Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD MEETING
Wednesday 25th April 2012
9.00 am Boardroom
Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
9.00	1.	Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Draft Minutes of meeting held on 29th February 2012	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	
9.10	5.	Chief Executive's Report	Dr G McSorley	**2**
Clinical Quality & Safety				
9.20	6.	Medical Director's Report - HSMR Update - Clinical Quality, Patient Safety Exception Report - Quality Account Priorities	Dr S Swart	**3**
Operational Assurance				
9.50	7.	Performance Report	Mrs C Allen	**4**
10.00	8.	Infection Prevention Report	Ms S Loader	**5**
10.10	9.	Finance Report	Mr J Drury	**6**
10.20	10.	HR Report	Mrs C Wilkinson	**7**
10.30	11.	Provider Management Self Certification	Mr C Pallot	**8**
10.35	12.	Transformation Programme Update	Mrs C Allen	**9**
	.	**BREAK**		
Strategic				
10.50	13.	Quality Strategy	Dr S Swart/Ms S Loader	**10**
11.00	14.	Patient Safety Strategy	Dr S Swart	**11**
11.15	15.	Communications Strategy	Mr C Pallot	**12**
11.25	16.	Staff Engagement Strategy	Dr G McSorley	**13**
11.35	17.	IT Strategy	Mr C Pallot	**14**
Governance				
11.45	18.	Corporate Objectives 11/12	Ms S Rudd	**15**

11.50	19.	Board Assurance Framework 11/12	Ms S Rudd	**16**
12.00	20.	Any Other Business		
	21.	**Date & time of next meeting** 9.30am Wednesday 27th June 2012, Boardroom, NGH		
		CONFIDENTIAL ISSUES To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Mr P Farenden	

Minutes of the Public Trust Board Meeting held on
Wednesday 29th February 2012 at 9.30am
Boardroom, Northampton General Hospital

Present:	Dr J Hickey	Chairman
	Dr G McSorley	Chief Executive
	Mr C Abolins	Director of Facilities & Capital Development
	Mrs N Aggarwal-Singh	Non-executive Director
	Mr C Astbury	Non-executive Director
	Mrs F Barnes	Interim Director of Nursing
	Mr J Drury	Director of Finance
	Mr B Noble	Non-executive Director
	Mr C Pallot	Director of Planning & Performance
	Mr N Robertson	Non-executive Director
	Ms C Wilkinson	Director of HR
	Mr P Zeidler	Non-executive Director
In attendance:	Mr P Farenden	Chairman (Designate)
	Mr G Kershaw	Associate Non-executive Director
	Ms D Alderson	Deputy Director of Operations
	Ms S Rudd	Company Secretary
	Mr M Essery	Shadow Lead Governor
	Mr F Evans	Shadow Governor
	Mr R Kelso	Shadow Governor
	Ms M McVicar	Shadow Governor
	Mr D Savage	Shadow Governor
	Dr C Elwell	(item only)
	Ms T Harris	(item only)
Apologies:	Mrs C Allen	Director of Operations
	Dr S Swart	Medical Director

TB 11/12 57 Declarations of Interest

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

TB 11/12 58 Minutes of the meeting held on 7th December 2011
The minutes of the previous meeting were approved as a true record.

TB 11/12 59 Chief Executive's Report
Dr McSorley presented his report and noted the details of the current organisational restructure and progress with appointments to posts. Recruitment will continue to fill vacant posts and the structure will be formally in place on 1st April 2012.

Mr Essery enquired about the reporting structure of the Group Directors and Dr McSorley responded that the Group Chairs have joint reporting lines to the Medical Director and Chief Operating Officer, the Group Directors report to the Chief Operating Officer and the Lead Nurses report to the Director of Nursing, Midwifery & Patient Services.

The latest thinking of the timetable of the Acute Services Review is that public consultation will start in July 2012. The individual groups are working up their service models between now and July and there is risk to this timetable if this work is delayed.

Mr Savage, public governor, noted that some shadow governors were involved in the PPI group, which were represented on the working groups.

Mr Robertson asked if there is sufficiently strong leadership in this process and Dr McSorley replied that there is, however some of the project management work has been slow.

The emergency part of the hospital has been under significant strain and a comprehensive review of the emergency care pathway is being undertaken. The principles of the review, resourcing and the programme structure have been agreed with the aim to improve the patient experience of their care. Further details will be provided to a future meeting.

Dr Hickey asked if the Trust has PCT support and Dr McSorley noted that they are very supportive, as are our clinical commissioning colleagues.

A refresh of the quality programme is being undertaken and the Trust has enrolled in the Institute for Healthcare Improvement's patient safety programme. The Medical Director, Chief Operating Officer and Director of Nursing (Designate) will attend the Patient Safety Executive Development Programme as part of continuing the drive for quality. The Quality Strategy is being revised, with new aims and objectives, and will be discussed in detail at the April meeting of the Board.

Attributes of high performing hospitals are that they support the overall well-being of their staff. Management and staff sides have agreed to work together to create a new partnership approach and the broader strategy for staff engagement will be presented to the Board in April. As part of this strategy, Cripps recreation centre and the Trust have created 'Trust Thursdays' allowing staff to use the centre free of charge. A number of staff have already taken up this opportunity.

The Board noted the report.

Action: Quality Strategy to be presented to April meeting
Staff Engagement Strategy to April meeting

TB 11/12 60 Medical Director's Patient Safety Report - HSMR Update

Mr Pallot presented the report on behalf of the Medical Director, noting the further improvement since the previous month to 97.4. This is a factor of the significant amount of work Dr Swart and colleagues have undertaken and, if this were rebased as per Dr Foster methodology, the Trust would no longer be a significant outlier compared to other Trusts.

Appendix 1 details areas of performance and the Trust is focusing on the differences in weekday and weekend mortality.

Mr Kershaw commented that there has been significant work carried out in this area, as demonstrated by the audit details contained in the report. Dr Hickey enquired about plans to maintain the momentum in this area. Dr McSorley replied that one of the key aspects of this work is engaging senior clinicians which also connects to the quality strategy.

Mr Essery, lead governor, enquired about the numbers of frail, elderly patients admitted where admission might have been avoided. Dr McSorley replied that it is proposed that there is an advanced plan put in place and that there is partnership working being undertaken with GPs.

Mrs Aggarwal-Singh asked that the Board acknowledge the work being undertaken by Dr Sonia Swart and her team and looks forward to on-going progress in this area.

TB 10/12 61 **Infection Prevention Report**

Mrs Barnes presented her report noting that there have been a total of 2 MRSA cases year to date, against the trajectory of 3 for 2011/12.

To date the Trust has had 47 cases of Clostridium Difficile (C diff) against a trajectory of 54 cases. 9 cases were reported in January, the largest number in any one month. Each case was sent for ribotyping which demonstrated that they were not due to cross infection. Detailed root cause analyses were carried out with actions set out in the report. In addition the infection prevention team are visiting wards on a daily basis. 1 case has been reported during February.

The C diff trajectory for next year will be challenging, 36 cases. The Department of Health (DH) have issued guidance regarding sample testing for 2012-13 and the Trust will apply this guidance after a sample has been sent and a positive toxin test reported to the ward. The Trust is expected to address issues of inappropriate sampling and will continue to use a 2-step testing protocol. Mrs Barnes noted that work will continue against Trust action plans.

Mr Robertson asked about the trajectory for MRSA next year of 1 case and how it compares to other hospitals in the region. Mrs Barnes replied that the DH are looking for a 27% reduction in cases year on year, therefore Trusts with only 1 case will see their trajectory reduced to 0.

Mr Pallot noted that the Trust is working closely with PCT colleagues regarding contractual requirements and the appropriate level at which to deploy financial penalties.

Dr Hickey pointed that these figures have been achieved at an extremely busy time for the Trust, with high levels of bed occupancy, which is a factor in infection prevention.

Dr Hickey noted the previous concern regarding surgical site infections and fractured neck of femur. Mrs Barnes replied that meetings have been held regularly with the team and a care bundle put in place. Interim results for January are 22 operations undertaken resulting in no infections to date.

The Board noted the report.

TB 11/12 62 **Quality Account Priorities**

Mrs Barnes presented the report noting that the Trust is required to submit Quality Accounts in June of this year and a long list of 7 potential priorities has been identified, as outlined in the report. Mrs Barnes detailed the timetable for development, consultation and approval and asked the Board to debate the long list of priorities.

Dr Hickey commented that the priorities need to say what the outcomes should be. Mr Zeidler felt that staff engagement should be a higher up the Trust agenda and Mr Robertson agreed that supporting staff should be a priority.

Mrs Aggarwal-Singh enquired if dignity and respect is an underpinning factor. Mrs Barnes replied that it is and is part of patient experience.

Mr Kershaw noted that patient Falls should also be a priority and Mrs Barnes replied that these are included in the work on the Safety Thermometer.

Dr Hickey felt that the headings should reflect the content and Mrs Barnes agreed to review the wording of the priorities. Mrs Barnes to circulate a revised list for comment.

Action: Comment on long list of priorities to Fiona Barnes

TB 11/12 63 **Creating a revolution in patient and customer experience**

Mrs Barnes presented the report noting the NHS Midlands and East implementation guidance for creating a revolution in patient and customer experience. This is one of the 5 ambitions that the NHS Midlands and East cluster is aiming to deliver over the next 18 months.

This is to be taken forward using an indicator called the 'net promoter' to ensure that patient experience is prioritised on all NHS Board agendas and given an equal standing with patient safety and clinical effectiveness.

Mr Astbury commented that a baseline is not available and Mrs Barnes replied that this will be conducted in March.

Mr Essery asked how the question will be proposed to patients and Mrs Barnes replied that this is currently by way of the Patient Experience Tracker (PET). The Trust is now working with Hospedia to utilise patient televisions. It is important that patients are able to answer questions independently.

Mr Noble enquired about costs and Mr Abolins responded that Hospedia will cost significantly less than the PET. 80% new screens have been installed and a test questionnaire has already been implemented.

Mr Zeidler commented that the question asked is fundamental and asked if will relate to service or the hospital. Dr McSorley replied that it will relate to this organisation.

Mrs Barnes noted the update in the report on other areas of work being carried out. It was noted that Mr Astbury had agreed to support this patient experience initiative.

Mr Robertson referred to the national inpatient survey and the question regarding opinion of the number of nurses on duty to care for you, as the Trust is an outlier on this question. Mrs Barnes responded that the Board has received a presentation on the Safer Nursing Care Tool and ward establishment. Mr Robertson noted that it is a public perception that there are not enough staff. Dr McSorley replied that the Trust should utilise the tools available and that the results indicated that overall the Trust has the right numbers of staff but that they could be distributed more appropriately. There is further investment being made in this area.

Mrs Barnes noted that the Board will receive the Patient Experience Strategy in May.

It was **agreed** to formally adopt the Net Promoter score and to support the development of the Patient Experience Strategy to be presented to the Board in

May.

Action: Patient Experience Strategy presented to May meeting

TB 11/12 64 **Outpatient Survey Results**

Mrs Barnes presented a summary of the Trust's National Outpatient Survey 2011 results noting that the Trust has maintained its position when compared to other Trust's nationally.

51 questions were asked in total, 2 questions had responses that resulted in the Trust scoring 'better' in comparison to other Trusts. All other responses were 'about the same'.

The report details the next steps having identified the areas with lowest results. A set of agreed standards have been developed and identified for launch in April 2012. Action plans will be submitted to and monitored by the Clinical Quality and Effectiveness Group.

Dr Hickey asked when the in-patient survey results will be available and Mrs Barnes replied that they should be available in April 2012.

The Board noted the report and agreed the next steps.

TB 11/12 65 **Performance Report**

Ms Alderson presented the report for January 2012, noting that the Trust achieved all minimum performance standards for the month, with the exception of the 4 hour transit time in A&E. During January 86.57% of patients were treated within 4 hours against a standard of 95%. The Trust recovery plan is being monitored by the Trust, NHS Northamptonshire and the SHA.

Non elective activity has increased, with an extra 13 patients per day being admitted compared to this time last year. Mr Robertson noted that the national position for A&E admission is a decrease of 1% against the increase seen at this hospital.

The building work for 10 additional cubicles in A&E is on track and recruitment for 2 extra consultants is well underway. Additional bank and locum staff are also in place.

All cancer standards were achieved and significant progress has been made against the 62 day recovery plan to deliver these targets.

The Board noted the report.

TB 11/12 66 **Finance Report**

Mr Drury presented his report noting that the position has improved in month 10, a deficit of £673k compared to a forecast position of £2,045k deficit. This is primarily due to agreement by the PCT to reinvest £1.7m of readmission income.

Pay costs are higher due to the high non elective activity and bank and agency staff. Non pay costs are also higher than planned driven by excluded medicines, which are funded in the income line.

£12.9m cost improvements delivered to date and forecast to deliver £18.4m by the year end. Capital expenditure is £8.6m for the period to January and 80% of the plan is committed.

Cash balance has decreased and the Trust expects to meet the EFL of £3.8m, however the Trust is discussing cash profile in relation to SLA income for the remainder of the year with NHSN.

The overall Financial Risk Rating is currently 3 however it is key for the Trust to improve this rating, particularly the liquidity ratio and surplus margin.

Mr Drury noted an amendment to EBITDA to read 4, rather than 3.

Accounting policies require a revaluation of the estate every three years which will result in a write down of asset value of £5.2m at the year end.

Aged debtors are reducing and Cripps recreation centre is on a payment plan and the exposure is reducing.

Mr Savage noted the improvement in the cost improvement delivery in the last few months and Mr Drury replied that this is in line with the plan set out at the beginning of the year.

The Board noted the report.

TB 11/12 67 **HR Report**

Ms Wilkinson presented her HR report noting that short term sickness absence has decreased by 0.2% to 2.36% in December against Trust target of 1.4%. Long term sickness absence increased by 0.17% to 1.9% but remains below the Trust target of 2%. This has been against a background of transformation and activity pressures in the Trust.

The Board noted the report.

TB 11/12 68 **Information Governance**

Mr Pallot presented the report noting that an annual assessment of information governance is made by way of the Information Governance Toolkit. The Toolkit is submitted on 31 March each year. The target compliance is 86% which is likely to be graded as 'not satisfactory' as all requirements must score a '2' or higher. In previous versions a score of 70% was a green grading.

The Trust has demonstrated strong compliance when benchmarked against local organisations.

There are two areas of challenge:

i) Information Governance Mandatory training – currently well below the target compliance rate of 95%. A range of methods is being implemented to raise the rate of compliance

ii) Main Diagnosis Recordings – there are a number of projects in place to improve clinical coding accuracy and 90% compliance is required for level 2.

No serious information breaches in 2011 have been reported. There have been two cases where staff have been disciplined for inappropriate access of information.

Loss of data remains a key risk for the Trust and a project to encrypt all portable devices is in place. There is also a clear policy in place for the transmission of confidential information.

Mr Pallot highlighted the increasing use of financial penalties by the Information

Commissioner for serious data breaches therefore the Trust must ensure improved compliance with mandatory training to reduce this risk and to support staff with their obligations.

The report includes details of the work plan for the coming year, which is reviewed by the Audit Committee on a regular basis.

Mr Drury commented on the easy access of training via the e-learning module.

The Board noted the report and **approved** the updated work programme.

TB 11/12 69 **Transformation Programme Update**

Mr Drury presented the report, which is in the form of a newsletter, and highlighted the staff salary sacrifice scheme which is currently being launched. It introduces a number of staff benefits such as a cycle to work scheme, car parking payments and the opportunity to purchase additional annual leave.

Mr Kershaw enquired if the purchase of additional annual leave would increase staffing costs. Ms Wilkinson replied that the purchase is made with the agreement of the line manager.

The report outlines the plans for the Transformation Programme 2012-13 and the significant work underway to develop workstreams.

The Board noted the update.

TB 11/12 69 **Provider Management Self Certification**

Mr Pallot presented the report noting that the Board is required to sign the governance declarations on a monthly basis. The Trust is currently below trajectory against the 95% transit time target for quarter and year end and it is proposed to sign declaration 2 on this basis.

Mr Drury noted that the Trust is also Amber rated with regard to finance and therefore declaration 2 also applies.

Dr McSorley noted that the governance declarations were implemented in January, initially in shadow form until April 2012.

The Board **agreed** the signing of declaration 2.

TB 11/12 69 **Cancer Strategy**

Mr Pallot presented the report and introduced Tracy Harris, Head of Cancer Services, and Dr Chris Elwell, Consultant Clinical Oncologist, to the meeting. As a Cancer Centre, NGH provides specialist care to a wider population of 880,000 people living in Northamptonshire, North Buckinghamshire and South Leicestershire. As part of the South East Midlands Acute Services Review (ASR) there will be a review of all cancer pathways and current provision of cancer services. The ASR Cancer Clinical Working Group is undertaking a review of all cancer pathways and flows and NGH aims to retain the specialist head and neck, gynaecological and urology cancer surgery currently provided at NGH. The Strategy sets out the local demands and requirements needed to support all those affected by cancer in this area.

Dr Hickey asked about the population requirements to be a specialist centre and Dr Elwell replied that for Urology, a population of 1m is suggested. Currently our population area is 880,000 but the expected population increases will take us to that figure.

Dr Hickey asked about the biggest challenges and Dr Elwell replied the fourth Linear Accelerator and its siting. Mr Pallot reported that we have been in discussion with Milton Keynes NHSFT in this regard for a while.

Dr McSorley noted that this is an excellent piece of work and the population is critical to serving everyone and we have received good support from the Cancer Network.

Dr Elwell said that there has been enormous help and support from the team helping us to gain the views of patients on existing services.

Mr Essery, Lead Governor, was interested in the Maggie Centre. Dr Elwell replied that the idea is that it is an open door drop in centre for people to have access to a cancer support specialist at any stage in their cancer experience. Ms Harris said that a centre at NGH would ensure that we have a place where people can go to for information.

Dr Hickey asked about the life of the existing accelerators and Mr Drury replied that these are part of our managed equipment service programme.

It was noted that actions are listed throughout strategy and these will be implemented through the Cancer Steering Group.

The Board **agreed** the Cancer Strategy 2012-2016.

Any Other Business

TB 11/12 69

Mr Evans, shadow governor, raised a question regarding length of wait for patient discharge. Mrs Barnes replied that the Trust is addressing the whole patient pathway and nurse led discharge. The Trust is looking at how to increase the number of patients that can be nurse led. Dr McSorley noted that the Urgent Care Pathway review will include discharge arrangements

Mr Astbury noted that this was Dr Hickey's final meeting and proposed a vote of thanks for his leadership and wished him well for the future.

Date and Time of Next Meeting
Wednesday, 25th April 2012, Boardroom, NGH

Actions arising

TB 11/11 55	Corporate Objective update	SR	Next meeting
TB 11/12 59	Quality Strategy presentation	SSw	April 2012
TB 11/12 59	Staff Engagement Strategy	GM	April 2012
TB 11/12 62	Comment on long list of priorities to Fiona Barnes	All	Asap
TB 11/12 63	Patient Experience Strategy	SL	May 2012

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title: -	Chief Executive's Report
Submitted by: -	Dr G McSorley, Chief Executive
Date of meeting: -	25th April 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 FOR APRIL PUBLIC BOARD MEETING

1 South East Midlands Acute Services Review (Healthier Together)

At the Healthier Together Programme Board held on Tuesday the 17th April, it was noted that the date for formal consultation on any proposals for reconfiguration for services for South East Midlands would begin on the 1st October I will keep the Board appraised should there be any slippage on this date.

The Patient and Public Involvement Group within the Healthier Together Programme have been considering the evaluation criteria for any proposals. This work will shortly conclude and I would aim to bring those draft recommendations from the patient and public involvement group to the next Board Meeting and also the next Shadow Governors Council.

2 Foundation Trust Application

Significant amount of activity is currently underway relating to our application to become a Foundation Trust. Independent reviews are underway of our quality and governance arrangements, our thinking on business planning for the next 5 years etc. All this work will be concluded by the middle of May for submission to the Strategic Health Authority.

3 Organisational Arrangements

Final appointments have been made to the Care Group Structure and a schematic of "who's who" is attached for the Board's information. At the Hospital Management Group (HMG) held on 17th April it was agreed that in light of the creation of the care group structure the HMG would meet less frequently but with a greater strategic focus. It was further agreed that HMG would be disbanded and replaced by a new body called the Strategic Management Board comprising of the Executive Directors, Care Group Senior Leadership Team, Clinical Directors and General Managers. A formal Terms of Reference for this Group will be brought back to the next Board Meeting.

4 Vascular Surgery

The Board is asked to note that the final reconfiguration of Vascular Services for Northamptonshire took place at the beginning of April. In collaboration with Kettering General Hospital, NGH will now act as the hub for Vascular Surgical Services for the County.

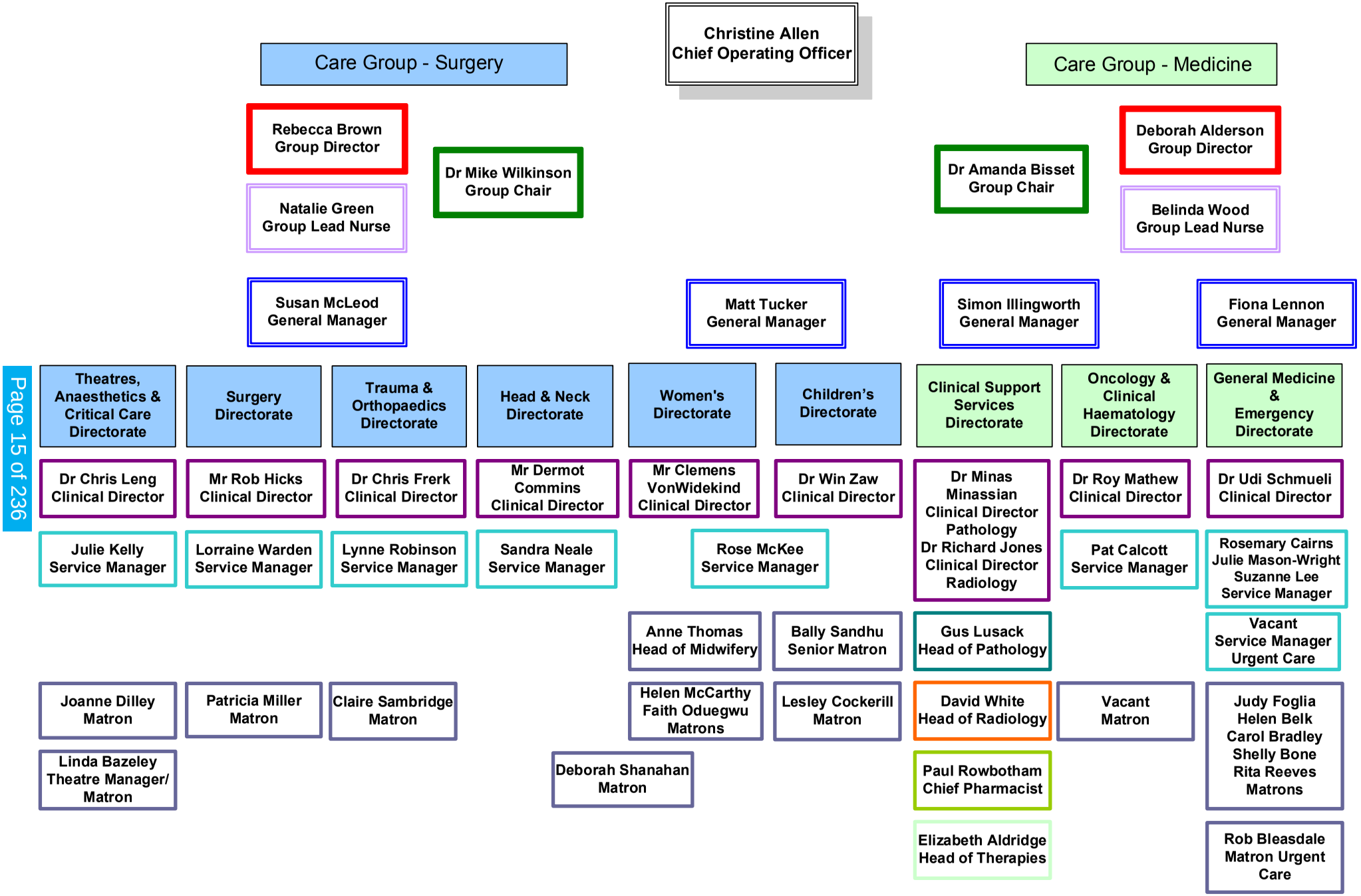
5 Trauma Network

As part of the national reforms on Trauma Services the East Midlands has confirmed that Nottingham University Hospitals will be the Major Trauma Centre for the East Midlands. In order to ensure high quality integration of trauma services a Trauma Network Board has been established – Mr Chris Pallot will be the Executive Director on the Trauma Board and Dr John Hare, Consultant Anaesthetist will be the clinical representative on the Trauma Network. Further discussions are underway in respect of how NGH fits within the East Midlands Trauma Network.

6 Creation of Academic of Health Science Networks

As part of national reforms relating to the way that education, training and innovation is promoted within the NHS, discussions are underway throughout England relating to the creation of Academic of Health Science Networks. These are virtual organisations, which brings together higher education institutes, major tertiary university academic hospitals and district general hospitals for shared collaborations. It is likely that later this summer the Government will publish further proposals as to how these networks are created and Dr Swart and I will bring back any recommendations on how NGH should join any particular network.

Dr Gerry McSorley
April 2012


Christine Allen
Chief Operating Officer
Care Group - Surgery
Care Group - Medicine
Rebecca Brown
Group Director
Dr Mike Wilkinson
Group Chair
Natalie Green
Group Lead Nurse
Dr Amanda Bisset
Group Chair
Deborah Alderson
Group Director
Belinda Wood
Group Lead Nurse
Susan McLeod
General Manager
Matt Tucker
General Manager
Simon Illingworth
General Manager
Fiona Lennon
General Manager
Theatres, Anaesthetics & Critical Care Directorate
Surgery Directorate
Trauma & Orthopaedics Directorate
Head & Neck Directorate
Women's Directorate
Children's Directorate
Clinical Support Services Directorate
Oncology & Clinical Haematology Directorate
General Medicine & Emergency Directorate
Dr Chris Leng
Clinical Director
Mr Rob Hicks
Clinical Director
Dr Chris Frerk
Clinical Director
Mr Dermot Commins
Clinical Director
Mr Clemens VonWidekind
Clinical Director
Dr Win Zaw
Clinical Director
Dr Minas Minassian
Clinical Director Pathology
Dr Richard Jones
Clinical Director Radiology
Dr Roy Mathew
Clinical Director
Dr Udi Schmueli
Clinical Director
Julie Kelly
Service Manager
Lorraine Warden
Service Manager
Lynne Robinson
Service Manager
Sandra Neale
Service Manager
Rose McKee
Service Manager
Pat Calcott
Service Manager
Rosemary Cairns
Julie Mason-Wright
Suzanne Lee
Service Manager
Anne Thomas
Head of Midwifery
Bally Sandhu
Senior Matron
Gus Lusack
Head of Pathology
Vacant
Service Manager
Urgent Care
Joanne Dilley
Matron
Patricia Miller
Matron
Claire Sambridge
Matron
Helen McCarthy
Faith Oduegwu
Matrons
Lesley Cockerill
Matron
David White
Head of Radiology
Vacant
Matron
Judy Foglia
Helen Belk
Carol Bradley
Shelly Bone
Rita Reeves
Matrons
Linda Bazeley
Theatre Manager/
Matron
Deborah Shanahan
Matron
Paul Rowbotham
Chief Pharmacist
Elizabeth Aldridge
Head of Therapies
Rob Bleasdale
Matron Urgent
Care

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title: -	Medical Director's Report – Mortality, Clinical Scorecard Exception Report, Quality Priorities
Submitted by: -	Dr S Swart
Prepared by: -	Dr S Swart
Date of meeting: -	25 April 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 in many areas to ensure improving clinical outcomes, improving focus on patient safety, improving patient experience and improving flows of information. There is a commitment to a re-design of the Emergency Pathway and increased focus and support for patient safety work. The articulation of quality priorities for next year reflects both the work to date and the commitment for the future. The need to ensure that there are clear and robust measures for quality remains paramount.

PATIENT IMPACT: -

High quality care for patients remains a priority. Patients will be able to view Quality Indicators in the public domain and Commissioners will increasingly commission on the basis of quality. The patient experience as part of the emergency pathway remains a key priority.

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.

RECOMMENDATION: -

Board members are asked to debate the issues raised and consider agreeing to support the investment required to ensure progress is made at pace.

SECTION 1

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

INTRODUCTION

This paper is a follow up to a number recent reports to the Board, which focuses specifically on areas noted to be at risk, that were highlighted for action.

Since the last Board meeting there has been further progress in a number of key areas including the Death Audit Review process, the regular meetings with coders and the Pneumonia Action Group. The improved partnership working arrangements agreed between clinicians, coders, information analysts and Dr Foster information systems, has continued and CHKS has made some progress in understanding how they can best assist us in the process of clarifying data.

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

This issue remains of key reputational importance for the Trust.

The PCT have continued to request information with respect to our progress and actions and this has been provided.

Current position HSMR

HSMR for 2011-12 (data to end January 2012), has improved slightly further since the previous month to **95.4 (839 deaths versus 879 expected).** If this were re-based as per Dr Foster methodology the number would be around **103** for the period from April 2011 – January 2012 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 45 Trusts have SMRs higher than that predicted for NGH. It also represents an improving position with respect to the previous month as reported in the last Board paper. If current improvements are maintained NGH will no longer be a significant outlier compared to other Trusts. The indications are that the rate of secondary coding and the rate of palliative care coding have fallen and are also low compared to other Trusts. Primary diagnosis coding has received increased scrutiny and there is some indication that this is improving which may relate to the significant clinical engagement in the issues and the improved interactions with clinical coders. There is a need to ensure that there is an improved understanding of the issues relating to the recording of palliative care coding, which must be done accurately more accurately.

For the 3 month period November 2011 – January 2011, the HSMR on the Dr Foster dashboard **(Appendix 1)** shows NGH as significantly better than average as indicated by the green bell with a 269 deaths versus 316 expected deaths. For January the SMR was **86**. There were 114 expected deaths and there were 99 actual deaths.

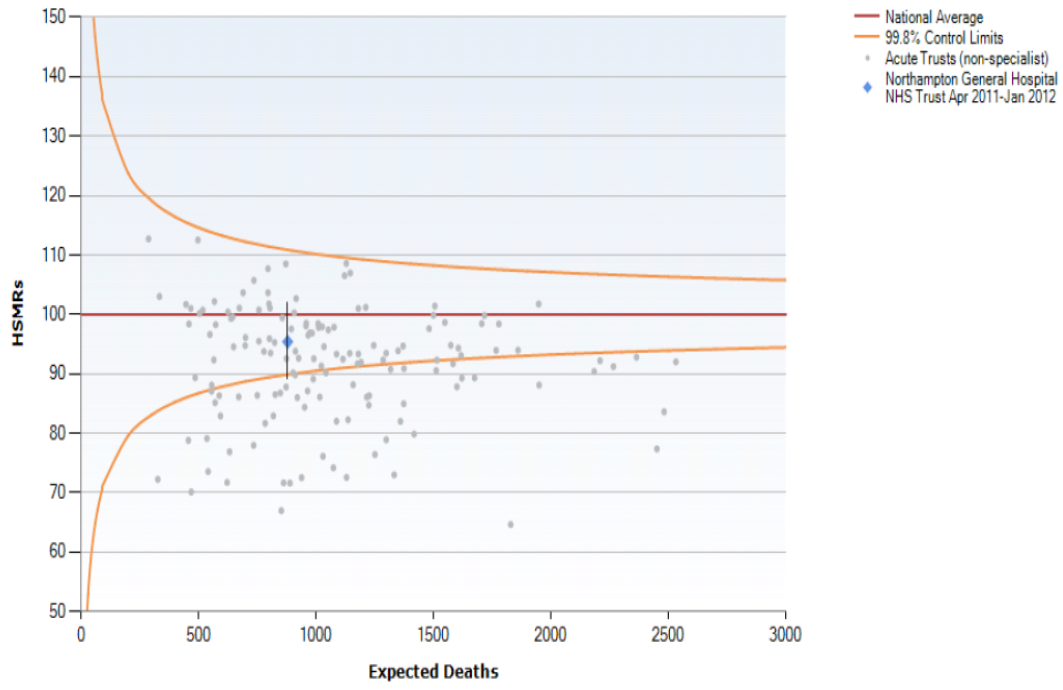
Another area of concern relates to the fact that in the Dr Foster Good Hospital Guide, NGH was named as amongst the Trusts with the largest difference in weekday and weekend mortality.

The position in this financial year for the nine months to the end of January has improved with a HSMR for weekend admissions of 112 versus 130 for the same period last year.

NGH is no longer an outlier with respect to mortality as measured by HSMR as shown below. It is also no longer an outlier for deaths in patients admitted at the weekend.

Acute Trust HSMRs Apr 2011-January 2012

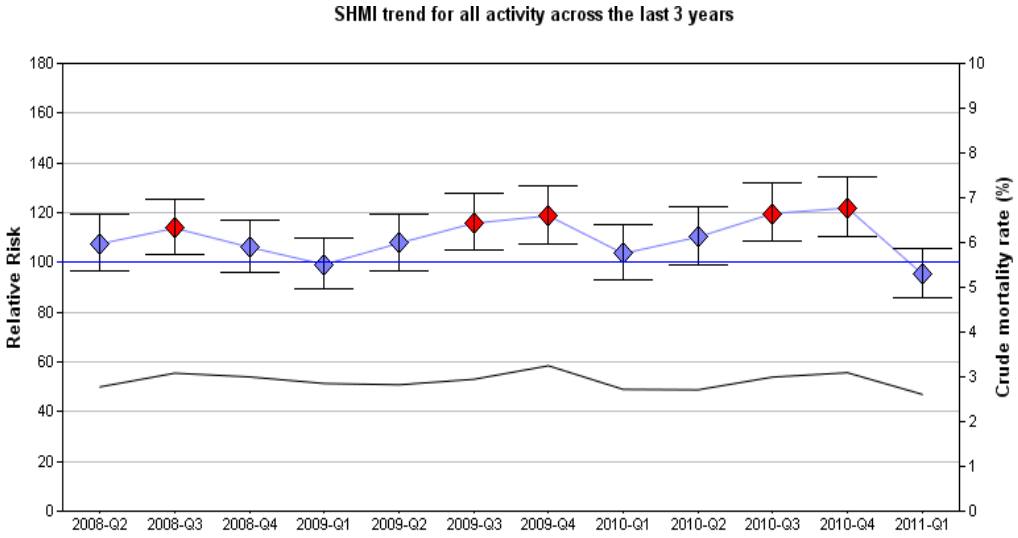
The background points show the HSMR for the current financial year **for each acute non-specialist trust in England.**



Standardised Hospital Mortality Indicator

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.



The SHMI roughly mirrors the HSMR for NGH. The latest SHMI shows an improvement from 114 to 111 (period up to June 2011 – rolling 12 months). There is no updated SHMI data for Q2 and Q3.

Dr Foster Patient Safety Indicator Dashboard February 2011- January 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 is generally good and better than average in a significant number of areas but gives cause for concern in the case of Obstetric trauma. The information has been sent to the directorate for review. I09 cases were reported versus an expected 88 cases for the time period in question. The directorate are currently validating the data.

Indicator		Observed	Expected	Observed rate/K	Expected rate/K	
Deaths in low-risk diagnosis groups*		10	28.4	0.27	0.76	more information
Decubitus Ulcer		109	160.1	12.96	19.04	more information
Deaths after surgery		39	33.1	155.38	131.89	more information
Infections associated with central line*		0	1.1	0.00	0.07	more information
Post-operative hip fracture*		1	1.6	0.04	0.06	more information
Post-op Haemorrhage or Haematoma		5	14.4	0.20	0.58	more information
Post-operative physiologic and metabolic derangements*		0	2.0	0.00	0.09	more information
Post-operative respiratory failure		9	14.9	0.45	0.74	more information
Post-operative pulmonary embolism or deep vein thrombosis		15	44.3	0.60	1.78	more information
Post-operative sepsis		4	5.1	4.84	6.17	more information
Post-operative wound dehiscence*		1	1.2	1.09	1.32	more information

Accidental puncture or laceration		30	67.3	0.46	1.03	more information
Obstetric trauma - vaginal delivery with instrument*		29	43.5	53.60	80.44	more information
Obstetric trauma - vaginal delivery without instrument*		109	88.3	45.84	37.12	more information
Obstetric trauma - caesarean delivery*		6	4.5	4.55	3.42	more information

A red bar signifies an indicator for which the lower end of the 95% confidence interval is worse than the national average. A green bar signifies and indicator which is at better than the national average. A blue bar means that the indicator is at the national average. Indicators that are * are not case-mix adjusted.

Reports on Key Areas for action:

1. Case Note review of 237 consecutive deaths: -

The Trust has, for many years, conducted a formal process for reviewing both clinical care and coding whenever mortality monitoring indicated a concern in a specific area. Over the last few months this has been supplemented by a detailed case review of consecutive deaths conducted by consultant medical staff from a range of specialities. This case note review combined a subjective assessment with an audit against certain standards and was undertaken in order to provide information to inform quality improvement initiatives. Following the return of over 200 completed forms a medically qualified audit assistant is pulling together key themes and been able to provide a high level report. Further analysis is in progress and will inform key safety and emergency re-design projects. An subset of notes have been examined by experienced nurses who also identified key areas for improvement.

From the case note review results to date there are clear areas which have been identified as targets for improvement activity and these will be linked to current and evolving projects.

The Consultant Team has continued to meet to discuss themes and discuss further actions and audits. The plan is to bring the final themes together with a multidisciplinary team and then to repeat the process in 6 months on a sample of 50 deaths.

There is a genuine interest from clinical and managerial staff involved in linking the themes identified as part of the case note review to the planned re-design of the Emergency Pathway, the safety improvement initiatives and the flow of information through the system particularly as it relates to record keeping.

There has also been significant interest in the information flow issues that have emerged and there is an increasing awareness of the importance of clear medical notes and summaries.

The Board should note that the current programme of patient safety work includes the themes from this review. In particular, the planned programmes of work will focus on record keeping, planning of care, identification of seriously ill patients and escalation of care and themes around communication and team working. The re-design of the emergency care pathway will focus on key elements which also relate to rapid access to right care, planning of care and continuity of care. These two programmes will interlink and key lessons from this case review will be incorporated in the programme of work.

Overall 73% of patients were judged to have excellent or good care but in 12 % the reviewers felt there was room for improvement in some aspect of care.

In 91% of patients who died it was felt that death would not have been avoidable even if care had been optimal in every way.

In 7% of cases the reviewers felt that better care might have prevented the death of the patient during the admission concerned. This is in line with international studies which have used this method of review to target quality improvement in their organisations.

76% of patients received care, which the reviewers felt they would have wished for their own family. In this category the commonest cause for concern related to clear planning with consultant input with comments relating to the number of different consultants involved in the care. Another theme related to the observation that the patient should have been allowed to remain at home rather than be admitted to hospital at the end of their life.

40% of case note reviews resulted in a change in the primary diagnosis recorded.

25% of admissions were regarded as possibly avoidable if better advanced care planning had been in place. 23% of these patients had Cancer and 15% had Dementia. Most of these patients were frail and elderly with numerous serious long term health problems.

Targeted improvement is recommended in the following areas: -

A. Record Keeping and Record Content

- Structure of the medical record
- Use of printed name and GMC stamp
- Recording of investigation requests and results
- Completion of the admission proforma
- Recording of treatment plan and diagnosis
- Recording of ward transfers and summary of care at key points
- Information on discharge or death
- VTE risk assessment recording
- Fluid balance recording
- Medication chart completion
- Nursing documentation

B. Quality of Care

- Consultant review within 12 hours
- Continuity of consultant care and continuous consultant cover
- Clear documentation of plans of care that bridge medical and nursing issues
- Transfers of patients between wards
- Escalation of care in response to the deteriorating patient
- Actions taken as a result of risk assessments
- Access to speciality wards
- Communication between specialist teams

C. Clinical Coding and Information flows

- Clarity of diagnosis and co-morbidities in the patient record
- Ownership of information in the medical record
- Accurate allocation of patient episodes to consultant teams
- Clinical coding interaction with clinical teams
- Recording of transfers of patients to and from community hospitals

D. Admission Avoidance

- Continue to work with commissioners to develop improved pathways of care to improve decision making at the end of life

Next steps

The Trust has already made a commitment to a programme of improvement for the Emergency Care Pathway and for key safety initiatives.

All the consultants and senior nursing staff involved in the project have been asked to feed back their views as well as specific ideas for re-design and these will be brought together in a final meeting once the complete case note audit results have been checked and finalised.

Expressions of interest for the posts of Clinical Leads for the re-design of the Emergency Care Pathway and the Safety Programme have been sought and will be appointed within the next month.

2. Respiratory Tract Illnesses: -

Following significant focus on the accurate diagnosis and treatment of pneumonia, further improvement has been noted although the Pneumonia Action Group will continue to meet and roll out education programmes to ensure that the care bundle approach is used consistently. This work has clear link with the work on the management of sepsis and can also be used as a platform for other safety work.

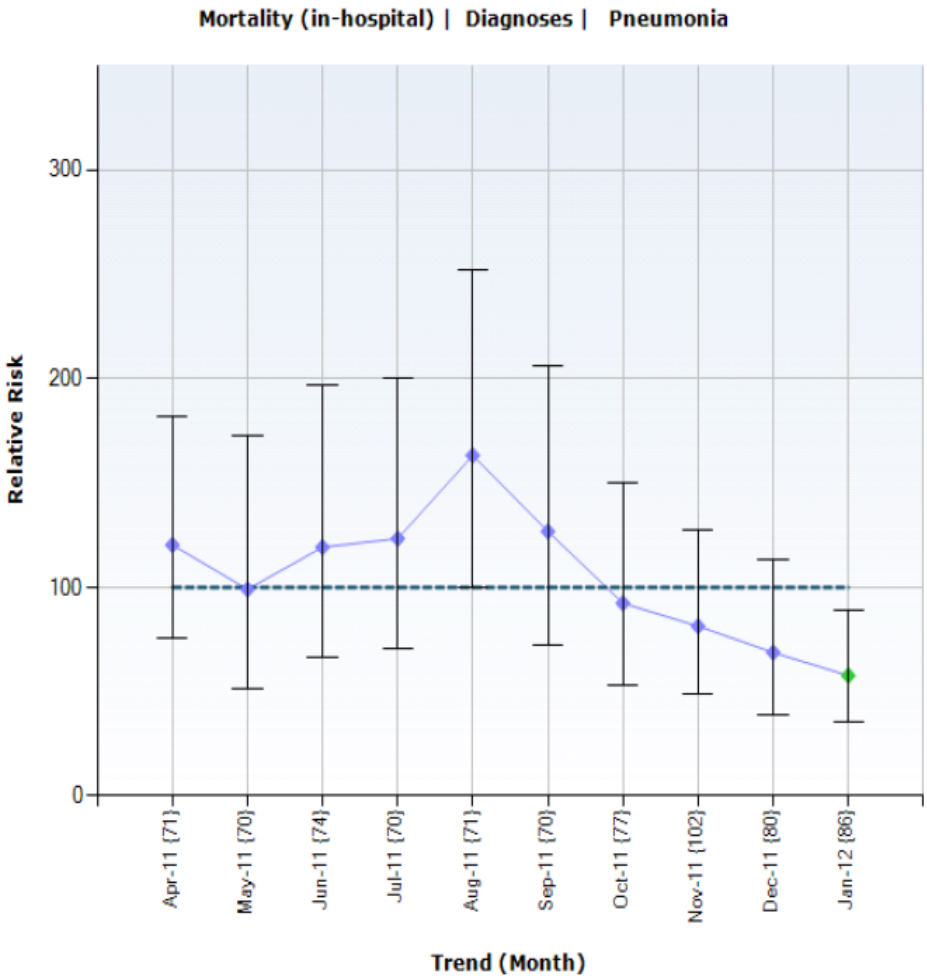
Meanwhile the latest data for Dr Foster again shows an overall improvement for this year with the SMR falling from 118 for 2010/11 to **96** for the period April 2011- January 2012 (no longer significantly different from other Trusts.

The SMR for January was **58** with 20 deaths compared to an expected number of 34.

It is of note that for the month of January in 2011 the SMR was 167 and in that month we had 37 deaths compared to an expected number of 22.

The rigorous approach to the coding of pneumonia combined with changes in clinical care are likely to be responsible for this change as the crude death rate for the 3 month period ending January 2012 was 20% compared to 24.5% in the same period the previous year.

Pneumonia SMR January 2011- January 2012



3. Cardiac diseases: -

Mortality from congestive heart failure is now as expected with an SMR of **98** (38 deaths, 39 expected). Ongoing work to ensure that clinical coders access the clinical teams should reduce errors of coding in this area. Mortality from **acute myocardial infarction** is currently as expected with a SMR of 101.

4. Hip fracture: -

Currently the improved performance for this group of patients has been sustained and the SMR for 2011/12 is **89,** which represent 26 deaths versus 29 expected from 374 spells. The volumes have increased around 20% in the last year.

This represents an improving position from the same period ending in January 2011 where the SMR for this group of patients was **163.** This maintains the improvement reported last month and this remains therefore the best performance recorded since 2003. The multidisciplinary audit of all deaths following admission with hip fracture continues to ensure that this improvement focus is maintained.

5. Specialist services: - Stroke and Renal Failure

The Stroke team continues to review all deaths to confirm coding accuracy and review standards of care. The SMR for 2011/12 is currently **98** with 110 deaths whereas 112 were expected.

The Renal team have met to look at the case note of the patients who died of renal failure. This meeting was set up to understand the SMR in patients with acute and unspecified renal failure which is high at **118** for 2011/12.

The indications are that one of the reasons may relate to the transfer of patients from other hospitals for treatment of acute renal failure. A significant number of these are recorded as elective admissions. This may reflect the fact that there is a service for acute renal failure at NGH but not at surrounding hospitals and admission may be arranged as an inter-hospital transfer, which is erroneously recorded as an elective admission. It is clear in this group that it is sometimes difficult to attribute the primary diagnosis in patients who are admitted with renal failure. Further work to clarify the issue and focus on accurate recording of information with the help of Dr Foster is in progress. The position appears to be improving with a SMR of 87 for January 2012.

6. Septicaemia

The mortality from Septicaemia has continued to be below average with a SMR of **62** and relatively high volumes of patients. This represents 15 deaths versus 24 expected. The work in this area will continue to ensure that this is maintained such that serious sepsis is recognised as quickly as possible and treated promptly.

6. Information and Coding Issues

A process has been set up to confirm that coding changes recommended from clinical reviews and audits are uploaded onto SUS. These changes are reported back to the mortality/coding review meeting held monthly with clinical and managerial staff and although there has been an improvement in clinical engagement with the process, there is still room for improvement in terms of engagement of directorate managers and finance advisors. This is essential in order to clarify information processes that feed into coding.The coding department is still without a substantive coding manager. Further meetings have been set up with the Information Technology Department to ensure that electronic information transfer systems can be streamlined. The results of the case note review highlight the need to ensure best use of electronic information systems at discharge and death.

Further Comments and Actions Planned: -

Further improvements in HSMR have been made in 2011/12 and have been sustained in the last month of available data. SHMI data is not available for the most recent period.

As it becomes increasingly clear that pressures on emergency care are dominating operational and quality discussions, it has now been recognised that the focus of transformation should be to address the key quality and safety issues by working towards a system where bed occupancy is reduced and the basic systems and processes ensure that high quality safe care can be delivered first time, every time.

The planned re-design of the emergency pathway will need to work alongside a refreshed and strengthened safety strategy led by the Executive Team in partnership with clinical leadership drawn from the organisation.

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. Strong clinical leadership will be essential and there are indications that clinical engagement with improvement work is increasing.

The Trust Board is asked to note and debate the contents of this report and to recognise both the improvement to date and the substantial investment and robust monitoring that will be required to underpin the work that will be required to improve quality of care and patient safety in the context particularly of the re-design of the emergency pathway.

SECTION 2

MONTHLY UPDATE ON QUALITY SCORECARD- APRIL 2012

The monthly report reviews exceptions from a rolling quarter and focuses on corporate measures identified to track clinical outcomes, patient safety and patient experience. Where these are outside of expected performance a narrative is provided.

This report includes a comprehensive target/trajectory with a descriptor for the target priority i.e. local or national target for January – March 2012 inclusive.

The indicators in this scorecard will 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. The full scorecard is provided in **Appendix 2.**

Directorate specific scorecards are available quarterly within the Patient Safety, Clinical Quality and Governance Progress report, which continue to be scrutinised by the members of the Healthcare Governance Committee (HGC).

Performance is reported by exception, i.e. where performance is below standard (red), 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. Commentary and associated actions are provided against the identified non-compliant indicators.

Further work is required to ensure that all measures are relevant and timely to facilitate 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 145 indicators, 36 (18/18) are rated as either red or amber status. This report outlines the underperforming indicators and details the remedial action(s) being taken. There are 5 indicators that are rated as grey, this is because either baseline data is still to be agreed or information is not currently available.

Section	Red Rated	Amber Rated	Green Rated	N/A
CQUIN 2011-12	1	2	26	0
Clinical Outcomes	4	11	21	0
Patient Safety	7	2	32	0
Patient Experience	6	3	25	5
TOTAL	**18**	**18**	**104**	**5**

- **EXCEPTION REPORT AND PROGRESS FROM PREVIOUS QUARTER: -**

Patient Experience	A & E Quality Indicators (5 indicators)	↑	**A&E Clinical Indicators:** **Transit time target** The Trust has not achieved the 95% A&E transit time target for the quarter and is now below target YTD. Performance for the 3 months (Jan-Mar 2012) was: January 82.8%, February 86.5%, March 89.7% The Trust achieved the minimum standards for timeliness and patient experience, however the following standards continue not to be achieved: ***Total Time in the A&E Department*** *(Admitted) – 95th Percentile 4 hours (Target)(Jan – 08:38, Feb – 09.02, Mar- 7.58)* ***Time to Initial Assessment*** *– 95th Percentile 15 minutes (Target)* *(Jan – 01:01, Feb – 00:59, Mar-00:47).* ***Longest Wait*** *– 6 hours both Admitted and Non Admitted Patients (Target)* *(Feb – 18:54 – Admitted Patient)(Jan – 18:05 – Non Admitted)(Mar – 17:10– Admitted Patient)* 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.
CQUIN 2011-12 **Target 12%**	Caesarean Section Rates	**14.3%** ↑	Caesarean section rate previously focused on total elective C-sections. This year's CQUIN target of 12% is an annual reduction of 1.5% from baseline for elective C-sections. There has been some decrease in the number of C-Sections acknowledged in Quarter 3 **16.3%** to Q4 **14.3%.** This can be attributed to the VBAC Clinics and revised new ways of working which forms part of a comprehensive obstetric action plan. The new target will demand continual audit against NICE guidelines

Patient Safety **Target 13**	Incidence of Pressure Ulcers	**5** ↓	The target set a one of the quality priorities for 2011-12 was a 20% reduction against 2010-11 out turn for Type 3 and Type 4 pressure ulcers (13). There were 10 pressure ulcers graded as Type 3 or 4 from Jan – March 2012 inclusive in comparison to 5 in Q3. The total for year end is 22. An improvement project has been launched.
Patient Safety **Target 9**	Falls	**3** ↑	The target set as one of the quality priorities for 2011-12 was a 20% reduction against 2010-11 out turn for catastrophic and major/severe falls (9). There were 3 falls from Jan – March 2012 inclusive classified as major/severe in comparison to 7 falls in Q3
Clinical Outcome **Target <100%**	HSMR (mortality 30 days in hospital)	**95.4** ↑	HSMR for 2011-12 (data to end January 2012) continues to show improvement at **95.4%.** If rebased as per Dr Foster methodology this would be approximately **103** for the period from April 2011 – January 2012 which represents an improving position from that reported at year end (**116**). If current improvements are maintained NGH will no longer be a significant outlier compared to other Trusts. Further information is detailed in the body of the report.

Patient Safety **Target 80%**	Mandatory Training	**68.5%** ↑	**Mandatory Training** **Information is available to February 2012 and indicates a cumulative position of 68.5% YTD. The subject of Mandatory Training has been referred to HGC following concerns raised at CQEG** An increase in end of year attendance for mandatory training subjects has been acknowledged. If the increased attendance continues during the month of March 2012 the target could be achieved. The mandatory training leads are ensuring that there are spaces to accommodate the number of staff that are identified as requiring training. Action plans from the leads to address the subject shortfalls with initiatives such as: • Monthly mandatory cluster days • Subject leads emailing managers to clarify which staff • should attend • Departmental and/or ward specific training • Expansion of E-Learning for some subjects • A review of staff required to undertake some subjects by the subjects leads • Targeting staff groups where up-take of training has been poor • Using the mandatory training look up tool to identify directorates where take up in their subject is poor • Establishing 'Mandatory Training Update Days' for staff to Attend and complete their yearly and role specific identified Mandatory Training
Patient Safety	Ward Traceability Compliance Number of Un-fated Units (0)	**55** ↓	**Ward Traceability Compliance Number of Un-fated Units** There were 55 cases of un-fated units from Jan – March 2012 against a target of 0 which is an increase against Q3 (49). Ward and directorate managers are notified daily of un-fated units which allows immediate investigation and identifies training or performance issues. Poor documentation is the cause of all Presumed Transfused units. Although there have been no reported serious transfusion errors this problem must be resolved and electronic tracking measures should be considered

The Trust Board is asked to note the scorecard and the exception report and to challenge the key issues raised. The performance issues relating to A&E will form part of the performance report.

SECTION 3

DRAFT - QUALITY ACCOUNT ARTICULATION OF QUALITY PRIORITIES FOR 2012/13

Our quality priorities for 2012/13 have been developed through wide involvement and consultation allowing us to identify the 4 Quality Priorities to be taken forward during 2012/13. These were supported by the Trust Board at its March 2012 meeting.

This report has been provided by the Governance team with appropriate input and gives further information on those priorities. This ensures that the Board has a further opportunity to challenge and inform the final Quality Account which will come to the May 2012 meeting for approval.

The setting out of priorities for improvement is one of the most important components of the quality account and provides an opportunity to ensure that key strategic objectives and priorities for improvement are aligned.

The 4 Quality Priorities for 2012/13 are detailed below: -

Quality Priority 1: Re-designing the Emergency Pathway

NGH has been subject to increasing emergency pressures in recent years.

In order to improve this situation the Trust will need to continue to work with the Healthcare Economy to address the issues which relate to the numbers of patients who attend Accident and Emergency (A&E) and require admission and to the difficulty that staff encounter in finding suitable places of care for those patients who have received treatment but no longer need to be in an acute hospital.

Meanwhile there is a significant amount of work to be done within the Trust to improve urgent care. NGH staff are working harder than ever before, bed occupancy is higher than ever before, and despite best efforts escalation areas are needed for emergency patients.

As part of NGH's focus on quality this priority would involve re-designing emergency pathways to ensure that the systems and processes are in place to support staff to deliver quality care first time every time. This will require dedicated project support, clinical leadership and investment in key services in order to ensure that a sustainable quality focussed plan can be supported by the Trust.

Aim: -

To support a structured, clinically led re-design of emergency care processes and systems to ensure that we consistently provide quality care using best practice standards.

Targets for 2012/13

The targets for improvements for 2012/13 are shown in the table below:

	Targets for achievement by end of March 2013
Improved patient access to consultant advice, improved clarification of consultant accountability and improved planning of care.	**All patients have improved access to consultant advice 7 days per week. All patients and staff are aware of each individual treatment plan, the responsible consultant and the planned discharge date.**
Improved patient experience and care in the emergency department and throughout the patient journey.	**All emergency patients are treated according to the nationally set urgent care standards.**
Improved patient flow to reduce delay and improve clinical outcomes.	All emergency patients who need admission are able to access an appropriate bed within 3 hours and all patients who require a longer stay in hospital are able to be transferred to their specialty ward within 24 hours.
Reduction in bed occupancy to improve patient experience and reduce harm.	Reduce bed occupancy on all wards to 90-95%.

Measures/Areas of improvement that have been introduced in 2011/12

During this last year we have increased consultant presence in the emergency department and in acute specialties. This has resulted in: -

- An increase in the numbers of hours our consultant physicians are present in the hospital over weekends and in the evenings
- An increase in the numbers of consultant led rapid assessments that take place and the majority of our patients are seen by a consultant within 12 hours of admission.
- We have also increased the numbers of nurses that support our emergency department
- We have improved the physical environment in the emergency department and have committed to an investment in additional staff over the next 3 years

Despite these improvements there has been great difficulty in providing the quality of care that we would like and we have now committed to a targeted improvement plan to ensure that standards can be raised yet further to the level to which we aspire.

Measures/Areas of improvement planned for 2012/13

In order to deliver the targeted improvement plan and further enhance the work already begun the Trust will: -

- Set up a clinically led project team to build on the work already in place and use a project management approach to address the need to embed systems and processes that will allow the right care to be given first time every time
- Support front line clinical staff by implementing a standardised approach that ensures that it is easy to do the right thing and difficult to do the wrong thing. This will require the use of technology to facilitate documentation and measurement for improvement as well as

exploration of different models to support care such as physician's assistants to support doctors and release time for medical and nursing care

- Support the best use of evidence for new models of care, a communication strategy and linkage with the work on quality and safety. It will support rapid tests of change and staff engagement through communication and learning events and ensure a collaborative approach across the health care economy to ensure that primary care and social care understand and support the impact of this work.

How Progress will be Monitored and Measured

The Transformation Programme Management Office will oversee the detail of the project which will also report to all Trust Groups and Boards including the Trust Board and HMG.

Quality Priority 2: - Caring for Vulnerable Adults

As part of the Trust's ongoing focus on supporting Vulnerable Adults, this priority focuses on making improvements in the care of patients with Learning Disabilities or Dementia.

It builds on the achievements over the last year to include increasing the training and development of staff to support the care for this group of patients. For patients with Learning Disabilities this will focus on communication skills and for patients with Dementia this will focus on the assessment of the patient during the initial admission to hospital.

Aim: -

To improve the care given to people with Dementia or Learning Disabilities.

Targets for 2012/13

The key targets set to enable delivery of this priority during 2012/13 are as follows: -

- To deliver dementia training to include all staff who engage with and/or care for patients with dementia as per the dementia training strategy
- To deliver learning disability and awareness and communication training at induction, preceptorship and bespoke training as required
- To develop a care pathway for the management of people with dementia at NGH
- To improve the quality of patient care and experience of patients with dementia or Learning Disabilities at NGH
- To develop patient and carer information in an appropriate format for patients with dementia or learning disabilities
- To deliver the dementia CQUIN target.

Measures/Areas of improvement that have been introduced in 2011/12 include:

- Establishment of the Trust multi-disciplinary Dementia Care Action Committee who developed and delivered a comprehensive action plan including: -

  - Adoption of a butterfly logo as a means of identification of patients with dementia or memory problems

- Utilise a ‘butterfly magnet’ on the ward white boards in order that all staff are made aware that the patient may require additional support
- To raise awareness regarding the additional needs of patients with dementia, the committee developed a variety of resources all utilising the butterfly logo: -

    - Advice sheets for different staff groups (porters and domestics and hostesses) regarding engagement with patients with dementia
    - A Patient Profile, to be completed with carers and kept at the bedside to be utilised by all staff groups and volunteers
    - A ‘Remember Me’ awareness poster
    - Guidance regarding communication and ‘aim for the familiar’
    - Relative and carer information
    - A Dementia, Delirium and Depression (3D’s) resource folder

- Pictorial communication folders were purchased to aid communication with various groups of patients, including those with dementia
- Activity boxes were purchased containing a variety of suitable photographs and activities to aid engagement with the patients to be utilised by staff, volunteers and visitors
- ‘Memory Boxes’ were provided which relatives are encouraged to fill with items significant to the patient
- At the end of September, the ‘Butterfly Care’ was launched in the Trust and all wards were provided with the above information and resources. They were also provided with ‘Memory Boxes’ which relatives are encouraged to fill with items significant to the patient

- In order to ensure we have an informed and effective workforce regarding dementia care, an education strategy has been developed and since September 2011, 34 ward cascade trainers have been trained with the remit to be responsible for the training of all ward staff
- Development and launch of the hospital passport and core assessment tool for patients with learning disabilities
- Learning Disability Liaison Nurse post full time at NGH for support and advice
- Launch of the A/E Pathway for people with learning disabilities
- Development of ‘easy read’ leaflets for various radiology investigations
- Development of pain assessment tool for individuals with communication /cognitive impairment.

Measures planned for 2012/13 are as follows: -

- A ward audit of the success of the ‘Butterfly Care’ will be undertaken in April 2012 which will include a review of the current documentation and information introduced
- The Dementia Care Committee will develop a specific care pathway for patients with dementia. The pathway will be based on the model published in the Healthcare for London Dementia Services Guide. This gives clear guidance regarding actions to be taken at each step of the patient journey and will include comprehensive guidelines and procedures within one document and will deliver the national dementia CQUIN
- Following liaison with Women’s Royal Voluntary Services (WRVS) plans are in place to develop a befriending service for patients with dementia at NGH
- A representative from NGH will join the Northamptonshire Dementia Action Alliance chaired by the Alzheimer’s Society to ensure learning, good practice and experience with the wider Health Economy. The Trust will host a dementia event at NGH for staff, members and the public
- The dementia training strategy will be reviewed to include the delivery of training to different departments and staff groups

- To increase the use of pictorial signage (eg signage for toilets and bathrooms, pictorial menus) for use with patients with communication difficulties
- In respect of the increased incidence of dementia in people with Down's Syndrome which can also be prevalent at an earlier age, the LD Liaison nurse will be a member of the Dementia Care Action Committee
- Development of accessible information for a variety of treatment options
- Introduction of accessible appointment letters
- Development of surgical and medical pathways which identify reasonable adjustments to ensure equality of access for people with learning disabilities
- Investigate the potential to introduce an electronic flagging system identifying patients with a learning disability
- To involve and engage with people with learning disabilities and their carers to ensure that services are developed to meet their needs wherever possible
- Introduce a schedule of audits to assess the effectiveness of the resources and policies developed for LD patients
- NGH to be identified as a 'Keep Safe' location.

How progress will be monitored, measured and reported:

The Board and Healthcare Governance Committee will review progress quarterly through the Patient Safety, Clinical Quality and Governance Report. The Clinical Quality and Effectiveness Group will receive quarterly performance reports. The SOVA steering group will receive monthly reports on progress.

Quality Priority 3: - Patient Safety Programme

The Trust has supported a variety of safety initiatives in recent years. In order to ensure this achieves the maximum effect a programme of training and investment is needed to ensure that every member of staff understands their role in patient safety and works towards it every day. As part of this Quality Priority the Trust proposes to invest in a programme of development to support a team of Leaders for Safety who will form a 'Safety Academy' under the leadership and direction of the Medical Director and the Director of Nursing supported by the Safety Lead. The clinicians who form this academy will roll out projects and education to all staff groups and be responsible for delivering a high profile portfolio of key projects that link the operational delivery of services with the need to improve quality. Investment in quality in this way will improve clinical outcomes and reduce overall cost to the system and will ensure that staff can be confident that they are delivering the safest care that they can.

Aim: -

To reduce all avoidable harm and save every life we can. Our high level aim is to save 300 lives over the next 3 years and to reduce avoidable harm by 50% over this period.

Trends and Targets for 2012/13

The Trust is continually striving to improve the safety and effectiveness of patient care. Some of the improvements that are expected in 2012/13 are set out below: -

	Targets for achievement by end of March 2013
A Safety Strategy for Improvement and a Safety Programme Outline are approved by the Board to include the formation of a Safety Academy and a focus on education and learning is designed and sustained.	Safety Academy formed and in place with regular reporting.
A reduction in harm from failure to plan care so that all patients and staff have an improved understanding of the plan of care in place and appropriate actions are taken.	50 % improvement in measures relating to planning of care.
A reduction in harm resulting from failure to rescue so that every acutely ill or deteriorating patient is recognised immediately and all appropriate actions are taken.	50 % improvement in measures relating to failure to rescue.
A reduction in harm resulting from failure to deliver care so that every patient receives improved essential care.	50% improvement in the measures that relate to basic delivery of care.

Measures/Areas of Improvement that have been introduced in 2011/12: -

In 2011/12 a variety of safety projects have been supported and progress has been made. These include: -

- Improved information for patients and staff visible in ward areas
- Improved information available to the Trust Board
- Involvement of all levels of staff in surveys to look at attitudes to safety
- Projects to improve care in high risk areas such as the treatment of pneumonia, fractured neck of femur and serious sepsis with a reduction in death rates in these areas
- Set up a variety of mechanisms to ensure that we are able to focus on continual improvement in systems and processes
- Reduction in serious infections such as MRSA and C-Difficile
- Reduced the infections that occur after operations
- Improvements in the approach to the prevention of blood clots
- Work with our most junior doctors as well as our senior consultant staff to reduce the death rate from serious sepsis using targeted education and novel approaches
- Developed a Patient Safety Board bringing together a variety of disciplines to present their improvement work and this is evolving into a meaningful and well supported forum.

Measures/Areas of Improvement Planned for 2012/13

We plan to appoint 5 clinical leads to take forward key areas for improvement. These individuals will help to support a Safety Academy co-ordinated by a Patient Safety Programme co-ordinator and supported by project leads to report to the Medical Director and Director of Nursing . They will be responsible for leading change and cascading training and development in the organisation so that there is a core of trained individuals who can support all staff to improve safe care. The 5 leads will be responsible for leading others to deliver projects to improve the planning of care, the care of the acutely ill or deteriorating patient, the delivery of essential care, learning from best practice and learning from errors. A detailed programme plan is in development and will track measures for improvement and test changes in cycles of development using recognised methods. A key feature will be the link of this programme of work with the re-design of the Emergency Pathway so that we can link effective care pathways to measures that ensure safe care. As a result of the combined effect of all the measures and projects we hope to save 300 lives over the next 3 years and reduce all avoidable harm to patients.

How progress will be monitored and measured

The Patient Safety Improvement Programme will report to all key Boards and Committees including the Trust Board, the Clinical Quality and Effectiveness Group and the Healthcare Governance Group.

The detailed progress of the work will be monitored through the Transformation Programme Management Office to ensure that improvements in quality and safety are linked to all transformation projects throughout the Trust.

Quality Priority 4: - Patient Experience

The Trust is committed to improving the Patient Experience across the organisation. This year the focus will be on implementing a number of Patient Experience initiatives as part of NGH's Patient Experience Strategy. Fundamental to that starting point is having a tool that will enable us to monitor and measure our progress.

NGH plans to implement a headline metric for monitoring real-time patient experience, which is a single question known as the Friends and Family test (previously known as the net promoter score), which asks simply; "How likely is it that you would recommend this service to a friend or family member?" This question will be standard across the Region and patients will be asked to respond to one of six standard responses on the day that they are being discharged.

Aim: -

The Trust will achieve a 10 point improvement on the Friends and Family Test, using April 2012 as the benchmark, by the end of March 2013.

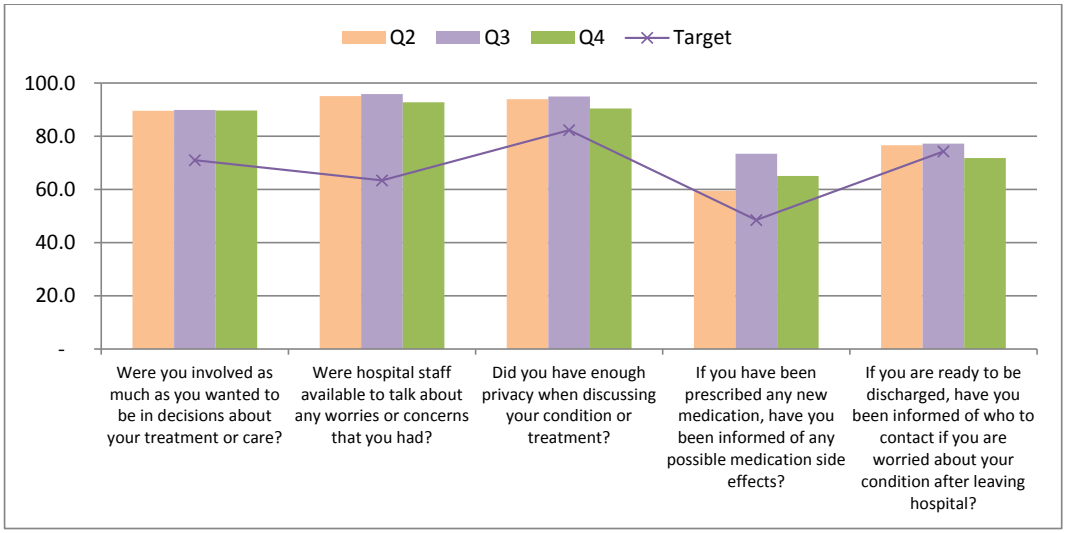
Targets for 2012/13

During the pilot phase (of 3 weeks) the Trust achieved a score of 8.87, which although regarded as being 'good' identifies that there is need for improvement. During the month of April 2012 the Trust will be collating the first reportable data on the Friends and Family test. The first month will be used as a baseline and the Trust will set a target to improve April's score by at least 10 points during the 2012/13 period.

Measures that have been introduced in 2011/12

CQUIN – Patient Experience

Through 2011/12 data for this CQUIN was collected using the Patient Experience Tracker devices. This indicator is calculated from 5 survey questions each describing a different element of the patients' experience. These questions and the Trust's performance are detailed in the graph below: -

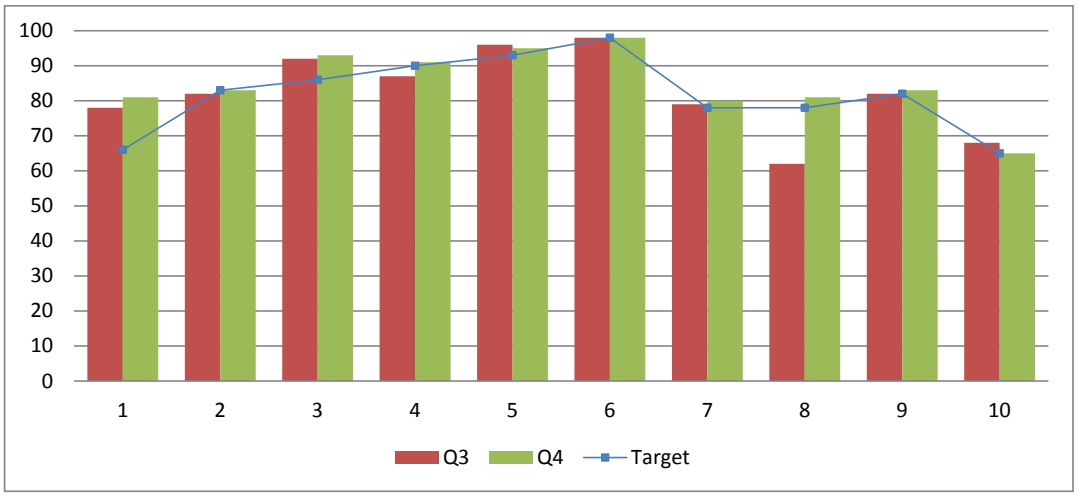


The Trust has performed well against all of the indicators during the year; however, has fallen slightly below target during this quarter on advising patients who to contact if they are worried about their condition after leaving hospital. This is being picked up as a part of the quality priority planning for 2012/13.

National Inpatient Survey 2010

The Trust has been collecting patient experience data in 10 areas identified as 'underperforming' in the National Inpatient Survey 2010, since October 2011. These areas included noise at night, sharing sleeping areas with the opposite sex and getting enough help with eating meals.

The Trust is demonstrating improvement in all areas and, as at the end of Quarter 4, is either on or above the target. The latest performance figures can be seen in the chart below: -



The labels 1-10 on the x axis are the questions as detailed in the table below: -

Q1	After you used the call button, how long did it usually take before you got help?
Q2	As far as you know, did doctors wash or clean their hands between touching patients?
Q3	Did nurses talk in front of you as if you weren't there?
Q4	Did the doctors talk in front of you as if you weren't there?
Q5	Did you ever share a sleeping area with patients of the opposite sex?
Q6	Did you feel threatened during your stay in hospital by other patients or visitors?
Q7	Did you get enough help from staff to eat your meals?
Q8	In your opinion, were there enough nurses on duty to care for you in hospital?
Q9	Were you ever bothered by noise at night from hospital staff?
Q10	Were you ever bothered by noise at night from other patients?

Measures planned for 2012/13 to achieve the patient experience are as follows: -

In order to achieve the patient experience aim, the following priorities have been identified: -

1. Introduce and implement the concept of co-production in the management of long term conditions
2. Increase community participation by refocusing the Patient and Public Involvement (PPI) group to ensure greater involvement in future planning and reconfiguration of services
3. Demonstrate reporting of patient experience to the Board monthly (including the Friends and Family Test score and real time monitoring of patient experience) and clearly demonstrate board challenge and actions relating to improvement
4. Engaging staff in co-production – develop a set of service standards and behaviours as the foundation for delivering excellent services.

How progress will be monitored and measured

Assurance reports will be received by the Board through the Patient Safety, Clinical Effectiveness and Patient Experience Report on a quarterly basis, this report will focus on Care Group and organisational measures. In addition, the Board will receive quality reports from the Medical Director and the Director of Patient and Nursing Services on a monthly basis relating to quality issues within their respective portfolios (this will include reporting on the Friends and Family Test).

The Trust Board is asked to read the proposals with regard to the quality priorities and to debate any issues relating to clarity of purpose or significant omissions. As this is a public facing document and needs to be written for a variety of audiences the language and structure of the final report will need to be revised to ensure a consistent structure and language that is appropriate whilst not diluting the content.

Further comments should be provided to the Governance Team who are also preparing the parts of the account as set out in the legislation. Further input from Board members regarding services that they would like to include as showcase examples are invited.

Dr Sonia Swart – Medical Director

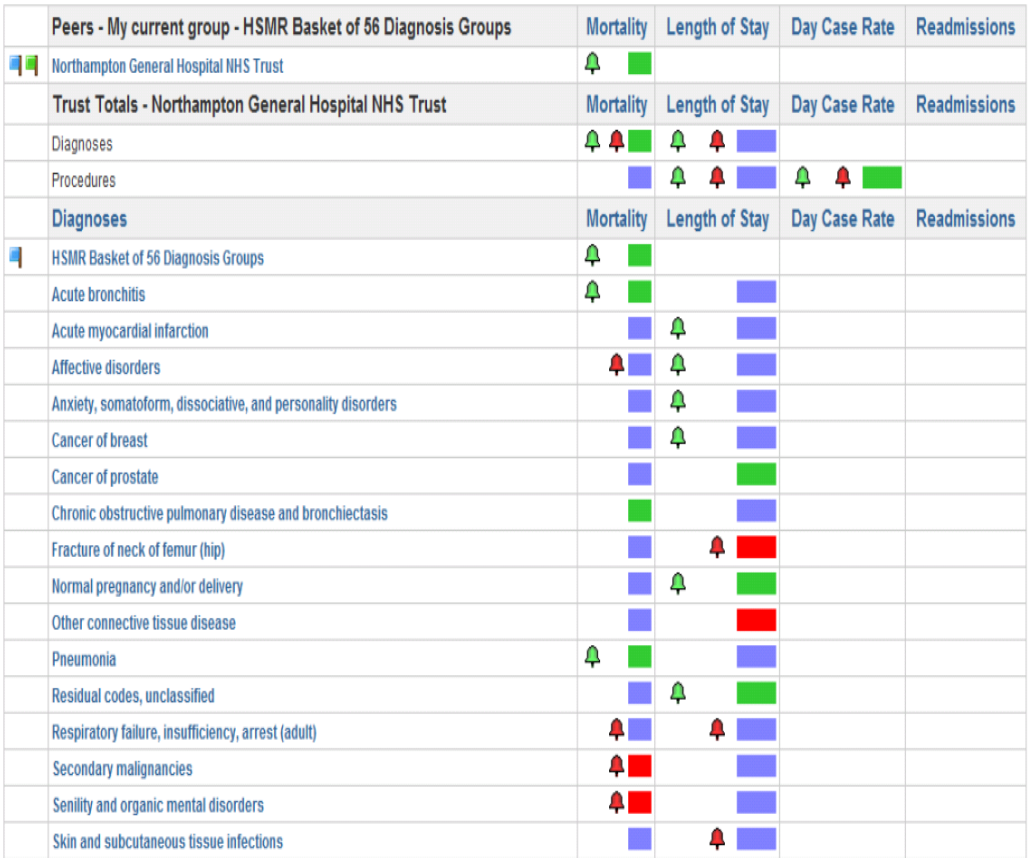
April 2012

Appendices

Appendix 1 – Dr Foster Dashboard

Appendix 2 - Clinical Quality Scorecard

Appendix 1 Dr Foster Dashboard November 2011 - January 2012



Peers - My current group - HSMR Basket of 56 Diagnosis Groups	Mortality	Length of Stay	Day Case Rate	Readmissions
Northampton General Hospital NHS Trust				
Trust Totals - Northampton General Hospital NHS Trust	**Mortality**	**Length of Stay**	**Day Case Rate**	**Readmissions**
Diagnoses				
Procedures				
Diagnoses	**Mortality**	**Length of Stay**	**Day Case Rate**	**Readmissions**
HSMR Basket of 56 Diagnosis Groups				
Acute bronchitis				
Acute myocardial infarction				
Affective disorders				
Anxiety, somatoform, dissociative, and personality disorders				
Cancer of breast				
Cancer of prostate				
Chronic obstructive pulmonary disease and bronchiectasis				
Fracture of neck of femur (hip)				
Normal pregnancy and/or delivery				
Other connective tissue disease				
Pneumonia				
Residual codes, unclassified				
Respiratory failure, insufficiency, arrest (adult)				
Secondary malignancies				
Senility and organic mental disorders				
Skin and subcutaneous tissue infections				

Red Bell	**Negative Threshold triggered in CUSUM**
Green Bell	**Positive Threshold triggered in CUSUM**
Red Square	**Significantly worse than benchmark**
Green Square	**Significantly better than benchmark**
Blue Square	**No significant variation from benchmark**
White Square	**No alert, no data or not monitored**

APPENDIX 2 – Clinical Quality Scorecard

Corporate Scorecard 2011-12																	
Patient Safety	Priority	*Target / Trajectory*	Apr-11	May-11	Jun-11	Q1	Jul-11	Aug-11	Sep-11	Q2	Oct-11	Nov-11	Dec-11	Q3	Jan-12	Feb-12	Mar-12	Q4
HQU01: HCAI measure (MRSA)	National	*3*	1	0	0		0	0	0		0	1	0		0	0	0	
HQU02: HCAI measure (CDI)	National	*54*	6	2	3		5	1	7		6	5	4		9	1	2	
HQU08: MMSA Numbers	Local	*No Target*	1	0	1		2	1	0		0	0	0		0	0	0	
E Coli ESBL Quarterly Average	National	*<17 Per Qtr*	3	5	3		2	1	2		3	1	1		3	1	4	
MRSA Screening Elective Patients	Local	*100%*	98.9%	98.9%	99.9%		99.6%	99.4%	99.9%		99.4%	99.6%	99.5%		99.9%	99.1%	99.9%	
MRSA Screening Non-Elective Patients	Local	*95%*	94.9%	96.0%	95.4%		98.3%	98.6%	95.7%		97.3%	97.0%	96.8%		97.3%	96.2%	91.1%	
Ward Traceability Compliance Number of Unfated Units	Local	*0*	24	25	28		27	20	32		20	13	16		24	14	17	
Incidence of pressure ulcers																		
Type 3	Local	*20% reduction vs 2010-11*	2	0	0		2	1	1		1	3	0		0	2	3	
Type 4	Local	*(Target 13)*	0	0	1		0	0	0		1	0	0		2	3	0	
Rate per 1,000 Bed Days (All Grades)	Local	*1.31*	1.37	1.26	0.98		1.07	0.93	1.34		1.34	1.08	-		0.45	0.63	0.60	
Reduce harm from falls	Local																	
Catastrophic	Local	*20% reduction vs 2010-11*	0	0	0		0	0	0		0	0	0		0	0	0	
Major/Severe	Local	*(Target 9)*	1	2	1		-	1	1		2	4	1		1	0	2	
Moderate	Local		-	4	1		3	4	5		6	2	2		1	2	3	
Mandatory Training compliance Fulll Year Impact																		
Primary Levels Excluding B&H	Local	*80%*	7.51%	14.50%	21.77%		27.74%	33.00%	38.76%		43.58%	49.15%	53.46%		61.21%	68.47%		
Attendance at Trust Induction	Local	*80%*	90.00%	81.00%	95.00%													
Number of surgical site infections																		
Frac neck of femur Number of Operations			Not reported Q1				Not reported Q2				29	33	29		32	19		
Infections	National	*1.90%*									0	0	0		0	1		
Long Bone Fracture (ORIF'S)			Not reported Q1				Not reported Q2				28	20	12		Not reported Q4			
Infections											0	0	0					
Large Bowel Surgery			Not reported Q1				Not reported Q2				Not reported Q3				22	20		
Infections															0	1		
Full implementation of patient safety alerts e.g. NPSA, CAS, Medical Device Alerts etc	National	*100%*																
Open Central Alert System (CAS) Alerts		*0%*	0	0	0		0	0	1		0	0	0		2	0	0	
Participation in National Audits on the Quality Account	National	*90%*	97.87%	97.87%	97.87%		97.87%	97.87%	95.74%		95.74%	93.62%	93.62%		91.49%			
NICE clinical practice guidelines and TAG compliance	National	*80%*			74%		74%	73%	82%		81%	77%	77%		81%	80%	81%	
Serious Untowards Incidents		*No Target*	2	4	5		4	3	5		5	6	5		15	12	14	
Never Events	National	*0*	0	0	0		0	0	0		1	0	0		0	0	0	
WHO Surgical Safety Checklist		*100%*	100%	100%	100%		100%	100%	100%		100%	100%	100%		100%	100%	100%	

Patient Experience		Target / Trajectory	Apr-11	May-11	Jun-11	Q1	Jul-11	Aug-11	Sep-11	Q2	Oct-11	Nov-11	Dec-11	Q3	Jan-12	Feb-12	Mar-12	Q4
HQU04: Patient Experience Survey																		
Grand Total	National	*86.8*		87.46	86.99		88.95	86.10	88.29		82.14	71.57	81.17		84.05	81.58		
Cancelled Operations not rebooked within 28 days	National	*0%*	0%	0%	0%		0%	0%	0%		0%	0%	0%		0%	0%	0%	
Hospital Cancelled Operations	Local	*6%*	5.1%	6.8%	6.0%		5.1%	7.3%	7.1%		5.5%	4.8%	6.2%		6.4%	6.4%	6.1%	
HQU16: Emergency Readmissions	National		PCT Reconcilliation awaited															
Number of written complaints received	National		37	42	49		48	42	39		51	44	29		39	48	49	
Complaints Responded to within agreed timescales	National	*100%*	100%	100%	100%		100%	100%	100%		100%	100%	100%		100%	100%		
HQU05-07: Referral to Treatment waits (95th percentile measures)	National																	
Admitted Patients																		
95th Percentile Target	National	*23Weeks*	17.64	17.51	17.56		17.71	17.82	17.83		17.70	17.82	17.88		17.85	17.93	18.60	
MedianTarget	National	*11.1Weeks*	7.20	7.81	7.77		7.03	8.94	8.63		7.80	7.28	8.68		7.60	7.35	10.00	
Non Admitted Patients																		
95th Percentile Target	National	*18.3Weeks*	12.52	13.45	13.31		14.06	13.59	14.53		14.31	14.90	12.83		14.11	14.66	15.10	
MedianTarget	National	*6.6Weeks*	3.97	5.34	5.11		5.22	5.19	5.90		5.36	5.04	4.67		5.66	4.40	4.60	
Ongoing Patients																		
95th Percentile Target	National	*28Weeks*	20.28	19.00	20.10		18.00	17.75	19.32		19.96	16.81	17.53		16.53	16.68	15.40	
MedianTarget	National	*7.2Weeks*	4.96	4.30	4.38		4.69	5.06	4.51		4.63	4.59	5.55		4.22	4.40	4.20	
HQU09-13: A&E Quality Indicators (5 measures)																		
Time Spent in A&E	National	*=<4 Hrs*	96.5%	96.4%	96.9%		95.3%	97.2%	95.1%		93.2%	91.3%	87.1%		82.8%	86.5%	89.7%	
Time Spent in A&E (Admitted)	National	*95th*	05:13	05:32	04:51		05:38	04:57	05:46		06:51	07:18	08:14		08:38	09:02	07:56	
Time Spent in A&E (Admitted)	National	*Longest*	09:21	13:32	11:52		11:02	12:03	13:52		19:40	18:08	17:54		18:28	18:54	17:10	
Time Spent in A&E (Non-Admitted)	National	*95th*	03:54	03:52	03:55		03:57	03:48	03:56		03:58	03:59	04:33		04:45	04:28	04:00	
Time Spent in A&E (Non-Admitted)	National	*Longest*	10:27	14:47	08:15		11:31	11:38	12:02		14:46	16:24	15:04		18:05	16:22	15:26	
Unplannned Reattendances	National	*>1% and <5%*	5.5%	3.7%	3.3%		3.7%	2.5%	3.1%		2.1%	2.7%	3.5%		2.8%	2.9%	3.7%	
Left Without Being Seen	National	*=<5%*	0.2%	0.3%	0.1%		0.1%	0.0%	0.1%		0.1%	0.2%	0.3%		0.4%	0.3%	0.3%	
Time To Initial Assesment For Patients Arriving By Ambulance Assess<20	National	*1*	82.0%	83.1%	86.3%		82.8%	90.8%	77.8%		75.1%	76.4%	80.8%		81.1%	82.3%	85.5%	
Time To Initial Assesment For Patients Arriving By Ambulance 95th percentile	National	*<15 mins*	00:49	00:48	00:37		00:50	00:31	01:05		01:16	01:01	01:06		01:01	00:59	00:47	
Time To Treatment Median	National	*<1hr*	00:56	00:52	00:58		00:55	00:39	00:44		00:55	00:46	00:46		00:42	00:40	00:51	
Time To Treatment 95th	National	*0*	03:04	02:56	03:05		03:09	02:39	02:47		02:54	02:43	03:00		03:01	02:39	02:51	
Cancer Wait Times																		
2 week GP referral to 1st outpatient	National	93.0%	97.6%	93.9%	96.1%		96.2%	95.1%	95.2%		94.6%	97.3%	97.5%		96.8%	96.4%	96.6%	
2 week GP referral to 1st outpatient - breast symptoms	National	93.0%	94.7%	82.8%	100.0%		100.0%	100.0%	100.0%		100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	
31 Day	National	96.0%	99.3%	98.7%	99.4%		98.7%	97.4%	99.4%		97.7%	98.2%	99.4%		99.4%	98.1%	99.3%	
31 day second or subsequent treatment - surgery	National	94.0%	100.0%	100.0%	100.0%		100.0%	92.0%	97.2%		95.5%	95.3%	100.0%		100.0%	100.0%	100.0%	
31 day second or subsequent treatment - drug	National	98.0%	98.3%	100.0%	100.0%		98.5%	100.0%	100.0%		100.0%	100.0%	98.5%		98.8%	100.0%	95.6%	
31 day second or subsequent treatment - radiotherapy	National	94.0%	99.0%	95.5%	96.0%		97.6%	96.5%	100.0%		99.0%	99.1%	97.2%		98.4%	100.0%	98.8%	
62 day referral to treatment from screening	National	90.0%	94.7%	100.0%	85.7%		82.4%	100.0%	100.0%		93.3%	100.0%	92.9%		100.0%	100.0%	100.0%	
62 day referral to treatment from hospital specialist	National	85.0%	92.9%	82.9%	86.4%		91.7%	94.7%	100.0%		94.4%	93.0%	97.7%		100.0%	100.0%	88.9%	
62 days urgent referral to treatment of all cancers	National	85.0%	90.4%	82.0%	86.5%		86.0%	79.4%	91.1%		79.6%	86.3%	89.9%		88.3%	86.0%	87.4%	
SRS08: Length of Stay (Acute & MH)																		
Elective	Local	*4.23*	4.09	4.07	3.84		3.55	4.93	6.06		5.61	4.35	5.40		4.54	4.25	3.37	
Non-Elective	Local	*6.34*	6.27	6.98	6.91		7.16	6.98	6.39		6.32	7.14	7.33		7.43	8.49	7.79	
Combined	Local	*5.33*	5.82	6.34	6.19		6.35	6.55	6.31		6.17	6.47	6.93		6.83	7.50	6.66	
SRS09: Daycase Rate	National	*81.50%*	84.7%	84.7%	83.8%		84.6%	85.6%	83.5%		84.9%	84.9%	82.8%		85.6%	84.8%	83.3%	
Day of Surgery Admission Rates (DOSA)	National				91.8%				91.7%				91.6%					
SQU11: PROMS Scores - Pre Operative participation rates																		
Groin Hernia - Participation Rate	National	*80%*										60.50%			Information awaited from HES			
Hip Replacement - Participation Rate	National	*80%*										81.21%						
Knee Replacement - Participation Rate	National	*80%*										90.91%						
Varicose Vein - Participation Rate	National	*80%*										47.54%						
All Procedures - Participation Rate	National	*80%*										75.88%						
(Please note PROMs Scores is national data from HES and reflects April 10 to March																		

Clinical Outcomes		Target / Trajectory	Apr-11	May-11	Jun-11	Q1	Jul-11	Aug-11	Sep-11	Q2	Oct-11	Nov-11	Dec-11	Q3	Jan-12	Feb-12	Mar-12	Q4
HSMR - cumulative Position from Apr 2011			112.80	100.70	101.00		103.60	103.10	99.3				96.7		95.4			
HSMR- Quart Position from Apr 2011					101.00				97.3				89.8					
SMR- cumlative Position from Apr 2011																		
Pneumonia	National	*<100*			125.00				120.0				106.5		95.7			
Fracture of neck of femur (hip)	National	*<100*			data problem				data problem				79.3		88.9			
Urinary Tract Infections	National	*<100*			78.00				96.0				94.2		88.5			
Acute Cerebrovascular disease	National	*<100*			103.00				91.0				96.0		97.1			
Aspiration pneumonitis, food/vomitus	National	*<100*			167.00				95.6				117.8		117.6			
Congest ve heart failure, nonhypertensive	National	*<100*			146.00				143.0				105.4		98.2			
Chronic obstructive pulmonary disease and bronchiectasis	National	*<100*			163.00				129.8				94.6		91.6			
Acute myocardial infarction	National	*<100*			133.00				124.6				107.6		101.2			
Billiary tract disease	National	*<100*			259 (not sig)				129.3				111.1		102.2			
Acute and unspecified renal failure	National	*<100*			130.00				142.8				131.8		118.4			
HSMR (Rolling 12 months Nov 10 to Oct 11)	National	*<100*																
Point of Delivery																		
Combined	National	*<100*	115	112.8	113.1		113.3	112.1	110.3		108.7	107.9	104.0		96.5			
Non-Elective	National	*<100*	115.6	113.4	113.5		113.4	112	110		108.5	107.9	104.0		98.1			
Elective	National	*<100*	95	95.1	98.1		105.8	105.8	105.8		94.3	92.9	90.8		98.4			
Diagnosis Group																		
Pneumonia	National	*<100*	127.5	128	128.8		130.3	133.3	134.7		130.9	113.2	107.8		106.8			
Chronic obstructive pulmonary disease and bronchiectasis	National	*<100*	117.9	116.3	120.2		135	132.1	132.1		131.4	77.1	69.7		95.2			
Urinary tract infections	National	*<100*	138.6	132.7	131.9		120.9	121	105.8		106.9	79.7	82.0		101.1			
Acute cerebrovascular disease	National	*<100*	119.2	116.2	112.1		111.7	106	102.8		101.9	86.7	82.2		99.3			
Fracture of neck of femur (hip)	National	*<100*	141.6	148.6	139.2		123.5	110.9	94.6		94.3	72.0	64.8		82.8			
Acute myocardial infarction	National	*<100*	121.5	125	125.1		127.2	127.4	128.7		136.2	79.2	69.7		91.2			
Congestive heart failure, nonhypertensive	National	*<100*	136.4	142.7	146.7		159.7	151.7	153.8		160.4	101.2	90.6		105.9			
SQU12: Maternity 12 weeks	National	*>90%*	85%	87%	88%		87%	86%	83%		83%	87%	81%		88%	87%	85%	
SRS10: Delayed Transfers of Care – Acute & MH	National	*3%*	1.6%	1.9%	1.5%		2.7%	2.7%	2.1%		2.0%	2.6%	1.8%		3.0%	2.5%	1.8%	
Fractured neck of Femur																		
Number of patients admitted with FNOF	TBC		29	27	23		23	28	42		38	37	36		42	21	32	
Patients fit for surgery within 48hrs	TBC		23	26	21		20	23	37		33	32	32		39	18	27	
Number of patients admitted with FNOF who were operated on within 48 hrs	TBC		13	23	17		19	22	32		29	27	32		36	16	26	
Percentage of patients admitted with FNOF operated on within 48 hours of admission	TBC	*100%*	57%	88%	81%		95%	96%	86%		88%	84%	100%		92%	89%	96%	
Cardiac Arrests (Numbers)	TBC		17	19	19		23	23	20		16	20	23					
Peri Arrests (Numbers)	Tbc		11	8	7		9	4	12		12	13	22					
Patients admitted as Emergency with GI Bleed scoped within 24 hours			44%	67%	90%		100%	84%	97%		94%	89%	67%		88%	82%	84%	
25% of suspected stroke patients given CT scan within 3 hours of arrival	Local	*25%*	83%	71%	84%		69%	83%	78%		77%	82%	92%		74%	81%	66%	
75% of suspected stroke patients given CT scan within 24 hours of arrival	Local	*75%*	98%	97%	100%		100%	100%	94%		100%	100%	100%		100%	100%	97%	
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	National	*65%*	80%	65%	85%		64%	62%	80%		69%	67%	78%		67%	77%	60%	
Patients who spend at least 90% of their time on a stroke unit	National	*80%*	80%	84%	88%		82%	81%	96%		92%	100%	88%		94%	89%	81%	
Breast Feeding initiation	National	*75%*	78%	75%	79%		79%	79%	79%		75.9%	77.0%	75.00%		73%	77%	74%	
Caesarean Section Rates - Total	National	*<25%*	24%	29%	28%		30%	29%	32%		30%	31%	29%		28%	30%	30%	
Caesarean Section Rates - Elective	National	*<10%*	13%	14%	13%		16%	16%	16%		17%	14%	13%		13%	13%	17%	
Home Birth Rate	Local	*<14%*	9%	8%	6%		7%	6%	6%		6.2%	7.0%	5.8%		8.2%	6.5%	7.6%	

CQUIN Schemes 2011-12		Target / Trajectory	Apr-11	May-11	Jun-11	Q1	Jul-11	Aug-11	Sep-11	Q2	Oct-11	Nov-11	Dec-11	Q3	Jan-12	Feb-12	Mar-12	Q4
SCHEME 1 Cancer	CQUIN																	
Improve appropriate assessment and Improve mortality rates	CQUIN																	
Percentage of Oncology patients deaths within 30 days of receiving chemotherapy	CQUIN		0.00%	0.00%	0.13%		0.43%	0.43%	0.74%		0.62%	0.56%	0.58%		0.50%	Information awaited from DFI		
Percentage of Haematology patients deaths within 30 days of receiving chemotherapy	CQUIN		0.42%	0.00%	0.00%		0.00%	0.00%	0.00%		0.00%	0.00%	0.00%		0.00%			
Performace Status Recorded	CQUIN	*Q.4 maintain current performance*	77%	89%	80%		90%	96%	90%		92%	91%	95%		97%	93%	97%	
Audit Size	CQUIN	*30 patients*	25%	19%	15%		13%	12%	16%		17%	39%	32%		38%	33%	35%	
Increase the number of patients receiving treatment via homecare	CQUIN	*Q.4 maintain current performance*	43%	38%	43%		41%	40%	29%		41%	33%	27%		10%	30%	31%	
Compliance with national cancer standards and best practice	CQUIN	*survey and aspects of national*	Audit completed in Q3 indicates the required improvemtn vs CQIN Target															
SCHEME 2 NEONATAL	CQUIN																	
Initial Parent Consultation with Senior medical Staff at admission to a neonatal units	CQUIN																	
Participation rate	CQUIN		0%	0%	0%		53%	72%	47%		60%	45%	42%		43%	45%		
Percentage Temperature taken within an hour of admission	CQUIN		0%	0%	0%		90%	80%	73%		88%	79%	78%		76%	Information awaited from Network		
Screening for cranial abnormality	CQUIN	*95%*	0%	0%	0%		100%	100%	100%		100%	100%	0		100%			
Screening rate for retinopathy of prematurity	CQUIN	*Q.4 maintain current performance*	0%	0%	0%		100%	100%	80%		100%	100%	0		100%			
SCHEME 8 Hepatitis C	CQUIN																	
To increase compliance with Hepatitis C	CQUIN	*Q.4 maintain current performance*																
To improve outcomes associated with Hepatitis C treatment	CQUIN																	
Non- Specialist																		
Reduce avoidable death, disability and chronic ill health from venous-thromboembolism	CQUIN	*90%*	91.6%	92.0%	92.3%		91.8%	90.0%	92.0%		93.1%	93.4%	94.8%		91.1%	92.9%	90.9%	
Improve responsiveness to personal needs of patients																		
Were you involved as much as you wanted to be in decisions about your care and	CQUIN	*7.10*															7.12	
Did you find someone on the hospital staff to talk to about your worries and fears?	CQUIN	*6.34*															6.20	
Were you given enough privacy when discussing your condition or treatment?	CQUIN	*8.23*															8.25	
Did a member of staff tell you about medication side effects to watch for when you went	CQUIN	*4.85*															4.80	
Did hospital staff tell you who to contact if you were worried about your condition or	CQUIN	*7.43*															7.66	
Normalising birth	CQUIN																	
Method of Delivery Description Rates	CQUIN	*Q4 <12%*	13%	14%	13%		16%	16%	16%		17%	14%	13%		13%	13%	17%	
Lifestyle																		
Is the smoking status recorded	CQUIN	*Q4 > 65%*							57%				69%				82%	
Number of smokers given brief advice	CQUIN	*Q4 > 65%*							97%				100%				100%	
End of Life	CQUIN																	
PPOC Documentation Rate > 90% @ Q4	CQUIN	*Q4 90% PPOC & 80% referral*															100%	
Referred to appropriate service	CQUIN																75%	
Ensuring effective Communication between Primary and Secondary Care	CQUIN	*Q4 75% discharged according to agreed protocol*																
Prescribing and Meds Management. Accuracy of medication on discharge	CQUIN	*Q4 70% of discharge letters without errror*															70%	
a) Interface prescribing Statins 2																		
Patients with a clear indication of ACS diagnosis	CQUIN	*Q4>86%*											86%					
Duration of treatment stated	CQUIN	*Q4>24%*											*24%*					
Step down treatment stated	CQUIN	*Q4>24%*											*24%*					
b) Interface prescribing Inhaled corticosteroids	CQUIN	*Q4 evidence that we are prescribing against agreed protocol*													Q4 evidence that we are prescribing against agreed protocol has been provided & accepted			
c) Interface prescribing Pregabalin and gabapentin	CQUIN	*Q4 evidence that we are prescribing against agreed protocol*																
d) Interface prescribing Exenatide and liraglutide (and other GLP-1 mimetics)	CQUIN	*Q4 evidence that we are prescribing against agreed protocol*																

Northampton General Hospital NHS
NHS Trust

TRUST BOARD SUMMARY SHEET	
Title: -	Performance Report
Submitted by: -	Christine Allen – Chief Operating Officer
Date of meeting: -	25th April 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 12 **(March 2012)**.

The Trust achieved all the minimum performance standards for March 2012, with the exception of the 4 hour transit time in A&E. The Trust achieved 90.66% against the standard of 95% of patients spending a maximum of 4 hours in A&E. The year end position is 92.87%.

PATIENT IMPACT: -

Patients waiting over the maximum waiting times

STAFF IMPACT: -

FINANCIAL IMPACT: -

N/A

RISK ASSESSMENT: -

N/A

EQUALITY & DIVERSITY IMPACT ASSESSMENT: -

N/A

RECOMMENDATION: -

Trust Board is asked to discuss the contents of this report and agree necessary action.

4

PERFORMANCE REPORT – APRIL 2012

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for **Month 12** (March 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 the score card)

2.1 March Performance

During March 2012, the Trust continued to achieve all the 18 week standards for median waits and the 95th percentile as well as continuing to meet the standard of 90% of all admitted and 95% of non-admitted patients treated within 18 weeks.

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

The Trust achieved all the Stroke standards of patients having a scan following a TIA within 24 hours and stroke patients spending at least 90% of their time on a stroke ward.

The Trust achieved all the cancer standards with the exception of 31 days from referral to treatment for subsequent treatments for drug therapy. The Trust achieved 97.4% against the standard of 98%. All cancer standards are monitored quarterly and the Trust has achieved all the cancer standards for quarter 4.

2.2 Year End Performance

As a result of continued progress throughout the year the Trust has successfully met the following performance standards for the year: -

- All 18 week standards
- All Stroke standards
- All quarterly Cancer standards
- All Diagnostics carried out within 6 weeks of request.

2.3 Urgent Care Standard Performance

The Trust achieved the minimum A&E standards grouped for timeliness and patient impact; however, did not achieve transit time of 95% of patients treated within 4 hours. During March 90.66% of patients were treated within 4 hours against the standard of 95%.The position has improved by 4.1% since February when the Trust achieved 86.52%.

In line with the actions included in the recovery plan there are early signs of improving performance, which continues in April. Progress against the recovery plan is monitored by the Trust, NHS Northamptonshire and the SHA.

The Trust has not achieved the year end standard for the number of patients treated within 4 hours. The Trust achieved 92.87% against the standard of 95%. As agreed by the Board, improvements in the Urgent Care Pathway are a priority for the Trust in order to manage the increase in activity and improve patient experience. Further updates will be provided to ensure the Board is fully aware of progress in this area.

3 RECOMMENDATIONS

Trust Board is asked to discuss the contents of this report and agree necessary action.

Appendix 1 SERVICE PERFORMANCE

Indicator	Monthly Target	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	YTD	Monthly Delivery	YTD Delivery
RTT waits (95th percentile measures)																
- *admitted 95th percentile*	23 Weeks	17.64	17.51	17.56	17.71	17.82	17.83	17.70	17.82	17.88	17.85	17.93	18.60	na		
- *non-admitted 95th percentile*	18.3 Weeks	12.52	13.45	13.31	14.06	13.59	14.53	14.31	14.90	12.83	14.11	14.66	15.10	na		
- *incomplete 95th percentile*	28 Weeks	20.28	19.00	20.10	18.00	17.75	19.32	19.96	16.81	17.53	16.53	16.68	15.44	na		
RTT (Median wait measures)																
- *admitted median wait time*	11.1 Weeks	7.20	7.81	7.77	7.03	8.94	8.63	7.80	7.28	8.68	7.60	7.35	10.00	na		
- *non-admitted median wait time*	6.6 Weeks	3.97	5.34	5.11	5.22	5.19	5.90	5.36	5.04	4.67	5.66	4.40	4.60	na		
- *Incomplete median wait time*	7.2 Weeks	4.96	4.30	4.38	4.69	5.06	4.51	4.63	4.59	5.55	4.22	4.40	4.17	na		
Percentage of Patients seen within 18 weeks across all speciality groups																
Admitted	90%	96.7%	97.5%	97.8%	96.7%	97.1%	96.3%	97.0%	96.4%	96.5%	96.5%	96.4%	95.8%	na		
Non-admitted	95%	98.1%	98.1%	98.1%	98.2%	98.4%	98.3%	98.4%	98.1%	98.5%	98.5%	98.6%	98.2%	na		
Audiology treatment	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	na		
A & E quality indicators																
- *unplanned re-attendance rate*	>1% and <5%	5.50%	3.70%	3.29%	3.74%	2.51%	3.14%	2.15%	2.73%	2.40%	2.78%	2.85%	3.67%	na		
- *total time spent in A & E (Admitted Patients)*	95th Percentile=<4 Hrs	05:13:00	05:32:00	04:51:00	05:38:42	04:57:57	05:46:00	06:51:42	07:18:33	08:14:09	08:38:18	09:02:30	07:56:03	na		
	Longest Wait =<6 Hrs	09:21:00	13:32:00	11:52:00	11:02:00	12:03:00	13:52:00	19:40:00	18:08:00	17:54:00	18:28:00	18:54:00	17:10:00	na		
- *total time spent in A & E (Non-Admitted Patients)*	95th Percentile=<4 Hrs	03:54:00	03:52:00	03:55:00	03:57:00	03:48:18	03:56:00	03:58:00	03:59:00	04:33:42	04:45:00	04:28:18	04:00:00	na		
	Longest Wait =<6 Hrs	10:27:00	14:47:00	08:15:00	11:31:00	11:38:00	12:02:00	14:46:00	16:24:00	15:04:00	18:05:00	16:22:00	15:26:00	na		
- *left department without being seen*	=<5%	0.18%	0.30%	0.13%	0.11%	0.05%	0.12%	0.12%	0.22%	0.30%	0.38%	0.35%	0.35%	na		
- *time to initial assessment (95th percentile < 15mins)*	=<15mins	00:49:00	00:48:00	00:37:00	00:50:00	00:31:00	01:05:00	01:16:00	01:01:27	01:06:00	01:01:00	00:59:00	00:47:00	na		
- *time to initial assessment (100% < 20mins)*	100%	81.99%	83.06%	86.26%	82.80%	90.83%	77.79%	75.10%	76.45%	80.76%	81.06%	82.35%	85.48%	na		
- *time to treatment in department (median)*	=<1 Hrs	00:56:00	00:52:00	00:58:00	00:55:00	00:39:00	00:44:00	00:55:00	00:46:00	00:46:00	00:42:00	00:40:00	00:51:00	na		
Number of diagnostic waits > 6 weeks	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		
Cancer Wait Times																
2 week GP referral to 1st outpatient	93%	97.60%	93.90%	96.10%	96.20%	95.10%	95.20%	94.60%	97.30%	97.50%	96.80%	96.40%	96.60%	96.10%		
2 week GP referral to 1st outpatient - breast symptoms	93%	94.70%	82.80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.10%		
31 Day	96%	99.30%	98.70%	99.40%	98.70%	97.40%	99.40%	97.70%	98.20%	100.00%	99.40%	98.10%	99.30%	98.80%		
31 day second or subsequent treatment - surgery	94%	100.00%	100.00%	100.00%	100.00%	92.00%	97.20%	95.50%	95.30%	100.00%	100.00%	100.00%	100.00%	98.21%		
31 day second or subsequent treatment - drug	98%	98.30%	100.00%	100.00%	98.50%	100.00%	100.00%	100.00%	100.00%	98.80%	98.90%	100.00%	97.40%	99.22%		
31 day second or subsequent treatment - radiotherapy	94%	99.00%	95.50%	96.00%	97.60%	96.50%	100.00%	99.00%	99.10%	97.90%	97.70%	100.00%	98.80%	98.07%		
62 day referral to treatment from screening	85%	94.70%	100.00%	85.70%	82.40%	100.00%	100.00%	93.30%	100.00%	93.30%	100.00%	100.00%	100.00%	96.80%		
62 day referral to treatment from hospital specialist	85%	92.90%	82.90%	86.40%	91.70%	94.70%	100.00%	94.40%	93.00%	100.00%	100.00%	100.00%	88.90%	94.01%		
62 days urgent referral to treatment of all cancers	85%	90.40%	82.00%	86.50%	86.00%	79.40%	91.10%	79.60%	86.30%	90.30%	88.30%	86.01%	87.40%	86.21%		
Stroke Indicators																
Proportion of people who have a TIA who are scanned and treated within 24 hours	60%	80.00%	65.22%	84.85%	64.29%	61.54%	80.00%	69.23%	66.67%	78.26%	66.67%	77.27%	60.00%	72.12%		
Proportion of people who spend at least 90% of their time on a stroke unit	80%	80.00%	83.64%	88.10%	82.26%	81.03%	96.15%	91.94%	91.30%	88.37%	94.34%	89.29%	81.48%	85.56%		

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title: -	Monthly Infection Prevention Performance Report
Submitted by: -	Suzie Loader, Director of Nursing
Prepared by: -	Pat Wadsworth, Lead Infection Prevention and Control Nurse
Date of meeting: -	25th April 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.

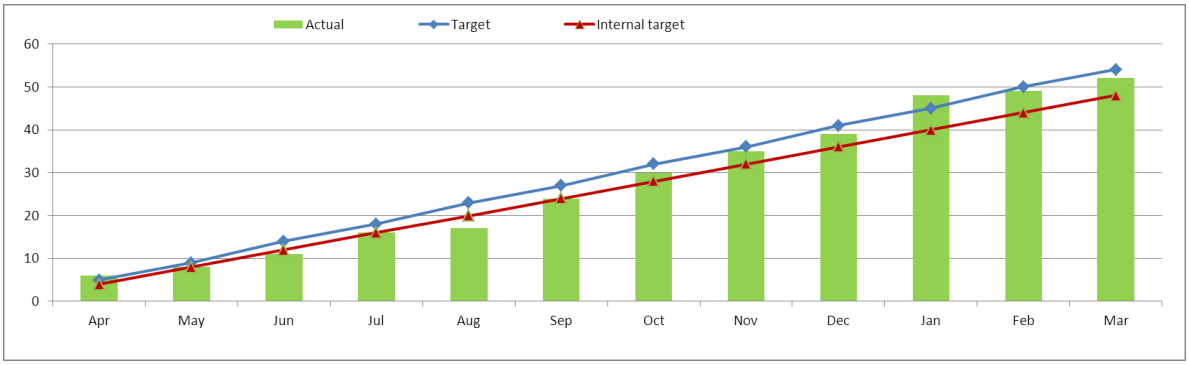
Introduction
The Board is aware of its duty to ensure appropriate infection prevention and control mechanisms are in place to promote patient safety and quality of care. This report provides the assurance required by the Board to satisfy its statutory requirements by providing an update as to the current situation in relation to Healthcare Associated Infections (HCAIs) within the Trust.

MRSA Bacteraemia (Appendix 1)
The Trusts trajectory for MRSA bacteraemia in 2011/12 is 3 cases. In March there were 0 >48hrs MRSA bacteraemia. The Trust is measured on the number of MRSA bacteraemia cases per 10,000 bed days. Last year the number of bed days was based on a fixed bed base of 575. This year the bed base will reflect the actual utilised bed base for the month which will vary from 575 that includes the community wards. The post-48 hour MRSA bacteraemia cases per 10,000 bed days year to date are 0.10. The Trusts trajectory for MRSA bacteraemia for 2012/13 is 1 case.

MRSA Colonisation (Appendix 2)
During March there were 16<48hrs and 6 >48hrs cases of MRSA colonisation. Internal patient verified data identifies 99.9% compliance for the screening of elective admissions during March. The compliance rate for emergency screening was 91% in March. This reduction has been shared with senior nursing and medical teams due to a recent change in admission documentation.

MSSA Bacteraemia (Meticillin Sensitive *Staphylococcus Aureus*)
During March there were 6 <48hrs and 2 >48hrs MSSA bacteraemia cases. Over the last year there has been a 50% reduction in post 48 hour MSSA from improved practice relating to central venous catheters in areas such as haematology, oncology and renal medicine.

Clostridium difficile (*C diff*, Appendix 3)
The Trust has a trajectory of 54 C. diff. cases with an internal stretch ceiling of 48 cases. During March the Trust identified 0<3 day and 3 >3 day cases of C. diff. which equates to a cumulative of 0.24 /1,000 bed day's year-to-date.



At the end of March the Trust had 50 cases of C. diff, with an additional case at Danetre and one at Isebrook. Therefore, an overall of 52 C. diff. cases, below our external trajectory. For the purposes of the HPA data capture system and subsequent information released to the public (data.gov.uk) the figure for the Trust remains at 50. Danetre and Isebrook are listed as PCT hospitals by the HPA and as separate units on the government website.

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

1. Surgical Site Surveillance of Fractured Neck of Femur Repairs

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

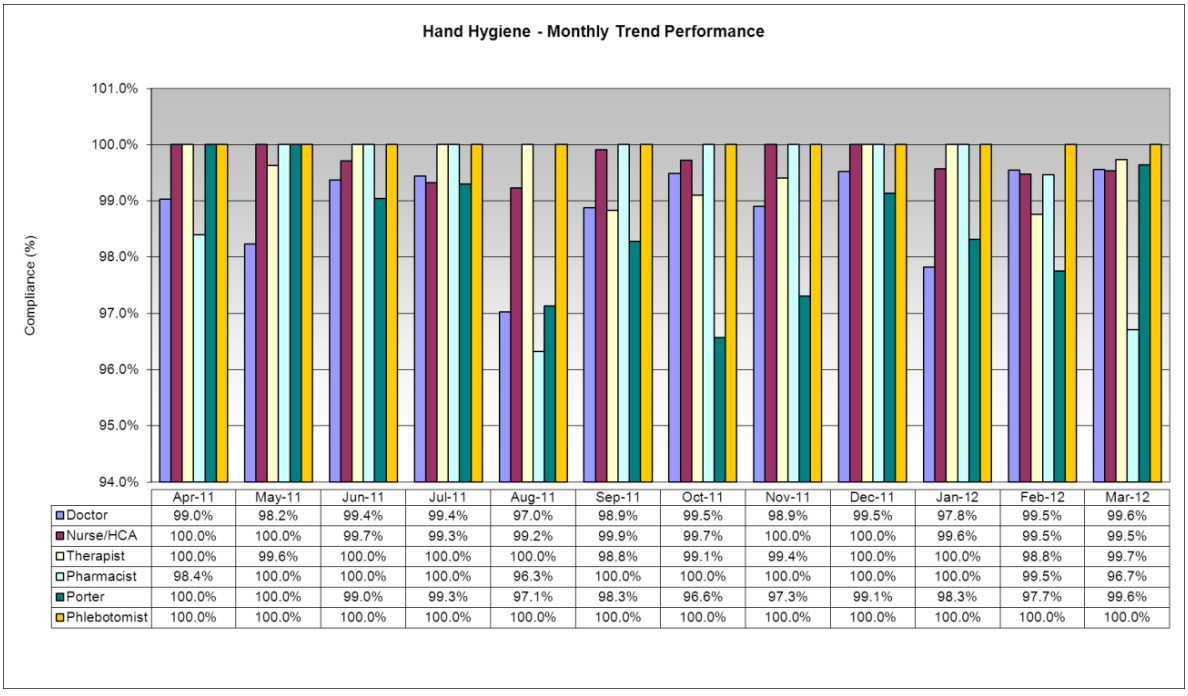
Although the HPA report will take some time to be generated, the interim results for March 2012 show that there were no infections resulting from 19 operations to repair #NOF's.

2. Surgical Site Surveillance of Large Bowel operation

Background
The national Surgical Site Infection Surveillance programme is auditing this category for quarter 4 (January to March).

Although the HPA report will take some time to be generated the interim results for March show that there were 24 operations undertaken resulting in no infections to date. These results are fed back to Clinical Quality and Effectiveness Group (CQEG) on a monthly basis.

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



	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Doctor	99.0%	98.2%	99.4%	99.4%	97.0%	98.9%	99.5%	98.9%	99.5%	97.8%	99.5%	99.6%
Nurse/HCA	100.0%	100.0%	99.7%	99.3%	99.2%	99.9%	99.7%	100.0%	100.0%	99.6%	99.5%	99.5%
Therapist	100.0%	99.6%	100.0%	100.0%	100.0%	98.8%	99.1%	99.4%	100.0%	100.0%	98.8%	99.7%
Pharmacist	98.4%	100.0%	100.0%	100.0%	96.3%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%	96.7%
Porter	100.0%	100.0%	99.0%	99.3%	97.1%	98.3%	96.6%	97.3%	99.1%	98.3%	97.7%	99.6%
Phlebotomist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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 2011-12
Ward	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	
Hawthorn																									0
Willow																1									1
Collingtree 23hr																									0
ITU		1																							1
HDU																									0
A & E	1																1								2
Abington																									0
Cedar																									0
Becket																									0
SingleHurst																									0
Knightley																									0
Gossett																									0
Disney																									0
Paddington																									0
Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer																									0
Sturtridge																									0
Allebone							1		1																2
Benham																									0
Creaton																									0
Dryden																									0
EAU																									0
Eleanor																									0
Victoria																									0
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 2011-12	1	1	0	0	0	0	1	0	1	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	6

Appendix 2
MRSA Colonisation Incidence by Ward

MRSA ISOLATES	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Trust Total 2011-12
Ward	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	
Hawthorn									1				1												2
Willow				1			2									3		1			1	1			9
Collingtree M																1		1							2
Collingtree S																					1				1
ITU	1								1				1				1								4
HDU																	1						2		1
A & E			1				1																		2
Abington		1	1	1						1											1				5
Cedar					1																1				2
Becket								1										1		1	1	3		2	7
SingleHurst																									0
Knightley						1			1		1												1	1	3
Gossett																									0
Disney																									0
Paddington	1		2										1				1		2				1		7
Balmoral										1						1								1	2
Robert Watson																									0
Sandringham																									0
Spencer	1																								1
Sturtridge																									0
Allebone	5		6		7		4		9		7		4		3		1		1		1				48
Benham																	2	1		1					4
Creaton		5				1	1			1				1					1	1					11
Dryden						1			2						1		1								5
EAU	10		4		6	1	5		6		10		2		8		4		8		8		10	1	72
Eleanor						1			2	1	1						1			1		2	2		9
Victoria																									0
Head & Neck Ward														1	1		1		1		2				6
Hazelwood (Community)														1		1									2
Danetre (Community)														1											1
Corby (Community)																			1	1					2
Rowan	1		2				1																	1	4
Finedon		1											1						2						4
Compton						2																			2
Brampton						2								1		1									4
Holcot																									0
Althorp																									0
Talbot Butler	1						1														1	1			4
Trust Total 2011-12	20	7	16	2	14	9	15	1	22	4	19	0	10	5	13	7	13	4	16	5	17	7	16	6	226

Appendix 3 **Clostridium Difficile Incidence by Ward**

CDT	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Trust Total 2011 -12
Ward	<3 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		2						1				1	1												5
Willow							1			1		1			1					1					5
Collingtree M															1					1	1				3
Collingtree S																									0
ITU												1													1
HDU							1							1		1									3
A & E																									0
Abington								1				1													2
Cedar																1				1					2
Becket																					1				1
SingleHurst																				1					1
Knightley														1										1	1
Gossett																									0
Disney																									0
Paddington																									0
Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer			1			1																			2
Sturtridge																									0
Allebone			1								3		1			1				2		1			9
Benham		1										1		1		1		1			1				6
Creaton		1		1										1		1				1					5
Dryden																									0
EAU	2				1	1					3		1				1				1			1	10
Eleanor																									0
Victoria		1																							1
Head & Neck Ward																									0
Hazelwood (Community)								1																	1
Danetre (Community)														1											1
Corby (Community)																									0
Rowan		1												1				2							4
Finedon				1																					1
Compton								2																	2
Brampton																									0
Holcot												1								1					2
Althorp						1														1				1	2
Talbot Butler							1					1						1							3
Trust Total 2011-12	2	6	2	2	1	3	3	5	0	1	6	7	3	6	2	5	1	4	0	9	4	1	0	3	73

Finance Report

March (M12) FY 2011-12

1.0 Overview

Summary

- The I&E position for the period to March is a deficit of £1.916m.
- The normalised position after adjusting for impairments is a surplus of £1.538m.
- The Trust must then discount the benefit associated with donated asset income when it reports to the DH as this is excluded from the control surplus and breakeven duty. The impact is to reduce the Trust surplus by £1.0m resulting in a reported surplus of £506k for the year versus control surplus of £500k.
- CIP delivery is recorded at £18.9m for the year. This includes £4.9m of non-recurrent actions.
- Capital expenditure of £9m is recorded for the year, £1.45m below the capital resource limit in line with projections.
- The cash balance at the end of the year was £3.9m.
- The shadow Monitor FRR is a score of 3.

NORTHAMPTON GENERAL HOSPITAL NHS TRUST
Key Numbers at a Glance

I&E Position		£000's	
	Reported Position	(1,916)	Draft final accounts position.
	Normalised for Impairment	1,538	£1.9m deficit adjusted for impairment of £3.4m.
	Adjusted for Donated Asset benefit	506	Deduct £1.032m for donated asset benefit.
	FIMS Plan (Year to date)	500	£500k surplus plan for 2011-12.
	PCT SLA Income Variance	7,452	£7.4m (3.4%) above plan.
	Full Year I&E Forecast	200	M11 surplus agreed with SHA.
	Breakeven Duty	2.6%	Cumulative breakeven position as % turnover

EBITDA Performance		£000's	
	Trust	734FAV	£0.7m ahead of plan

Cost Improvement Schemes		£000's	
	Full Year delivery	18,993	£18.9m CIPs recorded for the year.
	Target	18,599	2011-12 Target including mitigations
	% Delivered	7.6%	CIPs delivered as a % of actual income

Capital		£000's	
	Year to date expenditure	9,085	Capital expenditure for period
	Committed as % of plan	83%	% of plan committed for year
	CRL underspend	1,458	CRL not exceeded in 11/12,

SoFP (movement in year)		£000's	
	Non-current assets	1,770	£1.7m increase in non-current assets
	Current assets	1,544	NHS debtors (NHSN)
	Current Liabilities	600	Deferred income & provisions

Cash		£000's	
	In month movement	2,540	Increase over February 12
	In Year movement	77	Increase over March 2011
	Debtors Balance > 30 days %	18.0%	Total outstanding over 30 days
	BPPC (by volume) YTD	89%	Target 95% paid in 30 days

KPIs			
	Financial Risk Rating (Shadow)	3	Overriding rules apply
	EBITDA	98.0%	EBITDA achieved 98% of plan
	Liquidity (days cover)	20.3	Incl. unused WCF of £18m
	Surplus Margin	0.2%	1% required for score of 3
	Pay / Income	64.2%	Pay 64% of Income for YTD

2.0 Summary

Key points to note

- The reported position is draft subject to external audit of final accounts.
- Provision for known liabilities as at balance sheet in redundancy costs of £0.6m.
- The SLA position reported is subject to a contract reconciliation process in Q1 2012-13.

The Trust has achieved the following statutory duties:

- Breakeven – the Trust has improved the break even performance with cumulative surplus now standing at 2.6% of turnover.
- EFL – The Trust has managed its cash resources within the prescribed External finance limit for the year.
- CRL – The Trust has not exceeded the Capital resource limit in 2011/12.
- Return on capital – The Trust has achieved a return on capital assets of 3.5%.

Better Payment Practice

- The Trust has not met the target to achieve 90% of invoices paid in time.

Finance Report

Appendices

Income

- £7.4m overperformance of Clinical SLA income (3.4%).
- Other clinical income £216k ahead of plan.
- Other income £7.2m ahead of plan largely due to transformation funding and donated asset income.

Expenditure

- Pay expenditure £2.4m above plan for the year.
- Non-Pay expenditure £6.6m above plan.

Capital Charges

- Depreciation £0.5m below plan.
- £27k interest received from short term investment of cash balances.

Normalising Items

- An impairment of fixed assets of £3.5m has been added back to the reported surplus deficit to arrive at the Trust surplus.
- The net value increase of £1m in relation to donated assets is discounted from the Trust position and is deducted to arrive at a reported surplus of £506k.

Appendix 1 I&E Position

I&E Summary	Plan 2011/12 £000's	Actual 2011/12 £000's	Variance to plan £000's
SLA Clinical Income	207,792	215,240	7,448 Fav
Other Clinical Income	2,581	2,797	216 Fav
Other Income	25,489	32,693	7,203 Fav
Total Income	**235,862**	**250,730**	**14,868 Fav**
Pay Costs	(158,622)	(161,020)	(2,398) Adv
Non-Pay Costs	(67,531)	(73,807)	(6,276) Adv
CIPs	6,617		(6,617) Adv
Reserves	(1,157)		1,157 Fav
Total Costs	**(220,692)**	**(234,826)**	**(14,135) Adv**
EBITDA	**15,170**	**15,904**	**734 Fav**
Depreciation	(10,550)	(10,063)	487 Fav
Amortisation	(10)	(10)	0 Fav
Impairment of Fixed Assets	0	(3,453)	(3,453) Adv
Net Interest	40	27	(13) Adv
Dividend	(4,150)	(4,320)	(170) Adv
Surplus / (Deficit)	**500**	**(1,916)**	**(2,416) Adv**
Normalised	**500**	**1,538**	**1,538 Fav**
Donated Asset Benefit		**(1,032)**	
I&E Control Surplus	**500**	**506**	**6 Fav**

SLA Income

- Continued Improvement in Daycase and Elective income now on plan combined. NEL income £8.9m above plan with a £0.4m impact of MRET.
- OPROCS £2.3m above plan for YTD.
- WIP £1.1m decrease since March 11.
- CQUIN accrued at 85% subject to agreement.

Analysis of Variance

- Analysis below shows the year to date price/volume variance for SLA income.
- Total volume variance amounts to £5.3m compared with price variance of £3.3m.

Provisions

- Readmissions accrued at £4.4m for YTD subject to ongoing validation process.
- New to follow up outpatient provision of £1m after review of exclusions per SLA contract.
- £1m accrual for non-payment for first £1m of over performance (NHSN only).

Variance	Volume	Price	Total
	£	£	£
DC	-875	327	(548) Adv
EL	-155	686	532 Fav
NEL	6,493	2,428	8,922 Fav
OPFA	-2,006	209	(1,797) Adv
OPFUP	-517	-64	(580) Adv
OPFASPNCL	153	15	168 Fav
OPFUPSPNCL	-307	-45	(352) Adv
OPPROC	2,562	-270	2,292 Fav

Appendix 2 SLA Income

POD	YTD Plan	YTD Actual	YTD Var
	£	£	£
DC	26,933	26,384	-548
EL	18,175	18,707	532
NEL	66,988	75,910	8,922
OPFA	12,851	11,054	-1,797
OPFUP	11,750	11,170	-580
OPFASPNCL	1,657	1,826	168
OPFUPSPNCL	2,568	2,216	-352
OPPROC	3,484	5,776	2,292
Excluded Medicines	9,580	10,536	957
A&E - PbR	6,469	7,636	1,167
TCS	7,182	7,270	88
Childrens Services	7,133	7,133	0
Critical Care & HDU	6,622	6,664	41
Pathology	5,296	5,532	235
Radiotherapy	4,225	4,273	48
Community Midwives	3,579	3,579	0
GPDA Radiology	1,955	2,423	468
Unbundled Chemotherap	2,171	2,292	121
Breast Screening	1,389	1,389	0
Ante-natal Pathology	1,213	969	-244
Excluded Devices	630	936	306
Limb Centre	887	897	10
Audiology	867	867	0
Cancer MDT Meetings	664	664	0
Rehab	0	477	477
Brachytherapy	312	361	49
Anti-Coagulation	334	334	0
Other Block	3,455	2,195	-1,261
MRET	-51	-456	-405
ARMD	898	1,063	165
Provisions	-4,756	-7,964	-3,208
CQUIN	2,920	2,581	-339
WIP	-22	-1,123	-1,101
CIPs	427	0	-427
Other / Readmissions	0	1,668	1,668
Grand Total	**207,789**	**215,240**	**7,452**

Appendix 3 Activity

SLA Activity

- Daycases 3% behind plan for the year.
- Elective activity 2% below plan.
- NEL 10% above plan.
- New and follow up Outpatients below plan
- OPROCS 77% above plan.
- A&E attendances 5% above plan.

Activity	Plan 2011-12	YTD Actual	YTD Plan	Var to plan	%
Daycase	41,403	40,207	41,403	-1,282	-3%
Elective Inpatients	7,140	7,091	7,140	-112	-2%
Non Elective	39,769	43,620	39,769	3,676	10%
Cons New Outpatients	79,025	66,719	79,025	-11,442	-16%
Cons Follow Up Outpatients	127,645	123,418	127,645	-4,676	-4%
NCL New Outpatient	22,351	24,409	22,351	1,915	9%
NCL Follow up Outpatients	72,562	63,886	72,562	-7,346	-11%
Outpatient Procedures	22,437	38,942	22,437	15,342	77%
A&E Attendances	78,596	82,167	78,596	3,571	5%

Non Current Assets

- Increase of £1.7m over the year due to net additions less depreciation.
- Revaluation exercise undertaken by DV gave rise to impairments of £3.5m at year end (excluded from Break Even Duty).

Current Assets

- £5.6m reduction in current assets in month due to payment for activity.
- Increase of £0.9m in NHS debtors (NHSN) and an increase of £77k in cash in year.

Current Liabilities

- Increase of £0.6m over the year.
- Reduction in NHS creditors of £1.4m.
- £280k increase in Trade creditors.
- Staff benefits accrual reduced by £811k since April (annual leave provision).

Reserves

- IFRS adjustment removing Donation reserve.
- £5.3m increase in revaluation reserve.

Appendix 4 Statement of Financial Position

	Balance at 31-Mar-11	Current Month Opening Balance	Current Month Closing Balance	Current Month Movement	Forecast end of year Closing Balance	Forecast end of year Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	133,605	133,605	133,605		133,605	
IN YEAR REVALUATIONS		575	1,167	592	1,167	1,167
IN YEAR MOVEMENTS		8,227	10,668	2,441	10,668	10,668
LESS DEPRECIATION		(9,193)	(10,065)	(872)	(10,065)	(10,065)
NET BOOK VALUE	**133,605**	**133,214**	**135,375**	**2,161**	**135,375**	**1,770**
CURRENT ASSETS						
INVENTORIES	4,555	4,786	4,723	(63)	4,723	168
RECEIVABLES						
NHS DEBTORS	4,812	12,149	5,742	(6,407)	5,742	930
OTHER TRADE DEBTORS	1,295	886	968	82	968	(327)
DEBTOR IMPAIRMENTS PROVISION	(166)	(166)	(149)	17	(149)	17
CAPITAL RECEIVABLES	118	96	31	(65)	31	(87)
NON NHS OTHER DEBTORS	345	256	19	(237)	19	(326)
COMPENSATION DEBTORS (RTA)	2,483	2,577	2,554	(23)	2,554	71
OTHER RECEIVABLES	817	464	550	86	550	(267)
IRRECOVERABLE PROVISION	(253)	(254)	(259)	(5)	(259)	(6)
PREPAYMENTS & ACCRUALS	686	1,029	1,980	951	1,980	1,294
	10,137	**17,037**	**11,436**	**(5,601)**	**11,436**	**1,299**
CASH	3,867	1,404	3,944	2,540	3,944	77
NET CURRENT ASSETS	**18,559**	**23,227**	**20,103**	**(3,124)**	**20,103**	**1,544**
CURRENT LIABILITIES						
NHS	4,177	3,976	2,758	1,218	2,758	1,419
TRADE CREDITORS REVENUE	3,528	5,048	3,808	1,240	3,808	(280)
TRADE CREDITORS FIXED ASSETS	2,401	1,578	2,759	(1,181)	2,759	(358)
TAX AND NI OWED	3,275	3,462	3,454	8	3,454	(179)
NHS PENSIONS AGENCY	1,831	1,790	1,784	6	1,784	47
OTHER CREDITORS	301	428	508	(80)	508	(207)
SHORT TERM LOANS	488	620	526	94	526	(38)
ACCRUALS AND DEFERRED INCOME	2,679	5,377	3,896	1,481	3,896	(1,217)
PDC DIVIDEND DUE		1,771		1,771		
STAFF BENEFITS ACCRUAL	1,440	900	629	271	629	811
PROVISIONS	354	102	978	(876)	978	(598)
PROVISIONS over 1 year	336	360	310	50	310	
NET CURRENT LIABILITIES	**20,810**	**25,412**	**21,410**	**4,002**	**21,410**	**(600)**
TOTAL NET ASSETS	**131,354**	**131,029**	**134,068**	**3,039**	**134,068**	**2,714**
FINANCED BY						
PDC CAPITAL	99,635	99,635	99,635		99,635	
REVALUATION RESERVE	28,738	30,734	34,046	3,312	34,046	5,308
DONATED ASSET RESERVE						
GENERAL RESERVES	2981	1,565	2,303	738	2,303	(678)
I & E CURRENT YEAR		(905)	(1,916)	(1,011)	(1,916)	(1,916)
FINANCING TOTAL	**131,354**	**131,029**	**134,068**	**3,039**	**134,068**	**2,714**

Appendix 5 Cashflow & EFL

MONTHLY CASHFLOW	Annual £000s	ACTUAL APR £000s	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	201,707	16,407	16,313	16,919	16,351	17,599	17,580	16,097	16,706	16,986	16,433	16,712	17,604
SLA Variable inc Over Performanc	10,331					287				2,439	1,100		6,505
SHA Payments (SIFT etc)	8,773	676	657	750	751	741	744	731	855	648	763	681	776
Other NHS Income	22,744	1,681	757	1,023	3,035	1,526	2,114	1,108	1,702	1,445	1,021	1,738	5,595
PP / Other (Specific > £250k)	1,857	368		290	294	305	276		324				
PP / Other	11,260	892	667	908	1,044	773	1,143	838	1,109	949	941	764	1,232
Salix Capital Loan	203									46	111	46	
EFL / PDC													
Temporary Borrowing													
Interest Receivable	27	2	2	2	4	2	4	1	3	3	2	2	1
TOTAL RECEIPTS	256,902	20,025	18,396	19,892	21,479	21,233	21,861	18,775	20,700	22,516	20,370	19,943	31,712
PAYMENTS													
Salaries and wages	156,833	12,677	12,787	13,068	12,882	13,073	13,108	13,136	13,200	13,179	13,146	13,301	13,277
Trade Creditors	64,124	5,132	4,534	6,045	4,092	4,869	6,010	4,362	3,736	5,179	6,733	4,506	8,925
NHS Creditors	21,374	1,423	2,187	991	2,792	784	1,329	1,432	1,660	1,767	1,648	1,891	3,470
Capital Expenditure	10,029	1,084	1,337	473	610	652	825	932	1,017	573	658	550	1,318
PDC Dividend	4,303						2,108						2,195
Repayment of Loans													
Repayment of Salix loan	165						70						95
TOTAL PAYMENTS	256,827	20,316	20,845	20,578	20,377	19,378	23,448	19,862	19,613	20,698	22,185	20,247	29,280
Actual month balance	75	-291	-2,449	-687	1,103	1,855	-1,587	-1,087	1,087	1,818	-1,814	-304	2,432
Balance brought forward	3,831	3,831	3,540	1,091	404	1,507	3,362	1,775	688	1,775	3,592	1,778	1,473
Balance carried forward	3,906	3,540	1,091	404	1,507	3,362	1,775	688	1,775	3,592	1,778	1,473	3,906

Notes to cashflow

- £3.9m cash balance achieves EFL statutory duty.
- £6.5m additional cash received in relation to SLA over performance with NHSN in March.

Appendix 6 Debtors

In month

- Increase of £0.8m in outstanding balances since April
- £603k (18%) over 90 days.

Problem Debtors

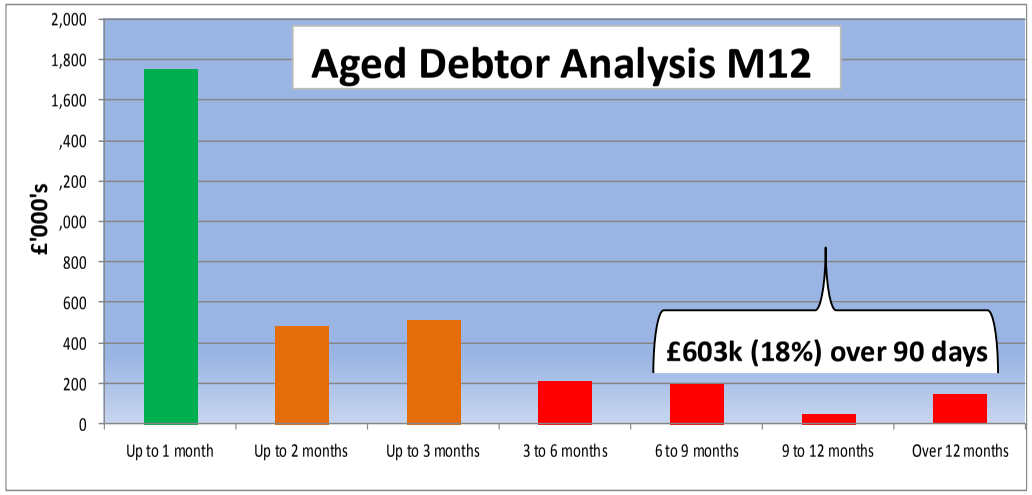
- CRIPPS
- KGH service level agreements resolved (March 12).

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

	Description	Value £	Date due:
Kettering General Hospital	Oncology Services	102,185.00	23/10/2011
Kettering General Hospital	Oncology Services	102,185.00	12/02/2012
Kettering General Hospital	Oncology Services	102,185.00	12/02/2012
Cripps Social Club	SLA 1.4.10 - 31.3.11	84,148.00	11/04/2011
Warwickshire pct	NCA Mth 9	38,240.00	27/02/2012
University Hospitals Leic	Qtr 3 Estates services etc	37,484.00	10/02/2012
Kettering General Hospital	Nuclear medicine rechagre	31,733.04	26/09/2011
Kettering General Hospital	Nuclear medicine rechagre	30,999.39	31/01/2011
Kettering General Hospital	Nuclear medicine rechagre	30,753.99	12/02/2012
Bedfordshire PCT	Chemotherapy medicines	23,431.55	12/02/2012

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

	Description	Value £	Date due:
Cripps Social Club	SLA 1.4.10 - 31.11.11	84,148.00	11/04/2011
University Hospitals Leic	Radiology recharge	21,355.00	16/04/2011
Kettering General Hospital	Dr Tan recharge	12,954.00	30/07/2011
NHS Northamptonshire	LAC Physical Health	11,514.00	19/08/2011
NHS Northamptonshire	Alcohol Liaison Nurse	18,005.64	29/08/2011
Kettering General Hospital	Oncology Services	102,185.00	23/10/2011
Kettering General Hospital	Nuclear Medicine recharge	31,733.04	26/10/2011
Kettering General Hospital	Nuclear Medicine recharge	3,099.39	30/11/2011
Kirklees PCT	NCA Episodes	15,152.00	17/12/2011
Bedford Hospitals	Equipment supplied	16,477.40	22/12/2011



Aged Debtors	01.04.10	June	September	December	March	YoY Change
	£'000	£'000	£'000	£'000	£'000	£'000
Up to 1 month	1,604	2,168	1,683	1,765	1,753	149
Up to 2 months	210	1,696	2,652	763	482	272
Up to 3 months	280	388	202	298	512	232
3 to 6 months	249	259	183	413	211	-38
6 to 9 months	50	140	194	104	197	147
9 to 12 months	12	24	26	136	49	37
Over 12 months	146	61	76	89	146	
Total	**2,551**	**4,736**	**5,016**	**3,568**	**3,350**	**799**

Appendix 7 Creditors

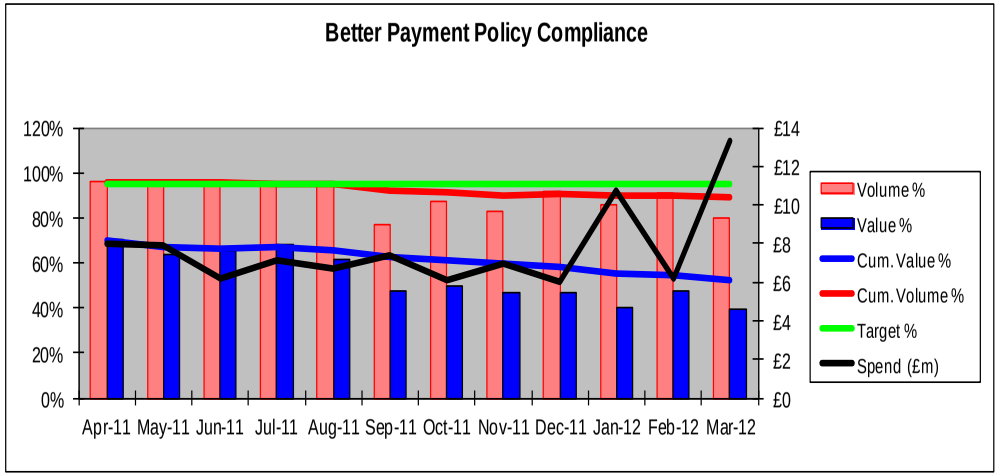
Balances

- Increase of £1.4m over March 11 balance.
- £6.5m > 90days.

BPPC Compliance (95% target)

- 5% below target compliance with 90% by volume.
- Low level of NHS compliance

	NHS			Non-NHS			Total		
	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%
Value £	2,016,483	15,853,739	13%	46,529,400	76,472,978	61%	48,545,883	92,326,717	53%
Volume	1,583	2,322	68%	54,424	60,734	90%	56,007	63,056	89%



Top 10 by age	Invoice Value £	Due Date
JOHN WEISS & SON LTD	132.00	29/09/2011
JOHN WEISS & SON LTD	144.00	06/10/2011
JOHN WEISS & SON LTD	72.00	30/11/2011
JOHN WEISS & SON LTD	78.00	25/12/2011
SOFTCAT LIMITED	195,119.08	06/01/2012
ALLIANCE HEALTHCARE (DISTRIBUTION) LTD	3.25	08/02/2012
JOHN WEISS & SON LTD	132.00	08/02/2012
JOHN WEISS & SON LTD	48.12	08/03/2012
MAWDSLEYS (MILTON KEYNES)	55.26	12/03/2012
AAH PHARMACEUTICALS LIMITED	153.70	12/03/2012

Top 10 by account	Account Balance £
NHS SUPPLY CHAIN	321,952.22
E7 CONTRACTING LTD	314,554.83
NHS SUPPLY CHAIN	247,206.39
SOFTCAT LIMITED	195,119.08
KETTERING GENERAL HOSPITAL NHS FOUNDATION TST	189,644.35
HEALTHCARE AT HOME LIMITED	183,139.71
GOODFELLOWS BUILDERS LIMITED	167,928.93
MOPEC EUROPE LIMITED	166,253.83
NOVARTIS PHARMACEUTICALS UK LIMITED	152,407.90
ROCHE PRODUCTS LIMITED	137,299.67

Notes to Capital Schemes

- Replacement Breast Screening mobile & trailer and static machine is second year of business case
- Emergency Care and Mortuary schemes - works commenced on site due for completion by June 2012
- Transformation Project approved digital dictation scheme, switchboard, E-fin / E-procurement update to date
- The Macmillan scheme works are completed , associated equipment is currently being finalised
- Medical Equipment was advanced from next years plan to manage slippage encountered
- A TCS transfer relating to assets at Danetre was included at £452k (was £473k - reduced for generator included in PFI) this had been included as a capital creditor since M1 and has now been treated as a prior year adjustment transfer in 2010/11
- Current EOY forecast is £10.668 million, i.e. underspend of £1.810 million
- Full year depreciation forecast is currently £10.063 million (was £10.060 million), following M10 review with external audit who agreed that we don't need to apply the building indexation in year as advised by the District Valuer if we are including the valuation as at April 2012 in the 2011/12 Trust accounts - this also includes what was previously donated element of £0.560 million

Appendix 8 Capital Expenditure

Category	Annual Budget 2011/12 £000's	Year to Date as at Month 12 Actual Spend £000's	Year to Date as at Month 12 Plan Achieved £000's
Breast Screening Business Case	535	495	93%
Emergency Care	879	744	85%
Transformation Project	406	383	94%
Mortuary Refurbishment	400	379	95%
Macmillan (Trust)	450	359	80%
Macmillan (Non Trust)	1,397	1,397	100%
MESC	1,154	1,441	125%
Estates	3,053	3,124	102%
IT	2,354	2,021	86%
Other	1,853	326	18%
Total - Capital Plan	**12,480**	**10,668**	**85%**
Less Charitable Funds	-1,583	-1,583	100%
Total - CRL	**10,897**	**9,085**	**83%**

Notes to FRR Score

- Aim to achieve minimum score of 3.
- Calculated score of 3 for March per forecast.
- EBITDA margin improved at 6.3%
- EBITDA achieved of 98% scores 4.
- ROA improved to 4.3%.
- Surplus margin score of 2 as less than 1%.
- Liquidity cover 20.3 days (includes WCF of £18m).

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 9 Shadow Monitor Financial Risk Rating

Financial Criteria	Metric	Weight %	Mar	Shadow Rating	YTD Score
Achievement of Plan	EBITDA Achieved (% of plan)	10%	98%	4	0.40
Underlying Performance	EBITDA Margin %	25%	6.3%	3	0.75
Financial Efficiency	Return on Assets	20%	4.37%	3	0.60
Financial Efficiency	I&E Surplus Margin	20%	0.2%	2	0.40
Liquidity	Liquidity Ratio (Days cover)	25%	20.31	3	0.75
Weighted Average		100%		Calculated Score	3
				Override	-
				Reported Score	3

	< 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

TRUST BOARD SUMMARY SHEET	
Title: -	HR REPORT
Submitted by: -	Chanelle Wilkinson, Director of HR
Date of Meeting: -	25th April 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 April 2012 which focuses on February 2012 and the following topics:-

- **Substantive Workforce Capacity**
  Substantive workforce capacity increased by 57.3 FTE from 3,811.11 to 3,868.54 which is below the plan (4,139.57) for the month. The % FTE of contracted workforce against budgeted establishment has increased by 1.38% to 93.45%
- **Temporary Workforce** (excluding Medical Staffing)
  Temporary Workforce Usage increased by 1.39% from 5.47% to 6.86% and remains above the planned temporary FTE target of 5%
- **Total Substantive Workforce plus Temporary Workforce** (excluding Medical Staffing)
  The total workforce % FTE against budgeted establishment FTE has increased by 2.95% to 100.34%
- **Calendar Days Lost to Sickness**
  The number of calendar days lost to sickness decreased by 57 from 6,374 to 6,317 in February 2012
- **Days Lost per Employee**
  The number of days lost per employee decreased by 0.03 from 1.41 to 1.38 in February 2012
- **Long Term Sickness Absence**
  Long term sickness absence increased by 0.06% in February 2012 to 1.90% and remains below the Trust target of 2%
- **Short Term Sickness Absence**
  Short term sickness absence has increased by 0.13% to 2.74% in February 2012 (Trust target 1.4%)
- **Staff Turnover**
  Staff turnover (leavers) has increased by 0.14% on the month to 8.02%, which is above the Trust target of 8%
- **Temporary Workforce Expenditure** (including Medical Staffing)
  The temporary workforce expenditure has increased by £54,393 from £1,039,113 to £1,093,506 = to 8.01% of the total workforce expenditure

- **Appraisals**
  The number of completed and booked appraisals has decreased by 1% in February 2012 to 85.0%
- **Mandatory Training**
  The Mandatory Training Activity Forecast shows an increase in training levels occurring in February 2012. We expect to achieve the desired minimum target of 75%.
- **Forecast & Risks**
  TDG has approved the case for improvements to the Trust roster management process and has agreed that a Rostering Partnership approach should be adopted within Medicine. Rostering in Partnership will improve the operational and strategic performance management of rosters including tighter controls over headroom management and use of overtime / bank / agency

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 the report.

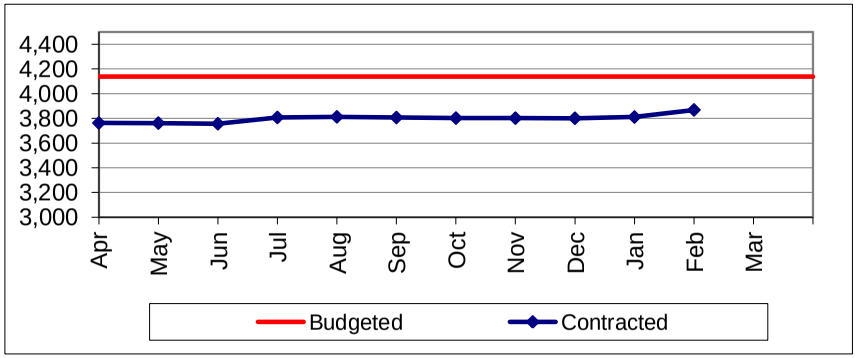
Workforce Capacity Summary M11

Target = 95%

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

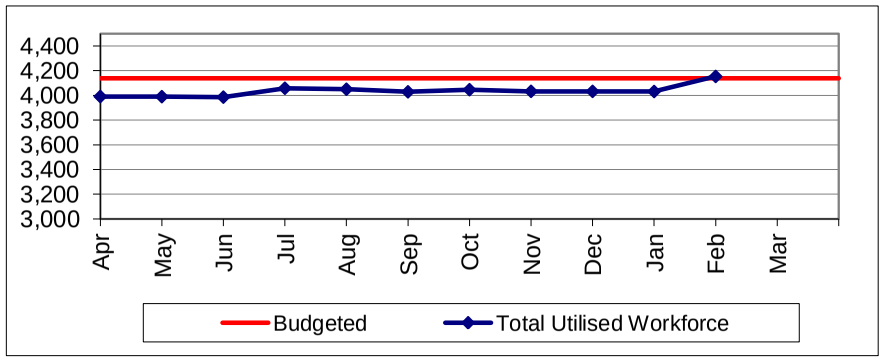
Substantive Workforce Capacity FTE

Directorate	Budgeted Establishment	M11 Contracted	Variance
Medicine	918.37	873.51	**-44.86**
Surgery	420.33	381.15	**-39.18**
Anaesthetics	172.80	157.96	**-14.84**
T&O	273.98	242.42	**-31.56**
Head & Neck	185.54	150.92	**-34.62**
Child Health	266.00	262.99	**-3.01**
Obs & Gynae	405.16	382.38	**-22.78**
Oncology	240.35	226.60	**-13.75**
Pathology	221.82	201.50	**-20.32**
Radiology	141.73	133.76	**-7.97**
Pharmacy	102.14	95.78	**-6.36**
Therapies	74.44	68.90	**-5.54**
Facilities	345.86	356.79	**10.93**
Hosp Support	371.05	333.88	**-37.17**
TOTAL	**4,139.57**	**3,868.54**	**-271.03**



Total Workforce Capacity FTE (Excluding Medical Staffing)

Directorate	Budgeted Establishment	* Total Utilised Workforce	Variance
Medicine	918.37	1016.13	**97.76**
Surgery	420.33	411.24	**-9.09**
Anaesthetics	172.80	170.95	**-1.85**
T&O	273.98	258.99	**-14.99**
Head & Neck	185.54	160.21	**-25.33**
Child Health	266.00	277.84	**11.84**
Obs & Gynae	405.16	398.69	**-6.47**
Oncology	240.35	240.96	**0.61**
Pathology	221.82	202.72	**-19.10**
Radiology	141.73	133.76	**-7.97**
Pharmacy	102.14	95.78	**-6.36**
Therapies	74.44	74.42	**-0.02**
Facilities	345.86	365.62	**19.76**
Hosp Support	371.05	346.30	**-24.75**
TOTAL	**4,139.57**	**4,153.59**	**14.02**



* Total Substantive Workforce plus Temporary Workforce (FTE)

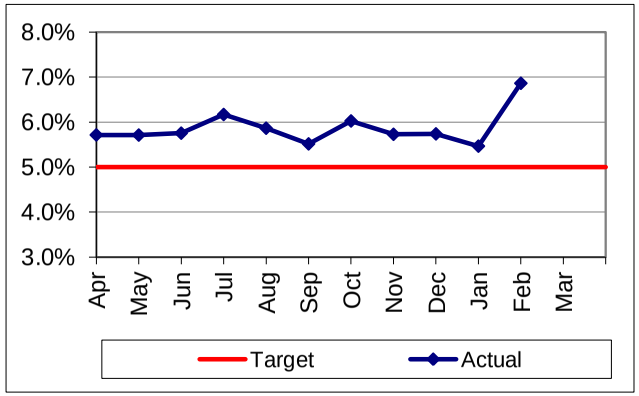
Workforce Performance Summary M11

Temporary Workforce Rate

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

(Excluding Medical Staffing)

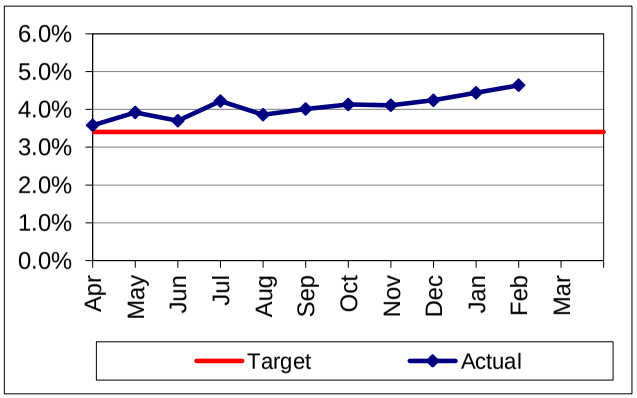
Directorate	Bank, Agency & Locum	Variance against Target	Variance from M10
Medicine	14.0%	9.0%	**2.6%**
Surgery	7.3%	2.3%	**1.8%**
Anaesthetics	7.6%	2.6%	**2.2%**
T&O	6.4%	1.4%	**0.7%**
Head & Neck	5.8%	0.8%	**0.3%**
Child Health	5.3%	**0.3%**	**0.3%**
Obs & Gynae	4.1%	**-0.9%**	**1.0%**
Oncology	6.0%	1.0%	**4.4%**
Pathology	0.6%	**-4.4%**	**-0.1%**
Radiology	0.0%	**-5.0%**	**0.0%**
Pharmacy	0.0%	**-5.0%**	**0.0%**
Therapies	7.4%	2.4%	**0.8%**
Facilities	2.4%	**-2.6%**	**0.6%**
Hosp Support	3.6%	**-1.4%**	**0.4%**
TOTAL	**6.86%**	**1.9%**	**1.4%**



Staff Sickness Absence Rate

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

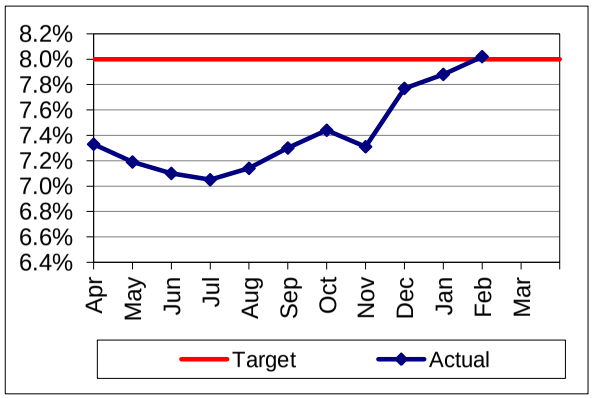
Directorate	Sickness Absence M11	Variance against target	Variance from M10
Medicine	5.25%	**1.85%**	**0.51%**
Surgery	5.69%	**2.29%**	**0.66%**
Anaesthetics	2.22%	**-1.18%**	**0.20%**
T&O	5.45%	**2.05%**	**-0.37%**
Head & Neck	5.52%	**2.12%**	**0.30%**
Child Health	4.48%	**1.08%**	**0.42%**
Obs & Gynae	4.91%	**1.51%**	**-0.60%**
Oncology	4.28%	**0.88%**	**0.66%**
Pathology	2.55%	**-0.85%**	**0.18%**
Radiology	3.95%	**0.55%**	**-1.67%**
Pharmacy	3.19%	**-0.21%**	**0.41%**
Therapies	3.29%	**-0.11%**	**-1.14%**
Facilities	5.58%	**2.18%**	**0.16%**
Hosp Support	3.30%	**-0.10%**	**0.42%**
TOTAL	**4.64%**	**1.24%**	**0.20%**



Staff Turnover

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

Directorate	M11	Variance against target	Variance from M10
Medicine	8.24%	0.24%	0.05%
Surgery	4.91%	-3.09%	-0.01%
Anaesthetics	2.64%	-5.36%	-0.74%
T&O	7.59%	-0.41%	-0.57%
Head & Neck	4.70%	-3.30%	0.05%
Child Health	12.08%	4.08%	1.44%
Obs & Gynae	9.95%	1.95%	0.25%
Oncology	7.00%	-1.00%	-0.76%
Pathology	6.49%	-1.51%	-0.15%
Radiology	2.06%	-5.94%	0.40%
Pharmacy	7.33%	-0.67%	1.54%
Therapies	9.23%	1.23%	-1.54%
Facilities	12.32%	4.32%	-0.09%
Hosp Support	9.02%	1.02%	0.52%
TOTAL	**8.02%**	**0.02%**	**0.14%**



HEATMAP - Staffing Indicators 2011-12

	Deliverable	Key	Threshold Target	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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	
	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	
	Temporary Workforce Utilised (FTE)		n/a	268.45	228.08	227.88	229.35	250.33	237.50	222.23	243.80	231.04	231.40	220.34	285.05	
	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	
	Contracted Workforce against Budgeted Establishment (% FTE)		95% to 97%	93.2%	90.9%	90.9%	90.75%	91.98%	92.10%	91.96%	91.86%	91.84%	91.82%	92.07%	93.45%	
	Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE)		100.0%	99.9%	96.4%	96.4%	96.3%	98.0%	97.8%	97.3%	97.7%	97.4%	97.4%	97.4%	100.3%	
	Temporary Workforce Rate (%FTE)	1	5.0%	6.7%	5.7%	5.7%	5.75%	6.17%	5.86%	5.52%	6.03%	5.73%	5.74%	5.47%	6.86%	
	Staff Turnover (% FTE)		8.0%	7.4%	7.3%	7.2%	7.1%	7.1%	7.1%	7.3%	7.4%	7.3%	7.8%	7.9%	8.0%	
	Recruitment Timeline	2	13 weeks	15	14.71	15.58	15.80	15.80	15.03	14.60	14.42	11.36	15.58	16.50	18.64	
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	
	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	
	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	
	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	
	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	
	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%	
Health & Wellbeing	Trust Headcount (Perm & FTC)		n/a	4436	4503	4506	4498	4558	4546	4522	4505	4507	4500	4506	4591	
	Calendar Days Lost to Sickness Absence		n/a	5044	4832	5552	5025	6029	5529	5567	5838	5711	6068	6374	6317	
	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	
	Short Term Sickness Absence		1.4%	2.0%	1.9%	2.2%	2.1%	2.3%	2.1%	2.3%	2.41%	2.38%	2.36%	2.61%	2.74%	
	Long Term Sickness Absence		2.0%	1.7%	1.7%	1.8%	1.56%	1.98%	1.82%	1.71%	1.71%	1.73%	1.90%	1.84%	1.90%	
	Total Sickness Absence		3.4%	3.7%	3.6%	3.9%	3.70%	4.22%	3.86%	4.01%	4.13%	4.11%	4.24%	4.4%	4.6%	
	Return to Work Interviews		100%	79.0%	82.0%	84.0%	76.0%	83.0%	76.0%	82.0%	78.0%	79.0%	84.0%	85.0%	80.0%	
Workforce Development	Personal Development Review / Plan Booked by Year End (Appraisal)		n/a		27.0%	27.0%	27.0%	45.0%	45.5%	37.0%	30.0%	26.6%	21.7%	18.0%	11.9%	
	Cumulative Personal Development Review / Plan Completion (Appraisal)		n/a		5.0%	9.0%	13.0%	17.0%	36.5%	46.0%	53.0%	57.5%	61.0%	68.0%	73.2%	
	Completed and Booked Appraisal		80%	65.0%	32.0%	36.0%	40.0%	62.0%	**82.0%**	**83.0%**	**83.0%**	**84.1%**	**82.7%**	**86.0%**	**85.0%**	
	Mandatory Training Activity Forecast (FYI)		100%	84.4%	90.1%	87.0%	87.1%	83.2%	79.3%	77.6%	74.86%	74.4%	71.3%	73.5%	74.5%	

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)

NHS
Midlands and East

SELF-CERTIFICATION RETURNS
Organisation Name:
Northampton General Hospital NHS Trust
Monitoring Period:
Mar 2012

NHS Midlands & East
Provider Management Regime
2011/12

8

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

NHS Midlands and East

NHS Trust Governance Declarations : 2011/12 In-Year Reporting

Name of Organisation:	Northampton General Hospital NHS Trust	Period:	Mar 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)	2.5
Financial Risk Rating (Assign number as per NHS Midlands and East PMR guidance)	2.9
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:	**Total time in A&E**
The Issue :	**The Trust has not delivered the 95% target in Q4 or in March**
Action :	**Integrated Health Economy action plan**

Target/Standard:	**Access to healthcare for people with a disability**
The Issue :	**two areas of partial compliance, development of comprehensive information for patients with LD re**
Action :	**Action plan developed and implemented**

ACUTE
GOVERNANCE RISK RATINGS 2011/12

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	Threshold	Weighting	April 2011	May 2011	Jun 2011	July 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments where target not achieved in month?
1	Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	54	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	YES	YES	
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	3	1.0	NO	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES	YES	
3	Quality	All cancers: 31-day wait for second or subsequent treatment, comprising either:	Surgery	94%	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	Drug Treatment 97%
			Anti cancer drug treatments	98%														
			Radiotherapy	94%														
4	Quality	All cancers: 62-day wait for first treatment, comprising either:	From urgent GP RTT	85%	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	
			From consultant screening service referral	90%														
5a	Patient Experience	RTT waiting times – admitted	95th percentile	23 wks	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	
5b	Patient Experience	RTT waiting times – non-admitted	95th percentile	18.3 wks	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	
6	Quality	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	
7	Quality	Cancer: 2 week wait from referral to date first seen, comprising either:	all cancers	93%	0.5	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	
			for symptomatic breast patients (cancer not initially suspected)	93%														
8a	Quality	A&E: Total time in A&E	Total time in A&E (95%)	≤ 4 hrs	1.0	YES	YES	YES	YES	YES	YES	NO	NO	NO	NO	NO	NO	
8b	Quality	A&E: NB Please record the areas not being met in the comments sheet	Total time in A&E (95th percentile)	≤4 hrs	No weighting	2	1	1	1	1	1	2	2	2	2	2	2	Mar 2012 - Total time in A&E (95th percentile) & Time to initial assessment: for ambulance arrivals (95th percentile)
			Time to initial assessment (95th percentile)	≤15 mins														
			Time to treatment decision (median)	≤60 mins														
			Unplanned re-attendance rate	≤5%														
			Left without being seen	≤5%														
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	No	No	No	No	No	No	No	No	No	No	No	No	
		CQC Registration																
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding.	0	1.0	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.	0	2.0	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	1.0	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	2.0	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	2.0	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	4.0	NO	NO	NO	NO	NO	NO	NO	NO	NO	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	NO	NO	NO	NO	NO	NO	NO	NO	NO	
				TOTAL		0.5	0.5	0.5	0.5	0.5	0.5	1.5	2.5	1.5	2.5	1.5	2.5	

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	4	5	4	4	4	3	3	3	3	4	4	3	Final EBITDA £0.7m ahaed of plan.
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	4	3	2	2	2	2	2	2	2	2	3	3	4	EBITDA of 6.3% achieved.
Financial efficiency	**Return on assets %**	20%	6	5	3	-2	<-2	3	3	2	2	2	2	1	1	2	2	2	2	3	Reurn of 4.34% achieved.
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	2	1	1	1	1	2	2	2	2	2	2	2	£0.5m surplus achieved 0.6% margin.
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	1	3	3	3	2	2	2	1	1	3	3	3	20.3 days cover including WCF.
Average	**Weighted Average**	**100%**						**2.9**	**2.6**	**2.8**	**2.6**	**2.6**	**2.3**	**2.1**	**2.1**	**2.0**	**2.0**	**2.9**	**2.9**	**2.9**	
Overriding rules	**Overriding rules**																	-0.9	-0.9		One criteria at 2
Overall rating	**Final Overall rating**							**2.9**	**2.6**	**2.8**	**2.6**	**2.6**	**2.3**	**2.1**	**2.1**	**2.0**	**2.0**	**2.0**	**2.0**	**2.9**	

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 2011/12

Northampton General Hospital NHS Trust

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

	Criteria	June 2011	Sept 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments on Performance in Month
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	Yes	Yes	No	Yes	No	EBITDA above plan Q4.
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	Yes	Yes	Yes	Yes	No	No	Forecast FRR 3 for 2012-13.
3	FRR 2 for any one quarter	Yes	Yes	Yes	Yes	Yes	Yes	FRR 2 Q1-3, improving to 3 at year end.
4	Working capital facility (WCF) agreement includes default clause	No	No	No	No	No	No	Not applicable
5	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes	Yes	Average balance > 90 days 18%
6	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	Yes	Yes	Yes	Yes	Yes	
7	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No	No	
8	Interim Finance Director in place over more than one quarter end	No	No	No	No	No	No	
9	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes	Yes	Below 10 days excluding WCF.
10	Capital expenditure < 75% of plan for the year to date	No	No	Yes	Yes	Yes	No	
	TOTAL	**5**	**6**	**7**	**6**	**6**	**4**	

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 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2011	Feb 2011	Mar 2011	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	G	G	G	G	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	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 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
1	SHMI - latest data	Ratio			111.4										Latest information reflects rolling 12 months July 10 to June 11 (latest HSMR shown seperately)
2	Venous Thromboembolism	%	91.6%	92.0%	92.3%	91.8%	90.0%	92.0%	93.1%	93.4%	93.3%	92.2%	93.6%	90.9%	
3a	Elective MRSA Screening	%	98.9%	98.9%	99.9%	99.6%	99.4%	99.9%	99.4%	99.6%	99.5%	100%	99.10%	99.93%	
3b	Non Elective MRSA Screening	%	94.9%	96.0%	95.4%	98.3%	98.6%	95.7%	97.3%	97.0%	96.8%	#####	96.20%	91.05%	
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation	Number	2	4	5	4	3	5	5	6	5	15	12	14	The data reflects the number of SI's requiring investigation as at 13th April 2012.
6	"Never Events" in month	Number	0	0	0	0	0	0	1	0	0	1	0	0	
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number	0	0	0	0	0	1	0	0	0	2	0	1	The data reflects the number of CAS Alerts which were due for implementation and closure during the reporting period and were NOT closed within the required timeframe
9	RED rated areas on your maternity dashboard?	Number	1	3	2	4	4	3	3	5	3	4	2	3	**CS** – 28.2% (30% Feb) Ongoing issue with elective caesarean section rate higher than target set by SHA. 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. Due to be discussed at Obstetric Governance Group 13th April and Healthcare Governance Meeting in May. All caesarean sections audited and reasons compliant with NICE guidance. Re-audit commenced 1st April 2012. On Risk register. **SOM**:Midwife ratio – red at 1:25 (red flag at 1:20). Succession planning in place, some midwives have completed the course but next LSA ratification not until May 2012. SOMs then need to be appointed by the LSAMO, action plan in place and on Risk Register. **PPH** > 2 litres – red at 3.2% (red flag at 2%) This is the first time in 2011/12 that PPH has red flagged. 12 women had a post partum haemorrhage in excess of 2 litres, no obvious trends identified. All cases have been reviewed by the Maternity Incident Review Forum and findings will be presented to the
10	Falls resulting in severe injury or death	Number	1	2	1	0	1	1	2	4	1	1	0	2	
11	Grade 3 or 4 pressure ulcers	Number	2	0	1	2	1	1	2	3	0	3	5	0	The data reflects the number of graded 3 and 4 pressure ulcers acquired within NGH during the reporting period. The data does not include the number of grade 3 and 4 pressure ulcers which were inherited and present upon admission to the organisation. This data has not been validated by the TVN and could be subject to change following further investigation.
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
13	Formal complaints received	Number	37	42	49	48	42	39	51	44	29	39	48	49	
14	Agency and bank spend as a % of turnover	%	5.5%	5.5%	4.8%	5.3%	5.5%	5.4%	5.0%	4.8%	5.5%	5.4%	5.50%	5.83%	
15	Sickness absence rate	%	3.6%	4.0%	3.7%	4.2%	3.9%	4.0%	4.1%	4.1%	4.2%	4.4%	4.4%	Not Av	
Supplementary submission	HSMR	Number	112.8	100.7	101.0	103.6	103.1	99.3	99.2	97.4	96.7	95.4	Not Av	Not Av	Latest information from DFI reflects cumulative position FYTD to Jan 12

Board Statements

Northampton General Hospital NHS Trust

Mar 2012

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 patient). • 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	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	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	Learning a) Disabilities: Access b) 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): 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? 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

Transformation Programme

April 2012

Monthly Feature—Outpatient Standards

Last year a project group was established to identify the top ten standards patient can expect for outpatient departments. Much work has been undertaken over the last 12 months to improve and streamline outpatient services across the trust. The outpatient standards, which underpin the other outpatient projects, have been developed by Patients and Staff and are from patient's point of view. The aim of this introducing a set of standards is to improve the overall quality and patient experience that outpatient departments provide.

Outpatients top 10 priorities

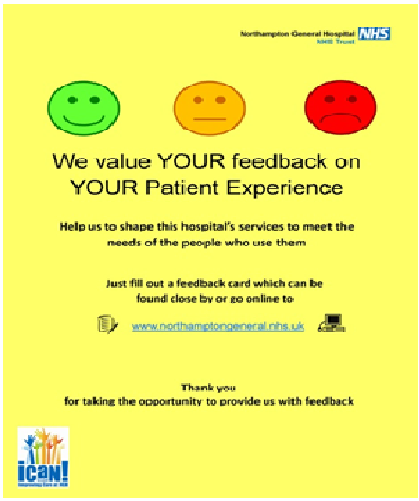
1. We will always introduce ourselves, greet patients politely and wear identification.
2. Patients will be informed of the clinic waiting time.
3. We will respond to all patient enquires regarding outpatient appointments within 1 working day.
4. We will give all patients an opportunity to feedback on their outpatient experience. Our responses with feedback will be displayed.
5. Outpatient areas and toilets will be cleaned and checked regularly.
6. All of our outpatient information leaflets and patient appointment letters will be written in plain English and can be translated on request.
7. The correspondence of a clinic consultation will be received by the patients and their GP within 10 working days.
8. Directions and signs to outpatient departments within the hospital will be clear and match information given to patient's.
9. We will see patients within 30 minutes of their scheduled appointment time.
10. We will not cancel appointments with less than 6 weeks notice, but where we do need to cancel appointments at short notice we will inform patients as to why.

Monthly feature continued over next page…..

Transformation Programme

Monthly Feature—Outpatient Standards

The two methods for collecting the outpatient standards have been agreed and are now in the process of being rolled out. Over the next few weeks, paper questionnaires will be available in each department for patients to complete should they wish to do so. Alternatively, patients can complete the questionnaire online. A nominated contact for each department has been sought and will collect and input the information monthly. Look out for a poster, questionnaire holder and collection box that will be going up in each department/clinic over the next couple of weeks.



Emergency Pathway

The Trust is committed to ensuring that there is a sustained approach to ensuring the delivery of high quality , safe care.

It is clear that our most pressing clinical need relates to the pressures on the emergency pathway and despite considerable efforts to improve medical and nursing input and to support an improved flow of patients through the organisation , we are not able to deliver the standards that we would like. This is having a negative impact on the experience for patients and staff and is not sustainable.

The Trust is therefore proposing to set up a project team led by a clinician to ensure that the emergency care pathway is improved through transformational change.

A key imperative and driver for the project will be to ensure that the focus on quality and safety drives the processes and standards agreed . This is in the firm belief that this will reduce our bed occupancy rates and ensure that it becomes possible to plan and deliver care more effectively on the wards and ensure that patients are not waiting in A&E where the pressures are extreme.

With this in mind the project will link closely with safety improvement initiatives and with the planned investment in underpinning safety improvements.

Transformation workstreams for 2012/13

Patient Flow (was previously Beds)	Outsourcing
Theatres	Nursing
Outpatients	Back office
Administration Review	Contract Compliance
Procurement	Pharmacy
Pathology	Controls
Therapies	HR Tactical
Medical	Workforce, Bank & Agency
Estates	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.

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, Pharmacy, Procurement, Back Office, Outsourcing, Service Line Management, IT enablement)

Chris Albone (Christopher.albone@ngh.nhs.uk—Ext 5909)
(Outpatients, Beds, Contract Compliance, On-Call)

Jatinder Singh (Jatinder.singh@ngh.nhs.uk—Ext 3317)
(Nursing, Estates, Workforce, 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.

BOARD SUMMARY SHEET	
Title: -	Draft Quality Strategy
Submitted by: -	Dr Sonia Swart, Medical Director Mrs Suzie Loader, Director of Nursing
Prepared by: -	Nina Fraser, Deputy Director of Nursing/ Head of Governance
Date of meeting: -	25th April 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:

- As part of the application process for Foundation Trust status, the Board has approved a Board Memorandum and self assessment of Monitor's Quality Governance Framework. In line with this work the Quality Strategy 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

PATIENT IMPACT:

The draft Quality Strategy outlines the Trust's commitment to delivering the very best care for all of our patients

STAFF IMPACT: -

The draft Quality Strategy recognises the importance of developing and making the best use of the potential and expertise of all those who work for the Trust to provide the highest standards of care to patients.

FINANCIAL IMPACT: -

Failure to achieve quality and safety standards could affect the Trust's FT application.

RISK ASSESSMENT:-

Non-achievement of the strategy: Likelihood= 3 Consequence= 4. Risk rating=12

EQUALITY & DIVERSITY IMPACT ASSESSMENT: -

The draft Quality Strategy gives strategic direction for quality care to be delivered for all patients.

RECOMMENDATION: -

The Board is asked to:

- Review and approve the draft Quality Strategy

Northampton General Hospital NHS
NHS Trust

QUALITY STRATEGY

2012-2015

DRAFT

Ratified as: Quality Strategy
Date First Ratified: 29/09/10
Most Recent Ratification: 29/09/10
Date(s) Reviewed:
Next Review Date: April 2015
Version Number: 5
Revised as: Quality Strategy
Responsibility for Review: Deputy Director of Nursing/ Head of Governance
Contributors: Director of Nursing, Medical Director, Chief Executive, Head Nurses, Modern Matrons, Hospital Management Group.

Index

1. Purpose

The ultimate purpose of this Quality Strategy is to provide the very best care for all of our patients.

'Equity and Excellence: Liberating the NHS' (DoH, 2010) sets out a vision for the NHS focused on improving quality and achieving world-class outcomes by ensuring that care providers: -

- Are genuinely centred on patients and carers
- Achieve quality outcomes that are amongst the best in the world
- Refuse to tolerate unsafe and substandard care
- Reduce mortality and morbidity

There are significant challenges in delivering reliable, responsive healthcare – increased public expectation, lifestyle changes, an ageing population, developments in technology and the current and projected economic context (which brings significant financial challenges). This strategy sets out how we will respond to these challenges, keep quality at the heart of everything we do, and provide excellent care to our patients in line with the NHS vision.

2. Our Vision

Our vision is to provide the very best care for all of our patients. This requires Northampton General Hospital NHS Trust to be recognised as a hospital that delivers safe, clinically effective acute services focussed entirely on the needs of the patient, their relatives and carers. These services may be delivered from our acute or community hospital sites or by our staff in the community.

In order to achieve this vision, the Trust has set out five aims, all of which reflect our vision for quality;

- Be a provider of quality care for all our patients
- Enhance our range of specialist services for the wider community
- Provide appropriate care for our patients in the most effective way
- Foster a culture where staff can give their best and thrive
- Ensure we invest wisely to make improvements in care

3. Definition of Quality

Being recognised as a hospital that delivers safe, clinically effective services focused entirely on the needs of the patient, their relatives and carer's means delivering the highest quality standards.

Northampton General Hospital NHS Trust defines quality as embracing three key components:

- Patient Safety – there will be no avoidable harm to patients from the healthcare they receive, this means ensuring that the environment is clean and safe at all times and that harmful events never happen.

- Effectiveness of care – the most appropriate treatments, interventions, support and services will be provided at the right time and in the right place to those patients who will benefit. Our patients will have healthcare outcomes which achieve those described in the NHS Outcomes Framework and NICE Quality standards.

- Patient Experience – patients will experience compassionate, caring and communicative staff who work in partnership with patients, relatives and their carers to achieve the best possible health outcomes.

4. What Quality means for Patients

Every Patient will: -

- Receive the right treatment at the right time and in the right place in line with national guidelines
- Be kept safe from avoidable harm
- Be treated as individuals and have their individual needs addressed
- Be treated with compassion, respect and dignity
- Be kept fully informed and share in decision making about their care
- Have any concerns addressed as early as possible
- Be cared for in a clean and safe environment

5. What Quality means for Staff

The Trust recognises the connection between the quality of care that our patients receive and the values, aspirations and skills that our staff hold. Organisations whose staff are better engaged deliver better care. There is compelling evidence that staff well being and staff experience correlate with patient experience and outcome improved.

We therefore strive to develop and make best use of the potential and expertise of all those who work for the Trust to provide the highest standards of care to patients. We will ensure that the capability and capacity of the workforce is able to support our aspirations.

Continuing education, training and professional development (ETD) for all our staff is essential to the delivery of high quality services. We will work with stakeholders to ensure that our staff and students receive the highest quality of teaching and training in line with our Workforce Development Strategy.

Communication to staff about performance against quality goals will be strengthened by further developing monthly communications to provide monthly Quality Update, with information about actions being taken to improve.

We will develop our staff so that: -

- All staff will recognise their contribution to quality and its improvement
- All staff will have the necessary training and development to improve service quality
- All workplaces will be safe with effective management of risks and hazards
- All staff will be appraised annually, and have agreed PDPs which harness their potential for quality improvement
- Staff concerns will be listened to
- When things have not gone well, we will focus on learning lessons and improving quality
- When things go well, information and learning will be shared so others can learn

6. What Quality means for the Trust and its partner organisations

- Quality will be at the heart of planning and performance management, with quality related objectives in every business plan
- The Quality Strategy will drive the organisation's strategic objectives
- The Trust's Quality Goals will be linked specifically to the strategic objectives and will be chosen to improve safety, clinical effectiveness and patient experience.
- The Trust will work in partnership with Commissioners and other key stakeholders including the public to deliver high quality care across the whole patient pathway
- The Trust will build on its culture of learning lessons when things go wrong to improve quality

7. Quality Accounts and Commissioning

On an annual basis the Trust will make information about quality publically available by publishing a report on the quality of our services, focusing on patient experience, clinical effectiveness and patient safety, and describing our quality improvement priorities for the coming year.

The Trust will work with Care Groups and Commissioners to align CQUIN improvement schemes with this strategy.

The Trust will engage and consult with Commissioners about our improvement plans to ensure they are consistent with the whole health economy.

8. Quality Goals

The Trust has identified three Quality Goals which link to the strategic objectives. The Quality Goals have been chosen to improve each of the three key components of Quality and form part of the driver diagrams contained in the next sections of this strategy.

The Trust's Quality Goals are: -

1. Reduce all avoidable harm and save every life we can (reduce harm by 50% over 3 years)
2. Improve the Patient Experience Friends and Family Test Score by 10 points each year
3. Patients will receive high quality evidenced based care

In order to ensure that the Quality Goals are embedded into the organisation they will link to each Care Group's Goals which will be agreed on an annual basis.

9. Patient Safety

The Trust will reduce all avoidable harm to patients and save every life we can. We aim to save 300 extra lives over the next 3 years.

The driver diagram on the following page shows the primary and secondary drivers that will help to achieve this aim.

9.1. Patient Safety Driver Diagram[1]:

Aim:
Reduce all avoidable harm and save every life we can

High level aim is to save 300 lives over 3 years and to reduce harm by 50% over this period

Primary Drivers:

Build a Safety Culture

Lead and support staff to improve safety

Integrate risk management activity

Promote incident reporting

Involve and communicate with patients and the public

Learn and share lessons

Implement solutions to prevent harm

Use a hierarchy of controls : reduce error by standardising and simplifying systems (see 8.2)

Secondary Drivers:

Develop a Safety Academy to lead and support an improvement culture

Develop a Patient Safety communications strategy to underpin training for all staff and make progress visible to staff and patients.

Use and develop safety training based on clinical simulation scenarios encompassing relevant mandatory training and learning from serious incidents

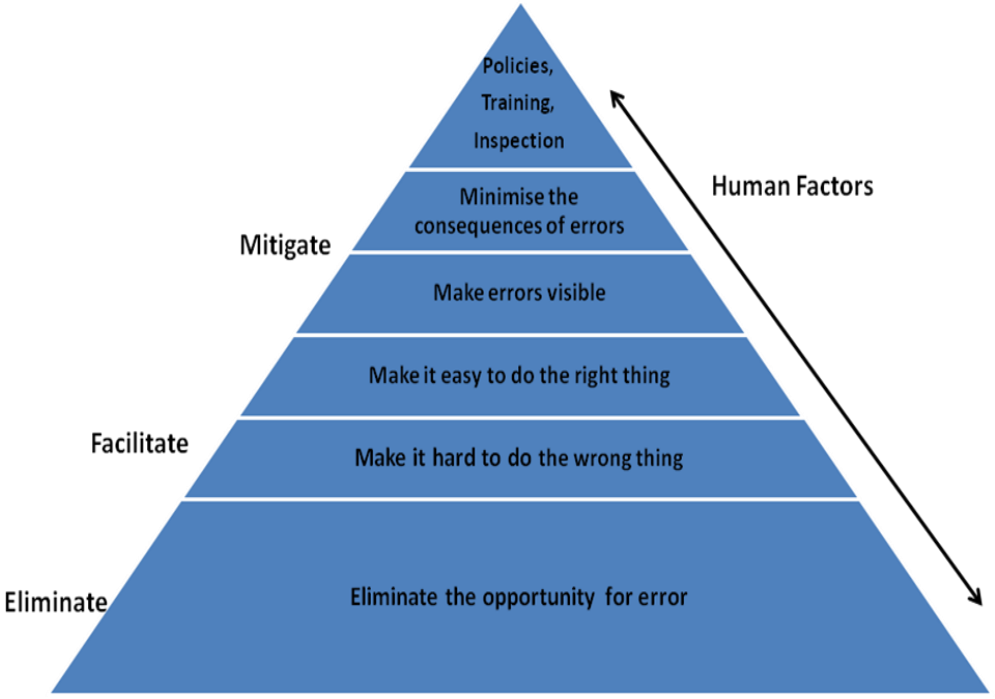
Expand patient safety conversations programme including improved Board Safety Rounds, targeted patient safety culture surveys and an extended patient stories programme

Support programmes to reduce and monitor harm based around 3 key projects to reduce harm from : failure to rescue, failure to plan and failures of care

Standardise format for Mortality and Morbidity Meetings and link to ongoing hospital standardised mortality monitoring process

[1] Driver diagrams show what we want to achieve (aim) and what actions we will take to achieve the aim. They are used to support improvement programme and show the plan in an easily understandable illustration. The secondary drivers are the actions or interventions that will be taken to achieve the aim.

9.2. Reduce error using a hierarchy of controls to standardise and simplify systems



9.3. Learning Culture

The Trust will have well developed governance and incident reporting procedures that promote an open, learning culture where incidents and claims are investigated thoroughly to establish the root causes [see Trust Management of Incidents Policy].

The Trust will have processes in place at clinical speciality, department, Care Group and corporate levels, for reviewing complaints, PALS, claims, incidents and near misses. This will ensure that trends are identified; risk registers and business planning are responsive to issues.

The Trust will actively seek to learn from other organisations, and will have strong links with the National Patient Safety Agency (or its successor) and national reporting and learning processes.

10. Patient Experience

The Trust will achieve a 10 point improvement in the Patient Experience Friends & Family Test Score[2] each year, using April 2012 as its benchmark.

The following driver diagram shows the primary and secondary drivers that will help to achieve this aim.

10.1 Patient Experience Driver Diagram

Aim:	**Primary Drivers:**	**Secondary Drivers:**
Improve the Patient Experience Friends & Family Test Score by 10 points each year	Leadership of patient experience	Identify Executive and Non-Executive Lead Matron walk rounds Patient Experience Board Patient Experience Lead
	Customer Experience	Real time monitoring Patient Experience reports to Board Monthly feedback to wards Accessible leaflets for PWLD Noise At Night
	Co-production between patients and professionals	Patient pathways Patient Information Policy PPI Forum/ LINKs/ Shadow Governors involvement Patient and Public Involvement Strategy
	Community Participation	Involvement in future planning and reconfiguration of services Shadow Governors/ members monitoring of patient experience Link with Transformation Programme

[2] The Patient Experience Friends & Family Test Score is obtained by asking patients a single question, i.e. "How likely is it that you would recommend our company to a friend or colleague?" Extremely Likely? Likely? Unsure? Unlikely? Not at all? Don't Know?". Based on their responses, patients are categorised into one of three groups:

- Promoters (9-10 rating)
- Passives (7-8 rating)
- Detractors (0-6 rating)

The percentage of Detractors is then subtracted from the percentage of Promoters to obtain a Net Promoter Score (NPS). NPS can be as low as -100 (everybody is a detractor) or as high as +100 (everybody is a promoter). An NPS that is positive (i.e. higher than zero) is felt to be good, and an NPS of +50 is excellent.

10.2 Complaints and PALS

The Trust seeks feedback from anyone who uses our services and uses feedback as a means to learn lessons and drive improvement. We will continue to aim for early and local complaint resolution and to reduce complaints wherever possible.

10.3 Patient and Public Involvement

The Trust will work to improve its services and facilities through listening to patients and the public including those from minority groups. It will involve them at the earliest opportunity in the review, reorganisation and planning of current services and facilities and in their future development. Patients will be fully informed about their own treatment and care and have every opportunity to be involved in the decisions that affect them.

Patients and the public will be engaged in developing the trust's Quality Accounts each year.

We will continue to develop the range of methods we use to gather feedback from patients and relatives, notably to understand why they would or would not recommend us to others.

11 Effectiveness of Care

The Trust will achieve the health outcomes (across a range of conditions) as set out in the NHS Outcomes Framework and NICE Quality Standards through delivery of safe, effective and evidence-based care.

The Trust will build on the well established culture of monitoring clinical outcomes and learning from best practice examples to improve the quality of health outcomes for our patients. A variety of mechanisms are in place to focus on key aspects relating to guideline development, learning from audits and enquiries and monitoring of clinical outcomes. There is a commitment to continuous improvement and challenge to ensure that there is appropriate challenge and refinement of key indicators of care and that reflection on the results of audits and enquires is embedded from the level of the individual through to the Trust Board.

The Trust aims to improve performance in clinical outcomes to ensure its services provide care which is as effective as the top quartile of hospitals in its peer group.

The Trust recognises the importance of clinical audit for improving the effectiveness of services.

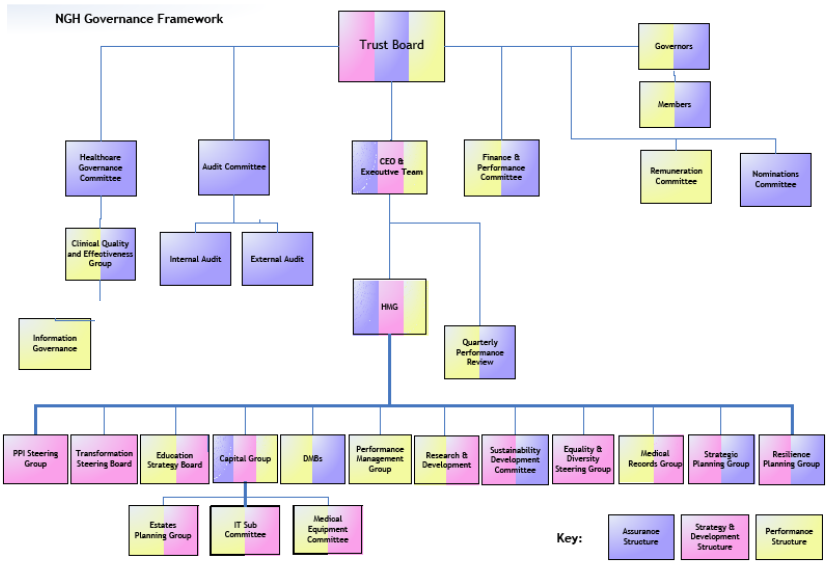
The following driver diagram shows the primary and secondary drivers that will help to achieve this aim.

11.1 Clinical Effectiveness Driver Diagram

Aim:	Primary Drivers:	Secondary Drivers:
Patients will receive high quality evidenced based care The Trust will achieve the health outcomes as set out in the NHS Outcomes Framework and NICE Quality Standards	**Ensure each individual patient is managed correctly** **Ensure all information relevant to providing good patient care is easily available and accessible** **Ensure each individual patient is managed in the correct setting** **Ensure timely interventions for all patients**	**Redesign of the emergency care pathway with a focus on quality and safety** **Extend and improve NGH Clinical Guidelines for all common conditions** **Extend and refine participation in and learning from National Audits and other key audits based on organisational risks and priorities . Ensure mandatory reflection on key audits for all consultant staff and clinical teams** **Increase the profile of learning from the results of National Confidential Enquires and similar reports** **Continue to develop and monitor indicators of care based on clinical outcome, safety and patient experience at speciality, directorate, managerial and Board**

12 Quality Governance Framework

The committee structure will provide assurance to the Board on quality issues and was agreed by the Board of Directors in 2009. This is set out in the diagram below: -



The role of the key committees in terms of quality and the groups that will feed into them are outlined below.

The **Healthcare Governance Committee** (HGC) is a Board committee that meets monthly and will be chaired by a Non-Executive Director. Members include all Non-executive Directors and all Directors. The minutes of the HGC will be received by the Board and the quality issues on which the HGC should focus will be agreed with the Board on a rolling basis. In addition, the HGC will receive notification from the Clinical Quality and Effectiveness Group regarding areas of quality requiring further scrutiny. Patient Safety and Patient Experience Reports and a trust wide quality dashboard will be received by HGC on a quarterly basis.

A **Clinical Quality and Effectiveness Group** (CQEG) will be chaired by the Medical Director or Director of Nursing, Midwifery & Patient Services. CQEG will receive Quality Reports from the Safety Academy, the Patient Experience Board and a trust wide quality dashboard for assurance purposes on a quarterly basis.

The **Patient Safety Board** will be chaired by the Medical Director or Director of Nursing, Midwifery & Patient Services, and will be an improvement/ learning forum attended by Patient Safety Leads throughout the organisation.

The **Safety Academy** will be chaired by the Medical Director and will manage the programme of work contained within the driver diagram in section 8.1.

The **Patient Experience Board** will be chaired by the Director of Nursing and will manage the programme of work contained within the driver diagram in section 9.1.

The **Finance and Performance Committee** receives Quality Impact Assessment scorecards monthly.

The **Procedural Document Group** has delegated authority for ratifying policy documents for the trust. This will be chaired by the Deputy Director of Nursing/ Head of Governance.

The **Hospital Management Group** (HMG) will be responsible for providing operational assurance and escalation of risks to the Trust Board. It will be chaired by the Trust's Chief Executive. It will receive a formal performance report, a monthly quality scorecard and exception report and ad hoc reports where there are concerns in respect of quality. It also receives reports from CQEG and recommends further actions for consideration by HGC or Trust Board as required.

Each **Care Group** will set up a monthly **Governance and Quality meeting** chaired by the Care Group Chair or the Care Group Lead Nurse. The Medical Director and Director of Nursing, Midwifery & Patient Services will be in attendance. The Governance and Quality meeting will receive monthly directorate level reports on patient safety, patient experience and clinical outcomes.

Quarterly Performance Reviews will be undertaken with each Care Group's senior team on a quarterly basis with the Chief Executive and his Director colleagues to provide scrutiny and challenge about how the Care Group is performing. Quality and Safety issues will be specifically focused on within the review as other areas of performance which reflect the Board's commitment to the wider quality agenda. These will include operational performance targets; finance; workforce issues; patient experience; directorate objectives; service strategy; risks.

Assurance reports will be received by the Board through the **Patient Safety, Clinical Effectiveness and Patient Experience Report** on a quarterly basis and will focus on Care Group and organisational quality measures. In addition, the Board will receive **quality reports from the Medical Director and the Director of Nursing, Midwifery & Patient Services** on a monthly basis relating to quality issues within their portfolio.

13 Roles and Responsibilities

The roles and responsibilities for quality are set out below:

The **Chief Executive** is the accountable officer and has ultimate responsibility for quality within the organisation.

The **Medical Director** and **Director of Nursing** are jointly responsible for Clinical Governance and all aspects of quality.

The **Director of Operations** is responsible for ensuring that quality performance outcomes are met within Care Groups.

The **Director of Strategy and Partnerships** is responsible for ensuring that quality information is available in a timely manner and that data quality meets national standards.

Each **Board member including Non-Executive Directors** are responsible for ensuring that quality is an integrated element of all major discussions and decisions. Quality is a core part of main Board meetings, and 'Patient Safety and Quality' forms a standing agenda item on both public and private Board agendas.

The **Care Group Director, Clinical Chair and Care Group Lead Nurse** are responsible for quality at Care Group level. They will establish a Care Group Governance meeting and report and discuss quality issues as part of the monthly meeting, using tools such as Directorate Scorecards to aid scrutiny.

All **members of staff** are responsible for ensuring that quality is at the heart of what they do. See section 5 for more detail of how quality will impact each member of staff's role in the trust.

14 Implementation Framework

Improving quality is a continuous process and the trust will build on our strengths and previous successes in patient safety, patient experience and on its existing clinical governance infrastructure.

The successful implementation of this strategy will require that the use of an appropriate range of improvement methodologies and tools, including measurement for improvement. An infrastructure will be set up to support the patient safety work and the patient experience work. This will be detailed within the Patient Safety Strategy and the Patient Experience Strategy. Leads will be identified for each work stream and timescales set for delivery.

14.1 Leadership

The importance of quality improvement for the trust's strategic and day to day objectives must be communicated to all our staff, who must be successfully engaged. The Trust Board will oversee implementation of the Quality Strategy, promote an improvement culture, support effective local leadership, and ensure an appropriate infrastructure. Links with the Transformation Programme will be made and expertise will be shared to ensure that the work is integrated and aligned. The Board will ensure that successes are recognised and communicated widely internally and to our community, patients, and partner organisations.

Clinical leaders will need to develop and implement a plan which is both challenging and realistic, and which recognises and articulates that improving efficiency is a mechanism for improving safety and patient experience.

14.2 Measurement for Improvement

'High Quality Care for All' envisaged that healthcare organisations would develop systems to define and measure quality, and deliver it in all their services, at all levels. The trust will continue to develop innovative and established process and outcome measures for use and reporting at Board, Care Group, Directorate, specialty and ward levels.

Northampton General Hospital NHS
NHS Trust

TRUST BOARD SUMMARY SHEET	
Title: -	Patient Safety Strategy
Submitted by: -	Dr S Swart
Prepared by: -	Dr S Swart
Date of meeting: -	25 April 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 since the Trust formally supported patient safety initiatives in 2008 and again in 2010. Following the lessons learned from this work and in recognition of the critical impact of improvement work underpinning successful patient safety work a new Patient Safety Strategy and Safety Improvement Programme has been designed to interlink with other transformation projects.

PATIENT IMPACT: -

High quality care for patients remains a priority. A critical part of this is ensuring that error in healthcare is eliminated and that systems are designed around the needs of patients.

STAFF IMPACT: -

Education and training for all staff are a key part of this programme and there is evidence that staff who understand the key principles of eliminating harm and improving processes to eliminate harm, have higher job satisfaction and deliver better care to patients.

FINANCIAL IMPACT: -

The ability to continually drive forward quality and safety 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 and safety across a range of services and failure to provide requisite quality standards will result in the risk of litigation.

RECOMMENDATION: -

Board members are asked to discuss the contents of this report and debate the issues raised and agree to support the investment required to ensure progress is made at pace.

Patient Safety Strategy
2012 - 2015

INTRODUCTION

In 2008, NGH participated in Leading Improvements in Patient Safety as supported by the NHS Institute for Improvement. NGH also signed up to Patient Safety First and developed a patient safety strategy which has sine evolved and been redefined.

During the last 4 years there has been a marked increase in focus on quality and safety at all levels within the Trust. There has been increasing understanding from and engagement of clinicians and managers as well as increasing support from the executive team and Trust Board for all improvement work related to quality and safety. This has been underpinned by improvements in the clinical governance framework and strong linkages between assurance functions and the need to improve and learn.

The refreshed safety strategy has been produced in recognition that the improvement work necessary to transform care and reduce harm requires rigorous management, supported clinical leadership and investment if it is to result in the significant changes in behaviour and process required to change the culture of the organisation.

Development of the Strategy

This strategy has been informed by the lessons learned over the last few years, by recent audits and lessons learned from both successful and unsuccessful projects, by comments from key individuals involved in safety work and by lessons learned through safety development programmes.

In particular the final version has been informed by the work done during the Institute of Health Improvement Executive Safety Programme, which was attended by the Medical Director, the Director of Nursing and the Chief Operating Officer earlier this year.

This Safety Strategy underpins the wider Quality Strategy.

Key Points of Note

The strategy contains elements of well understood and recognised drivers for safe care which are contained in the driver diagram as ‘primary drivers’ necessary to ensure that we achieve our high level aim of saving 300 additional lives over the next 3 years and we reduce harm by 50% over this period of time.

It is not possible when developing aims and ideas in this field to precisely link any one initiative with specific reductions in deaths or mortality but the principle is that by supporting a portfolio of projects the desired effect will result. This is the principle that has been adopted throughout the safety work.

A key feature of this strategy and one which is emphasised as a primary driver and also separately illustrated is the hierarchy of controls diagram. This is based on the essential and vital principle that the systems and processes need to be set up to force the correct actions by staff. It needs to be easy to do the right thing, difficult to do the wrong thing and there need to be mitigations to reduce the chance of error further.

The role of policies and guidelines is there but it should not be the fundamental tool for driving improvements.

The secondary drivers listed in the diagram give an outline of the projects identified in more specific terms and these are explained in the strategy.

It is in these specific projects that the role of measurement for improvement and project management against measures will be essential.

Another key component is the formation of a team of safety leaders who will drive the projects forward in a robust project management structure with support from senior clinical and managerial staff under the direction of the Medical Director and the Director of Nursing.

These individuals will form the core of a Safety Academy which will also involve the formation of a much larger group of champions in the Trust who will be trained in Safety methodology and the tools required to effect change.

One of the overall aims of the training and education programmes will be to ensure that every member of staff understand their role in patient safety and works towards that every day. This implies a change in behaviour, which in time will lead to cultural change in the organisation. In order to be able to sustain and underpin the major commitment to education and training for all staff, it will probably be essential to frame the safety training in terms which encompass other aspects of mandatory training and learning from error. The Trust is fortunate to have excellent educational facilities including a simulation suite which could be used innovatively for this purpose.

Progress to Date

The Draft Safety Strategy has been circulated to clinical staff and expressions of interest for Clinical Leads have been requested. There is considerable interest in these roles which reflects the successful engagement of clinicians to date and the improvements that have commenced. There is agreement that there will need to be project management support, which may overlap with the emergency pathway re-design work which will also be clinically led. There will also need to be support from an individual trained in analysing information and improvement methodology. The proposal is that the Programme Management Office for the transformation work will support and oversee progress for this work.

The Trust Board is asked to consider this draft strategy and give it support and suitable challenge. This work will require considerable investment but this investment is likely to ensure that the Trust will achieve improvements in the quality of care provided. If systems are redesigned to eliminate error then cost should also be reduced.

Patient Safety - Strategy for Improvement and Programme Outline

2012 - 2015

DRAFT

Patient Safety Strategy:
Date of Issue: April 2012
Date(s) Reviewed:
Next Review Date: April 2015
Version Number: 4
Revised as:
Responsibility for Review: Medical Director / Director of Nursing/Deputy Director of Nursing/ Head of Governance
Contributors: Chief Operating Officer, Chief Executive, Director of Strategy ,Care Group Lead Nurses, Modern Matrons, Hospital Management Group

Index

1. Purpose

The purpose of this Safety Strategy, which outlines the Patient Safety Programme, is to provide an outline and working document to articulate the improvement programme that underpins the Trust Quality Strategy.

This strategy builds on previous strategies (2008 and 2010) which articulated portfolios of projects and underpinning levers and principles. There are significant numbers of projects and initiatives in place and the purpose of this new strategy is to bring them together in a refreshed and updated form. It also aims to bring clarity with respect to the aims, objectives and measurable deliverables for Patient Safety.

2. Our Vision for Safety

Our vision is to provide the very best care for all of our patients. This requires Northampton General Hospital NHS Trust to be recognised as a hospital that delivers safe, clinically effective acute services focussed entirely on the needs of the patient, their relatives and carers. These services may be delivered from our acute or community hospital sites or by our staff in the community.

In order to achieve this vision, the Trust has set out five aims, all of which reflect our vision for quality;

- Be a provider of quality care for all our patients
- Enhance our range of specialist services for the wider community
- Provide appropriate care for our patients in the most effective way
- Foster a culture where staff can give their best and thrive
- Ensure we invest wisely to make improvements in care

As part of this vision it is essential that there is a strong focus on patient safety. The overall vision for safety is therefore to provide the safest possible care for patients by ensuring that all our systems and process minimise the chance of error and there is a hierarchy of controls in place to assist in this process. In order to achieve this every member of staff will need to understand their role in patient safety.

3. Definition of Quality and Patient Safety

Being recognised as a hospital that delivers safe, clinically effective services, focused entirely on the needs of the patient, their relatives and carer's, means delivering the highest quality standards.

Northampton General Hospital NHS Trust defines quality as embracing three key components: -

- Patient Safety – there will be no avoidable harm to patients from the healthcare they receive, this means ensuring that the environment is clean and safe at all times and that harmful events never happen.

- Effectiveness of care – the most appropriate treatments, interventions, support and services will be provided at the right time to those patients who will benefit. Our patients will have healthcare outcomes which achieve those described in the NHS Outcomes Framework and NICE Quality standards.

- Patient Experience –patients will experience compassionate, caring and communicative who work in partnership with patients, relatives and their carers to achieve the best possible health outcomes.

4. What Safety means for Patients

Safety and Quality are interlinked and can in many instances not be separated. The element of quality that is generally articulated specifically as safety relates to the reduction of avoidable harm and the reduction of death rates. In order to achieve this it is widely understood that patients must also receive the right care in the right environment.

Thus in order for care to be safe, every patient will: -

- Receive the right treatment at the right time in line with national guidelines
- Be kept safe from avoidable harm
- Be cared for in a clean and safe environment

5. What Safety means for Staff

The Trust recognises the connection between the quality of care that our patients receive and the values, aspirations and skills of our staff. Organisations whose staff are better engaged deliver better care, and in particular safer care. There is compelling evidence that staff wellness and staff experience correlate with patient experience and outcome.

We therefore strive to develop and make best use of the potential and expertise of all those who work for the Trust to provide the highest standards of care to patients.

In addition to the continuing education, training and professional development (ETD) for all our staff, which is essential to the delivery of high quality services, there is a need to develop a targeted training programme with a specific focus on patient safety.

This relates to the high risk of error in all healthcare systems.

We will develop our staff so that: -

- All staff will recognise their contribution to patient safety and its improvement
- Staff concerns relating to patient safety will be listened to and there will be a structured method of receiving this feedback
- When things have not gone well, we will focus on learning lessons and improving safety
- When things go well, information and learning will be shared so others can learn

6. What Safe Care means for the Trust and its partner organisations

- Quality and Safety will be at the heart of planning and performance management, with quality and safety related objectives in every business plan
- The Quality Strategy (which contains a high level articulation of this Safety Strategy) will drive the organisation's strategic objectives
- The Trust's Quality and Safety Goals will be linked specifically to the strategic objectives and will be chosen to improve safety, clinical effectiveness and patient experience.
- The Trust will work in partnership with Commissioners and other key stakeholders including the public to deliver high quality and safe care across the whole patient pathway
- The Trust will build on its culture of learning lessons when things go wrong to improve quality and safety

7. Patient Safety Aim

The Trust will articulate a high level aim that can be understood by staff and patients.

This is articulated as follows: -

'At NGH we aim to reduce all avoidable harm to patients and save every life we can. We aim to save 300 extra lives over the next 3 years.'

The following driver diagram shows the primary and secondary drivers that will help to achieve this aim: -

7.1 Patient Safety Driver Diagram[1]:

Aim:
Reduce all avoidable harm and save every life we can

High level aim is to save 300 lives over 3 years and to reduce harm by 50% over this period

Primary Drivers:

Build a Safety Culture

Lead and support staff to improve safety

Integrate risk management activity

Promote incident reporting

Involve and communicate with patients and the public

Learn and share lessons

Implements solutions to prevent harm

Use a hierarchy of controls : reduce error by standardising and simplifying systems (see 9.2)

Secondary Drivers:

Develop a Safety Academy to lead and support and improvement culture

Develop a Patient Safety communications strategy to underpin training for all staff and make progress visible to staff and patients.

Use and develop safety training based on clinical simulation scenarios encompassing relevant Mandatory training and learning from serious incidents

Expand patient safety conversations programme including improved Board Safety Rounds ,targeted patient safety culture surveys and an extended patient stories programme

Support programmes to reduce and monitor harm based around 3 key projects to reduce harm from : failure to rescue, failure to plan and failures of care

Standardise format for Mortality and Morbidity Meetings and link to ongoing hospital standardised mortality monitoring process

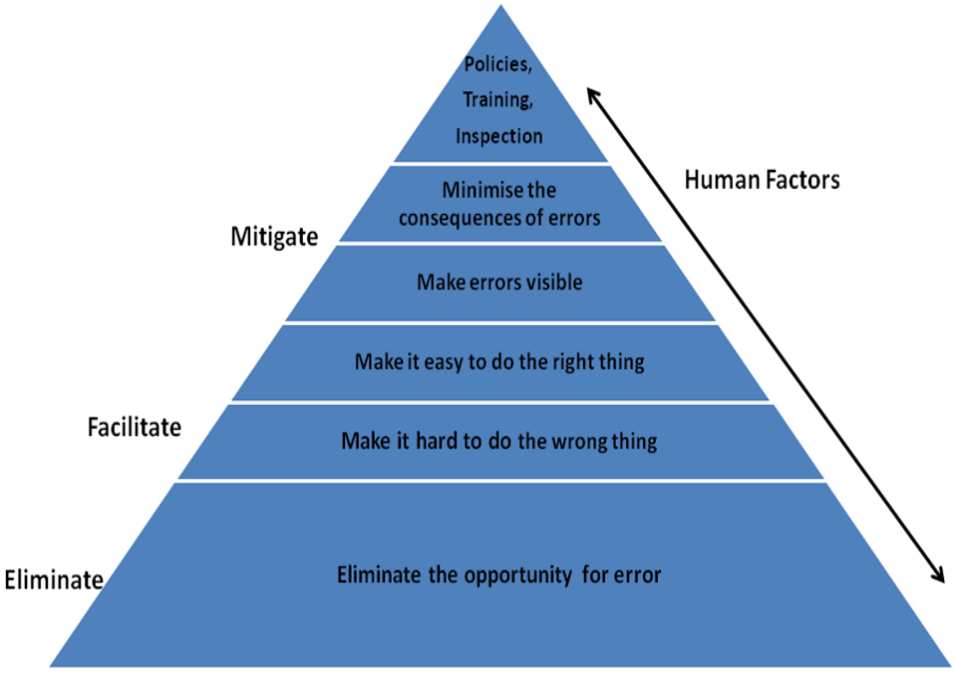
[1] Driver diagrams show what we want to achieve (aim) and what actions we will take to achieve the aim. They are used to support improvement programme and show the plan in an easily understandable illustration. The secondary drivers are the actions or interventions that will be taken to achieve the aim.

7.2 Primary Drivers necessary to achieve the Patient Safety Aim

The primary drivers are indicated in the diagram and are based on the National Patient Safety Association articulation of the seven steps to patients' safety. In addition the Trust is committed to the reduction of error through a formal commitment to the use of improvement methodology to ensure that the reduction of error focussed as much as possible on the elimination of error followed by the facilitation of 'right care' and then mitigation of the consequences of error. All these are necessary to reduce error in healthcare. In addition the human factors that result in error need a specific focus and continual improvement in the development of systems to track and measure quality is required.

This is illustrated below: -

7.2.1 Reduce error using a hierarchy of controls to standardise and simplify systems



7.3 Secondary Drivers for Patient Safety

The Trust recognises the need to formalise the patient safety programmes currently in place and invest in clinical leadership and staff education to ensure that the Trust high level aim for patient safety is achieved. Having set up a number of projects and improvement programmes in recent years, it will now be possible to take this work to a new level. The Trust will therefore commit to a formal project structure led by clinicians responsible to the Medical Director via the Senior Nurse who is Assistant to the Medical Director for Patient Safety and quality.

7.3.1 Formation of a Safety Academy

There will be 5 clinical leads joining the Medical Director, the Nursing Director and other key individuals supported by a Project Management Team trained to support improvement techniques and linking with current individuals supporting quality information flows. These individuals will be developed to be able to cascade and support the training and development of a much larger team of up to 70 individuals trained in safety science. They will help to support a collegiate approach to Patient Safety where all staff are trained and empowered to deliver safe care. In time, one of these clinical leads will be able to take on the role of Trust Patient Safety Lead Clinician and be able to strategically lead and oversee the programme of work. This work will report into key committees and boards and also through structured reporting to the Transformation Programme Management Office.

This team will lead in 5 key areas of improvement all of which will use a system wide approach: -

1. Reducing Harm from failure to Rescue
2. Reducing Harm from failure to Plan
3. Reducing Harm from failures of Care
4. Learning from and sharing lessons from failures and successes
5. Human factors and scenario training incorporating mandatory training , essential training and training in safety theory based around clinically relevant issues

Each clinical safety lead will be responsible for leading in one of these 5 priorities and will be provided with support and training to do so.

7.3.2 Development of a Communication Strategy for Patient Safety

The Medical Director and Director of Nursing will lead the work required to ensure that there is a communication strategy which links and underpins safety improvement work to all mandatory standards and current work in progress . This is vital to ensure that staff understands the importance and meaning of this work, which will give meaning to regulatory standards in a refreshed format and will help to define the training needs for staff in a similar way. The Safety Academy members will help to inform this work as will the

Governance Team. This work will therefore link assurance standards with improvement work.

7.3.3 Expand and extend conversations relating to patient safety and information for patients on patient safety

The Leadership for safety rounds in place for members of the executive team will be reviewed; refined and extended to Non Executive Directors and will focus on key themes with a structured format.

These themes will also be used at Board and significant meetings where patient stories are used to improve understanding and give emphasis to issues.

The safety climate culture questionnaires which have been piloted over the last year will be refined to ensure that they can be used effectively

Patient safety information in clinical areas and patient input into patient safety improvement work will be improved.

7.3.4 Improving Safety relating to Planning of Care

This will take the form of a project lead by a clinician. The project will focus on reducing the harm resulting from Failure to Plan (see appendix 1). This will be monitoring using compliance tracking against a bundle of measures for each indicator as illustrated.

This project will focus on standards of record keeping and general documentation as well as standards of documentation of plans in the medical and nursing notes and will be using improvement methodology to test cycles of change. The focus will be on the systems and processes which improve the documentation of plans and diagnoses and the way key findings and actions are handed over between clinical teams including to primary care.

There is abundant evidence that clear medical note keeping and the requirement to document findings and diagnoses and treatment plans improves the quality of care. It also improves the flow of information that results in the information collected on hospital information systems and the information required for clinical coding.

7.3.5 Reducing Harm resulting from ‘Failure to Rescue’

This will also take the form of a project lead by a clinician. The project will focus on ensuring that there is compliance with recording of observations and with all policies that relate to the actions taken as a result of observations that indicate that the patient is very ill or deteriorating. This project will also encompass the use of care bundles to provide facilitation of correct treatments but also to ensure that the most seriously ill patients are treated appropriately. New approaches to the recognition and prioritisation of the most seriously ill patients will be piloted and new approaches to learning from

situations where there have been failures to recognise or act on deterioration will be adopted. More detail is provided in Appendix 2, which gives the key areas identified and the bundles to be monitored.

7.3.6 Reducing Harm resulting from failures of essential care.

This will be a clinically led project which will encompass many aspects of care which are set as basic standards in our regulatory frameworks. In some of these areas we already have significant emphasis. In some areas significant improvement has already taken place and in others there is a need to extend and accelerate progress. This project encompasses many key areas where harm is known to occur such as Healthcare Associated Infection, Medication errors, Hospital Acquired Thrombosis, falls, pressures sores, catheter associated urinary tract infection, care of vulnerable patients including those with dementia, fluid management, nutrition support and Never Events. A bundle of measures has been identified as indicated in Appendix 3

7.3.7 Learning and sharing the lessons from failures and successes of care

An effective safety culture needs to include a clear, agreed and comprehensive system for accelerating and sharing learning. In the case of patient safety this needs to cover learning from all areas that impact on patient safety including incidents (especially serious incidents and “never events”), complaints , litigation , issues identified from audits , mortality and morbidity meeting conclusions and hospital standardised mortality monitoring. It is essential that the lessons of successful intervention are shared as well as the lessons resulting from error and failure. This project lead will consolidate and agree current mechanisms and take forward improvement initiatives to ensure both organisational and individual learning is in place with a focus on personal reflection and education.

7.3.8 Human factors, patient safety education and scenario training

The clinical lead for this project will have a major role in assimilating the themes from all the projects to lead the cascade training on patient safety necessary for the success of this programme. It is envisaged that this will include developing the programme that trains up to 70 individuals in safety science as well as ensuring that there are links between safety champions throughout the organisation. Another key role will be planning and helping to deliver scenario based training that will combine elements of mandatory training with specific training in safety methodology and theory. The key focus of this project will be to specifically consider the human factors that impact on understanding, training and failures of care.

8. Patient Engagement in Patient Safety

Patients should be involved in helping to inform patient safety work whenever possible. Patient stories told to staff groups in a facilitated session can be effectively used as an education tool and patients should help to inform the structure and content of information given to them. They should also help to identify issues from their perspective. The existing patient and public involvement groups will be used to ensure appropriate input is given.

9. Specific Programmes aimed at improving patient safety as part of Postgraduate and Undergraduate Medical Education

The part of the workforce which consists of doctors in training is significant and requires a specific focus. Building on the success of the programmes to date involving both medical students and junior doctors, the Trust has committed to developing a leadership programme for speciality training registrars with a view to developing their skills to lead improvement initiatives through rapid tests of cycles of change. We have successfully involved a number of our most junior doctors in improvement projects and it is clear that they have found the ability to effect change very exciting and rewarding. We plan to extend and improve this work.

10. Safety Governance Framework

The patient safety work has largely been separated into those components which are part of clinical governance and assurance and components which are focussed on improvement and learning.

This separation has allowed improvement work to flourish whilst recognising that projects on completion can then be consolidated into what is a normal process.

It is essential that the links between formal clinical governance processes and improvement projects are maintained whilst allowing patient safety improvement work to continue in an environment of freedom to act in an environment of psychological safety. A key feature of some of the successful work to date has been giving support to allow tests of cycles of change.

The role of the key committees in terms of quality and safety and the groups that will feed into them are outlined below.

The **Healthcare Governance Committee** (HGC) is a Board committee that meets monthly and will be chaired by a Non-Executive Director. Members include all Non-executive Directors and all Directors. The minutes of the HGC will be received by the Board and the quality issues on which the HGC should focus will be agreed with the Board on a rolling basis. In addition, the HGC will receive notification from the Clinical Quality and Effectiveness Group regarding areas of quality requiring further scrutiny. Patient Safety and Patient Experience Reports and a trust wide quality dashboard will be received by

HGC on quarterly basis. This committee also scrutinises the compendium of information provided in the quarterly report where there is a focus on quality, safety and mandatory assurance. Patient safety project progress is reported here. That reporting format is to be refined as part of the new Patient Safety programme.

A **Clinical Quality and Effectiveness Group** (CQEG) will be chaired by the Medical Director or Director of Patient and Nursing Services. CQEG will receive Quality Reports from the Safety Academy, the Patient Experience Board and a trust wide quality dashboard for assurance purposes on a quarterly basis.

The **Serious Incident Group** which is chaired by the Senior Risk Manager is responsible for identifying and investigating serious incidents as well as recommending changes and action required to resolve system issues. This has an important link with patient safety and will formally feed into the Safety Academy's work plan.

The **Patient Safety Board** will be chaired by the Medical Director and will be an improvement/ learning forum attended by Patient Safety Leads throughout the organisation. This meeting is run bi-monthly as a series of presentations which are challenged. Another bi-monthly meeting will provide a more structured report on projects which will be provided to CQEG and to HGC in the quarterly report.

The **Safety Academy** will be chaired by the Medical Director and will manage the programme of work contained within the driver diagram in section 8.1.

The **Patient Safety Learning Forum** will be chaired by the Assistant to the Medical Director for Quality and Safety and is a mechanism for Trust wide learning from significant events. Representatives from all areas of the Trust are invited and have a mandate to share lessons with their departments.

The **Hospital Management Group** (HMG) will be responsible for providing operational assurance and escalation of risks to the Trust Board. It will be chaired by the Trust's Chief Executive. It will receive a formal performance report, a monthly quality scorecard and exception report and ad-hoc reports where there are concerns in respect of quality. It also receives reports from CQEG and recommends further actions for consideration by HGC or Trust Board as required. It will receive an update from the patient safety academy on a quarterly basis.

Each **Care Group** will set up a monthly **Governance and Quality meeting** chaired by the Care Group Chair or the Care Group Lead Nurse. The Medical Director and Director of Patient and Nursing Services will be in attendance. The Governance and Quality meeting will receive monthly directorate level reports on patient safety, patient experience and clinical outcomes. The patient safety academy reports and other quality scorecards will also be available here.

Quarterly Performance Reviews will be undertaken with each care Group's Senior Team on a quarterly basis with the Chief Executive and his Director colleagues to provide scrutiny and challenge about how the Care Group is performing. Quality and Safety issues will be specifically focused on within the review as other areas of performance which reflect the Board's commitment to the wider quality agenda. These will include operational performance targets; finance; workforce issues; patient experience; directorate objectives; service strategy; risks.

The **Transformation Programme Management Office** will oversee the programme of work outlined for patient safety and will report to the **Transformation Programme Management Board**. There are clear linkages with the redesign of the emergency pathway which will be facilitated by this reporting framework.

Assurance reports will be received by the Board through the **Patient Safety, Clinical Effectiveness and Patient Experience Report** on a quarterly basis and will focus on Care Group and organisational quality measures. In addition, the Board will receive **quality reports from the Medical Director and the Director of Patient and Nursing Services** on a monthly basis relating to quality and safety issues within their portfolio.

11. Roles and Responsibilities

The roles and responsibilities for quality and safety are set out below and mirror those set out in the quality strategy: -

The **Chief Executive** is the Accountable Officer and has ultimate responsibility for quality within the organisation.

The **Medical Director** and **Director of Nursing** are jointly responsible for Clinical Governance and all aspects of quality.

The **Medical Director**, supported in this work by the senior nurse who is the Assistant to the Medical Director for Quality and Safety, will be responsible for directing the Patient Safety Leads in the Safety Academy . The clinical leads will be supported by a project management structure managed by the Assistant to the Medical Director who will act as programme manager for this work. The Medical Director will lead the work relating to patient safety for doctors in training and chairs the Patient Safety Board.

The **Director of Operations** is responsible for ensuring that quality performance outcomes are met within Care Groups.

The **Director of Strategy and Partnerships** is responsible for ensuring that quality information is available in a timely manner and that data quality meets national standards.

Each **Board member including Non-Executive Directors** are responsible for ensuring that quality is an integrated element of all major discussions and decisions. Quality is a core part of main Board meetings, and 'Patient Safety and Quality' forms a standing agenda item on both public and private Board agendas.

The **Care Group Director, Clinical Chair and Care Group Lead Nurse** are responsible for quality at Care Group level. They will establish a Care Group Governance meeting and report and discuss quality issues as part of the monthly meeting, using tools such as Directorate Scorecards to aid scrutiny.

All **members of staff** are responsible for ensuring that quality and safety is at the heart of what they do.

12. Implementation Framework for Safety

Improving quality and safety is a continuous process and the trust will build on our strengths and previous successes in patient safety, patient experience and on its existing clinical governance infrastructure and the safety improvement work accomplished to date.

The successful implementation of this safety strategy will require that the use of an appropriate range of improvement methodologies and tools are extended supported by appropriate development for individuals. The use of well recognised tools such as measurement for improvement and PDSA cycles will be essential. An infrastructure will be set up to support the patient safety work as indicated above. A structured project team will be required to implement the work as described in section 7 including the detailed plans articulated in the Appendices.

13. Leadership in Patient Safety

The importance of quality and safety must be consistently emphasised at all Trust meetings and events and be embedded into everyday working. This requires strong clinical and operational leadership based on a programme of organisational development to underpin the drive towards continuous improvement. The Board will ensure that successes are recognised and communicated widely internally and to our community, patients, and partner organisations.

Clinical leaders will need to develop and implement plans which are both challenging and realistic, and which focus on redesigning systems to ensure that the opportunity for error in healthcare is eliminated where it can be, and that systems facilitate the right care and mitigate error when it occurs. They also need to recognise that a focus on quality and safety should be considered in all service redesign and that significant efficiency can result from this work.

Appendix 1

SAFETY IN PLANNING- standards to be confirmed once lead in place

Overall Aim: - Improved record keeping , planning of care , articulation of plans, handover of plans, communication to primary care.

10 metrics each built of components– progress against each tracked and reported in a RAG rated dial constructed from a numerical base.

1. Medical Record keeping Standards - Generic

Bundle to include the following (building block for planning medical care): -

- Hospital standards – e.g. black ink, every page with an identifier for patient, in order , no loose sheets, printed name with each entry from anyone who makes entries in the notes
- Medication charts and observation charts are updated to reflect best practice
- Standardised recording of information in the notes
- Links to electronic information clear
- Information consolidation electronically for use in EDN or when patients transferred across the system to include summary record

Measures could be for example: (2 points each to build to score)

1. New medical record policy in place
2. Agreed medical record standard measures for directorate scorecard

3. Audit monthly -10 sheets in 10 notes on each ward – 10 consecutive entries plus overall standards such as? Any loose sheets,? missing proformas, medication charts etc- 80% complete
4. Consolidated lists of department attendances and admissions in place
5. Information from primary care available for each admission to include co-morbidities and medication

2. Medical Notes Documentation Standards for Doctors

Bundle to include: -

- Clarity of who is seeing the patient and when
- Clarity of the contact details of the doctor
- Clarity with respect to the plan of treatment and the course of the patient
- Clarity with respect to what the patient and family know

Measures could include: -

1. Record of most senior person seeing the patient in 100% of cases
2. Daily entry in the notes in 80% of patients (entries include printed name, bleep number, GMC number) medical entry on ward transfer
3. Develop Standardised use of Admission proforma in all areas
4. Doctor's entries clarify progress of patients and course of patient clear from notes in 90% of cases
5. Notes contain evidence of discussions with patient and family in 100% of cases where DNAR in place or patients approaching the end of life

3. Nursing Documentation Standards

Bundle to include the following :(building block for planning nursing care)

- Clarify which assessments need to be done how often , who , etc
- Agree simplification of documentation and recording of actions taken
- Agree audit methodology appropriate
- Agree links to 'the story' in the medical notes??

Measures to include: -

1. Agree audit methodology for nursing records
2. Nursing risk assessments on admission in 90% of patients as determined by sample audits
3. Transfer checklist complete in 90% of patients
4. Actions from risk assessments documented and clear in 90% of patients
5. Nursing records convey a 'story' of care and concerns in 90% of patients

4. Ward Round Checklist and Ward Round Protocols

Bundle of issues: -

- Senior medical review on ward rounds should ensure confirmation of the diagnosis, co- morbidities, VTE risk assessment, investigations and treatments including medication – currently included on ward round checklist sticker
- Joint nursing and medical review can pick up social issues, nursing assessments and aid communication with the patient
- Ward round protocol to cover the above
- Protocol for board rounds to include documentation

Measures could include: (2 points each): -

1. Agree ward round checklist sticker protocol
2. Agree protocol of nurse/medical ward round to follow set standards following formal pilots in 3 areas
3. Agree board round standards including who, when, where
4. Increase use of ward round checklist – 80% of patients have entry with sticker in use during admission
5. Increase number of wards where ward round protocol followed as agreed - 80% of wards use protocol

5. Standards for Consultant Review

Bundle of issues: -

- Affirm and review Current standard is that every patient is reviewed in 12 hours b y a consultant on admission
- Review standards for daily and weekend review – face to face
- Review standards for board rounds

Measures could include: -

1. 80% of patients reviewed by a consultant within 12 hours of admission
2. Agree standards for review of patients after admission
3. Agree weekend review standards
4. Agree Board Round review process
5. 50% increase in documented consultant reviews for agreed patent groups from baseline

6. Documented Plans in Notes

Bundle of issues: -

- A summary of the main problems being treated should be articulated on admission
- A treatment plan should be confirmed by the consultant
- Investigations planned recorded
- Results recorded with clarification of treatments in relation to an outline of the treatments in place already or yet to be given

- Communication of plan and results to patient and relatives
- (CQC standard for x-rays results as an example)

Measures could include: -

1. Treatment plan documented on admission clerking
2. Treatment plan confirmed by consultant in notes after admission
3. Investigations requested are recorded in the notes
4. Results of investigations are recorded in the notes
5. Evidence of communication of treatment plan and test results to patient/family

7. Protocol for Medication Chart Review on Ward

Bundle of issues: -

- Use of the ward rounds to check include aspects of effective medicines management, completion of all sections of drug chart, discuss omissions with nurses, ? pharmacists on ward rounds, basic checks etc
- Incorporation in ward round of checklists to be developed? How many checklists can one have?
- Consider links with the ward round checklist

Measures could include: -

1. Agree test protocol for review of medication chart on ward rounds with simple checks
2. Implement pilot to test efficacy in acute medical wards initially
3. Roll out standards for medication chart review across all wards
4. Pilot pharmacy input to ward rounds versus normal pharmacy input
5. Agree PDSA cycles to monitor improvement

8. Handover – include all aspects of handover

Bundle to include: -

- Standards for night team and electronic handover
- Weekend handovers
- Links between these
- Shift to shift nursing handover
- Medical handovers in specialities
- Board round handover

Measures could be: -

1. Formalise electronic handover process for night team
2. Agree standards for weekend handover
3. Agree task lists for hospital wide sharing and prioritisation for on-call teams- set in context of SAP process
4. Agree mechanism for sharing nurse handover and medical handover – preferably electronically
5. Agree board round process and documentation thereof where used for handover

9. Electronic discharge standards

Bundle of issues: -

- Who should complete, when, what level of detail, what should links be to other discharge information e.g. social care
- Set basic standards for core information with forcing functions to ensure completion
- What is the patient most worried about - add patient concerns (this is a field in admission proforma rarely filled in) to ensure doctors address questions
- What is the risk of readmission – introduce this as a mandatory field – what needs to be done to mitigate this and who should do it

Measures could include: -

1. New electronic discharge form in place with forcing functions
2. Agree risk criteria for readmissions and include on EDN
3. Agree method for recording patient concerns and actions to be taken from this
4. All EDN to be sent within 24 hours- reduce failures by 50%
5. Agree actions to be taken for high risk of readmission

10. Communication with GPs and Social/Intermediate Care

Bundles could include: -

- Setting standards in relation to risk of readmission and risk of failures of care
- Setting standards as to when there should be specific communications and who should be responsible for what aim and what the mode should be – focus on conversations etc
- Thinking about on admission as well as on discharge
- Including standards for family involvement

Measures could be: -

1. Patients at risk for readmission are identified formally and the risk stratified
2. Patients at this risk of re-admission have targeted interventions to include communication with patient, family, GP, social care according to escalation protocol
3. High risk patients are discussed on admission when agreement has been reached that this would be helpful
4. Patients at risk for failure of care on discharge are identified (e.g. compliance issues, deteriorating chronic condition, patient anxiety, family anxiety)
5. Patient/family involvement in discharge documented

Appendix 2

RESCUING SAFELY- detail to be confirmed once clinical lead in place

Overall Aim: - Improve the recognition and treatment of the acutely ill or deteriorating patient

Compliance tracked against the 10 key components and presented numerically

1. Compliance with Early Warning Score recording standards

Bundle to include: -

- Correct observations done
- Added up correctly
- Frequency according to protocol (was the frequency needed clear)
- Referenced in paperwork

Measures could include:

1. Trust wide launch and education to cover new early warning score
2. Trust wide spot audit on scores
3. Process in place for continual measurement and reporting
4. Trust wide process for measuring specific components (e.g. recording)
5. Process agreed for recording of EWS the case notes

2. Compliance with Escalation Protocol from Nursing Staff

Bundle to include: -

- Correct person called
- Repeat call and escalated if no response
- Observations increased according to protocol
- SAP form filled in and recorded in notes

Measures could include: -

1. Trustwide launch of escalation policy for nursing staff

2. Trustwide audit of compliance with policy
3. Trustwide audit of compliance with observations frequency
4. Mechanisms agreed for tracking failure to escalate at ward level
5. Mechanism agreed for tracking SAP form compliance and usage- involving junior doctors

3. Compliance with response to EWS escalation from medical staff

Bundle to include: -

- Appropriate doctor attends
- Appropriate actions taken including understanding need for senior advice
- Documentation of discussion with consultant where appropriate
- Deviation from protocols documented

Measures could include: -

1. Method developed for recording and tracking response to calls relating to deteriorating patients
2. Method developed for handing over calls to responsible clinical team
3. Tool for audit of escalation policy compliance developed
4. Audit put in place with help of doctors in training and 3 PDSA cycles completed to improve
5. Audit results fed back to clinical teams

4. Use of SAP (Situation, Assessment, Plan) forms

Bundle to include: -

- Forms used to improve communication for high risk patients
- Forms filled in correctly
- Response referenced in notes
- Linked to prioritisation for junior doctor task lists

Measures could include: -

1. Numbers of SAP forms ordered by wards
2. Process designed for review and challenge of forms
3. Cycles of testing to improve use in key areas with improved operational policy designed following this
4. Agreed mechanism for recording SAP form request and action in the notes
5. Agreed mechanism for prioritisation junior doctors task lists with reference to SAP forms versus other tasks

5. Use of Pneumonia Care Bundle

Bundle to include: -

- Care bundle sticker availability on key wards
- Care bundles used for pneumonia patients- audit process
- Education programme in place for pneumonia to include CURB score
- Pneumonia diagnosis education programme for medical staff
- Links to EWS response

Measures could include: -

1. Relaunch care bundle stickers on medical wards
2. Extend care bundles to all acute wards
3. Design case based scenarios for pneumonia teaching for multidisciplinary use
4. Design medical student teaching module around pneumonia including oxygen therapy
5. Deliver 3 week medical student programme tarageting pneumonia

6. Use of Sepsis Care Bundle

Bundle to include: -

- Ongoing education of ward staff in targeted areas
- Sepsis Sticker compliance audit
- Sepsis Box compliance audit
- Links to EWS escalation procedures
- Links to critical care /outreach calls

Measures could include: -

1. Re-launch of Sepsis linked to pneumonia teaching
2. Compliance audit of sticker usage – 2 cycles
3. PDSA cycles to improve sticker usage – 3 cycles in 6 weeks
4. EWS scoring audit as part of PDSA cycle
5. Project set up to include Outreach in PDSA cycles

7. Education Programme for all Staff based on the recognition of the acutely ill and deteriorating patient

Bundle to include: -

- How to score
- Why to score
- Links between sepsis, pneumonia, general
- Lessons from Serious Events
- Results of audits of sepsis, pneumonia, EWS etc (time to antibiotics? , time to assessment ?, co-ordination of response, process measures, outcome measures, learning measures)

Measurement could include: -

1. Agree education programme for Trust including target audience
2. Agree linkage with key clinical scenarios where appropriate
3. Develop programmes that pick up mandatory training aspects with EWS with key clinical risk areas around the acutely ill patient
4. Test educational materials

5. Launch programmes and attain milestones set

Bundle to include: -

- Mandatory reflection on failures of escalation agreed e.g. huddle
- Specific feedback targeted at key groups such as junior doctors, consultants, and ward nurses
- Usage of existing mechanisms formalised (patient safety learning forum, morbidity and mortality meetings, grand rounds, breakfast meetings)

Measures to include: -

1. Pilot to develop and test ' huddle ' approach to failure to escalate (use as model for other incident procedures)
2. PDSA cycles to develop this – 4 cycles in 8 weeks
3. Formalise and agree safety learning forums as above and ensure reporting and standards
4. Develop reflection template for appraisal for nursing staff
5. Extend current reflection template for medical staff
6. PDSA cycles for Code Red or equivalent

Bundle to include: -

- Principles of testing agreed
- Targeted interventions in key acute areas
- Multidisciplinary learning to include outreach
- Outreach education links established
- Method for tracking reduction of cardiac arrest calls

Measures could include: -

1. Use 4 PDSA cycles for Code Red on 2 emergency wards
2. Meet with leads to agreed further steps
3. Re-design process to link with EWS
4. Agree education strategy prior to launch
5. Launch Code Red

10. Efficient Effective Outreach Team Usage

Bundle to Include: -

- Consider outreach calls with no involvement of base team
- Consider inappropriate involvement of outreach
- Outreach involvement in handovers of care for acutely ill patients

Measures could include: -

1. Agree outreach education programme for wards with critical care lead
2. Support programme to include outreach education with patient safety leads
3. Arrange case note review for inappropriate referrals to outreach
4. Arrange case note review where no involvement of base team

5. Set up mechanism for outreach involvement in handover of acutely ill patients

Appendix 3

Reducing Harm from failures of care- Detail to be confirmed once clinical lead in place

Aim: - Reduce harm to patients resulting from failures in required basic care

10 metrics each built of components– progress against each tracked and reported in a RAG rated dial constructed from a numerical base.

1. Reduce Harm from MRSA/MSSA/Cdiff/Surgical Site Infection

MRSA (Mandatory Target- need to reinforce existing controls)

Bundle to include: -

- Screening according to protocols
- Decontamination according to protocols
- RCA of all bacteraemias to continue
- Colonisation protocol to continue

C Difficile (Mandatory Target- need to reinforce existing controls)

Surgical Site Infections

Bundle to include: -

- HPA reporting across surgical speciality sites
- Focus on key areas of concern with continual audit
- Agreement on hospital wide programme

Measures to include: -

1. Antibiotic subgroup in place
2. C Diff wards rounds in place
3. Isolation policy in place
4. All testing according to protocol
5. Audit programme for antibiotic compliance
6. Health economy plan to address prescribing
7. RCA process for MRSA and C Diff
8. Hospital wide surgical site programme agreed
9. Continual audit process agreed for outliers for surgical site infection
10. HPA reporting in place across surgical specialities

2. Reduce Harm from Poor Medicine Management

Bundle to include: -

- New drug chart introduced
- Key metrics monitored on safety scorecard
- Medicine administration standards on wards agreed
- Basic training standards agreed

Measures might include: -

1. Drug chart piloted
2. Drug chart introduced on all wards
3. Omitted medicines Audit/allergy audit
4. Reduction in omitted medicines by 50%
5. Oxygen prescribed on chart in 80%
6. Audit of oxygen prescribing agreed
7. Basic training standards agreed for all staff and programme in place
8. Feedback system for errors agreed
9. Allergy recording improved by 50%
10. Oxygen prescribing improved by 50%

3. Reduce Harm from High Risk Medications

Bundle to include: -

- Harm index for each high risk medication agreed
- Reporting mechanism in place
- Learning from error mechanism agreed
- Forcing functions to reduce error agreed

Measures might include: -

1. Each of 4 high risk medications has agreed method of tracking harm- 2 points
2. Harm Index developed as combined score and tracked on corporate scorecard – 1 point
3. RCA of all harm events from high risk meds agreed with medication safety committee- 2 points
4. Learning mechanisms agreed for high risk meds using the event as a trigger to look for possible harm and error- 1 point
5. Introduce system changes to reduce error for each- 1 point

6. Reduce avoidable harm related to high risk medications by 50%- 3 points

4. Reduce Harm from Falls

Bundle to include: -

- Improve training
- Improve assessment
- Environmental factors
- Linking to actions
- Links to reduction in serious falls

Measures could include: -

1. Falls nurse in place
2. Falls group reports formally with multidisciplinary membership and action login place
3. Training programme in place
4. Falls medication focus for medical notes agreed
5. Fall risk assessments- % compliance measure agreed
6. Actions from falls risk assessments taken appropriately (agree audit measure)
7. Serious falls reduction by 20% per year
8. Effective reporting of falls to set baseline
9. Reduction in all falls by 10% per year
10. Bone health improvement programme agreed

5. Reduce Harm from Pressure Sores

Bundle to include: -

- Risk assessments for pressure ulcers
- Relevant actions from risk assessments
- Links to nutrition specified and strengthened
- Tissue viability nurse input agreed
- Training programme for staff
- Clarification of equipment needs
- Inclusion on ward round checklists

Measures could include: -

1. Revise /challenge risk assessment for pressure sores
2. Baseline audit of actions resulting from pressures sore risk assessment
3. Agree PDSA testing cycles to improve actions
4. Revise guidelines for actions from risk assessments
5. Agreed roles and responsibilities of key staff in relation to pressure ulcers
6. Agree training programmes
7. Gap analysis for equipment needs done
8. Agree methodology of combining nurse risk assessment with consultant ward rounds

6. Reduce Harm from VTE

Bundle includes: -

- Risk Assessment for 90% of admission
- NICE compliant guidelines in place for Trusts
- Agreed plan to work towards NICE quality standards- improvement as % of baseline
- Correct TP prescribed in 90% of patients
- RCA for all HAT with themes fed back and actioned

Measures could include: -

1. Introduce new focus on thrombosis prescription as part of new drug chart
2. Commence audit of reassessment of risk after change in condition
3. Revise root cause analysis form for hospital acquired thrombosis
4. Agree audit project for failures of correct thromboprophylaxis
5. Ongoing reporting of RA for VTE and correct TP audits on monthly basis

7. Reduce Harm from Catheter related UTI

Bundle to include: -

- Catheter insertion bundle agreed and in place on all wards
- Reemphasise NPSA alert re female/male catheters
- Define catheter associated UTI – use most up to date agreed definition
- Regular audit of CAUTI
- Agree main areas for focus for improvement

Measures could be: -

1. Catheter Care bundle agreed and in place on all wards
2. Standardised approach to implementation of bundle with appropriate recording
3. Revised procedures for male/female catheters in place
4. Training programme agreed and implemented
5. Audit programme agreed
6. Reduction in numbers of CAUTI by 20% per year

8. Reduce Harm from Never Events

Bundle includes: -

- Policies in place to cover all the listed events
- Training for staff to ensure full understanding
- Maximise learning from events
- Ensure fair and just response
- Reduce numbers

Measures could include: -

1. Take list of never events and ensure procedures/policies in place and up to date for each
2. Re-launch key initiatives where necessary
3. Ensure specific process for ensuring learning from Never Events as part of the SIG group- must include multidisciplinary feedback process for reflection- must emphasise fair and just culture
4. Introduce mandatory interactive training session for the team involved in a never event- include both the specifics of the event and team awareness/building (facilitated session)
5. Reduce number of Never Events to less than 1 per year

9. Reduce Harm from failure to manage patients with Dementia and poor mental capacity

Bundle to include: -

- Awareness and training for dementia and mental capacity
- Appropriate actions to support patients including involvement of the family
- Plan to achieve NICE quality standards over an agreed period of time
- Effective multidisciplinary Dementia/safeguarding vulnerable adults group

Some example of measures would be: -

1. Effective group in place
2. Training programme in place to include refresh of core assessments/advice procedures
3. NICE quality standard action plan in place
4. Pilot environmental signposting with input from patients and families

10. Reduce Harm from failure to manage fluids and nutrition

Bundle to include: -

- Training and education on fluids, fluid balance, physiology of basic fluids in use to be delivered to all nursing and medical staff- focus on why this is important
- Audit of fluid balance charts- both prescription of the fluids and the charting/ addition etc
- Set hospital agreed guidelines for types of fluids to be used (based on issues already identified as a result of trust wide audit
- Audit of types of fluid used- prescription by department and indication according to standards
- Nutritional assessments and actions taken – who should do what – clarify the roles of nurses , doctors, dietician etc (stop over reliance on waiting for dietician – decrease artificial feeds and increase feeding regimes from volunteers etc)
- Education programme to cover the importance of nutrition

Measures could include: -

1. Training programme set up for fluids- 1 point

2. Training programme set up for nutrition- 1 point
3. Audit agreed for fluid balance and mechanism to regular audit cycle- 1 point
4. Hospital fluid prescription guidelines agreed- 1 point
5. Audit of fluid prescription agreed and programme in place to re-audit after 3 months
6. Nutrition /feeding action plan agreed with measures to assess efficacy
7. Audit of weight recording on admission and repeated for all at risk patients
8. Reduction in weight loss in high risk groups as identified (frail elderly ward as pilot)
9. Formal identification of barriers to weight recording
10. Introduce formal volunteer feeding programme

BOARD SUMMARY SHEET	
Title: -	Communications & Engagement Strategy
Submitted by: -	Chris Pallot, Director of Strategy and Partnerships
Prepared by: -	Tony Delaney, Head of Communications
Date of meeting: -	25 April 2012
Corporate Objectives Addressed: -	Foundation Trust status application Patient and public engagement Staff engagement GP engagement

SUMMARY OF CRITICAL POINTS: -
Supports corporate priority to enhance staff, patient and public engagement
Introduces increased opportunities for two-way communication with all audience groups

PATIENT IMPACT: -
Increased insight into the work of the Trust
Increased staff engagement will improve the patient experience

STAFF IMPACT: -

Increased staff engagement has been shown to improve staff satisfaction with attendant increases in productivity and effectiveness

FINANCIAL IMPACT: -
Neutral

EQUALITY AND DIVERSITY IMPACT: -
Increased communication with hard to reach population groups

LEGAL IMPLICATIONS: -

RISK ASSESSMENT: -
Multiple sources of communications activity may lead to confused messaging. This will be mitigated through the establishment of a co-ordinating mechanism through the implementation of the Strategy

RECOMMENDATION: -

The Board is asked to discuss the contents of this Strategy

Northampton General Hospital NHS
NHS Trust

12

COMMUNICATIONS AND ENGAGEMENT STRATEGY

2012 - 2013

Contents

INTRODUCTION

This Communications Strategy is designed to support the Trust's vision, aims and strategic direction as well as the Annual Plan and the first year of the Integrated Business Plan. In turn, the Annual Plan is aligned with the plans of Commissioners and with regional and national priorities.

Northampton General Hospital NHS Trust (NGH) is experiencing an era of NHS evolution when financial challenges are greater than at any time in NHS history, and providers of acute healthcare are compelled to review their business models in the light of increasing competition and required service developments. Simultaneously, external factors - including rising healthcare demand from an ageing population and increasing pharmaceutical and medical technology costs - exert a divergent set of pressures.

For NGH, effective communication with its internal and external audiences is always important; but never more so than in current operating conditions. This is reflected in one of the four corporate priorities newly identified by the Board – to enhance staff, patient, and public engagement.

During 2012/13 there are four particularly significant strands of activity that arise from this background and will be delivered against it.

- **NGH Transformation Programme**. This is the Trust's continuing response to the need to make savings of £19 million in 2012/13, in addition to the £18 million reduction in 2011/12, at the same time as improving quality, innovation and productivity.

- **NGH Foundation Trust status application**. All NHS hospital Trusts are required to achieve NHS Foundation Trust status by April 2014. NGH's application is scheduled to go forward in July 2012.

- ***Healthier Together* – South East Midlands Acute Services Review.** A project designed to develop reconfiguration options for hospital services provided by the five district general hospitals serving Northamptonshire, Milton Keynes and Bedfordshire. These changes are aimed at improving patient outcomes and making cost savings primarily by concentrating certain services in fewer centres.

- ***Delivery of the Trust's Quality Strategy.*** In particular patient safety, the re-design of the Pathway for unscheduled care and the programme to improve patient experience.

There are interdependencies between these four topics. Clearly, each has its own implications for the hospital, its staff, patients, the public and stakeholders. Each topic has its own Communications Action Plan (see appendices, but each plan will have some shared messages for their shared audiences). As a result an overarching communications vehicle will present all four topics in the context of the future development of NGH as defined by the Integrated Business Plan. This matrix will require careful management to ensure consistency and credibility.

Beyond these headline topics there is a full range of continuing communications activity designed to engage all of the Trust's audiences.

1. Why Communicate?

There is a wide range of evidence to support the significant contribution that effective communication can make to improving organisational effectiveness and performance.

According to a study by Capgemini Ernst & Young in 2003, between 80–85% of the market value of the top 500 US companies was comprised of intangible assets such as reputation. And when looking at the impact of reputation on customer loyalty, a study of the US airline industry by M. Graham and P. Bansdal in 2007 found that for each one-point increase in an airline's reputation, consumers were willing to pay $18 more for a plane ticket. In short, there is much evidence that reputation is a key contributor to the health and performance of businesses.

The evidence that communication makes a vital contribution to organisations applies to public services as well as to businesses. Over the years, the survey research organisation Ipsos MORI has developed a substantial amount of data related to the overall performance of local public services and their communication effectiveness. Within the NHS, it found that better-performing trusts committed more resources to communication, were more likely to have marketing strategies in place, and had communication teams that were more influential. It also found that staff in trusts rated as 'excellent' were significantly more likely to understand their roles than those in weak-performing ones.

Ipsos MORI also looked at the communication effectiveness of 29 London local authorities, including 7 that were rated as 'excellent' by the Audit Commission for 2003/4. It found that all 7 'excellent' councils were also among the top 11 councils rated by the public as being the best at keeping them informed.

Good communication is also important for engaging with staff. The Cabinet Office carried out a review of the evidence base for employee engagement during 2007, as part of its work on improving engagement with civil servants across all government departments. It showed that engaged staff are 43% more productive,

perform up to 20% more effectively and take an average of 3.5 fewer sick days a year than disengaged staff.

A key element in management of the Trust's reputation is its staff. Many of the 4,000+ workforce have a direct interface with patients and are in a position to influence patients' perceptions of the Trust and the services we provide. All staff have family or friends on whom they can have a similar impact. If staff are positive about the Trust it will reflect in their performance which, in turn, will impact on the patient experience.

So, good communication that engages staff, customers/patients and stakeholders is vital to organisational success.

2. Aims

The principle aim of this strategy is to promote understanding of and support for the Trust's vision and strategy among its key audiences and to contribute to providing the best possible patient experience. Additional aims are: -

- To ensure staff are aware of the challenges facing NGH, share in the values and strategic objectives of the organisation and understand their contribution to making them a reality
- To engage and empower staff in the day-to-day running of our hospital and with the Trust's longer-term strategic goals and those of the NHS
- To promote a quality-focused culture throughout NGH encouraging an open and transparent two-way flow of information between wards/departments and the Board
- To support the health and wellbeing of all staff for their benefit and that of our patients and the wider community
- To respect the rights of staff and to deliver our responsibilities as set out in the NHS Constitution
- To develop clear two-way communications with all partners and influential local opinion formers to support close working and understanding. This will help to ensure a positive image and reputation for the organisation
- To continue to build trust in the organisation by users of the service and the general public and to build and protect NGH's reputation
- To build loyal and lasting relationships and confidence in NGH through active patient, carer, visitor, member and public engagement

- To focus in particular on supporting and promoting
    - Service transformation projects and anticipated quality benefits, cost savings and efficiency gains.
    - NGH's application for NHS Foundation Trust status and Membership Strategy
    - The increased visibility of Executive Directors and Senior Managers

3. Audiences

Internal

- All staff groups
- Shadow and subsequently elected FT Staff Governors
- Trust Members
- Trust Board
- Trade Union full time officers, staff-side representatives and their members
- Volunteers and Friends of NGH

External

- Public, patients, family and carers

The following have been identified as hard to reach groups within our locality: -

- People with disabilities
- The deaf and hard of hearing
- Carers
- Children and young people
- Certain BME groups

- GPs and Clinical Commissioning Groups
- Northamptonshire LINk (to be subsumed into HealthWatch)
- Local Strategic Partnerships
- Our local health and social care system
- Other health partners including East Midlands Ambulance Trust, Northamptonshire Healthcare NHS Foundation Trust, and other neighbouring acute and Primary Care Trusts
- Strategic Health Authority
- Local Medical Committee

- Northamptonshire County Council (NCC), Northampton Borough Council, District Councils other relevant local authorities
- NCC Health Overview and Scrutiny Committee
- Emerging Health and Wellbeing Boards
- Voluntary organisations (e.g. Help the Aged and Family Carer/Patient groups)
- The business community
- MPs
- The media

4. Key Messages

Key messages serve many purposes. They help to focus thoughts on the story we want to convey. They can be developed with staff to help them feel part of the organisation and disseminating them widely helps the public understand our vision and their local hospital. They also support consistency across all communications channels.

Key messages also help to evaluate and measure the success of any campaigns by testing awareness before, during and after, as well as their take-up by the media.

Key messages should be devised, and adapted for specific audiences, for all campaigns, projects or initiatives to reflect the organisation's priorities.
There are already a number of core key messages arising from and supporting the Trust's vision of providing the very best care for all our patients.

- NGH provides high quality, clinically safe and financially sustainable services for all our patients

- The Trust is continuously seeking to develop innovative services and care pathways which meet the needs of our population, not least by consolidating and enhancing our position as one of the hyper acute hospitals in the South East Midlands network

- Developing a staff culture in which delivering excellent patient care in an environment in which they are proud to work

- Developing effective partnerships – such as working alongside commissioners to re-design the emergency care pathway - which will be crucial to realising our future

5. IMPLEMENTATION

5.1 Internal Communications

Internal communications are targeted at all staff groups and volunteers. Specific communication plans and messages are produced for all key developments and major projects in the Trust and these are aligned with the Communications Strategy and appropriate business/organisational plans.

One in four patients gain their impression of the health service directly from friends and family who work in the NHS and these impressions last. Around 4,000 members of staff and some 200 volunteers work for the Trust and how they interact with people has the potential to either enhance or tarnish the Trust's reputation.

Motivated and involved staff are better placed to know what is working well and how to improve services for the benefit of patients and the public.

5.1.2 Methods for Internal Communication

The Communications Department uses a wide range of methods to inform and encourage two-way communication with staff and volunteers. Some new or revitalised methods are highlighted in the following lists.

Written

- The Point newsletter – (published via the intranet/email)
- **Core Brief – supports team briefing (*designed to promote feedback*)**
- Summary Trust Annual Plan (published on the website)
- Staff handbook
- Pay slip attachments

E-Communications

- Broadcast email
- **Online surveys using Survey Monkey – hard copies can be produced (*designed to promote feedback*)**
- Social media (online communities or networks) are being looked at as a means of improving communication to those that do not access existing methods. Feedback is integral to these channels.

Meetings

- Corporate Managers – for cascading corporate information down through the organisation via team briefing
- Staff induction – CEO welcome address
- Chief Executive/Executive Director Transformation Briefings Briefing with Q&A sessions if a particular issue demands e.g.
- Chief Executive Question Times. A rolling programme of events where the Chief Executive attends a pre-arranged ward or department meeting to communicate directly with staff in face-to-face Q&A sessions. Non-Executive Directors attend as appropriate. Question Times are arranged by the Communications Department, with a lead member of staff identified to communicate arrangements to their teams. Staff are encouraged to ask questions or, if they would prefer these to be anonymous, to provide them in advance to be answered during the session. The same approach may be applied to larger scale 'Town Hall' staff meetings.

Other

- Clinical and environmental walkabouts help improve the visibility and accessibility of senior managers to staff across NGH and highlight important quality messages

Awards and Recognition

- External awards e.g. Health and Social Care Awards, Health Service Journal Awards, Nursing Times Award etc. The Communications Department will promote entry and support staff with their applications
- Internal awards - annual Star Awards
- Volunteers and Friends of the Hospital, who act as ambassadors for the Trust will continue to receive recognition for their valued contribution

5.2 External Communications

External communications are targeted at all our identified external audiences. Specific Communication Plans and messages will be produced for all key developments and major projects in the Trust. These are aligned with the Communications Strategy and appropriate business/organisational plans.

It is important for NGH to be seen as an organisations that generates confidence, puts patients first, values its staff, is continuously looking to improve the quality and accessibility of its services, and is honest, open and transparent.

We will encourage active partner engagement to build loyal and lasting relationships and underscore confidence in NGH.

Communication with hard to reach groups is a real challenge. The Trust will co-operate closely with Commissioners and other stakeholders to continuously identify and address issues specific to the hard-to-reach community groups.

5.2.1 Trust members and Board of Governors

A positive aspect of our Foundation Trust application has been the engagement and input of Trust members. To date we have more than 4,000 local people who want to be more informed and involved in the work of NGH. Members will continue to be involved in the identification of future quality priorities and feedback on our services.

The Governors will be supported in their role of representing the views of the public and ensuring membership is representative of the people we serve. We will continue to hold special interest talks that attract large audiences and offer further opportunity for feedback on our services.

5.2.2 Patient and Public Engagement

The Trust supports a range of methods to hear the views of our patients and wider public. Our listening tools include: -

- Ongoing patient surveys in all wards and many departments (reported to the Trust Board monthly)
- Identification of themes from complaints and PALS
- Membership of, and attendance at, voluntary organisation meetings
- Patient user and support groups
- Patient stories at the Board and Director ward visits

We will promote how patients and the public can make their views known and equally important the changes/improvements put in place in response to this feedback.

5.2.3 GPs

GPs are taking on the role of Commissioners of Services. NGH will build on the existing good relationships with GPs to work more closely with them to shape future service provision that best meets the needs of local people.

GPs are among the most trusted sources of healthcare information for patients. They have a strong influence over patients' choice of healthcare provider and therefore warrant our communications and marketing focus.

GP News, the electronic quarterly newsletter will continue to be developed in response to GP feedback. This will now form part of a wider GP Engagement plan (See *Appendix 3*)

5.2.4 The Media

Health and the NHS are particularly newsworthy and attract a great deal of interest from the media who can have a disproportionate influence on public perception of the Trust's services. The Communications Strategy aims to promote the good work of the Trust and to develop and protect its reputation with and through the media. An outline Media Plan has been produced (See *Appendix 4*). Another tool to support media handling activity is a monthly Media Planner (See *Appendix 5),* which will include information about proactive media activity as well as highlighting potential media interest forecast as a result of horizon scanning activity.

We will respond promptly and robustly to negative publicity to minimise its impact. We will closely monitor external website such NHS Choices, Patient Opinion and Netmum sites which encourage patients to share their experience of a hospital and its services on line.

5.2.5 Methods for External Communication

The Trust uses a wide range of methods to inform and encourage two-way communication with our external audiences/partners

Written

Newsletters

- Quarterly FT Members newsletter
- Quarterly GP Update
- Summary Annual Plan
- Annual Report
- Quality Strategy
- Quality Accounts
- Board Reports
- Posters/Flyers

E-Communications

The use of social media such as Facebook, Twitter and YouTube is being explored as means of creating online communities for Trust membership. This will be particularly useful in broadening the appeal of membership. A Facebook and Twitter presence for NGH will allow distribution of media releases and other publicity to new audiences. An NGH YouTube channel is under consideration. For the moment, e-communication is limited to: -

- Web site
- Section on external web site for Trust membership
- Broadcast emails to Trust membership
- Media coverage summary email to shadow Board members

Meetings

We will maintain contact with all our external partners and in particular meet regularly with: -

- Colleagues in the local health and social care system and local government
- GPs and emerging GP Commissioners
- Representatives of LINks
- MPs
- The media

Other meetings include: -

- Trust Board
- Shadow Board of Governors
- Special Interest Talks for Trust members
- Use of focus groups as appropriate
- Regional and county communication networks

Freedom of Information Act 2000

The Freedom of Information (FOI) Act 2000 has given the public unprecedented access to information, files and decision-making processes of the Trust at all levels. The FoI Act requires that trusts produce a Publication Scheme to show what information will be available on request. The Trust has agreed to make as much as possible available, particularly on the website, to reduce requests for information.

6. Communications Evaluation

Action Plans will be evaluated using detailed assessment of feedback from: -

Internal

- Staff surveys
- Staff conversations
- Patient surveys
- Chief Executive staff briefings
- Feedback forms attached to team briefing
- Quarterly Board report

External

- Annual NHS staff survey
- Annual NHS patient surveys
- Analysis of complaint letters and comments received by PALs
- Analysis of our Trust membership
- Engaged FT members questionnaires and Active FT members focus groups
- Future reports and feedback from LINks
- Usage of the intranet and Internet sites monitored through traffic analytics.
- Interactive surveys/polls on the website
- Press cuttings taken to assess coverage and the balance between positive and negative stories. We will benchmark this quality balance and then digitise the media coverage information flow to produce a monitoring system that can provide quarterly and annual performance reports.

- Close monitoring of websites which carry feedback from patients who have experience of NGH services. These include: -

    - NHS Choices
    - Facebook
    - Patient Opinion.orgNetmums.com (Netmums is the UK's fastest-growing online parenting community with over 1.2 million members and 5 million visits. Netmums is a family of local sites offering information to mothers and discussion forums

7. Implementation Plan

It is important to recognize that these deliverables will all contain bespoke key messages linked to the Trust's vision, aims and strategic direction.

Issue	What will be delivered	When	Subject Matter Expert
NGH strategy and objectives	**Annual Plan** Produce summary of the Annual Plan for internal and external circulation. **Corporate messages** Communicate the challenges facing the Trust, and the tactics being used to meet them including QIPP and the service Transformation programme. Advise on messages and support for stakeholder meetings and team briefings Specific work plans to be produced for key projects/developments including • NGH Transformation/CIP • Actions recommended to increase visibility of Executive Directors and Senior Managers • Quality Strategy Clinical – quality priorities, quality walkabouts, quality posters. • NGH NHS FT application • Urgent care pathway redesign • Healthier Together (ASR)	**April** **Ongoing** **As required** **End April**	Karen Spellman Appropriate senior manager(s) Appropriate senior manager(s)
Reputation Management and Marketing	**Brand Management** Promote, develop and protect the Trust's brand image and corporate identity	**Ongoing**	Chris Pallot Karen Spellman

	Quality Accounts **Annual Report** Lead the production and distribution of these key public documents. **Marketing** Support the development and implementation of the marketing strategy		Exec Team Nina Fraser Chris Pallot Karen Spellman Sean McGarvey
NHS Foundation Trust	**NHS FT Application** Develop refreshed approach and messages for internal and external audiences Regular communications and reminders of the benefits of FT status. Provide support for the two sub committees of the Shadow Board of Governors: • Patient and Public Engagement • Membership Provide support for the Membership including: • Quarterly newsletter • password protected Governor site Provide support for Special Interest Talks **Plans in development for communications post authorisation**	**Immediate**	Appropriate senior manager(s) Nell Morton
Staff engagement	**Staff Governors** Provide communications support for Staff Governors **Communications Survey** Use Survey Monkey service to		

	develop in-house survey to gather feedback on the effectiveness of staff communications. • The Point e-newsletter • Relaunched Core Brief – supports team briefing (*designed to promote feedback*) • Summary Trust Annual Plan (published on the website) • Staff handbook • Pay slip attachments **Meetings** • Corporate Managers – for cascading corporate information down through the organisation via team briefing • Staff induction – CEO welcome address • Chief Executive/Executive Director Briefing with Q&A sessions if a particular issue demands e.g. Transformation Briefings • Chief Executive Question Times. A rolling programme of events where the Chief Executive attends a prearranged ward or department meeting to communicate directly with staff in face-to-face Q&A sessions. Non-Executive Directors attend as appropriate. Question Times are arranged by the Communications Department, with a lead member of staff identified to communicate arrangements to their teams. Staff are encouraged to ask questions or, if they would prefer these to be anonymous, to provide them in advance to be answered during the session. The same approach may be applied to larger scale 'Town Hall' staff meetings.		Various sources Appropriate senior manager(s) Appropriate senior manager(s)

	Other • Clinical and environmental walkabouts help improve the visibility and accessibility of senior managers to staff across NGH and highlight important quality messages **Awards and Recognition** • External awards e.g. Health and Social Care Awards, Health Service Journal Awards, Nursing Times Award etc. The Communications Department will promote entry and support staff with their applications • Internal awards - annual Star Awards		Appropriate senior manager(s) Appropriate senior manager(s)
Relationship with partner organisations, stakeholder, key opinion formers	Attendance and participation in NHS Northamptonshire series of Health Communications Network meetings for health economy comms leads.	**Regular attendance**	Tony Delaney

8. Looking forward

This element of the strategy looks at opportunities for development of more effective internal and external communication.

Most significant is the absence of a formal staff engagement policy. As a result there are no consistent communication channels or forums which contain the opportunity for two-way engagement. Such channels as exist work very well for the purposes for which they were developed. In many cases this does not cater for the need for two-way communication back up through, or indeed across, the organisation.

The adoption by NGH of the Listening into Action (LiA) staff engagement strategy will bring about positive change in this and other facets of staff engagement. The communications will be able to provide information, advice, facilitation and support.

A second observation is that there are a number of centres of communications activity across NGH that operate independently of each other. In addition to the communications team they include: -

- Membership management
- Patient and public involvement
- GP relationship management
- PALS and Complaints
- Freedom of Information
- Marketing

These are all excellent resources. However, one of the imperatives of corporate communications is that there should be consistency of messaging. In that context, current circumstances represent a risk. Mitigation can be achieved through the creation of a steering group to provide co-ordination and the development of a shared approach.

Conclusion

This strategy provides an overall framework to support the Trust's internal and external communications for the coming year and includes detailed plans for some already known topics. It identifies ways in which its effectiveness can be measured. It supports the development of the "Listening into Action" staff engagement strategy and provides a platform to allow the drawing together of strands of communications activity across the Trust to ensure consistency of message in terms of both content and tone.

Appendix 1: Communications Principles

Open: Our decision-makers will be open to dialogue. Where it is not possible to provide information, we will explain why.

Two-way: We will encourage feedback from staff, patients, the local community and other stakeholders and use it to improve services and inform our decision-making.

Timely: We will provide information when it is required and in time for people to make informed choices and decisions.

Clear: Plain English will be used whenever possible so information is accessible to diverse audiences and there is no scope for misinterpretation.

Corporate: Our messages will reflect our corporate aims and objectives, and those of the wider NHS and our partner organisations.

Consistent: Messages given to different audiences must not conflict, although they may vary and we may use different language or modes of communication.

Accurate: We will aim to ensure high standards of accuracy in the information we provide and the way it is communicated.

Trust-wide: Everyone working for the Trust communicates on its behalf. All staff members are responsible for ensuring good communications.

Accessible: We will aim to ensure all audiences can access and understand information about the Trust, regardless of ability or circumstances, by using a variety of communications tools and making information available on request in other formats.

Appendix 2: Foundation Trust Communications Plan

Narrative

Northampton General Hospital has served its population since the first Infirmary was opened in 1743.

Since then it has been at the forefront of healthcare provision development; from raising public subscriptions locally and expanding in the 18th and 19th centuries, through the emergence of the NHS in 1948, to today with the explosion of medical advances that have seen NGH become a leading district general hospital whose offering includes hyperacute services and operating as the area's cancer treatment centre.

NGH's vision is to provide the best possible patient experience through achieving its aims of: -

- Being a provider of quality care for all our patients'
- Enhancing our range of Hyper Acute services for the wider community
- Providing appropriate care for our patients' in the most effective way
- Fostering a culture where staff can give their best and thrive
- Ensuring we invest wisely to make improvements in care

NHS hospitals can apply to become NHS Foundation Trusts (FTs). The additional freedoms enjoyed by FTs will enable NGH to deliver its aims and vision successfully through greater control of its own destiny, balanced by a greater level of accountability to its population.

At present NGH is an NHS Trust. In 2006 the hospital began its journey toward achieving NHS Foundation Trust status. Much has been accomplished and now that journey is reaching its final phase. In July 2012 our Business Plan will be submitted for approval. If successful, NGH will be an NHS Foundation Trust within 12 months.

We believe that Foundation Trust status will offer us greater flexibility to tailor our services to meet the needs of our local community and respond more quickly to their needs. As an NHS Foundation Trust we will fully be part of, and committed to, the NHS and provide services to our patients' on the basis of need, not the ability to pay. However, we will have greater freedom from the controls of government to enable us to respond more rapidly to any changes in services that are required to reflect local needs and priorities.

We already have a committed core of Members who have been recruited to help us ensure our services meet local expectations and needs. Our Shadow Governors' Council is active in supporting the wider work of the hospital and the Trust Board. We continually seek to expand membership.

NHS Foundation Trusts are membership organisations free from central government control. There is an independent regulator called Monitor to protect the public interest.

If Foundation Trusts make a surplus they can invest this in services. At present if NGH makes more money than it spends, the surplus can be taken back by the NHS. Foundation Trusts also have more freedom to borrow for capital projects like new buildings.

Foundation Trusts have to deliver on national targets and standards like the rest of the NHS, but they are free to decide how they achieve this.

Key messages

These need to excite people about new developments and better services, and the chance to have a real say in how their health services are run, but also to provide reassurance that what will happen is fully within the values and structure of the NHS.

- We will have much more freedom to make sure our future plans best meet the unique needs of our local community. That's important because of what we already know about the future of our population – growing, ageing and living longer

- We will be able to retain any extra money we generate to invest in new services for our population, and we will be able to borrow money to support these investments

- We will be more accountable and answerable to local people through the Trust Membership and our Council of Governors, so you have the chance to have a real say in how your health service is run

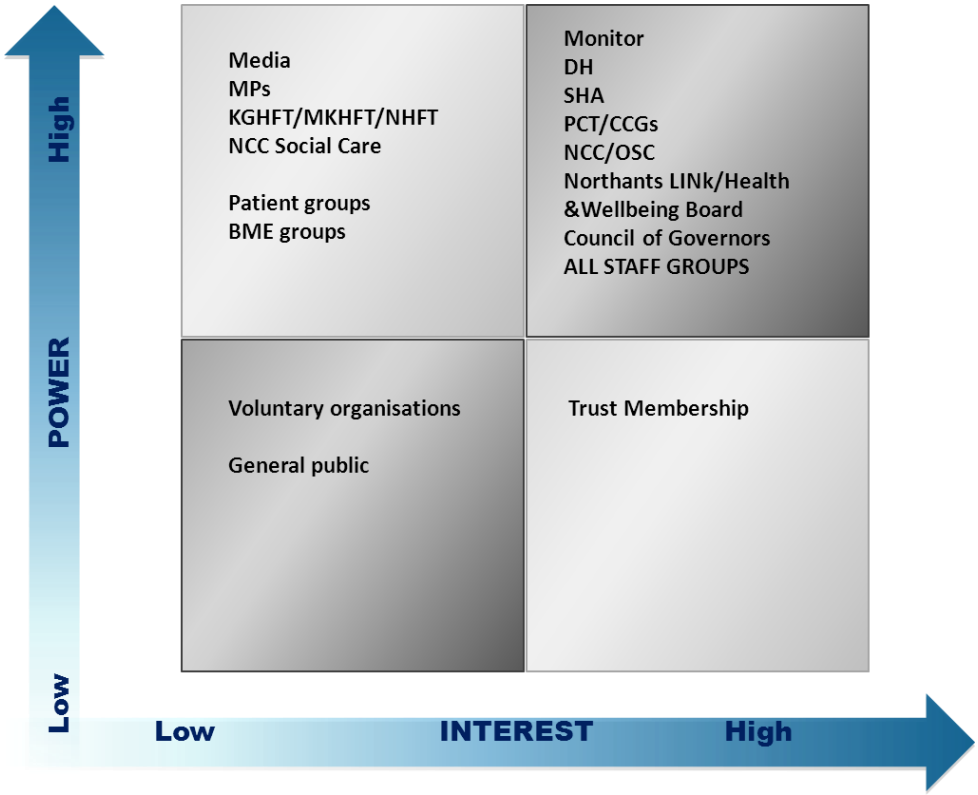
- Quality is, and will continue to be, a central plank of everything we do – from providing patient care to managing our resources (This is a particularly important element in staff communication)

Interacting with our Audiences

The people who make up these audiences are not necessarily members of just one group. While consistency in message delivery across the board is important, there is also opportunity in the ability to vary the emphasis between audiences to enhance our ability to influence responses.

Staff is the most significant audience in terms of their ability to influence the application process directly and to influence the attitude of others.

Stakeholder map



Group	Organisation	Communication activity	Timescale
Public Affairs	NCC/OSC./Health & Wellbeing Board Northamptonshire LINk MPs (All Northants + MK) Voluntary organisations	Letter from CEO with supporting information Offer of meeting/briefing Speaker at meetings offer	April 2012 and ongoing as part of the phased plan
NHS	SHA PCT cluster GPs/CCGs	Letter from CEO with supporting information, Offer of meeting/Include as agenda item in	April 2012 and ongoing as part of the phased plan

	KGH/MKH NHFT NCC Social Care	meetings already scheduled Speaker at meetings offer GP News e-zine	
Staff Engage and involve (active 2 way engagement/communication)	All staff groups within NGH	Senior management interactive presentations Team-based Q&A sessions Interactive online survey (must include Quality for submission evidence) The Point e-newsletter Intranet Posters Wallet card with Visions and Aims External Facebook and Twitter promoted internally	April 2012 and ongoing as part of the phased plan
Governors and Membership Engage and involve (active 2 way engagement/communication)	Council of Governors Staff Governors Membership	Senior management interactive presentations Membership magazine (not precluding additional 'special editions') Interactive online survey (must include Quality for submission evidence)	April 2012 and ongoing as part of the phased plan

Media	Print, broadcast and online Mainstream Professional	Media releases Senior management interview access Staff Governor interview access Council of Governors spokesperson interview access Membership voices interview access	April 2012 and ongoing as part of the phased plan
Patients/Public Engage and involve (active 2 way engagement/communication)	Patient groups General public Nene Commissioning Patient Congress BME groups	Offer to send speaker to meetings Insight magazine Media relations activity results (inc. BME media) Website page Interactive online survey Facebook Twitter	

Evaluation

- The initial staff online survey will service as benchmark of opinion, satisfaction with staff comms etc
- Response and feedback from online surveys of staff, patients, public, membership, Governors
- Web activity levels
- Social media development/interaction levels
- Level of participation in events of other organisations and partners

Appendix 3: GP Engagement Plan

GP ENGAGEMENT PLAN

1 INTRODUCTION

Northampton General Hospital is committed to developing and improving communication and engagement with all GPs in the county and surrounding locality. To do this, we will undertake a planned and sustained approach to communication and engagement to support our core business of delivering high quality care to patients.

A key aim for NGH is to maintain and enhance our position as the local provider of choice through delivering patient centred services. Central to our success is a positive and constructive relationship with our patients, GPs and the wider community. We recognise the importance of focussing on our customers' requirements, seeking feedback on our services and responding to their needs with service changes that deliver ever increasing levels of patient satisfaction.

This plan is aligned to the wider NGH communications strategy (2012) and concentrates on the communication and engagement requirements of NGH with GPs and local stakeholders.

In developing our external approach, there will be a range of ways of engaging with local GPs to ensure continual feedback and provide them with access to good, reliable information about our services. This plan is designed to enable a policy of active engagement with all GP stakeholders in order to enhance our reputation and to generate an appreciation in the community of the progress that has been made at NGH to improve service quality.

A wide range of actions relating to communications and engagement have been developed and are highlighted and reviewed throughout the strategy.

2 COMMUNICATIONS

A key principle of this plan is to develop improved two-way communication with an emphasis on consultation and encouraging constructive debate and feedback. This plan proposes to make greater use of electronic communication as well as developing opportunities for face to face communication between NGH staff and GPs. This will be achieved by: -

- **A lead for co-ordinating GP liaison and communication.** This is a central role in the organisation responsible for co-ordinating all GP liaison. This role will ensure appropriate NGH representation at all key stakeholder and locality meetings. They will co-ordinate feedback from GPs and ensure a responsive approach to requirements

- **Update the NGH website.** GPs have requested easier access to contact details of consultants at NGH. The updated website will include details of services provided and contact details for consultant teams

- **GP Directory.** In addition to the information provided on the NGH website, a detailed directory of all services and contact details for all NGH consultants and their secretaries has been published to the Pathfinder website. Annually a full review and update is carried out with ad hoc changes made throughout the year

- **Promote the use of Advice and Guidance.** Local GPs have asked that NGH and GPs increase the use of the Advice and Guidance facility on Choose and Book for communicating with consultants. We will promote the system with GPs and consultants and develop a robust monitoring system to review its usage and effectiveness

- **GP Buddy Scheme.** This is a scheme by which NGH consultants are partnered with GP practices within a locality to enable two-way communication between each organisation at a clinical level. The consultants have made initial visits, with each practice choosing the most appropriate way forward for them. Feedback from consultants and a review of the scheme is currently being undertaken.

- **News for GPs.** This e-newsletter incorporates updates on service developments, and performance achievements. There are opportunities for GPs to feed back any comments or requests for specific information. The distribution and format of the newsletter will be monitored continuously by the NGH communications team

- **Attend all Nene Commissioning Locality meetings.** Nene Commissioning host monthly locality GP meetings. The lead for co-ordinating GP liaison will ensure appropriate representation at each of these meetings. There will be a feedback mechanism at NGH to ensure any issues identified will be fed back to the relevant team. Attendance at these meeting will be by invitation.

- **Co-ordinate all GP communication and marketing with the NGH Public and Patient Involvement Strategy and NGH Communication Strategy.** GP engagement and communication will not be carried out in isolation of other NGH communication and engagement strategies. A series of approaches is required In order to ensure ongoing engagement with all stakeholders.

- **Issues Log.** This is a joint pilot scheme carried out by Nene Commissioning, NGH and KGH. This scheme has been piloted across 16 GP practices and the Medical Directorate at both hospitals. A review of this scheme is currently being undertaken to determine the success and possible future roll-out.

3 MARKETING AND ENGAGEMENT

Ongoing market assessment is required to assess our current market position and identify any key issues that are likely to impact on demand for our services. This will be achieved through the following: -

- **Marketing Group.** There will be a small group established at NGH with the responsibility of co-ordinating the marketing approach and GP liaison. This will consist of, Deputy Director of Strategy & Partnerships, Business Development Manager (lead for coordinating GP Liaison), Head of Communications and NGH Membership Manager

- **Ongoing Market Analysis of Activity.** Activity will be monitored on a quarterly basis by specialty and locality using Dr Foster and NGH systems to identify any trends and changes in activity and referral patterns. This is carried out for the 6 key localities, Northampton Central, Northampton West, Northampton South East Daventry North, Daventry South and Wellingborough. Market analysis feedback will be forwarded to the Executive Team and relevant directorates. The ongoing market analysis will ensure resources are targeting practices and localities with greatest potential impact

- **Ongoing monitoring of Business Intelligence.** On a weekly basis, all relevant local and national sites will be monitored to identify any changes that are perceived as having a potential effect on NGH's service delivery. This will include infrastructure developments within Northamptonshire as well as specific health care developments. Details will be collated and submitted to the Executive Team by 14:00 on a Friday to enable submission to the Executive Team Meeting's agenda. The responsibility for this lies with the Business Development Manager

- **Face to face Feedback.** The GP Liaison role will ensure NGH representation at all Nene Commissioning locality meetings. There will be a standardized template to complete following every meeting detailing any feedback GPs, suggestions for improvements or access to services etc.

- **Centrally held repository for collating and analysing GP Feedback.** There will be a centrally held repository, managed by the Planning and Performance department for collating and analysing the GP feedback gained from the annual survey and attendance at all locality and stakeholder meetings. This will ensure a coordinated response to all requirements

4 SUMMARY

This strategy outlines a range of activities developed to ensure a robust process is in place to develop continuing communication and engagement with our local GP partners. All communication and engagement activities will be evaluated and the impact monitored. By understanding our stakeholder expectations and taking a responsive approach to their requirements, the Trust will be able to continue to improve and promote the services that it offers to patients, protect the Trust's reputation and continue to remain the hospital of choice.

GP Engagement Action Plan March 2012

	Action	Lead	Timescale
1	Ongoing market analysis of activity. Across NGH's key catchment localities	Sean McGarvey	Quarterly
2	Carry out ongoing monitoring of business intelligence	Sean McGarvey	Weekly
3	GP e-newsletter	Tony Delaney	Quarterly
4	Attend Nene Commissioning locality meetings as requested	Chris Pallot Karen Spellman	Monthly

5	Maintain a centrally held repository for collating and analysing GP feedback	Sean McGarvey	Ongoing
6	Review GP Buddy Scheme	Chris Pallot Sonia Swart	April 2012
7	Maintain Consultant Directory	Sean McGarvey	Ongoing
8	Issues Log	Sean McGarvey	April 2012

Appendix 4: MEDIA RELATIONS PLAN

Media Activity Planning for 2012/13

INTRODUCTION

This media plan is designed to support the delivery of the Communications Strategy and its role in the fulfilment of the Annual Plan and IBP. This proactive media programme will contribute to enhancing our reputation and increase awareness and understanding of our offer.

The limiting factor for planned proactive media activity is the significant additional commitment to unpredictable reactive media management requirements that form a substantial part of our activities overall. The implicit level of team time allocation to this plan reflects this dynamic.

There is a strategic element in this plan in that there is a need to inform and enthuse colleagues who are the internal gatekeepers for the information that forms the raw material for all proactive media activity. Continuing relationship building with editors, producers, specialist writers and reporters who are the gatekeepers for our target media is also a key activity strand.

This plan also identifies the means by which its achievements will be measured. Internally, there is a mixed level of interest and consideration of proactive media management as a promotional tool. Our challenge here is to provide information and motivation that will raise awareness of the business value of planned media relations activity for appropriate areas of Trust activity.

ISSUES AND ACTIVITIES

A wide range of other issues will be **supported by proactive media and public relations work** such as patient and public engagement activities, support for social marketing initiatives, public health campaigns etc. In addition there is an annual calendar of known events (e.g. Board meetings, AGM, the opening of the Haematology Building, various dedicated condition-related Days, Weeks and Months (e.g. No Smoking Day, and the Choice and Winter Messages campaigns) which will form an extensive basis for further activity.

A continuing rolling programme of **face-to-face relationship building** with key media figures has already begun. Where appropriate a journalist at these meetings will be offered exclusive access to an agreed piece of information.
Subsequently it is intended to **introduce journalists individually to the staff** members who will become frequent media contributors of comment and expertise. Eventually it is intended to hold occasional **media receptions** to allow journalists to meet senior managers and spokespeople on a semi-formal basis with no apparent agenda. Such events are often used fill in gaps in journalists' awareness of background information either about the organisation or current issues.

TIMING

Waiting for things to happen and then responding is not authentic media relations. At best, it is missing the boat, at worst it is dangerously hasty damage limitation in a crisis. Media relations activity should set out to intercept and influence the media agenda. This can be achieved by either news creation or news management.

News creation operates by having knowledge and understanding of what will make news and then originating a development which will attract coverage.
News management is considerably more sophisticated and requires an appreciation of the media agenda on a par with senior journalists and broadcasters. It also requires a realistic appreciation of one's own organisation's limitations as to weight and relevance in specific circumstances without precluding the possibility for improvement.

In presenting NGH material to the media, news creation and news management will be employed to generate proactively **a minimum of four positive news releases a month**. Which issues are chosen will be a function of one or more of a number of factors. There may be an urgent need for immediate publicity; there may have been a longstanding diary item. A **monthly work plan** will be produced to identify topics and their intended treatment (See Appendix 5).
In addition, **an organic approach** will be applied to information on any development that emerges from the organisation and which has **news value** that may or may not have been recognised by its originator.

TOOLS

The tools to achieve this programme include: -

- News releases/statements
- Picture stories
- Letters to editors
- Editor meetings
- Interview opportunities

- Placed articles and features
- Media conferences
- Public speaking opportunities

IN-HOUSE ACTIVITIES

A campaign will be undertaken to **inform and motivate** NGH clinical leads and managers with a view to increasing their awareness of the positive contribution media communications can make to their projects. This will include a series of media awareness seminars consisting of presentations from the communications team as well as **risk-free encounters with guest print, radio and TV journalists** who will explain their own needs and priorities and those of their particular medium.

There will also be a refresher internal campaign to deliver advice on **how to** access the services of the communications team.

Specialist **media interview training** courses will also be provided for those staff members who are likely to be called on to take part in print, radio or TV interviews.

METRICS

Media Monitoring is the most obvious method for measuring quantitatively and qualitatively the results of media and public relations activity. The communications team maintains continuous monitoring activity and apportions a three-point favourability rating to each piece of coverage - Positive, Balanced and Negative. There is also a measurement of column inches/centimetres achieved.

Equivalent Advertising Value (EAV) is a measure of **return on investment** employed widely in the public relations industry. This value is generated by applying media advertising space rates to the editorial content space achieved by media and public relations activity. Because editorial coverage is given a much greater degree of credibility by audiences, a multiplier is applied to the basic advertising rate to arrive at an EAV. The multiplier varies widely across private sector PR agencies, some using as high as twelve times the advertising space rates. We shall be using a multiplier of three.

EAV can only be a crude measure. However, taken together with media monitoring quality scoring, it is believed these metrics will offer acceptable qualitative and quantitative measures of outcomes.

Appendix 5: Monthly Media Planner

Monthly Media Plan

April 2012

Date	Topic	Treatment	Objective	Key messages

Planning/Monitoring

TRUST BOARD SUMMARY SHEET	
Title: -	Staff Engagement Strategy – Listening into Action
Submitted by: -	Dr G McSorley, Chief Executive
Date of meeting: -	25th April 2012
Corporate Objectives Addressed: -	To develop an effective, efficient and flexible workforce to support the changing environment.

SUMMARY OF CRITICAL POINTS: -
Staff engagement is a critical component of our approach to quality of care

PATIENT IMPACT: -
High

STAFF IMPACT: -
High

FINANCIAL IMPACT: -
High

EQUALITY AND DIVERSITY IMPACT: -
High

LEGAL IMPLICATIONS: -
N/A

RISK ASSESSMENT: -
Failure to enhance the engagement of staff will impact on our ability to deliver enhanced quality of care.

RECOMMENDATION: -

The Board is asked to approve the staff engagement strategy.

NGH STAFF ENGAGEMENT STRATEGY – LISTENING INTO ACTION

BACKGROUND AND CONTEXT

There is widespread recognition across the National Health Service of the absolute need to engage and empower all staff, particularly clinicians, around the delivery of better outcomes for patients, for staff themselves and for their Trusts. Whilst there are parts of the Hospital with high morale, engagement etc; the results of our Staff Surveys over a number of years shows that generally we are seen as not being amongst the best of employers or places to work.

NGH has set out to become one of the best places to work. Our approach to this clear aspiration is how we engage our staff in how the hospital 'runs'. To support this aspiration we need a clear approach to staff engagement and our plan is to use Listening into Action, (LiA).

Listening into Action (LiA) is a systematic, compelling and practical response to these challenges. It has been developed through intensive, hands-on work with over 40,000 NHS staff and leaders from across more than 70 NHS Trusts' since 2007, with national endorsement and a keen interest from many of the Senior Leaders across the Service.

The foundations for LiA are based on: -

- The need for Senior Leaders to connect the right people around all our major challenges
- Providing service teams with the opportunity to collaborate and share ideas
- Having 'permission' to get on and deliver actions which will benefit patients and staff
- Fostering a sense of collective ownership by the teams themselves for delivery of results.

There has already been widespread adoption of Listening into Action (LiA) at a number of Trusts over the past 5 years. Not only has it provided a vehicle for those organisations to achieve a sustainable, upward shift, in their national Staff Survey results, but the positive impact on staff morale and motivation has inevitably led to a wealth of service improvements, delivered and owned by the teams themselves who feel a new sense of enthusiasm and empowerment to affect the positive changes they want to see.

We have been invited to adopt LiA as a 'National Pioneer', as part of a larger spread of this approach across Trusts where there is a high level of commitment to adopt, spread and embed a new way of working, which unleashes the talent, enthusiasm and will of all staff.

What it means to be a National Pioneer of LiA

As a hospital that has recognised the need to tackle the existing challenges facing our Trust in a new and collaborative way, we will be supported and coached by Optimise through the adoption and spread of Listening into Action (LiA) over the next 12 months. The process will be based on a tried and tested 'Route Map' which has been developed, proven and continually improved, through intensive work with nine NHS Trusts' and, prior to that, more than 50 pilot sites.

This Route Map comprises four phases: -

Phase 1: - Committing to a new way of working, which includes: -

- Set up of your own LiA Sponsor Group
- Agreeing the outcomes you want to see across the Trust
- Getting leaders on board with the journey
- Launching a 'fundamental shift' campaign
- 'Pulse Checking' staff across the Trust to see how they are feeling right now

Phase 2: - Engaging staff around what matters, which includes: -

- Preparation and hosting of five, high profile, Chief Executive-led LiA Staff Conversations with a rich mix of people from across all levels and roles at each
- Making it appealing for people to want to come
- Harnessing their ideas and quickly consolidating these into an unprecedented view of 'what matters' and 'what gets in the way'
- Agreeing corporate-wide quick wins and enablers in response
- Advertising the opportunity for the 'First 10' teams/wards/departments/pathways to pioneer adoption of LiA for themselves and prepare them ready for action

Phase 3: - Mobilising and empowering staff to drive change, which includes: -

- Supporting and coaching the 'First 10' Pioneering Teams to adopt the LiA '7 steps' to engage all the right people around the changes they want to see
- Cross-learning between teams
- Enlisting managers to help 'unblock the way'
- Helping the teams to measure progress and outcomes, holding up their stories and results as inspiration to others to 'fuel' wider spread

- Building pride and giving recognition for their success
- Attracting the 'Next 20' teams to get on board

Phase 4: - Embedding LiA as 'the way we do things around here', which includes: -

- Getting to grips with the organisational implications of embedding this as a new way of working
- Adjusting systems and processes to 'enable' rather than 'disable' widespread adoption
- Continuing the spread to new teams in a way that starts to get a life of its own
- Holding a 'Pass it On' event to share stories and celebrate successes so far.

Each of the phases is designed to build momentum and a sense of 'something different' happening at the Trust for staff, which helps challenge existing convention in a positive way, and overcomes staff skepticism that this is 'just another initiative'. As such, it is critical that the broad timescales for each phase are adhered to by the Trust, and that the commitment is there from Senior Leaders to see this new way of working and engaging with staff as part of their day job - not an additional set of responsibilities.

Optimise Support to our journey

Navigation Days

The main vehicle to support adoption will be a series of nine, pre-planned 'Navigation Days' at key points throughout the process: -

Navigation Day 1:	Hitting the ground running (May 2012)
Navigation Day 2:	Preparing for CEO-led LiA Conversations to take place in July (June 2012)
Navigation Day 3:	Framing 'what matters to staff', ideas for action, proposed 'First 10' teams (end July 2012)
Navigation Day 4:	Support for 'First 10 teams' (beginning September 2012)
Navigation Day 5:	Check point (mid-October)
Navigation Day 6:	Sharing stories from 'First 10' teams and attracting 'Next 20' (end-November 2012)
Navigation Day 7:	Starting up 'Next 20' teams (January 2013)
Navigation Day 8:	Sustainability and 'Pass It On' event (early-March 2013)
Navigation Day 9:	What we have achieved in the first 12 months (end-April 2013).

As far as possible, the Chief Executive and the overall sponsor for this work will attend all of these events, along with our LiA Lead and one other Key Director. The Navigation Days will provide a unique opportunity for cross-learning and sharing of ideas with other LiA organisations. There will also be time for our team to reflect, focus, plan and

continually 'raise the bar' together, as well as the option to book time with Optimise on the following day for specific input and coaching support.

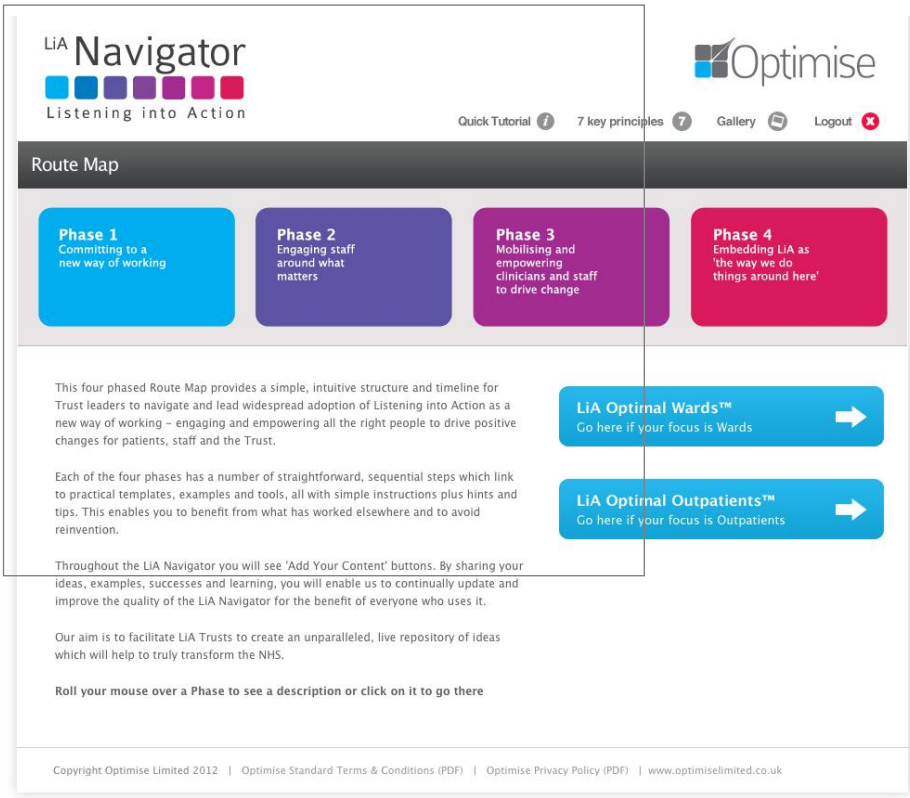
In addition to the main focus for each Navigation Day, every session will include discussion on 'hot topics' such as sustainability, momentum, the communication campaign, pro-activity of the Sponsor Group, actions to 'unblocking the way', and overcoming obstacles.

Ongoing Coaching and Support

Following this, and in addition to the formal Navigation Days, our team will have ongoing access to Optimise via booked calls and via e-mail for advice, coaching and support throughout the 12 months. They actively encourage us to consider them as part of your 'master mind' team, using us a sounding board and a point of reference for ideas and solutions as you go. It may also be possible to provide 'hands-on' consultancy support from time-to-time, although this will be at additional cost and dependent on availability.

The LiA Navigator®

As a National Pioneer, our Trust will have access to the LiA Navigator - their market-leading, web-based toolset, which codifies and consolidates all aspects of the LiA approach and helps to enable local ownership. This will be used as the backbone for many of the Navigation Days.



The LiA Navigator has a simple structure based on the four phases, with a series of steps within each, and more than 70 resources – tools, templates and examples – which can be downloaded and adapted for your own use. This provides practical support and ideas for the LiA Lead, enables cross-sharing of good ideas between Trusts' and avoids re-invention.

National Interest

The concept of parallel adoption is proving interesting to many stakeholders and commentators in the NHS, and also to other organisations outside the healthcare sector. The Optimise Directors will be co-ordinating: -

- Articles for the Health Service Journal, which is covering the 12-month journey (first article is booked for the 19th April)
- Other national coverage and PR for the Trusts involved based on success stories
- Liaison with Oxford University's Said Business School including their Health Experience Institute
- Updates to Sir Bruce Keogh, NHS Medical Director, who is taking a keen personal interest
- Liaison with the National Quality Board, who welcome this work, and other national NHS bodies
- Interest from Birmingham Business School and Lancaster Business School.

Commitment from our Trust

Based on experience with previous Trusts, we know that the three success factors for this work are: - **1)** the structured, proven 'methodology', **2)** Optimise's coaching and support through the journey of adoption, and **3)** the unwavering commitment and relentless pursuit of success by our Sponsor Group.

Specifically, we will commit the Trust in a number of ways that may be different from 'usual' to maximise the benefits and outcomes: -

- Adoption of LiA is led and sponsored by me as Chief Executive, with my unwavering commitment, as part of a personal mission to focus on the engagement and empowerment of all staff in a way that embeds and becomes 'the way we do things around here'
- Absolute commitment by key members of our team

- Willingness to break through existing assumptions, myths, bureaucracy, blockages, blockers and engrained ways of working to make room for something new

- Alignment of our Senior Team around wanting to see a real and sustainable shift - with everyone on the same page, in it together, committed to a common set of outcomes and ready to cut through 'all the usual reasons why not' to accelerate progress and results

- A Sponsor Group led by you and including Key Directors and others, the communication campaign lead, and representation from staff-side. This important group meets regularly to focus entirely on navigating this journey of adoption across your Trust

- A dedicated LiA Lead, working directly to me, c-ordinating and organising adoption and spread across the Trust on a day-to-day basis. This person (to be identified) will be persuasive, a great communicator, able to work with all types and levels of clinicians and staff, able to coach and 'hand hold' teams through their first round of adoption of a new way of working, and somebody who will not give up. They will be committed full-time, supported and enabled by the Sponsor Group, and given administrative support throughout

- Committed to following the 12 month 'Route Map' which is tried and tested, ensures momentum and enables cross-learning with other LiA organisations

- As an organisation we are committed to the 7 Principles of LiA: -

1. **Changing the way we do change: -**
   Are we happy with the current pace of change? Is it delivering the ambitious outcomes we want to see? If so, we don't need this

2. **It's all about outcomes: -**
   This is sharply focused on making changes that benefit our patients, our staff and our organisation – if not, why do it?

3. **Based on 'pull' not 'push': -**
   Making it compelling for people to get on board so that there is real enthusiasm, pride and shared ownership, which will underpin the fundamental shift we are looking for

4. **Go where the energy is: -**
   Using those who 'get it' to begin the groundswell, holding up their stories as inspiration to others and to 'fuel' wider spread

5. **Cut through 'all the usual reasons why not': -**
   Breaking down myths, re-setting expectations and ambitions, and giving staff 'permission' to get on and make the positive changes they want to see

6. **Different from usual: -**
   Same old way gets the same old results so this needs positive challenge and new thinking to ensure it feels different every step of the way

7. **Moving forward every day: -**
   A new pace of change, with real and ongoing momentum to get it going, keep it going and embed it into the fabric of our organisation.

RECOMMENDATION

The Trust Board is asked to support the Engagement Strategy.

Gerry McSorley
Chief Executive
April 2012

BOARD SUMMARY SHEET	
Title: -	**ICT Strategy 2012-2017**
Submitted by: -	Christine Malcolmson
Date of meeting: -	25th April 2012
Corporate Objectives Addressed: -	ICT Strategy to underpin the Trust's ICT plans over the next 5 years and to support the NGH application for Foundation Trust status.

SUMMARY OF CRITICAL POINTS: -

This should be read in conjunction with the EPR Strategy March 2012.

The document details the Strategic Aims and objectives for the NGH ICT service over the next five years, including the effective use of IT to support efficiency, productivity and quality in the support of new models of care delivery.

Details of achievements to date in line with the previous IT strategy are provided and a strategy for the provision of a secure, up to date and flexible IT infrastructure with the capacity to support new ways of working and mitigation of disaster recovery and business continuity risk are included.

ICT service provision will be improved to ensure it is cost effective and meets expected standards including end user engagement and customer service.

High level plans for programme delivery and governance are included.

PATIENT IMPACT: - Clinicians will have better access to improved information and technology in order to treat patients.

STAFF IMPACT: - This is a challenging strategy which will require sufficient and adequately trained IT resource to be implemented successfully.

FINANCIAL IMPACT: - TBC

RISK ASSESSMENT: -

EQUALITY & DIVERSITY IMPACT ASSESSMENT: -

RECOMMENDATION: -

This strategy should be adopted as the Trust's ICT Strategy for the next 5 years and should act as a baseline for measurement of the technological improvements to be implemented in that time period.

Northampton General Hospital NHS
NHS Trust

Information Technology Strategy
2012 - 2017

v. 1.0 Final

Document ID	ICT Strategy 2012-2017
Version	1.0
Status	Final
Date	April 2012
Author	Christine Malcolmson
Review Date	April 2017

Contents

1 Introduction and Purpose

"It is the vision of the Trust to move to a paperless hospital in 5 years. The development of an Electronic Patient Record will make information more accessible to clinicians to allow for more efficient treatment of patients. We are committed to invest in easy access to good quality clinical information. Our first priority is to invest in the current infrastructure to ensure that access to the systems is quick, easy and reliable."

As part of the Trust's Transformation Programme the Executive Team stated this vision and an EPR Strategy was written to take this forward. This ICT strategy should be read in conjunction with the EPR Strategy March 2012, (attached as Appendix 1)

The purpose of this document is to set out the proposed direction of travel for Information Technology (IT) over the period from 2012 – 2017.
Specifically the document is intended to:

- Assess current IT capacity and capability.
- Assess the current status of IT in the Trust.
- Identify local and national changes that impact IT requirements.
- Ensure continued fit of IT development objectives with Trust business objectives and the new national direction of IT in the NHS.
- Set out a timeline for IT developments.
- Act as a baseline against which progress can be regularly monitored.

2 Background

Northampton General Hospital NHS Trust (NGH) currently provides services from four locations and a number of smaller facilities. The main site in Northampton provides a full range of acute services; but both acute and community services are also provided at Danetre Hospital in Daventry, Isebrook Hospital in Wellingborough and Corby Community Hospital, together with services provided in the local community such as midwifery.

The Trust is also an accredited cancer centre delivering cancer services to a wider population of 880,000 from the whole of Northamptonshire and parts of Buckinghamshire and specialist service development includes vascular, renal, stroke and enhanced cardiology services.

As NGH works towards achieving Foundation Trust status, the landscape for the provision of acute healthcare is changing rapidly and the Trust's corporate strategy seeks to consolidate and enhance our position as one of the hyper acute hospitals in the South-East Midlands network.

The ICT service must be developed to support these changes and must also acknowledge the increasing complexity of the medical and other services that NGH is committed to provide.

The National Programme for IT (NPfIT) has now ended, and whilst it has delivered a few national systems such as the Spine, N3 Network, NHSmail, Choose and Book, Secondary Uses Service and Picture Archiving and Communications Service (PACS or Digital X-Ray/CT/MRI Imaging) it has not delivered the vision intended and as a consequence there is a need for a coherent and comprehensive ICT strategy at Trust level.

The Department of Health now advocates a "connect all" approach rather than a "replace all" and this is the path NGH has followed to date, integrating its many IT systems where possible, whilst awaiting delivery of Lorenzo functionality under NPfIT.

Some revision of contracts are also underway regarding iPM (PAS) and Lorenzo (EPR), the current PACS contract is extendable from June 2013 to June 2016 and a national framework for procuring a system beyond that is being prepared.

In this time of unprecedented reform and uncertainty in the NHS, Information Technology has been identified as being indispensable to the support and improvement of the Trust's clinical and administrative processes.

This ICT strategy outlines a programme of work that not only ensures ICT is an enabler of the Trust's own strategy but it also fits within the national direction.

3 The Strategy

The main themes of this strategy are:

- Provision of integrated electronic clinical records including ordering and reporting, electronic prescribing, patient administration functions, clinical documentation and bed management, presented through a common patient view. (The EPR).
- Development of the IT architecture to support the integration of clinical systems.
- Improved electronic clinical information flows.
- Support of delivery of new models of care (e.g. provision of access to information systems at off-site locations and in the community, mobile computing, telecare / telehealth / telemedicine).
- Effective use of IT to support efficiency, productivity and quality improvements.
- Completion of the IT infrastructure upgrade with the capacity to support new ways of working (including mitigation of key IT business continuity risks).
- Review of IT service provision to ensure it is cost effective and meets expected standards.
- Development of IT capability and capacity.
- Improvement of IT engagement with users so that investment is prioritised in line with clinical / user need and delivers genuine clinical benefit.

A detailed review of these themes is included in section 8

The Trust IM&T Subcommittee review outlined in section 4 and the review against the 2006-11strategy in section 6 are not negative but do indicate an appetite for improved ICT service provision within the Trust in a challenging financial environment.

In order to meet the challenge of delivering the strategy it is important that:

- There is a positive outcome from the Transformation Programme.
- There is sufficient internal investment in processes, people and software
- There is a coherent strategy for Care Group/clinically owned benefits definition and realisation throughout the project lifecycle at Trust level

4 Capacity & Capability

The Trust IM&T Subcommittee and Transformation Group undertook a review of the IT function and IT strategy in mid 2011. The key findings were:

- IT strategy needed to be more closely aligned with Trust business objectives, and clinical needs.
- Electronic patient record (EPR) strategy should be driven by clinical benefits and not by the National Programme for IT (NPfIT).
- A new Health Records strategy was needed to inform EPR development.
- The IT department was technically strong, but there was a need to review and update the technical and systems architecture in line with revised business vision and strategy.
- Service arrangements were structured correctly but needed stronger focus on user requirements and capacity / demand management.
- The IT organisational structure needed to be reviewed.
- Infrastructure must be strengthened and improved and there are a number of significant opportunities for utilising new and emerging technologies.
- Weaknesses in business continuity arrangements must be addressed.
- A stronger approach to IT benefits realisation was needed.
- Better IT / user relationships must be developed to ensure that IT provided real value to the business.

5 IT Focus Group/Questionnaire

A well-attended IT focus group was held as part of the consultation process for this ICT strategy. This proved effective in determining the priorities of clinicians and other end users of the ICT service and a follow up questionnaire was subsequently circulated based on the output of the focus group.

Respondents were asked for general feedback on the customer service aspects of the IT service, to prioritise the seven components of an EPR as identified in the EPR strategy and to suggest and prioritise new initiatives that would take the IT service to the next level.

5.1 General feedback on customer service:

It was felt that the general mind-set and positive attitude of most IT staff was good and there was an openness to find new solutions and ways of working from key people in the IT department. There is however always room for improvement particularly in communicating IT initiatives or updates on outstanding tasks to the service users.

There is a need to orientate the IT service around the needs of the new Care Group structure now in place in the Trust and we must adopt a proactive approach in improving the perception of the IT service on offer.

5.2 EPR Priorities:

The overwhelming priority for clinicians are clinical documentation and a patient centred single view of clinical data and these elements should therefore be prioritised when implementing the EPR strategy.

EPR constituent	Priority (Questionnaire)	Priority (Focus Group)	Priority (Overall)
Electronic document management (scanned records)	3	4	3
Patient centred single view of clinical data	2	1	1
Clinical documentation	1	2	1
Decision support	7	6	7
Electronic prescribing	6	5	5
Advanced PAS functionality (bed management etc.)	5	7	6
Electronic order entry for a range of clinical services	4	3	3

1= Highest
7 = Lowest

5.3 Priority on new IT initiatives:

Initiative	Priority
IT account managers linked to each department	1
Mobile technicians out and about around the trust	6
IT clinical user group to represent clinicians on IT developments, to cascade useful information on IT matters and to provide hints and tips on best use of existing systems	5
General user group (mix of clinicians and admin staff)	8
Outlook calendar synchronisation to personal smart phones	7
Paperless requesting/reporting for pathology	2
Patient update of demographic data	3
Dedicated PACs PCs	9
Faster roll-out of new/wireless PCs	3

It is clear from this process that interested users want to embrace new technology and these priorities will be taken into account with the restructure of the IT department and planning of initiatives going forward.

6 Current status (Where are we now?)

Key deliverables of the previous 2006 -2011 ICT strategy were:

Care Record Service (CRS) - The immediate requirement for NGH being to complete the implementations of PAS, Pathology, PACS (digital imaging services), and Radiology systems, with Maternity and A&E systems being the next priorities	These and many other systems have all been replaced and implemented, either under NPfiT (PAS, PACS and iLab), or integrated best of breed in Medway (Maternity) and Symphony (A&E), ICE Order comms, CIS eChemotherapy prescribing, DAWN, Badgernet, Somerset, eDN, PCS, Digital dictation/Voice recognition and many more.
Choose & Book - Choose and Book (C&B) is the national electronic appointment scheduling system supporting the patient appointment process throughout the NHS. Once PAS deployment was complete the Trust would begin the migration from the interim booking service to the fully integrated directly bookable C&B service.	Roll out of Directly bookable services is now 80-90% complete.
Data Repository - A comprehensive data repository to aggregate and analyse patient data for outcome measurement, clinical governance, clinical audit, reporting, and management information would be developed.	The Trust's own bespoke Oracle data warehouse has been developed significantly to include feeds from all core new systems implemented. The data warehouse feeds the Service Line Reporting/PLC system and the capacity planning system as well as providing all statutory, business and operational reporting.
Business Systems - Continued development of business systems and improved provision of management information would be key to the future success of the Trust.	Business Objects/Infoview, the Trust's chosen business intelligence tool has been upgraded and significantly developed to utilise new features, providing a comprehensive suite of reports.
The implementation of the national ESR (HR and payroll) system	Complete and integrated with UIM for identity and smartcard management.

Rollout of the e-Procurement system would be completed	This is well underway by the Finance IT team.
High priority would be given to improving management information, particularly the introduction of a balanced scorecard /digital dashboard application.	Completed using Business Objects/Infoview.
Infrastructure - The ICT infrastructure would continue to be enhanced to ensure that it is of the highest standard, and has the capacity and resilience to support the CRS and other developments.	A huge amount of work has already taken place to • stabilise the email system and move from the outdated Exchange 5.5 • to move the entire Trust to Active Directory • to replace ageing PCs under the new desktop refresh programme • to provide wireless devices in some clinical areas and • to "virtualise" the server estate, in itself saving a significant amount of money for the Trust. • A wireless network has been installed and • the wired network is currently undergoing complete replacement including all cabling and dual homing to provide resilience.
Data quality - High quality data is critical to the success of the strategy and Trust business processes. Continued improvement of data quality would be addressed in a number of ways including: moving to a single master patient index, mandatory use of the NHS number, positive patient identification processes, enhanced clinical coding processes, enhanced system security, and more training.	Data quality continues to be a high priority. All new systems are mandated to display the NHS number in the appropriate format and are interfaced to iPM to maintain iPM as the master patient index. Clinical coding has been improved by the implementation of the electronic discharges system amongst other initiatives and the clinical systems trainers continue to train best practice process when system training.
Security - Individual user registration and role based access controls, with single sign-on, would be implemented to ensure security and	The Trust won accolades for being national "first of type" for the ESR/UIM integration project. This involved IT and HR working closely together to integrate the process of

confidentiality of electronic clinical records.	identification, role based access and smartcard production interfacing the ESR and UIM systems. Single sign on project now underway.
M&T Resources - IM&T resources would be reviewed and restructured where necessary, to ensure that they would be utilised as effectively as possible. Additional investment in IM&T resources would need to be made to meet increased demand, and increased dependency on clinical ICT services.	ICT resources underwent one round of restructure to implement an element of ITIL best practice and to align the service with the major amount of IT development required by the Trust. Investment in IT resources has not increased significantly due to financial constraints in the NHS as a whole and a second restructure is due for consultation in the next period.

7 Strategic Context

7.1 Strategic Aim

The overall strategic aim for ICT remains - to develop and improve the utilisation of IT in the delivery of excellent quality care to patients of NGH in line with the Trust vision, values and aims (restated in 6.2).

7.2 Context

The major factors currently influencing strategic IT development are:

National

- NHS Health Informatics implications coming out of '*Liberating the NHS: An Information Revolution'*
- The quality, innovation, productivity and prevention challenge (QIPP).
- The changed economic and funding environment
- The Information Governance Toolkit
- The Acute Services Review

Local

- NGH Integrated Business Plan
- NGH Transformation Programme
- NGH Health Records strategy 2011 - 2016
- Local commissioning plans
- Quality strategy

Liberating the NHS: An Information Revolution

A new national Information Strategy is expected following the '*Information Revolution'* consultation process. It is not envisaged that this will significantly change the direction

of travel in respect of EPR et al. However, it is clear that the new strategy will introduce requirements to make health data and information more freely available for a variety of purposes including provision of information to support patients in actively managing their health and care.

There will also be a move away from the 'one size fits all' approach of NPfIT towards a more heterogeneous approach to delivering EPR.

QIPP

Quality, Innovation, Productivity and Prevention (QIPP) is a large-scale transformational programme for the NHS that aims to improve the quality of care the NHS delivers, while making up to £20 billion efficiency savings by 2014-15. IT is seen as a key enabler for the QIPP challenge.

Working processes and pathways will be redesigned for maximum efficiency under the QIPP programme and IT systems will support this work eg. use of ward-based phlebotomy trolleys will be rolled out as part of the paperless phlebotomy project, using the existing ICE system.

Economic and Funding Environment

The economic and funding environment over the period of this strategy will continue to be very challenging, with the requirement on the NHS to reduce costs. One effect of this is that support services must demonstrate value for money through delivery of cost saving benefits and / or innovative models of service provision.

ICT will continue to investigate and implement new and more efficient technologies and systems enabling new ways of working and thereby reducing the overall cost of patient care.

Information Governance (IG)

Increased emphasis on strong information governance and particularly the security of personal data has brought higher expectations from the IT function. ICT and will IG work closely; to ensure that the Trust works towards compliance with the Care Records Guarantee. In particular there will be a requirement from 2014 to allow patients some access to their own electronic records.

Acute Service Review

The South East Midlands Acute Service Review (ASR) aims to improve quality and outcomes for patients and ensure that the health system across the South East Midlands is in a position to face a set of significant challenges in the near future. This will mean more provision of specialist services, in locations not currently connected to the Trust's ICT infrastructure.

Trust Vision and IBP

Vision:	NGH is committed to providing the very best care for all our patients
Values: • To put our patients first to ensure they receive the care they need • To treat all patients with respect, dignity and compassion • To value and support the contribution of staff, volunteers, governors and other partners in working together to provide the *very* best care for all our patients • To effectively manage our resources • To seize every opportunity to offer improved and innovative care • To value learning and continuous improvement	
Aims: • Be a provider of quality care for all our patients • Enhance our range of hyper acute services for the wider community • Provide appropriate care for our patients in the most effective way • Foster a culture where staff can give their best and thrive • Ensure we invest wisely to make improvements in care	

Transformation Programme

There are several strands of the Trust Transformation Programme for which IT is a key enabler including outpatient redesign, hybrid mail, automated patient reminders, multifunctional device roll out, digital dictation/voice recognition etc.

Health Records Strategy

The new Trust Health Records strategy sets out a vision for the NGH Health Record to become progressively paper light. In order for this to happen, suitable robust electronic systems eg. Document scanning must be implemented and accessible at the point of care.

8 The Strategy in detail

Delivering the strategic objectives:

8.1 Provision of integrated clinical records and development of an integrated IT architecture (EPR)

In light of the cessation of the National Programme for IT (NPfIT), the Trust will examine alternative options for completing the provision of integrated patient data at the clinicians desktop.

- This includes core PAS functions and advanced PAS functionality
- Electronic diagnostics and pharmacy

- Patient centred single view of clinical data
- Clinical or nursing documentation
- Decision support
- Electronic order entry and electronic prescribing
- Advanced clinical decision support
- Electronic image management

A separate EPR strategy document has been produced and should be read in conjunction with this strategy.

Some key departmental clinical systems will be replaced or re-provided during the period of the strategy – including Pharmacy systems, Laboratory systems, PACS and Radiology systems and new systems will be commissioned to support services provided by NGH as a hyper acute Trust, such as Renal, Vascular and Paediatric eChemotherapy prescribing.

The increased demand from networks and CCGs to implement systems of their choice within acute hospitals may lead to strategic issues and all such intentions should be approved by IT sub-committee to ensure strategic fit.

8.2 Improved electronic clinical information flows

IT will be utilised to improve efficiency, improve communication, and reduce clinical risk through streamlining of clinical information flows and minimising the need for paper reports and correspondence. This will include:

- Provision of secure electronic clinical correspondence to GPs, tertiary services and other care providers, either system to system (via DTS) or via NHSmail.
- Trust-wide implementation of digital dictation and voice recognition systems (linked to the electronic clinical correspondence system – currently Teleologic Patient Content Store (PCS)).
- Continuing to develop the functionality of the ICE system, to allow paper free / paper light requesting and reporting processes to be extended to other clinical and diagnostic services.
- Completion of the roll-out of doctors/ ward handover functionality.
- Investigating opportunities for using telemedicine.
- Completing the migration to Direct Bookable Services in line with national choice and commissioning requirements.
- NGH will play its part on the NICP IM&T Steering Group, set up to establish an operational IT architecture to support clinical information flow across the local health community (LHC).
- A multitude of small clinical systems have sprung up around the Trust over many years, causing risk to the Trust and limited access to clinicians. Where possible these will be migrated onto the Teleologic PCS system making them more accessible at the point of care and in a move towards a full EPR.
- A suitable repository will be implemented for Medical Illustrations, whether that is PACS, document scanning or the EPR system, thereby improving data security and improving patient care.

8.3 IT to support new models of care delivery

Plans for delivery of care in new and innovative ways will be supported by IT in a number of ways. Including:

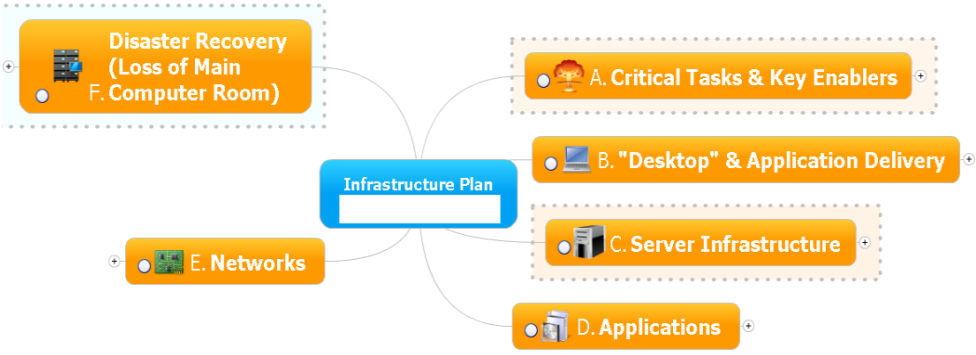
- Provision of access to NGH IT systems in satellite locations.
- Improved networking capacity where necessary.
- Mobile computing facilities.
- Telemedicine / telehealth facilities.

8.4 Effective use of IT to support efficiency, productivity and quality

IT has already allowed significant cost savings to be made through sustainability and the transformation agenda. It will continue to be used to improve efficiency, productivity and quality gains through a number of developments and initiatives:

- Completion of the e-Rostering and automated time and attendance management implementation.
- Wider use of digital dictation/voice recognition
- Hybrid Mail roll out.
- Multifunctional device roll out.
- Extending the provision of remote /home working facilities.
- Further development of the data warehouse and self-service business intelligence facilities.
- Wider use of video-conferencing.
- Increased use of wireless technology.
- Revisiting the benefit of self-service kiosks in outpatient clinics areas following the outpatient transformation work stream.

8.5 Provision of a secure, up to date and flexible IT infrastructure with the capacity to support new ways of working and mitigation of disaster recovery and business continuity risk



The infrastructure development and refresh programme will continue, with the aim of bringing workstations across the Trust up to an acceptable standard, improving server

room and network capacity and performance, reducing risk, and reducing TCO (total cost of ownership). The technology roadmap will be updated to reflect advances in technology and National Infrastructure Maturity Model (NIMM) compliance. Activities include:

- Completion of the LAN upgrade to include built in resilience, VLANs and DHCP/IP readdressing. This will provide an acceptable network platform for the introduction of EPR functionality. The secondary N3 connection must also be relocated to reduce the current risk of both connections being adjacent to one another.
- Continued improvement of access to systems through the provision of more mobile devices via the wireless LAN.
- Implementation of single sign on technology to speed up login times and improve security.
- Virtualisation of the desktop estate.
- Improvement in business continuity arrangements to eliminate potential single points of failure affecting critical clinical and operational services. Particularly important is the need for secondary server room facilities for key systems and services, preferably in an off-site location.
- Further work on encryption and access control technologies to minimise risk of data loss / data leakage.
- Continuing the implementation of energy conservation measures in line with the Government 'Green IT' agenda (including a complete redesign of the existing server room to improve heat extraction and reduce climate control costs).
- Provision of the Telecommunications function within the Trust will transition to the ICT department, with a view to the creation and implementation of a Unified Communications strategy including Voice over IP (VOIP).
- Provision of automatic identification and tracking of medical devices, medical record folders, etc via Radio Frequency Identification (RFID)

(Please see Appendix 2 Infrastructure Plan (requires Adobe 10))

8.6 Review of ICT service provision to ensure it is cost effective and meets expected standards

There is a national drive and a local demand to improve IM&T capability and capacity (with targets set in the NIMM). There is also a need to ensure good integration of IT services across the LHC to support the delivery of care across all settings. Activities as follows:

- Collaboration where appropriate with ICT services across the South East Midlands cluster.
- IT job descriptions will be amended in some cases to provide an Account Management service to the new Care Groups at NGH.
- Introduce Service Level Management arrangements to improve transparency of service provision to user departments.

- Monitor and review third party contractual arrangements to ensure Service Level Management targets are met and the Trust strikes the correct balance between internal and external service provision.
- Review the organisation and structure of IT resources across the Trust to ensure that these are utilised in the most cost effective manner.
- Review procurement and provisioning strategies and consider joint arrangements with the other local healthcare providers for some 3rd party services and functions.
- Continue to develop best practice standards (i.e. adoption of ITIL standards) in the delivery and management of IT.
- Obtain national service desk accreditation.
- A recent review found evidence of non-strategic IT development occurring outside of the IT department, and of 'piecemeal' development; developments started but not fully followed through as a result of lack of resources, or lack of commitment and ownership. It was also clear that, although good project management principles are always applied in larger IT initiatives, they are applied less consistently in smaller ones. All IT initiatives in the Trust will be submitted to the IM&T subcommittee for approval and schemes will not be approved if they are not conformant with the overall ICT strategy and sufficiently resourced, with a clear statement of quantifiable benefits and clinical ownership.

8.7 Improved IT engagement with users

ICT will proactively improve its relationships with users across the Trust and other users of the service. ICT is a service function supporting virtually all aspects of patients' pathway so ensuring ICT works for all staff that use it is a core purpose. All interactions with ICT should be helpful and courteous showing that all service users are valued.

- Representatives will be made available to update users at specific existing meetings.
- Consideration needs to be given to channels / forums that achieve greater engagement with users in determining the direction for IT development. For example: regular account management / service review meetings with user department management and an internal/clinical user group as supported by the IT focus group.

8.8 Delivery and Governance

Given the importance and scope of the programme, it is essential that it is appropriately managed. A structured approach, using appropriate programme and project management methodologies, will be employed.

The IM&T Subcommittee will act as the overall Strategy Programme Delivery Board.

All projects will be managed using PRINCE2 methodology; this is the Trust and NHS standard for project management. All projects will have an appointed Project Manager, who should be a qualified PRINCE2 practitioner.

Before being approved for the annual work programme, a Project Brief must be produced for all projects and larger projects will need a supporting business case. Benefits must be clearly stated and a process for monitoring realisation of benefits must be an intrinsic part of each project, owned by Service Managers/Clinicians. As a minimum, a full Project Initiation Document, Project Plan, Communication Plan, Issues/Risks log and Cost Matrix must support each ICT project. Reference should be made to the Trust *Service Planning Framework* and *IT Change Planning* documents for further details of the business case and approvals process.

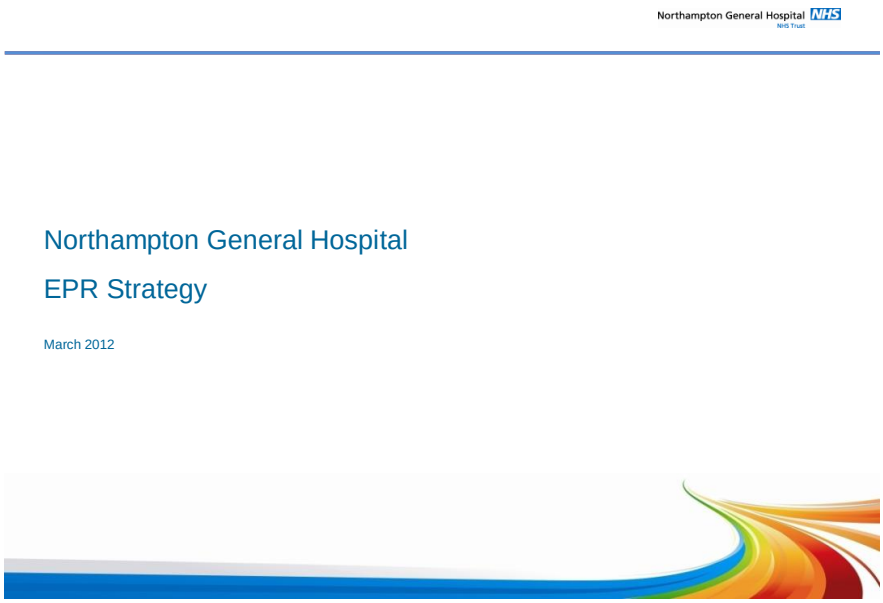
Directorates and departments will be involved in delivering the work programmes. Unless a project is purely technical in nature, directorate or department staff must be involved in the planning and delivery of projects that affect their area at both Project Board and Project Team levels. A senior member of the directorate or department should take the role of project sponsor.

Given the objectives of the programme it is essential that clinical staff are involved in the specification, planning, and control of all projects which affect clinical processes. All new projects must conform to clinical safety requirements dictated by DSCN 14/2009 "Patient Safety Risk Management System – Manufacture of Health Software" and clinical safety hazard assessments will be carried out in line with NHS CFH Clinical Safety Guidance and the Trust's Clinical Safety policy.

Appendix 3 provides an overview of the strategic developments planned over the five year period covered by this document with an indicative time line. This will be converted into an annual work programme, and specific projects identified and approved, as part of the annual planning cycle, through the service and IT change planning processes.

Appendix 1- EPR Strategy

(Double click on image to open)



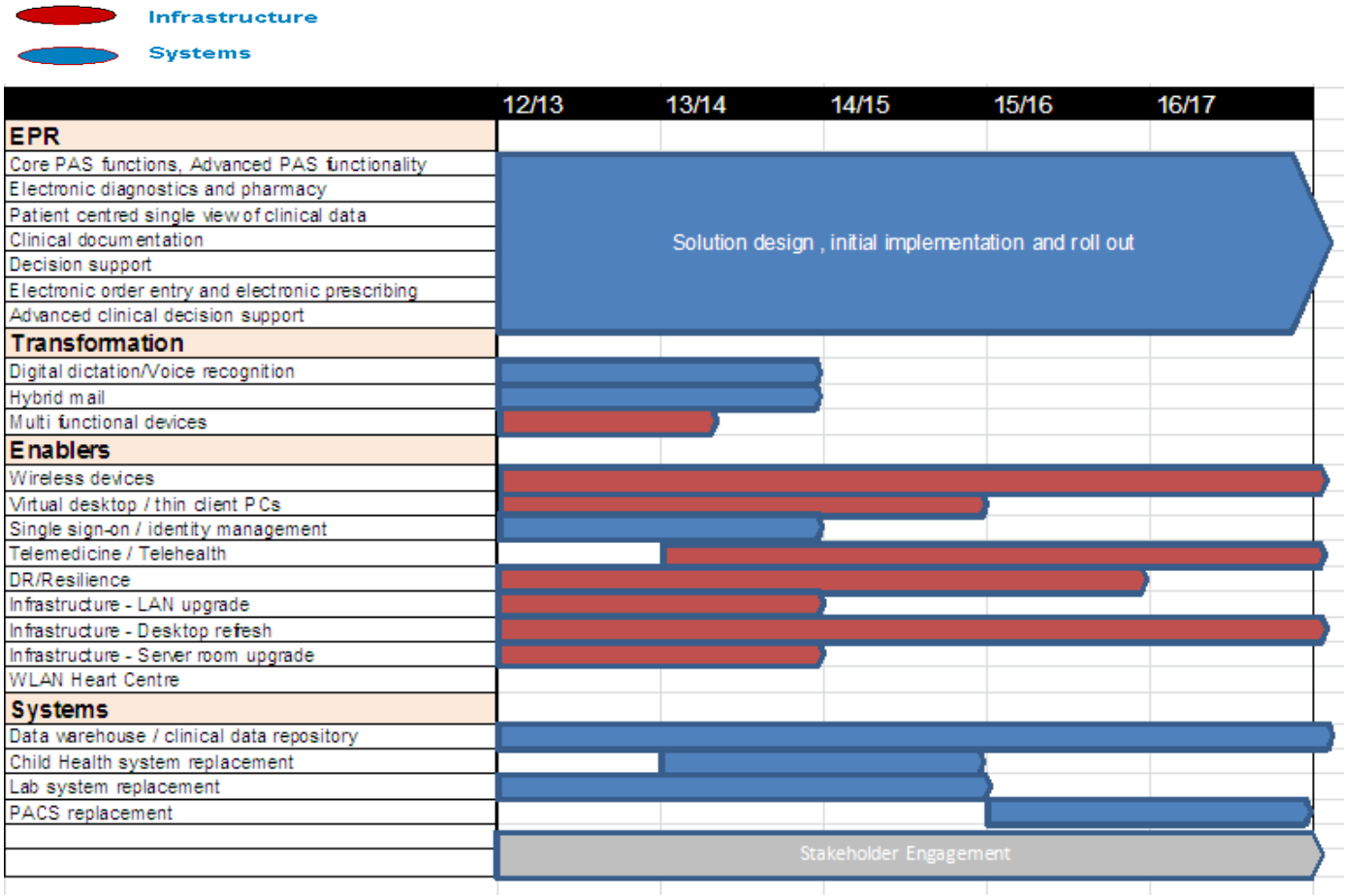
14

Appendix 2 - Infrastructure

(Double click icon to open – requires Adobe 10)

Adobe Acrobat Document

Appendix 3 – High level work plan



BOARD SUMMARY SHEET	
Title	Corporate Objectives 2011/12 Quarterly Progress Update
Submitted by	Ms S Rudd, Company Secretary
Date of meeting	25th April 2012
Corporate Objectives Addressed	

SUMMARY OF CRITICAL POINTS

Enclosed is a year end update on progress and achievement against the Trust 2011/12 Corporate Objectives for discussion.

PATIENT IMPACT -

STAFF IMPACT -

FINANCIAL IMPACT

EQUALITY AND DIVERSITY IMPACT -

LEGAL IMPLICATIONS -

RISK ASSESSMENT - :

RECOMMENDATION

The Board is asked to consider and discuss the year end position of the Corporate Objectives.

Northampton General Hospital NHS
NHS Trust

CORPORATE OBJECTIVES 2011/12

Objectives	Measures of success	Timescale	Monitoring	Current Position/RAG Rating
1. To improve the clinical quality of patient care focusing on safe, effective treatment that is patient centred.	**Safety**			
	➢ Increase safety incident reporting in line with peer average.	➢ March 2012.	➢ Quarterly monitoring reporting to CQEG.	Risk Manager reviewing current Trust incident reporting against peer group. March – Trust now in middle 50% of reports of all incidents; however, below 50th percentile (NPSA). Amber
	➢ Decrease harm events (falls, pressure ulcers, medication safety measures as per Quality Accounts).	➢ March 2012	➢ Quarterly CQEG, HGC, Trust Board. ➢ Patient Safety Board.	Falls – Red Pressure Ulcers – Green Medication errors- Green
	➢ Increase staff ownership of safety issues.	➢ Ongoing	➢ HNQI ➢ Bi-annual safety climate questionnaire	Patient Safety Board Development Green Current incident trends to be discussed at Patient Safety Board Second survey sent out – refresh of questionnaire under discussion. Amber Patient Safety Board standardised and Patient Safety Books on Wards, completed. Green
	➢ Develop refreshed Patient Safety Strategy to underpin Patient Safety Programme	April 2012	CQEG, Patient Safety Board, Transformation Steering Board, Trust Board	Safety Programme agreed and strategy prepared – Green. Clinical Lead roles agreed and advertised. Amber

Objectives	Measures of success	Timescale	Monitoring	Current Position/RAG Rating
	➢ Appoint Patient Safety Team to deliver the programme of work **Effective Patient Centred Treatment** ➢ Support enhanced recovery. ➢ Right bed, right care. ➢ Patient experience additional focus on vulnerable/dementia patients. ➢ Reduce hospital mortality. ➢ Full Compliance with CQUIN Measures. Re-design the Emergency Pathway by setting up a formal project team, clinically led and managerially supported	May 2012 ➢ March 2012. ➢ Monthly to CQEG and HMG. August 2012 – March 2012	➢ Quarterly Quality Accounts. ➢ Quarterly Patient Safety Clinical Quality & Governance progress report. ➢ HMG, CQEG, Quarterly Quality Review Meeting with PCT. ➢ Monthly MD sign off of achievement in accordance with Quality Schedule. ➢ Quarterly Patient Safety CQEG Progress Report, Quarterly Review with PCT.	Enhanced Recovery – Amber Right bed, right care – Amber Patient Experience –Green HSMR – Amber CQUIN EMSHA – Green NHSN- Amber Emergency Clinical Lead Job description agreed and post advertised, Project Manager in place; support structure under design – Amber

Objectives	Measures of success	Timescale	Monitoring	Current Position/RAG Rating
2. To develop an effective, efficient and flexible workforce to support the changing environment.	➢ Increased performance against all key HR Performance Indicators.	➢ March 2012.	➢ Trust Board (monthly) CQEG (mandatory training) DMs/HR Forum.	HR KPIs progress: slight increase on sickness absence from 4.44% in January to 4.64% in February 2012. Red Turnover has increased from 7.88% in January to 8.02% in February 2012 Amber Increase in utilised temporary workforce (excluding Medical Staffing) from 220.34 WTE in January to 285.05 WTE in February 2012. Red Total substantive workforce plus temporary workforce (excluding Medical Staffing) against budgeted establishment (%WTE) has increased from 97.39% in January to 100.34% in February 2012. Amber Substantive WTE below budgeted establishment in February 2012 with a variance of 271.03 WTE. Amber Mandatory training activity forecast (run-rate) by year end – 74.5%. Amber

Objectives	Measures of success	Timescale	Monitoring	Current Position/RAG Rating
				Completed Personal Development Reviews – 73.2% at February 2012. Amber
	➢ Workforce changes and workforce savings achieved in line with Trust Performance and Financial Plans.	➢ In line with Trust Performance timeline	➢ HR Forum Trust Board/Trust Performance.	Workforce changes underpinning implementation of Care Group Green Temporary Workforce usage is higher than expected due to demand on services and inability to close beds as planned. Red
	➢ Highly skilled & knowledgeable workforce capable of supporting the transformation and emerging strategies of the Trust.	➢ Ongoing. ➢ On-going	➢ HR Forum, Monthly ➢ Control Group/TP/HR Tactical Changes ➢ Band 1 to 4 Education and Development Band Group in place ➢ Skills Point monitoring spend against bid	Care Group re-structure in place. Green Phase 2 organisational changes to workforce (Core and Temporary) identified. Green Tactical changes identified Phase 2 and project timetable. Amber Band 6/8 management and leadership programme in place. Green

Objectives	Measures of success	Timescale	Monitoring	Current Position/RAG Rating
	➢ External funding pursued to support Bands 1 to 4 and Apprentice Scheme	➢ Ongoing	➢ HR Forum Monthly, HMG, Trust Board (6-monthly)	Apprentice Scheme in place and ongoing. Green
	➢ Talent management & succession planning implemented	➢ Ongoing ➢ Revised time-table to be agreed		TM&SP implementation plan developed. Amber
	➢ Developing a culture and environment where the workforce can excel and the Trust becomes an employer of choice. (Staff Survey)	➢ Revised time-table based on implementation of staff engagement programme and revised staff survey action .		Revised Action Plan relating to Strategic and Local actions developed to support improvements in Staff Survey results. Amber Further progress required to Implement staff survey results such as Harassment & Bullying campaign and Health & Well-being. Red

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

Objectives	Measures of success	Timescale	Monitoring	Current Position/RAG Rating
6. **To agree a revised Estate Strategy in the context of the Trusts Service Strategy, Transformation Programme and the Acute Services Review, which explores alternative funding mechanisms and is completed in line with the FT Application Timetable.**	➢ Revised medium to long term Estate Strategy that reflects Service Plans and Strategic Priorities. ➢ Revised 5 Year Capital Investment Plan that is affordable. ➢ Fit for purpose and appropriately sized estate to deliver Trust activity. ➢ Revised strategy approved by Trust Board and incorporated into IBP.	➢ Approval by Trust Board April 2012	➢ Estates Planning & Development Group. ➢ Capital Committee ➢ Finance & Performance Committee. ➢ Estate KPI's.	Timeline now revised to March 2012 to enable full consideration of commissioning intentions and Trust Service Plans Amber
7. **To develop, implement and sustain transformation in the way we deliver our services in order to maintain quality and deliver c£18million reduction in cost base by the end of 2011/12.**	➢ Transformation Programme delivery reducing cost base by £18 million.	➢ March 2012.	➢ Transformation Delivery Group, HMG, Trust Board.	£18.9m delivered at the financial year-end. Green

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

TRUST BOARD SUMMARY SHEET	
Title: -	Review of 2011/12 Board Assurance Framework
Submitted by: -	Ms S Rudd, Company Secretary
Date of meeting: -	25th April 2012
Corporate Objectives Addressed: -	All

SUMMARY OF CRITICAL POINTS: -

The Board Assurance Framework (BAF) is a tool for the Board to assure itself about successful delivery of the organisation's principle objectives and to focus the Board on controlling principle risks threatening the delivery of those objectives.

The attached BAF provides the Trust Board with a progress report for the financial year ending 2011/12.

PATIENT IMPACT: -
High

STAFF IMPACT: -
High

FINANCIAL IMPACT: -
High

EQUALITY AND DIVERSITY IMPACT: -

LEGAL IMPLICATIONS: -

RISK ASSESSMENT: -

RECOMMENDATION: -

The Board is asked to review and discuss the attached Board Assurance Framework

BOARD ASSURANCE FRAMEWORK 2011/12
March 2012

BAF No.	Risk Reg Ref/ CQC	Principal Risks to Strategic Objectives	Lead	Key Controls	Assurances on controls	Gaps in control	Gaps in assurance	Risk mitigation/control plans	Rating
TRUST OBJECTIVE 1: To improve the clinical quality of patient care focusing on safe, effective treatment that is patient centred									
BAF 1	**PNS24** **PNS30** **Med54** **PNS2** 016	Risk of failure to continue improvement in line with CQC, other mandatory regulatory bodies e.g. NHSLA	Director of Nursing (supported by MD)	Quality Strategy, Risk Management Strategy, Patient Safety Strategy, Clinical Governance Review Scheme, Compliance Monitoring Schemes	CQEG meeting/mins HMG meeting/mins HGC meeting/mins Trust Board meeting/mins Patient Safety Board Patient Safety Learning Forum Pt Safety and clinical Quality & Governance Progress Report	Reports to committees not always complete and challenged Governance structures still evolving	Information quality Record keeping Incomplete information	Improved information and reporting schedules Reports have improved and agreed reporting schedules planned by March 2012	**A**
BAF 2	**T&O26** **PP12** **PP13** **PP14** **O4** **O16**	Risk of failure to investigate and instigate improvement plans for any area that has concerns re HSMR or other key quality outcomes	Medical Director	Dr Foster Monitoring process Mortality/HSMR review project	CQEG meeting/mins HGC meeting/mins Trust Quality Scorecard Task and Finish Groups Fractured NOF and Caesarean Section and Septicaemia) HMG Trust Board	Data Issues that cause confusion Insufficient ownership at service level	Inadequate progress due to difficult issues requiring long term solutions and investment	Continue current focus and explore further external support and analysis (MD supported by Director of Planning) Extensive audit in place supported by clinicians across the specialties	**A**
BAF 3	**O4**	Failure to address recommendations of external reports	Director of Nursing and Medical Director	Agreed process for receiving and disseminating reports	Reports requested from the directorates to CQEG	Gap Analysis may be incomplete	Poor reports received or reports highlight issues that are impossible to solve	Reporting of external reports improved but further local ownership required	**A**

BAF No.	Risk Reg Ref/ CQC	Principal Risks to Strategic Objectives	Lead	Key Controls	Assurances on controls	Gaps in control	Gaps in assurance	Risk mitigation/control plans	Rating
TRUST OBJECTIVE 2: To develop an effective, efficient and flexible workforce to support the changing environment									
BAF 4	**A20** **O13**	Risk of failure to change the pattern of medical training to adapt to the modern NHS	Medical Director	DTIG Junior Doctors Patient Safety Board	Education and Training reports	Poor engagement from Supervising consultants	Incomplete reports	New structure for education reporting to be set up with Director of Medical Education and MD	**G**
BAF 5	**F16** **TRA06** **O13** **O12**	Inability to recruit/redeploy/retain staff during transformation of services	Director of Human Resources	Sub-Group of JCNC set up and T of R agreed with SS to support transformational change (Audit/skills matrix agreed) Fortnightly Controls Group in place Weekly Vacancy Control panel in place Controls Group reports to TDG Vacancy reports and Establishment reports go to Controls Group	Jointly agreed with SS ToR and written agreement on key stages of management of change process to support changing environment Workforce Plan in place Detailed vacancy and establishment reports TB reporting	None	None	Continuous monthly monitoring and stock take of vacancies/turnover and bank and agency usage against planned workforce establishment and spend. Recruitment campaigns and on-going recruitment to fill vacancies where required in place	**G**
BAF 6	**F19** **O13**	Failure to maintain balanced rosters and efficient and effective staff utilisation across Trust	Director of Human Resources	E-rostering team in place Control Group in place Tight authorisation procedures for the use of agency and temporary staff in place Robust Rostering	Workforce information reports from both e-rostering and ESR produced E-rostering roll out on plan Target for Core workforce and	Not all wards are using e-rostering effectively No workforce planning group (key budget holders for workforce) in place	Partial reporting available on e-rostering Development of reporting on bank efficiencies through e-rostering required.	A new post will be introduced to the core iworkforce group to support safe and efficient rostering whilst at the same time challenging poor rostering practices. This will also support the planned reduction in temporary workforce usage Develop comprehensive e-	**A**

BAF No.	Risk Reg Ref/ CQC	Principal Risks to Strategic Objectives	Lead	Key Controls	Assurances on controls	Gaps in control	Gaps in assurance	Risk mitigation/control plans	Rating
				and Annual leave policy implemented E-rostering implementation for bank staff commenced January 2012	temporary in place and performance against this measured on a monthly basis A new post to be introduced to central team to support safe and efficient rostering TB reporting Agency/ Temporary workforce usage Group			rostering reports to support total roll out. Workforce Planning Group Proposal to go to TDG	
BAF 7	O14	Inability to identify talent and effectively succession plan	Director of Human Resources	Talent Management and Succession Planning Strategy agreed by TB Talent Management and Succession Planning Implementation Process has been developed and pilot agreed (band 7 and above)	Appraisal linked to TM&SP Appraisal Target 100% Personal Development Plan Target 100% TB reporting	Proposals within TM&SP Implementation plan to be agreed by TB Resources to be identified to support implementation (	Appraisal paperwork to be amended to include TM&SP forms and guidance Central Funding of OD plans to be agreed to support proposals set out in implementation plan	Full implementation plan developed. Proposals to be agreed before TM&SP can be implemented Training posts advertised	A
BAF 8	O14	Failure to develop a culture and environment where the workforce can excel	Director of Human Resources	Revised action plan relating to strategic and local level actions developed to support improvements in staff survey results	Staff Survey Results Pulse Survey Results Plans revised to take account of latest results Communication	Care Groups need to be fully engaged and involved in work and progress made	TB approval for revised strategic and local level plans to support improvements in staff survey results Staff Partnership Agreement to be developed in	Staff Engagement Programme to be introduced led by CEO and top team Refreshed Strategic initiatives identified and Departmental specific plans to be developed in conjunction with staff On going action to imbed	A

BAF No.	Risk Reg Ref/ CQC	Principal Risks to Strategic Objectives	Lead	Key Controls	Assurances on controls	Gaps in control	Gaps in assurance	Risk mitigation/control plans	Rating
				TB reporting Staff engagement programme to be led by CEO Staff Partnership Agreement	programme and focus group plans		conjunction with staff side	appraisal in place On-going action to stamp out bullying and harassment in place	
TRUST OBJECTIVE 3: Develop a revised Business Strategy, reflected in our Integrated Business Plan to obtain Secretary of State approval for NGH to become a Foundation Trust by July 2012									
BAF 9		Inability to develop revised business strategy due to ASR, external environment and commissioning intentions	Director of Strategy & Partnerships	CEO and Director membership in ASR groups GP Engagement strategy Contract review meetings	ASR Project Plan Quarterly report to HMG from GP Liaison Manager Contract Review Minutes	Lack of sole ownership of the ASR programme, commissioning intention process or the PCTs annual planning process	Nil	Full involvement of PCT and GP commissioners in the annual planning process and convergence with activity and financial assumptions	**A**
BAF 10		Failure to produce a service strategy that delivers clinically excellent and sustainable services into the future	Director of Strategy & Partnerships	Revised Trust Strategy designed in January 2012 to reflect current operating environment Service Strategies at directorate level outline actions to reduce waits and improve clinical quality. Analysis of referral data on a monthly basis to monitor trend PET data informs	Quarterly Market assessment Business intelligence networks	Access to business intelligence Timely market analysis data Acute services review	Information may be inconclusive and subjective	Directorate service strategies have been refreshed and incorporated into the Annual Plan Trust service strategy will be re-written once the direction of the Acute Services Review is known	**G**

BAF No.	Risk Reg Ref/ CQC	Principal Risks to Strategic Objectives	Lead	Key Controls	Assurances on controls	Gaps in control	Gaps in assurance	Risk mitigation/control plans	Rating
				areas for attention					
BAF 11	O16	Failure to produce adequate IBP	Director of Strategy & Partnerships	Revised FT project plan with clear timescales and responsibilities documented Milestone delivery to StHA FT application timeline	StHA feedback Quarterly board reports	Acute services review and the impact of national policy	CIP delivery, LTFM and liquidity strategy, ASR timescales	Board approval of the revised project plan and Board development programme	G
BAF 12		Failure to respond to tenders or market development opportunities	Director of Strategy & Partnerships	Service Planning Framework Strategic Planning Group	Board approval of the Framework All development cases considered and approved by HMG	Trust is unable to influence the timing or scope of market opportunities	Board reporting on all market development opportunities required	NGH is registered on Supply2Health which alerts the Trust to market development opportunities. The Planning Frameworks and process for responding to tenders all mitigate this risk	G
BAF 13	F16 O26	Failure to generate cash balance of circa £10m to cover 15 days operating expenditure	Director of Finance	Transformation Programme and PMO to provide assurance over CIP delivery Controls over capital expenditure in 11/12 and 12/13. CIP requirement for 12/13 to be set higher than national requirement Revised	Fortnightly reporting and change control process 2011/12 and 2012/13 capital plan scaled back Transformation Steering Board and TSG review of 2012/13 CIP plans	Delivery of mitigating actions to deliver 2011/12 forecast outturn Identification, assessment and delivery of 2012/13 transformation programme Process for receiving cash on timely basis from commissioners	Nil	Develop capital approval process to allow detailed monthly cash flow projections 2012/13 to include specific clauses in respect of payment for over performance	A

BAF No.	Risk Reg Ref/ CQC	Principal Risks to Strategic Objectives	Lead	Key Controls	Assurances on controls	Gaps in control	Gaps in assurance	Risk mitigation/control plans	Rating
				Transformation governance structure					
TRUST OBJECTIVE 4: To develop a strategic partnership with Nene Commissioning and other Commissioners and enhanced working relationships with all local GPs									
BAF 14	**O26**	Loss of market share leading to increased CIP requirement	Director of Strategy & Partnerships	Quarterly Market Assessment Reports Monthly referral monitoring reports	Annual refresh of the market assessment strategy with links to annual planning process Quarterly Monthly board reports	Inability to control or influence the activities of other NHS or private providers who may target local GPs	None	Enhance links between market assessment and directorate service plans to ensure coherence with GPCC aims and activity intelligence	**G**
BAF 15		Failure to develop a strategic relationship leads to a decline in reputation with local commissioners	Director of Strategy & Partnerships	GP Engagement Strategy	Quarterly report to HMG from GP Liaison Manager	Transition of PCTs to Cluster arrangements and increased influence of GPCC	Lack of robust governance arrangements for Acute involvement in new GPCC	Continue pro-active approach to maintain relationship management and to ensure representation on all formal and informal boards with GPCC	**G**
BAF 16	**O16**	Failure to develop a partnership with Nene will constrain our ability to redesign services to provide innovative patient pathways	Director of Strategy & Partnerships	Quarterly Market Assessment Reports Monthly referral monitoring reports GP Engagement Strategy Membership of the Integrated Care Partnership	Quarterly report to HMG from GP Liaison Manager Minutes from the NICP Consultant / GP buddy scheme	Possible desire for commissioners to develop Any Willing Provider schemes that may not include NGH	None	GP engagement strategy; open and transparent approach to pathway redesign; active involvement in all Commissioner-led programmes	**G**
TRUST OBJECTIVE 5: Develop critical clinical care pathways to deliver effective integrated care as part of the Acute Services Review									

BAF No.	Risk Reg Ref/ CQC	Principal Risks to Strategic Objectives	Lead	Key Controls	Assurances on controls	Gaps in control	Gaps in assurance	Risk mitigation/control plans	Rating
BAF 17		Risk of slow pace and lack of agreement with commissioners and healthcare partners as to how to agree or execute changes in delivering pathways of care	Chief Executive & Medical Director	County Leaders Group Acute Services Review NICP Board	Active Engagement with these groups Regular reports	Poor project management	Slow pace and poor reports (positive assurance is continued high level engagement with process)	Continued engagement from as many as possible	A
TRUST OBJECTIVE 6: To agree a revised Estate Strategy in the context of the Trusts Service Strategy, Transformation Programme and the Acute Services Review, which explores alternative funding mechanisms and is completed in line with the FT Application Timetable									
BAF 18	O10	Insufficient capital funding identified for statutory maintenance, replacement infrastructure, patient environment improvements and infection control which would adversely impact on health and safety, patient experience and quality of care	Director of Facilities and Director of Finance	Estates Planning and Development Group Health and Safety Committee	Regular reports to Capital Committee Monthly financial reporting to Trust Board	Funding gaps in 11/12and 12/13 due to liquidity problems Alternative capital funding sources not yet identified Revised Estates Strategy not yet completed	Nil	Agreed Estates Strategy Annual capital programme in place to meet requirements Business Continuity plans in place to manage risks from infrastructure failures	A
TRUST OBJECTIVE 7: To develop, implement and sustain transformation in the way we deliver our services in order to maintain quality and deliver c£18million reduction in cost base by the end of 2011/12									
BAF 19	F16 O26	Failure to implement the changes needed to deliver CIP plan	Chief Operating Officer	Transformation Delivery Group weekly meeting, PMO in place, tracking tool in place. Change control system in place Finance & Performance Committee	Monthly board report, weekly TDG minutes	Savings estimates may not equate to actual savings	Nil	Quarterly "stock take" of delivery against schemes, continuous development of new schemes to replace others, contingency reserve in place.	G

BAF No.	Risk Reg Ref/ CQC	Principal Risks to Strategic Objectives	Lead	Key Controls	Assurances on controls	Gaps in control	Gaps in assurance	Risk mitigation/control plans	Rating
BAF 20	Med55	Non elective activity levels exceeding plan leading to inability to implement bed closure programme which is a significant part of the transformation programme	Chief Operating Officer	Bi weekly updates to TDG, tracking tool in place Finance & Performance Committee	TDG reporting, tracking tool data	Trust is unable to impact further demand management for non-elective activity ,current increase is 5% above plan.	Nil	Contingency reserve and replacement schemes	R
BAF 21	O26	Failure of Transformation Programme to deliver £18m of cost reduction in 2011/12 and £18m in 2012/13	Director of Finance	Transformation Programme and PMO to provide assurance over CIP delivery Finance & Performance Committee Revised governance structure in place and introduction of Transformation Steering Board	Fortnightly reporting and change control process Identification of mitigating actions to date	Identification, assessment and delivery of 2012/12 transformation programme	Nil	Identification and work up of plans for closing 2012/13	A
TRUST OBJECTIVE 8: To implement effective service line management across the organisation by 31 December 2011 and to develop underpinning business processes that deliver increased managerial control									
BAF 22	F16	Failure to implement the revised organisational structure which will deliver increased managerial control	Chief Executive	TDG reporting	Monthly board report, weekly TDG minutes	Savings estimates may not equate to actual savings	Nil	Contingency reserve and replacement schemes	G
BAF 23		Failure to implement service line reporting system	Director of Finance	Project Board and Resource Plan	Project Board minutes and delivery of actions	Identify directorate clinical champions for rollout phase	Nil	Additional consultancy commissioned to maintain speed of implementation Directorate champions to be identified in rollout phase (Q4 2012/13)	A

BAF No.	Risk Reg Ref/ CQC	Principal Risks to Strategic Objectives	Lead	Key Controls	Assurances on controls	Gaps in control	Gaps in assurance	Risk mitigation/control plans	Rating
BAF 24		Failure to engage clinicians in service line reporting and obtain acceptance as business tool	Director of Finance	Rollout process Directorate Champions	Sign off on service line reporting assumptions and outputs by directorates	Identify directorate clinical champions for rollout phase	Nil	Additional consultancy commissioned to maintain speed of implementation Directorate champions to be identified in rollout phase(Q4 2012/13)	A

CQC Outcomes

Outcome 1: Respecting and involving people who use services
Outcome 2: Consent to care and treatment
Outcome 4: Care and welfare of people who use services
Outcome 6: Cooperating with other providers
Outcome 7: Safeguarding people who use services from abuse
Outcome 8: Cleanliness and infection control
Outcome 9: Management of medicines
Outcome 10: Safety and suitability of premises
Outcome 11: Safety, availability and suitability of equipment
Outcome 12: Requirements relating to workers
Outcome 13: Staffing
Outcome 14: Supporting workers
Outcome 16: Assessing and monitoring the quality of service provision
Outcome 17: Complaints
Outcome 21: Records.
Outcome 26- Finance