Northampton General Hospital NHS
NHS Trust

A G E N D A

TRUST BOARD MEETING HELD IN PUBLIC
Thursday 27th September 2012
9.30 am Boardroom, Danetre Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Draft Minutes of meeting held on 25th July 2012	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	
09.35	5.	Chief Executive's Report	Dr G McSorley	**2**
Clinical Quality & Safety				
09.45	6.	Medical Director's Report	Dr S Swart	**3**
10.00	7.	Patient Experience – Friends & Family Test	Ms S Loader	**4**
10.10	8.	Monthly Infection Prevention Performance Report	Ms S Loader	**5**
Operational Assurance				
10.20	9.	Operational Performance Report	Mrs C Allen	**6**
10.40	10.	Finance Report	Mr A Foster	**7**
10.50	11.	Human Resources Report	Ms G Opreshko	**8**
11.00	12.	Transformation Programme Newsletter	Ms G Opreshko	**9**
11.05	13.	Provider Management Self Certification	Mr C Pallot	**10**
11.10	14.	Equality and Human Rights Annual Report	Ms G Opreshko	**11**
11.20	15.	Seasonal Plan	Ms C Allen	**12**
11.25	16.	Annual Fire Safety Report	Mr C Abolins	**13**
Governance				
11.30	17.	Any Other Business		
	18.	**Date & time of next meeting:** 9.30am Thursday 25th October 2012, Boardroom, NGH		
	19.	**CONFIDENTIAL ISSUES :** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Mr P Farenden	

Minutes of the Trust Board Meeting held in public on
Wednesday 25th July 2012 at 9.30am
Boardroom, Northampton General Hospital

Present:	Mr P Farenden	Chairman
	Mr C Abolins	Director of Facilities & Capital Development
	Mrs C Allen	Deputy Chief Executive and Chief Operating Officer
	Mr C Astbury	Non-executive Director
	Ms S Loader	Director of Nursing, Midwifery and Patient Services
	Dr G McSorley	Chief Executive
	Mr B Noble	Non-executive Director
	Mrs G Opreshko	Interim Director of Workforce and Transformation
	Mr C Pallot	Director of Strategy and Partnerships
	Dr S Swart	Medical Director
In attendance:	Mr G Kershaw	Associate Non-executive Director
	Mr J Bufford	Interim Head of Corporate Affairs (minutes)
	Mr M Essery	Shadow Lead Governor
	Mr R Kelso	Shadow Governor
Apologies:	Mrs N Aggarwal-Singh	Non-executive Director
	Mr N Robertson	Non-executive Director
	Mr P Zeidler	Non-executive Director

TB 12/13 38 Declarations of Interest

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

TB 12/13 39 Minutes of the meeting held on 27th June 2012

It was agreed that the following amendments should be made:

The second paragraph of TB 12/13/33 to be amended to:

> Mr Farenden asked how appropriate ownership would be achieved and Ms Loader confirmed that in some directorates there were patient experience champions and this would be adopted across the Trust. There were also plans to ensure that staff were informed of what was expected of them in relation to attitudes and behaviours. A Standards and Behavioural framework would be developed which would form part of the appraisal process. There had been discussions regarding support being provided for this project via the Transformation Programme Office.

Subject to this amendment and correction of some minor typographical errors the minutes were agreed as a true and correct record.

All matters arising were on the agenda.

TB 12/13 40 Chief Executive's Report

Dr McSorley reported that following the discussion at the June Board the Executive Team had recommended that it would make sense for the Trust's primary Academic Health Science Network (AHSN) to be the East Midlands and for the Trust to also be an associate member of the Oxford network. Board were content with this approach.

Dr McSorley congratulated the Diabetic Foot Team for reaching the finals of the *HSJ/Nursing Times.*awards. He was also pleased to announce that the Danetree hospital and a member of the infection control team had won awards – he would provide details at the next meeting.

He thanked Andrew Foster and Christine Allen on behalf of the Board for their work in getting the Transformation programme off the ground. Andrew had now returned to work full time within the finance Directorate. Jane Harper-Smith had taken on the programme management role and Mrs Opreshko would be the lead director.
James Drury had been seconded to a senior leadership post at the SHA and Dr McSorley recorded Mr Drury's significant contribution to the Trust. It was hoped to make an interim Finance Director appointment shortly.

The clinical working groups of the Acute Services Review were now working up a limited number of models in preparation for a public consultation in the Autumn. Dr Swart asked when staff could be briefed on the outcome. Directors agreed that staff must be briefed on progress but as no decisions on which services and which sites had yet been made there was little that could be said at this stage. The Board agreed that messages would need to be agreed and consistent across all Trusts involved in the review.

The Board of Directors NOTED the report

TB 12/13 41 Medical Director's Report

Dr Swart presented her report. She confirmed the improving position for HSMR with a year-end rebased figure of 102 versus 116 the previous year. She noted that the SMR for NGH was 85 for the month of April. The SHMI also showed an improvement with the 12 month rolling mortality for December 2011 running at 106.

The Trust continues to closely monitor patient possible areas for concern with a view to the early identification of problems. An apparent rise in mortality from secondary malignancy and senility was apparent and a sample of case notes had been analysed - the coding accuracy was now being checked.

A concern had been raised around the coding and care for patients who had died with a diagnosis of inflammatory bowel disease and as a result a case note review was under way.

The Chairman noted that it was good to see that the mortality figures were improving but that nevertheless the Trust needed to continue to be vigilant.

The Board of Directors NOTED the report.

TB 12/13 42 **Patient Experience Strategy Implementation Plan**

Ms Loader introduced the implementation plan for the strategy that Directors had approved at the June meeting.

The Chairman asked about levels of enthusiasm for the plan. Mr Astbury asked whether the plan was ambitious enough. Ms Loader reported that there was enthusiasm for the plan and felt that the plan stuck the right balance between achievability and ambition. Dr McSorley felt that it was important that staff saw that the different initiatives in the organisation were co-ordinated – Mr Kershaw commented that the organisation needed to keep the number of initiatives to manageable levels. Ms Allen asked about the costs of the plan – Ms Loader noted that she was still in discussion regarding how the plan would be funded and that she was currently funding it out of vacancy monies.

The Board of Directors APPROVED the Patient Experience Strategy Implementation Plan and the proposed structure outlined in the paper to support the strategy.

TB 12/13 43 **Patient Experience – Friends and Family Test**

Ms Loader introduced the paper and highlighted the difference between the manual and Hospedia systems. She drew Directors attention to the decision made by the SHA to use the manual figure for its June publication. Directors noted that both manual and Hospedia scores were showing improvement.

Mr Astbury and Mr Noble both felt that the system should be audited. The Chairman asked about the cost of the Hospedia system – Ms Loader would investigate. **Action Ms Loader**

The Board of Directors NOTED the improving scores, and APPROVED the use of both manual and Hospedia systems in the short term.

TB 12/13 44 **Infection Prevention Report**

Ms Loader presented the report and noted that the Trust was doing well compared to other organisations, although there was still more work that could be done.

Mr Noble drew attention to the differences between wards and non-ward areas in respect of hand hygiene. Mr Kershaw was concerned about disparities in compliance between different wards.

Directors agreed that work needed to focus on hand hygiene outside wards and to bring outlying wards up to the same standard across the Trust. Ms Loader would report back to the September Board. **Action Ms Loader**

The Board of Directors NOTED the report and APPROVED the further actions.

TB 12/13 45 **Research and Development Report**

Dr Swart presented the report emphasising the following points: the increasing important of research in the NHS; the improvements in trial recruitment at ~NGH and the need to improve the linkages between research activity and Trust risks and priorities. Mr Noble asked how easy it was to identify costs associated with R&D – Dr Swart responded that these were not always separated out from other clinical or administrative costs. The Chairman felt that the R&D lead was key – Dr Swart was searching for a suitable candidate.

The Board of Directors NOTED the report and supported the proposals in the paper.

TB 12/13 46 **Performance Report**

Ms Allen introduced the report. The key issue was the volume of admissions through A&E. Ambulance handover times had been significantly improved. Work was focusing on discharge where an eight week programme to discharge patients had been introduced in collaboration with the CCG. In response to a question from the Chairman Ms Allen confirmed that the Trust was working on ensuring that all patients had an expected discharge date on admission.

Mr Abolins asked how other Trusts were faring. Ms Allen reported that many were seeing similar pressures. Dr Swart reported that there was learning from clinical support from other Trusts and as a result there had been an increase in clinical resources and a focus on discharge.

In response to a question from Mr Noble, Ms Allen confirmed that the Trust was seeing between 60 and 90 patients per day, those admitted having an average length of stay of 5 days.

Actions under way included the following:

- Extra clinical resources being provided to support discharges
- External teams to come into hospital to plan discharges
- 8 week programme to assist with discharge

Ms Allen would report back on progress at the next meeting.

Action: Ms Allen

The Board remained concerned at the failure to deliver the A&E transit time and requested a further report on progress on delivery and actions at the Finance and Performance Committee on the 23rd August to ensure improvements were being delivered.

Mr Kershaw had raised the issue of cancer standards. A significant issue was emerging with urology patients with a complex pathway – which was impacted on especially by the way in which patients with prostate problems took to get through the system.

Actions that were being taken to address this included:

- looking at inter-Trust transfers where patients were referred to NGH much later that desired,
- examining the head and neck pathway to make sure that there were no unnecessary delays
- the scheduling of oncology pathways.
-

In response to a question from Mr Astbury Ms Allen and Mr Pallot both felt that this was a temporary issue and the July performance was picking up.

The Board of Directors NOTED the report and APPROVED the actions being taken to address underperformance

TB 12/13 47 **HR Report**

Mrs Opreshko introduced the report which was based on May figures as June data was not yet available. Early indications were that sickness absence had decreased, however a programme of action was under way to reduce this further: the policy was being revised to support managers and a high profile campaign to make staff aware of the cost of sickness was planned.

Mr Astbury drew attention to the current in-post establishment figures. Executive Directors noted that a pragmatic approach was being taken managers and in some areas staffing levels were kept below establishment for practical operational reasons. It was agreed that Mrs Opreshko would bring a report on establishment to the next meeting.

Action: Mrs Opreshko

The Board of Directors NOTED the report.

TB 12/13 48 Transformation Programme Newsletter

The Board of Directors NOTED the newsletter

TB 12/13 49 Provide Management Self Certification

The Board of Directors APPROVED the signing of Declaration 2.

TB 12/13 50 Security Annual Report

Mr Abolins presented the report. He noted the increase in incidents but also a reduction in reported crime. The key concern is the increase of reports of physical assault on staff. Investigation had shown that this was mainly from patients with dementia, mental health issues or drug users. As a result the restraint policy was being further developed to ensure that staff in high risk areas were supported and had the wherewithal to handle any such attacks.

Other issues that had been addressed had been an investment of £100k on CCTV in high risk areas.

In response to a question from Mr Kershaw, Mr Abolins confirmed that the security staff were trained to handle attacks on staff, but it was much better for staff (and patients) for clinical staff to be trained as well. Mr Kershaw asked what impact on sickness these attacks had – Mr Abolins felt that in the main they were not serious enough to have much of an impact. Dr Swart drew attention for the need for increased psychiatric support for mental health patients and also mentioned the work that was being done on managing dementia.

Mr Astbury asked for more information on incidents in A&E. Mr Abolins said that these were now being reported fully (under-reporting had been an issue in the past) but that the division between minors and majors and the redesign of the department had helped reduce these.

The Board of Directors NOTED the report

TB 12/13 51 Any Other Business

In response to a question from a member of the public, the Chairman reported that no decision had yet been made about the Trust's Foundation Trust Application.

Action Log for the Board meeting held in public in July 2012

Ref	Paper/Agenda Item	Date Arose	ACTIONS	Responsibility	Date Due/ Completed	RAG
TB 12/13 43	Friends and Family Test	25 July 2012	Ms Loader to investigate the cost of conducting the FFT audit on Hospedia	Ms Loader		
TB 12/13 44	Infection Control Report	25 July 2012	Ms Loader to brief Board on plans to address variances in hand hygiene in wards	Ms Loader		
TB 12/13 46	Performance Report	25 July 2012	Ms Allen to brief Board on progress to tackle discharge	Ms Allen		
TB 12/13 47	HR Report	25 July 2012	Mrs Opreshko to report on over-establishment	Mrs Opreshko		

Key	
	Completed
	On Track
	Some slippage
	Serious issue

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

1. Annual General Meeting

The Trust Annual General Meeting took place on the 19th September and was a great success. There were over 100 attendees and some very interesting questions from the floor. Dr Jonathan Timperley, one of our Consultant Cardiologists, delivered a very interesting presentation on some of the great work done by the Northampton Heart Centre which was very well received by the audience.

2. Foundation Trust

In July 2012 our business plan was submitted and the approval process was begun. However we decided to ask for more time because we need to make some improvements to our operational performance. We also plan to recruit two new Non-Executive Directors to fill vacancies and recruiting permanent Executive Directors to the key posts of Director of Finance and Director of Workforce & Transformation which are currently filled on an interim basis.

Another factor influencing our decision to extend the path to FT status is the continuing development of the Healthier Together South East Midlands Acute Services Review. The review has reached a critical stage as its initial clinical recommendations have just been published and are now to be tested for business viability. The results of that appraisal will be put out for public consultation in the New Year. Since some of the possible outcomes could affect our business model, again it was felt that more needed to be known before taking the FT process further.

The Strategic Health Authority has agreed to our request for more time and has invited us to submit our revised application in July 2013. A formal resolution for the Board to approve is listed later on the agenda.

3. Listening into Action

As you will be aware the first of the staff conversations concluded at the end of July and we are now moving into the next stage of the project. I am pleased to be able to tell the Board that such was the energy and enthusiasm for the project we have decided on 12 first LiA teams and not 10. Jackie Boore, our LiA lead, is meeting with these teams in order to support them in taking things forward at a local level. There will be a formal feedback session in February however I will keep the Board abreast of progress in the meantime.

Dr Gerry McSorley
Chief Executive
September 2012

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

Significant progress has been made to ensure improving clinical outcomes as illustrated by the falling mortality rates at NGH. There will continue to be a focus on improving on patient safety, improving patient experience and improving flows of information. The work on the redesign of the emergency pathway has started and there is now increased focus and support for patient safety work. The need to ensure that there are clear and robust measures for quality remains paramount. The need to improve information flows and clinical coding is emphasised.

PATIENT IMPACT

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

STAFF IMPACT

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

FINANCIAL IMPACT

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

LEGAL IMPLICATIONS

Trust Boards are mandated to examine quality across a range of services and failure to provide requisite quality standards will result in the risk of litigation. The high number of NHSLA claims compared to our SHA should be noted.

RECOMMENDATION

Board members are asked to 1.Challenge and debate the issues raised 2. Note the continued improvement in HSMR

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 21 months which was set up in response to address the high HSMR and has supplemented the regular scrutiny of mortality data which has been in place for many years. The Board is reminded that each month all possible causes of concern are discussed by the Associate Medical Director and the Medical Director and the data and action log are signed off at this meeting.

This issue remains of key reputational importance for the Trust and there have been regular reports provided to the PCT and SHA. In this report an overview of progress in high risk diagnoses groups is provided in the context of performance over the last 10 years.

2. Current Position HSMR

The HSMR for 2011/12 has been re-benchmarked to **101.9** which is a large improvement on 2010/11 (**116**). This reflects a reduction of 125 actual deaths over the year despite rising admissions. The HSMR for the first quarter of 2012/13 is **94** which is predicted to rise to 100 after re-benchmarking.

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 as reflected by the fact that the rate of palliative care coding is 2/3 of the national rare and the Charlson co- morbidity score is lower than average (88 versus an average of 100).

For June the HSMR was **93.** There were 89 expected deaths and there were 83 actual deaths.

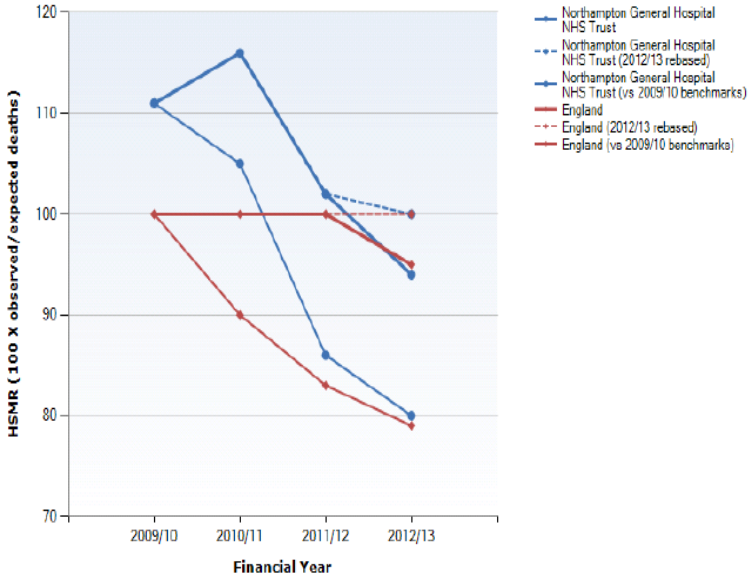
NGH is not an outlier with respect to mortality as measured by HSMR as shown below.

3. Acute Trust HSMRs April 2011 - March 2012

The background points show the HSMR (rebased) for the first quarter of 2012/13 for each acute non specialist Trust in England.

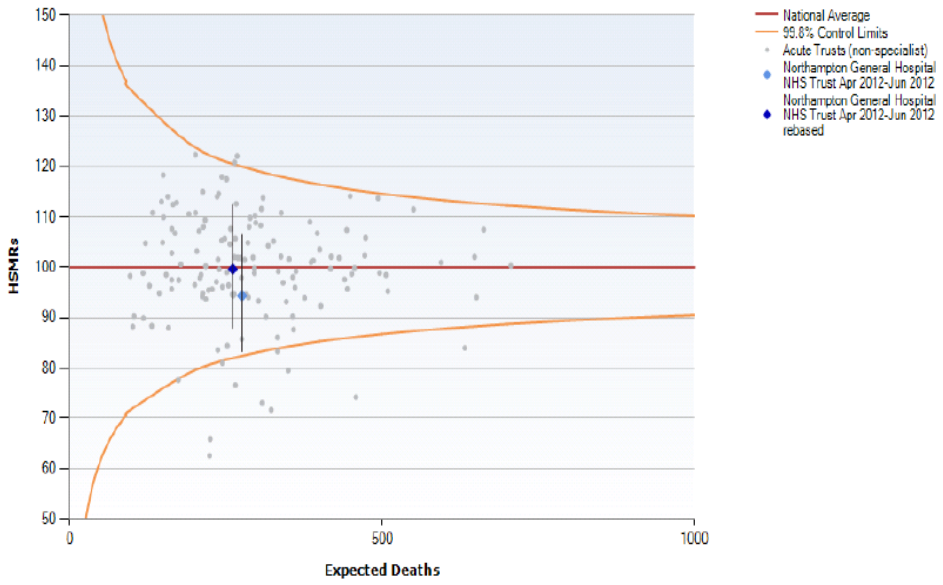
The Board is reminded that the rebased position reflects the fact that each year the mortality figures improve for all Trusts but the improving position for NGH indicates that this Trust has improved more rapidly than others over the last financial year.

Trend in HSMR



Acute Trust HSMRs Apr 2012-Jun 2012

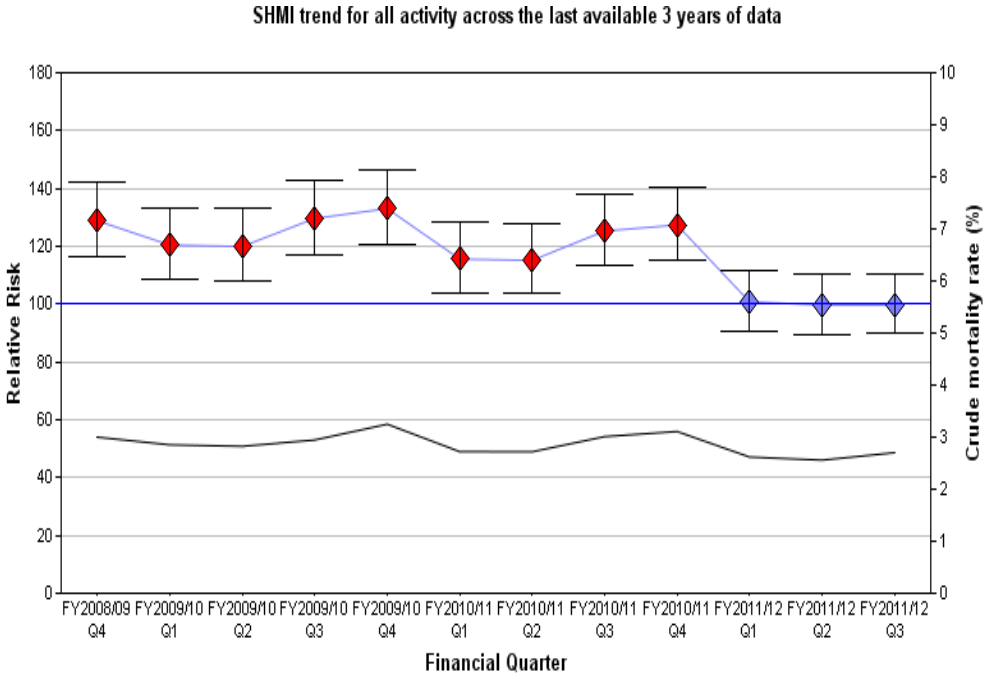
The background points show the HSMR for the **current financial year** for each acute non-specialist trust in England. Use the controls below to toggle between the current and rebased values.



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.



At present, the SHMI roughly mirrors the HSMR for NGH. The latest SHMI is reported on rolling 12 months basis and shows an improvement from 114 for the financial year April 2010-April 2011 to **106** (period up to December 2011 – rolling 12 months). The quarterly position for the first 3 quarters of 2011/12 is as expected at **99.6.** 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)

There are currently no concerns in relation to the Dr Foster Patient Safety Indicators. The previous alert relating to obstetric trauma related to a data issue which has been corrected.

Jul 2011 to Jun 2012

Indicator		Observed	Expected	Observed rate/K	Expected rate/K	
Deaths in low-risk diagnosis groups*		22	24.8	0.60	0.68	more information
Decubitus Ulcer		117	192.2	13.61	22.36	more information
Deaths after surgery		37	27.8	133.57	100.42	more information
Infections associated with central line*		0	0.8	0.00	0.05	more information
Post-operative hip fracture*		0	1.7	0.00	0.07	more information
Post-op Haemorrhage or Haematoma		4	13.7	0.17	0.58	more information
Post-operative physiologic and metabolic derangements*		0	1.6	0.00	0.08	more information
Post-operative respiratory failure		10	14.0	0.52	0.73	more information
Post-operative pulmonary embolism or deep vein thrombosis		21	38.4	0.88	1.61	more information
Post-operative sepsis		3	4.6	4.07	6.20	more information
Post-operative wound dehiscence*		2	1.1	2.21	1.18	more information
Accidental puncture or laceration		28	73.7	0.43	1.13	more information
Obstetric trauma - vaginal delivery with instrument*		25	39.3	52.63	82.71	more information
Obstetric trauma - vaginal delivery without instrument*		92	89.2	38.54	37.37	more information
Obstetric trauma - caesarean delivery*		7	4.5	5.36	3.43	more information

Key

A red bar signifies an indicator for which the lower end of the 95% confidence interval is above the national average.

A green bar signifies an indicator for which the higher end of the 95% confidence interval is below the national average.

A blue bar signifies an indicator for which the relative risk equals the national average value within 95% confidence.

* For indicators marked with an asterisk expected values are derived from the national average crude rate and are not casemix adjusted.

6. Reports on Key Areas for action or of importance:

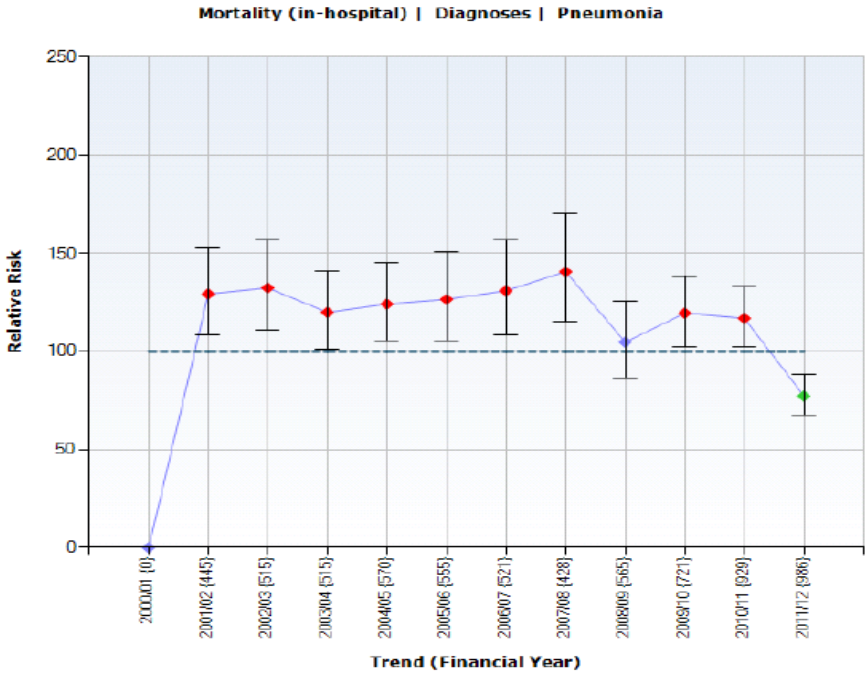
a) Mortality from High Risk Diagnoses

Mortality resulting from the 5 high risk diagnoses groups which are **Acute Cerebrovascular Disease, Pneumonia. Acute Myocardial Infarction, Congestive Cardiac Failure and Fractured Neck of Femur** is within acceptable parameters. The Board should note that there has been considerable improvement in these in recent years and the current SMR is **66** which is better than average.

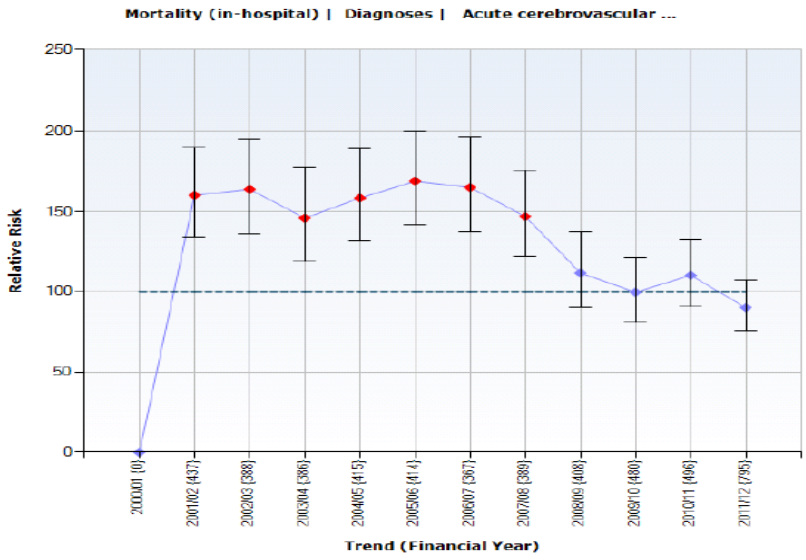
Looking back over the last 10 years a number of key improvements can be noted. These reflect improvements in medical care over this period. They also show a greater than average improvement in care at NGH compared to other UK hospitals.

For **Pneumonia** the death rate has fallen from a high of 31% for admissions in 2001/2 to 21% in 2011/12

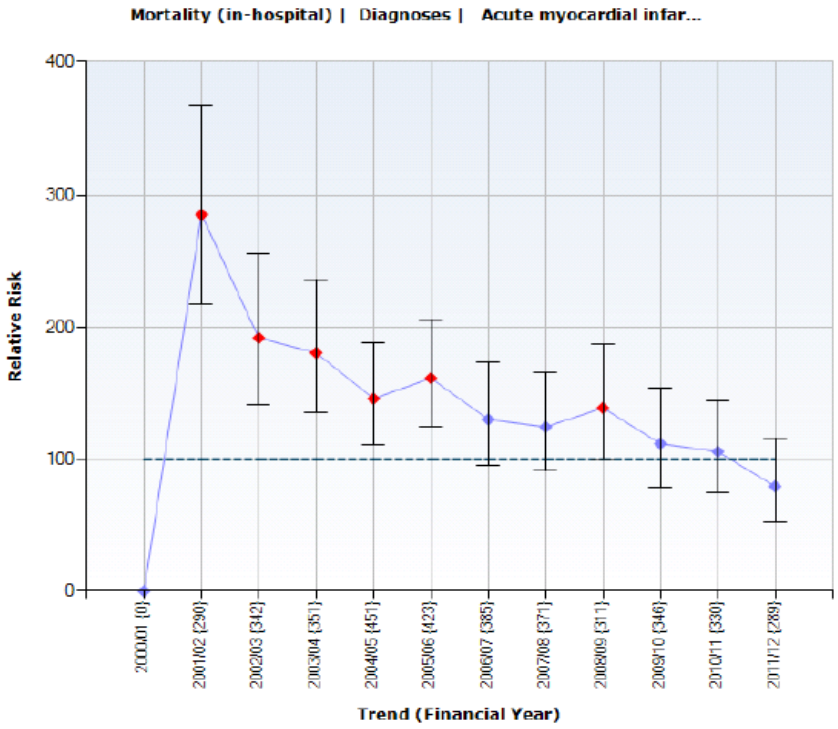
The relative risk rate using 2009/10 as a benchmark is illustrated on the graph below which has been reproduced from the data provided by Dr Foster Intelligence:



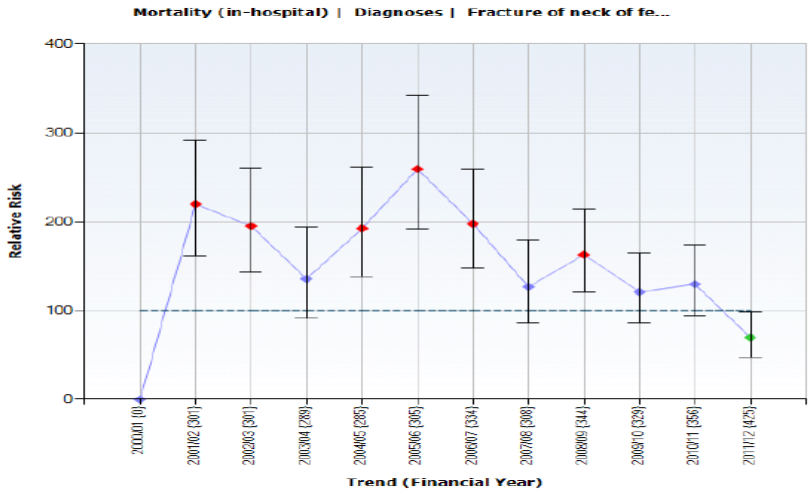
For **Stroke** in 2001/2002 31% of people admitted with a stroke died . In 2011/12 the figure was 16%.The graph below illustrates the relative risk of death benchmarked to 2009/10.



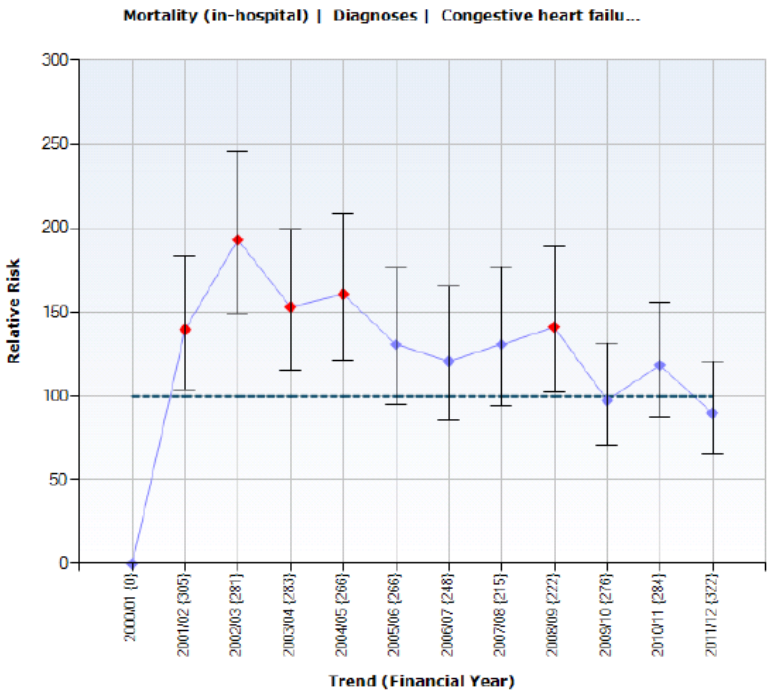
For **Myocardial Infarction** the death rate has fallen from 21% in 2001/2002 to 9% in 2011/12.The following graph illustrates the relative risk rate of death using 2009/10 as a benchmark.



For **Fractured Neck of Femur** the fall in actual death rate is from 16 % in 2001/2002 to 7.5 % in 2011/12.The graph below shows the relative risk of death with 2009/10 as a benchmark.



For **Congestive Heart Failure** there was a death rate of 23.5% in 2002/3 and this has fallen to 14% in 2011/12.The following graph illustrates the relative risk rate using 2009/10 as a benchmark.



The death rate from Septicaemia remains below average at 14% compared to a high 37% in 2003/4. The death rate from Elective repair of Aortic Aneurysm has been 0% for the last 3 years (compared to a high of 18% in 2006/7).

b) Possible areas for Concern under investigation

There are a number of areas currently under review as a result of our internal Dr Foster monitoring processes. The results of more detailed case note and coding reviews are still awaited for these areas which include diabetes, inflammatory bowel disease, senility and secondary malignancy.

c) Information and Coding Issues

There continues to be a need for consistent and continual challenge of coding and information processes through mortality/coding reviews including clinical and managerial teams. Due to vacancies in the information department these meetings have been on hold over the summer months and this time has been used to set up a new process led by the Associate Medical Director for clinical governance. This will be supported by the new members of the information team and will be an adjunct and extension to the current mortality monitoring processes. As part of a piece of work to examine flows of patients into the Trust and flows of information relating to clinical processes a review of clinical coding practice will be commissioned to strengthen our understanding of the current position. It is anticipated that the improved understanding of issues that emerges from this work will be useful in framing improvement activity. The Trust has received and agreed the final proposal in relation to this analytical work which is awaiting a funding decision.

7. Further Comments and Actions Planned

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

In order to improve mortality the planned redesign of the emergency pathway and the patient safety programme will continue to evolve. A programme of work is currently under construction and includes a significant investment in organisational training in patient safety 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. A structured project framework will be set up as soon as project management support can be put in place 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 and this paper continues to highlight the importance of data flows and information. There is a recognition that the trust needs to improve the infrastructure in this area. A revised mortality / coding review meeting process will be set up to add weight to current case note and coding reviews and the previous case note review process is to be repeated when resources permit.

The Trust Board asked to note and debate the contents of this report and to recognise the improvement to date.

It is increasingly evident 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.

Section 2

1. The Quality Observatory Scorecard

The East Midland Quality Observatory has published a scorecard for 2011-12 which contains data up to the end of Quarter 4 for some data and for up to the end of Quarter 3 for others.

This scorecard is set out against the NHS Outcomes Framework Categories and is provided as **Appendix 3 for NGH and Appendix 4 for the East Midlands.**

Section 1 is Preventing People from Dying Prematurely and this is where the mortality data is reported.

Mortality on this dashboard is reported as SHMI rather than HSMR and the data is to Q3 of last year and is reported as a 12 month rolling year figure. This means that it will include data from December 2010 to December 2011. The Board will recognise the areas that the Trust has been concerned about which reached their most concerning point in December 2010 through to March 2011 and this scorecard indicates below average SHA performance for a number of these in line with the reports received by the Board over the last 12 months. The position is however improved compared to that on the last QO scorecard reported to the Board in May 2012.

There is one category on this scorecard which has not been routinely reported to the Board. This is 'mortality from conditions amenable to healthcare'. These are conditions where the conditions are easily classified, the number of annual deaths is significant and healthcare interventions are known to be effective. The list includes selected infections, selected cancers, diabetes, certain alcohol and drug related disorders, epilepsy, hypertension, valvular and ischaemic heart disease, pulmonary embolism, stroke, aortic aneurysm, Influenza, COPD, asthma, peptic ulcer, acute abdominal emergencies, prostate disease, perinatal complications, accidents and suicides. It is of interest that NGH has a low mortality from these conditions but the significance of this is not understood as yet and the reported trend in mortality is rising indicating that there may be data issues.

NGH also has a better than SHA average mortality rate for death from low risk HRGs, operations for fractured NOF within 48 hours and cancer waits.

The other sections of this scorecard cover many of the section covered in our own quality dashboard although again the time periods may be different. The areas of concern on this dashboard relate to readmissions, A&E performance, caesarean section rates, nursing and midwife sickness levels, and inappropriate A&E attendances. There is also an apparently high rate of admission for ambulatory. Most of these should be familiar to the Board. The high rate of medication error reporting almost certainly relates to the work of the medication safety group which has encouraged reporting in this area and contrasts with the relatively low rate of incident reporting elsewhere. This is no longer regarded as a 'red' area on the dashboard following discussions with the QO. The Board should also note the high rate of day case procedures and the low rate of palliative care coding and secondary coding depth. This mirrors our own reports on this matter. The previous high rate of NHSLA claims is no longer an issue.

2. NGH Monthly Quality Scorecard

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

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

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

Of 124 indicators, 36 (32/4) are rated as either red or amber status. This report outlines the underperforming indicators and details the remedial action(s) being taken. There are still 22 indicators that are rated grey. This is because either baseline data is still to be agreed or information is currently not available.

Summary Rating

Section	Red Rated	Amber Rated	Green Rated	N/A
CQUIN 2012-13	3	0	21	11
Clinical Outcomes	13	0	14	4
Patient Safety	6	3	12	6
Patient Experience	10	1	19	1
TOTAL	**32**	**4**	**66**	**22**

The Board is asked to note these scorecards and debate any issues that arise from them.

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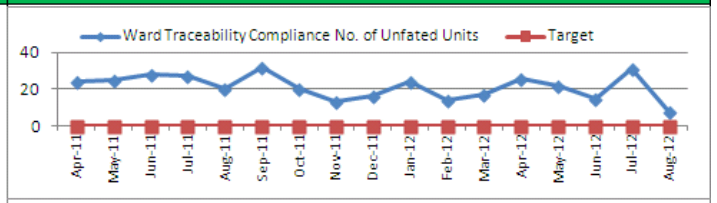
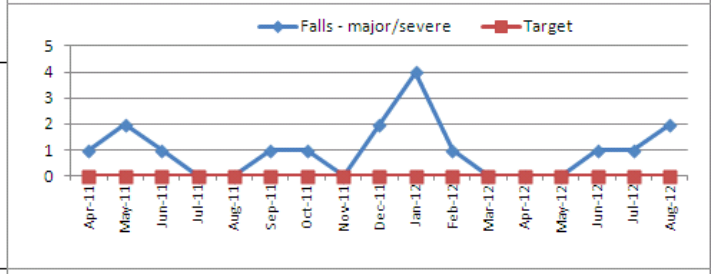
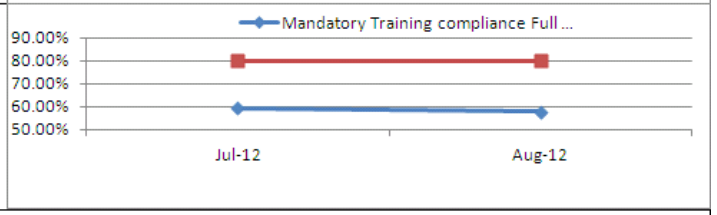
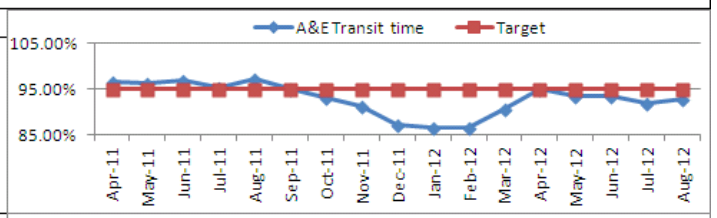
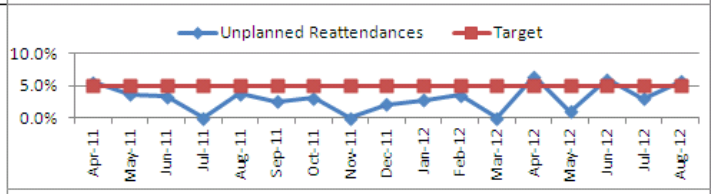
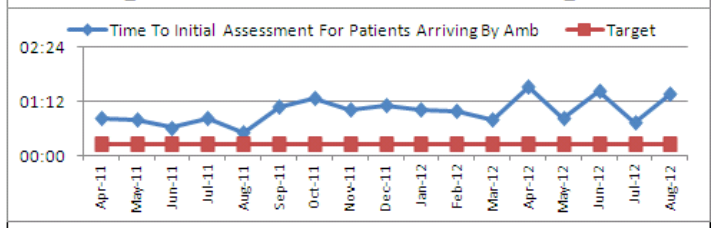
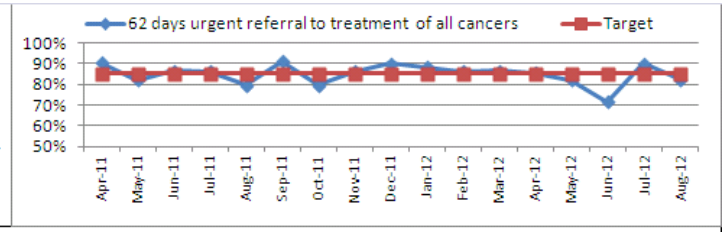
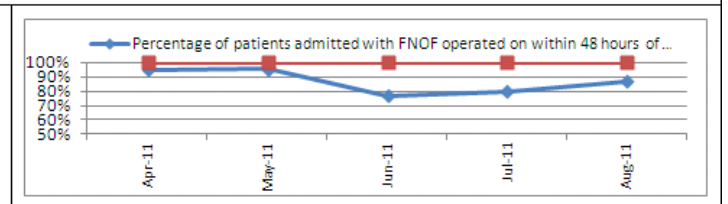
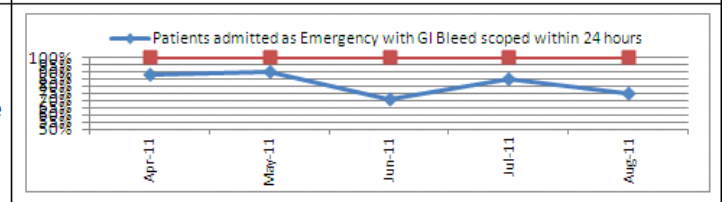
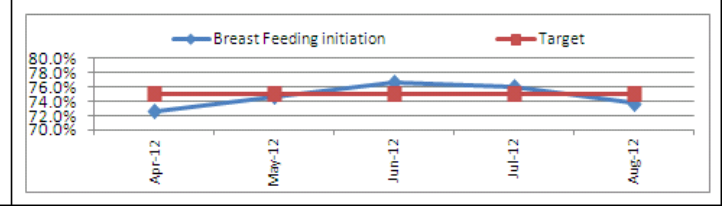
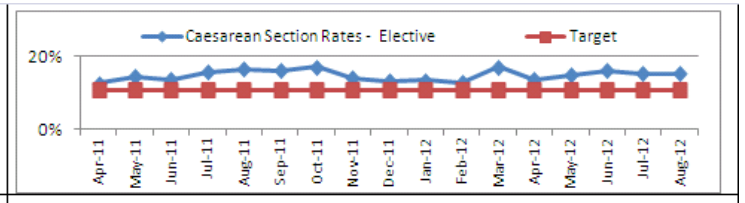
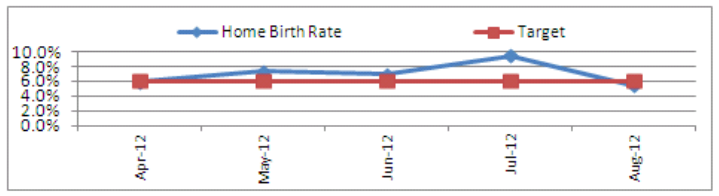
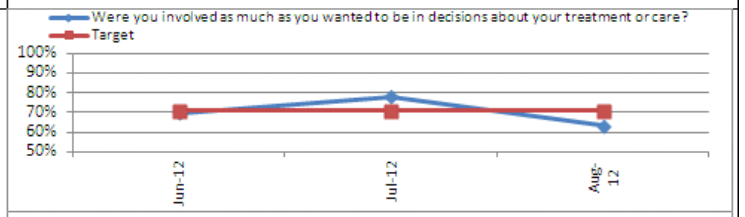
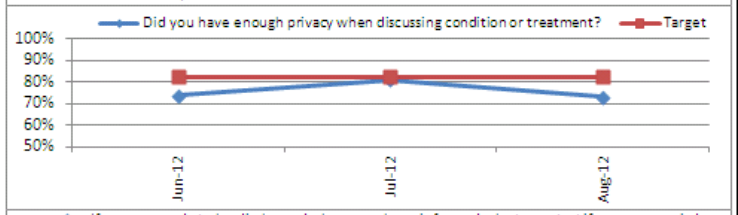
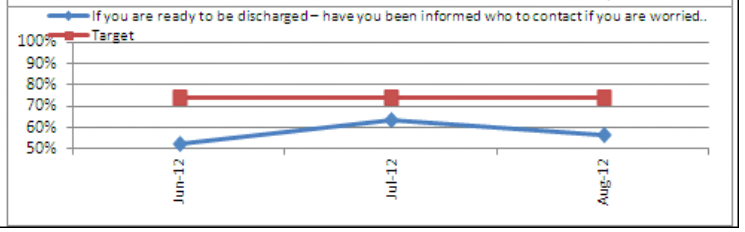
EXCEPTION REPORT – AUGUST 2012

Domain	Indicator	Target	Month performance	Exception Narrative	Trend Chart
Patient Safety	Ward Traceability Compliance Number of Un-fated Units	0	↓ 55 (Q1 2012-13)	Ward Traceability Compliance Number of Un-fated Units - There were 63 cases of un-fated units in Q1 2012-13 against a total of 55 for Q4 2011-12. Ward and directorate managers are notified daily of un-fated units which allows immediate investigation and monitoring of unfated cases has been added to the weekly performance meeting. Q2, Jul-12 to Aug-12 to date is showing 39 cases.	
Patient Safety	Reduce harm from falls	0	↑ 3	There was 2 falls of a major/severe category reported in August. This makes 3 major / severe falls this quarter (Q2 2012-12). This is in comparison to 0 in Q2 2011-12.	
Patient Safety	Mandatory Training compliance Full Year Impact: Primary Levels Excluding B&H	80%	↓ 57.70%	Mandatory training subjects have not been calculated on the run rating as previous reports. It is calculated against the target audience which has been agreed by the Mandatory Training Leads and formatted within OLM	
Patient Safety	Never Event	0	↑ 1	Third independent WHO audit completed in August incorporating direct observation, self reporting and records review. Formal records of training utilising the WHO DVD have commenced, cascade training remains in place	
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 July and August (92% & 92.8%). 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 missed two elements. 1. Unplanned re-attendance rate sits at 5.66% in August 12, this is above the 5% national target. 2. The time to initial assessment for patients arriving by ambulance was 36 mins with the national target being 15 minutes. The Trust is investing in increased medical and nursing staff to improve the clinical care in A&E and planning a redesign of the emergency pathway to improve flow through the hospital as well whilst focusing on quality, safety and patient experience.	  

Patient Experience	62 Day Cancer wait time	85%	↓ 82.5%	The Trust has delivered the 62 day cancer wait time target for July 2012 (90.1%) and is currently showing 82.5% for August. This is attributed to complexity of cases and to delay in referrals received form other providers. An ongoing action plan is in operation and dialogue with other providers is ongoing	
Patient Experience	PROMS Scores	80%	↓ 71.8% Overall Score	The Trust is reliant on national data for this indicator. The overall score of 71.8 reflects the latest figures (August 2012) for the period Apr-11 to Mar-12. This is a slight reduction on the previous score of 72.8 (May 2012) for the period April 11 to Dec 11.	
Clinical Outcomes	Percentage of patients admitted with FNOF operated on within 48 hours of admission	100.0%	↓ 87.0%	There were 6 patients that did not meet this target: 4 were listed on a theatre session within 48hrs, but unfortunately they were cancelled due to insufficient time 1 patient there was no slot available 1 patient was admitted with UTI so unfit on admission, the patient was declared fit within 48hrs but then cancelled off list due to lack of time	
Clinical Outcomes	Patients admitted as Emergency with GI Bleed scoped within 24 hours	100.0%	↓ 75.0%	The key issues resulting in the failed outcome for this target was same sex accommodation issues and consultant annual leave. Action plans are now in place to address these points.	
Clinical Outcomes	Breast Feeding initiation	75.0%	↓ 73.7%	Marginally below targets. However trends show continued achievement against targets. Continued monitoring is taking place on a monthly basis	

Clinical Outcomes	Caesarean Section Rates	10.6%	**15.2%**	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.	
Clinical Outcomes	Home Births	6.0%	**5.4%**	Slightly below targets. However trends show continued achievement against targets. Continued monitoring is taking place on a monthly basis	
CQUIN	Improve responsiveness to personal needs of patients (5 questions based on inpatient survey results)	1. 71.0% 2. 82.3% 3. 74.3%		There are 5 quality questions as part of the CQUIN. Two of the 5 questions for improving responsiveness to personal needs of patients have returned as under target. These being: 1. Were you involved as much as you wanted to be in decisions about your treatment or care? (63.2% against a target of 71%) 2. Did you have enough privacy when discussing condition or treatment? (73.1% against a target of 82.3%) 3. If you are ready to be discharged – have you been informed who to contact if you are worried about your condition after leaving hospital? (56.5% against a target of 74.3%) These responses are currently collected via the Hospedia system which is in the process of constructive review .	  

CORPORATE SCORECARD AUGUST 2012

Corporate Scorecard 2012-13							
Patient Safety	**Target 2012-13**	**Apr-12**	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**RAG**
HQU01: HCAI measure (MRSA)	1 per year	1	0	0	0	0	
HQU02: HCAI measure (CDI)	36 per year	3	1	4	3	0	
HQU08: MMSA Numbers	0	0	0	0	0	0	
E Coli ESBL Quarterly Average	7 per month	5	4	1	0	5	
VTE Risk Assessment completed	90% month on month	91.4%	91.4%	90.3%	93.0%		
MRSA Screening Elective Patients	100% month on month	99.8%	99.7%	99.8%	99.5%	99.5%	
MRSA Screening Non-Elective Patients	100% month on month	94.2%	96.9%	98.5%	96.6%	94.9%	
Ward Traceability Compliance Number of Unfated Units	0 month on month	26	22	15	31	8	
Incidence of pressure ulcers							
Type 3	0	0	2	2	1	0	
Type 4	0	1	2	0	0	0	
Rate per 1,000 Bed Days (All Grades)	0.60	0.70	0.82	1.34	1.21	0.91	
Reduce harm from falls							
Catastrophic	0	0	0	0	0	0	
Major/Severe	0	0	0	1	1	2	
Moderate	0	2	2	0	0	0	
Mandatory Training compliance Full Year Impact							
Primary Levels Excluding B&H	80%	104.67%	90.14%	80.64%	NA	N/A	
Attendance at Trust Induction	80%	88.14%	87.70%	87.70%	NA	N/A	
Number of surgical site infections							
Frac neck of femur Number of Operations		27	29	21	26	53	
Infections	0	0	1	0	0	0	
Breast Surgery		30	40	29	38	30	
Infections	0	0	0	0	0	0	
Limb Amputations		11	7	10	16	12	
Infections	0	0	0	0	0	0	
Full implementation of patient safety alerts e.g. NPSA, CAS, Medical Device Alerts etc							
Open Central Alert System (CAS) Alerts	0	1	0	0	0	0	
NICE clinical practice guidelines and TAG compliance	80%	81%	81%	82%	-	84%	
Serious Untoward Incidents	-	12	3	9	14	4	
Never Events	0	0	0	0	0	1	
WHO Surgical Safety Checklist	100%	100%	100%	100%	100%	100%	
Patient Experience	**Target 2012-13**	**Apr-12**	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**RAG**
Cancelled Operations not rebooked within 28 days	0%	0%	0%	0%	0%	0%	
Hospital Cancelled Operations	6.0%	5.9%	7.3%	8.7%	5.5%	5.1%	
Number of written complaints received		50	51	39	48	33	
Complaints Responded to within agreed timescales	100.00%	88%	80%	87%	100%	100%	
Referral to Treatment waits							
Admitted Patients	90.00%	96.43%	96.56%	97.40%	96.61%	96.43%	
Non Admitted Patients	95.00%	97.70%	98.33%	98.80%	98.61%	98.43%	
Ongoing Patients	92.00%	98.21%	97.83%	97.13%	97.30%	97.21%	
A&E Quality Indicators (5 measures)							
Time Spent in A&E (Month on Month)	95%	95.05%	93.37%	93.33%	91.98%	92.80%	
Time Spent in A&E (Cumulative)	95%	95.05%	94.16%	93.88%	93.38%	93.27%	
Total time in A&E (95th percentile)	95th	04:00	05:00	04:50	05:19	05:04	
Time to initial assessment (95th percentile)	<1hr	00:30	00:50	00:39	01:14	00:36	
Time to treatment decision (median)	<15 mins	00:46	00:54	00:54	00:52	00:42	
Unplanned re-attendance rate	=<5%	6.37%	1.00%	5.91%	3.00%	5.66%	
Left without being seen	>1% and <5%	0.26%	0.33%	0.20%	3.50%	0.18%	
Cancer Wait Times							
2 week GP referral to 1st outpatient	93%	96.3%	95.6%	95.0%	96.6%	95.4%	
2 week GP referral to 1st outpatient - breast symptoms	93%	100.0%	100.0%	100.0%	100.0%	100.0%	
31 Day	96%	96.5%	98.9%	96.9%	99.4%	99.3%	
31 day second or subsequent treatment - surgery	94%	96.2%	97.5%	100.0%	100.0%	100.0%	
31 day second or subsequent treatment - drug	98%	100.0%	97.8%	100.0%	100.0%	100.0%	
31 day second or subsequent treatment - radiotherapy	94%	100.0%	99.2%	100.0%	98.5%	100.0%	
62 day referral to treatment from screening	90%	100.0%	100.0%	100.0%	81.8%	87.5%	
62 day referral to treatment from hospital specialist	85%	92.0%	91.7%	93.1%	93.3%	91.7%	
62 days urgent referral to treatment of all cancers	85%	85.4%	81.8%	71.4%	90.1%	82.2%	
SRS08: Length of Stay (Acute & MH)							
Elective	3.20	3.70	4.1	4.2	4.1	4.2	
Non-Elective	5.30	6.00	5.9	4.4	4.4	4.3	
SRS09: Daycase Rate	85%	85.7%	85.2%	83.2%	84.0%	85.0%	
SQU11: PROMS Scores - Pre Operative participation rates							
Groin Hernia - Participation Rate	Nat.Ave 60.5% (target 80%)		42.30%		48.20%		
Hip Replacement - Participation Rate	Nat.Ave 82.0% (target 80%)		97.40%		91.40%		
Knee Replacement - Participation Rate	Nat.Ave 87.5% (target 80%)		94.90%		88.20%		
Varicose Vein - Participation Rate	Nat.Ave 49.1% (target 80%)		31.10%		33.30%		
All Procedures - Participation Rate	Nat.Ave 74.0% (target 80%)		72.80%		71.80%		

Clinical Outcomes	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	
HSMR - cumulative position for 2011-12	<100	93.6	93.9	94.3	94.0	101.9	
HSMR - cumulative position from Apr 12 - May 2012		NA	NA	85.0	87.4	94.4	
SMR- cumulative position for 2011-12							
Pneumonia	<100	90.7	83.5	82.2	81.5	70.2	
Fracture of neck of femur (hip)	<100	82.3	80.6	80.6	80.9	99.5	
Urinary Tract Infections	<100	96.0	92.9	93.2	93.4	121.2	
Acute Cerebrovascular disease	<100	98.4	99.3	99.7	99.1	97	
Aspiration pneumonitis, food/vomitus	<100	116.7	107.5	93.2	93.2	88.5	
Congestive heart failure, nonhypertensive	<100	98.2	96.0	97	96.8	98.7	
Chronic obstructive pulmonary disease and bronchiectasis	<100	90.0	109.2	118.2	119.1	119.2	
Acute myocardial infarction	<100	88.8	85.9	85.9	85.9	87.1	
Biliary tract disease	<100	112.6	86.2	98.7	98.8	99.8	
Acute and unspecified renal failure	<100	120.7	121.3	121	125.3	111.2	
HSMR (Rolling 12 months Jun 11 to May 12)							
Point of Delivery							
Combined	<100	95.8	93.9	94.4	91.8	101.9	
Non-Elective	<100	95.5	93.4	93.8	91.3	97.9	
Elective	<100	96.2	102.7	102.5	100.0	110.7	
SQU12: Maternity 12 weeks	90%	86%	97%	86%	98%	98%	
SRS10: Delayed Transfers of Care – Acute & MH	3.00%	3.64%	3.12%	2.62%	3.29%	2.32%	
Fractured neck of Femur							
Number of patients admitted with FNOF	-	27	30	21	26	52	
Patients fit for surgery within 48hrs	-	21	23	13	25	47	
Number of patients admitted with FNOF who were operated on within 48 hrs	-	20	22	10	20	41	
Percentage of patients admitted with FNOF operated on within 48 hours of admission	100%	95%	96%	77%	80%	87%	
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	88%	90%	71%	85%	75%	
25% of suspected stroke patients given CT scan within 3 hours of arrival	25%	68%	77%	75%	67%	70%	
75% of suspected stroke patients given CT scan within 24 hours of arrival	75%	95%	100%	96%	97%	97%	
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	60%	68.00%	75.00%	90.91%	71.43%	95.83%	
Patients who spend at least 90% of their time on a stroke unit	80%	100.00%	95.56%	96.67%	82.81%	84.38%	
Breast Feeding initiation	75%	72.6%	74.6%	76.6%	76.1%	73.7%	
Caesarean Section Rates - Total	<25%	25.7%	25.6%	27.1%	25.1%	28.50%	
Caesarean Section Rates - Emergency	14.98%	12.10%	11.00%	11.20%	9.8%	13.30%	
Caesarean Section Rates - Elective	10.06%	13.60%	14.60%	15.90%	15.3%	15.20%	
Home Birth Rate	6.00%	5.9%	7.3%	6.9%	9.4%	5.40%	

CQUIN 2012-13	Target 2012-13	Apr-12	May-12	Jun-12	Jul-12	Aug-12	RAG
National CQUINS							
1a. 90% of all adult inpatients to have a VTE risk assessment	90% month on month	91.4%	91.4%	90.3%	93.0%		
1b. High risk patients receive appropriate treatment	100% Month on month	94.9%	96.3%	93.7%	98.5%		
2. Improve responsiveness to personal needs of patients (5 questions based on inpatient survey results)							
Were you involved as much as you wanted to be in decisions about your treatment or care?	>71.0			69.7%	78.0%	63.2%	
Were hospital staff available to talk about any worries or concerns that you had?	>63.4			74.9%	84.0%	66.6%	
Did you have enough privacy when discussing condition or treatment?	>82.3			73.8%	81.0%	73.1%	
If you have been prescribed any new medication, have you been informed of any possible medication side effects?	>48.5			47.8%	51.0%	55.9%	
If you are ready to be discharged – have you been informed who to contact if you are worried about your condition after leaving hospital?	>74.3			52.7%	63.6%	56.5%	
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting							
a) Dementia case finding	90%	Awaiting data- Review and validation of data required					
b) initial diagnostic assessment	90%						
c) referral for specialist diagnosis	90%						
4. Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE	-	Monthly data submitted for all ward areas from Apr 12. Theatre recovery area submission from June 12.					
Submission of 3 consecutive months of survey data, covering 100% of appropriate patients per Quarter	RAG						
Regional CQUIN							
1. Establish question and baseline Net Promoter score	Q1 10%	11%	11%	13%			
2, Board and Commissioner reporting	Submission to HCG	Submitted to HCG					
3. Weekly reporting	-	target from Q2					
4. Performance improvement by 10%	10 point improving	- 29.98	- 30.86	0.42	57	57	
Local CQUINS							
1. Implement Oesophageal Doppler Monitoring (ODM) or similar fluid management technology	-	Baseline audit undertaken					
2a, Ensure that a greater number of patients are seen and discharged within 3 hours of arrival time at A&E (CQUIN negotiations ongoing)	-	Audit agreed and currently in progress					
2b. Appropriate referrals to CECs/ Intermediate service from A&E		Baseline audit 50 cases in Q1					
3a. Accuracy of medicines information on discharge	75% error free	Q4 primary care audit, internal assurance programme being formalised					
3b. Analgesic transdermal patches (CQUIN negotiations ongoing)	-	Dataset sent to PCT for approval					
3c. Oral nutritional supplements (ONS) - reduce the use of ONS	Q2 & Q4 Audits - stretch targets to be agreed	Audit methodology currently been agreed					
3d. Triptorelin	Qu Audit 10% increase on 50% baseline (80% @Q4)	Monthly audit currently being undertaken					
4a. Implementation of a policy to send first outpatients letters back to referring rather than registered GP.	Quarterly Updates internal	Awaiting report on progress					
4b. NGH will scope electronic communications systems and implement within 1 year if possible to ensure the swift and secure transfer of information.	Quarterly Updates Primary Care	Awaiting report on progress					
MESCG CQUINS							
1. Quality Dashboards	-						
Identify and provide contact details of the following:							
- an overall dashboards lead for the Provider		Confirmed					
- a dashboard lead in each clinical area for which a dashboard is required in 12/13	-	Clinical Directors (TBC)					
Provide a summary setting out the plans for implementation of the dashboards within the required timescale							
3. Use of Intensity Modulated Radiotherapy	Target to be derived from Q1 data	9%					
4a. Cancer Chemotherapy Performance Status	-	91.7%	93.3%	99.2%	95.1%	95.0%	
4b. Cancer Chemotherapy Performance status 2 or above		-	-	100%	100%	-	
4c. Improve appropriate assessment and Improve mortality rates							
Percentage of Oncology patients deaths within 30 days of receiving chemotherapy		0.10%	0.43%	0.27%	0.25%		
Percentage of Haematology patients deaths within 30 days of receiving chemotherapy		0.00%	0.00%	0.00%	0.00%		
5. Hepatitis C. Compliance with treatment / improved patient outcomes	-	Quarterly audit undertaken					
7. Reduction of catheter - related CONS	7% Baseline 2011-12	Awaiting data from BADGER					

APPENDIX 3 – QUALITY OBSERVATORY DASHBOARD (Northampton General Hospital)

Created and maintained by NHS Midlands and East Quality Observatory

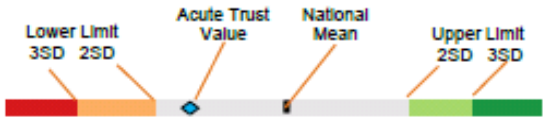
Acute Trust Quality Dashboard

NORTHAMPTON GENERAL HOSPITAL NHS TRUST

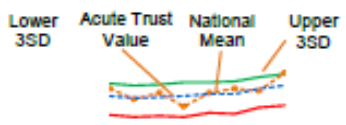
Release 4.00 : Summer 2012

Northampton General Hospital NHS Trust (NGH) is a medium sized acute hospital with a busy emergency department, maternity unit, acute renal unit and interventional cardiology unit. NGH is a cancer centre providing services for patients form Northampton, Kettering and Milton Keynes and is a designated Stroke Centre. Outpatient and Day Surgery services are also provided at Danetre Community Hospital, Daventry.

Spine Charts



SPC Sparklines



		1. Preventing People from dying prematurely	Period	Value	National Mean	Chart	Trend
Clinical Effectiveness	PD02	Age / Sex standardised hospital mortality from conditions amenable to healthcare	RY Q4 1112	85.5	100.0		
	PD03	Age / Sex standardised in hospital mortality in low risk HRGs	RY Q4 1112	59.5	100.0		
	PD04	Crude in hospital perinatal mortality per 1,000 births (including still births)	RY Q4 1112	8.36	6.64		
	PD06	Summary Hospital-level Mortality Indicator (SHMI) - Emergency & Elective	RY Q3 1112	106.3	100.3		
	PD07	SHMI - Elective (pending data)	xxx	xxx	xxx		
	PD08	SHMI - Emergency (pending data)	xxx	xxx	xxx		
	PD09	SHMI - Stroke (sub-group 66)	RY Q3 1112	86.2	100.4		
	PD10	SHMI - COPD (sub-group 75)	RY Q3 1112	115.1	100.4		
	PD11	SHMI - MI (sub-group 57)	RY Q3 1112	86.5	100.2		
	PD12	SHMI - #NOF (group 120)	RY Q3 1112	109.4	99.7		
	PD13	SHMI - Pneumonia (sub-group 73)	RY Q3 1112	133.4	100.2		
	PD14	SHMI - CHF (sub-group 65)	RY Q3 1112	117.6	100.2		
	PD15	SHMI - Renal (sub-group 99)	RY Q3 1112	117.1	100.2		
	PD16	SHMI - Diabetes (sub-group 34+35)	RY Q3 1112	112.3	100.6		
	PD25	% of patients with a fractured neck of femur operated on within 48 hours	Q4 1112	80.9%	77.9%		
	PD30	Cancer waits – % waiting less than 31 Days from decision to treat to first treatment	Q4 1112	99.0%	98.4%		
	PD31	Cancer waits – % waiting less than 62 days from GP referral to first treatment (HQU15)	Q4 1112	87.1%	87.5%		
		2. Enhancing quality of life for people with long term conditions	Period	Value	National Mean	Chart	
	EQ01	% emergency admissions for >65 years old with dementia	Q4 1112	15.1%	15.6%		
	EQ02	LOS (Days) for patients >65 years old admitted in an emergency with Dementia	Q4 1112	22.9	14.9		
	EQ03	LOS (Days) for patients >65 years old admitted in an emergency	Q4 1112	13.0	10.3		
	EQ04	Ambulatory care sensitive conditions - % of emergency admissions for cellulitis and DVT (based on SQU04_01)	Q4 1112	1.76%	1.46%		
	EQ05	% of admissions with zero day LOS for emergency ambulatory care conditions	Q4 1112	33.8%	41.2%		
		3. Helping people to recover from episodes of ill health or following injury	Period	Value	National Mean	Chart	
	IH01	Emergency readmission - % within 30 days following non-elective admission	Q4 1112	13.02%	13.06%		
	IH02	Emergency readmission - % within 30 days following elective admission	Q4 1112	5.82%	6.42%		
	IH03	Emergency readmission - % within 2 days following non-elective admission	Q4 1112	2.12%	2.49%		
	IH04	Emergency readmission - % within 2 days following elective admission	Q4 1112	0.92%	0.98%		
	IH31	Emergency readmission - % within 30 days following non-elective admission (Same Specialty)	Q4 1112	8.47%	6.96%		
	IH32	Emergency readmission - % within 30 days following elective admission (Same Specialty)	Q4 1112	3.21%	2.79%		
	IH33	Emergency readmission - % within 2 days following non-elective admission (Same Specialty)	Q4 1112	1.39%	1.33%		
	IH34	Emergency readmission - % within 2 days following elective admission (Same Specialty)	Q4 1112	0.52%	0.48%		
	IH05	Emergency readmission - % within 30 days following discharge - Angina	Q4 1112	18.67%	14.73%		
	IH35	Mean length of stay (LOS) for patients admitted for Angina	Q4 1112	3.2	4.2		
	IH06	Emergency readmission - % within 30 days following discharge - Asthma	Q4 1112	5.56%	11.90%		
	IH36	Mean length of stay (LOS) for patients admitted for Asthma	Q4 1112	7.9	5.8		
	IH07	Emergency readmission - % within 30 days following discharge - CCF	Q4 1112	15.85%	18.03%		
	IH37	Mean length of stay (LOS) for patients admitted for CCF	Q4 1112	9.9	11.1		
	IH08	Emergency readmission - % within 30 days following discharge - COPD	Q4 1112	17.88%	22.89%		
	IH38	Mean length of stay (LOS) for patients admitted for COPD	Q4 1112	8.3	7.3		
	IH09	Emergency readmission - % within 30 days following discharge - Diabetes	Q4 1112	8.00%	16.71%		
	IH39	Mean length of stay (LOS) for patients admitted for Diabetes	Q4 1112	23.7	11.5		
	IH10	Emergency readmission - % within 30 days following discharge - Epilepsy	Q4 1112	25.00%	15.10%		
	IH40	Mean length of stay (LOS) for patients admitted for Epilepsy	Q4 1112	9.1	6.3		
	IH11	Emergency readmission - % within 30 days following discharge - Renal	Q4 1112	15.46%	14.57%		
	IH41	Mean length of stay (LOS) for patients admitted for Renal	Q4 1112	10.0	7.8		
	IH21	% patients discharged to usual place of residence	Q4 1112	95.9%	95.0%		
	IH22	% of eligible patients taking part in PROMS (eligible FCEs) (Apr-Sept 11)	1112	54.8%	54.6%		
	IH23	Patient Reported Outcome Measures - % Patients reporting an improvement following hip replacement (Apr-Dec 11)	1112	84.7%	87.4%		
	IH24	Patient Reported Outcome Measures - % Patients reporting an improvement following knee replacement (Apr-Dec 11)	1112	77.3%	79.3%		
	IH25	Patient Reported Outcome Measures - % Patients reporting an improvement following varicose vein procedure (Apr-Dec 11)	1112	0.0%	50.4%		
	IH26	Patient Reported Outcome Measures - % Patients reporting an improvement following hernia procedure (Apr-Dec 11)	1112	54.2%	51.5%		

APPENDIX 4 – QUALITY OBSERVATORY DASHBOARD (East Midlands)

Created and maintained by NHS Midlands and East Quality Observatory

Acute Trust Quality Dashboard

Patient Experience	4. Ensuring that people have a positive experience of care		Period	Value	National Mean	Chart
	PE00	95th Percentile wait for elective inpatient treatment (weeks)	Apr-12	17.8	21.6	
	PE01	Median wait for elective inpatient treatment (weeks)	Apr-12	7.39	8.29	
	PE02	Diagnostic Waits - % of patients waiting over 5 weeks	Q4 1112	0.00%	4.33%	
	PE03	Cancer waits – % seen within 14 days of GP referral to first out-patient appointment (HQU14)	Q4 1112	96.6%	96.2%	
	PE23	A&E - % of patients admitted, tranferred or discharged within 4 hours of arrival	Q4 1112	87.2%	92.7%	
	PE08	A&E re-attendance - % within 7 days (HQU09)	Q4 1112	6.4%	6.7%	
	PE10	Median total time in minutes spent in A&E for admitted and non admitted patients (HQU10)	Q4 1112	121	133.0	
	PE11	A&E attendances - % of patients who leave without being seen (HQU11)	Q4 1112	3.3%	2.8%	
	PE12	A&E - Median Time to initial assessment for patients brought in via ambulance in minutes (HQU12)	Q4 1112	7.0	3.0	
	PE13	A&E - Median Time to treatment in minutes (HQU13)	Q4 1112	61.0	54.0	
	PE14	A&E - % Admissions with zero day LOS	Q4 1112	20.9%	25.0%	
	PE15	Mixed sex accommodation breach rate per 1000 FCEs (HQU08)	May-12	0.00	0.27	
	PE16	On the day cancellations of elective surgery per 1000 procedures for non-clinical reasons	Q4 1112	16.3	9.6	
	PE17	Overall inpatient experience measure	1011	7.4	7.4	
	PE18	Overall outpatient experience measure	1011	7.8	7.9	
	PE19	Overall A&E experience measure	0809	75.7	75.7	
	PE20	Mother satisfaction measure	2010	84.7	83.8	
	PE21	Delayed Transfers of Care per 1,000 occupied beds - NHS Responsibility	Q4 1112	1092.7	574.6	
	PE22	Delayed Transfers of Care per 1,000 occupied beds - Social Care Responsibility	Q4 1112	0.0	159.3	

Patient Safety	5. Treating and caring for people in a safe environment and protecting them from avoidable harm		Period	Value	National Mean	Chart
	SC01	Rate of patient safety incidents reported in trusts per 100 admissions	APR11-SEP11	5.66	6.32	
	SC02	Rate of "serious harm" patient safety incidents reported in trusts per 100 admissions	APR11-SEP11	0.22	0.42	
	SC03	% of all admissions who have venous thromboembolism risk assessment (SQU01)	Mar-12	90.9%	92.8%	
	SC04	Rate of surgical site infections per 10,000 specified orthopaedic operations	1011	175.4	97.1	
	SC05	HCAI - MRSA bacteraemia rate per 1,000,000 occupied beds (HQU01)	Q4 1112	0.0	13.3	
	SC06	HCAI - C. diff bacteria rate per 100,000 bed days (HQU02)	Q4 1112	2.40	2.25	
	SC20	HCAI - MSSA rate per 100,000 bed days	Q4 1112	8.0	8.0	
	SC07	Adult - BADS Efficiency Score (As per BADS V4 directory thresholds)	Q4 1112	83.7	81.8	
	SC21	Paediatric - BADS Efficiency Score (As per BADS V4 directory thresholds)	Q4 1112	84.4	86.5	
	SC08	% of planned day case procedures that are converted to inpatients on the day	Q4 1112	4.1%	4.4%	
	SC09	% of deliveries via Caesarean Section - Elective	Q4 1112	12.66%	10.45%	
	SC10	% of deliveries via Caesarean Section - Non Elective	Q4 1112	18.55%	14.29%	
	SC11	% Admission of full-term babies to neonatal care	Q4 1112	Methodology Currently Being Reviewed		
	SC12	Emergency readmission - % babies within 30 days following delivery	Q4 1112	7.14%	6.96%	
	SC17	Medication errors per 1,000 bed days	APR11-SEP11	8.74	7.25	
	SC19	Incidence of patients with pressure ulcers per 1000 admissions	Mar-12	0.75	2.06	

Organisational Context	6. Organisational Context		Period	Value	National Mean	Chart
	OQ01	Admitted Patient Care - % Valid data (Average for all fields)	Apr-12	99.7%	96.88%	
	OQ02	Out Patient - % Valid data (Average for all fields)	Apr-12	92.3%	94.53%	
	OQ03	Accident and Emergency - % Valid data (Average for all fields)	Apr-12	99.7%	95.81%	
	OQ21	Admitted Patient Care - % Records submitted with valid HRG on first submission	Mar-12	99.2%	95.2%	
	OQ04	Elective - Depth of coding (mean number of secondary diagnosis)	Q4 1112	1.53	2.17	
	OQ05	Non-elective - Depth of coding (mean number of secondary diagnosis)	Q4 1112	3.65	4.32	
	OQ06	Rate of palliative care (ICD10: Z515) per 1,000 episodes	Q4 1112	2.84	7.80	
	OQ20	Rate of palliative care (main specialty 315) per 1,000 episodes	Q4 1112	0.00	0.36	
	OQ18	Rate of use of integrated palliative care pathway (ICD10: Z518) per 1,000 episodes	Q4 1112	5.89	5.43	
	OQ07	Rate of written complaints per 1,000 episodes	1011	4.52	3.91	
	OQ08	NHSLA Claims per 10,000 bed days	1112	1.75	1.91	
	OQ09	Workforce - FTE Nurses per bed day	Mar-12	1.74	1.87	
	OQ10	Workforce - Sickness % - Medical	Mar-12	0.72%	1.17%	
	OQ11	Workforce - Sickness % - Nurse	Mar-12	5.5%	4.4%	
	OQ12	Workforce - Sickness % - Midwife	Mar-12	5.3%	4.5%	
	OQ13	Workforce - Sickness % - Other	Mar-12	4.5%	4.4%	
	OQ14	Staff recommendation of the trust as a place of work (CQC survey)	2011	47.5%	52.4%	
	OQ15	Staff recommendation of the trust as a place to receive treatment (CQC Survey)	2011	52.4%	62.8%	
	OQ16	Overall medical trainees global satisfaction score (GMC survey)	2012	77.8	78.6	
	OQ17	Consultant clinical supervision trainers given to their trainees	2012	87.6	86.8	
	OQ19	% of A&E attendances which are "inappropriate" (V08 / VB11Z)	Q4 1112	16.7%	15.4%	

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title	Patient Experience – Friends and Family Test
Submitted by	Suzie Loader, Director of Nursing
Prepared by	Jan Grant, Patient Experience Lead (interim)
Date of meeting	27th September 2012
Corporate Objectives Addressed	Improve Clinical Quality and Safety

SUMMARY OF CRITICAL POINTS

Friends & Family Test Scores (FFT) data for August: -

- **Manual collection: +76**
- **Hospedia bedside collection: 25**
- **Combined score: 57**

CQUIN target for Friends and Family Test improvement by 31 March 2013 is 80. This figure is a 10% increase on the baseline figure of 70 (July's manually collected FFT result rate)

PATIENT IMPACT

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

STAFF IMPACT

The FFT Score provides staff with real time feedback.

FINANCIAL IMPACT

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

If the Trust fails to achieve the regionally set CQUIN, this will have financial implications through the reduction of the CQUIN payment

EQUALITY & DIVERSITY

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

LEGAL IMPLICATIONS

Nil

RECOMMENDATIONS

- The Board continue to support the dual collection of patient experience data until the end of September 2012, when it will be reviewed.
- Members of the Board are asked to note the contents of this report and to challenge as appropriate.

1.0 Introduction

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

The FFT score is calculated as follows:

> *'The number of promoters (people who scored between 10-9) – the number of detractors (people who scored between 6-0) divided by the total number of responses received, multiplied by 100 = FFT'.*

FFT score calculated for August 2012 is as follows: 317 – 14/399 x 100 = 76.

It should be noted the manual questionnaires (data from which is submitted monthly to the SHA) was completed by only 9.47% of discharged patients during August rather than 10% of discharges required in the CQUIN. However, when combined with the Hospedia data, the total response rate was 15.3%. Although the SHA have stated that they want to report only our manual data, because we didn't achieve the 10% footfall required, a decision was made by the Chief Executive to submit the combined score for August, which equated to 57. It is recognised that this will bring our overall score down and that for August we will be in the bottom quartile, but felt that it was more important to achieve the CQUIN target. From October, we will only be collecting manual data and have put more robust monitoring systems in place to ensure that we exceed the 10% footfall in future. Care Group Lead Nurses and Matrons are supporting the Patient Experience Lead to monitor and encourage all wards to collect the data. This has been discussed at the Nursing and Midwifery Board and the Senior Nurses meeting (where all Matrons are in attendance). The Board should be re-assured that the September figures generated to date exceed the 10% required for manual data collection.

The Trust noted a discrepancy between the verbal accounts of patients experience and the consistently low responses reported on the Hospedia bedside system. To accurately report patients' responses to the question ***'Would you or your family recommend this hospital service to family and friends?'*** a manual collection of patient's views was introduced on 24 June 2012. Since that time the manual results have improved significantly. The Hospedia bedside collection results although demonstrating an improvement remain unreliable and places the Trust as a significant outlier when measured against other NHS Trusts in the SHA.

Following a discussion with a member of the Performance Team at the Strategic Health Authority in July, the Trust was advised to only submit the manually collected results as these are now validated and better reflect the views of patients with greater accuracy than the information collected from the Hospedia bedside unit. The SHA Performance Report submitted to the SHA Board in June 2012 included manually collected data from Northampton Hospital. The Trust agreed to continue to collect both manual and Hospedia data until the end of September 2012, when a decision will be made regarding future data collection.

2.0 Results

The manual collection of the Family and Friends Test continues to demonstrate positive results as indicated in the table below.

Table 1: FFT manual collection results for June, July and August 2012

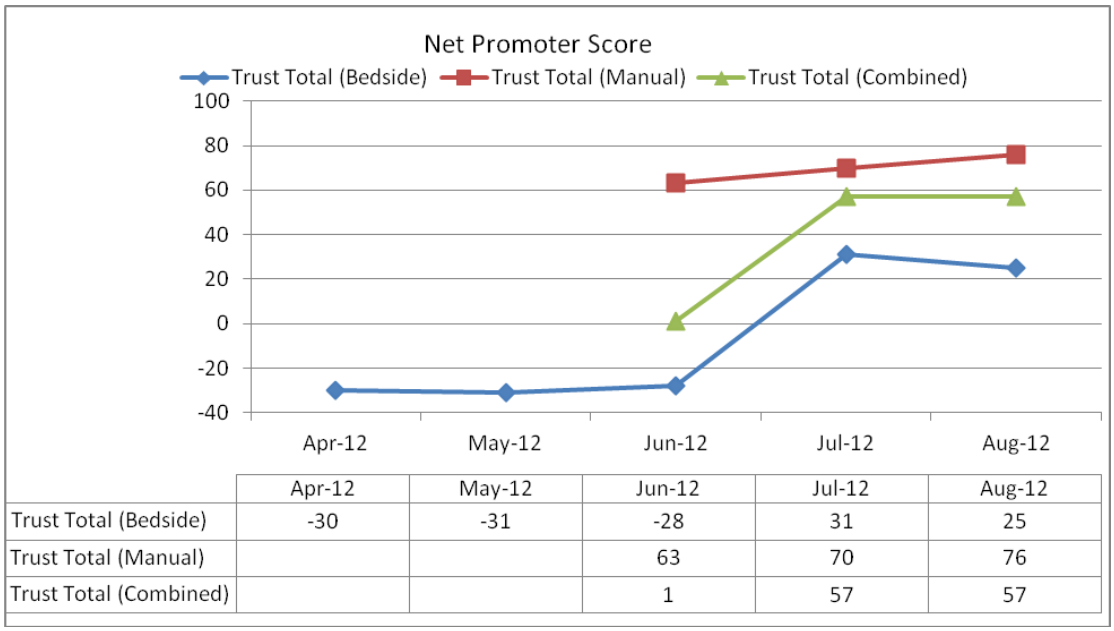
Monthly FFT results	June 2012	July 2012	August 2012
Manual collection	+63	+70	+76
Bedside (Hospedia collection)	-28	+31	+25
Combined collection	0.417	+57	+57

2.1 Circulating the results across the Trust

Results from the previous week's Family and Friends Test results are circulated to ward and departmental Matrons and Ward Managers early in the following week, affording them an opportunity to respond to comments or concerns raised by patients. Directorate Governance Facilitators have been asked to place FFT results as a standing agenda item on their Directorate Governance meetings.

The following graph demonstrates the monthly FFT scores by the different data capture methods used to date: bedside, manual and combined reporting.

Table 2: Monthly Friends and family (Net Promoter) scores April – August 2012



	Apr-12	May-12	Jun-12	Jul-12	Aug-12
Trust Total (Bedside)	-30	-31	-28	31	25
Trust Total (Manual)			63	70	76
Trust Total (Combined)			1	57	57

2.2 Reduction of FFT responses: manual collection, August 2012

As indicated above, the Trust discharged 4209 patients during August 2012, however only 399 (9.47%) discharged patients completed the manual questionnaire, although overall data collection stands at 15.3%. Following a discussion between the Director of Nursing, CEO and the SHA, it was agreed that the combined score for August would be submitted to the SHA. This combined figure exceeds the 10% discharge collection target, but revises the Trust's monthly FFT score down from 76 to 57.

As highlighted above, more robust monitoring systems have since been put in place to prevent re-occurrence. The drop in the number of manual respondents was raised with Matrons and Ward Managers and their assistance requested to improve the number of responses during September 2012.

This item is now a standing agenda item on the Matron's and Sisters meeting and the Nursing and Midwifery Board. The responsibility to improve the discharge questionnaire FFT data collection rests with Matrons who are supporting the ward areas to ensure the data collection figures remain consistently above 10%.

3.0 FTT improvement: CQUIN baseline score

All Trusts in Midlands and East SHA must demonstrate a minimum 10 point improvement in the Family and Friends Test scores by 31 March 2013, or demonstrate that they are in the top quartile of trusts. This regional CQUIN is predicated on the baselines agreed with local commissioners. Northampton Commissioners agreed to adopt the baseline score from July 2012. The baseline for the CQUIN was agreed as 70. Therefore the CQUIN challenge for this Trust will be to improve our FFT scores to **80** by 31 March 2013. The financial value for the achievement of this Patient Experience CQUIN is £251,000.

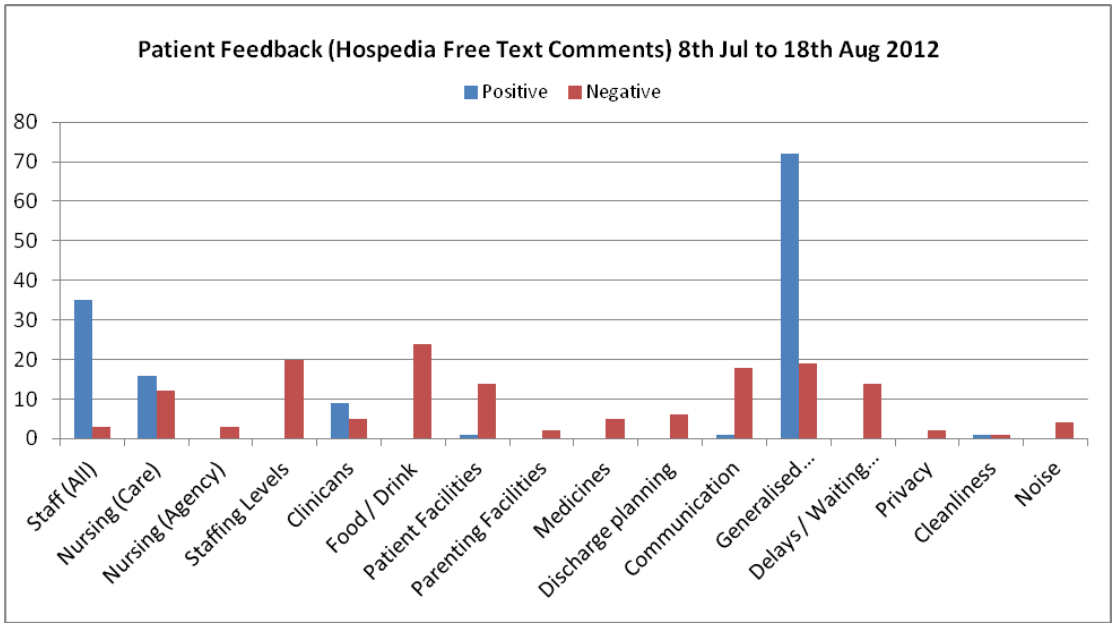
4.0 Themes

Many patients are providing commentaries on the manual FFT questionnaires which provide an unexpected opportunity for wards and departments to collect real time feedback. This information is shared with Matrons, Care Group Lead Nurses and Governance Facilitators weekly. 287 comments were received between July and August of which 135 were positive and 152 negative. The top five negative comments were related to: -

- Food (24)
- Staffing levels (20)
- Communication (18)
- Delays/waiting times (14)
- Facilities (14)

72 positive comments were received in the generalised comments field and this was the highest recorded number of results in any category. The comments are categorised into themes and illustrated in the table below. The generalised column is an amalgamation of comments with no particular theme e.g. *"Nurse X was particularly helpful."*

Table 3: FFT Patient comments: 8 July -18 August 2012



5.0 Bedside unit (Hospedia) data collection

Following a review of the three month pilot to manually collect FFT questionnaires, a decision to continue with the manual collection has been taken by the Director of Nursing and Patient Services. She will be discussing the FFT data collection feature of the Hospedia contract with representatives from Hospedia in the forthcoming weeks.

6.0 Other developments

6.1 Learning from other organisations

Sherwood Forest NHS Foundation Trust consistently receives a FFT score of +89 making the organisation the highest rated hospital across Midlands and East SHA. The Patient Experience Lead visited the organisation in July to learn from their success which they attribute to the following: -

- Identifying a dedicated team to visit wards, distribute and collect FFT questionnaires
- Setting ward targets for number of questionnaires to be collected each week
- Clinical Directors “owning” and reporting on FFT results during the monthly Governance meetings
- Inviting Ward Managers and Consultants to account for poor FFT results in their Directorates/Wards at Governance meetings

Care Group Lead Nurses and Matrons are agreeing individual ward/departmental targets for the collection of this data with Ward/Departmental Managers.

6.2 Midlands and East SHA results

Family and Friends Test results comparing hospitals across Midlands and East SHA during Quarter 1 indicate that we continue to improve our scores. The table below was produced by the SHA and received into the Trust during August 2012.

Table 5: Midlands and East SHA organisational results of outlier organisations - April – July 2012

	Apr-12	May-12	Jun-12	July-12 *
Chesterfield Royal Hospital NHS Foundation Trust	31	35	58	55
Derby Hospitals NHS Foundation Trust	69	60	52	62
Kettering General Hospital NHS Foundation Trust	52	64	68	63
Milton Keynes Hospital NHS Foundation Trust	39	48	46	60
Northampton General Hospital NHS Trust			63	70
Nottingham University Hospitals NHS Trust	50	55	59	64
Sherwood Forest Hospitals NHS Foundation Trust	95	83	89	88
United Lincolnshire Hospitals NHS Trust				67
University Hospitals of Leicester NHS Trust	51	51	53	54

6.3 Picker Project – Testing the reliability of the Family and Friends Test Data

The Picker Institute completed a project to identify a single question which could meaningfully gain consistent information about patients' experiences of different services. The project was initiated as a number of concerns were raised regarding the validity of the interpretation of the Friends and Family question in healthcare settings and was shared across the NHS earlier this month.

The results indicate the Family and Friends Test question (Net Promoter Score) is not recommended for use in the NHS, as they found that patients reacted badly to the concept of "recommendation", particularly as a number of interviewees misunderstood what the question was asking. Picker researchers recommended that a simple overall question with minimum wording and an 11 point Likert scale was well understood by interviewees and proved successful as a measure of overall patient experience.

They concluded their report with the recommendation that the following question is adopted for future national surveys**. "Overall I had a very poor/good experience"** which will be assessed using the Likert scale as indicated below.

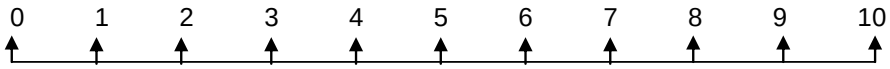
This question will be piloted alongside the current data collection across the Trust in October as there is the potential for this to be adopted as the national Patient Experience CQUIN question from 1 April 2013.

Recommended patient experience question from the Picker Institute project: June 2012

Overall…..

I had a very poor experience

I had a very good experience



7.0 Recommendations

Members of the Board are asked to:

- Challenge the content of the report and support the actions defined.

Appendix 1

Family and Friends Test: Combined Results by Ward: August 2012

Northampton General Hospital NHS
NHS Trust

Northampton General Hospital (T3)

How likely is it that you would recommend this service to Friends or Family?

August Monthly Report (Manual & BSU Data)
Date: 29/07/12 - 01/09/12

	Green	Amber	Red
Benchmark against:	1	0	

Ward Name	Responses	Results			NET Promoter Score
		Promoter	Passive	Detractor	
Collingtree Medical	13	2	9	2	0
Cedar	14	7	5	2	36
Rowan	26	15	6	5	38
Allebone	9	5	1	3	22
Creaton	10	5		5	0
Dryden	19	14	4	1	68
Finedon	14	6	4	4	14
Abington	10	6	2	2	40
Talbot Butler	5	3		2	20
Willow	21	16	3	2	67
Eleanor	10	6	4		60
Paddington	37	26	7	4	59
Robert Watson	39	26	8	5	54
Spencer	27	18	4	5	48
Disney	32	26	3	3	72
Althorp	11	7	2	2	45
Hawthorn	46	41	5		89
Balmoral	109	79	23	7	66
Head & Neck	7	7			100
Becket	36	23	11	2	58
Collingtree Surgical	43	34	8	1	77
Holcot	33	25	6	2	70
Knightley	15	11	4		73
Benham	23	9	8	6	13
EAU	20	7	7	6	5
Brampton	11	9	2		82
Head and Neck	4	4			100
Grand Total	644	437	136	71	57

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Appendix 2

Family and Friends Test -Manually Collected Results by Ward: August 2012

Northampton General Hospital NHS
NHS Trust

Northampton General Hospital (T3)

How likely is it that you would recommend this service to Friends or Family?

August Monthly Report (Manual)
Date: 29/07/12 - 01/09/12

	Green	Amber	Red
Benchmark against:	1	0	

Ward Name	Responses	Results			NET Promoter Score
		Promoter	Passive	Detractor	
Collingtree Medical	4	1	3		25
Cedar	9	5	4		56
Rowan	16	12	3	1	69
Creaton	1	1			100
Dryden	10	8	2		80
Finedon	6	2	2	2	0
Abington	5	3	1	1	40
Talbot Butler	2	2			100
Willow	15	15			100
Eleanor	9	6	3		67
Paddington	15	13	2		87
Robert Watson	24	20	4		83
Spencer	10	9	1		90
Disney	22	20		2	82
Althorp	6	4	1	1	50
Hawthorn	36	32	4		89
Balmoral	94	73	17	4	73
Head & Neck	1	1			100
Becket	27	17	8	2	56
Collingtree Surgical	37	31	5	1	81
Holcot	20	17	3		85
Knightley	13	9	4		69
Benham	2	2			100
EAU	1	1			100
Brampton	10	9	1		90
Head and Neck	4	4			100
Grand Total	399	317	68	14	76

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Appendix 3

Family and Friends Test Bedside Collected Results by Ward: August 2012

Northampton General Hospital NHS
NHS Trust

Northampton General Hospital (T3)

How likely is it that you would recommend this service to Friends or Family?

August Monthly Report (BSU Data)
Date: 29/07/12 - 01/09/12

	Green	Amber	Red
Benchmark against:	1	0	

Ward Name	Responses	Results			NET Promoter Score
		Promoter	Passive	Detractor	
Collingtree Medical	9	1	6	2	-11
Cedar	5	2	1	2	0
Rowan	10	3	3	4	-10
Allebone	9	5	1	3	22
Creaton	9	4		5	-11
Dryden	9	6	2	1	56
Finedon	8	4	2	2	25
Abington	5	3	1	1	40
Talbot Butler	3	1		2	-33
Willow	6	1	3	2	-17
Eleanor	1		1		0
Paddington	22	13	5	4	41
Robert Watson	15	6	4	5	7
Spencer	17	9	3	5	24
Disney	10	6	3	1	50
Althorp	5	3	1	1	40
Hawthorn	10	9	1		90
Balmoral	14	5	6	3	14
Head & Neck	6	6			100
Becket	9	6	3		67
Collingtree Surgical	6	3	3		50
Holcot	13	8	3	2	46
Knightley	2	2			100
Benham	21	7	8	6	5
EAU	19	6	7	6	0
Brampton	1		1		0
Grand Total	244	119	68	57	25

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Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title	Monthly Infection Prevention Performance Report
Submitted by	Suzie Loader, Director of Nursing, Midwifery, Patient Services/DIPC
Prepared by	Pat Wadsworth Infection Prevention and Control Lead Nurse
Date of meeting	27th September , 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 discuss and where appropriate challenge the content of this 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.

2 MRSA Bacteraemia

Bed days data are statistics based on an approximate count of the average number of occupied hospital beds in a trust each day (bed days). This data is collated by the Department of Health. The MRSA rates for each trust represent the average number of MRSA bacteraemia reports per 1000 bed days, for that 6 month period.

The Trusts trajectory for MRSA bacteraemia in 2012/13 is 1 case. During July and August there were **0 >48hrs** MRSA bacteraemia, with a total of 1 case for the year to date.

MRSA Colonisation & Screening

During the summer there were15<48hrs (July) and 7<48hrs (August) and **2>48hrs** cases of MRSA colonisation for July and August respectively.

Compliance with the screening of elective admissions = 99.5% (July and August)
Compliance rate for emergency screening was:

96.7% in July
94.9% in August

Special Measures - MRSA

Definition

A period of increase incidence is defined by the Health Protection Agency as 2 or more new cases of post admission *C.difficile* or MRSA colonisation on a ward in a 28-day period. Post admission is defined as:

- *C.difficile* sample dated over three days after admission
- MRSA swab dated over 48 hours after admission

Action

If this occurs on a ward, **Special Measures** will be implemented. Special Measures actions will vary for *C.difficile* and MRSA due to the nature of each organism.

Knightly ward was on special measures due to two >48hrs cases of MRSA colonisations in July. However, this could have been reduced to 1 if one of the patients had been screened on admission. Findings from the special measures were a dusty vent in the clean room, and some furniture not fit for purpose - these were actioned accordingly.

Dryden ward is on special measures due to two>48hrs cases of MRSA colonisations in August. These measures are on-going with the findings being presented in the October board report.

MSSA Bacteraemia (Meticillin Sensitive *Staphylococcus aureus*)

During July there were 5<48hrs and **1>48hrs** MSSA bacteraemia cases. A Root Cause Analysis (RCA) was undertaken on the 1 > 48 hours MSSA bacteraemia case on **Creaton ward.** Learning from this RCA surrounded the treatment of diabetic foot ulcers and wound care plans not being used effectively. A group has been formed between the diabetic foot team and tissue viability services to identify additional information which will go into the complex wound nursing care plan.

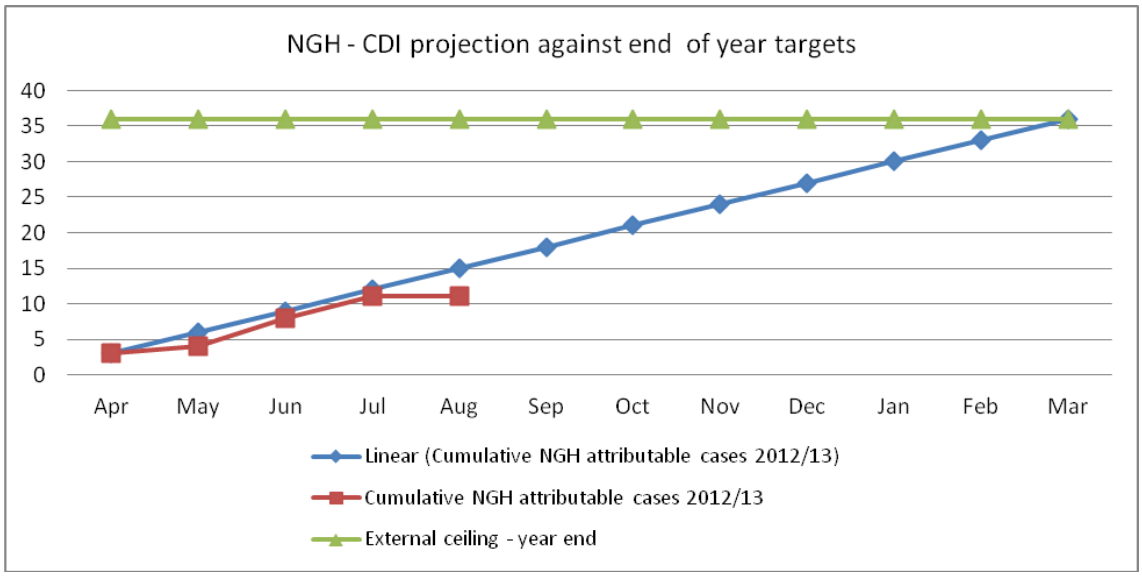
During August there were 6<48hrs and **1 >48hrs** MSSA bacteraemia cases. A Root Cause Analysis (RCA) was undertaken on the 1 > 48 hours MSSA bacteraemia case on **Finedon ward.** This is a complex case; the patient is a renal patient with an invasive device (permacath) who was originally a patient in ITU at Kettering General Hospital. The RCA has not yet been completed and so results will be presented next month.

3 Clostridium difficile

The annual target identified for each trust is calculated on the total number of bed days for patients 65 years and over, divided by the total number of bed days for patients 65 years and over.

Trust Rate = (Number of Cdifficile reports from that Trust for the time period) x 1,000
(Total bed –days, in the Trust, for patients aged >65 years over the time period)

The Trust has an annual target of 36 C. diff. cases or less. During July the Trust identified 2<3 day and **3 >*3 day cases of C. diff*,** and for August 4<3 day and **0>*3 day cases of C. diff,*** which totals 11 >3 day cases of C. Diff for the year (4 under the anticipated trajectory – see graph below).



Brampton ward were placed on special measures for 2 post C.diffs in July, even though these were more than 28days apart. This action was taken as a precaution, however on review, nothing significant was found. An antimicrobial review identified no major concerns with prescribing antibiotics, however there were a couple of minor issues with the course length, which the antimicrobial pharmacist discussed with the junior doctors at that time.

4 Surgical Site Infection Surveillance Scheme (SSIS)

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

Surgical Site Infection Surveillance

Background

The patient is monitored from operation until discharge for up to 30 days following admission. Therefore when submitting the results to the Board the surveillance is still ongoing and has not been completed and infection rates are classed as **interim results**.

The interim results for July 2012

- Repair #NOF's. show that there were ***no infections*** resulting from 26 operations
- Breast operations show that there were ***no infections*** resulting from 38 operations
- Limb amputation operations show that there were ***no infections*** resulting from 16 operations

The interim results for August 2012

- Repair #NOF's. show that there were ***no infections*** resulting from 53 operations
- Breast operations show that there were ***no infections*** resulting from 30 operations
- Limb amputation operations show that there were ***no infections*** resulting from 12 operations

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

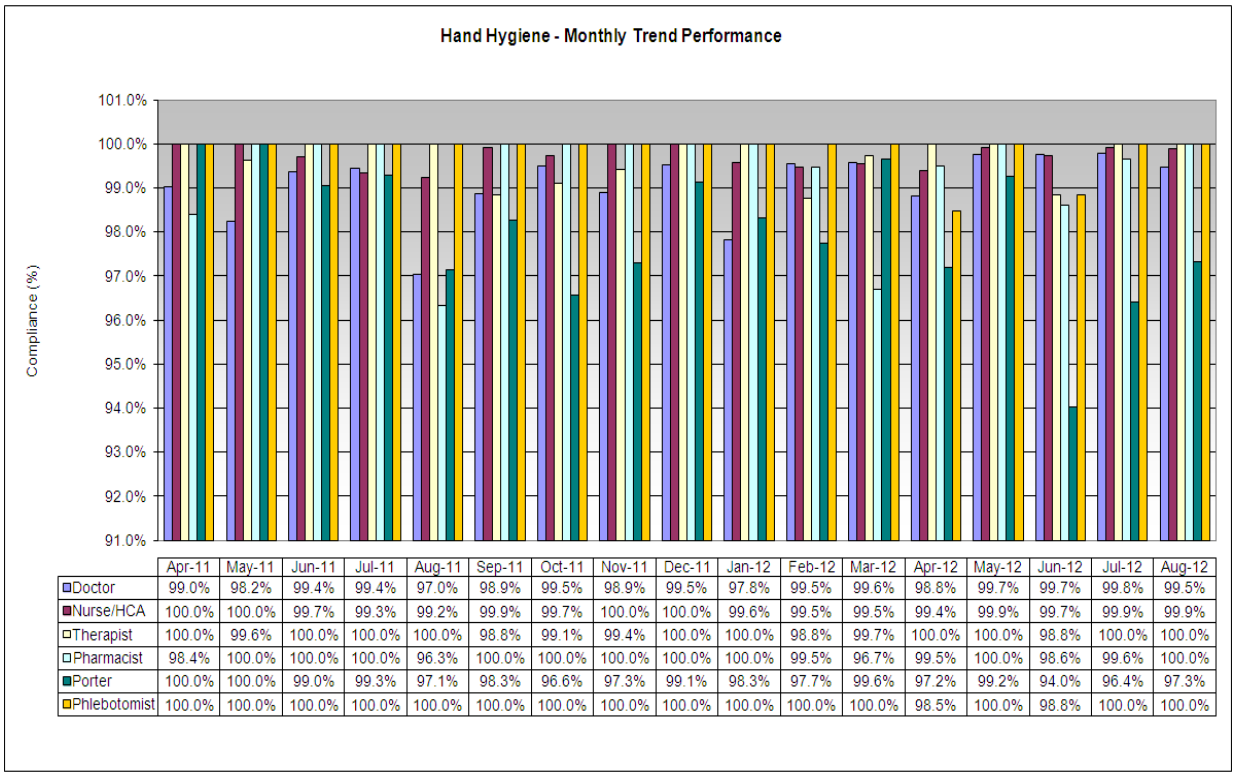
5 Hand Hygiene Audit

Information from the Hand Hygiene Observational Tool (HHOT) data shows that in:

- July overall Trust compliance for hand hygiene was 91.2%. Seven areas failed to submit the completed audit.
- August overall Trust compliance for hand hygiene was 84.4%. Thirteen areas failed to submit the completed audit.

The non-compliant areas are being investigated by the Matrons, who have been tasked with presenting improvement plans to the October Infection Prevention meeting.

The graph below demonstrates hand hygiene compliance in the ward areas only, which is considerably higher than the overall trust score.



	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	Jun-12	Jul-12	Aug-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%	99.7%	99.8%	99.5%
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%	99.7%	99.9%	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%	98.8%	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%	98.6%	99.6%	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%	94.0%	96.4%	97.3%
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%	98.8%	100.0%	100.0%

The Trust is reviewing the way that infection prevention audits are undertaken. Currently the majority of them are done via self-assessment. However, concerns were raised at the July Infection Prevention meeting regarding the robustness of this methodology. It was agreed that for the following two months, the Matrons would conduct peer review hand hygiene audits in addition to the self-assessment audits. It was clear from the results that Peer Review is a more reliable data collection method, as the results obtained were lower than for self-assessment. As a result, the Infection Control Team in conjunction with the Matrons are reviewing all the Saving Lives audits to identify which ones can move to peer-review and which ones need to remain as self -assessment. Once this review is complete, the new methodology will be introduced.

Tuberculosis (TB) at Harborough Lodge

Harborough Lodge in Northampton provides a dialysis service to local people. Although the estate is owned by NGH, the renal dialysis service is provided by Universities Hospital of Leicester (UHL) Renal Dialysis Unit and not NGH.

A renal dialysis patient was diagnosed with TB in July 2011. The patient subsequently died. A second renal dialysis patient at Harborough Lodge was diagnosed with TB in 2012 and has also died. Following investigation, it was identified that both patients dialysed in adjacent stations on the same session. They sat next to each other for approximately 4 hours per day, three times per week.

Harborough Lodge was originally designed as a 6 bedded renal unit; it has since expanded to 15 dialysis stations with a weekly capacity of 84 patients. The dialysis stations are closely spaced, which indicates a potentially higher infection risk. At the time of the incident, the estate required some remedial repair & refurbishment, which has now been carried out.

All close contacts and staff have had blood tests and all previous patients have been re-x-rayed to test for further positive cases – non have been identified.

In order to reduce the risk of any future possible cross infection due to the close proximity of the dialysing units, the number of patients dialysing has been reduced.

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

BOARD SUMMARY SHEET	
Title: -	Performance Report
Submitted by: -	Christine Allen – Chief Operating Office and Deputy Chief Executive
Date of meeting: -	27th September 2012
Corporate Objectives Addressed: -	Enhance all urgent care pathways, including critical care Use information on quality finance and demand to determine service priorities Invest in enhanced quality

SUMMARY OF CRITICAL POINTS: -

This report sets out the key areas of performance for Northampton General Hospital NHS Trust for Month 5**(August 2012)**.

- The Trust achieved 92.8% in August against the standard of 95% of patient spending a maximum of 4 hours in A&E. Action plans are in place to recover the year-end position and achieve the target for each month from October 2012.
- **62 day standard -** Trust achieved 82.2% against the target 85% for August whilst still maintaining the Q2 position at 85.6%
- **62 day standard for screening** – The Trust achieved 87.5% against the standard of 90% for August whilst still maintaining the Q2 position.

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 – September 2012

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for **Month 5** (August 2012). The report is based on the NHS Performance Framework - Service Performance Standards and Targets.

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

2. SERVICE PERFORMANCE

See Appendix 1 for score card

2.1 A&E Clinical Indicators

The Trust did not achieve the 4 hour A&E transit time. During August 92.8% of patients were treated or admitted within 4 hours against the standard of 95%. The year to date performance is 93.43%.

Action plans are in place to recover the year-end position and achieve the target for each month from October 2012. A revised trajectory model has been agreed and submitted to the SHA. Please see the A&E paper for the latest position and actions taken.

2.2 Referral to Treatment Time (RTT)

During August 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 August there were 55 patients waiting over 26 weeks to start elective treatment. Reasons for delay continue to 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 from November 2012 onwards.

2.3 Cancer Standards

In August the Trust did not achieve the following two cancer standards;

62 day standard from urgent referral to start of treatment.

Trust achieved 82.2% against the target 85% for August whilst still currently maintaining the quarter 2 position at 85.6%. There continues to be breaches in the Urology and Upper GI pathways. For the Upper GI patients, these are as a result of the complex pathway between NGH and UHL and the number of diagnostics required for some patients. All Urology patients requiring specialist treatment such as brachytherapy, surgery or radiotherapy breach as a result of delays for clinical reasons or patient choice reasons. A breach analysis is carried out for all breaches and a full recovery plan has been developed and will be monitored through the performance meeting.

This is a quarterly standard and the Trust is on track to achieve the quarterly position. There is continued focus across the Trust on delivering the action plans to meet this standard.

62 day standard from screening.

The Trust achieved 87.5% against the standard of 90% for August whilst still maintaining the Q2 position. Small numbers of patients are treated each month against this standard: between 10-15. Patients who have breached have been delayed for the following reasons: patient choice and complex diagnostic pathway. A full breach analysis has been carried out and actions included in the recovery plan will be monitored through the weekly performance meeting.

This is a quarterly standard and the Trust is on track to achieve the quarterly position. There is continued focus across the Trust on delivering the action plans to meet this standard.

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	Jun-12	Jul-12	Aug-12	Monthly Delivery	YTD Delivery
Referral to Treatment Times Percentage of Patients seen within 18 weeks across all speciality groups								
Admitted	90%	96.43%	96.56%	97.40%	96.61%	96.43%		
Non-admitted	95%	97.70%	98.33%	98.80%	98.61%	98.43%		
Incomplete pathways	92%	98.21%	97.83%	97.13%	97.30%	97.21%		
No of patients on n incomplete pathwaty with a wait time > 26 weeks	0	27	26	25	49	55		
Number of diagnostic waits > 6 weeks	0	0	0	0	0	0		
A&E 95% Transit time target								
Cumulative	95%	95.05%	93.37%	93.33%	91.98%	92.80%		
Month on Month	95%	95.05%	94.16%	93.88%	93.38%	93.27%		
Cancelled Operations not rebooked within 28 days	0%	0%	0%	0%	0%	0%		
Cancer Wait Times								
2 week GP referral to 1st outpatient	93%	96.30%	95.70%	94.80%	96.59%	95.40%		
2 week GP referral to 1st outpatient - breast symptoms	93%	100.00%	100.00%	100.00%	100.00%	100.00%		
31 Day	96%	96.50%	98.10%	95.90%	99.40%	99.30%		
31 day second or subsequent treatment - surgery	94%	96.20%	97.40%	100.00%	100.00%	100.00%		
31 day second or subsequent treatment - drug	98%	100.00%	95.45%	100.00%	100.00%	100.00%		
31 day second or subsequent treatment - radiotherapy	94%	100.00%	98.10%	100.00%	98.50%	100.00%		
62 day referral to treatment from screening	85%	100.00%	100.00%	100.00%	90.00%	87.50%		
62 day referral to treatment from hospital specialist	85%	92.00%	90.90%	89.30%	93.30%	91.70%		
62 days urgent referral to treatment of all cancers	85%	85.40%	81.51%	68.50%	90.10%	82.20%		
Stroke Indicators								
Proportion of people who have a TIA who are scanned and treated within 24 hours	60%	68.00%	75.00%	90.91%	71.43%	95.83%		
Proportion of people who spend at least 90% of their time on a stroke unit	80%	100.00%	95.56%	95.56%	82.81%	84.38%		
Activity vs. Plan								
Elective Inpatients	>=0%	17%	23%	15%	9%	-1%		
Daycase	>=0%	9%	16%	1%	4%	1%		
Non- Elective	>=0%	13%	26%	6%	2%	4%		
OP 1	>=0%	5%	17%	6%	0%	-7%		
OP Procedures	>=0%	10%	4%	5%	2%	-2%		
New to Follow UP Ratio	2.01	2.05	1.89	1.98	2.00	1.98		
GP Referrals	0%	2.8%	1.4%	1.1%	0.4%	-2.0%		
Day Case Rates	81%	85.74%	85.20%	83.24%	84%	85%		
Sleeping Accommodation Breach	0	0	0	0	0	0		

Northampton General Hospital NHS Trust

Finance Report

Period ended August 2012/13 (M5)

Executive Summary

Year to Date Position

The year to date I&E position is a deficit of £4.6m, £3.6m adverse to plan.

The Trust's CIP programme is £1.2m behind plan for the year to date with total slippage of £2.3m identified compared to the original plan.

In month Position

The position for August is a deficit of £1.5m compared to a planned deficit of £0.4m.

Overall income levels were £66k below forecast, offset by significant increases in expenditure compared to forecast primarily due to variable costs and the cost of staffing escalation areas to manage non-elective demand.

Forecast Position

The headline forecast is for an income and expenditure deficit of £10m. Recovery plan actions totalling £8m have been identified giving rise to an unmitigated deficit of £2m.

The SHA control total for 2012-13 is a surplus of £1m and as such the forecast position is currently a £3m variance to plan.

The key assumptions driving the forecast have been shared with the local Clinical Commissioning Group .

The outcome of the EMPACT clinical audit of readmissions is awaited and forms a key element of the recovery plan.

Financial Risk Rating

Due to the current YTD deficit the Trust is recording a FRR of 1.

At present the liquidity score is calculated as 3 (including WCF). This position may weaken in September when the PDC dividend half year payment is made.

Key Issues

The Trust is forecasting SLA over performance of £12.5m (6%) in 2012 -13. This in turn is driving an expenditure overspend of c. £14m. The lack of PCT QiPPS delivery is evident in Q1 and current activity levels and capacity issues are hampering cost reduction.

There are a number of known risks included in the current forecast but these will need to be refined as risks crystallise.

To deliver financial targets mitigations totalling £11m are required to be delivered in year.

Actions Required

The Trust should continue to focus early attention in delivering mitigating actions.

The Trust should open early dialogue with the PCT to address the costs of transformation and additional capacity.

The decision to proceed with several key transformation schemes needs to be made in light of the potential cost implications to the Trust. The decision to proceed with additional developments should be reviewed in light of the current financial position.

The emerging financial recovery plan requires further development, robust performance management and should be shared with key stakeholders.

Key Numbers

KPIs		
Financial Risk Rating (Shadow)	1	Overriding rules apply
EBITDA	26.8%	EBITDA achieved 27% of plan
Liquidity (days cover)	15.9	Incl. unused WCF of £18m
Surplus Margin	-4.5%	1% required for score of 3
Pay / Income	67.6%	Pay 68% of Income for YTD

I&E Position	£000's	
Reported Position	(4,598)	Deficit of £4.6m to month 5.
FIMS Plan (Year to date)	(1,043)	£1.0m deficit plan to month 5.
PCT SLA Income Variance	2,487	2.8% above plan.
Unmitigated Forecast	-10,030	Forecast before mitigating actions
SHA control total (NGH)	1,000	SHA control total £1m surplus.
Mitigated Forecast	-2,049	Forecast after mitigating actions.

EBITDA Performance	£000's	
Variance from plan	(3,551)ADV	£3.6m behind plan

Cost Improvement Schemes	£000's	
YTD Plan	5,178	£5.2m target to month 5.
YTD Actual	3,981	£3.9m delivered to month 5.
% Delivered	77%	CIPs delivered as a % of plan .
LTF	13,818	Latest Thinking Forecast for year.
Slippagge Identified	2,282	Mitigation Target in LTF
Annual Plan	16,100	Annual Transformation Target.
LTF v. Plan	86%	% of LTF compared to annual plan.

The Board is currently reviewing the forecast I&E position given the YTD deficit incurred for the period to August. Whilst recovery actions have been identified an unmitigated deficit of £2.0m is forecast. For this reason the Board cannot currently confirm that the Financial Risk rating will improve significantly compared to the current score by the financial year end.

Capital	£000's	
Year to date expenditure	2,225	Capital expenditure for period
Committed as % of plan	35%	% 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	(1,373)	Revaluation+Additions - depreciation
Current assets	(761)	Reduction in cash balance.
Current Liabilities	2,042	NHS creditors, accruals and dividend.

Cash	£000's	
In month movement	(858)	Decrease between July and August.
In Year movement	(2,648)	Reduction since March 2012
Debtors Balance > 90 days	615	16% of balances outstanding over 90 days
Creditors > 90 days	98	1.8% of creditors waiting over 90 days
BPPC (by volume) YTD	93.4%	Target 95% paid in 30 days

Shadow FRR

	Metric	Weight %	Aug	Shadow Rating	YTD Score
Achievement of Plan	EBITDA Achieved (% of plan)	10%	27%	1	0.10
Underlying Performance	EBITDA Margin %	25%	1.3%	2	0.50
Financial Efficiency	Return on Assets	20%	-2.18%	1	0.20
Financial Efficiency	I&E Surplus Margin	20%	-4.5%	1	0.20
Liquidity	Liquidity Ratio (Days cover)	25%	16.40	3	0.75
Weighted Average		100%		Calculated Score	2
				Override	-1
				Reported Score	1

I&E

I&E Summary	Plan 2012/13	YTD Actual	YTD Plan	Variance to plan	Forecast EOY
	£000's	£000's	£000's	£000's	
SLA Clinical Income	212,676	90,831	88,345	2,487 Fav	219,605
Other Clinical Income	2,663	1,049	1,108	(59) Adv	2,663
Other Income	23,219	9,977	9,313	664 Fav	23,859
Total Income	**238,558**	**101,857**	**98,766**	**3,091 Fav**	**246,127**
Pay Costs	(153,682)	(68,840)	(65,182)	(3,658) Adv	(164,149)
Non-Pay Costs	(67,612)	(31,717)	(28,274)	(3,444) Adv	(75,183)
CIPs	0	0	0	(0) Adv	
Reserves	(1,850)	0	(459)	459 Fav	(2,410)
Total Costs	**(223,143)**	**(100,557)**	**(93,915)**	**(6,643) Adv**	**(241,742)**
EBITDA	**15,415**	**1,300**	**4,851**	**(3,551) Adv**	**4,385**
Depreciation	(10,184)	(4,131)	(4,131)	0 Fav	(10,184)
Amortisation	(10)	(4)	(4)	(0) Adv	(10)
Impairments	0	0	0	-	0
Net Interest	29	8	12	(4) Adv	29
Dividend	(4,250)	(1,771)	(1,771)	0 Fav	(4,250)
Surplus / (Deficit)	**1,000**	**(4,598)**	**(1,043)**	**(3,555) Adv**	**(10,030)**
Recovery Plan Actions	**0**	**0**	**0**	**-**	**7,981**
Mitigated Forecast Surplus / (Deficit)					**(2,049)**

The year to date position is a deficit of £4.5m compared to a planned position of £1m deficit giving rise to an adverse variance of £3.6m.

The planned position for the full year is for a surplus of £1m.

SLA Income continues to overperform by £2.5m (2.8%). This position includes provision for readmissions fines which are currently subject to a clinical audit.

Expenditure is currently £6.6m above plan driven by temporary staffing costs, non-elective demand and slippage in the Transformation programme delivery of cost improvements.

The headline forecast is for a deficit of £10m by the financial year end. Recovery actions totalling £8m have been identified giving rise to an unmitigated forecast deficit of £2m (£3m adverse to plan).

Recovery Plan Actions

I&E Forecast (2012-13)	£000s
Baseline Forecast (M5+7)	*(10,030)*
Actions to improve M3+9 forecast:	
CQUIN 15%	563
Ward Capacity	180
A&E Investment	512
Emergency Care Project	1,000
Funding for Transformation Costs	2,210
Reinvestment of Readmissions Fines	
Operational Expenditure Measures	620
Review of Care Group forecasts	2,034
Other Measures	200
Transformation Programme	2,618
Risks	(1,805)
Cost Pressures	(150)
TOTAL I&E	**(2,049)**
Control Surplus	1,000
Variance	**(3,049)**

The emerging financial recovery plan includes the following key elements:

- An increase in the level of CQUIN income recognised in the accounts based on projected CQUIN delivery.
- Request to the CCG to fund the non-recurrent impact of non-elective demand and the subsequent impact on A&E and escalation beds across the Trust.
- Agreement from the CCG to invest £1m to support the ongoing Emergency Care Project.
- A requirement to secure up to £2.2m of non-recurrent funding to meet the forecast costs of implementing the Transformation Programme.
- Operational expenditure controls and performance management of Care groups.
- Stretch targets to improve overall CIP delivery as part of the Transformation Programme.

The forecast position includes risks associated with contractual fines, legal costs and the potential impact of PCT QIPP schemes in the second half of the financial year.

Run Rate

3 Month Run Rate £000's	June		July		August	
	Actual	Plan	Actual	Plan	Actual	Plan
SLA Clinical Income	17,062	16,948	19,115	18,043	18,164	18,191
Other Clinical Income	118	220	308	227	164	222
Other Income	1,853	1,891	1,960	1,850	2,119	1,903
Total Income	**19,033**	**19,060**	**21,383**	**20,119**	**20,447**	**20,316**
Pay Costs	(13,737)	(12,994)	(14,062)	(13,121)	(13,908)	(12,958)
Non-Pay Costs	(5,940)	(6,021)	(6,514)	(5,578)	(6,810)	(5,665)
CIPs	-	0	-	(0)	-	0
Reserves	-	119	-	(35)	-	(154)
Total Costs	**(19,676)**	**(18,897)**	**(20,576)**	**(18,734)**	**(20,718)**	**(18,778)**
EBITDA	**(644)**	**163**	**807**	**1,385**	**(271)**	**1,539**
Depreciation	(825)	(825)	(828)	(828)	(828)	(828)
Amortisation	(1)	(1)	(1)	(1)	(1)	(1)
Impairment of Fixed Assets	-	-	-	-	-	-
Net Interest	1	2	2	2	2	2
Dividend	(354)	(354)	(354)	(354)	(354)	(354)
Surplus / (Deficit)	**(1,822)**	**(1,014)**	**(374)**	**204**	**(1,452)**	**358**

The run rate analysis shown in the table opposite highlights the volatility of SLA income casemix month on month, notably in July.

Pay costs have averaged £13.8m during the year but have increased above this level in the last two months. The cost of temporary and interim staffing remains an area of focus with clear plans to reduce the reliance on temporary Nursing staff by December.

Non-pay expenditure has averaged £6.3m per month. There was a significant increase in the run rate in August.

SLA Income & Activity

	ACTIVTY				INCOME						
	YTD Activity Plan	YTD Actual Activity	Activity Variance	% Var	Income Plan £	Income Actual £	Income Variance £	% Var	Volume £	Price £	Total £
DC	15,256	16,056	800	5.2%	9,071,634	9,230,486	158,852	1.8%	227,615	-68,763	158,852
EL	2,403	2,698	295	12.3%	7,254,374	7,042,704	-211,670	-2.9%	531,432	-743,102	-211,670
NEL	17,310	18,786	1,476	8.5%	29,006,891	31,604,919	2,598,028	9.0%	1,857,669	740,359	2,598,028
OPFA	26,543	27,430	887	3.3%	4,316,029	4,527,069	211,040	4.9%	-288,560	499,600	211,040
OPFUP	48,685	48,450	-235	-0.5%	4,446,663	4,418,432	-28,231	-0.6%	-124,701	96,470	-28,231
OPFASPNCL	9,864	11,547	1,683	17.1%	871,930	1,039,259	167,329	19.2%	58,607	108,722	167,329
OPFUSPNCL	26,916	25,386	-1,530	-5.7%	1,292,154	1,246,920	-45,234	-3.5%	-60,829	15,596	-45,234
OPPROC	16,097	16,695	598	3.7%	2,330,363	2,404,701	74,338	3.2%	55,362	18,977	74,338
BLOCK / CPC					28,489,551	29,680,544	1,190,993	4.2%			
MRET											
ARMD	1,545	1,754	209	13.5%	436,937	483,842	46,905	10.7%			
Provisions					-1,534,787	-2,849,790	-1,315,003	85.7%			
CQUIN					2,096,865	1,904,634	-192,231	-9.2%			
WIP						53,908	53,908	100.0%			
CIPs					297,000		-297,000				
Other					-31,438	43,541	74,979	-238.5%			
Total					**88,344,166**	**90,831,168**	**2,487,002**	**2.8%**			

SLA income remains above plan for most points of delivery although the financial casemix value of elective activity is significantly below plan.

Non-elective activity is 8.5% above plan for the year to date and represents £2.6m of the financial overperformance compared to plan.

The Trust has not currently triggered the MRET penalty having provided £2m for potential readmissions fines (subject to clinical audit).

Expenditure

Staff Group £000's	June		July		August		YTD	YTD	Av.
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	YTD
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Medical Staff	3,717	3,609	3,808	3,553	3,803	3,550	18,598	17,944	3,720
Nursing Staff	5,276	5,060	5,417	5,013	5,265	5,059	26,583	25,305	5,317
Managerial & Admin	2,111	2,096	2,060	2,059	2,078	2,122	10,245	10,483	2,049
Other Clinical Staff	871	938	862	954	901	954	4,346	4,727	869
Scientific & Technical Staff	1,046	1,108	1,060	1,096	1,073	1,103	5,276	5,515	1,055
Estates Staff	96	88	81	88	74	100	408	474	82
All Other Staff	620	604	774	737	714	581	3,383	3,124	677
Cost Challenges	-	(509)	-	(378)	-	(512)	-	(2,392)	-
Total Pay Expenditure	**13,737**	**12,994**	**14,062**	**13,121**	**13,908**	**12,958**	**68,840**	**65,181**	**13,768**

Pay

Nursing costs currently £1.3m adverse to plan due to high levels of bank and agency expenditure and the costs of staffing escalation areas (Victoria Ward £60k per month).

Medical staffing cost £0.6m adverse to plan due to additional cost of locum doctors and additional duty payments.

Cost challenges include central CIP initiatives and mitigations required to deliver the Transformation programme targets.

Staff Group £000's	June		July		August		YTD	Av. YTD
	Actual	Plan	Actual	Plan	Actual	Plan	Actuals	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Medstaff WLI & ADH's	69	8	88	(18)	130	2	398	80
Agency Medstaff (Senior)	107	6	165	6	143	9	549	110
Agency Medstaff (Junior)	220	13	215	13	171	13	951	190
Bank Staff - Nursing	355	-	406	-	357	-	1,922	384
Agency Staff - Senior Nursing	233	-	327	-	275	-	1,371	274
Agency Staff - Junior Nursing	149	-	143	-	106	-	708	142
Agency Staff - Management	24	2	69	6	78	5	186	37
Bank Staff - Admin	101	1	129	1	117	1	490	98
Agency Staff - Admin	22	-	32	-	38	-	148	30
Bank & Agency Staff - Other	79	5	128	5	148	7	521	104
Total Tempoary Staffing	**1,360**	**34**	**1,703**	**12**	**1,563**	**36**	**7,243**	**1,449**

Temporary Staffing

Temporary staff costs totalling £7.2m have been incurred for the year to date, £3.3m of which relate to Nursing staff.

Recruitment plans are in place to enable the Trust to cease the use of agency Nursing in most operational teams by December.

Non-Pay £000's	June		July		August		YTD	YTD	Av. YTD
	Actual	Plan	Actual	Plan	Actual	Plan	Actuals	Plan	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Clinical Non Pay - Fixed	332	299	328	276	317	292	1,570	1,462	314
Clinical Non Pay - Variable	3,637	3,995	4,036	3,511	4,184	3,591	19,631	18,052	3,926
Non Clinical Non Pay - Fixed	1,729	1,460	1,872	1,516	2,083	1,513	9,226	7,415	1,845
Non Clinical Non Pay - Variable	161	188	197	196	206	190	945	948	189
Expenditure SLAs	81	79	81	79	20	79	345	397	69
Total Non-Pay	**5,940**	**6,021**	**6,514**	**5,578**	**6,810**	**5,665**	**31,718**	**28,274**	**6,344**

Non-Pay

Clinical costs are £1.7m adverse to plan for the year to date, driven by and adverse variance of £1.2m in drug costs. The costs of mattress hire are also significantly contributing to the level of overspend.

Non-clinical costs are £1.2m adverse to plan of which increased Energy costs account for £0.3m.

Statement of Financial Position

	Balance at 31-Mar-11	Current Month Opening Balance	Current Month Closing Balance	Current Month Movement	Forecast end of year Closing Balance	Forecast end of year Movement
	£000	£000	£000	£000	£000	£000
OPENING NET BOOK VALUE	135,075	135,075	135,075		135,075	
IN YEAR REVALUATIONS		505	533	28	2,116	2,116
IN YEAR MOVEMENTS		1,826	2,224	398	8,533	8,533
LESS DEPRECIATION		(3,302)	(4,130)	(828)	(10,188)	(10,188)
NET BOOK VALUE	**135,075**	**134,104**	**133,702**	**(402)**	**135,536**	**461**
INVENTORIES	4,723	4,498	4,474	(24)	4,862	139
RECEIVABLES						
NHS DEBTORS	5,730	5,134	6,273	1,139	5,742	12
OTHER TRADE DEBTORS	985	973	950	(23)	(149)	(1,134)
DEBTOR IMPAIRMENTS PROVISION	(149)	(149)	(149)		1,460	1,609
CAPITAL RECEIVABLES	31				31	
NON NHS OTHER DEBTORS	70	245	348	103	19	(51)
COMPENSATION DEBTORS (RTA)	2,554	2,590	2,531	(59)	968	(1,586)
OTHER RECEIVABLES	549	497	716	219	574	25
IRRECOVERABLE PROVISION	(283)	(283)	(283)		(283)	
PREPAYMENTS & ACCRUALS	1,458	2,762	2,213	(549)	2,554	1,096
	10,945	**11,769**	**12,599**	**830**	**10,916**	**(29)**
NON CURRENT ASSETS FOR SALE	300	300	300			(300)
CASH	3,944	2,154	1,873	(281)	5,690	1,746
NET CURRENT ASSETS	**19,612**	**18,421**	**18,946**	**525**	**21,468**	**1,856**
NHS	1,673	2,723	3,551	(828)	2,386	(713)
TRADE CREDITORS REVENUE	3,655	3,289	3,738	(449)	3,655	
TRADE CREDITORS FIXED ASSETS	2,759	1,121	1,057	64	2,046	713
TAX AND NI OWED	3,454	3,433	3,441	(8)	3,454	
NHS PENSIONS AGENCY	1,784	1,923	1,963	(40)	1,784	
OTHER CREDITORS	510	417	258	159	510	
SHORT TERM LOANS	526	526	526		526	
ACCRUALS AND DEFERRED INCOME	4,018	5,462	5,638	(176)	4,031	(13)
PDC DIVIDEND DUE		1,361	1,715	(354)		
STAFF BENEFITS ACCRUAL	629	629	629		629	
PROVISIONS	1,603	289	232	57	978	625
PROVISIONS over 1 year	310	310	310		310	
NET CURRENT LIABILITIES	**20,921**	**21,483**	**23,058**	**(1,575)**	**20,309**	**612**
TOTAL NET ASSETS	**133,766**	**131,042**	**129,590**	**(1,452)**	**136,695**	**2,929**
PDC CAPITAL	99,635	99,635	99,635		99,635	
REVALUATION RESERVE	34,046	34,467	34,467		35,675	1,629
DONATED ASSET RESERVE						
I & E ACCOUNT BALANCE	385	386	386		885	500
I & E CURRENT YEAR		(3,146)	(4,598)	(1,452)	500	500
FINANCING TOTAL	**134,066**	**131,342**	**129,890**	**(1,452)**	**136,695**	**2,629**

Non-current assets are reduced by £1.373m since the start of the financial year due to the impact of in year depreciation and the slow start to the capital expenditure programme.

Current assets are reduced by £761k primarily due to a reduction in cash balances since March.

Current liabilities are increased by £2.042m due to an increase in NHS creditors, accruals and deferred income.

Cost Improvement Programme (CIP)

£000's	Aug		YTD		
Workstream	Plan	Actual	Plan	Actual	Var
Beds / Patient Flow	42	24	155	70	(85)ADV
Theatres	38	9	133	44	(89)ADV
Outpatients	10	27	51	157	106FAV
Admin Review	-	-	-	-	
Procurement	100	72	500	362	(138)ADV
Pathology	16	3	33	16	(17)ADV
Therapies	10	1	10	3	(7)ADV
Medical	40	-	60	-	(60)ADV
Estates	6	4	28	19	(9)ADV
Outsourcing	-	1	-	7	7FAV
Nursing	-	-	-	-	
Back Office Phase	-	10	-	52	52FAV
Contract Compliance	38	246	213	421	209FAV
Pharmacy	38	106	188	308	121FAV
Controls	46	4	229	19	(210)ADV
HR Workforce Planning	11	-	22	-	(22)ADV
Workforce, Bank & Agency	79	-	396	-	(396)ADV
Directorate 3% Schemes	545	607	2,407	2,501	94FAV
New Schemes					
NGH Mitigation	151	-	755	-	(755)ADV
Grand Total	**1,169**	**1,116**	**5,178**	**3,981**	**(1,197)ADV**

Workstream Performance

The table opposite shows the savings delivered by each of the key work streams within the Transformation Programme.

At present the overall programme is £1.2m behind plan primarily due to shortfalls in delivery for the Procurement, Controls, Banks & Agency work streams.

Mitigating actions of £755k are also outstanding for the year to date.

Workstream	Plan £000	LTF £000	Var
Beds / Patient Flow	300	151	(149)ADV
Theatres	424	142	(282)ADV
Outpatients	165	378	213FAV
Admin Review	385	120	(265)ADV
Procurement	1,200	1,100	(100)ADV
Pathology	147	99	(48)ADV
Therapies	80	47	(33)ADV
Medical	250		(250)ADV
Estates	316	45	(271)ADV
Outsourcing	111	29	(82)ADV
Nursing	58	58	(0)ADV
Back Office Phase 2	506	155	(351)ADV
Contract Compliance	1,000	1,000	-
Pharmacy	450	600	150FAV
Controls	550	550	-
HR Workforce Planning	1,183		(1,183)ADV
Workforce, Bank & Agency	950	554	(396)ADV
Directorate 3% Schemes	6,205	6,205	0FAV
New Schemes		2,585	2,585FAV
Mitigation Required	1,820	2,282	462 Increase
Grand Total	**16,100**	**16,100**	**0FAV**

Latest Thinking Forecast (LTF)

The latest assessment of the LTF for the Transformation programme indicates delivery of savings totalling £13.8m, of which £2.6m relates to new initiatives developed during the year.

A mitigations target of £2.3m remains to be found to deliver the full year Transformation target of £16.1m .

Cashflow

MONTHLY CASHFLOW	Annual £000s	APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
		ACTUAL					FORECAST						
RECEIPTS													
SLA Base Payments	205,754	15,448	17,959	18,311	17,011	17,091	17,222	17,119	17,119	17,119	17,119	17,119	17,119
SLA Variable inc Over Performanc	9,466				1,965	151	350	2,000			2,000		3,000
SHA Payments (SIFT etc)	9,336	266	1,300	671	942	672	681	896	765	765	765	765	849
Other NHS Income	19,275	1,933	2,568	1,108	1,420	1,495	1,750	1,500	1,500	1,500	1,500	1,500	1,500
PP / Other (Specific > £250k)	259		259										
PP / Other	11,891	821	768	796	1,013	793	1,100	1,100	1,100	1,100	1,100	1,100	1,100
Salix Capital Loan	469								300		169		
EFL / PDC													
Temporary Borrowing													
Interest Receivable	31	1	2	2	2	2	3	3	3	3	3	4	4
TOTAL RECEIPTS	256,482	18,469	22,857	20,888	22,352	20,204	21,106	22,618	20,787	20,487	22,656	20,488	23,572
PAYMENTS													
Salaries and wages	160,519	13,081	13,813	13,339	13,233	13,513	13,380	13,280	13,400	13,280	13,400	13,400	13,400
Trade Creditors	62,526	4,285	6,274	5,734	5,915	6,238	3,700	6,500	4,300	4,500	5,772	5,000	4,307
NHS Creditors	15,667	1,546	1,938	1,480	2,151	965	1,077	1,277	1,277	1,277	1,277	700	700
Capital Expenditure	11,274	789	1,503	763	517	371	594	1,154	1,017	1,038	1,348	1,161	1,020
PDC Dividend	4,194						2,069						2,125
Repayment of Loans													
Repayment of Salix loan	249						95						154
TOTAL PAYMENTS	254,428	19,701	23,528	21,316	21,815	21,087	20,915	22,211	19,994	20,095	21,797	20,261	21,706
Actual month balance	2,054	-1,232	-671	-428	537	-883	190	406	792	391	858	227	1,866
Balance brought forward	3,906	3,906	2,675	2,003	1,575	2,112	1,229	1,419	1,825	2,617	3,009	3,867	4,094
Balance carried forward	5,960	2,675	2,003	1,575	2,112	1,229	1,419	1,825	2,617	3,009	3,867	4,094	5,960

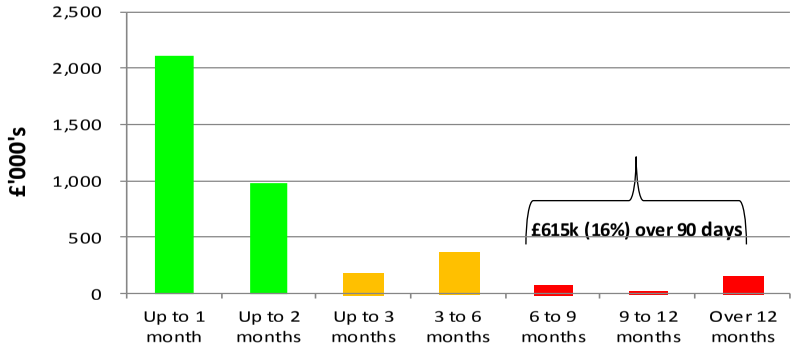
The original cashflow plan aimed to undershoot EFL by up to £2.0m in an attempt to increase cash holding year on year. Forecast restrictions on creditor payments in the latter stages of the financial year may render this plan unachievable.

The Trust has invoiced and received payment from the CCG for the estimated value of overperformance against the SLA for the first 4 months of the financial year.

The Trust has made the first half repayment (£2m) of the PDC dividend in September which will adversely impact on the amount of available cash to meet creditor demand in the short term.

Capital expenditure cashflow is anticipated to rise in H2 which coupled with the emerging I&E forecast may give rise to the need to consider temporary borrowing.

Working Capital



Aged Debtors

Total outstanding debtors have increased by £1.7m since the start of the financial year although amounts over 90 days have not increased significantly.

Problem debtors continue to include the CRIPPS recreation centre.

Aged Creditors	01.04.12	NHS	Trade	Capital	Total
	£'000	£'000	£'000	£'000	£'000
Up to 1 month	3,673	704	2,291	72	3,067
Up to 2 months	2,408	706	838	318	1,862
Up to 3 months	10	314	131	-0	445
Over 3 Months	197	100	-2		98
Total	**6,288**	**1,824**	**3,259**	**390**	**5,473**
				Over 90 Day	**98**
				% Balance	**1.80%**

Aged Creditors

Total outstanding creditors are reduced from the balances recorded at the end of March with Trade creditors being largely settled within 60 days.

The level of unmet creditor demand has been steadily rising and is likely to increase significantly in September.

	NHS			Non-NHS			Total		
	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%
Value £	1,101,373	5,449,355	**20%**	24,786,331	34,068,598	**73%**	25,887,704	39,517,954	**66%**
Volume	660	907	**73%**	28,978	30,836	**94%**	29,638	31,743	**93%**

Better Payment Practice

The Trust has achieved 93% compliance by volume against the required 95% compliance standard for better payments.

NHS compliance is low with the focus being on maintaining Trade creditor payments in the first half of the financial year.

Capital

Category	Approved Annual Budget 2012/13 £000's	Year to Date as at Month 5 Actual Spend £000's	Year to Date as at Month 5 Plan Achieved £000's	Year to Date as at Month 5 Actual Committed £000's	Year to Date as at Month 5 Plan Achieved £000's
Breast Screening Business Case	59	59	100%	59	100%
Emergency Care	385	177	46%	177	46%
Endoscopy / Urodynamics	553	32	6%	45	8%
Mortuary Refurbishment	80	36	45%	55	68%
Macmillan (Trust)	91	6	6%	23	26%
Macmillan (Non Trust)	13	0	0%	0	0%
MESC	998	336	34%	371	37%
Estates	3,884	828	21%	1,357	35%
IT	3,373	840	25%	1,167	35%
Other	158	29	18%	69	44%
Total - Capital Plan	**9,593**	**2,343**	**24%**	**3,324**	**35%**
Less Charitable Funds	-579	-118	20%	-131	23%
Total - CRL	**9,014**	**2,225**	**25%**	**3,193**	**35%**

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

BOARD SUMMARY SHEET	
Title	Human Resources Report
Submitted by	Geraldine Opreshko, Director of Workforce & Transformation (Interim)
Prepared by	Mark Ingram, Head of e-Workforce
Date of meeting	27th September 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 Human Resource report for September 2012 which focuses on the following Human Resource Workforce Indicators for Month 5:

- Workforce Capacity
- Workforce Expenditure
- Health & Wellbeing
- Workforce Development

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 support the ongoing actions.

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 5

The Human Resource Workforce Indicators have been updated for Month 4. Please refer to the following pages of this report.

The salient points of change to date are:

Workforce Capacity

Substantive Workforce Capacity increased by 3.81 FTE from 3,837.97 FTE to 3,841.78 FTE which is below the plan (4,245.56 FTE) for the month.
The % FTE of contracted workforce against budgeted establishment has decreased by 0.07% to 90.49%.

Temporary Workforce (excluding Medical Staffing) usage increased by 0.15% from 7.75% to 7.90% and remains above the planned temporary FTE target of 5%.

Total Substantive Workforce plus Temporary Workforce (excluding Medical Staffing) % FTE against budgeted establishment FTE has increased by 0.09% from 98.16% to 98.25%.

Staff turnover (leavers) has increased by 0.36% on the month to 8.58%, which remains above the Trust target of 8%.

Recruitment Timeline is above the threshold target of 13 weeks at 13.80 weeks.

Health and Wellbeing

Calendar Days Lost to Sickness The number of calendar days lost to sickness decreased by 603 from 6,699 to 6,096 in August 2012.

No. of Days Lost per Employee decreased by 0.13 from 1.48 days to 1.35 days.

Long term sickness absence increased by 0.12% to 2.34% which is above the Trust target of 2%

Short Term Sickness Absence absence has decreased by 0.53% to 1.89% (Trust target 1.4%).

Total Sickness Absence has decreased by 0.40% to 4.23% (Trust target 3.4%).

Workforce Expenditure

Temporary Workforce Expenditure has decreased by £190,344 from £1,615,000 to £1,424,656 which is equal to 10.20% of the total workforce expenditure.

Workforce Development

Appraisals are centrally recorded on OLM and reported on a quarterly basis. The Training and Development Department is responsible for the centralised management of recording appraisals, the HR Business Partners are working with Managers to implement the process of submitting appraisal records.
For Quarter 1 2012 1.30% of staff have completed appraisals, compared to 13.00% in Quarter 1 the previous year.

Mandatory Training Compliance shows a decrease of 1.71% compliance in August 2012 with a total Trust compliance of 57.71%

Forecast and Risks

The Temporary Workforce Capacity percentage remains above target due to the demand for temporary nursing staff continues due to vacancies. An overseas recruitment program for trained nurses is in place. In the pipeline 28 nurses from Portugal are scheduled to start in October and 25 nurses from Ireland are scheduled to start in November 2012.

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 5

WORKFORCE CAPACITY (Temporary Workforce Capacity Excludes Medical Staffing)

Performance Indicator	Performance Target	Trust YTD	Aug-12	Peformance vs. Prev. Month	Comments and or Plans
Budgeted Workforce Establishment (FTE)			4,245.56	Higher	
Contracted Substantive Workforce (FTE)			3,841.78	Higher	
Temporary Workforce Utilised (FTE)			329.34	Higher	
Total Substantive Workforce plus Temporary Workforce (FTE)			4,171.12	Higher	
Contracted Workforce against Budgeted Establishment (% FTE)	95% to 97%		90.49%	Lower	
Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE)	100%		98.25%	Higher	
Temporary Workforce Rate (%FTE)	5%		7.90%	Higher	Temporary Workforce Rate excludes Medical Staffing
Staff Turnover (% FTE)	8%		8.58%	Higher	
Recruitment Timeline	13 Weeks		13.8	Higher	Recruitment Timeline is adjusted to take into account the 3 weeks Regional Restricted Access

WORKFORCE EXPENDITURE (Temporary Expenditure Includes Capacity Medical Staffing)

Performance Indicator	Performance Target	Trust YTD	Aug-12	Peformance vs. Prev. Month	Comments and or Plans
Contracted Workforce Expenditure		62,239,108	12,537,895	Higher	
Contracted Workforce Enhanced Overtime		350,589	70,250	Higher	
Contracted Workforce Plain Time OT		17,197	4,473	Higher	
Temporary Workforce Expenditure		6,655,178	1,424,656	Lower	Temporary Workforce Expenditure = Bank, Agency and Locum (including Medical Staffing)
Total Utilised Workforce Expenditure		68,894,287	13,962,551	Lower	
Temporary Workforce Expenditure (% of Total Workforce Expenditure)		9.66%	10.20%	Lower	

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 5

HEALTH AND WELLBEING

Performance Indicator	Performance Target	Trust YTD	Aug-12	Peformance vs. Prev. Month	Comments and or Plans
Trust Headcount (Permanent & FTC)			4,516	Lower	
Calendar Days Lost to Sickness Absence		32,907	6,096	Lower	
Days Lost Per Employee			1.35	Lower	
Short Term Sickness Absence	1.4%		1.89%	Lower	
Long Term Sickness Absence	2%		2.34%	Higher	Interim HR Business Partner support in place to specifically manage short and long term sickness absence
Total Sickness Absence	3.40%		4.23%	Lower	

WORKFORCE DEVELOPMENT

Performance Indicator	Performance Target	Trust YTD	Aug-12	Peformance vs. Prev. Month	Comments and or Plans
Mandatory Training Compliance	100%		57.71%	Lower	

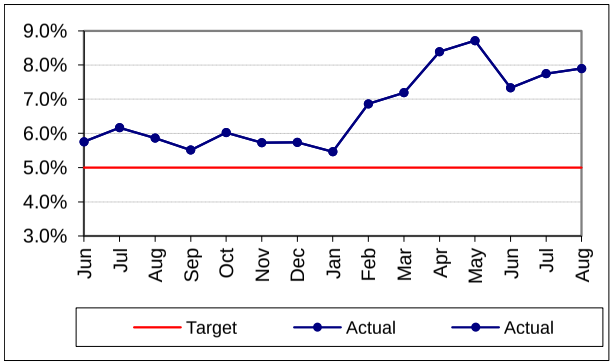
Performance Indicator	Performance Target	Trust YTD	Nov-00	Peformance vs. Q1 2011	Comments and or Plans
Cumulative Personal Development Review / Plan	100%		1.30%	Lower	Reported quarterly from central source from April 1st 2012. Q1 Previous year = 13%

HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 5

DIRECTORATE WORKFORCE PERFORMANCE SUMMARY

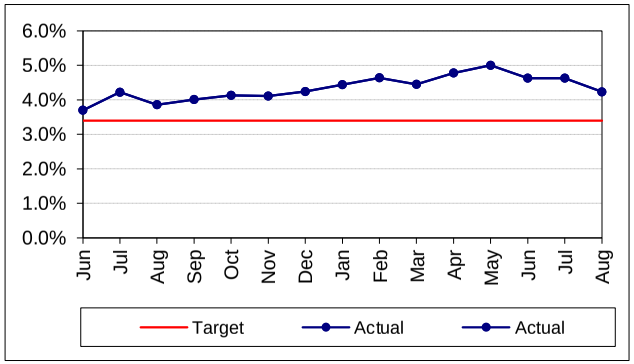
Temporary Workforce Rate

Directorate	Bank & Agency (Excl. Locum) M5	Variance Against Target	Variance From M4
Target = 5.0%		<-1.0%	>0.0%
Medicine	13.61%	8.61%	0.37%
Surgery	10.64%	5.64%	-2.18%
Anaesthetics	7.25%	2.25%	0.85%
Trauma & Orthopaedic	7.83%	2.83%	-0.35%
Head & Neck	9.04%	4.04%	1.59%
Child Health	3.50%	-1.50%	-1.03%
Obstetrics & Gynae	4.03%	-0.97%	-0.21%
Oncology	6.77%	1.77%	0.59%
Pathology	4.30%	-0.70%	1.45%
Radiology	0.00%	-5.00%	0.00%
Pharmacy	0.00%	-5.00%	0.00%
Therapies	15.90%	10.90%	1.92%
Facilities	3.43%	-1.57%	0.15%
Hospital Support	5.30%	0.30%	0.29%
Total	7.90%	**2.90%**	0.15%



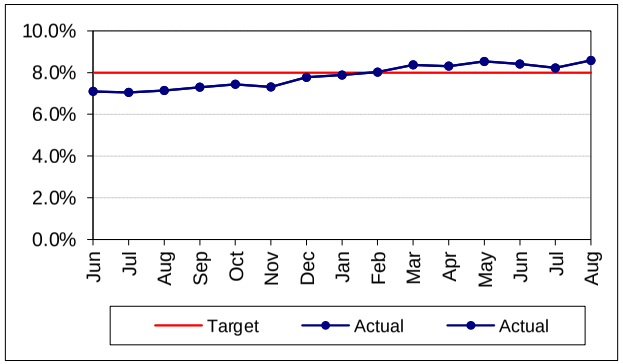
Staff Sickness Absence Rate

Directorate	Sickness Absence M5	Variance Against Target	Variance From M4
Target = 3.4%		<-0.0%	>0.0%
Medicine	4.14%	0.74%	-0.42%
Surgery	3.76%	0.36%	-1.45%
Anaesthetics	3.77%	0.37%	-0.93%
Trauma & Orthopaedic	4.10%	0.70%	-0.62%
Head & Neck	7.12%	3.72%	-0.25%
Child Health	3.24%	-0.16%	-0.48%
Obstetrics & Gynae	5.99%	2.59%	-0.15%
Oncology	4.04%	0.64%	-0.98%
Pathology	2.12%	-1.28%	-1.38%
Radiology	2.95%	-0.45%	-1.18%
Pharmacy	2.54%	-0.86%	1.18%
Therapies	7.11%	3.71%	2.55%
Facilities	5.81%	2.41%	0.67%
Hospital Support	3.25%	-0.15%	0.03%
Total	**4.23%**	**0.83%**	**-0.40%**



Staff Turnover

Directorate	Turnover M5	Variance Against Target	Variance From M4
Target = 8.0%		<-0.0%	>0.0%
Medicine	8.14%	0.14%	#REF!
Surgery	7.05%	-0.95%	#REF!
Anaesthetics	4.48%	-3.52%	#REF!
Trauma & Orthopaedic	6.84%	-1.16%	#REF!
Head & Neck	5.47%	-2.53%	#REF!
Child Health	13.75%	5.75%	#REF!
Obstetrics & Gynae	7.48%	-0.52%	#REF!
Oncology	8.63%	0.63%	#REF!
Pathology	9.60%	1.60%	#REF!
Radiology	3.70%	-4.30%	#REF!
Pharmacy	5.28%	-2.72%	#REF!
Therapies	8.76%	0.76%	#REF!
Facilities	13.15%	5.15%	#REF!
Hospital Support	12.82%	4.82%	#REF!
Total	**8.58%**	**0.58%**	**#REF!**

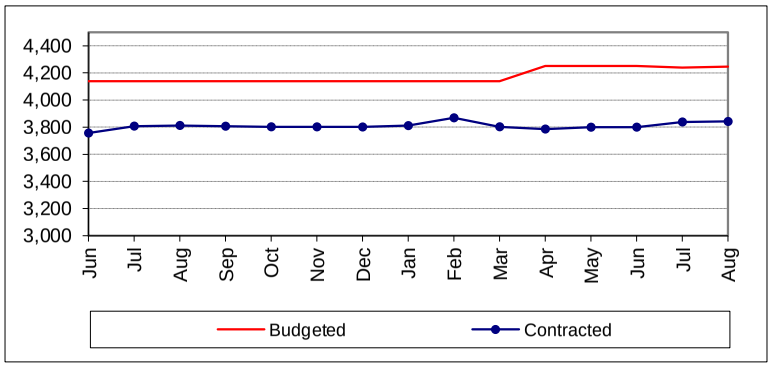


HUMAN RESOURCE WORKFORCE INDICATORS 2012/13 — Month 5

DIRECTORATE WORKFORCE CAPACITY SUMMARY

Substantive Workforce Capacity FTE (Target = 95%)

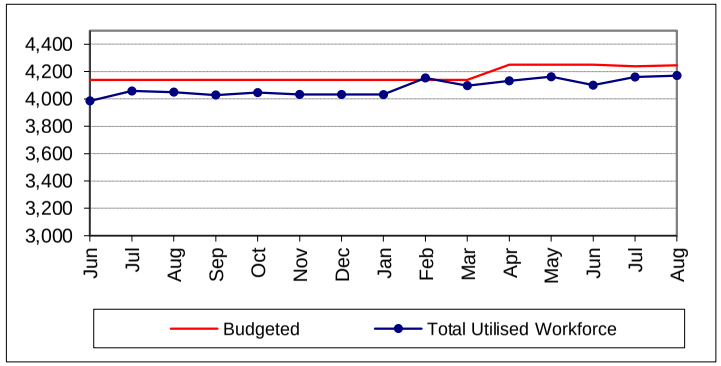
Directorate	Budgeted Establishment	M5 Contracted	Variance %	Variance FTE
Medicine	1,069.13	940.43	-12.04%	-128.70
Surgery	296.07	265.97	-10.17%	-30.10
Anaesthetics	328.37	302.18	-7.98%	-26.19
Trauma & Orthopaedic	254.91	235.67	-7.55%	-19.24
Head & Neck	173.33	152.07	-12.27%	-21.26
Child Health	265.06	254.36	-4.04%	-10.70
Obstetrics & Gynae	379.79	362.96	-4.43%	-16.83
Oncology	224.77	225.02	0.11%	0.25
Pathology	226.15	192.05	-15.08%	-34.10
Radiology	143.45	132.99	-7.29%	-10.46
Phamacy	101.56	99.81	-1.72%	-1.75
Therapies	79.37	68.71	-13.43%	-10.66
Facilities	347.56	281.31	-19.06%	-66.25
Hospital Support	356.04	328.26	-7.80%	-27.78
Total	**4,245.56**	**3,841.78**	**-11.90%**	-403.78



Total Workforce Capacity FTE (Excluding Medical Staff)

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

Directorate	Budgeted Establishment	Total Utilised Workforce	Variance
Medicine	1,069.13	1,088.61	19.48
Surgery	296.07	297.63	1.56
Anaesthetics	328.37	325.79	-2.58
Trauma & Orthopaedic	254.91	255.71	0.80
Head & Neck	173.33	167.18	-6.15
Child Health	265.06	263.57	-1.49
Obstetrics & Gynae	379.79	378.19	-1.60
Oncology	224.77	241.34	16.57
Pathology	226.15	200.68	-25.47
Radiology	143.45	132.99	-10.46
Phamacy	101.56	99.81	-1.75
Therapies	79.37	81.70	2.33
Facilities	347.56	291.29	-56.27
Hospital Support	356.04	346.62	-9.42
Total	**4,245.56**	**4,171.12**	-74.44



Northampton General Hospital NHS
NHS Trust

Transformation Programme

September 2012

Monthly Feature—Salary Sacrifice update

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

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

We've currently had 25 staff members order green cars (with 5 already delivered) and have a further 20 live quotes, with logging on activity still continuing.

Iain Bonnar from Willow ward who has received his Citroen C3 Picasso said *'The whole process was incredibly quick and easy. I ordered the car in July and received it at the beginning of September. I wouldn't have been able to afford a brand new car any other way, so it was great.'*

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

****Please remember that the Green Car and Cycle to work schemes are available all year round.****

Transformation Programme

MFD (Multi-Functional Devices) update

The trust currently uses 1086 printers, including 163 different models from 13 different manufacturers. This includes many high cost desk-top printers.

A national framework agreement/contract has been signed with Ricoh to enable NHS trusts to benefit from reduced prices. Ricoh have undertaken a review of our print options and proposed that we reduce the number of desk-top printers and primarily use Multi-Functional Devices (MFDs). These devices print, fax, photocopy and scan, so will also reduce the need for other devices in offices. The Child Health team have been piloting the system and have found it very positive.

The executive team have established a project team to install these devices where possible. This will provide the following benefits:

- You will be able to collect your printing from any MFD in the trust.
- Toners will be ordered automatically without the need to monitor stocks.
- Users will be given a unique pin number to improve confidentiality.

One of the benefits will be the reduction in paper usage, and ability to default to black and white, and duplex printing.

There are things you can do right NOW!

Does your PC default to black and white? Does your PC default to print on both sides? If not, follow these instructions:

1. Left click on the Start button and select Printer and Faxes
2. Right click on your defaulted printer and select 'Printing preferences'
3. Select black and white and change Duplex to 'open to left'
4. Click 'Apply' and all your new documents will default to these settings

Did you know it takes roughly 24 trees to produce a ton of printing paper and that one mature tree can release enough oxygen back into the atmosphere to support two human beings.

The average employee prints at least 6 wasted pages per day, which amounts to 1,410 wasted pages per year per person!

Hybrid Mail update

Hybrid mail is a system that sends letters electronically to a 3rd party provider to be printed, enveloped and posted. All attachments such as information leaflets and hospital maps are also printed by the 3rd party and included in the envelope. The e-mails are encrypted to ensure that the contents is kept confidential and letters are traceable through the 3rd party until they are posted, so the risk of letters getting lost is reduced. Hybrid Mail is being rolled out across the trust. This delivers savings in postage costs and reduces pressure on administrative staff by eliminating printing, collating, folding and enveloping time.

The following areas are already using Hybrid Mail: Child Health, Maxillo Facial, Members Office, Ophthalmology, Orthoptics, Children's Outpatients, ENT, Cardiology, Cardiothoracic surgery, Chemical Pathology, Endocrinology, Gastroenterology, Nephrology, Neurology, Neurosurgery and Rehabilitation.

So far 56,804 letters have been sent through the Hybrid Mail system!

Outpatients update

The automatic patient reminder system continues to help reduce the amount of money that is typically lost each month due to patients not attending their outpatient clinic appointments. The DNA rate for the trust remains below the target limit set of 5.5% and is currently at 4.7%. This financial year, the system is expected to generate £256k in additional income for the trust.

QIAs (Quality Impact Assessments)

Every project or intended change needs to be assessed for its quality impact before changes are made. This is to ensure that quality of care and patient experience is not adversely impacted in an effort to save money. QIAs have been undertaken for all projects and challenge sessions held before they were signed off.

The QIA template and policy is currently being reviewed to make improvements in response to feedback from users.

Transformation Mitigation

The trust's target of £19m savings this year has been very challenging and we still need to identify new projects & make every effort to reduce spending where it is safe to do so.

We are currently working on a mitigation plan which includes:

- Office furniture freeze—the trust has put a freeze on the acquisition of new office furniture and are promoting recycling and sharing of furniture.
- Printing rationalisation—as mentioned in the MFD (multi-functional devices) update

If you have any ideas for schemes that can deliver cost or quality benefits, please discuss them with your manager, or contact one of the Transformation Team Members below.

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 (HR, Finance, IT, MFDs, R&D)
- Pharmacy
- Procurement
- Outsourcing (3rd Party Pharmacy, Hybrid Mail)

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

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

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

- Nursing
- Estates
- Bank & Agency
- Therapies

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

- Theatres
- Administration Review
- Controls

BOARD SUMMARY SHEET	
Title: -	Self-Certification Return
Submitted by: -	Chris Pallot, Director of Strategy & Partnerships
Date of meeting: -	27th September 2012
Corporate Objectives Addressed: -	Performance Assurance.

SUMMARY OF CRITICAL POINTS: -

This report details the hospital's current position as at August 2012 with regard to:

- Effectiveness
- Patient Experience
- Quality
- Patient Safety
- Financial Risk

The Board is currently reviewing the forecast I&E position given the YTD deficit incurred for the period to August. Whilst recovery actions have been identified an unmitigated deficit of £2.5m is forecast. For this reason the Board cannot currently confirm that the Financial Risk rating will improve significantly compared to the current score by the financial year end.

PATIENT IMPACT: -

N/A

STAFF IMPACT: -

N/A

FINANCIAL IMPACT: -

N/A

RISK ASSESSMENT: -

N/A

EQUALITY & DIVERSITY IMPACT ASSESSMENT: -

N/A

RECOMMENDATION: -

Trust Board are asked to discuss the contents of this report, determine the response to point 4 of the Board Statements section and sign off the return.

SELF-CERTIFICATION RETURNS
Organisation Name:
Northampton General Hospital
Monitoring Period:
August 2012
NHS Trust Over-sight self certification template

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

TFA Progress

Aug-12

Northampton General Hospital

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Due or Delivered Milestones	Future Milestones	Comments where milestones are not delivered or where a risk to delivery has been identified
1	Deloite Board Development / BGAF review	Jul-12	Not fully achieved		Board development and BGAF review is ongoing. Board Development programme to be finalised at the Board Developmenmt session facilitated by Deloitte on 20/09/12
2	Recruitment process for the Director of Finance and Director of Workforce and Transformation commences	Aug-12		On track to deliver	
3	Director of Finance appointed	Oct-12		Risk to delivery within timescale	Timescale for recruitment. Interviews are scheduled for 20th November
4	Director of Workforce and Transformation appointed	Oct-12		Risk to delivery within timescale	Timescale for recruitment . Interviews are scheduled for 20th November
5	Trust to review the TFA in response to the Healthier Together Consultation	Oct-12		Risk to delivery within timescale	
6	In-month delivery of 95% A&E 4-hour indicator	Oct-12		On track to deliver	
7	Recovery plan agreed at Board to stabilise financial position	Oct-12		On track to deliver	
8	First draft of 2 years CIPS, including implementation plans and QIAs submitted to Finance and Performance Committee (2013/14, 2014/15)	Nov-12		On track to deliver	
9	First draft of Monitor compliant LTFM to Finance and Performance Committee	Nov-12		On track to deliver	
10	In-month delivery of 95% A&E 4-hour indicator	Nov-12		On track to deliver	
11	Review TFA with NTDA based on the Healthier Together consultation	Nov-12		On track to deliver	
12	Trust 5-year Strategy revised and submitted to Trust Board	Dec-12		On track to deliver	
13	Trust BGAF self-assessment approved by Board and submitted to SHA	Dec-12		On track to deliver	
14	Quality Assurance Framework self-assessment approved by the Board and submitted to the SHA	Dec-12		On track to deliver	
15	Quarterly delivery of 95% A&E 4-hour indicator	Dec-12		On track to deliver	
16	In-month delivery of 95% A&E 4-hour indicator	Jan-13		On track to deliver	

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

Name of Organisation:	Northampton General Hospital	Period:	August 2012

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance, 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 SOM guidance)	
Financial Risk Rating (Assign number as per SOM guidance)	1
Contractual Position (RAG as per SOM guidance)	

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

Governance Declarations

NHS Trusts 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 :	
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:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

GOVERNANCE RISK RATINGS

Northampton General Hospital

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

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Dec-11	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Current Data: Jul 12	Current Data: Aug-12	Current Data: Sep-12	Current Data: Qtr to Sep-12	Comments where target not achieved
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a	N/a	N/a	Yes	
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	N/a	N/a	Yes	Yes	Yes		Yes	Incompete pathway target of 92% monitored from April 2012. (Previous year targets were monitored for compliance against median and 95 percentile waits)
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5			Yes	Yes	Yes		Yes	
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	No	Yes	No		No	62-day urgent GP referral for suspected cancer target not achieved in Q1 2012-13 and Aug 12. 62-day screening referral target not achieved in Aug 12. August data awaiting verification.
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes		Yes	
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes		Yes	
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	No	No	No	No	No		No	
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	3j	Category A call –emergency response within 8 minutes		75%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
Safety	4a	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	4b	MRSA	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No		No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No		No	
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No		No	
				TOTAL		**1.0**	**1.0**	**2.0**	**1.0**	**2.0**	**0.0**	**2.0**	

RAG RATING :

GREEN	**= Score of 1 or under**
AMBER/GREEN	**= Score between 1 and 1.9**
AMBER / RED	**= Score between 2 and 3.9**
RED	**= Score of 4 or above**

Overriding Rules - Nature and Duration of Override at SHA's Discretion												
i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Breaches its full year objective	No	No	No	No	No			
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Breaches its full year objective Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.	No	No	No	No	No			
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter	No	No	No	No	No			
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.	No	Yes	Yes	Yes	Yes			
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter	No	No	No	No	No			
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter	N/a	N/a	N/a	N/a	N/a	N/a		
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter	N/a	N/a	N/a	N/a	N/a	N/a		
viii)	Any Indicator weighted 1.0	Breaches the indicator for three successive quarters.	No	Yes	Yes	Yes	Yes			A&E: From arrival to admission / transfer / discharge max. wait time of 4 hours not achieved for Q3 & Q4 2011-12 and Q1 2012-13 (Achieved in Q1 & Q2 2011-12)
		Number of Overrides Triggered	***0.0***	***2.0***	***2.0***	***2.0***	***2.0***	***0.0***	***0.0***	

FINANCIAL RISK RATING

Northampton General Hospital

								Insert the Score (1-5) Achieved for each Criteria Per Month				
			Risk Ratings					Reported Position		Normalised Position*		
Criteria	Indicator	Weight	5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	Forecast Outturn	Comments where target not achieved
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	2	3	2	3	1.3% YTD
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	1	3	1	3	27% YTD
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	1	3	1	3	-2.2% due to YTD deficit of £4.6m
	I&E surplus margin %	20%	3	2	1	-2	<-2	1	2	1	2	-4.5% due to YTD deficit of £4.6m
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	16 days cover (incl. est WCF)
Weighted Average		**100%**						**1.8**	**2.8**	**1.8**	**2.8**	
Overriding rules								1		1		
Overall rating								**1**	**3**	**1**	**3**	

Overriding Rules :

Max Rating	Rule					
3	Plan not submitted on time	No				
3	Plan not submitted complete and correct	No				
2	PDC dividend not paid in full	No				
2	One Financial Criterion at "1"					
3	One Financial Criterion at "2"		3		3	
1	Two Financial Criteria at "1"		1		1	
2	Two Financial Criteria at "2"					

* Trust should detail the normalising adjustments made to calculate this rating within the comments box.

FINANCIAL RISK TRIGGERS

Northampton General Hospital

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

	Criteria	Historic Data			Current Data				Comments where risks are triggered
		Qtr to Dec-11	Qtr to Mar-12	Qtr to Jun-12	Jul 12	Aug-12	Sep-12	Qtr to Sep-12	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	Yes	No	No	No	No		No	Achieved Q3 and Q4 11-12 but not achieved Q1 12-13.
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	Yes	No	No	No	No		No	Forecast to achieve Level 3 by Q4.
3	Working capital facility (WCF) agreement includes default clause								
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes		Yes	£615k (16%)
5	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	Yes	No	No	No		No	
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No		No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No		No	
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes		Yes	-11 days excluding WCF.
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No		No	

CONTRACTUAL DATA

Northampton General Hospital

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

Criteria	Historic Data			Current Data				Comments where reds are triggered
	Qtr to Dec-11	Qtr to Mar-12	Qtr to Jun-12	Jul 12	Aug-12	Sep-12	Qtr to Sep-12	
Are the prior year contracts* closed?	Yes	Yes	No	No	No		No	Still to finalise issue around readmissions for 2011/12. To be agreed on 21/09/12
Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes		Yes	
Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes		Yes	
Are there any disputes over the terms of the contract?	No	No	No	No	No		No	
Might the dispute require SHA intervention or arbitration?	N/a	N/a	N/a	No	No		No	
Are the parties already in arbitration?	N/a	N/a	N/a	No	No		No	
Have any performance notices been issued?	Yes	Yes	Yes	Yes	No		Yes	Contract queries in relation to A&E have been issued by both Commissioner and Provider.
Have any penalties been applied?	No	No	No	No	No		No	

QUALITY

Northampton General Hospital

Insert Performance in Month

	Criteria	Unit	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Comments on Performance in Month
1	SHMI - latest data	Ratio	109.2							109.2	109.2	109.2	106	106.0	SHMI - Latest position reported in Aug 12 reflects Jan 11 - Dec 11
2	Venous Thromboembolism (VTE) Screening	%	92.0%	93.1%	93.4%	93.3%	92.2%	93.6%	90.9%	91.4%	91.9%	90.3%	93.0%		August data is due to be generated last week of September
3a	Elective MRSA Screening	%	99.9%	99.4%	99.6%	99.5%	100%	99.10%	99.93%	99.8%	99.4%	99.8%	99.5%	99.50%	
3b	Non Elective MRSA Screening	%	95.7%	97.3%	97.0%	96.8%	97.31%	96.20%	91.05%	95.1%	95.7%	96.4%	96.7%	94.90%	
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	5	5	6	5	15	12	14	12	3	9	5	4	
6	"Never Events" in month	Number	0	1	0	0	1	0	0	0	0	0	0	1	An investigation is currently being undertaken into this event.
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number	1	0	0	0	2	0	1	1	0	0	0	0	
9	RED rated areas on your maternity dashboard?	Number	3	3	5	3	4	2	3	1	2	1	1	2	Number of deliveries; benchmarked to 4500 deliveries per annum. Highlighted in view of requirement for second middle tier of obstetricians in line with the recommendations from Safer Childbirth
10	Falls resulting in severe injury or death	Number	1	2	4	1	1	0	2	0	0	1	2	2	
11	Grade 3 or 4 pressure ulcers	Number	1	2	3	0	3	5	0	1	4	2	1	0	
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
13	Formal complaints received	Number	39	51	44	29	39	48	49	50	51	39	48	33	
14	Agency as a % of Employee Benefit Expenditure	%	5.4%	5.0%	4.8%	5.5%	5.4%	5.50%	5.83%	6.4%	6.6%	7.0%	8.0%	7.70%	Aug 12 - Bank & Agency Spend £1.563m / £20.318m income
15	Sickness absence rate	%	4.0%	4.1%	4.1%	4.2%	4.4%	4.6%	Not Av	4.8%	5.0%	4.6%	4.6%	N/a	Sickness absence rates are not available prior to 6 weeks post month end.
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	This information is not currently available in the trust. Discussions are to take place on the viability and benefits of routinely collecting this data.

Board Statements

Northampton General Hospital

August 2012

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

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the 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.	Yes
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality	Yes
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes

	For FINANCE, that:	Response
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes

	For GOVERNANCE, that:	Response
6	The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.	Yes
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.	Yes
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans for mitigation of these risks.	Yes
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR; and a commitment to comply with all known targets going forwards.	No
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	Yes
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	Yes

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO			
Chair			

Notes

Ref	Indicator	Details
Thresholds	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%.	
1a	Data Completeness: Community Services	Data completeness levels for trusts commissioned to provide community services, using Community Information Data Set (CIDS) definitions, to consist of: - Referral to treatment times – consultant-led treatment in hospitals and Allied Healthcare Professional-led treatments in the community; - Community treatment activity – referrals; and - Community treatment activity – care contact activity. While failure against any threshold will score 1.0, the overall impact will be capped at 1.0. Failure of the same measure for three quarters will result in a red-rating. **Numerator:** all data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems). **Denominator:** all activity data required by CIDS.
1b	Data Completeness Community Services (further data):	The inclusion of this data collection in addition to Monitor's indicators (until the Compliance Framework is changed) is in order for the SHA to track the Trust's action plan to produce such data. This data excludes a weighting, and therefore does not currently impact on the Trust's governance risk rating.
1c	Mental Health MDS	Patient identity data completeness metrics (from MHMDS) 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 refer to the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq) **Denominator:** total number of entries
1d	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** the number of adults in the denominator whose employment status is known 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 month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Accommodation status: **Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known 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 month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Having a Health of the Nation Outcome Scales (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. **Denominator:** The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.
2a-c	RTT	Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the threshold on a monthly basis. Consequently, any failure in one month is considered to be a quarterly failure. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process. Will apply to consultant-led admitted, non-admitted and incomplete pathways provided. While failure against any threshold will score 1.0, the overall impact will be capped at 2.0. The measures apply to acute patients whether in an acute or community setting. Where a trust with existing acute facilities acquires a community hospital, performance will be assessed on a combined basis. The SHA will take account of breaches of the referral to treatment target in 2011/12 when considering consecutive failures of the referral to treatment target in 2012/13. For example, if a trust fails the 2011/12 admitted patients target at quarter 4 and the 2012/13 admitted patients target in quarters 1 and 2, it will be considered to have breached for three quarters in a row.
2d	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 (DH, 2008): a) Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: - treatment options; - complaints procedures; and - appointments? c) Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the 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: trust boards are required to certify that their trusts meet requirements a) to f) above at the annual plan stage and in each month. Failure to do so will result in the application of the service performance score for this indicator.
3a	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. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter.. Will apply to any community providers providing the specific cancer treatment pathways
3b	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. 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. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. National guidance states that 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 the SHA receive evidence of 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. In the absence of any locally-agreed contractual arrangements, the SHA encourages trusts to work with other providers to reach a local system-wide agreement on the allocation of cancer target breaches to ensure that patients are treated in a timely manner. Once an agreement of this nature has been reached, the SHA will consider applying the terms of the agreement to trusts party to the arrangement.
3c	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. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways.

Notes

Ref	Indicator	Details
3d	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. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA 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 CPA who were discharged from psychiatric inpatient care. 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. 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. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the
3g	Mental Health: DTOC	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed during the month. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led) during the month. Delayed transfers of care attributable to social care services are included.
3h	Mental Health: I/P and CRHT	This indicator applies only to admissions to the foundation trust's mental health psychiatric inpatient care. The following cases can be excluded: - planned admissions for psychiatric care from specialist 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. The indicator applies to users of working age (16-65) only, unless otherwise contracted. 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 this guidance, the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven days a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face-to-face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team.
3i	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
3j-k	Ambulance Cat A	For patients with immediately life-threatening conditions. The Operating Framework for 2012-13 requires all Ambulance Trusts to reach 75 per cent of urgent cases, Category A patients, within 8 minutes. From 1 June 2012, Category A cases will be split into Red 1 and Red 2 calls: • Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing. • Red 2 calls are serious cases, but are not ones where up to 60 additional seconds will affect a patient's outcome, for example diabetic episodes and fits. Ambulance Trusts will be required to improve their performance to show they can reach 80 per cent of Red 1 calls within 8 minutes by April 2013.
4a	C.Diff	Will apply to any inpatient facility with a centrally set C. difficile objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Both avoidable and unavoidable cases of C. difficile will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health trust without a C. difficile objective acquires a community provider without an allocated C. difficile objective) we will not apply a C. difficile score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of C. difficile is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency indicates multiple outbreaks. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation. If the Health Protection Agency indicates that the C. difficile target is exceeded due to multiple outbreaks, while still below the de minimis, the SHA may apply a score.
4b	MRSA	Will apply to any inpatient facility with a centrally set MRSA objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Those trusts that 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 the Department of Health. We expect those trusts without a centrally calculated MRSA objective as a result of being in the best performing quartile to agree an MRSA target for 2012/13 that at least maintains existing performance. Where there is no objective (i.e. if a mental health trust without an MRSA objective acquires a community provider without an allocated MRSA objective) we will not apply an MRSA score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of MRSA is set at 6. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation.

BOARD SUMMARY SHEET	
Title: -	Equality and Human Rights Annual Report 2011/2012
Submitted by: -	Geraldine Opreshko
Date of meeting: -	27th September 2012
Corporate Objectives Addressed: -	Enhance all urgent care pathways, including critical care
SUMMARY OF CRITICAL POINTS: - The report reviews the progress Northampton General Hospital has made to promote equality and celebrate diversity; highlights good practice and presents data for 2011/12	
PATIENT IMPACT: - to provide assurance that service users are treated fairly and not subject to unfair discrimination	
STAFF IMPACT: - to provide assurance that staff are treated fairly and not subject to unfair discrimination	
FINANCIAL IMPACT: - none	
EQUALITY AND DIVERSITY IMPACT: - this is a fundamental component in the Trust's equality and diversity work	
LEGAL IMPLICATIONS: - it is a legal duty to provide this information	
RISK ASSESSMENT: -	
RECOMMENDATION: - The Board is asked to note the report.	

Northampton General Hospital NHS
NHS Trust

Northampton General Hospital

Equality and Human Rights Annual Report 2011/2012

June 2012

EXECUTIVE SUMMARY

The Equality and Human Rights Annual Report for 2011/2012 reviews the progress Northampton General Hospital has made to promote equality and celebrate diversity in the year 2011 to 2012.

From a Service prospectus this report demonstrates that we have an understanding of the service needs against the Northamptonshire population and we are developing services in response to these needs as well as making improvements to the estate that will support our service users.

In addition, we have provided areas of good practice such as examples of providing reasonable adjustments for individuals with Learning Disabilities and those patients with Dementia. We have also demonstrated the language support we have provided and alternative ways of communicating to our patients with the purchase of pictorial folders for the ward areas to aid basic communication and easy read leaflets suitable for the use by people with learning disabilities, reading or cognitive problems or patients whose first language is not spoken English.

Our legal duty to monitor our workforce is also addressed in this document. The report provides equal opportunities information for some of the protected characteristics in the following areas:

- Trust's Workforce Profile
- Human Resources (HR) Recruitment Activity
- HR Caseload Activity
- Training and Development Activity

INTRODUCTION

Northampton General Hospital believes that Equality and Diversity (E&D) is central to what we do. Equality is about creating a fairer society where everyone has the opportunity to fulfill their potential.

The Trust recognises the right of all patients, visitors and employees to be treated fairly and considerably in access to services and employment, irrespective of age, gender, marital status, religious belief, ethnic background, nationality, sexual orientation, disability and social status.

The Trust aims to deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of the different groups and individuals we serve and the staff we employ.

To achieve this aim, we want to ensure that service users and employees are not subject to any form of discrimination or unequal treatment. Everyone can expect to be treated with equal respect and dignity regardless of their background or circumstances.

It is important to us that we eliminate discrimination in the way we provide our services and the way we recruit, train and support our workforce. The Trust does not tolerate any forms of unlawful or unfair discrimination. In addition it recognises that all people have rights and entitlements.

Equality and Diversity remains high on the Trust's agenda and much work is underway to implement its Equality Delivery System. This work is overseen by the Equality and Human Rights Steering Group and the Chief Executive has been actively involved in the development of its key objectives and action plans which were published in April 2012 and will be implemented during 2012/13.

Our Annual Report for 2011/2012 identifies the progress we have made in relation to the implementation of the Equality Delivery System and our duty to monitor our workforce and service profiles.

TRUST OVERVIEW

Northampton General Hospital NHS Trust (NGH) is a 619 bed acute hospital (excluding day case and community beds) providing services from four main sites and a number of smaller facilities. The largest hospital site is based in Northampton town centre providing a full range of acute services. It has operated on this site since 1793. The other hospital site is in Daventry, providing further acute services. We also provide care at Hazelwood Ward, Isebrook Hospital and Corby Community Hospital. We serve a growing population which is currently around 380,000 inhabitants. The Trust is also an accredited Cancer Centre delivering cancer services to a wider population of 880,000 from the whole of Northamptonshire, and parts of Buckinghamshire. Hyper acute service development has included cancer, vascular, renal, stroke and enhanced cardiology services.

The Trust has recognised that the landscape for the provision of acute healthcare is changing rapidly and developed a strategy that will consolidate and enhance our position as one of the hyper acute hospitals in the South-East Midlands network. The strategy was developed through the engagement and involvement of senior clinicians and managerial staff from the Trust. Our principal commissioner is NHS Milton Keynes and Northamptonshire. This cluster PCT was established in June 2011 with a budget of £1.4bn and includes 108 GP practices, 76 in Northamptonshire and 32 in Milton Keynes.

The Trust employs 3,815 WTE members of staff, a headcount of 4,512 people, (as at January 2012). The Trust implemented a Clinical Care Group Structure on 1st April 2012 to strengthen the delivery of the strategic aims of the Trust. The new structure enables increased ownership of Clinical Service Unit performance and will assist with transformation delivery.

OUR STRATEGY

Our Strategy - Key Points:

The Trust strategy was written in partnership with senior clinicians and managerial staff.

The NGH vision is to provide the very best care for all our patients.

We aim to:

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

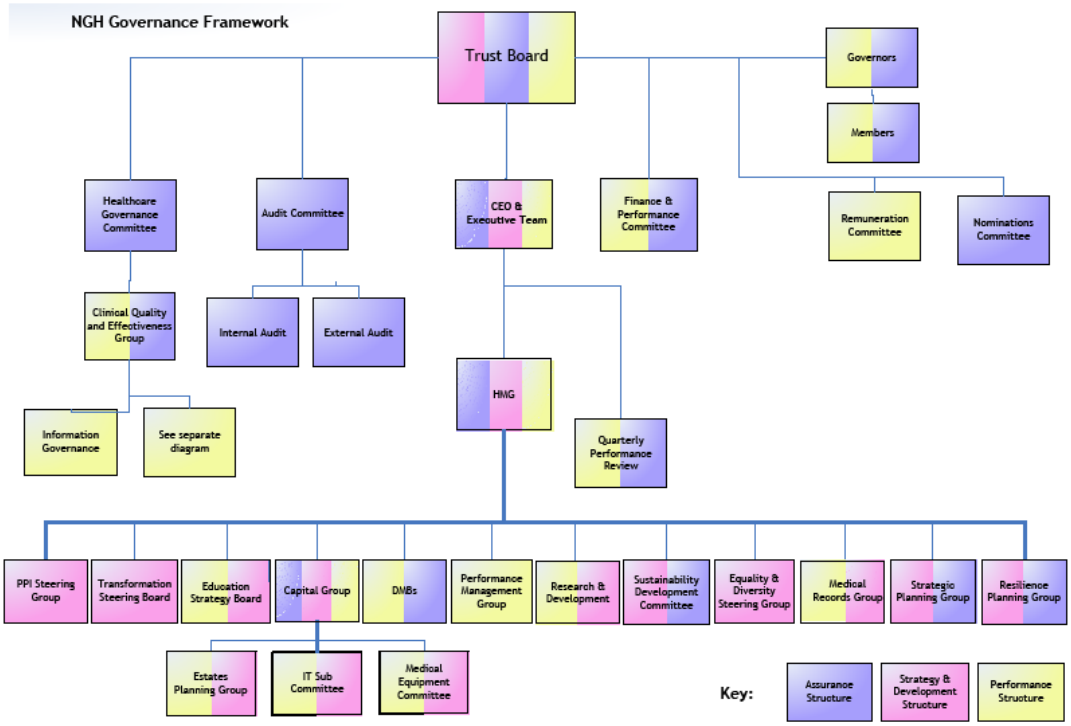
The Trust has full support from our commissioners NHS Milton Keynes and Northamptonshire and Nene Commissioning of NGH to become a Foundation Trust.

As at March 2012, we have 4250 public recruited members. The Trust aims to have a minimum of 5000 public members on authorisation.

The Trust will continue to develop strategic partnerships with commissioners and other providers as we enhance our range of hyper acute services for the wider community.

GOVERNANCE ARRANGEMENTS

The Governance arrangements at the Trust are provided in the framework below and demonstrate that the Equality and Human Rights Steering Group is in a position to lead the way in setting the strategic direction as well as monitoring and providing assurance of delivery of equality issues.



DEMOGRAPHICS WITHIN NORTHAMPTONSHIRE

Northamptonshire has a population of 684,000 people, with over 85% living in town and urban areas. Black and minority ethnic groups constitute less than 10% of the population of Northamptonshire. However, the ethnic mix of the population is changing, with more ethnic diversity found in the younger age groups. Current estimates suggest that 89% of the under 16 population are white, compared to 92% of the adult population and 97% of the retirement age population.

The level of migration into Northamptonshire both internationally and internal to the UK has reduced in recent years with the number of new national insurance registrations to overseas nationals falling from 8,140 in 2007 to 4,980 in 2009. In 2009 there were 67.1 live births per thousand women aged

between 15 and 44 in Northamptonshire, reversing a previously declining trend and a higher rate than the general fertility rate for England. About 1 in 5 children were born to mothers born outside the United Kingdom (source. JSNA Executive summary 2011).

There are a number of traveller sites across Northampton and Wellingborough with 294 caravans identified in the county, predominantly on authorised sites. The travelling community were identified as the most at risk health group in the UK with the lowest life expectancy and the highest child mortality rate. Different approaches and communications are required to ensure inclusion of this group[1].

In addition, there are growing proportions of refugees and asylum seekers. The county also has a relatively high migration population from countries recently joining the EU, some of whom are not registered with a primary care service. The impact of this can be seen in the increase in A&E attenders and first presentations to our maternity services of women with no previous ante-natal care.

Northampton General Hospital NHS Trust has ensured that its strategic direction is aligned with that of the wider NHS community. An aging population is likely to impact significantly on health services, with the number of people living in Northamptonshire with long term conditions increasing.

Table 2: Adult long term conditions for Northamptonshire

PANSI* Projections	2010	2015	2020	Change
Diabetes adults 18-64	14,311	14,755	15,599	9% increase
Longstanding health condition caused by a stroke adults 18-64	1,315	1,381	1,449	10% increase
Adults 18-64 dependant on drugs	14,728	15,102	15,562	6% increase
Hearing impairment adults 18-64	17,426	17,891	19,192	10% increase
Adults 18-64 with moderate or serious physical disability	44,349	45,319	47,714	8% increase
Adults 18-64 with a common mental disorder	69,638	71,301	73,417	5% increase

Projecting Adult Needs & Service Information (Source: JSNA 2011)

It has already responded by developing its stroke service at NGH, transferring PPCI to Kettering General Hospital NHS Foundation Trust and developing the countywide model for vascular surgery from 1st April 2012.

[1] http://www.rcn.org.uk/development/practice/social_inclusion/gypsy_and_traveller_communities

LOCAL HEALTH ECONOMY Key Points:

- High fertility rates compared to England average
- Increasing population (slowed on previous forecasts)
- Increasing elderly population (increase in long term conditions)
- High migration from countries outside the UK
- 10% black and ethnic minority
- 25% population under 20 years of age
- 16% population over 65 years of age
- Pockets of disease due to poor health and lifestyle choices (obesity and smoking related disease and deprivation)

THE LEGAL FRAMEWORK

The Equality Act 2010, its regulations and guidance replaces previous anti-discrimination laws with a single act. It has simplified the law, removing inconsistencies and making it easier for people to understand and comply with. It also strengthened the law in important ways, to help tackle discrimination and equality. The public sector equality duty, which applies to all NHS organisations, is made up of a general duty which is supported by specific duties.

The general duty requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited under the Act
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

Having due regard entails considering the above three aims of the equality duty and how they are an integral component of the decision making in:

- How the organisation acts as an employer
- How policies are developed, reviewed and evaluated
- How services are designed, delivered and reviewed
- How they procure from others.

Advancing equality of opportunity involves removing or minimising disadvantage encountered by people due to their characteristic, meeting the

needs of people with protected characteristics and encouraging people with protected characteristics to participate in public life where participation is low.

Fostering good relations involves tackling prejudice and promoting understanding between people who share a protected characteristic and others.

The Equality General Duty is supported by specific duties, set out in regulations which came into force in September 2011. The specific duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty and to set themselves specific, measurable equality objectives.

The protected characteristics covered by the Equality Duty are;

- Age
- Disability
- Gender-reassignment
- Marriage and civil partnership (but only in respect of eliminating unlawful discrimination)
- Pregnancy and maternity
- Race – this includes ethnic or national origins, colour or nationality
- Religion or belief – this includes lack of belief
- Sex
- Sexual orientation

We are required to publish information to show our compliance with the Equality Duty, at least annually. This was published by Northampton General Hospital in January 2012 in the Equality Assurance document which can be accessed on the Trust's internet site.

PROGRESS IN 2011-12

Equality Delivery System

During 2011 and 2012 the Trust has made progress in working on the Government's revised Equality agenda for NHS organisations which for the NHS is the development of the Equality Delivery System (EDS). This is aimed at improving the equality performance of the NHS and embedding equality into mainstream business.

By using the EDS, the Trust will be able to meet the requirements of the Equality Act 2010 and we will be better placed to meet the registration requirements of the Care Quality Commission (CQC).

The Trust's Equality and Human Rights Steering Group has revised its terms of reference to reflect the work that is in progress and its purpose is to champion and steer the work of the hospital so that it is in full and positive compliance with equality and human rights legislation, regulations and codes of practice including NHS and DoH standards. The group leads, advises and inform on all aspects of policy making, service delivery and employment

including various engagements related to equality and inclusion legislation and policy direction.

In addition, the Groups aim is to lead and monitor progress on the development of the action plan required in accordance with the NHS Equality Delivery System. (APPENDIX 1)

In April 2011, the Trust developed an Equality and Human Rights Strategy and questionnaire, which was distributed to 20 community and voluntary sector organisations within Northamptonshire, to LINk representatives, Union colleagues and other key stakeholders across the county with a purpose to understand the needs of the diverse community.

In addition, throughout October 2011 senior managers in the Trust carried out a self-assessment on the four EDS goals:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and included staff
- Inclusive leadership at all levels.

The Trust's Equality and Human Rights Steering Group agreed the self-assessment ratings in October 2011. The grading agreed for most of the 18 EDS outcomes was amber (developing) and the reasons for this were generally the gap in the evidence available regarding meaningful and sustained engagement with both staff and communities and the limited data collection and analysis regarding all protected groups. These gaps have informed the development of the four year action plan.

A summary of evidence was identified and in December 2011 the self-assessment was examined with our Staff Side colleagues and comments were provided. APPENDIX 2. This, together with the validation of the self-assessment by a Northamptonshire and Milton Keynes Health Equality Group, which is a partnership between the community sector and local NHS organisations, will review grading actions and provide recommendations for the Trust in order to develop and finalise the EDS Action Plan.

At the time of publication, the review had taken place but the assessment was not finalised. However, work will continue to progress the Action Plan in the second quarter of 2012.

Health Equality Group

Throughout the year the Equality Lead and Deputy Director of Human Resources have been working with other NHS organisations in the Northamptonshire/Milton Keynes cluster and LINk organisations in Northamptonshire and Milton Keynes, to establish a Health Equality Group. The Group which was established in December 2011 is a partnership between the community sector and local NHS organisations to support the implementation of the EDS. Its purpose is to act as a coordinating panel to facilitate and validate engagement and analysis of EDS on behalf of

communities and to review grading actions and recommendations for the NHS Trust's and Consortia.

The Group has identified an agreed methodology to enable the 2011/2012 grading to be supported and validated in a practical way through a peer review. Northampton General Hospital was peer reviewed by the Deputy Director of Human Resources at Northamptonshire and MK NHS and the RAG rating was agreed.

The Health Equality Group has recruited community equality representatives from the community to work with each organisation to provide a 'critical friend', who will also provide access to broader community views through their organisations in addition to providing support through the grading review.

ENGAGEMENT, CONSULTATION and INVOLVEMENT

Service Engagement - Patients and the Community

NGH is committed to involving and consulting patients, carers and the public on developing closer links with our local population through governors, members and staff. The Trust works towards ensuring that there is a flexible approach to involvement so that everyone, despite their background, location or particular needs can be involved.

The Trust aims to be proactive in its approach to Patient and Public Involvement by seeking the views of its patients and the public through:

- Focus Groups which were established in 2010 with the aim to promote partnership working and provide a means of communication for patients, public and staff to the Patient and Public Strategic Steering Group (PP SSG) to help shape the strategic development of services within the Trust
- Involving people with disabilities through representation on the Northampton Borough Council Disability Forum
- Attending quarterly meetings of the NGH/Black Minority Ethnic Sub Regional Partnership User Group
- The Patient Advisory and Liaison Service (PALS) and the Complaints department, the Dignity Forum and the Safeguarding Vulnerable Adults Group who work closely with the Trust's Equality Lead to raise and address, wherever possible, issues raised around the equality agenda
- Engaging in partnership working with other agencies and healthcare professionals regarding equality issues and a Trust member meets regularly with the East Midlands Inclusion Group
- Close working relationship with the Northamptonshire Local Involvement Network (LINk) that provides a critical view of the

engagement work undertaken and importantly assists in the equality of access to engagement opportunities for all sections of the community.

However, the recently completed Equality Delivery System self assessment identifies that the Trust cannot evidence the involvement and engagement with patients from all protected groups. A proposal for changes to the Public & Patient Involvement Strategy was agreed by the Board in March 2012 to ensure that the Trust will engage with a wider group of service users.

By reviewing the current Trust engagement with service users and establishing a robust reporting mechanism for all current and new service user groups, patients from all protected groups will be included.

By enhanced engagement with local interests we will be able to focus on those matters that are most important to patients and communities. This will help the Trust to plan, develop and manage our services as well as reduce health inequalities.

The improved service user engagement constitutes one of the Trust's Equality Objectives for the next four years. (Appendix 1)

In order to empower staff on quality and safety, the Healthcare Governance Committee has recently approved an action plan to improve the culture in which incident reporting is actively encouraged and seen as an opportunity to learn rather than blame. In addition, the Trust has undertaken a patient safety climate questionnaire, which focuses on staff perceptions of safety in relation to management support, supervision, risk taking, safety policies and practices, trust and openness. The analysis of the questionnaire will be reviewed and ranked against the following:

- Knowledge and training
- Attitudes to safety
- Safety climate.

In order to further engage clinical leadership at strategic level in patient safety the Trust is in the process of forming a Patient Safety Academy. As part of this the Trust is inviting 5 lead clinicians the opportunity to influence the redesign of systems to ensure we are able to offer safe effective care and minimise the risk of harm to patients and reduce unnecessary deaths.

Staff Engagement

The Trust recognises the need to make improvements in involving and engaging with staff as we have set out to become one of the best places to work. Our approach to this clear aspiration is how we engage our staff in how the hospital 'runs'. To support this aspiration we need a clear approach to staff engagement and our plan is to use 'Listening into Action.'

Listening into Action (LiA) is a systematic, compelling and practical response to these challenges. It has been developed through intensive, hands-on work with over 40,000 NHS staff and leaders from across more than 70 NHS Trusts

since 2007, with national endorsement and a keen interest from many of the senior leaders across the Service.

The foundations for LiA are based on:

- The need for senior leaders to connect the right people around all our major challenges
- Providing service teams with the opportunity to collaborate and share ideas
- Having 'permission' to get on and deliver actions which will benefit patients and staff
- Fostering a sense of collective ownership by the teams themselves for delivery of results.

The Listening into Action staff engagement programme will start in earnest in July 2012 and forms part of our Four Year Plan.

Alongside this initiative the Trust is in the process of engaging with Staff following the receipt of the 2011 Staff Survey results. Our corporate action plan will be underpinned by Care Group specific action plans which are based on the results of feedback from staff through staff focus groups. The plans will support tangible improvements in the areas where the Trust has scored poorly compared to other acute Trusts. These areas relate to:

- Improving Communication, increasing staff involvement and engagement
- Improving Appraisal and Personal Development Plan Rates
- Stamping out Bullying and Harassment in the work place
- Reducing Work Pressure and Increasing Work Life Balance
- Supporting the Health and Well Being of Staff
- Reducing the percentage of staff witnessing potentially harmful errors, near misses or incidents.

Leadership and Management Training

The Trust recognises the importance that leaders play and their role in developing an engaged and empowered workforce in the Trust. To this end it has undertaken a number of initiatives to ensure the development of its managers and leaders. This has involved the development of an accredited leadership and management programme tailored to the needs of line manager's bands 6 to 8. In addition, the Trust has supported the development of senior staff through the East Midlands Leadership Academy and the use of the Leadership Qualities Framework 360^{o} assessment. Clinical Leaders have also been supported through a number of individual development programmes. In addition the Board and the Council of Governors have been involved in a number of developmental activities to support improved leadership.

In order to ensure that we are working to 'world best' standards of safety design and delivery, along with many hospitals in the UK, we have enrolled in

the Institute for Healthcare Improvement's patient safety programme. Recently we have used funds provided by the SHA to allow the Medical Director, Chief Operating Officer, and Director of Nursing (designate) to attend the Patient Safety Executive Development Programme in early March 2012. The Quality and Patient Safety strategies were subsequently approved by the Board in April 2012

Consultation and Involvement

The hospital promotes partnership working and is currently in the process of jointly developing a Partnership Agreement with the Staff Side. The intention is to take the involvement and engagement of the Staff Side to an even more powerful level.

The Partnership Agreement will be based on the Trust's vision, values and a set of shared principles. The Chief Executive who is working closely with Staff Side to develop a suitable Partnership Agreement Model for the Trust is leading this piece of work.

EQUALITY ASSESSMENTS

Although Equality Impact Assessments are no longer a legal requirement, identifying and responding to the affect of activities on different groups remains of fundamental importance in the context of giving due regard to meeting the three aspects of the general duty.

Equality analysis remains a key component in delivering service excellence, by helping to ensure that the needs of different communities are met, and that people are not being excluded. Therefore the Trust has continued to utilise its systems for carrying out Equality Impact Assessments on policies, functions and change programmes to assess whether they have the potential to affect people differently. The Trust recognises this process identified and addresses real or potential inequalities resulting from policy, practice or service development and in particular at a time when the Trust is making significant changes through its Transformation Programme.

Any negative consequences for a particular group or section of service users/staff can be eliminated, minimised or counterbalanced by other measures, wherever possible, in order to take account of and meet the needs of all our communities so the continuation of the equality impact assessments will ensure that consideration will be given to:

- Effective processes and communication between staff and service users
- Physical access
- Provision of information in a format which can be understood
- Cultural norms, preferences and practices of equality groups taken into account
- Available relevant data and service user / staff feedback.

SERVICE INFORMATION

Patient Profile

There were 96,399 admissions in 2011/12, 330,975 outpatient attendances and 22,528 non attendances.

Ethnicity

The ethnicity of the patients attending NGH 2011/12 is shown in the table below. This shows that there are a disproportionate number of non-attendances at outpatient departments from the Bangladeshi and Black African community. By working with the Health Equality Group we will identify the specific needs of these groups to address any shortfalls identified in this report.

Ethnic Group description	% Total Admissions	% Total Out patient	% Total DNAs
Not known	0.59	2.33	3.87
White – British	81.25	76.21	66.09
White – Irish	1.37	1.50	1.38
Any other white background	4.01	2.47	3.14
Mixed – White and Black Caribbean	0.64	0.42	0.91
Mixed – White and Black African	0.26	0.16	0.38
Mixed – White and Asian	0.21	0.14	0.24
Mixed – Any other mixed background	0.42	0.27	0.51
Asian or Asian British – Indian	1.73	1.59	1.78
Asian or Asian British – Pakistani	0.52	0.35	0.67
Asian or Asian British – Bangladeshi	0.80	0.53	1.03
Asian or Asian British – any other Asian	0.55	0.40	0.59
Black or Black British – Caribbean	0.89	1.0	1.50
Black or Black British – African	1.68	1.11	2.39
Black or Black British – Any other Black	0.35	0.25	0.55
Other Ethnic Group - Chinese	0.26	0.28	0.27
Other Ethnic Group	1.0	0.73	1.29
Not stated	3.47	10.24	13.42

Gender

The Gender of patients attending NGH 2011/2012 is shown in the table below and correlates with the population of Northamptonshire whereby the 2012 projected population by gender is 49.6% males and 50.4% females.

% Total Admissions		% Total Outpatients		%Total DNAs	
Male	**Female**	**Male**	**Female**	**Male**	**Female**
41.23	58.76	43.55	56.44	48.34	51.64

Age

The Age profile of patients attending NGH 2011/2012 is shown in the table below. This demonstrates that 36% of admissions were over the age of 60 years and the age group with the largest % of non attendance at outpatients was the 17-30 age group. Whilst there is some correlation with the age ranges within Northamptonshire such as a high proportion being over the age of 70 there needs to be an understanding as to why the numbers not attending in the 17-30 age range is occurring. With the implementation of a Care Group structure and the fact that the members of the Care Group form part of the Equality and Human Rights Steering Group membership will provide an opportunity for discussions to be held and measure put in place to address this issue.

Age Group	% Total Admissions	% Total Out patient	%Total DNAs
0-16	14.95	9.3	18.16
17-30	16.12	11	20.10
31-40	11.46	10.74	14.04
41-50	9.99	12.63	14.19
51-60	11.25	14.13	10.94
61-70	15.11	18.67	10.04
71-80	11.85	14.73	7.16
81-90	7.91	7.96	4.65
91-108	1.38	0.83	0.72

Faith and Belief

Patients admitted to NGH in 2011/12 identified 66 different faiths and beliefs. The following is a summary of the main faiths:

Faith or Belief	% of Total Admissions
Christian (all denominations)	51.36
Not Known	33.24
No faith or belief	10.49
Moslem	1.75
Atheist	0.68
Hindu	0.72
Sikh	0.27
Jewish	0.11
Buddhist	0.13

Agnostic	0.11

Disability - Reasonable Adjustments

The Equality Duty acknowledges that the needs of people with disabilities may be different from those of non-disabled people. The Trust must therefore take account of disabled people's impairment when making decisions about policies or services. The latter may entail making reasonable adjustments or treating disabled people differently in order to meet their needs.

Best Practice Examples of Reasonable Adjustments:

Learning Disabilities

The Trust has recognised the importance of ensuring that we provide accessible and equitable healthcare to patients with a Learning Disability.

Since August 2011 the Trust have contributed to the cost of the Learning Disability Liaison Nurse to enable the post to be full time. This has resulted in access to expertise and enabled a programme of strategic developments to be put in place.

Communication tools have been developed to improve the communication between health care staff and patients with a learning disability. This includes the following:

- A Hospital Passport – this is completed by carers who know the individual well and shares important information about how to support the individual including communication and how they demonstrate they are anxious or in pain
- Core Assessment – Prompts nursing staff to consider areas such as capacity, carers support, and pain management
- Re-launch of the A & E Pathway
- Re-launch of the A & E Grab sheet

Learning Disability training is delivered as part of the Healthcare Assistant Induction and the Preceptorship programmes. Bespoke training is also undertaken with ward teams. This enables staff teams the opportunity to discuss their challenges when supporting patients with a learning disability and identify practices and strategies to implement and improve the experience for both the patient with a learning disability and the healthcare team.

Within this year all wards complete a programme of peer reviews (benchmarking against best practice) which the Learning Disability Acute Liaison Nurse has attended a number of these supporting teams with developing action plans. This has also enabled Trust wide issues to be taken forward, such as the introduction of photographic menus for patients who have limited communication abilities.

Reasonable adjustments are made to the service to ensure patients with a learning disability receive equitable healthcare, for example, where a patient

with severe learning disabilities required treatment for two medical procedures, through the support of both medical consultants and departments both procedures were carried out during one appointment thus avoiding unnecessary stress on the patient to attend the Trust on two separate occasions. The patient in question lacked mental capacity and the Trust also understood its responsibilities towards the Mental Capacity Act (2005) by ensuring that treatment was received in the best interest of the patient.

Dementia Care

The Trust's multi-disciplinary Dementia Care Action Committee was established in February 2011 with the agreed aim to improve the experience of patients with dementia and the quality of their care while at NGH. The Committee developed a comprehensive action plan based on national and local strategies and have met monthly to deliver the plan.

The Committee decided to adopt a butterfly logo as a means of identification of patients with dementia or memory problems. A variety of resources were purchased and information was developed to include:

- A 'butterfly magnet' to be used on the ward white boards in order that all staff are made aware that the patient may require additional support
- Advice sheets for different staff groups (porters, domestics and hostesses) regarding engagement with patients with dementia
- A Patient Profile, to be completed with carers and kept at the bedside to be utilised by all staff groups and volunteers
- A poem entitled 'Remember Me' was composed by a committee member to highlight good practice regarding dementia care. The poem was distributed as a poster for display in all ward areas
- Guidance regarding communication and 'aim for the familiar' to assist staff to orientate and engage with patients with dementia
- Information to notify relatives and carers about the 'Butterfly Care' scheme
- A Dementia, Delirium and Depression (3D's) resource folder
- Pictorial communication folders were purchased to aid communication with various groups of patients, including those with dementia
- Activity boxes were purchased for all wards containing a variety of suitable photographs and activities to aid engagement with the patients to be utilised by staff, volunteers and visitors
- Individual patient 'Memory Boxes' were provided which relatives can fill with items which may help to reassure the patient

At the end of September 2011, the 'Butterfly Care' scheme was launched in the Trust and all wards were provided with the above information and resources.

Training in dementia care was delivered throughout the year. All wards now have trained cascade trainers who will continue to deliver training throughout the coming year.

The Committee have developed a detailed action plan for 2012/13 to embed and build on the achievements to date.

A Disability Resource Folder is kept in all ward areas and the majority of Out Patient Departments within the Trust. This folder contains information referencing best practice and signposting to the various advice and support groups; deaf and deafened patients, patients with visual impairments, learning disabilities and physical disabilities. This folder was developed utilising information sourced from local and national disability groups.

Patient Complaints 2011 to 2012

The Complaints department and Patient Advice and Liaison Service (PALS) are a valuable source of information on dissatisfied patients and evidence for whether the services provided do not meet the needs of protected groups.

In the reporting year 2011-2012 the Trust received 517 complaints that were investigated through the NHS Complaints Regulations. This is in comparison to the 466 complaints that were received in the previous year. 278 complainants provided their ethnicity status and the remainder declined to even though the information is handled on an anonymised basis. The ethnicity of the complainants who responded, is detailed in the table below. 247 of those complainants were white British which reflects the Northamptonshire population figures as detailed on page 21.

Ethnicity	Number
White British	247
White Irish	5
White other	7
Mixed white and black Caribbean	1
Mixed white and black African	1
Mixed white and black Asian	0
Mixed other	2
Asian or Asian British Indian	6
Asian or Asian British Pakistani	1
Asian or Asian British Bangladeshi	0
Asian or Asian British other	1
Black or black British Caribbean	1
Black or black British African	4
Black or black British other	1

Chinese/ other Chinese	1
Other ethnic	0
Not stated	239
Total	517

There were equality issues identified within 18 of the complaints:
Race: 2
Mental capacity: 3
Discrimination: 1
Gender: 1
Staff attitude: 4
Vulnerable adult: 7

Service Communications

Language Support

The Trust recognises that patients who have a first language which is not spoken English, have the right to professional language support. Inadequate communication with people whose first language is not spoken English limits their ability to access services. It can also have a major impact on the quality of care and treatment they receive when they do access care when communications between clinicians and patients is inadequate.

Throughout 2011/12 the Trust has utilised interpreters for 31 different languages on approximately 1,700 occasions with the most demand being for Polish, Bengali, Russian, Lithuanian and British Sign Language interpreters.

The translation of information into different languages or formats, such as Braille, can be made on request. This year we have had no requests for the information to be provided in Braille or in different formats such as large type.

Easy Read Leaflets

The Trust has continued to develop easy read leaflets regarding some clinical interventions. The leaflets are suitable for the use by people with learning disabilities, reading or cognitive problems or patients whose first language is not spoken English.

Pictorial Communication

The ability for patients to be able to communicate with both staff and visitors is recognised as a priority by the Trust. The Trust purchased a pictorial folder for all wards to aid basic communication for patients who may have difficulty communicating, for example, following a stroke, where the patient has dementia or learning difficulties as well as where the patient's first language is not spoken English.

The Estates department are increasing the pictorial signage on toilet and bathroom doors across the ward areas in the Trust.

The catering department are working closely with the Learning Disability Liaison Nurse to develop photo menus to be initially piloted on 3 wards.

Appointment Reminders

Telephone appointment reminders were introduced in June 2011 and have been introduced to approximately 42% of all outpatient appointments. Where they have been introduced, they have substantially reduced the Did not Attend (DNA) rates, especially in the older age groups of 65-84 which are 35% of our patients. It has reduced the DNA rate by half for follow up appointments in the Ophthalmology outpatients department.

ESTATES CAPITAL SCHEMES AND WORKS

As in previous years provision has been made within the annual capital plan to improve the environment and access for staff, patients and visitors with a disability. Below is a summary of the works carried out during 2011/2012 some of which are dedicated access works in response to access surveys and assessments whilst others have been incorporated as part of phased building upgrading work.

Summary of Works:

- Automated doors, external ramped access, disabled WCs and new reception counters have been installed within the haematology department
- New disabled toilets and a reception counter has been installed in A&E
- Improved access and a disabled toilet has been provided within integrated surgery
- Automated access to external doors by the Board Room and west end of Hospital Street
- Automated access to external doors by the Blood Taking Unit
- Hearing aid loops installed in all wards and clinics
- Installation of 'Changing Places' facilities for profoundly disabled adults commenced in Hospital Street.

WORKFORCE PROFILE – APRIL 2011 to MARCH 2012

The Trust continues to monitor the demographics of the workforce and in particular, analyse data on applications through to appointment for employment in the Trust. This enables us to closely monitor the diversity of applicants and highlight any trends or concerns that need to be addressed. This monitoring takes place through the Equality and Human Rights Steering Group. In addition, reporting of monitoring will continue to take place in relation to training access and our Human Resources caseload activity.

Currently several of the protected characteristics are not recorded on the Trust's Electronic Staff Record (ESR) system as the systems have not included these newer protected characteristics when they were first designed. The ESR is a national payroll system for the NHS and the Trust currently

awaits information on whether these characteristics will be added. It will be difficult to monitor fully some of the characteristics such as gender reassignment and this is recognised in the government guidance which accompanied the Equality Act 2012.

The Trust does not capture workforce data through ESR on marriage and civil partnership, gender reassignment or pregnancy and maternity and therefore limited information is available on those protected characteristics.

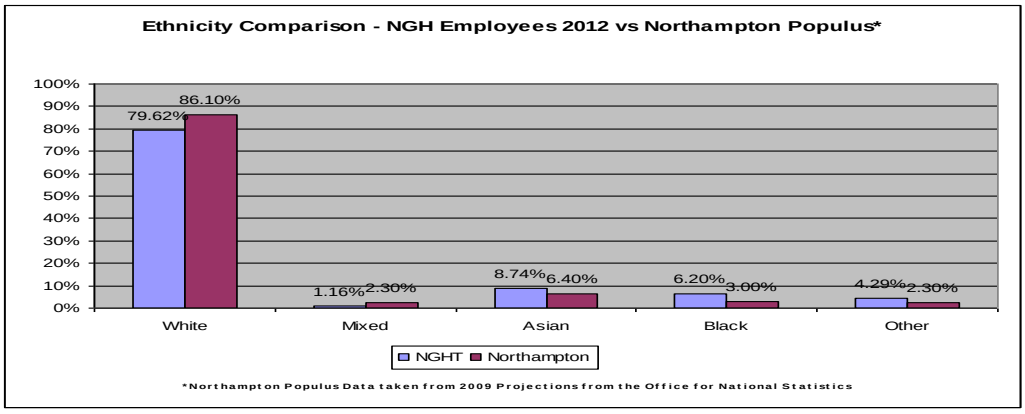
However, this section of the report provides an overview of the Trust's workforce profile as at the end of March 2012 for the following:

- Ethnicity of the working population, staff group and pay band
- Age of the working population
- Gender breakdown of the working population
- Disability
- Religion and Belief
- Sexual Orientation

All figures used in these reports have been based on headcount (Staff in Post) on primary roles only, not the whole time equivalents (WTE).

Workforce Ethnicity

The table below shows the ethnicity breakdown for Northampton in comparison with the percentage number of staff in post by ethnicity as at 31 March 2012.



The Trust has a lower proportion of white and mixed race employees against the Northamptonshire local population profile. However, this is not the case with those staff within the Asian and Black ethnic minority categories as the Trust continues to have a higher proportion against the local population figures. In order to address this disproportion the Trust will work with the relevant community groups to provide information about how to work at the Trust. Initial discussions will take place through the Health Equality Group.

A further breakdown of staff in post is detailed in the charts below, A & B. The first chart shows the percentage number of staff in post by ethnicity (% rounded up) whilst the second details ethnicity by staff group.

Chart A

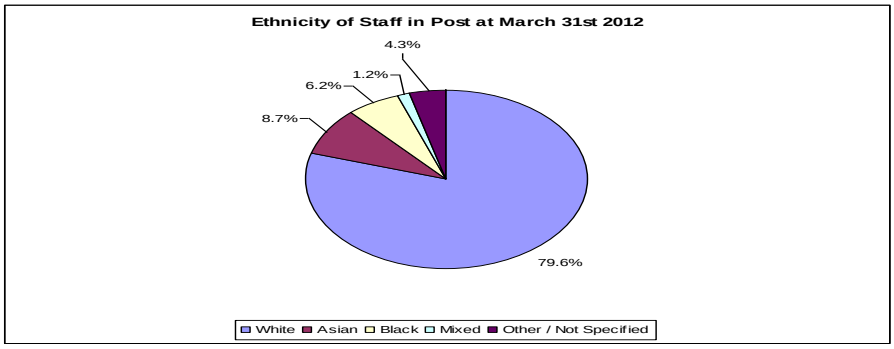


Chart B

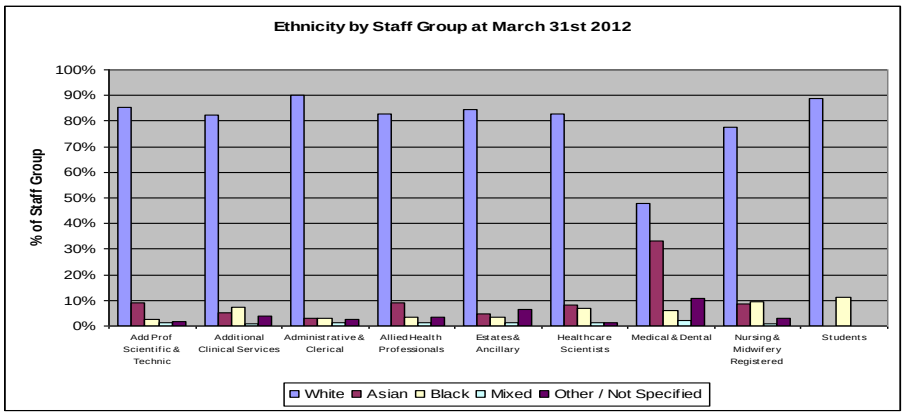
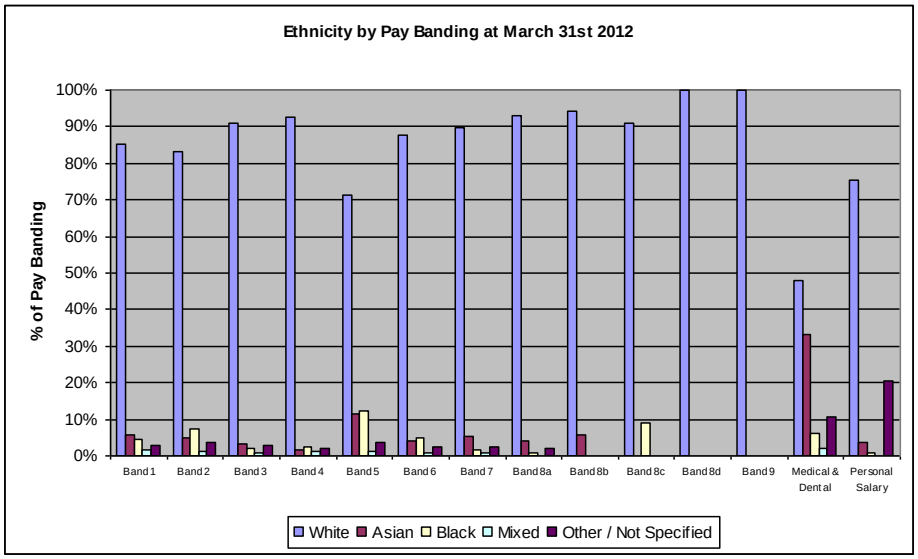


Chart C below shows the numbers of staff in post by ethnicity for medical staff and staff on agenda for change pay bands 1 to 9. The medical staff group identifies that there is a greater diversity in the medical staff workforce with a high percentage of staff within the White and Asian categories. This same proportion is reflected in the 'NHS Workforce Census 2001 to 2011 for Medical and Dental Staff'[2] which identifies from a total number of medical and dental staff of 105,711 there were 58,250 White staff and 27,924 Asian/Asian British within the professions. These two ethnic types far exceed the numbers employed in all other ethnic categories.

There is some concern at the higher pay bands 8c to 9 as these are largely filled by staff that are from a white ethnicity. In the coming year, and where possible, due to the low numbers recruited to, any positions advertised will be sampled as part of the Trust's recruitment sampling activity to identify if there are any concerns. Action will be identified and monitored if required.

[2] http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-2001--2011-medical-and-dental

Chart C

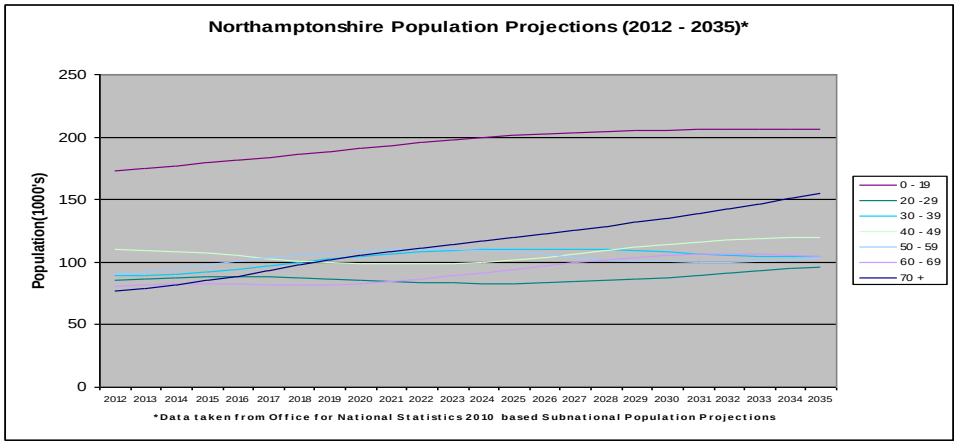


Workforce – Age

The underlying potential workforce changes over the next twenty years within Northamptonshire are shown in Chart D below and the key messages are as follows:

- The total population of Northamptonshire is predicted to increase over the next twenty years to 2033
- The age structure of the population is changing and the trend towards an ageing population continues
- The largest percentage increases can be seen in the over 70 age groups
- The percentage of the working age population is predicted to decrease

Chart D



The **0 - 19** age group will initially decrease to the year 2020 and then from 2020 will increase up to the year 2025. Thereafter this age group will remain fairly static up until 2033.

The **20 – 29** age group will initially increase to the year 2013 and then from 2020 will decrease up to the year 2023. Overall there will be an increase of 7% up to the year 2033.

The **30 – 39** age group shows a steady increase to the year 2025, and then predictions estimate a decrease in this age group. There will be an increase of 22% up to the year 2033 as compared to the figures of 2009.

The **40 – 49** age group will increase by 13% to the year 2033. This does not involve gradual increase but the predictions are that this age group will remain static until 2012, then decrease up to the year 2024 to eventually increase up to year 2033.

The **50 – 59** age group shows a large increase to the year 2023, it is then predicted to decrease to the year 2033. Overall this age group will increase by 23% to the year 2033 across Northamptonshire.

The **60 – 69** age group will increase by 40% in Northamptonshire between 2017 and 2033.

The biggest increase in age is determined in the over 70 age range and this is likely to have the greatest impact on future employment especially with the changes to the retirement legislation.

The pattern of change in the age structure suggests that the Trust will be more likely to recruit and retain workers in the higher age ranges in future years.

The projected population for 2012 by age (Chart E) below shows that within Northamptonshire the highest number of individuals is within the 40-44 and 45-49 age ranges with a significant increase in the numbers of individuals in the over 70 age range. Chart F on staff in post at 31 March 2012 shows that the highest category by age is within the 46-50 age range which confirms similarities to the local population figures. However, there is little correlation with the numbers of staff employed over 70 to the local population but this will be due to the fact that the default retirement age did not cease until September 2011. The Trust has removed the default retirement age in line with legislation.

It must be noted that the age ranges used by projected 2012 population are different to the recognised NHS age ranges on ESR as demonstrated in Chart F.

Chart E

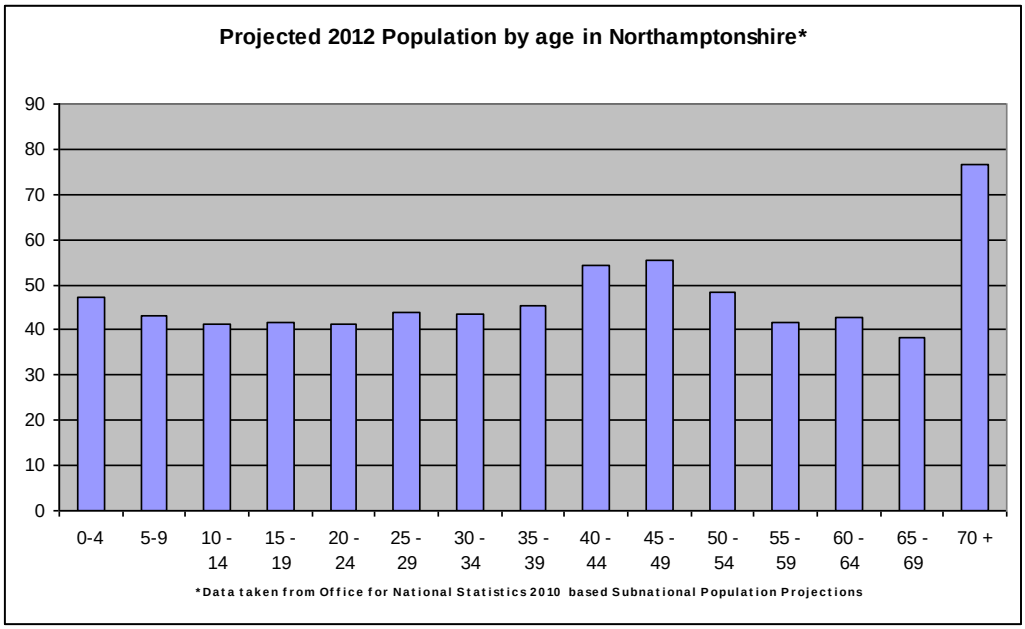
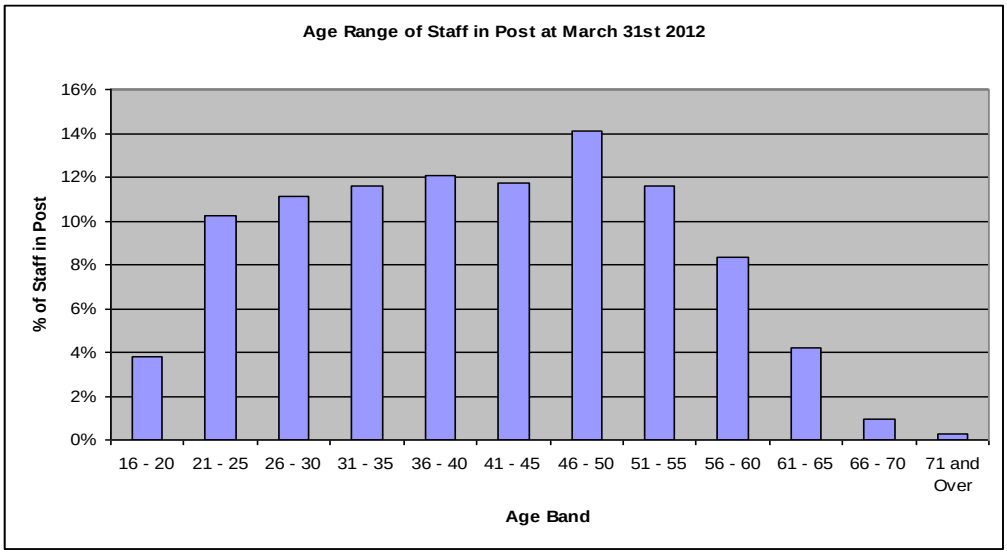


Chart F



In addition, the Trust's age range are representative of the national picture as demonstrated in the table below. (Source: NHS Workforce Census 2001 to 2011 – September 2011)[3]

NHS Workforce Census 2001 to 2011 – NHS Information Centre (as at September 2011)							
	All Ages	Under 25	25 to 34	35 to 44	45 to 54	55 to 64	65 & over
Total non-medical staff	**1,083,637**	**54,603**	**226,472**	**289,851**	**332,080**	**168,111**	**12,520**

Despite the Government's focus to provide more employment opportunities for the under 25 age range, the numbers employed in the younger age group is not increasing significantly. However, the Trust has utilised the national Apprenticeship Scheme and increased the number of apprentices being employed at the Trust in 2011/2012. Currently, the Trust has 14 apprentices who work in largely administrative roles, however some work within a clinical setting.

Workforce – Gender

The gender chart (Chart G) shows a significant difference between the ratio of male and female employees against the gender ratio by population within Northamptonshire (Chart H). The NHS is notorious for having a higher number of female employees because of the numbers of nursing posts within the workforce. Nationally as at September 2011 the gender mix for non-medical staff is 80.9% female with 19.1% male. (Source of Information – NHS Workforce Non-Medical Census 2001 to 2011)[4]

Chart G

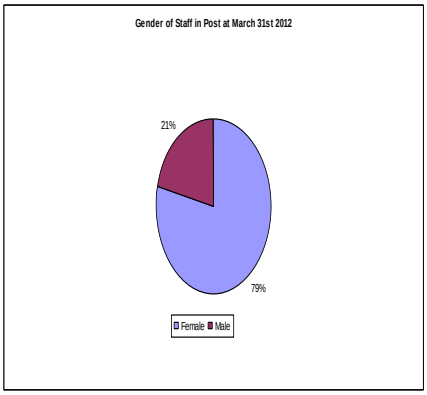
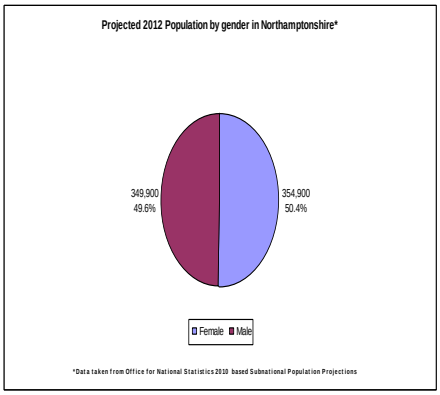


Chart H



[3] http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-2001--2011-non-medical

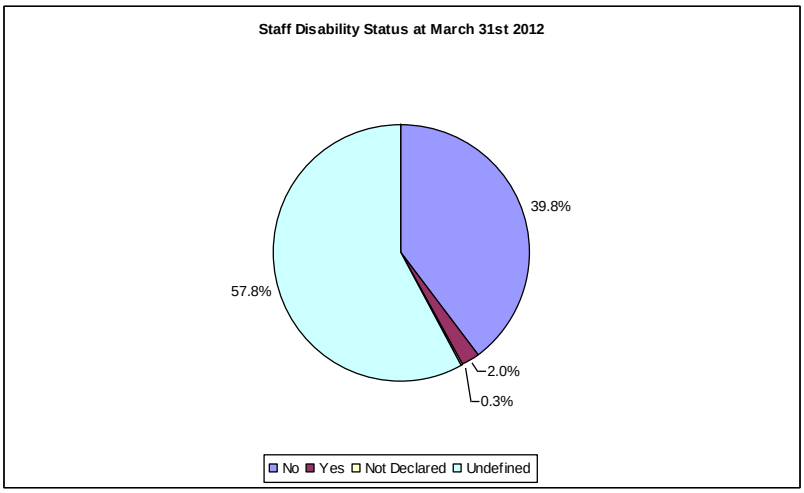
[4] http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-2001--2011-non-medical

Workforce - Disability

Following a data verification exercise in late 2010 / early 2011 there has been an increase in the numbers of staff who have declared that they do not have a disability. However, the percentage numbers declaring that they have a disability have not changed significantly and records still demonstrate a high proportion of individuals have not declared either, as demonstrated in the undefined category in Chart I. Further work is required to improve the Trust's data collection on disability as there could be a variety of reasons why the undefined category is at 39.8%. Reasons such as:

- Individuals do not consider their condition to be a disability
- Individuals feel uncomfortable declaring that they are disabled because they have concerns that they may not be able to continue in their role.

Chart I



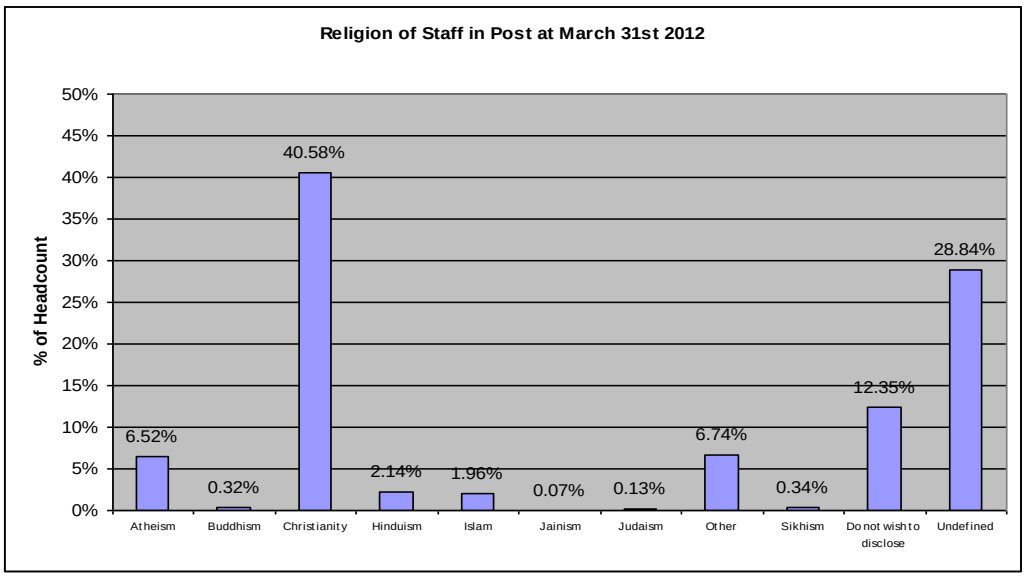
The Trust is committed to supporting staff with a Disability and has mechanisms in place to do this. The HR staff work closely with the Occupational Health department who provide advice on reasonable adjustments and phased returns to work. In addition, the Trust has revised its Employment of Disabled People Policy which includes support to take Disability leave. The Disability Leave Scheme (DLS) provides a newly disabled employee, or a disabled employee whose condition has deteriorated, with a period of time off work to adjust to the change in personal and professional circumstances. This scheme is applicable to all existing employees whether full or part time.

Workforce - Religion and Belief

Chart J below confirms that the majority of staff are Christians with small percentages of staff confirming that they have other religions such as Hinduism, Islamic and Sikhism. Concerns remain at the numbers of staff who are reported in the undefined category even though the Trust carried out a

detailed data verification exercise with staff during 2010/2011. In order to support religious groups other than the Christian religious group the Trust will work with the relevant community groups to provide information about how to work at the Trust. Initial discussions will take place through the Health Equality Group.

Chart J

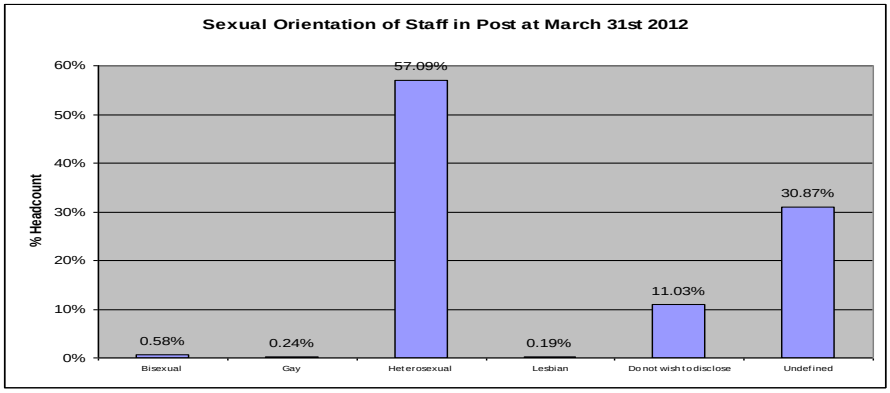


Workforce - Sexual Orientation

The data verification exercise in late 2010 / early 2011 did help to reduce the number of staff in the 'do not wish to disclose' category for their sexual orientation. (Chart K) This has been reduced to 11.03% from the previous year's percentage of 12.28%. However, there still remains a high proportion at 30.87% who have not defined their sexual orientation. Further work is required to make better use of the Trust's systems but in addition raise awareness to all staff of the importance of providing accurate information for the purpose of monitoring the protected characteristics and where relevant putting actions in place to address any inconsistencies.

To support staff there has been a review of the 'Protecting Staff against Violence, Aggression, Discrimination and Harassing Situations from Patients and Members of the Public. The purpose of this policy is to provide managers and staff with a clear process for the prevention and management of violent aggressive, discrimination and harassing incidents towards staff of all protected characteristics by patients and members of the public.

Chart K



RECRUITMENT ACTIVITY – APRIL 2011 TO MARCH 2012

This report is based on the information collected by the HR Service Centre between April 2011 and March 2012 and consists of the numbers of applicants, those short listed and the staff appointed from the protected characteristics for which information is collected.

Equality and Diversity is addressed throughout the recruitment process from advertisement to appointment, such as following the Trust's advertisement process targeting a wide range of audiences.

Managers receive anonymous applications to ensure the selection process is equal and fair. Shortlisted candidates for interview are based on their education, qualification, experience and the personal specification.

The HR Service Centre staff have received training on Equality and Diversity to support them in their role.

Recruitment - Ethnicity

The three charts (Charts L to N) below show the number of applications that have been received, shortlisted and appointed to between April 2011 and March 2012 by ethnicity. The most prominent ethnic group is the White British Category as there were 50% of White British applicants who applied for posts within the Trust and of this percentage 73% were appointed. The high proportion of White British correlates with the local population which indicates 86.10% of the Northampton populous are from the White category.

There has been an increase in applications from the numbers of Asian or Asian British Indian who have applied for posts in that 36% applied this year against 12% for the last financial year. Out of these percentages, 9% were shortlisted and 5% appointed. There has been a small decline of White Irish applying (7%) for posts, with 9% shortlisted and 9% appointed. Smaller numbers in the mixed categories applied for posts and were appointed.

Whilst it is encouraging that more Asian individuals applied for posts in this financial year, which reflects the higher number of Asians within the local

population, a trend continues as the percentage of Asian individuals are not being appointed to positions within the Trust. As highlighted earlier in order to understand the reasons for this, work needs to commence with the local community groups and this will be discussed as to how to approach this at the Health Equality Group.

Chart L

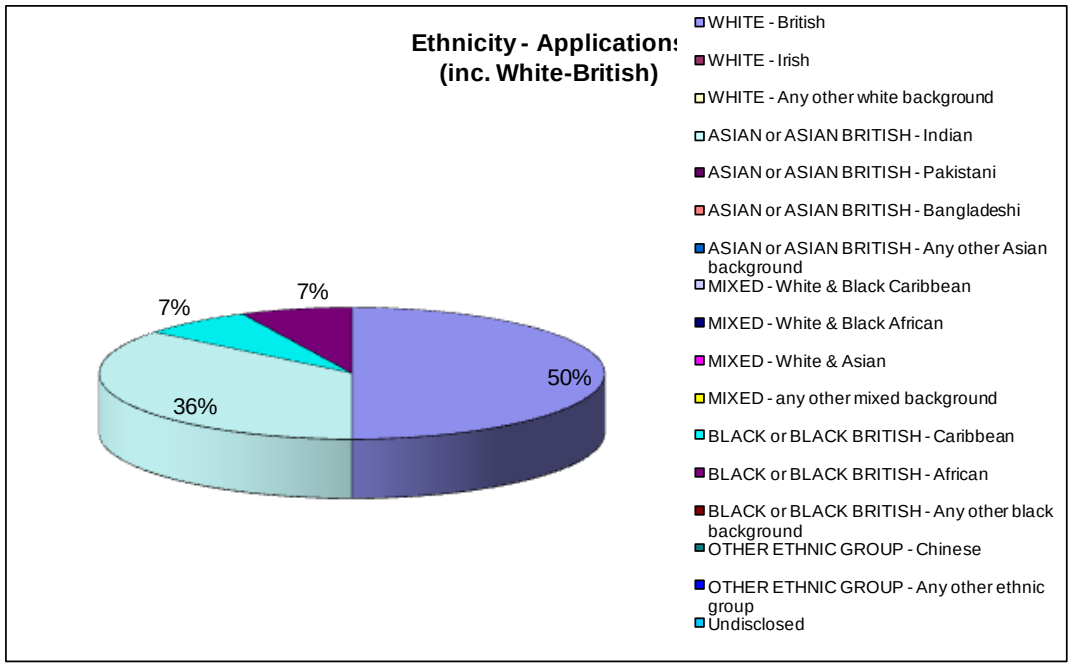


Chart M

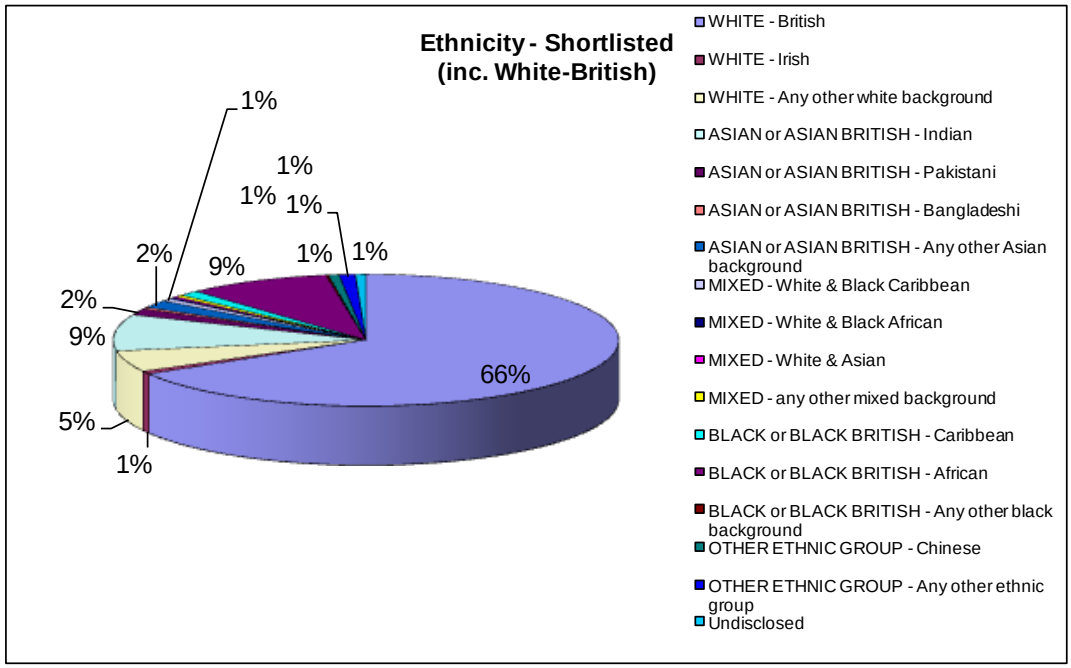
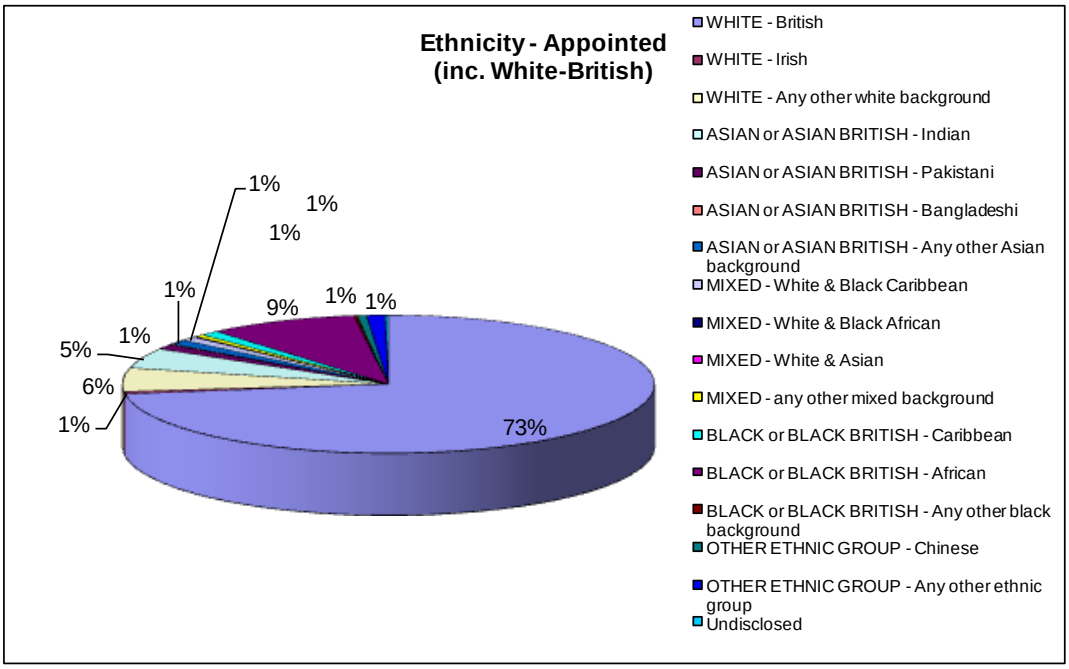


Chart N



*ethnic *it must be noted that where the number of applications were very small the pie chart has not been populated. It is only at the short listing and appointment stage that this has been identified; hence the reason why there are more ethnicity groups shown in the short listing and appointment pie charts.*

Recruitment - Age

The four charts (Charts O to R) below show the number of applications that have been received and those shortlisted and appointed between April 2011 and March 2012 by age group. *It must be noted that where the number of applications were very small the pie chart has not been populated. It is only at the short listing and appointment stage that this has been identified, hence the reason why there are more age bands shown in the short listing and appointment pie charts. This is further demonstrated in the age band – data comparison chart where the numbers are so small it is difficult to see the representation.*

In 2010/2011 the highest number of applications were received from the 20 – 24 age range therefore there has been a shift in the number of people applying in 2011/2012 to the highest age range of 30-34. 29% applied this year as opposed to 23 % in 2010/2011. Within the 30-34 age range 14% were shortlisted and 13% appointed. 29% applied within the 40-44 age range, with 11% being shortlisted and 11% appointed. The next two age groups are 25-29 and 35-39, each with 14% applications, with 15% and 13% appointed respectively.

The legislative changes in relation to retirement has not shown an increase in the higher age ranges applying for posts and only 1% in the 60-64 age range have been shortlisted and 1% appointed. The investigations that have been carried out in the Trust show that there is an increase of older people wishing to join the Trust's Bank which enables them to have a more flexible working arrangement as they can choose when they wish to work. However, now that the Trust has removed the default retirement age it is envisaged that there could be an increase in the numbers applying and being successful at appointment in the 60+ age ranges.

The Trust is involved in the initiative to introduce apprentices to the workplace and we have been successful in appointing further apprentices across the Trust this year. This is not reflected in the charts below as some apprenticeship posts are appointed through the Job Centre and are not recorded through our Electronic Staff Record (ESR).

The Trust will be developing it's Work Experience programme to attract younger people to the Trust in order to address the shortfall of numbers of younger people working in the Trust against the local population figures.

In addition, discussions will take place around the way the Trust advertises posts as currently the predominant method is through NHS Jobs. Consideration will need to be made in relation to expanding the methods used such as through media sites and mobile applications, in order to attract a wider range of job seekers.

Chart O

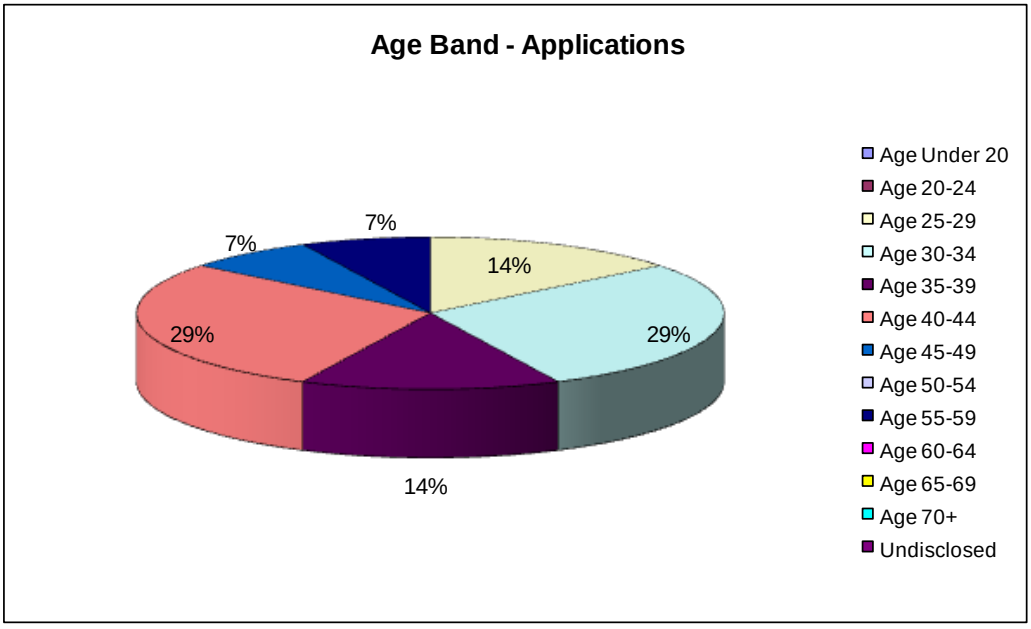


Chart P

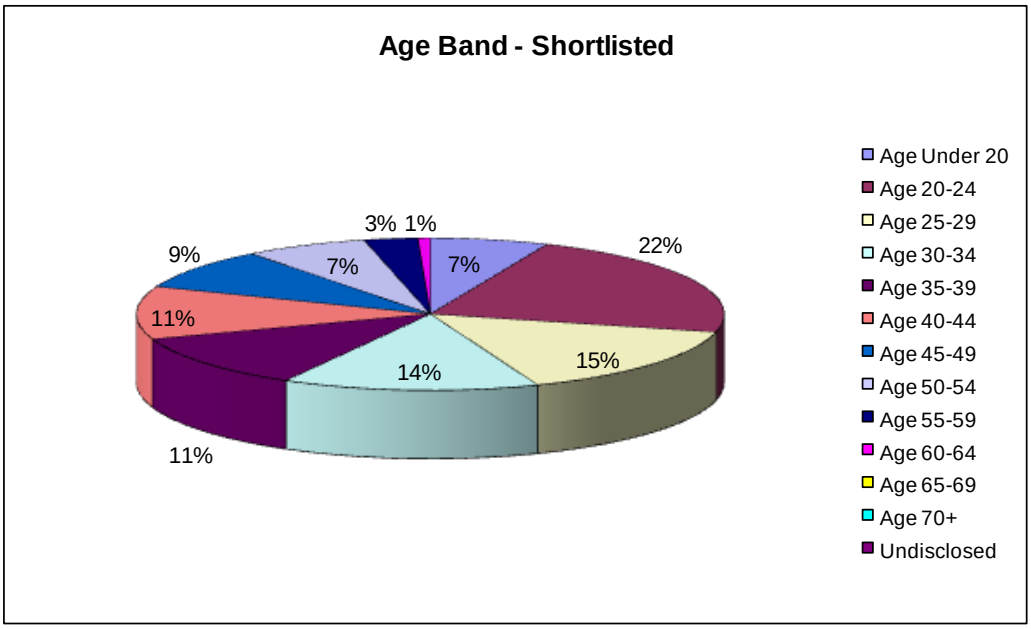


Chart Q

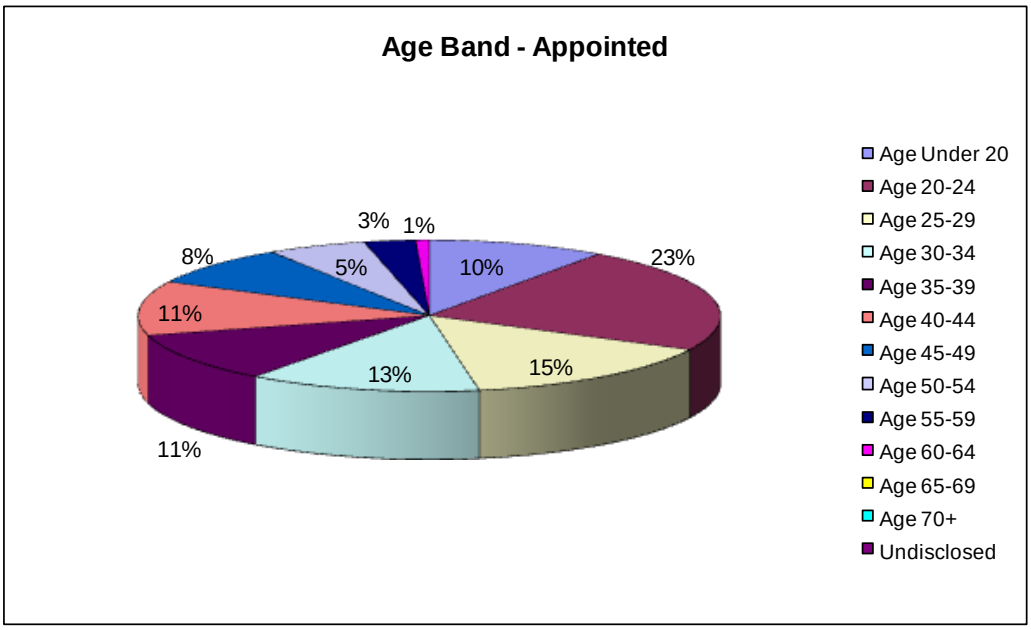
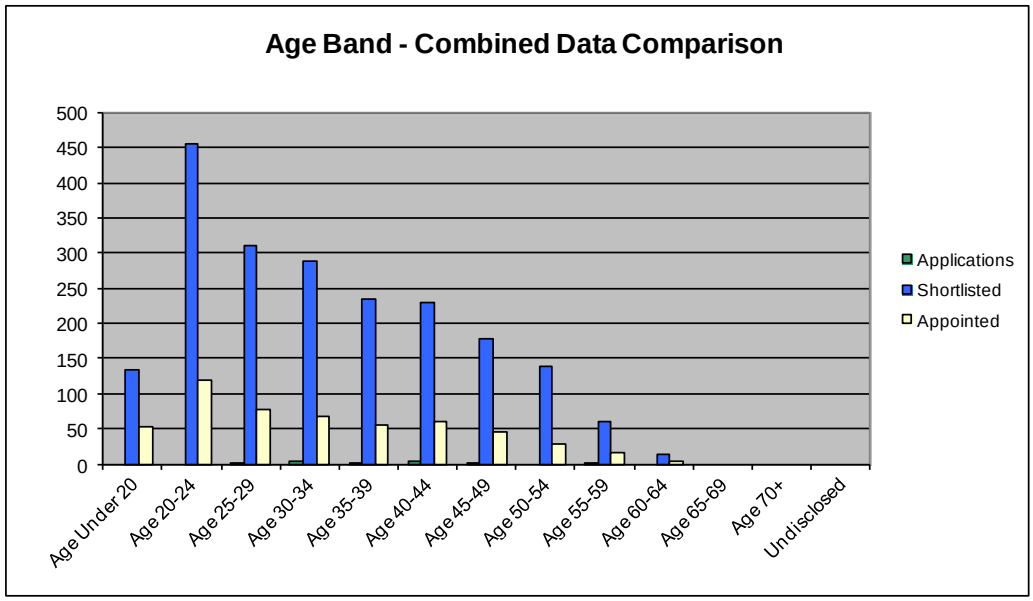


Chart R



Recruitment - Gender

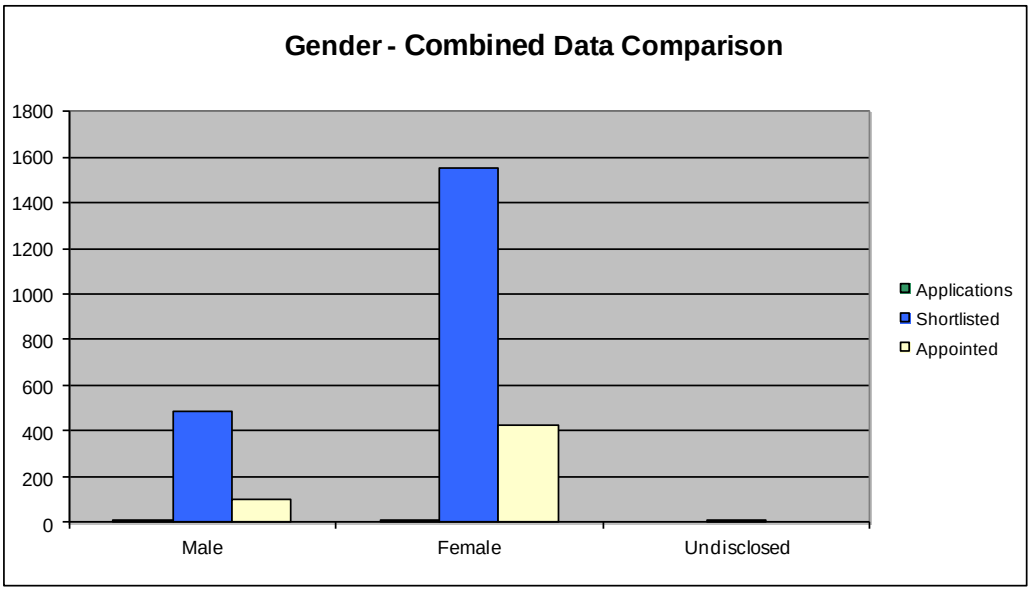
As in previous years there is a significant correlation between the gender population of the Trust and the recruitment to posts by gender and this year it is no different with the Trust appointing a higher proportion of females with 71% applying for posts, 76% being shortlisted and 81% appointed. There has been a slight increase with applications from males – 29% applied, 24% were short listed and 19% appointed.

Explanations for the correlations have been provided in the Workforce Gender Profile section of this Annual Report.

Applications are anonymised so that Recruitment Managers are unable to identify the protected characteristics of individuals at both the application and short listing stages. This provides reassurance that this significant difference is not discriminatory at any stage.

	Males	Females
Applicants	29%	71%
Shortlisted	24%	76%
Appointed	19%	81%

Chart S



Recruitment - Disability

The Trust is committed to supporting disabled people as it has retained the 'Two Ticks' symbol which provides recognition by Job Centre Plus that employers have made certain commitments regarding employment, retention training and career development of disabled people. The Trust believes that its' continued commitment will encourage disabled people to apply for the jobs within the Trust and the evidence in the table below suggests that the Trusts' Guaranteed Interview Scheme is being applied as 4% of disabled people were shortlisted and 3% were appointed. *It must be noted that where the number of applications were very small the pie chart T has not been populated. It is only at the short listing and appointment stage (Charts U and V) that this has been identified, hence the reason why there are more disability percentages shown in the short listing and appointment pie charts.*

	With a Disability	**Without a Disability**	**Undisclosed**
Applicants	3%	96%	1%
Shortlisted	4%	95%	1%
Appointed	3%	97%	

Chart T

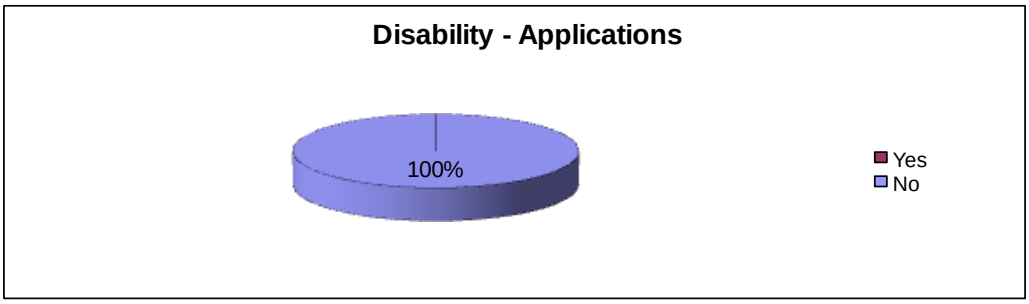


Chart U

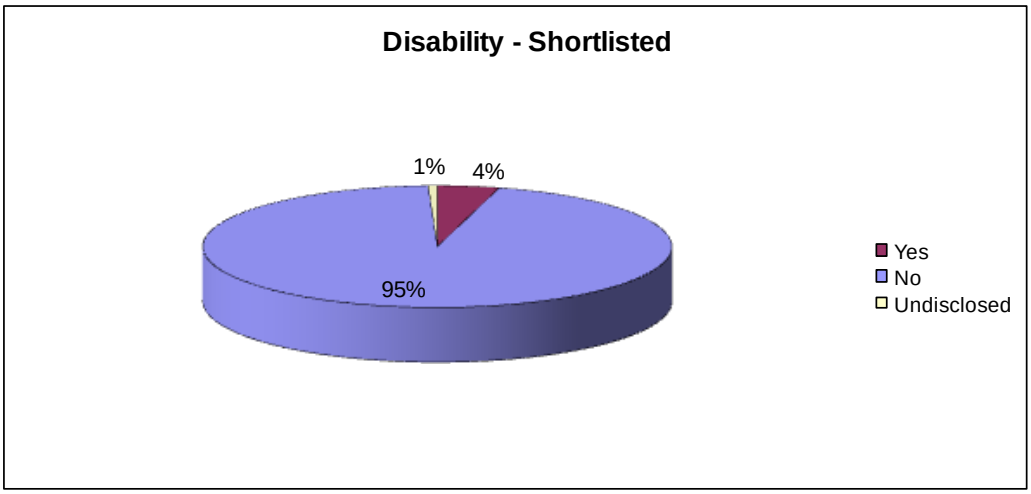


Chart V

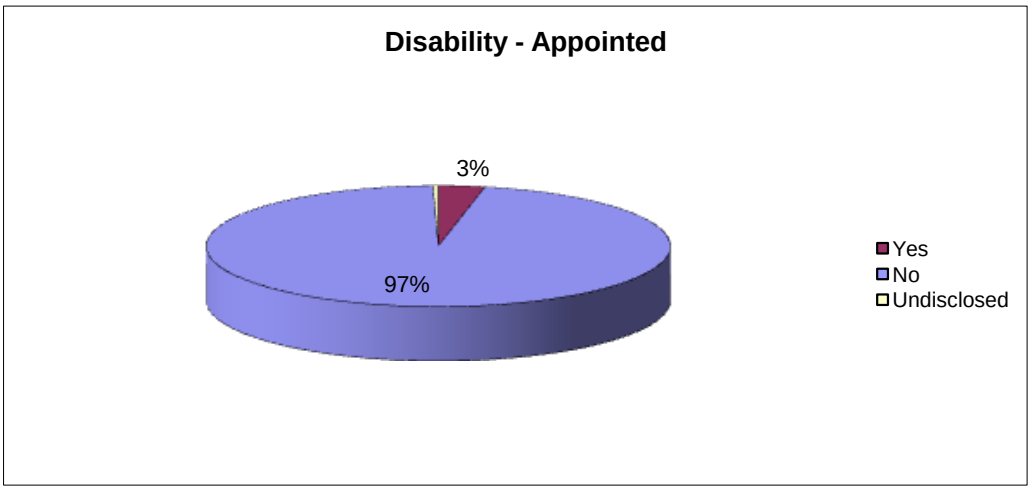
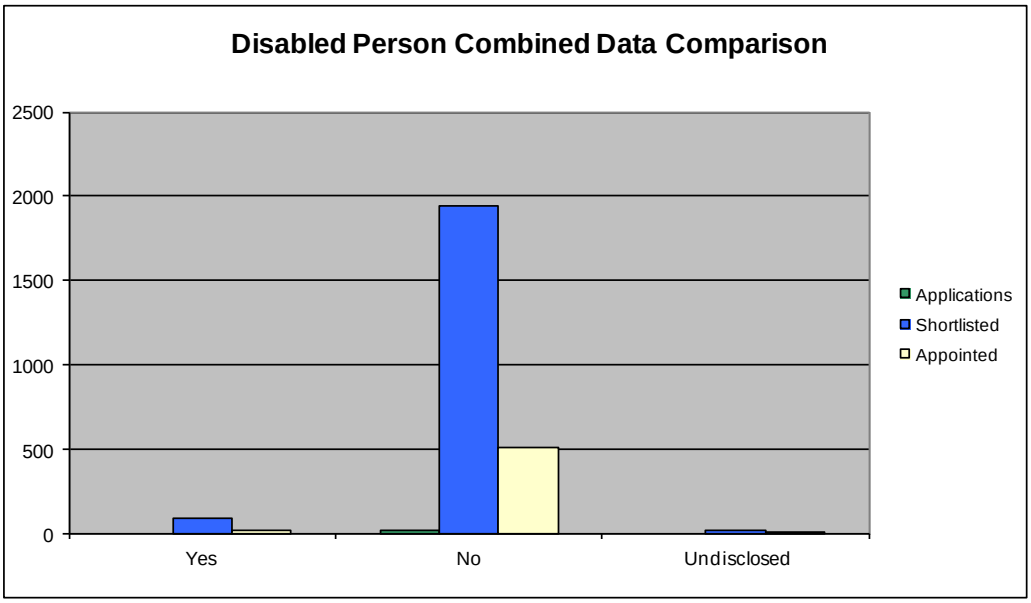


Chart W



Recruitment - Religious Belief

Charts X to AA identify the number of applications that have been received, shortlisted and appointed between April 2011 and March 2012. Compared to last years' figures (57% applications from Christians), there is a notable difference with only 36% of applications from the White British category. However, of these 61% were shortlisted and 66% were appointed.

We have also seen a large increase in the number of applications received from the Hinduism category with 29% compared to 7% in 2010/2011. Of this number, 3% were shortlisted and 1% appointed.
In addition, 7% of the applicants recorded their religion in the other category and of these 10% were shortlisted and 10% appointed. This does raise some concern that in future it may be more difficult to understand trends within the religious belief protected characteristics as it is not possible to know the religion of those recording the 'other' category.
In the future it is now important to consider working with all religious groups and as mentioned previously this will be carried out in conjunction with the Health Equality Group. *It must be noted that where the number of applications were very small the pie chart X has not been populated. It is only at the short listing and appointment stage (Charts Y and Z) that this has been identified, hence the reason why there are more religious belief percentages shown in the short listing and appointment pie charts.*

Chart X

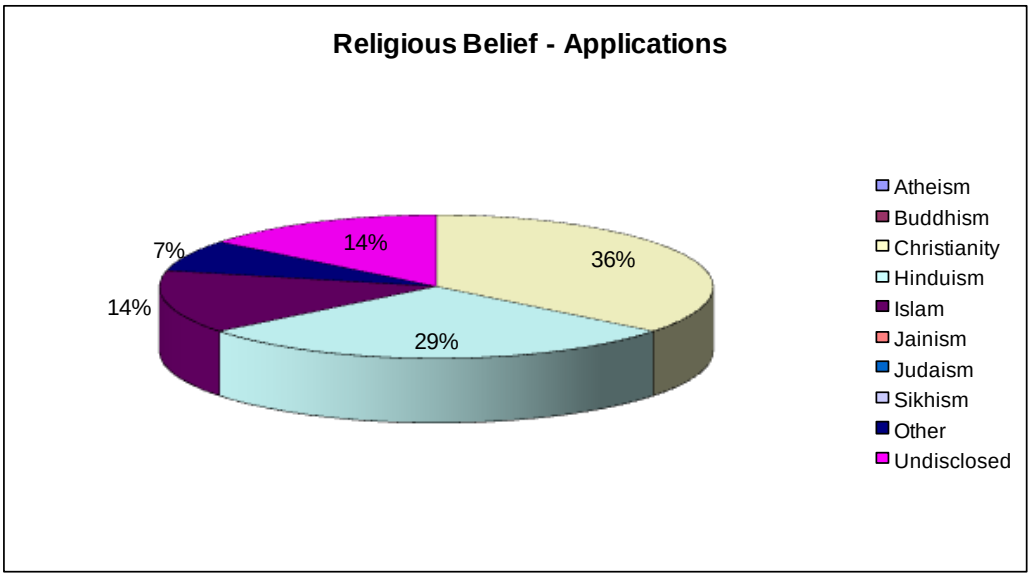


Chart Y

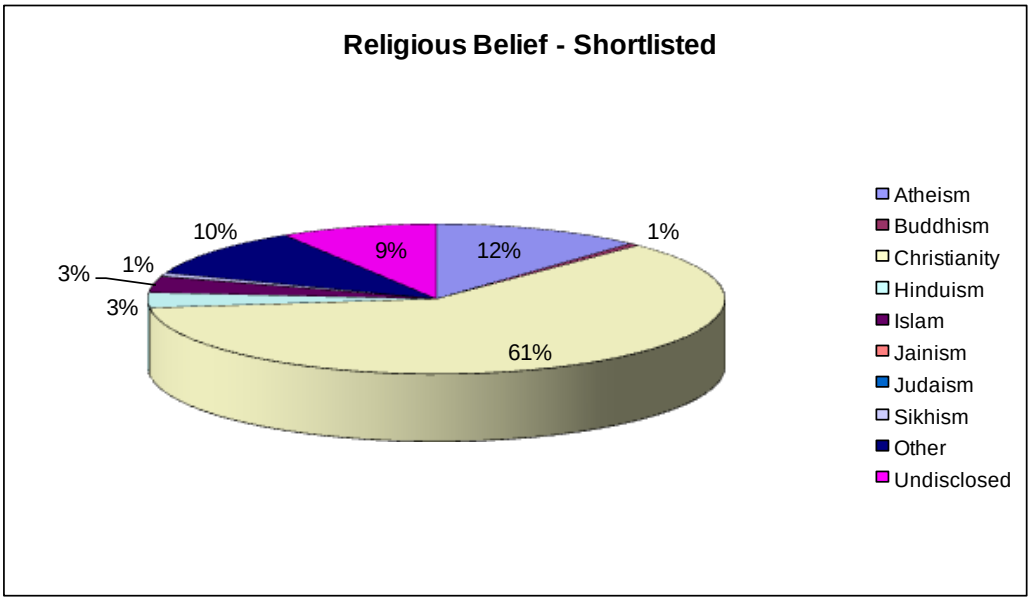


Chart Z

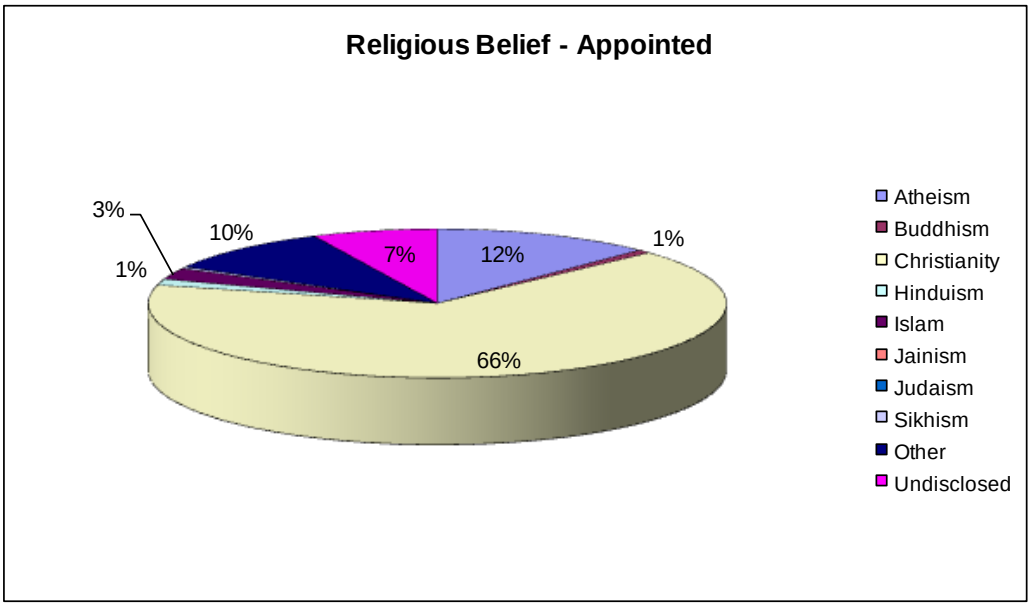
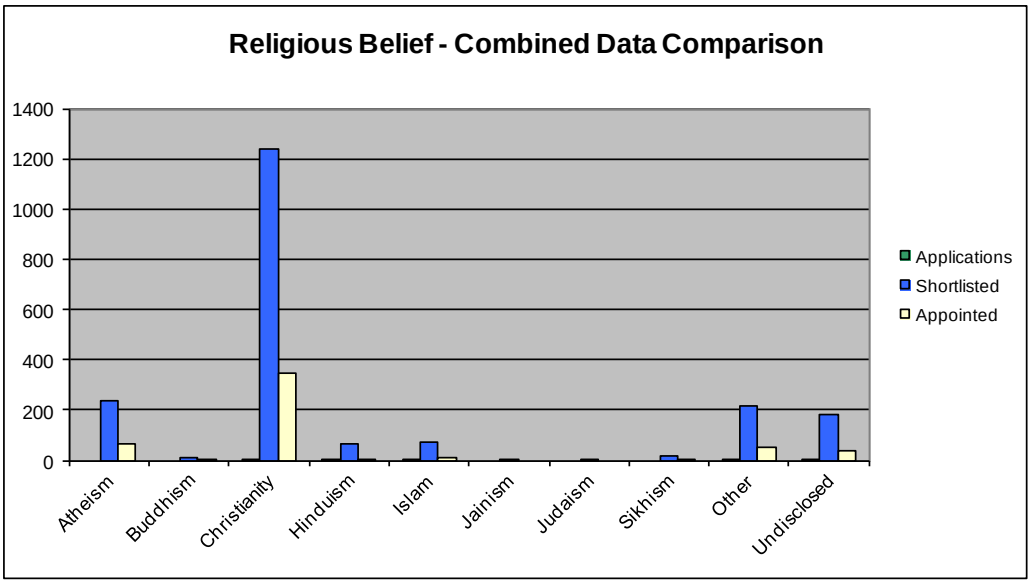


Chart AA



Recruitment - Sexual Orientation

The highest number of individuals applying for posts and being appointed was from the heterosexual group with 86% applying, of those 93% were shortlisted and 95% appointed. 7% of applicants did not disclose their sexual orientation, with 5% being shortlisted and 4% being appointed. 7% of individuals from the Lesbian, Gay and Bisexual Groups applied, with 2% being shortlisted and 1% being appointed.

Chart BB

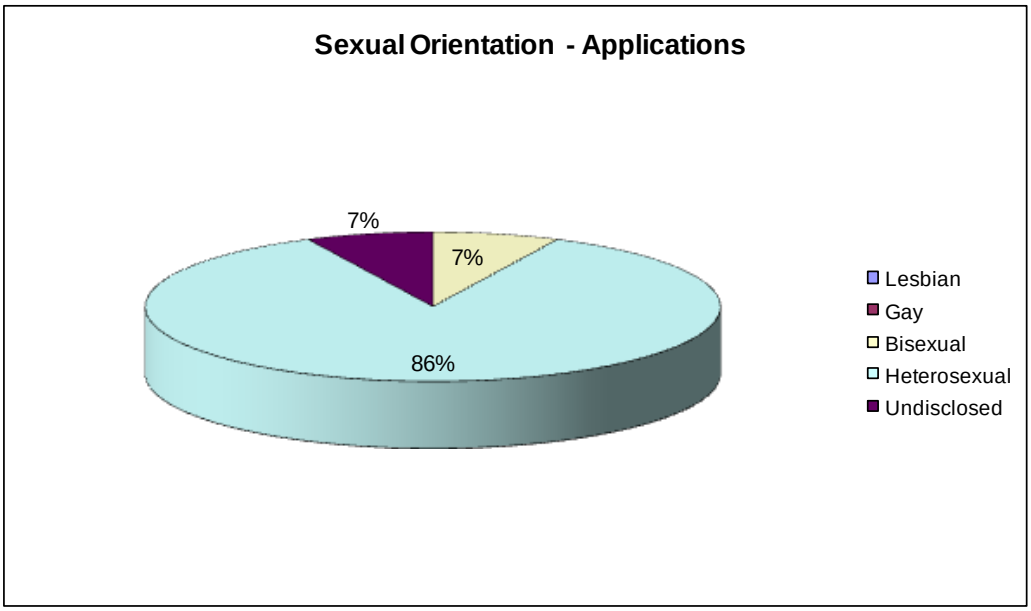


Chart CC

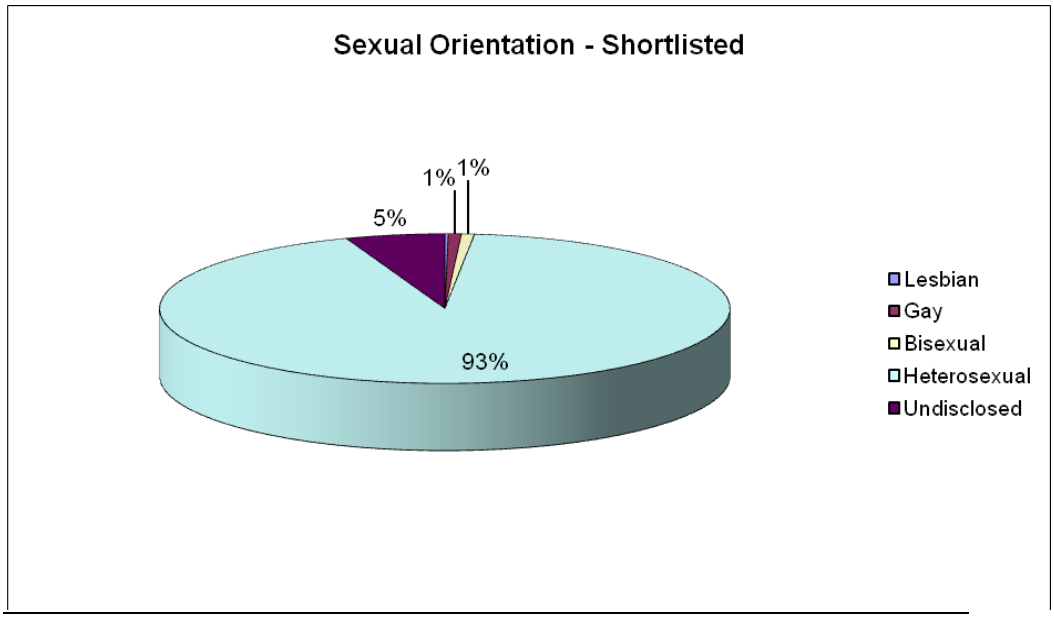


Chart DD

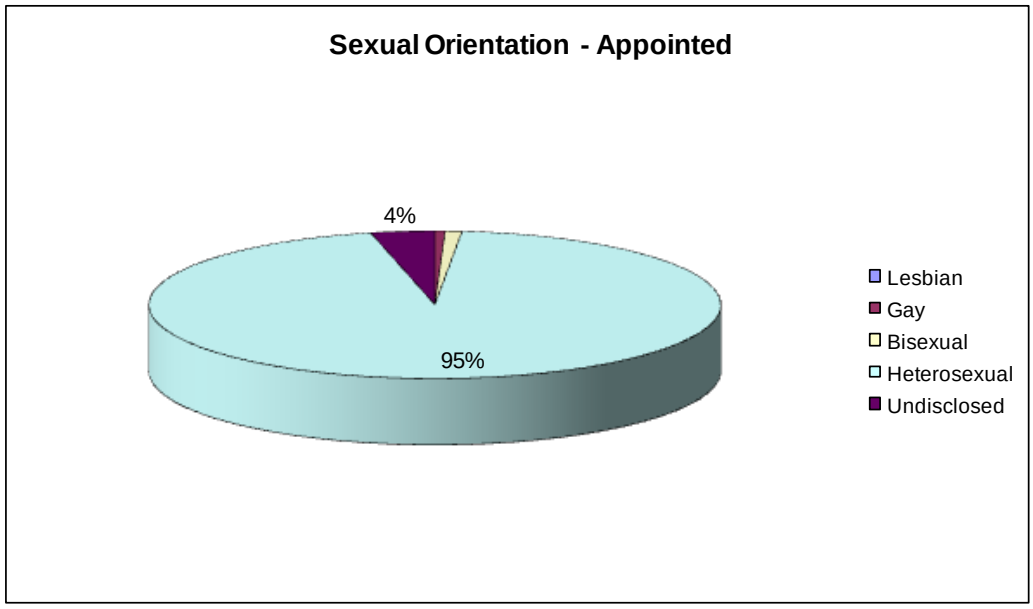
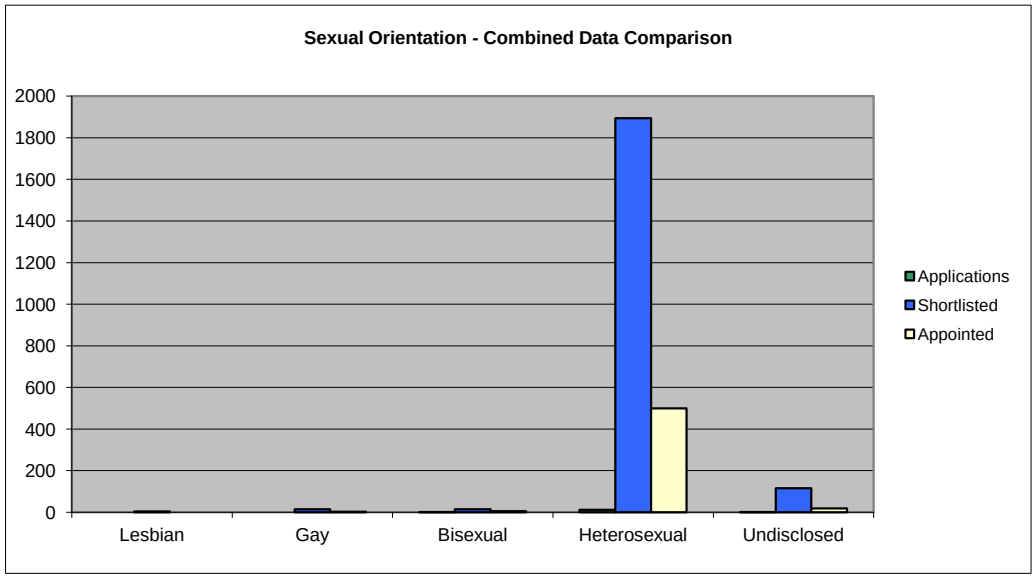


Chart EE



HUMAN RESOURCES (HR) CASELOAD ACTIVITY – APRIL 2011 TO MARCH 2012

Background

This section of the report provides the equal opportunities breakdown of 8 of the 9 protected characteristics as per the Equality Act 2010 for the formal Human Resources (HR) caseload activity across the Trust between the period of April 2011 and March 2012 for both open and closed formal cases.

The protected characteristics reported on are:
age, disability, marriage / civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

The Trust does not currently record any data for its employees in the area of gender reassignment.

Following a Trust wide exercise data collection exercise in 2010/2011the information that the Trust holds on the protected characteristics has significantly improved, but some staff did not return the questionnaire, did not complete it in full or chose not to disclose information regarding sexual orientation or religious belief for example, which is reflected in some of the figures that follow.

The HR activity has been broken down into the following categories:

- Capability – Work Performance
- Conduct – Disciplinary
- Harassment and Bullying
- Grievances
- Sickness Absence
- Employment Tribunals
- Suspensions
- Other

HR Caseload - Ethnicity

The majority of case work relating to sickness absence involves employees from 'White' origin, which is proportionate to the white ethnicity of the Trust. The highest percentage of cases involving the 'Ethnic Minority' category relates to case work for sickness absence, conduct and capability. This does not correlate with the percentage number of the workforce population and will require further investigation in the coming year.

Ethnicity	Ethnic Minority	%	White	%	Unknown	%
Capability	3	12.5	4	3.7	0	0
Conduct	10	41.7	15	14	1	25
Harassment & Bullying	0	0	1	0.9	0	0
Grievance	2	8.3	0	0	0	0
Sickness	7	29.1	81	75.8	3	75
Employment Tribunal	0	0	1	0.9	0	0
Suspension	1	4.2	3	2.8	0	0
Other	1	4.2	2	1.9	0	0
Total Cases	**24**	**100**	**107**	**100**	**4**	**100**

HR Caseload - Age

The majority of the formal casework being dealt with by the HR Department is within the '40-44, and '50-54' age groups. This correlates with the numbers of

staff within the Trust as the highest proportion of staff are within these age ranges.

Age	%	Numbers
16 - 19	0	0
20 -24	10.4	14
25 - 29	11.1	15
30 - 34	9.6	13
35 - 39	12.6	17
40 - 44	16.3	22
45 - 49	13.3	18
50 - 54	15.6	21
55 - 59	8.9	12
60 - 64	1.5	2
65+	0.7	1
Total Cases	**100**	**135**

HR Caseload - Gender

The table below demonstrates that the majority of formal HR cases are in relation to females. This is reflective of the Trust's workforce which consists of predominantly females in employment. However the statistics show that there is a higher proportion of males being seen in relation to conduct and capability. Further investigations cannot conclude the reasons for this and there is no evidence or trend that these issues relate to any specific area or particular staff group in the Trust.

Gender	Male	%	Female	%
Capability	4	11.8	3	2.9
Conduct	10	29.4	16	16
Harassment & Bullying	0	0	1	0.9
Grievance	0	0	2	1.9
Sickness	18	53	73	72.5
Employment Tribunal	1	2.9	0	0
Suspension	1	2.9	3	2.9
Other	0	0	3	2.9
Total Cases	**34**	**100**	**101**	**100**

HR Caseload - Disability

With the exception of the sickness absence category, the majority of employees involved in formal action do not have a disability, however, there are a large number of people involved in formal action where the disability is unknown. Again the majority of these are linked to formal sickness procedures. This demonstrates, as in previous sections, that further work needs to be carried out in relation to data collection for disabled employees. Investigations have also shown that the sickness cases are related to long term sickness absence which is managed with the support of the Occupational Health Department who provide advice on reasonable adjustments and redeployment.

Disability	Yes	%	No	%	Unknown	%
Capability	0	0	2	4.2	5	6.2
Conduct	1	16.6	9	18.7	16	19.8
Harassment & Bullying	0	0	1	2.1	0	0
Grievance	0	0	1	2.1	1	1.2
Sickness	5	83.4	32	66.6	54	66.7
Employment Tribunal	0	0	0	0	1	1.2
Suspension	0	0	1	2.1	3	3.7
Other	0	0	2	4.2	1	1.2
Total Cases	**6**	**100**	**48**	**100**	**81**	**100**

HR Caseload - Marriage / Civil Partnership

The majority of employees involved in formal action are married with a high proportion also recorded as single. The Trust's systems do not distinguish between marriage and civil partnership so we are unable to establish if there are any concerns regarding this protected characteristic.

Marital Status	Divorced	%	Legally Separated	%	Married	%	Single	%	Unknown	%	Widowed	%
Capability	0	0	0	0	4	5.9	3	6.3	0	0	0	0
Conduct	1	12.5	0	0	16	23.5	8	16.6	0	0	1	25
Harassment & Bullying	0	0	0	0	0	0	1	2.1	0	0	0	0
Grievance	0	0	0	0	0	0	1	2.1	0	0	1	25
Sickness	6	75	3	100	43	63.2	33	68.7	4	100	2	50
Employment Tribunal	0	0	0	0	1	1.5	0	0	0	0	0	0
Suspension	0	0	0	0	3	4.4	1	2.1	0	0	0	0
Other	1	12.5	0	0	1	1.5	1	2.1	0	0	0	0
Total Cases	**8**	**100**	**3**	**100**	**68**	**100**	**48**	**100**	**4**	**100**	**4**	**100**

HR Caseload - Pregnancy / Maternity

The table below shows that two people were involved in formal action when they were either pregnant or on maternity leave. This equates to 1.48% of the total number of staff involved in the HR Caseload activity and does not present concerns as at anyone time approximately 5 to 6% of the Trust is absent due to maternity leave.

Maternity / Paternity	Maternity	%
Capability	0	0
Conduct	1	50
Harassment & Bullying	0	0
Grievance	0	0
Sickness	1	50
Employment Tribunal	0	0
Suspension	0	0
Other	0	0
Total Cases	**2**	**100**

HR Caseload - Religion / Belief

The highest percentage of staff involved in formal cases, involve employees from the 'Christian' category. Across all the categories sickness cases, in the main, have the highest percentage. This correlates with the number of staff within the Trust as Christians are by far the largest religious group in the Trust.

Religion	Atheism	%	Christianity	%	Hinduism	%	Islam	%	Other	%	Unknown	%	Not Disclosed	%
Capability	0	0	2	3.5	0	0	0	0	1	12.5	3	7.9	1	5
Conduct	3	37.5	9	15.8	3	100	1	100	0	0	7	18.4	3	15
Harassment & Bullying	0	0	0	0	0	0	0	0	1	12.5	0	0	0	0
Grievance	0	0	2	3.5	0	0	0	0	0	0	0	0	0	0
Sickness	5	62.5	41	71.9	0	0	0	0	4	50	27	71.1	14	70
Employment Tribunal	0	0	0	0	0	0	0	0	0	0	0	0	1	5
Suspension	0	0	2	3.5	0	0	0	0	0	0	1	2.6	1	5
Other	0	0	1	1.8	0	0	0	0	2	25	0	0	0	0
Total Cases	**8**	**100**	**57**	**100**	**3**	**100**	**1**	**100**	**8**	**100**	**38**	**100**	**20**	**100**

HR Caseload - Sexual Orientation

The category of 'Heterosexual' shows the highest proportion of staff involved in formal cases which correlates with the number of staff in the Trust who report they are heterosexual.

Sexual Orientation	Bisexual	%	Gay	%	Heterosexual	%	Unknown	%	Not Disclosed	%
Capability	0	0	0	0	4	4.8	3	7.7	0	0
Conduct	1	100	0	0	17	20.5	7	17.9	1	9.1
Harassment & Bullying	0	0	0	0	1	1.2	0	0	0	0
Grievance	0	0	0	0	2	2.4	0	0	0	0
Sickness	0	0	1	100	54	65.1	28	71.8	8	72.7
Employment Tribunal	0	0	0	0	0	0	0	0	1	9.1
Suspension	0	0	0	0	2	2.4	1	2.6	1	9.1
Other	0	0	0	0	3	3.6	0	0	0	0
Total Cases	**1**	**100**	**1**	**100**	**83**	**100**	**39**	**100**	**11**	**100**

TRAINING AND DEVELOPMENT – APRIL 2011 TO MARCH 2012

Background

The Trust utilises the Oracle Learning Management System (OLM) to capture training information. Whilst this is a centralised system the focus since it's implementation in 2009 has been to record and report on mandatory training. However, the Trust also records clinical training such as venepuncture and management training is also included in this section of the report. In addition, this year, due to our Transformation programme there has been an increase in interview skills, CV writing and presentation skills training.

The tables below show the Trust headcount by protected characteristics and the number of training courses attended. The variance indicates whether the protected characteristics are accessing the training by proportion of headcount. It is important to note that these reports will differ from the information above as they include the Trust's bank staff.

Equality and Diversity Training

Our commitment to ensuring all our staff have appropriate equality and diversity training is borne out in the results of the Staff Survey which demonstrates we compare most favourably with other acute Trusts in this area. Being in the top 20% of acute Trust's for access to this training is as a result of several years of ensuring equality and diversity training is mandatory for all staff.

To ensure staff are able to access this subject, we have various delivery styles; the NHS E-learning package and classroom sessions. In addition, all new staff are trained in Equality and Human Rights as part of their Trust Induction.

All staff attending the Equality & Human Rights training are given an awareness of the nine protected characteristics under the Equalities Act 2010 and the adverse impact on clinical care if they are not respected.

Ethnicity Profile of Staff Undertaking Training & Development

The figures indicate that training is provided to all staff and the Trust headcount and numbers of training courses attended by all staff reflects the Trust's ethnic population. For example the highest number of staff in the Trust are of white ethnicity with the second group being Asian and the third category from Black / Black British.

Ethnic Origin	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance
A White - British	3,965	73.88%	25,629	70.99%	-2.88%
B White - Irish	63	1.17%	413	1.14%	-0.03%
C White - Any other White background	181	3.37%	1,276	3.53%	0.16%
C3 White Unspecified	2	0.04%	22	0.06%	0.02%
CA White English	6	0.11%	31	0.09%	-0.03%
CC White Welsh	1	0.02%	2	0.01%	-0.01%
CFWhite Greek	2	0.04%	23	0.06%	0.03%
CG White Greek Cypriot	1	0.02%	4	0.01%	-0.01%
CH White Turkish	0	0.00%	1	0.00%	0.00%
CK White Italian	10	0.19%	199	0.55%	0.36%
CP White Polish	11	0.20%	71	0.20%	-0.01%
CX White Mixed	4	0.07%	40	0.11%	0.04%
CY White Other European	27	0.50%	479	1.33%	0.82%
D Mixed - White & Black Caribbean	21	0.39%	137	0.38%	-0.01%
E Mixed - White & Black African	5	0.09%	13	0.04%	-0.06%
F Mixed - White & Asian	17	0.32%	86	0.24%	-0.08%
G Mixed - Any other mixed background	15	0.28%	104	0.29%	0.01%
GA Mixed - Black & Asian	1	0.02%	0	0.00%	-0.02%
GC Mixed - Black & White	1	0.02%	2	0.01%	-0.01%
GD Mixed - Chinese & White	1	0.02%	0	0.00%	-0.02%
GF Mixed - Other/Unspecified	1	0.02%	14	0.04%	0.02%
H Asian or Asian British - Indian	339	6.32%	2,459	6.81%	0.50%
J Asian or Asian British - Pakistani	48	0.89%	397	1.10%	0.21%
K Asian or Asian British - Bangladeshi	13	0.24%	54	0.15%	-0.09%
L Asian or Asian British - Any other Asian background	53	0.99%	385	1.07%	0.08%
LD Asian East African	0	0.00%	0	0.00%	0.00%
LE Asian Sri Lankan	10	0.19%	51	0.14%	-0.05%
LG Asian Sinhalese	1	0.02%	1	0.00%	-0.02%
LH Asian British	3	0.06%	17	0.05%	-0.01%
LJ Asian Caribbean	0	0.00%	9	0.02%	0.02%
LK Asian Unspecified	2	0.04%	16	0.04%	0.01%
M Black or Black British - Caribbean	63	1.17%	409	1.13%	-0.04%
N Black or Black British - African	238	4.43%	2,061	5.71%	1.27%
P Black or Black British - Any other Black background	21	0.39%	113	0.31%	-0.08%
PC Black Nigerian	3	0.06%	22	0.06%	0.01%
PD Black British	7	0.13%	52	0.14%	0.01%
PE Black Unspecified	1	0.02%	15	0.04%	0.02%
R Chinese	22	0.41%	235	0.65%	0.24%
S Any Other Ethnic Group	25	0.47%	224	0.62%	0.15%
SB Japanese	1	0.02%	14	0.04%	0.02%
SC Filipino	2	0.04%	18	0.05%	0.01%
SD Malaysian	1	0.02%	28	0.08%	0.06%
SE Other Specified	12	0.22%	91	0.25%	0.03%
Z Not Stated	120	2.24%	598	1.66%	-0.58%
Undefined	47	0.88%	285	0.79%	-0.09%
Total	**5,367**		**36,100**		

Age Profile of Staff Undertaking Training & Development

Training is offered to all age groups and there is a distinct correlation between staff in post by age band and the higher numbers trained. For example the highest number of staff in post are within the 46 – 50 age range and the highest numbers trained are in the following categories:

- 36 – 40 age range
- 41 – 45 age range
- 46 – 50 age range.

However, there is a greater variance of non-attendance in the over 50 age ranges and in the younger age range 16 to 20.

The factors contributing to this could be:

- More part time staff in these age ranges (training is largely provided between 9.00am and 5.00pm)
- Attendance at universities / colleges and even schools
- Staff working evenings and weekends.

Age Band	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance
16 - 20	203	3.78%	1,234	3.42%	-0.36%
21 - 25	548	10.21%	4,780	13.24%	3.03%
26 - 30	598	11.14%	4,701	13.02%	1.88%
31 - 35	624	11.63%	4,272	11.83%	0.21%
36 - 40	647	12.06%	4,283	11.86%	-0.19%
41 - 45	630	11.74%	4,282	11.86%	0.12%
46 - 50	757	14.10%	5,035	13.95%	-0.16%
51 - 55	622	11.59%	3,787	10.49%	-1.10%
56 - 60	449	8.37%	2,580	7.15%	-1.22%
61 - 65	226	4.21%	928	2.57%	-1.64%
66 - 70	50	0.93%	178	0.49%	-0.44%
71 & above	13	0.24%	40	0.11%	-0.13%
Total	**5,367**		**36,100**		

Gender Profile of Staff Undertaking Training & Development

More females are attending training than males which correlates to the workforce profile. However, the table also identifies that less males are completing training by proportion. On further investigation the highest proportion of the male population are within the medical, estates and management positions so further investigations need to take place to determine the reasons why these staff are not accessing the training.

Gender	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance
Female	4,226	78.74%	29,726	82.34%	3.60%
Male	1,141	21.26%	6,374	17.66%	-3.60%
Not Stated	0	0.00%	0	0.00%	0.00%
Total	**5,367**		**36,100**		

Disability Profile of Staff Undertaking Training And Development

The table below demonstrates that training is accessible to disabled staff as they completed more training (2.28%) than the Trust disabled headcount (2.05%).
All training rooms provide good access for disabled staff members and with an increase in the opportunity to access the training subjects by e-learning staff have greater access because they can complete their training at their usual place of work.

Disability	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance
Yes	110	2.05%	824	2.28%	0.23%
No	2,138	39.84%	15,965	44.22%	4.39%
Not Stated	3,119	58.11%	19,311	53.49%	-4.62%
Total	**5,367**		**36,100**		

Religious Belief Profile of Staff Undertaking Training & Development

The highest proportion of training was completed by the Christian religious group which correlates with the workforce profile. Likewise for those religious groups where the Trust headcount is higher i.e.: Atheism, Hinduism, Islamic and the other categories training is being completed proportionately.

Religious Belief	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance
Atheism	350	6.52%	2,749	7.61%	1.09%
Buddhism	17	0.32%	137	0.38%	0.06%
Christianity	2,178	40.58%	15,645	43.34%	2.76%
Hinduism	115	2.14%	876	2.43%	0.28%
Islam	105	1.96%	852	2.36%	0.40%
Jainism	4	0.07%	24	0.07%	-0.01%
Judaism	7	0.13%	27	0.07%	-0.06%
Other	362	6.74%	2,664	7.38%	0.63%
Sikhism	18	0.34%	136	0.38%	0.04%
I do not wish to disclose my religion/belief	663	12.35%	4,081	11.30%	-1.05%
Not Stated	1,548	28.84%	8,909	24.68%	-4.16%
Total	**5,367**		**36,100**		

Sexual Orientation of Staff Undertaking Training & Development

The figures demonstrate that all categories of sexual orientation are attending the Trust training programmes and this correlates with numbers of staff in post. The fact that those who do not wish to disclose their sexual orientation and those who have not stated their sexual orientation remains high continues the trend throughout this report that data collection awareness must be improved.

Sexual Orientation	Trust Headcount	Trust Headcount %	Trained Headcount	Trained Headcount %	Variance
Bisexual	31	0.58%	265	0.73%	0.16%
Gay	13	0.24%	86	0.24%	0.00%
Heterosexual	3,064	57.09%	22,340	61.88%	4.79%
Lesbian	10	0.19%	41	0.11%	-0.07%
I do not wish to disclose my sexual orientation	592	11.03%	3,655	10.12%	-0.91%
Not Stated	1,657	30.87%	9,713	26.91%	-3.97%
Total	**5,367**		**36,100**		

Conclusion

With an increase in attendance of training for 2011/12, we can conclude that access to training and learning and development for all staff has improved. As a Trust it is of paramount importance that all of our training is accessible and we must continue to ensure that we listen to staff feedback. To this end, provision has been developed to offer flexible approaches to learning that remove barriers to access for groups with protected characteristics. Some of our training for staff has been delivered outside of the normal 37.5 hour week thus ensuring accessibility of training is available.

Training and Development continues to communicate to staff the Trust Mandatory Training Policy. This policy ensures that all staff are aware of the mandatory training they are required to undertake and for the Trust to be compliant against is regulatory requirements.

For the year end 2011/2012 the Trust met its external compliance target and achieved 80.76% overall of the mandatory training subjects, this confirms that our staff are utilising the various methods of training and our training areas are accessible.

PLANS FOR 2012/2013

The Trust has agreed and published its Equality Objectives for 2012/16 as required by the Specific duties of the Equality Act 2010. The delivery of the objectives will be led by the Trust's Equality and Human Rights Steering Group which meet quarterly.

The Trust will report annually on progress on the objectives and the report will be published on the Trust's internet site.

In addition, in order for the Trust to assess our performance we will also use this data published to take actions from the anomalies we have identified.

This will include:

- Working with health colleagues and the community to make improvements where necessary
- Taking action from the analysis on the areas of concern
- Working with managers and staff to improve their skills and understanding of our equality data.

COMMENTS OR FEEDBACK

If you have any comments or wish to provide feedback on this report, please send them to the Trust's Service Equality Lead at:

Northampton General Hospital
Cliftonville
Northampton
NN1 5BD

Northampton General Hospital NHS
NHS Trust

Equality Objectives 2012 to 2016

Equality Delivery System Goal	Narrative: The NHS is asked to……	Objective	Executive Lead	Key Actions	Timescales
1. Better Health outcomes for all	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence needs and results.	We will develop a programme of data collection and analysis to understand areas where there are health inequalities amongst protected groups. This will be completed in line with the Trust's quality programme and in conjunction with NHS Northamptonshire.	Chief Operating Officer	Identify the Trust's annual service priorities within the Quality Programme. Target data collection and analysis by protected groups on annual service priorities. In conjunction with NHS Northamptonshire target specific areas where health inequalities are known and collect and analyse information by protected groups. Report findings on a six monthly basis to the Equality and Human Rights Steering Group. Put in place action plans across the services to address identified inequalities in service delivery, where possible.	April 2012 From October 2012 October 2012/ongoing December 2012/ongoing February 2012/ongoing

2. Improved access and experience	The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	The Trust will increase the engagement and involvement with representatives from protected groups. In 2 years we will aim to achieve representation from 100% of the protected groups.	Director of Nursing and Patient Services	Review of the Service User Engagement structure and reporting mechanism to the Equality and Human Rights Steering Group. Every six months themes from the protected groups via the Public and Patient Involvement Steering group (PPI) will be reviewed and reported to the Equality and Human Rights Steering Group. Action plans from the PPI group will be developed where appropriate. Consultation mechanisms will be developed to further improve involvement and feedback in service delivery.	July 2012 January 2013 January 2013/ongoing Ongoing

3. Empowered, engaged and well supported staff	The NHS should increase the diversity and quality of the working lives of the paid and non paid workforce supporting all staff to better respond to patients' and communities' needs	We will aim by 2014 to improve our staff satisfaction rates as reported in the annual staff survey so that we are in the top 25% of Trust's for response to the question regarding whether staff would recommend the Trust as place to work.	Chief Executive	Develop and implement a staff engagement programme centered on the Trust's vision and values and the desired behaviors and performance of staff. Carry out focus groups to identify the key annual priorities for improvement as identified in the Staff Survey and develop action plans to implement these priorities. Develop a Staff Wellbeing forum. Develop systems to capture data on all of the protected characteristics to analyse to identify if any staff groups are being disadvantaged	April 2012 to March 2015 April 2012 onwards August 2012/ongoing September 2012/ongoing

4. Inclusive leadership at all levels	NHS organisations should ensure that equality is everyone's business and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	To develop a management and leadership strategy and programme for all staff based on the standards set out in the NHS Leadership Framework and its supporting frameworks.	Director of Workforce and Transformation	To continue the development of the accredited leadership and management programme tailored to the needs of managers bands 6 to 8. Embed equality within the new Care Group structure. Senior members of the Care Group to be members of the Equality and Human Rights Steering Group and report to the group on action plans in place to address equality issues. To adopt and implement a talent management and succession planning strategy that encompasses all protected groups at a Care Group and Corporate level.	October 2012 April 2012/ongoing October 2012/ongoing

Northampton General Hospital

Summary of EDS Self Assessment December 2011

Goal	EDS Outcome	Executives & Senior Managers (Agreed by E&HRSG 27.10.11)	Staff	Local interests	Overall rating
1. Better health outcomes for all	1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well being and reduce health inequalities	Amber Developing	Amber Developing		
	1.2 Patients' health needs are assessed and resulting services provided in appropriate and effective ways	Amber Developing	Amber Developing		
	1.3 Changes across services for individual patients are discussed with them and transactions are made smoothly	Amber Developing	Amber Developing		
	1.4 The safety of patients is prioritised and assured. In particular patients are free from abuse, harassment, bullying, violence from other patients and staff with redress being open and fair to all	Amber Developing	Amber Developing		
	1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups	Amber Developing	Amber Developing		

2. Improved patient access and experience	2.1 Patients, carers and communities can readily access services and shouldn't be denied access on reasonable grounds	Amber Developing	Amber Developing		
	2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment	Amber Developing	Amber Developing		
	2.3 Patients and carers report positive experiences of their treatment and care outcomes and being listened to and respected and of how their privacy and dignity is prioritised	Amber Developing	Amber Developing		
	2.4 Patients' and carers' complaints about services and subsequent claims for redress should be handled respectfully and efficiently	Green Achieving	Green Achieving		

3. Empowered, engaged and well supported staff	3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades	Amber Developing	Amber Developing		
	3.2 Levels of pay and related terms and conditions are fairly determined for all posts with staff doing equal work and work rated of equal value being entitled to equal pay	Amber Developing	Amber Developing		
	3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately	Amber Developing	Amber Developing		
	3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues with redress being open and fair to all	Amber Developing	Red Underdeveloped		
	3.5 Flexible working options are made available to all staff consistent with the needs of the service and the way that people live their lives	Amber Developing	Amber Developing		
	3.6 The workforce is supported to remain healthy with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population	Amber Developing	Amber Developing		

4. Inclusive leadership at all levels	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced and good relations fostered within their organisations and beyond	Amber Developing	Amber Developing		
	4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination	Amber Developing	Red Underdeveloped		
	4.3 The organisation uses Competency Framework for Equality and Diversity Leadership to recruit, develop and support strategic leaders to advance equality outcomes	Amber Developing	**To be confirmed by Staff Side**		

BOARD SUMMARY SHEET	
Title	Seasonal Plan Summary
Submitted by	Christine Allen, Deputy Chief Executive/Chief Operating Officer
Prepared by	Deborah Alderson/James Rogers
Date of meeting	27th September 2012
Corporate objectives addressed	Invest in enhanced quality including improvements in the way in which we deliver care

SUMMARY OF CRITICAL POINTS
Throughout the winter season the Trust could potentially face a number of risks including increased admissions, staffing shortages due to sickness and increased cases of influenza or other infectious diseases causing an impact on the trusts ability to effectively manage demand.

This plan details the actions and procedures that the Trust will use to mitigate these risks, review its response and further plan its activity.

PATIENT IMPACT
Reduced length of hospital stay for patients.
Better and safer patient movement from attendance to A/E through to discharge or transfer

STAFF IMPACT
Flex in capacity will mean that some staff will be required to work across directorate wards

FINANCIAL IMPACT
Escalation beds if required will be staffed by bank
Other potential directorate specific increases in pay and non pay will be agreed and authorised by the Care Group Boards and/or SMB.

EQUALITY & DIVERSITY IMPACT

LEGAL IMPLICATIONS

RISK ASSESSMENT
Bed & flow management:
Demand management schemes and increase in emergency activity potentially resulting in delays to transfer patients to beds
Increased risk of admissions due to influenza throughout winter

RECOMMENDATION
Board members are asked to note the contents of the summary and seek further clarification and assurance as required.

Northampton General Hospital Seasonal Plan

October 2012 - March 2013 (winter)

Version & Date	**Version 1.0 - August 2012**
Plan Authors	**Deborah Alderson**
Distribution	**Partner Senior Management Teams**
Review Date	**Post Incident/ New Guidance/ Annually**
NOTE	**This plan remains a LIVE DOCUMENT and will change as planning assumptions develop, new guidance is issued or partner plans evolve.**

Northamptonshire Countywide Health and Social Care Community

- Corby Healthcare CCG
- East Midlands Ambulance Service (EMAS)
- Kettering General NHS Foundation Trust
- Local Medical Committee (LMC)
- Nene Commissioning CCG
- NHS Milton Keynes & Northamptonshire PCT Cluster
- Non-emergency Patient Transport Services (NSL Ltd.)
- Northamptonshire General Practice, Pharmacy, Optical and Dental Services (In-hours and Out-of-Hours)
- Northampton General NHS Trust
- Northamptonshire Healthcare Foundation Trust
- Northamptonshire County Council

Change Control

Version	Nature of amendment
1.0	22 Aug 2012. Initial version
2.0	
3.0	

Table of Contents

1 Purpose

The purpose of this plan is to outline the developments and changes in services throughout the 2012/13 Winter period at Northampton General Hospital (NGH) to:

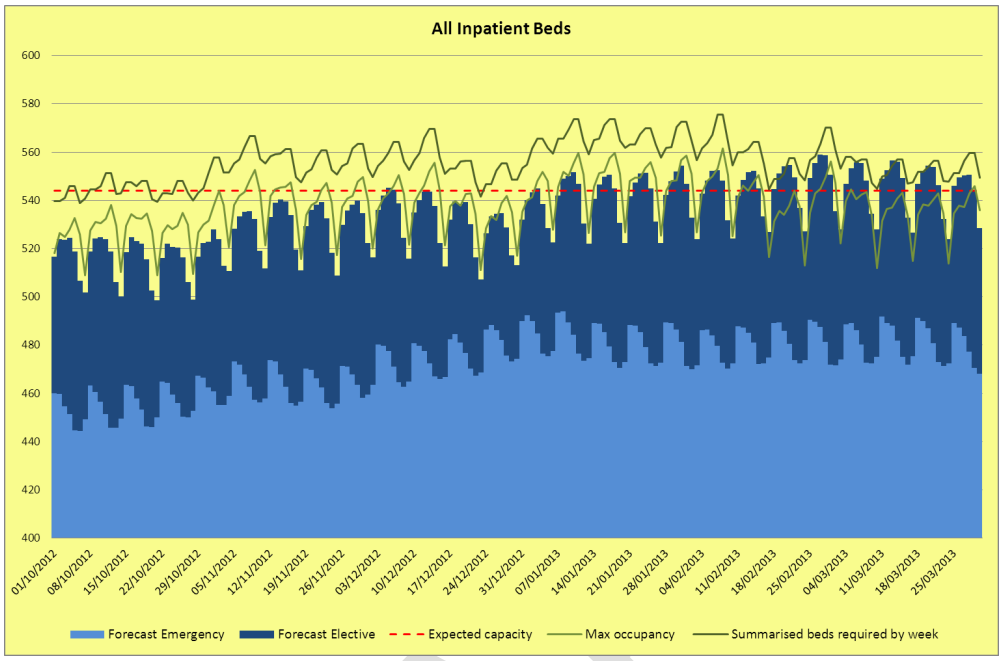
1. Ensure a safe and effective patient pathway for all A&E attendees and admissions
2. Ensure the most efficient use of resources
3. Keep health and social partners appraised of NGH developments and plans

2 Situation

2.1 Key Risks

Increased difficulties in recruiting junior doctors has compromised the Trusts ability to maintain safety, clinical outcomes, training and compliance of hours and the necessity to minimise these risks has led to substantial agency costs. The Deanery is unable to consistently fill training post rotations year on year and the ability to recruit locally remains a challenge.	High risk
Pandemic Flu/Contagious Illness.	Moderate
Failure of the Trust to effectively manage bed capacity due to an increased number of patients resulting in a decrease in the quality of care provided to patients in A&E.	High risk
Medical patients being treated in non-medical beds due to capacity, leading to an extended LOS and decreased patient safety.	Low risk
Risk to patient safety and the Trust's A&E Clinical Quality Indicators due to inadequately skilled Middle Grade Doctors in the Department. Risk to delivering urgent care quality indicators and ensuring early reviews for appropriate patients.	Low risk

2.2 Demand Profile



2.2.1 Capacity & Bed base

Dependant on activity, during October 2012 an additional 18 beds will be opened and will remain open until March 2013. These beds can be used flexibly across both care groups

Assessment beds will be allocated to A&E (numbers to be confirmed)

Hot clinics across medicine and surgery will commence in September

Development of an Oncology assessment unit, peadiatric assessment unit and surgical assessment unit will be in place from October 2012

Level 1 capacity will be increased to 12

An additional 30 spaces have been made available in the mortuary

2.2.2 Commencement/termination of services

As above

2.2.3 Building Programmes

Work to allow Endoscopy to receive male and female patients simultaneously will be completed.

2.2.4 Technology

The Trusts IT department continually monitors and updates the facilities available to ensure that working is as effective as possible. Current projects include:

- Further development and utilisation of the trusts wireless network, including the introduction of Tablet computers for capacity team members/ operational managers.

- Development of a back-up server facility
- LAN upgrade

2.2.5 Staffing/Resources

Additional nurses are being recruited from Ireland and Portugal. The Trust will be fully staffed (nurses) during in November 2012.

Additional A&E consultants & surgical staff grade based in A&E

Additional porters will be in place

Interim head of capacity

Additional discharge facilitator

Upper limb locum consultant service will be expanded

2.2.6 Service Delivery and Improvement

The Trust is developing its IPG plan – to follow

2.2.7 Preparing to Utilise DH Winter Funding

Additional funding has been applied for via the PCT

3 Delivery

3.1 Prevention/Anticipation

3.1.1 Flu immunisation

A full immunisation programme will be delivered and available for all staff. This will be delivered locally. The trust has set a target of 60% uptake amongst front line staff. Details to follow.

3.1.2 Weather Warnings/Flood Warnings

The Trust has a tested plan in place for responding to severe weather incidents, this includes measures for Warnings sent from the met office to be circulated to on call teams. See Appendix 3

3.1.3 Gaining and Maintaining Situational Awareness

The Trust maintains its situational awareness via a number of sources, these include:

- Capacity review meetings at 1030 and 1400 daily
- Constant Operational oversight via the Capacity Team and Operational Leads
- Use of the County wide predictive planning data and CapPlan data.

The Trust is then informed of the ongoing status via:

- 3x daily escalation reports
- CMS
- Emails
- Symphony

Further details can be found in the Trusts Escalation Procedures. See Appendix 3

3.1.4 Balancing Demand and Capacity

A weekly demand and capacity (cap plan) meeting is in place and led by the General managers. Looking at 2 weeks ahead.

Capacity planning meeting also held fortnightly across health and social care and led by the PCT

Extra resource will be allocated at weekends to ensure maximum discharges

Mortuary capacity will be highlighted on the escalation reports.

3.1.5 Xmas and New Year

A full plan covering this period will be developed separately to ensure all resource is maximised.

3.1.6 Cold Weather Plan

N/A

3.2 Escalation

3.2.1 Managing Surges in Demand

The Trust has the following measures in place to manage surges in demand:

- Trust Escalation Policy which details:
  - Triggers
  - Responses
  - Actions
  - Management structures
- Critical care surge plan
- Established On-Call Structures

The Trust is also in the process of implementing a Site Management Model which will further enable it to respond to surges in demand. See Appendix 3 for further details

3.2.2 Escalating Issues that constrain Patient flow in County

Issues will be escalated to names individuals both internally and externally to NGH

Stroke repatriations circulated daily and delays highlighted to KGH

Daily county wide conference calls are also used to monitor any issues

3.2.3 Escalating Issues that constrain Patient flow out of County

All other repatriations discussed at bed meetings, senior operational lead will contact partner organisation daily to ensure speedy repatriation

3.2.4 Escalation Plan(s)

An Escalation plan is in place with new triggers aligned to those used at KGH and detailing the actions required of all staff members. See Appendix 3

3.2.5 Ambulance Turnround Protocol

Delays greater than 30 mins escalated to senior operational lead during hours and manager on call OOH. See Appendix 3

3.2.6 8-Hour Breach Protocol

Protocol in place. Senior manager on call to contact the PCT at 10pm and 8am to update on situation. During the day from 9 hours onwards the escalation is made by the senior operational lead. Full procedures to follow.

3.3 Response

3.3.1 Service Support and Mutual Aid Arrangements

This will be arranged via the conference calls and escalated as necessary (link with partner plans)

Primary care protocol in place and bypass numbers circulated

Request for ambulance divert to be advised and agreed by senior operational lead in hours and senior manager OOH.

3.3.2 Gold and Silver Arrangements

The Trust has a exercised and ratified Major Incident plan that details its response to Major Incidents, including command and control structures.

The Trusts Escalation policy clearly defines the triggers for transition from Black to Major Incident

3.3.3 Health Gold and Silver Arrangements

N/A

3.3.4 Debrief and Learning

RCA to be completed for any patients waiting over 8hrs from DTA

Weekly cap plan meeting will undertake debrief for previous week and take learning and actions forward for next 2 weeks plan.

Countywide predicative planning meeting is used to review activity and identify learning points

3.4 Contingencies

3.4.1 Pandemic Influenza

Extra capacity will be open

Pandemic flu plan in place and tested

See Appendix 3 for the full plan

3.4.2 Fuel Shortages

The rust has a local Plan in place that has been tested. County wide planning is still in progress due to the changes in central government approach.

See Appendix 3 for the full plan

3.4.3 Adverse Weather

Plan in place and tested. See Appendix 3

3.4.4 Infection Control

The Trusts Infection Prevention team will continue to provide its usual level of service across the period, maintaining an over view of any infection issues and responding where required.

The team will also support the Trust flu response through Fit Testing and advice.

3.4.5 Ambulance

The trust works in close liaison with EMAs to ensure appropriate deployment of resources such as the DECC and HALOs to limit A+E attendance and ensure smooth turnaround of crews at time of peak pressure.

3.4.6 Patient Transport Services

Currently the Trust is supported by the NSL PCT area contact for in and out of hours provision. Private providers will be used if required. NEPT manager in place to manage any issues.

3.4.7 Social Care

N/A

3.4.8 Primary Care

Use of GP's in A&E weekly

3.4.9 Loss of Capacity

The Trust has tested its BCM plans across the trust as well as responding to various industrial action.

3.4.10 Short Term Commissioning

Extra beds available to purchase at Cliftonville care home as required (linked to capacity and demand analysis)

3.4.11 Change to Admission and Discharge Criteria

The Trust has an agreed procedure in place to allow the Medical Director to instigate change in the admission and discharge criteria.

4 Stakeholder Plans

4.1 NGH - Acute

N/A

4.2 NGH - Community Hospitals

N/A

4.3 Communications

N/A

5 Coordinating Arrangements

5.1 Points of Contact

In hours operational manager – bed manager bleep 6040
Senior operational lead – contact to be advised

Out of hours
On call manager and Director are available via switchboard

5.2 Leadership and Management Chain

Chief operating officer – Christine Allen
Care Group Directors – Deborah Alderson / Rebecca Brown
General Managers – Fiona Lennon / Simon Illingworth / Sue MacLeod / Matt Tucker

Resilience leads – James Rogers

5.3 Timeline

Public Holidays, Tuesday 25th Dec, Wednesday 26th Dec, Tues 1st January, 29th March

5.4 Daily Rhythm

0700	Site Hand Over
0800	1st Site Status Email
1030-1130	Capacity Review Meeting
1130	2nd Site Status Email
1130	PCT Escalation teleconference
1300	Site Review
1430-1500	Capacity Review Meeting
1500	3rd Site Status Email
1700	Site Handover meeting
2000	Site Review

5.5 Media Communications Support

Communications in hours is via the communication officer on ext 3871
OOH any media enquiry is via the Director on call through NGH switchboard

5.6 Business Continuity

The Trust has tested BCM plans in place for all areas of operation as well as specific plans for fuel shortages, supplies and utilities failures.

5.7 External Support

Currently working with the IST to ensure delivery of a new urgent care pathway and sustainable transit time performance

5.8 Workforce

5.8.1 Recruitment to Known Shortfalls

All nursing posts will be recruited into by November 2012

All agency nursing (except specialist areas) will cease from November

Consultant and junior medical staff vacancies will be filled with locums (where possible)

ITU/HDU staffing will be addressed through increased recruitment and the internal Critical Care surge plan, if required

6 Assurance & Review

6.1 Assurance Process

The plan will be been approved by the Medical and Surgical Care Group Boards and be discussed at the Strategic Management Board and Trust Board

6.2 SHA Assurance

N/A

6.3 Service Assurance

Daily reporting of performance and clinical quality via directorates

6.4 Review Points

Actions arising from lessons leant will be added to the action log for the Urgent care work stream

This document will remain a working plan throughout the period leading up to and including winter

6.5 Debrief

The Trust will hold a weekly debrief to identify immediate lessons and issues attened by

Head of Capacity

Care Group Directors

Care Group Chairs

Others as requested

The Trust will also hold monthly debriefs chaired by the CCO or appropriate director.

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title	Annual Fire Safety Report 2011/12
Submitted by	Charles Abolins Director of Facilities and Capital Development
Date of meeting	27th September 2012
Corporate Objectives Addressed	Fit for purpose facilities and equipment for effective and efficient delivery of services

SUMMARY OF CRITICAL POINTS

For the period 1st January 2011 to 31st December 2011, all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005.

The organisation has developed a programme of work to eliminate or reduce as low as reasonable practicable the significant fire risks identified by the fire risk assessments.

PATIENT IMPACT

Assurance of safe environment and safe procedures in event of fire

STAFF IMPACT

Statutory requirement for annual refresher training

FINANCIAL IMPACT

Continued capital investment required to maintain fire alarm system and to invest in the building fabric to improve the fire integrity. Currently managed through Estate capital stream with allocations based on risk prioritisation.

EQUALITY AND DIVERSITY IMPACT

Planned investment will provide flashing beacons to supplement audible sounders which will address concerns raised by patients who have hearing impairment.

LEGAL IMPLICATIONS

Potential breach of Regulatory Reform (Fire Safety) Order if Fire and Rescue Service are not satisfied with levels of refresher training, emergency plans and fire drills.

RISK ASSESSMENT

The Trust's Fire Safety advisor has carried out fire safety risk assessments for the Trust and the significant risks have been included on the Risk Register.

RECOMMENDATION

The Trust Board is asked to note the contents of the report and recognise the improvements in fire safety over the last 12 months. The Board is asked to support continued investment through the Trusts capital programme to address the residual fire risks and maintain the fire alarm system.

The Trust Board is also requested to support initiatives that will ensure staff attend statutory fire refresher training.

Northampton General Hospital NHS

NHS Trust

ANNUAL FIRE SAFETY REPORT

2011 - 2012

13

1.0 Introduction

This report has been produced to provide the Trust Board with an overview of the current position of fire safety and to provide assurance that the Trust is meeting its statutory responsibilities.

A copy of the 'Annual Statement of Fire Safety 2011", signed by Chief Executive, Dr Gerry McSorley in February 2012 has been included in appendix 1 for reference.

2.0 Governance and Assurance

All fire safety arrangements within the Trust are modelled on the recommendations made by the Department of Health's Firecode fire safety guidance documents. These are referenced and supported within the Trust's Fire Safety Policy.

On an annual basis the Trust's Chief Executive is required to sign and return the *Annual Statement of Fire Safety 2011* to the Department of Health for the previous year. This is to provide assurance that the hospital is complying with its statutory obligations and has a plan of action for dealing with gaps in compliance.

Through the *'Annual Statement of Fire Safety 2011",* the Trust has declared;

'*That for the period 1st January 2011 to 31st December 2011, all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005'*. And that;

'*The organisation has developed a programme of work to eliminate or reduce as low as reasonable practicable the significant fire risks identified by the fire risk assessments'.*

3.0 Fire Risk Assessments

During 2011, annual fire risk assessments for all areas owned or occupied by the Trust were completed.
There are four main areas identified in the risk assessments that could impact on the ability of the Trust to provide a safe environment for patients, visitors and staff.
These are: Buildings/structural, fire alarm, system, vertical evacuation and staff training.

3.1 Buildings/Structural

Hospitals are designed and constructed to allow patients to remain inside, within fire safety compartments should a fire occur in another part of the building. This requires them to be constructed using high levels of fire resistance to divide the building into designated compartments. The Trust occupies many buildings dating from 1793, some of which have been built using construction methods that no longer satisfy current standards, for example the "Oxford Method". The affected buildings using "Oxford" were built in the late 1970s and currently house: Main Theatres, A&E, Fracture Clinic, Radiology, ITU/HDU and neighbouring wards. This construction method relied on the fire integrity of a suspended asbestos ceiling to provide fire resistance to the floor above and the steel frame of the building. The void created by the suspended ceiling was not provided with cavity barriers, allowing a very large uncompartmented area through which fire, smoke and heat could spread unchecked.
From previous investigations of fires that have occurred in this type of construction elsewhere in the UK, there is evidence that the ceiling did not provide the required level of fire resistance.

The Trust has carried out remedial work, on a phased basis, by installing cavity barriers in the voids during capital upgrading works. Asbestos ceiling tiles require specialist removal that would require lengthy closure of areas during the work, it is therefore operationally impractical to check the extent to which further fire compartmentation is required however it is considered that the areas still requiring work include: Radiology and part of Main theatres.

The risk has been mitigated by the installation of an automatic fire suppression system throughout the basement and other high-risk areas such as kitchens, stores and medical records, automatic fire detection system, staff training, emergency plans and an on site Fire Response Team. Over the past two years there have been substantial works to upgrade the fire alarm system by the installation of additional automatic fire detection and the upgrade of the systems control panels.

When the opportunity arises through capital refurbishment or emergency repair works fire safety improvements are included wherever practicable.

Building works incorporating Fire Safety completed during 2011 – 12:

- Improved fire exits in Gossett Ward, ENT outpatients, Barratt Maternity Home
- Completion of covered bin store area to the rear of Cedar and Willow Wards
- Completion of alterations in Breast Screening, X-Ray (new scanning room and increased day bed area), new Head & Neck Ward in Spencer Ward, new Haematology extension, Endoscopy to improve scope cleaning facilities, Purchasing Offices, new public toilets adjacent to Collingtree Ward
- Completion of Mortuary facilities & office extension in Histopathology
- Completion of A & E temporary Minors including asbestos removal & protection of steel work in ceiling void

3.2 Fire Alarm System

The Trust's fire alarm has been extended and modified to ensure that it covers the whole site in accordance with relevant codes of practice and guidance.

The element of the fire alarm with the highest risk (replacement of the interconnection between fire alarm panels) and the replacement of all control panels have now been completed during this year. However investment to improve the alarm system will need to extend into future years as part of a continued phased improvement.
The remaining risks are being monitored and mitigation plans are in place but ongoing investment is required to maintain risks at an acceptable level which in turn also demonstrates to the enforcing body that the Trust is satisfactorily managing its fire risk.

The following additional works were completed during this period as part of the upgrading :–

- Replaced the existing detectors in Billing House, Outpatients Department, William Kerr Building, Manfield Theatre, Integrated Surgery Centre, Cedar-Collingtree-Hawthorn-Rowan & Willow Wards & Orthopaedic Administration Centre with multi-sensor detectors, installing sounder bases, sounders & beacons as necessary
- Replaced the existing repeater panels served from Integrated Surgery control panel with Autrosafe models.
- Installed additional Autrosafe repeater panels at the following locations – Althorp ward, Nursing floor, A & E and Pathology.

3.3 Vertical Evacuation

Patient evacuation stretchers were purchased and deployed in all areas where vertical evacuation is required. This completes the provision of evacuation equipment and therefore reduces the risk to the Trust.

3.4 Staff Training

It is a statutory requirement of the Regulatory Reform (Fire Safety) Order and a mandatory requirement of Firecode that all members of staff undertake annual fire training and take part in a fire drill. Where patients are dependent on the staff for their safe evacuation this training is vital.

i. Training sessions

The Trust Fire Safety Advisor organises and delivers monthly fire training days in the Training and Development Department.

In addition to these pre planned monthly sessions, training within a number of departments across the Trust has also been provided as requested by those areas. Fire training has also been included in the Training & Development Department cluster days which have been organised to allow staff to attend training on a range of mandatory subjects.

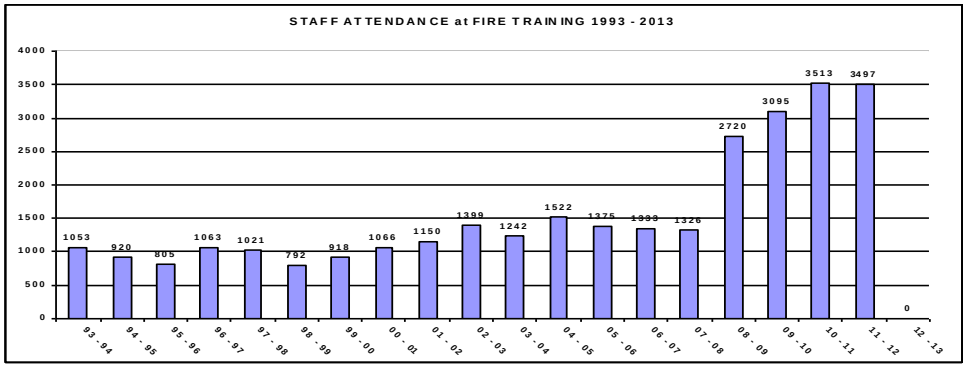
ii. Attendance

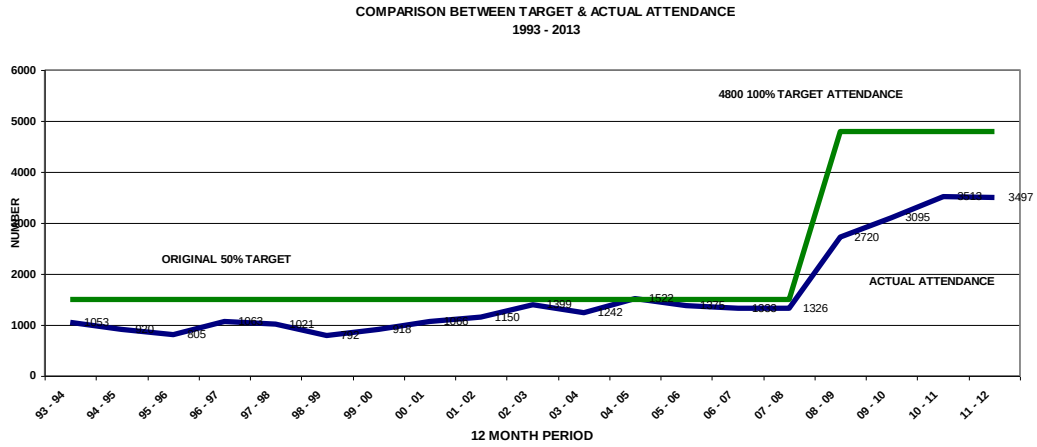
From the records of attendance during 2011/12 3497 members of staff received training which equates to 73%, a slight decrease of 61 over the previous year's attendance.

This remains a high risk to the Trust and Directorate managers are being tasked with ensuring that staff that out of date attend fire refresher training as soon as possible.

To address this risk the Trust Fire Safety Advisor has started regular contact with Directorate managers reminding them of the requirement for all staff to attend fire training and advising them on how to achieve compliance. This is also being monitored by the Trust Fire Committee and reported through CQEG.

In order to improve attendance, training has been provided in various flexible ways. This includes holding them locally in wards/departments and the option of completing via E learning. There has been an increase in attendance through these means and locally delivered departmental training now exceeds those attending sessions held in the Training and Development Centre.





iii. Fire Drills

Allied to the fire training provided it is important for the Trust to be assured that staff know instinctively the actions to take should a fire occur. This can be demonstrated by holding regular fire drills. However, in order to hold a meaningful fire drill the ward/department must have an emergency/evacuation plan on which to base their drill. It is therefore important for all areas to have in place an emergency plan. Fire drills have been undertaken during 2011/12, which have highlighted organisational and administration weaknesses which are being addressed, resulting in 65% compliance. To address this shortfall the Trust Fire Safety Advisor has started regular contact with Directorate managers reminding them of the requirement to have a current emergency/evacuation plan. This is also being monitored by the Trust Fire Committee and reported through CQEG.

iv. Evacuation Training

In response to the report from NHS London on their 5 fires the Trust purchased 70 “Albacmat” stretchers during 2010 for use in the evacuation of non-ambulant patients down stairs. An additional 20 of these stretchers have been purchased in 2012 to supplement that original purchase. In conjunction with the supplier, the Manual Handling Department and the Fire Safety Advisor have received training in their deployment. The Manual Handling team, who have devised a specific training package, continue to train staff who will use these stretchers.

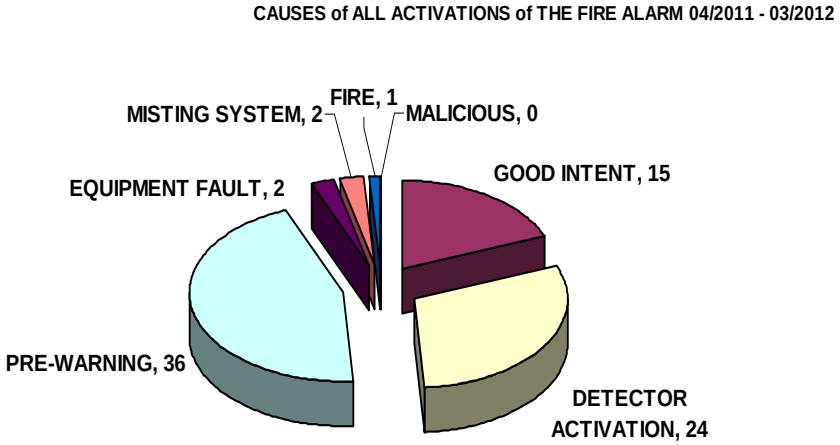
v. Resources

There is a resource risk to the Trust as there is only one Fire Safety Advisor who is responsible for carrying out all Trust fire training. At present there is no back-up facility for this post should the Fire Safety Advisor be unavailable for whatever reason, this leaves the Trust vulnerable.

The Trust Fire Safety Manager and Fire Advisor are investigating ways to address this risk and have set a target date of January 2013 to have a solution in place.

4.0 Fire Alarm Activations

There were a total of 79 activations of the fire alarm during the reporting period, an increase of 10 from the last report.



Fires

The fire incident involved a battery operated tug which was on charge in the Sterile Services Department. A fault occurred on the charging system which caused it to overheat which in turn heated up the plastic insulation causing it to decompose. The fumes from the decomposition were noticed by an operator who quickly isolated the electrical supply and raised the alarm by operating a fire alarm call point. The Department was quickly evacuated and the situation dealt with by the Fire Service.

Good Intents

The 15 good intents were caused by members of staff operating a call point suspecting a fire after smelling smoke/burning.

Pre Warnings

36 pre-warnings were caused by detectors either going out of sensitivity or, briefly sensing smoke/dust/aerosols but were not enough to trigger a full alarm.

Detector Actuations

24 actuations of detectors can be summarised as follows –
Contractors caused 3;
Unknown caused 2;
Detectors sensing smoke, dust or fumes caused 19.

Equipment Faults

These were both caused by faults within the control and indicating equipment.

Misting System

The misting system interfaces with the fire alarm system for raising the alarm – one of the causes of the alarm was due to the accidental operation of one of the misting heads when it was struck by a moving object. The other cause was due to an electrical problem.

The Trust has already commenced action to reduce activations by improving control and management of external contractors; increasing ventilation where heat is identified as a problem; installing a foot operated switch on toasters and improving the reporting and analysis to reduce the numbers of unknown causes.

5.0 Fire Safety Objectives for 2012/13

Training

- Increase the attendance of all staff at fire training – Managers to be targeted to ensure that staff are released to attend; continue to offer flexible training times and places; alternative training methods utilised e.g. online.
- The Fire Response Team to be provided with a manual and to receive continued training.

Fire Safety

- All areas to have a current emergency/evacuation plan.
- All areas to have a current fire warden in place.
- Fire drills to be undertaken throughout the Trust to ensure that everyone knows the correct actions to take in a fire incident. Any lessons learnt from the drills to be incorporated into the emergency plan.

Fire Alarm System

- Install multi-sensor fire detectors, incorporating sounder bases, in all new build and refurbishments
- Replace all existing single state fire detectors with multi-sensor detectors
- Investigate and amend if required the cause and effect of the fire alarm system to ensure that the correct signal is given in all areas

Risk Assessment

- Continue completing fire risk assessments to ensure all areas have a current assessment
- Re-assess the provision of fire fighting equipment across the site

Resources

- Implement resilience plan to reduce the risk of only one Fire Safety Advisor being responsible for carrying out all Trust fire training

6.0 Conclusion:

It has been a positive year in terms of Fire Safety management with significant improvements being achieved particularly in relation to alarm system upgrades.

There has been an increase in alarm activations over the previous year although the causes have been minor and the responses to these have been timely and effective.

Training all Trust staff on an annual basis continues to be a challenge and further work is required to improve performance in this area.

The Trust has continued to prioritise investment in fire safety through the annual capital plan to ensure that building/structural fire risks are eliminated or mitigated as much as practicable.

Appendix 1 – Annual Statement of Fire Safety 2011

GATEWAY ID: 17066 ROCR ID: ROCR/OR/0139/002

Annual Statement of Fire Safety 2011

NHS Organisation Code: RNS	NHS Organisation Name: Northampton General Hospital NHS Trust	
I confirm that for the period 1st January 2011 to 31st December 2011, all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and (*please tick the appropriate boxes*):		
1	There are no significant risks arising from the fire risk assessments.	
OR 2	The organisation has developed a programme of work to eliminate or reduce as low as reasonably practicable the significant fire risks identified by the fire risk assessment.	√
OR 3	The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks.*	
*Where a programme to mitigate significant risks HAS NOT been developed, please insert the date by which such a programme will be available, taking account of the degree of risk. Date:		
4	During the period covered by this statement, has the organisation been subject to any enforcement action by the Fire & Rescue Authority? (Delete as appropriate) If Yes - Please outline details of the enforcement action in Annex A – Part 1.	No
5	Does the organisation have any unresolved enforcement action pre-dating this Statement? (Delete as appropriate) If Yes Please outline details of unresolved enforcement action in Annex A – Part 2.	No
AND 6	The organisation achieves compliance with the Department of Health Fire Safety Policy, contained within HTM 05-01, by the application of Firecode or some other suitable method.	Yes
Fire Safety Manager	Name: Kevin Hackett	
	E-mail: Kevin.hackett@ngh.nhs.uk	
Contact details:	Telephone: 01604 545903	
	Mobile: 07799037695	
Chief Executive Name:	Dr Gerry McSorley	
Signature of Chief Executive:		
Date:	6th February 2012	
Completed Statement to be forwarded to the NHS Information Centre to arrive no later than 24th February 2012.		

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Northampton General Hospital NHS
NHS Trust

A G E N D A

TRUST BOARD MEETING HELD IN PUBLIC
Thursday 27th September 2012
9.30 am Boardroom, Danetre Hospital

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
09.30	1.	Apologies	Mr P Farenden	
	2.	Declarations of Interest	Mr P Farenden	
	3.	Draft Minutes of meeting held on 25th July 2012	Mr P Farenden	**1**
	4.	Matters Arising	Mr P Farenden	
09.35	5.	Chief Executive's Report	Dr G McSorley	**2**
Clinical Quality & Safety				
09.45	6.	Medical Director's Report	Dr S Swart	**3**
10.00	7.	Patient Experience – Friends & Family Test	Ms S Loader	**4**
10.10	8.	Monthly Infection Prevention Performance Report	Ms S Loader	**5**
Operational Assurance				
10.20	9.	Operational Performance Report	Mrs C Allen	**6**
10.40	10.	Finance Report	Mr A Foster	**7**
10.50	11.	Human Resources Report	Ms G Opreshko	**8**
11.00	12.	Transformation Programme Newsletter	Ms G Opreshko	**9**
11.05	13.	Provider Management Self Certification	Mr C Pallot	**10**
11.10	14.	Equality and Human Rights Annual Report	Ms G Opreshko	**11**
11.20	15.	Seasonal Plan	Ms C Allen	**12**
11.25	16.	Annual Fire Safety Report	Mr C Abolins	**13**
Governance				
11.30	17.	Any Other Business		
	18.	**Date & time of next meeting:** 9.30am Thursday 25th October 2012, Boardroom, NGH		
	19.	**CONFIDENTIAL ISSUES :** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Mr P Farenden	