AGENDA

PUBLIC TRUST BOARD MEETING
Wednesday 1st December 2010
9.30 am Room 1 Training & Development Centre, NGH

TIME	ITEM	TOPIC	PRESENTED BY	ENCLOSURE
9.30	1.	Apologies	Dr J Hickey	
	2.	Declarations of Interest	Dr J Hickey	
	3.	Draft minutes of meeting held on 4th October 2010	Dr J Hickey	**1**
	4.	Matters arising	Dr J Hickey	
9.40	5.	Chief Executive's Report	Mr P Forden	**2**
Clinical Quality & Safety				
9.55	6.	Infection Prevention Report	Ms S Hardy	**3**
10.05	7.	Quality Account Update	Dr S Swart	**4**
10.15	8.	Annual Research and Development Report	Dr S Swart	**5**
Operational Assurance				
10.25	9.	Performance report	Mrs C Allen	**6**
10.30	10.	Finance report	Mr J Drury	**7**
10.40	11.	HR Report	Ms C Wilkinson	**8**
Strategic Issues				
10.50	12.	Sustainability Action Plan	Mr C Abolins	**9**
10.55	13.	Any Other Business		
11.00	14.	**Date & time of next meeting** 9.30am Wednesday 23rd February 2011, Boardroom, NGH		
		CONFIDENTIAL ISSUES To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Dr J Hickey	

Minutes of the Public Trust Board Meeting held on
Monday 4th October 2010 at 9.30am
Boardroom, NGH

Present:	Dr J Hickey	Chairman
	Mr P Forden	Chief Executive
	Mr C Abolins	Director of Facilities & Capital Development
	Ms N Aggarwal-Singh	Non-Executive Director
	Mrs C Allen	Director of Operations
	Mr J Drury	Director of Finance
	Ms S Hardy	Director of Nursing, Patient Services & Midwifery
	Mr G Kershaw	Associate Non-executive Director
	Mr B Noble	Non-executive Director
	Mr C Pallot	Director of Planning & Performance
	Mr N Robertson	Non-executive Director
	Dr S Swart	Medical Director
	Ms C Wilkinson	Director of HR
	Mr P Zeidler	Non-executive Director
In attendance:	Ms S Rudd	Company Secretary
	Mrs S Watts	Head of Communications (Item only)
	Mr M Essery	Shadow Lead Governor
	Mr R Jones	Shadow Staff Governor
	Cllr C Long	Shadow Governor
	Mr A McPherson	Shadow Governor
	Ms M McVicar	Shadow Governor
	Ms D Atkinson	Deputy Director, Strategy & System Development, NHS East Midlands
	Ms D Cecchini	Special Projects Officer, Performance & Finance, NHS East Midlands
Apologies:	Mr C Astbury	Non-executive Director
	Mr D Savage	Shadow Governor

TB 10/11 19 Declarations of Interest

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

TB 10/11 20 Minutes of the meeting held on 30th June 2010

The minutes of the previous meeting were approved as a true record.

TB 10/11 21 Matters Arising

Dr Hickey enquired about the work relating to demand management that is being undertaken in conjunction with the PCT, Kettering General Hospital NHS Foundation Trust (KGH), Community Services and Nene Commissioning. Mr Forden noted that a further joint meeting will be taking place towards the end of October. Dr Swart noted that Nene Commissioning are taking a proactive stance, including the Community Geriatrician project in conjunction with our clinicians

within A&E and a support team in the Community. The proposal is that the urgent care commissioning focus will increase and report into the QIPP board.

Mr Forden reported that there is a proposal from Nene Commissioning to review the structure of the QIPP board, to include a clinical challenge advisory group, which is a change to the current framework. Mr Robertson asked if the PCT are sufficiently aware that the Trust does not require more volume. Dr Hickey noted that the Trust has reiterated this point.

The Board requested that it receive a Learning Disabilities update in six months.

Action: Ms Rudd to include in Board cycle of business

TB 10/11 22 Chief Executive's Report

Mr Forden noted that the Trust is currently undergoing a public consultation on its Foundation Trust application. A programme of engagement is taking place and the outcome will be reported to the Trust Board in December 2010, following the closure of the consultation on 12 November 2010.

The Trust held its Open Day and AGM in September and extremely positive comments were received. Mr Forden noted his thanks to all staff for an excellent day.

There has been media coverage in Daventry regarding the PCT's plans to divest itself of its community services provider arm and it is proposed that we manage the community beds in Daventry as well as run the minor injuries unit (MIAMI). The request is being considered however a due diligence exercise will be undertaken prior to submitting firm recommendations to the Board. In the meantime however discussions will be held with appropriate staff to reassure them that there are no plans to close the unit, although we would seek to streamline the discharge processes.

Dr Hickey enquired about the remainder of the community beds. Mr Forden noted that these would be managed by KGH and that we would seek to ensure that there is a service level agreement in place for the beds that we currently access.

Mrs Aggarwal-Singh enquired as to the timescale. Mr Pallot responded that a business case is currently being written by the PCT and that transfer would be anticipated 1 April 2011. Dr Swart noted that the location of rehabilitation beds for our Stroke service is key. Mr Drury noted that the PCT have commissioned a due diligence report for their provider arm which should be completed by end of October. We will then utilise that report as a base for our due diligence process.

Mr Robertson enquired as to the extent of control the Trust would have over Danetre. Mr Drury replied that the PCT will retain the land and buildings under PFI schemes.

Mr Essery noted that recent press coverage has reported the position erroneously, and that communication with the staff should take place as soon as possible. Mr Pallot agreed and a meeting is being convened with the Friends of Danetre to discuss our current plans for the site.

Mr Forden noted that we continue to deliver against all of the national targets whilst remaining in budget.

In other news it was reported that NGH has been chosen as a pilot site to develop,

test and evaluate an improvement programme focusing on therapy services.

NGH history is on display along North Street and covers the hospital's history from founding to present day. The next project is 'Faces of NGH' where staff volunteers will have their picture taken in the workplace to 'bring the hospital to life' for our visitors.

Visitors to the hospital in July and August were invited to taste the hospital food. The event was covered by BBC Radio Northampton with sample dishes being delivered directly to them. Mr Abolins commented that the media coverage had been very positive and there had been good patient feedback. Mr Noble noted that patient food was highlighted on the patient survey and Mr Abolins replied that a significant amount of work was carried out over spring and summer in this area and would expect the results of the next survey to reflect that.

It was noted that a joint meeting of the Board and Shadow Council of Governors is taking place in December and the meeting will be served with hospital food.

The Board **noted** the report.

TB 10/11 23 Infection Prevention Report

Ms Hardy presented her report, which covers two months. In August there was 1 post 48 hour MRSA, which gives us a year to date total of 2 bacteraemias against the Trust ceiling of 6. A ratio of 0.23 per 10,000 bed days.

A full root cause analysis will be carried out and the learnings will be presented at Hospital Management Group.

Dr Hickey enquired about the differences in testing methods across Trusts and asked if we use a more sensitive test. Ms Hardy replied that we do and that there is a Group reviewing this which will report on a standard test that should be used across all Trusts.

Hand hygiene compliance by visitors is audited on a quarterly basis and the infection prevention team will be working with the Communication Team to raise public visitor awareness of good infection prevention practices.

Mrs Allen asked if we understand why visitors have low compliance rates and Mr Noble asked if the signage within the Trust was adequate. Ms Hardy replied that public awareness of the importance needs to be raised. Ms Hardy feels that the signage is as good at NGH as in other Trusts. Ms McVicar noted that the signage within the hospital has vastly improved.

It was suggested that an article on the subject be placed in the Members newsletter and Ms Rudd agreed to action.

Ms Hardy noted that a local survey indicated that infection in hospital is a major concern and Mr McPherson suggested that this topic could be discussed by the PPI focus groups.

Dr Hickey enquired if there were any issues relating to Compton Ward has they had experienced 1 post 48 hour colonisation in July and 2 in August.

Ms Hardy responded that the root cause analysis carried out revealed no linkage between the two events.

Action: Ms Rudd to ensure article on hand hygiene is included in Members newsletter.

The Board **noted** the report.

TB 10/11 24 Patient Experience Update

Ms Hardy presented her report providing an overview of ongoing actions following the results from the National Inpatient Survey 2009, patient experience tracker results, discharged patients survey and the Trust's Quality Account priority.

The Trust rewards good performance of patient experience tracker results with certificate presentations on the Wards with Mr Forden and Ms Hardy. The average score for all questions is now 93% and, for the two questions used as a barometer for the Trust (would you recommend NGH and would you be willing to return) currently stands at 97% over a 3 month period surveying 4903 patients. The Trust is now awaiting results from the latest patient survey.

Mr Noble asked if we felt that we will we see these better responses reflected in the survey. Ms Hardy noted that the concern is that the patients from August are only now being asked to comment, and at that time we had some adverse publicity which may have an effect.

Mr Forden noted that in the future the intention is that up to 10% of our income will be based on patient satisfaction scores. Difficulties arise with the small sample size used and the delay in asking for their opinion. We have attempted to triangulate our results by having real time PET and Fabio results and also follow up of a sample of discharged patients received telephone calls.

Ms McVicar noted that she has been assisting with the telephone survey of patients and has received very positive responses.

Mr Kershaw noted that issue of staff shortages arose at the AGM and in the survey results. Ms Hardy replied that papers have recently been submitted to Board on this issue and that a decision has been made to commence international recruitment. There are approximately 70 nursing vacancies and it is hoped recruitment will start this month.

The Board **noted** the report.

TB 10/11 25 Safety: What the Board needs to know

Dr Swart presented Safety: What the Board needs to know. Safety is a component of Quality, and the Board needs to understand the importance of harm both for clinical outcome and cost. The Board also needs to understand the patient safety system in the UK, what has been shown to work well to improve safety, and the governance systems in place.

Dr Swart discussed the safety projects in place, the aim and vision of the patient safety strategy and the objectives to be delivered by the programme for Safety. A Patient Safety Project Board is to be developed to take the place of the Patient Safety Strategy Group to drive innovation and improvement. Safety champions will take forward issues at ward level with involvement of directorate teams.

Mr Zeidler commented that it was evident that we have a good focus on safety and enquired if we have sufficient peer review from other Trusts. Dr Swart noted that all those involved in safety projects ensure that they gather as much information as

possible from other Trusts, the regional safety group also shares information.

Mrs Allen asked what was expected from Directorate Managers to support the processes. Dr Swart responded that their help is required in developing directorate scorecards, which takes information provision a step further.

Dr Hickey noted his concern about the number of projects underway, and if there are processes in place to identify the rogue practitioner early.

Dr Swart responded that information through Dr Foster analysis is to Consultant level. Within the Trust we also have reflection processes on serious incidents and complaints, ensuring triangulation. Mr Forden noted that there are also informal mechanisms so that people are able to discuss concerns.

Dr Swart commented that once work on projects is underway they then need to become part of business as usual.

The Board thanked Dr Swart for her presentation.

TB 10/11 26 Performance Report

Mrs Allen presented her report noting that the year to date position for A&E performance is 97%.

The Trust did not achieve the 62 day cancer standard from screening, achieving 86% against the standard of 90%. The year to date position is 95.6%.

With regard to reperfusion thromobolysis the Trust achieved 67% against the standards of 68%, with year to date position of 88%.

The Board **noted** the report.

TB 10/11 27 Finance Report

Mr Drury presented his report noting that performance against plan is a position for August of 16k surplus against planned FIMS surplus of £799k, an adverse variance of £783k against plan. The revised forecast prepared in August was for a deficit of £71k at the end of month 5.

SLA Income continues ahead of plan, primarily due to non-elective activity. The emergency rate tariff has not yet been triggered due to case mix. There is a continuing risk payment will not be received for over performance and the Trust needs to ensure that income projections are affordable to the PCT. Proposed financial recovery measures implemented by the PCT will mitigate this risk. It was noted that payment has been received from the PCT to month 4.

Pay costs increased in August month on month primarily due to a backlog of agency invoices relating to prior months. Increased controls over vacancies and the use of agency staff remain in place. Medical locum costs rose in August with additional hours linked to Junior doctors to maintain European Working Time Directive compliance. There is potential to recruit 5 to 6 substantive junior doctors, against a vacancy of 10 on-call rotas. Victoria Ward was closed in July, utilising substantive staff across the Trust to reduce the need for temporary staffing.

There was a reduction of £324k in non pay expenditure between July and August notably within clinical supplies, prosthesis and laboratory consumables. Pathology has a financial recovery plan in place to drive down consumable costs and remains

a focus. Medicine is over spent due to the over performance seen.

It was noted there are costs related to the Transformation Programme, with the associated benefits not yet being seen. The most recent independent business review has been held with Cardiology.

Cost improvement programme delivery remains a risk. A forecast outturn was undertaken during July/August, action plans are much more robust and the run rate of delivery is expected to increase.

The cashflow position is improving month on month and improved in August, mainly due to the agreement and settlement of 09-10 year end outturn SLA position with the PCT. There is a continued improvement in the level of better payment practice compliance which now stands at 58% by volume and 53% by value.

Dr Hickey asked Mr Drury what he considers to be the top three financial risks in order. Mr Drury highlighted the following:

i) continued locum and agency expenditure, and the ability to recruit substantively would impact this financial year.
ii) Payment under the emergency rate tariff due to over performance
iii) the delivery of the Trust cost improvement programme

Dr Hickey asked about the situation if the PCT were unable to pay for the increased activity. Mr Drury noted that payment has been received to month 4, the PCT are forecasting to end of year and we are engaging with them on demand management schemes.

Mr Forden noted that the PCT have agreed a payment into the proposed Community Geriatrician programme which should help to reduce the demand on the Trust.

Mrs Aggarwal-Singh asked when payment is anticipated and Mr Drury noted that there is agreement of payment of 85% of invoice within 5 weeks of the end of the month.

Mrs Allen noted the increased cash balance in August. Mr Drury replied that the balance was due to the timing of receipt of cash and the subsequent payment run.

Mr Noble commented that we struggle to recruit to establishment. Mr Forden responded that we need to ensure that we continue to control vacancies but that does not apply to ward nurse staffing. We experience a 10% turnover of staff in this area which minimises the risk of over recruitment. The Trust is currently considering creating an internal pool of staff to use more flexibly in the Trust.

Mr Noble asked if we utilise bank and agency more than other Trusts. Mr Forden noted that our usage is comparable locally although it is still considered to be too high. Mr Drury noted that the procurement hub is reviewing bank and agency rates and there is a comparison table that he can make available.

Dr Swart noted that recruitment of junior doctors is complex and must be carried out in conjunction with the Deanery. Dr Hickey enquired about the possibility of an internal pool in conjunction with KGH. Dr Swart noted that this option was being explored.

Ms Hardy noted that in relation to recruitment of nurses there seems to be a county

wide problem, for example Nottingham has a surplus of nurses. Overseas recruitment is expensive however it is the best option at the present time.

Dr Hickey asked Mr Drury about confidence of achieving the forecast year end position. Mr Drury responded that it is still achievable and the Trust is on track to deliver. The main concern is the emergency rate tariff and demand management of the system.

The Board **noted** the report.

TB 10/11 28 HR Report

Ms Wilkinson presented her report detailing the HR casework and workforce trends.

Mrs Allen commented on the sickness absence benchmarking and the good performance of University Hospitals of Leicester NHS Trust (UHL). Ms Wilkinson agreed and noted that UHL have a number of initiatives in place including e-rostering and external assistance. NGH is taking a number of steps to manage sickness absence which includes the revision of the sickness absence policy and the introduction of e-rostering.

E-rostering is being introduced from 1st November into 5 ward areas, HR and Finance, to provide real time information on how rosters are being filled. Mr Kershaw noted that e-rostering has a proven impact and would like to see the rate of implementation increased. Mr Drury noted that introduction in these areas initially would allow testing.

Mr Noble commented on the real costs of sickness absence, including agency costs and the effect on staff morale, there is a real incentive to address this area. Ms Wilkinson noted that there is increased focus in the Trust, return to work interviews are carried out, HR business partners in each directorate are closely involved in the process and the sickness absence policy has been revised and is being launched this week. The policy is invoked following 10 days sickness absence in a 12 month period. Mr Forden commented that a balanced approach will be taken as we do not expect nurses that are ill to be nursing patients. He also noted that achievement of the target of 3.5% would place us in the top Trusts in the country.

Dr Hickey asked if we are focusing on areas that particular issues. Ms Wilkinson responded that the HR Business partners are allied to directorates and they are therefore able to identify and monitor individuals. She reiterated that the policy is not to be implemented in a punitive way.

The Board **noted** the report.

TB 10/11 29 Communications Strategy Update

Mrs S Watts, Head of Communications, attended the meeting to present her report updating the communications activity against the communications strategy that was approved by the Board in June 2009. There has been steady and sustained progress against the themes of engaging with the workforce and promoting the NGH brand and managing reputation.

There is still work needed against the third key theme of building communications capability and capacity. It is a small communications team therefore the focus is to educate staff to communicate more effectively with their teams. A series of

workshops is planned for directorate managers, assistant directorate managers, matrons, senior head nurses and heads of departments. These workshops will aim to reinforce the Trust objectives with particular emphasis around transformation programme and the challenges faced going forward.

More than 20 members of staff have been trained as web coordinators, and the most visited area of our internet site is about our services. Work is now underway on redevelopment of the Trust intranet, and the communications team are working staff to discuss requirements and to ensure robust testing.

Close links have been developed with external media and we respond quickly to adverse publicity. A GP liaison has now been identified and the communications team are working to identify the most effective way of engaging with local GPs.

The focus going forward is to make the best use of resources and to incorporate the use of social media as a timely, effective and efficient way of communicating with the wider and local community.

Mr Zeidler noted that the Communications Strategy was presented to the Board in June and felt that he was not able to align this update with the strategy that was presented. There has been a lot of work undertaken that is not reflected in the update and there are also items that have not been addressed. He asked if the Board could assist in achieving all the actions outlined in the strategy. Mrs Watts replied that the update was intended to be strategic and that she would circulate a detailed action plan against the strategy in order to provide assurance. Mr Zeidler also requested an update of the GP liaison work being undertaken

Mr Noble asked about staff that do not have access to a computer. Mrs Watts replied that managers are encouraged to talk to their teams, and to print off and display communications. Mr Noble also asked if we feel that we sell our services. Mr Forden noted that it is a balance as direct marketing would not be a good use of our resources, however we do undertake engagement events such as evening public meetings.

Mr Essery noted that we receive coverage in the Chronicle and Echo, but asked about regional newspapers. Mrs Watts replied that we circulate our releases to all the local media.

Dr Hickey and Mr Forden commented that we should meet with local editors to discuss our initiatives in their areas. Cllr Long agreed as it is beneficial to discuss some items to ensure they are accurately reflected.

Action: Mrs Watts to circulate action list against June 2009 strategy.

The Board **noted** the content of the report.

TB 10/11 30 Haematology Development Update

Mr Abolins provided an update to the Haematology development and noted that MacMillan have given their approval as there is a high level of confidence that their target will be achieved.

The timescale is early November for receipt of tenders, 26th November discussion at Macmillan Board. Start on site is anticipated in early January, with commissioning around November.

Dr Hickey asked if there were any particular financial issues for us. Mr Abolins

replied that there were none at this time and that there are contingencies built in to the process. Mr Drury noted that the financial risk is that we fund the design costs etc. Invoices are raised to Macmillan immediately and they are always paid promptly.

The Board **noted** the report.

TB 10/11 31 **Any Other Business**
There being no further business the meeting was declared closed.

TB 10/11 32 **Date and Time of Next Meeting**

Wednesday, 1st December 2010, Room 5 Training and Development Centre

Actions arising

TB 10/11 21	Commentary on action plan timeline achievement in next Learning Disabilities update to the Board	SH	May 2011
TB 10/11 23	Hand Hygiene visitors compliance article in Members newsletter	SR	Next edition
TB 10/11 29	Mrs Watts to circulate action list against June 2009 strategy.	SW	asap

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title	Chief Executive's Report
Submitted by	Paul Forden – Chief Executive
Date of meeting	1st December 2010
Corporate Objectives Addressed	
SUMMARY OF CRITICAL POINTS	
PATIENT IMPACT	
STAFF IMPACT	
FINANCIAL IMPACT	
EQUALITY AND DIVERSITY IMPACT	
LEGAL IMPLICATIONS	
RISK ASSESSMENT	
RECOMMENDATION The Board is asked to note the report. The Board is asked to approve the proposal that the minimum age for membership of the Trust remain at 16 years old.	

Summary

We have now concluded our consultation as to whether we should apply to become an NHS Foundation Trust or not. We received more responses this time than we did during our original consultation 4 years ago. In total we received 299 responses.

The overwhelming view was that of support for our application. I have attached as Appendix 1 a summary of the responses against each of our 8 questions highlighting those in favour and those against our proposals. The only area where there was not a majority in favour of a proposal was in response to the question "Do you agree with the proposed lower age limit of 14 for membership?" in which 169 responses disagreed with the proposal and only 126 were in favour. I would therefore propose that we agree not to reduce the lower age limit to 14 for membership and maintain it at the current minimum age limit of 16.

As discussed at our last Public Trust Board meeting, we have been asked by Northamptonshire PCT to consider taking over management responsibilities for both Community beds in Daventry and the minor injuries unit in Northampton known as MIAMI. We have over recent weeks been undertaking a due diligence review of these services. In the meantime Chris Pallot and myself have met the staff at Daventry in order to open a dialogue as to how we can work together to improve patient care further.

Other News

NGH scoops national award for same sex accommodation
NGH has scooped a national award for its response to providing same sex accommodation at the hospital. Following an extremely rigorous judging process undertaken by some of the most experienced and influential people within the industry, staff from the estates and facilities team were presented with the award by Dairmuid Gavin at the Building Better Healthcare Awards on 11th November.

New en-suite toilet and shower pods were constructed outside existing hospital buildings and were directly linked to existing bed bays. By using this novel solution the hospital lost no beds to provide extra bathrooms, and in some cases two-storey pods were constructed for multi-storey ward blocks.

By working to a tight timescale, and within strict financial restraints, work was carried out whilst wards were closed for planned maintenance and deep cleaning. The project provided much wider benefits than the original privacy and dignity brief. Accessibility to toilet and shower facilities has been improved so that the maximum distance from a bed to a toilet/shower is no more than 7m, compared to 32m before. A key benefit is that patients no longer have to pass bays of patients of the opposite sex, and the shorter distance has helped promote patient independence.

NGH staff have huge impact on Ghana hospital
Another successful visit has been made by NGH staff and other local people to Nandom Hospital in northern Ghana, which is twinned with NGH. Built more than forty years ago the hospital, which serves a population of up to one million people, has had barely no investments, few repairs and has just three doctors to tend to 171 beds.

FREED UK, a Northampton charity set up by NGH maxillofacial surgeon Dery Tuopar, who grew up in Ghana, has already trained 12 nurses and shipped over equipment in an attempt to raise standards. Clinical nurse specialist Anne Hicks has been a member of the charity

since its inception, and has seen it develop from beyond a focus on dental services to helping the wider community in Nandom, with the help of volunteers from varying professional backgrounds.

A major project has been the building of a kitchen on site, as many children and adults die following successful operations due to starvation or malnutrition. During their recent trip, FREED UK officially opened the kitchen and invited local dignitaries to the commissioning ceremony.

As well as the hospital itself, other group members are overseeing a series of projects all funded by UK donations, working on dental services, a laboratory, the local school, orphanage and library.

Disney sister Joy is commended

Disney senior ward sister Joy Margetts has been commended by the University of Oxford for recruiting more families to a research study than any other participating hospital.

Jane Lambie is the lead research nurse for the Genetics of Otitis Media Study, which is looking into why what is sometimes referred to as 'glue ear' is often passed down through generations. She said: "We're asking 1,000 families to help us find out why this is. After setting up the study in Northampton, we applied to the local research network to fund a local nurse to recruit families on Disney children’s ward. Joy took a particular interest in the research and has proved to be a great success.

"Through her skills and dedication, she has recruited 107 families (414 people) which is the highest individual number out of all 16 hospitals participating. We are now more than half way to our overall target, with many thanks to Joy, who is now handing the baton over to the dedicated research nurse team in the hospital, who have a hard act to follow!

Keyhole ops available in HD

New high-tech operating equipment, including high-definition cameras, are being used in keyhole surgery techniques at NGH. Over the last six months the hospital has invested in state-of-the-art laparascopic equipment, replacing all the older theatre equipment. This has included the purchase of high definition cameras, as well as new retractors and scalpels.

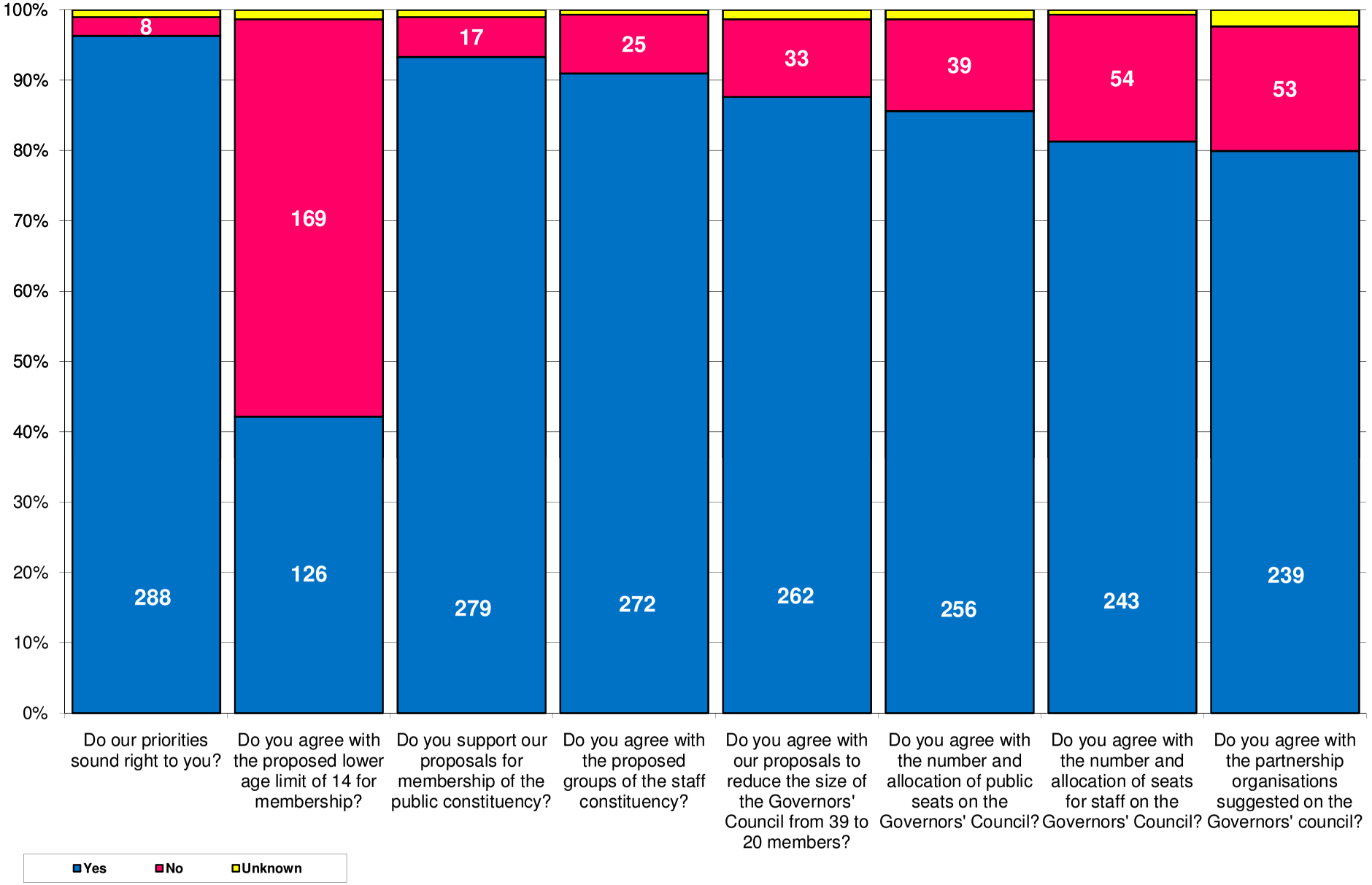
In addition, three new laparascopic specialist surgeons have been appointed in the last 12 months to develop keyhole surgery at NGH. These posts have been instrumental to the development of the laparascopic service at the hospital, and key to delivery of new training which has attracted surgical trainees from elsewhere.

Consultation date: 23/8/10 to 12/11/10
Total number of responses = 299

Response to the Public Consultation on our application to become a Foundation Trust

Northampton General Hospital NHS
NHS Trust

Appendix 1



Ser	Monitor Scorecard Indicators (Apr 2010)	Thresholds	Monitoring Period	Weighting	Apr	May	Jun	Jly	Aug	Sep	Oct
Mon01	Clostridium difficile year on year reduction	Trajectory (98 Full Year)	Quarterly	1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mon02	MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level	Trajectory (6 Full Year)	Quarterly	1	1.0	0.0	0.0	0.0	1.0	0.0	0.0
Mon03	Maximum waiting time of 31 days for subsequent treatments for all cancers	Surgery – 94% Drug – 98% Radiotherapy – 94%	Quarterly	1	0.0	0.3	0.0	0.0	0.0	0.0	0.0
Mon04	Maximum two month wait from referral to treatment for all cancers	85%	Quarterly	1	0.0	1.0	0.0	0.0	1.0	0.0	1.0
Mon05	For admitted patients, maximum time of 18 weeks from point of referral to treatment	90%	Quarterly	1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mon06	For non-admitted patients, maximum time of 18 weeks from point of referral to treatment	95%	Quarterly	1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mon07	Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98%	Quarterly	1	1.0	0.0	1.0	0.0	0.0	0.0	0.0
Mon08	People suffering heart attack to receive thrombolytic within 60 minutes of call (where this is the preferred local treatment for heart attack)	68%	Quarterly	1	0.0	0.0	0.0	0.0	1.0	0.0	0.0
Mon09	Maximum waiting time of two weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	93%	Quarterly	1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mon10	Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96%	Quarterly	1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mon11	Screening all elective in-patients for MRSA	100%	Quarterly	1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mon12	Each national core standard	0	Ad-hoc	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
					2.0	**1.3**	**1.0**	**0.0**	**3.0**	**0.0**	**1.0**

Ser	Performance Indicators	Target	Monitoring Period		Apr	May	Jun	Jly	Aug	Sep	Oct
PI01	Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission	9%	Monthly		7.90%	7.52%	6.33%	7.34%	6.43%	5.34%	6.07%
PI02	18 weeks RTT - admitted	90%	Monthly		94.89%	96.25%	97.76%	97.16%	97.84%	97.52%	97.37%
PI03	Elective Activity Total		Monthly		4,231	3,899	4,411	4,188	3,625	4,251	3,993
PI04	Non-Electivity Activity Total		Monthly		3,066	3,346	3,290	3,334	3,232	3,382	3,568
PI05	GP referrals - % variance against capacity plan	0%	Monthly		8.73%	6.59%	10.20%	11.31%	9.49%	10.32%	9.66%
PI06	Sickness Absence	5%	Monthly		4.85%	4.79%	4.74%	3.81%	4.55%		

Ser	Corporate Clinical Measures & Patient Safety	Target	Monitoring Period		Apr	May	Jun	Jly	Aug	Sep	Oct
C&PS 01	HSMR - Elective	<100	Quarterly		91.9%	98.8%	102.4%				
C&PS 02	HSMR - Non-Elective	<100	Quarterly		127.5%	108.0%	90.5%				
C&PS 03	MRSA Cases per 10,000 pop, using average bed base of 575	0.29%	Monthly		0.58%	0.29%	0.19%	0.14%	0.23%	0.19%	0.16%
C&PS 04	CDIFF Cases per 1,000 pop, using average bed base of 575	0.46%	Monthly		0.41%	0.37%	0.34%	0.30%	0.24%	0.24%	0.24%
C&PS 05	Serious Untowards Incidents		Quarterly		1	1	2	5	2	1	4

Ser	Patient Experience Measures	Target	Monitoring Period		Apr	May	Jun	Jly	Aug	Sep	Oct
PE 01	Length of Stay Elective	3.1	Monthly		3.23	3.32	3.52	3.51	3.52	3.53	3.59
PE 02	Length of Stay Non-elective	4.6	Monthly		4.65	4.69	4.73	4.77	4.74	4.79	4.83
PE 03	Readmission Rates	6%	Quarterly		4.6%	5.2%	5.1%	5.2%	5.8%		
PE 12	Would you be willing to be treated in this hospital again?	95%	Monthly		96.9%	96.5%	98.0%	97.3%	97.7%	97.7%	
PE 13	Delivering Same Sex Accomodation	0	Monthly		3	0	2	0	2	0	0

BOARD SUMMARY SHEET	
Title	Monthly Infection Prevention Performance Report
Submitted by	Sue Hardy
Prepared by	Fiona Barnes
Date of meeting	1st December 2010
Corporate Objectives Addressed	To develop and embed measures for quality and clinical outcomes to achieve the highest standards

SUMMARY OF CRITICAL POINTS
Monthly update on reportable HCAIs

PATIENT IMPACT
High – review of incidents and trend analysis of HCAIs is paramount to improving patient safety and quality of care.

STAFF IMPACT
High – review of incidents and trend analysis of HCAIs is paramount to improving patient safety and quality of care and also impacts on staff safety and wellbeing.

FINANCIAL IMPACT
Will be identified as required

EQUALITY AND DIVERSITY IMPACT
Applicable to all

LEGAL IMPLICATIONS
The Board has a statutory obligation to ensure appropriate infection prevention and control mechanisms are in place.

RISK ASSESSMENT
Failure to review infection prevention and control would be considered to be high risk.

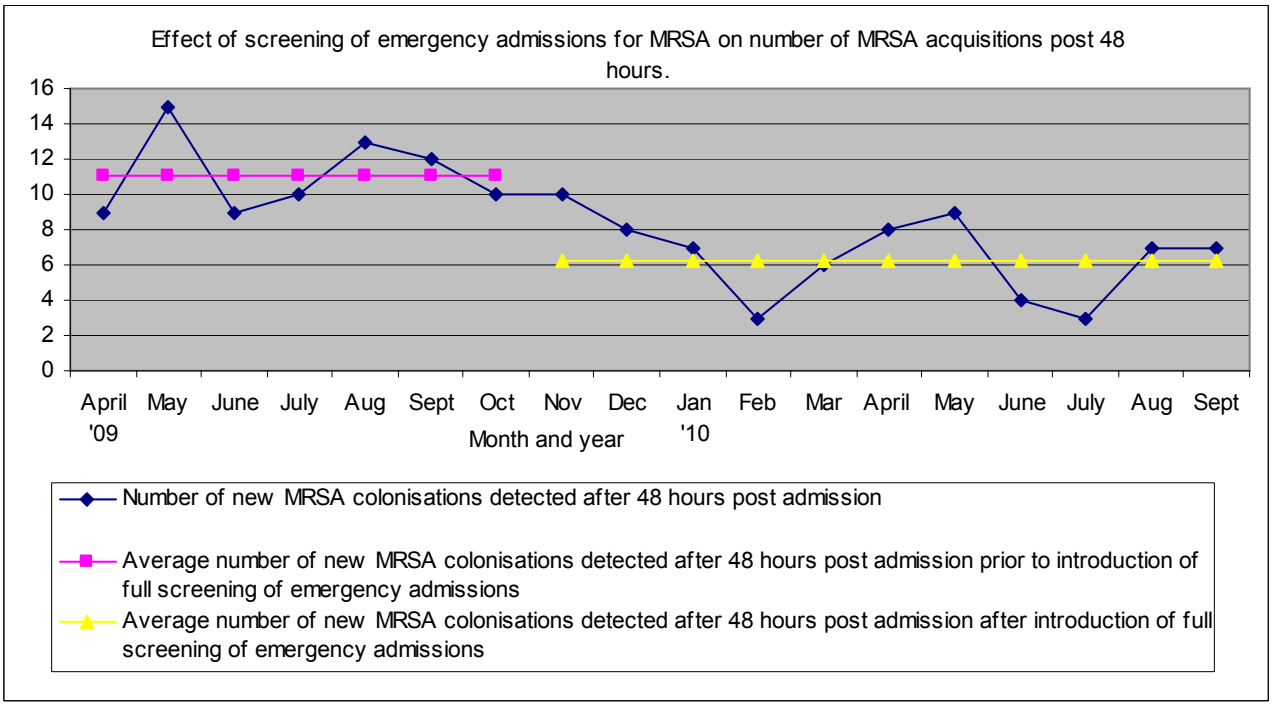
RECOMMENDATION
The Board is asked to consider the content of this report.

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

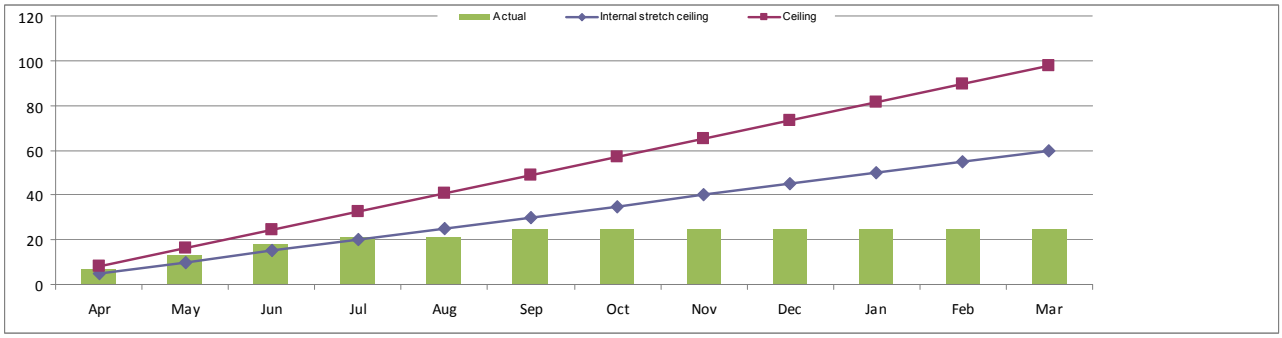
MRSA Bacteraemia (Appendix 1)
The Trust is measured on the number of MRSA bacteraemias cases per 10,000 bed days based on a bed base of 575. The Trusts ceiling for MRSA bacteraemias is 6 cases. In October there were no >48hrs MRSA bacteraemias. Our year to date number of >48hrs MRSA bacteraemias is 2 which is currently 0.16 / 10,000 bed days.

MRSA Colonisation (Appendix 2)
During October there were 17<48hrs and 3>48hrs cases of MRSA colonisation. No ward was placed on 'Special Measures' this month.

Internal patient verified data identifies 99.1% compliance for the screening of elective admissions during October. The compliance rate for emergency screening was 94.7%. Operational teams continue to work to reach 100% but this has to be risk assessed against the matched census approach, where we achieved 122% for elective screening. However the screening programme is clearly having an effect on the number of colonisations we are now seeing. The following graph demonstrates a 'step-change' reduction in the number of MRSA colonisations following the introduction of the screening of emergency admissions.

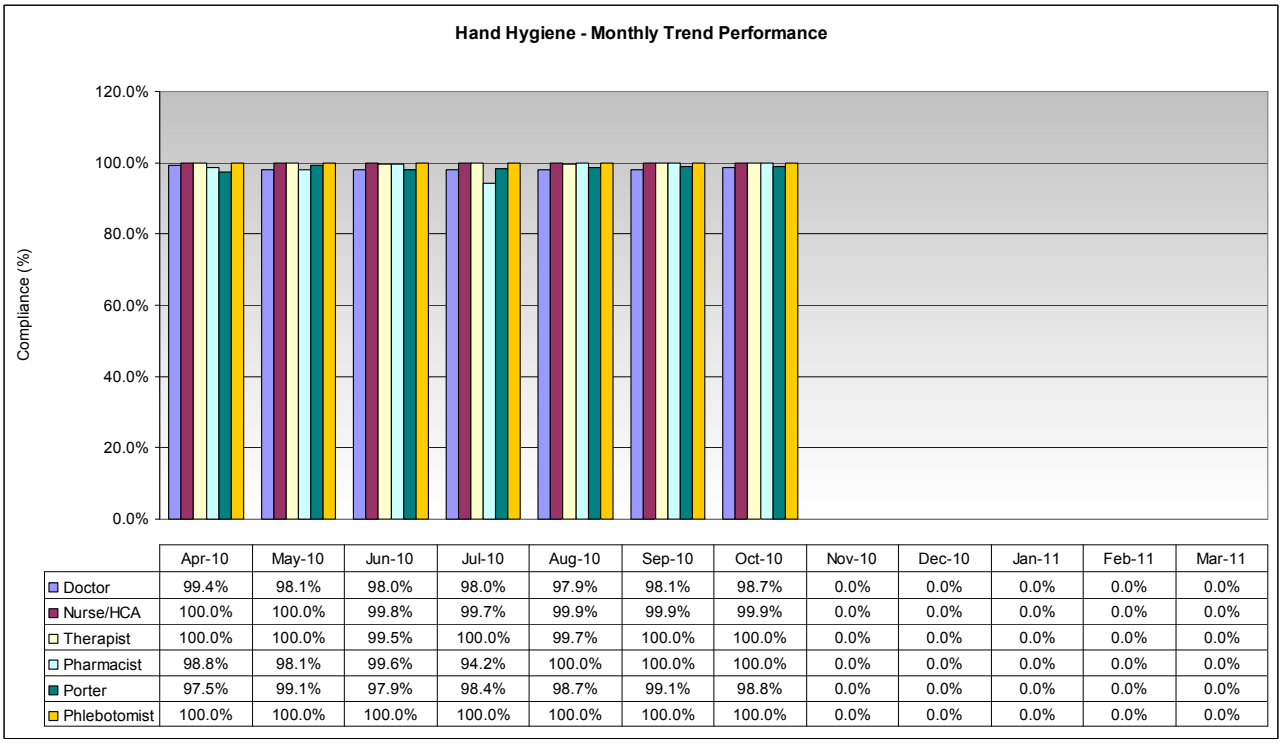


Clostridium Difficile (C Diff) (Appendix 3)
The Trust has a ceiling target of 95 C. Diff. cases with an internal stretch ceiling of 60 cases. During October the Trust identified 1 < 3 day and 4 > 3 day cases of C. Diff., which equates to a cumulative of 0.24 /1,000 bed days.



Hand Hygiene Audit

Information from the Hand Hygiene Observational Tool (HHOT) shows that in October the data return was 100% giving an overall compliance to hand hygiene of 99.5% which is the best performance to date.



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Doctor	99.4%	98.1%	98.0%	98.0%	97.9%	98.1%	98.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Nurse/HCA	100.0%	100.0%	99.8%	99.7%	99.9%	99.9%	99.9%	0.0%	0.0%	0.0%	0.0%	0.0%
Therapist	100.0%	100.0%	99.5%	100.0%	99.7%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Pharmacist	98.8%	98.1%	99.6%	94.2%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Porter	97.5%	99.1%	97.9%	98.4%	98.7%	99.1%	98.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Phlebotomist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Recommendation

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

Sue Hardy
Director of Nursing, Midwifery & Patient Services
DIPC

Appendix 1
MRSA Bacteraemia Incidence by Ward

MRSA Bact	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		
Ward	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	Trust Total 2010-11
Hawthorn																									0
Willow		1																							1
Collingtree 23hr																									0
ITU																									0
HDU																									0
A & E																									0
Abington																									0
Cedar										1															1
Becket																									0
SingleHurst																									0
Knightley																									0
Gossett																									0
Disney																									0
Paddington																									0
Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer																									0
Sturtridge																									0
Allebone																									0
Benham																									0
Creaton	1																								1
Dryden																									0
EAU																									0
Eleanor																									0
Victoria																									0
Rowan																									0
Finedan																									0
Compton																									0
Brampton																									0
Holcot																									0
Althorp																									0
Talbot Butler			1																						1
Trust Total 2010-11	1	1	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4

Appendix 2

MRSA Colonisation Incidence by Ward

MRSA ISOLATES	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Trust Total 2010-11
Ward	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	<48	>48	
Hawthorn					1							4													5
Willow		1								2			2												5
Collingtree				1					1		2														4
ITU	1	1					1																		3
HDU					1																				1
A & E							1						1												2
Abington																									0
Cedar				1						2	1	1	1												6
Becket																									0
SingleHurst																									0
Knightley			1	2																					3
Gossett																									0
Disney	1						1																		2
Paddington									1																1
Balmoral																									0
Robert Watson																									0
Sandringham																									0
Spencer					1																				1
Sturtridge																									0
Allebone										1															1
Benham				1				1					1	1											4
Creaton				1	1		1					2													5
Dryden					1	1	2																		4
EAU	9		11		5		9		8		17		11												70
Eleanor				1										1											2
Victoria		2		1																					3
Rowan			2					1					1												4
Finedon																									0
Compton			1					1		2	1														5
Brampton		2																							2
Holcot		2		1	1	2								1											7
Althorp						1																			1
Talbot Butler																									0
Trust Total 2010-11	11	8	15	9	11	4	15	3	10	7	21	7	17	3											0

Appendix 3

Clostridium Difficile Incidence by Ward

CDT	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Trust
Ward	<3da	>3 d	<3da	>3 d	<3da	>3 da	<3da	>3 d	<3da	>3 d	<3da	>3 d	<3da	>3 d	<3da	>3 d	<3da	>3 d	<3da	>3 d	<3da	>3 d	<3da	>3 d	Total
Hawthorn												1													1
Willow																									0
Collingtree												1		1											2
ITU																									0
HDU		1		1		1																			3
A & E																									0
Abington																									0
Cedar		2		1		1					1														5
Becket						1		1					1												3
SingleHurst																									0
Knightley																									0
Gossett																									0
Disney																									0
Paddington																									0
Balmoral																									0
Robert Watson					1																				1
Sandringham																									0
Spencer														1											1
Sturtridge																									0
Allebone		1										1													2
Benham				1		1																			2
Creaton		1		1		1					1			1											5
Dryden																									0
EAU	1	1	1		1				3		1														8
Eleanor																									0
Victoria																									0
Rowan		1					1																		2
Finedon							1																		1
Compton				2										1											3
Brampton												1													1
Holcot																									0
Althorp								1																	1
Talbot Butler								1																	1
Trust Total 2010-1	1	7	1	6	2	5	2	3	3	0	3	4	1	4	0	0	0	0	0	0	0	0	0	0	42

BOARD SUMMARY SHEET	
Title	Quality Account Update
Submitted by	Dr Sonia Swart Medical Director
Prepared by	Mrs Nina Fraser Deputy Director of Nursing/ Head of Governance
Date of meeting	1 December 2010
Corporate Objectives Addressed	Develop and embed measures for quality and clinical outcomes to achieve the highest standards

SUMMARY OF CRITICAL POINTS

- Progress has been made towards achieving the Quality Goals for 2009/10
- The Quality Goals have the ability to impact on the Trust's financial position as well as the Trust's reputation
- 2 CQUIN indicators that are linked to the Quality Goals may not be fully achieved

PATIENT IMPACT
Achieving high quality care for patients remains a priority and the quality accounts are available to patients on the NHS choices website as well as on our own Trust website

STAFF IMPACT
The Quality Account provides an opportunity for staff to understand the importance of the improvements identified and to engage in identifying further areas for improvement

FINANCIAL IMPACT
The ability to continually drive forward quality is increasingly important and will also affect our income

EQUALITY & DIVERSITY
This quality account may need to be made accessible for hard to reach groups

LEGAL IMPLICATIONS
The Quality Account is mandatory

RECOMMENDATIONS
Board Members are asked to note the content of this report and debate key issues

1. Background

In June 2010, the Board approved the Trust's first Quality Accounts for April 2009-April 2010. Subsequently, a Quality Strategy and Quality Memorandum has been approved and further work undertaken to develop and implement a Quality Impact Assessment Policy.

Within the Quality Accounts 4 Quality Goals were identified for 2010/11 to ensure that we move towards our goal of delivering the safest, most clinically effective acute services in the country focussed on the needs of the patient. These are:

1. Improving the experience for patients by focussing on essential care in every ward
2. Improving the effectiveness, safety and patient experience for Stroke Services
3. Improving the prevention of blood clots through implementation of best practice for risk assessment and prescription of clot preventing drugs according to National Institute for Health and Clinical Excellence (NICE) guidelines
4. Improving patient safety by reducing all infections including MRSA, Clostridium Difficile and Surgical Site Infections

Within each Quality Goal, where relevant a number of areas for improvement were also identified. A quarterly report is submitted to Board within the Patient Safety, Clinical Quality and Governance Progress Report and is scrutinised by the Healthcare Governance Committee. At the last Board meeting an update was provided on the process for development of the Quality Account for 2011/12 and a report on the process for monitoring progress against improvement priorities identified for 2010/11 and proposals for ensuring consultation were outlined.

2. Progress in Quarter 2

Appendix 1 provides Board members with the opportunity to review progress with implementing the 4 Quality Goals and areas for improvement over the first 2 quarters. In summary, the following progress has been made;

Priority 1
Improving the experience for all patients by focussing on essential care in every ward and department

- The Trust set a target of assessing 95% of patients for their possibility of falling and ensuring appropriate care plans are in place. During quarter 1 an increase had been made to 93% and whilst there was a small drop in performance in quarter 2, improvement from 2009/10 was maintained at 92%.
- The target for increasing the number of patients who are assessed for their nutritional needs to 95% was achieved for quarter 2
- Improvements were identified for decreasing the incidence of pressure ulcers, however, during quarters 1 and 2 the Trust has been working to increase reporting and therefore set a credible baseline. This is yet to be agreed.
- The pilot telephone survey of patients who were discharged from hospital has commenced and will be reported in quarter 3.

Priority 2
Improving the effectiveness, safety and patient experience for the Trust's Stroke Services

- Patients who spent more that 90% of their time in hospital on a Stroke Unit was 51% against the target of 60%
- Deaths from stroke was 25% against the Trust target of 28%
- 98% of patients received a brain scan within 24 hours of admission against the Trust target of 75%
- 22% of appropriate patients received all 9 indicators measured in the Sentinel Stroke Audit against the Trust target of 29%

Priority 3
Improve the prevention of blood clots through implementation of best practice for risk assessment and prescription of clot preventing drugs according to NICE guidance

- 63% of patients admitted to hospital had a documented risk assessment to determine the risk of developing a thrombosis against the Trust target of 90% by year end

Priority 4
Reducing all infections including MRSA, C Difficile and Surgical Site infections

- 2 patients developed MRSA year to date against a Trust ceiling of 6 cases throughout the year
- 25 patients developed Clostridium Difficile year to date against the Trust's ceiling target of 98 cases with an internal stretch target of 60 cases.

3. Implications for 2010/11

There are links between achieving the Trust's Quality Goals and the current CQUIN indicators. However, equally important is the impact on the reputation of the Trust.

The following indicators are at risk:

Indicators at risk of non-achievement:	**Total Value of Indicator:**	**Payment based on YTD**
Indicator 1: VTE (achieving 75% of target YTD)	£298,000	£223,500
Indicator 16: Stroke (potential for 20% penalty)	£175,000	£140,000
Total Values of those indicators at risk:	£473,000	£363,500

4. Recommendations

The Board is asked to review the progress towards achieving the Quality Goals and support the ongoing reporting against the quality priorities through directorate performance reviews, the clinical quality and effectiveness group (CQEG), the Trust Clinical Scorecards and the Integrated Healthcare Governance Group (IHGC).
Identification of quality priorities should continue during the year in order to inform key priorities for 2011/12 and the link with priorities identified in the CQUIN payment framework is likely to continue in view of the fact that CQUIN payments should be linked to key issues for both the local and national HealthCare Community.

Northampton General Hospital NHS
NHS Trust

BOARD SUMMARY SHEET	
Title	Annual Research and Development Report
Submitted by	Dr Sonia Swart Medical Director
Prepared by	Mrs Julie Wilson Research and Development Manager
Date of meeting	December 1 2010
Corporate Objectives Addressed	Develop and embed measures for quality and clinical outcomes to achieve the highest standards

SUMMARY OF CRITICAL POINTS

- The Research and Development Department has successfully bid for increased funding to increase the number of research studies across the Trust
- A new structure to support he nursing staff involved in research is currently under discussion
- There is a need to formalise the reporting and accountability structures for the Research and Development Department to ensure best use of this important resource

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

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

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

EQUALITY & DIVERSITY
Not assessed

LEGAL IMPLICATIONS
Governance arrangements for research trials are scrutinised carefully

RECOMMENDATIONS
Board Members are asked to note the content of this report and debate key issues

Research and Development Northampton General Hospital

Annual Report October 2010

Prepared by the R&D Office

Introduction

In 09/10 the R&D Office, has given Trust management approval to many projects - 254 Research studies were ongoing during this time. This covers projects from student research to full randomised controlled trials and the numbers have increased this year. The R&D office has been attempting to record recruitment figures for the first time this year and has established that 1900 patients were recruited to studies in NGH in 09/10. These figures were declared in the quality account 09/10. We also declared that the R&D Office issued 42 letters of access or honorary research contracts following the introduction of the Research Passport Scheme. During a difficult year for the NHS, health research continues to generate good support from the Department of Health and the National Institute of Health Research. The Trust has seen more directorates involved in more research this year.

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

National Picture

The new NHS constitution and the NHS operating framework both include statements on research to encourage Trusts to make research core business. Furthermore, the Government announced in the outcome of the Spending Review on 20 October 2010, that the Department of Health will increase spending on health research in real terms. From this, additional funding will be made available so the NIHR can lead the way in pulling basic scientific advances through into benefits for patients and the economy. It is anticipated that this is a 4% uplift plus inflation. R&D Offices are being asked to disseminate the following key messages with regards to R&D

- High-performing organisations understand the competitive advantage gained through an ability to absorb and generate research knowledge.
- All NHS organisations, large and small, can benefit from greater engagement with research.
- NHS organisations that are research active appear to have better overall performance than non research active trusts.

Finance

R&D trial income received YTD at **31/10/10 PART YEAR**	£ 318,516
Research Network Income Full year allocation **2010/11**	£ 896,865
R&D service support income	£ 30,000

Projected Research Turn over year end **£1.5 million**

Future Plan and Challenges in 20010/11

1. At Risk Funds

Research and Development receives funding from multiple sources. A substantial amount is from the National Institute of Health Research via a variety of research networks. We are advised that future funding is dependant on activity as we move to an activity based funding model. In addition the Trust agreed to increase recruitment by 17.5% for 2010/11. The Trust will achieve this because the R&D office is vigilant and monitors the research portfolio. However in future years beyond 2011/12 this will depend on encouraging more consultants to take on more portfolio research.

The issues for 2010/11

The single outstanding issue is Flexibility and Sustainability Funding (FSF). This is a funding stream designed to cover the salary costs of staff between grants and also to support the administration for studies. This is the most vulnerable funding stream and is widely thought to be cut and this is expected soon. The R&D Office is advising that the Trust should not approve any new posts because of the employer liability for posts funded through FSF funding.

2. Future Funding

In order to achieve future funding and even maximise income we need to recruit more patients to more studies with the same workforce. To achieve this we are undertaking a systematic review of :-

- Exploring our research portfolio
- Review the Research workforce, in terms of:
    - Medical
    - Nursing
    - Support services

Briefly exploring each in turn.

Research portfolio

It has been made clear that funding will follow activity. Furthermore there will be a system of ranking recruitment so that Trusts which participate in highly resource dependant research such as randomised clinical controlled trials are acknowledged. Northampton General Hospital does well in comparative data with other Trusts in this measure. The National Institute for Health Research are also actively pushing Trusts to participate in trials with commercial partners and again NGH score well in this measure with 15% of current portfolio trials being fully commercial. This is the highest in the Leicestershire Northampton and Rutland region.

The R&D office is currently reviewing the national portfolio to look for trials that fit both the Trust strategic direction and will also ensure a balanced portfolio of research for the forthcoming years in order to maximise income from the research networks. We need to ensure a mechanism to incentivise Consultants and departments to become involved in research.

Review Research workforce

- **Medical**

The R&D Department employ three part time Associate Specialists. In addition, it successfully bid for funding for a total of 16.5 consultant programmed activity sessions (Pas) which equates to £200K as follows:-

Oncology	4
Medicine	4.5
Paediatrics	3
Obs and Gynae	1
Head and Neck	1
Surgery	1
Anaesthetics	1
A&E	1

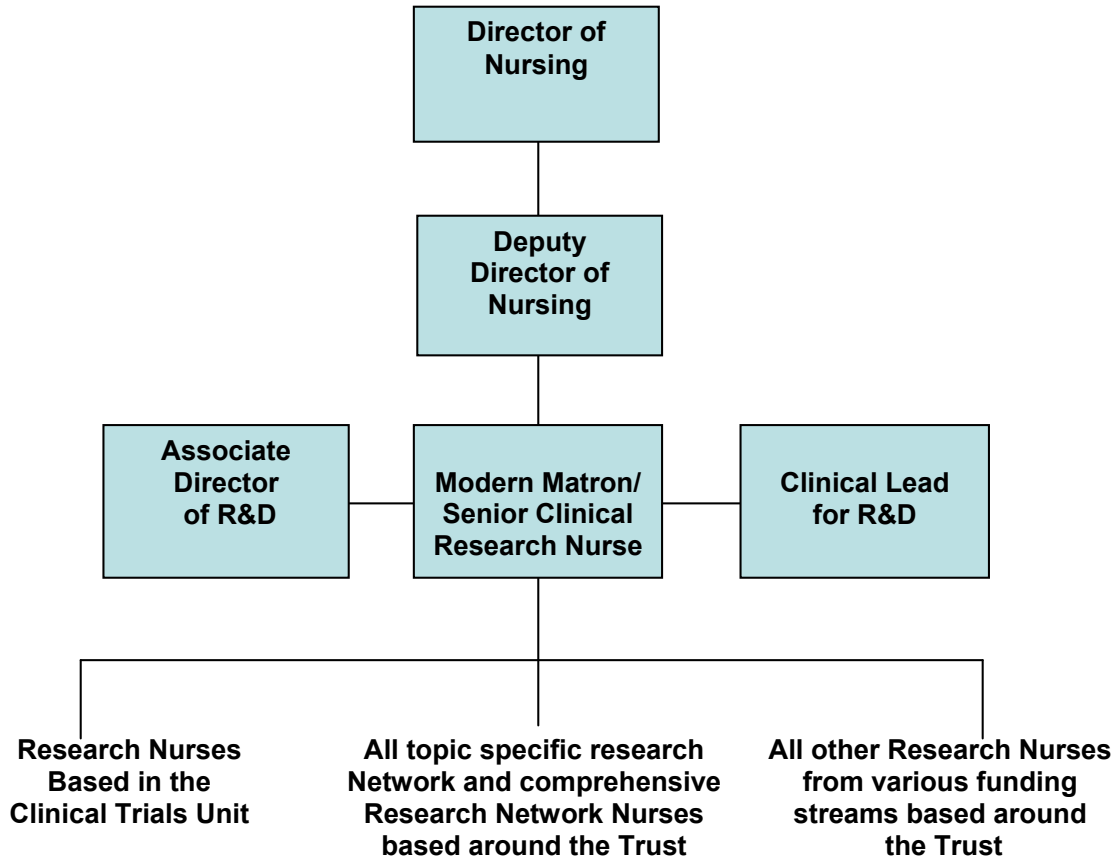
These PAs are only intended to be allocated to named individuals where specific research time has been identified in their job plan. This funding is for portfolio research only and is proving difficult to administer. Continuation of this funding will be dependent on demonstrating recruitment to the appropriate studies. How this can be used to incentivise consultants to participate in portfolio research is the current area of concern. It should be noted that we can maximise income if we can maximise engagement. The Clinical Lead discusses the allocation annually and the PAs are currently allocated to support consultant Supporting Professional Activity time within Job Plans.

- **Nursing**

We have prepared a paper and are currently in the process of consulting with the Nursing and Midwifery Board to introduce a new structure for the employment of Research Nurses. Current issues include:-

- Differing accountability structures.
- Inefficient use of nursing time.
- Where resource is short there is serious risk to the Trust and potentially patient care in the event of sickness/annual leave and maternity leave.
- Research is a skilled activity and the development needs of these nurses needs to have a more formal evaluation.
- KSF and appraisal needs are an issue for this group.
- The Trust needs to ensure full financial recover of costs associated with these posts.

The Proposed New Structure for Research Nurses across the Trust



We suggest that the proposed structure will address many of the issues mentioned above. In summary we hope that this structure will

1. Consolidate the role of the current Senior Research Nurse for the Trust. We anticipate that the job description of the current post holder may be subject to review and re banding to reflect the substantial increase in job responsibilities. The R&D budget could absorb these additional costs.

2. The new structure would ensure that all Research Nurse are professionally accountable to the Director of Nursing.

3. The senior R&D nurse would be tasked with:-

   a. The allocation of work such that R&D can maximise efficiencies.
   b. Developing an appraisal system for all R&D nurses.
   c. Support the professional development of these nurses.
   d. The point of contact for the 6 topic specific networks that we deal with and other stakeholders that may develop under the new government.

4. The Trust can be much more responsive to new work with this generic approach. The clinical trials unit has already established that the concept works as all research nurses currently based in the clinical trials unit have generic job descriptions.

5. The critical mass of research nurses means there is adequate support for sickness or maternity leave.

6. The generic approach would endure that cross directorate nursing support would be available. This can be used to develop some areas of the Trust that are currently not research active

- **Support services**

The funding for support services is highly dependant on the research portfolio. The support services that currently receive infrastructure funding include Medical records, the pathology labs, pharmacy and medical physics. On top of the infrastructure funding the R&D Office can recover the excess costs to cover any involved in research from the service support budget from the comprehensive networks. Thus the R&D office ensures support services are fully financially recompensed when they support research. The challenge for the future is the ongoing cost of drugs for patients at the end of their participation in research. We have two examples of problems in this area, where GPs have raised concerns when patients have moved to more expensive drugs regimes, despite clearly demonstrating health improvements. The R&D office is in contact with Nene Commissioning to attempt to resolve these issues.

Accountability and Reporting Arrangements for Research and Development

The department is managed by a senior manager who reports to a Clinical Lead who is accountable to the Medical Director. Whereas the governance arrangements and management of trials has not been a matter for concern there is a need to clarify the accountability arrangements within the Trust governance structures. This is a matter which will be resolved as part of the current discussions around restructuring of directorates.

Northampton General Hospital NHS
NHS Trust

PUBLIC TRUST BOARD SUMMARY SHEET	
Title: -	Performance Report
Submitted By: -	Christine Allen - Director of Operations
Date of Meeting: -	1st December 2010
Corporate Objectives Addressed: -	

SUMMARY OF CRITICAL POINTS: -

This report sets out the key areas of performance for Northampton General Hospital NHS Trust for Month 7 **(October 2010)**.

During October the following performance issues are of note:-

- **Transit Time Performance**. The month position was 95.54%.The year to date position is 96.72%.
- **Cancer Waiting Times**. The Trust did not achieve the following standards in September but continues to meet the targets for year-to-date performance:
  - 62 days from screening referrals to treatment, the Trust achieved 80% against the standard of 90%; the year to date position is 95.5%.
  - 62 days from consultant upgrade to treatment, the Trust achieved 83.5% against the standard of 85%, the year to date position is 97.5%.

PATIENT IMPACT: -

N/A

STAFF IMPACT: -

N/A

FINANCIAL IMPACT: -

N/A

RISK ASSESSMENT: -

N/A

EQUALITY & DIVERSITY IMPACT ASSESSMENT: -

N/A

RECOMMENDATION: -

Trust Board are asked to note the contents of this report.

PERFORMANCE REPORT – NOVEMBER 2010

1. INTRODUCTION

This report sets out key areas of performance for Northampton General Hospital NHS Trust for **Month 7** (October 2010). The report is based on the NHS Performance Framework - Service Performance Standards and Targets.

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

2. SERVICE PERFORMANCE

2.1 Performance Against National Targets

Performance Indicator	Monitoring	Standard	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10
Four-hour maximum wait in A&E from arrival to admission, transfer or discharge	YTD	98%							
Cancelled ops-breaches of 28 days readmission guarantee as % of cancelled ops	YTD	5.00%							
MRSA	YTD	6							
C Diff	YTD	98							
18 weeks RTT-admitted	Quarter	90%							
18 weeks RTT-non- admitted	Quarter	95%							
Achievement of standards in all specialties	Quarter	0							
2 week GP referral to 1st outpatient	YTD	93%							
2 week GP referral to 1st outpatient-breast symptoms	YTD	93%							
31 day second or subsequent treatment-surgery	YTD	94%							
31 day second or subsequent treatment-drug	YTD	98%							
31 day second or subsequent treatment-radiotherapy	YTD	96%							
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments) compared to plan	Q4	94%(Q4)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
62 day referral to treatment from screening	YTD	90%							
62 day referral to treatment from hospital specialist	YTD	85%							
62 days urgent referral to treatment of all cancers	YTD	85%							
Reperfusion: Primary Angioplasty (PPCI)	YTD	75%							
Reperfusion: Thrombolysis	YTD	68%							
2 week RACP	YTD	98%							
Delayed transfer of care	Total in period	3.50%							
Patients that have spent more than 90% of their stay in hospital on a stroke unit	2008-09	60%							

2.2 Transit Time Target

During October 2010, the monthly position for the 4 Hour Transit Time Standard reduced to 95.54%.
Projections show that in order to manage the demands of the winter period and deliver the year end target of 95%, the Trust must achieve performance of 97.5% - 98% for the period of September to December.

The year to date position is 96.72%, in order to regain the weekly performance target the trust will focus on timely discharge to improve patient flow. The Trust will also continue to plan the management of sustained peaks in demand using forecast modelling.

2.3 Cancer Waiting Times

2.3.1 62 Days from Screening Referral

In October the Trust achieved 80% against the standard of 90% for patients being treated within 62 days from a Cancer Screening Programme. Two patients referred through the Bowel Screening Service breached however from 6th December 2010, NGH will be participating in the Bowel Screening Programme and this position is expected to improve. The year to date performance is 95.5% against the target of 95%.

2.3.2 62 Days from Consultant Upgrade

In October the Trust achieved 83.3% against the standard of 85% for patients treated within 62 days following a consultant upgrade for suspected cancer. This was a result of one patient being transferred between hospitals for treatment. The year to date position is 97.5% and remains on target.

3. RECOMMENDATIONS

Trust Board is asked to discuss and debate any issues arising from this report.

Northampton General Hospital NHS
NHS Trust

FINANCE REPORT
OCTOBER (MONTH 7)
2010/11

Key numbers at a glance

I&E Position	£000's	
In-month I/E	335	£335k Surplus
Forecast YTD	852	£852k Forecast surplus YTD
Actual Year to date I/E	592	£592k I/E surplus YTD
FIMS Plan (Year to date)	1,150	£1.15m Surplus YTD
PCT SLA Income Variance	1,426	Above plan for YTD
Full Year I&E Forecast	2,000	Forecast achievement of plan
Financial Risks to Forecast	4,041	CIP Delivery / PCT affordability

EBITDA Performance	£000's	
Trust	(640)ADV	

Cost Improvement Schemes	£000's	
In month delivery	1,796	CIPs achieved in October
Year to date	5,606	CIPs achieved to October
Year to Go	6,394	67% of CIP target to be delivered
Full Year Forecast	11,430	Total target £12m
FYE Unidentified	570	Total target £12m

Capital	£000's	
Year to date expenditure	3,942	Capital expenditure for period
Forecast as % of plan	94%	Target minimum of 75%

SoFP (movement in year)	£000's	
Non-current assets	(1,011)	In-year depreciation plus Capex
Current assets	1,750	Increase in prepayments & accruals
Current Liabilities	(94)	Reduction since March 10.

Cash	£000's	
In month movement	(1,223)	Decrease over September 10
In Year movement	(1,223)	Decrease over March 2010
Debtors Balance > 30 days	1,930	Total outstanding over 30 days
BPPC (by volume) YTD	67%	Target 95% paid in 30 days

KPIs		
Financial Risk Rating (Shadow)	3	ROA / Surplus Margin low
EBITDA	94.5%	95% achievement of plan
Liquidity	15.5	Incl. unused WCF of £17m
Surplus Margin	0.2%	Due to low level of surplus overall
Pay / Income	66.1%	0.42 % above plan for period

Overview Month 7

Performance against plan: The position for October is a year to date surplus of £592k compared to a planned surplus of £1.15m (FIMS) giving rise to an adverse variance of £558k against plan, (last month £257k surplus, £892k adverse to plan). The forecast prepared in August was for a surplus of £852k at the end of month 7.

SLA Income: Income from PCT SLAs is £1.4m (1.2%) ahead of plan (including £0.9m efficiency target). Elective workload is £0.9m behind plan notably in T&O(£650k) and General Surgery (£360k). Day case activity is performing 4% ahead of plan. Non elective activity now stands at £1.3m ahead of plan (MRET adjustment estimated at £26k only). Outpatient procedures have increased and area performing £1.4m above the plan set by the PCT for the year. The trust is over performing the cost per case contract for Critical Care Beds by £24k for the year to date, (this area is now included in the calculation of monthly WIP). A&E performance remains at 6% below plan for the year to date. Income for excluded medicines has increased in line with spend but remains £52k below plan overall. Total provisions of £1.4m have been included in the financial position to cover contract challenges. WIP has increased by £245k since the start of the year. Plan for October includes £167k for Stroke Centre opening. Non elective case mix reduced by £300k in October primarily in T&O and Obstetrics.

Other Clinical Income: Private Patient Income is £199k (20%) behind plan and RTA and CRU income is £91k behind plan.

Other Income: Other income is £952k ahead of plan primarily due to R&D income, Medicine sales and VAT claims.

Risks: The Trust continues to identify the following factors as significant risks to the financial position:
- NEL activity demand
- CIP Delivery
- Ongoing Junior doctors recruitment
- Cytokine Inhibitors (Excluded Medicine)
- PCT affordability of forecast SLA performance

Pay: Pay increased by £74k between September and October, although October included an additional pay week (c. £200k) indicating an underlying reduction in run rate on a month on month basis. October saw a £90k reduction in the run rate for Medical locums. The executive team continue to oversee the vacancy control procedure and increased controls over the use of agency staff remain in place. The Trust closed Victoria Ward (medical) on 3rd July utilising 21 WTE substantive staff to reduce the need for temporary staffing across the medicine speciality. Medical Locum costs were £90k lower in October (£85k lower than the average YTD). The overall cost of Nursing services increased by £70k month on month. Within this figure bank costs accounted for a £32k increase and agency expenditure a £32k increase. The action plan generated in August details further initiatives aimed at driving down the pay bill.

Headcount: At the end of October the Trust employed 3,655 WTE (contracted). Worked WTE amounted to 3,891 WTE including 186 WTE Bank Staff, 50 WTE Agency and 9 WTE Medical Locums utilised during October.

Non-Pay: There was a reduction of £337k in non-pay expenditure between September and October, notably in medicines, clinical supplies, prosthesis and consultancy fees. Within the position for medicines the cost of Cytokine Inhibitors is forecast to grow significantly over the financial year and currently stands at £282k above plan.

Cash: The reduction in cashflow during the month is due to continued requirement to manage the creditor run rate. BPPC compliance now stands at 67% by volume and 48% by value for the year to date (in month 91% by volume and 64% by value). The Trust has invoiced the PCT for an agreed £1m cash relating to M1-6 overperformance which is anticipated to be received in December.

Forecast: The Board received a detailed financial forecast in August which will deliver the year end surplus of £2m subject to the actions identified being delivered. The Trust also needs to ensure that income projections are affordable to the PCT and to stay abreast of any financial recovery measures to be implemented by the PCT during the remainder of the financial year. The position for October indicates some slowdown in the level of over performance coupled with a delay in fully establishing the Stroke Service from October.

1.2 Income & Expenditure Account (last 3 months)

3 Month Run Rate £000's	August		September		October			Av. YTD
	Actual	Plan	Actual	Plan	Actual	Plan	Forecast	Actual
SLA Clinical Income	16,672	16,590	17,539	16,984	17,400	17,812	17,935	17,183
Other Clinical Income	168	247	217	201	225	247	270	199
Other Income	1,921	1,849	2,137	2,139	2,113	1,846	1,892	2,066
Total Income	**18,762**	**18,685**	**19,893**	**19,323**	**19,739**	**19,905**	**20,096**	**19,448**
Pay Costs	(12,963)	(12,771)	(12,807)	(12,506)	(12,881)	(12,692)	(12,634)	(12,851)
Non-Pay Costs	(5,062)	(4,928)	(5,674)	(5,239)	(5,337)	(5,044)	(5,679)	(5,360)
CIPs	0	167	0	167	0	165		0
Reserves	0	(336)	0	(336)	0	(257)		0
Total Costs	**(18,025)**	**(17,867)**	**(18,481)**	**(17,914)**	**(18,218)**	**(17,829)**	**(18,312)**	**(18,211)**
EBITDA	**737**	**818**	**1,412**	**1,409**	**1,521**	**2,076**	**1,784**	**1,236**
Depreciation	(775)	(821)	(820)	(830)	(835)	(835)	(822)	(799)
Amortisation	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Impairment of Fixed Assets	0	0	0	0	0	0		0
Net Interest	2	1	4	1	4	1		2
Dividend	(354)	(354)	(355)	(354)	(354)	(354)	(354)	(354)
Surplus / (Deficit)	**(391)**	**(357)**	**241**	**224**	**335**	**888**	**608**	**85**

- £335k surplus achieved in month of October, £273k below forecast.
- SLA income£535k below forecast for the month due to casemix
- Expenditure below forecast for October, but pay running ahead of forecast.
- Income Generation and Other income ahead of plan and forecast

4.0 Capital Expenditure Schemes

Category	Annual Budget 2010/11	Year to Date as at Month 7		Year to Date as at Month 7		EOY Forecast as at Month 7	
		Actual Spend	Plan Achieved	Actual Committed	Plan Achieved	Forecast Spend	Under (+) / Over
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Breast Screening Business Case	600	549	91%	549	92%	549	-51
A&E / Fracture Clinic / EAU	500	1	0%	35	7%	100	-400
Room A (General X Ray Room)	350	346	99%	347	99%	347	-3
Room 5 (Interventional Room)	1,200	98	8%	1,160	97%	1,200	
IGRT retrofit to Linear Accelerator	575	39	7%	509	89%	509	-66
MESC	1,004	554	55%	714	71%	999	-4
Estates	3,760	1,354	36%	1,874	50%	3,740	-20
IT	2,565	1,027	40%	1,902	74%	2,615	50
Other	928	191	21%	287	31%	744	-185
Disposals							
Total - Capital Plan	**11,482**	**4,159**	**36%**	**7,377**	**64%**	**10,803**	**-679**
Less Charitable Funds	-880	-217	25%	-332	38%	-880	0
Total - CRL	**10,602**	**3,942**	**37%**	**7,045**	**66%**	**9,923**	**-679**

- Replacement Breast Screening mobile & trailer is second year of business case (completed)
- Room A (completed) and Room 5 (due to complete December / January) - replacement of existing radiology rooms
- IGRT retrofit improves patient treatment utilising existing linear accelerator (due December)
- Current plan includes £660k relating to Macmillan scheme which has proceeded to tender stage in September
- Current EOY forecast is £10.726 million i.e. an underspend of £0.733 million
- Depreciation forecast in year has reduced by £75k to £9.118 million

5.0 Statement of Financial Position

	Balance at 31-Mar-10	Current Month Opening Balance	Current Month Closing Balance	Current Month Movement	Forecast end of year Closing Balance	Forecast end of year Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	132,332	132,332	132,332		132,332	
IN YEAR REVALUATIONS		638	697	59	697	697
IN YEAR MOVEMENTS		2,638	3,890	1,252	11,056	11,056
LESS DEPRECIATION		(4,757)	(5,598)	(841)	(9,847)	(9,847)
NET BOOK VALUE	**132,332**	**130,851**	**131,321**	**470**	**134,238**	**1,906**
CURRENT ASSETS						
INVENTORIES	3,992	4,132	3,970	(162)	3,992	
RECEIVABLES:						
NHS DEBTORS	6,102	5,905	7,567	1,662	5,524	(578)
OTHER TRADE DEBTORS	976	1,038	957	(81)	976	
DEBTOR IMPAIRMENTS PROVISION	(187)	(187)	(187)		(187)	
CAPITAL RECEIVABLES		110	23	(87)		
NON NHS OTHER DEBTORS	127	511	453	(58)	127	
COMPENSATION DEBTORS (RTA)	2,428	2,485	2,448	(37)	2,428	
OTHER RECEIVABLES	864	839	831	(8)	864	
IRRECOVERABLE PROVISION	(259)	(258)	(259)	(1)	(259)	
PREPAYMENTS & ACCRUALS	534	2,030	2,057	27	534	
	10,585	**12,473**	**13,890**	**1,417**	**10,007**	**(578)**
CASH	2,352	2,042	819	(1,223)	3,761	1,409
NET CURRENT ASSETS	**16,929**	**18,647**	**18,679**	**32**	**17,760**	**831**
CURRENT LIABILITIES						
NHS CREDITORS	3,724	4,199	3,469	730	3,720	4
TRADE CREDITORS REVENUE	3,580	2,749	2,183	566	3,234	346
TRADE CREDITORS FIXED ASSETS	1,635	752	1,446	(694)	1,635	
TAX AND NI OWED	3,087	3,243	3,306	(63)	3,150	(63)
NHS PENSIONS AGENCY	1,676	1,736	1,735	1	1,676	
OTHER CREDITORS	443	348	435	(87)	380	63
SALIX LOANS			64	(64)	437	(437)
ACCRUALS AND DEFERRED INCOME	3,210	4,334	4,631	(297)	3,210	
PDC DIVIDEND DUE			354	(354)		
STAFF BENEFITS ACCRUAL	1,234	1,234	1,234		1,234	
PROVISIONS	820	171	128	43	372	448
PROVISIONS (> 1 year)		330	330		374	(374)
NET CURRENT LIABILITIES	**19,409**	**19,096**	**19,315**	**(219)**	**19,422**	**(13)**
TOTAL NET ASSETS	**129,852**	**130,402**	**130,685**	**283**	**132,576**	**2,724**
FINANCED BY						
PDC CAPITAL	99,635	99,635	99,635		99,635	
REVALUATION RESERVE	29,257	29,781	29,781		29,783	526
DONATED ASSET RESERVE	6,343	6,108	6,056	(52)	6,537	194
I & E ACCOUNT BALANCE	(5,383)	(5,379)	(5,379)		(3,379)	2,004
I & E CURRENT YEAR		257	592	335		
FINANCING TOTAL	**129,852**	**130,402**	**130,685**	**283**	**132,576**	**2,724**

Non current assets reduction since March due to low level of capex and in year depreciation charges.

DV to be consulted on indexation of Non-current assets.

Reduction in Pharmacy stock in October

Reduction in cash due to payment of additional creditors.

Increase in liabilities due to capital creditors.

Receipt of £64k of Salix Loan in month.

£3.8m year end cash target to meet EFL duty.

6.0 Cashflow

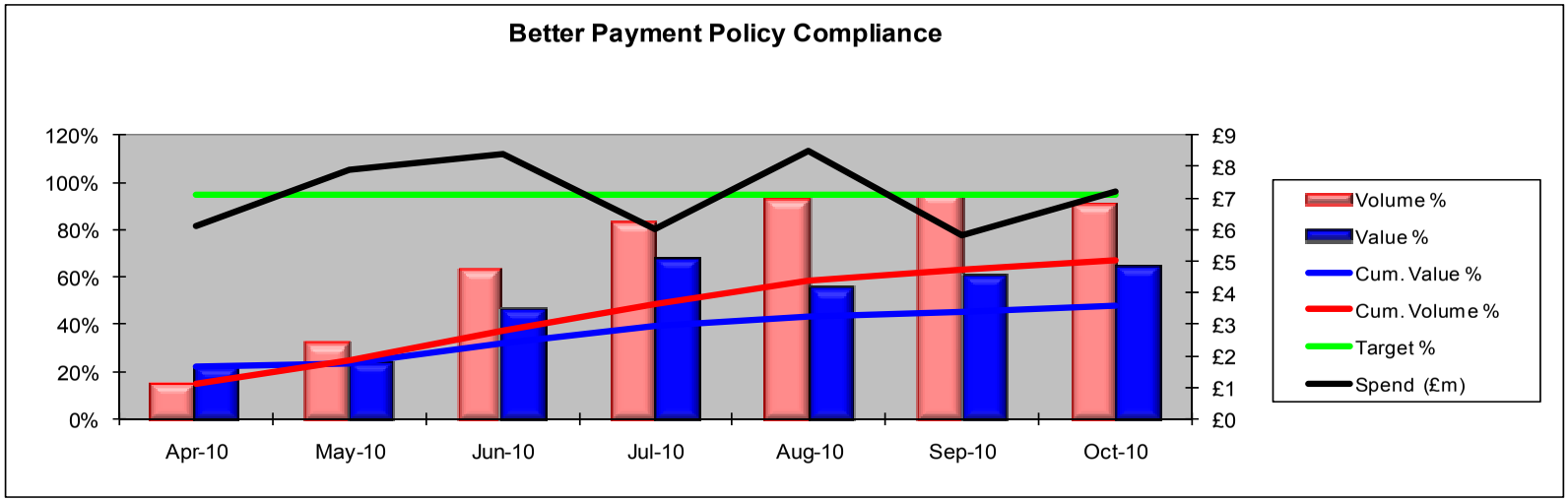
MONTHLY CASHFLOW	Annual £000s	APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
NHS Contracts	209,326	17,179	16,722	17,237	17,703	19,921	17,660	16,612	17,258	17,258	17,258	17,258	17,258
SLA Performance	5,000	0	0	0	0	0	0	0	0	1,000	1,000	1,000	2,000
Debtors > 60 Days	625	0	0	0	0	0	0	0	125	125	125	125	125
Other Income	13,645	1,138	1,631	770	1,043	1,061	1,790	963	1,100	950	1,100	1,000	1,100
PP/ Other	10,653	745	937	704	1,108	670	1,019	1,171	800	800	900	800	1,000
New Loans :	0												
Salix Capital Loan	500	0	0	0	0	0		64	321	115	0	0	0
EFL / PDC	0	0	0	0	0	0		0	0	0	0	0	0
Temporary borrowing	0	0	0	0	0	0		0	0	0	0	0	0
Interest Receivable	25	2	2	2	1	2	4	4	2	2	2	2	2
Sale of Assets	0	0	0	0	0	0		0	0	0	0	0	0
TOTAL RECEIPTS	**239,775**	**19,064**	**19,292**	**18,713**	**19,855**	**21,653**	**20,473**	**18,813**	**19,606**	**20,250**	**20,385**	**20,185**	**21,485**
PAYMENTS													
Salaries and wages	149,692	12,252	12,427	12,443	12,586	12,525	12,531	12,378	12,450	12,600	12,450	12,450	12,600
Trade Creditors	71,770	4,658	7,448	6,195	6,524	6,663	7,782	7,170	5,511	5,511	5,511	5,495	3,303
Creditors > 30 Days	2,000	0	0	0	0	0	0	0	500	500	500	500	0
Capital Expenditure	10,501	826	479	274	580	513	524	492	1,327	1,155	1,767	1,637	926
PDC Dividend	4,254	0	0	0	0	0	2,127	0	0	0	0	0	2,127
Repayment of Loans	0	0	0	0	0	0		0	0	0	0	0	0
Repayment of Salix Loan	63	0	0	0	0	0		0	0	0	0	0	63
TOTAL PAYMENTS	**238,279**	**17,736**	**20,354**	**18,913**	**19,690**	**19,701**	**22,965**	**20,040**	**19,788**	**19,766**	**20,228**	**20,082**	**19,018**
Actual month balance	1,495	1,328	-1,062	-199	165	1,952	-2,491	-1,226	-182	484	157	103	2,467
Balance brought forward	2,321	2,321	3,649	2,587	2,388	2,553	4,505	2,014	787	605	1,089	1,246	1,349
Balance carried forward	3,816	3,649	2,587	2,388	2,553	4,505	2,014	787	605	1,089	1,246	1,349	3,816

- £1m SLA overperformance invoiced to be received in December (relating to M1-6 overperformance)
- Capital expenditure run rate increasing in Q3 and Q4.
- Assumes £9.8m SLA overperformance (PCT affordability issues)
- £64k SALIX loan received in October. £321k received in November.

6.1 Better Payment Policy Code (BPPC)

	NHS			Non-NHS			Total		
	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%
Value £	1,587,687	8,860,533	**18%**	22,222,939	40,752,806	**55%**	23,810,626	49,613,339	**48%**
Volume	764	1,299	**59%**	23,733	35,406	**67%**	24,497	36,705	**67%**

- Continued performance and compliance by volume in October achieving 91% by volume.
- Difficult to recover cumulative performance to meet target over remainder of financial year.
- Agreement with PCT to bring forward payment date of monthly mandate and performance.
- £0.4m+ owed by PCT from 09-10 (Maternity Matters).
- Target BPPC compliance is 95%



BOARD SUMMARY SHEET	
Title	HR REPORT
Submitted by	Chanelle Wilkinson Director of HR & Organisational Development
Date of meeting	1st December 2010
Corporate Objectives Addressed	Objective 5

SUMMARY OF CRITICAL POINTS

This is the monthly HR report for November 2010 and focuses on the following topics:-

- Appraisal Monitoring Update
- E-Rostering
- Return to Work Monitoring
- HR Caseload Activity
- Workforce Trends – KPIs for the months of July and August 2010

PATIENT IMPACT - All

STAFF IMPACT - All

FINANCIAL IMPACT -

EQUALITY AND DIVERSITY IMPACT - None

LEGAL IMPLICATIONS – N/A

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

RECOMMENDATION
The Board is asked to note the contents of this report.

1. HR DIRECTORATE UPDATE

This report provides a brief overview of the progress made with appraisal monitoring, E-rostering, return to work monitoring and the HR caseload activity undertaken in September 2010. In addition, the report provides a summary of the Trust's HR Key Performance Indicators for September 2010.

2. APPRAISAL MONITORING UPDATE

The Training and Development department have produced new guidance on the personal development review process. The personal development review paperwork has been simplified in order for individuals to have a greater understanding of the objective setting process and clearer guidance for completing a personal development plan including a mandatory training plan.

Paul Forden, CEO has supported the importance of completing personal development reviews by issuing a letter, together with the documentation, which has been cascaded to all staff and is attached as appendix 1.

In addition, the HR Business Partners have requested by directorate, numbers of staff who have been appraised and have a PDP between April 2010 and September 2010. This will enable the HR Directorate to have a baseline figure in order to report to the Trust Board on the progress towards the 80% corporate objective target by the end of the financial year. This figure will not provide a compliance rate only the numbers completed in the financial year up until September 2010. Future reports will be provided quarterly to Trust Board showing progress made to meet the target.

The Training and Development department have also requested individual appraisal information and copies of personal development plans. This will enable centralised recording and reporting.

3. E-ROSTERING UPDATE

The E-rostering project commenced on 16 November 2010. Confirmation has been provided that the configuration of IT and the training environment is functional. System administration and database training has taken place for the project team and from 1 December 2010 staff from the pilot wards and units within ITU / HDU and 4 medical wards – Becket, Compton, Creaton and EAU will start their training on the system. Training will continue throughout December 2010.

The first live rosters are scheduled to start in February 2011 and within this month the Finance Department will be the first support function to go live with web timesheets.

In January 2010, Althorp, Benham, Brampton, Allebone/Eleanor and Finedon wards will start training and the Human Resource Department will be the second support function to go live with web timesheets.

4. RETURN TO WORK MONITORING

The table below summarises the results by directorate of the % number of return to work interviews completed against the number of staff who were recorded as having been off work and returned in the month of September 2010 due to sickness absence.

Directorate	April 2010 (%)	May 2010 (%)	June 2010 (%)	July 2010 (%)	August 2010 (%)	September 2010 (%)
Medicine	17.5%	41%	47%	54%	31.5%	12.1%
Surgery	Not Available	71%	62%	72%	75%	84%
Anaesthetics	Not Available	87.5%	100%	87%	95%	81%
T&O	62.5%	67%	72%	80.9%	91%	65.6%
Head & Neck	45%	83%	55%	83%	86%	88%
Child Health	70%	50%	22.4%	30.9%	44%	59%
Obs & Gynae	50%	56%	12%	11%	22%	46%
Oncology	62%	48%	57%	62%	32.5%	72%
Pathology	70%	80%	74%	78%	51%	89%
Radiology	100%	100%	90%	81%	56%	78%
Pharmacy	100%	100%	100%	100%	100%	100%
Therapies	100%	100%	100%	100%	81%	94%
Facilities Hospital Support	41% 15.3%	27.6% 54.4%	43% 49%	54.4% 67.4%	95% 70.5%	69% 91.5%

Overall there has been some improvement in the number of return to work interviews that have been carried out in Diagnostics, Surgery, Hospital Support, Head and Neck and Obstetrics and Gynaecology. The increase in Obstetrics and Gynaecology was predicted last month as there have been interventions and promotions by the HR Business Partner to improve the percentage rate of return to work interviews being carried out. Improvements in Oncology and Child Health may also be as a result of a HR Business Partner being designated to the two directorates from September 2010 and for the first time since the HR Business Partner model was introduced.

However, poor results have been recorded for Medicine, Trauma and Orthopaedics and Facilities. The HR Business Partners for these directorates are investigating the reasons for the poor returns and will be reporting this back to the Directorate Managers. The HR Business Partner for Medicine has confirmed that following correspondence to the ward managers higher numbers of return to work interviews have been sent in for the months of October and November 2010. It must be noted that these three directorates also have an increase in their sickness absence rates which correlates with the poor results for the return to work interviews.

In addition, to put the percentages into perspective, the table below breaks down the numbers of staff off sick during the month of September 2010 and the numbers of staff who received a return to work interview.

Directorate	September 2010 (%)	Numbers of staff off sick in September 2010	Numbers of Return to work interviews carried out in September 2010
Medicine	12.1%	174	21
Surgery	84%	77	65
Anaesthetics	81%	32	26
T&O	65.6%	32	21
Head & Neck	88%	25	22
Child Health	59%	56	33
Obs & Gynae	46%	67	31
Oncology	72%	39	28
Pathology	87%	46	40
Radiology	79%	33	26
Pharmacy	100%	10	10
Therapies	94%	18	17
Facilities	69%	61	42
Hospital Support	91.5%	48	44

5. HR CASE WORK

The table below identifies the active HR case work across the Trust up to the end of October 2010.

Type	Open Cases July 2010	Open Cases August 2010	Open Cases September 2010	Open Cases October 2010
Capability	8	5	3	2
Conduct	16	12	12	17
Harassment & Bullying	6	5	6	7
Grievance	12	9	10	10
Sickness	65	63	66	63
Employment Tribunals	2	2	2	1
Suspension	0	1	1	1
Other	9	5	5	6
TOTAL	**118**	**102**	**105**	**107**

The increase in conduct and harassment and bullying cases are mainly from the diagnostics directorates. The designated HR Business Partner is managing these in accordance with the Trust's policies. There are no other exceptions to report for HR caseload activity for September 2010.

The number of grievances remains static and following further investigation these cases are either payment related or in relation to annual leave entitlement. A breakdown of the grievances lodged is as follows:

- 4 x Bullying & Harassment
- 1 x Payments related
- 2 x Annual Leave carry forward
- 1 x Car Parking
- 2 x annual leave entitlement

6. WORKFORCE TRENDS – Key Performance Indicators (KPIs)

The section of the report below identifies the key themes emerging from the Human Resources KPI report for September 2010 and identifies trends against Trust targets. A summary of the key actions taken to meet targets is as follows:

Total Trust Sickness Absence - September 2010 - Appendix A

The total sickness absence rate for all staff has increased from the August 2010 figure of 3.55% to 4.04% in September 2010 and remains above the Trust target of 3.5%.

Ward based sickness absence for staff on Band 5 and above increased from 4.16% in August 2010 to 5.20% in September 2010.

Total Sickness Absence by Directorate – September 2010

Table 1 below shows total sickness absence by Directorate between July 2010 and September 2010. The table provides evidence that in a number of directorates there has been an increase in sickness absence rates since August 2010. The directorates where there are the most concerns are as follows:

- Medicine
- Surgery
- Anaesthetics
- Trauma & Orthopaedic
- Child Health
- Pathology
- Radiology
- Pharmacy
- Facilities

Table 1

Directorate	Total Sickness Absence July 2010 (%)	Total Sickness Absence August 2010 (%)	Total Sickness Absence September 2010 (%)
Medicine	3.93	3.62	4.17
Surgery	3.22	2.83	3.66
Anaesthetics	3.92	3.71	4.66
T&O	4.61	3.32	4.12
Head & Neck	5.55	4.24	3.74
Child Health	3.24	3.71	4.45
Obs & Gynae	4.61	4.19	4.08
Oncology	5.83	4.87	4.41
Pathology	3.92	3.36	4.08
Radiology	1.66	1.08	3.09
Pharmacy	3.03	1.41	1.76
Therapies	2.40	4.97	4.86
Facilities	4.79	4.33	6.01

The HR Business Partners continue to target areas of concern and the summary in the section below provides more detail of the reasons for concern and the actions that have been taken.

Summary by Directorates - September 2010

Short term and long term sickness absence is measured separately. Please note that the summary below has taken into account the information in both Table 1 and Table 2 and for the purpose of this section of the report, ward sickness absence includes all staff working in ward areas.

Table 2

Directorate	Short Term August 2010 (%)	Short Term September 2010 (%)	Long Term August 2010 (%)	Long Term September 2010 (%)
Medicine	2.15	2.22	1.47	1.95
Surgery	1.65	2.61	1.18	1.05
Anaesthetics	2.45	2.77	1.26	1.89
T&O	1.69	2.43	1.63	1.70
Head & Neck	1.35	1.87	2.89	1.88
Child Health	1.06	2.50	2.65	1.95
Obs & Gynae	1.65	1.66	2.54	2.42
Oncology	2.00	1.93	2.87	2.48
Pathology	1.69	1.79	1.67	2.29
Radiology	0.46	2.32	0.62	0.77
Pharmacy	1.41	1.76	0.00	0.00
Therapies	3.52	3.40	1.45	1.45
Facilities	3.09	3.56	1.24	2.45

In Medicine the total sickness absence has increased by 0.55% in September 2010. The four main areas of concern within the Directorate are the Heart Centre 16.67%, Cardiology Research 12.06%, Elderly Outpatients 8.99% and Dryden Ward 8.34%. Actions to trigger a reduction include ward sickness reviews at budget meetings and implementation of the Trust's Management of Sickness Absence Policy.

In General Surgery total sickness absence has increased from 2.83% in August to 3.66% in September 2010. Colorectal Nursing has a high sickness absence rate of 27.78%, representing 1 of the 4 nurses on long term sickness absence. There are also areas of concern to include the New Day Surgery at 9.73% and Integrated Surgery Outpatients at 6.29%. Managers within the directorate are having regular 1:1 meetings with the HR Business Partner to initiate actions to reduce the sickness absence rate.

In Anaesthetics, the total sickness absence has increased to 4.66% an increase of 6 episodes of sickness. The majority of sickness absence can be attributed to short term sickness with 33 episodes for the month. The HR Business Partner is promoting the revised sickness policy. Sickness absence within the Pain Clinic is high at 10.83% despite 100% of return to work interviews being carried out.

The total sickness absence for the Trauma & Orthopaedics in September 2010 was 4.12%, which has increased by 0.8% from August 2010. However, ward level sickness absence has decreased to 3.56%, a reduction of 0.33% from August 2010. Long term sickness absence is 1.70% with 5 members of staff reported as being off long term. Current areas of high sickness are Fracture Clinic at 10.6% with one employee on long term sick and Housekeeping at 21.95% with two members of staff on long term sick leave. The long term sickness cases are being managed in accordance with Occupational Health and Human Resources. Action is being taken to assist the staff members with a return to work.

Head & Neck total sickness absence was 3.74%, which decreased by 0.5% from August 2010. There has been a reduction in the number of staff on long term sick leave, all of which are being managed according to the Trust policy. Ward level sickness for September 2010 was 7.72%, with two areas of concern, Singlehurst Ward at 6.30% and Knightly Ward at 8.84%

In Child Health sickness absence has increased since August 2010 from 3.71% to 4.45% in September 2010. Of particular concern is Paddington Ward where absence has almost doubled since August 2010. The HR Business Partner will be supporting the manager to identify measures that can help to reduce the absence rate. Guidance has been issued on the informal management of sickness absence and the HR Department will be providing to training throughout December 2010 and January 2011. Focus will also be given to long term absentees with a view to helping them return to work if necessary via the redeployment process.

Within Obstetrics and Gynaecology total sickness absence continues to decrease as a result of staff returning to work from long term sick leave. Sickness absence continues to be high in Endoscopy due to one long term sickness case in a small workforce, to which resolution continues to be progressed through Occupational Health.

Both long and short term sickness absence have reduced in Oncology and total sickness absence continues to reduce falling to 4.41% in September 2010. Long term sickness absence remains high in Clinical Haematology Anti Coagulant 7.05%, Oncology Administration 19.12% and Oncology OPD at 14.25%. A focus on long term sickness continues throughout the Directorate and work is continuing to be undertaken where possible to support a return to work for individuals and using redeployment where appropriate.

Pathology total sickness absence has increased in September 2010 to 4.08% from 3.36% in August 2010 due to an increase in both long and short term cases. There were 6 long term cases in September 2010 of which one employee is being considered for redeployment, one employee is leaving voluntarily on 31st December 2010 and another employee is looking at returning in the near future.

Total sickness absence has increased within Radiology from 1.08% in August to 3.09% in September due to 1 long term sickness case and an increase of 1.86% short term cases (16 episodes), all of which are being managed in accordance with the Trust's Management of Sickness Policy.

In Pharmacy total sickness absence continues to be well below the Trust target of 3.50% at 1.76% in September 2010 with no long term sickness absence cases.

Within Therapies there has been a slight reduction in the total sickness absence falling to 4.86% in September 2010 from 4.97% in August 2010, due to fewer short term absences.

The sickness absence level within Facilities has increased from 4.33% in August to 6.01% in September 2010. Short term sickness absence increased slightly from 3.09% in August to 3.56% in September 2010; however, there was a significant increase in long term sickness from 1.24% in August 2010 to 2.45% in September 2010. The HR Business Partner is supporting a focus to proactively manage all sickness absence cases and reviewing in line with the Trust's new Management of Sickness Absence Policy.

Staff Turnover September 2010 - Appendix B

The cumulative staff turnover rate (leavers) decreased from August 2010 to September 2010 from 8.17% to 7.85%, representing the lowest staff turnover rate in the past 12 months. The public sector average is 8.60%, as reported in the Chartered Institute and Personnel Development "Annual Survey Report 2010".

The actual turnover of leavers for September 2010 was 7.85% with a turnover rate of internal transfers of 9.72% an increase of 2.01% from August 2010. The reason for the continued increase in the percentage of internal transfers is due to ongoing work that Finance has carried out in relation to structural changes in the cost centres.

Turnover by Directorates – September 2010

The table below details the actual turnover rate for September 2010 by Directorate:

Directorate	July 10 (%)	Aug 10 (%)	Sept 10 (%)
Medicine	8.52	7.48	6.32
Surgery	8.7	6.2	6.02
Anaesthetics	7.04	4.56	5.74
T&O	9.78	9.19	10.19
Head & Neck	8.09	7.97	9.29
Child Health	8.47	8.03	7.8
Obs & Gynae	7.54	6.53	7.47
Oncology	10.21	8.7	10.42
Pathology	10.89	8.9	7.88
Radiology	4.9	3.77	4.76
Facilities	7.94	8.51	8.41
Hospital Support	10.04	11.44	11.87
Pharmacy)	5.71	6.41	5.5
Trust Total	**8.73**	**8.17**	**7.85**

*Please note the formula for staff turnover is the number of leavers in the year divided by average total staff in the year.

Number of Staff in Post - September 2010

The number of staff in post, excluding bank staff, has increased from 4,295 in August 2010 to 4,338 in September 2010. This figure is based on the number of staff with primary posts.

Full Time Equivalents September 2010 - Appendix C

The workforce full time equivalents decreased from 3,644 in August 2010 to 3,637in September 2010.

Bank and Agency September 2010- Appendices D and E

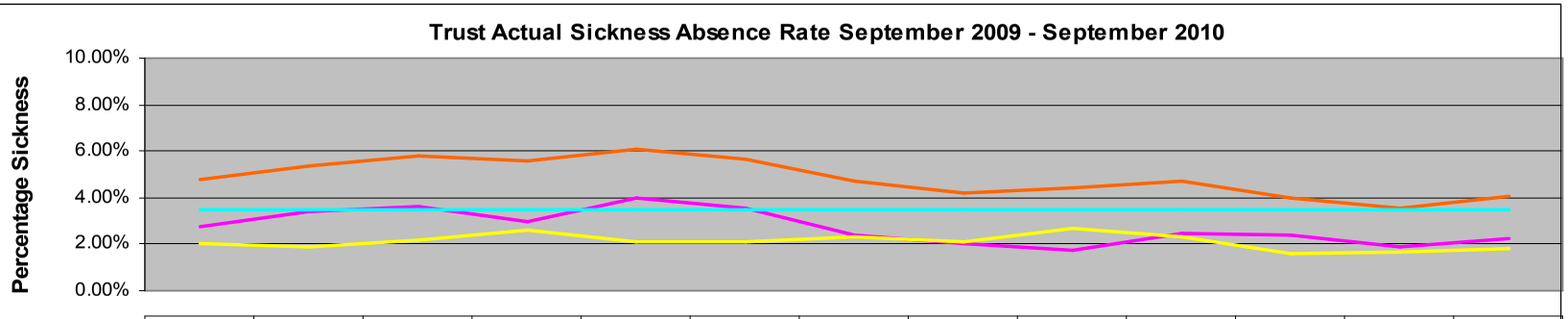
Bank expenditure for September 2010 was £446,816, a decrease of £49,929 on the previous month. Nursing and administrative & clerical agency expenditure has decreased. Agency expenditure for September 2010 was £191,516, a decrease of £165,413 on the previous month. The combined bank and agency spend for both staff groups has decreased by £215,342 on the previous month.

The total agency expenditure (to include medical locums) for September 2010 was £514,174, a decrease of £192,799 on the previous month.

The total number of bookings received increased by 276 in September 2010 compared with the previous month. The bank shift fill rate for September 2010 was 83% which continues to be above the Trust target of 80%. In total 6,423 bookings were received, 4,321 were filled by bank and 1,024 were filled by agency. The number of agency filled bookings has increased by 200 compared with the previous month.

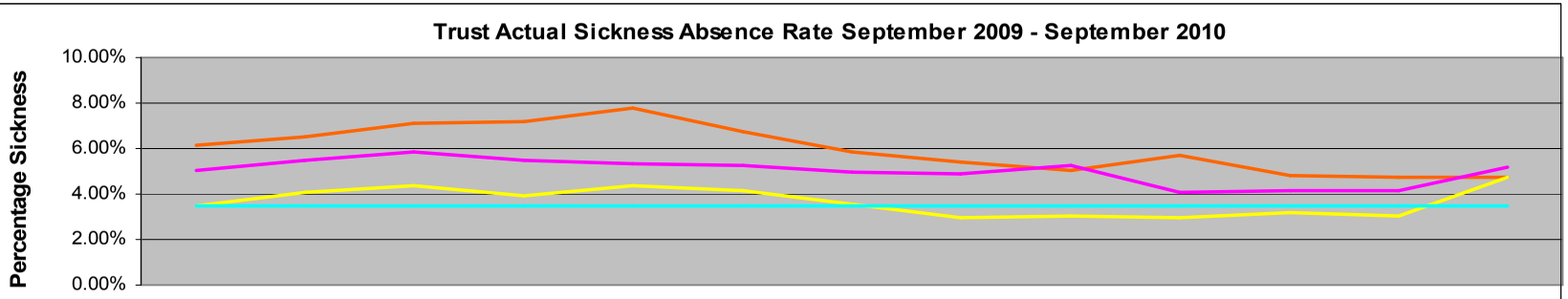
Chanelle Wilkinson
Director of Human Resources and Organisational Development
December 2010

Appendix A



	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
All Staff	4.79%	5.33%	5.78%	5.56%	6.11%	5.63%	4.71%	4.18%	4.40%	4.74%	3.96%	3.55%	4.04%
All Staff - Short Term	2.76%	3.43%	3.63%	2.96%	3.98%	3.57%	2.42%	2.05%	1.73%	2.45%	2.38%	1.87%	2.27%
All Staff - Long Term	2.03%	1.90%	2.14%	2.60%	2.13%	2.07%	2.29%	2.13%	2.67%	2.29%	1.59%	1.69%	1.78%
Trust Target	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%

CIPD Annual Absence Management Survey 2009 Quotes Public Sector Sickness rate at an average of 9.7 days per employee
Sickness Absence is calculated by the Proportion of the FTE Days Lost to Sickness expressed as a %

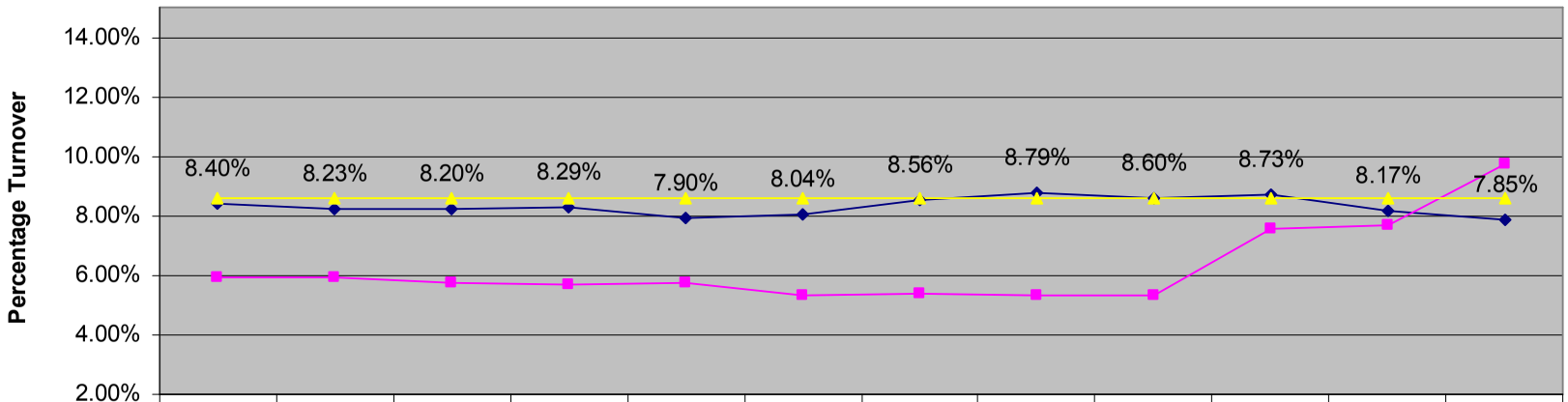


	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
Bands 1 - 4	6.16%	6.55%	7.11%	7.15%	7.80%	6.71%	5.87%	5.42%	5.06%	5.72%	4.80%	4.76%	4.74%
Ward Staff - Band 5 & Above only	5.02%	5.46%	5.85%	5.45%	5.31%	5.29%	4.95%	4.88%	5.23%	4.07%	4.14%	4.16%	5.20%
All Staff - Band 5 & Above only	3.46%	4.10%	4.41%	3.94%	4.35%	4.15%	3.56%	2.94%	3.03%	2.97%	3.15%	3.06%	4.71%
Trust Target	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%

CIPD Annual Absence Management Survey 2009 Quotes Public Sector Sickness rate at an average of 9.7 days per employee
Sickness Absence is calculated by the Proportion of the FTE Days Lost to Sickness expressed as a %

Appendix B

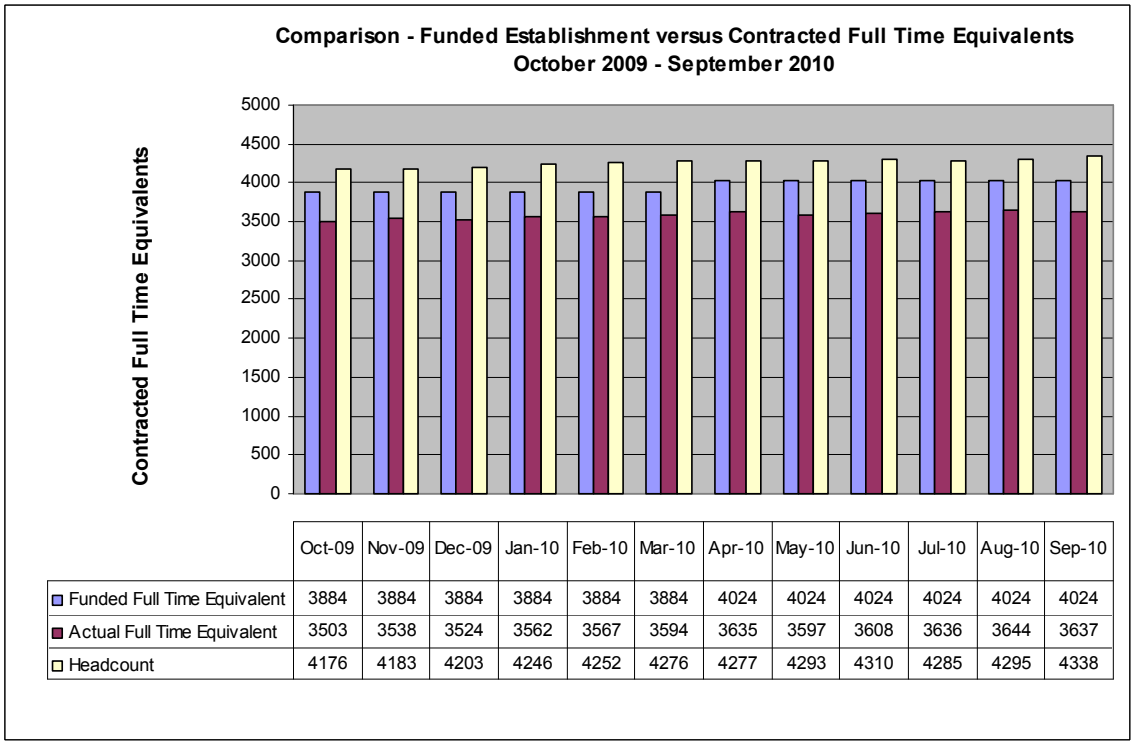
Staff Turnover October 2009- September 2010. Cumulative Data for Rolling 12mths



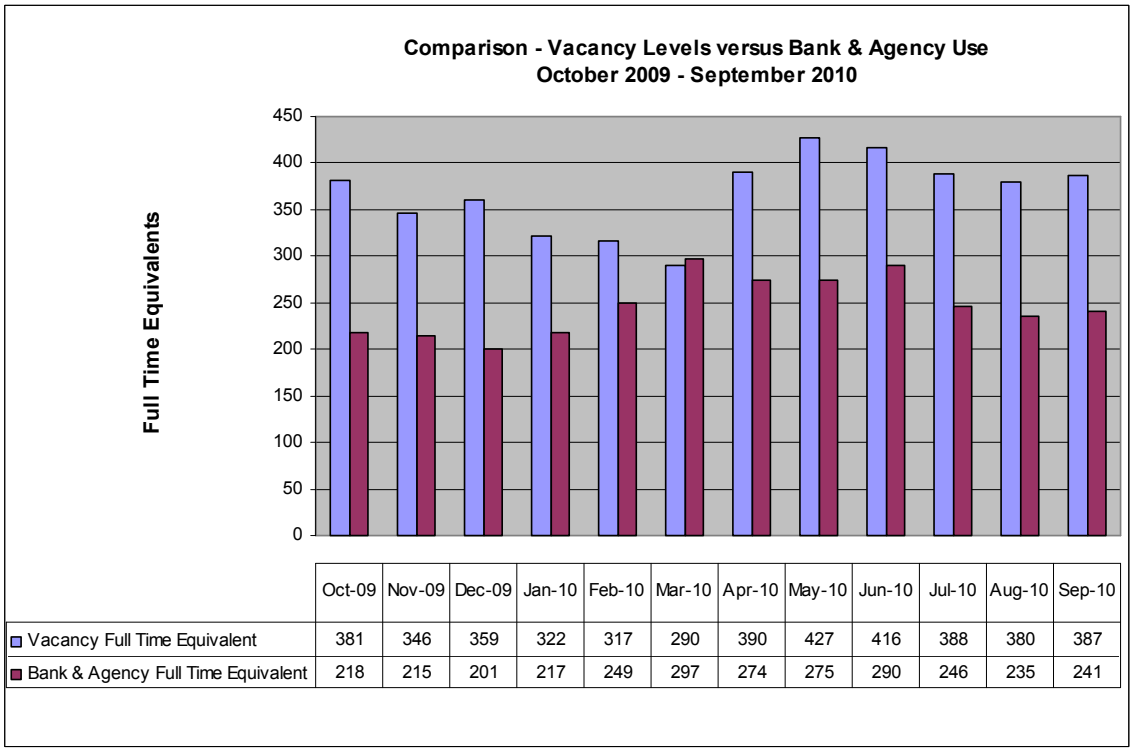
	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
Staff turnover*	8.40%	8.23%	8.20%	8.29%	7.90%	8.04%	8.56%	8.79%	8.60%	8.73%	8.17%	7.85%
Internal Turnover**	5.92%	5.91%	5.73%	5.69%	5.73%	5.34%	5.36%	5.30%	5.30%	7.59%	7.71%	9.72%
Public Sector Avg***	8.60%	8.60%	8.60%	8.60%	8.60%	8.60%	8.60%	8.60%	8.60%	8.60%	8.60%	8.60%

***Staff Turnover is calculated as the total number of people leaving the Trust divided by the average number of Staff in Post over a 12 month period**
**** Internal Turnover is calculated as the total number of staff transfers internal divided by the average number of Staff in Post over a 12 month period**
***** Public Sector Information taken from the CIPD Annual Survey Report 2010**

Appendix C

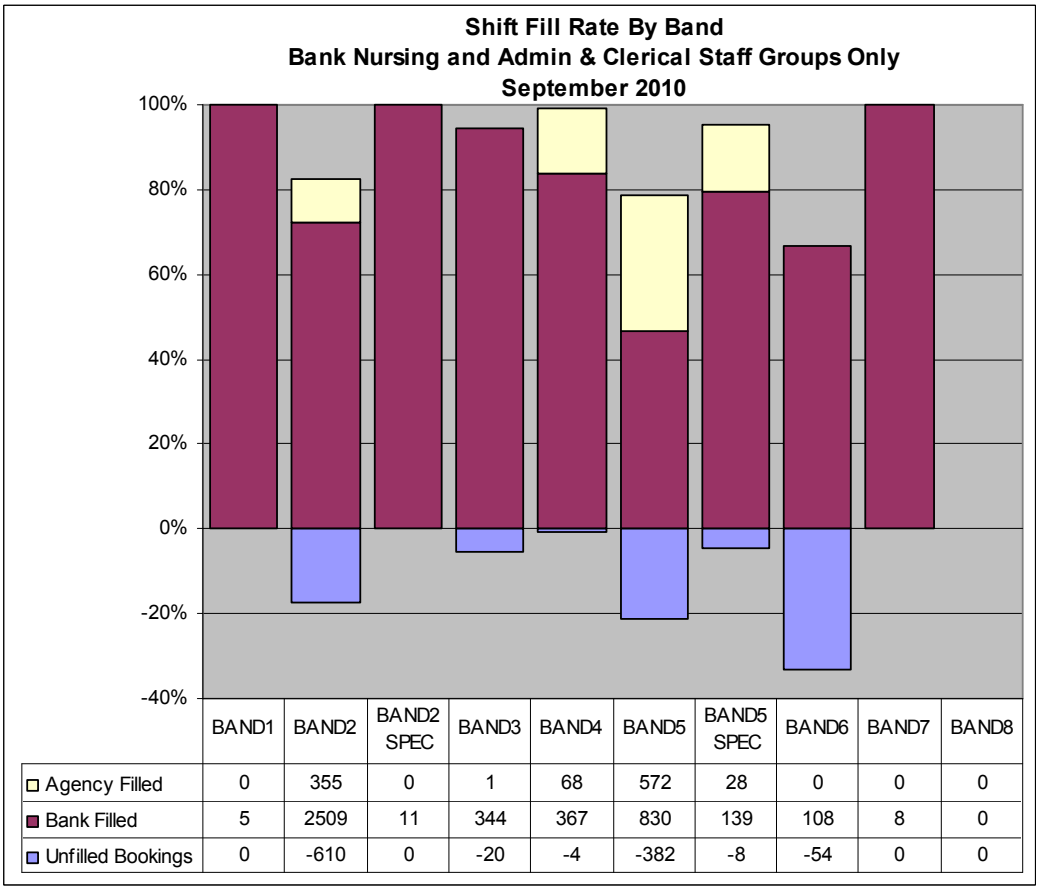


	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
Funded Full Time Equivalent	3884	3884	3884	3884	3884	3884	4024	4024	4024	4024	4024	4024
Actual Full Time Equivalent	3503	3538	3524	3562	3567	3594	3635	3597	3608	3636	3644	3637
Headcount	4176	4183	4203	4246	4252	4276	4277	4293	4310	4285	4295	4338



	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
Vacancy Full Time Equivalent	381	346	359	322	317	290	390	427	416	388	380	387
Bank & Agency Full Time Equivalent	218	215	201	217	249	297	274	275	290	246	235	241

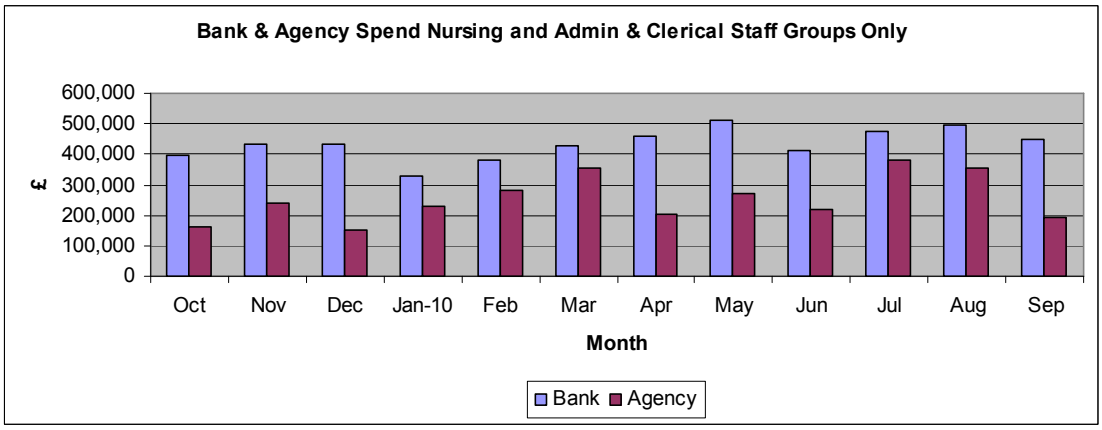
Appendix D



	BAND1	BAND2	BAND2 SPEC	BAND3	BAND4	BAND5	BAND5 SPEC	BAND6	BAND7	BAND8
Agency Filled	0	355	0	1	68	572	28	0	0	0
Bank Filled	5	2509	11	344	367	830	139	108	8	0
Unfilled Bookings	0	-610	0	-20	-4	-382	-8	-54	0	0

Booking Grade	Total Bookings	Unfilled Bookings	Bank Filled	Bank Filled Hours	Agency Filled	Agency Filled Hours	Fill Rate
BAND1	5	0	5	29	0	0	100%
BAND2	3474	-610	2509	18257.35	355	2569	82%
BAND2SPEC	11	0	11	72	0	0	100%
BAND3	365	-20	344	2381.5	1	7.5	95%
BAND4	439	-4	367	2468.75	68	502	99%
BAND5	1784	-382	830	6917.45	572	4451.95	79%
BAND5SPEC	175	-8	139	1024.75	28	267	95%
BAND6	162	-54	108	825.75	0	0	67%
BAND7	8	0	8	53	0	0	100%
BAND8	0	0	0	0	0	0	0%
Totals:	**6423**	**-1078**	**4321**	**32029.55**	**1024**	**7797.45**	**83%**

Appendix E


Bank & Agency Spend Nursing and Admin & Clerical Staff Groups Only
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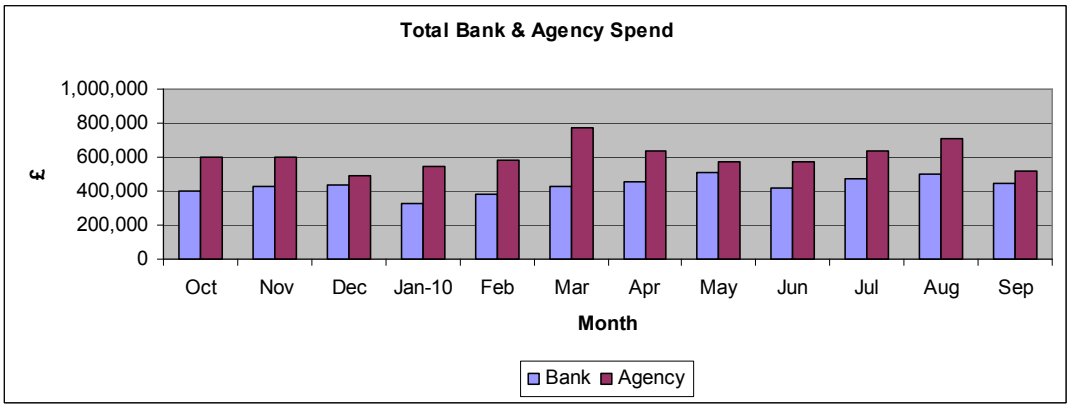
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8

Northampton General Hospital NHS
NHS Trust

From the office of Paul Forden
Direct Dial: 01604 545457
Direct Fax: 01604 545890
e-mail: paul.forden@ngh.nhs.uk

Cliftonville
Northampton
NN1 5BD
Switchboard: 01604 634700

Our Ref: PF/tr

Thursday 28 October 2010

Dear Colleague

Re: Annual Personal Development Review (Appraisal) and Personal Development Plans

My purpose in writing to you is to bring your attention to the importance of annual personal development reviews (PDR) and personal development plans (PDP) and to ensure that work is well underway to support this in all areas of the Trust. I would therefore ask that you please take the time to read this, as it is important to all of us.

We consider our staff at Northampton General Hospital to be our best asset but also our most expensive one so it is vital they perform to best effect in delivering our core aims. The way we ensure this is happening is through the annual personal development review and personal development plan process.

The PDR - appraisal process is based on a sensible conversation about how we need people to perform, how they are performing and how we are going to close any gap identified. It provides you as a manager with an opportunity to fully engage with your staff and for your staff to understand how their contribution can help the hospital function well for its patients.

Personal Development Plans are essential if we are to be able to respond to the development needs of our staff and to design appropriate learning and development programmes to support them in the workplace.

As a manager the approach you take to this process is critical as it must support an environment where staff feel engaged, valued and developed in order to effectively underpin the delivery of safe and excellent patient care. Aligning and measuring personal objectives against those of your department and ultimately the Trust are essential if we are to do this successfully. Reviewing past work, setting clear and agreed objectives for the forthcoming period and determining any gaps in skills or knowledge on the personal development plan are all key components of an effective appraisal process.

Managing staff through the PDR appraisal process is pivotal to moving the organisation into the leading role we all know and want for NGH. Our staff have the right to be properly appraised and supported in their jobs and it is your responsibility as a manager to deliver against this expectation.

As part of this expectation you will need to ensure that you and your managers are identifying when appraisal is due and that this process is being conducted in an effective and timely way.

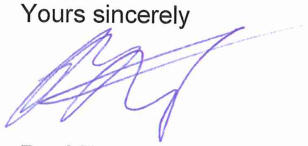
To ensure this is happening we will be collecting information and reporting on appraisal and personal development plan rates on a regular basis across the Trust. Please do your best to co-operate with any requests for information as we need not only to ensure that this process is fully embedded in the Trust but that we have the evidence to provide assurance this is happening.

In-house training is available for all managers and can be booked by calling x 5171 or emailing training@ngh.nhs.uk.

We have revised our PDR and PDP forms so that they are much more simple to complete, these forms together with guidance notes are attached to this email for you to download and use. The Training and Development intranet page, which will include a whole section on the appraisal process, is being updated but we will let you know when this is in operation.

Finally, embedding performance development reviews and personal development plans across the Trust is your responsibility; it relies on you and your commitment to do this. Please make sure you and your managers are playing a part in that process.

Yours sincerely



Paul Forden
Chief Executive

BOARD SUMMARY SHEET	
Title	Progress on Sustainability incorporating the Sustainable Development Action Plan
Submitted by	C Abolins Director of Facilities
Date of meeting	1st December 2010
Corporate Objectives Addressed	Objective 17. To demonstrate commitment to improving sustainability in all aspects of the Trust's core business in line with the NHS Carbon Reduction Strategy.

SUMMARY OF CRITICAL POINTS

- Following Board approval of the Sustainability Strategy the Sustainable Development Committee has now completed an action plan for the next twelve months to move the Sustainability agenda forward within the Trust.
- Attached also is a briefing paper on current sustainability issues.

PATIENT IMPACT -

STAFF IMPACT -

FINANCIAL IMPACT

EQUALITY AND DIVERSITY IMPACT -

LEGAL IMPLICATIONS -

RISK ASSESSMENT - :

RECOMMENDATION

- The Trust Board are asked to consider the attached papers, support the Action Plan and note the progress being made on sustainability matters.

PROGRESS ON SUSTAINABILITY
(Incorporating the Sustainable Development Action Plan)

Introduction

Following Board approval of the Sustainability Strategy on 28th April 2010, a Sustainable Development Committee has been established meeting bi-monthly.

A key focus for the committee has been to develop a Sustainable Development Action Plan for the next twelve months.

This is now complete and is attached for Board approval.

The Action Plan not only reflects the longer term aspirations of the strategy but also concentrates on laying firm foundations from which to move forward in a structured way.

It is important for us to understand how the Trust is performing, in relation to its carbon emissions, energy consumption, etc, on the basis that "If you can't measure it you can't manage it".

Therefore many of the actions within the plan relate to the establishment of accurate baselines and the development of realistic targets for improvements.

Another focus for the committee is to develop communication arrangements aimed at raising awareness of sustainability issues within the organisation as a first step to embedding sustainability into the way the Trust conducts its business.

Sustainability Launch

In order to heighten awareness within the Trust a "Suss out Sustainability" launch will take place on Thursday 2nd December. An information stand manned by Sustainable Development Committee members will be set up between 10.00am – 3.00 pm in Hospital Street, showcasing the different facets of sustainability.

There will be literature, fact sheets and promotional materials available including competitions to win an HP Netbook and sat nav. The launch will also be an opportunity to canvass staff for interest to become sustainability champions.

Following the launch there will be a quarterly programme of initiatives running throughout next year focusing on specific themes such as energy, waste and travel.

Appointment of Sustainability Manager

This position was advertised earlier in the year but unfortunately it was not possible to make an appointment.

The post has subsequently been re-advertised with interviews taking place in November.

I am pleased to inform the Board that an offer of employment has been made and it is anticipated that the successful candidate will take up her post early next year.

This will be a key position to enable the Sustainability agenda to move forward within the Trust.

Energy and C02 Savings

The Board will be aware that the Trust has borrowed £500k from the Salix Energy and Environmental Loan Scheme to invest in energy saving and carbon reduction technologies. This is an interest free loan with payback over a four year period.

A range of schemes have been identified and are progressing well, including replacement windows, energy saving light fittings, thermostatic radiator valves, insulation and heating controls.

We are confident that the investment will save £124k as well as reducing C02 emissions by 560 tonnes annually. The Facilities Directorate are currently working on proposals to access further funds in the New Year.

Carbon Reduction Commitment (CRC)

As a first step towards simplifying CRC Government have published a formal consultation to amend the CRC Energy Efficiency Scheme Order 2010.

Proposed amendments are primarily focused on extending the introductory phase and postponing the start of Phase 2 until 2013. A further update will be provided following completion of the consultation.

C. Abolins, Director of Facilities and Capital Development.

Northampton General Hospital NHS
NHS Trust

Sustainable Development Action Plan 2010/11

The following actions reflect the Trust's commitment to fully embedding sustainability into its activities and organisation. Responsibility for implementation will be allocated together with a realistic timescale. Progress will be monitored regularly via the Sustainable Development Committee and reported to the Trust Board, HMG and communicated to staff.

1. Governance and Responsibility

Aims	Ref	Action	Responsibility	By When
To ensure the Trusts commitment to sustainable development is reflected in management structure and accountability arrangements	1	Review and where appropriate update risk register to include Climate Change and Sustainable Development	All	Ongoing
	2	Agree Terms of Reference and Membership of Sustainability Group, set up programme of meetings.	CA	Completed
	3	Appoint to Sustainability Manager position	KH	Dec 10
	4	Sign up to Good Corporate Citizenship (GCC) and undertake regular self assessment	KH	Completed
	5	Agree performance measurement methodology against GCC, NHS Carbon Reduction Strategy, Carbon Management Programme and this SDAP	CA/KH	Jan 11
	6	Review and update existing environmental policy – clarify reporting responsibilities for sustainability matters	KH/CA	Jan 11

2. Compliance with Environmental Legislation

Aims	Ref	Action	Responsibility	By When
To ensure full compliance with all applicable environmental legislation and other requirements	1	Develop a full central register of environmental legislation applying to the Trust, to be updated regularly	Sustainability Manager	April 2011
	2	Audit compliance with environmental legislation to establish a baseline and develop priorities for action as appropriate	Sustainability Manager	June 2011

3. Energy Management

Aims	Ref	Action	Responsibility	By When
To reduce energy consumption and carbon footprint, in line with NHS targets	1	Confirm the Trusts current carbon footprint. Develop a baseline from which to measure progress.	KH	Nov 2011
	2	Agree appropriate energy and associated carbon reduction targets , which will meet the NHS Carbon Reduction targets	CA/KH	Dec 2011
	3	Reinvigorate energy awareness campaign using 'energy 'network and utilise the communications strategy to raise the profile of energy saving and sustainability	Sustainability Manager	Feb 2011
	4	Review and update Energy Policy	Sustainability Manager	Apr 2011
	5	Review potential for renewable energy installation at NGH	KH	Nov 2011
	6	Prepare for the implementation of the Carbon Reduction Commitment, including analysis of financial implications and reporting requirements	DS	Nov 2011
	7	Develop an energy reduction plan for 2011/12 and identify impact on Trusts carbon footprint	KH / Sustainability Manager	Feb 2011

4. Procurement

Aims	Ref	Action	Responsibility	By When
To embed sustainable procurement principles in specifications and procurement of goods and services on behalf of the Trust	1	Review Re:source sustainable procurement policy for Trust purchasing decisions and incorporate as appropriate into local Trust Policies	AR	Jan 2011
	2	Agree a long-term strategy to embed sustainable procurement principles within the Trust and its suppliers	AR	June 2011
	3	Conduct a Training Needs Analysis for procurement personnel to identify skills gaps relating to sustainable procurement. Develop appropriate training	AR	Dec 2010
	4	Review demand for individual suppliers services and investigate sustainable alternatives		On going
	5	Set guidance for Trust staff producing specifications to include sustainable procurement considerations	AR	Dec 2010
	6	Develop a Sustainable Procurement Policy. Communicate sustainable procurement policy and long term strategy to all relevant personnel including suppliers; specification writers; contract manager; stores departments and users	AR	Nov 2010
	7	Identify the impact on carbon footprint for 2011/12 of the above measures	AR / Sustainability Manager	Mar 2012

5. Travel and Transport

Aims	Ref	Action	Responsibility	By When
To ensure a co-ordinated approach to encouraging low carbon alternatives for all travel associated with Trust staff, patients, visitors and	1	Review and update green travel plan and associated policies Include consideration of carbon emissions and sustainable travel options for Trust business within travel plan	BW	Dec 2011
	2	Clarify the level of carbon emissions arising from staff commuting, patient and visitor travel to / from the Trusts sites, business travel etc to enable overall transport footprint to be determined	BW	Feb 2011

suppliers	3	Communicate travel strategy and policies to all Trust stakeholders and raise awareness of low carbon alternatives available to staff, patients and visitors travelling to site	BW	On going
	4	Implement review of business needs for Trust travel and available modes of transport considered to prioritise, where practical, low emission options	BW	May 2011
	5	Set appropriate targets to reduce Trust business travel and increase uptake of low carbon travel alternatives	BW	June 2011
	6	Work with local partners to determine low carbon travel options and where appropriate incorporate into the Trusts travel strategy	BW	On going
	7	Identify impact on Trusts carbon footprint for 2011/12	BW / Sustainability Manager	Mar 2012

6. Waste and Water Management

Aims	Ref	Action	Responsibility	By When
To reduce waste produced, waste sent to landfill and increase recycling rates across the Trust and to minimise water consumption on site	1	Set appropriate targets relating to reduction of waste to landfill and increasing recycling rates (both direct and indirect)	AW	Dec 2010
	2	Review opportunities for waste reduction and improved recycling across the Trust site	AW	Jan 2011
	3	Set targets on reduction of water consumption and installation of water efficient technologies	SF/KH	Feb 2011
	4	Review alternative sources of water provision eg bore holes and identify impact on Trusts carbon footprint	KH / Sustainability Manager	April 2011
	5	Review options available for water storage and recycling of greywater in relation to new building projects planned for NGH	AOD/KH	On going
	6	Identify waste and recycling programme and impact on Trusts carbon footprint for 2011/12	AW / Sustainability Manger	Feb 2011

7. Communications and Engagement

Aims	Ref	Action	Responsibility	By When
To ensure that staff, patients, visitors and local partners are made aware of NGH initiatives and Trusts commitment to sustainability	1	Develop a comprehensive Communications Strategy	SAW	Nov 2010
	2	Develop web communications to enable staff to access sustainability information via intranet and patients / visitors via Trust website	SAW	Dec 2010
	3	Engage as appropriate with local partners eg local authority to review strategic options for sustainability which may have mutual benefit	CA	On going

8. Finance

Aims	Ref	Action	Responsibility	By When
To embed 'Carbon Literacy' and analysis into Financial models and business plans	1	Finance department to routinely include 'whole-life analysis' in financial decisions / business cases and develop 'carbon literacy'	JD	On going
	2	Ensure a standard definition of sustainability is developed and understood for use across the Trust to incorporate financial, healthcare and environmental sustainability considerations	Sustainable Development Committee	Dec 2010
	3	Ensure that the financial implications of the Carbon Reduction Commitment (CRC) are fully understood and that a robust process for forecasting emissions is in place	DS/KH	Mar 2011
	4	Ensure that the CRC account is managed effectively and appropriate controls are in place	DS	On going

9. Organisational and Workforce Development

Aims	Ref	Action	Responsibility	By When
To ensure that all levels Of staff have the Appropriate Understanding, skills and accountability for support of and engagement with Sustainability strategy	1	Incorporate sustainability into the Trusts induction programme	CW	Dec 2010
	2	Ensure that all job descriptions reflect responsibility for sustainability	CW	Nov 2010 / Ongoing
	3	Embed sustainability delivery into managers appraisal framework	CW	Feb 2011
	4	Develop structure of Energy Champions into an effective network, and provide support, direction and accountability/reporting/feedback requirements	Sustainability Manager / SDC	Feb 2011

10. Building Design

Aims	Ref	Action	Responsibility	By When
To capture opportunities when designing new or refurbished facilities to reduce carbon intensity and create improved energy efficiency, waste and water management	1	Incorporate sustainability considerations and specifications into the design brief as standard for all projects	AOD/KH	Jan 2011 / On going
	2	Review existing buildings against BREEAM, and identify potential practical opportunities for improvement	AOD/KH	July 2011
	3	Include effect of climate change on design and operation of buildings in Risk Register where appropriate	AOD/KH	On going