Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD MEETING
Wednesday 27th June 2012
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
9.30	1.	Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Draft Minutes of meeting held on 25th April 2012	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	
9.35	5.	Chief Executive's Report - Healthier Together Update	Dr G McSorley	**2**
Clinical Quality & Safety				
9.50	6.	Medical Director's Report	Dr S Swart	**3**
10.05	7.	Quality Account 2011/12	Ms S Loader	**4**
10.10	8.	Patient Experience – Friends & Family Test	Ms S Loader	**5**
10.20	9.	Infection Prevention Report	Ms S Loader	**6**
Operational Assurance				
10.30	10.	Performance Report	Mrs C Allen	**7**
10.40	11.	Finance Report	Mr A Foster	**8**
10.50	12.	HR Report	Ms G Opreshko	**9**
11.00	13.	Provider Management Self Certification	Mr C Pallot	**10**
11.10	14.	Transformation Programme Update	Mrs C Allen	**11**
Strategic				
11.20	15.	Patient Experience Strategy	Ms S Loader	**12**
11.35	16.	Carbon Management Plan	Mr C Pallot/ Dr C Topping	**13**
Governance				
11.45	17.	Corporate Objectives 11/12 & Board Assurance Framework 12/13	Dr G McSorley	**14**
12.00	19.	Any Other Business		
	20.	**Date & time of next meeting** 9.30am Wednesday 25th July 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 25th April 2012 at 9.30am
Boardroom, Northampton General Hospital

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

The Chairman welcomed Ms S Howlett and Ms D Ceccini from the SHA to the meeting.

TB 12/13 01 **Declarations of Interest**

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

TB 12/13 02 **Minutes of the meeting held on 29th February 2011**
The minutes of the previous meeting were approved as a true record.

TB 12/13 03 **Chief Executive's Report**
Dr McSorley presented his report and noted that the date for formal consultation on proposals for reconfiguration for services for South East Midlands would begin on 1st October. The Patient and Public Involvement Group have been considering evaluation criteria for proposals and the Chairman of that Group, Steve Lowden values the opportunity to talk to Boards and Governors Councils. It was agreed that Mr Lowden be invited to the June meeting.

Ongoing work as part of the Foundation Trust application is underway and includes independent reviews of quality and governance arrangements. Submission of the outcomes of this work is to be made during May to the Strategic Health Authority.

The revised Care Group organisational structure came into effect from 1st April and a structure chart is included with the report. All posts have been filled and, as part of the new governance arrangements, the Hospital Management Group will be

disbanded and replaced by the Strategic Management Board. Membership will consist of Executive Directors, Care Group Senior Leadership, Clinical Directors and General Managers.

The final reconfiguration of Vascular Services took place at the beginning of April and NGH now acts as the hub for the County.

Nottingham University Hospitals will be the Major Trauma Centre for the East Midlands and a Trauma Network Board has been established. Mr Pallot is the Trust representative on this Board.

National discussions are underway regarding the creation of Academic Health Science Networks and it is likely that all hospitals will be required to participate. Further proposals regarding the creation of the networks will be published later in the year and a recommendation will be brought to the Board.

Action: Recommendation for joining an Academic Health Science Network to be discussed when available.

Action: Ms S Rudd to arrange for attendance by Mr S Lowden to June meeting

The Board noted the report.

TB 12/13 04 Medical Director's Patient Safety Report - HSMR Update

Dr Swart presented her report noting Hospital Standardised Mortality Rate (HSMR) is discussed at Board on a monthly basis. It is a representation of the work that has been ongoing for 18 months and reflects the commitment of the organisation to review ongoing care.

The overall mortality rate for this financial year has shown further improvement and, once rebased at the end of the year will be 103 compared to 116 last year. This is a significant improvement and is mainly due to improvements in clinical care and better engagement in clinical systems and coding.

The weekend mortality rate is no longer an outlier but we are committed to improving our care pathway.

The Patient Safety Indicator dashboard identifies obstetric trauma – vaginal delivery without instrument as an area of concern. Current data indicates that this has reduced.

A detailed analysis of case notes relating to 237 consecutive deaths has been undertaken. Actions have been identified and shared with consultants. Case note review is a well documented method of identifying areas for improvement. There has been excellent involvement by the consultants and the audit will be repeated every 6 months to see progress against areas identified.

Mr Farenden noted that it is pleasing to see the improvement in performance and that clinical engagement is key and clearly needs to continue and will this be sustained. Dr Swart replied that enthusiasm has not dropped, there has been a lot of interest expressed in the role of safety leads.

Mr Robertson asked about the 25% of admissions regarded as avoidable. Dr Swart replied that we have engaged with PCT colleagues regarding the provision of services in the community.

Mr Zeidler queried the numbers of patients diagnosed with respiratory pneumonia compared to last year. Dr Swart replied that this relates to the way pneumonia is diagnosed and the type of pneumonia. This has a resultant effect on the expected death rate.

Dr Swart highlighted the exception report from the monthly update on the quality scorecard. The Trust is investing in the redesign of the emergency care pathway to improve clinical care in A&E and improve patient flow through the hospital.

C-Section rates are above target due to a number of factors, including patient choice. We are working towards full compliance and will be continually audited against NICE guidelines.

Pressure sores are a key focus area for staff as is falls prevention. Mandatory training also remains an area of focus and the patient safety strategy will link to mandatory training topics in a simulation session. There has been good progress on uptake of e-learning and cluster training days.

Mr Kershaw highlighted the number of falls and that the target has not been met. Dr Swart replied that it is an improvement on the last quarter but continued focus is required. Staff are being trained in additional measures and Junior doctors are also engaged in the work.

Dr Kelso, Shadow Governor, asked about mandatory training rates at other trusts. Ms Wilkinson replied that benchmarking information is difficult to obtain. Dr Swart noted that each Trust deals with mandatory training in a different way and with different systems. Linking mandatory training to a patient safety scenario, with different elements included, will help with compliance.

The Quality priorities were agreed at the last meeting and the report provides the detail behind each of these priorities, including targets for improvement.

With regard to vulnerable adults, there will be an extension of the work carried out to date, dementia is a national issue. Ms Loader noted that significant amounts of training planned for this year for caring for people with dementia. It was also noted that the Trust is formally committing to the Net Promoter score.

Patient experience was formerly captured using the patient experience tracker. This has now moved to the Hospedia television system within the Trust and patients are asked if they would recommend this hospital to family and friends.

Mr Zeidler commented that it would be helpful if could define the measures of success in more detail. Dr Swart replied that this will be reviewed once the project lead is in place.

TB 12/13 05 **Performance Report**

Mrs Allen presented her report noting that 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 a standard of 95%.

The Trust achieved all the cancer standards with the exception of 31 days from referral to treatment for subsequent treatments for drug therapy. 97.4% against a standards of 98%, and the standard is monitored quarterly, this is an in month variation. Two patients did not receive treatment within the timeframe and a root cause analysis has been carried out to prevent future occurrences.

The Trust did not achieve the year end standard for the number of patients treated within 4 hours, 92.87% against the standard of 95%. Improvements in the urgent care pathway are a priority for the Trust. The non elective pressures continued in March and the achievement of the targets was against a backdrop growth, transformation and reorganisation.

Mr Farenden asked when the recovery plan and the health economy plans are going to deliver in a sustained way. Mrs Allen replied that the detail of the urgent care recovery plan includes FIT, fast assessment of a patient by a clinical team. It will require considerable investment in the coming year to build on the investment already made.

Mr Noble asked about the ability to cope if demand continues to increase. Mrs Allen replied that there are things that can be done internally and the focus is on taking out the delays in the pathway. The Trust is focussing on all areas that are internal to ensure that everything possible has been done.

Dr McSorley commented that A&E is a daily conversation and there is a thematic review of each day and each breach. It is evident that the East Midlands is standing out compared to the rest of the country. The numbers are increasing and the time of presentation is changing. We are seeing a shift to late evening. The acuity of patients is also increasing, particularly frail elderly patients.

Mr Robertson commented that the performance over the last month is impressive and asked how the redesign will affect bed occupancy levels. Mrs Allen replied that this is a clear measure and suitable levels will be set for each area. Dr Swart noted that the project is defined on a specialty basis.

Mr Evans, shadow governor, asked if the refurbishment work in A&E was completed. Mrs Allen replied that phase 1 is now complete, minors have been refurbished and work is now commencing on the area around the nurses' station. Mr Abolins said that the whole programme will be completed in June.

TB 12/13 06 **Infection Prevention Report**

Ms Loader presented the report noting that there were no post 48hr cases of MRSA bacteraemia in March, against the Trust trajectory of 3 cases. There was 99.9% compliance with screening.

There has been a 50% reduction in MSSA bacteraemia which relates to improved practice.

Clostridium difficile trajectory is 54 cases and the Trust identified 3 post 48hr cases in March. Year to date there have been 50 cases, with 2 additional cases at community hospitals.

Hand hygiene compliance was 99.5% for the month. Ms Loader reported that she will be reviewing how the audits are undertaken and making any changes that are necessary.

Mr Farenden noted the good performance but commented on the difficulty of achieving the target set for this year. Dr Swart replied that the Trust will work in partnership to develop revised action plans and will work towards the standard of 1 case.

TB 12/13 07 **Finance Report**

Mr Drury presented his report noting that 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.

Cost improvement delivery was £19.1m against a target of £18.6m, and includes £4.9m of non recurrent items.

Capital expenditure is £9m, which is £1.45m below the capital resource limit and is in line with projections. The cash position at the end of the year was £3.9m. The Better Payment Practice code was not achieved in year, but as reported to the Finance & Performance Committee cash was received in March allowing significant inroads into payment of creditors.

SLA income, day case and elective are now on plan and non elective income was £8.9m above plan, with a £0.4m impact of MRET.

Mr Farenden commented on the achievement of the £19.1m CIP delivery. Dr McSorley agreed that it is an impressive achievement and is a tribute to staff who undergone major changes.

TB 12/13 08 **HR Report**

Ms Wilkinson presented her report noted that total utilised workforce is above workforce funded established and bank and agency staff have been utilised due to increased pressures.

Mr Noble asked about the bank and agency figures and Ms Loader reported that the efficiency of ratios is being reviewed. Workshops for ward sisters and matrons are being held to help reduce bank and agency and improve continuity.

Mr Kershaw asked about sickness absence and the actions being taken to address. Ms Wilkinson replied that there are higher levels of sickness absence in the Trust and that there is always a slight increase during the winter. There have been additional pressures on staff this year and additional HR support is being put in as well as in Occupational Health to support staff.

Dr McSorley noted that this has been discussed with staff side. The sickness absence policy has improved our awareness and benchmarking shows that the Trust is not an outlier. Mr Zeidler asked if any group of staff is particularly vulnerable. Ms Wilkinson replied that bands 1-4 are more vulnerable, particularly within nursing. Initiatives are focussed on this area.

Mr Zeidler commented that the number of appraisals carried out has reduced. Ms Wilkinson will provide a yearend update to the next meeting on the number of appraisals carried out. Mr Kershaw said that it is important to review the quality of appraisals, not just the numbers. Ms Wilkinson noted that there has been appraisal training for managers and also the introduction of team appraisals. There is a talent management and succession planning strategy in place.

Action: Ms Wilkinson, year appraisal report to May meeting.

TB 12/13 09 **Provider Management Report**

Mr Pallot presented the report recommending that the Board approve the signing of Declaration 2.

The overall governance rating for the month is 2.5 due to the cancer standards, A&E performance and Learning Disability. Ms Loader reported that there is an action plan in place for Learning Disability and therefore should be rated green in May.

The Board **agreed** to the signing of Declaration 2.

TB 12/13 10 **Transformation Programme**

Mrs Allen presented the newsletter that is circulated to staff and which translates the details of what the programme means to staff.

The monthly focus is outpatients and is about ensuring the right staff are in the right place and the top 10 priorities are detailed in the report.

Workstreams for 2012/13 have been developed and are similar or a continuation of the schemes from this year.

Dr Swart highlighted Quality Impact Assessments (QIA) noting that the outpatient standards were a direct result of the QIA at the beginning of the process.

Mr Noble commented that the work carried out in this area is tremendous and enquired if there is a team of people who can take this work forward. Mrs Allen replied that there has been a transfer of skills from the work carried out at the beginning of the programme.

TB 12/13 11 **Quality Strategy**

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

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

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

Action: Patient Experience Strategy, June meeting.

TB 12/13 12 **Patient Safety Strategy**

Dr Swart presented the strategy noting that a new Patient Safety Strategy and Safety Improvement Programme has been designed to interlink with other transformation projects. The strategy sets out the principles and focuses on engaging and communication with all levels of staff.

The Patient Safety Driver diagram discusses reducing avoidable harm and saving lives. The primary drivers discuss using a hierarchy of controls to reduce errors by standardising and simplifying systems.

A Patient Safety Academy will be formed with Champions identified. The champions will require significant training and good clinical engagement has been seen. There are 5 key areas of improvement identified.

The strategy needs to be measured and report using project management methodology. Mr Farenden commented that the CIP delivery and Transformation programme were effective due to the project management as asked about the reporting to the Board. Dr Swart replied that there will be a programme coordinator and reporting will be through the Patient Safety Steering Group.

Ms Loader noted that she was part of the development of the strategy prior to

joining the Trust and it addresses the fundamental elements of care.

The Board approved the Strategy.

TB 12/13 13 **Communications and Engagement Strategy**

Mr Pallot presented the strategy noting that it is important that there is consistency of messages to staff. The strategy will help to enhance staff, patient and public engagement and introduces increased opportunities for two way communication with audience groups.

Mr Abolins asked about team briefings, high level communications do not necessarily reach the shop floor. Mr Pallot replied that the structure in included to facilitate all levels of communication and that there will be a real time survey to assess feedback.

Mr Zeidler referenced the aim of staff feeling valued and would appreciate a more explicit reference to the aims so that we are moving our culture to recognition of staff.

The Board **approved** the Strategy.

TB 12/13 14 **Staff Engagement Strategy – Listening into Action**

Dr McSorley presented the strategy commenting that we know there is a link to outcome of care and staff satisfaction at work.

The programme is structured to be evidence based and has been used in many hospitals to date. Those hospitals that have implemented the programme have seen significant improvement. It is a tried and tested method and supports our philosophy of engaging with our staff and lays out the process we will use to further develop the work. The staff side sponsor group will oversee the programme.

Mr Kershaw commented that the staff survey results indicate that this is necessary and asked who will be leading the work. Dr McSorley replied that the Board will need to participate in events and that this is a personal mission for him and is committed to the programme. A programme manager will be recruited to drive forward.

The Board **approved** the Strategy.

TB 12/13 15 **ICT Strategy 2012-2017**

Mr Pallot presented the report noting that it sets out the strategic aims and objectives for the Trust ICT department for the next five years.

The IT subcommittee and focus groups have helped to define priorities which include integration of clinical records supporting new models of care. The aim of the strategy is to support the ongoing work.

Mr Essery, Lead Governor, asked if the strategy will improve discharge procedures. Mr Pallot replied that it would from an electronic perspective and that GPs have commented that we have a high level of electronic communication. Dr Swart noted that there is a commitment to linking with the operational process on the ward and there will be a variety of testing projects.

Mr Noble asked about common systems and Mr Pallot replied that the national programme for IT has delivered some elements but not one common system. We have had to determine as an organisation how we move forward.

Mrs Allen noted that it is important that this strategy supports the strategies of the Trust and supports staff to do the right thing.

The Board **approved** the strategy.

TB 12/13 16 **Corporate Objectives 2011/12**
Ms Rudd presented the quarterly update to the 2011/12 corporate objectives and the progress against achievement.

The 2012/13 objectives will be discussed at the next meeting.

Action: 2012/13 Corporate Objectives to June meeting

TB 12/13 17 **Review of 2011/12 Board Assurance Framework**
Ms S Rudd presented the progress report for the financial year ending 2011/12.

Mr Robertson noted that focus must now be on the board assurance framework for next year.

Action: 2012/13 Board Assurance Framework to June meeting

TB 12/13 18 **Any other business**
There being no further business the meeting was declared closed.

TB 12/13 19 **Date and Time of Next Meeting**
Wednesday, 27th June 2012, Boardroom, NGH

Actions arising

TB 12/13 03	Recommendation for joining an Academic Health Science Network to be discussed when available	GM	October 2012
TB 12/13 03	Attendance by Mr S Lowden to June meeting	SR	June 2012
TB 12/13 08	Year appraisal report	CW	Completed
TB 12/13 11	Patient Experience Strategy	SL	June 2012
TB 12/13 17	2012/13 Corporate Objectives	GM	June 2012
TB 12/13 17	2012/13 Board Assurance Framework	GM	June 2012

BOARD SUMMARY SHEET	
Title: -	Chief Executive's Report
Submitted by: -	Dr G McSorley, Chief Executive
Date of meeting: -	27th June 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
JUNE BOARD MEETING

1. Academic Health Science Networks

Further to my previous report we are still awaiting publication of the governments thinking on the creation of the Academic Health Science Networks. As soon as that report is published I will appraise the Board further on the options available for NGH.

2. County Leaders Group

As part of the County Leaders Group programme of improvements in emergency care NHS Northamptonshire is currently considering proposals for a review of care models and implementation of the ideal model of care for frail elderly people in Northamptonshire. It is expected that a report on how the current arrangements could be improved will be available in September 2012.

3. Staff Engagement

As part of updating staff on the current strategy for the Trust both in 2012/12 but also going forward into future years I have undertaken a number of staff briefing sessions over the last few weeks. These have been both well attended and well received. They will now be supported further transformation communications, the proposed Listening into Action sessions in July, and the development of departmental/directorate Listening into Action work from September.

4. Annual Plan Review

As part of the routine arrangements to review all Trusts annual plans the Strategic Health Authority will be holding a joint meeting with joint officers on the 26th June. I will give an oral update to the Board at its meeting.

Dr Gerry McSorley
Chief Executive
June 2012

HEALTHIER TOGETHER PROGRAMME (SOUTH EAST MIDLANDS ACUTE SERVICES REVIEW)
PROGRESS REPORT FOR ALL PARTNER ORGANISATIONS

1. Introduction

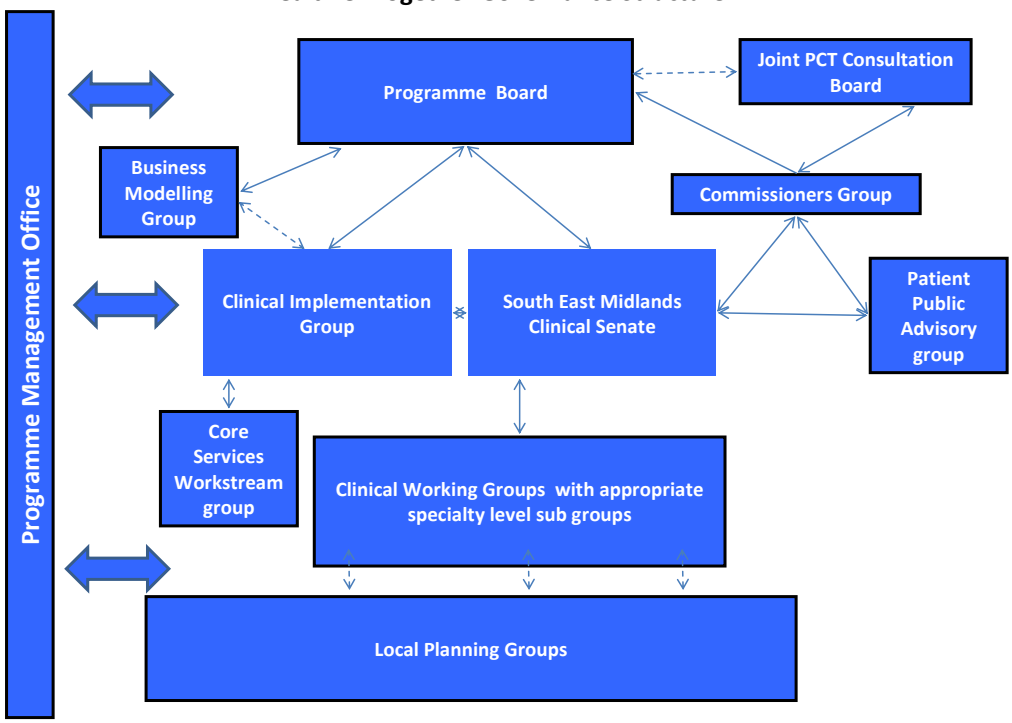
The purpose of this paper is to provide the Trust Boards of partner organisations with an update on the Healthier Together Programme (South East Midlands Acute Services Review). An earlier paper was received by Boards in November/December 2011 which resulted in all 12 partners signing up to the Programme and its objectives.

Ahead of a formal public consultation in the autumn, the Programme Office will now provide Boards with monthly updates to ensure they are kept up to date with developments and remain engaged.

2. Governance structure

The governance structure for the Healthier Together Programme has been agreed by the Programme Board.

Healthier Together Governance Structure



The Programme Board is made up of the Accountable Officers of the 12 partners' organisations:

Programme Board Partners		
Northampton General Hospital NHS Trust	Nene CCG	NHS Milton Keynes & Northamptonshire PCT Cluster
Bedford General Hospital NHS Trust	Corby CCG	NHS Bedfordshire & Luton PCT Cluster
Luton & Dunstable Hospital NHS Foundation Trust	Luton CCG	
Kettering General Hospital NHS Foundation Trust	Bedfordshire CCG	
Milton Keynes Hospital NHS Foundation Trust	Milton Keynes CCG	

Partner, stakeholder and patient and public representation is embedded throughout the governance structure. All the governance groups have been operating since January/February 2012 and are progressing well. This is a commissioner-led Programme with the clear support of the Strategic Health Authority. The Commissioner Group is co-chaired by Dr Paul Hassan from Bedfordshire and Dr Darin Seiger from Northamptonshire. A draft commissioner concordat between the five CCGs and two Clusters has been agreed on how they will work together through the Programme.

The group is developing a joint commissioner vision for the South East Midlands which is focused on improvement of clinical outcomes. The vision will be developed at a commissioner workshop on 13th June.

A patient and public advisory group (PPAG), with an independent Chair has been established and has met on four occasions. There are approximately 30 members of the group with good representation from local community groups as well as members/governors from each hospital and LINks. A Joint Health Overview and Scrutiny Committee has been established with representation from all five local authorities in the South East Midlands and observers from neighbouring local authorities.

Clinical engagement is central to the Programme's success. A Programme Clinical Lead has been appointed, Mr Edmund (Ed) Neale, Consultant Obstetrician and Gynaecologist and Medical Director of Bedford Hospital. Ed chairs the Programme's Clinical Senate. Six Clinical Working Groups (CWGs) have been established and are chaired by a practising clinician from within the South East Midlands. The CWGs are made up of hospital consultants, GPs, nurses, health and social care and patient and public representatives. Clinical engagement has been excellent and there are over 110 clinicians involved in the Programme.

The Chairs of the CWGs are:

Clinical Working Group	Chair
Cancer	Dr Christine Elwell, Consultant Oncologist, Northampton General Hospital
Children	Dr Beryl Adler, Consultant Paediatrician, Luton & Dunstable Hospital NHS Foundation Trust
Emergency Care	Dr Naeem Shaukat, Consultant cardiologist, Kettering General Hospital Foundation Trust
Long Term Conditions	Dr Monica Alabi, General Practitioner, Luton
Maternity	Mr Paul Wood, Consultant Obstetrician & Gynaecologist, Kettering Hospital Foundation Trust
Planned Care	Mr Rob Hicks, Consultant Vascular Surgeon, Northampton General Hospital

The CWG reports are currently being drafted. The reports will outline proposed models of care for the six specialty areas. The first draft of reports will be reviewed by the Clinical Senate at the end of May and a further iteration at a full day meeting in the middle of June. The Senate, membership of which includes hospital, community and ambulance clinicians as well as PPAG representatives, will propose clinical models of care and key clinical interdependencies.

A Clinical Implementation Group consisting of Medical Directors, CCG chairs, PPAG Chair and Ambulance Trust Medical Director will, in early July consider the models of care proposed by the Senate and start to develop proposals for reconfiguration models.

3. Communications and engagement

Communications and engagement activity to date has focused on:

- Raising awareness and understanding of the Programme's vision and case for change
- Ensuring engagement at all levels of the Programme

Tailored communications and engagement plans have been developed for each clinical working group. Joint working with voluntary and community sector organisations has been established to ensure targeted engagement with harder to reach groups.

The following is a sample of the communications and engagement activity undertaken to date:

- The Case for Change leaflet, *'Why we need to change'* has been distributed widely via hospitals, GP surgeries, pharmacies, libraries, LINk groups and third sector groups
- A telephone survey in February 2012 with a representative sample of the local population (1600)
- A full set of communications materials provided to partner organisations to ensure local audiences and staff are kept informed and aware of the opportunities to get involved
- Regular monthly Update newsletter
- An extensive Programme of public, stakeholder and third sector meetings/ presentations

- Road shows in April in busy areas such as shopping centres and train stations
- Local radio advertisements for a 3 week period during April with seven advertisements a day and an audience reach of 600,000 people, a third of all adults in the South East Midlands area
- Week long feature on BBC Three Counties Radio/BBC Radio Northampton in May
- New media strategy with a reach of more than 28,000 Twitter and Facebook accounts
- An interactive website, with online surveys, DVD and vox pops films, which has had more than 3,800 visitors
- A DVD of the case for change circulated to GP surgeries and hospitals for use in public areas
- Information screen slides developed for Hospitals, GP surgeries and main Post Offices from April
- Posters *'What do you think?'* in GP surgeries, libraries, Post Offices and other public areas
- Regular MP briefing

The following feedback has been published on the Healthier Together website:

- A full report with feedback and a series of infographics from the five public deliberative events in Wellingborough, Bedford, Milton Keynes (2) and Luton.
- Feedback from the telephone survey of 1600 people (representative sample)
- Feedback from the Case for Change questionnaire and online **survey -** over 1200 responses received to date. Themes include:
  - A wish to see improvements around weekends, 24/7
  - The importance of caring, qualified staff
  - People want to access to expertise and the best possible treatment
  - There is support for centres of expertise but people do have concerns about travel

A final report summarising all the pre-consultation engagement will be prepared to provide assurance that best practice has been followed ahead of a formal public consultation.

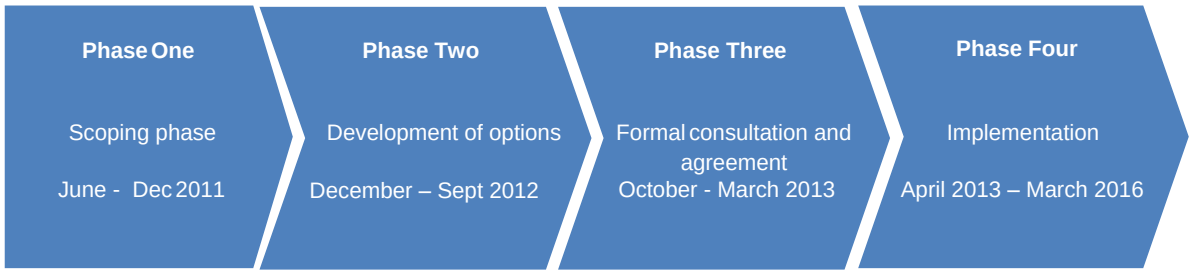
4. Programme Enablers

Business modelling support to the Programme has been commissioned to assist financial and activity modelling of proposed scenarios. The modelling will also include travel and transport analysis.

Travel and transport is an area of concern for patients and the public and a Travel and Transport task and finish group is being established, with the first meeting planned for early June. Membership of the group will include; PPAG representatives, Ambulance and patient transport services; public transport providers and those with a wider strategy view from the Local Enterprise Partnerships and Local Authorities.

An Impact Assessment steering group has been established and is meeting at the end of May. The steering group will oversee development of quality and equality impact assessment tools which will be used to assess clinical service models.

5. Timeline



6. Key Milestones

- Commissioner vision and health outcomes to Programme Board – late June
- Proposals from Clinical Senate on recommendation for core services and options for clinical models to Programme Board – late June
- Options for clinical models to Clinical Implementation Group (CIG) – late June
- Joint Health Overview & Scrutiny Committee – mid July
- First draft of options on models and locations from CIG and Clinical Senate to Programme Board – late July
- Final draft Consultation document to the Programme Board – late August
- Final consultation document (having been through JHOSC) to Programme Board – mid September
- Final consultation document to Joint PCT Consultation Board – mid September
- Consultation starts – Monday 1st October 2012 for 13 weeks

7. Recommendation

The Board is asked to note progress to date and feedback any queries through their Programme Board representative.

BOARD SUMMARY SHEET	
Title	Medical Director's Report – Mortality, Clinical Scorecard Exception Report
Submitted by	Dr Sonia Swart, Medical Director
Prepared by	Dr Sonia Swart, Medical Director
Date of meeting	June 27 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

This paper summarises the data relating to mortality monitoring and presents an improved position for the financial year 2011/12. Key ongoing areas of investigation are noted. The quality scorecard highlights areas where performance remains a concern and provides assurance that these are recognised and actions are underway.

PATIENT IMPACT

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

STAFF IMPACT

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

1. Note and debate the issues raised in the report
2. Note the investment agreed to support analysis of information to inform the emergency care redesign project and improve information flows alongside the projects designed to improve quality and safety.
3. Challenge any issues raised from the monthly scorecard
4. Debate any further information issues that should be investigated as part of the analysis currently being commissioned.

Section 1

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

1. Introduction

This paper summarises progress in the work relating to the additional work undertaken over the last 18 months set up to supplement the regular scrutiny of mortality data as provided by Dr Foster Intelligence.

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

2. Current Position HSMR

HSMR for 2011-12 (data to end March 2012) has remained at the level reported in the last Board report **93.9 (1038 deaths versus 1105 expected).** If this were rebased as per Dr Foster methodology the number would be around **102** for the period from April 2011 – February 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 75 Trusts have SMRs higher than that predicted for NGH.

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

For March the HSMR was **97**. There were 112 expected deaths and there were 109 actual deaths. This was higher than the figure for February but remains within expected limits.

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

The position in this financial year for the nine months to the end of February has improved with a HSMR for weekend admissions of **107** 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.

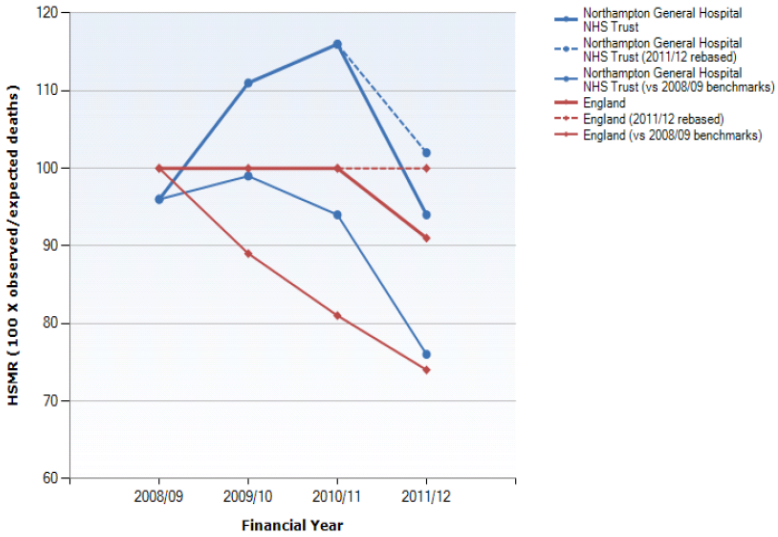
3. Acute Trust HSMRs April 2011 - March 2012

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

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

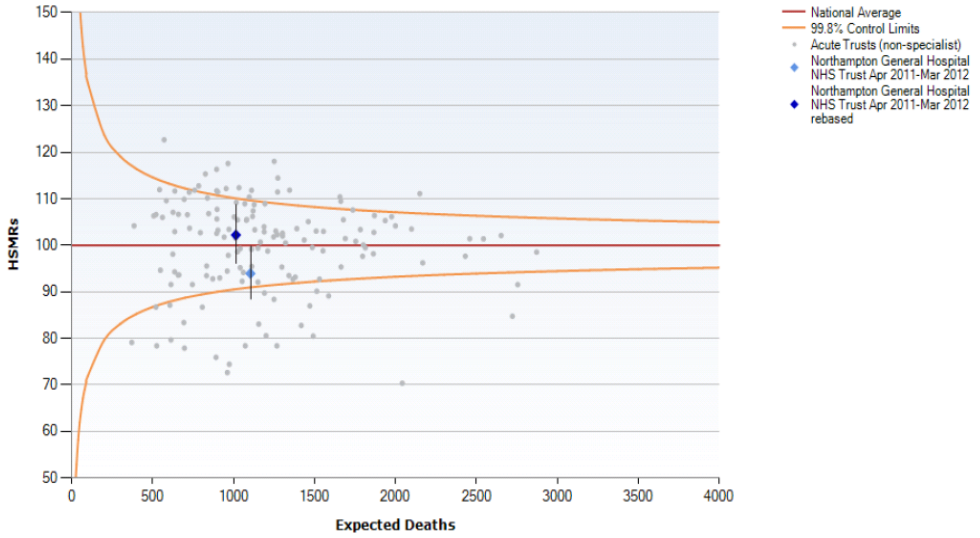
HSMR Trend

Trend in HSMR



Acute Trust HSMRs Apr 2011-Mar 2012

The background points show the HSMR for the **current financial year** for each acute non-specialist trust in England. Use the controls below to toggle between the current and rebased values.

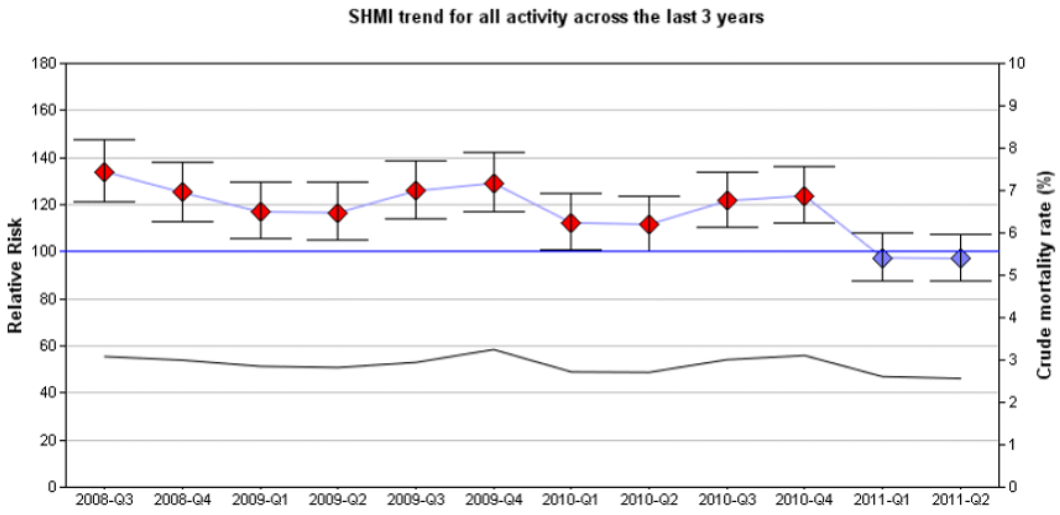


4. Standardised Hospital Mortality Indicator (SHMI)

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

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

SHMI trend for all activity across the last 3 years



At present, the SHMI roughly mirrors the HSMR for NGH. The latest SHMI is reported on rolling 12 months basis and shows an improvement from 114 to 109 (period up to September 2011 – rolling 12 months). The quarterly position for the first 2 quarters of 2011/12 is as expected at **97 .** In addition crude mortality fell during this period from 3% to 2.6%. The SHMI is benchmarked each quarter unlike HSMR which is benchmarked at the end of the year**.**

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

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

The performance against these indicators is generally good and better than average in a significant number of areas as reported in the last Board report but a concern was raised in the case of Obstetric trauma. This indicator reflects the numbers of patients with significant trauma after normal delivery. The directorate have now confirmed that the problem relates to coding issues and not to any actual harm and have arranged a meeting with Dr Foster to understand the precise composition of the indicator so that it can be routinely included on the directorate scorecard

6. Reports on Key Areas for action:

1) Case Note review

The draft case note review report has been shared with experts in the field and been very well received. The comments received will help to inform the final format of the report which was quoted by the Chief Executive of Dr Foster Intelligence at the National Patient Safety Congress in June as an example of best practice in the context of a Hospital's approach to understanding mortality. NGH has been complemented on the detail and quality of the work done. As reported at previous Board meetings, the recommendations have been used to frame the targeted improvement projects relating to patient flow and quality of care which will be integrated and aligned to ensure that the Emergency Care Redesign project and the programme of work articulated in the Patient Safety Strategy complement and support each other.

As part of the focus on quality and safety and in order to ensure that the improvements made are sustained the Trust is commissioning a further piece of work to ensure that the processes of care and the flows of information that feed into clinical coding are optimised. There is an acceptance that regular interaction that between coders and clinical teams will need to be continued.

There are further specific areas of work that will need to have some input from the information and coding teams to ensure that there is regular review and scrutiny of all information and coding issues and that this is reported to directorate management boards.

2) Respiratory tract illnesses:

The Pneumonia SMR for 2011/12 continues to improve and to date is **84** versus **127** for 2010/11. This represents 215 deaths versus 257 expected deaths for the year. There was a large rise in the number of admissions during February and March . The **launch** of the pneumonia care bundle is under revision and there is a plan to combine the documentation for the Pneumonia Care Bundle with the Sepsis 6 bundle in order to increase uptake and improve the ease of use. This will now be monitored quarterly.

3) Cardiac diseases:

Previous concerns were raised by the CQC in relation to mortality from congestive heart failure and complex cardiac disease in the elderly. Mortality from **Congestive Cardiac Failure** is now as expected with an SMR of **96** (45 deaths, 47 expected). This will now be monitored quarterly. 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 also currently as expected with a SMR of **86**. A clinician is reviewing each death from Myocardial Infarction to assist in accurate coding and monitoring is now quarterly.

4) Hip fracture:

Currently the improved performance for this group of patients has been sustained and the SMR for 2011/12 is **81** which represent 32 deaths versus 40 expected from 448 spells. The volumes have increased around 20% in the last year.

This represents an improving position from the same period ending in February 2011 where the SMR for this group of patients was **151.** 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. This has now moved to quarterly monitoring.

5) Specialist services: Stroke and Renal failure:

The stroke team continue to review all deaths to confirm coding accuracy and review standards of care. The SMR for 2011/12 is currently **100** with 132 deaths whereas 132 were expected. Concerns have been raised with respect to the quality of data relating to source of admission and discharge and the team continues to examine the data in detail.

The renal team have continued to focus on issues that may impact on the SMR in patients with acute and unspecified renal failure which is high at **121** for 2011/12.

The issues relating to the recording of admission as elective versus emergency have not yet been fully resolved. Further work is required by the information team, coders and operational staff to resolve this.

7. Possible areas for Concern under investigation

There are a number of areas which have caused concern raised by our Dr Foster monitoring processes internally. One is an apparent rising mortality from secondary malignancy (SMR for 2011-12 currently 177). It is possible that this relates to changes in coding practice and to the failure to code the active cancer under the co-morbidities as well as failure to record palliative care coding or even a lack of specialist palliative care input. This is currently under investigation. The other is a rise in the SMR for 'senility' (which includes acute confusion and dementia) during 2011/12. This SMR is 207 (25 deaths during 209 admissions versus 12 expected). This is also currently under investigation.

There is further concern which was raised by a national report. The **National Diabetes Information Service** recently published data relating to deaths from inpatients with Diabetes between April 2009 and March 2011. Our current data does not indicate that our death rate from patients admitted who have diabetes is significantly higher than the national average overall but for patients with a primary diagnosis of diabetes it was high in 2011/12. This relates to 10 deaths over the year versus 5 expected deaths and a case not review of all the deaths is being conducted.

Mortality for patients with a comorbidity of diabetes appears to be lower than expected

During the investigation of this data it has however emerged that the Trust codes fewer patients with the comorbidity of diabetes than other Trusts despite the fact that we have a higher than average incidence of diabetes. Further work is in progress to improve the capture of information in this area.

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

8. Information and Coding Issues

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

9. Further Comments and Actions Planned:

The improvement in HSMR and SHMI have improved during 2011/12 and have been sustained in the last month of available data.

In order to improve mortality further the clinical work-streams set up to improve care for patients and pneumonia and septicaemia will continue and will support the planned redesign of the emergency pathway and the patient safety programme. Clinical leads have been recruited for the Emergency Pathway Redesign and for 3 of the Patient Safety Workstreams and will work together to support the quality priorities under the umbrella of a strengthened safety strategy led by the executive team with the support of the Safety Academy of 50-70 safety champions. Both these programmes of work need to be managed in a structured project managed framework and will report through the current transformation programme management office drawing from that resource as required.

The clinical improvement work will require strong support from the information team. There is a recognition that the trust needs to improve the infrastructure in this area. This refers not only to clinical coding as highlighted in this paper, but also to all the information flows and scorecards produced. In addition to the commissioned review of clinical coding, investment has been agreed to support a detailed piece of analytical work supported by the Quality Observatory which will include an analysis of the case-mix and origin of emergency admissions, the provision of care in the community including community hospitals, the usage of beds at NGH, the work done to date to examine and improve mortality and the link between processes of care and the information flows that result from this.

The Trust has set aside a substantial amount of resource (£1 million) to be used to support the quality improvement programmes. This will include any required investment required to ensure that appropriate metrics and data flows are supported as part of the projects. Clearly this will need to be linked to current information systems and data flows so that they can be improved.

The Trust Board is asked to note and debate the contents of this report and to recognise both the improvement to date and the on-going challenges. As part of the investment in the redesign of the emergency pathway the work designed to examine information flows in and through the Trust will be supplemented by an analysis of our coding function and the work to date on HSMR. This will be required to underpin the work has been agreed and should provide further assurance for the Board. There is no doubt that the very significant emergency pressures provide a significant risk to the quality of care we provide and it will be essential to link all the improvement work in an informed redesign of care processes. The Board is asked to debate the approach taken and to challenge where appropriate.

Section 2

NGH Monthly Quality Scorecard

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 2011 – May 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.

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.

Patient Experience outcomes are not reported within this report. The Family and Friends Test question “How likely is it that you would recommend this service to Friends and Family?” has been collected weekly through the Hospedia system.

Currently the weekly results place Northampton General Hospital in the lowest quartile across Midlands and East SHA. Work is in place to review these results. A manual collection of this question was held on 3 wards during a weekend in June. The results from this pilot are promising and illustrated a 100% improvement. Work continues to explore the reason for the discrepancies with the manual and electronic data collected.

The above-mentioned question will be posed to all patients during hospital discharge to complement the Hospedia data collection. This is planned to be introduced consecutively for the forthcoming 3 months, and results will be available for Quarter 2 Patient Safety, Clinical Quality and Governance Progress report.

This report does not include outcomes for this year’s CQUIN measures which have recently been confirmed this is because either baseline data is still to be agreed or information is not currently available.

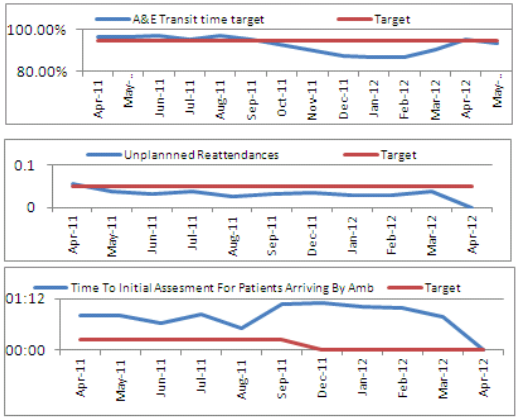
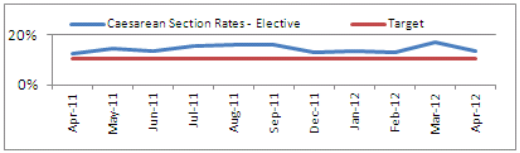
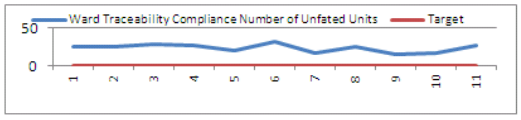
HSMR is reported as year to date. A continual process of refinement of indicators is required and this will include new indicators to monitor the safety improvement programme and the emergency pathway redesign project.

Of 94 indicators, 25 (8/17) are rated as either red or amber status. This report outlines the underperforming indicators and details the remedial action(s) being taken against the red rated indicators. There are 16 indicators that are rated as grey, this is because either baseline data is still to be agreed or information is not currently available

Summary Rating

Section	Red Rated	Amber Rated	Green Rated	N/A
CQUIN 2012-13	0	0	1	14
Clinical Outcomes	1	11	16	0
Patient Safety	2	2	16	2
Patient Experience	5	4	22	0
TOTAL	**8**	**17**	**53**	**16**

EXCEPTION REPORT JUNE 2012

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Experience	A & E Quality Indicators (5 indicators)			**A&E Clinical Indicators:** Transit time target The Trust has not delivered the 95% A&E transit time target in May (94.16%) and is now behind trajectory YTD, remedial action plans have been developed and ongoing dialogue via urgent care networks continues. This set of clinical indicators has been removed from Operating framework for 2012-13 and been passed to Commissioners for local management, the Trust has delivered the overal target but has missed two elemets 1.Unplanned re-attendance rate has risen to 6.37% in April 2012, this is above the 5% national target. 2. The time to initial assesment for patients arriving by ambulance has reduced in April 12 to 30 minutes, this is still above the national target of 15 minutes The Trust is investing in increased medical and nursing staff to improve the clinical care in A&E and planning a redesign of the emergency pathway to improve flow through the hospital as well whilst focusing on quality, safety and patient experience.	
CQUIN 2012-13	Caesarean Section Rates	10.60%	14.60%	Ongoing issue with elective caesarean section rate. Emergency caesarean section remains lower than national average. Action plan developed May 2011 and monitored quarterly at Obstetric Governance Group and 6 monthly at Integrated Healthcare Governance Meeting. All caesarean sections audited and reasons compliant with NICE guidance. Re-audit commenced 1st April 2012. The directorate have commenced a patient experience survey to capture what influences patients' informed consent, to progress with a Caesarean Section. This is a midwife led survey.	
Patient Experience	PROMS Scores	80%	72.80 Overall Score	Thr Trust is reliant on national data for this indicator the overall score of 72.8 reflects the latest published figures (April 2012) for the period April 12 to Dec 12 and reflects scores against 4 key procedures Groin Hernia - Participation Rate Hip Replacement - Participation Rate Knee Replacement - Participation Rate Varicose Vein - Participation Rate All Procedures - Participation Rate	No trend analysis available at time of publication
Patient Experience	62 Day Cancer wait time	85%	79.70%	The Trust has not delivered the 62 day cancer wait time target for May 2012 and is now behing target for the quarter, this is attributed to complexity of cases, specifically in Urology, Head & Neck and Gynae specialties and to delay in referrals received form other providers, an ongoing action plan is in operation and dialogue with other providers remains ongoing	
Patients Safety	Number of surgical site infections	0		There has been one isstance of Surgical site infection in May 2012 this is against a target of 0. - Patient BC female aged 79 years - 9/5/12 Operation Repair # Neck of femur - 21/5/12 Washout & debridement of wound - deep incisional wound - hip tissue specimen pus cells seen & isolated Enteroccus faecalis An RCA wil be completed to identify any avoidable cause.	
Patient Safety	Ward Traceability Compliance Number of Un-fated Units	0	22	Ward Traceability Compliance Number of Un-fated Units There were 22 cases of un-fated units in May 2012. This is in comparison to 26 cases in April 2012 against a target of 0. The position for Q4 was 55 in total. Ward and directorate managers are notified daily of un-fated units which allows immediate investigation and moniring of unfated cases has been added to the weekly performance meeting	

CORPORATE SCORECARD – JUNE 2012

Corporate Scorecard 2012-13						
Patient Safety	Priority	Target 2012-13	Apr-12	May-12	RAG	Comments
HQU01: HCAI measure (MRSA)	National	1 per year	1	0		
HQU02: HCAI measure (CDI)	National	36 per year	3	1		
HQU08: MMSA Numbers	Local	0	0	0		
E Coli ESBL Quarterly Average	National	7 per month	5	4		
VTE Risk Assesment completed	National	90% month on month	91.4%	91.9%		
MRSA Screening Elective Patients	Local	100% month on month	99.8%	99.7%		
MRSA Screening Non-Elective Patients	Local	100% month on month	95.6%	95.7%		
Ward Traceability Compliance Number of Unfated Units	Local	0 month on month	26	22		
Incidence of pressure ulcers						
Type 3	Local	0	0	2		
Type 4	Local	0	1	2		
Rate per 1,000 Bed Days (All Grades)	Local	0.60	0.70	0.82		
Reduce harm from falls	Local					
Catastrophic	Local	0	0	0		
Major/Severe	Local	0	0	0		
Mandatory Training compliance Fulll Year Impact						
Primary Levels Excluding B&H	Local	80%				
Number of surgical site infections	National					
Frac neck of femur Number of Operations			27	29		
Infections		0	0	1		Surgical site surveillance requires that the post-operative wounds under surveillance are reviewed for a 30 day period in order to determine whether a surgical site infection develops.
Breast Surgery			30	40		
Infections		0	0	0		The data for this table is therefore completed retrospectively 30 days after the end of each month. (Results included for Apr 12 reflect an interim position and are subject to change.)
Limp Amputations			11	7		
Infections		0	0	0		
Full implementation of patient safety alerts e.g. NPSA, CAS, Medical Device Alerts etc	National					
Open Central Alert System (CAS) Alerts		0	1	0		
NICE clinical practice guidelines and TAG compliance	National	80%	81%			
Serious Untowards Incidents		-	12	3		
Never Events	National	0	0	0		
WHO Surgical Safety Checklist		100%	100%	100%		
Patient Experience	Priority	Target 2012-13	Apr-12	May-12	RAG	Comments
Cancelled Operations not rebooked within 28 days	National	0%	0%	0%		
Hospital Cancelled Operations	Local	6.0%	5.9%	6.10%		
Number of written complaints received	National		50	50		
Complaints Responded to within agreed timescales	National	100.00%	100%	NA		
Referral to Treatment waits	National					
Admitted Patients	National	90.00%	96.43%	95.99%		Targets reverted to percentage measure in 2012-13
Non Admitted Patients	National	95.00%	97.70%	98.33%		Targets reverted to percentage measure in 2012-13
Ongoing Patients	National	92.00%	98.21%	97.23%		Targets reverted to percentage measure in 2012-13
A&E Quality Indicators (5 measures)						
Time Spent in A&E (Month on Month)	National	95%	95.05%	93.37%		
Time Spent in A&E	National	95th	04:00	05:00		
Unplannned Reattendances	National	>1% and <5%	6.37%	1.00%		
Left Without Being Seen	National	=<5%	0.26%	0.33%		
Time To Initial Assesment For Patients Arriving By Ambulance 95th percentile	National	<15 mins	00:30	00:50		
Time To Treatment Median	National	<1hr	00:46	00:54		
Cancer Wait Times						
2 week GP referral to 1st outpatient	National	93%	96.30%	95.70%		
2 week GP referral to 1st outpatient - breast symptoms	National	93%	100.00%	100.00%		
31 Day	National	96%	96.50%	98.10%		
31 day second or subsequent treatment - surgery	National	94%	96.20%	97.40%		
31 day second or subsequent treatment - drug	National	98%	100.00%	95.50%		
31 day second or subsequent treatment - radiotherapy	National	94%	100.00%	98.10%		
62 day referral to treatment from screening	National	90%	100.00%	100.00%		
62 day referral to treatment from hospital specialist	National	85%	92.00%	90.90%		
62 days urgent referral to treatment of all cancers	National	85%	85.40%	81.50%		
SRS08: Length of Stay (Acute & MH)						
Elective	Local	3.20	3.70	4.1		Target based on Peer Group UQ (DFI March 11 to Feb 12)
Non-Elective	Local	5.30	6.00	5.9		Target based on Peer Group UQ (DFI March 11 to Feb 12)
SRS09: Daycase Rate	National	85%	85.7%	83.5%		
SQU11: PROMS Scores - Pre Operative participation rates						
Groin Hernia - Participation Rate	National	59.00%	42.30%	No update		Information based on 9 months HES data to December 2012, Target for 2012-13 is measured against national average for the period and not not the national target of 80% for all procedures
Hip Replacement - Participation Rate	National	80.80%	97.40%	No update		
Knee Replacement - Participation Rate	National	85.40%	94.90%	No update		
Varicose Vein - Participation Rate	National	48.30%	31.10%	No update		
All Procedures - Participation Rate	National	72.50%	72.80%	No update		

Clinical Outcomes	Priority	Target 2012-13	Apr-12	May-12		Comments
HSMR - cumulative Position from Apr 2011		<100	93.6	93.9		Latest DFI Apr11 to Mar 12 (HSMR)
SMR- cumlative Position from Apr 2011						
Pneumonia	National	<100	90.7	83.5		Latest DFI Apr11 to Mar 12 (HSMR)
Fracture of neck of femur (hip)	National	<100	82.3	80.6		Latest DFI Apr11 to Mar 12 (HSMR)
Urinary Tract Infections	National	<100	96.0	92.9		Latest DFI Apr11 to Mar 12 (HSMR)
Acute Cerebrovascular disease	National	<100	98.4	99.3		Latest DFI Apr11 to Mar 12 (HSMR)
Aspiration pneumonitis, food/vomitus	National	<100	116.7	107.5		Latest DFI Apr11 to Mar 12 (HSMR)
Congest ve heart failure, nonhypertensive	National	<100	98.2	96.0		Latest DFI Apr11 to Mar 12 (HSMR)
Chronic obstructive pulmonary disease and bronchiectasis	National	<100	90.0	109.2		Latest DFI Apr11 to Mar 12 (HSMR)
Acute myocardial infarction	National	<100	88.8	85.9		Latest DFI Apr11 to Mar 12 (HSMR)
Billiary tract disease	National	<100	112.6	86.2		Latest DFI Apr11 to Mar 12 (HSMR)
Acute and unspecified renal failure	National	<100	120.7	121.3		Latest DFI Apr11 to Mar 12 (HSMR)
HSMR (Rolling 12 months Mar 11 to Feb12)	National					
Point of Delivery						
Combined	National	<100	95.8	93.9		HSMR (Rolling 12 months Mar 11 to Feb12)
Non-Elective	National	<100	95.5	93.4		HSMR (Rolling 12 months Mar 11 to Feb12)
Elective	National	<100	96.2	102.7		HSMR (Rolling 12 months Mar 11 to Feb12)
SQU12: Maternity 12 weeks	National	90%	86%	97%		
SRS10: Delayed Transfers of Care – Acute & MH	National	3.00%	3.64%			
Fractured neck of Femur						
Number of patients admitted with FNOF	National	-	27	30		
Patients fit for surgery within 48hrs	National	-	21	23		
Number of patients admitted with FNOF who were operated on within 48 hrs	National	-	20	22		
Percentage of patients admitted with FNOF operated on within 48 hours of admission	National	100%	95%	96%		
Patients admitted as Emergency with GI Bleed scoped within 24 hours		100%	88%	95%		
25% of suspected stroke patients given CT scan within 3 hours of arrival	Local	25%	68%	77%		
75% of suspected stroke patients given CT scan within 24 hours of arrival	Local	75%	95%	100%		
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	National	60%	68.00%	75.00%		
Patients who spend at least 90% of their time on a stroke unit	National	80%	88.89%	94.74%		
Breast Feeding initiation	National	75%	72.60%	74.60%		
Caesarean Section Rates - Total	National	<25%	25.70%	25.60%		
Caesarean Section Rates - Emergency		14.98%	12.10%	11.00%		
Caesarean Section Rates - Elective	National	10.06%	13.60%	14.60%		
Home Birth Rate	Local	6.00%	5.90%	7.30%		
CQUIN 2012-13	Priority	Target 2012-13	Apr-12	May-12	RAG	Comments
1a. 90% of all adult inpatients to have a VTE risk assessment	CQUIN	90% month on month	91%	92%		
1b. High risk patients receive appropriate treatment	CQUIN	-	Q1 Reporting			
Improve responsiveness to personal needs of patients	CQUIN	-	Q1 Reporting			
Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	CQUIN	-	Q1 Reporting			
Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE	CQUIN	-	Q1 Reporting			
1. Establish question and baseline Net Promoter score	CQUIN	-	Q1 Reporting			
2. Board and Commissioner reporting	CQUIN	-	Q1 Reporting			
3. Weekly reporting	CQUIN	-	Q1 Reporting			
4. Performance improvement by 10%	CQUIN	-	Q1 Reporting			
Implement Oesophageal Doppler Monitoring (ODM) or similar fluid management technology	CQUIN	-	Q1 Reporting			
2a. Ensure that a greater number of patients are seen and discharged within 3 hours of arrival time.	CQUIN	-	Q1 Reporting			
2b. Manage a greater number of patients suspected of having a P.E. that are medically stable and appropriate to be treated as an outpatient.	CQUIN	-	Q1 Reporting			
3a. Accuracy of medicines information on discharge	CQUIN	-	Q1 Reporting			
3b. Analgesic transdermal patches	CQUIN	-	Q1 Reporting			
3c. Oral nutritional supplements (ONS) - reduce the use of ONS	CQUIN	-	Q1 Reporting			
3d. Triptorelin	CQUIN	-	Q1 Reporting			
4a. Implementation of a policy to send first outpatients letters back to referring rather than registered GP.	CQUIN	-	Q1 Reporting			
4b. NGH will scope electronic communications systems and implment within 1 year if possible to ensure the swift and secure transfer of information.	CQUIN	-	Q1 Reporting			
Quality Dashboards	CQUIN	-	Q1 Reporting			
Use of Intensity Modulated Radiotherapy	CQUIN	-	Q1 Reporting			
Cancer Chemotherapy a) Performance Status	CQUIN	-	Q1 Reporting			
Hepatitis C. Compliance with treatment / improved patient outcomes	CQUIN	-	Q1 Reporting			
Reduction of catheter - related CONS	CQUIN	-	Q1 Reporting			

BOARD SUMMARY SHEET	
Title: -	Quality Accounts 2011/12
Submitted by: -	Dr Sonia Swart, Medical Director and Suzie Loader, Director of Nursing, Midwifery and Patient Services
Date of meeting: -	27th June 2012
Prepared by: -	Roz Young, Quality Assurance Manager
Corporate Objectives Addressed: -	To improve clinical quality and safety

SUMMARY OF CRITICAL POINTS: -

- The Quality Accounts were presented to Trust Board in May 2012 and were approved subject to the submission of the external reviews from the Commissioners, Overview and Scrutiny Committee and LINks
- Following feedback from the May Board, minor changes have been made to ensure accuracy and improve presentation of the report
- The report has been submitted to external audit for approval and their report is shown in annex 1.

PATIENT IMPACT : -

The priorities for quality improvement at NGH have been determined throughout the year and informed by the experiences of patients through the consultation process.

STAFF IMPACT: -

Staff consultation and ownership of the priorities for improvement should be demonstrated throughout the year and referenced in the Quality Account.

FINANCIAL IMPACT: -

The priorities for improvement link, where possible, to the priorities identified through the CQUIN scheme

EQUALITY AND DIVERSITY IMPACT: -

The Quality Accounts and consultation process have been accessible to as many patients and members of the public as possible.

LEGAL IMPLICATIONS: -
The Health Act 2009 requires all NHS providers of healthcare services in England to provide a Quality Account from April 2010.

RISK ASSESSMENT: -

Moderate – a robust consultation and engagement process will support the Trust to identify the quality priorities for 2012/13 that are owned by the organisation and members of the public.

RECOMMENDATION: –

The Board is asked to: -

1. Review the external reviews on the Quality Account on pages 44-45
2. Approve the list of changes made to the report

Quality Accounts 2011/12

1. Introduction

Quality Accounts are annual reports to the public that give details about the quality of services that are delivered within a healthcare environment. They outline the quality priorities and plans for improvement.

As the Board is aware, the Quality Accounts were presented in May 2012 and ratified pending external audit approval and comments from external partners. The report has been modified following comments received from the May board, with comments from external partners being added.

2. Statements from Overview & Scrutiny Committee, Commissioners and LINkS

Statements from external partners were requested on the 4th May from LINks, Northampton County Council Overview and Scrutiny Committee, the NHS Milton Keynes and Northamptonshire PCT Cluster and Nene Clinical Commissioning Group. Statements from external partners have been received with the exception of Northampton County Council Overview and Scrutiny Committee. These can be found in the revised Quality Accounts 2011/12 which are attached.

3. Summary of changes made to the version presented to the May Board

1. Pictures have been selected to ensure a cross section of staff are included, ensuring that they adhere to Trust uniform and infection prevention policies
2. The CQUIN tables (page 23) have been amended to include targets
3. The score card in section 3 (page 39) has been amended to exclude any gaps in performance reporting and to include 2 never events which were omitted from the previous version.
4. HSMR- a new paragraph has been added in response to PCT feedback to explain SHMI reporting (page 55).
5. The document has been reviewed for inaccuracies and amended accordingly.

4 Next Steps

The following timescales have been identified to ensure the document is published as required; to maximise engagement and consultation and to allow for feedback to be incorporated into the final document: -

30th May: -	Draft Quality Account approved by Board with minor amendments suggested
14th June	Statements of external review submitted to NGH and included into the Quality Accounts
14th June	Submitted to Audit Commission for final review
15th June	Response from Audit Commission
27th June	External statements and changes to the Quality Account approved by Board
30th June	Upload Quality Accounts onto the NHS Choices website
30th June	Send a copy of the Quality Accounts to the Secretary of State

Recommendations

The Board is asked to: -

1. Review the external reviews on the Quality Account on pages 44-45
2. Approve the list of changes made to the report.

INDEPENDENT AUDITOR'S LIMITED ASSURANCE REPORT TO THE DIRECTORS OF NORTHAMPTON GENERAL HOSPITAL NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

I am required by the Audit Commission to perform an independent assurance engagement in respect of Northampton General Hospital NHD Trust's Quality Account for the year ended 31 March 2012 ("the Quality Account") as part of my work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and the National Health Service (Quality Account) Amendment Regulations 2011 ("the Regulations"). I am required to consider whether the Quality Account includes the matters to be reported on as set out in the Regulations.

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

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

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the Quality Account is not consistent with the requirements set out in the Regulations.

I read the Quality Account and conclude whether it is consistent with the requirements of the Regulation and to consider the implications for my report if I become aware of any inconsistencies.

This report is made solely to the Board of Directors of Northampton General Hospital Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Assurance work performed

I conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor Guidance 2011/12 issued by the Audit Commission on 16 April 2012. My limited assurance procedures included:

- making enquiries of management;
- comparing the content of the Quality Account to the requirements of the Regulations.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

The scope of my assurance work did not include consideration of the accuracy of the reported indicators, the content of the quality account or the underlying data from which it is derived.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that the Quality Account for the year ended 31 March 2012 is not consistent with the requirements set out in the Regulations.

John Cornett
District Auditor
Unit 10 Whitwick Business Centre
Whitwick Business Park
Stenson Road
Coalville
LE67 4JP

22 June 2012

BOARD SUMMARY SHEET	
Title	Patient Experience – Friends and Family Test
Submitted by	Suzie Loader, Director of Nursing
Prepared by	Suzie Loader, Director of Nursing
Date of meeting	27 June 2012
Corporate Objectives Addressed	Improve Clinical Quality and Safety

SUMMARY OF CRITICAL POINTS

- There continues to be confusion regarding the 'pop' up question on Hospedia from which the FFT data is obtained, suggesting that it is not robust. Additional work is being undertaken to validate these scores.
- The PCT have agreed that the baseline data for the FFT can be determined by the Trust: it is suggested that the June 2012 data be used, as opposed to the April data.
- A pilot of manual data collection of the FFT question, was conducted the weekend of the 8-11 June on 3 wards, the results from this were much more favourable. It is intended that manual data collection will be rolled out across the Trust week commencing 24 June.

PATIENT IMPACT

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

STAFF IMPACT

The FFT Score provides staff with real time feedback.

FINANCIAL IMPACT

The ability to continually drive forward quality is increasingly important and has the potential to affect NGH income.

EQUALITY & DIVERSITY

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

LEGAL IMPLICATIONS

Nil

RECOMMENDATIONS

- That the Board support the proposal that the baseline data for the Regional FFT CQUIN be set at June 2012, as opposed to April 2012
- That the Board support the manual collection of patient experience data, to run in parallel to the Hospedia data collection until there is confidence that the Hospedia data is reflective of patient experience, or until another data collection tool is identified.
- Members of the Board are asked to note the contents of this report and to challenge as appropriate.

1.0 Introduction

The 'Patient Revolution' is one of the 5 ambitions for NHS Midlands and East. The SHA has defined three elements within 'Patient Revolution', one of which is the need to drive improvements in patient and customer experience.

NHS Midlands and East have devised a standardised approach with a single metric to obtain real-time monitoring of Patient Experience. The Friends and Family Test (FFT) captures perceptions of patients about the health care that they have received whilst staying with us, by asking the question: '***If you are being discharged today, how likely is it that you would recommend this service to friends and family? This refers to Hospital not to Hospedia'.*** Data collection against this metric commenced in April 2012. Bench marking data collected across the cluster will be published in July 2012 and David Cameron has stated that the FFT will be rolled out across the rest of England by April 2013.

The score is the difference between the proportion of people surveyed who said they would recommend the local service and the proportion who said they would not or are unsure (don't know). Originally patients were asked to score against narrative. This has now been changed to a numerical presentation from 1 - 10 (1 = would not recommend, 10 = would recommend). The % of Detractors (score of 6 and under) is then subtracted from the % of Promoters (score of 7 and above) to obtain the FFT Score. Therefore, the score is the difference between the proportion of people surveyed who said they would recommend the local service and the proportion who said they would not. The parameters within which the data is collected are:

- 10% of inpatient discharges in any given week
- At or within 48 hours of discharge

2.0 Results

Given the concerns over the electronic version; a pilot of manual data collection was conducted over the weekend of the 08-11 June 2012 on 3 wards, the results are as follows.

08/06/2012 - 11/06/2012 Friends & Family Questionnaire			
Ward	**No. Patients**	**Score**	**Comments**
Paddington	3	1 x 8	
		1 x 9	
		1 x 10	
Spencer	5	4 x 10	Thank you for your care and support
		1 x 9	All staff were friendly and concerned. Treatment and results etc were explained clearly and made me feel "in the loop" (11/06/2012)
Willow	11	1 x 7	(09/06/2012)
		4 x 8	Not being able to sleep because of noise / Nursing great, bit noisy at night, not nurses fault ((11/06/2012)
		3 x 9	Very good (11/06/2012)
		3 x 10	Nursing exemplary, thank you (11/06/2012)
Total	19		

This is a vast improvement to previous scores collected via Hospedia. As a result, manual data collection will be rolled out across the Trust week commencing 24 June 2012 to run in parallel to the Hospedia data collection, until a more robust method can be identified. Further work is underway to continue to educate staff and to understand why the Hospedia scores are so different to anecdotal evidence and the pilot results.

Because of concerns over data validity, the Trust did not believe that the April 2012 result formed the baseline from which the Patient Experience Regional CQUIN indicator for 2012/13 was set. The PCT have now confirmed that the baseline can be set locally by the Trust. It is suggested therefore, that the June data form the baseline as scores will be published across the cluster from July 2012 onwards; Trust Board are asked to ratify this decision.

3.0 Additional Actions

During May, a meeting was held with all Ward Sisters and Matrons, whereby there was a discussion about improving the patient experience. Following the meeting, Ward Sisters were asked to have further discussions with their teams and to each identify 3 things which will make a difference to the patient experience. Action plans are currently being developed, which will be monitored via the Patient Experience Board, to be chaired by the Director of Nursing.

In the May Patient Experience report, the Trust informed the Board that an application had been submitted to the Kings Fund to participate in their *'Patient and Family Centre Care programme'*. Unfortunately, the Trust was unsuccessful this time. However, the tools and techniques which underpin this programme are available free of charge and will be used by the Trust to support the implementation of the Patient Experience Strategy.

A Patient Experience Strategy has been written and is being presented to the June Trust Board for ratification. The outline of the strategy has been shared with the PPI group who supported the principles contained within.

Draft Terms of Reference have been developed for the Patient Experience Board which is in the process of being established.

4.0 Recommendations

Members of the Board are asked to:

- Agree that the June data can form the baseline for the Patient Experience Regional CQUIN
- Agree that manual data collection should continue in parallel to the Hospedia data collection until a more robust method can be identified and implemented
- Challenge the content of the report and support the actions defined.

BOARD SUMMARY SHEET	
Title	Monthly Infection Prevention Performance Report
Submitted by	Suzie Loader, Director of Nursing, Midwifery & Patient Services/DIPC
Prepared by	Pat Wadsworth, Lead Infection Prevention and Control Nurse
Date of meeting	27th June 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.

Monthly Infection Prevention Performance Report

1. 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.

1.1 MRSA Bacteraemia (Appendix 1)

The Trusts trajectory for MRSA bacteraemia in 2012/13 is 1 case. In May there was 0 >48hrs MRSA bacteraemia. The Trust is measured on the number of MRSA bacteraemia cases per 10,000 bed days. The post-48 hour MRSA bacteraemia cases year to date is 0.25 /10,000 bed days.

1.2 MRSA Colonisation (Appendix 2)

During May there were 12<48hrs and 3 >48hrs cases of MRSA colonisation. Internal patient verified data identifies 99.7% compliance for the screening of elective admissions during May. The compliance rate for emergency screening was 95.7% in May, both are within our target.

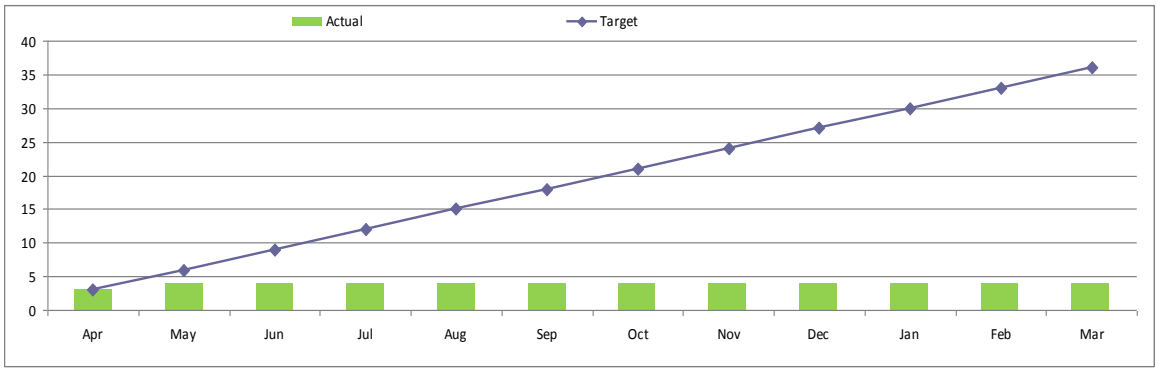
1.3 MSSA Bacteraemia (Meticillin Sensitive Staphylococcus Aureus)

During May there were 4<48hrs and 1 >48hrs MSSA bacteraemia cases.

1.4 Clostridium Difficile (C diff, Appendix 3)

The Trust has a trajectory of 36 C. diff. cases for the year. During May the Trust identified 1<3 day and 1 >3 day cases of C. diff. This is a total of 4 cases which equates to a cumulative of 0.10 /1,000 bed day's year to date.

Currently we are awaiting confirmation of the Trust trajectory submission to the Department of Health. It is proposed that future data will reflect the "seasonal" incidence of C. diff. rather than the uniform 3 cases every month.



2. Pertussis (Whooping cough)

The Infection Prevention team were notified on the 15th May of a Paediatrician with a confirmed Pertussis result. All clinical staff (medical and nursing) who have direct patient contact in the neonatal unit and Paediatrics Departments are in the process of being vaccinated to minimise further transmission by Occupational Health. Vaccinating all staff in the neonatal unit is most important as new born babies have a reduced immunity and are likely to have adverse outcomes if infected. Senior medical/ Trust executive support will be required if there is sub-optimal response to the offer of vaccination. While all vaccination decisions are voluntary, staff have a professional obligation to accept vaccination to minimise further spread. There have been four deaths due to

Pertussis this year in other hospitals around the country. Protecting healthcare workers looking after babies/children is vital to minimise transmission risks in hospital.

The Infection Prevention team have raised awareness among all staff across the paediatric wards, the Maternity Unit and A&E to be aware of Pertussis symptoms and the need to promptly report any illness to Occupational Health.

Alongside this work the Trusts monthly "Bug of the Month" and Alert was focused on Pertussis for May. The Infection Prevention team are maintaining heightened surveillance for further cases in the above staff groups by visiting the wards on a daily basis.

At the time of writing this report the trust was 96% compliant with the vaccination programme.

3. 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).

3.1 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 May 2012 show that there was ***1 infection*** resulting from 29 operations to repair #NOF's.

3.2 Surgical Site Surveillance of Breast operation

Background
The national Surgical Site Infection Surveillance programme is auditing this category for quarter 1 (April to June).

Although the HPA report will take some time to be generated the interim results for May show that there were 40 operations undertaken resulting in ***no infections*** to date.

3.3 Surgical Site Surveillance of limb amputation operation

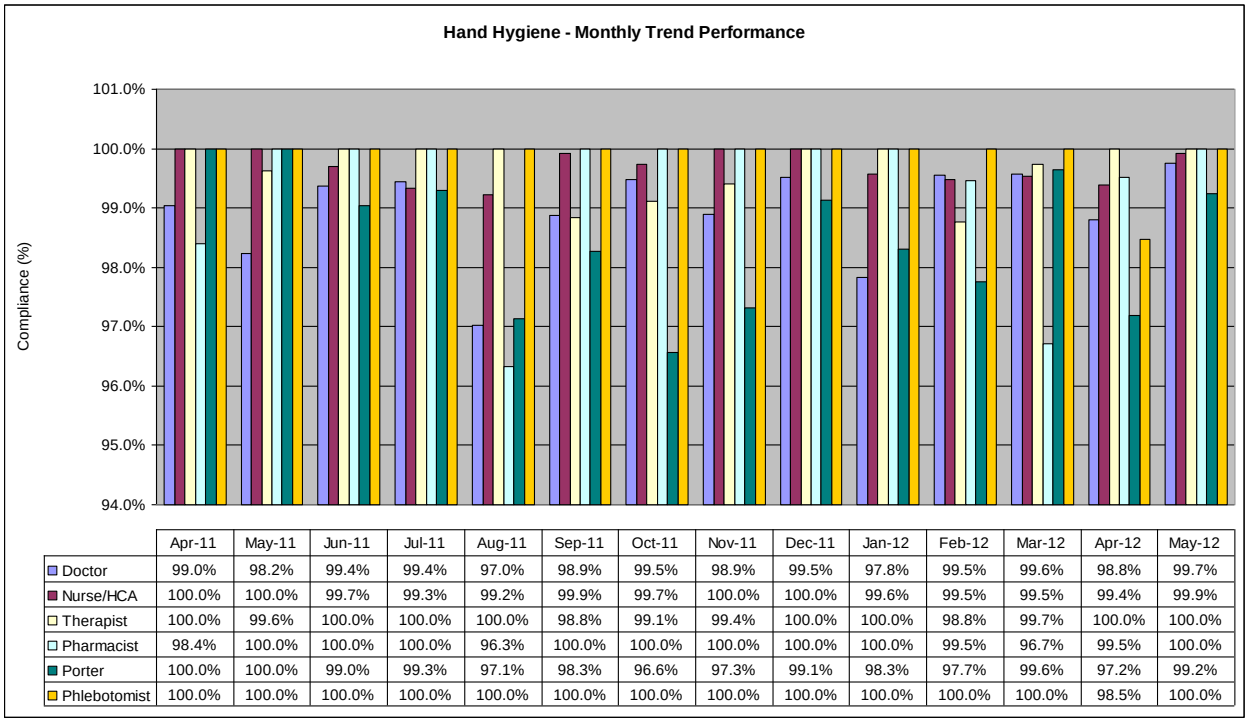
Background
The national Surgical Site Infection Surveillance programme is auditing this category for quarter 1 (April to June).

Although the HPA report will take some time to be generated, the interim results for May 2012 show that there were ***no infections*** resulting from 7 operations.

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

4. Hand Hygiene Audit

Information from the Hand Hygiene Observational Tool (HHOT) shows that in May the overall compliance for hand hygiene was 99.8%.



	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-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%	98.8%	99.7%
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%	99.4%	99.9%
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%	100.0%	100.0%
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%	99.5%	100.0%
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%	97.2%	99.2%
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%	98.5%	100.0%

5. Recommendation

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

Appendix 1 **MRSA Bacteraemia Incidence by Ward**

MRSA Bact	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Trust Total 2012-13
Ward	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	
Hawthorn																									0
Willow		1																							1
Collingtree 23hr																									0
ITU																									0
HDU																									0
A & E																									0
Abington																									0
Cedar																									0
Becket																									0
SingleHurst																									0
Knightley																									0
Gossett																									0
Disney																									0
Paddington																									0
Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer																									0
Sturtridge																									0
Allebone																									0
Benham																									0
Creaton																									0
Dryden																									0
EAU																									0
Eleanor																									0
Victoria																									0
Head & Neck Ward																									0
Hazelwood (Community)																									0
Danetre (Community)																									0
Corby (Community)																									0
Rowan																									0
Finedan																									0
Compton																									0
Brampton																									0
Holcot																									0
Althorp																									0
Talbot Butler																									0
Trust Total 2012-13	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1

Appendix 2 **MRSA Colonisation Incidence by Ward**

MRSA ISOLATES	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Trust Total 2012-13
Ward	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	
Hawthorn																									0
Willow			1																						1
Collingtree																									0
ITU																									0
HDU																									0
A & E																									0
Abington	1		1																						2
Cedar																									0
Becket			1																						1
SingleHurst																									0
Knightley																									0
Gossett																									0
Disney																									0
Paddington																									0
Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer			1																						1
Sturtridge																									0
Allebone	1		2																						3
Benham		1																							1
Creaton				1																					1
Dryden																									0
EAU	6		5																						11
Eleanor	1		1	1																					3
Victoria																									0
Head & Neck Ward																									0
Hazelwood (Community)																									0
Danetre (Community)																									0
Corby (Community)																									0
Rowan				1																					1
Finedon		1																							1
Compton																									0
Brampton		2																							2
Holcot																									0
Althorp																									0
Talbot Butler																									0
Trust Total 2012-13	9	4	12	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	28

Appendix 3 **Clostridium Difficile Incidence by Ward**

CDT	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Trust Total 2012-13
Ward	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	<3 day	>3 day	
Hawthorn																									0
Willow																									0
Collingtree																									0
ITU																									0
HDU																									0
A & E																									0
Abington		1																							1
Cedar																									0
Becket																									0
SingleHurst																									0
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Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer																									0
Sturtridge																									0
Allebone																									0
Benham				1																					1
Creaton		1																							1
Dryden																									0
EAU			1																						1
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Corby (Community)																									0
Rowan																									0
Finedon																									0
Compton																									0
Brampton																									0
Holcot		1																							1
Althorp																									0
Talbot Butler																									0
Trust Total 2012-13	0	3	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5

TRUST BOARD SUMMARY SHEET	
Title: -	Performance Report
Submitted by: -	Christine Allen – Chief Operating Office and Deputy Chief Executive
Date of meeting: -	27th June 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 2 **(May 2012)**.

- The Trust did not achieve the 4 hour A&E transit time. During May 93.37% of patients were treated or admitted within 4 hours against the standard of 95%. The year to date performance is 94.16%
- The Trust did not achieve the following two cancer standards for May however these are monitored quarterly.
  - 62 days from urgent referral to treatment. The Trust achieved 81.5% against the standard of 85%
  - 31 days from decision to treat to start of first treatment for subsequent drug therapy. The Trust achieved 95.50% against the standard of 98%

PATIENT IMPACT: -

Patients waiting longer than maximum wait time

STAFF IMPACT: -

N/A

FINANCIAL IMPACT: -

Failure to achieve standards could result in contractual penalties

RISK ASSESSMENT: -

N/A

EQUALITY & DIVERSITY IMPACT ASSESSMENT: -

N/A

RECOMMENDATION: -

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

PERFORMANCE REPORT – June 2012

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for **Month 2** (May 2012). The report is based on the NHS Performance Framework - Service Performance Standards and Targets.

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

2. SERVICE PERFORMANCE

See Appendix 1 for score card and trend charts

2.1 A&E Clinical Indicators

The Trust did not achieve the 4 hour A&E transit time. During May 93.37% of patients were treated or admitted within 4 hours against the standard of 95%. The year to date performance is 94.16%.

Activity levels during April and May are above the 2012/13 plan and May activity is compared to 2011-12 as detailed below;

	Apr	May
All attends 2012-13	7,633	8,534
All attends 2011-12	7,976	8,114
Variance	-343	420
	-4.3%	5.2%

Figure 1-Activity vs. Plan, Emergency Department 2012/13

	Apr	May
ED Attends Contract Actuals 2012-13	7,234	7,963
ED Attends Contract Plan	6,480	6,493
Variance	754	1,470
	11.6%	22.6%

Figure 2 A7E attendances 2011-12 vs. 2012-13

Progress against Recovery Plan

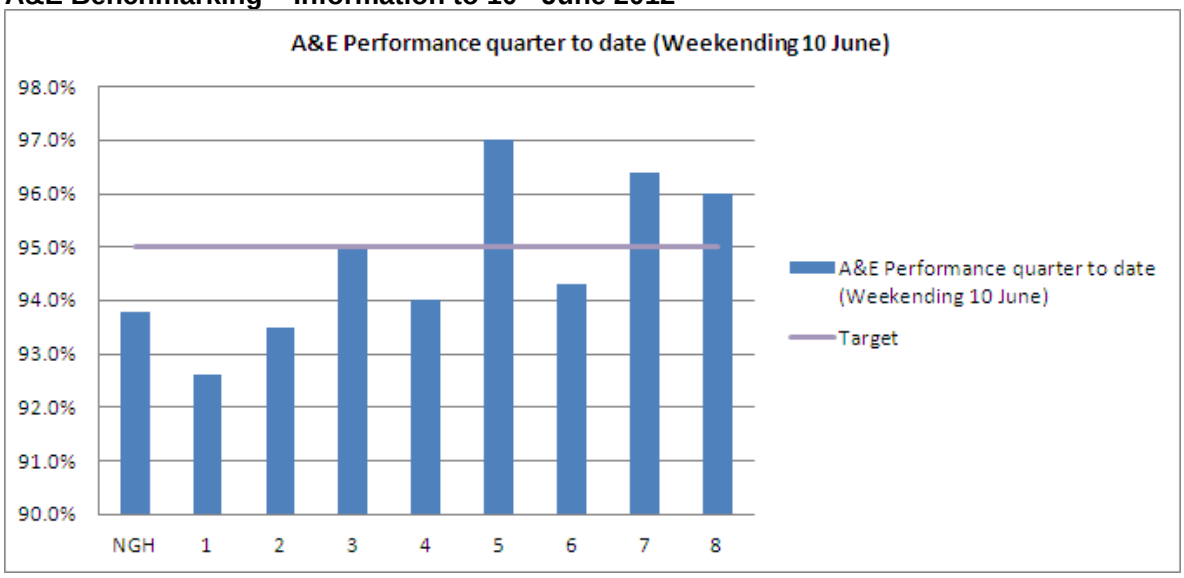
- The Trust has introduced a single point of access (SPA) from 7th June. The full impact of this will be reported at the July Trust Board however early indications are positive, the service is running 24 hours a day and all patients are rapidly assessed by a team of doctors and nurses. The service is consultant led from 8am to 9pm.

- Refurbishment of A&E is now complete; all minors are still separated from the main A&E whilst the SPA is trialled.

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

- Following a review of activity and staffing skill mix by hour of day, we have increased our junior doctor presence overnight and we are currently seeking an additional locum consultant to work from 8pm till 4am. Recruitment to the substantive Consultant positions is proving difficult, interviews are being held in August. Portering has also been increased during the evenings

A&E Benchmarking – Information to 10th June 2012



2.2 Referral to Treatment Time (RTT)

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

Incomplete pathways over 26 weeks, pathways where a patient has not yet started their first treatment, are being monitored monthly by NHS Midlands and East. In May there were 27 patients waiting over 26 weeks to start elective treatment, an increase from 26 patients in April. Reasons for delay include patient choice and capacity within the Orthodontic Department. Plans are in place to increase capacity and reduce waits within orthodontics thus reducing the number of incomplete pathways over 26 weeks.

2.3 Cancer Standards

The Trust did not achieve the following two cancer standards:

- 62 days from urgent referral to treatment. The Trust achieved 81.5% against the standard of 85%. The quarter to date position is 83.45%. This standard is at risk for quarter 1.
- 31 days from decision to treat to start of first treatment for subsequent drug therapy. The Trust achieved 95.50% against the standard of 98%. Quarter to date position is 97.75%.

62 day standard

During May there were an increased number of breaches of this standard. The reasons for the breaches include an increase in the number of patients referred from other trusts that had already breached, complex pathways particularly in Head and Neck and Urology, and patient choice. The following actions have been put in place as part of the Trust's recovery plan:

- A breach reallocation policy has been developed and agreed in principle by the LNR Cancer Board as part of the East Midlands Cancer Network
- Additional capacity has been created for the combined oncology and surgical Head and Neck cancer clinic
- No 2ww referrals will be downgraded to routine referrals
- The process for scheduling oncology patients has been reviewed

31 days from decision to treat to start of first treatment for subsequent drug therapy
During May the Trust achieved 95.5% against the standard of 98%. The process for monitoring and scheduling all patients has been reviewed to ensure all patients are scheduled with their target dates.

3. RECOMMENDATIONS

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

Appendix 1

Service Performance

Indicator	Monthly Target	Apr-12	May-12	YTD	Monthly Delivery	YTD Delivery
Referral to Treatment Times Percentage of Patients seen within 18 weeks across all speciality groups						
Admitted	90%	96.43%	96.0%	na		
Non-admitted	95%	97.68%	98.3%	na		
Incomplete pathways	92%	98.22%	97.2%	na		
No of patients on n incomplete pathwaty with a wait time > 26 weeks	0	26	27	na		
Number of diagnostic waits > 6 weeks	0	0	0%	0%		
A&E 95% Transit time target						
Cumulative	95%	95.05%	94.16%	na		
Month on Month	95%	95.05%	93.37%	na		
Cancellation of Elective surgery for non-clinical reasons either pre or post admission	6%	5.90%	6.10%	5.90%		
Cancelled Operations not rebooked within 28 days	0%	0%	0%	0%		
Cancer Wait Times						
2 week GP referral to 1st outpatient	93%	96.30%	95.70%	95.92%		
2 week GP referral to 1st outpatient - breast symptoms	93%	100.00%	100.00%	100.00%		
31 Day	96%	96.50%	98.10%	97.34%		
31 day second or subsequent treatment - surgery	94%	96.20%	97.40%	96.88%		
31 day second or subsequent treatment - drug	98%	100.00%	95.45%	97.65%		
31 day second or subsequent treatment - radiotherapy	94%	100.00%	98.10%	99.12%		
62 day referral to treatment from screening	85%	100.00%	100.00%	100.00%		
62 day referral to treatment from hospital specialist	85%	92.00%	90.90%	91.49%		
62 days urgent referral to treatment of all cancers	85%	85.40%	81.51%	83.39%		
Stroke Indicators						
Proportion of people who have a TIA who are scanned and treated within 24 hours	60%	68.00%	75.00%	71.93%		
Proportion of people who spend at least 90% of their time on a stroke unit	80%	90.00%	94.74%	92.31%		
Activity vs. Plan						
Elective	0%	19%	41%			
DC	0%	9%	11%			
Non-Elective	0%	8%	27%			
OP 1sts	0%	4%				
Op Procs	0%	10%				
New to Follow Up Ratios	2.01	2.05				
GP Referrals	0%	2.8%	1.4%			
Day Case Rates	81%	85.74%	83.46%			
Sleeping Accommodation Breach	0	0	0	0		

Indicator	Monthly Target	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	YTD	Monthly Delivery	YTD Delivery
Referral to Treatment Times Percentage of Patients seen within 18 weeks across all speciality groups																
Admitted	90%	96.4%	96.0%											na		
Non-admitted	95%	97.7%	98.3%											na		
Incomplete pathways	92%	98.2%	97.2%											na		
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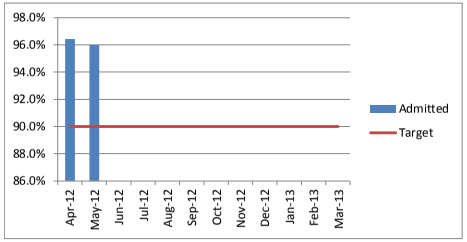

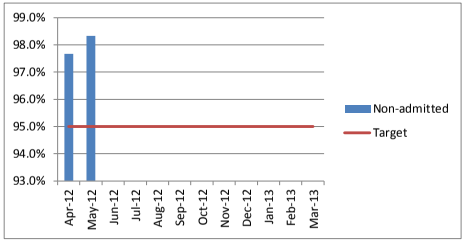

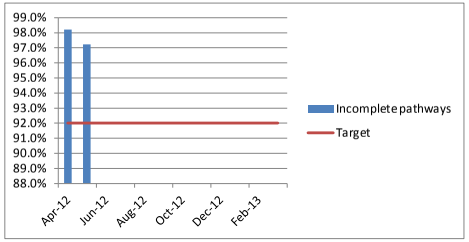

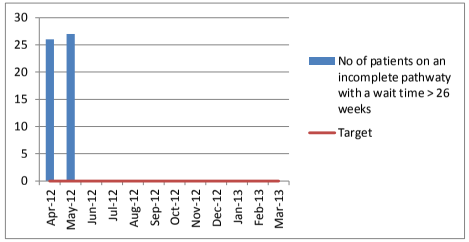

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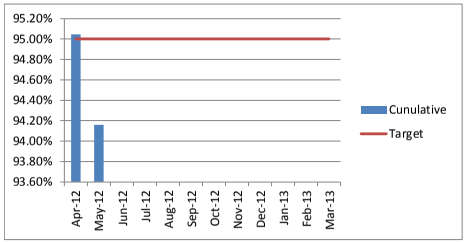

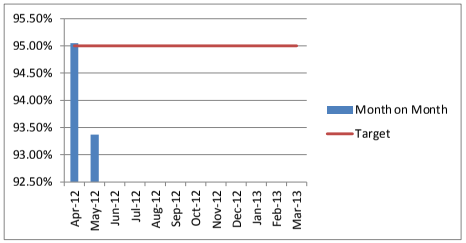

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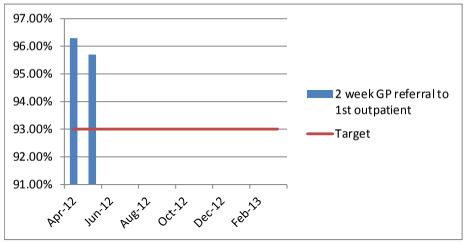
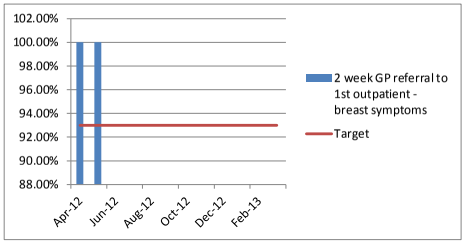
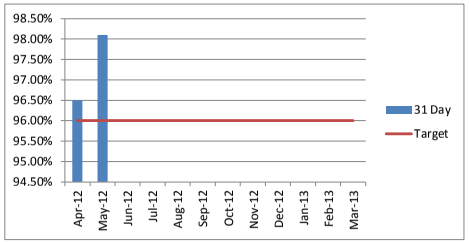
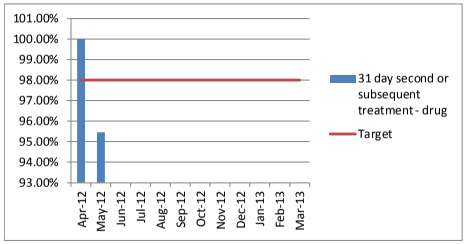
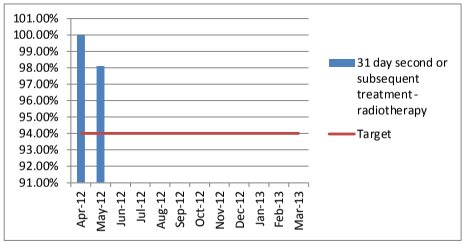
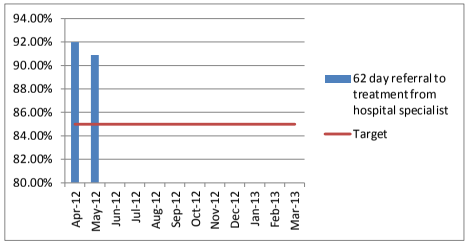


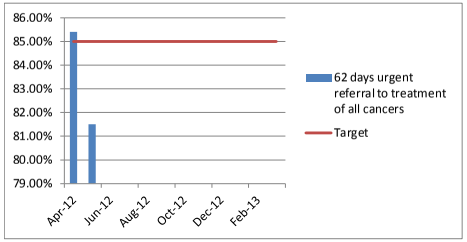


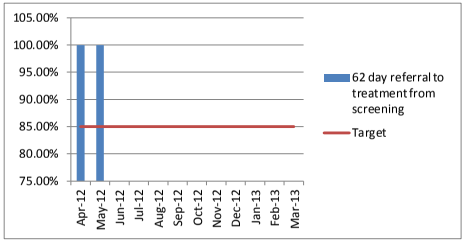


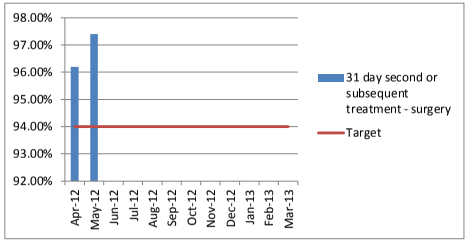












Finance Report

May (M2) FY 2012-13

1.0 Overview

Summary

- The I&E position for the period to May is a deficit of **£0.95m** (£1.2m April)compared to a planned deficit of £0.365m.
- The in month position for May is a surplus of **£312k** compared to a planned surplus of £284k.

Key Issues

- SLA income and activity levels performing above plan by £**1.3m (3.7%).**
- CIP delivery **£660k** behind plan to Month 2. Mitigating actions to be advanced.
- **£1.5m** of Nurse bank and agency expenditure to May.
- Pay / Income ratio **66%** for year to date (average in 2011/12 65%).

Risks

- Final contract reconciliation for 2011-12 to be agreed with PCT.
- CIP slippage and identification of mitigating actions.
- Cashflow remains tight with unmet creditor demand in May and June.
- BPPC performance **95%** by volume but only achieving **70%** by value.

I&E Position	£000's	
Reported Position	(950)	Deficit of £0.95m to month 2.
FIMS Plan (Year to date)	(365)	£365k deficit plan to month 2.
PCT SLA Income Variance	1,327	£1.44m (4%) above plan.
Full Year I&E Forecast	1,000	Annual Plan surplus agreed with SHA

EBITDA Performance	£000's	
Trust	(583)ADV	£0.6m behind plan

Cost Improvement Schemes	£000's	
YTD Plan	1,819	£1.8m target in month 2.
YTD Actual	1,159	£1.2m delivered to month 2.
% Delivered	64%	CIPs delivered as a % of plan .
LTF	16,100	Latest Thinking Forecast for year.
Annual Plan	16,100	Annual Transformation Target.
LTF v. Plan	100%	% of LTF compared to annual plan.

Capital	£000's	
Year to date expenditure	766	Capital expenditure for period
Committed as % of plan	23%	% of plan committed for year
Annual Plan	9,014	Capital Resource Limit of £9m for 2012-13.

SoFP (movement in year)	£000's	
Non-current assets	(679)	Revaluation+Additions - depreciation
Current assets	619	NHS debtors, pre-payments & accruals
Current Liabilities	338	NHS & Trade creditors, provsions.

Cash	£000's	
In month movement	(694)	Reduction between April and May.
In Year movement	(1,946)	Reduction since March 2012
Debtors Balance > 90 days	386	9.1% of balances outstanding over 90 days
Creditors > 90 days	193	3.1% of creditors waiting over 90 days
BPPC (by volume) YTD	94.8%	Target 95% paid in 30 days

KPIs		
Financial Risk Rating (Shadow)	2	Overriding rules apply
EBITDA	70.7%	EBITDA achieved 98% of plan
Liquidity (days cover)	13.0	Incl. unused WCF of £18m
Surplus Margin	-2.3%	1% required for score of 3
Pay / Income	66.2%	Pay 66% of Income for YTD

2.0 Executive Summary

SLA Income (Appendix 3)

- The Trust is performing above plan overall by **£1.3m (4%).**

Other Clinical Income

- Private Patient income is **£22k** above plan with RTA and CRU £2k below plan for year to date.

Income Generation

- **£0.376m** above plan primarily due to external drug sales.

Pay Expenditure (Appendix 5)

- **£1.03m** adverse to plan (4%).

Non-Pay Expenditure (Appendix 7)

- **£1.48m** (14%) above plan for year to date.

CIP (Appendix 14)

- **£0.6m** delivered in May but schemes **£0.66m** behind plan for year to date.

Activity (Appendix 4)

- Non-Elective activity **+12%,** A&E attendances **+17%** above plan.

Workforce (Appendix 5)

- **4103 WTE** worked in May compared to budget of **4123 WTE**. Contracted WTE total **3799 WTE**.

Cashflow (Appendix 9)

- Cash balance decreased since March by **£1.9m** but creditors > 90 days reduced to **£0.2m or 3%.**

SoFP (Appendix 8)

- Increase in net assets of **£0.45m** led by reduction in trade and capital creditors.

Capital Expenditure (Appendix 12)

- **£0.8m** of expenditure in April (23% of plan committed). Risk of triggering PMR KPI.

Shadow Monitor FRR (Appendix 13)

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

Forecast

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

3.0 Conclusions & Actions

Conclusions

- The financial position for the May indicates stronger income performance in May with the Trust exceeding the overall I/E planned surplus for the month.
- Despite some reduction in elective referrals, there is little evidence that PCT QiPP schemes will substantially impact the first quarter of the financial year with non-elective activity 12% above plan and A&E attendances 17 % above plan. The target to deliver £2.9m (full year) of QiPP savings has therefore been partly offset by SLA over performance in the first two months of the financial year.
- The requirement to identify and action additional CIP mitigations remains a priority.

Actions

- Increased monitoring of Bank and Agency expenditure and nursing recruitment plans to be formally reported to F&PC.
- Transformation Steering Board to review CIP mitigations and action through TDG.
- Analysis of overspending budgets to be prepared and monitored with relevant budget holders.
- Enforce clear message that budgets must be adhered to.
- Bid to access the PCT/SHA 2% strategic reserve to meet the costs of reorganisation arising out of the Transformation Programme.
- Undertake formal financial forecast exercise at Quarter 1 covering a range of potential QiPP scenarios and incorporating the costs of delivering the Transformation Programme.

Finance Report

Appendices

Full Year

- Annual plan is for a surplus of £1m.
- Forecast is for achievement of plan at month 2.

Year to date

- £0.95m deficit to May . Key variances to plan:
  - SLA income over performance £1.3m
  - Other Income favourable variance of £0.4m less,
  - £1m Pay overspend
  - £1.4m non-pay overspend

- YTD plan was for a deficit of £0.365m giving rise to an adverse variance of £0.585m compared to plan.

- EBITDA £1.4m positive achieves 71% of planned EBITDA.

- No MRET adjustment despite 12% NEL over performance.

- Other income generation£0.34m above plan due to external drug sales (£0.35m).

Appendix 1 I&E Position

I&E Summary	Plan 2011/12 £000's	YTD Actual £000's	YTD Plan £000's	Variance to plan £000's	Forecast EOY
SLA Clinical Income	212,104	36,490	35,163	1,327 Fav	212,104
Other Clinical Income	2,643	460	439	21 Fav	2,643
Other Income	24,150	4,045	3,668	376 Fav	24,150
Total Income	**238,898**	**40,995**	**39,270**	**1,724 Fav**	**238,898**
Pay Costs	(153,283)	(27,133)	(26,108)	(1,025) Adv	(153,283)
Non-Pay Costs	(67,924)	(12,454)	(10,971)	(1,483) Adv	(67,924)
CIPs	0	0	0	(0) Adv	0
Reserves	(2,275)	0	(202)	202 Fav	(2,275)
Total Costs	**(223,483)**	**(39,587)**	**(37,281)**	**(2,307) Adv**	**(223,483)**
EBITDA	**15,415**	**1,407**	**1,990**	**(583) Adv**	**15,415**
Depreciation	(10,184)	(1,649)	(1,649)	0 Fav	(10,184)
Amortisation	(10)	(2)	(2)	(0) Adv	(10)
Impairment of Fixed Assets	0	0	0	-	0
Net Interest	29	3	5	(2) Adv	29
Dividend	(4,250)	(708)	(708)	0 Fav	(4,250)
Surplus / (Deficit)	**1,000**	**(950)**	**(365)**	**(585) Adv**	**1,000**
Normalised	**0**	**0**	**0**	**-**	**0**

Appendix 1.1 I&E Run Rate

3 Month Run Rate £000's	March		April		May	
	Actual	Plan	Actual	Plan	Actual	Plan
SLA Clinical Income	19,928	18,221	17,065	16,900	19,425	18,262
Other Clinical Income	344	215	178	220	282	220
Other Income	5,413	1,998	2,013	1,834	2,031	1,835
Total Income	**25,684**	**20,435**	**19,256**	**18,954**	**21,738**	**20,317**
Pay Costs	(14,237)	(13,139)	(13,485)	(13,082)	(13,649)	(13,027)
Non-Pay Costs	(7,769)	(5,658)	(5,854)	(5,291)	(6,600)	(5,681)
CIPs	-	1,268	-	147	-	(145)
Reserves	-	(635)	-	(200)	-	(2)
Total Costs	**(22,006)**	**(18,164)**	**(19,339)**	**(18,426)**	**(20,248)**	**(18,855)**
EBITDA	**3,678**	**2,271**	**(83)**	**528**	**1,490**	**1,461**
Depreciation	(870)	(926)	(825)	(825)	(825)	(825)
Amortisation	(1)	(1)	(1)	(1)	(1)	(1)
Impairment of Fixed Assets	(3,453)	-	-	-	-	-
Net Interest	3	3	1	2	2	2
Dividend	(369)	(346)	(354)	(354)	(354)	(354)
Surplus / (Deficit)	**(1,012)**	**1,002**	**(1,262)**	**(649)**	**312**	**284**

Income

- SLA income £1.163m above plan in May.

Pay

- May pay costs above average level for 2011-12 (£13.468m). Note: March figures include year end provisions of £0.8m.

Non-Pay

- Non-Pay run rate £0.4m above average for 2011-12 (£6.2m) but consistent with increased activity and income.

Reserves

- Whilst no actual costs are presented in the table opposite against reserves, pay and non pay include £0.1m of cost in relation to items budgeted in reserves.

Capital Charges

- Reduction in depreciation due to revaluation exercise. April and May accrued to plan pending Q1 additions.
- Dividend accrued pending half yearly payments in September and March.

Appendix 2 Directorate Performance

Trading Summary £	General Surgery		Anaes & CC		T & O		Head & Neck		Child Health	
	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var
Total Income	4,327	34 Fav	1,637	(97) Adv	3,464	(118) Adv	3,290	93 Fav	2,565	82 Fav
Pay	(2,090)	(90) Adv	(2,613)	36 Fav	(1,567)	(80) Adv	(1,334)	(60) Adv	(1,959)	(34) Adv
Non-Pay	(315)	(56) Adv	(750)	(39) Adv	(665)	(17) Adv	(526)	(66) Adv	(304)	(58) Adv
Other Expenditure	(2,481)	(88) Adv	2,049	159 Fav	(1,426)	(34) Adv	(1,469)	(31) Adv	(331)	4 Fav
EBITDA	**(558)**	**(199) Adv**	**323**	**59 Fav**	**(194)**	**(250) Adv**	**(39)**	**(64) Adv**	**(30)**	**(6) Adv**
EBITDA %	**-12.9%**		**19.7%**		**-5.6%**		**-1.2%**		**-1.2%**	
ITDA	(191)	1 Fav	(70)	1 Fav	(131)	1 Fav	(137)	1 Fav	(106)	1 Fav
Surplus / (Deficit)	**(749)**	**(198) Adv**	**253**	**59 Fav**	**(325)**	**(249) Adv**	**(177)**	**(63) Adv**	**(136)**	**(5) Adv**

Trading Summary £	Obs & Gynae		General Medicine		Pathology		Radiology		Oncology	
	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var
Total Income	3,861	10 Fav	12,032	810 Fav	1,296	(52) Adv	865	57 Fav	4,381	265 Fav
Pay	(2,509)	(62) Adv	(7,046)	(555) Adv	(1,272)	95 Fav	(1,069)	93 Fav	(1,496)	(9) Adv
Non-Pay	(331)	(26) Adv	(2,206)	(247) Adv	(1,017)	39 Fav	(340)	(9) Adv	(1,785)	(332) Adv
Other Expenditure	(1,485)	5 Fav	(3,074)	(31) Adv	1,218	24 Fav	910	2 Fav	(587)	9 Fav
EBITDA	**(464)**	**(74) Adv**	**(293)**	**(24) Adv**	**225**	**105 Fav**	**367**	**144 Fav**	**513**	**(67) Adv**
EBITDA %	**-12.0%**		**-2.4%**		**17.4%**		**42.4%**		**11.7%**	
ITDA	(159)	1 Fav	(414)	3 Fav	(174)	1 Fav	(297)	1 Fav	(342)	2 Fav
Surplus / (Deficit)	**(623)**	**(72) Adv**	**(708)**	**(20) Adv**	**51**	**106 Fav**	**70**	**144 Fav**	**172**	**(65) Adv**

Trading Summary £	Hospital Support		Facilities		Central		TOTAL	
	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var	YTD Actuals	YTD Var
Total Income	1,368	309 Fav	728	68 Fav	1,180	265 Fav	40,995	1,724 Fav
Pay	(2,918)	89 Fav	(1,254)	66 Fav	(7)	(514) Adv	(27,133)	(1,025) Adv
Non-Pay	(2,468)	(136) Adv	(1,713)	(219) Adv	(35)	(317) Adv	(12,454)	(1,483) Adv
Other Expenditure	4,465	3 Fav	2,210	(22) Adv	-	389 Fav	(0)	389 Fav
EBITDA	**448**	**265 Fav**	**(29)**	**(107) Adv**	**1,138**	**(178) Adv**	**1,407**	**(396) Adv**
EBITDA %	**32.7%**		**-4.0%**		**95.5%**		**2.8%**	
ITDA	(301)	0 Fav	(34)	0 Fav	(2)	(16) Adv	(2,357)	(2) Adv
Surplus / (Deficit)	**147**	**265 Fav**	**(63)**	**(107) Adv**	**1,137**	**(194) Adv**	**(950)**	**(585) Adv**

SLA Income

- Daycase income £209k (£40k) ahead of plan.
- Elective income £66k ahead of plan (£72k behind plan).
- Non-elective income £1142k (£140k) above plan.
- A&E £263k above plan.
- Critical Care £24k below plan.
- WIP increase of £0.205m since March 12.
- CQUIN accrued at 75% pending achievement of measures.

Provisions

- Provisions against PCT contract challenges have been made totalling £1.6m in May. Of this sum £0.8m relates to readmissions fines (based on experience of 2011-12 and subject to Clinical Audit) and a further £0.2m relates to the year end contract reconciliation for 2011-12.

Appendix 3 SLA Income

POD	YTD Plan	YTD Actual	YTD Var
	£	£	£
DC	3,575	3,784	209
EL	2,859	2,925	66
NEL	11,560	12,703	1,142
OPFA	1,701	1,875	174
OPFUP	1,752	1,840	87
OPFASPNCL	344	426	82
OPFUPSPNCL	509	518	9
OPPROC	919	969	50
Excluded Medicines	2,059	2,205	146
A&E - PbR	1,240	1,503	263
TCS	1,270	1,270	0
Childrens Services	1,202	1,202	0
Critical Care & HDU	1,138	1,113	-24
Pathology	876	879	3
Radiotherapy	685	624	-61
Community Midwives	595	595	0
GPDA Radiology	373	460	87
Unbundled Chemotherapy PSD	603	691	88
Breast Screening	246	246	0
Ante-natal Pathology	158	158	-1
Excluded Devices	150	128	-23
Limb Centre	152	158	7
Audiology	142	142	0
Cancer MDT Meetings	109	109	0
Rehab	93	7	-86
Brachytherapy	64	70	7
Anti-Coagulation	55	55	0
Other Block	220	303	84
MRET	0	0	0
ARMD	175	180	5
Provisions	-614	-1,562	-948
CQUIN	839	673	-166
WIP	0	205	205
CIPs	116	0	-116
Other	0	37	37
Grand Total	**35,163**	**36,490**	**1,327**

Appendix 4 Activity

SLA Activity (Figures in brackets prior month)

- Activity performing above plan for all points of delivery:

- Daycases 10% (9%) above plan.
- Elective activity 20% (17%) above plan.
- Non elective 12% (7%) above plan.
- A&E attendances 17% (12%) above plan.
- New Outpatients 8% (2%) above plan.
- Outpatient Procedures 7% (10%) above plan.

Activity	Plan 2012-13	YTD Actual	YTD Plan	Var to plan	%
Daycase	36,675	6,623	6,013	610	10%
Elective Inpatients	5,779	1,135	945	190	20%
Non Elective	41,288	7,695	6,901	794	12%
Cons New Outpatients	63,593	11,296	10,459	837	8%
Cons Follow Up Outpatients	116,000	20,286	19,188	1,098	6%
NCL New Outpatient	23,711	4,754	3,889	865	22%
NCL Follow up Outpatients	64,701	10,555	10,611	-56	-1%
Outpatient Procedures	38,571	6,769	6,346	423	7%
A&E Attendances	77,823	15,197	12,973	2,224	17%

Appendix 5 Pay Expenditure

Notes to Pay Expenditure

- £13.65 m cost in May (£13.5m cost in April).
- At M2 pay is £1m over budget.
- Nurse recruitment plan in place to bridge current level of vacancies.
- Medical Locum spend continues to decreased from M12 and overall medical costs within budget in month of May.
- QiPPs targets offset by additional activity and income delivered in April and May.

Temporary Staffing

- Total expenditure in May £1.188m (April £1.13m).
- £185k expenditure on Medical Locums in (April 227k).
- Agency Nursing £412k (April £344k) , higher than with March levels.
- Bank Nursing £444k (£418k in April).
- Other Bank and agency £92k.

YTD Variances to Plan

- Substantive Nursing Qualified £0.7m (9%) favourable to plan.
- Substantive Nursing Unqualified £0.3m (17%) favourable to plan.
- Junior Medical £196k (7%) favourable to plan.
- Managerial Staff £168k (11%) favourable to plan.

Staff Group £000's	March		April		May	
	Actual	Plan	Actual	Plan	Actual	Plan
Senior Medical Staff	1,950	2,310	2,202	2,350	2,175	2,340
Junior Medical Staff	1,253	1,301	1,237	1,352	1,272	1,352
Salary Recharge Exp. - Medical Staff	43	27	57	53	57	53
Salary Recharge Inc. - Medical Staff	(121)	(77)	(154)	(184)	(141)	(137)
Capitalised Salary - Medstaff	-	-	-	-	-	-
Medstaff WLI & ADH's	57	3	72	8	81	8
Agency Medstaff (Senior)	113	8	61	6	50	6
Agency Medstaff (Junior)	181	14	166	13	135	13
Total Medical Staff	**3,475**	**3,585**	**3,640**	**3,598**	**3,630**	**3,635**
Nursing Staff - Qualified (Band 5 +)	4,215	4,183	3,901	4,309	4,009	4,342
Nursing Staff Unqualified	714	782	674	850	711	827
Salary Recharge Exp. - Nursing Staff	6	5	4	2	4	6
Salary Recharge Inc. - Nursing Staff	104	(78)	(91)	(78)	(95)	(84)
Capitalised Salary - Nursing	(6)	-	(2)	-	-	-
Bank Staff - Nursing	420	-	418	-	336	-
Agency Staff - Senior Nursing	297	-	220	-	264	-
Agency Staff - Junior Nursing	79	-	124	-	148	-
Total Nursing Staff	**5,830**	**4,891**	**5,248**	**5,083**	**5,377**	**5,091**
Managerial Staff	892	775	676	771	688	761
Salary Recharge Exp. - Managers	23	1	13	1	12	1
Salary Recharge Inc. - Managers	(28)	(3)	(7)	(14)	(17)	(16)
Capitalised Salary - Managers	(24)	-	(9)	-	(9)	-
Agency Staff - Management	15	1	1	1	21	1
Administration Staff	1,336	1,366	1,275	1,383	1,198	1,350
Salary Recharge Exp. - Admin Staff	-	-	-	-	-	-
Salary Recharge Inc. - Admin Staff	(18)	(14)	(18)	(19)	(19)	(18)
Capitalised Salary - Admin	-	-	-	-	-	-
Bank Staff - Admin	27	6	24	1	108	1
Agency Staff - Admin	32	-	27	-	34	-
Total Managerial & Admin	**2,256**	**2,132**	**1,981**	**2,125**	**2,015**	**2,081**
Other Clinical Staff	858	902	837	936	874	944
Scientific & Technical Staff	1,050	1,073	1,046	1,108	1,052	1,100
Estates Staff	110	79	81	91	76	108
All other Staff	615	633	585	631	575	619
Salary Recharge Exp. - Other Staff	(5)	33	22	13	9	13
Salary Recharge Inc. - Other Staff	(65)	(42)	(51)	(38)	(51)	(45)
Capitalised Salary - Other Staff	-	-	-	-	-	-
Bank & Agency Staff - Other	113	3	94	4	92	6
Total Other	**2,676**	**2,683**	**2,615**	**2,744**	**2,626**	**2,745**
QIPPS			-	**(331)**	-	(379)
CIPS	-	(75)	-	(157)	-	(157)
Additional Activity	-	-	-	20	-	20
Vacancy Factor	-	(78)	-	0	-	(3)
Total Cost Challenges	**-**	**(154)**	**-**	**(468)**	**-**	**(521)**
Total Pay Expenditure	**14,237**	**13,139**	**13,485**	**13,082**	**13,649**	**13,031**

Appendix 6 Workforce

Summary

•4103 WTE worked in May compared to budget of 4123 WTE. Contracted WTE total 3799 WTE.

Temporary Staffing

•15 WTE Medical Locums.
•129 WTE Bank Nurses.
• 104 WTE Agency Nurses.

Variances from Plan (Worked v Budget)

• Junior Doctors 8 WTE below plan
•Qualified Nurses 158 WTE below plan
•Unqualified Nurses 90 WTE below plan
•Managerial Staff 24 WTE below plan
• Administration 117 WTE below plan

Staff Type:	Worked Mth 12 WTE 2011/12	Worked Mth 2 WTE 2012/13	WTE Budget 2012/13 M2	Contracted Mth 2 WTE 2012/13
Senior Medical Staff	192.52	197.94	209.31	193.46
Junior Medical Staff	252.27	256.66	264.96	261.63
Salary Recharges Expenditure - Medical Staff	5.38	5.32	4.11	
Salary Recharges Income - Medical Staff	-13.76	-7.09	-13.52	
Medical Locums (Agency - Senior)	5.03	2.46	0.17	
Medical Locums (Agency - Junior)	12.32	11.98		
Total Medical Staff	**453.76**	**467.27**	**465.03**	**455.08**
Nursing Staff - Qualified (Band 5 +)	1161.21	1169.62	1327.70	1196.55
Nursing Staff Unqualified	392.24	373.27	462.94	408.29
Salary Recharges Expenditure - Nursing Staff	1.67	1.10	1.10	
Salary Recharges Income - Nursing Staff	-28.14	-23.82	-39.01	
Bank Staff - Nursing	141.91	128.77		2.40
Agency Staff - Senior Nursing	41.43	45.72		
Agency Staff - Junior Nursing	64.30	57.81		
Total Nursing Staff	**1774.62**	**1752.47**	**1752.73**	**1607.24**
Managerial Staff	141.66	141.81	166.05	142.05
Salary Recharges Expenditure - Managers	1.00	2.00		
Salary Recharges Income - Managers	-2.05	-2.05	-2.00	
Agency Staff - Management	1.00	2.00		
Administration Staff	631.12	610.72	728.51	609.86
Salary Recharges Expenditure - Admin Staff				
Salary Recharges Income - Admin Staff	-6.73	-5.26	-4.41	
Bank Staff - Admin	62.66	73.39	0.60	
Agency Staff - Admin	5.15	11.25		
Total Managerial & Admin	**833.81**	**833.86**	**888.75**	**751.90**
Other Clinical Staff	262.45	264.21	304.64	262.27
Scientific & Technical Staff	369.21	371.10	402.21	386.19
Estates Staff	32.63	32.74	38.19	26.00
All other Staff	370.10	350.67	405.84	310.75
Salary Recharges Expenditure - Other Staff	5.30	7.20	5.00	
Salary Recharges Income - Other Staff	-4.60	-2.62	-7.53	
Agency Staff - Other	25.38	26.01	0.80	
Total Other	**1060.47**	**1049.31**	**1149.15**	**985.21**
CIPS			-10.30	
Additional Activity				
Vacancy Factor			-1.00	
Total Cost Challenges			**-11.30**	
Total Worked WTE	**4122.66**	**4102.91**	**4244.36**	**3799.44**

Summary

•Non pay is £1.4m over budget in M2 primarily driven by activity.

Clinical

• Medicines over budget by £0.7m of which £0.3m relates to external drug sales recovered through other income.

Non-Clinical

• Adverse variance due to increased Gas and Electricity charges compared to plan.

Other

• PCT QiPPs savings targets contribute £0.17m to the overspend .

Appendix 7 Non-Pay Expenditure

Non-Pay £000's	March		April		May	
	Actual	Plan	Actual	Plan	Actual	Plan
Clinical Non Pay - Fixed						
Equipment Hire	83	47	71	57	72	47
Equipment Maintenance	276	234	217	253	235	238
Clinical Non Pay - Fixed Total	**359**	**281**	**288**	**310**	**307**	**285**
Clinical Non Pay - Variable						
Prosthesis	220	117	151	120	173	137
Patient & Surgical Appliances	157	146	169	147	221	167
Patient Clothing & Travel	17	11	6	9	7	11
Lab Equipment Consumables	314	419	312	344	374	418
Blood	191	147	129	116	129	136
Medicines	1,975	1,697	1,963	1,670	2,089	1,729
Medical & Surgical Items	1,241	939	800	789	1,069	1,017
Dressings	77	55	62	50	72	58
Medical Gases	14	18	23	15	23	18
X-Ray Consumables	6	1	-	1	1	1
Clinical Non Pay - Variable Total	**4,212**	**3,551**	**3,616**	**3,262**	**4,159**	**3,692**
Clinical Non Pay - Total	**4,571**	**3,831**	**3,903**	**3,572**	**4,466**	**3,978**
Non Clinical Non Pay - Fixed						
Building & Engineering Equipment	288	312	255	266	250	276
Cleaning Equipment	47	37	54	47	55	47
Energy & Utilities	255	225	252	203	292	180
Rates	60	65	68	68	68	68
Printing & Stationery	85	68	72	67	75	64
Computer Equipment & Maintenance	101	115	105	126	133	129
Communications	113	61	73	73	77	73
Office Equipment	31	27	4	6	5	6
Non Pay CIP's	-	(140)	-	(199)	-	(189)
Non Pay QIPP's	-	-	-	(85)	-	(85)
Other Fee's	422	120	128	168	146	168
Losses & Compensations	140	21	12	28	50	28
CNST	418	418	467	467	467	467
Consultancy Fee's	56	41	51	44	96	40
Training	189	71	59	73	31	71
Travel & Benefits	674	92	98	92	96	90
Staff Advertising	5	5	2	5	1	5
Non Clinical Non Pay - Fixed Total	**2,886**	**1,540**	**1,699**	**1,449**	**1,842**	**1,438**
Non Clinical Non Pay - Variable						
Patient Provisions	121	101	103	107	126	104
Patient Linen	92	77	69	82	82	82
Non Clinical Non Pay - Variable Total	213	177	172	189	209	186
Non Clinical Non Pay - Total	**3,099**	**1,717**	**1,871**	**1,638**	**2,051**	**1,624**
Expenditure SLAs:						
N PCT Services	64	57	80	79	83	79
NHT Transport	9	11	-	(0)	-	(0)
Library Facilities - Northamptonshire PCT	15	10	-	(0)	-	(0)
Two Shires - Ambulances	-	0	-	-	-	-
ECR	-	0	-	-	-	-
Oxford - Ambulances	-	-	-	-	-	-
Danetre Facilities	11	32	-	(0)	-	(0)
Sub-Total Non-Pay	**7,769**	**5,658**	**5,854**	**5,290**	**6,600**	**5,681**

Non Current Assets

- Decrease of £0.5m in month due to net additions less depreciation and reclassification of £300k of assets for sale.

Current Assets

- Overall decrease of £101k in month.
- £0.255m reduction in NHS debtors.
- Cash balance reduced by £0.7m in month.
- Non-current asset for sale relates to Sunnyside building.

Current Liabilities

- Increase of £1.3m in month.
- Increase in NHS creditors of £428k.
- £623k reduction in Trade creditors.
- £952k reduction in capital creditors..

Reserves

- Revaluation reserve movement of £533k relating to indexation of non-current assets.

Appendix 8 Statement of Financial Position

	Balance at 31-Mar-12	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	135,375	135,375	135,075	(300)	135,375	
IN YEAR REVALUATIONS		594	503	(91)	1,816	1,816
IN YEAR MOVEMENTS		368	767	399	8,533	8,533
LESS DEPRECIATION		(826)	(1,649)	(823)	(10,188)	(10,188)
NET BOOK VALUE	**135,375**	**135,511**	**134,696**	**(515)**	**135,536**	**161**
CURRENT ASSETS						
INVENTORIES	**4,723**	**4,533**	**4,592**	**59**	**4,862**	**139**
RECEIVABLES						
NHS DEBTORS	5,730	6,649	6,394	(255)	5,742	12
OTHER TRADE DEBTORS	985	858	984	126	968	(17)
DEBTOR IMPAIRMENTS PROVISION	(149)	(149)	(149)		(149)	
CAPITAL RECEIVABLES	31	49	19	(30)	31	
NON NHS OTHER DEBTORS	70	176	370	194	19	(51)
COMPENSATION DEBTORS (RTA)	2,554	2,565	2,596	31	2,554	
OTHER RECEIVABLES	549	588	594	6	574	25
IRRECOVERABLE PROVISION	(283)	(283)	(283)		(283)	
PREPAYMENTS & ACCRUALS	1,458	2,464	2,685	221	1,460	2
	10,945	**12,917**	**13,210**	**293**	**10,916**	**(29)**
CASH	3,944	2,692	1,998	(694)	5,690	1,746
NON-CURRENT ASSETS FOR SALE			300	300		
NET CURRENT ASSETS	**14,889**	**15,609**	**15,508**	**(101)**	**21,468**	**1,856**
CURRENT LIABILITIES						
NHS	1,673	2,311	2,737	(426)	2,386	(713)
TRADE CREDITORS REVENUE	3,655	4,327	3,704	623	3,655	
TRADE CREDITORS FIXED ASSETS	2,759	2,327	1,375	952	2,046	713
TAX AND NI OWED	3,454	3,384	3,517	(133)	3,454	
NHS PENSIONS AGENCY	1,784	1,951	1,960	(9)	1,784	
OTHER CREDITORS	510	415	324	91	510	
SHORT TERM LOANS	526	526	526		526	
ACCRUALS AND DEFERRED INCOME	4,018	5,087	5,181	(94)	4,031	(13)
PDC DIVIDEND DUE		298	652	(354)		
STAFF BENEFITS ACCRUAL	629	629	629		629	
PROVISIONS	1,603	1,005	324	681	978	625
PROVISIONS over 1 year	310	310	330	(20)	310	
NET CURRENT LIABILITIES	**20,921**	**22,570**	**21,259**	**1,311**	**20,309**	**612**
TOTAL NET ASSETS	**134,066**	**133,083**	**133,537**	**454**	**136,695**	**2,629**
FINANCED BY						
PDC CAPITAL	99,635	99,635	99,635		99,635	
REVALUATION RESERVE	34,046	34,579	34,467	(112)	35,675	1,629
DONATED ASSET RESERVE						
I & E ACCOUNT BALANCE	385	385	385		885	500
I & E CURRENT YEAR		(1,516)	(950)	566	500	500
FINANCING TOTAL	**134,066**	**133,083**	**133,537**	**454**	**136,695**	**2,629**

Appendix 9 Cashflow

MONTHLY CASHFLOW	Annual £000s	ACTUAL APR £000s	ACTUAL MAY £000s	FORECAST JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	204,967	15,448	17,959	17,156	17,156	17,156	17,156	17,156	17,156	17,156	17,156	17,156	17,156
SLA Variable inc Over Performanc													
SHA Payments (SIFT etc)	9,002	266	1,300	735	735	735	735	735	735	735	735	735	820
Other NHS Income	19,502	1,933	2,568	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
PP / Other (Specific > £250k)	259		259										
PP / Other	14,089	821	768	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250
Salix Capital Loan													
EFL / PDC													
Temporary Borrowing													
Interest Receivable	35	1	2	3	3	3	3	3	3	3	3	4	4
TOTAL RECEIPTS	247,854	18,469	22,857	20,644	20,644	20,644	20,644	20,644	20,644	20,644	20,644	20,645	20,730
PAYMENTS													
Salaries and wages	161,294	13,081	13,813	13,380	13,380	13,500	13,380	13,380	13,500	13,380	13,500	13,500	13,500
Trade Creditors	56,248	4,285	6,274	5,500	5,500	5,000	3,500	4,500	4,500	5,000	5,000	5,000	2,189
NHS Creditors	13,103	1,546	1,938	1,077	1,077	1,077	1,077	1,077	1,077	1,077	1,077	500	500
Capital Expenditure	11,117	789	1,503	648	842	677	700	1,045	1,370	1,222	1,137	886	298
PDC Dividend	4,118						2,031						2,087
Repayment of Loans													
Repayment of Salix loan	190						95						95
TOTAL PAYMENTS	246,070	19,701	23,528	20,605	20,799	20,254	20,783	20,002	20,447	20,679	20,714	19,886	18,669
Actual month balance	1,784	-1,231	-671	39	-155	390	-139	642	197	-35	-70	759	2,061
Balance brought forward	3,906	3,906	2,675	2,003	2,042	1,887	2,277	2,137	2,779	2,976	2,941	2,870	3,630
Balance carried forward	5,690	2,675	2,003	2,042	1,887	2,277	2,137	2,779	2,976	2,941	2,870	3,630	5,690

Notes to cashflow

- Forecast aims to undershoot EFL by up to £1.7m. May require restrictions on creditor payments in March.
- Cashflow restricted in Q1but BPPC performance on plan for Trade creditors and creditor balances reduced overall.

Appendix 10 Debtors

In month

- Increase of £2.09m in outstanding balances since March.
- Amount outstanding over 90 days static.

Problem Debtors

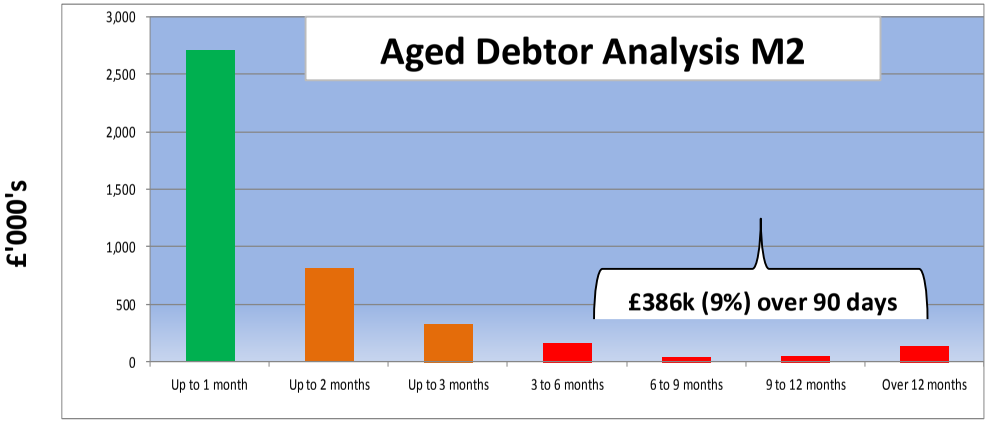
- CRIPPS – part payment against oldest invoices expected June 12.

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

	Description	Value £	Date due:
Cripps Social Club	SLA 1/4/10-31/3/11	84,148.00	10/04/2011
Cripps Social Club	SLA 1/4/11-31/3/12	84,147.96	31/03/2012
Milton Keynes Gen Hospital NHS Trust	Oncology services Jan-Mar 12	46,479.84	11/03/2012
BMI THREE SHIRES HOSPITAL	Radiology tests Feb & est Mar 12	41,053.82	20/04/2012
University Hospitals Leics NHS Trust	Drugs recharge Jan-Mar 12 (est)	35,791.33	08/04/2012
NHS NORTHAMPTONSHIRE	Activity not on SLAM	25,852.00	14/04/2012
University Hospitals Leics NHS Trust	Radiology recharge Apr 11-Mar 12	21,800.00	23/03/2012
University Hospitals Leics NHS Trust	Radiology rechg HLRU Apr 10 - Mar 11	21,355.00	15/04/2011
NHS NORTHAMPTONSHIRE	Alcohol Liaison Nurse Q3 and Q4	18,005.64	28/08/2011
Cripps Social Club	Salary recharges Feb 12	17,207.86	19/04/2012

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

	Description	Value £	Date due:
Cripps Social Club	SLA 1/4/10-31/3/11	84,148.00	10/04/2011
University Hospitals Leics NHS Trust	Radiology rechg HLRU Apr 10 - Mar 11	21,355.00	15/04/2011
NHS NORTHAMPTONSHIRE	Alcohol Liaison Nurse Q3 and Q4	18,005.64	28/08/2011
Milton Keynes Gen Hospital NHS Trust	Oncology services Jan-Mar 12	46,479.84	11/03/2012
University Hospitals Leics NHS Trust	Radiology recharge Apr 11-Mar 12	21,800.00	23/03/2012
Cripps Social Club	SLA 1/4/11-31/3/12	84,147.96	31/03/2012
University Hospitals Leics NHS Trust	Drugs recharge Jan-Mar 12 (est)	35,791.33	08/04/2012
NHS NORTHAMPTONSHIRE	Activity not on SLAM	25,852.00	14/04/2012
Cripps Social Club	Salary recharges Feb 12	17,207.86	19/04/2012
BMI THREE SHIRES HOSPITAL	Radiology tests Feb & est Mar 12	41,053.82	20/04/2012



Aged Debtors	01.04.11 £'000	April £'000	May £'000	YTD Change £'000
Up to 1 month	1,097	5,480	2,710	1,613
Up to 2 months	523	524	809	286
Up to 3 months	100	115	330	230
3 to 6 months	202	127	158	-44
6 to 9 months	54	35	33	-21
9 to 12 months	24	68	54	30
Over 12 months	146	143	141	-5
Total	**2,146**	**6,492**	**4,235**	**2,089**

Over 90 Days	386
%	9.12%

Appendix 11 Creditors

Balances

- Reduction of £163k over March balance.
- Balance > 90days £0.2m. (3.15%).

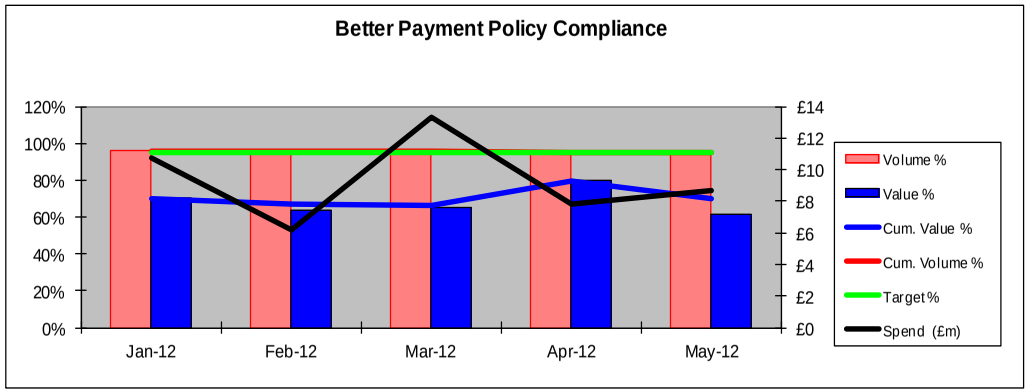
BPPC Compliance (95% target)

- Achieving target compliance by volume.
- Low level of NHS compliance.

Top 10 by age	Invoice Value £	Due Date
DR ZAM CADER	100.00	09/06/2011
SOFTCAT LIMITED	195,119.08	06/01/2012
CREATIVE PROMOTIONS	96.00	10/01/2012
MICROGEN LIMITED	296.40	22/03/2012
MULTICARE	33.60	06/04/2012
NHSBSA PRESCRIPTION PRICING DIVISION	75,677.97	10/04/2012
NORTHAMPTONSHIRE HEALTHCARE NHSFT	65,282.00	15/04/2012
HUMAN TISSUE AUTHORITY	1,369.38	20/04/2012
SRC	43,515.60	22/04/2012
TWOFOLD LIMITED	387.50	25/04/2012

Top 10 by account	Account Balance £
NHS LITIGATION AUTHORITY	1,156,747.38
NHS SUPPLY CHAIN	459,643.36
VARIAN MEDICAL SYSTEMS UK LTD	283,720.80
ROCHE PRODUCTS LIMITED	250,714.29
NHS BLOOD AND TRANSPLANT	243,778.45
SOFTCAT LIMITED	195,119.08
HEALTHCARE AT HOME LIMITED	166,548.47
NHSBSA PRESCRIPTION PRICING DIVISION	153,217.07
NOVARTIS PHARMACEUTICALS UK LIMITED	136,762.36
ALLIANCE HEALTHCARE (DISTRIBUTION) LTD	128,986.09

	NHS			Non-NHS			Total		
	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%
Value £	519,813	2,260,007	**23%**	10,994,527	14,216,401	**77%**	11,514,340	16,476,407	**70%**
Volume	289	380	**76%**	11,542	12,097	**95%**	11,831	12,477	**95%**



Aged Creditors	01.04.12 £'000	NHS £'000	Trade £'000	Capital £'000	Total £'000
Up to 1 month	3,673	1,757	1,973	313	4,043
Up to 2 months	2,408	447	870	192	1,509
Up to 3 months	10	283	13	83	379
Over 3 Months	197	-1	-1	195	193
Total	**6,288**	**2,487**	**2,855**	**783**	**6,125**

Over 90 Day	**193**
% Balance	**3.15%**

Notes to Capital Schemes

- Year to date expenditure of £2.053m (23%) of plan.
- Replacement Breast Screening ultrasound is the final year of business case.
- Emergency Care and Mortuary schemes - works commenced on site due for completion by June 2012.
- Endoscopy / Urodynamics - subject to business case approval and charitable funds donation.
- The Macmillan scheme works are completed, although final account is awaited.
- Full year depreciation forecast is currently £10.184 million

Appendix 12 Capital Expenditure

Category	Approved Annual Budget 2012/13 £000's	Year to Date as at Month 2 Actual Spend £000's	Year to Date as at Month 2 Plan Achieved £000's	Year to Date as at Month 2 Actual Committed £000's	Year to Date as at Month 2 Plan Achieved £000's
Breast Screening Business Case	100	0	0%	0	0%
Emergency Care	335	113	34%	139	41%
Endoscopy / Urodynamics	600	0	0%	0	0%
Mortuary Refurbishment	80	19	24%	77	96%
Macmillan (Trust)	91	0	0%	21	23%
Macmillan (Non Trust)	13	0	0%	0	0%
MESC	998	187	19%	336	34%
Estates	3,933	342	9%	874	22%
IT	3,373	179	5%	621	18%
Other	70	12	16%	69	99%
Total - Capital Plan	**9,592**	**851**	**9%**	**2,138**	**22%**
Less Charitable Funds	-578	-85	15%	-85	15%
Total - CRL	**9,014**	**766**	**9%**	**2,053**	**23%**

Appendix 13 Shadow Monitor Financial Risk Rating

Financial Criteria	Metric	Weight %	May	Shadow Rating	YTD Score
Achievement of Plan	EBITDA Achieved (% of plan)	10%	71%	3	0.30
Underlying Performance	EBITDA Margin %	25%	3.4%	2	0.50
Financial Efficiency	Return on Assets	20%	-0.18%	2	0.40
Financial Efficiency	I&E Surplus Margin	20%	-2.3%	1	0.20
Liquidity	Liquidity Ratio (Days cover)	25%	13.04	2	0.50
Weighted Average		100%		Calculated Score	2
				Override	
				Reported Score	2

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

Notes to YTD Score

- Plan to achieve minimum score of 3.
- Calculated score of 2 in May limited to a score of 2 due to overriding rules (2 or more scores of 1).
- EBITDA achieved of 71% delivers score of 3.
- ROA score driven by YTD deficit.
- Deficit and FOT give rise to a score of 1 for surplus margin.
- Liquidity cover 13 days (includes WCF of £18m).
- Note: Monitor review on a quarterly basis.

Overriding Rules :

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

Appendix 14 CIP Programme

Total savings of £1.159m have been recorded for the period to May.

The latest forecast (LTF) is to substantially achieve the planned target for the year but this will require the delivery of £3.7m of mitigating actions.

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

Workstream	Plan £000	LTF £000	Var
Beds / Patient Flow	300	218	(82)ADV
Theatres	424	345	(79)ADV
Outpatients	165	217	52FAV
Admin Review	385	144	(241)ADV
Procurement	1,200	1,180	(20)ADV
Pathology	147	111	(36)ADV
Therapies	80	80	-
Medical	250	250	-
Estates	316	66	(250)ADV
Outsourcing	111	111	-
Nursing	58	42	(17)ADV
Back Office Phase 2	506	126	(380)ADV
Contract Compliance	1,000	1,000	-
Pharmacy	450	450	-
Controls	550	420	(130)ADV
HR Workforce Planning	1,183	969	(214)ADV
Workforce, Bank & Agency	950	515	(435)ADV
Directorate 3% Schemes	6,205	6,091	(114)ADV
NGH Mitigation	1,820	3,766	1,946 Increase
Grand Total	**16,100**	**16,100**	**0FAV**

Workstream Savings - May

£000's	May		YTD		
Workstream	Plan	LTF	Plan	LTF	Var
Beds / Patient Flow Total	22	7	44	7	(38)ADV
Theatres Total	19	19	38	28	(10)ADV
Outpatients Total	7	51	13	65	52FAV
Admin Review Total	-	-	-	-	0FAV
Procurement Total	100	81	200	161	(39)ADV
Pathology Total	-	-	-	-	0FAV
Therapies Total	-	-	-	-	0FAV
Medical Total	-	-	-	-	0FAV
Estates Total	6	6	11	11	0FAV
Outsourcing Total	-	-	-	-	0FAV
Nursing Total	-	-	-	-	0FAV
Back Office Phase 2 Total	-	-	-	-	0FAV
Contract Compliance Total	23	23	45	45	0FAV
Pharmacy Total	38	38	75	75	0FAV
Controls Total	46	4	92	8	(84)ADV
HR Workforce Planning Total	-	-	-	-	0FAV
Directorate 3% Schemes	406	382	841	760	(81)ADV
Workforce, Bank & Agency T	79	-	158	-	(158)ADV
NGH Mitigation Total	151	-	302	-	(302)ADV
Grand Total	**895**	**609**	**1,819**	**1,159**	**(660)ADV**

TRUST BOARD SUMMARY SHEET	
Title	HR REPORT
Submitted by	Andrea Chown, Deputy Director HR
Date of meeting	27 June 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 June 2012 which focuses on the figures for April 2012 and the following topics :-

- **Substantive Workforce Capacity**

Substantive workforce capacity decreased by 16.67 FTE from 3,802.52 to 3,785.85 FTE which is below the plan (4,250.48) for the month. The % FTE of contracted workforce against budgeted establishment has decreased by 2.79% to 89.07%. For the financial year 2012/13 the Budgeted Workforce Establishment (FTE) increased by 110.91 FTE.

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

Temporary Workforce Usage increased by 1.2% from 7.19% to 8.39% 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 decreased by 1.75% from 98.98% to 97.23%.

- **Calendar Days Lost to Sickness**

The number of calendar days lost to sickness increased by 217 from 6,384 to 6,601 in April 2012.

- **Days Lost per Employee**

The number of days lost per employee increased by 0.06 from 1.42 to 1.48 in April 2012.

- **Long Term Sickness Absence**

Long term sickness absence increased by 0.36% in April 2012 to 2.56% which is above the Trust target of 2%.

- **Short Term Sickness Absence**

Short term sickness absence has decreased by 0.03% to 2.22% in April 2012 (Trust target 1.4%).

- **Staff Turnover**

Staff turnover (leavers) has decreased by 0.06% on the month to 8.31%, which remains above the Trust target of 8%.

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

The temporary workforce expenditure has decreased by £142,708 from £1,278,223 to £1,135,515 which is equal to 7.48% of the total workforce expenditure.

- **Appraisals**

It is proposed and subject to Trust Board approval, that for the financial year 2012/2013, all appraisals will be centrally recorded on OLM and reported on a quarterly basis. The Training & Development Department will be responsible for the centralised management of recording appraisals and the HR Business Partners will work with Managers to implement the process of submitting appraisal records.

Mandatory Training

The Mandatory Training Activity Forecast shows an increase in training levels occurring in April 2012. If the run rate is maintained the Trust will achieve a 97.11% rate at year end.

Forecast & Risks

For the financial year 2012/13 the Budgeted Workforce Establishment (FTE) increased by 110.91 FTE, which has contributed to the decrease of Contracted Workforce against Budgeted Establishment of 2.79%.

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

PATIENT IMPACT - High

STAFF IMPACT - High

FINANCIAL IMPACT- High

EQUALITY AND DIVERSITY IMPACT - Low

LEGAL IMPLICATIONS - None

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

RECOMMENDATION: The Board is asked to discuss and debate the contents of this report.

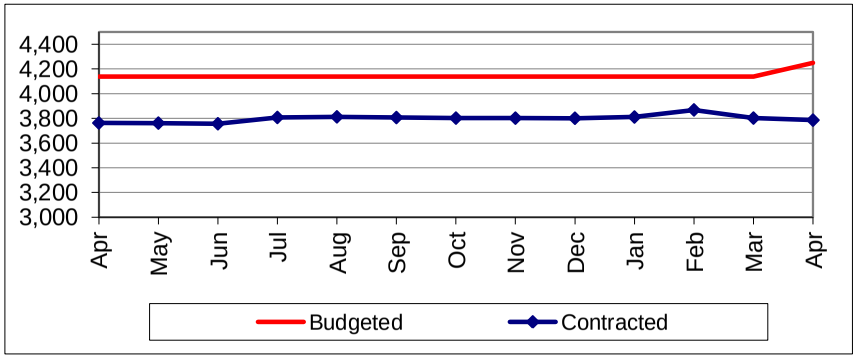
Workforce Capacity Summary M1

Target = 95%

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

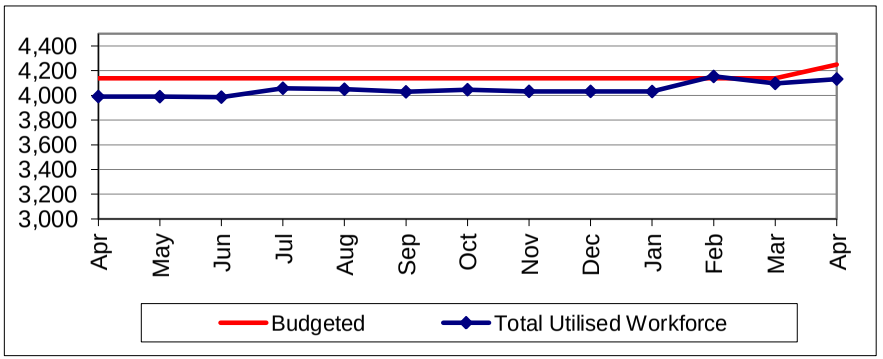
Substantive Workforce Capacity FTE

Directorate	Budgeted Establishment	M1 Contracted	Variance
Medicine	1,072.05	893.35	**-178.70**
Surgery	293.18	257.40	**-35.78**
Anaesthetics	330.97	301.37	**-29.60**
T&O	254.91	233.54	**-21.37**
Head & Neck	165.39	147.37	**-18.02**
Child Health	259.97	255.95	**-4.02**
Obs & Gynae	377.72	363.21	**-14.51**
Oncology	224.19	226.47	**2.28**
Pathology	213.40	197.19	**-16.21**
Radiology	143.96	130.36	**-13.60**
Pharmacy	101.26	97.17	**-4.09**
Therapies	79.32	66.52	**-12.80**
Facilities	347.56	284.31	**-63.25**
Hosp Support	386.60	331.64	**-54.96**
TOTAL	**4,250.48**	**3,785.85**	**-464.63**



Total Workforce Capacity FTE (Excluding Medical Staffing)

Directorate	Budgeted Establishment	* Total Utilised Workforce	Variance
Medicine	1,072.05	1059.63	**-12.42**
Surgery	293.18	292.73	**-0.45**
Anaesthetics	330.97	314.60	**-16.37**
T&O	254.91	258.16	**3.25**
Head & Neck	165.39	158.63	**-6.76**
Child Health	259.97	276.44	**16.47**
Obs & Gynae	377.72	384.77	**7.05**
Oncology	224.19	239.43	**15.24**
Pathology	213.40	200.29	**-13.11**
Radiology	143.96	130.36	**-13.60**
Pharmacy	101.26	97.17	**-4.09**
Therapies	79.32	79.26	**-0.06**
Facilities	347.56	292.08	**-55.48**
Hosp Support	386.60	348.99	**-37.61**
TOTAL	**4,250.48**	**4,132.54**	**-117.94**



* Total Substantive Workforce plus Temporary Workforce (FTE)

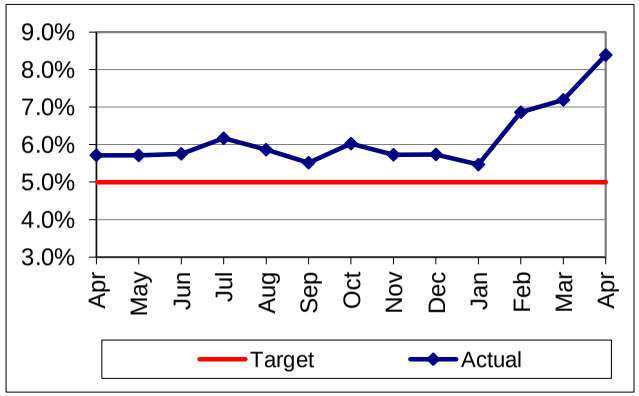
Workforce Performance Summary M1

Temporary Workforce Rate

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

(Excluding Medical Staffing)

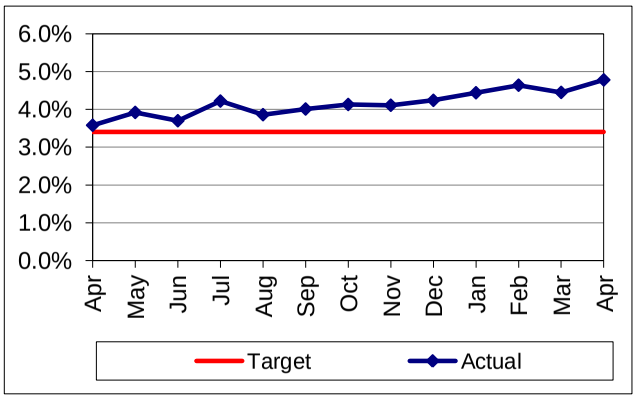
Directorate	Bank, Agency & Locum	Variance against Target	Variance from M12
Medicine	15.7%	10.7%	**1.0%**
Surgery	12.1%	7.1%	**4.5%**
Anaesthetics	4.2%	-0.8%	**-3.1%**
T&O	9.5%	4.5%	**2.9%**
Head & Neck	7.1%	2.1%	**0.8%**
Child Health	7.4%	**2.4%**	**1.9%**
Obs & Gynae	5.6%	**0.6%**	**2.1%**
Oncology	5.4%	0.4%	**-0.1%**
Pathology	1.5%	**-3.5%**	**0.9%**
Radiology	0.0%	**-5.0%**	**0.0%**
Pharmacy	0.0%	**-5.0%**	**0.0%**
Therapies	16.1%	11.1%	**9.1%**
Facilities	2.7%	**-2.3%**	**0.0%**
Hosp Support	5.0%	**0.0%**	**0.6%**
TOTAL	**8.39%**	**3.4%**	**1.2%**



Staff Sickness Absence Rate

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

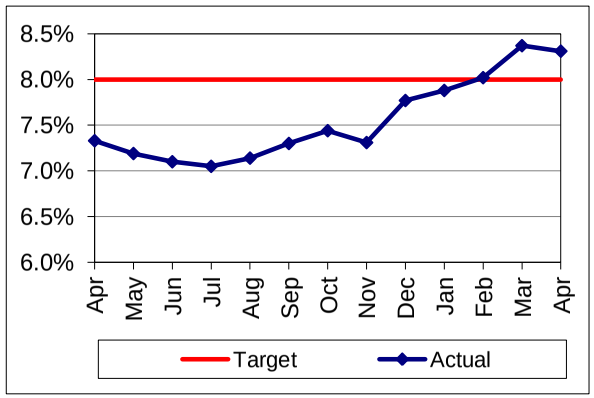
Directorate	Sickness Absence M1	Variance against target	Variance from M12
Medicine	5.27%	**1.87%**	**0.26%**
Surgery	5.89%	**2.49%**	**0.31%**
Anaesthetics	3.97%	**0.57%**	**1.72%**
T&O	4.59%	**1.19%**	**-1.92%**
Head & Neck	7.10%	**3.70%**	**1.02%**
Child Health	3.07%	**-0.33%**	**-1.00%**
Obs & Gynae	6.54%	**3.14%**	**1.92%**
Oncology	4.81%	**1.41%**	**-0.10%**
Pathology	3.84%	**0.44%**	**1.74%**
Radiology	3.03%	**-0.37%**	**-0.12%**
Pharmacy	4.46%	**1.06%**	**0.72%**
Therapies	5.12%	**1.72%**	**2.66%**
Facilities	4.88%	**1.48%**	**-0.40%**
Hosp Support	2.94%	**-0.46%**	**0.87%**
TOTAL	**4.78%**	**1.38%**	**0.33%**



Staff Turnover

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

Directorate	M1	Variance against target	Variance from M12
Medicine	8.10%	0.10%	0.16%
Surgery	6.10%	-1.90%	0.06%
Anaesthetics	4.26%	-3.74%	0.49%
T&O	8.77%	0.77%	0.72%
Head & Neck	3.87%	-4.13%	0.00%
Child Health	12.44%	4.44%	-0.15%
Obs & Gynae	9.70%	1.70%	-0.67%
Oncology	8.22%	0.22%	-0.07%
Pathology	5.94%	-2.06%	-0.24%
Radiology	2.85%	-5.15%	0.41%
Pharmacy	7.43%	-0.57%	1.13%
Therapies	7.21%	-0.79%	-0.72%
Facilities	14.69%	6.69%	0.57%
Hosp Support	9.46%	1.46%	-0.47%
TOTAL	**8.31%**	**0.31%**	**-0.06%**



HEATMAP - Staffing Indicators 2011-12,2012-13

	Deliverable	Key	Threshold Target	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12
Workforce Capacity (Temporary Workforce Capacity excludes Medical Staffing)	Budgeted Workforce Establishment (FTE)		n/a	4,024.00	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,139.57	4,250.48
	Contracted Substantive Workforce (FTE)		n/a	3,751.96	3,762.79	3,761.78	3,756.49	3,807.58	3,812.43	3,806.72	3,802.41	3,801.90	3,801.12	3,811.11	3,868.54	3,802.52	3,785.85
	Temporary Workforce Utilised (FTE)		n/a	268.45	228.08	227.88	229.35	250.33	237.50	222.24	243.80	231.04	231.40	220.34	285.05	294.69	346.69
	Total Substantive Workforce plus Temporary Workforce (FTE)		n/a	4,020.41	3,990.87	3,989.66	3,985.84	4,057.91	4,049.93	4,028.96	4,046.21	4,032.94	4,032.52	4,031.45	4,153.59	4,097.21	4,132.54
	Contracted Workforce against Budgeted Establishment (% FTE)		95% to 97%	93.24%	90.90%	90.87%	90.75%	91.98%	92.10%	91.96%	91.86%	91.84%	91.82%	92.07%	93.45%	91.86%	89.07%
	Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE)		100.0%	99.91%	96.41%	96.38%	96.29%	98.03%	97.83%	97.33%	97.74%	97.42%	97.41%	97.39%	100.34%	98.98%	97.23%
	Temporary Workforce Rate (%FTE)	1	5.0%	6.68%	5.71%	5.71%	5.75%	6.17%	5.86%	5.52%	6.03%	5.73%	5.74%	5.47%	6.86%	7.19%	8.39%
	Staff Turnover (% FTE)		8.0%	7.41%	7.33%	7.19%	7.10%	7.05%	7.14%	7.30%	7.44%	7.31%	7.77%	7.88%	8.02%	8.37%	8.31%
	Recruitment Timeline	2	13.6 weeks	15.00	14.71	15.58	15.80	15.80	15.03	14.60	14.42	11.36	15.58	16.50	18.64	12.47	12.28
Workforce Expenditure (Temporary Workforce Expenditure includes Medical Staffing)	Contracted Workforce Expenditure		n/a	11,650,670	12,035,402	12,303,538	12,301,743	12,387,348	12,438,724	12,407,344	12,433,670	12,375,872	12,452,393	12,606,300	12,565,284	12,777,007	14,055,230
	Contracted Workforce Overtime		n/a	75,636	70,663	69,162	60,692	69,889	67,770	64,261	70,014	65,958	63,437	63,406	69,256	71,774	74,079
	Contracted Workforce Excess Hours		n/a	4,518	3,212	4,378	4,864	3,427	7,144	3,305	2,153	3,943	1,962	1,137	3,201	3,340	2,777
	Temporary Workforce Expenditure	3	n/a	1,167,330	957,598	1,064,462	878,257	1,020,652	1,005,276	1,042,907	1,009,306	951,117	1,028,691	1,039,113	1,093,506	1,278,223	1,135,515
	Total Utilised Workforce Expenditure		n/a	12,818,000	12,993,000	13,368,000	13,180,000	13,408,000	13,444,000	13,450,250	13,442,975	13,326,988	13,481,084	13,645,412	13,658,790	14,055,230	15,190,745
	Temporary Workforce Expenditure (% of Total Workforce Expenditure)		n/a	9.11%	7.37%	7.96%	6.66%	7.61%	7.48%	7.75%	7.51%	7.14%	7.63%	7.62%	8.01%	9.09%	7.48%
Health & Wellbeing	Trust Headcount (Perm & FTC)		n/a	4436	4503	4506	4498	4558	4546	4522	4505	4507	4500	4506	4507	4504	4472
	Calendar Days Lost to Sickness Absence		n/a	5044	4832	5552	5025	6029	5529	5567	5838	5711	6068	6374	6202	6384	6601
	Days Lost per Employee		n/a	1.14	1.07	1.23	1.12	1.32	1.22	1.23	1.30	1.27	1.35	1.41	1.38	1.42	1.48
	Short Term Sickness Absence		1.4%	2.02%	1.86%	2.17%	2.14%	2.25%	2.05%	2.30%	2.41%	2.38%	2.36%	2.61%	2.74%	2.25%	2.22%
	Long Term Sickness Absence		2.0%	1.69%	1.72%	1.75%	1.56%	1.98%	1.82%	1.71%	1.71%	1.73%	1.90%	1.84%	1.90%	2.20%	2.56%
	Total Sickness Absence		3.4%	3.71%	3.58%	3.92%	3.70%	4.22%	3.86%	4.01%	4.13%	4.11%	4.24%	4.44%	4.64%	4.45%	4.78%
	Return to Work Interviews		100%	79.00%	82.00%	84.00%	76.00%	83.00%	76.00%	82.00%	78.00%	79.00%	84.00%	85.00%	80.00%	67.69%	
Workforce Development	Cumulative Completed Personal Development Review / Plan (Appraisal)		n/a		5.00%	9.00%	13.00%	17.00%	36.50%	46.00%	53.00%	57.50%	61.02%	68.00%	73.16%	75.12%	
	Mandatory Training Activity Forecast (FYI)	4	100%	84.40%	90.11%	86.98%	87.08%	83.23%	79.31%	77.61%	74.86%	74.38%	71.30%	73.46%	74.53%	80.78%	97.11%

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

NHS
Midlands and East

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

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

NHS Midlands and East

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

Name of Organisation:	Northampton General Hospital NHS Trust	Period:	May 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)	3.0
Financial Risk Rating (Assign number as per NHS Midlands and East PMR guidance)	2.0
Contractual Position (RAG as per NHS Midlands and East PMR guidance)	A

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

Governance Declarations

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

Supporting detail is required where compliance cannot be confirmed.

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

Governance declaration 1

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

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

Governance declaration 2

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

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

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

If Declaration 2 has been signed:

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

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

Target/Standard:	**All cancers: 62-day wait for first treatment /31 day subsequent treatment (Drug)**
The Issue :	**Due to complexities of care and delay in initial referral from the other providers, the Trust has not**
Action :	**Recovery plans have been developed and dialogue with partner providers is ongoing**

ACUTE
GOVERNANCE RISK RATINGS 2012/13

Northampton General Hospital NHS Trust

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

Ref	Area	Indicator	Sub Sections	Thresh-old	Weight-ing	Apr 2012	May 2012	June 2012	Jul 2012	Aug 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Comments where target not achieved in month?
1	Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	36	1.0	Yes	Yes											
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	1	1.0	Yes	Yes											
3	Quality	All cancers: 31-day wait for second or subsequent treatment, comprising either:	Surgery	94%	1.0	Yes	No											Anti cancer drug treatments 95.5% for May 12
			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	No											From urgent GP RTT 81.5% for May 12
			From consultant screening service referral	90%														
5a	Patient Experience	RTT waiting times – admitted	95th percentile	23 wks	1.0	Yes	Yes											The GRR is based on delivery of the 90% RTT Target
5b	Patient Experience	RTT waiting times – non-admitted	95th percentile	18.3 wks	1.0	Yes	Yes											The GRR is based on delivery of the 95% RTT Target
6	Quality	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes											
7	Quality	Cancer: 2 week wait from referral to date first seen, comprising either:	all cancers	93%	0.5	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	No											May 93.37%
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	2											May 2012 - Time Spent in A&E & 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	Yes	Yes											
		CQC Registration																
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding	0	1.0	No	No											
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding	0	2.0	No	No											
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	1.0	No	No											
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	2.0	No	No											
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	2.0	No	No											
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	4.0	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											
			TOTAL			0.0	3.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

FINANCIAL RISK RATING 2011/12

Northampton General Hospital NHS Trust

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

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Annual Plan 2011/12	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments on Performance in Month
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	1	2											Improvement in EBITDA in May
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	1	2											56% achieved
Financial efficiency	**Return on assets %**	20%	6	5	3	-2	<-2	3	2	2											Due to YTD defciit of £1.2m
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	1	1											Due to YTD defciit of £1.2m
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3											Calculation includes £18m WCF assumption.
Average	**Weighted Average**	**100%**						**3.0**	**1.7**	**2.1**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	
Overriding rules	**Overriding rules**								-0.7	-0.1											Two criteria "2" in May
Overall rating	**Final Overall rating**							**3.0**	**1.0**	**2.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	

Overriding Rules :

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

FINANCIAL RISK TRIGGERS 2012/13

Northampton General Hospital NHS Trust

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

	Criteria	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Comments on Performance in Month
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No											Achieved Q3 and Q4 11-12.
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	No	No											Forecast to achieve Level 3 by Q2.
3	FRR 2 for any one quarter	Yes	Yes											FRR 2 in Q1 to Q3 11-12.
4	Working capital facility (WCF) agreement includes default clause	No	No											N/A
5	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes											£386k (9%)
6	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No											£193k (3.15)%
7	Two or more changes in Finance Director in a twelve month period	No	No											
8	Interim Finance Director in place over more than one quarter end	No	No											
9	Quarter end cash balance <10 days of operating expenses	Yes	Yes											-10 days excluding WCF.
10	Capital expenditure < 75% of plan for the year to date	No	No											
	TOTAL	**3**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

NB Scoring: An answer of "YES" = 1.0

RAG RATING :

GREEN	**= Score between 0 and 1**
AMBER	**= Score between 2 and 4**
RED	**= Score over 5**

CONTRACTUAL RISK RATINGS 2011/12

Northampton General Hospital NHS Trust

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

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

QUALITY

Northampton General Hospital NHS Trust

Insert Performance in Month

Criteria		Unit	Apr 2012	May 2012	June 2012	Jul 2012	Aug 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Comments on Performance in Month
1	SHMI - latest data	Ratio	109.2	109.2											SHMI - Latest position reflects October 11 to September 12
2	Venous Thromboembolism (VTE) Screening	%	91.4%	91.9%											
3a	Elective MRSA Screening	%	99.8%	99.4%											
3b	Non Elective MRSA Screening	%	95.1%	95.7%											
4	Single Sex Accommodation Breaches	Number	0	0											
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	12	3											
6	"Never Events" in month	Number	0	0											
7	CQC Conditions or Warning Notices	Number	0	0											
8	Open Central Alert System (CAS) Alerts	Number	1	0											
9	RED rated areas on your maternity dashboard?	Number	1	2											Total Deliveries & Supervisor to midwife ratio
10	Falls resulting in severe injury or death	Number	0	0											
11	Grade 3 or 4 pressure ulcers	Number	1	4											
12	100% compliance with WHO surgical checklist	Y/N	Y	Y											
13	Formal complaints received	Number	50	50											
14	Agency and bank spend as a % of turnover	%	6.4%	6.6%											Indicative numbers/ validation ongoing M2 Bank & agency cost of £1.247m divided by M1 income of £19.001m giving 6.6%.
15	Sickness absence rate	%	4.8%	NA											
Supplementary submission	HSMR	Number	93.6	93.9											Information supplied for May 2012 is reflective of the period Apr 11 to March 12

Board Statements

Northampton General Hospital NHS Trust

41030

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

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	✓

If the Trust Board is unable to make the above statement, the Board must:

2	Be satisfied that, to the best of its knowledge and using its own processes (supported by CQC information and including any further metrics it chooses to adopt), its Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	✓
3	Be satisfied that, to the best of its knowledge and using its own processes, plans in place are sufficient to ensure ongoing compliance with the CQC's registration requirements	✓
4	Certify it is satisfied that processes and procedures are in place to ensure that all medical practitioners providing care on behalf of the NHS foundation trust have met the relevant registration and revalidation requirements.	✓
4	Be satisfied that the Trust is embedding patient experience into the service design, improvement and delivery cycle.	✓

	For SERVICE PERFORMANCE, that:	Response
5	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and compliance with all targets due to come into effect during 2011/12.	✗

	For RISK MANAGEMENT PROCESSES, that:	Response
6	Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner	✓
7	All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned	✓
8	The necessary planning, performance management and risk management processes are in place to deliver the annual plan	✓
9	A Statement of Internal Control ("SIC") is in place, and the trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see http://www.hm-treasury.gov.uk)	✓
10	The trust has achieved a minimum of Level 2 performance against the key requirements of the Department of Health's Information Governance Toolkit	✓

	For COMPLIANCE WITH THE NHS CONSTITUTION, that:	Response
11	The Board is assured that the trust will, at all times, have regard to the NHS constitution	✓

	For BOARD, ROLES, STRUCTURES AND CAPACITY, that:	*Response*
12	The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board	✓
13	The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability	✓
14	The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills	✓
15	The management team have the capability and experience necessary to deliver the annual plan	✓
16	The management structure in place is adequate to deliver the annual plan objectives for the next three years.	✓

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

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

June 2012

Monthly Feature—Green Car Scheme

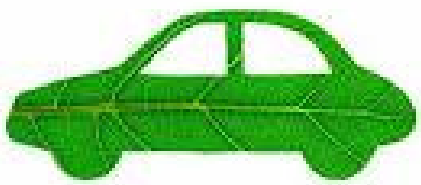
One of the ways the trust can save money is through Salary Sacrifice schemes. These schemes benefit both the employee and the employer because payments are taken out of staff salaries before tax and national insurance are applied. This reduces the amount of tax that employees pay, and therefore also reduces the national insurance and pension contributions made by the trust on the employee's behalf. The trust has already implemented several schemes such as; cycle to work scheme, buy-back of annual leave, and the busy bees child care vouchers.

The next scheme to be introduced is Green Car. This will enable staff to lease a brand new car at a much reduced cost. The scheme is building on the Government initiative to promote energy efficient cars.

Benefits of the Green Car scheme:

- Significant savings for staff when compared to high street deals.
- The more environmentally friendly the better the savings for staff.
- No capital or deposit required.
- Environmentally friendly, supporting the trust's energy policies

The scheme is due to be advertised in July, in time for the September registration plates, so keep your eye out for the launch event at the Cyber café and further communications.



Procurement update

As part of their 2012/13 plan the procurement team have established a range of workstreams that are expected to deliver over £1m towards the trust's transformation targets. This includes reduced prices, changes to supplier, or even new product lines.

Many of these workstreams are joint projects with care group and corporate teams to ensure that quality and safety issues are fully included in any specifications that are developed as part of the negotiations.

In April this year, the procurement team saved £145,383.50, and are well on the way to exceeding their target.

The team are also working on a number of tenders for new equipment such as the pharmacy robot replacement, and are supporting the commercial aspects of the roll out of the hybrid mail system.

Hybrid Mail update

Hybrid mail is one of many projects being undertaken as part of the Trusts 'Transformation Programme'.

While this (desk top mail) postal service is still seen as providing a timesaving and cost effective alternative to "franked" mail, especially since the postal rates price increase, implementation is taking longer than planned. This has been due to technical issues which are important to resolve to ensure that future users have a robust, user friendly, alternative to current franked mail services.

This has meant that we have not been able to deliver this alternative solution as quickly as we would like to. Even with the slower roll out than anticipated (since February this year) we have been able to send out over 25,000 items of mail using the Hybrid mail services. This has resulted in postal and stationery savings.

We want to assure you that the "roll out" of the hybrid mail service is continuing and to thank all the departments that have provided specific information and attachments that will be linked into future hybrid mail services. The project team would like to reassure you that as this service rolls out you will be fully informed and involved with the process.

Outpatients update

The DNA patient reminder system continues to work well and generated an additional £11.5k in income last month that would have ordinarily been lost due because patients had failed to turn up to their appointments.

The Outpatient Standards go public this month. The 10 outpatient standards will be available for all to view on the NGH website and on The Street. Measuring us against these standards, patients are now be able to leave feedback for their outpatient visit either by filling out a paper questionnaire, found in clinic waiting areas, or by going on to the NGH website.

The booking centre has now devolved. Specialties/Care Groups will now be responsible for monitoring their booking services and ensuring acceptable levels of service are maintained. Performance levels for the Trust's booking system will be continually monitored to identify areas that are underperforming. Central referrals are now managed by Oncology staff.

Transformation workstreams for 2012/13

Patient Flow	Outsourcing
Theatres	Nursing
Outpatients	Back office
Administration Review	Contract Compliance
Procurement	Pharmacy
Pathology	Controls
Therapies	HR Tactical (On-call and Out of Hours)
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
- Back Office
- Pharmacy
- Procurement
- Outsourcing
- Service Line Management
- IT enablement

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

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

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- Nursing
- Estates
- Bank & Agency
- Therapies

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

- Theatres
- Administration Review
- Controls

Thank you to Nick Penney who e-mailed a money saving idea to Gerry McSorley recently. Nick's suggestion was to make use of the free Google Translate App on smartphones in clinics. The Transformation Delivery Group discussed this idea and felt that whilst there may be some difficulties using this kind of system in clinics, there may be some merit in using similar systems for translating documents.

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	The Patient Experience: Strategy for Improvement 2012-2015
Submitted by	Suzie Loader, Director of Nursing, Midwifery & Patient Services
Prepared by	Jane Salvage, Health Consultant
Date of meeting	27 June 2012
Corporate Objectives Addressed	Improve Clinical Quality and Safety

SUMMARY OF CRITICAL POINTS

- This is the Trust's first patient experience strategy.
- It builds on previous and current work in the Trust and other related strategies and initiatives, and draws on national and regional guidance and projects.
- It highlights four key areas for improvement.
  1. Help leaders to improve the patient experience.
  2. Help staff to improve the patient experience.
  3. Engage patients in improving the patient experience.
  4. Improve services through measuring the patient experience.
- It brings under one umbrella the diverse range of patient experience initiatives already under way in the Trust.

PATIENT IMPACT

The strategy aims to improve the experiences of all patients who use services at our acute and community hospital sites and in the community.

STAFF IMPACT

Every Trust staff member, whatever their role, will take personal responsibility for their part in implementing this strategy. Various actions are proposed to ensure this**.**

FINANCIAL IMPACT

TBC

EQUALITY & DIVERSITY

TBC

LEGAL IMPLICATIONS

Nil

RECOMMENDATIONS

- Members of the Board are asked to note the contents of this report and to challenge as appropriate.
- That the Board ratify the Patient Experience Strategy

Northampton General Hospital NHS
NHS Trust

12

The Patient Experience: Strategy for Improvement 2012-2015

Ratified as: The Patient Experience: Strategy for Improvement 2012-2015
Date of Issue: June 2012
Date(s) Reviewed:
Next Review Date: June 2015
Version Number: 1
Revised as:
Responsibility for Review: Director of Nursing, Midwifery & Patient Services
Contributors: Chief Executive, Medical Director, Deputy Chief Executive, Deputy Director of Nursing (Governance), Deputy Director of Nursing (Professional Standards), Complaints Manager, Patient Experience Manager

Index

1 Introduction

The Trust Quality Strategy states: '*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*.' It says high quality care has three key interlinked components: patient safety, effectiveness of care, and the patient experience. Here we set out our plan to tackle the third component.

This, the Trust's first patient experience strategy, aims to improve the experiences of all patients who use services at our acute and community hospital sites and in the community.

We know that most patients are generally satisfied with their care, and that our staff work with dedication and skill to make the patient experience as good as possible. We also know, however, that there is plenty of room for improvement. Judging by the results of the latest National Survey of Adult In-patients, our Trust's performance on patient experience is about average compared with other NHS trusts, and worse in one or two respects (Care Quality Commission 2012).

Being just average is not good enough – we want to be among the very best, so that we can say with confidence, 'The care we give at Northampton General Hospital NHS Trust is exactly what we would want for our loved ones and ourselves.'

This strategy builds on previous and current work in the Trust and other related strategies and initiatives, and draws on national and regional guidance and projects. It highlights four key areas for improvement, shown in Box 1. It sets out clear aims and objectives in each area to improve the experiences of every one of our patients and their families and carers.

As the best mechanism for making these improvements, the strategy proposes to bring under one umbrella the diverse range of patient experience initiatives already under way. This will enable a better co-ordinated approach to measuring, monitoring and reporting patient experience across all our services. It also aligns with our other strategies and governance structure. A more detailed patient experience improvement action plan will be presented to the Board in July.

Box 1: Four key areas for improving patients' experiences

1. Help leaders to improve the patient experience.
2. Help staff to improve the patient experience.
3. Engage patients in improving the patient experience.
4. Improve services through measuring the patient experience.

2 Our vision

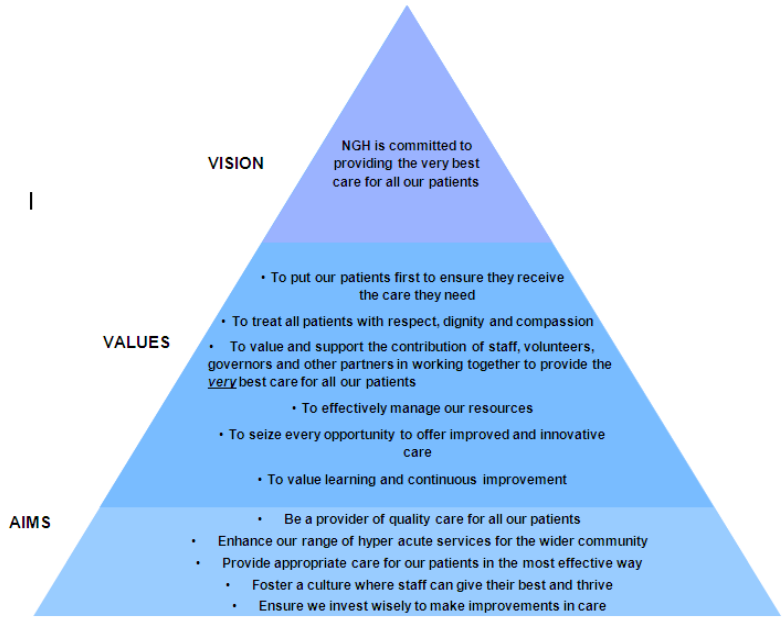
The Trust is 'committed to providing the very best care for all our patients'. The values that underpin our vision (see Box 2) are all relevant to improving the patient experience.

This commitment requires us to do everything in our power to ensure that the experiences of patients, families and carers are positive, supportive and conducive to their health and wellbeing at every stage of their care pathway. They will be cared for and treated with competence and kindness, and their dignity and individuality will be respected at all times.

Every Trust staff member, whatever their role, will take personal responsibility for their part in achieving this goal. As a key dimension of high quality care, the patient experience will be at the heart of our planning and performance management, with related objectives in every business plan.

Box 2: The Trust's vision, values and aims

'Right care, first time, every time'



3 Our framework

The patient experience is at the heart of everything we do. It is shaped by a huge range of factors, some of which we cannot influence but many we can. Formulating an achievable, sustainable and inspiring strategy is a difficult challenge. Before developing this strategy, we reviewed the following:

- our own activities and performance;
- what some other trusts are doing;
- relevant national and regional guidance and toolkits.

We found the *Transforming Patient Experience* approach advocated by the NHS Institute for Innovation and Improvement (NHSI 2012) particularly clear and comprehensive. It is evidence-based, stimulates innovative thinking using tested approaches, and provides the evidence and processes we need to influence everyone at all levels to focus on improving the patient experience.

What follows here utilises that framework and builds in our own experiences and goals. First we address the 'why?' of understanding our patients' experiences of our services in section 4. Then we turn to the 'how?' in section 5, which sets out our objectives and actions.

4 Why it is essential to understand the patient experience?

We begin by making the case for exploring the value of understanding patient experience. We will then look briefly at the research evidence and the policy frameworks.

4.1 Making the case for exploring the patient experience

'*I am, yet what I am none cares or knows*,' begins a famous poem written by John Clare, the Northamptonshire Peasant Poet, when he was a patient in the Northampton General Lunatic Asylum (now St Andrew's Hospital) in 1844. No patient should ever feel like that. Our belief in the importance of every person in our care, and our commitment to humanitarian values and the NHS Constitution, means we must strive to make the patient experience as good as it can be.

There is also a compelling business case for doing this. It includes the evidence of the impact of patient experience on the Trust's reputation; the impact of patient choice and increased control of care and treatment on their experiences; the link between experience and health outcomes; the link between experience and cost of care; and the relationship between staff engagement and patient experience.

Organisations that pay full attention to providing high-quality patient experience, through engaging well with both patients and staff, appear to

achieve better health outcomes and to be more cost-effective, says the NHS Institute for Innovation and Improvement.

So how well are we doing? As noted above, our performance in the National Survey of Adult In-patients for 2011 was about average, and worse in one or two respects compared with 2010. More encouragingly, we achieved some significant improvements: a shorter wait before being admitted to a ward; not having to share sleeping areas or facilities with members of the opposite sex; and doctors and nurses working better together. We know that a lot of what the Trust does is good and that patient satisfaction is generally high.

These improvements are welcome but we cannot stand still, especially if the Trust is to thrive in these uncertain times. There is plenty of room for much more improvement. On patients being bothered by noise at night from other patients and from hospital staff, we were rated worse than most other trusts. Since the previous year, the rating of our hospital food had deteriorated and – crucially important to this strategy – so had the responses to the question, 'During your stay, were you ever asked to give your views on the quality of your care?'

Making the case, the 'why', involves several considerations and principles, explored briefly below:

- start with the patient;
- change how we think and act; and
- work within national policy frameworks.

4.2 Start with the patient

Starting with the patient, listening to their needs, and co-designing the experience to meet those needs results in an environment where people feel cared for, supported and safe. It is an achievable process and we aim to develop a more coherent and focused approach to it, using tested tools to help us create simple, sustainable solutions.

It means putting patients and their representatives in the driving seat: involving them every step of the way, in giving feedback, collecting data, identifying what needs to be done, shaping solutions and implementing them.

All our staff need to 'start with the patient'. This is stating the obvious, but it is easily forgotten in the pressure of daily work. Staff are so familiar with their working environment that they can forget how strange and intimidating it may appear to patients, who will usually feel anxious and apprehensive. Front line staff need to understand why a positive patient experience is so important, and what the benefits are for patients and staff. We need to find effective ways of helping staff routinely to share their ideas on improving patients' experiences, and to introduce small incremental changes that can make a big difference.

4.3 Change how we think and act

Fundamental engagement with the idea of starting with the patient is essential. Becoming an organisation that routinely focuses on listening and acting on patient feedback involves changing the way we think and act. It is not a tick-box exercise and cannot happen without visible leadership and full engagement, beginning with the Board – both executive and non-executive directors - and shadow governors. The Trust needs to accelerate the change processes in our quality strategy if we are to use the evidence effectively and improve the patient experience. Visible leadership will be more important than ever as we move towards foundation trust status and continue to face the challenges of health service reorganization, reductions in income and service transformation.

Changing the way we think and act is hard, as it may threaten some of our traditional ways of working. There is also much external turbulence, which tends to encourage resistance to change. Research shows we need to invest in understanding patient experience and providing support for staff at all levels. As our Quality Strategy says, '*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*.'

Encouraging input and eliciting ideas from all levels of staff right from the start helps ensure that they feel a sense of involvement and ownership. They are then more likely to feel responsible for implementing initiatives to which they have contributed actively.

4.4 Work within national policy frameworks

In response to widespread concerns about the quality of care across the UK, individual patients, families, carers, service user groups and the media are calling for a greater focus on patients' experiences. They are backed by national and regional bodies, commissions and public inquiries. This upsurge of interest is stimulating the development and refinement of a wide range of evidence-based approaches, tools and frameworks.

Fortunately there is a growing evidence base to help us decide what to do. In 2010 the Department of Health and the NHS Institute for Innovation and Improvement commissioned a research programme*, What matters to patients? Developing the evidence base for measuring and improving patient experience* (King's College London and the King's Fund 2011). It sets out strong arguments for how the NHS can improve services and patients' experiences of them.

A number of national policies require healthcare organisations and professionals to measure and improve patient experience. The policies aim to provide a patient-centered service that meets the population's physical and emotional needs, and in doing so uphold the three purposes of the *NHS*

Outcomes Framework 2012-13 (Department of Health 2011). These are accountability (reporting upwards); transparency (reporting out to patients and the public, which means reporting measures that people understand); and improvement.

A growing set of useful national and regional guidance, projects and resources is available. The *NHS Patient Experience Framework* published by the Department of Health (2012) is an important reference point. It provides, for the first time, a national evidence-based framework that is expected to guide the measurement of patient experience across the NHS. Appendix 1 shows the elements it outlines as critical to patients' experiences. They include:

- respect for patient-centred values, preferences, and expressed needs;
- coordination and integration of care across the health and social care system;
- good information and communication;
- physical comfort; and
- emotional support.

Although most NHS organizations undertake a range of activities to improve patients' experiences, they are only just beginning to develop overall strategies for improving patient experience. By developing and implementing this strategy, the Trust is therefore in the forefront.

These are some of the major reasons *why* we should work on improving the patient experience. We turn now to looking at *how* we can tackle it.

5 How we will improve the patient experience

Our plans need to demonstrate how feedback can be gathered; the process of identifying and implementing improvements with patients and staff; and what the benefits will be for patients, staff and the organization. They cannot succeed without some essential underpinnings, says a King's Fund expert (Cornwell 2012):

- a defined budget;
- personnel with relevant expertise to collect, analyze and present data; and
- an education and training plan with a budget for improving patient experience.

We will now look at how various parts of the Trust's health system can improve the experience of the patients in their care and work towards our overarching aim for improving the patient experience (box 3):

Box 3: Overarching aim for improving the patient experience:

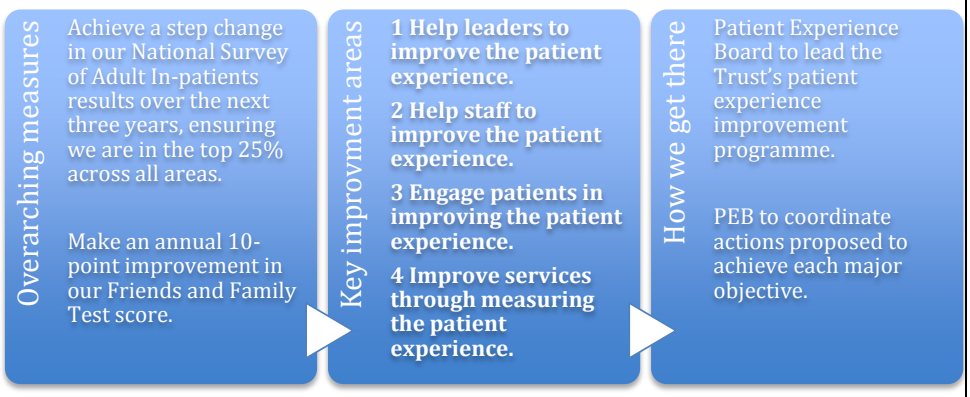
'**We will do everything in our power to make the experiences of patients, families and carers consistent with our vision. Every Trust staff member, whatever their role, will take personal responsibility for their part in achieving it.**'

Box 4 below, summarises the main drivers of our strategy, including the four key improvement areas already listed in Box 1 above. To lead the patient experience improvement programme and coordinate actions proposed to achieve each major objective, we propose to establish a Patient Experience Board. Table 1 at the end of Section 5 summarises the specific actions proposed in each of the key improvement areas. The two overarching measures of progress we will use are:

- achieve a step change in our National Survey of Adult In-patients results over the next three years, ensuring we are in the top 25% in all areas;
- make an annual 10-point improvement in our Friends and Family Test score.

We will now discuss all these elements of the strategy in more detail.

Box 4: Main drivers of the Trust Patient Experience Strategy



5.1 Key area 1: Help leaders to improve the patient experience

Rationale:

Many senior leaders and others charged with improving quality in the NHS do not know, or do not believe, that there is an evidence base on patient

experience and they are not confident about measuring it (Cornwell 2012). Yet the evidence shows that visible leadership is one of the two main attributes of health organisations that collect experience data and use it to make changes.

Strong leadership will be vital for improving patient experience in our Trust. This leadership is exercised by our Board, which bears responsibility for setting our tone and culture. As we move towards foundation trust status, non-executive directors and shadow governors should be fully involved in shaping and implementing this strategy.

Our strategic objectives are already driving our Quality Strategy, which contains a high-level articulation of this patient experience strategy. The goals we choose to improve patient experience must be linked specifically to our strategic objectives. The patient experience, as a key dimension of high quality care, must have a high profile at the heart of our planning and performance management, with related objectives in all our business plans.

To ensure high-level commitment to improving the patient experience across the organisation, the Director of Nursing, Midwifery and Patient Services, who is responsible for managing patient experience at board level, will engage with the senior team.

Staff designated as patient experience leads in each directorate will need to engage colleagues and the senior team to ensure they understand what patient experience is, and what it means for the Trust. Each lead will be responsible for holding up a mirror to their colleagues so they can work with patients to identify how to improve the patient experience in their patch - often small, achievable actions that can make a big difference.

The Trust works in partnership with commissioners and other partners and stakeholders to deliver high quality care and excellent patient experience across the whole patient pathway. These partners need to be informed of and fully engaged with this strategy. Voluntary organisations that advocate for patients or provide services and support need to be fully on board as they provide a rich source of expertise and understanding of the patient experience.

Actions:

1. Include patient experience objectives in every Trust business plan.
2. Ensure full involvement of the Board and shadow governors in implementing this strategy.
3. The Director of Nursing, Midwifery and Patient Services will engage with the senior team to ensure effective implementation.
4. Ensure engagement of all partner and stakeholder organizations.
5. Designate patient experience leads in all directorates and formalise their terms of reference.
6. Develop plans to improve key aspects of the patient experience, including:
    a. the discharge process;

b. noise at night; and
c. the quality of hospital food.

5.2 Key area 2: Help staff to improve the patient experience

Rationale:

There is compelling evidence of a strong relationship between staff wellness and experience, patients' experiences and outcomes. Staff who are better engaged deliver better, safer care and take less sick leave, as the Boorman report confirmed (Department of Health 2009). The Trust recognises that the quality of patient care and patients' experiences largely depends directly or indirectly on the skills, knowledge, and attitudes of all 4,000 of our staff members.

An organisational culture in which staff know that patient experience is a priority is the second main attribute of health organisations that collect experience data and use it to make changes. There are strong links between the experience indicators and trusts' scores in NHS staff surveys, as the 2007 National Acute Inpatient Survey revealed. Where staff had clear and planned goals, patients were more likely to report good communication, such as being involved in decisions about their care.

Some areas of our Trust have high morale and good engagement, but there is much more to be done. Our aim is to become one of the best places to work. This requires a clear approach to staff engagement and we are tackling this in various ways, primarily through the Listening into Action (LiA) approach as the key to our new Staff Engagement Strategy (2012). We are already committed to the seven principles of LiA, which are equally relevant to this Patient Experience Strategy.

We would also like to highlight some additional principles. We want the values shown in Box 2 to drive staff attitudes and behaviours, so that they underpin and are demonstrated in everyday practice. Every single person in whatever role must be helped to take individual responsibility for the part they play in making the experiences of patients, carers and families as positive as possible. We will develop a Trust Standards of Behaviour Framework that builds on the value statement to highlight our expectations of staff attitudes and behaviours, including such key areas as respect and compassion.

All staff members must be helped to understand that everything we do and the way we do it, from the way we write our admission letters to car parking to clinical practice, shapes the experiences of our patients while they are in our care. A single careless or unkind word or action by a clinician or receptionist can colour the patient's whole perception of a care episode, and slow down their recovery.

As already stated, this will require nothing less than a culture change, especially in the parts of our organisation where staff performance and morale

fall short. We also want to raise the bar for everyone. Fullest possible engagement of staff and patients cannot happen overnight and we want the change to be sustainable, which requires long-term commitment and hard work.

At the same time we need to act quickly and purposefully, because poor patient experiences should no longer be tolerated. Small but significant incremental changes can make a huge overall difference; our goals are ambitious but we will succeed if everyone contributes, from cleaner to chief executive.

Continuing education, training and professional development for all staff is essential to the delivery of high quality services. We need to develop a targeted training programme with a specific focus on patient experience. We will also review existing training programmes and introduce where appropriate a module on desired behaviours to improve the patient experience.

Clinical staff are key to making improvements in service quality, which includes treating patients with kindness and respect at all times, unfailingly. We must further encourage clinical leadership and engagement in patient experience. Some directorates have patient experience leads/champions and this should be extended to all. One starting point used successfully elsewhere is for each directorate to engage staff and patients in producing a description of what its service should look like - from a patient viewpoint.

All clinicians should act on the new quality standards produced by the National Institute for Health and Clinical Excellence (NICE) in Clinical Guideline 138 (NICE 2012). This national framework, *Patient experience in adult NHS services: improving the experience of care for people using adult NHS services* sets out the components of a good patient experience, providing 'the evidence and direction for creating sustainable change that will result in an NHS cultural shift towards a truly patient-centred service.' (See Appendix 2).

Finally, patients should know exactly what they can expect from us, and what they can do to express appreciation or tell us when we fail. Some trusts are tackling this by giving a pledge card or leaflet to all new patients, such as a feedback card encouraging patients to send 'a message to Matron'. Earlier efforts to produce and implement a Trust customer care code of practice should be revived.

Actions:

1. Develop a Trust Standards of Behaviour Framework to outline our expectations of staff attitudes and behaviours. This will be used:
    a. in staff appraisals;
    b. in recruitment and selection;
    c. in the development of a Trust customer care code of practice; and
    d. in other ways to be identified.

2. Develop a staff development programme with a specific focus on patient experience, with the following goals:
    a. all staff will understand the importance of providing a good patient experience, and its impact on patient and their carers and on the organisation as a whole;
    b. all staff will recognise their contribution to the patient experience and its improvement;
    c. staff concerns relating to the patient experience will be listened to and there will be a structured method of receiving this feedback;
    d. staff will know how to learn lessons and improve the patient experience when things do not go well; and
    e. staff will know how to learn, share information and reward success when things go well.

3. Review existing training programmes and introduce where appropriate a module on desired behaviours to improve the patient experience, based on these goals.

4. Address the patient experience as a key theme in Listening into Action.

5. Ensure compliance with NICE Clinical Guideline 138 in all clinical areas.

6. Continue and enhance the patient experience work stream in the Nursing and Midwifery Strategy 2011-2014, including registered nurses conducting a care round on every shift; and a review of care environments to identify improvements.

7. Liaise with local health professional education providers to:
    a. strengthen the acquisition of patient experience competences; and
    b. explore how health professional students undergoing practice learning experiences in the Trust can be fully engaged in improving the patient experience.

5.3 Key area 3: Engaging patients in improving the patient experience

Rationale:

Evidence, and common sense, tells us that the more we engage patients, families and carers as partners in improving the patient experience, the more successful we will be. They can and should be involved at every stage, from collecting data to using that information in the redesign of services. Traditionally patients have been regarded as passive recipients of services, but the best health and business outcomes are achieved when they are actively engaged. This culture shift is a challenge to staff who are accustomed to more hierarchical professional-patient relationships.

The term ‘patient and public involvement’ (PPI) has become synonymous with a number of activities in the NHS. It encompasses patients, carers, families,

service users, clients, individuals, groups and communities. It is a national structure designed to ensure that the voice of patients is central to the planning, development, improvement and delivery of health services. It is also the framework by which we encourage patients to have a voice in decisions made about their own care. Our own PPI steering group coordinates input from a wide range of service users' groups.

The Trust has many other mechanisms for engaging patients. These include the Patient Advice and Liaison Scheme (PALS), LINKs, the complaints process and focus groups. We already work with patients' groups and advocates and with individual patients, families and carers to gather their views on their experiences and ideas for improvement. We seek feedback from anyone who uses our services, and uses it as a means to learn lessons and drive improvement. We aim for early and local complaint resolution and to reduce complaints wherever possible.

We also work to improve our services and facilities through listening to patients and the public, including seldom heard groups. We must do more to involve them at the earliest opportunity in the review, reorganisation and planning of current services and facilities and in their future development. Patients must be fully informed about their own treatment and care and have every opportunity to be involved in the decisions that affect them.

All these groups must be actively engaged in developing and implementing this Patient Experience Strategy. Some of our processes work better than others, however so, it is timely to review the effectiveness of our patient engagement structures and processes to ensure they are fit for purpose and can contribute fully to shaping and implementing our patient experience strategy.

The technique called experience-based design, or more precisely co-design, can improve services in a way that really makes a difference to patients and service users. It was designed for and within the NHS to develop simple solutions that offer patients a better experience of treatment and care. We propose to use the free King's Fund *Experience-based co-design* toolkit, which gives a step-by-step guide to improving patient experience.

Actions:

1. Review the effectiveness of all Trust patient engagement structures and processes, including the relevance and robustness of data we collect.

2. Routinely involve patients and shadow governors proactively in service design and development, piloting the process in a designated directorate with the free King's Fund *Experience-based co-design* toolkit.

3. Routinely involve patients and volunteers in data collection on the patient experience, including the Friends and Family Test, and the project involving 50 members of the public in monthly audits of noise at night across the hospital.

4. Engage patients and the public in developing the trust's annual Quality Accounts.

5.4 Key area 4: Improving services through measuring the patient experience

Rationale:

The way NHS organisations approach improving patients' experiences tends to be dominated by essentially technical questions - what indicators should we use? How many data points are sufficient? Which method should we use to collect the data? Before collecting feedback from patients, however, we should first ask two fundamental questions:

- What problem are we trying to solve?
- When we have the data, what will we do with it?

The data collected from patients helps us to make better decisions about how to improve services. The measurement of patient experience is a growing field. It is not sufficient to measure only patient *satisfaction*. More detail is required to ensure that the measures lead to positive change for patients. We need a mixture of quantitative and qualitative measures that give us immediate and recent data that is sufficiently detailed and meaningful to influence staff and managers.

There are real and important conceptual differences between different types of measure, such as measures of satisfaction, experience, patient-reported outcomes (PROMS) and patient-defined outcomes. Measures of patient experience must be aligned with clinical level data on process and outcomes; must be rigorously based on evidence; and must be simple. They should be embedded in NICE Clinical Guideline 138 (Appendix 2).

As well as requiring different types of measure, the way that feedback is collected can also influence the type of information and how it is useful. For example, real time patient experience information is of use directly by teams, but can also be collated and compared across services and at board level.

Like other NHS trusts, we use many different qualitative and quantitative methods for gathering formal and informal feedback from patients and carers. For maximum effectiveness we need to co-ordinate them, and assess the quality of the data. We also need to have robust processes in place that enable everyone to act continually on the information.

We need the capacity to collate and analyse data, and good systems for managing and tracking the data collected. We should urgently review and streamline the range of methods we use to gather feedback from patients and relatives to understand why they would or would not recommend us to others. This will help us to determine which measures are essential and which are

desirable. Outcomes should include a clinical dashboard for instant feedback and action.

The Trust already uses the Department of Health *Patient Experience First Steps (Diagnostic) Tool* (2010). This analyses data from the national inpatient survey to identify areas where the Trust can improve the patient experience.

As previously reported to the Board, NHS Midlands and East SHA cluster has asked trusts to adopt a standardized monitoring framework or 'headline metric' for monitoring real time patient experience data across the region (NHS Midlands and East SHA 2012). From April 2013, every NHS hospital will be required to ask patients on wards whether they would want a friend or relative to be treated there in their hour of need, using a simple metric, the Friends and Family Test (FFT).

As set out in the Trust's overarching quality strategy, we aim to achieve an annual 10-point improvement in our FFT score, using June 2012 as our benchmark. We have recently changed from using the Patient Experience Tracker (PET) to the Hospedia system, and have built the FFT question into it. We are currently identifying other data collection methods to run in parallel so that we can check the validity of the results.

These two overarching metrics will help us to ascertain in broad terms how well our strategy is working.

Actions:

1. Review and streamline the range of methods we use to gather feedback from patients and relatives to understand why they would or would not recommend us to others. This will help us to determine which measures are essential and which are desirable.
2. Develop an action plan for engaging each clinical area in measurement through assessing and piloting different metrics, including creation of a dashboard for instant feedback and action.
3. Make more regular and consistent use of the Department of Health *Patient Experience First Steps (Diagnostic) Tool* (2010) to identify areas where the Trust can improve the patient experience.
4. Check the validity of our Friends and Family Test measurement, and identify how to achieve an annual 10-point improvement in our FFT score.

5.5 How we will organise our improvement programme

The Trust recognises the need to formalise the patient experience programmes currently in place, and invest in clinical leadership and staff education to ensure that our high-level aim is achieved. Having set up a number of projects and improvement programmes in recent years, we will now take this work to a new level.

An effective way to organise a patient experience improvement programme is to determine which parts of the system to focus on, as the improvement activities will vary depending on the focus: patient, individual staff member, team, service, organisation or whole health system.

The Trust will establish a Patient Experience Board, chaired by the Director of Nursing, to lead the Trust's patient experience work. It will identify, coordinate and streamline what is already happening; eliminate duplication; and disseminate good practice. This will ensure that all patient experience projects have a structure for delivery and have a profile within the organisation.

The terms of reference of the new board will include:

- establish the governance framework for improving the patient experience;
- approving detailed action plans for achieving each strategic objective, linking in closely with patient experience leads, heads of department and clinical leaders;
- monitor the impact of these action plans on outcomes, ensuring clear lines of accountability are understood and implemented;
- define the budget;
- review mechanisms for collecting, analysing and presenting data;
- review our patient engagement structures and processes;
- develop an education and training plan for improving patient experience; and
- monitor and evaluate exemplar and sub-optimal practice, ensuring that exemplar practice is shared.

Some directorates already have designated patient experience leads/champions and we will extend this to every directorate, giving them clear terms of reference including an identified role in implementing this strategy.

We need to raise the profile of good practice and stories from satisfied patients, for appreciation and motivation of staff and pointers to service improvement. Our Communications and Engagement Strategy for 2012-2013 recognises this and should be evolved to support patient experience improvement through, for example, participating in patient group meetings; contributions to *Insight* magazine; better use of public-facing media and social networking such as the Trust website, Facebook and interactive online surveys.

We are also applying to participate in national projects to enhance learning opportunities, raise the Trust's profile and seek some external funding for patient experience work. We have explored a number of learning resources and toolkits. Some are freely available, while others require competitive admission to a structured programme and may demand immediate investment. Appendix 3 gives full details of these sources of support.

Actions:

1. Establish a Patient Experience Board to lead, monitor and evaluate the Trust's patient experience improvement programme.
2. The Director of Nursing, Midwifery and Patient Services, who is responsible for managing patient experience at board level, will engage with the senior team to ensure that this strategy is implemented with good effect.
3. Use national tools and participate in national projects to enhance learning opportunities, raise the Trust's profile and seek external funding.
4. Develop a communications plan for contributing to improvement of the patient experience.

Table 1: Summary of key objectives and actions

Objective	Actions
1: Help leaders to improve the patient experience	1. Include patient experience objectives in every Trust business plan. 2. Ensure full involvement of the Board and shadow governors in implementing this strategy. 3. The Director of Nursing, Midwifery and Patient Services will engage with the senior team to ensure effective implementation. 4. Ensure engagement of all partner and stakeholder organizations. 5. Designate patient experience leads in all directorates and formalise their terms of reference. 6. Develop plans to improve key aspects of the patient experience, including: a. the discharge process; b. noise at night; and c. the quality of hospital food.
2: Help staff to improve the patient experience	1. Develop a Trust Standards of Behaviour Framework to outline our expectations of staff attitudes and behaviours. This will be used: a. in staff appraisals; b. in recruitment and selection; c. in the development of a Trust customer care code of practice; and d. in other ways to be identified. 2. Develop a staff development programme with a specific focus on patient experience, with the following goals: a. all staff will understand the importance of providing a good patient experience, and its

Objective	Actions
	impact on patient and their carers and on the organisation as a whole; b. all staff will recognise their contribution to the patient experience and its improvement; c. staff concerns relating to the patient experience will be listened to and there will be a structured method of receiving this feedback; d. staff will know how to learn lessons and improve the patient experience when things do not go well; and e. staff will know how to learn, share information and reward success when things go well. 3. Review existing training programmes and introduce where appropriate a module on desired behaviours to improve the patient experience, based on these goals. 4. Address the patient experience as a key theme in Listening into Action. 5. Ensure compliance with NICE Clinical Guideline 138 in all clinical areas. 6. Continue and enhance the patient experience work stream in the Nursing and Midwifery Strategy 2011-2014, including registered nurses conducting a care round on every shift; and a review of care environments to identify improvements. 7. Liaise with local health professional education providers to: a. strengthen the acquisition of patient experience competences; and b. explore how health professional students undergoing practice learning experiences in the Trust can be fully engaged in improving the patient experience.
3: Engage patients in improving the patient experience	1. Review the effectiveness of all Trust patient engagement structures and processes, including the relevance and robustness of data we collect. 2. Routinely involve patients and shadow governors proactively in service design and development, piloting the process in a designated directorate with the free King's Fund *Experience-based co-design* toolkit. 3. Routinely involve patients and volunteers in data

Objective	Actions
	collection on the patient experience, including the Friends and Family Test, and the project involving 50 members of the public in monthly audits of noise at night across the hospital. 4. Engage patients and the public in developing the trust's annual Quality Accounts.
4: Improve services through measuring the patient experience	1. Review and streamline the range of methods we use to gather feedback from patients and relatives to understand why they would or would not recommend us to others. This will help us to determine which measures are essential and which are desirable. 2. Develop an action plan for engaging each clinical area in measurement. through assessing and piloting different metrics, including creation of a dashboard for instant feedback and action 3. Make more regular and consistent use of the Department of Health *Patient Experience First Steps (Diagnostic) Tool* (2010) to identify areas where the Trust can improve the patient experience. 4. Check the validity of our Friends and Family Test measurement, and identify how to achieve an annual 10-point improvement in our FFT score.
Organise a patient experience improvement programme	1. Establish a Patient Experience Board to lead, monitor and evaluate the Trust's patient experience improvement. 2. Use national tools and participate in national projects to enhance learning opportunities, raise the Trust's profile and seek external funding. 3. Develop a communications plan for contributing to improvement of the patient experience.

6 Overarching measures of progress

The Trust is already committed to using two overarching measures of its performance, as outlined above. Both are closely related to our patient improvement strategy (Box 4). They provide a proxy measure of our progress on improving the patient experience.

The Trust already uses the Department of Health *Patient Experience First Steps (Diagnostic) Tool* (2010). This analyses data from the National Survey of Adult In-patients to identify areas where we can improve the patient experience, focusing primarily on those where we score poorly in comparison with others. We aim to achieve a step change in our survey results over the

next three years, moving the Trust from being ‘about the same’ as other trusts to being better than 75% of other trusts.

In addition, all trusts are being asked to adopt a standardized monitoring framework or ‘headline metric’ for monitoring real time patient experience data. This is a simple metric called the Friends and Family Test (FFT). As set out in our quality strategy, we aim to achieve an annual 10-point improvement in our FFT score.

7 Resources

The Deputy Director of Nursing (Governance), sponsored by the Director of Nursing, is currently reviewing the human, training & education and financial resources needed to lead and support the improvement of the patient experience.

8 Roles and responsibilities

Trust roles and responsibilities for quality are as follows:

The **Chief Executive** is the accountable officer and has ultimate responsibility for quality in 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 in 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,** is 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 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 to discuss and report patient experience and quality issues as part of the monthly meeting, using such tools as directorate scorecards to aid scrutiny.

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

9 References and resources

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Appendix 1: *NHS Patient Experience Framework*

The *NHS Patient Experience Framework* published by the Department of Health (2012) is an important reference point. It provides, for the first time, a national evidence-based framework for patient experience, and is expected to guide the measurement of patient experience across the NHS. The elements outlined in the framework as critical to patients' experience are shown in Appendix 1.

- Respect for patient-centred values, preferences, and expressed needs, including: cultural issues; the dignity, privacy and independence of patients and service users; an awareness of quality-of-life issues; and shared decision-making.

- Coordination and integration of care across the health and social care system.

- Information, communication, and education on clinical status, progress, prognosis, and processes of care in order to facilitate autonomy, self-care and health promotion.

- Physical comfort including pain management, help with activities of daily living, and clean and comfortable surroundings.

- Emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families and their finances.

- Welcoming the involvement of family and friends, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as care-givers.

- Transition and continuity as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions.

- Access to care with attention, for example, to time spent waiting for admission or time between admission and placement in a room in an in-patient setting, and waiting time for an appointment or visit in the out-patient, primary care or social care setting.

Appendix 2: NICE quality statements

These quality statements are from the 2012 NICE clinical guideline 138 and quality standard on patient experience in adult NHS services in England.

1 Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

2 Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills.

3 Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.

4 Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.

5 Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.

6 Patients are actively involved in shared decision making and supported by healthcare professionals to make fully informed choices about investigations, treatment and care that reflect what is important to them.

7 Patients are made aware that they have the right to choose, accept or decline
treatment and these decisions are respected and supported.

8 Patients are made aware that they can ask for a second opinion.

9 Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.

10 Patients have their physical and psychological needs regularly assessed and
addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.

11 Patients experience continuity of care delivered, whenever possible, by the same healthcare professional or team throughout a single episode of care.

12 Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals.

13 Patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care.

14 Patients are made aware of who to contact, how to contact them and when to make contact about their ongoing healthcare needs.

Guidance

1.1 Knowing the patient as an individual
Patients value healthcare professionals acknowledging their individuality and the unique way in which each person experiences a condition and its impact on their life. Patients' values, beliefs and circumstances all influence their expectations of, their needs for and their use of services. It is important to recognise that individual patients are living with their condition, so the ways in which their family and broader life affect their health and care need to be taken into account.

1.2 Essential requirements of care
Patients have needs other than the treatment of their specific health conditions. There should be recognition of the potential need for psychological and emotional support, as well as of the importance of meeting fundamental needs such as nutrition and pain management. Attention to these fundamental needs applies particularly to inpatient settings, but they should also be addressed in other settings where healthcare is provided.

1.3 Tailoring healthcare services for each patient
Patients wish to be seen as an individual within the healthcare system. This requires healthcare professionals to recognise the individual, and for services to be tailored to respond to the needs, preferences and values of the patient. Advice on treatments and care, including risks and benefits, should be individualised as much as possible.

1.4 Continuity of care and relationships
Continuity and consistency of care and establishing trusting, empathetic and reliable relationships with competent and insightful healthcare professionals is key to patients receiving effective, appropriate care. Relevant information should be shared between professionals and across healthcare boundaries to support high-quality care.

1.5 Enabling patients to actively participate in their care
Many patients wish to be active participants in their own healthcare, and to be involved in creating and managing their health strategy and use of services. Self-care and self-management are particularly important for people with long-term conditions.

Appendix 3: Programmes, resources and toolkits

NHS Institute for Innovation and Improvement (undated). *Transforming Patient Experience: the essential guide.* This is a free online resource that aims to provide the evidence needed to influence people at board and team level to focus on improving patient experience. It offers research evidence, stories from patients and staff and innovative ideas.
The Trust is using this free resource to ensure that its strategy is evidence-based and to stimulate innovative thinking.

The King's Fund *Experience-based co-design* toolkit gives a step-by-step guide to improving patient experience using a technique called experience-based co-design (EBCD). It can improve services in a way that really makes a difference to patients and service users. It captures the experiences of patients, carers and staff through discussion, observation and filmed interviews. It then brings staff and patients together to explore the findings and to work in small groups to identify and tackle areas for service improvement. It was designed for and within the NHS to develop simple solutions that offer patients a better experience of treatment and care. This comprehensive online toolkit includes free downloadable resources such as template forms, letters, presentations and other materials.

The Trust proposes to use this excellent free resource to help us implement our new strategy.

The NHS Institute for Innovation and Improvement (NHSI) *NHS Patient Feedback Challenge* will provide an opportunity to radically transform patient experience, to spread this learning widely across healthcare systems, and reward those who are making this happen. It is backed by a £1m challenge fund which will support the development of ambitious demonstration sites that:

- Develop a fully integrated patient experience measurement system that leads to continuous improvement cycles.
- Create wholly patient focused organisations.
- Encourage spread and adoption of positive patient experience practice within and across organisations.
- Develop sustainable approaches that live beyond the initial programme.

The Trust is currently exploring whether to apply for this new programme.

BOARD SUMMARY SHEET	
Title	Carbon Management Plan
Submitted by	Charles Abolins, Director of Facilities and Capital Development
Date of meeting	27th June 2012
Corporate Objectives Addressed	**Ensure most efficient, effective and productive use of resources**

SUMMARY OF CRITICAL POINTS

The Trust is required to reduce carbon emissions in accordance with NHS Carbon Reduction Strategy and this is reflected in commissioning plans for the Trust. Targets set include a 10% reduction by 2015 and 34% by 2020 and the implementation of a Carbon Management Plan (CMP).

This Carbon Management Plan defines our carbon management programme of activity until the end of 2015/16. It sets out the strategic context, the current level of carbon emissions, the programme of proposed projects and actions to reduce our emissions. The plan outlines how much this will cost and save, as well as the governance arrangements to keep the programme on track.

PATIENT IMPACT

Improved internal environment – temperature, ventilation and lighting effectiveness.
Improved air quality – reduced emissions for burning natural gas and other fossil fuels.
Mitigation of climate change impacts – reduction of greenhouse gas emissions.

STAFF IMPACT

Improved internal environment – temperature, ventilation and lighting effectiveness.
Improved air quality – reduced emissions for burning natural gas and other fossil fuels.
Mitigation of climate change impacts – reduction of greenhouse gas emissions.

FINANCIAL IMPACT

Effective delivery of the CMP will result in a £1m reduction or cost avoidance in energy costs by 2015.

EQUALITY AND DIVERSITY IMPACT

LEGAL IMPLICATIONS

RISK ASSESSMENT

RECOMMENDATION

The Trust Board are asked to review the content of the plan and give their support to the implementation of the programme.

Carbon Management Plan 2012

Northampton General Hospital NHS Trust
Cliftonville
Northampton
NN1 5BD

This Carbon Management Plan describes our 5-year commitment to reduce the Trust's carbon dioxide emissions by 25% and realise around £1 million per year in avoided energy costs

Contents

Carbon Management Plan (CMP)

Foreword from Dr Gerry McSorley, Chief Executive

I am pleased to present this Carbon Management Plan for Northampton General Hospital NHS Trust. Sustainability is fundamental to how we plan for the future and are fully committed to supporting the Trust objective to reduce our impact on the environment through the delivery of our healthcare services.

This document sets out how we plan to reduce carbon emissions. Reducing our carbon emissions will not only equate to cost savings but will also have direct public health benefits for our patients and the wider community. We therefore see this as a positive step in ensuring the delivery of cost effective, safe, and excellent quality patient care in fit-for-purpose environments.

We have already begun to optimise the performance of our estate and we have achieved the 10% reduction target (against a 2007 baseline) that we set ourselves in 2009; implementing energy efficiency opportunities, integrating sustainability criteria into our maintenance, refurbishment and procurement policies and using our space more efficiently wherever possible.

This plan sets a new carbon reduction target, a further 25% or 3,800 tonnes less CO_2 emitted per year to be achieved by March 2016. The target is set against a new baseline carbon footprint for 2010 of 15,442 tonnes per year.

This will be a challenging target but with foundations already in place together with robust plans for the future I am confident of success.

1. Introduction

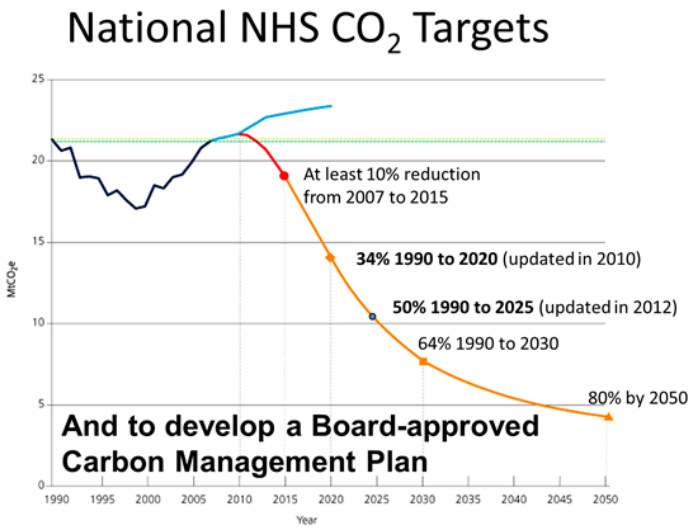
This Carbon Management Plan defines our carbon management programme of activity until the end of 2015/16. It sets out the strategic context and the 'case for action', our current carbon emissions, our programme of proposed projects and actions to reduce our emissions, how much this will cost and save, as well as the governance arrangements to keep our programme on track.

2. The national context for Carbon Management

It is now widely recognised that climate change is a serious threat to life, our health, and our wellbeing. Unless effective action is taken now, millions of people around the world will suffer hunger, water shortages and coastal flooding as the climate changes. The scale of the transformation we need to make to avoid dangerous climate change is huge; however it is clear that the NHS, as one of the world's largest organisations, is uniquely placed to realise the health, social and financial benefits from carbon reduction. We have a national and international mandate to act in order to make a real difference and to set an important example.

Measures to increase energy efficiency will reduce energy costs, which is particularly important for the future given the predicted increases in energy prices and increasingly constrained financial resources. Energy and fuel costs continue to rise and this trend is expected to accelerate.

The increasing cost of fossil fuels, concerns regarding climate change and the long term stability and resilience of the UK's energy supply systems have made Carbon Management become an integral part of being a resource efficient, financially viable organisation. Carbon management is likely to become increasingly part of the regulatory and NHS performance management framework.



The UK Government has placed an emphasis on the public sector setting a leading example on Climate Change. Public sector leadership will be critical to the achievement of the Government's climate change objectives.

The Climate Change Act 2008 specified legally binding carbon reduction targets of at least 34% by 2020, and a reduction of at least 80% by 2050, against a 1990 baseline.

Figure 1: UK and NHS Carbon Reduction Commitments

The NHS Sustainable Development Unit published the NHS Carbon Reduction Strategy, "Saving Carbon, Improving Health" setting a target for NHS Trusts to reduce their carbon emissions by at least 10% between 2007 and 2015, 34% by 2020, 50% by 2030 and 80% by 2050 and to develop a Board approved carbon management strategy. See Figure 1.

As a major employer and through its business activities, Northampton General Hospital as a healthcare provider that promotes wellbeing, the Trust has an important responsibility to minimise the impact on the environment, ensure efficient use of resources and maximise funds available for patient care.

Increasingly it will be seen that Regulators and Commissioners of services will incorporate sustainability and the effective use of natural resources in their performance management, compliance and contracting regimes. This will require Trusts to demonstrate commitment and progress towards reducing their carbon footprint. Healthcare and sustainability are inextricably linked. Reducing carbon emissions will enable the Trust to improve public health, meet its legislative requirements and to save money.

3. Our low carbon vision and target

Our Vision:

Northampton General Hospital NHS Trust will continue to build on its reputation as a Good Corporate Citizen by:

- ***Cutting its greenhouse gas emissions ahead of national requirements***
- ***Reducing its consumption of finite resources and dependency on fossil fuels***
- ***Protecting the environment and the communities it serves***

Our Target:

Northampton General Hospital NHS Trust will reduce the carbon emissions from its buildings and vehicles by 25%, from a 2010 baseline, by the end of 2015.

4. Our drivers for reducing our carbon emissions

Climate change is globally recognised as the greatest environmental and economic threat faced by national governments and individuals. It is also an opportunity for energy efficiency and financial savings.

Below we set out, our main drivers for taking action to reduce our carbon emissions and energy consumption:

- Meeting our commitments as part of the NHS and the Public Estate
- Environmental savings and natural resource efficiency
- Financial savings
- Ensuring legislative and audit compliance
- Enhancing and maintaining our reputation
- As a tool for retention and recruitment of our workforce
- Health and wellbeing of patients and the community

5. The local context for our Carbon Management Plan

In response to the 2009 NHS Carbon Reduction Strategy we initiated a programme of initiatives that also helped NGH save money year on year on its total energy bill of £2.5 million.

As a first step we launched our 2009 Energy Strategy setting out our first carbon reduction target of 10% by 2015 from a 2007 baseline, a target that we have already achieved.

This enabled us to achieve early wins whilst developing a far wider reaching and long term Sustainability Strategy, approved by Board in April 2010. The Sustainability Strategy and the Sustainability Committee that it brought in to being has enabled us to engage decision makers across the Trust in the key sustainability issues we face including energy, climate change, waste and transport.

The resulting Sustainability Action Plan (December 2010) set out objectives for all Directorates to achieve and the creation of a specific Carbon Management Plan to target effort on reducing greenhouse gas emissions and driving down the impact of energy demand and cost increases was one of those objectives.

6. Partnership with the Carbon Trust

Following our expression of interest to the Carbon Trust in 2010, we were accepted on to the sixth phase of the NHS Carbon Management (NHSCM) Programme. From June 2011 to March 2012 we have been working through the 5 step Carbon Management process, with technical and change management support provided by the Carbon Trust and Programme Advisors.

This 5 step programme involves:

- Mobilise the organisation – building the team and determining the scope.
- Set Baseline, forecast and targets – setting the baseline for the programme and its goals
- Identify and Quantify options – identifying the risks and opportunities presented by climate change
- Finalise strategy and implementation plan – designing a cost effective strategy to cut emissions and save money
- Implement the plan – complete with budgets, targets and success metrics.

The process helped us create a systematic analysis of our carbon footprint and develop a structured action plan for realising carbon savings and embedding best practice in the organisation's day-to-day operations.

7. Emissions baseline and projections

8. Our Baseline

As a baseline, we have assessed our carbon footprint in line with the Greenhouse Gas Protocol Initiative which is the most widely used international accounting tool for government and business leaders to understand, quantify and manage greenhouse gas emissions. The protocol was developed by the World Resources Institute and the World Business Council for Sustainable development.

This has allowed us to quantify our carbon emissions sources, allow monitoring of our action plan and is summarised in Table 1 and **Figure 2** below. All annual figures coincide with our financial accounting periods and run from April through to March (i.e. 2010 implies the year April 2010 to March 2011).

9. Stationary Sources

The Trust operates from the large single Cliftonville campus with a centralised gas-fired steam plant and distribution system.

The emissions that come from energy used in buildings represents 97% of our Carbon Footprint. Almost all of the energy is provided by either natural gas or grid-supplied electricity with a very small amount of oil consumed by back-up generators and main boiler testing.

10. Transport Sources

Fuel consumed and distance travelled by staff whilst on Trust business has been established directly from travel claims and from fuel card invoices. Transport emissions account for around 3% of our Footprint emissions.

11. Further Sources

Further emissions sources have also been established:

- Water consumption has been established from a metered consumption via invoices
- Refrigerant has been collated from chiller maintenance reports
- Waste has been collated from invoices supplied by our waste management contractor

Significantly, the carbon emissions from our waste is counted as zero because our waste management contractor ensures that none of the waste generated by the Trust is sent to landfill i.e. it is all re-used, recycled or burned with energy recovery.

	CO_2 (tonnes)	**%**	**Cost (£)**
Stationary	14,950	97%	£2,750,000
Transport	402	3%	£240,000
Further Sources	90	1%	£330,000
	15,442	**100%**	**£3,320,000**

Table 1: Summary Breakdown of Baseline Emissions

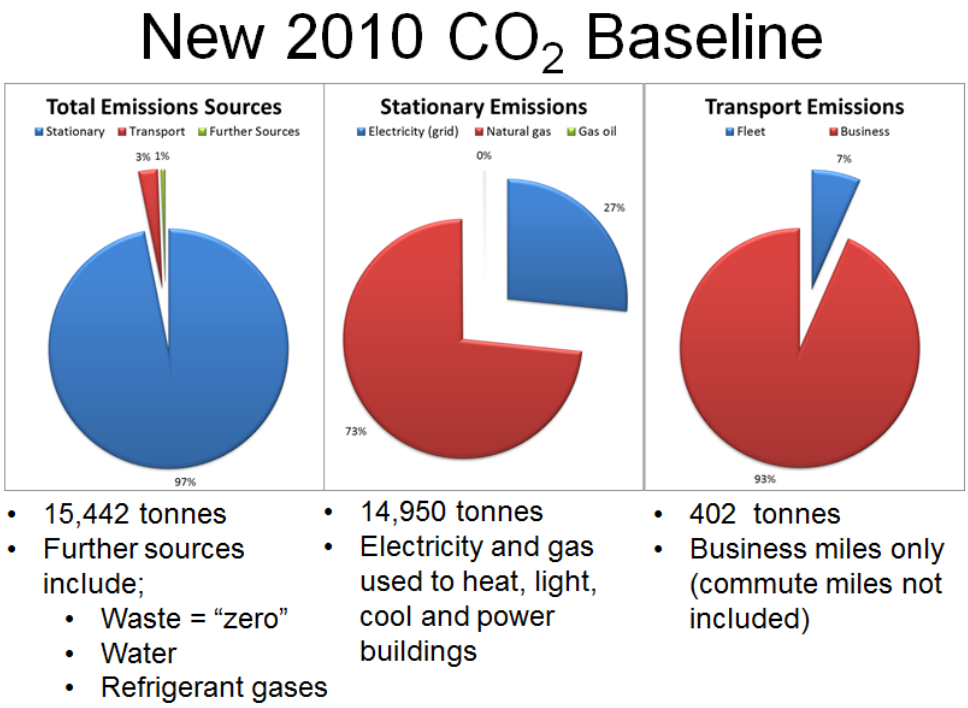


Figure 2: Summary Breakdown of Baseline Emissions

12. Emissions Projection and Value at Stake

The Value at Stake (VAS) is the year-on-year difference between the Business as Usual (BAU) and Reduced Emissions Scenario (RES) approaches. The Value at Stake illustrates the expected savings, or avoided cost, from implementing our plan and hitting our target against the alternative of doing nothing (BAU).

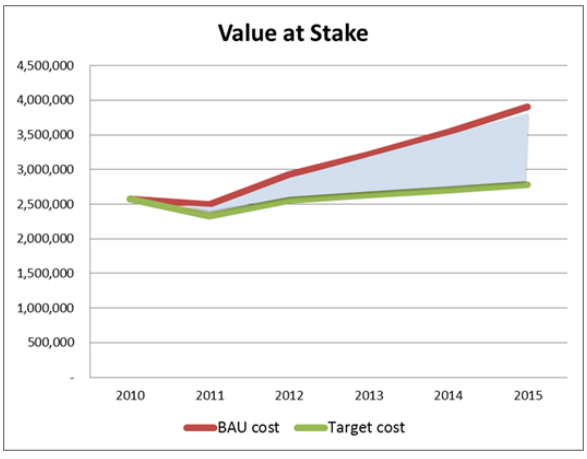


Figure 3 shows the VAS as the difference between the BAU scenario (our costs if we take no action to reduce our carbon emissions) and the RES scenario (our costs if we meet our reduction target). It can be seen that the RES is actually on a slight upward trend; this is due to the effect of increasing energy costs. The difference between this line and the VAS line (shown shaded) represents the cost savings or avoided costs.

Figure 3: Financial Value at Stake

Table 2: Final year financial impacts

shows that the the CMP is projected to save over £1 million in energy and fuel costs and £50,000 in reduced Carbon Reduction Commitment tax (at todays level of £12 per tonne CO_2)

Table 2: Final year financial impacts

Final year annual cost breakdown	BAU	RES
Energy and Fuel Cost	**£3,728,313**	**£2,660,521**
CRC	**£174,869**	**£124,786**

13. Carbon Reduction Projects

In total 62 emissions reductions projects were identified and selected for prioritisation and consists of existing projects that have been implemented since the baseline year together with short, mid and long term projects to be implemented. Around 60% of the emissions reductions are expected to come from the existing and short term projects which account for around 60% of the financial investments see Figure 4.

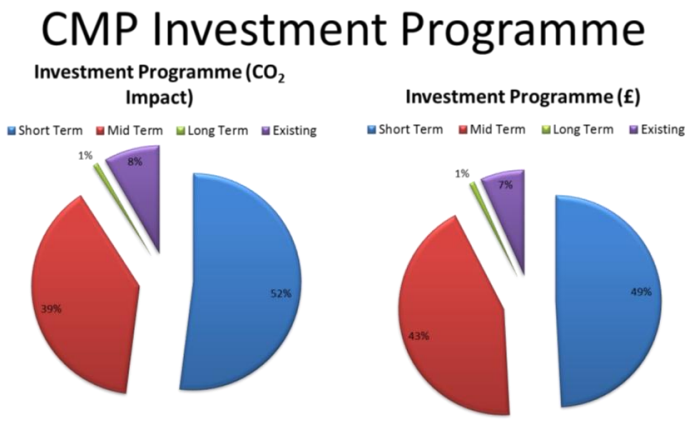


Figure 4: Project Investments

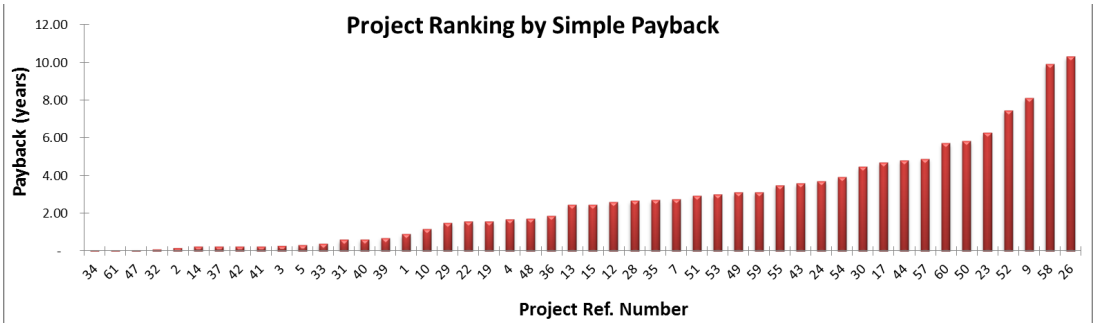


Figure 5: Project Payback

The prioritisation of projects was based on analysis to determine their payback or return on investment. Figure 5 illustrates the range of projects and paybacks considered, It is essential that projects that offer the best return are undertaken early so that the financial returns can be used to part fund further investment so that overall financial and carbon benefits can received for longer.

14. Summary of Short Term and Existing Projects

Because we have already begun implementing short term carbon reduction projects these are projects that are implemented from 2010/11 to 2013/14. Key aspects of these projects include:

- £940,000 investment
- Over £600,000 secured from the SALIX scheme (2012/12 and 2012/13)
- Average payback 1.5 years
- Includes
  - Studies/audits
  - Lighting projects
  - Insulation projects
  - Awareness raising & Training
  - Metering and monitoring
  - Departmental Energy Budgets

15. Summary of Mid Term Projects

These are projects that are implemented from 2013/14 to 2015/16. Key aspects of these projects include:

- £2.4 million investment
- Average payback 4 years
- Includes
  - Energy Centre re-investment
  - Renewables, PV possible biomass wood fuel
  - Insulation projects
  - Awareness raising & Training

16. Long Term Projects

These are projects that are expected to be implemented after 2016/17 and have a longer term payback.

17. Achieving the 25% target

All projects that have been identified have been quantified using the energy model described in section 8 and have been peer reviewed and corrected by both the Trust and the additional expertise afforded to the Trust through the Carbon Trust's Carbon Management Programme.

The total potential emissions reduction that has been identified as achievable within the Project list is over 5,750 tonnes CO_2 which exceeds our stated target by 50%. However, these savings must be weighted to account for the potential uncertainty in implementation of the projects.

Each project was reviewed in terms of confidence in implementation including availability of finance and given a weighting. The weightings used depend on the certainty associated with implementing the projects with each receiving a weighting of ether 100%, 75% or 50% and these weightings were used to amend the savings that could be expected. The resulting weighted emissions reduction accounts for 100% of the target, i.e. after the weightings were taken into account the Project list savings matched our stated target.

All figures calculated within this Plan are estimates based on best available knowledge at the time of writing. Figure 6 shows the predicted business-as-usual (BAU) emissions and the target emissions over the life time of this Plan.

The 'emissions in chosen plan' line shows the emissions reductions from the identified projects including the effect of BAU forces. BAU forces represent trends such as continuing increase in demand due to expansion of service provision etc. These trends act as a background to the projected emissions reduction plan imposing an upward pressure against which the reduction projects must compete e.g. if in year 3 no additional projects were implemented the emissions would begin an upward trend parallel to the BAU line.

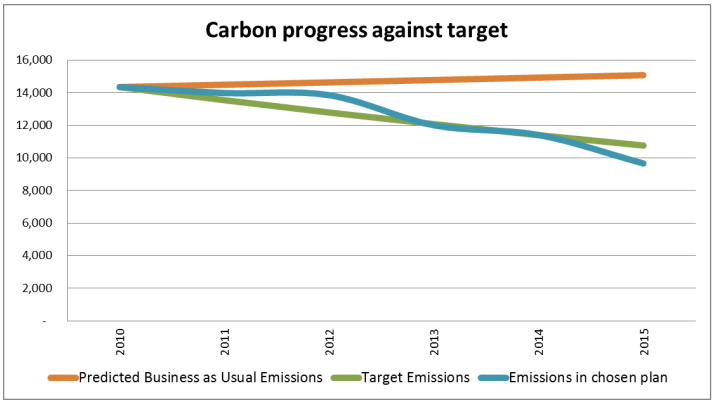


Figure 6: Projected Carbon Reduction Progress

18. Carbon Management Plan Financing

To implement all of the projects defined in the Project list it will cost £3.4 million:

- Around £1M has been identified for existing and short term projects; of which
- Over £650,000 has already been secured from SALIX funds
- A further £2.4 million will be required for mid term projects with a collective payback of under 5 years.

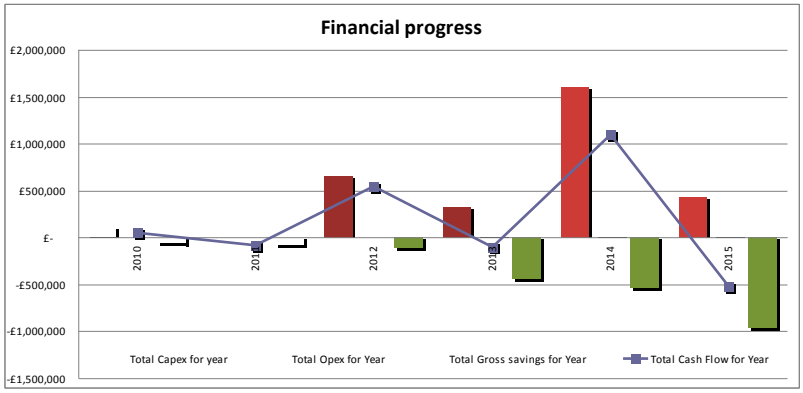


Figure 7 illustrates the financial aspects of the Plan and shows how the projects deliver a negative net cost i.e. **a positive saving, within the lifetime of the Plan**.

Figure 7: Financial Progress Summary

19. Quantified Benefits

The Plan sets out a route to achieve significant financial savings for the Trust. Figure 7 shows how it can achieve a positive return on the investment within the 5 years of the Plan and Figure 8 summarises the annual financial and carbon benefits.

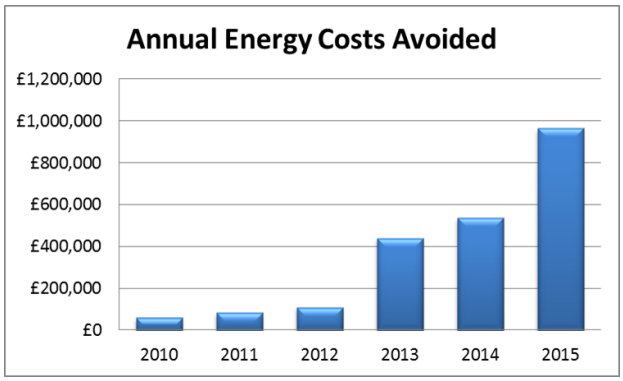


Figure 8: Financial savings

20. Un-quantified Benefits

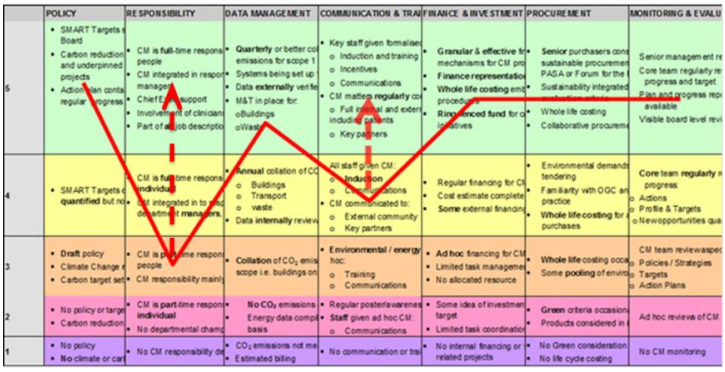
There are also benefits from the Plan which cannot be quantified. For example:

- A better working environment for staff
- A healthier environment for patients
- Encouraging healthier, low-carbon living from staff & patients
- Contributions to wider sustainable development within the local economy
- Placing the Trust at the forefront of the NHS strategy to reduce greenhouse gas emissions

21. Funding and sources of funding

All short term Projects have had funding identified from within existing budgetary provision. However, it is important to recognise that it is anticipated that the Trust will identify and acquire sources of external funding, within a Board-approved business case, where it is deemed beneficial to the Trust. This is likely to include external, third-party finance provided by technology or utilities providers and may be based on shared financial returns.

22. Embedding Carbon Management into the Trust



The Trust has already done much to ensure that carbon issues are embedded in the management decisions of the hospital. An assessment of our approach is shown in the carbon management assessment matrix used by the Carbon Trust reproduced in Figure 9 which highlights two aspects.

Figure 9: Carbon Management Matrix

Whilst the Trust scores a maximum 5 in most areas – indicating a high level of embeddedness - the profile shows a low score with respect to;

- "Responsibility": this reflects the fact in the context of an acute hospital under increasing financial constraints Carbon Management cannot be justified as a single full time occupation.
- "Communications and Training". Sustainability training is already delivered within staff induction training with additional detailed training is provided to key domestic and security staff that can play a role in demand management. Under this Plan and continuing within the Action Plan embedded within the Trust's Sustainability Strategy that training and communications on energy and carbon will receive an increasing focus and greater resources.

Annual reporting of carbon emissions has already been incorporated into the Trust's annual accounts and reports and with Board approval and adoption of our Energy Strategy and Sustainability Strategy in 2009 and 2010 respectively we have ensured a strong corporate ownership with responsibilities at senior levels across the Trust.

The Sustainability Committee will continue to oversee the operational delivery of the Carbon Management Plan and report progress regularly to the Trust Board.

23. The management of our CMP

Sustainability and Carbon Management as a core element is a complex agenda which requires leadership, transformational change and an understanding of corporate social responsibility in order to ensure successful implementation of the strategy.

The Sustainable Development Committee, as a sub Committee of the Hospital Management Group (HMG) will oversee the implementation of this Carbon Management Plan within its approved Terms of Reference. The Committee meets no less than four times per year and will report progress to the Trust Board.

The establishment of our Sustainability Committee has allowed us the create a fully inclusive and senior level Carbon Management Plan Programme Board and Project Team that will oversee and manage our Carbon Management Plan and ensure that its delivery is fully embedded.

The Carbon Management Plan Programme Board will meet within the framework of our Sustainability Committee structure, whilst the Project Team will meet bi-monthly and reflect operational activities.

24. The Carbon Management Team – delivering the projects

Project Team		
Project Leader	Dr C Topping	Energy & Sustainability
Carbon Management Team members	Stuart Finn (Deputy Project Leader)	Facilities and Estates
	Andrea Chown	HR & Workforce Development
	Bill Wood	Clinical Services- Nursing
	Dr Natasha Robinson	Clinical Services - Medical
	Peter Kennell	Communications and PR
	Maintenance Manager (TBC)	Buildings, Maintenance & Water management
	Derek Stewart	Finance
	Brian Willett	Travel & Transport
	Andy Watkins	Waste management
	Allan Rivans	Procurement
	Sanjiv Lal	I.T. Services
	Fred Evans	Board of Governors

Project Sponsor: Charles Abolins Director of Facilities.

13

Northampton General Hospital NHS
NHS Trust

TRUST BOARD SUMMARY SHEET	
Title: -	2012/13 Corporate Objectives and Board Assurance Framework
Submitted by: -	Dr G McSorley, Chief Executive
Date of meeting: -	27th June 2012
Corporate Objectives Addressed: -	All

SUMMARY OF CRITICAL POINTS: -

The Trust Board has agreed the attached Corporate Objectives for the year 2012/13 with details of measures of success. The Board will receive quarterly updates as to progress.

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 2012/13 BAF provides the Trust Board with an assessment of the risks and current mitigations and progress.

PATIENT IMPACT: -
High

STAFF IMPACT: -
High

FINANCIAL IMPACT: -
High

EQUALITY AND DIVERSITY IMPACT: -

LEGAL IMPLICATIONS: -

RISK ASSESSMENT: -

RECOMMENDATION: -

The Board is asked to review, discuss and approve the attached Board Assurance Framework

Northampton General Hospital NHS
NHS Trust

DRAFT CORPORATE OBJECTIVES 2012/13

Aims	Objectives	Measures of Success
Be a provider of quality care for all our patients	Invest in enhanced quality including improvements in the environment in which we deliver care	• Reduction in SHMI and HSMR • Demonstrated improved clinical effectiveness as demonstrated through NICE compliance and effective use of clinical audit • Reduction in harm to patients as measured through patient safety programme metrics • CQC Scores • Patient & Staff Surveys • PEAT Scores • Estate KPIs
Enhance our range of hyper acute services for the wider community	Develop critical clinical care pathways to deliver effective integrated care as part of the Acute Services Review.	• To deliver the countywide vascular service from 1 April 2012 • To renegotiate the contract for oncology services with Milton Keynes Hosptial NHS Foundation Trust by 30 June 2012
	Develop strategic approaches to relationships with other health provider and stakeholder organisations	• To agree a concordat for the development of a strategic relationship with Nene Commissioning by 30 June 2012 • To investigate the development of closer links with KGHFT through the establishment of a federated model
Provide appropriate care for our patients in the most effective way	Enhance all urgent care pathways, including critical care	• Achieve Urgent care standards by Jan 2013 • Increased critical care and level 1 capacity by

Aims	Objectives	Measures of Success
		reducing delayed transfers by December 2012 • Reduced outliers to less than 10 for both medical and surgical by September 2012 • Reduce DTOC by 50% by Jan 2013 • Reduce Bed occupancy to 95% by Jan 2013 • Eliminate the use of all escalation areas by December 2012
	Use information on quality, finance & demand to determine service priorities	• Implement specialty scorecard including service line reporting, quality and activity information • Clinical acceptance of basis of preparation of service line reporting and confidence to use in decision making • Service line reporting information providing input into Trust's response to Acute Services Review
Foster a culture where staff can give their best and thrive	To enhance staff, patient and public engagement	• Improved Staff Survey • Improved Patient Survey • Nurses Dashboard • Staff turnover • Bank / agency use • Mandatory Training Scores
	Establish an exemplar leadership development programme to ensure we attract, recruit and retain the highest quality staff	• Improved Staff Survey • Improved Patient Survey • Nurses Dashboard • Staff turnover • Bank / agency use • Mandatory Training Scores

Aims	Objectives	Measures of Success
		• Development of exemplar leadership programme
Ensure we invest wisely to make improvements in care	To develop, implement and sustain transformation in the way we deliver our services in order to maintain quality, deliver improvement in surplus margin and deliver c£19million reduction in cost base by the end of 2012/13	• Deliver £19.0m cost improvements in 2012/13 financial year. Increase surplus margin by £0.5m to £1.0m for 2012/13 financial year

BOARD ASSURANCE FRAMEWORK 2012/13
May 2012

BAF No. / Linked Risk	Risk Type: Link to CQC/NHSLA/ National Target	Risk Description	Director Responsible	Key Controls	Potential Sources of Assurance	Gaps in control	Gaps in assurance	Consequence	Likelihood	Risk Rating	Risk mitigation/control plans	Progress against Mitigation	Action Update	Committee Responsible	Date Discussed at Board
	Which Outcome/ Standard/ Aim the risk relates to	**What could prevent this corporate objective being achieved**	**Lead Executive Director**	**What controls/ systems we have in place to assist securing delivery of our objectives**	**Where we can gain evidence that our controls/ systems on which we are placing reliance are effective**	**Where are we failing to put effective controls/ systems in place**	**Where are we failing to gain evidence about the effectiveness of one or more controls we are relying on**	**Obtained using Trust's risk matrix**			**Plans to address the gaps in control and/ or assurance and indicative completion dates**	**Progress made implementing action plans to address gaps in control and/ or assurance**			
Trust Aim: Be a provider of quality care for all our patients															
TRUST OBJECTIVE 1: Invest in enhanced quality including improvements in the environment which we deliver care															
BAF1 (link to Risk ID 32, 36, 22, 12, 231) O16 O7 IBP Risk 1	Principle Risk affecting delivery of core aims, CQC outcomes, NHSLA standards, patient safety	**Risk of failure to continue improvement in line with CQC, other mandatory regulatory bodies e.g. NHSLA and learn from incidents and complaints**	Director of Nursing (with MD)	Board approved Quality Strategy, Risk Management Strategy, Patient Safety Strategy, Clinical Governance Review Scheme in place Compliance monitoring schemes	CQEG meetings and minutes SMB meeting and minutes HGC meeting and minutes Trust Board meetings and minutes Patient Safety Board Patient Safety Learning Forum Patient Safety, Clinical Quality & Governance quarterly report (includes complaints, incidents, learning from harm etc.) Board walkabouts Confirm and Challenge process	Reports to committees not always complete and challenged Governance structures still evolving	Information quality and record keeping incomplete information	**4**	**4**	**16**	Improved information and reporting schedules Reports have improved and agreed reporting schedules planned by May 2012	Safety leads appointed and plans for Safety Academy in place	June 2012	HGC	Monthly Performance report, most recently May 12 Monthly Medical Director's Report, most recently May 12

BAF No. / Linked Risk	Risk Type: Link to CQC/NHSLA/ National Target	Risk Description	Director Responsible	Key Controls	Potential Sources of Assurance	Gaps in control	Gaps in assurance	Consequence	Likelihood	Risk Rating	Risk mitigation/control plans	Progress against Mitigation	Action Update	Committee Responsible	Date Discussed at Board
	Which Outcome/ Standard/ Aim the risk relates to	**What could prevent this corporate objective being achieved**	**Lead Executive Director**	**What controls/ systems we have in place to assist securing delivery of our objectives**	**Where we can gain evidence that our controls/ systems on which we are placing reliance are effective**	**Where are we failing to put effective controls/ systems in place**	**Where are we failing to gain evidence about the effectiveness of one or more controls we are relying on**	**Obtained using Trust's risk matrix**			**Plans to address the gaps in control and/ or assurance and indicative completion dates**	**Progress made implementing action plans to address gaps in control and/ or assurance**			
BAF 2 (Link to Risk ID 32,36) O4 O16 IBP Risk 1	Principle Risk affecting delivery of core aims, CQC outcomes, NHSLA standards, patient safety	**Risk of failure to investigate and instigate improvement plans for any area that has concerns re HSMR**	Medical Director	Dr Foster monitoring process Mortality/HSMR review project Ophthalmology Action Plan	CQEG and HGC meeting minutes Trust Quality Scorecard reported to Board Task and finish groups (#NOF, Septicaemia) Strategic Management Board reporting Monthly Trust Board reports	Data issues that cause confusion	Nil	**5**	**4**	**20**	Continue current focus and explore further external support and analysis Extensive audit in place supported by clinicians across the specialties	HSMR falling and improvements noted, focus maintained	June 2012	HGC Trust Board	Monthly Medical Directors Report most recently May 12
BAF 3 (link to Risk ID20)	Principle Risk affecting delivery of core aims, CQC outcomes, NHSLA standards, patient safety	**Risk of failure to follow up patients which serious eye disease or other key quality outcomes compared to other trends**	Medical Director	Ophthalmology action plan Monitoring of plans by CQEG	CQC HGC Directorate Management meetings	Insufficient ownership at service level	Inadequate progress to solve difficult issues requiring long term solutions and investment	**5**	**4**	**20**	Additional Consultant recruitment	Consultant advertisement placed	June 2012	HGC	Risk Register discussion, April 2012
BAF 4 (link to risk 13) O4	Principle Risk affecting delivery of core aims, CQC outcomes, NHSLA standards, patient safety	**Risk of failure to adequately address recommendations of external reports**	Medical Director	Agreed process for receiving and disseminating reports from National Clinical Audits, NCEPOD other external reports with gap analysis	Actions required reported on directorate governance reports Reporting and monitoring to CQEG and HGC	Gap analysis may be incomplete Audit data may be incomplete	Poor reports received or reports highlight issues that are impossible to solve	**4**	**4**	**16**	Quality of reporting of external reports/gap analysis continually improved. National Audit reflection mandatory for Consultant Revalidation	Care Group schedule asked to focus on resolving cross specialty issues	June 2012	HGC	Quarterly Patient Safety, Clinical Quality & Governance Report, Trust Board, most recent April 2012

BAF No. / Linked Risk	Risk Type: Link to CQC/NHSLA/ National Target	Risk Description	Director Responsible	Key Controls	Potential Sources of Assurance	Gaps in control	Gaps in assurance	Consequence	Likelihood	Risk Rating	Risk mitigation/control plans	Progress against Mitigation	Action Update	Committee Responsible	Date Discussed at Board
	Which Outcome/ Standard/ Aim the risk relates to	**What could prevent this corporate objective being achieved**	**Lead Executive Director**	**What controls/ systems we have in place to assist securing delivery of our objectives**	**Where we can gain evidence that our controls/ systems on which we are placing reliance are effective**	**Where are we failing to put effective controls/ systems in place**	**Where are we failing to gain evidence about the effectiveness of one or more controls we are relying on**	**Obtained using Trust's risk matrix**			**Plans to address the gaps in control and/ or assurance and indicative completion dates**	**Progress made implementing action plans to address gaps in control and/ or assurance**			
BAF 5 (link to Risk ID 256) O10	Principal Risk affecting delivery of core aims Safety and Suitability of Premises	**Risk of failure of estate infrastructure**	Director of Facilities	Annual Plan risk prioritisation 5year Capital Programme approved by Board Board approved Estate Strategy Business continuity plan Environmental Audits within Infection Prevention Estate related policies e.g. Legionnaires on intranet	External review of statutory compliance by regulatory bodies Insurance inspections CQC Outcome compliance Inspections regime for policy compliance monitored through Estates processes	Mandatory training compliance	Nil	**5**	**4**	**20**		Maintaining focus on ensuring 100% training compliance			
BAF 6 (link to Risk ID256)	Principal Risk affecting delivery of core aims Safety and Suitability of Premises	**HSE has formally informed the Trust that it is currently in breach of the law with regard to the management of COSHH. The HSE have given the Trust a short timeframe (3-6 months) to resolve this situation. Failure to resolve will result in the HSE taking enforcement action**	Director of Facilities	Regular reporting to Trust Board of progress against action plan Formation of Steering Group	Health & Safety Committee reports CQEG reports with escalation as necessary to HGC	Nil	Nil	**5**	**4**	**20**	Board approved action plan developed Steering Group established to monitor the implementation of the Action plan Monitoring of progress through CQEG and HGC Review the need to appoint temporary staff to assist with implementing action plan	Two meeting held and third one imminent, actions agreed currently on plan			
BAF 7 O13	Principle Risk affecting delivery of core aims, CQC outcomes, NHSLA standards, patient safety	**CQC are aware that staff have raised concerns re nursing staff shortages and the potential impact on nursing care**	Director of Nursing, Midwifery & Patient Services	Action Plan discussed at CQEG Triangulation of data, complaints, PALS, incidents in relation to staffing down to ward level which will be reviewed on a monthly basis	Staff survey Risk Register CQC Inspection Internal Bank & Agency meetings CQC Assessments Performance Indicators	Maintaining data quality	Data quality	**4**	**4**	**16**	Reviewed issues raised, action plan in place Continually verify that data presented to bank and agency group is correct, triangulating with other sources of assurance HR plan discussed at CQEG	Triangulation of data underway Majority of wards have met and shared CQC response and action. HR plan discussed at CQEG	June 2012	HGC	SNCT January 2012

BAF No. / Linked Risk	Risk Type: Link to CQC/NHSLA/ National Target	Risk Description	Director Responsible	Key Controls	Potential Sources of Assurance	Gaps in control	Gaps in assurance	Consequence	Likelihood	Risk Rating	Risk mitigation/control plans	Progress against Mitigation	Action Update	Committee Responsible	Date Discussed at Board
	Which Outcome/ Standard/ Aim the risk relates to	**What could prevent this corporate objective being achieved**	**Lead Executive Director**	**What controls/ systems we have in place to assist securing delivery of our objectives**	**Where we can gain evidence that our controls/ systems on which we are placing reliance are effective**	**Where are we failing to put effective controls/ systems in place**	**Where are we failing to gain evidence about the effectiveness of one or more controls we are relying on**	**Obtained using Trust's risk matrix**			**Plans to address the gaps in control and/ or assurance and indicative completion dates**	**Progress made implementing action plans to address gaps in control and/ or assurance**			
BAF 8 (link to Risk ID 9) O13	Principle Risk affecting delivery of core aims, CQC outcomes, NHSLA standards, patient safety	**Continue to have high use of Bank and Agency staff due to existing vacancies and ward development**	Director of Nursing, Midwifery & Patient Services	Mandatory roster workshops for all Ward Sisters, Matrons and Lead Nurses E-roster system rules reviewed by Bank & Agency group Set KPIs for ward sisters which will be monitoring at Bank & Agency group	Maintaining data quality	Data quality		**4**	**4**	**16**	Reviewing recruitment processes and possible use of recruitment agencies. Continue to monitor recruitment against spend on a weekly basis at Bank and Agency meetings, taking further action as necessary. Agreed HR/Finance/Operational vacancies and recruitment figures correspond with each other	At the end of June review ward KPIs and take action as appropriate. Outliers will be asked to present improvement plans to bank and agency group. Rostering 'star ' of the month ward presentations at nursing business meeting. Commenced an active recruitment programme Implemented e-rostering in all wards	June 2012	HGC	Monthly Finance Report most recently May 2012
Trust Aim: Enhance our range of hyper acute services for the wider community															
TRUST OBJECTIVE 2: Develop critical clinical care pathways to deliver effective integrated care are part of the Acute Services Review															
TRUST OBJECTIVE 3: Develop strategic approaches to relationships with other health provider and stakeholder organisations															
BAF 9 (linked to Risk ID 220) IBP risk 6	Principal risk affecting delivery of core aims and affecting the Foundation Trust Application	**Inability to develop revised business strategy due to ASR, external environment and commissioning intentions**	Director of Strategy & Partnerships	CEO, Director and Clinician membership in Acute Services Review groups GP Engagement Strategy Commissioner support for IBP which encompasses Trust strategic direction	Acute Services Review Project plan Healthier Together reports to Trust Board Annual Planning Framework IBP Annual Plan	Lack of sole ownership of the Acute Services Review programme, commissioning intentions process or the PCTs annual planning process	Nil	**4**	**3**	**12**	Full involvement of PCT and GP commissioners in the annual planning process. Convergence with activity and financial assumptions achieved through the contracting process	Support from Commissioners for FT application and Trust Strategy as outlined in Integrated Business Plan	June 2012	Trust Board	Monthly Trust Board updates, most recently May 2012

BAF No. / Linked Risk	Risk Type: Link to CQC/NHSLA/ National Target	Risk Description	Director Responsible	Key Controls	Potential Sources of Assurance	Gaps in control	Gaps in assurance	Consequence	Likelihood	Risk Rating	Risk mitigation/control plans	Progress against Mitigation	Action Update	Committee Responsible	Date Discussed at Board
	Which Outcome/ Standard/ Aim the risk relates to	**What could prevent this corporate objective being achieved**	**Lead Executive Director**	**What controls/ systems we have in place to assist securing delivery of our objectives**	**Where we can gain evidence that our controls/ systems on which we are placing reliance are effective**	**Where are we failing to put effective controls/ systems in place**	**Where are we failing to gain evidence about the effectiveness of one or more controls we are relying on**	**Obtained using Trust's risk matrix**			**Plans to address the gaps in control and/ or assurance and indicative completion dates**	**Progress made implementing action plans to address gaps in control and/ or assurance**			
BAF 10 (linked to Risk ID 6)	Principal risk affecting delivery of core aims and affecting the Foundation Trust Application	**Failure to deliver a successful FT application leading to loss of strategic direction and organisational stability**	Director of Strategy & Partnerships	FT project plan Milestone delivery to SHA Tri-Partite Formal Agreement	SHA feedback Quarterly board report FT project plan	Acute Services Review Impact of national policy Commissioning Intentions	CIP delivery LTFM and liquidity strategy Acute Services Review timescales	**4**	**4**	**16**	Board approval of the FT project plan Board development programme	SHA Board to Board Project Plan Deloitte engagement for support for board development programme	June 2012	Trust Board	Most recently May 2012
BAF 11 (link to Risk ID 16) IBP Risk 5 O16	Principle risk affecting delivery of core aims Assessing and monitoring the quality of service provision	**Failure to develop strategic relationships with Commissioners constrains our ability to redesign services to provide innovative patient pathway and a decline in reputation with local commissioners**	Director of Strategy & Partnerships	GP Engagement Strategy Quarterly Market Assessment Reports Monthly external monitoring reports Membership of Integrated Care Partnership	Minutes from NICP Consultant/GP buddy scheme Concordat with Nene Commissioning	Transition of PCTs to Cluster arrangements and increased influence of GPCC Positive desire for commissioners to develop Any Willing Provider schemes that may not include NGH	Lack of robust governance arrangements for Acute involvement in new GPCC	**3**	**3**	**9**	Continue proactive approach to maintain relationship management and to ensure representation on all formal and informal boards with GPCC Open and transparent approach to pathway redesign, active involvement in all commissioner led programmes	Convergence with Commissioners during the contracting round Support for IBP and FT application	June 2012	Trust Board	Most recently April 2012
Trust Aim: Provide appropriate care for our patients in the most effective way															
TRUST OBJECTIVE 4: Enhance all urgent care pathways, including critical care															
BAF 12 (link to Risk ID24) IBP Risk 2	Principle Risk affecting delivery of core aims, CQC outcomes, NHSLA standards, patient safety and is a National Target	**Non elective activity levels exceeding plan leading to inability to safely manage urgent care patients and urgent care standards**	Deputy Chief Executive/ Chief Operating Officer	Weekly performance meetings Bi weekly updates DH Intensive Support Team support Escalation to Trust Board Working group in place Urgent Care Delivery Plan	Finance & Performance Committee SHA Quality review CQC Inspections	Trust is unable to impact further demand management for non elective activity, current increase is 6% above plan	Nil	**5**	**4**	**20**	Urgent Care Delivery Plan discussed at Finance & Performance Committee and Trust Board Single point of access – method of treating patients quickly creating capacity to manage the increase Additional investment for refurbishment to create space for majors. Recruitment of additional consultants Redesign of Urgent Care pathway linked to Patient Safety work.	Clinical lead appointed Data diagnostic planned for August	June 2012	F&P	Urgent Care Recovery Plan February 2012 Monthly performance report, most recently May 2012
TRUST OBJECTIVE 5: Use information on quality, finance and demand to determine service priorities															

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BAF 13	Principal Risk affecting delivery of financial strategy	**Failure to embed service line reporting system due to poor clinical engagement/acceptance of basis of preparation and lack of robustness of information**	Director of Finance	Clinical and operational leads review Application controls on data quality	Data reconciliation in software package subject to validation Directorate review of data and output as part of audit process	Identification of clinical and operational leads for rollout	SLR and data quality internal audit included in 2012/13 plan	**3**	**4**	**12**	Rollout plan to identify clinical and operational leads		June 2012	F&P	SLR report to F&P May 2012
BAF 14 (linked to Risk ID 11) IBP Risk 1	Principle risk affecting delivery of improving outcomes and quality of care, reputational risk	**The accuracy and quality of management information should be at the optimum level, failure to deliver could lead to:** **Financial risk/penalty** **Failure to deliver corporate objectives** **Damage to organisation reputation**	Director of Strategy & Partnerships	2012-13 Contract – information schedule and data challenge process Quarterly data quality reports to CQEG Monthly monitoring via HSMR/Coding review group	Internal audit External Audit	Clinical Coding results	Nil	**4**	**4**	**16**	Development of an overarching data quality strategy that is owned and managed by Care Groups and other supporting services	Mortality reviews Internally managed coding audits Medical Records strategy ESR strategy	June 2012	Audit Committee	EPR Strategy April 2012, Medical Records Strategy Medical Directors report, most recently May 2012
Trust Aim: Foster a culture where staff can give their best and thrive															
TRUST OBJECTIVE 6:To enhance staff, patient and public engagement															
BAF 15 IBP Risk 4 O14	Principle risk affecting delivery of core aims	**Robustness of policies to support both staff and the organisation creating a culture and environment where the workforce can excel**	Director of Workforce & Transformation (Interim).	Health and Wellbeing activities and increased promotion of opportunities Policy framework and key policies reviewed to ensure they are fit for purpose Joint working with Communications team Action plan developed to support improvements in staff survey results	Staff Survey results Pulse survey results Outcomes of LiA initiative Reduction in sickness absence	Care Groups need to be fully engaged and involved in work and progress made		**3**	**3**	**9**	Enabling empowering staff to have a voice Introduction of Listening into Action, led by CEO Ongoing actions to embed appraisals Review of resource utilisation across key teams	Recruitment of LiA project lead Clinicians including Care Group Director part of the LiA sponsorship group Update on staff survey actions to Board in July 2012 Interim Director in post and recruitment to permanent post in train	June 2012	Audit Committee	Staff Survey Action plan, May 2012

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				with input from staff and staff side reps											
BAF 16 (link to Risk ID231) O12	Principle risk affecting delivery of core aims	**Inability to meet the Trust target of 100% Mandatory Training due to the demands and pressures on clinical and non clinical areas and the inability to release staff**	Director of Workforce & Transformation (Interim).	Operational Mandatory Training leads group meeting regularly Monthly reporting to CQEG Mandatory Training policy and the matrix updated and reviewed	Escalation of issues to HGC and to Audit Committee Internal Audit		Robustness of centralised data collection	**3**	**5**	**15**	Recruitment to substantive posts in training department Provision of additional e-learning options Centralising of 'did not attend' letters Develop competency based learning assessments Provision of cluster mandatory training sessions Review of ESR use to simplify reporting	Substantive Learning & Development Manager starts on 23 July Interview to be held for Trainer post	June 2012	HGC	Monthly HR report, most recently May 2012
TRUST OBJECTIVE 7: Establish an exemplar leadership development programme to ensure we attract, recruit and retain the highest quality staff															
BAF 17 O13 O12	Principle risk affecting delivery of core aims	**Risk of failing to retain talent/leaders as knowledge is invaluable to developing expertise to run a high performing organisation**	Director of Workforce & Transformation (Interim).	Monitor wastage/staff turnover figures by banding Develop a leadership programme spanning 12 month period for the top 30 or so leaders/managers in the organisation	Trust Board Executive Team	Resource to actively make use of appraisal data in relation to learning and development needs particularly in clinical areas		**4**	**3**	**12**	Continuous monthly monitoring and stock take of vacancies/turnover and bank and agency use against planned workforce establishment and spend. Externally tendered leadership programme – include requirement for detailed evaluation pre and post improvement skills and knowledge review Work with Care Group Directors to identify and support more junior members of teams with leadership potential	End of first quarter expressions of interest Provider agreed – end September Programme commencement in autumn/early winter. Will be linked to recruitment to key posts	June 2012	Trust Board	
Trust Aim: Ensure we invest wisely to make improvements in care															
TRUST OBJECTIVE 8: To develop, implement and sustain transformation in the way we deliver our services in order to maintain quality, deliver improvement in surplus margin and deliver c£19m reduction in cost base by the end of 2012/13															
BAF 18 (link to Risk ID18, 19)	Principal Risk affecting delivery of financial strategy, SHA control total and affecting the Foundation Trust application	**Failure of Transformation Programme to deliver £19m of cost reduction in 2012/13 and £14.3m in 2013/14**	Director of Finance	Transformation Programme and PMO, Transformation Steering Board and Transformation Delivery Group to	Fortnightly reporting and challenge control process Review of action plans	Actions to address non delivery of 2012/13 transformation programme year to date not fully	2013/14 cost improvements not formalised with project plan milestones, delivery dates etc.	**5**	**5**	**25**	Identification and work up of plans for closing 2013/14 Mitigations for 2012/13 to be worked up in July in conjunction with stocktake of 2012/13 Transformation Programme		June 2012	F&P	Monthly Transformation Report most recently May 2012

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IBP Risk 2 c) & d)				provide assurance over CIP delivery action plans. Finance & Performance Committee review of performance, actions and outcomes. TDG and Trust Board review of mitigation	Cost improvement plans for 2013/14 and mitigations for 2012/13 formalised in full in project plans with milestones, delivery dates etx	evidenced									
BAF 19 (link to Risk ID 253) IBP risk 2	Principal risk affecting contractual obligations and financial strategy	**Failure to meet contractual requirements or breach of targets leading to financial penalties**	Director of Strategy & Partnerships	Performance management regime Care Group accountability and governance	Finance & Performance Committee Audit Committee Weekly performance meetings Care Group performance framework	Failing to respond to increases in demand	Delivery of PCT demand management schemes	**4**	**5**	**20**	Ongoing contract management process Countywide Urgent Care programme	Submit bid for funding of urgent care programme to PCT Agreement of open book approach for delivery of QiPP with Nene Commissioning	June 2012	Trust Board HGC	Monthly Finance Report most recently May 2012
BAF 20	Principal Risk affecting delivery of CQC registration requirements and it is a national target.	**Failure to close escalation beds as a consequence of our inability to manage increased non elective demand**	Deputy Chief Executive/ Chief Operating Officer	Weekly performance meetings Bi weekly updates Escalation to Trust Board Working group in place Urgent Care Delivery Plan Transformation Delivery Group – attendance of workstream leads Attendance at County Wide leaders group	Finance & Performance Committee SHA Quality review CQC inspections	Trust is unable to impact further demand management for non elective activity, current increase is 6% above plan		**4**	**4**	**16**	Countywide Discharge Management Group, focus on patients fit for discharge	Appointed a clinical lead and a management lead to attend the group	June 2012	F&P	Monthly performance report, most recently May 2012

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

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD MEETING
Wednesday 27th June 2012
9.30 am Boardroom, Northampton General Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
9.30	1.	Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Draft Minutes of meeting held on 25th April 2012	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	
9.35	5.	Chief Executive's Report - Healthier Together Update	Dr G McSorley	**2**
Clinical Quality & Safety				
9.50	6.	Medical Director's Report	Dr S Swart	**3**
10.05	7.	Quality Account 2011/12	Ms S Loader	**4**
10.10	8.	Patient Experience – Friends & Family Test	Ms S Loader	**5**
10.20	9.	Infection Prevention Report	Ms S Loader	**6**
Operational Assurance				
10.30	10.	Performance Report	Mrs C Allen	**7**
10.40	11.	Finance Report	Mr A Foster	**8**
10.50	12.	HR Report	Ms G Opreshko	**9**
11.00	13.	Provider Management Self Certification	Mr C Pallot	**10**
11.10	14.	Transformation Programme Update	Mrs C Allen	**11**
Strategic				
11.20	15.	Patient Experience Strategy	Ms S Loader	**12**
11.35	16.	Carbon Management Plan	Mr C Pallot/ Dr C Topping	**13**
Governance				
11.45	17.	Corporate Objectives 11/12 & Board Assurance Framework 12/13	Dr G McSorley	**14**
12.00	19.	Any Other Business		
	20.	**Date & time of next meeting** 9.30am Wednesday 25th July 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	