UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 28 May 2020

09:30

Via Teleconference
Northampton General Hospital

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

A G E N D A

NHS
Northampton General Hospital
NHS Trust

PUBLIC TRUST BOARD

Thursday 28 May 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 26 March 2020	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	7.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	8.	Chief Executive's Report	Receive	Dr S Swart	**C.**
	9.	Integrated Performance Report	Assurance	Dr S Swart	**D.**
	10.	COVID19 NGH response	Assurance	Mrs D Needham	**E.**
	11.	Reset Plan	Assurance	Mrs D Needham	**F.**
	12.	Infection Prevention & Control Board Assurance Framework	Assurance	Ms S Oke	**G.**
	13.	Future Risks to COVID19	Assurance	Ms S Oke Mr M Metcalfe	**H.**
11:00	**14.**	**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 25 June 2020 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 25 March 2020
09:30 by ZOOM teleconference

Present		
	Mr A Burns	Chairman (Chair)
	Dr S Swart	Chief Executive Officer
	Mrs D Needham	Chief Operating Officer and Deputy CEO
	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 T Richard-Noel	Next NED Scheme
	Mr M Smith	Chief People Officer
In Attendance		
	Mr C Pallot	Director of Strategy and Partnerships
	Ms C Campbell	Director of Corporate Development Governance and Assurance
	Mr S Finn	Director of Facilities and Capital Development
	Ms K Palmer	Executive Board Secretary
Apologies		
n/a		

TB 19/20 109 **Introductions and Apologies**

Mr Burns welcomed those present to the meeting of the Public Trust Board.

TB 19/20 110 **Declarations of Interest**

No new Declarations of Interest were noted.

TB 19/20 111 **Minutes of the Public Trust Board held on 20 January 2020**

The minutes of the Public Trust Board held on 20 January 2020 were presented and **APPROVED** as a true and accurate recording of proceedings.

TB 19/20 112 **Matters Arising and Action Log Public Trust Board**

The Matters Arising and Action Log were considered and noted.

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

TB 19/20 113 **Chairman's Report**

Mr Burns advised that the Non-Executive Directors needed to understand how to best support the Executive Team. He asked the Executive Team to ask for help from the Non-Executive Directors if needed.

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

TB 19/20 114 Chief Executive's Report

Dr Swart reported that in regards to COV- 19 the Trust had been planning intensively for the previous 4 weeks. She hoped that the Trust would be able to deal with the upcoming tsunami and the marathon going forward. She noted that A&E was currently very quiet. There were zero patients in both resus and FIT.

Dr Swart remarked that the hospital was being decongested to make space and the right capacity. The Trust was following infection control best practice.

Dr Swart stated that a key issue was the ventilation of patients. Also PPE and the how this would be received into the Trust. She was keen to get quicker patient and staff testing in place. This would help also with the workforce.

Dr Swart discussed staffing. The Trust had planned for significant staff absence. There was considerable staff anxiety at all levels. In the national news the field hospital in Excel London had been announced. She also remarked that the staff had been amazing.

Mrs Needham was asked how the hospital felt. Mrs Needham explained that every day felt more real. She would be doing a vlog from the Incident Room to share on the daily update. The Trust was learning from what was happening in Italy and Spain. The hospital was relatively quiet at the minute. It was understandably dealing with a large amount of emotion and anxiety from staff.

Ms Gill asked if any retired staff had returned. Mrs Needham commented that there had been a large number of volunteers however she was not aware of any retired staff returning.

Mr Smith informed the Board that the retirees would be coordinated centrally. These would be centrally checked, then placed in their preference area also taking into account geographic needs. Mr Metcalfe had skyped 11 medical students from Leicester and London who would be joining the Trust. Ms Oke confirmed she had also worked with the University of Northampton on the year 2 and year 3 nurses coming into the Trust.

Prof Robinson remarked that at UHL there was 30% of staff in isolation. It currently felt like the calm before the storm and noted the anxiety at the front line. It was apparent that teamNGH were coming together and had been impressed by the communication. He had been invited to join the NGH medical leadership Whatsapp group. Prof Robinson had been incredibly impressed by the Executive Team at NGH. Mr Moore echoed this.

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

TB 19/20 115 Integrated Performance Report

Mr Burns asked if there was anything the Committee Chair's wished to raise.

Prof Robinson advised that the QGC papers had been circulated and these had been detailed. There were no significant issues in the papers that needed to be discussed. He noted the outstanding Medical Examiner survey and understood that this would be done once there is capacity again.

Mr Burns stressed that there should be a minimalist approach to Committees and the papers required in the coming months. He suggested in future weekly updates with the Executive Team.

Mr Moore commented that Finance & Performance had a virtual meeting the

day before. The Committee had been kept up to date with what was happening with COV- 19 and the financial arrangements.

Ms Gill advised that Workforce had been stood down. She suggested that Medical Education deep-dives would be picked up in the April Committee. Mr Metcalfe did not support the deep-dive and the Board believed that this should not be the priority at the current time as training had been suspended.

Mr Archard-Jones reported that at Audit Committee it had been noted that some maverick transactions had been accepted. The Auditors were happy with this as long as Mr Moore and Mr Archard-Jones had oversight.

Mr Bradley remarked that financial governance had to continue however understood the need to be flexible. The financial accounts had been put back. The block payments are expected to be paid 01 April and 15 April. He has agreed with Mr Moore that he would receive regular updates against cov-19 spend.

Mrs Needham informed the Board that Transformation work had ceased as had performance management. There would still be the two weekly Cancer PTLs.

Mr Pallot advised that the Finance & Performance Committee had approved the £200k to provide remote monitoring equipment in the community.

Mr Smith stated that the GMC survey had also been stood down this year.

Mr Burns reported that the CQC had put back inspections by a quarter.

Dr Swart reported that Mr Metcalfe was coordinating the medical workforce for the next 3 months. It was noted that London and Birmingham had ceased all training posts.

Ms Houghton asked if the Trust was coordinating its communication with KGH. Dr Swart confirmed ideas were shared with KGH.

Mr Burns stressed that his first priority was minimising the demand on the Executive Directors. Dr Swart concurred with this.

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

TB 19/20 116 Emergency Preparedness Annual Report inc Winter Plan

The Board **NOTED** the Emergency Preparedness Annual Report inc Winter Plan.

TB 19/20 117 Covid-19 update

Dr Swart thanked the team formally for everything they had done over the past few weeks.

Mrs Needham advised that from 02 March 2020 daily SILVER meetings commenced with initial two weekly GOLD meetings. On 16 March 2020 the Incident Room was planned followed by it going live 20 March 2020.

Mrs Needham stated that it followed the EPRR principles. There were 17 bronze cells. The lead of these cells is reported to Silver via daily teleconference. This is currently in place Monday to Friday and is likely to extend to 7 days. There is now GOLD in place daily in which the CEO and

COO attend.

Mrs Needham explained that Silver is split into three groups and these included Directors, deputies and general managers. These three groups are headed by the COO, the Medical Director and the Director of Nursing. The groups run a 7 day stretch and the Incident Room is open 7 days 8am to 8pm. This was detailed in the circulated paper.

Mrs Needham reported that the plan was to send cancer patients to Three Shires for surgery to minimise risk. At current Walter Tull, Esther White and Creaton are the isolation wards. The issue was that the results could take up to 5 days to receive results.

Mrs Needham commented that there was an outpatient cell which was working with every specialty to see what could be postponed. This was variable. There was a staff cell, providing advice for staff with anxiety and also helping with the recruitment of volunteer staff. The car park would now be free on site for staff. The rest of the site was closed to the public. There would be no visiting unless for end of life patients, maternity and paediatrics. There were currently 200 staff working from home.

Mrs Needham advised that there were issues with PPE and stock as there have been limited deliveries. She gave the example of when 200 hand sanitisers had been ordered and only half had turned up.

Mrs Needham stated that staff anxiety is high. There had also been some challenging behaviours noted.

Mrs Needham shared with the Board that there are 16 critical care beds which can increased to 38. The pods from Theatres can also be used. The Trust has been asked to multiply this capacity by three. Ultimately, the Trust can accommodate up to 70 level 3 ventilation beds.

Mrs Needham stated that there are 377 staff isolating. There are 20 patients positive. There had been two deaths.

Dr Swart remarked that she and Mr S Weldon (CEO at KGH) have had discussions on capacity. The Commissioners are also looking at the capacity outside of the hospital. Dr Swart advised that there was 140 empty beds in the hospital yesterday. There are however still a number of patients who have been in hospital over 21 days and the Trust is trying to get the long stay patients discharged.

Dr Swart summarised that the key issues for NGH were the same as those reported nationally. The lack of PPE, staff testing, support for staff and ventilators.

Mr Burns asked Mr Metcalfe regarding ethics support. Mr Metcalfe was leading an ethics cell. He had utilised work from a Medical Director at another Trust and was waiting on national guidance.

Mr Richard-Noel queried the bleep system as issues with this had been previously reported and also the mortuary capacity. Mrs Needham clarified that the mortuary capacity was reasonable at current. The Trust has made a contingency for an additional 20 spaces and anything above this would be CCG responsibility. Mrs Needham confirmed that the black bleeps had changed to white bleeps. These were more resilient and had a better connection. The backup would be to use the radio.

Mr Burns asked about the Oxygen resilience. Mr Finn commented that there were two VI tanks which had a large amount of capacity. The calculations had been done and he believed these to be satisfactory. Dr Swart had asked for an additional cylinder for oxygen.

Mr Burns request further clarity on the use of Three Shires. He was informed that this would be predominantly cancer patients and the blood taking unit. This would limit the number of patients on site. Mr Metcalfe also remarked that some minor trauma may go to Three Shires also.

Ms Campbell reminded the Board of the Business Continuity Terms of Reference that had been circulated the day before. This allowed the Board to use emergency powers as stated within the Standing Orders (4.1) and proposed these be reviewed in June 2020. The Board **APPROVED** the Business Continuity Terms of Reference.

Mr Archard-Jones asked for an update on the programme of support between NGH and KGH. Dr Swart confirmed that there were regular phone calls between KGH, NGH and UHL.

Ms Kirkham noted the slow turnaround of results and asked whether this would speed up. Mrs Needham remarked that the time had reduced from 5 days to 3 days however had now gone back up to 4 days. The swabs needed to be sent to Birmingham. There had been a suggestion for these swabs to go to Leicester however Leicester was now struggling with their own. The Trust hoped to get kit on site. Prof Robinson further expanded and advised the Board that the Leicester machines had been commandeered by the Army. These had been sent to Milton Keynes.

Mr Smith stated that it was important to stick behind the teamNGH mantra. It was becoming hard to manage the anxiety in both Trusts.

The Board were reminded of the importance to not believe all urban myths or rumours that were circulating.

Mr Burns asked that a weekly catch up via telephone conference was set up between the Executive Director for Silver that week and the Non-Executive Directors. This would be to talk exclusively about COV- 19.

Action: Ms Campbell/Ms Palmer

The Board **NOTED** the Covid-19 update.

TB 19/20 118 Staff Survey Results

The Board **NOTED** the Staff Survey Results.

TB 19/20 119 NGH Improvement Plan

Ms Campbell reported that Mr Metcalfe had contacted the CQC in her absence to advise of a delay of all deadlines within the plan by 3 months at this time.

The Board **NOTED** the NGH Improvement Plan.

TB 19/20 120 Capital Plan

The Board **NOTED** the Capital Plan

TB 19/20 121 Any Other Business

Dr Swart advised once Benham had been updated it could be used for respiratory support patients.

Mr Burns stated that it was remarkable what had been done to date. He was happy to convene in the best way possible if things are needed to be approved. Mr Burns reminded the Non-Executive Directors to minimise what the Executive Team needed to do in relation to papers. He again commended the remarkable effort by all.

Date of next meeting: Public Trust Board - Thursday 28 May 2020 at 09:30 in the Board Room at Northampton General Hospital.

Public Trust Board Action Log **Last update** **08/04/2020**

Item No	Month of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Updates
Actions - Slippage								
Actions - Current meeting								
121	Mar-20	TB 19/20 117	Cov-19	Mr Burns asked that a weekly catch up via telephone conference was set up between the Executive Director for Silver that week and the Non-Executive Directors. This would be to talk exclusively about COV- 19.	Ms Campbell/Ms Palmer	Apr-20	On Agenda	**confirmation given that this was actioned**
Actions - Future meetings								
120	Jan-20	TB 19/20 100	Agency Staff Governance	Mr Burns asked for an update at a future Board.	Ms Oke/Ms Curtis	TBC	TBC	

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Report To	**Public Trust Board**
Date of Meeting	**28 May 2020**

Title of the Report	**Chief Executive's Report**
Agenda item	**8**
Presenter of Report	Dr S Swart, Chief Executive
Author(s) of Report	Dr S Swart – Chief Executive Mrs S-A Watts – Associate Director of Communications

This paper is for:	
✓ 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 report highlights key business and service issues for Northampton General Hospital NHS Trust in recent weeks.

Related Strategic Pledge	Which strategic pledge does this paper relate to? *ALL*
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) 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)
Financial Implications	None
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 the contents of report.

UNIVERSITY OF LEICESTER
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Public Trust Board
28 May 2020

Chief Executive's Report

1. COVID-19

Our response to COVID-19 remains the key focus at NGH and is likely to remain so for the foreseeable future .There are three papers updating progress on this Board agenda. The key elements of our strategic approach to COVID were discussed at the last Board of Directors meeting and the situation remains extremely challenging

The immediate health and care response to CVOID-19 has been exceptional across the health and care sector in the UK and the outbreak has changed the way we work bringing in significant transformation occurring despite the immense pressure. For that reason there is an overwhelming national realisation that this is the time to rebuild the NHS

We continue to care for patients with COVID at NGH and although the numbers are not as high as they were during April the response still requires significant modifications with respect to the way our hospital operates. It is important to note that we have continued our 7-day-a-week executive led incident response team for Covid-19 with a focus on devolved ownership and responsibility in the supporting bronze cells. This incident response structure has worked effectively to manage the impact of Covid-19 for our patients and our staff during all the phases of COVID to date. We have been able to respond well both clinically and operationally to the needs of critically ill COVID patients as well as to patients requiring other urgent and emergency care and cancer during the COVID response and we have been able to continue much of our Outpatient work.

We have also now put in the plans to lead us into restoration, reset and redesign of services. We aim to continue to harness the enthusiasm and commitment of the staff who planned and worked through the COVID plans from the beginning so that they can use their learning and enthusiasm for transformation as they plan the next phase of our response to COVID. We are following the national guidance asking us to consider how some services can be safely re-instated whilst we retain an ability to respond to further surges in COVID

Our staff have shown a commendable and often outstanding willingness to lead and to adapt and change , developing new ways of working at pace. We are determined to learn from the changes made and to keep the key successful elements of the new ways of working in place as we move into our next phase of planning. This response has been evident from our frontline clinicians, all our support staff and our managers

There are many aspects of our COVID response, which have been highlighted as priorities for the future. These include making the best use of working from home and remote solutions for outpatients as well as capturing the best way of providing full seven- day services. We have also had a very strong focus on staff health and well-being during the COVID response and plan to strengthen this as we move through this next challenging phase. We also know that our staff have hugely appreciated our daily communications and we aim to keep that going in the next phase of our response

As we move through the phases of COVID it is becoming increasingly clear that testing for COVID both for staff and patients will become more and more critical.

We have been supporting all measures to allow us to access suitable testing for both patients and staff. In terms of staff testing were able to set up a swabbing/testing station within a matter of days that has tested more than 5000 people to date, including members of TeamNGH, staff from KGH, NHFT, St Andrews, the Fire Service, Police, Council and wider health and care community. We have also supported local patient testing and our lab and Microbiology Consultant team have worked exceptionally hard to support these endeavours. We are exploring collaborations with nearby labs to increase our resilience.

There is outstanding work across all the areas of our COVID response – it is a tale of heroes – many unsung. It is worth noting that our supplies team working closely with our infection control team has worked tirelessly to ensure that our staff have access to adequate supplies of PPE, and that we have been able to access all the items of appropriate equipment needed across the hospital. Protecting staff and patients from infection will continue to be important during the reset period and is supported by the COVID testing in place. There will continue to be challenges in this area. We normally use around 100000 surgical facemasks a year. We are now using about 50,000 surgical facemasks a week

Our Kindness and communications teams have managed more than 300 donations and acts of kindness by members of the local community. Last week we began to receive 100 BOOST ward packs each weekday from Salute the NHS for distribution to key wards and departments, and will continue until the end of July. This is in addition to the numerous donations of food and meals; support from Meals for Heroes, thousands of Avon products, donations from TUI and other external organisations. None of this could have been achieved without many members of TeamNGH going above and beyond what would normally be expected of them in their roles. Our PALS and bereavement team have a bereavement tree and book of remembrance for all patients who have died from Covid-19 and have supported our initiatives with relatives. In addition to our employed staff many volunteers have supported this and other initiatives.

With the support of the Northamptonshire Health Charity members of the public have been able to show their support and donated a number of gifts for patients, including mobile devices so that they can stay in touch with relatives who are unable to visit. The support from our local community, our local health and care partners , local government and Universities our own volunteers as well as national schemes has been outstanding and has been a great boost to morale and we will in due course find a way of thanking everyone

Our HR and OD team, with support from colleagues, have set up NGH Our Space in the former blood-taking unit. This is a space where members of TeamNGH can go for some quiet time away from the pressures of the workspace. There is information there about accessing the support that is available for those who need it. The NGH Supporting our Staff team continue to be a vital part of our psychological support offer and we will be extending this in the coming months. Our work in this area has been outstanding.

Staff and patient anxiety remains high whilst there is still no vaccine for COVID, while there are still significant numbers of CVOID positive patients and while some individuals have underlying risks factors .We have been working with managers across the Trust to ensure that staff members are risk assessed and given appropriate advice. There has been a particularly focus on staff from a BAME background and we are taking measures to offer specific support to any individuals raising concerns

It remains important to remember the human cost of COVID in terms of human suffering, risks to quality, safety, and deaths. Moving into the next phase of our response we will continue to adopt a risk based approach to decisions and increasingly this will be shared across our health and social care economy as we work with primary and social care. In keeping with the national picture, around 60% of patients requiring admission are safely discharged but sadly around 40% of patients do not survive despite our best efforts. This is in line with the national picture.

Sadly, we in early April we lost a member of our TeamNGH. Joanna Klenczon was a domestic supervisor who had been with us for just over ten years. She was a much liked and well-respected member of the team who will be sadly missed by all who knew her.

2. TeamNGH

Despite the challenge of dealing with the coronavirus outbreak, there has been time for some moments of joy and celebration. During May we celebrated the International Day of the Midwife, ODP Day and International Nurses' Day.

Each Thursday evening members of TeamNGH have taken part in the 8pm #Clap for our Carers' and have been supported by members of the ambulance, police and fire service.

Our new deputy director of midwifery won a national midwifery award for her work to transform midwifery services.

Trish Ryan, who joined NGH earlier this year, won the Royal College of Midwives Leadership Award for work in her previous role, at the Luton and Dunstable hospital, to improve services and the quality of care for women.

The prestigious award recognises someone who demonstrates excellent leadership in maternity services and someone who strives to make improvements or changes to benefit families. She was recognised for her work to strengthen maternity services and her implementation of initiatives designed to improve care and outcomes for women and babies. We are delighted that Trish has joined us and look forward to working with her to further improve our maternity services.

Last week one of our paediatric secretaries retired after 50 years' service to NGH completed without a single day sick leave .Linda Warren was an integral part of the paediatric team and was well known for her exceptional and kind commitment to our patients and to the paediatric team as well as for her efficiency . She will be sorely missed and everyone will be keen to learn the secret of her excellent health

3. Returning to a ' New Normal'

There is uniform agreement that the disruptive impact of COVID however difficult and challenging it has been has brought and energy an enthusiasm for change which has galvanised a desire the rebuild the NHS. This is already forming the basis for a new

conversation across the NHS. The themes of this centre around an understanding that clinical services need to be realigned locally whilst new ambitions for what the health and care system should achieve need to be defined. Some key components of this will need to redefine how health and social care will operate and under what form of system architecture. It seems inevitable that there will be a campaign to reform social care to ensure that it receives as much support as the NHS as part of this broader reform

4. Celebrating Success

During COVID there have been many outstanding contributions from staff and volunteers and many examples of individuals providing exceptional service. There have also been a host of contributions from organisations and individuals outside the hospital and an outpouring of support for NGH and the NHS generally. We will need to find meaningful ways of recognising all the amazing contributions in a way that is fair, equitable, and suitably celebratory. Much of this will need to wait until after COVID but staff recognition mechanisms will need to be developed as the response to COVID continues through the next phase. As in many situations, the leaders that have emerged are usually also supported by some steadfast followers and all of these deserve to be recognised.

From a personal perspective, I would like to thank all our staff for their outstanding efforts and also pay tribute to all our supporters in our communities. As well as a hospital response, this has been a health and care response, a public service response and a community response.

Dr Sonia Swart
Chief Executive

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Report To	**Public Trust Board**
Date of Meeting	**28 May 2020**

Title of the Report	**Integrated Performance Report**
Agenda item	**9**
Presenter of Report	Sonia Swart (CEO)
Author(s) of Report	Sean McGarvey (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 target, 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 – 1.2
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: May 2020
Reporting Period: April 2020

Northampton General Hospital NHS
NHS Trust

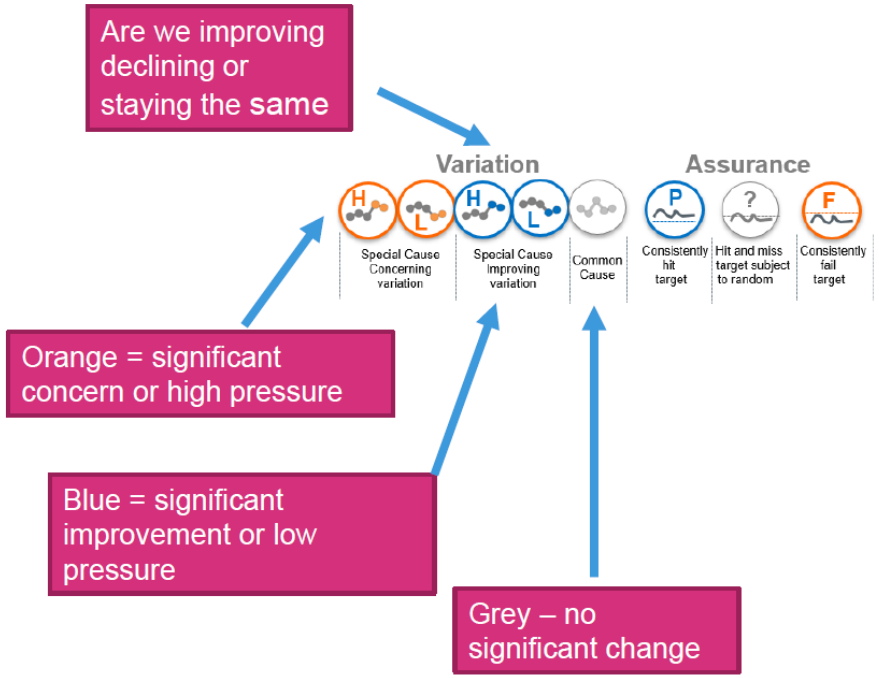
Pilot SPC Charts

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:	Mar-20	Apr-20	Chart
Caring	Compliments	N/A	3,278	N/A	

Domain	Metric	Target	Variation	Assurance	Chart
Effective	Length of stay - All	4.2	No Update due to Covid-19		Page 9
Effective	Percentage of discharges before midday	25%			Page 10
Effective	# NoF - Fit patients operated on within 36 hours	80%	Outside Control Limits		Page 15
Effective	Maternity: C Section Rates	29%			
Effective	Mortality: HSMR	106	No Update due to Covid-19		
Effective	Mortality: SHMI	109			
Effective	Stranded Patients (ave.) as % of bed base	40%	Outside Control Limits		Page 11
Effective	Super Stranded Long Stay Patients (ave.) as % of bed base	25%			

Domain	Metric	Target	Variation	Assurance	Chart
Safe	HOHA and COHA (C-Diff > 2 Days)	3	No Update due to Covid-19		
Safe	MSSA > 2 Days	1			
Safe	VTE Risk Assessment	95%	Outside Control Limits		Page 27
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%	Outside Control Limits		Page 16

Safe Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Mar-20	Apr-20	Chart
Safe	Never event incidence	0	0	2	
Safe	Number of Serious Incidents (SI's) declared during the period	N/A	0	6	
Safe	MRSA > 2 Days	0	0	0	
Safe	New Harms	<=2%	2.8%	1.3%	
Safe	Appointed Fire Wardens	>=85%	100.0%	100.0%	
Safe	Fire Drill Compliance	>=85%	92.0%	90.9%	
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%	Outside Control Limits	?	Page 12
Responsive	Average Ambulance handover times	00:15:00	Outside Control Limits	?	Page 13
Responsive	Ambulance handovers that waited over 30 mins and less than 60 mins	25		F	Page 14
Responsive	Ambulance handovers that waited over 60 mins	10		?	
Responsive	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	L	?	
Responsive	Delayed transfer of care	23		?	
Responsive	Average Monthly DTOCs	23	Outside Control Limits	?	Page 17
Responsive	Average Monthly Health DTOCs	7	Outside Control Limits	?	Page 18
Responsive	Cancer: Percentage of patients treated within 31 days	96%		?	

Domain	Metric	Target	Variation	Assurance	Chart
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%		?	
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%		?	
Responsive	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	Outside Control Limits	F	Page 19
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	L	?	
Responsive	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	99%		?	
Responsive	Stroke patients spending at least 90% of their time on the stroke unit	80%	L	?	
Responsive	Suspected stroke patients given a CT within 1 hour of arrival	50%		P	

Responsive Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Mar-20	Apr-20	Chart
Responsive	RTT Average wait incomplete pathways	<=10.9	9.3	N/A	
Responsive	Unappointed Follow Ups	=0	6,302	7,230	
Responsive	Cancer: Faster Diagnosis Standard	>=63%	0.7	N/A	

Domains: Well Led

Domain	Metric	Target	Variation	Assurance	Chart
Well Led	Income YTD (£000's)	0%	Outside Control Limits	?	Page 21
Well Led	Surplus / Deficit YTD (£000's)	0%	Outside Control Limits	?	Page 22
Well Led	Pay YTD (£000's)	0%	Outside Control Lits	F	Page 23
Well Led	Non Pay YTD (£000's)	0%	L	?	
Well Led	Bank & Agency / Pay %	7.5%	Outside Control Limits	F	Page 24
Well Led	CIP Performance YTD (£000's)	0%	Outside Control Limits	?	Page 25
Well Led	Sickness Rate	3.8%	No Update due to Covid-19		

Domain	Metric	Target	Variation	Assurance	Chart
Well Led	Staff: Trust level vacancy rate - All	9%	No Update due to Covid-19		
Well Led	Staff: Trust level vacancy rate - Medical Staff	9%			
Well Led	Staff: Trust level vacancy rate - Registered Nursing Staff	9%			
Well Led	Staff: Trust level vacancy rate - Other Staff	9%			
Well Led	Turnover Rate	10%			
Well Led	Percentage of all trust staff with mandatory training compliance	85%			
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%			

Well Led Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Feb-20	Mar-20	Chart
Well Led	CIP Performance - Recurrent	N/A	38.3%	N/A	
Well Led	CIP Performance - Non Recurrent	N/A	57.5%	N/A	
Well Led	Percentage of all trust staff with mandatory refresher fire training compliance	>=85%	83.4%	N/A	

Directors view – Director of Nursing

The focus since the last Board report remains to provide the 'Best Possible Care' to our patients in response to Covid 19. A significant amount of work has been undertaken to address this, noting especially the changes we have had to make to our daily way of working in the Trust, which includes the temporary suspension of visiting times and staff absences which have necessitated our staff to work differently. Other notable issues to highlight are:

Infection Prevention / Personal Protected Equipment – We have used national guidance to ensure that we have been able to consistently provide adequate volumes of appropriate PPE for our staff and patients. This has not been without challenge at times and we have used our networks and mutual aid to support. There has been good collaboration with the IPC team at KGH to develop shared practices and joint policies.

Volunteers – Additional ward and response volunteers have been 'employed' since the outbreak, they are undertaking an invaluable role supporting our staff and patients including the communication with family initiatives as outlined below, patient property drop offs to wards and many other ad hoc requests.

Communication with Families – A number of initiatives were initiated from early on in the pandemic which have been hugely appreciated by both patients and their loved ones including:

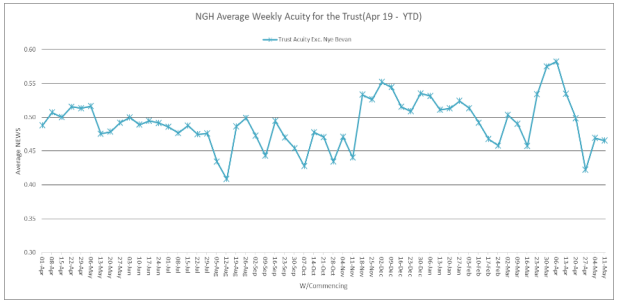
- A 'relatives helpline' for family members to call for an update on their loved one
- Electronic devices now available on all wards to enable patients to communicate directly with friends/family.
- 'Letters to Loved Ones' gives an opportunity for messages to be sent in electronically, these are printed daily and taken to the wards by our volunteers
- 'Connected Hearts' which allows for a lasting end of life connection with a deceased relative

Patient Feedback – Although the Friends and Family testing has been temporarily suspended, we recognise the opportunity now to explore how we can collect patient feedback as our services are reset. We have already started exploring the opportunity to obtain real time patient feedback as part of virtual outpatient appointments.

Directors view – Chief Operating Officer / DCEO

Performance - A&E 4hrs

- Performance Improved in April 2020
- Emergency activity both AE attenders and emergency admissions was significantly reduced due to covid-19 as part of the national lockdown.
- Stranded patient numbers reduced in month due to the system focus on releasing capacity.
- The timings of patients arriving at AE did not differ from previous months.
- Those in the age group 85+ contributed to the highest cohort of AE attenders.
- Numbers of stranded patients reduced as a system effort to swiftly discharge patients took place during March & April to as part of the preparations for the response to covid-19.
- The acuity graph below shows the increased acuity during the pandemic in April.



Cancer waiting times

- 62 day performance increased in month (March)
- Performance will deteriorate in April and May due to the numbers of patients who have been held on the pathway waiting diagnostic procedures.
- A large number of patients throughout April and May are refusing to attend to have diagnostics and/or treatment.
- There are currently in excess of 170 patients on the tracking list who have breached 62 days, many are not diagnosed.

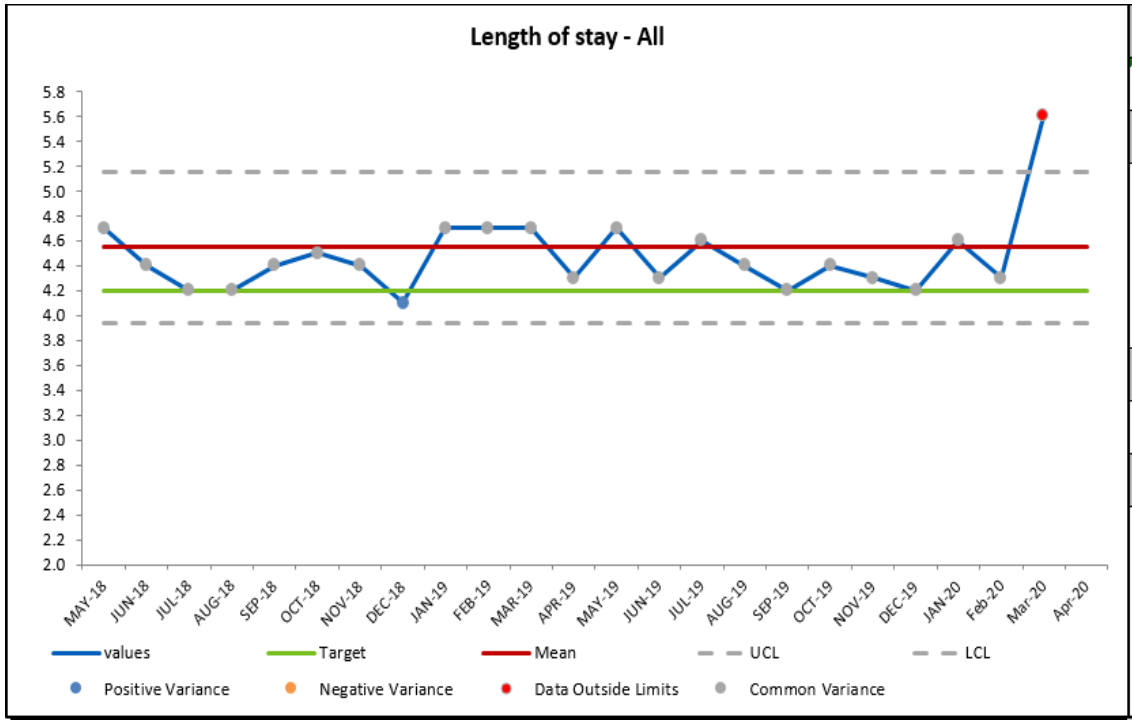
Actions being taken:

- 2 x weekly PTL meetings have continued throughout the pandemic.
- Endoscopy is starting to take place.
- Urgent cancer operations have been taking place at NGH and a local private hospital.
- Modelling is now taking place to plan recovery however this is challenging due to many variables relating to covid-19.
- Cancer is included as part of the Trusts reset programme.

Elective care (RTT)

- With the onset of the Covid-19 pandemic, a sharp reduction in the RTT incomplete pathways has been noted, this is mainly due to EReferrals being switched off during April & May and validation of the waiting list.
- The over 18 week breaches continue to climb, with a number of 52 week breaches now showing as a result of the need to cancel most elective activity.
- Elective activity is planned to restart this month.
- NHS elective operating at the local private hospital will continue throughout the year.

SPC Charts – Length of Stay all admission methods



Apr-20
#N/A
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
4.2
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

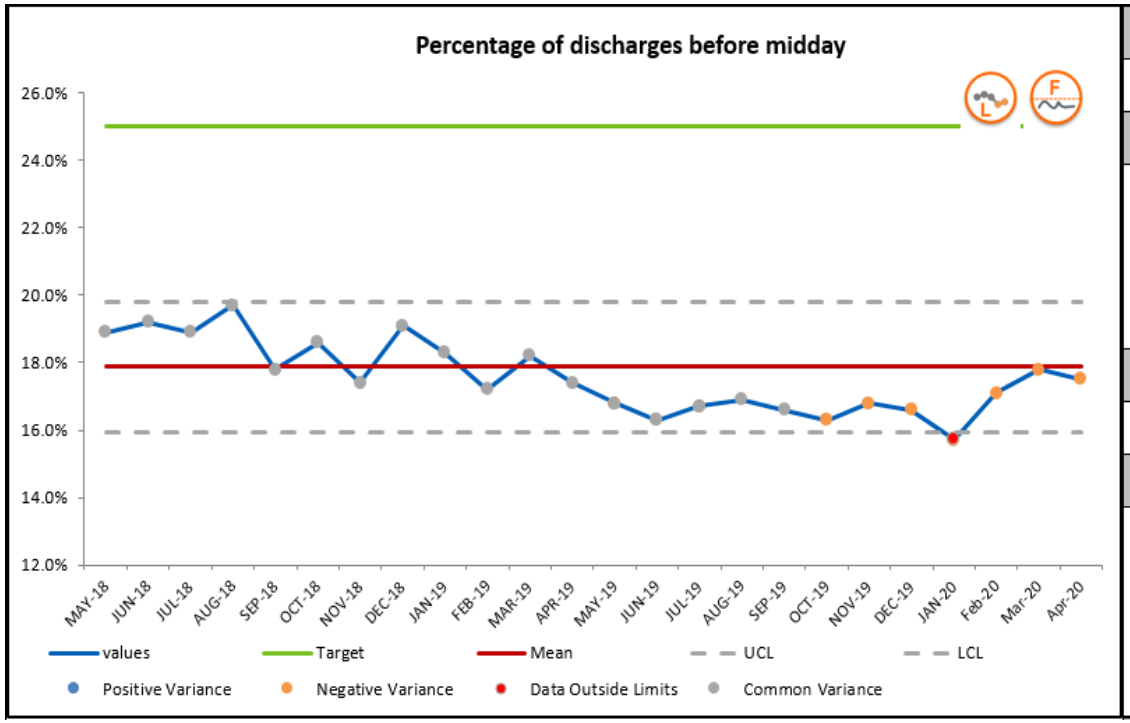
Context:

At the start of the covid-19 pandemic, a whole system response was put into place to swiftly transfer patients. The LOS is taken from patients discharged and as such many long stay patients were rapidly discharged, increasing the overall LOS.

Actions:

- None

SPC Charts – Discharges by Midday



Apr-20
18%
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:

- None

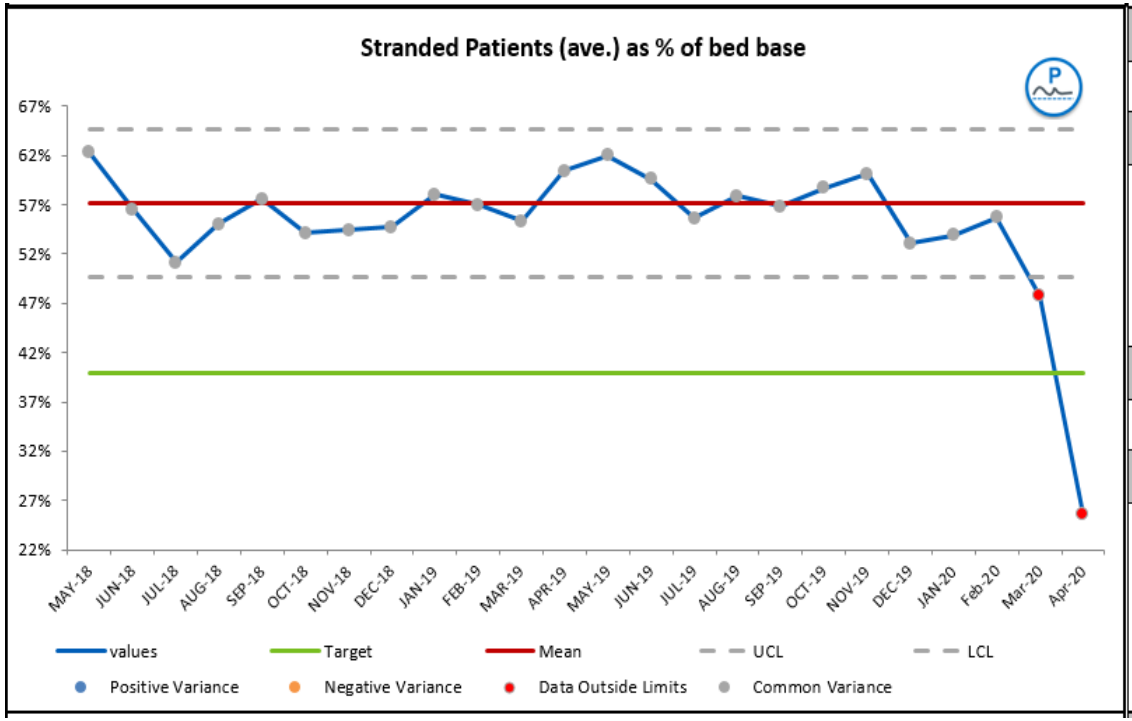
Context:

• Current performance of 17.5% discharges against a target of 25%
The above performance figure has been maintained during the pandemic despite the huge workforce and patient acuity challenges
• Junior doctor gaps delays the timely production of EDN's and TTO's
• Ambulance provider has a 2.5 hour window for collection if the transport is booked on the day
• Many care packages and rehab community beds are notified to the trust on the day they become available so transport cannot be booked prior to the notification

Previous Actions:

• With a huge push on discharge to create 300+ empty beds in the preparation for COVID the issue of patients being discharged by midday has not been the main focus of attention.
• Flow has been maintained and Favel House has been opened to take COVID positive patients waiting to return to their care homes

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



Apr-20
25.6%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
40%
Target Achievement
Metric is consistently achieving the target

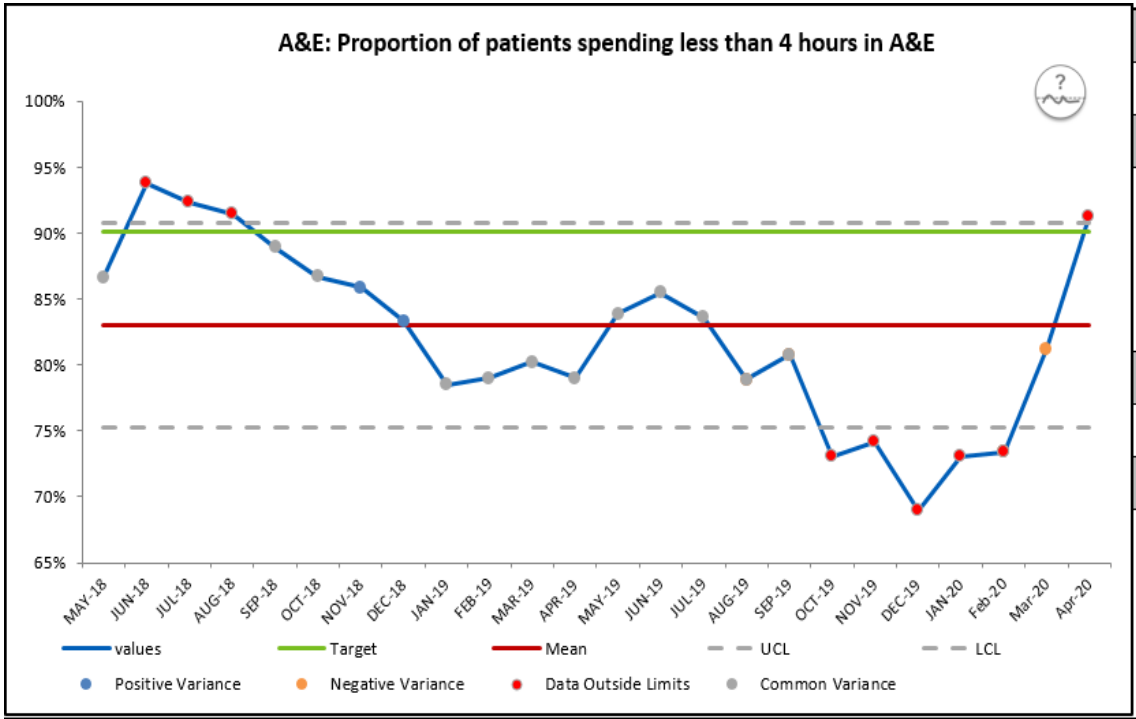
Context:

At the start of the covid-19 pandemic, a whole system response was put into place to swiftly transfer patients. This was done to ensure enough beds on the hospital sites were available for the potential covid admissions.

Actions:

A provider demand & capacity plan is being developed along with modelling for social care to ensure additional capacity is provided and stranded patients do not increase once activity increases to normal levels.

SPC Charts – A&E: Proportion of patients spending less than 4 hours in A&E



Apr-20
91.2%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
90.1%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:

As occupancy reduced in the organisation to prepare for the high numbers of covid patients, patient movement through AE and into the organisation was much quicker.

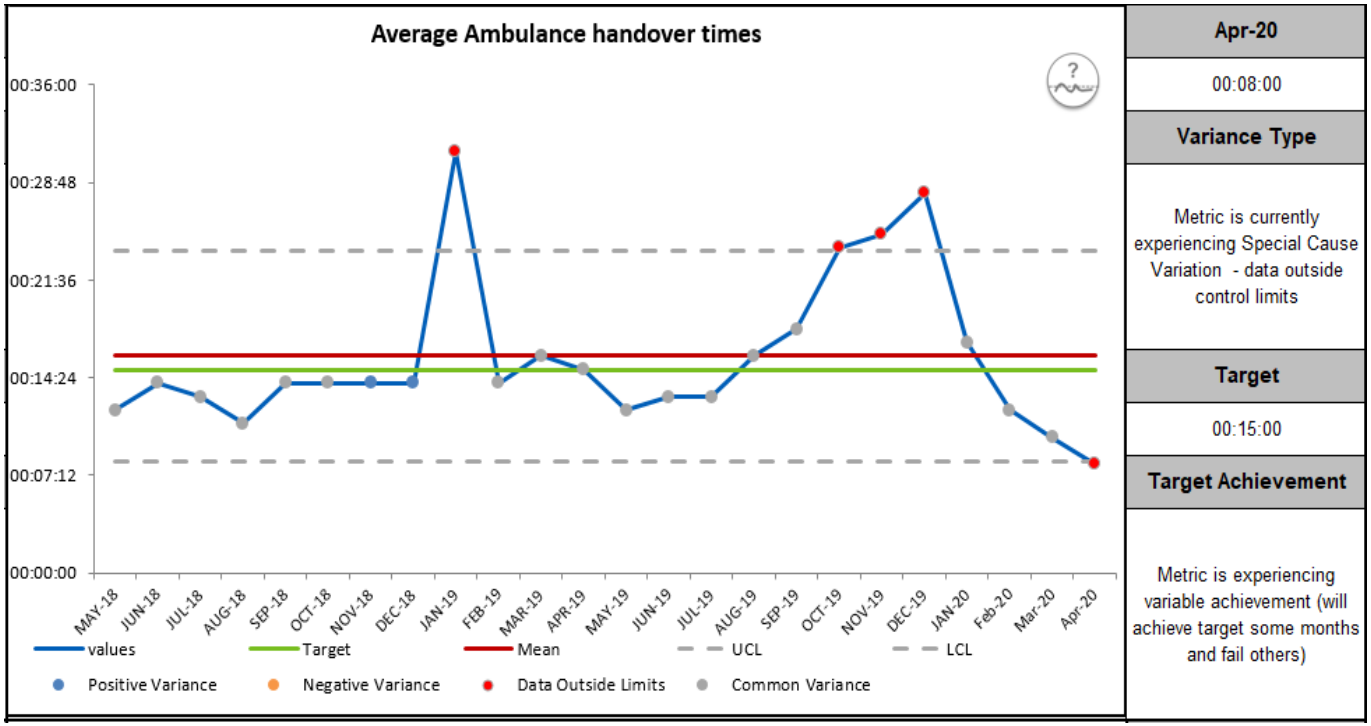
The number of attendances to AE decreased also by up to 50% on most days during lockdown.

Full detailed activity analysis is show in the response paper.

Actions:

Actions being taken to ensure performance is sustained are highlighted in the reset paper

SPC Charts – Average Ambulance Handover Times

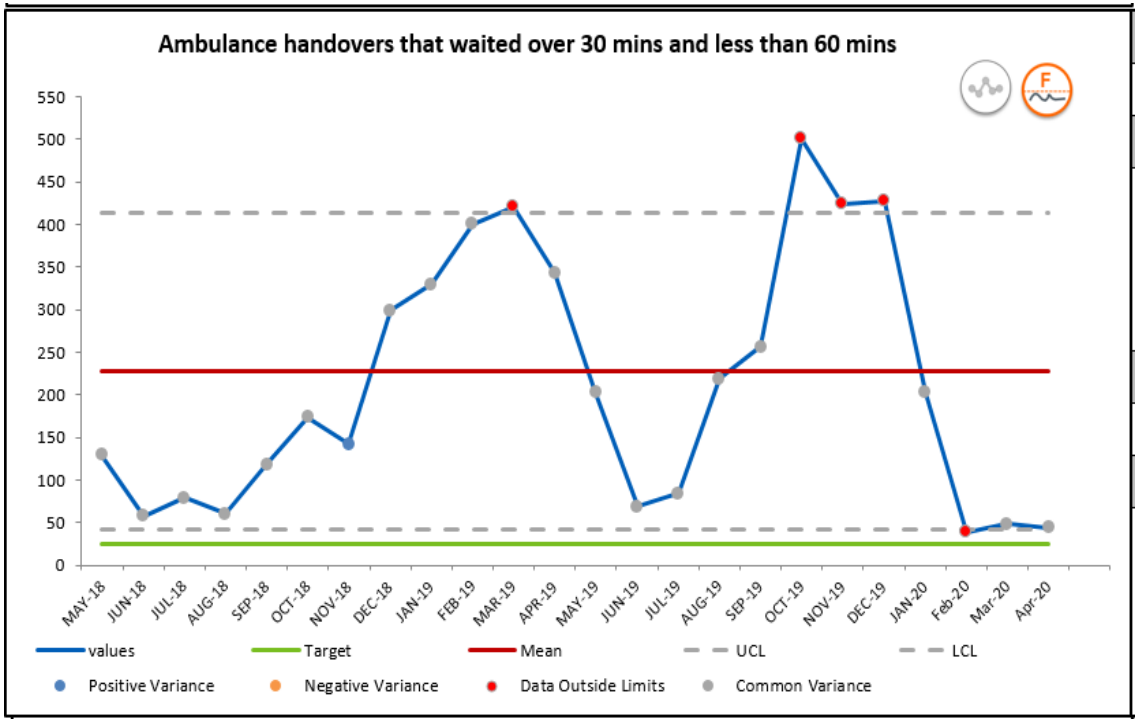


Apr-20
00:08:00
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
00:15:00
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:
Ambulance Handover times continue to improve and are better than national target

Actions:

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



Apr-20
44
Variance Type
Metric is currently experiencing Common Cause Variation
Target
25
Target Achievement
Metric is consistently failing the target

Actions:

- Resus Area to re-open as an 'open' area and will enable Fit Stop to increase trolley availability for ambulance off loads.

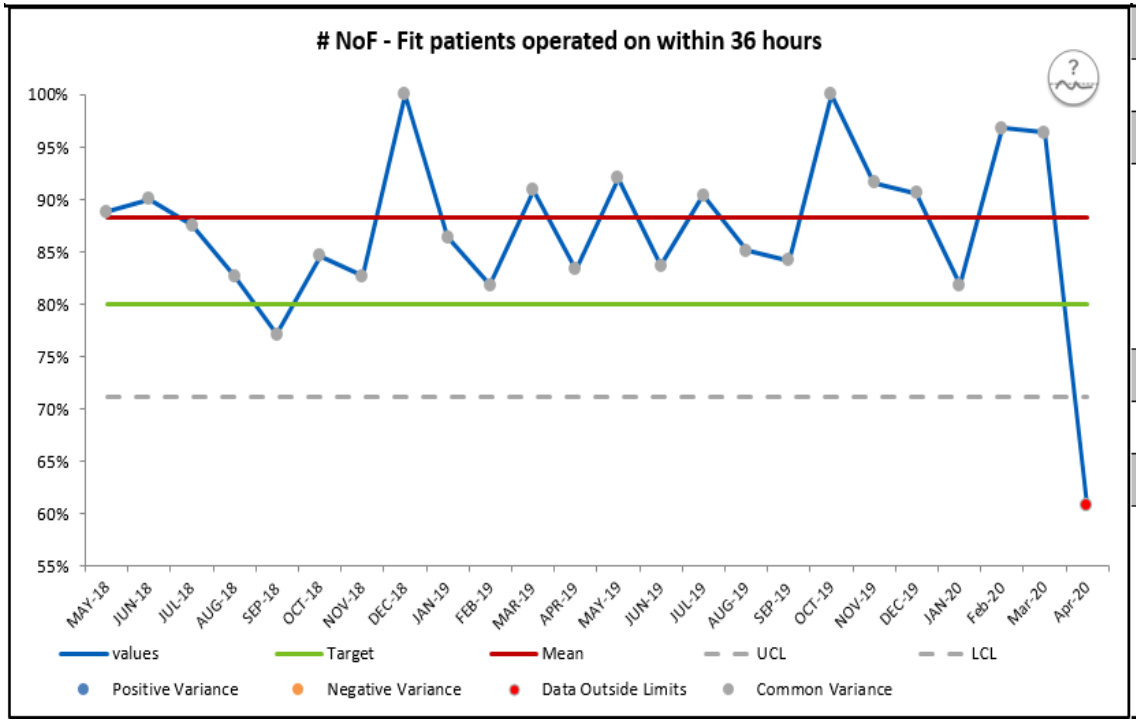
Context:

- Performance has significantly improved since mid Jan 2020,.Data quality issues with EMAS remains an issue which has been escalated. Realistically, a target of 25 >30-60mins in any given month will be particularly challenging as this is a tolerance of less than 1 a day, when we receive almost 100 ambulances per day. Although conveyance rate continues to decrease due to national Pandemic the amount of time taken for teams to handover due to the Personal Protective Equipment requirements and appropriate areas for patients will have an adverse effect.
- The use of Fit Stop as a 'clean Resus' area decrease overall availability of trolley space for ambulance off loads – however there was a 9% decrease on number of >30 mins compared with March 2020.

Actions Completed:

- Corridor use remains for departing patients when required to create capacity.
- Expectations of Nurse in Charge role has been addressed to highlight importance of Ambulance monitoring.
- Dedicated Information and ED team to 'deep dive' EMAS data – daily communication with EMAS to challenge any non-sign off from ambulance crews.

SPC Charts – #NoF – Fit Patients Operated on Within 36 Hours



Apr-20
60.7%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
80%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:

- There were 11 patients deemed fit for surgery but no operated on within 36 hours due to:
- 1. 5 x Lack of time
- 2. 4 x No space on list
- 3. 1 x patient awaiting CT chest
- 4. 1 x equipment needed to be ordered

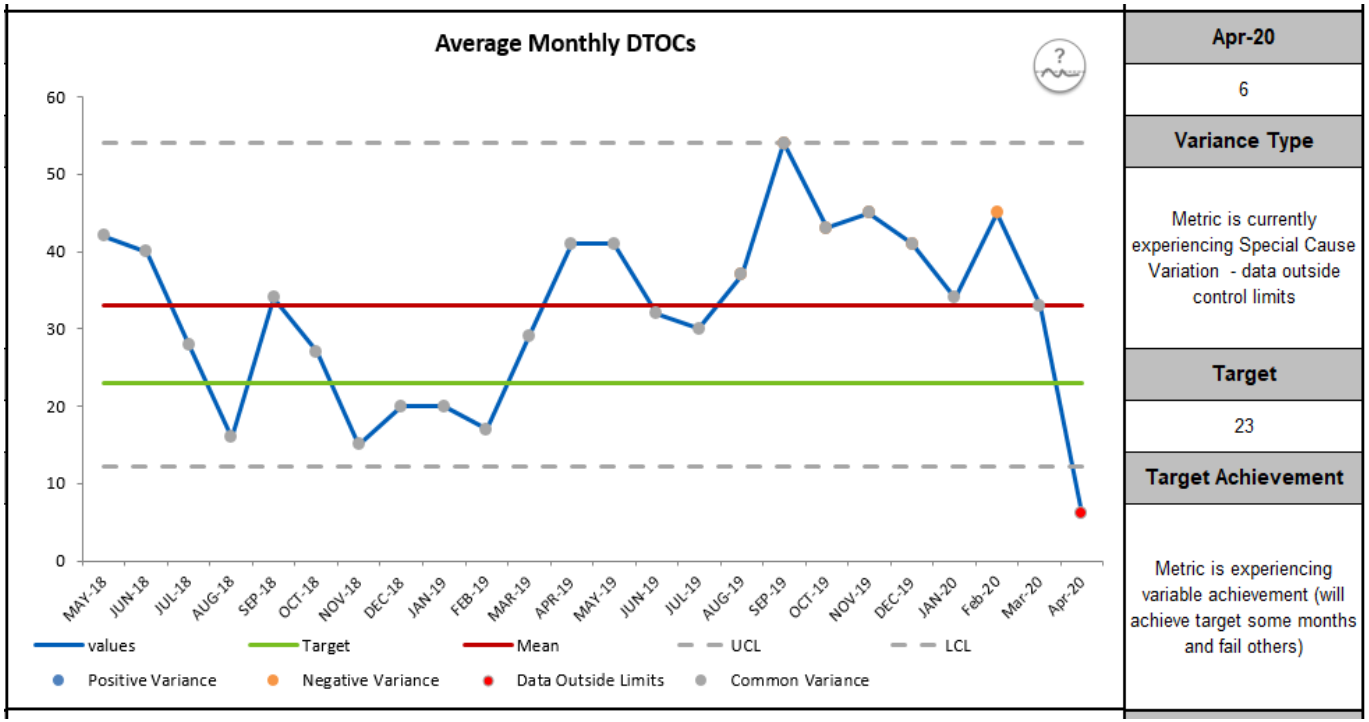
Actions Completed:

- Audit undertaken to understand reasoning.
- Additional trauma capacity put on to meet peaks of demand. This is continually reviewed.

Actions:

- CD and DD written to with details of audit and asked to communicate to orthopaedic consultants about clinical need to ensure we prioritise surgery within 36hrs as it is clinically beneficial - 22/5/2020

SPC Charts – Average monthly DTOCs



Apr-20
6
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
23
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

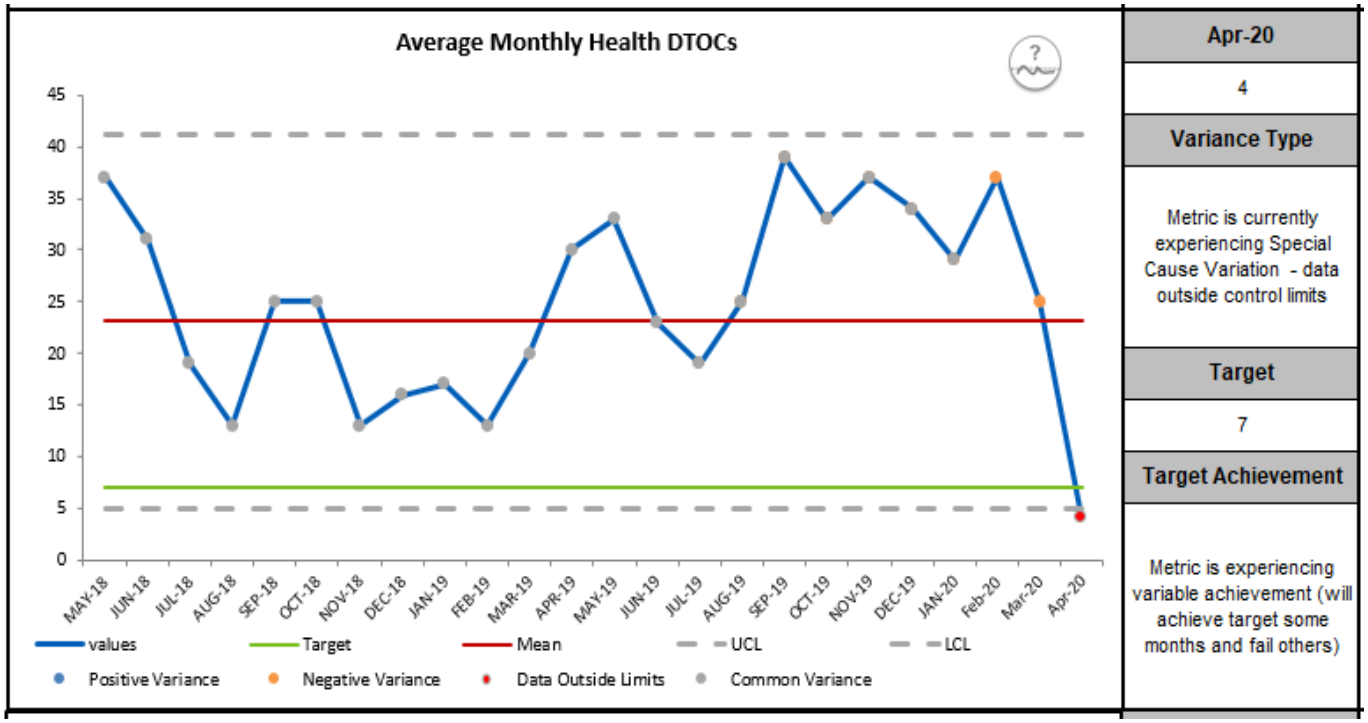
Context:

At the start of the covid-19 pandemic, a whole system response was put into place to swiftly transfer patients. This was done to ensure enough beds on the hospital sites were available for the potential covid admissions.

Actions:

A provider demand & capacity plan is being developed along with modelling for social care to ensure additional capacity is provided and stranded patients do not increase once activity increases to normal levels.

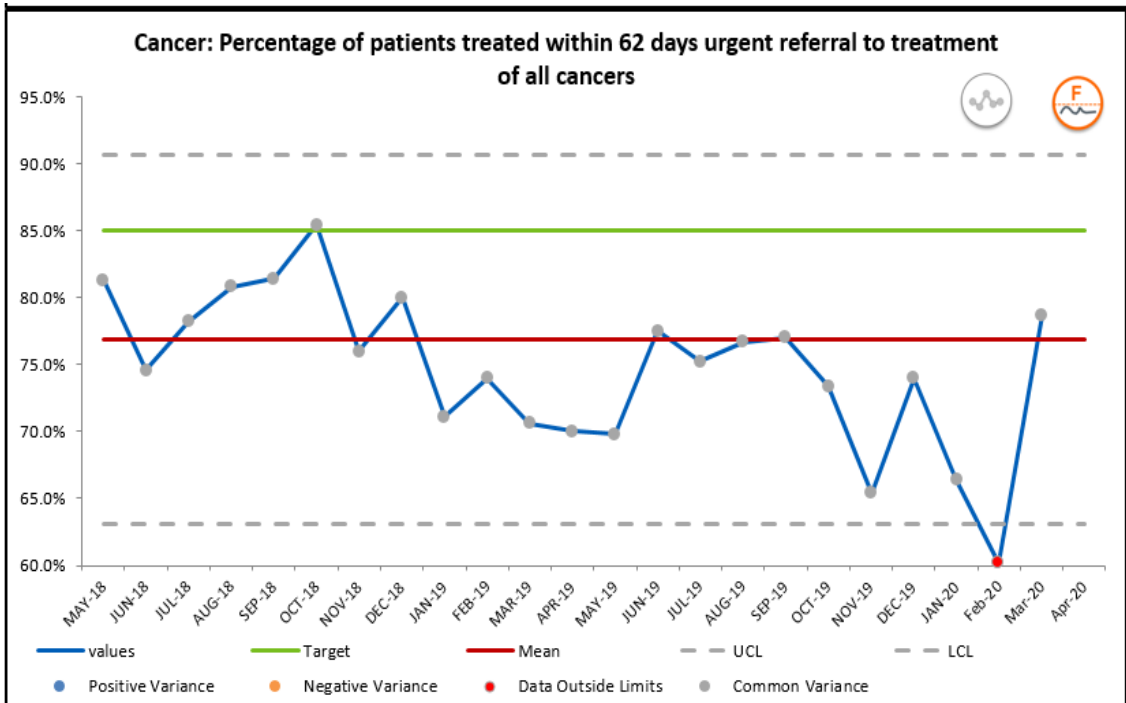
SPC Charts – Average monthly health DTOCs



Apr-20
4
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
7
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:
At the start of the covid-19 pandemic, a whole system response was put into place to swiftly transfer patients. This was done to ensure enough beds on the hospital sites were available for the potential covid admissions.

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



Mar-20
78.7%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is consistently failing the target

Context:

- It remains a challenge for the Trust to achieve the 62 day standard, this remains a national challenge and in particular in the east midlands. The Trust has achieved 77.6% against the 85% standard. Whilst this has not been achieved it is a 17% improvement on last month. The impact of Covid 19 has been felt this month with diagnostic pathways largely being paused, in the most challenged sites, colorectal and Lung

Actions completed:

- There has been an increase in treatments in March compared to last month, this compared with legacy patients being paused on their pathway resulting in less breaches has accounted for improved performance

Actions:

- Twice weekly ptl meetings have continued throughout the covid pandemic, these are supported by site ptl meetings.
- A task and finish group has been established in order to accelerate where possible a full recovery of cancer services. Endoscopy remains the biggest challenge. The three shires has commenced albeit small numbers endoscopy procedures. An overview and data has been provided by cancer services to each tumour site to support recovery planning, this is reliant at present on ECAG and professional bodies guidance expected in the next week to support pathway changes due to the pandemic

Directors view – Director of Finance

The Trust ended the month April 2020 with a break-even financial position and was therefore £4.8m favourable to the deficit plan. £4.4m of the favourable variance relates to non-recurrent support from NHSE/I in relation to national funding to reimburse COVID costs as well as offset any loss of income.

COVID spend for the month is £2.4m and is expected to be fully reimbursed as part of the top-up income. The spend includes pay cost of £0.9m and non-pay cost of £1.5m.

Non-COVID operational activity was down as expected leading to a £9.7m shortfall in clinical income, however this is offset by the national block funding arrangement currently in place (confirmed for the first 7 months of the year).

Other income is down by £0.2m due to loss of catering, car parking and other income.

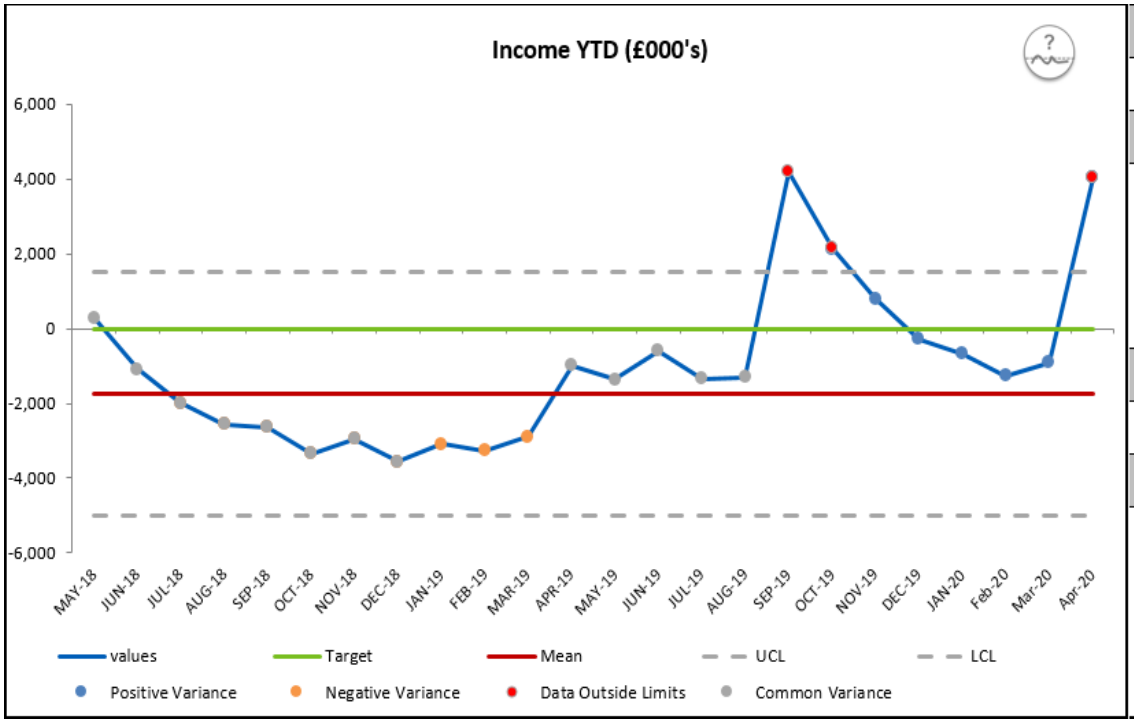
Pay and Non-pay are underspent by £0.6m. When COVID spend of £2.4m is excluded, this means an underspend of £3.0m which is not unexpected given the reduction in operational activity and consequent underachieved income of £9.7m as highlighted above.

This unfavourable position is reflected in the Divisional performances, with all the Divisions showing adverse variance positions due to the lack of operational non-COVID activity. As the Trust moves to a RESET phase, Divisions will be expected to continue to monitor and manage their expenditure budgets accordingly.

The Capital spend in the month is £1.5m mainly relating to COVID expenditure. The processes around Capital spend approval and reimbursement keep changing as NHSE/I introduces frequent changes.

Cash balance at the end of the month is £31.3m as NHSE/I provided additional funding for next month in advance.

SPC Charts – Income YTD



Apr-20
4,045
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)

Actions:

The SLA Clinical Income position is reported against draft plan values, as submitted to the STP in January 2020 (excluding the transformation contribution).

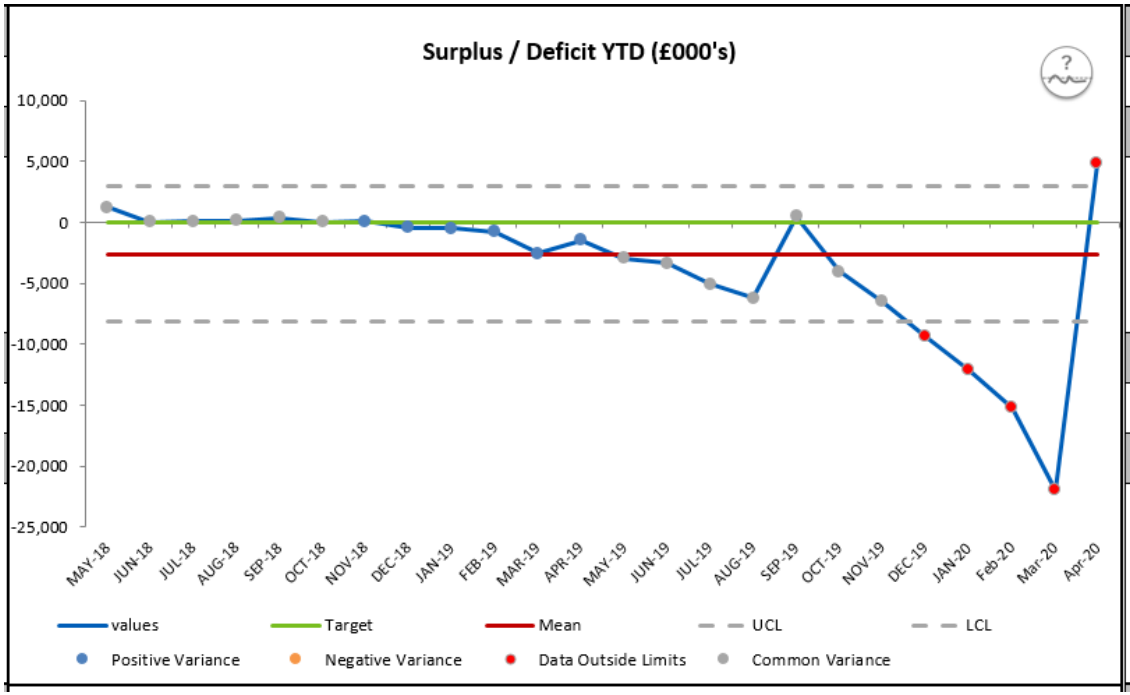
Reports activity and income, based on traditional PbR calculations using 2020/21 consultation tariff (a final tariff has not been published).

We have introduced an 'adjustment to block values' line which effectively shows the value of income between the PbR costed activity and the value of the national blocks currently being received.

Other Clinical Income now includes the NHSE Top-up payment. This is designed to cover lost NCA income, other reduced income streams and to close the gap between cost and income to a breakeven position.

- As expected the majority of planned activity remained extremely low as COVID-19 prioritisation continued to dominate.
- A&E continued at c. 1,200 attendances per week, with a rise to 1,450 at the end of April.
- Day Case and Elective activity in April was approximately 30% of expected levels, with First Outpatient appointments at 50%
- Outpatient Follow-ups were only 7% below draft plans, but over 30% below PbR value as activity has been converted to non-face-to-face.
- NEL discharges were between 700 and 750 per week, compared over 1,000 per week during January and February.
- The adjustment to block values has been derived at CCG level, adjusting the PbR calculated position to the block values received.

SPC Charts – Surplus/Deficit YTD

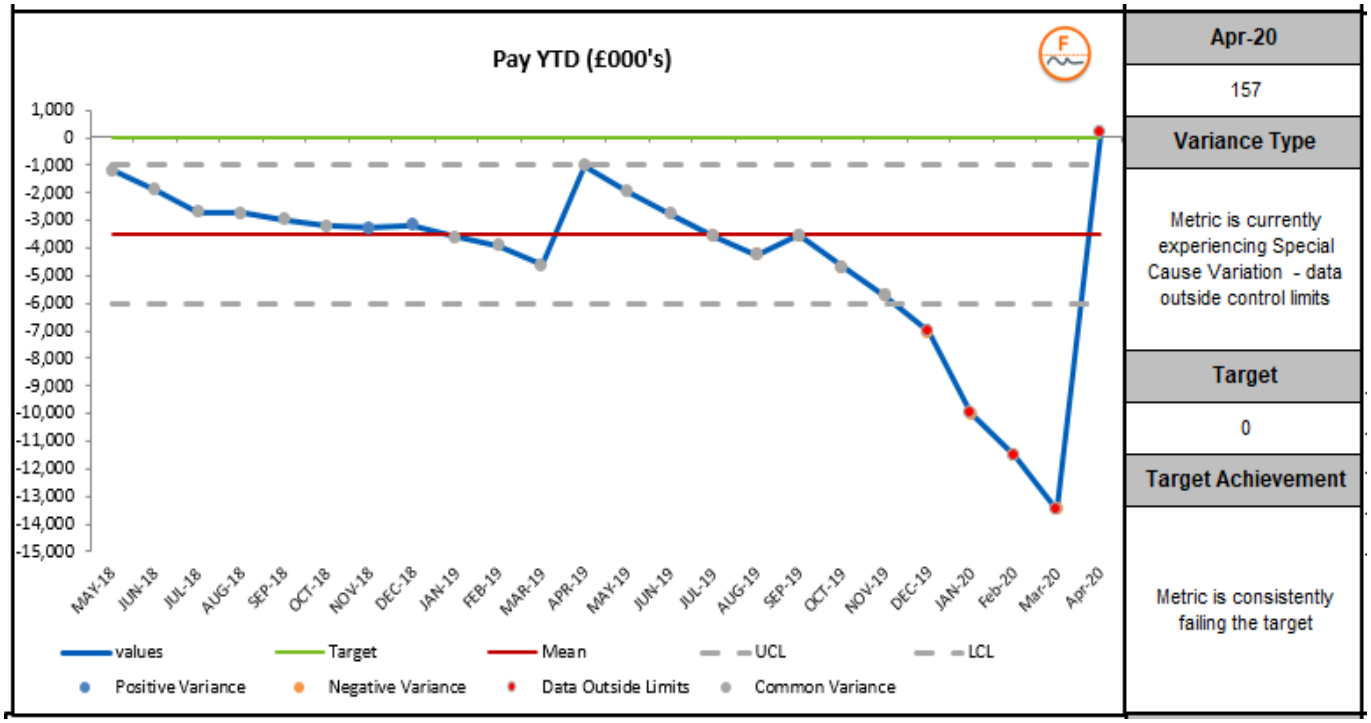


Apr-20
4,826
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context: See Directors view

Actions:

SPC Charts – Pay YTD

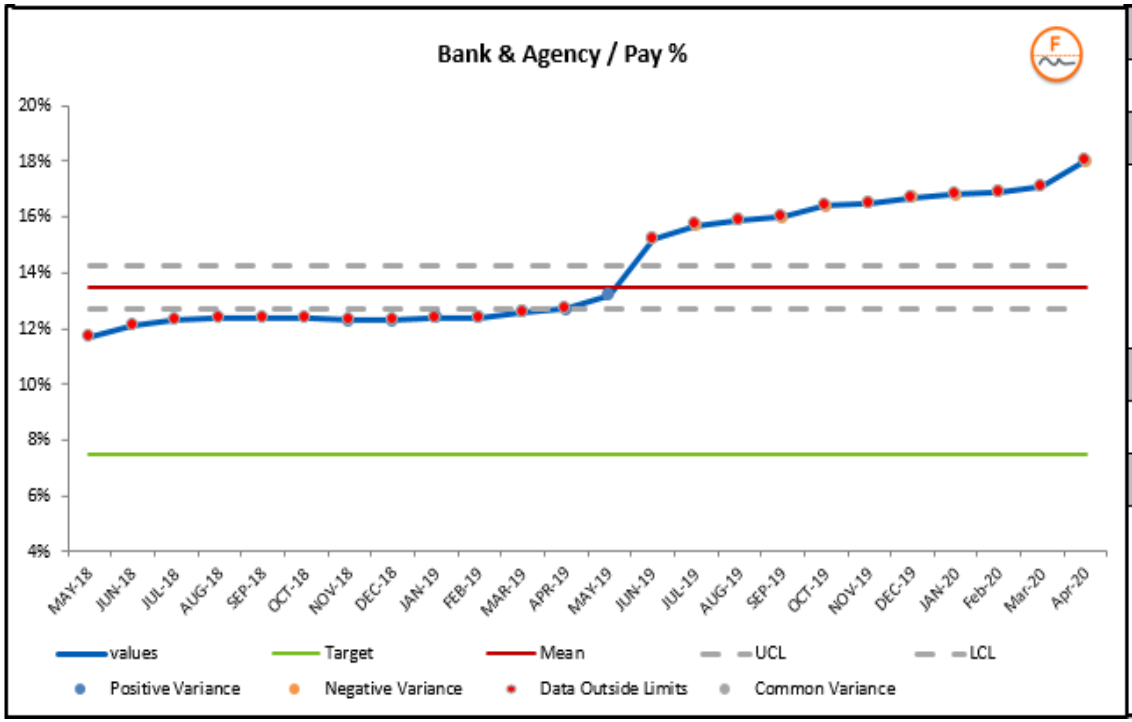


Apr-20
157
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is consistently failing the target

In Month 1 pay expenditure was £21.8m against a plan of £21.9m; resulting in a £0.16m favourable variance to plan in month

- £930k of pay costs in Month 1 have been attributed to COVD-19 response including £871k of temporary staff costs for either backfill for higher sickness absence or additional shifts due to operational pressures.
- Overall pay costs increased by £180k from the previous month. As well as COVID-19 related costs increasing pay costs also included pay awards for both agenda for change staff (2.8%) and junior medical staff (2%).
- Temporary staff costs decreased overall with £749k of the total expenditure of £3.9m related to COVID-19 backfill for sickness absence or operational pressures. There has been significant reduction in nursing bank and agency spend whilst medical staff temporary staff costs increased.
- Pay budget for 2020/21 currently includes a non-recurrent CIP target of £575k per month as recognition that a certain number of established posts are vacant at any one time. The budget also includes an additional activity budget of £913k per month. This was part of the cost response to both 2019/20 run rate and 2020/21 activity growth.
- Medical pay costs £459k above plan in month with an increase in both temporary and substantive staff numbers and costs. £225k of this overspend has been attributed to COVID-19 with the remaining overspend being incurred due to numbers of temporary staff working in Oncology/Clinical Haem and across Medicine Division.

SPC Charts – Bank & Agency spend

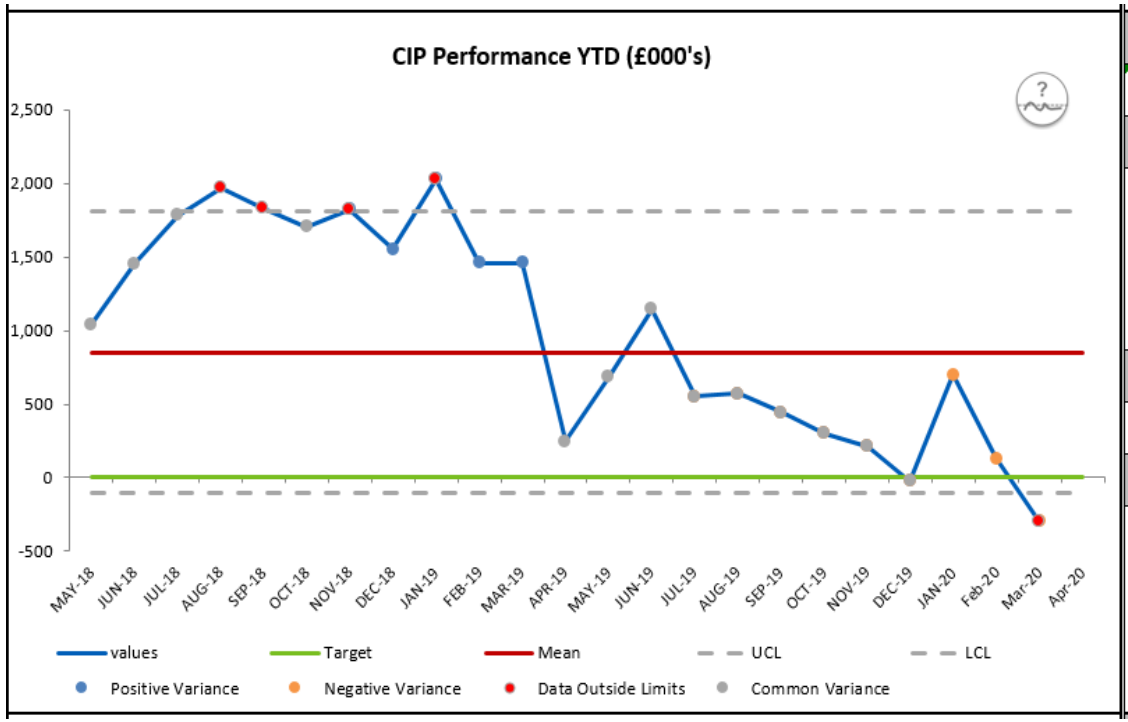


Apr-20
18.0%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
7.5%
Target Achievement
Metric is consistently failing the target

Actions:

- NHS Improvement issued a maintained expenditure limit of £11.208m for the financial year 2020/21.
- Agency spend in 2019/20 was £18.598m
- Senior Medical Agency maintained a high level of expenditure in Urgent Care and Oncology.
- Nursing Agency decreased again and is now £200k below the pre-Covid levels, as activity is severely reduced across the Trust.

SPC Charts – CIP Performance YTD (£000s)



Apr-20
#N/A
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)

Actions: There are no CIPs in place for 2020/21

Directors view – Chief People Officer

The below information is provided to the Board with regards to the actions undertaken in response to Covid-19 for our colleagues within NGH. There has been a huge amount of work which has been undertaken in a very short time to ensure we are providing a safe working environment, protecting and supporting colleagues to provide the Best Possible Care, for which thanks is extended to all colleagues supporting these efforts. The workforce committee was provided with information, including a summary of system working and suggested next steps which are starting to be worked upon as part of the next phase of managing this pandemic. Both KGH and NGH are working together as part of the RESET programmes the workforce element is outlined in the Board papers, both Trusts have been collaborating during the pandemic, sharing good practice, ideas and a weekly FAQ document to all staff to ensure consistency in application. There has also been a focus on system working and support including national information and updates.

Absence

As at week commencing 18 May 2020 – Overall sickness absence was 10.54%. Non-Covid Sickness Absence was 3.04%. Covid Related Sickness Absence was 7.5%. This demonstrates a reduction in overall absence which peaked at 13%, however at time of writing this report absence has increased once more back at peak levels. The introduction of symptomatic staff and family member testing supported a reduction in covid isolation absence, however the national isolation absence has increased during the pandemic and absence could be further impacted in the near future taking into account asymptomatic staff testing commencing 26th May, the potential impacts on the track and trace system and the international quarantine measures expected to be announced. In modelling the workforce moving into RESET a 10% absence rate is being modelled, which coupled with the requirement of colleagues to take leave who have not been able, this could lead to temporary staffing expenditure in the support of delivering services.

Health and Wellbeing

There has been the introduction and extension of a huge number of health and wellbeing support within the Trust, notably, SoS (Support our Staff) sessions for all teams but particularly support is given to areas with a high death rate / expressing high levels of anxiety or stress / exhaustion / either caring for a colleague ensuring there is no breach to patient confidentiality in this instance, Opening of 'Our Space' – a new Health and Wellbeing Centre open 24/7, free provision of accommodation on site and at the university with a cleaning service. Support for BAME colleagues given the known impact of the virus on this community has been provided via a letter from the CEO, BAME network Chair, Head of Equality, Diversity and Inclusion and CPO, a virtual BAME network meeting with colleagues and members of the executive team, also the development of conversation tools prior to possible risk assessments to be undertaken.

Covid Recruitment

74 medical students and 62 nurse students were recruited within a average timescale of 2.5 weeks to support in providing care. A further 116 members of staff have been recruited to date purely as part of the Covid-19 response. These included nurses, volunteers, radiographers and ODPs who were recruited within an average recruitment timescale of just under two weeks.

Directors view – Medical Director

Overview

Since the last report to trust board the predominant focus of this portfolio as for others relates to supporting the covid-19 response, covered in other papers. Some broader updates are provided below.

Venous Thromboembolism prophylaxis (VTE)

VTE assessment is now recorded on paper and integrated into the admissions clerking proforma. Audits of prophylaxis have confirmed good compliance which is particularly important for covid patients given the high risk of thrombotic episodes and complications. In the critical care unit hogh doses of prophylaxis are given (treatment levels) due to the increased risk.

Patient harm

As part of a review of the "governance lite" arrangements instituted during pahse 1 of the covid response, review of harm meetings and limited investigations of harm incidents have been resumed. Case reviews are replacing RCA where possible to reduce impact on clinician time.

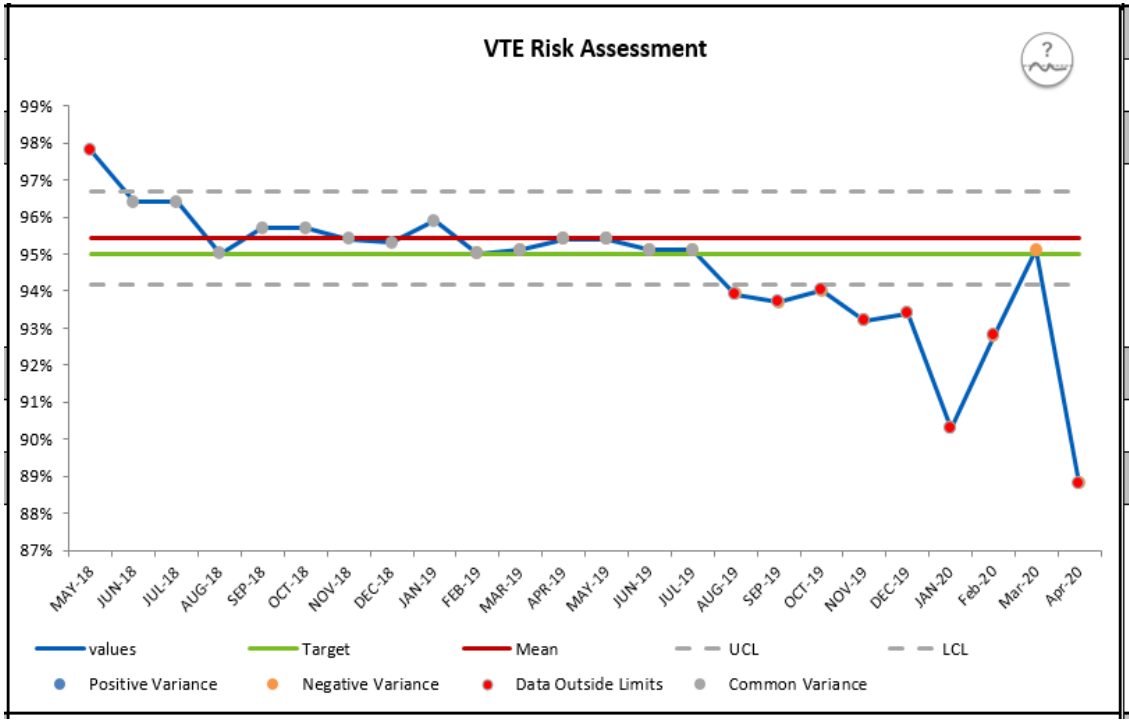
Mortality

The rise in crude mortality in December and January, associated with a spike in deaths of patients admitted on a Sunday has now translated to an increased HSMR (109). The SHMI is still as expected (97) and the pattern is recognised to be consistent with winter admissions of care home residents and other frail patients in the absence of alternative community provision. A trust wide mortality review will be undertaken. An apparent spike in mortality from secondary malignancy is explained by an anomaly in HSMR calculation, linking NGH transfers to a hospice to our mortality data.

ePMA

Negotiations with EMIS have been progressing and an agreement in pronciple has been reached on re-introducing an upgraded ePMA later this calender year.

SPC Charts – VTE Risk Assessment



Apr-20
88.8%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
95%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:

- Lack of forcing function via ePMA as ePMA no longer used in Trust.
- As a result returned to completing risk assessment using VitalPac- a which requires the user to log on separately to other IT systems used during admission process (ie is not part of the normal work flow)

Actions completed:

- Incorporated paper based VTE assessment into admission proformas

Actions:

- Short term - identify method for auditing paper forms
- Long term - reintroduce an ePMA system

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Report To	**Public Trust Board**
Date of Meeting	**28 May 2020**

Title of the Report	**Our response to Covid-19 Pandemic**
Agenda item	**10**
Presenter of Report	Deborah Needham (Chief Operating Officer/Deputy CEO)
Author(s) of Report	Jeremy Meadows (Head of Emergency planning) Bronze cell leads

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

A paper which sets out our internal response to the level 4 national incident; Covid -19.
It outlines the process followed during the incident including delegated decision making, daily reporting & strategic overview using our internal major incident command and control process.
Each of the bronze cells (projects) have highlighted actions taken and these are outlined in the appendix of the report.

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 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*
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 – 6.1

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	All appropriate Covid - 19 related expenditure during the response has been captured and reported.
Legal implications / regulatory requirements	None

Actions required by the Trust Board

The Trust Board is asked to receive the paper and note the update provided, seeking any areas of clarification during the meeting.

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Our response to Covid-19 Pandemic

28th May 2020

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

Providing the Best Possible Care

Planning for our response to the COVID-19 pandemic in line with national guidance

On 17th March 2020, NHS England and Improvement wrote to all Trusts, commissioners and primary care. This set out a number of steps being taken nationally to support the response to the COVID-19 pandemic. It also gave direction to systems and organisations in their planning.

Planning and responses at NGH have been organised into six areas*:

1. Free-up the **maximum possible inpatient and critical care capacity**
2. Prepare for, and respond to, **large numbers of inpatients requiring respiratory support**
3. **Support our staff** and maximise staff availability
4. Stress-testing **operational readiness**
5. **Ensuring appropriate organisational governance** during the pandemic
6. Supporting **distributed working**

* The six areas are adapted from the national communications to ensure applicability at a Trust level.

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Planning for our response to the COVID-19 pandemic - Strategic Principles

This briefing summarises the steps that NGH have taken in response in line with the originally agreed strategic principles.

1. Hospital Capacity and Complexity including defining Essential Components
2. Protection and Support of Health Care workers
3. Outline of a Strategy to allocate and prioritise resources
4. Development a robust, transparent and open communication plan internally and with partners
5. Development of a series of systems and controls to manage operational and clinical risk and log these in an agreed framework considering ethical considerations including personal responsibility
6. Working with systems in health and social care locally and nationally to coordinate the response

A summary of the key work completed to date is shown within this briefing

The briefing builds upon the weekly briefings that have been provided to Executive & Non-Executive Directors. Throughout the response there has been a key focus on Infection and Prevention Control , on clear communication and on coordinated work with local, regional and national systems across the public sector.

Introduction

COVID-19 has brought an unprecedented series of issues and problems across the globe and is outside the experience of any of us. In addition we were faced with the critical issue of high bed occupancy and pressure on staff as we entered a period of emergency planning for the surge in patients that were expected to present.

Despite some obvious day-to-day challenges, Team NGH excelled and the social movement of our staff was palpable every day during the early stages of the incident response.

During the evolving situation there were daily policies, plans, reports & guidance regionally & nationally, on occasions these changed meaning we had to act quickly & safely to ensure we were fully up to date with best practice to ensure patients & staff remained safe at all times.

System discussions and action led to the decongestion of the acute hospitals in the county, with the numbers of patients who were delayed reducing.

We continue to follow all the latest guidance from Public Health England and involving our clinical teams in the critical ethical and clinical discussions that have been needed to expand our ability to treat seriously ill patients. This work will continue as the response remains in place.

For the NHS and for Northamptonshire this current crisis comes on the back of a long-standing difficulty in terms of urgent care capacity. There is now a real appetite to consider how we can do things differently for the greater good, both for the short term in response to COVID-19 and leading into the future.

Command and Control

On 20th March 2020, we set up a 7-day-a-week incident room & response team for COVID-19 and continue to follow our own NGH major incident procedures in order to handle the various components of the pandemic as it developed. Because this is not something any of us have ever experienced, the level of anxiety was high but we have also seen a fantastic energy and response from a range of staff across the hospital.

We have also shared approaches with KGH and ensured our efforts are aligned as much as possible.

The purpose of streamlining our operational processes was to make it easier for decisions to be taken and enacted at the most appropriate level. Where possible this has taken place at the individual Bronze team level.

Some decisions have had Trustwide implications (e.g. suspension of outpatients or visiting times) or have affected other system partners (e.g. suspension of certain direct access/walk in services). It is impossible to have clearly defined lines and hence why each Bronze has a lead, senior Clinical Lead and an Executive Director attached to them.

However, in the event of any doubt, all decisions can be escalated to the Incident Team (Silver Command). The aim is to facilitate swift and decisive action but to have back up available should it be needed.

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Command and Control: BRONZE Commands

The following Bronze cell arrangements have been established. Included in each team is a facilitator who logs key decisions made by the team and actions agreed using a trust approved template for which they have
received training. Each team has been responsible for setting up their own meetings and sharing actions.

One member from Bronze team is required to join the daily 08:15hrs update call and must have all necessary information available at that time. Arrangements for putting this into place are delegated to the leadership of each Bronze.

- Ethics
- Human Resources, Staff Welfare, Occupational Health and Volunteers
- Communications
- Outpatients
- Electives & Pathways
- IT and Informatics
- Logistics/Procurement/Supply Chain
- Pathology, Mortuary & Therapies
- Endoscopy, Imagining and Pharmacy
- Emergency & Critical Care Pathways/Training
- Facilities
- Finance
- Working from Home
- Inpatient Capacity
- Maternity
- IPC
- Paediatrics

Command and Control: SILVER Command

An incident team was established for the management of the hospital and this will remain in place until the government move from a level 4 incident and trusts are asked to step down their internal response.

Acting as the Single Point of Control, it is open daily between 08:00hrs – 20:00hrs, 7 days a week.

The Executive Team are primarily responsible for staffing the Incident Room. They have been split into three teams, each led by one of the Executive Directors (COO/MD/DoN) who also attend Gold and provide the daily update.

Co-ordinating the entire Trust via the Bronze teams that have been established, it is the single point that external organisations use to contact the Trust and ensure all information requirements of the hospital, and external partners are co-ordinated.

Each of the teams manage the Incident Room for a seven-day period. Each period commences at 08:00hrs on Friday morning and run to the same time the following week. They ensure the Incident Room is staffed for the daily 12-hour period.

The Incident Room is also be staffed by a loggist, administrator and information analyst.

Daily battle Rhythm:
08:15 – Silver call: Lead Silver Commander with one member from each Bronze team and each Divisional Director, MD, DoN & COO, each bronze lead will update on actions taken and seek support for issues or cross divisional work.
12:00 – Gold meeting: Led by Gold Command (CEO or Deputy CEO) with Executive team & Communications lead.
16.30 – Northants County-wide conference: NGH Silver Commander & External Partners.

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Command and Control: GOLD Command

At the start of the incident response the daily Gold Command meetings were attended by the Chief Executive, Chief Operating Officer/Deputy CEO, Medical Director, Director of Nursing & Associate Director of Communications.

More recently the attendance has been broadened to include the whole executive team.

This meeting provides basis for not only strategic decision making but also discussion which may be required from silver.

The silver commander provides a daily update on activity, items for information and items requiring decision.

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Protecting our staff with PPE

From the outset our procurement team have prioritised ensuring we have a controlled, maintained and healthy stock of PPE. Working pro-actively, in line with national guidance, to understand and react accordingly.

Understanding PPE guidance

- COVID-19 is an airborne virus spread from person to person through small droplets from the nose or mouth, which are expelled when a person with COVID-19 coughs, sneezes or speaks, and through contact with contaminated surfaces. During Aerosol generating procedures (AGP's) (e.g. manual ventilation, intubation, extubating, etc.) there is an increased risk of spread of infectious agents and additional precautions must be implemented when performing an AGP on a suspected/ confirmed COVID-19 patient
- Public Health England guidance has been updated/ changed several times since the start of this pandemic. The latest guidance now refers to optimising the use of PPE and use of PPE when in short supply, including the sessional and reuse of PPE

Items determined as being PPE include:

- Aprons
- Eye protection – goggles or visors
- Fluid Repellent Surgical Masks
- FFP3 masks (disposable or re-usable respirators)
- Gowns
- Coveralls
- Hand sanitiser
- Gloves

- PPE guidance is published by The Public Health England PPE guidance (next slide) sets out the recommended PPE for hospital staff in a variety of contexts).

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Public Health England | Academy of Medical Royal Colleges | GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales | Health Protection Scotland | HSC Public Health Agency | NHS

Recommended PPE for healthcare workers by secondary care inpatient clinical setting, NHS and independent sector

Setting	Context	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-resistant coverall/gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection[1]
Acute hospital inpatient and emergency departments, mental health, learning disability, autism, dental and maternity settings	Performing a single aerosol generating procedure[2,9] on a possible or confirmed case[3] in any setting outside a higher risk acute care area[4]	✓ single use[5]	✗	✓ single use[5]	✗	✗	✓ single use[5]	✓ single use[5]
	Working in a higher risk acute care area[4] with possible or confirmed case(s)[3]	✓ single use[5]	✓ single use[5]	✓ sessional use[6]	✗	✗	✓ sessional use[6]	✓ sessional use[6]
	Working in an inpatient, maternity, radiology area with possible or confirmed case(s)[3] – direct patient care (within 2 metres)	✓ single use[5]	✓ single use[5]	✗	✗	✓ sessional use[6]	✗	✓ sessional use[6]
	Working in an inpatient area with possible or confirmed case(s)[3] (not within 2 metres)	✗	✗	✗	✗	✓ sessional use[6]	✗	✓ risk assess sessional use[6,7]
	Working in an emergency department/acute assessment area with possible or confirmed case(s)[3] – direct patient care (within 2 metres)	✓ single use[5]	✓ single use[5]	✗	✗	✓ sessional use[6]	✗	✓ sessional use[6]
	All individuals transferring possible or confirmed case(s)[3] (within 2 metres)	✓ single use[5]	✓ single use[5]	✗	✗	✓ single or sessional use[5,6]	✗	✓ risk assess single or sessional use[5,6,7]
	Operating theatre with possible or confirmed case(s)[3] – no AGPs[2]	✓ single use[5]	✓ single use[5]	✓ risk assess single use[5,7]	✗	✓ single or sessional use[5,6]	✗	✓ single or sessional use[5,6]
	Labour ward/area – 2nd/3rd stage labour vaginal delivery (no AGPs[2]) – possible or confirmed case[3]	✓ single use[5]	✓ single use[5]	✓ single use[5]	✗	✓ single or sessional use[5,6]	✗	✓ single or sessional use[5,6]
	Inpatient care to any individuals in the extremely vulnerable group undergoing shielding[8]	✓ single use[5]	✓ single use[5]	✗	✓ single use[5]	✗	✗	✗

Table 1

1. This may be single or reusable face/eye protection/full face visor or goggles.
2. The list of aerosol generating procedures (AGPs) is included in section 8.1 at: www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe. (Note APGs are undergoing a further review at present).
3. A case is any individual meeting case definition for a possible or confirmed case: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection
4. Higher risk acute areas include: ICU/HDUs; ED resuscitation areas; wards with non-invasive ventilation; operating theatres; endoscopy units for upper Respiratory, ENT or upper GI endoscopy; and other clinical areas where AGPs are regularly performed.
5. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
6. A session refers to a period of time where a healthcare worker is undertaking duties in a specific care setting/exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the healthcare worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and considered where there are high rates of hospital cases. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
7. Risk assessed use refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets of blood or body fluids.
8. For explanation of shielding and definition of extremely vulnerable groups see guidance: https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19
9. Ambulance staff conveying patients are not required to change or upgrade PPE for the purposes of patient handover.

Patient use of PPE: In cohort wards, communal waiting areas and during transportation, it is recommended that suspected or confirmed cases wear a surgical face mask if this can be tolerated. The aim of this is to minimise the dispersal of respiratory secretions, reduce both direct transmission risk and environmental contamination. A surgical face mask should not be worn by patients if there is potential for their clinical care to be compromised (e.g. when receiving oxygen therapy).

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APPENDIX 1

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Maximum possible Inpatient & critical care capacity - Inpatient capacity

A Proactive response delivered to meet the changing needs of the patients being admitted to hospital

- Hospital divided up into COVID Positive, COVID Negative and Query COVID wards and flexed accordingly to meet changes in presentations
- Summary of ward changes includes:

  Nye Bevan Unit became COVID assessment unit and took most of the patients needing CPAP support
  Abington ward became a COVID Negative ward for patients who had tested negative but had been exposed and needed to stay in hospital
  Cedar ward became a COVID Negative ward
  Collingtree became a COVID Positive ward
  Hawthorn became a COVID Negative ward
  Knightly became a COVID Negative ward
  Creaton became a COVID Positive ward
  Rowan became a COVID Positive ward
  Willow became a COVID Positive ward

- Surgery was moved to the Head & Neck / Spencer Footprint to try and keep that part of the hospital a COVID free area At the commencement of the response, the hospital discharged in excess of 300 patients within a short period of time, patients were discharged home or into care home beds
- Stranded Numbers reduced from 320 to 150, super stranded from 130 to 33 with up to 300 empty beds
- All patients who were medically suitable for discharge were pro-actively managed each day via a system call
- A community bedded facility was opened as a ‘step down facility’ for COVID Positive patients who were waiting to return to their care homes
- As the peak of the pandemic passed wards began to be reconfigured to meet the needs of ‘normal’ Non COVID medical cases with Dryden and Walter Tull wards becoming general medical wards
- Roll out of Consultant Connect to all specialties including using photo version for ECG’s and Rapid access chest pain clinic

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Maximum possible Inpatient & critical care capacity - Reducing elective activity

To enable sufficient capacity for the potential increase in emergency admissions and to prevent unnecessary footfall within the hospital all non urgent surgery was paused.

- From 17 March 2020 the Surgery Division stopped all non-urgent surgery. Trauma and emergency lists are being run in Mansfield theatres. Additional capacity to continue urgent and cancer surgery has also been commissioned & has taken place at the local private hospital.
- Outpatient work was mostly ceased, or moved to virtual or telephone appointments where possible across all Divisions. Examples of this include virtual Respiratory outpatient appointments via a video conference, and the move to telephone antenatal clinics.
- Not all activity was ceased onsite, exceptions are as follows:
  - Cancer and other urgent elective surgery, both IP and DC, all specialties
  - Trauma theatres running routinely with 2 theatre lists, 3 when needed.
  - Continued emergency theatre and vascular emergency surgery however with reduced demand.
  - Outpatient 2WW and urgent referrals -Risk assessed telephone outpatient appointments where possible.
  - Chemotherapy and inpatient or emergency diagnostics
  - Limited Endoscopy sessions running with reduced numbers to maintain social distancing & time for donning/doffing of PPE.
  - Ophthalmology – Eye casualty and urgent procedures.
  - Running 1 or 2 all day cancer lists where patients require Critical Care which is unable to be provided at a local private hospital.
- Governance process has been devised to ensure our patients receive follow up care post discharge from Three Shires
- In addition to efforts undertaken internally in the Trust, national guidance was also published that recommended GP referrals were paused.

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Maximum possible Inpatient & critical care capacity - Emergency and Critical Care

This cell was established originally to set up the positive / negative covid areas for critical care and increase the bed base to provide level 3 care as well as CPAP/NIV

- Pods of 3 beds put in place in the main theatre area – a total of 12 additional beds with a further expansion in recovery as required.
- Guidance provided to facilities regarding estimated stock requirements for CPAP/NIV & daily overview.
- Consultant Connect service established in 20 services for support to primary care and within hospital.
- Junior medical rota with redeployed doctors from Surgery, Orthopaedics, Paediatrics and Gynae is in place.
- Work undertaken to match NIV/CPAP and patient acuity on wards with nursing staffing levels.
- Medical consultant rota changes to provide greater support.

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Maximum possible Inpatient & critical care capacity - Paediatrics

A Proactive response delivered to meet the changing needs of the patients being admitted to hospital

- Early planning, initial discussions in late February creating a Covid committee and formal meeting by 6th March.
- Redesigned the wards and patient flow to create Covid isolation area for both Paediatrics and Neonates
- All clinical staff redesigned their working arrangements. Matron is available in the unit late in to the evening and over the weekends. Consultants changed their rota to provide Covid and No Covid ward rounds. Neonatal consultants took over the work usually done by juniors as juniors doctors were released to the Trust Covid rota
- Rearrange out patient activities to ensure that all families were contacted and children were seen according to clinical priority
- Moved the Oncology work to area which used to be “Discharge lounge” and thereby continued to provide oncology services without disruption.
- All children with Cystic Fibrosis were managed outside hospital preventing any hospital admissions. This is one of the most vulnerable group
- Identified all the vulnerable children in our case loads and individually contacted those families to provide information on what extra precautions they need to take
- We maintained the same level of care for children who presents with safeguarding concerns
- Still conducted Governance meeting, directorate management meeting as scheduled and consultant meetings more frequently (once a week instead of once in two weeks)

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Maximum possible Inpatient & critical care capacity - Maternity

As an essential service, maternity needed to continue to offer safe care to women, whilst embedding new national covid-related guidance and providing this service with fewer staff

- The maternity Bronze cell developed a structured approach with leads for each workstream meeting daily, including a lead for communication with staff and patients.
- All maternity outpatient services (antenatal clinic, community midwifery, maternity day unit) moved to one location in the Day Surgery Unit to streamline appointments and pool staff resources in an area that allowed us to improve social distancing.
- All possible appointments were converted to telephone appointments including the initial booking appointment with the midwife (done by midwives shielding) and an initial consultant telephone appointment for new antenatal clinic patients.
- Pathways were developed on labour ward to safely manage birth pathways for women who were proven/potentially covid positive. Guidance was also developed to manage pregnant women who required admission with severe covid symptoms as they require both respiratory and obstetric input. A designated covid area was developed on the labour ward to separate these patients.
    - Additional changes to ensure service ran safely
    - Homebirth service suspended but reviewed weekly (driven by staffing levels)
    - Daily overview of all elective maternity activity such as inductions and planned caesarean sections
    - Women undergoing induction of labour admitted to birth centre to free space on labour ward
- Communication with users was maintained at all times through letters, phone calls, social media and a weekly zoom call with the Maternity voices Partnership.

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Maximum possible Inpatient & critical care capacity - Outpatients

Face to face outpatients was mostly ceased and various new ways of undertaking out patient appointments has been put into place.

All booked OPA were triaged and a decision made regarding pause, virtual OP or face to face OP.

- Attend Anywhere platform (triage & virtual) project rollout has been completed
- Sub group set up to manage the roll out of ICS outsourcing OPD clinics.
- Blood Taking Unit has been relocated to a local private hospital
- Consultant connect – use of video for outpatients
- Polling ranges reduced to zero and a central ASI list developed
- Upgrading of IT equipment to increase use of virtual platforms

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Maximum possible Inpatient & critical care capacity - Endoscopy, Imaging and Pharmacy

All non-urgent imaging diagnostics have been reduced in line with government guidance and to support social distancing and unnecessary travel.

- 2ww activity continued as normal
- All screening programmes have been paused in line with government guidance.
- The Interventional Radiology Service has been reduced to urgent cases only.
- Radiologist rota developed to support more off-site reporting and to improve resilience.
- Isolated 2 Plain film rooms and 1 CT scanner for Covid-19 +ve patients to reduce infection risk.
- Increased numbers on out of hours shifts for plain film and CT recognising imaging patients in PPE is more challenging.
- Radiology advice moved to telephone only to reduce footfall and face to face contact.
- Admin staff split into 2 teams to improve resilience and social distancing.
- Relaxation of some medicines management procedures during this time.
- Improve monitoring & regional reporting of renal replacement consumables to ensure good allocation of supplies
- .
- Aseptic Unit produced medicines in ready to use form for critical care during this time.
- Developed solution to enable prescribing from virtual clinics.

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Maximum possible Inpatient & critical care capacity & supporting our staff - Pathology, Mortuary & Therapies

The main area of work has been patient & staff testing and due to the original lack of testing availability nationally a local solution was put into place.

- Patient testing – Set up testing for Covid-19 in Microbiology. Current capacity about 100/day with a 4-6hr turnaround time.

- Staff testing – Daily drive through for staff swabbing including staff from partner organisations NHFT, EMAS, CCG, NASS, NCC, Council, Care Homes, St Andrews, Police & Fire. This will soon be expanded to include asymptomatic staff.

- Mortuary - Increased capacity at NGH.

- Access to Phlebotomy – Blood taking unit temporarily moved to the local private hospital.

- Remote working –
  - Slide management software being purchased to aid remote reporting by Haematologists.
  - Hand therapists now doing Attend Anywhere online clinics.

- Therapies - Supporting patient care by managing CPAP/NIV/Proning/Preventing deconditioning and working on Frailty. Introduced 7-day working for Therapists.

- New documents and processes set up -
  - Process for notifying GPs of patients COVID-19 results
  - Protocol for COVID-19 testing for patients in Microbiology
  - Algorithm for Patients discharge to Care homes
  - Death certification changes
  - Letter to bereaved families informing about care of the deceased at Wollaston

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Maximum possible Inpatient & critical care capacity & supporting our staff - Facilities

Facilities & Estates were able to react quickly to the many needs & wants of the organisation to support additional space & to keep staff safe.

- Partitioning of wards has been undertaken to support infection control and to make it easier to cohort patients.
- Staff accommodation team has been set up to manage staff requests and external offers received.
- No.3 café closed and Café Royale closed to visitors. Restaurant remains open to staff only with social distancing process in place.
- Food for heroes in place and accessible to staff free of charge 7 days a week day.
- The two VIE O2 storage tanks have been separated giving the site 4,800ltrs/min supply. We have sourced a method of non contact measurement of the flow of oxygen from our VIE tanks. These new meters will allow us to continuously measure the actual flow of oxygen without having to isolate/disturb the current infrastructure. This will enable us to predict the limits of the system and set trigger points. A daily update is provided trust wide on Oxygen capacity.
- Estates service has been extended to run from 7am to 7pm, 7 days a week
- Floor signage to support social distancing is in place.

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Maximum possible Inpatient & critical care capacity & Supporting our staff - Logistics & Procurement

It was noted early in the pandemic response that the stock levels for PPE, ordering and supply may become problematic not only for NGH but nationally.

- A critical stock list for ITU with projected weekly usage quantities based on 100% occupancy and the theatre pods enabled contingency planning. Forward purchases made and stock ring fenced in stores mid-March. Additional storage was acquired in the Trust to hold PPE pallets securely.

This list provided resilience when:-

- NHSSC overwhelmed and supplies disrupted.
- Manufacturers overwhelmed by global demand and lead times went from days to weeks.
- Rapid identification of product issue ,where countries closed borders, and the need to source alternatives or reverse engineer.

PPE was recognised as being a global issue. Initial stock from the National Pandemic Stock pile (NPSS) was random and sporadic with three types of FFP3 masks, absence of fit test solution and Tiger goggles. PPE was then moved to an alternative distributor by NHSSC.

To maintain safe working for our staff:-

- Ordered re-usable FFP3 which would provide sustainable protection for 10 years and remove dependency on disposable.
- Protected sterile gowns by using coveralls (sourced locally, and CCG sourced). ITU early on novated onto re-usable gowns through the linen room laundry supply.
- Requested our logistic provider to ring fence aprons in the event of NPSS short falling supply
- Acknowledge through comms' our community donating FFP2, goggles and visors
- Applying the National Supply Disruption Process when PPE push failing to meet demand
- Operated 7 days internal distribution for a number of weeks during the spike and central management

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Supporting our staff - IPC

Expert knowledge was required very early in the pandemic with the aim of keeping our patients and staff safe.

- Moved to 7-day working
- 8-6 cover every day
- Enhanced visibility and higher profile of the IPC team
- Large number of staff trained in PPE usage and fit-tested at commencement of the pandemic
- Additional staff moved to support the team have both assisted with workload and provided a new perspective on IPC processes. Leadership strengthened.
- Opportunity used to look at and modify existing processes, increasing team efficiency
- Strengthened links with other teams.
- Revised bronze cell structure has enhanced the communication within the wider IPC team (DIPC, Microbiology and IPC Nurses)

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Supporting our staff - Workforce & Staff Welfare

An extraordinary amount of help and support has been required during the response & this continues into the reset, to ensure we keep our staff well, safe, motivated & working.

- A kindness email has been established and a process to ensure all donations are shared equitably
- Volunteers form the governance team have taken on the role of phoning staff with their swab results
- A process for providing staff in our residences who are self isolating or shielding has been put into place
- A SOS team has been set up to support staff
- The “NGH Our Space” has been put into place, a quiet area for our staff to reflect and take some time out.
- A central list of staff who can be redeployed has been generated and staff moved as required.

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Supporting our staff - Working From Home

Early in the response we needed to ensure we had less staff on the hospital site, in line with government recommendation we had to allow as many staff as possible to work from home.

- 450 additional laptops handed out to staff
- We have now got an average of 500 plus members staff working from home. The WFH cell have developed and implemented excellent support processes for IT, from the original paper request in the beginning to an electronic version of request.
- Collecting evidence on what we have learnt with the benefits of WFH in releasing estates resource, i.e releasing office and car parking capacity.
- We have seen a very highly maintained work ethic from most staff who are WFH, with a continued sense of purpose in doing the right thing by WFH and staying safe.
- Usage of Microsoft Teams continues to increase. A method is now in place for Teams to be set up, usage has peaked at 730 active users. To enhance virtual meeting, Zoom licences have been purchased for secretaries.
- As we have more VPN connections into the trust the utilisation of our current 200Mb internet connection has been impacted, this has bee n increased to 920Mb in order to provide increased resilience and capacity.
- The Trust's VPN firewall has been migrated to more powerful virtual device to ensure that we can support more users.
- An additional 60 telephone lines have been purchased and these have been made live. This adds capacity for incoming and outgoing telephone calls.

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Supporting our staff - Ethics

A multidisciplinary group including Medical Staff, Nurses, Safeguarding specialists, non clinical staff & End of Life specialists with the intention to support frontline Clinicians in any difficult ethical decisions that may be required.

- The Ethics Cell has met 'virtually' on a weekly basis
- Clinicians felt very strongly that they made ethical decisions every day and had strong supporting networks in place in addition to existing guidance / thresholds for ICU admissions
- Terms of Reference were developed for the Ethics Cell and approved by Silver & Gold Command . These were shared with KGH and other Trusts.
- A 'Decision Supporting Framework' was developed by the Cell , providing healthcare professionals and managers with a framework they can access for support, reassurance and guidance if and when needed
- The Ethics Cell through escalation via Silver and Gold, reminded Clinicians of relevant processes that are already in place within the Trust, including the discussion with patients regarding early appropriate DNACPR decision making and thresholds of care/ Treatment Escalation Plans. Good documentation including Mental Capacity.
- All relevant National Guidance in relation to Covid-19 Ethical decisions were shared rapidly with the group

Supporting our staff - Communications

Throughout the response and now into reset communication both internally & externally has played a key part and has been welcomed by many internally especially those who have been WFH.

- Daily briefings, twice daily during initial phase of pandemic
- Increased membership of TeamNGH Community Facebook group
- Facebook Live events, executive team briefings and a weekly quiz night
- Book of positivity
- Thank you letter and gift from CEO to children/grandchildren/siblings of TeamNGH members
- Communications team also actively involved in #kindness, packing and distributing 5,000 Avon gift bags, responding to numerous online enquiries and offers of support
- Salute the NHS – logistical support to co-ordinate delivery and distribution
- Hundreds of posters and signage around the site to support various messages
- Automated media monitoring
- Secure website for junior doctor induction training from July 2020

Supporting our staff - IT

Covid-19 became a huge challenge for the organisation and the Information Technology department supported all levels of the response

From March 2020:

- Created COVID flags within iBox so we could understand how many patients were Inpatients
- Ordered 200 laptops and 179 all-in-one computers to cope with 'working from home' requirements
- Built an incident room for COVID Silver team with multiple large screen displays
- Built a reporting tool to capture COVID Cell teams actions and feedback for governance
- Implemented a reporting structure on the intranet to help find performance dashboards easier
- Enabled bed management visibility via iBox and infection control reporting
- Installed and implemented Microsoft Teams across the estate to enable video-conferencing communications for remote working.

During the initial COVID period of April and early May:

- Created electronic reporting for Mortuary Spaces
- Count deaths from coded data and built reporting dashboards
- Monitored Oxygen from the 2 Tanks and created ward collection via iBox
- Created a Virtual Ward for Oxygen, Covid and Deteriorating Patients
- Enable Covid reporting direct from pathology tests rather than counting/sorting
- Created a new Bed management view for whole hospital including new PAR wards
- Enable Video-consultations by implementing 'Attend Anywhere' & 'Consultant Connect'
- Expand wifi to cope with new demand for bandwidth.
- Medical records management for cancelled OP appointments
- Scanning Deceased medical records to enable off-site coding.

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Ensuring appropriate organisational governance – Finance

Devolved decision making to the bronze cell leads was put into place at the start of the incident response with clear lines of authority for bronze and silver leaders.

- Focus has been to maintain comprehensive financial governance with full decision making audit trails.
- Distinct Covid Finance email account has helped in identifying Covid costs.
- Clear delegation process for Bronze, Silver and Gold has speeded decisions up.
- National COVID cost identification guidance and capital flexibilities has enabled much speedier decisions.
- Finance team have been able to mostly work from home with limited requirement to work in the office, though this option has remained open to all the team.
- Superb support from IT in supporting those getting to be able to and whilst WFH.
- Significant reduction in paper based transactions as we move to electronic means.

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APPENDIX 2

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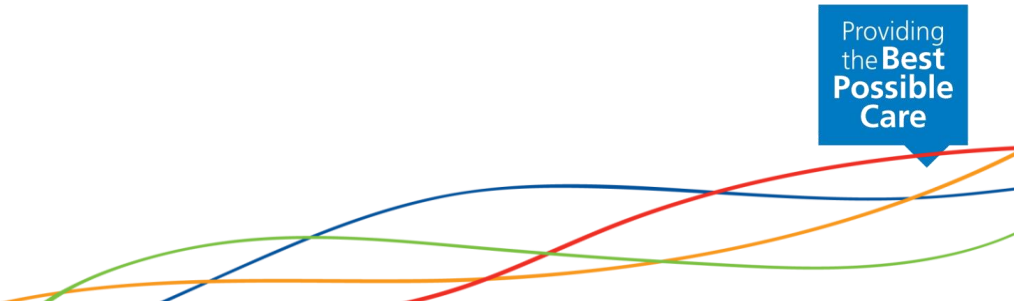
COVID-19 Response: Activity Analysis



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A&E Attendance - Activity

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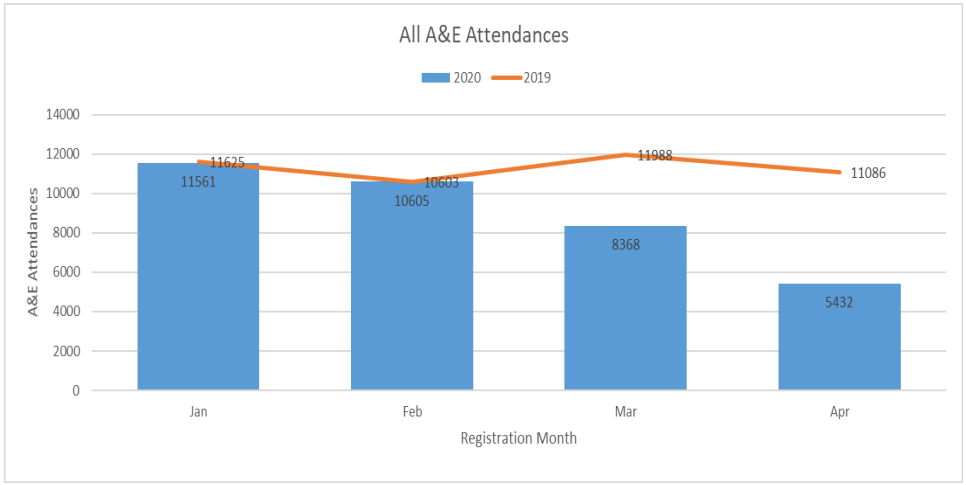
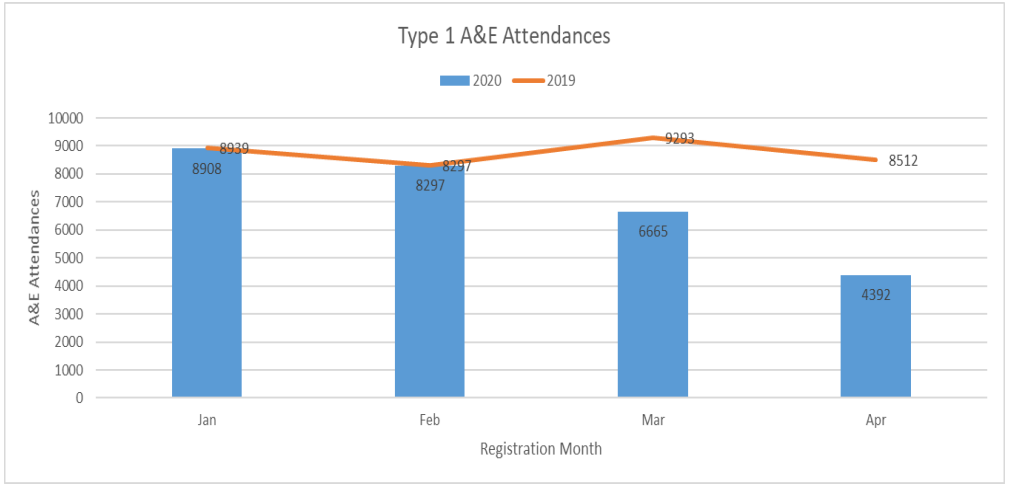
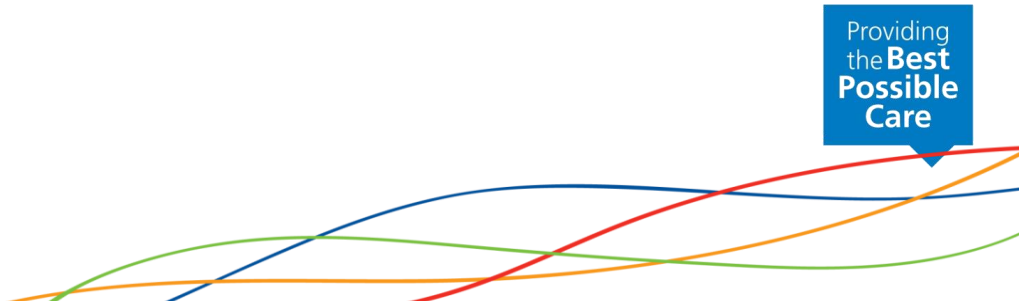




A significant reduction is noted in attendances to A&E, across all attendance types (type 1 – ED, type 2 – Eye Casualty and type 3 – Springfield House) over the two months of March and April 2020 with circa. 5,000 fewer attendance in April 2020 contrasted to February 2020.

The highest numbers are those attending the Emergency Department (ED).

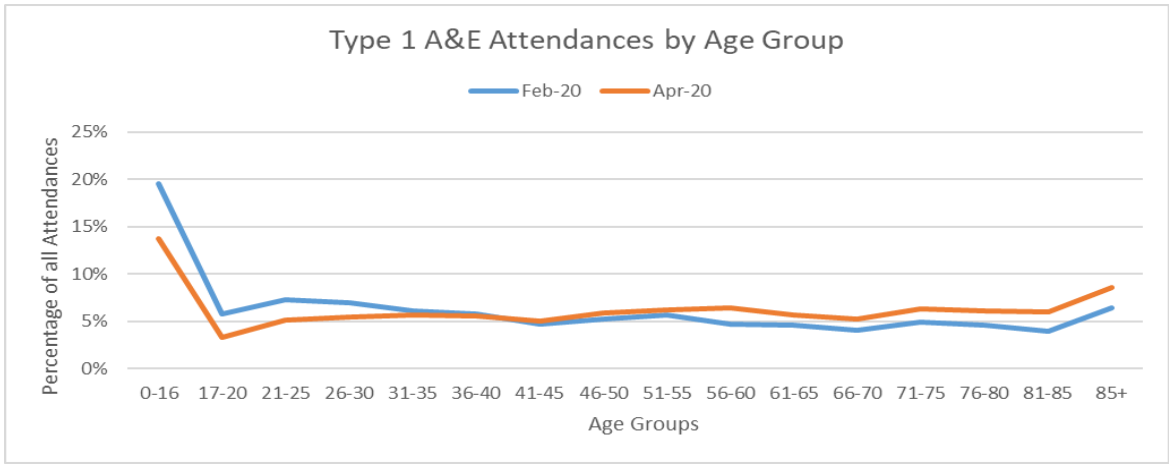
Note: Despite the reduction in numbers there is still little of note around the times that patients present



A&E Attendance
Age group / Gender split

Attendance by Age Group

Ages	Feb-20	Apr-20
0-16	20%	14%
17-20	6%	3%
21-25	7%	5%
26-30	7%	5%
31-35	6%	6%
36-40	6%	6%
41-45	5%	5%
46-50	5%	6%
51-55	6%	6%
56-60	5%	6%
61-65	5%	6%
66-70	4%	5%
71-75	5%	6%
76-80	5%	6%
81-85	4%	6%
85+	6%	9%



The age group split identifies the largest reduction is that of children 0-16 years, followed by 17-20 years and the 85+ group has increased.

Note: there is no significance in the gender split attending A&E

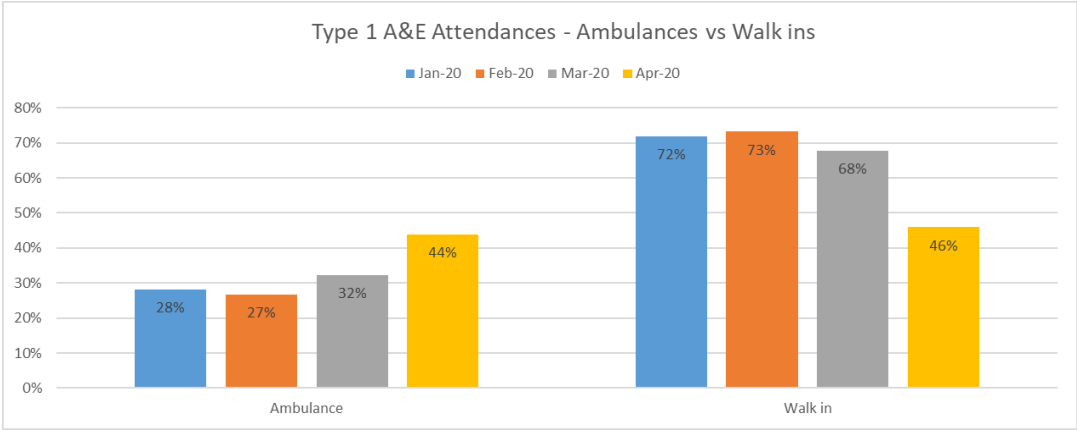
Attendance by Gender Split

Gender	Jan-20	Feb-20	Mar-20	Apr-20
Male	52%	53%	51%	50%
Female	48%	47%	49%	50%

A&E Attendance
Method of arrival/ Presenting complaint

The reduction in the numbers attending ED relate to the walk-in attenders rather than the ambulance attendance; ambulance attendances are broadly the same as those in February

When reviewing the presenting complaint of ED attenders we note an increase in the number of patients recorded as “Unwell Adult”, up 2% when compared with February. Not surprisingly an increase is noted in “shortness of breath” and “Chest Pain” with chest pain rising by 2% and shortness of breath rising by 7%. “Unwell Child” is aligned to the decrease in attenders in the age group 0-16 years as already identified.



Top 20 Type 1 presenting complaints 2020 – Numbers & as a percentage of all attenders

Presenting Complaint	Jan-20	Feb-20	Mar-20	Apr-20	Feb-20	Apr-20
Unwell Adult	1410	1227	995	660	15%	17%
Chest Pain	604	555	522	310	7%	9%
Shortness of Breath	469	423	439	439	5%	12%
Abdominal pain	511	463	382	192	6%	6%
Unwell Child	394	405	360	101	5%	3%
Falls	391	329	273	151	4%	4%
Head Injury	316	346	244	144	4%	4%
Wounds	260	213	166	137	3%	4%
Ankle	245	239	205	83	3%	2%
Overdose/Poisoning	204	190	150	75	2%	2%
Mental Illness	157	212	161	46	3%	1%
Finger	143	186	133	67	2%	2%
Foot	177	166	108	58	2%	2%
Hand	183	175	105	34	2%	1%
Wrist	187	154	99	55	2%	1%
Knee	163	150	135	40	2%	1%
Urinary Problems	132	127	127	73	2%	2%
Collapsed Adult	157	128	92	59	2%	2%
Arm	107	126	86	57	2%	2%
Stroke	98	105	86	85	1%	2%

Top Type 1 presenting complaints 2020 conversion rates

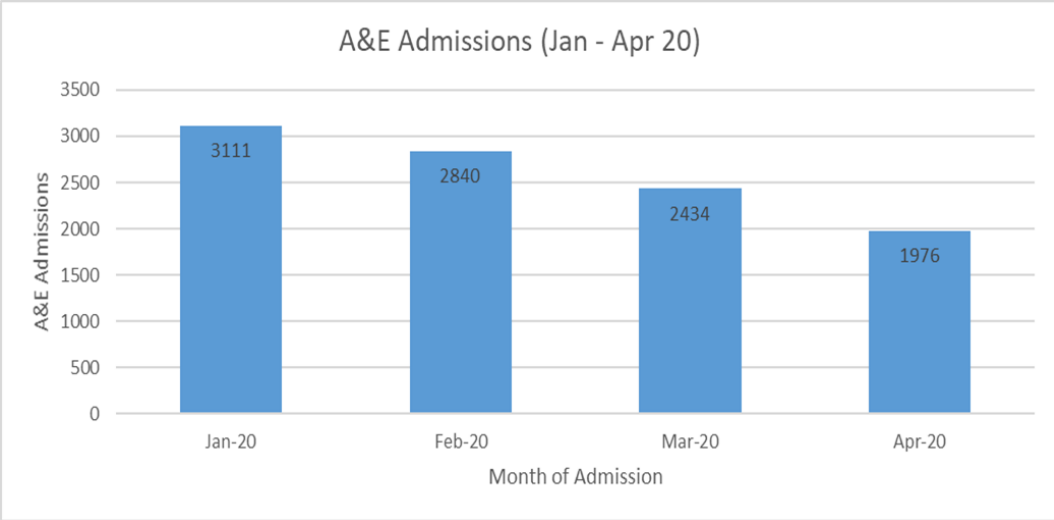
Presenting Complaint	Jan-20	Feb-20	Mar-20	Apr-20
Unwell Adult	53.8%	51.2%	52.1%	64.0%
Chest Pain	28.1%	32.8%	29.3%	39.5%
Shortness of Breath	64.4%	61.2%	59.7%	72.4%
Abdominal pain	38.0%	42.3%	42.1%	44.3%
Unwell Child	24.4%	24.2%	26.4%	24.6%
Falls	52.7%	49.8%	56.4%	64.9%
Head Injury	14.5%	13.6%	13.9%	26.4%
Wounds	7.7%	6.6%	9.0%	5.0%
Ankle	3.7%	4.6%	4.9%	13.0%
Overdose/Poisoning	49.0%	55.8%	55.3%	70.5%
Mental Illness	53.5%	52.4%	54.7%	49.1%
Stroke	81.6%	84.8%	80.2%	83.9%
Collapsed Adult	38.2%	44.5%	48.9%	66.7%

Non-Elective Admissions Activity / ALOS

In line with the reduction of attenders at A&E, there has been a sharp decrease in the number of non-elective admissions, approximately 30% decrease from February 2020.

This appears to be in line with the national reduction.

The split between male & female admissions (in total) is not showing any significant difference.



ALOS increased in March & again in April 2020 due to the rapid discharge of patients into the community, this can be seen in the reduced numbers of both stranded and super stranded inpatients.

Additional capacity was sought in care homes and choice was removed from patients making it much easier to discharge.

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Stranded & Super Stranded

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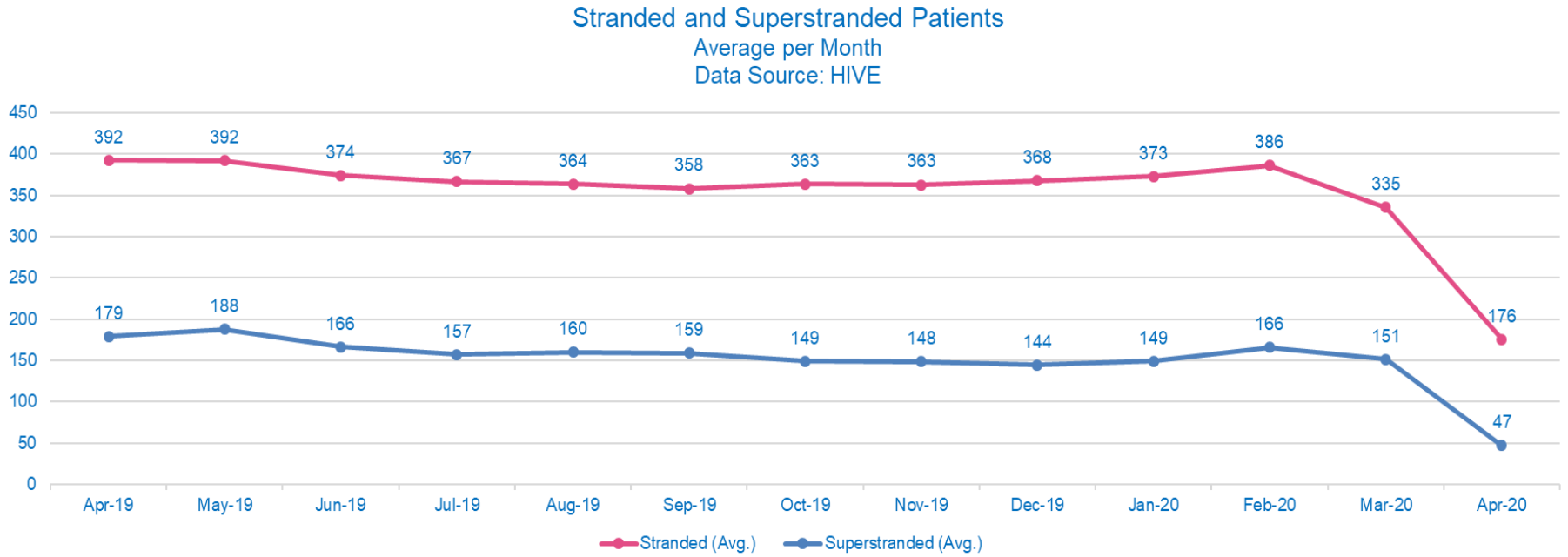

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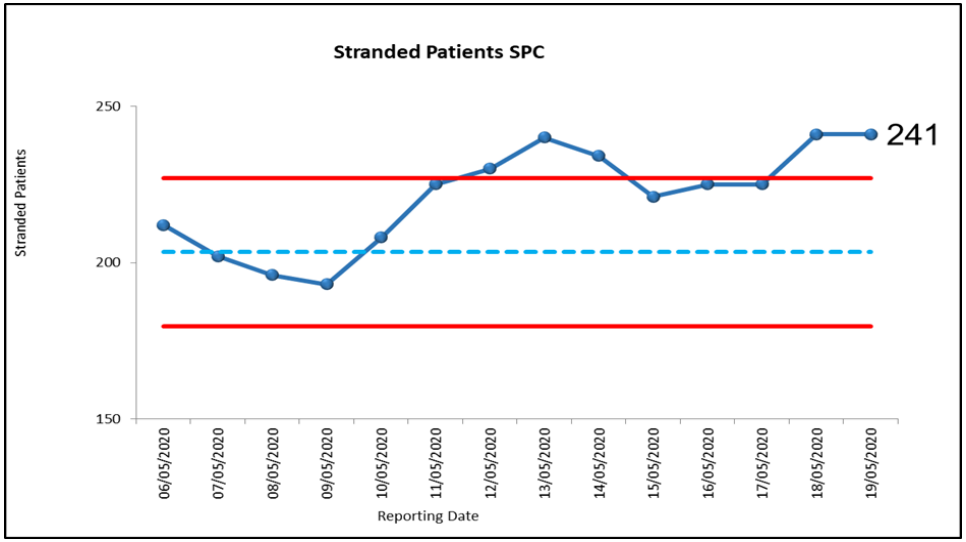
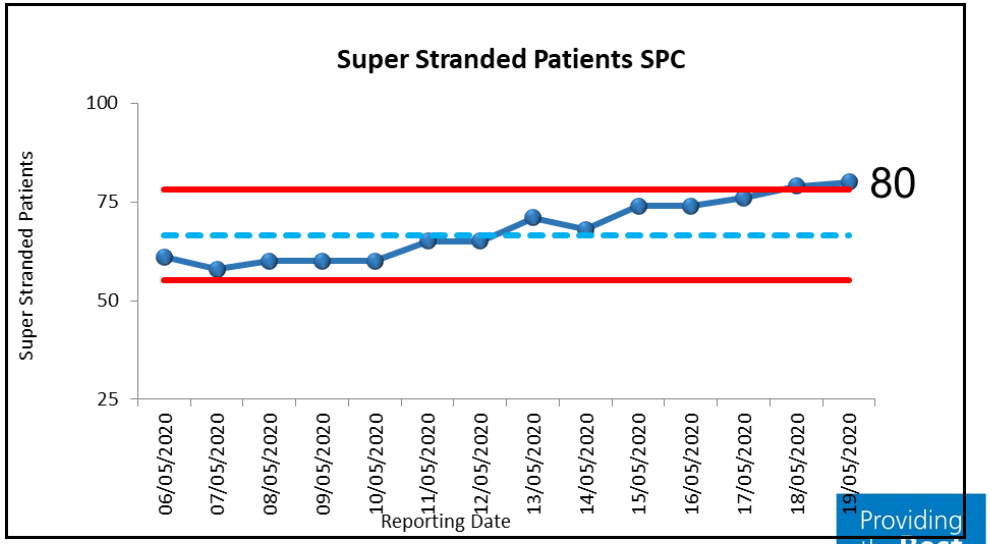
Stranded & Super Stranded

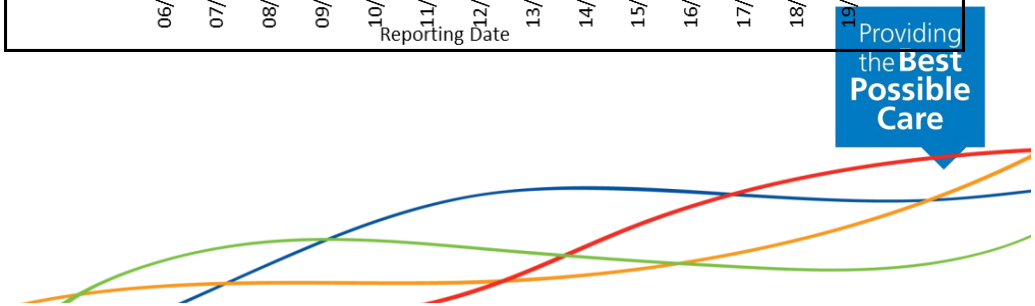
As at 19th May 2020, 23% of the Trust's stranded patients (7-20 days) were recorded as COVID positive.

54% of patients with a LOS of 21 or more days are recorded as COVID positive.

The longer length of stays recorded by COVID positive patients whilst awaiting their return to 'medically fit' combined with the reluctance from Care Homes to take back patients, both COVID positive and negative has had an adverse impact on our stranded and super stranded numbers throughout May to date.







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Non-Elective Admissions – COVID

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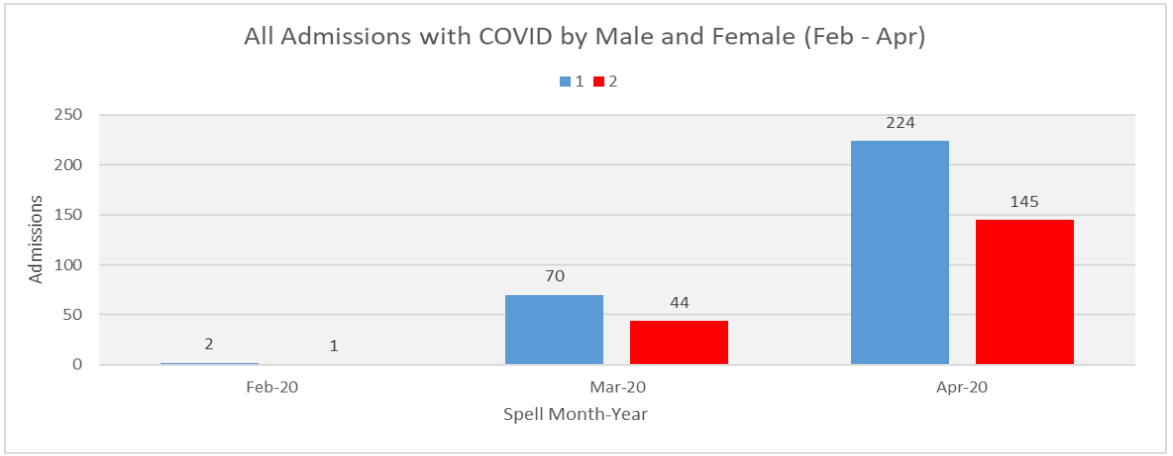
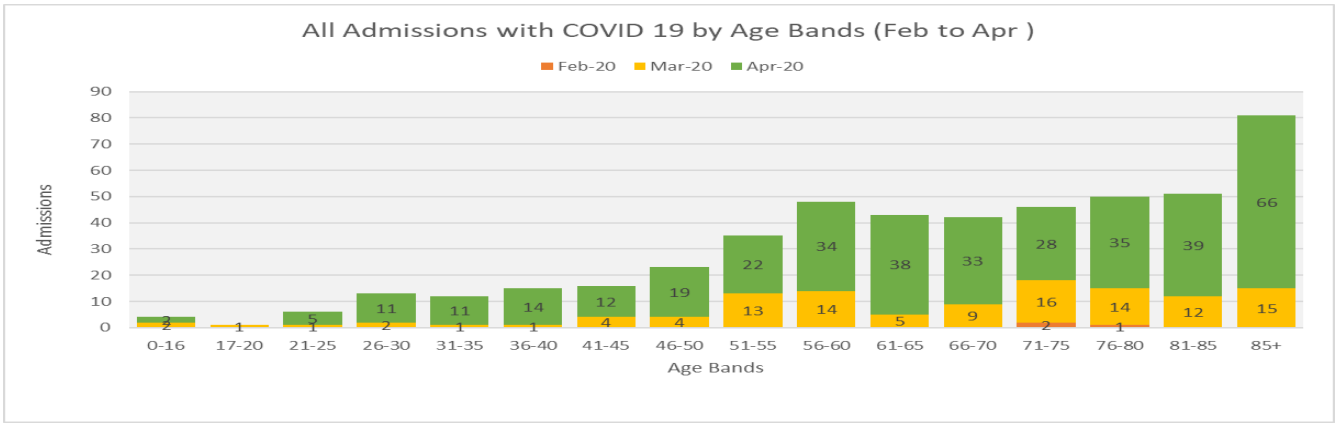
To date, the level of anticipated COVID-19 activity has been lower than anticipated with a total of 369 admissions diagnosed & discharged for this condition in April.

As at 19/05/2020 there are 97 inpatients who are diagnosed positive. A further 42 are awaiting test results.

To date there have been 207 deaths attributed to COVID-19 within the Trust. 335 COVID+ patients have been discharged.

The incidence of admitted patients for COVID-19 is higher amongst male patients. A breakdown by age group is shown below.





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Elective Activity – Cancer 2ww

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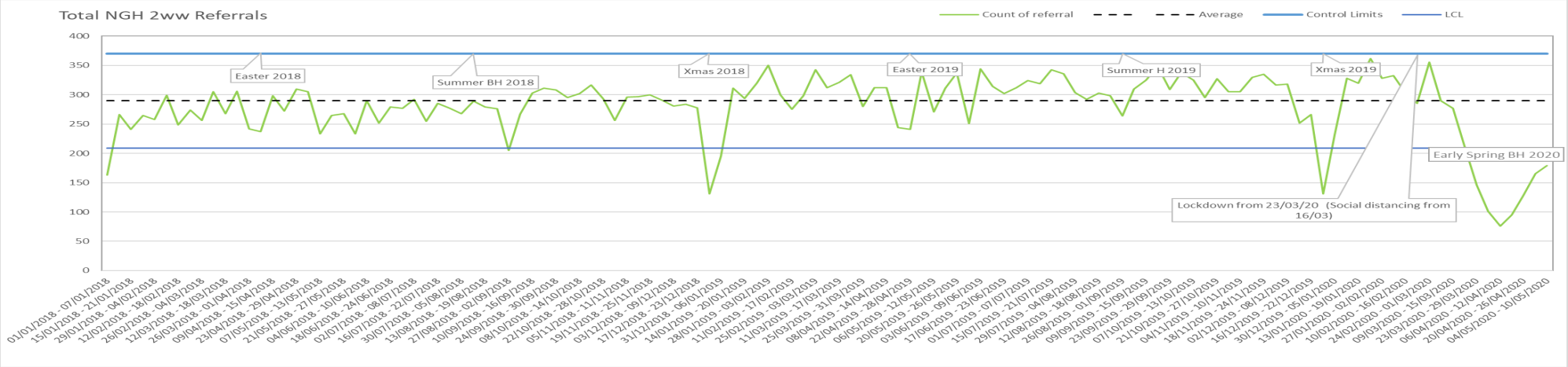

Since the COVID-19 pandemic all patients remain active on the PTL under national safety netting guidance. The cancer team have developed a coding system to identify those patients' pathways affected by COVID, either due to patient initiated delays or hospital suspension of milestones, such as endoscopy in line with national guidance. Somerset have now developed an at risk flag which is also being utilised for reporting purposes. Paused patients are shown on the following slide.

The site specific Clinical Nurse Specialists are proactively contacting patients on their caseload to undertake a "wellness call", identifying any exacerbation of symptoms that require urgent assessment and providing an on-going point of contact for any worries/concerns. The Macmillan Information Centre is undertaking wellness calls to patients referred on the 2ww system, identifying any changes in condition, providing an on-going point of contact. They are keeping in contact with patients who have declined an appointment reviewing dates of self-isolation, screening to enable patients to move along the pathway

The number of patients on the PTL with no next step has increased even with the reduction in referrals from GP's, referral rates are shown below and saw a 65% reduction at the peak of the pandemic.

With the national and local campaign that the NHS is open for business the number of 2ww referrals is set to rise and has seen a 24% increase in May to date compared to April. There will be a finite window the trust has in order to tackle the current backlog before referral rates return to normal.

There are currently 468 patients on the PTL paused, with the majority awaiting diagnostic tests.

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Elective Activity

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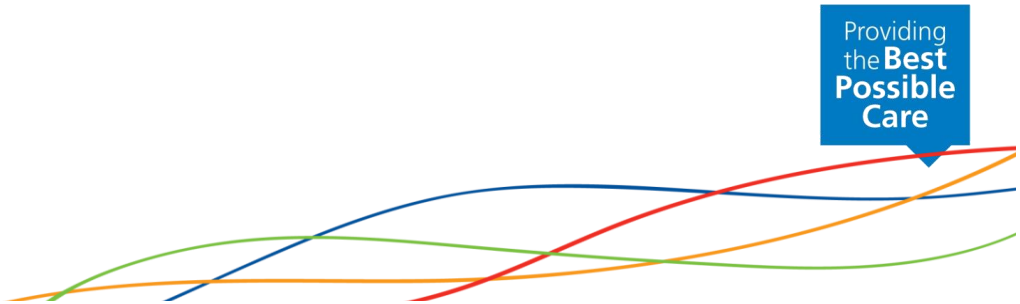
Diagnostic Tests / Procedures Carried Out

Further reductions in diagnostic tests/procedures are noted between March and April 2020.

The majority of this reduction is due to the nationally recommended suspension of all but urgent and cancer diagnostics.

The Radiology Department are now working towards 'reset' in order to provide support to specialties across the Trust. The team are working closely with the IPC Team to implement a safe environment for both patients and staff.

	Test/Procedure	Mar-20 Tests carried out	Apr-20 Tests carried out	Variance Mar-Apr
Imaging	Magnetic Resonance Imaging	1537	859	-678
	Computed Tomography	2066	720	-1346
	Non-obstetric ultrasound	1075	249	-826
	Barium Enema	0	6	6
	DEXA Scan	0	0	0
Physiological Measurement	Audiology - Audiology Assessments	334	43	-291
	Cardiology - echocardiography	700	200	-500
	Cardiology - electrophysiology	0	0	0
	Neurophysiology - peripheral neurophysiology	217	60	-157
	Respiratory physiology - sleep studies	32	114	82
	Urodynamics - pressures & flows	78	0	-78
Endoscopy	Colonoscopy	337	35	-302
	Flexi sigmoidoscopy	114	18	-96
	Cystoscopy	195	33	-162
	Gastroscopy	257	34	-223
	Total	**6942**	**2371**	**-4571**



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Elective Activity

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RTT Incomplete Pathways

With the onset of the Covid-19 pandemic, a sharp reduction in the RTT incomplete pathways is noted.

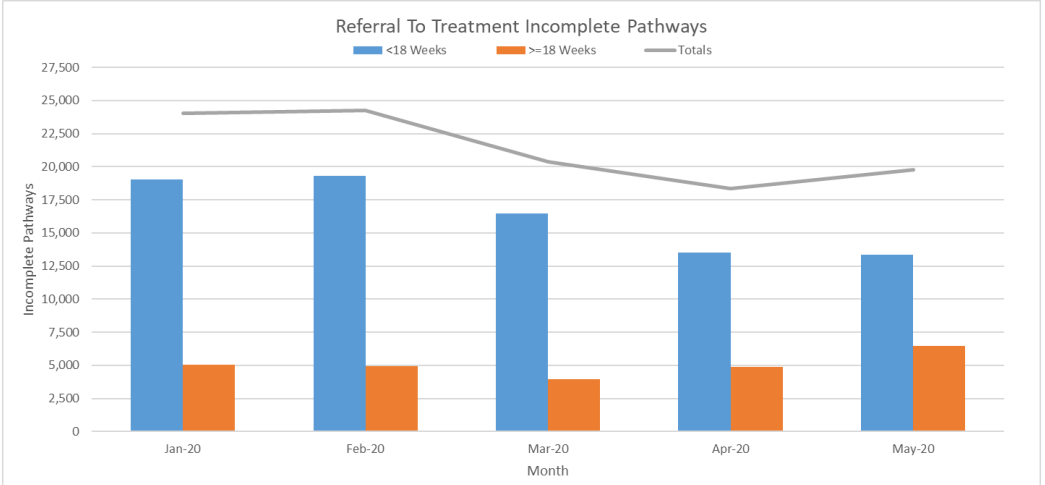
Much of this reduction for April and May is a result of e-referrals being switched off though out these months and the reluctance of patients to be referred into the hospital.

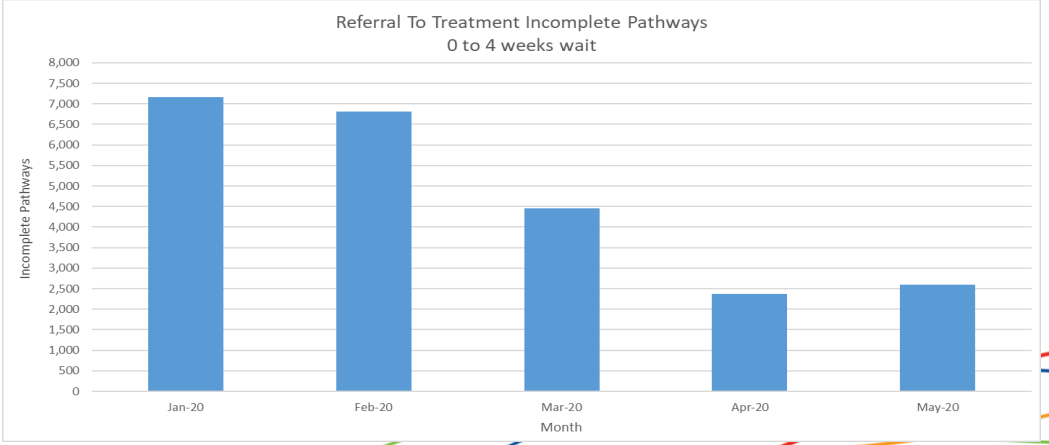
A number of patients have asked to be put on active monitoring (closing their pathway) until they consider it safer to attend; the advantage of this is that the patient will not start from the beginning again with a new referral and their clinical care can be managed.

The over 18 week breaches continue to climb, with a number of 52 week breaches now showing as a result of the need to cancel most elective activity.

Referrals have started to increase again, as seen by the 0-4 week wait incomplete pathways but the total figure for incomplete pathways is circa. 4,000 lower than before the Covid-19 situation.

Reviews of pathways by clinicians accounts for some of this reduction as work was undertaken to rationalise the need for further follow-ups or to safely discharge the patient back to their GP.





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Report To	**Public Trust Board**
Date of Meeting	**28 May 2020**

Title of the Report	**NGH Reset Plan**
Agenda item	**11**
Presenter of Report	Debbie Needham, Chief Operating Officer & Deputy Chief Executive Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Chris Pallot, Director of Strategy and Partnerships Debbie Needham, Chief Operating Officer & Deputy Chief Executive

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 presentation sets out Northampton General Hospitals approach to reset planning including links with system partners and planning. It highlights the phased programme approach to the scale of work required to reset and restart activities.

The approach and governance arrangements have been mirrored with those in place at Kettering General Hospital NHS Trust (KGH) to ensure equity of patient access across the county.

The Board needs to be aware and assured that there are robust plans to reset and restart activities in a safe manner in response to the NHSI/E requirement for key services to restart from 15 June 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. *Create a sustainable future supported by new technology* 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
Related Board Assurance Framework entries	BAF – please enter BAF number(s): 1.2, 1.4, 1.5, 1.6, 2.1, 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	To be quantified
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: No

Actions required by the Board:

The Trust Board is asked to debate and approve the reset plan.

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Our Reset Plan

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

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We are developing a 'Reset Plan' that will set out our operational approach for the rest of the year and beyond

As the **initial peak of the COVID-19 pandemic passes** our focus moves towards creating robust, sustainable plans for the future as well as maintaining our preparedness for future peaks in the virus. Work is in progress **to define our 'Reset Plan'.** This terminology has been deliberately chosen; **our view is that the immediate focus is around 'Reset' for the organisation,** ahead of a move to a 'new normal' in the future**.** The term "recovery" is deliberately omitted as for many areas we do not wish to recover to our pre-Covid state but instead harness the learning that has been made. We will do this with our colleagues at **KGH and the broader health system**.

There are a **number of core components** that make up the plan, which can be grouped across three themes:

Phased operational reopening	Operational re-start period	Recognition of our people	Reintroduce corporate priorities
• Initial reset during Q2 2020 • Medium term plans to Q1 2021/22	• Initial period between modelled peaks (*currently forecast between June and October, subject to change*)	• Plans partially dependent on the relaxing of social distancing • Adoption of flexible working	• Initial reset duringQ2 • Medium term plans to Q1 2021/22
Recovery	**Restoration**		**Renewal**

There are a **range of models for reset** that have been produced at regional- and system-levels, as well as by different organisations. These have been considered in the **design of a plan specific for NGH.** There is alignment with the plans being developed at KGH, **to ensure system-wide coherence and equity for patients.**

Note that this is **an initial outline of the 'Reset Plan' that will evolve over time and in consultation with the organisation.** We will seek feedback and clinical input to refine this plan. **Lessons learned** preparing for the COVID-19 pandemic initial peak **will also inform our planning for future peaks, as set out on in this plan.**

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There will be a staged approached to bringing operational capacity back online – phased operational re-opening

There is an **emergent plan to resume a greater range of services,** that have been scaled back as part of the COVID-19 response, following national guidance. We **expect a level of deferred demand that will need to be met:**

Design principles:	Q2 to Q4 plan:	Future plans:

• As many services will be provided virtually or off-site as possible to reduce cross-infection.
• Where services cannot be provided virtually or on non-NGH sites, we will provide them from partitioned zones within the hospital, totally separate from inpatient areas with dedicated entrance and exits.
• Staff welfare, recognition, rest and recuperation will be considered at every staff of our planning.
• Independent sector capacity has been commissioned nationally and should be utilised where practical to support separation. We will encourage regulators to centrally commission these services for as long as possible.
• A detailed demand and capacity plan for all areas will inform the design of our new capacity.
• Ward moves to support the COVID-19 pandemic response will be kept in place and reviewed in Q4 after the expected second peak.
• Subject to demand and capacity plans, surge capacity is maintained to Q4, subject to clinical review of effectiveness; service plans should reflect this.
	From Q2 onwards, the following services would be resumed on the **NGH main site**:
	• All cancer services to include 2WW, diagnostics, inpatient, chemotherapy and radiotherapy (aligned to that currently offered at Three Shires Hospital).
	• Screening services, primarily:
	  • Breast
	  • Endoscopy
	  • Bowel
	  • Ophthalmology
	  • Diabetes outpatients
	  • AAA
	• Cardiac procedures in the Northamptonshire Heart Centre
	• Paediatrics, Maternity, Obstetrics and Gynaecology will continue with the entire department being partitioned from the rest of the hospital.
	• Area K will continue to provide medical outpatients, pre-op assessment, ENT and day surgery. This too will be partitioned.
	NGH will explore **alternative settings for the following:** (peripheral site or virtually)
	• All outpatient appointments – where **most** first appointments are virtual and **all** follow-up appointments are virtual.
	• Phlebotomy and anticoagulation – site to be established.
	• Mobile MRI scanner – move to an off site facility.
	• In-line with national requirements the trust will recommence certain services to pre-Covid levels in the next 6-weeks.
		Some services will **retain the arrangements, originally enacted to support the COVID-19 pandemic response**:
		• Eye casualty will move to a triage and not walk in service.
		• Some services will continue to be offered by the independent sector – this will build on the growing relationship, that is mutually beneficial, and also be subject to a clinical review of effectiveness.

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Plans are in place to support our people following the initial peak – restoration period and recognition

The organisation has been in a **heightened state of readiness and operational pressure** for a period of months. We have asked a lot of all of our staff **who have gone above and beyond to support the local community.** In doing so every one of them has **experienced truly exceptional working conditions.** Our plan must recognise this, give all staff time to recuperate and recognise the achievements they have made.

Operational restoration period

This includes the following activities and initiatives:

- Increasing the **annual leave allowance from 15% to up to 25% of WTE**, and enabling staff to take leave before the next forecast peak.
- We anticipate that this will result in an **increased used of temporary staff** to provide cover, and will make provision for this.
- Allowing staff to take their annual leave **entitlement over 2-years.**
- The **NGH Space and SOS service will remain open and fully staffed through Q2. Staff have access to support through services such as the Employee Assistance Programme as well as face-to-face support where required.**
- Staff will have **access to IAPT (psychological therapies)** through an agreement we are putting in place with NHFT.
- Critical care and medical staffing models **will be reviewed to ensure that this service can also benefit from the above,** whilst noting that demand is likely to remain higher.

Recognition of our people

Dependent on social distancing rules being relaxed, we plan to offer two key events to recognise the contribution our staff have made:

- **A family day** for the organisation to recognise not only the efforts of the staff we directly (and indirectly) employ, but also their family members.
- **A event** to thank those who have shown kindness to #TeamNGH by donating items to staff during the pandemic. This will additionally provide an opportunity for networking with Trust staff and other local businesses, supporting the local economic recovery (a key determinant of health).
- A **large evening event**, open to every member of #TeamNGH and in partnership with our charity and other health partners to thank staff.
- **Review of all positive staffing changes** made in response to the pandemic, e.g. remote and/or flexible working with a view to making these permanent.
- Review a range of possible reward offers for staff providing exceptional services during the pandemic response.

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Positives from the new ways of working will be retained – reintroducing corporate priorities

Rapid changes in **ways of working were made to respond to the COVID-19 pandemic.** In times of normal operation these would be piloted and tested prior to roll out, **which was not possible in the time available.** This has resulted in **some positive changes** alongside the **pausing of processes and functions that now need to be restarted:**

New ways of working that will be maintained:

- As above, we will **follow the Government advice on social distancing**, and this will inform when we bring staff back onto site to work. When we do, the **positives of flexible and distributed working will be retained.**
- This is supported by the **roll out of laptops (over XXX people now have a VPN-enabled laptop)**, improvements to the VPN and the imminent launch of **virtual desktops.**
- Connected, we will **retain a commitment to virtual meetings over face-to-face.** We know that this means **more people are able to attend** in a sustainable way. This will be increasingly important as we move to the Group model.
- **7-day working** has been embraced across the organisation
- We will **continue to collect staff feedback via the *Listening into Action* app.** This will also help us **collect data on the changes that staff view positively ('treasure') and negatively {'trash').**
- **All staff will be encouraged to contribute** to the review following the same process as for the Trust Strategy and Summer of Engagement.

Capturing the Learning

- Learning the lessons internally and with the system. Our Transformation Team will support all cells to identify and evidence our learning.

Paused processes that will be restarted:

- Core Quality Assurance (QA) processes will be reinstated, though these **will focus initially on areas not experiencing high. demand.** This will support our preparations for CQC reinspection.
- A fuller **training programme** will be offered. This will be enabled by **a significant amount of training now being offered virtually.** Staff will be released to ensure compliance with training requirements.
- Staff **appraisals will be encouraged to restart**, with an intention that formal reporting on the completion rate begins again formally in Q3.
- **Revised and updated budgets** within our existing envelope to take account of the changes enacted.
- **Operational structures** (the way we work) that were set aside during the outbreak **will be readopted**. We will learn where from the process where we need to, ensuring our **leadership and governance** structures are fit for purpose.
- **Hospital Management Team will oversee the operational reset** as a forum with the requisite membership.

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Delivering the Reset

We will have a single plan for elective and outpatient reset with our colleagues at KGH to ensure equity of access for all patients in the county. For these, and all other elements we will also align with the boarder system plan, led by NHS Nene and Corby CCG.

We will retain daily oversight of our reset via **the Bronze groups that were established** as part of the Covid-19 incident response. They will now have a dual purpose, **delivery of our operational response** to the pandemic and **design and delivery of our reset** moving towards a new NGH**.** Daily silver calls will now focus on each of these elements. These are listed in the appendix.

A new oversight group has been established to **oversee the reset from a strategic perspective**. This will be Chaired by the Director of Strategy and Partnerships. The oversight group will report into existing governance arrangements via the **Executive Team and HMT**.

Daily Silver Calls:

- Operational response **managed alongside** the reset.
- Daily update on **actions and emergent plans.**
- **Coherence** with national and local requirements.
- **Alignment with the broader hospital strategy** for the reset.
- Operational aspects **aligned with KGH to ensure equity of service** opening and function across the county.
- Tasks and membership of each bronze cell confirmed in the following pages.

Weekly Oversight Group:

- Develop a **phased reset operational plan** in-line with emerging national policy and aligned to that of KGH. Identify key priorities to specifically deliver jointly with KGH including OPD and elective restoration as well as the joint work with specialities previously agreed.
- Agree the **baseline position to monitor, model and address the impact of increased waiting times, changes in referral patterns** and volumes.
- Produce a **detailed demand and capacity plan** for all areas for 2020/21 from the baseline above.
- **Re-introduce corporate priorities** and ensure that new working practices which have added value are maintained (treasured) and those not are not re-introduced (trash).
- Agree the **plans for operational restoration**.
- Produce a **detailed plan that enables sufficient recovery time for our staff along with a significant recognition programme.**
- **Align to the wider Northamptonshire system recovery.**

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System Reset

The Trust is working with other system partners in a weekly reset group the key aim to co-ordinate provider and commissioner planning alongside all system cell activity as it relates to the restoration and reset phase.

The group aims to reset services where possible to a 'new normal'. This will involve keeping those things that have worked well as part of the pandemic response, restarting the most urgent services in new, innovative ways and restoring other services.

The group identified a number of core principles to be considered and applied;

- Virtual working/ digital transformation
- Diagnosis (new and innovative treatment models)
- Safeguarding
- Public Health and Self Care
- Communications and public engagement

Six themes have been identified to focus the work over the coming weeks;

- Hospital discharge and flow
- Cancer (to include screening, endoscopy and referral management)
- Integrated Care (with a focus on care homes, primary care and system flow)
- Referral & Treatment (outpatients and elective with links to primary and out of hospital care)
- Population Health & Wellbeing (with a specific focus initially on mental health)
- Staff Support & Wellbeing

In addition to the system work the Trust is working closely with Kettering General Hospital regarding approach and timings of reset and restart of common services.

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Responding to the Operating Framework

On Friday 15 May 2020 NHSI/E published a new Operating framework for urgent and planned services within hospitals. This guidance includes advice regarding careful planning, scheduling and organisation of clinical activity and a scientifically guided approach to **testing the right patients and staff, at the right time and frequency** that will underpin efforts to minimise COVID-19 transmission in hospitals.

Key messages that we must consider when developing our reset plans and communicating with patients and public;

- Any **elective admission** (includes day case) – patients should **isolate for 14 days** prior to admission **along with members of their household**. As and when feasible this should be supplemented with a pre-admission test (conducted a maximum of 72 hours in advance) allowing patients who tested negative to be admitted with IPC and PPE requirements that are appropriate.
- Other day interventions – testing and isolation to be determined locally, based on patient and procedural risk.
- **Outpatients** – only patients that are asymptomatic should attend ensuring they can comply with normal social distancing requirements.
- Ensure planned activity aligns with other dependencies, inc. testing capacity, medicines supply, consumables and PPE
- **Asymptomatic staff testing** – additional available NHS testing capacity should be used to routinely and strategically test asymptomatic front line staff as part of infection prevention and control measures.

The Trusts system reset plan is looking at creating an admissions and attendance policy that incorporates this guidance but also NGH specific measures.

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Next Steps

The Trust has over the COVID-19 period still been carrying out some levels of activity where possible in offsite locations and with the support of the independent sector. Over the next four weeks we will be developing the programme reset plans that set out the phased restart of operational activity with particular focus on cancer, screening services, diagnostics and urgent surgical activity.

The aim is to have all plan for the reset/ restart of phase one of operational activity signed off in order to enable patients to be seen from the 15 June 2020.

In order to achieve the above timescales there are a number of dependencies that need to be understood and considered;

- Rest and recovery for NGH staff
- Testing capacity
- PPE availability
- Patient/ public behaviour
- Primary care support/ coherence of approach
- Emergency/ incident response requirements
- Estates/ equipment requirements

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Appendix – Our Reset Groups

We put patient safety above all else
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Reset Plan - BRONZE

INPATIENT CAPACITY

Ward changes
Site meetings process
Complex discharge changes
Escalation policy refinement & incident room use for opel 3 & 4
Medical leader of the day
On call tiers Inc. nursing hub

LEAD: Carl Holland

IPC

Strengthened team
Response review for second wave & winter

LEAD: Ros Pounds

URGENT CARE

New ways of working in AE (split area)
Medical rota changes
Increase hot clinics (by 8 June 2020)
Commence frailty service

LEADS: Rob Hicks/Fiona Poyner

ELECTIVE ROUTINE CARE

Reintroduction of routine RTT work (by 8 June 2020)
Virtual pre-op
Use of private sector (continuation after June 2020)
Endoscopy (by 8 June 2020)

LEAD: Matt Tucker

OUTPATIENT CARE

Virtual OP
Patient initiated FU
Referral streaming
Combine areas for Screening recommencing
Increased activity

LEADS: Mary Visser/Julie Mason

DIAGNOSTICS

Ongoing swabbing changes
No medical rehab internally
Re-introduction of routine radiology
Ring fencing for urgent/cancer
New venue for BTU & BTU in community

LEAD: Davis Thomas

CHILDRENS

PAU expansion to reduce activity in AE
New children AE expansion

Lead: Lalith Chandrakantha

MATERNITY

Re-introduction of community deliveries
Re-introduction of community OP
Movement from Area K

Lead: Sue Lloyd

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Reset plan - BRONZE

STAFF WELLBEING & EXTERNAL SUPPORT

Volunteers
Leadership
Welfare & SOS
Kindness
Annual awards & recognition
Annual leave carry over
Thankyou events for local businesses/people who have supported us/staff
Our space expansion

LEAD: Bronwen Curtis

PROCUREMENT

Integrated procurement from all areas
Shared procurement across KGH/NGH

LEAD: Allan Rivans

WFH

Services/roles WFH
Hot desking on site
Admin typing pool – WFH
Guidelines/policy

LEAD: Sandra Neale

ESTATE & FACILITIES

Releasing estate
Doors/partitions on ward bays
Changing rooms for all staff
Use of facilities

LEAD: Stuart Finn

INFORMATION TECHNOLOGY

Virtual meetings (Teams/Zoom)
Hardware for WFH
Modelling
Tracking recovery
Providing weekly reports to the reset group

LEAD: Hugo Mathias

FINANCIAL GOVERNANCE

Delegated decision making

LEAD: Phil Bradley

CANCER

Re-introduction of full OP & screening
FU
Re-introduction of Elective work at BMI & NGH

LEAD: Owen Cooper

CORPORATE GOVERNANCE

Governance lite (fewer meetings)
Use of teams/Zoom for board & committees
Revised ToR
Joint Working with KGH

LEAD: Claire Campbell

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Reset plan - BRONZE

LEADERSHIP

Capturing learning from the incident room & command/ control process.
Modelling leadership values & inclusivity.
Re-Establishing business as usual whilst treasure/trash is maintained.

LEAD: Mark Smith

COMMUNICATIONS

Continued through reset as part of ongoing incident response & reset.

LEAD: Sally Watts

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Report To	**Public Trust Board**
Date of Meeting	**28th May 2020**

Title of the Report	**Infection Prevention & Control Board Assurance Framework**
Agenda item	**12**
Presenter of Report	Ms S Oke- Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Graham Pike – Infection Prevention Lead / Matron Elderly Care Ms S Oke- Director of Nursing, Midwifery & Patient Services

This paper is for: (delete as appropriate)

Receive	Assurance
To discuss, in depth, a report noting its implications for the Committee or Trust without formally approving it	To reassure the Committee that controls and assurances are in place

Executive summary

On 4th May 2020 NHS England/Improvement published an Infection Prevention & Control Framework. It is not compulsory to complete the framework however, it is provided to enable organisations to self-assess our compliance with Public Health England (PHE) guidance.

The Infection Prevention & Control Team have completed the self-assessment, the key areas of focus will be on auditing our current practice including:

- Audit of patient notes regarding 'streaming'
- Audit of PPE compliance across the organisation

The outcome of these audits will be shared as part of future Infection Prevention & Control reports.

Appendix A provides the full assessment.

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
Related Board Assurance Framework entries	BAF – 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)

	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	On-going expenditure discussed with Finance team and recorded against Covid 19.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: Health & Social Care Act – regulation 12

Actions required by the Committee:

The Committee is asked to note the content of the report and continue to provide appropriate support for our Infection Prevention Team.

Appendix A
Infection Prevention and Control Board Assurance Framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	Patients are split into two streams in the Emergency Department: those with signs and symptoms suggestive of COVID and those who are not suspected of having COVID-19. All patients admitted non-electively are swabbed for COVID-19 using a swab which is processed in-house in a matter of hours.	Audit of notes to check assessment of risk prior to streaming is required.	IPC liaising with Site team and Urgent Care Matrons on a daily basis in order to identify any issues with this process.
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Those suspected of COVID-19 are moved from ED to Esther White Ward to await the results of their swab. Patients are bedded in bays with doors and en-suite facilities to minimise the number of other patients they are exposed to. If positive they are then moved to a COVID-positive cohort ward. If negative, following guidance from the Royal College of Pathology (13/05/2020), they are required to be swabbed again in 48 hours to reduce the risk of false negatives before they can be moved to a negative ward. Once		

	the second swab result is known these patients are moved to a COVID-positive or COVID-negative ward as appropriate.  Patient flow.pdf		
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Patients are de-isolated from isolation or cohorting following both PHE and RCP guidance. Patients being discharged to other healthcare settings are swabbed for COVID-19 using same-day in-house testing. Patients being transferred to care homes as part of their on-going care are being screened for Covid 19 and need to have a negative swab result prior to transfer.		
• patients and staff are protected with PPE, as per the PHE national guidance	PPE is used as per PHE guidance. We have tailored the PHE poster to each clinical area and we have had no supply issues with PPE. We have fit-tested staff for FFP3 masks in all areas where aerosol-generating procedures (as defined by PHE) are undertaken and we have have a good stock of unused, reusable FFP3 masks.  Fit check poster.pptx On-ward training in PPE has, and continues to be, delivered by the IPC team, as well as updates going out via	Audit of PPE usage required.	IPC team visible in clinical areas and are promoting correct use of PPE as part of 'spot checks'.

	the daily bulletin. The Team also provides a Frequently Asked Questions on PPE section on the Trust intranet. The IPC team visit wards daily and clarify any misconceptions, providing reassurance.  PPE doffing - droplets.pptx  PPE doffing - suspected or confirm		
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Any updates in national guidance have been incorporated into local guidance and communicated to clinical teams. IPC guidance is reviewed at the Trust 'bronze' cell meetings held daily and escalated through our Silver to Gold as required.		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Flowcharts showing above processes have been shared with all wards and embedded, by e-mail and via hard copy, as well as being distributed via the daily bulletin from the Trust's Comms. team. The most up-to-date guidance is also accessible via the Trust intranet page. Board Assurance report made to Trust Board (28th May 2020).		
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	Risks are added to the Infection Control risk register and escalated to corporate level if necessary (dependent on level of risk after mitigation). Risks are summarised in section 1.7 of the Board Assurance Framework.		

• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Patients who are not suspected of COVID-19 are still following pre-COVID pathways with only minor changes: they are swabbed in ED using same-day in-house testing, medical patients move to Walter Tull assessment unit and speciality patients (e.g. surgery, T&O) do not move to their speciality ward until their swab result is known to be negative. If it is positive they move to a COVID-positive cohort ward.		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	As above regarding training given to ward staff. Domestic staff have been given training and updated with posters and leaflets. Increase in IPC Team to provide additional resource to support all services, including the Domestic teams  Covid -19 Facilities.pptx		
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to	Additional touch and isolation cleaning training actioned and ongoing. PPE training and correct usage of PPE in place in line with government and		

COVID-19 isolation or cohort areas.	local guidance. Designated and trained staff in place to undertake isolation and deep cleaning. Procedures and SOP's available to evidence.		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Isolation cleans are performed for bed spaces vacated by suspected and confirmed cases of COVID-19, as well as for other infections with alert organisms (in line with national guidance).		
• increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	This is in place and risk assessed against the national standards of cleanliness "high risk" assessment with the addition of comprehensive PPE training.		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Correct procedures are in place for safe handling and removal of linen confirmed as COVID 19 possible contamination using correct water soluble inner bag and correct outer bag. External laundry services provider confirmed their procedures for handling and washing complies with the national guidance provided to them.		
• single use items are used where possible and according to Single Use Policy	This includes cleaning cloths, mops and isolation materials / chemicals used.		
• reusable equipment is appropriately decontaminated	Equipment and plastic equipment including signage are all		

in line with local and PHE and other national policy	decontaminated using appropriate decontamination supplies.		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	An evidence based guideline has been published on the trust intranet: *COVID-19 guideline: antibiotics for pneumonia in adults in hospital.* In addition healthcare professionals are encouraged to promote the use of the '*Start Smart, then Focus'* when prescribing antimicrobials. Pharmacy is providing a service on all wards to offer antimicrobial stewardship advice to the multidisciplinary team. They are also contactable out of hours via the on-call system. Microbiology is available to be contacted regarding any stewardship advice.		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national	Visitors are not permitted aside from the exceptions in the national guidance, however we have deviated slightly in that we allow two visitors in cases of		

guidance on visiting patients in a care setting	end-of-life care, as we felt it was important for the person visiting to have someone to support them. Guidance on this has been jointly written by the Trust's Palliative Care and IPC teams and PPE is provided as indicated.  Visiting guidance may 2020s.docx  End of life visiting - staff advice.docx		
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	We are treating all patients as potentially positive so the above restrictions apply to all areas within the Trust.		
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	Information & guidance available on the website with easy read versions		
• infection status is communicated to the receiving organization or department when a possible or confirmed COVID-19 patient needs to be moved	The Site team oversee all internal transfers between wards. COVID-19 results are send directly to the Site team from the Microbiology department. These results are used to inform patient moves.		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection	See answers in Section 1		
• patients with suspected COVID-19 are tested promptly	See answers in Section 1		
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	An algorithm based on both PHE and RCP guidance has been developed and shared with clinical and site teams. This shows the processes to follow regarding patient isolation and testing when this situation arises. In summary, patients are promptly isolated and tested.		
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Patients are advised in their appointment letters not to attend if they have symptoms of COVID-19. Patients attending have their temperatures checked and are asked if they have any symptoms. Patients who display symptoms are advised to isolate at home as per national guidance. The		

	Trust has continued with a number of Out patient clinics 'virtually' as appropriate.		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	See answers in Section 1 As part of the Trust management of the pandemic there has been proactive support for staff to 'Work from Home' and are preparing 'Social Distancing' guidance for staff working in the clinical & non-clinical environment.		
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	See answers in Section 1		
• a record of staff training is maintained	Record of annual training updates is maintained by HR. Trust induction also covers PPE usage. Significant COVID-specific PPE training has been delivered on an ad-hoc basis, talking to whichever staff are present and available on clinical areas		

• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	We have sufficient stock & supply of PPE so have not had to implement any re-use of PPE.		
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	We have sufficient stock of PPE so have not had to implement any re-use of PPE.		
• adherence to PHE national guidance on the use of PPE is regularly audited	Audit of PPE usage required to be completed by IPC during May 2020.	Section 1	IPC team visible in clinical areas and are promoting correct use of PPE.
• staff regularly undertake hand hygiene and observe standard infection control precautions	Ward audits are submitted monthly. Validation audits are performed three-monthly by the IPC team, in high risk areas these are been performing twice monthly. As part of the trust wide Assessment & Accreditation – A&A (standard 5) a joint review by trust A&A Lead & IPC is being undertaken during May 2020.		
• staff understand the requirements for uniform laundering where this is not provided for on site	Those staff that laundered uniforms off site have been instructed of the necessary washing requirements. The Trust has also received many donated linen bags for staff to use to transport their uniforms home to wash as advised.  Guidance for cleaning of uniform.d		
• all staff understand the symptoms of COVID-19 and	Guidance sent to all staff via Communications team and displayed		

take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	on Trust intranet. Frequently asked questions around this are listed and answered on the Trust intranet by our HR team and supported through the trust daily Communications Briefing.		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	See answers to Section 1		

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance • screening for other potential infections takes place	SARS-CoV-19 molecular testing is undertaken in-house by qualified biomedical scientist under the supervision of the microbiology consultants. We follow PHE guidance on testing all patients on admission (symptomatic and asymptomatic). All inpatient suspected cases are tested. Any suspicion of other co-infections is tested as required. We are isolating our patients with symptomatic infections, including c.diff; we are continuing our HOHA/COHA surveillance and post infection reviews. Our isolation process has been challenging but the IPC team are working closely with the Site team to isolate patients promptly.		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert	Policies are shared through various forums across the Trust and supported by IPC team to understand &		

organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance • PPE stock is appropriately stored and accessible to staff who require it •	implement. The Trust has 'NetConsent' on the intranet to enable staff to review each policy/guidance prior to accessing Outlook. Comm. Daily briefing provide updates and are supported by different media methods. This is re-enforced through the Bronze, Silver & Gold daily meetings. Due to the increase of clinical waste additional facilities have been provided around the Trust that are monitored by the Domestic staff and supported by the IPC team. Daily update on all stores (PPE) are provided as part of the internal management of the pandemic (Silver Meeting update from Bronze work streams		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and	Covid Risk assessments currently being completed by managers – including BAME risk assessments. Managers contacting OH Department for support with mental wellbeing		

psychological wellbeing is supported	through referrals to Health Psychologist and for advice regarding workplace adjustments		
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	IPC team provide training and maintain a record of those who have received training.		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	OH telephone support line set up for out of hours. Self-isolating staff contacted by OH for welfare call on receipt of list from HR. The line-manager is also engaged to provide support to their individual staff.		
• staff that test positive have adequate information and support to aid their recovery and return to work.	OH contacting positive staff with their results and advising on their return to work		

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UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Private Trust Board**
Date of Meeting	**28th May 2020**

Title of the Report	**Future Risks to COVID19**
Agenda item	**13**
Presenter of Report	Mr M Metcalfe – Medical Director Ms S Oke – Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Mr M Metcalfe – Medical Director Ms S Oke – Director of Nursing, Midwifery & Patient Services

This paper is for:

	Noting		

Executive summary

This paper illustrates the way in which the covid-19 strategic and corporate risks are likely to complicate the reset process for the delivery of clinical services as we progress through response phases.

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* *(Delete as applicable)*
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 – please enter BAF number(s)

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	
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper

Actions required by the Board

The Board is asked to:

Future Risks of Covid-19

Introduction

Risks relating to Covid 19 have been reviewed, revised and updated to ensure that the strategic and corporate risks encompasses the overall impact of the Trust being unable to respond appropriately to the pandemic. These were presented at the April Board of Directors, and for ease of reference repeated here;

Strategic risk

"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."

Corporate Risks

1. Procurement and Supplies: Risk of availability of or timely/ consistent delivery of supplies of medical devices, clinical consumables and medicine
2. Business continuity: Risk that critical and essential business activities are impaired
3. Workforce: Risk of shortages of competent staff to provide clinical care to Covid patients
4. Communication/ IT Technology: Risk of low public engagement with new systems and reduced public confidence
5. IT: Increased demand on IT infrastructure and increased risk of Cyber-attacks resulting in interruption/ loss of access to digital services
6. Long- Term recovery: Risk of long term impact of Covid 19 on unmet demand in the community and impact on future service delivery and ability to meet patients' needs
7. Infection Prevention: Inadequate environment, facilities and systems in place to manage and monitor the prevention and control of infection to safely manage the Covid 19 pandemic

The purpose of this paper is to provide a narrative illustration of some of the ways in which these risks may manifest as we move through phase 2 of the covid-19 response and beyond.

Procurement and Supplies: Risk of availability of or timely/ consistent delivery of supplies of medical devices, clinical consumables and medicine

The availability of supplies remains precarious across multiple critical areas, including but not limited to;

- PPE (masks and gowns being repeatedly reduced to less than 3 days supply)
- Critical care equipment (ventilators, oxygen efficient CPAP machines, kidney dialysis equipment and solution)
- Drugs (including propofol and muscle relaxants)

These are not only essential for patient and staff safety during covid-19 response but also for resuming other clinical services. For example, the ability to surge ventilated bed capacity in the event of a second or subsequent peaks of covid depends upon the use of ventilators normally used for routine surgical operations. Anaesthetic drugs are also needed to maintain patients when ventilated on intensive care units. The trust has not received any additional ventilators and has periodically had to use alternative drug choices to standard first line treatment when stores have been low. Provision of these drugs and equipment are centrally controlled.

At times when national stock levels of key items are low, regulatory advice, eg from PHE and HSE, has been adapted to reflect the shortages in a way which threatens confidence and credibility with staff.

Business continuity: Risk that critical and essential business activities are impaired

This risk reflects potential outputs of the other corporate risks articulated. There are instances where this has been inevitable and unavoidable, such as interruption to certain categories of chemotherapeutic treatment for cancer patients (in line with national guidance) due to the risks to patients.

In the ideal scenario that mitigations for all other covid-19 specific risks are full and sustained there remains the residual issue of clearing the backlog of work deferred during phases 1 and 2 of the covid-19 response. There are elements to some clinical pathways which were rate limiting locally and nationally prior to the covid-19 response and for which there are no near term solutions. Examples of these include breast radiology and endoscopy. For these and other instances the reality of the mitigations is that they are likely to be incomplete and intermittent.

Workforce: Risk of shortages of competent staff to provide clinical care to Covid patients

At present this presents the greatest risk to the delivery of care to covid-19 and non covid-19 patients.

The risks currently and over the coming months are substantial. There are consistently over 400 staff off work for covid-19 related reasons in addition to non-covid related staff sickness. The total is consistently over 12% of the combined work force.

The imminent advent of asymptomatic staff testing, based on prevalence studies in other trusts, is likely to take hundreds more staff out of the work place. Similarly the risk assessments undertaken for BAME staff and other high risk groups are likely to exacerbate the absence rate still further although this can be partially mitigated for some staff groups through remote working. It is not anticipated that the shielding advice will change significantly in June when it is reviewed by the government.

The impact of these trust level figures are readily exemplified at a more local level. Already we have experienced the haematology service reduced from 6 to just 1 consultant able to work on site delivering patient facing care, with a similar reduction in junior staff necessitating contingency planning with university hospitals of Leicester for emergency patient transfers.

Covid-19 absence has resulted in the cancellation of cancer surgery in specialities where surgeons have gone off sick and surgery through the three shires hospital is being reduced to day cases only at the time of writing due to difficulties in providing resident medical cover overnight for the site.
There has been an outbreak of covid-19 on one of our wards identified when 3 patients tested positive after admission with non-covid symptoms and an increase in covid related staff absence. Asymptomatic testing was instituted and 18 members of staff were found to be covid-19 positive.

At the time of writing 9 doctors from the same speciality are absent for suspected covid-19 symptoms, all have been tested and of the 5 results returned all are positive.

It is not currently possible to readily pull out staff group level data on positive testing, but over the last 2 weeks there has been a notable increase among the clinical work force.

The psychological impact on those staff who are caring for patients with covid-19 disease is substantial and the long term impact in terms of PTSD is yet to be quantified. The trust has rolled out training in the identification and response to this as mitigation. Broader staff anxieties in relation to contracting covid-19 or transmitting it to their households also impact on available workforce, in particular to bringing back on site some for whom an appropriate period of covid related absence has ended.

Communication/ IT Technology: Risk of low public engagement with new systems and reduced public confidence

Bandwidth available to support direct clinical care and essential management functions whilst socially distancing is an increasing risk to care. Examples include;

i. Delayed transfer of radiology images delaying care
ii. Degraded connectivity for consultations and meetings virtually

The cybersecurity risk posed by the virtual delivery of care and back office function is increased.

As the covid response progresses through to phases 3 and 4 the risk of retaining clinical engagement with new efficient models of care supported by IT against an inherent desire to revert to comfortable practice is anticipated.

The reduced ability to undertake physical examination of patients is currently offset by the risk reduction in transmitting covid-19 to patients and staff. As the risk of covid-19 transmission diminishes in later phases of the response the relative risks of remote clinical care delivering will require re-visiting.

Infection Prevention: Inadequate environment, facilities and systems in place to manage and monitor the prevention and control of infection to safely manage the Covid 19 pandemic

Alongside the challenges of securing adequate PPE to protect staff and patients are 2 further key risks to infection prevention in relation to covid-19.

i. Social distancing, a key element to reducing transmission, is not always possible to achieve in the NGH estate and sometimes imperfectly observed where possible. This will prevent minimisation of transmission.
ii. Testing capacity and timeliness. Although huge improvements in capacity and process have been achieved, the asymptomatic staff testing programme is only able to test the workforce every 10 days and the turn around time for test results is currently approximately 2 days. These currently unavoidable limitations impact the efficacy to reduce transmission.

Steps taken to maximise social distancing in the hospital, creating one way systems, reducing throughput of areas and cleaning between cases by way of examples substantially reduce productivity per clinical session.

Despite every tool currently deployed there will still be outbreaks in the trust in the green zones it seeks to establish to allow the safe restoration of non-covid non-urgent work.

The notable recent increasing profile of regulatory bodies also represents a level of risk to subsequent covid-19 response phases, illustrated here by introduction this week of the requirement to secure prior regulatory approval for any capital expenditure required to minimise covid risk for staff and patients. Previously this has only required approval through the trusts incident response process. Delays or refusals will directly delay resumption of non-essential clinical services, as the trust does not have sufficient capital in the CRL to address the estates essential and urgent maintenance backlog and therefore cannot divert this to address covid-19 specific risks.

Long- Term recovery: Risk of long term impact of Covid 19 on unmet demand in the community and impact on future service delivery and ability to meet patients' needs

The tolerance of our patients and their relatives to the restrictions we have required deleterious to their experience, for example the exclusion of patient visitors, has for the large part been a model of understanding. This is likely to become increasingly strained the longer the restrictions are necessary and at present it is not possible to forecast their safe lifting.

The anxieties of patients around contracting covid-19 during visits to hospital, which have some basis in the observation of hospital acquired covid-19 disease are resulting in patients declining to attend even for some urgent investigations and treatments, despite widely broadcast encouragements to do so.

A synthesis of all the risks illustrated above highlights the very substantial likelihood that there will be prolonged delays to the restoration of non-urgent, non-covid-19 clinical services despite the excellent work across the organisation to prepare for and respond to the global pandemic. There are also delays and other adverse impacts on some urgent care delivery.

UNIVERSITY OF LEICESTER
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PUBLIC TRUST BOARD

Thursday 28 May 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 26 March 2020	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	7.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	8.	Chief Executive's Report	Receive	Dr S Swart	**C.**
	9.	Integrated Performance Report	Assurance	Dr S Swart	**D.**
	10.	COVID19 NGH response	Assurance	Mrs D Needham	**E.**
	11.	Reset Plan	Assurance	Mrs D Needham	**F.**
	12.	Infection Prevention & Control Board Assurance Framework	Assurance	Ms S Oke	**G.**
	13.	Future Risks to COVID19	Assurance	Ms S Oke Mr M Metcalfe	**H.**
11:00	**14.**	**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 25 June 2020 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).