UHN Boards of Directors (Part I)
Meetings in Public (KGH/NGH)

Fri 04 October 2024, 09:30 - 14:30

Boardroom, Kettering General Hospital

Agenda

09:30 - 09:30
0 min

1. Welcome, apologies and declarations of interest

Andrew Moore

- 1. UHN Boards Part I Agenda 041024.pdf (2 pages)

09:30 - 10:00
30 min

2. Patient Story - Gabriella's Story

Presentation *Julie Hogg*

10:00 - 10:05
5 min

3. Minutes of the previous meeting held on 2 August 2024 and Action Log

Decision *Andrew Moore*

- 3.1 240802 Draft Minutes UHN Public Part I Board of Directors meeting.pdf (11 pages)
- 3.2 Board Action Log Updated 240802 Part I Boards.pdf (1 pages)

10:05 - 10:20
15 min

4. Chair's report (verbal)

Information *Andrew Moore*

4.1. UHN/UHL Chief Executive's report (verbal)

Information *Richard Mitchell*

4.2. UHN Chief Executive's report

Information *Laura Churchward*

- 4.2 CEO update public board October 2024 - final (1).pdf (3 pages)

10:20 - 11:10
50 min

5. Integrated Governance Report and Board Committee Chairs' reports and

Assurance *Richard Mitchell / Executive Leads / Board Committee Chairs*

BREAK 11:00-11:10

- 5. Cover sheet_IGR.pdf (2 pages)
- 5.0 Group Upward Reporting to UHN 041024 Boards.pdf (13 pages)
- 5. Sep24IGR -compressed.pdf (115 pages)

11:10 - 11:20
10 min

6. Northamptonshire Integrated Care Board (NICB) Operating Plan 2024-25

Receive *Richard Wheeler / Polly Grimmett*

- 6. UHN Cover Sheet NICB 2425 Plan.pdf (2 pages)
- 6. Operational plan Final plan for UHN Boards 041024.pdf (6 pages)

11:20 - 11:30
10 min

7. Patient Safety and Incident Response Frameworks (PSIRF) (not received - withdrawn)

Hemant Nemade

11:30 - 11:45
15 min

8. Winter Plan

Decision *Sarah Noonan*

- 8. Board Winter Plan Cover Sheet 041024 Final (2).pdf (5 pages)
- 8. UHN Winter Plan_Oct 24.pdf (16 pages)

11:45 - 12:00
15 min

9. KGH Neonatal Unit Transition Plan

Assurance *Julie Hogg*

- 9. Board Neonatal unit transition plan October.pdf (3 pages)

12:00 - 12:15
15 min

10. Maternity Perinatal Dashboards

Assurance *Julie Hogg*

- 10. UHN PQSM Dashboards Front Page.pdf (3 pages)
- 10. Appendix 1 NGH PQSM Dashboard (Jul 24 Data) v2.pdf (9 pages)
- 10. Appendix 2 FINAL KGH Dashboard July 24 data for TB.pdf (5 pages)

12:15 - 13:30
75 min

11. Annual Report of the Northamptonshire Healthcare Charitable Fund and appointment of KGH Trustees

Presentation and Decision *Jonathan McGee, NHCF CEO*

LUNCH AND WARD VISITS 12:30-13:30

- 11. UHN Cover Sheet NHCF annual reports and Trustee appointments.pdf (2 pages)
- 11. NHCF Charity KGH NGH Board presentation deferred to 041024.pdf (9 pages)

13:30 - 13:45
15 min

12. Workforce Race and Disability Equality Reports (WRES / WDES)

Assurance *Paula Kirkpatrick*

12.1. KGH WDES

- 12.1 Final WDES KGH Report 2023-24.pdf (9 pages)

12.2. NGH WDES

- 12.2 Final WDES NGH Report 2023-24_.pdf (9 pages)

12.3. KGH WRES

- 12.3 Final WRES KGH Report 2023-24.pdf (11 pages)

12.4. NGH WDES

- 12.4 Final WRES NGH Report 2023-24.pdf (11 pages)

13:45 - 14:00
15 min

13. Freedom to Speak Up (FTSU) Reports: 2024-25 Quarter One

Assurance *FTSU Guardians*

- 13. Cover Sheet October 2024 Boards UHN FTSU Quarter 1 2425 Report (1).pdf (2 pages)
- 13. UHN FTSU Report quarter 1 2425 FINAL.pdf (7 pages)

14:00 - 14:10
10 min

14. Board Assurance Framework (BAF)

Assurance *Richard Apps*

- 14. Boards BAF Cover Paper_Oct24.pdf (2 pages)
- 14. Appendix A_ Group BAF_25SEPT24.pdf (15 pages)
- 14. Appendix B_Corporate risks aligned to BAF risks @ Sept 2024.pdf (2 pages)

14:10 - 14:15
5 min

15. Non-Executive Directors appointments to committees and lead roles

Decision *Andrew Moore*

- 15. NED and Committee appointments 041024.pdf (3 pages)
- 15. Appendix Committee allocations for Boards 041024.pdf (1 pages)

14:15 - 14:20
5 min

16. Integrated Leadership Team (ILT) Terms of Reference

Decision *Richard Apps*

- 16. ILT Terms of Reference cover.pdf (2 pages)
- 16. UHN_Integrated Leadership Team_Terms of Reference v1.2.pdf (6 pages)

14:20 - 14:25
5 min

17. Questions from the public

14:25 - 14:30
5 min

18. Any other business and close

University Hospitals of Northamptonshire NHS Group (UHN): Meeting in Public of the Boards of Directors of Kettering General Hospital NHS Foundation Trust (KGH) and Northampton General Hospital NHS Trust (NGH)

Meeting	Boards of Directors (Part I) Meeting in Public
Date & Time	Friday 4 October 2024, 09:30-14:30
Location	Boardroom, Kettering General Hospital

Purpose and Ambition
The Boards are accountable to the public and stakeholders; to formulate the Trusts' strategies; ensure accountability; and to shape the culture of the organisations. The Boards delegate authority to Board Committees to discharge their duties effectively and these committees escalate items to the Boards, where Board oversight, decision making and direction is required.

Item	Description	Lead	Time	Purpose	P/V/Pr
1	Welcome, Apologies and Declarations of Interest	Chair	09:30	-	Verbal
2	Patient Story – Gabriella's Story	Chief Nurse	09:30	Discussion	Presentation
3	Minutes of the Previous Meeting held on 2 August 2024 and Action Log	Chair	10:00	Decision Receive	Attached Attached
4	4 Chair's Report 4.1 UHN/UHL Chief Executive's Report (including Integrated Care Board) 4.2 UHN Chief Executive's Report	Chair Chief Executive Officers	10:05	Information Information Information	Verbal Verbal Attached
Operations					
5	Integrated Governance Report (IGR) / Board Committee Chairs' Reports	Chief Executive and Executive Directors / Committee Chairs	10:20	Assurance	Attached
	BREAK		11:00		
6	Northamptonshire Integrated Care Board (NICB) Operating Plan 2024-25	CFO / Director of Strategy	11:10	Receive	Attached
7	Patient Safety and Incident Response Frameworks (PSIRF)	Medical Director	11:20	-	Withdrawn

8	Winter Plan	Chief Operating Officer	11:30	Decision	Attached
9	KGH Neonatal Unit Transition Plan	Chief Nurse	11:45	Assurance	Attached
10	Maternity Perinatal Dashboards	Interim Chief Nurse	12:00	Assurance	Attached
Culture					
11	Annual Report of the Northamptonshire Healthcare Charitable Fund (NHCF) and appointment of Trustees	NHCF Chief Executive / Director of Corporate and Legal Affairs	12:15	Discussion and decision	Attached
	LUNCH AND WARD VISITS		12:30		
12	Workforce Race Equality (WRES) and Disability Equality (WDES) reporting: 12.1 KGH WDES 12.2 NGH WDES 12.3 KGH WRES 12.4 NGH WDES	Chief People Officer	13:30	Assurance	Attached
13	Freedom to Speak Up Reports (2024-25 Quarter One)	FTSU Guardians	13:45	Assurance	Attached
Governance					
14	Board Assurance Framework	Director of Corporate and Legal Affairs	14:00	Assurance	Attached
15	Non-Executive Directors: appointments to committee and lead roles	Chair	14:10	Decision	Attached
16	Integrated Leadership Team Terms of Reference	Director of Corporate and Legal Affairs	14:15	Decision	Attached
17	Questions from the Public	Chair	14:20	Information	Verbal
18	Any Other Business and close	Chair	14:25	Information	Verbal

Minutes of the Meeting

Meeting	Boards of Directors of the University Hospitals of Northamptonshire NHS Group (UHN) comprising Northampton General Hospital (NGH) and Kettering General Hospital (KGH) (Part I) Meeting together in Public
Date & Time	Friday 2nd August 2024, 09:30-12:30
Location	Creative Hub, Northampton University, Northampton

Purpose and Ambition
The Trust Board is accountable to the public, stakeholders and Council of Governors to formulate the Trust's strategy, ensure accountability and shape the culture of the organisation. The Board delegates the authority to Board Committees to discharge its duties effectively and these committees escalate items to the Board where Board decision making, and direction is required.

Attendance	Name and Title	
Present		
	Andrew Moore	Trust Chair, UHN
	Richard Mitchell	Chief Executive, UHN
	Richard Apps	Director of Corporate and Legal Affairs, UHN
	Natalie Armstrong	Non-Executive Director, KGH
	Polly Grimmett	Director of Strategy, UHN
	Julie Hogg	Interim Chief Nurse, UHN
	Sam Holden	Director of Communications and Engagement, UHN
	Jill Houghton	Non-Executive Director, UHN
	Paula Kirkpatrick	Chief People Officer, UHN
	Sarah Noonan	Interim Chief Operating Officer, UHN
	Trevor Shipman	Non-Executive Director, KGH
	Caroline Stevens	Non-Executive Director, NGH
	Becky Taylor	Director of Transformation and Continuous Improvement, UHN
	Damien Venkatasamy	Non-Executive Director, KGH
	Chris Welsh	Non-Executive Director, UHN
	Richard Wheeler	Chief Finance Officer, UHN
	Palmer Winstanley	Interim Chief Executive, NGH
In Attendance		
	Simon Baylis	Lead Governor, KGH
	Jonathan McGee	Chief Executive Northamptonshire Health Charity
	Yvonne Musademba	UHN Volunteer (Item 2)
	Mara Tonks	Director of Midwifery, KGH
	Mia Tysoe	Volunteer Services Administrative Officer, UHN (Item 2)
	Victoria Wallace	Deputy Trust Board Secretary, KGH

	Emma Wimpress	Head of Volunteer Services, UHN (Item 2)
Apologies for absence		
	Natasha Chare	Chief Digital Information Officer, UHN
	Alice Cooper	Non-Executive Director, KGH
	Stuart Finn	Director of Estates, Facilities and Sustainability UHN
	Denise Kirkham	Non-Executive Director, NGH
	Hemant Nemade	Medical Director, UHN
	Rachel Parker	Non-Executive Director, NGH
	Ballu Patel	Associate Non-Executive Director, KGH
	Elena Lokteva	Non-Executive Director, NGH
	Deborah Manger	Non-Executive Director, KGH
	Andre Ng	Non-Executive Director, NGH

Item	Discussion	Action Owner
1	**Welcome, Apologies and Declarations of Interest** The Chair welcomed colleagues to meeting and noted apologies for absence as listed above. There were no declarations of interest relating to specific agenda items. Prior to the commencement of the formal agenda, the Boards of Directors welcomed the Regional Organiser from UNISON, who addressed the Boards of Directors about the ongoing dispute in relation to Healthcare Support Workers. The Boards of Directors listened to and acknowledged the views provided by the UNISON representative who was invited to address the Boards of Directors. The Chief Executive provided an update to the Boards of Directors on the discussions that had taken place and were ongoing with UNISON representatives.	
2	**Patient and Staff Story: Volunteer's Story** Emma Wimpress, Mia Tysoe and UHN volunteer Yvonne Musademba were welcomed by members of the Boards of Directors to the meeting. They presented an overview to the Boards of the valuable work of the volunteers at both hospitals, the reasons why people chose to volunteer and highlighted the diversity of the volunteers. The Boards were informed of some of the initiatives introduced by the volunteer service, such as: • The Oncology Café which was run by the volunteers and had been supported by the Northamptonshire Health Charity. • The 'volunteer to career' programme which worked with the Kettering Department of Work and Pensions to support people to gain full time employment at Kettering General (KGH) Hospital and Northampton General Hospital (NGH). The Boards welcomed Yvonne Musademba who shared her experiences as a volunteer and spoke of the invaluable support she had	

	received from the volunteer team. She spoke of how volunteering had been an invaluable experience for her future career in the NHS where she was soon to start work as a Healthcare Assistant (HCA), and highlighted the invaluable work undertaken by the volunteers at both hospitals. The Chair thanked Emma, Mia and Yvonne for their presentation and members of the Boards commented on the contribution to, and dependence of, the trusts on the volunteers and how appreciated by the organisations they were. Board members noted and congratulated the volunteer service for recruiting such a diverse group of volunteers. The Chief People Officer of whose portfolio the volunteer service was part, spoke of how this service brought joy to her job and highlighted how the volunteer team flexed to accommodate the need and demand from different departments across the hospitals. She emphasised the team working of the volunteers with different departments and the learning that could be taken from the volunteer service in reaching such a diverse group of people.	
3	**Minutes of the last meeting held on 5 June 2024 and Action Log** The Minutes of the meeting of the Boards of Directors of Kettering General Hospital (KGH) and Northampton General Hospital (NGH) held on 5 June 2024, were approved as a correct record. The Boards received an update on outstanding actions from the Chief Finance Officer, who informed them of the following regarding salary overpayments: • Salary overpayment recovery averages were approximately 38% by value and 30% by volume. • 57% of current employees with an outstanding balance had deductions in July and the remainder had queries to be resolved or adjustments to be actioned. • Some high value cases had monthly deductions until 2027, 2028 and beyond. 27 employees had deductions up to 2025. The Chief Finance Officer informed the Boards that letters to budget holders would be issued shortly, to remind them of budget responsibilities.	
4	**Chair's Report** The Chair updated the Boards of Directors on the process to appoint to University Hospitals of Northamptonshire (UHN) Non-Executive Director roles. Appointments to these roles had been made subject to the approval of NHS England and the KGH Council of Governors. The Chair wished those who had not been appointed well with their future endeavours and thanked them for their contributions during their time as members of the KGH and NGH Boards of Directors. The Chair emphasised his expectation that the UHN Board of Directors would be a highly effective and high performing unitary board of directors that would focus on shaping and implementing the future strategy for UHN.	

	The Chair set out some rules by which he wanted members of the Board to abide which were to read the meeting papers, to turn up and contribute and to challenge each other and colleagues, including in areas that were not their specialism. The Chair emphasised the need for timely submission of Board papers by Executive Directors. The Chair emphasised the challenges and uncertainties that were faced by the organisations and that it was the Board's responsibility to prioritise actions with the greatest positive impact for patients and colleagues, to avoid being distracted by external factors over which there was little influence and to have the confidence to exercise judgement. The Chair highlighted the importance of ensuring good feedback mechanisms were in place from colleagues and patients. The Chair highlighted the following areas of focus which had been referenced at the UHL (University Hospitals of Leicester) Board of Directors meeting; he stated that UHN faced similar challenges, many of which could be addressed through collaboration: 1. The delivery of budgets for workforce and cost improvement programmes (CIPs), and the importance of collaboration. 2. Waiting lists and targets relating to this. 3. Patient experience. The need for having a good mechanism for understanding patient feedback and the importance of Board member walkabouts was highlighted. 4. The experience of colleagues. The importance was highlighted of demonstrating that action was taken in response to staff feedback. 5. The opportunity to work with the University of Leicester on education, training and coaching and the importance of attracting and retaining talent was highlighted. The Chair would be undertaking listening groups with staff and encouraged other Board members to do the same. 6. Internal and external collaboration. The Chair highlighted that feedback from committees should focus on the issues the Board needed to address. The Boards of Directors **NOTED** the Chair's report.	
4.1	**Chief Executive's Report** The Chief Executive thanked the University of Northampton for hosting the Boards of Directors meeting and presented his report which focussed on the opportunities for UHN to improve the hospitals as places to be treated and to work, highlighting culture change as a priority. The Chief Executive highlighted the following to the Boards of Directors: • The importance of communicating effectively with colleagues and to build confidence and clarity in what UHN was. • The launch of the NHS Staff Survey was expected later in September. • That despite close working with NHS and local authority colleagues, the Chief Executive was not confident that the local health system had a winter plan that enabled safe, timely and	

	affordable care. • The operational response to the HCA industrial action and the GP collective action. Jill Houghton thanked UHN colleagues for giving up their time to participate in the Pride March for Northampton. The Chief People Officer would provide the Chief Executive with the names of these staff so they could be written to and thanked. The Chief Finance Officer informed the Boards that he had taken part in the judging panel for the Staff Excellence Awards to shortlist nominations, over 800 of which had been received. The Chief People Officer and Interim Chief Nurse updated the Boards on the Health Care Support Workers' industrial action and the operational response planned for this. Health Care Support Workers' right to strike was recognised and work was being undertaken to ensure an agile and safe response to this. The Interim Chief Nurse informed the Boards that derogations had been requested but had been declined by UNISON however, direct contact to UNISON had been provided if difficulties were experienced. While this was a long period of action, the Interim Chief Nurse and Chief People Officer were confident that all steps were in place to keep the organisations safe. The Chief People Officer informed the Boards that all arrangements were being put in place to ensure colleagues who chose to strike were paid correctly. The Chief Executive highlighted that this was an important issue for the trusts but recognised the right to strike and supported colleagues who chose to do so. The Chief Executive informed the Boards that he had met with the unions several times. The Interim Chief Operating Officer updated the Boards on the preparation for the GP collective action and provided an overview of the anticipated potential impacts of this on the trusts. The Boards were informed that it was at the discretion of individual GP practices whether they participated in this action. An additional 130-170 attendances to Urgent and Emergency Care at both trusts were expected as a result of this. There had been an increased number of arrivals by ambulance of patients with lower acuity, which suggested the impacts were already being seen. The Boards were informed that there was no end date for this action and there was no national funding available for the response. The Boards **NOTED** the Chief Executive's report.	**PK**
5.	**Board Committee Summaries and Integrated Governance Report (IGR)** The Chief Executive invited committee convenors and executive leads to bring significant items and exceptions to the Boards' attention from the Integrated Governance Report, including performance variations set out within the document: *Finance and Investment Committee* In addition to the upward report, the Boards were informed that:	

	- The committee had requested a further report to provide an update on the progress on the savings plans. - Challenges, concerns and risks regarding the deficit and the delivery of the efficiencies plan were highlighted. Noting that 45% of the planned deficit had already been incurred at Month 3, the committee sought more assurance on the efficiencies plan, the actions being taken against items of limited assurance and dates for delivery of the plan. The Northamptonshire Integrated Care Board (ICB) had been asked to provide clarity on the delivery of plans to NHS England by 14 August 2024. - An overview of the work to deliver efficiencies was provided. Based on current run rates and industrial action adding to the risks, the Chief Finance Officer advised that the risk to delivering the plan was significant. - The People Committee had had an in-depth discussion regarding financial controls in relation to the workforce. A report on improvement plans and trajectories would be presented to both the Finance and Investment and People Committees. - The need to deliver the cost improvement plan in a safe manner was highlighted. *Audit Committees* The Boards were informed that: - NGH accounts had been submitted on 19th July 2024. - Limited assurance was noted in relation to the KGH annual report and accounts, which were close to completion but not yet ready for submission. The Chief Executive was keeping the ICB updated on this. A lessons report would be produced and presented to the KGH Audit Committee and the Board of Directors was assured that the trust would not be in this position again next year. *People Committee* The Boards were informed that: - In addition to having a robust conversation about finances, the committee had focussed on culture and the key issues being addressed by the organisation in relation to this. - An independent review of the safer staffing nursing care tool had been commissioned by the Interim Chief Nurse. - Speaking Up was escalated to the Boards following reports received by the committee which had indicated that there were more people wishing to speak up anonymously. Freedom to Speak Up guardians felt that there was a fear of detriment and lack of confidence that the organisation would respond to issues being raised by those speaking up. This issue had been reflected in the staff survey results. The executive lead for Freedom to Speak Up informed the Boards that the staff survey was being reviewed and consideration was being given to the communication of the purpose of Freedom to Speak Up. A UHN model for Freedom to Speak Up and improving colleagues' confidence	

	in this was being worked on. The Chair would be contacting other high performing organisations to discuss good practice in this area. The convenor of the UHN Clinical Quality and Safety Committee requested that any Freedom to Speak Up quality issues were reported to this committee. The Boards of Directors would receive an update on the work of the Freedom to Speak Up team and the plan to strengthen this function and staff members' confidence in it, at its October 2024 meeting. *Clinical Quality and Safety Committee* The Boards of Directors were informed that the committee had: - Received two patient stories; the first from a patient who was deaf and the second was a carer's experience of using the Call 4 Concern service. The committee commended both stories to the Boards. - Received upward reports from 14 subgroups containing 72 items. Items of limited or no assurance had been discussed by the committee. The committee's convenor drew the Boards' attention to the following: - Four 'never' events across UHN had been reported to the committee as matters of urgent business; two 'never' events had occurred in Ophthalmology. All four events were under investigation. - Several actions had been taken to resolve the issue previously identified with the Transient Ischemic Attack service at KGH. The backlog of patients awaiting an appointment had reduced significantly and all new patients referred to the service were offered an appointment withing 24 hours. - The committee had noted with concern action being taken in the maternal medicine pathway which affected a small cohort of women with specific and complex conditions. These women received treatment at Oxford, which had advised it would no longer provide this service because a commissioning agreement was not in place. - The KGH neonatal unit would not move to a level two service on 1st September 2024 and remained a work in progress with relevant assurances to be provided. - The action plan following the KGH Care Quality Commission (CQC) report published in May 2024, was under development. - The papers for the two meetings being reported to the Board, amounted to 1295 pages in 106 documents; a situation which could not continue. A review of what and how subjects were reported and discussed at this committee was required. *Operational Performance Committee* The committee's convenor highlighted the following to the Boards of Directors: - Concern regarding the lack of a system wide winter plan and lack of an action plan following the Urgent and Emergency Care Summit which had taken place in July 2024. - The committee had received an in-depth review of super-stranded	

	patients, an item which had been referred to the committee by the Clinical Quality and Safety Committee in Common. It was noted by the committee that 50% of super-stranded patients were not medically fit for discharge. - The importance of the interface and relationship with partners was highlighted by the committee. *UHL/UHN Partnership Board (Committee)* The committee: - Had considered a report setting out the drivers for collaboration, acknowledging further work was required to articulate vision and objectives. - Had endorsed and recommended approval of the terms of reference and collaboration agreement. - Had received a paper setting out progress and success against eight key collaboration workstreams during 2024-25 including examples of shared learning and joint work on tackling racism and sexual safety, mutual aid between the trusts and progress towards the appointment of an Associate Director of Research and Innovation. Medium- and longer-term outcome measures needed to be identified and evidenced. - Had considered the development of a Clinical Services Strategy which aligned with the trusts' strategies that focussed on delivering a high-quality strategy, financially viable care, research and education. The Boards **NOTED** the IGR and committee summaries.	
6.	**Continuous Improvement Strategy** The Director of Continuous Improvement presented the UHN Improving Together Strategy which had been considered and endorsed by the UHN Clinical Quality and Safety Committee. An overview of the work undertaken to develop the strategy was provided. A launch event was planned for 19th August 2024. Board members were keen to see results and progress sooner than five years and highlighted the need for a culture of empowerment rather than one of asking for permission. The Boards queried how the impact of the strategy would be measured. The Boards of Directors **APPROVED** the UHN Improving Together Strategy.	
7.	**Annual Report of the Northamptonshire Healthcare Charitable Fund (NHCF) and appointment of KGH Trustees** This item was deferred to the next meeting.	
8.	**Use of the KGH Trust Seal** The KGH Board of Directors **NOTED** the use of the Trust Seal in	

	respect of the Licence to undertake alterations to Nene Park Outpatients on 3rd July 2024, affixed by the Group Company Secretary in the presence of the Director of Estates, Facilities and Sustainability.	
9.	**Review of implementation of revised governance operating model** The UHN Director of Corporate and Legal Affairs presented the review of the implementation of changes to the UHN governance operating model following three months' operation and highlighted the following to the Boards: - An informal monthly meeting between Non-Executive Director committee convenors had been introduced to discuss items that crossed the span of committee terms of reference. - Auditors supported the recommendation to enable audit committees to meet in common from a point at which they felt confident to do so. Members of the Boards queried which committee should have oversight of the digital roadmap which was previously within the remit of the Digital Hospital Committee. Consensus was that this best sat with the UHN Operational Performance Committee; however, overlap with some of the other committees' terms of reference was acknowledged. The Integrated Governance Report (IGR) was discussed. It was highlighted that some of the improvements and changes to be made to the IGR relied on the data warehouse and others were dependent on an improvement in the commentary accompanying the data which the Chief Executive assured the Boards would change by October 2024. The Boards of Directors **APPROVED** the recommendations that: 1. Committees' Terms of Reference be amended to reduce Non-Executive membership to two UHN NEDs per committee. 2. Audit committees meet 'in common' from September 2024, with the option for trust-only committees to convene extra meetings if required, retaining membership of three NEDs in accordance with Code of Governance requirements. 3. The changes implemented in April 2024 should be retained for a further review at six months, at which points Boards could expect to be able to identify specific case studies of added value. 4. NHS England be requested to carry out an external review by way of follow up to its previous review of collaboration governance arrangements for UHN and UHL, to inform the six-month reviews. 5. Board colleagues who had yet to do so, attend the Committee Masterclass facilitated by NHS Providers, taking place in November 2024 (date to be confirmed). 6. Board committees to receive, analyse and act upon specific feedback from the three-month reviews, including an integrated review of executive membership. 7. The Integrated Leadership continued to review its effectiveness and to provide a forum for triangulation of key items discussed at Board Committees. 8. The results of the six-month review to be reported to the Boards of Directors meeting in December 2024.	

	In addition, the Boards of Directors **AGREED** to delegate authority to the Chair to confirm the appointment of Non-Executive Directors to committees, on conclusion of the current recruitment and selection process to UHN Non-Executive Director roles.	
10.	**UHN/UHL Partnership Joint Committee** **10.1 Terms of Reference** The Boards of Directors considered and **APPROVED** the revised terms of reference which: 1. Renamed the body to the UHN/UHL Partnership Committee 2. Strengthened and confirmed references to 'collaboration', and 3. Reduced non-executive membership to the Trusts' Chair, UHL and UHN Vice-Chairs. **10.2 UHN/UHL Collaboration Agreement** The Boards of Directors considered and **APPROVED** the final draft Collaboration Agreement with the University Hospitals of Leicester NHS Trust (UHL). This set out the overarching framework for collaboration between the partners building on work undertaken to date and set out: - The vision, collaborative purpose, objectives and priorities of the Collaborative, and - The governance structure established by the partners to enable them to come together to make informed and binding decisions in identified areas.	
11.	**Maintaining focus and oversight on quality of care and experience in pressurised services** The Boards of Directors considered the report which provided assurance that sufficient actions were taken and there was effective oversight to address quality and safety issues within the trust during times of pressure. The Boards of Directors were informed that: • There was a gap in the review and oversight of the seven-day services audit which was planned to be reviewed by the divisions and reported into the Clinical Quality and Effectiveness Group. • Work was ongoing as part of the UHN collaboration to strengthen the quality assurance framework across the organisation. During its discussions relating to this item, Board members highlighted the following: • Consistency of and capturing feedback from Non-Executive Director walkarounds needed to be improved. It was suggested that the feedback form used by NEDs undertaking visits at KGH could be used for visits at NGH. The organisation of visits and process of capturing feedback would be considered by the Interim Chief Nurse. • The challenges and pressures staff faced; it was highlighted that these were system and not staff issues. • While the cost and productivity of care was focussed on, it was suggested that the volume of care provided also needed to be	**Julie Hogg**

	considered. It was highlighted that there was constant demand for provision of more volume of care at a fixed cost. • The bed deficit was highlighted as a significant concern. Admission avoidance schemes, preventative measures and more emphasis on pre-hospital and out of hospital services were needed to prevent patients having to access treatment in an acute setting and to reduce the demand for beds. • The need for a system plan for winter and a longer-term plan for urgent and emergency care was highlighted. The Boards were informed that UHN had a plan for the provision of more beds this winter and the intention was to develop a system winter plan by September 2024. This would be discussed at the October Boards of Directors meeting. The UHN Operational Performance Committee would have oversight of this plan and would receive updates on this and the situation in relation to the bed deficit. The Boards of Directors: 1. **RECEIVED** the update, noting the actions being taken across UHN. 2. **NOTED** the two areas for action and **APPROVED** the monitoring of the actions through the Clinical Quality and Safety Committee in Common.	
12.	**Questions from the Public** There were no questions from the public.	
13.	**Any other business and close** The Boards of Directors thanked Sam Holden, Interim Director of Communications and Engagement, whose last Boards of Directors meeting this was, for all the work that he had done and wished him well for the future.	

Action Log

Meeting	Boards of Directors (Part I) Meeting in Public
Date & Time	Updated following 2 August 2024 meeting

Minute Ref.	Action	Owner	Due Date	Progress	Status
Feb 24 5(ii)	The Board welcomed progress with the head and neck collaboration and invited service representatives to address a future meeting to celebrate progress and identify challenges and learning for future clinical collaborations.	HN	Dec 24	Deferred: Patient/Staff Story on this topic requested for a forthcoming Boards' meeting	OPEN
Aug 24 4	Names of staff who had supported Northampton Pride march to be provided for Chief Executive to write letters of thanks.	PK	Oct 24	Chief People Officer to confirm completion	OPEN
Aug 24 11	Consider process for capturing feedback from Non-Executive Director visits.	JH	Oct 24	Visits to take place between Board meetings from October 2024; Chief Nurse to outline process	OPEN

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Cover sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	4th October 2024
Agenda item	4.2

Title	Chief Executive's report (CEO)
Presenter	Laura Churchward UHN CEO
Author	Laura Churchward UHN CEO

This paper is for			
☐ Decision	☐Discussion	✓ Note	☐Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Group priority				
✓ Patient	✓ Quality	✓ Systems & Partnerships	✓ Sustainability	✓ People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
For the Boards' information.	None
Executive Summary	
This report is an update for August and September 2024 on the University Hospitals of Northamptonshire NHS Group from the new UHN CEO.	
Appendices	
None	
Risk and assurance	
Information report – no direct implications.	
Financial Impact	
There is no financial impact	
Legal implications/regulatory requirements	
There is no legal impact	
Equality Impact Assessment	
Information report – neutral	

Welcome

This meeting marks my first as Chief Executive of University Hospitals of Northamptonshire (UHN). I am so pleased to join the Boards - and the wider UHN organisation - and I look forward to meeting many of our staff and the individuals who use our services in my initial months.

As some of you may know, this is my local NHS Trust and I am passionate about providing the highest quality healthcare for the people of Northamptonshire, despite challenging circumstances. Thank you to everyone who has welcomed me into the organisation thus far.

I'm pleased to announce several new appointments (and one return) to our executive leadership team at UHN during my first Board meeting:

Group Chief Digital Information Officer
I am delighted to welcome Will Monaghan as our Group Chief Digital Information Officer to his first board(s) meeting. Will intends to improve digital services and data initiatives across both University Hospitals of Leicester and University Hospitals of Northamptonshire, working at scale to enhance the experience for staff and patients alike.

UHN Chief Operating Officer
In August, Sarah Noonan was appointed as our substantive Chief Operating Officer (COO) following a competitive recruitment process. Sarah has already made a significant impact since joining us in January 2024 as interim COO and I am thrilled to have her on board permanently as we prepare our hospitals for winter 2024/25.

UHN Director of Communications
I'd also like to welcome back Suzie O'Neill to our executive team following her maternity leave. I very much look forward to working with her.

Finally, I want to extend my gratitude to Sam Holden for his contributions to UHN over the past year. His energy and enthusiasm have been greatly appreciated, and I wish him all the best in his next role.

Great Place to Receive Care

GIRFT Programme
The Getting It Right First Time (GIRFT) programme is a national initiative aimed at enhancing patient care. In January, UHN joined the "Further Faster" programme to rapidly transform our services and reduce waiting lists. We have received positive feedback from Professor Tim Briggs, the National Chair of the GIRFT programme, regarding our progress in improving elective care pathways over the past six months. In September, we held our first UHN-wide GIRFT workshop, bringing together clinicians and management teams from six specialties to share insights. I am keen to hear further updates from the surgical teams as I get to know the organisation.

Improving Together
In August, we launched our "Improving Together" initiative across UHN, showcasing quality improvement (QI) projects from both hospitals. Over two days, more than 300 attendees learned about our ongoing efforts in clinical and corporate areas. On October 1st, we kick off "Improving Tuesdays" to highlight these projects. I look forward to collaborating with the team to drive improvements across all our services.

Hand Therapy Team Shortlisted for HSJ Award
The NGH Hand Therapy team has been shortlisted for an HSJ Award in the "Towards Net Zero

Award” category, recognizing their commitment to supporting patients while reducing carbon emissions. The ceremony will take place in November, and I wish the team the best of luck.

Working within our Communities

Spinney Fields
I want to thank all the staff involved in establishing the Spinney Field Specialist Care Centre in August. This facility, created in partnership with North Northamptonshire Council, will provide vital rehabilitation and support for patients before discharge. This will be a significant benefit to patients in Kettering and the wider geographical area.

Community Diagnostic Centres (CDC)
We have now started the construction of two Community Diagnostic Centres in Corby and Kings Heath, Northampton. Many local residents joined us to witness the arrival of the modular units, which are now being installed. These centres will offer a range of diagnostic tests (such as MRI and CT) closer to those who need convenient access.

Great Place to Work

Ensuring our hospitals are the best place to work is a top priority for me as Chief Executive. I look forward to launching the NHS national staff survey on October 7th to gather insights on what our team values about working at UHN and where we could do better for our teams.

National Recognition at EDI Awards
In August, it was announced that six colleagues and two teams from UHN reached the finals of the National Black, Asian and Minority Ethnic (BAME) Health & Care Awards, which is a fantastic achievement. Well done to all.

UHN Excellence Awards
In September, we celebrated the annual UHN Excellence Awards, receiving a record number of nominations. Congratulations to all who were nominated and to those who won in their categories.

Looking to Our Future

Much has been accomplished at UHN in the first half of the year, but I know that we face ongoing challenges particularly in balancing financial pressure and operational performance. In the latter half of the year, we will focus on two key priorities for 2024/25:

- Delivering the safest possible care for our patients
- Meeting our financial forecasts

It is also my intention to ensure UHN is an outstanding place to work for our staff. Without our teams, we will not achieve these priorities.

Once again, thank you to everyone for the warm welcome I’ve received thus far. I look forward to getting to know both Kettering and Northampton Hospitals and building on the significant progress that has been made to bring the teams together under the UHN umbrella.

Cover sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	4 October 2024
Agenda item	5

Title	Board Committee summaries and the Integrated Governance Report (IGR)
Facilitator	Richard Mitchell, UHN/UHL Chief Executive
Author	Richard May, UHN Company Secretary

This paper is for			
☐ Approval	☐Discussion	☐Note	✓ Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Group priority				
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Reason for consideration	Previous consideration
The Integrated Governance Report (IGR) provides a mechanism to provide a holistic overview to both KGH and NGH's performance to support overarching governance of the respective boards in promotion of	The IGR is produced on a monthly basis and is presented at each public Board on a bi-monthly basis.

assurance and continuous improvement. Board Committee summaries enable the Boards of Directors to be assured around organisational performance on an exception reporting basis. Committee Chairs and Executive Leads will be invited to draw the Board's attention to other significant items considered at meetings, indicating the degree of assurance the committee is able to provide in each case.	

Executive Summary

Board Committee summaries and the Integrated Governance Report for August - September 2024 are enclosed. Committee Chairs and Executive Leads will be invited to draw the Board's attention to other significant items considered at meetings, indicating the degree of assurance the committee is able to provide in each case.

Board Members' attention is drawn to an accompanying note setting out the purpose and objectives of the IGR and Committee summaries, which is available in the 'documents' section of the Board portal.

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Appendices

Board Committee Summaries, August - September 2024
Integrated Governance Report, September 2024. Board Members' particular attention is drawn to the following Committee cover sheets:

- Clinical Quality and Safety (page 5 of 115)
- Finance and Investment (page 41 of 115)
- Operational Performance (page 56 of 115)
- People (page 100 of 115)

Briefing note (documents section of Board portal only)

Risk and assurance

The appendices provide key controls and assurances to inform the effective management of strategic risks, set out in the Group Board Assurance Framework.

Financial Impact

No direct implications relating to this assurance report.

Legal implications/regulatory requirements

No direct implications relating to this assurance report.

Equality Impact Assessment

Neutral

BOARD COMMITTEE SUMMARIES

University Hospitals of Northamptonshire Boards of Directors Meeting: 4 October 2024

AGENDA ITEM 5

Operational Performance Committee: 22 August and 20 September 2024

Clinical Quality and Safety: 28 August and 25 September 2024

Audit Committees: 29 August (KGH only) and 2 September 2024

Finance and Investment Committee: 24 September 2024

People Committee: 26 September 2024

UHN Operational Performance Committee Upward Report to Board of Directors	Date of reporting group's meeting: 22nd August 2024		
Reporting Non-Executive Director: Trevor Shipman			
Agenda Item	**Description and summary discussion** **The committee:**	**Decision / Actions and timeframe**	**Assurance level ***
Operational performance	Noted: 1. The trusts' performance remained strong compared to regional peers in key performance areas. There were no 78-week breaches in July, the target was expected to be met in August. The Trusts had the 2nd lowest number of 65-week waiting patients in the region (366). The trusts had the lowest number of 52 week waiting patients (1670) and 62+ day waiting cancer patients (233), and the highest RTT performance in the region (64.5%). Patients are moving between sites to where the capacity is and have been receptive to this, with good support provided by clinicians. 2. Diagnostics was showing good improvements in performance and reduction in backlogs with the best DM01 in the region. NGH was already hitting the diagnostics target and work was being done with NGH colleagues and the community diagnostic centres to improve 3. Positive news of the opening of Spinneyfields for 29 patients. 4. Emergency Department performance remained challenging with both sites' occupancy over 98%. 5. Super stranded numbers at NGH remained high with challenges relating to adult social care. Despite ongoing challenges, the committee was substantially assured by the actions being taken, collaborative working and the awareness of the ongoing issues evidenced during the committee's discussions.	-	Substantial
NGH Emergency Department & Urgent Treatment Centre Reporting Position	Noted a detailed update on the NGH ED and Urgent Treatment Centre reporting position following a change to the national reporting of the 4-hour ED target. Considering the work being done to resolve this issue and the options presented, the committee confirmed its reasonable assurance on this issue.		Reasonable
Health Intelligence Update	1. Noted good progress on the health intelligence/data warehouse project which was in phase II and progressing at pace. This work would enable effective monitoring and assurance on operational performance through robust metrics and dashboards. 2. Noted that the programme was on track and the first drop of data is expected in mid-September.		Reasonable

UHN Operational Performance Committee Upward Report to Board of Directors	Date of reporting group's meeting: 22nd August 2024
Reporting Non-Executive Director: Trevor Shipman	

Agenda Item	Description and summary discussion **The committee:**	Decision / Actions and timeframe	Assurance level *
Federated Data Platform	Received an update on the federated data platform which has supported improvement on the elective care pathway and for which UHN is a national incubation site.		n/a
Elective Productivity Dashboard	Was updated on the development of an elective productivity dashboard to provide visibility to services of metrics to enable data led decision making and improvement plans. This is on schedule for delivery by the end of August 2024. Roll out to all divisions and specialities will follow.		n/a

UHN Operational Performance Committee Upward Report to Board of Directors	Date of reporting group's meeting: 20th September 2024		
Reporting Non-Executive Director: Trevor Shipman (Convenor)			
Agenda Item	**Description and summary discussion** **The committee:**	**Decision / Actions and timeframe**	**Assurance level ***
Operational Performance	Noted continued good performance in key performance areas: 1. There had been no 78-week breaches for UHN in August. 2. UHN had the lowest number of 65-week cohort waiting patients in the region (537 patients), the lowest number of 52 week waiting patients in the region (1585 patients) and the lowest number of 62+ waiting cancer patients in the region (237 patients). 3. UHN had the highest referral to treatment (RTT) performance in the region at 63.3%. 4. There has been an improvement in diagnostics with a reduction in backlogs with the best CM01 in the region at 12% or 88% less than 6 weeks. Noted that while UHN performance is better than peers, patients are still waiting too long for their treatment and work continues, to improve this. Noted that the target of achieving zero 65-week breaches by 30th September is a significant challenge.		Substantial
Winter plan	1. Noted the winter plan which is scheduled for discussion by the Boards of Directors. The Operational Performance Committee will have continuous oversight of the implementation of the plan via the monthly reporting from the Chief Operating Officer. 2. Noted that a UHN Urgent and Emergency Care Steering Group has been set up with workstreams focussing on admissions avoidance and reducing demand.	On Boards' agenda	Reasonable
Cancer 62 day standard	1. Considered a detailed review of the cancer performance across UHN with respect to the 62-day standard whereby 70% of patients should start treatment for cancer within 62 days of referral. 2. Noted that compared to the Midlands region, UHN is the best performer with the smallest backlog of patients waiting more than 62 days for treatment. 3. Noted that both trusts are continuing to develop best practice pathways for patients developing new roles to expedite the patients' progress through the diagnostic pathway to treatment. 4. Noted that Urology and lower GI are the main areas of challenge for UHN however, UHN is providing mutual aid to the region for robotic prostatectomies, which is adding to the backlog as these patients are referred with significant delays.		Substantial

UHN Finance and Investment Committee Upward Report to Boards of Directors	Date(s) of reporting group's meeting(s): 24 September 2024		
Reporting Group Chair: Damien Venkatasamy			
Agenda Item	**Description and summary discussion**	**Decision / Actions and timeframe**	**Assurance level ***
Finance Report M5	UHN budgeted for a £29.1m deficit by month 5 (£14.1m KGH, £15.1m NGH) and was reporting a £38.3m deficit (£17.7m KGH, £20.6m NGH) £9.1m worse than plan (KGH £3.7m, NGH £5.5m). The Committee discussed the UHN Weekly Deficit Recovery Actions which were detailed in appendix 2 of the report to bring down the UHN deficit to £80-88m (from the unmitigated full year deficit of £102m). The pay award impact would be reflected in month 6 reporting and would be processed in October pay. Confirmation had just been received that the £50m deficit target set for the system will now be funded. The distribution of this funding is being finalised but is likely to result in and additional £32.9m of cash payment in October (KGH £16.3m, NGH £16.7m) requirements but it is likely to mean the forecast receipt of revenue support for October will not be required. The Committee agreed for a monthly trajectory forecast to be included in the finance report until year end.	Financial recovery report on Private agenda 4/10/24	To be advised
Temporary Staffing Update	The Committee received an update from HR on temporary staffing. Key areas to note was that both Trusts were above national cap, however NGH was on a downward trend. KGH had fluxes upwards/downwards and this was being explored.	-	To be advised
Annual Plan Efficiencies – Delivery plan for 2024-25	To date £26.6m schemes have been identified, costed and worked up, with a further c.£4m expected from the work to reduce the headcount by 180 FTE, and a further £2.9m in the pipeline. Currently identified with worked up bottom-up plans was 73% of the total target, which rises to c.80% of the target if the pipeline is included. The biggest challenge would be month 6 as the Trusts approached the winter period.	-	To be advised

KGH Audit Committee Report to the Boards of Directors	Date of reporting group's meeting: 29 August 2024

Reporting Director: Alice Cooper (Chair)

Agenda Item	Description and summary discussion	Decision / Actions and timeframe	Assurance level
Audit Findings Report (AFR) 2023-24 (draft)	The Committee received the draft AFR and discussed the findings within it and timetable for completion, including proposed management responses. These would form the basis for an action plan, which would be submitted to a future Committee meeting.	November 2024	-
KGH Annual Report and Accounts 2023-24	The Annual Report and Financial Statements 2023-24 were recommended for **approval** by the Board of Directors, subject to clarification of a number of issues (non-material) which would require delegated authority from the Board. The Committee indicated concern and the delays to the production and audit of the annual accounts and requested learning to prevent future recurrences. The delays were largely attributable to capacity and succession planning issues within the finance team, and the committee requested that a full lessons learnt exercise be conducted by the Chief Finance Officer and shared at the earliest opportunity.	Approved by the Board, 29 August	-

KGH/NGH Audit Committees Upward Report to Boards of KGH & NGH	Date of reporting group's meeting: 2 September 2024

Reporting Chair: Alice Cooper

Agenda Item	Description and summary discussion	Decision / Actions and timeframe	Assurance level *
Internal Audit	The Committees received completed internal audit reports and received additional assurances regarding the deliverability of 2024-25 work plans due to concern at the concentration of completion dates towards the end of the financial year. The Committees expressed concern regarding the Dedalus LIMS implementation (NGH) audit which, given the lack of management responses, gave rise to an indicative finding of 'no assurance'. There were significant issues affecting implementation across a number of providers, and a regional partnership board was in place to work with the supplier to resolve the issues.	N/A	Reasonable
Anti-Financial Crime	The Committees received reports detailing activity against agreed counter fraud annual work plans. The Committees indicated 'reasonable' assurance in respect of the delivery of the annual plan, requesting adjustments to performance indicator reporting methodology and presentation to provide more meaningful and contextual information.	N/A	Reasonable
Financial Governance	The Committees reviewed the NGH Financial Governance report, noting with concern that the KGH report was not available due to capacity issues; significant exceptions were requested to be reported to the Boards. The Committees expressed continuing concerned regarding continuing high salary overpayment levels, acknowledging that data accuracy had improved following recent focus in this area.	4 October meeting (exceptions)	Limited
Board Assurance Framework	The Committees received the Board Assurance Framework and expressed concern regarding missing risk updates, acknowledging that the meeting was scheduled during the midpoint of quarter 2, and that the recent executive leadership review had caused some delay and uncertainty. The Committees were nevertheless able to indicate 'reasonable' assurance in respect of this item.	On Boards' agenda 4 Oct	Reasonable
Clinical Audit report	The Committees received a consolidated Clinical Audit compliance report for UHN and indicated their assurance that a robust programme of clinical audit and effectiveness was in place at UHN, based on the report and presentation, and that the annual programme of audits was informed by, and input to, the organisational risk profile.		Reasonable
Good governance review	The Director of Corporate and Legal Affairs drew attention to a recommendation and management action from the recent NHS England review of UHN collaboration to undertake an assessment to local health system relationships against 2022 guidance. This would involve a self-assessment exercise and survey with Boards' members and other key external stakeholders. The Committees were unable to provide an assurance level due to this work not having commenced.	Nov 2024	No assurance
External Audit procurement	The Committees were advised that the procurement for the re-tendering of the external audit contract would be undertaken via an approved framework; following stakeholder engagement, including with KGH Governors, the successful bidder would commence the contract on 1 April 2025. The Committees noted the latest position.	Nov 2024	Reasonable

Group People Committee Reports to the Boards of Directors	Date of reporting group's meeting: 26 September 2024

Reporting Group Chair: Denise Kirkham

Agenda Item	Description and summary discussion	Decision / Actions and timeframe	Assurance level *
Culture & Safety Report	Occupational Health and Wellbeing Services across UHN were being aligned. This included health & wellbeing, psychological support and Trauma Risk Management. OD leadership was being aligned across UHN to deliver a consistent approach. The MSK physio service was taking data hot spot areas to talk to teams on how best to support them. The staff survey would be running from 07 October to 29 November – the uptake target had been set at 62%.	-	Reasonable
Medical Revalidation & Appraisal	The Committee received the report and was requested to approve the submission of the paper to the regional medical director. UHN was compliant with policies and the metrics were positive. Work was underway to align NGH/KGH in monthly reporting and forward planning. Benchmarking had been completed last year for NGH, which had shown NGH to be good comparatively. This would be repeated every three years for both Trusts. The Committee approved the submission.	Submission to NHS England – October 2024	Reasonable
WRES & WDES (Workforce Race and Disability reporting)	The Committee was asked for approval to publish the report. It was noted the different range of data from both organisations, it would take another year to settle and become more comparable. The WRES had shown improvements in both organisations. Greater improvements had been seen at NGH and there would be a focus on KGH to present a similar picture. Staff stories and examples would be strengthened, the Director of Comms would work with the Senior Diversity & Inclusion Specialist on this. The Committee approved publication of the report.		Reasonable
Guardians of Safe Working	The annual and quarterly KGH Guardian of Safe Working Hours Report & the quarterly NGH Guardian of Safe Working Hours Report were presented. The KGH report had identified no new risks, breaches of contract or financial penalties.	-	Reasonable
Temporary Staffing Report	A discussion was had in relation to an informal update presented to the Clinical Quality & Safety Committee on the Safer Nursing Tool. An update on this would be presented to the next People Committee. The Committee commented on the use of the bank: it would always be required; however when it continuously tips in to high usage (as seen currently), it becomes a concern. It was agreed that the flexibility of the bank is useful for both staff and staff shortages. The main area of worry was within medical agency, mitigations included reviewing the highest paid positions.	-	Limited

UHN Clinical Quality and Safety Committee in Common Upward Report to Board of Directors	Date of reporting group's meeting: 28th August 2024

Reporting Non-Executive Director: Chris Welsh

Agenda Item	Description and summary discussion **The committee:**	Decision / Actions and timeframe	Assurance level *
Subgroup reports	Noted an item of limited assurance from the KGH Quality Governance Steering Group regarding the provision of palliative care in the urgent care setting, for which an investment case to continue the service was submitted but not taken forward due to cost pressures. The current project which has been successful, will cease on 31st December 2024.	-	Limited
Quality Impact Assessment Process	Was assured that appropriate Quality Impact Assessment (QIA) controls are in place across UHN with the Transformation team providing support to teams to complete QIAs for all service changes. The committee noted that all financial savings schemes have been through a full impact assessment process.	-	Substantial
Responses to the independent inquiry to issues raised by the David Fuller case	1. Received updates on the responses of both trusts in relation to the inquiry into issues raised by the David Fuller case. 2. Noted that there were significant shortfalls on the KGH site which the committee has been assured have been/are being addressed. 3. Expressed concern that actions previously reported as being undertaken at KGH had not been completed. The need to learn from this oversight was emphasised.	-	Reasonable
Maternity	Noted: 1. Ongoing issues with RAAC and the estate at KGH. 2. The move to new premises at KGH was successful. 3. Following KGH entering the Maternity Safety Support Programme (MSSP), the first meetings have taken place with the NHSE Maternity Improvement Advisor and a deep dive into Equality and QI is planned for 10th October.	-	Reasonable
KGH Neonatal Unit Transition Plan	Noted an update on the plans to reinstate a level two service at the KGH neonatal unit with a phased approach from 30th September 2024.	-	Reasonable

UHN Clinical Quality and Safety Committee in Common Upward Report to Board of Directors	Date of reporting group's meeting: 28th August 2024		
Reporting Non-Executive Director: Chris Welsh			
Agenda Item	**Description and summary discussion** **The committee:**	**Decision / Actions and timeframe**	**Assurance level ***
Autistic Spectrum Disorder (ASD) assessments	Received an update on NGH's inability to provide ASD assessments to children aged 5-11 years from 31st August 2024 due to closure of the current provider. This presents a significant challenge for which there is currently no solution.		Limited
TIAA assurance review of incident response and reporting review	Noted an update on the implementation of PSIRF following a TIAA audit report for each site, the recommendations from which are being actioned.	-	Reasonable
Urgent and Emergency Care Standards	1. Highlighted concerns regarding quality and safety for urgent and emergency care at NGH due to the pressures resulting from the high level of attendances at NGH. 2. Noted concerns in relation to urgent and emergency care for the coming winter and the winter plan, the completed version of which has not yet been seen.	-	Reasonable
KGH CQC Inspection report	Was assured that the actions relating to the KGH CQC inspection are in hand.	-	Reasonable
Chief Nurse Exception report	Received and noted the Chief Nurse Exception report and received assurance that falls, pressure ulcers, hospital acquired infections and nutrition and hydration are monitored, validated and reported effectively. There were no issues from this report to bring to the Boards attention.		Reasonable

UHN Clinical Quality and Safety Committee in Common Upward Report to Board of Directors	Date of reporting group's meeting: 25th September 2024		
Reporting Non-Executive Director: Chris Welsh			
Agenda Item	**Description and summary discussion** **The committee:**	**Decision / Actions and timeframe**	**Assurance level ***
Items of urgent business	1. Received an update from the Chief Nurse on the circumstances of a patient who had absconded from a ward at KGH and was found deceased. The case is subject to ongoing coroner and Police investigation. An initial rapid review has been completed and a wider audit is being carried out. 2. Was informed of a maternal death following the termination of a non-viable baby. Postmortem results had confirmed the lady's cause of death and a Maternity and Newborn Safety Investigation (MSNI) referral has been completed. The initial review of the case has found no lapses in care.	-	n/a
Matters arising from the previous meeting	Received a verbal update on the neonatal unit transition plan noting a plan to go live with 30-week babies in October however, this is subject to further discussions which are ongoing with ICB and regional colleagues and ensuring staff are prepared for this.	-	n/a
Subgroup reports	1. Reviewed and discussed items of limited assurance from the Nursing, Midwifery and AHP steering group, UHN Patient Safety Committee and Digital Delivery Group. 2. Noted that the ICB has commissioned the Child Death Overview Panel to undertake a review of neonatal deaths over the last five years, which will be completed by the end of December. 3. Noted with concern that the Memorandum of Understanding for GP prescribing for pregnant mothers ends on 1st November. 4. Was informed of a risk regarding aseptic procedures for chemotherapy patients with services at KGH and NGH both stretched. 5. Noted the ongoing concerns about the provision of autistic spectrum disorder assessments, and that discussions about this will take place with the primary/secondary care user interface group. 6. Approved the Terms of Reference for the Nursing Midwifery and Allied Health Professionals Committee.	-	Reasonable

UHN Clinical Quality and Safety Committee in Common Upward Report to Board of Directors	Date of reporting group's meeting: 25th September 2024

Reporting Non-Executive Director: Chris Welsh

Agenda Item	Description and summary discussion **The committee:**	Decision / Actions and timeframe	Assurance level *
Maternity	Noted: 1. The successful move from Rowan ward to Sir Thomas More ward and Willow ward at KGH. 2. An MSNI letter of concern received by NGH highlights concern about the accuracy of ultrasound scans, the storage of still images and unavailability of video recordings to support reporting and quality assurance 3. An issue relating to the timeline for PMRT reviews being undertaken, which could compromise NGH's CNST compliance.	-	Reasonable
Safeguarding	Welcomed the first joint UHN report, noting that actions are being taken to address several risks highlighted in the report.	-	Reasonable
Board Assurance Framework	Discussed concerns about the status of the academic strategy and notes that a UHL/UHN Director of Research and Innovation is being recruited and there are plans for a UHN Director of Medical Education.	-	Reasonable
KGH CQC inspection report	Welcomed the improved report which provided the committee with substantial assurance on the actions being taken and the progress made in relation to these.	-	Substantial
KGH response to the Fuller Inquiry	Was assured that the appropriate actions are being taken at KGH in response to recommendations from the Fuller Inquiry.		Reasonable

*The Committee will indicate the level of assurance it is able to provide to the Boards of Directors using the following definitions:

Substantial Assurance	There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)
Reasonable Assurance	There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance.
Limited Assurance	There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed
No Assurance	Management cannot clearly articulate the matter or issue; something has arisen at Committee for which there is little or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing

University Hospitals of Northamptonshire NHS Group is a collaboration between Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

NHS
University Hospitals of Northamptonshire
NHS Group

IGR

September 2024

Dedicated to excellence

Introducing the IGR

This IGR pack has three main sections in alignment with the Committees the metrics support:

1) Clinical Quality and Safety Committee (pages 4 to 39) covering metrics aligned to our ‘patient’ and ‘quality’ dedicated to excellence values
2) Finance and Investment Committee (pages 40 to 51) covering metrics aligned to our ‘sustainability’ dedicated to excellence values
3) Operational Committee (pages 52 to 97) covering metrics aligned to our ‘sustainability’ and ‘systems and partnerships’ dedicated to excellence values
4) People Committee (pages 98 to 115) covering metrics aligned to our ‘people’ dedicated to excellence values

It is worth noting:

- Only metrics that have a) had data provided and b) have been signed off, will be published – therefore, this could lead to some gaps in reporting.
- Many of our metrics are aggregated as they show the high-level performance of the Trust in this area (e.g. mandatory training). Therefore, there may be higher/ lower levels of performance at local level which will be monitored and acted upon accordingly.

Metric Categorisation Information

On this dashboard, metrics have been categorised to indicate whether or not they have met their Target, and whether this is likely to be consistent based on statistical analysis of historic results.

- **'Target Met (Consistent)'** = The target has been met and is likely to be consistently met going forwards according to historic values.
- **'Target Met (Inconsistent)'** = The target has been met, however with analysis of past results it may not be met next month.
- **'Target Not Met (Inconsistent)'** = The target has not been met and is likely to be consistently met going forwards according to historic values.
- **'Target Not Met (Consistent)'** = The target has not been met and is likely to be consistently met going forwards according to historic values.

Statistical analysis method: standard deviation analysis of historic values per metric. If the target is met by two standard deviations above/below the mean then this means new metric results are statistically 95% likely to meet the target. NB: this is purely statistical analysis and does not consider real-world information.

Assurance Icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. **Grey** icons tells you that sometimes the target will be met and sometimes missed due to random variation.

Variance Icons: **Orange** indicates concerning variation requiring action (e.g.: trending away from target). **Blue** indicates potential improvement. **Grey** indicates no significant change (common cause variation).

HEALTHi

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NHS
University Hospitals of Northamptonshire
NHS Group

Clinical Quality and Safety Committee

Dedicated to excellence

University Hospitals of Northamptonshire NHS Group is a collaboration between Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

Clinical Quality and Safety Committee

Exec owners: Julie Hogg, Hemant Nemade, Sarah Noonan, Palmer Winstanley, Becky Taylor

In reminder, this Committee monitors the 'quality' metrics and the 'patient' metrics within the IGR.

This cover sheet is designed to **highlight to the Committee saliant messages from the IGR metrics** for this month:

1. % Patient satisfaction score – A&E – Both KGH and NGH saw an increase in FFT satisfaction scores compared with the previous month. However, the narrative has indicated a decline in feedback responses.
2. Both KGH and NGH are displaying a downward trend for the Complaints response performance metric. The narrative for KGH has indicated that responses are not being returned in a timely fashion due to sickness and Annual Leave. Reporting of this metric is currently being revised to ensure both Trusts are using the same method for calculating the response rate.
3. Safe Staffing continues to show an upward trend. Even though the value for KGH did reduce slightly for August, the levels remain the highest seen in the past 2 years. NGH have indicated issues in certain sectors such as Nursing and Midwifery with more than 30% unavailability. This has been supported by temporary staffing measures via Bank and Agency.

Key **developments with the IGR** itself for the Committee to note:

1. COVID 19 metrics have been removed following discussions with the Nursing Leads. Please indicate if you wish for these metrics to be added again?
2. Safeguarding, Compliments and Complaints metrics are under review.
3. Safe Staffing Metric – Which Committee should this metric be reported in? People or Quality?
4. The development of the HSMR/SHMI/Crude Death rate metrics are currently in progress. The data will be sourced from Dr Foster.

Worth remembering for all metrics, only metrics that have a) had data provided and b) have been signed off, will be published – therefore, this could lead to some gaps in reporting.

Summary Table

Committee Name: All

Group Name: Patient

Metric Name: Multiple selections

Site: All

Variation: All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
KGH	Patient	% Patients satisfaction score - Trustwide	01/08/24	96.00%	95.00%	89.09%	92.18%	95.26%			Not Consistently Anticipated to Meet Target
NGH	Patient	% Patients satisfaction score - Trustwide	01/08/24	92.30%	95.00%	86.95%	89.58%	92.22%			Consistently Anticipated to Not Meet Target
KGH	Patient	% Patients satisfaction score - inpatients	01/08/24	94.00%	95.00%	87.35%	92.26%	97.17%			Not Consistently Anticipated to Meet Target
NGH	Patient	% Patients satisfaction score - inpatients	01/08/24	93.10%	89.50%	88.65%	92.46%	96.27%			Not Consistently Anticipated to Meet Target
NGH	Patient	% Patients satisfaction score - A&E	01/08/24	85.70%	88.00%	70.66%	78.14%	85.63%			Consistently Anticipated to Not Meet Target
KGH	Patient	% Patients satisfaction score - A&E	01/08/24	85.00%	95.00%	67.97%	77.71%	87.44%			Consistently Anticipated to Not Meet Target
NGH	Patient	% Patients satisfaction score - maternity	01/08/24	93.60%	96.80%	86.61%	93.68%	100.76%			Not Consistently Anticipated to Meet Target
KGH	Patient	% Patients satisfaction score - maternity	01/08/24	96.00%	95.00%	80.88%	93.33%	105.77%			Not Consistently Anticipated to Meet Target
NGH	Patient	% Patients satisfaction score - outpatients	01/08/24	94.90%	93.80%	92.05%	93.64%	95.24%			Not Consistently Anticipated to Meet Target
KGH	Patient	% Patients satisfaction score - outpatients	01/08/24	97.00%	95.00%	93.04%	95.96%	98.89%			Not Consistently Anticipated to Meet Target
KGH	Patient	Number of complaints	01/08/24	38	0	13	44	75			Consistently Anticipated to Not Meet Target
NGH	Patient	Number of complaints	01/08/24	45	0	19	37	56			Consistently Anticipated to Not Meet Target
NGH	Patient	Complaints response performance	01/08/24	34.00%	90.00%	71.93%	92.08%	112.23%			Not Consistently Anticipated to Meet Target
KGH	Patient	Complaints response performance	01/08/24	29.00%	90.00%	10.92%	46.16%	81.41%			Consistently Anticipated to Not Meet Target

% Patients satisfaction score - A&E

Committee Name: All

GroupName: Patient

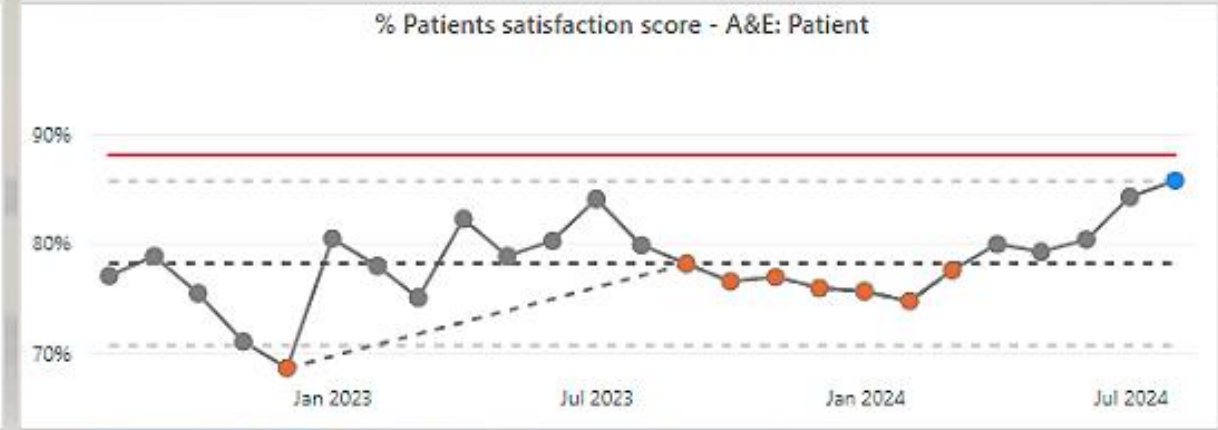
MetricName: % Patients satisfaction score - A&E

Date: 3/1/2021 – 8/1/2024

85.00%	95.00%	85.70%	88.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses.	The ED satisfaction score increased by 1% in August to 85% when compared with July (84%). In EDs, we received 335 responses to the Friends and Family Test. This was a decrease of 99 when compared with July and a decrease of 26 compared with August 2023.	All areas saw a decline in feedback responses in August.	Any learning actions identified through the FFT are highlighted in the monthly divisional updates which are discussed in divisional governance meetings. Bi-Monthly, updates on actions and learning from feedback are reported to the Patient Experience & Engagement Steering Group (PESG).	Response rates and satisfaction score information is shared with all Service Leads to ensure relevant actions are in place to better performance.
NGH	01/08/24	The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses.	There was a increase in FFT satisfaction scores of 1.5% in August compared with the previous month. In total there were 1,753 responses received through the FFT during the month of August for the Emergency Department Services.	Decline noted in SDEC (Quinton Ward), although improvement seen in Accident & Emergency, Paediatric ED, Springfield and Eye Casualty.	Data relating to the different services within the Emergency Department continues to be shared with relevant management teams in order to focus on any areas that require improvement.	FFT performance continues to be monitored, with negative themes highlighted to the relevant departments and senior leads.

% Patients satisfaction score - inpatients

Committee Name: All

GroupName: Patient

MetricName: % Patients satisfaction score - inpatients

Date: 3/1/2021 – 8/1/2024

94.00%	95.00%	93.10%	89.50%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses.	Our Inpatient satisfaction score increased by 1% in August to 94%, when compared with July (93%). In inpatient areas, we received 875 responses to the Friends and Family Test. This was a decrease of 81 compared with July and a decrease of 71 compared with August 2023.	Twywell, Ashton and Lilford all had declines in response rates in August.	Any learning actions identified through the FFT are highlighted in the monthly divisional updates which are discussed in divisional governance meetings. Bi-Monthly, updates on actions and learning from feedback are reported to the Patient Experience & Engagement Steering Group	Response rates and satisfaction score information is shared with all Service Leads to ensure relevant actions are in place to better performance.
NGH	01/08/24	The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses.	Our Inpatient FFT satisfaction scores decreased by 1.5% in August (93.1%) when compared with July (94.6%). There were 806 responses received for inpatient services in August.	No specific issues noticed.	Any learning actions identified within the FFT continue to be shared with service leads and raised at divisional and bimonthly governance meetings.	FFT satisfaction scores continue to be reported and shared with all service leads. Further night audits also to be conducted.

% Patients satisfaction score - maternity

Committee Name: All

GroupName: Patient

MetricName: % Patients satisfaction score - maternity

Date: 3/1/2021 – 8/1/2024

96.00%	95.00%	93.60%	96.80%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital

% Patients satisfaction score - maternity

Committee Name: All

GroupName: Patient

MetricName: % Patients satisfaction score - maternity

96.00%	95.00%	93.60%	96.80%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses.	The Maternity Services satisfaction score remained the same at 96% in August when compared with July. In maternity services, we received 214 responses to the Friends and Family Test, which was a decline of 17 when compared with July, but an increase of 110 when compared with August 2023.	Kettering Community Midwives and Rowan had a decrease in responses in August.	Any learning actions identified through the FFT are highlighted in the monthly divisional updates which are discussed in divisional governance meetings. Bi-Monthly, updates on actions and learning from feedback are reported to the Patient Experience & Engagement Steering Group (PESG).	Response rates and satisfaction score information is shared with all Service Leads to ensure relevant actions are in place to better performance.
NGH	01/08/24	The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses.	Maternity FFT satisfaction scores decreased in August by 3.3% compared with the previous month.	There were 4 poor ratings for Maternity Observation ward/Induction of Labour. Two FFT scores did not leave any comments, the other two FFT scores related to staff attitude and Induction of Labour delays. The Induction of labour (IOL) take place at NGH, and due to acuity, quite often long delays are experienced, resulting in dissatisfaction.	The Patient Experience Team continue to joint work with the Patient Experience Midwife and Midwifery Teams. There is now an 'Induction Of Labour Working Group' that is exploring ways to improve the Induction of Labour pathway. Negative FFT responses related to attitude and behaviour of staff have been escalated to Line Management and Ward Sister for review.	The Patient Experience Team will continue to monitor patient satisfaction scores and work alongside the Patient Experience Midwife & Midwifery Teams.

% Patients satisfaction score - outpatients

Committee Name: All

GroupName: Patient

MetricName: % Patients satisfaction score - outpatients

Date: 3/1/2021 – 8/1/2024

97.00%	95.00%	94.90%	93.80%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital

% Patients satisfaction score - outpatients

Committee Name: All

GroupName: Patient

MetricName: % Patients satisfaction score - outpatients

97.00%	95.00%	94.90%	93.80%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses.	The Outpatient satisfaction score remained the same at 97% for August when compared with July. In outpatient areas, we received 3,257 responses to the Friends and Family Test. This was a decrease of 1,113 compared with July and an increase of 2,005 compared with August 2023.	Medical SDEC had a slight decline in satisfaction score in August 2024. Nuffield and Frank Radcliffe had significant declines in responses in August.	Any learning actions identified through the FFT are highlighted in the monthly divisional updates which are discussed in divisional governance meetings. Bi-Monthly, updates on actions and learning from feedback are reported to the Patient Experience & Engagement Steering Group (PESG).	Any learning actions identified through the FFT are highlighted in the monthly divisional updates which are discussed in divisional governance meetings. Bi-Monthly, updates on actions and learning from feedback are reported to the Patient Experience & Engagement Steering Group (PESG).
NGH	01/08/24	The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses.	Our Outpatient FFT satisfaction scores slightly increased by 0.8% in August (94.9%) compared with July (94.1%). Within the outpatient areas, we received 2,684 responses during August compared with 2,480 responses the previous month.	Some of the outpatient areas have a 'lower than expected rate' of FFT response rates compared with the volume of attendances due to survey fatigue built into the survey processes.	Any learning actions identified within the FFT performance, are highlighted to service leads and shared at divisional and bimonthly governance meetings.	All outpatient service managers receive the monthly FFT performance results that are drilled down by division, directorate and departmental level. All reporting is reported to senior management.

% Patients satisfaction score - Trustwide

Committee Name: All

GroupName: Patient

MetricName: % Patients satisfaction score - Trustwide

Date: 3/1/2021 – 8/1/2024

96.00%	95.00%	92.30%	95.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses.	The Trustwide satisfaction score increased by 1% to 96% in August, however, when compared with LY there was an increase of 3%. As a Trust, we received 4,681 responses to the Friends and Family Test. This was a decrease of 1,310 compared with July but an increase of 1,874 compared with August 2023.	No areas had a decline in satisfaction score in August.	Any learning actions identified through the FFT are highlighted in the monthly divisional updates which are discussed in divisional governance meetings. Bi-Monthly, updates on actions and learning from feedback are reported to the Patient Experience & Engagement Steering Group (PESG).	Response rates and satisfaction score information is shared with all Service Leads to ensure relevant actions are in place to better performance.
NGH	01/08/24	The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses.	Our Trust wide FFT satisfaction score saw a slight increase of 0.7% from July (91.6%) to August (92.3%). A total of 6,344 responses to the FFT were received.	Most services saw in increase in their FFT performance apart from Inpatient areas (decreased by 1.5% from 94.6% in July to 93.1% in August) and Maternity Services (decreased by 3.3% from 96.9% in July to 93.6% in August).	Any learning and actions identified through the FFT, are highlighted within the monthly divisional reports that are discussed at divisional governance meetings and bi-monthly Patient Carer Experience & Engagement Group.	All satisfaction scores, response rates and negative themes continue to be shared with relevant service leads .

Complaints response performance

Committee Name: All

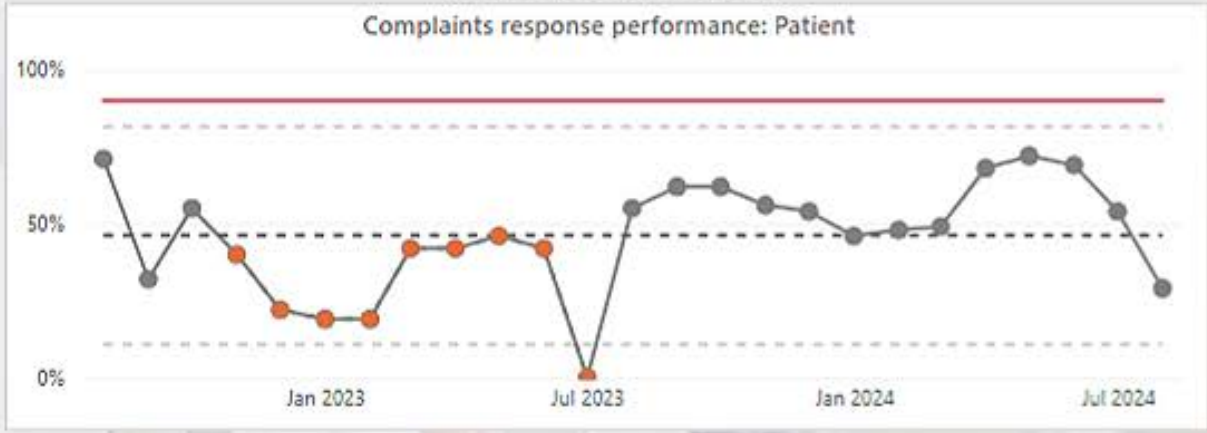
GroupName: Patient

MetricName: Complaints response performance

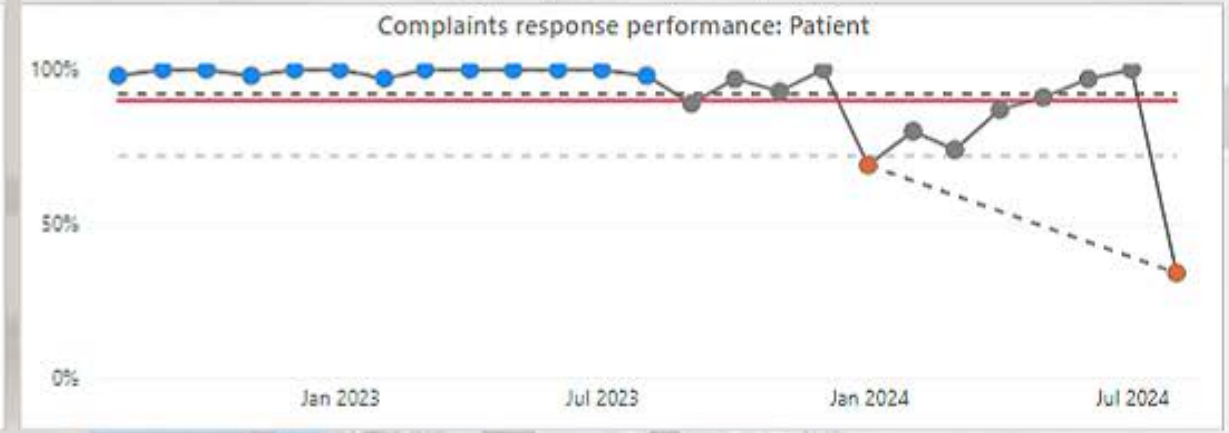
Date: 3/1/2021 – 8/1/2024

29.00%	90.00%	34.00%	90.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Complaints response performance

Committee Name: All

GroupName: Patient

MetricName: Complaints response performance

29.00%	90.00%	34.00%	90.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

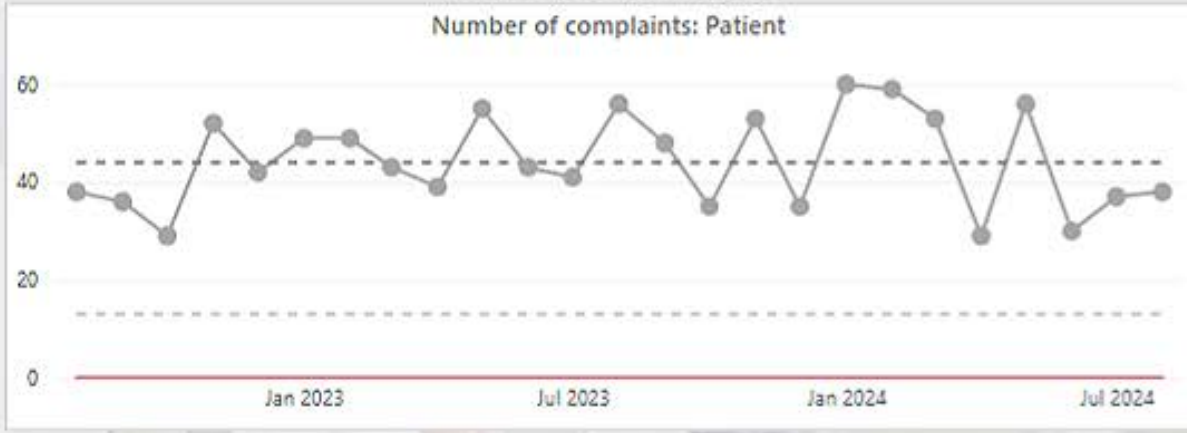
Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Complaints performance – Providing a written response to a complaint within an agreed timescale	We only performed 29% this month. This was due to 51 cases being due to be sent out and only 15 achieved. Out of the 36 that did not go out within 60 days, 9 of those closed a week late. The other 25 in either drafting, or investigation stage. This is due to leave within the team and also divisions. This should improve for Sep. Complainants kept updated as appropriate.	Responses not coming back into the team on time, due to sickness and annual leave left team drafting responses. However, Head of Complaints leading some focused work on drafting cases Sep 2024.	Head of Complaints leading some focused work on drafting cases Sep 2024. Head of Complaints managing with an overdue meeting every Tues where every cases is deep dived and discussed to action.	Leave Divisional responses not back within Aug. Head of Complaints managing with an overdue meeting every Tues where every cases is deep dived and discussed to action.
NGH	01/08/24	Complaints performance – Providing a written response to a complaint within an agreed timescale	The Trust response rate, when extension of times are excluded is 34% (reporting is currently in the process of being revised in line with KGH reporting to ensure that both Trust's are using the same method of calculating the response rate). It should be noted that the figures reported in July were incorrect due to a reporting issue.	There remains a backlog of complaints within the Complaints team which currently stands at 65 (complaints awaiting a letter of response where the investigation has been completed). Work is currently ongoing to secure some additional temporary support to the complaints team to counter the increasing numbers over the last 12 months. Concerns re staff burnout.	A review is currently being completed of the resource levels within the Complaints team as currently the activity exceeds the resources available. This is now at approval stage.	The Complaints team continue to have a backlog of complaints awaiting a response which is due partly to the long term sickness absence of a member of staff but also the increased number of complaints received when compared year on year (around 35%). A service review is currently awaiting approval.

Number of complaints

Committee Name	GroupName	MetricName	Date
All	Patient	Number of complaints	3/1/2021 – 8/1/2024

38	0	45	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital

Number of complaints

Committee Name: All

GroupName: Patient

MetricName: Number of complaints

38	0	45	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Number of complaints received in month. This is the number of complaints that proceeded to a formal investigation. Any complaints that were locally resolved withdrawn or escalated to the patient safety team would not be included in this figure, this figure can be provided if required.	We logged 38 new complaints in Aug 2024. This is one more than July 2024. Generally, logging lower (e.g in Aug 2023 54 cases). This should help with improving performance score. Promoting the resolution of cases with PALS (203 cases logged in Aug) rather than log formally.	None specific	Continue to promote local resolution at ward level, or PALS	PALS Local Res
NGH	01/08/24	Number of complaints received in month. This is the number of complaints that proceeded to a formal investigation. Any complaints that were locally resolved withdrawn or escalated to the patient safety team would not be included in this figure. this figure can be provided if required.	45 new complaints were received in August compared to the 32 received in July. which is an increase of 27%. Additionally the Complaints team resolved 14 potential complaints through local resolution with a further 6 signposted to PALS for informal resolution.	The number of complaints received regarding appointments delays / cancellations and those relating to communication have all increased this month.	Complaints & PALS have both been involved in delivering training sessions this month and are now included within Trust induction which should help both awareness and understanding moving forwards.	The Complaints team continue to have a backlog of complaints awaiting a response which is due partly to the long term sickness absence of a member of staff but also the increased number of complaints received when compared year on year. A service review is awaiting approval.

Summary Table

Committee Name: All

Group Name: Quality

Metric Name: Multiple selections

Site: All

Variation: All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
NGH	Quality	Serious or moderate harms	01/08/24	9	0	6	27	49			Consistently Anticipated to Not Meet Target
KGH	Quality	Serious or moderate harms	01/08/24	10	8	-1	7	14			Not Consistently Anticipated to Meet Target
NGH	Quality	Serious or moderate harms – falls	01/08/24	0.05	0.06	0.4	0.4	0.4			Not Consistently Anticipated to Meet Target
KGH	Quality	Serious or moderate harms – falls	01/08/24	0.19	0.18	0.28	0.28	0.28			Not Consistently Anticipated to Meet Target
KGH	Quality	Serious or moderate harms – pressure ulcers	01/08/24	0.32	0.69	0.51	0.51	0.51			Consistently Anticipated to Meet Target
NGH	Quality	Serious or moderate harms – pressure ulcers	01/08/24	0.32	0	1.76	1.76	1.76			Consistently Anticipated to Not Meet Target
NGH	Quality	Number of medication errors	01/08/24	126		65	123	181			Consistently Anticipated to Not Meet Target
KGH	Quality	Number of medication errors	01/08/24	45		35	64	93			Consistently Anticipated to Not Meet Target
NGH	Quality	Hospital-acquired infections	01/08/24	7	7	0	8	17			Not Consistently Anticipated to Meet Target
KGH	Quality	Hospital-acquired infections	01/08/24	11	7	-2	11	24			Not Consistently Anticipated to Meet Target
NGH	Quality	MRSA	01/08/24	0	0	-1	0	1			Not Consistently Anticipated to Meet Target
KGH	Quality	MRSA	01/08/24	0	0	-1	0	1			Not Consistently Anticipated to Meet Target
KGH	Quality	C Diff	01/08/24	3	2	-2	3	8			Not Consistently Anticipated to Meet Target
NGH	Quality	C Diff	01/08/24	10	4	-1	7	16			Not Consistently Anticipated to Meet Target
NGH	Quality	SHMI	01/08/24	94		87	89	92			Consistently Anticipated to Not Meet Target
KGH	Quality	SHMI	01/08/24	105.80		109.92	109.92	109.92			Consistently Anticipated to Not Meet Target
NGH	Quality	HSMR	01/08/24	93	100	89	90	92			Consistently Anticipated to Meet Target
KGH	Quality	HSMR	01/08/24	95.00	100	103.65	103.65	103.65			Not Consistently Anticipated to Meet Target

Summary Table

Committee Name: All

Group Name: Quality

Metric Name: Multiple selections

Site: All

Variation: All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
NGH	Quality	SMR	01/08/24	95		88	90	92			Consistently Anticipated to Not Meet Target
KGH	Quality	SMR	01/08/24	96.40		103.56	103.56	103.56			Consistently Anticipated to Not Meet Target
KGH	Quality	Safe Staffing	01/08/24	102.04%	96.00%	91.05%	95.66%	100.27%			Not Consistently Anticipated to Meet Target
NGH	Quality	Safe Staffing	01/08/24	107.10%	96.00%	98.44%	102.66%	106.89%			Consistently Anticipated to Meet Target
KGH	Quality	30 day readmissions	01/08/24	0.00%	12.00%	-3.63%	7.08%	17.8%			Not Consistently Anticipated to Meet Target
NGH	Quality	30 day readmissions	01/08/24	14.82%	12.00%	8.09%	13.24%	18.39%			Not Consistently Anticipated to Meet Target
KGH	Quality	Never event incidence	01/08/24	0	0	0	0	0			Not Consistently Anticipated to Meet Target
NGH	Quality	Never event incidence	01/08/24	1	0	-1	0	1			Not Consistently Anticipated to Meet Target
KGH	Quality	Food wastage	01/08/24	6.22		9.22	9.22	9.22			Consistently Anticipated to Meet Target
NGH	Quality	Food wastage	01/08/24	7.70		12.37	12.37	12.37			Consistently Anticipated to Meet Target

Serious or moderate harms

Committee Name: All

GroupName: Quality

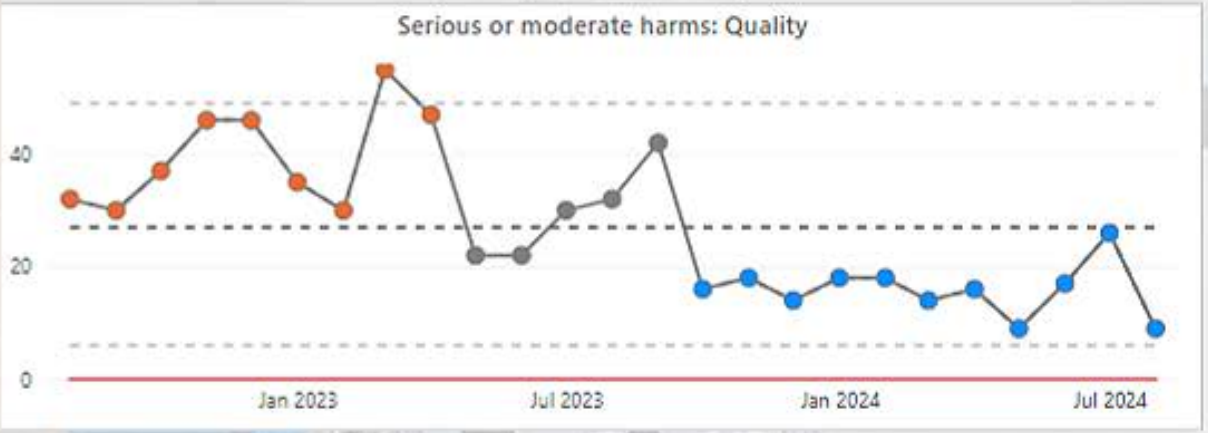
MetricName: Serious or moderate harms

Date: 01/03/2021 – 01/08/2024

10	8	9	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital



Serious or moderate harms

Committee Name	GroupName	MetricName
All	Quality	Serious or moderate harms

10	8	9	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Patients experiencing moderate, severe, catastrophic harm or patient death as a result of a patient safety incident.	The chart is showing common cause variation with variable assurance. The ceiling was set on the average based on Dec-19-Mar-22 numbers and may require revision	KGH has an average reporting number of 6.85 for the time period Dec-19-Mar-22. 2020-2021 average reporting was 7.25. 2021-22 average reporting number was 6. KGH propose to set the ceiling at 8 pending review. Caution must be applied as harms levels can change pending investigation which may take several months.	The Trust recognises that there will be incidents that do not meet the Serious Incident reporting threshold. Where moderate harm has occurred, such incidents fall within the scope of the Policy For The Reporting And Management Of Serious Incidents, Never Events And Investigations Into Moderate Harm Incidents and its guidance, in terms of provision of root cause analysis investigations and evidence of assessment of harm and duty of candour by the Serious Incident Review Group (SIRG).	For the time period stated, moderate, severe, catastrophic harm or patient death as a result of a patient safety incident equates to 4.18% of all incidents with a patient harm incurred, and 1.02% of all incidents reported.
NGH	01/08/24	Patients experiencing moderate, severe, catastrophic harm or patient death as a result of a patient safety incident.	Patients experiencing moderate, severe, catastrophic harm or patient death as a result of a patient safety incident.	All incidences are reviewed to identify any themes or immediate actions required to mitigate against further incidences.	All moderate and above harms are considered in the twice weekly incident review group meeting to agree the level of harm caused, a proportionate response is considered and whether the incident meets the threshold to consider a Patient Safety Incident Investigation (PSII) and whether reporting to external agencies is required	Incidences are investigated using a proportionate response including Swarms, MDT review, After Action Review (AAR) or Patient Safety Incident Investigation (PSII) Learning is identified through these methods and include reccomendations to mitigate against further occurences.

Serious or moderate harms – falls

Committee Name: All

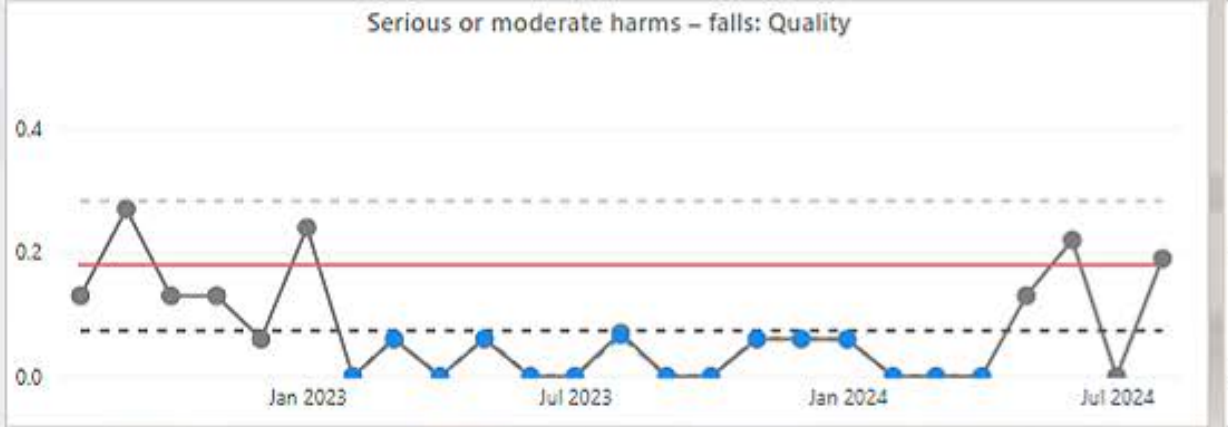
GroupName: Quality

MetricName: Serious or moderate harms – falls

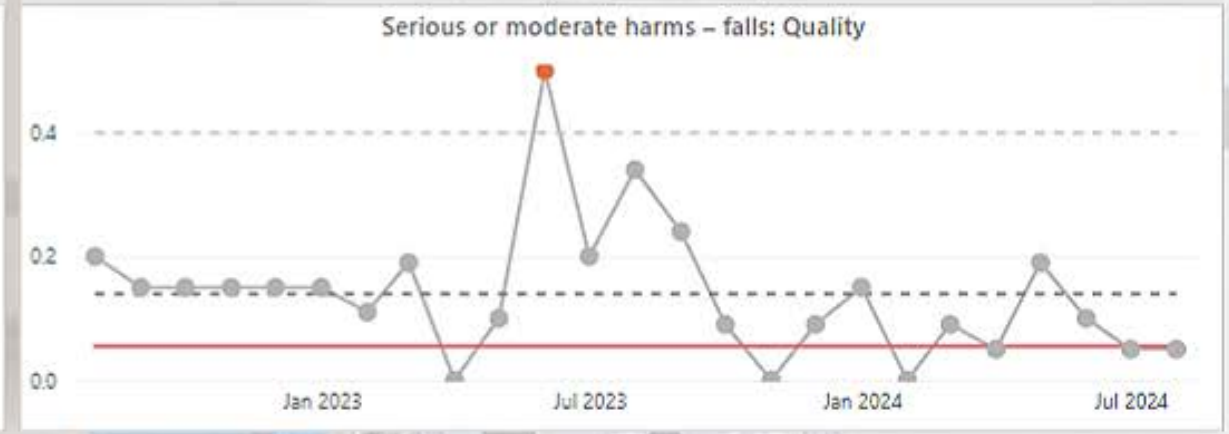
Date: 01/03/2021 – 01/08/2024

0.19	0.18	0.05	0.06
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Patients experiencing falls with moderate harm or above per 1000 bed days.	The chart is showing common cause variation with variable assurance, however sustained positive performance for twelve consecutive months.	There were three falls with severe harm on August. These will be reviewed by the Harm Free Scrutiny Group.	Three weekly focus on falls as part of the Friday Harm Free Care Meetings. Bi-weekly Harm Free Scrutiny panel meets to review any incidents with harm relating to falls.	Significant work has been undertaken over the last two years, with a revision of paperwork and mandatory training for relevant staff. All falls with harm are reviewed by the Falls Prevention Lead and Practice Development Team in conjunction with the clinical area
NGH	01/08/24	Patients experiencing falls with moderate harm or above per 1000 bed days.	There was 0.05 moderate severe catastrophic falls/1000 bed days during the month of August 2024.	There was 1 severe harm inpatient fall, the patient sustained a fractured femur requiring surgical fixation.	Post falls review completed and immediate learning circulated.	Falls reviewed through validation, learning and themes discussed at falls MDT and Trust action plan reviewed in line with these.

Serious or moderate harms – pressure ulcers

Committee Name: All

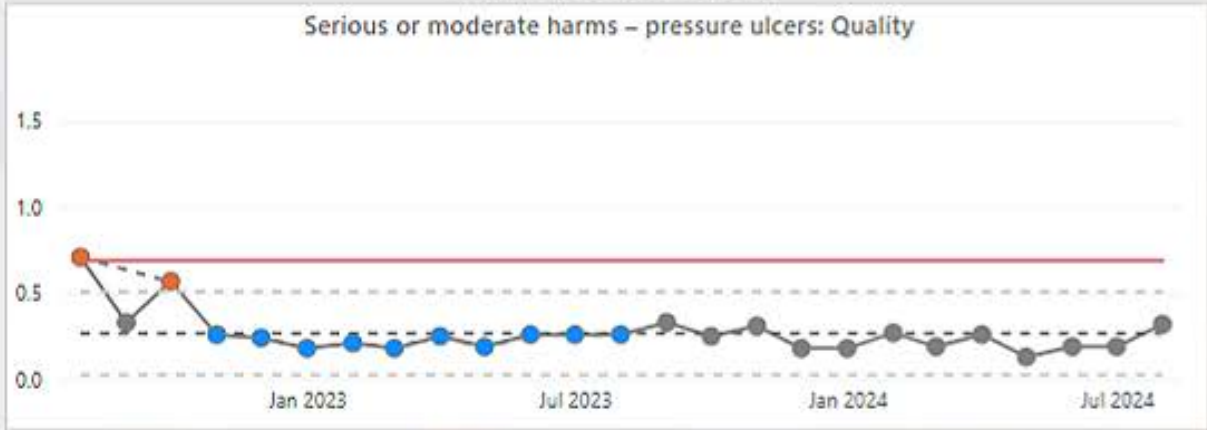
GroupName: Quality

MetricName: Serious or moderate harms – pressure ulc...

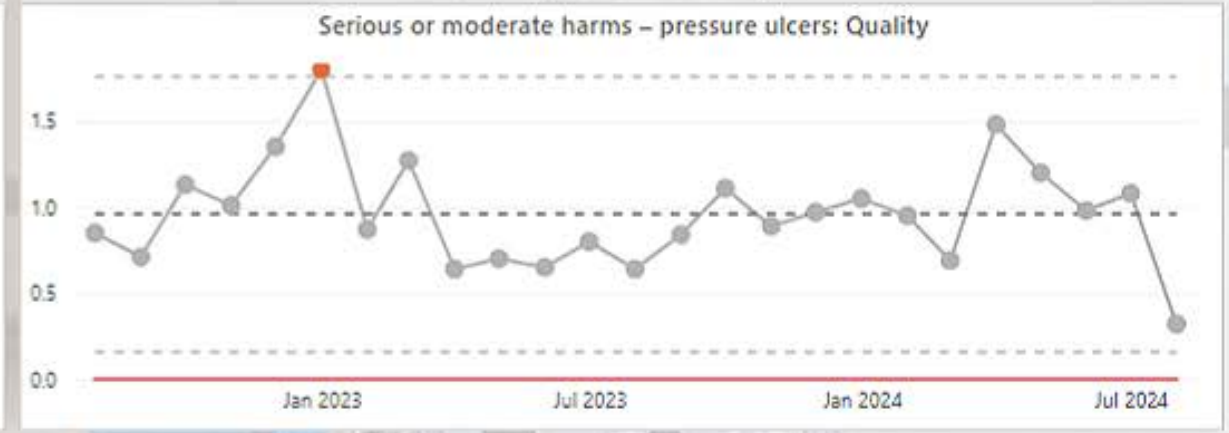
Date: 01/03/2021 – 01/08/2024

0.32	0.69	0.32	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Patients experiencing pressure tissue damage category 2, 3, 4 or unstageable developed or worsened in hospital per 1000 bed days. Not including moisture associated skin damage or deep tissue injury	The chart is showing common cause variation with positive low assurance.	With the development of the IGR, the defined metric has been agreed as: Patients experiencing pressure tissue damage category 2, 3, 4 or unstageable developed or worsened in hospital per 1000 bed days. (Not including moisture associated skin damage or deep tissue injury).	The SSKIN Risk Assessment and Care Plan are established and in use across the Trust. Compliance with this is now being monitored through the 'Perfect Ward' system. Three weekly focus on pressure ulcers as part of the Friday Harm Free Care Meetings	The Tissue Viability Nurse reviews all Category 2 and above pressure ulcers, providing validation and education.
NGH	01/08/24	Patients experiencing pressure tissue damage category 2, 3, 4 or unstageable developed or worsened in hospital per 1000 bed days. Not including moisture associated skin damage or deep tissue injury	There was 0.32 HAPU/1000 bed days (excluding DTI's) during the month of August.	There were 6 category 2 pressure ulcers and 1 unstageable pressure ulcer. 7	Incidents reviewed through share and learn.	Learning is reviewed through share and learn and disseminated through the pressure ulcer steering group.

Number of medication errors

Committee Name: All

GroupName: Quality

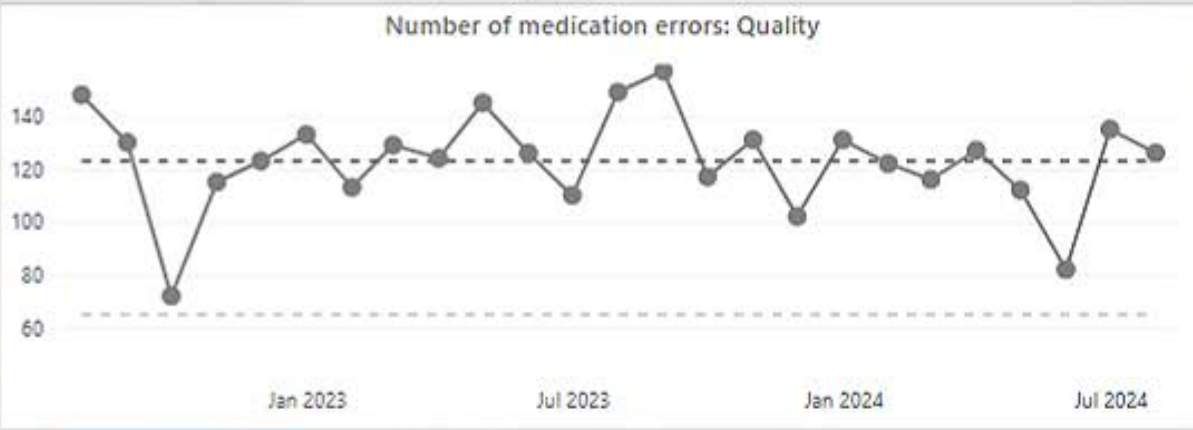
MetricName: Number of medication errors

Date: 01/03/2021 – 01/08/2024

45		126	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital



Number of medication errors

Committee Name: All

GroupName: Quality

MetricName: Number of medication errors

KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target
45		126	

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Medication incidents reported irrespective of subclass of incident (prescribing, dispensing, administering) and irrespective of harm or level of harm.	The Chart shows common cause variation with no agreed target. Historically the Trust had taken a proactive approach to encouraging incident reporting.	A 'low' reporting rate from an organisation should not be interpreted as a 'safe' organisation, and may represent under-reporting. Subsequently, a 'high' reporting rate should not be interpreted as an 'unsafe' organisation, and may actually represent a culture of greater openness.	The reporting of incidents to a national central system (The National Reporting and Learning System (NRLS)) helps protect patients from avoidable harm by increasing opportunities to learn from mistakes where things go wrong. At a national level the NHS uses these reports to identify and take action to prevent emerging patterns of incidents on a national level via patient safety alerts. At a local level these reports are used to identify and target areas of risk emerging through deficiencies in policy, practice process or therapeutics.	There were no moderate harm incidents reported. All medication incidents are reviewed at local level without oversight of ward pharmacy.

Hospital-acquired infections

Committee Name: All

GroupName: Quality

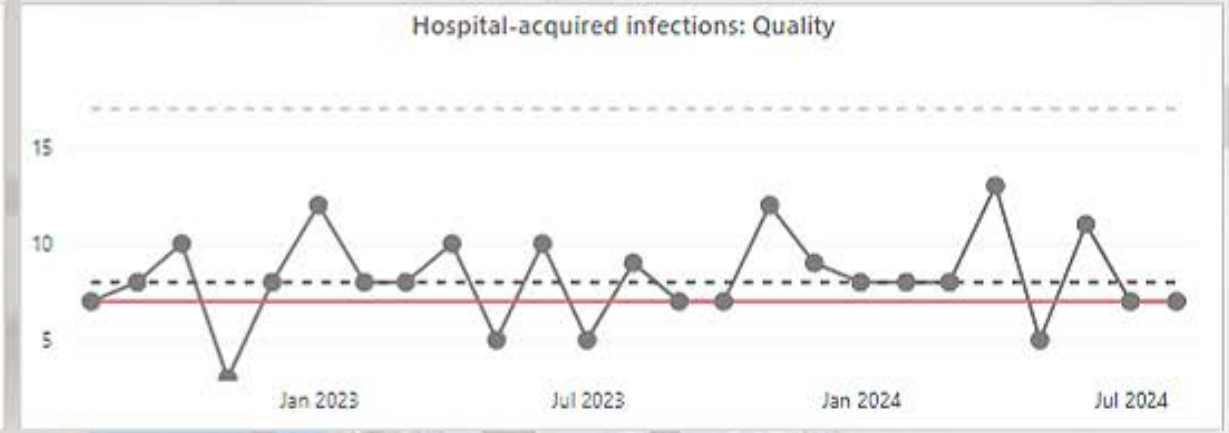
MetricName: Hospital-acquired infections

Date: 01/03/2021 – 01/08/2024

11	7	7	7
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital



Hospital-acquired infections

Committee Name: All

GroupName: Quality

MetricName: Hospital-acquired infections

11	7	7	7
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

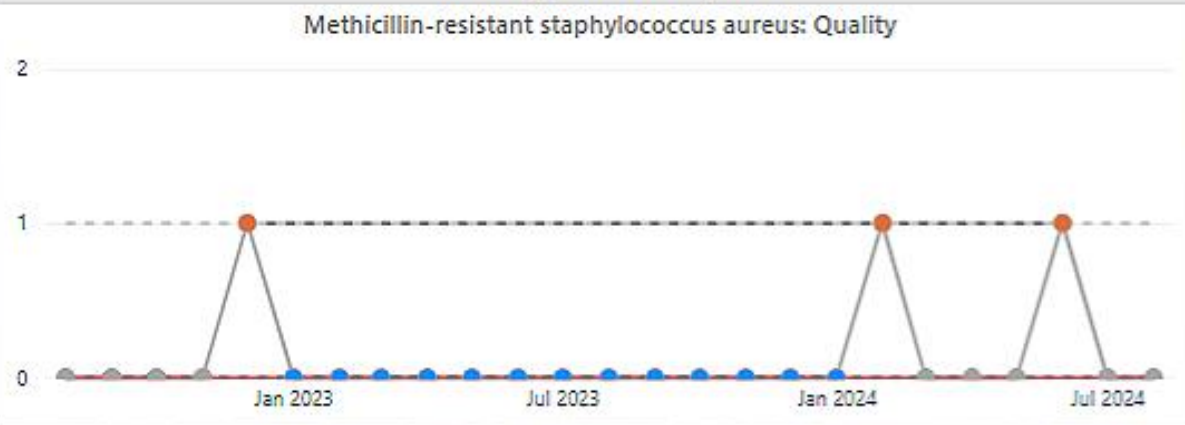
Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Patients experiencing a Gram-negative Hospital Onset Healthcare Associated (HOHA) or Community Onset Healthcare Associated (COHA) infection, defined as: E.coli, Pseudomonas aeruginosa and Klebsiella species.	The chart is showing common cause variation and variable assurance. Patients experiencing a Gram negative Hospital Onset Hospital Acquired (HOHA) or Community Onset Hospital Acquired (COHA) infection, defined as: E-Coli, Pseudomonas aeruginosa and Klebsiella species. E-Coli occurrences.	The NHS Standard Contract 2024/25 for Minimising Clostridioides difficile and Gram-negative bloodstream infections has yet to be published. Therefore ceilings have been set based on 2023/24 figures, which will be revised retrospectively.	Full RCAs are undertaken on all cases followed by a subsequent MDT review. Identified learning is action planned and presented at IPSG	Full RCAs are undertaken on all cases followed by a subsequent MDT review. Identified learning is action planned and presented at IPSG
NGH	01/08/24	Patients experiencing a Gram-negative Hospital Onset Healthcare Associated (HOHA) or Community Onset Healthcare Associated (COHA) infection, defined as: E.coli, Pseudomonas aeruginosa and Klebsiella species.	7 patients developed a healthcare associated Gram-negative blood stream infection (GNB) this month	The NHSE standard contract for GNB for NGH 2024/25 was published in August as 58 E.coli, 29 Klebsiella and 6 Pseudomonas aeruginosa. Currently under trajectory with 24 E.coli, 10 Klebsiella but have exceeded trajectory for Pseudomonas with 8 cases year to date.	1 patient comprises 3 Pseudomonas GNBs cases with a source of infective endocarditis. The Consultant Microbiologist has reviewed this patient, there was no learning or prevention from an IPC perspective, and is planning to set up an Infective Endocarditis MDT with Cardiology.	The GNB position and actions are monitored monthly through the HCAI Annual Plan at the new UHN Infection Prevention Assurance Committee, are raised quarterly via the IPC report to Patient Safety Committee and monthly via the harm free care report for discussion and oversight.

MRSA

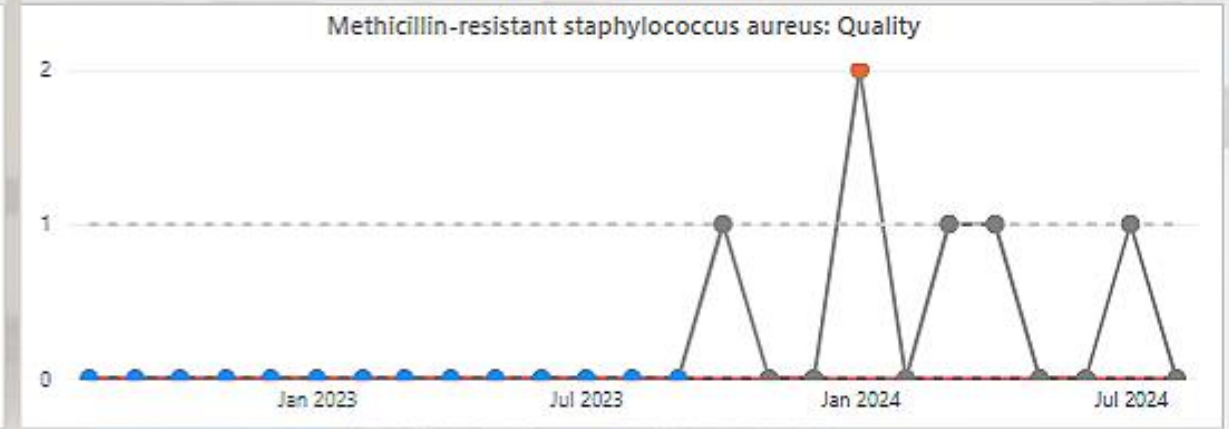
Committee Name	GroupName	MetricName	Date
All	Quality	MRSA	01/03/2021 – 01/08/2024

KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target
0	0	0	0

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Patients experiencing a MRSA Bacteraemia	The chart shows common cause variation with variable assurance	None	All MRSA bacteraemia undergo robust root cause analysis	IPC measures are reviewed and revised in line with National Changes.
NGH	01/08/24	Patients experiencing a MRSA Bacteraemia	0 patients developed a MRSA bloodstream infection this month.	There is no national trajectory for MRSA or MSSA bloodstream infections, but it is good practice to conduct surveillance on these cases and identify learning opportunities as generally a zero-tolerance approach to these infections is adopted.	The IPC team continue to deliver the MRSA and MSSA section of the HCAI Annual plan.	The HCAI Annual plan will now be monitored through the UHN Infection Prevention Assurance Committee.

C Diff

Committee Name: All

GroupName: Quality

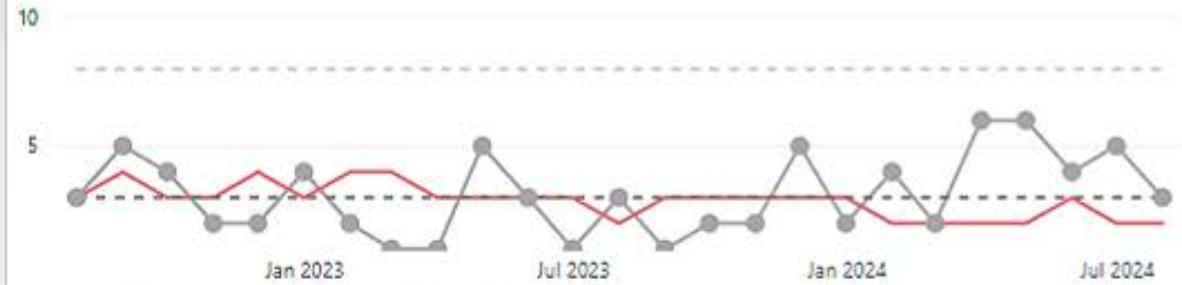
MetricName: C Diff

Date: 01/03/2021 – 01/08/2024

3	2	10	4
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Clostridium difficile: Quality



Northampton General Hospital

Clostridium difficile: Quality

C Diff

Committee Name: All

GroupName: Quality

MetricName: C Diff

3	2	10	4
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Reduce the number of patients who develop healthcare associated C.diff infection. NHSE trajectories for 2024/25 not yet set	The chart is showing common cause variation and variable assurance.	The NHS Standard Contract 2024/25 for Minimising Clostridioides difficile and Gram-negative bloodstream infections has yet to be published. Therefore ceilings have been set based on 2023/24 figures, which will be revised retrospectively.	SIGHT tool being promoted in clinical areas from the IPC team on ward meetings. IPC working with matrons and action plans have been drawn up in clinical areas to assist with auditing and education. Pharmacy are discussing correct prescribing of antibiotics within guidance for CDT patients with medical staff.	IPC daily visits to laboratory to check stool samples and liaising with the clinical areas to ensure all appropriate actions (SIGHT) have been put in place in the area. SIGHT posters given to clinical areas for nursing staff and medical staff. Stool chart audits by IPC on clinical area to ensure SIGHT tool. Isolation and stool sampling is in line with guidance. Actions then given back to clinical area.
NGH	01/08/24	Reduce the number of patients who develop healthcare associated C.diff infection. NHSE trajectories for 2024/25 not yet set, but internal ceiling of 50 cases has been set	10 patients developed a healthcare associated C.diff infection this month	The NHSE standard contract for CDI for NGH 2024/25 was published in August as 93. Currently over trajectory with 41 actual against 39 targeted C.diff toxin positive patients year to date.	SWARMs and after actions review meetings are completed as required for each HOHA and COHA CDI case using the PSIRF framework and learning is shared back to clinical teams via huddle sheets. Directorate Governance reports and IPOG. Themes centred on antimicrobial stewardship and inappropriate sampling. C.diff study sessions are to commence in October and a stool sampling decision aid has been cascaded in September. The IPC Team are actioning the CDI Improvement Plan and are supporting the IV to oral UHN collaborative QI project.	The CDI position and actions will be monitored quarterly through the CDI Improvement Plan at the new UHN Infection Prevention Assurance Committee, are raised quarterly via the IPC report to Patient Safety Committee and monthly via the harm free care report for discussion and oversight.

SHMI

Committee Name: All

GroupName: Quality

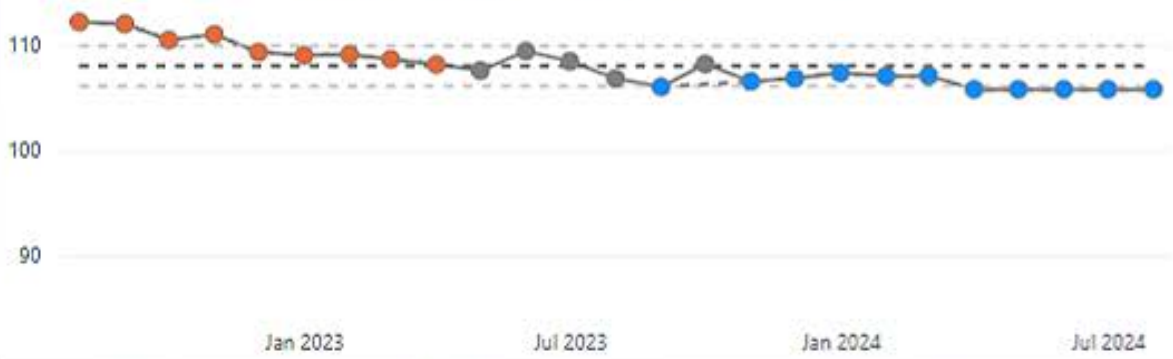
MetricName: SHMI

Date: 01/03/2021 – 01/08/2024

105.80		94	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

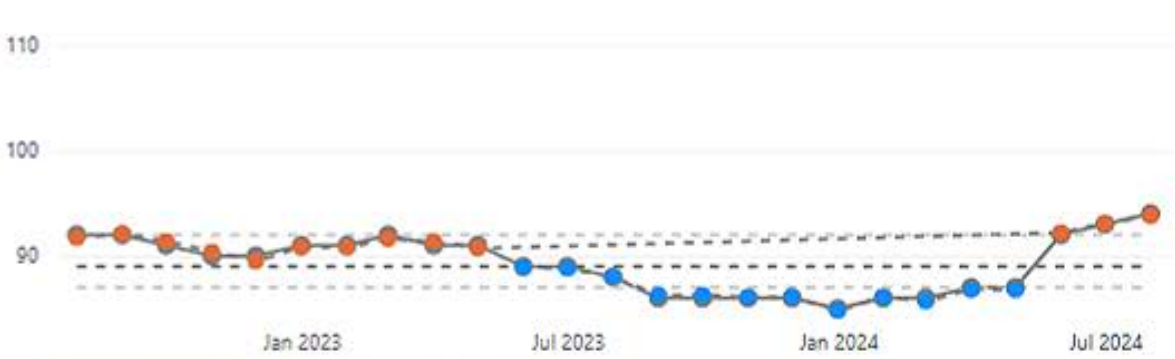
Kettering General Hospital

Summary Hospital-level Mortality Indicator: Quality



Northampton General Hospital

Summary Hospital-level Mortality Indicator: Quality



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/08/24	Summary Hospital-Level Mortality Indicator (SHMI) is an indicator of healthcare quality that measures whether the number of deaths in hospital, or within 30 days of patients leaving hospital, is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. A higher score means more deaths; a lower score, fewer.	SHMI = 93.8, continues in the "as expected" range	No current exceptions	Nil	Nil

HSMR

Committee Name: All

GroupName: Quality

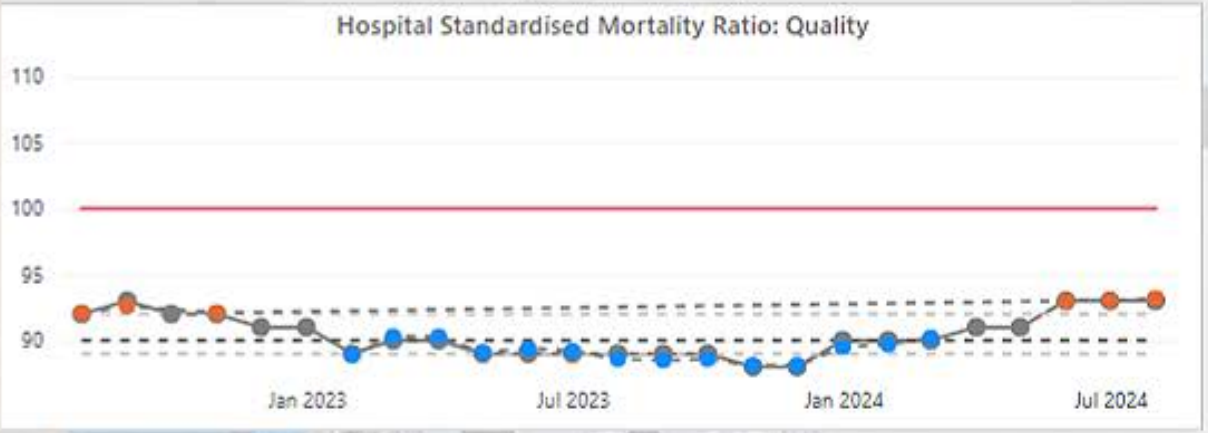
MetricName: HSMR

Date: 01/03/2021 – 01/08/2024

95.00	100	93	100
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/08/24	Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. A higher score means more deaths; a lower score, fewer. Statistically, the HSMR is the relative risk of in-hospital mortality for patients admitted within the 56 diagnosis groups that account for 80% of in-hospital deaths.	HSMR = 93.2, continues in the "below expected" range	No current exceptions	Nil	Nil

SMR

Committee Name: All

GroupName: Quality

MetricName: SMR

Date: 01/03/2021 – 01/08/2024

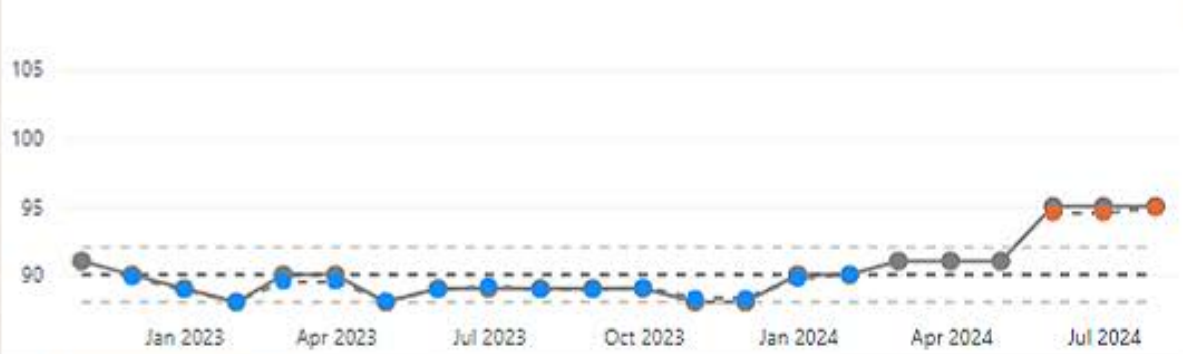
96.40		95	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Standardised Mortality Ratio: Quality

Northampton General Hospital

Standardised Mortality Ratio: Quality



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/08/24	Standardised Mortality Ratio (SMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. A higher score means more deaths; a lower score, fewer. Statistically, the SMR is the relative risk of in-hospital mortality for all patients admitted.	SMR = 94.9, continues in the "below expected" range	No current exceptions	Nil	Nil

Safe Staffing

Committee Name: All

GroupName: Quality

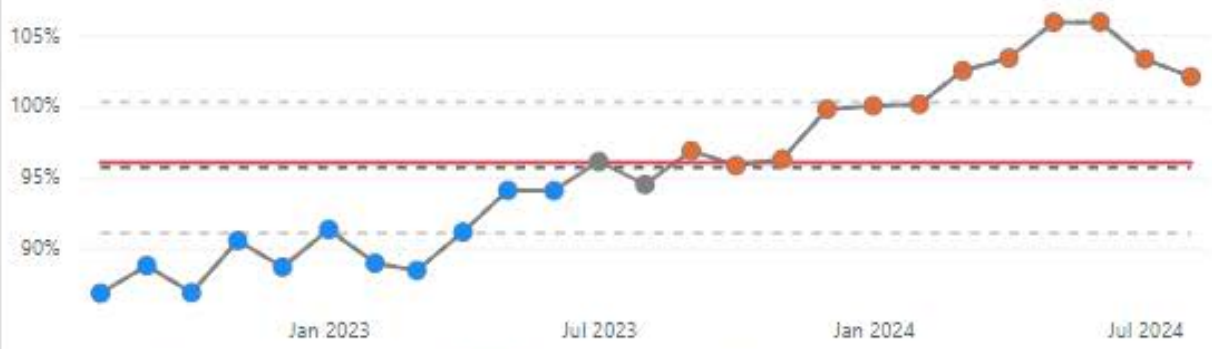
MetricName: Safe Staffing

Date: 01/03/2021 – 01/08/2024

102.04%	96.00%	107.10%	96.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Safe Staffing: Quality



Northampton General Hospital

Safe Staffing: Quality

Safe Staffing

Committee Name: All

GroupName: Quality

MetricName: Safe Staffing

102.04%	96.00%	107.10%	96.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Combined day & night shift fill rate % for registered & non-registered Nursing, midwifery & AHP staff. Reported nationally to NHSE in accordance with National Quality Board guidance.	The value has reduced slightly this month, though remains within the highest levels seen in the past 2 years. This provides assurance that staffing levels are safe for both registered and unregistered groups	No issues	Continue with recruitment and the NA deployment planning. We continue to review the "specialing" requirement and utilisation across the trust	Temporary staffing and internal deployment is utilised as required, being managed monitored through twice daily staffing cells
NGH	01/08/24	Combined day & night shift fill rate % for registered & non-registered Nursing, midwifery & AHP staff. Reported nationally to NHSE in accordance with National Quality Board guidance.	107.1% This is the combined day and night shift fill rate % for registered and non-registered nursing staff. Reported nationally to NHSE in accordance with the National Quality board guidance. The value tells us that the combined registered and non-registered nursing and midwifery fill rates are above the current NGH target and but has increased by 3.3% since Nov 23 (103.8%). This means that the actual staffing levels met the planned staffing levels 100.4% of the time in January which has a positive impact on patient safety, quality of care and patient experience.	Despite the decrease in actual staffing fill rates, Nursing and Midwifery continues to be more than 30% unavailability with parenting rates of 4.9% and sickness rates at 7.3%, this indicates that the actual staffing fill rates have been supported by temporary staffing measures via bank and agency. The above 100% is a result of enhanced observation of care being in addition to budgeted establishment but essential to providing safe care to patients requiring enhanced levels of care and un-reflected roster templates changes awaiting to be updated. Enhanced care team is now in post and should see a reduction in the use of 1:1, although this may take a few months for the vacancies to be fully recruited. Current issues are HCA strikes that occurred during the first 2 weeks of August.	The monthly roster metric KPI meetings will continue to focus on managing unavailability, there have been improvements in terms of other leave and roster housekeeping however high rates of sickness require a greater focus. The trust wide ongoing work around agency reduction plans will also be introduce at these meetings for discussion and assurance, as well as the weekly recruitment and retention meetings and progress tracker. Agency HCA has now been switched off at present across the trust.	NGH hold twice daily safety huddles to monitor and mitigate staffing concerns and shortfalls where plans are made to provide internal mitigations and redeployment of staff to maintain safety. Temporary staffing is utilised when all opportunity for internal mitigation is exhausted. More recently UHN RAG rating for staffing shortfalls have been agreed and implemented, this has given greater objectivity in relation to evaluation of shortfalls, this has ensured alignment of approach to staffing evaluation across KGH and NGH. There were HCA strikes for the first 2 weeks of August.

30 day readmissions

Committee Name: All

GroupName: Quality

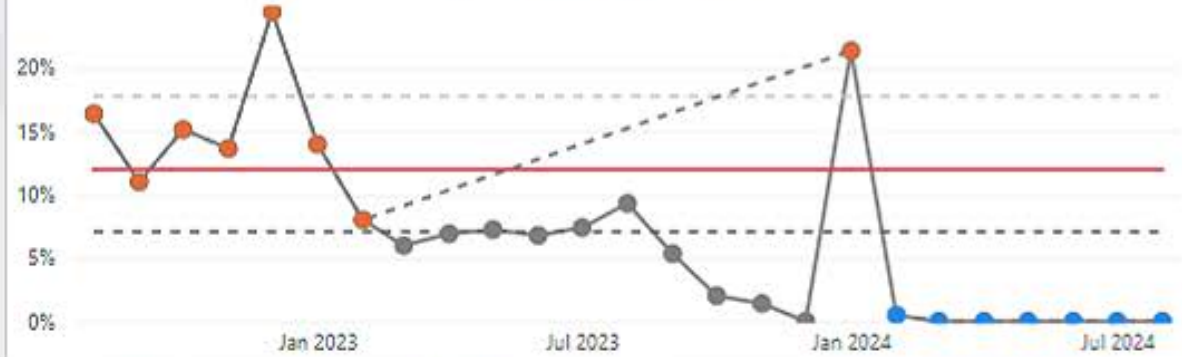
MetricName: 30 day readmissions

Date: 01/03/2021 – 01/08/2024

0.00%	12.00%	14.82%	12.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

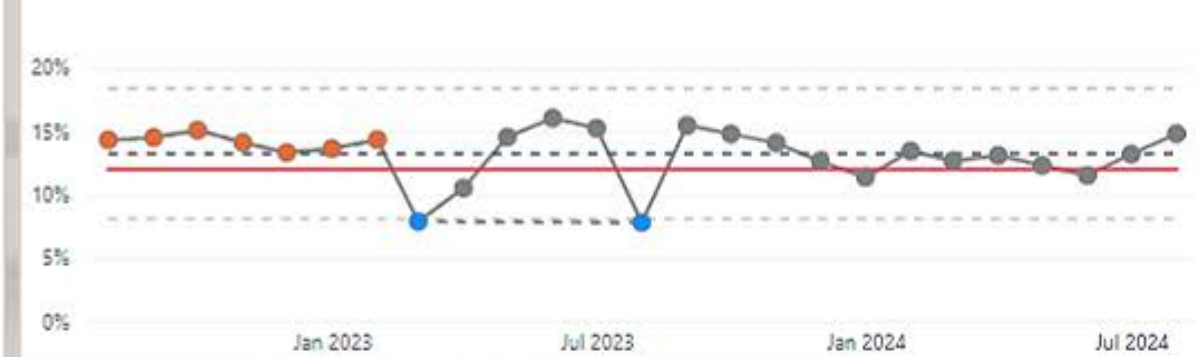
Kettering General Hospital

30 day readmissions: Quality



Northampton General Hospital

30 day readmissions: Quality



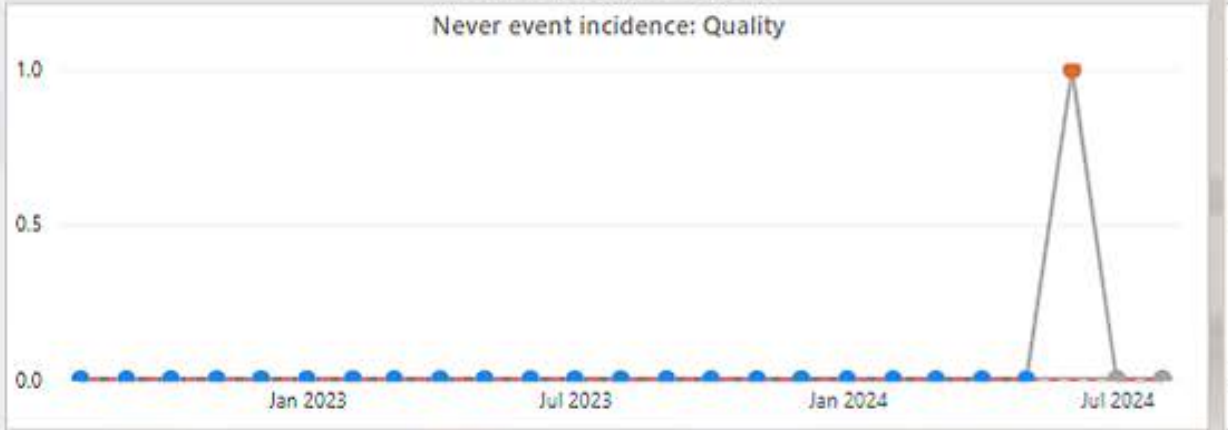
Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Number of patients readmitted within 30 days of discharge	No data available to report on	No data available to report on	Information team asked to diagnose the issue	No data available to report on

Never event incidence

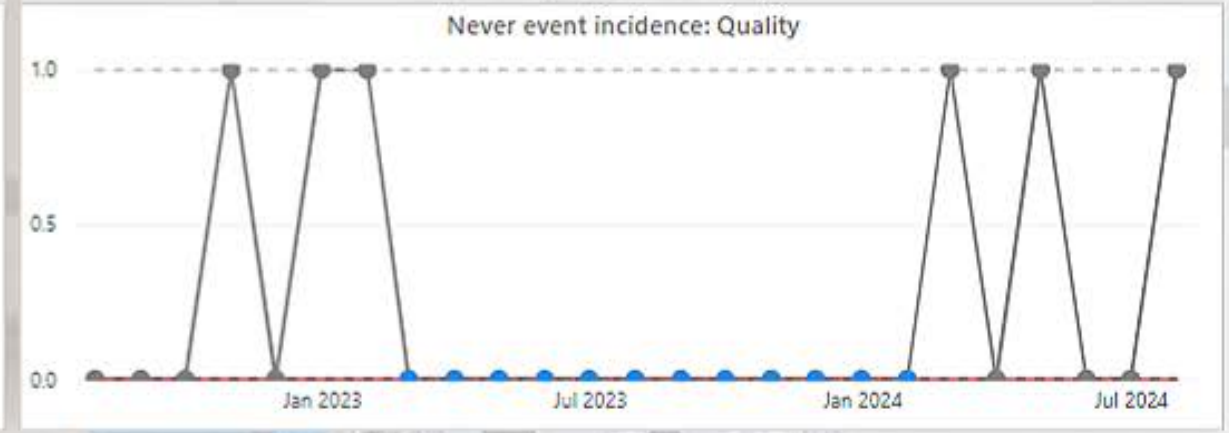
Committee Name	GroupName	MetricName	Date
All	Quality	Never event incidence	01/03/2021 – 01/08/2024

0	0	1	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Never event incidence

Committee Name: All

GroupName: Quality

MetricName: Never event incidence

0	0	1	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. As context between 01 April 22 and 31 March 23, 410 never events were reported nationally. National themes are shared across the NHS for learning.	There was one Never Event declared in June, the first since November 2021. A full investigation will take place.	None	None	None
NGH	01/08/24	Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. As context between 01 April 22 and 31 March 23, 410 never events were reported nationally. National themes are shared across the NHS for learning.	Never events are patient safety incidences that are wholly preventable where guidance or safety recommendations that provide strong, systemic protective barriers are available at a national level and have been implemented by healthcare providers. Never events are reported nationally and themes are shared across the NHS for learning.	There was 1 Never Event declared in August	incidences are reviewed in the twice weekly incident review meeting, and if they meet the criteria set out in the current never event list they will be considered for never event status	Events that are identified as meeting the Never Event criteria, are investigated using PSII and will include recommendations and actions to mitigate against further occurence.

Food wastage

Committee Name: All

GroupName: Quality

MetricName: Food wastage

Date: 01/03/2021 – 01/08/2024

6.22		7.70	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/08/24	A Group sustainability priority for reduction of the carbon footprint of food waste. Financial savings for Trust.	no material change from mean	Food wastage too high	Coloured plates which have had some success in other Trusts are being reviewed. Has cut waste up to 20%. Leanpath waste measuring is being rolled out with scales now arriving. Digital food ordering is still WIP	None

HEALTHi

Informatics | Intelligence | Insight | Integration | Improvement

NHS
University Hospitals of Northamptonshire
NHS Group

Finance and Investment Committee

Dedicated to excellence

Finance and Investment Committee

Exec owner: Richard Wheeler

In reminder, this Committee monitors the 'sustainability' metrics within the IGR.

This cover sheet is designed to **highlight to the Committee saliant messages from the IGR metrics** for this month:

1

At month 5, the ytd position is a £38.2m deficit, (£17.7m KGH, £20.6m NGH) which is £9.1m worse than plan. (£3.7m KGH, £5.5m NGH) These variances include ongoing UEC, inflationary and specific service pressures recognised as risks in the plan, along with the impact of industrial action. ERF income is exceeding planned values and partially mitigating the variance from plan. Further work is required to identify the full CIP programme from the original submission and with the inclusion of ERF performance for the first time in month 5 the programme is £0.5m ahead of plan, (KGH £0.7m worse than plan, NGH £1.2m better than plan)
At month 4 UHN compiled a forecast that indicated a potential gross £102m deficit for the year, reduced to £80m , £25m worse than the £55m plan after accounting for the targeted delivery of further workforce and agency staffing reductions, stringent non pay and other expenditure reviews and a level of stretch target for further divisional and corporate savings opportunities. Work is ongoing to secure these additional targeted savings and identify further opportunities for further reduce the forecast from £25m worse than plan.
Additional income will be received from month 6 onwards to cover the majority of the planned deficit and therefore aggregate deficit values will reduce in future months but variances from the revised plan will continue unless further mitigations are confirmed.

Key **developments with the IGR** itself for the Committee to note:

Worth remembering for all metrics, only metrics that have a) had data provided and b) have been signed off, will be published – therefore, this could lead to some gaps in reporting.

Sustainability

KGH | NGH

Committee Name: All

GroupName: Sustainability

5 Exec comments KGH

0 Exec comments NGH

14 Total No. of Metrics

Site	MetricName	Value
KGH	Theatre sessions planned	319
KGH	Surplus / Deficit YTD (M)	-3.46
KGH	Pay YTD (M)	24.03
KGH	Outpatients activity (& vs plan) 2	0
KGH	Non-elective activity (& vs plan) 2	0
KGH	Non Pay YTD (M)	11.34
KGH	Income YTD (M)	33.14
KGH	Elective inpatient activity (& vs plan) 2	0
KGH	Elective day-case activity (& vs plan) 2	0
KGH	CIP Performance YTD (M)	1.37
KGH	Capital Spend (M)	1.76
KGH	Beds available	504
KGH	Bank and Agency Spend (M)	4.13
KGH	A&E activity (& vs plan) 2	9,347

Metric	Comment
M5 Position	The in-month position is a £3.5m deficit which is £1.4m worse than the £2.1m plan. Adverse variances include ongoing UEC, unfunded inflation and other specific service pressures along with the impact of industrial action in the month. This continues to be partially offset in the month due to additional recognition of favourable ERF and excluded drugs and devices performance. The efficiency plan profile accelerated significantly in month 4 but a large proportion of this planned acceleration remains unidentified. In the month ERF benefits have been recorded as an efficiency for the first time and efficiency delivery is currently £0.7m behind plan.
YTD Position	The ytd position is a £17.7m deficit which is £3.7m worse than the £14.1m plan. Variances include ongoing UEC, unfunded inflation and other specific service pressures identified as risks in the compilation of the plan, £0.6m of industrial action pay costs and £0.7m of efficiency delivery shortfall. Additional income will be received from month 6 onwards to cover the majority of the planned deficit and therefore aggregate deficit values will reduce in future months but variances from the revised plan will continue unless further mitigations are confirmed.
Income	Year to date income is £3.4m better than plan. £1.4m relates to ERF, £1.0m relates to additional non recurrent income recognised as an efficiency in month 4, the remainder is largely due to excluded drugs and devices performance.
Non Pay	Year to date non pay excluding depreciation is £3.4m worse than plan. This includes a level of unfunded inflation identified as a risk in the plan and clinical expenses in pursuit of elective recovery partly offset by lower than anticipated utility costs. The efficiency plan profile accelerated significantly in month 4 but schemes to deliver the full increase remain under development and will require recovery in future months.
Pay	Year to date pay costs are £5.0m worse than plan including the impact of ongoing UEC and other unfunded service specific pressures identified as risks in the plan along with the impact of industrial action. Efficiency target profile increased in month 4 but plans to deliver these savings are not fully developed and are therefore contributing to the overall pay overspend.

Sustainability

KGH | NGH

Committee Name: All

GroupName: Sustainability

0	5	14
Exec comments KGH	Exec comments NGH	Total No. of Metrics

Site	MetricName	Value
NGH	Theatre sessions planned	630
NGH	Surplus / Deficit YTD (M)	-3.37
NGH	Pay YTD (M)	29.69
NGH	Outpatients activity (& vs plan) 2	42,340
NGH	Non-elective activity (& vs plan) 2	6,011
NGH	Non Pay YTD (M)	13.59
NGH	Income YTD (M)	41.54
NGH	Elective inpatient activity (& vs plan) 2	416
NGH	Elective day-case activity (& vs plan) 2	4,378
NGH	CIP Performance YTD (M)	4.37
NGH	Capital Spend (M)	2
NGH	Beds available	599
NGH	Bank and Agency Spend (M)	5.89
NGH	A&E activity (& vs plan) 2	11,348

Metric	Comment
M5 Position	The in-month position is a £3.4m deficit which is £1.3m worse than the £2.0m plan. Adverse variances include ongoing UEC, unfunded inflation and other specific service pressures which were risks that were identified in the compilation of the plan along with the impact of industrial action. In addition, utilities pressures continued in the month due to the failure of the CHP system. This is partially offset in the month due to continued favourable ERF performance. The efficiency plan profile accelerated significantly in month 4 but a large proportion of this planned acceleration remained unidentified. In the month ERF benefits have been recorded as an efficiency for the first time and efficiency delivery is currently £1.2m ahead of plan.
YTD Position	The ytd position is a £20.6m deficit which is £5.5m worse than the £15.1m plan. Variances include ongoing UEC, unfunded inflation and other specific service pressures identified as risks in the compilation of the plan, £0.7m of industrial action pay costs and £1.1m of efficiency delivery shortfall. Additional income will be received from month 6 onwards to cover the majority of the planned deficit and therefore aggregate deficit values will reduce in future months but variances from the revised plan will continue unless further mitigations are confirmed.
Income	Year to date income is £6.6m better than plan . This includes significant estimated overperformance against the ERF target and a number of minor variances across of range of areas, including High Cost Drugs and Devices which offset related non pay overspends.
Non Pay	Year to date non pay excluding depreciation is £5.7m worse than plan. This includes a level of unfunded inflation identified as a risk in the plan and the cost of clinical expenditure supporting elective recovery and excluded drugs and devices partly covered by additional income. Efficiency targets were budgeted to increase in month 4 but schemes to deliver the full increase remain under development and will require recovery in future months.
Pay	Year to date pay costs are £6.3m worse than plan including the impact of ongoing UEC, inflationary and other unfunded service specific pressures identified as risks in the plan, an element of late submitted staffing costs relating to 2023/24 and the impact of industrial action. Efficiency target profile increased in month 4 but plans to deliver these savings are not fully developed and are therefore contributing to the overall pay overspend.

Summary Table

Committee Name: All

Group Name: Sustainability

Metric Name: Multiple selections

Site: All

Variation: All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
NGH	Sustainability	Income YTD (M)	01/08/24	41.54	40.11	54.19	54.19	54.19			Not Consistently Anticipated to Meet Target
KGH	Sustainability	Income YTD (M)	01/08/24	33.14	32.61	44.78	44.78	44.78			Not Consistently Anticipated to Meet Target
NGH	Sustainability	Pay YTD (M)	01/08/24	29.69	28.77	39.31	39.31	39.31			Not Consistently Anticipated to Meet Target
KGH	Sustainability	Pay YTD (M)	01/08/24	24.03	22.98	32.51	32.51	32.51			Not Consistently Anticipated to Meet Target
NGH	Sustainability	Non Pay YTD (M)	01/08/24	13.59	11.83	14.7	14.7	14.7			Not Consistently Anticipated to Meet Target
KGH	Sustainability	Non Pay YTD (M)	01/08/24	11.34	10.21	12.01	12.01	12.01			Not Consistently Anticipated to Meet Target
KGH	Sustainability	Surplus / Deficit YTD (M)	01/08/24	-3.46	-2.07	3.66	3.66	3.66			Not Consistently Anticipated to Meet Target
NGH	Sustainability	Surplus / Deficit YTD (M)	01/08/24	-3.37	-2.04	2.22	2.22	2.22			Not Consistently Anticipated to Meet Target
KGH	Sustainability	CIP Performance YTD (M)	01/08/24	1.37	1.8	3.24	3.24	3.24			Not Consistently Anticipated to Meet Target
NGH	Sustainability	CIP Performance YTD (M)	01/08/24	4.37	2.03	5.5	5.5	5.5			Not Consistently Anticipated to Meet Target
KGH	Sustainability	Bank and Agency Spend (M)	01/08/24	4.13	2.28	5.18	5.18	5.18			Consistently Anticipated to Meet Target
NGH	Sustainability	Bank and Agency Spend (M)	01/08/24	5.89	3.25	7.82	7.82	7.82			Consistently Anticipated to Meet Target
NGH	Sustainability	Capital Spend (M)	01/08/24	2	2	-2	2	7			Not Consistently Anticipated to Meet Target
KGH	Sustainability	Capital Spend (M)	01/08/24	1.76	2.05	6.06	6.06	6.06			Not Consistently Anticipated to Meet Target

Income YTD (M)

Committee Name: All

GroupName: Sustainability

MetricName: Income YTD (M)

Date: 01/03/2021 – 01/08/2024

33.14	32.61	41.54	40.11
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital

Pay YTD (M)

Committee Name: All

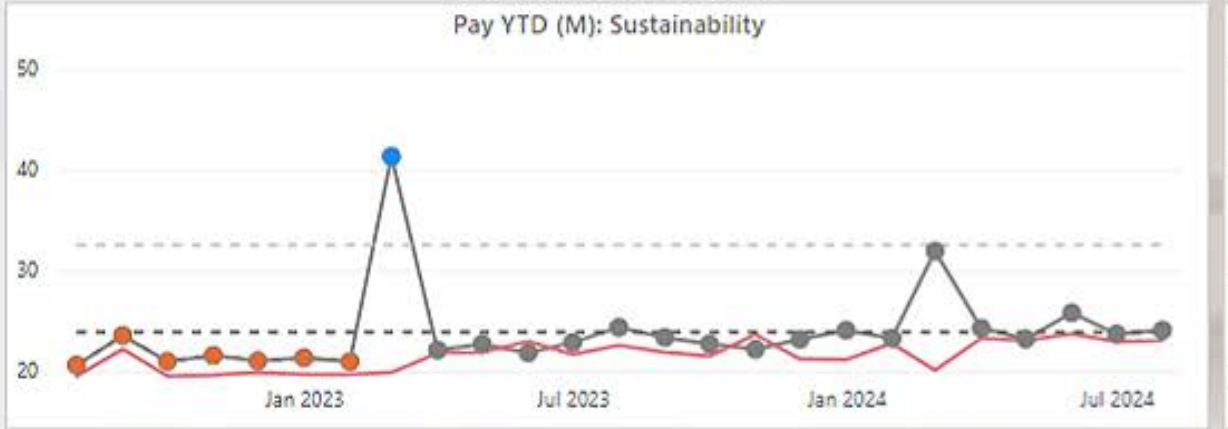
GroupName: Sustainability

MetricName: Pay YTD (M)

Date: 01/03/2021 – 01/08/2024

24.03	22.98	29.69	28.77
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital

Non Pay YTD (M)

Committee Name	GroupName	MetricName	Date
All	Sustainability	Non Pay YTD (M)	01/03/2021 – 01/08/2024

11.34	10.21	13.59	11.83
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital

Surplus / Deficit YTD (M)

Committee Name: All

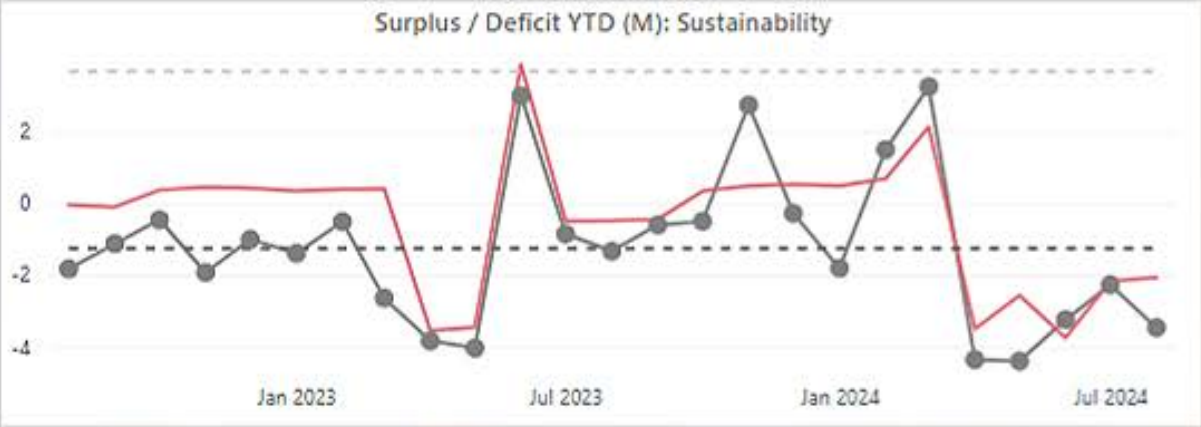
GroupName: Sustainability

MetricName: Surplus / Deficit YTD (M)

Date: 01/03/2021 – 01/08/2024

-3.46	-2.07	-3.37	-2.04
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital

CIP Performance YTD (M)

Committee Name	GroupName	MetricName	Date
All	Sustainability	CIP Performance YTD (M)	01/03/2021 – 01/08/2024

1.37	1.8	4.37	2.03
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital

Bank and Agency Spend (M)

Committee Name: All

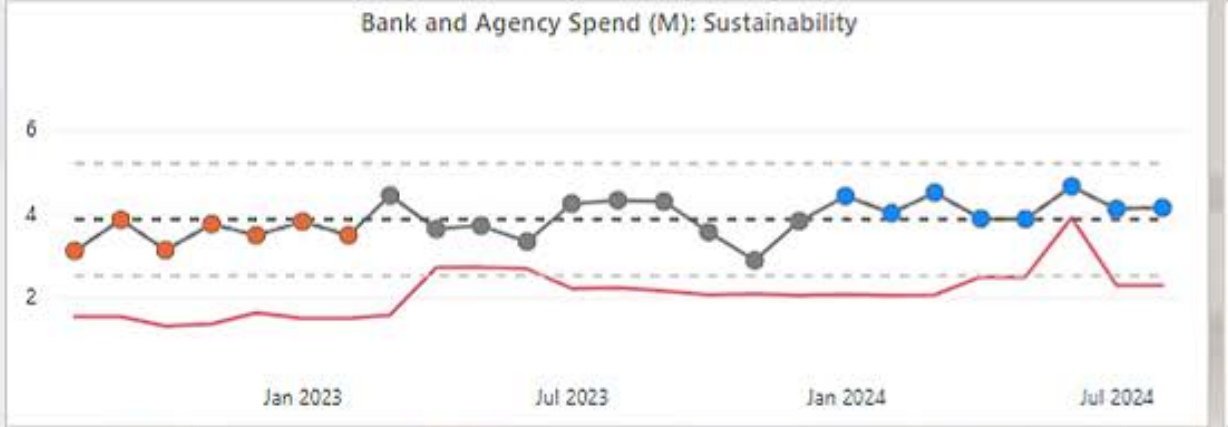
GroupName: Sustainability

MetricName: Bank and Agency Spend (M)

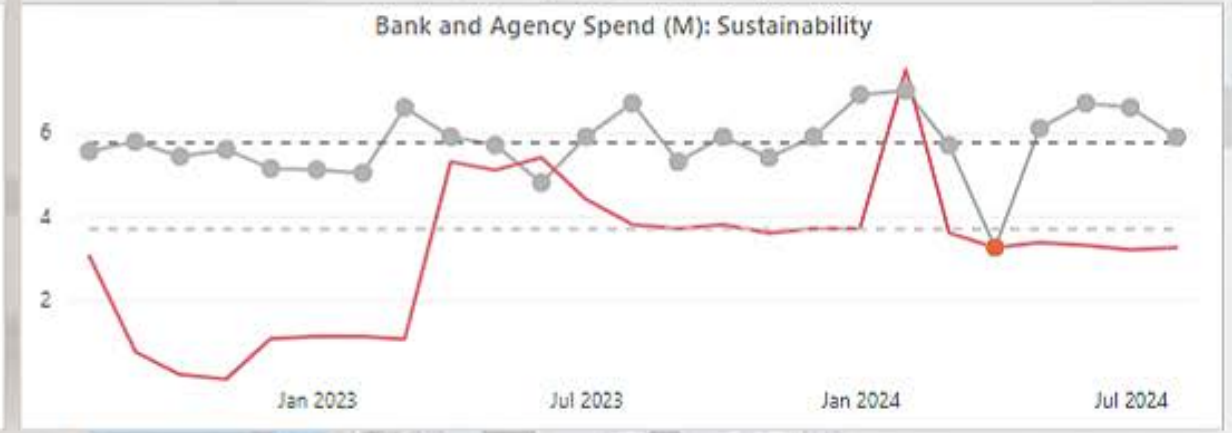
Date: 01/03/2021 – 01/08/2024

4.13	2.28	5.89	3.25
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Capital Spend (M)

Committee Name: All

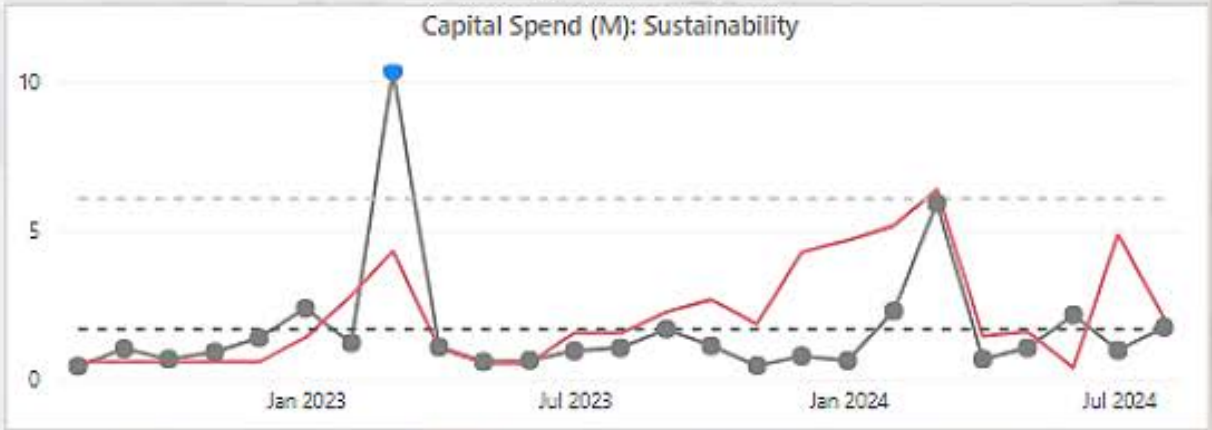
GroupName: Sustainability

MetricName: Capital Spend (M)

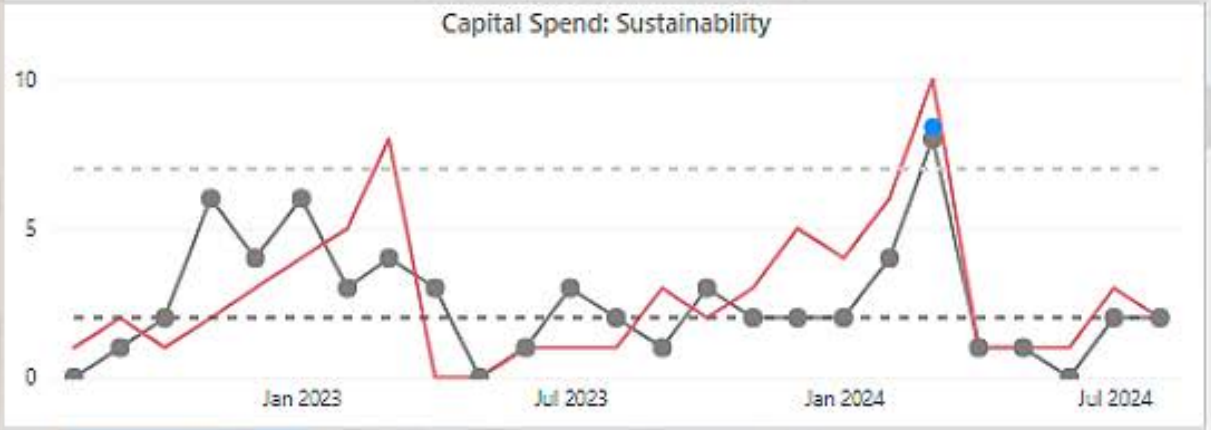
Date: 01/03/2021 – 01/08/2024

1.76	2.05	2	2
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



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NHS
University Hospitals of Northamptonshire
NHS Group

Operational Performance Committee

Dedicated to excellence

Summary Table

Committee Name: All

Group Name: Multiple selections

Metric Name: Multiple selections

Site: All

Variation: All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
KGH	Sustainability	Beds available	01/08/24	504		513	523	534			Consistently Anticipated to Meet Target
NGH	Sustainability	Beds available	01/08/24	599		600	621	642			Consistently Anticipated to Meet Target
KGH	Sustainability	Theatre sessions planned	01/08/24	319		113	287	461			Consistently Anticipated to Meet Target
NGH	Sustainability	Theatre sessions planned	01/08/24	630		561	607	654			Consistently Anticipated to Meet Target
NGH	Sustainability	A&E activity (& vs plan) 2	01/08/24	11,348	7966	9613	11946	14278			Consistently Anticipated to Meet Target
NGH	Sustainability	Non-elective activity (& vs plan) 2	01/08/24	6,011	2106	5204	5813	6421			Consistently Anticipated to Meet Target
NGH	Sustainability	Elective inpatient activity (& vs plan) 2	01/08/24	416		254	363	471			Consistently Anticipated to Meet Target
NGH	Sustainability	Elective day-case activity (& vs plan) 2	01/08/24	4,378		3222	4055	4888			Consistently Anticipated to Meet Target
NGH	Sustainability	Outpatients activity (& vs plan) 2	01/08/24	42,340	51465	32997	43751	54505			Not Consistently Anticipated to Meet Target
KGH	Sustainability	A&E activity (& vs plan) 2	01/08/24	9,347		5587	9032	12478			Consistently Anticipated to Meet Target
KGH	Sustainability	Non-elective activity (& vs plan) 2	01/08/24	0		910	1973	3036			Consistently Anticipated to Meet Target
KGH	Sustainability	Elective inpatient activity (& vs plan) 2	01/08/24	0		86	269	452			Consistently Anticipated to Meet Target
KGH	Sustainability	Elective day-case activity (& vs plan) 2	01/08/24	0		1168	3039	4910			Consistently Anticipated to Meet Target
KGH	Sustainability	Outpatients activity (& vs plan) 2	01/08/24	0		17097	27084	37071			Consistently Anticipated to Meet Target
KGH	Systems and Partnerships	31-day wait for first treatment	01/07/24	93.40%	96.00%	88.94%	94.64%	100.34%			Not Consistently Anticipated to Meet Target
NGH	Systems and Partnerships	31-day wait for first treatment	01/07/24	95.40%	96.00%	79.73%	90.81%	101.89%			Not Consistently Anticipated to Meet Target
KGH	Systems and Partnerships	62-day wait for first treatment	01/07/24	57.10%	85.00%	30.78%	58.09%	85.39%			Not Consistently Anticipated to Meet Target
NGH	Systems and Partnerships	62-day wait for first treatment	01/07/24	72.30%	85.00%	45.4%	63.57%	81.75%			Consistently Anticipated to Not Meet Target

Summary Table

Committee Name: All

Group Name: Multiple selections

Metric Name: Multiple selections

Site: All

Variation: All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
KGH	Systems and Partnerships	Cancer: Faster Diagnostic Standard	01/07/24	85.70%	75.00%	79.52%	85.15%	90.78%			Consistently Anticipated to Meet Target
NGH	Systems and Partnerships	Cancer: Faster Diagnostic Standard	01/07/24	87.50%	75.00%	77.45%	83.57%	89.7%			Consistently Anticipated to Meet Target
KGH	Systems and Partnerships	6-week diagnostic test target performance	01/08/24	79.00%	99.00%	53.81%	64.78%	75.74%			Consistently Anticipated to Not Meet Target
NGH	Systems and Partnerships	6-week diagnostic test target performance	01/08/24	97.43%	99.00%	66.2%	75.62%	85.05%			Consistently Anticipated to Not Meet Target
NGH	Systems and Partnerships	Unappointed outpatient follow ups	01/08/24	28,703	0	19504	23176	26849			Consistently Anticipated to Not Meet Target
KGH	Systems and Partnerships	Unappointed outpatient follow ups	01/08/24	7,361		3709	6124	8538			Consistently Anticipated to Not Meet Target
KGH	Systems and Partnerships	RTT over 52 week waits	01/08/24	351	0	221	335	449			Consistently Anticipated to Not Meet Target
NGH	Systems and Partnerships	RTT over 52 week waits	01/08/24	1,137	0	862	1150	1437			Consistently Anticipated to Not Meet Target
NGH	Systems and Partnerships	Size of RTT waiting list	01/08/24	41,186	0	37099	39666	42233			Consistently Anticipated to Not Meet Target
KGH	Systems and Partnerships	Size of RTT waiting list	01/08/24	28,781		26501	27899	29297			Consistently Anticipated to Not Meet Target
NGH	Systems and Partnerships	Theatre utilisation	01/08/24	82.00%		73.45%	77.88%	82.32%			Consistently Anticipated to Meet Target
KGH	Systems and Partnerships	Theatre utilisation	01/08/24	82.00%		41.95%	66.44%	90.93%			Consistently Anticipated to Meet Target
NGH	Systems and Partnerships	Bed utilisation	01/08/24	88.77%		85.04%	88.31%	91.59%			Consistently Anticipated to Meet Target
KGH	Systems and Partnerships	Bed utilisation	01/08/24	96.96%		96.53%	97.93%	99.33%			Consistently Anticipated to Meet Target
NGH	Systems and Partnerships	Stranded patients (7+ day length of stay)	01/08/24	367		332	375	417			Consistently Anticipated to Not Meet Target
KGH	Systems and Partnerships	Stranded patients (7+ day length of stay)	01/08/24	273		253	278	304			Consistently Anticipated to Not Meet Target
KGH	Systems and Partnerships	Super-Stranded patients (21+ day length of stay)	01/08/24	90	0	78	97	116			Consistently Anticipated to Not Meet Target
NGH	Systems and Partnerships	Super-Stranded patients (21+ day length of stay)	01/08/24	155	0	123	167	210			Consistently Anticipated to Not Meet Target

Summary Table

Committee Name: All

Group Name: Multiple selections

Metric Name: Multiple selections

Site: All

Variation: All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
NGH	Systems and Partnerships	Patients with a reason to reside	01/08/24	70.64%	95.00%	63.22%	68.01%	72.81%			Consistently Anticipated to Not Meet Target
KGH	Systems and Partnerships	Patients with a reason to reside	01/08/24	76.68%		70.44%	74.82%	79.21%			Consistently Anticipated to Meet Target
KGH	Systems and Partnerships	Ambulance Handover	01/08/24	330		-73	163	399			Not Consistently Anticipated to Meet Target
NGH	Systems and Partnerships	Ambulance Handover	01/08/24	434		-13	258	529			Not Consistently Anticipated to Meet Target
KGH	Systems and Partnerships	Time to initial assessment	01/08/24	72.71%		51.68%	61.74%	71.81%			Consistently Anticipated to Meet Target
NGH	Systems and Partnerships	Time to initial assessment	01/08/24	40.76%		41.91%	47.95%	54%			Consistently Anticipated to Meet Target
KGH	Systems and Partnerships	Average time in department - Admitted	01/08/24	585		446	582	718			Consistently Anticipated to Meet Target
KGH	Systems and Partnerships	Average time in department - Discharged	01/08/24	208		203	227	252			Consistently Anticipated to Meet Target
KGH	Systems and Partnerships	4hr ED Performance	01/08/24	81.60%		52.23%	58.79%	65.35%			Consistently Anticipated to Meet Target
NGH	Systems and Partnerships	4hr ED Performance	01/08/24	73.04%		61.26%	67.13%	73.01%			Consistently Anticipated to Meet Target
NGH	Systems and Partnerships	Average time in department - Discharged	01/08/24	175		171	205	239			Consistently Anticipated to Meet Target
NGH	Systems and Partnerships	Average time in department - Admitted	01/08/24	893		648	906	1164			Consistently Anticipated to Meet Target

Operational and Performance Committee

Exec owners: Sarah Noonan, Palmer Winstanley

In reminder, this Committee monitors the 'sustainability' metrics and the 'systems and partnerships' metrics within the IGR.

This cover sheet is designed to **highlight to the Committee saliant messages from the IGR metrics** for this month:

1. Stranded Patients with a Length of stay >7 days has increased slightly for NGH but remained static for KGH. The narrative for NGH has indicated some delays in TOC completions and a reduction in Pathway 1 discharges compared to June and July.
2. Time to Initial Assessment metric percentage continues to show an upward trend for KGH and is the highest since Sept 21 though KGH have indicated that during heighten periods of activity, the ability to complete the TTIA within the time standard is impacted.
3. Both KGH and NGH have seen a minimal decreases in the number of Patients waiting greater than 52wks. The narrative has indicated that Clock starts continue to be in an excess of Clock stops. KGH have continued to offer NGH support with long waiting patients. NGH have indicated Annual, sickness and the cancellation of Elective Activity has impacted clearance.

Key **developments with the IGR** itself for the Committee to note:

1. Health Intelligence Transformation Programme will be developing the IGR as part of the NEW data warehouse initiative.
2. 30-Day Re-admission Rate – The logic for KGH is corrupt and requires a full re-build. Before the work commences – Is this metric still relevant?
3. Successful Making Dating Count meetings with follow up sessions planned.
4. Reporting logic for the metric Unappointed outpatient follow ups is under review.

Worth remembering for all metrics, only metrics that have a) had data provided and b) have been signed off, will be published – therefore, this could lead to some gaps in reporting.

Beds available

Committee Name: All

GroupName: Sustainability

MetricName: Beds available

Date: 01/03/2021 – 01/08/2024

504		599	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Beds available: Sustainability

Northampton General Hospital

Beds available: Sustainability

Theatre sessions planned

Committee Name: All

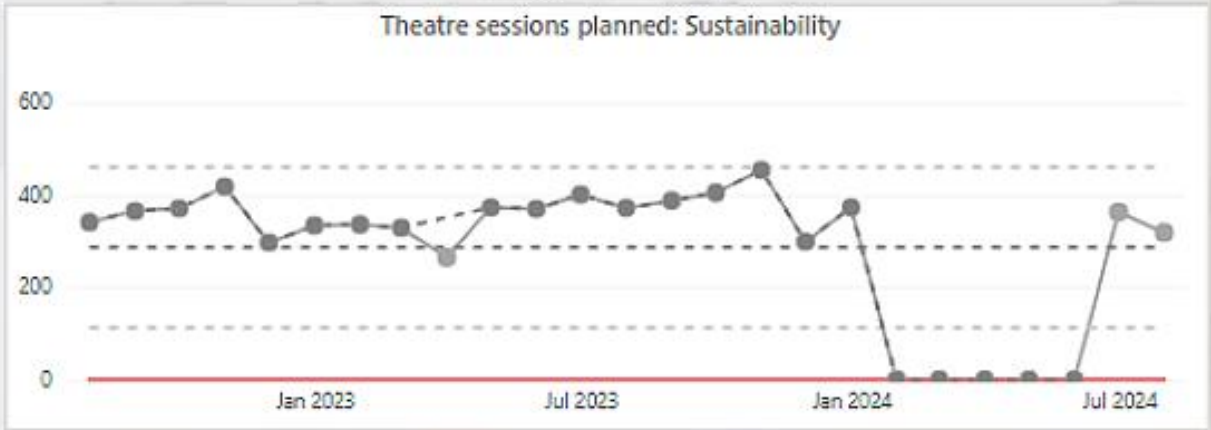
GroupName: Sustainability

MetricName: Theatre sessions planned

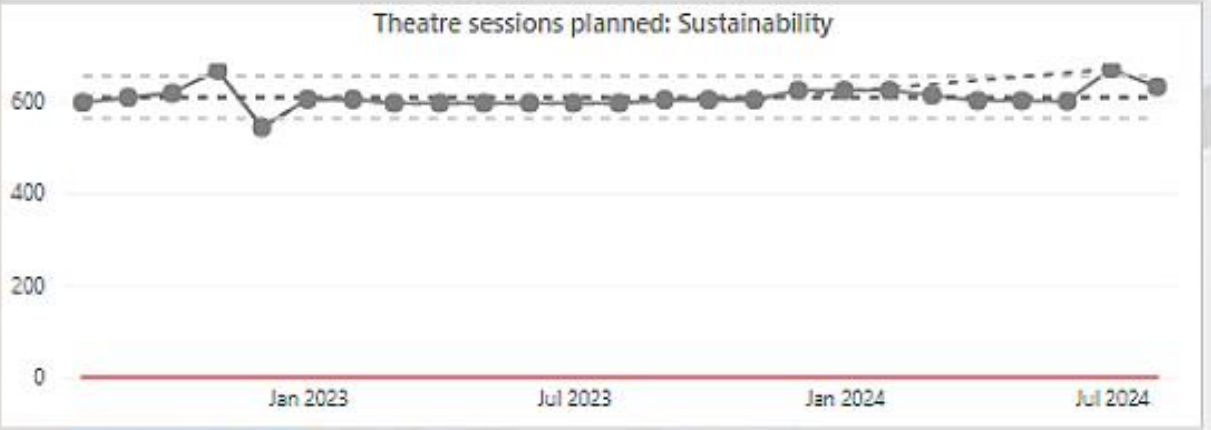
Date: 01/03/2021 – 01/08/2024

319		630	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	To monitor number of elective theatre sessions	The chart tells us the number of theatre sessions used during August was 319.	Higher than average adversely affected the number of theatre lists run during August.	Backfill of theatre sessions to be encouraged from specialties	Weekly Theatre Planning meeting used to ensure sessions are backfilled wherever possible
NGH	01/08/24	To monitor number of elective theatre sessions	669 sessions planned for this month	Lack of Anaesthetists resulting in many cancellations of planned lists.	Ongoing substantive and locum recruitment. KGH and MK anaethetists have been asked if willing to work at NGH weekdays. Development of a workforce plan	Use of locum and agency staff. Additional weekend lists for long waiting and cancer patients

A&E activity (& vs plan) 2

Committee Name: All

GroupName: Sustainability

MetricName: A&E activity (& vs plan) 2

Date: 01/03/2021 – 01/08/2024

9,347		11,348	7966
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

A&E activity (actual vs plan): Sustainability

Northampton General Hospital

A&E activity (& vs plan) 2: Sustainability

A&E activity (& vs plan) 2

Committee Name: All

GroupName: Sustainability

MetricName: A&E activity (& vs plan) 2

9,347		11,348	7966
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	A&E attendances	Total attendances in August 2024 are 3.8% higher than in August 2023; the increase continues to be across our unheralded cohort	Safety concerns remain in respect of the risk of overcrowding in ED, which further impacts the following: High number of self-presenters increasing the risk of overcrowding in the waiting room impacting patient experience and outcomes. Overcrowding impacting our ability to improve our compliance with quality and safety KPI's around TTIA, wait to be seen by a clinician and pain management. Trust capacity impacting performance against the 4-hour National Standard and Ambulance handovers	Ongoing collaborative meetings with EMAS and CUCC colleagues to discuss appropriateness of conveyances and/or alternative streaming options. Engagement work ongoing with our Primary care colleagues via the GP Liaison Lead. Plan for one of our acute medical consultants to join the primary/secondary interface meetings with GP colleagues to discuss challenges with access and streaming pathways.	Implementation of the Trustwide. escalation protocol Move of patients against confirmed and predicted discharges from base wards to support capacity pressures in ED.
NGH	01/08/24	A&E attendances	We have seen a marginal increase in attendances of 274	We continue to have overcrowding in ED which attributes to risk to patient safety as this causes delays to treatments. Lack of bedded spaces in ED for extended wait patients while awaiting specialty beds, due to poor backend flow. Management of pressure areas of extended wait patients who remain in a chair often exceed over 24hours leading to deconditioning in frail patients particularly	Continue to actively stream and redirect patients to alternative pathways and services, active pulling to SDEC of appropriate patients from ED after further diagnostics rules out more serious conditions. Drive direct referrals to SDEC, reminding EMAS to refer directly as well. We continue to audit out continuation of care, patients NEWS scoring and	Continue to board on the escalation areas - Nye Bevan have 10 additional patients (for over 6 months now)

Non-elective activity (& vs plan) 2

Committee Name: All

GroupName: Sustainability

MetricName: Non-elective activity (& vs plan) 2

Date: 01/03/2021 – 01/08/2024

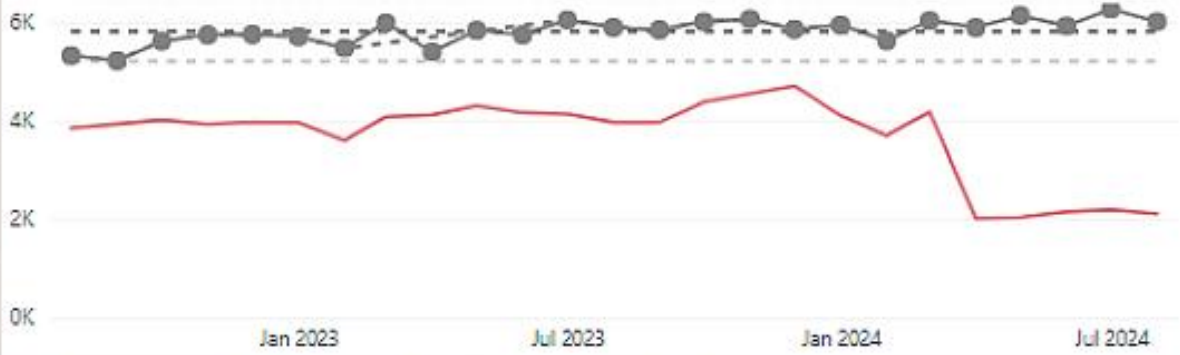
0		6,011	2106
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Non-elective activity (actual vs plan): Sustainability

Northampton General Hospital

Non-elective activity (& vs plan) 2: Sustainability



Elective day-case activity (& vs plan) 2

Committee Name: All

GroupName: Sustainability

MetricName: Elective day-case activity (& vs plan) 2

Date: 01/03/2021 – 01/08/2024

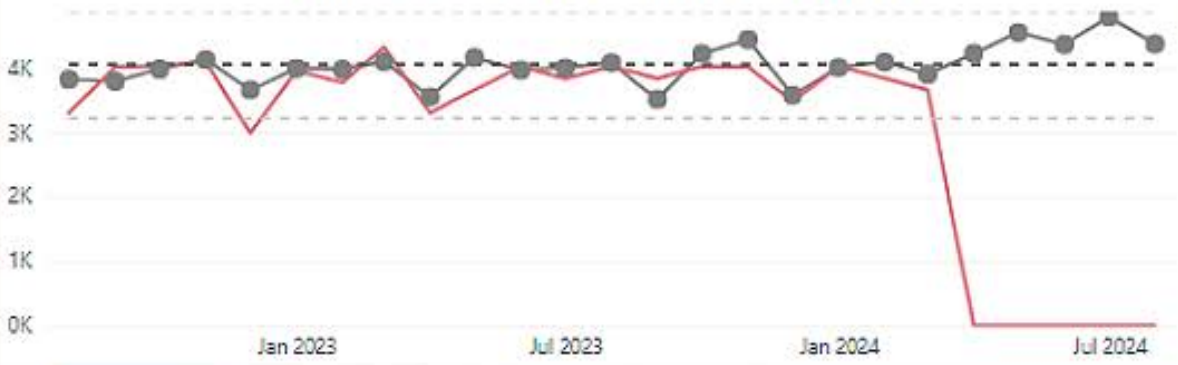
0		4,378	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Elective day-case activity (actual vs plan): Sustainability

Northampton General Hospital

Elective day-case activity (& vs plan) 2: Sustainability



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/08/24	Elective day case activity actuals v plan	Data shows that we delivered reduced Elective Day Case activity in August as expected (4,378 vs 4,799 previous month) this activity is still ahead of the mean of 4,055	Activity remains strong and ahead of mean with activity expected to increase in September once the main holiday period has past	Cancer and long waiter lists prioritised with transfer of activity to KGH/Woodlands. Recruitment of consultant anaesthetists continues	NGH continues to use I5 (Woodlands) to support its long waiters and deliver the max waiting time targets however we are now struggling to find suitable patients to outsource due to comorbidities or complex surgery

Elective inpatient activity (& vs plan) 2

Committee Name: All

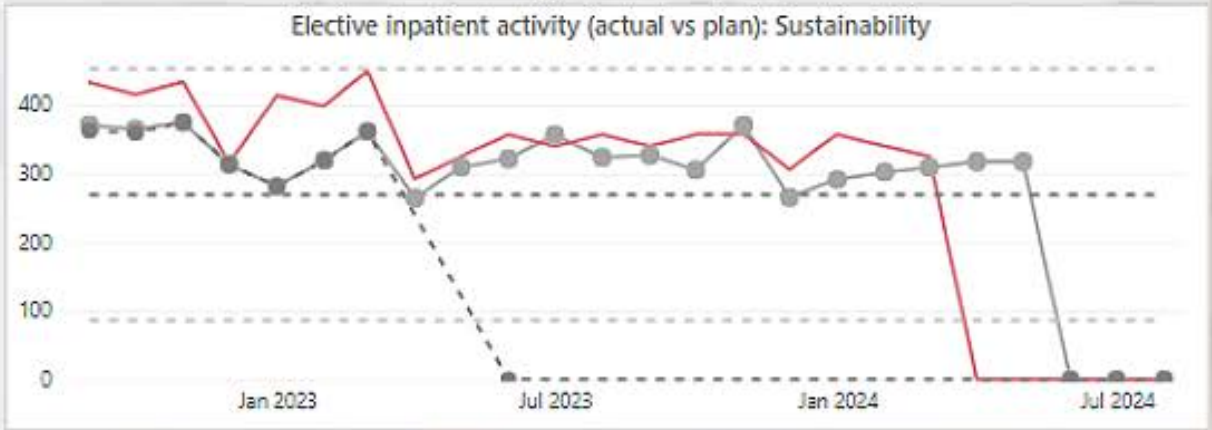
GroupName: Sustainability

MetricName: Elective inpatient activity (& vs plan) 2

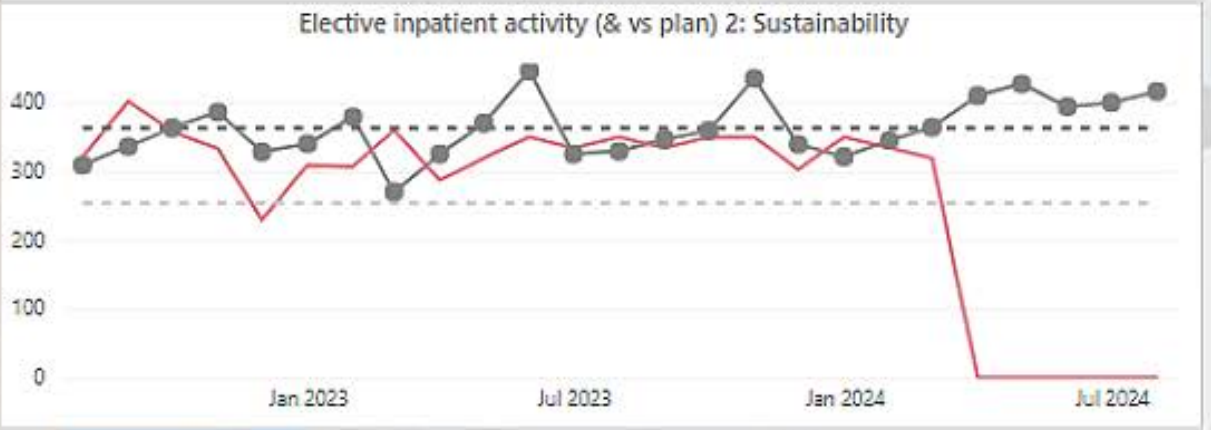
Date: 01/03/2021 – 01/08/2024

0		416	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/08/24	Elective inpatient activity actuals v plan	Data shows that we delivered a slightly increased Elective Inpatient actvity in August (416 vs 400 previous month) this actvity is still ahead of the mean of 363	Activity remains strong and ahead of mean despite the main holiday period as we focus on the larger more complex surgery backlog	Cancer and long waiter lists prioritised with transfer of actvity to KGH/Woodlands. Recruitment of consultant anaesthetists continues	NGH continues to use I5 (Woodlands) to support its long waiters and deliver the max waiting time targets however we are now struggling to find suitable patients to outsource due to comorbidities or complex surgery

Outpatients activity (& vs plan) 2

Committee Name: All

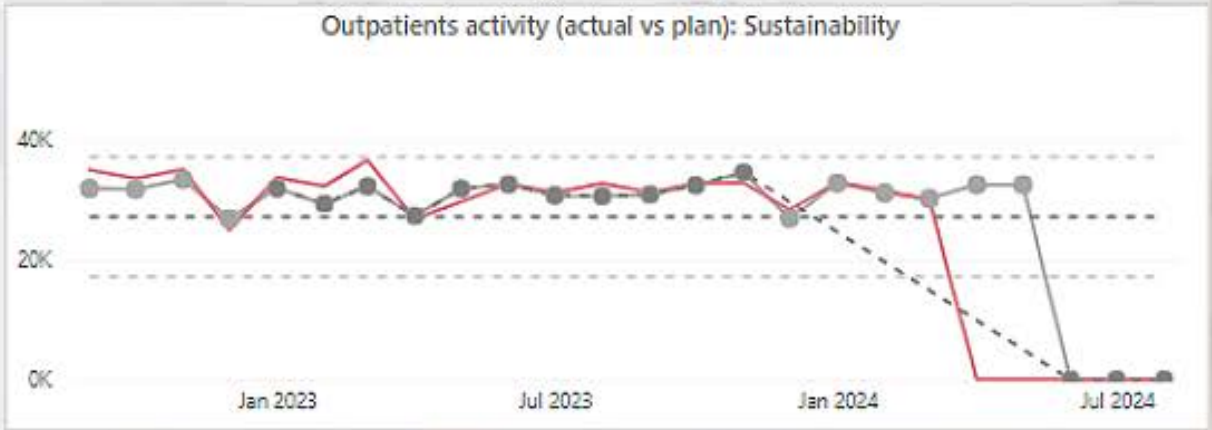
GroupName: Sustainability

MetricName: Outpatients activity (& vs plan) 2

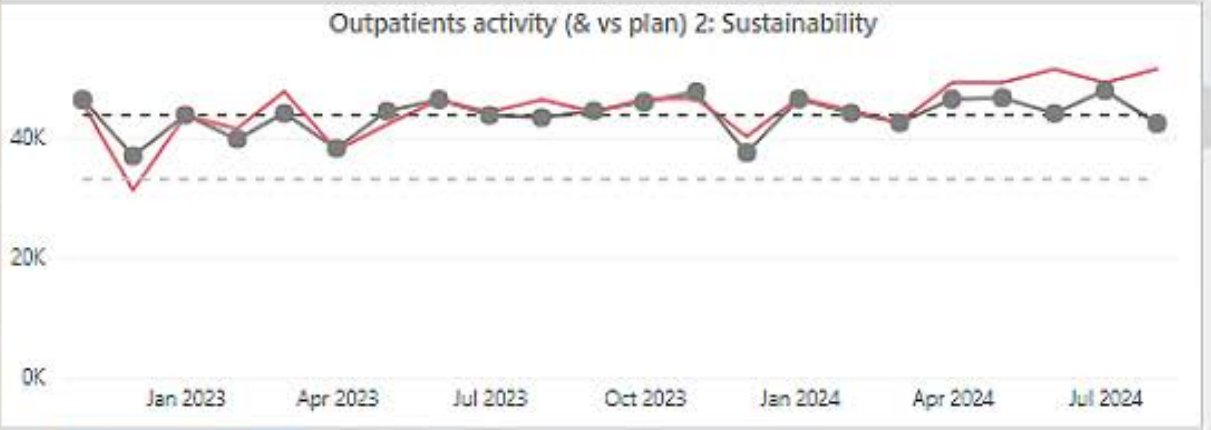
Date: 01/03/2021 – 01/08/2024

0		42,340	51465
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



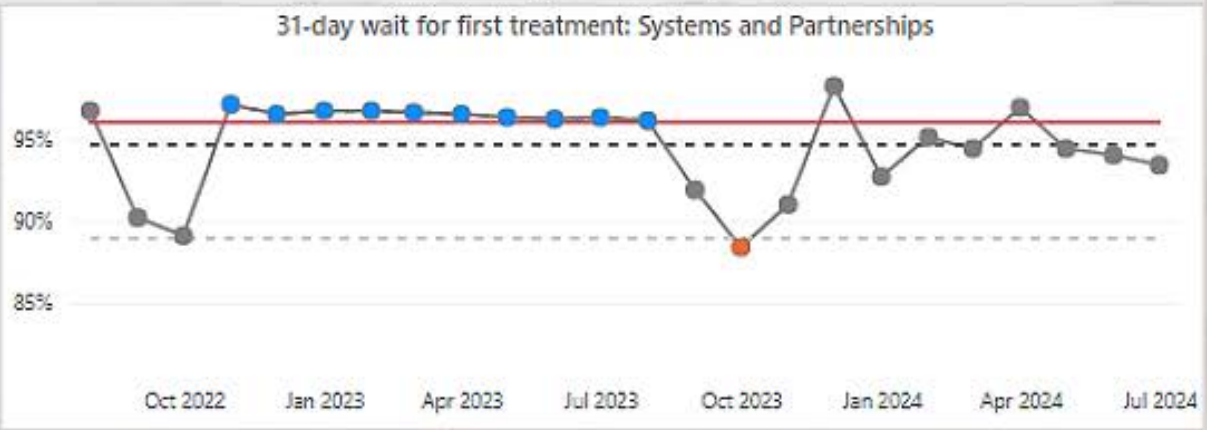
Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/08/24	This is the total number of outpatient appointments in the month (face to face and virtual, new and follow up)	Data shows that we delivered a decrease in Outpatient activity in August as expected (42,340 vs 47,833 previous month) given that this was main holiday period and included a bank holiday	Activity is planned to increase in September once the main holiday period is past	Increased use of PIFU, application of the access policy for DNA's and a push to increase the numbers of virtual appointments is being picked up with the clinical and admin teams via the Elective Productivity and GIRFT Governance Group that are chaired by a Dep Medical Director every week	Outpatient improvement project continues across the group with a Regional focus on DNA's, referral triage, PIFU and patient validation

31-day wait for first treatment

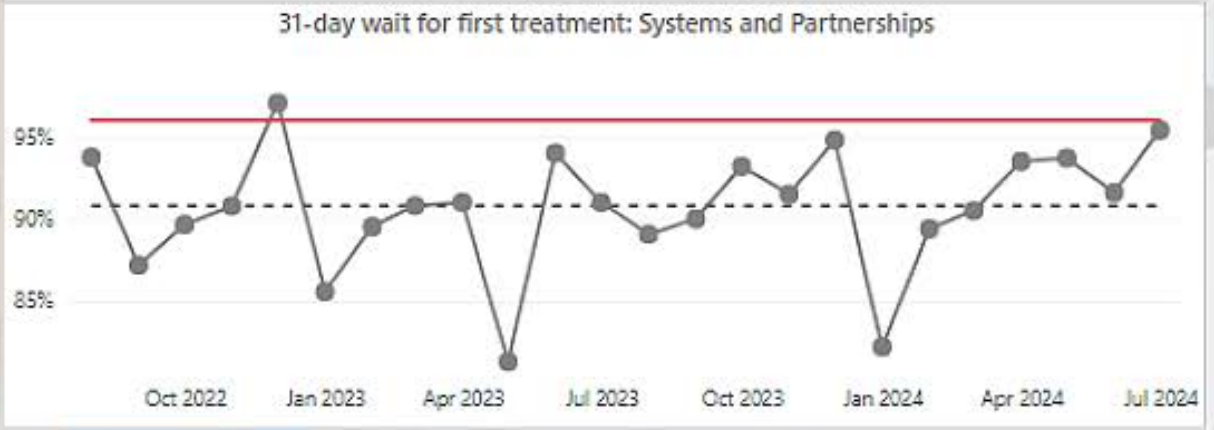
Committee Name	GroupName	MetricName	Date
All	Systems and Partnerships	31-day wait for first treatment	01/03/2021 – 01/08/2024

93.40%	96.00%	95.40%	96.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



31-day wait for first treatment

Committee Name	GroupName	MetricName
All	Systems and Partnerships	31-day wait for first treatment

93.40%	96.00%	95.40%	96.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

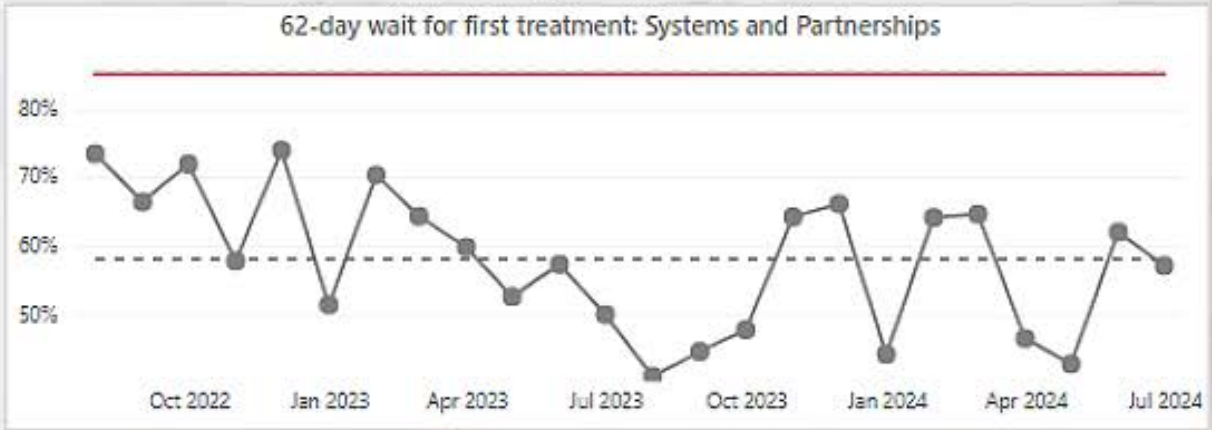
Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/07/24	% of patients whose treatment is initiated within 31 days of the decision to treat	The Trust recorded 92.3% against the standard of 96%	The Trust's combined performance for July was recorded at 92.3%. 208 treatments were recorded and included 16 breaches. A number of breaches were recorded in Skin and Colorectal and due to capacity. It is worth noting that despite not achieving 31 day standard every effort was made to meet the 62 day standard.	Ensure clear communication with waiting list teams in terms of breach dates. Continue discussions regarding performance against the standard at Patient Access Board. Dermatology recruited clinician start date ? November	31d and subsequent tracking lists are reviewed weekly by cancer services tracking team. Potential breaches are escalated to the service and action is recorded in patient tracking notes. Weekly PTLs commenced to review days 0-31 to identify any issues and potential blockages to prevent potential breaches. Waiting list attendance at twice weekly PTLs
NGH	01/07/24	% of patients whose treatment is initiated within 31 days of the decision to treat	It is disappointing that for July the Trust just missed the 96% standard, achieving 95.4%	542 treatments occurred of which 25 breached. 21 of the breaches were due to surgical capacity with 4 in oncology planning and further diagnostic delays	National recovery of the 31 day standard has been identified by NHSE as a priority area. NGH have struggled for many years to achieve this standard. The trust continues to prioritise cancer. Moving patients to treatment remains the biggest challenge.	Site and corporate ptl's provide full visibility of patient pathways, the trust escalation policy identifies patients not meeting key milestones for services to address, weekly access committee to highlight areas of concern to divisional teams, monthly cancer strategy group overseeing and driving improvements

62-day wait for first treatment

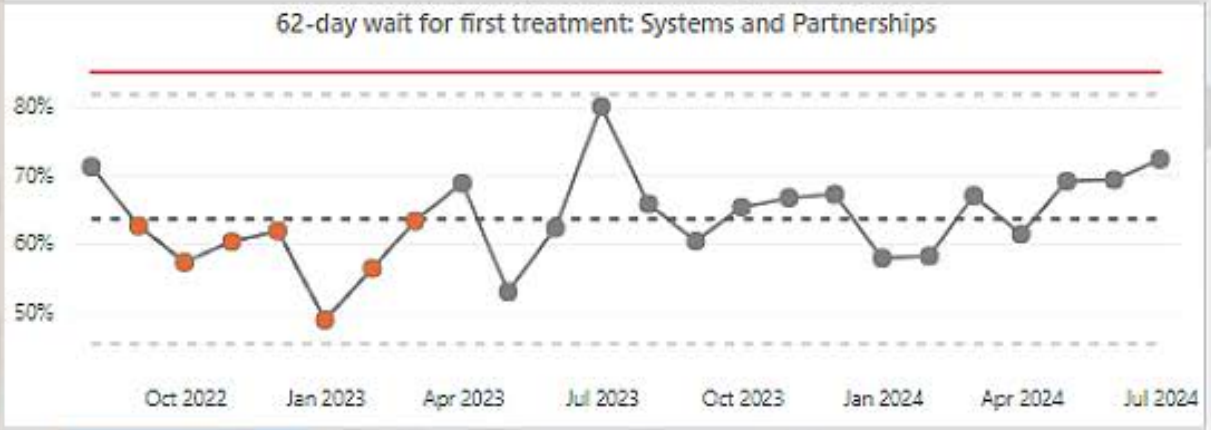
Committee Name	GroupName	MetricName	Date
All	Systems and Partnerships	62-day wait for first treatment	01/03/2021 – 01/08/2024

57.10%	85.00%	72.30%	85.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



62-day wait for first treatment

Committee Name: All

GroupName: Systems and Partnerships

MetricName: 62-day wait for first treatment

57.10%		72.30%	85.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/07/24	% of patients whose treatment in initiated within 63 days of urgent referral	The Trust did not meet the standard of 85%. Performance for the month of July was recorded at 65.1%.	The Trust recorded a performance of 65.1% against the standard of 85%. Although not an improved position from June, the Trust is on plan against trajectory. 175 treatments were recorded this included 61 breaches. The number of patients passed breach date has continued to reduce and this is having a positive affect on performance. Common themes relating to breaches include: Complex pathways - where opinions required from other tumour sites, ?metastatic disease Tertiary centres MDT and diagnostics Surgical capacity Increased number of and repeated diagnostics	No change - Cancer recovery action plan discussed and updated by Head of Nursing for Cancer and presented weekly at patient access board. No change - Impact of industrial action added to risk register, updated and reviewed regularly and discussed at operational risk management group. Ongoing - Attempt to employ overseas pathologist - feasibility of employing by 3rd party (Medica) explored and is possible costings reviewed by exceutives. Rate limiting step now the procurement process and whether a tender is required. Implementation of clinical review of site specific PTLs and ensure this is custom practice to ensure patients are moved though the pathway without delay Review of cancer access policy inline with new CWT version 12 changes. Policy changes now ratified and endorsed Key stakeholder follow up meeting planned to discuss issues affecting patients timely transition through the colorectal pathway	Weekly PTLs for patients with 31 days left on pathways held with tracking team and service support managers from divisions take place. Weekly PTLs commenced to review days 0-31 to identify any issues and potential blockages to prevent potential breaches. Performance against the standard is discussed weekly at Patient Access Board and presented monthly at the Cancer Management Group Twice weekly confirm and challenge meetings continue to take place with Head of Access, Cancer Management team, Service Support Managers, Radiology and Histopathology attend. Waiting list team are invited to attend to ensure TCIs are booked within breach dates

62-day wait for first treatment

Committee Name	GroupName	MetricName
All	Systems and Partnerships	62-day wait for first treatment

57.10%		72.30%	85.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/07/24	% of patients whose treatment in initiated within 63 days of urgent referral	The Trust did not meet the standard of 85%. Performance for the month of July was recorded at 65.1%.	Patient choice during the diagnostic phase Patient fitness Immunotesting - particularly specific to Lung	Explore potential of further expediting Rapid Prostate Pathway by changing from 2 stop to 1 stop clinic, meeting convened with stakeholders - radiology to explore possibility. Explored but rate-limiting step now identified as radiology stffing resource. To remain on cancer action plan and for review once additional radiology resource commenced in post and embedded in practice. SOP for turnaround times for immunotesting - discussions taking place with histopathology UHL to formulate SOP. Further explore CTC bookings to shorten pathway,specifically prescribing prep at point of OPA - meeting held, SOP to be reimplemented and go live date Nov 24 once Gastro graffin back in circulation	Weekly calls take place with tertiary centres for next steps of patients, both NGH, UHL and St Marks commenced Training completed of admin staff to book CTC scans, resulting in releasing clinical staff and expediting bookings by more frequent contact with patients

62-day wait for first treatment

Committee Name: All

GroupName: Systems and Partnerships

MetricName: 62-day wait for first treatment

57.10%		72.30%	85.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/07/24	% of patients whose treatment in initiated within 63 days of urgent referral	The target for March 2025 is for Trusts to achieve 70%, for July NGH achieved 72.3%	235 treatments were delivered of which 65 breached. This originated from urgent suspicion of cancer referrals from GP's, screening and consultant upgrades. Top breach reasons included health provider initiated delay, meaning one or more avoidable delays, outpatient capacity, elective treatment capacity, with patient choice and fitness also featuring this month	The trust continues to prioritise cancer, Moving patients to treatment remains the biggest challenge.	Site and corporate ptl's provide full visibility of patient pathways, the trust escalation policy identifies patients not meeting key milestones for services to address, weekly access committee to highlight areas of concern to divisional teams, monthly cancer strategy group overseeing and driving improvements

Cancer: Faster Diagnostic Standard

Committee Name: All

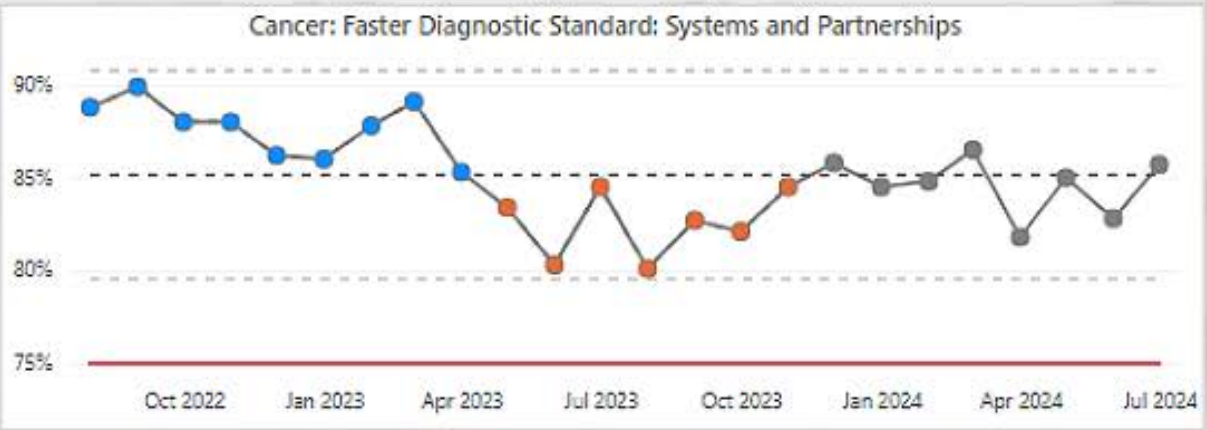
GroupName: Systems and Partnerships

MetricName: Cancer: Faster Diagnostic Standard

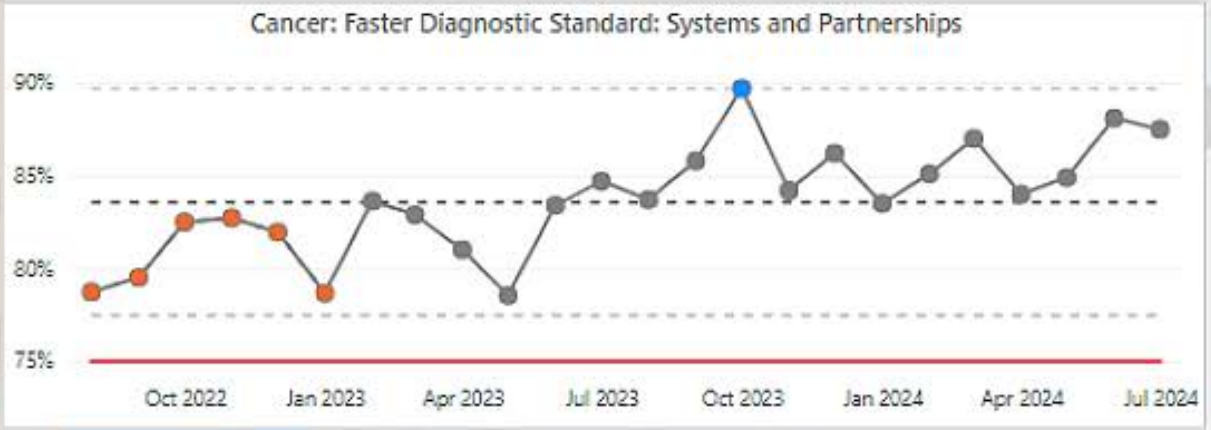
Date: 01/03/2021 – 01/08/2024

85.70%	75.00%	87.50%	75.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Cancer: Faster Diagnostic Standard

Committee Name: All

GroupName: Systems and Partnerships

MetricName: Cancer: Faster Diagnostic Standard

85.70%		87.50%	75.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/07/24	% of patients diagnosed in less than 28 days	The Trust achieved the faster diagnosis standard for the month of July at 85.2%	The Trust continues to achieve and exceed the standard, resulting in recognition in being one of the best performing trusts in the region. Continued challenges affecting the standard have included outpatient and straight to test capacity, patient choice resulting in delay to performing diagnostics.	Divisions to continue to monitor performance against the standard Increased PTL meetings continue to maintain focus and performance	Performance against the standard is discussed weekly at Patient Access Board and presented monthly at the Cancer Management Group and Northamptonshire Cancer Board As above, achievement of FDS is discussed at existing PTL meetings Attendance at twice weekly PTL meetings from histopathology, radiology and waiting list to ensure focus on FDS standard Urology CNS now has access to CRIS to enable more efficient checking of results and next steps Cystoscopy nurse now in post
NGH	01/07/24	% of patients diagnosed in less than 28 days	The Trust continues to exceed the 75% standard reaching 87.5% for July	None standard exceeded	Within the East Midlands there is evidence to suggest trusts are ruling out a diagnosis of cancer in a timely manner but diagnosing cancers is taking longer, although NGH are surpassing the standard this continues to be an area of focus over the coming months	First seen within 7 days. Diagnostics request to report stretch target 7 days Histology 7 days TAT Trust escalation policy and ptl meetings with oversight of all patients Effective MDT meetings

6-week diagnostic test target performance

Committee Name: All

GroupName: Systems and Partnerships

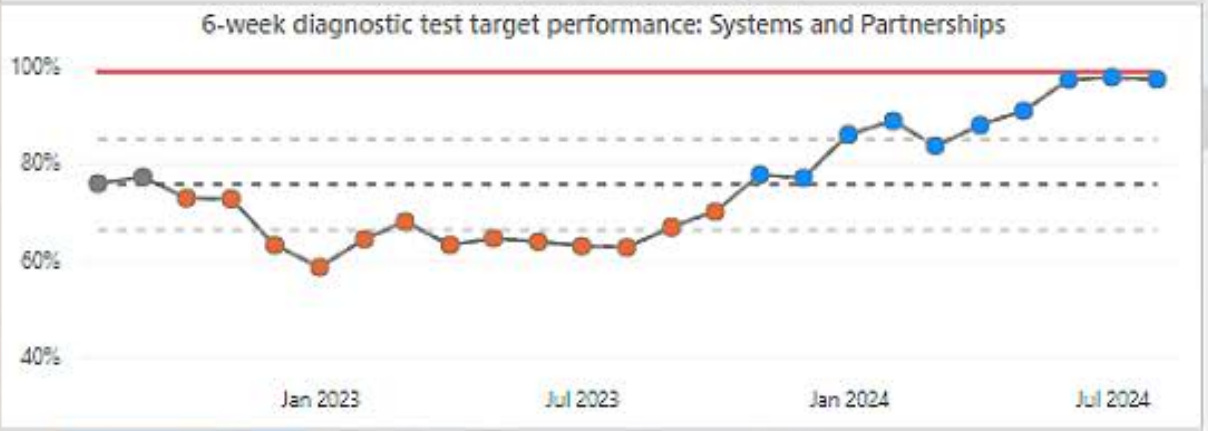
MetricName: 6-week diagnostic test target performance

Date: 01/03/2021 – 01/08/2024

79.00%	99.00%	97.43%	99.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital



6-week diagnostic test target performance

Committee Name: All

GroupName: Systems and Partnerships

MetricName: 6-week diagnostic test target performance

79.00%		97.43%	99.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	% of patients not seen within six weeks	Performance for August was 79%	Workforce gaps in MRI has impacted ability to produce planned activity numbers Skill mix in NOUS has cause backlogs with tests Cardiac MRI workforce gaps have cause a backlog for Cardiac Radiology Tests	Recruitment continues of x7 posts within Radiology will support with gaps in workforce for MRI and CT Changes workplans and workforce within NOUS has allowed more capacity for testing Return of Cardiologist will support in more sustained capacity for Cardiac MRIs	Bi Weekly PTL Meetings dedication to reduction of 13w+
NGH	01/08/24	% of patients not seen within six weeks	Diagnostic performance has increased to 98% month end August.	- TOES and DSE's constrained however mitigation plan with locum in place to support - Audiology has had sickness however maintaining position with forward look in place to mitigate breaches - Neurophysiology constrained with vacancy/sickness plan in place for locum to support	-Ambition to deliver 95% by March 25 which has been exceeded. -NGH has 4 patients over 13 week waiting or 0.1% of the Diagnostic waiting list this is due to sickness and locum availability in Cardiology and constraints around Paediatric sedations. -Audiology has seen a fantastic improvement in performance since last month with the introduction of 'super weekends' which has cleared the backlog and we are now achieving 93% within 6 weeks -MRI, CT and U/S has also seen improvement and are all now greater than 95% - TOES and DSE's constrained however mitigation plan with locum in place to support - Audiology has had sickness however maintaining position with forward look in place to mitigate breaches - Neurophysiology constrained with vacancy/sickness plan in place for locum to support	- Standing agenda item at Access Committee and Diagnostic PTL on-going

Unappointed outpatient follow ups

Committee Name: All

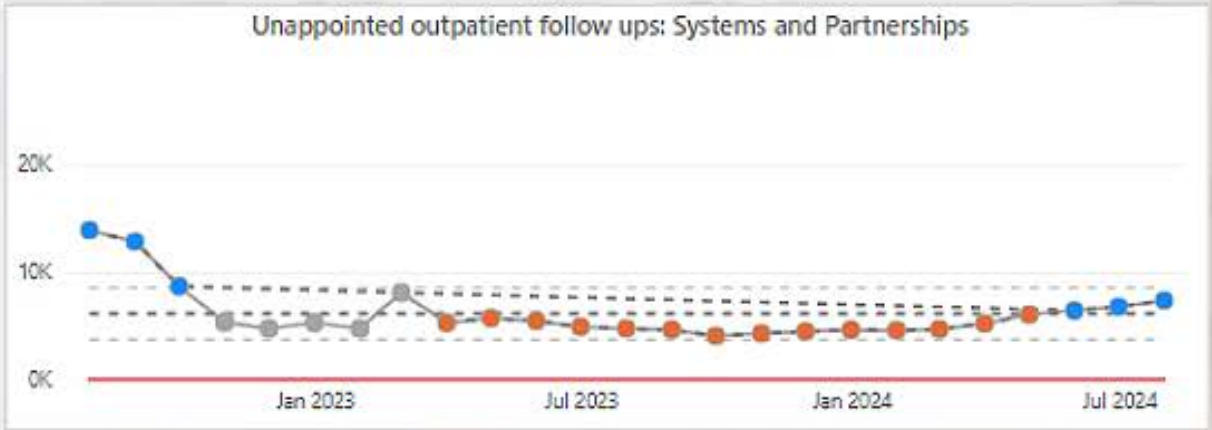
GroupName: Systems and Partnerships

MetricName: Unappointed outpatient follow ups

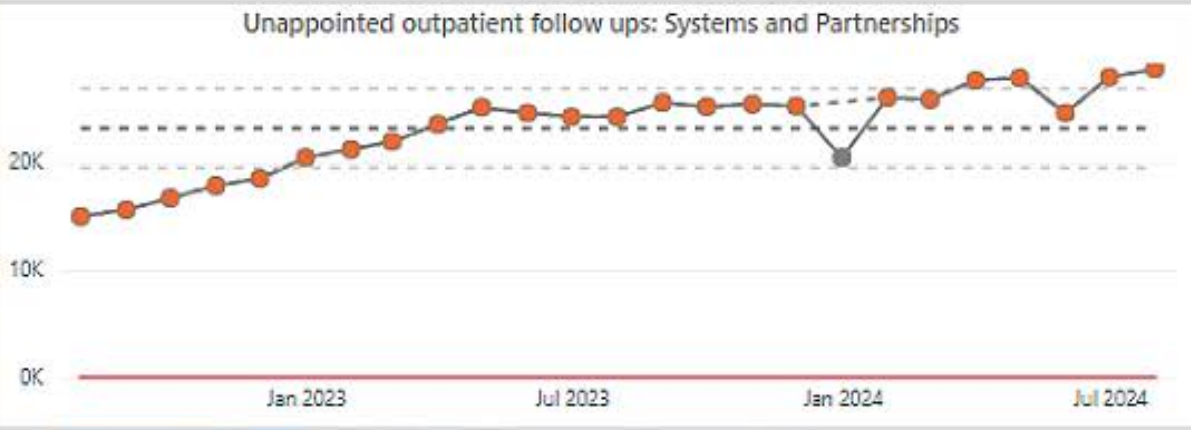
Date: 01/03/2021 – 01/08/2024

7,361		28,703	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Unappointed outpatient follow ups

Committee Name: All

GroupName: Systems and Partnerships

MetricName: Unappointed outpatient follow ups

7,361		28,703	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Count of patients who do not have a booked appointment and are past their due date	Patients waiting 6 months or more past their review date with no appointment booked continues to increase. 7361 as at the end of August 2024	Capacity within divisions for follow up activity Capacity within divisions for validation of patients within this cohort Financial challenges to mitigate both the above issues Lack of oversight and access to accurate data to review these.	Deployment of FDP Outpatients Validation by Bank Continues circulation of data to support visualisation	Deployment of FDP Outpatients Validation by Bank Continues circulation of data to support visualisation
NGH	01/08/24	Count of patients who do not have a booked appointment and are past their due date	Patient 6 months or more past their review with no appointment booked has increased to 8,500 from last month.	- Administrative resource to validate - Capacity to deliver FU requirements	- Prioritisation of patients 12 months past review date and continued circulation of patient level data to support tracking and management - Implementation of Outpatients FDP to support management - to be launched within challenged specialties first - Continued work on the deployment and extended use of PIFU - GIRFT Further Faster program.	- Standing Agenda Item at Access Committee - Project focus through further faster and GIRFT

RTT over 52 week waits

Committee Name: All

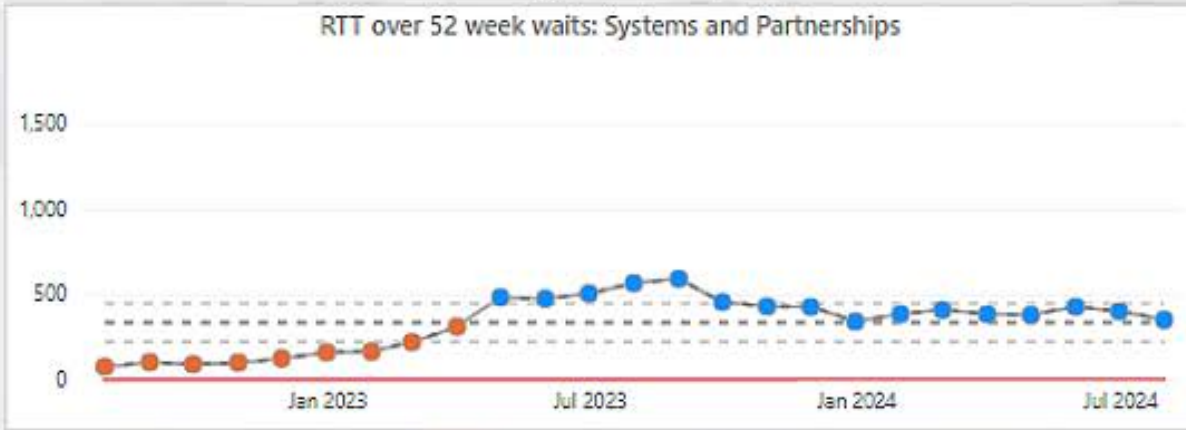
GroupName: Systems and Partnerships

MetricName: RTT over 52 week waits

Date: 01/03/2021 – 01/08/2024

351	0	1,137	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital

RTT over 52 week waits

Committee Name: All

GroupName: Systems and Partnerships

MetricName: RTT over 52 week waits

351	0	1,137	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	No. of patients waiting greater than 52 weeks from referral to treatment (RTT)	The actual number of patients waiting 52 weeks or more for June 2024 (un-validated) has seen a decrease from 387 to 351	Clock Starts continue to be in excess of Clock Stops. In aims of seeing consistent reduction, stops will need to overtake starts. August performance saw an increase in clock starts and a decrease in clock stops. Capacity for both new and follow up OPAs 1st OPAs in Resp and Dental in excess of 40 weeks Continued support being offered to NGH of long waiting patients.	Respiratory Service continues to hold the biggest risk with aims of having zero patients over 65 week by the end of September. There are plans to engage with UHL for support, however this may not impact the 65w cohort in time. The trust continues to receive support from IS providers for ENT, Gastro and T&O Winter planning has started and includes plans for addition beds to allow for escalation beds to be returned to such. FDP RTT Validation is being rolled out which will allow for real time mitigation and validation by teams. CYP PTL meetings have been established with the addition of bi-weekly cohort analysis being circulated. Weekly discussion at PAG also supporting with oversight.	PTL Validation continues 12w repeat validation at 90% Deployment of FDP Validation Tool Accountability via PAG

RTT over 52 week waits

Committee Name: All

GroupName: Systems and Partnerships

MetricName: RTT over 52 week waits

351	0	1,137	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/08/24	No. of patients waiting greater than 52 weeks from referral to treatment (RTT)	52+ Actuals: delivering ahead of route to 0 trajectory with August un-validated position of 1137 reduced from last month which was 1,200 against trajectory of 1,216. 52+ cohort further reduced delivering ahead of trajectory to deliver 0 52+ weeks by March 25 (62% reduction since 12/5/24 reduced by 18,905) to 11,414	-Whilst ambition is route to 0 trajectory of 1,305 has been submitted for March 25 position given the level of clock starts VS stops and lack of additionality to support increased capacity. - Constrained specialties still remain ENT, T&O, Surgery, Urology, Gynaecology - Clearance has been impacted by increased clock starts vs Stops Annual leave, Sickness, Cancelled elective activity due to shortage/lack of availability of anaesthetic cover for theatre lists. -As above HCA and Junior Dr strikes have heavily impacted plans throughout the year, this has been monitored and mitigated as much as possible, but IA was specifically excluded from the planning cycle at the request of NHSE. This has been exacerbated with Anaesthetic workforce constraints resulting in cancellations of list and already constrained T&O capacity hence the risk around delivery has materialised and NGH now forecasts to have 45 patients waiting over 65 weeks at the end of September. -Whilst Independent sector has been used to mitigate risk to date financial constraints and complex case-mix of patients remaining in the September cohort has meant this isn't an option for the remaining patients requiring surgery in September. Teams have been asked to use IS for those breaching in September onward and to support the ask around 52+ weeks. Mutual Aid has also been explored with KGH or UHL who are unable to support T&O for those remaining in September.	- Daily monitoring of long waiting patients - Standing Agenda item at Access Committee - PTL weekly; weekly PTL meetings ensures pathways are monitored, managed, and escalated. -Utilisation of independent sector capacity for General Surgery, Urology and T&O on-going. -Support from KGH with long waiters This is on-going -Weekend clinics and Theatre lists within surgical division	-Weekly reports circulated with those requiring first OPA by December and standing agenda item at Access Committee.

Size of RTT waiting list

Committee Name: All

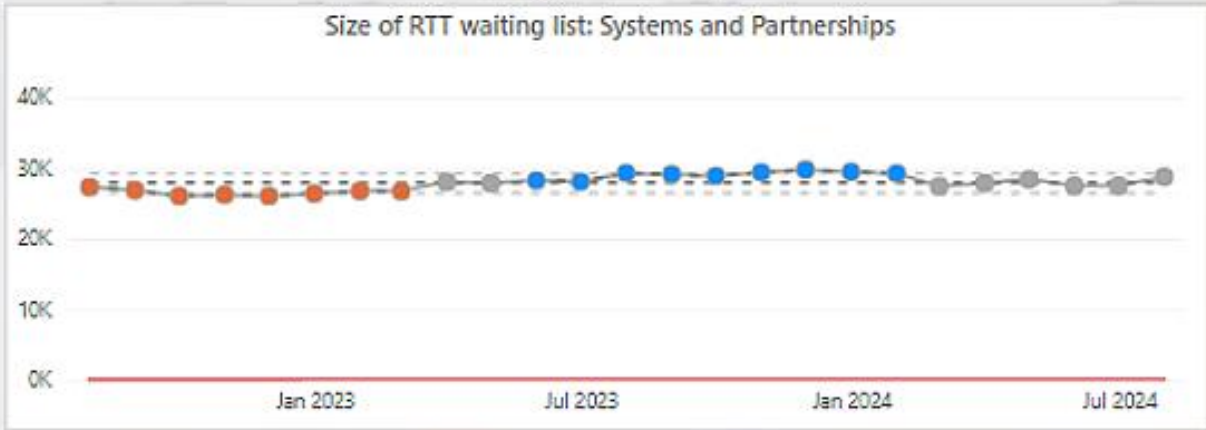
GroupName: Systems and Partnerships

MetricName: Size of RTT waiting list

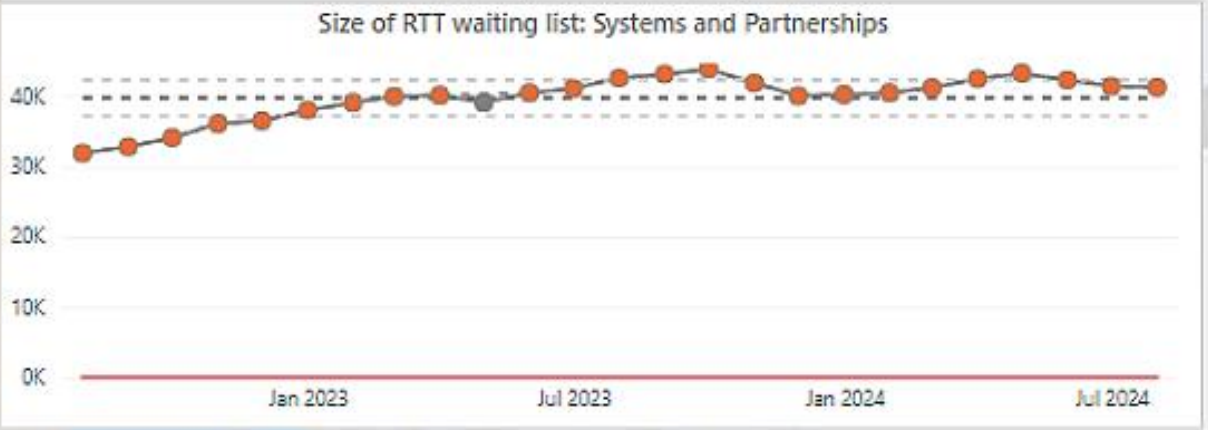
Date: 01/03/2021 – 01/08/2024

28,781		41,186	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Size of RTT waiting list

Committee Name: All

GroupName: Systems and Partnerships

MetricName: Size of RTT waiting list

28,781		41,186	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Count of patients actively waiting against the 18 week RTT target	Unvalidated position has seen an increase in the overall size of the PTL to 28,781. Figures remain below trajectory.	Impact of seasonal leave from workforce has resulted in the usual decline of clock stops but has also seen the usual decline in clock starts as patients are finding time to attend GPs and Community Services. Vacancies within some specialties remain hard to fill Continued settling of Head and Neck across sites August saw a decline in clock stops to just over 5.1k lower than the FYI average of 5.8k	IS continues to provide support some of the more challenging specialties ICB has been asked to support with Corneal transplant waiting Engagement with other providers UHL & NGH UHL to be providing respiratory support in the coming month Continued work on future collaborative / shared services	Weekly PTL Meetings Validation FDP Outpatients and RTT Validation Further Faster & Transformation Accountability through PAG, OMG and ILT

Size of RTT waiting list

Committee Name: All

GroupName: Systems and Partnerships

MetricName: Size of RTT waiting list

28,781		41,186	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/08/24	Count of patients actively waiting against the 18 week RTT target	PTL size month end August unvalidated is 41,186 this is reduced from last month July 41,458 a 1% reduction. This is on track with IBP plan and reduction has been supported by Intensive validation by the central validation team.	Clearance has been impacted by increased number of referrals into the Trusts with increased clock starts vs Stops. There has also been Annual leave, Sickness, Cancelled elective activity due to lack of availability of anaesthetic cover for theatre lists.	Deep dive into 'other' referrals with report being sent out to teams to review those that fall into this category – ongoing DQ reports being sent out with quick wins i.e. Duplicates with training support allocated to key directorates to mitigate DQ issues going forward. Foundry RTT validation has been implemented and is now in use by the central validation team which should support reduction. This has been trialled with T&O at PTL meetings and will continue to be used for that specialty with Cardiology next. Collaboration with KGH and UHL to review scope for mutual aid and support for challenged specialties in spirit of ensuring equitable waits across the Trusts. Transformation department working with ICB and Primary care to review pathways into the Trust. GIRFT Further Faster workstreams in place to support reduction which includes outpatient productivity, Daycase and Theatre Utilisation management. Validation has remained above 90% with 93%% being validated within 12 weeks. The deployment of the RTT Validation tool has made this much easier and efficient for the team	- Standing agenda item Access Committee - Weekly PTL - Validation (ongoing)

Theatre utilisation

Committee Name: All

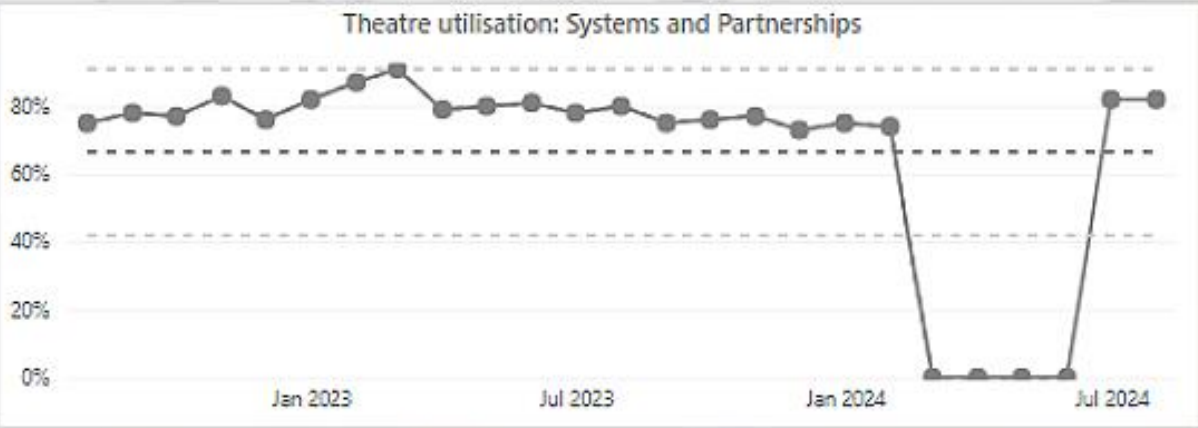
GroupName: Systems and Partnerships

MetricName: Theatre utilisation

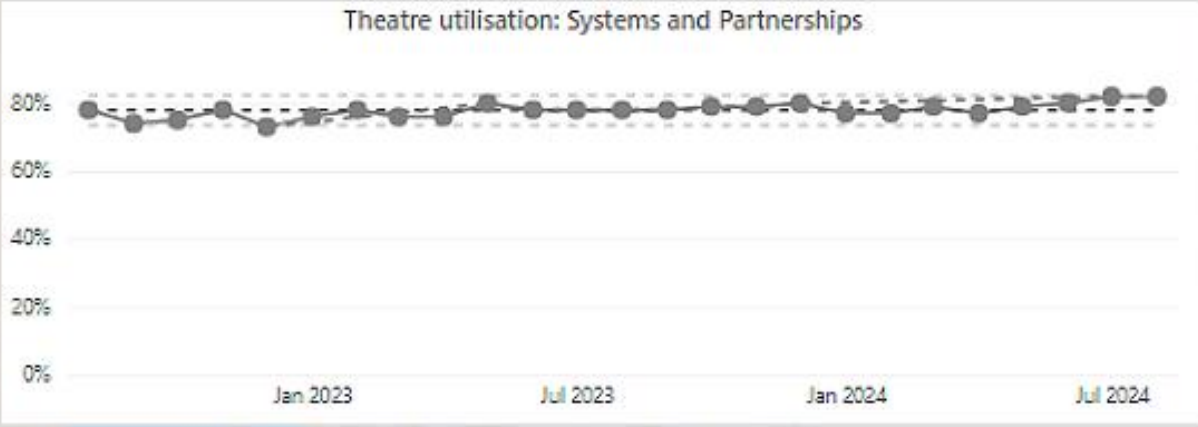
Date: 01/03/2021 – 01/08/2024

82.00%		82.00%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Theatre utilisation % against 85% national target	The chart tells us that theatre utilisation was at 82% in August.	Theatre utilisation is affected by high inter-case downtime and an increase in DNAs the day cancellations, but is consistently above the national median. Urology posted the highest capped utilisation in England during August	Increased focus on theatre delays caused on wards and booking processes	Fortnightly Theatre Improvement meetings chaired by Deputy COO to provide assurance - also reported through Performance Review Meetings
NGH	01/08/24	Theatre utilisation % against 85% national target	Theatre Utilisation - Touch time = 82%	Sustainment of utilisation. Nexus is not pulling surgeon timings into Palantir.	6-4-2 weekly meeting Planning meetings with Consultants	Newton investigating surgeons timings. Awaiting Nexus upgrade.

Stranded patients (7+ day length of stay)

Committee Name: All

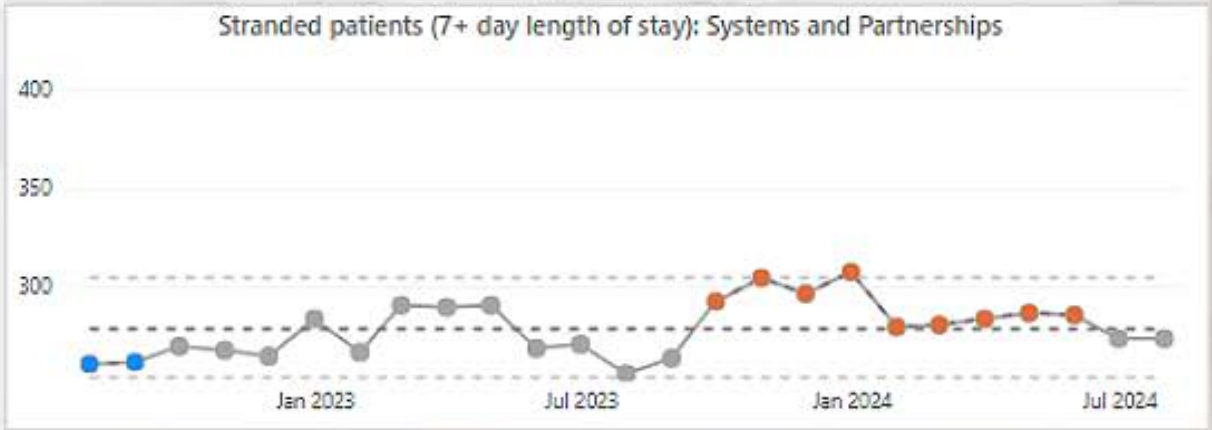
GroupName: Systems and Partnerships

MetricName: Stranded patients (7+ day length of stay)

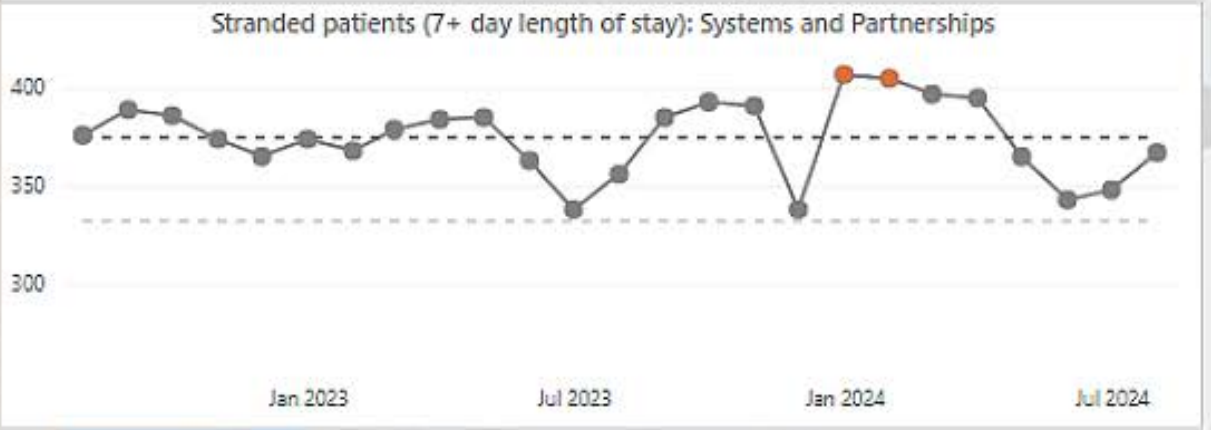
Date: 01/03/2021 – 01/08/2024

273		367	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Stranded patients (7+ day length of stay)

Committee Name: All

GroupName: Systems and Partnerships

MetricName: Stranded patients (7+ day length of stay)

273		367	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Number of patients with a LoS > 7 days	A further reduction on the past 2 months stranded LoS	Medical LoS increased to 10.2 days against plan of 9.5 days, equiv of 21 bed demand increase over plan Emergency admission demand 1.2% higher than planned, equiv of 7 bed demand increase than planned	Continued focus of complex discharge process and minimise delays with allocation of required package - we are sustaining a TAT of <2.5 days for completion and decision on package Opened 29 sub acute care beds at Spinneyfields care home to compensate for the loss of beds due to RAAC and filled 19 in the 1st week Focus on ensuring effective board rounds with daily completion of actions to generate discharges Criteria led discharge work across surgery moving to nurse led discharge.	Bi Weekly Patient time matters meeting to oversee progress and provide scrutiny and advice Upwards reporting to UEC Delivery Board also Bi weekly Senior nursing support to wards Consideration of external support to review gaps in mitigations
NGH	01/08/24	Number of patients with a LoS > 7 days	Number of patients with length of stay over 7 days has slightly increased since July however 131 patients not medically fit for discharge	Some delays in TOC completion, evident particularly over the weekend. Reduction in pathway 1 discharges compared to June and July. Barriers preventing a P1 same day referral to acceptance process seen to be administration structure with ASCW and ward nurses understanding of referral process and the information required.	Move of TBC hub meeting to Monday's from Wednesday to support with post weekend traction. Email sent out to all wards with actions required and same day turnaround of TOC submission requested. New provider contracted to ASCW which is seeing increased referal to discharge times. ASCW working closelyh with provider - regular communication and NGH presence at the West Place Board. Ward training to increase understanding around P1 referral process with an aim to move to a same day referral to acceptance process. Review of Patient Time Matters dashboard to support with ensuring a clear picture of the ASCW P1 process.	Continuing to work closely with ASCW to support with early identification and referrals encouraging referrals to continue over the weekend with a view to increase early in the week discharges. Working with NHFT to review alternative ways to fill siderooms - identification of appropriate P1 patients whilst awaiting care packages.

Super-Stranded patients (21+ day length of sta

Committee Name: All

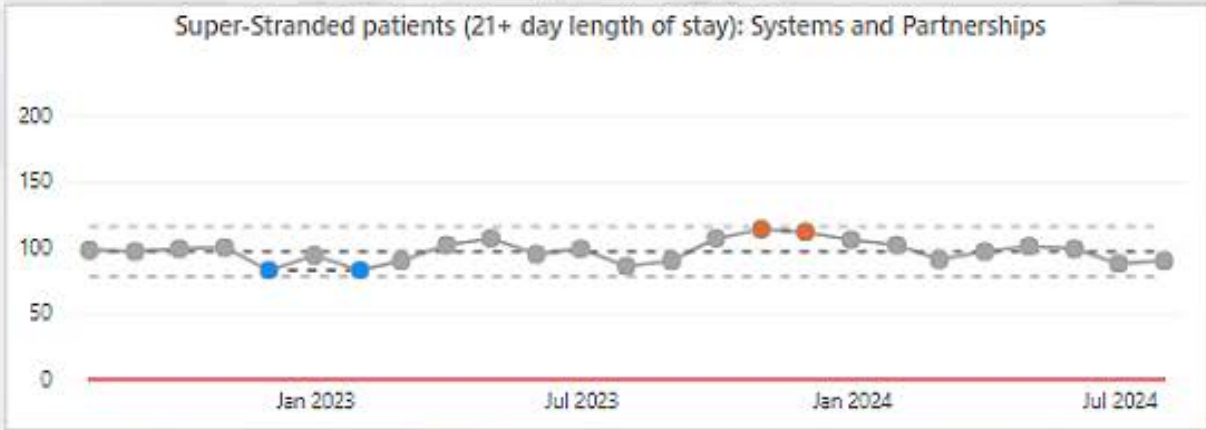
GroupName: Systems and Partnerships

MetricName: Super-Stranded patients (21+ day length ...

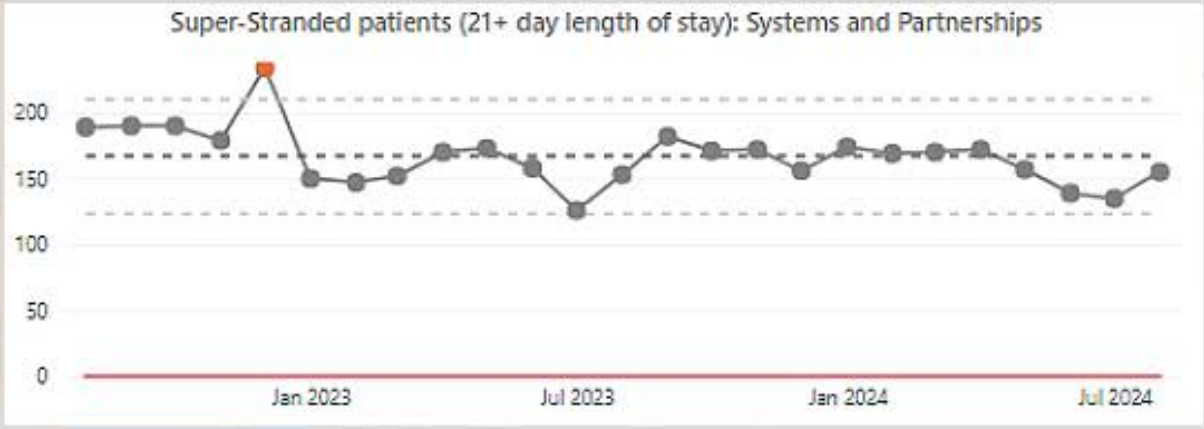
Date: 01/03/2021 – 01/08/2024

90	0	155	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Super-Stranded patients (21+ day length of sta[redacted]

Committee Name: All

GroupName: Systems and Partnerships

MetricName: Super-Stranded patients (21+ day length of...

90	0	155	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Number of patients with a LOS> 21 days	Slight decrease in number of super stranded patients	Difficulties in discharging patients with acute confusion/delirium/dementia are continuing due to high level of support required. Access to medical rehab PW2 beds remains responsive but due to high volumes LoS across the pathway has increased High numbers of patients waiting for Pathway 2 = 23 and Pathway 3 = 29. Pathway 1 remains steady with good flow. Spinneyfields open to 29 beds but teething problems with effective utilisation have made keeping all 29 beds full a challenge	continued working with system partners to reduce pathway delays and ensure patients are able to be discharged in timely manner. Areas of focus within the system are stroke pathway, bariatric and acute confusion. Current work underway across the system to deliver additional Dementia and Delirium capacity and additional sub acute beds in Spinneyfields care home to compensate for the loss of beds due to RAAC	7 day service from complex discharge team with additional MDT hubs to support Industrial Action and Bank Holidays. MADE events to deep dive inpatients MOFD.
NGH	01/08/24	Number of patients with a LOS> 21 days	Slight increase in number of super stranded patients however 65 patients are not medically fit for discharge	Barriers to some complex patients discharge difficult to unblock. Long delays for delerium beds, barratric beds and Robin Beds	System wide deep dive now arranged every Thursday to support with unblocking barriers. Ongoing work with system partners and attendance at West Place Board. Sharing of data from MADE events system wide.	Mini MADE/deep dives to continue when the Trust is suffering a low discharge profile. Expansion of virtual wards to now include acute medicine, general diagnostic waits. Paedatric diagnostic waits is currenly being worked up.

Patients with a reason to reside

Committee Name: All

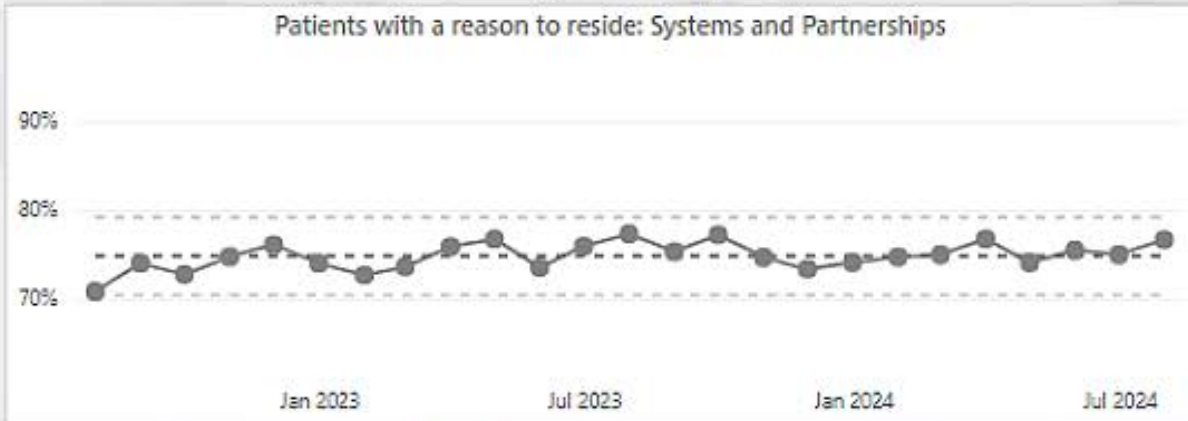
GroupName: Systems and Partnerships

MetricName: Patients with a reason to reside

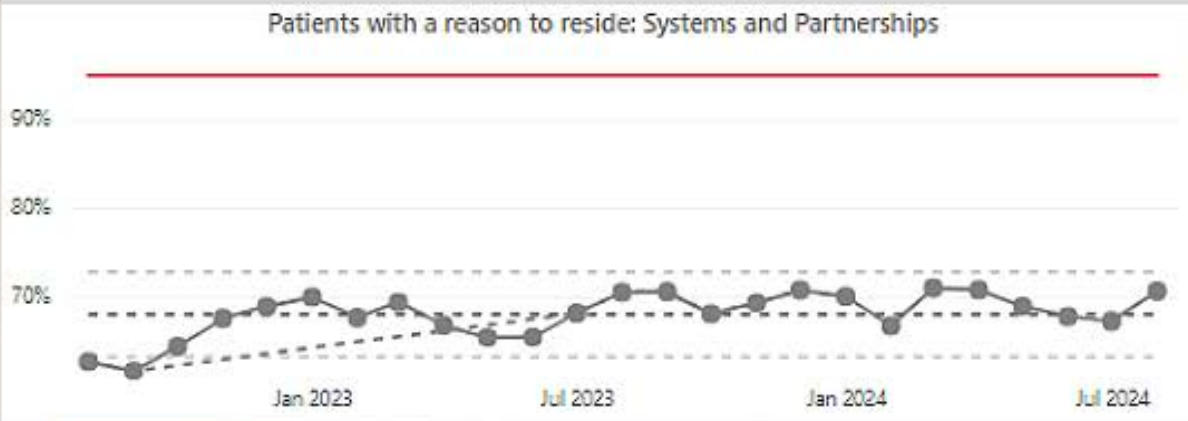
Date: 01/03/2021 – 01/08/2024

76.68%		70.64%	95.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Number of patients who have a reason to reside in hospital based on national reason to reside criteria	Number of patients who have a reason to reside in hospital based on national reason to reside criteria.	30% of patients have no reason to reside (approximately 101) and of these 68 patients are awaiting supported discharge with biggest delays being in P2 (rehab) 26 patients and P3 (nursing and residential home) 29 patients. The remaining 33 are classed as pathway zero or are not yet on a pathway and the operational teams focus on a daily basis is to expedite these - on average 80% of these patients are discharged.	System level challenge for patients who have been declined by more than 3 care homes - weekly meeting set up Review of patients awaiting community hospital beds for rehab weekly to identify those that could change to pathway 1 Expand screening at the front door to include pathways other than acute medicine Continued work with partners to ensure a continual flow of supported discharges and identify gaps in provision System level work, led by COOs, on improving P2 and P3 pathway flow - opened additional capacity in spinney fields	Review of Super stranded patients 2 x weekly concentrating on medicine Daily focus on pathway zero patients to ensure same day discharge Review and challenge all patients who have been declined by 3 care homes

Ambulance Handover

Committee Name: All

GroupName: Systems and Partnerships

MetricName: Ambulance Handover

Date: 01/03/2021 – 01/08/2024

330		434	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Ambulance handover (delays over 60 minutes): Systems and Partnerships

Northampton General Hospital

Ambulance handover (delays over 60 minutes): Systems and Partnerships

Ambulance Handover

Committee Name: All

GroupName: Systems and Partnerships

MetricName: Ambulance Handover

330		434	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	EMAS ambulance handovers > 60 minutes	The organisation has seen an increase in the number of black breaches during August. (internally validated number = 185).	We continue to experience an increase in attendances, further impacted by Trust capacity pressures impacting our ability to offload within 15 mins. We continue to see a surge in arrivals during peak times of the day;	Planned review of internal SOPs and escalation protocol to support focus on handover <45 mins [current Trust position = 80% of handovers <45 mins] Develop trajectory and actions to support delivery. Engagement with EMAS lead to review appropriateness of conveyances, use of alternative pathways and handover expectations Continue to facilitate physician and nurse assessment for patients where handover is delayed to ensure safety and minimum care standards are maintained.	No incidents of harm identified from the harm reviews undertaken.
NGH	01/08/24	EMAS ambulance handovers > 60 minutes	A slight decrease in attendances who have breached over 60minutes	Poor flow through backend wards means patients are not moving through ED quick enough. Treating patients on back of ambulances due to no capacity within ED. Rapid transfers of patients to wards reliant on early discharges from other wards and porters.	If patients are held on ambulances, treatment starts immediately, and a clinician will attend the patients in the back of ambulances. Using Ambulance Escalation SOP , now complete and ready to be ratified?. Having a Snr decision maker in FIT to see and discharge patients who are able to be discharged quickly. Having a transfer nurse and ensuring we have at least 3 porters to help with transfers	Monitoring of the Clinical Care Standards that safety is maintained throughout, on all patients that are being held over 30min. Early board rounds on Nye Bevan led by Senior Clinicians. Supported discharges and Criteria led discharges for the next day identified and actioned as early as possible to facilitate early flow across the Trust.

Time to initial assessment

Committee Name: All

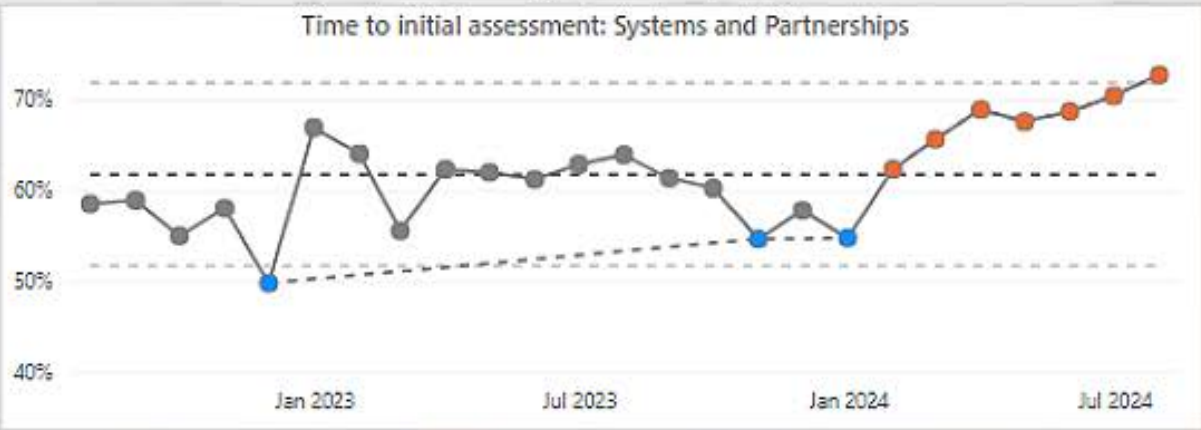
GroupName: Systems and Partnerships

MetricName: Time to initial assessment

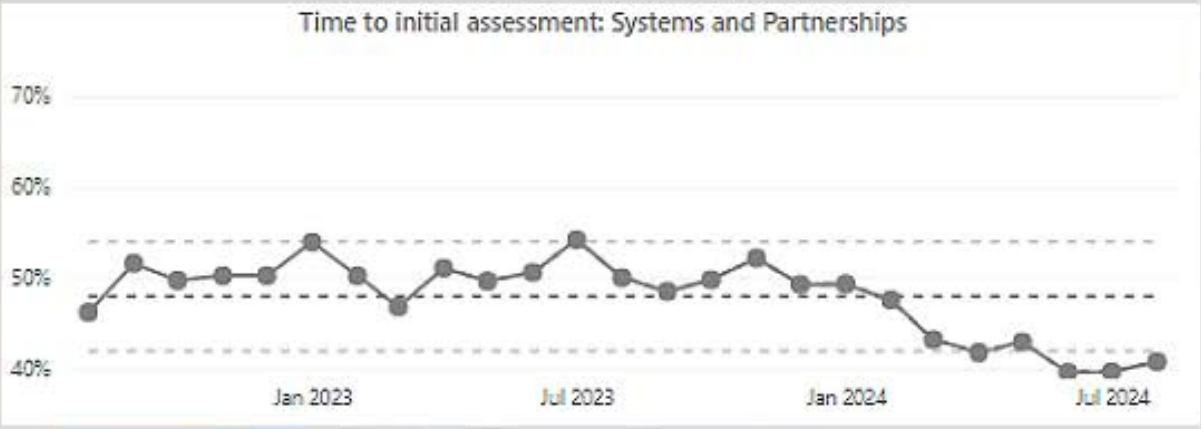
Date: 01/03/2021 – 01/08/2024

72.71%		40.76%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Time to initial assessment

Committee Name: All

GroupName: Systems and Partnerships

MetricName: Time to initial assessment

72.71%		40.76%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	The percentage of patients who had an initial assessment within 15 minutes arriving at the department.	TTIA compliance within 15 remains the highest that KGH has seen since Sept 21.	Our ability to complete TTIA within time standard continues to impacted during periods of heightened activity further impacted by nursing numbers inhibiting our ability to increase triage rooms in ED Assessment space available to increase triage rooms limited due to current estate footprint.	Continued provision of additional triage rooms to support at times of a surge in activity (depending on staffing levels).	Staffing reviewed twice daily via staffing cell with staff re-deployed from other areas to support safe staffing levels. MIAMI and resus patients excluded from denominator giving assurance that the metric is appropriately measured.
NGH	01/08/24	The percentage of patients who had an initial assessment within 15 minutes arriving at the department.	A slight increase in the number of patients having their initial assessment within 15 minutes	When we have an influx of patients, streaming will take longer as the area is small (i.e. only two rooms), which leads to delays in patients being seen by a Snr clinician	Reviewing streaming, i.e. initiating automatic streaming (patients in particular with injuries to use Ipads to ensure they are themselves streaming to the correct service before booking in). Plan to extend the current streaming hub. Ensure that assessment areas' (i.e. the 20's are not used to bed patients)	Ensuring that flow out of ED happens as soon as possible

Average time in department - Admitted

Committee Name: All

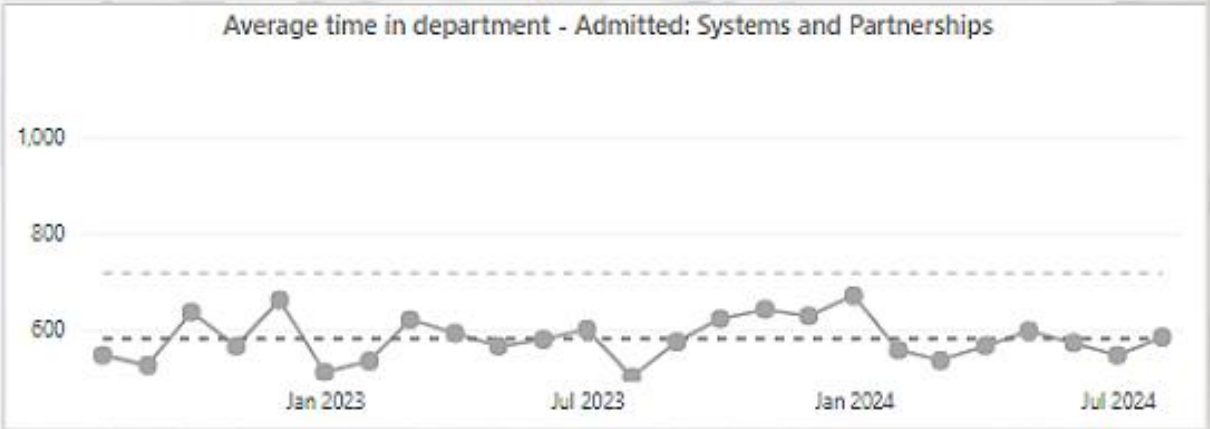
GroupName: Systems and Partnerships

MetricName: Average time in department - Admitted

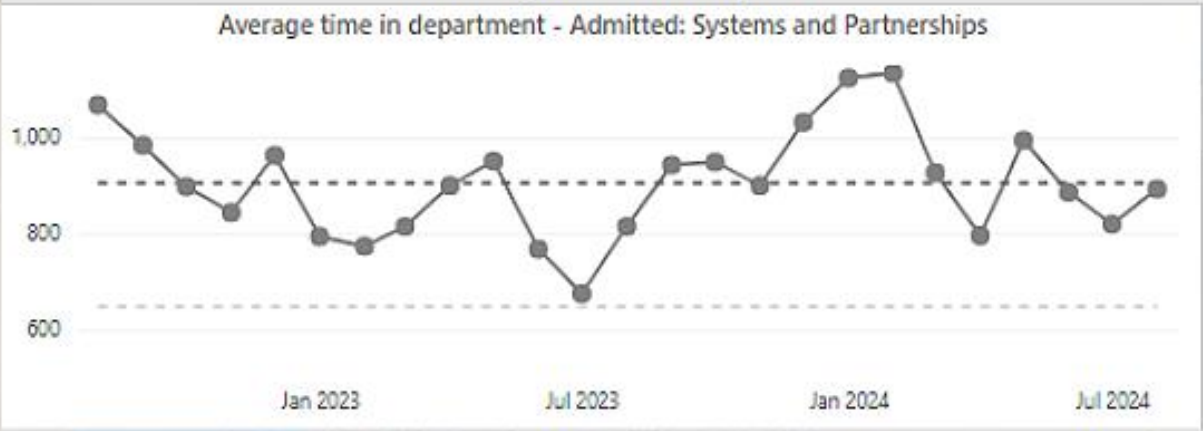
Date: 01/03/2021 – 01/08/2024

585		893	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Average time in department for those patients who are admitted to the hospital	The data shows an increase from the previous month with average time to discharge for admitted patients.	This is not solely an ED Metric but a Whole System metric and largely impacted by capacity and flow out of ED. Admission of MH patients into UC wards continues due to the unavailability of inpatient beds in the community.	Continue with direct admission into acute medical wards for patients with EDD >48hours Continue with MSDEC in reach to ED in the morning A&E cardiology pathway direct to MSDEC open Gynae SDEC opened 24/7	Use of escalation areas and outlying capacity Rapid transfer protocol
NGH	01/08/24	Average time in department for those patients who are admitted to the hospital	A marginal decrease in time patients are staying in the department	Poor flow still causes increase in length of stay in ED. Delays in diagnostics (radiology) in particular after 18:00. OOH continue to stop taking patients early due to high volumes of telephone calls to answer, meaning that patients will need to come to ED	Continue to do safety rounding of those patients held in ED. Live declaration and allocation of beds. Full model of patients from ED to SDEC and UTC. Streaming hub to redirect patients attending ED to out of hours, UTC & SDEC. Specialties to work to Professional Standards	

Average time in department - Discharged

Committee Name: All

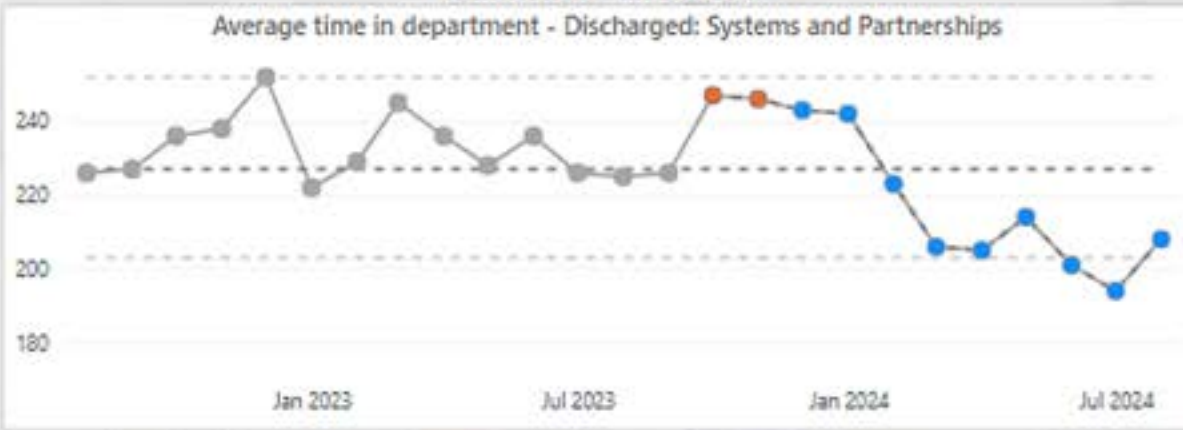
GroupName: Systems and Partnerships

MetricName: Average time in department - Discharged

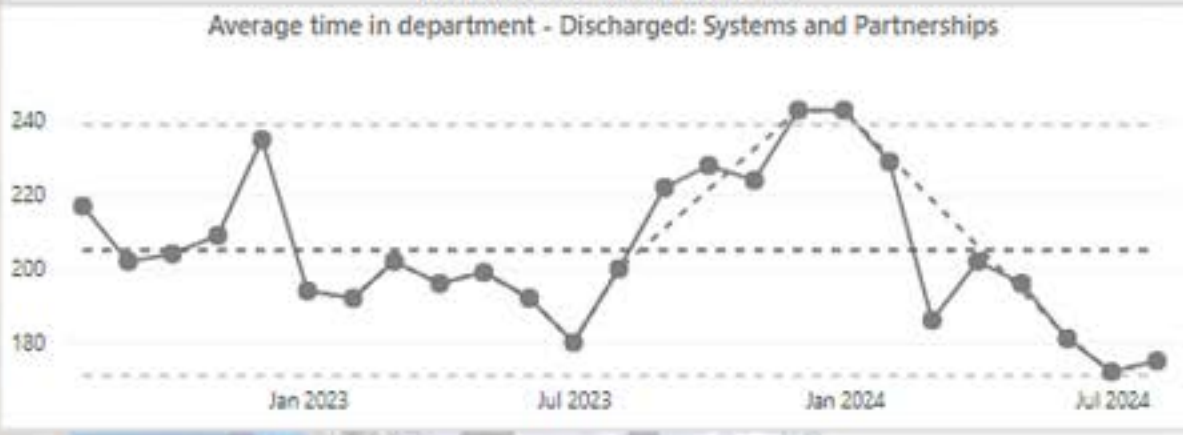
Date: 01/03/2021 01/08/2024

208		175	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Average time in department - Discharged

Committee Name: All

GroupName: Systems and Partnerships

MetricName: Average time in department - Discharged

208		175	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Average time in department for those patients who are not admitted to the hospital	The data shows us that the average time in the department for discharged patient in August was 208 mins. This performance is within the 4-hr time Standard.	Recognised limitations with regards to existing streaming and re-direction pathways available from ED. Timely review of patients further challenged by lack of capacity within the department footprint It is recognised that this current data includes patients against which a confirmed admit has been applied; however, due to lack of Trust capacity these patients have experienced extended lengths of stay before becoming fit to be discharged home.	Continue to embed Ambulatory Majors pathway Currently looking to establish a streaming and re-direction working group with multi-agency stakeholders. EDU operational hours revised to reflect demand Ongoing engagement with EMAS/CUCC at monthly collaborative meetings	Use of streaming pathways to MSDEC, MIAMI and in reach in the department to support medical on call for patients who can be discharged on the same day Use of EDU
NGH	01/08/24	Average time in department for those patients who are not admitted to the hospital	For those patients who attend ED who do not need to be admitted, their average discharge time in minutes remains under the 4hr Key Standard.	As the department gets more busy we become less efficient in processing patients	Safety rounds are done throughout the day to ensure patients are safe. Audits are carried out to ensure Standards are maintained	Actively streaming patients to alternative services, UTC, SDEC and pharmacy. Patients who get sent home after having a DTA are skewing this data set, so we know the discharge average is not truly reflective of actual timeframes.

4hr ED Performance

Committee Name: All

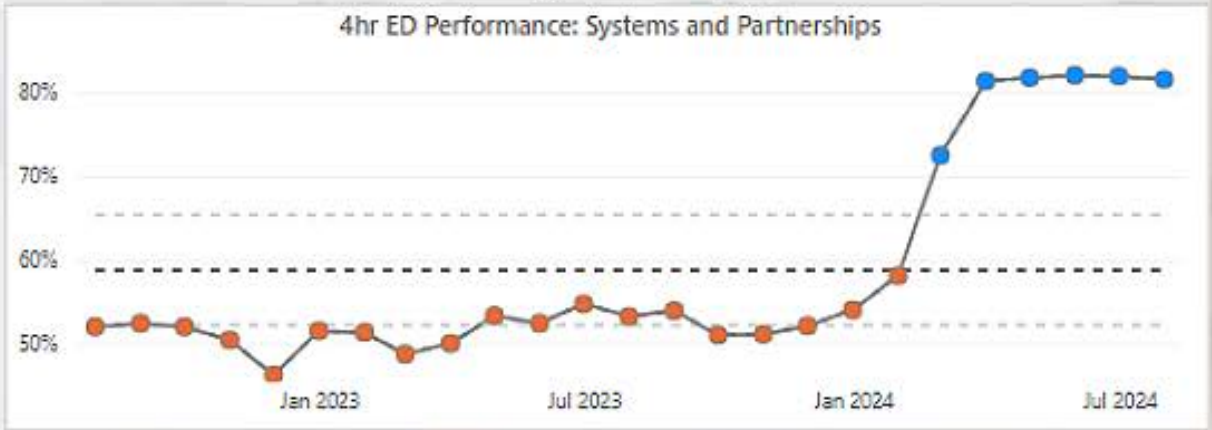
GroupName: Systems and Partnerships

MetricName: 4hr ED Performance

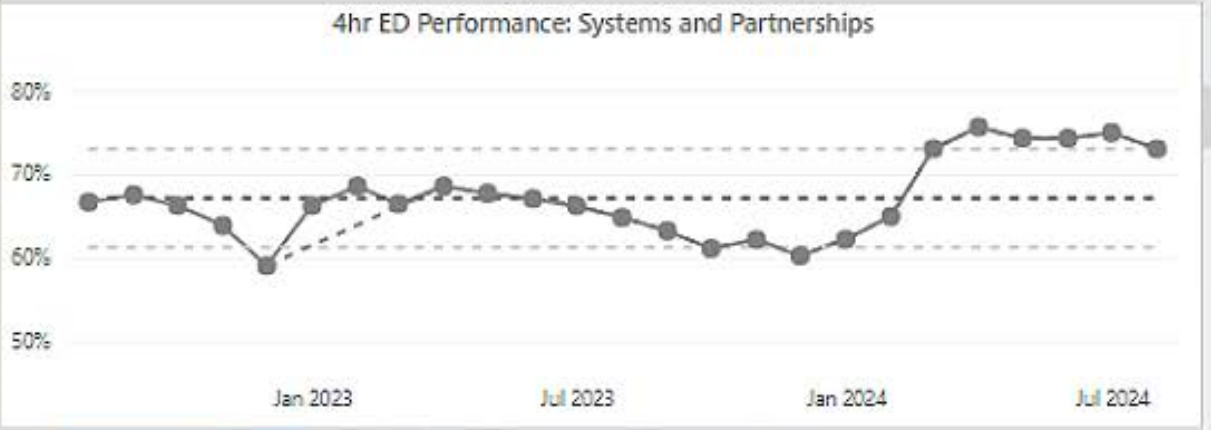
Date: 01/03/2021 – 01/08/2024

81.60%		73.04%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



4hr ED Performance

Committee Name: All

GroupName: Systems and Partnerships

MetricName: 4hr ED Performance

81.60%		73.04%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	% of emergency patients seen, treated if necessary, and either discharged or admitted, within four hours of arrival in ED	Overall performance = 82%. (KGH + CUCC from 25/3/24)? - KGH = 67%, Non-admitted = 79.2%	The requirement to embed renewed focus across the system with regards to working to the standard Patients requiring admission with an extended LOS in ED Inability to stream to an SDEC outside of the medicine division directly from triage Restricted pathways to stream and redirect outside of the Trust due to our current governance and workforce structure	Engagement work ongoing with our Primary care colleagues via the GP Liaison Lead. Plan for one of our acute medical consultants to join the primary/secondary interface meetings with GP colleagues to discuss challenges with access and streaming pathways. Continue to embed Ambulatory major's pathway Looking to establish a streaming and redirection working group with multi stakeholders Currently exploring options for establishing an AAU (Acute Assessment Unit). Awaiting outcome of review of UEC Board/4-hour group meeting structure to reflect UHN Group model.	Implement rapid flow protocol Appropriate use of operational escalation protocol
NGH	01/08/24	% of emergency patients seen, treated if necessary, and either discharged or admitted, within four hours of arrival in ED	A substantial increase in performance since April 2023 but we have seen a decline in performance since last month	Discharge profile for the Trust impacts ED leading to extended waits for beds. Professional standards between specialties still a concern and attributes to patients not being seen in good time	UTC has extended opening hours to 04:00am. Increase nursing and Drs numbers to manage volumes of patients and awaiting beds in ED. Maintaining safe nursing care ensuring documentation is correct through auditing and shared learning. Providing timely escalation & treatment of patients with NEWS scoring. Use of observation area for those that may go home and also Mental Health patients (COA). To initiate Red to Green days on backend wards.	Focusing on second boardrounds on wards. Making sure there are early escalations of any patient blockers. Post Take ward rounds of all patients waiting in ED for a bed, to make sure they have an active treatment plan in place and that its overseen by a consultant prior to admission on ward. Post, post take ward round to identify those patients improving can go home before needing the ward. We average 6 patients' turnaround each weekday

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NHS
University Hospitals of Northamptonshire
NHS Group

People Committee

Dedicated to excellence

Summary Table

Committee Name: All

Group Name: People

Metric Name: All

Site: All

Variation: All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
NGH	People	Mandatory training compliance	01/08/24	89.95%	85.00%	86.81%	87.6%	88.39%			Consistently Anticipated to Meet Target
KGH	People	Mandatory training compliance	01/08/24	91.79%	85.00%	90.43%	91.75%	93.06%			Consistently Anticipated to Meet Target
KGH	People	Appraisal completion rates	01/08/24	86.16%	85.00%	80.79%	83.82%	86.85%			Not Consistently Anticipated to Meet Target
NGH	People	Appraisal completion rates	01/08/24	78.37%	85.00%	75.08%	77.25%	79.41%			Consistently Anticipated to Not Meet Target
NGH	People	Sickness and absence rate	01/08/24	4.52%	5.00%	4.2%	5.53%	6.85%			Not Consistently Anticipated to Meet Target
KGH	People	Sickness and absence rate	01/08/24	4.53%	5.00%	4.31%	5.07%	5.83%			Not Consistently Anticipated to Meet Target
NGH	People	Vacancy rate	01/08/24	11.40%	8.00%	9.85%	11.29%	12.72%			Consistently Anticipated to Not Meet Target
KGH	People	Vacancy rate	01/08/24	12.04%	8.00%	10.82%	12.19%	13.57%			Consistently Anticipated to Not Meet Target
NGH	People	Turnover rate	01/08/24	5.80%	8.50%	6.95%	7.48%	8.01%			Consistently Anticipated to Meet Target
KGH	People	Turnover rate	01/08/24	7.20%	8.50%	8.11%	8.54%	8.97%			Not Consistently Anticipated to Meet Target
NGH	People	Formal procedures	01/08/24	23		6	16	26			Consistently Anticipated to Meet Target
KGH	People	Formal procedures	01/08/24	17		6	12	18			Consistently Anticipated to Meet Target
NGH	People	Roster publication performance	01/07/24	36	42	32	39	45			Not Consistently Anticipated to Meet Target
KGH	People	Roster publication performance	01/08/24	42	42	36	43	50			Not Consistently Anticipated to Meet Target
NGH	People	Time to hire	01/07/24	97.80	91	101.86	101.86	101.86			Not Consistently Anticipated to Meet Target
KGH	People	Time to hire	01/08/24	68.10	91	79.87	79.87	79.87			Consistently Anticipated to Meet Target
KGH	People	Number of volunteering hours	01/08/24	2,128		1440	1970	2499			Consistently Anticipated to Meet Target
NGH	People	Number of volunteering hours	01/08/24	3,763		2349	3112	3875			Consistently Anticipated to Meet Target

People Committee

Exec owner: Paula Kirkpatrick

In reminder, this Committee monitors the 'people' metrics within the IGR.

This cover sheet is designed to **highlight to the Committee saliant messages from the IGR metrics** for this month:

1. Mandatory training compliance metric is above target for both KGH and NGH. Commentary has indicated areas have maintained continued compliance. NGH have indicated a focus on Doctors induction to support compliance and passporting.
2. Both KGH and NGH has seen a decrease in sickness rates. Narrative for NGH has indicated 'hot spot' areas of concern in Clinical Support Services, Medical Division, Radiology and Community Stroke Team.
3. Turnover Rate continues to show a downward trend with both KGH and NGH, reporting data under target. Commentary for KGH indicates a range of Health and Wellbeing initiatives are available including financial wellbeing support.

Key **developments with the IGR** itself for the Committee to note:

1. Cautionary note around aggregated data has been added to the introductory page to the wider IGR pack following feedback regarding mandatory training.
2. WRES and WDES data is picked up in wider People reporting
3. Safe Staffing Metric – Which Committee should this metric be reported in? People or Quality?

Worth remembering for all metrics, only metrics that have a) had data provided and b) have been signed off, will be published – therefore, this could lead to some gaps in reporting.

Mandatory training compliance

Committee Name: All

GroupName: People

MetricName: Mandatory training compliance

Date: 01/03/2021 – 01/08/2024

91.79%	85.00%	89.95%	85.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	% of staff compliant with their mandatory training	% of staff compliant with their mandatory training profiles	Overall compliance has been maintained. A few challenges with ESR this period have impacted minimally and are all now resolved.	Working closely with ESR and the National project to align requirements and frequency	Operational pressures and summer holiday season always sees a reduction in completions
NGH	01/08/24	% of staff compliant with their mandatory training	% of staff compliant with their mandatory training	A continual improvement across the profiles and competencies >>medical compliance is the slowest to improve	A focus on Drs induction this year to support compliance and passporting	Operational pressures and summer holiday season always sees a reduction in completions

Appraisal completion rates

Committee Name: All

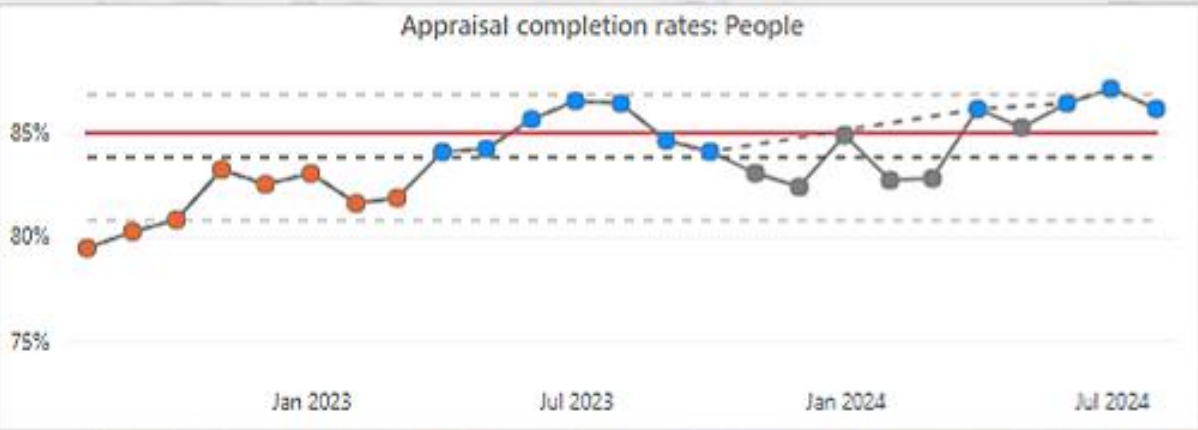
GroupName: People

MetricName: Appraisal completion rates

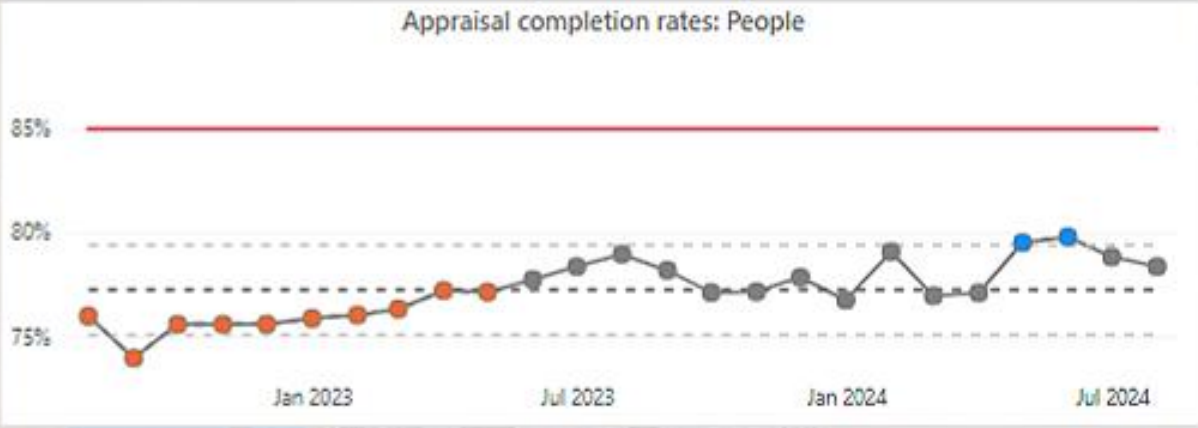
Date: 01/03/2021 – 01/08/2024

86.16%	85.00%	78.37%	85.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	% of staff having completed their appraisal	"% of staff who have had a documented appraisal in the past 12 months"	"There has been a sustained improvement with no key areas outlying with small numbers in all areas outstanding."	Launch of the new appraisal documentation and reiteration of the recording processes for launch on the 16th September	"Ongoing chase and challenge to both staff member and manager"
NGH	01/08/24	% of staff having completed their appraisal	"% of staff who have had a documented appraisal in the past 12 months"	Many areas remain below the benchmark, but with the areas of focus improving.	Launch of the new appraisal documentation and reiteration of the recording processes for launch on the 16th September	"Ongoing chase and challenge to both staff member and manager"

Sickness and absence rate

Committee Name: All

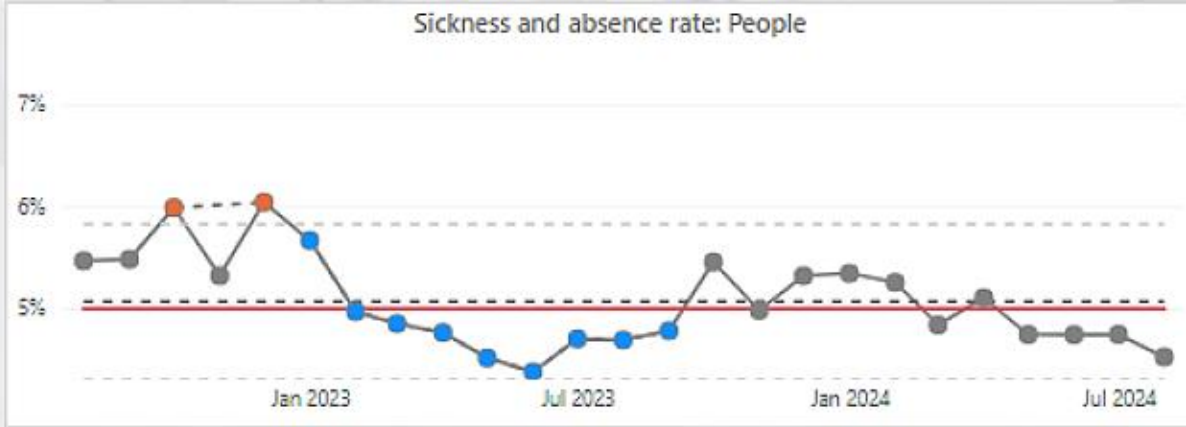
GroupName: People

MetricName: Sickness and absence rate

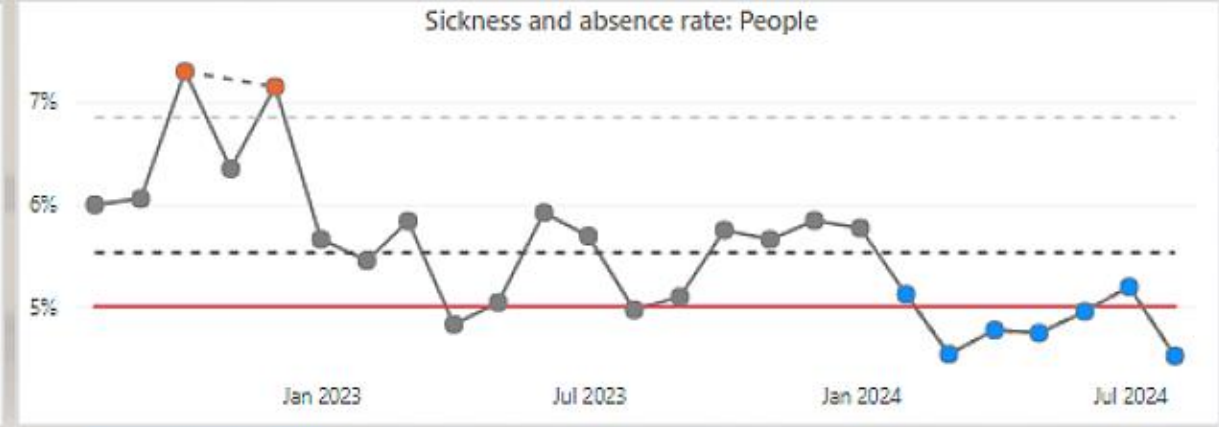
Date: 01/03/2021 – 01/08/2024

4.53%	5.00%	4.52%	5.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Sickness and absence rate

Committee Name: All

GroupName: People

MetricName: Sickness and absence rate

4.53%	5.00%	4.52%	5.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	% of Staff absent	Sickness rates have reduced across the Trust from 4.75% in July to 4.53% in August, the overall pattern continues to show a reducing trend.	Main reported reasons for sickness were cough/cold/Flu 180, Gastro 169 and Anxiety/stress/depression 96	We continue to engage with the divisions sending out trigger reports on absences, arranging long term and short term sickness reviews as required.	We are launching our new Wellbeing at work policy in October and are looking at how we support employees through a more coordinated approach through our wellbeing service.

Sickness and absence rate

Committee Name: All

GroupName: People

MetricName: Sickness and absence rate

4.53%	5.00%	4.52%	5.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/08/24	% of Staff absent	Target achieved: Currently is 4.52%, 0.48% below the target of 5%. Results are within the statistical boundary. Mean absence has decreased 0.67% from previous month at 5.19%.	* Short term absences in prevalence relate to 1) Gastroenteritis. 2) Cough/Cold/ COVID-Flu, and 3) Anxiety/Depression/Stress. Short term absence and hot spot areas of concern: Clinical Support Services and Medical Division Radiology, Community Stroke Team. * Long term absence: Women, children and oncology division. * OH Management referrals have highlighted a combination of MSK related referrals due to leisure injuries and older age rheumatoid health concerns impacting on sickness absence. Drug testing requests have also increased. * Staff Psychology and TRiM referrals from distressed teams in high demand clinical areas such as breast screening unit, neonatal unit, oncology, haematology plus individual complex referrals in collaboration with	* Targeting areas with high sickness absence (hot spots). High prevalence of very long term sick staff in health care assistant roles. Workforce analysis of impact on retention and recruitment to support and manage HCSW's has been completed. Plan to address at recruitment and through clearance the impact of mental health and role specific challenges through OH-HWB-HRBP processes. * Actively managing attendance against absence triggers - in Long term condition/ MSK cases are being actively managed in RTW programme on therapeutic hours and being offered supportive multidisciplinary approaches to their recovery through occupational health assessment, psychological support and long-term condition support peer group attendance. UHN long term conditions support group and a joint UHN-IAPT/Talking Health self-management programme has been commissioned to proactively target staff with complex MSK recovery.	* UHN Sickness Absence Strategy Review underway with a working party led by the Head of Service for Health and Wellbeing. Analysing varied systems, services and processes for managing absence and radical solutions to reduce long and short term absence within the next 2 years. for discussion at the People Committee in October. * The UHN Health and Wellbeing at Work policy has been developed as an "umbrella" approach to preventative-proactive management of staff absence and sickness including both physical and psychological wellbeing. This is the overarching strategic change of approach to developing a group harmonised attendance management policy and a preventative systematic approach to sickness management across the UHN group.

Sickness and absence rate

Committee Name: All

GroupName: People

MetricName: Sickness and absence rate

4.53%	5.00%	4.52%	5.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/08/24	% of Staff absent	Target achieved: Currently is 4.52%, 0.48% below the target of 5%. Results are within the statistical boundary. Mean absence has decreased 0.67% from previous month at 5.19%.	HRBPs to manage challenging absence cases with medical suspension related to individual staff who struggle to work within the Trust's Professional Behaviour expectations. * Management inability to be able to adequately address the impact of unprofessional behaviours and microagressions on staff wellbeing to prevent sickness absence from work stress is visible in business partner and OHWB case loads. * Doctor Wellbeing: Ongoing work to engage doctors with wellbeing interventions. Issues continue to be reported with lack of support from managers-supervisors with mental health difficulties and following incidents at work. LED doctors support and IMG doctors with transitional psychological and social adjustment to new roles and country of work.	HRBP initiatives: Protracted internal processes causing lengthy absence - this is due to capacity issues and managers taking inappropriate action or nil action at an early stage and failing to address the problem appropriately. Recruitment and partnering query whether new managers - are they being recruited with the right skill sets? Are they being given capacity in their role to undertake the people management elements? * Proactive offer of psychological safety and self-compassion interventions/workshops for teams in distress and senior staff groups including clinical and divisional directors. * Medical Engagement/ Doctors Wellbeing Strategy: To work with the medical leadership and medical education teams to continue to develop a package of preventative support for doctors at all levels of training and employment to enhance their psychological wellbeing. Includes focusing on FY1/2, junior consultant development programmes, all new medical staff inductions and	* Wellbeing at Work resources, guidance and training have been developed with the Policy Task and Finish Group to support managers and employees. Including, HSE workplace stress assessment, health and disability passport, staff support referral guidance, health and wellbeing conversations training. * Neurodiversity Working Group led by Head of OD in collaboration with Head of H&WB to scope out neurodiverse support pathways for diagnosed and self-diagnosed staff including awareness raising for employees, managers and HRBPs to facilitate early intervention and support where needed. Including guidance on how staff with neurodivergence children can access community support.

Sickness and absence rate

Committee Name: All

GroupName: People

MetricName: Sickness and absence rate

4.53%	5.00%	4.52%	5.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/08/24	% of Staff absent	Target achieved: Currently is 4.52%, 0.48% below the target of 5%. Results are within the statistical boundary. Mean absence has decreased 0.67% from previous month at 5.19%.	* HRBP feedback: External factors increasing sickness, work related sickness linked to internal grievance or disciplinary processes. Mental Health issues increasing within workforce and lack of skill set within the ER and managerial teams to remedy , managers not recognising need or having capacity to manage sickness in a timely and effective way. *Executive changes in UHN: Changes at executive level and lack of clarity as to what will happen in the organisational change process and possible change to clinical structures is causing anxiety, lack of psychological safety and organisational concern. Particularly observed in corporate nursing team. * Key issues for workplace sickness: Moral distress/ injury experienced by staff that are unable to work to	IMG doctors' recruitment and support programme. In addition, Doctors Experience working group reviewing medical rotas, estates and facilities services to manage practical impacts of rotational shifts on their wellbeing as per the BMA 5 Priorities for Improving Wellbeing at Work guidance (2024). * Development of Professional Behaviours Agreement Guidance and SOP for HR and managers that provides a robust and evidence-based process for the management of unprofessional and inappropriate behaviours concerns at work. This is in a 1st draft form and being consulted upon within People directorate for roll out by the end of 2024. * Training to the HWB services practitioner on understanding and screening for ADHD. Joint work with the Neurodiversity lead/OD on developing a Toolkit and training programme on Neurodiversity workplace support for managers and colleagues (diagnosed and self-diagnosed).	* Continue to provide UHN Group wide Health & Wellbeing Conversations training and staff suicide risk management training in a 6-week rolling programme to prevent the impact of mental and physical health deterioration of staff on their service delivery and absences and to engage leaders in their proactive management of staff wellbeing. * High profile and promotion of H&WB services to support staff and engage early intervention for staff support through new H&WB communication strategy, NGH induction programmes, UHN Policy reviews. * Ensuring wellbeing support services are working with the managers to provide the support needed with any change, making referrals to OH and

Sickness and absence rate

Committee Name: All

GroupName: People

MetricName: Sickness and absence rate

4.53%	5.00%	4.52%	5.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/08/24	% of Staff absent	Target achieved: Currently is 4.52%, 0.48% below the target of 5%. Results are within the statistical boundary. Mean absence has decreased 0.67% from previous month at 5.19%.	their own standards and values of high quality care and burnout due to work pressures, changes in the workplace (either happened, happening or uncertainty) causing anxiety - ie collaboration and ward moves and changes to work requirements i.e working across two sites, additional or onerous on-call commitments, managers requiring staff to be on-site rather than supportive of home working, workplace conflict.	* Heads of Service / People Leadership Team Workstreams focusing on ensuring HR policies are proactive, supportive and that the Unavailability Working Group targeting processes and systems impacting on attendance including: * Co-ordinated strategy across the People Directorate to improving attendance from recruitment, pre-employment OH screening, local onboarding to management induction following a preventative framework. * Managing unavailability with a prevention focused approach, using the newly developed UHN Health and Wellbeing at Work Policy and SOP, utilising the staff support service guidance and health passport scheme at employment commencement and through career journey engaging HRBPs and managers for early intervention and workplace adaptations to reduce agency and temporary staffing. * Partnership working with unions.	making reasonable adjustments, ensuring clear communication and feedback loops through the managers, listening and addressing concerns, risk assessments, supporting agile working where possible. Reintroduced sending out monthly trigger reports however staff triggering formal management should be picked up by the line manager conducting the RTW.

Vacancy rate

Committee Name: All

GroupName: People

MetricName: Vacancy rate

Date: 01/03/2021 – 01/08/2024

12.04%	8.00%	11.40%	8.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital

Vacancy rate

Committee Name: All

GroupName: People

MetricName: Vacancy rate

12.04%	8.00%	11.40%	8.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	% difference between budgeted establishment and actual establishment	The value tells us the percentage of budgeted posts that are vacant	Particular staff group hotspots for vacancy rates are AHPs, Nursing and Midwifery, Additional Clinical Services (HCAs), Additional Professional Scientific and Technical and Estates and Ancillary. Factors impacting these particular areas relate to a shortage of staff nationally, and for non qualified staff comparability of pay rates to other industry sectors in the job market and associated need to develop an attraction strategy.	The Attraction workstream has formally commenced and focus groups are scheduled to develop the attraction strategy. The Redefining the Process workstream has also formally commenced and will be working through streamlining, aligning all documents and processes to make Recruitment more efficient whilst also giving candidates a quicker and better experience. Recruitment trajectories and pipelines are being mapped against agency long lines. Process Automation (RPA) projects have been mapped during a workshop to develop programs of work aimed at reducing time to hire. Recruitment campaign being looked at specifically for Pharmacy. Recruitment activity continues to be high volume.	Weekly meetings are in place to monitor recruitment activities for each Division in a way in which they are mapped to long terms agency use and to ensure that any delays are unblocked and minimised. Time to Hire reporting is broken down into each stage of the recruitment process and monitored accordingly enabling targeted intervention and support as and when required.

Turnover rate

Committee Name: All

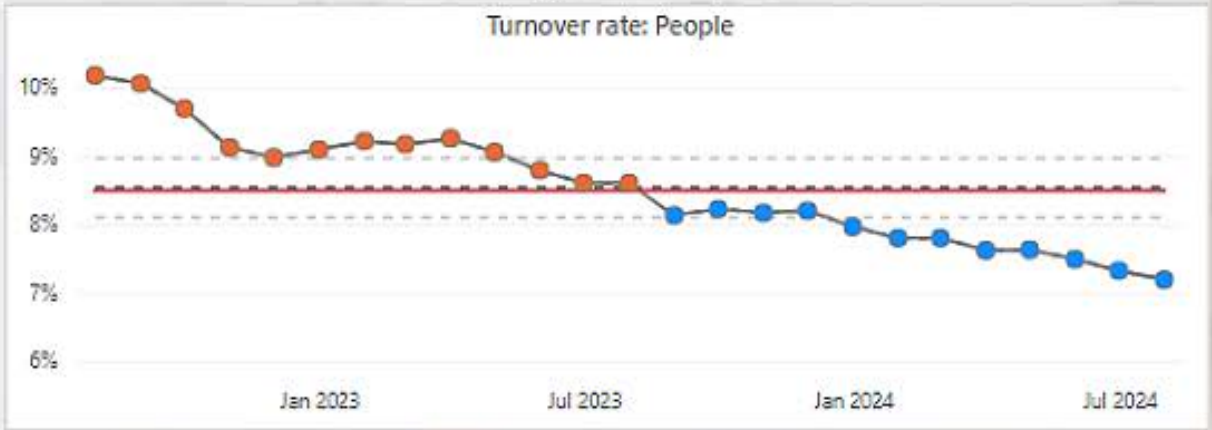
GroupName: People

MetricName: Turnover rate

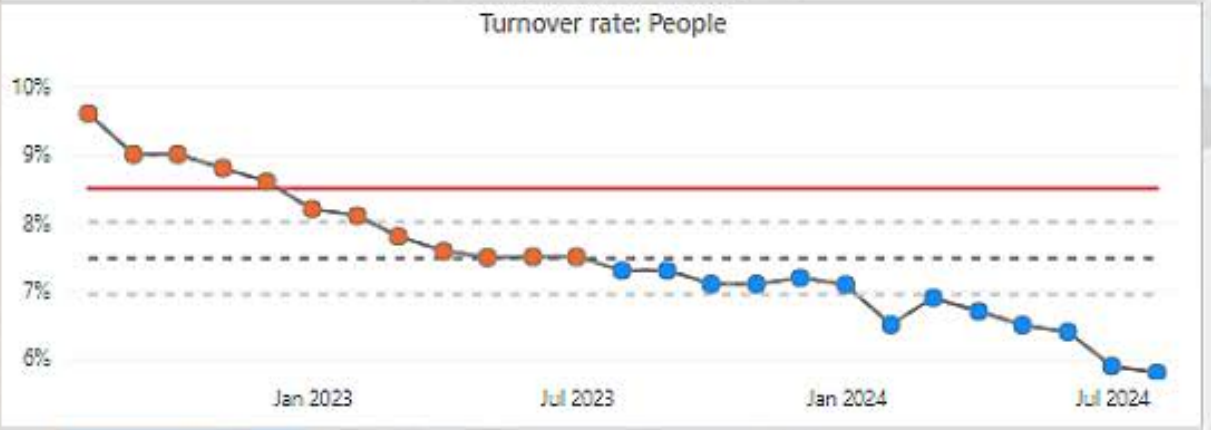
Date: 01/03/2021 – 01/08/2024

7.20%	8.50%	5.80%	8.50%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Formal procedures

Committee Name: All

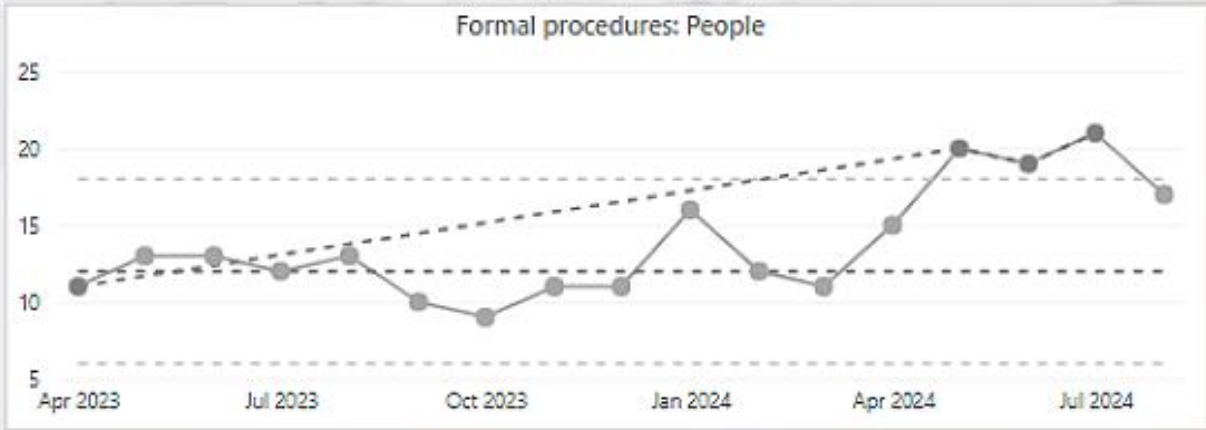
GroupName: People

MetricName: Formal procedures

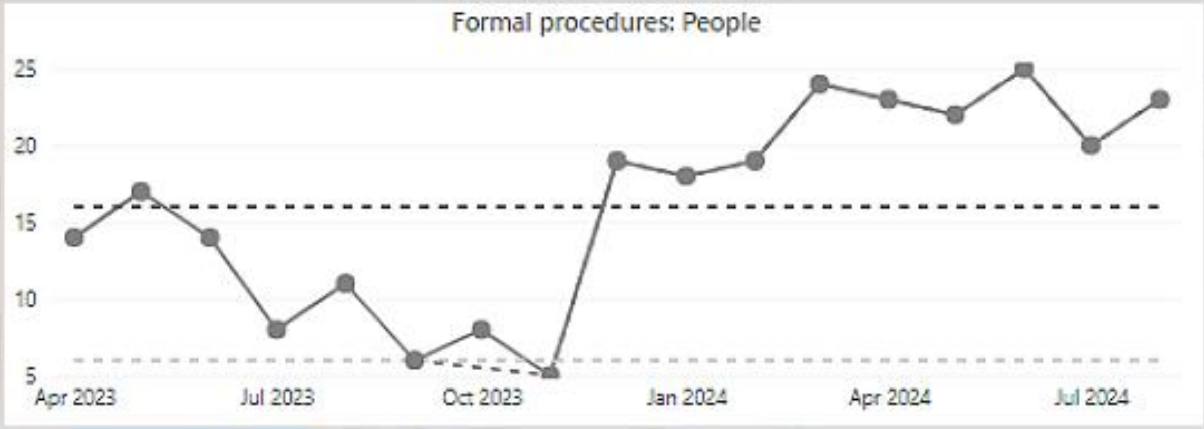
Date: 01/03/2021 – 01/08/2024

17		23	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Number of formal complaints – active and open	The number of open formal disciplinary cases has fallen from 11 to 8 from August to September. A number of long standing cases were resolved in this period. The number of open formal grievances also fell from 10 to 9 from August to September.	There are currently two active disciplinary suspensions. These case are progressing and a hearing is scheduled for one. There continues to be difficulties with availability of investigators and with availability of management and staff side.	There are a number of areas where we have seen grievances, freedom to speak up concerns raised where we are looking to proactively intervene with the support of our OD team, or by using more informal mediation approaches.	We are looking at our training offerings to support managers in resolving issues at a more informal level, ensuring a just culture approach becomes embedded.
NGH	01/08/24	Number of formal complaints – active and open	There are currently 14 formal Disciplinary Cases and 9 formal grievances, with 5 active suspensions	Availability of staff in a timely manner to be able to attend formal meetings continues to be an issue. This is partly due to staff shortages/pressures in Staffside and also management availability, due to annual leave. Additionally a number of current cases have involved multiple witnesses which elongates the process.	We continue to follow a Just Culture approach and will resolve at an informal level if possible, ensuring that the appropriate learning and expectations are clearly set out.	Some lower level investigation interviews are being held on teams, where appropriate We also work proactively with staffside around their availability in order to schedule meetings when all can attend.

Roster publication performance

Committee Name: All

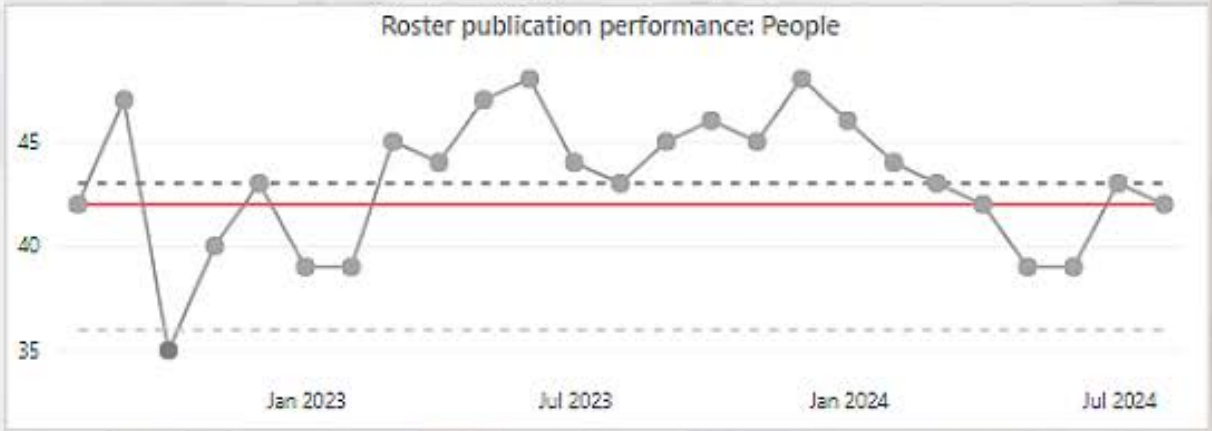
GroupName: People

MetricName: Roster publication performance

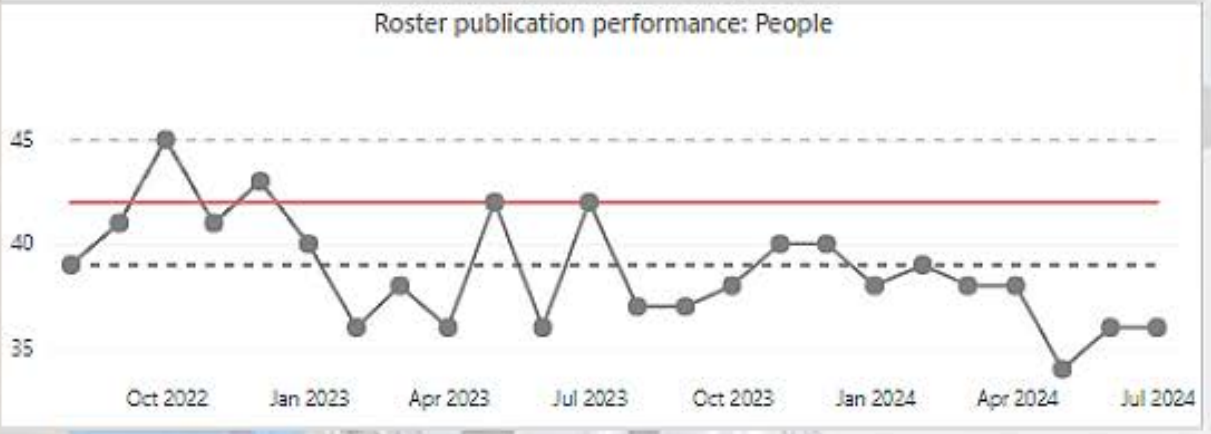
Date: 01/03/2021 – 01/08/2024

42	42	36	42
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Time to hire

Committee Name: All

GroupName: People

MetricName: Time to hire

Date: 01/03/2021 – 01/08/2024

68.10	91	97.80	91
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Time to recruit from Advert – to in post – target 13 weeks	Time taken to on board a candidate from authorisation to confirmed start date.	Requirement to streamline and reduce as far as possible with a view to reducing any associated agency costs.	See vacancy narrative	See vacancy narrative

Number of volunteering hours

Committee Name: All

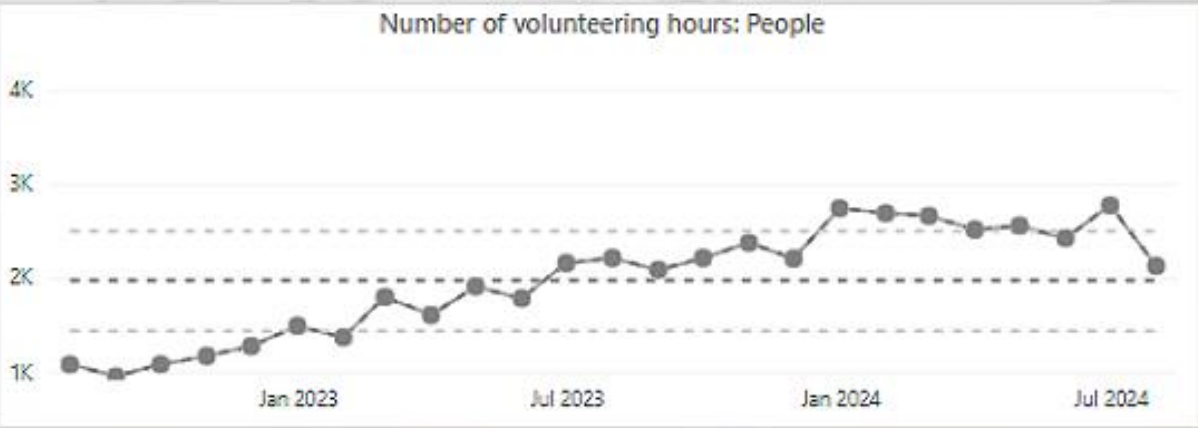
GroupName: People

MetricName: Number of volunteering hours

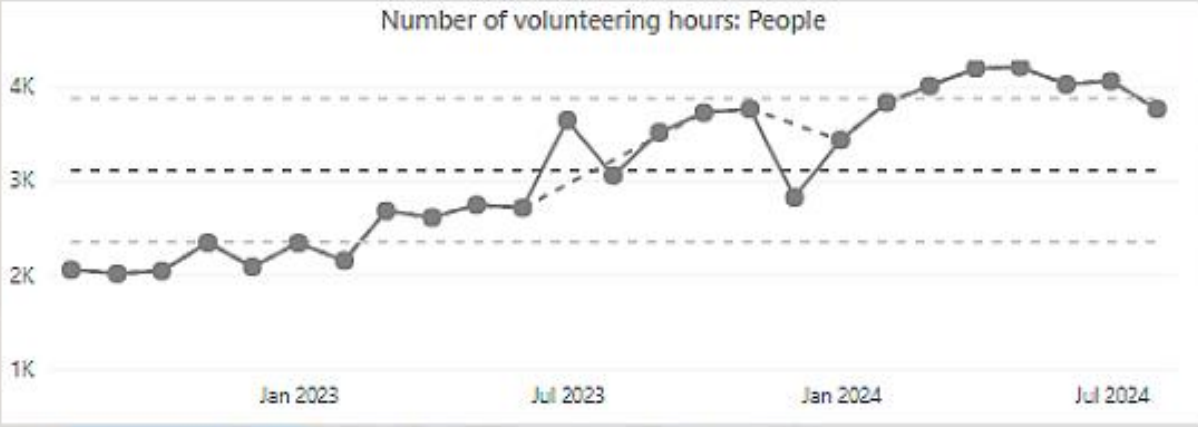
Date: 01/03/2021 – 01/08/2024

2,128		3,763	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/08/24	Number of volunteering hours	2128	Hours have fallen significantly	30 applicants were sucessful from the interviews 5/8 and 60 applicants are going to interview early september from the August advert	Hours tend to fall during August due to holidays and the loss of the students going to univeristy/final year of 6th form. The effects of not recruiting since March are reflecting the decrease in hours
NGH	01/08/24	Number of volunteering hours	3763	Reduction in hours	71 applicants were sucessful at interview on 26/8	Hours tend to fall during August due to holidays and the loss of the students going to univeristy/final year of 6th form. The effects of not recruiting since March are reflecting the decrease in hours

Cover sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	4 October 2024
Agenda item	6

Title	Northamptonshire Integrated Care Board (NICB) Operating Plan 2024-25
Presenters	Richard Wheeler, Chief Finance Officer Polly Grimmett, Director of Strategy
Authors	Richard May, Company Secretary Karen Spellman, Director of Strategy and Planning, NICB

This paper is for			
☐Decision	☐Discussion	☑ Receive and note	☐Assurance
To formally receive and discuss a report and determine its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Group priority				
☐Patient	☐Quality	☑ Systems & Partnerships	☐Sustainability	☐People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
To receive and note the summary of the final submitted and agreed Operational and Financial Plan for the NICB for 2024-25	NICB, 15 August 2024 UHN Boards and Board Development, April to July 2024

Executive Summary
The report sets out a summary of the final NHS Northamptonshire ICB Operational and Financial plan supported by provider and ICB Boards and submitted to NHSE on 12th June 2024. For 2024/25, we plan to deliver elective activity recovery targets, key operational performance targets and a reduction in bank and agency usage across the System. We plan to achieve a £55m deficit financial position which includes a challenging efficiency target. Risks to the plan include: • Further Industrial Action • Inflation costs over funding settlement • Management of UEC within current capacity • Productivity improvement and CIP delivery • NICE guidance and prescribing expenditure • Pay award – funding of total costs
Appendices
NICB Final Operational Plan 2024-25
Risk and assurance
Delivery of the plan mitigates all Board Assurance Framework risks – details at agenda item 14
Financial Impact
As set out in the appendix
Legal implications/regulatory requirements
No direct implications
Equality Impact Assessment
No direct implications relating to this information report.

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24/25 Final Operational Plan

Introduction

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The Final Plan submission was made on the 12th June and the plan details are included within this paper. The summary headlines are below;

Activity
- Activity planned to deliver the Elective Recovery Fund (ERF) target of 109%

Performance
- Risks to delivery of the Urgent and Emergency care standards. 4 hour planned to achieve 78% this includes Corby Urgent Care Centre activity as agreed with NHSE. Diagnostics - achieve 93.7% against the 95% standard overall. Audiology planned to achieve 68%. The Trusts and Elective Collaborative are working to mitigate this performance trajectory.
- Plan to clear 65 week waits by September 24 and achieve interim 62-day cancer standard (70%) and 28-day faster diagnosis standard (77%) by March 25.
- Forecast to continue to reduce mental health out of area placements.

Workforce
- Reduction in staff in post across 2024/25 (0.56%). Small increase in budgeted establishment across 2024/25 (0.44%)
- Bank reduction of 4.17% across the system
- Agency reduction of 34.8%

Finance
- The final Northamptonshire 2024/25 plan submission is a £55m deficit.

Risks to the Plan include

- Further Industrial Action
- Inflation costs over funding settlement
- Management of UEC within current capacity
- Productivity improvement and CIP delivery
- NICE guidance and prescribing expenditure
- Pay award – funding of total costs

24/25 Performance Summary

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Area	National NHS Objectives 2024/25	NHSE Standard/Target	Plan 2024/25	RAG Rating/Distance from Target
Urgent and emergency care	Percentage of attendances at type 1 / other A&E departments where the patient spent less than 4 hours from time of arrival to admission / discharge / transfer (E.M.13a & E.M.13b)	78%	66.5%	11.5%
Community Services	Improve Community Waiting Times - 52 week waits (at Q4)	N/A	446	N/A
Primary Care	Appointments in General Practice and Primary Care Networks (E.D.19)	N/A	4,603,000	N/A
	Percentage of appointments seen within two weeks (E.D.21)	N/A	89%	N/A
Elective care	Eliminate waits of over 65 weeks for elective care by Sept 2024 (except where patients choose to wait longer or in specific specialties) - ICB	0	0	0
	Deliver elective activity in line with national value weighted target of 107%	109%	109%	0%
	Increase first outpatient appointments or outpatient procedures to 46% of all outpatient attendances	46%	49.2%	3.2%
Cancer	Meet the cancer faster diagnosis standard by March 2025 so that 77% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days	77%	81.19%	4.2%
	Improve performance against the 62 day cancer standard to 70% by March 2025	70%	72.41%	2.4%
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	95%	93.7%	1.3%

Notes

- We will achieve 78% by March 25 with the inclusion of Type 2 and 3 including Corby Urgent Care Centre.
- National standard for community services and primary care is to improve waiting times, with a focus on reducing long waits. No national targets.
- Diagnostics-Across the system we will achieve 93.7% due to challenges with Audiology, Ultrasound and Dexa. All other diagnostic tests will achieve 95%.

24/25 Performance Summary

NHS
Northamptonshire
Integrated Care Board

Area	National NHS Objectives 2024/25	NHSE Standard/Target	Plan 2024/25	RAG Rating/Distance from Target
Mental health	Improve patient flow and work towards eliminating inappropriate out of area placements	0	0	0
	Increase the number of people accessing transformed models of adult community mental health in line with national ambition of 400,000	5,057	8,416	3359
	Increase the number of people accessing perinatal mental health services in line with national ambition of 66,000	905	1,231	326
	Increase the number of children and young people accessing mental health services in line with national ambition of 345,000 above 2019 levels	9,600	10,270	670
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies in line with the national ambition of 700,000	8,387	8,387	0
	Improve the improvement achieved through Talking Therapies to 67%	67%	67%	0%
	Improve reliable recovery rates achieved through Talking Therapies to 48%	48%	48%	0%
	Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025	60%	66.9%	6.9%
	Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025	66.7%	66.7%	0%
Learning Disabilities/ Autism	Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025	75%	75%	0%
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults for every 1 million population	30	30	0
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 12–15 under 18s for every 1 million population	15	6	9

Notes

Across Mental Health and Learning disabilities we will achieve the national standards

Key

	Plan is achieving/overachieving NHSE target performance
	Plan does not achieve NHSE target performance (outside of 5% tolerance)
	Plan is within 5% of achieving NHSE target performance

2024/25 Financial Plan

NHS
Northamptonshire
Integrated Care Board

The 2024/25 financial plan includes the following assumptions:

- 5% CIP for all organisations
- Minimal workforce growth other than for agreed investments and SDF
- Significant reductions in bank and agency expenditure
- Excess inflation assumptions reduced as part of April flash submission and final submission
- Very limited investment in service critical areas only
- Maintaining low benchmarked CHC and prescribing spend
- Repayment of Prior Year Deficit - £3.2m
- Meeting MHIS and BCF minimum contribution

2024/25 Financial Plan

Northamptonshire Integrated Care Board

Income and Expenditure Plan

Financial Position Reported	Annual Plan
	£'000
ICB	0
KGH	(29,200)
NGH	(25,800)
NHFT	0
Total System (deficit)/surplus	**(55,000)**

- 2024/25 planned deficit of £55m
- UHN and NHFT plans reflect transitional support from the ICB

Capital Plan

Northamptonshire Capital	
	Plan Y/Ending £'000
KGH	10,313
NGH	14,145
NHFT	6,556
ICB	1,327
System Capital Allocation	**32,341**
KGH	5,836
NGH	6,125
NHFT	400
IFRS reduction	(4,362)
IFRS 16/ Leases	**7,999**
Total System Capital Inc IFRS 16	**40,340**
KGH	17,888
NGH	10,567
NHFT	659
National Capital / PFI	**29,114**
Total Capital	**69,454**

- The System capital plan is adjusted for confirmed lease funding of £8m from NHSE.

Cover sheet

Meeting	University Hospitals of Northamptonshire (UHN) NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	4 October 2024
Agenda item	UHN Winter Plan
Item number	8

This paper is for			
✓Approval	✓ Discussion	☐Note	✓ Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

UHN priority				
✓ Patient	✓ Quality	✓ Systems & Partnerships	☐ Sustainability	☐ People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration / Recommendation	Previous consideration
Seeking the Boards' assurance and direction in respect of the trusts' plans to maintain safety during winter.	Clinical Quality and Safety Committee Operational Performance Committee

Executive Summary

Based on the demand and capacity (bed) models we know there is a bed deficit on both sites (-125 beds for UHN) so there are more patients predicted to require a bed than the number of beds we have available. The unmitigated position presents a significant patient safety risk and is therefore the primary focus, not performance.

After local health system contribution (24 beds) and turning boarding space into established bed capacity (19 beds) the remaining deficit can be largely mitigated through the following;

- 18 beds reopening Sir Thomas Moore Ward, KGH in Dec 24 – reliant on RAAC concrete remedial works (at risk)
- 26 beds top floor Spinney – assessment of staffing options underway (revenue likely required)
- 21 beds repurposing Grafton Ward, NGH from offices into medically fit ward – assessment of staffing options underway (revenue likely required)

There is the possibility of revenue required to staff Spinney and Grafton but at present the extent is unknown while further assessment is undertaken.

Recommendations

The Boards are asked to;

1. note the winter plan;
2. support the position that this relates to patient safety and not solely performance;
3. take a view on revenue spend if it is required to open Spinney top floor and/or Grafton and the risk of not doing so;
4. support the reprioritisation of the capital plan to enable the Grafton work;
5. Indicate in-principle support for the Grafton scheme for subsequent business case determination in accordance with approved schemes of delegation.

Appendices

Slides: UHN Winter Plan

Risk and assurance

UHN04: Failure of the Integrated Care System (ICS) to deliver transformed care will result in an impact on the quality of service provided across the Group. Corporate risks NGH424 and KGH011 are both focussed on capacity and flow. Specific risks outlined in the report below and slide pack.

Financial Impact

Unknown at present

Legal implications/regulatory requirements

Data sharing agreements across the two organisations will be in place

Equality Impact Assessment

Delivery pf the ICB 5-year strategy for urgent and emergency care will give rise to positive impacts in respect of patients and residents with protected characteristics relating to age and disability – see slide 9 for further information.

Paper

Situation

This paper seeks to summarise the baseline demand and capacity position across UHN, the work internally and externally to support Urgent and Emergency Care (UEC) over the winter months (and beyond) and options for additional bed capacity on both sites.

Background

Based on the demand and capacity (bed) models we know there is a bed deficit on both sites so there are more patients predicted to require a bed than the number of beds we have available. This is evidenced through patients waiting for beds in ED continuously. This results in an inability to create space in ED and off load ambulance in a timely way. During the colder months the bed deficit is exacerbated due to demand rising which in turn puts additional pressure at our front doors and in the community.

The unmitigated position presents a significant patient safety risk and is therefore the primary focus, not performance. This has been noted in the ICB Quality Board and the UNH Clinical Quality and Safety and Operational Performance Committee.

Assessment

The baseline model shows that at its worst the bed deficit is -125 across UHN (-54 at KGH and -71 at NGH).

There is a 24-bed contribution from schemes started in Winter 24/25, BCF Discharge Funding growth and new West Northamptonshire Council contractual arrangements for P1 capacity from system partners.

19 beds have been approved to start installation of curtain tracks and bed services (call bell, oxygen and suction). Previously these were used as boarding spaces but the decision to establish these as core beds has been made.

The remaining deficit can be largely mitigated through the following;

- 18 beds reopening Thomas Moore Ward, KGH in Dec 24 – reliant on RAAC works (at risk)
- 26 beds top floor Spinney – assessment of staffing options underway (revenue likely required)
- 21 beds repurposing Grafton, NGH from offices into medically fit ward – assessment of staffing options underway (revenue likely required)

Revenue implications for Spinney top floor and Grafton are being assessed currently.

- Spinney – the existing ground floor model is being reviewed to ensure staffing ratios are appropriate for medically fit patients and to reduce the medical oversight, moving to a virtual ward model. These measures would release existing funding to support the opening of the top floor. It is unknown at present if this will be enough.

  No estates work needed so limited lead time.

- Grafton – the staffing in ED is being reviewed as part of the SNCT work taking place during October to assess the feasibility of moving the additional staffing in place to support the patient waiting beds to Grafton. It is unknown at present if this will be enough.

  Requires re-prioritisation of capital programme and 3-month lead time.

Key risks to an unmitigated bed position:

- Overcrowding in ED & the significant associated safety risks
- Inability to off load ambulances in a timely way severely increasing cat 2 ambulance response times and thereby increased risk to patients waiting in the community
- Rising waiting times in ED (4 hours and 12 hours) resulting in a poorer outcomes, safety and experience for patients
- Delay in remedial RAAC work at KGH which will reduce capacity and further increase the bed gap by -18
- Standing down the elective programmes to use elective surgery, T&O and cardiology beds which would result in cancelations of elective activity, associated income & increased costs
- Extreme pressure for staff
- Increased regulatory pressure on quality and performance measures

Recommendations

The Boards are asked to;

1. note the winter plan
2. support the position that this relates to patient safety and not solely performance
3. take a view on revenue spend if it is required to open Spinney top floor and/or Grafton and the risk of not doing so
4. support the reprioritisation of the capital plan to enable the Grafton work
5. Indicate in-principle support for the Grafton scheme for subsequent business case determination in accordance with approved schemes of delegation.

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UHN Winter Plan

Sarah Noonan – UHN COO

Oct 2024

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National Priorities

- **Reducing 12 hour total time breaches in ED:** Reducing the number of patients having to wait >12-hour from arrival to discharge/ admission is a key metric for this year, not only will it improve Patient Safety within ED by reducing overcrowding, it will also support the front door in reducing the number of ambulance delays.

- **Improve A&E waiting times compared to 2023/24,** with a minimum of 78% of patients seen within 4 hours by March 2025

- **Ambulance handovers:** Support EMAS colleagues to improve cat 2 responses by ensuring at least 90% of Ambulance handovers are completed within 30mins

- **Improving hospital flow:** Continuing to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge

- **Patient safety:** Ensuring safety rounds are undertaken and minimal care standards delivered to patients waiting to be off loaded from an ambulance

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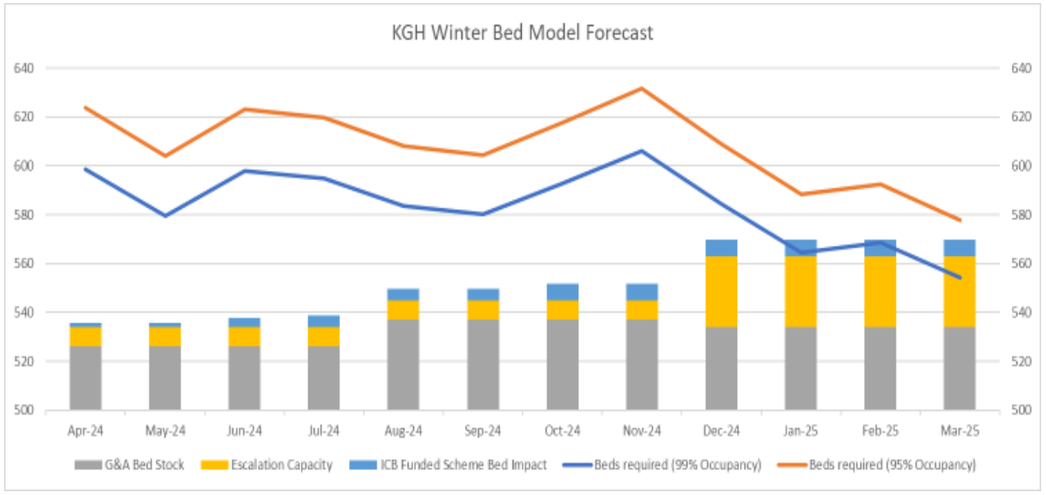
Bed Models – Demand & Capacity Baseline

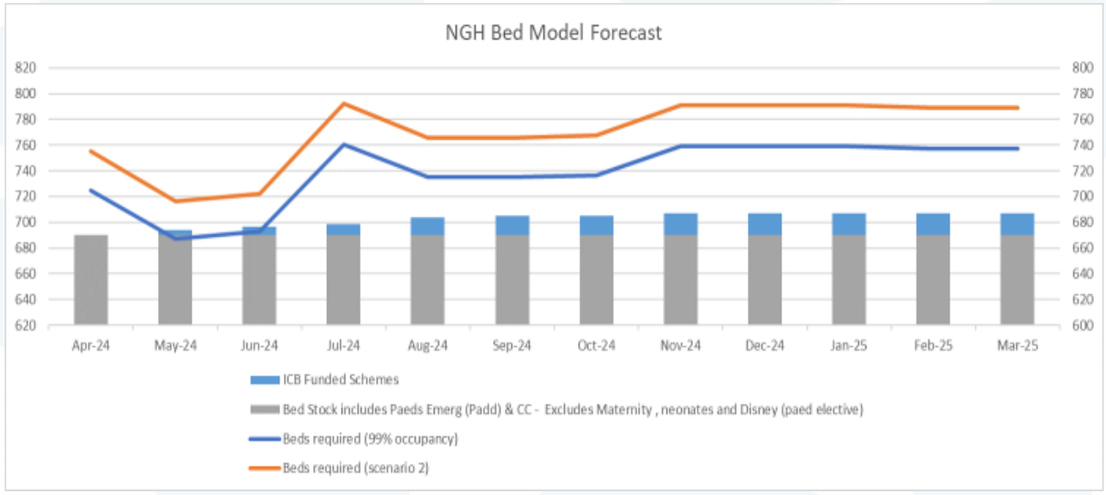
Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

KGH Bed Model:
The bed model, below, predicts that throughout winter 2024 the worst case KGH capacity is a deficit of **-54 beds** (including Paediatric beds). This is based on a 99% bed occupancy. This model also includes system schemes which equate to the equivalent of 7 beds. This is based on a 99% bed occupancy. 18 beds at risk due to delay of RAAC.



NGH Bed model:
At NGH the worst case is predicted to be a deficit of **-71 beds**. This model also includes system schemes which equate to the equivalent of 17 beds. This is based on a 99% bed occupancy. The national recommended occupancy is 92%, this would deteriorate the bed gap by a further 24 beds.



UHN bed deficit – 125 beds

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UHN Programmes of work

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UHN UEC Steering Group

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

- UHN UEC Steering Group starts September 2024
- Brings together the previous work programmes of NGH and KGH into UHN work programmes
- Three programmes;
  - Admissions avoidance
  - In Hospital flow
  - Discharge
- Coordinated efforts focused on specific areas to maximise impact
- Opportunities to review lessons from 23/24 as well as share learning and good practice between sites

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UEC PROGRAME OF IMPROVEMENT

Guiding Principles – Improved capacity and flow, delivering optimal patient experience and by doing so achieving the NHSE Recovery Metrics

Workstreams	Reducing input via admission avoidance, redirection & streaming **SRO – Linda McGranahan**	Optimising flow through the hospital/post Admission **SRO's – Robin Binks/Joanne Smith**	Maximising Output/Discharge **SRO – Jo Sturgess**
Projects (Leads to be Confirmed)	Implement GIRFT "Alternatives to ED (A-tED)" (redirection & streaming)	Fully optimised SDEC's to meet demand across all specialities	Criteria Led Discharge
	Implement GIRFT "Alternatives to Admission (A-tA)" (criteria led admission)	Point of Care Testing	Virtual Wards (cross workstreams inc Admission Avoidance)
	Implement GIRFT "Frailty Alternatives to ED Attendance (Frail –tED)" & optimise Frailty SDEC	Direct Admission to Base Wards for agreed pathways	System wide cohesive escalation to minimise extended LOS
	Senior Decision Makers at the Front Door for effective Redirection & Streaming	Effective Board Rounds with robust Red to Green process/Criteria to reside	Day before Discharge planning
	Optimisation of Virtual Wards (also within Discharge)	Complex discharge process for same day TOC/SBAR submission	
Deliverables	Redirection where clinically suitable to avoid admission & achieve 78% non admitted performance Use 100% Virtual Ward capacity – aiming for 50 admissions Reduced delays in ambulance handovers	Improved flow and reduced length of stay post initial admission Red to Green daily board rounds Reduced LOS across 7 and 24 days	Reduction in delays post DRD (discharge ready date) across a) % patients discharged on their DRD and b) average delay for patient snot discharged on DRD
RAG			

Aims, Drivers & Required Activities/Areas of Focus

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

GOAL/AIM	PRIMARY DRIVERS	SECONDARY DRIVERS	REQUIRED ACTIVITIES
Improve capacity and flow throughout the ED and Urgent Care services across UHoN in line with National Recovery Plan – reducing time in department and time to admission to improve patient experience and clinical outcomes	Improved patient experience, safety and quality	78% of ED patients being admitted, transferred or discharged within 4 hours by March '25	Full optimisation of virtual wards Criteria Led Discharge Implement GIRFT "Alternatives to ED (A-tED)" Implement GIRFT "Alternatives to Admission (A-tA)" Implement GIRFT "Frailty Alternatives to ED Attendance (Frail –tED)" & optimise Frailty SDEC Fully optimised SDEC's to meet demand across all specialities Senior Decision Makers at the Front Door for effective Redirection & Streaming Point of Care Testing Direct Admission to Base Wards for agreed pathways Effective Board Rounds with robust Red to Green process Effective Complex Discharge process for same day TOC/SBAR submission System wide cohesive escalation to minimise extended LOS Day before Discharge planning (ie Transport/EDN/Carer & Family Communication)
	NHSE Urgent and Emergency Care Recovery Plan: Year 2	Reduction in Ambulance Handover delays	
	UEC GIRFT Improvement Recommendations	Reduced Time in ED Departments for all presentations	
	Internal Professional Standards compliance and performance	Improved LOS for all admitted patients (specifically emergency admission with LOS 1+ day)	
	Access to and receipt of required diagnostic, treatment, therapy needs across 7 days	Reduction in delays post DRD (discharge ready date) across a) % patients discharged on their DRD and b) average delay for patient snot discharged on DRD	

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Northamptonshire Integrated Care Board (NICB) programmes of work

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ICB UEC 5 Year Strategy

Six key programmes:

- Self-Care and Prevention: Supporting the estimated 10,000 people living with **multiple long term conditions** to **live well** and thrive in their communities, supported by services delivered at **place-level**. Each will have a comprehensive holistic care plan which is visible to all partners; increased use of **remote monitoring; peer support groups and increased annual health checks.**
- Rapid Access to Primary and Community Care: We will ensure those with a non-emergency need but requiring same day support can access the most appropriate professional through delivering **primary care services at scale** at locations around the county.
- Rapid, Co-Ordinated Urgent Care Response: We will expand and embed a **single point of access** to respond to escalating needs to safely avoid a conveyance or admission to hospital, enabling the person to complete their recovery in their place of usual residence. Including **24/7 Urgent Community Response**; **management of certain EMAS calls; alignment with mental health response and primary care.**
- Sub-Acute Care: Where hospital examination or diagnostic tests are required we will provide **same day access** to services where possible. Assessments and diagnostics will be undertaken locally to enable patients to stay at home overnight with **local community bed step up capacity** when 24hr observation is required. Aligned to the **community diagnostic centres** and increased **remote monitoring** with **SPOA support.**
- Acute Emergency Care: When time critical **acute or mental health** responses are required within a **hospital setting**, **treatment will not be not delayed**. Patients will receive care specific to their presenting need with follow up treatment in the **most appropriate location**. Achieved by delivering a **primary and community-based response** to lower level attendances and **recovering independence workstreams.**
- Recovering Independence: To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

ICB UEC 5 Year Strategy Pillars

Kettering General Hospital NHS Foundation Trust

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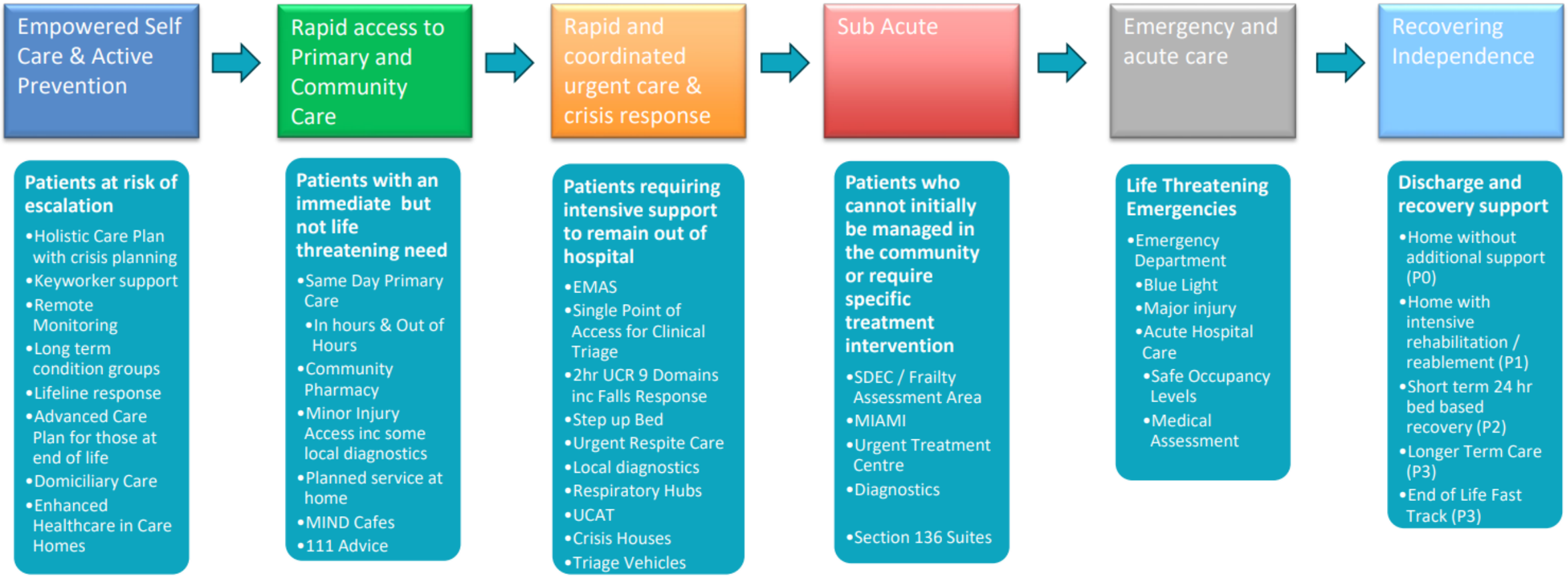

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UEC system-wide transformation

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

- In order to support implementation of the UEC strategy, it has been agreed that we will stand back up a transformation programme around UEC, with a focus on developing the year-by-year plan and beginning work on year 1 transformation priorities, with a focus on impact and benefits.
- The transformation programme shaping will be led by UHN Director of Continuous Improvement, who has agreed this with all parties across the system, including primary care, NHFT, NNC, WNC and the ICB.
- The UEC transformation programme will report into the system UEC board, which UHN Director of Continuous Improvement is now invited to, and will be standing up robust data and reporting, and programme updates across all workstreams.
- We have had provisional agreement for all parties to input transformation or BI resources into the programme to make this work.
- The initial step is to establish the programme of work through a workshop to be held in October, which will:
  - Review the data on current and activity across the whole pathway across the system
  - Review the current work occurring in all organisations and ensure there is clarity on benefits and impact so we can assess effectiveness
  - Identify areas based on the data where there are gaps in the programmes of work across the system
  - Agree governance and resource required to implement
- We are anticipating this will:
  - Bolster visibility and transparency of all the work happening across the system
  - Ensure the transformational programme of work and the delivery of the strategy is based on data and evidence
  - Ensure there are clear benefits and impact identified for all the work underway, and prioritise investment and resources to the highest impact interventions, given the challenges that we have around the financial position
  - Support the progression of additional areas where changing pathways and working in an integrated way will improve the position

Options for additional capacity

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Options for additional Acute capacity

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

KGH	Beds	Financial impact	Status
Lamport	1	Bed head services and curtain tracks	Approved
Tywell	1	Bed head services and curtain tracks	Approved
Nasby B	1	Bed head services and curtain tracks	Approved
DDU	6	Curtain tracks	In discussion
Spinney	6	None	Approved
Total	**15**		

NGH	Beds	Financial impact	Status
Nye Bevan	10	Bed head services and curtain tracks	Approved
Grafton ward	24	Ward refurb (£1m) & office decant (£1.5m)	In discussion
Spinney top floor	26	Revenue	Flooring (capital) approved Staffing in discussion
Total	**60**		

Thomas Moore at risk of not coming back online from November – 18 beds

Old ITU (24 beds) will be medical ward in 25/26 as involves a 12m lead time

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Bed Models – Demand & Capacity

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

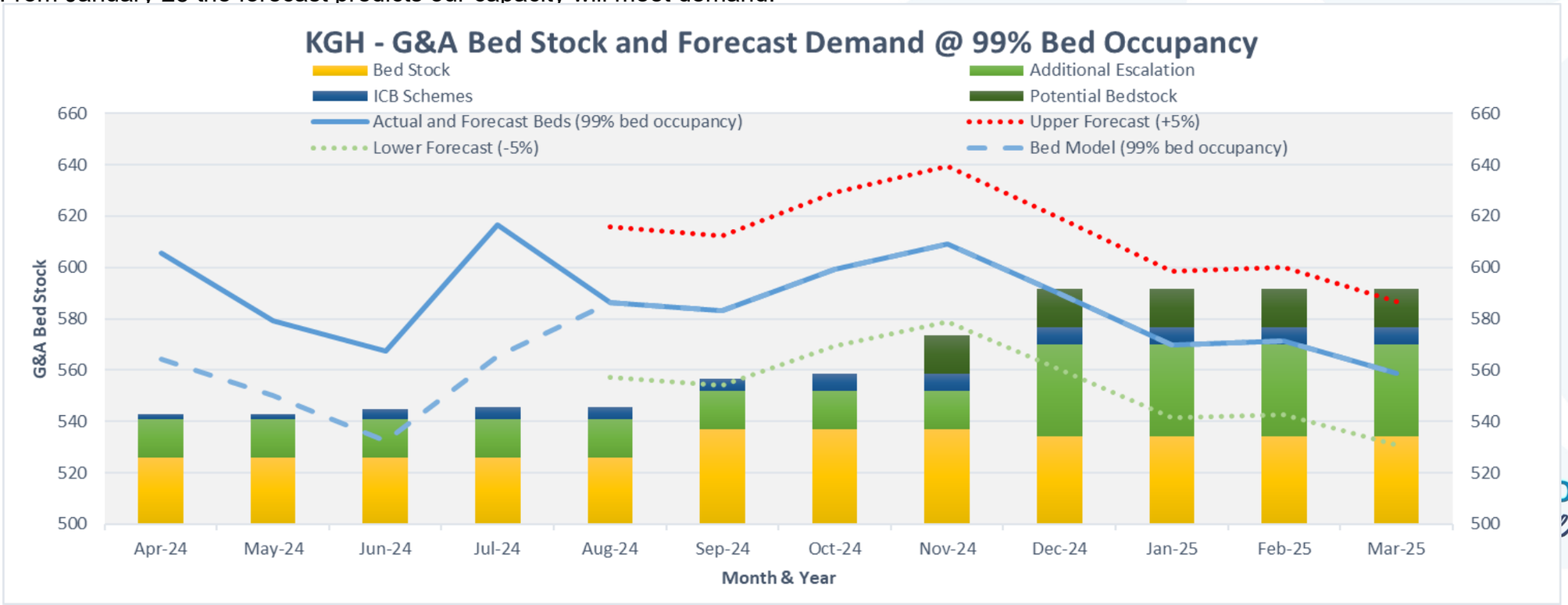
KGH Bed Model:

The bed model, below, shows that we have had higher non-elective admissions in the first 4 months than predicted with a bed demand about 5% higher than forecast. Thus for winter 2024 we expect to follow the upper forecast bed demand.

Bed stock assumes:

- 99% bed occupancy, national expectations are 95%, and this does impact significantly on operational daily flow. To reach 95% occupancy a further 45 beds are required
- Thomas Moore is available (maternity decanted) from December 24 (additional escalation)
- Spinnyfield ground floor opens 6 additional beds (potential bedstock)
- Additional beds are opened on current base wards incl DDU (potential bedstock)
- System schemes equate to the equivalent of 7 beds are delivered

In Sept, Oct, Nov and Dec we are forecasting a deficit of 56, 71, 65 and 28 beds based on the upper forecast bed demand. This impact ED and ambulance handover performance. From January 25 the forecast predicts our capacity will meet demand.



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Bed Models – Demand & Capacity

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

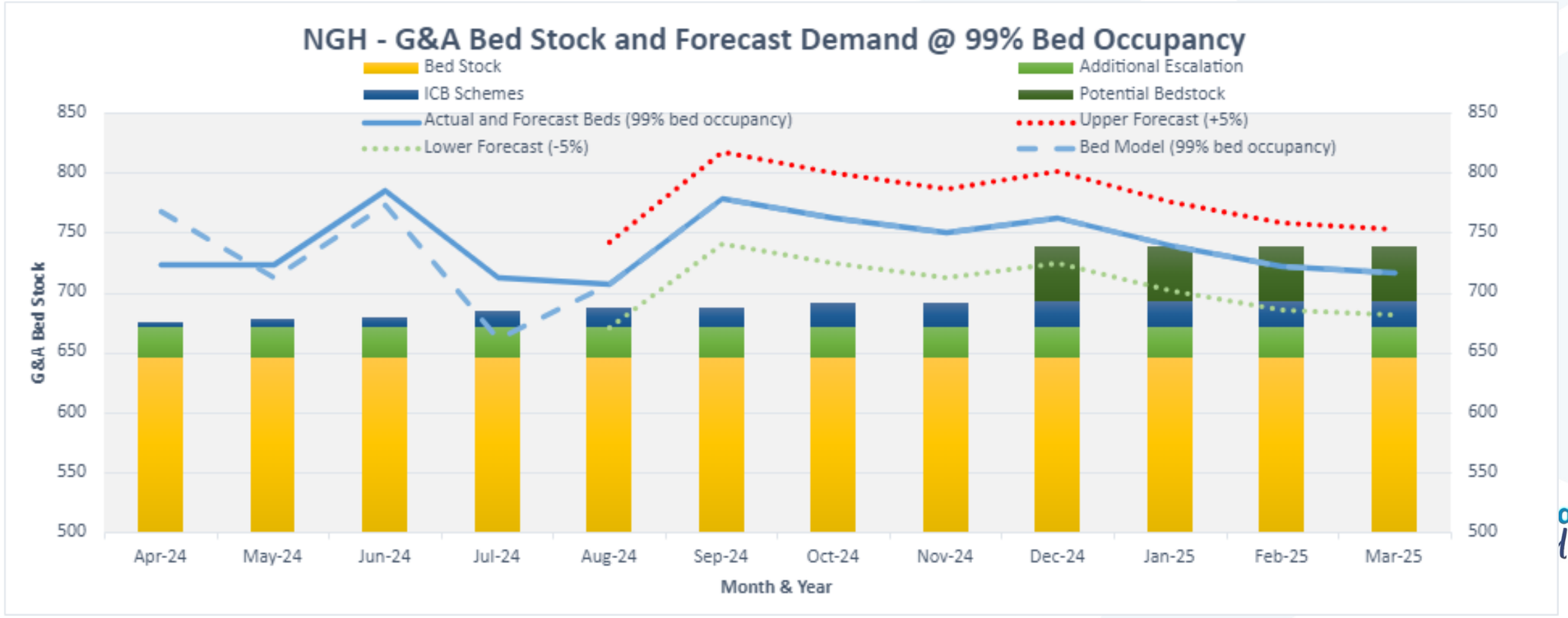
NGH Bed Model (scenario A):

The bed model, below, shows non-elective bed demand in the first 4 months are near planned levels. Thus for winter 2024 we expect to follow the forecast bed (solid blue) demand.

Bed stock assumes:

- 99% bed occupancy, national expectations are 95%, and this does impact significantly on operational daily flow. To reach 95% occupancy a further 55 beds are required
- Spinnyfield 1st floor opens to 26 beds from December 24 (potential bedstock)
- Grafton ward (21 beds) is available from December 24 (potential bedstock)
- System schemes equate to the equivalent of 17 beds are delivered

In Sept, Oct, Nov and Dec we are forecasting a deficit of 92, 71, 58 and 24 beds based on the forecast bed demand. This impact ED and ambulance handover performance. From January 25 the forecast predicts our capacity will meet demand.



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Risks

Key risks to an unmitigated bed position:

- Overcrowding in ED & the significant associated safety risks
- Inability to off load ambulances in a timely way severely increasing cat 2 ambulance response times and thereby increased risk to patients waiting in the community
- Rising waiting times in ED (4 hours and 12 hours) resulting in a poorer outcomes, safety and experience for patients
- Delay in remedial RAAC work at KGH which will reduce capacity and further increase the bed gap by **-18**
- Standing down the elective programmes to use elective surgery, T&O and cardiology beds which would result in cancelations of elective activity, associated income & increased costs
- Extreme pressure for staff
- Increased regulatory pressure on quality and performance measures

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Cover sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	4 October 2024
Agenda item	9

Title	KGH Neonatal Unit Transition Plan
Presenter	Julie Hogg, Interim Chief Nurse
Authors	Jane Lafferty, Matron for Neonatal Services Abraham Isaac, Neonatal Lead Consultant

This paper is for			
☐ Decision	☐Discussion	☐Note	X Assurance
To formally receive and discuss a report and determine its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Group priority				
X Patient	X Quality	X Systems & Partnerships	☐ Sustainability	☐ People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
For Boards' assurance, setting out the latest positions regarding plans to reinstate level 2 cots at the KGH neonatal unit.	Action plan has been considered & supported through Family Health Division governance Regional Neonatal Network supporting redesignation. Boards of Directors, 5 June 2024

	Clinical Quality and Safety Committee, August 2024

Executive Summary

In September 2023 the neonatal service was downgraded to a Special Care Unit following safety concerns. The downgrade has resulted in babies born under 32 weeks have been transferred to other neonatal centres including Northampton, Leicester and Nottingham. While this has provided safe care for the babies it has impacted on family experience and parental wellbeing.

Since then, actions have progressed against transition plan which covers the following:

- Nurse staffing levels
- Medical staffing level
- Multi-professional training compliance
- Tertiary unit & network support
- Peer support from NGH
- Psychological support

At the point of writing this report, the actions are almost complete. There remain two substantive consultant posts and AHP recruitment outstanding. Interviews are scheduled and mitigation is in place with locum staffing.

These actions enable us to safely transition to level 2 unit. A phased return is proposed with babies from 30 weeks in the first instance, extending to babies from 28 weeks following monitoring and review.

An extensive review by the ICB and regional colleagues has now been conducted and the service is on track to reinstate level 2 cots with a phased approach from 7th October 2024. This is pending final sign off at the NHSE Midlands board.

Appendices

None

Risk and assurance

No new risks identified.

Financial Impact

None relting to this assurance report.

Legal implications/regulatory requirements

None known

Equality Impact Assessment

Equality impact will improve with the reinstated level 2 cots (for example, cost to families in travelling/accessing other centres)

Cover Sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	4 October 2024
Agenda item	10

Title	UHN Perinatal Surveillance Dashboards
Presenter	Julie Hogg, Interim UHN Chief Nurse
Authors	Ilene Machiva - NGH Director of Midwifery Mara Tonks – KGH Director of Midwifery

This paper is for			
☐ Approval	☐ Discussion	☐ Note	**X Assurance**
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Group priority				
X Patient	**X Quality**	**X Systems & Partnerships**	☐ Sustainability	☐ People
Excellent patient experience shaped by the patient voice.	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
The Perinatal Surveillance dashboard is underpinned by 5 key principles –pertaining to Trust, Local Maternity System (LMS)/ Integrated Care System (ICS), regional and national levels oversight of maternity services; ensuring maternity services can deliver effective perinatal clinical quality to ensure a positive experience for women and their babies. In short the dashboard ensures that Trust boards have oversight on any key safety issues within maternity services, ensuring they can be addressed in a timely manner without the need for external intervention.	Maternity & Neonatal Safety Champions Clinical Quality and Safety Committee

Executive Summary

NGH - Assessment (Monthly Exceptions) – June Dashboard

1. **Item(s) for Escalation:**
   - MNSI Letter of Concern received which is as an action from a concern's panel which took place on 11 September 2024. The concerns noted by the panel are as follows and a response is due by 20 September 2024:
     - The accuracy of the ultrasound scans
     - The storage of still images and unavailability of video recordings to support reporting and quality assurance
     - The process for audit of growth scans and uterine artery Doppler scans
     - Staff awareness within the maternity and obstetrics service of the local radiology standard operational procedure for obstetric ultrasound examinations

   The Trust has responded to concerns raised, detailing the actions already in progress, to address areas of concern.

- A demand and capacity review has been undertaken of the NGH maternity scanning pathways, insufficient capacity to cope with increase in demand, due to the increased pregnancy surveillance that has resulted from implementation of the Saving Babies lives Care Bundle (SBLCB). Solutions being worked through with the support of Imaging Department.
- Delay in commencing PMRT review for one case in May 2024, and issue found with completion of mandatory questions for three cases. This presents risk to Trust compliance with Maternity Incentive scheme will not meet CNST MIS Year 6 Safety Action 1. Actions implemented to ensure that this issue does not recur, and discussed with NHS Resoltuion.

2. **Successes:**
   - Increase in saving babies lives care bundle (SBLCBv3) compliance to 83% across the bundle, with all six elements meeting minimum MIS year 6 standards
   - Quality Improvement Project in Antenatal Pertussis Vaccination Uptake in Maternity at NGH won first prize at the UHN Clinical Audit and QIP Presentation Day
   - Gosset Ward BLISS accreditation – when the evidence for the Silver Award was submitted, BLISS were very impressed with the 'baby's firsts' evidence and wanted to share this with other units and in their newsletter
3. **Perinatal Surveillance Dashboard:**
   - At NGH, there were seven moderate or above incidents declared in July 2024, following IRG review three were downgraded to low harm and one to near miss
   - There were 11 perinatal losses in July, an increase on previous months. Details included in the Perinatal Surveillance Dashboard is attached as Appendix 1.
4. **Staffing position for Maternity Services:**
   - NGH vacancy position 31.57 WTE (15.41%). Increase in vacancy partly due to the correction of the funded establishment, aligning it the funded establishment on the financial ledger, and the Birthrate Plus recommendations. Good numbers of midwives expected to join the service during Q3.
   - Obstetric Consultant staffing position improving, with two new Consultants appointed, and due to commence in post in Q3 2024/25. Audit evidence of Obstetric Consultant attendance to labour ward when indicated, demonstrates compliance in line with RCOG guidance.
   - 99.7% of women received one to one care in labour in July.
   - The Band 7 Co-ordinator lost supernumerary status on one occasion in July.
5. **Training Compliance:** NGH training compliance for multi-professional increased to 90% in July. Compliance below 90% for Anaesthetist and MSWs. Additional sessions planned in October.
6. **Governance Compliance including Maternity Dashboard Exceptions and Learnings from Serious Incidents (reported separately to the Boards' private meeting):**
   - There were no PSII's/ MNSI investigations declared or closed in July 2024. Two complaints and two PALs concerns received in July.
   - Five MNSI investigation in progress
   - No new or closed Claims in July 2024
7. **Saving Babies Lives Care Bundle:** NGH fully complaint with two out of the six elements of the SBLCB v3. Compliance to 83% across the bundle, with all six elements meeting minimum MIS year 6 standards.
8. **Maternity Incentive Scheme (MIS), CNST Year 6:** Safety action 1 now red due to the missed PMRT review and is now at risk of non-compliance. Safety actions 7 and 8 at risk. Work in progress to meet the standard.

KGH - Assessment (Monthly Exceptions) – May Dashboard

1. **Item(s) for Escalation:**
   - Successful move from Rowan Ward to STM and Willow ward. Rockingham. Oversight Committee ongoing for the Medium- and Long-term redevelopment of Rockingham Wing
   - Planned deep dive in Equality and QI planned for 10th October 2024. Officially on boarding date to be announced
2. **Success:** Midwife and Elective Caesarean Section team awarded CMIDO Silver awards. Improvement in SBLCB compliance to 94%
3. **Perinatal Surveillance Dashboard:** Exceptions against Core Competency Training figures below trajectory in Anaesthetics, improved position forecasted for October 24 (no training takes place over summer months)
4. **Staffing position for Maternity Services:** KGH vacancy position 18.6 WTE, following the alignment of the PWR data and the finance ledger, however 20WTE bank staff used to offset vacancy. 5 red

flags were reported for loss of supernumerary status for the Band 7 Co-ordinator, however nil were raised for providing 1:1 care. 1:1 care on labour was 100%. Obstetric Consultant Led Board rounds took place 100% AM and 100% PM of the time in July

5. **Training Compliance:** CNST training compliance met for all staff groups with the exception of Anaesthetic Registrars and Consultants. Action plan in place
6. **Governance Compliance including Maternity Dashboard Exceptions and Learnings from Serious Incidents:** X2 Serious Incidents were closed in July. X2 MNSI reports outstanding (although now received at time of report writing)
7. **Update on progress with Saving Babies Lives Care Bundle:** KGH fully compliant in Elements 2, 3, 4 and 6 and partially compliant in the 2 other elements. Overall compliance risen from 79% to 94%.
8. **Maternity Incentive Scheme (MIS), CNST Year 6:** On track to deliver all 10 safety actions with further support needed in safety action 4, to support compensatory rest for obstetric consultants, however action plan will be in place to mitigate

Recommendation

The Boards are requested to note the report and appended dashboards and to indicate assurance regarding the safety and effectiveness of UHN perinatal services.

Appendices
Appendix 1 – NGH PQSM Dashboard Appendix 2 – KGH PQSM Dashboard
Risk and assurance
Non delivery of National and Local recommendations and improvements in maternity care which compromises our Trust strategic objectives and may result in increased claims, poor patient outcomes/ experience and Trust reputation.
Financial Impact
Potential for increased/changes to workforce and equipment. Failure to achieve our CNST incentive reduction (>£200k). Possible support available through NHS England funding vis LMNS work streams.
Legal implications/regulatory requirements
It is a requirement by the CQC that Board members are aware of key maternity risk through the Perinatal Scorecard.
Equality Impact Assessment
This is applicable to all staff within Northamptonshire LMNS and all women accessing care within the LMNS.

NGH Perinatal Quality Surveillance Model—July 2024

Maternity CQC rating (last inspected Nov 2022)	Safe	Effective	Caring	Responsive	Well-Led	Overall

Maternity Perinatal Mortality Data

Perinatal Mortality Cases

		Monthly Perinatal Losses	Total number of losses reported to MBRRACE	Number of losses reported to MBRRACE within 7 days	Perinatal Surveillance completed within 1 month	Number that meet PMRT criteria	Parents informed and questions/ concerns noted	PMRT completed by MDT and comply with CNST submission requirements	Late Fetal Loss >22/40	Stillbirths	NND born and died at NGH	NND (born, NGH transferred and died at other Trust)
Q3 2023/24	Oct-23	1	5	5	5	2	100%	2	2	1	0	0
	Nov-23	3								1	2	0
	Dec-23	1								1	0	1
Q4 2023/24	Jan-24	1	1	1	0	0	N/A	0	0	0	1	0
	Feb-24	3	3	3	3	2	100%	0	2	2	1	0
	Mar-24	2	2	2	2	1	100%	2	0	1	0	0
Q1 2024/25	Apr-24	0	2	2	2	2	100%	1	0	0	0	2
	May-24	4	3	3	3	3	100%	2	1	3	0	0
	Jun-24	5	1	1	1	0	N/A		1	0	0	0
Q2 2024/25	Jul-24	11	4	4	4	4	3	2	0	2	3	0
	Aug-24											
	Sep-24											

Level of Investigation

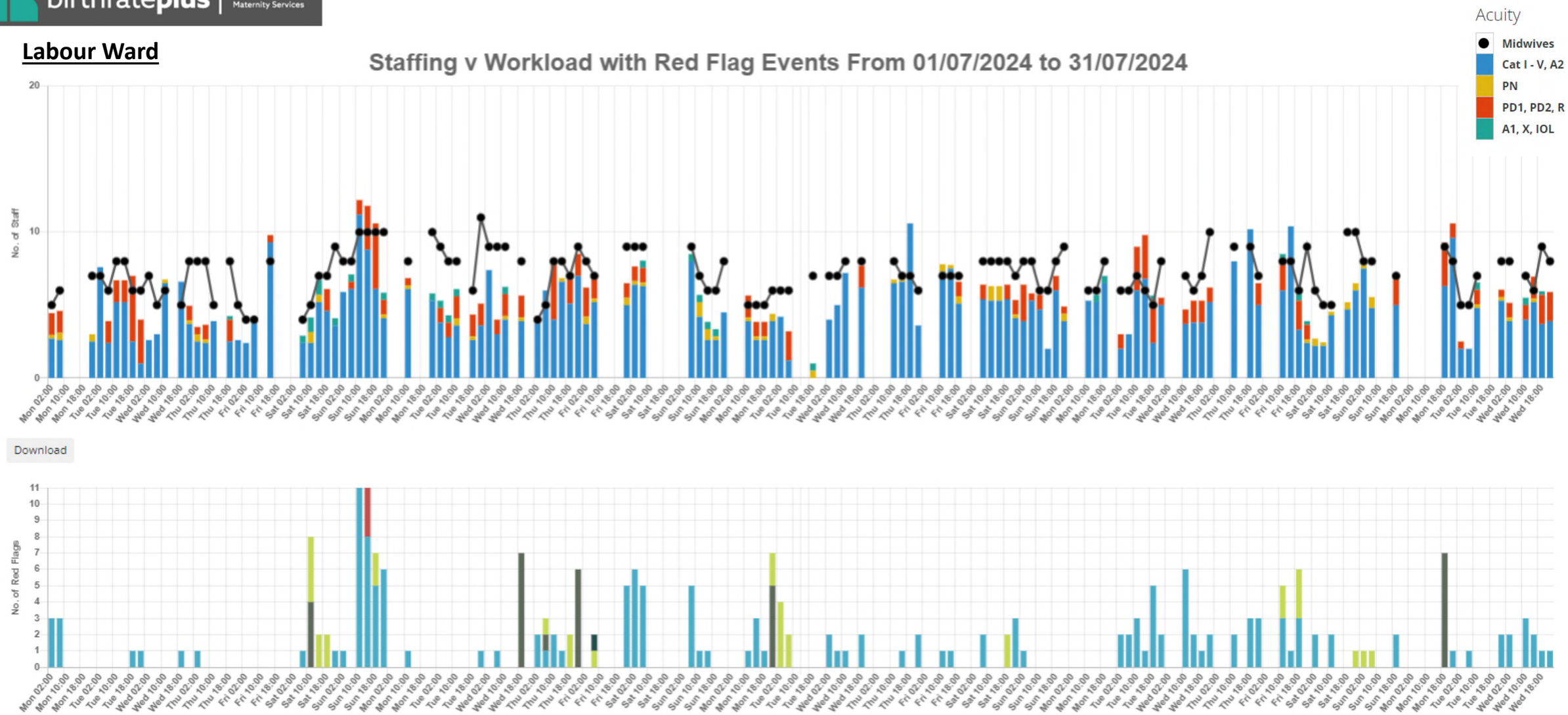
Level of investigation	Obstetric Datix (Moderate & Above)	Internal Local Level Investigation (CI)	PSII	MNSI
Q3 2023/24	0	0	0	0
Q4 2023/24	6	0	0	3
Q1 2024/25	24	0	0	2
Q2 2024/25	7	0	0	0

Staff Survey QR Code Relaunched 5th July 2024

Review of all Maternity Moderate & Above Incidents

Q2 24/25 July		
Incident type	**Description**	**Outcome/Learning**
IUD	Presented to triage with a history of absent fetal movements. Diagnosed IUD on scan	Incident reviewed at MIRF. Appropriate advice and management when presented with reduced fetal movements. For joint PMRT review with KGH.
IUD	IUD confirmed at growth scan	Notes reviewed. No care and service delivery iissues dentified. For PMRT review.
NND	Twins attended in premature labour—neonatal deaths.	Reviewed at Trust IRG appropriate management
Pressure Ulcer	Small pressure sore noted following caesarean section.	Reviewed at MIRF and IRG—no omission in care identified, downgraded
Maternal Collapse	Maternal Collapse on antenatal postnatal ward	Transfer was outside normal standard practice due to high activity. Learning has been shared.—IRG recommendation to downgrade to near miss.
MOH	Major Obstetric Haemorrhage	Incident reviewed at MIRF and IRG. Appropriate management—agreed downgrade from moderate to low harm.
Postnatal Readmission	Re-admission with post caesarean section wound infection.	IRG agreed recommendation to downgrade to low harm.

Labour Ward



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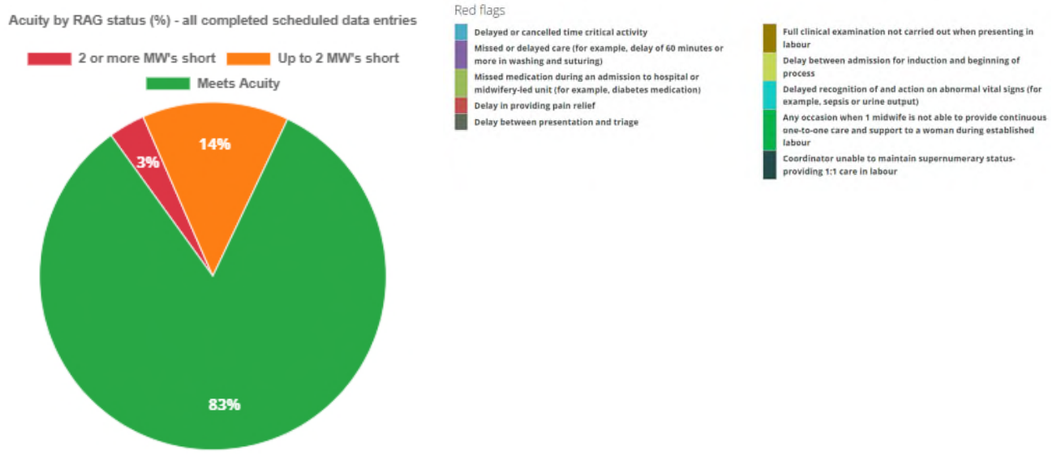
Overall compliance during the data period for weeks commencing 01/07/2024

Completed scheduled data entry	69.6%
Missed scheduled data entries	30.4%



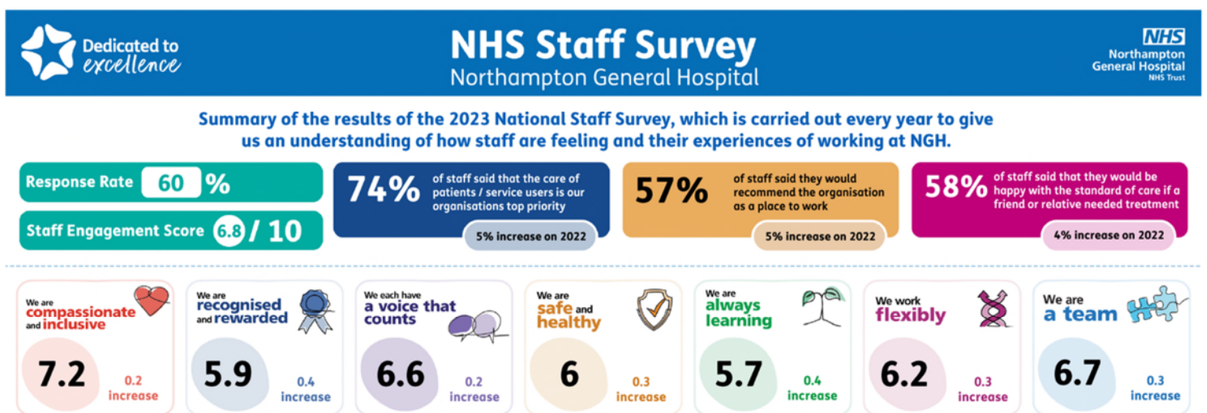
Red Flag Exceptions

July 2024

There were a total of **223** red flags reported in July, a decrease of 39.8% from June. The highest recording red flag was Delayed or cancelled time critical activity which accounted for **70%** of the total red flags. The 2nd highest recording red flag was Delay between admission for Induction and beginning of process that accounts for **14%** of the total. *Due to the ward reporting tool being unavailable. Red flags are shown for labour ward only. NGH reports red flags for every occasion when there is a delay in transfer to Labour Ward for IOL. Process is different to UHL and KGH. Agreed reporting with KGH and UHL to commence in August 2024*

Maternity Red Flags—LW
May— 392
June— 370
July—223

Red Flag Event	No.	Mitigation
Delayed or cancelled critical activity	157	• Relates to delays with transfers to Labour Ward to continue the process of induction of labour or timely completion of elective caesarean section • Escalation process in place via Midwifery Manager on call in relation to delays in labour pathway • Induction of Labour working group in place from November 2022 reviewing IOL pathways. Outpatient induction of labour commenced January 2024 and Cooks Balloon use commenced March 2024 • Where possible women are offered transfer to other units
Delay between admission for induction and beginning of process . Induction of labour delayed starting by 2 hours	32	• Capacity and staffing impact on timely commencing IOL • Outpatient induction of labour commenced January 2024 and Cooks Balloon use commenced March 2024
Delay between presentation and triage	30	• Unable to facilitate timely assessment of women presenting to Triage • Under review by Triage Lead Midwife and Intrapartum Matron
Delay in providing pain relief	3	• Appropriate escalation implemented
Coordinator unable to maintain supernumerary status-providing 1:1 care in labour	1	• Escalation process implemented to support return of Labour Ward Co-ordinator to supernumerary



- SCORE Survey completed October 2023—results received and Triumvirate worked with KornFerry and disseminated to staff
- NHS 2023 Staff Survey completed—summary below.
- Staff Survey QR Code pilot currently in progress

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July 2024
Maternity Statistics

194 Vaginal births

31 Instrumental births

26 Laboured in water

10 Birth centre births

13 Home birth births

180 girls

370 babies born

190 boys

2 Sets of twins

Our heaviest baby weighed in at 4.765kg (10lb 8oz)

16 Babies born on our busiest day

We remember precious babies and their heart broken parents

22 Preterm babies

NHS
University Hospitals of Northamptonshire
NHS Group

52.7%
Vaginal births
(84.0% unassisted, 16.0% assisted)

47.3%
Caesarean section births
(44.3% elective, 55.7% emergency)

25.8% Had an Induction of Labour

82.3%
Breastfeeding initiation rate

Maternity Services

Northampton General Hospital

Service User Feedback

Positive comments received in July

"Always well informed, staff kind, patient and understanding, felt safe and listened to, didn't feel judged."

"I had the most amazing midwives, they were very patient with me throughout my labour, really appreciate this for their efforts, love, care and understanding."

"Well cared for by attentive, knowledgeable staff."

"Very attentive, proactive and understanding."

"My midwife was very exceptional and supportive all the way."

"Staff are always very friendly and reassure you and offer lots of advice, also never running behind so appointments are on time."

PALS Complaints

	MAY 2024	JUNE 2024	JULY 2024
Number	2	2	2
Themes	Issue with Midwife Delay in IOL and not being listened to	Something was not quite right with newborn baby Aftercare for wound management	Medication not given at correct times on Labour Ward Patient being charged for prescriptions when pregnant

CNST Claims Scorecard

	MAY 2024	JUNE 2024	JULY 2024
New	1 Alleged failure to advise of the risks of continuing the pregnancy, including the risk of stillbirth. Also, alleged failure to advise that her options were either to undergo induction or to remain under surveillance	3 Alleged failure to recognise the Claimant as being at higher risk of severe and acute Covid-19 maternal illness; to recognise the Claimant was having a high-risk pregnancy and that she had additional risk factors. Baby born in poor condition requiring full resuscitation and subsequent transfer to tertiary neonatal unit for cooling Alleged failure to advise the Claimant she had a rare immune disorder	0
Closed	0	0	0

Feedback and Actions Taken (Staff) – March 2024

Our Safety Champions for Maternity Services

Nerea Odongo
Chief Nurse
Executive Safety Champion for Maternity Services

Jill Houghton
Non-Executive Director
Non-Executive Safety Champion for Maternity & Neonatal Services

You Said.... 16.03.24: Review of pathways across MDU and Triage

We Did.... HoM will be working with the matrons to review pathways between MDU and Triage, now new Inpatient Matron has commenced in post. Service review of Triage to commence June 2024

You Said.... 16.03.24: Member of staff considering reducing hours to take 10% of her pension

We Did.... General Pensions information can be found on the Intranet: Departments, HR and then on the right-hand side under the section Retirement and Pensions

You Said.... 16.03.24: Band 3 concerns about the number of Band 3 staff in the service

We Did.... Maternity has aligned with the rest of the Trust with all Maternity Support Workers commencing in post at bottom of Band 3, working through the competency process to reach the top of Band 3

You Said.... 16.03.24: Delays in induction of labour processes

We Did.... Outpatient induction of labour pathway and Mechanical induction launched. Further work in progress to align indications for IOL with national guidance, led by Consultant Midwife

You Said.... 16.03.24: Increasing MDU opening hours

We Did.... An area of interest for us as a service, which will be led by the new Inpatient Matron

You Said.... 16.03.24: Service user concerns about communication in theatre and team's lack of awareness of the woman hearing their comments

We Did.... Feedback shared with Team leads and PD Team for inclusion in scenario training

Ilene Machiva
Director of Midwifery

Clare Flower
Head of Midwifery

Dr Amrita Datta
Clinical Director

Dr Nick Barnes
Lead Neonatal and Cardiology Consultant

Complaints

	MAY 2024	JUNE 2024	JULY 2024
Number	3	1	2
Themes	Concerns not taken seriously Issue with Community Midwife Consent and risks not discussed prior to C-Section	Multiple failures in the standard of care provided, particularly in relation to pain management and the administration of the epidural. Meet the Matron Appointment offered	4th Degree Tear Issues with timely administration of pain relief, lack of communication, inappropriate comments, lack of opportunity to advocate for herself

Indicator	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY
FFT Satisfaction Score: Antenatal Community	100.0%	No Responses	100.0%	99.1%	100.0%	96.4%	100.0%	100.0%	98.2%	94.6%	92.8%	97.1%
FFT Satisfaction Score: Birth	90.2%	89.8%	85.7%	92.9%	88.8%	93.4%	93.9%	83.0%	95.5%	90.6%	87.9%	93.2%
FFT Satisfaction Score: Postnatal Ward	97.9%	100.0%	88.9%	88.5%	92.3%	92.2%	81.8%	96.4%	96.1%	97.3%	94.9%	96.7%
FFT recommend: Postnatal Community	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	98.5%	100.0%	95.0%	100%	100%

Maternity Specific Training—June 2024

PROMPT overall compliance – **90%** ↑

Module 3: Maternity emergencies and multi-professional training:

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024
Midwives	94%	92%	83%	86%	90%	89%	93%
Consultants	100%	100%	100%	100%	100%	80%	90%
Obstetric Doctors	98%	86%	86%	76%	82%	85%	100%
Anaesthetists	81%	75%	71%	82%	79%	83%	80%
MSW's	82%	79%	80%	83%	83%	78%	80%

Newborn life support (NBLS/NLS) overall compliance – **97.2%** ↑

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024
Midwives	94%	95%	94%	91%	91%	89%	95%
Neonatal Consultants	100%	100%	100%	100%	100%	100%	100%
Neonatal Junior Doctors (who attend births)	100%	94%	100%	100%	95%	94%	100%
Neonatal Nurses (Band 5 and above QIS)	100%	100%	100%	100%	100%	100%	100%
Advanced Neonatal Practitioners (ANNP)	100%	100%	100%	100%	100%	100%	100%

Challenges:

- Support from Anaesthetic Team to facilitate training sessions remains a challenge due to their clinical commitments
- Ensuring a complete and accurate database that has all employed staff within it. Concerns regarding ascertaining maternity bank staff nominal roll/complete staff list
- Difficulty with roster templates for obstetric staff that does not allow attendance for the full training week
- Resuscitation Department does not currently support NBLS/NLS training for Midwives

Actions taken:

- In addition to the Maternity Training Week, additional PROMPTS are planned to capture out of date staff. Planned for October 3rd and 7th
- Maintain good communication links with community and hospital-based ward managers to ensure compliance by offering maternity ward manager meetings
- Support from E-Roster team to enable sickness and maternity leave reports to be run in a timely manner
- Identification of staff returning to work and ensuring mandatory training is completed as soon as possible
- Continue with early dissemination of planned training days, attendance, and facilitation expectation
- Deep dive on those non-compliant, ensure denominator is correct with regard to bank staff no longer working at NGH
- Further escalation of concerns regarding bank staff list to improve accuracy of database and subsequent patient safety
- Maternity Practice Development Midwife is facilitating the NBLS training updates on the core modules day on the Maternity Training Week
- Targeted deep dive to ensure those out of date are prioritised to attend NBLS sessions
- Further facilitation of NLS days planned across the next 18 months to improve the number of gold standard NLS trained staff

PROMPT Training inclusion criteria:

- Postpartum Haemorrhage
- Antepartum Haemorrhage
- Impacted Fetal Head
- Pre Eclampsia
- Uterine Rupture
- Maternal Collapse & Resuscitation
- Vaginal Breech
- Shoulder Dystocia
- Cord Prolapse
- HDU & MEOWS charts
- Structured Review Proformas
- Escalation & Thresholds
- Timing of Birth
- Immediate Postnatal Care & VTE
- MDT Ward Rounds

SAFEGUARDING TRAINING

Safeguarding Adults Level 3 – 94.1 ↑
Safeguarding Children's Level 3 – 85.3↑

The Safeguarding Team do the following to support staff training compliance:

- SGL3 Training (full day) is held every month via MST
- Training dates are advertised in the monthly Safeguarding Bulletin and on the Safeguarding page on the Street
- Staff are notified via ESR when they are out date
- The Safeguarding Team email staff on a monthly basis to inform them when they are out of date
- There are no issues with accommodating SGL3 due to capacity

Maternity Dashboard Key Indicators

2024	Goal	May	June	July
Midwife to birth ratio	01:27	01:27	01:26	01:26
BBA	0	0	3	3
MNSI Declared	0	2	0	0
PSII Declared	0	0	0	0
Patient Safety Event Declared	0	0	0	0
Number of overdue management actions	0	3	2	0
Term admissions	≤3%	4.8%	3.8%	3.8%
3rd/4th Degree tears	≤3.4%	2.9%	3.3%	2.6%
Babies transferred for cooling	0	1	0	0
ENS Babies	0	1	0	0
ITU/HDU Admissions	0	0	4	0
Term neonatal deaths (non-abnormalities)		0	0	0
Maternal Death	0	0	0	0
Total stillbirths	0	3	0	2
Term stillbirths	0	2	0	1
Pre-term stillbirths 24-36+6	0	1	0	1
FFT satisfaction score: Antenatal Community	≥96%	94.6%	92.8%	97.1%
FFT satisfaction score: Maternity - Birth	≥96.6%	90.6%	87.9%	93.2%
FFT satisfaction score: Postnatal ward	≥93.7%	97.3%	94.9%	96.7%
FFT satisfaction score: Postnatal Community	≥97.5%	95.0%	100%	100%
CO levels documented at booking	≥90%	91.8%	94.2%	92.2%
Safeguarding children level 3 training	≥90%	79.48%	89.77 %	85.3%
PROMPT training compliance - all staff. (Excluding sickness and mat leave)	≥90%	87.00%	85.00%	90%

Workforce Data

	May-24	Jun-24	Jul-24
MW Vacancy WTE	24.19	23.40	31.57
MW Vacancy Rate	12.40%	11.99%	15.41%
% of women receiving 1:1 care in labour	100%	100%	99.7%
No of occasions LWC was NOT supernumerary	0	0	1

Midwives vacancies have gone up despite having additional Midwives in post due to our funded establishment being aligned with the financial ledger which has 204 WTE vs the 198 WTE we were working with

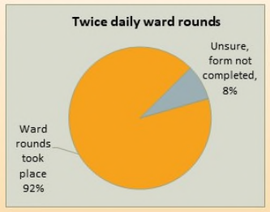
NGH Turnover for last 12 months (01.06.2023 – 31.05.2024):
- MSWs – 6.13%
- Midwives – 5.15%

OBSTETRIC STAFFING UPDATE
- 9.8 WTE currently in position (7.8 WTE Substantive Consultants + 2 WTE Locum Consultant)
- 3 WTE vacancies within the recruitment process – 3 WTE offered and accepted pending references
- 6.8 WTE Consultant able to undertake full clinical duties
- 1X Vacancy currently going thorough RCOG JD approval process for Special Interest in College Tutor role

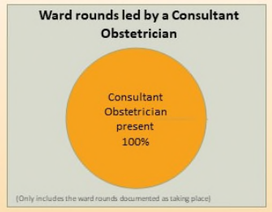
One to One Care in Labour— 99.7%
LW Co-ordinator was not supernumerary— There was 1 occasions in July when LW Co-ordinator provided 1:1 care in labour
Continuity of Carer—No CoC team at present and 1 team focussing on BAME woman for Antenatal & Postnatal Care

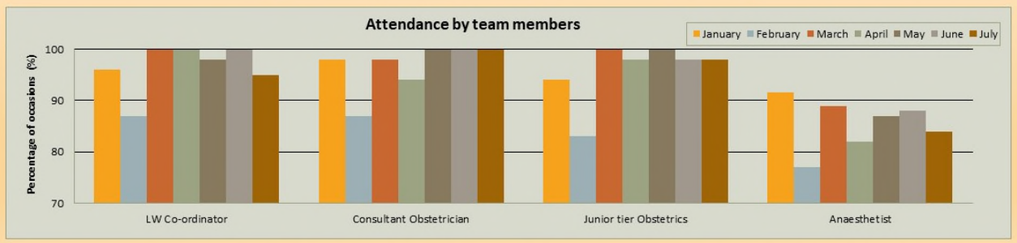
Dashboard Exceptions	Comments
BBA	No calls made to triage, delivered at home Called in advanced labour, ambulance crew already in attendance Called triage at 04.12, invited in, baby delivered at 04.30 at home, ambulance called
Term Admissions	Term Admissions continue to be reviewed as a MDT in MIRF and ATAIN. Monthly and quarterly reports are completed and presented at Maternity Risk and Governance meeting on a quarterly basis.
Total Stillbirths	**Term Stillbirth:** PMRT review as per process. **Pre-term Stillbirth:** For review at PMRT- KGH to attend PMRT review.
FFT Satisfaction score: Maternity-Birth	There were not actually any negative comments for 'Birth' in July. The lower score is a result of x3 'neutral' scores. Looking at the 'birth' comments the only feedback was from a patient stating she was left alone and did not receive adequate pain relief – she was one of the 'neutral' scorers. The two other 'neutral' scorers did not leave any comments regarding their experience. The Scoring overall is as follows: 93.2% positive 6.8% neutral 0.0% negative
Safeguarding children level 3 training	SGL3 Training (full day) is held every month via MST. Training dates are advertised in the monthly Safeguarding Bulletin and on the Safeguarding page on the Street. Staff are notified via ESR when they are out date. The Safeguarding Team email staff on a monthly basis to inform them when they are out of date. Review of ESR interface underway to ensure compliance data capture is accurate. There are no issues with accommodating SGL3 due to capacity.

Consultant-led ward rounds (Ockenden)
July 2024



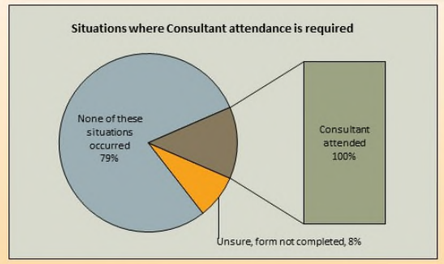
Minimum MDT members required
Consultant Obstetrician
Labour Ward Co-ordinator
Junior Tier Obstetrician
Anaesthetist



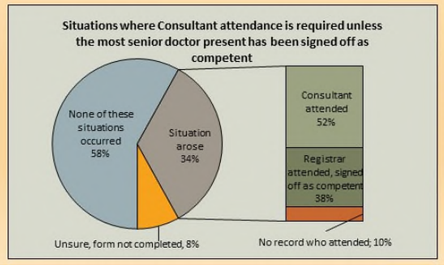


Please remember to complete these forms at every ward round

Consultant attendance for required situations (RCOG)
July 2024



Situations where Consultant attendance is required
- Obstetric return to theatre;
- MEOWS/sepsis screening tool suggests critical deterioration where HDU/ITU care is likely; Eclampsia;
- Caesarean for placenta praevia/abnormally invasive placenta (AIP);
- Caesarean less than 28 weeks gestation;
- Caesarean for women with a BMI >50;
- Unexpected intrapartum stillbirth;
- Preterm multiples <30 weeks gestation;
- 4th degree OASI repair;
- PPH >2litres where the haemorrhage is continuing and the MOH protocol activated;
- Maternal collapse (e.g. septic shock, massive abruption);
- Maternal debrief;
- Team debrief requested
- In the event of high levels of activity (e.g. 2nd theatre required or unit closure)



Situations when Consultants are required to attend unless the most senior doctor present has been signed off as competent
- EBL >1.5l and ongoing bleeding;
- Trial of instrumental birth;
- Vaginal twin birth;
- Caesarean birth at full dilatation;
- Caesarean birth for women with a BMI >40;
- Caesarean birth for transverse lie;
- Caesarean birth at <32 weeks gestation;
- Vaginal breech birth
- 3rd degree perineal tear repair

Please remember to complete these forms at every ward round

Saving Babies Lives Care Bundle Version 3 Progress

Saving Babies Lives Care Bundle v3					
Element 1	**Element 2**	**Element 3**	**Element 4**	**Element 5**	**Element 6**
Partially Implemented	Partially Implemented	Fully Implemented	Fully Implemented	Partially Implemented	Fully Implemented
LMNS Assurance					
Partially Implemented	Partially Implemented	Fully Implemented	Partially Implemented	Partially Implemented	Fully Implemented

Overall compliance for SBLCB v3 is 71%

Ockenden Dashboard—Insight Visit 30/10/23

SAFETY ACTIONS	RAG RATING
Safety Action 1 – Enhanced Safety	
Safety Action 2 – Listening to Women & Families	
Safety Action 3 – Staff Training & Working Together	
Safety Action 4 – Managing Complex Pregnancy	SBLCBv3 fully compliant with 3 Elements and partially compliant with the other 3. Trust using regional tool—overall compliance is 71%
Safety Action 5 – Risk Assessment throughout Pregnancy	Risk assessment tool reviewed and new tool currently being piloted
Safety Action 6 – Monitoring Fetal Wellbeing	Current compliance for PROMPT below the required standard of MIS of 90%. Action Plan in place
Safety Action 7 – Informed Consent	Trust website update in progress
Workforce Planning / Guidelines	

CNST Year 6 Current Position

SAFETY ACTION REQUIREMENTS:

Safety Action	Red	Amber	Green	Blue	Total Requirements	Overall Compliance
1	0	6	0	0	6	
2	0	2	0	0	2	
3	2	2	0	0	4	
4	0	20	0	0	20	
5	0	6	0	0	6	
6	0	6	0	0	6	
7	3	4	0	0	7	
8	2	15	0	0	17	
9	0	7	1	1	9	
10	1	7	0	0	8	
Total	8	75	0	0	85	

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

UNIVERSITY OF LEICESTER

Affiliated Teaching Hospital

Maternity Perinatal Mortality

Inspected and rated Requires Improvement

CareQuality Commission

KGH Perinatal Quality Surveillance Model, July 2024.

NHS Kettering General Hospital NHS Foundation Trust

Maternity CQC rating (Last Inspected Feb 2019 & Oct 2023 Safe and well-led only)	Safe	Effective	Caring	Responsive	Well-led	Overall

Perinatal Mortality Data

		Monthly perinatal losses	Total Number of Losses reported to MBRRACE	Number of losses reported to MBRRACE within 7 days	Perinatal Surveillance completed within 1 month	Number that meet PMRT criteria and 72hr review completed	Parents informed and questions/ concerns noted	PMRT completed by MDT team and comply with CNST submission requirements	Breakdown of perinatal losses			
									Late Fetal Loss >22/40	Stillbirths	NND born and died at KGH	NND (born KGH, transferred and died at other Trust)
Q3 2024	SEPTEMBER											
	AUGUST											
	JULY	0										
Q2 2024	JUNE	3	4	4	1	1	1/100%	1/100%	0	2(1CI)	2(2<22/40)	1
	MAY	1										
	APRIL	0										
Q1 2024	MARCH	1	8	8	7	7	7/100%	7/100%	1	5	2 (1<22/40)	1
	FEBRUARY	4										
	JANUARY	3										
Q4 2023	DECEMBER	1	10	10	6	6	4/66%	6/100%	1	6 (2 CI & IUD 1 twin)	3(1<22/40)	0
	NOVEMBER	4										
	OCTOBER	5										

MBRRACE-UK Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Level of Investigation

Level of investigation	Obstetric Datix	Briefing Paper	Internal Local Level Investigation	SI External Review	MNSI
Q3 2024					
Q2 2024	4	0	0	0	0
Q1 2024	7	2	0	0	0
Q4 2023	6	1	0	1	1

Review of all maternity Moderate Incidents.

Q2 July 24 ongoing	
Type of Incident	Incident grading/ Decision
Transfer of Patient	Patient Safety/Governance informed Maternity incident does not need to be presented. Actions: Action Plan to complete learning for Maternity. Action plan attached to Datix
Readmission with Raised Bilirubin.	Incident present at SIRG. Incident downgraded to Near Miss. Actions: Action Plan to complete learning for Maternity. Action Plan attached to Datix

Q3 October—December 23	
Type of Incident	Outcome/Learning
20/40 Miscarriage	Incident discussed at the Maternity Round Table. Incident downgraded to Low Harm.
Admission to SCBU	Discussed at the Maternity Round Table. Neonatal Manager and Lead Neonatal Consultant present. Decision made for the Incident to be downgraded to No Harm.
Meows 12	Presented at the Maternity Round Table and SIRG. Declared at SIRG as a SI
Neonatal Death (Day 2)	Discussed at the Maternity Round Table. Presented at SIRG. Will be investigated by MNSI. Will go on STEIS
Results reporting	Patient was under care of Safeguarding team, no harm identified. Local Level.

Q1 April 24—Jun 24	
Type of Incident	Incident grading/ Decision
Return to Theatre	Incident downgraded to Low Harm at the Maternity Round Table.
Baby Born in Poor condition	Incident downgraded to Low Harm at the Maternity Round Table meeting. No Maternity Learning. Actions for Neonatal team
Mid trimester miscarriage	Incident discussed at SIRG. Incident downgraded to local level.
Major Obstetric Haemorrhage.	Incident discussed at the Maternity Round Table. Decision made for the Incident to be downgraded to Low Harm.
25+5. Unable to obtain bed for inutero Transfer.	Incident presented at SIRG and a Serious Incident declared.
Retained Placenta and Major PPH.	Incident presented at SIRG and a Serious Incident declared.

Q4 Jan 24—March 24	
Type of Incident	Incident grading/ Decision
Baby born in poor condition	Presented at SIRG. Declared as SI.
22+3 late fetal loss	Presented at SIRG. Panel felt further assurance was needed regarding actions which are being undertaken to prevent recurrence of incident. Further investigation into incident is not required as omissions in care have been identified.
Maternal Death	Presented at SIRG. Declared as a Serious Incident. To be investigated by MNSI.

MNSI/SI Maternity Investigations Update

No MNSI or PSIIs were declared in July 2024.

Ongoing MNSI cases x2:

Draft report has been sent back to MNSI. When MNSI have shared the report with the family. KGH will receive the Final Report.

Draft report has been sent back to MNSI. Report was shared with the family, but they had some concerns around the care that was given by the GP. MNSI have gone back to the GP surgery to discuss the concerns.

CLOSED SIs and MNSI INVESTIGATIONS

Serious Incidents

2x Completed Serious Incidents were closed in July 2024

Baby Born in Poor Condition

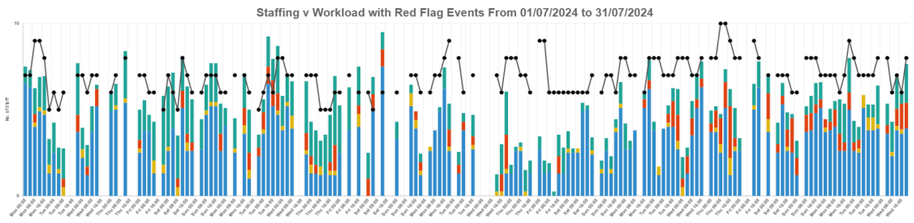
Failure to Escalate

National Chief Midwife awards recognise KGH staff for their commitment to good care

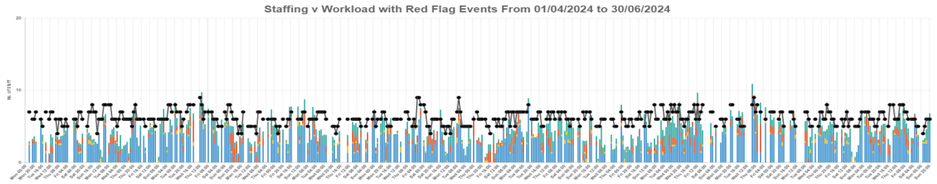
A Kettering General Hospital midwife and a KGH team that supports families having caesarean sections have won national awards from England's top midwife

Safe Staffing Requirements - Q1/ Q2/ Q3 & Q4 Delivery Suite Midwifery Staffing versus Acuity.

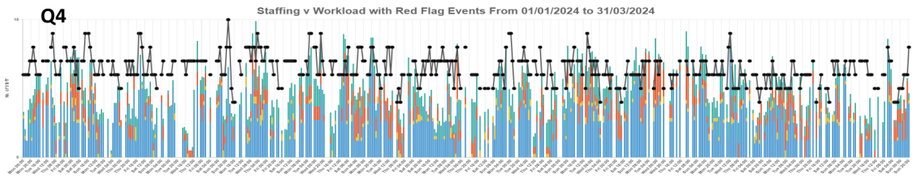
Q2 24/25



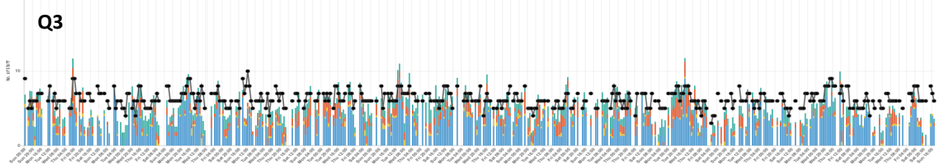
Q1 24/25



Q4



Q3



Key

Acuity

- Midwives
- Cat I– V, A2
- PN
- PD1, PD2, R
- A1, X, IOL

Red Flags

Q2 24/25 = 107
Q1 24/25 = 268
Q4 23/24 =217
Q3 23/24 = 278

No Consultant Gaps on Delivery Suite rota for Q1&Q2&Q3 &Q4 23/24

60 hours met per week. 66 hours from 17th May 2021

The run charts to the left demonstrate the actual numbers of midwives required to deliver the acuity of care on the delivery suite. This data is captured 4 hourly throughout the week by the delivery suite coordinator. The coordinator can also report on an adhoc basis allowing for any peaks in acuity (within the 4 hour reporting period) to assess staffing vs acuity levels. This enables the coordinator to redeploy midwives from other areas (escalation rota, specialist midwifery, offices, antenatal/postnatal ward or community) to ensure the safe staffing of acuity for delivery suite, enabling all women on deliver suite to have the correct midwife to woman 'care hours' and the provision for allocating 1:1 care in labour.

Maternity red flags (based on the NICE red flags) are also monitored through the birth rate acuity app. There has been a drive on improving data entry to capture red flags. An monthly exception report is reported to the O&G governance meeting detailing the red flag episodes and actions taken. Please note that red flags may be counted for the same patient up to 6 times in a 24 hour period . Each patient red flag are reported onto within the exception report at the O&G governance meeting.

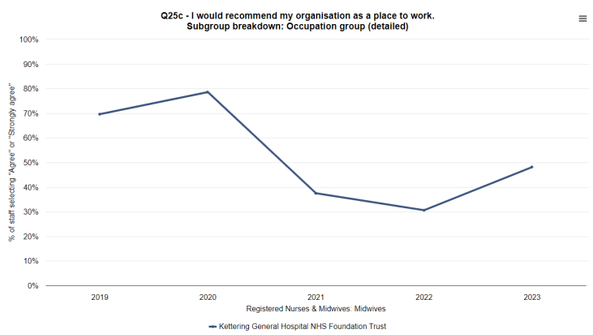
Since the release of the Ockenden Report (December 2020) all maternity services are now required to undertake a full Birth Rate Plus staffing exercise. Birth Rate Plus enables services to assess whether there established WTE matches the requirement of care hours for women accessing their services. The Bi-annual staffing review was presented at the People Committee in November 23 and again in May 24 . Ockenden also required an increased consultant presence for labour ward rounds out of hours. KGH have met the requirement by increasing our consultant cover on labour ward from 60 hours per week to 66 hours per week, to ensure consultant presence on evening ward rounds at weekends. Consultant ward round compliance in July was 100% AM and 97% PM.

Red Flag exceptions July 24
There were 107 Red Flags reported in July which is a static position on the previous month, (June 108). 93 Delayed ARMS (RF1) static from 91 in June. There were 7 delays in admission to IOL process (RF7) . There were 5 RF reported for Delivery Suite Coordinator not being supernumerary, not providing 1:1 care.

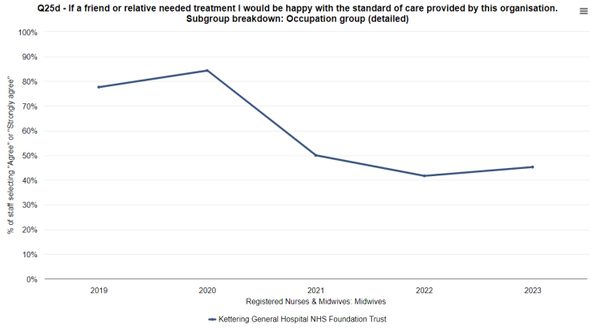
Consultant obstetric Cover on Delivery Suite

							2023/24											
AREA	INDICATOR	MEASURE/ COMMENT	DATA SOURCE	INDICATOR SOURCE	GREEN	RED	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July
WORK-FORCE	Weekly hours of consultant cover on labour ward	Hours/ week	Intrapartum scorecard	National - Safter Childbirth 2007 Minimum 60 Hours	>60	1	66	66	66	66	66	66	66	66	66	66	66	66

Proportion of Midwives who responded to 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment in the KGH NHS 2023 staff survey:



2019	2020	2021	2022	2023
69.62%	78.57%	37.50%	30.61%	48.15%



2019	2020	2021	2022	2023
77.63%	84.34%	50.00%	41.67%	45.28%

Staff survey action plan in place being monitored by the Lead PMA and tracked through O&G governance meeting.

Proportions of speciality trainees in O&G responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours.

Post Specialty	Trust / Board	Indicator	2019	2021	2022	2023
Obstetrics and gynaecology	Kettering General Hospital NHS Foundation	Overall Satisfaction	76.86	81.67	75.42	84.23
Obstetrics and gynaecology	Kettering General Hospital NHS Foundation	Clinical Supervision	92.14	87.64	89.09	90.48
Obstetrics and gynaecology	Kettering General Hospital NHS Foundation	Clinical Supervision out of hours	90.91	88.02	86.11	87.12

GMC indicator above demonstrates a continued improvement by the service for clinical supervision of speciality trainees out of hours (please note there was no survey in 2020). These are the most recent results, with the GMC 2023 KGH has been recognised as one of the best preforming O&G GMC results in the Midlands 2023.

Service User Feedback—and actions taken.

Q3 (Oct, Nov, Dec) 23/24 feedback:

- Women over hearing staff conversations. Leading to concerns about confidentiality.
- Medical terminology used in front of women. A woman was upset hearing 'failure to progress' thinking she had done something wrong.
- Sometimes staff do not follow birthing plan

Q4 23/24 (Jan-/Feb/Mar) feedback:

- Better information regarding IOL
- Compliments regarding debrief following traumatic delivery.
- Long time waiting to go to delivery suite when induced.
- Good continuity.

Q1 24/25 (April,/ May/ June) feedback:

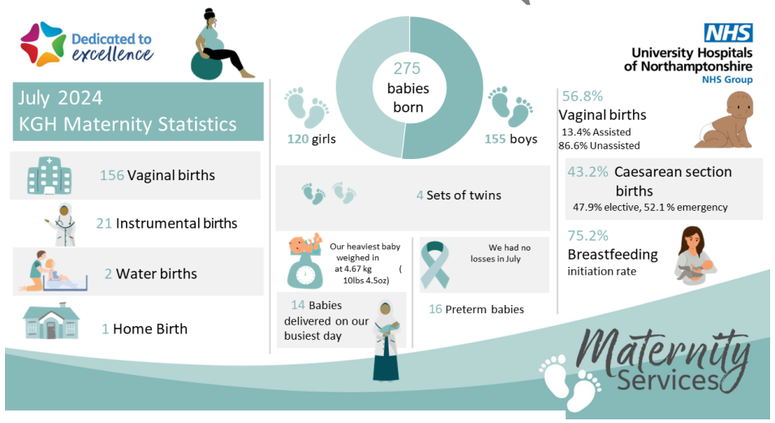
- Delay in pain relief
- Really good care in labour.
- Women not feeling listened to.
- Excellent care during elective LSCS.
- Birth trauma from previous pregnancy.

Q2 (July,24/25 feedback:

- Delayed analgesia on Rowan ward
- Treated with kindness and respect.

- MVP Facebook page activity currently being managed by LMNS Digital Lead in the absence of a MNVP Chair
- Monthly away days with LMNS, MVP representative in attendance. New Service users for KGH July 2024.
- Lead PMA and Patient Experience Midwife—will work closely with MVP representatives.
- Healthwatch visit 19th August 2024

NORTHAMPTONSHIRE
Maternity and Neonatal
Voices Partnership
Working in partnership to improve maternity and neonatal services



Safety Champion Feedback

August 23
You said: How do we monitor our personal exposure to Entonox.
We did: Personal monitors purchased and training video on use available

September 23
You said: When will staffing be better?
We did: 7 new midwives will join us in September with a further 5 planned this year. We will also offer jobs to our students qualifying in Jan and April 24, as well as continuing to recruit.

October 23
You said: Is there an issue with the PMA provision for debriefs.
We did: The PMAs will now acknowledge every email request with the person who has made the referral. There is no issue with PMA provision.

November 23
You said: Should we be worried about the Rockingham roof?
We did: Weekly executive briefings with staff will take place to keep staff updated. There is no known current risk to our staff working in Rockingham following the relocation

December 23
You said: Staff morale on Rowan ward is bad.
We did: Paula S and Paula A are planning team building events for Rowan ward staff. We also want to reintroduce the core staff again on Rowan.

January 24
You said: Concerns raised re; RAAC, is the building safe to work in?
We did: Continuing weekly staff engagement sessions with execs (including Director of Estates) to provide staff with the most up to date information.

Kerry Williams
Head of Midwifery
Kerry.williams40@nhs.net

Julie Hogg
Chief Nursing Officer
Julie.hogg1@nhs.net

Natalie Armstrong
Non – Executive Director
Natalie.armstrong5@nhs.net

Sree Biswas
Clinical Director
Sreeparna.biswas1@nhs.net

. February 24
You said: When will we get more midwives.
We did: Met with all bank midwives to offer substantive contract. Developed a Workforce plan to recruit to all vacancies this year.

March 24
You said: We feel that information could be communicated better.
We did: New HoM polled staff of types of feedback they want. Monthly sessions with HoM now in place.

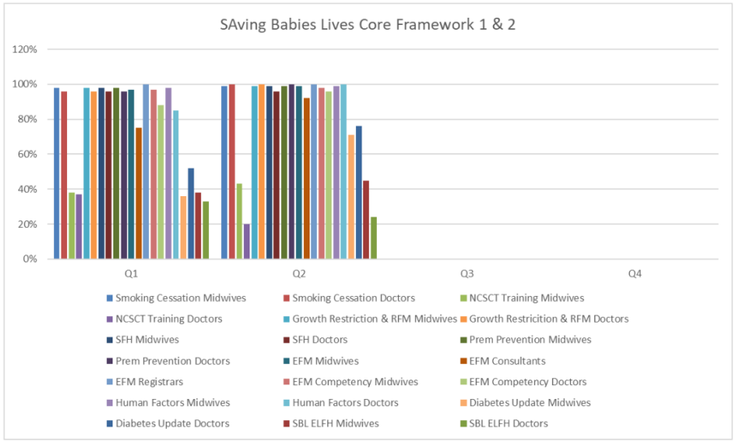
April 24
You said: poor feedback re; rotation.
We did: Undertaken a 'preferred place of work' prior to the next rotation. This aims to improve staff morale and improve team working.

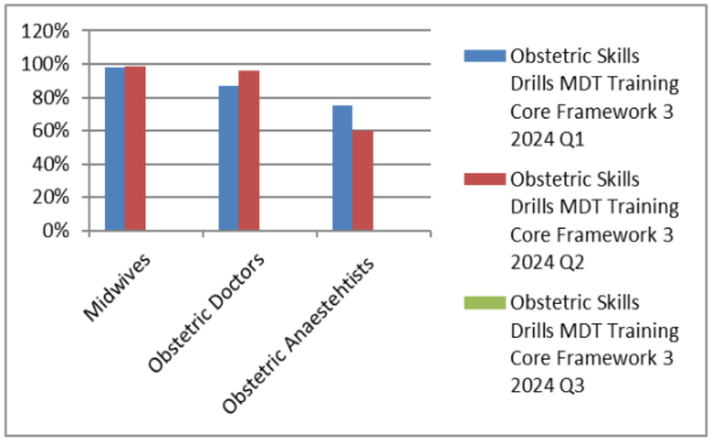
May 24
You said: We have not had any feedback regarding the RAAC works.
We did: Set back up fortnightly team briefings re; RAAC works and proposed changes.

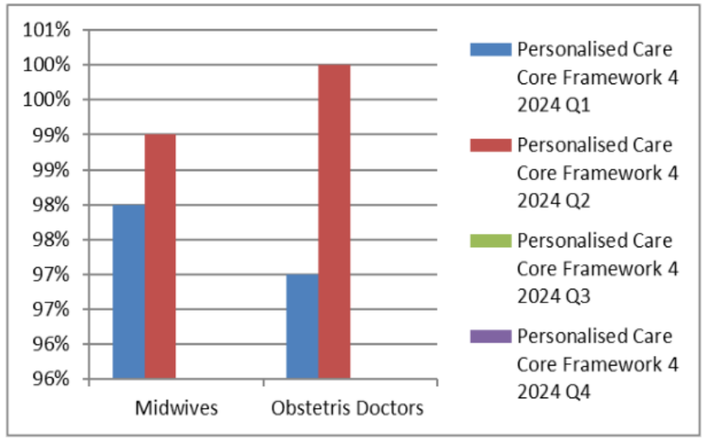
June 24
You said: New midwives have reported some poor behaviours i.e. lack of support.
We did: Met with DSC to ensure Rowan ward is supported out of hours as well to address other issues.

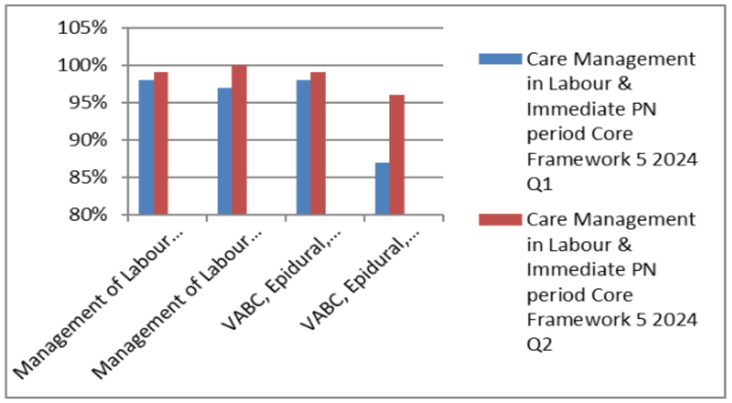
July 24
You said: Heat is unbearable on Rowan Ward.
We did: Airconditioning unit in place, staff reminded to use external canopies and PMAs delivered Ice lollies and cold drinks.

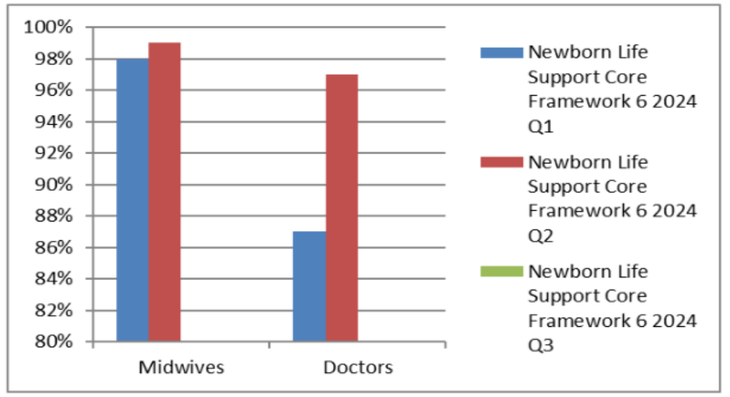
Training Compliance against Core Competency Framework.

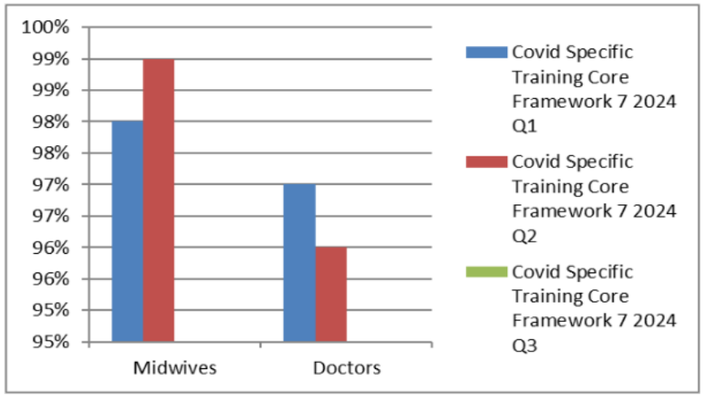


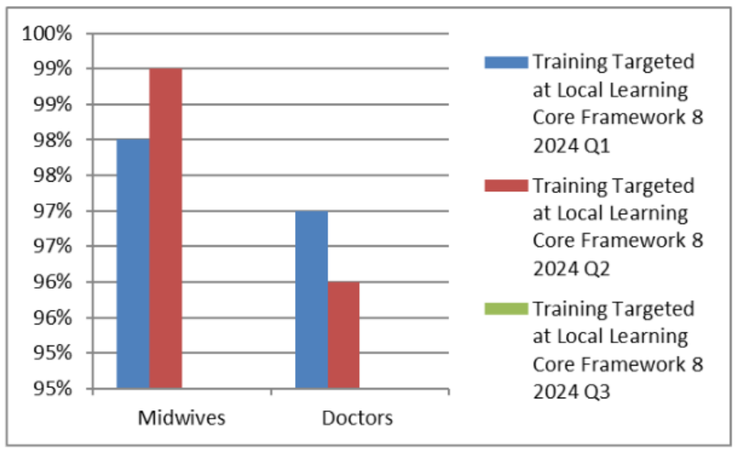












CNST training compliance met for all staff groups with the exception of Anaesthetic Registrars (63%) and consultants (43%).Action plan in place, recovered position by October 24.

July 2024 —Criteria Framework 1 & 2

Smoking Cessation

Midwives	**97%**
Obstetric Doctors	**100%**

SFH, RFM, Growth Restriction & Prem Prevention

Midwives	**97%**
Obstetric Doctors	**100%**

IA, AN EFM & Intrapartum EFM with surveillance

Midwives	**99%**
Doctors	**96%**

CTG Competency Assessment (Test)

Midwives	**97%**
Doctors	**96%**

Human Factors Training

Midwives	**97%**
Doctors	**96%**

Criteria Framework 3

Midwives	**98%**
Doctors	**96%**
Anaesthetists	**53%**

Criteria Framework 4

Midwives	**99%**
Doctors	**100%**

Criteria Framework 5

Covered on mandatory midwifery

Management of Labour (Annual) & Perineal Trauma (Bi annual)

Midwives	**99%**
Doctors	**100%**

Covered on Obstetric Skills Drills

VBAC, Epidural Update, Operative Birth, Critical Care & Enhanced Recovery

Midwives	**99%**
Doctors	**96%**

Criteria Framework 6

Midwives	**99%**
Doctors	**96%**

Criteria Framework 7 Covid Specific Training

Midwives	**99%**
Doctors	**96%**

Criteria Framework 8

Midwives	**99%**
Doctors	**100%**

Course commissioned for all midwives to receive enhanced cultural awareness and inclusivity training.

Safety Action CNST year 6 scheme.	Progress with achievement.
SA1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	
SA2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	
SA3. Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units programme?	
SA4. Can you demonstrate an effective system of clinical workforce planning to the required standard?	
SA5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
SA6. Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 3?	
SA7. Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your MVP to coproduce local maternity services?	
SA8. Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last year?	
SA9. Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	
SA10. Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to the NHS Resolutions Early Notification scheme?	

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	50%	Partially implemented	60%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	90%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	67%	Partially implemented	67%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	79%	Partially implemented	79%	CNST Met

Implemented
ially Implemented
Implemented

100% of babies requiring Transitional Care (TC) receive TC, but not always at their mothers side—this is measured by quarterly audits. TC on the postnatal ward does not support all 7 pathways of the BAPM TC criteria. Therefore some babies requiring TC will be resident on the Local Neonatal Unit.

Transitional care delivery 23/24	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July
% of babies eligible and TC delivered	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Continuity of carer 23/24 progress	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July
% of women booked on CoC pathway	22.5%	26%	23.7%	21%	25.6%	23.7%	21.35%	22.8%	21.8%	19.7%	15.3%	15.8%	
%of women delivered on a CoC pathway (including LSCS team)	28.31%	16.68%	25.76%	21.51%	30.36%	35.25%	28.04%	26.02%	26.50%	26.41%	18.75%	14.57%	
% of BAME women on a CoC pathway	94.5%	98.7%	94.44%	98.07%	100%	84.31%	88.13%	91%	77%	92%	73%	64%	

One to One care in labour 23/24	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July
% of women receiving 1:1 care in labour	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Supernumerary status of DSC - 23/24	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July
No of occasions DSC was NOT supernumerary	7	3	6	5	2	1	0	1	6	1	4	3	5

CNST — Compliance was met in 8 out of the 10 SA in Year 5. Action plans in place to support the compliance of SA 3 and SA 6 in year six.

SBLCB —Kettering has fully embedded 2 element of the SBLCBv3 and partially in 4. Assurances/exceptions on each element are reported monthly to the O&G Governance meeting with the SBLCB dashboard. Overall improvement from 64% to 76% to 79% in the last 2 quarters.

Continuity of Carer—Kettering has achieved the NHSE ambition to deliver 35% CoC by March 21. The national target has now been removed in response to the Ockenden report. KGH and NGH maternity services have coproduce with the LMNS a CoC action plan for across the county.

Following final Ockenden report Risk assessment completed and COC discussed at board—decision made to support 2 teams

One to One Care in Labour—All women at KGH receive one to one care in labour (established). Our escalation policy supports this.

Supernumerary Status of the DSC— Each month at the O&G Governance Meeting the Inpatient Matron reviews all red flags and provides an exception report. In June the supernumerary status of the Delivery Suite Coordinator red flagged x3 however they did not provide 1:1 care at any time. (Exceptions described above in staffing section above pg2).

Ockenden— The Ockenden Implementation Assurance group has now been stepped down as the Service has developed an action plan to address all recommendations. This will now be monitored through the Maternity Safety Champions and CQSP CiC. .

Phase 1 Ockenden evidence submission = 80%
Phase 2 presented to Board 31st March 2022.
Final Ockenden report published 30th March 2022
X2 exceptions (Centralised CTGs and QIS %) reported to CQSP CiC March 24. Ockenden actions now in place.

Initial benchmark against final Ockenden report and risk assessment for COC presented at Public Trust Board May 22. Insight visit took place on 6th September 2022. Insights visit by ICB on 21st June 2023.

East Kent Report—Published in October 2022. Updates provided through Maternity Safety Paper.

Maternity Dashboard exceptions July 24

Homebirths – 9 booked with EDD in July (1 achieved was due in August but delivered in July)
1 x NVD at home but in August
1 x NVD at home but in June
2 x NVD in hospital - maternal choice
1 x NVD in hospital – laboured at home -
1 x Kiwi in hospital – laboured at home -
1 x NVD in hospital –
1 x Em LSCS –
1 x NBFD –

Escalation to community – 9 entries – 6 care episodes
1: 02.17/04.00 – Amber acuity and staffing reduction after twilight. (Week 1 staffing charts above)
2: 00.00 – 2 IUT identified and supported. (Week 1)
3: 21.00/00.00 – IUT and Amber acuity (Week 1)
4: 12.00/16.00 – High acuity and discussed with MOC. (Week 1)
5: 12.00 - Red acuity with 6 1:1 (Week 2)
6: 01.48 – Amber acuity and high 1:1 acuity. (Week 2)

Datix – 100 reported

Epidural rate There is no evident theme arising from the one-off increase in epidural rate this month.

Neonatal Exceptions—June 2024 data.

Nursing Staffing – Opel Status: All shifts throughout June were staffed with the correct nursing skill mix, in order to safely care for the acuity and capacity of babies on the unit.
Areas Requiring Improvement:

- ***Antenatal steroids compliance*** – 50% – Out of the 2 eligible mothers, 1 had a complete course and the other was a 25-week lady who delivered immediately after receiving one dose. Neonatal team continue working in close collaboration with maternity services to capture this data on a monthly basis, in order to ensure it is inputted accurately onto Badgernet.
- ***Temperature on admission compliance*** – 50% – Out of the 2 eligible, 1 baby's temperature was within the normal range and the other was a 25 weeker who's temperature was 36.4 C. Maternity have ensured their delivery room temperatures are increased, there is a warm towels trolley established on Delivery Suite and increased training and education has taken place to midwives regarding effective skin to skin techniques.
- ***Breastmilk within 24 hours of birth compliance*** – data inputted incorrectly and now resolved so should be 50% compliant when charts are rerun. BFI lead continues training and educating nursing and medical staff regarding the importance of promoting breastfeeding. Working towards Stage 2 BFI Accreditation at present.

Areas of Good Practice:

- ***Magnesium sulphate compliance*** – 100%.
- ***Intrapartum antibiotic compliance*** – 59% with a positive special cause (blue dotted line).
- ***Delayed cord clamping compliance*** – 100%.
- ***Parental consultation compliance*** – 85%. 15 parents consulted within 24 hours.
- ***Parental inclusion on ward rounds compliance*** – 46.1% with a positive special cause (blue dotted line). Parents actively encouraged to be present for ward rounds. Consultants continue reviewing the documentation of each admission to ensure parents are updated within the first 24 hours of their baby being admitted.
- ***Timely ROP screening compliance*** – 100%.

Overall, since our Data Analyst started in post and has cleansed all the data from January 2024 to present day, there has been a **SIGNIFICANT** improvement in the amount of missing data. As a result, this month's SPC charts show a clear and more accurate reflection of the service provided at KGH highlighting areas that we are exceeding in and others that require more focus and attention.

Cover sheet

Meeting	University Hospitals of Northamptonshire (UHN) NHS Group Boards of Directors (Part I) Meeting in Public
Date	4 October 2024
Agenda item	11

Title	Report on the activities of the Northamptonshire Health Charity (NHCF) and appointment of Trustee
Presenters	Richard Apps, Director of Corporate and Legal Affairs Jonathan McGee, Chief Executive, NHCF
Author	Richard May, UHN Company Secretary

This paper is for			
☒ Decision	☒ Discussion	☐Note	☐Assurance
To formally receive and discuss a report and determine its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Group priority				
☐Patient	☐Quality	☒ Systems & Partnerships	☐Sustainability	☒ People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
The Terms of Nomination require the submission of annual reports on the NHCF's activities on an annual basis. To fill current a vacancy to the position of Trustee to take account recent changes to the senior leadership structure.	Deferred from the 2 August 2024 meeting

Executive Summary

The NHCF acts as trustee for the Trusts' charitable funds, following asset transfer by NGH and KGH in 2018 and 2021 respectively.
Jonathan McGee from the NHCF will attend the meeting to present a review of the Charity's activities during the past year, as set out in the **attached** slides.
The presentation is for the Board's receipt, information and consideration.

Following changes to its Constitution, the NHCF charity Board of Trustees currently includes **one** nominated trustee from each hospital. Trustees are members of sub-committees for each trust; these committees have responsibility to oversee all expenditure incurred by KGH and NGH Funds as well as approving spend above fund advisors' delegated limits.
Nominated Trustees have dual roles as members of sub-committees for each trust's funds, and as trustees of the NHCF charity.
Jill Houghton is the NGH-appointed Trustee, and is currently serving a term of office between 2021-2025.

Recommendation

Following recent senior leadership changes and changes to Board composition, the Boards of Directors are requested to **approve** the appointment of the UHN Chief Executive as Trustee of the Northamptonshire Health Charitable Fund, and to designate the Director of Corporate and Legal Affairs to deputize in the even of the Trustee's absence, with immediate effect.

Appendix

Presentation: Reflecting on the activities of the charity during the last year

Risk and assurance

No direct implications

Financial Impact

No direct implications

Legal implications/regulatory requirements

As set out in 'Reason for consideration' above

Equality Impact Assessment

The charity's activities generate positive equality impacts, as specified in the presentation.

Report from the charity

UHN Boards of Directors Meeting, 4 October 2024

Presented by Jonathan McGee
Chief Executive, Northamptonshire Health Charity

April 2023 to March 2024

We spent £1,107,363 improving your hospitals for patients and staff

Total number of funded requests: 492
Total charitable expenditure FY23/24: £1,170,810

Patient Care examples

NGH Highlights Include: Activities for children with type 1 Diabetes, Bras for post-operative cancer patients, Activities for Dementia patients, Swan Rooms, TVs for waiting rooms . . .

KGH Highlights Include: Activities for Dementia patients, Music therapy for SCBU, Yoga Sessions for cancer patients, Coolcaps, Lost baby funerals, Chairs for Haematology, Urgent Care, & Phlebotomy patients, Drinks and snacks for patients waiting in ED . . .

Enhancing spaces examples

Gosset ward parents' accommodation (NGH)

Crazy hats treatment centre (KGH)

Organ & Tissue donation memorial garden (NGH)

Staff Wellbeing & Development examples

NGH Highlights Include: PNA Restorative team building days, Nursing, Midwifery & AHP conference, Our Space centre and Dementia Simulator Bus.

KGH Highlights Include: Care Café Improvements, Kings Coronation Celebrations & Easter Eggs For Staff, plus Excellence Awards (Group Wide)

Our new strategy

Our Goals

1 Sustainable income generation

- Double income from £1.2m to £2.4m by 2027;
- Increase unrestricted income;
- Focus on regular giving, legacy programs, and expanding philanthropy;
- Expand fundraising and supporter engagement.

2 Support patient care pathways

- Collaborate with clinical staff to fund prevention, diagnostics, treatment, research, and recovery;
- Enhance NHS provisions to reduce hospital time and improve outcomes.

3 Enhance environments across estates

- Work with Trusts on capital projects and create therapeutic environments;
- Improve patient and staff environments beyond NHS budgets.

4 Support the Trusts' staff wellbeing and development

- Develop a strategic framework to support NHS staffs' well-being and professional growth;
- Create equitable support systems to reduce pressure and aid staff retention.

5 Opportunities to support integrated care

- Partner with the Integrated Care System (ICS) to address health inequalities;
- Extend the charity's remit to support broader community health needs

Our Enablers

Unrestricted income

A focus on increasing unrestricted income will allow us to do more for patients and staff across the Trusts

High value income

We will increase our high value supporter income with dedicated resource to focus on corporates, grants and major donors

Funds management

We will simplify and improve the application process, and reduce number of funds to allow more equitable expenditure

Capability and resource

We will invest in and develop the charity's capability, capacity and resources to enable high performing teams to deliver increased income and expenditure

Measurable outcomes

We have implemented performance driven measurable outcomes to monitor progress and ensure we are delivering on our objectives

Example projects in the pipeline

Patient care

- Take5 Care+ - Haematology (NGH) – Pilot scheme with Open University to empower patients following their cancer diagnosis
- The Real Birth company Maternity app (NGH) - to ensure antenatal care is easily and readily accessible and inclusive
- Skin to Skin chairs for parents in SCBU (NGH)

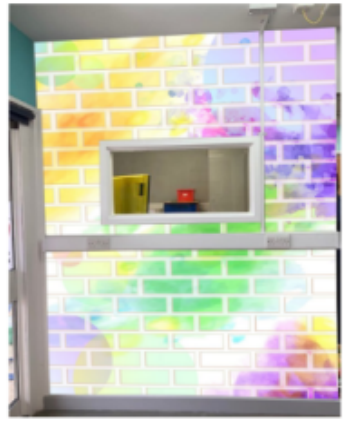
Environments and Enhancements

- Viewing room & Family room in ED (KGH)
- Young Persons Chill Zone (NGH)
- Sensory Room for Paeds in ED (KGH)
- Oncology Health & Wellbeing room (NGH)
- Child Development Centre (NGH)

Staff wellbeing and development

- Improving staff rooms
- Excellence awards 2024
- Team building days

Exterior Wall Artwork Mock-up


Exterior Return Wall Artwork Mock-up

This financial year (24/25)

Focus on unrestricted and regular income

- Sign ups to the charity and regular monthly giving

Close existing appeals

- Children's gardens; bereavement suites

Larger capital appeals

- On top of core unrestricted income, we will also look to support significant £1m+ appeals
- Work with Trusts to focus on priority projects

Working collaboratively

- The charity can do so much more with the support of the Trusts
- Visibility; Staff referrals; Staff participation – we are <u>your</u> charity

greenheart@nhcf.co.uk
www.northamptonshirehealthcharity.co.uk

Any questions?

Cover sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	4th October 2024
Agenda item	12.1
Title	Workforce Disability Equality Standard (WDES) reporting: Kettering General Hospital (KGH)
Presenter	Paula Kirkpatrick, Chief People Officer
Author	Farhana Ahmedabadi-Patel, Diversity & Inclusion Specialist

This paper is for

☐ Decision	☐ Discussion	☐ Note	X Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Group priority

☐ Patient	☐ Quality	X Systems & Partnerships	X Sustainability	X People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
• To receive the KGH WDES progress report and action plan • To provide assurance to the Boards on progress against the People Delivery Plan	People Committee approved the publication of the 2023/24 WDES report in their meeting of 26th September 2024

Executive Summary

This paper sets out the latest annual Workforce Disability Equality Standard (WDES) report for Kettering General Hospital (KGH).

Risk and assurance

Mandated in the NHS contract and considered by the CQC
BAF ref: UHN01

Financial Impact

N/A

Legal implications/regulatory requirements

Public Sector Equality Duty

Equality Impact Assessment

The proposed action will promote equality of opportunity

Dedicated to excellence

Paper

Situation

This paper sets out the latest annual Workforce Disability Equality Standard (WDES) metrics and report for Kettering General Hospital (KGH). While progress has been made in some areas, the results highlight the continued disparity of experience for our colleagues with disabilities, health conditions and neurodifferences compared to those without, with these gaps in experience increasing in many cases. WDES report forms an integral driver of transformation in KGH's workforce commitment to inclusion. Appendix 1 provides background and context to the WDES.

A note on language: the term 'disabled colleagues' is used throughout this report to refer to anyone with a disability, long term health condition or neurodifference that is protected under the Equality Act 2010. This is in line with the language used throughout WDES.

The data for WDES return has been sourced from Electronic Staff Records (ESR) as disability data is routinely gathered on a 'voluntary self-reporting' basis from colleagues. Colleague declaration of disability is therefore important in enabling the Trust to present a true and accurate picture of disability in the organisation. and is based on self-reporting through ESR or the National Staff Survey.

It should be noted that some colleagues may not consider themselves 'disabled' and caution should be used in applying this term to individuals. 'Non-disabled' is used throughout the report to refer to anyone who has recorded having a disability, long term health condition or neurodifference, to their ESR or National Staff Survey response

Background

The Workforce Disability Equality Standards (WDES) was introduced in 2019 and is designed to improve the experiences of Disabled and those with Long Term health Conditions (LTC) people working in or seeking employment within the NHS. This mandated collection of evidence-based metrics helps an organisation understand more about the experiences of its colleagues.

WDES is a set of ten specific metrics to enable NHS organisations to compare the career and workplace experiences of disabled and non-disabled colleagues. The metrics also examine and highlight inequalities between disabled and non-disabled colleagues and is a clear commitment in support of the Government's aims of increasing the number of disabled people in employment.

The data findings are presented on an infographic in Appendix 2 along with action plans agreed with the Disability and Wellbeing Support Network (DAWS)

Assessment

In summary, there is an improvement in the position against three of the ten metrics since 2023:

- Metric 1: percentage of disabled staff compared with overall workforce
- Metric 2: relative likelihood of being appointed from shortlisting. Non-disabled and disabled applicants are equally as likely to be appointed after shortlisting
- Metric 8: percentage of staff saying their employer has made adequate adjustments to enable them to carry out their role

There has been a slight worsening in the position for seven of the ten metrics

- Metric 3: relative likelihood of entering the formal capability process. Disabled staff are 4.19 times more likely to enter the formal capability procedure than non-disabled staff.
- Metric 5: percentage of staff believing that the Trust provides equal opportunities for career progression or promotion
- Metric 6: percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
- Metric 7: percentage of staff saying they are satisfied with the extent to which their organisation values their work
- Metric 9a: staff engagement score
- Metric 10: difference between the Board voting membership and its overall workforce.

It must be noted that Metric 4 – related to staff survey results, regarding bullying, harassment or abuse from patients and service users, managers and other colleagues, comprises of four component parts.

The Trust has and continues to take action to ensure the voices of disabled colleagues are heard and acted upon by continuing to support the DAWS Network to grow and develop. The network has an active involvement in the WDES action plan alongside their own priorities, with the support of Polly Grimmett as executive sponsor.

DAWS Staff Network
DAWS network continues to share colleague stories, talk openly about and increase understanding of disability, health conditions and neurodifferences to develop a culture where colleagues feel comfortable and confident to share their personal experiences, including recording this on ESR.

DAWS Network activities were limited during the past year, the network has only 1 chair and as such it has been difficult to increase membership whilst leading on colleague support projects. DAWS has been predominantly involved in re-establishing themselves this past year and supporting individual colleague concerns.

The plan for the next 12 months is to merge DAWS with NGH's Disability And Wellbeing Network (DAWN) and led by co-chairs from both NGH & KGH whilst being supported by the EDI Team. The new UHN network plans to rename themselves to Disability Accessibility Wellbeing & Neurodiversity (DAWN) Network. The plan is to:

- Raise awareness of neurodiversity
- Promote the Sunflower Badge Scheme to support colleagues with hidden disabilities
- Continue supporting colleagues and patients with access support

It must be noted that KGH is a Level 3 Disability Confident Leader and the membership will require renewal in May 2025.

Risk and Implications
EDI continues to be a high priority within the NHS, the next steps in our organisational maturity would be to introduce lessons from our DAWN Staff Network to make real sustainable cultural change through local leadership within individual teams. The expectation that success would be replicated driving positive change through diverse local leadership supported by the EDI team, staff networks and executive sponsors. This approach is necessary to integrate inclusive approaches to EDI that supports the wider health inequalities of workforce and community.

Recommendations

The Boards are asked to note:

1. the need to further strengthen our work to support colleagues with a disability given the deterioration in our overall WDES position.

2. the positive benefit we anticipate will be created by joining the NGH and KGH staff networks to ensure learning and improvement can be shared across UHN.

3. People Committee has approved the publication of the WDES report in line with the Public Sector Equality Duty

Appendix 1

Background and context to the Workforce Disability Equality Standard; definitions, language and underpinning principles

- The WDES was introduced in the NHS as an evidence-based tool to compare the workplace and career experiences of disabled and non-disabled colleague, leading to robust action, monitoring and evaluation to support positive change and a more inclusive environment for disabled people working and applying to the NHS.
- At a national level, the evidence clearly highlights that many disabled colleague continue to experience inequality in the workplace when compared to their non-disabled colleagues. This provides year on year analysis of progress for disabled colleague.
- Under the Equality Act 2010, a person is 'disabled' if they have a physical or mental impairment that has a 'substantial' and 'long term' negative impact on their ability to do normal daily activities.
    - 'Substantial' means more than minor or trivial, for example taking longer to complete a daily task.
    - Long term means lasting or expected to last 12 months or more.
- This definition covers a broad range of conditions, impairments or disabilities, visible and invisible, including but not exclusive to: heart disease, musculoskeletal conditions, lung or respiratory conditions, stroke, mental health conditions, sensory impairments, progressive and fluctuating conditions, auto-immune conditions, developmental or learning disabilities, HIV, cancer, some injuries and neurodiversity.
- Nationally, data from the Office for National Statistics in September 2018 tells us that 22% of the working age population has a disability, the vast majority of whom do not use a wheelchair or any other visible aid. 83% of people acquire their disability, impairment or condition in adulthood, which for many will be during their working lives.
- It is estimated that by 2030, 40% of the working age population in the UK will have at least one chronic health condition or disability; this does not currently include the effects of long Covid.
- Many people who are 'disabled' under the Equality Act do not consider themselves to be disabled or may use other language to describe themselves. This report refers to 'disabled colleague' or 'colleague with disabilities, health conditions and neurodifferences' as shorthand, while recognising that this may not be how people talk about themselves.
- Our disabled colleague work in a broad range of roles across the Trust, at all levels of seniority and across all colleague groups.
- Questions about disability or health conditions are asked differently at various stages of the employee journey:
    - When applying for a role at our hospitals through TRAC portal, to assure applicants that reasonable adjustments will be made available should they be invited to interview
    - On ESR portal, colleague can add a disability or health condition at any stage of their employment
    - Through the NHS Staff Survey
- Underpinning principles: The WDES is underpinned by the social model of disability, the ethos of 'Nothing About Us Without Us' and the concept of 'Disability as an Asset', which is advocated by Disabled people and disability rights organisations.

- The social model of disability recognises that Disabled people face a range of societal barriers, including buildings and estates, limited job and career opportunities, working environment and attitudinal challenges from colleagues and the public. It is these barriers, rather than an individual's impairment or long-term condition, which create disability.

- The ethos of 'Nothing About Us Without Us' means that any actions or decisions that affect Disabled people should be informed by the views of Disabled people. It is therefore vital that our Disabled colleague are involved with the WDES and have co-produced the action plan, through the DAWS Network.

- The concept of 'Disability as an Asset' refers to the benefits of employing Disabled colleague and the positive impact that disability inclusion can have in the workplace. We are striving to create a culture where people can speak openly and positively about disability, bringing their lived experience into work. Disabled colleague are visible and feel supported

Workforce Disability Equality Standard 2023/24

NHS Kettering General Hospital NHS Foundation Trust

Total Workforce Population based on Disability

Disabled: 244
Non-Disabled: 4088
Unknown: 668
Total Workforce: 5,000

1 Percentage of disabled staff: **5%**

2 Relative likelihood of non-disabled applicants being appointed from shortlisting across all posts compared to disabled applicants: **0.86**

3 Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff: **4.19**

4b Percentage of disabled staff who reported harrassment, bullying and abuse: **46%**

5 Percentage of disabled staff believing the trust provides equal opportunities for career progression or promotion: **45%**

6 Percentage of disabled staff saying they felt pressure from their manager to come to work when unwell: **33%**

7 Percentage of disabled staff satisfied with the extent to which the organisation values their work: **27%**

8 Percentage of staff with a long term condition saying their employer has made adequate adjustments: **71%**

9 Disabled staff engagement score: **5.9**

10 Disabled Board Membership difference: **0%**

Percentage of disabled staff experiencing harassment, bullying or abuse from:

- Staff: **31%** (4aiii)
- Manager/Team Lead: **19%** (4aii)
- Patients & Relatives: **32%** (4ai)

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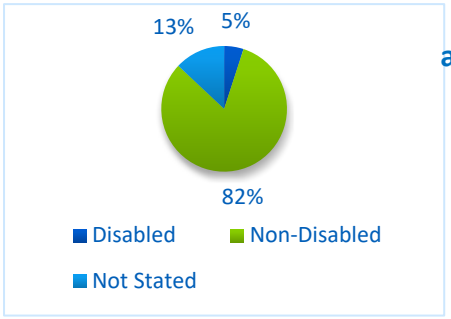
NHS
Kettering General Hospital
NHS Foundation Trust

Workforce Disability Equality Standard (WDES) Data 2023/2024



Percentage of staff members at KGH who are disabled, non-disabled or have not stated their disability status

Total Workforce = 5000
Disabled = 244
Non-Disabled = 4088
Not stated = 668

AFC Bands

	Disabled	Non-Disabled	Not Stated
<1-4	4.5%	84%	11.5%
5-7	4.8%	82%	13.2%
8A-8D	1.4%	82.7%	15.9%
9-VSM	100%	0%	0%

Medical & Dental

	Disabled	Non-Disabled	Not Stated
Consultants	2.84%	74.41%	22.75%
Career Grade	2.33%	95.35%	2.33%
Trainee Grades	0.34%	91.89%	7.77%

WDES Indicators

1. Percentage difference between the organisations' Board membership and its overall workforce
   - Disabled 0%
   - Non-Disabled 9%
   - -4% for disabled staff in 2022/2023
2. **0.86** — 0.66 in 2022/2023
   Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts
3. **4.19** — 0 in 2022/2023
   Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff
4ai. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
   - Disabled 32%
   - Non-Disabled 25%
   - 36% disabled staff in 2022/2023
4aii. Percentage of staff experiencing harassment, bullying or abuse from a manager in the last 12 months
   - Disabled 19%
   - Non-Disabled 11%
   - 19% for disabled staff in 2022/2023
4aiii. Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months
   - Disabled 31%
   - Non-Disabled 21%
   - 27% disabled staff in 2022/2023
4b. Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
   - Disabled 46%
   - Non-Disabled 48%
   - 49% for disabled staff in 2022/2023
5. Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion
   - Disabled 45%
   - Non-Disabled 52%
   - 50% for disabled staff in
6. Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
   - Disabled 33%
   - Non-Disabled 24%
   - 37% for disabled staff in 2022/2023
7. Percentage of staff satisfied with the extent to which their organisation values their work
   - Disabled 27%
   - Non-Disabled 41%
   - 29% for disabled staff in 2022/2023
8. Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work
   - **71%**
   - 74% for disabled staff in 2022/2023
9. Engagement score for disabled staff compared to non-disabled and overall engagement score out of 10
   - Disabled 5.9
   - Non-Disabled 6.7
   - Overall 6.5
   - 6.1 for disabled staff in 2022/2023
10.

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NHS
Kettering General Hospital
NHS Foundation Trust

Workforce Disability Equality Standard (WDES) Plans 2022-24

1

Work with disabled staff and the Disability and Wellbeing Network (DAWN) to better understand the reasons why colleagues may not have declared a disability on ESR, with a view to closing the gap between ESR and National Staff Survey declaration rates

We will work to provide staff with psychological safe space to explore reasons why they are reluctant to declare disability/long-term conditions and use the opportunity to provide staff with reasons why information is collected and how the information is used and that their personal data is kept safely and remains confidential.

Reduce the number of disabled colleagues experiencing harassment, bullying and abuse from patients/public and staff.

Working with disabled staff and our DAWN colleagues, we will:

a) Discuss experiences of harassment, bullying or abuse with disabled staff, ensuring that there is a safe person/space for any discussions
b) Launch a communications campaign focussed on reducing harassment, bullying and abuse
c) In conjunction with unions, freedom to speak up guardians, and staff networks, review and improve support for staff who experience bullying, harassment or abuse. This will include access to specialist support for staff who harassment, bullying and abuse including SOS team, Stronger Together and Safeguarding teams.
d) Working with system colleagues and DAWN members, review NHS England's Civility and Respect toolkit and adopt identified practices set out

2

3

Work with disabled staff and other partners to improve the management of workplace adjustments

a) Review the reasonable adjustments good practice published by NHS Employers
b) Introduce workplace adjustments passports, which enable disabled staff to record and share the details of the reasonable adjustments they need at work.
c) With system partners, review reasonable adjustments policies to ensure Group and system-alignment with national good practice examples
d) Explore the introduction of a centrally funded budget to enable managers to purchase any equipment required for reasonable adjustments

Deliver the 'Dedicated to Excellence' Culture and Leadership Programme, ensuring diverse representation from across the Group to build psychological safety and ensure all staff voices are heard

4

Cover sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	4th October 2024
Agenda item	12.2
Title	Workforce Disability Equality Standard (WDES) reporting: Northampton General Hospital
Presenter	Paula Kirkpatrick, Chief People Officer
Author	Farhana Ahmedabadi-Patel, Diversity & Inclusion Specialist

This paper is for

Approval	☐ Discussion	☐ Note	X Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Group priority

☐ Patient	☐ Quality	X Systems & Partnerships	X Sustainability	X People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
• To receive the WDES progress report and action plan • To provide assurance to the Board on progress against the People Delivery Plan	People Committee approved the publication of the 2023/24 WDES report in its meeting of 26th September 2024

Executive Summary

This paper sets out the latest annual Workforce Disability Equality Standard (WDES) report for Northampton General Hospital (NGH).

Risk and assurance

Mandated in the NHS contract and considered by the CQC
BAF ref: UHN01

Financial Impact

N/A

Legal implications/regulatory requirements

Public Sector Equality Duty

Equality Impact Assessment

The proposed action will promote equality of opportunity

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Paper

Situation

This paper sets out the latest annual Workforce Disability Equality Standard (WDES) metrics and report for Northampton General Hospital (NGH). While progress has been made in some areas, the results highlight the continued disparity of experience for our colleagues with disabilities, health conditions and neurodifferences compared to those without, with these gaps in experience increasing in many cases. WDES report forms an integral driver of transformation in NGH's workforce commitment to inclusion. Appendix 1 provides background and context to the WDES.

A note on language: the term 'disabled colleagues' is used throughout this report to refer to anyone with a disability, long term health condition or neurodifference that is protected under the Equality Act 2010. This is in line with the language used throughout WDES.

The data for WDES return has been sourced from Electronic Staff Records (ESR) as disability data is routinely gathered on a 'voluntary self-reporting' basis from colleagues. Colleague declaration of disability is therefore important in enabling the Trust to present a true and accurate picture of disability in the organisation. and is based on self-reporting through ESR or the National Staff Survey.

It should be noted that some colleagues may not consider themselves 'disabled' and caution should be used in applying this term to individuals. 'Non-disabled' is used throughout the report to refer to anyone who has recorded having a disability, long term health condition or neurodifference, to their ESR or National Staff Survey response

Background

The Workforce Disability Equality Standards (WDES) was introduced in 2019 and is designed to improve the experiences of Disabled and those with Long Term health Conditions (LTC) people working in or seeking employment within the NHS. This mandated collection of evidence-based metrics helps an organisation understand more about the experiences of its colleagues.

WDES is a set of ten specific metrics to enable NHS organisations to compare the career and workplace experiences of disabled and non-disabled colleagues. The metrics also examine and highlight inequalities between disabled and non-disabled colleagues and is a clear commitment in support of the Government's aims of increasing the number of disabled people in employment.

The data findings are presented on an infographic in Appendix 2 along with action plans agreed with the Disability and Wellbeing Network (DAWN)

Assessment

In summary, there is an improvement in the position against six of the ten metrics since 2023:

- Metric 2: relative likelihood of being appointed from shortlisting. Non-disabled and disabled applicants are equally as likely to be appointed after shortlisting
- Metric 6: percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
- Metric 7: percentage of staff saying they are satisfied with the extent to which their organisation values their work

- Metric 8: percentage of staff saying their employer has made adequate adjustments to enable them to carry out their role
- Metric 9a: staff engagement score

There has been no change in the position for seven of the ten metrics

- Metric 1: percentage of disabled staff compared with overall workforce
- Metric 3: relative likelihood of entering the formal capability process.
- Metric 5: percentage of staff believing that the Trust provides equal opportunities for career progression or promotion
- Metric 10: difference between the Board voting membership and its overall workforce.

It must be noted that Metric 4 – related to staff survey results, regarding bullying, harassment or abuse from patients and service users, managers and other colleagues, comprises of four component parts.

The Trust has and continues to take action to ensure the voices of disabled colleagues are heard and acted upon by continuing to support the DAWN Network to grow and develop. The network has an active involvement in the WDES action plan alongside their own priorities, with the support of Tracey Robson as executive sponsor.

DAWN Staff Network

DAWN network continues to share colleague stories, talk openly about and increase understanding of disability, health conditions and neurodifferences to develop a culture where colleagues feel comfortable and confident to share their personal experiences, including recording this on ESR.

DAWN Network has been actively supporting colleagues and patients with accessibility concerns. DAWN Network has worked closely with Patient EDI Lead at NGH to support various patient accessibility requirements. The network has 2 co-chairs, who have been supporting REACH & PRIDE network with intersectional projects. They have seen an increase in requests around reasonable adjustments for colleagues within a spectrum of neurodiverse conditions.

The plan for the next 12 months is to merge with KGH's DAWS to create a single staff network aimed at supporting colleagues with disability and long-term health conditions. This network will be led by co-chairs from both NGH & KGH whilst being supported by the EDI Team. The new UHN network plans to rename themselves to Disability Accessibility Wellbeing & Neurodiversity (DAWN) Network. The plan is to:

- Raise awareness of neurodiversity
- Promote the Sunflower Badge Scheme to support colleagues with hidden disabilities
- Continue supporting colleagues and patients with access support

It must be noted that NGH is a Level 3 Disability Confident Leader and the membership will require renewal in May 2025.

Risk and Implications

EDI continues to be a high priority within the NHS, the next steps in our organisational maturity would be to introduce lessons from our DAWN Staff Network to make real sustainable cultural change through local leadership within individual teams. The expectation that success would be replicated driving positive change through diverse local leadership supported by the EDI

team, staff networks and executive sponsors. This approach is necessary to integrate inclusive approaches to EDI that supports the wider health inequalities of workforce and community

Recommendation(s)

The Boards are asked to note:

1. the improvement in the NGH WDES position and the ongoing work to further improve the experience of our colleagues with a disability, supported by the DAWN network.

2. People Committee has approved the publication of the NGH WDES report in line with the Public Sector Equality Duty

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Appendix 1

Background and context to the Workforce Disability Equality Standard; definitions, language and underpinning principles

- The WDES was introduced in the NHS as an evidence-based tool to compare the workplace and career experiences of disabled and non-disabled staff, leading to robust action, monitoring and evaluation to support positive change and a more inclusive environment for disabled people working and applying to the NHS.
- At a national level, the evidence clearly highlights that many disabled staff continue to experience inequality in the workplace when compared to their non-disabled colleagues. This provides year on year analysis of progress for disabled staff.
- Under the Equality Act 2010, a person is 'disabled' if they have a physical or mental impairment that has a 'substantial' and 'long term' negative impact on their ability to do normal daily activities.
    - 'Substantial' means more than minor or trivial, for example taking longer to complete a daily task.
    - Long term means lasting or expected to last 12 months or more.
- This definition covers a broad range of conditions, impairments or disabilities, visible and invisible, including but not exclusive to: heart disease, musculoskeletal conditions, lung or respiratory conditions, stroke, mental health conditions, sensory impairments, progressive and fluctuating conditions, auto-immune conditions, developmental or learning disabilities, HIV, cancer, some injuries and neurodiversity.
- Nationally, data from the Office for National Statistics in September 2018 tells us that 22% of the working age population has a disability, the vast majority of whom do not use a wheelchair or any other visible aid. 83% of people acquire their disability, impairment or condition in adulthood, which for many will be during their working lives.
- It is estimated that by 2030, 40% of the working age population in the UK will have at least one chronic health condition or disability; this does not currently include the effects of long Covid.
- Many people who are 'disabled' under the Equality Act do not consider themselves to be disabled or may use other language to describe themselves. This report refers to 'disabled staff' or 'staff with disabilities, health conditions and neurodifferences' as shorthand, while recognising that this may not be how people talk about themselves.
- Our disabled staff work in a broad range of roles across the Trust, at all levels of seniority and across all staff groups.
- Questions about disability or health conditions are asked differently at various stages of the employee journey:
    - When applying for a role at our hospitals through TRAC portal, to assure applicants that reasonable adjustments will be made available should they be invited to interview
    - On ESR portal, staff can add a disability or health condition at any stage of their employment
    - Through the NHS Staff Survey

- Underpinning principles: The WDES is underpinned by the social model of disability, the ethos of ‘Nothing About Us Without Us’ and the concept of ‘Disability as an Asset’, which is advocated by Disabled people and disability rights organisations.

    - The social model of disability recognises that Disabled people face a range of societal barriers, including buildings and estates, limited job and career opportunities, working environment and attitudinal challenges from colleagues and the public. It is these barriers, rather than an individual’s impairment or long-term condition, which create disability.

    - The ethos of ‘Nothing About Us Without Us’ means that any actions or decisions that affect Disabled people should be informed by the views of Disabled people. It is therefore vital that our Disabled staff are involved with the WDES and have co-produced the action plan, through the DAWS Network.

    - The concept of ‘Disability as an Asset’ refers to the benefits of employing Disabled staff and the positive impact that disability inclusion can have in the workplace. We are striving to create a culture where people can speak openly and positively about disability, bringing their lived experience into work. Disabled staff are visible and feel supported

Workforce Disability Equality Standard 2023/24

Northampton General Hospital NHS Trust

Total Workforce Population based on Disability

Disabled: 327
Non-Disabled: 5178
Unknown: 653
Total Workforce: 6,158

1 5% Percentage of disabled staff

2 0.82 Relative likelihood of non-disabled applicants being appointed from shortlisting across all posts compared to disabled applicants

3 Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff: 0

4b 53% Percentage of disabled staff who reported harrassment, bullying and abuse

5 Percentage of disabled staff believing the trust provides equal opportunities for career progression or promotion: 51%

6 Percentage of disabled staff saying they felt pressure from their manager to come to work when unwell: 29%

7 Percentage of disabled staff satisfied with the extent to which the organisation values their work: 37%

8 Percentage of staff with a long term condition saying their employer has made adequate adjustments: 75%

9 Disabled staff engagement score: 6.5

10 Disabled Board Membership difference: -5%

Percentage of disabled staff experiencing harassment, bullying or abuse from:

- Staff: 29% (4aiii)
- Manager/Team Lead: 15% (4aii)
- Patients & Relatives: 32% (4ai)

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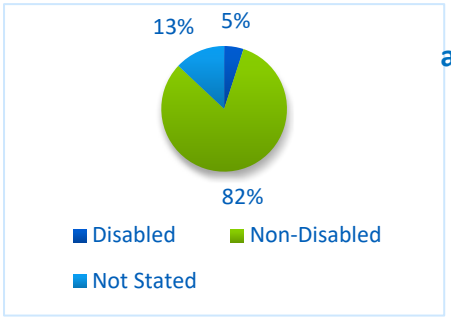
Workforce Disability Equality Standard (WDES) Data 2023-24



Percentage of staff members at KGH who are disabled, non-disabled or have not stated their disability status

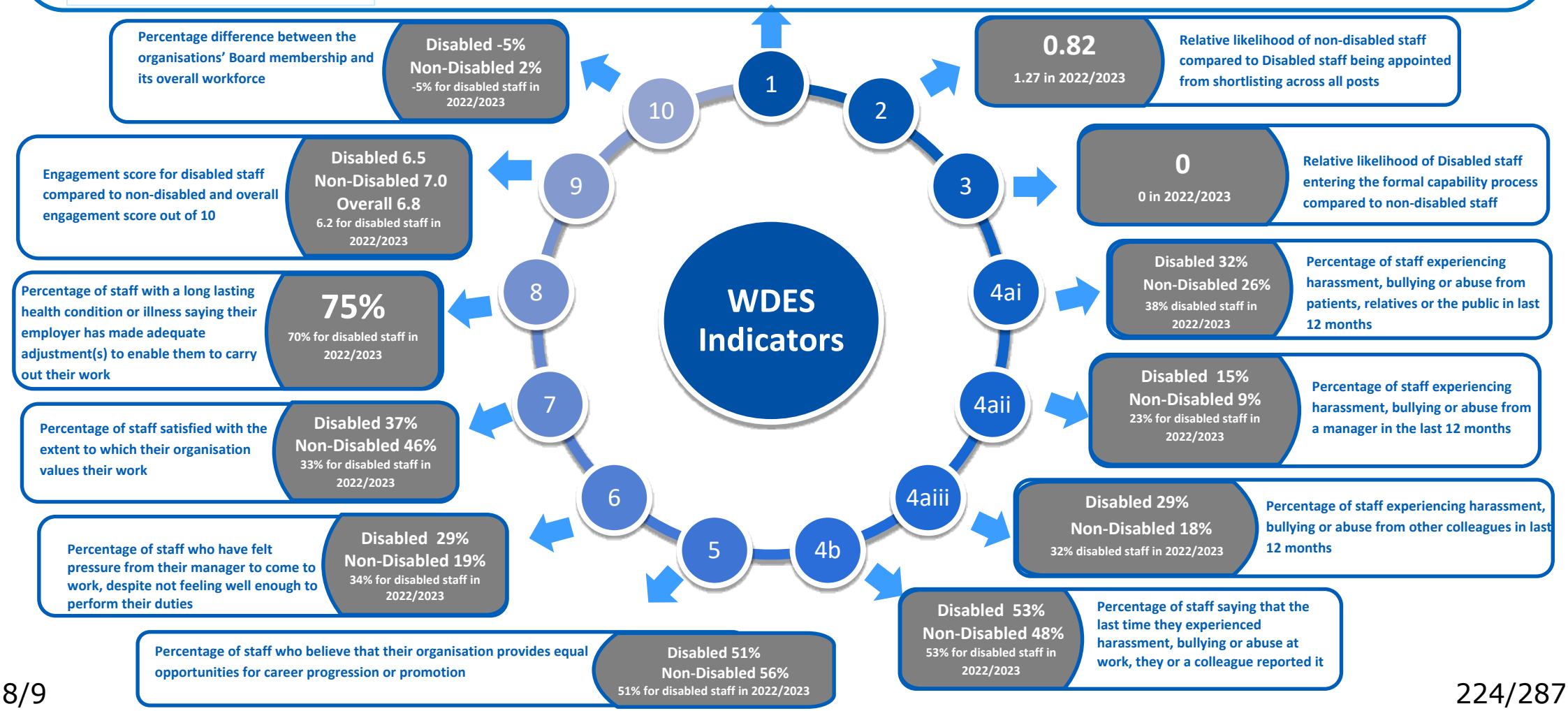
Total Workforce = 6158
Disabled = 327
Non-Disabled = 5178
Not stated = 653

AFC Bands

	Disabled	Non-Disabled	Not Stated
<1-4	6.4%	85.6%	8%
5-7	4.7%	85.1%	10.2%
8A-8D	5.6%	83.2%	11.2%
9-VSM	0%	100%	0%

Medical & Dental

	Disabled	Non-Disabled	Not Stated
Consultants	2.82%	76.41%	20.77%
Career Grade	1.83%	89.45%	8.72%
Trainee Grades	3.49%	85.66%	10.85%



1 — Percentage difference between the organisations' Board membership and its overall workforce: Disabled -5%, Non-Disabled 2%, -5% for disabled staff in 2022/2023

2 — 0.82 (1.27 in 2022/2023): Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts

3 — 0 (0 in 2022/2023): Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff

4ai — Disabled 32%, Non-Disabled 26%, 38% disabled staff in 2022/2023: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

4aii — Disabled 15%, Non-Disabled 9%, 23% for disabled staff in 2022/2023: Percentage of staff experiencing harassment, bullying or abuse from a manager in the last 12 months

4aiii — Disabled 29%, Non-Disabled 18%, 32% disabled staff in 2022/2023: Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months

4b — Disabled 53%, Non-Disabled 48%, 53% for disabled staff in 2022/2023: Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

5 — Disabled 51%, Non-Disabled 56%, 51% for disabled staff in 2022/2023: Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion

6 — Disabled 29%, Non-Disabled 19%, 34% for disabled staff in 2022/2023: Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

7 — Disabled 37%, Non-Disabled 46%, 33% for disabled staff in 2022/2023: Percentage of staff satisfied with the extent to which their organisation values their work

8 — 75% (70% for disabled staff in 2022/2023): Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work

9 — Disabled 6.5, Non-Disabled 7.0, Overall 6.8, 6.2 for disabled staff in 2022/2023: Engagement score for disabled staff compared to non-disabled and overall engagement score out of 10

10 — Disabled 32%, Non-Disabled 26%, 38% disabled staff in 2022/2023: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

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Workforce Disability Equality Standard (WDES) Plans 2023-24

1

Work with disabled staff and the Disability and Wellbeing Network (DAWN) to better understand the reasons why colleagues may not have declared a disability on ESR, with a view to closing the gap between ESR and National Staff Survey declaration rates

We will work to provide staff with psychological safe space to explore reasons why they are reluctant to declare disability/long-term conditions and use the opportunity to provide staff with reasons why information is collected and how the information is used and that their personal data is kept safely and remains confidential.

Reduce the number of disabled colleagues experiencing harassment, bullying and abuse from patients/public and staff.

Working with disabled staff and our DAWN colleagues, we will:

a) Discuss experiences of harassment, bullying or abuse with disabled staff, ensuring that there is a safe person/space for any discussions
b) Launch a communications campaign focussed on reducing harassment, bullying and abuse
c) In conjunction with unions, freedom to speak up guardians, and staff networks, review and improve support for staff who experience bullying, harassment or abuse. This will include access to specialist support for staff who harassment, bullying and abuse including SOS team, Stronger Together and Safeguarding teams.
d) Working with system colleagues and DAWN members, review NHS England's Civility and Respect toolkit and adopt identified practices set out

2

3

Work with disabled staff and other partners to improve the management of workplace adjustments

a) Review the reasonable adjustments good practice published by NHS Employers
b) Introduce workplace adjustments passports, which enable disabled staff to record and share the details of the reasonable adjustments they need at work.
c) With system partners, review reasonable adjustments policies to ensure Group and system-alignment with national good practice examples
d) Explore the introduction of a centrally funded budget to enable managers to purchase any equipment required for reasonable adjustments

Deliver the 'Dedicated to Excellence' Culture and Leadership Programme, ensuring diverse representation from across the Group to build psychological safety and ensure all staff voices are heard

4

Cover sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	4 October 2024
Agenda item	12.3
Title	WRES Report Kettering General Hospital
Presenter	Paula Kirkpatrick, Chief People Officer
Author	Farhana Ahmedabadi-Patel, Diversity & Inclusion Specialist

This paper is for

Approval	☐ Discussion	☐ Note	X Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Group priority

☐ Patient	☐ Quality	X Systems & Partnerships	X Sustainability	X People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
• To receive the KGH WRES progress report and action plan • To provide assurance to the Boards on progress against the People Delivery Plan	People Committee approved the publication of the 2023/24 WRES report in its meeting of 26th September 2024

Executive Summary

This paper sets out the latest annual Workforce Race Equality Standard (WRES) report for Kettering General Hospital (KGH).

Risk and assurance

Mandated in the NHS contract and considered by the CQC
BAF ref: 001

Financial Impact

N/A

Legal implications/regulatory requirements

Public Sector Equality Duty

Equality Impact Assessment

The proposed action will promote equality of opportunity

Paper

Situation

This paper sets out the latest annual Workforce Race Equality Standard (WRES) metrics and report for Kettering General Hospital (KGH). While progress has been made in most areas, the results highlight the continued disparity of experience for our Race Ethnicity and Cultural Heritage (REACH) colleague. WRES report forms an integral driver of transformation in KGH's workforce commitment to inclusion. Appendix 1 provides background and context to the WRES.

A note on language: there has, and continues to be, much local and national debate regarding the terminology best employed to respectfully and accurately make reference to ethnicity. Both NHS England and WRES material use the term Black and Minority Ethnic (BME), following internal discussion it has been agreed that for the purposes of this report and future documentation we will use this terminology the term 'REACH colleague'. The term REACH replaces BAME/BME used nationally and is in line with the language used throughout WRES.

The data for WRES return has been sourced from Electronic Staff Records (ESR) as equality data is routinely gathered on a 'voluntary self-reporting' basis from colleague. Colleague declaration is therefore important in enabling the Trust to present a true and accurate picture of equality in the organisation and is based on self-reporting through ESR or the National Staff Survey.

Background

The Workforce Race Equality Standards (WRES) was introduced in 2015 and is designed to improve the experiences of REACH colleagues working in or seeking employment within the NHS. This mandated collection of evidence-based metrics helps to understand and address the disparities in experiences of our colleagues.

This report provides an overview of WRES, within KGH against the nine indicators set out in WRES. These nine WRES indicators depict metrics for:

- Four indicators focus on workforce data
- Four indicators are data from the national NHS Staff Survey
- One indicator focuses upon REACH representation on boards.

The data findings are presented on an infographic in Appendix 1 along with action plans agreed with the Race.

Assessment

In summary, there is an improvement in the position against eight of the nine metrics since 2023:

Metric 1: staff in post by pay band
Metric 2: relative likelihood of being appointed from shortlisting.
Metric 3: relative likelihood of entering formal disciplinary investigation
Metric 4: relative likelihood of accessing non-mandatory training.

Metric 5: percentage of staff experiencing harassment, bullying and abuse from patients, relatives or the public in the last 12 months.
Metric 6: percentage of staff experiencing harassment, bullying and abuse from staff.
Metric 7: percentage of BAME staff believing that the Trust provides equal opportunities for career progression or promotion
Metric 8: percentage of staff experiencing discrimination at work from manager or team

There has not been any improvement in the position for one of the nine metrics
Metric 9: BME representation at Board.

Progression for clinical REACH colleagues was a priority for improvement on the WRES. This is driven by the success of our international nurse recruitment programme which has led to an increase of REACH colleagues at Band 5, however, the rate at which REACH colleagues have commenced in roles within the Trust outpaces the rate at which they progress leading to an increasing race disparity ratio.

Progression is affected by a range of factors including differences in cultural expectations, with good examples of local initiatives that have been taking place to support progression such as our UHN award winning Levelling Up programme, use of Inclusive Recruitment Champions (IRC) at interview panels for all posts Band 7 and above to support recruiting managers and debias the recruitment process for senior roles. These initiatives offer a good foundation to build and address the significant gap between our REACH nurses' expectations and the reality of the Trust's processes. This should enable the Trust to continue improving and meet the WRES targets that have been set within the Action plan.

REACH Staff Network
The Trust has and continues to take action to ensure the voices of REACH colleagues are heard and acted upon by continuing to support the REACH Network to grow and develop. The network has an active involvement in the WRES action plan alongside their own priorities, with the support of Deborah Needham & Paula Kirkpatrick as their executive sponsor.

REACH network continues to support new internationally educated colleagues through the Shared Decision-Making Council (SDMC) chaired by Plaxedes Mudadi by giving them an opportunity to connect within and across cultures. A support framework is established which encourages colleagues to share stories in a safe space, where colleague feel comfortable and confident. SDMC & REACH network provide a supportive framework for Internationally Educated Nurses & Midwives (IENMs) by offering them career development conversations along with a range of cultural celebration events both within UHN and with the wider Northamptonshire community.

While the REACH Network is a strong advocate for REACH colleagues within the organisation, the network still operates as a reactionary function, rather

than a governance function. The network acts as a forum for colleague discontent rather than driving the conversation for change and tackling processes and policies that create barriers for REACH colleagues.

The network's focus for the next 12 months is to work with NGH REACH Network to create a single UHN REACH Network led by co-chairs from both KGH & NGH. The network plans to drive some positive changes with the support from the EDI Team to:

- Formulate & strengthen the new UHN Single REACH Staff Network
- Continue working with Exec Sponsors to challenge race-based discrimination
- Support the delivery of Rething Racism Education Programme
- Continue with Career & Leadership Development (mentoring, Levelling Up)

Tackling Racism at UHN

Between September-December 2023, EDI Team ran several engagement sessions to listen to all our stakeholders which included NEDs, colleagues, volunteers and governors. Data from these sessions was collated and presented to stakeholders to define the framework of our Tackling Racism Strategy. Collaboration between REACH Network and EDI Team has resulted in the production of:

1. UHN Antiracist Statement (Appendix 2)
2. designing UHN's Tackling Racism Strategy
3. drafting the Rethinking Racism Education Programme
4. Extended Annual Leave Guidance
5. Tackling Racism Toolkit
6. Expanding Network Leadership from single chair to co-chair model, with the appointment of Ruby Matthew & Hildah Matiashe. This new model has been pivotal in widening participation and supporting REACH women into leadership positions
7. Creation of an EDI Steering Group chaired by CEO that meets bi-monthly and provides assurance to the People Committee

In February 2024, during Race Equality Week, we launched UHN's Tackling Racism Plan, this coincided with the release of Roger Kline & Joy Warmington's 'Too hot to Handle Report' highlighting racism in NHS organisations. The report findings served to confirm our own internal findings and highlighted the need to address the micro incivilities and covert racism in the form of assumptions, stereotypes and biases that often minimise the issues raised by REACH colleagues. At UHN, the priority actions are:

1. We must get comfortable thinking, understanding, engaging & owning Rethinking Racism at every level, everyday
2. Look proactively for preventative/interventional methods for reducing racism rather than wait for individuals to raise concerns

3. Practical Steps supported by formal data to address causes rather than symptoms

The success of our WRES action plan and our tackling racism strategy requires:

- Cultural Transformation - To see the change that we would like to see, we needed to change our approach
- Allyship from the top and fairer share of power through our EDI Steering Group – not afraid of speaking truth to power
- Our Leaders don't just act as Exec Sponsors at staff networks/attend cultural events – we require them to demonstrate true proficiency through allyship

We plan to inform and educate colleagues through our Rethinking Racism Education Programme, support managers and leaders through toolkits and interventional mechanisms including compassionate conversations and continue with our ward walks to engage colleagues from our underreached groups. Our aim is to shift the current culture and improve the work experience for REACH Colleagues.

Risk and Implications

Tackling Racism continues to be a high priority within the NHS, the next steps in our organisational maturity would be to scale up the impact of our Tackling Racism Programme to make real sustainable cultural change through local leadership within individual teams. The expectation that success would be replicated driving positive change through diverse local leadership supported by the EDI team, staff networks and executive sponsors. This approach is necessary to integrate inclusive approaches to EDI that supports the wider health inequalities of both the workforce and community.

Recommendation(s)

The Boards are asked to note:

1. the improvement in KGH WRES scores whilst acknowledging the experience of our REACH colleagues is below the standard we consider acceptable.

2. the considerable amount of focus on improving the experience of colleagues of a REACH heritage with a focus on education to improve cultural competence, allyship and distributed leadership.

3. People Committee has approved the publication of the WRES report in line with the Public Sector Equality Duty

Appendix 1

Background and context to the Workforce Race Equality Standard; definitions, language and underpinning principles

- Implementing the WRES is a requirement for all NHS Commissioners and NHS Healthcare providers through the NHS Standard Contract

- Why WRES is important? - The WRES is a tool for identifying a number of key gaps, referred to as metrics, between White and Black Asian Minority Ethnic (BAME) colleague experience of the workplace - gaps which must be closed. The WRES demonstrates the organisation's clear commitment in developing KGH to be an exemplar employer and to support the UK Government's aims of increasing representation in the workplace to ensure employees from BAME backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

- WRES was mandated in 2015, following engagement and consultation with NHS organisations across England, the WRES was mandated through the NHS standard contract, starting in 2015/16.

- The 2022 WRES data report compares data from previous years to assess trends. NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BAME board members across the organisation.

- The first phase of the WRES focused on supporting the system to understand the nature of the challenge of workforce race equality and for leaders to recognise that it was their responsibility to help make the necessary changes. The next phase of the WRES will focus on enabling engagement through communications to build capacity and capability

- Our organisational workforce demographic continues to change with increases in overall number of colleagues from BAME background at all levels. This change of demographics needs reflection through improved representation in supervisory and management roles.

- Closing gaps will achieve tangible progress in tackling discrimination, promoting a positive culture and valuing all colleagues for their contributions to their work. This will in turn positively impact on patients, as it is known that a decrease in discrimination against REACH colleagues is associated with higher levels of patient satisfaction. An environment that values and supports the entirety of its diverse workforce will result in high quality patient care and improved health outcomes for all.

- Research and evidence such as that from Prof Michael West and Prof Jeremy Dawson has found that less favourable treatment of Black and minority ethnic (BME) colleagues in the NHS, through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by patients. West and Dawson assert "*The*

greater the proportion of staff from a Black or minority ethnic background who report experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction. The experience of BME staff is a very good barometer of the climate of respect and care for all within NHS Trusts"

- Questions about equality are asked differently at various stages of the employee journey:
    - When applying for a role at our hospitals through TRAC portal, to assure applicants that reasonable adjustments will be made available should they be invited to interview
    - On ESR portal, colleague can add a disability or health condition at any stage of their employment
    - Through the NHS Staff Survey

Appendix 2 UHN Antiracist Statement

NHS University Hospitals of Northamptonshire NHS Group

Our UHN Co-produced Antiracist Statement

At University Hospitals of Northamptonshire, we acknowledge that racism exists in our hospitals, and we take responsibility by taking action to reduce health & workplace inequalities. We work together to champion racial equity to ensure better experiences for our colleagues, patients, their families and the community we serve.

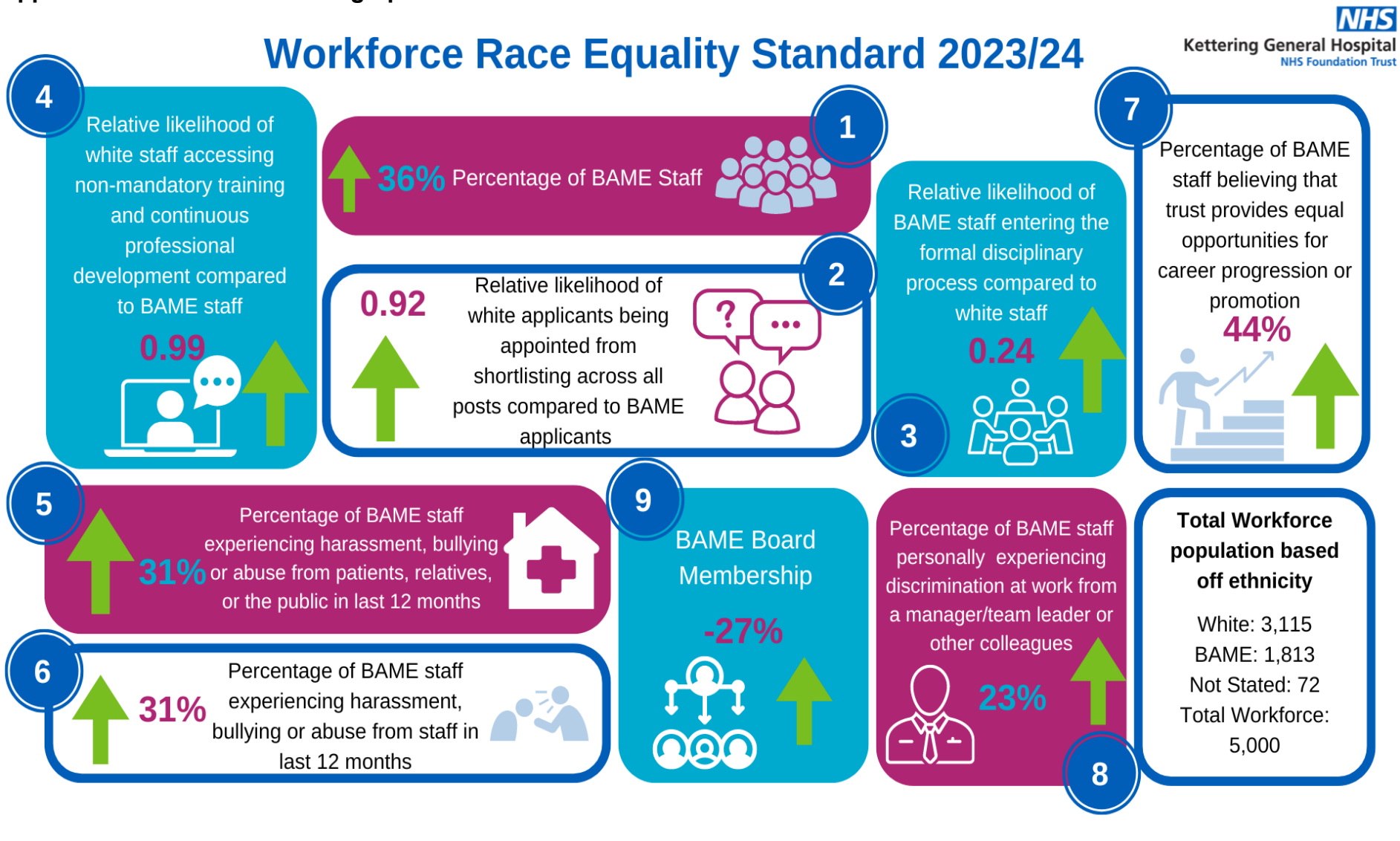
We recognise that tackling racial discrimination requires change from within our organisations. To make a difference, we are working to strengthen our staff networks and patient voice to remove barriers and provide safe care that we deliver through the diversity of thought, approach and culture of our colleagues

We do not tolerate racism, discrimination or violence of any kind and are committed to the wellbeing of our teams and patients. We aim to eliminate barriers across our organisations to build an inclusive workplace that reflects the community we serve. Our leadership will embrace diversity, call out discrimination and put equality at the heart of our service delivery.

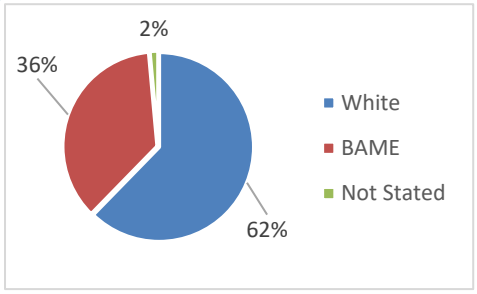
We prioritise and value the diversity of our people and are committed to having an inclusive culture that enables equal access to the best local healthcare and career development opportunities. Together with our teams, communities and partners, we will strive to improve the experience of our colleagues and patients to create a safe environment, where they feel listened to, understood and valued.

Dedicated to excellence

Appendix 3 WRES 2023-24 Infographics & Action Plan



Workforce Race Equality Standard (WRES) Data 2023-24



Percentage of staff members at KGH who are White, BME or have not stated their ethnicity.

Total Workforce = 5000
White = 3115
BME = 1813
Not stated = 72

AFC Bands

	White	BME	Not Stated
Bands 1-4	75.81%	22.66%	1.53%
Bands 5-7	57.07%	42.07%	0.86%
Bands 8A-VSM	85.00%	13.46%	1.54%

Medical & Dental

	White	BME	Not Stated
Consultants	30.33%	67.30%	2.37%
Senior Medical Manager	50.00%	50.00%	0%
Non-Consultant Career Grade	13.95%	83.72%	2.33%
Trainee Grades	13.51%	82.43%	4.05%

WRES Indicators

1. **Percentage difference between the organisations' Board voting membership and its overall workforce**
   BME -27%
   White 29%
   An improvement of 1% from the previous year
2. **0.92**
   An improvement of 2.55 in comparison to 2022/23
   Relative likelihood of White staff being appointed from shortlisting compared to
3. **0.24**
   Improvement of 0.95 since 2022/23
   Relative likelihood of BME staff entering the formal disciplinary process compared to White staff
4. **0.99**
   Improvement of 0.21 since 2022/23
   Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff
5. **BME 31%**
   White 25%
   5% improvement for BME staff
   Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
6. **Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last**
   BME 31%
   White 26%
   3% improvement for BME staff
7. **Percentage of staff believing the hospital provides equal opportunities for career progression or**
   BME 44%
   White 53%
   2% improvement for BME staff
8. **Percentage of staff who have personally experienced discrimination at work from Manager/Team leader**
   BME 23%
   White 9%
   3% improvement for BME staff and 1% deterioration for White staff
9.

What are we doing / plan to do within the hospital:

1. To streamline the Inclusive Recruitment Champion process to ensure that our recruitment and selection process is not only effective but also sustainable
2. To strengthen the RCN Cultural Ambassador programme to support REACH staff during formal and informal HR process to ensure a space/ atmosphere of safety, transparency and support that is offered to the staff.
3. Align FTSU and EDI compassionate walks and conversations to encourage REACH colleagues to seek early support or raise concerns in a psychologically safe environment.
4. Amplify REACH voice through a single UHN REACH network that supports REACH colleagues in all staff groups
5. Promote REACH Network Drop In Service to create a safe space for Network members to share feedback on activities or raise cultural issues/concerns to a respective Co-Chair of the Network in confidence. Provide support to those members who need it.
6. Roll out Tackling Racism Toolkit and create Rethinking Racism Education Programme and Microaggressions Toolkit to embed cultural change within organisation whilst creating a safe space for protected groups

Specific Board Actions:

1. Continue the Mentoring Programme and expand participants to other protected groups whilst retaining a significant percentage of REACH staff, Board Members to invite their mentor to Board to expand learning for all Board Members.
2. Commitment to support EDI Steering Group as our new assurance framework for colleagues
3. Inclusion of a protected group role model staff story at Board meetings so viewers in those groups can relate.
4. Expansion of Executive Sponsorship to include Non-Exec Directors as Sponsors for all Networks and continue to retain the engagement of the Exec Sponsors for the Networks.
5. Commitment to a Board Development Session to continue to focus on Diversity & Inclusion. To include Rethinking Racism Education Programme
6. Take supportive action to increase the diversity of the Board across the Group.

Cover sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	4th October 2024
Agenda item	12.4
Title	Workforce Race Equality Scheme (WRES): Report Northampton General Hospital (NGH)
Presenter	Paula Kirkpatrick, Chief People Officer
Author	Farhana Ahmedabadi-Patel, Diversity & Inclusion Specialist

This paper is for

Approval	☐ Discussion	☐ Note	X Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Group priority

☐ Patient	☐ Quality	X Systems & Partnerships	X Sustainability	X People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
• To receive the WRES progress report and action plan • To provide assurance to the Board on progress against the People Delivery Plan	People Committee approved the publication of the 2023/24 WRES report in its meeting of 26th September 2024

Executive Summary

This paper sets out the latest annual Workforce Race Equality Standard (WRES) report for Northampton General Hospital (NGH).

Risk and assurance

Mandated in the NHS contract and considered by the CQC
BAF ref: 001

Financial Impact

N/A

Legal implications/regulatory requirements

Public Sector Equality Duty

Equality Impact Assessment

The proposed action will promote equality of opportunity

Paper

Situation

This paper sets out the latest annual Workforce Race Equality Standard (WRES) metrics and report for Northampton General Hospital (NGH). While progress has been made in most areas, the results highlight the continued disparity of experience for our Race Ethnicity And Cultural Heritage (REACH) colleague. WRES report forms an integral driver of transformation in NGH's workforce commitment to inclusion. Appendix 1 provides background and context to the WRES.

A note on language: there has, and continues to be, much local and national debate regarding the terminology best employed to respectfully and accurately make reference to ethnicity. Both NHS England and WRES material use the term Black and Minority Ethnic (BME), following internal discussion it has been agreed that for the purposes of this report and future documentation we will use this terminology the term 'REACH colleague'. The term REACH replaces BAME/BME used nationally and is in line with the language used throughout WRES.

The data for WRES return has been sourced from Electronic Staff Records (ESR) as equality data is routinely gathered on a 'voluntary self-reporting' basis from colleague. Colleague declaration is therefore important in enabling the Trust to present a true and accurate picture of equality in the organisation and is based on self-reporting through ESR or the National Staff Survey.

Background

The Workforce Race Equality Standards (WRES) was introduced in 2015 and is designed to improve the experiences of REACH colleagues working in or seeking employment within the NHS. This mandated collection of evidence-based metrics helps to understand and address the disparities in experiences of our colleagues.

This report provides an overview of WRES, within NGH against the nine indicators set out in WRES. These nine WRES indicators depict metrics for:

- Four indicators focus on workforce data
- Four indicators are data from the national NHS Staff Survey
- One indicator focuses upon REACH representation on boards.

The data findings are presented on an infographic in Appendix 1 along with action plans agreed with the Race.

Assessment

In summary, there is an improvement in the position against six of the nine metrics since 2023:

Metric 1: staff in post by pay band
Metric 2: relative likelihood of being appointed from shortlisting.
Metric 5: percentage of staff experiencing harassment, bullying and abuse from patients, relatives or the public in the last 12 months.

Metric 6: percentage of staff experiencing harassment, bullying and abuse from staff.
Metric 7: percentage of BAME staff believing that the Trust provides equal opportunities for career progression or promotion
Metric 8: percentage of staff experiencing discrimination at work from manager or team

There has been a slight worsening in the position for two of the nine metrics:

Metric 3: relative likelihood of entering formal disciplinary investigation
Metric 4: relative likelihood of accessing non-mandatory training – however we have identified that non-mandatory clinical & non-clinical training predominantly for nursing & midwifery colleagues including Levelling Up is recorded on standalone systems and not on ESR from where the data for WRES is collated and as such review has commenced to strengthen our data collection.

There has not been any improvement in the position for one of the nine metrics:

Metric 9: BME representation at Board.

Progression for clinical REACH colleagues was a priority for improvement on the WRES. This is driven by the success of our international nurse recruitment programme which has led to an increase of REACH colleagues at Band 5, however, the rate at which REACH colleagues have commenced in roles within the Trust outpaces the rate at which they progress leading to an increasing race disparity ratio. Progression is affected by a range of factors including differences in cultural expectations, however we have overcome these and there are some good examples of local initiatives that have been taking place to support progression such as our UHN award winning Levelling Up programme, use of Inclusive Recruitment Champions (IRC) at interview panels for all posts Band 7 and above to support recruiting managers and debias the recruitment process for senior roles.

REACH Staff Network

The Trust has and continues to take action to ensure the voices of REACH colleagues are heard and acted upon by continuing to support the REACH Network to grow and develop. The network has an active involvement in the WRES action plan alongside their own priorities, with the support of Palmer Winstanley as their executive sponsor.

REACH network continues to support new internationally educated colleagues through the Shared Decision Making Council (SDMC) by giving them an opportunity to connect within and across cultures. A support framework is established which encourages colleagues to share stories in a safe space, where colleague feel comfortable and confident. SDMC & REACH network provide a supportive framework for Internationally Educated Nurses & Midwives (IENMs) by offering them career development conversations along with a range of cultural celebration events both within UHN and with the wider Northamptonshire community.

The network's focus for the next 12 months is to work with NGH REACH Network to create a single UHN REACH Network led by co-chairs from both NGH & NGH. The network plans to drive some positive changes with the support from the EDI Team to:

- Formulate & strengthen the new UHN Single REACH Staff Network
- Continue working with Exec Sponsors to challenge race based discrimination
- Support the delivery of Rething Racism Education Programme
- Continue with Career & Leadership Development (mentoring, Levelling Up)

Tackling Racism at UHN

Between September-December 2023, EDI Team ran several engagement sessions to listen to all our stakeholders which included NEDs, colleagues, volunteers and governors. Data from these sessions was collated and presented to stakeholders to define the framework of our Tackling Racism Strategy. Collaboration between REACH Network and EDI Team has resulted in the production of:

1. UHN Antiracist Statement (Appendix 2)
2. designing UHN's Tackling Racism Strategy
3. drafting the Rethinking Racism Education Programme
4. Extended Annual Leave Guidance
5. Tackling Racism Toolkit
6. Supporting 2 newly appointed KGH REACH Network co-chairs to strengthen KGH REACH Network and open avenues for collaborative working

In February 2024, during Race Equality Week, we launched UHN's Tackling Racism Plan, this coincided with the release of Roger Kline & Joy Warmington's 'Too hot to Handle Report' highlighting racism in NHS organisations. The report findings served to confirm our own internal findings and highlighted the need to address the micro incivilities and covert racism in the form of assumptions, stereotypes and biases that often minimise the issues raised by REACH colleagues. At UHN, the priority actions are:

1. We must get comfortable thinking, understanding, engaging & owning Rethinking Racism at every level, everyday
2. Look proactively for preventative/interventional methods for reducing racism rather than wait for individuals to raise concerns
3. Practical Steps supported by formal data to address causes rather than symptoms

The success of our WRES action plan and our tackling racism strategy requires:

- Cultural Transformation - To see the change that we would like to see, we needed to change our approach
- Allyship from the top and fairer share of power through our EDI Steering Group – not afraid of speaking truth to power
- Our Leaders don't just act as Exec Sponsors at staff networks/attend cultural events – we require them to demonstrate true proficiency through allyship

We plan to inform and educate colleagues through our Rethinking Racism Education Programme, support managers and leaders through toolkits and interventional mechanisms including compassionate conversations and continue with our ward walks to engage colleagues from our underreached groups. Our aim is to shift the current culture and improve the work experience for REACH Colleagues.

Risk and Implications

Tackling Racism continues to be a high priority within the NHS, the next steps in our organisational maturity would be to scale up the impact of our Tackling Racism Programme to make real sustainable cultural change through local leadership within individual teams. The expectation that success would be replicated driving positive change through diverse local leadership supported by the EDI team, staff networks and executive sponsors. This approach is necessary to integrate inclusive approaches to EDI that supports the wider health inequalities of both the workforce and community.

Recommendation(s)

The Boards are asked to note:

1. the improvement in NGH WRES data showing an improvement in the experience of our REACH colleagues and the leadership provided by the REACH network.

2. our ongoing commitment to tackling racism

3. People Committee has approved the publication of the WRES report in line with the Public Sector Equality Duty

Appendix 1

Background and context to the Workforce Race Equality Standard; definitions, language and underpinning principles

- Implementing the WRES is a requirement for all NHS Commissioners and NHS Healthcare providers through the NHS Standard Contract

- Why WRES is important? - The WRES is a tool for identifying a number of key gaps, referred to as metrics, between White and Black Asian Minority Ethnic (BAME) colleague experience of the workplace - gaps which must be closed. The WRES demonstrates the organisation's clear commitment in developing NGH to be an exemplar employer and to support the UK Government's aims of increasing representation in the workplace to ensure employees from BAME backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

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- The first phase of the WRES focused on supporting the system to understand the nature of the challenge of workforce race equality and for leaders to recognise that it was their responsibility to help make the necessary changes. The next phase of the WRES will focus on enabling engagement through communications to build capacity and capability

- Our organisational workforce demographic continues to change with increases in overall number of colleagues from BAME background at all levels. This change of demographics needs reflection through improved representation in supervisory and management roles.

- Closing gaps will achieve tangible progress in tackling discrimination, promoting a positive culture and valuing all colleagues for their contributions to their work. This will in turn positively impact on patients, as it is known that a decrease in discrimination against REACH colleagues is associated with higher levels of patient satisfaction. An environment that values and supports the entirety of its diverse workforce will result in high quality patient care and improved health outcomes for all.

- Research and evidence such as that from Prof Michael West and Prof Jeremy Dawson has found that less favourable treatment of Black and minority ethnic (BME) colleagues in the NHS, through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by patients. West and Dawson assert "*The*

greater the proportion of staff from a Black or minority ethnic background who report experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction. The experience of BME staff is a very good barometer of the climate of respect and care for all within NHS Trusts"

- Questions about equality are asked differently at various stages of the employee journey:
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Appendix 2 UHN Antiracist Statement

Our UHN Co-produced Antiracist Statement

NHS University Hospitals of Northamptonshire NHS Group

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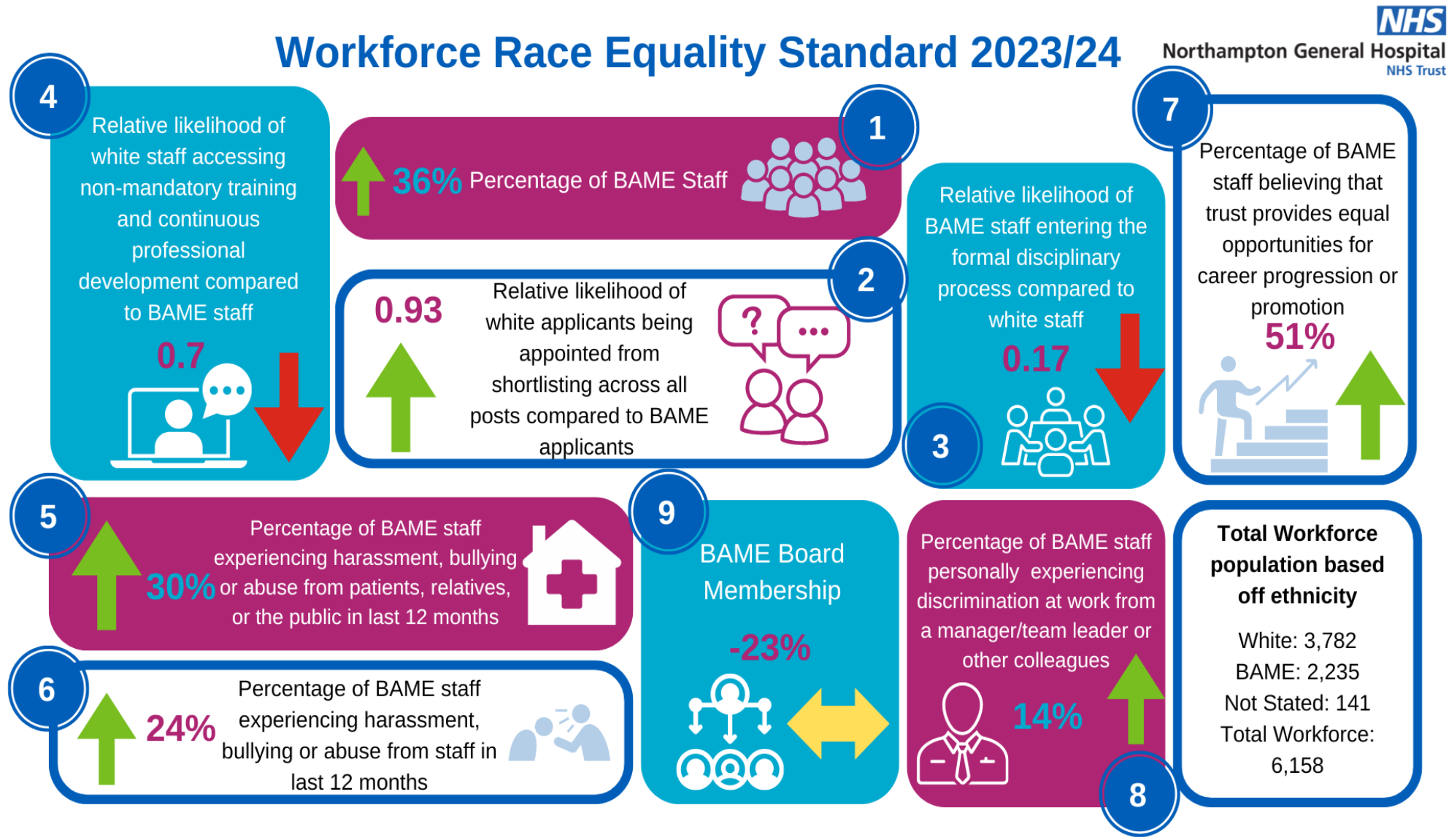
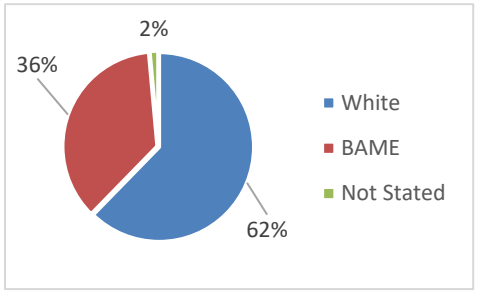
Dedicated to excellence

Appendix 3 WRES 2023-24 Infographics & Action Plan



Workforce Race Equality Standard (WRES) Data 2023-24



Percentage of staff members at NGH who are White, BME or have not stated their ethnicity.

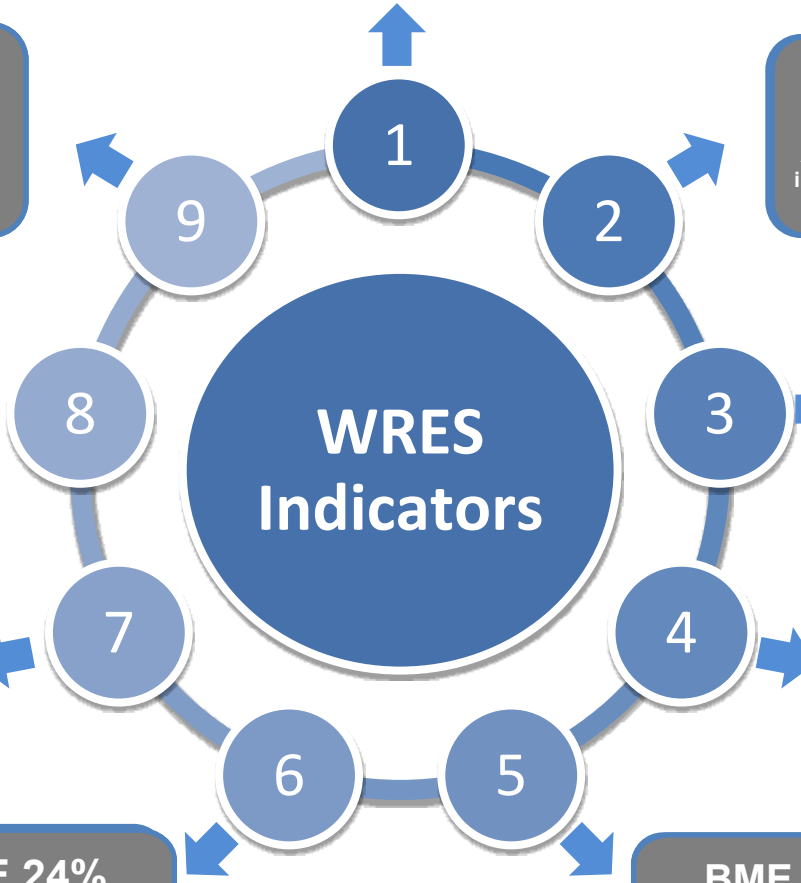
Total Workforce = 6158
White = 3782
BME = 2235
Not stated = 141

AFC Bands

	White	BME	Not Stated
Bands 1-4	74.38%	23.54%	2.08%
Bands 5-7	56.35%	41.33%	2.32%
Bands 8A-VSM	81.09%	17.95%	0.96%

Medical & Dental

	White	BME	Not Stated
Consultants	42.96%	54.93%	2.11%
Senior Medical Manager	33.33%	33.33%	33.33%
Non-Consultant Career Grade	15.60%	80.73%	3.67%
Trainee Grades	21.71%	73.64%	4.65%



1. **0.93** — An improvement of 0.03 in comparison to 2022/23 — Relative likelihood of White staff being appointed from shortlisting compared to
2. **0.17** — Deterioration of 0.3 since 2022/23 — Relative likelihood of BME staff entering the formal disciplinary process compared to White staff
3. **0.7** — Deterioration of 0.27 since 2022/23 — Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff
4. **BME 30% White 26%** — 2% improvement for BME staff — Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
5. **BME 24% White 25%** — 6% improvement for BME staff — Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last
6. **BME 51% White 56%** — 11% improvement for BME staff — Percentage of staff believing the hospital provides equal opportunities for career progression or promotion
7. **BME 14% White 9%** — 5% improvement for BME staff and 1% deterioration for White staff — Percentage of staff who have personally experienced discrimination at work from Manager/Team leader
8. **BME -23% White 25%** — Unchanged from the previous year — Percentage difference between the organisations' Board voting membership and its overall workforce

What are we doing / plan to do within the hospital:

1. To streamline the Inclusive Recruitment Champion process to ensure that our recruitment and selection process is not only effective but also sustainable
2. To strengthen the RCN Cultural Ambassador programme to support REACH staff during formal and informal HR process to ensure a space/ atmosphere of safety, transparency and support that is offered to the staff.
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Specific Board Actions:

1. Continue the Mentoring Programme and expand participants to other protected groups whilst retaining a significant percentage of REACH staff, Board Members to invite their mentor to Board to expand learning for all Board Members.
2. Commitment to support EDI Steering Group as our new assurance framework for colleagues.
3. Inclusion of a protected group role model staff story at Board meetings so viewers in those groups can relate.
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5. Commitment to a Board Development Session to continue to focus on Diversity & Inclusion. To include Rethinking Racism Education Programme
6. Take supportive action to increase the diversity of the Board across the Group.

Cover sheet	
Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	4th October 2024
Agenda item	13
Title	UHN Freedom to Speak Up (FTSU) Report Quarter 1 24/25 and Data Comparison with the National Guardian's Office 23/24 Report
Presenters	Susan Clennett, FTSU Guardian (KGH) Jane Sanjeevi, FTSU Guardian / Luke Sullivan, FTSU Guardians (NGH)
Author	As above

This paper is for			
Approval	X Discussion	Note	X Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Group priority				
X Patient	X Quality	Systems & Partnerships	Sustainability	X People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
To discuss themes and required actions to further improve the Boards' involvement in FTSU to continuously develop a positive culture across UHN. To be assured on the work of the FTSU Guardians to support staff to speak up and organisational improvements.	The report was considered by the People committee in July 2024.

Executive Summary

The quarter 1 24/25 report highlights:

- Learning and actions taken to support staff;
- Comparison with the NGO 23/24 Annual Report, in terms of percentage of concerns received, shows UHN reports more than the national rate of concerns relating to inappropriate behaviour, worker safety (more prominent at NGH), patient safety/quality and significantly more concerns received anonymously (mostly at KGH – NGH anonymous reporting tool developed in qtr 1 24/25). There are fewer concerns relating to bullying and harassment. Nursing staff continue to be the prominent staff group speaking up, mirrored in the NGO report;
- A combined reflection and planning tool will be considered by the October 2024 People Committee;
- Feedback to the Guardians continues to be positive.

Appendices

Report

Risk and assurance
As detailed in the 2023 Staff Survey, staff report a lack of confidence that speaking up will result in improvements/changes. More work is required to promote the benefits of speaking up and sharing learning. October Speaking Up Month promotions are planned, together with a recording of a staff story around experiences of speaking up.
Financial Impact
None
Legal implications/regulatory requirements
A positive speaking up culture is part of CQC Well Led requirements.
Equality Impact Assessment
Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? More work is planned to improve confidence in speaking up Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? No – assurance not decision item.

University Hospitals of Northamptonshire

Freedom to Speak Up Report: Q1 2024/25

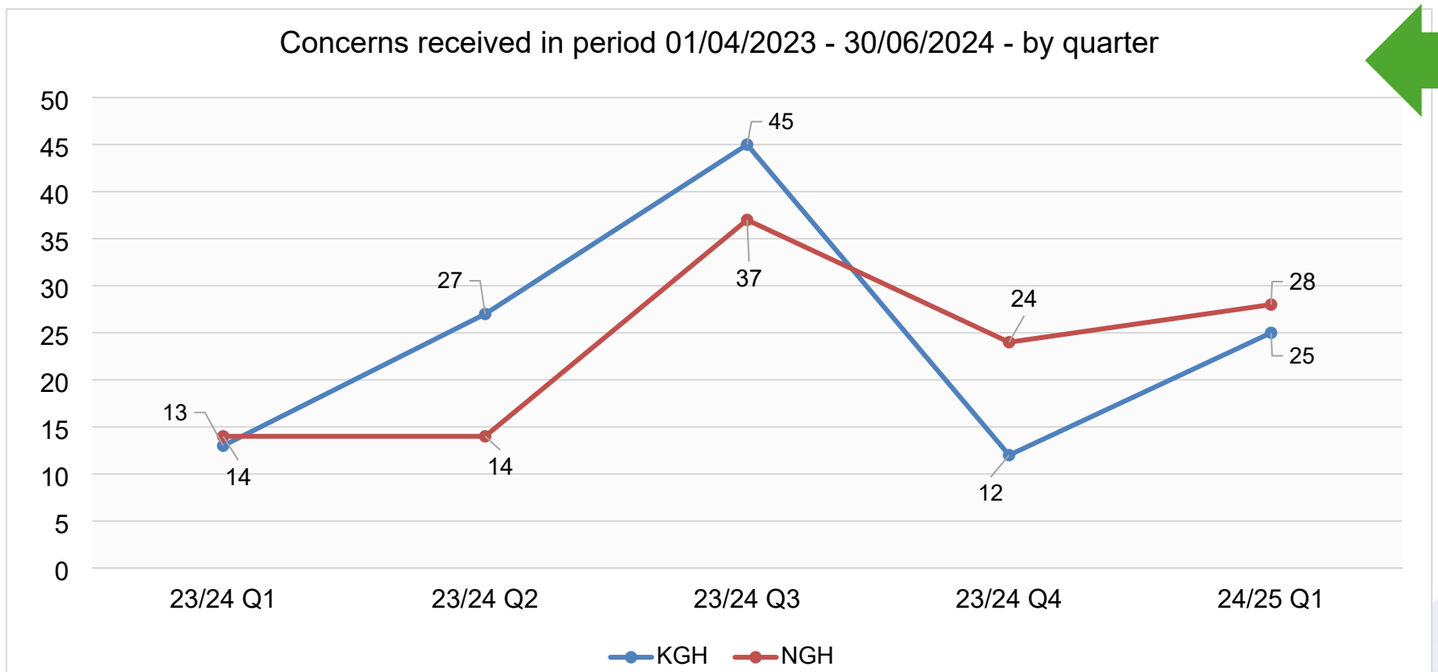
Including 23/24 Annual Comparisons with NGO Annual Report

Authors: Susan Clennett - FTSU Guardian, KGH

Jane Sanjeevi - FTSU Guardian, NGH

Luke Sullivan - FTSU Guardian, NGH

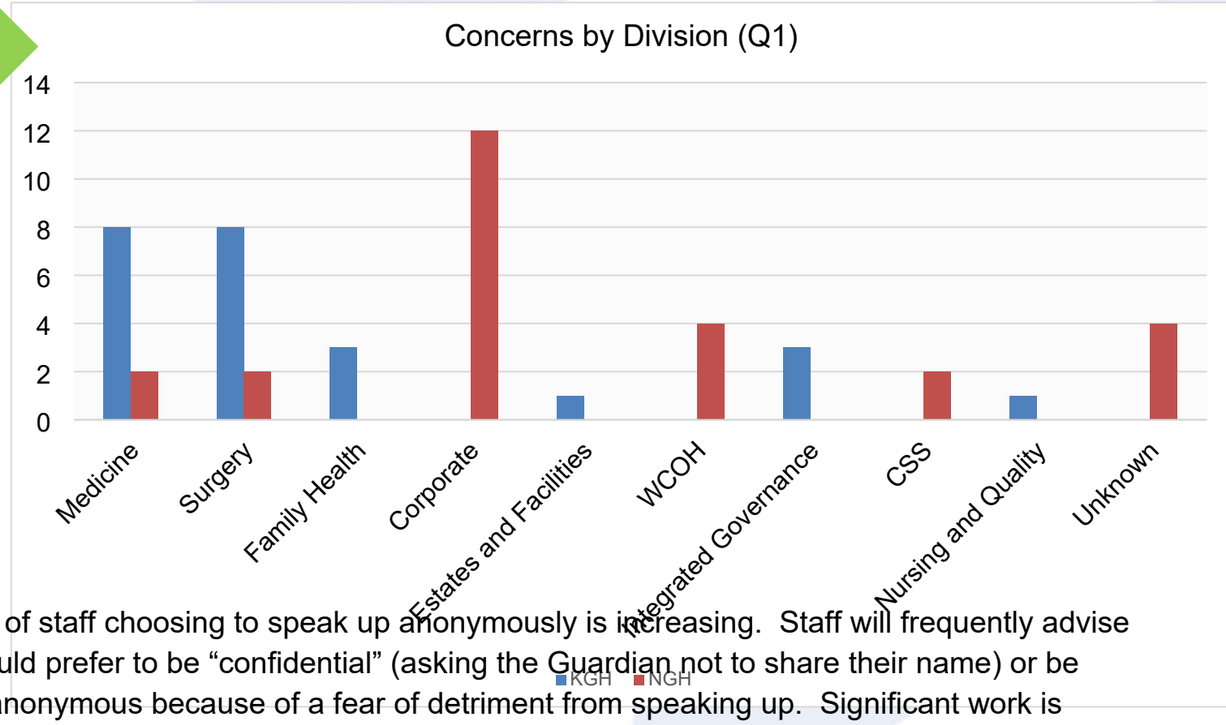
Freedom to Speak Up Overview

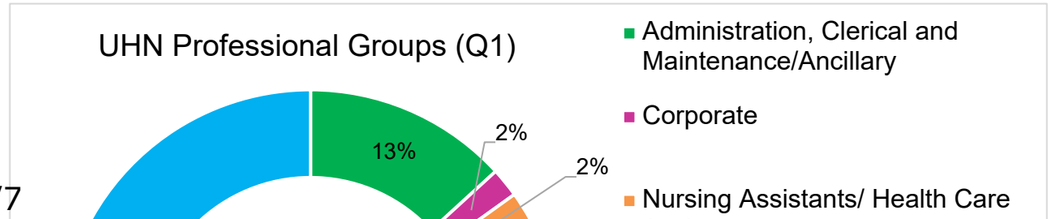


What is the data telling us?

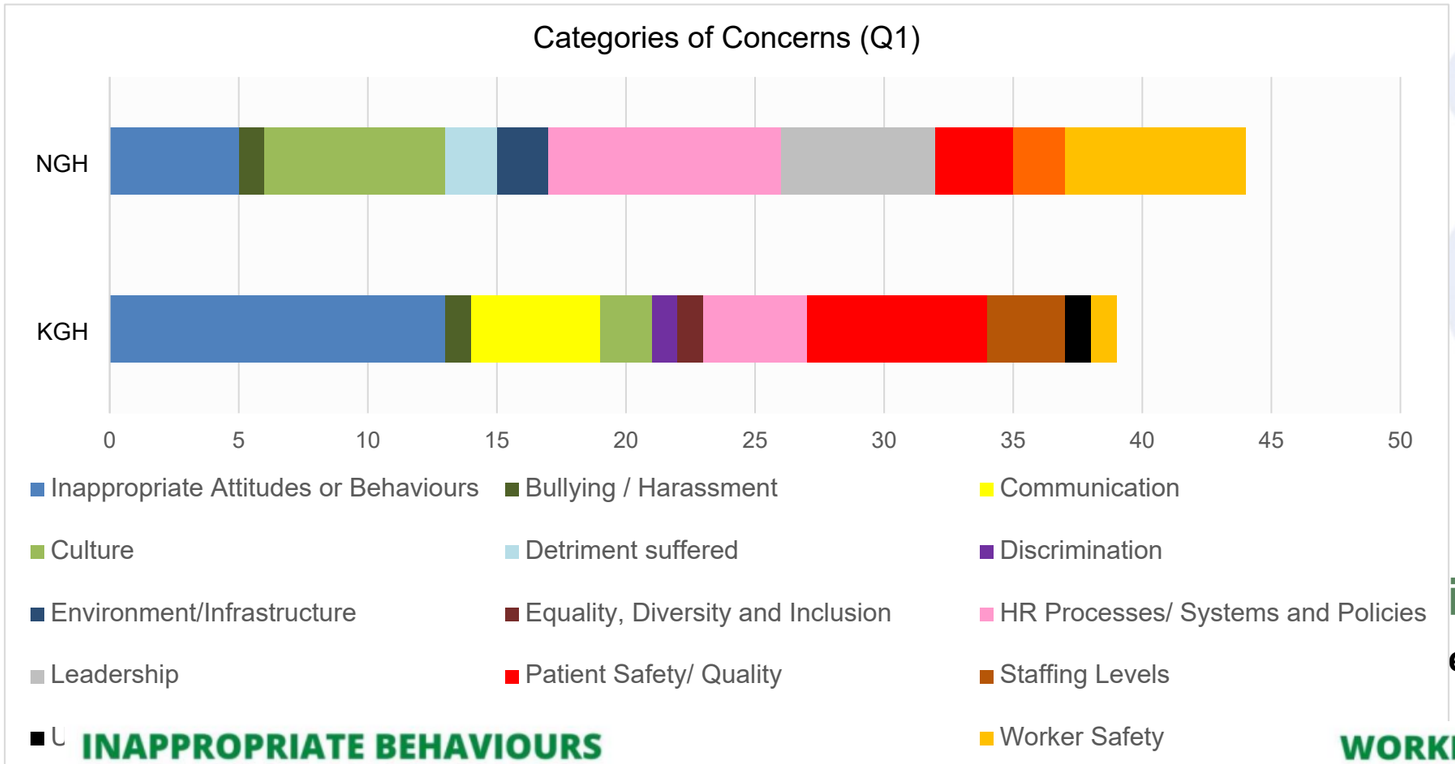
- The sharp increase in concerns for Quarter 3 23/24 (KGH) is the result of a group of nursing staff from one ward speaking up about the lack of communication around the urgent evacuation of the ward due to the present of RAAC (reinforced autoclaved Aerated Concrete) safety risks. This group of staff also felt that they had been singled out for evacuation due to their ethnicity rather than safety (viewing it as another ward move for managing capacity);
- The increase in concerns for Quarter 3 23/24 (NGH) is linked to speaking up month promotions.

- Concerns reported under 'Corporate' (NGH) increased in this period due to lots of estates issues around parking, smoking being raised, as well as queries around policy and very overarching concerns about the organisation as a whole;
- 'CSS' for NGH has services that come under 'Family Health' at KGH. Work has commenced to align the clinical services for future reports.
- The 'unknown' category at NGH relates to staff who have made contact but do not wish to pursue their concerns.





- The number of staff choosing to speak up anonymously is increasing. Staff will frequently advise that they would prefer to be "confidential" (asking the Guardian not to share their name) or be completely anonymous because of a fear of detriment from speaking up. Significant work is required across the organisation to instil confidence in the value of speaking up and that this will not be viewed negatively or result in detriment to their work environment or career development;



- Categories of concerns by division will often exceed the number of staff speaking up and this is because staff will usually raise several issues when speaking up. For example, a colleague may speak up about a problem with a policy and also how their manager has behaved when they have tried to discuss this with them (the categories of policy and behaviours will be used);
- Guardians will be working to align the categories across UHN.

ith UHN for 23/24

e at KGH and 3% decrease at NGH)

INAPPROPRIATE BEHAVIOURS

Two in every five cases (38.5%) involved an element of inappropriate behaviours and attitudes.

WORKER SAFETY AND WELLBEING

One in every three cases raised (32.3%) involved an element of worker safety or wellbeing.

61% across UHN with similar levels reported at both sites
More than the national rate

39% across UHN. A more prominent concern in NGH compared to KGH

Slightly more than national rate

PATIENT SAFETY AND QUALITY

18.7% of cases raised included an element of patient safety/quality

a marginal drop compared to 2022/23 (19.4%).

39% across UHN. For KGH, the second largest category and at NGH the lowest category. More than the national rate

BULLYING AND HARRASSMENT

19.8% of cases reported included an element of bullying or harassment.

A 2-percentage point fall compared to 2022/23.

15% across UHN with an almost equal split between sites. Less than the national rate

ANONYMOUS CASES

The percentage of cases which were raised anonymously is ten percent (9.5%).

This was similar to the percentage raised anonymously in 2022/23 (9.4%).

16% across UHN with the majority of anon cases at KGH
More than national rate. NGH did not have established system for anon concerns until 24/25 year

PROFESSIONAL GROUPS

Workers from a range of professional groups spoke up to Freedom to Speak Up Guardians.

Nurses and midwives accounted for the biggest portion (28.3%) of cases raised.

The bigger proportion at UHN was also nurses and midwives at 37% with a higher number at KGH. More than the national

*Work is planned to triangulate staff survey themes with the group speaking up themes

Developments

Collaboration

Our NGH report on speaking up details the joint work that has commenced so that UHN can work to a single Speaking Up Strategy, reporting tools and style and service for staff who wish to speak up. Best practice in speaking up culture is continually sought and during June 24, the UHN Guardians met with South Warwickshire University NHS Foundation Trust and George Elliot NHS Trust. Collaboration with Guardians at UHL has taken place with further meetings arranged. It is reassuring that the Trusts external to UHN/UHL have similar practices/initiatives for speaking up although the development of an App for staff to use is something that UHN will explore further as we bring our data tools together. Joint cover across sites is also being explored.

Speaking up reflection planning tool

The deadline of January 2024 for KGH was missed due to FTSU staffing constraints and this is being completed during quarter 2 24/25. This will be compared with the NGH completed reflection and planning tool to inform developments required of not just Guardians but senior leaders across the organisation in order to improve capability and culture improvements. A combined reflection and planning tool will be considered by the October 2024 People Committee.

Engagement

As a result of close working with the Senior Diversity and Inclusion Specialist across the UHN Group, Guardian attendance at staff networks has been secured. Joint visits to departments and clinical areas has also commenced with planned dates secured throughout the year. Separate presentations to staff groups also take place by the Guardian and there is clear evidence that this gives staff the confidence to speak up. The paediatric inpatient ward staff spoke up following a visit to the ward and where speaking up was promoted. Leaders are also now starting to invite the Guardian onto training days; Therapies Leadership Day, Pharmacy Team Speaking Up Awareness Session and CYP Medical Staff Education Session.

Communication plan

This plan is vital for continuous improvement in development of our speaking up culture and formed part of the KGH Speaking Up Strategy. This will be developed for UHN as part of the collaborative work across both sites. During quarter 1, cross site executive briefings to all staff have included discussions on the value of speaking up.

A draft “Manager’s Handbook” will be reviewed for consideration of use across UHN. We are currently working on a pop-up banner, leaflets and business cards to use when attending FTSU events and on walkarounds to raise awareness about FTSU and provide important information and contacts for speaking up at UHN.

Learning a peaking Up

Across KGH a r ons have taken place during the quarter, as a direct result of staff speaking up:

- A member vigate/understand the flexible working application process and how to utilise the appeal process. This also supported learning for the manager involved;
- Decluttering of storage rooms in clinical areas reduced the risk of health and safety related accidents;
- Assurance provided on the senior oversight of paediatric patient assessments in ED via a ED Registrar specific to paediatrics;
- A number of supportive interventions have taken place to improve working relationships and in some cases, the HR team has supported this;
- A manager and Staff Bank Manager were able to intervene with a bank member of staff who was reported to be disrespectful/uncompassionate to a patient;

- Improved communication and understanding of business continuing plans between interventional nursing teams and operational radiology managers;
- A manager was helped to understand the value of their team member reporting into Datix, potential health and safety risks associated with sharps disposals;
- During April 2024, visa restrictions for some staff were made more stringent, resulting in some staff already in the recruitment process having offers of employment withdrawn. This caused significant distress to two candidates who were planning to move from nursing roles to corporate patient safety roles. Learning actions included:
  - Education sessions for the People Team on the new visa regulations;
  - Levelling Up Programme and REACH Network information to raise awareness around visa restrictions/rules;
  - Future job adverts will clearly state roles where visa restrictions apply;
  - Improvement on the standard of compassionate communications with staff when job offers are being withdrawn.
- Organisational development intervention within a team;
- Senior clinical reflection on behaviours and how communications at times of urgent patient interventions can negatively impact on team members and patient experience.
- QI support accessed within a team to redesign required structure within budget.

A number of open cases at NGH has delayed identification of learning for the quarter.

Staff stories/experience of speaking up are being collated with a plan to launch a recording of a member of staff describing her experience of speaking up and improvements made.

Freedom to Speak Up – Feedback

Return of feedback forms following resolution of concerns raised, remains limited. New ways of seeking feedback are being explored across UHN. Staff seem to prefer to send individual emails expressing their appreciation (or negative experience), but this does not allow for diversity and inclusion monitoring.

Some feedback received during quarter 1 included:

‘Thank you, for all your support with this’

“Concern was acted on very quickly”

‘Thank you so much Susan for your effort to support us’

‘First and foremost, I'd like to thank you for responding to our problem so quickly and providing us with the assistance we needed’

“I was taken seriously and confidentially; I think this is an important facility to maintain for all staff”

‘Thanks so much for your support throughout this process’

‘I felt you listened to us and understood our struggle’

KEY: **KGH**
NGH

Cover sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	4 October 2024
Agenda item	14

Title	Board Assurance Framework (BAF)
Presenter	Richard Apps, Director of Corporate and Legal Affairs
Author	Debbie Spowart, Head of Risk

This paper is for			
☐Approval	☐Discussion	☐Note	☑ Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Group priority				
☑Patient	☑Quality	☑Systems & Partnerships	☑Sustainability	☑People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
To provide assurance of relationship between the Group Board Assurance Framework (BAF) and the Corporate significant risks at both Kettering General and Northampton General Hospitals.	Previously considered by relevant committees in common during September 2024 and Boards in June 2024.

Report

This report provides oversight of the Group Board Assurance Framework at 16th September 2024 and the relationship between the strategic risks on the Group BAF and the significant risks contained on the Corporate Risk Registers at both Kettering General (KGH) and Northampton General Hospitals (NGH) that potentially impact on the BAFs strategic risks.

Risk Management is both a statutory requirement and an indispensable element of good management and is a fundamental part of the total approach to quality, corporate and clinical governance and is essential to the Trusts abilities to discharge its functions as a partner in the local health & social care community, as a provider of health services to the public and an employer of significant numbers of staff.

To ensure best practice in good governance, and to reach an outstanding rating under the CQC well-led domain, the Trust must demonstrate delivery of best practice and performance in risk

management.

Each assigned BAF monitoring committee received the Group BAF in September 2024 alongside the associated significant corporate risks from each hospital.

Following Executive reviews, the following changes were made:

- UHN01 - Updates to further planned actions across all existing controls. New gaps in assurances detailed at L1,5 and 6. No change to risk score.
- UHN02 – No changes were made during this review. Wider work on the UHN Clinical Strategy is planned to commence in Q4.
- UHN03 – Updates to further planned actions and reduction of some controls that were no longer relevant. Extension to some further planned action dates and change of action owner. No change to risk score
- UHN04 – Changes were made to action owners
- UHN05 – Completion of further planned actions on L1,2, 3 and 6. New actions added to L3. Change made to action owner and new due date on L5.
- UHN06 – No changes made in this review. The risk will be further reviewed in Q4 once the UHL:UHN Director of Research and Innovation has commenced in post and Corporate structures across UHN relating to professional education programmes are aligned.
- UHN07 - Updates to further planned actions on L1 and 2 and completion of further planned action on L3. Control gaps added at L2. No change to risk score.
- UHN08 – Updated further planned actions at L1,2 and L3. Further planned action achieved on L4. Further planned actions added to L8. Risk score increased from 16 to 20

Appendix A details the group BAF and Appendix B details the alignment of significant corporate risks at both KGH and NGH @ 25th September 2024.

In line with good governance, deep dives of BAF Risks UHN02 and UHN03 were completed in July 2024.

Appendices

Appendix A – UHN Group BAF @ 25/09/2024

Appendix B – Alignment of significant corporate risks at both KGH and NGH @ 16/09/2024

Risk and assurance

As set out in the report.

Financial Impact

Financial risks are detailed within the BAF

Legal implications/regulatory requirements

Duty to identify and manage risks / CQC Well-Led

Equality Impact Assessment

Neutral

Group Board Assurance Framework

25th September 2024

University Hospitals of Northamptonshire NHS Group

Ref	Group Priority	Scrutinising Committee	Risk Title	Initial Risk Level (July 2022)	Current Risk Level (August 2024)	Movement (from Initial)	Residual Risk Level	Risk Appetite	Date Last Reviewed	Summary Updates
UHN01	People	Group People Committees in Common	Challenges in our ability to attract, recruit, develop and retain colleagues means we are unable to deploy the right people to the right role at the right time resulting in potential detriment to patient care.	**16**	**16**	→	**12**	**Moderate**	Q3 (Sept 2024)	Updates to further planned actions across all existing controls. New gaps in assurances detailed at L1, L5, L6. No change to risk score.
UHN02	Quality	Quality Safety Committee in Common	Failure to deliver the UHN Clinical Strategy and clinical collaboration may result in some areas of clinical and financial unsustainability	**12**	**16**	↑	**8**	**Low**	Q3 (Sept 2024)	No changes were made during this review
UHN03	Patient	Quality Safety Committee in Common	Failure to deliver the group Nursing, Midwifery and Allied Health Processionals (NMAHP) Strategy may result in inequity of clinical voice, failure to become a truly clinically led organisation and centre of excellence for patient care	**12**	**12**	→	**8**	**Low**	Q3 (August 2024)	Updates to further planned actions and reduction of some controls that were no longer relevant. Extension to some further planned action dates and change of action owner. No change to risk score.
UHN04	Systems and Partnership	Operational Performance Committee	Failure of the Integrated Care Board (ICB) to deliver transformed care will result in an impact on the quality of service provided across the Group	**16**	**16**	→	**12**	**High**	Q3 (Sept 2024)	Updates to the further planned actions owners on L1 and L2
UHN05	Sustainability	Finance and Investments Committee in Common	Risk of failing estate buildings and infrastructure due to age and suitability and, failure to deliver Group strategic estates plans, may prevent delivery of key Group strategies, eg Clinical Strategy	**12**	**12**	→	**6**	**High**	Q3 (Sept 2024)	Completion of further planned actions on L1, L2, L3 and L6. New actions added to L3. Change made to action owner and new due date on L5.
UHN06	Quality	Quality Safety Committee in Common	Failure to deliver the long-term Group Academic Strategy may result in University Hospitals Northamptonshire's (UHN) ability to attract high calibre staff and research and education ambitions. Recognition of impact on financial income to the Group	**12**	**12**	→	**4**	**Low**	Q3 (Sept 2024)	No changes made in this review. The risk will remain the same until the restructure of the group services is completed.
UHN07	Quality	Quality Safety Committee in Common	Failure to deliver the Group Digital Strategy may result in our staff and patients not having the tools or information they need to deliver, and receive safe, high quality patient care.	**16**	**16**	→	**16**	**High**	Q3 (Sept 2024)	Updates to further planned actions on L1, L2 and completion of further planned action on L3. Control gaps added at L2. No change to risk score.
UHN08	Sustainability	Finance and Investments Committee in Common	Failure to deliver a Group Medium Term Financial Plan results in an inability to deliver Trust, Group and system objectives.	**16**	**20**	↑	**12**	**High**	Q3 (Sept 2024	Updated further planned actions at L1, L2, L3. Further planned action achieved on L4. Further planned actions added to L8. Risk score increased to 20.

Principal Risk No:	UHN01	Risk Title:	Challenges in our ability to attract, recruit, develop and retain colleagues means we are unable to deploy the right people to the right role at the right time resulting in potential detriment to patient care.
		Materialising in [any/several] of the following circumstances:	The Group People Committee will determine circumstances in which it considers the risk to have materialised, having regard to key qualitative and quantitative evidence including: (1) Sustained declines in Staff and People Pulse Survey key indicators in respect of response rates, discrimination and advocacy (2) Key metrics relating to sickness absence, turnover, vacancies and statutory and mandatory training/appraisal completions in special cause variation for at least three consecutive reporting periods (3)Key metrics relating to safe staffing in special cause variation for at least three consecutive periods (4)Customer experience performance/concerns referred from quality committees (5) Cumulative qualitative and anecdotal evidence identified in the course of business-as-usual activities e.g. Non-Executive site visits/presentations to Committee/regular communication mechanisms. (6)Corporate Risks (below) materialise.

Date Risk Opened:	April 2021	Date last reviewed	September 2024	Risk Classification:	Operational / Infrastructure	Risk Owner:	Group Chief People Officer	Scrutinising Committee:	People Committees in common

Corporate Risk Register Links:			
NGH CRR:	NGH46 - Detrimental staff wellbeing and mental health including self-harm and suicide (Current risk score 20) NGH47 - HCSW Retention (Current risk score 16) NGH49 - Staff Morale (Current risk score 16)	KGH CRR:	KCRR017 - Organisational challenge in relation to staffing with the potential to impact negatively on patient experience and outcomes (Current risk score 16) KCRR069 – Management of V&A incidents to staff and impact on staff well-being (Current risk score 15)

Initial Risk Score		Current Risk Score		Residual Risk Score		Risk Appetite
16 (Extreme)		16 (Extreme)		12 (High)		Moderate
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	4	4	4	4	3	People

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
1	Culture, Leadership & Inclusion programme including Leadership Programme	National Staff Survey staff engagement and morale scores reviewed by People Committee (Internal) Anti- racism plan (Internal) UHN Anti-racism statement (Internal) Board Development session delivered compassionate inclusive leadership with commitment to individual EDI objectives Numbers completing leadership training & impact assessment reported to People Committee (Internal) National Staff Survey staff engagement and morale scores reported to People Committee (Internal) Appraisal completion rates reported to People Committee (Internal)	Delivery of staff survey 2024. . No advanced leadership programme	Central oversight of actions to improve colleague experience Rethinking Racism education programme not fully developed	Delivery of staff survey engagement campaign 2024 Development of approach to share staff survey outcomes as soon as known and support improvement planning Delivery of Rethinking Racism programme and associated toolkits being embedded across UHN Develop Advanced leadership programme	Culture Lead Inclusion Lead Head of People Development	30.11.2024 31.12.2024 31.03.2025 31.03.2025
2	Attraction and Resourcing Strategy, including international recruitment and Agency Transformation Programme	KPIs to identify whether risk is being realised: Vacancy rates, Turnover rates, Time to Hire, Agency Spend reported to People Committee (Internal)	Challenges recruiting shortage groups Time to Hire - process improvements required supported by digital enhancements		Targeted improvement programme to address high agency/bank use, growing worked WTE Recruitment and onboarding workstream to deliver improvements in TTH, onboarding experience and process efficiency, including automation	Head of People Planning/Process	31.03.2025 30.10.2024
		Early adopter trial collaborative bank (internal)	Requirement for UHN induction programme		Develop induction in line with national programme of work	Head of People Development	31.12.2024
		Aligned bank rates and enhanced/escalated rates (internal)	ESR functionality constraints and different use on both sites		ESR working group to develop plan for increasing and aligning functionality and self service	Head of People Planning/Process	31.12.2024
		Temporary staffing hub governance processes at NGH (internal)					
		DBS recheck process commenced in NGH (internal)	Aligned approach to DBS recheck funding		Complete DBS harmonisation by introducing Trust pays across UHN	Head of People Planning/Process	31.03.2025
		Recruitment and onboarding transformation scoping stage complete and workstreams developed (Internal)					
		Agency spend (WTE, % pay bill above cap and off framework) reported to Finance Committee and People Committee (Internal) and ICB Financial Recovery Board (external)					

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
2			Single UHN approach to international Doctor recruitment and pastoral programme and consistent on boarding programme for international medical recruits		Develop Group Induction Pack for IMGs and pastoral programme	Head of People Planning/Process	31.03.2025
			Challenge in ability to attract and retain and engage Jnr/middle grade doctors		Develop and implement improving working lives for Jnr Doctors national programme	Head of People Planning/Process	31.03.2025
		National Staff Survey morale score reported to People Committee (Internal)					
		Audit of recruitment processes reported to Audit Committee according to schedule (Internal)					
3	Retention Strategy, including Health and Wellbeing and Recognition	Vacancy & Turnover rates, Absence rates reported to People Committee (Internal) Exit interview analysis reported to People Committee (Internal) National Staff Survey engagement and morale scores reported to People Committee (Internal) Greater consistency in approach to restorative justice across UHN evidenced in similar case load in both Trusts(internal) Opened Our Space at NGH & New restaurant facility at KGH (internal) Just Culture approach embedded throughout policy harmonisation (Internal)	Restructure, alignment and funding of the UHN staff support offers . HCA career pathway	.	Development of Health and Wellbeing Strategy Delivery of UHN stay conversation tool kit Review HCA pathway including consideration of band 3 roles, cognisant of national Unison Fair Pay campaign	Head of HWB Head of HWB Director of People with DoN	31.12.2024 31.12.2024 01.04.2025
4	Learning and Development Strategy	Statutory and mandatory training completion rates (MAST) and Appraisal completion rates reported to People Committee (Internal) Training audit (internal)	Appraisal process not yet tested		Embed approved new appraisal process and supporting training package National induction and National mandatory training alignment	Head of People Development	31.12.2024 31.12.2024
5	Clinical Strategy including detailed speciality strategies and workforce plans	Oversight of strategy documents to Group Transformation Committee (Internal) Workplan of prioritised alignment of policies (internal)	Prioritised timebound plan to deliver clinical collaboration (including enabling functions) 19 policies remaining to complete over remainder of year. Challenge for capacity with staff side to review and meaningfully consult	Development of People structure to Development of People Services structure to support integrated clinical divisions to be finalised when agreed clinical model developed	Development of updated clinical strategy and associated supporting service strategies Deliver People team structure Completion of workplan of prioritised aligned UHN policies	Board Chief People Officer Head of People Partnering	31.03.2025 31.03.2025 31.03.2025

Current Controls		Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
6	Safe Staffing Strategy	Safe staff metrics including Roster publication performance reported to People Committee (Internal) Compassionate rostering programme (KGH) (Internal) Self-rostering pilot (NGH) (Internal) Agile working Audit (NGH) (Internal) UHN Agile working policy ratified	Industrial relations climate/strikes	No Nursing and midwifery and AHP workforce plan Validation of SNCT professional judgement and alignment with rosters	HCA back pay process to be enacted Nursing and midwifery and AHP workforce plan to be developed SNCT external roster review	Deputy Chief People Officer CNO CNO	31.12.2024 31.12.2025 31.10.2024
7	Volunteering strategy	Number of volunteer hours/month reported to People Committee (Internal) Volunteer to career programme launched January 2024 (Internal) Improved diversity profile of volunteers reported to People Committee (internal)	Gap in a formal pathway from Volunteer to career (V2C) Additional transport options needed for KGH to support patients/carers with mobility needs to move within the building Develop patients on admission role No funding for schools' outreach work		Develop proposals for second phase of Volunteer to Career programme Develop internal transport provision for patients and extend successful trials to KGH Trial admission role with i9dentified wards Continue to support school outreach work on more limited basis	Head of Volunteer Services	31.12.2024 31.12.2024 31.12.2024 31.12.2024

Principal Risk No:	**UHN02**	**Risk Title:**	Failure to deliver the UHN Clinical Strategy and clinical collaboration may result in some areas of clinical and financial unsustainability						
		Materialising in any/several of the following circumstances:	Fragmented and inefficient service delivery Service cessation or interruption of service provision for fragile services Sub-optimal outcomes and patient experience Negatively impacting staff retention, recruitment and morale						
Date Risk Opened:	April 2021	**Date last reviewed**	September 2024	**Risk Classification:**	Quality, Operational, Infrastructure, Financial	**Risk Owner:**	Medical Director	**Scrutinising Committee:**	Quality Safety Committee in Common

Corporate Risk Register Links:			
NGH CRR:	NGH88 - Failure to Meet National Cancer Waiting Times Standards (Current risk score 16) NGH885 - Loss of PIFU data leading to loss of patient care and unquantifiable harm (Current risk score 16)	**KGH CRR:**	KCRR049 - If Radiology imaging is not completed within 6 weeks of referral the Diagnostic target will be breached (Current risk score 16) KCRR065 – Safe delivery of T&O Spinal Surgery (Current Risk score 15)

Initial Risk Score		**Current Risk Score**		**Residual Risk Score**		**Risk Appetite**
12 (High)		20 (Significant)		8 (High)		Low
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	3	4	5	4	2	Quality

	Current Controls	**Plan Delivery Assurance/ Group IGRs (Internal / External)**	**Control Gaps**	**Assurance Gaps**	**Further planned actions to mitigate gaps**	**Action Owner**	**Due date**
1	The Clinical Strategy oversight through UHN ILT and the Clinical Quality and Safety Committee (Axis 1) and the UHN / UHL partnership board (Axis 2)	UHN Board governance updates (Quality, Finance, Transformation) (Internal) ILT updates and assurance (Internal) External reviews (Neonatal) (External) Agreement of 11 workstreams at partnership board April 2024 (Internal)	Resource constraints – clinical and project resource (Industrial action, Financial deficit. Ability to influence systemwide patient pathway changes		Review of enabling clinical capacity to affect change. Progress pathway reviews across system UEC and across Axis 2	Medical Director, Chief Operating Officers Medical Director, Chief Operating Officers	31.12.2024 31.12.2024
2	Detailed plan for subsequent phase of work that will focus on the integration of specific services – Review of Target Operating Models	Schedule of service strategy developments (Group) (Internal) Oversight monitoring through Asana Project Software (Group) (Internal) Standing clinical collaboration updates to Clinical Quality Safety and Performance Committees (Group) (Internal)	Resource Gaps Resource constraints – clinical and project resource		Progress the review of all services against Target Operating Model Review of enabling clinical capacity to affect change	Chief Operating Officers, Medical Director	30.09.2024

Principal Risk No:	**UHN03**	**Risk Title:**	Failure to deliver the group Nursing, Midwifery and Allied Health Professionals (NMAHP) Strategy may result in variation in patient outcomes and experience and failure to become the employer of choice for NMAHP's						
		Materialising in any/several of the following circumstances:	Deterioration in patient outcomes and experience Increase in vacancy and turnover rates Reduction in colleague engagement across the professions						
Date Risk Opened:	April 2021	**Date last reviewed**	September 2024	**Risk Classification:**	Quality, Operational, Infrastructure, Financial	**Risk Owner:**	Chief Nurse	**Scrutinising Committee:**	Quality Safety Committee in Common

Corporate Risk Register Links:			
NGH CRR:	NGH39 - Risk of lack of adherence to good safeguarding practices in the trust (current risks score 16) NGH42 - Risk that patients in NGH will suffer harm from falling (Current risk score 15) NGH74 - Risk of harm to patients from physical and psychological deconditioning (current risks score 16) NGH307 - There is a risk of an adverse event as a result of incorrect CTG interpretation (current risk score 15) NGH562 - Risk that children & pregnant women at risk may not be identified due to insufficient skill & availability within Safeguarding (Current risks score 20) NGH686 – There is a further risk regarding women leaving Community appointments without their next appointment being booked. NGH752 - Not Sharing the New Born NHS Number at Birth with Social Care NGH885 - Loss of PIFU data leading to loss of patient care and unquantifiable harm (Current risk score 16)	**KGH CRR:**	

Initial Risk Score		**Current Risk Score**		**Residual Risk Score**		**Risk Appetite**
12 (High)		12 (High)		8 (High)		Low
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	4	4	3	4	3	Patient

	Current Controls	**Plan Delivery Assurance/ Group IGRs (Internal / External)**	**Control Gaps**	**Assurance Gaps**	**Further planned actions to mitigate gaps**	**Action Owner**	**Due date**
1	NGH and KGH have a shared Nursing, Midwifery & AHP professional strategy (IGNITE) monitored via hospital Nursing and Midwifery Boards/Nurse Executive Meeting.	NGH completed and achieved Pathway to Excellence re-accreditation (June 23) (external) KGH are due to commence @Quality Framework' implementation (internal) All focused works streams have updated year 3 plan and commenced to refresh metrics moving into year 3 or strategy (Internal)	Current strategy is in its final year, new strategy is being developed across UHN and will be required for September 2024 Ward to board oversight at KGH is not in place as quality framework is not yet implemented. Adoption of National Workforce Safeguards is incomplete & RCN safe staffing standards.	Both the Pathways and Quality Frameworks have similar pillars and will be allow for comparative measurements in most areas and be tracked within the IGR CQC has identified ED as inadequate for safe and maternity has moved onto the MSSP Vacancy and turnover rates are above regional average at both sites.	Total quality management review planned – externally led CNO safe staffing faculty review of workforce safeguards adoption at UHN.	CNO	31.10.2024
2	Aligned reporting and monitoring of outcomes and experience across the Group.	We will develop a care thermometer of metrics with consistent measurement of metrics to ensure benchmarking.	The is lack of consistency across the two hospitals in how we measure patient & colleague outcomes. Teams continue to be hospital based with separate policies and procedures	Care thermometer has not been developed. Adoption of national evidence base is applied inconsistently	Total quality management review planned – externally led Teneo support with restructure	CNO	01.04.2025
3	Workstream leads and working groups identified to define progress against objectives.	There will be a single NMAHP committee to oversee the delivery of the strategy with agreed deliverables. Progress against metrics is presented by NGH and KGH to People and Quality Committee in Common (internal)	Oversight committee commences in September 2024. Strategy and deliverables are not finalised.	Metrics agreed for year 3 and being measured not yet presented to Committees in Common.	Strategy and nursing governance alignment in progress.	CNO	31.12.2024
4	Delivery and Assurance structure agreed	Reports to Clinical Quality and Safety Committee in Common, supported by UHN Nursing, midwifery and Allied Health Professionals Committee – ToR agreed and first meeting September 2024 IGR now with agreed metrics and benchmarks (internal)	Refreshed priorities being worked up	Assurance process in work up		CNO	30.11.2024

Principal Risk No:	**UHN04**	**Risk Title:**	Failure of the Integrated Care System (ICS) to deliver transformed care will result in an impact on the quality of service provided across the Group
		Materialising in any/several of the following circumstances:	Risk to delivering locally for our patients the core aims of Integrated Care Systems to; 1. Improve outcomes in population health and healthcare. 2. Tackle inequalities in outcomes, experience and access.3. Enhance productivity and value for money 4. Help the NHS support broader social and economic development.

Date Risk Opened:	April 2021	**Date last reviewed**	September 2024	**Risk Classification:**	Quality, Financial	**Risk Owner:**	Director of Strategy and Strategic Estate	**Scrutinising Committee:**	Operational Performance Committee

Corporate Risk Register Links:

NGH CRR:	NGH 424 - Risk of reduced patient safety when demand exceeds capacity (Current risk score 15)	**KGH CRR:**	KCRR011 - Continued extreme pressure on capacity and reported incidents of low nursing levels and delayed discharges creates the risk of creates the risk of poor quality of care and patient safety, combined with staff well-being. (current risks core 20)

Initial Risk Score		**Current Risk Score**		**Residual Risk Score**		**Risk Appetite**
16 (Extreme)		16 (Extreme)		12 (High)		High
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	4	4	4	4	3	Systems and Partnership

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
1	The development and delivery of the Northamptonshire Integrated Care System (ICS) to include the Northamptonshire Integrated Care Board and the Northamptonshire Integrated Care Partnership	UHN Chair and GCEO representation at the Integrated Care Partnership and the Integrated Care Board (internal/ external) Integrated Care Partnership 10-year Strategy and Outcomes Framework (external) Alignment of the Health and Wellbeing Boards (North and West) strategies and ICB 5-year plan to the ICP 10-year strategy (external) ICB Strategy and planning group established to deliver ON THE 5 year forward plan as per national guidance (internal / external) Group engagement with NEDS on existing ICB architecture (internal) Governance mapping complete and shared with ILT (internal)	Alignment of ICB plan with the Integrated Care Partnership strategy, Health and Wellbeing Boards strategies, operational planning requirements and UHN Group strategies and planning	Level of focus on system resilience and working as a system to ensure delivery of collaborative working to deliver the strategies and supporting operational plans. Assurance to delivery of system delivery plans	Further strengthening of the System Urgent and Emergency and discharge planning to Be Plans developed- delivery to be led at Place for North and West Mapping of all partnership strategies and plans into a clear framework and resetting of governance workstreams (COMPLETE)	DCI DoS	31.12.2024 31.03.2025
2	Implementation of the ICS operating model to deliver good quality care, financial balance and improved outcomes. UHN leadership system, workstreams to develop Collaboratives, Place, Clinical Model, and enablers e.g., Digital, People, Estates, Finance with supporting delivery plans	Collaborative Boards developing prioritised delivery plans ((Internal / External); • MHLDA • Elective Care • CYP Establishment of Place Delivery Boards, Local Area Partnerships to deliver improved outcomes in population health and healthcare (Internal / External) Population Health Board (Internal / External) System Clinical Leads Board (Internal / External) System Quality Board (Internal / External) System Boards for enablers(Internal / External); • Estates • People • Digital Urgent and Emergency Care system Board and Planning (Internal / External)	Connection of decision making across the ICB to include Place and Collaboratives UHN Place based approach and strategies	Assurance to delivery of system delivery plans for collaboratives and Place	Prioritisation of delivery and Out of Hospital, discharge, UEC strategy and Plans (to replace iCAN) priorities across the collaboratives and Place System workshop to be arranged for end October 24 by Director of Continuous Improvement to reset all programmes that were in iCAN.	DCI DCI	31.03.2025 31.10.2024

Principal Risk No:	**UHN05**	**Risk Title:**		Risk of failing estate buildings and infrastructure due to age and suitability and, failure to deliver Group strategic estates plans, may prevent delivery of key Group strategies, eg Clinical Strategy.					
		Materialising in any/several of the following circumstances:		May result in care delivery from poor clinical environments, cost inefficiencies, health and safety incidents, accidents and statutory non-compliance attributable to some degree to substandard existing estate, and lost opportunities for integrated care delivery at place, resulting in serious safety incidents causing injury or death, fines, prosecution and associated reputational damage.					
Date Risk Opened:	April 2021	**Date last Reviewed**	September 2024	**Risk Classification:**	Quality, Finance Infrastructure	**Risk Owner:**	Director of Strategy and Strategic Estate Director of Operational Estates	**Scrutinising Committee:**	Finance and Investments Committee in Common

Corporate Risk Register Links:

NGH CRR:	NGH259 - Risk of exposure to asbestos fibre from lack of management to exposure (Current risk score 15) NGH 262 - Risk of asbestos related diseases from exposure to asbestos fibre (Current risk score 20) NGH 265 - Heating and hot water infrastructure (Current risk score 16) NGH 270 - Risk of failure to meet national standards of cleaning (Current risk score 16) NGH 301 – Risk of failure of gas interlock system (Current risk score 15) NGH 258 - Risk of incorrect disposal of clinical waste at source (Current risk score 15)	**KGH CRR:**	KCRR015 - No sustainable capacity for urgent care (Current risk score 20) KCRR026 - Risk of loss of power or reduced power to site if the main high voltage incoming switchgear fails (Current risk score 15) KCRR030 - Loss of heating and hot water failures and interruptions to some or all areas of the trust due to age of boiler system (Current risk score 16) KCRR059 - Risk to patient safety and quality of care due to the current layout of LNU as there is a lack of visibility of all babies and the lack of continuous supervision of these babies (Current risk score 16) KCRR036 - Recognition that due to the age of the Trusts estate not all wards or services have suitable environments to be able to provide a high-quality service from. (Current risk score 16) KCRR040 - Recognition that due to the age of the some of the medical and diagnostic equipment, maintenance and replacement parts are no longer available (Current risk score 15) KCRR045 - A significant increase in headcount coupled with reduced useable office accommodation puts at risk operational and clinical efficacy and compliance with workplace occupational health and safety regulations (Current risk score 16) KCRR055 - Recognition that areas of Trust could fall into darkness due to aged lighting that is no longer available (Current risk score 15) KCRR070 - Impact on delivery of services during inspection of RAAC found to be present in Rockingham Wing (Current risk score 15)

Initial Risk Score		Current Risk Score		Residual Risk Score		Risk Appetite
12 (High)		12 (High)		6 (Moderate)		High
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
3	4	3	4	3	2	Sustainability

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
1	Completed and approved Group Clinical Strategy will define the clinical requirements of both sites for the future.	Clinical service strategy focus and implementation plan (internal) Target Operating Model (TOM) work complete (internal)	Scope of Clinical collaboration required to inform required estate resources		Developmental Control Plan (NGH) (Presentation to ILT)	DofS&SE	31.12.2024
2	Kettering Hospital now have a full Development Control Plan for the whole site, forming part of the HIP2 and other programmes. Northampton Hospital have a site masterplan. OBC has been submitted NGH Masterplan funding	Kettering HIP2 SOC has been submitted and a Local Development Order has been signed with Kettering Planning Authority (Internal / External) Board oversight of KGH outline business case (internal) Development Control Plan (NGH)					

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
3	These foundations will come together to start to form the Group Strategic Estates Plan.			The Group requires a joint Strategic Estates Plan that supports delivery of the Group Clinical Strategy	Group Strategic Estates Plan to be commissioned in Autumn 2021 following completion of the Group Clinical Strategy. Bed capacity Model (first step of strategic estates model)	DofS&SE	2025/26 20.10.2024
4	A System Estates Board is in place across the ICS with all Health and Care partners.			The System Estates Strategy is not strategic and needs further development System wide view of all provider / partner strategic estate need / plans	Outcome of Draft Northamptonshire Infrastructure Strategy that has been completed and submitted Strategy to be refreshed on completion of Estates planning demand and capacity modelling – ICB Director of Strategy and Planning. Undertake an annual review of the strategy in line with our 5 Year plan – ICB, Director of Strategy and Planning	ICB Director of Strategy and Planning UHN DoE&F	31.12.2024 01.04.2025 01.08.2025
5	All key estates infrastructure elements have independent AE (authorising engineers) appointed, annual audits and action plans in place; technical and trust meetings in place.	Monthly estates assurance report for each hospital is presented at the Finance CiC (internal) Technical meetings in place to review progress against audit plans (internal)			Review of technical meetings effectiveness	DofE&F KGH and NGH	10.01.2025
6	Business continuity plans and infrastructure resilience/back up systems are in place	Estates infrastructure is regularly tested (internal) Risk rated capital backlog plans in place (internal) Estates strategies for each site (internal)	Infrastructure is aging and estates capital plans are insufficient to replace all equipment	assurance for Estates infrastructure BCP to be included in estates assurance reporting, with input from EPRR leads	Annual review of Business Continuity Plans	EPRR Leads	31.03.2025
7	Estates backlog capital programme	Trust capital committees (internal) KGH 6 Facet Survey (internal)		NGH 6 Facet survey due for renewal 24/25	Tender for completion of a full site 6 facet survey for NGH	DofE NGH	01.01.2025

Principal Risk No:	**UHN06**	**Risk Title:**	Failure to deliver the long-term Group Academic Strategy may result in inability to attract high calibre staff and deliver on our research and education ambitions.						
		Materialising in any/several of the following circumstances:	Sustainability of 5-year project Impact on financial income to the Group Impact on patient outcomes and experience Lack of progress with our academic partnerships and collaborations with local universities, with potential to impact on University status						
Date Risk Opened:	April 2021	**Date last Reviewed**	September 2024	**Risk Classification:**	Quality, Finance	**Risk Owner:**	Medical Director Director of Strategy	**Scrutinising Committee:**	Quality Safety Committee in common

Corporate Risk Register Links:			
NGH CRR:		**KGH CRR**	KCRR017 - Organisational challenge in relation to staffing with the potential to impact negatively on patient experience and outcomes (Current risk score 20)

Initial Risk Score		**Current Risk Score**		**Residual Risk Score**		**Risk Appetite**
12 (High)		12 (High)		4 (Moderate)		Low
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	3	4	3	4	1	Quality

	Current Controls	**Plan Delivery Assurance/ Group IGRs (Internal / External)**	**Control Gaps**	**Assurance Gaps**	**Further planned actions to mitigate gaps**	**Action Owner**	**Due date**
1.	Academic and Research Strategy oversight through UHN ILT and the Clinical Quality and Safety Committee (Axis 1) and the UHN / UHL partnership board (Axis 2)	UHN Board governance updates (Quality, Finance, Transformation) (Internal) ILT updates and assurance (Internal) External reviews (Neonatal) (External) Agreement of 11 workstreams at partnership board April 2024 (internal)	Resource constraints – clinical and project resource (Industrial action, Financial deficit Ability to influence systemwide recruitment of patients into research.		Review of enabling clinical capacity to affect change. Progress standardisation of academic and research governance, operational structures, recruitment key joint posts and expansion of opportunities for cross organisational trials	Medical Directors Chief Nursing Officers	31.12.2024 31.12.2024

Principal Risk No:	**UHN07**	**Risk Title:**	Failure to deliver the Group Digital Strategy may result in our staff and patients not having the tools or information they need to deliver, and receive safe, high quality patient care.						
		Materialising in any/several of the following circumstances:	- Patients are not in control of, or kept well informed of, their care so we fall behind standards and expectations of patients - Clinicians do not have the access to full, accurate and timely patient information when they need it, leading to a negative impact on patient care decisions - and therefore outcomes - Staff (clinical and non clinical) do not have the tools, (or the tools are not based on a secure and reliable supporting digital infrastructure), to perform their roles effectively, resulting in poor productivity, poorer outcomes for patients, and a block on their ability to collaborate easily and well, within UHN and also more widely. - Managers and clinicians do not have relevant, accurate, consistent and reliable data readily available in a useful form, to make timely informed decisions, leading to greater operational challenges for UHN, and poorer patient outcomes as result.						
Date Risk Opened:	April 2021 Revised April 2023	**Date last Reviewed**	September 2024	**Risk Classification:**	Quality, infrastructure, finance	**Risk Owner:**	Group Chief Digital Information Officer	**Scrutinising Committee:**	Quality Safety Committee in common
Corporate Risk Register Links:									
NGH 93 - Clin Apps - No Electronic Prescribing and Medicine Administration System (EPMA) (Current risk score 16) NGH 114 - TECH - threat to our IT systems and / or infrastructure from a cyber or malware attack resulting in a loss of service or data (Current risk score 15)		**KGH CRR:**	KCRR038 - Loss of the current Intranet service and experience a loss of data contained therein. (Current risk score 16) KCRR009 - Threat to IT systems from Cyber security and malware attacks (Current risk score 16)						

Initial Risk Score		Current Risk Score		Residual Risk Score		Risk Appetite
16 (Extreme)		16 (Extreme)		16 (extreme)		High
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	4	4	4	4	4	Sustainability

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
1	Digital Transformation governance structure to monitor and support project delivery against plan	Digital Transformation governance structure including programme boards (EPR; digital transformation, infrastructure boards; health intelligence transformation; robotic process automation and communication and engagement group) with accompanying reports (internal) UHN Digital Forward View summarising plan and priorities for the year ahead – agreed by ILT (internal) Regular updates to ILT on digital delivery and any UHN decisions needed (e.g. on re-prioritisation of the plan as needs arise) (internal) UHN attendance at ICS digital and data board to help tie UHN and ICS ambitions together and also secure support from wider ICS colleagues where required (Internal) TIAA audit (reasonable assurance report)(Internal) ICS Digital Director involvement and ICS involvement with digital strategy (external) Digital Delivery Group set up as sub-committee of Quality Committee – upward reports sent for assurance (internal) Robotic Process Automation feeds into Digital Delivery Group (internal) UHN Digital attendance at wider governance forums for updates/ sharing of information – e.g. Divisional meetings (internal)	ICS Digital Strategy oversight group to link in all CIOs from Northamptonshire (upward group from ICS digital and data board)	Benefits reporting to showcase impact of digital transformation, and ensure lessons learnt (and then communicate this back to our colleagues) Ongoing clarity on digital ambitions and priorities of the ICS, and timescales of key projects they are leading on. Confirmation UHN health intelligence service will be able to meet needs of UHN after the conclusion of the data warehouse/ health intelligence transformation programme Clarity and assurance on digital collaboration agenda with UHL	Robotic Process Automation Deep Dive to be presented at Digital Delivery Group (and shared at Quality Committee) Ensure UHN digital continues to engage with evolving governance forums to communicate, engage and assure on delivery – these will change over next year in line with wider UHN changes Reporting into Performance Committee: 1) To give overview of health intelligence transformation programme 2) Update on health intelligence form/ service offering Review governance, opportunities and priorities for UHN/ UHL digital	CDIO CDIO CDIO UHN / UHL CDIO	31.10.2024 31.03.2025 31.10.2024 28.02.2025

Current Controls		Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
2	Operational governance structure (meetings/committees) to review and oversee the performance of the 'business as usual' parts of the Digital Division's work (e.g. financial control & risk management, and performance of ICT areas such as security, systems performance, upgrades, hardware management, etc))	Digital Operational Meeting oversees with reports feeding in from Data Security and Protection Group, risk, finance as well as oversight of operational KPIs and incident management. Digital Operational Meeting feeds into sub-committee structure through Digital Delivery Group (internal)	Visibility of ICS wide CISO over plans		ICS CISO to be brought into UHL and UHN digital team sessions.	CDIO	30.11.2024
3	Prioritisation governance process (including representatives from a diverse range of staff) to oversee digital transformation prioritisation.	Regular updates to ILT on digital delivery and any UHN decisions needed regarding re-prioritisation of the plan as needs arise) (internal) Operation of key forums from Digital which feed into prioritisation process including the Clinical Design Authority (main forum for clinical and operational input into digital transformation agenda) and Technical Design Authority (main forum for checking ideas are technically feasible for consideration) authority groups. (internal / External)	Visibility of prioritisation changes to Board Committee	Require continual review of priorities – will need assurance the dynamism of process will be ongoing. Clinical Design Authority needs regular attendance and engagement from clinical colleagues Historic backlog of work remains across digital – although prioritisation exercise encompassed all, given volume the review of relevancy of these requests needs to be conducted and backlog reduced	Review clinical design authority attendance ensuring representation from clinical leaders to steer prioritisation recommendations for ILT Review and consolidation required of historic backlog	CCIO Head of DT&I	30.09.2024 30.09.2024
4	Structured communication and engagement activities with clinical and operational leadership on the digital agenda including:	UHN Digital Communications and Engagement Group with communication and engagement plan (internal) UHN Digital Champion network (internal) UHN Digital academy to oversee digital training and support and digital competency Internal) Digital UHN branding (internal) UHN Digital Communications and Engagement Group feeds into sub-committee structure through Digital Delivery Group (Internal)		Need to include targets or assess how we will measure improvements in staff and patient engagement Greater evidence of user-led design Greater evidence of patient engagement Build on UHN digital branding for UHN digital vision (e.g. e-hospital)	Evidence of service designer within digital driving user-led approach Regular attendance at patient engagement forums (internal and ICS) Work with Communication Team on branding	Head of DT&I CCIO CCIO	30.11.2024 31.10.2024 30.09.2024
5	Plan to have the resource (digital, clinical and operational) required to ensure capability and capacity required to deliver	Restructure of digital teams into UHN team for greater flexibility and wider skill set to draw upon (internal) Reporting through digital programme groups on resource requirements/ engagement (internal)	Vacancy controls and financial constraints resulting in vacancy gaps	Resource dependency to be highlighted as critical factor through programme reporting structure to give assurance necessary capability/ capacity is in place for key priority work, and to understand risks and specific areas of pressure. Unknown future industrial action which may impact ability for digital change to be enacted across UHN	Resource risk to be continued to be monitored through governance structure	CDIO	31.03.2025
6	Supplier management process to manage relationships with key digital suppliers and key contracts, to ensure confidence in their ability to deliver and manage any risks.	Contractual meetings between Digital SLT and account managers of suppliers (internal) Reporting through digital programme groups on supplier delivery (internal) Regular Exec meetings with KGH EPR supplier (internal) East Midlands Acute Partners group set up to jointly manage/ mitigate NGH EPR supplier risk– regular attendance by UHN CDIO (External / Internal) EPR governance across UHN reviewed and reinvigorated with steering groups chaired by Medical Director and CDIO (Internal)		NGH Exec EPR supplier meeting	Regular NGH Exec EPR supplier meeting - complete Regular attendance at East Midlands Acute Partners EPR group	CDIO/ MD CDIO	31.08.2024 31.10.2024

Current Controls		Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
7	Strategy/ approach to seek out nationally funded programmes of work (e.g. EPR) to ensure necessary funding to deliver as much of our strategic ambitions as possible, as soon as possible	CDIO / ICB Digital Director/ NHFT CDIO collaboration – regular meetings to determine national funding options (External) CDIO interaction with National CDIO forums and NHS England (External)		Opportunity/ horizon scanning – implementation of Digital Commercial Manager to support this activity	Recruit into Digital Commercial Manager position UHN/ UHL CDIO to be appointed to work more closely with NHS England and capitalise opportunities for funding across all organisations	Head of DT&I UHN/ UHL CDIO	30.11.2024 30.09.2024

Principal Risk No:	**UHN08**	**Risk Title:**	Failure to deliver improvement in underlying revenue finances and develop a path out of financial deficit to breakeven over the medium term:						
		Materialising in any/several of the following circumstances:	The Finance and Investment Committee will advise the Trust Boards on financial performance: - Financial run rate deteriorating - Efficiency delivery not meeting targets - Cost assumptions including inflation materialising at high levels than planned - Industrial actions creating unplanned and unfunded costs - Medium term financial plan development is not underpinned by clinical and operational strategy. - Capacity, consistency and accountability leads to different approaches in each Trust						
Date Risk Opened:	April 2021	**Date last reviewed**	September 2024	**Risk Classification:**	Financial Operational	**Risk Owner:**	Chief Finance Officer	**Scrutinising Committee:**	Finance & Investment Committee

Corporate Risk Register Links:			
NGH CRR:	NGH 35 - Failure in having financial control measures to deliver the 23-24 Financial Plan and return to medium term financial balance (Current risk score 20) NGH 38 - The Trust may not have sufficient capital for Capital requirements or may not be able to maximise its capital spend (Current risk score 15)	**KGH CRR:**	KCRR056 - Failure in having financial control measures to deliver the 22-23 Financial Plan and return to medium term financial balance (Current risk score 20)

Initial Risk Score		**Current Risk Score**		**Residual Risk Score**		**Risk Appetite**
16 (Extreme)		20 (Significant)		12 (High)		High
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	4	4	5	3	2	Sustainability

	Current Controls	**Plan Delivery Assurance/ Group IGRs (Internal / External)**	**Control Gaps**	**Assurance Gaps**	**Further planned actions to mitigate gaps**	**Action Owner**	**Due date**
1	Budgets	• Documented, understood and signed off budgets by budget managers • Alignment of bottom up evidenced based budgets with top down high level budget • Agreed risk and contingency approach aligned to Board risk appetite	Capacity gap on budget consistency due to both Deputy CFO absent on long term sickness since October 2023 and identified differences in budget setting approaches	Documented sign off by all Budget Managers	Lessons learned produced from 23/24 IBP taken into planning for 25/26	Hospital Director of Operational Finance	31.10.2024
2	Affordability / Accountability	• Equal focus is given to funding (affordability) of investments as determining the costs • Have defined goals and priorities to support budget setting • Involve stakeholders effectively in the budget process sharing analysis, risks, and working to understand choices • Establish clear roles and responsibilities	Culture of investigating funding options and focus on affordability Evaluate budget setting process to consider achievements and challenges Focus on benefits realisation	Ensure all financial controls are operating efficiently and effectively. Business cases focus on benefits and affordability	Financial performance has significant focus and increased profile across UHN. Underlying review being procured through competitive process	Chief Financial Officer	31.11.2024
3	Reporting / Risk Appetite / Planning / Performance Management	• Reporting, Provide accessible online reporting replacing fixed emailed reports. • Risk appetite / risk and contingency planning. Alongside budget setting develop and agree an approach to risk and contingency. • Planning. Financial planning is one element of effective public financial management along with budget preparation, performance management and stakeholder reporting. • Performance Management	Static reporting and access to financial information is lacking Workforce has grown and risk of breaching agency cap and establishment	Methodology and governance is in place to support effective use of staffing, reduce variation and deployment. Performance management operates without a documented and understood framework with differential approaches	Performance assurance process documented and refreshed. Power BI reporting with external capacity in progress, although with some IT risks	Interim Deputy CFO	Budget Manager reports 31.10.2024 KPI Dashboards 31.12.2024
4	Culture / Choices / Control	• Finance's partnership role in businesses will "shift upstream" from budgeting and reporting to scenario planning and advanced forecasting. • Exploit the technology, including through automation to eliminate manual tasks within finance • Streamline intergroup transactions and recharges	Single set of Standing Financial Instructions across UHN Capacity in Financial Management teams with a high level of turnover High number of procurement waivers and non-compliance	Budget management training and support effectiveness to be reviewed Corporate teams within Finance Directorate to considered against optimised arrangements across UHL /UHN	Financial Services restructure delayed due to Annual Report and Accounts delays Finance Team objectives in progress, and has highlighted previous lack of appraisals		Objectives 31.10 2024 Financial Services Restructure 31.01.2025

		• Complete the financial services restructure following pre-consultation engagement. • Eliminate breaches of SFIs in relation to procurement, locally described as Maverick and Waivers, avoid direct awards and drive value through clear documented outcome based specifications. • Develop senior finance team capacity and support professional development including considering One NHS Finance resources • Support identification of organisational choices	Senior Finance team structure does not promote accountability and ownership across UHN Framework for tough choices to be developed				

Corporate Risks Aligned to BAF risks @ 16th September 2024

BAF Link	Risk ID (BAF/CRR)
UHN001 (Group People Plan)	KCRR017 - Organisational challenge in relation to staffing with the potential to impact negatively on patient experience and outcomes (Current risk score 16)
	NGH46 - Detrimental staff wellbeing and mental health including self harm and suicide (Current risk score 20) NGH47 - HCSW Retention (Current risk score 16) NGH49 - Staff Morale (Current risk score 16)
UNH002 (Clinical Strategy)	KCRR065 – Safe delivery of T&O Spinal Surgery (Current Risk score 15)
	NGH88 - Failure to Meet National Cancer Waiting Times Standards (Current risk score 16) NGH885 - Loss of PIFU data leading to loss of patient care and unquantifiable harm (Current risk score 16)
UHN003 (Group Nursing, Midwifery and Allied health Professionals strategy)	
	NGH39 - Risk of lack of adherence to good safeguarding practices in the trust (current risks score 16) NGH42 - Risk that patients in NGH will suffer harm from falling (Current risk score 15) NGH74 - Risk of harm to patients from physical and psychological deconditioning (current risks score 16) NGH307 - There is a risk of an adverse event as a result of incorrect CTG interpretation (current risk score 15) NGH562 - Risk that children & pregnant women at risk may not be identified due to insufficient skill & availability within Safeguarding (Current risks score 20) NGH686 – There is a further risk regarding women leaving Community appointments without their next appointment being booked. NGH752 - Not Sharing the New Born NHS Number at Birth with Social Care
UHN004 (Integrated Care Board)	KCRR011 - Continued extreme pressure on capacity and reported incidents of low nursing levels and delayed discharges creates the risk of creates the risk of poor quality of care and patient safety, combined with staff well-being. (current risks core 20)
	NGH424 - Risk of reduced patient safety when demand exceeds capacity (Current risk score 20)
UHN005 (Group Strategic Estates Programme)	KCRR015 - No sustainable capacity for urgent care (Current risk score 20) KCRR026 - Risk of loss of power or reduced power to site if the main high voltage incoming switchgear fails (Current risk score 15) KCRR030 - Loss of heating and hot water failures and interruptions to some or all areas of the trust due to age of boiler system (Current risk score 16) KCRR059 - Risk to patient safety and quality of care due to the current layout of LNU as there is a lack of visibility of all babies and the lack of continuous supervision of these babies (Current risk score 16) KCRR036 - Recognition that due to the age of the Trusts estate not all wards or services have suitable environments to be able to provide a high-quality service from. (Current risk score 16) KCRR045 - A significant increase in headcount coupled with reduced useable office accommodation puts at risk operational and clinical efficacy and compliance with workplace occupational health and safety regulations (Current risk score 16) KCRR055 - Recognition that areas of Trust could fall into darkness due to aged lighting that is no longer available (Current risk score 15) KCRR070 - Impact on delivery of services during inspection of RAAC found to be present in Rockingham Wing (Current risk score 15)
	NGH258 - Risk of incorrect disposal of clinical waste at source (Current risk score 15) NGH259 - Risk of exposure to asbestos fibre from lack of management to exposure (Current risk score 15) NGH 262 - Risk of asbestos related diseases from exposure to asbestos fibre (Current risk score 20) NGH 265 - Heating and hot water infrastructure (Current risk score 16) NGH 270 - Risk of failure to meet national standards of cleaning (Current risk score 16) NGH 301 – Risk of failure of gas interlock system (Current risk score 15)
UHN006 (Group Academic Strategy)	KCRR017 - Organisational challenge in relation to staffing with the potential to impact negatively on patient experience and outcomes (Current risk score 20)

BAF Link	Risk ID (BAF/CRR)
UHN007 (Digital Strategy)	KCRR038 - Loss of the current Intranet service and experience a loss of data contained therein. (Current risk score 16) KCRR009 - Threat to IT systems from Cyber security and malware attacks (Current risk score 16)
	NGH 93 - Clin Apps - No Electronic Prescribing and Medicine Administration System (EPMA) (Current risk score 16) NGH 114 - TECH - threat to our IT systems and / or infrastructure from a cyber or malware attack resulting in a loss of service or data (Current risk score 20) NGF 904 - Failure to Implement NGH EPR due to resourcing (Current risk score 16)
UHN008 (Group Medium Term Financial Plan)	KCRR056 - Failure in having financial control measures to deliver the 23-24 Financial Plan and return to medium term financial balance (Current risk score 20)
	NGH 905 - Failure in having financial control measures to deliver the 24-25 Financial Plan and return to medium term financial balance (Current risk score 20) NGH 906 - The Trust may not have sufficient capital for Capital requirements or may not be able to maximise its capital spend (2024/25) (Current risk score 15)

Cover sheet

Meeting	Boards of Directors of KGH and NGH (Part I) Meeting in Public
Date	4 October 2024
Agenda item	15

Title	Appointments to Non-Executive positions and Committees
Presenter	Richard Apps, Director of Corporate and Legal Affairs
Author	Richard May, Company Secretary

This paper is for			
☑ Decision	☐Discussion	☑ Note	☐Assurance
To formally receive and discuss a report and determine its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Group priority				
☐Patient	☐Quality	☐Systems & Partnerships	☐Sustainability	☑ People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
To note recent Non-Executive Director appointments, consider a recommendation to appoint a Designate Non-Executive Director and confirm appointments to Board Committees	KGH Council of Governors, September 2024

Executive Summary
The KGH Council of Governors and NHS England agreed to enact changes to the composition of the KGH and NGH (UHN) Boards to recruit to group non-executive director positions on both Boards of Directors, as part of the continuing evolution

and consolidation of collaborative working between the trusts and complementing also recent changes to the executive leadership structure.

Nine expressions of interest were received by Non-Executive Directors, who were interviewed between 24-29 July by a Panel comprising the KGH Lead Governor, Trust Chair, Northamptonshire Integrated Care Board Chair, NHS England representative and Inclusive Recruitment Champion.

Following interviews the Panel chose the following preferred candidates, whose appointments have since been confirmed by the KGH Council of Governors and NHS England Appointments Committee: Alice Cooper, Jill Houghton, Denise Kirkham, Trevor Shipman, Caroline Stevens and Chris Welsh. The Boards are invited to note the appointments and to extend their congratulations to the appointees, extending also their thanks and best wishes to non-executive colleagues who have left the trusts: Deborah Manger and Ballu Patel (KGH), Elena Lokteva, Andre Ng and Rachel Parker (NGH).

Following Andre Ng's departure, the University of Leicester has confirmed that Professor Natalie Armstrong its representative on both Boards of Directors

The panel also wished to appoint Damien Venkatasamy to a voting UHN Non-Executive Director position, Damien has served as a KGH Non-Executive Director (voting) since 2018. NGH is currently restricted on the maximum number of non-executive positions set out within the Trust's Establishment Order. A change to this Order to provide an additional voting position has been formally requested via the Department of Health and Social Care; however, due to technical and consultative requirements, confirmation of this change has not yet been received. The **NGH Board of Directors** is therefore requested to **approve** the appointment of Damien Venkatasamy to the position of **Designate Non-Executive Director** (non-voting), until the Establishment Order change is confirmed enabling Damien to take up the voting position at this point. Remuneration for the role would be in line with other non-executive appointments at the approved rate of £13,000 per annum, plus a complexity allowance to reflect the UHN role of £5,000, giving total remuneration of £18,000 per year.

Appointments to Committees

The Boards are requested to **endorse** the enclosed schedule of non-executive appointments to Committees and lead roles.

Appendices
Schedule of non-executive appointments to Committees and lead roles.
Risk and assurance
No direct implications for the Board Assurance Framework
Financial Impact
Non-Executive remuneration costs will be split equally between the trusts and will give rise to a recurring annual savings for each.
Legal implications/regulatory requirements
As set out in the report above.
Equality Impact Assessment
Neutral

Committee		Alice Cooper	Denise Kirkham	Trevor Shipman	Chris Welsh	Damien Venkatasamy	Jill Houghton	Caroline Stevens	Natalie Armstrong	Andrew Moore
Operational Performance (OPC)	Chair			x						
	2nd							X		
	Deputy				X					
Finance and Investment (FIC)	Chair					x				
	2nd							x		
	Deputy			x						
Clinical Quality and Safety (CQSC)	Chair				x					
	2nd						x			
	Deputy								x	
People (GPC)	Chair		x							
	2nd	x								
	Deputy						x			
Remuneration and Appointments (RAC)	Chair		x							
	2nd	X								
	3rd				X					
	4th					X				
	Deputies			X			X	X		
Audit	Chair	x								
	2nd						x			
	3rd			x						
	Deputy							x		
UHL UHN Partnership Committee	Chair									x
	2nd			X						
Vice Chair				x						
Senior Independent Director								x		
Health and Wellbeing Guardian (PC Chair)			x							
Freedom to Speak Up (PC Chair)			x							
Doctors' Disciplinary (CQSC Chair)					x					
Security (Vice-Chair)				X						
Maternity & Neonatal Champion							x			
Northants Health Charity Trustee							x			
ICB Integrated Planning and Resources Committee (FIC Chair)						x				
ICB Quality Committee (CQSC Chair)					x					
ICB Delivery and Performance Committee (OPC Chair)				x						
REACH Network Sponsor			X				X			
PRIDE Network Sponsor										
DAWN Network Sponsor								X		

Cover sheet

Meeting	University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital and Northampton General Hospital)
Date	4 October 2024
Agenda item	16

Title	Integrated Leadership Team (ILT) Terms of Reference
Presenter	Richard Apps, Director of Corporate and Legal Affairs
Author	Richard May, Company Secretary

This paper is for			
☑ Decision	☐Discussion	☐Note	☐Assurance
To formally receive and discuss a report and determine its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Group priority				
☐Patient	☐Quality	☐Systems & Partnerships	☑ Sustainability	☐ People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
The Boards are requested to approve revised ILT Terms of Reference	ILT, 2 September 2024

Executive Summary
ILT has reviewed its Terms of Reference after six months of operation and has endorsed proposed changes for ratification by the Boards. The changes have been informed by members' feedback as part of the three-month review of the revised governance operating model, agreed by Boards in April 2024, contain

typographical amendments and cross-reference ILT duties when constituted as the Patient Safety Committee. The proposed changes are marked in the **enclosed Appendix** and are **recommended** for the Boards' **approval.**
Appendices
Revised draft ILT Terms of Reference.
Risk and assurance
No direct implications.
Financial Impact
None.
Legal implications/regulatory requirements
None.
Equality Impact Assessment
Neutral

Integrated Leadership Team Terms of Reference

Approved by the UHN Boards on *9 April 2024*

Version control table

Version	Date	Summary of changes
V1.0	December 2023	Drafted by Teneo
V1.1	March 2024	Presented to ILT for approval
V1.2	August 2024	Cross-reference ILT duties when constituted as the Patient Safety Committee. Minor typographical amendments

1.Purpose

1.1. The purpose of the Integrated Leadership Team (ILT) is to act as the executive-level decision making group of UHN, with delegated authority to undertake a leadership role on behalf of the Chief Executive to drive and support collaboration and ensure the delivery of the UHN strategic objectives.

1.2. The ILT will be accountable to the UHN/UHL Chief Executive

2. Membership

Membership

2.1 ILT comprises the following postholders:

- UHN Chief Executive (Chair, to nominate a Deputy in his/her absence)
- UHN/UHL Chief Executive
- ,All Executive Directors
- All NGH Divisional Directors and KGH Divisional Chiefs

2.2 If a member is unable to attend a meeting of the ILT, they will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered to represent their topic effectively.

2.2.1 The Deputy should be notified to the Chair in advance of the relevant meeting

2.2.2 The Deputy is eligible vote and should count in the quorum

2.3 At the discretion of the chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

2.3.1 Senior managers where items are discussed relating to their portfolio

2.3.2 Representatives of Trust organisations, who are not part of the core membership

2.3.3 Members of the Trust core teams and external advisers.

3. Secretary

3.1 The Director of Corporate and Legal Affairs will make arrangements to ensure effective administration support is provided to the meeting, including agenda and workplan setting, timely papers distribution, minute taking and recording and tracking of meeting actions. In addition, ~~they will~~they will ensure adequate training and support, and effective systems to the distribution of papers are available to the group administrator.

4. Meetings and Quorum

4.1 The quorum for meetings is at least one third of the Executive Directors (including the Chair or Vice Chair) and one Divisional Directors from each Trust. The Chief Financial Officer (or nominated deputy) must be in attendance for all items seeking financial investment.

4.1 No more than two deputies shall count towards the quorum. A duly convened meeting of the Integrated Leadership Team at which a quorum is present shall be competent to exercise all or its authorities, powers, and discretionary duties.

Frequency of meetings

5.1 The ILT will meet weekly (including by telephone or video conferencing), or as determined by the Chair. Any member of the Group can ask the Chair to call a meeting to be convened in person, by videoconference, or by telephone, or for a matter to be considered in correspondence.

~~5.1~~5.2 Once per month the ILT will be constituted as the Patient Safety Committee (under separate Terms of Reference). The Patient Safety Committee will report to the Trust Boards Clinical Quality and Safety Committee-in-common.

~~5.2~~5.3 Members are expected to attend a minimum of 75% of meetings on an annual basis. Attendance will be monitored as part of the appraisal process.

Notice of meetings

~~5.3~~5.4 Unless otherwise determined by the Chair, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers shall be circulated to each member of the ILT and any other person required to attend, no later than two clear working days before the date of the meeting (i.e. excluding the day of dispatch and the day of the meeting).

6. Declarations of Interest

6.1 All members must declare any actual or potential conflicts of interest relevant to the work of the meeting, which shall be recorded in the Minutes accordingly.

6.2 Members should exclude themselves from any part of a meeting in which they have a material conflict of interest. The Chair will decide whether a declared interest represents a material conflict of interest.

7. Duties and responsibilities

7.1 Ensure timely clinical and strategic decision making in line with the Schemes of Delegation (SoD) and Standing Financial Instructions (SFIs). (Note: Decisions relating to the collaboration between UHN and UHL should be referred to the Partnership Board.)

7.2 Oversee major work and UHN-wide risks set out in the Board Assurance Framework

7.3 Oversee the delivery of UHN's objectives and annual plans

7.4 Development, oversight and delivery of UHN's Strategy, Priorities and transformation initiatives, ensuring that a joined-up approach is taken across UHN

7.5 Develop, provide oversight to ensure delivery of the Trusts' annual integrated business plans, covering quality, finance, people and performance

7.6 Ensure a UHN-wide approach is taken to performance review and strategy development

7.7 Be responsible for the achievement of strategic objectives, compliance with statutory duties, performance standards and quality care

7.8 Promote and embed UHN's values and reinforce an open and inclusive culture

7.9 Support individual Executive Directors to deliver their delegated responsibilities by providing a forum for exchange of information, mutual support, and resolution of issues and achievement of agreement.

7.10 Identify issues for escalation to the appropriate Board committee as appropriate

7.11 Scrutinise any issues recommended for escalation to the Board and Committees, to ensure quality and accuracy

7.12 Identify opportunities for strategic alignment with external partners

7.13 Determine, or make recommendations, in respect of business cases, proposals and decisions, in line with approved limits set out within the Standing Financial Instructions and Schemes of Delegation and Reservation

7.14 Receive any escalations from the UHN Policy Ratification Group, regarding any documents which have a significant implication for UHN and are delayed in review

7.15 Provide a forum for exchanging information and providing mutual support between the trusts, identifying and disseminating good practice and/ or discussing and agreeing corrective actions where performance needs to improve, across UHN

7.16 Provide a mechanism for effective two-way communication and engagement between the Boards, ILT, and divisions.

Standing agenda items

The agenda and work plan will be structured around the themes of performance, finance, workforce and quality, ~~.~~ Once per month the ILT will be constituted as the Patient Safety Committee (under separate Terms of

Reference). The Patient Safety Committee will report to the Trust Boards Clinical Quality and Safety Committee-in-common.

- Feedback from the Board, Committees and Partnership Board
- Significant exceptions from trust operational teams and key messages for dissemination
- Group BAF, including escalation of distributed risk
- Items to escalate to the Board, Committees and Partnership Board
- Reports from sub-groups (where established)
- Policy approvals

8. Reporting responsibilities

The ILT is accountable to the UHN Boards through the Chief Executive, and it will formally escalate issues and decisions as required (as set out in its terms of reference), at the request of the UHN Board, or at the discretion of the Integrated Leadership Team Chair.

The ILT will make whatever recommendations to the UHN Board and Committees it deems appropriate in any area within its remit

Inputs:

The ILT will receive escalations/ exceptions from any sub-groups of the ILT,

9. Other matters

9.1 Amendments to these Terms of Reference must be approved by a resolution of each of the Boards of Directors. (KGH, NGH)

The ILT will:

9.2 Have access to sufficient resources to carry out its duties, including access to the Corporate Governance Team Governance team for assistance as required;

9.3 Consider any other matters where requested to do so by the UHN Boards;

9.4 Review its Terms of Reference to ensure that it is operating effectively at three monthly intervals for the first 12 months from the approval of these Terms of Reference, and thereafter annually. These reviews will be formally reported as part of the Chief Executive's appraisal.

10. Authority

The ILT is authorised to:

10.1 Seek any information it requires, or request attendance at a meeting, from any employee of KGH or NGH, in order to perform its duties;

10.2 To appoint groups with such membership and terms of reference as the Integrated Leadership Team may determine and delegate any of its responsibilities to such groups.