Northampton General Hospital NHS Trust

A G E N D A

PUBLIC TRUST BOARD MEETING
Wednesday 25th July 2012
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Draft Minutes of meeting held on 27th June 2012	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	
09.35	5.	Chief Executive's Report	Dr G McSorley	**2**
Clinical Quality & Safety				
09.50	6.	Medical Director's Report	Dr S Swart	**3**
10.00	7.	Patient Experience Strategy Implementation Plan	Ms S Loader	**4**
10.10	8.	Patient Experience – Friends & Family Test	Ms S Loader	**5**
10.20	9.	Infection Prevention Report	Ms S Loader	**6**
10.30	10.	Research and Development Annual Report	Dr S Swart	**7**
Operational Assurance				
10.40	11.	Performance Report	Mrs C Allen	**8**
10.55	12.	Finance Report	Mr J Drury	**9**
11.05	13.	HR Report	Ms G Opreshko	**10**
11.15	14.	Transformation Programme Newsletter	Ms G Opreshko	**11**
11.20	15.	Provider Management Self Certification	Mr C Pallot	**12**
11.25	16.	Security Annual Report	Mr C Abolins	**13**
Governance				
11.30	17.	Any Other Business		
	18.	**Date & time of next meeting:** 9.30am Thursday 27th September 2012, Boardroom, NGH		
	19.	**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.	Mr P Farenden	

Northampton General Hospital NHS Trust

Minutes of the Public Trust Board Meeting held on
Wednesday 27th June 2012 at 9.30am
Boardroom, Northampton General Hospital

Present:	Mr P Farenden	Chairman
	Dr G McSorley	Chief Executive
	Mrs C Allen	Director of Operations
	Mr C Astbury	Non-executive Director
	Ms S Loader	Director of Nursing
	Mr B Noble	Non-executive Director
	Mr C Pallot	Director of Planning & Performance
	Mr N Robertson	Non-executive Director
	Dr S Swart	Medical Director
	Mrs G Opreshko	Interim Director of Workforce and Transformation
	Mr A Foster	Deputy Director of Finance (For Mr Drury)
	Mrs N Aggarwal-Singh	Non-executive Director
In attendance:	Mr G Kershaw	Associate Non-executive Director
	Ms S Rudd	Company Secretary
	Mr M Essery	Shadow Lead Governor
	Mr F Evans	Shadow Governor
	Ms M McVicar	Shadow Governor
	Mr D Savage	Shadow Governor
	Mr J Uckworth	3M Healthcare
Apologies:	Mr J Drury	Director of Finance
	Mr P Zeidler	Non-executive Director
	Mr C Abolins	Director of Facilities & Capital Development

TB 12/13 20 Declarations of Interest

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

TB 12/13 21 Minutes of the meeting held on 30th May 2011

TB 12/13 08 should read the ‘KPIs to measure the efficiency of rotas are being reviewed’.

Actions arising – TB 12/13 03 will come to the July meeting and not October.

TB 12/13 22 Chief Executive’s Report

Dr McSorley presented his CEO report and highlighted the item on Academic Health Sciences for which the paper had been published early which had resulted in an unhelpful timeline. This meant that the Trust needed to identify its preferred network by the 9th July 2012. Oxford wanted NGH to be part of their network; however there was an East Midlands Network which was also aligned with the Local Education and Training Board, and proposed Clinical Senate. The Trust must be a member of one of the networks, however can pick a primary and secondary choice. Dr McSorley proposed that the Board take a decision to approve its preference virtually with ratification taking place at the July Board.

Action: Company Secretary to add to agenda.

The second item on Dr McSorley’s report was an update from the County Leaders

Group and highlighted that the first piece of work underway, which was linked to the Healthier Together work was the Frail Elderly care pathway. This was still not in the public domain, but Dr McSorley felt that some of the work would be helpful to the Trust. Mr Robertson asked if this work would have an impact on the 25% of admissions that were felt to be avoidable to the Trust. Dr Swart confirmed that on review of these cases that they were not always avoidable, but that this work should have an impact on those that were. Dr McSorley confirmed that the first dataset would be available in October when it would be possible to see any impact that this work had had on Trust admissions.

As part of the communications and staff engagement strategy Dr McSorley would be undertaking staff briefings that was hoped would reach 600 staff, he confirmed that this would dovetail into the Listening into Action programme that was now running.

The Trust had the previous day met with the SHA to have the annual plan reviewed and Dr McSorley was pleased to report that the SHA had been impressed with the plan both the sustainability and quality. This plan would feed into the work that was underway for the Foundation Trust application, whilst the SHA cannot approve the plan they can make suggestion and the Trust would receive a letter from the SHA as part of the outcome of the meeting. Mr Robertson sought confirmation as to whether the Board should be reviewing this plan over the year; Mr Pallot clarified that the activity plan would be reviewed by the Board on an on-going basis.

Dr McSorley noted that the initial plans for the Healthier Together programme would be approved by the Programme Board the following week. There would also be a decision on the timetable for implementation.

TB 12/13 23 **Medical Director's Patient Safety Report**

Dr Swart presented her report and confirmed that on the 2011/12 figures the Trust had seen an improvement in the HSMR figures which had taken them to within acceptable limits. The Trust was now using SHMI figures and HSMR. Following the recent work on pneumonia figures, Dr Swart confirmed that this would now be taken forward by the Care Groups and Directorates. The lessons learnt will be included as part of the Emergency Care pathway. There was sustained improvement on the Respiratory Tract Illness. Deaths resulting from Fractured Neck of Femur remain under review. A review had still not identified the issue with Acute Renal cases; however it was thought that this may be related to the specialist unit within the Trust and the acceptance of incoming referrals.

Dr Swart voiced her concern that the Trust were not capturing all dementia cases, there was a new tool that the Trust would begin to use on the 2nd July 2012.

There would be further report to the Board on Inflammatory Bowel Disease and diabetes both of which are being reviewed. Dr Swart confirmed that she still believed that this was a data issue. Mr Farenden said that this report was impressive and showed that the Trust was actively reviewing these figures and not being complacent. He was encouraged that the Trust were able to be open and share this with the public. He was also keen to encourage the focus being shown by Dr Swart and her clinical colleagues.

Mr Robertson asked if the Trust had been successful in appointing a new clinical coding manager. Mr Pallot confirmed that whilst an appointment had not yet been made the Trust continued to actively recruit to this role, there was a paper currently proposed in order to reinstate recruitment and retention for coding staff. There was also a plan to use an agency to assist with the recruitment and the Trust were redoubling their efforts, although this was a difficult post to recruit to nationally, Dr

Swart confirmed that the current interim to this role was very good and improvement was being seen.

On review of the Clinical Quality Scorecard it was noted that the A&E target would be discussed further later in the meeting. Another area on the scorecard was that of Caesarean Section rates this was currently with the directorate to produce an action plan to address the figures, the percentage against NICE guidelines was also a figure awaited for review. The rate remained too high and focus would remain on this. Mr Noble asked if it was a woman's choice to have a caesarean section and it was confirmed that this was indeed the case, however the onus was on the Trust to ensure that women were fully informed and that the Trust could evidence that they had done so.

TB 12/13 24 Quality Accounts

The Quality Accounts was presented by Mrs Loader and she confirmed that this new version now incorporated comments by external stakeholders. Dr Swart said that this was the 3rd year that these had been produced and was the result of a huge amount of work from many staff; it had again been well received and was forming part of the staff communication programme.

Mr Farenden said that he was pleased to see that the comments from external stakeholders had been included.

Mr Farenden drew to the Board's attention the letter from the Auditors, who had undertaken a review of the Quality Accounts and the Auditor had confirmed that the Accounts were consistent with the requirements set out the in the regulations.

The Board NOTED the letter received from the Auditors in regard to the Quality Accounts.

TB 12/13 25 Patient Experience – Friends and Family Test

Mrs Loader confirmed that the Trust were now using the Hospedia system, however this was causing confusion for patients who thought that this related to the television service and due to this the Trust was now collecting data manually, currently the manual data was shown to be positive comparable to the Hospedia data. There would also be training given to staff that would enable them to undertake this as part of the discharge process. The agreed CQUIN for the year demanded that the Trust show a 10 point improvement in its score, to this end it was necessary to define the start point for the Trust and the suggestion was that this would be June. Mr Astbury asked if this data was better than May and Dr McSorley confirmed that the data for May was mainly Hospedia and this was flawed. Dr McSorley asked that the Board approve that the Executive Officers make this decision with the Chairman and to agree to the on-going manual data collection.

Board agreed to defer this decision to the Executive Officers and also to the on-going manual collection of data.

TB 12/13 26 Infection Control Report

Mrs Loader reported that there had been 1 MRSA case to date and 3 Clostridium Difficile which was still below the trajectory. One issue was that of a case of whooping cough and the Trust had undertaken to ensure all staff were vaccinated., This was at 98% at the time of the Board meeting which was due to staff that were currently absent and had not been vaccinated as a result.

Mr Farenden asked about surgical site infections and whether staff realised that this was still a priority for the Trust. He also asked if it was appropriate that NEDs undertake infection control rounds to help to reinforce. Mrs Allen confirmed that all Executive Officers undertook these rounds and that Non-Executive colleagues were welcome to accompany them.

TB 12/13 27 Performance Report

Mrs Allen confirmed that the transit time target had been missed for May. Mrs Allen confirmed that all of the refurbishment works were now completed in A&E and the Single Point of Access was now in use. There were some issues with the level of cover, however there was a meeting planned with the Consultants to address this. Mr Astbury asked if the Trust worked with other agencies in order to address patient flow and it was confirmed that there was a workshop at the end of May which looked at ways which these agencies work together, discussions had taken place with EMAS to share the process of Single Point of Access with them. Dr Swart confirmed that a clinical lead for the urgent care pathway had now been appointed and interviews would be taking place for a project manager to support the on-going work with the pathway. Dr McSorley said that the work on the urgent care pathway would not be the solution in the short term for the transit time target. Mrs Aggarwal-Singh asked if the A&E team were aware of the impact of this on the patient flow within the Trust and it was confirmed that they were, but the key message needed to be that of good patient care for all. Mr Essery asked if patient opinion had been sought on the success of the Single Point of Access and Mrs Allen said that at this stage it was still too early to measure, Mrs Loader added that the Family and Friends test would also contribute to forming a picture of patient opinion. Mr Farenden said he was pleased to hear that the guiding principle of this was that of patient experience.

Mrs Allen drew attention to those patients that were on a 26 week pathway and that these patients were within the Trauma and Orthopaedic Directorate but that there was a plan in place to address this.

Mr Pallot said that the Trust was currently at 81.5% on the 62 day target against the 85% required. This was a quarterly target contractually; however the Trust was required to report on a monthly basis for the PMR. The increase in breaches was attributable to the stage at which patients were referred to NGH from other Trusts. There was a recovery action plan in place and all patients on the pathway were being reviewed. Mr Farenden asked if the Trust was on track to hit the quarterly target and Mr Pallot said that this did not look to be the case. He confirmed that due to the complexity of the pathways sometimes as fewer patients as 2 could change the percentages. Mr Pallot confirmed that discussions were underway with Kettering General Hospital Foundation Trust in respect to sharing the breaches which may address this issue. It was less likely that the 31 day target was recoverable. Mr Farenden confirmed that the Board noted the difficulties being faced and also the actions in place to bring the Trust back to the expected standards.

Mrs Allen confirmed that there had been a slight change in how the targets were being reported to the Board in respect to the trends and asked that Board members feedback any comments on this new reporting to her.

TB 12/13 28 Finance Report

Mr Foster presented the finance report and noted that in the first 2 months of the year had seen an improvement of £300k in the I&E figures from May. This resulted in a £950k deficit year to date, he confirmed that the plan did forecast for a deficit. The transformation programme had saved £1.2m so far which was £700k short of the forecast. Much of this was down to the bank and agency costs however some could be attributed to mitigation slippage.

Currently MRET was within accepted levels, however it was important to note that whilst the Trust continued to over perform, some of which attributable to PCT QIPP schemes not working, there was a risk that the PCT would not be in a position to afford to pay.

The PMR financial risk rating was 2; Mr Foster also noted that the liquidity rate was down to 12 days, this was due to the better payment scheme with which the Trust was compliant.

Mr Farenden asked if there was a recovery plan for the Transformation Programme and Mrs Allen confirmed that there was a stock take and reforecast planned and that this would be bought back to the Board for review and approval. Mr Farenden voiced his nervousness that the Trust would be able to bring this into line within the timeframe required and Dr McSorley confirmed that the programme required further resource and that there were interviews for a new Programme Director for the programme the following day.

Mrs Aggarwal-Singh asked what the implications of the over performance in general medicine had on bank and agency costs and it was confirmed that the non-elective activity had a big impact on the medicine care group. Mr Kershaw asked what the impact of e-rostering had had on bank and agency costs and Mrs Loader confirmed that it had become apparent that there was more use of agency than thought so there were other methods for recruitment now being explored. She also confirmed that all ward sisters would receive further training to promote best practice; there would also be new KPI monitoring tools in use from June. It was hoped that there would be a significant reduction in quarter 3 and 4 resulting from this work.

Mr Noble asked what impact the cost of utilities had and Mr Foster confirmed that it was quite considerable; Mr Noble said that a further breakdown of these costs would be useful to see.

Mr Farenden said that the Board should have sight of a more granular report to the July meeting as he had concern over the position and the Board needed to understand what additional decisions might need to be taken.

TB 12/13 29 **HR Report**

Mrs Opreshko presented the HR report and confirmed that future reports would be changed and that reports would also include a percentage of headcount. She reported that the Trust was 464 down on WTE figures; however this was mainly attributed to the increase in establishment.

Sickness absence was higher in areas with a higher incidence of vacancy and there was also an increase in staff turnover, although this remained below the national figures, this could also be down to the transformation programme.

TB 12/13 30 **Quality Strategy**

Dr Swart presented the Strategy noting that it has been reviewed and strengthened to identify a clear framework for quality. Trust wide quality goals have been identified covering patient safety, patient experience and effectiveness of care. This will be followed up by the Patient Experience Strategy, to be discussed at the June meeting.

The Clinical Effectiveness Driver Diagram details the drivers to achieve the aim. There is a shared agenda for Nursing and Medicine and there will be a clarification of responsibility.

The quality indicators will help embed quality throughout the Trust and the Board **approved** the strategy.

Action: Patient Experience Strategy, June meeting.

TB 12/13 31 PMR Reporting

Mr Pallot confirmed that the Trust was RED rated for A&E, Cancer and finance all as discussed earlier in the meeting. It was agreed that the Trust sign off declaration 2.

TB 12/13 32 Transformation Programme

Mr Foster highlighted that the Green Car Scheme was launching on the 16th July as part of the salary sacrifice scheme and the benefits as highlighted in the report were noted.

TB 12/13 33 Patient Experience Strategy

The quality strategy had been written using the 3 principles of Clinical Effectiveness, Patient Experience and Patient Safety and the patient experience strategy had been written following this same methodology. The strategy outlined the aims and timelines and a more detailed implementation plan would be bought back to the Board in July.

Mr Farenden asked how appropriate ownership would be achieved and Mrs Loader confirmed that in some directorates there were patient experience champions and this would be adopted across the Trust. There were also plans to ensure that staff were informed of what was expected of them and this would also form part of the appraisal process, there would also be support from the Transformation Programme office.

Mrs Opreshko also confirmed that this would run in parallel with the Listening into Action Programme and it was confirmed that the Board fully supported the strategy.

The Board **SUPPORTED** the strategy.

TB 12/13 34 Corporate Objectives

Dr McSorley confirmed that this had been presented to the Board previously in draft form and that these objectives were now bought for formal sign off.

The Board signed off the corporate objectives.

TB 12/13 35 Board Assurance Framework

All agreed that this still required further work and it was resolved that this would form the main part of the joint Audit and Healthcare Governance Committee in July.

For full review at Joint Audit and Healthcare Governance Committee.

TB 12/13 36 Carbon Management Strategy

Dr Topping presented the Carbon Management Strategy to the Board. She confirmed that the strategy outlined some of the works required in order to bring the Trust in line with its carbon requirements. This would require some capital investment, however much of this would be funded by third parties.

TB 12/13 19 Date and Time of Next Meeting

Wednesday, 27th June 2012, Boardroom, NGH

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<u>Actions arising</u>

TB 12/13 03	Recommendation for joining an Academic Health Science Network to be discussed when available	GM	July 2012
TB 12/13 11	Patient Experience Strategy	SL	Completed
TB 12/13 17	2012/13 Corporate Objectives	GM	Completed
TB 12/13 17	2012/13 Board Assurance Framework – to go to joint Audit and Healthcare Governance Committee	GM	July 2012

BOARD SUMMARY SHEET	
Title: -	Chief Executive's Report
Submitted by: -	Dr G McSorley, Chief Executive
Date of meeting: -	25th July 2012
Corporate Objectives Addressed: -	All
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.	

CHIEF EXECUTIVE'S REPORT
JULY BOARD MEETING

1. Academic Health Sciences Networks

Following my last update on the Academic Health Science Networks I can confirm that following discussion at the Strategic Management Board we have declared our preferences for our primary network; East Midlands and our secondary network; Oxford.

2. Patient Safety and Care Integration Awards 2012

I am delighted to report that at the recent awards sponsored by the Nursing Times and Health Service Journal, a joint team from NGH and NHFT were a finalist in the Diabetes Care awards for their work on the integrated diabetic foot pathway. The Board would, I am sure, wish to express its grateful appreciation of the team's work and commitment to their patients and families.

3. Finance and Transformation

In order to strengthen our focus on finance and transformation I am very pleased to report that we have been able to appoint Jane Harper-Smith as Interim Programme Director for the Transformation Programme Office thereby releasing Andrew Foster to commit full time to his role as Deputy Director of Finance. Geraldine Opreshko, interim Director of Workforce and Transformation has become lead Director for the Transformation Programme allowing Christine Allen to focus on operational performance. I would like to propose a thank you on behalf of the Board to Andrew and Christine for their exemplary leadership in establishing the programme and the substantial progress made to date.

4. Listening into Action

We will have held two conversations with staff by the time of the Board meeting. This first cycle of conversations will be concluded on the 30th July. I am very pleased to report the appointment of Jackie Boore, currently training and development manager, to the post of Listening into Action Programme Manager.

Dr Gerry McSorley
Chief Executive
July 2012

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title	Medical Director's Report – Mortality, Clinical Scorecard Exception Report
Submitted by	Dr Sonia Swart
Prepared by	Dr Sonia Swart
Date of meeting	July 25 2012
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 to ensure improving clinical outcomes, improving focus on patient safety, improving patient experience and improving flows of information. There is a commitment to a redesign of the emergency pathway and increased focus and support for patient safety work. The need to ensure that there are clear and robust measures for quality remains paramount. The need to improve information flows and clinical coding is emphasised

PATIENT IMPACT

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

STAFF IMPACT

Staff morale relating to failure to deliver high quality care in the face of increasing emergency pressures and adverse publicity relating to the NHS has been a recognised issue. The current projects designed to focus primarily on quality and ensuring that staff are able to deliver should improve matters.

FINANCIAL IMPACT

The ability to continually drive forward quality is increasingly important and will also affect our income. Investment in quality is likely to reduce cost in the long term.

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. The high number of NHSLA claims compared to our SHA should be noted.

RECOMMENDATION

Board members are asked to note the continued improvement in HSMR and challenge and debate the issues raised.

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Section 1

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

1. Introduction

This paper summarises progress in the work relating to the additional work undertaken over the last 18 months set up to supplement the regular scrutiny of mortality data . The Board is reminded that each month all possible causes of concern are discussed by the Associate Medical Director and the Medical Director and the data and action log are signed off at this meeting.

This issue remains of key reputational importance for the Trust and there have been regular reports provided to the PCT and SHA.

2. Current Position HSMR

HSMR for the last available rolling 12 months (data to end April 2012) has improved a little compared to the level reported in the last Board report **91.8 (1018 deaths versus 1108 expected over the year).** The financial year 2011/12 data up to the end of March gives a rebased position were rebased of around **102** which represents an improving position from that reported for the previous financial year when the number was **116** at this stage in the year (rebased figure).

Currently around 75 Trusts have SMRs higher than that predicted for NGH.

There continues to be a need to ensure that there is an improved understanding of the issues relating to the recording of primary diagnoses, secondary diagnoses and palliative care coding which must be done more accurately.

For April the HSMR was **85.** There were 98 expected deaths and there were 83 actual deaths.

Another area of concern for the last financial year related to the fact that in the Dr Foster Good Hospital Guide NGH was named as amongst the Trusts with the largest difference in weekday and weekend mortality.

The position in this financial year for the rolling 12 months to the end of April has improved with a HSMR for weekend admissions of **105 (not rebased)** versus **131** for the same period last year. There is considerable controversy with regard to the validity of looking at mortality for this group of patients as there is clearly a different case mix and the Dr Foster tool was probably not designed to be able to cover this.

NGH is no longer an outlier with respect to mortality as measured by HSMR as shown below.

3. Acute Trust HSMRs April 2011 - March 2012

The background points show the HSMR (rebased) for the last financial year for each acute non-specialist trust in England. No graph is as yet available for the last data update for the 12 months ending April 30 2012.

The Board is reminded that the rebased position reflects the fact that each year the mortality figures improve for all Trusts but the improving position for NGH indicates that this Trust has improved more rapidly than others over the last financial year.

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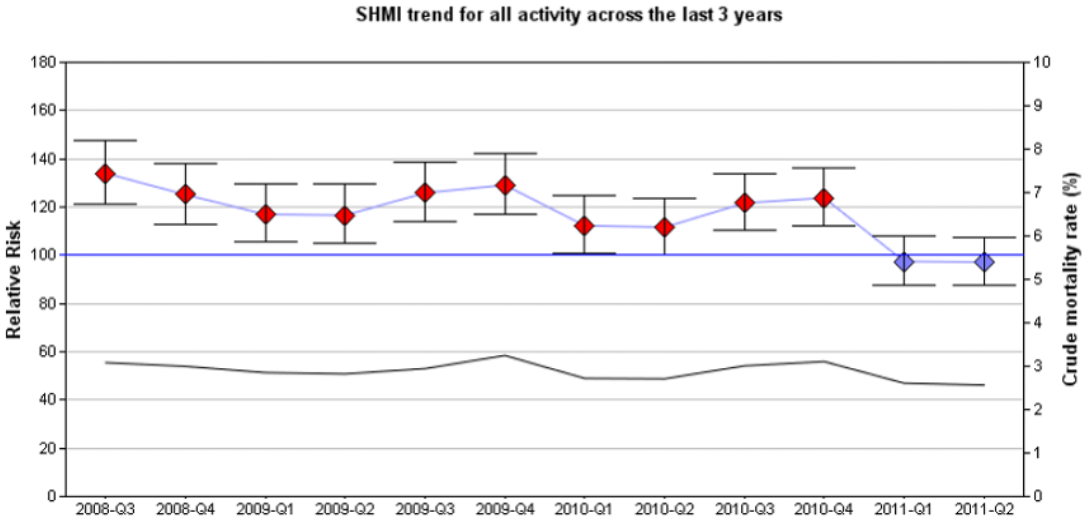
4. Standardised Hospital Mortality Indicator (SHMI)

In addition to HSMR another mortality indicator known as SHMI is now in standard use. Like all mortality indicators, the SHMI shows whether the number of deaths linked to a particular hospital is more or less than expected, and whether that difference is statistically significant. It covers all English acute non-specialist providers.

The dataset used to calculate the SHMI includes all deaths in hospital, plus those deaths occurring within 30 days after discharge from hospital. The expected number of deaths is calculated from a risk-adjustment model developed for each diagnosis grouping that accounts for age, gender, admission method and co-morbidity (using the Charlson index). SHMI does not make allowances for palliative care coding.

SHMI trend for all activity across the last 3 years



At present, the SHMI roughly mirrors the HSMR for NGH. The latest SHMI is reported on rolling 12 months basis and shows an improvement from 114 for the financial year April 2010- April 2011 to **106** (period up to December 2011 – rolling 12 months). The quarterly position for the first 2 quarters of 2011/12 is as expected at **97.** In addition crude mortality fell during this period from 3% to 2.6%. The SHMI is benchmarked each quarter unlike HSMR which is benchmarked at the end of the year**.**

5. Dr Foster Patient Safety Indicators (March 2011 - March 2012)

The Patient Safety Indicators are adapted from the set of 20 devised by the Agency of Healthcare Research and Quality (AHRQ) in the US. The AHRQ developed its indicators after extensive research and consultation and they have the benefit of being based on routinely available data.

The performance against these indicators has been generally good and better than average in a significant number of areas as reported in the last Board report but a concern was raised in the case of Obstetric trauma. This related to data entry issues which have now been corrected but the changes have not as yet been uploaded onto the hospital information system. There is a further concern relating to the Dr Foster methodology which has been raised directly with Dr Foster Intelligence.

6. Reports on Key Areas for action:

Mortality from High Risk Diagnoses

Mortality resulting from the 5 high risk diagnoses groups which are: Acute Cerebrovascular Disease, Pneumonia. Acute Myocardial Infarction, Congestive Cardiac Failure and Fractured Neck of Femur is within acceptable parameters.

Possible areas for Concern under investigation

There are four areas which have caused concern raised by our Dr Foster monitoring processes internally. One is an apparent rising mortality from secondary malignancy It is possible that this relates to changes in coding practice and to the failure to code the active cancer under the co-morbidities as well as failure to record palliative care coding or even a lack of specialist palliative care input. This is currently under investigation. Examination of the case notes has not revealed any concerns relating to quality of care in this group of patients. It is very likely that there is a combination of issues relating to the number of admissions at the end of life period and the coding accuracy. All deaths from secondary malignancy are currently under review with respect to coding accuracy.

Another is a rise in the SMR for 'senility' (which includes acute confusion and dementia) during 2011/12. This is also currently under investigation. In this area it is likely that there are problems capturing dementia as a primary diagnosis in that NGH records fewer spells with this as a primary diagnosis than other similarly sized Trusts. All spells in April are currently under review.

In the case of diabetes there is an on-going notes review of all patients who died with diabetes as a primary diagnosis to examine the accuracy of coding and ascertain whether there are any clinical care issues. During the investigation of this data it has however emerged that the Trust codes fewer patients with the comorbidity of diabetes than other Trusts despite the fact that we have a higher than average incidence of diabetes. Further work is in progress to improve the capture of information in this area.

A further case note review of coding and clinical care is underway for patients who died with a diagnosis of inflammatory bowel disease following a concern raised with respect to data quality and care as a result of the national IBD audit and a higher than expected mortality as a result of Dr Foster monitoring. This review is still underway.

Information and Coding Issues

There is consistent and continual challenge of coding and information processes through the monthly mortality/coding review. Active efforts to recruit a clinical coding manager have been agreed in order to ensure a high calibre, well trained individual can be attracted to a post at this Trust. As part of a piece of work to examine flows of patients into the Trust and flows of information relating to clinical processes a review of clinical coding practice will be commissioned to strengthen our understanding of the current position. It is anticipated that the improved understanding of issues that emerges from this work will be useful in framing improvement activity. The Trust is still awaiting the final proposal in relation to this analytical work.

Further Comments and Actions Planned

The improvements in HSMR and SHMI have continued and have been sustained in the last month of available data.

In order to improve mortality further the clinical work-streams will continue as articulated and will support the planned redesign of the emergency pathway and the patient safety programme. Clinical leads have been recruited for the Emergency Pathway Redesign and for the 5 Patient Safety Work streams and will work together to support the quality priorities under the umbrella of a strengthened safety strategy led by the executive team with the support of the Safety Academy of 50-70 safety champions. Both these programmes of work need to be managed in a structured project managed framework and will report through the current transformation programme management office drawing from that resource as required. The programme of work will be set up over the next 2 months and as soon as project managers are recruited.

The clinical improvement work will require strong support from the information team and this paper continues to highlight the importance of data flows and information. There is a recognition that the trust needs to improve the infrastructure in this area.

The Trust Board asked to note and debate the contents of this report and to recognise both the improvement to date and the on-going challenges. As part of the investment in the redesign of the emergency pathway the work designed to examine information flows in and through the Trust will be supplemented by an analysis of our coding function and the work to date on HSMR. This analysis will be important to underpin the work that has already been agreed and should provide further assurance for the Board.

There is no doubt that the very significant emergency pressures provide a risk to the quality of care we provide and it will be essential to link all the improvement work in an informed redesign of care processes.

Section 2

NGH Monthly Quality Scorecard

The indicators in this scorecard match those required by our commissioners and by the provider monitoring framework required by the SHA, although further work is required to ensure that the alignment is accurate.

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

Further work is required to ensure that all measures are relevant and timely to facilitate ongoing comprehensive monthly reporting. This report includes both current and previous CQUIN measures. HSMR is year to date. A continual process of refinement of indicators is required and this will include new indicators to monitor the safety improvement programme and the emergency pathway redesign project.

Of 117 indicators, 42 (13/29) are rated as either red or amber status. This report outlines the underperforming indicators and details the remedial action(s) being taken. There are still 15 indicators that are rated grey. This is because either baseline data is still to be agreed or information is currently not available.

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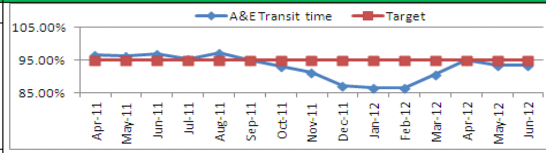
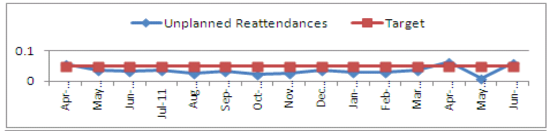
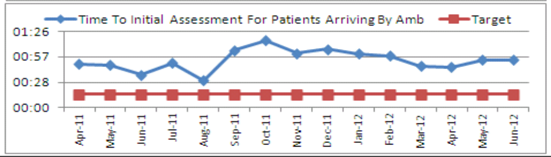
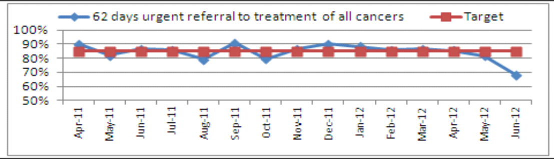
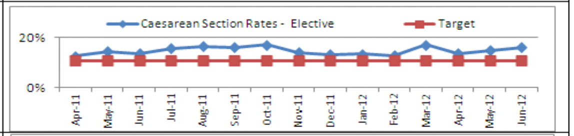
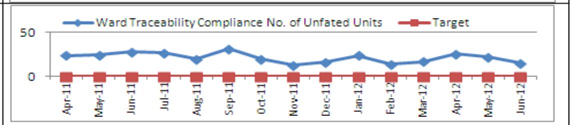
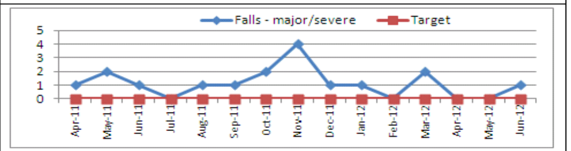
Summary Rating

Section	Red Rated	Amber Rated	Green Rated	N/A
CQUIN 2012-13	**2**	**5**	**13**	**12**
Clinical Outcomes	**2**	**16**	**13**	**0**
Patient Safety	**2**	**5**	**14**	**3**
Patient Experience	**7**	**3**	**20**	**0**
TOTAL	**13**	**29**	**60**	**15**

EXCEPTION REPORT – JULY 2012

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Experience	A & E Quality Indicators (5 indicators)			**A&E Clinical Indicators:**	
			↓	Transit time target The Trust has not delivered the 95% A&E transit time target in June (93.33%) and is now behind trajectory YTD (93.88% Cumulative), remedial action plans have been developed and ongoing dialogue via urgent care networks continues.	
			↓	This set of clinical indicators has been removed from Operating framework for 2012-13 and been passed to Commissioners for local management, the Trust has delivered the overall target but has missed two elements. 1.Unplanned re-attendance rate has risen to 5.91% in June 12, this is above the 5% national target. 2. The time to initial assessment for patients arriving by ambulance has reduced in June to 39 mins from the May time of 50 mins but this is still above the national target of 15 minutes	
			↓	The Trust is investing in increased medical and nursing staff to improve the clinical care in A&E and planning a redesign of the emergency pathway to improve flow through the hospital as well whilst focusing on quality, safety and patient experience.	
Patient Experience	62 Day Cancer wait time	85%	↓ **68.5%**	The Trust has not delivered the 62 day cancer wait time target for June 2012 (68.5%)and is now behind target for the quarter. This is attributed to complexity of cases and to delay in referrals received form other providers. An ongoing action plan is in operation and dialogue with other providers is ongoing	
Patient Experience	PROMS Scores	80%	↑ **72.8% Overall Score**	The Trust is reliant on national data for this indicator. The overall score of 72.8 reflects the latest published figures (May 2012) for the period April 11 to Dec 11. This is an improved response compared to the Apr 09 - Mar 10 baseline figure of 43.6% and also the Apr 11-Sept 11 data published in Feb 12 (70.0%).	
Clinical Outcomes	Caesarean Section Rates	10.6%	↓ **15.9%**	Ongoing issue with elective caesarean section rate. Emergency caesarean section remains lower than national average. Action plan developed May 2011 and monitored quarterly at Obstetric Governance Group and 6 monthly at Integrated Healthcare Governance Meeting. All caesarean sections audited and reasons compliant with NICE guidance. Re-audit commenced 1st April 2012. On Risk register	
Patient Safety	Ward Traceability Compliance Number of Un-fated Units	0	↓ **55 (Q1 2012-13)**	Ward Traceability Compliance Number of Un-fated Units - There were 63 cases of un-fated units in Q1 2012-13 against a total of 55 for Q4 2011-12. Ward and directorate managers are notified daily of un-fated units which allows immediate investigation and monitoring of unfated cases has been added to the weekly performance meeting	
Patient Safety	Reduce harm from falls	0	↑ **1**	There was 1 fall of a major/severe category reported in June. This was the first major / severe fall this quarter (Q1 2012-12). This is in comparison to 4 in Q1 2011-12.	
CQUIN	Improve responsiveness to personal needs of patients (5 questions based on inpatient survey results)			There are 5 quality questions as part of the CQUIN. Two of the 5 questions for improving responsiveness to personal needs of patients have returned as under target. These being: 1. Did you have enough privacy when discussing condition or treatment? (73.78% against a target of 82.3%) 2. If you are ready to be discharged – have you been informed who to contact if you are worried about your condition after leaving hospital? (52.71% against a target of 74.3%) These responses are currently collected via the Hospedia system which is in the process of constructive review .	Metrics will be available from Q2 as this outcome has not been previously reported in this format.

CORPORATE SCORECARD – JULY 2012

Patient Safety	Target 2012-13	Apr-12	May-12	Jun-12	RAG
HQU01: HCAI measure (MRSA)	1 per year	1	0	0	
HQU02: HCAI measure (CDI)	36 per year	3	1	4	
HQU08: MMSA Numbers	0	0	0	1	
E Coli ESBL Quarterly Average	7 per month	5	4	1	
VTE Risk Assesment completed	90% month on month	91.9%	91.2%	91.5%	
MRSA Screening Elective Patients	100% month on month	99.8%	99.7%	99.8%	
MRSA Screening Non-Elective Patients	100% month on month	94.2%	96.9%	98.5%	
Ward Traceability Compliance Number of Unfated Units	0 month on month	26	22	15	
Incidence of pressure ulcers					
Type 3	0	0	2	2	
Type 4	0	1	2	0	
Rate per 1,000 Bed Days (All Grades)	0.60	0.70	0.82	1.34	
Reduce harm from falls					
Catastrophic	0	0	0	0	
Major/Severe	0	0	0	1	
Moderate	0	2	2	3	
Mandatory Training compliance Fulll Year Impact					
Primary Levels Excluding B&H	80%	8.28%	14.33%	NA	
Attendance at Trust Induction	80%	88.14%	87.70%	NA	
Number of surgical site infections					
Frac neck of femur Number of Operations		27	29	21	
Infections	0	0	1	0	
Breast Surgery		30	40	29	
Infections	0	0	0	0	
Limp Amputations		11	7	10	
Infections	0	0	0	0	
Full implementation of patient safety alerts e.g. NPSA, CAS, Medical Device Alerts etc					
Open Central Alert System (CAS) Alerts	0	1	0	0	
NICE clinical practice guidelines and TAG compliance	80%	81%	81%	82%	
Serious Untowards Incidents	-	12	3	9	
Never Events	0	0	0	0	
WHO Surgical Safety Checklist	100%	100%	100%	100%	

Patient Experience	Target 2012-13	Apr-12	May-12	Jun-12	RAG
HQU04: Patient Experience Survey					
Patient Experience Headline score for safe high quality coordinated care					
Patient Experience Headline score for Better Information, more choice					
Patient Experience Headline score for Building Closer Relationships					
Patient Experience Headline score for Clean, comfortable, friendly place to be					
Grand Total					
Cancelled Operations not rebooked within 28 days	0%	0%	0%	0%	
Hospital Cancelled Operations	6.0%	5.9%	7.3%	8.7%	
Number of written complaints received		50	51	39	
Complaints Responded to within agreed timescales	100.00%	88%	0%	0%	
Referral to Treatment waits					
Admitted Patients	90.00%	96.43%	96.56%	97.12%	
Non Admitted Patients	95.00%	97.70%	98.33%	98.57%	
Ongoing Patients	92.00%	98.21%	97.83%	96.48%	
A&E Quality Indicators (5 measures)					
Time Spent in A&E (Month on Month)	95%	95.05%	93.37%	93.33%	
Time Spent in A&E (Cumulative)	95%	95.05%	94.16%	93.88%	
Total time in A&E (95th percentile)	95th	04:00	05:00	04:50	
Time to initial assessment (95th percentile)	<1hr	00:30	00:50	00:39	
Time to treatment decision (median)	<15 mins	00:46	00:54	00:54	
Unplanned re-attendance rate	=<5%	6.37%	1.00%	5.91%	
Left without being seen	>1% and <5%	0.26%	0.33%	0.20%	
Cancer Wait Times					
2 week GP referral to 1st outpatient	93%	96.30%	95.60%	94.80%	
2 week GP referral to 1st outpatient - breast symptoms	93%	100.00%	100.00%	100.00%	
31 Day	96%	96.50%	98.90%	96.90%	
31 day second or subsequent treatment - surgery	94%	96.20%	97.50%	100.00%	
31 day second or subsequent treatment - drug	98%	100.00%	97.80%	100.00%	
31 day second or subsequent treatment - radiotherapy	94%	100.00%	99.20%	100.00%	
62 day referral to treatment from screening	90%	100.00%	100.00%	100.00%	
62 day referral to treatment from hospital specialist	85%	92.00%	91.70%	89.30%	
62 days urgent referral to treatment of all cancers	85%	85.40%	81.80%	68.50%	
SRS08: Length of Stay (Acute & MH)					
Elective	3.20	3.70	4.1	4.2	
Non-Elective	5.30	6.00	5.9	4.4	
SRS09: Daycase Rate	85%	85.7%	85.2%	83.2%	
SQU11: PROMS Scores - Pre Operative participation rates					
Groin Hernia - Participation Rate	59.00%	No update	42.30%	No update	
Hip Replacement - Participation Rate	80.80%	No update	97.40%	No update	
Knee Replacement - Participation Rate	85.40%	No update	94.90%	No update	
Varicose Vein - Participation Rate	48.30%	No update	31.10%	No update	
All Procedures - Participation Rate	72.50%	No update	72.80%	No update	

Clinical Outcomes	Target 2012-13	Apr-12	May-12	Jun-12	
HSMR - cumulative Position from Apr 2011	<100	93.6	93.9	94.3	
HSMR - cumulative Position from Apr 2012				85	
SMR- cumlative Position from Apr 2011					
Pneumonia	<100	90.7	83.5	82.2	
Fracture of neck of femur (hip)	<100	82.3	80.6	80.6	
Urinary Tract Infections	<100	96.0	92.9	93.2	
Acute Cerebrovascular disease	<100	98.4	99.3	99.7	
Aspiration pneumonitis, food/vomitus	<100	116.7	107.5	93.2	
Congest ve heart failure, nonhypertensive	<100	98.2	96.0	97	
Chronic obstructive pulmonary disease and bronchiectasis	<100	90.0	109.2	118.2	
Acute myocardial infarction	<100	88.8	85.9	85.9	
Billiary tract disease	<100	112.6	86.2	98.7	
Acute and unspecified renal failure	<100	120.7	121.3	121	
HSMR (Rolling 12 months Mar 11 to Feb12)					
Point of Delivery					
Combined	<100	95.8	93.9	94.3	
Non-Elective	<100	95.5	93.4	93.8	
Elective	<100	96.2	102.7	102.5	
SQU12: Maternity 12 weeks	90%	86%	97%	86%	
SRS10: Delayed Transfers of Care – Acute & MH	3.00%	3.64%	3.12%	2.62%	
Fractured neck of Femur					
Number of patients admitted with FNOF	-	27	30	21	
Patients fit for surgery within 48hrs	-	21	23	13	
Number of patients admitted with FNOF who were operated on within 48 hrs	-	20	22	10	
Percentage of patients admitted with FNOF operated on within 48 hours of admission	100%	95%	96%	77%	
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	200%	100%	200%	
25% of suspected stroke patients given CT scan within 3 hours of arrival	25%	68%	77%	75%	
75% of suspected stroke patients given CT scan within 24 hours of arrival	75%	95%	100%	96%	
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	60%	68.00%	75.00%	90.91%	
Patients who spend at least 90% of their time on a stroke unit	80%	90.00%	89.13%	92.59%	
Breast Feeding initiation	75%	72.60%	74.60%	76.6%	
Caesarean Section Rates - Total	<25%	25.70%	25.60%	27.10%	
Caesarean Section Rates - Emergency	14.98%	12.10%	11.00%	11.20%	
Caesarean Section Rates - Elective	10.06%	13.60%	14.60%	15.90%	
Home Birth Rate	6.00%	5.90%	7.30%	6.90%	

CQUIN 2012-13	Target 2012-13	Apr-12	May-12	Jun-12	RAG
National CQUINS					
1a. 90% of all adult inpatients to have a VTE risk assessment	90% month on month	91.9%	91.2%	92%	
1b. High risk patients receive appropriate treatment	100% Month on month	Awaiting data			
2. Improve responsiveness to personal needs of patients (5 questions based on inpatient survey results)					
Were you involved as much as you wanted to be in decisions about your treatment or care?	>71.0			69.72%	
Were hospital staff available to talk about any worries or concerns that you had?	>63.4			74.91%	
Did you have enough privacy when discussing condition or treatment?	>82.3			73.78%	
If you have been prescribed any new medication, have you been informed of any possible medication side effects?	>48.5			47.77%	
If you are ready to be discharged – have you been informed who to contact if you are worried about your condition after leaving hospital?	>74.3			52.71%	
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting					
a) Dementia case finding	90%	Awaiting data			
b) initial diagnostic assessment	90%				
c) referral for specialist diagnosis	90%				
4. Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE	-	Monthly data submitted for all ward areas from Apr 12. Theatre recovery area submission from June 12.			
Submission of 3 consecutive months of survey data, covering 100% of appropriate patients per Quarter	RAG				
Regional CQUIN					
1. Establish question and baseline Net Promoter score	Q1 10%	11%	11%	13%	
2, Board and Commissioner reporting	Submission to HCG	Submitted to HCG			
3. Weekly reporting	-	target from Q2			
4. Performance improvement by 10%	10 point improving	- 29.98	- 30.86	0.42	
Local CQUINS					
1. Implement Oesophageal Doppler Monitoring (ODM) or similar fluid management technology	-	Baseline audit undertaken			
2a, Ensure that a greater number of patients are seen and discharged within 3 hours of arrival time at A&E (CQUIN negotiations ongoing)	-	Clinical discussions ongoing			
2b. Appropriate referrals to CECs/ Intermediate service from A&E		Baseline audit 50 cases in Q1			
3a. Accuracy of medicines information on discharge	75% error free	Q4 primary care audit, internal assurance programme being formalised			
3b. Analgesic transdermal patches (CQUIN negotiations ongoing)	-	Clinical discussions ongoing			
3c. Oral nutritional supplements (ONS) - reduce the use of ONS	Q2 & Q4 Audits - stretch targets to be agreed	Audit methodology currently being agreed			
3d. Triptorelin	Qu Audit 10% increase on 50% baseline (80% @Q4)	Awaiting data			
4a. Implementation of a policy to send first outpatients letters back to referring rather than registered GP.	Quarterly Updates internal	Awaiting quarterly report on progress			
4b. NGH will scope electronic communications systems and implement within 1 year if possible to ensure the swift and secure transfer of information.	Quarterly Updates Primary Care	Awaiting quarterly report on progress			
MESCG CQUINS					
1. Quality Dashboards	-				
Identify and provide contact details of the following:					
- an overall dashboards lead for the Provider		Confirmed			
- a dashboard lead in each clinical area for which a dashboard is required in 12/13	-	Clinical Directors (TBC)			
Provide a summary setting out the plans for implementation of the dashboards within the required timescale					
3. Use of Intensity Modulated Radiotherapy	Target to be derived from Q1 data	Awaiting audit data			
4a. Cancer Chemotherapy Performance Status	-	91.7%	93.3%	99.2%	
4b. Cancer Chemotherapy Performance status 2 or above		0%	0%	100%	
5. Hepatitis C. Compliance with treatment / improved patient outcomes	-	Awaiting audit data			
7. Reduction of catheter - related CONS	7% Baseline 2011-12	0%			

TRUST BOARD SUMMARY SHEET	
Title	Patient Experience Strategy: Implementation Plan
Submitted by	Suzie Loader, Director of Nursing, Midwifery & Patient Services
Date of meeting	25 July 2012
Corporate Objectives Addressed	Improve Clinical Quality and Safety

SUMMARY OF CRITICAL POINTS

- Outline of the structure required to support the implementation of the Patient Experience Strategy
- Presentation of the Patient Experience Strategy Implementation Plan for discussion & ratification

PATIENT IMPACT
To enhance the quality of service experience delivered to patients and their carers

STAFF IMPACT
To enhance staff morale as patient experience increases

FINANCIAL IMPACT
Yet to be determined.

EQUALITY & DIVERSITY
N/A

LEGAL IMPLICATIONS
Nil

RECOMMENDATIONS

Members of the Trust Board are requested to: -

- Discuss and challenge the contents of this paper
- Approve the contents of the Patient Experience Strategy Implementation Plan.
- Agree the structure outlined to support the implementation of the Patient Experience Strategy

4

1.0 Introduction

In June 2012, the Board approved the Patient Experience Strategy and it was agreed that the overarching implementation plan for this strategy would be submitted to the July Trust Board meeting for approval.

It was necessary to write the strategy and implementation plan in a short time period and as a result a fairly limited consultation had taken place. However, the draft strategy had been discussed at the PPI forum and the Implementation Plan (Appendix 1) was circulated and discussed with members of the Strategic Executive Team for comments and amendments prior to submission to Trust Board members.

The five recommended aspects of NICE Clinical Guideline: 138 (Knowing the patient as an individual; essential requirements of care; tailoring care for each patients; continuity of care and partnerships; and enabling patients to actively participate in their care) are incorporated into the implementation plan.

2.0 The implementation plan

The implementation plan highlights the objectives to be attained which will facilitate the achievement of the four key areas identified within the strategy: -

- Help leaders to improve the patient experience
- Help staff to improve the patient experience
- Engage patients in improving the patient experience
- Improving services through measuring patient experience

Successful implementation of the plan is dependent on sustained commitment and shared ownership of the principles of the Patient Experience Strategy for improvement across corporate directorates.

It links closely with the Listening into Action & Patient Safety Strategies, utilising the same staff engagement techniques to gain commitment and involvement in its implementation, which in turn will help to transform the organisational culture. This will have a positive impact on patient & carers, all of our workforce and to a lesser extent our estate. The plan includes objectives which require external facing partnerships with local education providers and medical education deaneries as well as continual sustainable relationships with patients, their representatives or carers and patient groups. These groups are a valuable quality barometer. They share their experiences of the services we deliver and provide important feedback which affords us an opportunity to continually improve the quality of services we provide. Improving the quality of the patient experience will facilitate our aspiration to become one of the best hospitals in the country.

3.0 Structure for Implementation

In order to be successful, the plan identifies the need to recruit Directorate Patient Experience Champions and Care Group Patient Experience Leads, whose responsibility it will be to support the directorates in identifying directorate patient experience improvement plans and monitoring the implementation of such. These champions/leads will be trained in the use of patient experience improvement techniques & good customer service principles lead by experts in the field from external organisations such as the Kings Fund, John Lewis etc. and supported by the Head of Patient Experience.

It is suggested that the strategy is supported via a committee structure (appendix 2) which includes: Surgical & Medical Care Group Patient Experience Committees, a task and finish Metrics group and PPI forum. These committees are headed up by the Patient Experience Board (chaired by the Director of Nursing), which it is proposed is a sub-committee of the Healthcare Governance Committee. The Trust Board's commitment to improving the quality of patient experience is reflected in the appointment of a Non-Executive Director to the membership of this Board.

4.0 Financial considerations

The successful implementation of the Patient Experience Strategy will require financial and human resources. Action 11 outlines a requirement for two additional members of staff, the ability to release clinicians from clinical commitments to undertake their Patient Safety Lead roles as well as yet unquantified resources for the development of educational improvement tools & techniques. Further discussions with the Project Management Office and the Chief Executive will be held to identify where additional support and funding may come from.

5.0 Implementation

Prior to full implementation of the strategy and implementation plan, a full communication plan will be developed to include the launch of the strategy. We propose to ask experts in the field (such as Jocelyn Cornwall (Kings Fund)) to come and launch the strategy to the organisation. Board will be invited to be fully involved with the launch and will provide on-going support for its implementation. Regular updates will be provided to the board in due course.

5.0 Recommendation

Members of the Trust Board are requested to: -

- Approve the Patient Experience Strategy Implementation Plan
- Endorse the implementation structure
- Agree that the Patient Experience Board should become a sub-committee of Health Care Governance

4

Appendix 1

Patient Experience Strategy Overarching Implementation Plan

Action Plan Lead: Suzie Loader, Director of Nursing, Midwifery and Patient Services

Sign Off: Chief Executive Officer

Monitoring Committee: Patient Experience Board **Date: 25 July 2012**

Area for Improvement		Lead	Deadline	Progress Update
Organise the patient experience improvement programme	1. Establish a Patient Experience Board to lead, monitor and evaluate the patient experience improvement programme. 2. Identify a Non-Executive Director to sit on the group. 3. Agree suitable terms of reference and seek ratification of these from the Healthcare Governance Committee. 4. Identify a committee group	Director of Nursing and Midwifery	30 Sept 2012 30 Sept 2012 30 Oct 2012 30 Sept	

Area for Improvement		Lead	Deadline	Progress Update
	structure to include the care groups, the PPI groups, transformation delivery & metrics.		2012	
	5. Introduce the use of national tools across the organization to facilitate the implementation of this strategy at ward/department and directorate level. 6. Participate in national projects to enhance learning opportunities, raising the Trusts profile, seeking external funding where appropriate	Patient Experience Lead	30 Mar 2013 30 Mar 2013	
	7. Identify existing good practise in relation to patient experience and where appropriate incorporate it into the detailed implementation plan.	Patient Experience Lead	31 Aug 2012	
	8. Agree with the Transformation Programme Office how this plan will be programme managed and supported by	Director of Nursing, Midwifery & Patient Services	30 Sept 2012	

Area for Improvement		Lead	Deadline	Progress Update
	the Transformation Team.			
	9. Identify a detailed project plan which supports the implementation of the strategy across individual services, wards / departments & directorates and signed off by Patient Experience Board/Executive Lead.	Patient Experience Lead	30 Sept 2012	
	10. Develop a communications plan regarding the Patient Experience Strategy & implementation plan, emphasising the importance of staff and patient/carer engagement to ensure success.	Patient Experience Lead in conjunction with the Communications Department	30 Sept 2012	
	11. Agree resources to support the programme (Corporate Patient Experience Lead, Administration support for data input (FFT), & external training / facilitation costs e.g. Kings Fund) 12. Identify how education will be	Director of Nursing, Midwifery & Patient Services Patient Experience Lead / Head of	30 Oct 2012 30 Oct 2012	

Area for Improvement		Lead	Deadline	Progress Update
	provided / resourced to the programme	Professional & Practise Development / Assistant Medical Director (Education)		
1. Help leaders to improve the patient experience				
	13. Include patient experience objectives in every Trust business plan.	General Managers / Deputy Director of Planning and Strategy (Contracting Department)	31 Mar 2013	
	14. Ensure full involvement of the Board and shadow governors in implementing this strategy through the introduction of the following: -	Director of Nursing, Midwifery and Patient Services	30 Oct 2012	
	• Continue to present patient stories at Board, however consider additional modes of delivery e.g. DVD, patients in person etc.	Medical Director / Director of Nursing, Midwifery & Patient Services	30 Oct 2012	
	• Bi annual invitation to patients to meet members of the Board	Head of Corporate Affairs	31 Mar 2013	

Area for Improvement		Lead	Deadline	Progress Update
	to share their stories (in private sessions) • Introduce 'Goldfish bowl' 'sessions across the organization. Frontline staff will hear directly from patients who will share their experiences of care at NGH.	Patient Experience Champions & Care Group Leads	31 Mar 2013	
	15. Engage with all senior teams to ensure effective implementation of the strategy through the implementation of an effective communication plan.	Deputy Director of Nursing, Midwifery and Patient Services / Communications Department	30 Oct 2012	
	16. Ensure engagement of partner and stakeholder organizations through membership and, or representation on the Patient Experience Board or its sub groups as appropriate.	Deputy Director of Nursing, Midwifery and Patient Services	30 Oct 2012	
	17. Designate senior clinicians /matrons as Care Group Patient Experience Leads and Directorate Patient Experience Champions and formalise their	Medical Director/ Deputy Director of Nursing (Quality and Governance)	30 Oct 2012	

Area for Improvement		Lead	Deadline	Progress Update
	terms of reference.			
	18. Develop plans to improve key corporate aspects of the patient experience, including: a. the discharge process; b. noise at night; and c. quality of hospital food.	Deputy Director of Nursing (Professional Lead) Patient Experience Champions General Managers Head Pharmacist Director of Facilities/Estates	30 Nov 2012	
	19. Support the Patient Experience Champions in developing Directorate plans	Patient Experience Lead	30 Nov 2012	
2. Help staff to improve the patient experience				
	20. Develop a Trust "Standard of Behaviour Framework", for use in: a. staff appraisals; b. recruitment and selection; c. development of a customer care code of	Interim Director of Transformation & Workforce Assistant Medical Director (Education) Director of Nursing, Midwifery & Patient Services	31 Mar 2013	

4

Area for Improvement		Lead	Deadline	Progress Update
	practice; d. education & training programmes. 21. Identify tools and techniques (e.g. use of role profiling and psychometrics) to assess values and beliefs as part of the recruitment process. 22. Implement the Customer Care (Code of Practice)	 Head of Complaints, PAL's and Bereavement	 31 Mar 2013 31 Mar 2013	
	23. Establish a staff development programme with a specific focus on the tools and techniques advocated by the Kings Fund to enhance patient experience. 24. Identify external organisations who are renowned for providing excellent customer service and who would be happy to support the trust in	Deputy Director of Nursing (Head of Governance) and Deputy Director of HR Head of Professional Practice Development Assistant Medical Director (Education)	30 Oct 2012 30 Sept 2012	

Area for Improvement		Lead	Deadline	Progress Update
	helping NGH to develop similar customer service standards and delivery across the Trust.	Patient Experience Lead		
	25. Review existing training programmes to include leadership development and introduce where appropriate a module on desired behaviours to improve the patient experience / customer care.	Deputy Director of HR and Service Development Lead Head of Professional Practice Development	30 Nov 2012	
	26. Explore the development of a Customer Care DVD for the following groups: - Nursing and Midwifery staff - Doctors - AHP's - Facilities staff - Support staff (porters, cleaners, ward clerks, administration staff etc.)	Patient Experience Lead	30 Oct 2012	
	27. Ensure that patient experience is a key theme in Listening into	CEO Interim Director of	30 Nov 2012	

Area for Improvement		Lead	Deadline	Progress Update
	Action.	Transformation & Workforce		
	28. Ensure compliance with NICE Clinical Guideline: 138 in all clinical areas through the inclusion of the following: - **Knowing the patient as an individual** a. Consultant Leads/ Matrons rounds to address patient concerns. b. Patient information is shared ensuring all information in relation to diagnosis, treatment and follow up care signposts the patient during the pathway of care. c. Information is delivered in a format or medium (tape recorded, Braille etc.) which is easily understandable. d. Appropriate use of patient	Consultants / Patient Experience Leads Matrons Ward/Departmental Managers Patient Experience Lead	30 Mar 2013	

Area for Improvement		Lead	Deadline	Progress Update
	notice boards which contains up to date information, presented in an easy to read format. **Essential requirements of care** a. Nutrition, pain management and addressing personal needs included in Care Rounds **Tailoring care for each patient** a. Patient Information is in a format easily understood by patients. **Continuity of care and partnerships** a. Ensuring the environment is conducive to discussions which respect patient privacy **Enabling patients to actively participate in their care** a. Shared decision making in all aspects of care (including the	Deputy Director of Nursing (Professional)		

Area for Improvement		Lead	Deadline	Progress Update
	appointment of IMCA's for those who lack capacity)			
	29. Liaise with local health professional education providers to: a. strengthen the acquisition of patient experience competences; b. explore how health professional students / junior doctors undergoing practice learning experiences can be fully engaged in improving the patient experience.	Deputy Director of Nursing (Professional Lead) Associate Medical Director (Education)	30 Mar 2013	
3. Engage patients in improving the patient experience				
	30. Review the effectiveness of all Trust PPI structures and processes, including the relevance and robustness of data we collect.	Deputy Director of Nursing (Professional Lead)	30 Nov 2012	

Area for Improvement		Lead	Deadline	Progress Update
	31. Routinely involve patients and shadow governors proactively in service design and development, piloting the process in a designated directorate.	Patient Experience Champions and Leads Deputy Director of Strategy & Planning	31 Mar 2013	
	32. Engage where appropriate a user representative as the joint patient experience lead in each care group.	Deputy Director of Nursing (Professional Lead)	30 Nov 2012	
	33. Routinely involve patients and volunteers in data collection on the patient experience, including: a. the Friends and Family Test; b. monthly audits of noise at night. c. Protected mealtimes d. Patient Quality Boards	Deputy Director of Nursing (Professional Lead) Head of Professional Practice Development	30 Nov 2012	
	34. Engage patients and the public in developing the annual Quality Accounts.	Deputy Director of Nursing (Head of Governance)	30 Mar 2013	

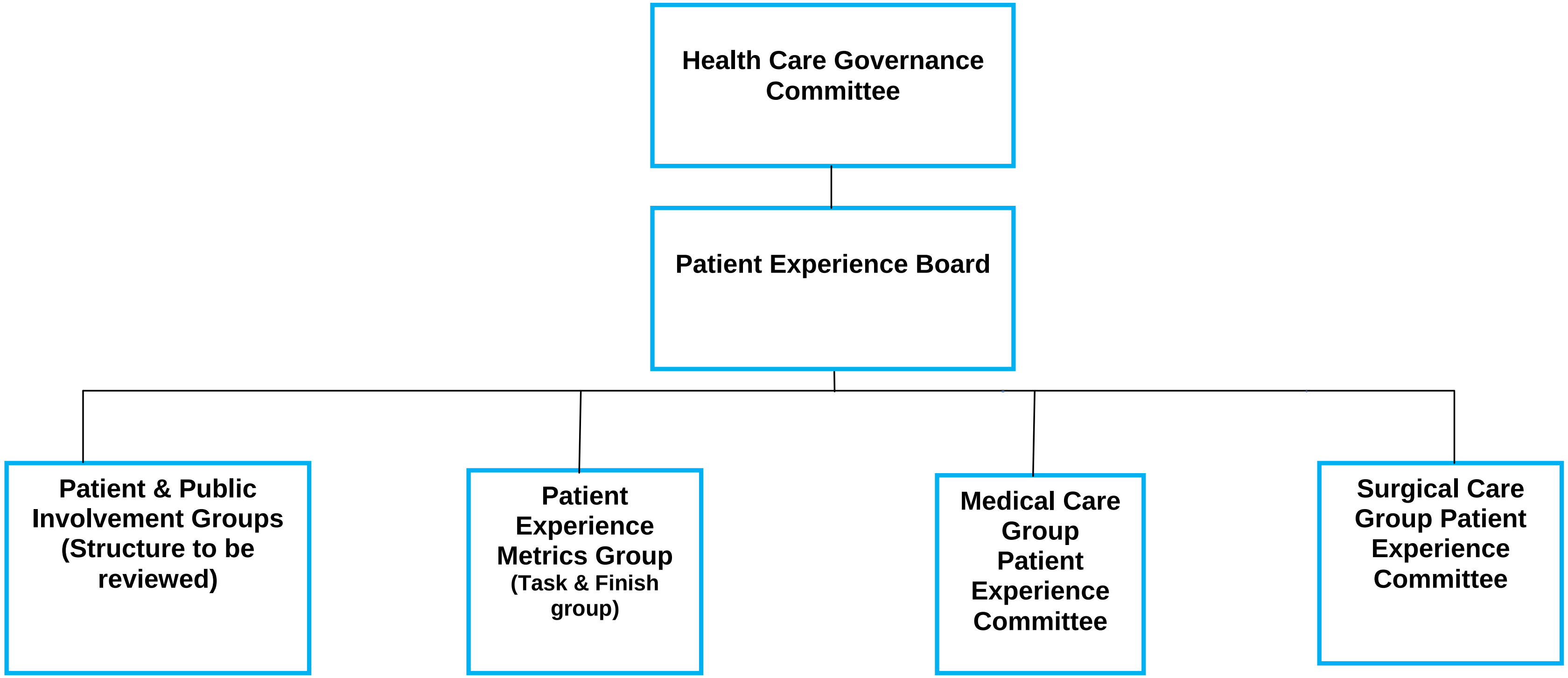
Area for Improvement		Lead	Deadline	Progress Update
4. Improve services through measuring the patient experience				
	35. Review and streamline methods to gather feedback from patients and relatives to understand why they would or would not recommend the Trust to others.	Deputy Director of Nursing (Head of Governance)/ Patient Experience Lead	30 Sept 2012	
	36. Establish a sub-group of the Patient Experience Board whose responsibility it will be to identify key metrics for measuring the patient experience across the organization. The group will be responsible for agreeing how data will be collected (taking into consideration audits which are currently undertaken), analyzed and presented, ensuring that the data is robust and specific to the organization's needs.	Deputy Director of Nursing (Head of Governance)	30 Sept 2012	

Area for Improvement		Lead	Deadline	Progress Update
	37. Metrics will be translated into a dashboard which will span ward / department to board and be used by individual departments / directorates and care groups for measuring improvements.	Deputy Director of Nursing (Head of Governance)	30 Nov 2012	
	38. Develop an action plan for engaging each clinical area in measurement through assessing and piloting different metrics, including creation of a local dashboard for instant feedback and action.	Deputy Director of Nursing (Head of Governance)	30 Nov 2012	
	39. Check the validity of our Friends and Family Test measurement, and identify how to achieve an accurate reflection of how patients feel regarding their care and an annual 10-point improvement in our score.	Deputy Director of Nursing (Head of Governance)	30 Sept 2012	

Appendix 2

Patient Experience Strategy Board Structure

(Draft)



Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title	Patient Experience – Friends and Family Test (FTT)
Submitted by	Suzie Loader, Director of Nursing
Prepared by	Jan Grant, Patient Experience Lead (interim)
Date of meeting	July 2012
Corporate Objectives Addressed	Improve Clinical Quality and Safety

SUMMARY OF CRITICAL POINTS

- Following the confusion regarding the 'pop' up question on Hospedia from which the FFT data is obtained, a supplementary manual trust wide data collection was initiated on 24 June 2012.
- Friends & Family Test Scores (FFT) data for June are: -
- **+ 63 (manual collection – part month only)**
- **- 28 Hospedia bedside collection**
- **0.417% combined score**
- The PCT agreed that the baseline data for the FFT CQUIN would be July 2012.

PATIENT IMPACT
The Friends and Family Test score is designed to capture perceptions of patients on the day of discharge about the service that they have received whilst an inpatient at NGH.

STAFF IMPACT
The FFT Score provides staff with real time feedback.

FINANCIAL IMPACT
The ability to continually drive forward quality is increasingly important and has the potential to affect NGH income.
If the Trust do not achieve the regionally set CQUIN, this could have financial implications

EQUALITY & DIVERSITY
The Hospedia television system may need to be made more accessible for patients with communication difficulties.

LEGAL IMPLICATIONS
Nil

RECOMMENDATIONS

- That the Board continue to support the manual collection of patient experience data, to run in parallel to the Hospedia data collection until there is confidence that the Hospedia data is reflective of patient experience, or until another data collection tool is identified.
- Members of the Board are asked to note the contents of this report and to challenge as appropriate.

1.0 Introduction

The Friends and Family Test (FFT) captures perceptions of patients about the health care that they have received, by asking the question: '*Would you or your family recommend this hospital service to family and friends?'* Data collection against this metric commenced in April 2012 whereby the trust is required to capture 10% of inpatient discharges per week at or within 48 hours of discharge. The FFT score is calculated as follows:

The number of promoters (people who scored between 10-9) – the number of detractors (people who scored between 6-0) divided by the total number of responses received, multiplied by 100 = FFT. E.g. 218 – 65/400x100 = +38

Due to the fact that the results from Hospedia remain unreliable, an additional manual data collection exercise was commenced on 24 June 2012. The results of this, together with the Hospedia results are presented below.

2.0 June Results

As the Trust is currently running parallel data collection systems, the results presented within this paper are as follows:

- Monthly FFT score for the later part of June (per ward/department)for the manual data collection: **+ 63**
- Monthly FFT score for June from the Hospedia bedside data collection: **– 28**

Both sets of figures are a significant improvement from previous months. However, you will note a remarkable variance between the manually and bedside collected results.

It is suggested that this is because nurses have to explain to patients about the manual data collection, but may not necessarily explain to patients about the Hospedia question as it automatically 'pops' up on the TV screen at 11.00hrs every day. In addition, ward staff have received more education regarding this initiative since the introduction of the manual data collection. It is clear from the results that this is reflected in the Hospedia results as they are closer to the manual data collection results than in previous month's results.

3.0 Data Validity

Dual data collection methods (manual & Hospedia) will continue until the end of September 2012, when the results will be analysed and a decision made regarding future data collection methods. It is clear that patients score the Trust higher when they are handed a questionnaire to complete during their discharge process. This supports the hypothesis that patients are mistaking the term "hospital services" as those provided by Hospedia e.g. television and telephone services when responding to the discharge question on the bedside units.

An expectation of the regional Patient Experience CQUIN is that all NHS Trusts in Midlands and East SHA must submit monthly FFT results to the Commissioners and the Strategic Health Authority. These results are in published and placed in the public domain. Members of the Board are requested to decide at the September Trust Board meeting whether the monthly results that we submit to the SHA should be taken from the: -

- bedside collection results only
- manually collected results only, or,

- the combined results

The result from July's data will be shared with the PCT and form the baseline of the Trust's Patient Experience Regional CQUIN indicator for 2012/13.

4.0 Recommendations

Members of the Board are asked to:

- Agree that manual data collection should continue in parallel to the Hospedia data collection for 3 months until either the Hospedia data has been validated as accurate or a more robust method is identified and implemented
- Challenge the content of the report and support the actions defined.

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title	Monthly Infection Prevention Performance Report
Submitted by	Suzie Loader, Director of Nursing, Midwifery, Patient Services/DIPC
Prepared by	Wendy Foster Infection Prevention and Control Specialist Practitioner
Date of meeting	25th July, 2012
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.

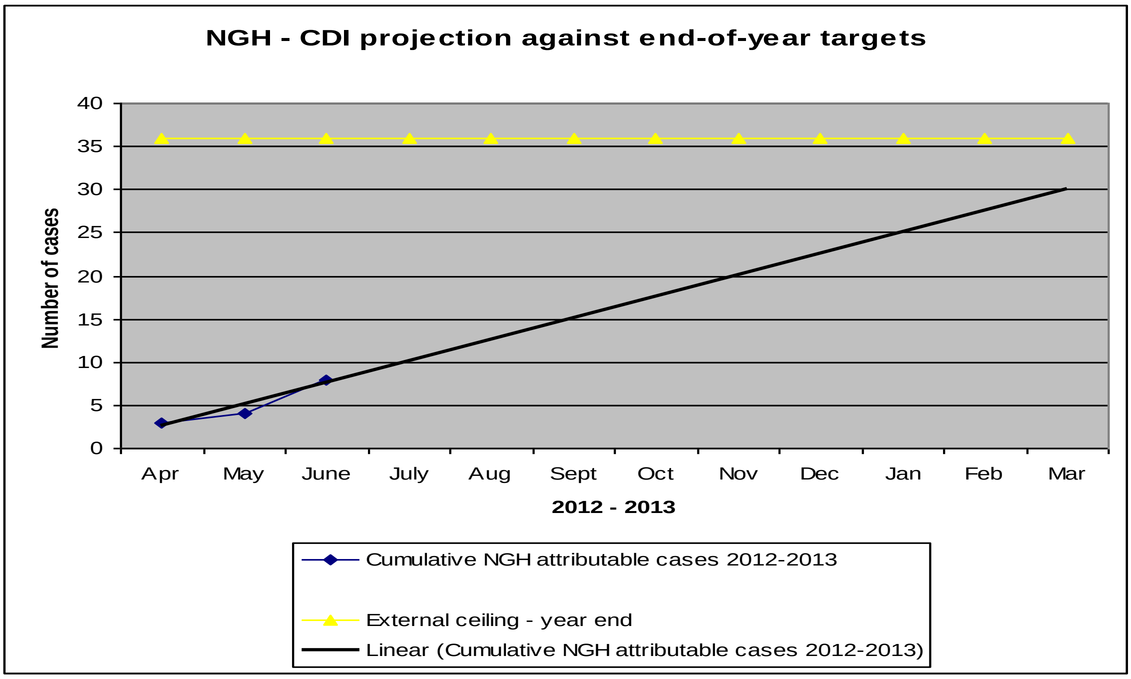
MRSA Bacteraemia (Appendix 1)
The Trusts trajectory for MRSA bacteraemia in 2012/13 is 1 case. In June there were *0 >48hrs MRSA bacteraemia*. The Trust is measured on the number of MRSA bacteraemia cases per 10,000 bed days. The post-48 hour MRSA bacteraemia cases year to date is 0.17 /10,000 bed days.

MRSA Colonisation (Appendix 2)
During June there were 15<48hrs and 7>48hrs cases of MRSA colonisation. Internal patient verified data identifies 99.8 % compliance for the screening of elective admissions and 96.4% compliance for emergency screening during June, which are both above target.

Special Measures
Willow ward were placed on 'special measures' for 2 post 48 hours MRSA colonisations. This means that the patients were found to have the organism, on their skin, the organism is multiplying, but not causing an infection. However, this cannot be ignored as MRSA is a pathogenic organism and has the potential to cause infection.

MSSA Bacteraemia (Meticillin Sensitive *Staphylococcus aureus*)
During June there were 4<48hrs and *1 >48hrs MSSA bacteraemia cases*. A Root Cause Analysis (RCA) was undertaken on the post 48 hours MSSA bacteraemia case.
Learning from this RCA involved Peripheral Vascular Cannulas' (PVC) as there was an increased risk to this patient as the cannula was in longer than 72 hours (the recommended maximum time when a cannula should remain in situ). The ward started daily PVC audits for insertion and on-going care for 1 week and then weekly until the end of June. The Infection Prevention and Control Team also undertook a PVC audit for June 2012, demonstrating varying compliance across the wards that were audited. A further audit is to be conducted by the Matrons and Ward Sisters across the organisation, utilising an adapted Saving Lives PVC tool. Results to be presented at the August 2012 (IPC) where improvement actions will be identified.

***Clostridium difficile* (*C diff*, Appendix 3)**
The Trust has a trajectory of 36 C. diff. cases for 2012/13. During June the Trust identified 3<3 day and *4 >3 day cases of C. diff,* which equates to a cumulative of 0.14/10,000 bed day's year to date. We remain on track to keep numbers below our target for the year.



Surgical Site Infection Surveillance Scheme (SSIS)

The Trust takes part in the national surgical site infection 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).

Surgical Site Infection Surveillance

Background
The national Surgical Site Infection Surveillance programme is continuing to audit this category throughout the year and reports are generated quarterly. Although the HPA report will take some time to be generated:-

The interim results for June 2012 are as follows:

- Repair #NOF's. show that there were ***no presumptive infections*** resulting from 21 operations
- Breast operations show that there were ***no presumptive infections*** resulting from 29 operations
- Limb amputation operations show that there were ***no presumptive infections*** resulting from 10 operations

All these results are fed back to Clinical Quality and Effectiveness Group (CQEG) on a monthly basis.

Hand Hygiene Audit
Over the last few months the Hand Hygiene Observational Tool (HHOT) data that has been presented to the Trust Board has been for the wards only. Previously it has been presented as a total percentage of the Trust which includes theatres and outpatient departments.

Month	**Ward compliance**	**Overall Trust compliance**
April	99.1%	95.5%
May	99.8%	91.7%

Information from the Hand Hygiene Observational Tool (HHOT) data shows that in June the overall compliance for hand hygiene was 90%, for the ward areas only it was 99.2%.

The Trust compliance reflects the number of wards who don't submit the hand hygiene observation audit tool (HHOT). It was agreed that from July, an additional box will be added to the audit results which flags those wards who have not undertaken their audit, so that this can be followed up by the respective Matron.

Future data presented will be for the overall trust compliance.

Pertussis (Whooping Cough)
The Infection Prevention team were notified on the 15th May 2012 of a Paediatrician with a confirmed Pertussis result. Clinical staff (medical and nursing) that have direct patient contact in the neonatal unit and Paediatrics Departments were vaccinated to minimise further transmission by Occupational Health. The Infection Prevention team continued to raise awareness among all staff in the paediatric wards and the maternity unit. 98.5% of available staff have been vaccinated, with those staff returning from sick leave and annual leave being offered vaccination on their return. The Primary Care Trust acknowledged the hard work undertaken to make this possible.

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

Suzie Loader
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 2012-13
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		1																							1
Collingtree 23hr																									0
ITU																									0
HDU																									0
A & E																									0
Abington																									0
Cedar																									0
Becket																									0
SingleHurst																									0
Knightley																									0
Gossett																									0
Disney																									0
Paddington																									0
Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer																									0
Sturtridge																									0
Allebone																									0
Benham																									0
Creaton																									0
Dryden																									0
EAU																									0
Eleanor																									0
Victoria																									0
Head & Neck Ward																									0
Hazelwood (Community)																									0
Danetre (Community)																									0
Corby (Community)																									0
Rowan																									0
Finedan																									0
Compton																									0
Brampton																									0
Holcot																									0
Althorp																									0
Talbot Butler																									0

Trust Total 2012-13	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1

Appendix 2

MRSA Colonisation Incidence by Ward

MRSA ISOLATES	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Trust Total 2012-13
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			1		1	2																			1
Collingtree																									0
ITU																									0
HDU						1																			0
A & E																									0
Abington	1		1																						2
Cedar																									0
Becket			1																						1
SingleHurst																									0
Knightley						1																			0
Gossett					1																				0
Disney																									0
Paddington																									0
Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer			1																						1
Sturtridge																									0
Allebone	1		2																						3
Benham		1			4	1																			1
Creaton				1																					1
Dryden						1																			0
EAU	6		5		6																				11
Eleanor	1		1	1	1																				3
Victoria																									0
Head & Neck Ward																									0
Hazelwood (Community)					2																				0
Danetre (Community)																									0
Corby (Community)																									0
Rowan				1																					1
Finedon		1																							1
Compton																									0
Brampton		2				1																			2
Holcot																									0

Althorp																									0
Talbot Butler																									0
Trust Total 2012-13	9	4	12	3	15	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	28

Appendix 3

Clostridium Difficile Incidence by Ward

CDT	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Trust Total 2012-13
Ward	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	
Hawthorn																									0
Willow																									0
Collingtree																									0
ITU																									0
HDU																									0
A & E																									0
Abington		1																							1
Cedar																									0
Becket																									0
SingleHurst																									0
Knightley																									0
Gossett																									0
Disney																									0
Paddington																									0
Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer																									0
Sturtridge																									0
Allebone																									0
Benham				1	1	1																			1
Creaton		1																							1
Dryden																									0
EAU			1		2																				1
Eleanor																									0
Victoria																									0
Head & Neck Ward																									0
Hazelwood (Community)																									0
Danetre (Community)																									0
Corby (Community)																									0
Rowan																									0
Finedon																									0
Compton																									0
Brampton						1																			0

6

Holcot		1				1																			1
Althorp																									0
Talbot Butler						1																			0
Trust Total 2012-13	0	3	1	1	3	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title	Annual Research and Development Report
Submitted by	Dr Sonia Swart Medical Director
Prepared by	Mrs Julie Wilson Research and Development Manager and Sonia Swart
Date of meeting	July 25 2012
Corporate Objectives Addressed	Develop and embed measures for quality and clinical outcomes to achieve the highest standards

SUMMARY OF CRITICAL POINTS

- The Research and Development Department has successfully bid for increased funding to increase the number of research studies across the Trust
- There is a need to formalise the reporting and accountability structures for the Research and Development Department to ensure best use of this important resource

PATIENT IMPACT

Participation in Research and Development is currently seen as a high priority area within the NHS and patients will expect their hospitals to offer access to clinical trials

STAFF IMPACT

An active Research and Development department is seen as beneficial for staff to encourage their development

FINANCIAL IMPACT

The income derived from Research and Development can support the Trust and also support supporting professional activity for Medical Consultants

EQUALITY & DIVERSITY

Not assessed

LEGAL IMPLICATIONS

Governance arrangements for research trials are scrutinised carefully

RECOMMENDATIONS

Board Members are asked to note the content of this report and debate key issues concerning the alignment of Research and Development with the Trust's Clinical Strategy

7

Northampton General Hospital NHS
NHS Trust

Research and Development - Annual Report July 2012

1. Introduction

Research is considered core business in the NHS and the NHS Operating Framework 2012/13 underlines this.

Northampton General Hospital (NGH) remains committed to research to be proactive and address future challenges. The NHS Constitution confirms: "The commitment of the NHS "to the promotion and conduct of research". This principle is further underpinned in the constitution that states that "The NHS will do all it can to ensure that patients, from every part of England, are made aware of research that is of particular relevance to them".

The national picture in relation to research in the NHS is confusing as it is clear that there will need to be reorganisation of area boundaries with respect to research. Hosting arrangements for research networks are being challenged and work is in progress to rationalise the number of research networks. However, high level objectives remain and include targets for recruitment of patients to research; a new target known at 'time to target' (recruitment with a timeframe) and a requirement to support commercial research which is supported within the HM Treasury Plan for Growth.

NGH has a good research reputation which it has developed over a number of years for participating in clinical research. The Trust has developed the Clinical Trials Unit and the research nurses have been employed as generic research nurses. This is a unique approach to research developed by NGH and the trust benefits from the efficiencies of a flexible workforce. This is seen the in the financial surplus at the year end. Other Trusts maintain an historical approach to research where specialist staff are employed within their individual specialist area. One main disadvantage of this approach is that it limits areas which have not developed research capability from participating in clinical research. This is why many district general hospitals do not participate in clinical trials. NGH is commended for its broad portfolio of research and in turn this ensures that the trust continues to meet its recruitment target of patients. This guarantees the continuation of Income from the networks. Furthermore NGH has received additional funding called Research Capability funding because the Research and Development (R&D) department have met their required recruitment targets.

Research and Development has three core functions within the Trust:

- Research Governance.
- Clinical support for academic and commercial trials.
- Operational research infrastructure embedded within the directorates and support departments

2. Research Governance

This is managed via the R&D Office. The office looks after all the requirements of Research Governance Framework for Health and Social care Second edition 2005 on behalf of the Trust. This is ensures that the statutory requirements are met and involves collaboration with other research governance frameworks.

3. Clinical support for academic and commercial trials

NGH has increased the number of National Institute of Health Research (NIHR) adopted studies in which we are participating. Once again, we have improved the recruitment rates of patients into clinical research and this has been formally acknowledged. This success has ensured that our bid for this year's infrastructure funding from the Comprehensive Local Research Network (CLRN) has been approved without cuts which is very positive in the current climate. New areas for research development have been with the Gynae Department and with Dermatology. Rheumatology, Cardiology, Cancer, Intensive Care and Accident and Emergency continue to contribute well to the local research portfolio. The Trust continues to participate in a wide range of research in addition to the portfolio work; we work with the Pharmaceutical Industry, Medical Device Industry in addition to Academia and the Medical Charities.

A full list of current activity is available from the R&D office.

Clinical support incorporates all the staff directly required for the delivery of R&D and includes doctors, nurses and allied health professionals. Within NGH the Clinical trials unit operates as a support service to any clinician or department within the Trust which wishes to participate in research. In addition there are some legacy staff who undertake R&D outside of the department. These staff are in the areas of oncology ,cardiology and stroke. The R&D Office still governs their workload and in discussion with the local comprehensive research network set recruitment targets for patient into portfolio trials. The Trust is in receipt of infrastructure funding to provide this activity. Further operational funding comes from commercial companies, medical charities and academic studies.

Figure 1 Northampton General Hospital NIHR reported recruitment to clinical research

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	Baseline
2011/12 Recruitment	15	79	157	239	324	407	650	764	934	989	1116	1281	1352	
2010/11 Recruitment		36	136	157	269	302	352	457	524	590	634	703		822
2011/12 Goal		84	167	251	334	418	502	585	669	752	836	919	1003	1003

The national system of gaining NHS permission is still causing problems at both a national and local level. It is anticipated that funding in future will be available from networks if the process and speed of research governance is improved. To support this, the Department of Health has introduced the Research Support Service. This will, in time, provide codes of practice that R&D offices will be required to adhere to. The penalty for failure to comply with this will be the withdrawal of network funding. It is therefore critical that the R&D office keeps updated and abreast of all new changes. One of the first requirements is that the Trust will be required to provide a Research Capability Statement signed off by the Trust Board. This is in the process of being drafted.

In addition, a number of new schemes are being introduced where the Trust need make decision on our participation and with whom. In particular -

- Academic Health Science Centres (AHSCs) which are partnerships which bring together a small number of health and academic partners to focus on the integration of world-class research, teaching and patient care. Approx 10 million pound budget.

- CLAHRCs are collaborative partnerships between universities and surrounding NHS organisations, focused on improving patient outcomes through the conduct and application of applied health research. Approx 20 million pound budget.

Both these schemes are currently in stages of set up.

4. Current picture

The R&D Office has noted a changing pattern in terms of recruitment over the past year. Commercial studies are more specific and more complex than ever before. Historically these commercial studies recruited higher numbers than they do now. Currently an average recruitment number for a commercial study is around ten which largely reflects the costs of research in the UK. Therefore NGH is doing more commercial studies but with less recruitment. It should be noted that not all commercial research is adopted onto the NIHR portfolio and is therefore not reflected in the table above. However in order to achieve our recruitment targets we actively search the portfolio for studies suitable for NGH. This proactive management has ensured we hit the recruitment target set and therefore maintaining funding.

Funding from the comprehensive network also comes with recompense for PA time for consultants who are actively involved in the recruitment process. These sessions are additional to their job plan and are short term to reflect the nature of the project. Current spend on PA 's is as follows. This reflects the workload required to enter patients into trials and maintain the necessary surveillance.

A total of

1 PA - Rheumatology consultants
1 PA - Neurology consultants
1 PA - ITU consultants
1PA - Accident and Emergency
1PA - Cardiology consultants
0.5 PA - Stroke
1 PA - Paediatric consultants

Recruitment into clinical trials is in alignment with the Trust's overall strategy to develop acute and specialist services. The departments which have seen the greatest increase in recruitment over the last year are Intensive Care team who have contributed particularly well to a pneumonia study and sepsis outcomes study.

Accident and Emergency have also recruited well to a head injuries study and study for patient presenting with severe asthma. In addition they have a number of other studies in the pipeline include a study to evaluating of learning of junior doctors in relation to acutely fevered children.

The Stroke team are recruiting better than in previous years but are struggling with a limited portfolio for future studies this is a national not a local issue

The Trauma team have historically always participated well in R&D, their current portfolio has an emphasis on DVT prophylaxis both in terms of medicines and medical devices.

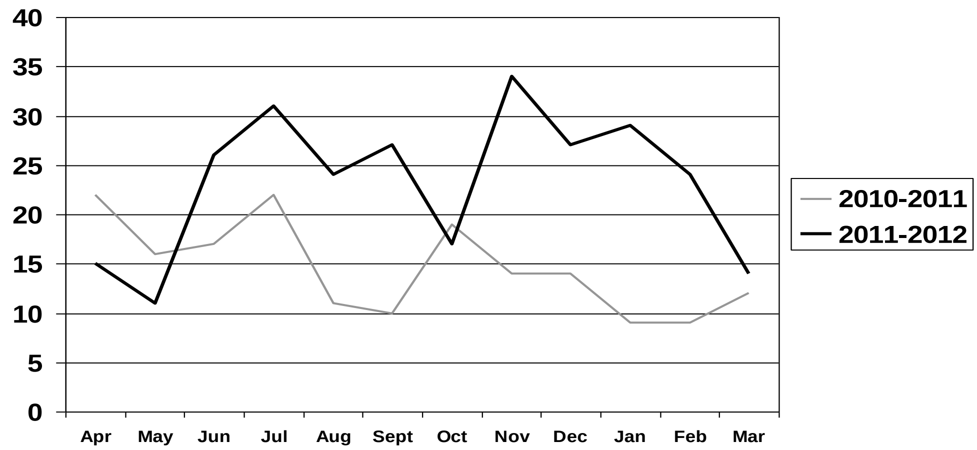
The Cardiology department has supported a number of commercial including those relating thrombin inhibitor studies. One of these drugs is now licensed for patients with Atrial Fibrillation.

The Cancer research team have expanded considerably with the addition of the equivalent of five research nurses which we successfully bid for from the comprehensive research network. The consolidation of this team has seen the improvements as shown in figure 2.

Figure 2

Oncology/Haematology Trial Recruitment April 2011 – March 2012
Compared to April 2010 – March 2011

Total Recruitment 2010/2011 = 175
Total Recruitment 2011/2012 = 279



Comparing recruitment for cancer trials with local stakeholder shows that NGH recruitment increased by 62%, Kettering increased by 53% however UHL fell by 10%. A recruitment target for the forthcoming year has been set and agreed by the team and we confidently hope to report a 20% increase next year. Although the recruitment to trial remains at only around a third of that of UHL, this is largely related to the significant difference in infrastructure. Expanding the research portfolio of the Trust will remain important in order to consolidate NGH's position as a cancer centre.

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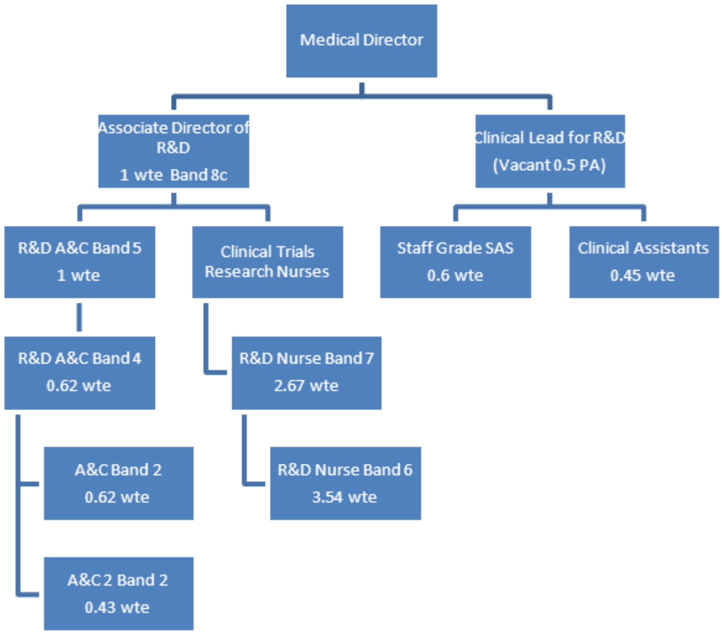
Further improvements with regards to research would be particularly desirable to support areas where the Trust is keen to develop services. The Trust will continue to support research initiatives relating to high profile services such as vascular services, paediatrics services and respiratory services

5. Operational and Research infrastructure

R&D Current Structure



A number of posts throughout the Trust are embedded in infrastructure posts and therefore support our activity:

Pathology
Pathology Administrator - Band 6 - 0.5 WTE
Deputy Head of Pathology - Band 8a - 0.2 WTE
Head of Histopathology - Band 8C - 0.05 WTE

Pharmacy
Advanced Specialist Pharmacist Cancer Services - Band 8a - 0.4 WTE
Senior Pharmacist - Band 8A - 0.1 WTE
Clinical Trials Pharmacist - Band 6 - 0.5 WTE

Radiotherapy
Deputy Head of Radiotherapy Medical Physics - Band 8C - 0.4 WTE
Principle Physicist - Band 8a - 0.5 WTE
Research Radiographer - Band 7 - 0.5 WTE

Radiology
Consultant Radiologist - 1PA
Head of Imaging - Band 8C - 0.05 WTE
Radiology Administrator - Band 3 - 0.5 WTE

Medical Records
Medical Records Co-ordinator - Band 3 - 1 WTE

All Topic specific research network and Comprehensive Research Network Nurses based around the Trust including T&O, Oncology Stroke etc

Band 7	1 WTE
Band 6	5.1 WTE

There are other research nurses from various funding streams based around the Trust.
Band 7 research nurses in cardiology 2 WTE
Band 7 research midwife 0.4 WTE

6. Finance for April 2011/12

Income £

CLRN 948,786
Other network funding embedded in Directorate - in the region of 100,000
Non Network Income (Academic partnerships, commercial companies) 259,317
Direct support income approximately 80,000
Research Capability funding 20,000
(Awarded from the Department of Health because the Trust achieved the Research Capability Criteria which is a new funding stream)

Total R&D income:- around 1.5 million

Surplus income to the Trust

Research and Development generate an operating surplus at the year end. The funding comes from efficiencies from the income received and utilising the workforce effectively. Surpluses are shown below and vary year on year.

Surplus income to the Trust £:

2011/12	62.3k
2010/11	391k
2009/10	94k

Unfortunately commercial income has reduced in the last couple of years because consultants have been reticent in undertaking commercial trials due to time constraints. In 2010/11 the surplus was high because there was no spend on PA activity and it remained in the R&D budget**.**

7. Future plans for R&D

Transformation process

- **Review of how to maximise income**
  One of the proposed goals in our cost improvement plan is to maximise income. To achieve this aim, the R and D department needs to review the current research portfolio and also to maximise the efficiency of research staff. In order to achieve this there is a need to ensure that all research staff managerially report to one point thereby ensuring:-

  1. There is a skilled but flexible research workforce that can maximise efficiency in terms of allocation of work.

2. Monitoring to ensure that as services are reconfigured the research impact to on-going trials is considered. Many research studies have a timeframe which extend over several years. The result of any changes will impact on the research workforce and subsequently we need a structure where research nurses can be flexible.

3. The generic approach to research would ensure that research support is available across the Trust. The resource can then be used to develop some areas of the Trust that currently are not research active or areas where the Trust would like to see more research activity.

- **Review where R&D sits within the new structure**
  To deliver a comprehensive research programme to the Trust we need to work within the Care Group Structure

- **Review the linkage between R&D and the Trust's clinical strategy and clinical risk profile**
  Linkages with clinical strategy can be confirmed through the Care Group Structures. Alignment with risk and audit should be facilitated through a formal linkage with the Trust Governance Structure.

- **Review the National changes within R&D**
  The R&D office needs to keep abreast of national changes in order to position NGH accordingly. One of the biggest issues for continued funding is the key performance indicator of 'time and target'. A considerable work plan needs to be established to review the coordinated system of gaining NHS permission (CSP). Currently this is run by a centralised structure from Leicester and is slow and cumbersome. The computerised infrastructure is also not working well. The Trust R&D Office needs to maintain a skill base so that we are in a position to intervene and speed up the process. This is essential if we are to achieve this key performance indicator which is a requirement for future funding.

The Trust Board is asked to consider the content of this report and acknowledge the importance of Research and Development in supporting the Trust's clinical strategy and quality of services. The Board is asked to debate what further support should be provided to support the required development. The Board should note that the clinical lead post is currently vacant and recruitment to this post will be a key imperative.

Northampton General Hospital **NHS**
NHS Trust

TRUST BOARD SUMMARY SHEET	
Title: -	Performance Report
Submitted by: -	Christine Allen – Chief Operating Office and Deputy Chief Executive
Date of meeting: -	25th July 2012
Corporate Objectives Addressed: -	

SUMMARY OF CRITICAL POINTS: -

This report sets out the key areas of performance for Northampton General Hospital NHS Trust for Month 3 **(June 2012)**.

- The Trust did not achieve the 4 hour A&E transit time. During June 93.33% of patients were treated or admitted within 4 hours against the standard of 95%. The figure for 1 – 12 July is 93.77%. Year to date performance is 93.86% as at 16 July 2012.
- The Trust did not achieve the 62 day cancer standard for either June or Quarter 1 with the position for April – June 2012 being 79.8%. The Trust will not upload June figures until early August and as such the position may alter slightly but not to the extent that the quarterly target will be delivered.

PATIENT IMPACT: -
To ensure that patients do not wait longer than maximum wait time and that all care is delivered as quickly and efficiently as possible.

STAFF IMPACT: -
N/A

FINANCIAL IMPACT: -
Failure to achieve standards could result in contractual penalties

RISK ASSESSMENT: -
N/A

EQUALITY & DIVERSITY IMPACT ASSESSMENT: -
N/A

RECOMMENDATION: -

Trust Board are asked to discuss the contents of this report and agree any further action necessary.

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PERFORMANCE REPORT – July 2012

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for **Month 3** (June 2012). 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

See Appendix 1 for score card.

2.1 A&E Clinical Indicators

The Trust did not achieve the 4 hour A&E transit time. During June 93.33% of patients were treated or admitted within 4 hours against the standard of 95%. The year to date performance is 93.86%.

Figure 1-Activity vs. 2011-12, Emergency Department

	Apr	May	Jun	YTD
All attends 2012-13	7,633	8,534	8,305	24,472
All attends 2011-12	7,976	8,114	8,212	24,302
Variance	-343	420	93	170
Variance %	**-4.3%**	**5.2%**	**1.1%**	**0.7%**
Plan	6,930	6,702	6,930	20,562
Variance to plan	703	1,832	1,375	3,910
Variance to plan %	**10.1%**	**27.3%**	**19.8%**	**19.0%**

Progress against Recovery Plan

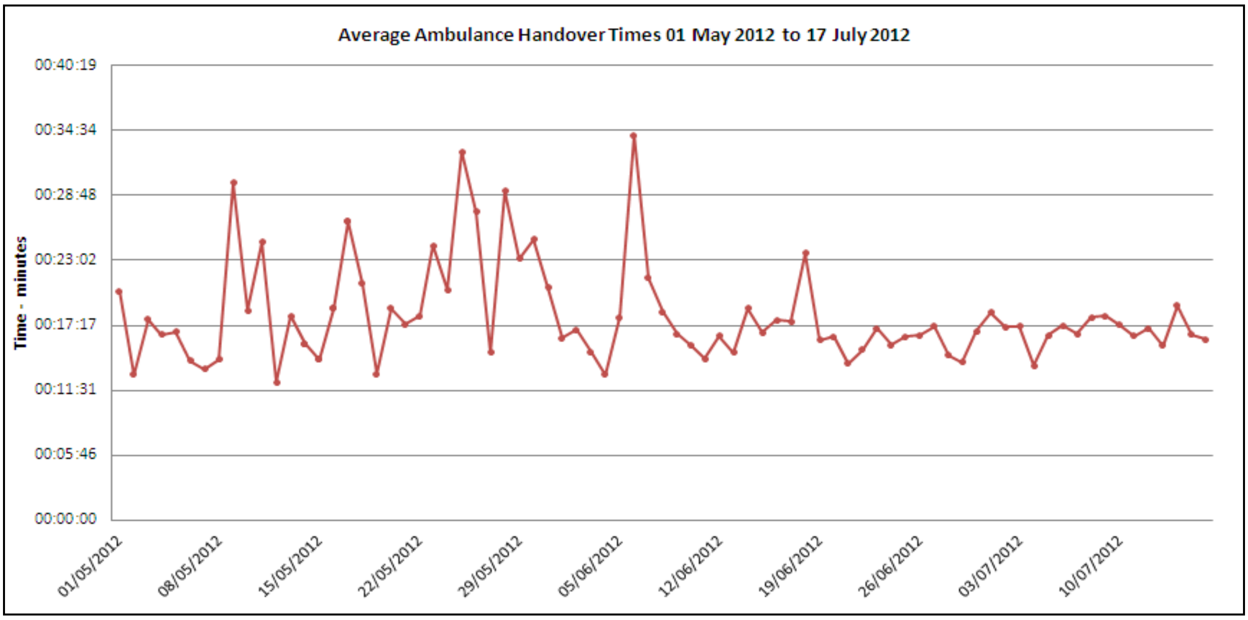
The improvement group led by the Medical Director and Deputy Chief Executive continues to meet fortnightly. Each directorate has plans in place to reduce ALOS, within medicine the introduction of the visual ward on 3 ward areas is in place and Surgery are concentrating on achieving ”work requested on the day to be done on the day”.

- The Trust has introduced a single point of access (SPA) from 7th June.
  The service is consultant led from 8am to 9pm, early indications of the new way of working is positive. Ambulance handover waiting times have significantly reduced and are now at an average of 15 minutes which is within target. The Surgical and medical care groups are both supportive that this model of working continues and a case for further investment for increased staffing will be presented at the next Strategic Management Board.

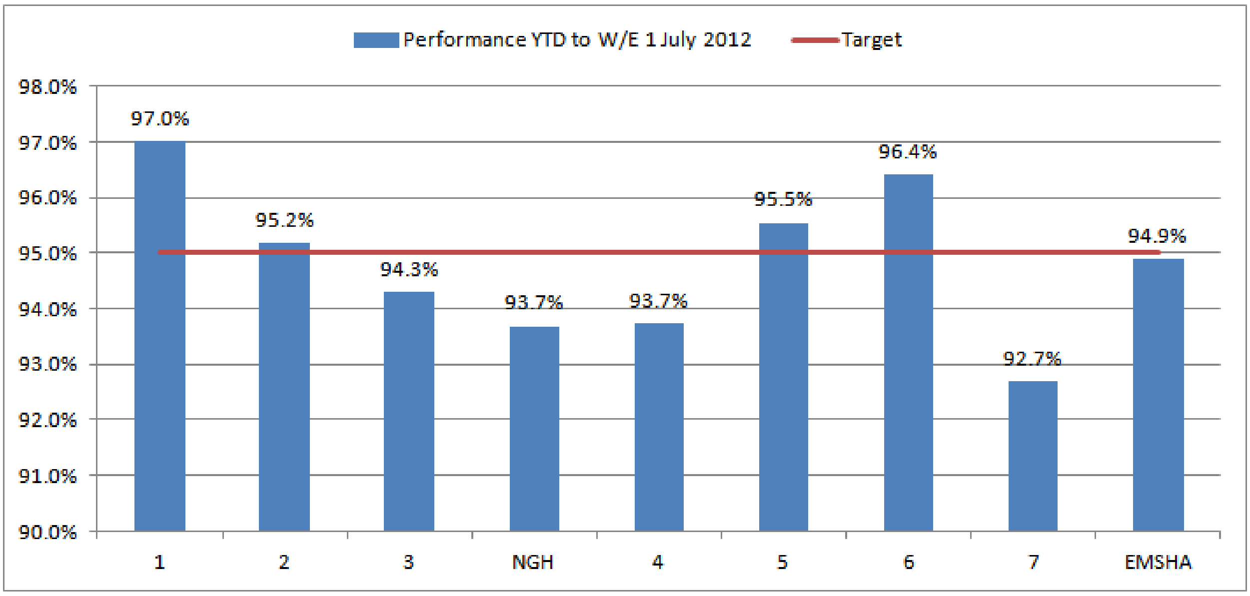
- Refurbishment of A&E is now complete; all minors are still separated from the main A&E, waiting times within the Minors area has significantly decreased.

- A full daily breach analysis is carried out and key themes collated and discussed each day with the relevant services, additional actions are then made to the recovery plan

- Following a review of activity and staffing skill mix by hour of day, we have increased our junior doctor presence, trackers and Portering overnight.



A&E Benchmarking – Information to 1 July 2012



2.2 Referral to Treatment Time (RTT)

During June 2012, the Trust achieved all of the RTT standards by each specialty.

Incomplete pathways over 26 weeks, pathways where a patient has not yet started their first treatment, are being monitored monthly by NHS Midlands and East. In June there were 25 patients waiting over 26 weeks to start elective treatment, a reduction from 26 patients in May.

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Reasons for delay include patient choice and capacity within the Orthodontic Department. Plans are in place to increase capacity and reduce waits within orthodontics thus reducing the number of incomplete pathways over 26 weeks.

2.3 Cancer Standards

The Trust did not achieve the 62 days from urgent referral to treatment standard for June delivering 70.6% against the quarterly standard of 85%, this is attributed to the number of patients referred from other trusts that had already breached, complex pathways particularly in Head and Neck and Urology, patient choice and complex pathways for rarer tumour sites that have to be treated within 31 days under this standard. The following actions have been put in place as part of the Trust's recovery plan:

- Detailed breach analysis and a review of pathways between trusts
- Review of the head and Neck pathway
- Review of urology pathways nationally to identify any areas of best practice that can be shared locally
- The process for scheduling oncology patients has been reviewed

3. RECOMMENDATIONS

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

Service Performance

Indicator	Monthly Target	Apr-12	May-12	Jun-12	Q1	Monthly Delivery	YTD Delivery
Referral to Treatment Times Percentage of Patients seen within 18 weeks across all speciality groups							
Admitted	90%	96.43%	96.56%	97.40%			
Non-admitted	95%	97.70%	98.33%	98.80%			
Incomplete pathways	92%	98.21%	97.83%	97.13%			
No of patients on n incomplete pathway with a wait time > 26 weeks	0	27	26	25			
Number of diagnostic waits > 6 weeks	0	0	0	0			
A&E 95% Transit time target							
Cumulative	95%	95.05%	94.16%	93.88%	93.88%		
Month on Month	95%	95.05%	93.37%	93.33%			
Cancellation of Elective surgery for non-clinical reasons either pre or post admission	6%	6.00%	5.92%	7.30%			
Cancelled Operations not rebooked within 28 days	0%	0%	0%	0%			
Cancer Wait Times							
2 week GP referral to 1st outpatient	93%	96.30%	95.60%	94.80%	95.59%		
2 week GP referral to 1st outpatient - breast symptoms	93%	100.00%	100.00%	100.00%	100.00%		
31 Day	96%	96.50%	98.90%	96.90%	97.50%		
31 day second or subsequent treatment - surgery	94%	96.20%	97.50%	100.00%	97.67%		
31 day second or subsequent treatment - drug	98%	100.00%	97.80%	100.00%	99.05%		
31 day second or subsequent treatment - radiotherapy	94%	100.00%	99.20%	100.00%	99.68%		
62 day referral to treatment from screening	85%	100.00%	100.00%	100.00%	100.00%		
62 day referral to treatment from hospital specialist	85%	92.00%	91.70%	89.30%	91.09%		
62 days urgent referral to treatment of all cancers	85%	85.40%	81.80%	70.59%	79.76%		
Stroke Indicators							
Proportion of people who have a TIA who are scanned and treated within 24 hours	60%	68.00%	75.00%	90.91%	71.93%		
Proportion of people who spend at least 90% of their time on a stroke unit	80%	90.00%	89.13%	89.13%	92.31%		
Activity vs. Plan							
Elective Inpatients	>0%	17%	23%	34%	24%		
Daycase	>0%	9%	13%	2%	8%		
Non- Elective	>0%	13%	23%	11%	15%		
OP 1	>0%	5%	16%	2%	8%		
OP Procedures	>0%	10%	4%	18%	11%		
New to Follow UP Ratio	2.01	2.05	1.89	1.98			
GP Referrals	>0%	254.9%	1.4%	1.1%			
Day Case Rates	81%	85.74%	85.20%	83.24%			
Sleeping Accommodation Breach	0	0	0	0	0		

Finance Report

May (M3) FY 2012-13

1.0 Overview

Summary

- The I&E position for the period to June is a deficit of £2.7m (£0.95m May) compared to a planned deficit of £1.5m.
- The in month position for June is a deficit of £1.8m compared to a planned deficit of £1.2m.

Key Issues

- SLA income and activity levels performing above plan by £1.3m (3.7%).
- CIP delivery £871k behind plan to Month 3. Mitigating actions to be advanced.
- £2.3m of Nurse bank and agency expenditure to June.
- Pay / Income ratio 68% for year to date (average in 2011/12 65%).

Risks

- Final contract reconciliation for 2011-12 to be agreed with PCT.
- CIP slippage and identification of mitigating actions.
- Cashflow remains tight with unmet creditor demand in May and June.
- BPPC performance 94% by volume but only achieving 67% by value.

I&E Position	£000's	
Reported Position	(2,772)	Deficit of £2.7m to month 3.
FIMS Plan (Year to date)	(1,558)	£1.5m deficit plan to month 3.
PCT SLA Income Variance	1,442	£1.44m (3%) above plan.
Full Year I&E Forecast	1,000	Annual Plan surplus agreed with SHA

EBITDA Performance	£000's	
Trust	(1,210)ADV	£1.2m behind plan

Cost Improvement Schemes	£000's	
YTD Plan	2,893	£2.9m target to month 3.
YTD Actual	2,022	£2m delivered to month 3.
% Delivered	70%	CIPs delivered as a % of plan .

Capital	£000's	
Year to date expenditure	1,283	Capital expenditure for period
Committed as % of plan	26%	% of plan committed for year
Annual Plan	9,014	Capital Resource Limit of £9m for 2012-13.

SoFP (movement in year)	£000's	
Non-current assets	(688)	Revaluation+Additions - depreciation
Current assets	(1,379)	NHS debtors and cash.
Current Liabilities	283	NHS & Trade creditors and dividend.

Cash	£000's	
In month movement	(387)	Reduction between May and June.
In Year movement	(2,330)	Reduction since March 2012
Debtors Balance > 90 days	598	16% of balances outstanding over 90 days
Creditors > 90 days	408	7% of creditors waiting over 90 days
BPPC (by volume) YTD	93.9%	Target 95% paid in 30 days

KPIs		
Financial Risk Rating (Shadow)	1	Overriding rules apply
EBITDA	38.7%	EBITDA achieved 38% of plan
Liquidity (days cover)	18.0	Incl. unused WCF of £18m
Surplus Margin	-4.6%	1% required for score of 3
Pay / Income	68.1%	Pay 68% of Income for YTD

2.0 Executive Summary

SLA Income (Appendix 3)

- The Trust is performing above plan overall by **£1.44m (3%)** (May £1.3m).

Other Clinical Income

- Private Patient income is **£11k below** plan with RTA and CRU **£72k below** plan for year to date.

Income Generation

- **£0.338m** above plan

Pay Expenditure (Appendix 5)

- **1.8m (4%) adverse to plan** (May £1.03m adverse to plan).

Non-Pay Expenditure (Appendix 7)

- **£1.48m** (8%) above plan for year to date,(May £1.48m).

CIP (Appendix 14)

- **£0.8m** delivered in June but schemes **£0.871m** behind plan for year to date.

Activity (Appendix 4)

- Non-Elective activity **+11%,** A&E attendances **+19%** above plan.

Workforce (Appendix 5)

- **4101 WTE** worked in June compared to budget of **4242 WTE**. Contracted WTE total **3815 WTE**.

Cashflow (Appendix 9)

- Cash balance decreased since March by **£1.3m.** Creditors > 90 days **£0.4m or 7%.**

SoFP (Appendix 8)

- Reduction in net assets of **£1.8m** led by reduction in NHS Debtors and cash.

Capital Expenditure (Appendix 12)

- **£1.2m** of expenditure for period to April (26% of annual plan committed).

Shadow Monitor FRR (Appendix 13)

- Indicative score of **1** (May 2) restricted by Monitors overriding rules.

Forecast

- Forecast is to achieve plan of **£1m surplus subject to risks noted**.

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3.0 Conclusions & Actions

Conclusions

- Whilst the planned financial position for June was a deficit of £1.2m, actual performance was a deficit of £1.8m in month, giving rise to an overall deficit of £2.7m for the year to date, £1.2m adverse to plan.
- Income achieved plan in month but pay costs were £0.7m above plan.
- Despite some reduction in elective referrals, there is little evidence that PCT QiPP schemes have substantially impacted the first quarter of the financial year with non-elective activity 11% above plan and A&E attendances 17 % above plan. The target to deliver £2.9m (full year) of QiPP savings has therefore been partly offset by SLA over performance in the first quarter of the financial year.
- The requirement to identify and action additional CIP mitigations remains a priority.

Actions

- Increased monitoring of Bank and Agency expenditure and nursing recruitment plans to be formally reported to F&PC.
- Transformation Steering Board to review CIP mitigations and action through TDG.
- Analysis of overspending budgets to be prepared and monitored with relevant budget holders.
- Enforce clear message that budgets must be adhered to.
- Bid to access the PCT/SHA 2% strategic reserve to meet the costs of reorganisation arising out of the Transformation Programme.
- Finance and Performance Committee to review the outcome of Quarter 1 forecast exercise at an extra-ordinary meeting in August.

Finance Report

Appendices

Full Year

- Annual plan is for a surplus of £1m.
- Forecast is for achievement of plan at month 3 although some risk is evident and requires mitigation.

Year to date

- £2.7m deficit to June . Key variances to plan:
  - SLA income over performance £1.4m
  - Other Income favourable variance of £0.3m
  - £1.8m Pay overspend
  - £1.4m Non-pay overspend
- YTD plan was for a deficit of £1.558m giving rise to an adverse variance of £1.214m compared to plan.
- EBITDA £0.8m positive achieves 38% of planned EBITDA.
- No MRET adjustment despite 11% NEL over performance.
- Other income generation£0.34m above plan due to external drug sales (£0.3m).

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	212,111	53,552	52,111	1,442 Fav
Other Clinical Income	2,643	578	660	(82) Adv
Other Income	24,150	5,898	5,560	338 Fav
Total Income	**238,905**	**60,028**	**58,330**	**1,697 Fav**
Pay Costs	(153,397)	(40,870)	(39,103)	(1,768) Adv
Non-Pay Costs	(68,028)	(18,394)	(16,973)	(1,421) Adv
CIPs	0	0	0	(0) Adv
Reserves	(2,066)	0	(281)	281 Fav
Total Costs	**(223,490)**	**(59,264)**	**(56,357)**	**(2,907) Adv**
EBITDA	**15,415**	**764**	**1,974**	**(1,210) Adv**
Depreciation	(10,184)	(2,474)	(2,474)	0 Fav
Amortisation	(10)	(2)	(2)	(0) Adv
Impairment of Fixed Assets	0	0	0	-
Net Interest	29	4	7	(4) Adv
Dividend	(4,250)	(1,063)	(1,063)	0 Fav
Surplus / (Deficit)	**1,000**	**(2,772)**	**(1,558)**	**(1,214) Adv**

Appendix 1.1 I&E Run Rate

Income

- SLA income on plan in June.

Pay

- June pay costs above average level for 2011-12 (£13.468m). YTD pay is 68% of YTD income.

Non-Pay

- Non-Pay run rate £0.5m below average for 2011-12 (£6.2m) but consistent with additional bank holidays in June.

Reserves

- No accruals made against reserves.

Capital Charges

- Dividend accrued pending half yearly payments in September and March.

3 Month Run Rate £000's	April		May		June	
	Actual	Plan	Actual	Plan	Actual	Plan
SLA Clinical Income	17,065	16,900	19,425	18,262	17,062	16,948
Other Clinical Income	178	220	282	220	118	220
Other Income	2,013	1,834	2,031	1,835	1,853	1,891
Total Income	**19,256**	**18,954**	**21,738**	**20,317**	**19,033**	**19,060**
Pay Costs	(13,485)	(13,077)	(13,649)	(13,031)	(13,737)	(12,994)
Non-Pay Costs	(5,854)	(5,290)	(6,600)	(5,681)	(5,940)	(6,002)
CIPs	-	145	-	(145)	-	0
Reserves	-	(203)	-	2	-	(80)
Total Costs	**(19,339)**	**(18,425)**	**(20,248)**	**(18,855)**	**(19,676)**	**(19,076)**
EBITDA	**(83)**	**528**	**1,490**	**1,462**	**(644)**	**(17)**
Depreciation	(825)	(825)	(825)	(825)	(825)	(825)
Amortisation	(1)	(1)	(1)	(1)	(1)	(1)
Impairment of Fixed Assets	-	-	-	-	-	-
Net Interest	1	2	2	2	1	2
Dividend	(354)	(354)	(354)	(354)	(354)	(354)
Surplus / (Deficit)	**(1,262)**	**(649)**	**312**	**285**	**(1,822)**	**(1,194)**

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	6,489	200 Fav	2,364	(256) Adv	4,766	(516) Adv	4,817	107 Fav	3,840	135 Fav
Pay	(3,087)	(98) Adv	(3,912)	62 Fav	(2,325)	(86) Adv	(2,022)	(111) Adv	(2,917)	(31) Adv
Non-Pay	(430)	(26) Adv	(1,113)	(6) Adv	(992)	25 Fav	(752)	(30) Adv	(428)	(45) Adv
Other Expenditure	(3,677)	(117) Adv	2,954	159 Fav	(2,111)	(37) Adv	(2,177)	(36) Adv	(499)	5 Fav
EBITDA	**(705)**	**(42) Adv**	**293**	**(42) Adv**	**(663)**	**(615) Adv**	**(134)**	**(71) Adv**	**(4)**	**65 Fav**
EBITDA %	**-10.9%**		**12.4%**		**-13.9%**		**-2.8%**		**-0.1%**	
ITDA	(286)	2 Fav	(105)	1 Fav	(197)	2 Fav	(206)	1 Fav	(160)	2 Fav
Surplus / (Deficit)	**(991)**	**(40) Adv**	**188**	**(41) Adv**	**(860)**	**(614) Adv**	**(340)**	**(69) Adv**	**(164)**	**67 Fav**

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	5,777	49 Fav	17,800	1,131 Fav	2,031	16 Fav	1,395	186 Fav	6,732	637 Fav
Pay	(3,752)	(78) Adv	(10,671)	(924) Adv	(1,912)	138 Fav	(1,626)	118 Fav	(2,250)	(20) Adv
Non-Pay	(495)	(19) Adv	(3,218)	(182) Adv	(1,553)	106 Fav	(533)	(32) Adv	(2,684)	(411) Adv
Other Expenditure	(2,216)	10 Fav	(4,690)	(155) Adv	1,873	108 Fav	1,421	79 Fav	(881)	11 Fav
EBITDA	**(686)**	**(37) Adv**	**(779)**	**(130) Adv**	**439**	**368 Fav**	**656**	**352 Fav**	**918**	**217 Fav**
EBITDA %	**-11.9%**		**-4.4%**		**21.6%**		**47.1%**		**13.6%**	
ITDA	(238)	2 Fav	(621)	5 Fav	(261)	2 Fav	(445)	1 Fav	(512)	3 Fav
Surplus / (Deficit)	**(924)**	**(35) Adv**	**(1,400)**	**(126) Adv**	**178**	**370 Fav**	**211**	**353 Fav**	**405**	**220 Fav**

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	1,878	231 Fav	1,084	94 Fav	1,056	(316) Adv	60,028	1,697 Fav
Pay	(4,436)	80 Fav	(1,884)	89 Fav	(76)	(907) Adv	(40,870)	(1,768) Adv
Non-Pay	(3,656)	(66) Adv	(2,504)	(240) Adv	(35)	(494) Adv	(18,394)	(1,421) Adv
Other Expenditure	6,695	11 Fav	3,307	(38) Adv	-	270 Fav	(0)	270 Fav
EBITDA	**480**	**256 Fav**	**3**	**(95) Adv**	**945**	**(1,448) Adv**	**764**	**(1,221) Adv**
EBITDA %	**25.6%**		**0.2%**		**89.4%**		**1.3%**	
ITDA	(451)	0 Fav	(51)	0 Fav	(2)	(24) Adv	(3,535)	(4) Adv
Surplus / (Deficit)	**29**	**256 Fav**	**(48)**	**(95) Adv**	**942**	**(1,472) Adv**	**(2,772)**	**(1,225) Adv**

SLA Income (figures in brackets are previous month variance)

- Daycase income £181k (£209k) ahead of plan.
- Elective income £4k behind of plan (£66k ahead of plan).
- Non-elective income £1,375k (£1,142k) above plan.
- A&E £425k (£263k)above plan.
- Critical Care £140k (£24k) below plan.
- WIP increase of £0.208m since March 12.
- CQUIN accrued at 75% pending achievement of measures.

Provisions

- Provisions against PCT contract challenges have been made totalling £1.9m in June. Of this sum £1.2m relates to readmissions fines (based on experience of 2011-12 and subject to Clinical Audit) and a further £0.2m relates to the year end contract reconciliation for 2011-12.

Appendix 3 SLA Income

POD	YTD Plan	YTD Actual	YTD Var
	£	£	£
DC	5,227	5,408	181
EL	4,180	4,176	-4
NEL	17,235	18,610	1,375
OPFA	2,486	2,723	237
OPFUP	2,563	2,675	111
OPFASPNCL	503	621	118
OPFUPSPNCL	745	746	0
OPPROC	1,344	1,404	59
Excluded Medicines	3,040	3,281	241
A&E - PbR	1,860	2,285	425
TCS	1,905	1,905	0
Childrens Services	1,803	1,803	0
Critical Care & HDU	1,697	1,558	-140
Pathology	1,307	1,291	-16
Radiotherapy	1,025	935	-91
Community Midwives	893	893	0
GPDA Radiology	556	673	117
Unbundled Chemotherapy PSD	886	954	68
Breast Screening	369	369	0
Ante-natal Pathology	237	232	-5
Excluded Devices	225	191	-34
Limb Centre	227	233	6
Audiology	213	213	0
Cancer MDT Meetings	163	163	0
Rehab	137	7	-130
Brachytherapy	95	100	5
Anti-Coagulation	82	82	0
Other Block	329	465	135
MRET	0	0	0
ARMD	262	281	19
Provisions	-921	-1,956	-1,036
CQUIN	1,258	983	-275
WIP	0	208	208
CIPs	177	0	-177
Other	0	41	41
Grand Total	**52,111**	**53,552**	**1,442**

Appendix 4 Activity

SLA Activity (Figures in brackets prior month)

- Activity performing above plan for all points of delivery:

- Daycases 7% (10%) above plan.
- Elective activity 19% (20%) above plan.
- Non elective 11% (12%) above plan.
- A&E attendances 19% (17%) above plan.
- New Outpatients 8% (8%) above plan.
- Outpatient Procedures 6% (7%) above plan.

Activity	Plan 2012-13	YTD Actual	YTD Plan	Var to plan	%
Daycase	36,675	9,431	8,794	637	7%
Elective Inpatients	5,779	1,633	1,376	257	19%
Non Elective	41,288	11,391	10,293	1,098	11%
Cons New Outpatients	63,593	16,453	15,294	1,159	8%
Cons Follow Up Outpatients	116,000	29,490	28,065	1,425	5%
NCL New Outpatient	23,711	6,943	5,691	1,252	22%
NCL Follow up Outpatients	64,701	15,190	15,528	-338	-2%
Outpatient Procedures	38,571	9,858	9,287	571	6%
A&E Attendances	77,823	23,075	19,452	3,623	19%

Notes to Pay Expenditure

- £13.7m cost in June (£13.65m cost in May).
- At M3 pay is £1.7m over budget.
- Nurse recruitment plan in place to bridge current level of vacancies.
- Medical Locum spend increased due to additional provision in A&E.
- QiPPs targets offset by additional activity and income delivered in Q1.

Temporary Staffing

- Total expenditure in June £1.291m (May £1.18m).
- £327k expenditure on Medical Locums in (May £185k).
- Agency Nursing £383k (May £412k).
- Bank Nursing £355k (£336k in May).
- Other Bank and agency £79k (£92k in May).

YTD Variances to Plan

- Medical staff overall £145k overspent.
- Substantive Nursing Qualified £1.1m (9%) favourable to plan.
- Substantive Nursing Unqualified £0.4m (17%) favourable to plan.
- Managerial Staff £126k (5%) favourable to plan.

Appendix 5 Pay Expenditure

Staff Group £000's	April Actual	April Plan	May Actual	May Plan	June Actual	June Plan
Senior Medical Staff	2,202	2,350	2,175	2,340	2,171	2,339
Junior Medical Staff	1,237	1,352	1,272	1,352	1,260	1,352
Salary Recharge Exp. - Medical Staff	57	53	57	53	59	58
Salary Recharge Inc. - Medical Staff	(154)	(184)	(141)	(137)	(171)	(168)
Capitalised Salary - Medstaff	-	-	-	-	-	-
Medstaff WLI & ADH's	72	8	81	8	69	8
Agency Medstaff (Senior)	61	6	50	6	107	6
Agency Medstaff (Junior)	166	13	135	13	220	13
Total Medical Staff	**3,640**	**3,598**	**3,630**	**3,635**	**3,717**	**3,609**
Nursing Staff - Qualified (Band 5 +)	3,901	4,309	4,009	4,342	3,939	4,306
Nursing Staff Unqualified	674	849	711	827	699	842
Salary Recharge Exp. - Nursing Staff	4	2	4	6	2	2
Salary Recharge Inc. - Nursing Staff	(91)	(78)	(95)	(84)	(102)	(89)
Capitalised Salary - Nursing	(2)	-	-	-	-	-
Bank Staff - Nursing	418	-	336	-	355	-
Agency Staff - Senior Nursing	220	-	264	-	233	-
Agency Staff - Junior Nursing	124	-	148	-	149	-
Total Nursing Staff	**5,248**	**5,082**	**5,377**	**5,091**	**5,276**	**5,060**
Managerial Staff	676	771	688	761	804	762
Salary Recharge Exp. - Managers	13	1	12	1	12	1
Salary Recharge Inc. - Managers	(7)	(14)	(17)	(16)	(18)	(16)
Capitalised Salary - Managers	(9)	-	(9)	-	(9)	-
Agency Staff - Management	1	1	21	1	24	2
Administration Staff	1,275	1,383	1,198	1,350	1,194	1,366
Salary Recharge Exp. - Admin Staff	-	-	-	-	-	-
Salary Recharge Inc. - Admin Staff	(18)	(19)	(19)	(18)	(18)	(18)
Capitalised Salary - Admin	-	-	-	-	-	-
Bank Staff - Admin	24	1	108	1	101	1
Agency Staff - Admin	27	-	34	-	22	-
Total Managerial & Admin	**1,981**	**2,125**	**2,015**	**2,081**	**2,111**	**2,096**
Other Clinical Staff	837	936	874	944	871	938
Scientific & Technical Staff	1,046	1,108	1,052	1,100	1,046	1,108
Estates Staff	81	91	76	108	96	88
All other Staff	585	631	575	619	582	631
Salary Recharge Exp. - Other Staff	22	13	9	13	11	13
Salary Recharge Inc. - Other Staff	(51)	(38)	(51)	(45)	(51)	(45)
Capitalised Salary - Other Staff	-	-	-	-	-	-
Bank & Agency Staff - Other	94	4	92	6	79	5
Total Other	**2,615**	**2,744**	**2,626**	**2,745**	**2,633**	**2,738**
QIPPS					-	(367)
CIPS	-	(331)	-	(379)	-	(157)
Additional Activity	-	20	-	(157)	-	20
Vacancy Factor	-	(3)	-	20	-	(3)
Total Cost Challenges	-	**(472)**	-	**(3)**	-	**(509)**
Total Pay Expenditure	**13,485**	**13,077**	**13,649**	**13,031**	**13,737**	**12,994**

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Appendix 6 Workforce

Summary

- 4101 WTE worked in June compared to budget of 4242 WTE. Contracted WTE total 3815 WTE.

Temporary Staffing used in month

- 15 WTE Medical Locums.
- 130 WTE Bank Nurses.
- 108 WTE Agency Nurses.

Variances from Plan (Worked v Budget)

- Junior Doctors 9.5 WTE below plan
- Qualified Nurses 161 WTE below plan
- Unqualified Nurses 85 WTE below plan
- Managerial Staff 22 WTE below plan
- Administration 119 WTE below plan

	Worked WTE Mth 12 2011/12	Worked Mth 3 WTE	WTE Budget 2012/13 M3	Contracted WTE Mth 12 2011/12	Contracted Mth 3 WTE
Staff Type:					
Senior Medical Staff	192.52	194.56	209.11	191.81	190.46
Junior Medical Staff	252.27	255.45	264.96	260.99	259.63
Salary Recharges Expenditure - Medical	5.38	4.32	4.31	0.00	0.00
Salary Recharges Income - Medical Staff	-13.76	-7.09	-13.52	0.00	0.00
Medical Locums (Agency - Senior)	5.03	1.92	0.17	0.00	0.00
Medical Locums (Agency - Junior)	12.32	12.82	0.00	0.00	0.00
Total Medical Staff	**453.76**	**461.98**	**465.03**	**452.79**	**450.08**
Nursing Staff - Qualified (Band 5 +)	1161.21	1162.24	1323.25	1203.46	1204.97
Nursing Staff Unqualified	392.24	378.25	462.94	405.11	406.75
Salary Recharges Expenditure - Nursing	1.67	1.10	0.50	0.00	0.00
Salary Recharges Income - Nursing Staff	-28.14	-23.82	-39.01	0.00	0.00
Bank Staff - Nursing	141.91	130.09	0.00	2.40	2.40
Agency Staff - Senior Nursing	41.43	43.19	0.00	0.00	0.00
Agency Staff - Junior Nursing	64.30	64.39	0.00	0.00	0.00
Total Nursing Staff	**1774.62**	**1755.44**	**1747.68**	**1610.97**	**1614.12**
Managerial Staff	141.66	142.19	164.59	142.62	142.25
Salary Recharges Expenditure -	1.00	2.00	0.00	0.00	0.00
Salary Recharges Income - Managers	-2.05	-2.05	-2.00	0.00	0.00
Agency Staff - Management	1.00	1.00	0.00	0.00	0.00
Administration Staff	631.12	611.91	731.28	613.99	610.86
Salary Recharges Expenditure - Admin	0.00	0.00	0.00	0.00	0.00
Salary Recharges Income - Admin Staff	-6.73	-5.46	-4.41	0.00	0.00
Bank Staff - Admin	62.66	63.39	0.60	0.00	0.00
Agency Staff - Admin	5.15	11.70	0.00	0.00	0.00
Total Managerial & Admin	**833.81**	**824.68**	**890.06**	**756.61**	**753.11**
Other Clinical Staff	262.45	266.13	302.74	260.92	268.89
Scientific & Technical Staff	369.21	370.78	402.99	389.08	383.44
Estates Staff	32.63	32.39	38.19	28.00	26.00
All other Staff	370.10	355.65	405.84	323.53	319.73
Salary Recharges Expenditure - Other	5.30	7.20	5.00	0.00	0.00
Salary Recharges Income - Other Staff	-4.60	-2.62	-5.33	0.00	0.00
Agency Staff - Other	25.38	29.51	0.80	0.00	0.00
Total Other	**1060.47**	**1059.04**	**1150.23**	**1001.53**	**998.07**
CIPS	0.00	0.00	-10.30	0.00	0.00
Additional Activity	0.00	0.00	0.00	0.00	0.00
Vacancy Factor	0.00	0.00	-1.00	0.00	0.00
Total Cost Challenges	**0.00**	**0.00**	**-11.30**	**0.00**	**0.00**
Total Worked WTE	**4122.66**	**4101.14**	**4241.70**	**3821.89**	**3815.38**

Summary

- Non pay is £1.4m over budget at M3 primarily driven by activity.

Clinical

- Medicines over budget by £0.5m of which £0.3m relates to external drug sales recovered through other income.
- Equipment hire £78k adverse to plan.

Non-Clinical

- £208k adverse variance due to increased Gas and Electricity charges compared to plan.
- £100k adverse variance for consultancy fees.

Other

- PCT QiPPs savings targets contribute £0.254m to the overspend .

Appendix 7 Non-Pay Expenditure

Non-Pay £000's	April		May		June	
	Actual	Plan	Actual	Plan	Actual	Plan
Clinical Non Pay - Fixed						
Equipment Hire	71	57	72	47	90	52
Equipment Maintenance	217	253	235	238	241	247
Clinical Non Pay - Fixed Total	**288**	**310**	**307**	**285**	**332**	**299**
Clinical Non Pay - Variable						
Prosthesis	151	120	173	137	159	145
Patient & Surgical Appliances	169	147	221	167	146	181
Patient Clothing & Travel	6	9	7	11	6	12
Lab Equipment Consumables	312	344	374	418	344	438
Blood	129	116	129	136	141	145
Medicines	1,963	1,670	2,089	1,729	1,814	1,954
Medical & Surgical Items	800	789	1,069	1,017	950	1,037
Dressings	62	50	72	58	61	63
Medical Gases	23	15	23	18	16	19
X-Ray Consumables	-	1	1	1	-	1
Clinical Non Pay - Variable Total	**3,616**	**3,262**	**4,159**	**3,692**	**3,637**	**3,995**
Clinical Non Pay - Total	**3,903**	**3,572**	**4,466**	**3,978**	**3,968**	**4,294**
Non Clinical Non Pay - Fixed						
Building & Engineering Equipment	255	266	250	276	242	288
Cleaning Equipment	54	47	55	47	44	47
Energy & Utilities	252	203	292	180	225	178
Rates	68	68	68	68	68	68
Printing & Stationery	72	67	75	64	68	65
Computer Equipment & Maintenance	105	126	133	129	113	127
Communications	73	73	77	73	66	73
Office Equipment	4	6	5	6	10	6
Non Pay CIP's	-	(199)	-	(189)	-	(232)
Non Pay QIPP's	-	(85)	-	(85)	-	(85)
Other Fee's	128	168	146	168	144	168
Losses & Compensations	12	28	50	28	23	28
CNST	467	467	467	467	467	467
Consultancy Fee's	51	44	96	40	110	72
Training	59	73	31	71	64	72
Travel & Benefits	98	92	96	90	79	91
Staff Advertising	2	5	1	5	6	5
Non Clinical Non Pay - Fixed Total	**1,699**	**1,449**	**1,842**	**1,438**	**1,729**	**1,441**
Non Clinical Non Pay - Variable						
Patient Provisions	103	107	126	104	89	105
Patient Linen	69	82	82	82	72	82
Non Clinical Non Pay - Variable Total	172	189	209	186	161	188
			-	-	-	-
Non Clinical Non Pay - Total	**1,871**	**1,638**	**2,051**	**1,624**	**1,890**	**1,629**
Expenditure SLAs:						
N PCT Services	80	79	83	79	81	79
Total Non-Pay	**5,854**	**5,290**	**6,600**	**5,681**	**5,940**	**6,002**

Non Current Assets

- Decrease of £0.3m in month due to net additions less depreciation.

Current Assets

- Overall decrease of £1.553m in month.
- £1.27m reduction in NHS debtors.
- Cash balance reduced by £0.4m in month.
- Non-current asset for sale relates to Sunnyside building.

Current Liabilities

- £40k reduction month on month.
- Increase in NHS creditors of £107k.
- £618k reduction in Trade creditors.
- £215k reduction in capital creditors..

Reserves

- Movement due to I&E deficit.

Appendix 8 Statement of Financial Position

	Balance at 31-Mar-11 £000	Current Month Opening Balance £000	Current Month Closing Balance £000	Current Month Movement £000	Forecast end of year Closing Balance £000	Forecast end of year Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	135,075	135,075	135,075		135,075	
IN YEAR REVALUATIONS		504	504		2,116	2,116
IN YEAR MOVEMENTS		767	1,282	515	8,533	8,533
LESS DEPRECIATION		(1,649)	(2,474)	(825)	(10,188)	(10,188)
NET BOOK VALUE	**135,075**	**134,697**	**134,387**	**(310)**	**135,536**	**461**
CURRENT ASSETS						
INVENTORIES	4,723	4,592	4,611	19	4,862	139
RECEIVABLES						
NHS DEBTORS	5,730	6,661	5,391	(1,270)	5,742	12
OTHER TRADE DEBTORS	985	981	978	(3)	968	(17)
DEBTOR IMPAIRMENTS PROVISION	(149)	(149)	(149)		(149)	
CAPITAL RECEIVABLES	31	19		(19)	31	
NON NHS OTHER DEBTORS	70	210	254	44	19	(51)
COMPENSATION DEBTORS (RTA)	2,554	2,596	2,528	(68)	2,554	
OTHER RECEIVABLES	549	473	516	43	574	25
IRRECOVERABLE PROVISION	(283)	(283)	(283)		(283)	
PREPAYMENTS & ACCRUALS	1,458	2,685	2,773	88	1,460	2
	10,945	**13,193**	**12,008**	**(1,185)**	**10,916**	**(29)**
NON CURRENT ASSETS FOR SALE	300	300	300			(300)
CASH	3,944	2,001	1,614	(387)	5,690	1,746
NET CURRENT ASSETS	**19,912**	**20,086**	**18,533**	**(1,553)**	**21,468**	**1,556**
CURRENT LIABILITIES						
NHS	1,673	2,947	3,054	(107)	2,386	(713)
TRADE CREDITORS REVENUE	3,655	3,494	2,876	618	3,655	
TRADE CREDITORS FIXED ASSETS	2,759	1,375	1,160	215	2,046	713
TAX AND NI OWED	3,454	3,541	3,432	109	3,454	
NHS PENSIONS AGENCY	1,784	1,741	1,898	(157)	1,784	
OTHER CREDITORS	510	504	307	197	510	
SHORT TERM LOANS	526	526	526		526	
ACCRUALS AND DEFERRED INCOME	4,018	5,181	5,670	(489)	4,031	(13)
PDC DIVIDEND DUE		652	1,007	(355)		
STAFF BENEFITS ACCRUAL	629	629	629		629	
PROVISIONS	1,603	344	335	9	978	625
PROVISIONS over 1 year	310	310	310		310	
NET CURRENT LIABILITIES	**20,921**	**21,244**	**21,204**	**40**	**20,309**	**612**
TOTAL NET ASSETS	**134,066**	**133,539**	**131,716**	**(1,823)**	**136,695**	**2,629**
FINANCED BY						
PDC CAPITAL	99,635	99,635	99,635		99,635	
REVALUATION RESERVE	34,046	34,467	34,467		35,675	1,629
DONATED ASSET RESERVE						
I & E ACCOUNT BALANCE	385	385	385		1,385	1,000
I & E CURRENT YEAR		(948)	(2,772)	(1,823)		
FINANCING TOTAL	**134,066**	**133,539**	**131,716**	**(1,823)**	**136,695**	**2,629**

Appendix 9 Cashflow

MONTHLY CASHFLOW	Annual £000s	APR £000s	ACTUAL MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	206,144	15,448	17,959	18,311	17,158	17,158	17,158	17,158	17,158	17,158	17,158	17,158	17,158
SLA Variable inc Over Performanc	1,609				1,609								
SHA Payments (SIFT etc)	9,247	266	1,300	671	966	745	745	745	745	745	745	745	829
Other NHS Income	19,110	1,933	2,568	1,108	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
PP / Other (Specific > £250k)	259		259										
PP / Other	13,635	821	768	796	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250
Salix Capital Loan													
EFL / PDC													
Temporary Borrowing													
Interest Receivable	33	1	2	2	3	3	3	3	3	3	3	4	4
TOTAL RECEIPTS	250,037	18,469	22,857	20,888	22,486	20,656	20,656	20,656	20,656	20,656	20,656	20,657	20,742
PAYMENTS													
Salaries and wages	161,253	13,081	13,813	13,339	13,380	13,500	13,380	13,380	13,500	13,380	13,500	13,500	13,500
Trade Creditors	57,032	4,285	6,274	5,734	6,500	5,000	3,500	4,500	4,500	4,500	5,000	5,000	2,238
NHS Creditors	13,506	1,546	1,938	1,480	1,077	1,077	1,077	1,077	1,077	1,077	1,077	500	500
Capital Expenditure	12,079	789	1,503	763	867	1,017	1,080	1,350	1,300	1,135	1,005	592	679
PDC Dividend	4,194						2,069						2,125
Repayment of Loans													
Repayment of Salix loan	190						95						95
TOTAL PAYMENTS	248,254	19,701	23,528	21,316	21,824	20,594	21,201	20,307	20,377	20,092	20,582	19,592	19,137
Actual month balance	1,783	-1,232	-671	-428	662	62	-545	349	279	564	74	1,065	1,605
Balance brought forward	3,906	3,906	2,675	2,003	1,575	2,237	2,299	1,754	2,103	2,382	2,945	3,019	4,085
Balance carried forward	5,690	2,675	2,003	1,575	2,237	2,299	1,754	2,103	2,382	2,945	3,019	4,085	5,690

Notes to cashflow

- Forecast aims to undershoot EFL by up to £1.7m (£5.7m - £3.9m). May require restrictions on creditor payments in March.
- Cashflow restricted in Q1 but BPPC performance on plan for Trade creditors and creditor balances reducing overall.

Appendix 10 Debtors

In month

- Increase of £1.5m in outstanding balances since March.
- Amount outstanding over 90 days £598k (16%).

Problem Debtors

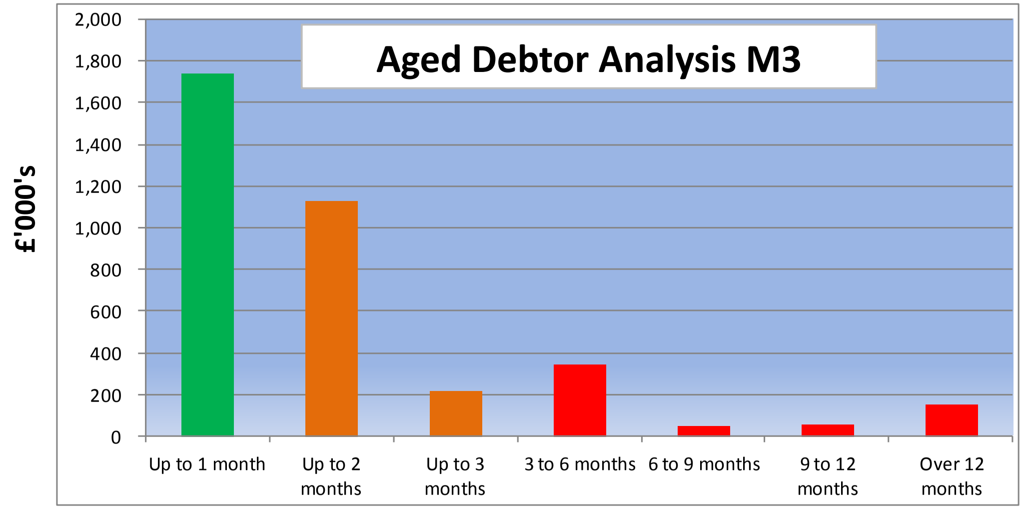
- CRIPPS – part payment against oldest invoices received in June 12.

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

	Description	Value £	Date due:
CRIPPS SOCIAL CLUB	SLA 1/4/10-31/3/11	84,148.00	10/04/2011
CRIPPS SOCIAL CLUB	SLA 1/4/11-31/3/12	84,147.96	31/03/2012
Milton Keynes Gen Hospital NHS Trust	Oncology services Jan-Mar 12	46,479.84	11/03/2012
University Hospitals Leics NHS Trust	Drugs recharge Jan-Mar 12 (est)	35,791.33	08/04/2012
University Hospitals Leics NHS Trust	Radiology recharge Apr 11-Mar 12	21,800.00	23/03/2012
University Hospitals Leics NHS Trust	Radiology rechg HLRU Apr 10 - Mar 11	21,355.00	15/04/2011
NHS NORTHAMPTONSHIRE	Alcohol Liaison Nurse Q3 and Q4	18,005.64	28/08/2011
MACMILLAN CANCER ENVIRONMENTS	Final balance Haem recharge	16,668.43	20/01/2012
INHEALTH	PET services energy costs 2008-12	11,735.16	12/04/2012
NHS NORTHAMPTONSHIRE	LAC physical health	11,514.00	18/08/2011

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

	Description	Value £	Date due:
CRIPPS SOCIAL CLUB	SLA 1/4/10-31/3/11	84,148.00	10/04/2011
University Hospitals Leics NHS Trust	Radiology rechg HLRU Apr 10 - Mar 11	21,355.00	15/04/2011
NHS NORTHAMPTONSHIRE	LAC physical health	11,514.00	18/08/2011
NHS NORTHAMPTONSHIRE	Alcohol Liaison Nurse Q3 and Q4	18,005.64	28/08/2011
MACMILLAN CANCER ENVIRONMENTS	Final balance Haem recharge	16,668.43	20/01/2012
Milton Keynes Gen Hospital NHS Trust	Oncology services Jan-Mar 12	46,479.84	11/03/2012
University Hospitals Leics NHS Trust	Radiology recharge Apr 11-Mar 12	21,800.00	23/03/2012
CRIPPS SOCIAL CLUB	SLA 1/4/11-31/3/12	84,147.96	31/03/2012
University Hospitals Leics NHS Trust	Drugs recharge Jan-Mar 12 (est)	35,791.33	08/04/2012
INHEALTH	PET services energy costs 2008-12	11,735.16	12/04/2012



Aged Debtors	01.04.11	April	May	June	YTD Change
	£'000	£'000	£'000	£'000	£'000
Up to 1 month	1,097	5,480	2,710	1,737	640
Up to 2 months	523	524	809	1,127	604
Up to 3 months	100	115	330	215	115
3 to 6 months	202	127	158	344	142
6 to 9 months	54	35	33	48	-6
9 to 12 months	24	68	54	52	28
Over 12 months	146	143	141	153	7
Total	**2,146**	**6,492**	**4,235**	**3,678**	**1,532**

Over 90 Days	598
%	16.3%

Balances

- •Reduction of £416k over March balance.
- •Balance > 90days £0.4m. (7%).

BPPC Compliance (95% target)

- •94% compliance by volume.
- •Low level of NHS compliance.

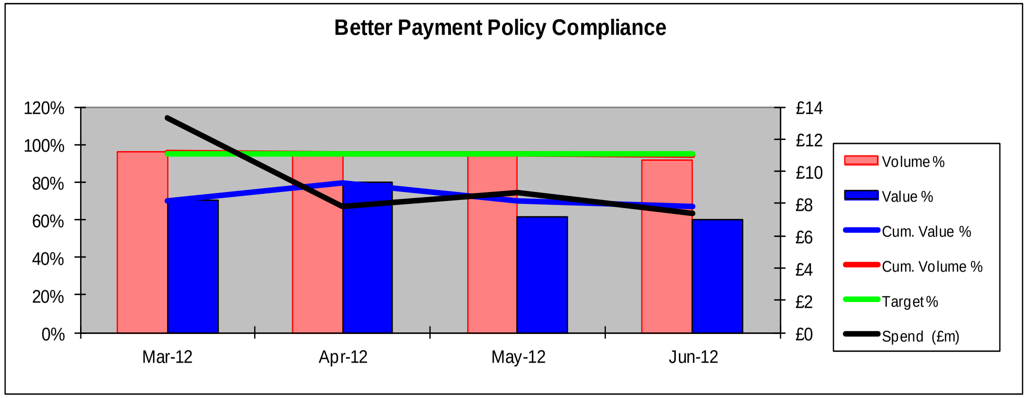
Top 10 by age	Invoice Value £	Due Date
DR ZAM CADER	100.00	09/06/2011
ALLIANCE MEDICAL LIMITED	3,084.00	03/07/2011
SOFTCAT LIMITED	195,119.08	06/01/2012
CREATIVE PROMOTIONS	96.00	10/01/2012
MICROGEN LIMITED	296.40	22/03/2012
NHSBSA PRESCRIPTION PRICING DIVISION	75,677.97	10/04/2012
HUMAN TISSUE AUTHORITY	1,369.38	20/04/2012
MTM LABORATORIES AG	543.32	27/04/2012
KETTERING GENERAL HOSPITAL NHS FOUNDATION TST	26,197.00	27/04/2012
CITY ELECTRICAL FACTORS LIMITED	52.58	04/05/2012

Top 10 by account	Account Balance £
NHS LITIGATION AUTHORITY	1,732,342.00
NORTHAMPTONSHIRE HEALTHCARE NHSFT	449,295.22
NHS SUPPLY CHAIN	299,672.91
VARIAN MEDICAL SYSTEMS UK LTD	283,720.80
NHSBSA PRESCRIPTION PRICING DIVISION	254,430.91
SOFTCAT LIMITED	195,119.08
ROCHE PRODUCTS LIMITED	117,159.48
NHS BLOOD AND TRANSPLANT	115,847.89
NHS SUPPLY CHAIN	111,652.44
ALLIANCE HEALTHCARE (DISTRIBUTION) LTD	85,821.03

9

Appendix 11 Creditors

	NHS			Non-NHS			Total		
	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%
Value £	742,028	3,180,863	23%	15,225,636	20,679,465	74%	15,967,664	23,860,327	67%
Volume	421	547	77%	16,914	17,912	94%	17,335	18,459	94%



Aged Creditors	01.04.12 £'000	NHS £'000	Trade £'000	Capital £'000	Total £'000
Up to 1 month	3,673	1,169	1,238	103	2,510
Up to 2 months	2,408	1,700	717		2,417
Up to 3 months	10	191	345		536
Over 3 Months	197	217	-3	195	408
Total	**6,288**	**3,277**	**2,297**	**298**	**5,872**

Over 90 Day	**408**
% Balance	**6.96%**

Appendix 12 Capital Expenditure

Category	Approved Annual Budget 2012/13 £000's	Year to Date as at Month 3 Actual Spend £000's	Year to Date as at Month 3 Plan Achieved £000's	Year to Date as at Month 3 Actual Committed £000's	Year to Date as at Month 3 Plan Achieved £000's
Breast Screening Business Case	100	59	59%	59	59%
Emergency Care	347	131	38%	138	40%
Endoscopy / Urodynamics	600	0	0%	0	0%
Mortuary Refurbishment	80	13	17%	54	68%
Macmillan (Trust)	91	6	6%	23	26%
Macmillan (Non Trust)	13	0	0%	0	0%
MESC	998	261	26%	360	36%
Estates	3,921	519	13%	950	24%
IT	3,373	362	11%	789	23%
Other	70	17	25%	69	99%
Total - Capital Plan	**9,592**	**1,368**	**14%**	**2,443**	**25%**
Less Charitable Funds	-578	-85	15%	-85	15%
Total - CRL	**9,014**	**1,283**	**14%**	**2,358**	**26%**

Notes to Capital Schemes

- Replacement Breast Screening ultrasound is the final year of business case
- Emergency Care (completed June 2012) and Mortuary scheme (due for completion July 2012)
- Emergency Pressures - £200k allocation subject to approval
- Endoscopy / Urodynamics - subject to business case approval and charitable funds donation
- The Macmillan scheme works are completed, although final account awaited
- Full year depreciation forecast is currently £10.184 million

Appendix 13 Shadow Monitor Financial Risk Rating

Financial Criteria	Metric	Weight %	June	Shadow Rating	YTD Score
Achievement of Plan	EBITDA Achieved (% of plan)	10%	38%	1	0.10
Underlying Performance	EBITDA Margin %	25%	1.3%	2	0.50
Financial Efficiency	Return on Assets	20%	-1.30%	2	0.40
Financial Efficiency	I&E Surplus Margin	20%	-4.6%	1	0.20
Liquidity	Liquidity Ratio (Days cover)	25%	18.01	3	0.75
Weighted Average		100%		Calculated Score	2
				Override	-1
				Reported Score	1

	< 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

Notes to YTD Score

- Plan to achieve minimum score of 3.
- Calculated score of 2 in June limited to a score of 1 due to overriding rules (2 or more scores of 1).
- EBITDA achieved of 38% delivers score of 1.
- ROA score driven by YTD deficit.
- Deficit and FOT give rise to a score of 1 for surplus margin.
- Liquidity cover 18 days (includes WCF of £18m).
- Note: Monitor review on a quarterly basis.

Overriding Rules :

Max Rating	Rule
3	Plan not submitted on time
3	Plan not submitted complete and correct
2	PDC dividend not paid in full
2	One Financial Criterion at "1"
3	One Financial Criterion at "2"
1	Two Financial Criteria at "1"
2	Two Financial Criteria at "2"

Appendix 14 CIP Programme

Total savings of £2.022m have been recorded for the period to June.

The latest forecast (LTF) is to substantially achieve the planned target for the year but this will require the delivery of £4.9m of mitigating actions.

A full report covering the activities of the Transformation Programme has been presented to the F&PC in July.

Workstream	Plan £000	LTF £000	Var
Beds / Patient Flow	300	218	(82)ADV
Theatres	424	142	(282)ADV
Outpatients	165	378	213FAV
Admin Review	385	154	(231)ADV
Procurement	1,200	840	(360)ADV
Pathology	147	118	(29)ADV
Therapies	80	47	(33)ADV
Medical	250	60	(190)ADV
Estates	316	45	(271)ADV
Outsourcing	111	29	(82)ADV
Nursing	58	58	0FAV
Back Office Phase 2	506	191	(315)ADV
Contract Compliance	1,000	1,000	-
Pharmacy	450	600	150FAV
Controls	550	413	(137)ADV
HR Workforce Planning	1,183	250	(933)ADV
Workforce, Bank & Agency	950	515	(435)ADV
Directorate 3% Schemes	6,205	6,193	(12)ADV
NGH Mitigation	1,820	4,851	3,031 Increase
Grand Total	**16,100**	**16,100**	**0FAV**

Workstream Savings - June

Workstream	Jun Plan	Jun Actual	YTD Plan	YTD Actual	YTD Var
Beds / Patient Flow	22	7	67	14	(53)ADV
Theatres	19	9	56	26	(30)ADV
Outpatients	17	37	30	102	72FAV
Admin Review	-	-	-	-	
Procurement	100	111	300	272	(28)ADV
Pathology	-	3	-	10	10FAV
Therapies	-	-	-	-	
Medical	10	-	10	-	(10)ADV
Estates	6	0	17	11	(5)ADV
Outsourcing	-	1	-	4	4FAV
Nursing	-	-	-	-	
Back Office Phase	-	10	-	31	31FAV
Contract Compliance	93	93	138	138	
Pharmacy	38	74	113	149	36FAV
Controls	46	4	138	11	(126)ADV
HR Workforce Planning	79	-	-	-	
Directorate 3% Schemes	462	429	1,335	1,254	(82)ADV
Workforce, Bank & Agency	-	-	238	-	(238)ADV
NGH Mitigation	151	-	453	-	(453)ADV
Grand Total	**1,041**	**778**	**2,893**	**2,022**	**(871)ADV**

Northampton General Hospital NHS Trust

TRUST BOARD SUMMARY SHEET	
Title	HR REPORT
Submitted by	Geraldine Opreshko, Director of Workforce & Transformation (Interim)
Date of meeting	25 July 2012
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 July 2012 which focuses on the figures for May 2012 and the following topics:

- **Substantive Workforce Capacity**

Substantive workforce capacity increased by 13.59 FTE from 3,785.85 to 3,799.44 FTE which is below the plan (4,250.48) for the month. The % FTE of contracted workforce against budgeted establishment has increased by 0.32% to 89.39%. For the financial year 2012/13 the Budgeted Workforce Establishment (FTE) increased by 110.91 FTE.

- **Temporary Workforce** (excluding Medical Staffing)

Temporary Workforce Usage increased by 0.32% from 8.39% to 8.71% and remains above the planned temporary FTE target of 5%. This is likely to be attributable to an increase in activity, nursing vacancies and sickness absence rates.

- **Total Substantive Workforce plus Temporary Workforce** (excluding Medical Staffing)

The total workforce % FTE against budgeted establishment FTE has increased by 0.69% from 97.23% to 97.92%.

- **Calendar Days Lost to Sickness**

The number of calendar days lost to sickness increased by 519 from 6,601 to 7,120 in May 2012.

- **Days Lost per Employee**

The number of days lost per employee increased by 0.11 from 1.48 to 1.59 in May 2012.

- **Long Term Sickness Absence**

Long term sickness absence increased by 0.14% in May 2012 to 2.70% which is above the Trust target of 2%.

- **Short Term Sickness Absence**

Short term sickness absence has decreased by 0.08% to 2.30% in May 2012 (Trust target 1.4%).

- **Staff Turnover**

Staff turnover (leavers) has increased by 0.22% on the month to 8.53%, which remains above the Trust target of 8%.

- **Temporary Workforce Expenditure** (including Medical Staffing)

The temporary workforce expenditure has increased by £134,485 from £1,135,515 to £1,270,000 which is equal to 9.30% of the total workforce expenditure.

- **Appraisals**

From 1st April 2012 appraisals will be centrally recorded on OLM and reported on a quarterly basis. The Training & Development Department is responsible for the centralised management of recording appraisals and the HR Business Partners will work with Managers to implement the process of submitting appraisal records.

Mandatory Training
The Mandatory Training Activity Forecast shows a decrease in training levels occurring in May 2012. If the run rate is achieved the Trust will achieve an 89.16% rate at year end.

Forecast & Risks
The total sickness absence rate in May 2012 (5%) has increased by 1.08% compared with May 2011. Work is planned to analyse reasons for sickness absence and Occupational Health referrals.

The Temporary Workforce Capacity percentage remains above target as the demand for temporary nursing staff continues due to nursing vacancies and increased activity.

PATIENT IMPACT - High

STAFF IMPACT - High

FINANCIAL IMPACT- High

EQUALITY AND DIVERSITY IMPACT - Low

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 this report and agree any actions.

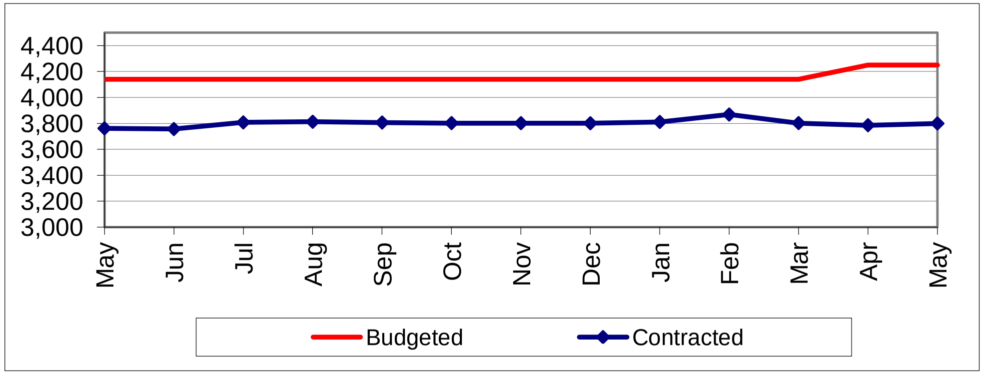
Workforce Capacity Summary M2

Target = 95%

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

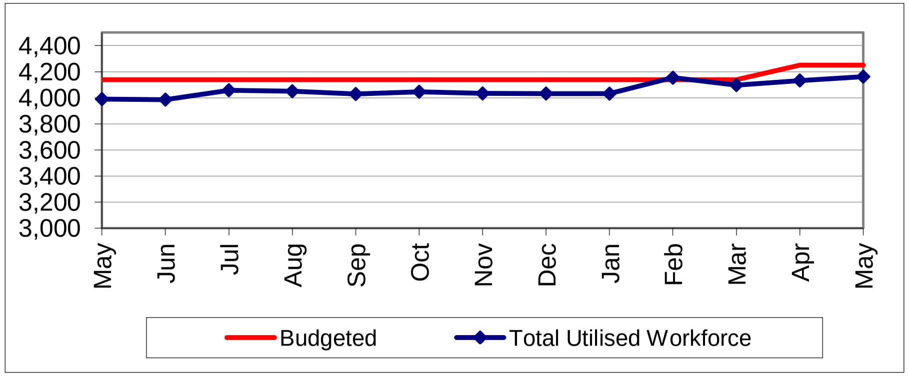
Substantive Workforce Capacity FTE

Directorate	Budgeted Establishment	M2 Contracted	Variance	
			%	FTE
Medicine	1,072.05	905.42	-18.40%	-166.63
Surgery	293.18	263.85	-11.12%	-29.33
Anaesthetics	330.97	301.89	-9.63%	-29.08
T&O	254.91	233.65	-9.10%	-21.26
Head & Neck	165.39	152.56	-8.41%	-12.83
Child Health	259.97	257.23	-1.07%	-2.74
Obs & Gynae	377.72	359.17	-5.16%	-18.55
Oncology	224.19	223.54	-0.29%	-0.65
Pathology	213.40	195.73	-9.03%	-17.67
Radiology	143.96	133.17	-8.10%	-10.79
Pharmacy	101.26	97.17	-4.21%	-4.09
Therapies	79.32	68.48	-15.83%	-10.84
Facilities	347.56	279.91	-24.17%	-67.65
Hosp Support	386.60	327.67	-17.98%	-58.93
TOTAL	**4,250.48**	**3,799.44**	**-11.87%**	**-451.04**



Total Workforce Capacity FTE (Excluding Medical Staffing)

Directorate	Budgeted Establishment	* Total Utilised Workforce	Variance
Medicine	1,072.05	1063.05	-9.00
Surgery	293.18	306.17	12.99
Anaesthetics	330.97	328.97	-2.00
T&O	254.91	261.65	6.74
Head & Neck	165.39	163.92	-1.47
Child Health	259.97	277.64	17.67
Obs & Gynae	377.72	380.34	2.62
Oncology	224.19	238.04	13.85
Pathology	213.40	199.70	-13.70
Radiology	143.96	133.17	-10.79
Pharmacy	101.26	97.17	-4.09
Therapies	79.32	77.85	-1.47
Facilities	347.56	289.50	-58.06
Hosp Support	386.60	344.82	-41.78
TOTAL	**4,250.48**	**4,162.00**	**-88.48**



* Total Substantive Workforce plus Temporary Workforce (FTE)

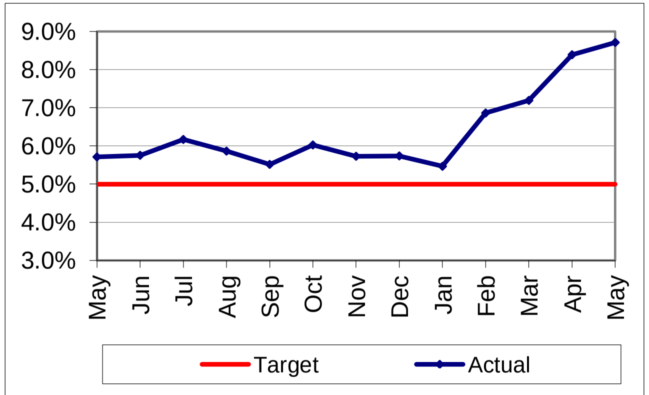
Workforce Performance Summary M2

Temporary Workforce Rate

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

(Excluding Medical Staffing)

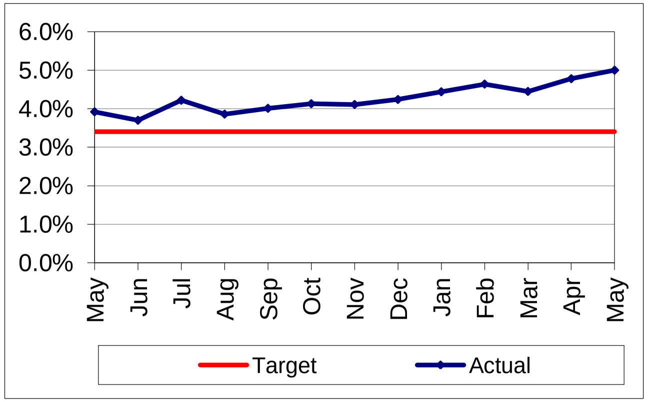
Directorate	Bank, Agency & Locum	Variance against Target	Variance from M1
Medicine	14.83%	9.83%	-0.864%
Surgery	13.82%	8.82%	1.753%
Anaesthetics	8.23%	3.23%	4.026%
T&O	10.70%	5.70%	1.166%
Head & Neck	6.93%	1.93%	-0.168%
Child Health	7.35%	2.35%	-0.061%
Obs & Gynae	5.57%	0.57%	-0.035%
Oncology	6.09%	1.09%	0.679%
Pathology	1.99%	-3.01%	0.440%
Radiology	0.00%	-5.00%	0.000%
Pharmacy	0.00%	-5.00%	0.000%
Therapies	12.04%	7.04%	-4.041%
Facilities	3.31%	-1.69%	0.653%
Hosp Support	4.97%	-0.03%	0.004%
TOTAL	**8.71%**	**3.71%**	**0.322%**



Staff Sickness Absence Rate

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

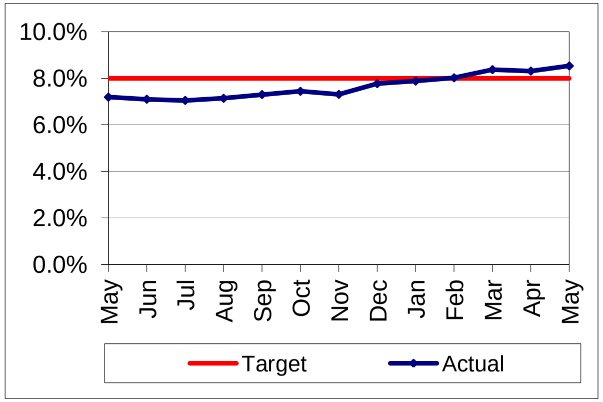
Directorate	Sickness Absence M2	Variance against target	Variance from M1
Medicine	5.21%	1.81%	-0.06%
Surgery	5.32%	1.92%	-0.57%
Anaesthetics	5.13%	1.73%	1.16%
T&O	3.95%	0.55%	-0.64%
Head & Neck	6.80%	3.40%	-0.30%
Child Health	4.12%	0.72%	1.05%
Obs & Gynae	6.59%	3.19%	0.05%
Oncology	4.85%	1.45%	0.04%
Pathology	5.29%	1.89%	1.45%
Radiology	3.03%	-0.37%	0.00%
Pharmacy	3.42%	0.02%	-1.04%
Therapies	6.47%	3.07%	1.35%
Facilities	4.79%	1.39%	-0.09%
Hosp Support	3.45%	0.05%	0.51%
TOTAL	**5.00%**	**1.60%**	**0.22%**



Staff Turnover

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

Directorate	M2	Variance against target	Variance from M1
Medicine	8.04%	0.04%	-0.06%
Surgery	6.84%	-1.16%	0.74%
Anaesthetics	4.25%	-3.75%	-0.01%
T&O	8.65%	0.65%	-0.12%
Head & Neck	5.66%	-2.34%	1.79%
Child Health	12.82%	4.82%	0.38%
Obs & Gynae	9.49%	1.49%	-0.21%
Oncology	9.24%	1.24%	1.02%
Pathology	5.50%	-2.50%	-0.44%
Radiology	3.56%	-4.44%	0.71%
Pharmacy	7.46%	-0.54%	0.03%
Therapies	7.65%	-0.35%	0.44%
Facilities	14.67%	6.67%	-0.02%
Hosp Support	10.26%	2.26%	0.80%
TOTAL	**8.53%**	**0.53%**	**0.22%**



HEATMAP - Staffing Indicators 2011-12,2012-13

Section	Deliverable	Key	Threshold Target	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Workforce Capacity (Temporary Workforce Capacity excludes Medical Staffing)	Budgeted Workforce Establishment (FTE)		n/a	4,024.00	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,250.48	4,250.48
	Contracted Substantive Workforce (FTE)		n/a	3,751.96	3,762.79	3,761.78	3,756.49	3,807.58	3,812.43	3,806.72	3,802.41	3,801.90	3,801.12	3,811.11	3,868.54	3,802.52	3,785.85	3,799.44
	Temporary Workforce Utilised (FTE)		n/a	268.45	228.08	227.88	229.35	250.33	237.50	222.24	243.80	231.04	231.40	220.34	285.05	294.69	346.69	388.18
	Total Substantive Workforce plus Temporary Workforce (FTE)		n/a	4,020.41	3,990.87	3,989.66	3,985.84	4,057.91	4,049.93	4,028.96	4,046.21	4,032.94	4,032.52	4,031.45	4,153.59	4,097.21	4,132.54	4,162.00
	Contracted Workforce against Budgeted Establishment (% FTE)		95% to 97%	93.24%	90.90%	90.87%	90.75%	91.98%	92.10%	91.96%	91.86%	91.84%	91.82%	92.07%	93.45%	91.86%	89.07%	89.39%
	Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE)		100.0%	99.91%	96.41%	96.38%	96.29%	98.03%	97.83%	97.33%	97.74%	97.42%	97.41%	97.39%	100.34%	98.98%	97.23%	97.92%
	Temporary Workforce Rate (%FTE)	1	5.0%	6.7%	5.71%	5.71%	5.75%	6.17%	5.86%	5.52%	6.03%	5.73%	5.74%	5.47%	6.86%	7.19%	8.39%	8.71%
	Staff Turnover (% FTE)		8.0%	7.41%	7.33%	7.19%	7.10%	7.05%	7.14%	7.30%	7.44%	7.31%	7.77%	7.88%	8.02%	8.37%	8.31%	8.53%
	Recruitment Timeline	2	13.6 weeks	15	14.71	15.58	15.80	15.80	15.03	14.60	14.42	11.36	15.58	16.50	18.64	12.47	12.28	12.09
Workforce Expenditure (Temporary Workforce Expenditure includes Medical Staffing)	Contracted Workforce Expenditure		n/a	11,650,670	12,035,402	12,303,538	12,301,743	12,387,348	12,438,724	12,407,344	12,433,670	12,375,872	12,452,393	12,606,300	12,565,284	12,777,007	12,342,533	12,379,000
	Contracted Workforce Overtime		n/a	75,636	70,663	69,162	60,692	69,889	67,770	64,261	70,014	65,958	63,437	63,406	69,256	71,774	74,079	69,175
	Contracted Workforce Excess Hours		n/a	4,518	3,212	4,378	4,864	3,427	7,144	3,305	2,153	3,943	1,962	1,137	3,201	3,340	2,777	3,204
	Temporary Workforce Expenditure	3	n/a	1,167,330	957,598	1,064,462	878,257	1,020,652	1,005,276	1,042,907	1,009,306	951,117	1,028,691	1,039,113	1,093,506	1,278,223	1,135,515	1,270,000
	Total Utilised Workforce Expenditure		n/a	12,818,000	12,993,000	13,368,000	13,180,000	13,408,000	13,444,000	13,450,250	13,442,975	13,326,988	13,481,084	13,645,412	13,658,790	14,055,230	13,478,048	13,649,000
	Temporary Workforce Expenditure (% of Total Workforce Expenditure)		n/a	9.11%	7.37%	7.96%	6.66%	7.61%	7.48%	7.75%	7.51%	7.14%	7.63%	7.62%	8.01%	9.09%	8.42%	9.30%
Health & Wellbeing	Trust Headcount (Perm & FTC)		n/a	4436	4503	4506	4498	4558	4546	4522	4505	4507	4500	4506	4507	4504	4472	4484
	Calendar Days Lost to Sickness Absence		n/a	5044	4832	5552	5025	6029	5529	5567	5838	5711	6068	6374	6202	6384	6601	7120
	Days Lost per Employee		n/a	1.14	1.07	1.23	1.12	1.32	1.22	1.23	1.30	1.27	1.35	1.41	1.38	1.42	1.48	1.59
	Short Term Sickness Absence		1.4%	2.0%	1.86%	2.17%	2.14%	2.25%	2.05%	2.30%	2.41%	2.38%	2.36%	2.61%	2.74%	2.25%	2.22%	2.30%
	Long Term Sickness Absence		2.0%	1.69%	1.72%	1.75%	1.56%	1.98%	1.82%	1.71%	1.71%	1.73%	1.90%	1.84%	1.90%	2.20%	2.56%	2.70%
	Total Sickness Absence		3.4%	3.7%	3.58%	3.92%	3.70%	4.22%	3.86%	4.01%	4.13%	4.11%	4.24%	4.44%	4.64%	4.45%	4.78%	5.00%
	Return to Work Interviews		100%	79.0%	82.00%	84.00%	76.00%	83.00%	76.00%	82.00%	78.00%	79.00%	84.00%	85.00%	80.00%	67.69%	71.65%	76.71%
Workforce Development	Cumulative Personal Development Review / Plan Completion (Appraisal) Reported quarterly from 1st April 2012		n/a		5.00%	9.00%	13.00%	17.00%	36.50%	46.00%	53.00%	57.50%	61.02%	68.00%	73.16%	75.12%		
	Mandatory Training Activity Forecast (FYI)	4	100%	84.4%	90.11%	86.98%	87.08%	83.23%	79.31%	77.61%	74.86%	74.38%	71.30%	73.46%	74.53%	80.78%	97.11%	89.16%

KEY:

1 Temporary Workforce Rate = % of Total Workforce which is a combination of Substantive and Temporary Hours Worked (excluding Medical Staffing)
2 The Recruitment Timeline is 13 weeks but adjusted to take into account the 3 weeks Regional Restricted Access
3 Temporary Workforce Expenditure =Bank, Agency and Locum (including Medical Staffing)
4 Internal Target 80% (Stretch Target 100%)

Transformation Programme

July 2012

Monthly Feature—Outpatients (Clinic templates)

At the start of the year, the enormous task of updating all iPM outpatient clinic codes began. This required clinic coordinators, consultants and general/service managers to review and update all of clinics within their area according to consultant jobs plans.

Even though clinic codes already existed, the problem was that, often, the templates did not reflect the actual flow required to plan effective outpatient clinics. Also, over the years, many ad-hoc clinics had been generated with little control over how and why they were being created. This meant that outpatient departments did not know their true capacity and nor did the trust.

In order to identify the trust's true capacity, a new clinic template and code had to be created for each and every outpatient clinic across the trust. This involved the service/general manager and consultant reviewing every clinic and confirming it with the clinic coordinator before being sent to the Nick Alex and Emily Osborne in the Clinical Applications Team where a new clinic code would be created. Then, the clinic booking staff had the arduous task of transferring patients over to the new clinic codes. Once all patients had been transferred, the old code could be closed down. Although it was not possible to calculate exactly how many patients had to be transferred over to new clinics, it started in the region of 15,000.

Now almost complete, the Clinical Applications team have created approximately 1500 new clinic codes that had been submitted on 1091 individual clinic forms for 146 consultants, all being monitored by Sarah Jeffreys of the Strategy and Partnerships team.

The next steps are now being made to ensure all this hard work that everyone has had to go through is not in vain. Controls are be implemented to ensure what happened before doesn't happen again. Clinic codes will be monitored to ensure only codes submitted through the Clinical Applications Team are used. Where necessary iPM permissions will be introduced.

The project has taken several months of hard work by many people and a lot of communication to get it to where it is today and will prove vital moving forward to improve outpatient processes and standards for staff and patients for many years to come.

DNA rates have reduced from 7.9% in May last year to 5.9% in May this year, which equates to approximately 650 additional patients per month.

Transformation Programme

Theatres update

Towards the end of May Sue Mcleod (the General Manager for Surgery) was asked to lead the Theatre Transformation, and there were a number of areas she wanted the group to focus on initially:

- Ensuring day cases that meet DSU criteria, are being sent to DSU
- That the 6:4:2 policy that was brought in last year is fully implemented and adhered to by all directorates
- Any lists that are under planned utilisation will be taken down

The plan still remains to increase all Theatres utilisation, reduce the number of cancellations and reduce the number of late starts. Our aim is to improve the efficiency of all our theatre lists to allow us to plan more proactively, enable surgeons, anaesthetists and theatre staff to plan for lists in advance, and accommodate any potential new work.

So far we have seen a 73% reduction in cancellations on the day and a 50% reduction of cancellations due to equipment issues, we've also seen an improvement in theatre utilisation in General Surgery from an average of 73% to 76%.

Green Car update

In February the Trust started to introduce travel schemes, which included Cycle to work scheme, Car Parking payment scheme. This was a great success, with over 5% of the Trusts population taking advantage of one or more of the schemes.

The Salary Sacrifice group are currently launching the Green Car scheme across the Trust, and a marketing event was held on Monday 16th July . If you missed this event, you can still access the CPC Drive online site via ngh.rewardwise.co.uk , you can browse the huge range of available cars, read all about the scheme, prepare quotations, compare cars and even request your vehicle order online!

If you are considering replacing your car logon to the website and view the large range of cars available. Visit the website through the rewardwise portal at https://ngh.rewardwise.co.uk where you will find all the details you need to be able to drive away a brand new vehicle. Logging on to the system is easy as your details will be the ones you received in a letter sent out to you in February at the launch of the salary sacrifice scheme. Your username will be your surname followed by your ESR (payroll) number.

Transformation Programme

Transformation Team update

The Trust is pleased to announce the appointment of Jane Harper-Smith as the Transformation Programme Director.

Jane has nearly 30 years experience working within the NHS across a variety of settings including 20 years working within the Acute sector both clinically as a nurse and operationally at Board level. She has a wealth of knowledge and expertise in health service transformation and brings with her financial and commercial acumen combined with a passion to continuously improve the patient experience and quality of care.

Jane will lead the Programme Management Transformation Team working closely with the Executive Team, Care Group Managers and clinicians as well as partners to deliver an integrated approach to quality and better value for money across the Trust.

Transformation workstreams for 2012/13

- Patient Flow
- Theatres
- Outpatients
- Administration Review
- Procurement
- Pathology
- Therapies
- Medical
- Estates
- Outsourcing
- Nursing
- Back office
- Contract Compliance
- Pharmacy
- Controls
- HR Tactical (On-call and Out of Hours)
- Workforce, Bank & Agency
- Directorate 3% CIPs

The project plans, scope and financial targets for the majority of the above workstreams are now in place, however a number of the larger more complex workstreams are continuing to be developed.

On a monthly basis we will update you on a number of the workstreams, their successes, their next steps, their financial targets and any risks to delivery.

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

Jenny Briggs, (Jenny.briggs@ngh.nhs.uk—Ext 3711)

- Pathology
- Back Office
- Pharmacy
- Procurement
- Outsourcing
- Service Line Management
- IT enablement

Chris Albone, (Christopher.albone@ngh.nhs.uk—Ext 5909)

- Outpatients
- Patient Flow
- Contract Compliance
- On-Call

Jatinder Singh (Jatinder.singh@ngh.nhs.uk—Ext 3317)

- Nursing
- Estates
- Bank & Agency
- Therapies

Lorna Gould (Lorna.gould@ngh.nhs.uk—Ext 5909)

- Theatres
- Administration Review
- Controls

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.

Midlands and East

SELF-CERTIFICATION RETURNS
Organisation Name:
Northampton General Hospital NHS Trust
Monitoring Period:
June 2012
NHS Midlands & East **Provider Management Regime** **2012/13**

12

Returns to providerdevelopment@eoe.nhs.uk by the last working day of each month

NHS Midlands and East

NHS Trust Governance Declarations : 2012/13 In-Year Reporting

Name of Organisation:	**Northampton General Hospital NHS Trust**	**Period:**	**June 2012**

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance as per the 2011/12 Provider Management Regime, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per NHS Midlands and East PMR guidance)	**2.0**
Financial Risk Rating (Assign number as per NHS Midlands and East PMR guidance)	**1.0**
Contractual Position (RAG as per NHS Midlands and East PMR guidance)	A

*** Please type in R, A or G**

Governance Declarations

NHS Midlands and East organisations, subject to the Provider Management Regime, must ensure that plans in place are sufficient to ensure compliance in relation to all national targets and including ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, CQC Essential standards and declare any contractual issues.

Supporting detail is required where compliance cannot be confirmed.

Please complete sign **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, you are required to print your name.

Governance declaration 1

The Board is satisfied that plans in place **are sufficient** to ensure continuing compliance with all existing targets (after the application of thresholds), and with all known targets going forward. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code) and CQC Essential standards. The board also confirms that there are no material contractual disputes.

Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		
Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		

Governance declaration 2

For one or some of the following declarations Governance, Finance, Service Provision, Quality and Safety, CQC essential standards or the Code of Practice for the Prevention and Control of Healthcare Associated Infections the Board cannot make Declaration 1 and has provided relevant details below.

The board is suggesting that at the current time there is **insufficient assurance available** to ensure continuing compliance with all existing targets (after the application of thresholds) and/or that it may have material contractual disputes.

Signed by :		Print Name :	Gerry McSorley
on behalf of the Trust Board	Acting in capacity as:		
Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		

If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1. For each area such as Governance, Finance, Contractual, CQC Essential Standards, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	**A&E: Total time in A&E**
The Issue :	**The Trust did not deliver the Transit time target in June 2012 and is now behind trajectory YTD**
Action :	**Internal remedial action plan in place and dialogue with wider HC ongoing**

Target/Standard:	**All cancers: 62-day wait for first treatment**
The Issue :	**Due to complexities of care and delay in initial referral from the other providers, the Trust has not**
Action :	**Recovery plans have been developed and dialogue with partner providers is ongoing**

ACUTE
GOVERNANCE RISK RATINGS 2012/13

Northampton General Hospital NHS Trust

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)
See separate rule for A&E

Ref	Area	Indicator	Sub Sections	Thresh-old	Weight-ing	Apr 2012	May 2012	June 2012	Jul 2012	Aug 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Comments where target not achieved in month?
1	Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	36	**1.0**	Yes	Yes	Yes										
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	1	**1.0**	Yes	Yes	Yes										
3	Quality	All cancers: 31-day wait for second or subsequent treatment, comprising either:	Surgery Anti cancer drug treatments Radiotherapy	94% 98% 94%	**1.0**	Yes	No	Yes										
4	Quality	All cancers: 62-day wait for first treatment, comprising either:	From urgent GP RTT From consultant screening service referral	85% 90%	**1.0**	Yes	No	No										Trust delivered 79.4% for the quarter
5a	Patient Experience	RTT waiting times – admitted	95th percentile	23 wks	**1.0**	Yes	Yes	Yes										The GRR is based on delivery of the 90% RTT Target
5b	Patient Experience	RTT waiting times – non-admitted	95th percentile	18.3 wks	**1.0**	Yes	Yes	Yes										The GRR is based on delivery of the 95% RTT Target
6	Quality	All Cancers: 31-day wait from diagnosis to first treatment		96%	**0.5**	Yes	Yes	Yes										
7	Quality	Cancer: 2 week wait from referral to date first seen, comprising either:	all cancers for symptomatic breast patients (cancer not initially suspected)	93% 93%	**0.5**	Yes	Yes	Yes										
8a	Quality	A&E: Total time in A&E	Total time in A&E (95%)	≤ 4 hrs	**1.0**	Yes	No	No										June 93.3%
8b	Quality	A&E: NB Please record the areas not being met in the comments sheet	Total time in A&E (95th percentile) Time to initial assessment (95th percentile) Time to treatment decision (median) Unplanned re-attendance rate Left without being seen	≤4 hrs ≤15 mins ≤60 mins ≤5% ≤5%	**No weighting**	2	2	2										June 2012 - Time Spent in A&E & Time to initial assessment: for ambulance arrivals (95th percentile)
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	**0.5**	Yes	Yes	Yes										
		CQC Registration																
A	Safety	CQC Registration	Are there any compliance conditions on registration	0	**1.0**	No	No	No										
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.	0	**2.0**	No	No	No										
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	**1.0**	No	No	No										
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	**2.0**	No	No	No										
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	**2.0**	No	No	No										
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	**4.0**	No	No	No										
G	Safety	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	**2.0**	No	No	No										
				TOTAL		**0.0**	**3.0**	**2.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	

FINANCIAL RISK RATING 2011/12

Northampton General Hospital NHS Trust

Insert the Score (1-5) Achieved for each Criteria Per Month

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Annual Plan 2011/12	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments on Performance in Month
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	3	1	2	2										1.3% YTD
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	5	1	2	1										38% achieved
Financial efficiency	Return on assets %	20%	6	5	3	-2	<-2	3	2	2	2										Due to YTD defciit of £2.7m
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	1	1	1										Due to YTD defciit of £2.7m
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	3	3	3	2										Calculation includes £18m WCF assumption.
Average	Weighted Average	100%						3.0	1.7	2.1	1.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Overriding rules	Overriding rules								-0.7	-0.1	-0.7										Two criteria "1" in June.
Overall rating	Final Overall rating							3.0	1.0	2.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

Overriding Rules :

Max Rating	Rule
3	Plan not submitted on time
3	Plan not submitted complete and correct
2	PDC divident not paid in full
2	One Financial Crieterion at "1"
3	One Financial Crieterion at "2"
1	Two Financial Criteria at "1"
2	Two Financial Criteria at "2"

FINANCIAL RISK TRIGGERS 2012/13

Northampton General Hospital NHS Trust

Insert "Yes" / "No" Assessment for the Month

	Criteria	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Comments on Performance in Month
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No										Achieved Q3 and Q4 11-12 but not achieved Q1 12-13.
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	No										Forecast to achieve Level 3 by Q2.
3	FRR 2 for any one quarter	Yes	Yes	Yes										FRR 2 in Q1.
4	Working capital facility (WCF) agreement includes default clause	No	No	No										N/A
5	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes										£598k (16%)
6	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No										
7	Two or more changes in Finance Director in a twelve month period	No	No	No										
8	Interim Finance Director in place over more than one quarter end	No	No	No										
9	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes										-10 days excluding WCF.
10	Capital expenditure < 75% of plan for the year to date	No	No	No										
	TOTAL	**3**	**3**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

NB Scoring: An answer of "YES" = 1.0

RAG RATING :

GREEN = Score between 0 and 1

AMBER = Score between 2 and 4

RED = Score over 5

CONTRACTUAL RISK RATINGS 2011/12

Northampton General Hospital NHS Trust

Insert R, A or G into appropriate row for the Month

Criteria	RAG	Apr 2012	May 2012	June 2012	Jul 2012	Aug 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Comments on Performance in Month
All key contracts are agreed and signed. Both the NHS Trust and commissioner are fulfilling the terms of the contract. There are no disputes or performance notices in place.	G	G												
The NHS Trust and commissioner are in dispute over the terms of the contract. Performance notices have been issued by one or both parties.	A		A	A										
One or more key contract is not signed by the start of the period covered by the contract. There is a dispute over the terms of the contract which might, or will, necessitate SHA intervention or arbitration. The parties are already in arbitration.	R													

QUALITY

Northampton General Hospital NHS Trust

Insert Performance in Month

	Criteria	Unit	Apr 2012	May 2012	June 2012	Jul 2012	Aug 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Comments on Performance in Month
1	SHMI - latest data	Ratio	109.2	109.2	109.2										SHMI - Latest position reflects October 11 to September 12
2	Venous Thromboembolism (VTE) Screening	%	91.4%	91.9%	90.9%										
3a	Elective MRSA Screening	%	99.8%	99.4%	99.8%										
3b	Non Elective MRSA Screening	%	95.1%	95.7%	96.4%										
4	Single Sex Accommodation Breaches	Number	0	0	0										
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	12	3	9										
6	"Never Events" in month	Number	0	0	0										
7	CQC Conditions or Warning Notices	Number	0	0	0										
8	Open Central Alert System (CAS) Alerts	Number	1	0	0										
9	RED rated areas on your maternity dashboard?	Number	1	2	1										C-Section rates
10	Falls resulting in severe injury or death	Number	0	0	1										
11	Grade 3 or 4 pressure ulcers	Number	1	4	2										
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	Y										
13	Formal complaints received	Number	50	51	39										
14	Agency and bank spend as a % of turnover	%	6.4%	6.6%	7.0%										
15	Sickness absence rate	%	4.8%	5.0%	NA										
Supplementary submission	HSMR	Number	93.6	93.9	94.3										Information supplied for June 2012 is reflective of the period Apr 11 to March 12

Board Statements

Northampton General Hospital NHS Trust

41061

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	✓
	If the Trust Board is unable to make the above statement, the Board must:	
2	Be satisfied that, to the best of its knowledge and using its own processes (supported by CQC information and including any further metrics it chooses to adopt), its Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	✓
3	Be satisfied that, to the best of its knowledge and using its own processes, plans in place are sufficient to ensure ongoing compliance with the CQC's registration requirements	✓
4	Certify it is satisfied that processes and procedures are in place to ensure that all medical practitioners providing care on behalf of the NHS foundation trust have met the relevant registration and revalidation requirements.	✓
4	Be satisfied that the Trust is embedding patient experience into the service design, improvement and delivery cycle.	✓
	For SERVICE PERFORMANCE, that:	**Response**
5	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and compliance with all targets due to come into effect during 2011/12.	✗
	For RISK MANAGEMENT PROCESSES, that:	**Response**
6	Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner	✓
7	All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned	✓
8	The necessary planning, performance management and risk management processes are in place to deliver the annual plan	✓
9	A Statement of Internal Control ("SIC") is in place, and the trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see http://www.hm-treasury.gov.uk)	✓
10	The trust has achieved a minimum of Level 2 performance against the key requirements of the Department of Health's Information Governance Toolkit	✓
	For COMPLIANCE WITH THE NHS CONSTITUTION, that:	**Response**
11	The Board is assured that the trust will, at all times, have regard to the NHS constitution	✓
	For BOARD, ROLES, STRUCTURES AND CAPACITY, that:	***Response***
12	The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board	✓
13	The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability	✓
14	The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills	✓
15	The management team have the capability and experience necessary to deliver the annual plan	✓
16	The management structure in place is adequate to deliver the annual plan objectives for the next three years.	✓

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO		**Gerry McSorley**	
Chair		**Paul Farendon**	

Ref	Area	Details
Thresh-olds		The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.
1	C.Diff	Performance against contract with main commissioner
2	MRSA	MRSA objective: those trusts which are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by DH. The SHA expects those NHS trusts without a centrally calculated MRSA objective to agree an MRSA target for 2011/12 that at least maintains existing performance. Where a trust has an annual MRSA objective of six cases or fewer and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purposes of the SHA's Provider Management Regime If a trust with an annual objective of six cases or fewer declares a risk of exceeding the de minimis level and its annual MRSA objective in-year, but has not yet done so, it will be required to [provide, and then] report monthly against, an MRSA action plan until the risk has been satisfactorily addressed.
3	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter.
4	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants, including consultant upgrades. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. For patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided there is written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA.
5a&b	RTT	While performance is measured on an aggregate basis, NHS trusts are required to meet the threshold on a monthly basis – consequently failure in any month represents failure for the quarter and should be reported via the exception reporting process.
6	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter.
7	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional). Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation
8a	A&E (Q1)	In Quarter one - 95th percentile waits for 4 hours or less to be used
8b	A&E (Q2)	From Quarter two: • 95th percentile waits for 4 hours or less to be used • Time to initial assessment: for ambulance arrivals. Initial assessment to include a pain score and early warning score. • Time to treatment decision: time from arrival to see a decision-making clinician (defining management plan and may potentially discharge the • Unplanned reattendance rate: within 7 days of original attendance. Includes patients referred back by another health professional. The SHA will not score this for paediatric specialist NHS trusts. • Left without being seen The SHA will keep these measures under review during 2011/12 and may change its implementation in line with national policy.
9	Stroke	The SHA will consider its introduction during 2011/12 following publication of DH's technical guidance.
10	Mental Health: CPA	7-day follow up: **Numerator**: The number of people under adult mental illness specialties on Care Programme Approach who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on Care Programme Approach who were discharged from psychiatric inpatient care. Contact can include face-to-face or telephone contact. Guidance on what should and should not be counted when calculating the achievement of this target can be found on Unify2. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** The number of adults in the denominator who have had at least one formal review in the last 12 months. Date last seen by care coordinator will be used as a proxy for formal Care Programme Approach review during 2011/12. **Denominator:** The total number of adults who have received secondary mental health services and who were on the Care Programme Approach at any point during the reporting period. For full details of the changes to the Care Programme Approach process, please see the implementation guidance, Refocusing the Care Programme Approach on the Department of Health's website. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: • patients who die within seven days of discharge; • where legal precedence has forced the removal of a patient from the country; or • patients discharged to another NHS psychiatric inpatient ward.
11	Mental Health: DTOC	**Numerator:** The number of non-acute patients (aged 18 and over) whose transfer of care was delayed averaged over the quarter. **Denominator:** Number of non-acute patients (aged 18 and over) admitted to the trust, summed across the quarter. Delayed transfers of care attributable to social care are excluded.
12 a) b) c) d) e)	Mental Health: I/P and CRHT	This indicator applies only to admissions to the NHS trust's mental health psychiatric inpatient care. The following cases can be excluded: • admissions to psychiatric intensive care units; • internal transfers of service users between wards in a trust and transfers from other trusts; • patients recalled on Community Treatment Orders; or • patients on leave under Section 17 of the Mental Health Act 1983. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in Guidance Statement on Fidelity and Best Practice for Crisis Services the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven day a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face to face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team
13	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
14 NB	Mental Health: MDS	Patient identity data completeness metrics (from Mental Health Minimum Data Set) to consist of: • NHS number; • Date of birth; • Postcode (normal residence); • Current gender; • Registered General Medical; • Practice organisation code; and • Commissioner organisation code. Numerator: count of valid entries for each data item above. NB For details of how data items are classified as VALID please visit the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq Denominator: total number of entries.
15	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** The number of adults in the denominator in paid employment (i.e. those recorded as 'employed') at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported quarter. **Denominator:** The total number of adults (aged 18-69) who have received secondary mental health services and who were on the Care Programme Approach at any point during the reported quarter. • In settled accommodation: **Numerator:** The number of adults in the denominator who were in settled accommodation at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported quarter. **Denominator:** The total number of adults (aged 18-69) who have received secondary mental health services and who were on the Care Programme Approach at any point during the reported quarter. • Having an HoNOS assessment in the past 12 months: **Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. NOTE: When implemented MHMDS v4 will allow services to report all HoNOS variants, including those for young people and people in secure services. Until this time trusts should report standard HoNOS inclusive of all ages and ward types. **Denominator:** The total number of adults who have received secondary mental health services and who were on the Care Programme Approach during the reference period.
16a	Ambulance Cat A	Life threatening
17 a) b) c) d) e) f)	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (2008): a) Does the NHS trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the NHS trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria?: • treatment options; • complaints procedures; and • appointments. c) Does the NHS trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the NHS trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the NHS trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the NHS trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: Boards are required to certify that their trusts meet requirements a to f above at the annual plan and in each quarter. Failure to do so will result in the application of the service performance score for this indicator.
18	DTCs	Performance against contract with main commissioner
19	GUM Access	Access to GUM within 48hours against a target of 95% compliance.
20	Chlamydia Screening	Performance against contract with main commissioner
21	Smoking Quitters	Performance against contract with main commissioner
22	6 Wk Wait Diagnostics	Access to diagnostics against a target of 100% compliance
23	New birth visits	Performance against contract with main commissioner
24	HPV	Human Papillomavirus (HPV) uptake Performance against contract with main commissioner
25	Comm'ty Equip Store	Responses within 7 days
26 a	Urgent DN	Response by a DN within 24 hours of receiving an urgent request / referral
26 b	Non-Urgent DN	Response by a DN within 48 hours of receiving a non-urgent request / referral

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title	Annual Security Report 2011/12
Submitted by	Charles Abolins, Director of Facilities and Capital Development
Date of Meeting	Wednesday 25 July 2012
Corporate objectives addressed	Provide appropriate care for our patients in the most effective way

Summary of Critical Points

- 11% overall increase in reported incidents
- 15% reduction in crime/thefts
- 39% increase in physical assaults reported predominantly attributed to the increasing care of dementia, mental health patients and patients undergoing detox programmes
- Priority to be given in 12/13 for training staff in high risk areas to undertake restraint training

Patient Impact

Staff Impact

Financial Impact

Equality & Diversity Impact

Legal Implications

Risk Assessment

Recommendation
That the Board note the contents of the report and support the key initiatives planned for 2012/13

13

Northampton General Hospital NHS
NHS Trust

Security Management Review

2011-2012

2011-2012 SECURITY MANAGEMENT REVIEW
REPORT TO THE TRUST BOARD

1.0 Executive Summary

2011/12 has again been a challenging and pro-active year for the Trusts Security Department. The report shows that criminal activity, physical assaults, verbal abuse and disturbances are a daily occurrence. In total there were **380** reported incidents either to security or reported through the Trusts Datix reporting system. This is an increase of 11% on last year's reported figure of **343.**

There were **28** reported crimes/thefts: This is the second year a reduction can be reported in this area, representing a **15%** reduction on incidents reported last year.

Reported physical assaults via Datix has again increased, this year by **39%.** This is the second year there has been a significant increase. This can be attributed to the increasing care of dementia patients, mental health patients and patients going through detox programmes. With the introduction of the Datix Reporting System it is also likely that staff are more open about reporting and documenting such incidents whereas in the past such incidents may have gone unreported.

With the increasing requirement to care for these patients, the use of restraint; (restrictive physical intervention) is becoming a regular procedure to protect the patients and staff.

In order to help protect staff and patients, clinical staff on the high risk wards/departments in particular, priority for staff should be given to undertake the appropriate training to enable them to effectively carry out RPI procedures.

This will equip clinical staff with the ability to handle most situations in a safe manner and protect themselves.

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

2.0 Introduction and Background

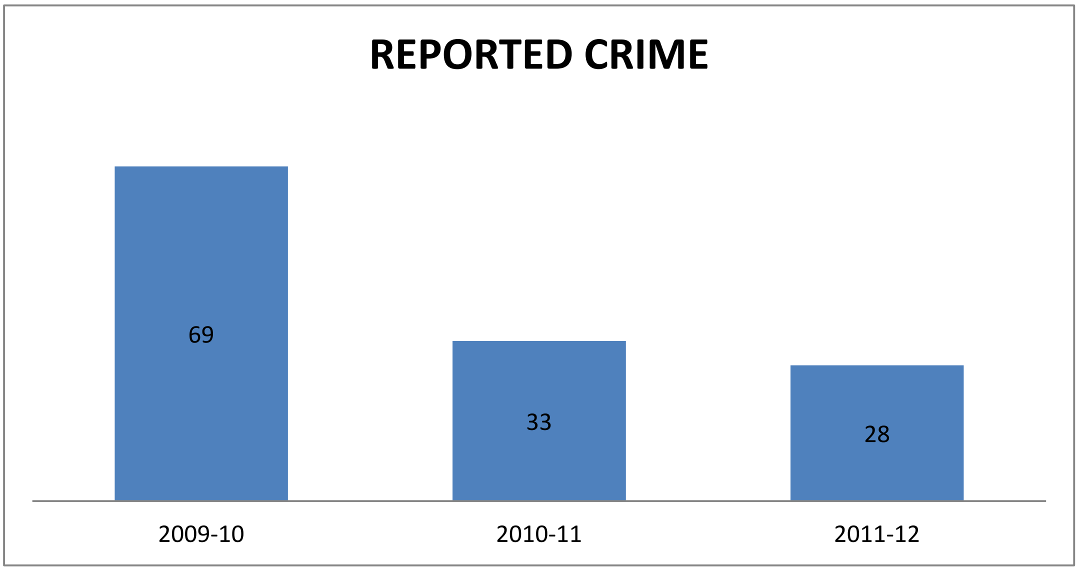
In December 2003 the Secretary of State launched the Security Management Strategy " A Professional Approach to the Management of Security in the NHS" This can be downloaded at www.nhsprotect.nhs.uk

Since 2003 the Trust has actively worked with the Security Management Services (SMS) to provide statistical data about physical assaults, this has helped SMS identify the scale of violence against all NHS staff. The Trust also reports on how many staff attend conflict resolution courses, this again allows for a better understanding of the training being provided within the NHS The Trust has shaped its security policies around guidance given by SMS.

The Facilities Directorate provides an in-house Security team which consists of 10 officers. The Security Department provides services 24/7. In addition portering staff provide support and back up to Security, all being in direct radio contact with each other. Security will attend routine calls as well as emergency calls such as fire alarms, intruder alarms and incidents in progress.

The Security Department manage the Trusts CCTV system of which there are now 100 cameras located within the hospital buildings, grounds and all major car parks. A regular replacement programme is in place.

2.1 Reported Crime Incidents 11/12 and comparative data.
The Security Department routinely collect data on incidents which are used to identify problem areas and assist in determining the most effective counter measures and initiatives.



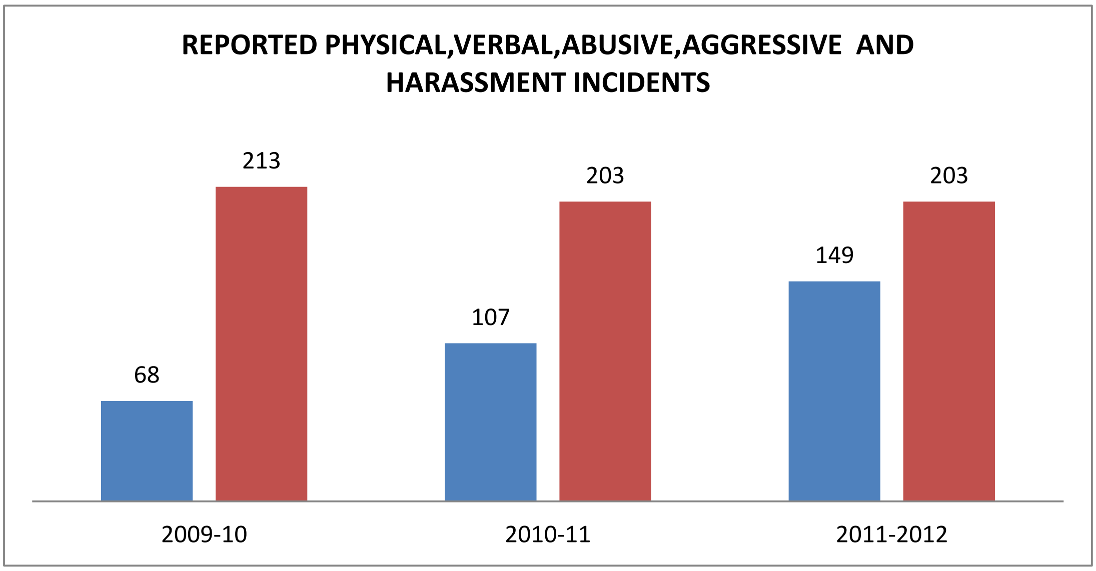
2.2 Data summary breakdown

- **15%** decrease in reported crime, this equates to an overall reduction of **81%** over the last two years. This is encouraging to report and can generally attribute to a more proactive approach being taken by staff in protecting the Trusts and their own property.
- The main theme of crime has been the theft of **18** bicycles from staff and visitors. Unfortunately the Trust has been the victim of organised gangs who have targeted our site and other major sites such as the train station, town centre locations and the University. Security has built up a portfolio of CCTV images of suspects which the police are actively following up but progress appears to be slow.
- There were what appears to have been another two thefts from staff of credit cards and that the thief was able to obtain pin numbers to obtain cash from cash dispensers and withdraw cash within the banks. Last year's report highlighted this type of crime when there were 4 incidents of this nature. Police have indicated that this is an organised gang and there is an ongoing national investigation by NHS Protect and the police. The Trust has contributed significant information including CCTV images of a suspect who is currently on remand on other related crimes. A BBC Crimewatch appeal for information on a number of suspects which has lead to further arrests.
- There were three reported thefts of personal items by staff, this is again a significant reduction on previous years.
- There were two reported thefts against patients however on further investigation by the attending officers, a baby buggy was returned to its rightful owner on a maternity ward and a mobile phone was found by a security officer on a patient that did not belong to them. The two victims did not want to take further action however security officers gave suitable advice.
- The cost to the Trust appears to be negligible as all crime/thefts related to the individuals and not the Trust.

2.3 Physical, Verbal Abuse, Aggressive and harassment Incidents Data
This information is compiled from the Trusts Datix reporting systems

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

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



- **39%** increase in physical assault reported incidents, this again is significant increase and constitutes a rise of **119%** over the last two years. This can be attributed to a combination of staff awareness on when to report an incident as a physical assault by understanding the definition through conflict resolution training and easier access to reporting through Datix. With the increasing care of dementia, mental health and detox patients it is inevitable that physical assaults will increase due to the patient's conditions. It should be noted that the majority of physical assaults are low level types, where scratching, pinching and flailing arms and legs connecting to staff being the main descriptions used via Datix. Acute hospital statistics indicate that 60-70% of inpatients are 65 and over and that 30% of them will have dementia. There is an increasing trend of this type of assault.
- Of the **149** physical assaults Creaton Ward has been identified as a high risk area accounting for **31%** of reported physical assaults on staff. These incidents include punching, kicking and spitting and are predominantly by patients with dementia, mental health conditions and drug and alcohol dependency conditions. As a comparison, the A+E department accounted for less than **3%.**
- A major concern within the Trust is the increasing requirement to restrain (restrictive physical intervention) in the best interests of confused patients both to protect them and staff. Security Officers are regularly being 'crash called' to attend incidents as currently they are best placed to deal with patients actions, as nursing staff have limited resources and experience to manage incidents to a safe conclusion. Facilities and Nursing and Midwifery are working together to provide safe procedures and training to clinical staff and security officers. Half of the Security Team have attended a five day course on restrictive physical intervention (RPI), which trains staff to allow them to safely restrain patients in a team of 3.

It is important that clinical staff are prioritised for this type of training especially within wards/departments, that have been identified as high risk areas to effectively carry out correct RPI procedures. The Security Team do not have the resources or clinical expertise to attend an incident and fully comply with RPI.

- The increasing demands on the Security Team to deal with such situations is having an adverse effect on their ability to carry out their full range of duties and can cause delays in attending fire alarms, other security incidents and regular patrolling of the site.
- **1060** staff attended the half day non intervention conflict resolution course during the year. During the last three years **3374** staff have attended.
- Reported verbal abuse, aggressive and harassment incidents remains consistent with the previous year.

4.0 Achievements During 11-12

- As part of the ongoing CCTV strategy additional cameras have been installed on site primarily within the hospital buildings and corridors. There are currently **100** cameras covering the Trust which are networked to authorised personal computers within the Security Department. This represents an increase of 29 on the previous year.
- A key project that was completed was the security upgrade of Paddington and Disney Wards. This has further heightened security awareness around these areas and increased restricted access for both staff and public, through improved door controls and ward staff taking ownership of access authorisation.
- Other areas of improved security through CCTV, swipe access door control and digital locks include, Labour Ward, A+E , EAU, ITU, main hospital corridors, bulk oxygen tanks, medical gas storage facilities and main outpatients block (Area K). In total around **£100K** has been spent on these projects during 2011/12.
- The Security Department and local police have continued to meet regularly with a further additional 2 meetings a year including A+E staff representation through a Consultant and Head Nurse.
- A mock lockdown exercise of the hospital site was undertaken by Security and Head of Resilience. This demonstrated that at short notice the hospital can effectively achieve lockdown status in the event of an incident.
- Security and Estates have introduced a new procedure when users request change of locks, digit code changes, new/additional keys.

5.0 Conclusion

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

The increase in reported physical assaults is a major concern. Where they continue to remain high, appropriate training in line with the Trusts RPI policy must be given priority by Clinical managers to equip staff to deal with such incidents. Care plans for disruptive patients should consider the appropriateness of patients being specialed (1 to 1 monitoring) and that the nursing staff used are trained for that purpose.

6.0 Key Initiatives Planned for 12/13

- Improvement of security arrangements on site (e.g. access controls and CCTV in midwifery area)
- Provide evidence of ongoing risk assessments undertaken by all wards and departments as per Trust Security Policy. This is a requirement to meet 4.1 of NHSLA standards.
- Review of current security arrangements for bikes and motorbikes and provide recommendations for improvements.
- Provision of Physical Restraint training for nursing staff in high risk areas.

Northampton General Hospital NHS Trust

AGENDA

PUBLIC TRUST BOARD MEETING
Wednesday 25th July 2012
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Draft Minutes of meeting held on 27th June 2012	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	
09.35	5.	Chief Executive's Report	Dr G McSorley	**2**
Clinical Quality & Safety				
09.50	6.	Medical Director's Report	Dr S Swart	**3**
10.00	7.	Patient Experience Strategy Implementation Plan	Ms S Loader	**4**
10.10	8.	Patient Experience – Friends & Family Test	Ms S Loader	**5**
10.20	9.	Infection Prevention Report	Ms S Loader	**6**
10.30	10.	Research and Development Annual Report	Dr S Swart	**7**
Operational Assurance				
10.40	11.	Performance Report	Mrs C Allen	**8**
10.55	12.	Finance Report	Mr J Drury	**9**
11.05	13.	HR Report	Ms G Opreshko	**10**
11.15	14.	Transformation Programme Newsletter	Ms G Opreshko	**11**
11.20	15.	Provider Management Self Certification	Mr C Pallot	**12**
11.25	16.	Security Annual Report	Mr C Abolins	**13**
Governance				
11.30	17.	Any Other Business		
	18.	**Date & time of next meeting:** 9.30am Thursday 27th September 2012, Boardroom, NGH		
	19.	**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.	Mr P Farenden	