Royal Berkshire NHS
NHS Foundation Trust

Agenda

Board of Directors

Tuesday 30 October 2012
9.00am – 2.30pm
Boardroom, Level 4, Royal Berkshire Hospital

Open Board Meeting – Part 1

Item			Lead	Time
	The meeting will commence with a patient story.		Craig Anderson	9.00 – 9.05
1.	Apologies for Absence (Caroline Ainslie, John Barrett and Sue Edees)		Stephen Billingham	-
2.	Minutes for Approval: 2 October 2012 (Attached)		Stephen Billingham	9.05 – 9.10
3.	a) b)	Matters Arising Schedule Outstanding Actions Schedule (Attached)	Stephen Billingham	9.10 – 9.15
4.	Declarations of Interest (Verbal)		Stephen Billingham	9.15 – 9.20
Performance Monitoring Items				
5.	a)	Chief Executive's Report (Attached)	Ed Donald	9.20 – 10.30
	b)	Integrated Performance Report (Attached)	Ian Stoneham	
	c)	Quality and Patient Safety Report (Attached)	Emma Vaux/ Caroline Ainslie	
	d)	Director of Finance's Report (Attached)	Craig Anderson	
Strategy/Major Items- Decision Items				
6.	Bracknell Clinic Update (To follow)		Ian Stoneham / Lindsey Barker	10.30 – 11.15

7.	Pathology Transformation Update (Attached)	Lindsey Barker/Ian Stoneham	11.15 – 11.30
8.	Synergy Contract Briefing Note (Attached)	Peter Malone	11.30 – 11.45
9.	Contract Changes for Adult Audiology Service (Attached)	Lindsey Barker	11.45 – 12.00

Governance Items- Decision Items

10.	Financial Forecast Update (To follow)	Craig Anderson	12.00 – 12.30
11.	CIPs Recovery Plan and Transformation Review (To follow)	Craig Anderson	12.30 – 1.00
	Lunch		1.00 – 1.20
12.	Monitor Quarterly Submission (Attached)	Craig Anderson/ Keith Eales/Ian Stoneham	1.20 – 1.40
13.	Open Board Meetings (Attached)	Keith Eales	1.40 – 1.55
14.	Minutes of Meetings: (Attached)		
	a) Council of Governors – 27 September 2012	Stephen Billingham	1.55 – 2.10
	b) Joint Board/ Council Workshop – 16 October 2012	Stephen Billingham	

Information Items

15.	Legislative Amendments to the Trust Constitution (Attached)	Keith Eales	-
16.	Half Year Annual Plan Review (To follow)	Ian Stoneham	-
17.	Dates of Next Meeting Thursday 29 November 2012	Stephen Billingham	
18.	Exclusion of Governors, the Press and Public (Verbal)	Stephen Billingham	-

Closed Board Meeting - Part 2

The following section of the meeting will be closed to Governors, the press and public as the material to be discussed discloses exempt information as defined by the Freedom of Information Act.

19.	Monitor Annual Plan Review (Section 43 FOI Act) (Verbal)	Ed Donald	2.10 – 2.25
20.	Quality and Patient Safety Report – Exempt Appendices (Section 40 FOI Act) (Attached)	Emma Vaux/ Caroline Ainslie	2.25 – 2.30
	Close		2.30

Royal Berkshire NHS
NHS Foundation Trust

Minutes of the Board

Board

Tuesday, 2 October 2012
9.00am – 12.55pm, Boardroom, Royal Berkshire Hospital, Reading

Members Present

Mr. Stephen Billingham	(Chairman and Non-Executive Director)
Mr. Edward Donald	(Chief Executive)
Ms. Caroline Ainslie	(Director of Nursing)
Mr. Craig Anderson	(Director of Finance)
Mr. John Barrett	(Non-Executive Director)
Mr. Tim Caiger	(Non-Executive Director)
Mr. Brian Hendon	(Non-Executive Director)
Mr. Peter Malone	(Care Group Director, Planned Care)
Ms. Jane May	(Non-Executive Director)
Mrs. Janet Rutherford	(Non-Executive Director)
Mr. Ian Stoneham	(Commercial Director)
Dr. Emma Vaux	(Interim Medical Director)

In attendance

Dr. Lindsey Barker	(Care Group Director, Networked Care)
Ms. Janine Clarke	(Director of Workforce Development & Human Resources)
Mr. Keith Eales	(Director of Corporate Affairs & Secretary)
Dr. Sue Edees	(Care Group Director, Urgent Care)
Mr. Alistair Flowerdew	(Medical Director from November 2012)

Apologies

The meeting commenced with a patient story from the Medical Director about the experience of a member of staff who had surgery in a neighbouring trust. The experience had provided the member of staff with a number of learning points that they would translate into their practice within the Trust. Areas included empowering staff to raise issues, acting on plans or providing feedback to patients, timely medication and diagnostics and protecting patient confidentiality. The member of staff had provided feedback to the trust providing the care.

138/12 Minutes: 31 July 2012

The minutes of the meeting held on 31 July 2012 were approved as a correct record and signed by the Chairman.

139/12 Matters Arising

The Director of Corporate Affairs & Secretary submitted the schedule of matters arising from the last meeting. Progress against each decision was noted.

In respect of minute 119/12, the Director of Nursing advised that a full report on separating pressure ulcers into avoidable and unavoidable categories would be submitted to the Board in the next integrated performance report.

The Director of Corporate Affairs & Secretary confirmed that items not concluded would be listed on the schedule of decisions outstanding.

Resolved: that the report be noted.

140/12 Schedule of Outstanding Decisions

The Director of Corporate Affairs & Secretary submitted the schedule of decisions outstanding from meetings of the Board prior to July 2012. Progress against each decision was noted.

The Commercial Director advised that validated performance against the cancer targets, referred to in minute 74/12, was set out in the integrated performance report.

In respect of minute 77/12, the clinical services strategy, the Commercial Director explained that he had met with Non-Executive and care group Directors to provide a briefing on the document.

The Director of Corporate Affairs & Secretary advised that items not concluded would remain on the schedule until completed.

Resolved: that the report be noted.

141/12 Chief Executive's Report

The Chief Executive introduced a report giving a strategic context to developments in the health economy, setting out progress on the annual plan themes and commenting on the overall performance of the Trust.

The Chief Executive provided an update on the Shaping the Future strategy.

The Chief Executive advised that Clinical Commissioning Groups in East Berkshire had indicated that they would not support day surgery at the Bracknell Clinic. This would mean that the activity based solution and planned partnership with Frimley Park Hospital NHS Foundation Trust originally envisaged could not proceed. The Executive team was considering alternative solutions, including an option based around a rental model, which would require a capital investment from Berkshire cluster PCT or the SHA to be feasible economically.

The Executive team had begun work on a new five year strategy for the Trust. The first stage of this was developing a market assessment. This would be discussed at the joint Board/Council of Governors meeting on 16 October.

The Chief Executive commented that a key stage had been reached with Heatherwood & Wexham Park Hospitals NHS Foundation Trust in respect of the pathology service joint venture. The Trusts were being recommended not to proceed with the commercial partner option. The Chief Executive explained that the Executive team wished to pursue an in-house joint venture between the two Trusts.

The Chief Executive updated the Board in respect of developments with the Oxford Academic Health Science Network. The aim of the Network, which was currently seeking formal designation, was to create a community of common interest that sought to achieve health and wealth creation across Thames Valley by deploying the latest research breakthroughs through a highly skilled and motivated workforce, for the benefit of patients and the local community.

The Chief Executive advised that the Monitor stage 2 review was nearing completion. The final report was expected in October.

The Chief Executive advised that the Trust was forecasting failing, in quarter 2, the targets in respect of the A&E four hour wait and two week suspected cancer. Plans were in place to achieve these targets in quarter 3. However, the A&E target remained a risk pending the commissioning of an additional 50 community beds. The forecast governance rating for Q2 was amber/ green, an improvement on the amber/red performance in Q1.

The Chief Executive advised that at the end of quarter 1 the Trust had achieved an FRR of 3, with significant underlying issues in respect of the extra cost of patients delayed in their discharge, lower than planned activity and cost improvement programmes (cips) behind plan. These pressures continued in August, with the additional impact of EPR costs. Immediate action had been taken to address these issues. The forecast for Q2 was delivery of an FRR3 although there was risk given the operating environment, cip position and costs associated with EPR that this could reduce to a FRR2.

The Chief Executive commented that the Trust was now achieving upper quartile clinical efficiency and effectiveness for existing models of care. The challenge for the remainder of the year was to drive further efficiency savings whilst developing a clinical services transformation programme that redesigned care pathways and models of care with partners. A QIPP programme board had been established to lead this work and also the delivery of the in-year cost savings programme, the aim being to achieve safe, high quality and affordable care.

The Chief Executive advised that a savings recovery plan would be submitted to the next Board meeting along with an outline transformation programme. This would be developed into a costed QIPP programme, following Board discussion and approval of the proposed approach. The Board asked that consideration be given to requesting the Audit Committee to review the savings recovery plan. The Board also requested that the plan contain 'what if' scenarios.

Resolved: that the report be noted.

142/12 Integrated Performance Report

The Commercial Director submitted the integrated performance report for August 2012.

The Commercial Director explained that the report set out the key performance risks for the month, the actions to be taken to address issues and the forecasted impact for quarter 2.

The Commercial Director provided an update to the report in respect of the performance agonist the cancer targets in August. Following validation, the only targets not achieved in August were those in respect of the four hour A&E wait and the two week wait for suspected cancer. The Board noted that it was unlikely that either target would be achieved in quarter 2. Plans were in place for the targets to be achieved by the end of quarter 3.

The Board sought further assurances in respect of the action being taken to improve performance against the targets that had been failed.

The Care Group Director, Urgent Care advised that, in respect of the four hour wait target, action had been taken to reconfigure A&E to improve the position in the short term. The possibility of capital investment was also being considered. However, key to achieving the target on a sustainable basis was an improved flow of patients through the Hospital, which necessitated more community beds. The Chief Executive advised that an additional 50 community beds were being commissioned. He would be meeting with the Chief Executive of NHS Berkshire West and the leaders of the unitary authorities to progress this. In the meantime, two-weekly capacity meetings were being held with commissioners. The Chief Executive confirmed that he would involve the Chairman and the Board if necessary to support the Trust position.

In respect of the two week wait suspected cancer target, the Care Group Director, Planned Care explained that 50% of the breaches related to patient choice and the remainder toinsufficient capacity. Staff recruitment was underway to address the capacity issues. The Chief Executive commented that, in addition, the Thames valley Cancer Network would be providing advice to the Trust.

Clarification was sought in respect of progress in implementing the plan to reduce the backlog of appointments in ophthalmology. The Care Group Director, Planned Care advised that the plan was on trajectory.

Assurances were sought in respect of achieving the 18 week wait target given the pressures in the Trust and theatre capacity issues. The Care Group Director, Planned Care advised that he was confident that the target would be achieved despite the current challenges, although there remained concerns about theatre capacity. The Chief Executive commented that the onus on the Executive would be to satisfy itself that the existing theatres were fully utilised before investing in additional capacity.

The Board noted that there was a significant under-achievement against cips. Clarification was sought in respect of the degree of planning underpinning each of the projects. Particular attention was drawn to the £2m divergence from plan in respect of capacity planning. The Chief Executive commented that, with regard to capacity planning, the Trust had not been able to close beds due to the number of patients in the Hospital who were medically fit for discharge. Commissioners had recognised this and had provided £750,000 one-off additional income in the first quarter. It was suggested that the report to the Board should reflect replacement or substitute savings. The Director of Finance undertook to provide this.

The Director of Finance commented that, on reflection, further planning could have been undertaken in respect of the efficient infrastructure cost improvement programme and, specifically, the £750,000 that related to estates and facilities. As a replacement for the planned savings, the estates team was targeting additional income.

The Director of Finance commented that negotiations were continuing to seek a reduction in EPR and CSC costs.

It was noted that each Care Group had been set a target of achieving savings of £1m. An assurance was sought that the process of agreeing savings to be achieved would include an assessment of the impact on quality. The Chief Executive confirmed that this would be the case.

Resolved: that the report be noted.

143/12 Director of Finance Report

The Director of Finance submitted a report on the financial performance of the Trust for August 2012.

The Director of Finance advised that the year to date deficit was £2.6m against a budget surplus of £0.1m.

The Director of Finance explained that

- income for the year, at £133.m, was £1.7mm ahead of budget However, underlying commissioner activity was £2m behind plan, predominantly in daycase and outpatient areas. The Board noted that activity needed to be £1m higher that the £24.2m recorded in August so as to maintain an FRR of 3

- Expenditure for the year was £135.8m, which was £4.4m adverse to the budget. The causes were pay, drugs, non-delivery of cips, clinical supplies, estates and the phasing of the non-pay budget

The Board noted that the EBITDA year to date was 5.1% against a budget of 7.2%.

The Director of Finance advised that cash, at £26.3m, was adverse to the budget of £27m.

The Director of Finance advised that the Financial Risk Rating for the year to date was 2.6, which, under Monitor methodology, would be rounded to a 3.

The Board sought the views of the Director of Finance on the likely performance of the Trust in September. The Director of Finance advised that the position would be clearer in the following week. He undertook to distribute a note to the Board in the next week.

Resolved: that the report be noted.

144/12 Quality and Safety Report

The interim Medical Director and the Director of Nursing introduced the monthly quality and safety report.

The interim Medical Director drew particular attention to performance against the target for reducing harm from sepsis and the CQUIN target in respect of venous thromboembolism (VTE).

In August, 40% of patients with suspected sepsis were given antibiotics within one hour of recognition. In respect of VTE, 82.46 of patients were assessed against a target of 90%. The interim Medical Director commented that this, in part, reflected a coding issue which had been identified following a review of healthcare records. The coding of patients would be amended to reflect this.

Clarification was sought with regard to the action being taken to improve coding. The interim Medical Director advised that the decision had been made to code from notes rather then the electronic discharge letter.. This would improve the depth and quality of coding. Clarification was sought as to whether the electronic discharge letter accurately reflected the notes. The interim Medical Director advised that electronic discharge letter were accurate. However, they did not always capture the complexity required by the coding rules.

The Director of Nursing provided an update on the Care Quality Commission (CQC) outcome compliance position. The Director of Nursing explained she had undertaken a robust assessment of the standards in the four outcomes for which she was responsible. However, it had not been possible to complete this by the internal deadline for reporting compliance. This had now been concluded and the supporting paperwork had been completed.

The Director of Nursing advised that the draft report had been received from the CQC following the Nutrition and Dignity Inspection for Older People carried out in August. The Trust was found to be compliant on the five CQC outcomes that had been reviewed and there were no compliance actions.

Clarification was sought on the action being taken in response to complaints about attitude and behaviour being above the threshold since June. The Director of Nursing advised that the causes of the increase had varied. However, it was clear that some related to frustrations caused by EPR. Action plans were in place to address the identified causes of the increase.

Resolved: that the report be noted.

145/12 Board Assurance Framework and Corporate Risk Register

The Director of Corporate Affairs & Secretary submitted a report setting out a proposed approach for developing the reporting of risk at the Board.

The Director of Corporate Affairs & Secretary explained that it was proposed to separate the current corporate risk register into two documents. It was proposed to submit to the Board a Board Assurance Framework drawing together risks associated with the delivery of the annual plan objectives along with significant risks escalated by the Executive. Alongside this, a corporate risk register would be produced setting out risks escalated from directorate and Care group Risk Registers.

It was proposed that the Board Assurance Framework and the corporate risk register would be reviewed by the Board on a quarterly basis. The documents would also be reviewed by the Executive on a monthly basis and at meetings of the Audit, Clinical Governance and Risk Management Committees.

In endorsing the approach, the importance of material changes to the Board Assurance Framework and the corporate risk register being escalated to the Board in between the quarterly review was emphasised.

The Board noted that the key risks in the Board Assurance Framework were EPR and IT, achievement of the national access standards and financial stability. It was noted that these risks reflected the nature of the discussions earlier in the meeting.

Resolved: that the revised approach for the reporting of risk be approved.

146/12 Minutes of Meetings

The Board received the draft minutes of the following meetings

Nominations Committee	25 and 27 July 2012
Council of Governors	26 July 2012
Remuneration Committee	31 July 2012
Risk Management Committee	3 September 2012

Audit Committee	11 September 2012
Clinical Governance Committee	13 September 2012
Joint Constitution Working Group	21 September 2012

The Chairman gave a verbal report on the meeting of the Council of Governors meeting held on 27 September 2012.

The Chairmen drew attention to significant issues discussed at the meetings.

The Chairman of the Audit Committee advised that there continued to be an issue in respect of the timely response to internal audit recommendations. He drew particular attention to a response in respect of an audit into the robustness of Trust IT systems which was still outstanding.

Resolved: that the minutes be received and the recommendations contained therein approved.

147/12 Information Items

The Board received, for information, the following reports

- workforce and organisational development
- schedule of outstanding items
- Board agenda plan

The Director of Workforce Development and Human Resources undertook to provide a briefing for Non-executive Directors on the approach to organisational development in the Trust.

148/12 Date of Future Meetings

The Chief Executive advised that the Executive had been reviewing timescales for the production of performance information for the Board. One of the challenges with the current pattern of Board dates, with meetings being held on the last Tuesday of the month, was that it was difficult to produce informed reports for the Board in months of four weeks. The timescale offered very little scope for Care Groups or the Executive to review data and provide a full assessment for the Board.

To address this, it would be possible for the Board to meet on the first Tuesday of the following month to allow an extra week for the preparation of reports.

The Board recognised the merit in allowing sufficient time for the submission of fully informed reports. However, a number of Board Directors commented that it was best practice for a board to meet within three to four weeks of the end of the month and that attention should be focussed on improving Trust systems which produced data.

The Chairman undertook to discuss the timing of Board meetings with the Chief Executive.

149/12 Exclusion of the Press and Public

The Board noted that, had the meeting been in public, the press and public would have been excluded at this stage given the exempt nature of the remaining business, as defined by the Freedom of Information Act. The Governors present left the meeting at this stage.

150/12 Bracknell Clinic Update

[Section 43, Freedom of Information Act]

The Commercial Director distributed a report on progress in respect of discussions to develop the utilisation of the Bracknell Clinic.

The Commercial Director explained the background to the purchase and development of the Clinic, including the funding obtained to bring the Clinic into use, its financial performance and the action taken to date to develop the utilisation of the Clinic.

The Commercial Director explained that the Berkshire Provider Development Group had identified a number of system issues to be addressed in Berkshire, including developing the use of the Bracknell Clinic. The Group had been discussing broad parameters for work to be commissioned from the Clinic, which had significantly influenced the Trust plans for its use.

The Board noted that an option now under consideration was a capital payment to assist in equalising the difference between the economic and market rents at the Bracknell Clinic. The Board noted that this could have a significant impact on the financial performance of the Clinic.

The Board endorsed the proposal that the Chief Executive should write to commissioners setting out the Trust proposition in respect of the Clinic. The draft letter would be sent to Board members for comment.

Resolved: that the report be noted.

151/12 Pathology Partnership

[Section 43, Freedom of Information Act]

The Commercial Director and the Director of Finance submitted a report on the outcome of the recent procurement exercise to find an external partner for the joint venture with Heatherwood & Wexham Park Hospitals NHS Foundation Trust in respect of the pathology service.

The Commercial Director and the Director of Finance set out details of the commercial offer submitted by the remaining external partner, set against the current cost of the service and an in-house of comparator. It was noted that the in-house comparator was a lower cost than the commercial offer. The Board noted that the treatment of VAT and pension costs had significantly impacted on the commercial offer.

The Commercial Director and the Director of Finance explained that the Pathology Steering Group, comprising representatives of both Trusts, had decided to halt the procurement process.

The Commercial Director and the Director of Finance advised that the Trust now wished to pursue an in-house joint venture without a commercial partner.

Resolved: that

(a) The decision of the Pathology Steering Group, endorsed by the Trust Executive, to halt the procurement process to identify a commercial third party be noted

(b) Continuing discussions be held with Heatherwood & Wexham Park Hospitals NHS Foundation Trust to develop an in-house pathology joint venture.

152/12 Quality and Safety Report Exempt Appendix

[Section 40, Freedom of Information Act]

The Board received a confidential appendix setting out details of serious incidents reported in June.

There had been four serious incidents reported in August. The Board noted the details of each.

The Board noted the schedule of open serious incidents as at the end of August 2012.

Resolved: that the report be noted.

Chairman

Date 30 October 2012

Board Schedule of Matters Arising **Agenda Item 3 a)**

Board Date	Board Minute	Subject	Decision	Owner	Update
2 October 2012	141/12	CEO's report – savings plan	The Chief Executive advised that a savings recovery plan would be submitted to the next Board meeting along with an outline transformation programme. The Board asked that consideration be given to requesting the Audit Committee to review the savings recovery plan. The Board also requested that the plan contain 'what if' scenarios.	Craig Anderson Craig Anderson	See report elsewhere on this agenda. Report will go to next Audit Committee. DoF suggests the needs to review the purpose of the Audit Committee and its relationship to Board matters. See Financial Forecast Paper for "what if" scenarios.
2 October 2012	142/12	IPR – capacity planning figures	The Chief Executive commented that, with regard to capacity planning, the Trust had not been able to close beds due to the number of patients in the Hospital who were medically fit for discharge. Commissioners had recognised this and had provided £750,000 one-off additional income in the first quarter. It was suggested that the report to the Board should reflect replacement or substitute savings. The Director of Finance undertook to provide this.	Craig Anderson	Now included in Board reports
2 October 2012	143/12	DoF report – September performance	The Board sought the views of the Director of Finance on the likely performance of the Trust in September. The Director of Finance advised that the position would be clearer in the following week. He undertook to distribute a note to the Board in the next week.	Craig Anderson	No interim report needed as maintained FRR of 3. See also FD Report
2 October 2012	150/12	Bracknell Clinic – letter to commissioners	The Board endorsed the proposal that the CEO write to commissioners setting out the Trust proposition for Clinic. The draft letter would be sent to Board members for comment.	Ed Donald (Ian Stoneham)	Completed

Board Schedule of Outstanding Decisions **Agenda Item 3 b)**

Board Date	Board Minute Ref	Subject	Decision	Owner	Report Due
November 2011	162/11	East Berkshire – collaborative approach	The Chief Executive advised that he had agreed to work with the Chief Executives of Heatherwood & Wexham and Frimley Park to assess the feasibility of making a collaborative response to the commissioning intentions of the Ascot and Bracknell clinical commissioning group. He would submit the case to the January 2012 Board for review.	Ed Donald (Ian Stoneham)	Final business case now planned for November. 2012 Board.
November 2011	167/11	Real Estate Strategy (RES)	Final strategy to be submitted in February 2012	Philip Holmes	Real estate strategy awaiting the clinical strategy and IBP.
June 2012	111/12	Bracknell Clinic Update	The Chief Executive commented that it would be appropriate for the Board to meet the Board of Frimley Park and for a similar meeting to take place at Executive level to discuss joint working	Ed Donald (Ian Stoneham)	Chairman and Chief Executive meeting has taken place
July 2012	119/12	Pressure Ulcers	The Director of Nursing consider the merit in differentiating between avoidable and unavoidable pressure ulcers and implementing a zero tolerance approach to the former	Caroline Ainslie	To be presented in Q&S report elsewhere on this agenda
July 2012	118/12	East Berkshire collaboration business case	A business case setting out the partnership approach and the financial implications for the Trust would be submitted to the September Board meeting.	Ian Stoneham	Scheduled for the November Board
July 2012	118/12	West Berkshire utilisation	The Chief Executive advised that a working group had been established to develop the use facilities at the West Berkshire Community Hospital (WBCH). A report on progress would be submitted to the Board in the autumn.	Peter Malone	Paper to be drafted for December Board
July 2012	118/12	EPR costs	A briefing note on the additional short and long term administrative costs to support Cerner Millennium be distributed	Elizabeth White	Briefing note with summary costs to be circulated week commencing 29 Oct
July 2012	122/12	Quality of Earnings Report	The Director of Finance give consideration as to whether it would be appropriate for the Audit Committee to review the report	Craig Anderson	Report to be discussed at next Audit Committee

Royal Berkshire NHS Foundation Trust **Agenda item 5 a)**

Board of Directors

Title: **Chief Executive's Report**

Date: **30 October 2012**

Lead: **Ed Donald**

Purpose: **To report on the key issues and action being taken to deliver the Trust's strategic objectives, governance and financial risk ratings in support of the Trusts vision to deliver the best healthcare in the UK for patients in our community.**

Key Points:

- **Strategic issues** – an outline transformation programme and in-year savings recovery plan has been developed; the Shaping the Future consultation was launched on 15 October and a Trust response will be developed during November; it is proposed that a strategy sub-group is established to take forward the development of the integrated business plan.
- **Strategic investments** – an updated business case has been prepared for the Bracknell Clinic; an updated business case for the Electronic Patient Record will be submitted to the November Board meeting.
- **Governance issues** – pressures in the operating environment continue to make the achievement of the four hour A&E wait challenging, with the focus being on the provision of additional community capacity to ease pressures; the key governance risks, as well as the A&E target, are ambulance waits and two week cancer wait targets.
- **Financial issues** – the Trust has achieved an FRR of 3 in quarter 2; key issues remain delivery of commissioner activity and income to plan, under performance of the cost saving plan, increased costs associated with EPR implementation and the cost of the prior major investments.

Decision required: The Board is asked to NOTE the report.

FOI Status This report will be made available on request

1.0 Context

The operating environment and the implementation of the Cerner Millenium system remain challenging and continue to impact the governance and financial performance of the Trust. At the half year, the Trust is forecast to be amber/green for governance and a FRR 3.

In response to the financial position, the executive has focused in month on concluding negotiations aimed at reducing the costs and maximising the benefits of the Electronic Patient Record (EPR) and Royal Berkshire Bracknell Clinic (RBBC) investments. The executive has also developed an outline transformation programme and in year savings recovery plan. Each of these areas of work underpins the financial forecast.

Key issues for discussion at the Board will include agreeing the way forward for the RBBC, the outline transformation programme and in year savings recovery plan, the governance and financial forecasts. Each of these items is the subject of a separate report to the Board.

2.0 Strategic issues

2.1 The outline transformation programme and in year savings recovery plan has been developed and is set out in a separate report (item 12), which includes a quality impact assessment. The Board is asked to approve the report so that the executive can implement the in-year plan and proceed to the diagnostic stage with the transformation programme. It is proposed to bring the results of the transformation programme diagnostic to the next Board meeting for approval to proceed to the launch and implementation phase.

2.2 Shaping the Future been launched for public consultation, which will run for three months from 15 October 2012. The consultation document has been circulated to Board members and the Council of Governors. It is recommended that the Council of Governors Strategy sub-committee is briefed and they consider how the full Council are engaged and wish to respond. A formal response from the Trust will be developed during November for agreement prior to the December Board meeting.

2.3 The Integrated Business Plan has been taken forward through a series of workshops with the executive, care groups and Council of Governors. It is recommended that a strategy task group is established, chaired by a non-executive director to lead this work. It is proposed this group meets fortnightly and updates the Board at its December seminar. This will cover the results of the health needs and market assessment, with strategic options presented by the Care Groups for discussion and approval.

2.4 Thames Valley Local Education and Training Board (TVLETB) have appointed Janice Shiner as the independent Chair, allowing me to step down as the interim Chairman. The Trust is set to gain an additional £1m of education funding. Other Trusts are set to lose funding, in line with national policy. The TVLETB has requested that the impact of this reduction is resolved before these funding changes are implemented. The other key issue for the Trust is the impact that under-representation of GPs and psychiatrists in training might have on training numbers. The risk is that this will be resolved by removing existing training posts from hospitals in the network, which would destabilise service delivery. I will keep the Board updated as progress is made.

2.5 The Oxford Academic Health Science Network application has been submitted to the Department of Health. This has been circulated to the Board and it is proposed that this forms part of the Integrated Business Plan update at the Board seminar in December.

3.0 Strategic investments

3.1 An updated business case setting out the options for the RBBC is the subject of a separate Board paper (item 7). The executive recommend the HealthSpace option for Board approval.

3.2 An updated Electronic Patient Record business case is being finalised regarding the cost and benefits of the Cerner Millenium system and associated CSC contract for IT infrastructure. This will be discussed by the executive and shared with the Board prior to its submission for approval at the November Board meeting.

3. Governance issues

3.1 The operating environment pressures described in previous Board reports is unchanged, with emergency attendances up 10% in A&E and emergency admissions up 6% year to date, a position reflected across the South of England. The Trust is doing everything it can to maintain safe, high quality care across all services and maintain financial balance. Plans to increase seven day working have been a key focus of care groups to support the recovery of performance for the associated A&E and ambulance access target.

3.2 While the Trust has responded in terms of the way it works it cannot achieve these targets alone and is working collaboratively with the clinical commissioning groups and Berkshire Healthcare FT. The focus is to deliver a west Berkshire plan that provides extra community capacity seven days a week, across health and social care services. This joint work is critical to reduce the number of patients medically fit for transfer who do not need to be in a hospital bed. The Trust is fully escalated in terms of bed capacity currently. It should be noted that an increase in flu is predicted compared to previous years.

3.3 The key governance issues facing the Trust currently are delivery of the A&E 4 hour target, ambulance waits target and 2 week cancer waits for suspected cancer. The recovery plans for each of these risk areas is set out in the Integrated Performance Report. It will be important to take this into consideration when the Board agrees its governance forecast to Monitor.

3.4 An Electronic Patient Record (EPR) stabilisation plan has been agreed, which will be performance managed on a weekly basis to minimise the impact on patient experience, operational delivery and increased costs, whilst assuring an accurate activity, income and performance position.

4. Finance issues

4.1 The financial position at the end of the half year is a FRR3, which was rounded up from FRR 2.6. The key issues remain delivery of PCT activity and income to plan, under performance of the cost savings plan in year, the increased costs associated with the EPR implementation and the costs of the Trust major investments in EPR and RBBC.

4.2 The key issues and actions being taken by the executive are set out in the Finance Directors report.

4.3 An outline transformation programme and in year savings recovery plan is set out in a separate report to the Board. The updated business case for RBBC identifies a way forward that reduces the current losses in the second half of the year and increases the potential to achieve break-even in the next 12 months. The result of these work areas has been incorporated into the financial forecast. It will be important to take this into consideration when the Board agrees its financial forecast to Monitor.

Trust News

5.1 There has been considerable media coverage – mostly highly positive – about the Trust's activities. A special media facility was organised to highlight the new Rushey birthing unit. It resulted in coverage on regional ITV, three radio stations, including the main feature on BBC Radio Berkshire's Andrew Peach Breakfast Show, as well as local papers. The national launch of the RoSPA KISS project in the Emergency Department was co-ordinated by the Trust's PR team. It resulted in a live outside broadcast for BBC radio as well as coverage on two commercial radio stations and a filmed package on BBC TV's South Today.

Contact: Ed Donald, Chief Executive.

Phone: 0118 322 7230

Board of Directors Briefing

Title: **Integrated Performance Report (IPR)**

Date: **30 October 2012**

Lead: **Ian Stoneham, Commercial Director**

Purpose: This paper is to update the Board on key risks in performance, in terms of both Governance and Financial Risk Rating in relation to the standards set by our Commissioners, the CQC and Monitor. It sets out the key risks and the actions being taken to ensure achievement of all targets and the delivery of our four simple aims going forwards.

Key Points: **Governance –** The implementation of the EPR Cerner Millennium system continues to impact on the Trust's ability to manage performance. A stabilisation plan has been developed and agreed by the Executive.

A&E – delivery of the A&E 4 hour target remains a key issue without further community capacity in place and therefore system wide discussions are underway to ensure partners hold each other responsible for the actions they have agreed to take within the agreed timescales. Delivery of both the internal and external actions will ensure that the A&E target will be met in Quarter 3, and the Executive will also be agreeing other remedial plans that need to be in place to support this achievement.

Cancer - At the time of writing the cancer targets are still undergoing validation, however we expect that all of these targets with the exception of the two week wait suspected cancer target will be met in September and for Quarter 2. A plan is now in place to address the issues that impact the Trust in achieving the two week wait target, and this is set out within this paper and as part of the EPR Stabilisation Plan and we therefore expect to achieve the two week wait target in Quarter 3.

Financial Risk Rating (FRR) – The Trust continues to be £3.0m adverse to budget which is being driven by reduced PCT activity, non delivery of CIPs and pay and non pay overspends. FRR of 3 is currently being maintained but only by the smallest of margins. A revised forecast and details of a CIP recovery plan will be presented to Trust Board for approval.

Summary

The key risks to the Governance and Financial Risk Ratings are set out above and detailed within the IPR. Achievement of all targets with the exception of A&E and two week cancer has led to an improvement in our rating to Amber Green in Quarter 2. Action plans are in place for all key areas of risk to assure ourselves of at least Amber Green Governance rating in Quarter 3.

Decision required:	To note the contents of the report.
Freedom of Information (FOI) Status	This paper will be released on request.

1 RECOMMENDATIONS

The Board is asked to note the risks and actions contained within this report

2 CONTACT

Ian Stoneham, Commercial Director (0118 322 8777)

Royal Berkshire NHS
NHS Foundation Trust

Trust Board Integrated Performance Report October 2012

Reporting Period: September 2012 (Month 6)

Ian Stoneham – Commercial Director

Trust Board Integrated Performance Report

Executive Summary

Commercial Director

Governance

At the time of writing the cancer targets are still undergoing validation, however we expect that all of these targets with the exception of the two week wait suspected cancer target will be met in September and for Quarter 2. A plan is now in place to address the issues that impact the Trust in achieving the two week wait target, and this is set out within this paper and as part of the EPR Stabilisation Plan and we therefore expect to achieve the two week wait target in Quarter 3.

The other key governance issue facing the trust currently is delivery of the A&E 4 hour target and ambulance waits target The recovery plans for each of these risk areas is set out in this report. Without further community capacity in place, delivery of this standard in the second half of the year will prove challenging and therefore system wide discussions are underway to ensure partners hold each other responsible for the actions they have agreed to take within the agreed timescales. Delivery of both the internal and external actions will ensure that the A&E target will be met in Quarter 3, and the Executive will also be agreeing other remedial plans that need to be in place to support this achievement.

Our emergency attendances have increased by 10% in A&E and emergency admissions are up 3% year to date - a position reflected across the South of England. The Trust is doing everything it can to maintain safe, high quality care across all services, whilst implementing plans to recover performance for the associated A&E and ambulance access targets, further reduce delayed discharges and maintain financial balance.

The implementation of the EPR Cerner Millennium system continues to impact on the Trust's ability to manage performance. A stabilisation plan has been developed and agreed by the Executive and will be presented to the Board for approval. This will be performance managed on a weekly basis to ensure the Trust is doing everything it can to minimise the impact on patient experience, operational delivery and increased costs, whilst assuring an accurate activity and income position.

Finance

The Trust continues to be £3.0m adverse to budget which is being driven by reduced PCT activity, non delivery of CIPs and pay and non pay overspends. FRR of 3 is currently being maintained but only by the smallest of margins. The greatest risk to maintaining FRR of 3 in Quarter 3 is the ongoing EPR spend, non-delivery of CIPS, and Non Pay spend in Clinical Supplies and E&F.

The key opportunities are ; recovery of PCT activity levels, income CIPs, and transitional funding from the PCT.
The team are currently working alongside PwC to produce a recovery plan for 2012/13 CIPs. Full details of the financial position and key actions are set out in the Finance Board report.

Each Care Group is now producing a monthly performance report at specific Care Group level in the same format as this Trust Board report and are available to members of the Board if they wish to see them.

Monitor Governance Rating - Summary

Commercial Director

MONITOR Target or Indicator (per Compliance Framework 12/13)	Scoring	Target QTR	Q1	July	August	September	Q2
18 Weeks: admitted patients	1.0	90%	93.1%	90.5%	90.8%	90.9%	90.8%
18 Weeks: non-admitted patients	1.0	95%	99.3%	98.4%	98.8%	98.5%	98.6%
18 Weeks: patients on incomplete pathways monthly target (See Note*)	1.0	92%	92.3%	92.3%	92.6%	93.0%	92.6%
A&E: 4hr Limit	1.0	95%	95.2%	95.7%	93.6%	94.6%	94.6%
Meeting the C.Diff objective	1.0	19	7	-	4	1	**5**
Cancer 31 day wait: surgery	1.0	94%	98.4%	100.0%	100.0%	95.0%	98.3%
Cancer 31 day wait: anti cancer drug treatments		98%	99.1%	100.0%	100.0%	100.0%	100.0%
Cancer 31 day wait: radiotherapy		94%	94.4%	95.1%	96.1%	94.0%	95.1%
Cancer 62 day wait: GP Referral	1.0	85%	85.2%	87.6%	86.8%	81.9%	85.4%
Cancer 62 day wait: NHS cancer screening service		90%	87.2%	94.4%	90.9%	77.8%	87.7%
Cancer 31 day wait: to first treatment	0.5	96%	96.9%	98.6%	97.8%	93.5%	96.6%
Cancer 2 week wait: cancer suspected	0.5	93%	91.8%	90.4%	88.3%	91.6%	90.1%
Cancer 2 week wait: breast patients		93%	93.1%	94.9%	87.1%	85.7%	89.2%
Meeting the MRSA objective	1.0	0	0.0%	0.0%	-	-	-
Actual & Forecast Governance Ratings			AMBER-RED	GREEN	AMBER-GREEN	AMBER-GREEN	AMBER-GREEN

Note*: Performance across quarter 1 for the Incomplete Pathways target was 88% in April, 95% in May and 92% in June and the breach of this target in April has resulted in the service performance score being re-evaluated to 2.5 in Q1 and, therefore, Amber-Red. Performance has improved in Q2.

Please note that some of the results for September are still undergoing validation, however the expectation is that the only targets not achieved in September will be the A&E 4 hour target and the cancer 2 week wait target. The cancer two week wait target is expected to achieve in Quarter 3. The Commercial Director will give a verbal update on actual performance at the Trust Board meeting.

Care Quality Commission (CQC)

Medical Director

Target or Indicator (per Compliance Framework 12/13)	target YTD	Scoring		Results	Any comments or explanations
Failure to comply with requirements regarding access to healthcare for people with a learning disability	N/A	0.5		No	
Risk of, or actual, failure to deliver mandatory services	N/A	4.0		No	
CQC compliance action outstanding (as at 30 Sep 2012)	N/A	special		No	
CQC enforcement action within last 12 months (up to 30 Sep 2012)	N/A	special		No	
CQC enforcement notice currently in effect (as at 30 Sep 2012)	N/A	4.0		No	
Minor CQC concerns or impacts regarding the safety of healthcare provision (as at 30 Sep 2012)	N/A	special		No	
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 30 Sep 2012)	N/A	special		No	
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 30 Sep 2012)	N/A	2.0		No	
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative	N/A	2.0		No	
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A	special		No	
Has the Trust has been inspected by CQC (in the quarter ending 30 Sep 2012)	N/A	special	*5 Essential Standards were inspected*	Yes	*The Trust was found to be compliant with all the standards inspected within the CQC planned review of Dignity & Nutrition for Older People which took place at the Royal Berkshire Hospital on August 14th 2012.*
If so, did the CQC inspection find non compliance with 1 or more essential standards	N/A	special	0	No	

Inspections

- The Trust has received the draft CQC Review of Compliance following the Nutrition and Dignity Inspection for Older people carried out on Emmer Green and Mortimer Wards at the Royal Berkshire Hospital on August 14th, 2012. The Trust was found to be compliant with the five Outcomes reviewed and there were no compliance actions.
- The final CQC report of the Inspection of Safeguarding and Looked After Children's Services in West Berkshire that place in July 2012 has been received by the Trust. The Trust will be contributing to the action plan which is being co-ordinated by NHS Berkshire.

Quality & Risk Profile (QRP)

Within the September 30 2012 QRP there are no red or amber risks and the Outcome level risk rating at summary Outcome level is unchanged from the previous QRP. There are 10 low yellow, 2 high yellow, 3 high green and 1 low green Outcome level risks.

Financial Risk Rating

Finance Director

Monitor Equivalent Risk Rating

Criteria	Metrics	Actual
Achievement of Plan	EBITDA achieved (Actual as % of plan)	3
Underlying Performance	EBITDA margin (EBITDA as % of income).	3
Financial Efficiency	Return on assets excluding dividend (surplus as a % of average assets employed); I&E surplus margin net of dividend (surplus as a % of income).	2
Liquidity	Liquidity ratio (days)	3
Rating after overriding rules		2.6

Over-riding rules - Monitor
One financial criteria scored at 1 or 2 - max 2 or 3 respectively
Two financial criteria scored 1 or 2 - max 1 or 2 respectively
PDC dividend not paid in full - max 2

The key financial aim for 2012/13 is to maintain our FRR of 3 through:

- Surplus of £3.2m (1% of Income)
- Maintaining cash balance of £20m – can mitigate some slippage in surplus and maintain FRR 3 (as in 2011/12)

- Current surplus £3.0m adverse to budget driven by reduced PCT activity, non delivery of CIPs and pay and non pay overspends

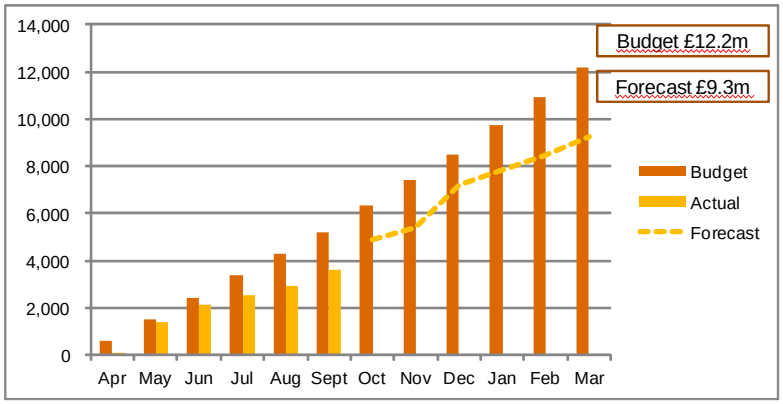
FRR of 3 maintained but only by the smallest of margins

Greatest risk to maintaining FRR of 3 in H2 is ongoing EPR spend, non-delivery of CIPS, Non Pay in Clinical Supplies and E&F

Key opportunities are ; recovery of PCT activity levels, income CIPs, and transitional funding from the PCT

Area of Review	Key Highlights	Month Rating	Projected Year End Rating
FRR	September YTD FRR 2.6 which rounds to a 3 for Monitor reporting		
Financial Position	YTD deficit of £(2.8)m vs budget £0.2m driven by variances in income and expenditure below.		
Activity/Income	YTD income of £160.5m, +£3.1m vs Budget with £1.7m of higher drugs income, £2.3m of incremental PCT funding, £1.0m settlement from prior year and some £1m of income CIPs all being offset by £1.8m of contract penalties and activity £2m behind budget in daycase and outpatients.		
Expenditure	YTD expenditure of £163.3m, £(5.9)m adverse vs Budget with pay £1.1m above budget, drugs £1.1m above budget (offset by incremental income), CIPs £0.9m below budget, EPR costs £750k above budget and estates some £0.5m above budget.		
EBITDA	YTD 5.4% vs Budget 7.3%		
Cash	Cash of £23.1m, vs Budget of £26.0m driven by lower EBITDA and higher capex		
Capital	YTD expenditure of £7.9m vs Budget of £7.2m driven by EPR		
CIPs	YTD delivery £3.6m , £(1.6)m behind plan		

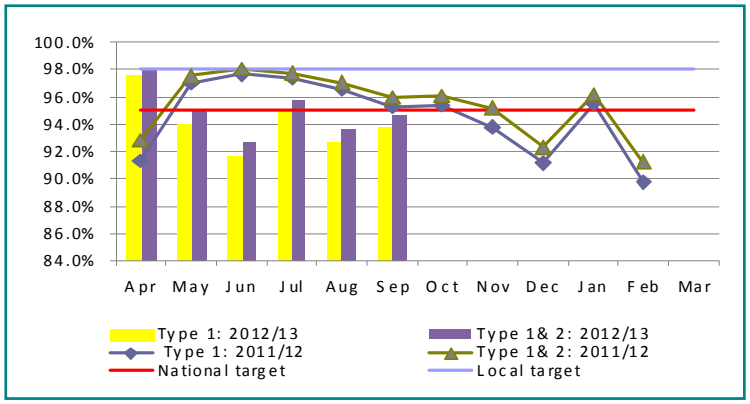
CIP Phasing - Cumulative Budget and Latest Forecast £'000



A& E & Ambulance Handovers

Director Urgent Care

Patient Experience	Exception Report 4: A&E performance							
	Target	**Apr-12**	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**Sep-12**	**YTD**
A&E attendances - Type 1 only	N/A	6,339	8,695	6,857	6,540	8,108	6,776	43,315
Seen within 4 hours - RBBH site Type 1 only	95%	97.54%	94.0%	91.6%	95.1%	92.7%	93.8%	94.0%
Seen within 4 hours - RBH site Type 1 & 2 only	95%	97.9%	94.9%	92.7%	95.7%	93.6%	94.6%	94.8%
Unplanned re-attendance rate	<5%	2.3%	1.9%	2.2%	2.2%	2.7%	2.3%	2.3%
Total time spent in A&E (95th percentile)	<4 hours	239	239	239	239	239	239	239
Left department without being seen	<5%	3.1%	4.2%	3.4%	3.7%	4.2%	3.6%	3.7%
Time to initial assessment (95th percentile)	<15 mins	0	0	0	0	0	0	0
Time to treatment in department (median)	<60 mins	66	75	77	64	58	62	67
Ambulance handover (emergency) H15 Compliance	<=15 mins	56.9%	58.2%	56.7%	63.2%	62.8%	71.2%	61.5%



A & E Target & Actions

- NEL activity has been 6% above same period last year (April – Sept)
- Inability to de-escalate within RBFT during the summer (21 beds de-escalated out of 76 escalation beds)
- Number of patients 'medically fit' to leave the Trust have remained between 48-60 daily

Performance

- Performance for EAT 4 hour standard for Q2 was below the standard at 94.6%.YTD position continues to be at risk at 94.8% and this pressure continues into Q3

Actions

- '50' additional care places to be identified across the health economy.
- Opening of Hurley Ward (10 beds available for remainder of winter)
- Reconfiguration of ED – additional options being considered, eg observation facility
- Service model options for managing daily NEL admissions and 7 day working across the Trust & consideration of temporary 'drop in' ward on RBFT site which would support ring-fencing elective beds and ensure continuation of elective work

Forecast – although achievement of this target will prove challenging without additional community capacity, the Executive are assured that delivery of these actions will enable the Trust to achieve the A&E target in Quarter 3 and will also agree other remedial plans to support it.

Ambulance Handovers -Action Plan

Admin post in place in ambulance arrived entrance in ED to co-ordinate and report ambulance breaches and provide early warning of any issues

Visit from Medical Director of SCAS has taken place. Actions from this visit include reviewing CDU processes as part of medical admissions management. SCAS to present their escalation process to inform a review of Trust escalation plans

'Smoothing' of GP expected ambulance arrivals throughout the day to reduce spike of arrivals in early evening. Evidence to inform a 'reasonable handover time' is being collated which will be discussed with Commissioners.

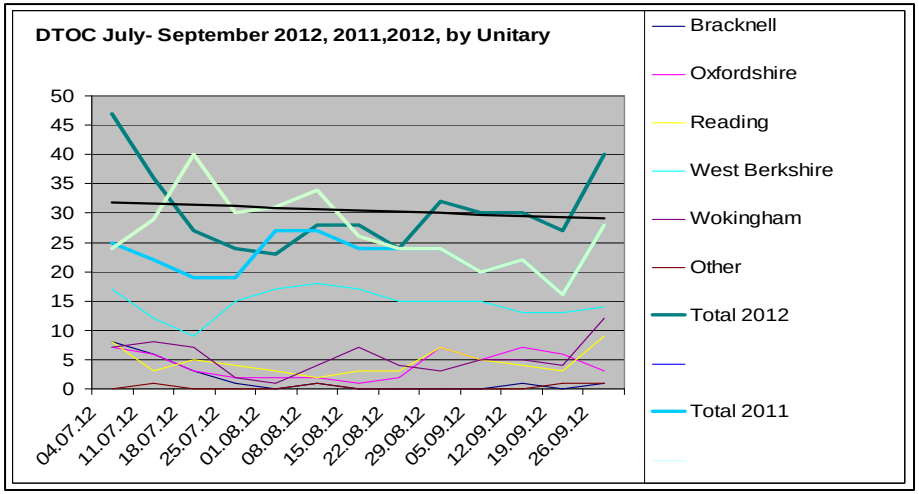
Senior nurse covering 'pre-triage' queue

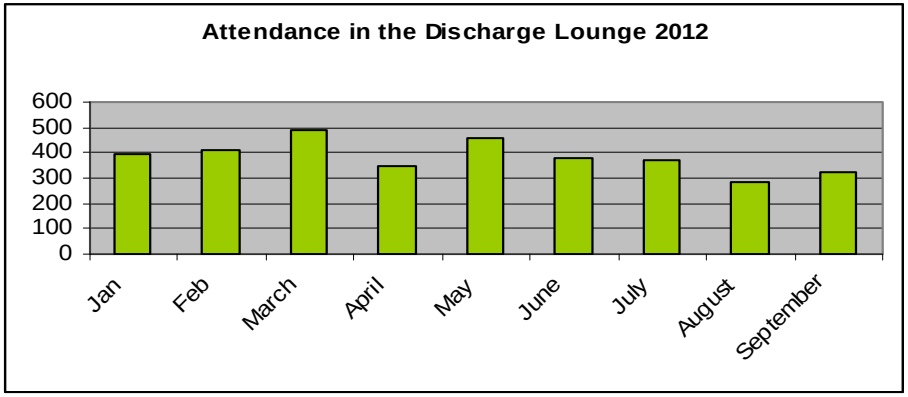
Delayed Transfers of Care

Director of Nursing

Delayed transfers by month

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	YTD
3.5% (CQC Target)	4.90%	5.74%	5.27%	6.28%	5.06%	5.80%	5.50%





Summary

During September the team assessed 247 people over the age of 65 in CDU and admission avoidance was achieved for 79 of them (32%).

The discharge lounge had 320 patients which was an increase of 35 on August and an increase of 78 as per September 2011, although figures were higher in the spring and early summer.

An interim measure has been put in place to address the conflict between West Berkshire Council and the PCT around continuing care funding. This is a short term measure which will ensure patients are moved on in a timely manner.

Actions

To meet weekly with West Berks Council and Continuing Healthcare to ensure West Berkshire patients are cared for in the right place.

The pan health economy winter capacity group has commenced fortnightly meetings. At October 24th an additional 15 of the 50 additional proposed beds has been provided. Actions include:

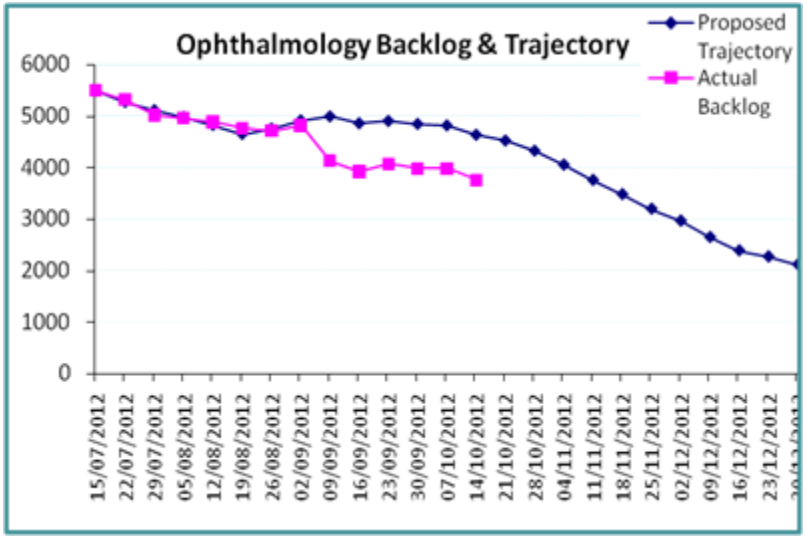
-'spot purchase' additional nursing home beds (Riverview)
- 7 day working and criteria review at Wills to utilise capacity
- Increase Intermediate Care capacity in Wokingham
- Single point of contact for all transfers of patients who are medically fit to go to maximise discharges
- Review service model for Service Navigation Team to give greater authority across the pathway and ensure patients are pulled through the system
- Work with GP's and SCAS to smooth out surge of GP referrals across the day

18 Weeks Targets

Director Planned Care

Planned Care - 18 Weeks Performance – September 2012

Specialty	Admit	Non Admitted	Incompletes
General Surgery	94.5%	98.3%	90.7%
Urology	88.4%	96.9%	85.7%
T&O	92.0%	98.2%	91.7%
ENT	94.7%	98.3%	96.3%
Ophthalmology	84.6%	98.5%	93.0%
Oral Surgery	85.5%	95.2%	87.5%
Plastic Surgery	95.2%	100.0%	92.4%
Gastroenterology	100.0 %	97.2%	93.8%
Gynaecology	92.2%	98.6%	88.3%
Trust Total	90.9%	98.5%	93.0%
B.W Total	90.3%	98.4%	93.0%



Context

The Incomplete target was achieved in September but the focus is now at specialty level. An action plan has been agreed with the PCT to address this – see below. Oral Surgery failed to achieve the admitted and non admitted targets in September. Remedial action plan (below) has been agreed with the PCT.

The failure of Urology and Ophthalmology is due to data quality issues.

Action Incomplete Pathways – action agreed with the PCT:

- Improvement of data quality through rigorous revalidation of breaches
- Ongoing programme of validation to be implemented to ensure consistent improvement in data quality
- It is expected that the majority of cases being flagged as breaches are data quality issues. Validation to data has shown that 75% of breaches currently shown can be removed. Re-run of September position is expected to show marked improvement.

Oral Surgery breaches – action agreed with PCT:

- Increase minor op sessions (MOS) capacity of up to 6 slots (2 sessions) per week by reviewing the skill mix of available doctors. Revised timetables with effect from 19/10/2012.
- Following 3 month post implementation review of EPR clinic .administration & SOPs some procedural changes are required.
- Review the DF2 contract. The current 6-8 week rotation and skills range can result in the cancellation/reduction of clinics, exacerbated by study days and Oxford Audit.
- Ensure adequate supervision by all Consultants of all grades of medical staff.
- Review potential of accommodating inpatients with co-morbidities on Dorrell Ward.

Graph 1 – Ophthalmology Backlog

The current total backlog stands at 3768, broken down as follows:

- 1841 – East Berks
- 1508 - West Berks
- 491 – other

The initial backlog stood at 5498. The reduction is 1730.

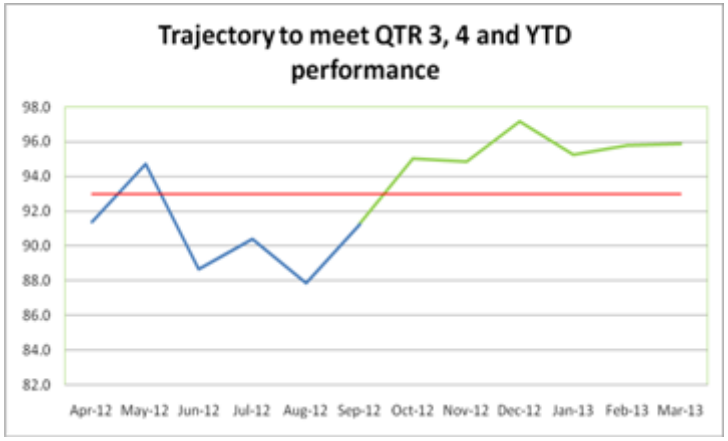
The backlog is reducing at a average rate of 133 p/wk. Additional activity is 570 p/wk (additions coming onto backlog). The reduction is ahead of that agreed with the PCT as shown in the trajectory graph. We expect c470 to be on the backlog at any one time.

Cancer Targets

Director Planned Care

	Target	May-12	Jun-12	Jul-12	Aug-12	Sep-12	YTD
		Trust	Trust				Trust
Two Week Wait	93%	93.4%	88.8%	90.5%	88.3%	91.6%	90.5%
2 week wait breast symptom	93%	97.4%	84.0%	94.9%	87.1%	85.7%	92.6%
31 day 1st treated	96%	94.4%	96.9%	97.9%	97.8%	93.5%	97.1%
31 day Chemo.	98%	95.9%	100%	100%	100%	100%	99.5%
31 day Surgery	94%	100%	88%	100%	100%	95%	98.2%
31 day Radiotherapy	94%	85.7%	100.0 %	92.9%	96.1%	94.0%	94.8%
Other	94%	100%	100%	100%	100%	100%	100.0 %
62 day (2ww)	85%	81.2%	83.3%	85.5%	86.8%	81.9%	85.7%
62 day screening	90%	90.9%	82.6%	94.1%	90.9%	77.8%	89.2%
62 day upgrade	Not pub	66.7%	100%	100.0 %	100.0 %	No Treatment	84.6%

Graph 1 - 2WW Performance



Context

September no's are still undergoing validation, however the expectation is that only the two week wait suspected cancer will not achieve in September. Based on the actions being taken below we expect to achieve the two week wait cancer target in Quarter 3.

Two Week Target – Actions for Recovery

•Review process for booking 1st appointments for suspected cancer patients. Any apt not booked within 48hrs of receipt will be escalated to the Dir Ops for appropriate action.
• Increase the resources within the 2ww booking team, increasing by 0.8 WTE.
• Publish Cancer specific PTL, on Trust reporting website, to improve visibility of breaches.
• Improved 2ww validation – 1 wk. backlog of validations to give a more accurate review of performance
• Workshop set up with PCT/TVCN

2ww - Dermatology - The locum consultant clinics have been expanded by 2 extra clinics per month.

2ww - Respiratory - 3 more 2WW outpatient appts. have been made available per week. A business case is being written for another consultant post.

2ww -Breast - Breast continues to have significant patient choice issues affecting performance. Discussions with the PCT to review access rules around patient choice – Thames Valley have accepted the access policy Swindon have produced, which states patients who choose to extend beyond 2 weeks or are on holiday for the whole 2 weeks, will have their referral date deferred. Had these rules applied in September for us, we would not have failed the target.

2ww -Endoscopy - The locum Consultant post has being interviewed and Fellow has been approved. The appointments will be made in line with the planned re-opening of the endoscopy suite at WBCH mid November. This will provide an additional 15 to 20 colonoscopies per week (majority for suspected cancer). 10 new outpatient appointments will also be provided. Additional endoscopy lists are running on every Thursday through October providing an additional 20 endoscopies.

2ww - Gastroenterology - The locum consultant post detailed above will contribute to 10 new outpatient appts per week. This will either take 2WWs or allow routines be moved from existing clinics for 2WWs.

Radiology - CT capacity has improved and the achievement of the 2WW target for diagnostic apts. is predicted

Forecast

All targets, apart from 2WWs, will be achieved for Q2 after validation. Quarter 3 2WW will be achieved.

Planned Care Activity Recovery Plan

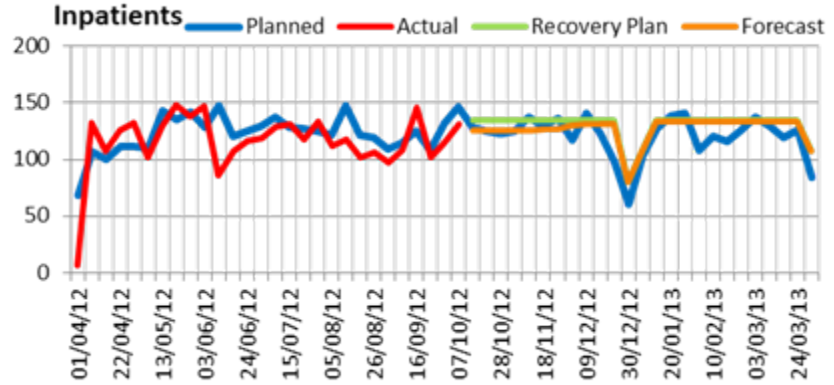
Director Planned Care

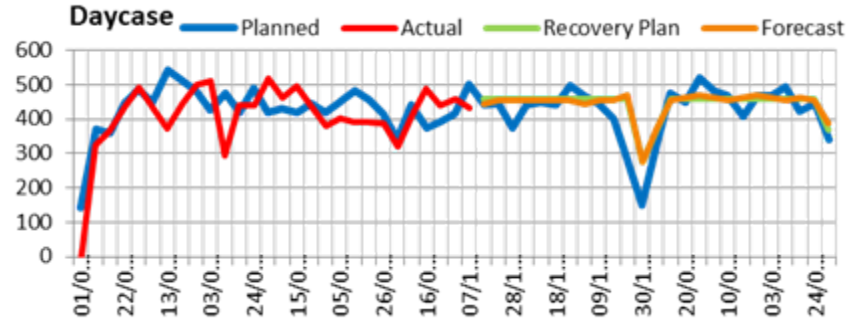
Activity recovery plans are collated from all specialties.

Urology Daycase recovery plan has been adjusted down by 781 to account for cystoscopies included in the plan which are now performed as OPPs.

There are also 106 Inpatients and 76 day cases which have been blocked from coming through into activity data as they were entered/corrected beyond freeze date. Due to freeze date extension, these should come through into activity data in due course.

Year End v Plan: IP +62; DC +51 (Inc. adjustments as mentioned above)





Speciality Recovery Plans

Cancer - Inpatient activity is poor against plan as admissions have been recorded as emergencies since EPR go-live. We are investigating which of these should be converted to electives. Given the low numbers this should be recoverable. Year End v Plan: IP -75 ; DC -95

ENT – Day case activity is on plan to achieve activity plan at year end based on run rate. Inpatient activity has a gap of 5 cases per week based on current run rate. This will remain challenging as there is a small pool of patients to select for overnight cases. Year End v Plan: IP -109 ; DC 0

Gynae - Forecast is based on Gynaecology running at 80% capacity (on average they have lost 3/14 lists since their theatres went down) and recovering 10% at 01/12/12 and the other 10% at 01/01/2013. Using these assumptions, at year end Inpatients will be down by 71 against plan, while day cases will be 101 up against plan. Year End v Plan: IP -96 ; DC +156

Ophthalmology - Inpatients are ahead of plan and are forecast to be ahead of plan by 73 at year end. At current run rate, day cases will end the year 21 below plan, however, lists at PCEU are now being proactively filled with patients from RBH where there are gaps, reducing RBH waiting times and ensuring that activity levels will be maintained. Year end v Plan: IP +74 ; DC +29.

Oral Surgery - Inpatients are below plan. Although there is a plan to have Inpatients, this was never agreed with nursing staff. Arrangements are being made to recommence treating overnight patients on Dorrell, and 1 case per week is enough to recover to plan, so we expect this to be achieved. Day cases are 3 below plan per week at current run rates. One all-day Saturday list will be run per month, treating 15 additional day cases each. Year End v Plan: IP 0 ; DC 0

General Surgery - General Surgery is forecast to be 146 inpatients ahead of plan at year end, while day cases are forecast at 259 below plan. Saturday lists, outsourcing and evening lists will continue in efforts to achieve the activity plan. Year End v Plan: IP +169 ; DC -111

T&O - T&O had a small gap against plan and have taken the following actions:
6 extra lists for caudal epidurals (60 patients total) to bring day cases back on plan. Additional capacity once Gynae theatres reopens will allow an extra 3 Inpatient cases per week from 01/12/12.Year End v Plan: IP +31 ; DC -24

Urology - Extra Saturday lists are running until Christmas, providing an additional 3 Inpatients and 6 day cases per list. From January, capacity will increase by the all-day list currently given up to Gynae, which will provide an additional 9 day cases per week. Year End v Plan: IP -104 ; DC -997 (when adjusted for cystoscopies, -209)

Maternity Dashboard

Director Urgent Care

		RAG rating paramaters													
		Goal / green	Red flag	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Births	Benchmarked to 5900 per annum	< 466 per month	> 520 per month	491	491	473	504	518	521						
Normal Vaginal Deliveries	SVD (proportion of total)	63%	<60%	56%	61%	59%	56%	60%	59%						
Rushey Midwifery led Unit	No of deliveries (proportion of total)	10%	<7%	15%	14%	14%	14%	14%	15%						
Hoembirths	No of deliveries (proportion of total)	> 5%	< 3%	3%	4%	3%	3%	2%	2%						
1:1 care in labour	Midwife care to women in established labour	>98%	<96%	95%	98%	98%	99%	97%	98%						
Caesarean sections	Elective	10%	> 11.4%	11%	12%	12%	13%	11%	12%						
	Emergency	13%	> 15%	16%	15%	12%	14%	13%	15.5%						
Staffing **	Hours per week of dedicated senior obstetric time on delivery suite	60 hrs	< 60 hrs	68.6	70.5	65	65	90							
	Midwife : birth ratio	1:34	>1:36	1:33	1:36	1:35	1:36	1:37	1:40						
	Midwifery vacancies	< 5%	> 10%	4.4%	6%	5%	7%	10.5%	10%						
Complaints	No of Complaints	<3	>7	5	5	2	2	4	4						
	No of times unit diversion policy implemented	<1	>3	2	2	2	8	6	2						
	No of times unit attempted to divert but no other unit able to accept	0	1 or more					1	1						

** Please note as from Aug 12 figures reported are 'consultant and post CCT' obstetric cover. Prior to Aug 12 the figures are consultants only.

- Number of births is to be monitored monthly. If the trend continues to rise this will be discussed with commissioners and SHA.
- The normal birth rate will increase when all 4 rooms are opened on Rushey Ward when midwifery staffing levels permit.
- The Consultant team and senior midwives are meeting in November to discuss additional suggestions for reducing caesarean sections. The consultant midwife is collecting information on the Robson criteria - a tool used to analyse caesarean sections. This information is being shared with the teams.
- Midwifery staffing levels - actions included in risk section. Midwife to birth ratio using TUW for September was 1:37; however this is not in line with our trajectory to achieve 1:32
- Unit diversions - The Strategic review of maternity service capacity across Berkshire, Oxfordshire and Hampshire commissioned by the PCT has commenced. Solutions for Public Health have been employed to gather information and to map current and future capacity needs. Their report will be completed by the end of the year. The report on the options study for the strategic development of the maternity block was presented to the Urgent Care Board. The options presented are to be discussed with the Director of Estates by the end of October

Stroke Targets

Director Urgent Care

	Targets	June	July	August	September
Proportion of people with high risk TIA fully investigated and treated within 24 hrs (national NHS target)	60% by April 2011	89%	87.5%	100%	100%
Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	90% by April 2011	64.9%	46.4%	52.4%	50%
Proportion of stroke patients scanned within 24 hours of hospital arrival	100% by April 2011	85.7%	90.9%	85.4%	89.1%
Proportion of patients spending 90% of their inpatient stay on a specialist stroke unit (national NHS target)	80% by April 2011	93%	80.4%	83.3%	84.8%

Context:

Increase in East Berks patients and above projected figure in original business case

Actions:

- Business case for more capacity in the community led by PCT is nearly complete.
- The majority of breaches result from delays in clerking in A&E.
- 2 pts unscanned – 1 on LCP and 1 was a repatriation that came in.
- Senior triage commenced in A&E in September.
- Issues flagging patients due to EPR and lack of Bed man functionality (discussions in progress)
- Additional 12 stroke rehab beds identified on Caversham as part of bed reconfiguration.
- HASU beds increased from 2 to 5.

Cost Improvement Programme

Finance Director

PMO Governance Report September 2012 - CIPs

Project Description	Exec Sponsor	In Year Annual Plan Target (000's)	Mth 6 Actual 12/13 (£000's)	YTD Actual (000's)	RAG (based on CIP delivery)	Current Risk Rated Forecast (000's)	PCT Transformation Investment (Year to date)	Comments & Progress
Efficient Resource Planning, including: Trust wide skill mix review Corporate function review Active Management of vacancies Stopping of EPR PAs	Director of Workforce & OD	£1,000	£186	£1,015	Green	£1,393		The £1m in year target on pay CIPs has now been achieved, primarily due to the delivery of nursing pay across the 3 care groups, and the management of vacancies during the summer period by the Urgent Care Group. Other CIPs are at risk however, for example the CDU triage, which is impacted by the high volume of activity at ED and the delayed transfers of care, and the review of the back office, which suggests very little cost savings opportunity although a project is now being taken forward to improve the contact centre which is likely to lead to significant productivity gains. The initial benchmarking report from Deloittes has been received and shows the Trust overall to be the most efficient amongst its peers, although there are potential areas of focus such as the number of medics, and number of senior management staff that require further review.
Efficient Capacity Planning, including: Review of Outpatients Review of theatre utilisation Decontamination contract & services Pathology shared services Bed base review	Commercial Director	£2,500	£0	£0	Red	£673	£1,500	The decontamination contract will be presented to the October Board for signature, with savings tracked from 1 April 2012, delivering £550k in year. A separate Board paper will be presented seeking approval to take forward the pathology transformation programme encompassing the in house collaboration with HWPH. The savings opportunity is c£3m recurrently p.a., however the timescale suggests that this may not be fully delivered in 2012/13. Incremental support of £1.5m received from BWPCT in recognition of high numbers of medically fit for discharge patients within the Trust, which has impacted on our ability to deliver CIP savings in this area (the original aspiration being to close down half a ward through the bed reconfiguration). Opportunities to deliver cost savings within outpatient clinics is now being reviewed looking at both skill mix and utilisation of clinics.
Efficient Procurement & Stock Control	Finance Director	£3,000	£182	£917	Amber	£2,554		Procurement continue to work across all functions of the Trust to deliver a further £3m of in year savings. A work shop was held with Care Groups on 17th October to identify additional projects to meet the current shortfall of £500k - these are now being developed and the teams will be meeting weekly to drive these through to implementation.
Drugs Spend, including: Review of Trust formulary Policing of non formulary Reduction in FP10 usage Review of cancer regimes	Networked care Group Director	£1,000	£38	£362	Amber	£574		Several initiatives have now been identified as offering savings with work being finalised to identify the value of these savings. A separate piece of work to review the cancer regimes has also commenced. One of the key actions of the drug CIP group is to re-negotiate the current arrangement with Baxters who provide the Trust's chemo drugs - currently the Trust pay a premium price per unit. A meeting with them is set for 9th November. A longer term project to review the options available to the Trust for the aseptics service has commenced. This will compare the benefits of moving to an in-house option with tendering the service.
Efficient Infrastructure & IT, including: Review of EPR contract with Cerner De-scoping of CSC contract Various individual estates & facilities projects	Finance Director & Director Estates & Facilities	£2,000	£4	£18	Red	£764		Estates & Facilities are currently reviewing their project plans to determine the level of savings for Q3&Q4. However the majority of their projects are income generation schemes rather than savings (see separate income CIP report). Negotiations with both Cerner and CSC are now concluding and suggest a positive outcome for CIP delivery.
Carry Forward projects from FY11/12	Finance Director	£3,000	£300	£1,300	Green	£3,304		The carry forward value of CIP projects from last year (full year effect) is £3.3m - this is phased to show c£1m achieved in each of the first 3 quarters in line with the budget set at the start of the year.
TOTAL CIPs FY 12/13		**£12,500**	**£711**	**£3,611**		**£9,262**	**£1,500**	

<u>September 2012 Trust Spend:</u> **Pay £15.6m** **Non Pay (excl. drugs) £9.3m** **Drugs £2.7m**	Year to date, the Trust has achieved £3.6m of CIPs but is behind plan against the original phasing. The PMO year end forecast remains at £9.2m, i.e. a shortfall of over £3m. Delivery of the capacity CIP (originally targeted at £500k) has been impacted by the volume of medically fit for discharge patients remaining in the Trust, and therefore as shown above, PCT support has been given in the first two quarters to recognise this and mitigate the non delivery. The QIPP Programme Board continues to meet fortnightly to drive forward the current CIPs and a CIP recovery plan for 2012/13 is underway, with the Exec working alongside PwC to identify current CIPs that can be pushed forward, and identification of new opportunities. The negotiations with CSC & Cerner are nearing completion and the outcome is likely to have a significant positive impact on the year end forecast.

Income CIPs

Finance Director

PMO Governance Report September 2012 - IIPs

Project Description	Exec Sponsor	In Year Annual Plan Target (000's)	Mth 6 Actual 12/13 (£000's)	YTD Actual (000's)	RAG (based on CIP delivery)	Current Risk Rated Forecast (000's)	PCT Transformation Investment	Comments
CQUINs, including: End of Life Dementia Reduce Elective Admissions Improvement in management of Unscheduled Care	Chief Nurse	£2,500	£481	£1,044	Amber	£2,114	£0	The Dementia scheme is working with EPR to find a more suitable way of reporting which is impacting on the forecast. The Sepsis CQUIN requires some investment to help to speed up the diagnoisis of Septic patients, thereby initiating quicker treatment within the CQUIN timescales.
Estates & Facilities, including: Asset rationalisation of Battle Site Car Parking barriers Recharge to 3rd parties	Director of Estates & Facilities	£1,138	£8	£11	Amber	£706	£0	The car parking barriers will be installed at the end of October to provide additional income. A final offer has been received for the Battle site from the developers but requires agreement from SCAS who own the remaining section of the proposed site.
Planned Care, including: Private Patient Income Sale of Infusion Pumps Enhanced EDL process	Clinical Care Group Director, Planned Care	£1,355	£129	£607	Amber	£1,071	£0	Private patient income continues to deliver against its target. The sale of the old infusion pumps will commence in Q4 following the approval of the new contract.
Urgent Care, including: HDU for Paeds	Clinical Care Group Director, Urgent Care	£450	£30	£128	Amber	£353	£0	The income for HDU in paeds continues to deliver.
Networked Care, including: Private Provision of Orthoses South Oxfordshire Wheelchair Service	Clinical Care Group Director, Networked Care	£18	£0	£12	Amber	£12	£0	Networked care's smaller projects continue to deliver against target.
Trustwide, including: Clinical Coding	Chief Finance Officer	£1,000	£38	£204	Red	£204	£0	Clinical coding continues to deliver a steady stream of income but an overoptimistic forecast means there is little chance of succeeding against this target.
TOTAL IIPs FY 12/13		**£6,461**	**£687**	**£2,005**		**£4,460**	**£0**	

September 2012 Trust Spend:
Pay £15.9m
Non Pay (excl. drugs) £8.3m
Drugs £2.7m

The current PMO risk rating of the IIP programme is £4.4m against an original target of £4.2m. Income schemes are being driven across the Care Groups with regular monthly meetings with the Directors of Ops and Directors of Finance and the PMO Care Group Leads. This provides an opportunity to review existing schemes as well as pursue other opportunities. A separate report to show CIPs and IIPs will now be provided enabling a more rigorous scrutiny of this work to take place.

Patient Experience – Feedback

Director of Nursing

NHS Choices Feedback	Number of responses	% recommendations
Frimley Park Hospital	89/102	87
Great Western Swindon	37/46	80
Hampshire Hospitals	27/36	75
Royal Berkshire Hospital	51/70	72
Oxford University Hospitals	34/47	72
Wexham Park Hospital	34/50	68

NHS Choices Feedback

We have continued to see a slight increase in feedback to NHS choices following promotion of the site earlier in the year. There were 3 positive and 1 negative comments posted in the last month.

Every comment posted is followed up and responded to by the individual department leader and action plans put in place.

We continue to promote the website and aim to double the number of responses per month and improve recommendation to 80%.

Patient Experience CQUIN **Based on 5 questions in the in patient survey** **Designed to test whether care is personalised**	National survey (weighted)	In house survey (weighted)
Question	**2011 score**	**September 2012 score**
Were you involved as you wanted to be in decisions about your care and treatment?	72	83
Did you find someone to talk to about worries and fears?	57	84
Were you given enough privacy when discussing your condition and treatment	82	89
Were you told about medication side effects to watch out for when you went home?	43	81
Were you told who to contact if you were worried about your condition after you left hospital?	80	90
Total composite score	66.8	85.4
Aim		70

Patient Experience

During September patient experience walkabouts have been carried out on Sonning ward and in the Audiology department. Positive feedback was received from patients and staff.

A customer care training programme is in place for ward clerks and Health Care Assistants. There are plan's afoot to use video's of patient stories to further inform this important training.

A young persons task group is being established to gain specific feedback from teenagers using artistic methods to understand what the most important things are for them when being treated in hospital.

Planned care group are focusing on improvement to the pre-assessment process and pathway.

Networked care have commenced a "welcoming ward" project.

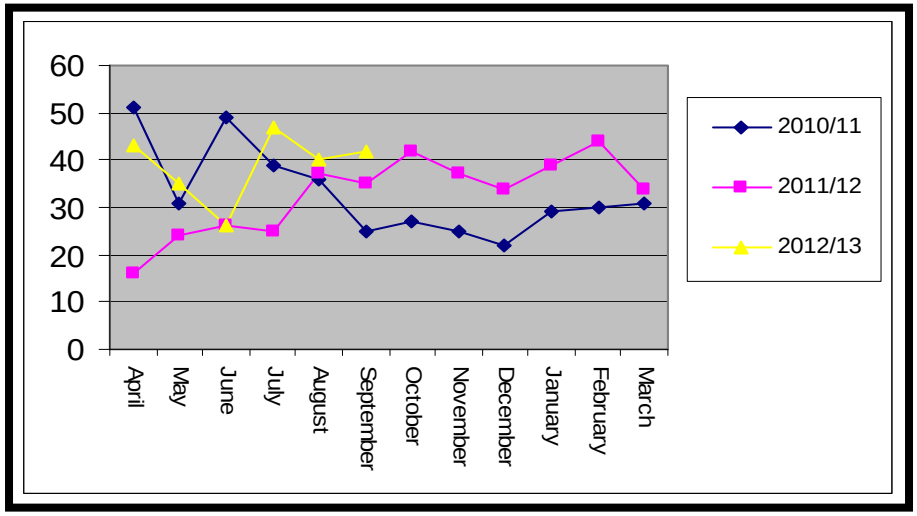
Patient satisfaction survey results (in house)	April	May	June	July	Aug	Sept
Overall rating recommendation rate	93%	96%	91%	97%	97%	97%

Patient Experience – Complaints

Director of Nursing

Complaints and PALS from July – September 2012				
	Complaints	**% response within 25 days**	**% response within 25 days or agreed extension**	**PALS**
July	47	30%	65%	375
August	40	30%	77%	374
September	42	19%	62%	231

Formal complaints received each month



Complaints referred to Ombudsman

No complaints were referred to the Ombudsman during September.

PALS

PALS queries have reduced significantly this month, mainly due to a reduction in EPR/Appointment related queries.

Complaint themes

The top 3 themes during September were:

•clinical treatment by doctor (13)

• communication by the doctor (9)

• administration (7)

Complaints relating to behaviour/communication and attitude have reduced significantly during September.

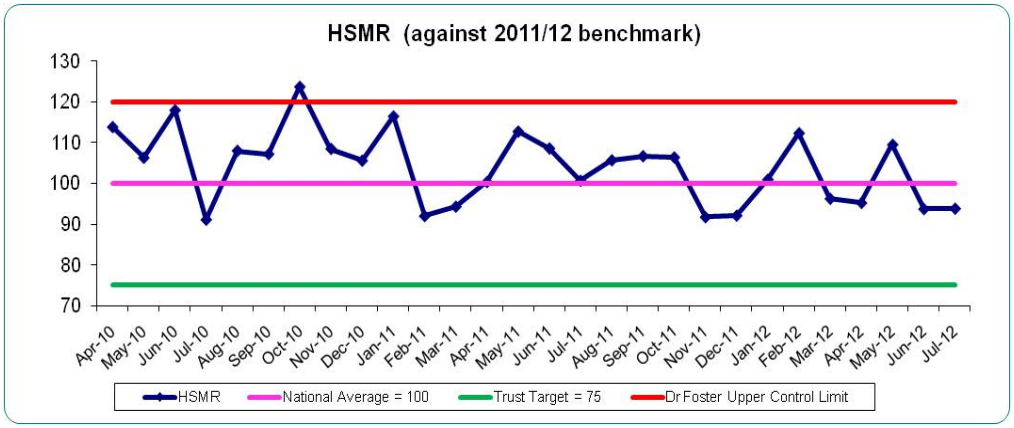
Care group action plans are in place. Themes and action plans are reviewed and monitored at Directorate and Care Group governance meetings.

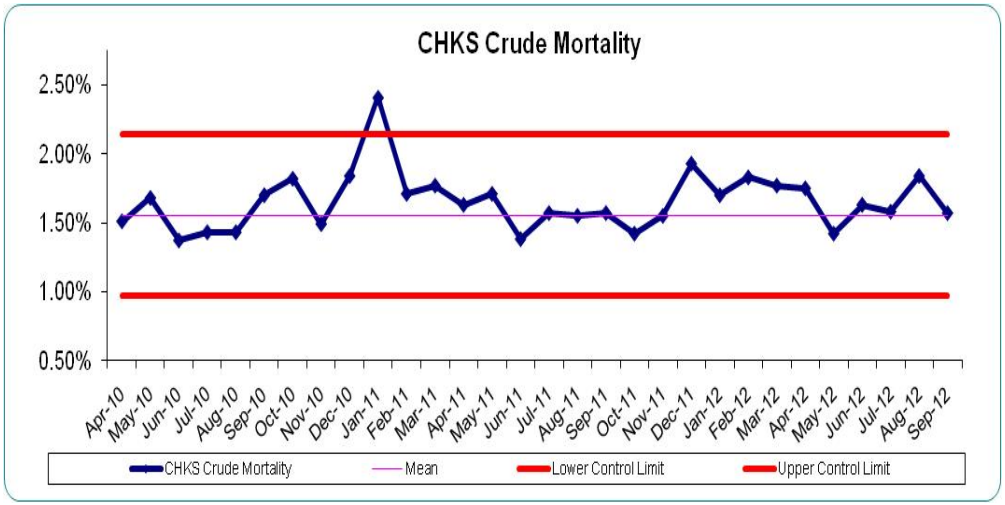
Response times

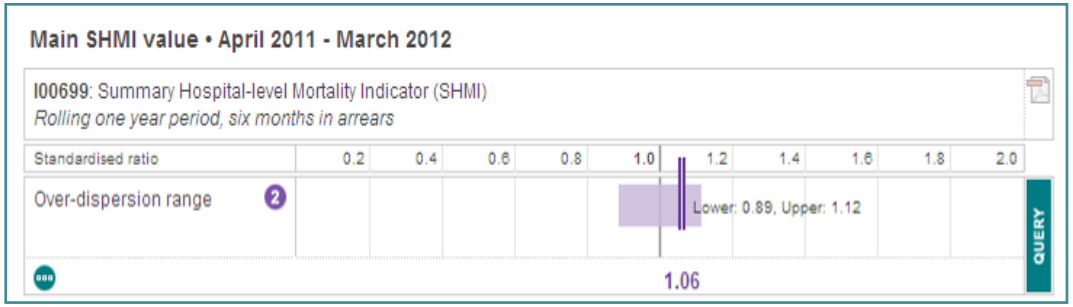
Response times continue to be of concern. The Director of Nursing has commenced a Trust wide review of complaints handling which will involve all Care Group and Directorate management teams.

Mortality and HSMR

Medical Director







Context

The HSMR for 2012/13 (Apr -Jul 12) is 92.3 (within expected range)

•The HSMR 12 months rolling (Aug-11 to Jul-12) is 96.5 (within expected range)

•The HSMR for elective admissions 12 months rolling (Aug-11 to Jul-12) is 126.3 (26 patient deaths out of an expected 21) – this is within the expected range. This is an improvement on last month when it was higher than the expected range.

•The HSMR for elective admissions in General Surgery 12 months rolling (Aug-11 to Jul-12) is 73.1 (6 patient deaths out of an expected 8.2) – this is within the expected range.

•The Trust's monthly HSMR for Jul 12 (most recent validated monthly data) is 82.2 (within expected range , though above the Trust's target of 75)

•The CHKS crude mortality rate for Sep-12 is 1.57% (within expected range)

•The SHMI for Apr-11 to Mar-12 is 1.06 (within expected range)

Action

<u>Coding reviews from notes</u>

•All elderly care patients

•Patients who have had a therapeutic endoscopic procedures on biliary tract – dedicated consultant engagement in coding process

•All deceased patients

<u>Outliers</u>

•Reviewed monthly - To date no areas of patient safety concern have been identified

•<u>Quality Improvement</u>

•Surgical high dependency unit to be in place by Dec 2012

•Improved co-morbidity coding directly from notes

•Bi-annual audit of 50 patients used to identify learning

•Joint project with GPs initiated to review deaths 30 days after discharge

Clinical Effectiveness

Medical Director

Dr Foster Patient Safety Indicators

Indicator	Oct-11	Jul-12	Observed	Expected	Observed rate/K	Expected rate/K
Deaths in low-risk diagnosis groups*			9	24.4	0.25	0.68
Decubitus Ulcer			285	234.2	28.75	23.62
Deaths after surgery			40	46.6	111.42	129.84
Infections associated with central line*			0	0.8	0.00	0.05
Post-operative hip fracture*			0	1.9	0.00	0.07
Post-op Haemorrhage or Haematoma			10	17.2	0.34	0.59
Post-operative physiologic and metabolic derangements*			2	2.0	0.08	0.08
Post-operative respiratory failure			17	16.4	0.72	0.69
Post-operative pulmonary embolism or deep vein thrombosis			64	48.5	2.16	1.63
Post-operative sepsis			3	5.2	3.05	5.33
Post-operative wound dehiscence*			3	1.4	2.56	1.18
Accidental puncture or laceration			72	66.5	1.17	1.11
Obstetric trauma - vaginal delivery with instrument*			71	71.5	82.08	82.71
Obstetric trauma - vaginal delivery without instrument*			83	118.9	26.08	37.37
Obstetric trauma - caesarean delivery*			2	5.2	1.31	3.43

CHKS Indicators - RBFT compared to best 12 Trusts

Indicator	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012
Average Length of Stay (Spell)	2.5	2.5	2.5	2.6	2.7	2.6
Complication Rate - Attributed (Spell)%	1.0	1.0	0.9	0.7	0.6	0.3
Complication Rate - Treated (Spell) %	2.5	2.2	2.2	2.5	2.1	1.3
Data Quality (FCE)	92.5	92.6	86.5	84.0	83.6	59.6
Day Cases (Spell) %	77.5	78.7	78.8	79.1	79.7	79.1
Day Cases - Basket of 25 (Spell) %	85.7	86.4	84.4	85.3	83.8	85.0
Misadventure Rate (Spell) %	0.11	0.15	0.09	0.09	0.12	0.05

> 5% better
>0% < 5% better
<5% > 10% worse
<5% > 0% better
<1% > 5% worse

Context

The Dr Foster Patient Safety Indicators are adapted from the set of 20 devised by the Agency of Healthcare Research and Quality (AHRQ) in the US. As can be seen, comparing data in October 2011 to July 2012, shows that we have changed status red/green in some areas

Pressure ulcers have increased to worse than expected (green to red). This is due to coding from notes in Elderly Care from October 2011, which means that more pressure ulcers are coded.

Accidental Punctures have decreased to average (red to blue). This is due to an active review by coding of any record where the EDL has generated this code, and a review of the notes to confirm/refute the code. This change to process was undertaken following a review by the Dr Foster Outliers Review Group. There has been very good engagement with the General Surgeons in further review of these cases.

Better than expected

Deaths in low-risk diagnosis groups have decreased to better than expected

Obstetric trauma - vaginal delivery without instrument has decreased to better than expected

CHKS

In comparison to the best 12 trusts (peer 3), we are within or better than expected for the majority of indicators. However, we are worse than expected for complication rate treated and data quality in September 2012.

Action

VTE post-op this has increased to worse than expected (blue to red) this month. The 40 patients who developed VTE post-op from January 2012 are undergoing review. On an initial look 18/40 did not appear to have VTE in their current admission.

Workforce Summary

Director of HR

	Month Target / Limit	Sep 2012						
		Trust	Urgent	Planned	Networked	Corporate	E&F	Corporate & E&F
Workforce turnover %	1.0	1.6	1.9	1.3	2.0	2.6	0.2	1.2
Vacancy rate %	5.0	5.2	5.2	6.6	-3.5	16.1	10.0	12.8
Sickness rate % (previous month)	2.8	3.0	3.1	3.4	2.1	1.4	4.7	3.3
Agency spend % of total staff cost	5.3	7.4	11.6	7.0	4.4	4.0	0.0	4.0
Appraisal rate %	95.0	70.7	71.8	59.8	79.6	63.8	83.8	76.4
Medics EWTD compliance %	100.0							

	12 Month Target / Limit	Rolling 12 Months to Sep 2012						
		Trust	Urgent	Planned	Networked	Corporate	E&F	Corporate & E&F
Workforce turnover %	12.0	13.3	12.8	13.3	15.5	17.2	6.0	11.1
Vacancy rate %	5.0							
Sickness rate % (previous month)	2.8	3.3	3.4	3.4	3.0	2.0	4.7	3.4
Agency spend % of total staff cost	5.3							
Appraisal rate %	95.0	70.7	71.8	59.8	79.6	63.8	83.8	76.4
Medics EWTD compliance %	100.0							

	Mandatory training rate	
	Patient related	Generic
Trust Total		
Planned Care		
Networked Care		
Urgent Care		
Corporate Total		
Chief Exec & Non-Execs		
Chief Medical Officer		
Chief Nursing Officer		
Commercial Directorate		
Corporate Affairs		
Estates & Facilities		
Finance		
Human Resources		
IT		

Code: Each course is rated as follows:
Red Less than 50% attendance
Amber 50-74% attendance
Green 75% and above attendance.

The compliance rates are then aggregated to produce an overall rating based on:

Patient focussed training :
Red 2 or more are at red
Amber 1 is red or amber
Green No reds and 1 amber

Generic focussed training:
Red 3 or more are at red
Amber 2 are red or amber
Green No reds and 1 amber

Current Position

Urgent Care Group : focus on recruitment of nursing staff both for the quality of care to our patients and also to reduce the rising cost of agency / NHSp shifts being used.

Estates &Facilities: Several recruitment activities are currently underway to address to vacancy rates both within estates & facilities. Long term sickness has improved in the estates and facilities staff after close management .

Planned Care Group: Following an increase in turnover in August 12 analysis of September 12 shows a decreased in turnover . Appraisals have increased and whilst this is positive PCG is still below trajectory

Networked Care group: Budgeted WTE was reduced in order to apply vacancy factor to each area. Currently 31.1 WTEs not working due to maternity/adoption leave, career breaks or external secondment. Pay Bill is currently under spent at the end of September by £206,000.

Mandatory Training: A revised system has been developed that now gives visibility on mandatory training rates.

Action –
E&F: Further work to be completed on management of sickness absence,.

PCG: The focus on appraisal is ongoing, with meetings held between Directorate Managers and Matrons to discuss their plans to ensure 95% completion rate by year end. A review of the reasons for absence is being undertaken .

NCG: All vacancies recruited to in Care Group are signed off by the Care Group Board and the financial impact closely monitored by the Finance Director to ensure pay remains within budget.

Mandatory training: The new system giving visibility is being data validated.
Mandatory trainers now increased capacity to meet demand
Further review of training to reduce requirements is being undertaken.

Appendices

Key Performance Indicators

Key Performance Indicators

	Target 2012/13	Out-turn 2011/12	Q1	Jul-12	Aug-12	Sep-12	Q2	YTD	Organisation requiring data: Monitor	DOH	CQC	PCT	Board
Patient Experience (1) Board Responsibility: Director of Nursing Caroline Ainslie													
Complaints - % timely response	90%	93%	77%	65%	77%	62%	68%	73%				X	X
Number of formal complaints received	-	393	104	47	40	42	129	233				X	X
Complaints received relating to behaviour and attitude	4.3	4.76	14	1	4	1	6	20					X
Patient Survey - Overall rating	-	94%	93%	97%	97%	97%	97%	95%		X		X	X
Inpatient survey question: "Involved as much as desired in decisions about care and treatment"	85	83	84	89	86	83	86	85					X
Inpatient survey question: "Informed about medication side effects"	70	65	69	76	86	81	81	75					X
Patients (in ED or CDU) with a diagnosis of sepsis receive antibiotics within an hour	>70%	Not measured	25.60%	40%	43%	0%	28%	27%					X
Participation in NHS Choices online feedback	62	31	23	5	5	Quality Board Report	10	33		X			X
Mixed sex accommodation - breaches	0	1	0	0	0	0	0	0		X		X	X
Patient Experience (2) Board Responsibility: Planned Care Group Director Peter Malone													
Admitted in 18 weeks percentage	90%	94.9%	93.1%	90.5%	90.8%	90.9%	90.8%	91.9%	X	X		X	
Non admitted in 18 weeks percentage	95%	99.5%	99.3%	98.4%	98.8%	98.5%	98.6%	98.9%	X	X		X	
18 weeks Incomplete pathways	92%	no data	92.3%	92.3%	92.6%	93.0%	92.6%	92.5%		X		X	
18 weeks - Admitted 95th percentile	<=23	19-20		20-21	21-22					X		X	
18 weeks - Admitted Median Wait	tba	7-8		9-10	8-9					X		X	
18 weeks - Admitted backlog	350	415		1138						X			
18 weeks - Non - admitted 95th percentile	<=18.3	10-11		13-14	12-13					X		X	
18 weeks - Non admitted Median Wait	tba	1-2		2-3	1-2					X		X	
13 week outpatient waits	99.97%	99.9%	99.8%	98.9%	tbc	95.2%		tbc		X		X	
26 week inpatient waits	99.97%	99.6%	99.4%	96.4%	tbc	96.6%		tbc		X		X	
Audiology - Non Admitted in 18 weeks	95%		100%	99.8%	99.6%	100.0%	99.8%	99.9%		X		X	
Audiology - Incomplete pathways				97.7%	99.6%	100.0%	99.1%	tbc					
Diagnostics in 6 weeks %	tba		100%	99.8%	97.3%	98.33%	98.5%	99.2%		X		X	
2 week wait for suspected cancer	93%	94.7%	91.8%	90.4%	88.3%	91.6%	90.1%	91.0%	X	X		X	
31 day first treatment: all cancers	96%	96.5%	96.9%	98.6%	97.8%	93.5%	96.6%	96.8%	X	X		X	
31 day subsequent treatment - Drugs	98%	99.5%	99.1%	100.0%	100.0%	100.0%	100.0%	99.6%	X	X		X	
31 day subsequent treatment - Surgery	94%	96.3%	98.4%	100.0%	100.0%	95.0%	98.3%	98.4%	X	X		X	
31 day subsequent treatment Radiotherapy	94%	96.7%	94.4%	95.1%	96.1%	94.0%	95.1%	94.7%	X	X		X	
62 day standard: all cancers	85%	85.0%	85.2%	87.6%	86.8%	81.9%	85.4%	85.3%	X	X		X	
62 day consultant upgrade: all cancers	not pub	91.7%	88.9%	100.0%	100.0%	none	100.0%	94.5%	X	X		X	
62 day screening standard: all cancers	90%	90.1%	87.2%	94.4%	90.9%	77.8%	87.7%	87.5%	X	X		X	
2 week wait breast symptoms	93%	93.1%	93.1%	94.9%	87.1%	85.7%	89.2%	91.2%	X	X		X	
C&B direct booking as % of total referrals	60%	56%	62.00%	60%	59%	60%	60%	61%		X		X	
C&B slots unavailable	0.04	0.06	0.06	0.03	0.04	0.03	0.03	0.05		X		X	
PROMS		Report to be developed								X			
Patient Experience (3) Board Responsibility: Urgent Care Group Director - Sue Edees													
A&E attendance within 4 hours Types 1 & 2	95%	95.7%	95.2%	95.7%	93.6%	94.6%	94.6%	94.9%	X	X		X	
Seen within 4 hours - RBH site Type 1 only	95%	TBC	94.3%	95.1%	92.7%	93.8%	93.9%	94.1%					
A&E Unplanned re-attendance rate	<5%	2.3%	2.1%	2.2%	2.7%	2.3%	2.4%	2.3%				X	
Total time spent in A&E - 4 hr wait (95th percentile) Non Admitted	240 mins	246	239	239	239	239	239	239				X	
A&E Left department without being seen	<5%	3.3%	3.6%	3.7%	4.2%	3.6%	3.8%	3.7%				X	
A&E Time to initial assessment (95th percentile)	<15 mins	0	0	0	0	0	0	0				X	
A&E Time to treatment in department (median)	<60 mins	70	73	64	58	62	61	68				X	
Mothers booked < 13 weeks	tba	89.3%	88.0%	88.6%	89.9%	87.5%	88.7%	88.3%		X		X	
Learning disability target out of 24 (multiple questions)	tba	pass		pass	pass	21		pass		X			

Key Performance Indicators

	Target 2012/13	Out-turn 2011/12	Q1	Jul-12	Aug-12	Sep-12	Q2	YTD	Organisation requiring data: Monitor	DOH	CQC	PCT	Board
Patient Experience (4) Board Responsibility: Interim Medical Director Emma Vaux													
Electronic Discharge letters in 24 hours	tba	93%	93.0%	93.9%	93.4%	95.0%	94.1%	93.5%				X	
Never Events	tba	1	0	1	0	0	1	1					
Best Healthcare Outcomes (1) Board Responsibility: Interim Medical Director Emma Vaux													
HSMR (56 diagnoses)12 months rolling	75	94.9		96.5	Not Validate	Not available				X			X
(SHMI) Statistical (OD) banding	2 (as	2 (as		2			2			X			X
SHMI Percentage of admitted patients whose treatment included palliative care	0.93%	1.10%		1.07%			1.07%			X			X
SHMI Percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care	16.60%	22.50%		21.06%			21.06%			X			X
30 day emergency re-admission rate	tba	6.8%	7.3%	7.7%	7.3%	7.0%	7.3%	7.3%				X	
30 day elective re-admission rate	tba	2.9%	3.6%	6.4%	5.0%	5.0%	5.5%	4.5%				X	
Emergency readmissions of patients aged over 16 to hospital within 28 days of discharge	11.6%	2.9%	2.9%	3.7%	3.3%	Superceded by 30 day re-admission rate				X			X
Emergency readmissions of patients aged 0-15 to hospital within 28 days of discharge	10.3%	5.4%	6.2%	6.6%	6.6%					X			X
Rate of Patient Safety Incid per 100 Admissions	5.9	4.7		5.3	6.6	6.3	5.4			X			X
Percentage of incidents resulting in severe harm and death	0.70%	1.00%		1.13%	0.92%	0.67%	0.51%			X			X
Unplanned return to theatre in 48 hrs	n/a	0.0%	0.0%	0.2%	0.0%	0.0%						X	
Risk Assessment VTE	90%	83.8%	81.7%	82.5%	86.2%			81.7%		X		X	X
Best Healthcare Outcomes (2): Board Responsibility: Director of Nursing Caroline Ainslie													
MRSA bacteraemias	1	0	0	0	0	0	0	0	X	X		X	
Clostridium Difficile post 48 hours	77	107	7	0	4	1	5	12	X	X		X	
MRSA screening (elective pts)	100%	TBC								X		X	
MSSA surveillance	tba	16	0	1	0	4	5	5		X		X	
Patient falls	5.6/ 1,000 bed days	5.8	6.8	5.1	5.9	6.5	6	tbc				X	
Incident (Red clinical reported)	0	51	17	7	3	3	13	30				X	
Serious falls (i.e. Severe Injury/Death)	0	18	4	3	2	0	5	9		X		X	
Pressure Ulcer Incidence	1.42	1.47	Report to be developed									X	
Appropriate VTE Prophylaxis for adult IP	85%	TBC	89.9%	80.7%	90.0%	94.6%						X	
Adverse events that happen to pts with dementia	98		10	4	4	3	11	21				X	

Key Performance Indicators

	Target 2012/13	Out-turn 2011/12	Q1	Jul-12	Aug-12	Sep-12	Q2	YTD	Organisation requiring data: Monitor	DOH	CQC	PCT	Board
Best Healthcare Outcomes (3) Board Responsibility: Urgent Care Group Director Sue Edees													
Caesarean Section rate	24%	26%	26%	27%	24%	27%	26%	26%				X	
Normal Births	63%	58%	59%	56%	60%	58%	58%	59%				X	
% Vaginal births following C Section	70%	58%	67%	71%	67%	78%	72%	70%				X	
Mothers breast feeding	nat av	78.7%	77.6%	79.4%	81.1%	75.4%	78.6%	78.1%		X		X	
Mothers smoking at the time of delivery	8%	8.2%	7.6%	6.5%	6.8%	6.9%	6.7%	7.2%		X		X	
# Neck of Femur Surgery in 36 hours	75%	73.32%	84.4%	63.3%	79.5%	78.6%	73.8%	79.1%				X	
Stroke pts spend 90% time in stroke unit	80%	80.98%	83.8%	80.4%	83.3%	86.0%	83.2%	83.5%		X		X	
TIA pts scanned and treated in 24 hours	75%	89.5%	93.9%	87.5%	data	97.0%		data		X		X	
Neonatal BCG	tbc		Report to be developed									X	
Maternity smoking cessation	tbc		Report to be developed									X	
Stroke: patients presenting with AF , anti-coagulated on discharge (60% by April 2011)	60%			61.5%	71%	55%	62%			X		X	
Stroke: High-risk TIA pts fully investigated and treated within 24 hours	80%			87.5%	100.0%	96.7%	94.7%			X		X	
Stroke: patients admitted directly to an acute stroke unit within 4 hours	90%			46.4%	50.0%	64.1%	53.5%			X		X	
Stroke: patients spending 90% of their inpatient stay on a specialist stroke unit					84.8%	85.9%							
Stroke: patients scanned within one hour of hospital arrival	50%			43.6%	45.3%	39.7%	42.9%			X		X	
Stroke: patients scanned within 24 hours	100%			90.9%	89.1%	94.8%	91.6%			X		X	
Stroke: patients supported by a stroke skilled Early Supported Discharge team	40%			16.7%	31.7%	16.7%	21.7%			X		X	
Stroke: patients and carers with joint care plans on discharge from hospital to final place of residence	85%			no data	no data	no data				X		X	
Stroke: Physiotherapist assessments < 72 hrs	95%			96.4%	96.9%	96.9%	96.7%			X		X	
Stroke: Occupational Therapist assessments < 72 hours	95%			96.4%	95.2%	95.2%	95.6%			X		X	
Stroke: MDT goal settings < 5 days	95.0%			98.2%	96.9%	98.4%	97.8%			X		X	
Average Length of Stay (LOS) from admission to discharge (days)				18.1	12.9	16.4	16			X		X	
Stroke: patients Swallow screened < 24 hours	95%			96.2%	100%	98%	98%			X		X	
Stroke: Door to needle time <60mins	95%			87.5%	83.3%	72.7%	81.2%			X		X	
Stroke: Patients discharged to pre-admission address				100%	98%	94%	97%			X		X	
Stroke: patients with 30 day mortality from stroke onset				1.8%	17%	9%	9%			X		X	
Best Healthcare Outcomes (4) Board Responsibility: Networked Care Group Director Lindsey Barker													
Think Glucose: Diabetes Assessment	83%	91.35%	94.0%	90.5%	98.8%		94.6%	94.3%				X	
Diabetes Discharge Plan of Care	90%	99.77%	100%	100%	98.6%		99.3%	100%				X	
Diabetic admitted LOS	2.6	>5	2.52	3.71	2.25		3	2.75				X	
Diabetes self medication	90%		54.3%					55.0%				X	
Trust Membership													
Total		23,278		23,295	23,410	23,613			X				
Public		18,123		18,297	18,422	18,667			X				
Staff		5,155		4,998	4,988	4,946			X				
Media coverage by tone:	Positive	58%		74%	79%	79%							X
	Negative	19%		4%	15%	0%							X
	Neutral	23%		22%	5%	21%							X

Key Performance Indicators

	Target 2012/13	Out-turn 2011/12	Q1	Jul-12	Aug-12	Sep-12	Q2	YTD	Organisation requiring data: Monitor	DOH	CQC	PCT	Board
Value for Money (1) Board Responsibility: Director of Finance Craig Anderson													
	(£m)												
Income	£315.63	317.41	78.80	27.46	26.89	27.31	81.66	160.46	X				X
Direct costs	-£289.66	(303.74)	(74.82)	(25.27)	(26.24)	(25.41)	(76.92)	(151.73)	X				X
EBIDTA	£25.97	13.68	3.98	2.20	0.65	1.90	4.75	8.73	X				X
Other costs	-£22.80	(22.53)	(5.49)	(2.01)	(1.98)	(2.06)	(6.04)	(11.54)	X				X
Net surplus/deficit	£3.16	(8.85)	(1.51)	0.19	(1.33)	(0.15)	(1.30)	(2.81)	X				X
Cost improvement Programme	£12.50	18.20	2.10	0.41	0.38	0.71	1.51	3.61	X				X
Value for Money (2) Board Responsibility: Care Group Directors Peter Malone, Lindsey Barker &Sue Edees													
Average elective length of stay	2.0	2.80	2.7	2.7	2.6	2.7	2.67	2.7		X			X
Average non-elective length of stay	5.0	4.40	4.49	4.2	4.50	4.30	4.33	4.44		X			X
New to follow up outpatient ratio	TBC	2.38	TBC	TBC	86.8%		0.87						X
Elective inpatients *	3,873	9,646	2,160	676	621	603	1,900	4,060		X		X	X
Non-elective inpatients*	18,604	43,206	11,074	4,252	3,912	3,743	11,907	22,981		X		X	X
Day cases*	14,214	33,344	7,821	2,531	2,423	2,305	7,259	15,080		X		X	X
New attended outpatients*	73,518	170,362	40,608	14,936	15,298	14,624	44,858	85,466		X		X	X
Outpatient DNA rate	5.0%	6.9%	6.7%	5.8%	6.4%	7.3%	6.5%	6.6%					X
Outpatient cancellation rate	TBC	26.6%	27.6%	21.4%	25.5%	26.0%	24.3%	25.7%					X
Delayed discharges	3.5%	4.31%	5.34%	6.28%	5.12%	5.93%	5.78%	5.40%	X	X		X	X
Theatre utilisation rate	98%	98.3%	98.6%	no data		90.9%		98.7%					X
Last minute non-clinical cancelled operations	A:<=0.8%	0.53%	0.33%	1.06%	0.78%	0.45%	0.77%	0.53%		X		X	X
Cancelled Operations not re-booked in 28 days	A:<=5%	2.20%	9.4%	6.45%	18.18%	15%	12.12%	11.22%		X		X	X
Coding completeness	100%	99.4	95.0%	89.8%	87.9%	56.2%	78.0%	92.3%				X	X
Ethnic coding	85%	89.8%	89.1%	88.7%	88.8%	89.1%	88.9%	89.1%		X			X
NHS number coding (IP)	99%	99.6%	99.4%	99.1%	99.2%	99.1%	99.1%	99.1%		X			X
Value for Money (3) Board Responsibility: Director for Corporate Affairs Keith Eales													
FOI's requests received	TBC	328	85	31	27	22	80	165					X
FOI breaches of statutory deadline	TBC	15%	16%	32%	7%	0%	13.0%	17%					X
Best Place to Work, Train & Learn Board Responsibility: Director of HR Janine Brennan													
Staff in post	12%	4,224	4,313	4,327	4,326	4,331	4,328	4,321					X
Workforce turnover	1%	11.95%	3.0%	1.1%	1.2%	1.6%	1.3%	5.5%					X
Vacancy rate	5%	4.17%	5.2%	4.9%	5.7%	5.2%	5.3%	5.2%					X
Sickness and absence rate (previous month)	2.8%	3.10%	3.3%	3.2%	3.0%		next mth	3.2%					X
Agency spend % of total staff cost	5.3%	5.81%	4.5%	4.6%	5.7%	7.4%	5.9%	5.2%					X
Appraisal rate	95%	63.3%	54%	62%	65%	71%	66%	58%					X
Medics EWTD compliance %	tbc	100%	100% Annual Audit										X
Staff costs as a % of income	tbc	59.05%	59%	56%	60%	58%	58%	58%					X
National Standards of Cleanliness													
Trust				93.9%	92.8%	93.3%	93.3%	93%					
Urgent care				94.0%	93.3%	94.2%	93.8%	94%					
Networked Care				93.8%	93.3%	93.7%	93.6%	94%					
Planned Care				93.6%	93.4%	93.2%	93.4%	93%					

Agenda Item 5 c)

Royal Berkshire NHS Foundation Trust

Board of Directors Briefing

Title:	**Quality and Patient Safety Report**
Date:	**30 October 2012**
Lead:	**Emma Vaux, Interim Medical Director** **Caroline Ainslie, Executive Director of Nursing**
Purpose:	This paper is to update the Board on significant issues related to clinical quality, patient safety, infection prevention and control, clinical standards and patients' experience. The paper relates to issues occurring during September 2012.

Key Points:

Complaints

- Complaints relating to attitude and behaviour have increased beyond the control limit in September
- In September patients felt that they were less involved with decisions about their care and treatment

Pressure ulcers

- The trust has had 17 hospital acquired grade 3 or 4 pressure ulcers since February 2012 and this is a cause for concern.

Nutrition

- 75% of patients are screened for malnutrition within 24hrs of admission rising to 87% within 48hrs of admission. The Trust target is 90% patients to be screened within 24hrs

Safety Thermometer

- The NHS Safety Thermometer shows that Nationally 91% of all NHS patients have harm-free care. On average we are providing 93.2% harm-free care
- New Pressure ulcers: RBFT is above the National average and not on target for the 10% reduction threshold.
- Falls Harm: RBFT is below the National average (which is good), but is not on target for the 10% reduction threshold

VTE

- VTE risk assessments reached 87.86% in September (target is 90%)

Quality Assurance Process for Quality Accounts

- An amended process is appended to reduce the number of Committee reviews required for the Quality Accounts. The Board is asked to establish a Quality Governance Group. This group will have a role in the Quality Accounts process to provide high level close scrutiny.
- 3 indicators in the Quality Accounts have to be audited for data quality assurance. The 3rd indicator needs to be agreed by the Council of Governors, as NHS foundation trusts need to obtain assurance through substantive sample testing of one local indicator included in the Quality Report, as selected by the governors.

Innovation Health and Wealth

- There are 6 high impact innovations, 5 of which we are addressing and 1 of which is reliant on developments by the Department of Health
- CQUIN payments are attached to the delivery of 5 of the High Impact Innovations during 2012/13 via a number of projects
- From April 2013, compliance with the high impact innovations will become a pre-qualification requirement for CQUIN payments (equating to 2.5% of contract value).

Research and Development

- R&D now has approximately £1million income from TVCLRN with additional income from other sources of £0.5 million
- Research studies and participation has risen steadily over the last 4 years
- Restoration of the Innovation Fund and development of a Clinical Research Facility will enable R&D to income generate for the RBFT

Decision required:	Approve
Freedom of Information (FOI) Status	Appendix 1 to this report contains confidential information which falls within the Freedom of information Exemptions guidance Section 40 – Personal information; as it contains detailed information on incidents that could be associated to the personal data (name) of patients, staff and public.

1 RECOMMENDATIONS

1.1 The Board is asked:

NOTE: To note the issues and actions contained within this report
AGREE: The amended process for the Quality Accounts Assurance

2 ATTACHMENTS

2.1 The following are attached to this report:

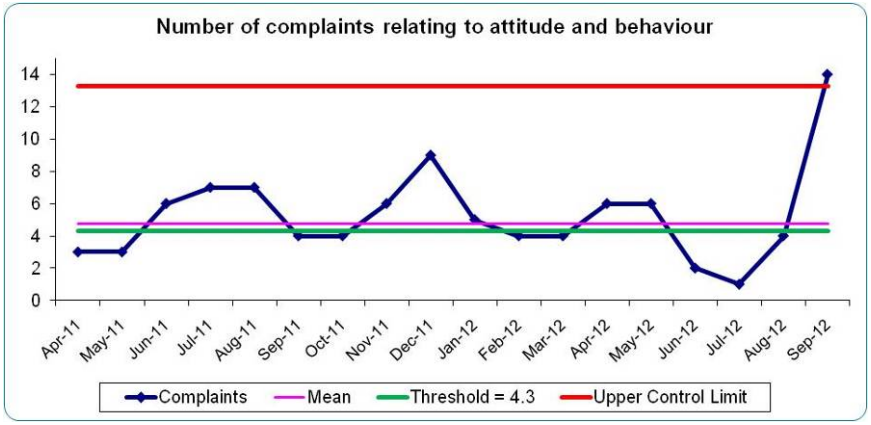
- Appendix 1: Incident Report (FOI Exemption Section 40)
- Appendix 2: Research and Development Report

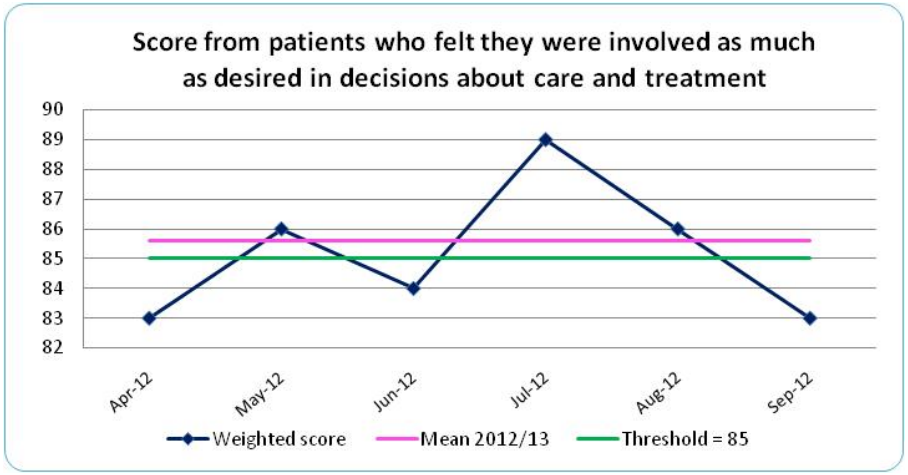
3 CONTACTS

Emma Vaux, Interim Medical Director (0118 322 7227)
Caroline Ainslie, Executive Director of Nursing (0118 322 7445)

Staff courtesy and communication

Quality Accounts priority 1: Providing a positive patient experience by improving staff courtesy and communication, measured by reducing the average (mean) number of complaints received relating to behaviour and attitude from 4.76 to 4.3 and by increasing the weighted score from the rolling inpatient survey for the question: "Involved as much as desired in decisions about care and treatment" from an average of 83 to an average of 85 for April 2012-March 2013.





We want to exceed our patient and customer expectations and part of this includes providing a positive patient experience. Therefore, once again we have chosen this as our number 1 priority for improvement this year (Quality Accounts). We recognise that staff courtesy and communication is a significant part of this process and this has been identified by the Trust Governors as a key issue.

Complaints relating to attitude and behaviour have increased beyond the control limit in September
In September patients felt that they were less involved with decisions about their care and treatment

Actions in progress

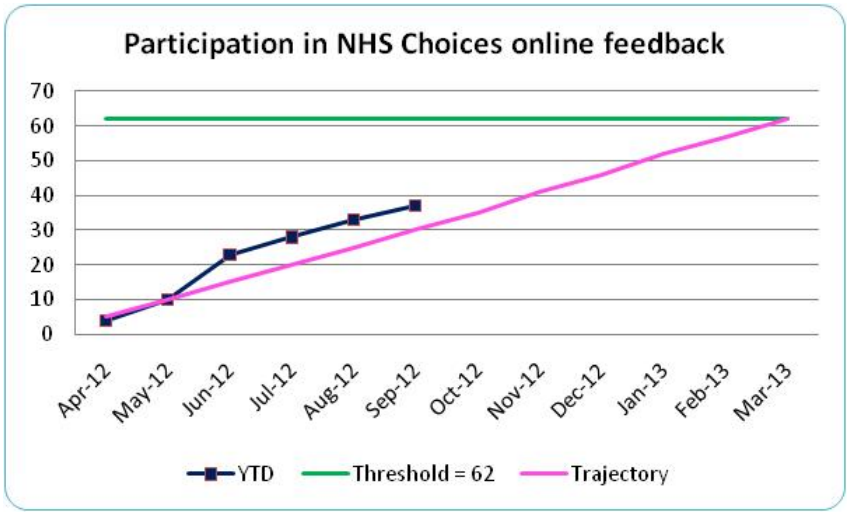
Networked Care

- Networked Care are commencing two projects:

1) "Welcoming Ward" – a team is currently being assembled and the first meeting will be held on 24 October. The aim of the project is to establish how the wards can be made more welcoming through directions and signage, information for patients and carers, appropriate and targeted customer service training, ward managers visibility and role modelling on the wards and considering staff satisfaction/morale.
2) "App and a map" - a route planning project looking at how the patient travels around the hospital without getting lost and how patients are assisted by staff.

Outpatient experience

Quality Accounts priority 2: Improving the Outpatient Experience by doubling patient participation in the online NHS Choices feedback (from 31 to 62 responses per year) by March 2013.



We are above trajectory for improving our patient participation rates in NHS Choices. While this is an improvement, we are aiming to go beyond the target.

To improve participation in NHS Choices we have added his Quick Response Code, which can be scanned by any smart phone and will instantly connect you to the NHS Choices webpage to our "How was your experience?" poster.

The National Outpatient Survey 2011 showed that across the NHS there have been improvements, such as being seen on time or early for an appointment, in the cleanliness of the outpatient department and toilets, the ratings of overall care received at the outpatient department, and in being treated with respect and dignity. However, nationally a number of findings have indicated a decline in performance.

In order to gather and respond to more timely feedback about Outpatients, we are focussing our efforts on the feedback on the independent NHS Choices website.

Actions in progress

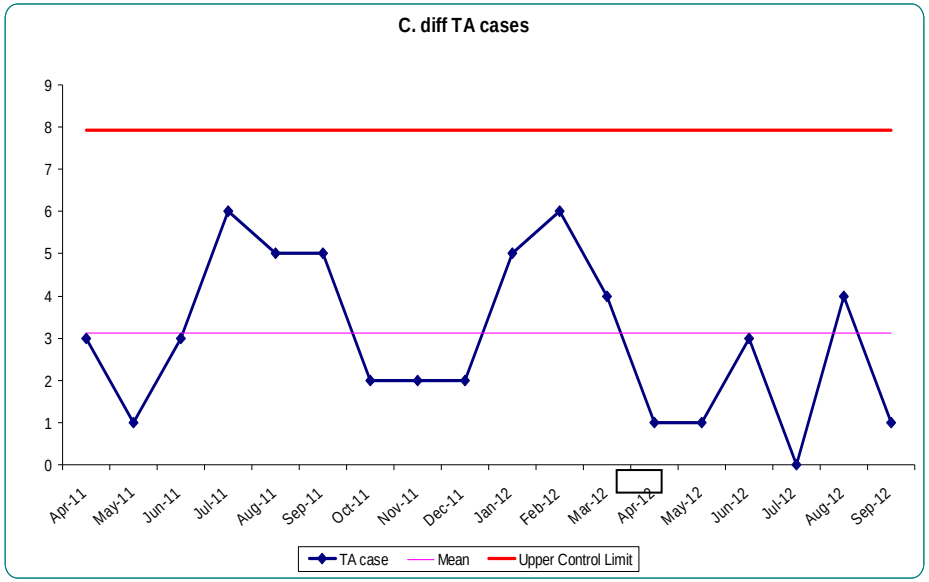
- Ophthalmology outpatients: A development strategy has been put in place with additional community clinics planned to improve capacity and improvements in the area are beginning.
- Patient Experience Executive Walkarounds: Physiotherapy was visited on 17 August 2012
- The patient relations team continue to encourage patients to add positive feedback to NHS Choices

Infection Control

The trust takes a zero tolerance approach to avoidable infections.

Quality Accounts priority 3: Decreasing hospital-associated infections by reducing the numbers of patients who are infected with Clostridium difficile while in hospital to less than 77 patients by March 2013.

The integrated performance report identifies that the trust is on trajectory for reducing hospital associated *Clostridium difficile* In line with the priority above. The chart below highlights that our performance has yet to make and sustain a step change in our performance.



Actions in progress to make a step change in reducing C diff

- Increased attention to timely isolation of patients with suspected infectious diarrhoea
- Agreement of a West Berkshire strategy for C diff
- Clear guidance re appropriate stool sampling
- Targeted Hand hygiene education where appropriate.

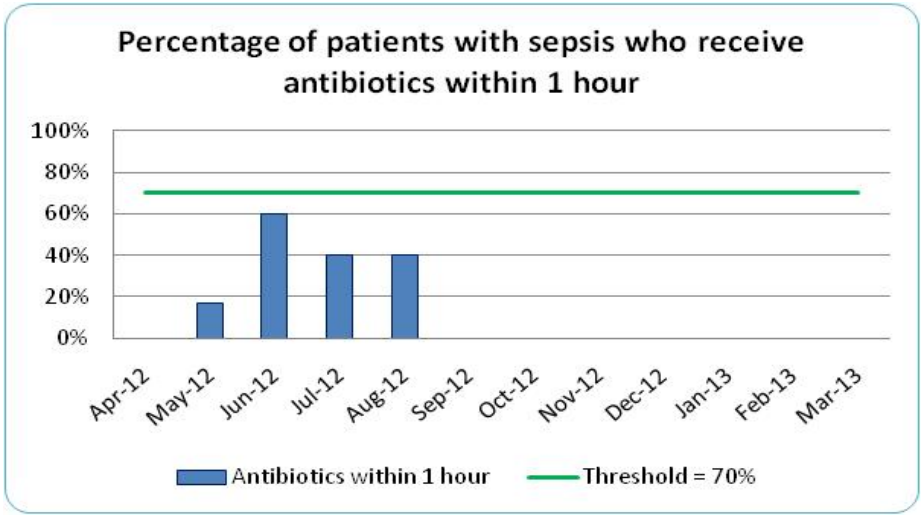
Hand hygiene with soap and water is needed to remove *C. diff* spores. The table below identifies the overall hand hygiene scores for the network by care group for April –September 2012

Ward	Apr 2012	May 2012	Jun 2012	Jul	Aug 2012	Sep 2012
Networked Care Group	94.57%	90.21%	98.69%	100	96.85%	93.92%
Planned Care Group	97.25%	95.85%	97.78%	96.2	95.84%	96.12%
Urgent Care Group	92.07%	97.72%	98.51%	93.1	94.55%	95.34%
Trust Total	**95.72%**	**98.10%**	**96.07**	**95.56%**	**95.57%**	

Royal Berkshire NHS
NHS Foundation Trust

Reducing Harm from Sepsis

Quality Accounts Priority 4: Reducing harm from sepsis by ensuring that at least 70% of patients (in the Emergency Department and Clinical Decision Unit) with a diagnosis of sepsis receive antibiotics within an hour by March 2013. This is also a CQUIN for 2012/13.



With the PCT we have agreed a local CQUIN target based on the percentage of adult patients admitted to the Emergency Department and CDU with a diagnosis of sepsis who receive intravenous antibiotics within one hour of medical assessment. This is measured by a monthly point prevalence audit on a single day of on average 25 patients.

	Apr	May	Jun	Jul	Aug	Sep
Number of patients receiving timely antibiotics	0	2	3	2	6	0
Number of patients with suspected sepsis	3	12	5	5	15	1
Number of patients reviewed	16	24	28	18	38	28

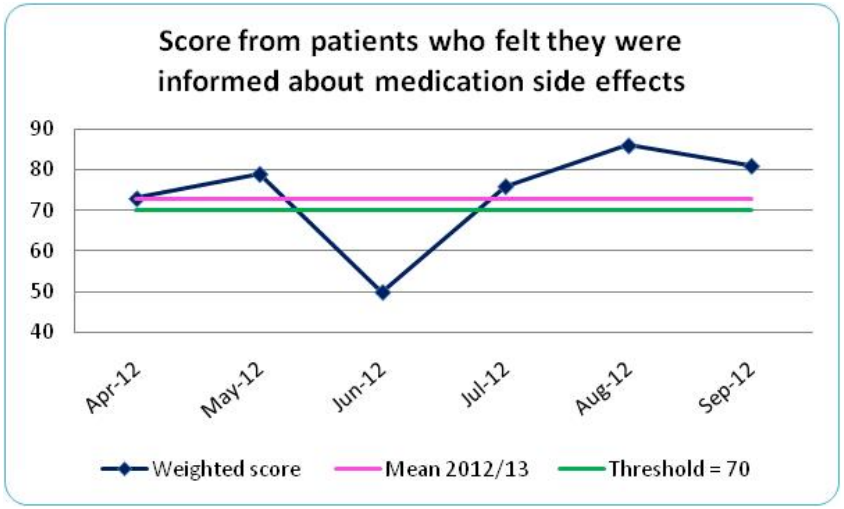
The September point prevalence audit showed that 0% of patients with suspected sepsis were given antibiotics within 1 hour. It should be noted that this was an audit of 28 patients, only 1 of whom had sepsis which is an unusually low number.

Actions in progress

- Develop a system of prioritising all patients including those with possible sepsis in ED and CDU. An RCA as a Serious Learning Event, is currently being undertaken following a patient with delayed antibiotics associated with lack of prioritisation in ED
- Patients admitted with RIF pain and SIRS signs. 10 set of notes pulled through Dr Foster are being reviewed by Phil Conaghan to follow up clinical management (Hester Wain)
- Work on possible sepsis stations and a pilot for training of Junior Doctors to give first dose of antibiotics is being taken forward by Chris Baker.
- Sepsis week was held in May with a focus on teaching for both doctors and nurses and patient awareness.
- Work with SCAS and patient representative to produce 4 x 5 minute Podcasts on sepsis in September (Karin Gerber and Gill Leaver)
- Shadowing of 5 patients in CDU/ ED to elicit possible reasons for delays to antibiotic administration
- Work with Clinical Engineering for wards to have own pumps for first dose antibiotic administration (Anne McDonald)
- The point prevalence audit will be undertaken at least twice a month, to ensure that it includes sufficient patients to provide a balanced representation

Timely Informed Discharge

Quality Accounts priority 5: Ensuring timely informed discharge by increasing the numbers of patients who are "Informed about medication side effects" measured by the rolling patient survey weighted score for that question, from 65 to 70 by March 2013.



Our 2011 Inpatient Survey results showed that we have significantly improved in giving enough information to families: our 2010 score of 41%, improved to 55% in 2011; and in telling patients who to contact if they are worried: our 2010 score of 76%, improved to 82% in 2011. Alongside this we scored 76% in giving copies of discharge letters to patients, significantly better than other trusts (66%). However, we still need to make improvements in the information given by us about medications during the discharge process.

On average our patients feel that they are more informed about medication side effects

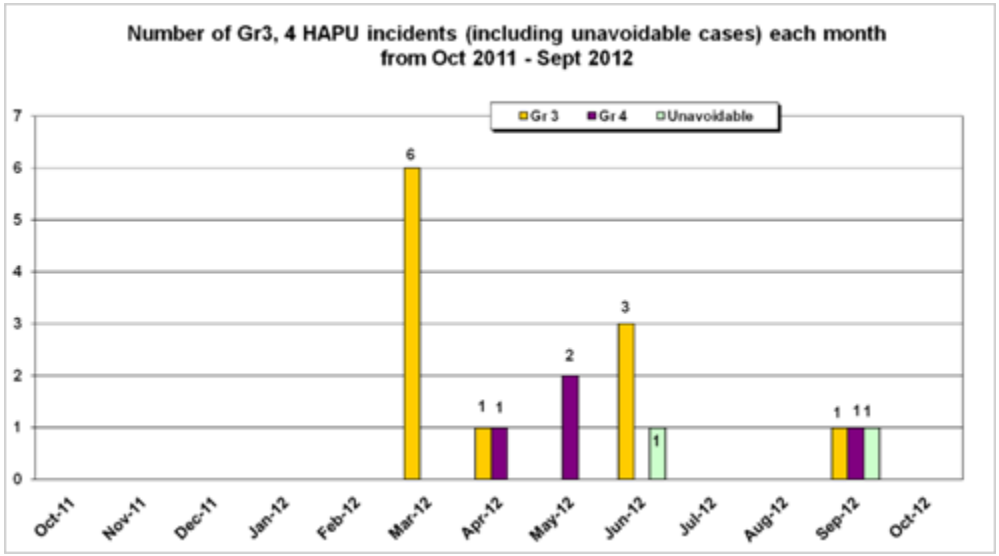
Actions in progress

- New nursing discharge letter training.
- This document is on the intranet and training has been given to wards. Feedback from stakeholders indicates that usage of the document is widespread and there have been no complaints to this team since the introduction of the form that DNs have not been informed of relevant discharges.
- Urgent Care are commencing a quality improvement project around this topic

Pressure Ulcers

The trust takes a zero tolerance approach to avoidable grade 3 and 4 pressure ulcers.

The trust has had 17 hospital acquired grade 3 or 4 pressure ulcers since February 2012 (see chart below) and this is a cause for concern.



Preventing pressure ulcers is an essential aspect of patient safety.

The treatment and management of pressure ulcers cost the NHS an estimated £1.8-2.6bn a year (Posnett and Franks, 2007) .

The Department of Health defines an avoidable pressure ulcer as one that occurs when risk assessments, preventive actions and continued evaluations have not been implemented.

Actions in progress

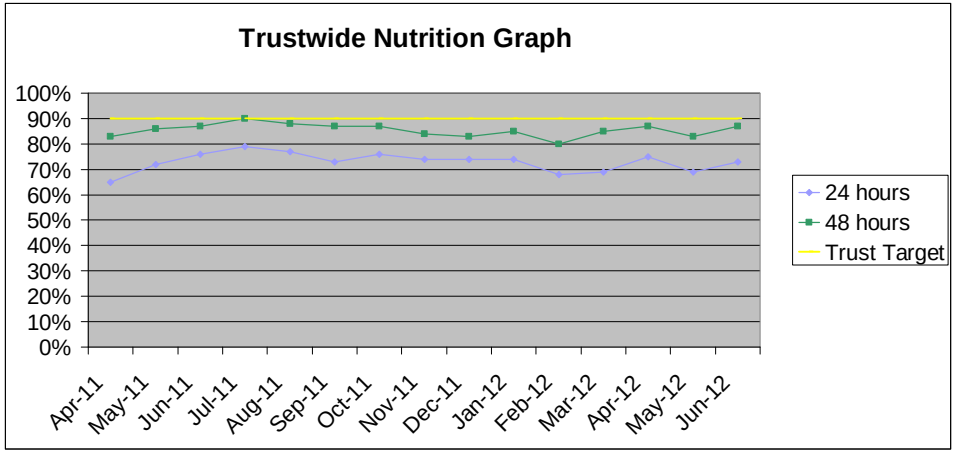
- Fortnightly root cause analysis meetings chaired by the director of nursing to learn trust wide lessons
- Implementation of a new Pressure Ulcer Prevention and Management Care Bundle
- Development of a dressing formulary to ensure appropriate care
- Nursing accountability for documenting care delivered to patients

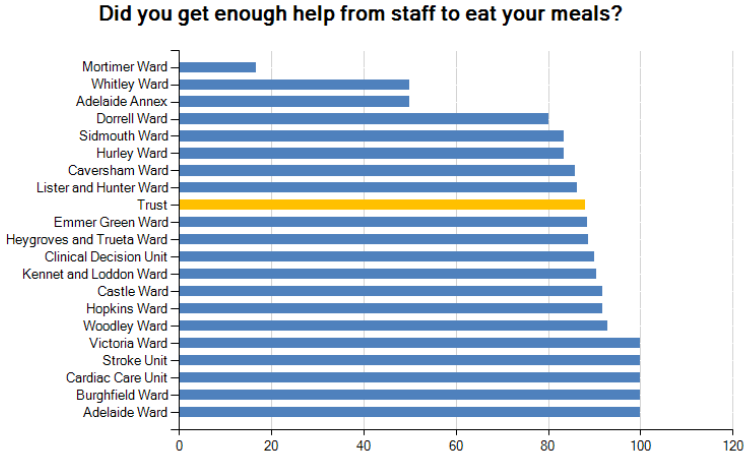
Nutrition and Hydration

Royal Berkshire NHS
NHS Foundation Trust

Screening for malnutrition

75% of patients are screened for malnutrition within 24hrs of admission rising to 87% within 48hrs of admission against a Trust target of 90% patients to be screened within 24hrs





Nutrition Group

The multi professional nutrition group meets monthly and has a wide brief of setting and implementing the Trust's Nutrition and Hydration strategy, covering all aspects of nutritional support within the hospital

Current performance

- CQC outcome 5 – Meeting nutritional needs; 75% of patients are screened for malnutrition within 24hrs of admission rising to 87% within 48hrs of admission.
- 87% of patients referred to dieticians are seen- approximately 25 patients per month are not seen
- 84% of patients said they got the help from staff to eat their meal
- Catering survey patient satisfaction- 81% (very good/good) with a 98% overall satisfactory .
- NICE Clinical Guideline 32 - Of the 9 recommendations, 6 are fully compliant, 1 is in progress, 1 partially compliant and 1 non-compliant
- NCEPOD Parenteral Nutrition – largely compliant across the Trust. Work continues to enable compliance with the use of PN in ICU

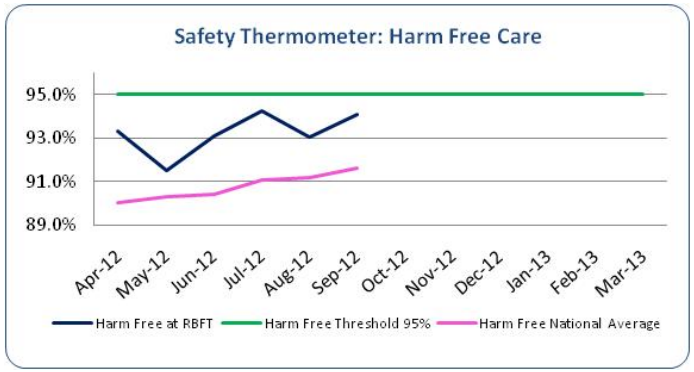
Actions in progress

- Continuing to work with wards through the nutrition champions network to increase screening to 90% within 24hr of admission.
- The dietetic service is being reviewed exploring the option of bring the service in house.
- Continue to recruit and train volunteers with an aim of having volunteers on all elderly care wards
- The CNS for nutrition will be undertaking the Non Medical prescribing course which will help resolve some of the issues around Parenteral nutrition
- A focused piece of work on hydration and fluid balance will be undertaken this year
- RBH has applied to be an intestinal failure centre with peer review taking place this month

Safety Thermometer (CQUIN)

Supporting harm free care

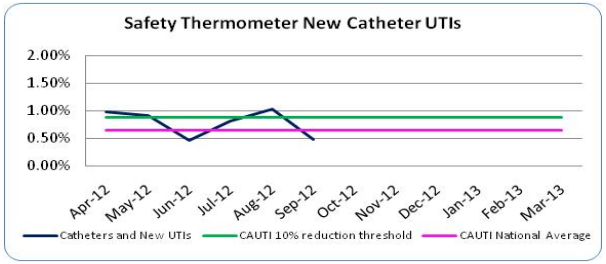
Data are generated by a monthly point prevalence audit of all inpatients (as defined in the NHS Safety Thermometer guidance) on a specified date for four outcomes. Data collection is defined in a CQUIN target, and improvement of 10% harm reduction via the Annual Plan.

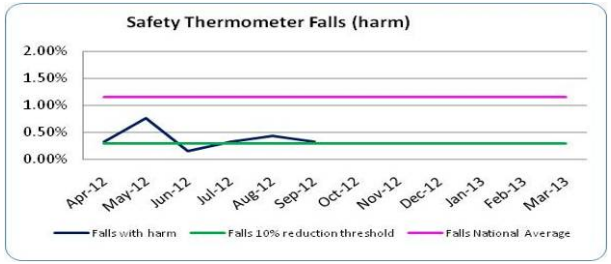


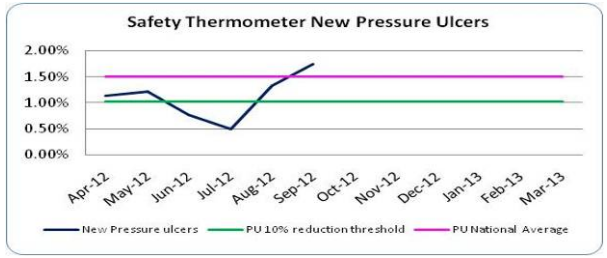
Context

The HSJ reported on 30 August that the NHS Safety Thermometer reveals that 9% of all NHS patients have suffered an avoidable harm (91% harm-free). The Department of Health's target is to deliver "harm-free care" to 95 per cent of patients "by 2012".

On average we are providing 93.2% harm-free care, above the National average and on target to achieve 95%.







September 2012

New Pressure ulcers: RBFT is above the National average and not on target for the 10% reduction threshold.

Falls Harm: RBFT is below the National average (which is good), but is not on target for the 10% reduction threshold

New Catheter UTIs: RBFT is below the National average, and on target for the 10% reduction threshold

Actions in progress

Falls

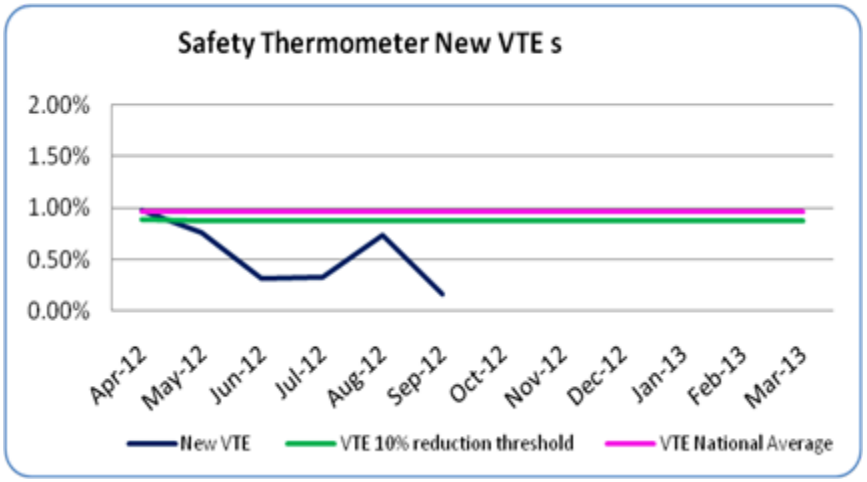
- Falls Strategy Group to review training plan about initial falls management including photographs of equipment to be used
- Re-structure current process for serious incident root cause analyses for falls to enable identification of more robust actions
- Falls 'Hot Topic' circulated in October to local Clinical Governance meetings

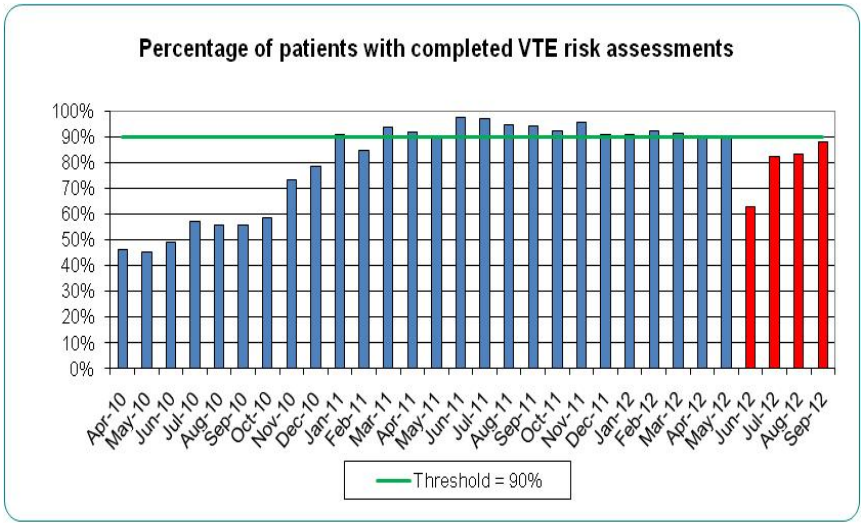
VTE – see relevant section

Pressure ulcer – see relevant section

Venous Thromboembolism (VTE)

For 2012/13 the Trust has a CQUIN target worth £241,000 for undertaking a VTE risk assessment on admission to hospital in at least 90% of patients.





Context

•VTE risk assessments reached 87.86% in September.

•The number of patients who develop VTE post-admission based on coding has been reviewed for July and August and it was confirmed that none of these patients developed hospital-acquired VTE. These data have been deemed unreliable since the introduction of EPR and will no longer be used.

•New VTEs: RBFT is below the National average and on target for 10% reduction threshold

Actions in progress

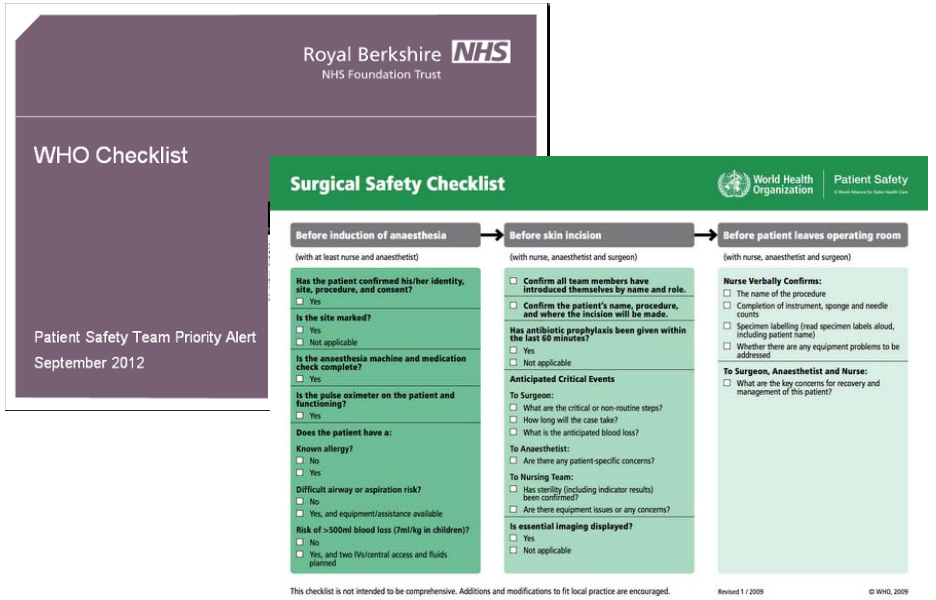
- VTE risk assessments undertaken in the Emergency Department need to be carried across so they can be viewed by the Clinical Decision Unit / Wards so they are included in the Unify report
- Ward staff require educating as to how to view VTE risk assessments undertaken in the pre-op assessment clinic. SOP to be developed by Sarah Cherrill.
- More computer tablets to be obtained to enable efficient data capture.
- New drug chart to contain prompt to complete VTE risk assessment
- Consultants to ensure that VTE risk assessments are completed electronically.
- New intake of junior doctors to undertake training on EPR and electronic VTE risk assessments
- Report on number of VTE risk assessments captured electronically to be ran weekly for weekly review and dissemination to clinical teams
- Wards to use outcome of Safety thermometer VTE prophylaxis to identify where standards are not met and develop action plans appropriately
- Tinzarparin to be reintroduced for VTE prophylaxis on 15 October
- VTE policy updated
- VTE hot topic delivered in October

Safer Surgery

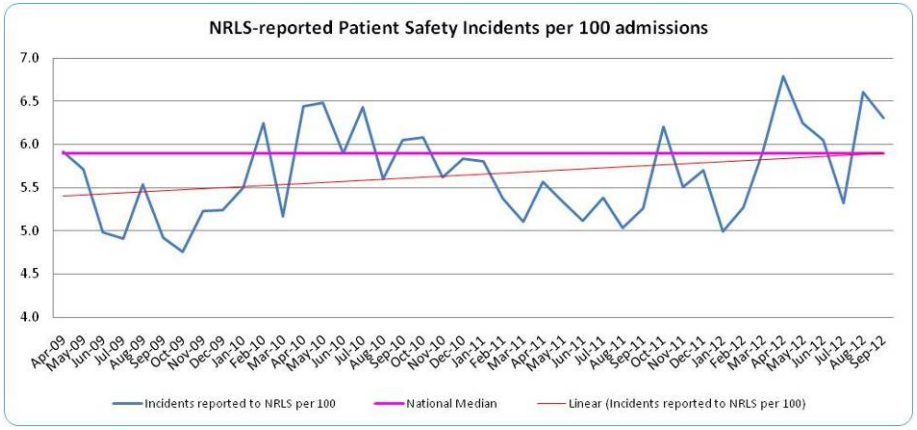
Implementing the Five Steps to Safer Surgery (WHO)
Safer Surgery week at the end of September was celebrated by Theatres with reminders of the 3 serious incidents of wrong site surgery have happened in this Trust in 2011 and 2012 and a re-emphasis on the WHO checklist

Actions in progress

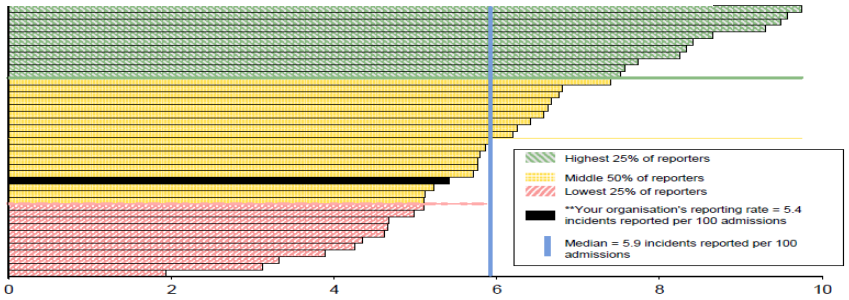
- Alice Jones, Matron for Theatres, has undertaken two observational audits of the WHO checklists; findings are being written up and actions implemented. Further observational audits will be undertaken on a monthly basis.
- The September Patient Safety Hot Topic was regarding the WHO Checklist. Patient Safety Hot Topics are discussed at local clinical governance meetings.



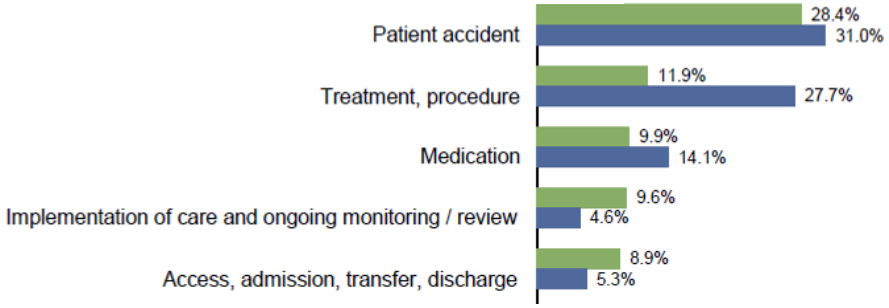
Incidents



NPSA/NRLS Incidents per 100 admits Oct-11 to Mar-12



NPSA/NRLS Comparison data Oct-11 to Mar-12



Incidents

The most recent NPSA/NRLS report (relating to incidents Oct-11 to Mar-12) shows that at 5.4 per 100 admissions (black bar) we are increasing our reporting (which is good) and are within normal reporting range (national median is 5.9). We also monitor this via a run chart in real time.

As usual, we reported more incidents (28% blue bar) relating to treatment/procedure than similar Trusts (12% green bar). This category is split as follows: delayed treatment (23%), inappropriate treatment (19%), failed treatment (14%) wound infections (12%) and other incidents. This is an area that is monitored carefully for any unusual changes

Serious incidents

•There were 3 serious incidents (no Never Events) reported to the PCT in September: 3 x pressure ulcers. Full details will be discussed at the Clinical Governance Committee. Root Cause Analysis are being undertaken to enable to the Trust to learn from these incidents.

•There were 6 Amber incidents reported, all now undergoing local Root Cause Analysis.

Action Progress: Closure Overdue with PCT

Our contract states that serious incidents must be investigated and final reports received by the PCT within 45 working days.

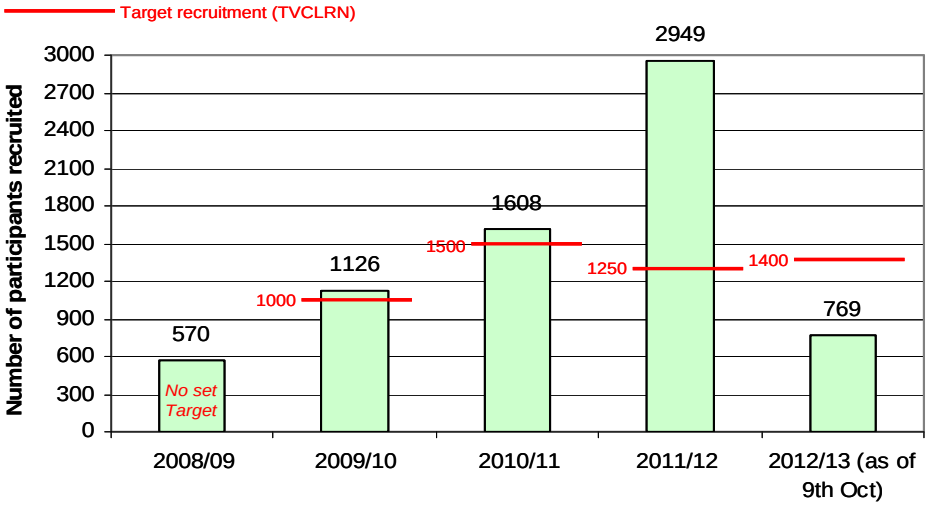
Urgent and Planned Care Group Directors have been made aware of overdue serious incidents listed below.

Incident Date	SI Number	Care Group	Category	Days overdue
23-Jul-12	2012/18392	Planned	Wrong site surgery (Never Event)	4
22-Aug-12	2012 22997	Planned	Confidential information leak	6
27-Mar-11	2011/5788	Urgent	Fall	Clock Stop agreed
15-Jul-12	2012/17271	Urgent	Unexpected death	36
16-Aug-12	2012/20405	Urgent	Fall	4

Research and Development (R&D)

National Institute for Health Research (NIHR) Priority: Improving the quality of care provided to patients through clinical trials and contributing to the wider goals of advancing healthcare research.

RBFT - Annual comparison of recruitment to NIHR studies



Funding for research is provided by the NIHR. The Thames Valley Comprehensive Research Network (TVCLRN) is part of the NIHR and we have agreed a local patient recruitment target of 1400 patients to be recruited into NIHR clinical trials for 2012/13 based on the number of studies open to recruitment within the trust.

There are currently 156 studies on the R&D database with 64% NIHR studies. There are 48 studies in follow up and 50 proposed studies pending R&D approval, 80% of these are NIHR studies.

- **Having a range of research studies offers more patient choice, as some treatments are only available within clinical trials.**
- **A number of studies are looking at offering care in the community, thus contributing towards the trust vision of treating more people at home, reducing running costs and improving the patient experience and best health outcomes.**
- **Being a research active organisation attracts high caliber personnel, thus contributing to being one of the best places to work, learn and train.**

2012 National Clinical Research activity League table published
RBFT 51st out of 405 Trusts

According to the National Clinical Research Activity League Table published in September 2012, RBFT is 51st out of 405 trust nationally for recruiting patients into world class multicentre clinical trials and 3rd out of 8 trust within the Thames Valley.

http://www.guardian.co.uk/healthcare-network-nihr-clinical-research-zone

Current progress against TVCLRN High Level Objectives

- Annual patient recruitment target = on target for achieving this objective.
- At least 80% of NIHR studies closing in 2012 / 13 meeting recruitment target within study time scales = mid year status under review.
- Increase the number of NIHR commercial research by an additional 5 studies for 2012 / 13 = One NIHR commercial research study approved, 7 in progress.
- Staff learning = Berkshire Healthcare Research Collaboration event on 11th January 2013 covering all aspects of how to initiate, conduct and manage research projects.

Risks identified

- The withdrawal of the Innovation Fund restricts R&D capability and the lack of a Clinical Research Facility reduces the ability to income generate.

Royal Berkshire NHS
NHS Foundation Trust

Innovation Health and Wealth

High Impact Innovations

WE WILL RAPIDLY ACCELERATE THE USE OF ASSISTIVE TECHNOLOGIES IN THE NHS, AIMING TO IMPROVE AT LEAST 3 MILLION LIVES OVER THE NEXT FIVE YEARS

WE WILL LAUNCH A NATIONAL DRIVE TO GET FULL IMPLEMENTATION OF ODM, OR SIMILAR FLUID MANAGEMENT MONITORING TECHNOLOGY INTO PRACTICE ACROSS THE NHS.

WE WILL LAUNCH A 'CHILD IN A CHAIR IN A DAY' PROGRAMME TO TRANSFORM THE DELIVERY OF WHEELCHAIR SERVICES THROUGHOUT THE NHS

WE WILL REQUIRE NHS ORGANISATIONS TO EXPLORE OPPORTUNITIES TO INCREASE NATIONAL AND INTERNATIONAL HEALTHCARE ACTIVITY AND WILL HOST A SUMMIT WITH UK TRADE AND INVESTMENT IN THE NEW YEAR

WE WILL REQUIRE THE NHS TO WORK TOWARDS REDUCING INAPPROPRIATE FACE-TO-FACE CONTACTS AND TO SWITCH TO HIGHER QUALITY, MORE CONVENIENT, LOWER COST ALTERNATIVES

WE WILL REQUIRE THE NHS TO COMMISSION SERVICES IN LINE WITH NICE-SCIE GUIDANCE ON SUPPORTING PEOPLE WITH DEMENTIA

Context

- Innovation Health and Wealth: Accelerating Adoption and Diffusion in the NHS which was published in December 2011
- All NHS Organisations are asked to lead this change (at Board level), and to make an immediate start by:
- Building the actions set out in the report into our planning processes for 2012/13;
- Planning in local areas to deliver the High Impact Innovations set out in the report;
- Developing a clear plan to improve the uptake of NICE technology appraisals; and
- Working together to develop local plans for the formation of Academic Health Science Networks.

High Impact Innovations

- There are 6 high impact innovations, 5 of which we are addressing and 1 of which is reliant on developments by the Department of Health
- CQUIN payments are attached to the delivery of 5 of the High Impact Innovations during 2012/13 via a number of projects
- From April 2013, compliance with the high impact innovations will become a pre-qualification requirement for CQUIN payments (equating to 2.5% of contract value).

Gap analysis and action plan (for details see appendix)
3 Million Lives Young People's Digital Diabetes Clinic Programme underway
Digital By Default Increase in electronic pathology and radiology requests from GPs; Providing hospital clinician generated pathology results to GPs via the ICE system; Sending radiology results to GPs via the ICE system; Sending discharge letters to GP electronically via ICE and Docman EDI Hub
Oesophageal Doppler Monitoring (ODM) Goal Directed Fluid Therapy programme underway
Child In A Chair In A Day Set up an on call peripheral wheelchair store with a private dealer (who already works with Whizz Kids).Redesign our referral form to add more detailed information so that more accurate assessment can be gained in advance of the appointment.
Carers For People With Dementia Dementia Screening, Dementia Risk Assessment and Dementia Referral for Specialist Diagnosis Programme underway
International and Commercial Activity Waiting on Department of Health scheme launch due in Autumn 2012

CQC Review of Compliance

All the patients we spoke with said they were treated kindly and with respect

A patient told us the care she received was excellent. She said "I couldn't be treated any better if I was the Queen"

Context

The CQC's Dignity and nutrition for older people reviews look at whether the dignity of older people is respected and if their nutritional and hydration needs are met. The RBFT was visited in August 2012 and the CQC's report has now been received.

The Trust was compliant with the following 5 Outcomes:

Outcome 1	Respecting and involving people who use services
Outcome 5	Meeting nutritional needs
Outcome 7	Safeguarding people who use services from abuse
Outcome 13	Staffing
Outcome 21	Records

The final report has now been published from the CQC's Inspection of Safeguarding and Looked After Children's Services in West Berkshire in July.

Actions

Outcome 1

Ensure patient assessment forms consistently completed upon admission, specifically including the patient's preferred name and food preferences

Outcome 5

Ensure TV Monitors are not serviced during protected mealtimes

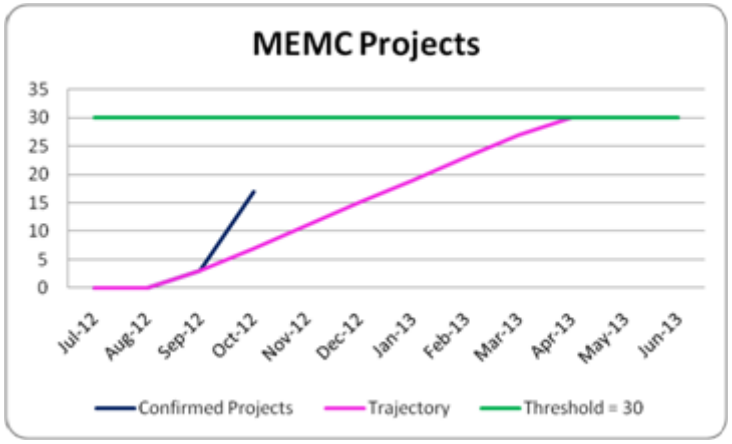
Patients can easily access red trays

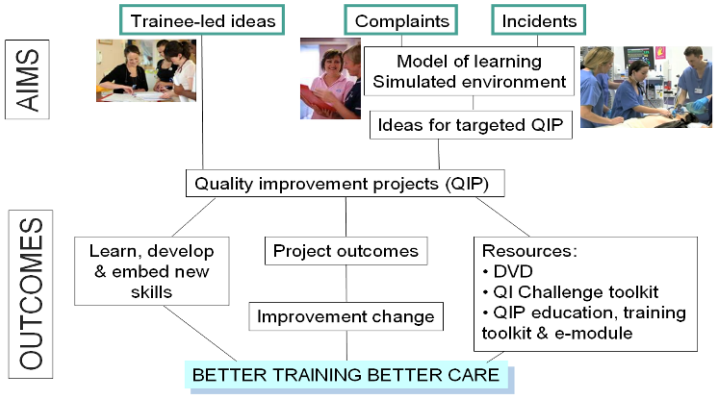
Staff to sit (rather than stand) next to patients to assist them during mealtimes

Safeguarding and Looked After Children's Services

Immediate action: To ensure the views and experience of young people and their families are routinely used to support the way local services are provided - Work is underway to set up a youth engagement group, led by Networked Care

Making Every Moment Count





Context

The Trust is leading the 'Making Every Moment Count' (MEMC) project funded by the Better Training Better Care Programme as part of Medical Education England. MEMC. This project aimed at junior doctors, helps to address the apparent gap between learning opportunities from every day recognised problems (e.g. working at the frontline, from incidents or complaints) and how these translate into effective action and improvement change.

Project Ideas

•Introducing a written handover for handover of Gynaecology patients between clinical teams

•To reduce anxiety in preoperative adult patients, by providing information through a looped DVD in pre-op clerking which answers the 10 most common concerns

•Operation notes – are we getting it right? Information about post-operative management

Actions

•Mock inquest filming agreed and participants briefed

•Serious incident filming agreed and participants briefed

•1:1 meetings with trainees and supervisors ongoing

•Project administrator soon to be in post

•Information pack for trainees and consultants distributed

•Summer Showcase Seminar being planned

Quality Accounts 2013

Notable changes to the 2013 Process

•The Board is asked to establish a Quality Governance Group. This group will have a role in the Quality Accounts process to provide high level close scrutiny.
•Each Care Group to submit 1 quality priority for consideration by 28 November
•Quality Accounts priorities to be reviewed by Executive, Clinical Governance Committee only
•1st draft of the Quality Accounts to be reviewed by Board, Risk Management Committee, Audit Committee , Council of Governors in March
•Information Assurance Framework to be reviewed by Risk Management Committee in March
•2nd draft of the Quality Accounts to be reviewed by Board, Audit Committee in May

Quality Accounts Internal Auditing Requirements and Actions

•3 indicators in the Quality Accounts have to be audited for data quality assurance.
•The 2 mandated indicators are:
1) MRSA, C. difficile (the foundation trust would choose one)
2) Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers
•The 3rd indicator needs to be agreed by the Council of Governors, as NHS foundation trusts need to obtain assurance through substantive sample testing of one local indicator included in the Quality Report, as selected by the governors.

Actions

Month	Action	Responsibility
October	Suggestion and collation of priority ideas	Staff, patient and public stakeholders, Governors, Trust Executive, Care Groups, Head of Patient Safety
November	Review of suggested priorities at Annual Members Meeting	Head of Patient Safety
December	Agree 3-5 priorities	Quality Governance Group
January	Quality Accounts Priorities reviewed Agree local indicator to be audited	Executive, Clinical Governance Committee Council of Governors
February	Agree 1st draft of the Quality Accounts	Quality Governance Group
March	1st draft of the Quality Accounts Assurance Framework	Board, Risk Management Committee, Audit Committee , Council of Governors Risk Management Committee
April	Agree 2nd draft of the Quality Accounts	Quality Governance Group
May	2nd draft of the Quality Account Final Quality Accounts sign off	Board, Audit Committee Chair, Chief Executive, Medical Director, and Executive Director of Nursing
June	Quality Accounts placed on NHS Choices website	Assistant Director of Public Relations

Dr Foster Hospital Guide 2012

Metric	RR	Banding
HG2012_ClinicalVariation_15_Elective Laparoscopic Cholecystectomy (Day Case Rate)	65.30	Higher than expected
HG2012_Orthopaedics_42_Elective Knee Replacement, 1 year Revision Rate (Crude)	2.75	Higher than expected
HG2012_EfficiencyIndicator_30_Admissions Where Procedure Not Performed (Crude Rate)	2.33	Lower quartile
HG2012_EfficiencyIndicator_18_7 Day Emergency Readmissions (Crude Rate)	2.46	Lower than expected
HG2012_ClinicalVariation_02_Short Stay Emergency Admissions for Skin Infection (Crude Rate)	34.22	Lower than expected

Context
Dr Foster will be publishing the 11th hospital guide on 26 November.
We have contributed directly to the information that support this by completing an organisational questionnaire.
This will be supplemented with a number of metrics derived by Dr Foster.
The outliers are presented here.

Actions
Elective Knee Replacement, 1 year Revision Rate is being reviewed by Planned Care Group

Appendix 2: Research and Development

1 Summary

1.0 This report summarises the clinical research activity at the RBFT and outlines the direction for Research and Development (R&D) which is in line with the trust objectives, The Thames Valley Comprehensive Local Research Network (TVCLRN) high level objectives and the Government's policy of embedding research and innovation into the NHS.

1.1 The Trust is required to submit this summary report to the Board for research governance purposes.

1.2 Key points of note are:

- Research and development is a strong strategic fit for the trust and the trust's simple aims
- Since inception in 2001 (annual income £30k) R&D now has approximately £1million income from TVCLRN with additional income from other sources of £0.5 million
- Research studies and participation in research studies has risen steadily over the last 4 years.
- R&D is funding and working closely with the Simulation Centre Director to develop innovative research in conjunction with Henley Business School
- The clinical research team work flexibly across the trust to enable clinicians to maintain clinical commitments and participate in clinical research.
- Restoration of the Innovation Fund and development of a Clinical Research Facility will enable R&D to income generate for the RBFT

2 Background

2.0 Research, development and innovation are important areas of activity for the trust.

(a) Research is a mechanism for improving patient care, developing science and developing individual careers.
(b) The presence of R&D activity not only increases the recruitment of the brightest, most experienced clinical staff, but also attracts commercial partners to generate income for the trust.
(c) Research stimulates the development of an intellectually rich environment
(d) The Government White Paper, Liberating the NHS (2010) and the national agenda demands a research-active organisation if excellence and first class UK healthcare systems are to be achieved
(e) Academic activity provides opportunities to develop strong specialist areas of research which are both nationally and internationally recognised.
(f) Successful R&D and innovation has great benefit for the image of the organisation

2.1 The Government's commitment to modernizing the NHS includes an investment of £4billion into R&D up to March 2015 via the National Institute for Health Research (NIHR).

2.2 The goal of the National Institute for Health Research (NIHR) is to create a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.

2.3 In line with this overall focus the Clinical Research Network (CRN), led by CEO, Jonathan Sheffield, has developed a number of initiatives to raise the profile of research across the NHS nationally. The 2011/12 NHS Trust Research Activity League Table places the RBFT 51st out of 405 NHS organisations nationally.

2.4 The trust's R&D reputation for national and international excellence is growing as it gains recognition for being the preferred host for collaborative and multi-centred research with commercial and non-commercial organisations. This benefits patients, staff, the wider NHS and the public.

2.5 The main source of funding for RBFT R&D is currently through the Thames Valley Comprehensive Research Network (TVCLRN). The TVCLRN is working to increase local NHS engagement with research and one of their core objectives for 2012/13 is to ensure

that the member trusts are reporting clinical research-related Key Performance Indicators to their trust Boards on a monthly basis. The TVCLRN is one of 25 CLRNs across England which forms part of the NIHR Comprehensive Clinical Research Network (CCRN). The CCRN provides support for clinical trials and other well designed studies in all areas of disease and clinical need. The TVCLRN is responsible for facilitating Research Governance approval for all trials on its portfolio and works closely with the RBFT R&D Department to monitor the level of activity ongoing within the trust.

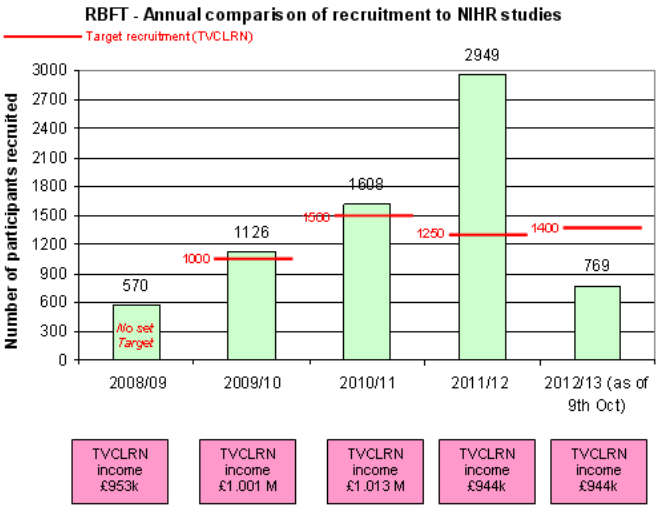
Portfolio trials are those registered on the United Kingdom Comprehensive Research Network (UKCRN) portfolio. Eligible studies include those funded by most of the major funding bodies such as the Medical Research Council, Health Technology Assessment (HTA) and the Department of Health. All researchers working or liaising with the trust to undertake research are strongly urged to register their trials on the UKCRN portfolio as two of the RBFT's key performance measures are the number of UKCRN studies in which we participate and the number of patients recruited into these trials.

RBFT participation in TVCLRN research studies has increased over the last 4 years. Patient recruitment into portfolio based studies has grown by an average of 74.3% over three years. Our patient recruitment targets for 2009/10, 2010/11, 2011/12 have been superseded as referenced in Graph 1. Our current target for 2012/13 is 1400 and is in line with the rest of the Thames Valley. This target is reflective of the number of studies currently open or closing to recruitment, as well as pending studies awaiting approval.

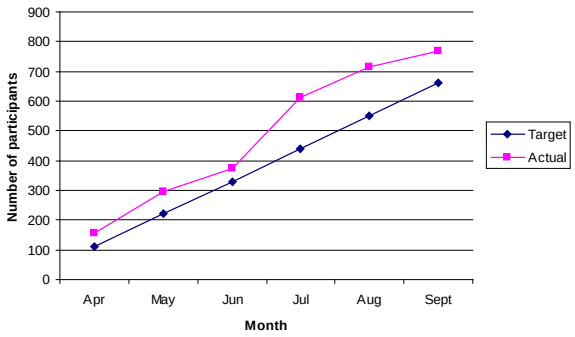
3 Development of R&D

3.0 R&D became operational within the trust in 2001 with an annual income of 30K. The annual budget allocated to the RBFT via the TVCLRN has been in the region of approximately £1million for the past three years. Additional income from other research networks, commercial studies and research grants provides the trust annual revenue in the region of £1.5 million annually. This has enabled the trust to establish a more stable infrastructure for conducting research with increased capacity to participate in portfolio studies.

Graph 1 - Summary of R&D activity (recruitment and RBFT TVCLRN income)



Graph 2 - Summary cumulative recruitment into NIHR studies (2012/13)



At mid year we are currently ahead of our set target by 5% as demonstrated in Graph 2.

Table 1 – Number of staff funded by R&D income

		URGENT CARE		PLANNED CARE		NETWORKED CARE		GENERIC / CORPORATE	
	WTE (ALL)	WTE in Post	WTE Vacancies	WTE in Post	WTE Vacancies	WTE in Post	WTE Vacancies	WTE in Post	WTE Vacancies
Medical Consultant	**1.3**	0.2		0.2		0.1		0.8	
Nurse	**19.0**	4.74	1	4.44		3.11		2.13	3.6
Midwife	**0.2**	0.2							
Radiographer	**2.3**			2.27					
Pharmacy	**3.3**					2.47	0.8		
Radiology	**0.6**	0.6							
Laboratory	**1.0**					1			
R&D Management	**4.6**							4.61	
Research Coordinator/Assistant	**7.6**			1	1			2.6	3
Total	**39.9**	**5.7**	**1.0**	**7.9**	**1.0**	**6.7**	**0.8**	**10.1**	**6.6**

There are 46 staff (30.47 WTE) currently employed by income received to support research activity (as of 1st October 2012). These are in a number of different roles across Care Groups as well as in generic roles that work flexibly across specialities (see Table 1 above).There are 9.4 WTE vacancies some of which can be accessed by trust staff in non research roles who are seeking career developmental opportunities.

4 Current R&D activity

4.0 As a research active organisation the R&D management team support our researchers to reduce avoidable harm and to improve patient care by offering experienced, trained research staff to enable clinicians to continue with their day to day work with minimal disruption. Our track record on utilising trained research staff to help enhance safety from a research governance perspective is excellent.

For our patients, our current aim is to deliver the best quality research care in an affordable way to ensure that each patient who enters the RBFT has the choice, if eligible, to be entered into a research study.

4.1 Research Governance

Research Governance is a broad range of regulations, principles and standards of good practice that exist to achieve, and continuously improve, research quality across all aspects of healthcare in the UK and worldwide. Research Governance in the RBFT:-

- Safeguard participants in research
- Protect researchers/investigators (by providing a clear framework to work within)
- Enhance ethical and scientific quality
- Minimise risk

- Monitor practice and performance
- Promote good practice and ensure lessons are learned

4.2 Core R&D Team

The prime responsibility of the R&D core team is for research governance and to provide services to assist in expanding the research capacity and capability across the trust. The R&D department has the responsibility for ensuring that approved trust research policies and procedures are followed for all trust research. A key to this is maintaining an open door policy for managing all aspects of the research, development and innovation process. This applies to all researchers and external organisations conducting research at the RBFT.

The R&D department has established links with the Research Design Service, Research Networks and NHS Innovations South East Hub in facilitating the protection and commercial exploitation of significant innovations arising out of trust research and other related activities.

4.3 Clinical Research Staff

R&D is committed to ensuring that research staff work flexibly across departments where portfolio projects are being conducted.

The clinical research team work flexibly across the trust to enable clinicians to maintain clinical commitments as well as enable them to participate in clinical research. As an integral part of this workforce we have looked at new ways of working and appointed Band 3 Research Assistants and Band 4 Research Coordinators in order to release research nurses from administrative duties, thus increasing capacity to recruit patients into research studies trust wide.

As an increasingly multi-strand organisation, carrying out many complex investigations and treatments, our research portfolio reflects this and is continuously growing in size and stature. We need to proactively examine new ways of working and delivering evidence based quality care and treatment to our patients and a flexible research workforce can help us do this.

4.4 Executive R&D Committee

The Executive R&D committee meets quarterly to direct and lead research, development and innovation activity in order to support and inform trust business planning and service development. The committee is comprised of a multidisciplinary clinical group and academic colleagues from the University of Reading. The meeting is chaired by the Medical Director. The R&D key performance indicators will be included in the Quality Report to the Board.

4.5 Good Clinical Practice (GCP)

GCP is an international quality standard that is provided by International Conference on Harmonisation (ICH), an international body that defines standards, which governs the regulations for clinical trials involving human subjects.

GCP guidelines include protection of human rights for participants in clinical trials. It also provides assurance of the safety and efficacy of newly developed medicines or devices. It includes standards on how clinical trials should be conducted and defines the roles and responsibilities of RBFT's researchers.

R&D has invested in training four (4) of our existing research staff as NIHR GCP facilitators to ensure that training is available to staff in Thames Valley and beyond. This is to enable researchers to adhere to the principles of conducting quality research. GCP training options have increased within the trust to provide a flexible programme in order to minimise the impact on clinical services whilst maintaining and achieving research responsibilities.

4.6 R&D Innovation fund

The innovation fund was launched in October 2010 to support and underpin the trust values of ambition, excellence and innovation. Awards have been made in the following areas to the amount of £34,791.78.

- Award 1 - Collaboration between Intensive Care Unit and Biochemstry looking at Plasma and Urine Neutrophil Gelatinase-Associated Lipocalin (NGAL) as markers of Acute Kidney Injury (AKI) in critically ill adults.
- Award 2 – Collaboration between Orthopaedics department and Microbiology examining the Incidence of Propionibacterium Acnes in patients with osteoarthritis undergoing primary joint replacement.
- Award 3 – Collaboration between Elderly Care and Simulation Centre with the aim to use the Trust's simulation facilities to develop and assess the utility of simulation scenarios in the training of elderly care staff and the resulting impact on patient safety.

Following a review by the finance department, funding previously identified for the innovation fund is no longer available

Two applications received prior to the above decision by finance and are pending final award. Access to funds is required to support these studies.

Care Group Finance Managers will be working more closely with R&D to ensure that research related income is managed in line with recent changes in accounting regulations.

4.7 Simulation Centre

R&D is funding and working closely with the Simulation Centre Director to establish research in conjunction with Henley Business School.

The collaboration will look at developing and evaluating clinical processes that can enhance the way the organisation operates. There will also be a thread looking at how to define, promote and assess team working to demonstrate strong team working. The aim will be enable reduced error rates, lower patient mortality, enhanced patient satisfaction and increased staff motivation. A multi-disciplinary, multi-professional simulation research group will be established to study the impact of simulation training across the trust.

4.8 Wider training function

R&D is now able to co-ordinate and host national courses at the RBFT to ensure that staff has optimum opportunities to access nationally accredited courses such as GCP inspections, auditing and monitoring study days, standard operating procedures and Bayley III paediatric training workshops. These courses are attended by research staff from a number of organisations nationwide.

5 Strategic Fit with Objectives

5.0 Research fits closely with the vision and simple aims of the trust, enhancing our ability to provide the best healthcare in the UK for patients in our community, and has direct impact on best outcomes, best patient experience and, through attracting higher quality of staff and staff development best place to work train and learn.

5.1 In a clinically-led system, involving clinicians in all aspects of running services around 3 different types of care is seen as an opportunity to help deliver affordable high quality research care using our existing resources. Within this structure, R&D activity is a streamlined thread which permeates across urgent, planned and networked care groups. We plan to achieve this in the following ways:-

- through engaging staff from a top down and bottom up approach
- build on lessons learnt, including challenges and achievements from previous years
- Integrate national and local research objectives to ensure that we remain competitive, ambitious and confident in our delivery of research services.

Our four aims	Annual Plan objectives	Lead
Provide the best experience for patients	1. Improve patient experience by providing choice to participate in more research studies across specialities. Increase by 3 new research active areas	Medical Director / R&D Lead Clinician / R&D Manager / R&D Clinical Implementation Manager
	2. Increase the number of health-services research studies on our portfolio with a focus on systems, processes and outcomes	R&D Lead Clinician / R&D Manager / Implementation Manager
	3. Achieve a rapid turnover in study approval by reducing time for R&D approval from an average of 40 days to 30 days	R&D Manager / R&D Clinical Implementation Manager
Deliver the best healthcare outcomes for our patients	4. Ensuring a streamlined and co-ordinated approach at local level to facilitate new portfolio studies from industry and Research Networks	R&D Lead Clinician / R&D Manager / R&D Clinical Implementation Manager
	5. Achieve 'better than expected' research outcomes by implementing the TVCLRN high level objectives	R&D Manager / R&D Clinical Implementation Manager
	6. Maximise opportunities for patients to be informed and made aware of research available within the trust through events such as international clinical trial days, members meetings and other media opportunities	R&D Lead Clinician / R&D Manager / R&D Clinical Implementation Manager
Provide the best value healthcare by living within our means	7. Expand our portfolio of clinical trials to improve our participation in randomised controlled clinical trials for cancer patients and achieve NCRN targets of 7.5%	R&D Lead Clinician / R&D Manager / R&D Clinical Implementation Manager
	8. Develop a clinical research facility to provide specialist research care and income generate for the RBFT	R&D Lead Clinician / R&D Manager / R&D Clinical Implementation Manager
	9. Plan and spend within budget by improving research capacity and delivering on our TVCLRN targets for 2012/13	R&D Manager / R&D Clinical Implementation Manager
Develop to be the best place to work, train and learn	10 Develop a generic training and induction package for research staff which can be used as a template across the Thames Valley. Achieve an appraisal rate of 100% and maintain research staff satisfaction rate	R&D Lead Clinician / R&D Manager / R&D Clinical Implementation Manager

6 Future developments:

6.0 Clinical Research Facility (CRF)

The aim is set up a CRF to provide support for researchers in the Thames Valley area and provide an opportunity to income generate for the RBFT. The CRF will operate from the RBFT / Bracknell sites. The unit will offer a purpose built, state-of-the-art, dedicated research facility which provide a specialist environment for the conduct of high quality clinical research. It will be supported by R&D, NIHR funds. The CRF staff will be available to investigators interested in undertaking clinical research and can provide research co-ordination support as well as nursing and technical support.

The CRF will be a resource open to researchers from all clinical disciplines encouraging collaboration with Research Networks, Charities, Medical Research Councils and the pharmaceutical industry to provide an opportunity to expand on existing research services.

7 References

- DH (2010) White Paper "Liberating the NHS: Legislative framework and next steps. DH. London.
- The Guardian Healthcare Network Clinical Research Zone (2012) http://www.guardian.co.uk/healthcare-network-nihr-clinical-research-zone

R&D SWOT analysis

Strengths:	**Weaknesses:**
• Sound reputation amongst RBFT staff for accessibility and quality of service from core management team. • Track record with TVCLRN for recruiting into studies. • Workforce model developed at RBFT recognized by TVCLRN who want to replicate it across the network. • Good links with research networks to continue building on existing portfolio of studies. • Low financial burden on RBFT. 98% of Trust research staff time currently paid from NIHR income (direct from R&D CLRN allocation or reimbursed from other research networks). • Numerous clinicians engaged and already research active. • Thames Valley speciality group leads based at RBFT for the following; 'Age and Ageing', 'Injuries and Emergencies', 'Critical Care' and 'Anaesthetics, peri-operative medicine and pain'	• Currently reliant on TVCLRN/NIHR annual income to support research activity (98% of research staff currently paid from NIHR income). • Low track record for attracting external research grants with poor in-house expertise to do so. • Poor availability to statistical expertise. • Income often allocated for length of project not on an annual basis which does not align with current accounting process. • Attracting the right calibre of staff due to contract terms and conditions. • Limited auditing and monitoring programme in place. • Lack of Innovation Fund available to pump-prime RBFT studies. • Funding not currently available to set up Clinical Research Facility (CRF).
Opportunities:	**Threats:**
• Staff infrastructure in place to attain a position of sustainability and continuity. • Further income generation opportunities attracting other programme grants (e.g. Service Delivery Organisation (SDO), Innovation for Invention (i4i) in conjunction with higher education institutions. • Possibility of increased income generation when we engage with new commercial studies. • Closer collaboration with Patient and Public involvement groups. • Application for Oxford Academic Health Science Network (AHSN) submitted. If awarded further collaborative opportunities will be available.	• No clinical space identified for Clinical Research Facility (CRF). • Inability to use budget within financial year due to recruitment issues and no identified location for CRF. • Re-structure of TVCLRN – may result in reduced funding • Expectation of increasing research activity but potential for reduced funding allocation. • High financial risk if external funding is reduced as currently only 2% of research staff are paid from departmental budget. • Training of new research staff / setting objectives for fixed term contracts. • External Inspection preparedness strategy not fully executed. • Lack of Innovation Fund available to pump-prime RBFT studies. • Funding not currently available to set up Clinical Research Facility (CRF).

High Level Objectives Summary

Objective	Measure	Timescale
Deliver Recruitment target	Target of 1400 for 2012/13	By end of March 2013
Non-commercial Studies -embed processes to measure time and target performance	-regular trust reporting of study performance by trust Research and Development Managers	-reported and updated monthly
Non-commercial Studies -meet CCRN time and target objective	-at least 80% of studies closing in 2012/13 meet time and target criteria	-at least 80% of studies closing in 2012/13 meet time and target criteria by year end
Industry -increase number of CCRN industry studies	-target of 5 industry studies at the trust recruiting one of more patients between 1st April 2012 and 31st March 2013	By end of March 2013
Industry -deliver against time and target metrics	-at least 80% of studies closing in 2012/13 to recruit in line with time and target criteria	By end of March 2013
RM&G - Median time in calendar days for **study-wide** checks to be completed - Median time in calendar days for **local** checks to be completed and NHS	30 calendar days	As at each month end and as measured on CCRN monthly activity report (subject to satisfactory operation of RDMIS system)
Escalation Policy for commercial and non-commercial studies	Develop and embed effective policies so that RM&G and study delivery issues can be promptly elevated and resolved	By end June 2012
Attendance at RM&G meetings	100% attendance required. R&D Manager to attend at least 75% of monthly RM&G meetings in person with option to delegate to other trust R&D staff if wished	By end of March 2013
Develop trust R&D website	New research pages on trust website developed in conjunction with CLRN website initiative	By end of March 2013
Research Event	Hold trust-wide research event to raise awareness of NIHR activities	By end of March 2013

Board of Directors

Title: **Director of Finance Report**

Date: **30 October 2012**

Lead: **Craig Anderson**

Purpose: **To update the Trust Executive and Board on the financial results of the Trust for September 2012**

Decision Required: **To NOTE the contents of this report**

Executive Summary

Financial Targets

- The key financial aim for 2012/13 is to maintain our FRR of 3 through:
  - Surplus of £3.2m (1% of Income)
  - Maintaining cash balance of £20m – can mitigate some slippage in surplus and maintain FRR 3 (as in 2011/12)
- Current surplus £3.0m adverse to budget driven by reduced PCT activity, non delivery of CIPs and pay and non pay overspends
- FRR of 3 maintained but only by the smallest of margins
- Greatest risk to maintaining FRR of 3 in H2 is ongoing EPR spend, non-delivery of CIPS, Non Pay in Clinical Supplies and E&F
- Key opportunities are ; recovery of PCT activity levels, income CIPs, and transitional funding from the PCT

Area of Review	Key Highlights	Month Rating	Projected Year End Rating
FRR	September YTD FRR 2.6 which rounds to a 3 for Monitor reporting		
Financial Position	YTD deficit of £(2.8)m vs budget £0.2m driven by variances in income and expenditure below.		
Activity/Income	YTD income of £160.5m, +£3.1m vs Budget with £1.7m of higher drugs income, £2.3m of incremental PCT funding, £1.0m settlement from prior year and some £1m of income CIPs all being offset by £1.8m of contract penalties and activity £2m behind budget in daycase and outpatients.		
Expenditure	YTD expenditure of £163.3m, £(5.9)m adverse vs Budget with pay £1.1m above budget, drugs £1.1m above budget (offset by incremental income), CIPs £0.9m below budget, EPR costs £750k above budget and estates some £0.5m above budget.		
EBITDA	YTD 5.4% vs Budget 7.3%		
Cash	Cash of £23.1m, vs Budget of £26.0m driven by lower EBITDA and higher capex		
Capital	YTD expenditure of £7.9m vs Budget of £7.2m driven by EPR		
CIPS	YTD delivery £3.6m , £(1.6)m behind plan		

1. Financial Position

Overall Financial Performance - Performance behind budget. FRR of 2.6.

Results for Month 6

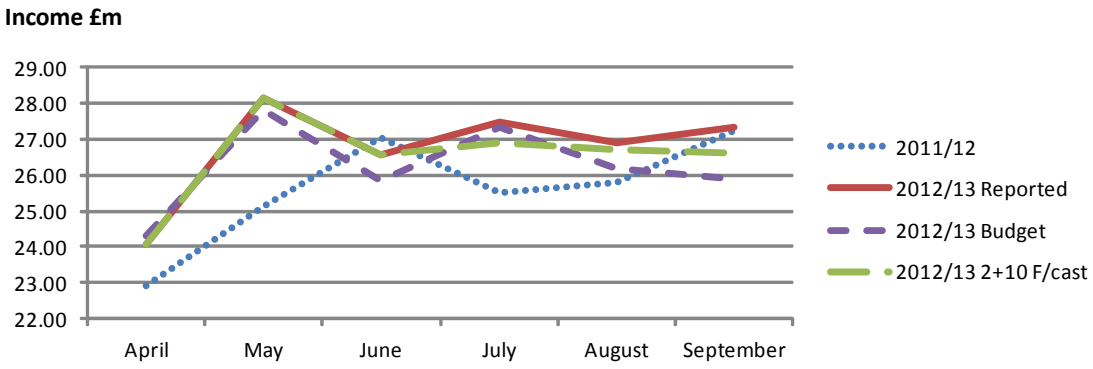
£m	Period			YTD		
	Actual	Vs Budget	Index PY	Actual	Vs Budget	Index PY
Income	27.3	1.4	100	160.5	3.1	104
Pay	(15.9)	(0.6)	104	(93.3)	(1.1)	103
Drugs	(2.7)	(0.2)	107	(16.0)	(1.1)	115
Non Pay ex Drugs	(8.3)	(0.9)	101	(50.4)	(3.7)	109
Other	(0.6)	(0.0)	85	(3.6)	(0.1)	87
Exceptional Items	0.0	0.0	(0)	(0.0)	(0.0)	2
Surplus/(Deficit)	**(0.2)**	**(0.3)**	**25**	**(2.8)**	**(3.0)**	**112**
FRR	**2.6**					

	Period		YTD	
	Actual	Budget	Actual	Budget
Cashflow from Operations	**(3.2)**	**(1.0)**	**(13.7)**	**(10.8)**
Cash	**23.1**	**26.0**	**23.1**	**26.0**
EBITDA	**1.9**	**2.0**	**8.7**	**11.5**
EBDITDA margin	**7.0%**	**7.7%**	**5.4%**	**7.3%**

- FRR of 2.6, but only just. Rounds up to 3.
- Ongoing issues with accurate capture of activity off EPR. Resulting judgements made in reporting of income that are significant in the context of the margin by which FRR achieved
- (£0.6m)for NEL Readmits penalty and (£1.2m) for NEL Threshold penalty – driven by high non elective work
- Ongoing EPR costs drive £0.5m of incremental cost in September
- Drugs costs 6% above budget YTD and 16% ahead of PY. Recovery % remains on target at 65% YTD
- Pay costs impacted by high agency in September.

Income ahead of budget and includes £1.9m of NEL admits and Threshold penalties for the first time

Income	MONTH			YTD		
	Actual £m	Vs Budget £m	Index PY	Actual £m	Vs Budget £m	Index PY
Income from Activities	25.5	1.5	106	148.8	2.4	105
Other Patient Care Income	0.5	0.2	106	1.9	0.1	104
Other Operating Income	1.3	(0.2)	50	9.8	0.6	92
Total Income	**27.3**	**1.4**	**100**	**160.5**	**3.1**	**104**



Analysis :

- Provision for NEL readmits (£0.6m) and NEL Threshold (£1.2m) created in September – reducing income by £1.8m.
- NEL Threshold provision would have been £0.6m higher if based on reported NEL activity, but adjusted because belief is that some activity reported as NEL is in fact EL. Work underway now to determine fact base.
- Income includes £1.0m activity estimated by care groups, not recorded on EPR
- Cquin income set at 100% based on expectation that PCT will agree to pay at that level. Otherwise would have been £0.7m lower.
- Transitional Funding at £288k (£2.2m YTD).
- £nil included for Contractual Risk on Follow Ups (risk £0.2m) or on other contractual risks (estimated risk £0.2m). These remain as a risk to our reported result.

Action :

- Evidence and quantify the extent to which reported NEL activity is in fact EL
- Seek agreement from PCT to pay Cquins at 100%

Pay costs £(1.1)m overspent YTD and 4% above PY driven by Medical and Nursing, predominantly Urgent Care (incremental funding received from PCT to compensate for this)

Analysis :

- Care Group pay is £(0.5)m vs Budget in September driven by Urgent Care
- Agency costs are down 16% vs PY, however bank % is low at 55%
- Other Pay driven by £(1.3)m YTD central pay CIPs. These have delivered £0.9m of benefit YTD elsewhere in the Trust, representing a shortfall vs budget of £(0.3)m

Action :

- Complete whole trust benchmarking exercise with Deloittes
- Review of medic resource plans underway to assess value for SPA cost
- Review of holiday planning underway to better manage main holiday periods
- Consider tightening controls over escalation to nursing agency

Non Pay Costs – Drugs £(1.1)m overspent YTD driven by Networked Care – recovery % in line with target at 64%

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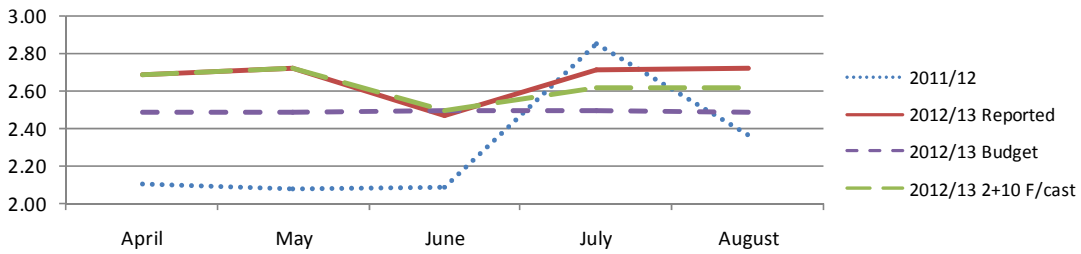


Analysis :

- Drugs costs were £(0.2)m adverse vs Budget in September but 2% down vs August
- Key driver of variance is Networked Care (Rheumatology) - this is offset by increased Drugs income so net impact is negligible
- There have also been stock adjustments with the introduction of JACs which require further investigation
- Drugs recovery % increased to 65% in September and remains broadly in line with target at 64% YTD

Action :

- Review of formulary by Drugs and Theraputics Group
- Conclude review of stock adjustments with new system
- Ensure ongoing links with Pharmacy experts in ProCure as ProCure is due to close in February
- Continue to drive maximum recharge of 64%

Non Pay Costs – Excluding Drugs £(3.7)m overspent vs Budget YTD and 9% ahead of PY driven by E&F CIPs and EPR .

Non Pay ex Drugs	MONTH			YTD		
	Actual £m	Vs Budget £m	Index PY	Actual £m	Vs Budget £m	Index PY
Clinical Service & Supplies	(3.0)	0.1	96	(18.7)	(0.5)	94
General Supplies & Services	(0.4)	0.2	81	(3.1)	0.1	105
Establishment Expenses	(0.2)	0.1	79	(1.6)	0.1	107
Other Establishment Expenses	(0.8)	0.1	122	(4.2)	1.4	114
Prem, Trans & Fixed Plant	(1.9)	(0.9)	147	(8.7)	(2.2)	138
Depreciation	(1.5)	(0.1)	119	(7.9)	(0.1)	121
Leases	(0.1)	0.1	65	(0.8)	0.3	81
Miscellaneous Services	(0.5)	(0.4)	47	(5.4)	(2.8)	127
Total Non Pay ex Drugs	**(8.3)**	**(0.9)**	**101**	**(50.4)**	**(3.7)**	**109**

Non Pay ex Drugs	MONTH			YTD		
	Actual £m	Vs Budget £m	Index PY	Actual £m	Vs Budget £m	Index PY
Urgent Care	(0.7)	0.1	88	(4.9)	0.2	94
Planned Care	(1.7)	0.3	93	(11.4)	1.1	93
Networked Care	(1.1)	0.1	67	(6.7)	0.2	74
Estates & Facilities	(1.1)	0.1	94	(7.8)	(0.8)	118
HFMS	0.2	(0.1)	81	1.6	(0.1)	114
Other Corporate	(3.8)	(1.4)	131	(21.2)	(4.4)	147
Total Non Pay ex Drugs	**(8.3)**	**(0.9)**	**101**	**(50.4)**	**(3.7)**	**109**

Analysis :

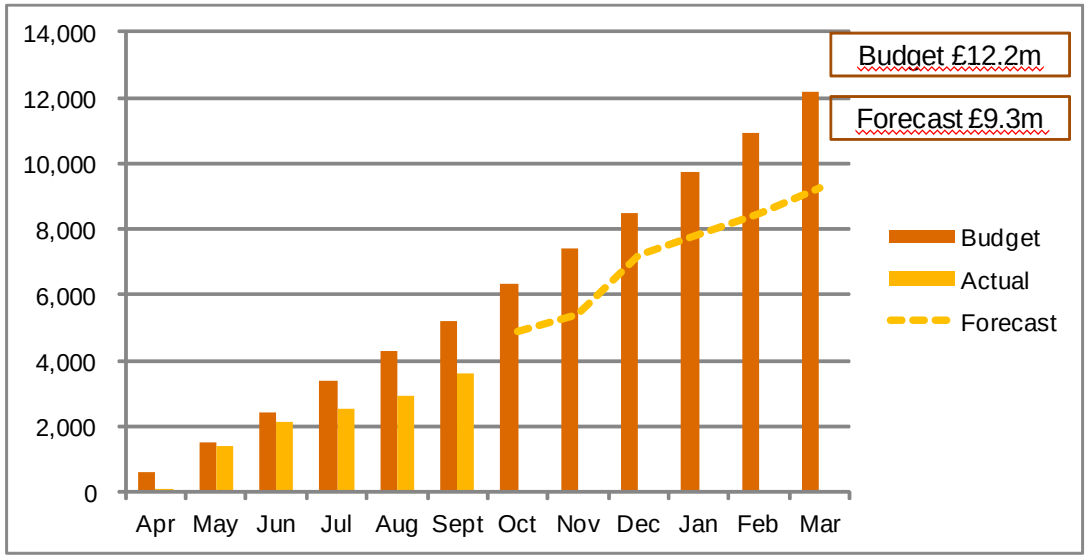
- Non-Pay ex Drugs £(0.9)m vs budget in September
- Key driver is £(0.5)m of EPR consultancy costs (within Other Corporate Misc Services).
- Care Groups +£0.5m but offsetting this are £(0.7)m of CIPs held within Corporate

Action :

- Benchmarking of clinical supplies spend underway, to be assisted by use of third party
- Monthly review of estates to control spend
- Discussion with PCT to support EPR costs

YTD Cost CIPs are £(1.6)m behind Budget, however income CIPs of £2.0m have been booked

CIP Phasing - Cumulative Budget and Latest Forecast £'000



Analysis :

- Cost CIPs £(1.6)m adverse to budget driven by Non-Pay
- Incremental Income CIPs of £2.0m have been booked
- Latest PMO full year assessment for cost CIPs is £9.3m versus full year budget £12.2m
- Main variances are Estates, IT, Capacity Planning and Drugs (see IPR)
- Full year income CIPs assessed at circa £5m

Action :

- QIPP Programme Board implemented, chaired by CEO
- Bi-weekly review of major projects by Commercial Director, FD and Head of PMO of major projects
- Actions plans to deliver CIPs being improved following PwC review
- Looking ahead focus on transformation programmes critical

2. Contractual Position with Commissioners for 2012/13

Agenda Item 5d)

Activity plans for 2012/13 have been agreed with all Commissioners with some contractual and pricing issues to be resolved with a few PCTs.

We have signed the contract with our main Commissioner, Berkshire West PCT. The financial risks on this contract from the PCTs QIPPS coming to fruition and emergency readmission penalties are being offset by agreements on transition funding. Such additional funding has been agreed in principle for stranded costs for lost income from QIPPS, costs arising on Neonatal care, the high levels of patients medically fit for transfer, rationalisation of estate and other service developments. Together this extra funding is expected to be in the region of £4.5m of which £2.0m has been recognised in the YTD reported income.

The Trust has been successful in negotiating a 3 months extension to the relaxation of the contractual penalty provisions to allow further time for EPR data issues to be resolved. Agreements on this point have been made with all of our significant commissioners (ie Berkshire West, Berkshire East, Oxfordshire and Buckinghamshire).

With respect to Berkshire East, Oxfordshire and Bucks PCTs the remaining negotiations on marginal rates and thresholds are planned to be completed in the next few weeks.
Monthly payments on account are being received from these PCTs and so the outstanding issues are only having a negligible impact on the Trust's cashflow.

However, we have seen an increasingly contractual position being taken by Berkshire West in recent weeks re A and E performance, Ambulance handovers and action plans relating to activity prior to EPR being implemented. The threat of contractual penalties and the withholding of cash have both been threatened, the latter being of greatest concern given their suggestion that they withhold 2% of each months total income due to our not yet agreeing an action plan re ambulance handover times.. A verbal update will be provided to the Board following further discussions with Berkshire West.

3. Other Information / Contracts and requisitions over £500k for approval

There are two contracts, listed below, for review and approval by the Board. A separate paper has been submitted to the Board for each of these.

1). Synergy decontamination
2). Audiology any qualified provider.

4. Appendices

The following reports are included as Appendices:

Appendix (i)	Statement of Comprehensive Income (SOCI): Month and Ytd Actual vs Budget
Appendix (ii)	Statement of Comprehensive Income (SOCI): July forecast vs Budget
Appendix (iii)	Income by Point of Delivery
Appendix (iv)	Care Group Financial Reports
Appendix (v)	Statement of Financial Position (SOFP)
Appendix (vi)	Cash Flow Statement
Appendix (vii)	Capital Expenditure Summary
Appendix (viii)	Financial Risk Rating
Appendix (ix)	Patient Level Reporting – 2011/12 FY, 2012/13 Q1

Appendix (i): Statement of Comprehensive Income (SOCI) – Month and YTD Actual vs Budget

APPENDIX 1: STATEMENT OF COMPREHENSIVE INCOME

	Month of September 2012 (£'000)				Year to September 2012 (£'000)			
Detail	**Actual**	**Budget**	**Variance Budget**	**Last Year**	**Actual**	**Budget**	**Variance Budget**	**Last Year**
Income from Activities	25,522	24,061	1,460	24,129	148,807	146,392	2,415	141,253
Other Patient Care Income	470	292	178	445	1,854	1,752	102	1,778
Other Operating Income	1,323	1,541	(218)	2,671	9,802	9,248	554	10,632
Income	**27,314**	**25,895**	**1,420**	**27,245**	**160,463**	**157,393**	**3,071**	**153,664**
Medical Staff	(4,532)	(4,421)	(111)	(4,434)	(26,716)	(26,554)	(162)	(25,795)
Nursing	(6,339)	(6,120)	(219)	(6,157)	(37,333)	(36,496)	(837)	(36,631)
PAMs	(882)	(896)	14	(852)	(5,148)	(5,352)	204	(4,906)
Scientist and PTBs	(1,016)	(1,082)	66	(998)	(6,007)	(6,492)	485	(5,935)
Pharmacists	(189)	(200)	11	(176)	(1,081)	(1,199)	119	(1,066)
Admin & Management	(2,175)	(2,099)	(76)	(2,006)	(12,600)	(12,680)	80	(12,241)
Ancillary & Maintenance	(749)	(677)	(72)	(654)	(4,310)	(4,200)	(110)	(4,207)
Other Pay	(12)	166	(177)	18	(59)	831	(890)	(12)
Pay	**(15,894)**	**(15,329)**	**(565)**	**(15,259)**	**(93,254)**	**(92,144)**	**(1,110)**	**(90,792)**
Drugs	(2,674)	(2,441)	(233)	(2,489)	(15,979)	(14,862)	(1,117)	(13,955)
Clinical Service & Supplies	(3,018)	(3,096)	78	(3,153)	(18,742)	(18,216)	(526)	(19,915)
General Supplies & Services	(350)	(540)	190	(432)	(3,143)	(3,216)	73	(2,983)
Establishment Expenses	(223)	(294)	71	(280)	(1,613)	(1,753)	140	(1,514)
Other Establishment Expenses	(778)	(925)	147	(637)	(4,190)	(5,546)	1,356	(3,692)
Prem, Trans & Fixed Plant	(1,881)	(997)	(883)	(1,275)	(8,679)	(6,478)	(2,201)	(6,288)
Depreciation	(1,463)	(1,317)	(146)	(1,227)	(7,929)	(7,813)	(116)	(6,558)
Leases	(93)	(176)	82	(143)	(771)	(1,053)	283	(952)
Miscellaneous Services	(502)	(92)	(410)	(1,077)	(5,361)	(2,605)	(2,756)	(4,217)
Non Pay	**(10,981)**	**(9,876)**	**(1,104)**	**(10,713)**	**(66,407)**	**(61,542)**	**(4,865)**	**(60,072)**
PDC Dividend	(482)	(482)	(0)	(726)	(2,891)	(2,891)	0	(3,618)
Interest Receiveable	(113)	(111)	(2)	25	(688)	(615)	(73)	(506)
Other	**(595)**	**(593)**	**(2)**	**(701)**	**(3,579)**	**(3,506)**	**(73)**	**(4,124)**
Total before exceptional items	**(155)**	**96**	**(251)**	**573**	**(2,778)**	**200**	**(2,978)**	**(1,324)**
Disposal of Assets	2	0	0	0	0	0	0	0
Exceptional Items	(1)	0	(1)	(1,181)	(20)	0	(20)	(1,177)
Exceptional	**1**	**0**	**(1)**	**(1,181)**	**(20)**	**0**	**(20)**	**(1,177)**
Total	**(154)**	**96**	**(252)**	**(608)**	**(2,797)**	**200**	**(2,998)**	**(2,501)**

Appendix (ii): Statement of Comprehensive Income (SOCI) – October Forecast vs July Forecast and vs Budget

Please refer to separate Board Paper

Appendix (iii): Income from Activities by Point of Delivery – month

Agenda Item 5d)

Income by POD

All PCTs (including NCAs) September 2012

POD Group	POD Detail	Annual Contract (Activity)	Annual Contract (£'000)	Mth 06 Only Contract (Activity)	Mth 06 Only Contract (£'000)	Mth 06 Only Actual (Activity)	Mth 06 Only Actual (£'000)	Mth 06 Var (Activity)	Mth 06 Var (£'000)
A&E	Accident & Emergency	105,016	10,750	8,632	884	8,417	860	(215)	(24)
A&E Total			**10,750**		**884**		**860**		**(24)**
Outpatient	Outpatient FA Multi Prof Cons Led	3,392	670	276	54	347	80	71	26
	Outpatient FA Single Prof Cons Led	130,899	21,377	10,642	1,738	11,905	1,944	1,263	206
	Add Back PCT QIPPs - Outpatient FA Single Prof Cons Led		(58)		(5)		0		5
	Outpatient FA Single Prof Non-Cons Led	9,700	1,151	789	94	725	82	(64)	(12)
	Outpatient FUP Multi Prof Cons Led	6,447	620	524	50	588	67	64	17
	Add Back PCT QIPPs - Outpatient FUP Multi Prof Cons Led		37		3		0		(3)
	Outpatient FUP Single Prof Cons Led	230,856	23,813	18,769	1,936	17,583	1,864	(1,186)	(72)
	Add Back PCT QIPPs - Outpatient FUP Single Prof Cons Led		356		29		0		(29)
	Outpatient FUP Single Prof Non-Cons Led	59,458	3,281	4,834	267	4,783	272	(51)	5
	Non Face to Face	1,204	31	98	3	143	4	45	1
	Outpatient Procedures	22,457	5,817	1,826	473	2,205	543	379	70
	Add Back PCT QIPPs - Outpatient Procedures		(625)		(51)		0		51
Outpatient Total			**56,470**		**4,591**		**4,856**		**265**
Inpatient	Elective Inpatients	8,957	26,405	728	2,147	612	2,004	(116)	(143)
	Add Back PCT QIPPs - Elective		26		2		0		(2)
	Elective Excess Bed Days	2,381	638	194	52	28	8	(166)	(44)
	Day Cases	31,541	29,786	2,564	2,422	2,530	2,470	(34)	48
	Add Back PCT QIPPs - Day Cases		1,075		88		0		(88)
	Regular Day Admission	3,393	1,059	276	86	595	185	319	99
	Emergency Inpatients (Excluding Maternity)	27,784	61,178	2,284	5,028	2,405	5,599	121	571
	Add Back PCT QIPPs - Emergency Inpatients (Excluding Maternity)		2,484		203		0		(203)
	Maternity Inpatients	11,980	15,375	984	1,264	1,023	1,313	39	49
	Emergency Same Day	923	831	76	68	61	54	(15)	(14)
	Emergency Short Stay	2,721	2,030	223	167	209	187	(14)	20
	Emergency Excess Bed Days	15,332	3,938	1,260	324	1,630	414	370	90
	Maternity Excess Bed Days	1,319	595	108	49	169	77	61	28
	Rehab Bed Days	5,607	1,777	456	144	963	305	507	161
Inpatient Total			**147,197**		**12,044**		**12,616**		**572**
Critical Care	Adult Critical Care	3,365	4,774	276	392	247	335	(29)	(57)
	Neonatal Critical Care	5,807	3,521	477	289	401	254	(76)	(35)
Critical Care Total		**9,172**	**8,295**	**753**	**682**		**589**		**(93)**
Renal	Renal	76,249	10,630	6,355	886	0	898		12
	Renal EPO Drugs		457		38		40		2
Renal Total			**11,087**		**924**		**938**		**14**
Drugs	PbR Excluded Drugs		17,788		1,482		1,984		502
	PbR Excluded Devices		1,984		166		213		47
Drugs Total			**19,772**		**1,648**		**2,197**		**549**
Other	Orthotics Direct Access	3,773	935	307	76	(100)	(11)	(407)	(87)
	Pathology Direct Access	2,722,543	6,330	221,345	515	242,053	556	20,708	41
	Add Back PCT QIPPs - Pathology Direct Access		247		20		0		(20)
	Radiology Direct Access	32,496	1,257	2,642	102	2,893	111	251	9
	Add Back PCT QIPPs - Radiology Direct Access		116		9		0		(9)
	Radiotherapy		4,499		366	0	402		36
	Radiotherapy IMRT		32		3	0	(13)		(16)
	Chemotherapy		2,837		231	0	197		(34)
	Pre-op Assessments	23,995	984	1,951	80	1,744	71	(207)	(9)
	Unbundled Activity		56		5	0	0		(5)
	Post Discharge Rehab	822	504	67	41	27	16	(40)	(25)
	Non PbR Block Items		7,358		613		620		7
	Other	50,397	1,400	4,092	114	3,757	98	(335)	(16)
Other Total			**26,555**		**2,174**		**2,047**		**(127)**
Adjustments	ESD Discount		(150)		(13)		(12)		1
	Audiology Hearing Aid Assessment Discount (re Pathway Tariff)		0		0		(19)		(19)
	SCAS Delays Penalties		0		0		2		2
	Best Practice Top Ups		0		0		129		129
	Non Elective Threshold		0		0		(1,127)		(1,127)
	Non Elective Readmissions		0		0		(556)		(556)
	Outpatient New to Follow Up Ratio		0		0		0		0
	OP Procedure to Daycase Ratio		0		0		0		0
	Contract Income Provision		0		0		(54)		(54)
	Contract Income Provision Release re 2011/12		0		0		775		775
	Add Back PCT QIPPs		0		0		0		0
	CQUINs		6,414		525		1,043		518
	PCT Transitional Funding		0		0		288		288
	Adjust re EPR Activity Errors		0		0		0		0
	Adjust re missing activity		0		0		471		471
	Adjust re Mths 3 & 4 Duplicate U Coded Spells		0		0		(300)		(300)
	Adjust Budget to Top-Down Total		4,210		351		0		(351)
Adjustments Total			**10,474**		**863**		**640**		**(223)**
Other Income from Activites	TVIC Dermatology		1,923		160		261		101
	Change re Spells in Progress (vs M12 11-12)		0		0		380		380
	Oxford Morbid Obesity Service		328		27		71		44
	Bowel Screening		537		45		45		0
	Others		237		20		21		1
Other Income from Activities Total			**3,025**		**252**		**778**		**526**
TOTAL (= 'Income from Activities' per MARS)			**293,625**		**24,061**		**25,521**		**1,459**

Appendix (iii): Income from Activities by Point of Delivery – ytd

Agenda Item 5d)

Income by POD

All PCTs (including NCAs) April to September 2012

POD Group	POD Detail	Annual Contract (Activity)	Annual Contract (£'000)	YTD Mth 06 Contract (Activity)	YTD Mth 06 Contract (£'000)	YTD Mth 06 Actual (Activity)	YTD Mth 06 Actual (£'000)	YTD Var (Activity)	YTD Var (£'000)
A&E	Accident & Emergency	105,016	10,750	52,652	5,390	49,462	5,146	(3,190)	(244)
A&E Total			**10,750**		**5,390**		**5,146**		**(244)**
Outpatient	Outpatient FA Multi Prof Cons Led	3,392	670	1,682	332	1,892	404	210	72
	Outpatient FA Single Prof Cons Led	130,899	21,377	64,917	10,602	67,150	11,003	2,233	401
	Add Back PCT QIPPs - Outpatient FA Single Prof Cons Led		(58)		(29)		0		29
	Outpatient FA Single Prof Non-Cons Led	9,700	1,151	4,811	571	4,856	583	45	12
	Outpatient FUP Multi Prof Cons Led	6,447	620	3,197	307	3,367	356	170	49
	Add Back PCT QIPPs - Outpatient FUP Multi Prof Cons Led		37		18		0		(18)
	Outpatient FUP Single Prof Cons Led	230,856	23,813	114,490	11,810	108,398	11,329	(6,092)	(481)
	Add Back PCT QIPPs - Outpatient FUP Single Prof Cons Led		356		177		0		(177)
	Outpatient FUP Single Prof Non-Cons Led	59,458	3,281	29,487	1,627	31,614	1,790	2,127	163
	Non Face to Face	1,204	31	597	15	728	19	131	4
	Outpatient Procedures	22,457	5,817	11,137	2,885	10,709	2,625	(428)	(260)
	Add Back PCT QIPPs - Outpatient Procedures		(625)		(312)		0		312
Outpatient Total			**56,470**		**28,005**		**28,109**		**104**
Inpatient	Elective Inpatients	8,957	26,405	4,442	13,095	4,001	12,432	(441)	(663)
	Add Back PCT QIPPs - Elective		26		13		0		(13)
	Elective Excess Bed Days	2,381	638	1,181	316	531	138	(650)	(178)
	Day Cases	31,541	29,786	15,642	14,772	14,995	14,007	(647)	(765)
	Add Back PCT QIPPs - Day Cases		1,075		536		0		(536)
	Regular Day Admission	3,393	1,059	1,683	525	2,107	657	424	132
	Emergency Inpatients (Excluding Maternity)	27,784	61,178	13,930	30,673	14,634	33,566	704	2,893
	Add Back PCT QIPPs - Emergency Inpatients (Excluding Maternity)		2,484		1,238		0		(1,238)
	Maternity Inpatients	11,980	15,375	6,006	7,709	6,434	8,426	428	717
	Emergency Same Day	923	831	463	417	388	356	(75)	(61)
	Emergency Short Stay	2,721	2,030	1,364	1,018	1,364	1,017	0	(1)
	Emergency Excess Bed Days	15,332	3,938	7,687	1,974	8,819	2,263	1,132	289
	Maternity Excess Bed Days	1,319	595	661	298	527	238	(134)	(60)
	Rehab Bed Days	5,607	1,777	2,781	881	2,546	807	(235)	(74)
Inpatient Total			**147,197**		**73,465**		**73,907**		**442**
Critical Care	Adult Critical Care	3,365	4,774	1,687	2,394	1,883	2,567	196	173
	Neonatal Critical Care	5,807	3,521	2,911	1,765	2,624	1,692	(287)	(73)
Critical Care Total		**9,172**	**8,295**	**4,598**	**4,159**		**4,259**		**100**
Renal	Renal	76,249	10,630	38,125	5,315		5,385		70
	Renal EPO Drugs		457		229		241		13
Renal Total			**11,087**		**5,544**		**5,626**		**83**
Drugs	PbR Excluded Drugs		17,788		8,894		10,434		1,540
	PbR Excluded Devices		1,984		994		1,113		119
Drugs Total			**19,772**		**9,888**		**11,547**		**1,659**
Other	Orthotics Direct Access	3,773	935	1,871	464	1,423	340	(448)	(124)
	Pathology Direct Access	2,722,543	6,330	1,350,204	3,139	1,481,260	3,429	131,056	290
	Add Back PCT QIPPs - Pathology Direct Access		247		123		0		(123)
	Radiology Direct Access	32,496	1,257	16,116	623	18,778	707	2,662	84
	Add Back PCT QIPPs - Radiology Direct Access		116		58		0		(58)
	Radiotherapy		4,499		2,231		2,336		105
	Radiotherapy IMRT		32		16		0		(16)
	Chemotherapy		2,837		1,407		1,181		(226)
	Pre-op Assessments	23,995	984	11,900	488	9,035	370	(2,865)	(118)
	Unbundled Activity		56		28		0		(28)
	Post Discharge Rehab	822	504	408	250	96	58	(312)	(192)
	Non PbR Block Items		7,358		3,679		3,721		42
	Other	50,397	1,400	25,055	696	23,956	629	(1,099)	(67)
Other Total			**26,555**		**13,202**		**12,771**		**(431)**
Adjustments	ESD Discount		(150)		(75)		(75)		0
	Audiology Hearing Aid Assessment Discount (re Pathway Tariff)		0		0		(113)		(113)
	SCAS Delays Penalties		0		0		(50)		(50)
	Best Practice Top Ups		0		0		629		629
	Non Elective Threshold		0		0		(1,127)		(1,127)
	Non Elective Readmissions		0		0		(556)		(556)
	Outpatient Follow Up Activity Penalty		0		0		0		0
	OP Procedure to Daycase Ratio		0		0		0		0
	Contract Income Provision		0		0		(323)		(323)
	Contract Income Provision Release re 2011/12		0		0		848		848
	Add Back PCT QIPPs		0		0		0		0
	CQUINs		6,414		3,197		3,631		434
	PCT Transitional Funding		0		0		2,259		2,259
	Adjust re EPR Activity Errors		0		0		0		0
	Adjust re missing activity		0		0		971		971
	Adjust re Mths 3 & 4 Duplicate U Coded Spells		0		0		(300)		(300)
	Adjust Budget to Top-Down Total		4,210		2,105		0		(2,105)
Adjustments Total			**10,474**		**5,227**		**5,794**		**567**
Other Income from Activites	TVIC Dermatology		1,923		962		1,039		78
	Change re Spells in Progress (vs M12 11-12)		0		0		(64)		(64)
	Oxford Morbid Obesity Service		328		164		197		33
	Bowel Screening		537		269		273		5
	Others		237		118		203		85
Other Income from Activities Total			**3,025**		**1,512**		**1,648**		**135**
TOTAL (= 'Income from Activities' per MARS)			**293,625**		**146,392**		**148,807**		**2,415**

Appendix (iv): Care Group Financial Reports - UCG

Urgent Care Group financial performance Month 6 2012/13	Month 6			Year to Date		
	2013 Actual	2013 Budget	2013 Variance	2013 Actual	2013 Budget	2013 Variance
Income from activities (excl d&d)	7,679,056	7,555,451	123,605	48,073,012	46,037,150	2,035,862
Drugs Income	301,373	140,785	160,588	1,314,040	844,710	469,330
Other Patient Care Income	21,958	67,882	(45,924)	279,081	407,292	(128,211)
Other Operating Income	70,090	83,550	(13,460)	451,855	501,300	(49,445)
Other income	92,048	151,432	(59,384)	730,937	908,592	(177,655)
Total income	8,072,478	7,847,668	224,810	50,117,988	47,790,452	2,327,536
Pay	(5,374,764)	(4,972,520)	(402,244)	(31,308,147)	(29,900,497)	(1,407,649)
Pay as % of income	*-67%*	*-63%*	*-179%*	*-63%*	*-63%*	*-61%*
Drugs	(351,306)	(361,934)	10,628	(2,437,408)	(2,195,602)	(241,806)
Clinical Services and Supplies	(547,405)	(673,008)	125,603	(3,984,378)	(4,038,050)	53,672
General Services and Supplies	(62,590)	(62,111)	(478)	(443,332)	(372,667)	(70,665)
Establishment Expenses	(41,442)	(57,259)	15,817	(245,233)	(343,552)	98,319
Other Establishment Expenses	(8,048)	(3,433)	(4,615)	(22,609)	(20,598)	(2,012)
Prem, Trans & Fixed Plant	(17,338)	(14,720)	(2,619)	(53,733)	(88,318)	34,585
Leases	335	401	(66)	547	2,404	(1,857)
Miscellaneous Services	(37,888)	(42,069)	4,181	(172,941)	(262,643)	89,702
Other Non Pay (excl dep'n)	(104,382)	(117,080)	12,698	(493,969)	(712,707)	218,738
Total Non Pay (excl dep'n)	(1,065,683)	(1,214,133)	148,450	(7,359,087)	(7,319,026)	(40,061)
EBITDA	1,632,031	1,661,016	(28,984)	11,450,755	10,570,929	879,826

Appendix (iv): Care Group Financial Reports - UCG

Commentary on the Urgent Care Group Financial position

Income £225k above budget M6 and £2.3m ytd driven by CDU, Gastroenterology and Respiratory. Non Elective Threshold and Re-admissions for the Care Group will reduced income by £700k. (of £1.8m Trust total).

Transitional funding coded to the Care Group year-to-date is £1.5m.

Pay £(402)k over budget in month - costs increased by £(165)k from August driven by:

Nursing costs increased by £(84)k :Paediatrics Nursing costs increased by £(48)k - NHSP agency & Thornbury, driven by 1:1 Mental Health Nursing requirements on Dolphin and high Neonatal Unit activity levels in the month.

A&E Nursing staff costs increased by £(8)k in Month 6 due to increased Band 6 costs, following the commencement of investment to address safety issues.

Respiratory Castle Ward costs increased by £(17)k - nurse on suspension, patient acuity and double running costs for 2 new starters.

Drs costs increased by £(43)k: Consultant Radiologists are overspent by £(11)k in Month 6 due to locums working on Plain Film and MRI backlog, sickness and maternity leave.

A&E and CDU Medics are overspent by £(12)k in Month 6 – following the commencement of investment to address safety issues.

Consultant job plan review back pay costs of £(22)k - future agreement of changes to be agreed to come through Care Group Board.

In Month 5 there was a one off credit on Consultants from repayment of £10k.

PAMS costs increased by £(28)k: Radiology PAMs costs increased by £(25)k in Main X Ray & CT Scanner Band 5 & 6's.

Non Pay £149k under budget in month - decreased by £241k from August to September due to one off benefits:

Approximately £100k one off benefit in Cardiology from adjustments and re-assessment of periodicity of an ICD and Pacemaker block contract.

Drugs costs were low in September compared to August (£110k benefit) the reported costs are volatile from one month to the next and are expected to increase significantly in Month 7.

The underlying position is broadly flat with Month 5.

Key risks:

Community based capacity does not materialise and further increases pressure upon the wards with operational efficiency impact.
NEL Threshold and Re-admission rates approx £(700)k M1-6.
Agency requirements maintain the current trajectory (approx £150k)
CDU not functioning as triage as it has in the first half (£300k).
Cardiology Emergency activity falls by 15% compared with the first half (as was the case in 2011/12) (£143k at 30% marginal rate) – not in activity plan.

Key Opportunities

Negotiation with PCT to achieve non recurrent funding for A&E - next two weeks.

Community based beds and ring fencing of triage in CDU saving approx £17k/week.

Recruit to vacancies reducing reliance on nursing agency staff shifts.

Achieve Paeds BPT, full achievement = £681k this is not in the income budget – need software system.

Further review of Cardiology consumables contracts - St Jude (Medtronic achieved approx £85k).

Non pay savings opportunities in Radiology at first through NHS Supplies.

New starters in Maternity and Paediatrics will reduce Thornbury usage

Recharging Mental Health 1:1 costs.

Actions

Weekly review of Nursing agency staffing requirements commencing Tuesday 23rd.

Bi-weekly meeting with procurement to drive through non pay savings opportunities.

Review of drugs expenditure through the new Qlikview report.

Review of ICU Nursing establishment & A&E staffing review.

Q2 Forecast to end of 2012/13 contribution to ohds £3.6m better than budget:

Income, £7.8m surplus, continuing post EPR trends in Gastro & Resp and transitional funding split over the 12 mths (NE threshold & re-admits would decrease it by approx £1.4m).

Pay forecast is £(3.5)m deficit, variation from Q1 forecast driven by £(0.5)m A&E investment to assist with national targets, agreement to recruit above establishment for Midwives to improve Midwife:Birth ratio £(0.3)m, CDU triage is forecast to run intermittently (£0.35)m.

Non Pay forecast is £(0.6)m, this is driven by increased spend in Months 4 & 5 and drugs forecast to continue the increased spend trend of the last quarter. One off benefits (approx. £250k) in M6 may improve this forecast.

Appendix (iv): Care Group Financial Reports - PCG

Planned Care Group

FINANCIAL YEAR 2012/13 - COMPARISON OF NETWORKED CARE ACTUAL RESULTS TO BUDGET

	MONTH 6			MONTH 6 YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Income from activities (excl drugs)	8,438,696	9,230,323	(791,627)	53,838,245	56,292,494	(2,454,249)
Drugs Income	813,928	633,345	180,583	4,805,815	3,800,070	1,005,745
Other Patient Care Income	135,099	74,977	60,122	1,137,788	449,862	687,926
Other Operating Income	165,377	107,652	57,725	687,022	578,979	108,043
Total Income	**9,553,100**	**10,046,297**	**(493,197)**	**60,468,870**	**61,121,405**	**(652,535)**
Medical Staff	(2,125,996)	(2,087,598)	(38,398)	(12,585,380)	(12,538,892)	(46,488)
Nursing	(1,938,009)	(2,052,827)	114,818	(11,567,502)	(12,241,465)	673,963
PAMs	(236,478)	(242,152)	5,674	(1,379,933)	(1,452,913)	72,980
Scientist and PTBs	(203,191)	(214,960)	11,768	(1,185,104)	(1,287,878)	102,774
Pharmacists	0	0	0	0	0	0
Admin & Management	(666,352)	(584,242)	(82,110)	(3,723,590)	(3,475,278)	(248,312)
Ancillary & Maintenance	(8,058)	(4,526)	(3,532)	(49,201)	(27,153)	(22,048)
Other Pay	14,046	20,505	(6,458)	72,404	123,028	(50,624)
Total Pay	**(5,164,037)**	**(5,165,799)**	**1,763**	**(30,418,307)**	**(30,900,550)**	**482,244**
Pay as % of income	*54%*	*51%*	*0%*	*50%*	*51%*	*74%*
Contracted wte	*-1323.13*	*-1409.73*	87	*-1318.08*	*-1405.27*	87
Drugs	(1,023,339)	(994,470)	(28,868)	(6,128,746)	(6,131,827)	3,081
Clinical Services and Supplies	(1,527,593)	(1,615,138)	87,545	(8,958,418)	(9,697,451)	739,033
General Services and Supplies	(68,314)	(75,636)	7,322	(457,342)	(454,400)	(2,943)
Establishment Expenses	(78,414)	(69,807)	(8,607)	(309,302)	(418,885)	109,584
Other Establishment Expenses	(591)	(6,048)	5,457	(5,771)	(36,289)	30,518
Prem, Trans & Fixed Plant	(27,571)	(26,315)	(1,256)	(208,185)	(182,529)	(25,656)
Leases	(39,736)	(43,650)	3,914	(246,533)	(261,898)	15,365
Miscellaneous Services (Excl Internal Recharges)	12,023	(238,232)	250,255	(1,170,576)	(1,398,098)	227,522
Internal Recharges	(11,542)	(15,805)	4,262	(74,864)	(96,054)	21,190
Other Non Pay (excl dep'n)	(145,831)	(399,856)	254,025	(2,015,231)	(2,393,754)	378,523
Total Non Pay (excl depn)	**(2,765,077)**	**(3,085,101)**	**320,023**	**(17,559,738)**	**(18,677,432)**	**1,117,694**
Operating Surplus (Loss)	**1,623,986**	**1,795,397**	**(171,411)**	**12,490,825**	**11,543,423**	**947,403**
Margin (Surplus/ Loss as a % income)	*17%*	*18%*	*35%*	*21%*	*19%*	*-145%*

Appendix (iv): Care Group Financial Reports - PCG

Financial position
Commentary:

Income:

PCG continues to under perform against PCT income targets. In September the breakdown by speciality is as follows: Abdominal Surgery (£337k), Specialist Surgery (£151k) and Berkshire Cancer Centre (£140k).

Private patient income continues to over perform against plan (£57k) in September. The majority of this (£53k) is in the Berkshire Cancer Centre.

The £58k favourable variance in Other operating income is due a reconciliation between League of friends at WBCH of income yet to be invoiced.

Pay:

Pay was £2k under budget in month with an increase of £113k on the monthly average.

Medics pay is over budget this month, primarily due to an increase in Specialist Registrar trainee costs. The increase in pay costs will be ongoing however there are currently 4 trainee posts which should currently sit in other Care Groups.

Nursing pay remains under budget, although there was a £9k increase in month 06, reflecting August bank holiday enhancements paid in September. The nursing CIP has been achieved and PCG continues to be under budget in Nursing pay due to vacancies.

The under spend to budget in PAMs and scientists remains consistent with run rate although some vacancies have been filled this month, reducing the under spend to budget.

Admin & Management continues to over spend against budget, the key reason for this is agency usage. Year to date PCG has spent £408k on agency, of which approximately £100k is attributed to EPR.

Non Pay:

In M06 there is a one off adjustment of £250k in the Miscellaneous Services account line, the underlying non-pay position is £68k favourable.

The one off adjustment is due to the release of provisions that were no longer required by the Planned Care Group.

Drugs costs are consistent with run rate for this year excluding one off credit notes, Pegfilgrastim usage continues to decline in line with plan.

The under spend in Clinical Services & Supplies is due to two main reasons - the achievement of the mattress library CIP & the control of outsourcing to private hospitals - BIH & Dunedin.

Key risks

The correct coding of activity in PCG - Non Elective activity, PCEU procedures

Private Patient office - ability to deliver service in the interim

Activity loss due to closure of Gynae theatres

Key Opportunities

PCEU Orthoptist - saving to be made by bringing the service back in house & having a consistent service across both sites.

CESP - Growth in private patient Ophthalmology income.

Depuy - metal on metal hip replacements

Actions

Forecast:

The starting basis for the Trust Q2 forecast was budget for months 6-12 with adjustments made to reflect that in some areas run rate is significantly different to budget.

The forecast assumes that PCG will achieve its CQUINS - 1.5% of PCT plan & that the Care group will be able to improve performance against PCT plan in the later half of this financial year. The two key reasons behind this assumption are the use of the Gynae theatres by January & a better understanding of the impact of EPR & the resolution of outstanding actions.

The HDU has been included in the forecast for the last three months of this financial year.

Appendix (iv): Care Group Financial Reports - NCG

FINANCIAL YEAR 2012/13 - COMPARISON OF NETWORKED CARE ACTUAL RESULTS TO BUDGET

	MONTH 6			MONTH 6 YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Income from activities (excl drugs)	5,545,568	5,435,248	110,320	32,763,628	33,020,488	(256,860)
Drugs Income	841,095	708,129	132,966	5,186,418	4,248,774	937,644
Other Patient Care Income	65,351	61,783	3,568	370,445	370,698	(253)
Other Operating Income	149,336	114,250	35,086	982,415	745,383	237,032
Total Income	**6,601,350**	**6,319,410**	**281,940**	**39,302,906**	**38,385,343**	**917,563**
Medical Staff	(862,760)	(884,736)	21,976	(5,059,529)	(5,337,941)	278,412
Nursing	(917,547)	(951,314)	33,767	(5,422,202)	(5,642,903)	220,701
PAMs	(317,351)	(319,303)	1,952	(1,862,579)	(1,890,178)	27,599
Scientist and PTBs	(659,239)	(693,638)	34,399	(3,874,469)	(4,158,356)	283,887
Pharmacists	(183,521)	(189,817)	6,295	(1,046,034)	(1,137,577)	91,543
Admin & Management	(259,590)	(246,798)	(12,793)	(1,435,038)	(1,521,543)	86,505
Ancillary & Maintenance	(7,649)	(8,538)	889	(60,393)	(51,226)	(9,167)
Other Pay	11,241	145,653	(134,412)	97,519	871,106	(773,587)
Total Pay	**(3,196,416)**	**(3,148,489)**	**(47,927)**	**(18,662,725)**	**(18,868,619)**	**205,894**
Pay as % of income	*48%*	*50%*	*17%*	*47%*	*49%*	*-22%*
Contracted wte	*-945.66*	*-906.54*	(39)	*-933.93*	*-905.48*	(28)
Drugs	(1,004,710)	(1,023,364)	18,654	(6,981,428)	(6,274,041)	(707,386)
Clinical Services and Supplies	(917,313)	(963,189)	45,877	(5,710,943)	(5,598,682)	(112,262)
General Services and Supplies	(24,368)	(22,971)	(1,396)	(169,396)	(137,246)	(32,150)
Establishment Expenses	(22,360)	(38,951)	16,591	(227,358)	(233,660)	6,302
Other Establishment Expenses	(4,949)	(4,689)	(261)	(17,661)	(26,286)	8,625
Prem, Trans & Fixed Plant	(20,206)	(51,283)	31,077	(181,724)	(290,913)	109,189
Leases	(0)	(3,403)	3,402	(349)	(20,415)	20,066
Miscellaneous Services (Excl Internal Recharges)	(117,275)	(115,177)	(2,097)	(280,810)	(458,364)	177,554
Internal Recharges	(7,201)	11,165	(18,366)	(92,598)	(110,223)	17,625
Total Non Pay (excl depn)	**(2,118,381)**	**(2,211,863)**	**93,482**	**(13,662,267)**	**(13,149,830)**	**(512,437)**
Operating Surplus (Loss)	**1,286,552**	**959,058**	**327,494**	**6,977,913**	**6,366,894**	**611,019**
Margin (Surplus/ Loss as a % income)	*20%*	*15%*	*116%*	*18%*	*17%*	*67%*

Appendix (iv): Care Group Financial Reports - NCG

Financial position

Income: The Care Group has seen a £392k increase in PCT income compared to last month.

Overall, the Care Group income has been reduced by £476k for NEL threshold penalties, which was not built into the budget.

Dermatology TVIC have received a one off benefit of £105k this month relating to 2011-12 penalties which were lower than anticipated.

Rehab have seen an additional £160k this month for rehab bed day income relating to catch up from July & Aug. An additional 510 bed days have now been recorded against these months.

Medicine central has again seen a £587k drop in income this month, there has been a shift in POD income and a £166k NEL penalty being incurred.

Pay: Pay was £48k over budget in month with an increase of £100k on the monthly average.

Medics – back pay paid to Dermatology consultants to cover extra sessions due to vacancy, (£20K).

Nursing - there was a £19k increase in month 06, reflecting August bank holiday enhancements paid in month.

PAMs - costs have increased - £7.5k of arrears payments in month.

Networked Care incurred £25k this month for Admin support of the Cerner Millennium service (agency and zero hour contract).

Non Pay: Month 06 is the lowest spend month to date with costs at £2.1m (£190k lower than the average monthly run rate). Drugs/ Clinical Services and supplies are the main areas where we have seen a reduction in September.

Renal transplant are seeing the benefit of savings achieved through using alternative drugs, an accrual for £70k was released this month as we are consistently seeing a greatly reduced monthly spend. Drug dispenses to Haematology were circa £50k lower in month 06.

Biochemistry Lab reagent costs are circa £78k lower than the quarter one average. The reagent spend pattern can be sporadic.

Key risks

Capturing & correct coding of activity undertaken within Cerner Millennium has been reviewed in depth in September's accounts and there is further work required for the Clinical Haematology activity & pricing.

As of the 08th October Hurley ward was open as an escalation ward. This will incur agency and bank costs plus operational equipment costs (outside of NCG budget).

The advent of AQP for Audiology from the 01st October within Berks West Region, will initially reduce tariffs/income & activity as patients become aware of choices.

There are a number of outstanding drugs invoices & credit notes that have never been processed - the value is unknown at present. A combined finance/ systems and pharmacy team are starting to resolve the causes of non-payment w/c 15/10.

Key Opportunities

Geoff Lester to report on the internal demand for lab tests and subsequent actions to reduce the demand.

The accuracy of the quarterly stock take processes has been identified as a project. Finance and Operations to ensure balance sheet stock reflects what is in the Trust's store cupboards and shelves.

A joint project between the T&O team and the Orthotics team is underway to identify ways of working to reduce the spend on expensive orthosis.

Actions

Measurement of the financial impact of the Audiology AQP and the mitigating actions of commissioning the mobile Audiology van plus expanding GP clinics.

The introduction of Haematology Dawn scheme and its pricing over 3 years to be discussed with the PCT in October.

Forecast

The starting point for the forecast uses the budget for M6-M12, which is adjusted in some areas to reflect the run rate being significantly different to the budget. The forecast has assumed budgeted CQUINs (1.5% of all PCT income) and no financial penalties in M6-M12, as we think these will offset each other.

The forecast income reflects a reduction in the over optimistic plan for Neurology activity in 12/13 and the impact of the Audiology tariffs/ activity levels in view of the roll out of AQP across South Central SHA.
As the bed reconfiguration is still being finalised, £629k for Hurley and winter escalation costs has been included in the forecast reflecting the change in care Group ownership of the wards.

Appendix (v): Statement of Financial Position

ROYAL BERKSHIRE NHS FOUNDATION TRUST — **BOARD**

STATEMENT OF FINANCIAL POSITION — **Current Month 12/13**

	July 12	August 12	September 12	BUDGET September 12
Assets	£m	£m	£m	£000
Assets, Non-Current				
Intangible Assets, Net	25,564	25,411	31,938	18,383
Property, Plant and Equipment, Net	206,439	206,251	198,013	200,133
Other Receivables, Non-Current	1,188	1,147	1,154	1,100
Assets, Non-Current, Total	**233,191**	**232,809**	**231,105**	**219,616**
Assets, Current				
Inventories	4,808	4,672	4,920	4,500
NHS Trade Receivables, Current	1,874	1,540	2,384	3,000
Non-NHS Trade Receivables, Current	2,463	2,440	2,348	2,800
Other Receivables, Current	1,042	2,283	1,138	1,000
Accrued Income	7,927	9,738	8,663	2,100
Prepayments, Current, non-PFI related	3,894	4,920	4,917	3,000
Cash and Cash Equivalents, **Total**	28,984	26,307	23,089	26,000
Assets held for sale	0	2,494	2,494	0
Assets, Current, Total	**50,992**	**54,394**	**49,953**	**42,400**
ASSETS, TOTAL	**284,183**	**287,203**	**281,058**	**262,016**
Liabilities				
Loans, non-commercial, Current (DH, FTFF, NLF, etc)	(3,669)	(3,669)	(3,669)	(2,818)
Provisions, Current	(8,655)	(8,635)	(5,791)	0
Current Tax Payables	(3,887)	(3,820)	(4,013)	(3,850)
Trade Creditors, Current	(4,405)	(5,770)	(6,797)	(6,600)
Other Creditors, Current	(2,351)	(2,328)	(2,466)	(2,300)
Capital Creditors, Current	(5,215)	(4,298)	(3,251)	(5,945)
Accruals, Current	(16,232)	(19,935)	(18,445)	(12,419)
Payments on Account	(2,524)	(2,159)	(2,477)	(2,500)
Finance Leases, Current	0	0	0	(6)
PDC dividend creditor, Current	(1,927)	(2,409)	0	0
Interest payable on non-commercial interest bearing borrowings, curr	(182)	(304)	(425)	(420)
Liabilities Current, Total	**(49,047)**	**(53,327)**	**(47,334)**	**(36,858)**
NET CURRENT ASSETS (LIABILITIES)	**1,945**	**1,067**	**2,619**	**5,542**
Loans, Non-Current non-commercial (DH, FTFF, NLF, etc)	(36,078)	(36,078)	(36,078)	(36,929)
Deferred Government Grant Income, Non-Current	0	0	0	
Provisions, Non-Current	(467)	(467)	(467)	(480)
Trade and Other Payables, Non-Current	(2,732)	(2,800)	(2,800)	(2,392)
Finance Leases, Non-current	(29)	(29)	(29)	(21)
Liabilities Non-Current, Total	**(39,306)**	**(39,374)**	**(39,374)**	**(39,822)**
TOTAL ASSETS EMPLOYED	**195,830**	**194,502**	**194,350**	**185,336**
Taxpayers' and Others' Equity				
Taxpayers' Equity				
Public Dividend Capital	156,548	156,548	156,548	156,534
Retained Earnings (Accumulated Losses)	12,249	10,922	10,767	1,767
Donated Asset Reserve	0	0	0	
Other Reserves				
Revaluation Reserve	26,545	26,545	26,545	26,545
Miscellaneous Other Reserves	490	490	490	490
TAXPAYERS' EQUITY, TOTAL	**195,832**	**194,505**	**194,350**	**185,336**
TOTAL ASSETS EMPLOYED	**195,830**	**194,502**	**194,350**	**185,336**
Other information				
Working Capital Facility				
Committed Working Capital facility in place	**20,000**	**20,000**	**20,000**	**20,000**

Appendix (vi): Cash Flow Statement

Cash Flow for Board - August 2012

	YTD Aug 2012 Actual £000	Sept 2012 Actual £000	YTD Sept 2012 Actual £000	YTD Sept 2012 Budget £000
Opening cash Balance	**36,797**	**26,307**	**36,797**	**36,797**
Income	133,149	27,314	160,463	**157,436**
Expenditure (excluding depreciation)	(126,321)	(25,411)	(151,732)	**(145,967)**
Cash generated	**6,828**	**1,903**	**8,731**	**11,469**
Working Capital				
(Increase)/decrease in inventories	(61)	(248)	(309)	**111**
(Increase)/decrease in receivables	(12,189)	1,464	(10,725)	**(3,106)**
Increase/(decrease) in payables	4,126	(2,536)	1,590	**(10,714)**
	(8,124)	**(1,319)**	**(9,444)**	**(13,709)**
Capex (Capital expenditure)	**(10,552)**	**(798)**	**(11,350)**	**(6,157)**
PDC paid	**0**	**(2,891)**	**(2,891)**	**(2,872)**
Financial Activity				
Interest income/ Expense	(556)	(112)	(669)	**(535)**
Other	1,000	(1)	999	**91**
	444	**(113)**	**331**	**(444)**
Loan Drawdown	**2,000**	**0**	**2,000**	**2,000**
Loan (Repayment)	**(1,084)**	**0**	**(1,084)**	**(1,084)**
Net increase / (decrease) in cash	**(10,490)**	**(3,218)**	**(13,708)**	**(10,797)**
Closing Cash Balance	**26,307**	**23,089**	**23,089**	**26,000**

Appendix (vii): Capital Expenditure Summary

September 12 Performance against capital budgets is

	2012/13 Original Plan	2012/13 Revised Forecast	Year to Date Budget	Spend to Date	Commit-ments	Orders to be raised
	£m	£m	£m	£m	£m	£m
Medical Equipment	1.50	2.04	0.65	(0.84)	(0.27)	(0.93)
Safety, regulatory , sustainability projects	4.60	4.60	0.90	(1.11)	(0.46)	(3.03)
Rushey Birthing Centre	1.05	1.05	1.05	(0.95)	(0.01)	(0.09)
EPR / IT	7.90	5.62	3.80	(4.59)	(0.06)	(0.97)
Other smaller projects	1.85	1.92	0.76	(0.30)	(0.34)	(1.28)
IT Infrastructure	2.40	4.40	0.00	0.00	0.00	(4.40)
Target Reduction	0.00	(0.33)	0.00	0.00	0.00	0.33
Sub Total	**19.30**	**19.30**	**7.16**	**(7.79)**	**(1.14)**	**(10.37)**

Appendix (viii): Financial Risk Rating

Risk Ratings September 12

		Weighting in FRR calculation	Period to date
Underlying performance			
	EBITDA Margin metric		5.4%
	EBITDA Margin rating	25%	**3**
Achievement of plan			
	EBITDA % of plan achived metric		75.4%
	EBITDA % of plan achieved rating	10%	**3**
Financial Efficiency			
	Net return after Financing metric		-2.4%
	Net return after financing rating	20%	**2**
	IS Surplus margin metric		-1.7%
	IS Surplus margin rating	20%	**2**
	Financial Efficiency		**2**
Liquidity			
	Liquidity days metric (WCF limited to 30 days)		18.0
	Liquidity days rating	25%	**3**
Weighted Average Rating			**2.6**

	Last Month	Current
Quick Ratio	**0.93**	**0.95**

Appendix (ix): Patient Level Reporting

- Patient level reporting excluding all impairments and exceptional items
- Indirect costs allocated on the basis of conversations with budget holders and reference to HFMA guidelines
- More details on allocation basis to be made available – next step is to identify owners for these to enable future management of changes

Patient Level Reporting £

		Full Yr 2011/12				Q1 2012/13				
Care group	Specialty	Total Income	Total Cost - All Impairment	Total Profit / (Loss) - All Impairments	Margin	Total Income	Total Cost	Total Profit / (Loss)	Margin	YoY Margin Variance
Networked	Audiological Medicine	3,458,704	(2,587,591)	871,113	25.2%	878,350	(724,293)	154,058	18%	-8%
Networked	Clinical Haematology	7,376,892	(7,356,438)	20,454	0.3%	1,867,556	(2,078,053)	(210,498)	-11%	-12%
Networked	Clinical Oncology	19,745,937	(23,095,244)	(3,349,308)	-17.0%	5,204,981	(6,063,311)	(858,329)	-16%	0%
Networked	Dermatology	2,457,704	(2,495,108)	(37,404)	-1.5%	693,115	(606,352)	86,764	13%	14%
Networked	Endocrinology	2,027,178	(2,384,868)	(357,690)	-17.6%	401,947	(486,940)	(84,993)	-21%	-4%
Networked	Geriatric Medicine	15,019,371	(15,662,611)	(643,240)	-4.3%	3,843,720	(3,930,087)	(86,367)	-2%	2%
Networked	GUM	4,992,559	(4,138,684)	853,874	17.1%	1,081,586	(1,078,654)	2,932	0%	-17%
Networked	Neurology	4,688,008	(4,261,267)	426,741	9.1%	892,406	(998,125)	(105,719)	-12%	-21%
Networked	Pain Management	725,591	(668,905)	56,686	7.8%	206,132	(214,612)	(8,480)	-4%	-12%
Networked	Rehabilitation	2,341,249	(2,774,488)	(433,240)	-18.5%	574,740	(677,687)	(102,947)	-18%	1%
Networked	Renal	15,965,271	(15,928,127)	37,144	0.2%	3,951,844	(4,031,189)	(79,345)	-2%	-2%
Networked	Rheumatology	5,683,661	(6,080,123)	(396,463)	-7.0%	1,562,859	(1,620,921)	(58,062)	-4%	3%
Networked	Wheel Chair Clinic	863,550	(942,194)	(78,644)	-9.1%	269,082	(259,173)	9,909	4%	13%
Networked	Sue Ryder	378,957	(400,702)	(21,745)	-5.7%	126,110	(106,380)	19,730	16%	21%
Networked total		**85,724,630**	**(88,776,351)**	**(3,051,722)**	-3.6%	**21,554,429**	**(22,875,776)**	**(1,321,347)**	-6%	-3%
Planned	Anaesthetics	135,127	(155,965)	(20,838)	-15.4%	54,515	(98,938)	(44,423)	-81%	-66%
Planned	ENT	5,793,515	(6,738,376)	(944,861)	-16.3%	1,415,466	(1,704,677)	(289,211)	-20%	-4%
Planned	General Surgery	23,173,720	(23,301,254)	(127,534)	-0.6%	5,556,541	(5,615,899)	(59,358)	-1%	-1%
Planned	Gynaecology	7,572,633	(7,551,831)	20,802	0.3%	1,760,207	(1,876,968)	(116,760)	-7%	-7%
Planned	Ophthalmology	21,206,675	(19,588,794)	1,617,881	7.6%	4,917,580	(4,866,260)	51,319	1%	-7%
Planned	Oral Surgery	2,978,062	(3,084,429)	(106,368)	-3.6%	701,764	(726,321)	(24,557)	-3%	0%
Planned	Plastic Surgery	484,093	(520,272)	(36,179)	-7.5%	124,178	(130,224)	(6,047)	-5%	3%
Planned	Thoracic Medicine	6,167,728	(6,123,503)	44,226	0.7%	1,708,249	(1,664,894)	43,356	3%	2%
Planned	Urology	10,403,867	(9,179,326)	1,224,541	11.8%	2,447,828	(2,361,463)	86,364	4%	-8%
Planned total		**77,915,421**	**(76,243,750)**	**1,671,671**	2.1%	**18,686,327**	**(19,045,644)**	**(359,317)**	-2%	-4%
Urgent	Accident & Emergency	10,840,106	(13,726,834)	(2,886,728)	-26.6%	2,839,450	(3,810,280)	(970,830)	-34%	-8%
Urgent	Breast Screening	1,264,702	(1,186,330)	78,373	6.2%	444,390	(318,032)	126,358	28%	22%
Urgent	Cardiology	13,886,625	(10,476,109)	3,410,516	24.6%	3,625,839	(2,945,302)	680,537	19%	-6%
Urgent	Critical Care Medicine	6,693,032	(7,348,457)	(655,425)	-9.8%	1,802,068	(1,861,806)	(59,738)	-3%	6%
Urgent	Gastroenterology	9,821,245	(9,102,894)	718,351	7.3%	2,680,252	(2,571,419)	108,833	4%	-3%
Urgent	Obstetrics	25,741,133	(26,695,466)	(954,333)	-3.7%	6,103,600	(6,856,567)	(752,967)	-12%	-9%
Urgent	Paediatric Community Nursing	552,973	(618,793)	(65,820)	-11.9%	133,322	(171,900)	(38,579)	-29%	-17%
Urgent	Paediatric Medicine	16,656,575	(16,635,488)	21,087	0.1%	3,649,917	(4,031,898)	(381,981)	-10%	-11%
Urgent	Radiology	1,997,391	(663,770)	1,333,622	66.8%	374,370	(152,063)	222,307	59%	-7%
Urgent total		**87,453,783**	**(86,454,141)**	**999,642**	1.1%	**21,653,208**	**(22,719,266)**	**(1,066,058)**	-5%	-6%
Other	Non Specialty Specific	593,580	0	593,580	100.0%	1,404,558	(79,563)	1,324,995	94%	-6%
Other	Trauma & Orthopaedics	40,981,425	(40,431,830)	549,595	1.3%	9,732,252	(10,070,145)	(337,894)	-3%	-5%
Other	Direct Access	10,233,374	(11,782,893)	(1,549,519)	-15.1%	2,539,225	(3,312,536)	(773,311)	-30%	-15%
Other	General Medicine	13,901,042	(12,092,118)	1,808,924	13.0%	3,442,681	(2,392,785)	1,049,896	30%	17%
Other total		**65,709,421**	**(64,306,841)**	**1,402,580**	2.1%	**17,118,716**	**(15,855,029)**	**1,263,686**	7%	5%
Total		**316,803,254**	**(315,781,083)**	**1,022,171**	0.3%	**79,012,679**	**(80,495,715)**	**(1,483,036)**	-2%	-2%

Royal Berkshire NHS Foundation Trust **Agenda item 7**

Board of Directors

Title: **Pathology Transformation Update**

Date: **30 October 2012**

Lead: **Lindsey Barker/ Ian Stoneham**

Purpose: The purpose of this paper is to seek approval from the Board on the proposed Pathology Joint Venture with Heatherwood and Wexham Park Hospital (HWPH)

Key Points:

- The Pathology Steering Group comprised of RBHFT and HWPH took a decision in September to halt the previous procurement process which sought to find a commercial third party to enter into a joint venture with and to act as prime service provider based on the significant risk around costs.
- Following this decision, it was agreed by both Trusts to undertake a strategic options review and to report back to both Trust Boards in October with a recommendation for next steps.
- The results of the review have led both the RBFT and HWPH teams to recommend that the programme to establish a Berkshire wide Pathology service should continue and approval is sought to develop the current proposed model to Full Business Case status that also to bring back to Trust Board for sign off at the end of January 2013.
- Indicative savings outlined in the previous OBC are c£3m pa (shared between both Trusts) although there is a risk that these will not be realised until 2013/14 due to the staff consultation and non-pay tender processes that are necessary in order to deliver the transformation.

Decision required:

The Board is asked to :

(a) **Note the recommendation of the Pathology Project team, endorsed by the Trusts Executive to establish a Berkshire wide partnership organisation, and that a full business case that fully tests all 5 generic options should therefore be prepared over the next 2-3 months to identify the optimal solution.**

FOI Status

1. Background

In 2010 a procurement process commenced which aimed to secure modernised and scale effective pathology services for Heatherwood and Wexham Park NHS Foundation Trust (HWPH) and Royal Berkshire NHS Foundation Trust (RBFT). The basis of this procurement being that working together and with a third party, these objectives could be met. This procurement was stopped by the steering board that was managing it in September 2012 when it became clear that the final proposition that the remaining bidder was able to make did not represent value for money to the NHS or taxpayer, largely as a result of outstanding concerns over the treatment of VAT and the cost of pensions for staff subject to TUPE.

The two organisations have accepted that there is not a "do-nothing" option, given the need to modernise, and the purpose of this paper is to outline and evaluate the available strategic options and to propose a recommended way forward.

In an Independent Review of NHS Pathology services a figure of £500 million per year is estimated as the potential for financial savings nationally. On a pro rata basis, the Berkshire element would be circa £3m and this is broadly in line with the eventual savings scoped for a Berkshire wide service collaboration during the previous procurement process (and by the in house comparator).

2. Strategic Options

The following generic strategic options have been identified:

- A Partnership between HWPH and RBFT with the potential to add new partners over time
- Either or both parties could partner with an alternative Trust with the potential to add new partners over time
- Either or both parties could go back to the market and start a new procurement for a private sector partner
- Either or both parties could join an existing collaboration
- Parties could (either together or individually) decide to outsource all pathology requirements

Each of these generic options is capable of combination with each other or to being modified. A full SWOT analysis (strengths, weaknesses, threats & opportunities assessment) was carried out by the pathology team.

3. Market Assessment

The potential for partnering with other Trusts in the immediate radius has been has been tested through a series of meetings and discussions by the RBFT Head of PMO and the Transformation Director at HWPH. An assessment of trends in the market place has identified that very few instances of collaboration with the private sector are evident, with those that do exist seemingly focussed on outsourcing rather than partnership style collaboration.

4. What this tells us about the Market

Analysis of the current market is relatively straightforward given the fact that very few instances of modernisation have actually been completed so far

- Some involvement between NHS and private sector providers is evident but the two most often quoted examples are not yet delivering:
    - Guys and St Thomas arrangement has required significant additional (and unplanned) NHS funding to support it
    - Somerset is in its early days but is troubled by issues around VAT recoverability
- Some other outsourcing deals with the likes of Lloyds and Boots are working
- There is a high level of understanding (locally and nationally) that cooperation and scale is important but exactly how to achieve this is frustrating the delivery of benefits
- A number of NHS to NHS co-operations have recently been established but it is too early to gauge the degree of success
- There is clear intent to conclude further such arrangements
- Commissioners are being encouraged to drive through change – the dilemma for the NHS is that increased scale and contestability in provision has some obvious conflicts.
- Alongside this, additional challenges are:
    - To find structures where demand for pathology can be actively managed and pathways can be joined up.
    - Users of pathology services will need to understand the necessary high level of investment required of providers and therefore the length of commitment required.

In short the market is both changing and developing, but its eventual shape is hard to predict. The implication of this is that strategies and attitudes towards pathology need to be flexible (both by providers and users of the services)

5. High Level Option Appraisal

A High Level option appraisal, scoring 4 key variables has been performed. The variables selected being:

1. **Deliverability of the Option –** a measure of complexity and obstacles and their effect on the likelihood of successful conclusion
2. **Sustainability of the Option –** potential to expand / potential to meet "Carter principles" and the longer term suitability of the option
3. **Likely Timeline to Implementation –** a measure of complexity and obstacles and their effect on the timeline to completion
4. **Perceived Internal View –** an attempt to measure likely resistance to the implementation of the option

25 staff have been canvassed individually on their views across the 2 organisations with a reasonable split between staff who worked on the recent procurement exercise and the in house comparator. A clear view has been expressed by the staff consulted in favour of the Berkshire wide partnership. The largest group were clinical and operational staff (over 80%). The least favoured options being re procurement and outsourcing.

As a result of the above, the SWOT, the current market review and the internal consultation of the generic strategic options, the recommendation from this review is straightforward.

The best solution for the future development of pathology services appears to be a partnership between HWPH and RBH to establish a Berkshire wide partnership organisation. A full business case that fully tests all 5 generic options should therefore be prepared over the next 2-3 months to identify the optimal solution. The business case should cover all significant areas of potential weakness and review alternatives on an equal basis to ensure robustness of the conclusion.

6. Next Steps and Implementation

The previous in house model suggested savings opportunities of c£3m pa split between pay savings of £1.8m and non pay of at least £1.1m, made up as follows:

Pay and Workforce
The WTE will reduce as a result of the new model by (44) from 302 to 258 WTE. The change in skill mix and the introduction of 24/7 x 365 working patterns where this is required means that the cash saving achieved annually of £1.8m i.e. 14%.

Non Pay Costs
The total net benefit within non pay costs is £1.1m, delivering a total annual cost saving of £2.9m. These levels of savings and the philosophy of the model are in line with the requirements of Carter. Additional savings of over £1m annually are likely to accrue from full market testing.

The key next steps required to build upon the in-house model to FBC along with testing of all of the generic options are as follows:-

Joint meeting with RBFT & HWPH pathology representatives to sign off next steps & agree work streams	23rd October 2012
Trust Board approval for development of FBC that tests all options	30th October 2012
Both Trusts to agree an initial budget of £50k each to enable development to FBC stage, prior to allocation of a formal budget (to cover recruitment of project management /initial legal fees etc.).	1st November 2012
Recruitment of an external generic project manager to support & drive the transition work to FBC stage. In parallel, planning for the recruitment of an experienced project manager at senior level to take forward implementation following FBC sign off.	1st December 2012 1st December 2012
Full Business Case completed for Executive discussion & sign off	Mid January 2013
Full Business Case taken to Trust Board for Approval	End January 2013
Implementation Begins	1st February 2013
Staff Consultation to commence	1st February 2013

Two factors key to the success of the project will be:

a) The continued engagement and enthusiasm of the pathology team to take this work forward, and therefore it will be important to ensure that those staff taking key leads in the project are fully committed to the solution, and

b) Having robust project management in place to ensure that all of the benefits are realised to their full potential within the timeframe set. Whilst a generic project manager will be important to move the work through to FBC stage, once approved the implementation will require a senior project manager with specific experience in this area.

7. Recommendation

The Board is asked to:

Note the recommendation of the Pathology Project team, endorsed by the Trusts Executive to establish a Berkshire wide partnership organisation, and that a full business case that fully tests all 5 generic options should therefore be prepared over the next 2-3 months to identify the optimal solution.

Contacts

Lindsey Barker, Care Group Director of Networked Care
Phone: 0118 322 7591

Ian Stoneham, Commercial Director
Phone: 0118 322 8777

Royal Berkshire NHS Foundation Trust **Agenda item 8**

Board of Directors

Title: **Synergy Contract Board Briefing Note**

Date: **30 October 2012**

Lead: **Craig Anderson**

Purpose: To obtain Board approval to sign the two year Synergy contract for decontamination of medical instruments.

Key Points:

- Signing this contract will safeguard decontamination provision until 31 March 2014.
- It gives the Trust breathing space to investigate an in-house option (while keeping the door ajar with Synergy for a longer term contract).
- If we do not sign this contract we have no security of supply for decontamination as the previous contract has currently expired.
- Financially it delivers £1.2m of cost savings over the twp years and avoids £340k of legacy liabilities (from the old contract) being invoiced on to the Trust.

Decision required: Approval of the contract

FOI Status This report will be made available on request

1 Background

1.1 Synergy Health Care, the current decontamination provider to the trust currently provide the service off-site on the Battle site, which the Trust is planning to divest.

1.2 A revised proposal for decontamination was provided at a cost of £2.5m a year for a seven year period. This was to be serviced from a different offsite location that would be leased by Synergy.

1.3 Due to the high cost of this service, a full review was undertaken of the options available before agreeing to the new contract with Synergy Health Care.

1.4 The current rate of usage for Synergy Health Care culminates in nine deliveries each day travelling to the site with sterile equipment. There are also a number of issues including contaminated goods being received, an admin heavy process and issues around the packing for safe transportation.

1.5 A working group was set up comprising of Finance, Infection Control, Medical Physics, Decontamination, Theatres, Estates & Facilities, Procurement and PMO. The purpose of this group was to review all decontamination options available to the Trust.

1.6 Following this review, it was proposed that we should, ideally, bring the service in-house on-site, which would bring clinical, operational and financial benefits. It was estimated that the running costs of providing this service on site would be £1.4m per annum – a saving of £1.1m per annum over the proposed seven year contract.

2 Negotiations

2.1 In order to give the Trust sufficient time to explore the in-house option (while keeping the door open to Synergy for a longer term deal but on a more favourable financial footing), it was agreed that we should discuss with Synergy the options around a medium term deal (1 April 2012 to 31 March 2014) operating out of the Battle facility.

2.2 The key points of this deal are as follows:

- Fixed service price of £1.7m pa assuming activity remains broadly in line with current levels (see note below).
- No indexation in 2013.
- Service as per existing arrangements for RBHT and West Berkshire Community Hospital, with no additional charges from either party such as fast track, transportation, 3rd party royalties, utilities, rent, etc.
- Service price includes consumable products within tray specifications (but excluding prosthesis and other medical products), with a price adjustment only in the event of material changes to tray specifications.
- Service price includes fast tracking, provided this does not exceed current modest levels.

2.3 This contract will provide the Trust with a saving of £1,153k over two years compared with current rates.

2.4 In addition, in return for this contract, Synergy have agreed to wave £340k of legacy liabilities (mainly costs indexation due and property development costs incurred by Synergy in respect of sourcing an off site location to replace Battle).

3 Reasons for Recommending the Two Year Contract

3.1 The key reasons for this recommendation are:

(a) It gives the Trust breathing space to investigate an in-house option (while keeping the door ajar with Synergy for a longer term contract).

(b) If we do not sign this contract we have no security of supply for decontamination as the previous contract has currently expired.

(c) Financially it delivers a large cost saving and avoids large legacy liabilities being invoiced on to the Trust.

4 Long Term Solutions

4.1 Work is currently underway looking at options for an in-house solution either on or off site. The work is also closely linked to additional theatre capacity and we are currently exploring an option to build a decontamination centre and additional theatres jointly as this has the potential to confer significant cost advantages (rather than treating the projects separately).

4.2 On signing of this contract we will also revisit the opportunity to work with Synergy to see if a more attractive deal can be pulled together over the long term.

4.3 Once we have appraised the options available we will revert to the Board. Given the need to be off the Battle site by 31 March 2014, we will aim to have the options mapped out and costed out by January 2013.

5 Conclusion and Next Steps

5.1 Signing the current contract will safeguard the service in the medium term and provide the Trust with significant cost savings. It provides enough time to enable the Trust to complete its option appraisal and bring an optimal solution for approval in the new year.

6 Recommendations

6.1 The Board is asked to approve the signing of the attached contract.

7 Attachments

7.1 The following are attached to this report:

(a) Appendix x – Synergy contract

8 Contact

Contact: Craig Anderson

Phone: 0118 322 8833

Royal Berkshire NHS Foundation Trust **Agenda item 9**

Board of Directors

Title: **Contract Changes for Adult Audiology Service for patients over 55**

Date: **30 October 2012**

Lead: **Lindsey Barker**

Purpose: To update the Trust Board on the change in contract for the provision of Adult Audiology Service for patients aged 55 years and above and approval to sign specific contracts.

Key Points: **BACKGROUND**

- Royal Berkshire NHS Foundation Trust has been providing Audiology services across Berkshire and surrounding areas for over 50 years. However, the Trust was given notice earlier this year by our commissioners that from 1st October 2012 it would no longer be the sole provider due to the introduction of the DoH policy of Any Qualified Provider (AQP) for this service.
- We currently enjoy a 97% service market share across Berkshire which is now at risk to new competitors entering the market.
- Our assessment is that the Trust is at high risk of losing between 25% and 30% of its current share of the total spend by West Berkshire PCT as a result of the changes in commissioning and the presence of national competitors with an established business model in public–private provision of services. Pathfinder departments in England have demonstrated the impact of this commissioning model. For example, the implementation of Any Qualified Provider (AQP) in November 2009 for Audiology at the Heartlands Hospital, Birmingham, saw an immediate reduction of 30% in activity.

- Furthermore, under the AQP Contract the Trust will*:*

    - Lose the Market Forces Factor (MFF) payment; and
    - The aftercare payment as the new Tariff includes aftercare for three years

- The Adult Hearing Service contribution in 2011/12 has been calculated to be c£1.364k but this is expected to reduce to c£826k in 2012/13. The full year reduction in contribution due to AQP will be reflected in 2013/14 and is estimated to reduce to c£389k. These figures are reflected in Annexe A, Table 1. Table 2 shows the potential financial impact of initial mitigating actions, increasing contribution at 13/14 to c£699k

- On the other hand, there are new income opportunities. AQP is an uncapped demand commissioning model. Further markets have been opened by surrounding counties also moving to an AQP commissioning model.

- A public–private pathway will offer extended choice to the Patient and provide a new income stream that could contribute to offsetting projected losses.

TENDER PROGRESS

AQP tender applications to provide Adult Hearing were submitted in March and April 2012/13 and we have successfully qualified to provide services in the following areas:

- Berkshire (West and East)
- Oxfordshire
- Buckinghamshire
- SH(I)P (Southampton, Hants, Portsmouth)
- London Clusters (North Central, North West, South East)
- Bristol, Gloucester, North Somerset

CONTRACTS & MOBILISATION

The commissioner' tender award processes are running late. In spite of their delay commissioners are intent on effecting the new AQP contracts in the shortest possible timescales.

- The new services will be offered through Choose and Book but access to this (and by definition new patient referrals) is dependent on contracts being first approved by provider Boards.
- Because of the delays in the tender process, the Trust has reached an agreement in principle with Berkshire that our services can commence by varying our existing contract.
- Due to the tighter AQP contract regime (below) we wish to take up the option of signing standalone AQP contracts as soon as possible to avoid any risk of any possible audiology penalties impacting our main service contract.
- Discussions with other commissioners require contracts to be signed by 31st October 2012. There is an imperative to do this to seize the opportunity of early mobilisation to gain a foothold in the new markets we have won.

MOBILISATION PLANS

- Market analysis has been carried out and a mobilisation plan compiled. A high-level overview is attached for reference at Annex B.
- Access to new markets is planned to be achieved through the use of the mobile service unit (s) and the use GP surgeries with high referral rates.
- Our top level approach to the markets is set out below:
    - Protection of Berkshire West activity
    - Expansion of Berkshire East activity
    - Protection and expansion of Oxfordshire activity
    - Gaining a foothold in London areas
    - Gaining a foothold in Bucks
    - Gaining a foothold in Southampton IoW and Portsmouth (SHIP)

CONTRACTUAL PERFORMANCE

KEY SERVICE OUTCOMES

- 90% of patients referred to the service should be assessed within 16 working days of receipt of referral

- 90% of patients requiring hearing aid fitting should be seen within 20 working days of the assessment
- 90% of follow-up appointments should be within 10 weeks of fitting
- 90% of patients should be able to access aftercare within 2 working days of a request
- 95% of responses received from patients sampled via a service user survey should report overall satisfaction with the service

The above outcomes already apply to the current service and controls already exist to meet the required outcomes. The Audiology department have a very good record of fulfilling their performance obligations.

POTENTIAL PENALTIES

20% of the total value for annual delivered activity will be subject to the achievement of the above key service outcomes. Each outcome will be weighted equally. A penalty will be applied on the individual indicator failed in accordance with weighting i.e.1 indicator failed is a penalty of 4% reduction; 5 indicators failed is a penalty of 20% reduction.

Controls are in place to ensure that no penalties are incurred and will be reviewed regularly.

RISKS

- Staff redundancy, if it is decided that RBFT do not wish to provide the Adult Hearing service. Commissioners have taken legal advice that TUPE is not applicable, although this may be open to legal challenge and
- Loss of contribution
- Excessive non performance

CONTRACT VALUE AND VOLUMES

Whilst this is a zero-value contract in that there are no guaranteed volumes and activity is driven on a per-patient basis, the attached appendix shows expected contract income of £1.5m in 2012/13 dropping to £0.8m in 2013/14 as we have a full year effect of the new contract. The contract is uncapped and it should also be noted that there are opportunities to win business out of area..

1 RECOMMERDATION

1.1 The Board is asked to APPROVE the Trust signing of AQP contracts for Adult Hearing Service for the above mentioned areas so that RBFT Business Development and Audiology teams can start work with a view to protecting its existing market and gaining market share in other areas.

ANNEX A – Audiology Paper

Table 1 – Financial impact of the Do nothing option

	2011/12	QTR 1	QTR 2	QTR 3	QTR 4	2012/13 - Forecasted Activity	2013/14 - Forecasted Activity	14/15 - Forecasted Activity
Adult Activity	5457	1295	1235	1013	1052	4,594	3,962	3962
Fit 1	865	167	192	181	165	705	615	615
Fit 2	3422	604	726	626	618	2,574	2,241	2241
Reduction due to GP transfers								
				(101)	(158)	(259)	(1,070)	(1,070)
Fit 1				(18)	(25)	(43)	(166)	(166)
Fit 2				(63)	(93)	(155)	(605)	(605)
Adult Activity - £56	£75,335	£33,740	£20,411	£11,550	£15,036	£80,737	£68,929	68,929
Fit 1	£280,471	£53,189	£61,151	£45,874	£39,551	£199,764	£126,604	126,604
Fit 2	£1,534,500	£265,986	£319,711	£215,610	£201,190	£1,002,496	£626,561	626,561
Fit Income	**£1,814,971**	**£352,914**	**£401,273**	**£273,034**	**£255,776**	**£1,282,998**	**£822,095**	**£822,095**
Aftercare Numbers	13,011	2,513	3,622	3,377	3,499	13,011	13,011	13,011
Aftercare @ £26	£388,961	£75,126	£108,279	£0	£0	£183,405	£0	0
Total Income	**£2,259,435**	**£428,039**	**£509,552**	**£273,034**	**£255,776**	**£1,466,402**	**£822,095**	**£822,095**
Income comparison to 11/12						(£793,033)	(£1,437,341)	(£1,437,341)
Costs								
Fit 1- £136	-£ 136	(£117,505)	(£22,686)	(£26,082)	(£22,098)	(£19,052)	(£89,919)	(£60,987)	(£60,987)
Fit 2 - £227	-£ 227	(£778,401)	(£137,392)	(£165,143)	(£128,054)	(£119,490)	(£550,078)	(£372,124)	(£372,124)
Reduction due to GP transfers								
Fit 1								
Fit 2								
Total	(£895,906)	(£160,078)	(£191,225)	(£150,152)	(£138,542)	(£639,997)	(£433,112)	(£433,112)
Cost comparison to 11/12						£255,909	£462,795	£462,795
Contribution	**£1,363,529**	**£267,962**	**£318,327**	**£122,882**	**£117,234**	**£826,405**	**£388,983**	**£388,983**
	60%	**63%**	**62%**	**45%**	**46%**	**56%**	**47%**	**47%**

Notes:

Q1 income will not be affected by the AQP pricing. The effect will be felt from month 6 in Q2.

Table 2. Comparison of the three potential options to mitigate the reduced surplus due to the introduction of AQP

	2011/12 adult audiology surplus		2012/13 Introduction of AQP - Do nothing	Purchase of Mobile Unit	Expansion into 4 Strategic GP sites		Projected surplus after mitigating
Annual activity	4,287		3,080	584	584		4,248
Annual income	£2,259,435		£1,466,402				£1,466,402
Annual direct costs	(£895,906)		(£895,906)				(£895,906)
Annual surplus	£1,363,529						
Reduced Fitting Costs			£255,909				£255,909
New Generated Income				£208,196	£118,358		£326,554
Purchase of the mobile unit				(£85,000)			(£85,000)
Mobile Unit running costs + consumables				(£126,244)			(£126,244)
Consumables, room rental & travel					(£80,227)		(£80,227)
Potential surplus	**£1,363,529**		**£826,405**	**(£3,048)**	**£38,131**		**£861,488**

	2011/12 adult audiology surplus		2013/14 Introduction of AQP - Do nothing	Purchase of Mobile Unit	Expansion into 4 Strategic GP sites		Projected surplus after mitigating actions - 13/14
Annual activity	4,287		2,085	1,008	1,008		4,101
Annual income	£2,259,435		£822,095				£822,095
Annual direct costs	(£895,906)		(£895,906)				(£895,906)
Annual surplus	£1,363,529						
Reduced Fitting Costs			£462,795				£462,795
New Generated Income				£359,352	£359,352		£718,704
Mobile Unit running costs + consumables				(£212,928)			(£212,928)
Consumables, room rental & travel					(£225,344)		(£225,344)
Potential surplus	**£1,363,529**		**£388,983**	**£146,424**	**£134,008**		**£669,415**

	2011/12 adult audiology surplus		2014/15 Introduction of AQP - Do nothing	Purchase of Mobile Unit	Expansion into 4 Strategic GP sites		Projected surplus after mitigating actions - 14/15
Annual activity	4,287		2,085	1,008	1,008		4,101
Annual income	£2,259,435		£822,095				£822,095
Annual direct costs	(£895,906)		(£895,906)				(£895,906)
Annual surplus	£1,363,529						
Reduced Fitting Costs			£462,795				£462,795
New Generated Income				£359,352	£359,352		£718,704
Mobile Unit running costs + consumables				(£212,928)			(£212,928)
Consumables, room rental & travel					(£227,145)		(£227,145)
Potential surplus	**£1,363,529**		**£388,983**	**£146,424**	**£132,207**		**£667,614**

ANNEX B – Audiology Paper

MOBILISATION MATRIX

MARKET	POTENTIAL	STRATEGIC AIM	PRIORITY	TIMESCALE	OPERATIONAL PLAN	REQUIRED RESOURCE
West Berkshire	5,300 new pathways in Berks West last year. Unmet demand 6x this. RBFT is an established provider with strong local reputation.	Plug gaps and increase presence in Berks West	High	Immediate Contract signing 30/9/12	Central Reading location: facility sourced at Walk-in Centre. Open Oct 2012 Central Newbury location – facility being researched GP fixed sites with strategic positioning - Balmore Park, Tudor House Mobile Unit – service Twyford , Goring	0.4 WTE audiologist Investment in rental for GP surgeries Business Development PMO Support
East Berkshire	5,000 new pathways. Established RBFT presence in Bracknell for 5 yrs. Windsor a fairly strong service.	Target Bracknell. Five high referrers in close proximity – establish GP site as referral hub	High	Immediate Contract signing 30/9/12	Contact the Bracknell practices and set up meetings to negotiate space Scope potential in Maidenhead	0.2 WTE audiologist Investment in rental for GP surgeries Business Development PMO Support
Oxfordshire	Established RBFT presence in South Ox. Poor service by the OJR. Some regions not serviced at all.	Increase reach from our S Ox base. Target using mobile unit. Scope to use AQP to promote RBFT specialist services and out-of-area referral – this work has much more margin	High	Immediate – yet to hear from Commissioner, assume contract signing 30/9/12	Target Abingdon immediately. Source premises for start in Oct. Will have to be a fixed site until mobile unit delivery (ETA end Nov) Target Wantage. Look for premises	0.4 WTE audiologist Investment in rental for GP surgeries Business Development
London	Difficult to assess referrals. Poor service in Ealing. Accessible from Reading, staff members also commute from here. Potential in other areas need to be better understood	Target Ealing. Other PCT Localities	High	Immediate Contract signing 30/9/12	Identify key sites; Southall, Handsworth Obtain referral activity – requested from SW	0.2 WTE audiologist - Ealing Investment in rental for GP surgeries Business Development, PMO Support
Bucks	Low C&B referral activity	Protect Berks borders, gain a foothold for longer-term expansion	Medium	Contract signing 30/9/12	Identify high referral GP site	TBC
SHIP	Low C&B referral activity on Hants border regions Portsmouth hospital has not qualified	Protect Berks borders, gain a foothold for longer-term expansion	Medium	Contract signing 30/9/12	Portsmouth: approach Portsmouth regarding partnership possibilities Hants: complete market analysis for placeholder site	TBC

Royal Berkshire NHS Foundation Trust

Board of Directors

Title: **Open Board Meetings**

Date: **30 October 2012**

Lead: **Keith Eales**

Purpose: To report the request made at the September Council of Governors meeting that the Board meets in public.

Key Points:

- At the September meeting of the Council of Governors, the Chairman undertook, in response to a question from a Governor, to raise with the Board the possibility of meetings being held in public in advance of the legislative requirement.
- The Council of Governors has formally requested on a number of occasions that the Board hold its meetings in public. The Board had decided on each occasion to continue to meet in private.
- The Board has been preparing for public meetings, with agenda being split into open and closed parts of the meeting. Items are categorised as being public or confidential on the basis of Freedom of Information Act exemptions
- The Health and Social Care Act 2012 requires foundation trust boards to meet in public, with scope for discussing confidential items in private. This is expected to come into force in April 2013.
- The Board is asked to consider whether or not it wishes to hold its formal meetings in public in advance of the requirement under the Health and Social care Act 2012.

Decision required The Board is asked to consider the request made at the September Council of Governors meeting that it holds its formal meetings in public.

FOI Status This report will be made available on request.

Contact: **Keith Eales, Director of Corporate Affairs**
Phone: **0118 322 8439**

Royal Berkshire NHS
NHS Foundation Trust

Council of Governors

Council of Governors

Thursday, 26 September 2012
6:05 pm – 8:00 pm
Seminar Room, TEC, Royal Berkshire Hospital

Present

Mr. Stephen Billingham	(Chairman)
Mrs. Vera Doe	(Public Governor, Wokingham) (Vice-Chair)
Dr. Muhammad Abid	(Public Governor, Reading)
Mrs. Aileen Blackley	(Public Governor, West Berkshire)
Mr. Jeremy Butler	(Public Governor, East Berkshire)
Mrs. Caroline Bowder	(Public Governor, Southern Oxfordshire)
Mrs. Rebecca Corre	(Staff Governor, Nursing and Midwifery)
Mr. Ian Clay	(Public Governor, West Berkshire)
Ms. Margie Cutts	(Public Governor, Reading)
Mr. Dave Dymond	(Public Governor, Reading)
Mrs. Sally Kemp	(Partner Governor, NHS South Central)
Mr. Colin Lee MBE	(Public Governor, West Berkshire)
Mr Jonathan Mason	(Staff Governor, Allied Health Professionals / Scientific)
Mr. John McKenzie	(Public Governor, Wokingham)
Mr. David Mihell	(Public Governor, East Berkshire)
Cllr. Bob Pitts	(Partner Governor, Wokingham Borough Council)
Mr. John Shaw	(Partner Governor, Princess Royal Trust for Carers)
Mr. Tony Skuse	(Public Governor, Wokingham)
Dr. Rod Smith	(Partner Governor, NHS Berkshire West)
Cllr. Bet Tickner	(Partner Governor, Reading Borough Council)
Ms. Maria Walker	(Staff Governor, Admin/ Management)

In attendance

Ms. Caroline Ainslie	(Director of Nursing)
Mr. Craig Anderson	(Director of Finance)
Dr. Lindsey Barker	(Networked Care Group Director)
Mrs. Janine Brennan	(Director of HR and Workforce Development)
Mr. Tim Caiger	(Non Executive Director)
Dr. Sue Edees	(Urgent Care Group Director)
Dr. Keith Eales	(Director of Corporate Affairs & Secretary)
Mr. Ed Donald	(Chief Executive)
Mr. Philip Holmes	(Director of Estates and Facilities)
Ms. Jane May	(Non Executive Director)
Ms. Janet Rutherford	(Non Executive Director)
Mr. Mike Robinson	(Head of Governance)
Mrs. Elizabeth White	(Head of Informatics)

Apologies

Mr. Carl Bruce	(Public Governor, Reading)
Mr. David Cooper	(Public Governor, Reading)
Mr. Ross Carroll	(Public Governor, East Berkshire)

Dr. Warren Fisher	(Staff Governor, Medical & Dental)
Miss Jana Hunter	(Partner Governor, Youth MP)
Cllr. Alan Law	(Partner Governor, West Berkshire Council)
Mr Sanusi Koroma	(Partner Governor, Reading CRE)
Mr. John Barrett	(Non-Executive Director)
Mr. Brian Hendon	(Non Executive Director)
Mr. Ian Stoneham	(Commercial Director)

82/12 Minutes for Approval

The Minutes of the meetings held on 26 July 2012 were approved as a correct record and signed by the Chairman. The Council noted the new matters arising schedule and that all actions from the previous meeting were complete. There were no matters arising.

83/12 Trust Briefing

The Chief Executive introduced the new quarterly Trust briefing and gave detailed a presentation on current issues. Comments on the format were welcome.

The Trust was working with other health organisations as part of the 'Shaping the Future' consultation to agree a collaborative approach to the provision of services in East Berkshire. This would involve more services at the Royal Berkshire Bracknell Clinic. Agreement would be achieved before the next financial year.

A Berkshire wide pathology service was being pursued with Heatherwood and Wexham Park NHS Foundation Trust. This had been the preferred option rather than a commercial solution.

The structure of the NHS was changing rapidly, however, there were good and stable local relationships with commissioning bodies.

There would be a Joint Board and Council Workshop on 16 October on issues to feed into the developing integrated business plan.

The Trust continued to experience a challenging operating environment with increases in urgent admissions. Coupled with continuing problems with delayed discharges amounting to 8% of the bed base, there had been an impact on performance standards such as waiting times. There had been investments in additional A&E capacity although additional community care beds were needed to improve patient flow through the hospital.

The Trust's governance rating was amber-red based on a failure to achieve A&E and cancer wait times. The financial risk rating remained at 3 and the Trust was around £3m behind plan with continuing efforts being made needed to increase elective activity and deliver cost improvement plans. Health outcomes were good with the hospitalised standard mortality ratio being in the 'as expected' range and the maternity department achieving a level 2 accreditation from the NHSLA. From a previous below average performance, figures for length of stay and new to follow up rations were in the upper quartile. The Trust continued to be MRSA free and C. difficile infection rates were the 2nd best in the region.

The appraisal rate stood at 65% and the Trust had performed very well regionally in junior doctor training and e-learning. Mandatory training across the Trust needed to be improved and had an increasing focus. The Trust was participating in 'project search' and was providing work experience for people with learning disabilities.

The Trust's rating on NHS choices had improved to 71% and it was noted there had been a range of measures to promote improved ratings. It was commented that large banners in the hospital were used at Frimley Park to promote such feedback. There had been an increase in complaints relating to administration issues, attitude of staff and medication delays which were being tackled and would be discussed later in the meeting.

There had been successful opening of the new Rushey midwife led birthing unit and the new linear accelerator.

The Trust had welcomed an increased investment in patient transport services of over £700k from South Central Ambulance service.

It was noted that Reading Borough Council was looking to provide a bus which would be staffed by volunteers to aid those affected by too much alcohol in the town centre at weekends. This would hopefully reduce unnecessary attendances at A&E. This was very welcome and the Urgent Care Group Director of Nursing would liaise with Bet Tickner over the initiative.

A governor who had recently attended the clinical decision unit praised the care and treatment offered. The Urgent Care Group Director explained that pilots were planned to review how CDU operated as both a ward and assessment centre.

It was noted that Bracknell Borough Council had a town centre manager who was working to relocate voluntary service organisations who may be displaced following the town centre regeneration. It was possible there may be some synergies with the Royal Berkshire Bracknell Clinic.

Resolved: that the report be noted.

84/12 EPR Briefing

The Head of Informatics gave a detailed presentation on the recent implementation of the new electronic patient record system (EPR). The system had been in place for three months and was beginning to become established as 'business as usual'. Although the implementation had been successful compared to other trusts, issues and implications remained for staff and patients which continued to be progressed. The Council noted a number of technical issues and interfaces which were being tackled. Backlogs and errors were reducing and a good deal of support for staff remained. Data quality issues were actively tracked and rectified.

It was highlighted that implementation to date covered only the first part of the process to creating a full EPR. Further enhancements and interfaces with other systems would need to be brought in to deliver the full functionality and benefits. Such issues, for example, connections to the Radnet system, were being actively prepared.

In response to a query, it was explained that the implementation and specifications were as expected compared with other trusts' experiences. The expectations from the original

contract and business case had been high but the product was the best on the market and had the capacity to deliver the required functionality. It was explained that Cerner were actively working to reduce the amount of time staff had to spend inputting data and to rationalise and integrate the number of required entries onto the system.

The Chief Executive felt that 95% of staff were now positive about the system and getting to grips with the required processes. Although there were workarounds and some use of paper, data was being entered onto the system and there were active checks.

Resolved: that the update be noted.

85/12 Finance Briefing

The Director of Finance gave a presentation setting out the current financial highlights. The August figures showed a £2.6m year to date deficit against a planned position of £0.1m surplus. This was driven in part by underperformance on the cost improvement plans and also to an agreed overspend from continuing to actively support EPR implementation. The Trust's cash position remained healthy and the Monitor financial risk rating was 3. Given the likely continued cash balances it was probable this rating would be maintained despite pressure on achieving the targeted 1% surplus.

In outlining the statement of consolidated income and cash flow statements, it was noted that there had been significant increases in drug costs, albeit some of that could be recovered from the PCT. There had also been an increase in capital expenditure on medical equipment and the aim was to increase this year on year.

It was noted that current budget risks were greater than the opportunities. However, a new QIPP Board had been established to drive further saving and income generation.

Resolved: that the update be noted.

86/12 Items from Governors

The following issues were raised:

a) Aileen Blackley raised a query in respect of open Board meetings. The Director of Corporate Affairs and Secretary explained that the Board would be required to meet in public by April 2013. The Chairman undertook to ask the Board to consider holding public Board meetings in advance of that deadline.

Action: Keith Eales

b) Aileen Blackley raised a query in respect of patient Wi-Fi access. The Head of Informatics agreed that internet access for patients was important and would be considered as part of required upgrades to wireless network capacity used by staff. However, patient access was unlikely to be proved during the current financial year.

c) Jonathan Mason raised a query in respect of the age of Trust PCs and the implications for staff working with slow equipment. The Head of Informatics confirmed that contractual discussions with the Trust's IT provider were nearing conclusion and the refresh of some hardware would soon recommence. Upgrades had been continued to be made on merit in the interim.

d) Several governors were experiencing problems receiving email attachments from the Trust. The Head of Informatics confirmed that a solution was being developed.

e) The Vice-Chair of Governors highlighted an issue discussed at a number of the Council's sub-groups, including the Clinical Assurance Committee, which had requested that the Director of Nursing provide an update on complaints. The Committee had discussed the increases seen in complaints and the perception that processes and the approach to complaint handling should be reviewed.

The Director of Nursing explained that although there were national requirements in respect of complaints procedures, the Trust was reviewing processes to ensure that complainants would receive swift and informal resolution. There were care group action plans which were being followed through to ensure lessons were embedded as well as work to ensure issues were shared Trust wide. The Networked Care Group Director agreed that processes could be faster and that there was an issue with staff communication and attitude which would be progressed. There was a new 'welcome ward' imitative and the Director of Human Resources and Workforce Development confirmed that new customer service training programme was being developed.

Governors noted that there had been an increase in complaints based around the administrative implementation of the new EPR system. However, of greater concern were the complaints in relation to attitude. It was considered that issues raised with the Trust were always the tip of the iceberg and that many patients were wary of making complaints. Efforts to encourage feedback continued to be important. Several governors detailed issues raised with them and personal experiences.

The Chief Executive explained that he knew from personal intervention that complaints could be resolved quickly and this needed to be the norm. The Director of Nursing highlighted that positive feedback was also common and referred to a recent CQC inspection which had yielded praise with all patients confirming they had been treated kindly and with respect.

87/12 Minutes of Committees and Groups

Clinical Assurance Committee – 5 September 2012

The Director of Nursing would be forwarding information on complaints to Bob Pitts.

Business Assurance Committee – 17 September 2012

In respect of the proposed consolidation of pathology services with Heatherwood and Wexham Park NHS Foundation Trust, the Chief Executive noted that the population served would reach a 'critical mass' of 1 million.

The external auditor had presented an annual report to the Committee highlighting their work and recommendations.

Patient Experience Group – 18 September 2012

The Networked Care Group Director confirmed that there was an action plan in place to improve the speed of patient discharge; this related to a number of factors including patient transport and, timely production of discharge letters. Although a long standing issue, it was hoped that improvements would soon be seen.

Joint Constitution Working Group – 5 September 2012

On behalf of the group, Sally Kemp outlined the recommendations to the Council for the revised constitution which would be prepared for consideration at the AMM. The proposals would also be considered by the Board. The recommendations were:

- There should be three year term of office for NEDs.
- To give volunteers a stronger voice the Council should have an extra elected staff constituency for volunteers in lieu of the partner governor for Reading / Thames Valley Universities.
- There should be no change to the overall numbers of governors nor the breakdown of public constituencies or the public constituency boundaries. However, a regular review of this against patient flows would be incorporated.
- The NHS Berkshire West and SHA appointed governor posts should be given over to the Berkshire West and Berkshire East clinical Commissioning Group Federations.
- The appointed governor post for a youth MP should be more broadly defined as a 'youth representative'.
- The quorum for the Council should be reduced to make it more manageable.
- There should be no change to the voting system for elected governors.

The Council discussed the proposals in respect of the recommended appointed governor posts. It was noted there were good working level relations with the universities and that the case for giving representation to specialist commissioners had not been considered.

Nominations Committee – 27 September 2012 (Verbal Update)

The Chairman explained that the meeting had recommended the terms of appointment of the new non executive directors should be phased, as previously agreed at its March 2012 meeting. This would result in better continuity for the Board. The proposals were agreed in that Janet Rutherford and Jane May's terms would be to December 2015 while those for Stephen Billingham and Brian Hendon would conclude in July 2016. It was also confirmed that the new NEDs' contracts would feature a month's notice period on either side.

Resolved:

a) that the minutes of sub-groups be received and the recommendations therein endorsed

b) that the appointments of Janet Rutherford and Jane May as NEDs end in December 2015 and the appointments of Stephen Billingham and Brian Hendon as NEDs end in July 2016.

c) that the NEDS' contracts feature a month's notice period on either side

88/12 Membership of the Council

It was noted that Lola Blissett and John Shaw were leaving their positions. The process for the main annual round of public and staff governor elections was underway.

Resolved: that the report be noted.

89/12 Dates of Meetings

The Council had previously agreed to meet quarterly and the proposed dates for 2013 were received and approved.

Resolved: that the revised quarterly dates for the Council in 2013 be approved.

89/12 Questions from the Public

There were no questions.

90/12 Mr John Shaw

The Council noted this was the last meeting of the Council for Mr John Shaw and thanked him for his service.

91/12 Date of Next Meeting

The next meeting would be held on 29 November 2012 at 4:00 pm. This would be in advance of the AMM that evening.

SIGNED

DATE

Royal Berkshire NHS
NHS Foundation Trust

Joint Board and Council Workshop

Tuesday 16 October 2012
3:35pm – 5:15pm
Boardroom, Royal Berkshire Hospital

Present

Mr. Stephen Billingham	(Chairman)
Mrs. Vera Doe	(Public Governor, Wokingham) (Vice-Chair)
Dr. Muhammad Abid	(Public Governor, Reading)
Ms. Caroline Ainslie	(Director of Nursing)
Mr. Craig Anderson	(Director of Finance)
Mr. John Barrett	(Non-Executive Director)
Mrs. Aileen Blackley	(Public Governor, West Berkshire)
Mrs. Janine Brennan	(Director of HR and Workforce Development)
Mr. Jeremy Butler	(Public Governor, East Berkshire)
Mr. Tim Caiger	(Non Executive Director)
Mrs. Rebecca Corre	(Staff Governor, Nursing and Midwifery)
Mr. Matthew Chobbah	(Commercial Manager)
Mr. Ian Clay	(Public Governor, West Berkshire)
Mr. David Cooper	(Public Governor, Reading)
Mr. Ed Donald	(Chief Executive)
Dr. Keith Eales	(Director of Corporate Affairs & Secretary)
Mr. Brian Hendon	(Non Executive Director)
Mr. Colin Lee MBE	(Public Governor, West Berkshire)
Ms. Jane May	(Non Executive Director)
Mr. John McKenzie	(Public Governor, Wokingham)
Mr. David Mihell	(Public Governor, East Berkshire)
Ms. Hannah Oatley	(Business Development Manager)
Ms. Janet Rutherford	(Non Executive Director)
Mr. Mike Robinson	(Head of Governance)
Mr. Tony Skuse	(Public Governor, Wokingham)
Mr. Ian Stoneham	(Commercial Director)
Cllr. Bet Tickner	(Partner Governor, Reading Borough Council)
Dr. Emma Vaux	(Interim Medical Director)
Ms. Maria Walker	(Staff Governor, Admin/ Management)

1 Welcome and Market Analysis

The Chairman welcomed those present and opened the meeting. The Commercial Director gave a short presentation outlining the contents of the circulated background information and key strategic and market analysis issues. This included an overview of the regional 'care for the future' strategy, the NHS wide financial position and likely need for increased collaboration and mergers, area demographic trends, competitor locations and market pressures, the impact of the private sector, the anticipated increases in non elective admissions and the need to make better use of a rationalised estate.

2 Feedback from Workshop Groups

The meeting split into four geographically based workshop groups. Each discussed the key issues facing the Trust overall, issues for that area and opportunities for collaboration.

a) Reading Group

Key Trust wide issues were:

- Uncertainty over AQP on processes, data and funding.
- The potential loss of market share from decreased referrals and increased competition
- The increase in unprofitable non elective urgent work
- The need to improve admission avoidance and delayed discharges
- Ensuring there was appropriate return on current investments. The Trust needs to make surpluses for reinvestment.
- Tackling estates issues – improving the appeal of the main site for planned care work.
- Ensuring staff retention and buy in to changes.

Key issues for Reading were:

- The pressure on maternity services form increasing birth rates
- Inequalities in life expectancy, pregnancy and obesity
- The high expectations of a diverse community
- Developing good relationships with stakeholders and partner organisations. Working with social care on integrated pathways and delayed discharge.
- Consideration of a Trust private patient offering

Opportunities for collaboration:

- Working with partners to deliver earlier discharges
- Intra NHS collaboration on rotas, back office support and integration of pathways.
- Strategic liaison on provision of medical specialties
- Risk sharing and pooling arrangements with partners

b) East Berkshire Group

Key issues were:

- Ensuring the volume of work undertaken by the Trust delivered a sustainable future for the organisation. Ensuring capacity was available to deliver that level.
- The need to recover loss of market share with a sense of urgency.
- The need to gain shared understanding and joint approaches with CCG and partners.
- An urgent need to build capacity at the Royal Berkshire Bracknell Clinic (RBBC).
- The need for a focus on employee and estates issues to facilitate the strategy.
- Looking to be best in class in order to compete.
- The pressures from an increasingly elderly population.
- The need for collaboration to protect market share, reduce costs and make best use of available NHS wide resources.

c) Wokingham Group

Key issues were:

- The need to focus on issues and factors important to patients in choosing the Trust.
- The need to tackle estates and maintenance backlog issues.
- The need to deliver sustainable market share for specialties, for example, a 1 million patient catchment.

- It was important to defend the Wokingham market. The Trust was hospital of choice but was facing competition from Frimley Park and others.
- Ensure there was partnership working with CCGs and GPs on models of care.
- Consideration of whether urgent care capacity was sufficient given increasing elderly population and non elective admissions.
- Maximise RBBC offering for Wokingham patients.
- Collaborate with Frimley Park over services in Ascot and Bracknell.

d) West Berkshire Group

Key points were:

- The difficulty in being the service of choice in a large rural area. Centres in Newbury and Thatcham were easier to engage but the wider communities were harder to attract and are subject to competition from Swindon and Basingstoke.
- A critical issue for patient choice on choose and book was availability of car parking. This and other patient satisfaction/experience issues were very important.
- The need to maximise the use of West Berkshire Community Hospital and work with owners of site. WBCH should be a hub for the local area.
- Opportunities for more elective work to be undertaken at WBCH. For example, day case work and outpatient activity.
- West Berkshire is a relatively affluent area and a target for private health providers.
- The need to work with partners to ensure community care availablity and reduce delayed discharges.
- Opportunities to place more acute work into GP surgeries.
- Opportunities and the need to build GP relationships to improve referrals. There was a need to increase personal contacts and confidence.

3 Plenary

The Commercial Director led a short plenary session drawing together the key issues from the workshop feedback.

It was noted that the development of the integrated business plan (IBP) would need to closely link to estates and personnel strategies to deliver.

It was felt a key recurring theme was the need for close and collaborative relationships – with GPs, CCGs and other providers.

The Chief Executive explained that although competition was an important element of the way forward, it was necessary to ensure collaboration so that the NHS overall was not destabilised.

The view was expressed that the Trust needed to urgently and actively promote its services with GPs and CCGs to maintain and gain market share.

4 Next Steps

The Commercial Director outlined the next steps in the development of the strategic planning process. This would build in the results from care groups plans and workshops, service development opportunities, cost improvement programmes, capacity planning and financial modelling. This would lead to the development of a brief, draft IBP by January 2013. The plan would not be a full IBP but would enable stakeholder engagement and the delivery of a robust Monitor Annual Plan.

The Chief Executive commented that the session had been a useful way of working for the Board and Council and the discussion showed the importance of the Trust focussing on its positioning and markets. The Trust would both compete and collaborate where needed to ensure sustainability. The challenge form the strategic planning process would be to ensure that the IBP was simple and clear. The Trust was well placed to deliver with its new care group structure.

End

Royal Berkshire NHS Foundation Trust

Board of Directors

Title: **Legislative Amendments to the Trust Constitution**

Date: **30 October 2012**

Lead: **Keith Eales**

Purpose: To report on changes required to the Trust Constitution by the Health and Social Care Act 2012.

Key Points:

- The provisions of the Health and Social Care Act 2012 will require significant amendments to the Trust Constitution. These are being drafted for approval by the Board, Council of Governors and the Annual Members Meeting in November.
- The majority of provisions in the Act are expected to come into force on April 2013.
- However, some provisions have been implemented from October 2012. Whilst the Trust is not yet able to amend the Constitution (as changes require the approval of a Members Meeting) there is a requirement to comply with the terms of the new provisions.
- The terms that have been implemented in October are
  a) Changing 'Independent Regulator to Monitor throughout the document
  b) Details on the principal purpose of the organisation (paragraphs 3.1-3.5 of the current Constitution)
  c) Introducing a legal duty to ensure income from NHS funded goods and services is greater than income from other sources (paragraph 3.3)
  d) Introduction of specific wording relating to the accounts, including the replacement of 'HM Treasury' with 'Secretary of State' as regard giving guidance over FT accounts (section 17)
  e) Introduction of additional scrutiny by the Council of Governors over activities generating non-NHS income (section 18)
- The wording required is set out as tracked changes in the Trust Constitution separately distributed to Board members.

- These changes, along with those required by the Health and Social Care Act 2012 and amendments agreed by the Board and the Council of Governors, will be included in the revised Constitution to be submitted to the November meetings.

Decision required	The Board is asked to note the changes required to the Trust Constitution.
FOI Status	This report will be made available on request.

Contact: **Keith Eales, Director of Corporate Affairs**
Phone: **0118 322 8439**

~~Draft: 14/02/2006~~

CONSTITUTION OF

ROYAL BERKSHIRE NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

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CONSTITUTION OF ROYAL BERKSHIRE NHS FOUNDATION TRUST
(A PUBLIC BENEFIT CORPORATION)

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1. DEFINITIONS

1.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this constitution bear the same meaning as in the Health and Social Care (Community Health and Standards) Act 2003.

1.2 References in this constitution to legislation include all amendments, replacements or re-enactments made.

1.3 Headings are for ease of reference only and are not to affect interpretation.

1.4 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

1.5 In this constitution:

"the 2003 Act"	means the Health and Social Care (Community Health and Standards) Act 2003;
"the 1977 Act"	means the National Health Service Act 1977;
"allied healthcare professionals"	means professionals regulated by the Council for Professions Supplementary to Medicine;
"appointed Governors"	means those Governors appointed by the appointing organisations;
"appointing organisations"	means those organisations named in this constitution who are entitled to appoint Governors;
"authorisation"	means an authorisation given by the ~~Independent Regulator~~Monitor;
"areas of the Trust"	means the five areas specified in Annex 1 which are (1) Reading, (2) Wokingham, (3) West Berkshire and borders, (4) East Berkshire and borders, (5) South Oxfordshire;
"Audit Commission"	means the Audit Commission for Local Authorities and the National Health Service in England and Wales;
"Board of Directors"	means the Board of Directors as constituted in accordance with this constitution;
"Council of Governors"	means the Council of Governors as constituted in accordance with this constitution, which has the same meaning as the board of governors in the 2003 Act;

"Director"	means a member of the Board of Directors;
"elected Governors"	means those Governors elected by the public constituencies and the classes of the staff constituency
"external auditor"	means the person appointed to carry out the functions set out in Schedule 5 to the 2003 Act;
"Financial year"	means: (a) the period beginning with the date on which the Trust is authorised and ending with the next 31 March; and (b) each successive period of twelve months beginning with 1 April.
"~~Independent Regulator~~Monitor"	means the regulator for the purposes of Part 1 of the 2003 Act;
"Local Authority Governor"	means a member of the Council of Governors appointed by one or more local authorities whose area includes the whole or part of the area of the Trust;
"member"	means a member of the Trust;
"the NHS Trust"	means the Royal Berkshire and Battle Hospitals NHS Trust which made the application to become an NHS foundation trust;
"Partnership Governor"	means a member of the Council of Governors appointed by a partnership organisation named in this constitution;
"PCT Governor"	means a member of the Council of Governors appointed by a Primary Care Trust for which the Trust provides goods or services;
"public constituency"	means (collectively) those members living in one of the areas of the Trust;
"Public Governor"	means a member of the Council of Governors elected by the members of one of the public constituencies;
"registered dentist"	means a registered dentist within the meaning of the Dentists Act 1984;
"registered medical practitioner"	means a fully registered person within the meaning of the Medicines Act 1983 who holds a licence to practice under that Act;
"Secretary"	means the Secretary of the Trust or any other

	person appointed to perform the duties of the Secretary, including a joint, assistant or deputy secretary;
"staff constituency"	means (collectively) those members of the five classes comprising the staff constituency;
"Staff Governor"	means a member of the Council of Governors elected by the members of one of the classes of the staff constituency;
"the Trust"	means the Royal Berkshire NHS Foundation Trust;

2. NAME AND STATUS

The name of the Trust is to be "Royal Berkshire NHS Foundation Trust". The Trust is a public benefit corporation authorised under the Health and Social Care (Community Health and Standards) Act 2003.

3. PURPOSE

3.1 The principal~~Trust's~~ purpose of the Trust ~~–~~is ~~to serve the community by~~ the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purpose related to

3.1.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness and

3.1.2 the promotion and protection of public health

3.5 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

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4. FUNCTIONS

4.1 The function of the Trust is to provide goods and services, including education and training, research, accommodation and other facilities, for purposes related to the provision of health care.

4.2 The Trust may also carry on other functions for the purpose of making additional income available in order to carry on the Trust's principal purpose better.

5. POWERS

5.1 The Trust may do anything which appears to it to be necessary or desirable for the purposes of or in connection with its functions.

5.2 In particular it may:

5.2.1 acquire and dispose of property;

5.2.2 enter into contracts;

5.2.3 accept gifts of property (including property to be held on trust for the purposes of the Trust or for any purposes relating to the health service);

5.2.4 employ staff.

5.3 Any power of the Trust to pay remuneration and allowances to any person includes the power to make arrangements for providing or securing the provision of pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay).

5.4 The Trust may borrow money for the purposes of or in connection with its functions, subject to any limit imposed by its authorisation or specified in the prudential borrowing code made by the ~~Independent Regulator~~Monitor from time to time.

5.5 The Trust may invest money (other than money held by it as trustee) for the purposes of or in connection with its functions. The investment may include investment by:

5.5.1 forming, or participating in forming, bodies corporate;

5.5.2 otherwise acquiring membership of bodies corporate.

5.6 The Trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.

6. COMMITMENTS

6.1 The Trust shall exercise its functions effectively, efficiently and economically.

Representative membership

6.2 The Trust shall at all times strive to ensure that taken as a whole its actual membership is representative of those eligible for membership. To this end:

6.2.1 the Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors, and shall be reviewed by them from time to time, and at least every three years;

6.2.2 the Council of Governors shall present to each annual members meeting:

6.2.2.1 a report on steps taken to secure that taken as a whole the actual membership of its public constituencies and of the classes of the staff constituency is representative of those eligible for such membership;

6.2.2.2 the progress of the membership strategy;

6.2.2.3 any changes to the membership strategy.

Co-operation with health service bodies

6.3 In exercising its functions the Trust shall co-operate with Health Authorities, Special Health Authorities, Primary Care Trusts, NHS Trusts and NHS Foundation Trusts.

Respect for rights of people

6.4 In conducting its affairs, the Trust shall respect the rights of members of the community it serves, its employees and people dealing with the Trust as set out in the Charter of Fundamental Rights of the European Union.

Openness

6.5 In conducting its affairs, the Trust shall have regard to the need to provide information to members and conduct its affairs in an open and accessible way.

Prohibiting Distribution

6.6 The profits or surpluses of the Trust are not to be distributed either directly or indirectly in any way at all among members of the Trust.

7. FRAMEWORK

7.1 The affairs of the Trust are to be conducted by the Board of Directors, the Council of Governors and the members in accordance with this constitution and the Trust's authorisation. The members, the Council of Governors and the Board of Directors are to have the roles and responsibilities set out in this constitution.

Members

7.2 Members may attend and participate at members meetings, vote in elections to, and stand for, election for the Council of Governors, and take such other part in the affairs of the Trust as is provided in this constitution.

Council of Governors

7.3 The roles and responsibilities of the Council of Governors, which are to be carried out in accordance with this constitution and the Trust's authorisation, are:

7.3.1 at a General Meeting:

7.3.1.1 to appoint or remove the Chairman and the other non-executive Directors;

7.3.1.2 to approve an appointment (by the non-executive Directors) of the chief executive;

7.3.1.3 to decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive Directors;

7.3.1.4 to appoint or remove the Trust's external auditor;

7.3.1.5 to be presented with the annual accounts, any report of the external auditor on them and the annual report;

7.3.2 to provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Trust's forward planning;

7.3.3 to respond as appropriate when consulted by the Board of Directors in accordance with this constitution;

7.3.4 to undertake such functions as the Board of Directors shall from time to time request;

7.3.5 from time to time to review and make recommendations regarding the Trust's membership strategy and its policy for the composition of the Council of Governors and of the non-executive Directors;

7.3.6 when appropriate to make recommendations for the revision of this constitution.

Board of Directors

7.4 The business of the Trust is to be managed by the Board of Directors, which (subject to any contrary provisions of the 2003 Act as given effect by this constitution) shall exercise all the powers of the Trust.

8. MEMBERS

8.1 The members of the Trust are those individuals whose names are entered in the register of members. Every member is to be either a member of one of the public constituencies or a member of one of the classes of the staff constituency.

8.2 Subject to this constitution, membership is open to any individual who:

8.2.1 is over sixteen years of age;

8.2.2 is entitled under this constitution to be a member of one of the public constituencies or one of the classes of the staff constituency; and

8.2.3 completes a membership application form in whatever form the Secretary specifies.

Public constituencies

8.3 There are five public constituencies corresponding to the five areas of the Trust specified in Annex 1. Individuals may become or continue as a member of a public constituency:

8.3.1 who live in the relevant area of the Trust;

8.3.2 who are not a member of another public constituency; and

8.3.3 who are not eligible to be members of any of the classes of the staff constituency.

8.4 The minimum number of members of each of the public constituencies is to be:

8.4.1 Reading - 100 members

8.4.2 Wokingham – 75 members

8.4.3 West Berkshire and borders– 75 members

8.4.4 East Berkshire and borders– 50 members

8.4.5 South Oxfordshire – 50 members

Staff constituency

8.5 The staff constituency is divided into five classes as follows:

8.5.1 registered medical practitioners and registered dentists

8.5.2 registered nurses and midwives

8.5.3 allied healthcare professionals/professional and technical

8.5.4 health care support workers and ancillary

8.5.5 managers and administrative and clerical.

8.6 Individuals may become or continue as members of one of the classes of the staff constituency:

8.6.1 who are employed under a contract of employment by the Trust and who either

8.6.1.1 are employed by the Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months; or

8.6.1.2 who have been continuously employed by the Trust for at least 12 months; or

8.6.2 who are not so employed but who nevertheless exercise functions for the purposes of the Trust and who have exercised the functions for the purposes of the Trust or the NHS Trust for a continuous period of at least 12 months. For the avoidance of doubt, this does not include those who assist or provide services to the Trust on a voluntary basis.

8.7 Where there is dispute as to the particular class of the staff constituency into which an eligible member of that constituency falls the matter shall be

referred to the membership sub-committee of the Council of Governors whose decision shall be final.

8.8 All individuals who are entitled under this constitution to become members of one of the classes of the staff constituency, and who

8.8.1 have been invited by the Trust to become a member of the appropriate class, and

8.8.2 have not informed the Trust that they do not wish to do so shall become members of the appropriate class.

8.9 A person who is eligible to be a member of one of the classes of the staff constituency may not become or continue as a member of any of the public constituencies, and may not become or continue as a member of more than one class of the staff constituency.

8.10 The minimum number of members of each class of the staff constituency is as follows:

8.10.1 registered medical practitioners and registered dentists – 25 members

8.10.2 registered nurses and midwives – 75 members

8.10.3 allied healthcare professionals/professional and technical – 25 members

8.10.4 healthcare support workers and ancillary – 50 members

8.10.5 managers and administrative and clerical – 50 members

9. TERMINATION OF MEMBERSHIP

9.1 A member shall cease to be a member if:

9.1.1 they resign by notice to the Secretary;

9.1.2 they die;

9.1.3 they are expelled from membership under this constitution;

9.1.4 they cease to be entitled under this constitution to be a member of any of the public constituencies or of any of the classes of the staff constituency;

9.1.5 if it appears to the Secretary that they no longer wish to be a member of the Trust, and after enquiries made by the membership sub-committee of the Council of Governors, they fail to demonstrate that they wish to continue to be a member of the Trust.

9.2 A member may be expelled by a resolution approved by a two-thirds majority of the Council of Governors present and voting at a General Meeting. The following procedure is to be adopted.

9.2.1 Any member may complain to the Secretary that another member has acted in a way detrimental to the interests of the Trust.

9.2.2 If a complaint is made, the Council of Governors may consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

9.2.2.1 dismiss the complaint and take no further action; or

9.2.2.2 for a period not exceeding twelve months suspend the rights of the member complained of to attend members meetings and vote under this Constitution;

9.2.2.3 arrange for a resolution to expel the member complained of to be considered at the next General Meeting of the Council of Governors.

9.2.3 If a resolution to expel a member is to be considered by the Council of Governors, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

9.2.4 At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

9.2.5 If the member complained of fails to attend the meeting without reasonable cause the meeting may proceed in their absence.

9.2.6 A person expelled from membership will cease to be a member upon the declaration by the Chairman of the meeting that the resolution to expel them is carried.

9.2.7 No person who has been expelled from membership is to be readmitted except by a resolution carried by the votes of two-thirds of the Council of Governors present and voting at a General Meeting.

9.2.8 General Meetings of the Council of Governors held to consider a resolution for expulsion of a member or readmission of an expelled member shall not be open to members of the public.

10. MEMBERS MEETINGS

10.1 The Trust is to hold a members meeting (called the annual members meeting) within nine months of the end of each financial year.

10.2 All members meetings other than annual meetings are called special members meetings.

10.3 Members meetings are open to all members of the Trust, Governors and Directors, and representatives of the external auditor, but not to members of the public unless the Council of Governors decides otherwise. The Council of Governors may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Trust to attend a members meeting.

10.4 All members meetings are to be convened by the Secretary by order of the Council of Governors.

10.5 The Council of Governors may decide where a members meeting is to be held and may also for the benefit of members:

10.5.1 arrange for the annual members meeting to be held in different venues each year:

10.5.2 make provisions for a members meeting to be held at different venues simultaneously or at different times. In making such provision the Council of Governors shall also fix an appropriate quorum for each venue, provided that the aggregate of the quorum requirements shall not be less than the quorum set out below.

10.6 At the annual members meeting:

10.6.1 the Board of Directors shall present to the members:

10.6.1.1 the annual accounts

10.6.1.2 any report of the financial auditor

10.6.1.3 any report of any other external auditor of the Trust's affairs

10.6.1.4 forward planning information for the next financial year

10.6.2 the Council of Governors shall present to the members:

10.6.2.1 a report on steps taken to secure that (taken as a whole) the actual membership of its public constituencies and of the classes of the staff constituency is representative of those eligible for such membership;

10.6.2.2 the progress of the membership strategy

10.6.2.3 any proposed changes to the policy for the composition of the Council of Governors and of the non-executive Directors

10.6.3 the results of the election and appointment of Governors and the appointment of non-executive Directors will be announced.

10.7 Notice of a members meeting is to be given:

10.7.1 by notice to all members;

10.7.2 by notice prominently displayed at the head office and at all of the Trust's places of business; and

10.7.3 by notice on the Trust's website

at least 14 clear days before the date of the meeting. The notice must:

10.7.4 be given to the Council of Governors and the Board of Directors, and to the external auditor;

10.7.5 state whether the meeting is an annual or special members meeting;

10.7.6 give the time, date and place of the meeting; and

10.7.7 indicate the business to be dealt with at the meeting.

10.8 Before a members meeting can do business there must be a quorum present. Except where this constitution says otherwise a quorum is one member present from each of the Trust's constituencies.

10.9 The Trust may make arrangements for members to vote by post, or by using electronic communications.

10.10 It is the responsibility of the Council of Governors, the Chairman of the meeting and the Secretary to ensure that at any members meeting:

10.10.1 the issues to be decided are clearly explained;

10.10.2 sufficient information is provided to members to enable rational discussion to take place.

10.11 The Chairman of the Trust, or in their absence the Vice Chairman of the Council of Governors, shall act as chairman at all members meetings of the Trust. If neither the Chairman nor the Vice Chairman of the Council of Governors is present, the members of the Council of Governors present shall elect one of their number to be Chairman and if there is only one Governor present and willing to act they shall be Chairman.

10.12 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

10.13 A resolution put to the vote at a members meeting shall be decided upon by a poll.

10.14 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the Chairman of the meeting is to have a second or casting vote.

10.15 The result of any vote will be declared by the Chairman and entered in the minute book. The minute book will be conclusive evidence of the result of the vote.

11. COUNCIL OF GOVERNORS

11.1 The Trust is to have a Council of Governors. It is to consist of Public Governors, Staff Governors, a PCT Governor, Local Authority Governors and Partnership Governors.

11.2 The aggregate number of Public Governors is to be more than half of the total number of members of the Council of Governors.

11.3 The Trust is to have a Code of Conduct for the Council of Governors which all Governors will be required to sign a declaration stating their commit to abide by the Code.

11.4 The Council of Governors shall seek to ensure, subject to the requirements of the 2003 Act, that the composition of the Council of Governors meets the following objectives:

11.4.1 the interests of the community served by the Trust are appropriately represented;

11.4.2 the level of representation of the public constituencies, the classes of the staff constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs;

and to this end, the Council of Governors:

11.4.3 shall at all times maintain a policy for the composition of the Council of Governors which takes account of the membership strategy; and

11.4.4 shall from time to time and not less than every three years review the policy for the composition of the Council of Governors; and

11.4.5 when appropriate shall propose amendments to this constitution.

11.5 The Council of Governors of the Trust is to comprise:

11.5.1 fifteen Public Governors, from the following public constituencies:

11.5.1.1 Reading –five Public Governors;

11.5.1.2 Wokingham – three Public Governors;

11.5.1.3 West Berkshire and borders – three Public Governors;

11.5.1.4 East Berkshire and borders – three Public Governors

11.5.1.5 South Oxfordshire – one Public Governor;

11.5.2 five Staff Governors from the following classes:

11.5.2.1 registered medical practitioners and registered dentists. – one Staff Governor;

11.5.2.2 registered nurses and midwives – one Staff Governor;

11.5.2.3 allied healthcare professionals / professional and technical – one Staff Governor;

11.5.2.4 healthcare support workers and ancillary – one Staff Governor;

11.5.2.5 managers and administrative and clerical – one Staff Governor;

11.5.3 one PCT Governor, to be appointed by Reading PCT;

11.5.4 three Local Authority Governors, to be appointed one each by Reading Borough Council, Wokingham District Council and West Berkshire District Council;

11.5.5 five Partnership Governors appointed by partnership organisations.

11.6 The partnership organisations that may appoint a Partnership Governor are

11.6.1 The Thames Valley Strategic Health Authority (one Partnership Governor)

11.6.2 The Princess Royal Trust for Carers (one Partnership Governor)

11.6.3 Reading Campaign for Racial Equality (one Partnership Governor)

11.6.4 One Youth MP to be appointed by (and representing the areas of) Reading Borough Council, Wokingham District Council or West Berkshire District Council in consultation with the Wokingham Youth Service

11.6.5 Reading University and Thames Valley University (one Partnership Governor between them)

Elected Governors

11.7 Public Governors are to be elected by the members of their public constituencies, and Staff Governors are to be elected by the members of their class of the staff constituency. Each class/constituency may elect any of their number to be a Governor in accordance with the provisions of this constitution.

11.8 If contested, the elections must be by secret ballot.

11.9 Elections shall be carried out in accordance with the rules set out in Annex 2 using the first past the post system.

11.10 A member of a public constituency may not vote at an election for a Public Governor unless within twenty-one days before they vote they have made a declaration in the form specified by the Council of Governors that they are qualified to vote as a member of the relevant constituency. It is an offence knowingly or recklessly to make such a declaration which is false in a material particular.

PCT Governors

11.11 The Secretary, having consulted Reading PCT and is to adopt a process for agreeing the appointment of the PCT Governor with that Primary Care Trust.

Local Authority Governors

11.12 The Secretary, having consulted Reading Borough Council, Wokingham District Council and West Berkshire District Council is to adopt a process for agreeing the appointment of Local Authority Governors with those local authorities.

Partnership Governors

11.13 The Partnership Governors are to be appointed by the partnership organisations in accordance with a process agreed with the Secretary.

Appointment of a Vice Chairman of the Council of Governors

11.14 The Council of Governors shall appoint one of the Public Governors to be Vice Chairman of the Council of Governors.

Terms of office for Governors

11.15 Elected Governors:

11.15.1 shall hold office for a period of three years commencing immediately after the annual members meeting at which their election is announced;

11.15.2 are eligible for re-election at the end of that period;

11.15.3 may not hold office for more than six consecutive years and shall not be eligible for re-election if they have already held office for more than three consecutive years.

11.16 Appointed Governors:

11.16.1 shall hold office for a period of three years commencing immediately after the annual members meeting at which their appointment is announced;

11.16.2 are eligible for re-appointment at the end of that period;

11.16.3 may not hold office for longer than six consecutive years and shall not be eligible for re-election if they have already held office for more than three consecutive years.

11.17 For the purposes of these provisions concerning terms of office for Governors, "year" means a period commencing immediately after the conclusion of the annual members meeting, and ending at the conclusion of the next annual members meeting.

Eligibility to be a Governor

11.18 A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so if:

11.18.1 they are a Director of the Trust, or a governor or director of a health service body (unless they are appointed by an appointing organisation which is a health service body);

11.18.2 they are the spouse, partner, parent or child of a member of the Board of Directors of the Trust;

11.18.3 they are under sixteen years of age;

11.18.4 being a member of one of the public constituencies, they refuse to sign a declaration in the form specified by the Council of Governors of the particulars of their qualification to vote as a

member of the Trust, and that they are not prevented from being a member of the Council of Governors.

11.18.5 they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

11.18.6 they have made a composition or arrangement with, or granted a trust deed for, their creditors and have not been discharged in respect of it;

11.18.7 they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed;

11.18.8 they are the subject of a sex offender order;

11.18.9 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

11.18.10 they are a person whose tenure of office as the Chairman or as a member or director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

11.18.11 they have had their name removed, by a direction under section 46 of the 1977 Act from any list prepared under Part II of that Act, and have not subsequently had their name included in such a list.

Termination of office and removal of Governors

11.19 A person holding office as a Governor shall immediately cease to do so if

11.19.1 they resign by notice in writing to the Secretary;

11.19.2 they fail to attend two meetings in any Financial Year, unless the other Governors are satisfied that:

11.19.2.1 the absences were due to reasonable causes; and

11.19.2.2 they will be able to start attending meetings of the Trust again within such a period as the other Governors consider reasonable.

11.19.3 in the case of an elected Governor, they cease to be a member of the constituency or class of the constituency by which they were elected;

11.19.4 in the case of an appointed Governor, the appointing organisation terminates the appointment;

11.19.5 they have refused without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake;

11.19.6 they have failed without reasonable cause to sign and deliver to the Secretary a statement in the form required by the Council of Governors confirming acceptance of the code of conduct for Governors;

11.19.7 they are removed from the Council of Governors under the following provisions.

11.20 A Governor may be removed from the Council of Governors by a resolution approved by not less than three quarters of the remaining Governors present and voting on the grounds that:

11.20.1 they have committed a serious breach of the code of conduct, or

11.20.2 they have acted in a manner detrimental to the interests of the Trust, and

11.20.3 the Council of Governors considers that it is not in the best interests of the Trust for them to continue as a Governor.

Vacancies amongst Governors

11.21 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

11.22 Where the vacancy arises amongst the appointed Governors, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

11.23 Where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty either:

11.23.1 to call an election within three months to fill the seat for the remainder of that term of office, or

11.23.2 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office.

Expenses and remuneration of Governors

11.24 The Trust may reimburse Governors for travelling and other costs and expenses at such rates as the executive remuneration committee of the non-executive Directors decides. These are to be disclosed in the annual report.

11.25 Governors are not to receive remuneration.

Meetings of the Council of Governors

11.26 The Council of Governors is to meet at least three times in each financial year. Save in the case of emergencies or the need to conduct urgent

business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published in a local newspaper or newspapers circulating in the area served by the Trust, and on the Trust's website.

11.27 Meetings of the Council of Governors may be called by the Secretary, or by the Chairman, or by ten Governors (including not less than five Public Governors) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request. The Secretary shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chairman or the ten Governors, whichever is the case, shall call such a meeting.

11.28 Save as stated otherwise in this constitution all meetings of the Council of Governors are to be General Meetings open to members of the public unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The Chairman may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.

11.29 Fourteen Governors including not less than eight Public Governors, not less than two Staff Governors and not less than four appointed Governors shall form a quorum.

11.30 The Chairman of the Trust or, in their absence, the Deputy Chairman of the Board of Directors, or in their absence one of the other non-executive Directors shall preside at meetings of the Council of Governors. If the person presiding at any such meeting has a conflict of interest in relation to the business being discussed, the Vice Chairman of the Council of Governors will chair that part of the meeting.

11.31 The Council of Governors may invite the Chief Executive or any other member or members of the Board of Directors, or a representative of the external auditor or other advisors to attend a meeting of the Council of Governors.

11.32 The Council of Governors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

11.33 Subject to this constitution and the following provisions of this paragraph, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes.

11.33.1 In case of an equality of votes the person presiding at or chairing the meeting shall have a casting vote.

11.33.2 No resolution of the Council of Governors shall be passed if it is unanimously opposed by all of the Public Governors present. This provision shall only apply if there are ten or more Public Governors present.

11.34 The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees consisting of its members, Directors and other persons to assist the Council of Governors in carrying out its functions.

11.35 The Council of Governors may, through the Secretary, request that advisors assist them or any committee they appoint in carrying out their functions.

11.36 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

Disclosure of interests

11.37 Any Governor who has a material interest in a matter as defined below shall declare such interest to the Council of Governors and:

11.37.1 shall not be present except with the permission of the Council of Governors during any discussion of the matter, and

11.37.2 shall not vote on any issue arising out of or connected with the matter (and if by inadvertence they do remain and vote, their vote shall not be counted).

11.38 Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Governors.

11.39 Subject to the exceptions below, a material interest is

11.39.1 any directorship of a company;

11.39.2 any interest held by a Governor in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;

11.39.3 any interest in an organisation providing health and social care services to the National Health Service;

11.39.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

11.39.5 any connection with any organisation, entity or company considering entering into a financial arrangement with the Trust including but not limited to lenders or banks.

11.40 The exceptions which shall not be treated as material interests are as follows:

11.40.1 shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

11.40.2 an employment contract held by a Staff Governor;

11.40.3 a contract with their PCT held by a PCT Governor;

11.40.4 an employment contract with a local authority held by a Local Authority Governor;

11.40.5 an employment contract with a partnership organisation, held by a Partnership Governor.

11.41 The Council of Governors is to adopt its own standing orders for its practice and procedure, in particular for its procedure at meetings.

Declaration

11.42 An elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Council of Governors of the particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of elected Governors.

12. BOARD OF DIRECTORS

12.1 The Trust is to have a Board of Directors. It is to consist of executive and non-executive Directors.

12.2 The board is to include:

12.2.1 the following non-executive Directors:

12.2.1.1 a Chairman, who is to be appointed (and removed) by the Council of Governors at a General Meeting;

12.2.1.2 up to seven other non-executive Directors who are to be appointed (and removed) by the Council of Governors at a General Meeting

in each case subject to the approval of a majority of the Council of Governors (in the case of an appointment) present and voting at the meeting, and a three-quarters majority of all of the members of the Council of Governors (in the case of a removal) voting at the meeting;

12.2.2 the following executive Directors:

12.2.2.1 a Chief Executive (who is the accountable officer), who is to be appointed (and removed) by the non-executive Directors, and whose appointment is subject to the approval of a majority of the members of the Council of Governors present and voting at a General Meeting;

12.2.2.2 a Finance Director, a registered medical practitioner or a registered dentist, a registered nurse or registered midwife, and up to three other executive Directors, all of whom are to be appointed (and removed) by a committee comprising the Chairman, the Chief Executive and the other non-executive Directors.

12.3 Only a member of a public constituency is eligible for appointment as a non-executive Director.

12.4 The Board of Directors shall elect one of the non-executive Directors to be Deputy Chairman of the Board of Directors. If the Chairman is unable to discharge their office as Chairman of the Trust, the Deputy Chairman of the Board of Directors shall be acting Chairman of the Trust.

12.5 Non-executive Directors are to be appointed by the Council of Governors using the following procedure.

12.5.1 The Council of Governors will maintain a policy for the composition of the non-executive Directors which takes account of the membership strategy, and which they shall review from time to time and not less than every three years.

12.5.2 The Chairman (or in the case of the appointment of the Chairman, the Deputy Chairman), or Vice Chairman of the Council of Governors, two Governors, the Chief Executive will work with an independent advisor to identify the skills and experience required for non-executive Directors.

12.5.3 Appropriate candidates will be identified by a nominations committee which will include the Chairman (or the Deputy Chairman (unless they are standing for appointment, in which case another non-executive Director, when a Chairman is being appointed) and at least one elected Governor and one appointed Governor. The nominations committee will take account of the policy maintained by the Council of Governors and the skills and experience required. The Chief Executive will be entitled to attend meetings of the Nominations Committee unless the Committee decides otherwise and the Committee shall take into account the Chief Executive's views.

Terms of Office

12.6 The Chairman and the non-executive Directors are to be appointed for a period of office of four years in accordance with the terms and conditions of office, including remuneration and allowances, decided by the Council of Governors at a General Meeting. Any re-appointment of a non-executive Director shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Board of Directors have approved.

12.7 The executive remuneration committee of non-executive Directors shall decide the terms and conditions of office including remuneration and allowances of all the executive Directors.

Disqualification

12.8 A person may not become or continue as a Director of the Trust if:

12.8.1 they are a member of the Council of Governors;

12.8.2 they are the spouse, partner, parent or child of a member of the Board of Directors of the Trust;

12.8.3 they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

12.8.4 they have made a composition or arrangement with, or granted a trust deed for, their creditors and have not been discharged in respect of it;

12.8.5 they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed;

12.8.6 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

12.8.7 in the case of a non-executive Director, they are no longer a member of a public constituency;

12.8.8 they are a person whose tenure of office as a Chairman or as a member or director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non attendance at meetings, or for non-disclosure of a pecuniary interest;

12.8.9 they have had their name removed, by a direction under section 46 of the 1977 Act from any list prepared under Part II of that Act, and have not subsequently had their name included on such a list;

12.8.10 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

12.8.11 in the case of a non-executive Director they have refused without reasonable cause to fulfil any training requirement established by the Board of Directors;

12.8.12 they have failed without reasonable cause to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors.

Committees and delegation

12.9 The Board of Directors may delegate any of its powers to a committee of Directors or to an executive Director.

12.10 The Board of Directors shall appoint a committee of non-executive Directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

12.11 The Board of Directors shall appoint an executive remuneration committee of non-executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the executive Directors.

Meetings of Directors

12.12 Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give to all Directors at least fourteen days written notice of the date and place of every meeting of the Board of Directors.

12.13 Meetings of the Board of Directors shall be held in private unless the Board of Directors decides otherwise in relation to all or part of a meeting.

12.14 Meetings of the Board of Directors are called by the Secretary, or by the Chairman, or by four Directors who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Directors as soon as possible after receipt of such a request. The Secretary shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chairman or four Directors, whichever is the case, shall call such a meeting.

12.15 Four Directors including not less than one executive Director, and not less than one non-executive Director shall form a quorum.

12.16 The Board of Directors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

12.17 The Chairman of the Trust or, in their absence, the Deputy Chairman of the Board of Directors, and in their absence one of the other non-executive Directors in attendance is to chair meetings of the Board of Directors.

12.18 Subject to the following provisions of this paragraph, questions arising at a meeting of the Board of Directors shall be decided by a majority of votes.

12.18.1 In case of an equality of votes the Chairman shall have a second and casting vote.

12.18.2 No resolution of the Board of Directors shall be passed if it is opposed by all of the executive Directors present or by all of the non-executive Directors present.

12.19 The Board of Directors is to adopt Standing Orders covering the proceedings and business of its meetings. The proceedings shall not however be invalidated by any vacancy of its membership, or defect in a Director's appointment.

Conflicts of Interest of Directors

12.20 Any Director who has a material interest in a matter as defined below shall declare such interest to the Board of Directors and:

12.20.1 shall not be present except with the permission of the Board of Directors during any discussion of the matter, and

12.20.2 shall not vote on any issue arising out of or connected with the matter (and if by inadvertence they do remain and vote, their vote shall not be counted).

12.21 Any Director who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Directors and (in the case of a non-executive Director) by the requisite majority of the Council of Governors.

12.22 A material interest is

12.22.1 any directorship of a company;

12.22.2 any interest (excluding a holding of shares in a company whose shares are listed on any public exchange where the holding is less than 2% of the total shares in issue) held by a Director in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;

12.22.3 any interest in an organisation providing health and social care services to the National Health Service;

12.22.4 a position of authority in a charity or voluntary organisation in the field of health and social care. any affiliation to a special interest group campaigning on health or social care issues;

12.22.5 any connection with any organisation, entity or company considering entering into a financial arrangement with the Trust including but not limited to lenders or banks.

Expenses

12.23 The Trust may reimburse Directors for travelling and other costs and expenses incurred in carrying out their duties at such rates as the executive remuneration committee of non-executive Directors decides. These are to be disclosed in the annual report.

12.24 The remuneration and allowances for Directors are to be disclosed in the annual report.

13. SECRETARY

13.1 The Trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Chief Executive or the Finance Director. The Secretary's functions shall include:

13.1.1 acting as Secretary to the Council of Governors and the Board of Directors, and any committees;

13.1.2 summoning and attending all members meetings, meetings of the Council of Governors and the Board of Directors, and keeping the minutes of those meetings;

13.1.3 keeping the register of members and other registers and books required by this constitution to be kept;

13.1.4 having charge of the Trust's seal;

13.1.5 publishing to members in an appropriate form information which they should have about the Trust's affairs;

13.1.6 preparing and sending to the ~~Independent Regulator~~Monitor and any other statutory body all returns which are required to be made.

13.2 Minutes of every members meeting, of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept. Minutes of meetings will be read at the next meeting and signed by the Chairman of that meeting. The signed minutes will be conclusive evidence of the events of the meeting.

13.3 The Secretary is to be appointed and removed by a nominations committee which will include the Chairman, the Chief Executive and the other non-executive Directors, subject to the approval of the Council of Governors.

14. REGISTERS

14.1 The Trust is to have:

14.1.1 a register of Members showing, in respect of each member:

14.1.1.1 the constituency to which they belong; and

14.1.1.2 where there are classes of the constituency, the class to which they belong;

14.1.2 a register of members of the Council of Governors;

14.1.3 a register of Directors;

14.1.4 a register of interests of members of the Council of Governors;

14.1.5 a register of interests of the Directors.

14.2 The Secretary shall remove from the register of members the name of any member who ceases to be entitled to be a member under the provisions of this constitution.

14.3 The Secretary is to send to the ~~Independent Regulator~~Monitor a list of persons who were first elected or appointed as Governors or Directors.

15. PUBLIC DOCUMENTS

15.1 The following documents of the Trust are to be available for inspection by members of the public free of charge at all reasonable times, and shall be available on the Trust's website:

15.1.1 a copy of the current constitution;

15.1.2 a copy of the current authorisation;

15.1.3 a copy of the latest annual accounts and of any report of the external auditor on them;

15.1.4 a copy of the report of any other external auditors appointed by the Council of Governors to review and publish a report on any other aspect of the Trust's affairs;

15.1.5 a copy of the latest annual report;

15.1.6 a copy of the latest information as to its forward planning;

15.1.7 a copy of the Trust's membership development strategy;

15.1.8 a copy of the Trust's policy for the composition of the Council of Governors and the non-executive Directors;

15.1.9 a copy of any notice given under section 23 of the 2003 Act (regulator's notice to failing NHS foundation Trust).

15.2 The registers shall be made available for inspection by members of the public, except in circumstances prescribed by the Public Benefit Corporation (Register of Member) Regulations 2004 (S.I. 2004 No. 539); and so far as they are required to be available they are to be available free of charge at all reasonable times.

15.3 Any person who requests it is to be provided with a copy or extract from any of the above documents or registers. The Trust may impose a reasonable charge for providing the copy or extract, but a member is entitled to a copy or extract from the documents or registers free of charge.

16. AUDITORS

16.1 The Trust is to have an external auditor and is to provide the external auditor with every facility and all information which he may reasonably require for the purposes of his functions under Part 1 of the 2003 Act.

16.2 A person may only be appointed as the external auditor if he (or in the case of a firm each of its members) is a member of one or more of the bodies referred to in paragraph 23(4) of Schedule 1 to the 2003 Act.

16.3 An officer of the Audit Commission may be appointed as the external auditor with the agreement of the Audit Commission.

16.4 The Council of Governors at a General Meeting shall appoint or remove the Trust's external auditor.

16.5 The external auditor is to carry out his duties in accordance with Schedule 5 to the 2003 Act and in accordance with any directions given by the ~~Independent Regulator~~Monitor on standards, procedures and techniques to be adopted.

16.6 The Board of Directors may resolve that other external auditors be appointed to review and publish a report on any other aspect of the Trust's performance. Any such auditors are to be appointed by the Council of Governors.

17. ACCOUNTS

17.1 The Trust ~~is to~~must keep proper accounts and proper records in ~~such form as the Independent Regulator~~Monitor ~~may with the approval of the Treasury direct~~relation to the accounts.

17.2 Monitor may, with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts

~~17.1~~

~~17.2~~17.3 The accounts are to be audited by the Trust's ~~external~~ auditor.

~~17.3~~17.4 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

~~17.3.1~~17.4.1 the accounts;

~~17.3.2~~17.4.2 any records relating to them; and

~~17.3.3~~17.4.3 any report of the external auditor on them.

17.5 The Trust ~~is to~~ shall prepare in respect of each financial year annual accounts in such form as the ~~Independent Regulator~~Monitor may with the approval of the Treasury direct.

17.6 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

~~17.4~~

~~17.5~~17.7 In preparing its annual accounts, the Trust is to comply with any directions given by the ~~Independent Regulator~~Monitor with the approval of the Treasury as to:

~~17.5.1~~17.7.1 the methods and principles according to which the accounts are to be prepared;

~~17.5.2~~17.7.2 the information to be given in the accounts;

~~17.6~~17.8 The annual accounts, any report of the external auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting.

~~17.7~~17.9 The Trust ~~shall~~must:

~~17.7.1~~17.9.1 lay a copy of the annual accounts, and any report of the external auditor on them, before Parliament; and

~~17.7.2~~17.9.2 once it has done so, send copies of those documents to the ~~Independent Regulator~~Monitor.

17.10 The Chief Executive as accounting officer is responsible for the preparation of the annual accounts, for laying before Parliament a copy of the annual accounts and any report of the external auditor on them, and for sending copies of such documents to the ~~Independent Regulator~~Monitor.

~~17.8~~

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18. ANNUAL REPORTS AND FORWARD PLANS

18.1 The Trust is to prepare annual reports and send them to the ~~Independent Regulator~~Monitor.

18.2 The reports are to give:

18.2.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of the public constituencies and the classes of the staff constituency is representative of those eligible for such membership; and

18.2.2 any other information the ~~Independent Regulator~~Monitor requires.

18.3 The Trust is to comply with any decision the ~~Independent Regulator~~Monitor makes as to:

18.3.1 the form of the reports;

18.3.2 when the reports are to be sent to him;

18.3.3 the periods to which the reports are to relate.

18.4 The Trust is to give information as to its forward planning in respect of each financial year to the ~~Independent Regulator~~Monitor. The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors.

18.5 Each forward plan must include information about –

18.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

18.5.2 the income that it expects to receive from doing so

18.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 18.5.1 the Council of Governors must

18.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment of its other functions, and

18.6.2 notify the directors of the Trust of its determination.

18.7 Where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England the Trust may implement the proposal only if at a quorate meeting, more than half of the members of the Council of Governors of the Trust present and eligibleto vote, approve its implementation.

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19. INDEMNITY

Members of the Council of Governors and the Board of Directors and the Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust. The Trust may purchase and maintain insurance against any such liability for its own benefit and the benefit of members of the Council of Governors and the Board of Directors and the Secretary.

20. EXECUTION OF DOCUMENTS

20.1 A document purporting to be duly executed under the Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed.

20.2 The Trust is to have a seal, but this is not to be affixed except under the authority of the Board of Directors.

21. DISPUTE RESOLUTION PROCEDURES

21.1 Any dispute touching and concerning membership of a constituency, the right to membership of the Trust or the conduct of individual Governors shall be referred to membership sub-committee of the Council of Governors for resolution.

21.1.1 The membership sub committee will be chaired by the Vice Chairman and comprise 5 other Governors at least two of whom must be from the public constituencies and one from the staff constituency.

21.1.2 The committee will be advised by the Secretary to the Trust.

21.1.3 If the membership sub-committee is unable to resolve the dispute the matter shall be referred to an Appeals Panel comprising no less than two Non-Executive Directors, a Governor of the relevant constituency and the Chief Executive whose decision shall be final.

21.2 Subject to the above paragraph, every unresolved dispute which arises out of this constitution between the Trust and:

21.2.1 a member; or

21.2.2 any person aggrieved who has ceased to be a member within the six months prior to the date of the dispute; or

21.2.3 any person bringing a claim under this constitution; or

21.2.4 an office-holder of the Trust

is to be submitted to an arbitrator agreed by the parties or in the absence of agreement to be nominated by the Strategic Health Authority. The arbitrator's decision will be binding and conclusive on all parties.

21.3 Any person bringing a dispute must, if required to do so, deposit with the Trust a reasonable sum (not exceeding £250) to be determined by the Board of Governors and approved by the Secretary. The arbitrator will decide how

the costs of the arbitration will be paid and what should be done with the deposit.

22. AMENDMENT OF THE CONSTITUTION

22.1 Proposals to amend this constitution can only be made by:

22.1.1 A majority of the Board of Directors, or

22.1.2 A two thirds majority of the Council of Governors present and voting at a General Meeting.

22.2 No amendment shall be made to this constitution unless:

22.2.1 it has been approved by a majority of those members of the Trust present and voting at a members meeting duly called by order of the Council of Governors in accordance with this constitution; and

22.2.2 it has been approved by the ~~Independent Regulator~~Monitor.

22.3 No amendment shall be made to the provisions of this constitution concerning the public constituencies unless it has also been approved by a majority of the members of all of the public constituencies voting at a members meeting.

22.4 No amendment shall be made to the provisions of this constitution concerning the staff constituency or the classes of the staff constituency unless it has also been approved by a majority of the members of all of the classes of the staff constituency voting at a members meeting.

23. MERGERS

The Trust may in accordance with section 27 of the 2003 Act apply to the ~~Independent Regulator~~Monitor jointly with another NHS Foundation Trust or an NHS Trust for authorisation of the dissolution of the Trust and the transfer of some or all of their property and liabilities to a new NHS Foundation Trust established under that section. Such application shall only be made if a majority of those members of the Trust present and voting at a members meeting shall have approved the making of such an application.

24. DISSOLUTION OF THE TRUST

The Trust may not be dissolved except by order of the Secretary of State for Health, in accordance with Section 25 of the 2003 Act.

25. HEAD OFFICE AND WEBSITE

25.1 The Trust's head office is at Royal Berkshire Hospital, London Road, Reading RG1 5AN

25.2 The Trust will maintain a website: www.rbbh.nhs.uk

25.3 The Trust will display its name on the outside of its head office and every other place at which it carries on business, and on its business letters, notices, advertisements, other publications.

26. NOTICES

26.1 Any notice required by this constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose. “Address” in relation to electronic communications includes any number or address used for the purposes of such communications.

26.2 Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice was given. A notice shall be treated as delivered 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

TRANSITION SCHEDULE

27. COUNCIL OF GOVERNORS

27.1 Not less than one third of the initial Public Governors and of the initial Staff Governors who polled the highest votes will serve a term of office ending at the conclusion of the annual members meeting in 2009; not less than one third of the Public Governors and of the Staff Governors who polled the next highest number of votes will serve a term of office ending at the conclusion of the annual members meeting in 2008; the remaining Public Governors and Staff Governors will serve a term of office ending at the conclusion of the annual members meeting in 2007.

27.2 Where following the outcome of elections in 2006, 2007 and 2008, the Council of Governors is of the view that on the basis of the policy for the composition of the Council of Governors, the interests of the community served by the Trust are not appropriately represented, or the level of representation of the public constituency, the staff constituency and the partnership organisations does not strike an appropriate balance having regard to their legitimate interest in the Trust's affairs, the Council of Governors may work with any of the appointing organisations to identify individuals who shall be invited to attend and speak (but not vote) at meetings of the Council of Governors.

27.3 Any such invitation shall be for a period of one year, and may be renewed, but may not extend beyond the annual members meeting in 2008.

27.4 In calculating the periods of three years and six years for the purposes of eligibility to seek re-election or to be re-appointed as Governors under this constitution, the period between their election or appointment as initial Governors and the conclusion of the annual general meeting in 2006 shall be ignored.

28. BOARD OF DIRECTORS

28.1 The power to appoint the initial Chairman of the Trust is to be exercised by appointing the Chairman of the NHS Trust, if they wish to be appointed.

28.2 The power to appoint the other initial non-executive Directors of the Trust is to be exercised, so far as possible, by appointing any of the non-executive Directors of the NHS Trust who wish to be appointed.

28.3 An initial non-executive Director appointed in this way does not have to be a member of a public constituency.

28.4 A Chairman or non-executive Director appointed in accordance with these provisions is to be appointed for the unexpired period of their term of office with the NHS Trust; but if on any such appointment, that period is less than 12 months, they are to be appointed for 12 months.

28.5 The initial remuneration and allowances of the initial executive Directors are to be determined by a committee of the non-executive Directors of the NHS Trust.

28.6 The power to appoint the initial Chief Executive of the Trust is to be exercised by appointing the Chief Executive of the NHS Trust, if they wish to be appointed. Such appointment does not require the approval of the Council of Governors.

28.7 The Board of Directors of the NHS Trust shall appoint the first Secretary of the Trust.

29. APPROVAL OF ELECTION PROCEDURES, MEMBERSHIP STRATEGY ETC.

29.1 For the purposes of the election of the first members of the Council of Governors, elections shall be carried out in accordance with the rules set out in Annex 2, using the first past the post method of voting.

29.2 The Board of Directors of the NHS Trust will prepare and approve the first membership strategy and the first policy for the composition of the Council of Governors and of the non-executive Directors.

29.3 These will be reviewed by the Council of Governors following the election and appointment of the initial Governors.

29.4 For the purposes of the period before the NHS Trust becomes the Trust:

29.4.1 the Board of Directors will prepare and approve:

29.4.1.1 a membership application form

29.4.1.2 a form of declaration required by section 36 (1) of the 2003 Act;

29.4.1.3 a form of declaration required by section 36 (2) of the 2003 Act; and

29.4.1.4 a form of declaration required by section 36 (3) of the 2003 Act;

29.4.1.5 a form confirming acceptance of a code of conduct for Governors;

29.4.2 the Chief Executive will consult and agree arrangements with the appointing organisations for the appointment of appointed Governors;

29.4.3 the Chief Executive will make a final decision about the class of the staff constituency of which an individual is entitled to be a member.

ANNEX 1

AREAS OF THE TRUST

1. READING

All the electoral wards in Reading Borough Council (unitary authority) area

2. WOKINGHAM

All the electoral wards in Wokingham District Council (unitary authority) area

3. WEST BERKSHIRE AND BORDERS

(a) all the electoral wards in West Berkshire District Council

(b) The following electoral wards from Basingstoke and Deane Borough Council area of north Hampshire

- Baughurst
- Burghclere
- Calleva
- East Woodhay
- Highclere and Bourne
- Kingsclere
- Pamber
- Tadley North
- Tadley South

(c) The following electoral ward from the Test Valley Borough Council area of north Hampshire

- Bourne Valley

4. EAST BERKSHIRE AND BORDERS

(a) All the electoral wards in Bracknell Forest Borough Council (unitary authority)

(b) All the electoral wards in Slough Borough Council (unitary authority)

(c) All the electoral wards in the Royal Borough of Windsor and Maidenhead (unitary authority)

(d) The following electoral wards from South Buckinghamshire District Council:

- Burnham Beaches
- Burnham Church
- Burnham Lent Rise
- Dorney and Burnham South
- Farnham Royal

- Iver Heath
- Iver Village and Rickings Park
- Stoke Pogis
- Taplow
- Wexham and Iver West

5. SOUTH OXFORDSHIRE

The following electoral wards from South Oxfordshire District Council:

- Chiltern Woods
- Cholsey and Wallingford South
- Crowmarsh
- Didcot All Saints
- Didcot Ladygrove
- Didcot Northbourne
- Didcot Park
- Goring
- Hagbourne
- Henley North
- Henley South
- Shiplake
- Sonning Common
- Wallingord North
- Woodcote

ANNEX 2

ELECTION RULES