UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 26 November 2020

09:30

Via ZOOM
Northampton General Hospital

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

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A G E N D A

PUBLIC TRUST BOARD

Thursday 26 November 2020
09:30 via ZOOM at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr A Burns	**Verbal.**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal.**
	3.	Minutes of meeting 24 September 2020	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Patient & Staff Vlogs	Receive	Ms S Oke	**Verbal.**
	6.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	7.	Group Chief Executive's Report	Receive	Mr S Weldon	**C.**
	8.	Hospital Chief Executive's Report	Receive	Mrs D Needham	**D.**
PERFORMANCE					
	9.	Integrated Performance Report	Assurance	Mrs D Needham Board Members	**E.**
	10.	Reset and Recovery Phase 3	Assurance	Mr C Holland	**F.**
	11.	Winter Plan	Assurance	Mr C Holland	**G.**
GOVERNANCE					
	12.	Terms of Reference for Joint Committees – Quality & Digital	Assurance	Ms C Campbell	**H.**
	13.	Terms of Reference – Audit Committee	Assurance	Ms C Campbell	**I.**
	14.	Board Assurance Framework	Assurance	Ms C Campbell	**J.**

Time	Agenda Item		Action	Presented by	Enclosure
STRATEGY & CULTURE					
	15.	Fire Plan	Assurance	Mr S Finn	**K.**
	16.	Academic Strategy	Assurance	Mr M Metcalfe	**L.**
	17.	Pathway to Excellence	Assurance	Ms S Oke	**M. Presentation**
	18.	Integrated Care System	Assurance	Mr S Weldon	**N.**
CLOSING ITEMS					
	19.	Questions from the Public (Received in Advance)	Information	Mr A Burns	**Verbal.**
11:50	**20.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on 28 January 2021 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

Minutes of the Public Trust Board

Thursday 24 September 2020
09:30 by ZOOM teleconference

Present		
	Mr A Burns	Chairman (Chair)
	Mr S Weldon	Group Chief Executive Officer
	Mrs D Needham	Hospital Chief Executive Officer
	Mr M Metcalfe	Medical Director
	Ms S Oke	Director of Nursing, Midwifery and Patient Services
	Mr P Bradley	Director of Finance
	Ms J Houghton	Non-Executive Director
	Mr J Archard-Jones	Non-Executive Director
	Ms A Gill	Non-Executive Director
	Mr D Moore	Non-Executive Director
	Prof T Robinson	Associate Non-Executive Director
	Ms R Parker	Non-Executive Director
	Ms D Kirkham	Associate Non-Executive Director
	Mr C Holland	Interim Chief Operating Officer
In Attendance		
	Ms C Campbell	Director of Corporate Development Governance and Assurance
	Mr M Smith	Chief People Officer
	Mr S Finn	Director of Facilities and Capital Development
	Mr T Richard-Noel	Next NED Scheme
	Mr C Pallot	Director of Strategy and Partnerships
	Ms K Palmer	Executive Board Secretary
Apologies		

TB 20/21 030 **Introductions and Apologies**

Mr Burns greeted those present to the meeting of the Public Trust Board. He welcomed members of the public watching via the live stream. The live stream had also been joined by Ms K Hooban.

Mr Burns remarked that this was Mr C Hollands first Public Trust Board as the interim Chief Operating Officer for the Trust.

TB 20/21 031 **Declarations of Interest**

There were no declarations of interest.

TB 20/21 032 **Minutes of the Public Trust Board held on 30 July 2020**

The minutes of the Public Trust Board held on 30 July 2020 were presented and **APPROVED** as a true and accurate recording of proceedings subject to the below amendments.

Mr Archard-Jones – page 10 – '*Mr Metcalfe confirmed that a detailed update would be presented to the Quality Governance Committee'.* Mr Archard-Jones confirmed that this had been presented to the Quality Governance Committee.

TB 20/21 033 Matters Arising and Action Log Public Trust Board

The Matters Arising and Action Log were considered and noted.

Action Log Item 123 – due October 2020

Action Log Item 124 – due January 2021

The Board **NOTED** the Matters Arising and Action Log.

TB 20/21 034 Patient & Staff Vlogs

Mr Burns advised that the vlog was of a patient Mr N Allard whom Mr Burns was grateful to for sharing his patient story. Mr Allard had maxo-facial cancer and his story was an extremely interesting one.

Mrs Needham introduced the vlog. The Trust Board was aware that Cancer was a priority for the Trust and part of this included improving the patient experience of the pathways in addition to cancer performance. The vlog highlighted how important timely investment was to cancer treatment. Ms Oke thanked Mr Allard for sharing his story and stressed the importance of receiving a cancer diagnosis during the COVID19 pandemic.

The vlog was then shared on the screen for all to watch.

Mr Allard had visited the dentist due to an abscess. When the antibiotics had not worked the dentist referred him to maxillofacial where he had an x-ray. He had two teeth removed and biopsy undertaken in addition to a blood test. Mr Allard had a CT scan on 01 June and then met the Consultant 08 June who gave him the diagnosis of cancer. He had a Pre-Op assessment and was sent home to self-isolate between 08 June until his operation on the 23 June. He was discharged on 04 July and now on 24 August started Radiotherapy

In the vlog Mr Allard was asked how it had felt undergoing this whilst in a state of lockdown. Mr Allard had found it to be a big shock. It had been hard as his wife could not bring him in or visit which had been traumatic. He was grateful however that after surgery that there were no visitors as it had given him a chance on getting better.

Mr Allard remarked that he had felt that the lead up to surgery had felt quite quick and the service had been amazing. When he was diagnosed he was in shock but made his mind up to tackle head on. He was asked what had worked well. He stated that the McMillan nurses were very supportive and he finds that he can still ring them now.

Mr Allard commented that is has affected his working life as he has not been able work since. His family life was a good as ever. He had felt very supported from his family, friends and NGH. He advised that the only negatives had been the nightmares of parking.

Mr Allard stated that he had found the process humbling. He has managed to beat his needle phobia.

Mr Burns thanked Mr Allard for his story and that his positivity had been remarkable.

Mr Archard-Jones commented that the Board should not believe that all patients are treated as well and that this patient has had good experience. This experienced needed to be delivered for all.

Mr Burns remarked the patient had been fortunate that his referral had gone through as some referral rates had dropped.

Mrs Needham agreed with Mr Archard-Jones. The vlog had showed that it was correct to have agreed as a Trust Board that cancer was the main priority. If the Trust needed to get that positive experience for all and it was the best thing the Trust could do for the patients. Mrs Needham wished Mr Allard well.

Mr Burns concurred. This was a good point and when the Trust Board sets a priority it needs to be followed through. It was a long standing problem at the Trust and the Trust was determined to fix this.

The Board **NOTED** the Patient Vlog.

TB 20/21 035 Chairman's Report

Mr Burns reminded the Board and the public watching that the track and trace app had launched. He asked all to consider downloading the app.

Mr Burns advised that there were interviews ongoing for the HCP Chair. He believed think that a candidate could be recommended for appointment to the post. This had to be approved by the Chief Executive of NHS England.

Mr Burns had attended a call hosted by NHSE/I. It had covered COVID19 and the current resurgence in COVID. It had stressed the importance on maintaining electives and links with the independent sector. The call had also discussed winter and the prospect of flu. It had encouraged all to attend for their flu vaccinations. It would make a huge difference if the Trust and nationally could manage to go through winter with virtually no flu outbreaks.

Mr Burns remarked that there was no further information on Brexit.

Prof Robinson referred the Brexit and whether there had been any commentary about the potential impact on drugs supply as this had previously been a concern. Mr Burns stated that the problem was known and there had been confidence shared that there were arrangements in place. The preparation for this was being done nationally and locally. There were people working hard on areas on short supply.

The Board **NOTED** the Chairman's Report.

TB 20/21 036 Chief Executive's Report

Mr S Weldon presented the Chief Executive's Report.

Mr Weldon emphasised the importance of downloading the track and trace app. He encouraged all to download the app. It was part of our ability to contain the spread of the virus and this was really important part of our armoury. He was happy that it was here and able to be used.

Mr Weldon advised that the dominant theme of the conversation revolved around the elective work and the phase 3 submission. This was key to remember in today's discussions. He remarked on the importance that for first time the Trust was not making submission as only an individual hospital but was also monitored as a system. The figures represented the Trusts latest and best position in terms of what the Trust believed was achievable. Although there was still work to be done he wished to highlight a few things where there was welcomed progress.

Mr Weldon reported on the recovery of the cancer backlog and how important it is to maintain these services. He was pleased progress made between KGH and

NGH. It was highly important that screening was restarted. The best public health interventions were to detect the disease before it became life changing. Mr Weldon thanked all the clinical teams who had worked incredibly hard to get to this position.

Mr Weldon commented that the Trust was planning that COVID did not come at the same level as it did in the first wave. The Trust would have more room to move operationally. There was the expectation the Trust could not switch of elective services as it did last time.

Mr Weldon stressed that the Trust needed to agree that it had done everything that it could to maximise the patient it treated. He was not thinking from a target perspective but from the point of view of this is what the Board would want for their family. It needed to know that the local hospital had done its best it could to maximise elective activity.

Mr Weldon advised of 111 would be expanded and had a great emphasis on the need to direct members of the public quickly. He noted the complications with needing to social distance in A&E.

Mr Weldon reported the at flu vaccination rate for staff was aimed at 100%.

Mr Weldon stated that the reset paper had a significant section on workforce. One thing for the Board to consider was whether it was doing all could do to support staff after one of the most difficult years in NHS.

Mr Weldon referred to the word cloud on the last page of his report. This spoke to values of what people want the Trust to address. These are the core values and he invited all to reflect on the word cloud. This would be brought back to the Board in the new year.

Mr Richard-Noel noted the significant change with 111. Mr Holland was leading the work locally on this. Mr Holland explained that this was a large piece of work. There was a push on getting patients out of ED to alternative accommodation. This work was due to go live end of October. He remarked that 111 were struggling with capacity and numbers.

Mr Burns remarked on the difficulties of using ED due to social distancing and it was not fair to make patients wait outside in winter therefore it was good to be looking at alternatives.

The Board **NOTED** the Chief Executive's Report.

TB 20/21 037 Integrated Performance Report

Mrs Needham advised that this was her second Trust board as interim Managing Director. She thanked all Board colleagues for their support so far. She noted the journey of improvement and better ways of working with KGH. Her deliverables were to improve staff experience, improve cancer performance and the recovery from COVID19 whilst planning for next phase of COVID19.

Mrs Needham stated that August had been busier than normal years. The operational levels were back to that of pre-COVID19. The recovery from COVID19 would be discussed in the reset.

Mrs Needham reported that performance for some key stands set to the NHS had improved. It was noted that A&E had a higher performance then the regional average and that wait times for cancer patients had decreased. There was 84 patients waiting over 62 days and the number of patients had been at 150. There

was 8 patients waiting over 104 days. This was a good improvement and the teams had done really well.

Mrs Needham commented on the key initiatives in month. There had been the development of academic strategy. There had been key appointments and the Trust had been working with partners at University of Leicester. Other initiatives included the reduction of medical agency staff, and she also welcomed on behalf of the Board the next tranche of oversea nurses.

Mrs Needham advised that HR and OD had done a large amount of work on Health & Wellbeing whom she formally thanked for this. The HR and OD teams had supported many teams and it was crucial this continued.

Mrs Needham believed that winter was likely to be challenging and the staff were 100% committed. It was important that staff were supported.

Mrs Needham was pleased to inform the Board that the Trust had broken-even for August.

Mrs Needham repeated her thanks to the staff in the most challenging of times. Their commitment had been unwavering.

Mrs Needham handed over to the Chair's of the Committees to deliver their update.

Mr Moore provided the Board with an update from the Finance & Performance Committee.

Mr Moore advised that the Finance & Performance Committee had met on the 23 September 2020. The Committee had scrutinised a range of metrics and noticed that activity recovery was down on previous years. There had been some metrics which had held up well post-COVID19.

Mr Moore reported that there were a range concerns related to RTT which had suffered due to COVID19. The average wait time was 13.5 The target was 0 and was close to meeting pre-COVID level.

Mr Moore noted that the Committee had felt that a significant amount of work had been undertaken to improve Cancer performance.

Mr Moore remarked that the Committee had received an iCan update. This was a system wide project for integrated care across Northamptonshire. The project was in the data collection phase. The project was focused on improvements to the quality and quantity of discharge. The Committee would receive regular updates.

Mr Moore stated that the Committee had discussed the Phase 3 reset. This was a thorough piece of work. The presentation had looked at risk of delivery and the basis of the piece of work was on R=1. The Palliative capacity model had been shared and this was regarding bed capacity and 85% occupancy. It had been positive to see many options for additional capacity had been explored and he noted the importance of this.

Mr Moore commented that in regards to finance, the PbR had been superseded by the block contract and top up system. He remarked that it was interesting that if the Trust had been on a PbR contract the Trust would have had a deficit by £10m. This underlined the loss of activity, clinical activity and no clinical revenue. It was down 43% year to date and was at 30% current. It was noted that

expenses remained the same, however COVID19 had led to a less efficient way of working.

Mr Moore advised that the Committee had been happy to see a reduction in agency staff in August. The Committee had received a report on major capital projects. This update had been positive. He stated that £850k had been received for Endoscopy equipment at Danetre. Mr Moore stated that in regards to digital imaging capacity a new deal was been discussed. In regards to IT, the Committee had been pleased with the digital initiatives and believed a discussion of these at Board would be beneficial.

Ms Houghton thanked Mr Moore for his comprehensive update. She asked whether iCan was helping with flow. She noted that the discharge before midday and hospital moves overnight metrics had a dip in performance. Mrs Needham concurred that these metrics had not been heading the right direction. Mr Holland explained that iCan had not been designed for this winter and it was an 18-24 month programme. The project was also about quality of discharge not just numbers. There was an internal discharge programme which would be supporting this winter.

Prof Robinson delivered an update from the Quality Governance Committee.

Prof Robinson advised that the key items from the September QGC was as follows; the Board Assurance Framework for the IPC was included in agenda item 10, the Safeguarding update was delivered under agenda item 13 and the annual IPC report had been shared with the Board under agenda item 14.

Prof Robinson remarked that the Non-Executive Directors had agreed that a system wide approach was needed for addressing the issues within safeguarding. The Committee had also highlighted the importance of cancer performance improvements and maternity aspects, which had been detailed in the Medical Director update.

Prof Robinson reported that there had been a discussion on mortality. The Medical Director had informed the Committee of the impact of discharge to hospice had on the Trust's mortality rates. He reassured the Board that when looking at an alternative mortality index, and compared against other trusts, the Trust fell in the required range.

Prof Robinson commented that there had been an update on VTE. The Medical Director had reassured the Committee that there was a quarter on quarter reduction on hospital acquired VTE. There was a clear action plan in place and follow up audits.

Prof Robinson remarked that as part of group model there had been a productive conversation had with equivalent in QGC membership at KGH. This joint Committee would look at sharing best practice and take the opportunity to look at services provided by the group. Also to ensure both Trusts of the quality and safety of services for residents of Northamptonshire.

Ms Houghton delivered an update on Maternity. She commented that from assurance perspective there had been a good discussion on the rise in Serious Incidents in maternity. A small number of Serious Incidents were now being investigated due to the new ADN for Midwifey who had given fresh eyes onto the metrics. The Committee had welcomed this.

Ms Gill shared a Workforce Committee update with the Board.

Ms Gill advised that in regards to vacancies overall, this was at 8.4%, which was below target. A factor within this was that medical vacancies however number of medical candidates were in clearance. A resource plan was being developed and an update would be shared at next Committee.

Ms Gill informed the Board of the good news in regards to nurse staffing. The first cohort of oversea nurses had arrived in August, in September another cohort had arrived followed by another cohort due in October. The Committee would hear about their experience at the October Committee.

Ms Gill stated that the Junior Doctor rotation in August had ran well.

Ms Gill remarked that in regards to AHP's good progress was being made to recruit into some of these vacancies however there remained a challenge with Radiographers. The Workforce Committee was going to take a further look at turnover data.

Ms Gill advised that time to hire was at 11.6 weeks and this hoped to be further reduced. She stated that the absence level was at 4.46%, which was slightly up from July but lower than the previous month.

Ms Gill shared the positive news that the Trust was one of two Trusts in the region to provide 24/7 COVID19 testing for staff.

Ms Gill commented that the SoS Team had been shortlisted for a Nursing Times Award in recognition of their work on staff engagement and wellbeing.

Ms Gill reported that the Committee had talked about medical rostering, which was an initiative that the Trust was moving towards implementing. It was currently being piloted and would be roll out next 12 months. This was positive for patients as it would reduce cancellations and would be beneficial for the Trust as there would be a reduction in ADH payments.

Ms Gill stated that appraisals had been discussed and the Trust would be using an appraisal light process at current.

Ms Gill advised that the month of September had also included the second joint Workforce Committee with KGH. There had been a number of important updates at the joint Committee which included the People Plan and the progress against the plan. The plan would be developed for the group and also aligned to the NHS People Plan.

Ms Gill commented that there had been a flu vaccination update and the staff survey timetable had been shared. The WRES data had been discussed to ensure the actions were being progressed.

Mr Archard-Jones noted that it was good that the oversea nurses had started. He remarked that these nurses usually lived in multiple occupancy households and queried what support was being given to keep these nurses safe. Ms Oke explained that there was a clear programme in place. It was clarified that accommodation was reserved for the nurses for the first few months. The nurses were informed about COVID19 and the behaviours they needed to adopt. The nurse would isolate for 2 weeks and in this time conduct virtual learning.

Ms Parker delivered an update on the CPC to the Board.

Ms Parker advised that the CPC had met twice since the last Trust Board. The aims of the group were to steer the delivery of group model ambitions and drive

delivery of the group strategy.

Ms Parker stated that recruitment to group posts was progressing. The group leadership post hoped to be filled October/November time. The Committee had discussed the priority was to attract the best candidate and the talent the group needed. The development of the group priorities was also key. The progress between the first and second CPC had been pleasing. Some groups were flying in terms of progress whilst others still had some way to go. She had attended an engagement event and it had been nice to see a good level of engagement from the wider hospital. The staff believed that their input mattered.

Ms Parker reported that in regards to joint Committees the Workforce Committee was leading the way. The CPC had planned into the programme to invite different Committees in for a deep dive. The next one was digital, then Finance & Performance.

Ms Parker remarked that the Clinical Collaboration had varying degrees of progress. There were challenges in ENT in light of the COVID19 response. The CPC would be inviting clinical leads to the December CPC for a progress update. There was governance work to done on reporting from the other Committees into CPC. A reporting template had been agreed and the CPC felt that other Committees should provide a one-page oversight of those Committees priorities to ensure they all linked together.

Mr Burns advised that he had asked for a mortality update to be shared at the October Board development session. He requested that this was done jointly with Dr Foster as it would be beneficial to look at from their perspective also.

Mr Burns noted the good progress made on the joint Workforce Committee. The planning of a joint QGC was in progress. He was aware that a joint Finance & Performance Committee was extremely complicated. Mr Burns believed that it would be helpful to bring this all together with input from the Executive Team to ensure all was synced.

The Board **NOTED** the Integrated Performance Report.

TB 20/21 038 NGH Improvement Plan

Ms Campbell presented the NGH Improvement Plan.

Ms Campbell advised that this had been discussed at the QGC. The likelihood scores had now been included within the report. Only one action had been scored as unlikely due to the lack of available capital funding, to make the necessary changes to the paediatric ED layout, however, funding had subsequently been received for this.

Ms Campbell reported that all ‘must do’ were completed and these were linked to the requirement notice. There were some actions, which still required evidence. She referred the Board to action 36.1 and updated the Board that the cancer recovery plan was now in place.

Ms Campbell commented that this would be taken back to QGC next month and she hoped to close down further minimal actions. The outstanding actions had been given to other governance processes to monitor.

Mr Burns was happy with the progress made and the Board agreed.
The Board **NOTED** the NGH Improvement Plan.

TB 20/21 039 IPC Board Assurance Framework

Ms Oke presented the IPC Board Assurance Framework.

Ms Oke advised that the overall purpose of the paper was to should that IPC practice was safe and robust at the Trust. She had engaged CQC in regards to the Emergency Support Framework (ESF) and after subsequent discussion, the Trust had provided additional evidence as required. The paper also provided an update on how the Trust managed IPC throughout COVID19.

Ms Oke stated that the Trust had worked with their partners; Public Health England, KGH, the CCG and NHSI.

Ms Oke informed the Board that there had been three outbreaks at NGH. It was noted that one of these had been amongst staff and two amongst patients. Each of these had been investigated and the learning had been actioned. She drew the Board to pages 62-63 that provided further detail.

Ms Oke referred to appendix 1 which included the most up to date IPC BAF. The first iteration had been presented in May, and it had evolved since then. It had been subsequently presented to IPC Group and QGC. She was grateful for all Board members engagement and support into the document.

Ms Oke explained that the IPC BAF had ten questions aligned with the ESF and it followed a RAG rated system. The front page listed the five priorities.

Ms Oke confirmed that updates were to be presented to the IPC Group which would then feed up to QGC.

Prof Robinson had been disappointed at the initial response of CQC. There had been a detailed discussion at QGC and with Non-Executive Directors, the Medical Director and the Director of Nursing. A comprehensive response had been submitted with a detailed action plan. The plan had clear areas to be monitored at QGC with a clear list of mitigations.

There would be a monthly audit comprised of a 40 point action list. The month to month ward performance was tracked. The latest updated showed that only 4 wards that did not meet 85% plus target. These wards had then targeted interventions and the audit would be redone. The Committee had been reassured that this was taken seriously and would receive monthly updates.

Ms Houghton thanked Ms Oke for the overview. It would be good to have a timescale on the IPC BAF to enable monitoring of the delivery of these. It had been encouraging to see a large amount of green on the BAF. In map across to ESF the CQC had felt that the Trust had only met 4 of 11. She asked whether the Trust had addressed the outstanding. Ms Oke would look at incorporating a timescale. In regards to the ESF, she had a constructive discussion with CQC and had provided additional evidence. She was still in regular contact with the CQC and hoped to receive communication from CQC recognising the additional effort and evidence.

Ms Oke confirmed that the Trust had been working well with KGH in regards to sharing of evidence and initiative. She talked to their DIPSY and the two Trusts were clearly working in parallel.

Ms Oke was working closely with the Medical Director to address the shortages of Microbiologists. Mr Metcalfe confirmed that there was a national shortage and the Trust would continue to try a variety of innovative ways of working. The Trust had made contact with neighbouring Trusts and had looked at joint appointments with

the University of Leicester.

Mr Weldon noted and welcomed the CQC reports. Though it provided with challenges, it was clearly welcomed as it came at a time to improve what the Trust did before the critical period of winter. He thought that it was important that conversation continued, as it was helpful for Board. It would also be helpful to hear from staff on work they do. This would create an opportunity to hear directly from staff on frontline on what went well and what needed addressing.

Mr Archard-Jones asked had the Trust compared themselves against others providers which had scored as excellent to identify the gaps. He also queried how the Trust was persuading patients to not fear attending for treatment. Ms Oke explained that the CQC ESF was confidential to an organisation. The Trust has spoken to KGH to see what evidence they produced. There was also a strong IPC network where best practice was shared. Mr Archard-Jones suggested asking the CQC if they could provide further details. Mr Weldon noted that the Trust had talked to regional chief nurse. She would support the Trust in ensuring that it had the best practice.

Ms Oke commented that in regards to patients confidence it was important to make sure patients had all the information. Mr Weldon shared the initiative of the cleaning with confidence campaign and the Trust was enthusiastic about joining in. This would help with patient confidence.

Mr Burns concurred and stressed that the Trust took this very seriously. He believed that the report was at the reassuring end of the spectrum.

The Board **NOTED** the IPC Board Assurance Framework.

TB 20/21 040 **Post Covid-19 Reset**

Mrs Needham introduced the presentation. She thanked Mr Pallot and all who were involved. The presentation outlined an ambitious plan.

Mr Pallot delivered the reset presentation supported by Mr Holland, Mr Smith and Mr Bradley. He noted the importance of this being a system plan and not just across the group.

The presentation would be available on the website.

Mrs Needham remarked that throughout the presentation the word ‘system’ was used a lot. This could relate to the commissioning group, the hospital, ambulance service and sometimes the council.

Ms Kirkham commented that the presentation was very good and comprehensive, however noted that the capacity forecasting was on R=1. She asked what modelling had been done around higher figures. Mr Pallot advised that R=1 had been used across NHS, however in our area, this was not translating into hospital demand. The Trust will adapt if required. The plan was the Trust’s most likely position and the plan had put in worst-case scenario however, the plan had not advised of this impact on the bed base. An increase of r=1, a flu outbreak or greater than normal winter pressures, would affect plan. The key mitigations was to have two ward areas bubbled.

Ms Kirkham queried that as a hospital/group had the Trust/group done modelling if the R number increased. Mr Pallot confirmed that it had. The mitigations had be outlined by Mr Holland in the presentation and including working with the system partners. Mr Holland stated that the Trust had worked through the COVID19 models.

Mr Burns remarked that it was good to have a plan and a back up plan.

Prof Robinson commented that the Trust anticipated increase of admissions. He noted the workforce impact this entailed for example the open beds. Prof Robinson noted the Cancer work on endoscopy and imaging, which had been successful. The Trust also needed to mitigate against the loss of the Three shires. He also stressed the importance of IT investment and structure.

Mr Moore advised that there had been lack of sensitivity around the R=1 concern at Finance & Performance Committee. The GP referrals were up to pre-COVID19 levels. The GP's were conducting less face to face appointments and were relying on virtual appointments or sending the patient direct to NGH. The Trust needed to ensure the gains made COVID19 in virtual technology was not lost.

Mr Holland reported that the independent sector contract was in the place to the end of calendar year. The Trust would use this capacity as much as possible The Trust had been in early discussion with the Three Shires to have a longer-term arrangement. Mr Holland stressed that the Trust's priority had to be the best treatment for patients. This would bring finance implications to Finance & Performance Committee.

Mrs Needham stated that a lot more work was needed to done. In regards to Finance, the Trust would have to reconcile all delivery. The Trust would have to make sure as system that all involved were signed up to the right thing for patients.

Mrs Needham commented that the Trust did not want to operate at bed capacity of 100%. This was not safe, especially during COVID19. She referred back to the earlier discussions that some patients felt afraid to come in organisation. She reassured the public that it was safe to come into the Trust. The Trust can contact patients via phone prior to their appointment to allay fear.

Mr Archard-Jones referred back to page 6 of the presentation. These were good commitments and he asked what level of confidence the Trust had in them. The bed capacity and additional beds were not all within the Trust's control. He asked whether the Trust was reliant on the additional beds. Mrs Needham remarked that the Executive Team stood behind the plan and the plan had been discussed with the Divisions who had assured that it could be delivered.

Mr Richard-Noel queried that if there was a worst case scenario, was the Trust prepared for this. Mrs Needham confirmed that there had been discussions about the next steps. The Trust knew worst case however could not fully mitigate this and were working with system to mitigate gap.

Mr Weldon remarked that this was the system plan and the Trusts contribution to it. He paid tribute to the staff and primary care colleagues who have helped develop it. They also had a role to help manage demand and get those who require our services to us.

The plan showed how the Trust could deliver. The key point was the number of delivery assumptions. The Trust had been clear that it needed support from system partners. He stressed that the plan relied on COVID19 remaining at a containable level. The worst cases scenario included having to use rationale and protect as much elective work as possible.

Mr Burns stated that this was a big item for staff and the occupancy/capacity of the Trust. The three key messages were to have your flu jab, download the

COVID19 app and follow rules. If you are worried about coming in, please make contact with the Trust.

The Board **NOTED** the Post Covid-19 Reset.

TB 20/21 041 Academic Strategy

Mr Burns advised that this was a very good positive story. This was a Board priority.

The Board **NOTED** the Academic Strategy.

TB 20/21 042 Safeguarding Annual Report

Mr Burns noted that the CQC are aware of the concerns. There was a summit to take forward of safeguarding. It had clearly be recognised as a problem in Northamptonshire.

Ms Oke stated discharge was key and reassured that the challenges around training had been pick up as a priority. Mr Burns had noted a lot of training issues and for these to be addressed in the Workforce Committee.

The Board **NOTED** the Safeguarding Annual Report.

TB 20/21 043 Infection Prevention Annual Report

Ms Oke presented the Infection Prevention Annual Report. This had been discussed at QGC.

Ms Oke remarked that the achievements in the last year had included a14% reduction in MSSA, increased compliance MRSA screening and no surgical site infections. She clarified that where there had been incidents there had been no harm noted.

Ms Oke reported that the Trust had performed over trajectory for MSSA. The Vascular Access Group had addressed any concerns. The Chair of this group had delivered a good presentation at QGC which had provided further assurance. The MSSA year to date sat at 3.

Ms Oke advised that Cdiff was over trajectory. The way it was measured had changed. The ceiling was 40 and there had been 44 in year. She remarked that all had been reviewed and there was no lapse in care identified.

Ms Oke commented that E-coli had a target to reduce the number of incidents by 50% by 2024 (launched 2017). There had been an increase of 5 last year however the Trust had not received the comparable figures yet.

Ms Oke stressed the focus was on the organisational readiness for the ongoing challenge COVID19 and IPC service.

Ms Houghton thanked Ms Oke for her good summary. She was very pleased that the Chief Nurse for the region was engaged. Ms Houghton queried whether a peer review could be organised. Mr Burns believed that this was a helpful suggestion.

Mr Burns referred to the earlier report on IPC and annual report. This was going to be year were infection control had to be rigorous. The outbreak reported in summer had raised Board level concerns. He liked the idea of peer review and input from the regional nurse. He would like a task and finish cross committee group. The group would covers a range of issues and he proposed that cross committee group conducted a deep dive with a progress report in October, and

thereafter, a full report in November. This was a reasonable way of assuring Board and reassuring the Public.
Action: Ms Oke

The Board **NOTED** the Infection Prevention Annual Report.

TB 20/21 044 Fire Safety Annual Report & Fire Safety Board Compliance Statement

Mr Finn presented the Fire Safety Annual Report & Fire Safety Board Compliance Statement. The report outlined April 2019 to March 2020.

The Board **NOTED** the Fire Safety Annual Report & **AGREED** to sign the Fire Safety Board Compliance Statement.

TB 20/21 045 Questions from the Public (Received in Advance)

There were no questions received in advance from the Public.

TB 20/21 046 Any Other Business

There was no other business to discuss.

Date of next meeting: Public Trust Board - Thursday 26 November 2020 at 09:30 in the Board Room at Northampton General Hospital.

Public Trust Board Action Log **Last update** **13/11/2020**

Item No	Month of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Updates
Actions - Slippage								
Actions - Current meeting								
123	Jul-20	TB 20/21 021	Board Assurance Framework	Mr Moore highlighted the target risk for BAF 1.7 and 1.8. He had raised this at the Finance & Performance Committee. It was not well articulated on how to get from a risk score of 20 to a risk score of 10. Ms Campbell would be discussing this with the relevant Executive and would update these with further details for the next presentation of the report	Ms Campbell	October-20, deferred to Nov-20	On Agenda	
125	Sep-20	TB 20/21 043	Infection Prevention Annual Report	Mr Burns referred to the earlier report on IPC and annual report. This was going to be year were infection control had to be rigorous. The outbreak reported in summer had raised Board level concerns. He liked the idea of peer review and input from the regional nurse. He would like a task and finish cross committee group. The group would covers a range of issues and he proposed that cross committee group conducted a deep dive with a progress report in October, and thereafter, a full report in November. This was a reasonable way of assuring Board and reassuring the Public	Ms Oke	Nov-20	On Agenda	
Actions - Future meetings								
124	Jul-20	TB 20/21 025	Equality, Diversity and Inclusion – BAME Staff Support	The Board requested a further update in 6 months	Mr Smith	Jan-21	On Track	

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Report To	**Public Trust Board**
Date of Meeting	**26 November 2020**

Title of the Report	**Group Chief Executive's Report**
Agenda item	**7**
Presenter of Report	Simon Weldon, Group Chief Executive
Author(s) of Report	Simon Weldon, Group Chief Executive

This paper is for: (delete as appropriate)

Approve	Receive	√ 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 Chief Executive Update: November 2020

Update on the Group Vision Mission and Values

The engagement with staff and the public continues around the future vision, mission and values of the Group. The draft vision and mission statements are shown below. The engagement will continue through December, with Boards considering feedback from the engagement ahead of approval at both January Boards.

Both executive teams have been working together on the development of the ambitions for the Group in five priority areas in support of achieving our vision and mission; Patient, Quality, People, Sustainability and Systems and Partnerships. For each area, we have been agreeing what our ambition is and how we will measure it, looking at the data and information we have about where we are currently, and identifying what the Group's initial areas of focus will be. In the coming months we will further develop these and mapping out where we want to be in a year and how we will get there together.

"Dedicated to Excellence"

Vision statement

Dedicated to outstanding patient care and staff experience by becoming a university hospital group and a leader in clinical excellence, inclusivity and collaborative healthcare

Mission statement

Provide safe, compassionate and clinically excellent patient care by being an outstanding employer for our people, creating opportunity and supporting innovation, and working in partnership to improve local health and care services

We continue to engage with staff, patients and local people about our emerging vision, mission and values. I have been delighted to take part in a dedicated public listening events with, at the time of writing, a further event planned on 26 November at 6pm, and two staff events. I was joined by Andy Callow, Mark Smith, Eileen Doyle and Debbie Needham. Jo Yeaman, strategic communications advisor, has been supporting us in facilitating these and other discussion sessions with a variety of groups. These have included sessions with groups of people who sometimes find it harder for their voices to be heard, so that we can be sure the views we hear are widely representative of the communities we serve.

We have spoken with leadership teams at both Trusts, staff groups (such as the Staff BAME Networks), patient groups (such as the Prostrate Cancer Support Network) and our healthcare partners across the county. I have included a list of groups at the back of my report.

The feedback and questions we've received during all engagement activities have led to interesting and lively discussions, and we have received widespread support for the proposed vision and mission as well as some helpful challenge for us to consider.

Feedback from all engagement activities will be shared at the Board development session in December for review and reflection, and the final statements will be signed off in the January Public Board session. We have also been using a graphic scribe to map the conversations in pictures, and I will be pleased to share the product of this activity in the next board session.

Covid-19

I'd like to take this opportunity to once again thank everyone across both hospitals for their continuing dedication and commitment to caring for all our patients during the COVID-19 pandemic.

It has been a challenging year so far, and the second wave means both hospitals are getting busier. This comes at the same time as winter pressures increase and we are fully committed to maintaining our planned care (elective or routine, appointments and surgery).

We must all take steps to protect ourselves and each other and I'd like to take this opportunity to encourage everyone to make sure we are all doing our bit by washing our hands, covering our faces and socially distancing as much as possible. Remember; Hands, Face, Space.

We have learned so much about COVID-19 and how to treat it over recent months, so we are much better placed to care for those who need admitting to hospital. But we also know we must look after our own staff and I would urge any members of Team NGH and Team KGH to take full advantage of the many measures we now have in place across both sites to support them – from protecting their mental and physical wellbeing to the continuation of free parking for all staff, free warm meals, and helping colleagues to work from home wherever this is possible.

Further support to help keep staff at work in a safe environment includes asymptomatic testing for them and their families, as well as the flu vaccine. We are also offering home-testing COVID kits for staff and we are working on plans for the roll out of the COVID-19 vaccine for NHS and care staff in Northamptonshire as soon as it becomes available.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable excellence through our people* 6. *Become a University Hospital by 2020 becoming a centre of excellence for education and research*
Risk and assurance	
Related Board Assurance Framework entries	All
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Financial Implications	To be advised as the plans develop
Legal implications / regulatory requirements	None

Actions required by the Board

The Board is asked to:

- Note the paper

Engagement sessions that have taken place:

Leadership:

- Hospital Management Team, Medical Leadership Group, Board and Governors

Staff

- Clinical Leads, Staffside, Staff Reference Group, Online Shielding Group, Equality, Diversity & Inclusion Steering Group, Staff BAME Network, Staff Disabilities Group, Volunteer Groups, All staff Group Briefings.

Patient Representative Groups and External Stakeholders

- Patient Experience & Involvement Steering Group, Patient & Carer Experience & Engagement Group, Patient and Family Partners, Prostate Cancer Support Group, Northants Health and Care Partnership, Healthwatch, Northampton Association for the Blind (NAB) and two Live events for all members of the public.

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Report To	**Public Trust Board**
Date of Meeting	**26 November 2020**

Title of the Report	**Hospital CEO report**
Agenda item	**8**
Presenter of Report	Deborah Needham – Hospital CEO
Author(s) of Report	Deborah Needham – Hospital CEO

This paper is for: (delete as appropriate)

□ Approve	□ Receive	X 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

Executive summary

The Hospital CEO report covering key activities throughout the last two months including:

- **Covid-19**
- **Our staff**
- **Performance headlines**
- **Estate**
- **Other activities which have taken place in October & November 2020**

Related Strategic Pledge	1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a great place to work, learn and care to enable excellence through our people*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks
Related Board Assurance Framework entries	BAF – NA

Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	NA
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper - No

Actions required by the Trust Board

The Board is asked to note this paper

Hospital Chief Executive's report

Deborah Needham
November 2020

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Contents

November Headline

“I am so proud of all that our staff have done & continue to do for our patients & for each other during what has been a most challenging year for so many reasons”

Deborah Needham
Hospital CEO

Covid - 19 Update

Covid continues to dominate our agenda in all that we do both at work and in our own family life. Activity in the region has increased and put additional pressure on all hospitals

- The number of people with Covid in the community is increasing & numbers of patients we are caring for in our hospital is also increasing
- At the height of Covid wave one we had 131 positive inpatients and a bed occupancy at best of 45%
- We are caring for 61* positive inpatients and a bed occupancy of 100%*
- In total we have cared for 1,155* Covid positive inpatients this year
- On average each day we have 700 staff working from home
- We have 126* staff self isolating with 30% diagnosed Covid positive

* Information as of 19th November 2020

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Covid - 19 Update

We have an ambitious target to restore outpatients & elective activity to 90% of last years activity

- Activity for October against the planned activity:
  - GP referrals – 78%
  - Outpatients – 92%
  - A&E attendees – 66%
  - Non elective inpatient – 92%
  - Day case – 87%
  - Elective inpatient – 97%
  - Diagnostic tests* – 142%

* Average of all modalities

Our staff

In October we have celebrated:

- World Mental Health Day
- Allied Health Professionals Day
- Clinical Engineering Day
- Baby Loss Awareness week
- Stoptober – for people wanting to stop smoking
- Pathology month
- F2SU month
- Halloween
- Two members of staff being awarded with a British Empire Medal
- Our very own best possible care awards

We launched our Flu campaign

- 57% of our staff have had their flu vaccine*

* Flu vaccine 57% as of 19th November 2020

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Our staff

Health & wellbeing of our staff is just as important as caring for our patients:

Last year TeamNGH said... **"We want our wellbeing valued more"**

Northampton General Hospital NHS Trust

So we....

- now have access to a psychology service for staff that can be accessed quickly and easily through Occupational Health or the SoS team
- now have an SoS team of 47 trained practitioners to support individuals or teams when things at work or home are not easy
- now have 'Our Space' as a place for any of us to take some time out if we need to
- currently have access to free onsite parking to make coming to work that bit easier

Our thankyou events:

- October – Avios points
- November – staff raffle
- December – Christmas jumper day, cards, & gifts
- January 21 – staff raffle

Northampton General Hospital NHS Trust

Performance headlines

Our hospital continues to be busy, our focus remains on recovery as well as ensuring we see and treat those who need us the most

- Cancer 62 day performance – the number of patients waiting over 62 days has reduced by 69% since July
- We have 46 patients* waiting over 62 days of which 7 have waited over 104 days
- RTT average wait has reduced to 9.5 weeks in November
- 78.3% of our patients were seen, treated and discharged/admitted from A&E within 4hrs in October (5% higher than Oct 2019)
- Our finance position for October is better than plan with improved agency spend
- Our overall vacancy continues to decrease and for October is 7.23%, sickness absence has however increased

* Information as of 19 November 2020

Our estate

We continue to make good progress with our estate developments:

- Children's AE – Building work has started & will be completed by the end of the year

- New main entrance – will be completed late spring

- ITU – Building work has started & the unit will be operational by July

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Other activities

During the last 2 months we have also:

- Launched datix cloud
- Doubled our oxygen tank capacity
- Re-established our swabbing drive through
- Launched the staff survey
- Changed some of our processes to support the launch of NHS 111 first
- Launched “cleaning for confidence” campaign
- Had a Trust wide poppy appeal & remembrance street display
- Developed a visitors pass
- Weekly themed days for our staff restaurant
- Free evening meals for staff
- Launched in your role for executive directors
- Continued to keep our staff updated with twice weekly bulletins, vlogs & blogs
- Held engagement events for the group vision, mission & values
- Received the money for our electrical safety works & new critical care unit
- Launched coffee & chat sessions with our hospital CEO
- Financial plans connected to Reset submitted as one system plan

Report To	**Public Trust Board**
Date of Meeting	**26 November 2020**

Title of the Report	**Integrated Performance Report**		
Agenda item	**9**		
Presenter of Report	Carl Holland, Chief Operating Officer		
Author(s) of Report	Adrian Marsden, Head of Information		
This paper is for: (delete as appropriate)			
☐ Approve	X Receive	☐ 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

Executive summary

The integrated performance report highlights via SPC charts any adverse variances in performance relating to national performance targets, financial performance, Quality & workforce metrics.

Each Director has provided a summary.

Related Strategic Pledge	1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a great place to work, learn and care to enable excellence through our people*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks Assurance on risk
Related Board Assurance Framework entries	BAF – All
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote

	good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	NA
Legal implications / regulatory requirements	None

Actions required by the Trust Board

The Trust Board is asked to receive the paper and note the performance & individual Directors summaries, seeking any areas of clarification to gain assurance during the meeting.

Corporate Scorecard – Integrated Performance Report

Date: November 2020
Reporting Period: October 2020

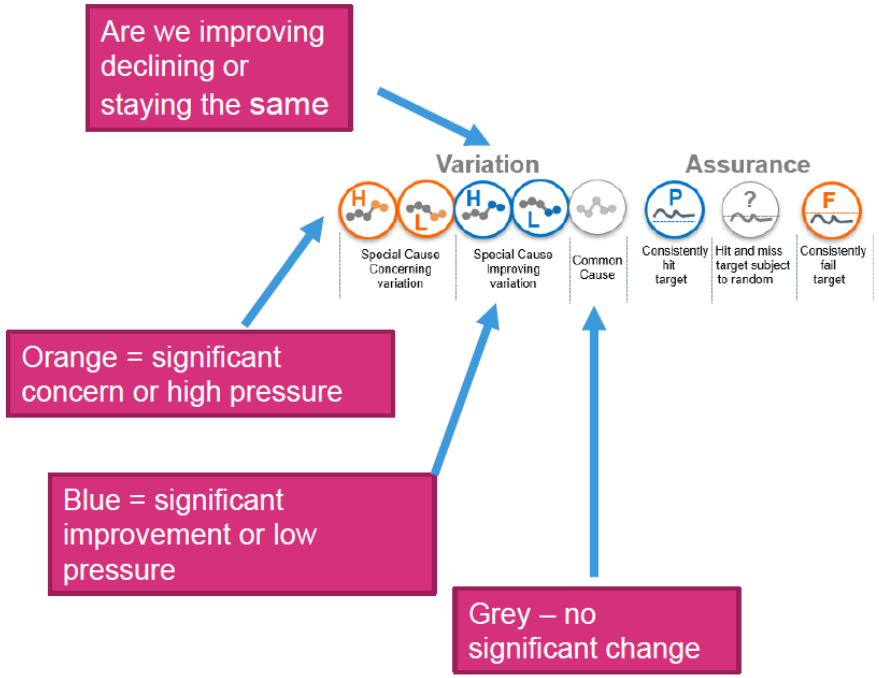
Pilot SPC Charts

Collaboration work with KGH and a wish to move to a common style of Board reporting was agreed by the Collaboration Steering Group in August 2019. Subsequently, an assessment of both Boards' report was completed, leading to eight metrics being agreed for both trusts to report on using SPC. The number of metrics moved to SPC will increase over the next few months, with the format of the Corporate Scorecard changing accordingly.

The reports that follow use the key below. A recap of using these descriptions is also included

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

High level key - variation



High level key - assurance

Domains: Caring, Effective & Safe

Domain	Metric	Target	Variation	Assurance	Chart
Caring	Complaints responded to within agreed timescales	90%			
Caring	Friends & Family Test % of patients who would recommend: A&E	86%	No Update due to Covid-19		
Caring	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	96%			
Caring	Friends & Family Test % of patients who would recommend: Maternity - Birth	97%			
Caring	Friends & Family Test % of patients who would recommend: Outpatients	94%			
Caring	Mixed Sex Accommodation	0			

Caring Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Sep-20	Oct-20	Chart
Caring	Compliments	N/A	No Update due to Covid-19		

Domain	Metric	Target	Variation	Assurance	Chart
Effective	Length of stay - All	4.2			
Effective	Percentage of discharges before midday	25%			Page 9
Effective	# NoF - Fit patients operated on within 36 hours	80%			
Effective	Maternity: C Section Rates	29%	Outside Control Limits		Page 27
Effective	Mortality: HSMR	106	Outside Control Limits		Page 28
Effective	Mortality: SHMI	109			
Effective	Stranded Patients (ave.) as % of bed base	40%	Outside Control Limits		Page 10
Effective	% Daycase Rate	80%			
Effective	Super Stranded Long Stay Patients (ave.) as % of bed base	25%	Outside Control Limits		Page 11
Effective	Readmissions within 30 days of previous reporting month	12%	No Data Available		

Effective Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Sep-20	Oct-20	Chart
Effective	Patient Ward Moves Overnight (22:00 - 06:59)	0	257	247	

Domain	Metric	Target	Variation	Assurance	Chart
Safe	HOHA and COHA (C-Diff > 2 Days)	3			
Safe	MSSA > 2 Days	1			
Safe	VTE Risk Assessment	95%	Outside Control Limits		Page 29
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	60			
Safe	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	98%			

Safe Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Sep-20	Oct-20	Chart
Safe	Never event incidence	0	1	1	
Safe	Number of Serious Incidents (SI's) declared during the period	N/A	8	9	
Safe	MRSA > 2 Days	0	1	1	
Safe	New Harms	<=2%	No Update due to Covid-19		
Safe	Appointed Fire Wardens	>=85%	100.0%	100.0%	
Safe	Fire Drill Compliance	>=85%	94.7%	90.0%	
Safe	Fire Evacuation Plan	>=85%	100.0%	100.0%	

Domains: Responsive

Domain	Metric	Target	Variation	Assurance	Chart
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	90%			
Responsive	Average Ambulance handover times	00:15:00	No Data Available		
Responsive	Ambulance handovers that waited over 30 mins and less than 60 mins	25	Outside Control Limits	F	Page 12
Responsive	Ambulance handovers that waited over 60 mins	10	L		
Responsive	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	L		
Responsive	Average Monthly DTOCs	23	No Data Available		
Responsive	Cancer: Percentage of patients treated within 31 days	96%			

Responsive Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Aug-20	Sep-20	Chart
Responsive	RTT median wait incomplete pathways	<=10.9	15.3	10.5	
Responsive	Cancer: Faster Diagnosis Standard	>=63%	64.8%	73.6%	

Section:	Indicator:	Target:	Sep-20	Oct-20	Chart
Responsive	Unappointed Follow Ups	=0	6,503	7,496	

Domain	Metric	Target	Variation	Assurance	Chart
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%	L		
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%			
Responsive	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	Outside Control Limits	F	Page 13
Responsive	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	Outside Control Limits	F	Page 14
Responsive	Cancer: Percentage of patients treated within 62 days of referral from screening	90%			
Responsive	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	85%			
Responsive	RTT over 52 weeks	0	Outside Control Limits	F	Page 15
Responsive	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	99%	Outside Control Limits	F	Page 16
Responsive	Stroke patients spending at least 90% of their time on the stroke unit	80%			
Responsive	Suspected stroke patients given a CT within 1 hour of arrival	50%	L	P	

Domains: Well Led

Domain	Metric	Target	Variation	Assurance	Chart
Well Led	Income YTD (£000's)	0	Outside Control Limits	?	Page 18
Well Led	Surplus / Deficit YTD (£000's)	0	Outside Control Limits	?	Page 19
Well Led	Pay YTD (£000's)	0		P	
Well Led	Non Pay YTD (£000's)	0		?	
Well Led	Bank & Agency / Pay %	7.5%	Outside Control Limits	F	Page 20
Well Led	Sickness Rate	3.8%		F	Page 22

Well Led Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Sep-20	Oct-20	Chart
Well Led	Percentage of all trust staff with mandatory refresher fire training compliance	>=85%	No Update due to Covid-19		

Domain	Metric	Target	Variation	Assurance	Chart
Well Led	Staff: Trust level vacancy rate - All	9%	Outside Control Limits	F	Page 23
Well Led	Staff: Trust level vacancy rate - Medical Staff	9%		?	
Well Led	Staff: Trust level vacancy rate - Registered Nursing Staff	9%	Outside Control Limits	?	Page 24
Well Led	Staff: Trust level vacancy rate - Other Staff	9%	Outside Control Limits	F	Page 25
Well Led	Turnover Rate	10%		P	
Well Led	Percentage of all trust staff with mandatory training compliance	85%	No Update due to Covid-19		
Well Led	Percentage of all trust staff with role specific training compliance	85%			
Well Led	Percentage of staff with annual appraisal	85%			
Well Led	Job plans progressed to stage 2 sign-off	90%			

Directors view – Chief Operating Officer

Performance - A&E 4hrs

- Performance was 78.37% for October which is a drop of 2.48% on Septembers figure of 78.37%.
- Emergency activity continues to increase to 11,793 attendances but this is still below pre Covid figures by approx. 30%. Admissions however are at 97% of pre COVID activity as we see the acuity rising.
- Ambulance conveyance has increased month on month with an increased acuity and resultant conversion rate. 2821 ambulance arrivals were recorded for October 2020. The average arrivals over the past 12 months is 2506 per month.
- Whilst the numbers attending ED are not as great as previous years the key difference is due to increased SDEC activity we are seeing less patients that typically didn't breach, required minimal input and good turnaround. Whilst this is definitely the right thing in terms of ED being kept for ED it has reduced our denominator in terms of easy none breach patients.
- Capacity of SDEC and Frailty will see an increase in Capacity in December when both Frailty and SDEC move to Quinton ward which is a significantly bigger footprint
- Additionally the need to stream patients based not just on acuity and skill set required but on IPC has resulted in delays to beds resulting in longer stays in ED.
- Currently all 'green' patients are required to have a negative covid swab prior to leaving ED this compounds delays and breaches.
- Stranded & super stranded patient numbers have reduced to 240 and 87 respectively although bed occupancy is now at 96% however 2 wards are currently closed.

Cancer waiting times

- Cancer Services Team transferred from Women's, Children's, Haematology and Oncology Directorate to Corporate function 01/11/20
- Review undertaken of pathway management meetings, move from twice weekly ptl meetings to once a week targeted ptl focused on escalated patients through individual tumour site ptl meetings
- Bid developed for pathway improvements through Rapid Diagnostic Centre funding streams
- 2ww referrals from GP's above pre covid levels from September onwards
- Legacy patients, those on their pathway in excess of 62 days is 57 as of the 16/11, compared to 150 in July. Patients waiting in excess of 104 days now 8 versus 69 in July **(As of 20/11 this figure is now 46 patients over 62 days and 7 patients waiting over 104 days)**
- 2ww Standard now being achieved from October 2020, last achieved September 2019
- All teams made considerable shift in capacity for patients to be seen in 7 days or less for first outpatient

Directors view – Chief Operating Officer

RTT – Average wait time

- The median wait for September was 10.5 weeks, a reduction from previous months; August (13.5), July (15.5) , June (16.5) and May (14.5).
- The number over 52+ weeks for September was 591 an increase from 462 in August and 351 in July.
- ***Current position week commencing 9/11/20;***
  - ***Median weeks wait was 9.5 weeks, a significant reduction from previous months.***
  - ***The total number of pathways at 52 + weeks is 654.***
  - ***The total number of pathways over 40 weeks is at 2187. This is a decrease from previous months.***
- The average wait to be seen and number of patients waiting 52+ has continued to be a challenge nationally with the COVID shut down of elective work.

Actions:

- Phase 3 recovery plans have been submitted and being progressed with the restoration of elective activity, priority is still being given to clinically urgent and cancer patients.
- Insourcing options being progressed to provide additional capacity within key surgical and medical specialties.
- Weekly PTL's in place with a focus on 52+
- Reset Delivery Group in place as part of Phase 3 recovery. A performance monitoring model aligned with KGH designed to provide a weekly view of how we are progressing against our phase 3 submission has been progressed and will form part of this Group.
- NEC's clinical validation programme being progressed to support prioritisation of elective activity. Healthcare Communications being utilised to support administrative screen as phase one of the NECS clinical validation programme and clinical validation approach to be agreed.
- Clear PTL is being used to target and focus validation in key areas of the PTL.
- Elective Care Hubs task and finish group in place to support system wide working.
- All available elective theatres operational from September 2020.
- Utilisation of Independent sector is maintained (BMI TSH)

Risk:

- Impact of a covid-19 surge and associated staffing risks

Diagnostics – 6 weeks

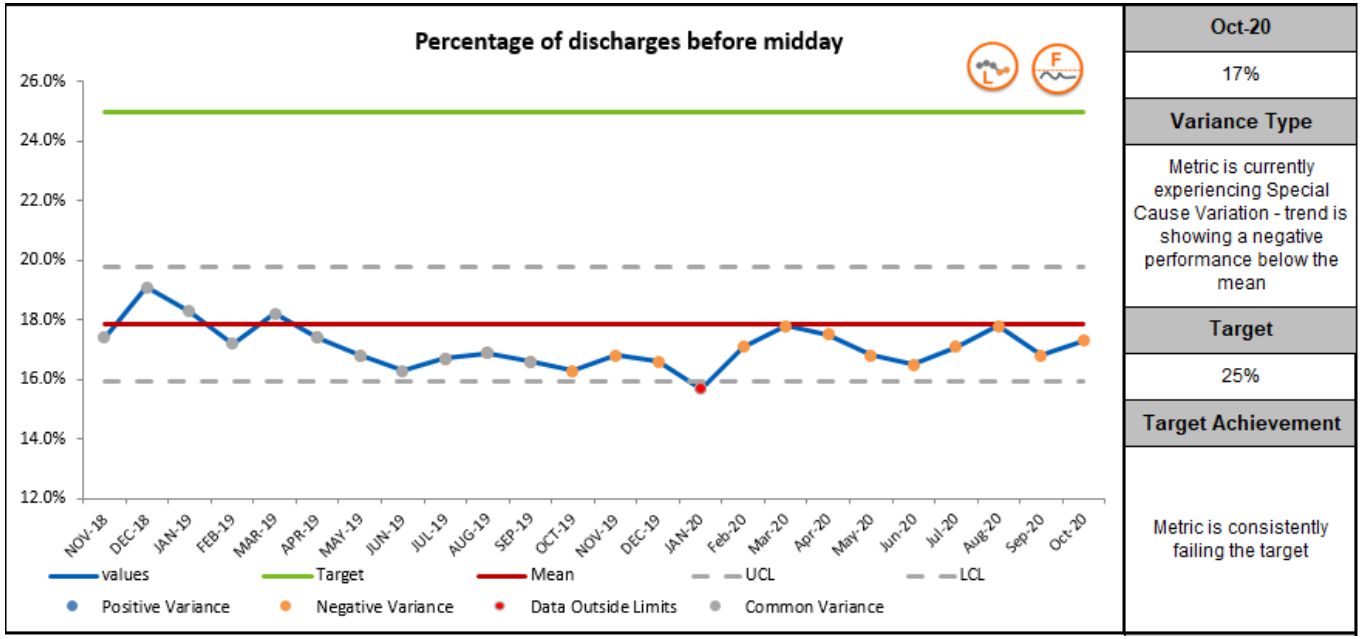
- Performance has Increased significantly from 46% to 74% due to all routine diagnostic procedures restarting post COVID phase 1 with all modalities now performing at >100% of pre-covid activity levels .

Actions being taken:

- Additional capacity (internal & external) is in place to manage the demand.
- Daily NHSE/I regional provider calls in place to support recovery.
- Work on-going with CCG to develop referral guidelines for GP requesting of MRI to better manage demand
- Routine MRI & CT now being booked within 6 weeks with exception of paediatric sedations and cardiac angiography CT scans
- Recovery will be slow due to the need to use PPE & socially distance which will make processes slower.
- Elective & Outpatient/diagnostic bronze cell in place as part of reset.

Please note variability in all performance metrics which is due to the covid-19 pandemic

SPC Charts – Discharges by Midday



Oct-20
17%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
25%
Target Achievement
Metric is consistently failing the target

Actions:

Trial with Discharge coordinators of a delays management process for the patients who are not super-stranded (pilot to be undertaken by end October)

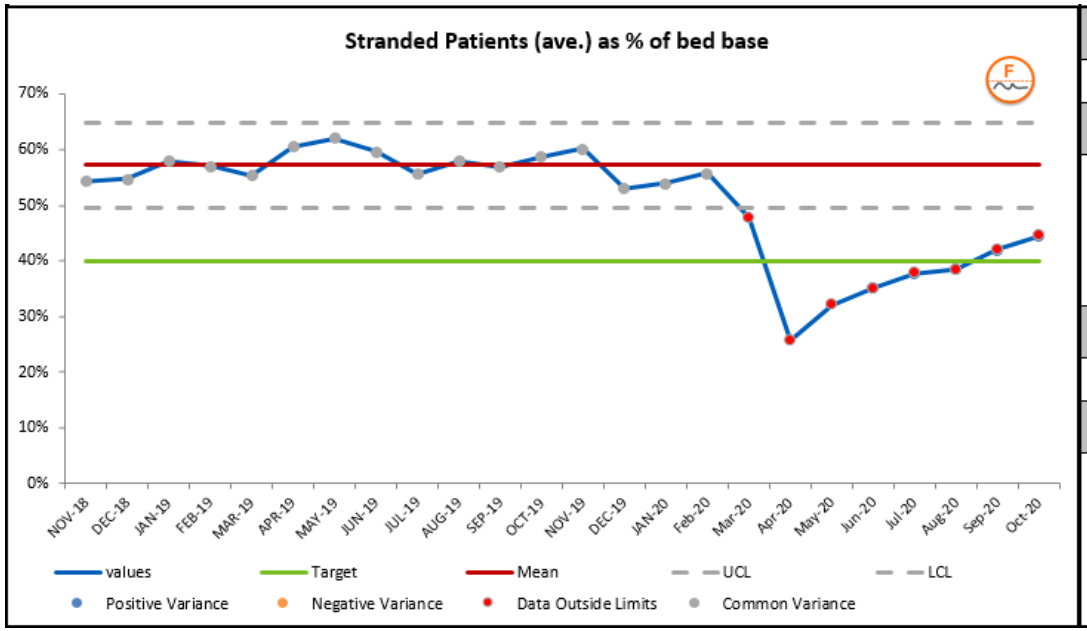
ICAN discharge pillar has completed the diagnostics phase of the programme and is now developing its key work streams to address the challenges identified

Context:

Discharges before Midday have improved in 2020 from the previous year but have now stubbornly sit at 17%

- data for the number of patients discharged daily against the LOS distribution broken into 0 day, 1-3, 3-7, 7-14, 14-21 & 21 days+ is being analysed
- introduced a daily multi-agency super stranded review meeting to highlight, challenge and support progression for our longest LOS patients.
- trial of a delays management process with the discharge team focussing on supporting delays raised at board rounds is underway
- EDN & TTO completion - in the short term a doctor has been employed to support rapid production, and the longer term plan is managed through the weekly discharge cell

SPC Charts – Stranded patients (avg.) as a % of bed base



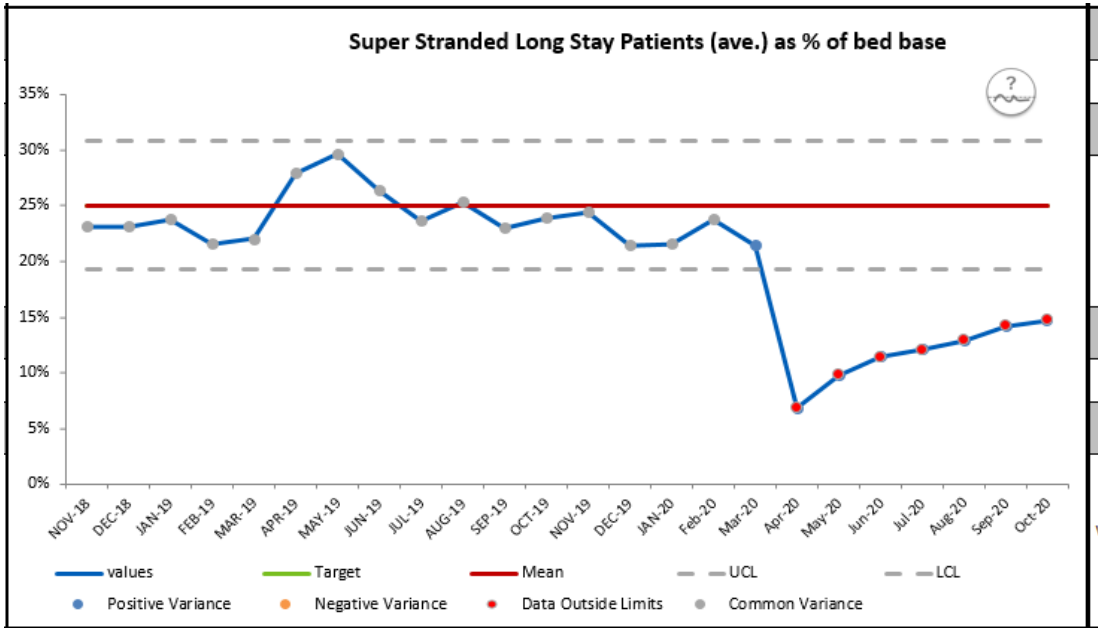
Oct-20
44.5%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
40%
Target Achievement
Metric is consistently failing the target

Context:
Stranded figures continue to increase slowly from the lowest ever figure during the pandemic when the hospital prepared to receive COVID patients. However the figure remains well below the previous years figures .

Actions:

- Ongoing work with the Reason to Reside Discharge Cell as a part of the ICAN Discharge long term project.
- National guidance released at the end of August on discharge makes far reaching expectations that the Trust and the 'system' have completed a gap analysis against and an action plan has been developed. This is being fast-tracked based on impending winter and COVID – 2 spike
- Review of project groups within the NGH Discharge cell, including refocus on why patients with a LOS below 21 days who do not have a Reason to reside remain in hospital. Those over 21 days are reviewed 5 days a week with Deputy Coo and senior leaders from partner organisations.

SPC Charts – Super Stranded patients (avg.) as a % of bed base



Oct-20
14.7%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
25%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

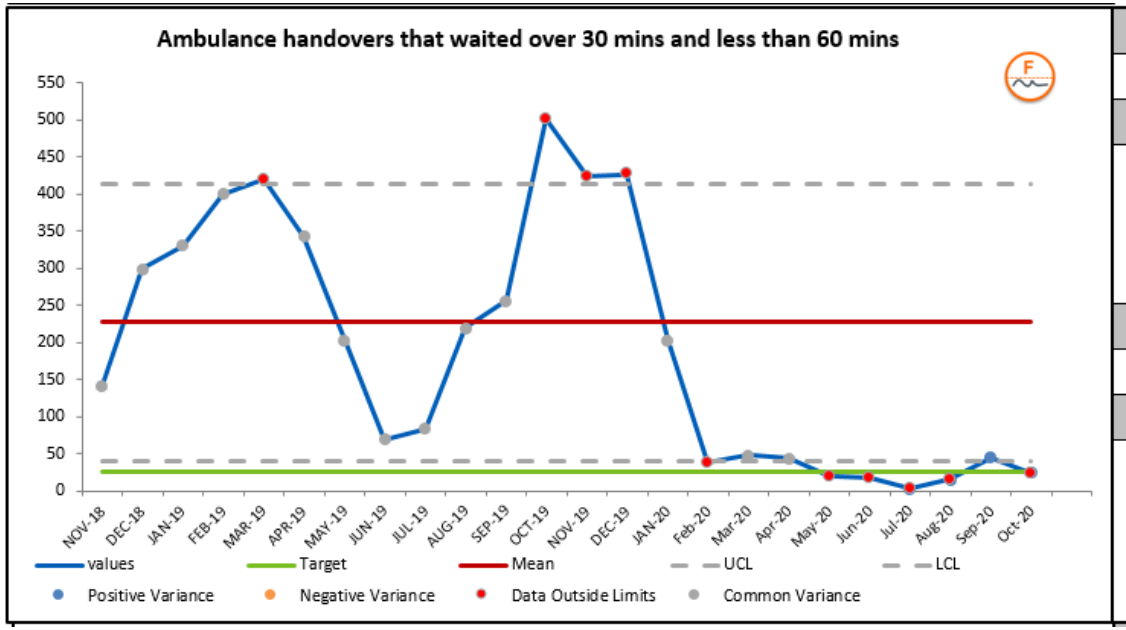
Context:

Super Stranded figures continue to increase slowly from the lowest ever figure during the pandemic when the hospital prepared to receive COVID patients. However the figure remains well below the previous years figures .

Actions:

- Ongoing work with the Reason to Reside Discharge Cell as a part of the ICAN Discharge long term project.
- National guidance released at the end of August on discharge makes far reaching expectations that the Trust and the 'system' have completed a gap analysis against and an action plan has been developed. This is being fast-tracked based on impending winter and COVID – 2 spike
- 5 days per week review of all patients both poorly and medically optimised for discharge by Dep Coo & senior members of partner organisations.

SPC Charts – Ambulance handovers that waited over 30 minutes and less than 60 minutes

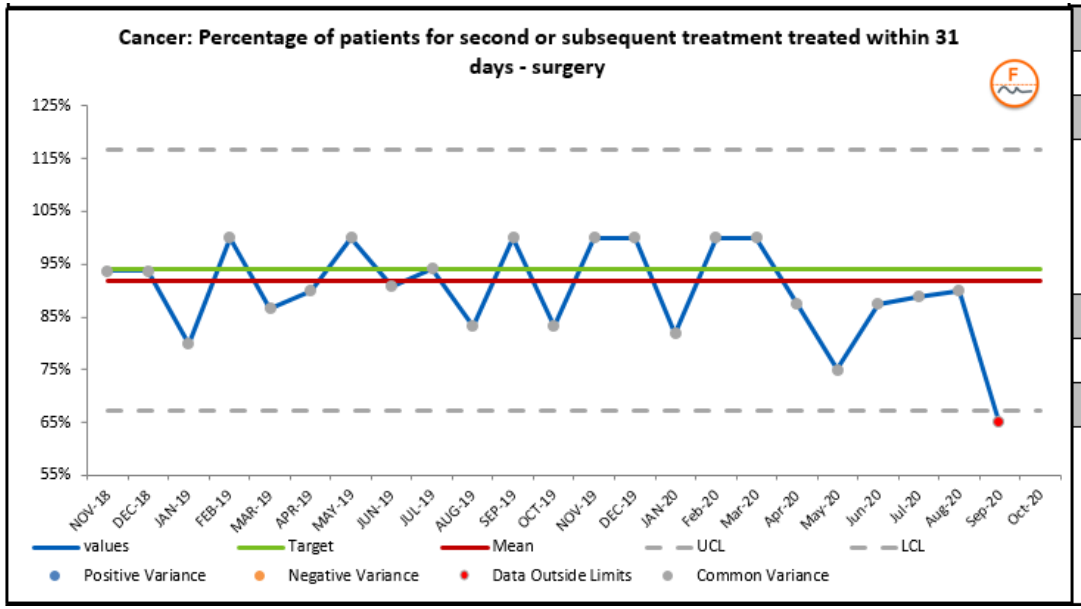


Oct-20
24
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
25
Target Achievement
Metric is consistently failing the target

Context:
Ambulance handover figures continue to be 'best in class' in the Midlands. Aided by an efficient FIT process on arrival in ED and effective streaming of patients to other urgent care services in the Trust
.

Actions:
Further winter development of Children's ED, 'talk before you walk' NHS111 new service that will go live at the end of September should help keep flow optimal into ED

SPC Charts – Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - Surgery



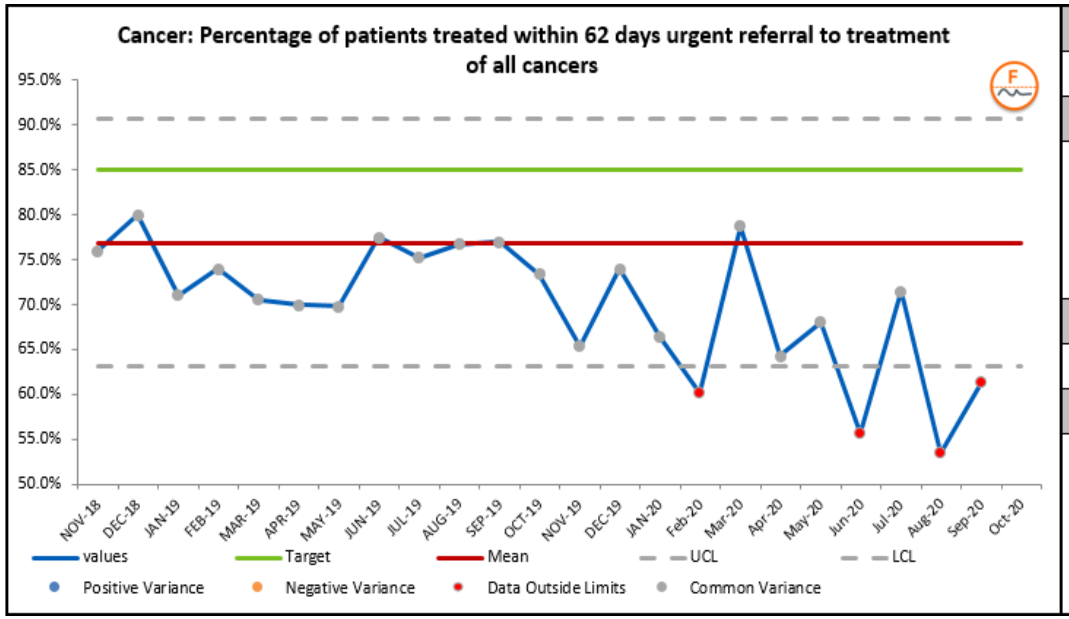
Sep-20
65%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
94%
Target Achievement
Metric is consistently failing the target

Context:
20 patients were treated as a subsequent surgery for September, of which 7 breached. Of these 6 of the 7 breached by 5 days or less.3 due to capacity, 1 due to patient fitness, 2 due to self isolation and 1 complex patient requiring investigation for another tumour.

Actions Taken:
Subsequent patients discussed at site ptl meetings weekly, self isolation requirements are unavoidable. However surgical capacity should not be an issue.

Actions:
Cancer Services team to link with tumour sites to understand breaches that could have been avoided and ensure booking process is aligned with the target.

SPC Charts – Cancer: Percentage of patients treated within 62 days



Sep-20
61.3%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
85%
Target Achievement
Metric is consistently failing the target

Actions:

- Teams to continue to deliver against their reset plans
- Cancer Services Team transferred from Women's, Children's, Haematology and Oncology Directorate to Corporate function 01/11/20
- Review undertaken of pathway management meetings, move from twice weekly ptl meetings to once a week targeted ptl focused on escalated patients through individual tumour site ptl meetings
- MD, COO and Cancer lead Clinician met individually with tumour site leads to discuss progress and support unblocking a number off issues

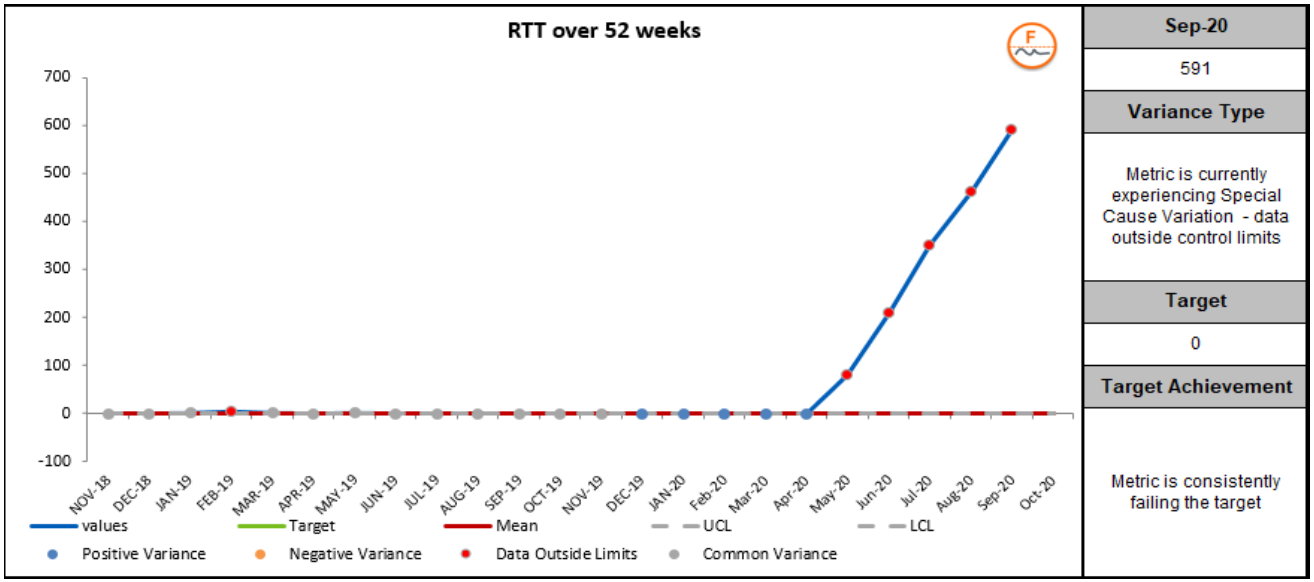
Context:

The trust did not achieve this standard reaching 61.4% against the 85% standard. The trust saw a 35% reduction in the number of patients during August compared to pre covid levels, this combined with legacy patients being treated that have had long waits due to covid has resulted in this performance
Legacy patients, those on their pathway in excess of 62 days is 57 as of the 16/11, compared to 150 in July.
Patients waiting in excess of 104 days now 8 versus 69 in July **(As of 20/11 this figure is now 46 patients over 62 days and 7 patients waiting over 104 days)**

Actions Taken:

- Improved diagnostic turnaround times Imaging request to report 7 days, improving picture across MRI and US, CT still challenged
- Review of endoscopy services complete and associated actions underway
- Endoscopy procedures secured in less than 7 days with slots carved out by endoscopy for colorectal straight to test pathway
- Breast have sourced additional capacity
- Access to tumour marker histology in house being explored
- KGH supporting Lung clinical team with biopsy training
- Additional clinics in place for Lung
- Radiology review complete
- Additional resource sourced for skin
- Gynaecology consultant started in post

Charts – RTT Incomplete Pathway 52 week breaches



Sep-20
591
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is consistently failing the target

Context:

Whilst all routine outpatient activity was ceased from April to June 2020 due to covid-19, the number of patients waiting over 52 weeks has increased to 591.

Clinically urgent & cancer appointments take priority over routine appointments and procedures.

- Full validation of all 52 week breaches is undertaken
- Review of harm is being conducted on every 52 week breach
- Non elective patients are being reviewed in virtual (non face to face) clinics to clear the backlog
- Support of in and out sourcing providers are being commissioned to support the recovery
- Across the Midlands there are 24,766 x52 week patient breaches (w/e 25/10/20) as all trusts struggle to managed the elective backlog from the pandemic

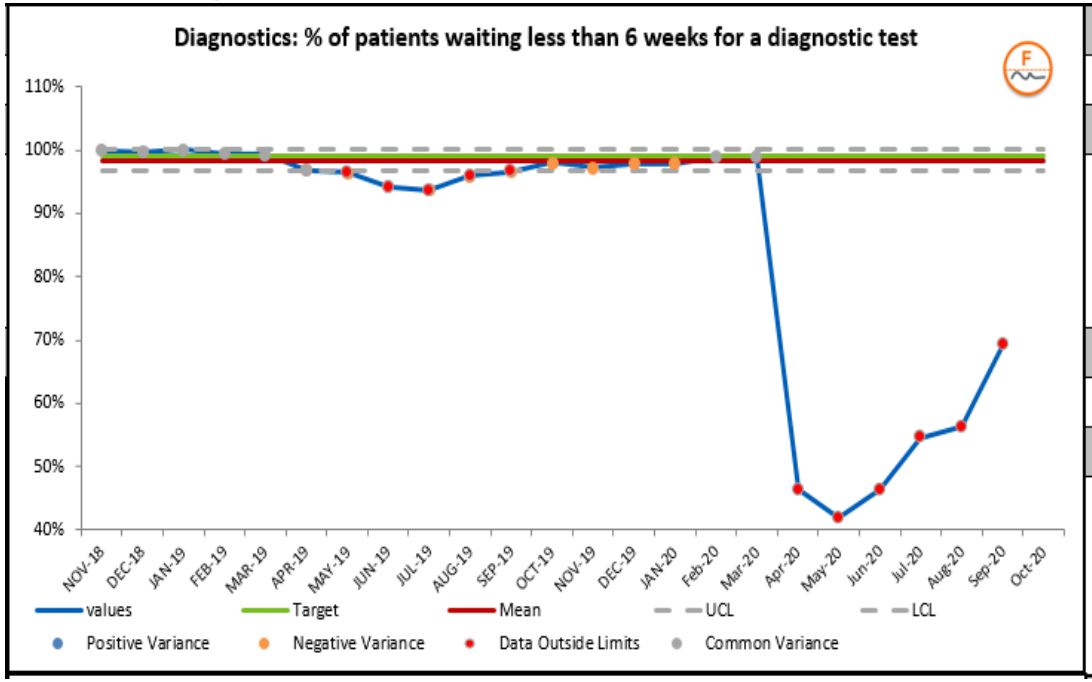
Actions:

- Phase 3 recovery plans have been submitted and being progressed with the restoration of elective activity, priority is still being given to clinically urgent and cancer patients.
- Insourcing options being progressed to provide additional capacity within key surgical and medical specialties.
- Weekly PTL's in place with a focus on 52+
- Reset Delivery Group in place as part of Phase 3 recovery. A performance monitoring model aligned with KGH designed to provide a weekly view of how we are progressing against our phase 3 submission has been progressed and will form part of this Group.
- NEC's clinical validation programme being progressed to support prioritisation of elective activity. Healthcare Communications being utilised to support administrative screen as phase one of the NECS clinical validation programme and clinical validation approach to be agreed.
- Clear PTL is being used to target and focus validation in key areas of the PTL.
- Elective Care Hubs task and finish group in place to support system wide working.
- All available elective theatres operational from September 2020.
- Utilisation of Independent sector is maintained (BMI TSH)

Risk:

Impact of a covid-19 surge and associated staffing risks to be highlighted as areas of concern

Charts – Diagnostic 6 week waits



Sep-20
69.3%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
99%
Target Achievement
Metric is consistently failing the target

Context:

- As per national guidance to take down elective work during the pandemic we have seen a huge fall in the percentage of patients having their diagnostic test in 6 weeks from 98+ % to a position of **74%** for September
- Third Phase of the COVID response was released by NHSEI with the expectation that 90% of last year's activity is reinstated by September and 100% by October
- Services are now operating at >100% of productivity compared with the same time last year

Actions:

- Rectification plans developed in all specialties
- Teams are using insourcing and outsourcing options with external providers as we have used in the past
- Additional lists are being provided in house where possible at weekends and evenings
- Full validation of all lists to ensure all breaches are accurate

Directors view – Director of Finance

The Trust ended October 2020 with a £0.3m deficit which is £0.2m better than the Phase 3 Reset plan.

COVID spend for the month is £0.8m (Month 6: £0.8m) and mainly includes pay costs of £0.6m.

As previously notified, the financial regime has changed from October and Trusts are expected to report against the Reset Phase 3 plan submitted last month. The Trust's Reset plan currently shows a deficit gap to the end of the financial year, but we continue to discuss with our System partners and Regulators on the final position. I am pleased to report that the Trust performed £0.2m better than the month 7 Reset plan.

Non-COVID operational activity continues to improve with Day case & Elective spells up 15% and 10% respectively on last month. Non-elective spells, A&E attendances and Outpatient appointments saw similar levels of activity to September.

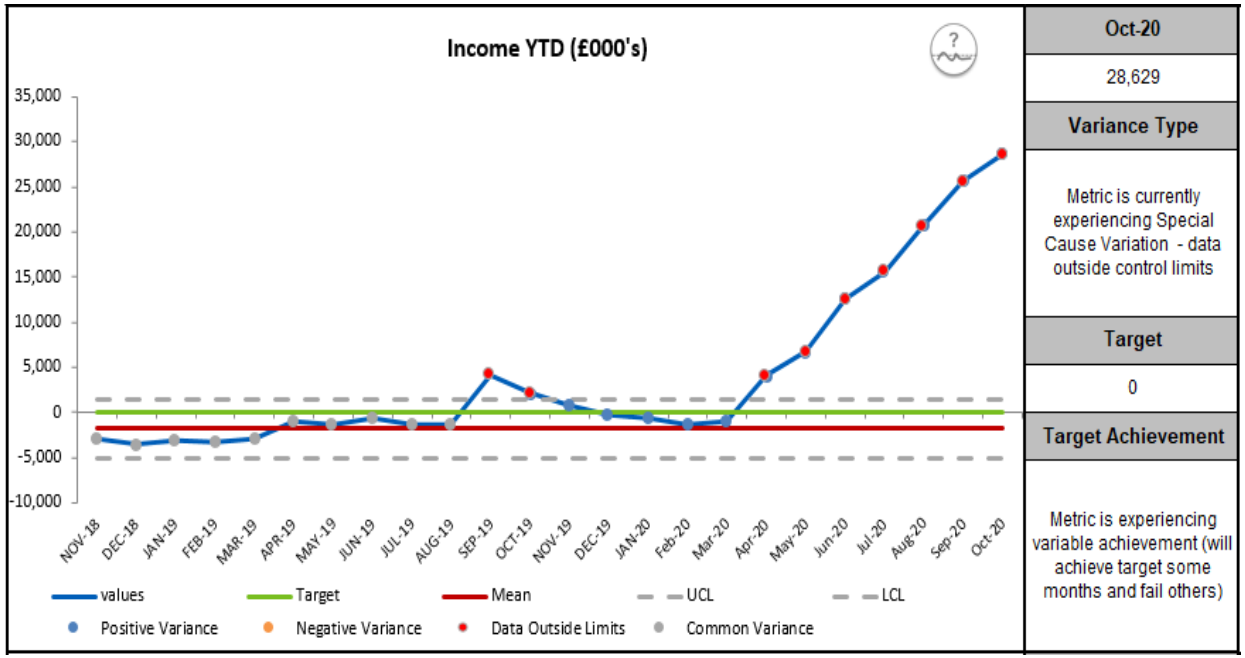
Pay expenditure is £22.9m, and is on par with last month, but £0.2m lower than the Reset plan, due to lower requirement for extra staffing for COVID reasons.

Agency spend is £1.4m and shows an improvement against September. £0.2m of the agency spend relates to COVID spend for sickness cover and additional shifts due to operational requirements.

Capital spend to date is £7.5m with a further £10.2m committed to spend. The overall capital plan is £41m (including the Critical care unit and ED Paediatrics unit), and the capital allocation is expected to be fully utilised before the end of the financial year. It is recognised that this will be a challenging task, but one that the Trust is committed to.

Cash balance at the end of the month is £32.0m and the Trust continues to have a healthy cash balance as a result of the current funding arrangements.

SPC Charts – Income YTD



Oct-20
28,629
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

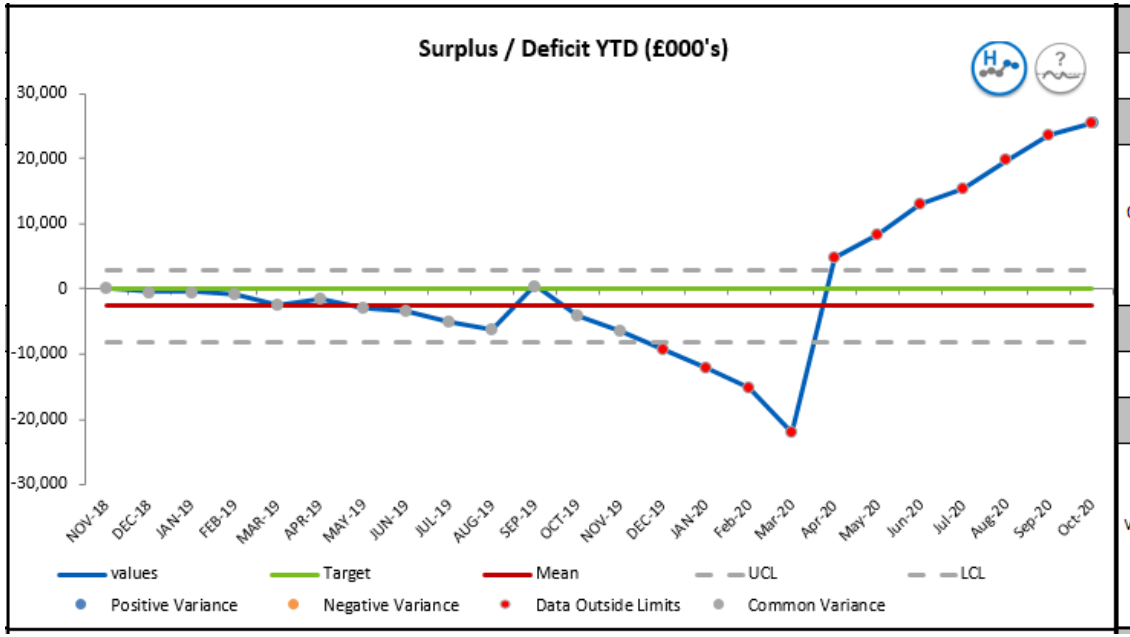
Context:

The Trust receives block funding for its clinical income, in addition to top-up funding.

- Day Case and Elective activity continued to see increased level of activity from September (up by 15% and 10% respectively).
- A&E, NEL and OP activity continued at similar levels to September.

Actions:

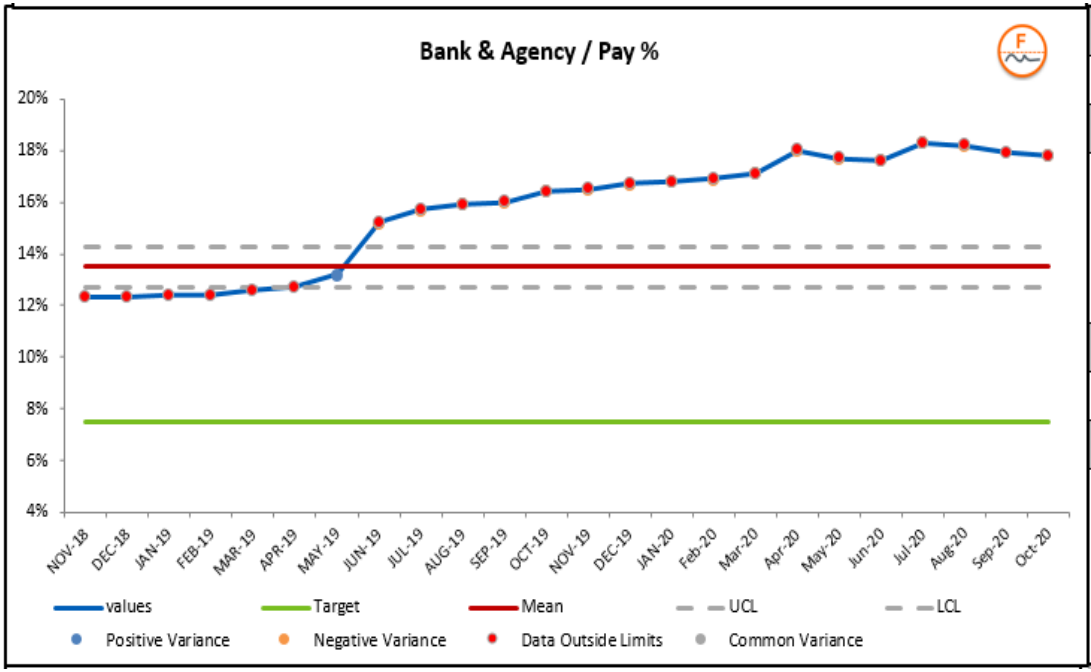
SPC Charts – Surplus/Deficit YTD



Oct-20
25,453
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance above the mean
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

The Trust reported a YTD position of which is £0.2m better than the Reset plan in month 7.

SPC Charts – Bank & Agency spend



Oct-20
17.8%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
7.5%
Target Achievement
Metric is consistently failing the target

Context:

- In Month 7 Temporary Staff expenditure (Bank and Agency) is £3.9m (previous month £3.8m)
- £0.5m of this spend is attributed to COVID-19 related spend (£0.5m in Month 6)
- In October, there has been a reduction in Agency spend which is offset by an increase in Bank spend , to do with operational pressures on wards, increased RESET activity and staff having to self-isolate due to COVID.

Directors view – Chief People Officer

Vacancy Position

- The overall Trust vacancy factor for October 2020 is 7.23%, which is a decrease for the third consecutive month and below the 9% target.
- The vacancy factor for medical staff is 6.98%, which is a decrease of 2.5% on last months figure and a decrease for the third consecutive month. Medical staff in clearance total 41, which are forecast to reduce medical vacancies against establishment to 8.97 WTE by December 2020 (1.45% vacancy factor) Recruitment agencies for hard to recruit residual vacancies are engaged and actively searching for candidates alongside internal resourcing activity.
- The nursing & midwifery vacancy factor for October 2020 is 3.96%, which is a decrease of 2% since last months figure and the fifth consecutive monthly decrease remaining below the Trust target of 9%. In October a total of 32 overseas nurses with a further 27 arriving in beginning of November 2020. A total of 132 overseas recruits have been onboarded since March 2020. All but 3 have passed their OSCE at the first attempt.
- Overall time to hire for October 2020 is an average of 12.87 weeks from authorisation to start

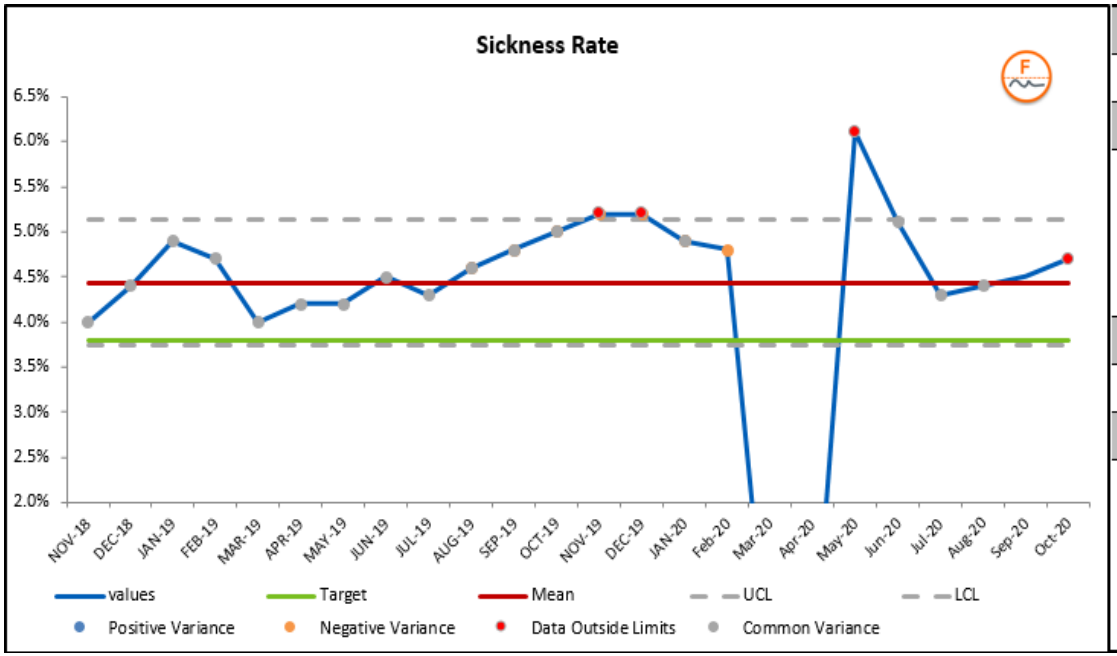
Attendance

- The Trusts sickness absence rate for October 2020 as reported through ESR is 4.80%, which is an increase for the third consecutive month.
- A proportion of this absence is due to Covid-19 and this absence is monitored and reported on daily basis via the Roster system. As at 18 November 2020 there were 175 members of staff absent due to Covid-19 and self isolation.
- The management of sickness absence and Covid-19 absence is being supported by HR Business Partners and Occupational Health.
- The top two reasons for non-Covid -19 related absence are Stress and Anxiety and Musculoskeletal.

Competence

- The overall appraisal compliance percentage for the month of October is 72.28%, which is an increase for the third consecutive month but remains below the 85% target. A simplified 'Appraisal Light' process has been launched to enable and facilitate further increases to the compliance percentage.
- The overall statutory and mandatory training position for the month of October 2020 is 86.10%, which is an decrease on the figure of 8.48% reported for September 2020 and remains above the Trust target of 85%. All statutory and mandatory training continues to be available via e-learning.

SPC Charts – Sickness Rate



Oct-20
4.7%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
3.8%
Target Achievement
Metric is consistently failing the target

Context:

- Anxiety and depression plus pregnancy related absences are high.
- As at 19 November 2020 a total of 175 staff were absent due to covid-19.

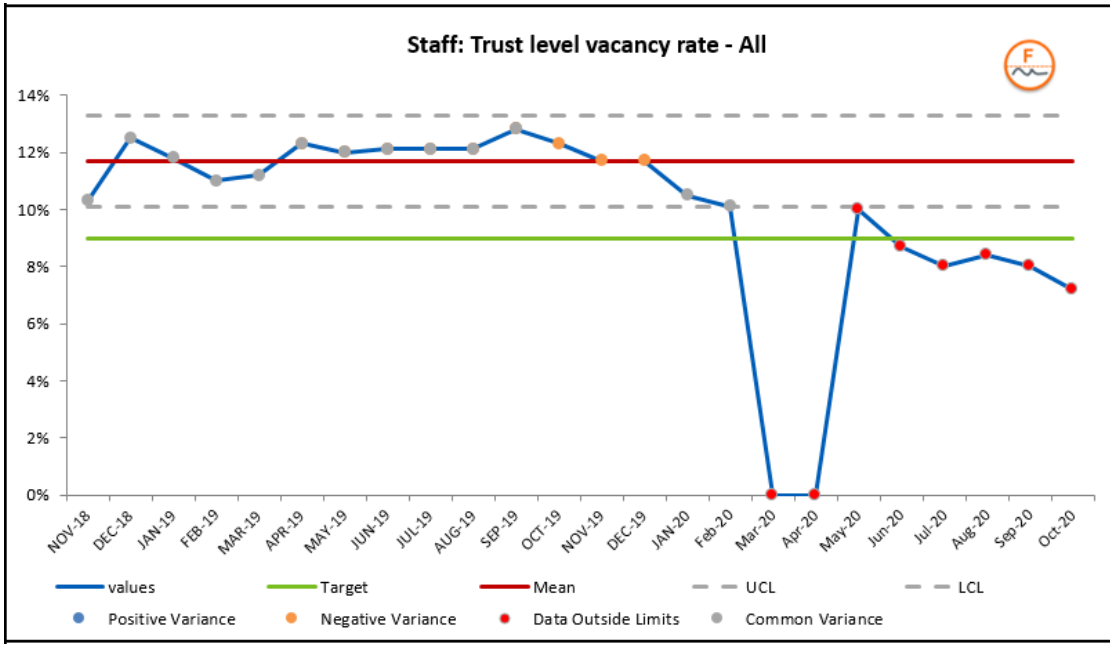
Actions completed:

- Robust sickness management continues with support from the HR Business Partners and HR Advisors. (February 2020)
- A number of OD initiatives to support staff are on-going including the SOS service.
- Guidance regarding staff in the extremely vulnerable to covid category has been distributed and support is provided to provide reassurance to staff around safety at work with risk assessments provided as appropriate.

Actions:

- Continue to manage sickness absence across all areas of the Trust. (On-going)
- HR Business Partners to raise sickness as part of the divisional management meetings. (On-going)
- Continue with health and wellbeing initiatives.
- Continue with OD initiative to support staff through the pandemic.

SPC Charts – Trust level vacancy rate - all



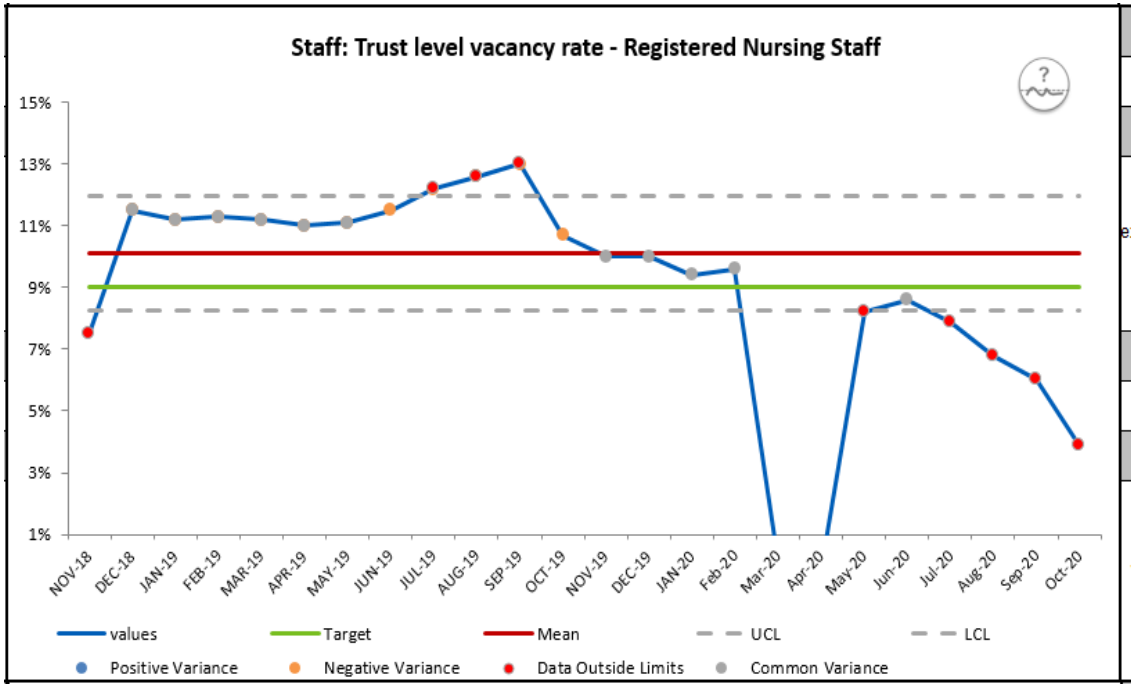
Oct-20
7.2%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
9.0%
Target Achievement
Metric is consistently failing the target

Context:
There is a national shortage of nursing staff along with a shortage within other professional allied specialities

Actions completed:
- Overseas nurse recruitment continues.
- Hard to recruit medical vacancies identified and agencies engaged to assist.
- Best of Both Worlds microsite is in the process of being refreshed.

Actions:
- Overseas nurse recruitment will continue
- Collaborative on-boarding of directly recruited overseas nurses with KGH to be scoped out
- Continue sourcing candidates and complete interviews for direct and agency candidates in particular for medical staff.

SPC Charts – Trust level vacancy rate – Registered nursing staff



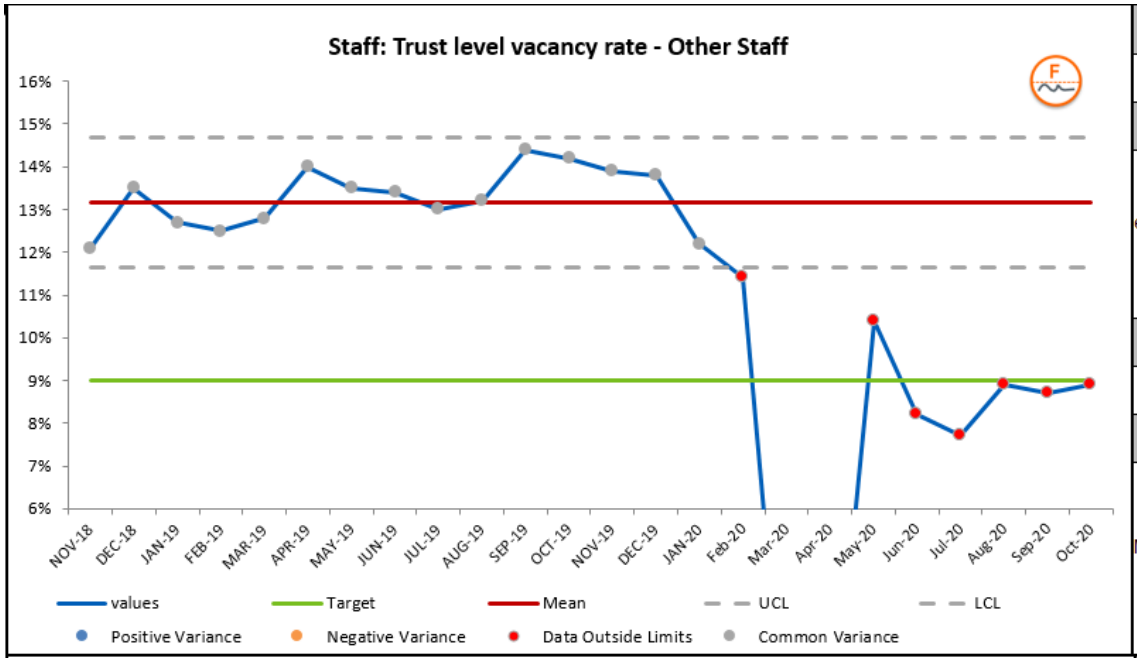
Oct-20
3.9%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
9.0%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:
There is a national shortage of nursing staff

Actions completed:
- A further 32 overseas nurse candidates have arrived during October 2020 with a further 27 arriving in in November 2020.
- 162K of funding was successfully bid for to assist with overseas nurse recruitment.
- Further funding successfully bid for to support existing eligible staff to take the necessary language skills training to obtain NMC registration and transition to qualified nurse status in the UK.
- Directly sourced candidates being actively pursued.

Actions:
- Continue with overseas recruitment programme
- Continue with collaborative overseas on boarding with KGH.
- Process existing staff to undertake language skills training.
- Interview and on-board directly sourced overseas recruits.
- Continue with local and national recruitment.

SPC Charts – Trust level vacancy rate – Other staff



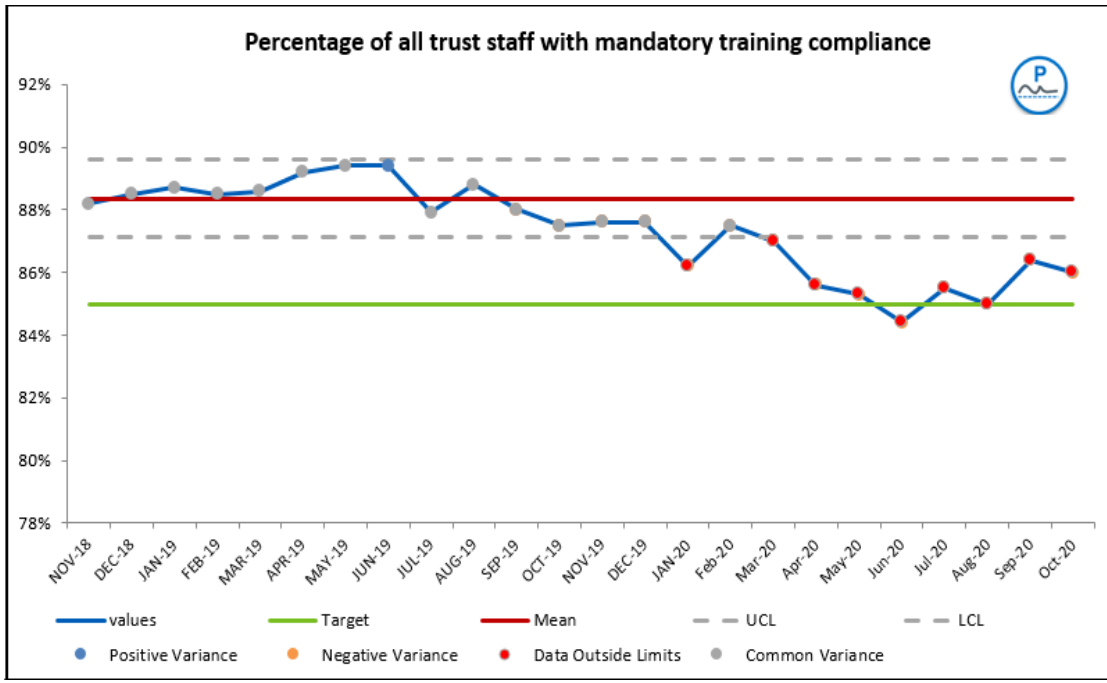
Oct-20
8.9%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
9.0%
Target Achievement
Metric is consistently failing the target

Context:
There is a national shortage within professional allied specialities

Actions completed:
- Local & National recruitment continues.

Actions:
- Focus on hard to recruit AHP vacancies to develop a resourcing plan.

SPC Charts – Percentage of all trust staff with mandatory training compliance



Oct-20
86.0%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
85.0%
Target Achievement
Metric is consistently achieving the target

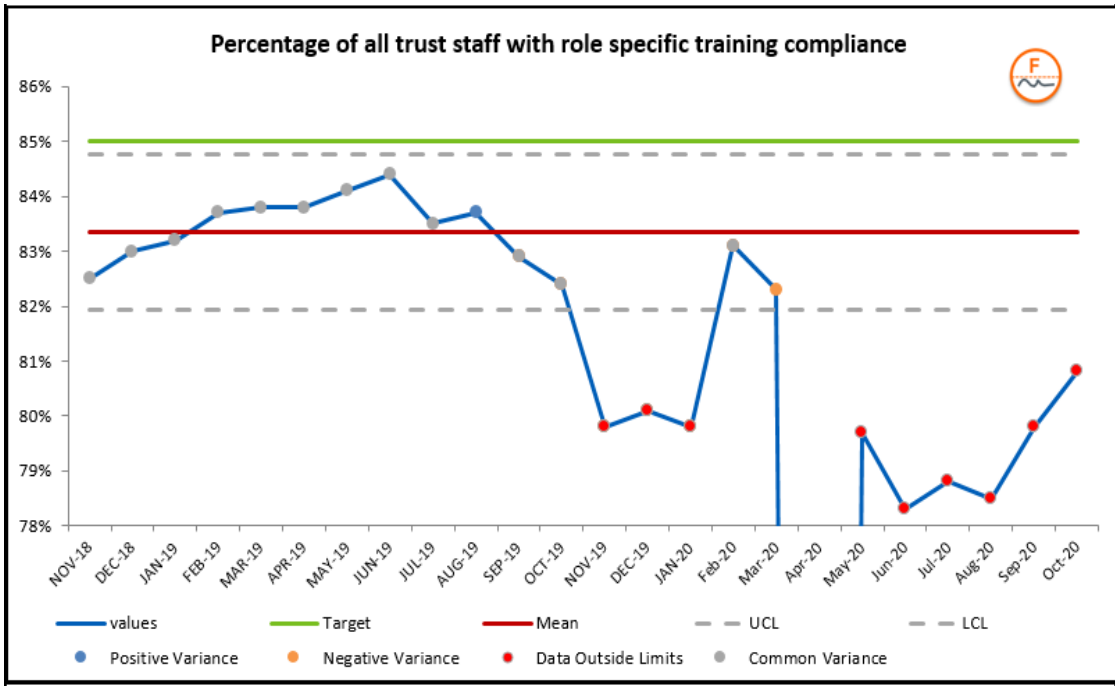
Context:

- A significant proportion of mandatory training has to be moved to e-learning due to covid-19.

Actions completed:

Actions*:*

SPC Charts – Percentage of all trust staff with role specific training compliance



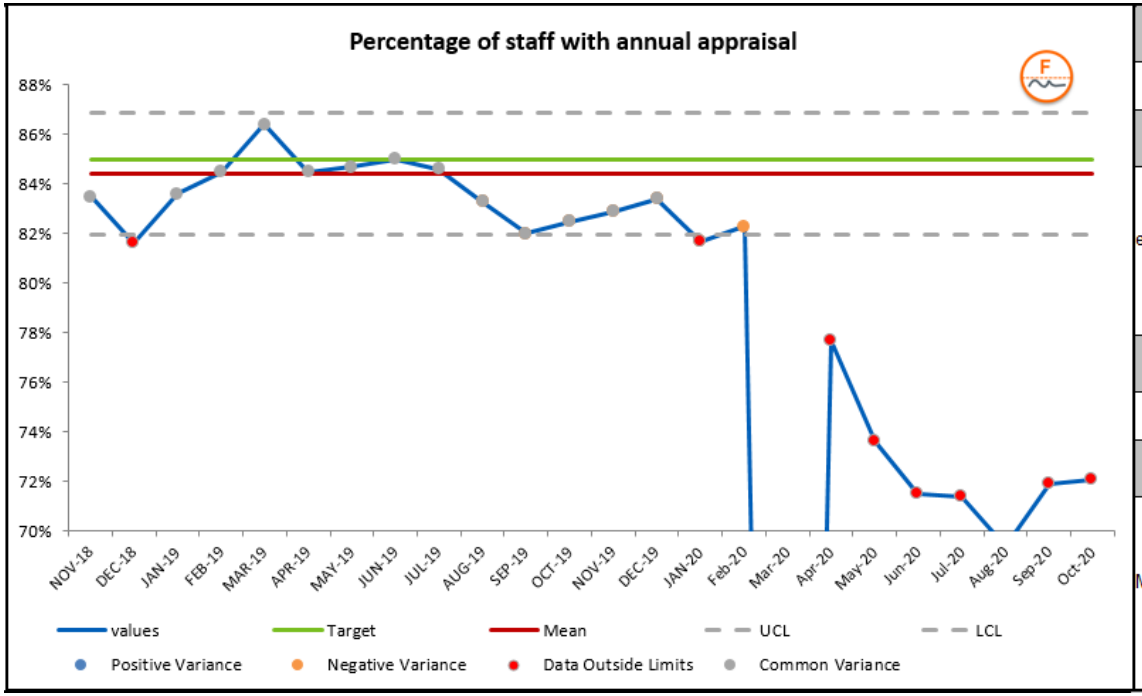
Oct-20
80.8%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
85.0%
Target Achievement
Metric is consistently failing the target

Context:
Covid-19 has impacted and continues to impact on staff ability to complete role specific training. Face to face training is not currently offered.

Actions completed:
- Training continues to be facilitated.
- Compliance reporting to managers continues.

Actions:
- Managers and staff will continue to be supported to improve compliance.
- ESR is being developed to accommodate greater degree of e-learning.

SPC Charts – Percentage of staff with annual appraisal



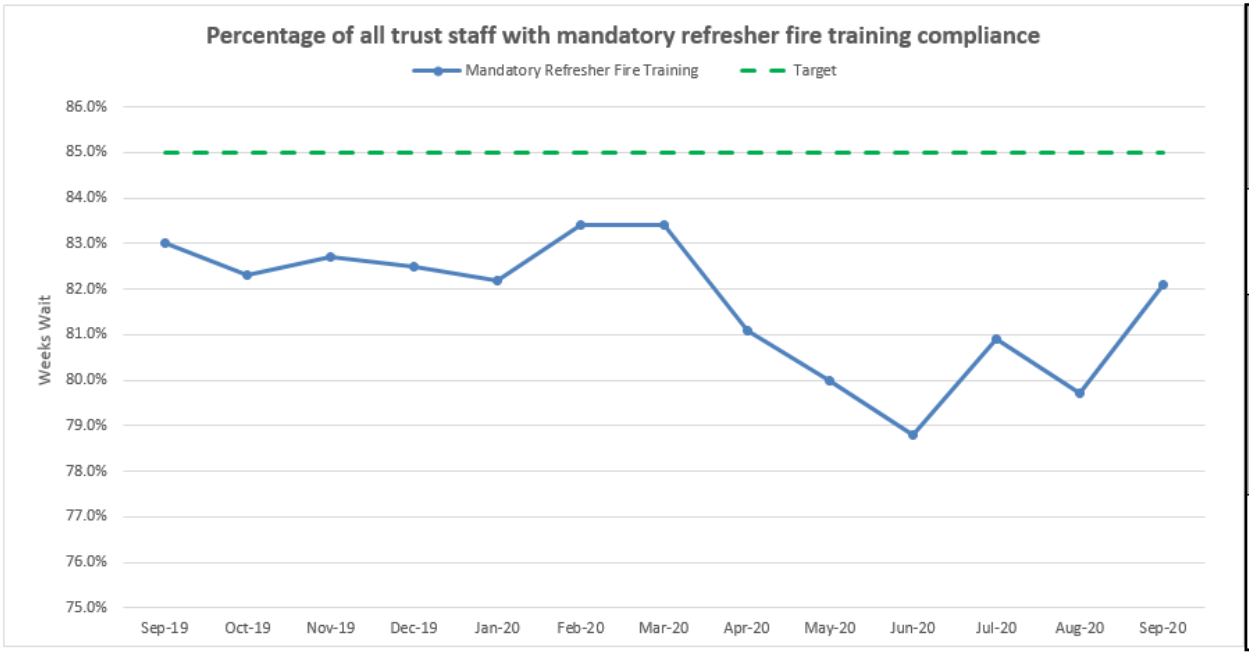
Oct-20
72.1%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
85.0%
Target Achievement
Metric is consistently failing the target

Context:
Capacity to undertake Appraisals has been impacted by Covid-19

Actions completed:
- A simplified 'Appraisal Light' process has been launched to enable and facilitate further increases to the compliance percentage

Actions:
- Support and monitor the take up of appraisal light process.

Non-SPC Chart – Percentage of all trust staff with mandatory refresher fire



Oct-20	Target
81.6%	>=85%

Context:
Covid-19 impacted upon staff completing fire training and induction no longer face to face.

Actions completed:
- Fire training continues to be provided by the fire officer.
- Compliance rates reported to Fire Officer

Actions:
- Continue to liaise with Fire Officer to improve compliance.
- Enhancement of E-Learning to be fully implemented to enable greater compliance.

Directors view – Director of Nursing

Friends & Family Test

The FFT is set to recommence nationally in December which will be reported as from January 2021, with a slightly revised question looking at the patient's satisfaction of their experience service rather than their recommendation rate.

As reported previously the Trust continues to collect feedback locally through SMS messaging and automated voice calls, we are however, not using paper survey cards on the advice of NHSE. We are one of the few Trusts across the country to maintain this service. Feedback is being reviewed as a period of time, separate to normal data collection months to prevent the skewing of data. Top themes for feedback are Communication and Waiting Times. These are being addressed through the Divisions, with 'communication' being highlighted as a key action within the Patient Experience priority for our Group hospital going forward.

Complaints / Compliments:

The NHS Complaints Procedure has now re opened and significant progress has been made in ensuring that all complaints received are appropriately investigated and responded to.

The Trust response rate for complaints registered in August was 100%. There were 2639 compliments received during October

Infection Prevention & Control Service:

During October there was 2 reported case of Clostridium difficile Toxin A & B, identified as hospital onset on Esther White and Holcot wards. Post infection reviews are currently in progress and will be reviewed internally and action plans developed. We had 1 reported case of MSSA BSI reported during October; post infection review is still in progress and awaiting the source of the bacteraemia. The Vascular Access Group continues to meet with a focused action plan of work , currently a review of all policies which include vascular devices is in progress to ensure consistency.

Covid Response

The IPC team continues to focus on leading and supporting the Trust in managing the Covid pandemic and in the safe management of reset for elective and cancer activity. The IPC Board assurance framework has been reviewed and will be presented to the November Quality Governance Committee. Progress has been made with particular attention being made to PPE training and increasing the provision of our domestic support team.

There have been 7 Covid-19 outbreaks reported across a range of clinical, administrative and specialist teams. Contributory themes include a lack of social distancing, and inappropriate doffing of PPE. Daily outbreak meetings occur with attendance of the CCG, PHE and NHSE/I. Regular audits are completed which reflect progress made.

Medical Director's view

Overview

The draft academic strategy is complete and presented in a separate report to board. The associate director of research, innovation and education has commenced in post, with her induction programme incorporating introductions to colleagues across the group at KGH and the University of Leicester among other partners.

E-rostering has been rolled out to all medical staff in Ophthalmology and is in progress for the next wave specialities.

Incidents

Incident reporting has dipped over the last month, which is likely to relate to some technical issues with a migration to a new Datix reporting system. These are being rapidly resolved and will facilitate both reporting and analysis once embedded. There have been 14 new serious incidents since the last report to board in September. These are subject to the normal investigation and improvement process. 4 relate to a maternity cases look back exercise and three to hospital acquired covid-19 infection.

Mortality

SHMI remains in as expected at 100.1. A mortality time out session identified three key areas to be developed into the coming years mortality reduction work programme – heart failure, lung cancer and a working diagnosis project.

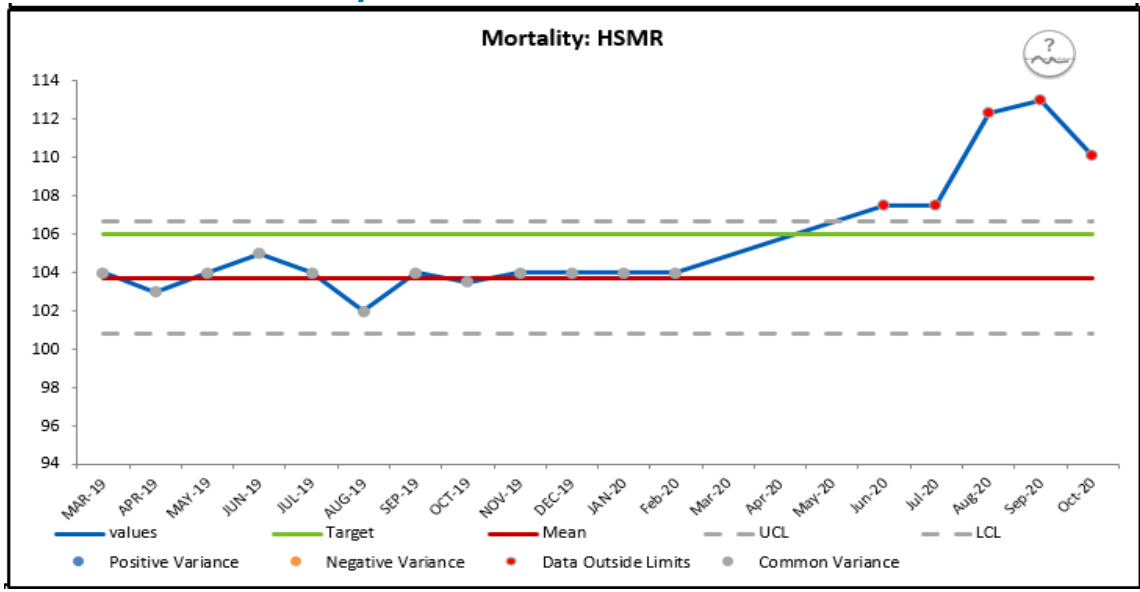
VTE prophylaxis and ePMA

The re-introduction ePMA upgrade to go live during Q4 remains on track. Interim improvement and assurance measures are in place during the paper based business continuity and compliance has substantially improved.

Deteriorating Patients

The digital support of delivering a bundle of care for acutely deteriorating patients has been developed through iBOX and is planed to launch trust wide in January 2021.

SPC Charts – Mortality: HSMR



Oct-20
110
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
106
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Actions:

Dr Foster will be providing NGH with a COVID-specific package with analysis report and 5 updates for review after 5th iteration so we can identify any future areas of concern as early as possible.

The Mortality team are conducting a trustwide review of all deaths identified with hospital acquired Covid-19 infection ("Review 14"), that have been referred for SJR by the Medical Examiner Team. These reviews will be conducted as part of the routine M&M process, and we aim to have the final report available to highlight key learning themes from the Covid-19 outbreak as soon as achievably possible.

We had a mortality team "time-out" day on the 4th November. 3 key priority workstreams were identified to prioritise over the next 12 months. The workstream plan will be submitted at the next MRG meeting for final approval.
Going forward, increased resources and support for patients in the community will result in decreased hospital admissions, and therefore decreased in-hospital mortality. The NGH Heart Failure service has been identified as a key target area going into 2021.

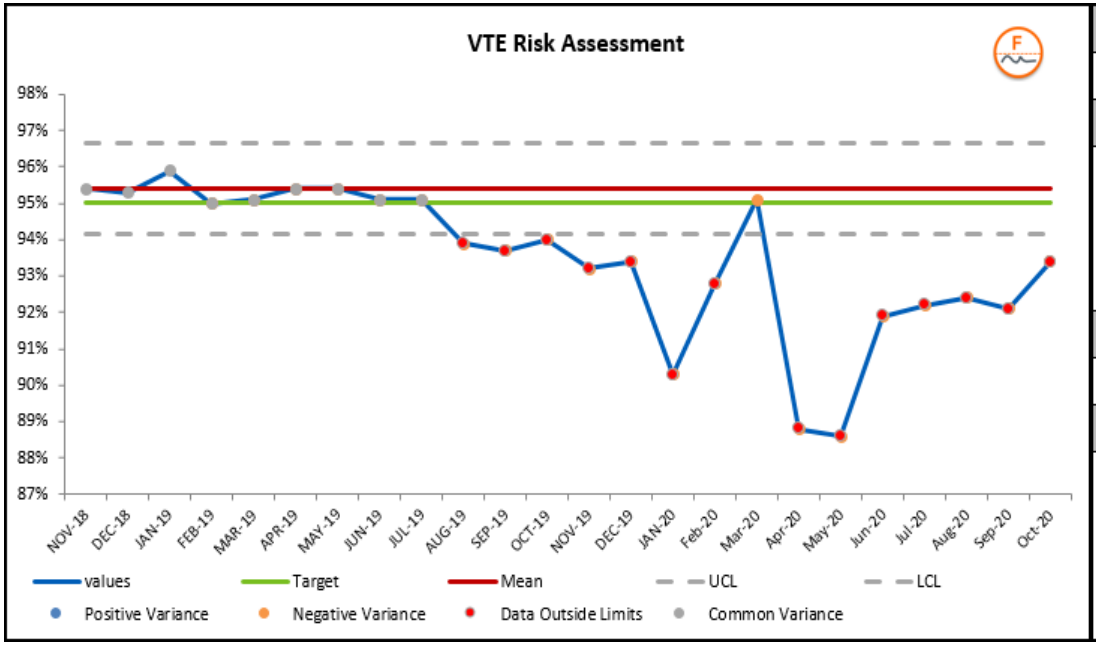
Context:

We anticipate HSMR is likely to remain elevated for a period of time due to the impact of both the December 2019 spike in Inpatient deaths, and the effects from Covid-19. With planning underway for a "2nd wave" of Covid-19 admissions, our HSMR may remain elevated for the foreseeable future.

The Mortality team are currently conducting a 100+ case note review of inpatient deaths in December 2019 ("Review 13"), using standard SJR methodology. Following conclusion of the review at the 2nd SJR meeting on the 6th November 2020, the final report will be completed and submitted to MRG in December. The aim of this review will be both to identify any gaps in care provided at NGH, and to identify the key feedback and learning themes.

The Medical Director has written to the Dr Foster team to directly request that hospice deaths be excluded from our figures, so we can have a fair comparison with our peers. This will enable us to identify and focus on areas of actual concern that need to be addressed, rather than having to continuously challenge if an "alert" is a genuine alert, or due to a data collection anomaly. We are currently awaiting the outcome of contract negotiations.

SPC Charts – VTE Risk Assessment



Oct-20
93.4%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
95%
Target Achievement
Metric is consistently failing the target

Context:

ePMA loss of service driving underperformance.

Improvement driven by mitigation introduced of integrated VTE assessment and drug charts.

Actions:

- ePMA project group and oversight exec committee established for re-introduction of further upgrade.
- Spot audits through pharmacy and medical examiner scrutiny demonstrate significant improvement.

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Report To	**Public Trust Board**
Date of Meeting	**26 November 2020**

Title of the Report	**Covid Reset**
Agenda item	**10**
Presenter of Report	Carl Holland, Chief Operating Officer
Author(s) of Report	Carl Holland, Chief Operating Officer Adrian Marsden, Head of Informatics

This paper is for: (delete as appropriate)

☐ Approve	☐ Receive	x 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

Executive summary

This report lays out NGH performance in October against the Reset (Phase 3) model submitted to NHSE/I on 21 September 2020. The Reset (Phase 3) model is based on September to March 2019-20 with assumptions built in to reflect transformation schemes, insourcing support and COVID impacts.

The October position identifies that referrals to the Trust are below the planned levels, this is attributed to GP referral being at 84% of the planned level, there is an increase of 23% in Other referrals The position in September was one of over achievement against the planned levels.

The total number of Outpatient attendances is below planned levels but the increase in Non-face to face appointments continues

Day case and inpatient elective activity remain below modelled levels, this is attributed to maximum theatre capacity not being available for the first three weeks of September and Waiting List and Insourcing support not being available until mid-November , it is anticipated that this will increase and be sustained going forward.

The reduction in day case and inpatient elective activity has had a direct impact on the number of patients waiting greater than 52 weeks for their treatment to commence, the number of patients waiting has increased from 454 in August to 654 at the end of October, increased resources and theatre sessions

as detailed above have commenced in November, this is supporting reduction in these numbers which we are now seeing.

The total number of patients on an incomplete pathway has increased against August but is below the modelled levels, the increase has a direct correlation with the overall reduction in Outpatient and Elective activities.

Both ED attendances and NEL activity are significantly below the modelled levels but there is a notable upward trend in the number of COVID related admissions.

As we approach winter and the impending peak in Covid-19 (Covid 2) this will impact on our ability to deliver the elective activity ask.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Create a great place to work, learn and care to enable excellence through our people*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: BAF 1.5
Related Board Assurance Framework entries	BAF – please enter BAF number(s) 1.1; 1.2; 1.4; 1.5; 1.9;
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	Nil
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: No

Actions required by the Trust Board

The Trust Board is asked to note the contents of this paper and the work underway at the Trust to reset services whilst in Phase 2 of COVID.

SUS/NHSi Technical rules applied as per the phase 3 submission

Trust exceeded activity / peformance forecast in Phase 3 submission
Activity / performance <5% below forecast in Phase 3 submission
Activity / performance >5% below forecast in Phase 3 submission
Demand-led metric

	October 2020									
	NGH			KGH			Group			
RTT	Submitted	Actual	Variance to forecast	Submitted	Actual	Variance to forecast	Submitted	Actual	Variance to forecast	Commentary
The total number of incomplete RTT pathways at the end of the month	24,246	22,363	92%	18,180	16,193	89%	42,427	38,556	91%	The PTL size in each of KGH and NGH, and the Group as a whole, is lower than forecast.
The number of incomplete RTT pathways (patients waiting to start treatment) of 52 weeks or more at the end of the reporting period	124	650	526%	0	0	-	124	650	526%	NGH had significantly more 52-week breaches than forecast whereas KGH had zero breaches as forecast. The Gropu as a whole had more breaches than forecast.
Referrals										
GP Referrals	6,371	5,395	85%	5,375	4,251	79%	11,746	9,646	82%	GP referrals to each of KGH and NGH, and the Group as a whole, are lower than forecast.
Other Referrals	2,425	2,940	121%	4,088	1,906	47%	6,513	4,846	74%	Other referrals are higher than forecast at NGH but lower than forecast at KGH. Overall, other referrals are lower than forecast across the Group.
Total Referrals	**8,796**	**8,335**	**95%**	**9,463**	**6,157**	**65%**	**18,259**	**14,492**	**79%**	Total referrals to each of KGH and NGH, and the Group as a whole, are lower than forecast.
Outpatients										
Consultant-led first outpatient attendances (face-to-face)	6,530	4,823	74%	3,435	4,020	117%	9,965	8,843	89%	Face to face first appointments were lower than forecast at NGH and higher than forecast at KGH, with the Group seeing less patients than forecast
Consultant-led first outpatient attendances (telephone/video)	1,289	3,812	296%	3,492	2,779	80%	4,782	6,591	138%	Telephone first appointments were higher than forecast at NGH and lower than forecast at KGH, with the Group seeing more patients than forecast
Consultant-led follow-up outpatient attendances (face-to-face)	19,278	9,296	48%	6,248	7,651	122%	25,526	16,947	66%	Face to face follow up appointments were lower than forecast at NGH (though the forecast was high) and higher than forecast at KGH, with the Group seeing less patients than forecast
Consultant-led follow-up outpatient attendances (telephone/video)	4,737	11,678	247%	9,760	9,023	92%	14,497	20,701	143%	Telephone follow up appointments were higher than forecast at NGH (though the forecast was low)and lower than forecast at KGH, with the Group seeing more patients than forecast
Total Outpatient Attendances	**31,835**	**29,609**	**93%**	**22,935**	**23,473**	**102%**	**54,770**	**53,082**	**97%**	Overall outpatients appointments were lower than forecast at NGH and about on forecast at KGH, with the Group seeing less patients than forecast
Electives										
Day Case spells	3,736	3,268	87%	2,679	2,648	99%	6,414	5,916	92%	Day case activity was lower than forecast at NGH and about on plan for KGH, with the Group being below plan
Ordinary spells	293	285	97%	301	333	111%	594	618	104%	Ordinary spell (mainly inpatients) activity was slighlty lower than forecast at NGH and above plan at KGH, with the Group being above plan
Total Elective spells	**4,029**	**3,553**	**88%**	**2,979**	**2,981**	**100%**	7,009	6,534	**93%**	Overall elective activity was lower than forecast at NGH and on plan for KGH, with the Group being below plan
Non Elective										
0 day length of stay	1,836	1,596	87%	909	471	52%	2,745	2,067	75%	0 day length of stay non-elective activity was below plan for NGH, KGH and the Group as a whole.
+1 length of stay - COVID	3	38	1271%	5	50	1000%	8	88	1101%	Covid inpatient non-elective activity was signficantly higher than forecast across the Group
+1 length of stay - Non-COVID	2,535	2,339	92%	1,951	1,794	92%	4,486	4,133	92%	Non-covid inpatient non-elective activity was slighlty lower than forecast across the Group
Total Non elective admissions	**4,374**	**3,973**	**91%**	**2,865**	**2,315**	**81%**	7,240	6,288	87%	Overall non-elective admissions was lower than forecast across the Group
A&E										
Type 1-4 A&E Attendances	11,793	8,893	75%	8,213	6,996	85%	20,006	15,889	79%	A&E attendances were lower than forecast across the Group
Demand and capacity										
Average number of G&A Beds occupied per day	609	609	100%	471	434	92%	1,080	1,043	97%	Bed occupancy was as planned at NGH, lower than planned at KGH and slighlty ower than planned across the Group
Average number of G&A Beds available per day	637	637	100%	523	523	100%	1,160	1,160	100%	Bed availability was as planned across the Group
%	96%	96%	100%	90%	83%	92%	93%	90%	97%	
Diagnostic Activity										
Diagnostic Tests - Magnetic Resonance Imaging	1,834	1,696	92%	1,545	1,316	85%	3,379	3,012	89%	MRI activity was below forecast across the Group
Diagnostic Tests - Computed Tomography	3,093	3,242	105%	2,775	2,827	102%	5,868	6,069	103%	CT activity was above forecast across the Group
Diagnostic Tests - Non-Obstetric Ultrasound	1,489	1,427	96%	2,961	2,859	97%	4,450	4,286	96%	Ultrasound activity was below forecast at NGH, above forecast at KGH and above forecast across the Group
Diagnostic Tests - Colonoscopy	188	354	188%	95	75	79%	283	429	152%	Colonoscopy activity was above forecast at NGH, below forecast at KGH and above forecast across the Group
Diagnostic Tests - Flexi Sigmoidoscopy	58	96	167%	220	185	84%	278	281	101%	Flexible sigmoidoscopy activity was above forecast at NGH, below forecast at KGH and above forecast across the Group
Diagnostic Tests - Gastroscopy	190	281	148%	175	198	113%	365	479	131%	Gastroscopy activity was above forecast across the Group
Cancer										
All patients urgently referred with suspected cancer by their GP who received a first outpatient appointment in the given month	1,200	1,059	88%	816	1,052	129%	2,016	2,111	105%	Less patients than forecast were seen following a suspected cancer referral at NGH, with more than forecast seen at KGH. Overall, more patients than forecast were seen across the Group
Number of patients receiving first definitive treatment following a diagnosis within the month, for all cancers	180	155	86%	94	92	98%	274	247	90%	Less patients than forecast were treated for cancer across the Group, particularly at NGH
Cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral at the end of the reporting period	90	102	113%	79	76	96%	169	178	105%	The cancer backlog was greater than forecast at NGH, lower than forecast at KGH and higher than forecast across the Group

Report To	**Public Trust Board**
Date of Meeting	**26 November 2020**

Title of the Report	**Winter Plan 2020/21**		
Agenda item	**11**		
Presenter of Report	Carl Holland (Chief Operating Officer)		
Author(s) of Report	Carl Holland (Chief Operating Officer)		
This paper is for: (delete as appropriate)			
□ Approve	□ Receive	□ 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
Executive summary The paper is presented to provide an update to the Board on the current plans for winter 2020/21.			
Related Strategic Pledge	Focus on quality and safety.		
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks (N) Risk of not delivering performance standards Associated fines Patient experience Reputation		
Related Board Assurance Framework entries	BAF – 1.2, 3.1		
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision /		

	document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Financial Implications	NA
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper (N)

Actions required by the Trust Board

The Trust Board is asked to:

- Note the summary report
- Seek areas for clarification

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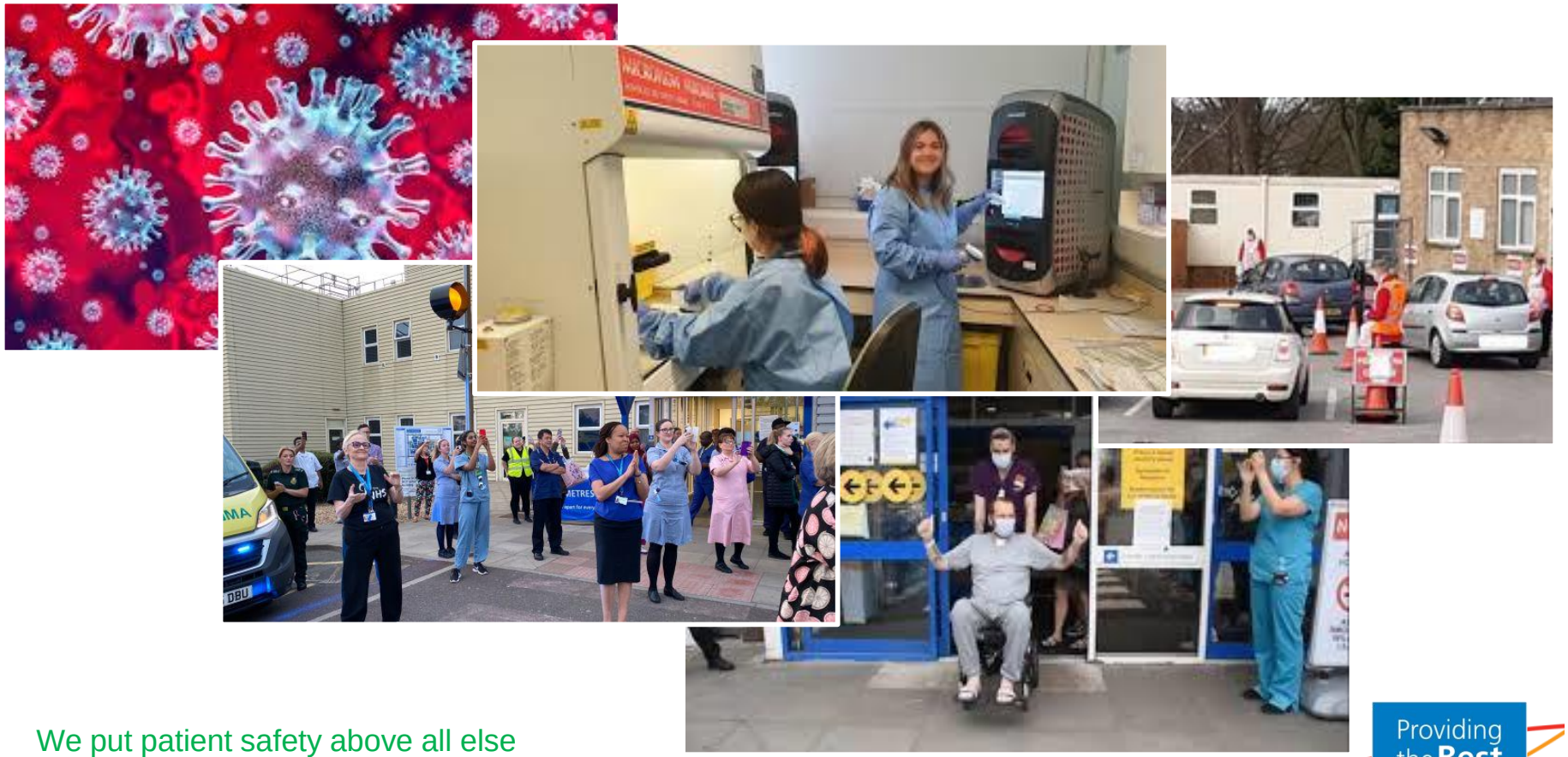
NGH Winter Plan 2020/2021



We put patient safety above all else
We aspire to excellence
We reflect, we learn, we improve
We respect and support each other

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Caring for those who care

FAQ
- The Street

Testing and vaccination
- Daily symptomatic testing for staff/family
- Targeted asymptomatic testing
- Flu vaccination available for all staff
- Covid vaccine when available
- Twice weekly Lateral self testing of all frontline staff

Vulnerable colleagues
- Work from home if clinically extremely vulnerable
- Provision of IT 'kit' to allow working from home
- Dynamic risk assessment process

Looking after your needs
- Free car parking
- Accommodation
- Free evening meals
- Support with transport
- Annual leave

Psychological support
- NHS helpline
- Northants IAPT mental health instant access support
- NGH SoS service
- Our Space open 24/7
- EAP scheme

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NGH Staff Support

Prioritising mental health has never been more important than it is now in these uncertain and challenging times. Making positive change can seem a challenge and sometimes it's hard to know where to start.

NGH has a range of staff support services that can help

Psychology Staff Support Service
Dr Claire Hallas,
Lead Health Psychologist
Psychological therapy, consultancy & training for teams and depts.
Contact: OD@NGH.NHS.UK

Occupational Health Service,
Team of Healthcare professionals
Management referrals for workplace stress
Contact: Occupational.Health@NGH.NHS.UK

SoS
Supporting our Staff

SoS Team , Multi-professional
Team peer support following an incident:
A confidential service to discuss incidents in a safe environment.
Contact: SoS.mailbox@NGH.NHS.UK

Organisational Development
Robyn Thorman, Acting Manager, OD
Workplace coaching, round tables & training.
Contact: OD@NGH.NHS.UK

Health and Wellbeing Service,
Anne-Marie Dunkley,
Health & Well-being Manager
Lifestyle support, Mental Health First Aid & Awareness Training, EAP service
Contact: wellbeing@ngh.nhs.uk

Chaplaincy Team
Offer a listening ear to all of the NGH Team. They provide a confidential and a non-judgemental space for all staff. They help everyone regardless of their religion, sexuality, belief, and culture.
Contact: george.sarmezey@ngh.nhs.uk

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Caring for those who care

Northamptonshire
Health and Care Partnership

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TALKING MATTERS
STAFF WELLBEING SUPPORT NORTHANTS

We know it can be hard to know where to turn when you are feeling down, struggling to cope or are just really run down. Below, are a number of different options that you can access yourself by contacting them directly – they are all ready to listen and support you.

Northampton General Hospital NHS Trust stafff support

Psychological Well-being Staff Support Service
Psychologist led service providing support for emotional issues within the workplace and home e.g. COVID, mood, trauma, burnout, bereavement, family.
E: od@ngh.nhs.uk

SoS (Supporting Our Staff) Service
Peer support service by trained staff offering clinical teams/individuals support for managing challenging incidents and issues.
E: SoS.mailbox@ngh.nhs.uk

Occupational Health Service
Support for staff returning to work, shielding or coping with workplace challenges/ transitions requiring OH support.
E: Occupational.Health@NGH.NHS.UK

Mental Health First Aid Support
Signposting and support for self-help and general health and well-being needs.

Health and Wellbeing Manager
T: 01604 545373
https://thestreet/HealthWellbeing/

Northamptonshire support

Changing Minds IAPT:
Provide Talking therapy for people who are feeling low in mood, exhausted, struggling to cope, stressed or anxious.
T: 0300 999 1616 (9 to 5 weekdays)
W: www.nhft.nhs.uk/iapt

Mental health integrated response hub:
A dedicated support number to provide access to mental health support in the county. Open 24/7 the team will provide initial triage and support those in a crisis.
T: 0800 448 0828

Bereavement support:
CRUSE offer bereavement support to those living in Northamptonshire.
T: 07772 428532 (9am to 5pm, Monday to Friday)
E: Northamptonshire@cruse.org.uk

National support

NHS confidential support by phone:
A dedicated number for NHS staff to call receive psychological support to those who need it:
General: 0300 131 7000 (7am to 11pm)
Bereavement: 0300 303 4434 (8am to 8pm)

NHS support by text:
Text 'FRONTLINE' to 85258 24 hours a day, seven days a week

Wellbeing apps:
Get free access to a number of wellbeing apps until the end of December 2020: www.people.nhs.uk/

Samaritans:
A phone, text or email away to support and listen to you - 24 hours a day / 365 days a year.
W: www.samaritans.org/

It's okay to not be okay and there is always support available to help you through.

Need more info?
Visit the 'Wellbeing page' on your organisations intranet for a list of more organisations and/ or advice on mental wellbeing support available to you

More to come via your organisation

#NorthantsWellbeing

V1-0820

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What have we been asked to do?

1. **Accelerating the return to near-normal levels of non-Covid-19 health services, making full use of the capacity available in the 'window of opportunity' between now and the end of December**
   i. Restoring full operation of all cancer services
   ii. Recovering the maximum elective activity possible between now and winter
   iii. Restoring service delivery in primary care and community services
   iv. Expanding and improving mental health services and services for people with learning disability and/or autism



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What have we been asked to do?

2. **Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid-19 spikes locally and possibly nationally**
   i. Utilising Independent Sector provision
   ii. Significantly expanded flu vaccination programme

3. **Doing the above in a way that takes account of lessons learned during the first Covid-19 peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff**



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NHCP Winter Communication Plan 2020/2021

Ten tactical aims

1. To encourage the public to choose the right NHS services
2. Help the worried well feel more assured about managing their own health
3. Signpost to alternative services other than ED and GPs
4. To inform target groups on how to stay well this winter, keeping health inequalities in mind
5. Raise awareness of the importance of getting the flu jab amongst target groups
6. Raise awareness of COVID-19 vaccine once it's available
7. To inform and update staff, stakeholders and public on our work to address the challenges facing urgent and emergency care this winter
8. To ensure *key operational* staff and stakeholders have clarity on our winter priority areas of focus, urgent and emergency care needs and *their responsibility* within this to support and address the needs of our communities
9. To support the national messaging around managing winter pressures
10. To support the national messaging around COVID-19



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19/20 What went well

- Nurses taking ownership of their patients
- EAB able to manage their patients better
- Less patients in corridors (Reverse corridor more effective)
- Second MRI Scanner
- Teams trying to do their best given the situation (COVID)
- Organisational reset
- EoL patients discharged quicker
- Site Office – porter support
- Dedicated discharge suite Doctor
- Everyone pulled together as one
- New booking process for interventional radiology
- Telephone calls to patients with cancer offering support
- Additional paediatric consultant to cover PAU
- Working from home
- Change in working hours for paediatric consultants
- Less meetings
- Gynae managed own bed base
- USS Nye Bevan also accessed by ACC
- Allocated Pharmacist (DWP)
- Planned workload using iBox
- Frailty unit funding
- Increased Pharmacy hours until 1900
- Improved access to community beds
- EDN Dr attached to site team
- Communications across divisions
- Fit 2 Sit in WT
- Prioritised ambulance off load
- Virtual consultations
- Reduced footfall through Trust
- Communications from board level



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19/20 What didn't work as well

- Winter doesn't end on 31st March
- Medical cover – provided by a high number of locums
- EPMA upgrade
- Outsourcing of activity to IS
- Shortage of porters at times
- Divisional Managers ceasing routine work to support flow
- Communication issues with some staff groups when opening beds
- PAU closing at 2200h
- Discharges happening late in the day
- Rapid Transfer of patients to wards at times of high escalation
- EAB open as escalation area
- Late EDN's
- Loss of elective ortho ward due to site pressures
- Distress to families who cannot see their loved ones
- Criteria led discharges low numbers
- Medical outliers very high
- Reduced junior doctors due to expanded bedbase
- Too many site meetings
- Lack of paediatric HDU capacity on occasions
- Reduced elective IP activity due to full bed base
- Consistent comms from Site Manager
- CNS team missing out on telephone consultations
- Insufficient capacity for medical admissions
- Poor discharge profiles
- Support from community partners



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NGH Winter Plan 2020/2021

- Developed as part of a wider Local Health Economy (LHE) plan to identify capacity and interventions to address anticipated increase in non-elective activity and surges in COVID-19 and/or Flu, ensuring compliance with local and national infection prevention guidance
- Focus on maximizing ambulatory pathways, reducing bed occupancy levels and increasing acute inpatient capacity
- Same Day Emergency Care and Frailty unit will move to purpose designed unit in Quinton
- Early 'wins' identified from Integrated Care Across Northamptonshire (iCAN) will be fastracked into place to support the winter position
- Trusted assessor appointed to assess patients on behalf of the care homes without waiting for homes to visit NGH
- As part of pandemic control at NGH, the development 'zoned' areas has taken place
- Zoning of the hospital in red, amber and green wards as per COVID-19 will be in place to manage further COVID outbreaks as well as supporting any other infective outbreak such as Influenza or Norovirus
- Impact can be tracked through a dynamic demand and capacity model based on midnight bed occupancy rates
- The detail of financial impact has worked through and shared with the System Finance Directors
- Greater challenges due to the COVID-19 pandemic



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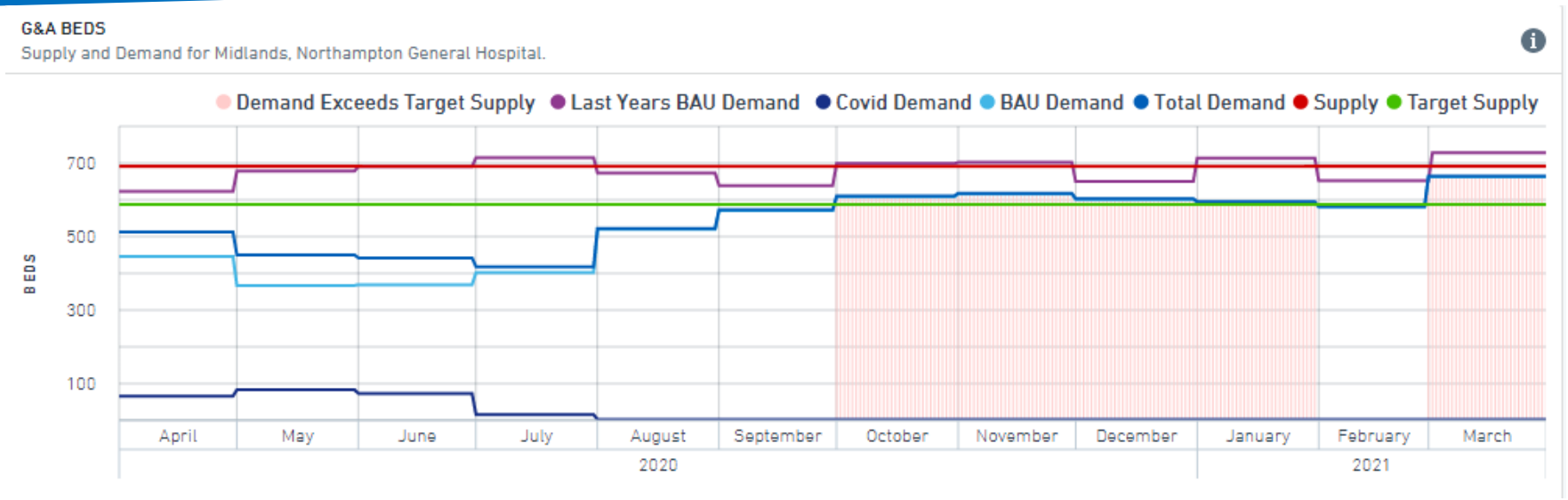
Palantir Model Output



Month	Beds (NEL + COVID + All EL) Demand	85% Occupancy	85% Variance	100% Occupancy	100% Variance
Sep-20	572	587	-15	691	-119
Oct-20	609	587	22	691	-82
Nov-20	615	587	28	691	-76
Dec-20	603	587	16	691	-88
Jan-21	592	587	5	691	-99
Feb-21	580	587	-7	691	-111
Mar-21	634	587	47	691	-57

Note: February showing excess beds due to rapid discharge of patients pre-covid in Feb 20
As of November NGH still has 2 wards vacant giving us 46 extra beds

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Capacity – Addressing the Gap

The largest bed gap range is 47 beds against a bed base of 691 beds, when aiming at 85% occupancy levels (March 2021). Due to the predicted demand and the reduction in bed capacity due to social distancing the following plan is proposed to mitigate the deficit in the bed base at 85% occupancy

Action	Additional Capacity	Description
COA	4 beds	Can be used to bed patients but will slow flow through ED
National Discharge Guidance	10 beds	System delivery of Discharge to Assess (D2A) will yield significant bed capacity
New Rehab Unit NHFT at Brackley Unit	18 beds	Will provide much needed capacity for general and stroke rehab
System winter plans	17 beds	NASS have commissioned 10 beds at Avery and at Angela Grace to support the discharge of patients over winter
'Think NHS111'	8 beds	Reduce footfall and admissions from ED to base wards
7 day frailty unit	10 beds	Ambulance handover directly to frailty unit and 72 hours max stay in bedded area
Total	**67 beds**	

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Capacity – Addressing the Gap

Additional actions being taken include:

Action	Additional Capacity	Description
Specialist care centres	130	The 3 units across county now under Social Care management will create 65 social care beds and 65 Discharge to Assess (D2A) beds
D2A Dom care introduced	TBC	Social Care have commissioned Domiciliary care providers to take patients for assessment
Angela Grace / Avery Care homes	17	For step down beds and available for spot purchase
QDS x 2 Packages of Care	TBC	2 carers 4 times a day are difficult packages to identify with long waits. Patients will be able to wait at the Specialist Care Centres or Extracare Homes for these.

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Winter Planning will ensure that:

- More people are treated closer to home
- Increased number of bookable appointments being booked by NHS111
- Decrease in number of unheralded patients being seen in A&E
- More people leaving hospital in a timely manner
- Fewer people being assessed in hospital and needing larger POC due to hospital decompensation
- More people returning to their normal place of residence
- System preparation and alignment ahead of winter surge/pressure and hospital flow maintained through the winter period
- Services are able to maintain safe IPC practice to manage further surges in Covid 19 presentations



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Specific Challenges – EU Exit

- Whether the UK leaves the EU with or without a deal on 31st December, Brexit will have a significant impact on the health sector.
- Previous planning undertaken has been helpful in strengthening our business continuity arrangements, especially in relation to supply of goods and services.
- The Department for Health and Social Care is pursuing a multi-layered approach to help minimise potential disruption to the supply of medicines and medical products.
- A single, unified, operational response structure will be in place, based in the Trust's incident room, EU Exit issues will be managed through established incident response structures and battle rhythms in place for Covid-19. Winter operations will also be aligned into this function.
- EU Exit issues requiring escalation should be escalated through current EPRR processes to regional and national Incident Control Centres.



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Report To	**Trust Board**
Date of Meeting	**26 November 2020**

Title of the Report	**Group Committee Terms of Reference**
Agenda item	**12**
Presenter of Report	Claire Campbell- Director of Corporate Development, Governance & Assurance
Author(s) of Report	Claire Campbell- Director of Corporate Development, Governance & Assurance (NGH) and Richard Apps- Director of Integrated Governance (KGH)

This paper is for:

☑ Approve	☐ Receive	☐ 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

Executive summary

Kettering General Hospital (KGH) Foundation Trust and Northampton General Hospital (NGH) are working together under a Group Management Model to strengthen acute care service provision across Northamptonshire, under the leadership of a jointly appointed Chair and CEO for both Trust Boards.

A common approach of working across both organisations and emphasis on acute pathway transformation and quality improvement is recognised as a priority. The approach of working as a Group Model across both organisations maintains the statutory duties and responsibilities of two separate Trust Boards.

As part of the collaboration planning work, and to facilitate the seamless implementation of Group Priorities following approval by Boards in January 2021, both Trusts have agreed to establish both a Committee in Common for Quality, Safety and Performance and Digital Hospital.

Committee in Common meetings are a recognised governance approach that enables collaboration between organisations to take decisions together on projects that cross boundaries without compromising the integrity of their own statutory requirements.

Following extensive development work in respect of a Group Model between the two Trusts, draft Terms of Reference for the following Joint Committees are presented as follows:

(a) Clinical Quality and Performance (Appendix A)
(b) Digital Hospital (Appendix B)

(a) Clinical Quality, Safety and Performance

Both KGH and NGH Trust Boards have agreed to establish a joint Committee for Quality, Safety and Performance to support both organisations' collaborative objectives for delivering the best possible outcomes of care for patients where it has been agreed to provide these services as a countywide initiative.

The Committee will focus on providing both Trust Boards with strategic oversight and assurance for activities relating to acute clinical service models that cross organisational and geographical boundaries for both Trusts, as well as quality performance across both Trusts. These Terms of reference have been developed with input from members of both organisations' respective quality committees and if approved the meetings of this committee will commence in January 2021.

Both Trusts will appoint Chairs, with the Chair presiding alternating between organisations.

(b) Digital Hospital

The importance of an ambitious, forward-looking digital strategy for the group is clearly emerging as we develop the group vision, mission and key objectives to ensure we have a coherent digital agenda across the group.

The joint Digital Hospital Committee will be supported by new operational level meetings at Trust and Group level.

Work has taken place to develop Terms of Reference for this new committee, including a workshop with a large number of stakeholders and if approved meetings of this Committee will commence in December 2020.

The Terms of Reference of both these Committees were discussed at the Collaboration Programme Committee, endorsed and approval recommended by both Trust Boards, noting they will be kept under review and iterated as necessary.

It is proposed that this meeting will be Chaired by the current Chair of the Digital Committee at KGH to ensure continuity. Northampton General Hospital Trust is able to delegate the chairmanship of this meeting under Standing Orders (section 5.1 & 5.2) and NGH Board approval is sought to action this.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable excellence through our people* 6. *Become a University Hospital by 2020 becoming a centre of excellence for education and research*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: Not approving these ToR will delay the commencement of key

	Group initiatives and therefore delay effective governance arrangements, which may result in delays in programme delivery across both Trusts and missed opportunities for collaboration and alignment.
Related Board Assurance Framework entries	All
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	None
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper

Actions required by the Board:

- Approve the Terms of Reference for the Joint Clinical Quality, Safety and Performance and the Joint Digital Hospital Committees.
- Approve delegation of the Chair of the Digital Hospital Committee to KGH under Standing Orders (5.1 & 5.2)

Clinical Quality, Safety and Performance Committee in Common

DRAFT Terms of Reference

Membership	**KGH** • 2 Non-Executive Directors (including Co-Chair for alternate meetings) • Hospital CEO • Medical Director • Director of Nursing • Chief Operating Officer • Director of Integrated Governance **NGH** • 2 Non-Executive Directors (including Co-Chair for alternate meetings) • Hospital CEO • Medical Director • Director of Nursing • Chief Operating Officer • Director of Corporate Development, Governance and Assurance
Quorum	• 4 members from each organisation (one of whom should be Non-Executive Directors
In Attendance	**Both Trusts** • Relevant Clinical Director for shared clinical services **KGH** • Nominated Governor
Frequency of Meetings	• Bi- monthly and scheduled to occur on the same day as KGH & NGH Quality Committees.

Accountability & Reporting	• Accountable to KGH & NGH Trust Boards
	• NED Chair of the Committee to alternate between both Trusts
	• Approved minutes available to all Trust Board members
	• Highlight report to be presented to;
	  ○ Both Boards
	  ○ Collaboration Programme Committee

Date of Approval by	January 2021

Committee in Common	
Date of Approval by KGH & NGH Trust Boards	November 2020
Review Date	

DRAFT Terms of Reference

1. Context

Kettering General Hospital (KGH) Foundation Trust and Northampton General Hospital (NGH) are working together under a Group Management Model to strengthen acute care service provision across Northamptonshire, under the leadership of a jointly appointed Chair and CEO for both Trust Boards. A common approach of working across both organisations and emphasis on acute pathway transformation and quality improvement is recognised as a priority. The approach of working as a Group Model across both organisations maintains the statutory duties and responsibilities of two separate Trust Boards.

As part of the collaboration planning work, both Trusts have agreed to establish a Committee in Common for Quality, Safety and Performance (Committee in Common – QSP) to provide the strategic oversight and assurance for activities relating specifically to acute clinical service models that cross organisational and geographical boundaries for both Trusts. Committees in Common are a recognised governance approach that enables collaborations between organisations to take decisions together on projects that cross boundaries without compromising the integrity of their own statutory requirements.

A Collaboration Programme Committee (CPC) has been established as a Committee of both NGH and KGH Boards with both Executive and Non- Executive membership. The CPC role is to drive the collaborative strategy across both Trusts, agree acute clinical models of care aligned with local system priorities for transformation informed by population health priorities.

2. Constitution

Both KGH and NGH Trust Boards have agreed to establish a Committee in Common for Quality, Safety and Performance to support both organisation's collaborative objectives for delivering the best possible outcomes of care for patients where it has been agreed to provide these services as a countywide initiative. The Committee will focus on providing both Trust Boards strategic oversight and assurance for activities relating to acute clinical service models that cross organisational and geographical boundaries for both Trusts. As well as quality performance across both Trusts.

Where activities are Trust specific, the individual Trust's Quality Committee will continue to be responsible for the assurance oversight for those specific services and report to the relevant Trust Board.

3. Purpose

The purpose of the Committee in Common for Quality, Safety and Performance is to:

- Ensure that the clinical priorities for transforming acute services across both organisations to countywide provision agreed by the Collaborative Programme Committee (CPC) and aligned with Northamptonshire Health and Care Partnership (NHCP) priorities, are progressed and delivered.
- Oversee the achievement of a standardised approach to service delivery that will ensure regardless of where services are accessed, acute services are in line with national best practice.
- Oversee development of robust integrated quality systems for quality planning, quality improvement and quality assurance.
    - Ensure the delivery of the quality improvement plan for service provision and ensure that the quality of care and clinical outcomes improve.

- Oversee the specific 'quality' metrics, outcomes and work streams and ensure action is taken on quality concerns where these relate to countywide acute services that cross organisational and geographical boundaries.
    - Oversee the safe transition and integration of quality and performance for service provision into a new architecture and transition from individual organisation to the group model approach at both place and scale.
    - Evaluate transformational change for agreed acute countywide service provision against agreed key KPI's and improve clinical outcomes for patients by providing a mechanism for collaborative decision making across both organisations. Ensure that quality and service outcomes are an integral part of the redesigned acute clinical pathway(s).
    - Review and monitor unwarranted variation in quality and performance across both Trusts to ensure that they are understood and investigated with any associated analysis and actions.
    - Oversee development and delivery of recovery plans to drive overarching performance and quality improvements for acute care provision.
- Ensure that there is an effective mechanism of integrated governance, risk management and control for those acute services that cross organisational boundaries and geographical locations.
- Share learning, enable participative/collegiate contributions to be timely and enable better-informed discussions and considerations for acute clinical service priorities and transformation, aligned with local system (NHCP) requirements and national imperatives.
- Seek assurance for timely alignment of key enablers (finance, workforce, IM&T, digitalisation and estate) for countywide service provision to enable acute clinical service transformation to be progressed with neither organisation becoming compromised during the process.
- Through membership of the Committee, seek assurance for proactive contribution for shaping strategic clinical leadership across both organisations in relation to the development of the county's acute care model that improve health outcomes. Consider service priorities and make recommendations for consideration to KGHFT and NGH Trust Boards, aligned with NHCP priorities.

4. Accountability and Reporting Arrangements

The Committee in Common – QSP will provide assurance to both Trust Boards through the Chair of the Committee on its proceedings after each meeting through a highlight report. This highlight report will also be shared with the Strategic Clinical Leaders Group of NHCP following approval from both Trust Boards.

Two Non-Executive Co-Chairs will be appointed (one from each Trust Board) by the Joint Chair, and each will Chair alternate Committee in Common meetings.

The Committee in Common will only operate within the parameters of the responsibilities delegated to it by both Trust Boards and as described in these Terms of Reference. Each Board will record the delegation within their Scheme of Reservation & Delegation.

5. Membership

The Committee membership is summarised at the front of this document.

6. Declaration of interests

All members must declare actual or potential conflicts of interest relevant to the work of the Committee and this shall be recorded in the minutes accordingly and added to the Conflict of Interest Register of individual Trusts.

Members should exclude themselves from any part of a meeting in which they have material conflict of interest. The Chair will decide whether a declared interest represents a material conflict of interest.

7. Quorum, Frequency of meetings and required frequency of attendance

Four members from each organisation (one of whom should be Non-Executive Directors) will constitute a quorum.

Both organisations Directors of Governance will monitor compliance with the Terms of Reference and will bring any non-compliance to the attention of the relevant Trust Board. In addition, the post holders will ensure that there are aligned governance and reporting processes between their respective Trust Boards, this Committee and the respective Quality Governance Committees.

The Committee will meet bimonthly. The timing of this meeting will be scheduled on the same day as the Quality Governance Committee meetings of KGHFT and NGH to ensure timely cascade of information between the two Quality Committees and the Committee in Common.

The agenda and supporting papers will be circulated to all members at least five working days before the date the meeting will take place. Extraordinary meetings may also be called giving at least five working days' notice before the meeting can take place.

Consideration should be undertaken by the Chair of the respective Trust Quality Committees when developing the agendas to ensure that all countywide service considerations are discussed at the Committee in Common and that the individual Trust Quality Committee's agenda reflects activities specific to the Trust.

Members of the Committee in Common are required to attend a minimum of 80% of the meetings held and not be absent for two consecutive meetings without prior permission of the Chair. Members of the Committee in Common can nominate a deputy but not for more than two consecutive meetings without prior permission of the Chair.

Virtual meetings, subject to minimum quoracy requirements will have authority to take decisions relating to countywide provision, meetings will be recorded, and minutes/action logs produced in the normal way.

In attendance

- Administrative Support from existing resources within both organisations.
- Others as requested by the Chair of the Committee

Others may be invited at the discretion of the Committee, although this will be in attendance only.

8. Alignment with system - NHCP Quality Committee, Governance and Reporting

NHCP has established a system Quality Committee to over oversee quality, performance, safety and safeguarding across health and care services for the county. The Medical

Directors and Directors of Nursing from both Trusts are members of the system wide Quality Committee. The Committee in Common will support delivery of the key priorities agreed as a system on behalf of both Trust Boards and report accordingly through a highlight report.

The clinical membership of the Committee in Common from both Trusts are also members of NHCP Clinical Leaders Group and as such will be the conduit for information flows to and from NHCP Clinical Leaders forum and the Committee in Common in respect to quality matters.

9. Administration

The Committee shall be supported administratively by resources from within the two Trusts's whose duties in this respect will include:

- Review of the Terms of Reference in line with requirements
- Maintain agenda against work planner/cycle of business
- Agreement of the agenda with the Chair and attendees and collation of papers;
    - Circulation of agendas and supporting papers to Committee members at least five working days prior to the meeting
    - Other members of the Committee should submit their agenda items to the Chair or Deputy Chair
    - Taking and issuing the minutes and preparing action lists in a timely way;
    - Keeping a record of matters arising and issues to be carried forward.
    - Maintain an on-going list of actions, specifying members responsible, timescales and keeping track of these actions
    - Drafting of minutes for approval by the Chair within five working days of the meeting and then distributed as outlined above within ten working days
- Keeping an accurate record of attendance

Other Trust Board members from either organisation may request or be required to attend meetings of the Committee when matters concerning their responsibilities are to be discussed or they are presenting papers submitted to the Committee.

10. Requirement for Review

These terms of reference may be amended in consultation with both Trust Boards, to reflect changes in circumstances that may arise. This Committee in Common is recognised as undertaking a role to support and enable collaboration of clinical service delivery and as such solutions considered may be iterative and designed to evolve over time. Together both Trust Boards will implement and review bi-annually the Terms of Reference.

11. FOI Reminder

The minutes (or sub sections) of the Trust Boards, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public through the meeting papers.

GROUP DIGITAL HOSPITAL COMMITTEE
TERMS OF REFERENCE

1. PURPOSE

1.1. The Digital Hospital Committee will oversee strategic aspects of the NGH and KGH Group's digital, technology and information agenda which includes:

1.1.1. Steering the creation of the Group Digital Strategy to align with the Group's overall strategy, and driving the overall digital ambition for the Group., with particular regard to:

- Creating a seamless experience for patients across both trusts; and
- Providing clinicians with the right digital tools to work safely and efficiently.

1.1.2. The Group Digital Hospital (GDHC) will oversee Trust specific roadmap development and delivery in line with developing a group Digital Strategy, and delivering the digital component of Group priorities.

1.1.3. Driving the NGH and KGH roadmaps and ensuring any workstreams are clinically-led and delivered successfully.

1.1.4. Oversee the Group's digital risk exposure and cyber security capabilities and assure that the appropriate risk management processes are in place.

1.1.5. Assuring the delivery of major Group digital transformation programmes, monitoring progress and supporting the alignment and assignment of relevant IT, project management and transformation teams across both Trusts.

1.1.6. To promote the application of the culture, processes, business models and technologies of the internet era to respond to people's raised expectations [Tom Loosemore's definition of Digital].

2. AUTHORITY

2.1. The Digital Hospital Committee ("the Committee") is a Committee in Common and has delegated authority from each Trust Board, as set out each Trust's Scheme of Delegation. The Committee has the responsibility for ensuring the delivery of the overall Group Digital Roadmap and will delegate this authority to individuals or groups as appropriate.

2.2. The Committee is charged with providing assurance to the Trust Boards and is authorised to investigate any activity within its Terms of Reference.

2.3. The Committee is required to escalate items to the Trust Boards, where their direction and decision making is required.

3. MEMBERSHIP AND ATTENDANCE

Role	KGH	NGH
Chair of Committee	Non-Executive Director	Non-Executive Director (TBC)
Members	Non-Executive Director (Deputy)	Non-Executive Director (Deputy)
	Group Chief Digital Information Officer (Accountable Executive)	
	Group Director of Finance	
	Chief Operating Officer	Chief Operating Officer
	Director of Strategy	Director of Strategy and Partnerships
	Director of Integrated Governance	Director of Corporate Development Governance and Assurance
Attendees	Chief Clinical Information Officer(s)	Deputy Medical Director / Chief Clinical Information Officer(s)
	Caldicott Guardian	Caldicott Guardian
	Digital Director	Digital Director
	Trust Governor(s)	
	Patient Advocacy Representative	
	Major IT System Suppliers (quarterly)	

3.1. Notes on membership and attendance:

The Committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate. The Chair of the Trust Board, Non-Executive Directors or other Executive Directors may be invited to attend any meeting of the Committee, particularly when it is discussing areas of the Trust's operation that are the responsibility of that director.

The role of the Non-Executive Directors on this Committee is to:

- Act as the Chair of the committee (for one nominated Non-Executive Director).
- Provide independent scrutiny and advice and to constructively challenge, influence and help on the digital strategy, its vision and roadmap, delivery performance and resources.
- Provide assurance that digital-related risks to the Trust and its patients, staff, carers and the public are managed and mitigated effectively.

4. MEETINGS AND QUORUM

4.1. Meetings of the Committee shall be deemed quorate when there is a minimum of four members present (one to be the Chair or Deputy Chair).
4.2. Members should nominate deputies to attend in their absence.
4.3. Meetings of the Committee will take place every other month, scheduled to support the business cycle of the Trust and the effectiveness of the Trust Board.

5. SUPPORT ARRANGEMENTS

5.1. The Digital Hospital Committee will be supported administratively by Board Secretary representatives from either Trust whose duties in this respect will include:-
- 5.1.1. Agreement of the agenda with the Chair.
- 5.1.2. Collation of papers.
- 5.1.3. Electronic distribution of papers no later than one week in advance of the meeting, with exceptional data to be added at least three days in advance of the meeting.
- 5.1.4. Making papers available to other members of the Trust Board for information.
- 5.1.5. Accurate minute taking and keeping a record of matters arising and issues to be carried forward.

6. DECLARATION OF INTERESTS

6.1. All members must declare any actual or potential conflicts of interest relevant to the work of the Committee, 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 (or Deputy Chair, when acting as Chair of the meeting) will decide whether a declared interest represents a material conflict of interest.

7. DUTIES

7.1. To have oversight of the delivery of the Group's Digital Roadmap and vision, and the projects that the key workstreams through:
- 7.1.1. Scrutiny of the plan's implementation.
- 7.1.2. Acting as a point of escalation for risks to delivery and supporting mitigations.
- 7.1.3. Ensuring the right resources are in place for successful delivery of these projects.
- 7.1.4. Monitoring benefits delivered by the projects, and ensuring these are in line with expected benefits laid out at the start of the projects, escalating this where necessary.
- 7.1.5. Ensuring lessons learned are incorporated into future projects, and learnings are disseminated across the Trust.
- 7.1.6. Recommend as appropriate business cases for onward approval, after consideration and discussion of their relevance to the Digital Roadmap.
- 7.1.7. Work with other committees, sub-committees and forums to ensure effective changes to culture and working practices are in place to make the most effective use of digital and technology solutions.

7.2. To act as a strategic point of alignment for IT within the Group and across the wider health and social care economy, and ensure coherence with all other major programmes across the Group.
7.3. Establish and oversee a single integrated decision-making framework for technology investment and prioritisation to make appropriate recommendations to the Trust Boards.

7.4. Through ongoing horizon scanning, provide digital and technology updates to the Trust Boards to support delivery of the Group's ambition to the most Digital Hospital Group in England.

7.5. Develop and oversee communications to ensure transparency, visibility and to ensure compliance with relevant legislation.

8. STANDING AGENDA ITEMS

1	Welcome & apologies
2	Declarations of interest
3	Minutes of the previous meeting
4	Action log review
5	Digital Roadmap overview
6	Project delivery updates on each key workstream
7	Other key projects being delivered, outside of the digital roadmap
8	Finance update
9	Agreeing / collating any performance improvement actions noted for escalation / feedback to other parties
10	Key risks and issues for escalation to the Board

9. REPORTING

Outputs

9.1. To Board:

9.1.1. The Committee is directly accountable to the Trust Board. The Chair of the Committee shall prepare a summary report to the Board detailing:

9.1.1.1. Decisions taken.

9.1.1.2. Items that require Trust Board assurance.

9.1.1.3. Items that need to be escalated to the Trust Board for direction or decision making.

9.2. To both NGH and KGH Hospital Management Team meeting (NHMT and KHMT):

9.2.1. The Committee is not directly accountable to NHMT or KHMT, but will provide the following information to note as appropriate:

9.2.1.1. Decisions taken.

9.2.1.2. Items that require Trust Board assurance.

9.2.1.3. Items that need to be escalated to the Trust Board for direction or decision making.

9.3. To NGH and KGH Risk Management Steering Group:

9.3.1. The Chair will report any specific issues on the risk register to the Risk Management Steering Group as appropriate.

9.4. NGH and KGH Investment Management Committees

9.4.1. The Committee will pass new funding requirements to the appropriate trust(s)the investment process for due consideration.

9.5. Targeted and ad hoc communication materials to other groups, focused on progress and success stories:

9.5.1. Nursing and Midwifery operations.
9.5.2. Digital transformation programme of the STP and wider East Midlands Group
9.5.3. Patient groups
9.5.4. AHP Groups
9.5.5. Other Board Members (incl. NEDS and Executive members)

Inputs

9.6. Inputs from the Trust Operational Groups (with GIRFT Model Hospital reporting digital inputs into the Operational Groups).
9.7. Inputs from the Clinical Senate.
9.8. Inputs from Patient Advocacy Groups on opportunities for improvement and feedback on existing digital solutions.
9.9. Inputs from Cyber Security and Digital Risk reviews.

10. PROCESS FOR MONITORING EFFECTIVENESS OF THE COMMITTEE

10.1. The Chair of the Committee will seek feedback on the effectiveness of the Committee meetings at frequent intervals, as deemed necessary by the Chair.
10.2. The Committee will produce an annual report on the actions taken by the Committee to comply with its Terms of Reference. The annual report will include information about compliance with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings.
10.3. The Committee Terms of Reference are to be reviewed at least annually.

Review date: November 2020
Next Review: November 2021

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Report To	**Trust Board**
Date of Meeting	**26 November 2020**

Title of the Report	**Audit Committee Terms of Reference**
Agenda item	**13**
Presenter of Report	C Campbell- Director of Corporate Development, Governance and Assurance
Author(s) of Report	C Campbell- Director of Corporate Development, Governance and Assurance

This paper is for:

√ Approve	Receive	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

Executive summary

The Audit Committee has overall responsibility for the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

The committee is required to review the terms of reference to ensure they reflect the duties the committee is required to discharge.

Following a review in September 2020 the following amendments have been proposed and agreed by the Audit Committee at the meeting in October 2020 (Appendix 1).

- 6.1 Addition of group risk
- 6.2 Updated to include relevant standards
- 6.4 Reference to meeting formally with Quality Governance Committee and Finance and Performance removed.
- All references to NHS Protect removed/ updated
- Reference to NHSLA updated to NHSR
- References to the Finance, Investment & Performance Committee updated

NED membership was discussed between the Committee Chair and Lead Executive. Guidance, including the HFMA NHS Audit Committee Handbook states only that the Chairman of the Trust should not be a member of the Audit Committee.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable excellence through our people* 6. *Become a University Hospital by 2020 becoming a centre of excellence for education and research*
Risk and assurance	The Audit Committee is the primary Assurance committee of the Trust Board and advises the Board on all matters related to risk management and internal control. It oversees the Annual Governance statement on behalf of the Board.
Related Board Assurance Framework entries	ALL
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Financial Implications	None
Legal implications / regulatory requirements	Every NHS organisation is required to have an Audit Committee that reports to its governing body (Trust Board).

Actions required by the Board:

The Board is asked to:

- Approve the Terms of Reference of the Audit Committee

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AUDIT COMMITTEE

TERMS OF REFERENCE

Membership	• Non-Executive Directors (Chair) • Two Non-Executive Directors • NED Chairs of each of the Trust Board subcommittees
Quorum	• Three Non-Executive Directors
In Attendance	• Director of Finance • Director of Corporate Development Governance and Assurance • Deputy Director of Finance • Head of Financial Services • External Audit • Internal Audit • Local Counter Fraud • CEO to present Annual Governance Statement, draft internal audit plan and the annual accounts. • Other Executive Directors as requested to present key papers • Executive Board Secretary
Frequency of Meetings	• At least four meetings per year
Accountability and Reporting	• Accountable to the Trust Board • Highlight report to the Trust Board by Chair of Committee after each meeting • Minutes available to all Trust Board members Annual report to the Trust Board on actions taken to comply with terms of reference
Date of Approval by Trust Board	• November 2020
Review Date	• October 2021

AUDIT COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Trust hereby resolves to establish a Committee of the Trust Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Membership

The Committee shall be appointed by the Board from amongst the non-executive directors of the Trust and shall consist of not less than three members. The Trust Board should satisfy itself that at least one member of the Committee has recent and relevant financial experience.

One of the members will be appointed chair of the Committee by the Board. In the absence of the Chair appointed by the Trust Board, once of the non-executive directors will be elected by those present to Chair the meeting.

The Chairman of the Trust shall not be a member of the Committee.

3. Quorum, Frequency of meetings and required frequency of attendance

No business shall be transacted unless three members of the Committee are present.

Meetings shall be held not less than four times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Members of the Committee should attend regularly and should not be absent for more than two consecutive meetings.

4. In attendance

The Director of Finance and appropriate internal and external audit representatives shall normally attend meetings.

The counter fraud specialist will attend a minimum of two committees a year.

The Accountable Officer should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. He or she should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

Other executive directors/managers should be invited to attend, particularly when the Committee is discussing areas of risk management or operation that are the responsibility of that director/manager.

Representatives from other organisations and other individuals may be invited to attend on occasion.

The Board Secretary shall be secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and committee members.

At least once a year, the Committee should meet privately with the external and internal auditors.

5. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by the Board to obtain outside legal or other independent professional advice and

to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. Duties

6.1 Integrated Governance, Risk Management and Internal Control

The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical) that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy and effectiveness of:

- All risk and control-related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other independent assurance, prior to submission to the Board
- The underlying assurance processes that indicate the degree of the achievement of the organisations objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. This may include risks related to both the organisation and Group.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications
- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by NHS Counter Fraud Authority.

In carrying out this work the committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages.

6.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the relevant standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Trust Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service and the costs involved
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Considering the major findings of Internal Audit work (and management's response) and ensuring co-ordination between the Internal and External Auditors to optimise audit resources

- Ensuring that the Internal Audit function is adequately resources and has appropriate standing within the organisation
- Monitoring the effectiveness of internal audit and carrying out an annual review.

6.3 External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the Board when appropriate)
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services

6.4 Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Resolution, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

The Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, the committee will work in close liaison with the Quality Governance Committee and the Finance and Performance Committee.

In reviewing the work of the Quality Governance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

6.5 Counter fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority standards and shall review the outcomes of work in these areas.

6.6 Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

6.7 Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letter of representation
- Explanations for significant variances

6.8 Whistleblowing

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

7. Accountability and Reporting arrangements

The Committee shall report to the Board on how it discharges its responsibilities.

The minutes of the Committee's meetings shall be formally recorded by the Board and Committee Secretary and submitted to the Board. The Chair of the Committee, via a formal highlight report, shall draw the attention of the Board any issues that require disclosure to the Board or require executive action.

The Committee will report to the Board at least annually on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality account.

This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

8. Sub-committees and reporting arrangements

The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-committees must be approved by the committee and regularly reviewed.

9. Administration

The Committee shall be supported administratively by the Board and Committee Secretary – his or her duties in this respect will include:

- Agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of papers in good time
- Ensuring that those invited to each meeting attend
- Taking minutes and helping the Chair to prepare reports to the Board
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the Chair – for example with the internal/external auditors or local counter fraud specialists
- Maintaining records of members' appointments and renewal dates etc
- Advising the Committee on pertinent issues/areas of interest/policy developments
- Ensuring that action points are taken forward between meetings
- Ensuring that Committee members receive the development training they need

10. Requirement for review

These terms of reference will be formally reviewed by the Committee at least annually.

11. FOI Reminder

The minutes (or sub-sections) of the Board, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

Report To	**Trust Board**
Date of Meeting	**26 November 2020**

Title of the Report	**Board Assurance Framework Q2 2020- 21**
Agenda item	**14**
Presenter of the Report	Claire Campbell, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Claire Campbell, Director of Corporate Development, Governance and Assurance

This paper is for: (delete as appropriate)

□ √**Note**	□√ **Assurance**
For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

1. Executive summary

The purpose of the BAF is to provide the Trust Board of Directors with a simple but comprehensive method for the oversight of the effectiveness of the controls on the principal risks to meeting the Trust's objectives. The BAF maps out both the key controls in place to manage the principal risks and also how sufficient assurance has been gained about the effectiveness of these controls. It also provides a structure for various audit programmes and evidence to support the Annual Governance Statement.

All Board committees and the Board review the BAF quarterly. Each risk has been assigned to one or more Board committees. The Board has agreed to maintain this reporting process and frequency.

This report includes the annual review of the BAF risks and their content and describes the updated Q1 position in relation to the risks associated to delivery of corporate objectives described on the BAF.

2. Assurance

The Trust Board is only properly able to fulfil responsibilities through an understanding of the principal risks facing the organisation. The Board therefore needs to determine the level of assurance that should be available to them with regard to those risks. Risks have been assigned to specific Board committees for discussion and challenge prior to presentation at Trust Board.

3. Population of the BAF

Executive Director Leads have reviewed and updated all sections of the BAF with a particular emphasis on any gaps in control, gaps in assurance, and the assurance position. The actions and milestones have been updated accordingly.

4. Changes to the BAF during Q2 2020/21

General changes made are as follows:

- Following discussion at Audit, Quality and Finance Committees regarding the timeframe for target date- it has been agreed that this will be in line with the date of the next full review of the BAF i.e. annually.

a. BAF Risk 1.1: Risk of failure to meet regulators minimum fundamental standards to avoid enforcement action, intervention or suspension of services- Quality Governance Committee

- Target score has been amended in discussion with key Exec colleagues
- Existing controls: Full Hospital Capacity protocol added
- Assurance of controls: IPC ESF added
- Actions updated: NGH Improvement Plan due to be closed at October QGC meeting. HEE/ GMC action plans date pushed back to November as reports need to be received at Workforce Committee. One CAS alert remains outstanding therefore date has been further extended but it is expected to close within this revised timeframe. Following further discussion the IPC ESF outcome has increased to full assurance. PCR review due to be held in October.
- Score: No change.

b. BAF Risk 1.2: Risk of Failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties- Finance & Performance

- Lead Executive updated
- Assurance of Control: Elective Care National support team review added.
- Actions updated: Appointment of Patient access manager added and completed. Theatre reset to 85% completed and exceeded and zoning bronze cell completed.
- Score: No change

c. BAF Risk 1.3: Risk of failing CQUIN standards leading to lost opportunity to improve service quality and financial risk of due to loss of funding associated with CQUIN attainment- Quality Governance Committee

- NHS England have confirmed that the operation of the 2020/21 CQUIN scheme (both CCG and specialised) for Trusts will remain suspended for all providers for the remainder of the year. This risk has therefore been removed for the current year.

d. BAF Risk 1.4: Risk of avoidable harm to patients and the associated loss of public confidence. Quality Governance Committee.

- Existing Controls: Maternity Dashboard, Saving Babies Lives – National Initiative and Neonatal Safety Champion Role added
- Assurance of Control: IPC ESF (L3), Maternity report to QGC (L1) and Maternity Forum (L1) added
- Gaps in control: HSMR outlier updated.
- Actions updated: Completion of work to mandate use of deteriorating patient care plan due date extended further. Mortality review of deaths deadline extended further. IPC SI process extended in line with SI reporting policy. Guidance on outbreaks completed. Two new actions added- Mortality presentation to Board in October and appointment of Deputy DIPC which has been completed.
- Score: No change.

e. BAF Risk 1.5: Risk that Trust fails to deliver high quality services across all wards and clinical departments at all hours on each day of the week resulting in skills and capacity constraints impacting on patient safety and experience- Quality Governance Committee. The risk title has been updated to “Risk that Trust fails to deliver high quality services in all clinical areas 24/7. The risk to capacity and capability is dealt with in section 3.

- Existing controls: No change.
- Assurance of Control: No change
- Gaps in assurance: No change.
- Actions updated: Quality Improvement strategy completed. Quality Account to be presented to October QGC.
- Score: No change.

f. BAF Risk 1.6: Inability to recruit adequate numbers of nursing staff- Quality Governance Committee/ People Committee

- Existing controls: No change.
- Assurance of Control: No change
- Gaps in control: Gap removed- see score rationale below.
- Actions update: NHS recruitment and retention collaboration completed.
- Score: Score reduced from 15 to 10 due to an influx of overseas nurses now in post and an improved retention rate. Score is now at target level.

g. BAF Risk 1.7: Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failure- Quality Governance Committee/ Finance & Performance Committee

- Existing controls: No change
- Assurance of Control: No change
- Gaps in control: No change.
- Actions updated: Recruit into key estates vacancies completed as all key posts now filled. Deliver action plans against key estates elements to improve assurance and reduce risks – Good progress continues to improve assurance levels. Water Safety has moved to Reasonable Assurance. Electrical and Ventilation assurance is expected to move to Reasonable assurance during Oct 20. Annual fire report delivered to Board. Due date will be ongoing due to age and risk of infrastructure. Review Estates strategy to align with KGH, STP/HCP and Clinical strategy – consultants have been commissioned to develop Development Control Plan / Master planning work at NGH (in conjunction with KGH HIP2 work). This work will take approx. 3 months. A proposal for joint strategy has been presented and is being discussed with KGH. This is approx. 6 month project. Seek additional routes to Capital funding to reduce backlog and align with Estates strategy & Masterplan and Clinical strategy - A proposal for joint estate strategy has been presented and is now being discussed with KGH. This is approx. 6 month project and will provide the basis for any future external funding/HIP 3 bid. Due date ongoing
- Score: No change

h. BAF Risk 1.8: Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust- Finance & Performance

- The target score has been increased from 8 to 16 (4x2 to 4x4) in discussion with key Executive colleagues.
- Lead Director changed from COO to DoF
- Existing controls: No change.
- Assurance of Control: No change
- Gaps in control: No change.
- Gaps in control: No change.
- Actions update: Actions 2 and 3 – due dates extended. Additional external assurance (DCIO) for data/information and new kitemark process completed.
- Score: No change

i. BAF Risk 1.9: The risk of the Trust being unable to deliver an appropriate response to Covid 19 in terms of quality of care, capacity and timeliness with consequential impact on patient and staff safety, patient experience and staff wellbeing- Board and all committees.

- Risk Owner: Changed to COO
- Existing Controls: Updated to reflect increase to 85% bed occupancy.
- Assurance of Control: No change.
- Gaps in control: No change.
- Actions update: Cyber security action completion- new action of additional staff to support cyber security added.
- Score: No change.

j. BAF Risk 1.10: Risk of the Trust being unable to deliver a recovery plan post covid-19 with consequential impact on patient and staff safety, patient experience and staff wellbeing- Board and all committees.

- Existing Controls: Updated to include Demand and Capacity plans completed for RTT and Cancer for all Specialties
- Assurance of Control: No change.
- Gaps in control: Gap of demand and capacity pan removed as completed. Additional Endoscopy air handling unit insufficient to maintain safe air flows added. See comments re score below.
- Actions update: Reset paper action completed. National review of elective waiting lists to ensure all patients still want / need to be seen and New Air handling unit on order, endoscopy moved to 3 day case theatres plus plan to open 2 rooms for endoscopy in Daventry added.
- Score: Decreased from 20 to 15. The gap in control is currently mitigated with use of theatres for

endoscopy lists with a plan to replace air units in place.

k. BAF Risk 2.1: Risk that the Trust fails to promote a culture which puts patients first- Quality Governance Committee. The risk title has been updated to" Risk that the Trust fails to provide an excellent patient experience".
- Existing Controls: No change.
- Assurance of Control: No change.
- Gaps in control: No change.
- Actions update: Three actions completed. Six new actions added.
- Score: No change.

l. BAF Risk 3.1: Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future- People Committee
- Existing controls: Minor updates made to existing controls.
- Assurance of control: No change
- Gaps in control: No change
- Actions update: Three actions completed and new action added to complete Oncology work.
- Score: No change

m. BAF Risk 3.2: Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future- People Committee
- Existing controls: No change
- Assurance of control: No change
- Actions update: Action 2 updated, action 3 completed and new action added regarding introduction of an appraisal "lite" system to enable appraisals to continue during potential second wave of pandemic.
- Score: No change

n. BAF Risk Score 3.3: Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optimal culture- People Committee
- Existing controls: No change
- Assurance of control: No change
- Actions update: Action 2 updated and amended and action 3 completed.
- Score: No change.

o. BAF Risk 4.1:Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire Health and Care Partnership will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access- Finance & Performance
- Existing controls: Amended and updated
- Assurance of control: Amended and updated
- Gaps in control: Amended and updated.
- Actions update: Action 1 completed. Action 2 amended and updated.
- Score: No change

p. BAF Risk 5.1: Risk that the Trust fails to have financial control measures in place to deliver its 2020/21 financial plan- Finance & Performance Committee
- Existing controls: No change
- Assurance of control: No change
- Gaps in control: No change
- Actions update: Actions 3-5 completed.
- Score: No change.

q. BAF Risk 5.3: Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements Finance & Performance Committee
- Existing controls: No change

- Assurance in control: No change
  - Gaps in control: Additional gap in control added – Inconsistent data requests and treat of removing previously approved capital risking achievement of Trusts CRL.
- Actions update: No change
- Score: No change

Risk Score: The risk score has decreased overall in this quarter from 236 for 16 risks to 226 for 16 risks. The BAF is attached (Appendix 1).

Related strategic aim and corporate objective	ALL
Risk and assurance	The Board assurance framework describes key risks to the Trust's corporate objectives and informs the organisational Annual Governance Statement
Related Board Assurance Framework entries	ALL
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? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	The Board assurance framework is cross referenced to the Care Quality Commission Standards of Quality and Safety which the organisation has a statutory duty to meet.

Actions required

The Board is asked to:

- Note and agree the changes made to the review of the BAF
- Consider if the Board is gaining sufficient assurance that controls and actions in place are mitigating risks described

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.		
BAF Risk No.1.1 Risk of failure to meet regulators minimum fundamental standards to avoid enforcement action, intervention or suspension of services		
Risk Classification: Compliance	**Risk Owner:** DCD,G & A	**Scrutinising Committee:** Quality Governance Committee
Date Risk Opened: 30/6/20	**Date of next full review of BAF:** 31/3/21	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks: 731,1303;1553; 1665; 1782; 1867;1879;1902; 1911; 1303; 2178	**Initial score**	**Current score**	**Target score**
	15 (5x3)	15 (5x3)	10 (5x2)

Existing Controls	**Assurance of Controls**
1. Clinical Governance structures and processes 2. Clinical Audit strategy 3. Board to Ward visits 4. Quality metrics in Performance report to Board 5. Divisional Quality Governance reports to Clinical Quality & Effectiveness Committee 6. Quality meetings with commissioners 7. Quality Governance committee 8. Clinical Quality & Effectiveness Group 9. Patient and Carer experience Group 10. ARC reports to QGC 11. Ward Accreditation- currently suspended 12. Virtual CQC Relationship meetings 13. CQC IPC Emergency Support Framework (ESF) 14. Full Hospital Capacity Protocol	• QGC report to Trust Board (L2) • Trusts Quality Improvement scorecards (L1) • Assessment and accreditation reports to Trust Board (L1) • Divisional Quality Governance assurance reports to CQEG (L1) • Compliance reports to QGC (L1) • Peer review & screening QA visits (L3) • Internal audit reports (L3) • ARC reports to QGC(L1) • CQC Insight report – Bi monthly (L3) • CQC Engagement meetings (L3) • IPC ESF (L3) +ve

Gaps in Controls

- Trust has red flags related to Medical Trainee reports
- CQC Insight report indicates that the Trust's composite indicator score is similar to other trusts that are more likely to be rated requires improvement.
- CQC Report (2019) overall rating of Requires Improvement
- Capacity Pressures impacting on SSNAP compliance

Further Actions	**Responsible Person/s**	**Due Date**
1. NGH Improvement Plan reviewed monthly in QGC	1. Claire Campbell	October 2020- complete
2. HEE/GMC action plans in progress	2. Matt Metcalfe	November 2020
3. Robust management of delays in CAS alerts	3. Claire Campbell	November 2020
4. Full capacity protocol instigated- Overflow stroke beds agreed to be monitored	4. Carl Holland	Completed
5. Virtual meeting to be held with CQC Relationship manager regarding the ESF	5. Claire Campbell	Completed
6. Standard 5- IPC enhanced and updated for ward accreditation	6. Sheran Oke	Ongoing
7. Urgent and Emergency Care Provider Collaboration Review	7. Claire Campbell	October 2020

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.

BAF Risk No. 1.2 Risk of failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties

Risk Classification: Operational	**Risk Owner:** COO	**Scrutinising Committee:** Finance & Performance Committee
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/3/21**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks: 1303; 1782; 1795; 1867; 1911; 1902;1930 1971;2132; 2341; Multiple sources of risk exacerbated by high demand and high patient acuity.	**Initial score**	**Current score**	**Target score**
	20 (4x5)	16 (4x4)	8 (4x2)

Existing Controls	**Assurance of Controls**
1. Performance management framework policy 2. Bed meetings and safety huddle daily with escalation processes in place 3. Symphony IT monitoring system in use for A&E 4. A&E delivery Board 5. Cancer Improvement Group meeting monthly 6. County wide Cancer Board meets monthly 7. Somerset reporting cancer 8. Twice weekly tracking for DTOC 9. Elective Care Board CCG Monthly 10. Weekly performance meeting in place 11. Twice weekly virtual cancer PTL meeting 12. Targeted support from regional NHSE/I to all Trusts in the region for cancer 62 days (Diagnostics) 13. Additional performance metrics now in place in relation to Covid-19	• Performance metrics at corporate, divisional and directorate level (L1) • Integrated performance report to Trust Board and committees (L1) • A&E received rating of Good in CQC inspection 2019 (L3) • Benchmarking against other Trusts. (L3) • Winter Plan. (L1) • Reset plan (L1) • Elective Care national support team review of Trust PTL (L3)

Gaps in Controls

1. Report to Board indicates under performance for: Cancer targets (62 days) / A & E /RTT
2. Attendances, admissions, and acuity remain high
3. Outsourcing of elective activity to reduce backlog
4. Social Care reductions impacting on discharge and flow in hospital
5. Key posts in A&E remain difficult to recruit to.
6. Key nursing and medical posts remain difficult to recruit to.
7. Staff sickness/shielding/isolation numbers remain high
8. Capacity reduced in elective by 65% and in OP by 50%
9. Diagnostic capacity reduced

Further Actions	**Responsible Person/s**	**Due Date**
1. Full covid response remains in place 2. Reset has commenced with 90% of theatres back in place but with reduced utilisation 3. Specific reset for OP, discharge, elective & cancer 4. Further outsourcing of routine work to private sector including endoscopy 5. System discharge work with external support 6. Zoning bronze cell in place 7. Appointment of Patient access manager for RTT support	1-7 Carl Holland	1. To continue – March 2021 2. Completed 3. Reset – ongoing through to 2021 4. Ongoing 5. Dec 2021 6. Completed 7. Completed

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.			
BAF Risk No.1.4 Risk of avoidable harm to patients and the associated loss of public confidence			
Risk Classification: Quality	**Risk Owner:** MD/DON	**Scrutinising Committee:** Quality Governance Committee	
Date Risk Opened: 30/6/20	**Date of next full review of BAF:31/3/21**		
Changes since last review:			
Underlying Cause/ Source of Risk: CRR reference risks: 1303; 1411,1478, 1776, 1782, 1867, 1879, 1911, 1955, 1972, 2150, 2187, 2195, 2216, 2219, Multiple sources of risk exacerbated by high demand and high patient acuity.	**Initial score** 10 (5x2)	**Current score** 15 (5x3)	**Target score** 5 (5x1)

Existing Controls	**Assurance of Controls**
1. Monthly review of Dr Foster information and alerts 2. Mortality Review Group 3. Audit plan 4. Incident and SI reporting policy 5. Monthly Clinical Quality and Effectiveness Group 6. Monthly Quality Governance committee 7. Countywide Patient safety M&M meetings 8. Review of Harm Group weekly 9. Dare to Share alternate monthly 10. FIT Group 11. MASH referral system 12. NGH Safeguarding Team 13. IP Steering Group 14. IPC Team 15. Maternity Dashboard 16. Saving Babies Lives – National Initiative 17. Neonatal Safety Champion Role	• Reports from Mortality review to CQEG and QGC (L1) • HSMR & SHMI data (L3) • CQEG reports to Quality Governance committee (L1) • Quality reports to Quality Governance and Trust Board (L1) • Quality Governance reports to Trust Board (L2) • Dr Foster data reports (L3) • Results from Clinical audit (L1) • Review of Harm Group monitoring implementation for SI action plans (L1) • National Learning and reporting system data (L3) • Incident report to Quality Governance committee (L1) • Safety thermometer metrics via DoN report (L2) • Delivery of infection control trajectory requirements at end of 2019/20 (L1) • Reports to FIT Group (L1) • IPC Assurance Framework (L3) • IPC ESF (L3) • Maternity report to QGC (L1) • Maternity Forum (L1)

Gaps in Control

1. HSMR outlier (Covid related)
2. NICE-/ VTE compliance remains inconsistent
3. Recurrent themes of harm identified requiring thematic approach to redress.
4. System Safeguarding resources and infrastructure
5. Delayed review of mortality
6. Outbreaks of nosocomial Covid 19 infection

Further Actions	**Responsible Person/s**	**Due Date**
1. Completion of work to digitise and mandate use of Deteriorating Patient Care Plan	1. Dr Hardwick	1. December 2020
2. Mortality review of deaths – Winter 2019	2. Matt Metcalfe	2. October 2020
3. IPC reviews of nosocomial full SI process to be completed	3. Sheran Oke	3. October 2020
4. Clear guidance on consequence related to nosocomial outbreaks to be communicated	4. Sheran Oke	4. Completed
5. Mortality presentation to Board (Dr Foster & Medical Director)	5. Matt Metcalfe	5. October 2020
6. Appointment of Deputy DIPC	6. Sheran Oke	6. Completed

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.				
BAF Risk No.1.5 Risk that Trust fails to deliver high quality services in all clinical areas 24/7				
Risk Classification: Quality	**Risk Owner:** MD/DON	**Scrutinising Committee:** Quality Governance Committee		
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/3/21**			
Changes since last review:				
Underlying Cause/ Source of Risk: CRR reference risks 979, 1188, 1445, 1665, 1764, 2188, 2219, 2359. Insufficient clinical staffing to provide 24/7 service.		**Initial score** 12 (4x3)	**Current score** 8 (4x2)	**Target score** 8 (4x2)

Existing Controls	**Assurance of Controls**
1. Reports to Clinical Quality and Effectiveness Group (CQEG) – 7 day services 2. CQEG reports to QGC 3. Job planning processes 4. Review of clinical models in line with Trust 60 bedded unit 5. Safe Nursing & Midwifery Staffing Report 6. Quality Account & process 7. Quality Strategy 8. Assessment and Accreditation report to Board on standards of nursing care- currently suspended	• Associate Medical Director report to CQEG (L1) • Quality Governance report to Trust Board (L2) • Clinical Collaboration work to ensure robust services county wide across both acute Trusts (L1) • Self-assessments (Assurance Framework return) undertaken biennially against 7 day services criteria (L1 • Mortality review reports to QGC and Trust Board (L1) • Safer staffing metrics (L1) • Delivery of Quality Priorities (L1)

Gaps in Controls

1. Weekend capacity of medical staffing
2.

Further Actions	**Responsible Person/s**	**Due Date**
1. Medical rota revision	1. Fiona Poyner	1. 31/12/2020
2. Plan to roll out ERostering	2. Geraldine Harrison	2. 31/12/2020
3. Revision/ update of Quality Improvement Strategy	3. Matt Metcalfe/ Sheran Oke	3. Completed
4. Quality Account to be presented to QGC for approval	4. Matt Metcalfe/ Sheran Oke	4. October 2020

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.			
BAF Risk No.1.6 Inability to recruit adequate numbers of nursing staff			
Risk Classification: Quality	**Risk Owner:** DON	**Scrutinising Committee:** Quality Governance & People Committee	
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/3/21**		
Changes since last review:			
Underlying Cause/ Source of Risk: CRR reference risks; 979, 1188, 1665, 1879,1962,1967,2219, 2334 National shortage of Nursing and Midwifery qualified staff.	**Initial score** 25 (5x5)	**Current score** **10** **(5x2)**	**Target score** 10 (5x2)

Existing Controls	**Assurance of Controls**
1. Nursing recruitment and retention plan including both UK and overseas recruitment programmes. 2. Three times daily safety/staffing huddles led by senior nursing team /Staffing escalation protocol 3. Nursing Talent Academy providing career pathway 4. Monitoring standards of care through the Assessment and Accreditation process reporting to Board 5. Patient and Carer Engagement and Experience Group 6. Safeguarding policies/ staff training 7. Nurse Staffing Recruitment and Retention Group 8. Nursing and Midwifery strategy 9. Quality Governance Committee 10. Workforce committee	• Nursing recruitment monthly recruitment pipeline tracker (L1) • Monthly reports from Workforce committee to Trust Board (L2) • Report to workforce committee (L1) • Quality Governance report to Trust Board (L2) • Incident reporting (L1) • Staff satisfaction survey (L3) • Patient feedback (L3) • Acuity and skill mix reviews (Bi- annual) (L1) • Open and Honest Care report (L1) • Safety thermometer (L1) • Patient harm data (Including falls, pressure ulcers)d incidence and benchmarking (L1) • Nurse fill rate (L1)
Gaps in Controls	

Further Actions	**Responsible Person/s**	**Due Date**
1. NHS Recruitment & Retention collaboration 2. Assessment & Accreditation roll out to Paeds, Maternity & Theatres	1. Fiona Barnes 2. QA Matron & PNS	1. Completed 2. Dec 2020

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.

BAF Risk No. 1.7 Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failures

Risk Classification: Infrastructure	**Risk Owner:** DE&F	**Scrutinising Committee:** Quality Governance & Finance & Performance
Date Risk Opened: 30/6/20	**Date of next full review of BAF: 31/3/21**	
Changes since last review:		

Underlying Cause/ Source of Risk:	**Initial score**	**Current score**	**Target score**
CRR reference risks; 258, 1174, 1177, 1287, 1699, 1701, 1702, 1703, 1738, 1373, 1893, 1986, 1414. Failure of multiple estates components or systems due to age, accessibility and lack of funding	20 (5x4)	20 (5x4)	15 (5x3)

Existing Controls	**Assurance of Controls**
1. Health and Safety committee 2. Fire safety committee 3. Estates Compliance group 4. Facilities Governance group 5. Water safety group 6. Resilience planning group 7. Business continuity plan 8. Training and scenario exercises undertaken 9. Annual capital programme 10. Medical Gas committee 11. Ventilation group 12. Asbestos group 13. Fire Safety Task and Finish Group 14. Assurance & Risk Committee 15. Additional screening/ doors in Covid areas 16. Oxygen monitoring system and dashboard for capacity monitoring	• H&S reports to Quality Governance committee (L1); QGC reports to Trust Board (L2); F & P reports to Trust Board (L2) • Resilience planning group reports to Assurance, risk & compliance group (L1) • Assurance, risk and compliance group reports to QGC (L1) • Capital Group reports to F& P committee (L1) • Annual Audit of high risk and statutory systems; ventilation, asbestos, electrical, medical gas, electrical, lifts, pressure systems, water • PLACE audits (L3); H&S risk assessments (L1) • Fire safety inspections (L3); Annual external review of water hygiene (L3) • HSE inspection(L3) ; ERIC self- assessment returns (L1) • Premises Assurance model self- assessment (L1); • Internal Audit report- Limited assurance opinion – Health and Safety (L3) • Back log maintenance programme in place based on risk assessment (L1)

Gaps in Controls

1. Large Backlog maintenance risk requires greater funding than is available
2. Estates strategy currently being reviewed for alignment in light of revised Clinical Strategy, KGH collaboration work and STP/HCP outputs.
3. Reduced capital plan due to financial constraints.
4. Review of internal assurance against key estates elements shows short fall.
5. Limited access to clinical areas to carry out maintenance and compliance work.
6. Lack of additional central funding from NHSE/I for urgent estates works to reduce the risk from Covid 19 pandemic.

Further Actions	**Responsible Person/s**	**Due Date**
1. Recruit into key estates vacancies	1. Stuart Finn	1. Completed
2. Deliver action plans against key estates elements to improve assurance and reduce risks	2. Stuart Finn	2. Ongoing
3. Review Estates strategy to align with KGH, STP/HCP and Clinical strategy	3. Stuart Finn	3. April 21
4. Seek additional routes to Capital funding to reduce backlog and align with Estates strategy & Masterplan and Clinical strategy	4. Stuart Finn	4. Ongoing

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.			
BAF Risk No. 1.8 Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust			
Risk Classification: Infrastructure	**Risk Owner: DOF**	**Scrutinising Committee:** Finance & Performance	
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/3/21**		
Changes since last review:			
Underlying Cause/Source of Risk: CRR reference risks 1733, 1984, 1482, 1684, 2020, 2151, and 2170. Cyber risks, Information security and aging ICT infrastructure.	**Initial score** 20 (4x5)	**Current score** 20 (4x5)	**Target score** **16** **(4x4)**

Existing Controls	**Assurance of Controls**
1. IT reporting to Finance and Performance committee 2. Elective access policy and Data quality SOPs in place 3. Microsoft Advanced Threat Detection (ATP) alerts 4. Intrusion Prevention blocking and alerts from the Trust's boundary firewalls 5. Anti-Virus in place. 6. Microsoft Patching – All Trust workstations and Servers are patched. 7. SPAM Emails are automatically quarantined. Any SPAM that is not quarantined is manually blocked when reported 8. Weekly Care Cert meetings held between NGH and KGH. 9. Web Filtering –blocks malicious and non-Trust related web traffic. 10. Enhanced Anti-Ransomware protection. 11. Tape backups (off-line backups) – The Trust now backs up data to tape regularly	• Reports from IT to Finance and Performance committee (L1) • Minutes from IT committee (L1) • Application of additional Sophos updates(L2) • IT strategy updated (L1) • Data Quality Audits. (L1) • Blocked Activity reported to IT Committee (L1) • Free NHS WiFi

Gaps in Controls

1. IT Team vacancies/ Ability for users to plug old equipment into network/ Limited knowledge of staff regarding cyber security and Potential for incorrect data input due to human error
2. Gaps in data team with SOP's/process and testing.
3. Gaps in Clinical Applications team daily service checks to provide assurance that all clinical systems are functioning as expected.

Further Actions	**Responsible Person/s**	**Due Date**
1. Training	1. Dave Smith	1. Mar 2021
2. Network access control	2. Dave Smith	2. Mar 2021
3. Plug in USB port control	3. Dave Smith	3. Feb 2021
4. Windows to migrate to Windows 7	4. Dave Smith	4. Nov 2020
5. Additional external assurance (DCIO) for data/information	5. Phil Bradley	5. Completed
6. New kitemark process	6. Hugo Mathias	6. Completed
7. New Daily service checks process for clinical systems	7. Miriam Jepson	7. Ongoing

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.				
BAF Risk No. 1.9 The risk of the Trust being unable to deliver an appropriate response to Covid 19 in terms of quality of care, capacity and timeliness with consequential impact on patient and staff safety, patient experience and staff wellbeing.				
Risk Classification:	**Risk Owner:** COO	**Scrutinising Committee:** Board and all committees		
Date Risk Opened: 20/04/20	**Date risk expected to be removed from BAF: 31/8/20**			
Changes since last review:				
Underlying Cause/ Source of Risk: CRR reference risks 1482,2287, 2305, 2307, 2313, 2334, 2336, 2341, 2359 Global pandemic relating to Covid 19 affecting the Northamptonshire healthcare system with high volumes of high acuity patients requiring healthcare.		**Initial score** 25 (5 x 5)	**Current score** 15 (5 x 3)	**Target score** 10 (5x2)

Existing Controls	**Assurance of Controls**
1. Covid Incident management plan 2. Revision of medical rotas to ensure staffing supports activity, recruitment of volunteer workforce, redeployment of staff to areas of greatest need 3. Digital solutions to allow continuation of Outpatient work where appropriate/ workforce permits 4. Critical Care Plan - Enhanced triage of patients to ensure best use of available experience 5. Maintain 85% bed occupancy 6. Capacity/ cohort plan 7. Use of private provider bed stock for additional capacity 8. National Guidance and webinars 9. Gold, Silver and Bronze Command structures and processes in line with Major Incident Policy 10. IPC Cell 11. Workforce Bronze cell and staff support network 12. Dedicated Covid 19 cost centre and coding to capture lost elective activity 13. Bi-Weekly System Strategic Command Group CEO 14. System Critical Care Group 15. System Discharge Group 16. SCG Command Structure under CCG 17. Regional Calls – CEO, MD, DN, AO – weekly 18. Twice weekly system Gold DCEO 19. Covid 19 Strategy 20. Resources – command structure flexes resource delivery according to demand	• Decision risk log (L1) • Incident log (L1) • Actions from System meetings (L2) • Twice weekly Gold meeting action log (L1) • Daily Silver meeting action log (L1) • Weekly Bronze meetings action log (L1) • Covid 19 Strategic response meetings (L1) • On site staff testing (L1) • SOS team/ NGH Our Space (L1) • Repository of all Covid information on the Shared drive (L1,2 & 3)

Gaps in Controls

- Cyber Security
- Plan for return to 'normal' unmet need of Covid patients in the community.
- Timely information relating to inpatients

Further Actions	**Responsible Person/s**	**Due Date**
1. Additional vigilance in area of cyber security with assurance provided	Hugo Mathias	Completed
2. Additional staff recruited to support cyber security	Hugo Mathias	Dec 2020
3. Continue with Bronze, Silver, Gold until national incident has been stood down	Carl Holland	Dec 2020

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.		
BAF Risk No. 1.10 Risk of the Trust being unable to deliver a recovery plan post covid-19 with consequential impact on patient and staff safety, patient experience and staff wellbeing.		
Risk Classification:	**Risk Owner:** COO	**Scrutinising Committee:** Board and all committees
Date Risk Opened: 20/07/20	**Date risk expected to be removed from BAF: Dec 2020**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks: 1482,2287, 2305, 2307, 2313, 2334, 2336, 2341, 2359 Global pandemic relating to Covid 19 affecting the Northamptonshire healthcare system. In recovery, backlogs of activity and reduced capacity.	**Initial score**	**Current score**	**Target score**
	20 (5 x 4)	15 (5 x 3)	10 (5x2)

Existing Controls	**Assurance of Controls**
1. Covid reset management plan 2. Digital solutions to allow continuation of Outpatient work where appropriate/ workforce permits 3. Maintain 75% bed occupancy 4. Capacity/ cohort plan for elective activity 5. Use of private provider bed stock for additional capacity 6. National Guidance and webinars 7. Gold, Silver and Bronze Command structures and processes in place with reporting twice weekly 8. System Discharge Group 9. Regional Calls – CEO, MD, DN, COO – weekly 10. Demand and Capacity plans completed for RTT and Cancer for all Specialties	• Actions from System meetings (L2) • Twice weekly reset meeting minutes (L1) • SOS team/ NGH Our Space (L1) • Repository of all recovery information on the Shared drive (L1,2 & 3) • Trust board reports • Covid scorecard

Gaps in Controls

- Endoscopy air handling unit insufficient to maintain safe air flows

Further Actions	**Responsible Person/s**	**Due Date**
1. Reset paper to September Trust Board	1. Carl Holland	1. Completed
2. National review of elective waiting lists to ensure all patients still want / need to be seen	2. Carl Holland	2. Nov 2020
3. New Air handling unit on order, endoscopy moved to 3 day case theatres plus plan to open 2 rooms for endoscopy in Daventry	3. Mary Visser	3. Dec 2020

Principal Risk 2 – Failure to deliver patient focussed care may lead to reputational risk and poor patient experience. this may cause the Trust to perform poorly against national and local patient experience surveys affecting reputation as hospital of choice for our local population and beyond.

BAF Risk No. 2.1 Risk that the Trust fails to promote a culture which puts patients first

Risk Classification: Patient Experience	**Risk Owner:** DON	**Scrutinising Committee:** Quality Governance
Date Risk Opened: 30/07/20	**Date of next full review of BAF: 31/03/21**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks 1955, 1867, 2003 Multiple sources of risk exacerbated by high demand and high patient acuity.	**Initial score**	**Current score**	**Target score**
	12 (4x3)	8 (4x2)	4 (4x1)

Existing Controls	**Assurance of Controls**
1. Patient and Carer experience and engagement Group with the following reporting: • Dementia Group • End of Life Group • Disability Partnership forum • Learning and Disability Group 2. PALS and Complaints team 3. Link with Health watch Northampton 4. Regular performance reviews by Division including patient experience KPIs 5. Patient Experience manager 6. Safeguarding policies and training 7. Appointment of Head of Diversity & Inclusion 8. Guidelines that identify how we manage patients with protected characteristics 9. Patient Involvement Strategy 10. Volunteer Strategy 11. Use of electronic devices/ letters to loved ones to connect families 12. The Knitted Hearts initiative for deceased patients and their families; 13. Volunteer support via drop off points, delivery service including prescriptions 14. Response volunteers linked to ward areas.	• Patient satisfaction survey (L3) • Complaints report to Quality Governance committee (L1) • Complaint review Panel (L1) • Quality Governance reports to Trust Board (L2) • NHS Choices feedback (L3) • CQC inspection (L3) • F&F tests results (2019) (L3) • Patient story to the Board (L1) • Board to Ward visits (L1) • National Survey results: Cancer; Urgent Care; Inpatient; Paediatric & Young people and Outpatient surveys (L3) • PLACE audits (L3) • Assessment and Accreditation scheme reports to Board (L1) • Divisional Quality Governance reports to CQEG (L1) • Pathway to Excellence (L3)

Gaps in Controls

1. Opportunity for collaborative working with patients and carers to improve and inform service development

Further Actions	**Responsible Person/s**	**Due Date**
1. Undertake a co design service development to enhance collaborative working	1 & 2: Rachel Lovesey	1. Completed
2. Enhance the role/ profile of patient experience champions locally		2. Completed
3. Findings of patient survey to be disseminated to Divisions for local implementation	3.Sheran Oke	3. Completed
4. Review of Patient Information- content and mode of delivery	4. Sheran Oke	4. Dec 2020
5. Friends and Family test to restart	5. Sheran Oke	5. Dec 2020
6. Re-instate Board to Ward visits virtually	6. Sheran Oke	6. Nov 2020
7. Work with Northamptonshire Healthwatch, carers and volunteers commenced	7. Sheran Oke	7. Ongoing
8. Trust working with National Cancer Collaborative to improve patient experience	8. Sheran Oke	8. Ongoing

Principal Risk 3 – Failure to develop, value and support our staff may lead to poor standards of care, poor staff training and difficulty in recruiting and retaining high calibre staff.		
BAF Risk No. 3.1 Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future		
Risk Classification: Human Resources	**Risk Owner:** CPO	**Scrutinising Committee:** People Committee
Date Risk Opened: 30/07/20	**Date of next full review of BAF: 31/03/20**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks 2075, 1188, 979, 1764, 1893, 2219 National workforce shortages of clinical staff	**Initial score**	**Current score**	**Target score**
	10 (5x2)	10 (5x2)	5 (5X1)

Existing Controls	**Assurance of Controls**
1. People Plan 2019 -2020 2. Nurse Recruitment and retention strategy 3. Recruitment policies and procedures 4. Workforce Plan submitted to LWAB 5. Sickness Absence management policy 6. Occupational Health Service 7. Temporary staff service 8. E-rostering 9. Apprenticeship scheme 10. Regular skill mix reviews in Nursing 11. Northamptonshire Branding- Best of Both Worlds campaign 12. Director of HR Agency meeting 13. Alternative pension contribution policy	• Workforce report to workforce committee (L1) • Workforce committee reports to Trust Board (L2) • Nurse Recruitment plan and retention report to Workforce Committee (L1) • Staffing data report to Workforce Committee and Quality Governance Committee (L1) • Patient survey (L3) • Staff survey (L3) • Medical Trainee survey (L3) • Internal Audit – Sickness Absence audit (L3) • OH Annual Report (L1)

Gaps in Controls

1. Difficulties in recruiting to vacancies due to national shortages
2. Challenges moving forward with the domestic supply of nurses with educational and placement issues following the pandemic
3. Trust has red flags related to Medical Trainee survey reports
4. Opening of escalation areas dilutes capacity with current issues regarding covid and non-covid treatment areas

Further Actions	**Responsible Person/s**	**Due Date**
1. Restart Oncology work in response to medical trainee comments	1. Mark Smith	1. Completed
2. Complete Oncology work in response to medical trainee comments	2. Bronwen Curtis	2. Dec 2020
3. Rebasing our international recruitment profile and domestic supply for nursing colleagues	3. Mark Smith and Sheran Oke	3. Completed
4. Review workforce capacity based on national guidance for colleagues i.e. colleagues shielding	4. Bronwen Curtis	4. Completed

Principal Risk 3 – Failure to develop, value and support our staff may lead to poor standards of care, poor staff training and difficulty in recruiting and retaining high calibre staff.		
BAF Risk No. 3.2 Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future		
Risk Classification: Human Resources	**Risk Owner:** CPO	**Scrutinising Committee:** People Committee
Date Risk Opened: 3/06/20	**Date of next full review of BAF: 31/03/21**	
Changes since last review:		

Underlying Cause/Source of Risk:	**Initial score**	**Current score**	**Target score**
Operational pressures impact on staff training and development	8 (4x2)	12 (4x3)	4 (4x1)

Existing Controls	**Assurance of Controls**
1. People Plan 2019-2020 2. Study leave policy 3. Appraisal policy 4. Statutory and mandatory training policy 5. Leadership and Management development programmes for leaders 6. Practice Development Team for Nursing staff 7. Director of Medical Education for medical staff 8. Consultant Foundation programme 9. Continuing professional development and in house training programmes for staff. 10. Nursing and Midwifery Committee	• Workforce report to workforce committee (L1) • Workforce Committee reports relating to revalidation and Medical Education (L1) • Workforce committee reports to Trust Board (L2) • Line managers receive compliance rates for appraisal (L1) • Staff survey results relating to training and development (L3) • Nursing revalidation report (L1) • Divisional scorecards and Performance Review process (L1)

Gaps in Controls

1. Underperformance against target on Statutory & Mandatory training for specific staff groups – pause on data publication during pandemic
2. Apprenticeship Levy attainment remains challenging
3. Organisational Pressures in releasing colleagues time to develop at the moment

Further Actions	**Responsible Person/s**	**Due Date**
1. Talent Management development	1. Mark Smith	1. Dec 2020
2. The Group People Plan will be submitted to Trusts Board for approval	2. Mark Smith	2. Jan 2021
3. Deep dive reports into staff group compliance with training upon commencement of reporting in Q2	3. Mark Smith	3. Completed
4. Introduce an Appraisal lite process	4. Bronwen Curtis	4. Nov 2020

Principal Risk 3 – Failure to develop, value and support our staff may lead to poor standards of care, poor staff training and difficulty in recruiting and retaining high calibre staff.

BAF Risk No. 3.3 Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optional culture

Risk Classification: Human Resources	**Risk Owner:** CPO	**Scrutinising Committee:** People Committee
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/03/21**	
Changes since last review:		

Underlying Cause/Source of Risk: CRR reference risks: 2003	**Initial score**	**Current score**	**Target score**
	15 (3x5)	15 (3x5)	6 (3x2)

Existing Controls	**Assurance of Controls**
1. Workforce committee 2. Equity and Diversity Steering Group 3. Staff networks including BAME, LGBTQ and Disability 4. Freedom to Speak up Policy and process 5. Bullying and Harassment Policy 6. Grievances at Work policy. 7. Health and Wellbeing Plan/Strategy 8. People Plan 2019-2020 9. Diversity & Inclusion Manager post 10. Development of TRiM training and our Support Our Staff (SOS) team	• Organisational Development updates to Workforce Committee, includes staff engagement and staff survey results(L1/ L3) • Equality and Human Rights Group (staff) reports to Workforce Committee and Trust Board (L1/ L2) • Web based incident reporting system available for staff (L1) • Staff survey (L3) • Guardian of Safe working hours report to Workforce Committee and annually to Trust board (L1) • Freedom to Speak Up Guardian Report to Workforce Committee and Trust Board (L1) • Workforce committee reports to Trust Board (L2) • Staff Friends and Family Test (L3) • Health & Wellbeing reports to workforce Committee (L1) • Sickness rate (L1) • Approval of People Plan by Trust Board (L1)

Gaps in Controls

1. Trust results in staff survey relating to bullying and harassment require improvement
2. Introduction of Workforce Race Equality Standards (WRES) action plan

Further Actions	**Responsible Person/s**	**Due Date**
1. Health & Well- Being interventions to be developed across the Group Model	1. Mark Smith	1. Sep 2020
2. Health and Wellbeing to be an integral element of the group People Plan to be submitted to the Trust Board	2. Mark Smith	2. Jan 2021
3. WRES Acton plan completed and implemented	3. Mark Smith	3. Completed

Principal Risk 4 – Failure to develop a sustainable future for Northampton General Hospital through delivery of high quality effective services in collaboration with partner organisations

BAF Risk No. 4.1 Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire HCP will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access.

Risk Classification: Partnerships	**Risk Owner:** DoS&P	**Scrutinising Committee:** Finance & Performance
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 31/7/20**	
Changes since last review:		

Underlying Cause/Source of Risk: CRR reference risks 1309, 2006
Northamptonshire HCP fail to deliver service and financial sustainability for NGH and local providers

Initial score	Current score	Target score
16 (4x4)	**12 (4x3)**	4 (4x1)

Existing Controls	Assurance of Controls
1. Board and Executive updated monthly on progress of the Health and Care Partnership 2. Executive oversight 3. Collaboration Programme Committee and associated governance framework 4. Non Exec Directors attend NED countywide and Chairs meetings 5. Integrated Business Planning Group/ Strategic planning group 6. Chair & CEO are members of HCP Board 7. System-wide approach to Phase 3 post-covid reset and board level approval of plans 8. Significant partnerships described in Annual Plan 9. Annual contract negotiation and service planning processes leading to a Board approved contract and annual plan 10. Regulatory oversight of the annual planning process 11. Establishment of the Group Model with Kettering General Hospital giving additional opportunities for service sustainability and collaboration	• New Trust strategy in place with aligned estates strategy in progress reports to Trust Board (L1) • Estates strategy and master plan in place with plans for Health and Well Being Campus being delivered alongside external partners (L1) • Service line reports (SLR) (L1) • Medium term financial sustainability plan (L1) • HCP Board in place update reports to Trust Board (L2) • Plans delivered for collaboration with partners in respect to: Rheumatology; Dermatology; Stroke, MSK (L2) • Joint clinical directors appointed for Breast and ENT with Cardiology to follow • Reports on all collaboration schemes to Collaboration Programme Committee (L2) • Annual capacity and demand analysis and associated contract agreements agreed with Commissioners (L2) • Service sustainability reviews undertaken as part of annual planning process (L1) • Partnership in place with UHL NHS Trust for oncology services (L1)

Gaps in Controls

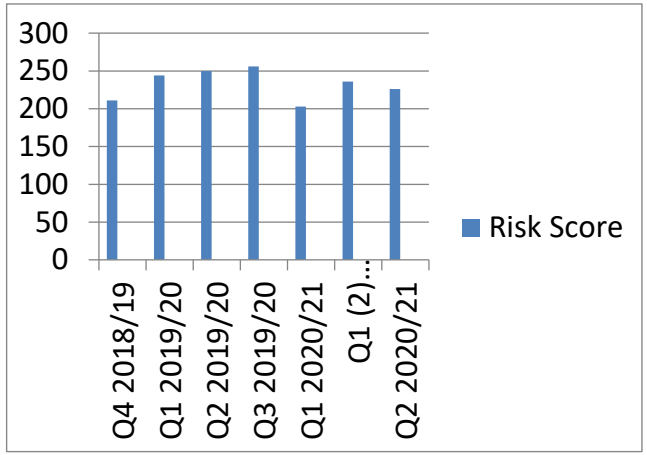
1. Development of the ICS remains in progress along with the evolution of the two new Unitary Authorities
2. Trust capacity issues have led to outsourcing and loss of market share in some specialities;
3. A risk that Out of hospital work-streams fail to deliver reductions in activity;
4. Effect of future surges in covid-19 related activity and the associated effect on demand, capacity and workforce availability
5. Reduction in funding of adult social care leading to increased admissions;

Further Actions	Responsible Person/s	Due Date
1. Implementation of Group model	1. Trust Board	1. Completed
2. Annual Planning process- delivering internal clinical sustainability reviews to inform future divisional clinical strategy design during 2021/ 22	2. DoS&P	2. 31/12/2020
3. Annual Planning - align processes with KGH to ensure single unified approach	3. DoS&P	3. 31/03/21
4. Continue to explore options to integrate tertiary services, e.g. Head & Neck on a regional basis	4. DoS&P	4. 31/03/21
5. Integration with new Unitary Authorities and Primary Care Networks	5. DoS&P	5. 31/03/21

Principle Risk 5: Failure to deliver financial stability may affect the quality of services and the future sustainability and viability of the Trust					
BAF Risk No. 5.1 Risk that the Trust fails to have financial control measures in place to deliver its 2020/21 financial plan					
Risk Classification: Finance	**Risk Owner:** DoF	**Scrutinising Committee:** Finance & Performance			
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 31/7/20**				
Changes since last review:					
Underlying Cause/Source of Risk: CRR reference risks; 2343, 2344, 2346. Requirement to return to financial balance in the medium term.			**Initial score** 25 (5x5)	**Current score** 10 (5x2)	**Target score** 5 (5x1)
Existing Controls			**Assurance of Controls**		
1. Finance and Performance committee 2. Divisional performance reviews 3. Audit arrangements 4. SFOs SFIs & SOD 5. Policies and procedures 6. Financial and accounting systems 7. Counter Fraud plan 8. Purchasing and Supplies Strategy & Policies 9. Financial Assurance correspondence with NHSE/I (monthly) 10. HCP Finance Director meetings			• Monthly report to Finance and Performance committee (L1) • Finance and Performance committee Report to Board (L2) • Finance KPIs (L1) • Audit committee reports to Trust Board (L2) • Outcome of NHSE/I accountability meetings (L3) • LCFS rated Green (L3) • NHSE/I rating for Single Oversight Framework (L3) • Internal Audit (L3) • External Audit (L3)		
Gaps in Controls 1. Pay spend above plan and activity below plan 2. Agency expenditure is currently above the set target for 2020/21.					
Further Actions			**Responsible Person/s**		**Due Date**
1. Transformation & efficiency programme changes to be implemented- once out of pandemic 2. System financial plans submitted to support LTP but currently on hold 3. Underlying financial position report received to be presented in July to Finance & Performance Committee 4. Balance sheet review paper to July Finance & Performance Committee 5. Reset finance submitted Sept 20. Currently showing a financial gap for remainder of 2020/21			1. Chris Pallot 2. Phil Bradley 3. Phil Bradley 4. Phil Bradley 5. Phil Bradley		1. TBA 2. TBA 3. Completed 4. Completed 5. Completed

Principle Risk 5: Failure to deliver financial stability may affect the quality of services and the future sustainability and viability of the Trust					
BAF Risk No. 5.3 Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements					
Risk Classification: Finance	**Risk Owner:** DoF	**Scrutinising Committee:** Finance & Performance			
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/03/21**				
Changes since last review:					
Underlying Cause/Source of Risk: CRR reference risks; 2345 Insufficient Capital funds to meet Trusts requirements			**Initial score** 10 (5x2)	**Current score** 25 (5x5)	**Target score** 10 (5x2)
Existing Controls			**Assurance of Controls**		
1. Capital Committee 2. Finance and Performance committee 3. 5 year capital plan 4. Purchasing and Supplies Strategy 5. Leasing strategy in place/ IFRS16 6. Hospital Management Team Meetings 7. Business Case process			• Finance report to Finance and Performance committee • Includes progress on capital planning and expenditure plus forecast expenditure (L1) • Report to Board (L2) • Internal audit (L3) • External Audit (L3)		
Gaps in Controls 1. The Trust has a large backlog maintenance programme and the estate is ageing. 2. Affordability of additional capital 3. Additional access to capital limited in infrastructure incidents. 4. Ineffective and lengthy regional and national Covid 19 related capital bids regime 4. Inconsistent data requests and treat of removing previously approved capital risking achievement of Trusts CRL.					
Further Actions			**Responsible Person/s**		**Due Date**
1. Submit additional bids wherever possible e.g. electrical infrastructure, IT and Paediatric ED 2. Emergency capital bid in train for a new ITU / HDU, electrical infrastructure and fire and safety works on the current critical care floor 3. Covid related Capital bid for additional ward capacity to maintain social distancing and zoning of hospital			1. Phil Bradley 2. Stuart Finn/ Phil Bradley 3. Phil Bradley		1. 31/3/21 2. Q2 2020/21 3. Q2 2020/21

	Movements on Board Assurance Framework (since previous report)
ADDITIONS	None
INCREASES	None
DECREASES	1.6 Decreased from 15 to 10 due to additional overseas nurses in post and increase in retention
	1.10 Decreased from 20 to 15 due to closure of gap in control and additional gap has mitigation in place
CLOSURES/ AMALGAMATED	None



Graph shows risk score of 226 for 16 Risks

Consequence Score/ Domain	Likelihood Score/Domain				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost certain
5 Catastrophic		1.6; 3.1; 5.1;	1.1; 1.4; 1.9;	1.7;	5.3;
4 Major		1.5; 2.1;	3.2; 4.1;	1.2: 1.10;	1.8;
3 Moderate					3.3;
2 Minor					
1 Negligible					

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

BAF risks in order of severity:

5.3	Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements	25
1.7	Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failures	20
1.8	Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust	20
1.2	Risk of failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties	16
1.10	Risk of the Trust being unable to deliver a recovery plan post covid-19 with consequential impact on patient and staff safety, patient experience and staff wellbeing	15
1.4	Risk of avoidable harm to patients and the associated loss of public confidence	15
1.9	The risk of the Trust being unable to deliver an appropriate response to Covid 19 in terms of quality of care, capacity and timeliness with consequential impact on patient and staff safety, patient experience and staff wellbeing.	15
3.3	Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optional culture	15
3.2	Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future	12
4.1	Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire Health and Care Partnership (Northamptonshire's Sustainability and Transformation programme) will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access.	12
1.6	Inability to recruit adequate numbers of nursing staff	10
3.1	Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future	10
5.1	Risk that the Trust fails to have financial control measures in place to deliver its 2019/20 financial plan	10
1.5	Risk that Trust fails to deliver high quality services in all clinical areas 24/7	8
2.1	Risk that the Trust fails to promote a culture which puts patients first	8

Executive Leads

CEO	Chief Executive Officer
COO	Chief Operating Officer
MD	Medical Director
DoN	Director of Nursing
DoF	Director of Finance
CPO	Chief People Officer
DoE&F	Director of Estates and Facilities
DoS&P	Director of Strategy and Partnerships
DoCD G&A	Director of Corporate Development, Governance and Assurance

CQC Fundamental standards

Regulation 8	General
Regulation 9	Person centred care
Regulation 10	Dignity and Respect
Regulation 11	Need for Consent
Regulation 12	Safe care and treatment
Regulation 13	Safeguarding service users from abuse and improper treatment
Regulation 14	Meeting nutritional and hydration needs
Regulation 15	Premises and equipment
Regulation 16	Receiving and acting on complaints
Regulation 17	Good governance
Regulation 18	Staffing

Levels of Assurance	**ASSURANCE LEVEL**
Level 1 (L1)	Management or Operational Assurance e.g. Reports to Board and Board committees
Level 2 (L2)	Oversight functions e.g. reports from Audit committee / Clinical Performance committee to Board
Level 3 (L3)	Independent / external assurance e.g. CQC inspection / audits / external review

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Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 November 2020**

Title of the Report	**Fire Safety Operational Plan 2020 - 2025**
Agenda item	**15**
Presenter of Report	Stuart Finn, Director of Estates and Facilities
Author(s) of Report	Paul Shead, Deputy Director of Estates and Facilities James Stewart, Estates Compliance and Fire Safety Manager

This paper is for:

Approve	□ Receive	□ Note	Assurance
		For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Executive summary

The Fire Safety Operational Plan 2020 – 2025 outlines the key fire safety priorities and frameworks to deliver safe and effective management of fire safety at Northampton General Hospital. It is being presented to give the Trust Board an overview of fire safety plans for the following 5 years.

The plan forms part of the Trust's overall fire safety management system and will be under constant review the by Trust's Fire Safety Group.

Fire Safety forms part of the Estates Compliance monthly report to Finance and Performance Committee; progress on the actions within the plan will be reported at this committee. The plan is being presented to the Board for information and assurance.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do*

Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks - Yes
Related Board Assurance Framework entries	BAF – please enter BAF number(s) 1.7
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? N If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? N If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	Failure to meet statutory obligations under Health and Safety legislation may result in fines. To maintain fire safe premises and services, continued capital investment, as agreed in the Estates Capital plan, must continue.
Legal implications / regulatory requirements	Failure to meet statutory obligations under The Regulatory Reform (Fire Safety) Order, Department of Health Firecode and Health and Safety legislation may result in fines and suspension of services
Actions required by the Board The Board is asked to: 1. Note the Plan 2. Seek areas of clarification as required 3. Support/approve the action plans	

Fire Safety Operational Plan 2020 - 2025

Contributors

James Stewart	Operational Fire Safety Manager	Version 5.3 October 2020
Stuart Finn	Director of Estates and Facilities	
Frank Pye	Deputy Director of Estates and Facilities (Interim)	
Paul Shead	Deputy Director of Estates and Facilities	
Kevin Frost	Compliance Manager	
Mark Ainge	Fire Safety Advisor	
Andy Wright	Fire Safety Officer	

Introduction

This operational plan outlines the key priorities and framework plans for delivery for safe and effective management of fire safety at Northampton General Hospital.

It will set out a framework programme to deliver a comprehensive 5 year operational delivery and capital investment plan to drive fire safety improvements within the Trust, whilst maintaining the current compliance regime.

In order that the operational plan continues to deliver on its objectives, it is important that the plan is reviewed on a regular basis through the Fire Safety Group, annual independent review and regular Board level reports during its life.

Purpose

Its purpose is to support the move towards the provision and maintenance in the areas of Fire Compliance to a 'safe' environment for all staff, visitors and patients throughout the Trust in order to minimise the risk to life, personal injury, damage to property and resulting loss of availability of services for patient care / support services and financial losses.

To identify issues and propose time, quality and costed remediation and track delivery of the plans aim and objectives and to communicate effectively at various levels of the organisation and operate a methodology of Plan, Do, Check, Act.

In conjunction with the relevant statutory, mandatory, Trust and Estates policies, it will provide a framework for identification, delivery and communications for the Estates Management Team to facilitate the production of appropriate, practical and functional plans and to ensure compliance.

Scope

The HTM suite of Fire related documents acknowledge the varied nature of activity in a hospital and the diversity of the people who occupy a hospital site. In addition it is recognised that it is not possible to reduce the risk of fire to negligible by the use of passive methods alone. This Operational plan provides an overview of the measures that the Estates team will adopt to ensure compliance in the areas of passive, non-passive, training and joined up cross discipline approach across the hospital.

Objectives

The primary objective is the provision and maintenance of buildings, fire safety systems and procedures so that in the event of fire, the occupants are able to ultimately reach a place of safety.

Achieving this objective will ensure compliance with fire safety and related legislations and current best practice across the Hospital.

The principal measures within the Operational Plan take account of:

- Provide and maintain passive and active fire protection measures according to the purpose or use of the hospital buildings, the number of occupants and the activities undertaken therein.
- Carry out a fire risk assessment to assess buildings and process fire risks, the existing preventative and proactive measures and identify areas for improvement.
- Prepare an action plan identifying the requirements of fire safety in accordance with the fire risk assessment as delivered and update when assessments are reviewed.
- Establish and deliver a programme of works to improve or maintain the existing fire safety specifications and seek approval and funding.
- Prepare and keep under review building specific fire safety plans.
- Establish clear lines of responsibility and authority for the day to day fire safety management.

- Identify competent persons with the responsibility for initiating the fire evacuation procedure and provide information and assistance to the fire service.
- Carry out regular reviews on all fire risk assessments.
- Collaborative working with the local brigade through regular engagement.

Capital Investment Programme

Capital investment in the Estate will continue to be prioritised to meet organisational / service need. This has to be balanced with the risk of a growing maintenance backlog and therefore investment in the Estate infrastructure is risk assessed, taking account of mitigation, to ensure the Trust Estate provides a safe environment for Patients, Visitors and Staff.

Major fire safety works will be managed by the Trust Estates Department and funded through the Trust Estates Capital Programme. All projects will be prioritised based on risk assessments and the requirement for compliance with statutory and mandatory regulations.

All fire related projects will be approved by the Fire Safety Group prior to being submitted for inclusion in the Capital Programme.

Key areas of review in this document, split into tangible assets in premises and process / people:

Premises:

1. Fire Risk Assessments
2. Electrical services
    a. Fixed Wire Testing
    b. High voltage and Low Voltage
    c. Electrical equipment (Portable)
    d. Lightning Protection
    e. Emergency lighting – monthly & annual full discharge
3. Maintenance of Fire Protection Systems and infrastructure
    a. Annual device testing
    b. Weekly Manual Call point testing
    c. Battery management
    d. Cause & Effect testing – to include door hold backs
    e. Voice Alarm System
    f. Magnetic Exit doors
    g. Fire Shutters
4. Fire Doors
5. Suppression systems:
    a. Misting and Sprinkler systems
    b. Gas suppression systems
    c. Kitchen Cooker Hood Fire suppression systems
6. Fire Dampers
7. Fire Fighting equipment
    a. Fire Extinguishers
    b. Fire Blankets
    c. Dry / Wet risers
    d. Fire Hydrants
8. Ventilation Systems
    a. Kitchens

b. General vent (in all areas)

Process:

1. Authorising Engineer – roles and responsibilities
2. Fire Safety Training
    a. Online
    b. Hands on
3. Fire Emergency Action Plans and Drills
4. False Alarms and Unwanted Fire Signals
5. Building Fire Strategy
6. Drawing management – fire lines, zonal drawings, dBA etc.
7. Contractor Management

Management of Remedial Works and Risk

Following a Fire Risk Assessment the actions will be generated and Estates will assign (where appropriate) to the responsible person who will action and sign off within that environment.

Prioritisation of areas by type

Priority	Description
1	Wards and other Patient Sleeping Risks ITU & HDU & Theatres
2	Staff Sleeping Accommodation
3	Outpatient and patient areas that do not have sleeping risks
4	Ancillary areas such as Plant rooms Laundry and other higher risk areas
5	Non patient and staff only areas
6	Other areas as identified

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	Fire Risk Assessment (FRA)			
Plan	**Description of control measure** The Regulatory Reform (Fire Safety) Order 2005 (RRFSO) and the Health Technical Memorandum (HTM) guidelines 05, applies to all workplaces where people are employed and requires a Fire Risk Assessment to be undertaken. All Fire Risk Assessments will be subjected to review annually or following internal or external changes to the layout or fabric of the premises or following a change in occupancy. "Fire Safety" NGH-PO-343 defines periodicity of inspections.			
Do	**How this is delivered?** • Currently 344 FRAs (as of Oct 2020) have been undertaken. These are significant in number and need to be reviewed on quantum. • FRAs currently carried out and managed by the Estates team [Business Compliance & Admin Team]. All Fire Risk Assessments will be held by the Fire Safety Advisor and department leads as defined in "Fire Safety" policy NGH-PO-343. • Areas are prioritised for life safety into 6 categories with inpatients in categories 1 Wards & other patient sleeping risks, ITU . HDU & theatres, 2 - Staff sleeping accommodation. 3 – Outpatient areas not involving sleep, 4 – ancillary areas - Plant rooms areas and other high risk areas , 5 – Staff areas, 6 – Corridors & Carparks. • An estimated number of 100-125 new FRAs will be undertaken at a (non-intrusive) level by the end of 2020 (still covering all areas). • All new full Fire Risk Assessments will be delivered to the PAS79 standard, which is over and above the regulated HTM. At ~ 90 per annum. This initial cycle will be completed by Feb 2021. • An Authorising Engineer (AE) is in place, who undertakes an audit annually and provides appropriate guidance on inspections & delivery. • An action plan and tracker of Fire Safety Improvements on existing significant actions is in place, but requires review and collation with new FRAs. • Actions reviewed monthly and presented to the Fire Safety Group. • Prioritisation will be undertaken of the assessment and remedial works will be reviewed and funding allocated.			
Check	**How is this monitored and reviewed?** • All Fire Risk Assessments will be subjected to annual review or as defined by risk (subject to policy review and agreement) or following internal or external changes to the layout or fabric of the premises or following a change in occupancy. Management Information via the software will be updated and shared / reported at no worse than monthly. • Action tracker will be kept current of all actions status in any given round of assessments. • Progress of FRA delivery, remedial actions and funding will be reported to Fire Safety Group every 3 Months • Annual Independent AE audit.			
Act	**Actions required**	**RAG**	**Who**	**When**
	Movement of FRAs to PAS 79 format.		Estates Business, Fire & Compliance Manager	Feb 21

	Creation of FRA action tracker / prioritisation / up keep / reporting		Estates Business, Fire & Compliance Manager	Nov 20
	5 year funding plan review		Head of Estates / Estates Business, Fire & Compliance Manager	March 21
	Actions closed within agreed timescales. Based on priority.		Estates Business, Fire & Compliance Manager / Capital programmes Manager	Ongoing
	Completion of statutory FRAs cycle		Estates Business, Fire & Compliance Manager	Feb 21
	Regular meetings Capital Programs and Fire Team		Estates Business, Fire & Compliance Manager / Capital programmes Manager / Head of Estates	Monthly
	Changes to Fire Policy to reflect risk based approach on periodicity and L1 statuses in non-clinical / accommodation		Estates Business, Fire & Compliance Manager	March 21

	Electrical Services – Electrical Test & Inspection and High Voltage Maintenance
Plan	**Description of control measure** Compliance and adherence to Health Technical Memorandum HTM06-03 Electrical Safety Guidance for High Voltage Systems and HTM 06-02 Electrical Safety Guidance for Low Voltage Systems, The Electricity at Work act, BS 7671 Requirements for electrical installations and guidance note 3. An Electrical Safety Policy implemented by the Estates & Facilities Department will set out how the Trust will provide a safe, high quality healthcare environment for patients, staff and visiting members of the public.
Do	**How this is delivered?** Low Voltage systems - Periodic inspection and testing of every electrical installation shall be carried out in accordance with BS 7671 in order to determine, so far as is reasonably practicable, whether the installation is in a satisfactory condition for continued service. This is carried out by an external contractor. Thermal imaging is undertaken to support the wider test programme and to support areas which cannot be fully tested due to operational activity. Guidance on the frequency of periodic inspection and testing of an installation is available in BS7671 and will be determined having regard to the

	type of installation and equipment, its use and operation, the frequency and quality of maintenance and the external influences to which it is subjected. The results and recommendations of all reports, shall be managed by the Estates department and monitored and tracked through the Trust Electrical Safety Group. Alterations and additions to wiring or fittings will only be carried out by authorised, competent electricians from or employed by the Estates & Facilities Department. Remedial works is prioritised for C2 (C1 are done immediately or isolated) and actioned through the DEL or contractors as necessary and tracked through the portal. An Authorising Engineer (AE) is in place for both high and low voltage systems, as are Authorised Persons (AP) and Competent Persons (CP). The site system is mid upgrade for larger HV site supplies / generator resilience. HV Transformer maintenance / switchgear is undertaken by contractor on prescribed intervals.
Check	**How is this monitored and reviewed?** Electrical Test & Inspection is reviewed as part of contractual meetings with LV and HV delivery contractors. Remedial follow on works reviewed as part of monthly Electrical Compliance meetings Authorising Engineer carries out annual audit on physical assets and compliance with HTM process and produces an annual report.

Act	Actions required	RAG	Who	When
	Category 2 T&I remedial actions closed out within 3 months of report & feedback to Electrical groups.		Electrical Services Maintenance Manager	Ongoing
	Formulise periodicity of T&I inspections by area / building and publish		Electrical Services Maintenance Manager	March 21
	Formulise periodicity and locations of supplementary thermal inspections and publish		Electrical Services Maintenance Manager	March 21
	Review of new infrastructure and tender / award new HV 5 year maintenance contract (ends March 2021)		Electrical Services Maintenance Manager	March 21
	Develop and publish a Trust Electrical Safety Policy		Electrical Services Maintenance Manager / Head of Estates	June 21
	Define areas which are not fully tested due to operational restrictions. Risk Assess other mitigations		Electrical Services Maintenance Manager	March 21
	Risk assessed approach plan by areas taking into account risk to patients and life of existing plant & Equipment		Electrical Services Maintenance Manager	March 21

	Completion of HV infrastructure works		Capital programmes Manager	March 21

	Electrical Services – Portable Appliance Testing / Lightning Protection			
Plan	**Description of control measure** All PAT testing will be carried out to the standard defined in C & G 2377 and the IEE Code of Practice for In Service Inspection and Testing of Electrical Equipment in order to ensure that all electrical equipment complies. Electrical equipment provides a high risk in starting fires where they are faulty or used in inappropriate areas. Portable Appliance Testing will be conducted for all portable equipment to ensure that basic electrical safety checks are maintained.			
Do	**How this is delivered?** Portable Appliance Testing – Contract in place covering the trust areas. This is completed circa November of each year Lightning Protection - Contract in place covering the trust areas.			
Check	**How is this monitored and reviewed?** Electrical Safety Group, Electrical Technical Group,			
Act	**Actions required**	**RAG**	**Who**	**When**
	Ensure continuity of contracts		Electrical Services Maintenance Manager	Dec 21
	2nd PAT round for 2020 will be required due to access Covid positive area not allowed.		Electrical Services Maintenance Manager	Q1 2021 (dependant on Covid)

	Electrical Services – Emergency Lighting

Plan	**Description of control measure** The trust approach is to use the British standard and fire code as a minimum standard for lighting levels. Emergency lighting systems are installed generally throughout all Trust buildings in compliance with HTM 06-01 and BS 5266 part 1. Lighting Guide 02: Hospitals and Health Care Buildings (Society of Light and Lighting SLL LG2). CIBSE, 2008. The lighting will be maintained through a planned preventative maintenance (PPM) testing programme, which is compliant with BS 5266-1:2011. All test results will be recorded on the Estates & Facilities Department Computer Aided Facilities Management system.			
Do	**How this is delivered?** All major refurbishments or Capital works ensure commensurate emergency lighting systems are installed, certificated and asset data shared with operational team and Trust CAFM system. The requirement is to carry out short duration tests monthly and annual full discharge tests. There are some systems within the Trust which are self testing with a review to be undertaken on extended roll out of these systems to provide effective management of this task.. Currently, testing is a mix of in house staff and contractors. The recording is across a myriad of platforms and is inconsistent. PPMs are created in the Estates CAFM system for monthly and annual tests on an area by area basis.			
Check	**How is this monitored and reviewed?** Reported as part of the Electrical, Fire and general compliance Safety meetings. Contract reviews			
Act	**Actions required**	**RAG**	**Who**	**When**
	Full review of Floor plans of existing emergency light fittings		Electrical Services Maintenance Manager	July 21
	Asset tagging and data capture of quantity of lights and entry into CAFM system for clustered PPMs		Electrical Services Maintenance Manager	Sept 21
	Formal handover process from projects of certification and asset data for CAFM		Electrical Services Maintenance Manager / Capital programmes Manager	July 21
	Lighting survey of lighting levels and compliance with relevant healthcare standards		Electrical Services Maintenance Manager	July 21
	Fire Protection Systems and infrastructure maintenance			

Plan	**Description of control measure.** Fire alarm system in place across Trust is primarily Autronica. Compliance with relevant HTM 05 Fire and BS5839-1 for Fire detection and Fire Alarm Systems and BS5839-8 for voice systems. Compliance with NGH Fire Policy NGH-PO-343. The fire alarm and automatic fire detection system is a fully integrated and functioning part of the fire safety measures in the Trust. There are twenty fire alarm panels across the site.			
Do	**How this is delivered?** External contract is in place for the cyclical maintenance of devices across the Estates Weekly Manual Call point tests are currently carried out by internal staff Review of false alarms / activations for root cause as per Part H of Firecode; Fire Safety in the NHS is undertaken by the Fire officer. Emergency Magnetic Door Release (green buttons) will be tested on an annual basis to ensure it operates as designed and to ensure it fails safe. Smoke vents – Actuation of smoke vents will be undertaken on a weekly basis by in-house staff. Annual maintenance will be undertaken by a suitably qualified contractor Voice communicating system (Nye Bevan) Will be tested as set out in BS 5839-8 - Maintenance of Voice Alarm Systems. The various tests include weekly, monthly, quarterly and 6 monthly. These checks will be undertaken by in-house staff and recorded in the Trust CAFM system.			
Check	**How is this monitored and reviewed?** Reported as part of the Electrical, Fire and general Compliance Safety group meetings. Contract reviews			
Act	**Actions required**	**RAG**	**Who**	**When**
	Review of PPMs in CAFM system to cover weekly MCP testing and ensure capture by panel		Electrical Services Maintenance Manager	Dec 20
	Review of existing asset information and detail and creation / modification of PPMs in CAFM system to cover Door releases (green button). Update drawings.		Electrical Services Maintenance Manager	Feb 21
	Review of existing asset information and detail and creation / modification of PPMs in CAFM system to cover Smoke vents. Update drawings.		Mechanical Services Maintenance Manager	Dec 21
	Review of existing asset information and detail and creation / modification of PPMs in CAFM system to cover Voice systems in Nye Bevan		Electrical Services Maintenance Manager	Jan 21
	Review of existing cause and effect by building / zone and ensure compliance with statutory instruments / Trust strategy		Electrical Services Maintenance Manager	June 21
	Review of current ARUP review of Fire Alarm systems and budget / plan for migration to open protocol system		Electrical Services Maintenance Manager /	May 21

			Capital programmes Manager / Head of Estates	

	Fire Doors			
Plan	**Description of control measure.** BS 9999 defines fire doors to be checked every 6 months unless risk assessed otherwise to either increase or decrease the periodicity of inspections. No current arrangement is in place to defer from this periodicity as a such defaults to 6 monthly. All fire doors will be checked regularly to ensure they function correctly and to review any failings of the door.			
Do	**How this is delivered?** A process of maintenance and "Front of House" checks includes a visual inspection of fire doors. The effectiveness of this process is under review. Quarterly Health & Safety Inspections and monthly Fire Warden inspections include fire exit routes.			
Check	**How is this monitored and reviewed?** Reported as part of the Electrical, Fire and general Compliance Safety group meetings. Contract reviews			
Act	**Actions required**	**RAG**	**Who**	**When**
	Review of existing fire compartmentation line drawings and all fire doors to be asset tagged and tag		Fire Safety Advisor	Feb 21
	Detail of existing technical detail by fire door to be collated and appended to CAFM		Fire Safety Advisor	May 21
	Create PPM schedule in CAFM to cover fire doors		Fire Safety Advisor	May 21
	Agree door checklist internally and with local brigade		Fire Safety Advisor	May 21
	Secure funding which will be needed for remedial works and implement remedial works based on risk		Fire Safety Advisor	Ongoing
	Completion of current works on 17 doors Buildings 41 & 42.		Capital programmes Manager	March 21

	Review of resources for completion of task by contractor / internal staffing.		Fire Safety Advisor / Head of Estates	March 21

	Suppression Systems			
Plan	**Description of control measure.** Automatic sprinkler systems must be maintained in accordance with Technical Bulletin 203:2018 and BS9251:2014 where appropriate to protect life by early extinguishing and limiting building damage, loss and business continuity. The Trust currently has separate and different systems which are Misting and sprinkler systems, Gas suppression systems and kitchen / cooker hood fire suppression systems. British standards BS EN 671, BS9990:2006, BS5306-1:2006, BS 588-12 and the building regulations for Non automatic fire protection systems. BS12845 2004 Automatic sprinkler systems and BS 9251 Sprinkler systems for residential and domestic occupancies.			
Do	**How this is delivered?** Maintenance is carried out annually / 6 monthly on these systems by specialist contractors.			
Check	**How is this monitored and reviewed?** Reported as part of the Electrical, Fire and general Compliance Safety group meetings. Contract reviews			
Act	**Actions required**	**RAG**	**Who**	**When**
	Review of existing systems and asset tag systems and populate CAFM system		Mechanical Services Maintenance Manager	Dec 20
	Review Certificate of Conformity for all systems for compliance by system.		Fire Safety Advisor	June 21
	Appoint an Responsible Person and Deputy for Sprinkler systems		Head of Estates	Dec20
	Set up PPMs for weekly, monthly, 6 monthly and annual tasks and implement		Mechanical Services Maintenance Manager	June21
	Set up long term contract with cost certainty for works and reporting.		Mechanical Services Maintenance Manager	June 21

	Fire Dampers

Plan	**Description of control measure.** Maintenance and testing is the responsibility of the Estates & Facilities Department in line with BS 9999 2017 covering routine Inspections and Maintenance Ventilation and Air Conditioning duct work. Maintenance will be undertaken at a maximum interval of 12 months. Testing and maintenance of Fire Dampers to BS EN 1366			
Do	**How this is delivered?** Areas are prioritised as per Fire Risk Assessments. 1 Wards & other patient sleeping risks, ITU . HDU & theatres, 2 - Staff sleeping accommodation. 3 – Outpatient areas not involving sleep, 4 – ancillary areas - Plant rooms areas and other high risk areas , 5 – Staff areas, 6 – Corridors & Carparks. Specific focus for current Capital works on top floor of Building 41 & 42 (Nursing floor & ITU/HDU). Plan to move theatres / Hospital Street and then X-Ray / A&E to follow. Smart Dampers being installed for better integration into Cause & Effect for increased safety. Works in Areas 41/42 has allowed scope (panel) for all of these buildings. Other areas to be identified and planned in based upon risk. Specialist contractor is employed to test and maintain known fire dampers			
Check	**How is this monitored and reviewed?** Reported as part of the Electrical, Fire and general Compliance Safety group meetings. Contract reviews			
Act	**Actions required**	**RAG**	**Who**	**When**
	Completion of Fire Dampers in Areas 41 & 42 Nursing Floor		Capital programmes Manager	March 21
	Completion of Fire Dampers in Areas 41 & 42 Hospital Street / Theatres – secure funding		Capital programmes Manager	March 22
	Completion of Fire Dampers in Areas 41 & 42 A&E / X-Ray– secure funding		Capital programmes Manager	March 23
	Plan to complete Ward areas – secure funding		Capital programmes Manager / Head of Estates	July 21
	Plan for rest of Estates – secure funding		Capital programmes Manager / Head of Estates	July 21
	PPM regime in place via Trust CAFM system		Mechanical Services Maintenance Manager	Ongoing
	Term Contract to be reviewed for Maintenance above current regime		Mechanical Services Maintenance Manager /	June 21

			Fire Safety Advisor	

	Fire Fighting Equipment – Fire Extinguishers, Blankets, Dry risers and Hydrants			
Plan	**Description of control measure.** Fire extinguishers are maintained on an annual basis through contract which meets the requirements of BS 5306-3: 2017 and BS5306 Part 8. Fire blankets to meet BSEN1869:1997. Dry Risers and Fire Hydrants are maintained as per BS9990:2015. Fire extinguishers have been standardised within the Trust to provide Wet Chemical (replaces water extinguisher) and CO_2 with fire blankets installed in kitchens and other risk areas as deemed necessary.			
Do	**How this is delivered?** Maintenance contract in place for all Fire Extinguishers and Fire Blankets and completed annually whilst the statutory periodicity is 13 months Maintenance contract ongoing for Dry risers and Fire Hydrants. Currently being delivered ad-hoc whilst procurement process completed. The Fire Response Team will have additional training in the use of extinguishers due to the need to attend a live incident.			
Check	**How is this monitored and reviewed?** Reported as part of the Electrical, Fire and general Compliance Safety group meetings. Contract reviews			
Act	**Actions required**	**RAG**	**Who**	**When**
	Live fire Extinguisher training Fire response team only – on induction and 2 yearly		Fire Safety Advisor	Ongoing
	Completion of procurement process for Dry Risers & Hydrants and mobilisation		Fire Safety Advisor	Jan 21
	Asset list creation and entry into Trust CAFM system		Fire Safety Advisor	Jan 21
	PPM regime to be created in Trust CAFM		Fire Safety Advisor	Jan 21
	Review of current number of extinguishers assets and apply to layered drawing.		Fire Safety Advisor	Aug 21

	Ventilation System - Kitchen, Accommodation & General Vent

Plan	**Description of control measure.** Fire Prevention in Hospital Main Kitchens is covered by HTM 05-03: Operational Provisions, Part 3: General Fire Safety. In addition, general ventilation areas can be covered by TR19. TR19 is a set of best practice guidelines created by BESA (Building Engineers Society Association), as a way to standardise extract and duct cleaning.
Do	**How this is delivered?** An Authorising Engineer (Ventilation) is appointed. Kitchen extract systems are maintained twice per annum by contract in addition to the fire suppression systems (covered separately). General ventilation should be reviewed periodically to ensure no significant build-up of contamination. HTM 03-01 indicates this could be greater than 10 years depending on levels of filtration. General ventilation is under review due to high contamination of ceiling voids and asbestos. TR19 methodology should be sued to ascertain levels of contamination periodically.
Check	**How is this monitored and reviewed?** Reported as part of the Electrical, Fire and general Compliance Safety group meetings. Contract reviews

Act	**Actions required**	**RAG**	**Who**	**When**
	Assets to be reviewed and added top Trust CAFM system and PPMs set up		Mechanical Services Maintenance Manager	May 21
	Contract review and retender for better value.		Mechanical Services Maintenance Manager	Aug 21
	Review of ducting arrangements. Gap analysis of duct cleaning regime and implement.		Mechanical Services Maintenance Manager	Dec21

Process:

1. **Authorising Engineer (Fire)**

Estates & Facilitates have appointed an Authorising Engineer. HTM 05-01 defines the role as:

Authorising Engineer (Fire): a chartered fire engineer, or a chartered member of an appropriate professional body, with extensive experience in healthcare fire safety.

They AE (F) will carry out an annual audit and report back findings on an annual basis to the Fire Safety Group for review and action. The audit cycle is such that reports will be submitted to the Fire Safety Group in Q1 of each calendar year.

2. **Fire Safety Training:**

All staff are mandated to carry out the Fire Safety online Training every 24 months. This is collated and reported centrally by the Trust. Currently, this is delivered via the National Skills Academy portal.

Hands on training is currently under review and is planned to be given to the Fire response team on induction and every 24 months as they are more likely to be involved in a live fire.

Fire safety training is a statutory requirement of the RRFSO and all staff without exception and the nature of their duties receive instruction, training and information as regards the fire safety procedures that are in operation within the Trust.

The Trust will provide:

- Fire Safety Induction Training (Statutory)
- Annual Fire Safety Awareness training (Annual Refresher)
- Annual Fire Safety Awareness electronic on-line assessment
- Review of Knowledge – to be reviewed.
- Fire Warden Training (3 Yearly)
- Nominated Person Training
- Annual Fire Response Team Training
- Site specific training can be delivered by the Estates & Facilities Department on request.
- Annual live fire extinguisher training (Fire Response team only)

All staff members must have had fire safety training for a period longer than 12 months either face-to-face or e-assessment. Training records are kept centrally within Training Department.

3. **Fire Emergency Action Plans and Fire Drills**

    a. Local Emergency Evacuation Plan (LEEP)

The basic concept in the design for escape from fire is that all occupants of a building will be able to turn their back on a fire, wherever it occurs, and move away from it using circulation spaces and stairways to a place of relevant safety or ultimate safety which is free from the effects of heat and smoke.

Each building and work area within the Trust has their own Local Emergency Evacuation Plan (LEEP) which is designed for the use and occupancy of each area and reflects these principles. The most senior manager or duty holder of the area or building will review their LEEP on an annual basis or, when there has been a significant change within the building or a change within its occupancy. The evacuation plan

will detail how patients, staff and visitors including disabled persons will be evacuated, what equipment to use and where to assemble.
The plan must include guidance on making a "Defend in Place" decision and consider, where appropriate, the evacuation of Bariatric patients. These plans will be kept in the Fire Safety Information Manual; they are to be updated/amended as appropriate and reviewed annually. These are held centrally on the Trust systems. A review on audit of LEEPS will be undertaken on roles and responsibilities and reporting.

b. Fire Drills

NGH-PO-343 defines a Fire Drill as;

An exercise designed to test the response of staff to the discovery of a fire or the sounding of the fire alarm and to prove the emergency plan. In addition, *A table top exercise "fire drill" carried out in areas where evacuation cannot be undertaken*

All members of staff must participate in a fire drill at least once per year. It is the responsibility of the ward / departmental manager to organise and conduct the fire drill. This will be done in conjunction with the Estates Fire Safety team and reported at each Fire Safety Group.

4. False Alarms & unwanted fire signals

Part H of Firecode; Fire Safety in the NHS. Health Technical Memorandum 05-03 Operational Provision requires the reduction of unwanted fire signals in healthcare premises.

There are many causes of unwanted Fire Alarms, but the more common ones include:

- Fumes from cooking or burnt food
- Steam from showers, faulty heating systems
- Dust from building work
- Insects
- Poorly trained users
- Lack of maintenance
- Incorrect or poorly designed systems

In order to be compliant with regulatory obligations under HTM 05-03, The Trust will:

- Appoint a Nominated Fire Safety Advisor as per the requirements of the Fire Safety Order 2005, to ensure adherence to all matters relating to fire safety within the premises, including the fire alarm system.
- Maintain the fire alarm system in good working order
- Ensure the alarm is appropriate to the risk
- Continue upgrading the fire alarm systems
- Ensure all relevant persons are made aware of the impact of unwanted Fire Alarms both on the business and on the fire and rescue service
- Consider implementing a delay in the system to allow for investigation.

5. Fire Strategy (Buildings)

Each buildings should have a cohesive fire strategy with the primary aim to design, manage, plan and co-ordinate appropriate fire safety procedures to reduce the risks of fire, thus ensuring the safety of the occupants. A fire strategy will **show compliance with Building Regulations**; mainly means of warning and

escape, internal fire spread (linings), internal fire spread (structure), external fire spread and escape, access and facilities for the fire service.

The following legislation, Firecode guidance and British Standard require a documented fire strategy in conjunction with a fire safety manual.

- Approved Document B Fire Safety;
- Firecode HTM 05/01 'Managing Healthcare Fire Safety'
- BS 5588 part 12 Managing Fire Safety;

A gap analysis will be carried out (by Dec 2021) to identify the gaps with buildings that are missing. These buildings will then be addressed on a case by case basis and Fire Strategy complied by building.

6. Drawing management

All drawings for relevant topics of fire will be held by the Estates Department. This will include but not limited to:

- Floor plans
- Fire compartmentation lines including fire doors
- Fire Dampers
- Placement of firefighting equipment – Fire extinguishers / Fire Blankets
- Dry risers
- Fiore plan zonal drawings
- Fire system dBA levels

7. Contract management

Estates & Facilities manages a range of contractors working on a range of infrastructure, plant and equipment. As contractor represent a general health & Safety risk, their management is of the upmost importance and in the area of fire safety, even more so to ensure Trust policy and procedures are followed. All contractors are governed by Health & Safety legislation, but the onus is to ensure that this is operated within the Trust and compliance with trust policy & procedures. The Trust Policy NGH-PO-1032 is due a review.

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	Process - Actions			
Act	**Actions required**	**RAG**	**Who**	**When**
	Fire Strategy (Building) – Gap analysis of existing documentation		Fire Safety Advisor	Sept 21
	Fire Strategy (Building) – Implement Building Fire Strategy for gaps		Fire Safety Advisor	Jan 22
	False Alarms & unwanted fire signals - Appoint a Nominated Fire Safety Advisor		Head of Estates	Ongoing
	Drawing management - Audit of existing fire Drawing with agreed		Fire Safety Advisor / Capital programme Manager	Aug 21
	Drawing management - Completion of drawing set post gap analysis.		Fire Safety Advisor / Capital programme Manager	Ongoing
	Contract management – Policy review.		Fire Safety Advisor / Head of Estates	March 21

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Appendix 1

FIRE OPERATIONAL PLAN RISK MANAGEMENT and CAPITAL PROGRAMME

Introduction:

In support of the Fire Operational plan and achieve compliance with statutory and mandatory regulations a risk prioritised 5 year Capital Plan has been developed which clearly identifies the risks, the locations and costs of remedial works focussed on Fire Compartmentation, Fire Dampers, Fire Alarm, Emergency Lighting and Fire doors. These topic areas represent large scale investments on behalf of the Trust which cannot be delivered through operational and revenue streams. This evaluation is based on the Oakleaf survey completed Q1 2019.

All major fire safety works projects will be planned and managed by the Trust Estates Department in close collaboration with the Fire Safety Group who will approve all fire safety related projects prior to inclusion in the Capital Plan

Table 1 shows the major areas where risk analysis has identified the need for fire safety improvements and is shown as a Priority Table of Works

TABLE1 – PRIORITIES BY DEPARTMENT TYPE & RISK

Priority	Description
1	Wards and other Patient Sleeping Risks ITU & HDU & Theatres
2	Staff Sleeping Accommodation
3	Outpatient and patient areas that do not have sleeping risks
4	Ancillary areas such as Plant rooms Laundry and other higher risk areas
5	Non patient and staff only areas
6	Other areas as identified

Further investigation and audit will be completed by the Fire Safety Team and a full and comprehensive Fire Risk Assessment undertaken by the end of February 2021. This will confirm and prioritise in detail through significant findings, the remedial works that will need to be undertaken in conjunction with the Oakleaf survey.

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Budget allocations as of 5 Year Plan 2019/20 as approved

Capital Works	Location	Risk Type	2020 / 21 £k	2021 / 22 £k	2022 / 23 £k	2023 / 24 £k	2024 / 25 £k	Comments
Fire Compartmentation	Nursing Floor	1	100					Works will complete March 2021
	Theatres	1		400				
	FRA Outcomes				450			
	FRA Outcomes					400		
	FRA Outcomes						600	
Fire Dampers	Nursing Floor	1	150					Works will complete March 2021
	Theatres	1		50				
	FRA Outcomes				50			
Fire Alarm Upgrade	Nursing Floor		655					Works will complete March 2021
	Childrens			400				
	FRA Outcomes				400			
	FRA Outcomes					200		
	FRA Outcomes						400	
Emergency Lighting	Gap Analysis							
	Gap Analysis			150				
	Gap Analysis				50			
	Gap Analysis					50		
	Gap Analysis						50	
Fire Doors	Nursing Floor		150					Works will complete March 2021
	Theatres			250				
	FRA Outcomes				250			
	FRA Outcomes					100		
	FRA Outcomes						100	
Totals			1155	1250	1200	750	1150	
Predicted Risk Rating (on completion of works)			25	16	15	15	12	12

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References:

Associated Trust Documents

- Fire Safety - NGH-PO-343 (Aug 2019)
- Fire Safety Policy Guidance (March 2008)
- HTM Guidelines
- Oakleaf Report Q1 2019
- Fire Cubed Fire Safety Audit DATE – 2019

Supporting References

- Regulatory Reform (Fire Safety) Order 2005
- HTM 05-01: Managing Healthcare Fire Safety
- Health & Safety at Work etc. Act 1974
- Building Regulations 2000 (approved document B)
- Care Commissioning Core Standards
- The Building Act 1984
- Management of Health and Safety at Work Regulations 1999
- Control of Substances Hazardous to Health Regulations 1977
- The Safety Representatives and Safety Committee Regulations 1977
- Construction, Design and Management Regulations 2004
- Equality Act 2010

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Report To	**Public Trust Board**
Date of Meeting	**26 November 2020**

Title of the Report	Academic Strategy 2020-23
Agenda item	**16**
Presenter of Report	Mr Matthew Metcalfe Medical Director
Author(s) of Report	Karen Spellman- Deputy Director of Strategy & Partnerships, Mr Matthew Metcalfe- Medical Director NGH, Dr Andrew Chilton – Medical Director KGH

This paper is for: (delete as appropriate)

x Approve	Receive	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

Executive summary

This paper presents the Academic Strategy developed as a joint Kettering General Hospital and Northampton General Hospital Group strategy. The strategy has been developed in collaboration with the University of Leicester and sets out our ambition to become a University Teaching Hospitals Group and achieve the University Hospitals Association criteria.

The vision of the Academic strategy is to; “Improve patient care through excellence in education and research”. It sets out how we aim to create an exemplar education and training system that is evidence based and underpinned by research and innovation.

This ambitious strategy will enable and bring to life the Group vision. The strategy will improve patient care and provide access to innovative treatments and involvement in research.

The strategy will build on and enhance the education and training offer to that of true excellence, generating a sustainable multidisciplinary workforce fit for the evolving health needs of patients.

We plan to build on our existing capacity and capability and to develop the Group as University Teaching Hospitals through investment in academic posts and estates infrastructure. A business case to implement the first year of the Academic Strategy and hence help achieve University Hospital Accreditation (UHA) status shall be presented to the Trust Board committees in December 2020.

Progress against delivery of the objectives set out in the strategy will be reviewed annually and assured

through the Group hospitals governance structures. A robust implementation programme is in place and will evaluate and measure the impact of our planned activities.	
Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable excellence through our people* 6. *Become a University Hospital by 2020 becoming a centre of excellence for education and research*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: A full risk log is incorporated in line with the development of the strategy implementation plans
Related Board Assurance Framework entries	1.4; 1.6; 3.1; 3.2; 3.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? no If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? no If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	The Academic Strategy outlines the financial implications, which shall be provided in further detail in the supporting business case to be submitted for Board approval in December 2020.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: Compliance with the national planning framework and contribution to the system control total

Actions required by the Board

The Board is asked to:

- Formally note and approve the recommendations issued within the Academic Strategy to support Northampton General Hospital NHS Trust and Kettering General Hospital NHS Foundation Trust in becoming university teaching hospitals

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NHS Foundation Trust

Academic Strategy 2020-2023

Contents

1. Executive Summary

Kettering General Hospital NHS Foundation Trust (KGH) and Northampton General Hospital NHS Trust (NGH) have embarked on an exciting journey with an ambitious goal to become a University Hospitals Group which will serve the whole of Northamptonshire and beyond through closer alignment and partnership with the University of Leicester and all our other University partners. This Academic Strategy details how the medical and research departments at both hospitals will be strengthened and coordinated by integrating research, innovation and education into multi-disciplinary training and education to deliver quality improvement in all domains. Together, we will develop hospitals delivering centres of excellence for clinical care and achieve international recognition as an academic centre that promotes and delivers better health service provision and health outcomes to our patients.

This strategy describes the key objectives to achieve University Hospital status. This strategy sets out how we will:

- Attract, retain and develop the country's top talent. Putting our staff and patients at the heart of its development by improving the training and development we offer
- Enable us to work more effectively with our health and care partners to collectively improve access, quality and consistency across local patient pathways and services
- Establish robust estates and digital infrastructure to support innovative clinical education and research
- Foster a culture of inclusivity and learning, with strong leadership championing the strategy
- Increase number of patients included in clinical trials and success of funding from research networks, grant giving bodies and commercial sources

2. Introduction

The Academic Strategy is a key strategic initiative and programme of work to deliver the Group vision, values and goals. Through enhancing and developing our multi-disciplinary academic offer, we will create an exemplar education and training system that is evidence based and underpinned by research and innovation. It is widely recognised that organisations with a reputation for providing excellence in education and research attract and retain high quality staff impacting positively on the delivery of patient care.

We plan to build on our existing capacity, capability and best practice to develop the Group as University Teaching Hospitals by 2021. The strategy sets out how the academic departments will be strengthened and coordinated to support this ambition by ensuring we integrate research, innovation and education and invest in our staff and facilities.

Key to this will be strengthening and formalising our existing partnerships with academic institutions principally the University of Leicester, University of Northampton, De Montfort University and the Open University. We will partner with the University of Leicester to meet the criteria set out by the University Hospitals Association to gain accreditation as a University Teaching Hospital. We will support the translational and clinical research priorities as set out by the University of Leicester College of Life Sciences. Our partnerships with all our key academic institutions and industry will provide significant opportunities and benefits to the way we deliver patient care in the future and will lead to better outcomes, improved quality and more efficient service delivery.

The successful implementation of this strategy will ensure a culture of research and innovation is fully embedded across the Group. We will be ambitious in our plans in order to attract and retain high calibre motivated and innovative staff to provide the best possible care for our patients.

3. Delivering the Group Vision and Values

This Academic Strategy is a key platform for delivering the Group vision and priorities. Our ambition is to become Northamptonshire University Hospitals Group, which will allow us to run vital clinical trials and in turn attract a workforce of highly skilled clinicians. Adopting a shared Group Model ensures each hospital has the funding, leadership and the opportunity to develop in areas needed for improvement. It allows the Group to set a consistent high standard of expectation, on top of joint aspirations and values for staff to follow, which will ensure better collaboration across the board.

This strategy will be aligned to the Clinical, People, Digital, Nursing, Midwifery and Allied Health Professional strategies as they are developed in line with the Group vision, values and priorities.

There is a clear association between research, innovation and supporting education and training to improve clinical outcomes and patient experience. The strategy sets out our ambition to grow and develop a sustainable, flexible, multi-disciplinary work force delivering improved outcomes for our patients.

The following summarises the key benefits to developing and delivering an academic strategy:

Strategic Priorities	Benefits
Patients	• Improved patient care and experience • Patient involvement in research leading to improved outcomes • Novel treatments in research delivered trials • Upskilled multi-disciplinary workforce resulting in improved patient care • Development of specialised services • Centre of excellence locally delivered
Quality	• Enhanced patient safety and improved patient outcomes • Evidence based care delivery and outcomes • Access to alternative and cutting edge treatments • Promoting a culture of innovation and quality improvement • Research active organisation leading to improved patient care
Systems and Partnerships	• Enhanced reputation and system partnership working improving recruitment and retention • Opportunities for developing specialist services and networks to deliver care locally in partnership with other centres • Multi-disciplinary education and research teams across the system • Leading the way in our system to support our patients locally
Sustainability	• Creating a learning culture • Improved staff retention resulting in improved clinical and financial sustainability • Innovation attracting additional resources and funding • Reputational benefits • Increased multi-disciplinary participation in clinical trials leading to increased clinical reputation and sustainability
People	• Improved recruitment and retention of high calibre staff • Motivation, opportunities to develop and progress • Developing and building future leaders, succession planning and opportunity to expand roles • Pride in the organisation and ambition to provide excellence in research and education • Multi-disciplinary training building teams and relationships for the future • Developing education and training opportunities for non-clinical staff

4. Engagement

We recognise that inclusive and meaningful stakeholder engagement is essential in order to embed a culture of multi-disciplinary education supported by excellence in research and innovation. We have identified and mapped all relevant partners and stakeholders to ensure there is a continuous engagement programme and we have aligned priorities and policies.

Figure 1 sets out our pathway for delivering and implementing the strategy and ensuring ongoing stakeholder engagement and communication.

Creating	Developing	Implementing	Embedding
• Visioning • Reviewing current strengths, weaknesses, opportunities and threats • Strategic aims and objectives	• Strategic priorities and roadmap • Identifing resoures required to support delivery • Delivery plan	• Creating sustainable resource to expand the academic and research workforce to enable delivery	• Establishing and developing strategic partnerships • Culture change • Monitoring and measuring outcomes

Staff and stakeholder engagement and communication

In developing our strategy we:

- Carried out a series of engagement sessions with our academic and research teams and colleagues across the system
- Surveyed our staff across the Group
- Surveyed our external partners
- Considered ongoing feedback from our student groups

In line with our core Group objective to provide excellent patient experience shaped by the patient voice, we will ensure our patients are at the centre of all our education and research programmes. We recognise research into new treatments and innovations provides assurance to patients and stakeholders that they are receiving the best possible evidenced based care.

The feedback we received helped us shape our vision, strategic priorities and plans to deliver these

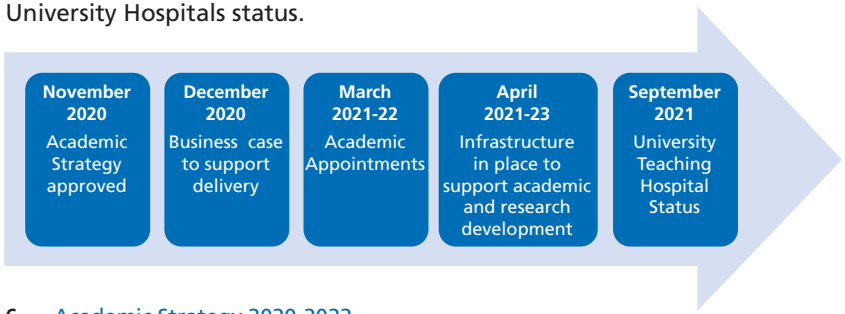
Figure 2 below illustrates the key words suggested by our stakeholders when thinking about a vision for the academic strategy.

5. Our Vision and Objectives

Our vision for the Academic Strategy is to; **Improve patient care through excellence in education and research.** We will achieve our vision by delivering the following eight objectives:

- OB1 Partnering with University of Leicester to become a University Teaching Hospital Group
- OB2 Foster a culture of learning, research and innovation with strong leadership championing the strategy
- OB3 Provide a multi-professional clinical academic programme and improved training and development offer for staff
- OB4 Increase opportunities and resources for innovation and research to be incorporated at the core of our work and clinical practice
- OB5 Build academic, research and digital infrastructure to support and grow innovative clinical education and an increased research portfolio
- OB6 Increase success of research funding from research networks, grant giving bodies and commercial sources
- OB7 Develop closer alignment with all our University partners
- OB8 Develop and promote the academic brand

Figure 3 below is the key timelines to deliver this strategy and achieve University Hospitals status.



6. Making it Happen

Objective 1 Partnering with University of Leicester to become a University Teaching Hospital

There are a number of requirements we have to meet in order to achieve University Hospital status. The Department of Health and Social Care and the University Hospital Association (UHA) specify that any NHS Trusts seeking to include the word 'university' in its title will be required to have applied for UHA membership and for the UHA to have agreed the terms of membership have been met. In developing its advice to ministers on whether the designation should be granted, Department of Health and Social Care officials look to written support from the associated medical and/or dental school confirming that the Trust meets the key requirements. Key to this objective therefore will be developing the formalised partnership with the University of Leicester.

Key deliverables:

- Finalise a Memorandum of Understanding on joint working for effective research governance
- Demonstrate evidence of significant research activity within the Group, much of which will be in collaboration with the University of Leicester staff
- Provide the University with practice placements for undergraduate and postgraduate medical students and students from the Leicester Medical School and from the School of Allied Health Professionals and ensure the infrastructure and facilities are in place to accommodate expanding numbers from 2020 onwards
- Continue to establish high quality clinical education to include appropriate human resources, a collaborative working partnership, appropriate placements resources and flexibility in changing needs of undergraduate and postgraduate students

Objective 2 Foster a culture of learning, research and innovation with strong leadership championing the strategy

In order to embed education, research and innovation across the organisation, cultural change will be required. We will invest in our staff, from all professional groups, to develop their skills and give them time to pursue their research ambitions. We will ensure education, research and innovation are our core business and the responsibility of everyone in the Group. We will reflect this in our planning, governance, staff appraisal and objective setting processes.

Key deliverables:

- Strengthen and promote partnerships across the system to establish a reputation as a leader in research and education
- Develop and invest in the workforce to support the ambition to become university teaching hospitals
- Foster our ambition to build expertise in research and innovation to enable staff to provide and contribute to evidenced based healthcare and thereby developing academic and clinical leaders of the future
- Enhance existing education and training programmes to equip staff across all professions with the skills to drive improvements and embed research into their practice

Objective 3 Provide a multi-professional clinical academic programme and improved training and development offer for staff

Key to achieving our vision is developing our workforce for the future. Our ambition is to create innovative and flexible education and training programmes that build the capacity and capability of our future workforce. We will strive to attract and retain a high quality diverse workforce who embrace and actively engage with research and innovation. We aim to create and deliver multi-professional training to ensure all staff work from a shared knowledge and practice base.

Key deliverables:

- Develop excellence in integrated multidisciplinary clinical education at undergraduate and postgraduate levels
- Improve student experience resulting in improved recruitment and retention of medical, nursing, midwifery, allied health professions and scientific staff
- Appoint education and block leads accordingly and ensure we can accommodate additional medical, nursing, midwifery and allied health professional students
- Identify best practice and any gaps to consolidate our teaching portfolio to support a return on investment
- Create innovative ways of training such as more ward based apprenticeship opportunities
- Expand the Talent Academy and review opportunities to introduce additional post graduate and advanced practitioner courses
- Market our courses locally, national and internationally and provide digital and on line learning opportunities
- Engage in national NHS funded programmes such as NHS Clinical Entrepreneur and NHS Accelerator
- Set up a Research and Innovation Academy to deliver our research and innovation training

Objective 4 Increasing opportunities and resources for innovation and research to be incorporated at the core of our work and clinical practice

To meet this objective we will establish an inclusive framework for research and innovation. Our aim is to maximise opportunities to increase our research capacity and capability. We will seek ways to include our patients and staff in all research and innovation that informs their clinical care.

We recognise the need to build research capacity, provide support and investment to our staff to enable progression and achieve our research and innovation ambition.

Key deliverables:

- Increase opportunities for patients to participate in high quality clinical research. Produce a strategy for patient, carer and public involvement and engagement in research
- Stock take and review current portfolios and resources. Create comprehensive plans to expand NIHR and commercial clinical trials with joint research and innovation programmes between our partners to increase breadth and depth of studies and associated income
- Support and foster staff to pursue funding and research by providing management support for research and innovation
- Substantial improvement in clinical trial delivery across the Group, enabling more patients access to innovative treatments
- Maximise innovation and research opportunities by appointing academic posts across the Group in partnership with the University of Leicester
- Extending existing academic honorary posts across a number of clinical professions with our partner universities
- Appoint joint PhD and Post Doctoral research posts in collaboration with our partner universities
- Enhance relationships with clinical and national research and innovation networks

Objective 5 Build academic, research and digital infrastructure to support and grow innovative clinical education and an increased research portfolio

We recognise that in order to deliver our education and research ambitions, we will need to invest in our infrastructure and clinical support services. In responding to Covid-19 we have identified and accelerated our blended learning approaches.

A key priority will be to strengthen and develop further our digital capabilities to provide on line learning and technology enhanced learning (TEL) platforms. As our student numbers grow and the requirement for social distancing continues we will increase our teaching and accommodation capacity.

The infrastructure, support and training will be available to increase the number of our staff leading and delivering research.

Key deliverables:

- Provide high quality dedicated education and research facilities to enable us to respond to growing demands and evolving requirements for undergraduate and postgraduate students across all disciplines
- Develop an Academic Hub for education, research and innovation across both sites for all professions and learners reflecting appropriately world class education delivery
- Ensure appropriate clinical support capacity and capability is available to enable our increased clinical trials portfolio. This will include research and innovation nurses, pharmacy and diagnostics, principal and chief investigators and non clinical support team
- Expand our clinical trials portfolio on offer by providing the resources and infrastructure to facilitate development of new methods of diagnosing, treating or preventing health conditions from concept through to a marketable product
- In line with the Group digital aim to be the most digitally enabled organisation, to create the digital infrastructure to provide state of the art facilities to support learning and research opportunities. This will include technology enhanced learning (TEL) platform areas to enable 24/7 learning for all
- Build on the Group digital ambition to embed digital transformation in our research and innovation activity

Objective 6 Increase success of research funding from research networks, grant giving bodies and commercial sources

Like the rest of the NHS, the KGH and NGH Group Hospitals face a challenging financial environment, we aim however to continue to utilise the strength of our combined expertise and resources to increase our research funding. We will invest this in developing our academic and research capacity and capability.

Key deliverables:

- Provide staff the education and opportunity to foster emergent research ideas leading to increased external research funding
- Improve our success in attracting grant funding from the major grant giving bodies
- Submit new innovations, research and development to national and international conferences
- Host an annual research conference to showcase our achievements in research including dissertation/thesis outputs and raise our profile locally and nationally
- Maximise the impact of our research outputs by strengthening our key partnerships with regional and national research bodies
- Work with academic and industry partners to apply for UKRI and NIHR grants and other grant sources to develop and commercialise our research

Objective 7 Develop closer alignment with all our University partners

Both hospitals within the Group have partnerships with a number of universities. Key to implementing this strategy will be developing synergies between our academic partners in order to foster greater interdisciplinary education, research and innovation.

Key deliverables:

- Strengthen and develop existing engagement with our partner universities to assure commitment and continue to develop capacity and capability for undergraduates. This in turn will strengthen curriculum development, student placement capacity across the system and student experience. The aim is to increase recruitment and ensure we are desirable employer organisations
- Work collaboratively with our university partners to promote and increase education offerings for post registration academia, including the advanced care practitioner role. This will enhance patient care delivery, reflect current healthcare priorities, address workforce needs and support retention of staff. Ultimately this will develop roles and careers for non-medical registered practitioners
- Expand opportunities to develop nursing, midwifery and AHP visiting professors and fellows and other honorary posts
- Continue to support education and development of staff through the Talent Academy, targeting a clear pathway for pre-professional staff to become registered non-medical practitioners
- Identify and create new academic research and innovation partnerships

Objective 8 Develop and promote the academic brand

To meet this objective we will establish an identifiable academic brand for the Group. We aim to maximise our opportunities as a University Hospitals Group for our patients and our staff.

Key deliverables:

- Develop a joint visual branding for the University Hospitals Group and actively advertise and share our values
- Include a clear academic branding in all recruitment, communication and social media campaigns
- Recognise, celebrate and promote academic and research success and achievements

7. Financial Investment

It has to be recognised that if we are to build our academic and research reputation and be successful at both pace and ambition, there will need to be significant investment in the programme. We will require a shift in mindset from assessing short-term gains to longer-term benefits and return on investment.

There will be a robust process of evaluation and benefits realisation monitoring of any investments made to ensure value for money and delivery of the anticipated benefits.

8. Implementing and Monitoring

In this strategy we have set out our ambition to develop our Group hospitals as learning organisations providing improved quality of care for our patients underpinned by a culture of research and innovation.

Working together with our University partners, we will make the best use of our collective resources to deliver excellence in training and education in order to generate a sustainable workforce fit for the future.

This ambitious strategy will enable and bring to life the Group vision. The strategy will improve patient care and provide access to innovative treatments and involvement in research.

The strategy will build on and enhance the education and training offer to that of true excellence, generating a sustainable multi-disciplinary workforce fit for the evolving health needs of patients.

Progress against delivery of the objectives set out in the strategy will be reviewed annually and assured through the Group hospitals governance structures. A robust implementation programme will be produced and evaluated to measure the impact of our planned activities.

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Report To	**Trust Board**
Date of Meeting	**26 November 2020**

Title of the Report	**Pathway to Excellence**
Agenda item	**17**
Presenter of Report	**Sheran Oke - Director of Nursing/Midwifery and Patient Services /DIPC**
Author(s) of Report	**Sheran Oke & Emily Lambert**

This paper is for: (delete as appropriate)

☐ Approve	☐ Receive	X 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

Executive summary

In 2018, Northampton General Hospital was the first Trust in the UK to receive Pathway to Excellence® designation from the American Nurse Credentialing Centre (ANCC). This international and national recognition demonstrates the application of a framework, which creates a positive practice environment for our staff and in so doing, highlights us as an 'employer of choice' especially with our international nurses. Embedding Pathway to Excellence has seen our overall nurse vacancy rate reduce from 13.8% in 2018 to 5% in October 2020.

The 'journey to reaccreditation' has begun, with us seeking to submit our written portfolio, across the '6 Pathway Standards' and survey our Nursing staff in the summer of 2022. The ANCC will be looking for us to demonstrate how we have continued to develop, embed and evolve the 'Pathway Standards' throughout the Trust.

Following our designation, the Trust have also been invited to provide guidance and mentorship to the 18 Trust's undertaking the CNO's Nursing and Midwifery Excellence programme due to the exemplars of positive practice seen here.

The presentation serves to inform the Board on the component standards of Pathway to Excellence® and outlines our journey to re-designation as well as highlighting the benefits

seen to staff, patients and the organisation. It also highlights our vision to build upon this in becoming a beacon of multi-professional excellence within our group hospital as well as both nationally and internationally.	
Related Strategic Pledge	1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 4. *Create a great place to work, learn and care to enable excellence through our people*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks NO
Related Board Assurance Framework entries	1.6; 3.1;
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics) (N)
Financial Implications	Nil currently
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: none

Actions required by the Trust Board

The Board is asked to note discuss and support the work undertaken to date and plan going forward.

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Pathway to Excellence®

Creating an Positive Practice Environment at Northampton General Hospital

Sheran Oke- Director of Nursing and Midwifery

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What is Pathway to Excellence®?

In 2018, NGH was the first Trust in the UK to achieve Pathway to Excellence Designation.

Pathway to Excellence® is an international nursing excellence credentialing programme that promotes and gives organisations a frame work to help create a **positive practice environment** . It can help address major recruitment and retention challenges, and empower staff to take actions that improve patient outcomes and staff satisfaction.

Pathway to Excellence® designation is earned by organisations that demonstrate a commitment to creating a positive practice environment where nurses flourish because they experience, among other things, job satisfaction, professional growth and development, respect, and appreciation.

ANCC, 2020

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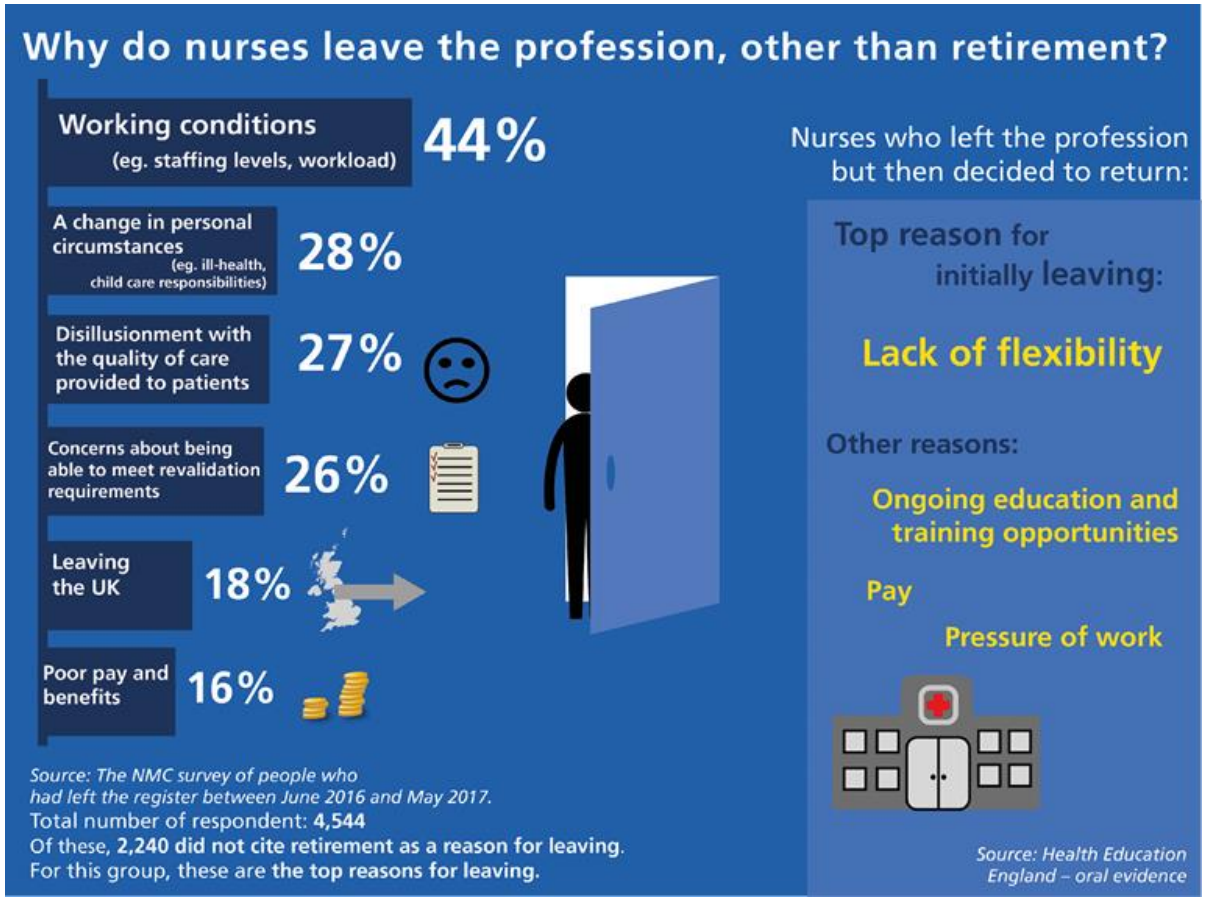
Why Pathway to Excellence at NGH?



NGH in January 2018;

- Vacancy rate 13.8%
- Staff leaving to move to bigger organisations due to lack of opportunities
- Lack of collective Nursing voice
- Staff felt unvalued

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Achieving Pathway

Designation was achieved by submitting

- An Organisational Overview(OO), Organisational Demographic Form (ODF), Continuous Information Form (CIF), and the Director of Nursing CV
- 62 pieces of written evidence, across the 6 pathway standards, shared decision making, leadership, safety, quality, wellbeing and professional development
- The written evidence shows the extent to which the framework is embedded throughout the organisation
- Finally, surveying all nurses to ensure the evidence we have collated depicts how the nursing workforce was feeling

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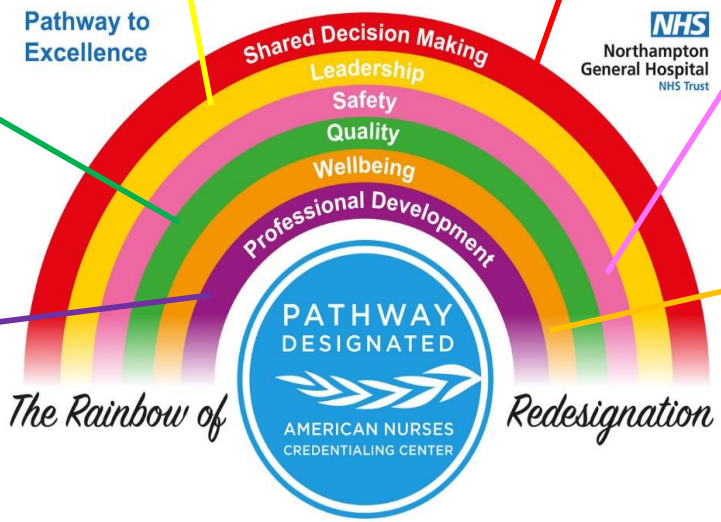
What are the Six Standards of Pathway to Excellence?

Leadership is based on collaboration and engaging with front line staff. Leadership development is integral.

Direct care nurses are involved in decision making. Interprofessional collaboration is paramount to innovation, addressing ethical concerns and health promotion.

Safety is key component to Nursing processes. Environment is safe free from incivility, bullying and violence.

Quality is developed through interprofessional collaboration. Use of evidence base practice throughout care system. Care is person and family centred.



Recognises the importance of professional development in the safe delivery of care. Focus on succession planning and individualised education.

Staff are involved in the planning, selection and evaluation of wellbeing initiatives. Culture of day to day recognition. Wellbeing of staff is key to recycling burnout.

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Survey Results in 2018

60% of all eligible nurses must complete the survey

✓- 82% Response Rate

50% of nurse respondents must respond strongly agree or agree on ALL 28 survey questions

✓ - Criteria Met

75% of nurse respondents must respond strongly agree or agree on at least 21 out of the 28 survey questions

✓ - 26/28 questions were 75% or above

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Shared Decision Making

- To date NGH have 21 councils across the Trust
- Councils run across wards, specialties or thematically an enable front line staff to proactively use their voice within the organisation
- Based on 4 Key principles of responsibility, authority, accountability and equity
- Supported by wider hospital team and by NHCF
- Reports in to Leadership council on bi-monthly basis reporting to DoN
- Chairs who stay within organisation use skills developed to apply for promotions

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Recognition (Meaningful)

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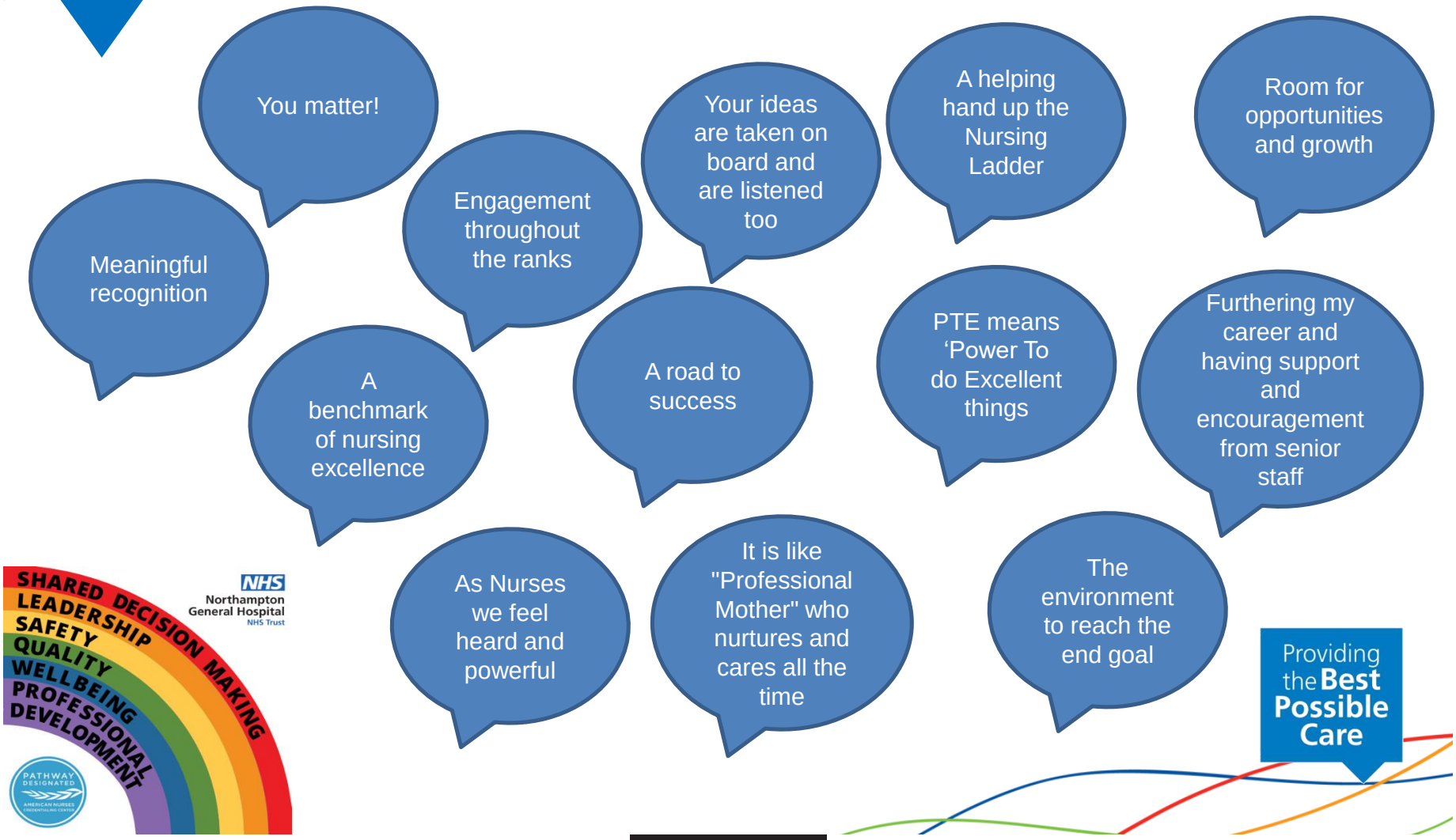
What does this mean to the staff…?



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Benefits to Staff

Pathway to Excellence® Designation which has benefitted our staff in the following ways....

- *RN vacancy rate down from 13.9% in June 2018 to 4% in October 2020*
- *Skill mix improved from 66.7 to 70.7 in line with the national average*
- *Improvement from 51% (June 2018) of RN with degree or higher to 67.5% (March 2020)*
- *Midwives and Nursing Associates now included at survey*
- *Internationally recruited Nurses choosing to come to the organisation due to designation as recognised as beacon of excellence internationally*

Providing the Best Possible Care

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What does this mean for the patient…?

- Quality care embedded and assessed across the organisation
- Staff working in an environment to safely deliver their roles
- Innovative care delivery
- Cared for by staff who access frequent training and updates
- Reduction in avoidable harms
- Better communication processes
- Empowered staff advocating for patient care

Providing the Best Possible Care

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What does this mean for the organisation…?

- Remain the only acute Trust within the UK to achieve designation
- Invited to provide guidance to 14 Trust's commissioned on Nursing and Midwifery Excellence journey by CNO
- Increased number of staff presenting and being accepted for publication nationally and internationally
- Increased culture of evidence based care in line with academic strategy
- Highlighted as exemplar of good practice when internationally recruited
- Pathway ethos now been shared with wider team NGH community. AHP's involved in Shared Decision Making and meaningful recognition activities
- Visibility as a beacon of good practice within the UK and NHS

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Best Possible Care Nursing Assessment & Accreditation

- The **Best Possible Care Nursing Assessment and Accreditation** framework is an evidence based tool designed to help nurses in practice, measures the quality of patient care, to create a radical new way of thinking within the organisation by releasing nurses to be leaders and to drive and contribute to cultural change within their clinical wards and departments.
- Supports nurses and midwives to understand how they deliver care, and identifies where further improvements can be made. Thus it provides a robust method for continuous improvement. Our teams love it!
- Each standard is subdivided into elements of Environment, Care and Leadership and also incorporates local and national performance indicators developed from complaints, concerns, adverse and quality improvement work
- Teams feel empowered and valued in working to achieve the standards
- It is endorsed and championed by the Chief Nursing Officer for England

Providing the Best Possible Care

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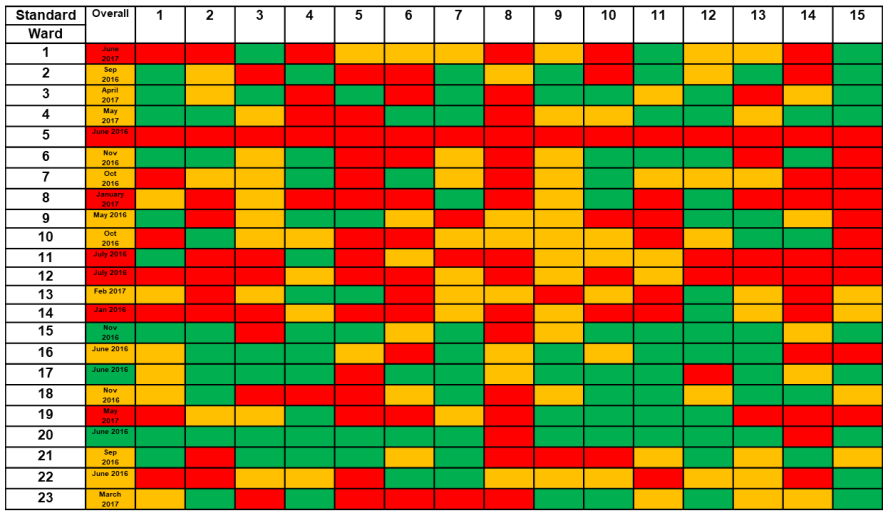
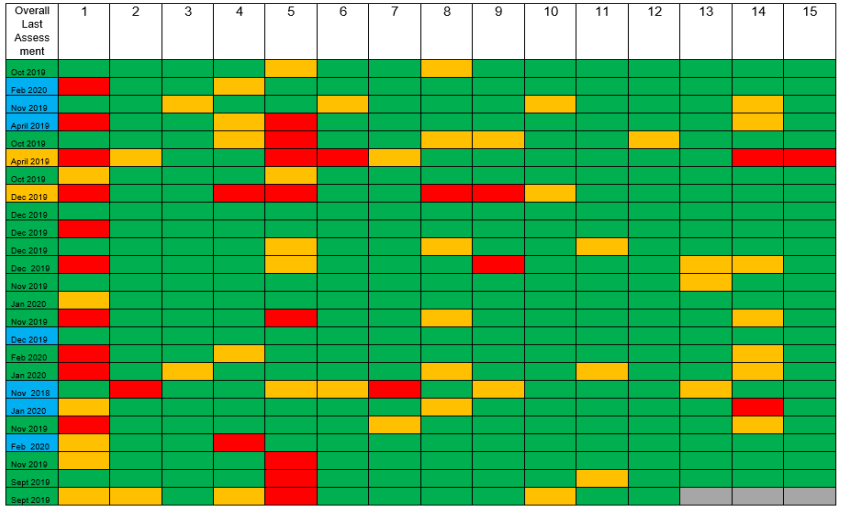
Our progress to date:

Ward First Assessment Results May 2016



Current Ward Assessment Results March 2020



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Changes for 2022 Designation

- Nursing Associates and Midwives now included at Survey
- Written EOP's reduced to 53
- NGH now asked to submit evidence on the organisations strategies to optimise Diversity and Inclusion within organisation and the training offered to employees
- Aiming to be the first UK Trust to achieve Re-designation

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Next Steps to Redesignation

- Continue to provide mentorship to UK organisations
- Begin to look at expansion of Nursing and Midwifery Excellence in to wider team- Assessment and Accreditation plus based on development of multi-professional tool for care Pathways
- Building upon Pathway to Excellence ethos throughout the organisation
- Increased research profile with front line staff leading on Research
- Increasing agenda for Diversity and Inclusion and integrating throughout standards

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NGH'S Covid Lifeline

- Staff are engaged and therefore, show discretionary effort in their roles
- Providing an opportunity for meaningful recognition
- Staff have a voice and feel a sense of value
- National profile – CNO Nursing and Midwifery Excellence meetings, International SDM recruitment and retention group, interested hospitals contact us re Pathway and SDM.

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NGH'S Covid Lifeline

The Board is asked to support our Pathway to Excellence redesignation journey so that NGH can not only become the first UK Trust to achieve redesignation but continue to expand the beacon of Nursing and Midwifery Excellence leading the way to multiprofessional Excellence.

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Report To	**Trust Board**
Date of Meeting	**26 November 2020**

Title of the Report	**Integrated Care System (ICS) Draft Development Plan**
Agenda item	**18**
Presenter of Report	Simon Weldon, Group Chief Executive
Author(s) of Report	Alison Gilbert NHCP Director Lead, Tim O'Donovan, NHCP Assistant Programme Director

This paper is for: (delete as appropriate)

X Approve	Receive	X 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

Executive summary

Draft NHCP ICS Development Plan and NHSEI feedback (Appendix A)

As part of the phase 3 COVID19 response letter (31st July) received from NHSEI, reiterated the move towards comprehensive ICS coverage by April 2021, and for all ICSs and STPs to embed and accelerate the joint working through a ICS development plan that would include:

- Collaborative leadership arrangements agreed with clearly defined arrangements for provider collaboration, place based leadership and integrated care partnerships
- Partnership Board in place
- Streamlined commissioning arrangements
- Plans for shared care record across the system

An initial draft ICS development plan was submitted to NHSEI on 21st September 2020, as part of the system phase 3 COVID 19 submission.

The latest NHCP working draft ICS development plan can be found in **Appendix A.**

The draft ICS development plan was reviewed by NHSEI national and regional colleagues in an informal meeting that took place 11th November 2020 and was positively received. The following feedback below was provided to support the final ICS development plan submission.

- Systems have an opportunity through the supporting letter signed by all system partners in providing a short summary demonstrating how the system is meeting, or is planning to meet, the consistent ICS operating arrangements.
- Describe how the ICS will enable and deliver Phase 3 restoration and COVID-19 response and don't undersell the progress that has been made throughout the pandemic
- Be mindful of "place" as a focus within the plan narrative, including the opportunity through unitary and the acute group model across Northamptonshire and showcasing the difference that the ICS will make in terms of impact and outcomes
- In meeting the consistent operating requirements and progress with the ICS maturity matrix domains, explain what the outcome and difference has made to patients and staff in working together that could not be made working as separate organisations
- Within the proposed case studies include iCAN, Digital and Mental Health as examples
- Include approach on health inequalities
- Recognised the NHCP Board development session on ICS vision in December has not yet happened
- NHSEI will explore how to support NHCP in revisiting the ICS maturity matrix self-assessment
- Ensure clinical and professional voice is clearly demonstrated throughout the plan

ICS Submission Requirements (Appendix B)

The ICS submission should contain the following components:

- A description of how the STP meets each of the ICS operating standards and progress demonstrated in accordance with the maturity matrix ICS maturity matrix. Further detail on the ICS operating standards can be found in Appendix B.
- A development plan which outlines system priorities for development and how these can be used to tackle some of the systemic challenges to the system.

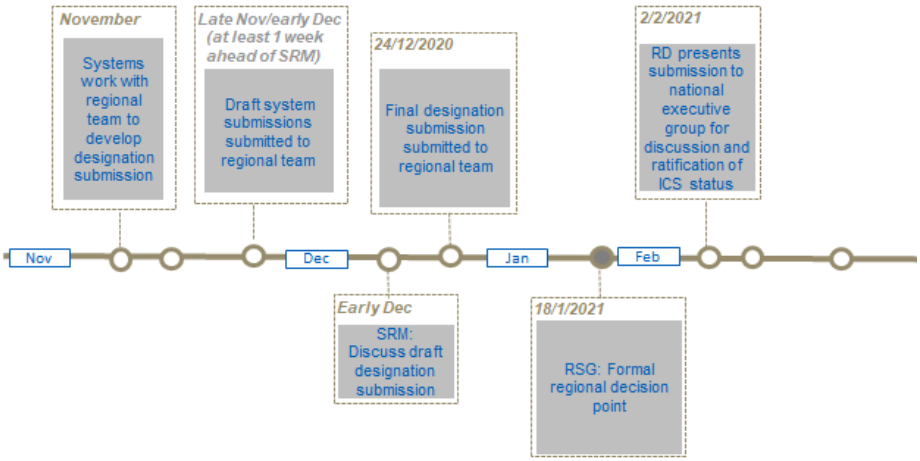
ICS designation process and timelines

Following confirmation of the national process for ratifying systems for ICS designation and the timings of December Quarterly System Review Meetings between NHSEI and STPs, there is now a revised timeline for ICS designation in February 2021 summarised in figure 1 below. Latest draft submissions will now be required one week in advance of the Quarterly System Review meeting.

For Northamptonshire that requires the latest draft of the ICS development plan to be submitted to NHSEI by 26th November 2020, ahead of the quarterly system review meeting taking place on the 3rd December 2020, with the final ICS designation submission to be submitted to NHSEI on the 24th December 2020.

The Regional Support Group will make a formal decision point in January 2021, with the Regional Director presenting the submission to the National Executive Group for discussion and ratification of ICS Status in February 2021.

Figure 1 ICS designation approval timelines



ICS Designation supporting letter

In addition to the ICS development plan submission it has also been agreed nationally, that systems must produce a letter signed by all system partners providing a short summary demonstrating how the system is meeting, or is planning to meet, the consistent operating arrangements. This will be considered by the national executive when they make the final decisions on ICS designation.

Next steps in progressing the ICS development plan submission

Further development of the final ICS development plan will be overseen by the Health and Care Executive Steering Group, with the NHCP core team holding a daily meeting to ensure the momentum is kept with the development of the plan.

Continued engagement of Governing Bodies, Trust Boards and key stakeholders is planned during November and December, noting it is proposed that the NHCP Board hold a development session on ICS vision and ICS development plan on 17th December 2020, prior to final submission of the ICS development plan to NHSEI on 24th December 2020.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable excellence through our people* 6. *Become a University Hospital by 2020 becoming a centre of excellence for education and research*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: No
Related Board Assurance Framework entries	BAF – please enter BAF number(s): 4.1
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N)

	If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	N/A
Legal implications / regulatory requirements	Regulatory requirements as set out within the NHS Long Term Plan (2019) 1.51. By April 2021 ICSs will cover the whole country, growing out of the current network of Sustainability and Transformation Partnerships

Actions required by the Trust Board

The Trust Board is asked to:

1. To note the feedback provided by NHSEI to support the final ICS development plan submission
2. To note the current version of the plan is a working draft, and to discuss and provide feedback to help further develop the ICS development plan
3. To note the revised ICS designation approval timelines and final submission date of 24th December 2020
4. To note the ICS submissions requirements including a letter signed by all system partners providing a short summary demonstrating how the system is meeting, or is planning to meet, the consistent operating arrangements.
5. To agree a Chairs action with regards to the signed ICS designation support letter and organisational sign off, noting there are no other formal boards prior to the 24th December 2020 final submission
6. To note the next steps highlighted in progressing the ICS development plan

Northamptonshire
Health and Care Partnership

DRAFT ICS DEVELOPMENT PLAN SUBMISSION 2020

V0.1

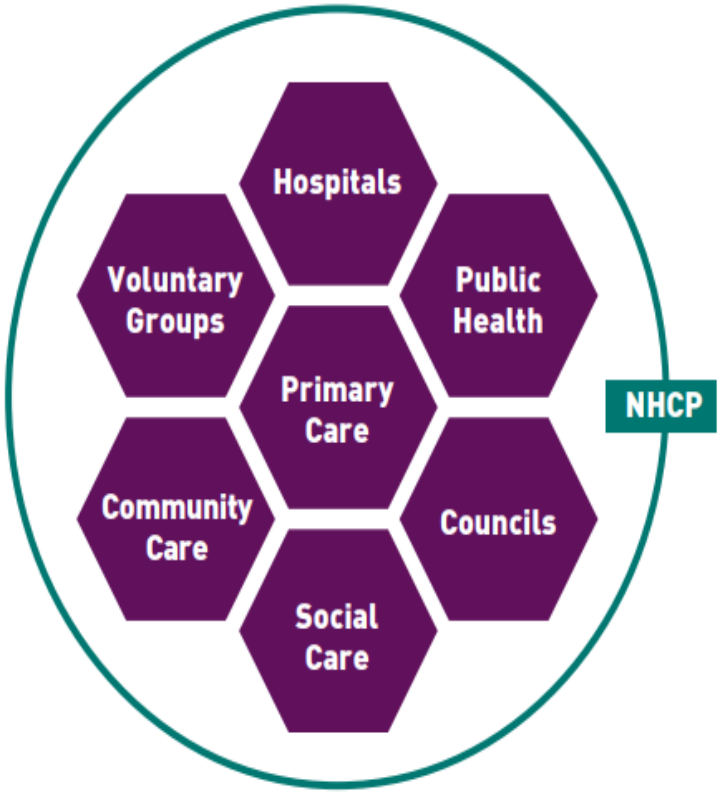
Contents

Northamptonshire
Health and Care Partnership

Section 1 - Our commitment to system working

Northamptonshire Health and Care Partnership

- Northamptonshire Health and Care Partnership (NHCP), formerly known as the Northamptonshire STP, consists of key health and care providers in the county.
- While we remain as separate organisations with our own local responsibilities for the services we provide, since 2016 and inception of STPs, we have been working together towards a positive future for our community.
- By working more closely in partnership and our shared ambition for greater integration across health and care, will allow people to tell their story once, navigate between organisations and experience greater continuity of care. The benefits to patients and carers would be limited working as individual organisations.
- We want to build on this foundation of partnership working and are fully committed to taking the next steps in our Integrated Care System development by achieving ICS status by April 2021, and to become a thriving ICS by April 2022.
- Section 2 highlights some of the work we undertaking as maturing ICS that is making a difference to local people, that has only been achieved by working together as one integrated care system



Mental health: Andy's story

As a former user of mental health services in Northamptonshire, Andy Willis has had the opportunity to get involved in coproduction, alongside many others like him.

Not only has this input been hugely valuable in the design and development of local services, but it also continues to play a key role in Andy's continuing recovery from severe mental illness.

"I was discharged in December 2017 and I was very privileged to be asked to get involved with some co-production," Andy recalls. "Although I was grateful to be discharged, I was far from completely well – and I had no self-esteem, no confidence and very little structure in my life.

"Recovery means different things to different people but, for me, to get that purpose back, that richness in my life, to sustain that recovery, co-production was absolutely at the core of it. And it continues to be because I will always be in recovery."

Andy reflects that had the crisis cafes and crisis houses been available in the county at the time he was a service user, he would certainly have benefited from these and other new services.

He says: "I've just seen so much continued, careful thoughtful innovation and progression and co-production has been at the heart of it. At a time of COVID the public need hope that care is going to continue to improve and it will do under co-production, there's no question about that."

WATCH Andy's video diary at:
www.northamptonshirehcp.co.uk/mental-health/transformation

Section 2 - Our commitment to patients, carers and the population of Northamptonshire – case studies

Northamptonshire Health and Care Partnership

iCAN

TO BE ADDED

Digital Transformation

Workforce & Estates

TO BE ADDED

Patient and Public Engagement

TO BE ADDED

Section 2 - Executive Summary

Northamptonshire Health and Care Partnership

Phase 3 OBJECTIVES
Collaborative leadership arrangements, agreed by all partners
Organisations within the system coming together to serve communities through a Partnership Board
A plan for developing and implementing a full shared care record
Plans to streamline commissioning through a single ICS/STP

Executive Sponsor:	Toby Sanders
Clinical Lead:	Dr Miten Ruparelia
SRO:	Alison Gilbert
System Governance Board	NHCP ICS Partnership Board & NHCP Digital Transformation Board

LOCAL CONTEXT

With the creation of two new unitary councils for 2021 and to become a maturing ICS for 2021, we have an once-in-a-lifetime opportunity to reshape our health services along the same geographic lines, with examples early steps taken highlighted below.

- Joining of Nene and Corby CCGs to create one new organisation NHS Northamptonshire CCG from April 2020 to serve the NHS commissioning needs of the whole county
- The formation of an acute hospital provider Group model bringing together the Northampton General Hospital (NGH) NHS Trust and the Kettering General Hospital (KGH) NHS Foundation Trust to provide and develop acute hospital services for the whole population of the County.
- Established 16 new Primary Care Networks (PCNs) with a named clinical director, bringing together integrated community based teams around a neighbourhood footprint, to deliver seamless care for both physical and mental health.
- An integrated provider of community and mental health services across the County, Northamptonshire Healthcare NHS Foundation Trust, with strong links to Leicestershire Partnership NHS Trust, the emerging regional mental health provider alliance and local GP Federations
- Community resilience demonstrated in response to Covid-19 supported by (Voluntary, Community, Social Enterprise) VCSE sector
- Completed system wide procurement for a shared care record resulting in purchase of Graphnet Care Centric Solution and in process of system wide deployment by early 2021.
- STP Executive Lead and NHCP ICS Partnership Board in place, with agreed ICS sub committee architecture and Chairs & NEDs oversight arrangements
- Formal offer to establish a single GP provider board

We have made great progress developing our relationships and working together over the last few years as NHCP. This has accelerated in our collective response to Covid-19 and we want to continue to embed and accelerate this joint working through our ICS development plan.

Northamptonshire
Health and Care Partnership

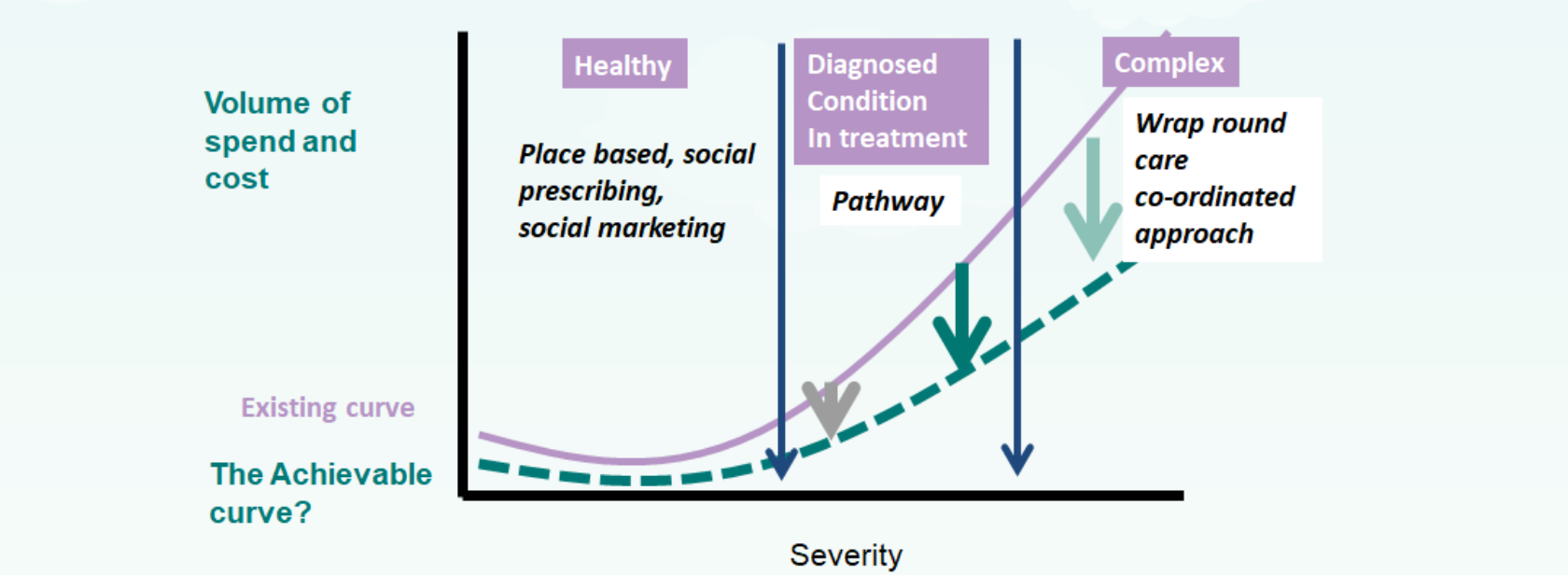
Section 3 – Challenges

Northamptonshire Health and Care Partnership

Northamptonshire faces a number of challenges that are putting significant pressure on our health and social care services. This includes the fastest growing over-65 population of any county, the fact that two out of three adults are overweight or obese and, in turn, there are 152 heart-related hospital admissions for every 1,000 people who live here. These factors – combined with a shortage of money and staff – mean we have more unplanned admissions of patients than any other area in the UK. We regularly have around 900 'long-stay' patients in our hospitals. Long-stay patients are adult patients who have stayed in an acute hospital bed for 21 days or more.

This pressure on our urgent and emergency care services, and adult social care provision, is a sign of a disjointed and reactive (rather than preventative) health and care system. So our plan aims to address the factors that lead to people needing more acute care and medical support, to help everyone involved take responsibility for seeing and looking after patients better and faster. By focusing more on preventing illness and identifying and treating ill health at an earlier stage, we can reduce demand for formal health and care services and help people to take control of factors that affect their health.

We now know that if we do not change how we work, in five years Northamptonshire will need 568 additional beds (which is the same as needing a new hospital), we will spend £90 million more a year on emergency care than we do now and we will have an annual funding shortfall of £148 million by 2023/24. Doing nothing is not an option.



Section 3 – Opportunities

Northamptonshire Health and Care Partnership

We have a great opportunity with local authority changes that are happening in Northamptonshire to review our ways of working. Two new unitary councils are being created – North Northamptonshire and West Northamptonshire. Unitary councils are responsible for providing all local government services within that area. This change gives us a once-in-a-lifetime opportunity to reshape our health services along the same geographic lines.

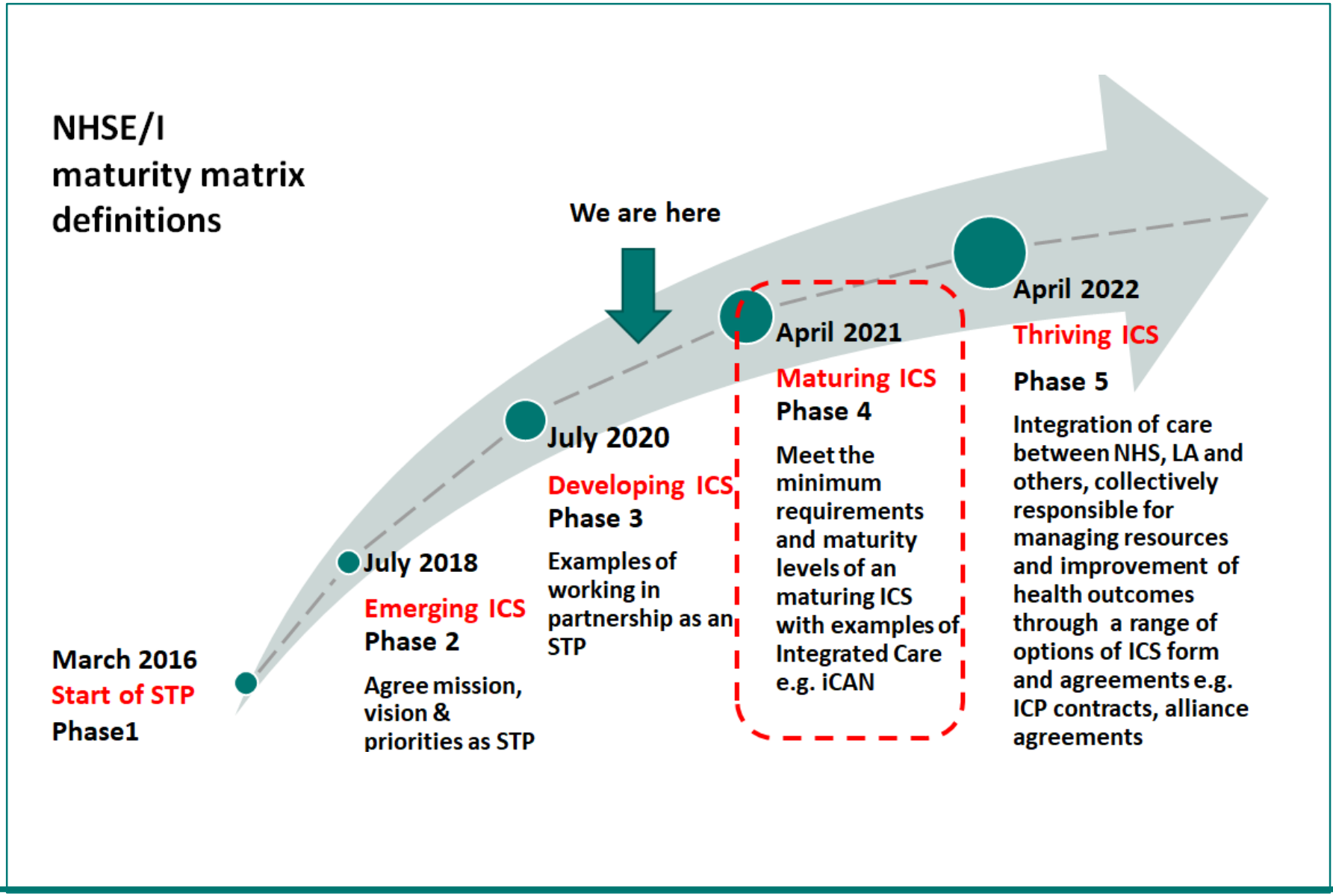
It will make sure that we deliver simpler, joined-up services that meet people's needs now and in the future. Because of this, our plan is ambitious and aims to address the long-term sustainability of our health and care services. Not only will we work in a more joined-up way in the future by delivering the health and care services people really need at a community level, but we will also transform the way we work with, and provide care to, the people of Northamptonshire. We aim to give people more control and a range of options when it comes to accessing health, care and wellbeing services in the future. This includes the introduction of digital appointments, an online directory of services, a county-wide social prescribing service and shared care personal health records that will be accessible to professionals and individuals. By making it easier to access support, we hope to keep more people well and reduce the wait for services if people do ever need them.

Wherever we work and whatever our role across health and care, our mission is for people in Northamptonshire to be able to choose well, stay well and live well.

- Working with the two unitary structure for the county
- Focusing on PCN structure as a driver
- CCG, LA and public health supporting the place based approach
- Improving our intelligence through alignment and responsiveness

Section 3 – Opportunities/Our ICS Roadmap

Northamptonshire
Health and Care Partnership

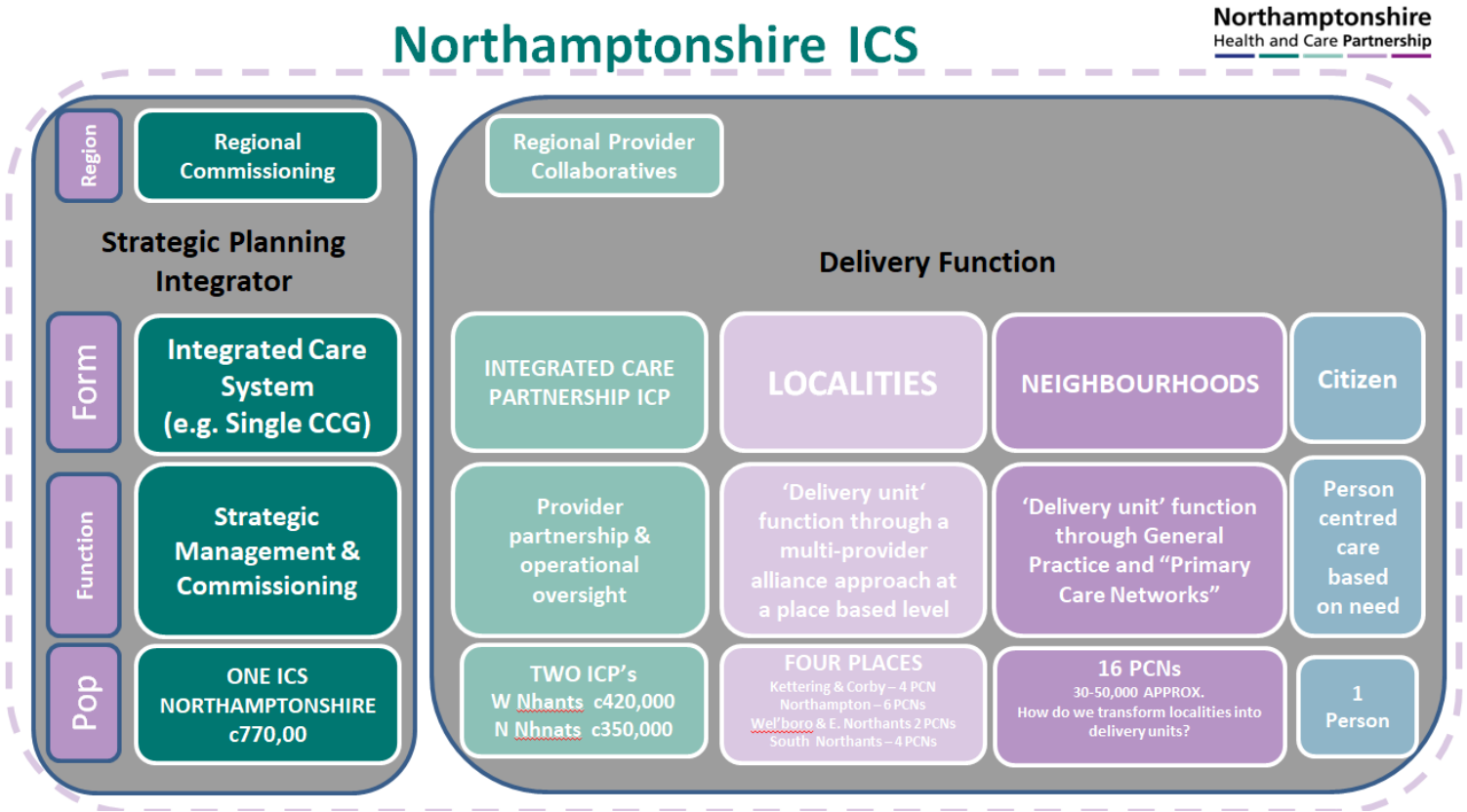


Section 4 – Impact

Northamptonshire Health and Care Partnership

In transitioning to a maturing ICS, we are breaking down historical barriers to collaboration and working together more seamlessly. This will not only be for health and social care services, but also with work on housing, leisure, education and employment, and the targeting areas of inequalities.

As a result of these changes, we will create a health and social care system for Northamptonshire with different levels and ways of working shown below. This will help us to work together more effectively and allow voices from all areas to be heard equally.



Northamptonshire
Health and Care Partnership

5. ICS Programme

- Programme Construct
- Programme milestones to April 2021
- Plan on a Page for each Pillar
- System Architecture and Governance

Section 5 - ICS Development Plans and Delivery

Northamptonshire Health and Care Partnership

KEY STRATEGIC AIMS ASSUMPTIONS UNDERPINNING DELIVERY

ICS

In order to support our journey to a thriving ICS by April 2022 and to take our next steps towards a maturing ICS by April 2021, a proposed programme construct has been agreed by NHCP Board to ensure a locally owned development plan meets the attributes and minimum requirements of a maturing ICS, in readiness for April 2021.

The ICS programme construct will be made up of five priority components highlighted below and is progressing through respective Governing Bodies and Trust Boards for formal approval.

1. **System Learning from Covid-19 into Recovery Plan** - Capturing the learning from C19 including shared multi agency decision making and collaboration to meet key tests of recovery

2. **System Leadership and Architecture** - Form the sub-committees and governance structure to support ICS decision making including place and neighbourhoods

3. **System Population Health Management** – Address health inequalities using population health management approach by using data insights model and shared care record implementation to support planning and delivery in the short, medium and long term

4. **Strategic Commissioning** - Simplify commissioning arrangements across Health, LA and NHSEI, enabling a single set of system-wide decisions in line with agreed different levels of the system and local needs

5. **Integrated Delivery Model** – How we are going to work together in practice at different levels of the system to support and complement each other, to achieve a truly interconnected approach including approach to collaborative leadership arrangements. NHCP Board have committed to a series of ICS vision workshops during September and October to agree approach to place based leadership, integrated care partnerships and provider collaboration.

Shared Care Record

The aim of the Northants Care Record (NCR) is to provide data to support direct care. Key information will be available at the point of care for all NHCP organisations and their respective individuals/teams providing direct care to patients.

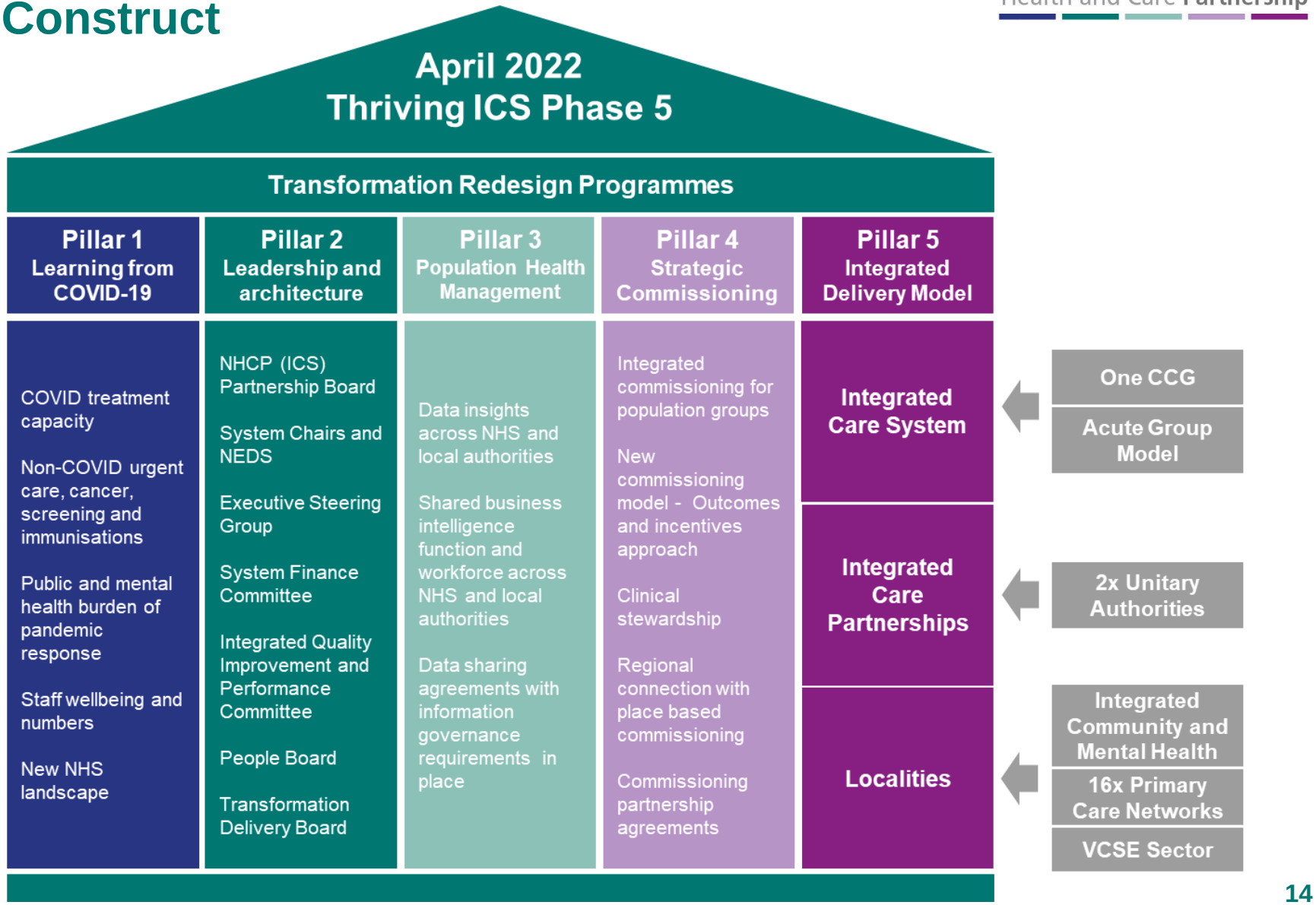
Providing a single view of the patient record will directly transform the way in which care is provided. The NCR solution is expecting to improve quality and efficiency, support new models of care and contribute to economies of scale service provision

2020/21 MILESTONES

Sept/Oct	• ICS - Proposal for new ICS Sub – Committees presented to NHCP Board • Interviews for NHCP Independent Chair • ICS - ICS Vision Workshops • NCR - sandpit, test and live environment build complete • NCR - Information Governance DPIA/ISA approved • NCR - Patient Safety sign-off complete • NCR - GP systems integration begins (EMIS) • NCR - NCC integration planning underway
Nov/Dec	• ICS – Hold NHCP Board ICS development session • ICS – Confirm approach to place based leadership ,integrated care partnerships and provider collaboration • ICS - Agree overall system architecture and governance including place • ICS - Systems provide draft ICS submission documentation to the regional team • ICS - Final submission of systems' application for Feb Review point. • NCR - GP systems integration continues (TPP) • NCR - Acute systems integration underway • NCR - Community system integration underway • NCR - EMAS access in place • NCR – Phased Go Live
Jan/Feb	• ICS - Documentation is submitted to National Incident Recovery Board/Joint Executive Group for review • ICS - Formally granted ICS status • NCR – In use with initial data sets
Mar/Apr	• NCR - EMAS data integration underway

Section 5 - ICS Programme Construct

Northamptonshire Health and Care Partnership



Section 5 - Plan on a Page EXAMPLE FOR EACH ICS PILLAR

Northamptonshire Health and Care Partnership

This programme aims to:
[*Describe the Programme aims for 20/21 21/22}*

Risks:
[*Provide an outline of strategic Programme Risks for system partners*]

Our objectives:
[Outline the objectives of the programme max 5/6 deliverables]

Investment:
[*provide outline of investment required for programme of work and when require*]

How we are going to deliver this:
[*Provide an outline how the objectives will be delivered what will the programme do]*

This will be deliver through

- Communication across the system via social media, newsletter, communication coming into greater coverage – demonstrating improve messages and information
- Provide adequate feedback and comment for example; you said, we did
- Work towards operating at system controlled level demonstrating maturity and test between organisations
- Measurement – as a system during the period there would be winners and losers for the greater good as a system –

Work in progress

Outcomes, outputs and quality improvements:
[Outline of benefits of programme and quality improvements for patients and staff]

Evaluate the messages on the people of Northamptonshire

Demonstrating the relationship with NHSE and local economy is based on realistic exceptions

30, 60 and 90 day plan
[outline what you will do with who and how 2/3 key points for 30 days/60days and 90days]

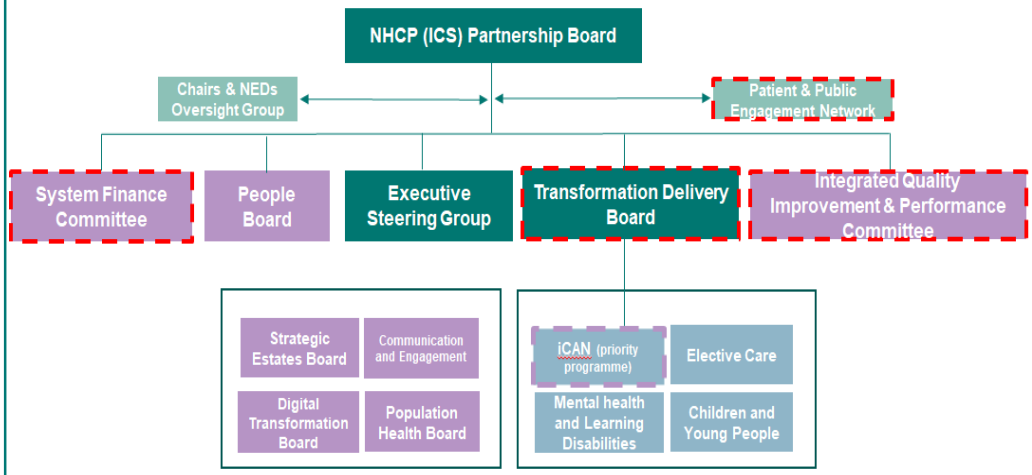
Our vision: A positive lifetime of health, wellbeing and care in our community

Section 5 - System Leadership and Architecture

Northamptonshire Health and Care Partnership

The NHCP has an existing governance framework that supports our transition to a maturing ICS and delivery of system priorities and improvements which is summarised in the current NHCP organogram below.

As much business, as possible that pertains to the system will be conducted via the system governance described within the NHCP Governance Framework. We recognise ICS the governance framework will continue to evolve as we progress our ICS development e.g. place based governance arrangements



* Indicative only - TBC

NHCP Governance and structures

The NHCP ICS Partnership Board and the sub-committees reporting to it will be the vehicle through which NHCP system business is conducted.

The partner organisations represented on the Northamptonshire Health and Care Partnership Board are jointly accountable for delivery for system plans.

Delivery will be supported by a distributed leadership model. Although governance arrangements include, for instance, an Independent Chair and a Partnership Lead, this does not detract from the joint accountability of the organisations within the partnership for delivery of system plans.

The NHCP ICS Partnership Board brings together Chairs, CEOs and key roles across the partnership providing strategic direction and leadership in moving towards a maturing ICS for Northamptonshire.

Northamptonshire
Health and Care Partnership

6. Progress made against ICS operating requirements and ICS maturity matrix

- ICS Dashboard Summary
- ICS minimum requirements
- ICS Maturity Matrix
- Where are we now? - ICS Maturity Action Plan for 2021 and 2022

Section 6 - Northamptonshire ICS Dashboard Summary

Northamptonshire Health and Care Partnership

System aspirations for ICS designation is (Nov or Feb review point)

Operating arrangements	Readiness for designation in relation to meeting the building blocks
Aspiration	
System Functions e.g. • System capabilities • Streamlined commissioning arrangements	• Single CCG across the system. NHS Northamptonshire CCG established in April 2020 • Agreed group model across Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust • The creation of two new unitary councils (West Northamptonshire and North Northamptonshire) in April 2021, • System ICS sub-committees agreed to oversee ICS functions Quality, Performance, Workforce, Finance • An integrated provider of community and mental health services across the County, Northamptonshire Healthcare NHS Foundation Trust, with strong links to Leicestershire Partnership NHS Trust, the emerging regional mental health provider alliance • 16 Primary Care Networks across the County bringing together groups of local GP practices to provide integrated care and the co-ordination of support from across health, care and voluntary sector services
Core Building Blocks e.g • A Leadership model • System-wide governance	• A single STP/ICS leader in place Toby Sanders • Independent Chair in place – Naomi Eisenstadt • Partnership Board in place underpinned by agreed high level ICS governance and sub-committee arrangements • STP Clinical Lead in place Dr Miten Ruparelia • STP Partnership Office in place led by STP Director Lead to support ICS Leadership Team
Robust system plans and track record of delivery e.g • System Plans • Capital and Estates • Incident Mgt and Restoration	• One plan for the county (alignment of HWBB strategy and LTP) • A plan in place for developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health. Population Health Board and Digital Transformation Board led by DPH • System Estates Strategy in place which spans Health and Care. Good rating with NHS Property Board • Whole system COVID-19 tactical structure & cells has built positive working relationships for the future. • Rapid delivery of new models of care during C19 involving increased use of technology and shared resources with partners

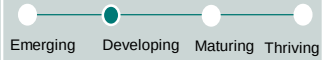
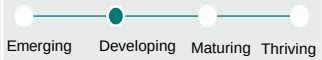
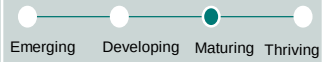
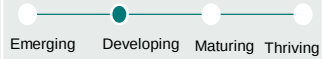
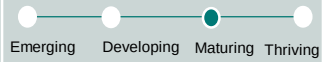
Section 6 - ICS minimum requirements

Northamptonshire Health and Care Partnership

ICS MINIMUM REQUIREMENTS	DELIVERABLES REQUIRED TO SUPPORT ICS STATUS BY 2021	Progress
1	Clear plan and coordination of system transformation @ ICS, Place and PCN – this must include workforce planning, population health management and quality improvement	Transformation Delivery Board agreed as ICS sub-committee to oversee and enable system transformation Shared BI Function in place across LA and NHS with NHS planning function led by DPH One plan for the county – Northamptonshire Health, Care and Wellbeing Plan
2	System architecture in place to manage performance this must include quality, health outcomes and operational and financial management	Agreed 4 ICS sub-committees of the ICS Partnership Board, which includes integrated quality and performance committee
3	ICS leadership team with sufficient capacity	STP Executive Lead, STP Director lead, STP Clinical Lead and Partnership Office in place
4	Effective system wide governance arrangements must include Partnership Board and Independent Chair	Partnership Board established. Independent Chair in place.
5	Agreed ways of engagement and effective working with Local Government and other partners	Weekly Health and Care Executive Steering Group established with Partnership Board wide ranging membership
6	Agreed ways of financial management	System Finance Committee to be established in Sept 2020 with Chair and NEDs membership
7	Confidence in the system to resolve current performance challenges	C19 tactical response and MDT decision making with all partners engaged, enabled rapid change and review in resolving challenges
8	Confidence in LTP Delivery	Digital solutions have moved forward at pace which has enabled service transformation e.g. video consultation, Shared Care Record delivery due in 2020
9	Self – Assessment against ICS Maturity Matrix	Last self assessment showed developing ICS, progress has been made through C19 e.g. integrated care models
10	Progress on key system transformation priorities	Progress is being made through iCAN programme, Service Transformation with Local Government & Mental Health Collaboration and New Commissioning Model

Section 6 - Northamptonshire ICS Maturity Matrix Assessment (August 2020)

Northamptonshire Health and Care Partnership

Domain	Where the system are now per maturity matrix assessment	How the system is demonstrating the characteristics of a maturing ICS?	The work underway	Emerging priorities
Domain one: System Leadership, Partnerships and Change Capability		• Collaborative and inclusive system multi professional leadership and governance developed • Shared BI Function in place across LA and NHS.	• Whole system ICS vision workshops planned for September 7 October 2020 • Whole system data sharing agreements being developed	• Collective agreed vision for ICS and delivery model at different levels of the system, place and neighbourhood with supporting infrastructure
Domain two: System Architecture and Strong Financial Management and Planning		• Single CCG in place - Northamptonshire CCG • System wide plans in place for Workforce, Estates and Digital • EQIA and Ethics Committee established as part of COVID tactical response	• Establishing System Finance Leadership Committee with Chairs and NED membership • New outcome-based commissioning in mental health across CCG, NHFT & VCSE	• integrated arrangements towards collaboration in commissioning plans at different levels of system • Agreed system control total approach and financial balance
Domain three: Integrated Care Models		• Good and developing PHM f[illegible] • Rapid delivery of new models of care through C19 • PCNs established • Community hubs established between NHS and LA (Corby, N'ton, S N'hants)	• NHCP supported the iCAN programme (primary care, frailty, discharge, NASS operating model • Mental Health Collaboration – working with VCSE sector through new service delivery models • Delivery of 4 Integrated Care Project sites bringing together wider MDT staff and acute services e.g. ageing well Wellingborough • Social Prescribing at Scale programme • Primary Care training hubs established	• ICAN and accelerating Health and Social Care Integration • Mental Health Collaborative
Domain four: Track Record of Delivery		• Rapid digital transformation through C19 • Evident improvements in the delivery of constitutional standards • One system plan	• Whole system approach to hospital transfer and restoration of services	• Phase 3 Recovery plan submission September 2020
Domain five: Coherent and Defined Population		• STP footprint c770,000 population • Place defined around unitary population footprint • 16 PCN aligned to 4 localities that are coterminous with Unitary footprint	• Shadow unitary councils in place for West and North Northamptonshire	• Developing new geographical footprints in Northamptonshire, including continued learning regarding patient flow as CCG boundary not aligned to local authority boundaries

To be refreshed

Section 6 - Where we are now?

Northamptonshire Health and Care Partnership

Domain	Where are we now?	Required action to progress to 'maturing' by April 2021	Required action to progress to 'thriving' by April 2023
1: System Leadership, Partnerships and Change Capability **SROs: NHCP Chair and Lead**	Medium/Developing	• Further development of system governance – bringing together NHCP and H&WBB to oversee delivery of the Northamptonshire Health, Care and Wellbeing Plan. • Further engagement with system partners and the public on NHCP vision and plan objectives • Primary care team supporting PCNs through Population Health approaches to provision and sub-commissioning and integration with Adult Social Care • Further development of relationships between PCNs and local VCSE groups. • Increasing system awareness of community assets at a system, place and neighbourhood level • Creation of a Clinical Leadership Model and Quality Improvement framework for the system that creates an open and supportive learning culture	• Complete integration of strategic intelligence and commissioning functions at a system level with one multi-professional board (including VCSE sector and local government) overseeing delivery of single strategic system plan • Governance aligned with new geographical arrangements with clear lines of escalation • Fully embedded Clinical Leadership Model that support current leaders and develops talent to ensure sustainable leadership across all sectors • Partners and public fully conversant with system plan(s) and clear on their role in delivering outcomes
2: System Architecture and Strong Financial Management and Planning **SROs: Directors of Finance, Directors of Strategy and Directors of HR/Resources**	Medium/Developing	• Regional teams are embedded in local architecture and plans are in development for greater local ownership • Integrated commissioning hub development being explored, with single business intelligence function using population health approaches underpinning work • Clear MOU between finance teams developed and finance leaders working in a transparent and open way. Plans for achieving a balanced system control total in place and process to identify and mitigate deviation in development (with population health) • System wide plans for workforce, estates and digital infrastructure are being implemented • System is managing resources collectively and is signed up to ICS financial framework	• Development of a tried and tested self-assurance process in place, with clear lines of communication with regional NHSE/I team and other regulators and governing bodies • Streamlined arrangements are embedded encompassing major commissioning and intelligence functions in system • System for sharing financial risk is developed using population health management models to better understand current and future health and care needs, resulting in progress towards balanced system control total • Process to incentivise providers (and potentially public) created to garner support for local objectives/improvements • Workforce support programme is created that delivers economies of scale and improved recruitment and retention of staff • Estates and digital assets are reviewed and streamlined, maximising opportunity to bring

Section 6 - Where we are now?

Northamptonshire Health and Care Partnership

Domain	Where are we now?	Required action to progress to 'maturing' by April 2021	Required action to progress to 'thriving' by April 2023
3: Integrated Care Models **SROs: Chief Operating Officers, Clinical Directors and DPH**	Maturing	• Outline PCN plans being implemented, using neighbourhood profiles to meet population needs and exploring the use of community assets • Delivery of 4 Integrated Care Project sites bringing together wider MDT staff and acute services • Population health management approaches are developed to identify and address unwarranted variation in access and outcomes, to deliver the 5 service changes in the LTP and to design prevention (targeted where needed to address inequalities) into new models of care and existing service lines • Population Health Programme Board matures, cementing plans for investment in, and development of, population health management approaches across the NHCP, allowing greater understanding of the needs of key groups and resource use	• Programme of support developed to fully integrate teams to deliver services closer to home, with appropriate evaluation of impact designed in • Creation of process that regularly creates insights relating to need and resource use at all three geographical levels, thereby allowing services to understand change and respond accordingly • Plan development for the reinvestment of funding/resource released through improved outcomes/efficiencies into preventative/proactive care approaches, thereby further reducing demand • Implementation plan for the 5 services changes rolled out in full, with appropriate monitoring and evaluation in place
4: Track Record of Delivery **SROs: DPH, Intelligence Leads, Directors of Finance and Contracting/Commissioning**	Medium/Developing	• Population health management approaches are developed to identify and address unwarranted variation in access and outcomes, to deliver the 5 service changes in the LTP and to design prevention (targeted where needed to address inequalities) into new models of care and existing service lines • Clear plans are created to address the delivery of constitutional standards to ensure targets attainment is consistently improving without quality of care being compromised • Robust annual system operating plan to be written that clearly links back to the five year plan and demonstrates a collective commitment to financial risk management • Plans to create Provider Alliances at a Place level are being	• Clear outcomes monitoring and reporting framework to be established, with a focus on the delivery of the 5 service changes set out in the LTP and population health outcomes (incl. reduction of inequalities) • System programme of risk mitigation to be developed to ensure the continued delivery of constitutional standards • Financial management and monitoring board established to ensure consistent delivery of system control total

Currently in development

Section 6 - Where we are now?

Northamptonshire Health and Care Partnership

Domain	Where are we now?	Required action to progress to 'maturing' by April 2021	Required action to progress to 'thriving' by April 2023
5: Coherent and Defined Population **SROs: Clinical Directors, VCSE Leaders, Local Authority Responsible Officers, Public Representatives, etc.**	Excellent/Thriving	• Continued support of the development of the new geographical footprints in Northamptonshire, including continued learning regarding patient flow • Further exploration of the relationships with larger geographies (regional, national and international) to develop partnerships with appropriate bodies to extend services (e.g. hyper-specialist provision) and grow local opportunity to engage in research and innovation	• Continued support of the development of the new geographical footprints in Northamptonshire, including continued learning regarding patient flow • Further exploration of the relationships with larger geographies (regional, national and international) to develop partnerships with appropriate bodies to extend services (e.g. hyper-specialist provision) and grow local opportunity to engage in research and innovation

Currently in development

Northamptonshire
Health and Care Partnership

Consistent operating arrangements for ICSs

System functions:

1

- **System capabilities** in place to perform the dual roles of an ICS, to co-ordinate transformation activity and collectively manage system performance, clearly defined at system, place and neighbourhood. These will include areas such as population health management, service redesign, provider development, partnership building and communications, workforce transformation, and digitisation. The system should also agree a sustainable model for resourcing these collective functions or activities. NHSEI will contribute part-funding for system infrastructure in 2020/21.
- **Streamlined commissioning** arrangements, including one CCG per system with clearly defined commissioning functions at system, place and neighbourhood. Formal written applications should be made at the latest by 30 September 2020 for a merger which is proposed for 1 April 2021 (or an agreed date in October by exception)
- **Plans for developing and implementing a full shared care record**, allowing the safe flow of patient data between care settings, and the aggregation of data for population health.

System planning:

2

- **System plans** that reflect the key local recovery, performance and delivery challenges and that incorporate a development plan for the system. This should explicitly reference delivery across the system architecture, i.e. place and provider collaborative(s).
- **Capital and estates plans** agreed at a system level, as the system becomes the main basis for capital planning, including technology.

System Leadership and Governance:

3

- **A leadership model** for the system, that explicitly includes the following:

1. ICS core leadership team including:
a. an STP/ICS leader with sufficient capacity and a non-executive chair appointed in line with NHSEI guidance and with delegated authority from system partners to act on their behalf and for the good of the local population.
b. Sufficient leadership and delivery capacity to carry out the functions above
2. Place leadership arrangements for each place within the system, ensuring that primary care (as a provider) is reflected in these arrangements.
3. Provider collaborative(s) lead arrangements for "hospital systems", ambulance services and "acute mental health systems"

- **System-wide governance** arrangements to set out clear roles of each organisation and enable a collective model of responsibility, and nimble decision-making between system partners. These arrangements will include a system partnership board that sits in public and should be complemented by a public engagement approach that ensures full transparency of decision-making. The system-wide governance arrangements should be underpinned by agreed decision-making arrangements across the system architecture (i.e. place and neighbourhoods/PCNs) and agreements with respect to financial transparency.

Other considerations to be considered as indicators of system maturity:

- Confidence in the system leadership to resolve current performance challenges
- Confidence in reprioritised LTP delivery and recovery plans
- Self-assessment against the ICS maturity matrix
- Key System Transformation priorities for 2020/21

The approach to the ICS designation will be light-touch, interactive, supportive and developmental for systems. The 'ICS Review' is part of a continuous dialogue between systems, regions and national teams, building on the evidence garnered through pre-existing work such as system LTPs, forthcoming recovery plans and on-going business-as-usual discussions between the system and regional team.

There will be four key components to the process:

Submission of draft documentation

The ICS submission should contain the following components:

- A description of how the STP meets each of the ICS operating standards (adjacent) and progress demonstrated in accordance with the maturity matrix ICS maturity matrix.
- A development plan which outlines system priorities for development and how these can be used to tackle some of the systemic challenges to the system.

Check & challenge session(s)-System Review Meetings

- A check & challenge session between the STP (CEO, Chair, system development lead & key partners such as local government rep) and region (RD and members of RLT) to discuss and further enhance the plans.

Submission of final documentation and co-signed letter from STP Execs

- Systems will be asked to iterate the submission in line with the check and challenge conversations and provide a short letter co-signed by each of the STP CEOs in support of the plans outlined in the submission
- A letter signed by all system partners providing a short summary demonstrating how the system is meeting, or is planning to meet, the consistent operating arrangements.

Designation approvals

- ICS designations to be submitted to the Regional Support Group for approvals. Following which these will be presented to the Joint Executive Group. This concludes the designation process.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 26 November 2020
09:30 via ZOOM at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr A Burns	**Verbal.**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal.**
	3.	Minutes of meeting 24 September 2020	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Patient & Staff Vlogs	Receive	Ms S Oke	**Verbal.**
	6.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	7.	Group Chief Executive's Report	Receive	Mr S Weldon	**C.**
	8.	Hospital Chief Executive's Report	Receive	Mrs D Needham	**D.**
PERFORMANCE					
	9.	Integrated Performance Report	Assurance	Mrs D Needham Board Members	**E.**
	10.	Reset and Recovery Phase 3	Assurance	Mr C Holland	**F.**
	11.	Winter Plan	Assurance	Mr C Holland	**G.**
GOVERNANCE					
	12.	Terms of Reference for Joint Committees – Quality & Digital	Assurance	Ms C Campbell	**H.**
	13.	Terms of Reference – Audit Committee	Assurance	Ms C Campbell	**I.**
	14.	Board Assurance Framework	Assurance	Ms C Campbell	**J.**
STRATEGY & CULTURE					

Time	Agenda Item		Action	Presented by	Enclosure
	15.	Fire Plan	Assurance	Mr S Finn	**K.**
	16.	Academic Strategy	Assurance	Mr M Metcalfe	**L.**
	17.	Pathway to Excellence	Assurance	Ms S Oke	**M. Presentation**
	18.	Integrated Care System	Assurance	Mr S Weldon	**N.**
CLOSING ITEMS					
	19.	Questions from the Public (Received in Advance)	Information	Mr A Burns	**Verbal.**
11:50	**20.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on 28 January 2021 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).