Public Trust Board - 30 September 2021

Thu 30 September 2021, 09:30 - 12:30

ZOOM

Northampton General Hospital NHS Trust

Agenda

09:30 - 09:30
0 min

1. INTRODUCTORY ITEMS

1.1. Introduction and Apologies

Information *Alan Burns*

1.2. Declarations of Interest

Information *Alan Burns*

1.3. Minutes of meeting 29 July 2021

Decision *Alan Burns*

1.3 a NGH Public Trust Board Minutes - July 2021.pdf (17 pages)

1.4. Matters Arising and Action Log

Discussion *Alan Burns*

1.4 Action Log Public Board.pdf (1 pages)

1.5. Staff Story

Information *Sheran Oke*

1.6. Chairman's Report

Information *Alan Burns*

1.7. Group Chief Executive's Report

Information *Simon Weldon*

1.7 Group CEO Report to Board September NGH.pdf (4 pages)

1.8. Hospital Chief Executive's Report

Information *Heidi Smoult*

1.8 HCEO board report Sept 2021.pdf (4 pages)

09:30 - 09:30
0 min

2. PERFORMANCE

2.1. Integrated Governance Report & Proposed Group IGR metrics

Discussion *Heidi Smoult & Andy Callow*

2.1 a NGH Cover Sheet and full report IPR.pdf (4 pages)
2.1 b NGH Performance Report September (August Reporting Period).pdf (61 pages)
2.1 c Finance Report M5_Board.pdf (6 pages)

2.1 d UHN Group IGR metrics - NGH cover sheet.pdf (2 pages)
2.1 e Boards Sept - IGR metrics D01.pdf (18 pages)

2.2. Elective Recovery Update – Theatre Efficiencies

Discussion *Andy Callow & Jo Fawcus*

2.2 a Theatres utilisation - NGH Board cover sheet.pdf (2 pages)
2.2 b Theatres utilisation.pdf (8 pages)
2.2 c 2021 Sept - Health Equalities Assessment - Elective D01.pdf (9 pages)

2.3. Winter Modelling

Discussion *Jo Fawcus & Andy Callow*

2.3 a NGH Winter Modelling Public.pdf (3 pages)
2.3 b Public Board Sept 2021 - Group Winter Modelling 2021 D01 (1).pdf (11 pages)

09:30 - 09:30
0 min

BREAK

09:30 - 09:30
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3. STRATEGY & CULTURE

3.1. Assessment & Accreditation

Information *Sheran Oke*

3.1 Assessment and Accreditation_Sept 21.pdf (7 pages)

3.2. Dedicated to Excellence Group Strategy Delivery

Information *Sheran Oke & Mark Smith*

- Nursing, Midwifery and AHP Strategy
- People Strategy

3.2 a Cover Sheet_NMAHP Strategy.pdf (2 pages)
3.2 b NMAHP Strategy Ignite Our Voice September 2021 Board.pdf (5 pages)
3.2 c NGH PP Progress Resport - Sept 2021.pdf (3 pages)
3.2 d People Plan Report - Sept 21.pdf (11 pages)

09:30 - 09:30
0 min

4. GOVERNANCE

4.1. Emergency Preparedness Annual Report

Information *Jo Fawcus*

4.1 Board EPRR Report - September 21.pdf (6 pages)

4.2. Infection Prevention Annual Report

Information *Sheran Oke*

4.2 IPC annual report 2020-21 FINAL.pdf (53 pages)

4.3. Safeguarding Annual Report

Information *Sheran Oke*

4.3 Safeguarding Annual Report 2020-21 V1 (5).pdf (26 pages)

4.4. Workforce Disability Equality Standards and Workforce Race Equality Standards 2021/22

Information *Mark Smith*

- 4.4 a NGH WDES and WRES Report - Sept 2021.pdf (2 pages)
- 4.4 b NGH BOD WRES WDES Infographic - Sep 21.pdf (4 pages)

4.5. Strategic Development Committee – Establishment of Committee in Common

Information *Claire Campbell*

- 4.5 Board report SDC CIC 290921.pdf (2 pages)

09:30 - 09:30
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5. CLOSING ITEMS

5.1. Questions from the Public (Received in Advance)

Information *Alan Burns*

09:30 - 09:30
0 min

6. ANY OTHER BUSINESS

Information *Alan Burns*

Minutes of the meeting

Meeting	Public Trust Board
Date & Time	29 July 2021 – 09:30am
Location	MS Teams

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

Attendance	**Name and Title**	
Present	Mr A Burns	Chairman
	Mr S Finn	Director of Estates & Facilities
	Ms E Doyle	Hospital CEO
	Mr S Weldon	Group CEO
	Ms D Kirkham	Non-Executive Director
	Ms T La Thangue	Group Communications and Engagement Director
	Mr M Metcalfe	Medical Director
	Ms K Spellman	Director of Strategy & Partnerships
	Ms A Gill	Non-Executive Director
	Ms S Oke	Nursing Director
	Ms J Houghton	Non-Executive Director
	Mr J Evans	Group Finance Director
	Ms R Parker	Non-Executive Director
	Mr A Callow	Chief Information Officer
	Mr M Smith	Chief People Officer
In Attendance	Ms S Tennyson	Agenda item Diversity and Inclusion Update
	Ms T Robson	Agenda item Diversity and Inclusion Update
	Ms L Luxton	Agenda item Diversity and Inclusion Update
	Ms F Ghaouch	Agenda item Diversity and Inclusion Update
	Ms U Akabogu	Agenda item Diversity and Inclusion Update
	Mr A Gore	Agenda item Diversity and Inclusion Update
	Mr A Srimansundarsingh	Agenda item Diversity and Inclusion Update
	Ms K Palmer	Executive Board Secretary (Minute taker)
	Ms H Smoult	Hospital CEO

Apologies	Prof T Robinson	Associate Non-Executive Director
	Ms J Fawcus	Chief Operating Officer

Item	Minute Number	Discussion	Action Owner
INTRODUCTORY ITEMS			
1.1	21/22 036	**Introduction and Apologies** Mr Burns welcomed Ms H Smoult who would be joining the Trust as the new Hospital CEO in the coming weeks. He also welcomed both Mr J Evans and Ms T La Thangue to their first Public Trust Board meeting. Mr Burns noted that there was a number of mentors attending for agenda item 11. There was Board members who had recently undergone reverse mentoring and the mentors were attending to also share their experiences. Apologies were noted above.	
1.2	21/22 037	**Declarations of Interest** There were no declarations of interest.	
1.3	21/22 038	**Minutes of meeting 27 May 2021** The minutes of the Public Trust Board held on 27 May 2021 were presented and **APPROVED** as a true and accurate recording of proceedings	
1.4	21/22 039	**Matters Arising and Action Log** The Matters Arising and Action Log were considered and noted. **Action Log Item 127** Emergency Preparedness Annual Report – this would be presented to either the September or November Trust Board meeting. The Board **NOTED** the Matters Arising & Action Log.	

1.5	21/22 040	**Staff Story** Ms Oke commented that it was her great pleasure to invite two midwives to present to the Board. She introduced Ms S Tennyson and Ms F Ghaouch who would deliver a presentation on continuity of care. The presentation can be viewed by clicking the link below. Link to presentation Mr Burns thanked both for the very impressive and interesting presentation. Ms Houghton remarked that she had been privileged to be able to shadow Ms Tennyson recently. She had attended a bump to baby session where 14 mothers had come from continuity to care team. The comments from those who had babies before believed it now to be a much better experience. The team was working with a charitable Trust to look at potential Moses basket package for those women most in need. Ms Oke confirmed that there was ongoing discussions with the Northampton healthcare charity to see what can be done. Mr Weldon commented that it was an extremely impressive presentation. He asked what was needed from the Trust Board and the Trust Board was aware that the maternity agenda was live. Ms F Ghaouch stated that training was discussed a lot. This included training for midwifes on culture awareness. These midwives needed to be educated as they looked after diverse communities and there needed to be more emphasis on this. Mr Smith remarked that it was a fantastic presentation. He noted that there was the roll out building cultural bridges programme. He also congratulated the team for their RCN shortlist and the team should be very proud. The Board **NOTED** the Staff Story.	

1.6	21/22 041	**Chairman's Report** Mr Burns congratulated Ms A Pritchard on becoming the new CEO for NHS England. She was the first women to take on this role. This was a remarkable achievement and was a popular appointment. Mr Burns advised that Ms N Eisenstadt was to be the ICS Chair going forward. The CEO of the ICS would be appointed September time. Mr Burns commented on the new front entrance. A Costa had been built and this was important. This was a place where staff and patients could be listened to. This was very welcomed. Mr Burns remarked that the new Paediatric ED opened next week. The new ITU was well advanced and would be a big well-designed space. This would open before winter. He commended Mr Finn on this. Mr Burns noted that the Trust had received a request from NHSE in regards to the next round of applications for the infrastructure programme. There would be major reinvestment and NGH had been invited to apply. The Trust would put together a bid and this would require quite a bit of work on strategic estates plan. The Board **NOTED** the Chairman's Report.	

1.7	21/22 042	**Group Chief Executive's Report** Mr Weldon advised that it had been nearly a month since the launch of the Group. He had time to reflect and thanked everyone involved in the day. He had attended the NGH site on launch day. He noted that the people had really enjoyed the launch day. It was important to highlight the University Hospital status. Mr Weldon thanked the Communications Team for the immense labour that went into that day. Mr Weldon discussed the challenges and the three items to reflect on. Firstly it was elective recovery and the high non elective demand. The Trust was in the teeth of a fierce winter in July and this was the reality the Trust was now dealing with. The Trust had kept Elective surgery going. This was a balancing act to do that and manage non-elective demand. He had been pleased to welcome the Chair of the ICS to KGH and would be inviting her to visit NGH. She had seen the hospital pressures and she was given a new appreciation of what a hot hospital looked like. Mr Weldon stated that as the Trust developed the IGR, theatre efficiencies data would be brought in to it. Secondly was the ongoing work with the ICS. There would be a new system in April 2022. This represented a number of huge opportunities. It was important put the right effort in or will live the consequences for the next 10 years. Ms Spellman was leading the work for the Trust and putting our views forward. The Trust would be asked to sign of the direction of travel and key design principles. He thanked Ms Spellman for her input. Thirdly Mr Weldon wished to highlight the E&D Strategy. There was a multi-culture, multi-faith and multi-race community at NGH. There was many diff backgrounds and Trust needed to continue the journey to become a more inclusive employer. The Board **NOTED** the Group Chief Executive's Report.	

1.8	21/22 043	**Hospital Chief Executive's Report** Ms Doyle complimented the new front entrance and that it was a great addition to the Trust. She thanked Mr Finn, his team and partner contractors. Ms Doyle advised that the Trust had appointed 3 new ED consultants. She congratulated Ms T Robson in her appointment as the new Director of HR at NGH. She was due to start 01 September 2021. Ms Doyle noted the rising COVID19 numbers and there was currently 45 in NGH and 3 in HDU. This showed that the vaccination was working and she encouraged all to have their double vaccination. Ms Doyle discussed 'Pingdemic'. Ms Oke and her IPC colleagues were holding daily panel to look through individual circumstances, if the member of staff works in an essential area. This was a challenge. Ms Doyle remarked that it was not just COVID19 pressures, the Trust was seeing a high number of admissions despite the conversion rate being low. There had been issues with the local nursing and residential homes due to their suspension of admission. Ms Doyle complimented the great effort by everyone and the staff had stepped up, despite feeling quite pressured. She thanked the staff for all their efforts. The Board **NOTED** the Hospital Chief Executive's Report.	
PERFORMANCE			

2.1	21/22 044	**Integrated Performance Report** Mr Metcalfe presented the Medical Directors update. He highlighted the University status for the hospital and Group. This had created a positive buzz. There had been recent external candidates who had mentioned this when they had applied. The Group must now deliver the benefits of having this status. Mr Metcalfe was delighted to say that the BAME fellow would continue her role in addition to her taking up a partnership role at a local GP. There would be work done with the GP head of school, HEEM deanery and the University of Northampton. Mr Smith delivered the Chief People Officer update. He commented that the hospital had been extremely busy. There had been18 months of challenges and believed that it was hard to reflect the sickness absence position. Prior to COVID19 this had been 3-4% and was now at 5/6%. There was Health & Wellbeing work highlighted in the report to help mitigate this. Mr Smith noted that the International nurses have started to arrive and embed themselves. He knew the challenges with temporary staffing and would work on reducing expenditure. Ms Oke presented the Director of Nursing Report. She had shared with the Board the Nursing & AP Strategy. She now looked forward to launching the group strategy at the end of August/ start of September which would highlight the direction for the future. Ms Oke advised that the team had submitted evidence for Ockenden and CNST. The Trust awaited feedback. Ms Oke commented that IPC and the Trust's COVID19 response had been a key priority. The team would continue to look at how to manage the third wave. The Trust had reacted speedily to guidance and a 'ping panel' had been formed to pick up COVID19 positive cases through track and trace. Ms Doyle provided the operational update. There had been an increase in the numbers coming in. It was noted that 4 hour performance was 86% and the conversion rate had gone down. The ambulance conversion had decreased however had then increased again in July. Ms Doyle advised that super stranded was at 89 and had increased to 113. The key moving forward was extended hours of SDEC which had moved to midnight, however this could be pushed longer to 2/3am. Ms Doyle reported that cancer continued to do reasonably well. There had been an increase in the number of referrals. The Trust would continue to work on 62 day standard. It was noted that Gynaecology was now doing better and this	

would be reflected in the next Board report however there was still a struggle with Oncology.

In regards to 52 weeks, this had moved down to 170. There had been validation issues at the start, however this had now decreased and the team was moving through the backlog. There had been backlogs in diagnostics and echo. The team hoped to clear these by the end of August. Ms Doyle stated that there was a theatre efficiency programme which was exploring how to maximise the use of our services.

Ms Doyle discussed the Unappointed issue. There was a task and finish group meeting daily. Of the patients gone through only 5% needed referrals. All of these were booked and could be seen in our current capacity.

Mr Moore referred back to theatre efficiency and asked what was being done with the independent sector. Ms Doyle explained that the private sector was working through their own waiting list therefore access to them is less. The Trust however was working with them and was building in to the plans.

Mr Moore queried whether the occupancy rates were still 85% of last year. Ms Doyle confirmed that this was correct and as the Trust goes into winter planning, that was what was aimed for.

Ms Kirkham remarked that it was good to see the turnaround in complaints. She asked if those outstanding from wave 2, how long had they waited for their compliant to be resolved. Ms Oke advised that for these patients a timescale had been negotiated for completion and accepted. It was noted that any new ones were working to the old timescales of 20-40 days.

Ms Gill asked how learnings from SI's was shared. Mr Metcalfe explained that there was a well established process for learning and this would be continued to be followed. The learning recommendations are agreed with areas, with the assurance team tracking progress against the actions.

Mr Weldon commented that in quarter 4 Northamptonshire was the 2nd biggest user of the independent sector. It was noted that last year there was a command-and-control contract, then in April it had gone back to the cost and volume approach.

Mr Weldon referred to theatre efficiency. The Trust needed to ask if it was making best use of the capacity it had. He hoped to shine the light on the data September to establish how can we do better and what take to get better. This would be looked at the September Trust Board.

Mr Evans presented the Finance update. He reported that the Trust was in line with plan and had a surplus of £1m. In

		half one the Trust had planned to deliver a breakeven position which was in line with plan. Mr Evans advised that the goal posts had now moved. The Trust had been notified to access funds it had become more stringent and this needed to be worked through on how to meet. The challenged had increased. On the urgent care side, further capacity was needed to support this. There had been a significant increase versus the plan of £3m, this was due to additional capacity to support elective care and additional temporary staffing. There had also been challenges on pay with self-isolation. The Trust was in line with plan capital spend and there was no slippage to report. Mr Burns referred to ERF. The Trust Board had made a decision at the end of May on how it would aim for a higher level activity. The Trust Board needed to formally say whilst it recognised the decision made in May, however despite recent changes made, the Trust Board needed to stick to decision it had agreed in May, noting the difficulty of remove capacity. Mr Evans explained that the Trust had been told by oversight colleagues, that the reported figures would be an unacceptable variance to plan. The Trust needed to understand what this meant to the Trust. The reminder of half one was expected to be that of a variation to the financial performance. The capacity put in place was working to the original plans put in place. Mr Burns remarked that by September he hoped to have a clear view if the plan could be met. Mr Weldon advised that half two's system plan was around the money and there are discussions on how was this handled as a system. The challenges have to be made at a system level. The impact of the Trust retracting capacity would be dramatic. Mr Burns set the Executives a challenge for the IGR that by end of September to have a matching IGR for the group. The KGH one is a national exemplar and he requested for their system to be used. Mr Weldon agreed that this was a fair challenged. It needed to be looked across and be comparable. This included looking at the core indicators and simplifying down. Mr Callow explained that a piece of work had kicked of this month to look at metrics across the group. There was work done a year ago to look at metrics and only 8 were the same. This was not an insignificant piece of work. The Board **NOTED** the Integrated Performance Report.	Executive Team

2.2	21/22 045	**2021/22 Activity Report** Ms Doyle advised that the report delivered an update on where the Trust was on the half one reset plans. The main principle was the over performance which was positive. – The Board **NOTED** the 2021/22 Activity Report.	
BREAK			

3.1	21/22 046	**Diversity and Inclusion Update** Mr Smith thanked and welcomed colleagues for attending. He had kept his promise made a year ago to deliver an update to the Trust Board. The presentation had 4 main aims and these included; To review our REACH network, to look at what has been done and what has been committed to, discuss the group strategy and reverse mentoring. Mrs T Robson delivered a presentation on progress made to date. NGH EDI Progress Board Jul 2021 V7.ppt Ms L Luxton then shared a REACH network update, followed by a reverse mentoring update which also included a video, finishing off with an update on the EDI Strategy. The presentation can be viewed by clicking the link below. Link to presentation Mr Smith thanked all for their part in the presentation. Ms Spellman remarked that this was a fantastic presentation. She had found the mentoring a real eye opener. She had challenged herself on what she can do to promote E&D and eliminate racism. Ms F Ghaouch echoed this. She had found it a great opportunity to have an open and honest conversation. It had helped give her confidence in herself and they both learnt from each other. Mr Moore recommended the subconscious bias training. He had also listened to Mr A Gore interviewing Ms Fawcus and had found this compelling viewing. Ms Parker asked if there was support for people who had spoken up and how was it monitored that there was no long term negative consequences. Mr Smith explained that colleagues were supported. Ms Campbell commented there was also the Freedom to Speak Up Guardian in post for support along with HR or SoS input required. The staff are always thanked for speaking up. Ms Houghton echoed the positive feedback. She remarked that it had been an absolute privilege to be involved. She shared a good example was the unconscious bias training she had attended. Following this, she had attended a Safety huddle and had noticed the BAME in one group and others in another group, therefore she went and stood with BAME colleagues. Since this she had noticed that these groups had merged more and more. Her mentor Ms S Tennyson had talked to other Trusts and there was two Freedom To Speak Up Guardians with one being from the BAME network. It was noted that across maternity and neonatal not all staff are aware of the opportunity to speak to the	

Freedom 2 Speak Up guardian. There needed to be a communication campaign on this and how useful it can be.

Ms Kirkham commented that it was a great presentation and congratulated all involved. She had found the unconscious bias training helpful. She stated that only a small percentage were targeted. There needed to be more and this needed to be done across the Board. Ms Kirkham had learnt a lot from the reverse mentoring and it had really helped focus not only on the differences but communication in general.

Ms Tennyson for the reverse mentoring had worked with Ms Houghton. She had found the mentoring fantastic as she had not had a voice before this. The reverse mentoring had given her courage and confidence to speak. In regards to Freedom To Speak Up she shared her call for training for REACH network to become BAME Freedom to Speak Up ambassadors. She believed this to be essential and would be a key part of the Trust.

Ms Gill was encouraged by what she had heard. She had joined the first REACH network as NED sponsor. Ms Gill had been impressed by the networks drive and commitment.

Ms U Akabogu had enjoyed the programme and was a good opportunity to help break down barriers. She had talked about the communication between leadership and the rest of the staff. The programme was a good step to break these down. It may still be tricky to speak up and be honest due to the fear of backlash to career.

Mr Metcalfe emphasised Ms Parkers point. He asked how the Board reacts when people got courage approach us with issue was pivotal. It had been raised by the BAME clinical fellow that some staff did not feel comfortable raising issues do to repercussions. The Trust had responded positively with the introduction of the BAME clinical fellow and support given to international recruitments. Mr Metcalfe explained that with clinical incidents it had been built into the clinical management system that if protected characteristics feature was flagged then the relevant EDI group would be involved in the close down.

Ms Luxton advised that the work needed to be scaled up as to spread the load. She had worked with staff members to give confidence to speak up. She asked all leaders to attend REACH meetings and training.

Mr Weldon wanted to thank all that had contributed to the debate. It was important to continue the progress made with giving staff a voice. He noted that it was positive to have this discussed at Board and the Board would strive to do its best to honour the contributions that had been made.

Mr Burns commented that when he had previously me the BAME fellow and Ms Luxton they had an open conversation on the topic. He had accepted that the Trust had a problem

		and that it needed to be addressed. He thanked all who had joined. It was good to hear the passionate stories.	
3.2	21/22 047	**ICS decision and Update** Ms Spellman advised that the report set out the ICS design principles. The report presented a high level update on the ICS design building blocks and blue print. This had been agreed by partners and the organisation. There had been a significant amount of work done under the blocks with all partners involved in this. Ms Spellman stated that the ICS was designed around the collaborates and there are 4 of these. These included; Mental health, electives, iCan and children/young people. The ICS had been developed with the two local authorities and would be worked through the incoming months. Ms Spellman referred to page 3 of the report which featured the endorsement statements. She informed that Trust Board that all Boards were being asked to sign up to these. She asked the Board to approve and endorse these with further details being shared in coming months. Mr Weldon thanked Ms Spellman for the presentation. The 4 domains contained on page 3 asked for comments and approval. There would be a fundamental change to the governance model and all we be held collectively to account. This was a significant decision feature that was needed to be got right. The NEDs would Mr Metcalfe referred to point 5 as this was not immediately clear and needed clarity as to why have two Health & Wellbeing in one county. Mr Weldon stated that there needed to be 1 set of priorities and look at the longer term model of health. The new unitary council wanted to be clear on how this was delivered. The Board **NOTED** the ICS decision and Update.	
GOVERNANCE			

4.1	21/22 048	**Freedom to Speak Up – Quarter 4 and Annual Report** Ms Campbell advised that the report had been presented to the People Committee in May 2021. Ms Campbell summarised that the Trust had 42 cases reported via the Freedom to Speak Up policy for 2020/21. This was in line with the average for a medium size Trust of 10 per quarter and she also noted the potential impact of COVID19 last year on this figure. Ms Campbell reported that 52% of cases were in regards to bullying and harassment. This keeping with national figures. Ms Campbell stated that there was 2 training sessions booked in September. She hoped that the REACH network and other networks would attended as the ambassadors should be reflective of staff cohorts. Mr Burns asked that the suggestions shared in the EDI presentation were considered. The Board **NOTED** the Freedom to Speak Up – Quarter 4 and Annual Report.	
4.2	21/22 048	**People Plan Update – People Partnering Pledge** Mr Smith advised that the disciplinary policy had been reviewed from a group perspective. This was the first one to go through this process. It had been picked first due to learning locally and nationally, as well as the impact of the policy on individuals. Mr Smith stated that the policy was there to be supportive and the policy had taken good practice from others. It was noted that people rarely come to work make a mistake and it was important to support staff if they do so. The policy would go on the website end of next week. The operational appendices would be developed. It was confirmed that the Board had reviewed the policy and there no adjustments or comments raised. The Board **NOTED** the People Plan Update – People Partnering Pledge.	

4.3	21/22 050	**Board Assurance Framework (BAF)** Ms Campbell advised that this was the revised and remodelled BAF which was aligned with KGH. There was 8 Group risks. She noted that the NGH risks had all been reviewed and updated by the lead executives to ensure that there was no overlap with group risk. Ms Campbell explained that to ensure a clear audit trail, the risks from the previous iteration for quarter 4 had been included to ensure that there was no risks lost in the changeover. The BAF had been to each committee in July. Mr Burns remarked that this was an important piece of paperwork and asked for feedback from the Committee Chairs. Mr Moore commented that it had been discussed at Audit Committee and it had been looked at from both a group and Trust level. It was noted that finance was at the top with a risk score of 25 at both Group and Trust level. It struck him as not intuitive and patient safety was the priority. He stated that Audit Committee looked at the Corporate Risk Register and how it could be built in to the BAF. Ms Parker delivered an update from a CPC and Finance & Performance perspective. She had found it easier to review risk as it was much clearer. It had been reviewed yesterday and the comments positive. It made more sense as points covered previously were in the risk register. Ms Gill commented that the People Committee had preferred this version and had found it much easier to navigate. Ms Houghton echoed similar feedback from the Quality Governance Committee. Mr Burns noted that this was positive and would continue to be improved further. Mr Evans commented that Finance & Performance had predominately focused on the format and had found it very positive. He was still to go through a detailed review of the finance risk and would update before presentation of the BAF. Mr Weldon advised that it was good to hear this version of the BAF had landed well. There would be work done on describing risks as a Trust and as a system. The finance risk could be read in two ways. It was to prevent finance failure and deliver assurance. He encouraged this debate to continue. The Board **NOTED** the Board Assurance Framework.	

4.4	21/22 051	**Fire Safety Annual Report & Fire Safety Board Compliance Statement** Mr Finn advised that the report covered April 2020 to March 2021. The Board had given a focus to fire over the last 18 months. The report stated that the Trust had meet statutory requirements and the Trust Board was to give approval to Mr Weldon to sign the annual statement. Mr Finn stated that there had been £2.5m invested in to fire safety which was £4m of the budget. There had been independent scrutiny with all risks managed and mitigated. The links with the fire service had been maintained. There had also been investment in the fire safety team. Mr Finn reported that there had been 2 fires on the same floor a week apart. On 08 November there had been a transformer fault and the floor was evacuated. On 11 November the roof contractors had set fire to the felt. The fire service commended the Trusts response and all patients were kept safe. Mr Finn advised that an update was presented monthly to Finance & Performance Committee and there was also a review of risk to ARC, numerous Board discussions, a Trust Fire Committee and an Estate Technical Committee. Mr Finn reported that the risk score had dipped from 25 to 20, and he expected further reduction. The next step was to create a heat map. This would look at the key risks and there would be focus in these areas. The Board **NOTED** the Fire Safety Annual Report & **APPROVED** the Fire Safety Board Compliance Statement.	
CLOSING ITEMS			
5.1	21/22 052	**Questions from the Public (Received in Advance)** There was no questions received from the Public.	
ANY OTHER BUSINESS			
6.0	21/22 053	Mr Burns advised that this would have been Prof T Robinson's last Public Trust Board. He thanked Prof Robinson's good chairing of the Quality Governance Committee. A replacement will be appointed in due course. Mr Burns stated that this was Ms E Doyle's last Public Trust Board as CEO. She had been Hospital CEO KGH and then had moved over to NGH. She has also contributed to the group model.	

Next meeting

Date & Time	30 September 2021 at 09:30
Location	TBC

Public Trust Board Action Log							Last update	07/09/2021
Item No	**Month of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
Actions - Current meeting								
127	Jan-21	TB 20/21 082	Emergency Preparedness Annual Report	Mr Weldon remarked that the EPRR arrangements had been tested to the max over the past year. This was an important report and he asked the team to work with KGH from a lessons learn point of view. He asked for when the second wave recedes that this was debated.	Ms Fawcus	Sep-21	On Agenda	
128	Jul-21	21/22 044	Integrated Performance Report	Mr Evans explained that the Trust had been told by oversight colleagues, that the reported figures would be an unacceptable variance to plan. The Trust needed to understand what this meant to the Trust. The reminder of half one was expected to be that of a variation to the financial performance. The capacity put in place was working to the original plans put in place. Mr Burns remarked that by September he hoped to have a clear view if the plan could be met	Executive Team	Sep-21	On Agenda	**Update Matters Arising**
Actions - Future meetings								

Dedicated to excellence

NHS
Northampton General Hospital
NHS Trust

Cover sheet

Meeting	Public Board
Date	30 September 2021
Agenda item	1.7

Title	Group CEO Report
Presenter	Simon Weldon, Group CEO
Author	Simon Weldon, Group CEO

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

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

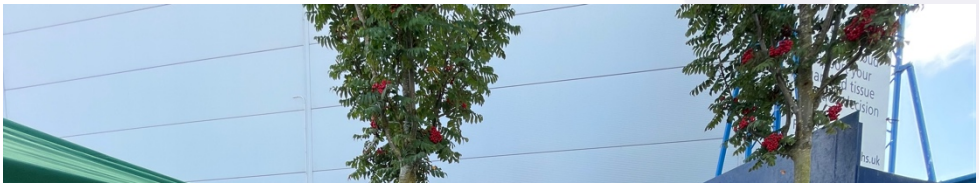
Reason for consideration	Previous consideration
The Board is asked to note the report.	N/A

Executive Summary

Group Chief Executive: September Board Update

As I write this report, it's Organ Donation Week. I had the opportunity to go and meet the Kettering team and thank them for the work that they do and hear for myself the impact that it has. Simply, it changes lives and it was a real honour to hear some of those stories.

The theme of this year's campaign is leave them certain (#leavethemcertain) and it reminds us all to have the conversations with our loved ones about what our preferences on donation are well in advance of the time a decision needs to be made. I would encourage everyone to do just that and also to sign up for the register.



As ever, the NHS has been much in the national news recently. Of particular note is the recent funding settlement which commits significant additional resource to the NHS in the second half of this year and into subsequent financial years. One pound in every three of taxpayers money now goes to the NHS. The funding settlement has been accompanied with challenges of what the NHS will deliver for patients. There are two main themes that I want to highlight:

First, the waiting list challenge. The ask here is to get control over the long waits. In the first instance, this will mean patients who have waited in excess of 104 weeks. While we are fortunate in Northamptonshire not to have any patients waiting this length of time, we know that we do have work to do to keep on top of our position and also potentially support other systems who are not in as fortunate a position as we are. Within the waiting list challenge, we will be asked to make sure we are doing as well as we can on making sure our sickest patients continue to get treated in a timely manner, despite the pressure of an upcoming winter. We also have been asked to maintain our 62 day cancer performance. We face all of these challenges from a relatively strong starting point and I must at this point thank and pay tribute to all of the clinical teams who have helped to achieve this. However, given the pressure in this area it is right that we assure ourselves and all those who needs us that we are making the very best use we can of our resources. That is why I am pleased that in our Boards we will start a conversation about how efficient our theatres are and what more we can do to improve.

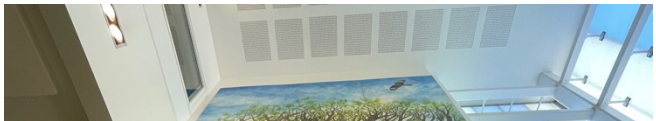
Secondly, the financial challenge. I want to make two points here. First, in the second half of the year, we will face an increased efficiency ask as the NHS starts to recalibrate post-Covid. As I write, the details of our precise ask are not yet clear but we can expect the ask to be in the region of 2-3%. I expect us to talk further on that issue in the month ahead as we run a short planning round. However, the underlying challenge is the one that will require significant focus over the next quarter. Put simply, how do we as a system shape and create a financial strategy that moves the system to financial balance over the medium term. Within this challenge, there are at least two elements. First, what can we as a group do to improve our position? This is a challenge that is beyond either hospital to meet on their own – it is one we must absolutely address together. Secondly, the size of the challenge means that we will need a conversation with system partners about the ways forward – we will not be able to close the position to sustainability on our own.

Finally, this month, I would like to reflect on three celebratory occasions.

Firstly, I was delighted to welcome Her Royal Highness the Princess Royal to Northampton this month to open the Paediatric Emergency Department. I think the cheer we heard from staff as we left the department was reflective of the impact the visit! It was also such a privilege to introduce the Princess Royal to the staff that have made such a contribution during the pandemic.

Secondly, this month, we said goodbye to Leanne Hackshall, our Director of Nursing at Kettering. It is difficult to summarise in words the contribution of a 37 year career in the NHS. I would like to say though, that perhaps the best way I can reflect her impact is in the number of people who have come forward to tell their story about how much Leanne has touched their lives and careers. I know also that she would want me to say she is most proud of the contribution she has made to improving patient care. So on behalf of our patients, our nurses and our Board, I would like to thank Leanne for her contribution to the NHS.

Thirdly, I was privileged to open the 'Tree of Hope' in the Kettering Hospital atrium. Created by a local artist, this installation reminds of those who we have lost in the pandemic, that we are a community that is genuinely stronger together and that we can have hope beyond the current



difficulties we face. For those of you who have yet to see it, I would encourage you to find a moment to visit and reflect what it means to you.
Appendices
None
Risk and assurance
N/A
Financial Impact
N/A
Legal implications/regulatory requirements
N/A
Equality Impact Assessment
N/A

This report may be subject to disclosure under the Freedom of Information Act 2000, subject to the specified exemptions.

Paper

Situation
(Please detail the situation of this paper)
Background
(Please detail the background to the recommendations in this paper)
Assessment
(Provide an assessment of the situation and background and identify the preferred outcome)
Recommendation(s)
(Please make a recommendation/recommendations for the action(s) required to achieve the preferred outcome, including immediate next steps)

Notes:

The paper section must not exceed four pages of A4 in total

Delete guidance notes

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NHS
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Cover sheet

Meeting	Northampton General Hospital Trust Board
Date	22 September 2021
Agenda item	1.8

Title	Hospital Chief Executive Report - September 2021
Presenter	Heidi Smoult
Author	Heidi Smoult

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

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

Reason for consideration	Previous consideration
HCEO activities and hospital highlights for the previous month	Reported bi-monthly to public Board
Risk and assurance	
Winter pressures and maintaining the elective recovery plans.	
Financial Impact	
None	
Legal implications/regulatory requirements	
Potential risk of not achieving the regulatory standards	
Equality Impact Assessment	
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 There is no potential that the content of this report will have any negative impact.	

This report may be subject to disclosure under the Freedom of Information Act 2000, subject to the specified exemptions.

HCEO Report

Thank you

Firstly, it is important I thank Eileen Doyle for her support and leadership at Northampton General Hospital NHS Trust until 31 August 2021. Eileen kindly handed over to me and I would like to personally thank Eileen on behalf of the wider team at NGH.

It is also important to thank everyone who has made me so welcome in my first few weeks. It is an honour have joined NGH as the HCEO. I have been able to really start to get to know people and understand the fabulous care being delivered across many teams.

In my first few weeks, I have met many people who have provided an invaluable insight into what it is like for them to work at NGH, which includes both positive examples, but also some of the challenges they are facing. I have appreciated the honesty and authenticity in the conversations. I inevitably have many more people to meet and teams to shadow in the coming months to truly get to know what it's like to work at NGH and how I can help make it an even better place to work, to provide excellent care for patients.

Some of the teams I have met to date, include the Freedom to Speak up Guardian and some ambassadors, Network representatives, unions representatives, porters, domestic teams, catering teams, sterile services, security, clinical teams, divisional teams, admin teams, mortuary, chaplaincy and site teams. I have also attended a shared decision-making council, which demonstrated some excellent work our nursing colleagues are taking forward.

I am grateful for the support from my executive team and other key colleagues in my first few weeks into the role.

Covid 19 and current context

High levels of emergency care demand continue in the county, and whilst the demand is in line with previous years (prior to the Covid-19 pandemic), we have reduced bed numbers, with different IPC requirements resulting in the overall capacity being reduced.

Covid numbers remain relatively stable in recent weeks and at the time of writing this paper, NGH had 34 Covid patients in the Trust. The team working on the winter plan and modelling to support this, have worked tirelessly to ensure we can prepare and plan effectively as a hospital, across the group and the ICS.

I want to commend the collaborative work I have experienced in my first few weeks in demonstrating the breadth of work across the system. I have been fortunate to build strong links into the system to start to work collaboratively, particularly with social care and other system partners on the stranded and super-stranded patients we continue to have within NGH.

We have commenced a focused piece of work to complement iCAN to ensure we drive improvements in areas that are contributing to stranded and super stranded patients. I have personally committed to have clear oversight of this, with some of my executive colleagues. This is also being supported by system partners.

Cancer and elective recovery

The operational and clinical teams continue to focus on Cancer and reducing our 52wk & diagnostic backlogs. Against the emergency pressures we have faced, the continued reduction of the backlogs and maintaining elective care for our patients must be recognised and celebrated.

In July, NGH ranked first in the region for our 2 week wait and 62-day performance and second in the Region for the 28 days faster diagnosis standard. This is a credit to our teams.

National figures in July also demonstrate the hard work and commitment by NGH teams, including:

- 2 week wait – National figure 85.6%, against NGH at 95.3%
- 62 Days - National figure 72.1%, against NGH at 82.1%
- 28 Days Faster Diagnostic Standard - National figure 73.9%, against NGH at 82.1%

Planned operational changes

Despite the significant operational pressure our teams remained focussed on delivering the planned ward moves, which included:

- Eleanor (Acute Stroke Unit) has moved to Benham Ward
- Frailty Unit (Quinton Ward) has relocated to Eleanor Ward

This is fantastic news for our patients & staff. Moving the acute stroke unit to Benham Ward provides an improved environment for patients, in particular better space for the use of equipment that our stroke patients need, as well as space for our therapy teams to work with patients.

The Frailty Unit moving to Eleanor Ward allows the Frailty Service to operate in an area which is for the assessment of patients that present in Urgent Care, as well as overnight beds for patients. This includes the ability commence treatment, be assessed by the community teams (where required) and then move to bring discharged from this unit. This is an agreed innovation in the iCAN programme and will be a great facility for our frail patients to access multi-disciplinary teams & treatments.

Finally, the move of Frailty out of Quinton Ward releases much needed space for the expansion of SDEC (Same Day Emergency Care).

I would like to note my sincere thanks to all the teams in NGH for their hard work and commitment, both in these areas of success, but also their focus on areas for improvement to strive to continuously improve the quality of care provided to patients.

Celebrating success

Whilst there are endless reasons to celebrate the success of our teams every day, there are some key aspects I would like to highlight:

Her Royal Highness - The Princess Royal Visit

Her Royal Highness The Princess Royal Visit officially opened Northampton General Hospital's new Paediatric Emergency Department on Tuesday, September 14, 2021. The Princess Royal arrived at the hospital and was received by the Lord Lieutenant of Northamptonshire- James Saunders Watson and Simon Weldon. They were joined by Alan Burns, the Princess Royal's lady in waiting, Caroline Nunneley and the Lord-Lieutenant's wife Lizzie Saunders Watson.

Her Royal Highness then met senior hospital leaders, clinicians, volunteers, and key NHS partners involved in the county's response to the Covid-19 pandemic, before moving onto the paediatric department itself, where she had a tour of the new building and met the clinicians and staff that run the department before unveiling a plaque to officially open it.

This was a real opportunity for staff to celebrate their hard work and for us to recognise their

hard work during the covid pandemic. Whilst some staff were able to meet Her Royal Highness- The Princess Royal, the recognition of hard work is inevitably extended across the trust to both clinical and non-clinical teams.

Nursing and AHP Strategy Launch

I was fortunate enough to spend the afternoon celebrating the launch of our Nursing and AHP Strategy with Sheran Oke and Emily Lambert, by meeting some of our nursing and AHP teams when I visited PAU, Althorp, VARG and met some of the newest international nursing cohort.

SSNAP

It is a great credit to all who contribute to the stroke service of the county at NGH that the SSNAP A rating has been retained in the latest quarter despite the extraordinary pressures upon the hospital which make delivering some of the standards very challenging.

This top rating for stroke services is a composite of attainment in ten domains across the stroke pathway and cannot be delivered without exemplary multidisciplinary and inter-service working, and indeed collaboration between partner organisations. This is perhaps best illustrated by way of examples. The hyper-acute end of the pathway is underpinned by the excellent care received from emergency department colleagues when suspected stroke patients arrive, rapid access to essential brain scanning provided by the radiology team, in addition to the stroke service themselves. Beyond the acute phase, the recovery of our stroke patients is supported by our therapy teams – physio, speech and language and occupational therapy.

The community stroke service team are not directly measured by SSNAP – however their pro-active work to help discharge patients from our hospital and deliver rehabilitation closer to home is excellent for patients, and also makes it easier for NGH to deliver the best possible care for the stroke patients who need to be in hospital.

Penna Award

Our fabulous team in Urology, are extremely proud to have been awarded the National Cancer Patient Experience Award. This important work was recognised for their prostate cancer project where they worked in co-production with men with lived experience on improvements in access to specialist information and support.

Pride

The Pride Network Joint Chairs & Co-Chairs joined the KGH & NHFT LGBTQ+ Networks in hosting a stand at the Northampton Pride Event on Sunday 12th September 2021, held in the Market Square. I personally went to support this important work as strive to ensure we value and embrace the diversity of all our colleagues across the hospital. I was joined in supporting this event with Jo Fawcus, as the Executive Sponsor for the Pride Network and Tracey Robson, our new Hospital Director of People.

Our fabulous network members were representing us at NGH and they described having a magical day at the event, which showcased lots of activities, talent, music and food from the Northamptonshire LGBTQ+ community.

Our stand had flyers, posters and presentations on our Networks and Trusts. With additional resources on gender, the transgender community, sexuality and mental health information which was extremely well received by the visitors.

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Cover sheet

Meeting	Trust Board
Date	23rd September 2021
Agenda item	2.1

Title	NGH Performance Report September (August Reporting Period)
Presenter	Heidi Smoult (Chief Executive Officer); Jo Fawcus (Chief Operating Officer); Matt Metcalfe (Medical Director); Mark Smith (Chief People Officer); Bola Agboola (Director of Finance); Sheran Oke (Director of Nursing)
Author	Jamil Iqbal (Head of Informatics)

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

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

Reason for consideration	Previous consideration
The Trust Board is asked to note the contents of this paper and note current performance against the key metrics	None

Executive Summary

This paper sets out performance against both national & local key quality and performance metrics.

Areas of focus are detailed as:

- Complaints responded to within agreed timescales
- Friends & Family Test % of patients who would recommend: A&E
- Friends & Family Test % of patients who would recommend: Inpatient/Day case
- Friends & Family Test % of patients who would recommend: Outpatients
- Mixed Sex Accommodation
- Never event incidence
- Number of Serious Incidents (SI's) declared during the period
- MRSA > 2 Days
- HOHA and COHA (C-Diff > 2 Days)
- MSSA > 2 Days
- VTE Risk Assessment
- Harmful Falls per 1000 occupied bed days (Exc. Maternity and Pead's)
- Fire Drill Compliance
- Fire Evacuation Plan
- Stranded Patients (avg) as % of bed base
- Super Stranded Long Stay Patients (avg) as % of bed base
- Length of stay - All
- Percentage of discharges before midday
- % Day case Rate
- Mortality: HSMR
- Mortality: SHMI
- Unappointed Follow Ups
- A&E: Proportion of patients spending less than 4 hours in A&E
- Ambulance handovers that waited over 30 mins and less than 60 mins

- Ambulance handovers that waited over 60 mins
- Operations: Number of patients not treated within 28 days of last-minute cancellations - non clinical reasons
- Cancer: Faster Diagnosis Standard
- Cancer: Number of Legacy Patients
- Cancer: Percentage of patients treated within 31 days
- Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug
- Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy
- Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery
- Cancer: Percentage of patients treated within 62 days of Consultant Upgrade
- Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers
- RTT Median wait incomplete pathways
- RTT over 52 weeks
- Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test
- Stroke patients spending at least 90% of their time on the stroke unit
- Sickness Rate
- Turnover Rate
- Percentage of all trust staff with mandatory training compliance
- Percentage of all trust staff with mandatory refresher fire training compliance
- Percentage of staff with annual appraisal

Appendices

None

Risk and assurance

None

Financial Impact

None

Legal implications/regulatory requirements

None

Equality Impact Assessment
There is no evidence that the proposed action will promote/have a negative impact on equality of opportunity

This report may be subject to disclosure under the Freedom of Information Act 2000, subject to the specified exemptions.

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Performance Report

September 2021

Reporting Period: August 2021

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Overview

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Medical Director's Overview

Academic strategy

The delivery of the academic strategy is progressing with the oversight of the Academic Strategy Programme Board. Key developments since last report to Public Trust Board include;

a. Approval of 3 Associate professor posts for NGH with 2 further nearing completion
b. Joining with University Hospitals of Leicester and University of Leicester in their bid to renew their NIHR Biomedical Research Centre status (2022-2027, £30 million)
c. Joining UHL and UoL in the renewal of their Clinical Research Facility funding for opening phase I and II clinical trials
d. Agreeing to join a collaborative research framework with UHL and UoL to facilitate the opening of clinical trials across the partnership
e. Welcoming increased numbers of medical students from UoL medical school, with an enhanced teaching programme to deliver the year 3 curriculum, evaluating very well with students
f. Recruiting additional nursing and administrative staff to increase research capacity

Clinical strategy

The clinical senate has met twice to review and improve the level of ambition for the strategy, in particular around centres of clinical excellence across the group. Engagement and collaborative approach has been excellent. In addition to enriching the ambition for individual services, principles around interdependencies have been established. Additional oversight is expected to take place by the end of November 2021 and the strategy to be signed off at that point.

Mortality

SHMI remains as expected at 97.1. There are no new alerts.

Chief People Officer's Overview

The context in which the hospitals are operating within has been very challenging during the reporting period, with non-elective pressure, ensuring elective performance and caring for patients with Covid-19. We have also been ensuring that colleagues have an opportunity for rest and recovery during this period.

Our absence is now consistently above target providing additional pressure, leading to an increased temporary staffing requirement. Benchmarked data across the Midlands and East region demonstrates our increase in absence is consistent with other acute providers comparators emphasising the need to continue communicating and strengthening our health and wellbeing offering with the Trust. We are in the final planning stages for our winter vaccination programme, inclusive of the covid booster and flu vaccinations launching in the coming weeks, encouraging as many colleagues as possible to be vaccinated to protect individuals, patients, colleagues and families.

Given the pressures described during the summer performance with regards to statutory and mandatory training and appraisal performance has deteriorated, whilst this is being monitored and there is a blended learning approach to training and a new 'light' appraisal process, further improvement is required to supporting colleagues to develop.

Our turnover position is strong, however across the ICS we are looking at this carefully, with regards to our age profile. The international nursing campaign continues successfully within the Trust. We continue to rely on temporary staffing solutions to support our medical vacancies and rotas, particularly within non-elective care and our transformation team are supporting with this situation, identifying solutions in the short and medium term.

Finally, during the month of September, we have launched our People Pulse survey, designed to enable us to hear from colleagues across the Group and within each Trust as to their feelings, opinions and suggestions as to what could be improved and areas of good practice to share and learn from. The results will be provided within October, enabling action to be taken in response. The national NHS staff survey commences in the coming weeks launching on the 4th October closing on 26th November 2021.

Director of Nursing & Midwifery's Overview

Friends & Family Test:

The Friends & Family Test continues to be the largest collector of patient feedback within the hospital, asking patients about their experience of the service they have received. The FFT is collected through multiple ways to ensure it is inclusive of all patient's needs. More recently, Posters with QR codes have been established in many different areas including Surgical outpatients, Eye Casualty and Gynae. The Divisions take accountability for the sharing and action of feedback, and this is shared with them through Divisional Performance Packs created each month by the Patient Experience Team. Feedback received in August showed a continuous decline in the feedback received for the Emergency Department, dropping to 76.2% satisfaction within A&E. From reviewing the comments received, the majority of the comments related to the attitude and behaviour of staff within the department, and the extensive waiting times. The department are receiving support through the Trusts wellbeing teams to support staff who are under immense pressure. Further actions will be undertaken to identify how the Volunteers can support patients in feeling more comfortable whilst waiting in the department. Inpatients continue to see satisfaction within normal variation (88.3% satisfaction for August). Outpatient areas have seen a statistically significant increase in satisfaction across a succession of months. This is largely attributed to patients appreciating the option of telephone/e-clinic consultations.

Complaints:

All complaints are triaged upon receipt and a decision made as to the most appropriate route through which the complaint should be handled / investigated. Where possible, and in agreement with the complainant, the Complaints team will try to locally resolve some complaints. However, for complaints, which meet the criteria for a potential incident / safeguarding, these are escalated to either Governance or the Trust's Safeguarding team. All such actions are agreed with the complainant from the outset. The complaints timeframe has now returned to the Trust's normal process of agreeing between 20-40 working days with those who raise a complaint formally. The team are working through the complaints from 20/21 with support. It has been identified that the complaints received recently are significantly more complex in terms of the contents. The Trust compliance rate response rate for complaints, reported in July was 100% with 97% achieved in August.

Infection Prevention & Control Service:

During July and August there were 10 reported cases of Clostridium difficile Toxin A & B identified as hospital onset, 6 in July and 4 in August, the IPC Team reviewed each patient and 3 of the July cases had lapses in care identified related to antibiotic prescriptions. The IPC Team have developed a C.diff Reduction Action Plan that includes actions around antibiotic stewardship. There were 0 reported cases of MSSA BSI or MRSA BSI reported during July and August.

Covid Response:

The IPC team continues to focus on leading and supporting the Trust in managing the COVID pandemic and in the safe management of reset for elective and cancer activity. The IPC COVID Board assurance framework has been reviewed, progress has been made with particular attention being made to PPE training and increasing the provision of our domestic support team. During July and August there were 3 COVID patient outbreaks reported, and 11 patients developed a hospital acquired COVID infection. As lockdown started to lift outside of hospitals in July, the Communication team relaunched the 'hands, face, space' respect and protect messaging across the Trust. Also, in July the IPC Team developed the COVID Contact Review Panel to discuss how staff can return to work safely following a COVID contact. In August the PPE Co-ordinator commenced in post to lead on fit-testing and PPE within the Trust.

Positive stories:

• NMAHP Strategy – 'Ignite our VoICE' was launched on 14th September.

• PEN Awards – Led by the Trust Cancer Lead Nurse, the Trust was the winner in the CPES category (Cancer Patient Experience) for the work undertaken to improve communication with patients diagnosed with Prostate Cancer.

Chief Operating Officer's Overview

Urgent Care

- Overall performance against the ED standard was 73.3% (July 80.1%)
- Attendances for August were 11,344 (11,935 July, 11,788 for June, May 11,277)
- Clinical staffing gaps experienced in July remained through August due to sickness & vacancies with limited uptake through bank & agency
- Flow from Urgent Care has been problematic given the rise in Covid inpatient numbers. This also impacted on our ability to step down from critical care and as a consequence there has been a rise in mixed sex breaches

Stranded Patient Metric

- Reduced care hours in the community impacted on supported pathway discharges
- Further initiatives with the adult social care team were rolled out on Creaton Ward to be piloted as part of iCAN and the board round transformation programme

Cancer Waiting Times

- The Trust met 5 of the 8 cancer waiting standards for July
- For the month of July 1587 patients were referred on the 2ww pathway by their GP, an increase of 5.4% compared to pre Covid July levels
- We continue to meet the 28 Faster Diagnosis Standard achieving 82.1% against the 75% standard. Q1 Faster diagnosis standard performance was 84%, second in the region

Elective Access

- The median RTT wait for August was 8.5 weeks
- The number over 52+ weeks for August was 118
- Challenges remained in August with staffing all theatre capacity due to sickness, self-isolation and limited uptake of bank & agency

Diagnostics

- Increased capacity at Danetre and use of private providers in place to support routine referrals
- Volume of cancer & urgent care work has impacted on the backlog clearance

SPC Charts Explained

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SPC Charts

Northampton General Hospital NHS Trust

making-data-count-strengthening-your-decisions.pdf (england.nhs.uk)

NHS England » Statistical process control tool

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 hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

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Caring

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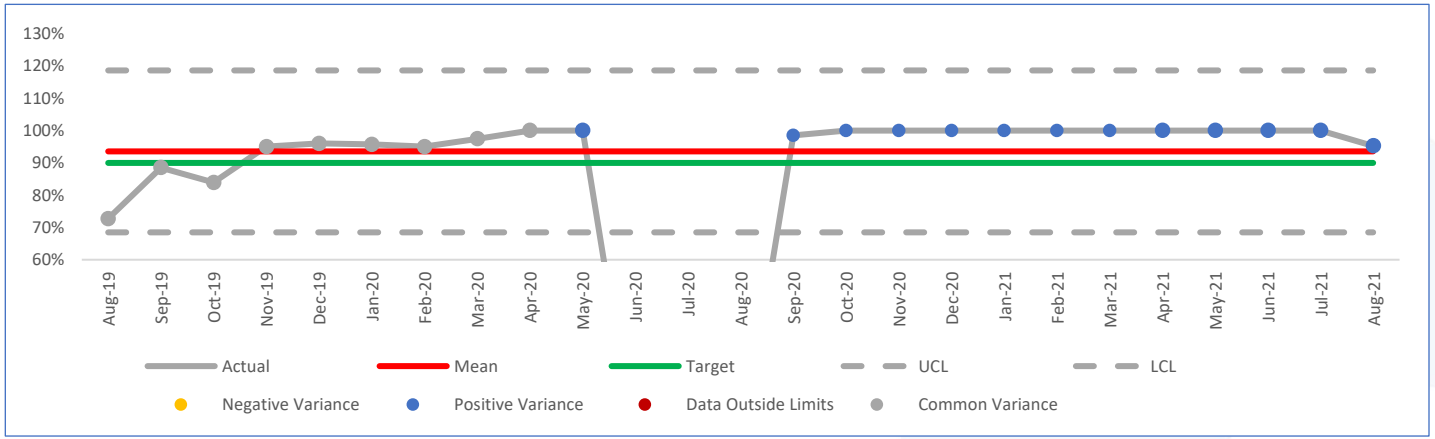
Caring Key Performance Indicators

Domain	Metric	Target	Actual in Month Performance
Caring	Complaints responded to within agreed timescales	>= 90.0%	95.2%
Caring	Friends & Family Test % of patients who would recommend: A&E	>= 88.0%	77.5%
Caring	Friends & Family Test % of patients who would recommend: Inpatient/Day case	>= 95.7%	91.0%
Caring	Friends & Family Test % of patients who would recommend: Outpatients	>= 94.0%	93.4%
Caring	Mixed Sex Accommodation	0	4

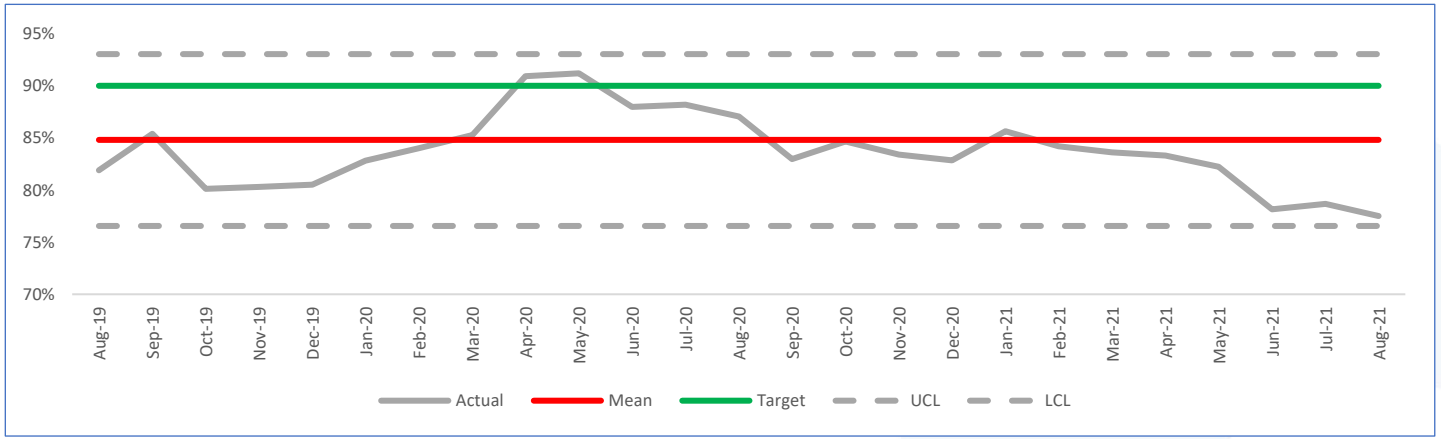
Caring - Complaints responded to within agreed timescales



Aug-21
95.2%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance above the mean
Target
>= 90.0%
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Complaints performance – Providing a written response to a complaint within an agreed timescale	Metric is Consistently achieving the target – Data not provided for Jun 20, Jul 20 and Aug 20.	No issues as target met	No actions as target met	No mitigations as target met

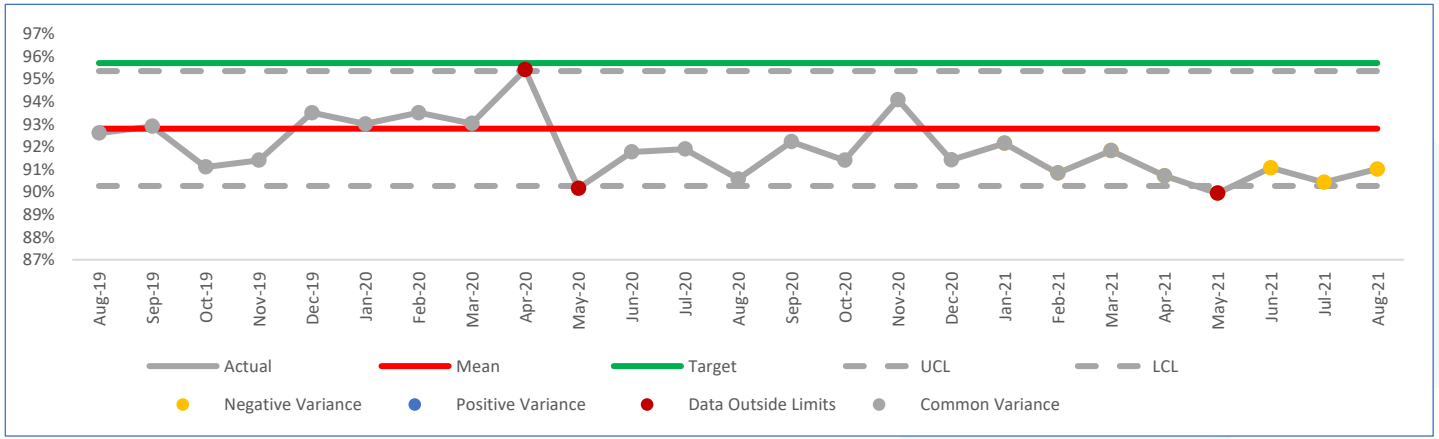
Caring - Friends & Family Test % of patients who would recommend: A&E



Aug-21
77.5%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
>= 88.0%
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 08:39:36 Friends & Family Test % of patients who would recommend: A&E	Metric is Consistently failing the target	ED has seen a decline in satisfaction scores over a period.	The senior nursing team are currently reviewing the feedback and working with wellbeing services within the hospital to support patients. Actions are being identified to understand how patients can be made more comfortable whilst waiting.	From reviewing the comments, it has been identified that patients have concerns with communication related to attitude and behaviour and waiting times.

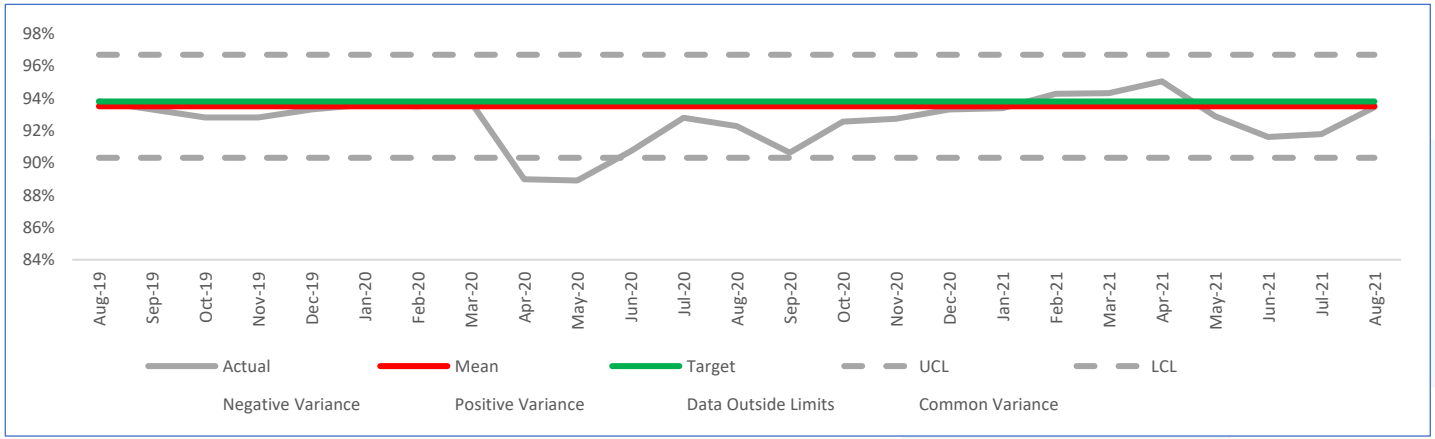
Caring - Friends & Family Test % of patients who would recommend: Inpatient/Day case



Aug-21
91.0%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
>= 95.7%
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Friends & Family Test % of patients who would recommend: Inpatient/Day case	Metric is Consistently failing the target	In terms of the Inpatient/day case, this part has supposed to have been split out	Confirm via board to have this metric split by IP and DC.	Inpatients, the target is 89.5% and the score for August was 88.3%. For Day Case the target is 98% and the August score was 93.9%

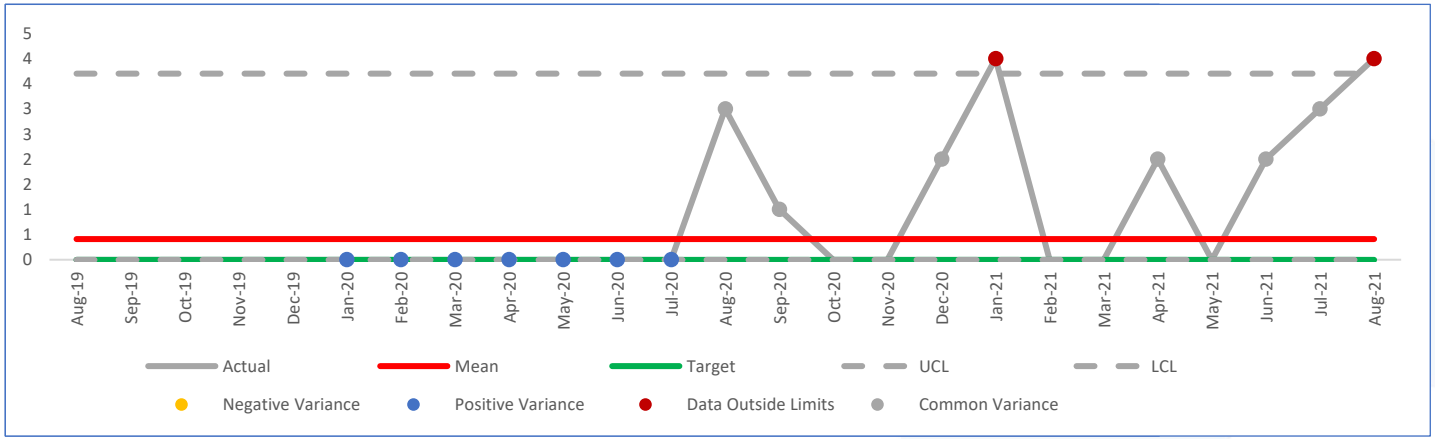
Caring - Friends & Family Test % of patients who would recommend: Outpatients



Aug-21
93.4%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
>= 94.0%
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:39 Friends & Family Test % of patients who would recommend: Outpatients	Metric is Experiencing variable achievement (will achieve target some months and fail others)	No issues provided	No actions provided	Although they are marginally below target, significant progress continues to be made which can largely attributed to patients' satisfaction with e-clinics and telephone consultations.

Caring - Mixed Sex Accommodation



Aug-21
4
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:25 Number of Mixed Sex Accommodation	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Increase in covid admissions & closure of beds due to IPC issues, use of escalation areas to decompress ED	Continue to prioritise critical care step downs through site operational meeting, focus on board round transformation to improve discharges and reduce need for escalation areas	Daily senior review and escalation of issues to COO/DON

Safe

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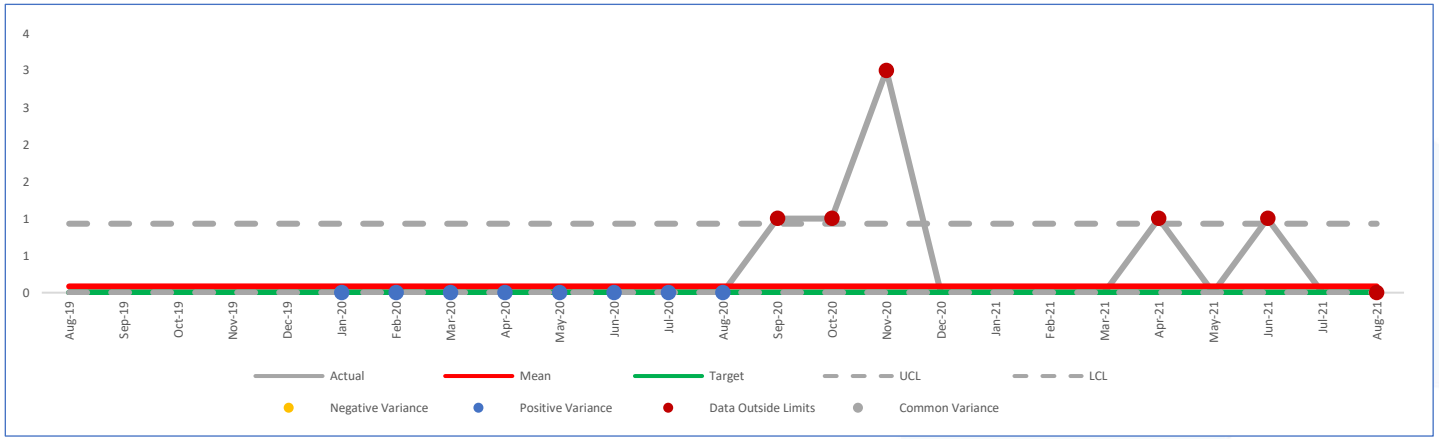
Safe Key Performance Indicators

Domain	Metric	Target	Actual in Month Performance
Safe	Never event incidence	0	No Data Received
Safe	Number of Serious Incidents (SI's) declared during the period	0	No Data Received
Safe	MRSA > 2 Days	0	0
Safe	HOHA and COHA (C-Diff > 2 Days)	<= 4	4
Safe	MSSA > 2 Days	<= 1	0
Safe	VTE Risk Assessment	>= 95.0%	92.9%
Safe	Harmful Falls per 1000 occupied bed days (Exc. Maternity and Pead's)	<=0.14	0.18%
Safe	Fire Drill Compliance	>=85.0%	99.4%
Safe	Fire Evacuation Plan	>=85.0%	100%

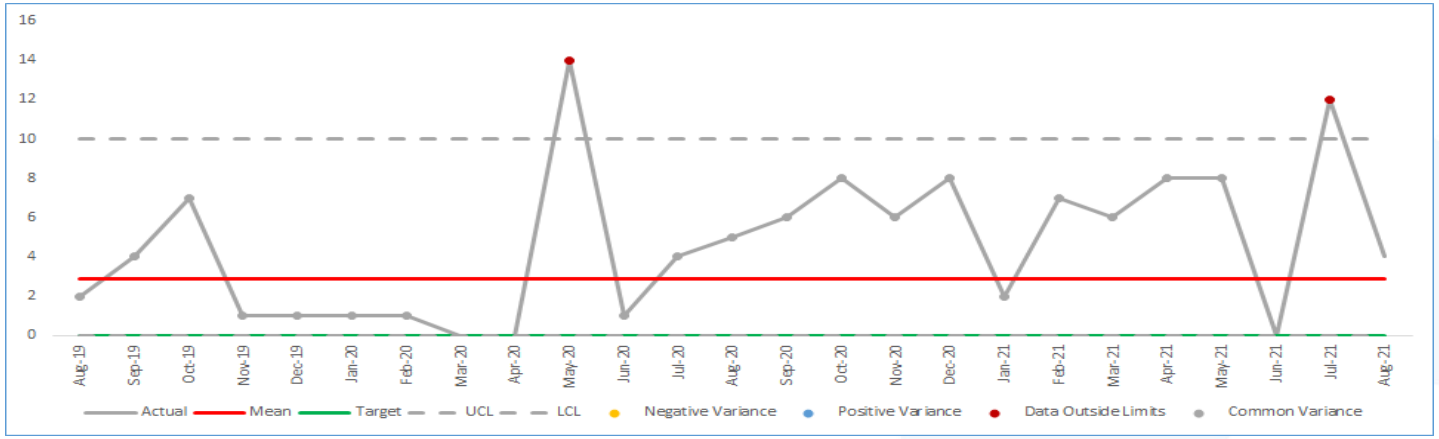
Safe - Never event incidence



Aug-21
0
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:38:35 Never event incidence	Metric is Experiencing variable achievement (will achieve target some months and fail others)	No issues as target met	No actions as target met	No mitigations as target met

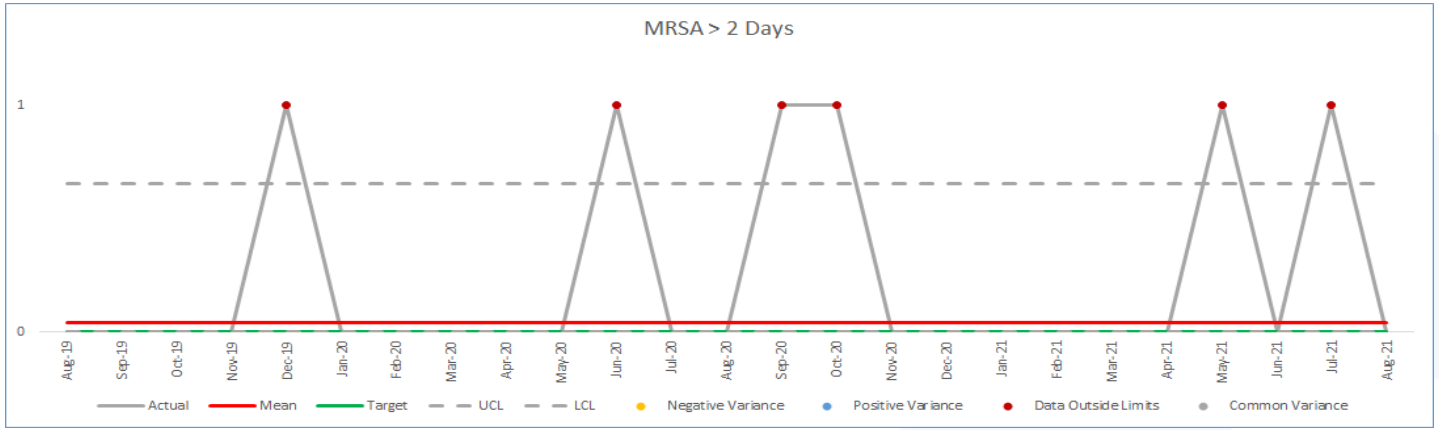
Safe - Number of Serious Incidents (SI's) declared during the period



Aug-21
4
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 08:33:35 Number of Serious Incidents (SI's) declared during the period	Metric is Consistently failing the target.	There have been 12 and 4 SI's declared in July and August, respectively. The numbers included infection outbreaks due to covid-19."	No actions provided	No mitigations provided

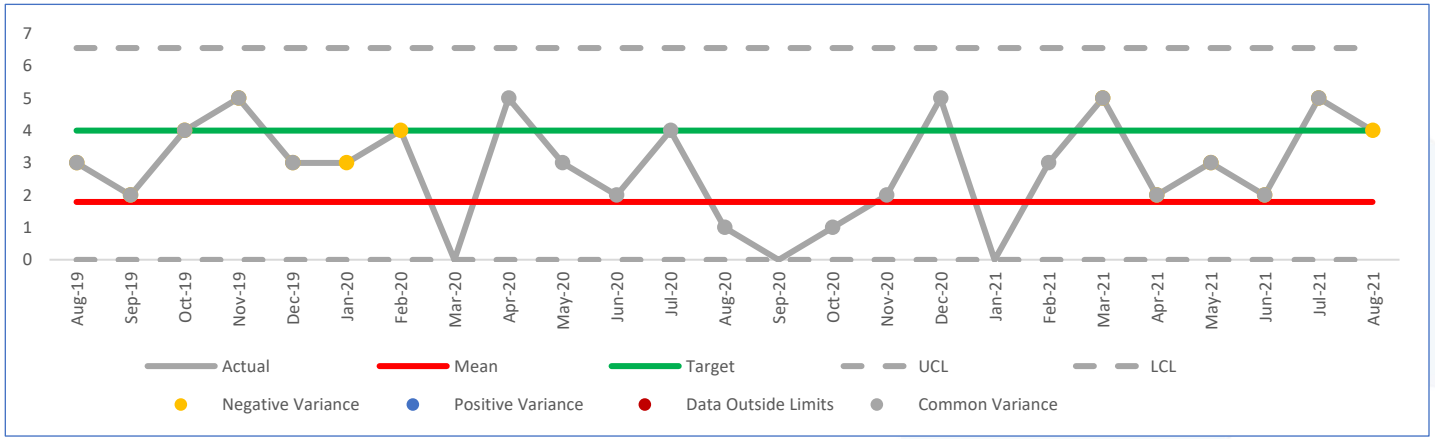
Safe - MRSA > 2 Days



Aug-21
0
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:35 MRSA > 2 Days	Metric is Experiencing variable achievement (will achieve target some months and fail others)	No issues as target met	No actions as target met	No mitigations as target met

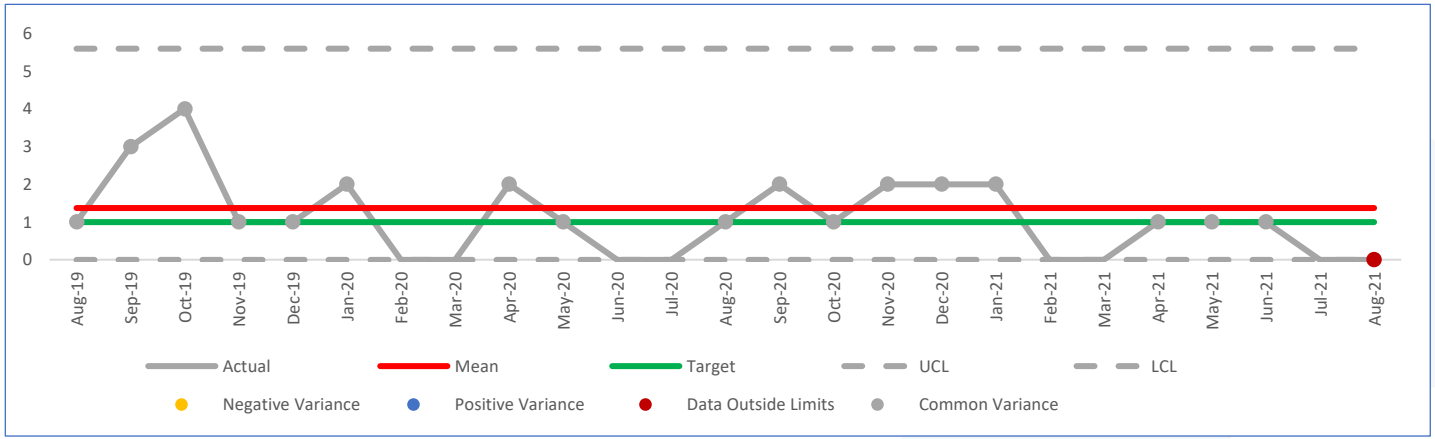
Safe - HOHA and COHA (C-Diff > 2 Days)



Aug-21
4
Variance Type
Metric is currently experiencing Common Cause Variation
Target
<= 4
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 08:31:35 Reduce the number of attributed Clostridium against CCG ceiling based on 2019-20 ceiling as no ceiling set for 2020-21.	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Patients requiring antibiotics to treat infections which they present to hospital with.	C.diff reduction plan put in place, discussed at IPSG. Plan to include daily review of patients in the admission wards to promote prompt stool sampling, plan to promote best practice with following antibiotics guidelines, isolate patients and continue enhanced cleaning.	Continuing above actions, plan to be reviewed monthly at IPSG.

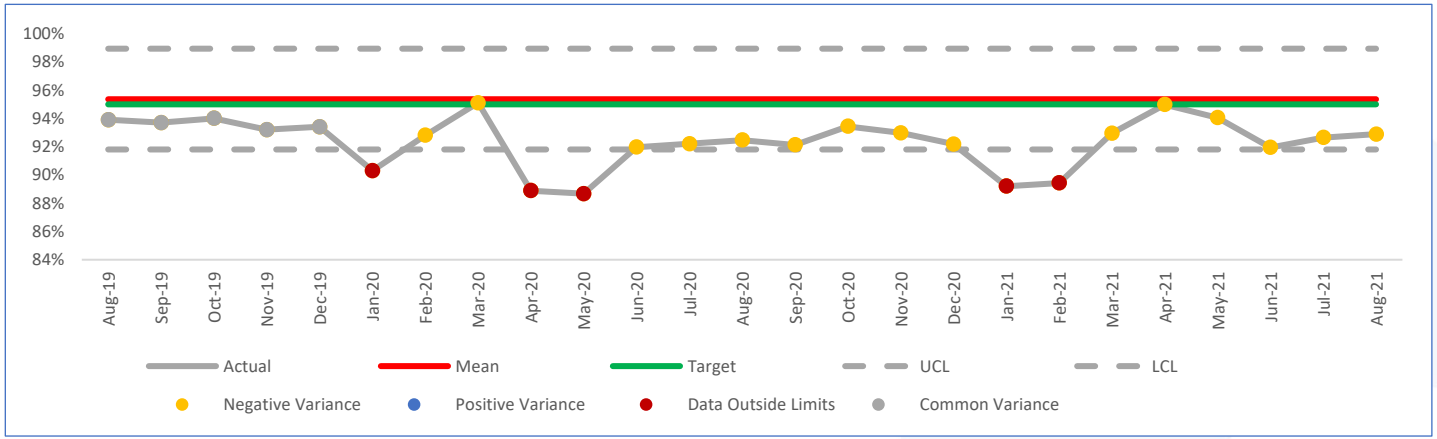
Safe - MSSA > 2 Days



Aug-21
0
Variance Type
Metric is currently experiencing Common Cause Variation
Target
<= 1
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:35 MSSA > 2 Days	Metric is Experiencing variable achievement (will achieve target some months and fail others)	No issues as target met	No actions as target met	No mitigations as target met

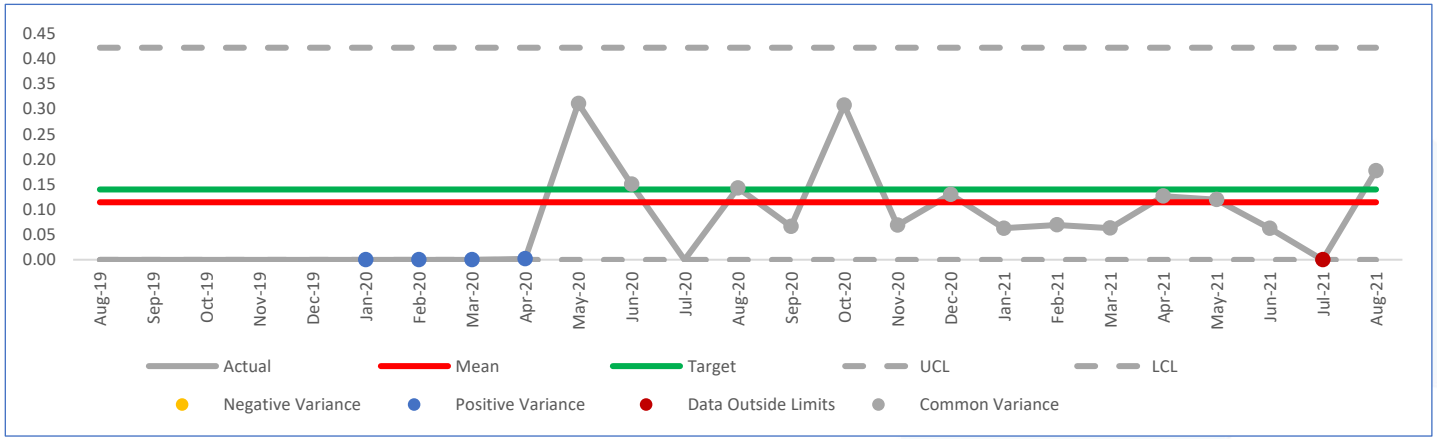
Safe - VTE Risk Assessment



Aug-21
92.8%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
>= 95%
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:35 VTE Risk Assessment	Metric is Consistently failing the target	No issues provided	The medium-term improvement plan is predicated on the recruitment of a VTE specialist nurse and the longer-term plan remains assessment and prophylaxis support through ePMA forcing functions. The latter is currently estimated to be rolled out by March 2023.	The completion of VTE risk assessment is addressed through integrated assessment and prescription charts with ward pharmacists supporting compliance and audit

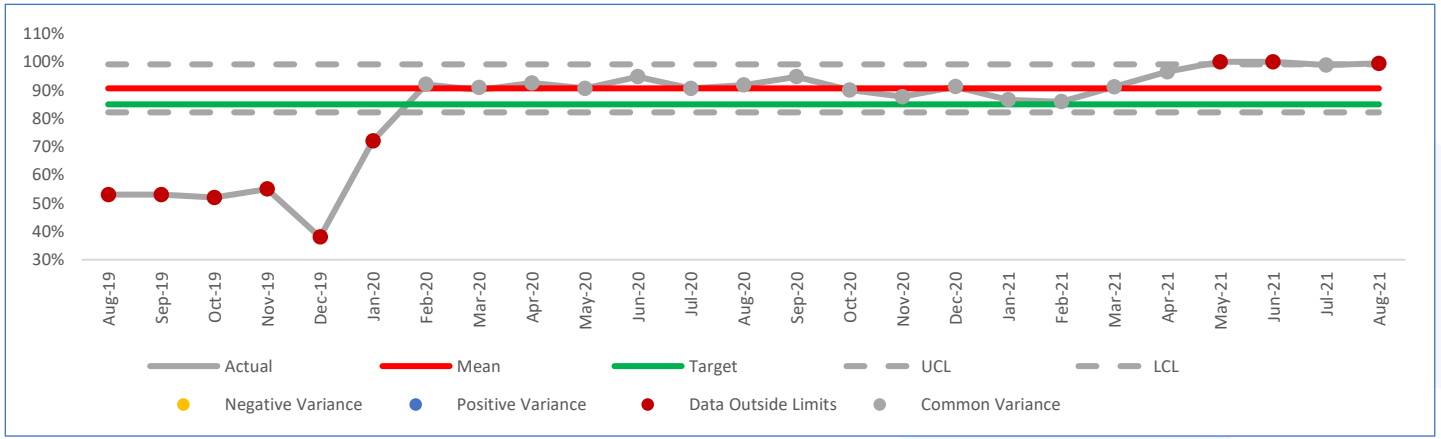
Safe - Harmful Falls per 1000 occupied bed days (Exc. Maternity and Pead's)



Aug-21
0.18%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
<= 0.14
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 16:30:35 Patients experiencing falls with moderate harm or above.	Metric is Experiencing variable achievement (will achieve target some months and fail others)	There were 2 moderate and 1 severe harm fall in the month of August. 1 is declared an SI and 2 are still being investigated under normal processes. One may be down graded following a doctors review.	Any learning identified is disseminated through the falls multidisciplinary working group which is scheduled monthly. Falls are reported quarterly through Care Quality Effectiveness Group and biannually to the Clinical Commissioning Group.	No mitigations provided

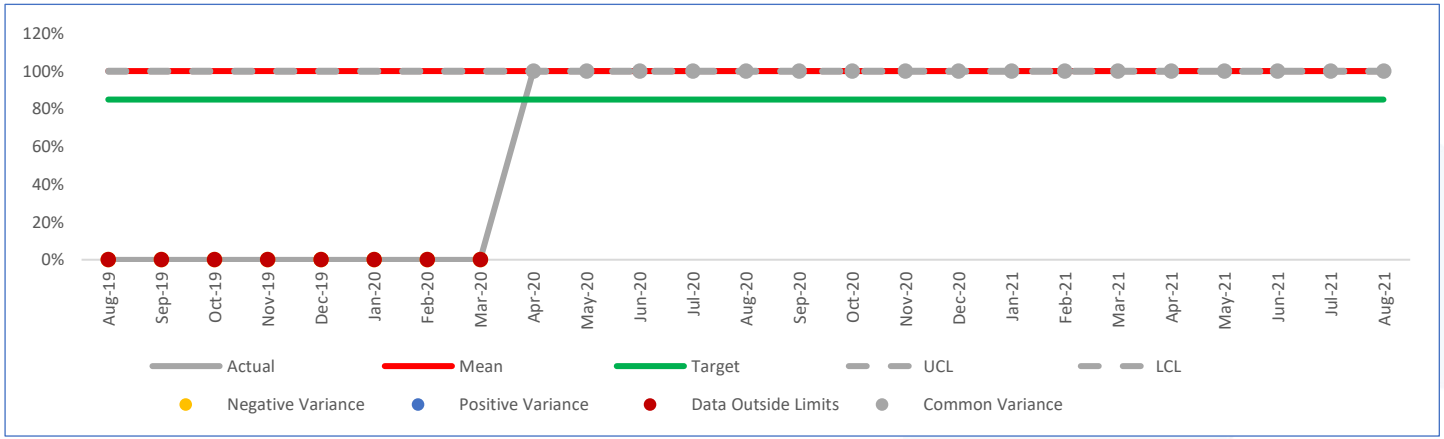
Safe - Fire Drill Compliance



Aug-21
99.4%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
>= 85%
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:38:35 Fire Drill Compliance	Metric is Consistently achieving the target	No issues as target met	No actions as target met	No mitigations as target met

Safe - Fire Evacuation Plan



Aug-21
100.0%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
>= 85%
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:38:35 Fire Evacuation Plan	Metric is Consistently achieving the target	No issues as target met	No actions as target met	No mitigations as target met

Effective

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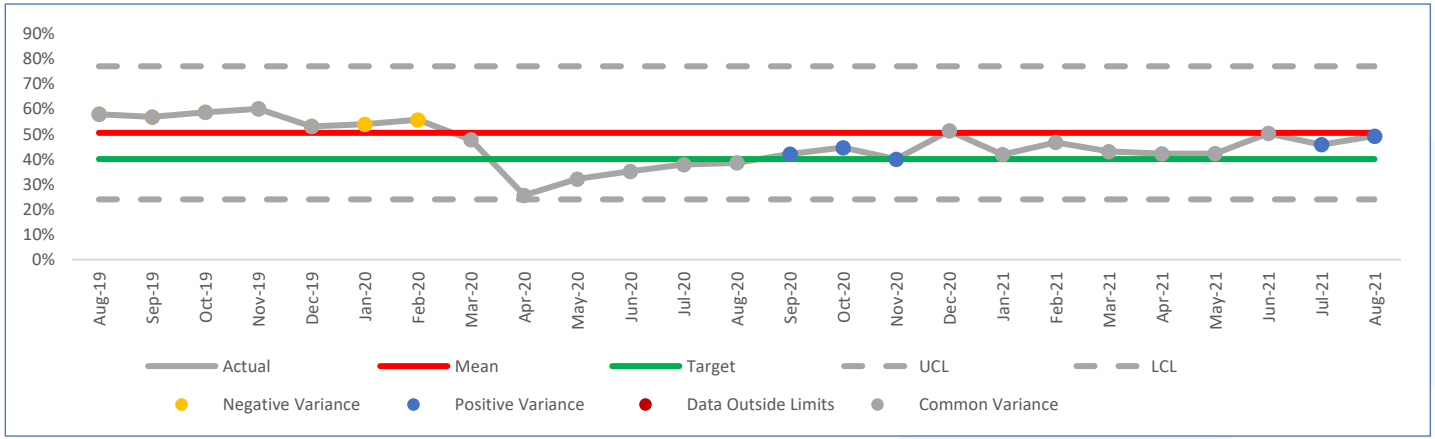
Effective Key Performance Indicators

Domain	Metric	Target	Actual in Month Performance
Effective	Stranded Patients (avg) as % of bed base	<= 40.0%	49.2%
Effective	Super Stranded Long Stay Patients (avg) as % of bed base	<= 25.0%	19.7%
Effective	Length of stay - All	<= 4.2	3.97
Effective	Percentage of discharges before midday	>= 25%	16.7%
Effective	% Day case Rate	>= 80%	85.5%
Effective	Mortality: HSMR	<= 106	105.1
Effective	Mortality: SHMI	<= 109	97.9
Effective	Unappointed Follow Ups	-	20,125

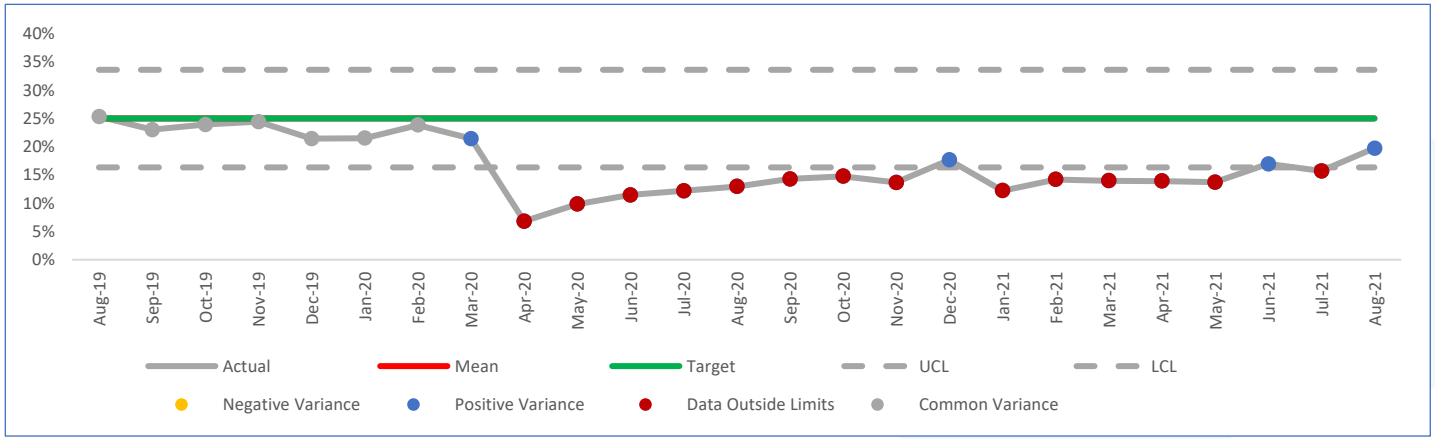
Effective - Stranded Patients (avg) as % of bed base



Aug-21
49.2%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance below the mean
Target
<= 40.0%
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:29:35 Percentage of patients with a LoS > 7 days	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Increase in stranded is due to several factors. Externally there has been a significant constraint on the number of care hours available for supported discharges(impact of staff isolating, sickness & vacancies). Internally the combination of medical leave, staff isolation & sickness has also impacted.	Daily call now in place which focusses on LOS <7days with the emphasis on patients not reaching 7 days and identifying the those atients that can be discharged independently of any support. Nye Bevn Unit identify patients to either remain in urgent care for discahrge or short stay for Creaton Ward	Daily Matron & senior divisional team support on wards to check, challenge & unblock delays

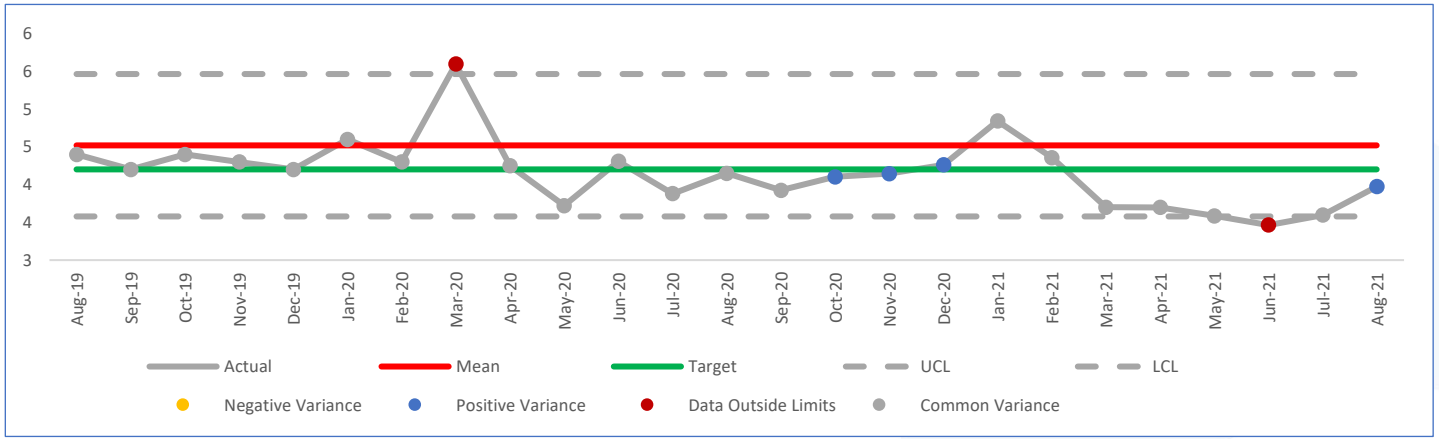
Effective - Super Stranded Long Stay Patients (avg) as % of bed base



Aug-21
19.7%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance below the mean
Target
<= 25.0%
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:35 Percentage of patients with a LoS > 21 days	Metric is consistently meeting the target	No issues as target met	No actions as target met	No mitigations as target met

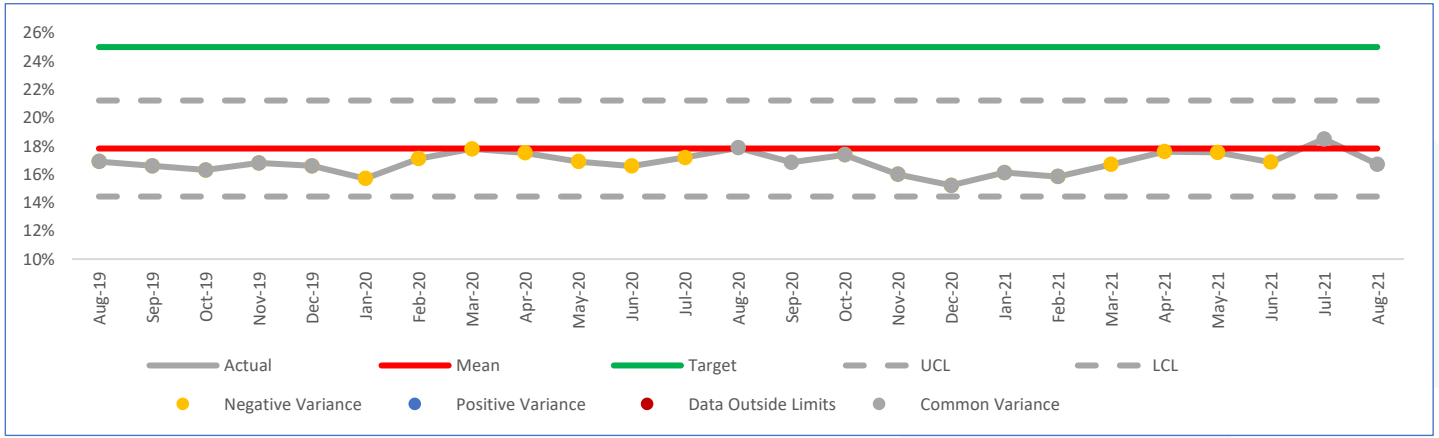
Effective - Length of stay - All



Aug-21
3.97
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
<= 4.2
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:35 Length of stay - All	Metric is Experiencing variable achievement (will achieve target some months and fail others)	No issues as target met	No actions as target met	No mitigations as target met

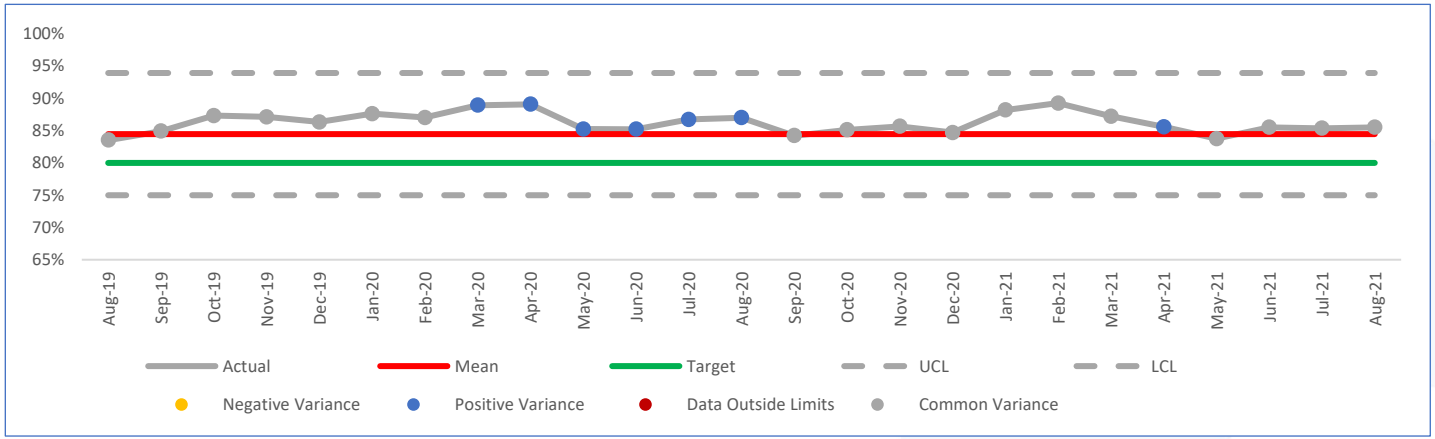
Effective - Percentage of discharges before midday



Aug-21
16.7%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
>= 25.0%
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:36 Percentage of discharges before midday	Metric is Consistently failing the target	No physical discharge lounge. Transport delays have increased significantly predominately driven by increase in OP activity.	A revised chart outlining transport criteria has been developed to be used by the wards when ordering transport.	Additional private ambulance crews are used to support discharges. Discussions with the CCG to agree alternative transport solution.

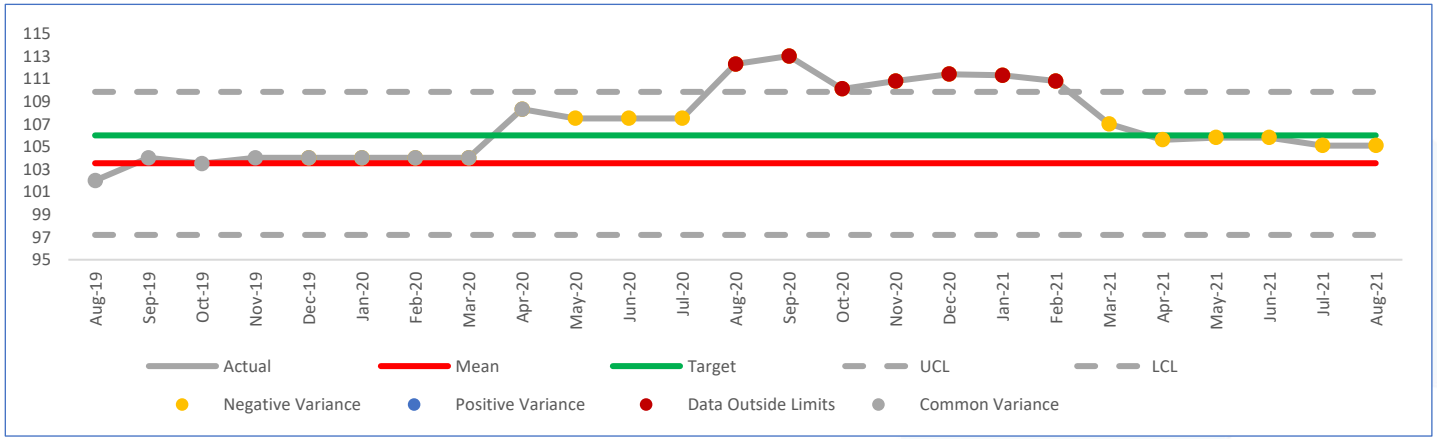
Effective - % Day case Rate



Aug-21
85.5%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
>= 80.0%
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:03 Daycases as percentage of all Elective activity	Metric is Consistently achieving the target	No issues as target met	No actions as target met	No mitigations as target met

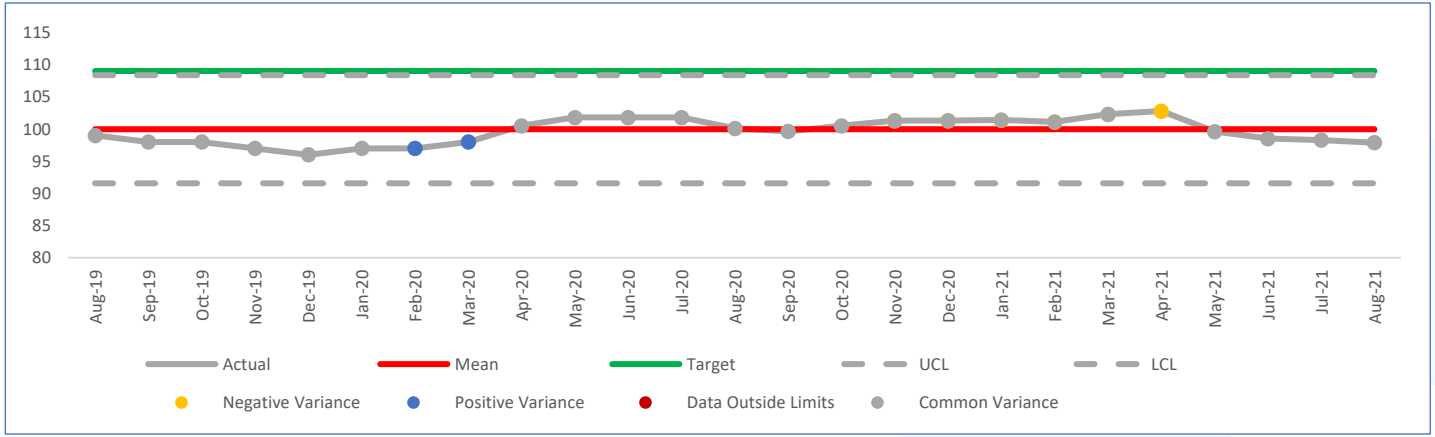
Effective - Mortality: HSMR



Aug-21
103.5
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
<= 106
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:35 Mortality: HSMR	Metric is experiencing variable achievement (will achieve target some months and fail others)	No issues as target met	No actions as target met	No mitigations as target met

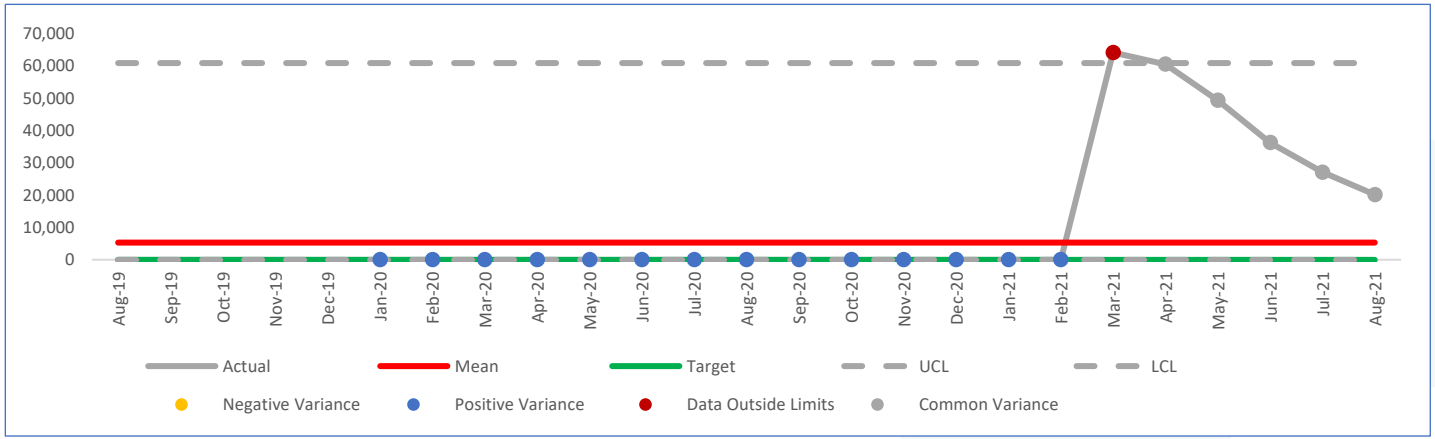
Effective - Mortality: SHMI



Aug-21
97.9
Variance Type
Metric is currently experiencing Common Cause Variation
Target
<= 109
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:24:35 Mortality: SHMI	Metric is Consistently achieving the target	No issues as target met	No actions as target met	Not Required

Effective - Unappointed Follow Ups



Aug-21
20,125
Variance Type
Metric is currently experiencing Common Cause Variation
Target
No Target
Target Achievement

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:35 Unappointed Follow Ups	We have reduced the number of unappointed follow ups by 68.8% - 40000 patient episodes have been validated manually from CaMIS. Work is ongoing in terms of validation.	Legacy data issue from old PAS system and CaMIS system	Trust wide programme to validate & ensure any patients that require follow up are booked. To date the validation has shown that 95% of the backlog is administration error with only 5% of the backlog requiring follow up appointments. Harm review process also in place	Harm review process will continue. Administration training programme and support to prevent future recurrence

Responsive

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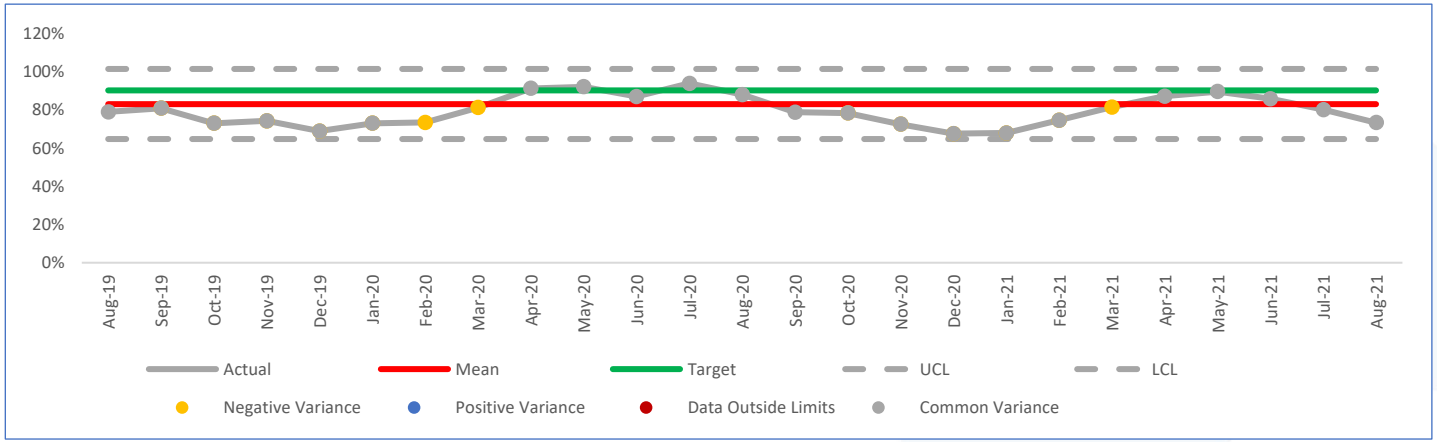
Responsive Key Performance Indicators

Domain	Metric	Target	Actual in Month Performance
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	>= 90.1%	73.3%
Responsive	Ambulance handovers that waited over 30 mins and less than 60 mins	<= 25	226
Responsive	Ambulance handovers that waited over 60 mins	<= 10	26
Responsive	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	0
Responsive	Cancer: Faster Diagnosis Standard	>= 75.0%	82.1% (July)
Responsive	Cancer: Number of Legacy Patients	-	65 (July)
Responsive	Cancer: Percentage of patients treated within 31 days	>= 96.0%	96.3% (July)
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>= 98.0%	98.7% (July)
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	> = 94.0%	96.0% (July)
Responsive	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	> = 94.0%	94.7% (July)
Responsive	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	>= 85.0%	84.1% (July)
Responsive	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>= 85.0%	82.0% (July)
Responsive	RTT Median wait incomplete pathways	<= 10.9	8.5
Responsive	RTT over 52 weeks	0	118
Responsive	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>= 99.1%	79.0%
Responsive	Stroke patients spending at least 90% of their time on the stroke unit	>= 80.0%	62.3%

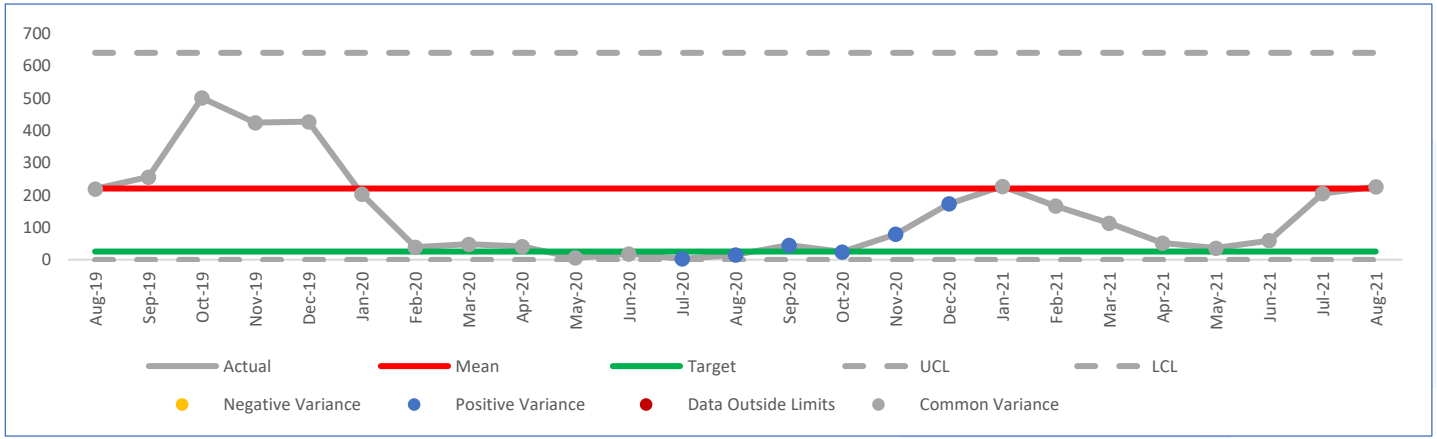
Responsive - A&E: Proportion of patients spending less than 4 hours in A&E



Aug-21
73.3%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
>= 90.1%
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 08:39:35 A&E: Proportion of patients spending less than 4 hours in A&E	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Performance against the 4hr standard remains challenging. Workforce issues and attendances particularly at night have impacted on department process & flow.	ED Consultants have adjusted their rota to better support the evening & night shift demand. The Medical Consultant rota has also been adjusted to support patient assessment in ED until 1am. SDEC & Springfield opening times expanded with further expansion planned in winter.	OOH Service working collaboratively with the ED team to stream patients at night.

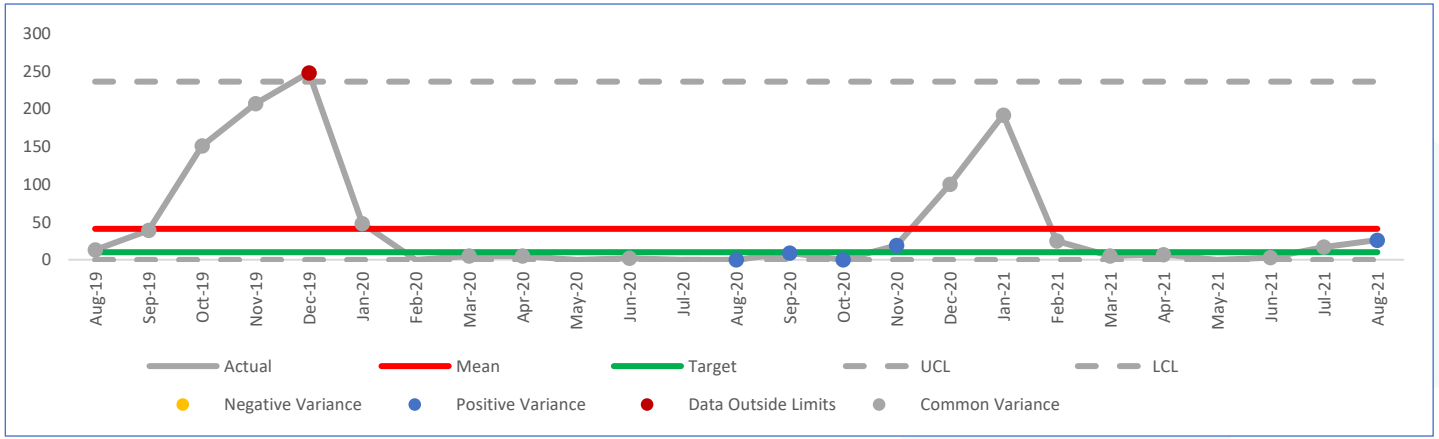
Responsive - Ambulance handovers that waited over 30 mins and less than 60 mins



Aug-21
226
Variance Type
Metric is currently experiencing Common Cause Variation
Target
<= 25
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Ambulance handovers that waited over 30 mins and less than 60 mins	Metric is Experiencing variable achievement (will achieve target some months and fail others)	The majority of ambulance delays are typically during the evening when peak activity is now occurring. This has been further compounded in August by an increase in Covid conveyances.	Senior flow nurse allocated to the ambulance assessment areas to unblock delays. Streaming to SDEC & Springfield. EMAS direct referral to SDEC. Patient booking via 111 to be rolled out in October which will signpost patients to alternatives rather than ED.	Clinical Site Manager supports during peak times.

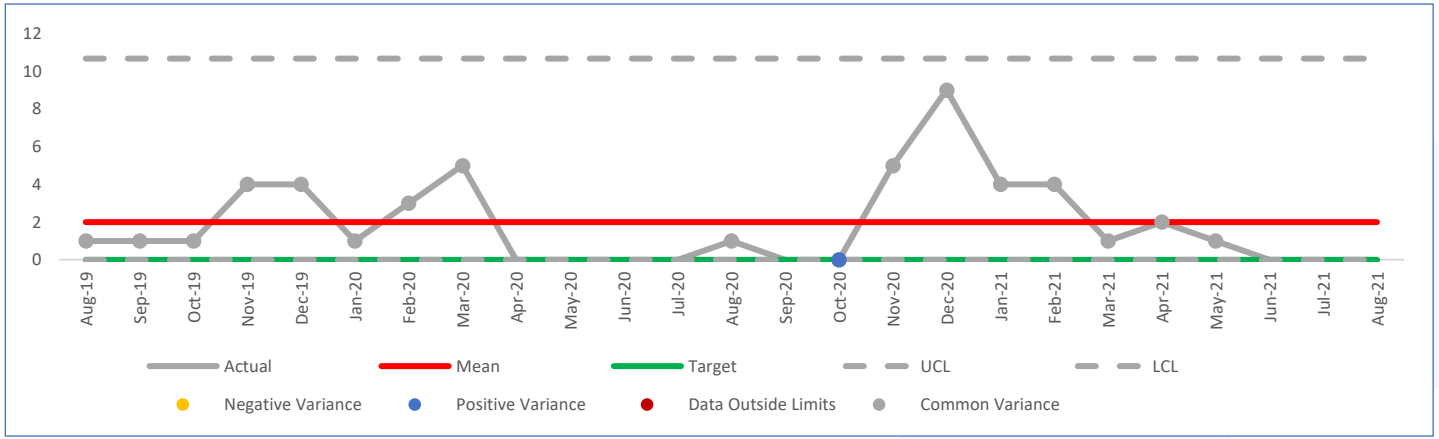
Responsive - Ambulance handovers that waited over 60 mins



Aug-21
26
Variance Type
Metric is currently experiencing Common Cause Variation
Target
< = 10
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:39 Ambulance handovers that waited over 60 mins	Metric is Experiencing variable achievement (will achieve target some months and fail others)	The majority of ambulance delays are typically during the evening when peak activity is now occurring. This has been further compounded in August by an increase in Covid conveyances.	Senior flow nurse allocated to the ambulance assessment areas to unblock delays. Streaming to SDEC & Springfield. EMAS direct referral to SDEC. Patient booking via 111 to be rolled out in October which will signpost patients to alternatives rather than ED.	Clinical Site Manager supports during peak times.

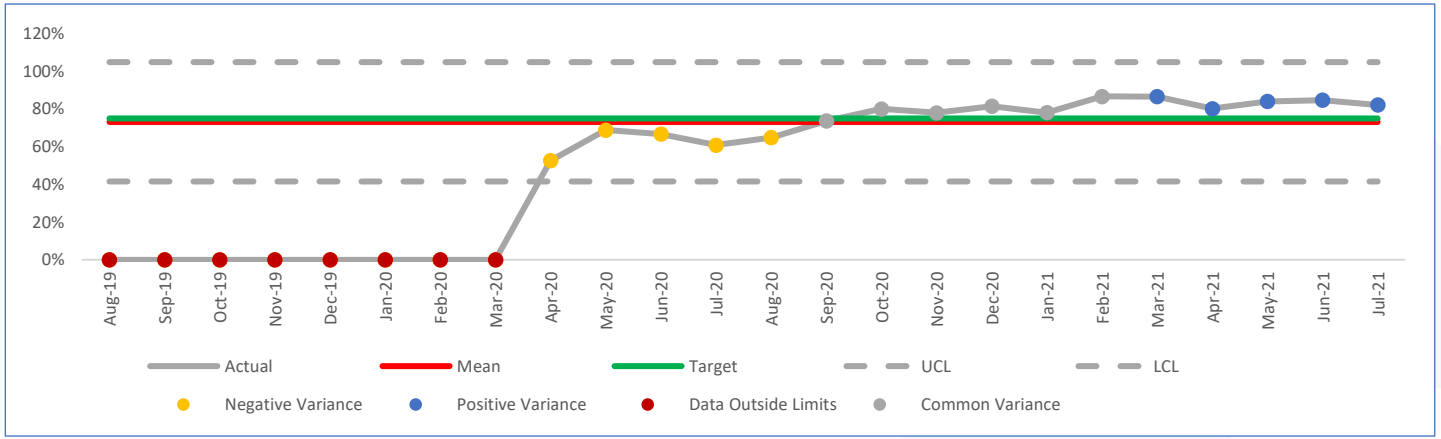
Responsive - Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons



Aug-21
0
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Metric is Experiencing variable achievement (will achieve target some months and fail others)	No issues as target met	No actions as target met	No mitigations as target met

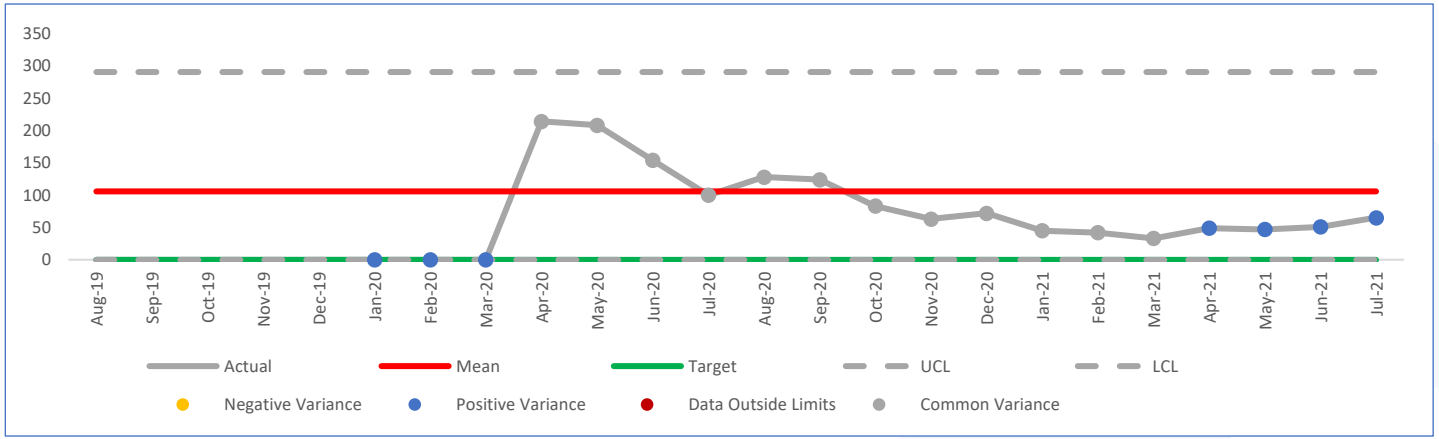
Responsive - Cancer: Faster Diagnosis Standard



Jul-21
82.1%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance above the mean
Target
>= 75.0%
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:35 Cancer: Faster Diagnosis Standard	Metric is Experiencing variable achievement (will achieve target some months and fail others)	No issues as target met	No actions as target met	No mitigations as target met

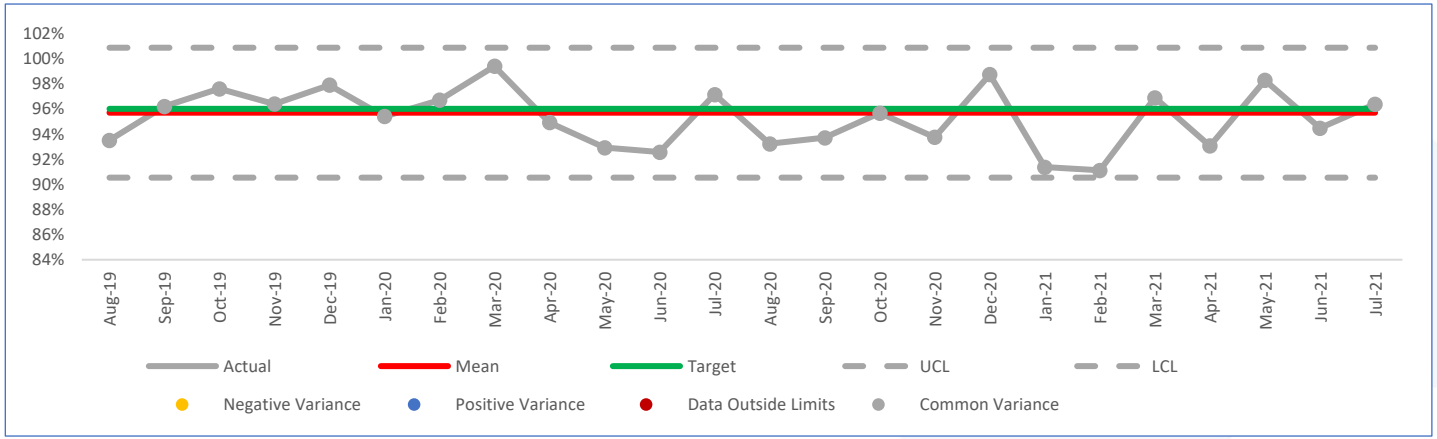
Responsive - Cancer: Number of Legacy Patients



Jul-21
65
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance below the mean
Target
<20
Target Achievement

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 08:39:35 Cancer: Number of Legacy Patients	Metric is Consistently not achieving the target	Delays at tertairy providers, complex patient pathways, patient choice, diagnostic capacity	Daily PTL review with check & challenge led by Deputy COO & Deputy Medical Director. Additional diagnostic capacity in place at NGH & Danetre	Extra operating & outpatient capacity. Use of IS capacity in place to also support.

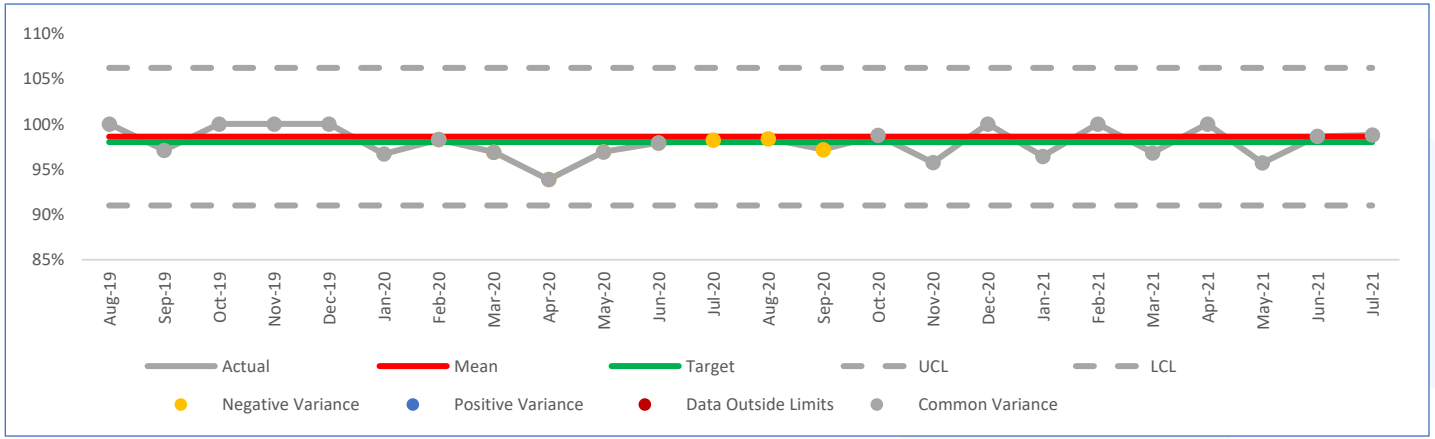
Responsive - Cancer: Percentage of patients treated within 31 days



Jul-21
96.3%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
>= 96.0%
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Patients should experience a maximum wait of one month (31 days) between receiving their diagnosis and the start of first definitive treatment, for all cancers. This is measured from the point at which the patient is informed of a diagnosis of cancer and agrees their package of care. The operational standard for this measure is 96%	Metric is Experiencing variable achievement (will achieve target some months and fail others)	No issues as target met	No actions as target met	No mitigations as target met

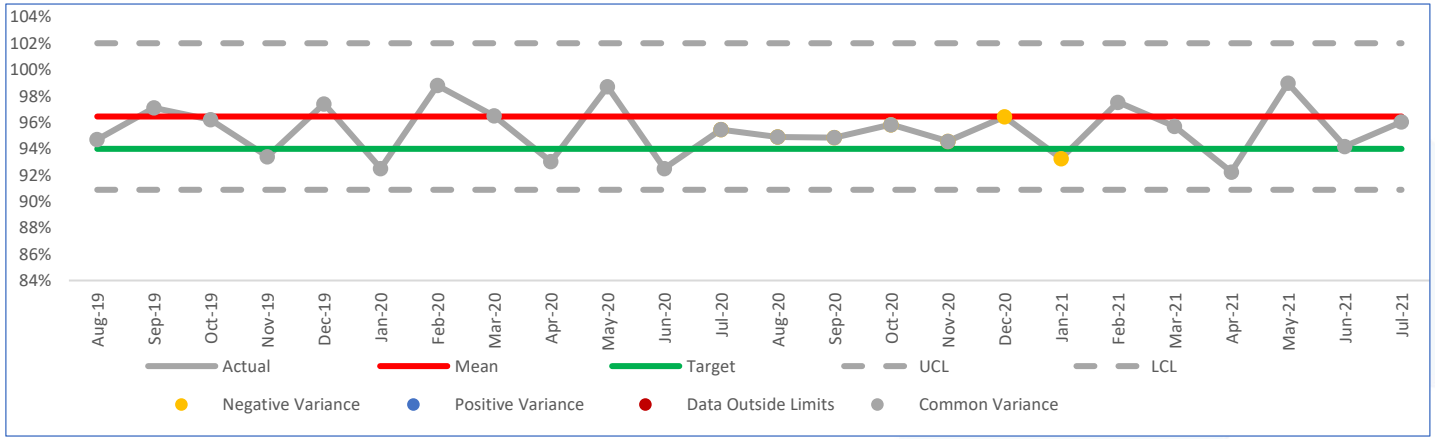
Responsive - Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug



Jul-21
98.7%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
>= 98.0%
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Patients should experience a maximum wait of 31 days for a second or subsequent treatment. Where that treatment is an anti-cancer drug regimen, the operational standard is 98%.	Metric is Experiencing variable achievement (will achieve target some months and fail others)	No issues as target met	No actions as target met	No mitigations as target met

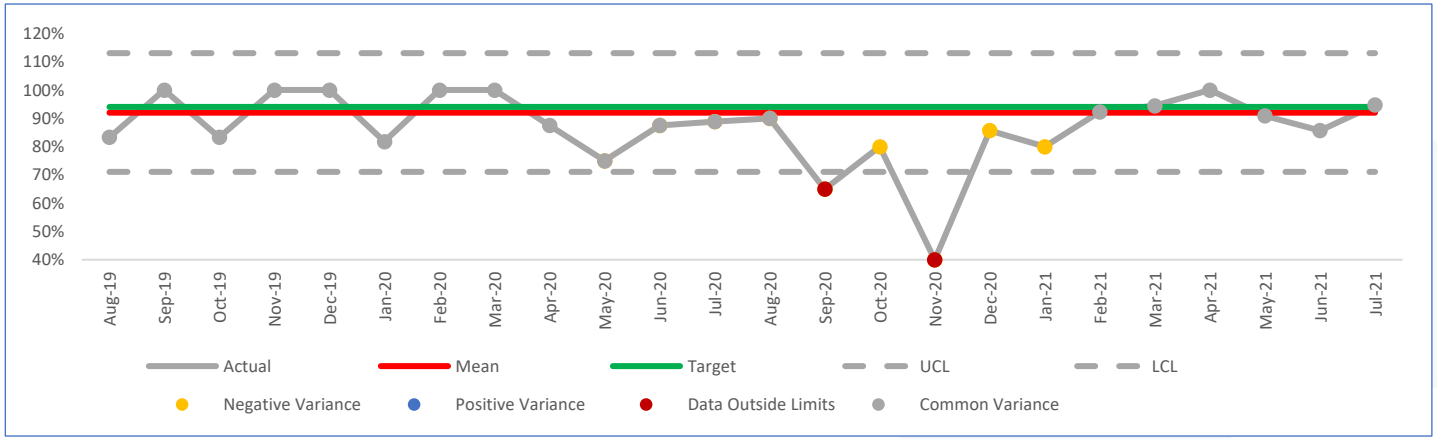
Responsive - Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy



Jul-21
96.0%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
> = 94.0%
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Patients should experience a maximum wait of 31 days for a second or subsequent treatment if that treatment is a course of radiotherapy. The operational standard for this requirement is 94%.	Metric is Experiencing variable achievement (will achieve target some months and fail others)	No issues as target met	No actions as target met	No mitigations as target met

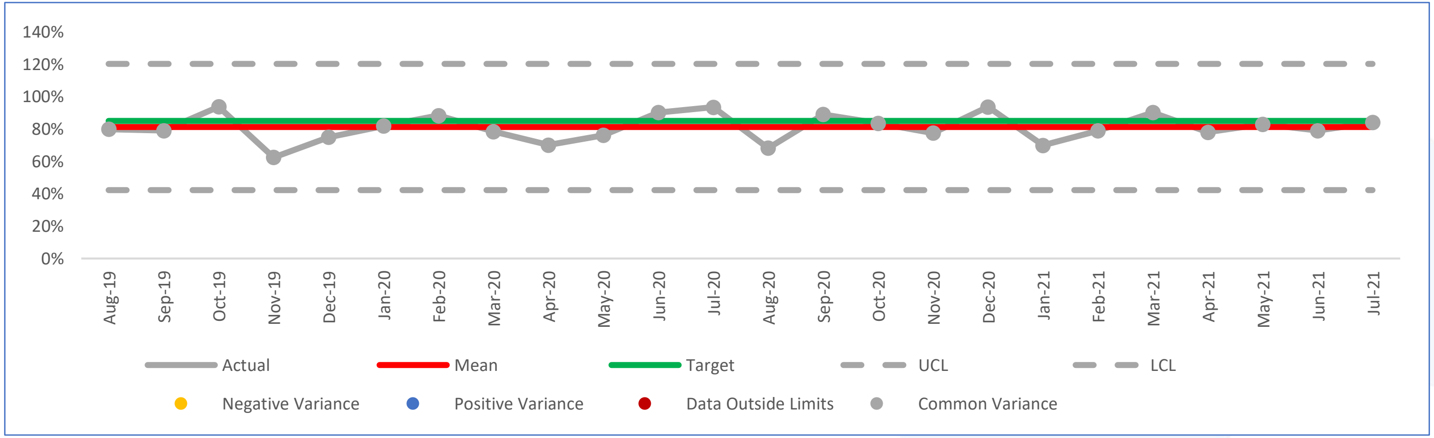
Responsive - Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery



Jul-21
94.7%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
> = 94.0%
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Patients should experience a maximum wait of 31 days for a second or subsequent surgical treatment. The operational standard for this measure is 94%.	Metric is Experiencing variable achievement (will achieve target some months and fail others)	No issues as target met	No actions as target met	No mitigations as target met

Responsive - Cancer: Percentage of patients treated within 62 days of Consultant Upgrade



Jul-21

84.1%

Variance Type

Metric is currently experiencing Special Cause Variation - trend is showing a positive performance above the mean

Target

>= 85.0%

Target Achievement

Not Met

Background:

An operational standard for the maximum 62-day wait for first treatment for those patients who are upgraded with a suspicion of cancer by the consultant responsible for their care has not been developed.

What the chart tells us:

Metric is Experiencing variable achievement (will achieve target some months and fail others)

Issues:

Complex pathways, patient fitness & choice, tertiary centre delays and internal capacity constraints.

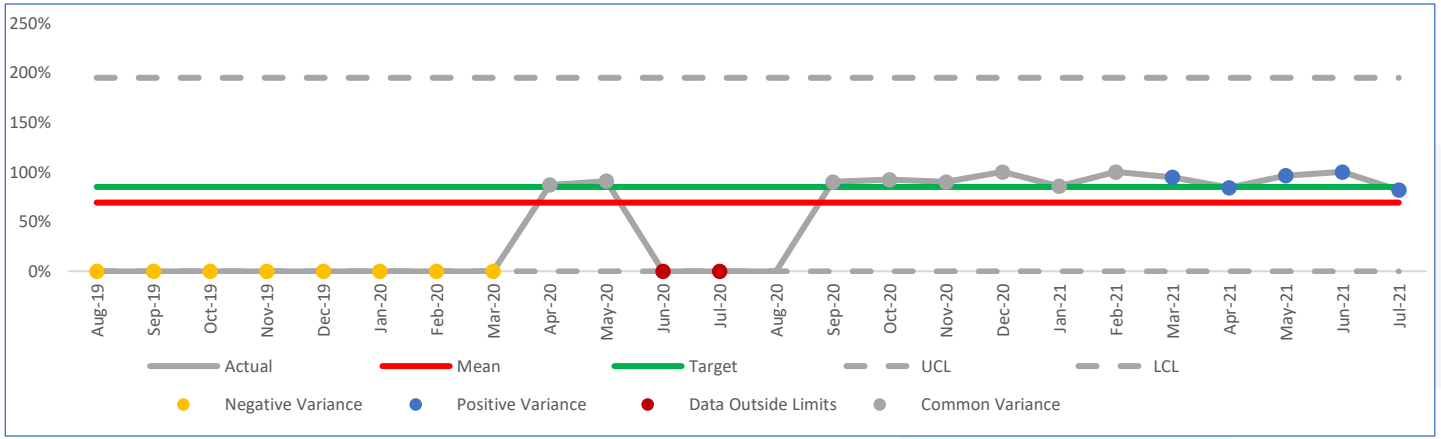
Actions:

Daily PTL review with check & challenge led by Deputy COO & Deputy Medical Director.
Additional diagnostic capacity in place at NGH & Danetre
Next step initiative - patients to leave with their next appointment - to be rolled out across all tumour sites.

Mitigations

Extra operating & outpatient capacity. Use of IS capacity in place to also support.

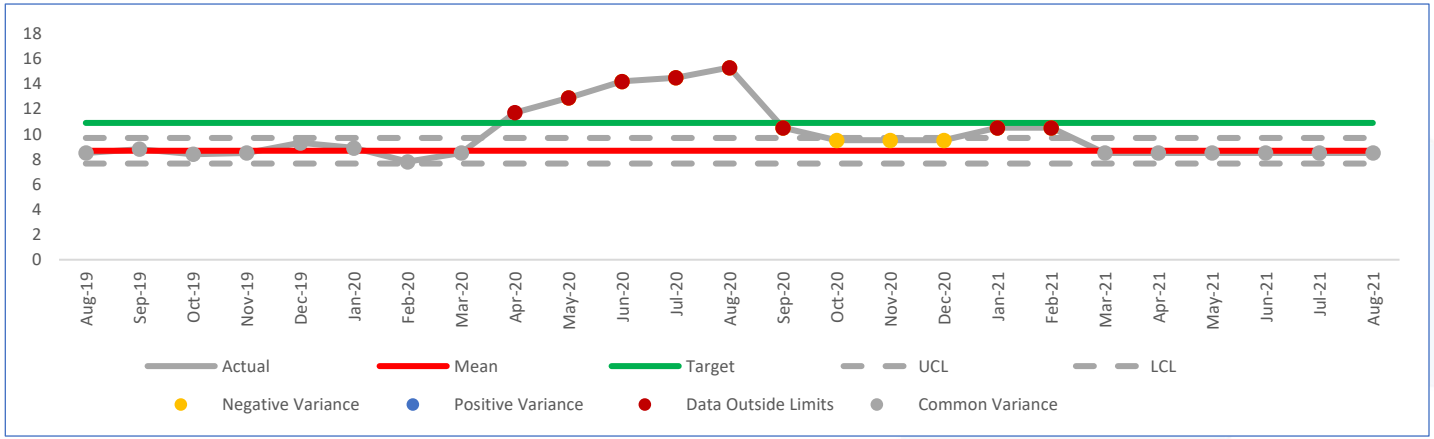
Responsive - Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers



Aug-21
82.0%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
>= 85.0%
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:13 Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Metric is Experiencing variable achievement (will achieve target some months and fail others)	There are a number of unavoidable breaches due to patient fitness & choice. However tertiary centre delays , internal diagnostic capacity, surgical & outpatient capacity issues have also impacted (summer leave, sickness & isolating have also contributed to internal issues).	Daily PTL review with check & challenge led by Deputy COO & Deputy Medical Director. Additional diagnostic capacity in place at NGH & Danetre Next step initiative - patients to leave with their next appointment - to be rolled out across all tumour sites.	Extra operating & outpatient capacity. Use of IS capacity in place to also support.

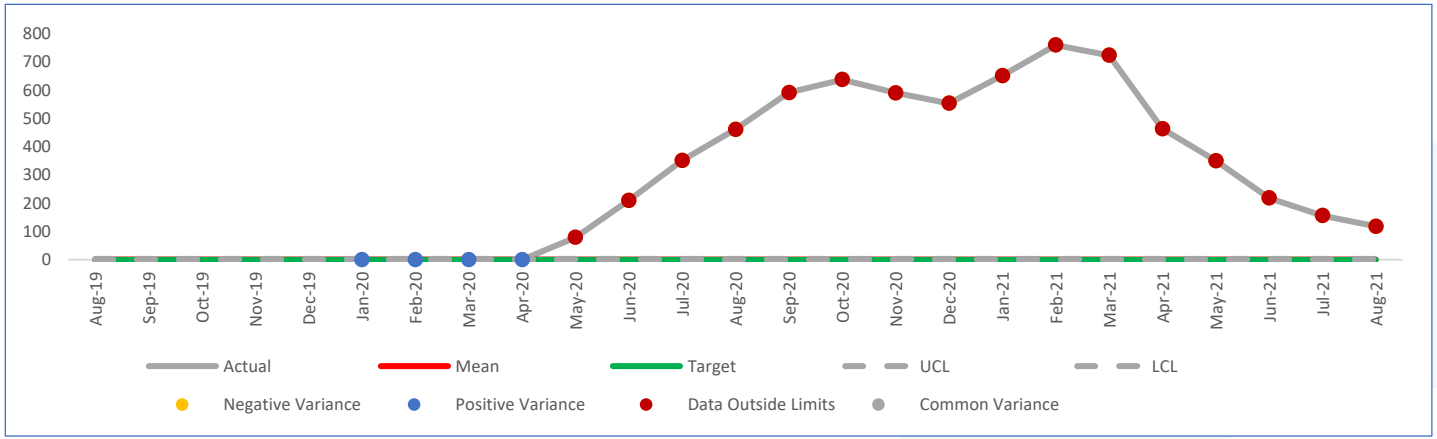
Responsive - RTT Median wait incomplete pathways



Aug-21
8.5
Variance Type
Metric is currently experiencing Common Cause Variation
Target
<= 10.9
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:35 RTT Median wait incomplete pathways	Metric is Consistently achieving the target	No issues as target met	No actions as target met	No mitigations as target met

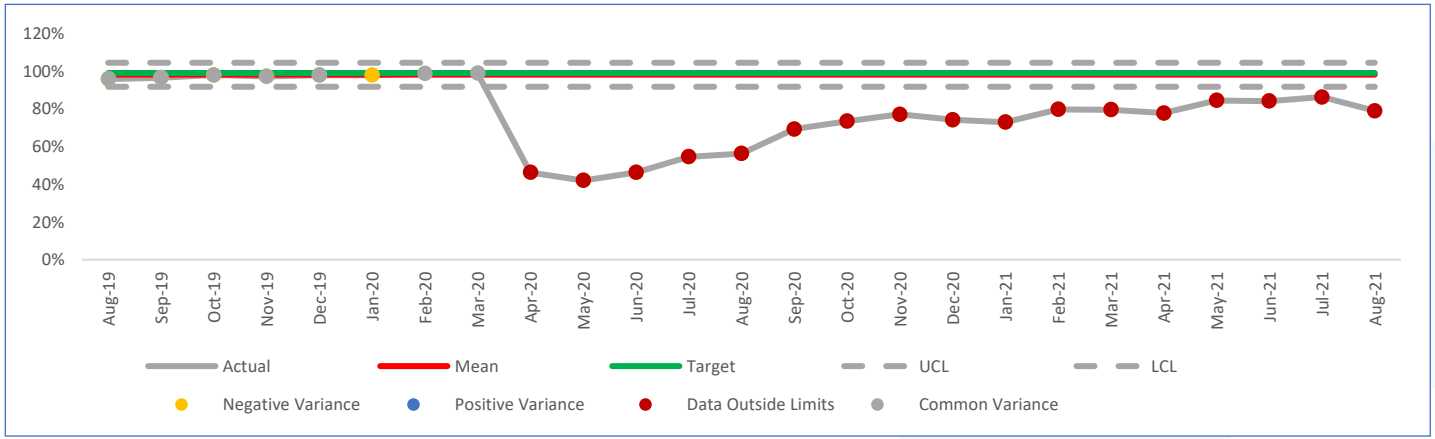
Responsive - RTT over 52 weeks



Aug-21
118
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
0
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 09:38:35 Number of patients waiting over 52 weeks for first definitive treatment at month end	Metric is Consistently failing the target	Conitune to work to trajectory - issues with running theatre sessions due to staff sickness & staff isolating. Volume of cancer work impacts on available slots for RTT patients	Trajectory moniotred through weekly Access Committee. Weekly PTL meetings by specialty, issues to unblock escalated to Deputy COO/COO.	Insourcing & additonal inhouse sessions at weekends. Independent sector capacity to be utilised.

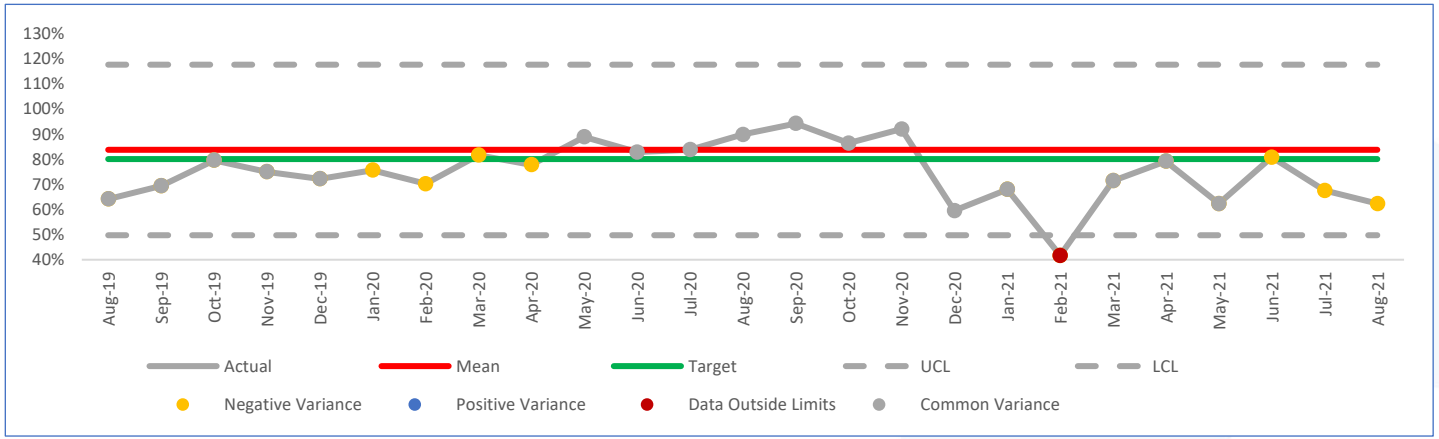
Responsive - Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test



Aug-21
79.0%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
>= 99.1%
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:59:35 % of patients not seen within six weeks	Metric is Consistently failing the target	High volume of general referrals, continued increase in cancer diagnostic work, inpatient and urgent care demand	Trajectory monitored through weekly Access Committee, actions from weekly PTL escalated as required to ensure delivery of trajectory by December 2021 Additonal capacity at NGH & Danetre in place	Further external diagnostic capacity agreed for ultrasound

Responsive - Stroke patients spending at least 90% of their time on the stroke unit



Aug-21
62.3%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
>= 80.0%
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 08:39:35 Stroke patients spending at least 90% of their time on the stroke unit	Metric is Experiencing variable achievement (will achieve target some months and fail others)	August has seen an increase in the number of stroke patients, demand has been higher than available capacity. Also community capacity to support discharge has been constrained.	Stroke capacity is discussed daily at site operational meetings and with community partners.	Eleanor Ward to move to a 21bedded unit in September 2021

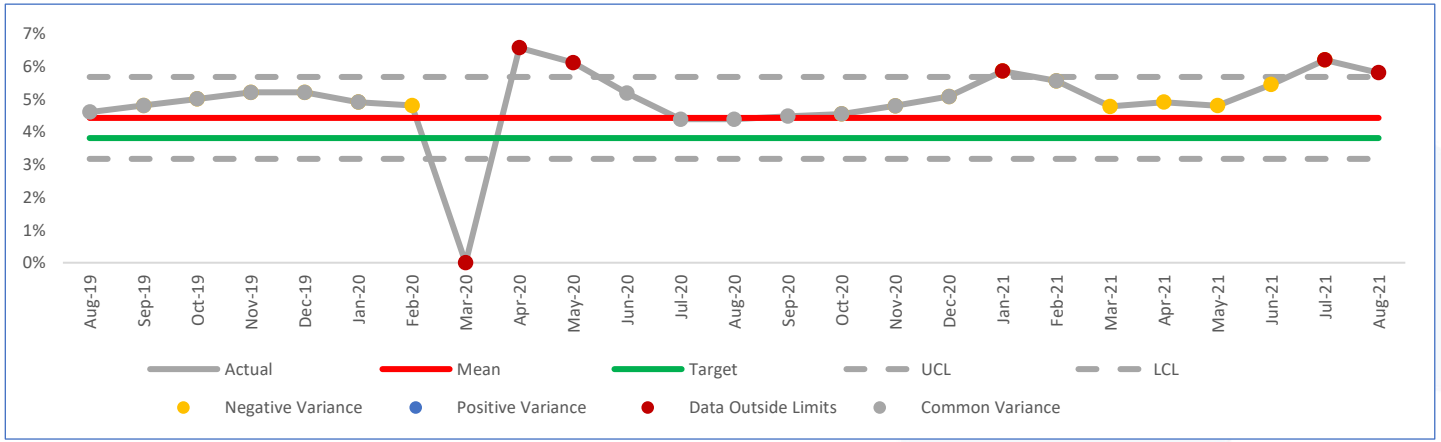
Well Led

Dedicated to excellence

Well Led Key Performance Indicators

Domain	Metric	Target	Actual in Month Performance
Well Led	Sickness Rate	<= 3.8%	5.8%
Well Led	Turnover Rate	<= 10.0%	8.0%
Well Led	Percentage of all trust staff with mandatory training compliance	>= 85.0%	85.9%
Well Led	Percentage of all trust staff with mandatory refresher fire training compliance	>= 85.0%	79.6%
Well Led	Percentage of staff with annual appraisal	>= 85.0%	78.4%

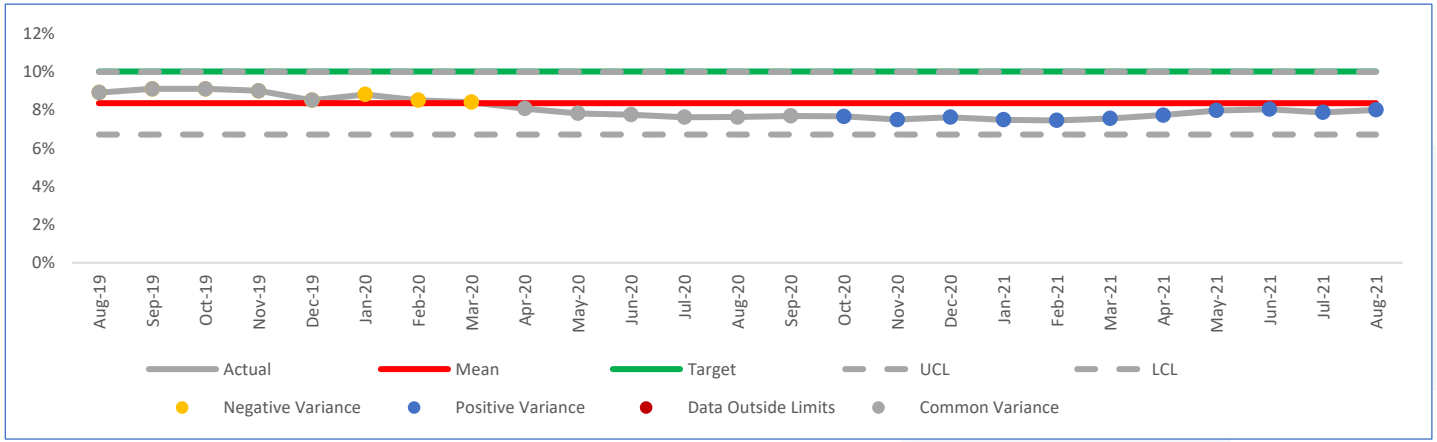
Well Led - Sickness Rate



Aug-21
5.8%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
<= 3.8%
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:38:35 Sickness Rate	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Covid related absence continues to contribute to the overall sickness absence rate. The impact of the pandemic on work and personal lives and on health/wellbeing – and the significant challenges now being faced in reset/winter/wave3 – likely to cause increased absence.	HR Business Partners continue to work closely with Divisions to identify preventative and supportive management of sickness absence.	Psychological PPE recommendations given to wards, teams and individuals Support communications “Talking Matters” Series signposting to IAPT & Samaritans Additional psychologist resource being recruited Enhancements to H&WB offer - signposting to in house & NCC wellbeing activities

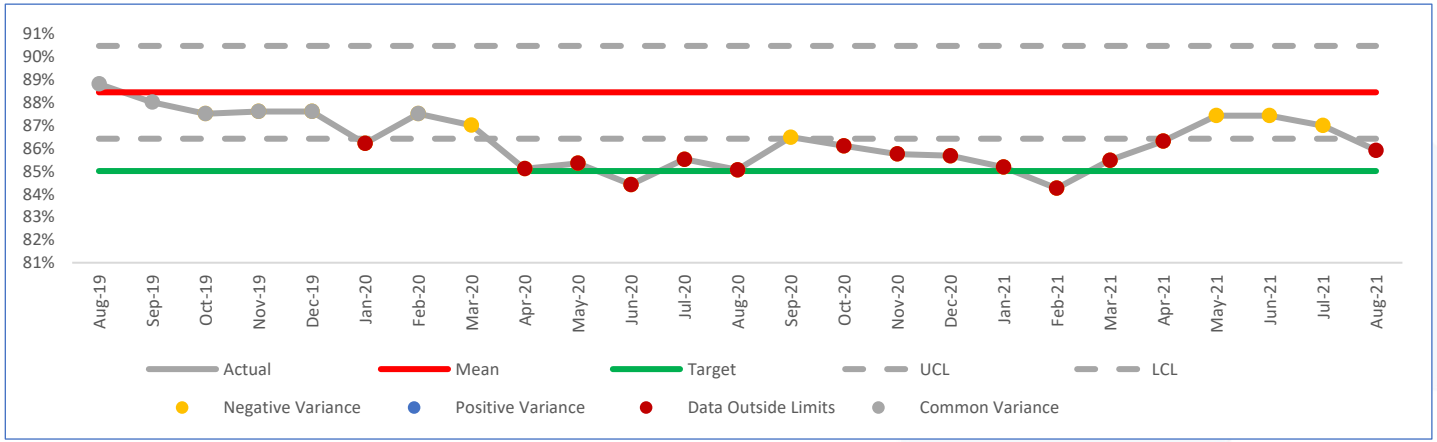
Well Led - Turnover Rate



Aug-21
8.0%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance below the mean
Target
<= 10%
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:38:35 Turnover Rate	Metric is Consistently achieving the target	Trust turnover has remained stable and a contributory factor is likely to be the uncertainty caused by the pandemic and an associated reduction in staff looking for alternative employment. Various retention initiatives particularly in regards to nursing and midwifery continue to be worked on.	No actions as target met	No mitigations as target met

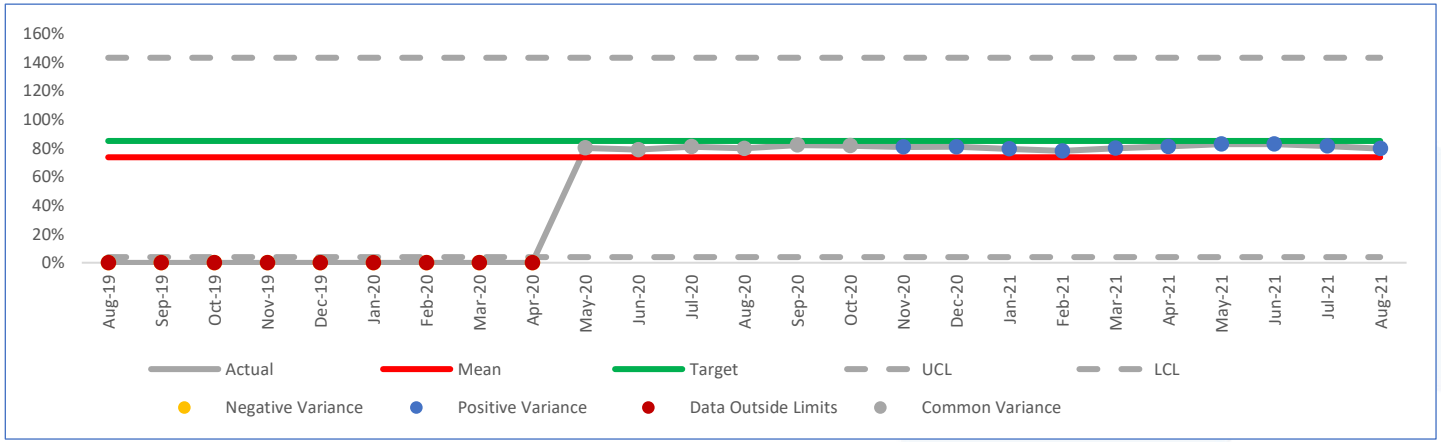
Well Led - Percentage of all trust staff with mandatory training compliance



Aug-21
85.9%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
>= 85%
Target Achievement
Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 08:29:35 Percentage of all trust staff with mandatory training compliance	Metric is Consistently achieving the target	The ability to adapt mandatory training to online courses and remote learning has been a pivotal factor in maintaining mandatory training compliance throughout the pandemic	Where possible more courses are reverting to face to face training in order to cater for differing learning styles to enhance the learning experience.	No mitigations as target met

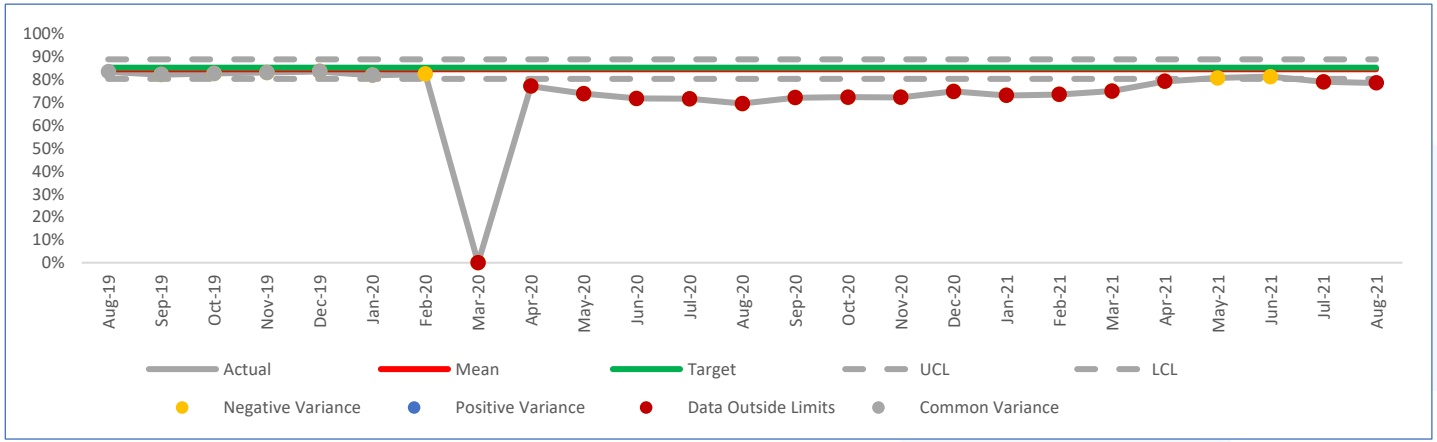
Well Led - Percentage of all trust staff with mandatory refresher fire training compliance



Aug-21
79.6%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance above the mean
Target
>= 85.0%
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 08:39:35 Percentage of all trust staff with mandatory refresher fire training compliance	Metric is Experiencing variable achievement (will achieve target some months and fail others)	COVID—this has had a large impact on the way we can currently provide training.	To mitigate the reduced face-to-face training, we have developed an online package that auto marks. We also have online induction training, although there are now increased face-to-face inductions taking place. Refresher training has now re-commenced for volunteers.	We assess around 150 to 200 staff per month via our assessment sheets. We do rely on our T&D department to forward details of staff who require training, which we then arrange and deliver.

Well Led - Percentage of staff with annual appraisal



Aug-21
78.4%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
>= 85.0%
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Palmer Kirsty 09/27/2021 06:39:38 Percentage of staff with annual appraisal	Metric is Consistently failing the target	Work to recover annual appraisal compliance rates to pre-pandemic level continues to be a challenge.	Appraisal reporting, training and support provided to managers	'Appraisal light' format continues to be available to managers to reduce administrative burden in a way that maintains the aim of the appraisal process whilst increasing compliance.

NGH Board
Finance Performance

Month 5 (August 2021)
FY 2021/22

Northampton General Hospital NHS Trust

Director of Finance Summary

The **Trust YTD position is a £0.3m deficit** compared to a planned surplus of £0.3m, resulting in an adverse position of £0.6m.

Deterioration in financial performance is due to the loss of ERF income due to national threshold changes (NGH: £1.1m unearned income due to the changes), with expenditure continuing to be incurred to deliver additional elective activity, and increased costs of providing increased urgent care.

Total pay remains over plan, £4.0m YTD and £0.4m in-month. Overspend in NGH is as a result of some prior period non-recurrent impacts in Q1 as well as temporary staffing to cover vacancies and operational pressures. The in-month variance is slightly lower than trend due to the allocation of budget relating to ADH costs linked to ERF activity.

NGH H1 forecast is currently expected to be a deficit of £1.4m compared to a breakeven plan, equivalent to the 'allowable' movement in ERF conditions. This assumes all other risks are mitigated. Conversations are on-going with system colleagues on mitigating this risk, with options in place to do so, but not yet finalised.

Efficiencies delivery for NGH total £4.4m (£0.1m ahead of plan) although this is being largely delivered through non-recurrent schemes. Efficiency plan progression is being monitored closely through the efficiency steering group.

Capital spend is £7.1m which is on course for the full year £18.9m programme. We are still awaiting final approval of the £2.0m Emergency Capital application with NHSEI. The cash position remains healthy at £26.8m.

Detailed financial arrangements for H2 not yet known, other than a continuation of block funding, increased efficiency requirement (up to 3%), tapering of COVID funding and ERF to fund elective recovery (conditions unknown).

2021/22 M5 I&E Summary

NGH Year To Date

Description	Plan £m's	Actual £m's	Variance £m's
Total Income	174.8	177.6	2.8
Total Pay	(119.8)	(123.7)	(4.0)
Total Non Pay	(52.5)	(51.9)	0.5
Operating (Deficit)	**2.6**	**2.0**	**(0.6)**
Capital Charges	(2.3)	(2.3)	0.0
I&E Surplus / (Deficit)	**0.3**	**(0.3)**	**(0.6)**

NGH In-Month

Description	Plan £m's	Actual £m's	Variance £m's
Total Income	34.8	34.6	(0.2)
Total Pay	(24.7)	(25.0)	(0.4)
Total Non Pay	(10.0)	(10.1)	(0.2)
Operating (Deficit)	**0.2**	**(0.5)**	**(0.7)**
Capital Charges	(0.5)	(0.5)	0.0
I&E Surplus / (Deficit)	**(0.3)**	**(1.0)**	**(0.7)**

NGH I&E YTD Overview

The YTD position of £0.3m deficit is £0.6m adverse to plan.

Income – The key driver in income is ERF, which is £1.55m above plan due to Elective and OP performance. No income has been achieved in Q2.

Pay – The £4.0m deficit is driven by a combination of non-recurrent pay events in Q1 (+£0.8m), continuing agency spend (+£2.6m) to ensure safe delivery of services, against a plan of reduced agency usage. Other additional pay relates to project spend, such as Respiratory home-monitoring and RPA, offset by funding in other income.

Non-pay – Underspends in non-pay are largely in Clinical Supplies while all theatres and elective inpatient activity returned to capacity.

NGH I&E In-Month Overview

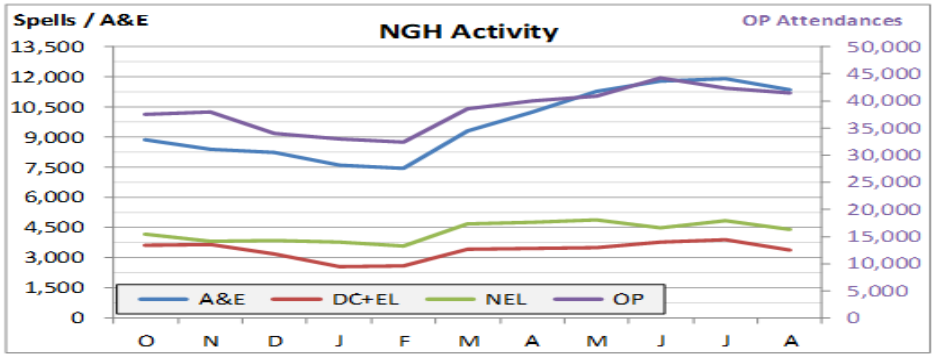
The in-month position of £1.0m deficit is £0.7m adverse to plan.

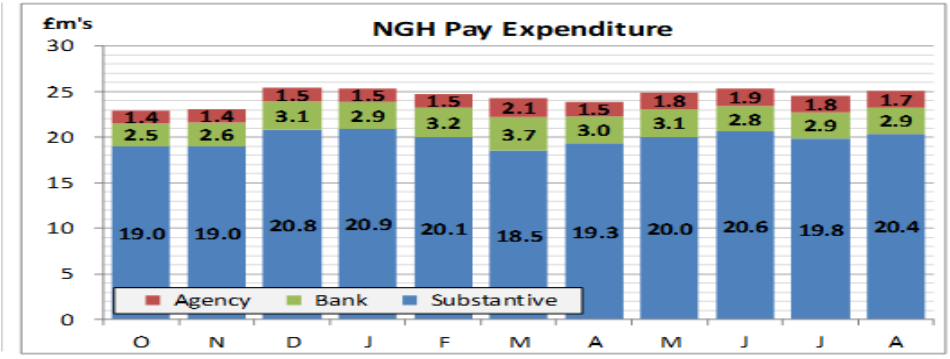
Income of £34.6m is on plan but is adverse against the M5 ERF plan of £0.6m. This in-month deficit is offset by prior month ERF (£0.15m) and Cost & Volume drugs (£0.3m)

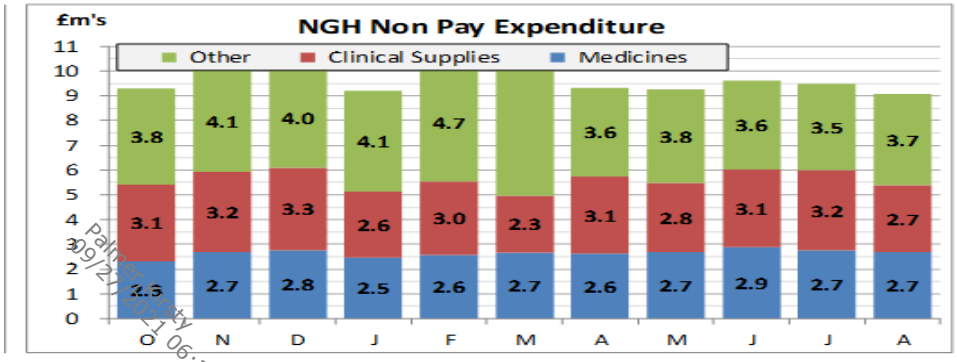
Pay – The £0.4m deficit in pay is aided by allocation of year-to-date budget to recognise additional pay costs to deliver ERF income. Agency spend covering vacancies and operational pressures continues to be c.£1.8m per month, £0.5m over plan.

Non-pay at £10.1m is broadly on plan, with the minor variance caused by project spend (e.g. home monitoring, RPA) covered by income.

Summary - Activity & Expenditure – Monthly Trend







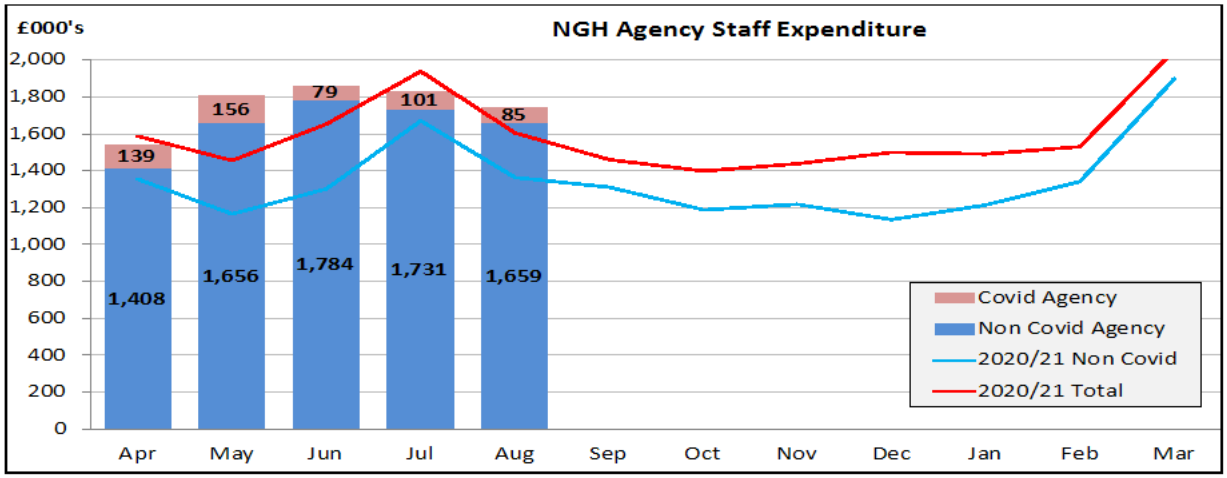
NGH Highlights / Key Issues:

Activity: A&E attendances shows the most marked change with a 50% increase on Jan/Feb levels.
DC+EL has made slower growth 1.5%/mth in 21/22, but (including OP) is performing above the 85% of 19/20 original ERF target.

Pay: Temporary staffing costs, still remain high due to vacancies, sickness cover & Opel 4 pressures. Temporary pay is 18.5% of total pay costs.

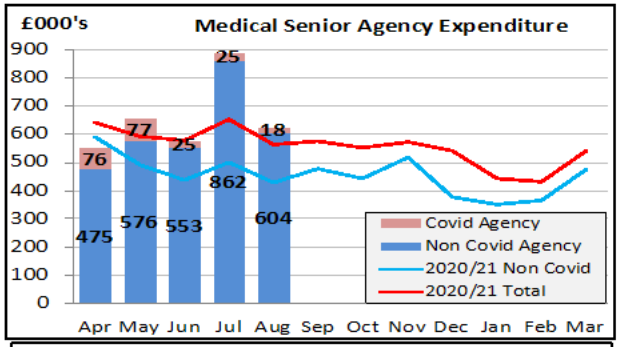
Non Pay: Clinical supplies /drugs expenditure remains consistent despite decreases in activity run-rate compared to Q1.

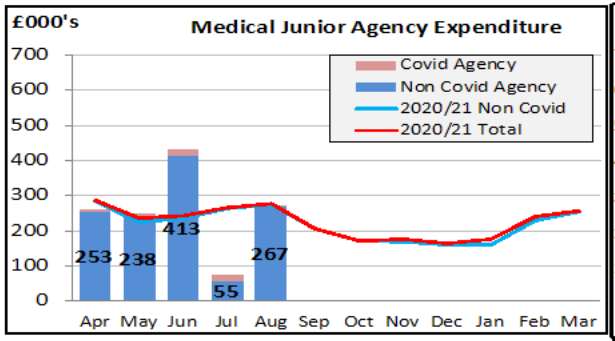
Agency Pay Expenditure

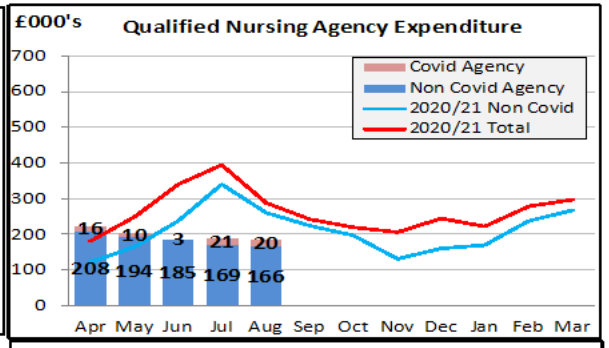


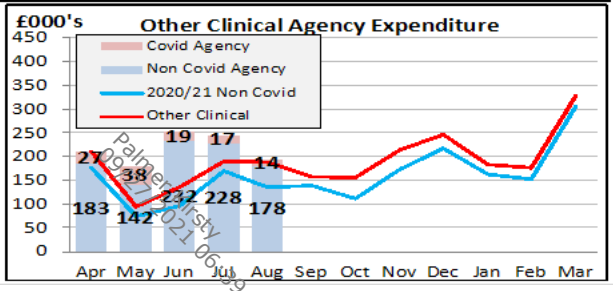
Monthly Agency spend was £1.7m in August, continuing the trend of costs above £1.6m since April 2021.

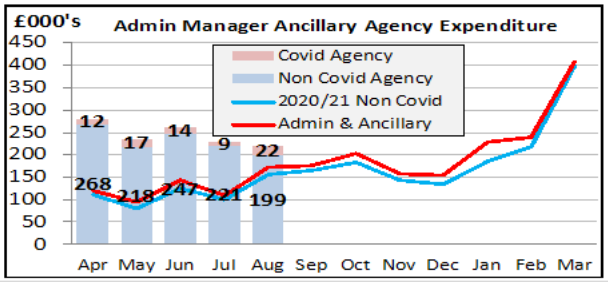
The significant levels of agency remain in medical staff due to vacancy cover and additional staffing to manage operational pressures and staff additional clinics.

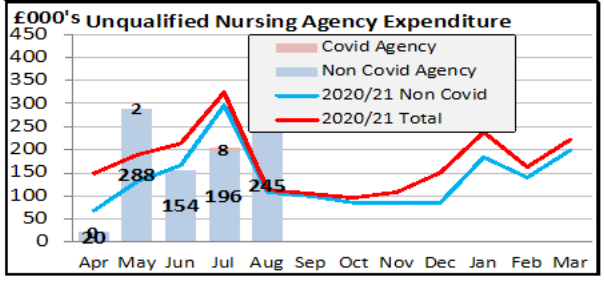












Statement of Financial Performance - NGH

TRUST SUMMARY BALANCE SHEET MONTH 5 2021/22	Balance at 31-Mar-21	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	188,782	188,782	188,782	0	188,782	0
IN YEAR REVALUATIONS	0	0	0	0	0	0
IN YEAR MOVEMENTS	0	6,116	7,130	1,014	19,075	19,075
LESS DEPRECIATION	0	(4,372)	(5,472)	(1,100)	(12,334)	(12,334)
NET BOOK VALUE	**188,782**	**190,526**	**190,440**	**(86)**	**195,523**	**6,741**
CURRENT ASSETS						
INVENTORIES	6,310	6,464	6,242	(222)	6,310	0
TRADE & OTHER RECEIVABLES	16,048	24,177	16,723	(7,454)	21,282	5,234
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CLINICIAN PENSION TAX FUNDING	966	966	966	0	966	0
CASH	25,428	23,713	26,845	3,132	1,500	(23,928)
TOTAL CURRENT ASSETS	**48,752**	**55,320**	**50,776**	**(4,544)**	**30,058**	**(18,694)**
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	34,787	43,795	40,271	(3,524)	24,307	(10,480)
FINANCE LEASE PAYABLE under 1 year	1,206	1,216	1,220	4	1,254	48
SHORT TERM LOANS	246	246	246	0	274	28
STAFF BENEFITS ACCRUAL	0	0	0	0	0	0
PROVISIONS under 1 year	2,477	1,739	1,717	(22)	2,477	0
TOTAL CURRENT LIABILITIES	**38,716**	**46,996**	**43,454**	**(3,542)**	**28,312**	**(10,404)**
NET CURRENT ASSETS / (LIABILITIES)	**10,036**	**8,324**	**7,322**	**(1,002)**	**1,746**	**(8,290)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**198,818**	**198,850**	**197,762**	**(1,088)**	**197,269**	**(1,549)**
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	8,323	7,915	7,812	(103)	7,069	(1,254)
LOANS over 1 year	763	701	640	(61)	669	(94)
PROVISIONS over 1 year	1,585	1,585	1,585	0	1,585	0
NON CURRENT LIABILITIES	**10,671**	**10,201**	**10,037**	**(164)**	**9,323**	**(1,348)**
TOTAL ASSETS EMPLOYED	**188,147**	**188,649**	**187,725**	**(924)**	**187,946**	**(201)**
FINANCED BY						
PDC CAPITAL	259,588	259,588	259,588	0	259,804	216
REVALUATION RESERVE	42,144	42,144	42,144	0	42,144	0
I & E ACCOUNT	(113,585)	(113,083)	(114,007)	(924)	(114,002)	(417)
FINANCING TOTAL	**188,147**	**188,649**	**187,725**	**(924)**	**187,946**	**(201)**

The key movements from the opening balance are:

Non Current Assets
- M5 cum capital additions of £2,463k.
- Depreciation charge of £3,867k.

Current assets
- Trade and Other Receivables – this has reduced in month for payments including ERF made in August.
- Cash – Decrease of £2,883k linked to deficit position off set by capital underspends.

Current Liabilities
- Trade and other payables – consistent with year end.
- Provisions – these have reduced due to the settlement of back pay.

Non Current Liabilities
- Loans over 1 year – Repayment of final loan instalment.

Financed By
- I & E Account - £1,427k unadjusted deficit in month.

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Cover sheet

Meeting	NGH Public Trust Board
Date	30th September 2021
Agenda item	2.1

Title	UHN Group IGR metrics and reporting
Presenter	Andy Callow, Group CDIO
Author	Andy Callow, Group CDIO

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

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

Reason for consideration	Previous consideration
As two hospitals, we need an effective way of managing performance across the Group, monitoring our key metrics – using the IGR process A process of engagement with executives and committees is underway to develop a single set of metrics for the Group IGR – this paper updates the Boards on the process through which the Group IGR is being developed	Group IGR metrics and reporting have been discussed in: - Collaboration Programme Committee - KGH Quality and Safety Committee Further sessions are planned in: - NGH Quality Governance Committee - Joint Finance and Performance Committee - Joint People Committee - Audit Committee

Executive Summary

In development of a single IGR across the Group, we are aiming for all committee and Board reporting to be run off a common dataset – with high-level measures being included in the IGRs for Boards, and Committees receiving a greater detail of measures. There are two stages to developing these measures:

1. Agreeing the key metrics committees would like to see in the Group IGR for review at Boards
2. Agreeing the key metrics committees would like to see in individual committees

In order to develop the Group IGR, engagement is underway with each of the committees to identify the key metrics for inclusion in the IGR such that they would always go to Boards. The proposed set of metrics will be agreed at October CPC, following which the Group Health Intelligence team will work to create the core datasets to be incorporated into January 22 Committee and Board meetings.

A draft set of 57 IGR metrics has been identified, grouped into the five Group priorities, which will be refined through the process of engagement with the committees.

Appendices

Risk and assurance

There is a risk that if the Group IGR metrics are insufficient for monitoring the performance of the two Hospitals that there is insufficient Board oversight and assurance of Trust performance

Financial Impact

Legal implications/regulatory requirements

Equality Impact Assessment

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

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University Hospitals of Northamptonshire
NHS Group

UHN Group
IGR Metrics and reporting

KGH and NGH Boards September 2021

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Presented By: Andy Callow, Group CDIO

Metrics and reporting across the Group to committees and Boards

- As two hospitals, we need an effective way of managing performance across the Group, monitoring our key metrics – using the IGR / IPR process:
  - The current process needs to be stabilised
  - There needs to be an agreed set of metrics across the group going forwards that aligns to the Group priorities and reflects the important measures for the Group
  - The SPC chart format is best practice and has been agreed by our Boards as our agreed methodology (where appropriate)

- We are aiming for all committee and Board reporting to be run off a common dataset – with high-level measures being included in the IGRs for Boards, and Committees receiving a greater detail of measures. There are two stages to developing these measures:
  1. Agreeing the key metrics committees would like to see in the Group IGR for review at Boards
  2. Agreeing the key metrics committees would like to see in individual committees

- Initial discussions have been held with executives to develop a draft metric list which was shared at the September Collaboration Programme Committee, at which it was agreed further engagement would be undertaken with the committees to define an initial candidate list of metrics for the committee and Board to start using.

Timeline for agreeing consolidated Group reporting for committees and Boards

Throughout August 21

Discussions with execs

September 21 CPC

Discussion on proposed set of IGR metrics, identifying that we need a short, succinct set of measures

Agreement for each committee to provide feedback on the 6 key metrics to include in the IGR

September 21 Committees

Each committee to discuss the six key metrics for nomination for inclusion in the IGRs

Discussion on metrics to be included in the committee paper

September 21 Boards

Discussion on proposed approach to developing IGRs, timeline and initial metrics discussed at CPC

October 21 CPC

Discussion on collated metrics from committee discussions

Following October CPC

Approval of proposed IGR metrics by Group committees

Alignment of metric definition and targets in preparation for first reporting

December 21

Health Intelligence Firebreak completed – resulting in a core set of reporting data sets available through Power BI

January 22

New Group metrics incorporated in Committee and Board meetings

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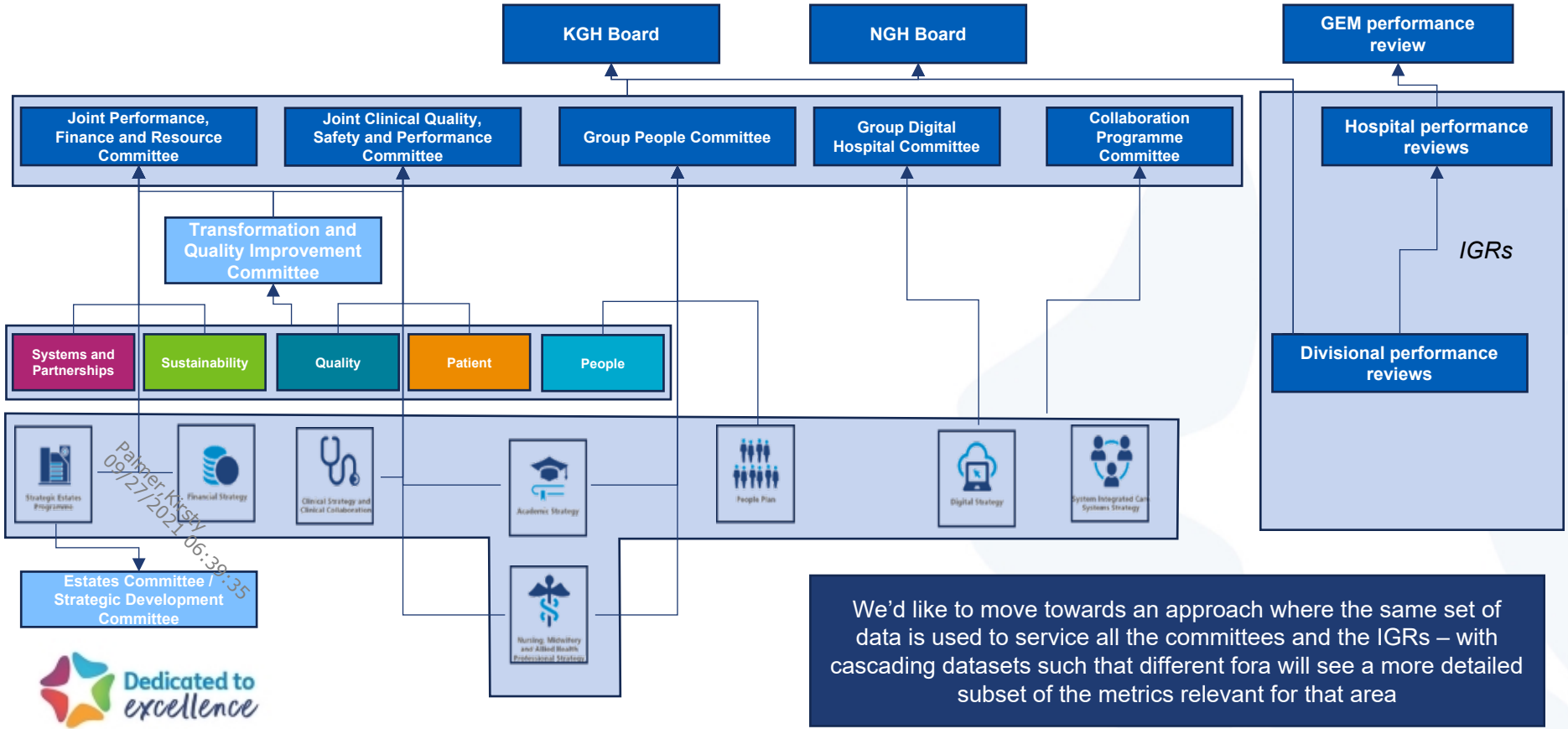
Engagement with Audit Committee chairs on the process to develop IGR metrics

Formal Reporting across the Group



We'd like to move towards an approach where the same set of data is used to service all the committees and the IGRs – with cascading datasets such that different fora will see a more detailed subset of the metrics relevant for that area

Moving Towards a Common Approach

University Hospitals of Northamptonshire NHS Group

- We currently have IGR/IPR reports that are created individually for each Trust.
- Previous analysis showed that there is very little overlap between the IGR and IPR in terms of metrics used:
  - Total NGH Metrics: 78
  - Total KGH Metrics: 50
  - Matches between NGH and KGH Metrics: 25
  - Metrics in NGH but not in KGH: 53
  - Metrics in KGH but not in NGH: 25

- There are differences in the definitions and targets of some IGR metrics, which also need to be aligned
- We now need to agree the set of common metrics that are aligned across both Trusts, arranged by our priority areas.
- Once we have an agreed set of metrics for the IGR, we will review the metrics going to the committees – ensuring that there is a cascading level of detail in those committees, and each committee able to formally escalate any areas of concern
- Those metrics will be used in the same way for each Trust, creating a IGR that will have the same styling and data layout for each
- Timescales for delivery to be agreed – a period of stabilisation is necessary across the Group first

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What measures should be included?

- In developing a draft list, we have:
  - Reviewed the current two IGRs
  - Looked at the IGRs from some neighbouring Trusts
  - Looked at the statutory reporting
  - Asked for feedback from committees

- We have tried to consolidate metrics included in the IGR in order that we have a succinct set of metrics. Further detail on each of the priority areas with more detailed metrics is expected to be included in committee packs, with the IGR providing the high-level overview of Group performance

- The IGR should help us to answer how our hospital Group is performing:
  - Are we providing a good experience for our patients?
  - Are we providing safe and effective care?
  - Are we supporting our staff?
  - Are we treating patients in a timely way?
  - Are we making effective use of our resources?

There are some core measures that appear in all IPRs, with others tailored to those Trusts

University Hospitals of Northamptonshire NHS Group

	UHL	OUH	MKUH
Patient	**Complaints** 4 patient FFTs Staff recommend as a place to care Mixed sex breaches	**Complaints** Patient FFT Safeguarding children Safeguarding adults DoLS Section 42 On-the-day cancellations	**Red complaints received** Complaints response in agreed time On-the-day cancellations Over 75s ward moves overnight Mixed sex breaches
Quality	**Never events** **8 Hospital-acquired infection metrics** **Falls and falls with moderate harm** **SHMI & HSMR** VTE risk assessments Pressure ulcers Emergency re-admission Overdue CAS alerts Emergency c-section NOF 2 Stroke measures	**Never events** **4 Hospital-acquired infection metrics** **Falls and falls with moderate harm** **SHMI & HSMR** Pressure ulcers Safe staffing Thrombosis Dementia screening Sepsis WHO checklists in theatres Excellence reporting (staff nominations) Incidents and serious incidents	**Never events** **4 Hospital-acquired infection metrics** **Falls with harm** **SHMI & HSMR** VTE risk assessments Emergency re-admission Midwife:birth rate Incidents and serious incidents Duty of candour breaches
People	Staff recommend as a place to work Turnover **Sickness / absence** **Appraisals** **Statutory & mandatory training** Nursing vacancies	Turnover **Sickness / absence** **Appraisals** **Statutory & mandatory training** Bank and agency spend RIDDOR reports	**Sickness / absence** **Appraisals** **Statutory & mandatory training** Vacancies Agency spend Completed job plans

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There are some core measures that appear in all IPRs, with others tailored to those Trusts

NHS University Hospitals of Northamptonshire NHS Group

	UHL	OUH	MKUH
Sustainability		Income & expenditure Commissioning income Pay expenditure Non-pay expenditure Cash Capital Forecast	Income Pay & non-pay Non-operating costs I&E Cash Savings delivered Capital expenditure
Systems and Partnerships	**ED 4 hour waits** 12 hour trolley waits Ambulance handover **Incomplete RTT** **52 week waits** **6 week diagnostic times** Cancelled patients not offered < 28 days Super-stranded patients EL / NEL LoS **8 cancer standards** DNA rate Virtual outpatient appointments 7 day turnaround of clinic letters New urgent care standards	**ED 4 hour waits** EL / NEL LoS **Incomplete RTT** **52 week waits** **6 week diagnostic times** Elective care prioritisation (P2 waiting times) **8 cancer standards**	**ED 4 hour waits** **Incomplete RTT** **52 week waits** **6 week diagnostic times** **3 cancer standards** Bed occupancy Ward discharges by midday Weekend discharges Follow-up ratio Stranded patients Super-stranded patients DTOCs Ambulance handovers A&E attendances Elective and non-elective spells Outpatient attendances
Other areas		IT service desk performance CYBER status Information request service Digital delivery HIMSS level FOI compliance Data security and protection breaches Data subject access requests DSPT training compliance	

Grouping our IPR metrics into priorities

Patient	Patient experience	2
	Complaints	1
	Friends and family test	1
People	Organisational development and inclusion	3
	People development	2
	People planning	2
	Health and wellbeing	1
Sustainability	Finance	7
	Resources	4
	Activity	6
Systems and Partnerships	Cancer	4
	Diagnostics	1
	Outpatients	2
	Elective care	4
	Urgent care	1
	Patient flow	4
Quality	Harm-free care	6
	Hospital acquired infections	1
	Mortality	1
	Re-admissions	1
	Staffing and accreditation	2

Total of 57 metrics

Draft IPR indicators

	Indicator
Patient	% of patients who would recommend
	Patient pulse feedback on communication
	Number of complaints
	Patient safeguarding
Quality	Number of new harms
	Number of serious or moderate harms per 1,000 bed days
	Number of serious or moderate harms per 1,000 bed days – falls
	Number of serious or moderate harms per 1,000 bed days - deteriorating patients
	Pressure ulcers
	Number of medication errors
	Hospital-acquired infections
	SHMI
	Safe Staffing
	MDT assessment and accreditation
	Readmissions within 30 days of previous reporting month
	Never event incidence

	Indicator	
Sustainability	Income YTD (£000's)	
	Pay YTD (£000's)	
	Non Pay YTD (£000's)	
	Surplus / Deficit YTD (£000's)	
	CIP Performance YTD (£000's)	
	Bank and Agency Spend (£000's)	
	Capital Spend	
	Beds available	
	Theatre sessions planned	
	Headcount actual (substantive / agency / bank)	
	Headcount planned (substantive / agency / bank)	
	Volumes of activity actual and % of plan delivered	A&E
		Non-elective
		Elective inpatient
		Elective day-case
		Outpatients
		Maternity
People	Quarterly People pulse advocacy questions	
	Quarterly People pulse engagement questions	
	People pulse 'how are you doing'	
	Mandatory training compliance	
	Appraisal completion rates	
	Sickness and absence rate	
	Vacancy rate	
	Turnover rate	

	Indicator
Systems and Partnerships	Two week wait
	31-day wait for first treatment
	62-day wait for first treatment
	Cancer: Faster Diagnostic Standard
	6-week diagnostic test target performance
	Unappointed outpatient follow ups
	Virtual outpatient appointments
	RTT over 52 week waits
	RTT median wait incomplete pathways
	Size of RTT waiting list
	Theatre utilisation
	Composite urgent care bundle - number of measures hit out of 7
	Bed utilisation
	Stranded patients (7+ day length of stay)
	Super-Stranded patients (21+ day length of stay)
	Patients with a reason to reside

This list of draft metrics have been created based on the agreed metrics in the Group Strategy augmented by discussions with the a number of Executives from both Trusts and at CPC in September. Template examples are provided in the Appendix.

Next steps

- Receive further feedback from committees on the key metrics for recommendation of inclusion in the IGR such that they would always go to Boards
- Collate feedback from the committees into a final proposed list of IGR metrics for discussion at October CPC
- Development of shared definitions for IGR metrics and alignment of targets
- Development of the Group IGR, aiming for first use at January 22 Boards

Appendix: Reporting Templates

Patient and Quality measures

		Indicator	Target	KGH		NGH		Group Total	
Patient	Patient feedback	Patients recommending as a place of care	>= 95%		Xx%		Xx%		Xx%
		Positive patient pulse feedback on communication	>= 95%		Xx%		Xx%		Xx%
	Comp laints	Number of complaints	<20		Xx		Xx		Xx
	Exper ience	Mixed sex accommodation breaches	0		Xx		Xx		Xx
Quality	A&A	MDT assessment and accreditation	100% Blue MDTs		Xx%		Xx%		Xx%
	HAI	Hospital acquired infections	tbc		Xx		Xx		Xx
	Mortality	SHMI	100		Xx		Xx		Xx
	Staffing	Safe Staffing Matrix - Nursing and Care Staff	tbc		Xx		Xx		Xx

Quality measures

		Indicator	Target	KGH		NGH		Group Total	
Quality	Readmissions	Readmissions within 30 days of previous reporting month	<= 12%		Xx%		Xx%		Xx%
	Harm-free care	Proportion of patients experiencing a new harm	<= 2%		Xx%		Xx%		Xx%
		Number of falls (All harm levels) per 1000 bed days	<= 5.5		Xx		Xx		Xx
		Number of serious or moderate harms per 1,000 bed days	Tbc		Xx		Xx		Xx
		Number of serious or moderate harms per 1,000 bed days - falls	<= 0.18		Xx		Xx		Xx
		Number of serious or moderate harms per 1,000 bed days - deteriorating patients	Tbc		Xx		Xx		Xx
		Number of medication errors	Tbc		Xx		Xx		Xx
		Never event incidence	0		Xx		Xx		Xx

People measures

		Indicator	Target	KGH		NGH		Group Total	
People	Health & wellbeing	Sickness and absence rate	<= 4%		Xx%		Xx%		Xx%
	Organisational development & inclusion	Quarterly People pulse advocacy questions	Last survey		Xx%		Xx%		Xx%
		Quarterly People pulse staff engagement questions	Last survey		Xx%		Xx%		Xx%
		People pulse 'how are you doing'			Xx%		Xx%		Xx%
	People development	Mandatory training compliance	>= 85%		Xx%		Xx%		Xx%
		Appraisal completion rates	>= 85%		Xx%		Xx%		Xx%
	People planning	All staff vacancy rate	<= 7%		Xx%		Xx%		Xx%
		Turnover rate	<= 10%		Xx%		Xx%		Xx%

Sustainability measures

		Indicator	Target	KGH		NGH		Group Total	
Sustainability	Finance	Income YTD (£000's)	Tbc		Xx		Xx		Xx
		Pay YTD (£000's)	Tbc		Xx		Xx		Xx
		Non Pay YTD (£000's)	Tbc		Xx		Xx		Xx
		Surplus / Deficit YTD (£000's)	Tbc		Xx		Xx		Xx
		CIP Performance YTD (£000's)	Tbc		Xx		Xx		Xx
		Capital Spend	Tbc		Xx		Xx		Xx
		Bank and agency spend	Tbc		Xx		Xx		Xx

Systems and Partnerships measures

University Hospitals of Northamptonshire NHS Group

		Indicator	Target	KGH		NGH		Group Total	
Systems and partnerships	Cancer	Two week wait	>= 93%		Xx%		Xx%		Xx%
		31-day wait for first treatment	>= 96%		Xx%		Xx%		Xx%
		62-day wait for first treatment	>= 90%		Xx%		Xx%		Xx%
		Cancer: Faster Diagnostic Standard	>= 75%		Xx%		Xx%		Xx%
	Diag	6-week diagnostic test target performance	>= 99%		Xx%		Xx%		Xx%
	Elective care	Unappointed outpatient follow ups	Tbc		Xx%		Xx%		Xx%
		RTT over 52 week waits	0		Xx		Xx		Xx
		RTT median wait incomplete pathways (weeks)	<= 10.9		Xx		Xx		Xx
	Patient flow	Stranded patients (7+ day length of stay)	Tbc		*Xx*		Xx		Xx
		Super-Stranded patients (7+ day length of stay)	Tbc		*Xx*		Xx		Xx
		Patients with a reason to reside	>= 95%		Xx%		Xx%		Xx%
		Composite urgent care bundle - number of measures hit							

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Exception reporting format

University Hospitals of Northamptonshire NHS Group

SPC

Variance type

KGH	NGH

Target

Target achievement

KGH	NGH

Background	What the chart tells us	Issues	Actions	Mitigations

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Cover sheet

Meeting	NGH Public Trust Board
Date	30th September 2021
Agenda item	2.2

Title	Theatres utilisation
Presenter	Jo Fawcus, COO Andy Callow, Group CDIO
Author	Jo Fawcus, COO Andy Callow, Group CDIO

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

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Reason for consideration	Previous consideration
Theatres utilisation is an increasing focus for the Group, and nationally, due to the elective recovery programme.	

Executive Summary

In support of elective recovery, ensuring that our operating theatres are productive to operate on as many patients as possible is critical.

This paper outlines:

- The different theatres utilisation measures used to understand theatres

performance, and the different drivers of each of those metrics - The latest data for theatres utilisation for both KGH and NGH - The programme of work which has been established to improve theatre efficiencies across the Group
Appendices
None
Risk and assurance
This report provides assurance to the Board on theatres performance and the improvement plan in place to improve performance
Financial Impact
None
Legal implications/regulatory requirements
None
Equality Impact Assessment
Impact assessments have been conducted as per Trust policy

This report may be subject to disclosure under the Freedom of Information Act 2000, subject to the specified exemptions.

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

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KGH and NGH Theatre Utilisation Update

KGH and NGH Boards September 2021

Presented By: Andy Callow, Group CDIO

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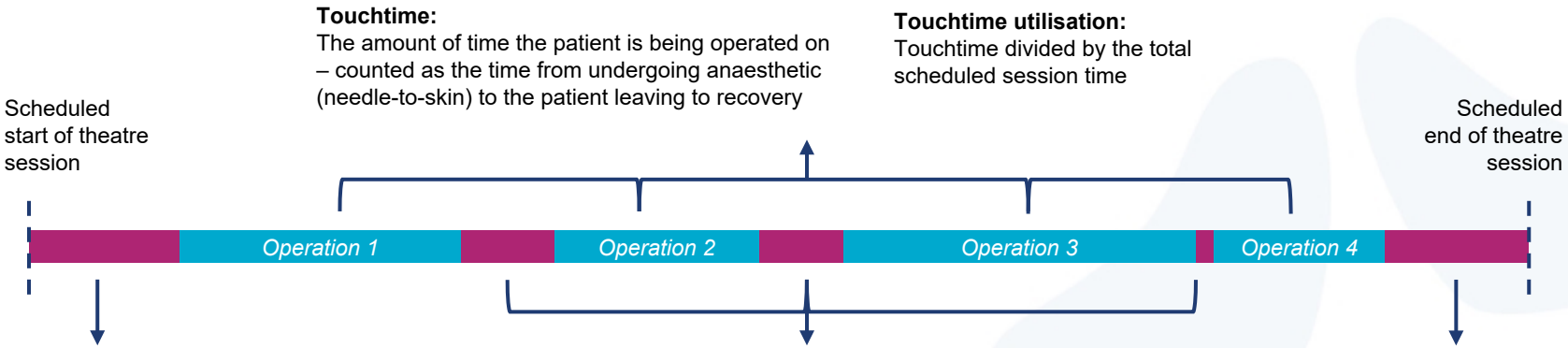
Theatre utilisation

- In support of elective recovery, ensuring that our operating theatres are productive to operate on as many patients as possible is critical
- NHSE/I have begun fortnightly data collections of theatre data in Model Hospital to monitor the utilisation of operating theatres. There are several data measures included within this data collection:
  - Touchtime utilisation
  - Late starts
  - Early finish
  - Intercase downtime
- In both KGH and NGH:
  - Theatre performance dashboards have been developed to improve visibility and quality of data
  - Programmes to improve performance have been re-vitalised

Visualising the different theatre measures by looking at a theatre session with several operations



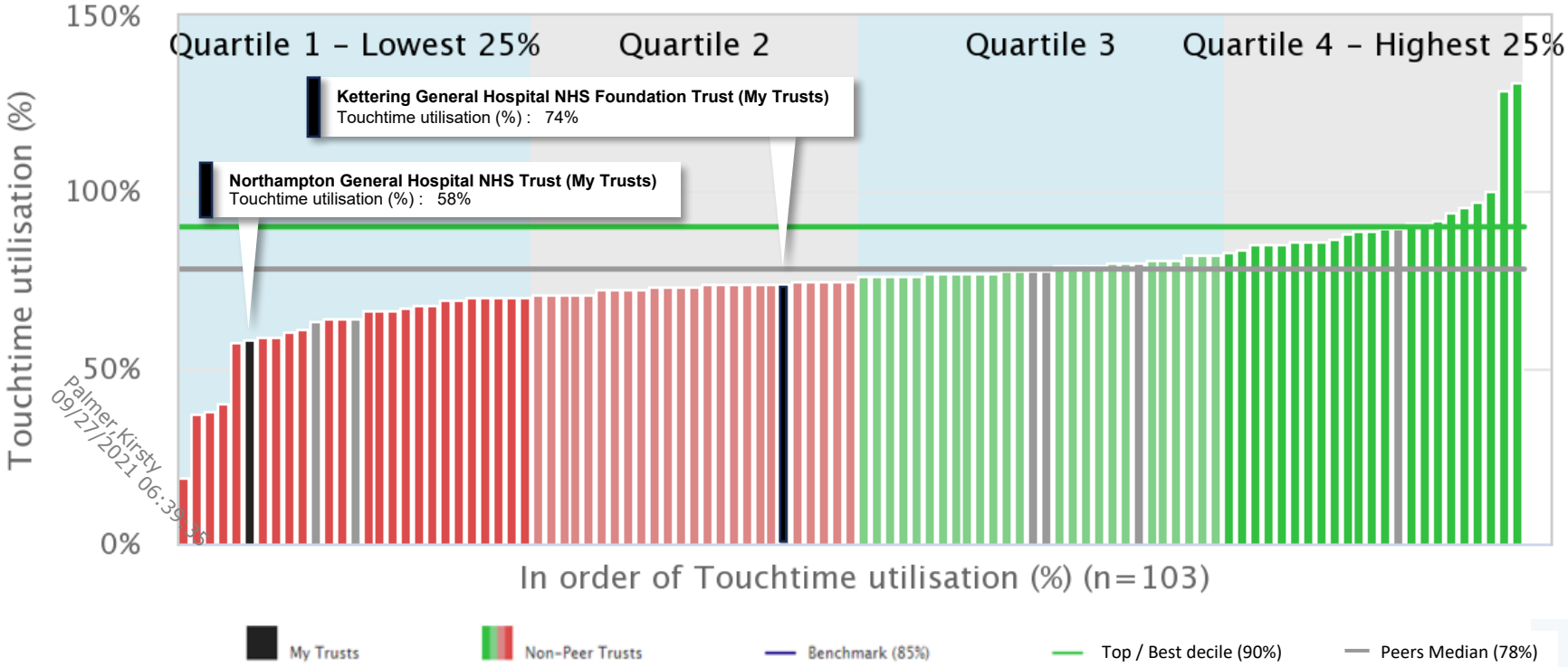
Drivers of the different theatre measures

Measure	Description	Potential drivers
Late starts	Average minutes that operating starts after the scheduled session start time	• Standardisation of start times of theatres • Alignment of rotas and job plans to start times • Streamlining pre-op rounds
Intercase downtime	Average minutes in between operations	• Theatre equipment and layout standardisation • Improving timing of calling next patient
Early finishes	Average minutes that operating finishes before the scheduled session end time	• Improving theatre scheduling and booking • On-the-day cancellations and DNAs

All impact on

Touchtime utilisation *Target 85%*	The amount of time the patient is being operated on – counted as the time from undergoing anaesthetic (needle-to-skin) to the patient leaving to recovery, divided by the total session length

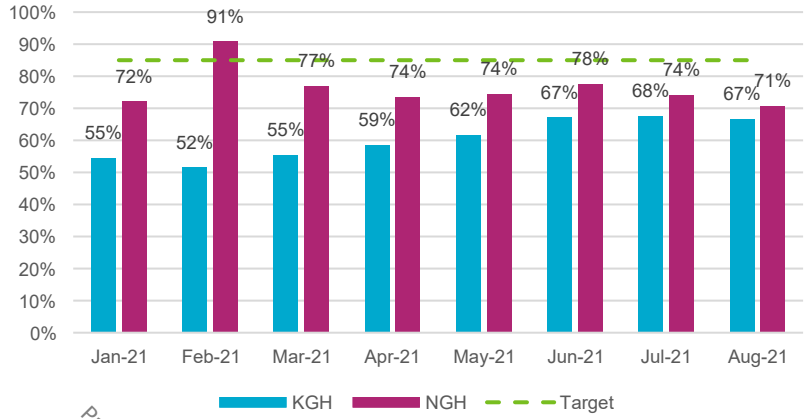
The latest Model Hospital data shows KGH and NGH below peer median at 58% and 74% touchtime utilisation



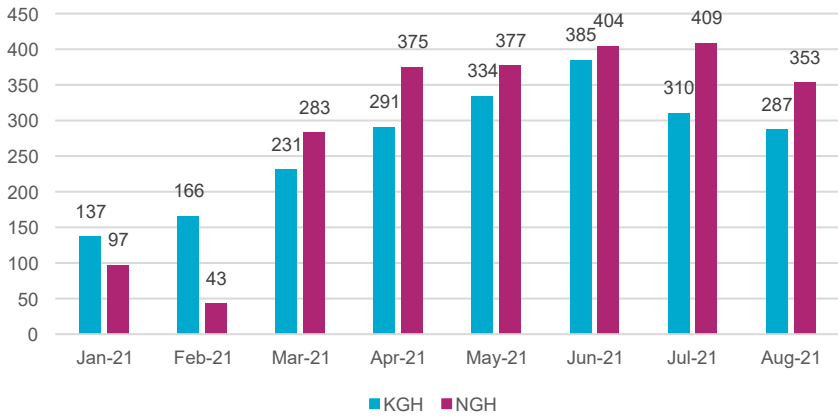
Theatre utilisation and throughput has improved across the Group in the last six months

University Hospitals of Northamptonshire NHS Group

Theatre utilisation



Number of theatre sessions



Narrative

- Over the past six months, in-session theatre utilisation has been increasing across the Group, driven by improvements in KGH. Session Utilisation at both Trusts is below the 85% target. This is due to late starts, early finishes and intercase downtime. Cancellations on the day also negatively affect utilisation. Data is being collated on all of these to target interventions to improve utilisation.
- During Spring, the number of theatre sessions has increased as Covid pressure on the elective pathway have eased. In July and August, the number of theatre sessions in KGH decreased due to challenges with staffing.

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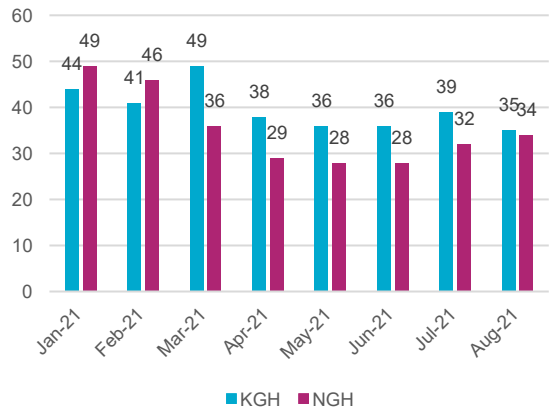
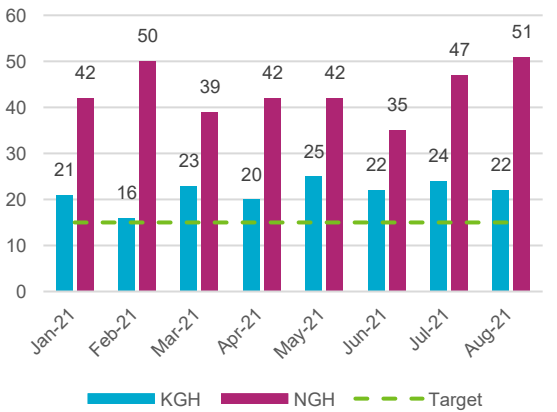
Both Trusts have reduced late starts, with further work to improve intercase downtime

University Hospitals of Northamptonshire NHS Group

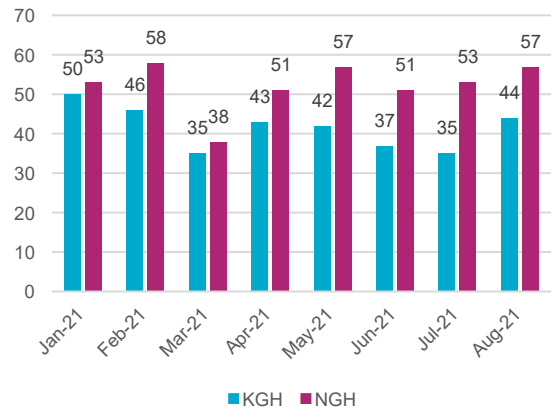
Late starts



Intercase downtime



Early finishes



Narrative

- Both KGH and NGH have reduced the average late start time for theatre sessions.
- Intercase downtime is lower in KGH than NGH, with both Trusts above the 15 minute GIRFT target. Observations in theatres are underway to identify opportunities for improvement, and to identify differences between KGH and NGH in order to share learning.
- After initial improvement going into spring as the elective pathway restarted, early finishes have remained above the national median at both Trusts. The reasons for these early finishes are being investigated along with the booking processes to ensure lists are booked efficiently. Work is underway to ensure accurate information is available to booking teams so that lists can be filled efficiently. Reasons for early finishes will be reviewed to identify interventions.

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Improvement programmes for theatres utilisation in both Trusts have been established

	KGH	NGH
Improving visibility and quality of performance data	◗ Theatres performance dashboards in both Trusts show key measures to allow performance monitoring, allowing the ability to drill-down into particular specialties and theatre suites ◗ Regular monitoring of the theatres dashboard through operational meetings	
	◗ The work done on the Theatre dashboards will be carried forward into a Group Theatre Productivity dashboard as part of the Health Intelligence "Firebreak" work due to complete in December	
Reducing late starts and intercase downtime through list efficiencies	◗ Data gathering on reasons for cancellations and delays in theatre taking place	
	◗ Gap analysis of GIRFT Theatre Principles underway in both Trusts	
		◗ Electronic TCI request trial started with Urology
Reducing early finishes through improving booking and scheduling	◗ Review of planning data and 6-4-2 booking process in order to ensure lists are fully booked is taking place	
Improving pre-op assessments	◗ Assessment of pre-op tooling and alignment with NGH	◗ MyPreop usage increasing following communication campaign
Reducing cancellations and DNAs	◗ Review of cancellations, particularly taking place on the day to identify reasons for delays	
Increasing staffing and improving culture and wellbeing	◗ Produce a dedicated theatres recruitment strategy ◗ Develop a supportive well-being culture	

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Health Inequalities Analysis

Electives

23 September 2021

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Background

- The theatre sessions from 1 April to 31 August 2021 have been analysed for health inequalities.
- In this period:
  - There were 1607 session KGH, treating 3852 patients
  - There were 1918 sessions at NGH, treating 5229 patients
- This data has been cross-referenced against protected characteristics where available and demographic data

Northamptonshire Indices of Deprivation

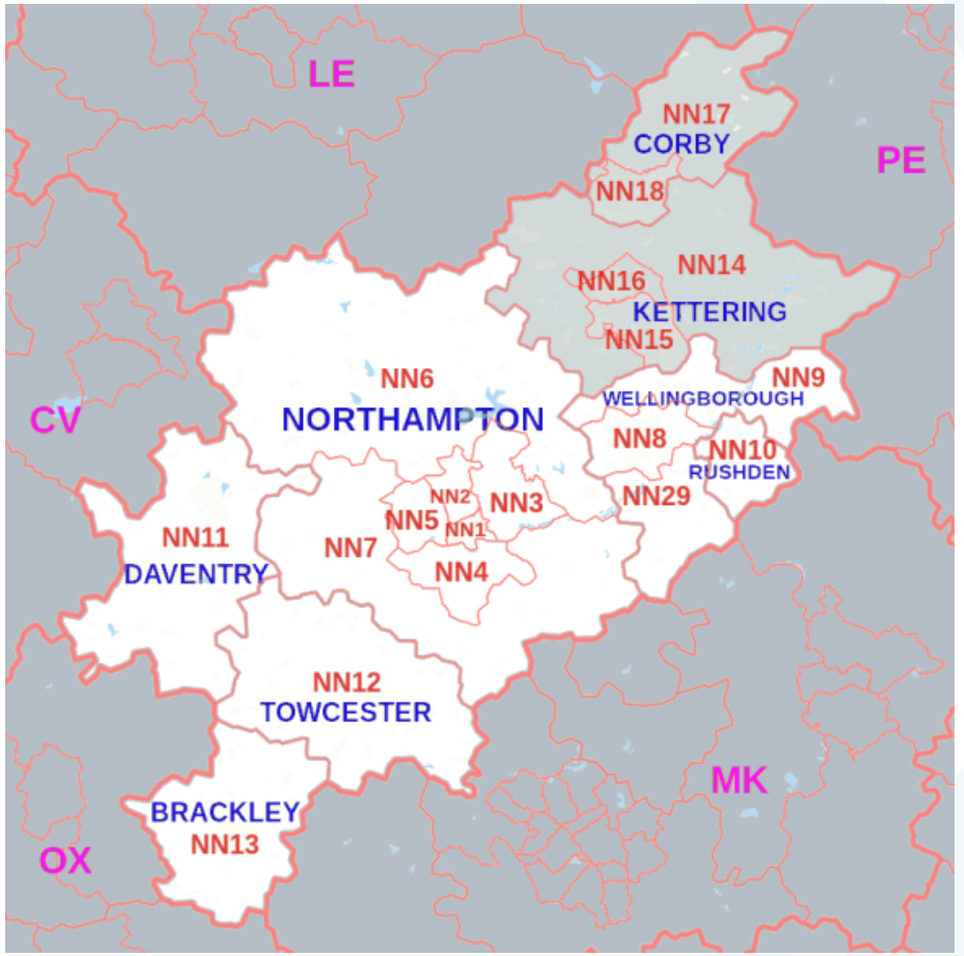
Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

The first part of the postcode has been grouped together and the mode index of multiple deprivation calculated.
: 1 is the most deprived in the country. The range of values for England are 1 – 32844.

NN2 and NN3 are the most deprived areas in Northamptonshire. The largest areas are 22% from NN3 for NGH and 14% of patients from NN8 for KGH.

Northamptonshire Postcode	Index of Multiple Deprivation (Mode)
NN2	185
NN3	185
NN99	1372
NN14	2269
NN16	2269
NN1	2420
NN4	2420
NN5	2420
NN6	2420
NN7	2420
NN17	5762
NN18	5762
NN10	9094
NN8	12909
NN9	12909
NN11	21461
NN15	23913
NN29	25263
NN13	28413
NN12	28968



Ward Population against Postcode

NN2	**37038**
Abington and Phippsville	381
Kingsthorpe North	12067
Kingsthorpe South	11964
Moulton	998
Riverside Park	
St. George	11628
NN3	**68971**
Abington and Phippsville	394
Billing and Rectory Farm	14566
Boothville and Parklands	10782
Delapre and Rushmere	58
Earls Barton	
Headlands	13161
Moulton	3435
Riverside Park	12325
St. George	
Talavera	14250

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Source of Deprivation index against postcodes:
https://www.doogal.co.uk/PostcodeCsvFields.php

Elective Activity by Postcode (Deprivation Index)

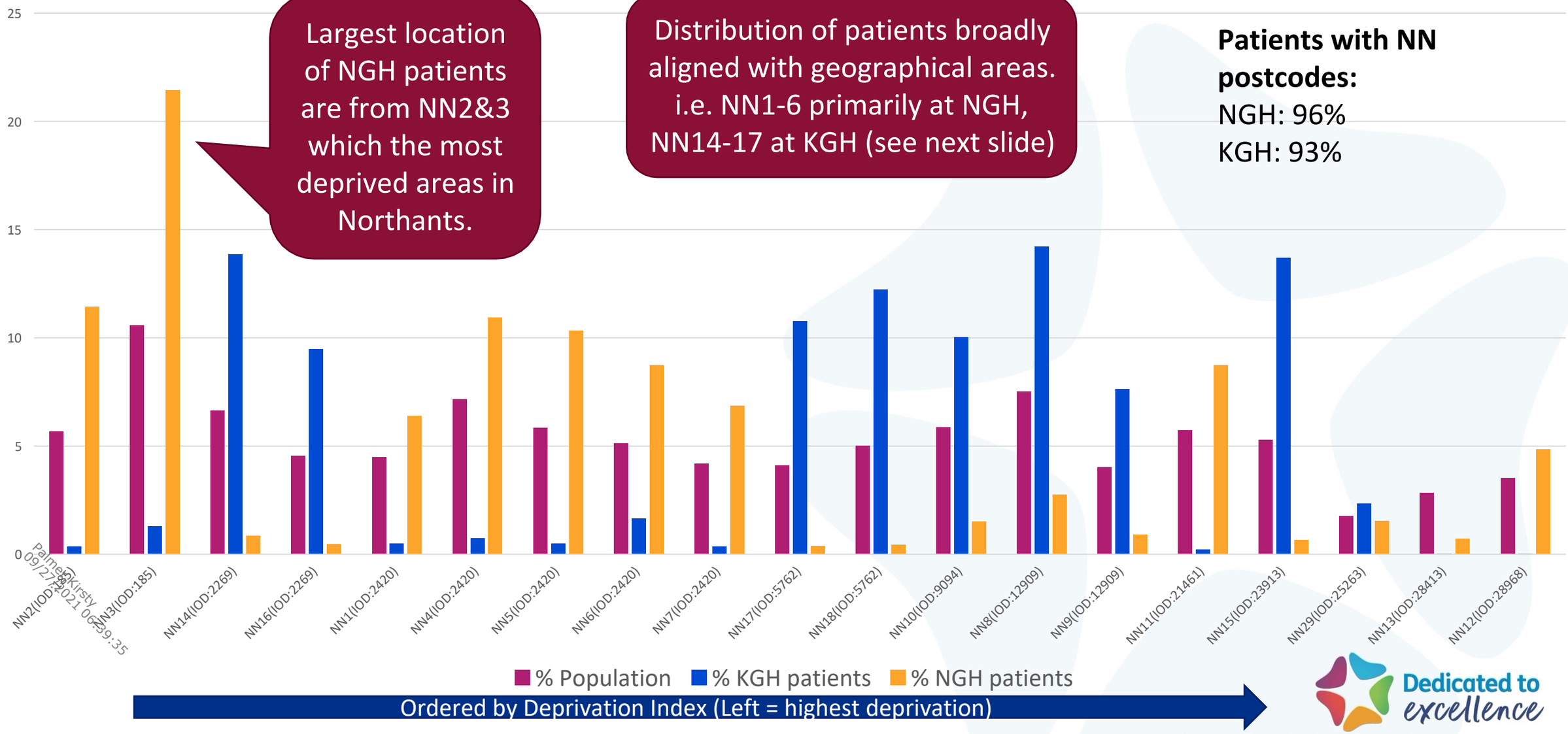
Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

Largest location of NGH patients are from NN2&3 which the most deprived areas in Northants.

Distribution of patients broadly aligned with geographical areas. i.e. NN1-6 primarily at NGH, NN14-17 at KGH (see next slide)

Patients with NN postcodes:
NGH: 96%
KGH: 93%



Ordered by Deprivation Index (Left = highest deprivation)

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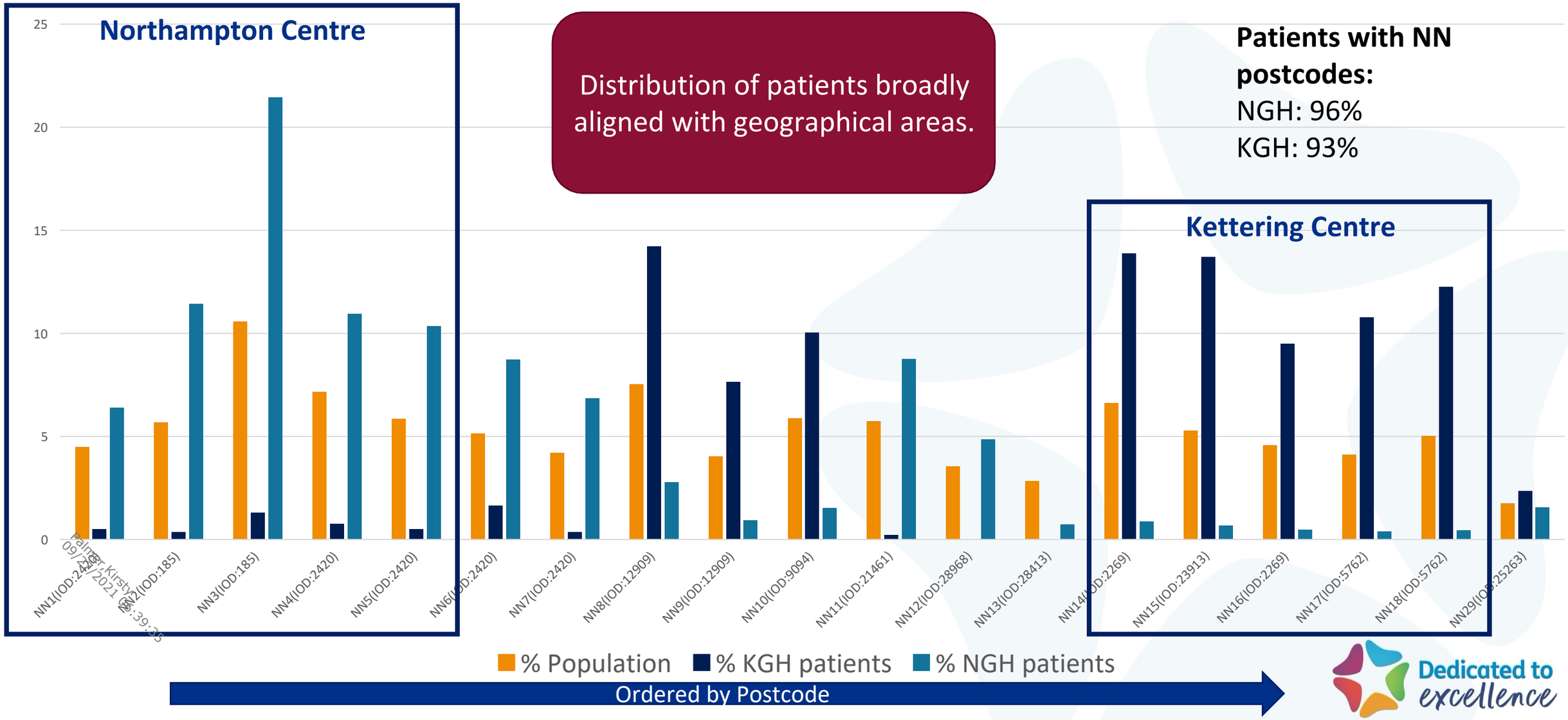
Source of Deprivation index against postcodes:
https://www.doogal.co.uk/PostcodeCsvFields.php

Elective Activity by Postcode (Deprivation Index)

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust



Distribution of patients broadly aligned with geographical areas.

Patients with NN postcodes:
NGH: 96%
KGH: 93%

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Source of Deprivation index against postcodes:
https://www.doogal.co.uk/PostcodeCsvFields.php

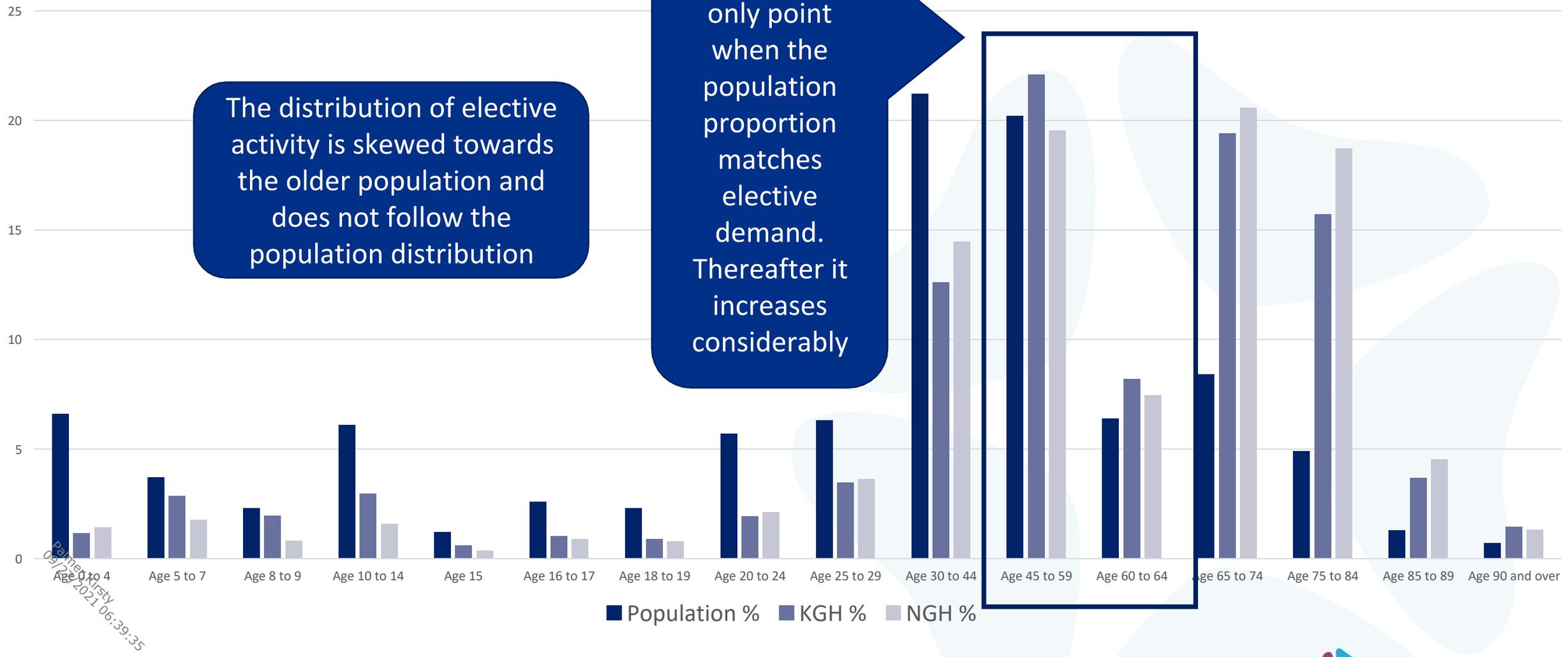
Elective Activity by Age

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

The distribution of elective activity is skewed towards the older population and does not follow the population distribution

Between ages 45-64 is the only point when the population proportion matches elective demand. Thereafter it increases considerably



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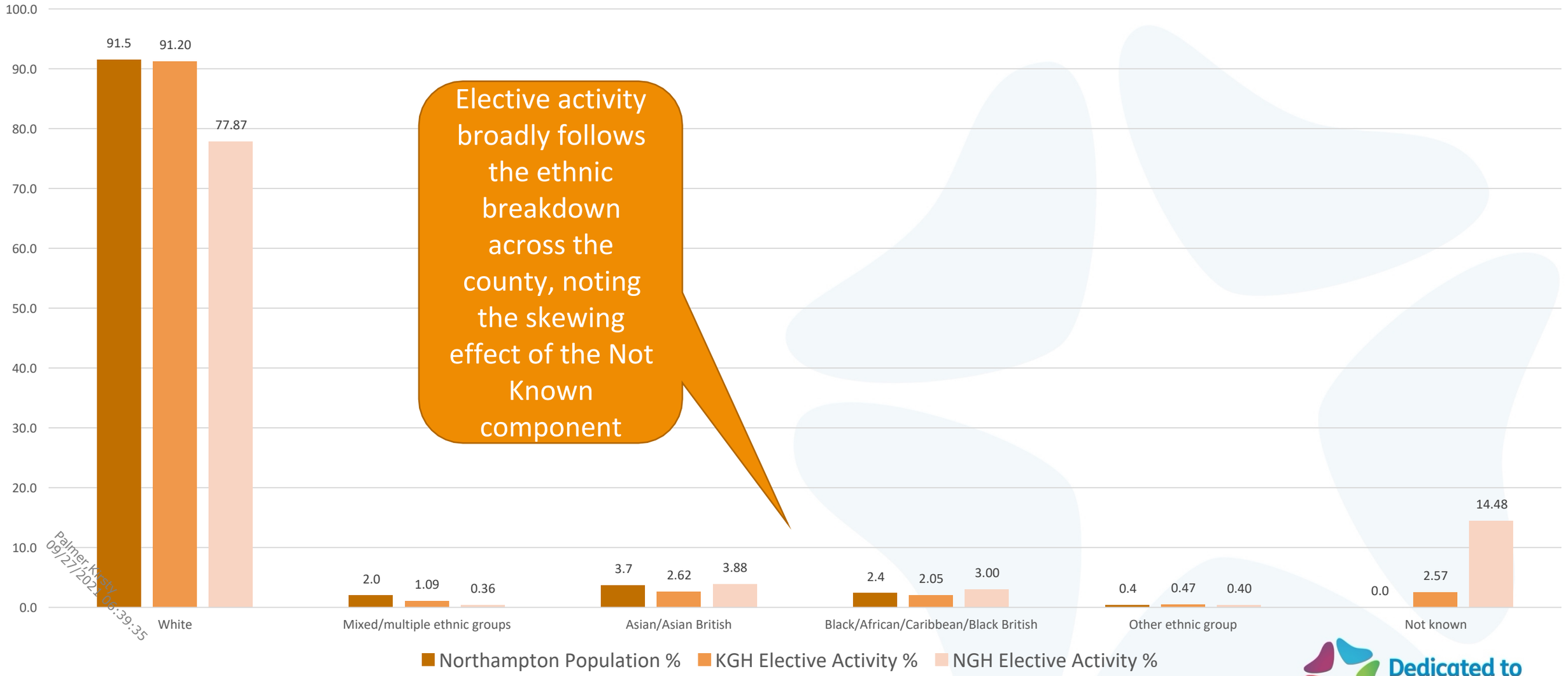
Source of population distribution: Census 2011 (ONS)

Elective Activity by Ethnicity

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust



Elective activity broadly follows the ethnic breakdown across the county, noting the skewing effect of the Not Known component

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Source of ethnicity distribution: Census 2011 (ONS)

Elective Activity by Ethnicity

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

Ethnic Group	Northampton Population %	KGH Elective Activity %	NGH Elective Activity %
White	91.5	91.20	77.87
Mixed/multiple ethnic groups	2.0	1.09	0.36
Asian/Asian British	3.7	2.62	3.88
Black/African/Caribbean/Black British	2.4	2.05	3.00
Other ethnic group	0.4	0.47	0.40
Not known	0.0	2.57	14.48

Not known consists of "patient not asked" and "patient refused". This large number skews the NGH figures

Source of ethnicity distribution: Census 2011 (ONS)

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Conclusions/Next Steps

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

- System Action
  - System Elective Care Board to review, set the strategic intent and drive the system response
- Group Action
  - Group Quality and Finance Committees in Common to deep-dive and steer the groups focus on health inequalities as standing items, reporting up to Boards
- Hospital Action
  - Elective Access forums to review waiting data and focus on improvements in data completeness and equity of access to services e.g. extend this analysis to review waiting times and DNAs against protected characteristics
  - For NGH to review the process of recording of ethnicity

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NHS Northampton General Hospital NHS Trust

Cover sheet

Meeting	Public Board
Date	30th September 2021
Agenda item	2.3

Title	Winter Modelling
Presenter	Jo Fawcus, Chief Operating Officer, NGH Andy Callow, Group Chief Digital Information Officer
Author	Jo Fawcus, Chief Operating Officer, NGH Fay Gordon, Chief Operating Officer, KGH Andy Callow, Group Chief Digital Information Officer

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

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

Reason for consideration	Previous consideration
This paper outlines how the demand & capacity model and associated bed predictions for KGH & NGH over winter have been calculated.	N/A

Executive Summary
The Trust has undertaken a comprehensive capacity and demand exercise in order to forecast Trust activity for winter as accurately as possible. Historic activity levels have been studied and reviewed alongside current organisational intelligence which has allowed us to predict the likely future activity.

In order to respond to the predicted demand, the Trust has developed a number of winter schemes which will mitigate some of the deficit in capacity. Externally we are working with partners to develop a system winter plan and once agreed these assumptions will be incorporated into the model. The success of the KGH and system winter schemes are all essential for the delivery of the plan.

Whilst funding is in place for some winter schemes, others will require additional funding if the full impact of the schemes are to be realised. The next step is for a system discussion to take place to ensure there is a collective view and agreement on how funding is allocated.

The model has been jointly developed with NGH to ensure a consistent approach across the group.

There are a number of risks associated with the winter plan particularly the potential impact on elective activity should the demand exceed the capacity, although Cancer and urgent cases will continue to be a high priority for the trust. In addition, we continue to work closely with our Independent Sector partners to ensure elective activity continues.

Appendices

Winter Modelling report

Risk and assurance

It is acknowledged that all models are flawed, and a pragmatic approach has been taken to balance perfection in modelling with sufficient information to make decisions.

Financial Impact

Funding of the winter schemes and impact of not supporting these schemes. Impact of opening escalation beds to support operational pressures.

Legal implications/regulatory requirements

None identified

Equality Impact Assessment

No direct implications

This report may be subject to disclosure under the Freedom of Information Act 2000, subject to the specified exemptions.

Paper

Situation

KGH & NGH have undertaken a comprehensive capacity and demand exercise to forecast activity for Winter as accurately as possible. Historic activity levels have been studied and reviewed alongside current organisational intelligence which has enabled us to predict the likely future activity and the associated bed modelling.

Background

Several assumptions associated with demand have been modelled and split into best, worst and likely scenarios.

The following assumptions have been applied:

- Target bed occupancy of 90%
- LOS profile is actual for April 21 – July 21 and is based on data for August and then estimated for September 2021 to March 2022
- Bed figures are initially presented as gross – i.e., before any winter scheme mitigations are applied

Whilst the methodology is the same for both KGH & NGH the parameters do vary between sites, this is due to clinical variation and case mix differences.

Assessment

We have looked at the scenarios based on a percentage increase in activity and adjusted the model to calculate the best, worst and likely scenarios. The modelling shows the below likely scenario for the two Trusts:

	KGH	NGH
Likely	-38	-47

Each organisation has several winter schemes which have been overlaid to mitigate some of the capacity gap (not included in the above). Once the green schemes have been incorporated into the "likely model", KGH has a deficit of 7 beds and NGH has a gap of 41. To bridge the remaining gap, we will be seeking support from our system partners. A system Winter plan is in development and once completed these assumptions will be incorporated into our plans.

Recommendation(s)

Due to the predicted demand and gap in capacity the Board are asked to acknowledge the outputs from the models and associated risks. In the case of KGH it is clear that the use of the Thomas Moore ward and other capacity will be required through winter 21/22 to safely manage the demand. For NGH the Board is asked to support the winter schemes that are critical to the operational management through winter The Board are asked to note the plan and support through Executive and Non-Executive communications with system partners, the need for effective system-wide working to maintain safe patient flow.

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Group Winter Modelling

Public Board – September 2021

All models are wrong,
but some are useful.

George Box, British statistician (1919 – 2013)

Adult Bed Model Parameters

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

Parameter	Notes
% ED (Emergency Department) of attendances relative to 2019 calendar year	2020 can't be used for modelling purposes due to pandemic impact. Profile of 2019 comparable to 2021 year to date, but showing generally higher relative attendances
% Admissions not via ED	These are admissions from outpatients, direct referrals and other routes
% ED conversion rate	The percentage of attendances that require admission
% of ED Admissions which are 1+ day LOS	Of those cases admitted, how many require a LOS (Length of Stay) of 1 day or more
% Medicine Admissions	Of those admitted with a LOS of 1+ days, how are they distributed over the three divisions. Historical data shows us that this is broadly static over the year, so these have been fixed in the model for NGH and KGH.
% Surgery Admissions	
% Family Health/WCOH Admissions	
Medicine Admissions LOS Profiles- Best/Likely /Worst	Medicine LOS varies considerably over the course of the year, whereas other Divisions are reasonably static
Surgery Admissions LOS	
Family/ WCOH Admissions LOS	

For each of these parameters, the best, likely and worst case has been estimated, based on historical data and current situational intelligence

Note: We have modelled the Adult bed demand using this model. Paediatric demand has also been modelled, but can be done using a simpler approach.

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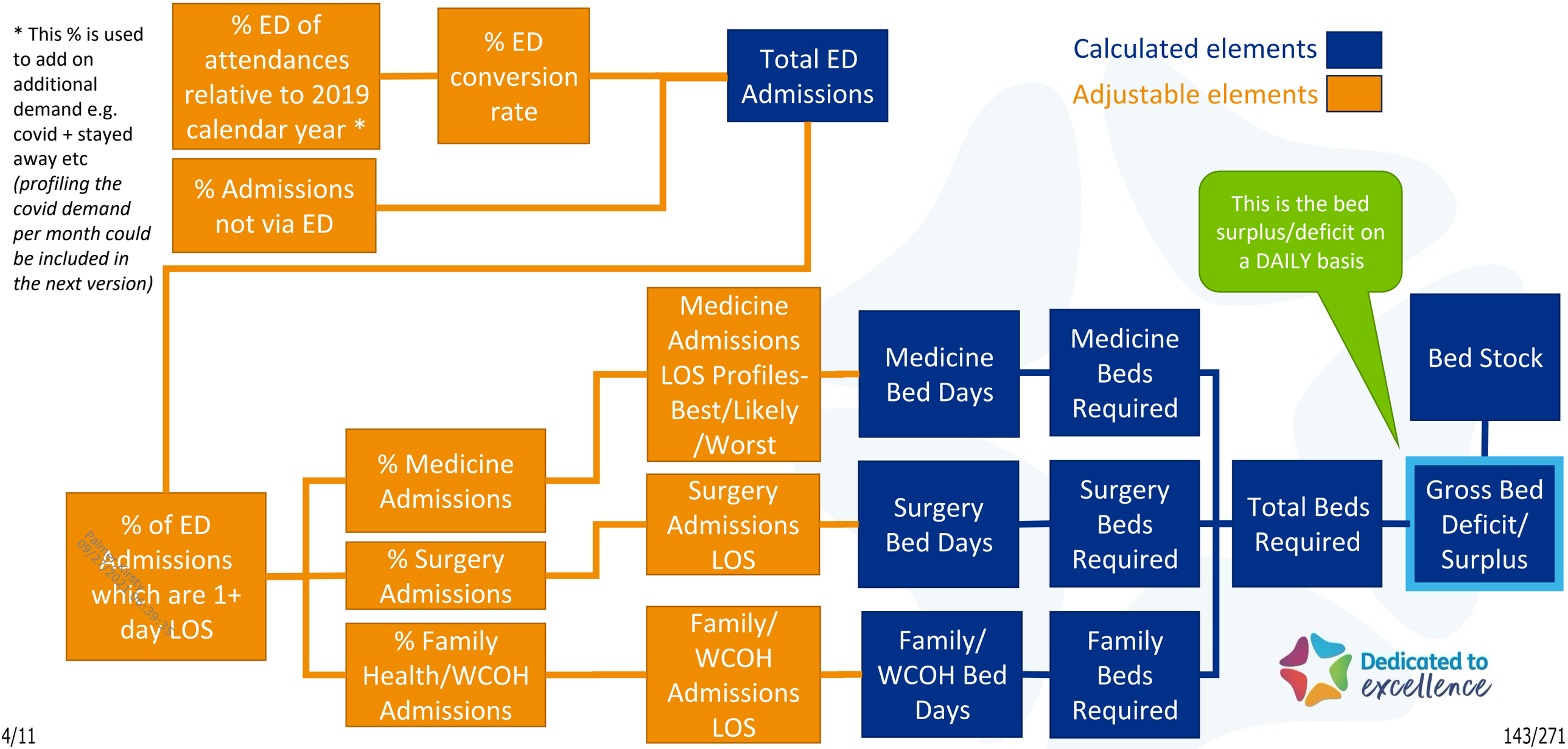
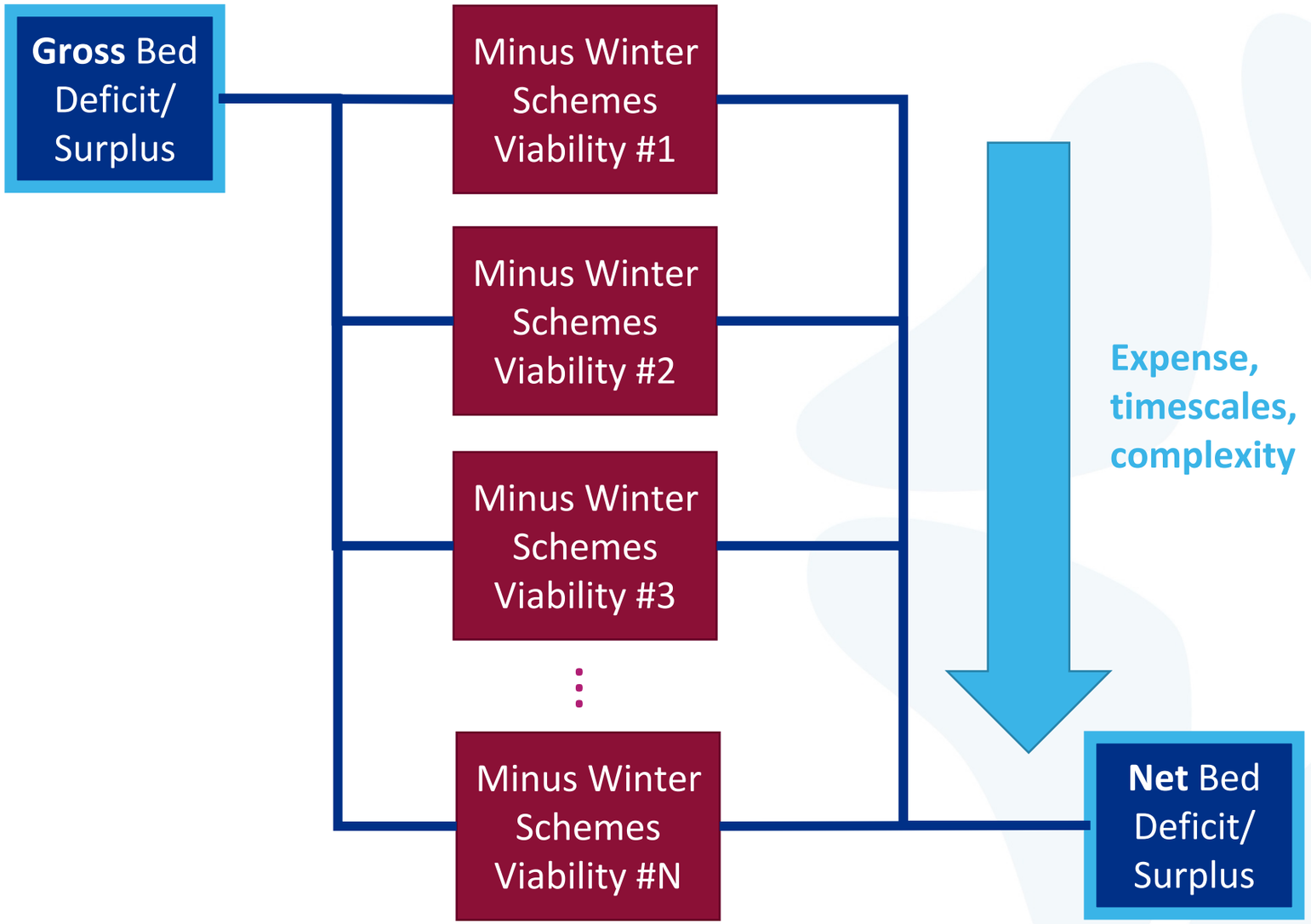
Scope of the Model

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust



Output of the Model



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Global Modelling Assumptions

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

For all of the scenarios, the following are applied:

- Target occupancy is 90%
- LOS profile is actual for April – July and based on partial data for Aug, estimated for Sept 2021 to March 2022
- Bed figures are initially presented as gross – i.e. before any winter scheme mitigations are applied

- For KGH
  - The improvements in pneumonia LOS is incorporated in the overall LOS figure i.e. the 21% reduction seen in pneumonia LOS Sept 20 – Jan 21 will continue.
  - The split in emergency admissions between medicine/surgery/family health are 64.5%/21.5%/14%
- For NGH
  - Home monitoring for covid and respiratory patients (using Doccla) is continued as BAU.
  - The split in emergency admissions between medicine/surgery/WCOH are 59.1%/23.5%/17.4%

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Model Results - Adults

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

Applying the best, likely and worst case parameters into the model gives us a range of gross results for adult beds. There are a number of schemes that can be applied to try and mitigate the bed demand. Each scheme has been rated Red, Amber of Green in terms of viability.

KGH

When the model parameters are applied for the likely case, the gross bed prediction is that:

- January 2022 will be the worst month for KGH, with a bed deficit of **-38** beds

For KGH, the Green Schemes are as follows:

Poplar Ward	Adult Beds	G
111 - ED Streaming and Navigation	Quality	G
Therapies - extended support to frailty and UC - scheme 1	Adult Beds	G
Virtual Ward – Respiratory **(-20 bed impact if not funded)**	Beds	G
Simple Discharge - enhanced capacity	Adult beds	G
Phlebotomy - start 1hr earlier	Adult beds	G

Applying these will provide 32 beds, leading to a **net bed deficit of -6** in January 22

NGH

When the model parameters are applied for the likely case, the gross bed prediction is that:

- March 2022 will be the worst month for NGH, with a bed deficit of **-47** beds

For NGH, the Green and Amber Schemes are as follows:

Nye Bevan	Adult Beds	A
Nye Bevan	Adult Beds	A
SDEC	Adult Beds	A
LOS Reduction Scheme	Adult Beds	G
LOS Reduction Scheme #2	Adult Beds	G

Applying these will provide 17 beds, leading to a **net bed deficit of -30** in March 22

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Model Results - Paeds

Most likely scenario based on PHE recommended model:

- Increased RSV impact could hit as early as August 2021, peak in November, and last throughout the winter period
- Model assumes a 20% / 50% increase on 2019 RSV peak activity.

KGH

In the 50% scenario, there is a requirement for 40 inpatients. Based on the current bed base and the below plan this leaves a **net deficit of 6 beds**.

Plan:

- Increase Skylark bed base by utilising Paediatric assessment unit (PAU) (6 beds).
- Ceasing of elective activity (6 beds)
- Remaining PAU beds to be utilised (2 beds)

NGH

Based on a 50% increase a total of **38 beds** is required to support the predicted demand. Based on the current bed base and the below we can open 43 beds

Plan:

- Move PAU to NGH Paediatric hub
- Paediatric oncology to continue, routine electives cease
- SOPs in place for stabilisation & management of patients who require level 3 transfer

Palmer Kirsty 09/27/2021 06:39:35

Given the potential demand, we are confident that we can meet the predicted demand by working as a Group.

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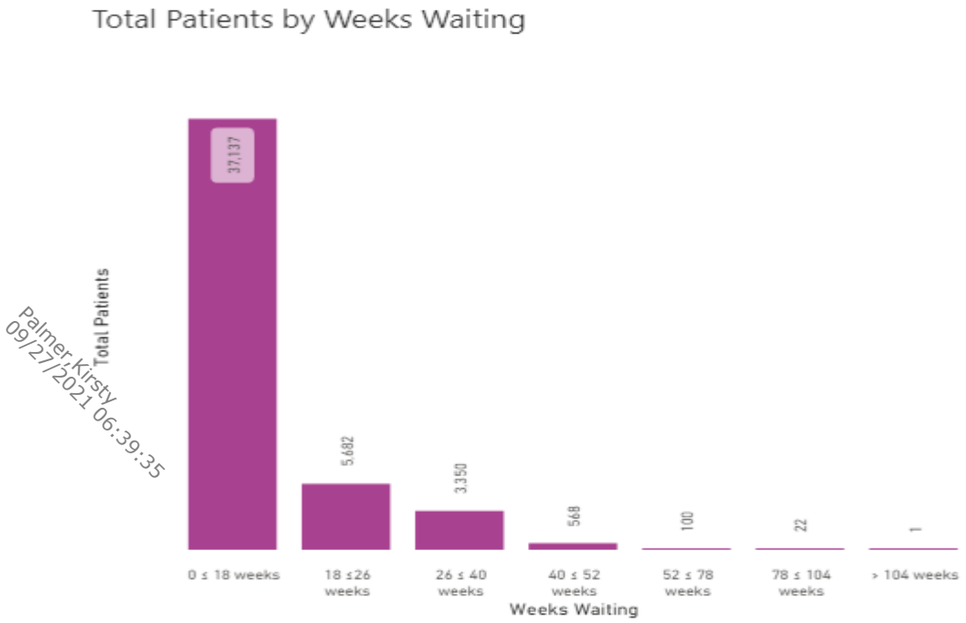
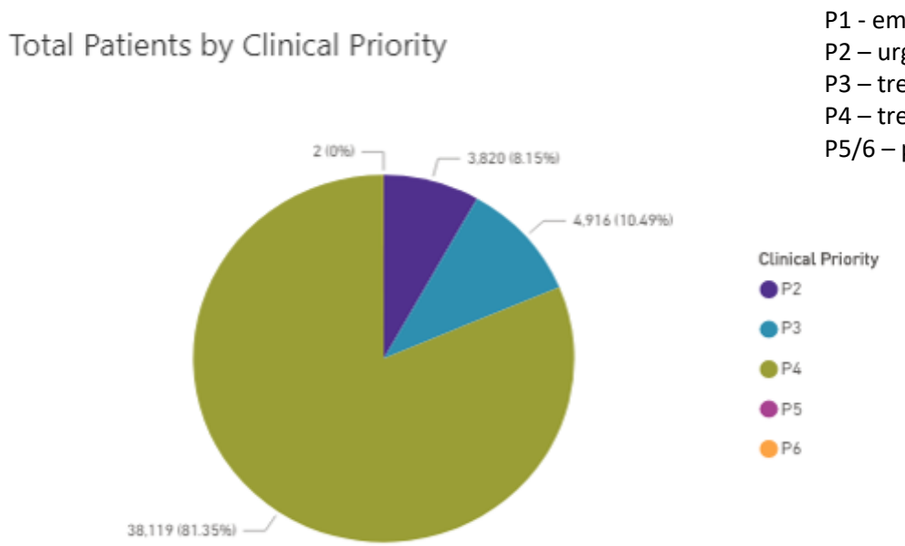
Elective Position

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

- Both Trusts are continuing to treat all urgent and cancer patients on their waiting lists and are committed to continuing this throughout winter 2021/22.
- The local Independent sector also continues to support delivering NHS treatments and they have committed to giving the same levels of capacity throughout the rest of this year to Northamptonshire NHS patients. Some of this is via direct GP referrals, but the Trusts continue to work closely with the independent sector to ensure that all patients that are likely to be waiting extended periods for their procedure, get clinically reviewed for a possible earlier treatment date in the independent sector. It should be noted that a transfer is not always possible due to the clinical limitations of having treatment in a facility with no ITU.
- Regionally KGH and NGH are in the best quartile for the length of time patients are waiting for treatment. By October no patient will be waiting more that 52 weeks for treatment at either Trust. The longest waiting times remain for endoscopy, ophthalmology and orthopaedics. Some Northamptonshire patients however are waiting significantly longer time periods for specialist treatments not provided within the county.
- If capacity at the two NHS Trusts becomes significantly compromised and/or there is a need to transfer staff delivering elective care to critical care facilities to support winter, then decisions to undertake operations in the Independent Sector will be made by a senior clinician on a patient by patient basis, balancing the risk of undertaking the procedure at a remote setting, with the risk of delaying the procedure.
- Work is currently taking place to explore options of co-locating elective inpatient procedures at one site or another for winter, to better protect elective beds and to co-locate staffing resource.





P1 - emergency
P2 – urgent under 1month
P3 – treatment required under 3 months
P4 – treatment can wait over 3 months
P5/6 – patient wishes to postpone

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Critical Care

- NGH & KGH both have clear escalation plans in place for expanding Critical care capacity should it be required
- Expansion is agreed using a phased approach in conjunction with the clinical network for Critical care. There is a daily Critical Care Network meeting in place to discuss capacity & transfers across the networks Before additional beds are commissioned the Trusts will seek support from the Network to safely transfer patient
- If external transfers are not possible additional capacity at each site will be facilitated using the agreed SOP

Risks, Issues & Mitigations

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

Description	Mitigation	Likelihood	Impact
Pathway capacity: Gaps in care hours due to ASC inability to be able to recruit staff to support patients being discharged on pathway one which is leading to protracted LOS and delays for patients' discharge.	System partners are in the process of developing a winter plan which includes a recruitment strategy KGH is exploring the option to increase KGH @ home capacity to support patients on pathways 1 & 3	H	H
IPC: Impact of Covid, Flu and other winter virus given the relaxing of social distancing and mask wearing.	Patients will continue to be screened for Flu and Covid at the front door and streamed into the appropriate bed.	H	H
Risk of Covid outbreaks in the hospitals, reducing bed availability and thereby compromising flow	Training and communication in relation to the adherence of strict IPC compliance remains in hospital, we will continue to test all patients for flu and covid at the point of entry. All good practice guidance will continue in relation to screening inpatients.	M	H
Staffing: Continued issues due to the ping-demic / staff moral/ resilience & sickness	All support mechanism for staff continue to be in place with other options being explored. EG) Listening events, "We Care café", Psychologist support.	M	H
Increase in Covid inpatients: These are not included in the modeling assumptions. This may impact bed capacity; flow and the ability sustain elective operating.	A number of admission avoidance schemes are being developed to support flow. Conversation have also commenced with the Independent sector to support elective care.	M	H
Cancelation of Elective activity: Financial risk/ ability to deliver sustained improvements in National waiting time targets	Discussions have commenced with the Independent sector to support elective care. Each trust is in the process of developing a robust Theatre program to ensure maximise utilisation of theatre capacity.	M	H
Paediatric demand: Based on the current modeling, there is a risk that demand may exceed capacity.	Conversations have commenced with NGH to explore the option to transfer Paediatric activity to NGH	M	M
Critical care capacity maybe insufficient to meet the demand	We will continue to work with the Networks for support to transfer critically ill adults and Children to specialist centers as required.	M	H

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Cover sheet

Meeting	Public Trust Board
Date	30th September 2021
Agenda item	3.1

Title	Assessment and Accreditation of Nursing and Midwifery Care Excellence
Presenter	Sheran Oke - Director of Nursing, Midwifery & Patient Services
Author	Jenny Scott - Lead Nurse Quality Assurance

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

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

Reason for consideration	Previous consideration
For the intelligence of the Board and to reassure the Board that controls and assurances are in place	Trust Board formally approved the relaunch of the Assessment and Accreditation programme in May 2021

Executive Summary

This paper will:

- Provide a background and summary position of Nursing and Midwifery Care Excellence A&A framework
- Describe the Nursing and Midwifery Care Excellence A&A framework
- Provide assurance that the quality and safety of nursing care is being reviewed using A&A Nursing and Midwifery Care Excellence framework.
- Describe the progress and plans made beyond ward areas including the Emergency Department, Theatres, Critical Care, Paediatrics and Maternity.

Appendices

Appendix 1- Assessment and Accreditation of Nursing and Midwifery Care Excellence Current Status

Appendix 2 - The 15 Care Standards in the Nursing and Midwifery Care Excellence Assessment Tool
Risk and assurance
The paper outlines assurance to the board of nursing care
Financial Impact
None
Legal implications/regulatory requirements
Ward and clinical areas requirements to comply with Trust Quality and Safety standards and Care Quality Commission (CQC) guidance
Equality Impact Assessment
The equality impact assessment is complete

The Assessment and Accreditation (A&A) Nursing Care Excellence Framework

1.0 Introduction

The Nursing Assessment and Accreditation Process has been in place within the Trust for several years and has provided assurance to our patients, staff, Divisions, Trust Board and regulators that optimal standards of nursing care are being delivered consistently and reliably by our health care workforce. It has become valued by our staff who strive for 'Nursing and Midwifery Care Excellence' status and as a beacon for best practice. Owing to the recent pandemic the process was paused in March 2020. Trust Board formally approved the relaunch of the Assessment and Accreditation programme in May 2021.

Since relaunch we have formally assessed 16 wards (Appendix 1). Dryden, Althorp and Collingtree and Spencer wards are subsequently planning to make their formal application to Accreditation Panel in October and November 2021, to be considered for 'Nursing & Midwifery Care Excellence' /Blue Ward Status. The 2 wards that have been assessed as Red are currently being provided with support and have actions in place to improve, 3 wards have been assessed as Amber. All 25 adult ward areas will be assessed before April 2022 as will assessment of the Paediatric areas, ED, and Critical Care which for these areas will be the first time they have been included. We aim to be including our maternity areas within the process, work to adjust and develop the tool will commence in the new year.

There is also an opportunity to strengthen this programme further by developing an enhanced multi professional accreditation model with our group partner hospital in 2022.

2.0 Assessment and Accreditation for Nursing and Midwifery Care Excellence

This assessment and accreditation framework has been developed to align with the Care Quality Commission's Core standards and incorporates the 6Cs Compassion in Practice values, reflects the Trust's vision and values, and recognises the allied health professional contribution to ward/ department success.

The framework is designed around fifteen standards (Appendix 2/Table 1) that is initially used to assess adult inpatient wards and departments on an annual basis, as a minimum, to ensure the relevant standards of quality and safety are implemented and maintained. Each standard is sub-divided into the following elements: Environment, Care and Leadership and incorporates national performance indicators as well as local indicators, developed from lessons learned arising from complaints, concerns, adverse and quality improvement work.

3.0 The Assessment Process

The Lead Nurse, Quality Assurance undertakes the review, acting as a quasi-external assessor. Each Ward and Department is assessed against the standards with each standard being RAG rated individually and when combined, an overall ward BRAG rating is then produced. The re-assessment timetable of the wards is dependent on the overall improvement and subsequent RAG, (Appendix 2/Table 2).

Each unannounced assessment begins at 07:15 to enable observation of handover between the night staff and day staff. Each assessment continues throughout the day to ensure that the ward is observed, and all aspects of care are considered, for example patient mealtimes, doctor's rounds and visiting time. Obtaining an opinion from patients, staff, a document review and observation of practice are key aspects of the process. At the end of the day initial feedback is provided to the Ward Sister/Charge Nurse prior to their overall RAG score being announced the following day.

The Ward Sister/ Charge Nurse, Matron and Associate Director of Nursing (ADN) are responsible for formulating a ward improvement plan, ensure that it is tracked and disseminated to all members of the ward team. The results and action plans from the

assessment contribute to individual service reviews, and the data collated will provide the Board with comprehensive information regarding care delivery within the organisation.

4.0 Assessment and Accreditation of Nursing and Midwifery Care Excellence

Current Status

The current status (Appendix 1) illustrates areas that required improvement, themes, and all areas of good practice. At the time of writing the report standard 9 (Pain), standard 2 (patients feeling safe) and standard 12 (EOL care) are highly scored with standard 1 (evidence of a safety culture) scoring low. All findings are shared with Ward Sisters/ Charge Nurses at regular meetings with the Lead Nurse Quality Assurance. The Lead Nurse for Quality Assurance also meets quarterly with the Associate Directors of Nursing to share these themes and any other issues that have been highlighted. A summary report for each of the Divisions, which highlights the 'areas for concern' is also shared monthly with updates being provided in our 'Nursing, Midwifery and AHP news'.

5.0 Assessment and Accreditation Nursing and Midwifery Care Excellence Recognition

Wards that achieve three consecutive green assessments, which will take at least 12 months, will be asked to produce a standardised panel document, and be invited to present this to A&A Nursing and Midwifery Care Excellence Panel. The panel may recommend the ward/clinical area to the Trust Board for approval of A&A nursing excellence status. The Director of Nursing, Midwifery and Patient Services has the authority to influence a recommendation to the Trust Board.

The Quality Assurance Lead Nurse on an annual basis will reassess the blue wards.

The Ward Sister/Charge Nurse may be invited to attend Trust Board or a subcommittee as part of the official recognition of their Blue Ward status. The ward staff will each receive a certificate and badge from the Director of Nursing, Midwifery and Patient Services and Chief Executive. A ward plaque will be displayed on the entrance to the ward/clinical area, informing patients that they are being cared for on a Blue ward.

The Ward Sister/Charge Nurse that has led their area to Blue status will be entitled to wear a Navy Uniform with Gold piping, earning recognition of their successful leadership within the organisation. They will be expected to share their experience by buddying up with Sisters/Charge Nurses from areas that are still working to achieve a green status.

Future Plans

The development of an electronic version of the assessment and accreditation tool is being explored by the Lead Nurse for Quality Assurance and our CNIO. It is hoped that this will improve efficiency of the process, additionally, the communications team continue to be in discussions with the Lead Nurse with the aim of having an intranet page launched to further support, develop staff knowledge, and provide information on A&A

At a group level we will, in alignment with our group partners, review our nursing midwifery Assessment and Accreditation tools as outlined within our NMAHP strategy, 'Ignite our VoICE 'recognising the value our staff place on the process, highlighting best practice and a driver for change when required.

Finally, one of our group objectives, under the Quality pillar is to develop an enhanced Assessment and Accreditation tool for the multidisciplinary team (MDT). It is envisaged that this will build upon the well-embedded nursing excellence framework and develop a more cohesive approach, with an enhanced MDT focus.

The Board are asked to note the content of the paper recognising forward plan and the progress which have been made over the past 4 months.

Appendix 1 –

The 15 Care Standards in the Nursing and Midwifery Care Excellence Assessment Tool

Table 1:

Number	Care Standard
1	There is **evidence of a safety culture** on the ward
2	**Patients feel safe**, secure and supported
3	The **environment is safe** for patients, staff and visitors
4	Avoidable harm will be eliminated in relation to **medicines management**
5	Patients are cared for in an environment where the risk of cross **infection** is minimised
6	**Nutrition and Hydration** – Patients receive sufficient food and fluids to meet their individual needs
7	Risks to the integrity of the patient's **skin** will be identified and actions taken to ensure that the condition will be maintained or improved
8	**Elimination** - Patients bladder and bowel needs are met
9	**Pain** will be controlled to an acceptable level for the patient
10	Patients will be supported to meet their **hygiene** needs
11	Patient centred care – every patient is treated as an individual, with **compassion** at all times
12	**End of life care** is patient and family centred
13	Patients and carers experience effective **communication**, sensitive to their individual needs and preferences
14	The clinical area is **effectively managed** and organised in a way that benefits patients, staff and visitors
15	The clinical area can provide **assurance** against key performance parameters

Table 2: RAG Criteria

Red	6 red standards	Reassess in 3 months
Amber	3-5 red standards	Reassess in 4 months
Green	2 red standards and 8 or more green standards Standard 5 & 15 must be Green (Standard 10 for OPDs)	Reassess in 6 months
Nursing Excellence Ward	3 consecutive green assessments	Reassess in 12 months

Appendix 2 Assessment and Accreditation of Nursing and Midwifery Care Excellence Current Status

Ward	Overall last Formal Assessment	Progress if Green*	Care Standards														
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Abington	**August 2021**	2															
Althorp	**May 2021**	**Awaiting panel**															
Cedar	Feb 2020	1															
Collingtree A	**August 2021**	**Awaiting panel**															
Collingtree B	**June 2021**																
Critical Care	Sept 2019																
Head & Neck	**July 2021**																
Willow	**July 2021**																
Spencer	August 2021	**Awaiting panel**															
Talbot Butler	**July 2021**																
Allebone	**Sept 2021**																
Becket	April 2019																
Benham	April 2019	2															
Brampton	**July 2021**	2															
Creaton	Nov 2019	1															
Dryden	**May 2021**	**Awaiting Panel**															
Eleanor	**Sept 2021**	3															
ED	Sept 2019	2															
Esther White	**August 2021**	2															

Finedon	**July 2021**																
Hawthorn	Awaited																
Holcot	**June 2021**	2															
Knightley	Jan 2020	1															
(SDEC)	Awaited																
Rowan	**August 2021**	1															
Victoria	Awaited																
Walter Tull	Feb 2020																
Total Red:			6	2	2	2	4	0	1	4	0	2	1	0	6	3	4

* When a ward reaches 3 successive green assessments it is eligible to apply for blue status.

Dedicated to excellence

NHS
Northampton General Hospital
NHS Trust

Cover sheet

Meeting	Public Trust Board Meeting
Date	30th September 2021
Agenda item	3.2

Title	Ignite our VoICE, our Nursing Midwifery and AHP strategy
Presenter	Sheran Oke, Director of Nursing, Midwifery and Patient Services
Author	Sheran Oke, Director of Nursing, Midwifery and Patient Services

This paper is for			
☐Approval	☐Discussion	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

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

Reason for consideration	Previous consideration
To provide assurance to the Trust Board on the progress and plans for delivery of our Nursing Midwifery and AHP strategy, launched on 15th September 2021	The Board has previously discussed and approved the strategy, recognising the opportunity presented for partnership and collaborative working with our Group NMAHP partners

Executive Summary
The Group Nursing, Midwifery and AHP strategy, 'Ignite our VoICE' was officially launched on 15th September 2021. The paper outlines the achievements made during August and work underway in September. The paper also includes confirmation of the Governance structure highlighting how the strategy will be reviewed and monitored

Work will take place to finalise the monitoring and reporting of the Strategy through the governance process. It is proposed that progress updates will be reported on a quarterly basis.
Appendices
Summary presentation of the N, M & AHP Strategy
Risk and assurance
The governance of the N, M & AHP Strategy will be through the development of a joint Nursing, Midwifery and AHP Steering Group which is due to be set up in quarter 3.
Financial Impact
None
Legal implications/regulatory requirements
The N, M & AHP Strategy links closely with the Working Group 'Dedicated to Excellence' Strategy.
Equality Impact Assessment
There is no evidence that the document will not promote/have a negative impact on equality of opportunity

This report may be subject to disclosure under the Freedom of Information Act 2000, subject to the specified exemptions.

‘Ignite our VoICE’

Nursing, Midwifery & AHP Strategy 2021-20244

Update September

IGNITE our VoICE - Our Strategy for Nurses, Midwives and AHPs 2021-2024

This strategy signals an era of change with our three professional groups now sharing a strategic vision as well as sharing the strategy across both organisations.

Our Ambitions for Nurses, Midwives & AHPs

We will excel in patient care, creating a positive practice environment for staff and be the employer of choice in Northamptonshire

We will work together to ignite the VoICE of Nurses, Midwives and Allied Health Professionals to be equal partners in the Clinically-Led Organisation

To underpin this, we aim to become the first Group hospital to be accredited as Pathway to Excellence® hospitals in England

Our Five Key priorities

Provide Safe & Quality Care

Strengthen Leadership

Value Our People

Develop our workforce

Empower and innovate

Our Commitments

We are dedicated to excellence by providing safe and high quality care. We will role model the Group value of Compassion by putting patients and their carers at the heart of everything we do.

We are dedicated to excellence by being inclusive leaders. We will role model the group value of integrity throughout our Nursing, Midwifery and Allied Health Professional leadership.

We are dedicated to excellence by ensuring our staff feel valued. We will role model the group value of respect throughout Nursing, Midwifery and our Allied Health Professional groups.

We are dedicated to excellence by ensuring our staff have development opportunities to reach their full potential. We are also dedicated to our future workforce and the creation of new innovative roles which cross professional boundaries across the ICS. We will role model the group value of accountability when developing our staff.

We are dedicated to excellence by ensuring our staff are empowered to innovate. We will role model the group value of courage when developing our staff to be trailblazers of excellence.

IGNITE our VoICE - Our Strategy for Nurses Midwives and AHPs 2021-2024

Our Ambitions for Nurses, Midwives & AHPs

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Our Five Key priorities

Provide Safe & Quality Care

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Value Our People

Develop our workforce

Empower and innovate

Our August Update 2021

- Agreed shared harm free quality metrics, reporting processes being put in place
- Compliance with IPC BAF
- Divisional patient experience meetings in progress
- Appointment of patient and family partners to 2 SDM councils
- Planned appointment of NED's to SDM councils
- 16 Assessment & Accreditation now undertaken
- PPE Coordinator commenced
- PPE rated green in IPC BAF

- Developing BAME leadership opportunity across group
- 2 Leadership Candidate commenced regional BAME programme
- Understanding number of local leaders from BAME background
- Plan to deliver Mary Seacole Leadership programme across county
- Leadership visits undertaken
- 5/7 DoN fellows appointed to programme including midwifery fellow
- Work already underway on reverse mentoring led by HR teams, to align plans
- Mock survey due to implemented during Excellence week

- Baseline reading taken at of appraisal rates
- ROSE Awards planned
- Recognition day held - included Daisy awards
- Leadership recognition event planned
- Pathway Awards in development
- ROSE awards in development and launch being planned
- Band 7 specific induction awaiting NMB approval

- Explored additional placement opportunities for student NMAHPs with UON and with HEE
- Successful expansion of maternity/leadership placements with UoL
- International Recruitment for Nursing programme delivering 150 started in group to date
- Educational Prospectus approved and with publisher
- Clinical Academic applications increased 3 applicants commencing modules
- Support package offered to Bronze applicants
- Evidence Based Practice Course completed celebration event planned

- CNIO & Digital Midwife recruitment completed, and commenced post
- Ongoing support to NMAHP undertaking QI and QIPS masters
- SDM leadership council completed with further developments planned
- EBP course completed and projects implemented. Celebration day planned.

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IGNITE our VoICE - Our Strategy for Nurses Midwives and AHPs 2021-2024

Our Ambitions for Nurses, Midwives & AHPs

We will excel in patient care, creating a positive practice environment for staff and be the employer of choice in Northamptonshire

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To underpin this, we aim to become the first Group hospital to be accredited as Pathway to Excellence® hospitals in England

Our Five Key priorities

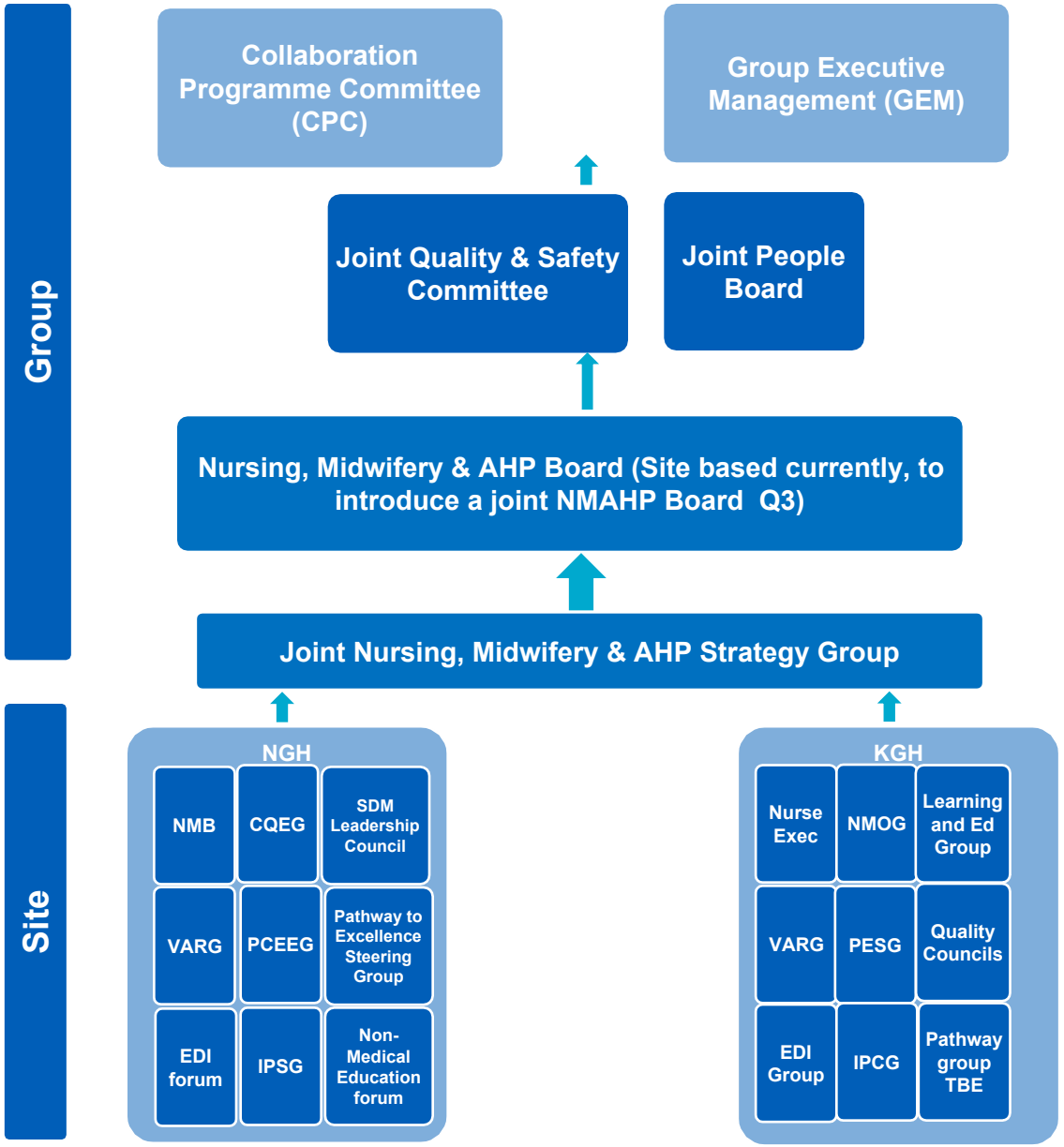
Provide Safe & Quality Care | Strengthen Leadership | Value Our People | Develop our workforce | Empower and innovate

Our NGH September Priorities 2021

- Our focused week on Pathway planned as part of our groups 'Dedicated to Excellence' fortnight
- Our first group NMAHP Board to commence in October
- Establish monitoring and reporting of Strategy delivery plan through joint NMAHP Steering Group
- Confirmation of BAME leadership offer across ICS
- Continue DoN 'Walkabouts' /Back to the Floor
- Agree criteria and launch of ROSE awards
- Begin review of educational offerings across the Working Group
- Support NMAHP's to apply for Trust's early career research grants
- Launch of our Clinical Educational Prospectus
- Meeting with academic partners at UoL to discuss academic opportunities
- 7/7 DON fellows will be appointed
- Reverse mentoring to be commenced with the senior leadership team

Nursing, Midwifery and Allied Health Professional Strategy Governance Summary

GOVERNANCE STRUCTURES



Dedicated to excellence

NHS
Northampton General Hospital
NHS Trust

Cover sheet

Meeting	Public Trust Board
Date	30th September 2021
Agenda item	3.2

Title	Dedicated to Excellence Group Strategy Delivery – Our People Plan
Presenter	Mark Smith, Chief People Officer
Author	Mark Smith, Chief People Officer

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

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

Reason for consideration	Previous consideration
To report on progress of the People Plan delivery across the University Hospitals of Northamptonshire Group	The People Plan was approved at the March Board of Directors meeting. The report was presented at the Collaboration Programme Committee in September

Executive Summary
One of our priorities within our Dedicated to Excellence strategy is People. To enable to delivery of this priority our **Group People Plan** was approved at our Boards at the end of March 2021. The plan consists of seven People Pledges and areas of focus for us across the Group

The plan outlined the **deliverables** over the next 12 months and 3 years and work has commenced in a number of these areas, examples contained within the report articulate the focus on our Equality, Diversity and Inclusion agenda, Health and Wellbeing services, our volunteers growth and support and our success in international nursing recruitment. There are areas we need to continue to develop in order to achieve our objectives and support the development of the group model inclusive of recruitment, development, temporary staffing and organisational development.

One of the key measures of success for the plan is centred on our **Group People pulse survey** which went live on 7th September, we are on track to exceed our first survey response rate target of 10%, it is acknowledged obtaining the feedback is the starting point, what will be key in the plan is our ability to respond to concerns corporately and within service areas and to enhance positive points raised across both Trusts which will require support from a number of areas.

In order to provide assurance on delivery of our plan we have redesigned the **Joint People Committee Performance pack** to include the metrics we identified in our Group People Plan, and give an overview of how we're delivering against each of the pledges in our Group People Plan. The committee work programme has been designed to deep dive into pledges of the People plan, with development sessions incorporating the attendance of colleagues working within each Trust – the most recent example in August being a presentation from our apprentices within both hospitals.

In order to support the full implementation of the plan we have also begun the process of aligning the Trust HR & OD teams into what will be known as the **People Services Directorate**, starting with the appointment of our two Directors of People, and continuing with the recruitment of our Deputy People Director and Heads of Service aligned to the People Pledges.

Our Group People Services directorate will be officially launched during **People week** in October in which we will be highlighting the great work already taking place, and discussing some exciting developments that staff can expect to see over the coming months e.g. working across sites

Appendices

People Plan Progress Report

Risk and assurance

The risks of not delivering the People Plan are documented within the Board Assurance Framework

Financial Impact

The cost of delivering the People Plan has been accounted for within the budgets of both Trusts for 2021/22. Non delivery of the pledges within the plan would have an financial impact on the Trusts which can be measured by increased vacancy, turnover, absence rates including an increased requirement for temporary staff.

Legal implications/regulatory requirements

These are outlined within the People Plan

Equality Impact Assessment

These are outlined within the People Plan, specifically within the OD and Inclusion pledge, which had as a deliverable to design and implementation of an Equality,

Diversity and Inclusion strategy for the Group, which was approved at the July Board meeting.

Dedicated to excellence

NHS
University Hospitals of Northamptonshire
NHS Group

People Plan Progress Report

Sept 2021

Services provided by Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

Executive Summary

NHS
University Hospitals of Northamptonshire
NHS Group

- Our **Group People Plan** was approved at our Boards at the end of March 2021. The plan consists of seven People Pledges and areas of focus for us across the Group
- The plan outlined the **deliverables** over the next 12 months and 3 years and work has commenced in a number of these areas, examples contained within the report articulate the focus on our Equality, Diversity and Inclusion agenda, Health and Wellbeing services, our volunteers growth and support and our success in international nursing recruitment. There are areas we need to continue to develop in order to achieve our objectives and support the development of the group model inclusive of recruitment, development, temporary staffing and organisational development.
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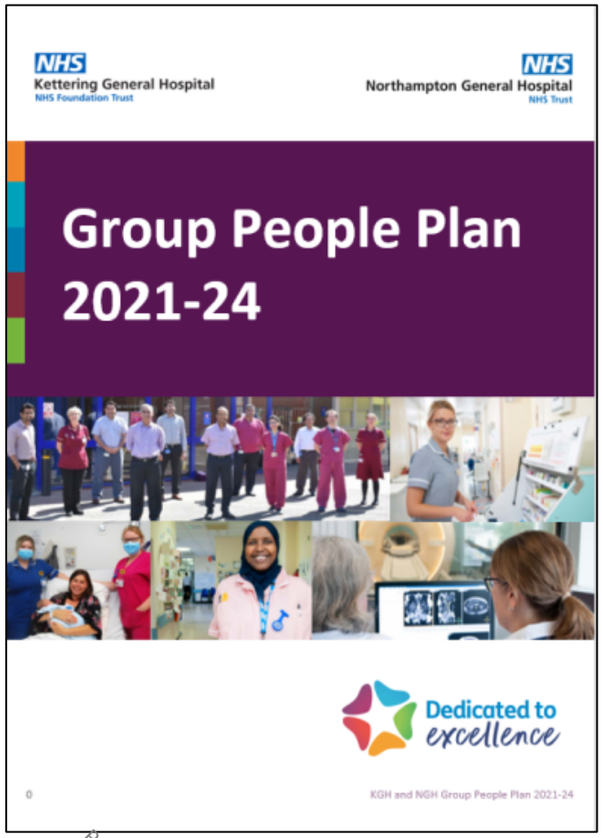
Dedicated to excellence

People Plan



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Key developments include:

- The production and approval of our Group EDI strategy
- Our international nursing programmes recruiting and educating colleagues to fill substantive vacancies
- The commencement of our Advanced Leadership programme and apprenticeship support across the Group
- Increasing our volunteers and providing consistency in support
- Our first joint disciplinarily policy has been agreed

Coming soon – MoU for cross site working…


Kettering General Hospital aims to double army of volunteers

Ambition to create one of the largest volunteer forces in the NHS

By Neil Burkett

Dedicated to excellence

People Plan

University Hospitals of Northamptonshire NHS Group

	What have we achieved so far	What are we doing now	What will we do this year
Health & Wellbeing	• KGH outdoor gym area opened during September • Access to psychological support through NHFT in place • Basic needs offer in place: free car parking for the year, refreshments through estates programme	• Flu Vaccination / Covid vaccination / winter campaign • MSK physio • Psychology / preventative health	• Bringing together the offer across both organisations to be under the same name and branding – including a stepped care offer – and making sure that our recruitment packs describe our offering • Review and bring together the Employee Assistance Programme • Plan for winter vaccination programme • Development of colleague spaces – Our Space – We Care Café • Creating a joint in-house occupational health service • Developing an in-house physio / OT service
People Planning	• 396 overseas nurses recruited to date • Job planning policy completed and delivery reviews being implemented • Medical Establishment review completed at NGH	• Overseas nurse recruitment • Aligning the teams • Temporary staffing & agency spend review and resourcing	• Medical establishment review at KGH • New role creation – e.g. ACP roles • Skill mix reviews • Developing and implementing an approach to workforce planning • Developing a joint recruitment / attraction strategy
People Processes	• RPA processes mapped and in early stages of development	• Providing an MoU to enable colleagues to work/transfer across both Trusts • Administration of Flowers outcome	• Bring together temporary staffing functions and review temporary staffing rates • Develop workforce intelligence capability • Development of self-service offerings • Payroll contract – single approach across the Group • Reviewing rostering system • Group staff bank • Standardised communications

Dedicated to excellence

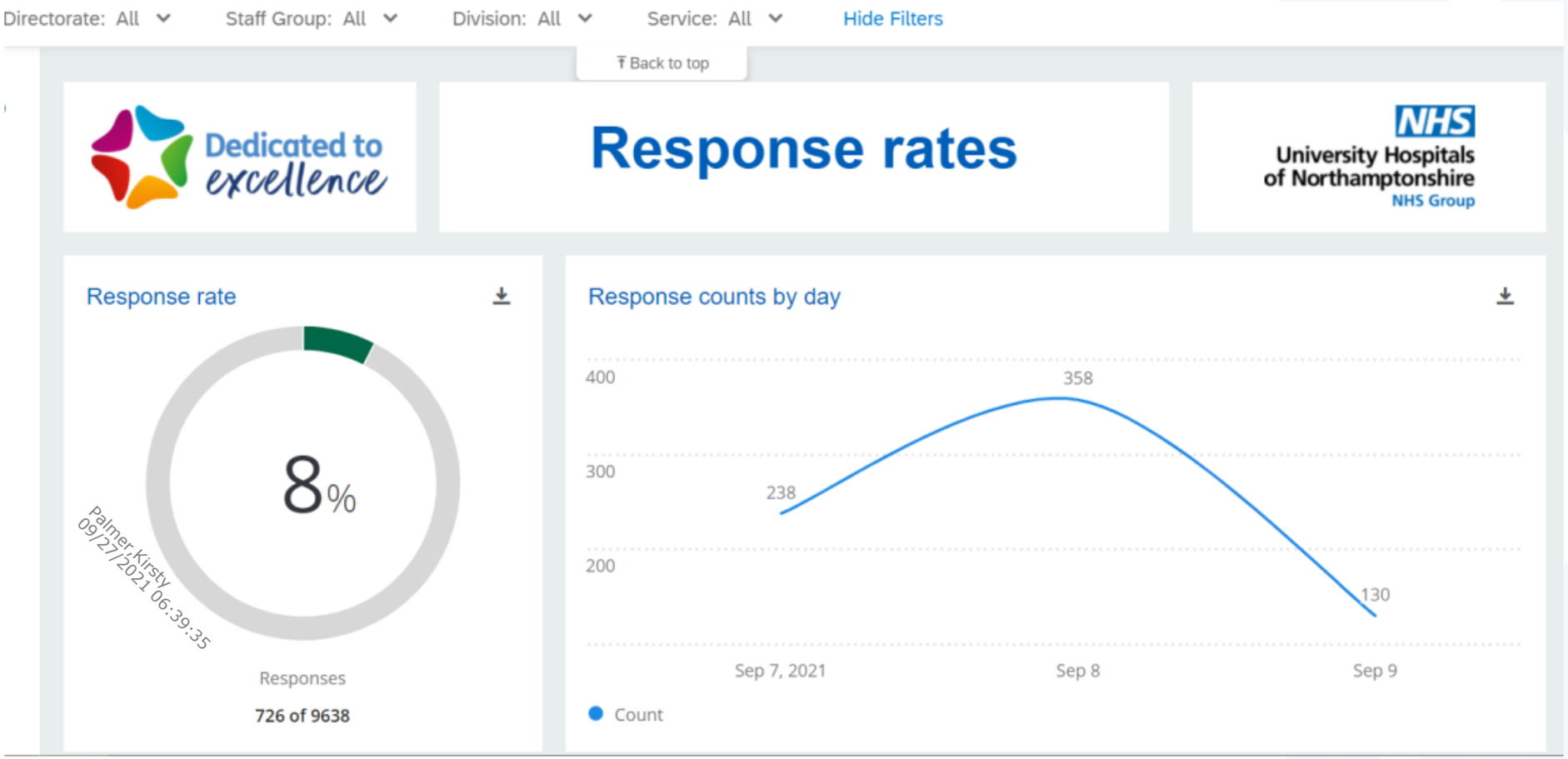
People Plan

University Hospitals of Northamptonshire NHS Group

	What have we achieved so far	What are we doing now	What will we do this year
Volunteering	• Secured charitable funding to support 'youth volunteers' • New uniform launched in KGH • NGH hub renovation underway	• Recruitment of diverse volunteers • Create an area for volunteers at KGH • Introducing volunteer ma nagement tool	• Standardise & digitizing our recruitment process • Increase the diversity of our volunteer workforce • Review/challenge volunteers in clinical areas • Increase community engagement • Grow the number of volunteers • Standardise good practice across both sites
Organisational Development & Inclusion	• Joint EDI strategy complete and approved • 4 staff networks in place	• Input to Flu Vaccinations • Trust values awareness • People Pulse outcomes • OD team resource at Kettering • Embedding the values	• Define EDI roles & definitions • Develop OD resource for Group collaboration, and skills within HR function • Leadership capability training for managers around how to have a good conversation etc. • Delivering the EDI strategy – joining up the networks across KGH and NGH etc. • Supporting clinical collaboration • Compassionism agenda
People Partnering	• Shared disciplinary policy approved and in place • Consistent ER tracker in place across the Trusts	• Aligning and developing our Policies across the Group • Branding of the HR & OD team to be 'People'	• Case management & People Partner resources • Restructuring the teams • Building capability with the current HR team • Building capability with the management teams • Strengthen bank investigators, following the KGH model • Developing a shared service model for transactional HR
People Development	• STAT/MAN training above target in both organisations • Good feedback from Advanced Leadership July cohort • EDI training catalogue launched at KGH	• Aligning our STAT/MAN training to be consistent building on our digital progress • Ensuring our apprenticeship offer is collaborative	• Updating the appraisals to include the new Group values and appraisal training • Development of a career hub • Leadership development programme • Development of a skills network • Enhancing BI reporting on training and development activities • Further development of digital learning

People pulse survey

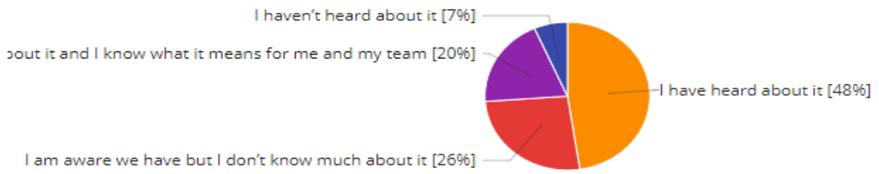
- Our Group People pulse survey went live on 7th September, and we are on track to exceed our response rate target of 10%.
- The focus now is on ensuring that the richness of feedback provided through the survey is utilised in our decision making, and that staff are able to see that change is happening as a result of their participation in the survey



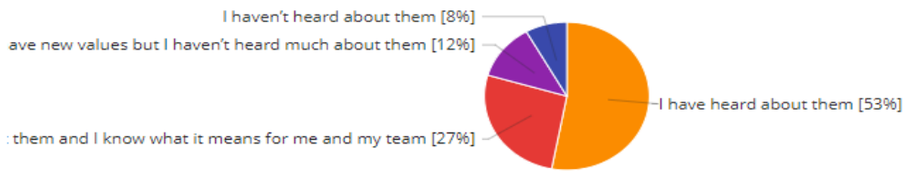
People pulse survey

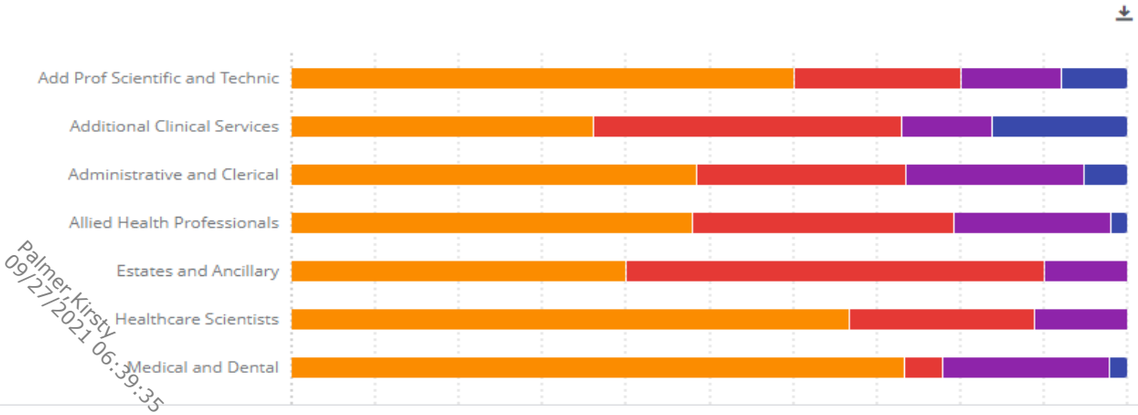
NHS
University Hospitals of Northamptonshire
NHS Group

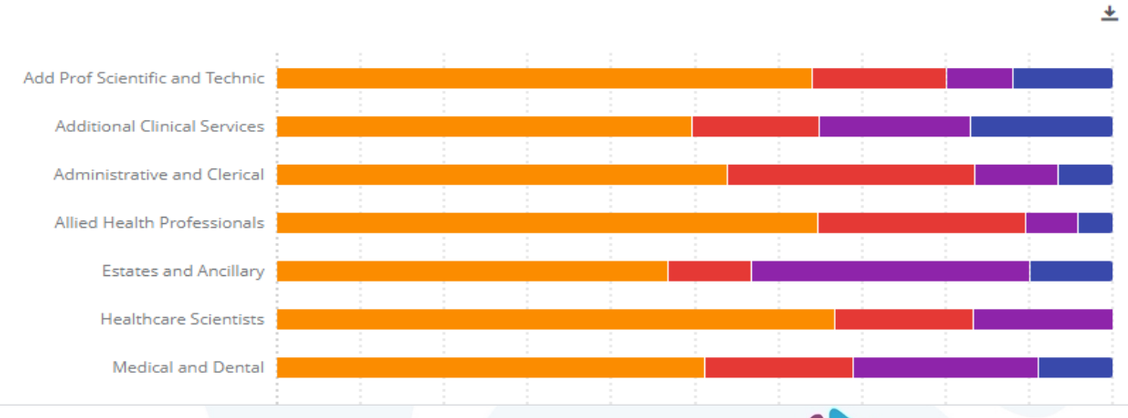
Have you heard about the Group?



Have you heard about our new values?







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People Plan – People Committee Performance Pack – July

NHS University Hospitals of Northamptonshire NHS Group

People Plan metrics on a page

NHS University Hospitals of Northamptonshire NHS Group

Theme	Objective	Metrics/measurement			
Health & Wellbeing	We will provide bespoke health and wellbeing spaces and access to health assessment and psychological support for all our people	Staff absence data, including reason for absence Target	WRES and WDES metrics Target	Staff Survey; Health and Wellbeing Target	
People Planning	We will support people plans for our patient services with effective attraction and retention plans that support new roles, new ways of working and career pathways.	Vacancy and Turnover Rates Target	Temporary Staffing usage Target	Number of colleagues recruited from overseas Target	
People Partnering	To consider how we work with one another, reflecting, learning and ensuring feedback is heard and actioned, leading to a reduction in formal employee relations management	Survey results Target	Divisional People Metrics inclusive of WRES, WDES and retention Target	Reduction in the number of formal procedures Target	
People Development	We will support colleagues to build a career providing opportunity for people joining us from any level and background to progress	Staff appraisals data Target	Statutory and mandatory training compliance Target	Staff survey; managers; Appraisal Quality; Leadership and Career Development Target	
People Processes	Colleagues will be able to access systems to enhance their work experience and flexibility	Roster publication performance Target	Temporary Staffing usage Target	Recruitment time to hire Target	Speed of T&C query resolution Target
Organisational Development & Inclusion	To bring our dedicated to excellence values to life, improving the way we work with each other, particularly focusing on empowerment and inclusion	WRES and WDES metrics Target	Excellence values in survey results Target	Successful clinical collaboration projects. Target	Continuous increase in survey participation Target
Volunteering	We aspire to have the largest volunteer base within the group across the NHS with volunteers that are representative of the population of Northamptonshire providing opportunities for our community.	Number of volunteers and hours in the Group Target	Patient Experience feedback Target	Diversity of our volunteers and the roles they undertake within the hospitals Target	

Key	
	Relevant up to date data not yet available
	On target in both organisations / due to meet target
	Target not met in both organisations but plan in place
	Target not met in both organisations and no plan in place

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University Hospitals of Northamptonshire NHS Group

People Development – progress update

Lead: Sheila Turner

University Hospitals of Northamptonshire NHS Group

Our Pledge: We will support colleagues to build a career providing opportunity for people joining us from any level and background to progress

Summary highlights
Statutory and mandatory training performs above target in both organsiations. Appraisal performance shows normal cause variance, but below the benchamarked target.

Deliverables during reporting period	RAG	Progress
Mandatory training competency alignment across both hospitals commenced		The mapping of both sites Mandatory and reportable profiles to consider the alignment and the skills for health benchmarking required. Work has commenced to align Statutory and Mandatory training across the Group. Mandatory Training workbook being devised for Volunteers at NGH.
Advanced leadership course		Combined Trust cohort commenced 19 candidates commenced on programme (day 4 22nd July). Good initial feedback, Delivery mode encourages learning, delivery in practice, feedback and reflection at each stage.
Leadership Development		Ongoing provision of staff and leadership development through online bite size programmes looking at topics such as navigating through work life change, leading teams under pressure, compassionate leadership, civility and respect, how to have a courageous conversation, tips on conflict resolution.
Masters in Leadership		All delegates passed first assignment
EDI training catalogue launched at KGH		A programme of sessions supporting the building of cultural bridges, having uncomfortable conversations and inclusive recruitment programmes working on ensuring this is robust in both Trusts
Coaching and Mentoring offer finalised across both Hospitals		Workshops underway for both managers and non-mangers, professional qualification recruitment underway, Recruitment for the professional qualification underway for commencement in September. Network being formed.
Apprenticeships		Ongoing recruitment of apprentices across the roles. KGH recognised as a leading Trust as recruited to the professional OT qualification, form school leavers.
360 Appraisal facilitators		5 facilitators trained and supporting feedbacks
Supporting team reset through Covid		Guides and sessions in place across both Trusts

Risks to delivery of pledge/deliverables
Limited workforce impact due to isolation and AL at this time.

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People Plan – People Committee Performance Pack – July

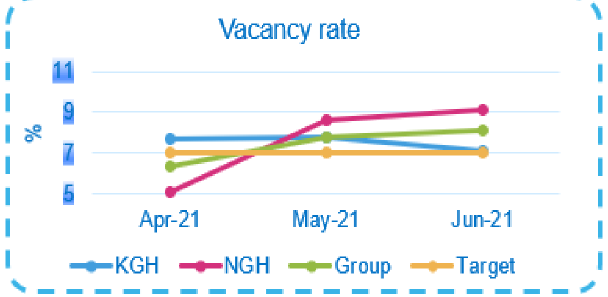
University Hospitals of Northamptonshire NHS Group

People planning – data

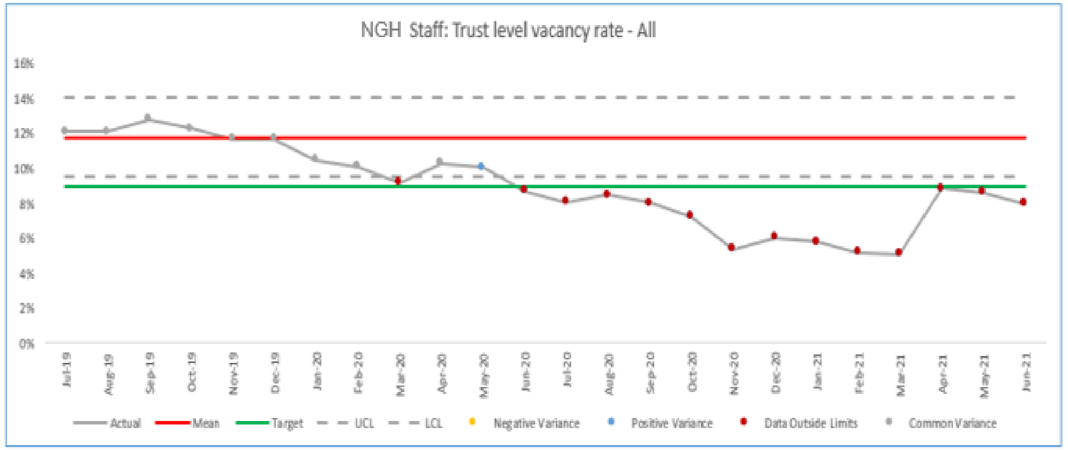
University Hospitals of Northamptonshire NHS Group

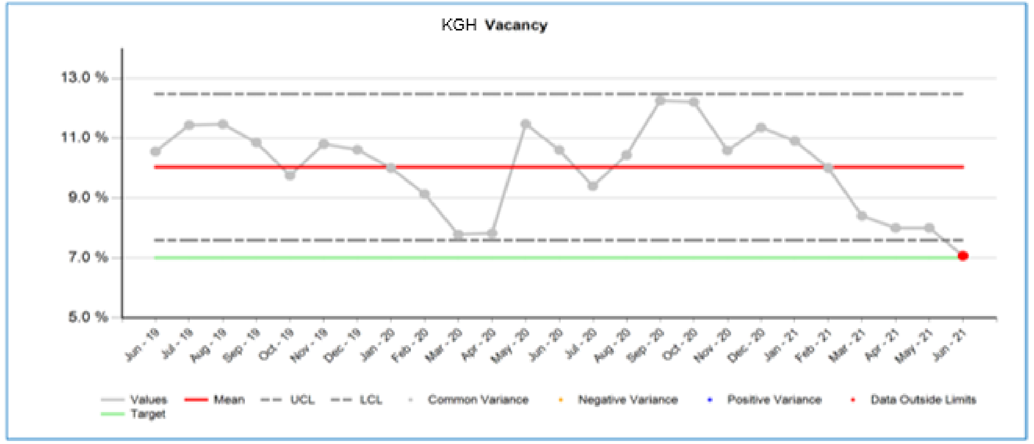
Vacancy Rates

Target – 7%



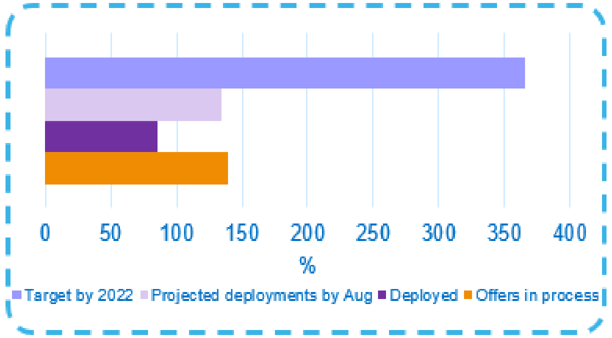
Narrative: Vacancy rates generally been falling consistently since December 2020 with the exception of the additional posts added to the NGH budget in April 2021. International nurse recruitment and HCA recruitment is reducing the gap.
The high number of new starters in the Group is causing pressures as existing staff seek to support and train new arrivals. Recruitment, Education and Nursing teams are working closely with divisional leadership to ensure this pressure is managed and new starters are welcomed to the Trusts and supported into their new role
Action: Further work is required with regards to a strategy for recruitment against Medical posts in both Trusts





Number of colleagues recruited from overseas

Target - 366



Narrative:

The international Nursing Project aims to deliver 396 nurses into the County be the end of March 2022. The project is currently on plan with 139 offers being processed and 85 nurses already deployed. A further 50 nurses will be arriving in August and weekly interviews are taking place.

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People Plan – Support

University Hospitals of Northamptonshire NHS Group

To build on the People Plan and obtain its objective, support will be required in future development and current pressures which include:

- People Pulse survey outcomes – our response and embedding these into health intelligence and performance management
- Building our OD capacity to support the current areas of challenge and in readiness to achieve the D2E and clinical strategy requirements
- Making our structural change across both Trusts, whilst maintaining business as usual
- Supporting the reduction in temporary staffing usage within both Trusts
- Policy development – providing consistency across both Trusts
- Embracing system changes and further use of technology to manage people services, building on our People Pulse

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NHS
Northampton General Hospital
NHS Trust

Cover sheet

Meeting	Trust Board
Date	30th September 2021
Agenda item	4.1

Title	EPRR Self-Assessment Assurance Report
Presenter	Joanna Fawcus, Chief Operating Officer
Author	Jeremy Meadows, Head of Resilience and Business Continuity

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

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

Reason for consideration	Previous consideration
The Board is asked to note the completion of EPRR Core Standards self-assessment and approve the proposed overall assessment of Fully Compliant.	Board receives annual assurance

Executive Summary
To provide an update of the EPRR self-assessment undertaken in August 2021 and progress against the NHS England Core Standards. As an acute provider of NHS Funded Care, the Trust is required to be able to plan for and respond to a wide range of emergencies and business continuity incidents

that could affect health or patient safety. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This is referred to as 'emergency preparedness, resilience and response' (EPRR).

The NHS England Core Standards for EPRR are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The following is a summary of the Trust's self-assessment against these requirements and governs the work plan for the next 12 months.

Appendices

Core Standards submission – Appendix 1

Risk and assurance

The report provides assurance of processes in place to ensure the Trust is able to respond to a major, significant or business continuity incident which are pertinent to patient and staff safety.

Financial Impact

None

Legal implications/regulatory requirements

The Civil Contingencies Act places a statutory duty on the Trust to fulfil its roles as a Category One responder.

Equality Impact Assessment

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**)

This report may be subject to disclosure under the Freedom of Information Act 2000, subject to the specified exemptions.

1. Introduction

Emergency Preparedness, Resilience and Response (EPRR) is key to ensuring that the Trust is able to respond to a variety of incidents whilst continuing to provide essential services. The Civil Contingencies Act (CCA, 2004) places a number of statutory duties on the Trust as a Category 1 Responder. These duties include:

- Risk assessments to inform contingency planning
- Emergency planning
- Business continuity planning
- Co-operation with other responders
- Information sharing with other responders
- Warning, informing and advising the public in the event of an emergency.

As an acute provider of NHS Funded Care, the Trust is required to carry out self-assessment against the NHS England Core Standards, and evidence appropriate planning and response mechanisms for a wide range of emergencies and business continuity incidents. These requirements are set out by the Civil Contingencies Act (2004) and NHS England's Emergency Preparedness, Resilience and Response (EPRR) Framework (2015).

2. Criteria for assessment of Core standards

The primary focus of 2020/21 has been the continued response to the coronavirus pandemic, which NHS England declared as a Level 4 national incident in January 2020. The Trust's Incident Coordination Centre has been operating from the outset of the pandemic, with command, control, coordination and communication arrangements in place to ensure that the strategic team has a clear line of sight to the impact of the pandemic across the Trust.

The NHS Core Standards for EPRR are the basis of the assurance process which has reverted to the 2019 format, following the introduction of lite version for 2020, as a result of the response to the Covid-19 pandemic.

A robust and stringent review process with Executive and Senior Management engagement has been followed to complete the self-assessment exercise to ensure that the results provide a true reflection of the Trust's overall position against the NHS Core Standards for Emergency Preparedness, Resilience and Response. The submission was provided to the CCG and NHSE/I Midlands EPRR teams on Tuesday 31st August 2021.

Following submission of the self-assessments the CCG and NHSE/I will review the submissions and follow up with individual Trusts regarding any supporting evidence required to confirm the self-assessment score.

The Trust is required to benchmark each theme against the following compliance levels:

- Fully Compliant
- Partially Compliant
- Non-Compliant

Table 1 below provides an overview of the Trust's position against the Core Standards which is described through a series of 49 criteria.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	9	9	0	0
Command and control	1	1	0	0
Training and exercising	0	0	0	0
Response	5	5	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	7	7	0	0
CBRN	12	12	0	0
Total	49	49	0	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Medical Gasses	4	4	0	0
Oxygen Systems	3	3	0	0
Total	7	7	0	0

Table 1: NGH Core Standards Review 2021.

A deep dive was also carried out on medical gasses and oxygen systems to provide assurance surrounding the resilience of our internal piped oxygen systems. It is deemed that the Trust is fully compliant with the seven core

standards because of the controls to mitigate the risk of the possible loss of supply through instruction to local staff on the interpretation of the monitoring equipment and what they could do in terms of equipment usage.

The VIE equipment utilises quad evaporators which allows for resilience should failure occur. At an early stage in the pandemic when it was realised that higher throughput ventilators would be used, telemetry monitoring was set up to check levels in storage tanks in order to main safe levels. Additional non-invasive ultrasonic monitoring was installed to measure usage in key areas to ensure that safe levels were maintained and this information was fed into the Trust Silver Group. Informed decisions could then be made as to the number and type of ventilator that could be used. Daily checks were performed on the VIE's to ensure there was no excessive freezing on the valves which could prevent supply at the height of the oxygen usage.

The EPRR self-assessment tool is attached for awareness. **APPENDIX 1**

Based on the Self-Assessment, the Trust will be declaring an overall rating of Fully Compliant, with 100% of all criteria being Fully Compliant. The definitions of full, substantial, partial and non-compliance are included below for awareness.

Compliance level	Definition
Fully compliant	Fully compliant with core standard.
Partially compliant	Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

3. Summary

Based on the assessment and evidence reviewed we assured that measures are in place to adequately respond to incidents. The Emergency Planning and

Business Continuity function has also observed improvement over the past few years in the Trust's capabilities to plan for and respond to a major incident or failure in business continuity.

In addition to the response to the Covid-19 pandemic, a number of moderate business continuity incidents have highlighted the Trust's ability to perform in accordance with the command and control structure, maintaining a focus on patient safety and providing the best possible care.

The emergency planning cycle will continue to determine the emergency planning and business continuity workplan for 2021-22. The key areas that will be prioritised within the next 12 months will continue to be Major Incident and Business Continuity planning and training and exercising, with an ongoing review of plans and close working with external stakeholders.

To provide further reassurance the Emergency Planning and Business Continuity Team will continue to engage with clinical and corporate teams to ensure the work programme is delivered to a high standard and timescale.

4. Recommendation

The Board is asked to note the contents of the report and approve the proposed overall assessment of Fully Compliant.

APPENDIX 1

B0628 - 2021 Core Standards amended

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NHS
Northampton General Hospital
NHS Trust

Cover sheet

Meeting	Public Trust Board
Date	30th September 2021
Agenda item	4.2

Title	Infection Prevention and Control Annual Report
Presenter	Ms S Oke
Author	Ms S Oke - Director of Nursing, Midwifery & Patient Services and Director of Infection Prevention & Control Ms R Pounds - Infection Prevention & Control Clinical Nurse Specialist Ms C Brown - Occupational Health Manager Mr G Luck - Decontamination Lead Mr S Hoque - Antimicrobial Pharmacist

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

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

Reason for consideration	Previous consideration
Requirement of the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance (Department of Health, 2015).	This is an annual standing agenda item

Executive Summary

The annual report for Infection Prevention and Control (IPC) outlines the Trust's performance for the prevention and control of infections in 2020/21 and the overarching IPC plan of work for 2021/22 to support the reduction in the risk of healthcare associated infections (HCAIs). The report outlines the measures implemented during the response to the worldwide COVID pandemic during 2020/21 and the Trust's approach to reducing the risk of all HCAI.

Appendices

Appendix 1 - IPCT Structure 2020/21
Appendix 2 - Terms of Reference for the Infection Prevention Steering Group
Appendix 3 - Terms of Reference for the Infection Prevention Operational Group
Appendix 4 - Healthcare Associated Infection Plan of Work, 2021/22

Risk and assurance

(Outline risk to the organisation in respect of paper, and assurance undertaken)

Financial Impact
To provide assurance in relation to The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance (Department of Health, 2015).
Legal implications/regulatory requirements
To provide assurance in relation to The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance (Department of Health, 2015).
Equality Impact Assessment
There is no potential for, or evidence that, this document will not promote equality of opportunity for all or promote good relations between different groups. There is no potential, for or evidence that, this document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics).

Contents

1 Introduction

This is a two-part document; a report on the developments and performance related to Infection Prevention and Control (IPC) during 2020/21 and the broad plan of work for 2021/22 to support reducing the risk of healthcare associated infections (HCAIs). The report outlines the challenges faced in the year 2020/21 and the Trust's approach to reducing the risk of HCAI.

A zero-tolerance approach continues to be taken by the Trust towards all avoidable HCAIs. Good IPC practice is essential to ensure that people who use the Trust services receive safe and effective care. Effective IPC practices must be part of everyday practice and be applied consistently by everyone. The publication of the IPC Annual Report is a requirement to demonstrate good governance and public accountability.

The report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving both the quality of patient care and stakeholders experience as well as helping to reduce the risk of infection. Additionally, the Trust continues to work collaboratively with a number of outside agencies as part of its IPC and governance arrangements in particular NHS Nene & NHS Corby Clinical Commissioning Groups, NHS England / Improvement (NHSE/I) and Public Health England (PHE).

2 Executive Summary

The annual report for Infection Prevention and Control outlines the Trust's performance for the prevention and control of infections in 2020/21. In addition, it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC), the Associate Director of Infection Prevention and Control (ADIPC) and the Infection Prevention and Control Team (IPCT).

The structure and headings of the report follow the ten criteria outlined in the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance (DH, 2015).

2.1 Reportable Infections

The six infections that are now mandatory for reporting purposes are listed below:

- Meticillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infections
- *Clostridioides difficile* infections
- Meticillin Sensitive *Staphylococcus aureus* (MSSA), *Staphylococcus schweitzieri* and *Staphylococcus argenteus* bloodstream infections
- *Escherichia coli* (*E. coli*) bloodstream infections
- *Klebsiella* species bloodstream infections
- *Pseudomonas aeruginosa* bloodstream infections

MRSA bloodstream infections and *Clostridioides difficile* infections are national contractual reduction objectives and there has been a continued focus on reducing both of these infection rates, but also on the reduction of MSSA and *E.coli* bloodstream infections.

2.2 Director of Infection Prevention Control Reports to the Board of Directors

The Director of Infection Prevention & Control (DIPC) delivers an Annual Report to the Board of Directors.

The Executive Team receive updates on patients with *Clostridioides difficile* infections and MRSA bacteraemia, exception only.

The Board of Directors receive:

- Director of Nursing Board Reports on IPC exceptions (monthly)
- IPC Clinical Quality and Effectiveness Group (CQEG) Report (quarterly)
- Quality Governance Committee (quarterly)

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

3 Governance and Monitoring

3.1 IPC Governance

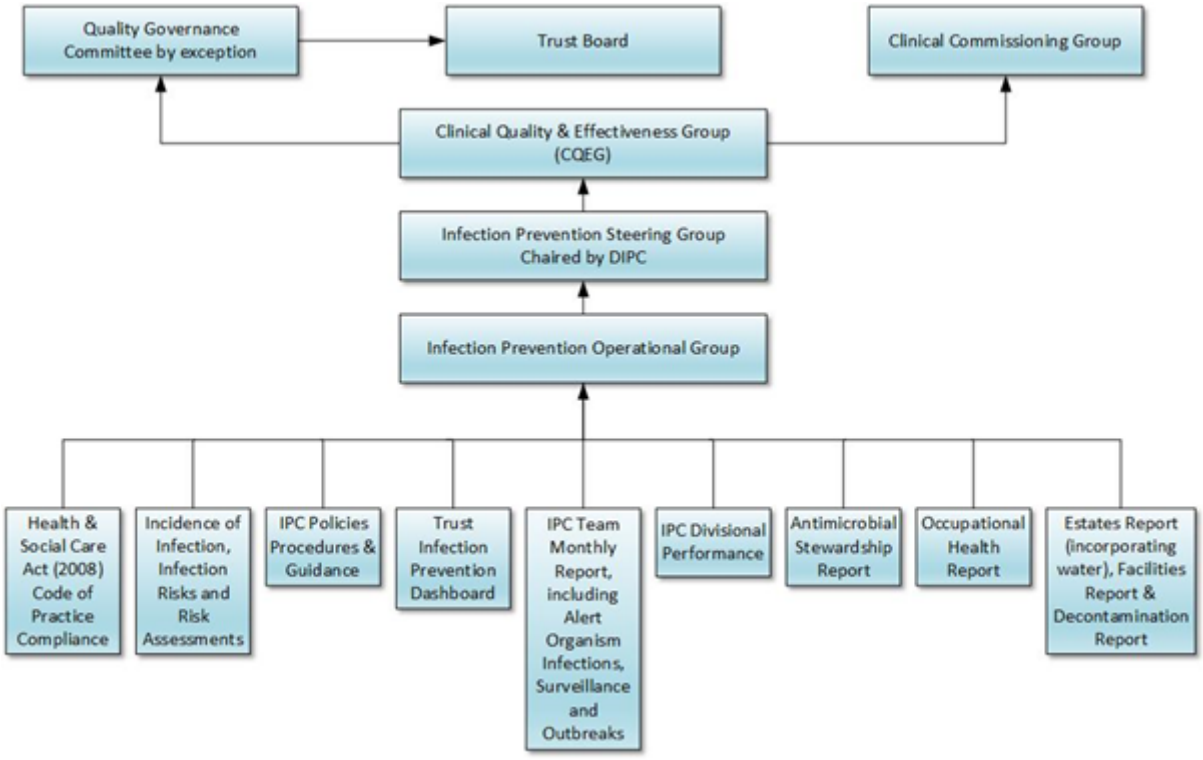
The Board of Directors has collective responsibility for keeping to a minimum the risk of infection and recognises its responsibility for overseeing IPC arrangements in the Trust.

The Trust Director of Infection Prevention and Control (DIPC) role is incorporated into the role of the Director of Nursing, Midwifery & Patient Services.

The DIPC is supported by the Medical Director, Consultant Microbiologist, Director of Estates and Facilities, the Matron for Infection Prevention & Control and the Trust Antimicrobial Pharmacist.

The Infection Prevention and Control Team (IPCT) include microbiology, virology, wound surveillance, and epidemiology. The IPCT works with pharmacy, facilities, associate directors of nursing, divisional directors, divisional managers, divisional matrons, ward managers, infection prevention and control link staff and sterile services.

Infection Prevention Steering Group Structure



Due to the SARS-CoV-2 pandemic in 2020/21 the Infection Prevention Steering Group (IPSG) and the Infection Prevention Operational Group (IPOG) did not meet on a monthly basis as planned, yet 8 of 12 meetings were held for both meetings and the IPC aanula plan of work was delivered successfully.

The IPSG provides assurance that a zero-tolerance approach to avoidable HCAIs is delivered. The purpose of the IPSG is to provide strategic direction for the prevention and control of HCAIs within the Trust that minimises the risk to patients, staff and visitors. The DIPC provides a quarterly IPC report to CQEG from IPSG and IPC. The DIPC also provides a quarterly report to the Quality Governance Committee (QGC).

The purpose of the IPOG is to ensure that there is a managed environment within Northampton General Hospital (NGH) NHS Trust that minimises the risk of infection to patients, staff and visitors. The group is responsible for providing IPC advice at an operational level and makes recommendations to the IPSG and divisions. The Decontamination Lead and the Estates and Facilities Teams report to the IPOG.

3.2 Quality Governance Committee

The Quality Governance Committee is a sub-committee of the Trust Board and reviews areas of concern and improvement arising from the IPSG.

3.3 Links to Clinical Governance and Patient Safety

The DIPC reports the Trust IPC position to CQEG on a quarterly basis. Learning from Post Infection Reviews (PIR) for MRSA bacteraemia and *Clostridioides difficile* infections are discussed at IPOG and emergent themes and learning are shared at IPSG and at CQEG.

3.4 Clinical Commissioning Group monitoring

NHS Nene & Corby Clinical Commissioning Group (CCG) is NGH's commissioning organisation. IPC is a key element of quality commissioning and forms part of a joint commissioning quality schedule. The IPCT prepare an assurance report every month for the CCG to monitor the Trust's rate of infection.

The CCGs participate in the post infection reviews for all patients who develop MRSA bacteraemia in line with the NHS England guidelines for the management of cases. They also oversee the cases of CDI, reviewing all cases and attributing any lapses in care.

3.5 Northamptonshire Health Economy HCAI Group

The IPCT are active members of the local whole health economy HCAI group. This group is in existence to drive forward the Northamptonshire approach to infection prevention and control working together to ensure the quality of patient experience throughout the county is of equally good quality.

3.6 Infection Prevention & Control Standards and Assurance

In 2020/21 the Trust declared full compliance with the Care Quality Commission, Section 20 regulation of the Health and Social Care Act (2008) Outcome 8 Cleanliness and Infection Control. This declaration was made with due regard to regulation 12 of the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The Trust undertakes interventions in relation to infection prevention and control as detailed within the HCAI plan of work 2020/21 (Appendix 4). This work is led by the Director of Infection Prevention and Control and supported by the Consultant Microbiologist & Infection Control Doctor, Medical Director and Matron for Infection Prevention and Control.

The IPCT continues to report numbers of MRSA/CDI to the Executive Team and to the Trust Board on a monthly basis and this is directly referenced in the Corporate Risk Register and Board Assurance Framework.

4 Healthcare Associated Infection Statistics and Targets

4.1 Surveillance

The Infection Prevention & Control Team (IPCT) undertakes continuous surveillance of alert organisms and alert conditions. Patients with pathogenic organisms or specific infections, which could spread, are identified from microbiology reports or from notifications by ward staff. The IPCT advises on the appropriate use of infection control precautions for each case and monitors overall trends.

4.2 Alert Organisms[1]

- MRSA
- *Clostridioides difficile*
- Group A *Streptococcus*
- *Salmonella* spp
- *Campylobacter* spp
- *Mycobacterium tuberculosis*
- Glycopeptide resistant *Enterococci*
- Multi - resistant Gram-negative bacilli e.g. extended spectrum beta-lactamase (ESBL) producers
- Carbapenemase-producing Enterobacterales (CPE)
- Influenza
- SARS-CoV-2
- *Neisseria meningitidis*
- Aspergillus
- Hepatitis A
- Hepatitis B
- Hepatitis C
- HIV

4.3 Alert Conditions

- Scabies
- Chickenpox and shingles
- Two or more possibly related cases of acute infection e.g. gastroenteritis
- Surgical site infections

4.4 Current Actions to Improve Surveillance

On a weekly basis, a ward round of all patients with CDI within the Trust is undertaken by a senior member of the IPCT and the antimicrobial pharmacist. Any concerns are raised with the Consultant microbiologist and the Consultant gastroenterologist. In 2020/21 there were weekly antimicrobial reviews of wards with the antimicrobial pharmacist and virtual meetings with the Consultant microbiologist.

4.5 Identified Priorities for 2020/21

In 2020/21, the Trust's HCAI Reduction Delivery Plan set out to:

- Reduce the number of patients with CDI and achieve the national targets and the Trusts' Quality Account
- Maintain the number of MRSA bacteraemia to achieve the national targets
- Reduce the number of patients with MSSA bacteraemia

[1] Alert organisms are organisms identified as important due to the potential seriousness of the infection they cause, antibiotic resistance or other public health concerns. This is a nationally recognised term; these organisms may be part of mandatory or voluntary surveillance systems and are used as indicators of general infection prevention and control performance.

- Support the Whole Health Economy to reduce the number of patients with *E.coli* bacteraemia

The IPCT have spent the majority of 2020/21 focusing on the SARS-CoV-2, but still managed to achieve a reduction of patients with CDI and MSSA bacteraemia.

4.6 *Staphylococcus aureus* Bacteraemia

All Staphylococcus aureus bacteraemia – sensitive to Methicillin (MSSA) or resistant to Methicillin (MRSA) – are reported on a mandatory basis through the Public Health England (PHE) HCAI Data Capture System. The Trust's incidence of MSSA and MRSA cases are reported on the PHE website. The incidence of these cases is reported publicly as acute Trust apportioned or otherwise.

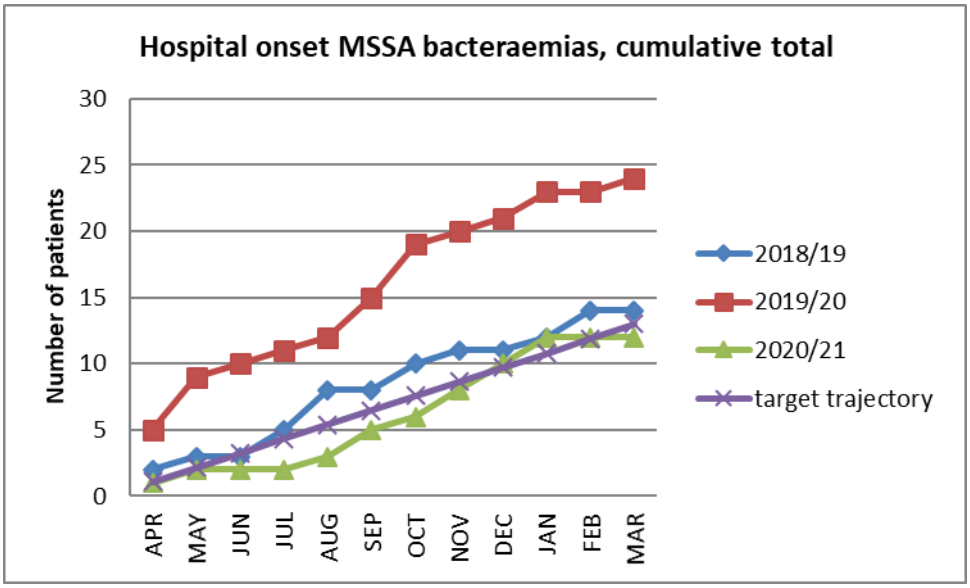
The reduction of all avoidable bloodstream infections including MSSA and MRSA continues to be an aim of the Trust.

4.7 MSSA Bacteraemia

For reporting purposes, cases are apportioned to the Trust as per MRSA bloodstream infections but there are currently no national targets. NGH Trust had set an internal ceiling of 13 hospital onset cases. During 2020/21 the trust came under this trajectory with 12 hospital onset MSSA bloodstream infections, which is a decrease from 2019/20 there were 24 hospital onset MSSA bacteraemia.

A vascular access group has been set up to review practice with invasive vascular devices, this met first in February 2020 and has met 4 times subsequently in 2020/21. The key aims are to review current policies, practice and documentation, and identify and disseminate learning from patients that develop vascular access device related infections. This gruop will continue in 2021/22.

Figure 1: hospital onset MSSA bacteraemia for the past 3 years



4.8 MRSA Bacteraemia

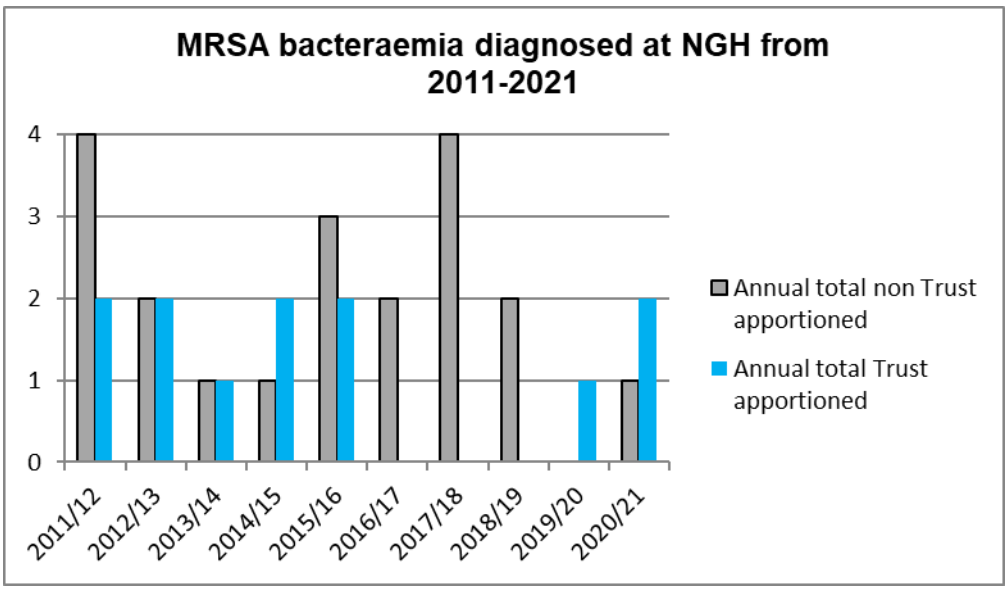
The HCAI objective for MRSA bloodstream infections for 2020/21 was 0 avoidable MRSA bacteraemia cases.

The Trust investigates every MRSA bacteraemia as an incident and undertakes a post infection review (PIR). These investigations are fed back to a multi-disciplinary group including the DIPC and members of the Clinical Commissioning Group (CCG) and are accompanied by an action plan. These actions are monitored through the IPCT.

Cases are defined as community onset if blood cultures are collected on the day of admission or the day after; all other cases are apportioned to the Trust and named as hospital onset. It is the hospital onset cases that are included as part of the national HCAI reduction targets.

During 2020/21 there were 2 hospital-onset MRSA bloodstream infections, which is an increase from 1 MRSA bloodstream infections in 2019/20. The first bacteraemia was from a patient who had a previous history of MRSA. The patient had intravenous cannula and a urinary catheter. The second case was from a patient who also had a previous history of MRSA, intravenous cannula and a urinary catheter, and who was non-compliant with treatment. Subsequently, the IPC team have reviewed the MRSA Policy to increase topical decolonisation treatment, which aims to reduce the risk of future MRSA bacteraemia for other patients.

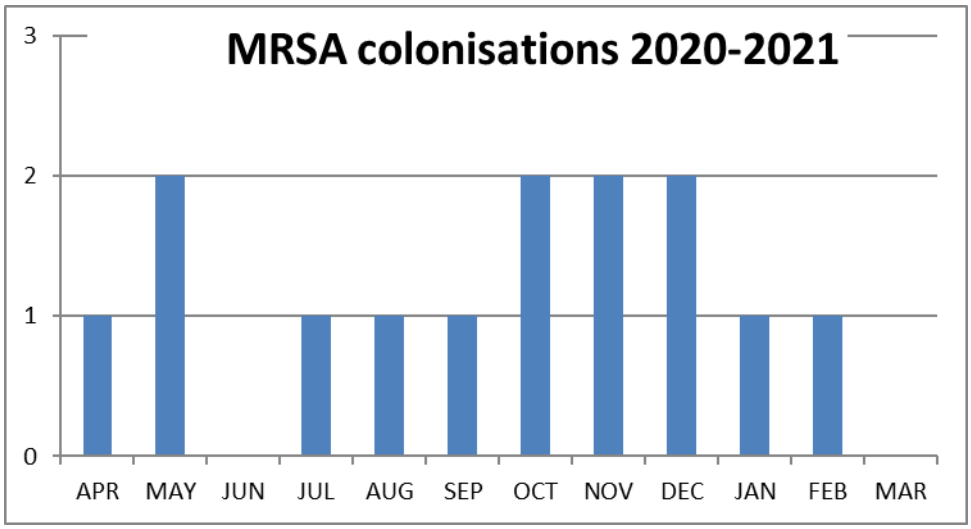
Figure 2: MRSA bacteraemia cases from 2011-2021 classified as either Community onset or hospital onset.



4.9 MRSA Colonisations

In 2020/21 there were 14 HCAI cases of MRSA colonisation, this was a decrease from 18 in 2019/20.

Figure 3: Monthly cases of MRSA colonisations attributed to the Trust during 2020/21



4.10 Period of Increased Incidence of MRSA Colonisation

A Period of Increased Incidence (PII) of MRSA colonisation is defined by Public Health England as 2 or more new cases of post admission MRSA colonisation on a ward in a 28-day period. Post admission is defined as any MRSA swab dated over 48 hours after admission.

The IPCT identified a range of actions which were implemented on any ward that had 2 or more new cases in a 28-day period. For 2020/21 there was 1 PII of MRSA colonisation on Cedar ward. A PII meeting was held and local learning was identified around screening and decolonisation that was implemented into practice.

4.11 MRSA Screening by Patient Group

In line with the Department of Health 'MRSA Screening - Operational Guidance 2' the following patient groups are screened as indicated below in Table 1.

Figure 4: MRSA Screening Criteria

Patient group / Admitted to	Screening
Elective admissions as described in DH letter and operational guidance (excludes same day case patients)	Time of listing Eradication of MRSA attempted before admission
Critical Care patients	On admission to Critical Care and then weekly
Renal dialysis patients	On admission and on a weekly basis
Cardiology patients	On admission and on a weekly basis
Surgical patients	On admission and on a weekly basis
All other patients including emergency admissions	On admission

In 2020/21 most elective surgery was either postponed or conducted in 3 Shires Hospital. MRSA screening had been more difficult to achieve due to patients having virtual appointments with Covid-19 restrictions on social distancing requiring patients to be swabbed by different departments, not just be the Pre-operative team as was practice prior to Covid-19.

The Trust achieved compliance with the requirements for all elective patients to be screened for MRSA colonisation, under the reporting methodology advocated by the Department of Health. The overall MRSA screening compliance for the year for elective patients was 95.96% (99.51% previous year) and 96.90% (96.74% previous year) for non-elective patients. Efforts continue to achieve greater compliance.

4.12 *Clostridioides difficile* infection (CDI)

Since January 2004 it has been a mandatory surveillance requirement for the Trust to report cases of *Clostridioides difficile* toxin A&B positive stool (previously known as *Clostridium difficile)*.

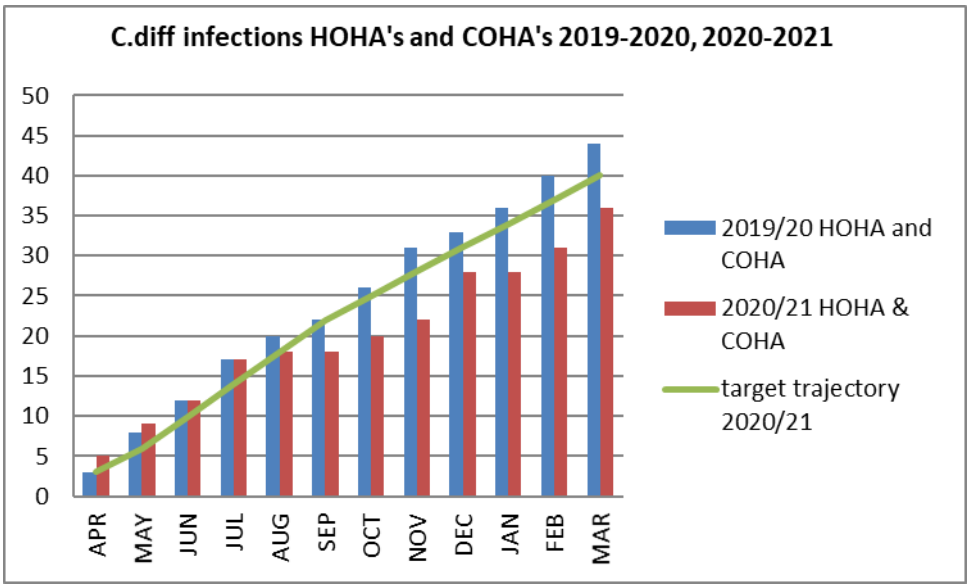
NHS England and NHS Improvement set new changes to *C. diff* infection (CDI) reporting and acute provider objectives for 2019/20 were set using two categories.

- Hospital onset healthcare associated: cases that are detected in the hospital two or more days after admission.
- Community onset healthcare associated: cases that occur in the community (or within two day of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

It is the Trust-apportioned cases (HOHA and COHA) that are included as part of the national HCAI reduction targets and the Trust's quality goal. The HCAI national objective set for NGH Trust apportioned

patient cases was set at 40 for 2019/2020. This was not reviewed for 2020/21 therefore an internal trajectory was set at 40 which was met with 28 HOHA and 8 COHA.

Figure 5: C.diff HOHAs and COHAs



All CDI cases have been investigated by the clinical teams, the IPCT, the Consultant Microbiologist and the Antimicrobial Pharmacist utilising a Post Infection Review (PIR) process. Wards that have had Trust attributable CDI are asked to feedback their findings from the PIR process at the monthly IPOG meeting, where their learning can be shared with members of the group. Findings from the PIR are also presented through IPSG and CQEG.

Of the patient cases, 28 were HOHA and 8 were COHA. The Clinical Commissioning Group (CCG) reviews all Trust attributable CDI PIRs. In March 2020 the CCG temporarily suspended the need for the Trust to send these PIRs to the CCG due to an increase in work as a result of the SAR-CoV-2 pandemic. The Infection Prevention and Control team are continuing to complete these post case reviews individually and continue to report to IPOG, IPSG, CQEG and Governance groups.

4.13 Actions completed in 2020/21 to reduce the risk of CDI

- Octenilin irrigation solution is being used Trust wide to manage chronic wounds that are colonised or infected with pathogens, to reduce the use of antibiotics for this wounds.
- On a weekly basis, a ward round of all patients with CDI within the Trust is undertaken a senior member of the IPCT and the antimicrobial pharmacist. Any concerns are raised with the Consultant Microbiologist and the Consultant Gastroenterologist and actioned appropriately.
- Enhance cleaning sign offs have continued; following a patient developing CDI the enhanced touchpoint cleaning procedure continues to be implemented and is now signed off by the ward Sister and Domestic manager upon completion.
- Estates, Domestic and Infection Prevention (EDI) reviews continue when a ward has a patient who has developed CDI to produce a thorough and a collaborative inspection of the ward from an IPC, cleanliness and environmental perspective.

4.14 Trust Apportioned CDI 2020/21

Table 2 presents the Trust apportioned cases of CDI for other Trusts within the locality of NGH to provide a benchmark for comparison against the Trust.

Figure 6: Trust Apportioned CDI for 4 Trusts

2019/20	Ceiling	Actual	Deviation
Northampton General Hospital	**40**	**36**	**-10%**
Kettering General Hospital	39	69	+44%
University Hospital Coventry and Warwick	60	107	+44%
Worcester Acute Hospital	53	128	+59%

4.15 Antimicrobial Resistance: ESBL Producers (Extended Spectrum Beta-Lactamase Producers)

ESBLs are a group of enzymes produced by bacteria. The enzymes break down antibiotics such as cephalosporins and penicillins, but the bacteria are usually susceptible to, and hence treatable with, the carbapenem antibiotics.

The epidemiology of these bacteria is not fully understood. The emergent nature of this field of microbiology is underlined by the absence of any national case definitions for community or hospital-acquired infections with ESBL producers, or recommendations on what constitutes an episode of infection with ESBL producing bacteria. In house surveillance within the microbiology department is no longer performed. It is reported in real time through an electronic system to Public Health England (PHE).

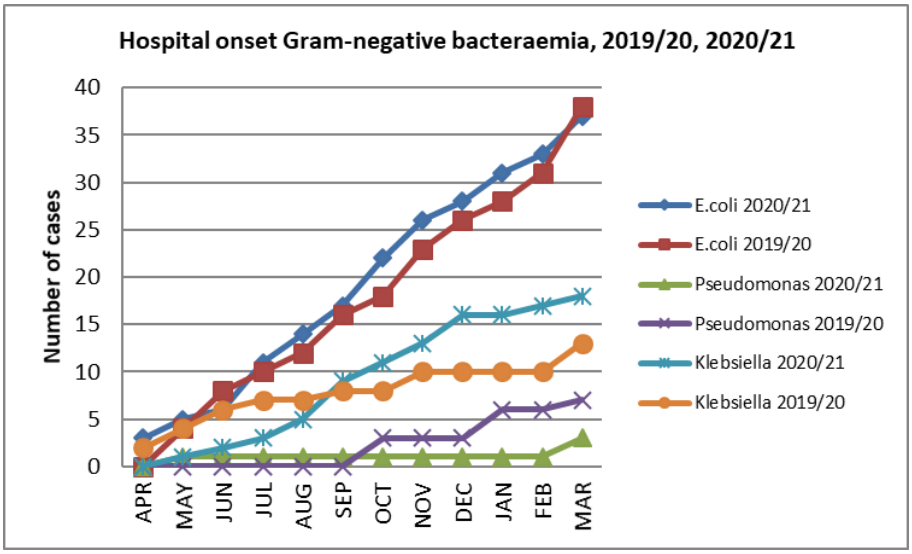
29 inpatients were identified with ESBLs or as AMP C producing organisms in 2020/21, which is a slight reduction from 34 in 2019/20. These are not classified as Trust acquired, but are identified in samples taken during admission.

4.16 Gram-Negative Bacteraemia

Hospital onset Gram negative bacteraemia: *Escherichia coli* (*E.coli) Klebsiella and Pseudomonas aeruginosa.*

For 2020/21 the IPCT has continued to follow the Gram-negative bacteraemia forward plan which includes work streams to reduce the risk of *E.coli* and the other Gram-negative bacteraemia. This has been reviewed and now is incorporated into the IPC forward plan as many elements were duplicated. This will be monitored quarterly through IPSG. The IPCT will also continue to work with the Whole Health Economy (WHE) and combine efforts to protect patients from Gram-negative bacteraemia. Standard contracts will be set in 2021/22 for these organisms to encourage further reductions nationally.

Figure 7: Hospital onset Gram-negative bacteraemia



4.17 *Escherichia coli* Bacteraemia

For reporting purposes, cases are apportioned to the Trust as per MRSA bloodstream infections. There are no standard contracts or external ceilings set for E.coli in 2020/21 but will be in 2021/22.

In 2020/21 37 patients acquired an E.coli bacteraemia, this is a reduction of 1 from 2019-20 when the number was 38.

The causes of the bacteraemia include 6 intra-abdominal, 7 hepatobiliary, 0 line associated, 15 urinary, 2 lower respiratory tract infection, 1 skin and soft tissue and 5 infections of unknown origin.

4.18 *Klebsiella* Species Bacteraemia

These Gram-negative bloodstream infections have been required to be reported to PHE from April 2017. For reporting purposes, cases are apportioned to the Trust as per MRSA bloodstream infections but there are currently no national ceilings. During 2020/21 there were 18 Trust apportioned Klebsiella species bloodstream infections which was an increase of 5 from 2019/20. The causes of these were 2 intravascular device related, 1 line related, 2 intraabdominal, 1 hepatobiliary, 1 biliary sepsis, 4 lower respiratory tract, 1 lower urinary tract infection and 6 of unknown causes.

4.19 *Pseudomonas aeruginosa* blood stream infections

From April 2017 Gram-negative bloodstream infections surveillance has been commenced by the IPCT (*Klebsiella* species and *Pseudomonas aeruginosa)*, which is also reported onto the PHE Data Capture System. This will enable PHE to identify trends at the end of the year which will then support Trusts to better understand these infections and also inform IPC practice to reduce the incidence of these bloodstream infections further. There are currently no national targets for these organisms.

In 2020/21 there were 3 Trust apportioned *Pseudomonas aeruginosa* bloodstream infections, 1 caused by an upper urinary tract infection, 1 by a lower respiratory tract infection and 1 of unknown cause. This is a reduction of 57% as there were 7 cases in 2019/20.

4.20 Antimicrobial Resistance: Carbapenemase Producing Enterobacteriales (formerly Carbapenemase Producing Enterobacteriaceae) (CPE)

CPE have similarities to ESBLs but with a wider range of effects on antibiotics – breaking down the carbapenem group of antibiotics.

In 2014/15 the DH issued guidance in the form of a toolkit and this predominantly concentrated on prevention: isolation of high-risk individuals and screening being of particular importance. Focus has been given to patients who have been an in-patient abroad in the past 12 months**.** In response to this, the IPCT collaborated with other local Trusts' and utilising the CPE toolkit has developed the following:

- A Trust wide CPE Procedural Document
- A Patient Information Leaflet
- A Staff Information leaflet
- A Training package on CPE
- A CPE surveillance sheet
- A flowchart and "how to" screen patients who are suspected to have CPE

Training on CPE is given in the IPC mandatory training sessions and workbooks for clinical staff.

In 2020/21 the IPCT continued to monitor the number of CPE screens obtained and report positive cases to IPSG. The IPCT perform daily surveillance on these patients during their hospital admission, and continue to collaborate with the Site Management Team to identify patients that require CPE screening on admission or repatriation from high risk countries and hospitals. The IPCT also work in collaboration with the domestic and catering team to ensure that both teams are fully aware of the side room location of these

patients, to ensure that the appropriate cleaning and catering facilities are available. The IPCT continue to work with the Pre-Operative Assessment Clinic to identify possible cases prior to admission as detailed in the HCAI forward plan.

In February 2020 a CPE outbreak was declared in the Critical Care unit. It started in Main theatres recovery, an area that was being used at the time to accommodate additional critical care patients as the regional Critical Care network needed to increase the capacity of Critical Care beds at the height of the second wave of Covid-19. In total 9 patients were identified as positive, it was not possible to identify the index case, but it is most likely to be one of two patients who were patriated from other hospitals in the region. This outbreak has been reported to the Review of Harm Group (RoHG) and a serious incident investigation report and action plan completed and delivered. The three key actions and learning that the Outbreak Control Group implemented were:

1. Change in PPE practice to be bare below the elbows in cohort AGP bays, with gloves and apron added on top for episodes of care in the bed space and effective hand hygiene to the elbow. This has been embedded in Critical Care and also disseminated to the other AGP COVID areas within the Trust.
2. Removal of proning gel pads that were not it for purpose or cleanable. New cleanable gel pads were utilised
3. Revision of CPE screening process to include screening of all admissions to the unit commenced immediately and was monitored weekly by the IPC Team while it embedded into daily practice. The Trust wide CPE Procedure has been revised and achieved ratification at the Procedural Document Group in August 2021.

4.21 Influenza ('flu)

No patients were identified with flu between 2020/21, which reflected the epidemiological picture both within the East Midlands and nationally.

4.22 SARS-CoV-2 (COVID-19)

On 11th March 2020 the World Health Organization declared a pandemic of COVID-19, a disease primarily affecting the respiratory system and caused by a new coronavirus known as SARS-CoV-2. To manage the pandemic the Trust instigated a major incident response to proactively manage the operational functions of the organisation. The management of Infection Prevention was central to this work and the IPC team reported on a daily basis to the Trust through the designated communication channels to the Executive team.

In May 2020 NHS England published an IPC COVID Board Assurance Framework (BAF) to enable NHS Trusts to any identify additional IPC measures required to deal with COVID-19 and reduce spread of the disease within hospitals. This was a detailed document containing 50 recommendations. The IPC team worked with Governance to liaise with multiple teams across the Trust in order to benchmark against the BAF and then to implement changes. Ongoing monitoring of the Trust's progress in meeting the IPC BAF recommendation is monitored through the Infection Prevention Steering Group monthly and reported to Quality Governance Committee quarterly.

28 new key lines of enquiry were added to the IPC BAF on 12th February 2021. These include the Chief Executive, Medical Director or Director of Nursing having daily sign off of the COVID sit rep, monitoring of patients wearing masks, written protocol and compliance monitoring for patient testing, and staff maintaining social distancing when travelling to work. The IPC Team continually update the BAF action plan to reflect any gaps and actions to implement these additional key lines of enquiry.

Areas where further work has been identified as being necessary are as follows:

PPE training

The BAF requirement is that all staff are trained in the correct use of PPE, so that they know when to use it and how to put it on and take it off safely. Although all of the types of PPE being used (masks, eye

protection, gloves and aprons) were already in use, so most staff would be familiar with them, the frequent and prolonged use required in a pandemic is very different from normal working.

Therefore the IPC team spent a lot of time at the start of the pandemic speaking to clinical staff and explaining the changes in when to use PPE, however much of this work was not formally recorded as training and so there is a need to gain assurance that staff have the correct knowledge. The IPC team have trained PPE-trainers in most departments where there are patient-facing staff, so that each department can take ownership for ensuring their staff are trained. The IPC Team have worked with Learning & Development to build a central register of PPE training compliance and by March 2021 84.33% of staff have received this training. It will remain amber on the IPC COVID BAF action plan until 85% compliance is achieved.

Cleaning

The IPC BAF recommended two key changes in the cleaning of the hospital environment:

- Twice-daily cleaning with a chlorine containing cleaning agent in high contaminations areas (e.g. red and yellow zones, PPE donning/doffing rooms)
- Twice-daily cleaning of frequent touchpoints in all areas

Implementing these changes has necessitated additional recruitment into the domestic team, in addition to their existing vacancies. Significant progress has been made on this and the BAF requirements have been implemented in all wards from Monday –Friday, but only to 75% of wards at weekends. For this reason, at the end of the year this element of the IPC BAF is now RAG-rated at amber and remains on the IPC COVID BAF action plan until fully compliant.

4.23 Incidence of COVID-19 in the Trust

The first patient identified with COVID-19 in the Trust was on March 13th 2020.

COVID acquisition is reported to NHS England as follows:

0-2 days	Community acquired
3-7 days	Indeterminate
8-14 days	Hospital-onset probable healthcare-associated (HOPHA)
15 + days	Hospital-onset definite healthcare-associated (HODHA)

The latter two categories (HOPHA and HODHA) are considered to be nosocomial infections and are investigated as such, with a Datix report being submitted and a root-cause analysis being completed.

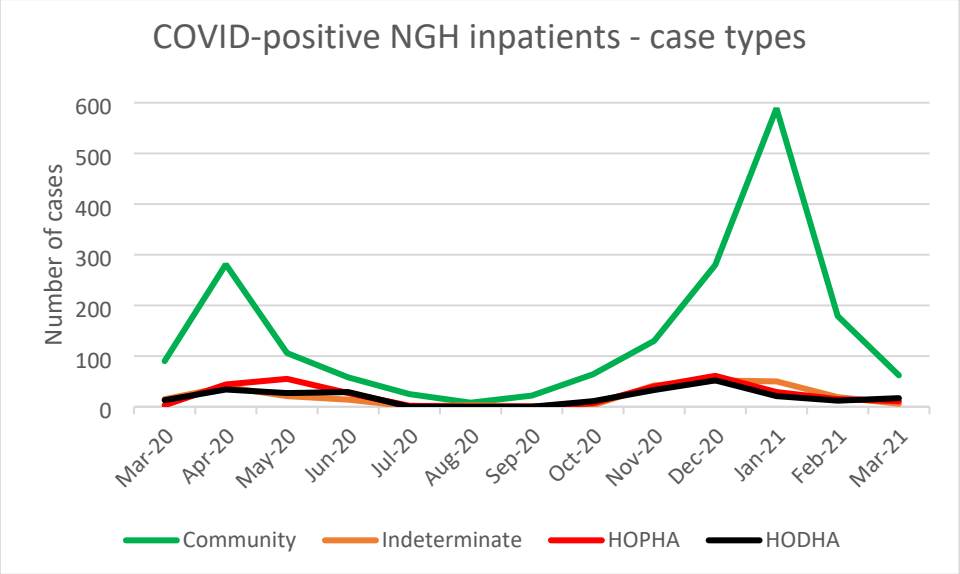
Between April 1st 2020-April 1st 2021, 2584 patients had been admitted with COVID-19 or had acquired it whilst an inpatient. 236 of these were identified as HODHA, 293 as HOPHA, 251 as indeterminate and 1804 as community acquired.

Figure 8 shows the numbers of patients falling into each category per month. This information is also portrayed in Figure 9. Figure 9 shows the contribution of HOPHA and HODHA cases to the overall nosocomial rate each month.

Figure 8: Covid positive NGH inpatients

Months:	Community	Indeterminate	HOPHA	HODHA	Total
Apr	281	39	44	34	398
May	106	21	55	27	209
Jun	58	14	27	29	128
Jul	25	1	2	0	28
Aug	8	3	0	0	11
Sep	22	1	0	0	23
Oct	64	3	7	11	85
Nov	130	42	40	33	245
Dec	280	52	61	52	445
Jan	589	50	29	21	689
Feb	179	19	15	12	225
Mar	62	6	13	17	98
Totals:	**1804**	**251**	**293**	**236**	**2584**

Figure 9: Covid positive NGH inpatients



Outbreaks of Covid-19 are defined as 2 or more cases in 1 area (e.g. ward, bay or department) at a period of time. 11 outbreaks were declared in staff with no patient involvement. 37 outbreaks were declared in clinical areas involving either patients only, or both patients and staff.

The Trust implemented a multitude of measures to protect patients from Coivd-19 as the pandemic progressed to reduce the risk of onward transmission to other patients and staff. These included erecting bay doors in some wards, implementing a Hospital Zoning Policy, streaming patients on the appropriate pathway on admission, implementing enhanced cleaning of the patient environment and patient equipment, creating physical barriers between patients, implementing sessional use of face masks, delivering PPE training to clinical staff, social distancing measures, reinforcing effective hand hygiene, robust admission screening for COVID-19 and actively encouraging staff Lateral Flow Device testing and vaccination uptake. Therefore COVID-19 continues to form the majority of the IPC team's work. The IPC team have also:

- Held daily meetings with the Consultant Microbiologist and Director of IPC in Bronze meetings, which have fed into daily Silver meetings with the aim to promote patient safety and prevent outbreaks.

- Worked with a variety of teams across the Trust to provide evidence for assurance that the Trust is meeting the recommendations of NHS England's *IPC Board Assurance Framework* and to identify those areas where further work is required.

- Further rolled out the "train the trainer" model for PPE training in clinical teams, alongside participating in the scheduled PPE training session organised by Practice Development.

- Continued to liaise with the Information Technology team as to whether technological solutions can assist in the management of COVID-19 and other infections

- Met thrice-daily with the Head of Capacity, Deputy Operating Officer and Deputy Director of Nursing to proactively manage capacity in the different zones.

- Conducted PPE audits twice-monthly in all wards and daily in active outbreak wards or whenever concerns are identified, alongside hand hygiene, social distancing and environmental cleanliness audits.

- Worked closely with Directorate Matrons to monitor IPC standards in their wards and to support efforts to drive improvements. This has included providing IPC support for the inspections against the Assessment & Accreditation Standard 5 assessment tool.

- Implemented the use of clear plastic curtains which divide the bed spaces promoting enhanced social distancing for patients. As SOP has been made to identify where these curtains can be used and the cleaning frequencies of them.

Lateral flow and Point of Care testing

- Lateral flow testing has been used by clinical staff since November 2020 for all staff from March 2021. This is reported nationally by the information team and staff across the Trust are actively encouraged to complete this twice a week.

- Point of care PCR testing was launched in the Emergency Department in February 2021 and is now being used for all patients being admitted to the Trust. This has had a positive impact as patients then go onto the correct pathway at the earliest opportunity.

Challenges for 2021-22

- Procurement of the ICNET software package will continue to be progressed to resolve the IT associated issues, this will lead to a more effective and efficient IPC service and reduce the risk of infection to patients. A business case for this is now moving through various committees for approval.

4.24 Mandatory Surveillance of Surgical Site Infections

In collaboration with the Trauma and Orthopaedic Directorate and the Surgical Division, the IPCT usually undertake four or five different categories of Surgical Site Infection (SSI) surveillance each quarter. Total hip replacement, total knee replacement and repair of fractured neck of femur surgeries are surveyed every quarter. The IPCT conduct further surveillance on one or two additional categories of operation every quarter that survey patients undergoing general, vascular, obstetrics and gynaecology surgeries.
All data for a surveillance period must be submitted within 90 days of the end of the quarter to PHE who collate and report on the data from all hospitals that have participated. The IPCT report SSI rates to IPSG quarterly for monitoring and assurance purposes.
However due to the COVID-19 pandemic and reduced elective activity at the Trust, surveillance of surgical procedures was not completed in Q1 and Q4 2020/21.

4.25 SSI Surveillance Conducted by the IPCT

During 2020/21 the IPCT conducted quarterly SSI surveillance on a variety of operations as presented in Table 3:

Figure 10: SSI Surveillance by Quarter 2020/21

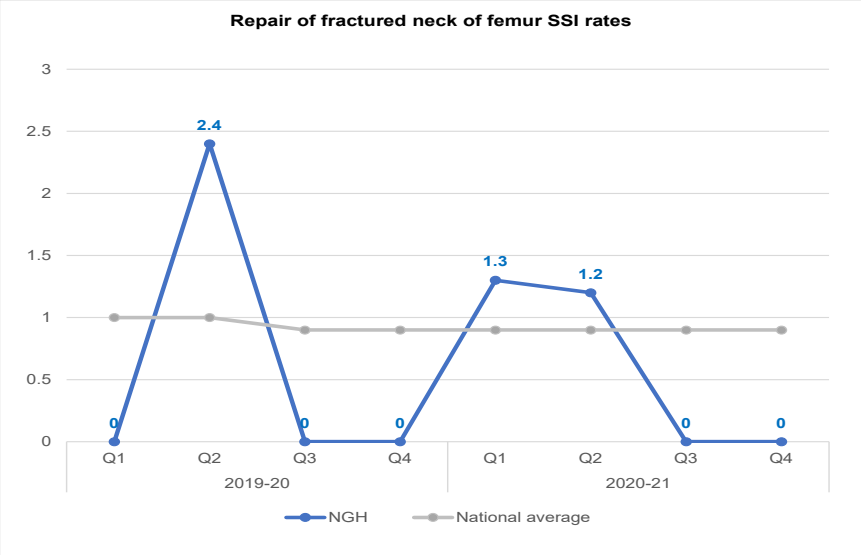
Quarter	Category	Number of operations undertaken at NGH	NGH SSI rate	National average SSI rate
2	Breast surgery	54	0%	0.6%
3	Breast Surgery	37	0%	0.6%
3	Caesarean sections	376	2.1%	3.3%

Within Quarter 3 376 caesarean sections were performed, 8 of which developed a superficial infection. 2 of the patients were reported as an SSI on readmission and 6 of the patients were reported by their Midwife post discharge. The micro-organisms identified were Coliforms, *Enterococci* and *Staphylococcus aureus*. This equates to 2.1% which is below the national average of 3.3%.

SSI Surveillance Conducted by the Trauma and Orthopaedic Directorate

Figure 11 presents the quarterly SSI rate for the 325 patients that underwent repair of fractured neck of femur surgery in 2020/21.

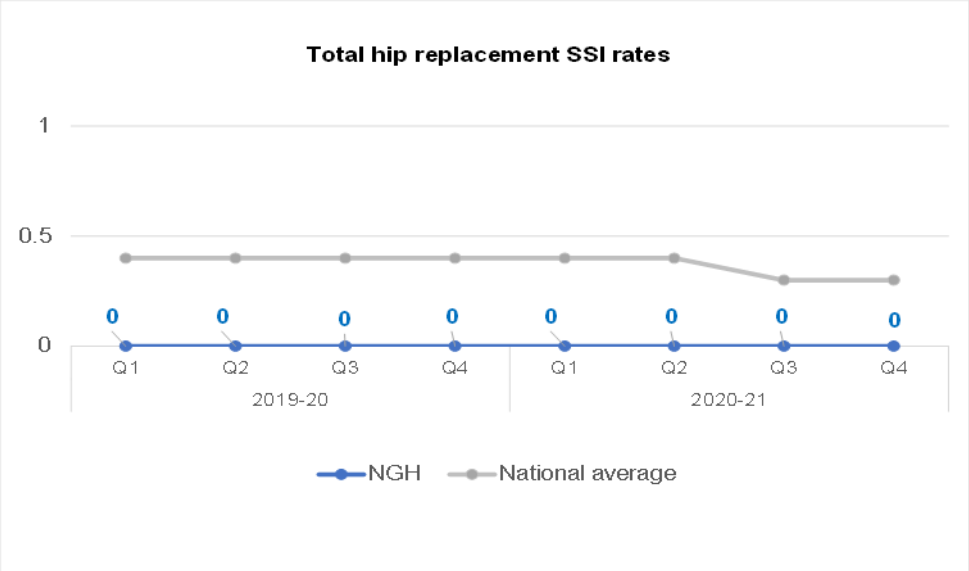
Figure 11



Following rates of SSI that were higher than the national average at the start of the year, with one patient developing an SSI in Q1 and Q2, both cases were discussed in the Surgical Site Infection group which is attended by the IPCT, the Matron for Trauma & Orthopaedics, Theatres, Microbiologist, Practice Development Team and Orthopaedic Surgeon. In Q3 and Q4, 0 patients developed an SSI.

Figure 12 presents the quarterly SSI rate for 51 patients who underwent total hip replacement surgery in 2020/21.

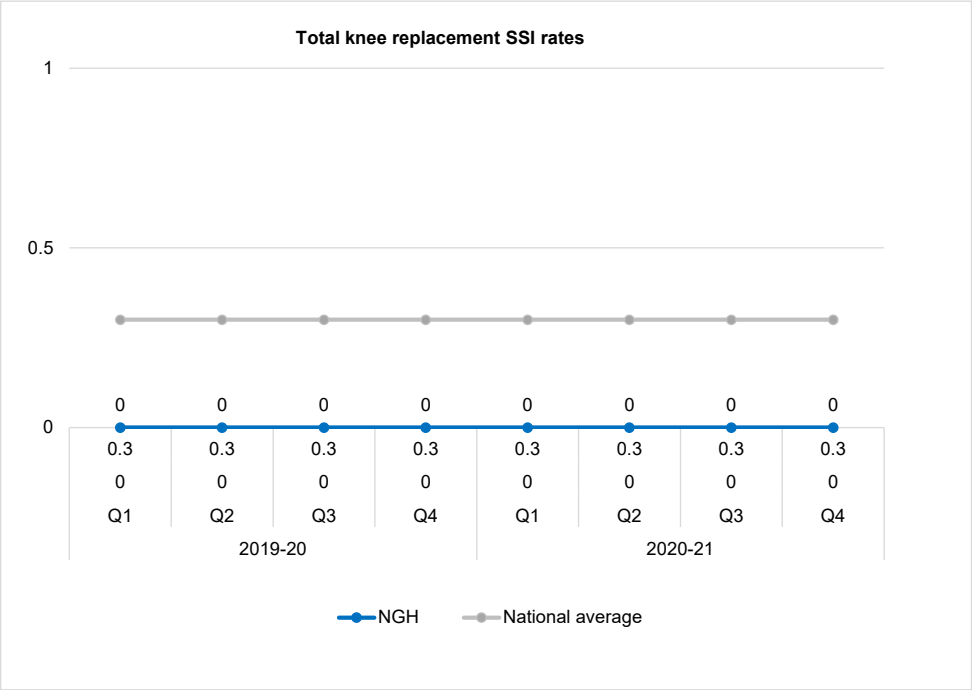
Figure 12



For total hip replacement surgeries, we had no patients develop a surgical site infection 2020/21.

Figure 13 displays the quarterly SSI rates for the 22 patients who underwent total knee replacement surgery in 2020/21.

Figure 13



For total knee replacement surgeries, surgeries, we had no patients develop a surgical site infection 2020/21. SSI surveillance continues in 2021/22 as detailed in the SSI forward plan.

4.26 Untoward Incidents and Outbreaks

	Annual audits	6 Monthly	Quarterly	Monthly Audits
Apr 2020	No audits completed due to Covid demands		FFP3 maintenance records audit One Together compliance audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste.
May 2020		Commode cleanliness audit	HHOT audit	
Jun 2020	Handling & disposal of sharps audit		Water outlet flushing audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste.
Jul 2020	Cannula-related BSI and, central-line related BSI prevalence audits.	Mouthcare audit	FFP3 maintenance records audit One Together compliance audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste.
Aug 2020			PICC line related BSI audit MSSA & MRSA decol compliance audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste.
Sept 2020	Catheter-related UTIs prevalence audit	Commode cleanliness audit	HHOT audit Water outlet flushing audit PICC line related BSI audit.	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste. PPE and Hand hygiene
Oct 2020			FFP3 maintenance records audit One Together compliance audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste. PPE and Hand hygiene
Nov 2020	Blood culture audit Risk assessment /transfer checklist audit		PICC line related BSI audit HHOT audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste. PPE and Hand hygiene
Dec 2020	Wound care plan compliance audit		Water outlet flushing audit One Together compliance audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste. PPE and Hand hygiene
Jan 2021	Hand wash basin cleanliness audit	Mouthcare audit	FFP3 maintenance records audit MSSA & MRSA decol compliance audit Water outlet flushing audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste. PPE and Hand hygiene
Feb 2021	Aseptic non-touch technique audit		PICC line related BSI audit HHOT audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste. PPE and Hand hygiene
Mar 2021	Standard precautions		MSSA & MRSA decol compliance audit Water outlet flushing audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste. PPE and Hand hygiene

Outbreaks of Covid-19 are defined as 2 or more cases in 1 area (e.g. ward, bay, or department) at a period of time. 11 outbreaks were declared in staff with no patient involvement. 37 outbreaks were declared in clinical areas involving either patients only, or both patients and staff. Outbreak Control Group was convened for each outbreak and meetings were held daily with Public Health England, NHS England/Improvement and the Clinical Commissioning Group IPC Leads and with attendance from the Ward team, Matron, IPC team, Domestics, Health and Safety and Governance.

4.27 Infection Prevention & Control Audit Plan 2020/21

The IPCT performed various audits throughout 2019/20 as illustrated in Figure 4. All audits for 2020/21 are reported at the Infection Prevention and Control Operational Group (IPOG) for discussion and actioning; and at the Infection Prevention Steering Group (IPSG) for assurance purposes

Figure 14: IPC 2020/21 Audit Plan

Compliance Criterion	What the registered provider will need to demonstrate
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

5 Environmental Cleanliness 2020/21

In 2020/21 the Trust continued to complete monthly environmental cleanliness audits using an electronic audit tool that reflects the National Specifications for Cleanliness in the NHS (NPSA, 2007) and additionally the PAS 5748 Specifications for Cleanliness (BSI, 2014). The electronic audit tool enables the Domestic Supervisor to generate an action plan which is shard with the relevant Ward Manager and Matron. All cleanliness audits scores are reported monthly to IPOG and any concerns or good practice are escalated to IPSG.

The IPCT continue to work collaboratively with the Domestics, Catering and the Estates Teams to maintain a clean and safe environment for patients.

The awaited new National Standards of Cleanliness new guidelines are expected in 2021/22. This will require Hotel Services and the Infection prevention team reviewing current criteria's of risk and perception.

Patient-Led Assessments of the Care Environment (PLACE) did not occur during 2020/21 due to the SARS-CoV-2 pandemic.

A full pest control contract is in place with fortnightly inspections site wide and proactive "call-out" procedures to deal with seasonal pests.

5.1 Sterile Services Department

The Sterile Services Department (SSD) processed 46,178 trays, procedure packs and supplementary medical devices between April 2020 and March 2021.

The department continues to provide a fully compliant service to NHFT Podiatry, GP's Clinic based in the community and a full theatre tray service to all Theatres at Northampton General Hospital.

Due to the worldwide Covid19 pandemic this has led to a decrease in the workload being seen in the department since March2020. SSD have only processed 46,178 devices which is a significant decrease based on the volumes of devices normally processed.

The reduction in workload has also allowed the Team to focus on the SSD Review Of Knowledge and specific SSD training and our staff are 98.37% compliant with their SSD specific related competencies.

Our staff have supported various other Departments and services during the initial Team NGH response to Covid-19 with staff assisting:

- Operating Theatres with additional storage racks for medical devices given the current Theatre displacement across site.
- The Portering Services Department with Ward decants and moves.
- The Estates Services Department with a Stores person and water flushing in unused areas.
- Helping to relocate the Community Midwifery service to The Saints Rugby Club facilities.
- Assisting the OD Team with the swift relocation of NGH "Our Space" from BTU up to the Boardroom.

SSD had had a remote Notified Body Audit carried out by our External Auditors SGS Ltd, this took place over a Two day period in May 2020 with the result of only 1 Minor Corrective Action Request (CAR) being raised and received. This CAR has already been addressed and closed off and will be reviewed by the Authorised body during the upcoming audit which is scheduled to take place in August.

Various changes are currently being made to the SSD Quality Management System (QMS) to ensure SSD is compliant with UK MDR 2002 (as amended). This will support our transition to UK MDR 2002 (as amended) from MED DEV 93/42/EEC, which will take place at the next external audit which is currently scheduled to take place in August 2021.

The SSD continues to be audited by our externally based Quality Advisor & Internal Auditor and these again are being carried out remotely to ensure the department maintains compliance with Trust procedures and all other relevant ISO standards.

Two members of staff were successful in their study for the Highfield Level 5 Diploma in Operations Leadership and Departmental Management (RQF), and both were awarded Distinction.

The Environmental checks continue to be carried out on a monthly basis and are a worthwhile indicator to ensure the team continues to reach or exceed the infection and prevention control standards within SSD.

On February 1st 2021 SSD at NGH closed to allow a major upgrade project of the Air Handling Unit that supplies the SSD Inspection Assembly and Packing room. The team were fortunate enough to be allowed to use the facilities at our sister hospital namely the Sterile Services Department at Kettering General Hospital NHS Foundation Trust for the duration of this project.

Compliance Criterion	What the registered provider will need to demonstrate
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

6 Antimicrobial Stewardship

6.1 Compliance with Trust Antibiotic Policy

The clinical pharmacists performed a Trust wide antimicrobial point prevalence audit in September 2020 over a 5 day period covering 26 wards. The aim was to audit antimicrobial prescribing and compliance to the Trust Antibiotic Policy.

This is in response to the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance, criteria 3 of which states that procedures should be in place to ensure prudent prescribing and antimicrobial stewardship to optimise patient outcomes and there should be an ongoing programme of audit, revision and update.

Data from the audit has been discussed with the microbiologist and will be used to review the antimicrobials guidelines, focus teaching and stewardship rounds.

Figure 15

Descriptor		
Total number of patients seen		380
Number of patients on antibiotics		143
Proportion of patients seen on antibiotics		38%
Total number of antibiotics prescribed		177
	Number of IVs	101 (57%)
	Number of orals	76 (43%)
Total compliance (for conditions stated in guidelines)		88%
	Medical wards only	86%
	Surgery wards only	90%
Microbiology advice		12%
cultures and sensitives for adherence		6%
Patients with penicillin allergies/side effects		18% (26)
Penicillin reaction not stated		3% (5)
Penicillin reaction unknown & unable to confirm		3% (5)

Conditions not stated in the guidelines		16% (28)
	Appropriate (after D/W Micro)	11% (20)
	Not enough information	5%(8)

- During the audit week, 29% of all IV antibiotics prescribed were on Critical care and Willow ward.
- The average number of days of IV antibiotics completed on the day of the audit was 3.3 days
- Microbiology advice was sought for 12% (22) of all prescriptions audited, of which 5% (9) was attributed to critical care.
- There were 19 prescriptions for lower UTI's of which 17 (89%) were compliant according to guidelines/microbiologist or sensitivities. Non-compliance was for co-amoxiclav for UTI, of which 1 had no urine culture and 1 had culture for amoxicillin (both with no indication it was being used for a dual indication such as LRTI).
- Meropenem compliance was 70%. 7 out of 10 prescriptions were as per guidelines or micro approved.
- Penicillin allergy was the most common antimicrobial allergy, with 26 out of 30 patients that reported an allergy to antimicrobials. 5 of these patients did not have any reaction or severity stated which affected alternative treatment options. The medication safety team have promoted allergy documentation during medication safety week (2/11/20 to 8/11/20) with posters and email communication.
- Prescriptions for which conditions were not found in the guidelines were not included in the compliance figures. They have been reviewed by the microbiologist and are shown separately in the table figures.
- The audit identified areas of development of the guidelines for diverticulitis and aspiration pneumonia, with these accounting for 8 prescriptions which either were not in guidelines or not compliant.

6.2 Anti-Microbial Resistance: Commissioning for Quality and Innovation (CQUIN)

The 2020/21 CQUINS have been on hold and have not restarted due to the COVID19 pandemic. We are awaiting an update regarding these.

6.3 Training initiatives

Training sessions have been provided to medical core trainees, junior doctors and clinical pharmacists in the previous 12 months. Key teaching themes emphasised effective stewardship, risks from resistance, developing understanding of antibiotics and *C.diff*. These will continue to be implemented. A role specific mandatory training package on antimicrobial stewardship has been developed by the antimicrobial pharmacists with input from infection prevention nurses and microbiologist. The e-learning package is mandatory for all prescribers, pharmacists and nurses and aims to cover key aspects of antimicrobial stewardship, awareness of current guidelines and important information on resistant pathogens such as CPE.

6.4 Antibiotic campaigns Antibiotic Awareness Week & European Antibiotic Awareness Day

The annual awareness week was done entirely remotely this year due to Covid-19 restrictions through a quiz, Q&A session and screen savers.

- The 30-minute Q&A with the Microbiologist and antimicrobial pharmacist was setup with IT support.
- An online quiz was sent out with stewardship and IPC themed questions

6.5 Antimicrobial Stewardship Group (ASG)

The remit of this group is to develop and implement the organisation's antimicrobials programme for patients admitted to hospital.

- Active participation in Anti-Microbial Resistance CQUIN and submission of data
- Maintaining and updating an action plan for antimicrobial stewardship in line with NICE gap analysis
- Review of antimicrobial guidelines and therapeutic drug monitoring
- Review of mandatory role specific training in Antimicrobials and Antimicrobial Stewardship
- Review and monitoring of antibiotic consumption and expenditure and as well any governance issues.

6.6 Other Antimicrobial Developments

During Covid-19, there was limitations to the usual stewardship activities due to restrictions in place. Weekly microbiologist and antimicrobial pharmacist ward rounds have restarted and the microbiologist is doing weekly critical care rounds again. An antimicrobial pharmacist attends the weekly *C. difficile* ward round with an infection prevention nurse.

Sepsis boxes are distributed around the hospital with 2 vials of Meropenem to be used in cases of red flag sepsis. A sepsis box service improvement project was conducted by one of the antimicrobial pharmacists. As part of this, an audit was conducted and results and actions were discussed and implemented with the sepsis nurse.

The antimicrobial pharmacists retrospectively review ICT scripts for narrow therapeutic antibiotics in terms of monitoring requirements or dose adjustments based on ICE results or concerns from the ICT team. The regular review of ICT scripts has restarted over the last few months as staffing and COVID19 pressures have eased.

The antimicrobial pharmacist team has been a part of the home IV discharge cell, meeting regularly to explore options to reduce patients hospital stay if it only due to administration of IV's. This work stream has finished and we are now a part of the new Integrated Care Across Northamptonshire (ICAN) project, which involves, NGH, NHFT and KGH.
ICAN is meeting regularly to look at issues with current home IV system and how this can be optimised.

An allergy task and finish group was set up by the trust to explore allergy standards and compliance to NICE guidance. The antimicrobial pharmacist team attend and contribute to this group.

New guidelines developed include:
- IV antimicrobial to oral switch guideline
- ICT referral guideline
- Pharmacist ICT screening SOP
- Antibiotic Patient information leaflet in urgent care
- Malaria antimicrobial guidelines

6.6 Planned Developments for 2021/22

Figure 16

Development	Timeline	Information
OPAT service	ongoing	Reviewing how to optimise current service with ICT and KGH through the ICAN project
Penicillin allergy de-escalation	September 2022	Involved in trust allergy task and finish group Exploring options for penicillin allergy de-escalation/de-labelling
Guidelines review and updates	June 2022	18 antimicrobial guidelines due for review by May 2022 and further 6 by December 2022. This will require a lot of resource allocation.

CQUIN Support	ongoing	Currently no information of CQUIN topics or date to restart
Antibiotic awareness week	November 18-24th 2021	Plan to promote awareness of antimicrobial stewardship
Continue education on stewardship to support reduction in consumption as part of NHS contract	Ongoing	Promote guidelines in the trust and conduct mini point prevalence audit to assess adherence to trust guidelines.
Quarterly: random audit	Ongoing	Assurance on compliance of appropriate review of antibiotics in patients
Update and develop Micro guide	ongoing	Update micro guide with approved guidelines and explore additional function as they become available.
Stewardship rounds	ongoing	Continuation of weekly antimicrobial stewardship rounds on one ward/month Attend weekly C. Difficile ward round Plan to consider attending weekly diabetic foot ward round
Update and develop E-learning	January 2022	Promotion of e-learning and collaboration with IPC for Nurse/midwife section

Compliance Criterion	What the registered provider will need to demonstrate
4	Provide suitable accurate information on infections to service users, their visitor and any person concerned with providing further support or nursing/medical care in a timely fashion.

7 Provision of IPC Information

Information pertinent to IPC is provided to patients, visitors and staff in a variety of appropriate mediums and reflects seasonal trends in local and national infections.

7.1 Information for patients and visitors

The Trust provides patients, carers and visitors with information as required through patient information leaflets, the Trust internet site and signage across the organisation. The IPCT are always widely available to discuss specific infections with patients, and their carers, and answer any questions that they may have.

7.2 Information for staff

Information for staff is available in the IPC policies, procedures and clinical guidelines on the Trust intranet. Care pathways and care plans also provide condition specific information for staff. The IPC intranet page also hosts information sheets on a variety of infectious diseases, videos for aseptic non-touch technique, blood culture collection and the CDI change package, and information on how to access IPC mandatory training and contact the IPCT.

HCAI information for staff is documented on patient admission proforma, interdepartmental transfer forms, relevant care plans and also on discharge letters. The community healthcare providers are informed by the Trust IPCT when patients are discharged with HCAIs where care is required to be continued.

In 2020/21 the IPCT prioritised Covid 19 and were therefore unable to continue with IPC monthly campaigns. These have restarted in quarter 1 2021. During the monthly focus, good news stories are published in the Trust insight magazine and e-bulletin, relevant screen savers are circulated, and the infection prevention information boards monthly reports to divisional governance meetings also encapsulate the focus of the month.

Compliance Criterion	What the registered provider will need to demonstrate
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

8 Identification of Patients with Infection

The IPCT ensure that patients with, or at risk of, infection are identified at the earliest opportunity and receive the appropriate treatment by:

- Visiting the Emergency Department and Admission Units daily to identify patients with suspected or confirmed infections on admission to the Trust
- Liaising with ED to ensure patients are screened for Covid-19 on admission
- Ensuring SOPs are in place for the identification of patients with Covid-19 and the management of these patients within the hospital
- Attending the daily clinical safety huddles virtually, when possible, to provide specialist IPC advice to the staff
- Linking with the Matrons via Whats app messenger groups to be alerted of patients / wards which they would like us to review
- Co-ordinating the daily update of the Side Room Monitor Tool on Ibox throughout 2020/21 to identify side rooms for patients with, or at risk of, infection.
- Checking of alert flags on Camis for patients with *C.diff* or resistant organisms
- Co-ordinating the weekly CDI ward round
- Conducting surveillance and follow up of patients with MSSA and MRSA colonisations, CDI, *C.diff* antigen carriers, patients at risk or confirmed with CPE or *Candida auris* and patients with catheter-associated urinary tract infection and surgical site infection, to work with the nursing, medical and pharmacy teams to ensure that they receive appropriate treatment and care to minimise the risk of cross-infection.
- The IPCT have put a bid in for IC Net which would help alert the team of patients with infections immediately and aid the prompt isolation and treatment of patients, this will also be invaluable with outbreak management, surgical site infection surveillance and audit programmes.

Compliance Criterion	What the registered provider will need to demonstrate
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

9 Staff IPC Training and Development

All staff roles include the relevant principles of infection prevention and control practice in the job description. How this is applied is outlined at the individual's local induction.

9.1 IPC Mandatory Training

Training was integral to developing staff knowledge of IPC practices and updates to policies in 2020/21. The IPCT, together with the Practice Development Team have provided face to face PPE training sessions for patient facing staff to ensure they are aware of the required process of donning and doffing. This will be included in the mandatory IPC training moving forward.

The IPCT annual clinical mandatory training has been delivered by e-learning or workbook for the duration of the pandemic as the IPC team were unable to offer large group sessions due to social distancing

requirements during the pandemic. This may have led to a slight drop in training data, however this has increased back to 83.32% by March 2020.

Completion of training is recorded on the Trust central training record database and compliance to IPC mandatory training is tracked within the IPC Reports. Figure 17 presents the Trustwide 2020/21 IPC mandatory training compliance.

Figure 17: IPC Mandatory Training Compliance

	2020									2021		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trained in month	123	176	215	330	291	353	110	129	110	124	199	322
Compliance	84.63%	83.35%	80.75%	82.77%	82.53%	83.6	82.63%	82.93%	82.56%	81.79%	81.09%	83.32%

The BAF requirement is that all staff are trained in the correct use of PPE, so that they know when to use it and how to put it on and take it off safely. Although all of the types of PPE being used (masks, eye protection, gloves and aprons) were already in use, so most staff would be familiar with them, the frequent and prolonged use required in a pandemic is very different from normal working.

In October the overall compliance for PPE training across the Trust was 46.13%. By the end of March 2020 this had risen to 83.33%, through a combination of direct training from IPC and Practice Development and cascade training via trained PPE trainers in many clinical areas. In addition a great deal of work has been undertaken by the Lead Nurse for Pathway to Excellence and her team, both in supporting with training and in ensuring the central training database accurately reflects the staff who have been trained and the staff who require training

Figure 18: PPE training compliance

	2020									2021		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trained in month	9	16	9	11	393	187	368	234	134	289	287	322
Compliance	14.76%	15.30%	15.92%	27.22%	34.20%	38.05	46.13%	50.78%	69.01%	75.50%	80.00%	84.33%

Compliance Criterion	What the registered provider will need to demonstrate
7	Provide or secure adequate isolation facilities.

10 Isolation

The majority of wards now have ibox. The few wards that remain without ibox will be having it installed in due course. Ibox is an electronic white board which has superseded the Electronic Side Room Monitoring Tool. Staff are able to identify patients that are managed in side rooms and the reason for their isolation. Each ward has the facility to identify and update ibox, so that patients can be transferred out of single rooms, in the event that another patient requires isolation. This is checked daily by a member of the IPCT and the information is available to the Site Management Team.
Ibox has been updated to include Covid 19 / suspected Covid 19 as a reason for patients to be isolated. The zoning of wards has also been added which the IPCT update when a ward changes the zoning colour. The requirement of patients to be swabbed at day 1,3,5 and then weekly has been added to Ibox to assist the ward teams in identifying patients who require swabbing.

Compliance Criterion	What the registered provider will need to demonstrate
8	Secure adequate access to laboratory support as appropriate.

11 Laboratory Services

Diagnostic microbiology is provided on site as part of NGH Pathology services. In 2020/21 the laboratory staff have increased the usual on-call overnight service to include at least 2 dedicated staff to process Covid 19 swabs. The IPCT have thanked the Microbiology team for providing this essential service.

Compliance Criterion	What the registered provider will need to demonstrate
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

12 Policies

The Trust has IPC policies, guidelines and standard operating procedures in line with the Health and Social Care Act 2008; Code of Practice on the Prevention and Control of Infections and Related Guidance.

These documents are monitored utilising a variety of audit tools to measure staff compliance with guidance as detailed in section 5 of this report. Additionally, through induction and ad-hoc bespoke sessions, training for all staff types is undertaken to ensure they are kept informed of current policies and procedures as outlined in section 9 of this report.

13 Enhanced Infection Prevention and Compliance Assessment Tool

Saving Lives is a National compilation of High Impact Interventions (HII) utilising a "Care Bundle" approach based on evidence based practice. It was first published in 2005 and updated in 2010. It was delivered at NGH in 2007. It directly measured clinical processes and therefore in addition to the IPC Audit Plan, each clinical area completed monthly a self-assessment audit against the relevant High Impact Interventions for that clinical area. These results populated the Trust's Infection Prevention dashboard along with results from the monthly hand hygiene observational audits, cleaning audits, MRSA bacteraemia and *Clostridioides difficile* infection figures. The IPCT updated these audit tools in April 2017 to reflect evidence-based best practice. In 2020 they have been reviewed and now form part of the Enhanced Infection Prevention and Compliance Assessment Tool which is undertaken by the departmental Matron and IPC team member. The Enhanced IPC Compliance Assessment Tool dashboard is reviewed monthly at IPOG and IPSG and quarterly at Quality Governance Committee.

14 Hygiene Code Compliance

The Trust is registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008, and as a legal requirement must protect patients, staff and others from acquiring healthcare associated infections by compliance with the Hygiene Code.

The IPCT continue to align and update supporting evidence to provide assurance of compliance with the Hygiene Code and report areas of non-compliance to IPSG for monitoring and assurance.

Compliance Criterion	What the registered provider will need to demonstrate
10	Ensure so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

15 Occupational Health

15.1 Activity

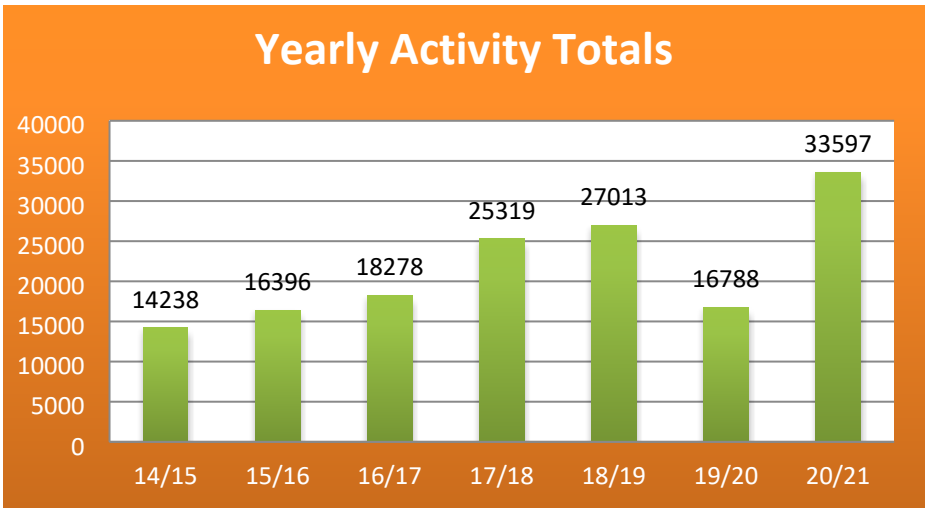
The aim of the clinical activity of the Occupational Health (OH) department is to look at the effects of health on work, and work on health. In screening our staff on employment, a programme of vaccinations and tests can be planned to protect the employee and the patients they care for, as well as making sure that any health matters are supported. During this year of the Covid-19 pandemic the OH department has been involved in a variety of Covid-19 related projects and interventions; from the post Covid-19 infection antibody testing, to Covid-19 swabbing, through to the Covid-19 vaccination service and risk assessment for staff either for REACH assessment or general return to work assessment after shielding at home. Due to the increase in PPE usage there was also dermatology assessments to support.

Figure 19

Clinical Activity	Total
Covid Antibody tests	3544
Covid Vaccinations	8645
REACH Risk Assessments	350
Dermatology Assessments	181

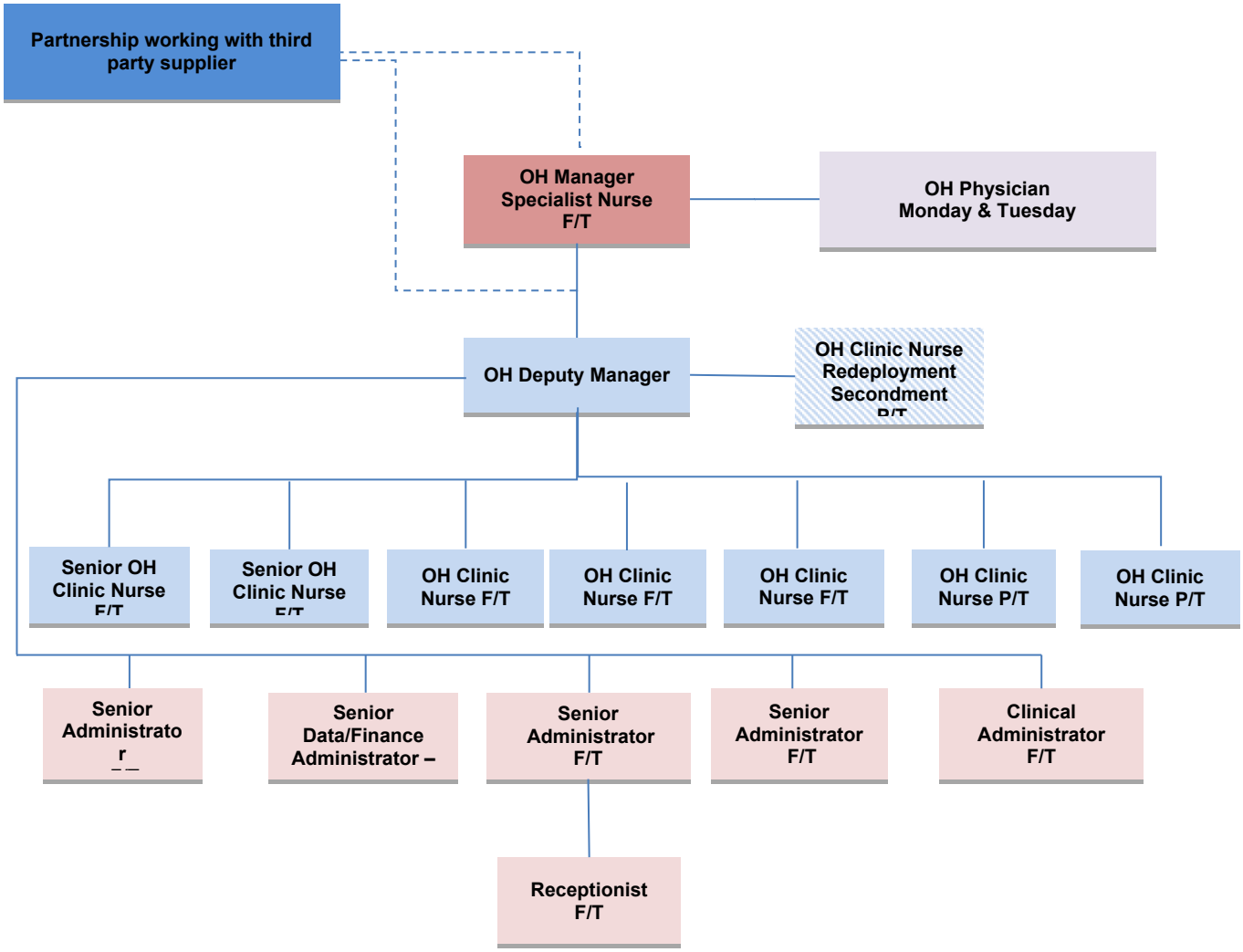
The significant increase in activity for 2020/21 is shown below (Figure 20). This includes vaccinations, blood tests, health surveillance, sickness absence managements and new employment health screening. There were 2640 new employment screenings carried out which included screening staff employed for the Vaccination Centre.

Figure 20



This level of activity was supported by an increase in the OH establishment which had been lacking in the previous financial year. The OH organogram is presented in Figure 21.

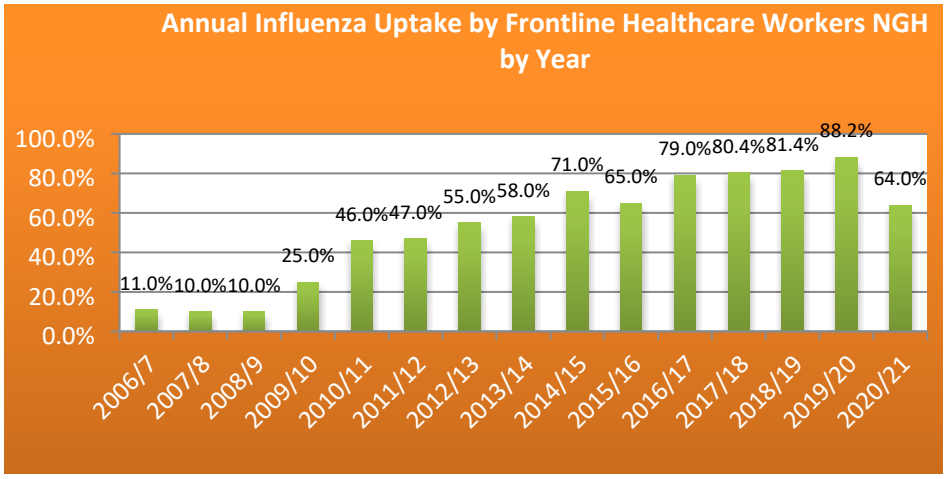
Figure 21: Occupational Health Structure 2020/21



15.2 Influenza Vaccination Campaign

The influenza vaccination campaign in 2020/21 was challenging due to the Covid-19 pandemic, which meant that usual vaccination roll out programme at departmental level was less achievable due to social distancing, ward closures and zoning restrictions. Therefore vaccinations were offered from the OH Department with additional measures in place to mitigate the effects of the pandemic on the campaign including additional opening hours, increasing weekend clinics and bespoke appointments. However these additional measures did not enable the target of 85% to be achieved. 64% of staff were vaccinated with 4373 vaccinations were given in total during the project.

Figure 22: Annual Influenza Uptake by Frontline Healthcare Workers at NGH by year

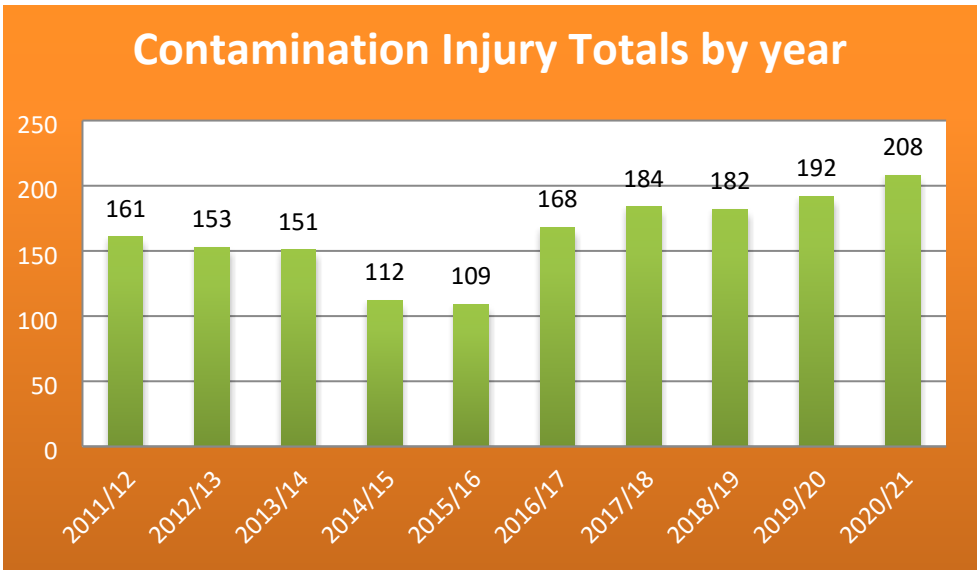


15.3 Contamination Injuries

In looking at the total number of contamination injuries by year we can see that there has been a small increase in injuries reported to OH in 2020/21 from 192 to 208. Figure 23 below shows data for all NGH employees including the Vaccination Centre.

Although there has been a small increase of injuries reported to the OH team, there was not the potential increase which may have occurred during the Covid-19 Vaccination project both at NGH, and the Vaccination Centre (the OH department was the lead OH service for the Vaccination Centre staff).

Figure 23: Contamination Injury totals by year



16 Appendix 1 – IPCT Structure 2020/21

Post	Post holder	WTE
Board Executive Lead (DIPC)	Ms Sheran Oke	Not defined
DIPC	Ms Sheran Oke	Not applicable
Chair of the Trust Infection Prevention and Control Steering Group	Ms Sheran Oke	Not applicable
Consultant Medical Microbiologist	Dr Basel Alouanti Dr Prasanna Kumari until May 2020	Not defined Not defined
Associate Director for IPC	Ms Holly Slyne commenced February 2021	1 x 1.0
Band 8a IPC Matron	Mrs Wendy Foster retired Dec 2020 Graham Pike interim from May 2020, formally commenced in post March 2021	1 x 1.0
Band 7 IPC Clinical Nurse Specialists	Mrs Ros Pounds Ms Natalie Clews	1 x 1.0 1 x 1.0
Band 6 IPC Support Nurses	Mrs Jean Hart Mrs Katie Draper Mrs Gill Jones Mrs Jane Sanjeevi Ms Hope Jarvis Ms Charlotte Crane	1x 0.4 1x 1.0 1x 0.8 1x 1.0 1x 1.0 1x 1.0
Band 4 Secretarial Administration and Surveillance	Mrs Karen Tiwary	1 x 1.0

Northampton General Hospital NHS Trust

Infection Prevention Steering Group (IPSG)

Terms of Reference

Membership	• Director of Nursing, Midwifery & Patient Services/DIPC or nominated Deputy (chair) • Matron for Infection Prevention & Control or nominated deputy • Consultant Microbiologist • Consultant Anaesthetist & Sepsis Lead • Deputy Director of Quality & Governance • Associate Director of Nursing for Medicine • Associate Director of Nursing for Surgery • Deputy Director of Midwifery • Associate Director of Nursing for Oncology • Head of Estates / Deputy Director of Facilities • Head of Hotel Services • Antimicrobial Pharmacist
Quorum	8 members
In Attendance	• Deputy Director of Nursing, Midwifery & Patient Services • Occupational Health Lead • Public Health England (PHE) representative • Patient representative • Sepsis Lead • Minute taker
Frequency of Meetings	• Monthly
Accountability and Reporting	• Accountable to the CQEG
Date of Approval by CQEG	• TBC
Review Date	• March 2022

Infection Prevention Steering Group

Terms of Reference

1. Constitution

The Trust hereby resolves to establish a steering Group of the Clinical Quality and Effectiveness Group (CQEG) to be known as the Infection Prevention Steering Group.

2. Purpose

The purpose of the Steering Group is to provide strategic direction for the prevention and control of Healthcare acquired infections in Northampton General Hospital NHS Trust that minimises the risk of infection to patients, staff and visitors.
The Steering Group will:

- Strengthen the performance management of Health Care Associated Infections (HCAI's) and cleanliness across the Trust
- Provide assurance to the Board that policy, process and operational delivery of infection prevention and control results in improved patient outcomes
- Make recommendations as appropriate on Infection Prevention Control matters to the Board via CQEG
- Performance Manage the Trust against the Infection Prevention and control strategy
- Will ensure that there is a strategic response to relevant new legislation and national guidelines

3. Membership

- Director of Nursing, Midwifery & Patient Services/DIPC or nominated Deputy
- Matron for Infection Prevention & Control or nominated Deputy
- Consultant Microbiologist
- Consultant Anaesthetist / Sepsis Lead*
- Deputy Director of Quality & Governance
- Associate Director of Nursing for Medicine*
- Associate Director of Nursing for Surgery*
- Associate Director of Midwifery*
- Associate Director of Nursing for Oncology*
- Head of Estates and Deputy Director of Facilities
- Head of Hotel Services
- Antimicrobial Pharmacist

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

- No business shall be transacted unless eight members of the Steering Group are present, one of whom must be the Chair or their nominated Deputy and 2 clinical representatives from the Divisions (as indicated by * above).
- The Steering Group will meet monthly.
- Members of the Steering Group are required to attend a minimum of 9 meetings held each financial year.

5. In attendance

In addition to the core membership, other staff will be invited to attend by the Chair of the Steering Group.

6. Authority

The Steering Group is authorised by CQEG to investigate any activity within its terms of reference and to seek any information it requires to provide assurance to the Board. The Steering Group will seek external expert advice and invite attendance if considered appropriate.

7. Duties

- To ensure the Trust adheres to the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Health and Social Care Act (2008)/ The Hygiene Code updated 2015.

- To fulfil the Trust's statutory and other responsibilities as provider of health services, achieving and maintaining the standards required by the Care Quality Commission and other National/Regulatory/Professional bodies.

- To review trust policies, procedures and guidance for the prevention and control of infection and to monitor their implementation; ensuring that such policies are evidence based, reflect relevant legislation and published professional guidance. Recommend submission and approval to Procedural Document Group.

- To develop the annual infection prevention and control programme of activity and ensure that it is submitted to Quality Governance Committee (QGC) and approved by the Trust Board

- Monitor achievement of the objectives contained within the annual programme.

- To receive, review and endorse the annual Infection Prevention and Control Report.

- Management and investigation of outbreaks of infection.

- To receive a written Infection Prevention & Control report which includes**:**

    i. Outbreaks of infection
    ii. MRSA & Clostridioides difficile data
    iii. Isolation deficits
    iv. Trust compliance with externally set targets
    v. Progress against the rolling infection prevention & control programme
    vi. Audit outcomes
    vii. Training and development plans/ compliance
    viii. Updates of relevant legislation / guidance/ best practice
    ix. Campaigns planned or delivered

- Receive a written highlight report with minutes as an appendix from the Infection Prevention Operational Group and review the TOR annually.

- To receive written reports from the Trust operational IPC group to ensure that assurance is gained as to the implementation of Infection Prevention & Control practices & policies within the Trust. Providing assurance that all appropriate measures are being taken to assist the achievement of the national and local infection present ambition.

- Receive written reports from Deputy Director of Estates and Facilities in relation to water safety, decontamination compliance, structural/ building works that are planned within the Trust. To

ensure that prevention and control of infection is considered as part of all service or building development activity, changes to HTM's or ACOP that may have infection control implications

- Receive written reports from the Head of Hotel services in relation to food hygiene, Environmental Health visits/ reports, PLACE outcome reports, cleaning compliance with standards and audits, domestic service training plans & compliance, and introduction of new cleaning products or systems of work.

- Receive written reports from the Occupational Health Manager which include needlestick injuries, flu vaccination programme compliance, outbreak issues affecting staff, any incidents of staff TB or BBV that have been or are currently under investigation or look back exercises for any infectious disease where an increased incidence has been reported nationally, to ensure that the staff and therefore the patients, are adequately protected where possible to do so.

- Receive written reports from the antimicrobial pharmacist which include an update from the Antimicrobial Stewardship Group.

- Receive written reports from the Associated Director of Nursing/Midwifery as requested by the Chair in relation to specific Infection Prevention and Control matters.

- To make recommendation to other committees and departments within the Trust on all infection control matters and techniques, and advise when necessary on the selection of equipment appropriate to the prevention of infections.

- To promote and facilitate education of all grades and disciplines of staff in procedures for the prevention and control of infection report compliance.

- Public Health England (PHE) update.

- To disseminate information and advice on prevention and control of infection to all appropriate Trust Division and their Directorates.

- To monitor the performance of the infection prevention and controls programme and make suggestions for improvement.

8. Accountability and Reporting arrangements

The minutes of the Steering Group meetings shall be formally recorded by the Secretary/Surveillance Assistant**.** Copies of the minutes of the Steering Group meetings will be provided to all members of the Group and will be available to all Trust Board members.

The Steering Group Chair shall prepare a written summary report to CQEG after each meeting. The Chair of the Steering Group shall draw to the attention of CQEG any issues that require escalation to the Trust Board, require executive action or support.

Sub-committee and reporting arrangements

The Steering Group shall have the power to establish sub-groups for the purpose of addressing specific tasks. In accordance with the Trust's Standing Orders, the Steering Group may not delegate powers to a sub-group unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-group must be approved by the Steering Group and reviewed as stated below.

9. Administration

The Infection Prevention Steering Group shall be supported administratively by the Infection Prevention and Control Secretary /Surveillance Assistant

- Agreement of the agenda for Steering Group meetings with the Chair

  Requesting of reports from authors in a timely manner in accordance with the reporting schedule

- Collation of reports and papers for Steering Group meetings

- Circulate agenda and papers for the meetings 7 days in advance of the Meeting

- Ensuring that suitable minutes are taken, a record of matters arising and actions are accurately documented

- All reports will be submitted in writing with a front sheet

10. Requirement for review

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

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

Northampton General Hospital NHS Trust

Infection Prevention Operational Group (IPOG)

TERMS OF REFERENCE

Membership	• Deputy Director of Nursing (Chair) • Matron for Infection Prevention • Matron for Surgery Division • Matron for Medical Division • Matron for Maternity • Matron for Paediatrics • Matron for Theatres • Estates Manager • Domestic Manager/Team Leader/Supervisor • Catering Manager or Team Leader • Therapies Manager • Head of Capacity or Deputy • Decontamination Lead
Quorum	Seven members that must include: • Deputy Director of Nursing (Chair or nominated deputy) • Matron for Infection Prevention or nominated deputy from Infection Prevention Team • Matrons from across the specialities (5)
In Attendance	• Minute taker The Group would have the authority to co-opt any person necessary to assist in its work plan or deliberations
Frequency of Meetings	Monthly
Accountability and Reporting	This group is accountable & reports into the Trusts Infection Prevention & Control Steering Group
Date of Approval by IPSG on behalf of Quality Governance Committee	March 2019
Review Date	March 2021

Infection Prevention Operational Group (IPOG)

TERMS OF REFERENCE

1. Constitution

The Infection Prevention Steering Group hereby establishes a sub-group known as the Infection Prevention Operational Group.

Its principle aim is to bring together, under the chairmanship of the Deputy Director of Nursing together with the Matrons, the Infection Prevention Team and the nominated Estates and Facilities Leads, to ensure that all operational practices and issues relating to infection prevention are evaluated and discussed.

2. Purpose

The purpose of the IPOG is to ensure that there is a managed environment within the Trust that minimises the risk of infection to patients, staff and visitors. The group is responsible for providing professional advice at an operational level to the Trust, sharing good practice and making recommendations to the IP Steering Group and Divisions.

3. Membership

- Deputy Director of Nursing (Chair)
- Matron for Infection Prevention
- Matrons (or nominated deputies)
- Estates Manager
- Domestic Manager/Team Leader/Supervisor
- Catering Manager or Team Leader
- Therapies Manager
- Clinical Site Manager for Capacity and Flow
- Decontamination Lead

The group have the authority to co-opt any person necessary to assist in its deliberations.

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

No business shall be transacted unless seven members of the group are present. This must include:

Seven members that must include:

- Deputy Director of Nursing (Chair or nominated deputy)
- Matron for Infection Prevention or nominated deputy from Infection Prevention Team
- Matrons from across the specialities (5)

The group will meet monthly. Members of the group are required to attend a minimum of 80% of the meetings held each financial year.

5. In attendance

- Administrative support
- Others may attend by invitation of the Chair.

6. Authority

The group is authorised by the Trust to investigate any activity within its terms of reference and to seek any information and to make any recommendations through the Infection Prevention Steering Group (IPSG), through its Chair that is deemed appropriate, or any area within the terms of reference where action or improvement is required.

7. Duties

- The Trust adheres to the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Health and Social Care Act (2015), (the “Hygiene Code”).
- To receive reports on specific operational problems with respect to the incidence of infection or of infection risks for evaluation and discussion, and to make appropriate recommendations to the IP Steering Group.
- To review, update and develop Trust policies, procedures and guidance for the prevention and control of infection and to monitor their implementation; ensuring that such policies reflect relevant legislation and published professional guidance, prior to approval by IP Steering Group.
- To monitor Divisional performance regarding adherence to infection control practice through the monitoring of the Trust Infection Prevention Dashboard, Infection Prevention and Control audits and ensure appropriate actions are put in place where required.
- To discuss relevant issues presented by the Infection Prevention & Control Team (IPCT) and any other member of the group
- To provide monthly reports and make recommendation to the IP Steering Group and departments within the Trust on all infection control matters and techniques, and advise when necessary on the selection of equipment appropriate to the prevention of infections.
- To promote and facilitate education of all grades and disciplines of staff, in procedures for the prevention and control of infection report compliance.
- To ensure that prevention and control of infection is considered as part of all service development activity.
- To disseminate information and advice on prevention and control of infection to all appropriate Trust Directorates.
- To monitor the performance of the infection prevention and controls programme and make suggestions for improvement, including review of improvement plans from Divisions.

8. Accountability and Reporting arrangements

The minutes of the group meetings shall be formally recorded by the minute taker. Copies of the minutes of group meetings shall be available to all members. The group will provide a monthly highlight report on its work to the IPSG with the minutes of this meeting included as an appendix.

19 Appendix 4 - Healthcare Associated Infection Plan of Work, 2021/22

Here is the forward plan for the IPC Team in 2021/22

Priorities and key goals for 2021-22

- Ensure safe processes for management of patients with known or suspected Covid-19 infection and embed Covid-19 into normal practice
- Provide IPC education to clinical staff including personal protective equipment donning and doffing
- Provide fit testing and FFP3 masks to staff who will need this
- Monitor compliance of PPE, hand hygiene, cleaning equipment and all other IPC standards
- A reduction in the number of patients with *Clostridioides difficile* infection CDI (<35 cases)
- Zero patients with MRSA bacteraemia
- A reduction in the number of patients with MSSA bacteraemias (<12 unavoidable cases)
- Sustain measurement of *E.coli* bacteraemia within the Whole Health Economy (<84 cases)
- Sustain measurement of CRUTI prevalence and incidence
- Sustain measurement of surgical site infection infections through PHE SSI surveillance system
- Sustain CPE screening processes

The plan is built upon the criteria of the Health and Social Care Act (2008) Code of Practice for Adult Social Care on the Prevention and Control of Infections and Related Guidance (2015). This set out ten criteria against which the Trust is assessed on how it complies with registration requirements of infection prevention.

BRAG Key	
	Complete
	On-track
	Delivery issues
	Unable to deliver

Hygiene Code Compliance Criterion 1 – Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
1 a There are appropriate management and monitoring arrangements for a zero tolerance approach to HCAIs	To agree the corporate priorities for HCAI reduction for 2021-22 as detailed above	Q1	IPC Matron					
	Clinical teams to undertake case review using principles of RCA and PIR on all cases of NGH attributable: • COVID-19 • CDI • MRSA bacteraemia • *Staph. Aureus, Schweizeri and Argenteus* bacteraemia • *E.coli* bacteraemia • *Klebsiella species bacteraemia* • *Pseudomonas aeruginosa bacteraemia*	Q1, 2, 3 and 4	IPC Matron					
	To prepare a monthly IPC report, which is presented monthly at IPSG and IPOG and quarterly at CQEG, on all cases and surveillance of NGH attributable: • COVID-19 • CDI • MRSA bacteraemia • *Staph. aureus* bacteraemia • *E.coli* bacteraemia • Klebsiella species bacteraemia • *Pseudomonas aeruginosa* bacteraemia	Monthly	IPC Matron					
	All deaths due to CDI (recorded on part 1a of the death certificate) and the CDI 30 day mortality data to be reported quarterly to IPSG and CQEG.	Quarterly	Consultant Microbiologist					

1 b Promote a culture of continuous quality improvement in IPC	To review and update IPSG terms of reference and IPOG terms of reference annually	February 2022	IPC Matron					
	To provide monthly Infection Prevention and Control report to IPSG giving assurance to the group and escalating any concerns	Monthly	IPC Matron					
	To provide quarterly Infection Prevention and Control report to CQEG giving assurance to the group and raising any concerns	Quarterly	IPC Matron					
	To present the COVID-19 Board Assurance Framework monthly at IPSG and provide a quarterly highlight report to CQEG and QGC	Monthly Quarterly	IPC Matron					
	To present the CDI PIRs monthly at IPOG, and share the learning to prevent further CDI acquisition	Monthly	Matrons and ward Managers					
	To implement the IPC audit plan for 2021-22 and report monthly at IPOG and IPSG. *(Please refer to the IPC annual audit plan).*	Monthly	IPC Matron					
	To implement the IPC surgical site surveillance plan for 2021-22 and report quarterly at IPSG and CQEG. *(Please refer to the IPC surgical site surveillance plan).*	Quarterly	IPC Matron					
	IPCT to deliver the 2021-22 communication plan *(Please refer to the 2021-22 Campaign plan)*	Ongoing	IPCT & comms team					
	To review trends and themes from monthly Enhanced IPC Compliance Tools, completed monthly by Matrons and reported to IPOG	Monthly	IPCT & Matrons					
	To improve IT infrastructure within the IPC Team to enable smarter working, including implementation of IC NET and electronic audit system	Monthly	Matrons					

Hygiene Code Compliance Criterion 2 – Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention of infections								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	

2 a Maintenance of a clean, safe and appropriate environment which facilitates the prevention and control of HCAI	The Trust Hotel Services Manager and Domestic Manager will report key issues monthly to IPOG as a standing agenda item	Monthly	Hotel Services Manager & Domestic Manager					
	Review and monitor monthly cleaning audit scores through the IPC monthly report at IPOG. For areas of poor compliance, Matrons are challenged by the chair of the group	Monthly	IPC Matron & Matrons					
	IPCT and Domestic Team to sustain the enhanced cleaning standard operating procedure to deliver enhanced touch point cleaning when required	Monthly	IPCN & Domestic Manager					
	IPC Team to join Domestic Team on a minimum of four Cleaning Audits a month, to peer review and reported in the IPC monthly report	Monthly	IPCT & Domestic Team					
	IPC Matron and Estates Manager to complete a bi-monthly review of the Trust Estate and action any IPC issues	Bi-monthly	Matron for IPC & Estates Manager					
	IPCT, Estates and Domestic Team to complete a review of the ward (EDI inspection) following every case of CDI, periods of increased incidence or outbreaks of infection and report outstanding issues to IPOG as a standing agenda	Monthly	Matron for IPC, Domestic Manager & Estates Manager					
	IPCT, Estates and Domestic Team to complete EDI inspections for all Out-Patient Departments (OPD) tri-annually as detailed in the EDI OPD forward schedule	Monthly	Matron for IPC, Domestic Manager & Estates Manager					
	IPCT & Estates perform Airborne Fungal Spores and Contamination of Water Services risk assessments prior to Estates work commencing	Ongoing	IPC Matron & Estates Projects Lead					
	The Trust Estates Maintenance Manager will report key issues monthly to IPOG as an agenda item	Monthly	Estates Maintenance Manager					
	The Deputy Director of Facilities will provide a comprehensive report quarterly to IPSG	Quarterly	Deputy Director of Facilities					

2 b Decontamination standards are monitored and adhered to	The Lead for Sterile Services reports up through the organisation through Governance meetings, Medical Devices Committee and IPOG.	Monthly	Decontamination Lead					
2 c Water safety requirements are monitored and adhered to	The Trust Water Safety Lead / Responsible Person will ensure that the Water Safety Group operates according to its terms of reference and reports quarterly to the IPSG as detailed on the Infection Prevention and Control forward plan	Quarterly	Deputy Director of Facilities					
	The Trust Deputy Responsible Person will report and update any water safety issues to IPSG as per the IPSG forward plan	Monthly	Estates Maintenance Manager					

Hygiene Code Compliance Criterion 3 – Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
3 a To improve antimicrobial prescribing and stewardship	The Trust Antimicrobial Lead will ensure that the Antimicrobial Stewardship Group will operate according to its terms of reference	Bimonthly	Antimicrobial Lead					
	The Antimicrobial Pharmacists will provide an Antimicrobial report quarterly to the IPSG as per the IPSG forward plan	Quarterly	Antimicrobial pharmacists					
	Antimicrobial audits will be presented to IPSG as part of the antimicrobial report as per the IPSG forward plan	Quarterly	Antimicrobial pharmacists					
	The Trust Antimicrobial Pharmacists will deliver the actions from the NICE antimicrobial guidance gap analysis as part of the antimicrobial report as per the IPSG forward plan	Quarterly	Antimicrobial pharmacists					
	The Antimicrobial Pharmacists will continue to prompt Proton Pump Inhibitor (PPI) review for patients commencing antibiotics as detailed in the *C.diff* Forward Plan	Monthly	Antimicrobial pharmacists					

Hygiene Code Compliance Criterion 4 – Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
4 a Provide useful information for staff on the prevention and control of infections	Produce Trust wide screensavers, huddle sheets or posters as required to clarify IP procedures and processes	Monthly	IPCT					
	Send out information via email system to communicate updates on IPC practices or polices as required e.g. during outbreaks	Monthly	IPC Matron					
	To implement the IPC communication strategy and monthly focus on specific aspect of IPC	Monthly	IPCT					
4 b Provide useful information for patients and visitors on the prevention and control of infections	Provide patient information leaflets on COVID, C.difficile, MRSA, ESBLs, CPE, norovirus, influenza, surgical site infection prevention, central venous access devices, peripheral venous cannulas, urinary catheters, enteral feeding and using decolonisation treatment	Monthly	IPCT					
	Provide outbreak information to patients and visitors regarding ward closures and preventing the spread of infection with the support of the Trust communications team	Q1,2,3,and 4	IPCT					

Hygiene Code Compliance Criterion 5 – Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing the infection on to other people								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
5 a To minimise the risk of CPE through screening and care of suspected, presumptive or	To update CPE Policy to reflect latest PHE national guidance and roll out across the Trust	Q1	IPCT					
	To update CPE screening processes across the Trust to reflect the CPE Policy: • Revised screening criteria required for Maternity, Pre-Operative Assessment	Q1-2	IPCT					

confirmed positive cases	Clinic, Paediatrics, Non-elective admissions • New process required for Oncology, Haematology, Renal and Critical Care							
	To develop CPE screening tool to be rolled out across the organisation to reflect the above screening requirements	Q1-2	IPCT					
	To continue daily review of CPE suspected or confirmed cases and report monthly cases of CPE positive patients to IPOG and IPSG via IPC monthly report and share any learning	Monthly	IPC Matron					
5 b To remain within the C.diff trajectory of 21 cases for 2018-19	To monitor C.diff trajectory and if ceiling is exceeded to develop C.diff forward plan and put on to the risk register	Monthly	IPC Matron					
	To conduct C.diff surveillance and conduct a C.diff ward round every week. This multidisciplinary ward round is attended by a Consultant Microbiologist, Antimicrobial Pharmacist and an IPC Nurse to review all patients with active C.diff infection in the Trust to ensure that they are being managed correctly from both a medical and nursing perspective	Q1, Q2, Q3, Q4	IPCT					
	To continue to identify wards that require support for 1 case of C.diff or period of increased incidence (2 or more cases within 28 days), conduct PIR for all post admission C.diff cases and maintain the C.diff antigen positive surveillance	Q1, Q2, Q3 and Q4	IPCT					
	All patients who have HOHA and COHA C.diff infection to be discussed at IPOG to share learning	Q1, Q2, Q3 and Q4	IPCT Matrons					
5 c To minimise the risk of infection to patients	To monitor MRSA trajectory and if ceiling is exceeded to develop MRSA forward plan and put on to the risk register	Monthly	IPC Matron					

by conducting MRSA screening and managing patients who are colonised or infected with MRSA effectively	To maintain MRSA screening processes according to Trust MRSA policy, monitor elective and emergency screening compliance and conduct surveillance of previous MRSA positive inpatients.	Q1, Q2, Q3 and Q4	IPCT					
	To maintain prophylactic decolonisation processes according to the MRSA Policy, audit compliance quarterly and report to IPSG	Q1, Q2, Q3 and Q4	IPCT					
	To scope out implementation of prophylactic decolonisation for all admissions, to reduce the risk of MRSA and MSSA colonisations and infections, leading to bloodstream infections	Q1-Q2	IPCT					
5 d To minimise the risk of infection to patients by preventing *Staph. aureus* bacteraemias	To monitor *Staph. aureus* bacteraemia trajectory and if ceiling is exceeded to develop *Staph. aureus* forward plan and put on to the risk register	Monthly	IPC Matron					
	To maintain surveillance of *Staph. aureus* bacteraemias and all patients who have HOHA and COHA *Staph. aureus* infection to have a PIR and discussed at IPOG to share learning	Monthly	IPCT Matrons					
5 e To minimise the risk of infection to patients by prevention Gram-negative bacteraemias (GNB)	To maintain surveillance of Gram-negative bacteraemias and report monthly cases of Gram-negative bacteraemias to IPOG and IPSG via IPC monthly report and share any learning	Q1, Q2, Q3 and Q4	IPCT IPC Matron Matrons					
	To compare surveillance data to last year's GNB data and if improvement is not sustained to develop a GNB forward plan and put on to the risk register	Monthly	IPC Matron					
5 g To minimise the risk of cross-infection for alert organisms	IPCT to review all patients who acquire an alert organism infection and provide ongoing advice and support to medical and nursing staff	Q1, Q2, Q3 and Q4	IPCT					
	IPCT to conduct surveillance and management of outbreaks of infection	Q1, Q2, Q3 and Q4	IPCT					
	IPCT to continue flagging patients with previous MRSA, C.diff, MSSA and CPE on CAMIS inpatient management system	Q1, Q2, Q3 and Q4	Matron for IPCT					
5 h	IPCT to report CAUTI case reviews quarterly to IPOG and IPSG to identify key themes	Q1, Q2, Q3 and Q4	IPCT					

To minimise the risk of infection to patients from catheter-associated urinary tract infections (CAUTI)	IPCT to scope out implementation of chlorhexidine solution for cleaning the site prior to catheterisation	Q1-Q2	IPCT					
	IPCT to continue improvement work around removing catheters as soon as they are no longer required to reduce the risk of infection	Q1, Q2, Q3 and Q4	IPCT					
5 i To minimise the risk of infection to patients from vascular access device related infections	To reconvene Vascular Access Group to meet monthly and review learning from line-related infections and implement evidence-based practice around vascular access devices	Q1, Q2, Q3 and Q4	IPCT					
	To conduct PICC-line and midline related bloodstream surveillance and report to IPOG and IPSG quarterly	Q1, Q2, Q3 and Q4	IPCT					
5 j To minimise the risk of infection to patients from influenza	To develop and implement a 2021-22 Flu Ready action plan in collaboration with Occupational Health Team to present at IPSG in Aug 2021	Q2	IPCT					
	To work with the Microbiology Laboratory Manager to support point of care testing for Influenza	Q1, Q2, Q3 and Q4	IPCT Microbiology Laboratory Manager					
5 k To minimise the risk of infection to patients from Middle Eastern Respiratory Syndrome (MERS)	To implement the MERS section of the Viral Respiratory Infections procedural document in the Emergency Department	Q1, Q2, Q3 and Q4	IPCT & ED Matron					
	To reflect and learn from each patient with suspected MERS in the ED to improve practice and share at IPOG	Q1, Q2, Q3 and Q4	IPCT & ED Matron					
5 l To minimise the risk of infection to patients from SARS-CoV- 2 (the virus which causes Covid-19)	To hold Bronze level meetings daily to review national guidance, discuss areas of concern and ensure guidance is shared and followed across the Trust. To report to Silver level group daily/twice weekly.	Q1, Q2, Q3 and Q4	IPCT, Microbiologists AD for IPC					
	To complete RCA for all patients that develop hospital acquired COVID infection and share learning at IPOG	Monthly	IPCT Matrons					
	To provide assurance that the Board Assurance Framework for COVID IPC is adhered to and any areas of non-compliance are addressed in the BAF action plan	Monthly	IPC Matron AD for IPC					

	To communicate with departments, to ensure understanding of guidance, provide teaching materials and ensuring adequate stocks of PPE are available	Q1, Q2, Q3 and Q4	IPCT					
5 m To minimise the risk of infection to patients from hospital acquired infection (HAP)	To audit mouthcare practice quarterly to ensure that evidence-based best practice is embedded and sustained	Q1, Q2, Q3 and Q4	IPCT					
5 n To minimise the risk of infection to patients from surgical site infection (SSI)	To continue SSI surveillance as per the IPCT SSI Surveillance Plan for 2021/22 and provide a quarterly SSI report to IPSG	Q1, Q2, Q3 and Q4	IPCT					
	To continue quarterly SSI group meetings to discuss patients that develop SSI within T&O and to address recurring themes and implement actions	Q1, Q2, Q3 and Q4	IPCT PDNs Matron for T&O T&O Consultants Theatre Educator					

Hygiene Code Compliance Criterion 6 – Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG				Progress and comments
				Q 1	Q 2	Q 3	Q 4	
6 a Staff receive appropriate IPC training	IPC is part of induction and mandatory training, including PPE training. IPC mandatory training is to be monitored and reported to CQEG by the Infection Prevention Matron	Quarterly	IPC Matron					
	Annual review of IPC mandatory training material and update to reflect latest guidance	Q1	IPC Team					
	To deliver ad-hoc teaching as requested by the Divisions e.g. SSI, blood cultures, ANTT	Q1, Q2, Q3 and Q4	IPCT					
6 b IPC workforce and capability	To ensure that all IPCT members are skilled, knowledgeable and have an appraisal process in place and up to date with mandatory training	Q1, Q2, Q3 and Q4	IPC Matron					
	IPC Team to attend training and IPC post-	Q1	IPCT					

	graduate courses to increase knowledge and professional development							
6 c Hand hygiene	Continue to reinforce the Hand Hygiene Code of Practice	Q1, Q2, Q3 and Q4	IPC Matron					
	Celebrate Hand Hygiene Week	Q1	IPCT					

Hygiene Code Compliance Criterion 7 – Provide or secure adequate isolation facilities								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
7 a To provide advice regarding appropriate isolation use	IPCT to undertake daily review of the urgent care wards ED & Nye Bevan to identify patients admitted that require isolation	Q1, Q2, Q3 and Q4	IPSNs					
	To attend the safety huddle daily to provide isolation and IPC advice	Q1, Q2, Q3 and Q4	IPSNs / IPCN / IPC Matron					
	IPCT to undertake daily review of patients in side rooms and update iBox to facilitate the Site Management Team in effective patient placement	Q1, Q2, Q3 and Q4	IPSNs					

Hygiene Code Compliance Criterion 8 – Secure adequate access to laboratory support								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
8 a The microbiology laboratory is accredited	The diagnostic microbiology is provided on site as part of the NGH pathology services. The Microbiology Laboratory Manager ensure that accreditation is achieved annually	Annually	Microbiology Laboratory Andrea O'Connell					

Hygiene Code Compliance Criterion 9 – Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	

9 a To ensure that evidence based IPC policies and associated procedural documents are available	The IPC policies and associated procedural documents are reviewed three yearly and in accordance with new guidance	Q1, Q2, Q3 and Q4	IPCT					
	IPC policies and procedural documents are audited as per the IPC annual audit programme in accordance with the requirements of the Hygiene Code	Monthly	IPCT					

Hygiene Code Compliance Criterion 10 – Ensure so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that staff are suitably educated in the prevention and control of infection associated with the provision of healthcare								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
10 a To ensure that healthcare workers are protected from communicable diseases and from work exposures	Occupational health advice is available for staff	Q1, Q2, Q3 and Q4	Occupational Health Team					
	Monthly review of Vaccination Centres is undertaken whilst they are open	Quarterly	IPC Matron Ad for IPC					
	Occupational Health Team provide a quarterly report to IPC regarding key issues	Quarterly	Occupational Health Team					
	IPC training is mandatory for all staff and reported quarterly to CQEG via the IPCT report	Quarterly	Matron IPC					
	IPCT to facilitate fit testing for FFP3 masks for paediatric staff, anaesthetic staff, Urgent Care staff and Critical Care staff	Q1, Q2, Q3 and Q4	IPCT					

Dedicated to excellence

NHS
Northampton General Hospital
NHS Trust

Cover sheet

Meeting	Public Trust Board
Date	30th September 2021
Agenda item	4.3

Title	Integrated Safeguarding Annual Report 2020-21
Presenter	Sheran Oke, Director of Nursing, Midwifery & Patient Services
Author	Integrated Safeguarding Team

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

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

Reason for consideration	Previous consideration
Assurance that legislation is embedded into the organisation	Previous safeguarding annual report presented to Safeguarding Assurance Group in July 2020

Executive Summary
This annual report provides the Safeguarding Assurance Group with information and assurance regarding the summary of the key issues and activity in relation to safeguarding at Northampton General Hospital NHS Trust in line with legislation and statutory guidance during 2020-21
Appendices
Risk and assurance
Assurance that legislation is being embedded within the organisation
Financial Impact
No financial impact
Legal implications/regulatory requirements

Human Rights Act 1999; Equality Act 2010; Children's Act 2004; Care Act 2014; Mental Capacity Act 2005; Mental Health Act 2007; Deprivation of Liberty Safeguards 2009
Equality Impact Assessment
Inclusive paper which considers and promotes equality of opportunity for vulnerable groups

INTEGRATED SAFEGUARDING ANNUAL REPORT

2020-2021

TRACY KEATS, HEAD OF SAFEGUARDING AND DEMENTIA

ELIZABETH MCKEEVER, NAMED NURSE FOR SAFEGUARDING ADULTS

SUE MCCRAE-SAMUEL, NAMED NURSE FOR SAFEGUARDING CHILDREN

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JULY 2021

CONTENTS

- SAFEGUARDING DASHBOARDS
- SAFEGUARDING STRATEGY 2019-22

- DISCLOSURE AND BARRING SERVICE (DBS)
- SAFEGUARDING CONCERNS
- QUALITY SCHEDULE
- CARE QUALITY COMMISSION
- PARTNERSHIP WORKING

- SAFEGUARDING ADULTS
  - NATIONAL CONTEXT
  - ACTIVITY
  - SAFEGUARDING ADULT REVIEWS
  - TRAINING
  - ALLEGATIONS MADE ABOUT STAFF
  - SAFEGUARDING ADULT REVIEWS
  - TRAINING
  - MENTAL CAPACITY ACT
  - DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)
  - COURT OF PROTECTION
  - PREVENT
  - MODERN SLAVERY
  - SAFEGUARDING ADULTS ACHIEVEMENTS
  - SAFEGUARDING ADULTS PRIORITIES 2020/21
- SAFEGUARDING CHILDREN
  - ACTIVITY
  - AUDIT ACTIVITY
  - TRAINING
  - PAEDIATRIC LIAISON NURSE
  - DESIGNATED OFFICER
  - CHILD SAFEGUARDING PRACTICE REVIEWS
  - CHILD PROTECTION INFORMATION SYSTEM (CP-IS)
  - SAFEGUARDING CHILDREN ACHIEVEMENTS
  - SAFEGUARDING CHILDREN PRIORITIES 2020/21
- SAFEGUARDING MATERNITY
  - ACTIVITY
  - TRAINING
  - FEMALE GENITAL MUTILATION
  - DOMESTIC ABUSE
  - SAFEGUARDING MATERNITY ACHIEVEMENTS
  - SAFEGUARDING MATERNITY PRIORITIES 2020/21

- REFERENCES AND FURTHER READING

Executive Summary

1. Northampton General Hospital NHS Trust is committed to ensuring safeguarding is part of its core business and recognises that safeguarding children, young people and adults at risk is a shared responsibility with the need for effective joint working between partner agencies and professionals. This annual report outlines how the safeguarding service is performing and promoting best practice. The report provides an update on safeguarding priorities during 2020/21 and identifies safeguarding key issues, risks and priorities for 2021/22.

2. The Safeguarding Assurance Group (SAG) is a strategic meeting responsible for disseminating and monitoring information from Northamptonshire Safeguarding Adult's Board (NSAB) and Northamptonshire Safeguarding Children's Partnership (NSCP). In turn as a partner agency, the Trust provides challenge and scrutiny to both the NSAB and the NSCP via the Clinical Commissioning Group (CCG) as one of the statutory partners, as this is an essential part of working together to keep children, young people and adults at risk safe.

3. There are three safeguarding 'active' risks on the Trust risk register which relate to: general governance processes in line with adult and children safeguarding external to the Trust, unauthorised Deprivation of Liberty Safeguards (DoLS) applications and safeguarding training compliance. These have been in place throughout the reporting period.

4. Safeguarding training has been revised to meet the national standards as identified in the revised children's and adult's Intercollegiate Guidance and incorporates local learning from serious incidents/reviews.

5. An external peer review of safeguarding within maternity services found that the service was robust with assurance of strong governance processes in place.

6. There has been two Safeguarding Adult Reviews (SARs) published within this reporting period. The statutory partnership has not published any Child Safeguarding Practice Reviews (CSPR's). All requests for information or to become panel members have been responded to in a timely manner.

7. There is a statutory duty for the Trust to comply with Domestic Homicide Reviews (DHR's). There are three reviews awaiting final ratification from the Home Office which related to deaths in the north of the county. There are three ongoing DHR's across the county. The Trust has completed IMR's to all reviews. All requests for information to potential DHRs have been completed in a timely manner.

8. The 'Mental Capacity Act including the Deprivation of Liberty Safeguards', 'Allegations Made against Staff,' Bruising in Non-Mobile Babies,' 'Missing and Absconding Patients,' 'Prevent,' Safeguarding Children's Policy,' 'Safeguarding Supervision' and 'Was Not Brought' policies have been reviewed by the safeguarding team.

9. Deprivation of Liberty Safeguards (DoLS) applications in the Trust significantly increased in 2020/21. There have been 809 DoLS applications in the Trust during the reporting period against 560 in 2019/20.

10. 2020-21 has been a challenging time for the safeguarding team. The safeguarding team have continued to work on site during the pandemic to ensure that safeguarding support was in place for Trust staff. The maternity safeguarding team in particular has had to concentrate on working with Northamptonshire children's services to ensure that the appropriate level of intervention/support was obtained for women and their families. Face-to-face training was suspended for a prolonged period of time so compliance with commissioner's expectations was a struggle to achieve.

1.0 Introduction

1.1 This annual report reflects the arrangements to safeguard and promote the welfare of children, young people and adults at risk within Northampton General Hospital NHS Trust for the period of April 2020 to March 2021. The report concentrates on the key safeguarding activity and risks within the organisation. In doing so, the Trust discharges part of its responsibility for Board-level assurance, scrutiny and challenge of safeguarding practice within the Trust, in line with the statutory requirements of section 11 Children Act (2004), Working Together to Safeguard Children (2018), the Mental Capacity Act (MCA) 2005, the Care Act 2014 and the Prevention of Terrorism Act (2005)

1.2 In addition to the requirements of the Care Act (2014) and the Children's Act 2004, the Trust, as a registered provider with the Care Quality Commission (CQC), must have regard for the Regulations as established under the Health and Social Care Act (2008). In relation to Safeguarding, including but not limited to, Regulation 13 and Regulation 17, relating to protecting service users from abuse and robust governance, respectively.

1.3 The Accountability and Assurance Framework (NHS England 2019) sets out the safeguarding roles, duties and responsibilities for all NHS organisations and this report reflects the integrated safeguarding portfolio. The report is arranged sequentially under safeguarding adults, safeguarding children and safeguarding within maternity services.

2.0 National

2.1 Safeguarding is a complex area of practice. The potential patient group is wide ranging from people able to self-care to those who are experiencing a short term illness or a long term disability. Abuse can happen in any context and takes many forms, some of which may not be obvious. Therefore it is essential that the Trust continues to promote the importance of safeguarding for our patients and community.

2.2 Unseen children in the pandemic, domestic abuse, gangs, child exploitation/sexual exploitation, the MCA and homelessness have been priority work streams highlighted either by central government or by national or local publications. The safeguarding team have revised their training programmes to highlight these themes for frontline staff and these have also been included in monthly safeguarding bulletins which are circulated across the organisation.

3.0 Local Context

3.1 Northampton General Hospital is a key partner agency for safeguarding within the county. This is achieved by:

- A strong robust safeguarding team across the whole organisation including maternity, paediatrics and adults. This is further complimented by the Mental Health and Mental Capacity Lead Practitioner, the Dementia Liaison Nurse and the Learning Disability Liaison Nurse as part of the wider team covering key vulnerable groups.
- Membership of Northamptonshire Safeguarding Adults Board (NSAB) delivery board and sub-groups of both the NSAB and the Northamptonshire Safeguarding Children's Partnership (NSCP)
- Membership of the Northamptonshire Strategic Health Safeguarding Forum
- Participation of the multi-agency audits from both the NSAB and NSCP and ensuring that internal audits are in place to respond to national and local trends
- Active contribution to both SAR's and CSPR's
- Active contribution to DHR's with the associated Community Safety Partnership
- Active participation at complex safeguarding meetings and arranging discharge planning meetings with multi-agency participation
- Attendance and dissemination of information at the Multi-Agency Risk Assessment Conference (MARAC) when appropriate

- Dissemination of domestic abuse notifications from the police regarding pregnant women
- Attendance to support the Prevent agenda and the Channel panel in Northamptonshire
- Close liaison and dissemination of information with and from the children's Multi Agency Safeguarding Hub (MASH)
- Paediatric Liaison Nurse in post who scrutinises the Emergency Department (ED) lists on a daily basis and shares information between hospitals and community services which enables children and their families to receive appropriate care and support post discharge
- Robust safeguarding administration from two specific members of the team who support the safeguarding team.

4.0 Safeguarding Governance

4.1 Named Safeguarding Roles

4.2 Northampton General Hospital is accountable for ensuring that its own safeguarding structure and processes meet the required statutory requirements of the Children's Act 2004, the Care Act 2014 and other statutory and national guidance. The safeguarding roles, duties and responsibilities of all organisations in the National Health Service (NHS) including the Trust, are laid out in the NHS England 'Accountability and Assurance Framework' (2019).

4.3 The Trust is highly committed to safeguarding with a strong culture of safeguarding vulnerable individuals of any age that have contact with services – either as patients, visitors or staff. Therefore robust governance processes are in place to ensure that services delivered are keeping people of all ages safe.

4.4 The Trust is statutorily required to maintain certain posts and roles within the organisation in relation to safeguarding. These have been fulfilled and enhanced throughout 2020/21 despite retirement of significant post holders.

4.5 The Director of Nursing, Midwifery and Patient Services is the executive lead for safeguarding and represents the Trust externally at the NSAB Delivery Board and the bi-annual NSCP meetings. The executive lead also acts as Named Senior Officer for allegations made against staff.

4.6 The Head of Safeguarding and Dementia provides strategic direction for adult, children's and maternity safeguarding and supports the Director of Nursing in the executive role. The role of Named Senior Manager for allegations against staff is fulfilled by the Head of Safeguarding and Dementia, who also attends the NSAB Delivery Board.

4.7 The Named Professionals provide the organisation with operational advice, support and input. The professionals are committed to supporting the workforce in understanding safeguarding, embedding it into 'everyday business' and improving outcomes. They are supported by safeguarding practitioners/advisors.

4.8 The aims of the safeguarding service are to:

- Provide visible and professional safeguarding leadership for all aspects of safeguarding adults, children and young people and midwifery to ensure that day to day advice, support and expertise is available to all staff in the hospital.

- This includes the responsibility of the implementation, maintenance and development of effective and efficient systems for the detection, prevention, surveillance, investigation and control of harm and abuse
- Provide challenge and scrutiny of safeguarding practice including the interface with statutory agencies
- Facilitate safeguarding training sessions across the hospital to ensure that learning, skills set and knowledge of staff is provided as per statutory and mandatory training requirements. This includes all matter of communication across the hospital to ensure that the local needs and risks of children, young people and adults are understood and dealt with to a degree by the frontline staff using lessons learnt from national and local case reviews, best practice and research. Ethical concerns, legislative processes and reporting processes are part of this training as per hospital staff's roles and responsibilities.
- Contribute to the development of appropriate systems including audit, governance policies and procedures to ensure safe practice in relation to the delivery of an effective safeguarding service across the hospital
- Provide guidance and advice to the Human Resources Department in staff investigations including disciplinary, related to vulnerable groups/adults at risk, children and young adults.
- Work in partnership with key internal and external stakeholders to deliver a comprehensive, cohesive, safe and effective safeguarding service for the hospital. This includes engagement with at risk patients, relatives and advocates in order to gain feedback in order to ensure services and service improvements are patient centred and enhance equality and parity of esteem.

4.9 The expected outcomes of the service are to:

- Facilitate the development of a confident, informed workforce in relation to their role and responsibilities to children, young people and adult welfare and safeguarding matters
- Improve outcomes for children, young people and adults
- Risk mitigation to children, young people, adults, visitors and staff
- Safe discharge from hospital

4.10 The Named Professional Team comprises of:

- 1.0 Full Time Named Nurse (Children)
- 1.0 Full Time Named Midwife (Children and Vulnerable Women)
- 1.0 Full Time Named Nurse (Adults)
- 2.0 sessions a week Named Doctor (Children)
- 1.0 sessions a week Named Doctor (Adults)

4.11 The Named Nurses are each individually supported by a 1.0 WTE safeguarding practitioner, who provide advice, support and training to all staff within the Trust about the management of safeguarding and vulnerability issues. A full-time paediatric liaison nurse is also in post. The Named Doctors also provide support to the team and the Trust. Two safeguarding administrators provide general assistance and support to the teams on a daily basis, including the management of and handling of sensitive, emotive and confidential information.

5.0 Safeguarding Assurance Group (SAG)

5.1 The SAG has been in place since 2015 and meets on a quarterly basis chaired by the Director of Nursing, Midwifery and Patient Services and seeks assurance that all safeguarding commitments and responsibilities for both adults and children are met. Highlights from this meeting are cascaded to senior managers via the Clinical Quality Effectiveness Group (CQEG) which again is on a quarterly basis.

6.0 Safeguarding Dashboards

6.1 Following the discontinuation of the Safeguarding Operational Group in March 2019, divisional safeguarding dashboards have been introduced to ensure that safeguarding and learning from safeguarding incidents is embedded into the organisation. The appropriate Divisional Associate Director of Nursing includes safeguarding highlights in their governance reports and to the Nursing and Midwifery Board.

7.0 Safeguarding Strategy 2019-2022

7.1 The safeguarding strategy was approved by the Safeguarding Assurance group (SAG) in October 2019. The safeguarding strategy sets out the strategic approach to ensure safe and effective services for safeguarding adults and children are in place for the next three years. The main objectives are to encourage continuous improvement in compliance with national and local policies, developing and implementing systems for quality monitoring that are robust, auditable and effective and raising the awareness of safeguarding making it 'everyone's business.' The associated action plan is presented and updated at the SAG on a bi-annual basis.

8.0 Disclosure and Barring Service (DBS)

8.1 The Trust has suitable and current policies in place to manage the requirements for checking the Disclosure and Barring Service (DBS) status of staff. All new employees and volunteers are checked as part of the employment/volunteer process. Safer recruitment processes are followed and the safeguarding team work closely with Human Resources when concerns are raised.

9.0 Safeguarding Concerns

9.1 Safeguarding concerns in the Trust are monitored by the safeguarding team. Some concerns are managed at ward level by the ward sister/department head and some are more complex which require reporting externally as per national legislation and local policy and procedures. The safeguarding team are involved in providing safeguarding expertise and concerns are analysed to detect trends and themes and to improve safeguarding.

The Head of Safeguarding and Dementia is a member of the Trust's Review of Harm Group, which meets on a weekly basis. In addition the safeguarding bulletin is distributed electronically via the Trust intranet site to support learning and practice.

10.0 Quality Schedule

10.1 The Clinical Commissioning Groups (CCG) Quality Schedule (2020-21 was suspended due to the pandemic along with the CCG quality visits.

11.0 Care Quality Commission

11.1 The Care Quality Commission (CQC) visited and inspected the Trust in July 2019 and was rated as requires improvement. The inspection team found that staff understood how

to protect patients from abuse and services work well with other agencies to do this. However not all staff had training on how to recognise and report abuse. This was particularly highlighted for medical staffing. A focussed inspection is expected in 2021.

12.0 Partnership Working

12.1 The Trust is committed to working with partners to improve outcomes for adults at risk, young people and children. Part of that commitment takes the form of attendance at, and active participation in, the NSAB and NSCP.

12.2 The table below highlights the attendance of the safeguarding team at the external NSAB and NSCP and subgroups. Commitment to these subgroups is substantial, not only in terms of attendance, but also with active participation and contribution to work streams:

Meeting	Frequency	Role
Northamptonshire Safeguarding Adults Delivery Board	Quarterly	Director of Nursing/Head of Safeguarding and Dementia
Learning and Development Committee (NSAB)	Quarterly	Named Nurse for Safeguarding Adults
Quality Assurance Sub Group (NSAB)	Quarterly	Named Nurse for Safeguarding Adults
Safeguarding Adults Review Subgroup (NSAB)	Quarterly	Head of Safeguarding and Dementia
Named and Designated Nurses Meeting (Adults)	Monthly	Named Nurse for Safeguarding Adults
Northamptonshire Safeguarding Children's Partnership (NSCP)	Bi-annually	Director of Nursing / Head of Safeguarding and Dementia
Child Death Overview Panel	Monthly	Named Doctor (Chair)
MASH Steering Group (NSCP)	Monthly	Named Nurse for Safeguarding Children
Learning and Development Committee (NSCP)	Quarterly	Named Midwife
Quality Sub-Group (NSCP)	Bi-monthly	Named Nurse for Safeguarding Children
Multi-Agency Safeguarding Development and Innovation Group (MASDIG)	Bi-monthly	Named Nurse for Safeguarding Children

Local Learning Review Subgroup (NSCP)	Quarterly	Head of Safeguarding and Dementia
Named and Designated Nurses Meeting (Children's)	Monthly	Named Nurse Children and Named Midwife
Safeguarding Health Strategic Forum	Quarterly	Director of Nursing/ Head of Safeguarding and Dementia

12.3 There has been two SAR's completed within this reporting period. These reviews take place after an adult dies or is seriously injured, and abuse or neglect is thought to be involved. The reviews look at lessons that can help prevent similar incidents from happening in the future. The statutory partnership has not published any CSPR's.

12.4 DHR's were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victim Act 2004. There are three outstanding DHR's which were undertaken and are awaiting ratification from the Home Office. Three further DHR's are in progress.

13.0 Safeguarding Adults

13.1 **National Context**

13.2 The Safeguarding Adults Collection (SAC) Annual Report 2019-20 published by NHS Digital in November 2020 presents information about adults at risk for whom safeguarding enquiries were opened during the reporting period 1 April 2019 to 31 March 2020. A safeguarding concern is where a local authority is notified about a risk of abuse, follows up the notification with information gathering, and if appropriate, instigates an investigation (enquiry) under the local safeguarding procedures. The report highlighted:

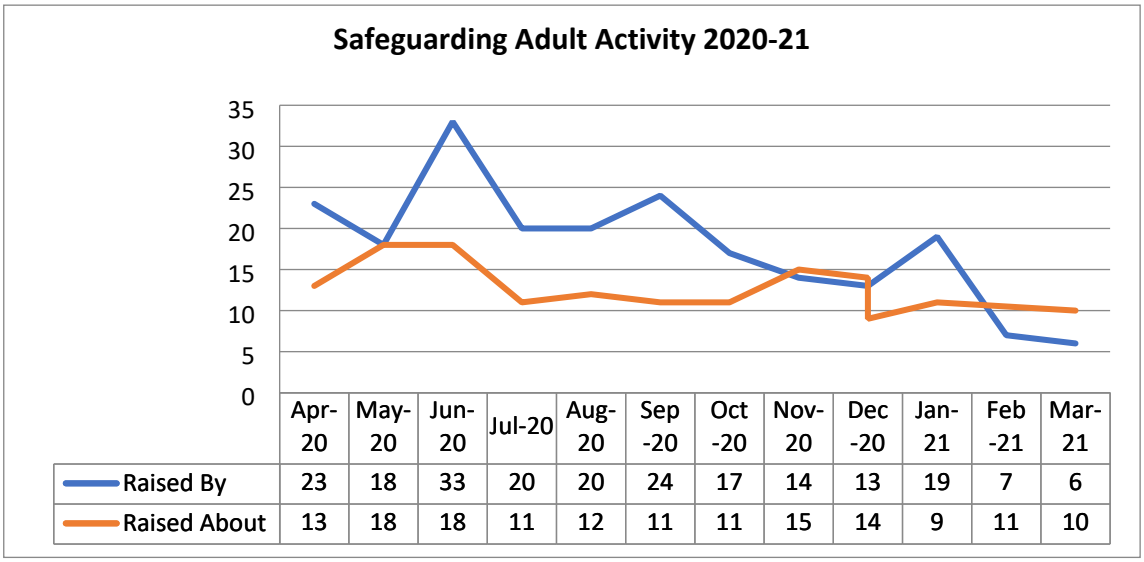
- There were 475,560 concerns of abuse raised during 2019-20 which is an increase of 14.6% on the previous year. The impact of the Covid-19 outbreak has not been a material factor in this increase as the pandemic only took hold at the very end of this annual report
- There were 161,910 individuals that were the subject of a safeguarding enquiry under Section 42 of the Care Act that started within the year. This is an increase of 12.9%% per cent on 2019-20.
- The most common type of risk in Section 42 enquiries that concluded in the year was neglect and acts of omission which accounted for 31.8% of risks
- The most common location of the risk was the person's own home (43.8%)
- In 89.5% of concluded Section 42 enquiries where a risk was identified, the reported outcome was that risk was reduced or removed.

14.0 Activity

14.1 There were 194 safeguarding adults referrals made by Trust staff during the reporting period which is a decrease compared to the same reporting period for 2019/2020 (209). This can be contributed to the pandemic and also the team has had to follow-up enquiries and outcomes from the Local Authority.

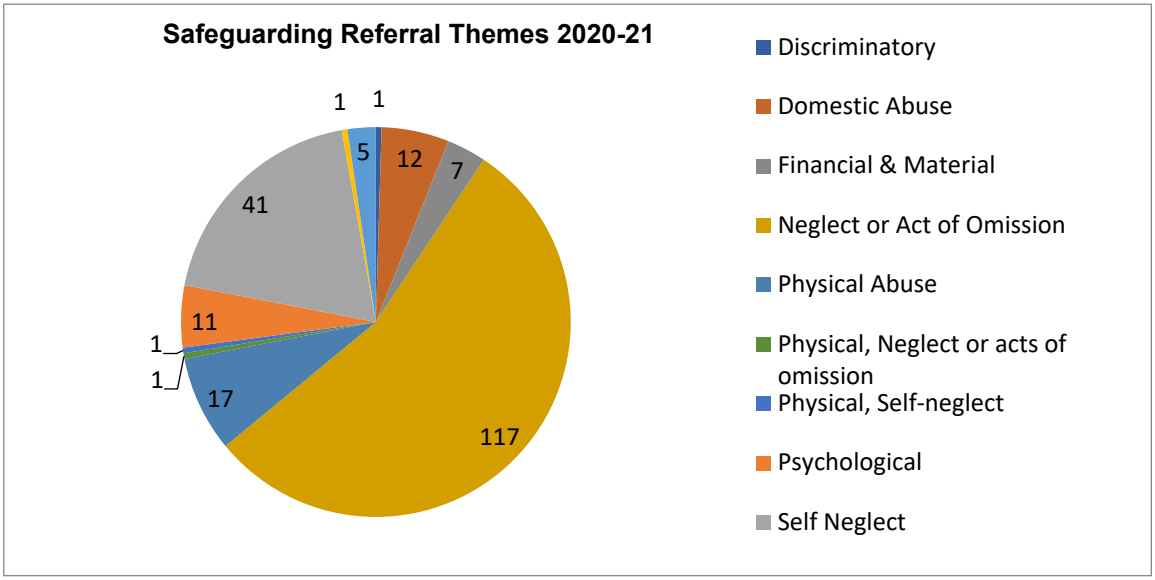
14.2 The majority of referrals were generated by the Emergency and Urgent Care Departments. These areas are often where initial assessments are undertaken prior to admission to the Trust in-patient wards.

14.3 The chart overleaf shows the number of safeguarding referrals that were made by and about the Trust for 2020-21. There were 153 safeguarding referrals raised about the Trust.



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Raised By	23	18	33	20	20	24	17	14	13	19	7	6
Raised About	13	18	18	11	12	11	11	15	14	9	11	10

14.4 The chart below highlights the themes of referrals made by the Trust during this reporting period. Neglect/or act of omission has been the highest level of safeguarding adult concern in terms of both referrals made by the Trust or about the Trust.



14.5 Safeguarding Adults investigations run on a 28 day timeline by the Local Authority. These were extended to 40 days in light of the pandemic and the impact on the capacity of staff to respond to enquiries/reports. Therefore despite this extension in place, the medicine division in particular had difficulty completing enquiries within this time period. This process will require more robust monitoring in 2021-22. The outcome of the investigations are as follows:

- 11 Substantiated
- 16 Partially Substantiated
- 22 Not Substantiated
- 21 Not Determined
- 11 Awaiting Outcome (of which 4 SI/Comprehensive Investigations and 2 Staff Allegations).

14.6 The themes of the allegations raised about the Trust predominantly refer to discharge arrangements in terms of timeliness, completeness of arrangements (i.e. home care package) and communication with carers and families prior to discharge.

14.7 The outcome of safeguarding investigations have been shared with staff members via ward / department meetings, matron and ward sister meetings to review and instigate processes/clinical practice to prevent similar incidents from occuring.

15.0 Allegations Against Staff

15.1 As part of the overarching safeguarding legilsative framework, the Trust has a statutory responsibility with regards to managing allegations against staff and there is a policy in place to support this. During 2020/21 there were 15 allegations (compared to 28 in 2019/20) made against staff which were investigated accordingly with outcomes of no further action, supportive frameworks or discplinary measures such as dismissal.

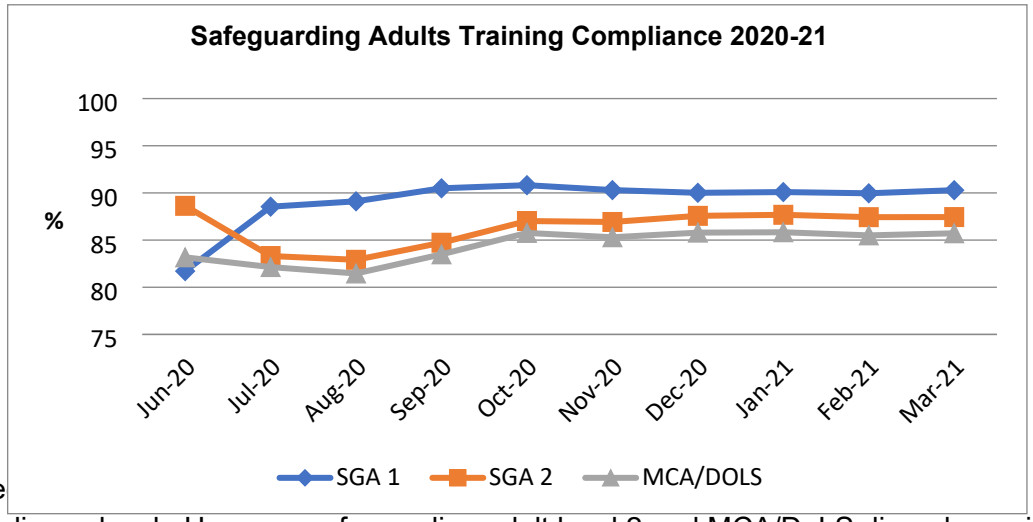
16.0 Safeguarding Adult Reviews (SAR's)

16.1 During the reporting period there were two SAR's published. The Trust contributed to both reviews with substantial contact with one of the adults at risk and in turn minimal contact with the other adult. Identified themes were the application of the MCA, homelessness and discharge planning. Recommendations from the reviews are monitored on a quarterly basis at the SAG..

17.0 Training

17.1 The safeguarding teams are committed to training and education which are fundamental to develop staff confidence and skills in relation to safeguarding. As discussed previously in the report, training compliance has been challenging during the reporting period due to the pandemic and the suspension of face-to-face training. Therefore alternative training programmes were put in place to encourage training compliance. This included e-learning, workbooks and reflective accounts.

17.2 The chart below highlights the safeguarding adult training compliance over the year of 2020/21 (please note that reporting was suspended from March to June 2020):



17.3 Safe compliance level. However safeguarding adult level 2 and MCA/DoLS dipped marginally just under compliance for four months during the reporting period.

17.4 Safeguarding adults level three training has been developed in light of the intercollegiate competency framework which was published in 2018. A training analysis was undertaken

at the end of 2020 and staff who engage in assessing, planning, intervening and evaluating the needs of adults when there are safeguarding concerns have been informed of the expectations to achieve compliance by the end of 2021.

18.0 Mental Capacity Act

18.1 The Mental Capacity Act (MCA) came into force in October 2007. The MCA provides a legal framework for assessing capacity and making decisions about the care and treatment of adults who lack capacity. This could be due to a mental health condition, a severe learning disability, a brain injury, a stroke or unconsciousness, etc. The MCA protects and empowers individuals who are unable to make all or some decisions for themselves. The MCA applies to everyone working in health and social care providing support, care or treatment to people aged 16 and over who live in England and Wales.

18.2 The safeguarding team has undertaken quarterly audits regarding the compliance and application of the MCA in practice, which have been presented to the SAG. The audit also forms part of the Trust quality schedule, which reports to the CCG.

18.3 The audit results over this reporting period have highlighted that the consistent application of the principles of the Mental Capacity Act when making undertaking assessments are not always clear. Also record keeping and information sharing in relation to assessments and best interest's decisions was variable.

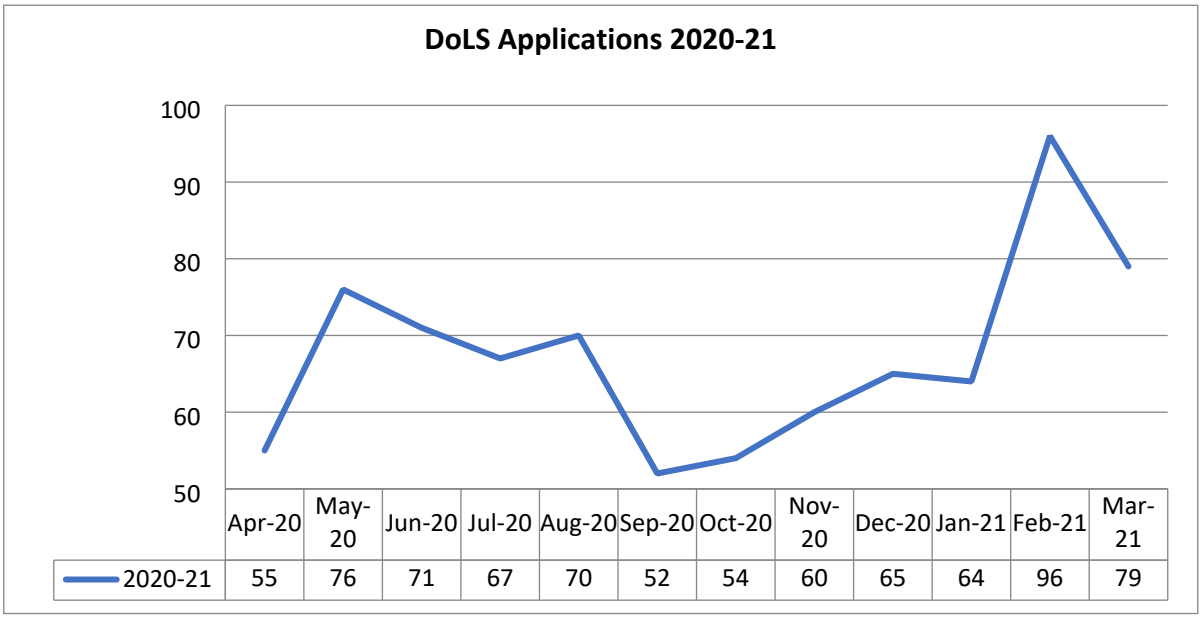
18.4 The Mental Health and Mental Capacity Act Lead Practitioner has developed bespoke training in response to a comprehensive investigation which highlighted poor application of the MCA. The training is face-to-face and scenario based and will be rolled out across the Trust in the coming year.

18.5 An Independent Mental Capacity Advocate (IMCA) supports people when they are assessed to lack capacity to make a best interest decision and they do not have family or friends appropriate to consult about the decision. During the reporting period the Trust made 12 referrals for an IMCA compared to 19 in 2019/20.

19.0 Deprivation of Liberty Safeguards (DoLS)

19.1 The Deprivation of Liberty Safeguards (DoLS) was introduced in 2009 and are part of the Mental Capacity Act 2005. They are used to protect the rights of people who lack the ability (mental capacity) to make certain decisions for themselves. The DoLS are set firmly within the empowering ethos of the MCA. They encourage all health and social care providers to put liberty and autonomy at the heart of care planning, to avoid wherever possible the need to deprive people of their liberty.

19.2 Deprivation of Liberty Safeguards (DoLS) applications in the Trust have significantly increased in 2020/21. There were 809 DoLS applications in the Trust during the reporting period against 560 in 2019/20.



19.3 The Trust continues to request Best Interest Assessments from the County Council under the legislative framework. However there have been no assessments carried out in the reporting period due to capacity issues associated with the Supreme Court ruling and there are over 3,500 outstanding Best Interest Assessments outstanding for the county. This concern is captured on the risk register within Patient and Nursing Services.

19.4 The Mental Capacity (Amendment Bill) Act 2019 received Royal Assent on 16th May 2019. The Liberty Protection Safeguards (LPS) will replace the current DoLS and was due to come into force on 1st October 2020. However due to Covid-19 this has been suspended until April 2022.

19.5 The safeguarding team will continue to attend both the countywide and health LPS steering groups to ensure there is consistent implementation across the county.

20.0 Court of Protection

20.1 The Trust made one application to the Court of Protection in this reporting period. The application related to a patient and discharge destination. The Court agreed with the proposal that the patient could be discharged to a discharge to assess bed.

21.0 Prevent

21.1 Prevent forms part of the Counter Terrorism and Security Act, 2015 and is concerned with preventing children and vulnerable adults becoming radicalised into terrorism. NHS Trusts are required to train staff to have knowledge of Prevent and radicalisation and to spot the vulnerabilities that may lead to a person becoming radicalised.

21.2 The purpose of Prevent is for staff to identify and report concerns where they believe young people or adults may be vulnerable to radicalisation or exploiting others for the purposes of radicalisation. The Named Nurse for Safeguarding Adults is the Prevent lead for the Trust.

21.3 The Named Nurse will make referrals and attends the Local Authority Channel panel when appropriate. This multi-agency panel discusses the risk posed by vulnerable people who are referred for multi-agency support.

21.4 All NHS Trusts and Foundations Trust are required to submit Prevent data to NHS England and NHS Improvement. This is submitted on a quarterly basis.

21.5 All staff members are required to receive basic awareness Prevent training and the Trust has achieved 90% compliance and this training is delivered on Trust induction. Level 3 training (Workshop to Raise Awareness of Prevent – WRAP) is at trajectory at 85%

22.0 Modern Slavery

22.1 Despite slavery being banned in the majority of countries for over a hundred and fifty years, modern slavery takes many forms. Forced labour, people trafficking, debt bondage and child marriage are all forms of modern day slavery that affects the world's most vulnerable people. It is estimated that there are over 13,000 people in modern slavery in the United Kingdom.

22.2 Modern slavery is incorporated within the safeguarding children and adult mandatory training from levels 1 -3, which applies to all staff employed by the Trust. Also the Trust's procurement department makes an annual statement in terms of systems and processes that are in place across the commissioning cycle.

23.0 Achievements in 2020/21

- Successful appointment and induction of the Named Nurse for Safeguarding Adults due to the retirement of the previous post holder
- Review of safeguarding data management processes to ensure that more robust systems are in place
- Completion of the NHS England NHS Improvement facilitated by the CCG Self-Assurance Safeguarding Framework with limited remedial actions
- Circulation of the monthly safeguarding bulletin with key safeguarding adult messages

24.0 Priorities for 2021/22

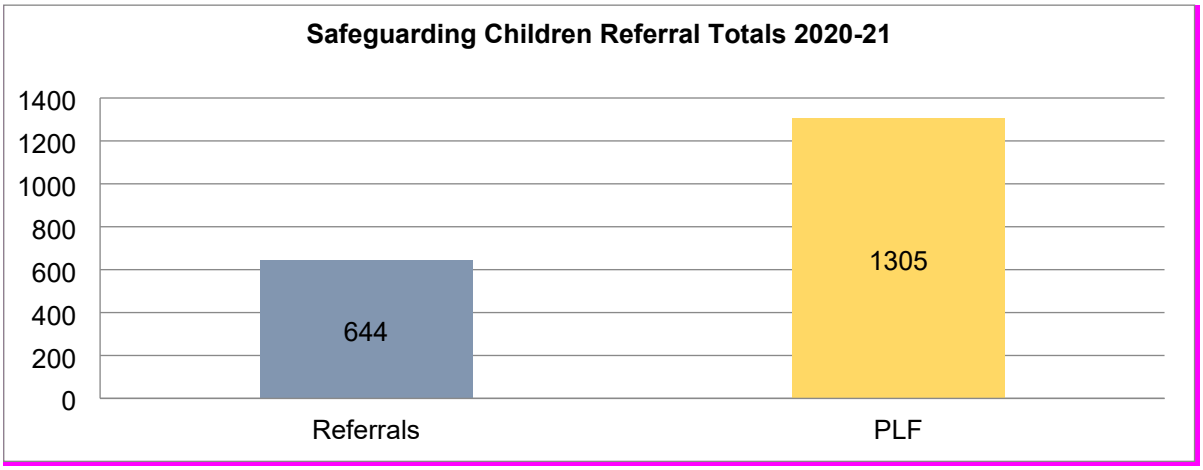
- Appointment and induction of the Safeguarding Adult's Practitioner to complement the return of the post holder from maternity leave on reduced hours
- Timely completion of safeguarding enquiries/investigations within the specified local time frame
- Increase quality assurance process of safeguarding enquiries/investigations and to facilitate training to ward sisters/matrons if required
- Attendance at the Countywide and Health LPS meetings to ensure that a robust and a consistent approach is in place to introduce and embed the new legislation within the Trust
- Concentration on the achievement of expected compliance at the end of 2021 of Level three safeguarding adults training
- Review MCA file audit to include DNACPR which will be carried out on a quarterly basis to inform areas of learning across the Trust
- Bespoke scenario based MCA training to multi-professionals across the Trust to endorse understanding the principles of the Act

25.0 <u>Safeguarding Children</u>

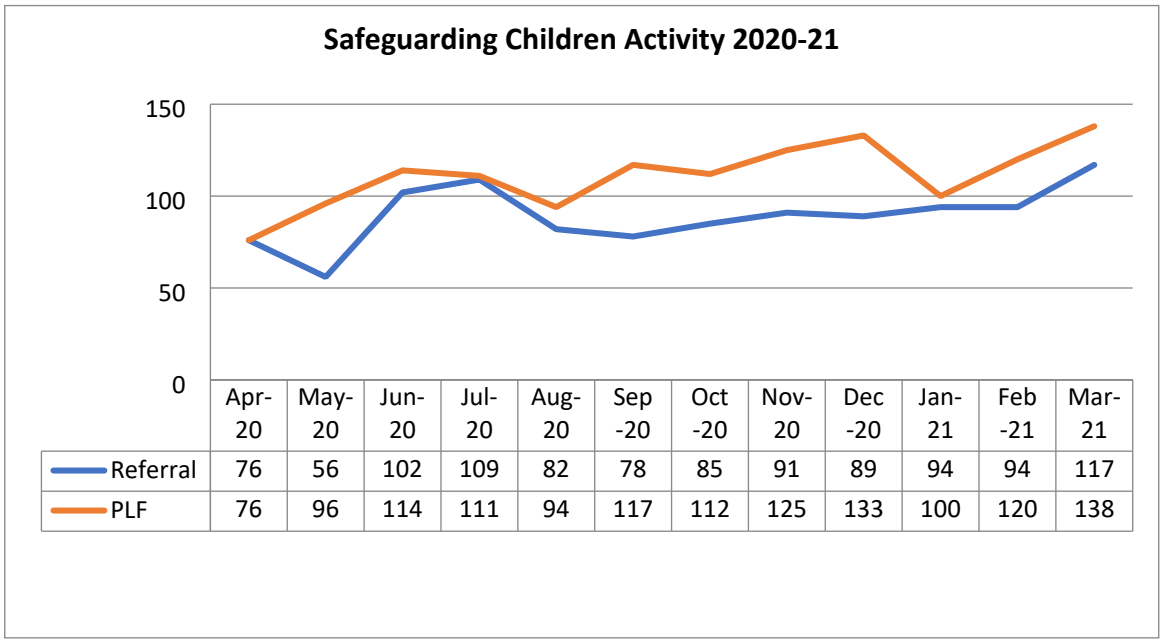
25.1 The Safeguarding Children's team are committed to safeguarding and promoting the health and wellbeing of all children and young people attending the Emergency Department (ED), as outpatient's or, those admitted to the paediatric wards, the Paediatric Assessment Unit (PAU), or any adult wards where 16 year olds and over have requested this. The Trust also have a 'duty of care' toward 'unseen' children whose parents have been admitted, or, have attended ED where there may be safeguarding concerns, for example, presenting with alcohol and drug misuse, suicidal ideation or in a mental health crisis.

26.0 Activity

26.1 There have been a total of 644 Multi-Agency Safeguarding Hub (MASH) referrals during 2020/2021 which is slight decrease than the previous year (691). This is despite a significant reduction in attendances and admissions of children and young people in the pandemic to the Trust.



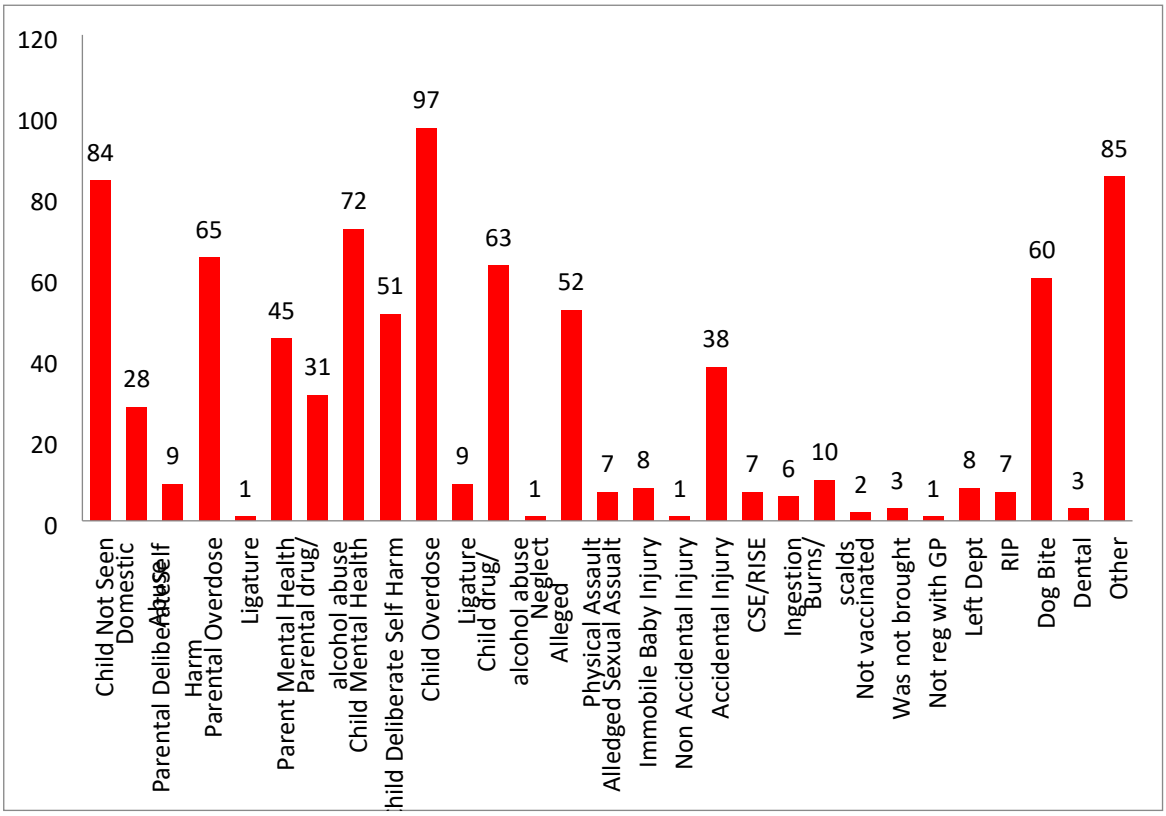
26.2 The chart below presents the safeguarding activity across the reporting period.



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Referral	76	56	102	109	82	78	85	91	89	94	94	117
PLF	76	96	114	111	94	117	112	125	133	100	120	138

26.3 There was 1305 paediatric liaison forms (PLF's) completed which highlights only a minimal decrease compared to last year when 1398 were raised. This evidences good practice in terms of timely information and liaison with external health colleagues such as GP's, health visitors and school nurses. This liaison work was highlighted as good practice within Laming recommendations in 2003 and Working Together (2018) in terms of the ethos of collaborative partnership working.

26.4 The bar chart overleaf presents the primary reason for MASH Referrals and Paediatric Liaison Forms by the Trust. However, there will often be multiple concerns or reasons for statutory intervention.



26.5 There has been a significant increase in child mental health presentations across the year. This includes self-harm and eating disorders which reflects trends in national reporting during lockdown. This is replicated in MASH and PLF's being raised for unseen children due to parents presenting with mental health issues as well.

26.6 There has been a slight increase in alleged assaults presenting to the ED across the year. Where the perpetrator of the assault is not disclosed by the victim, the safeguarding outcome will be no further action, although information is shared via MASH across the statutory partnership.

26.7 Dog bites have increased due to the risk to children and young people due to prolonged periods of time in the household rather than being in a school environment.

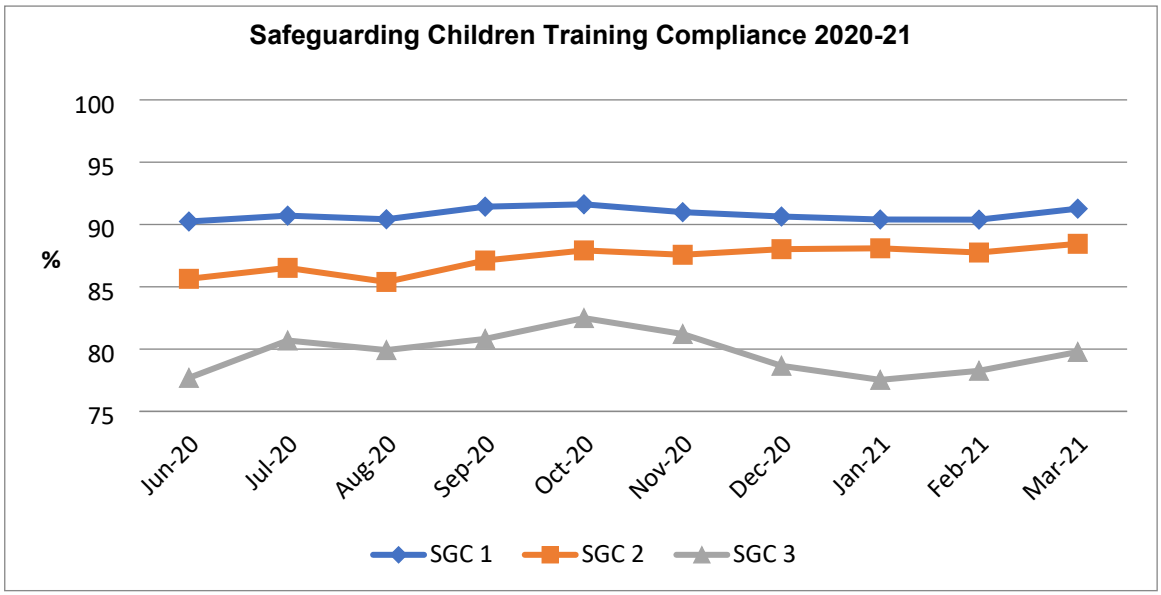
27.0 Audit Activity

27.1 The safeguarding children's team have remained proactive in conducting audits to review and inform front line practice. 'Prevalence of babies under twelve weeks presenting to the ED,' Children and Young People leaving the ED before being seen' and 'Children with Disabilities' have been completed and presented to the Safeguarding Assurance Group to provide assurance regarding themes and concerns identified both internally and across countywide multi-agencies.

27.2 The safeguarding team has attended the Quality and Governance sub group of the NSCP and was part of a Multi-Agency Case Audit (MACA) on child sexual exploitation. In addition a multi-agency safeguarding referral audit was undertaken across the county with health agencies auditing their peers. The audit proposal was to review the quality of information which ultimately informs decision making on the part of MASH. No serious concerns were highlighted for the Trust.

28.0 Safeguarding Children Training

28.1 As highlighted within the safeguarding adult section, training compliance has been challenging during the reporting period due to the pandemic and the suspension of face-to-face training. Therefore alternative training programmes were in place to encourage training compliance. This included e-learning, workbooks and reflective accounts. Safeguarding children training compliance is evidenced in the graph overleaf:



28.2 Level 1 and Level 2 safeguarding children training remained above the trajectory of 85% throughout the reporting period. However Level 3 remained a challenge across the reporting period with four months demonstrating compliance.

29.0 Paediatric Liaison Nurse (PLN)

29.1 The Paediatric Liaison Nurse (PLN) is the vital link between the Trust and community health services and social care colleagues ensuring pertinent and timely information about children aged 0-19 years (and beyond, for example, children with disabilities, Looked after children) are shared and exchanged with the professionals in the community to enhance continuity of care and inform safeguarding and promoting the welfare of children and young people.

29.2 The role of the PLN ensures that the ED child attendance lists are scrutinised on a daily basis to ensure MASH referrals and PLF's are raised appropriately to other professionals involved in the child's care.

30.0 Designated Officer (LADO)

30.1 The Designated Officer (formerly known as the Local Authority Designated Officer or LADO) at Northamptonshire County Council is informed by the Trust of all cases in which it is alleged that a person who works with children has behaved in a way that has harmed, or may have harmed a child or behaved in a way that indicated they may pose a risk to children. There have been two LADO enquiries received from the Designated Officer during the reporting period regarding Trust staff.

31.0 Child Safeguarding Practice Reviews (CSPR's)

31.1 There has not been any CSPR's published in the reporting period.

32.0 Child Protection Information Sharing (CP-IS)

32.1 The Child Protection Information Sharing (CP-IS) system is an NHS England NHS Improvement sponsored work programme dedicated to developing an information sharing solution that will deliver a higher level of protection to children who visit unscheduled health care settings. Data relating to children (including unborn children) with a child protection plan, or with looked after status, is securely transferred to and stored on CP-IS on the NHS Spine and is presented as a flag indicating the patient is a vulnerable child to all frontline practitioners.

32.2 By sharing data across regional boundaries CP-IS helps health care professionals build up a picture of a child's visits to unscheduled care settings supporting early help detection and intervention in cases of potential or actual abuse. It also enables information as to ED/PAU attendance to children's services and health colleagues in the community accessing this system.

33.0 Achievements in 2020/2021

- Successfully appointed Named Nurse for Safeguarding Children following the retirement of the previous post holder
- Completion of the NHS England NHS Improvement self-assessment framework facilitated by the CCG with limited remedial actions
- Audit activity both internally and externally has been completed in the form of multi-agency case audits to ensure that safeguarding activity within the Trust reflects good practice. Internal audits have included: babies presenting to ED, disabled children.
- Paediatric safeguarding quality visit by the CCG with positive feedback
- Ongoing pre-arranged, ad hoc safeguarding supervision to paediatric wards, teams and departments throughout the pandemic

34.0 Priorities for 2021/2022

- Audit and monitoring of CP-IS within ED and paediatric areas.
- Review of MASH internal governance process
- Review the job descriptions of the safeguarding children's advisor and the paediatric liaison nurse to amalgamate to one role.
- Safeguarding children Level 3 training to consistently be at expected trajectory (85%)training compliance to be maintained as per the CCG quality schedule
- Review of MASH internal governance process including escalating cases which have not been taken forward into assessment despite meeting threshold of safeguarding concerns.
- Review of safeguarding children supervision arrangements to all staff working with children
- Review of internal relationship meetings between the safeguarding children's team and paediatrics and ED.

35.0 Safeguarding Within Maternity Services

35.1 The Named Midwife for Safeguarding is supported in her role by two Band 6 safeguarding midwives, one 0.6WTE and the other 0.4WTE. The maternity safeguarding team supports both hospital and community based staff, and ensures that safeguarding is embedded into practice.

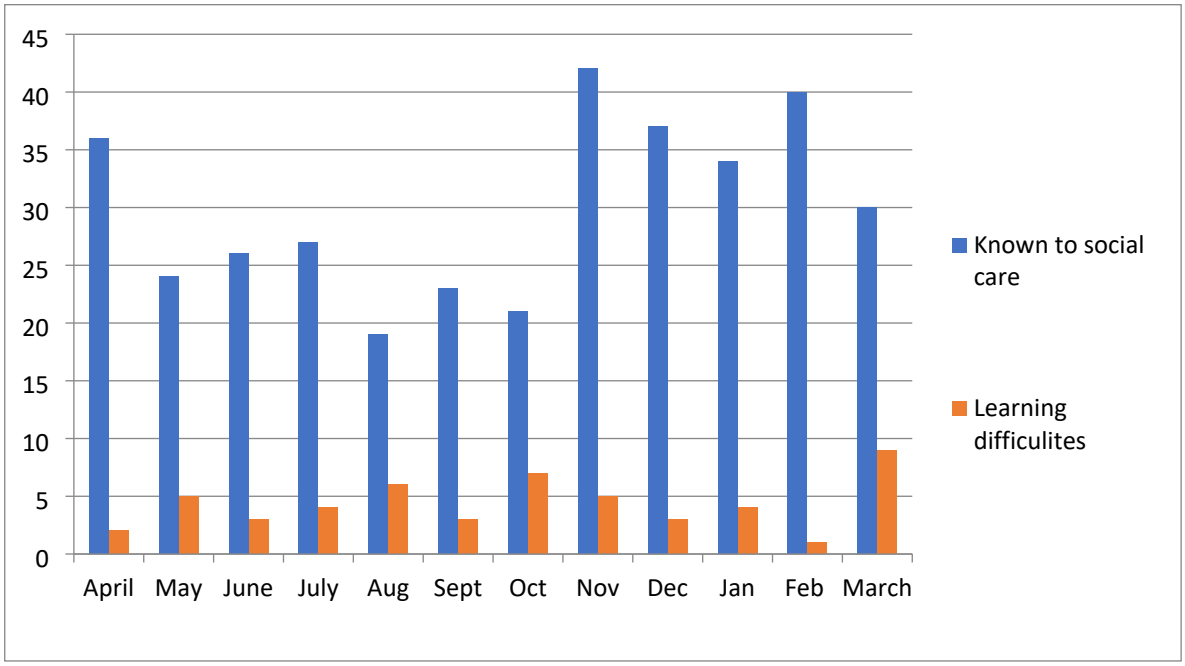
35.2 The central midwifery team has three full time (including a perinatal mental health midwife) and five part-time midwives in post. The midwives support women who have currently children's services involvement, or cases which are being escalated by the Named Midwife when children's services have determined that the case is closed. The midwives provide continuity of care for vulnerable women and families across Northampton, Daventry and Towcester. The team work alongside a multitude of professionals, such as social workers, police and other health sectors to support the women and their families.

35.3 The maternity safeguarding team provides safeguarding supervision to each central team member team on a monthly basis or where an individual case requires more frequent focus. A safeguarding supervision plan has been devised and this is documented within the woman's records and recorded on the maternity safeguarding team database. The Named Midwife also provides bespoke training sessions on themes and concerns that have become apparent in the midwifery/child protection cases.

35.4 The central team represent the Trust at safeguarding meetings, such as strategy discussions, child protection conferences, core meetings and child in need meetings. The central team will feedback to the maternity safeguarding team when issues arise, such as drift in adhering to the agreed NSCP pre-birth pathway.

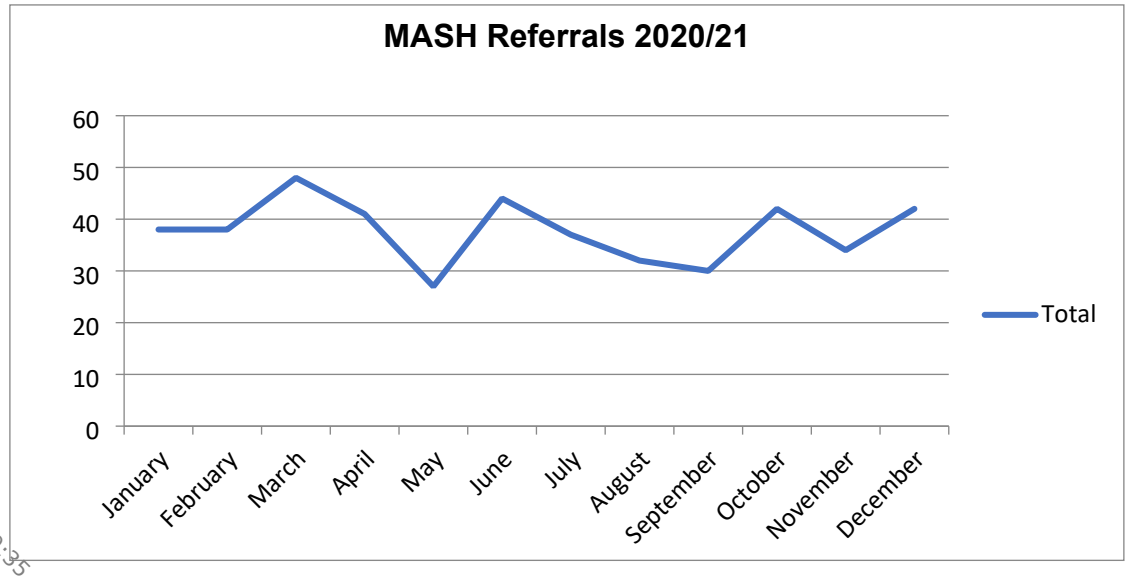
35.5 A number of maternity safeguarding cases continue to identify the absence of pre-birth assessments and the cases being held at a lower safeguarding threshold, such as children in need by children's social services. The maternity safeguarding team have had to ensure that any concerns from the service are escalated. Therefore due to the number of escalations, a service manager at children's services has been allocated as the single point of contact for the maternity safeguarding team so that cases can be discussed as soon as possible to reach the appropriate threshold of intervention. Midwives are still encouraged to raise their concerns with the allocated social worker, in accordance with the NSCP escalation procedure. When issues/concerns are not resolved through liaison with the social worker and team manager, concerns are then escalated by the safeguarding maternity team to the service manager, who explores these further.

35.6 The maternity safeguarding team systematically reviews all bookings for women who have current or previous children's services involvement or has a learning disability. During the last year, 359 women have been identified as having current or previous children's services involvement and 52 women have been identified as having a learning disability (detailed in the graph below). By reviewing the records, a MASH is often required and this is then discussed and completed by the allocated midwife. This process has been educational for midwives and most importantly, relevant safeguarding referrals have been generated and shared with the local authority.



36.0 Maternity Activity

36.1 The total number of referrals made to the MASH during 2020/21 was 545, which is a 28% increase from 2019/20 (353) and 41% increase from 2018/19 (265). On average during 2020/2021, the number of referrals made to social care each month has increased which is displayed in the chart below:



36.2 Each referral that is sent to MASH is forwarded to the maternity safeguarding team, who will review the referral and MASH outcomes are followed up on a weekly basis to ensure

that appropriate plans are in place. When necessary, if the case is closed by MASH, the outcome will be challenged by the Named Midwife to ensure that the correct plans and provisions are in place for the family. Two hundred and twenty two assessments were completed by children's services in 2020/2021 following MASH referrals being raised by maternity services. This is compared to one hundred and fifty eight in 2019/20 is an increase of 40%. This demonstrates that midwives are informed about what they need to refer, able to articulate the needs of vulnerable women and their unborn and where no further action is an outcome, this is challenged early by the maternity safeguarding team.

36.3 Every safeguarding referral received by the maternity safeguarding team is screened to establish the primary reason for the concerns being raised. A number of maternity cases will have a number of complicating factors, which include the trilogy of risk – domestic abuse, substance misuse and poor parental mental health. The primary leading cause for MASH referrals being completed in maternity services continues to be due to the mother/family already being known to children's services. During the last year, the team have been obtaining a secondary reason for MASH referrals being completed. The secondary reason for MASH referrals being completed across the year has been due to domestic abuse concerns, followed by poor maternal mental health. An increase in concealed pregnancies has been identified since the pandemic and this has been recognised as a national theme.

37.0 Training

37.1 The current safeguarding children level three training figures for Obstetrics and Gynaecology is 80% As previously discussed in both the adult and child training section, training compliance has been challenging during the reporting period due to the pandemic and the suspension of face-to-face training due to infection prevention. Therefore alternative training programmes were in place to encourage training compliance. This included e-learning, workbooks and reflective accounts.

38.0 Female Genital Mutilation (FGM)

38.1 Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act (2003). It is a form of child abuse and violence against women. FGM comprises of all procedures involving partial or total removal of the external female genitalia for non-medical reasons.

38.2 Section 5B of the 2003 Act introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report 'known' or potential risk of FGM in under eighteens to the Police. The duty came into force on 31st October 2015. During the reporting duty the Trust did not refer any children to the Police under this framework. However statistical information is gathered regarding women who have had FGM and present to the Trust. During 2020/2021 there were forty five women identified as having FGM when booking their pregnancy with the Trust. This is a decrease of 24%, compared to 2019/2020. The majority of these ladies were from Somalia. Other countries cited were Sudan, Djibouti, Tanzania, Kenya, Yemen, Iraq, Nigeria, Ethiopia and Liberia.

38.3 The Female Genital Mutilation Risk Information System (FGM-RIS) is a national information technology system that supports the early intervention and ongoing safeguarding of girls, under the age of 18, who are potentially at risk of FGM.

38.4 This system was launched by the Department of Health and NHS England in July 2014 which enables recording the potential risk of FGM on a girl's health record. This is

particular pertinent to maternity services as the most likely point for identifying that a girl is potentially at risk of FGM is when she is born to a mother with FGM. Eighteen infant females had FGM-RIS alerts added onto the NHS summary care records as per guidance by NHS England and NHS Improvement.

38.5 A FGM audit was repeated following the initial audit completed in December 2019. The repeated audit in December 2020 evidenced compliance with CP-IS and information sharing with partner agencies.

39.0 Domestic Abuse

39.1 The Hospital Independent Domestic Violence Advisor (HIDVA) role at the Trust was decommissioned in March 2020. Prior to this, the IDVA would support staff in offering advice, safety planning and support to staff and patients experiencing domestic abuse. The hospital remains in liaison with the Sunflower Centre (voluntary domestic abuse support services), who continue to support the organisation and provide domestic abuse training to professionals.

39.2 All midwives are required to routinely ask every woman about domestic abuse at least twice during the woman's pregnancy, as well as adopting a target approach where signs or indicators of domestic abuse are observed at any time throughout maternity services – during the antenatal or the post-natal period.

39.3 The maternity safeguarding team receives Police Protection Notifications (PPN's) from Northamptonshire Police on a weekly basis regarding domestic abuse incidents involving pregnant women. The maternity safeguarding administrator will alert maternity services of the notification by uploading the information onto the woman's maternity electronic records. In addition, the allocated midwife will receive an email alerting them to the notification and prompting them to discuss domestic abuse at each contact where possible. This is an opportunity for a referral to domestic abuse support services such as Victim or the Sunflower Centre

39.4 During the last year, the maternity safeguarding team have received three hundred and sixteen PPN's from Northamptonshire Police which details different levels of risk. The information shared is categorised into three levels of risk: standard (no significant current indicators); medium (identifiable indicators of harm) and high (indefinable indicators of risk of serious harm). The maternity safeguarding team noted a significant rise in domestic abuse notifications in August (38). On average the team receives twenty five domestic abuse notifications each month.

39.5 Whilst the prevalence and impact of domestic abuse amongst patients is acknowledged at a local and national level, it must not be forgotten that these issues also affect NGH staff. Reminders have been circulated to remind staff that referrals to the Sunflower Centre can be made and there is a staff domestic abuse policy in place to support.

40.0 Domestic Homicide Reviews

40.1 There are three reviews awaiting final ratification from the Home Office. Action plans from the reviews are reviewed and monitored at the Safeguarding Assurance Group on a quarterly basis. Three other DHR's are in progress across the county.

41.0 Achievements during 2020/2021

- Domestic abuse guideline was revised and updated to include;
  - Creating a safe space for domestic abuse disclosures/ support
  - Domestic abuse enquiry in a virtual setting

    - Updated domestic abuse workflow
    - Information regarding Honour based violence and forced marriage
- Teenage pregnancy guideline was revised to include a teenage pregnancy risk assessment form.
- Repeated FGM audit which evidence compliance with CP-IS and information sharing with partner agencies
- Further development of the unborn tracking meetings to share and escalate concerns.
- Monthly liaison meeting with Named Midwife for safeguarding at Kettering General Hospital including information sharing with regards to cases, sharing of guidelines and enhancing pathways collaboratively
- Did Not Attend (DNA) guideline was further developed and ratified, which includes more robust follow up for women with safeguarding needs
- Successfully leading on adult risk management meetings for women with extensive adult safeguarding concerns in pregnancy and postnatally- This included the first Adult Risk Management meetings which was led by NGH.
- Strengthened the safeguarding supervision offer for the central team who case hold vulnerable women and community sisters
- Quarterly strategic meetings chaired by the Deputy Director of Children Services, following an accumulation of concerns escalated to the Local Authority by the Head of Safeguarding which has strengthened multiagency working
- Arranged DASH training for a number of midwives and other professionals across the Trust by the Sunflower Centre
- Implementation of the concealed pregnancy guideline, following an increase in presentations during the start of Covid-19 pandemic. The guideline includes information regarding;
    - Unbooked at Northampton General Hospital/ transferring care from another NHS Trust
    - Safeguarding Alerts/ National Alerts
- Completion of the NHS England NHS Improvement Safeguarding Self-Assessment Framework facilitated by the CCG with limited remedial actions
- Specific maternity policy developed and ratified

42.0 Priorities for 2021/22

- Safeguarding training compliance to be achieved as per quality schedule.
- Escalation of safeguarding cases to children's services when concerns that the appropriate threshold of intervention has not been met
- Further development of the learning disability pathway for pregnant women.

<u>References and Further Reading</u>

- Adult Safeguarding : Roles and Competencies for Health Care Staff (2018) London: Royal College of Nursing
- Care Act (2014)
- Children's Act (2004)
- Counter Terrorism and Security Act (2015)
- Deprivation of Liberty Safeguards (2009)
- Domestic Violence, Crime and Victims Act (2004)
- Female Genital Mutilation Act (2003)
- Health and Social Care Act 2008
- Laming (2003)
- Mental Capacity Act (2005)
- NHS England (2019) 'Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework' HMSO: Department of Health
- Northamptonshire Safeguarding Adult Board Procedures
- Northamptonshire Safeguarding Children Board Procedures
- Safeguarding Children and Young People Intercollegiate Guidance (2019) HMSO: Department of Health

- Supreme Court (2014) http://www.supremecourt.uk/decidedcases/docs/UKSC_2012_0068_Judgment.pdf
- Working Together to Safeguard Children and Young People Intercollegiate Guidance (2018)

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Cover sheet

Meeting	Public Trust Board
Date	30th September 2021
Agenda item	4.4

Title	Workforce Disability Equality Standards and Workforce Race Equality Standards 2021/22
Presenter	Mark Smith, Chief People Officer
Author	Mark Smith, Chief People Officer

This paper is for			
☐Approval	☐Discussion	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

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

Reason for consideration	Previous consideration
To report on the WDES and WRES 20/21 position for the Trust.	The Board received a presentation, paper and EDI Group strategy at the July meeting, outlining the Trust responses to the attached results

Executive Summary
Attached are Workforce Disability Equality Standards (WDES) & Workforce Race Equality Standard results for the Trust. The Trust Board has regular updates on Equality, Diversity and Inclusion and at the most recent Board in July 2021 approved a set of actions to address the attached results and underpin the Equality, Diversity and Inclusion Strategy (effective July 2021) that is aligned to the EDS 2 Goals (objectives) and the new Group People Plan.

Of the nine, WRES indicators, there have been improvement in five, deterioration in three and for one indicator (number 8) there has been a mix. There are actions in place as reported to the Board of Directors in July, inclusive of Board specific actions, centred on awareness, visibility and support.

Our WDES indicators outline areas of concern with regards to how colleagues with a disability feel within our Trust. Actions being taken are articulated within the report, a focus is on relaunching the Disability and Wellbeing Network (DAWN) who can provide, support and drive actions from lived experience.

Appendices

WDES and WRES results infographic

Risk and assurance

The risks of not improving our WDES and WRES position, will impact, colleagues ability to work within the Trust, our ability to attract colleagues to work in the Trust. A risk within our Trust includes resourcing the EDI agenda, which has been mitigated in the short term via a secondment and longer term will be resolved with the People directorate structure

Financial Impact

The cost of delivering the WDES and WRES has been accounted for within the budgets of both Trusts for 2021/22.

Legal implications/regulatory requirements

Implementing the WDES and WRES is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract.

Equality Impact Assessment

This work focusses on the three general duties of the Equality Act 2010: Enhancing equal opportunities,

- Fostering good community relations between groups
- Eliminate discrimination, harassment, and victimisation.
- With a specific emphasis on the Race and Disability protected characteristics.

The WRES and WDES is an equality analysis. Data is collected and analysed for inequalities and actions are developed in response. The process is established within NGH and across the UHN Group to involve staff and stakeholders in the discussion and action planning.

Workforce Race Equality Standard (WRES) Data 20/21

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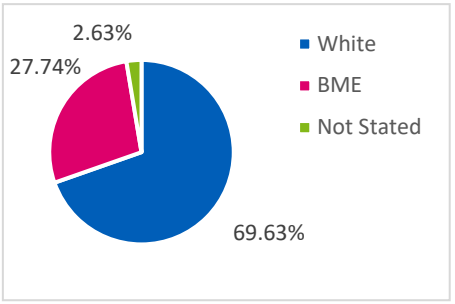

Percentage of staff members at NGH who are White, BME or have not stated their ethnicity.

Total Workforce = 5973
White = 4159
BME = 1657
Not stated = 157

AFC Bands

	White	BME	Not Stated
Bands 1-4	81.37%	18.63%	1.79%
Bands 5-7	64.77%	35.23%	2.55%
Bands 8A-VSM	85.66%	14.34%	1.55%

Medical & Dental

	White	BME	Not Stated
Consultants	48.43%	47.64%	3.94%
Senior Medical Manager	100%	0%	0%
Non-Consultant Career Grade	22.22%	72.22%	5.56%
Trainee Grades	26.38%	64.64%	8.99%

WRES Indicators

1. **Percentage difference between the organisations' Board voting membership and its overall workforce**
   BME -21.5%
   White 24.1%
   An improvement of 2.9% from the previous year
2. **0.93**
   An improvement of 0.13 in comparison to 2019/20
   Relative likelihood of White staff being appointed from shortlisting compared to BME staff
3. **1.52**
   Deterioration of 0.22 since 2020
   Relative likelihood of BME staff entering the formal disciplinary process compared to White staff
4. **1.80**
   Deterioration of 0.79 since 2020
   Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff
5. **Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months**
   BME 30%
   White 28%
   6% improvement for BME staff
6. **Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months**
   BME 34%
   White 29%
   4% improvement for BME staff
7. **Percentage of staff believing the hospital provides equal opportunities for career progression or promotion**
   BME 64%
   White 87%
   4% improvement for BME staff
8. **Percentage of staff who have personally experienced discrimination at work from Manager/Team leader**
   BME 22%
   White 7%
   1% deterioration for BME staff and 1% improvement for White staff
9. **Percentage difference between the organisations' Board voting membership and its overall workforce**
   BME -21.5%
   White 24.1%
   An improvement of 2.9% from the previous year

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Workforce Race Equality Standard (WRES) Data 20/21

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

1. To implement the Inclusive Recruitment Champion process to help eliminate any bias during recruitment and selection process. The aim is to increase diversity at all levels within the Trust for REACH staff and all other protected groups. Phased approach – Interviews for Band 7 and above. Medical & Dental interviews are being reviewed.
2. To implement the RCN Cultural Ambassador programme to support REACH staff during formal and informal HR process to ensure a space/ atmosphere of safety, transparency and support that is offered to the staff.
3. Campaign is currently in planning stages to recruit more FTSU Values Ambassadors, beginning with REACH members. This will involve work with Comms to promote the value of FTSU and the positive cultural changes that can occur when staff feel safe to speak up. Increasing visibility for Values Ambassadors to be a champion of FTSU in their respective areas of work.
4. Continually champion and foster cultural change within the Trust via specific training programmes with OD team and other measured approached. Work with HRBP's to triangulate DATIX's involving REACH staff and hotspot areas of concern.
5. Promote REACH Network Drop In Service to create a safe space for Network members to share feedback on activities or raise cultural issues/concerns to a respective Co-Chair of the Network in confidence. Provide support to those members who need it.

6. Continue to promote training programmes at a national, regional, system and local level. Incorporating in-house programmes (Unconscious Bias, Courageous Conversations, KGH Building Cultural Bridges) to embed cultural change within organisation whilst creating a safe space for protected groups

Specific Board Actions:

1. Continue the Reverse Mentoring Programme and expand participants to other protected groups whilst retaining a significant percentage of REACH staff, Board Members to invite their mentor to Board to expand learning for all Board Members.
2. Commitment to 6 monthly Inclusion update on EDI progress with rolling protected groups focus.
3. Inclusion of a protected group role model staff story at Board meetings so viewers in those groups can relate.
4. Expansion of Executive Sponsorship to include Non-Exec Directors as Sponsors for all Networks and continue to retain the engagement of the Exec Sponsors for the Networks.
5. Commitment to a Board Development Session to continue to focus on Diversity & Inclusion. To include cultural change training programmes such as Building Cultural Bridges.
6. Take supportive action to increase the diversity of the Board across the Group.

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Workforce Disability Equality Standard (WDES) Data 20/21

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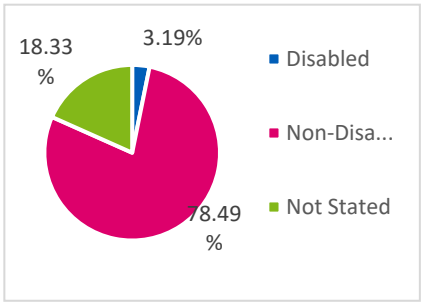

Percentage of staff members at NGH who are disabled, non-disabled or have not stated their disability status

Total Workforce = 5973
Disabled = 174
Non-Disabled = 4283
Not stated = 1000

AFC Bands

	Disabled	Non-Disabled	Not Stated
1-4	4.99%	82.37%	12.64%
5-7	4.74%	81.51%	13.75%
8A-8D	17.65%	78.15%	4.20%
9-VSM	0%	95%	5%

Medical & Dental

	Disabled	Non-Disabled	Not Stated
Consultants	1.57%	66.54%	31.89%
Sen. Medical Manager	0%	100%	0%
Career Grade	22.22%	63.89%	36.11%
Trainee Grades	3.19%	82.61%	14.2%

WDES Indicators

1. **1.12** — Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts
2. **5.85** — Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff
3. Disabled 35% / Non Disabled 27% — Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
4. Disabled 21% / Non Disabled 13% — Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months
5. Disabled 31% / Non Disabled 21% — Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months
6. Disabled 50% / Non Disabled 44% — Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
7. Disabled 77% / Non Disabled 84% — Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion
8. Disabled 36% / Non Disabled 22% — Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
9. Disabled 36% / Non Disabled 49% — Percentage of staff satisfied with the extent to which their organisation values their work
   - 9a
   - 9b
   - 9c
10. **79%** — Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry
11. Disabled -5% / Non Disabled -17% — Percentage difference between the organisations' Board voting membership and its overall workforce

Dedicated to excellence

Workforce Disability Equality Standard (WDES) Data 20/21

NHS Northampton General Hospital NHS Trust

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

1. To implement the Inclusive Recruitment Champion process to help eliminate any bias during recruitment and selection process. The aim is to increase diversity at all levels within the Trust for disabled staff and all other protected groups. Phased approach – Interviews for Band 7 and above. Medical & Dental interviews are being reviewed.
2. Focus considerable energy into the relaunched DAWN (Disability & Wellbeing Network) to foster a culture of openness, understanding and action amongst disability issues including mental health and general wellbeing of staff.
3. To implement the RCN Cultural Ambassador programme to support disabled staff during formal and informal HR process to ensure a space/ atmosphere of safety, transparency and support that is offered to the staff.
4. Continually champion and foster cultural change within the Trust via specific training programmes with OD team and other measured approached. Work with HRBP's to triangulate DATIX's involving disabled staff and hotspot areas of concern.
5. Continue to promote Health & Wellbeing offerings at a national and local level. Continue to share best practice at system meetings to feed back to DAWN and wider organisation.
6. Disabled staff and staff from other protected groups to attend Board and share their lived experiences within the organisation, utilise Exec Sponsors of DAWN to provide these opportunities and remain a champion at Exec level.

Specific Board Actions:

1. Continue the Reverse Mentoring Programme and expand participants to other protected groups (disabled) post-REACH cohort, Board Members to invite their mentor to Board to expand learning for all Board Members.
2. Commitment to 6 monthly Inclusion update on EDI progress. Expand focus to disabled staff.
3. Inclusion of a protected group role model staff story at Board meetings so viewers in those groups can relate.
4. Expansion of Executive Sponsorship to include Non-Exec Directors as Sponsors for all Networks and continue to retain the engagement of the Exec Sponsors for the Networks.
5. Commitment to a Board Development Session to continue to focus on Diversity & Inclusion. To include cultural change training programmes such as Building Cultural Bridges.
6. Take supportive action to increase the diversity of the Board across the Group.

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NHS
University Hospitals of Northamptonshire
NHS Group

Cover sheet

Meeting	Northampton General Hospital Public Trust Board
Date	30 September 2021
Agenda item	4.5

Title	Strategic Development Committee – Establishment of Committee in Common
Presenter	Ms C Campbell
Author	Ms P Grimmett

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

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

Reason for consideration	Previous consideration
The establishment of Committees is reserved to the Board of Directors	None; however, the proposal will also be submitted to the Kettering General Hospital Foundation Trust NHS Trust Board of Directors at its meeting on 29 September 2021.

Executive Summary
Kettering General NHS Foundation Trust already has established a Strategic Development Committee (SDC), which oversees the Strategic Estates developments and modernisation of the Trust's estate, to ensure that is a key enabler to deliver clinical service ambitions. NGH has recently submitted an expression of interest for inclusion in the next phase of the government's Hospital Infrastructure Programme (HIP3). The Group Clinical Strategy is due to be presented to both Board of Directors at end of November 2021. Following that approval, there will be requirement for a Group Estate strategy that supports delivering the clinical ambition and sets out the priorities for estates strategic development projects over the coming years. The Director of Strategy (KGH) assumed responsibility for strategic estates across the hospital group on 1 September 2021. It is recommended therefore that to develop an equivalent SDC at NGH would enable the same level of detailed oversight of these common pieces of work. In light of these developments, the Board of Directors is recommended to **APPROVE** the reconstitution of the Strategic Development Committee as a Committee in Common with NGH. Subject to approval of this recommendation, the Committee in Common will meet in shadow form in October and November 2021, pending the submission of updated Terms of Reference to Boards for approval.
Appendices
None
Risk and assurance
The establishment of a Committee in Common will provide an important control against Group Risk GSI05 relating to the Strategic Estates Programme.
Financial Impact
No direct implications.
Legal implications/regulatory requirements
As set out above.
Equality Impact Assessment
Neutral