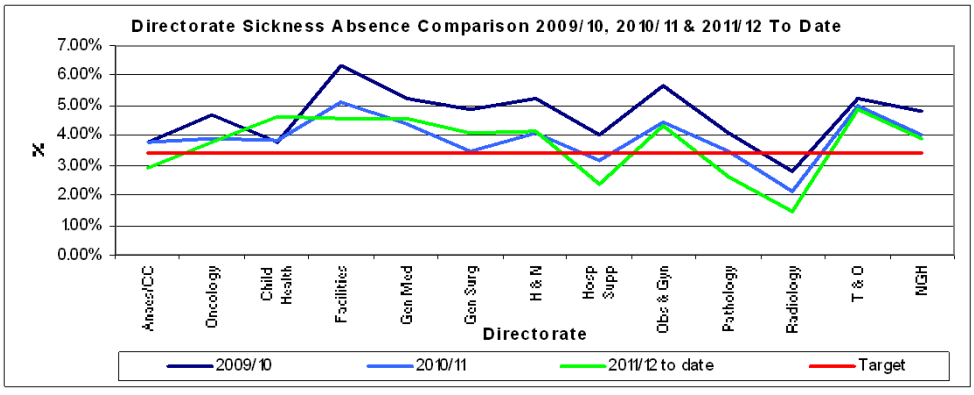
2.4 Directorate Sickness Absence Comparison, the year on year comparison of Directorate total sickness absence as detailed in Figure 9 below shows that for 2010/11 it has remained consistently lower than the previous year and in the majority of Directorates for 2011/12 to date, the trend continues to be lower than the previous year.

When considering levels of sickness absence per Directorate, the highest area of sickness absence in September 2011 was within T & O with a percentage sickness absence of 5.87%. This can be accredited to 9 long term sickness cases comprising of 7.64 FTE within the Directorate and these cases are being actively managed in line with Trust Policy. Four of the cases will be concluded imminently through a return to work and a further five cases are being reviewed by Occupational Health.

In September 2011, with the exception of Anaesthetics, Pharmacy, Radiology and Hospital Support all other Directorates were above the Trust target. Work is ongoing in all Directorates to decrease sickness absence levels below the target.

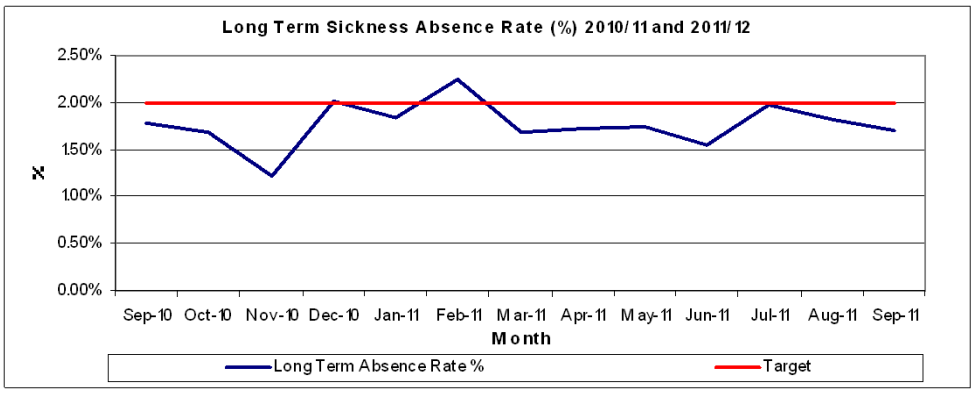
Figures shown for Financial Year 2009/10, Financial Year 2010/11 and Financial Year 2011/12 to date.

Figure 9



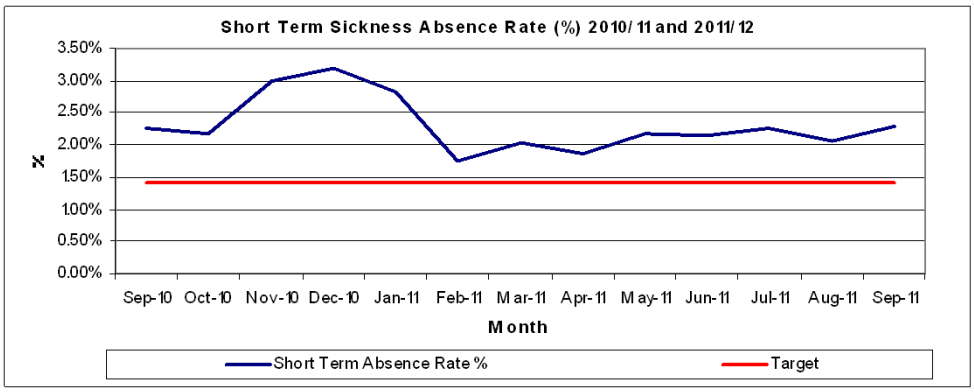
2.5 Long Term Sickness Absence Rate decreased by 0.1% to 1.7% in September 2011, as detailed in Figure 10 below. The Trust target in 2011/12 is 2.0%.

Figure 10



2.6 Short Term Sickness Absence Rate increased by.0.25% to 2.3% in September 2011, as detailed in Figure 11 below. The Trust target in 2011/12 is 1.40%.

Figure 11



3 Mandatory Training Activity

This report identifies, by all subjects, that if the mandatory training leads continue to train the same numbers of staff that they have done between April 2011 and September 2011, 76.4% of staff will be trained in all subjects by the financial year end as detailed in Figure 12. It must be noted that for the purposes of this report the mandatory training subject on Harassment and Bullying has been removed from the report as all staff received the required level of training in May 2011. This means the percentages would have been much higher and therefore provided a misrepresentation for the other subjects.

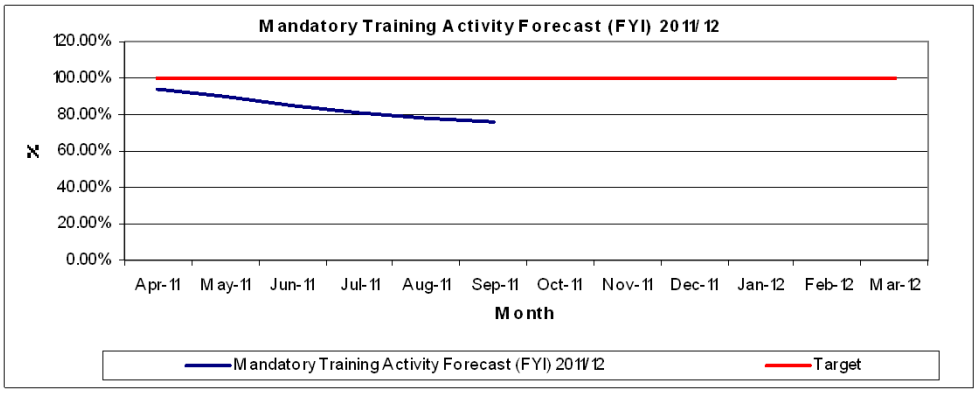
The Mandatory Training leads meet on a monthly basis and where necessary have action plans to address any shortfalls in training. The action plans, together with the activity, are reported and monitored at the Clinical Quality and Effectiveness Groups (CQEG) on a monthly basis. In recent weeks there has been work carried out on DNA's where Training and Development are providing Directorate Managers with up to date reports on those staff that DNA from courses and those that are to expire with their training within the next 3 months. Further work is continuing to identify the cost of DNA's by subject. A sample of DNA's for three subjects is shown as follows:

Subject	Actual trained in month	DNAs in month
Fire	194	54
Information Governance	158	40
Slips, Trips and Falls	78	21
Totals for all subjects	**535**	**151**

The Mandatory Training subject leads identified in April 2011, the population of staff requiring training per month plus an additional 10% to ensure meeting the 2011/2012 internal Trust target of 100%. The class capacity for a mandatory training session is 25 and the Mandatory Training leads have over established the number of sessions within the financial year to accommodate the Trust target. The Mandatory Training leads have expressed their continuing concerns; staff are not booking onto mandatory courses and compounding this is the amount of staff DNA's from courses. Both concerns have an impact in working towards meeting the Trust target.

Training & Development and the Mandatory Training Leads are working extremely hard to meet the Trust internal 100% target and are executing their action plans and communicating with CQEG and the Trust Managers in working together to achieve this target.

Figure 12



Appendix 1 - Workforce Performance Dashboard Summary 2011-12 (M6)

Northampton General Hospital NHS
NHS Trust

Workforce Performance Dashboard Summary 2011-12 (M6)

Workforce Capacity

Target = 95%

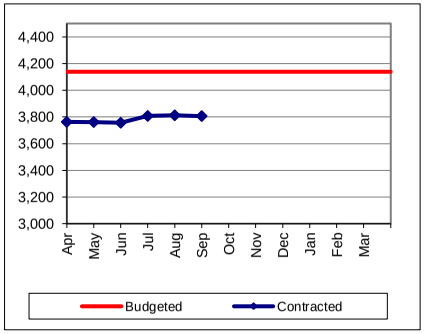
<95% = Under Establishment (-) | 95% to 97% Establishment | 97% to 100% Establishment | Over Establishment

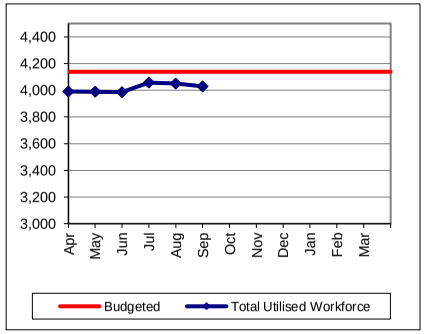
Substantive Workforce Capacity FTE

Directorate	Budgeted Establishment	M6 Contracted	Variance
Medicine	918.37	866.14	-52.23
Surgery	420.33	380.43	-39.90
Anaesthetics	172.80	157.64	-15.16
T&O	273.98	250.70	-23.28
Head & Neck	185.54	159.74	-25.80
Child Health	266.00	261.44	-4.56
Obs & Gynae	405.16	368.04	-37.12
Oncology	240.35	233.83	-6.52
Pathology	221.82	196.11	-25.71
Radiology	141.73	132.14	-9.59
Pharmacy	102.14	95.10	-7.04
Therapies	74.44	69.58	-4.86
Facilities	345.86	296.60	-49.26
Hosp Support	371.05	339.24	-31.81
TOTAL	**4,139.57**	**3,806.73**	**-332.84**

Total Workforce Capacity FTE

Directorate	Budgeted Establishment	* Total Utilised Workforce	Variance
Medicine	918.37	946.58	28.21
Surgery	420.33	413.43	-6.90
Anaesthetics	172.80	166.65	-6.15
T&O	273.98	270.91	-3.07
Head & Neck	185.54	175.30	-10.24
Child Health	266.00	265.64	-0.36
Obs & Gynae	405.16	381.77	-23.39
Oncology	240.35	249.12	8.77
Pathology	221.82	199.76	-22.06
Radiology	141.73	132.14	-9.59
Pharmacy	102.14	95.10	-7.04
Therapies	74.44	75.23	0.79
Facilities	345.86	305.89	-39.97
Hosp Support	371.05	351.44	-19.61
TOTAL	**4,139.57**	**4,028.96**	**-110.61**



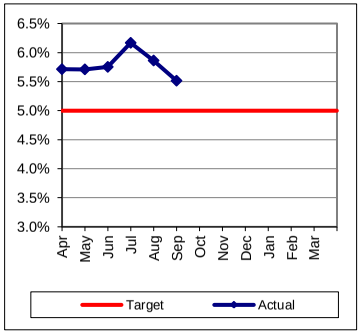


* Total Substantive Workforce plus Temporary Workforce (FTE)

Temporary Workforce Rate

Target = 5.0% | < -1.0% | > 0.0%

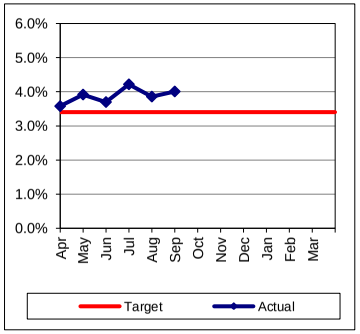
Directorate	Bank, Agency & Locum M6	Variance against Target	Variance from M5
Medicine	8.5%	3.5%	-0.8%
Surgery	8.0%	3.0%	-0.5%
Anaesthetics	5.4%	0.4%	-1.0%
T&O	7.5%	2.5%	1.4%
Head & Neck	8.9%	3.9%	-0.4%
Child Health	1.6%	-3.4%	-0.1%
Obs & Gynae	3.6%	-1.4%	-0.3%
Oncology	6.1%	1.1%	-0.9%
Pathology	1.8%	-3.2%	-0.3%
Radiology	0.0%	-5.0%	-0.1%
Pharmacy	0.0%	-5.0%	0.0%
Therapies	7.5%	2.5%	-0.8%
Facilities	3.0%	-2.0%	0.2%
Hosp Support	3.5%	-1.5%	-0.4%
TOTAL	**5.5%**	**0.5%**	**-0.3%**



Staff Sickness Absence Rate

Target = 3.4% | < 0% | > 0%

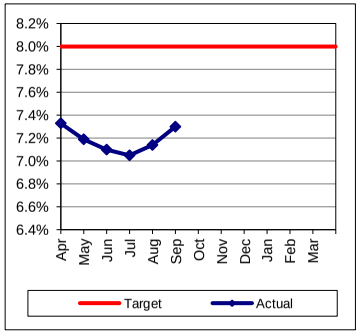
Directorate	Sickness Absence M6	Variance against target	Variance from M5
Medicine	4.70%	1.30%	0.8%
Surgery	4.74%	1.34%	0.1%
Anaesthetics	2.77%	-0.63%	1.5%
T&O	5.87%	2.47%	1.2%
Head & Neck	3.08%	-0.32%	-1.7%
Child Health	4.42%	1.02%	-0.6%
Obs & Gynae	3.45%	0.05%	-0.7%
Oncology	4.28%	0.88%	-0.1%
Pathology	3.77%	0.37%	1.5%
Radiology	1.58%	-1.82%	-0.5%
Pharmacy	1.82%	-1.58%	0.6%
Therapies	5.16%	1.76%	2.1%
Facilities	3.85%	0.45%	-1.1%
Hosp Support	2.80%	-0.60%	-0.1%
TOTAL	**4.01%**	**0.61%**	**0.1%**



Staff Turnover

Target = 8% (FTE) | < 0% | > 0%

Directorate	M6	Variance against target	Variance from M5
Medicine	6.1%	-1.9%	1.1%
Surgery	6.6%	-1.4%	-0.1%
Anaesthetics	4.1%	-3.9%	-0.9%
T&O	6.2%	-1.8%	-0.8%
Head & Neck	6.0%	-2.0%	-1.8%
Child Health	8.7%	0.7%	0.8%
Obs & Gynae	7.9%	-0.1%	-0.4%
Oncology	7.3%	-0.8%	-1.0%
Pathology	9.2%	1.2%	0.2%
Radiology	4.3%	-3.7%	-0.3%
Pharmacy	3.1%	-4.9%	0.0%
Therapies	9.2%	1.2%	-1.7%
Facilities	12.1%	4.1%	2.1%
Hosp Support	8.4%	0.4%	-0.1%
TOTAL	**7.3%**	**-0.7%**	**0.2%**



Northampton General Hospital NHS
NHS Trust

Transformation Programme

October 2011

Current Position

So far this year we have managed to save over £8m through our Transformation Programme. Despite this success, the financial climate remains very difficult. At the end of September our Income and expenditure position was £1.1m behind plan and we will need to recover this shortfall by March 2012. During the current financial year the Trust has seen unprecedented levels of non-elective demand and A&E activity. This has meant that our plans to reduce overall bed numbers, Outpatient and Theatre capacity have had to be revised. In November we are planning a series of ward moves to make sure we have permanent and cost effective escalation areas to deal with pressures over the winter period. We are in active discussion with our Commissioners about the impact the additional workload has made to our financial plans. In the meantime we need to continue to focus on delivering the remaining planned savings this year and to seek out new initiatives to support our Transformation programme.

Monthly Feature—QIA's (Quality Impact Assessments)

As a Trust we need to minimise costs, whilst at the same time achieve National Targets and maintain and/or improve the Quality of services we provide. This is not going to be easy; therefore it is vital that Quality is assessed when looking at significantly changing any part of a service.

Any significant change to a service requires a Quality Impact Assessment to provide assurance that the impact on Quality has been considered, any potential risks mitigated and monitored.

All Transformation Projects have been Quality Impact Assessed and we have developed a Transformation 'Quality' scorecard as a tool to monitor the impact each phase of the projects has on the Quality of services provided.

Background to the Transformation Programme

- By 2013-14 the NHS in England needs to identify recurrent savings of £20bn. For most organisations this will equate to a year on year efficiency saving of at least 5% for the next 4 years

- For NGH the financial gap, over a 2 year period is £30m to break even. This comprises of £19.8m in 2011-12 and £9m in 2012-13.

- In March 2010 NGH embarked upon a transformation programme to close this gap, with some targeted service reviews, which provided detailed data, without a clear plan for progression.

- In January 2011 the Trust contracted with Ernst & Young (E&Y) to develop and support a refreshed Transformation Programme. The first phase of this was to develop a plan identifying savings, milestones and accountabilities. This influenced the identification of the workstreams that are detailed within this newsletter.

- Each workstream has an executive sponsor to steer the work, a project lead to manage the work, supported by a clinical lead. Project management support provided by the remaining 4 members of the Service Improvement Team, other additional support from a further 2 project managers.

- As part of the project a Programme Management Office (PMO) was established to ensure on going active implementation of schemes as E&Y reduced their support to the Trust, transferring responsibility for delivery in July 2011. Monitoring of schemes is undertaken by members of the Trusts executive team through the Transformation Delivery Group (TDG). The TDG provides assurance to the Trusts Executive Team and Trust Board, reporting on progress and realisation of benefits.

- E&Y remain on site in a part time capacity until December 2011 to provide critical support to agreed workstreams, and assurance on progress. They will also assist in the identification and development of workstreams and cost improvement programmes for 2012 – 13.

- The Transformation programme was allocated the target of £15.1m to deliver in 2011/12.

Transformation Programme

Workstream Savings

Progress to date

Total savings of £8.2m have been recorded for the year to date. This includes £1.8m in relation to funding for EY fees and £0.5m of additional income.

There are 2 schemes that are off track in October:

- Beds £64k (due to ward closure delays)
- IBRs £123k (due to elective Orthopaedic activity reduction).

The table below demonstrates the planned financial delivery for each workstream , with the following pages providing more detail on individual scheme progress for October .

Workstream	Plan	YTD Actual	October Red Rated	October Delivered
	£k	£k	£k	£k
Theatres	399	129		26
Beds	1,299	157	64	92
Outpatients	210	57	-47	57
Pharmacy	702	455		63
Procurement	1,300	630		95
Controls	4,485	946	-135	308
Non Clinical	218	-	-9	
Estates	60	10		10
IBRs	1,924	785	123	61
Diagnostics	345	130	9	26
Reorganisation	70	-		
Back Office	50	-		
Medical Productivity	50	-		
2% CIPs	4,789	2,614	-81	465
Total	**15,899**	**5,913**	**-76**	**1,203**
Existing Mitigations	**2,700**	**2,275**		**355**
Total CIP Delivery	**18,599**	**8,188**	**-76**	**1,558**

Theatres Update

RAG status: Amber

Progress:
•The BADs (British Association of Day surgery) tool has been completed and will be ready for implementation in Danetre and DSU in the next few weeks
•Improvement has been seen in some KPI's i.e late starts and early finishes

Key Achievement:
•Communication text system set up for theatre staff that signed up to the system
•Head & Neck now sending patients to MTAU prior to surgery

Next milestones:
•The theatre dashboard is being scrutinised for all areas
•Business case to be developed for a new clean room to accommodate the ARMD clinic

Delivery risks:
•Commissioning intentions haven't significantly reduced—unable to remove theatre sessions Efficiency not improving substantially , resulting in no PA reductions

Savings:
•Savings are behind due to delays in removing consultant PA's, increase in T&O commissioning intentions and slow reduction of commissioning in General Surgery

Outpatients Update

RAG status: Amber

Progress:
•Workstreams reviewing outpatient support staff skill mixes
•iPM clinic data is being cleansed so that we definitively know our capacity. To date, over 700 updated clinic templates received back to clinical apps team from all specialties with over 400 having been processed already.
•Work is underway to identify considerations and savings attributed to devolving booking centre back out to directorates

Key Achievement:
•Outpatient standards for all clinics agreed
•Patient appointment reminder system implemented

Next milestones:
•Identify savings for skill mixes and reductions in consultant PAs associated to outpatient clinics as a result of matching capacity with demand
•Collection boxes for outpatient standards questionnaires will be put up in every clinic area Data collection methods agreed now to be put into action

Delivery risks:
•Capacity and demand focussing on areas with known opportunity as priority to mitigate delays encountered

Savings:
•Patient appointment reminder system currently saving the Trust a minimum of £3.5k per month

Diagnostics Update

RAG status: Green

Progress:
•Both Radiology and Pathology are on track with their planned schemes.
•The Pathology team are working up additional ideas in preparation for next year.

Key Achievement:
•Partial booking for non-obstetric ultrasound implemented
•Change in supplier for send away tests
•Change in platforms for tests delivering savings to reagent costs

Next milestones:
•Currently working in partnership with Milton Keynes around Pathology provision.

Delivery risks:
•Staff issues resulting from potential changes regarding OOH (Out Of Hours) work.

Savings:
•On track to meet all the targets with mitigating schemes planned or in place

Beds Update

RAG status: Green

Progress:
•We have closed Victoria and Compton Wards
•Patient flow group focusing on improving MDTs (Multi Displinary Team), patient pathway flow and discharge coordination to improve quality whilst driving down average length of stay for patients.

Key Achievement:
•SSE was launched at the start of September. Further data collected shows improvement on September with ALOS for Brampton (SSE) ward for October being 12.3 with 71 discharges in the month.

Next milestones:
•Agreement reached with directorate managers on new bed base. Implementation group established . Moves to start in latter part of November.

Delivery risks:
•Winter pressures. We have been on black Alert in October which has meant Knightly has not been able to close due to medical bed pressures. NEL (Non-Elective) activity remains higher than predicted.

Savings:
•The August Stock Take identified that the Beds programme would deliver £1.3m. We are on track to deliver this, however there may be risks associated to delivery linked to NEL (Non Elective) activity and winter pressures

Transformation Programme

Procurement Update

RAG status: Green

Progress:
•On target to deliver the stretch target set for procurement

Key Achievement:
•Exceeding initial target
•Working on a number of trust-wide tenders and workstreams too

Next milestones:
•Tenders around Occupational Health provision
•3rd party pharmacy potential tender

Delivery risks:
•No serious unmitigated risks

Savings:
•On track to exceed target and deliver £1.3m

Back Office update

RAG status: Amber

Progress:
•Workstreams in IT (Information Technology), HR (Human Resources), Occupational Health and Finance established and currently being costed

Key Achievement:
•Project plans developed and project teams established
•Steering group established

Next milestones:
•Develop fully costed plan

Delivery risks:
•Risks are currently being identified and mitigated as part of establishing the projects

Savings:
•Savings have not been scoped in detail yet, they are expected to deliver in the next year's plans. If possible savings will be brought forward into this year, dependent on HR processes.

Pharmacy update

RAG status: Green

Progress:
•Pharmacy on track to exceed their planned savings

Key Achievement:
•Patient's Own Medicine scheme extended to EAU and Spencer
•Savings achieved through contract negotiations and changes in prescribing practice

Next milestones:
•OOH (Out Of Hours) consultation to commence along with the Trustwide plan

Delivery risks:
•No serious risks currently unmitigated

Savings:
•On track to exceed the target

Non Clinical Update

RAG status: Amber

Progress:
- Project plans revised to reflect slight delay in delivering the milestones
- Mitigations in place to compensate for the delay
- Implementation groups in place and working well
- QIA submitted and approved
- Risk and issues updated regularly

Key Achievement:
- EPR demo scheduled for 25 Nov
- Switchboard go live date set
- HR mapping for Pooling & Standardising completed

Next milestones:
- Agree start date for HR consultation for pooling and standardising
- Mail start going out through hybrid mail
- External Voice Operators in place

Delivery risks:
- HR process for pooling and standardising may lead to delay in start date of benefits.
- Clarify issues around contract with hybrid mail provider
- IT infrastructure to deliver digital dictation.
- Plans in place to mitigate.

Savings:
- Benefits latest thinking forecast for FY 2010/11 £ 164 K.

Medical Productivity Update

RAG status: Green

Progress:
- 2011/2012 job plan reviews underway
- More detailed understanding of capacity against demand

Key Achievement:
- Alignment of consultant capacity to demand – starting to be understood and captured

Next milestones:
- Incorporate Theatre & Outpatient Transformation Reviews into job plans
- Present data on delivery of DCC (Direct Clinical Care) sessions to date
- Present evidence of SPA (Supporting Professional Activities) activity

Delivery risks:
- Resistance to any proposed future changes.
- Potential delay to completion of all reviews prior to 31st March 2012

Savings:
- Benefits to be realised in second review – work in progress to identify in line with Theatres/Outpatients and SPA reviews.

IBR Update

Review of joint Rheumatology/Orthopaedic clinic

RAG status: Amber

Progress:
•Joint rheumatology clinics are to continue with income split with the Medical Directorate

Key Achievement:
•Patients will continue to benefit from a collaboratively provided service

Next milestones:
•Identify income generated for T&O Directorate and if there is any shortfall from the target

Delivery risks:
•Impact on income generated by general medicine directorate will fall.

Savings:
•Identify income generated for T&O Directorate. Work currently being done.

Cessation of Health Psychology service

RAG status: Green

Progress:
•Service ceased on 21st Oct 2011

Key Achievement:
•More effective utilisation of resources benefiting NGH patients.

Next milestones:
•No further milestones

Savings:
•Full savings for Oct will not be achieved due to be implemented on the 21st.

Delivery risks:
•No further risks

Transformation Programme

Key actions in November……..

- Further progression of the Pooling & Standardising recommendations.
- Focus on the 2012-13 CIP (Cost Improvement Programmes) to identify potential directorate schemes
- Completion of QIAs, consolidation of dashboard and agreement of thresholds.
- Review capacity plan for Outpatients and Theatres work streams.
- Review financial LTF's (Latest Thinking Forecast) for all schemes.
- Development of options for Outpatient clinic staffing
- Ongoing 'Clean up' of clinic templates on IPM
- Installation of boxes in Outpatient areas to collect questionnaires
- Bed re-base implementation which will see the current escalation areas not being utilised for additional out of hours capacity
- Commencement of further consultations as identified through IBRs, specific workstreams and Trustwide
- Electronic Patient Record (EPR) presentations

Transformation Programme

Who to contact……..

If you have any comments or questions related to anything contained within this newsletter, please don't hesitate to contact any member of the Transformation team listed below

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We would also be interested in any ideas you may have regarding any part of the Transformation Programme, whether it is a suggestion for potential cost improvements or for something you would like to see featured within the newsletter.

BOARD SUMMARY SHEET	
Title	South East Midlands Acute Services Review
Submitted by	Dr G McSorley, Chief Executive
Date of meeting	1st December 2011
Corporate Objectives Addressed	

SUMMARY OF CRITICAL POINTS

Updates the Board on the outcome of Phase 1 and proposes an approach to Phase 2.

PATIENT IMPACT –
Design of patient pathways going forward is a key priority.

STAFF IMPACT -
Engagement of key clinical staff essential with consequent time commitment.

FINANCIAL IMPACT
Possible impact in the future as service design is agreed.

EQUALITY AND DIVERSITY IMPACT -
To be built into the clear commissioning vision at the end of Phase 2.

LEGAL IMPLICATIONS -
The programme must be designed, delivered and implemented with good practice in mind.

RISK ASSESSMENT - :
The Trust must ensure that the benefits to patients and any impacts on the organisation are properly considered and managed.

RECOMMENDATION
The Board is asked to discuss and agree its approach to Phase 2.

South East Midlands Acute Services Review

Paper for all Acute Services Review (ASR) partner organisations' Boards

15th November 2011

1. Background

Hospitals and Commissioners have been working together for the last year on proposals to review acute services across the South East Midlands. The current work began in earnest in Spring 2011 with a focus on the services provided by the five District General Hospitals.

Twelve NHS organisations (two PCT Clusters, five Clinical Commissioning Groups and five District General Hospitals) came together in partnership to take forward this ambitious programme of work which aims to improve quality and outcomes for patients and ensure that the health system is in a position to face the extensive challenges facing the NHS in the future.

There is a phased approach to the Review which is scheduled to run until March 2015 when all service changes will have been implemented. Phase One commenced in June 2011 and this Board paper marks the end of this initial scoping phase. Phase Two is due to start in early December and a full public consultation is planned for Phase Three which will start in May 2012.

At the final Programme Board meeting of Phase One on 10 November 2011 all partners showed a strong commitment to taking the Review forward in partnership and there is strong support for the aims of the Review from key stakeholders such as the Local Authorities, LINKs and MPs.

2. Case for Change

Work undertaken during Phase One has led to the development of a Case for Change which outlines the current and future challenges facing the health system and concludes that these issues can not be solved if hospitals and other services work in isolation from each other. Three of the biggest challenges both nationally and locally are:

- A growing and ageing population with rising levels of long term conditions
- Sustaining the current quality and safety of services as well as improving services and optimising patient volumes for best outcomes in complex services
- The most difficult financial situations ever faced by the NHS

The full Case for Change is attached at Appendix 1.

3. Patient, Public and Clinical Engagement

Clinical engagement has been a key feature of Phase One. This has been led by the Clinical Reference Group with representatives from all acute trusts, Clinical Commissioning Groups (CCGs) and other stakeholders. The Medical Directors of all five Trusts have provided an important leadership role. A number of clinicians have undertaken media training relating to the ASR and

subsequently have taken part in presentations to patient groups as well as media work leading to positive local coverage.

Multiple stakeholders have been represented at all the governance groups including LINks, ambulance trusts, adult social care and community trusts. A two day engagement event, U-Collaborate, brought together nearly 80 people from over 29 organisations including patient representatives.

Face to face briefings have been held with MPs, Health and Wellbeing Boards and LINk representatives from across the South East Midlands and presentations at the local Health Overview and Scrutiny Committees are planned for November and December 2011. An agreement has been reached in principle to establish a Joint Overview and Scrutiny Committee.

Patient and public engagement will now be strengthened as the Review moves into Phase Two ensuring that meaningful engagement is undertaken with the local population and that they have the opportunity to shape the development of proposals. As part of this, the intention is to set up a Patient Panel, with an independent Chair, to provide advice on and assurance about the Review's engagement processes and to co-develop key principles which will shape proposals.

4. Future Programme Process, Governance and Timescales

A Senior Responsible Owner (SRO) has been appointed to oversee and drive the Review which will be managed through a Programme Board made up of the twelve Accountable Officers from partner organisations. New clinical models will be developed through a series of Clinical Working Groups reporting to a Clinical Senate. The Clinical Senate will be made up of the Chairs of the Clinical Working Groups, with representatives from the acute Medical Directors, CCG lead clinicians and representatives from ambulance, community, local authority and patient representatives. The Chair of the Clinical Senate will be a local clinician from primary or secondary care, and will appointed by the Programme Board. An external clinical adviser will also be appointed to provide independent assurance and expertise. The Clinical Senate will make recommendations on new clinical service models to the Programme Board.

Where proposals suggest a reduction in the number of hospital sites a specific service should be delivered from, or a change in the existing hospital configuration, these proposals will then be given to the Clinical Implementation Group, made up of Medical Directors from both Acute Trusts and CCGs, to develop proposals for locations.

See Appendix 2 for the proposed structure of the ASR Review.

The Review will be commissioner led with a broader scope than originally defined. Clinical Working Groups will develop clinical models based on the whole pathway of care, from primary care to hospital and specialist care and from low to higher acuity.

Key outputs from Phase Two will be:

- The development of an overarching commissioning vision and principles for South East Midlands that will define the pattern of care for the future
- The development of a range of local proposals drawn up by individual CCGs with their local partners. This work will link into the wider ASR process to understand the different impacts and to share learning and ideas
- The development of what will constitute the core clinically viable services at all five local hospitals

- The development of proposals for service reconfiguration across South East Midlands where change would lead to qualitative improvements

By the end of Phase Two there will be a clear commissioning vision, a wider understanding by the local population and stakeholders of the need to change and a suite of proposals ready for public consultation. The intention is for a public consultation to start in May 2012.

5. Resources Required

The costs of the Review programme are forecast to be in the region of £2m up to December 2012, of which 33% is for the remainder of this year and 67% next. These costs include key staff time and external support.

Costs will be shared between commissioners and providers. The provider contribution will be made up of dedicated managerial and clinical staff time which is expected to be significant.

6. Next Steps

The work outlined below will commence following agreement from the Boards of all the ASR partner organisations:

- The establishment of the groups outlined in the governance structure and appointment of the relevant Chairs and external adviser
- The establishment of and appointment to a central Programme Office
- The establishment of a Patient Panel
- The establishment of the Commissioning Group to start the development of the commissioning vision and principles
- Pre-consultation engagement with patients and the public in line with a communications and engagement strategy that has been agreed by the Programme Board
- The Case for Change will be used as a basis for a short and compelling public facing document to help raise awareness and understanding of the challenges faced by the local NHS
- Data collection and analysis to support the Clinical Working Groups. These group will start work in January 2012

6. Recommendations

Boards are asked to:

- Note the above and associated appendices
- Endorse the proposed approach
- Confirm their continuing commitment to the Review programme

Appendices:

1. The Case for Change
2. Proposed Governance

South East Midlands Acute Services Review
The Case for Change

15th November 2011

Case for change

The NHS faces the most challenging period in its history, but also one where there are opportunities to improve care. The NHS in Bedfordshire, Luton, Milton Keynes and Northamptonshire - the South East Midlands - is working together to plan how health services need to change over the next few years to respond to this. In this document we set out our ambition to improve the quality of care for the public and be better placed to face the significant challenges ahead as finances tighten and demand increases. Many of the very challenging issues facing hospitals in the region cannot be solved if hospitals and other services work in isolation from each other. Furthermore, without the right sort of change, the local NHS is likely to fall behind in its ability to maintain the current level of quality delivered as well as miss the opportunity to improve outcomes for the population.

There are five district general hospitals in the South East Midlands area in Bedford, Kettering, Luton, Milton Keynes and Northampton. When people need more specialist treatment, typically they are referred to centres in Oxford, Cambridge, Leicester, Nottingham and London. Until recently the hospitals worked largely independently of each other partly due to administrative regional boundaries but, following the recent administrative changes within the NHS, there is now a greater opportunity for the five hospitals to work more closely together in a number of areas. If services share their resources and expertise it should be possible to sustain services locally that might otherwise have to move to specialist centres. It may also be possible to provide more specialist care, currently provided outside the area, more locally reducing the need for people to travel long distances. This means we can be more ambitious about the way that care is provided, its quality and how we improve the experience of patients. But, there is also an urgent need to look at how services are organised to ensure that they can meet the standards of safety and quality we will expect in the future and to adapt to the demands of an increasing and ageing population and the challenging economic climate.

Our ambitions

In the last two decades not only has medical care improved enormously but we also know much more about what is needed to ensure we offer the highest quality and safety of care. We want to set ambitious goals for what the health care system should achieve and how it operates, for example:

- The way that emergency care is organised can be a matter of life or death. For a number of conditions it is vital that we can provide access to a specialist opinion 24 hours a day, 7 days a week. Up to now this has not been the case locally or across most of the UK. There is strong evidence that this needs to change. By working together hospitals could ensure that this level of expertise is available to patients that need it. Similarly, well organised specialist teams for heart attacks and strokes, special units for people with multiple injuries and ensuring that there is a high quality surgical service at nights make a big difference to patients' survival and longer term health. We want to make improvements in these areas and our intention is to save 1000 lives over the next five years, 400 of these lives would be saved by changes to stroke services [1]
- We want to reduce the number of people who have to travel to hospital for tests, treatments and appointments that could be carried out in a GP surgery or a more convenient local location
- We want to improve the quality of life of people with long term conditions, particularly frail older people and reduce the risk that they will need emergency admission to hospital by making sure that services are properly coordinated and that they provide easy access to specialist advice
- Using health services in an emergency and out of hours is often confusing. We want to make sure that using the NHS is as simple and straightforward as possible for patients, their carers and families, particularly at times of crisis
- There is a need to improve the care of pregnant women, particularly those who are at higher risk of a complication, so that the number of normal births is increased. Elsewhere 'high risk' obstetric units have reduced artificial inductions of labour by up to 33%. If a similar reduction was achieved in South East Midlands about 400 fewer women would experience an artificially induced labour each year [2]
- People who are nearing the end of their lives would generally prefer to be at home; too often they receive their final care in hospital when this is neither necessary nor what they and their families want. Better planning of services at the end of life would allow more than 2000 people a year across the South East Midlands to die at home rather than hospital [3]
- The number of people aged 0-74 years whose death is potentially preventable with timely and effective healthcare has improved in the UK but could still be better in comparison to other countries such as France. Comparative to other parts of the UK, in parts of the South East Midlands area death rates from conditions regarded as amenable to health care are relatively high. As the following graph shows, none of the five local hospitals have lower than expected standardised mortality rates for death in and within 30 days of admission. We believe that the reorganisation of services can have a significant impact on potentially preventable deaths and that this review offers the opportunity to improve these outcomes for our population

1. Figure derived from utilising London's Stroke Network figures. NHS London has a population of 7.6m and the Stroke Network saved 400 lives. SEM has a population of 1.6m thus 84 lives would be saved each year or 420 lives over five years

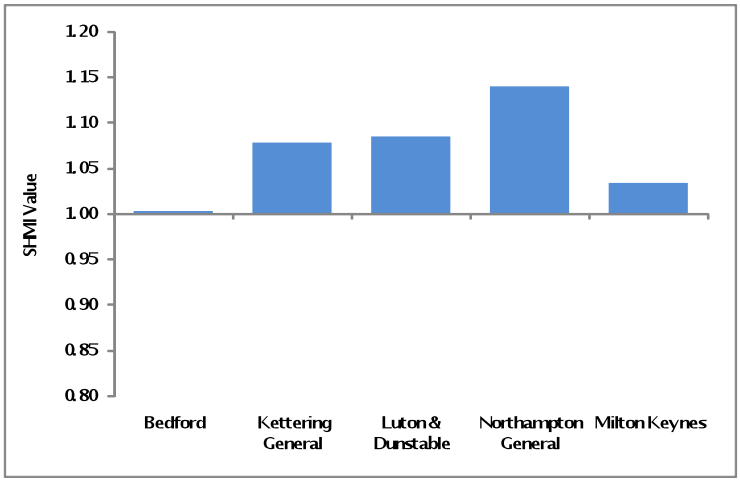
2. Figure derived from using BirthChoiceUK's statistics on numbers of birth and percentages of induced deliveries, and national statistics on high-risk births. According to BirthChoiceUK's figures the regions trusts had 20200 births in 2010. 6% of births are high risk meaning that 1212 births would be high risk within the region. This figure would thus be reduced by 33% meaning 404 fewer induced births.

3. Figure of 2000 derived from calculating mortality rate for a population of 1.6million from National Office of Statistics, forecasting the number of people who would die in hospital, and applying a 30% reduction.

In-Hospital Mortality

All the SEM acute hospital trusts had higher SHMI scores than the national index (1).

Summary Hospital Mortality Indicator (SHMI), for acute hospital trusts in 2010/11



Source: Information Centre for Health and Social Care 2011

Challenges

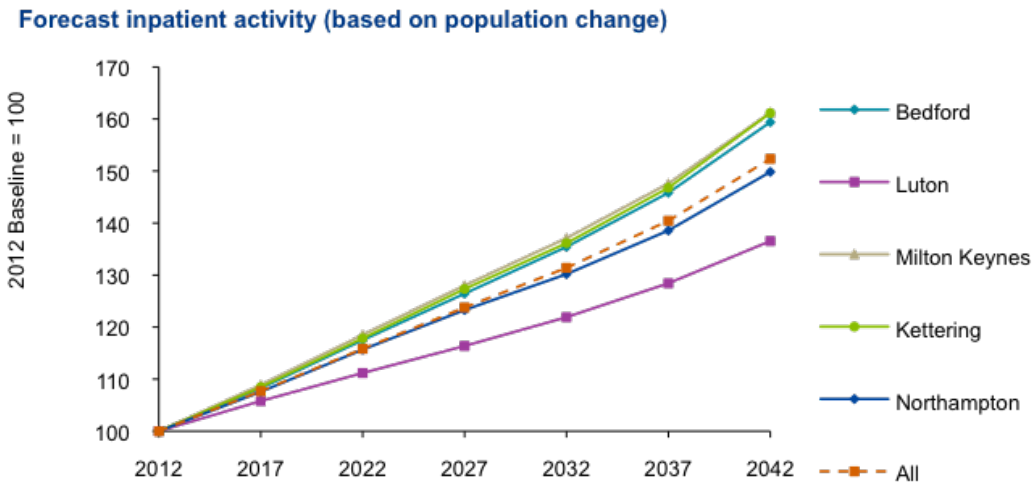
The ambition to improve and achieve excellence for the public is set against a context of significant challenges currently facing the NHS. These challenges give urgency to the need to work differently to achieve better organised healthcare and better health outcomes for the population. The NHS has to change radically over the next few years if it is to continue to improve and meet the expectations of patients, carers and families.

Three of the biggest challenges both locally and nationally are:

1. A growing and ageing population with rising levels of long term conditions
2. Sustaining the current quality and safety of services as well as improving services and optimising patient volumes for best outcomes in complex services
3. The most difficult financial situation ever faced by the NHS

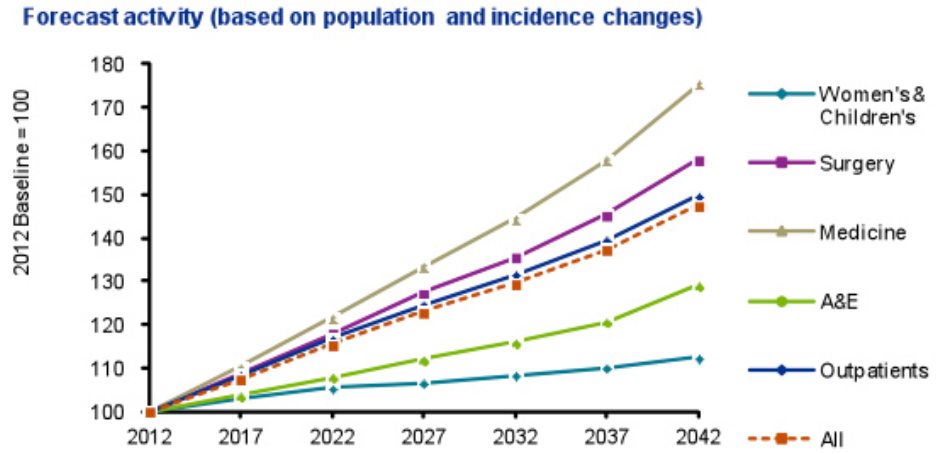
1. A growing and ageing population

As the population rises, if we remain with the current model of care we can expect to see the amount of hospital activity rise by 50% over the next 30 years. This increase in demand would be felt across the whole area but particularly in Bedford, Kettering and Milton Keynes.



Source: KPMG analysis based upon demographic and activity data provided by the five acute trusts 2011

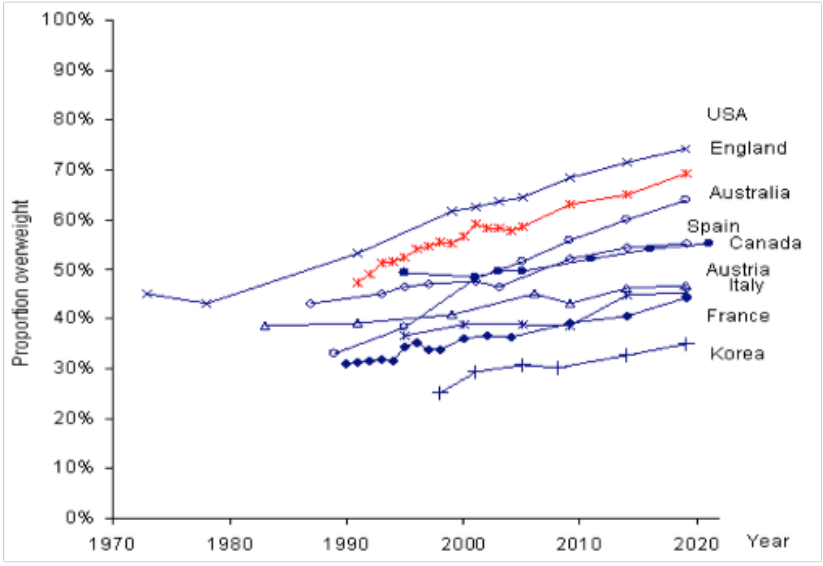
The graph below shows the forecast inpatient activity by speciality.



Source: KPMG analysis based upon demographic and activity data provided by the five acute trusts 2011

Not only is the population growing but it is also ageing and unfortunately risk factors like diabetes and obesity are increasing. Obesity is a problem facing countries around the world and, as the graph below shows, England faces a greater challenge than many others. This rise in obesity will lead to a significant rise in the numbers of people needing joint replacements. We can also expect to see more people who have more than one chronic condition whereas, in the past, hospitals were generally organised to support people who have a single problem. We need to ensure that all our services are able to support people with the complex demands that changes in the pattern of disease are going to produce. Increasingly this will mean that general practice, community services, social services and hospital care will need to work together much more closely to deliver coherent care for patients.

Past and projected future overweight rates in selected OECD countries

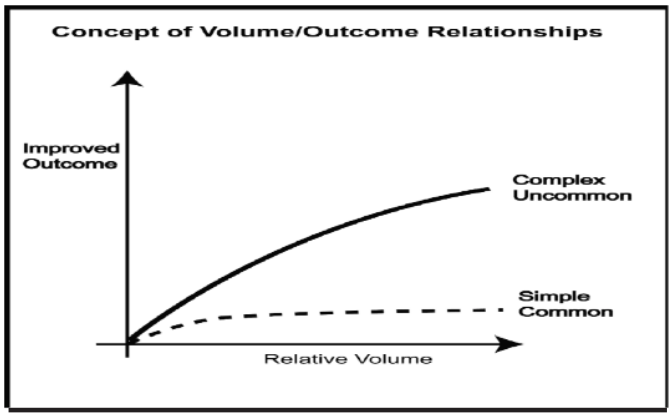


Source: Organisation for Economic Cooperation and Development

2. Sustaining and improving services

Some services need to change to ensure that they can continue to deliver safe high-quality care and meet the standards that are expected of them.

For a number of conditions it is clear that larger units that treat a high volume of patients produce significantly better outcomes than smaller units that treat fewer patients. This is because larger units can bring the right combination of multi-disciplinary expertise together. For some services it is also true that individuals and teams of clinicians who see higher volumes of particular problems often become very good at treating specific and complex conditions in a way that is not possible for individuals and teams with smaller case loads who invariably see the condition less often. This has already happened in cancer care both nationally and internationally with specialist surgery for certain types of cancer now concentrated in a smaller number of hospitals. The diagram below shows the realtionship between volume and outcome. [4]



Source: Report from the Volume/ Outcome Subgroup to NHS Scotland [4]

Changes to stroke and some specialist heart surgery have taken place already in Northamptonshire and other areas such as London, Manchester and Buckinghamshire have introduced similar changes across a range of areas including complex surgery, intensive care for children and new born babies, life-threatening multiple injuries, stroke and some types of heart attack. In all of these areas, where services have been concentrated in specialist units, there have been improvements in the outcomes for patients. This does mean that these services now cover much larger areas than a traditional hospital and for a small number of patients there is a need to travel further.

Across the South East Midlands there are a number of other areas where change is needed to take full advantage of these opportunities to improve outcomes. These include emergency surgery out of hours, vascular surgery, paediatric surgery, high risk maternity care and major trauma.

4. Report from the Volume/ Outcome Subgroup to the Advisory Group to the National Framework of Service Change for NHS Scotland, 2005

Improved infection control rates

When patients have surgery such as joint replacements, there can sometimes be complications such as an infection in the wound. Nationally the infection rate for joint replacements (knee, hip and ankle) is 1-4%.

In hospitals that serve a large population, such as 1.5m people and undertake a very high volume of joint replacements, infection rates have been seen to fall to levels as low as 0.2%.
In the South East Midlands, across the five hospitals in 2010 there were 2,440 joint replacements undertaken and registered with the National Joint Registry. If the infection rate were to fall from a supposed average of 2.5% to 0.5% this would improve the outcomes for approximately 50 patients a year.

There are also practical difficulties in keeping some smaller services working in a way that is safe and sustainable. Across the country hospitals providing care for rarer conditions or smaller specialties can struggle to find enough specialist staff to provide a reliable service with the full range of care 24 hours a day. Simply employing more specialists – even if they were available - would not be the ideal option either because there is not enough work to ensure they will be busy enough to maintain and develop their skills. Some of the services in the South East Midlands are vulnerable to individual doctors leaving, going on holiday or being off sick. This risk could be reduced if hospitals worked together more closely, a national example of this is the Primary Percutaneous Coronary Intervention (PPCI) in Greater Manchester (see box below). [5]

Hospitals working together

Services need to have a certain number of consultants in order to be able to support access to the service in the night time as well as in the day time. Some services are only able to run within the working day or in the week days as there are not enough doctors to cover the services safely overnight or at weekends and therefore patients may need to travel to a different hospital to get the right care out of hours. These arrangements can be confusing and are not the optimum way to deliver care. If hospitals are able to work together to share their resources both their clinical teams and consultants as well as their beds, equipment and finances then they are able to deliver care to patients in a safer and more convenient way both in and out of hours.

This has been successfully achieved in Greater Manchester with the Primary Percutaneous Coronary Intervention rota which covers the fourteen hospitals across the Greater Manchester area. The service is delivered from two sites, Central Manchester Foundation Trust and University Hospitals South Manchester, but the rota is staffed by consultants from across the other hospitals. This is a 24 hours a day, 7 days a week service. There is a sharing of tariff across the organisations to enable the service to operate across all areas.

5. Greater Manchester and Cheshire Cardiac and Stroke Network PPCI factsheet http://www.gmccsn.nhs.uk/cmsupload/E2_Articles-_PPCI.pdf

There are some services that hospitals may want to consider delivering in an alternative model to the traditional inpatient hospital setting. A good example of this is inpatient children's services, which are proving difficult to sustain in many parts of the country. Where new services which are more flexible and adaptable have been introduced they have been a great success with both the public and professions and the learning from these new services could be considered in the South East Midlands.

Innovative models for paediatric care

In Somerset an Integrated Therapy Service for Children and Young People brings together a range of services and creates an easy route for children and their parents to gain access to the services they need whilst keeping children out of hospital. [6]

Another example of innovation is a range of five projects undertaken in the East of England, one of which resulted in a 45% reduction in paediatric attendance at the West Suffolk Hospital, following GP consultation by phone with a paediatrician prior to making a decision regarding attendance at hospital. [7]

Applying these sorts of approaches locally could mean that in some cases specialists and their teams could work on several different sites or that some people would need to travel further to be treated by a specialist team. However, in the main this would be for complex cases allowing the patients the best chance of a good outcomes. The aim is to design services which improve care locally and keep the numbers of people needing to travel further to a minimum. In children's services, for example, elsewhere it has proved possible to provide a wide range of treatments for children locally with only very specialist care brought together in fewer sites.

Ambulance services have an increasingly important role to play. Ambulance services in the UK now have a very advanced ability to identify which patients need specialist units and who can be treated by more general services. This means that even where specialist centres have been established many patients can continue to be treated locally without having to be taken longer distances.

New technology and ways of working also offer the opportunity to provide many hospital services in local settings. Services such as outpatients, ultrasound, blood tests and a wide range of treatments that used to require a trip to hospital can be provided in a range of local settings – particularly if GP surgeries work together to support this approach. In cases where patients need a long convalescence or rehabilitation it will be important to ensure that patients can be cared for nearer to their homes so that their relatives are able to visit them – technology and skilled nurses based in the community can help with this. Although there are examples of good practice in parts of the South East Midlands we believe there is more to be done to gain the full benefits of new technologies.

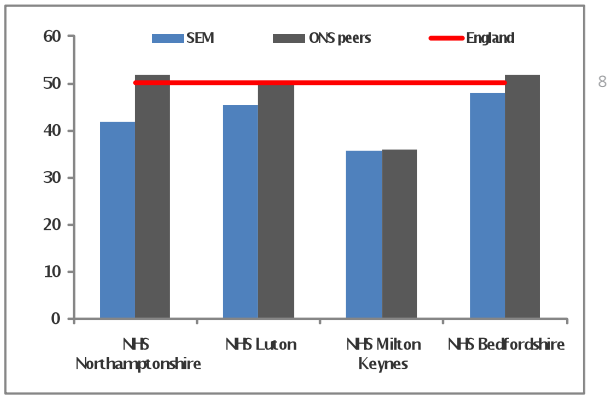
We know that there is much more we can do to improve the management of many long term conditions and the quality of people's lives. For example, at the moment too few people receive all the elements of care that are known to reduce life changing complications and premature death. The following graph shows that, along with the rest of the country, only half of our population with diabetes receive all nine of the key criteria for the best practice management of their condition.

6. Somerset Partnership NHS Foundation Trust http://www.somerset.nhs.uk/integratedtherapies/Professionals.htm

7. Strategic Network for Child Health and Well-Being - regional network for paediatric ambulatory Care/Maynard Debbie. 2011

Evidence shows that our population does less well in this than other parts of the country with similar demographic characteristics.

Diabetes care



8

Source: NDA Diabetes audit and intergrated performancne Monitoring Return Q1 2011/12

The way that diabetic care has changed over the years demonstrates how services can be more convenient, patients can be more in control of their condition and outcomes can be improved. Much of this necessary care can now be managed by people themselves with help from their GP and specialist staff closer to where they live and outside of hospital. Again technology, some of it quite simple, can make a big difference and reduce the need for patients to be admitted to hospital as an emergency. Our aim is a more joined up model of care that brings specialists, general practitioners, specialist nurses and other clinical experts together into an integrated service, puts new technologies in local clinics and people's homes and gives them access to specialist advice at the end of telephone.

People admitted to hospital usually want to return home at the first opportunity. Hospitals are well designed for managing the care of people who are acutely ill but are much less suitable for rehabilitation or convalescence. Better integration between the hospital, community services and social care will offer the chance to provide a more appropriate service by providing more care locally or in people's own homes. Elsewhere simple things, such as better planning of care prior to admission and the introduction of the enhanced recovery programme for surgery, has significantly reduced the length of stay and allowed people to make proper plans for coming home.

8. NDA Diabetes audit and intergrated performancne Monitoring Return Q1 2011/12

Enhanced recovery [9]

The national enhanced recovery programme is focused on improving patient outcomes and speeding up people's recovery after surgery. This results in people being actively involved in their care from before admission to hospital all the way through their hospital stay allowing everyone to plan better discharge and the post discharge care enhanced recovery.

Outcomes of the enhanced recovery programme:

- better outcomes and patients can return home more quickly
- greatly reduced lengths of hospital stay
- increased numbers of patients being treated or reduced levels of resources required
- better staffing environment (multi-professional approach)

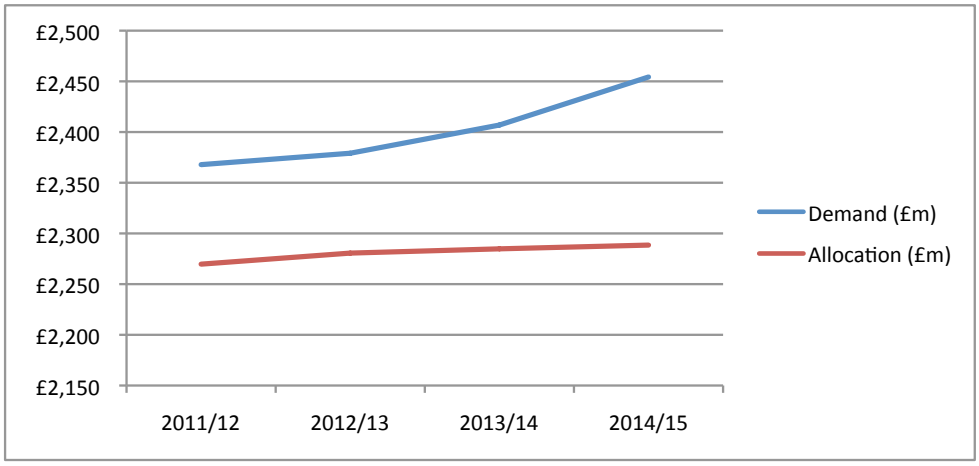
Torbay Hospital built on their existing integrated care service and introduced enhanced recovery for bowel surgery. This involved a strong partnership between the Consultant, Named Nurse, the patient and their family. More time was spent preparing patients for surgery and planning for their discharge at the beginning of the process. In addition improving the post operative care patients received led to patients being able to go home more quickly.

9. Enhanced Recovery Programme, Quality and Service Improvement Tools, NHS Institute for Improvement and Innovation 2008 http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/enhanced_recovery_programme.html

3. Growing financial pressures

Although the finances of the NHS are under major pressure, improving the quality of care delivered remains the prime reason behind our ambition to change services. However, it is essential to address the reality of the economic and financial challenges that the health service faces now and in the future. This will require us to work more efficiently. Although the government has promised to protect the health budget in real terms, it will not rise at a rate that matches the rising demands that demographic and other changes will place on the service. The status quo for service delivery will not be an option as the increasing pressure of the growing and ageing population and technological advances means that current service configurations will become unaffordable. The Department of Health has set the NHS a national challenge to improve its efficiency by up to 20% by 2014/15. It would be prudent to plan as though continued significant improvements in efficiency and productivity will be required year on year for a decade or more.

Size of the financial gap in the South East Midlands between 2011/12 to 2014/15



source: local PCT QIPP plans 2012

Conclusion

It is very clear that the pressures of increasing demand on health services as a result of a growing and ageing population, the ever higher expectations of our patients and the scarcity of resources means that we need to change and improve across all our services. Without change we will be unable to continue to deliver healthcare at the current level of quality and outcome. In order to grasp the many opportunities that exist to improve health services and provide better outcomes and improved experience for patients we must work together across the health economy to organise services in different and more innovative ways. In many cases, these new approaches will not only improve quality and bring services closer to people's homes, but also make services more efficient, so we can do more with the money we have and build the basis for a sustainable health care system for our population in the future.

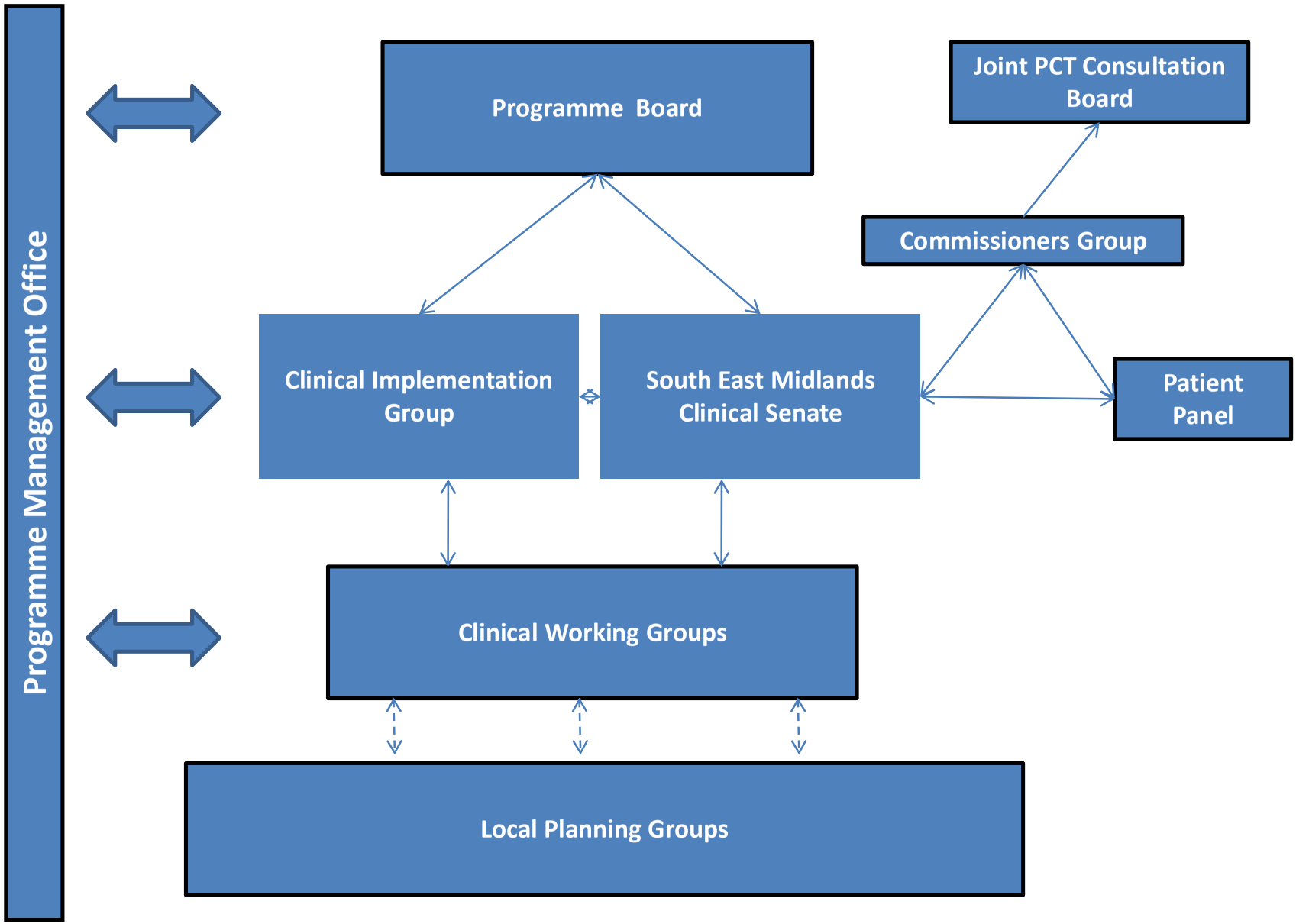
This is a very demanding task. Simply reinvesting in doing more of the same will not work. Increasing quality, ensuring our hospitals are fit to face a challenging future and making big efficiency gains will require significant change. The challenge is to make those changes in a way that improves outcomes for patients and the local population. We believe that we can do this if we work together.

Proposed

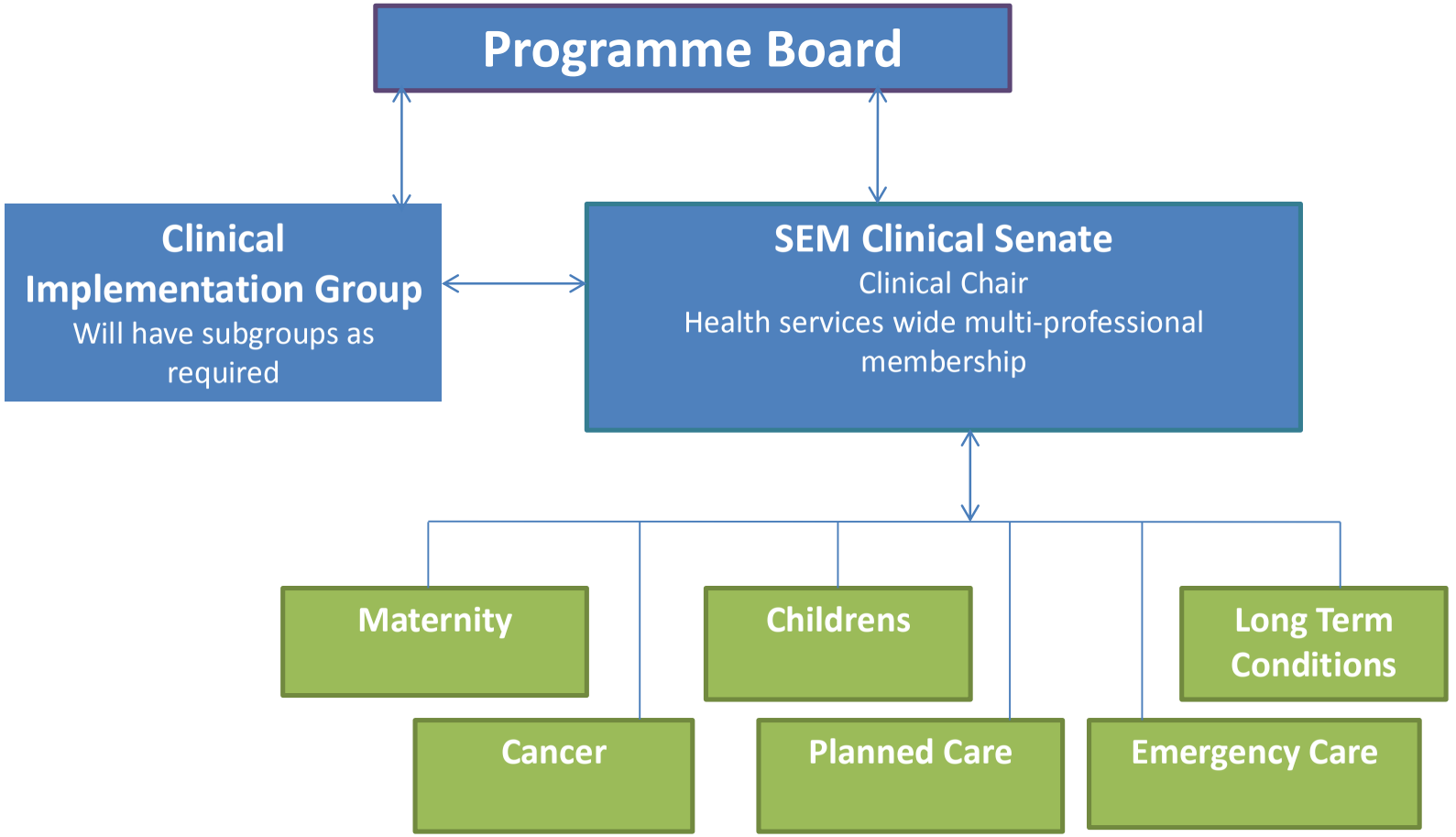
SEM ASR governance structure

14th November 2011

PROPOSED GOVERNANCE STRUCTURE



PROPOSED INITIAL CLINICAL WORKING GROUPS



PROPOSED GOVERNANCE ROLES

Joint Consultation Board – joint PCT committee formally delegated by PCT Boards to approve, carry out and take decisions on the formal consultation (will formally include CCGs as they are authorised)

Programme Board – decision making body made up of the accountable officers of the 12 partners, the chair of the clinical senate and the SRO for the programme

Commissioners Group – development of commissioning vision and key principles for South East Midlands

Patient Panel – input into the development of commissioning vision and key principles

Clinical Senate – responsible for co-ordinating, challenging and consolidating the work of the Clinical Working Groups to provide recommendations to the Programme Board and Commissioners Group

Clinical Implementation Group – development of proposals for site locations

Clinical Working Groups – detailed development of clinical models and proposals for the Clinical Senate

Programme Management Office – drive and support to all aspects of the programme

BOARD SUMMARY SHEET	
Title	Corporate Objectives 2011/12 Quarterly Progress Update
Submitted by	Dr G McSorley, Chief Executive
Date of meeting	1 December 2011
Corporate Objectives Addressed	

SUMMARY OF CRITICAL POINTS

A quarterly update on progress and achievement against the Trust 2011/12 Corporate Objectives for discussion.

PATIENT IMPACT -

STAFF IMPACT -

FINANCIAL IMPACT

EQUALITY AND DIVERSITY IMPACT -

LEGAL IMPLICATIONS -

RISK ASSESSMENT - :

RECOMMENDATION

The Board is asked to consider and discuss the current progress update of the Corporate Objectives.

Northampton General Hospital NHS
NHS Trust

CORPORATE OBJECTIVES 2011/12

Objectives	Measures of success	Timescale	Monitoring	Current Position/RAG Rating
1. To improve the clinical quality of patient care focusing on safe, effective treatment that is patient centred.	**Safety**			
	➢ Increase safety incident reporting in line with peer average.	➢ March 2012.	➢ Quarterly monitoring reporting to CQEG.	Risk Manager reviewing current Trust incident reporting against peer group. Paper to be presented to CQEG – Nov. Amber
	➢ Decrease harm events (falls, pressure ulcers, medication safety measures as per Quality Accounts).	➢ March 2012	➢ Quarterly CQEG, HGC, Trust Board. ➢ Patient Safety Board. ➢ HNQI	Falls – Red Pressure Ulcers – Green Medication errors- Green
	➢ Increase staff ownership of safety issues.	➢ Ongoing	➢ Bi-annual safety climate questionnaire	Patient Safety Board development Green Current incident trends to be discussed at Patient Safety Board Second survey due to be sent out Amber Patient Safety Board standardised and Patient Safety Books on Wards, completed. Green
	Effective Patient Centred Treatment			
	➢ Support enhanced recovery.	➢ March 2012. ➢ Monthly to CQEG and HMG.	➢ Quarterly Quality Accounts.	Enhanced Recovery – Amber
	➢ Right bed, right care.		➢ Quarterly Patient Safety Clinical Quality & Governance progress report.	Right bed, right care – Amber
	➢ Patient experience additional focus on vulnerable/dementia patients.			Patient Experience –Green

Objectives	Measures of success	Timescale	Monitoring	Current Position/RAG Rating
	➢ Reduce hospital mortality. ➢ Full Compliance with CQUIN Measures.		➢ HMG, CQEG, Quarterly Quality Review Meeting with PCT. ➢ Monthly MD sign off of achievement in accordance with Quality Schedule. ➢ Quarterly Patient Safety CQEG Progress Report, Quarterly Review with PCT.	HSMR – Red CQUIN EMSHA – Green NHSN- Amber
2. To develop an effective, efficient and flexible workforce to support the changing environment.	➢ Increased performance against all key HR Performance Indicators.	➢ March 2012.	➢ Trust Board (monthly) CQEG (mandatory training) DMs/HR Forum. ➢ HR Forum	HR KPIs progress: slight increase on sickness absence from 3.86%in August to 4.01% in September 2011. Amber Turnover static at 7.1%. Green Reduction in utilised temporary workforce from 237.50wte in August to 222.23 wte in September 2011. Red Substantive wte below budgeted establishment in September with a variance of 332.84wte. Red Mandatory training run rate by year end - slippage to 76.4%. Amber Workforce changes progressing with

Objectives	Measures of success	Timescale	Monitoring	Current Position/RAG Rating
	➢ Workforce changes and workforce savings achieved in line with Trust Performance and Financial Plans.	➢ In line with Trust Performance Timeline.	Trust Board/Trust Performance.	WTE worked headcount reduced by 100 in six months ended 30 September 2011. Amber WTE worked headcount has not reduced further due to high use of agency in staffing escalation areas in response to non – elective activity. Contracted reduced by 34 FTE Red
	➢ Highly skilled & knowledgeable workforce capable of supporting the transformation and emerging strategies of the Trust.	➢ September 2011.	➢ HR Forum, Monthly Workforce Development Board, Trust Board (6 monthly).	Care Group restructure on track for implementation in January 2011. Amber
	➢ Talent management & succession planning implemented	➢ September 2011.		Management development to commence in the new year. Take up good in particular in midwifery. Amber
	➢ Developing a culture and environment where the workforce can excel and the Trust becomes an employer of choice. (Staff Survey)	➢ On-going.	➢ HR Forum Monthly, HMG, Trust Board (6 monthly).	Further progress required to implement staff survey results such as Harassment and Bullying campaign and Health and Well-Being. Red
3. Develop a revised	➢ Completed final IBP that reflects	➢ July 2011.	➢ HMG & Trust	

Objectives	Measures of success	Timescale	Monitoring	Current Position/RAG Rating
Business Strategy, reflected in our Integrated Business Plan to obtain Secretary of State approval for NGH to become a Foundation Trust by July 2012.	Business Strategy and outcomes of Acute Services Review.		Board.	The Trust's Service Planning Framework will be used as the basis for the plan to produce the revised strategy. Board meeting in November will feature a workshop to approve the Marketing Strategy with the final strategy being approved in January 2012 Green
4. To develop a strategic partnership with Nene Commissioning and other Commissioners and enhanced working relationships with all local GPs .	➢ Jointly agreed clinical pathways commissioned & jointly owned. ➢ Regular discussion forum with Clinical leaders & GP's, plus clinical specialty & GP discussion.	➢ Work programme developed by December 2011.	➢ HMG & Trust Board.	Close clinical links have now been developed with Nene with representation from the Trust on the clinical workstreams to produce the 2012/13 Commissioning Intentions Green
5. Develop critical clinical care pathways to deliver effective integrated care as part of the Acute	➢ Agreed distribution of services supported by referral pathways with agreed clinical outcome measures.	➢ December 2011.	➢ Trust Board. ➢ ASR Programme Board	Board approval from 5 participating trusts awaited. Clinical groups to be set up. Timescale now May 2012. Red

Objectives	Measures of success	Timescale	Monitoring	Current Position/RAG Rating
Services Review.				
6. To agree a revised Estate Strategy in the context of the Trusts Service Strategy, Transformation Programme and the Acute Services Review, which explores alternative funding mechanisms and is completed in line with the FT Application Timetable.	➢ Revised medium to long term Estate Strategy that reflects Service Plans and Strategic Priorities. ➢ Revised 5 Year Capital Investment Plan that is affordable. ➢ Fit for purpose and appropriately sized estate to deliver Trust activity. ➢ Revised strategy approved by Trust Board and incorporated into IBP.	➢ Approval by Trust Board February 2012	➢ Estates Planning & Development Group. ➢ Capital Committee. ➢ Finance & Performance Committee. ➢ Estate KPI's.	Timeline now revised to March 2012 to enable full consideration of commissioning intentions and Trust service plans Amber
7. To develop, implement and sustain transformation in the way we deliver our services in order to maintain quality and deliver	➢ Transformation Programme delivery reducing cost base by £18 million.	➢ March 2012.	➢ Transformation Delivery Group, HMG, Trust Board.	£6.5m delivered to the end of month 6 Mitigating actions in place and allocated to workstreams Pay stabilised, non pay overspending at month 6 by £1.3m Amber

Objectives	Measures of success	Timescale	Monitoring	Current Position/RAG Rating
c£18million reduction in cost base by the end of 2011/12.				
8. To implement effective service line management across the organisation by 31 December 2011 and to develop underpinning business processes that deliver increased managerial control.	➢ 2010/11 reference costs submitted using SLR System. ➢ Report suite in place 2011/12. ➢ Shadow budgeting process using HRG cost and activity.	➢ 31 July 2011. ➢ 30 September 2011. ➢ 31 March 2012.	➢ Project Board, HMG Trust Board.	Reference costs submitted in July 2011 Basic report suite in place. Further development work in Q3 Amber/Green

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD MEETING
Wednesday 7th December 2011
9.30 am Room 1, Training & Development Centre,
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 28h September 2011	Dr J Hickey	**1**
	4.	Matters arising	Dr J Hickey	
9.35	5.	Chief Executive's Report	Dr G McSorley	**2**
Clinical Quality & Safety				
9.45	6.	Medical Director's Patient Safety Report/SHMI Update	Dr S Swart	**3**
10.00	7.	Infection Prevention Report	Mrs F Barnes	**4**
10.05	8.	NHSLA Assessment	Mrs F Barnes	**5**
Operational Assurance				
10.10	9.	Performance report	Mrs C Allen	**6**
10.20	10.	Finance report	Mr J Drury	**7**
10.30	11.	HR Report	Mrs A Chown	**8**
Strategic				
10.40	12.	Transformation Programme Update	Mrs C Allen	**9**
10.50	13.	Acute Services Review SEM Phase 1 Completion & Phase 2 Proposals	Dr G McSorley	**10**
10.55	14.	Corporate Objectives Progress Update	Dr G McSorley	**11**
11.00	15.	Any Other Business		
	16.	**Date & time of next meeting** 9.30am Wednesday 29th February 2012, 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	