Public Trust Board - May 2021

Thu 27 May 2021, 09:30 - 12:30

ZOOM

Northampton General Hospital NHS Trust

Agenda

09:30 - 10:15
45 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 25 March 2021

Decision *Alan Burns*

2.0 Draft Public Trust Board Minutes 25 March 2021.pdf (14 pages)

1.4. Matters Arising and Action Log

Information *Alan Burns*

Action Log Public Board.pdf (1 pages)

1.5. Patient Story

Information

1.6. Chairman's Report

Information *Alan Burns*

Verbal

1.7. Group Chief Executive's Report

Information *Simon Weldon*

7.0 Group CEO Report.pdf (4 pages)

1.8. Hospital Chief Executive's Report

Information *Eileen Doyle*

8.0 HCEO board report May 21 v3 final.pdf (3 pages)

10:15 - 11:55
100 min

2. PERFORMANCE

2.1. Integrated Performance Report

Information *Executive Team*

9.0 IPR Front Sheet May 21.pdf (1 pages)

9.1 IPR April 21.pdf (61 pages)

2.2. 2021/2022 Planning

Discussion *Ms B Agboola & Ms K Spellman*

To Follow

Operational Plan Front Cover May 21 FV2.pdf (4 pages)

2.3. Assessment & Accreditation for Nursing Excellence

Information *Sheran Oke*

11.0 AA board paper board V9_final.pdf (23 pages)

11:55 - 12:10
15 min

3. STRATEGY & CULTURE

3.1. Nursing, Midwifery & Allied Health Practitioner Strategy

Decision *Sheran Oke*

12.0 Cover sheet_Nursing Midwifery AHP strategy approval (2).pdf (3 pages)
12.1 Group NMAHP Strategy Delivery Plan 21-22 plus draft Measures of success for discussion V6.pdf (1 pages)
12.2 Nursing midwifery and AHP strategy v15 (2).pdf (21 pages)

12:10 - 12:10
0 min

4. GOVERNANCE

4.1. Annual Self Certification

Decision *Claire Campbell*

13.0 Board Self cert 2021.pdf (6 pages)

4.2. Board Assurance Framework

Information *Claire Campbell*

14.0 Trust Board BAF Q4 2020 21.pdf (5 pages)
14.1 Q4 2020 21 BAF update Final.pdf (20 pages)

4.3. Group Risk Appetite

Decision *Claire Campbell*

15.0 Group Risk Appetite paper Board May 2021.pdf (2 pages)

12:10 - 12:15
5 min

5. CLOSING ITEMS

5.1. Questions from the Public (Received in Advance)

Information *Alan Burns*

12:15 - 12:20
5 min

6. ANY OTHER BUSINESS

Information *Alan Burns*

Minutes of the Public Trust Board

Thursday 25 March 2021
09:30 by ZOOM teleconference

Present		
	Mr D Moore	Non-Executive Director
	Mr S Weldon	Group Chief Executive Officer
	Ms E Doyle	Interim Hospital Chief Executive Officer
	Mr M Metcalfe	Medical Director
	Ms S Oke	Director of Nursing, Midwifery and Patient Services
	Ms J Houghton	Non-Executive Director
	Mr J Archard-Jones	Non-Executive Director
	Prof T Robinson	Associate Non-Executive Director
	Ms R Parker	Non-Executive Director
	Ms D Kirkham	Associate Non-Executive Director
	Ms J Fawcus	Interim Chief Operating Officer
	Ms A Gill	Non-Executive Director
	Mr A Callow	Chief Digital Information Officer
	Mr M Smith	Chief People Officer
	Ms B Agboola	Interim Director of Finance
In Attendance		
	Ms C Campbell	Director of Corporate Development Governance and Assurance
	Mr S Finn	Director of Facilities and Capital Development
	Ms K Spellman	Interim Director of Strategy and Partnerships
	Ms K Palmer	Executive Board Secretary
Apologies		
N/A		

TB 20/21 087 **Introductions and Apologies**

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

Mr Burns welcomed Ms E Doyle to her first Public Trust Board as interim CEO and Ms J Fawcus as interim COO.

TB 20/21 088 **Declarations of Interest**

There were no declarations of interest.

TB 20/21 089 **Minutes of the Public Trust Board held on 28 January 2021**

The minutes of the Public Trust Board held on 28 January 2021 were presented and **APPROVED** as a true and accurate recording of proceedings.

TB 20/21 090 **Matters Arising and Action Log Public Trust Board**

The Matters Arising and Action Log were considered and noted.

Action Log Item 124 – included within report pack

Action Log Item 127 – TBC

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

TB 20/21 091 **Staff Story**

Mr Metcalfe stated that the member of staff concerned was unable to be at Trust Board today. If here, the staff member would illuminate the experience of a clinician involved in a never event.

Mr Metcalfe advised that in regards to the never event he had met with the teams involved. The approach had been supportive and orientated around learning. There had been no personal blamed laid.

Mr Metcalfe reported that a thematic review had been conducted to look at the drivers behind the never event. It was noted that what came through was that the trauma from the first wave of COVID19 had affected performance. There was a desire to attend to patients who had waited a long time due to COVID19. Mr Metcalfe discussed the COVID19 safe pathways in place rather than the traditional speciality pathways, which had caused inevitable disruption to normal teams and ways of working. All these factors needed to be taken in to account as look at restoration of non-COVID19 activity and induction of staff back.

Mr Metcalfe remarked on the importance of team building, welfare checks and specific subject matter training bundles implemented

Mr Metcalfe informed the Committee that this pattern of incidents did not just affect NGH but was similar across the region. It was noted that NGH have taken a thematic approach based on human factors and had asked NHSE/I to support this work.

The Board **NOTED** the Staff Story.

TB 20/21 092 **Chairman's Report**

Mr Burns presented the Chairman's Report.

Mr Burns advised that the Trust had won a national health and wellbeing award at the 'Our Health Hero' awards. The video of the award being given was shared. Mr Smith thanked the team for their hard work, which had resulted in the Trust winning the award. This had had been awarded on national COVID19 day of reflection.

Mr Archard-Jones asked how the award was it was scored. Mr Smith explained that the Trust had made a submission, which had outlined what NGH had implemented the last year, and then a panel reviewed submission.

Ms Gill commented as the NGH Chair of the People Committee that this was fantastic recognition for the Trust for looking after the health and wellbeing of staff.

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

TB 20/21 093 **Group Chief Executive's Report**

Mr S Weldon presented the Group Chief Executive's Report.

Mr Weldon referred to the recent Quality Summit that linked to many agenda items on the Trust Boards agenda. He paid tribute to the work done in the preparation of the Quality Summit and the leadership on the day. It was a thoughtful reflective and insightful event in which people contributed honestly about the front line. He thanked Mr Metcalfe and the team for the success of the summit.

Mr Weldon advised that he had received a letter from the Trust's CQC

relationship manager. The CQC manager had been impressed by the honesty of the conversation at the summit. There was no issue dodged and the staff had spoken about how they had felt, what needed to be done and the impact.

Mr Weldon referred to the bigger picture for NGH and noted that the Trust was about to go into a very sustained period of elective recovery. The Trust had not had waiting list as long as the one it was facing for many years. He reminded the Trust Board that the staff could not simply start again as if nothing happened and that they needed to be taken care of. He wanted to convey that message. Mr Weldon wanted the Trust Board to remember this as it moved into the debates about the people plan. It required to be connected and meaningful.

Mr Burns remarked on the clear thread between the Health and Wellbeing award and need for staff to be looked after. There was academic evidence that better supported staff delivered a better quality of patient care.

Prof Robinson advised that these never events were brought to attention of the Quality Governance Committee immediately as happened. The Committee had been regularly updated. Prof Robinsons stated that the summit was excellent. The environment allowed open discussion including what went well, ways in which to ensure this would not happen again as well as the impact on patients and staff.

Ms Houghton echoed Mr Weldon's and Prof Robinson's comments. In addition to these, she highlighted that there had been no excuses from the teams involved in regards to the never events. The presentations made by the clinicians explained what happen and what had been done to prevent reoccurrence. It was noted that not one person used COVID19 as an excuse. This was impressive.

Mr Burns believed that this had changed the NHS attitude towards these type of incidents. The event was not used to discipline and instead discuss the lessons learnt with no secrecy. The Quality Summit had approximately 150 hospital people attend.

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

TB 20/21 094 Hospital Chief Executive's Report

Ms Doyle presented the Hospital Chief Executive's Report.

Ms Doyle advised that her report detailed the numbers waiting for treatment. This was not to purposely cause the Board concern however; she wanted to highlight the significant waits. The Trust had now come out other side of the last Covid wave and staff were very tired. She reiterated the need to look after our staff.

Ms Doyle reported that there was a plan on how pull out all patient waits including diagnostics. The most important thing was that the Trust had a plan. It would take time to work through to try to create a break in those queues. The work would be done with the clinical teams to figure out the best way of doing this. The Trust also needed to start to plan for next winter, the details of which would become available over the next month.

Ms Doyle had attended a virtual attend council meeting and all NGH staff had been given freedom of borough. It was a positive recognition from the council and community.

Mr Burns thanked Ms Doyle for her report.

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

TB 20/21 095 **Integrated Performance Report**

Ms Doyle introduced the Integrated Performance Report in which the Executive Leads presented their element of the report.

Ms Fawcus delivered the Chief Operating Office update. She reported that A&E performance was at 73.7% for February and this had improved on January. She asked the Board to note that ambulance conveyances was at 2934, which was a massive increase on same period last year. The conversion rate being higher than normal reflected COVID19 and winter. The Trust now needed to prepare for winter.

Ms Fawcus advised that there had been a detailed debate on cancer at the Quality Governance Committee. The performance was not as it should be and there had been a dip in January performance due to patient choice. She remarked that the legacy number however had improved which was a good marker.

Ms Fawcus stated that the tertiary centres had suffered delays in terms diagnostics. She stressed that staff did not underestimate the backlog. In regards to RTT, the median wait was 10.5 weeks. The Trust had started elective activity again and reopened theatres. She had met with the Divisional Directors and Divisional Managers to discuss further. The number over 52 weeks for February was 759 compared to 651 in January. This was a challenge ahead for the Trust but that the teams were ambitious. She reminded the Board to be mindful of the significant finance implications as the Trust cleared the backlog.

Ms Fawcus reported that in regards to diagnostics performance for February was 20.26%. There was a high number waiting for ECHO, ECHO capacity would be increased during March. It was noted that MRI and CT were now below 6 weeks. A draft plan would become available on how to clear the diagnostic waits.

Mr Archard-Jones commented that the patients arriving in A&E appear to be of higher acuity then normal did the trust need to rethink how it managed A&E. He queried whether it was currently set up appropriately.

Ms Houghton drew the Board to page 50 of the report pack and highlighted the stroke metric ‘Stroke patients spending at least 90% of their time on the stroke unit’ was a long way from the national standard. She asked if this was of concern and if was there a plan in place.

Mr Moore asked what was happening with the independent sector and the Three Shires. He concurred with Mr Archard-Jones comment on increase acuity and question what the underlying reason was. The Group Finance and Performance Committee had discussed RTT. The Committee believed that 52 weeks was just a point in time and this needed to be profiled in detail to see where the ‘hump’ was.

Ms Fawcus explained that the clinical director in A&E who was looking at changing the process and how to deal with ambulance arrivals. The department would start a pilot of a new flow nurse. She asked the Board to note that A&E discharged 50% ambulance conveyances. There would also be key focus on flow into SDEC. She commented that surgical assessment units had existed before and would be explore again. There was a committed team in A&E and she was very impressed on how they had talked through the pathways.

Ms Fawcus discussed stroke performance. The flow had been very comprised for 6 weeks. The numbers of stranded patient had increased and this had affected the flow in and out of the stroke unit. The physical layout also an issue. She had met with team to discuss solutions to improve the process.

Ms Fawcus commented on the ED conveyances. Ms Doyle had met with EMAS to look at undertaking an audit over a few days which will include an independent review from NHSI. The audit would look at the discharge and the alternative pathways as well as iCan.

Ms Fawcus stated that with RTT and the use of the independent sector, this would continue to be used. She was mindful that the independent sector had their own waiting list and the Trust needed to work in partnership with them. There were currently 989 patients waiting over 45 weeks and 1045 over 40 weeks. There was a big backlog sitting between 40 and 52 weeks+. The profile below this was better. There was an external confirm and challenge happening with the team to ensure that the PTL clean, validated and all rules had been applied. The review would also look at the profile of the waiting list.

Mr Metcalfe referred to the stroke metric highlighted to the Board. He advised that at the peak of COVID19 the Trust had 250 plus patients who were positive and that stroke patients had needed to be protected from the risk of hospital acquired COVID19. The Trust had to change ward designations and many of stroke patients had to be co- located with cardiac patients to ensure they were not exposed to risk of COVID19. He expected a sharp significant recovery of this metric and though the service provided excellent stroke care with an A rating, the physical space on the acute ward was suboptimal. A piece of work was underway with the senior leadership team on how to improve this with a number of options.

Mr Metcalfe referred to cancer legacy and the need to clear a backlog on cancer pathway. Performance will continue to fluctuate due to treating patients in time order and clinical priorities. Currently, the only reliable indicator is those in the legacy backlog and this has come down significantly.

Mr Weldon expected that the NHS planning guidance was to be issued imminently and he encouraged colleagues to read as soon as possible. It would make clear the set of challenges not seen for 15 or so years in the NHS and the size of the recovery challenge. There would be a multi-year effort to get back to the position pre-COVID19. The Trust needed to think strategically what was prioritised in the year ahead. When the Trust Board next meet in May it would look at the recovery strategy and for the Board to be clear on how it interpreted the planning guidance.

Mr Weldon remarked that activity and referrals had dropped. The Trust needed to think about what extent do we plan for work to come back into NHS. The Trust would want to balance support for patients but also not go too fast in the recovery, which would push staff beyond what was reasonable to do so.

Mr Metcalfe shared the Medical Directors update with the Board.

Mr Metcalfe was grateful for the comments received in regards to the quality summit and the response the Trust had made to the never events.

Mr Metcalfe announced that Dr T Evans had been appointed as Associate Medical Director for primary care engagement. An initial area of focus would be supporting the iCAN programme and he will be leading one of the pillars of this work, working closely with Mr Metcalfe and Ms Fawcus.

Mr Metcalfe stated that there had been good progress made with the joint academic strategy. It was noted that both Boards had approved the strategy and both Finance and Performance Committees had endorsed the 5 year business case. There had already been a return on investment with the year 1 income target already exceeded.

Mr Metcalfe advised that the deteriorating patient work stream had gone live. This work enables early identification of patient through the early warning score. A series of comprehensive responses are then supported through the electronic white boards. The patient safety team are supporting embedding this throughout the organisation.

Prof Robinson remarked that at the February Quality Governance Committee the annual research report had been shared. It was reported that there had been a 200% increase in patient involvement in NHRI studies and NGH was one of the top 10 recruiters to the recovery trial. Mr Burns agreed that this was a positive achievement.

Ms Oke presented the Director of Nursing update to the Board.

The Friends & Family Test recommenced nationally on 01 December 2020. The inpatient and day case Satisfaction scores have remained between 90%-95%. The Patient Experience Group will reconvene in the next 4 weeks and the group would agree priorities.

Ms Oke advised that the COVID19 response had been a high priority. The peak of the pandemic in February saw 259 COVID19 inpatients and today this number was 19. There had been a huge amount effort from IPC to provide leadership and support across the Trust. The team had worked on the IPC BAF and kept on top of any changes in PPE compliance rates. The Trust had two COVID19 outbreaks during the report period and a root cause analysis was done. There were lessons learnt and these were put in to action.

Ms Oke informed the Board that there had been an outbreak of CPE in the critical care unit in 9 patients. She explained that CPE was a bug that lived in the gut with normally no signs and symptoms. If the bug gets in to other areas of the body it can cause infection and it has a resistance to antibiotics. Work had been done to manage the outbreak. There were 3 cases that remained, this involved 1 positive and 2 contacts. There had been no further cases.

Ms Parker referred to complaints and noticed the timeframe was revised to a maximum of 6 months where required. She asked if Ms Oke was comfortable with this. Ms Oke clarified that this gave the team breathing space they required for a thorough investigation.

Mr Burns asked Ms Oke to provide an update to the Board on the new complaints review process. Ms Oke explained that a complaints review panel had been set up and would be chaired initially by Mr Burns. This would look at how the Trust managed their complaints, what outcomes were and what lessons could be learnt. Mr Burns would be requesting that a NED take over as Chair.

Mr Moore noted the investment in international nurses and asked how this was progressing in the current climate. He was informed that the Trust had a nursing 1.6% vacancy rate, which had been positively contributed to by the oversea nurses. The associate nurse turnover rate was equally as good. The international nurses had set up a shared governance council and they are playing an active role in future recruitment.

Ms Agboola delivered the Director of Finance update to the Board.

She advised that the Trust ended the month with a small surplus of £40k which maintained the year to date position at break-even, in line with the forecast. This position was achieved after accounting for £1.2m of System support funding offset by increased annual leave accrual of £1.4m.

Ms Agboola stated that in February the Trust saw a reduction in the Pay and Non-pay spend run rate because of the reduction in elective work due to theatre closures. It was noted that agency spend was £1.5m which was similar to recent months, as the Trust continued to cover staff sickness and self-isolation.

She updated the Board on the capital position. At the end of February the Trust had spent £22m with a further commitment to bring the total spend for the year to £36.6m. This will be £5.6m short of our capital plan and related to the Critical Care unit which as previously reported arose due to finding asbestos. The Trust had been discussing this with NHSEI, in particular wanting assurance about receiving the needed increase in our 21/22 capital limit. Ms Agboola confirmed that the capital allocations for 2021/22, had at least £4m allocated towards this.

Ms Agboola reported that cash balance at the end of the month was £37.5m, which is in line with previous months; the Trust expected that this balance would drop as from April as NHSEI will withdraw the one-month advance funding that was in place in 20/21. The team would continue to monitor and manage the cash flow.

Ms Agboola advised that the I&E forecast for 2020/21 was being worked through and the Trust expected to meet the forecast position of a break-even position.

Ms Agboola commented that the Trust was still waiting on the planning guidance for 2021/22. The Trust had been told that it should expect to be funded for the first half of 2021/22 on the same basis as this year which was made up of block funding and top up arrangements. The Trust also understood that the System plans are expected to be submitted by 6 May.

Ms Agboola reported that the team had been working with Divisions to develop an expenditure budget, and will develop this further once more planning info available. This would be used to update the activity, workforce and financial plans with an update at a future Board.

Ms Agboola stated that the Trust would continue to work with System partners to develop a 3-year financial plan.

Mr Burns believed that the Trust appeared to be on track and awaited planning guidance

Mr Smith presented the Chief People Office update to the Board.

Mr Smith advised that the vacancy factor and turnover had reduced. Ms Oke was leading a key piece of work on international nurse across the county. This would help in the medium and long term. He believed that agency spend should come down.

Mr Smith stated that for sickness absence there had been an increase in January. This was in line with COVID19 and the prevalence of the virus in the community. It was noted that NGH had not seen a sharp rise in county as other counties had however it had not as equally seen a significant drop as others.

He commented that work was being done on how bring back clinical vulnerable colleagues. This involved looking at risk assessments and having appropriate conversations. He was concerned about sickness, particularly mental health

Mr Smith remarked that appraisal and education targets were strained. There was plans in place to look at e-learning and more simple modules.

Mr Smith reminded the Board that NGH was the lead employer for the vaccination programme for the county. There was 600 people working through vaccination centre to undertake the programme in the county.

Ms Kirkham queried the statistics of rate vaccination. Mr Smith confirmed that at NGH 85% staff had their first dose and this included bank colleagues. The 1st dose was available at the vaccination centre. The Trust had written to all colleagues who had not yet had the vaccination with documentation to encourage them to do so.

Ms Parker queried whether there was a way of measuring this. This was subjective and wondered how this could be captured and progress tracked. Mr Smith advised that there was a lot of data set which could be looked at. This included reason for absence and psychological support was being offered. There was a piece of collaborative work with our charity at NGH. This was creating a stronger together hub which would enable quicker access to provision. The last 3 weeks the team had worked intensively with theatres, and now staff were coming back into theatres from ITU and reteaming. There was many interventions in place.

Mr Moore referred to the commitment to have 100% risk assessment compliance. This was sad to note is had not been achieved. Mr Smith believed this figure was in close to 99%. This would always fluctuate due to new starters.

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

TB 20/21 096 **Facing the challenge of elective recovery**

Ms Fawcus presented the Facing the challenge of elective recovery.

The presentation had been developed by Mr Callow, Ms Gordon (KGH COO) and herself. The presentation covered the approach and the data which would be used to track recovery.

The presentation was then shared with the Board and was included within the Board pack. Mr Burns remarked that the presentation was impressive and featured many good opportunities on joint working.

Ms Kirkham reiterated Mr Burns point. She noted the importance on the involvement from the people team to ensure the right balance was struck. Ms Fawcus clarified that she had discussed with Director of HR and had also looked at the staff survey results. She recognised the issues and the need to support staff during this time. The theatre team had a reset week recently, the over-riding feeling was that these staff wanted to get back to be theatre staff however were feeling fatigued. Ms Fawcus stated that all feel staff were feeling that sense of tiredness and she had talked with the Director of HR in regards to how to provide support.

Ms Houghton commented that there had been a good discussion at the Quality Governance Committee. It included how staff would look after the patients presenting at front door which could be increased due to patients previously staying away because of COVID19. Ms Houghton asked if there had been any discussions with the new associate director of primary care. Ms Fawcus explained that it was in discussion. The team was looking at MRI referrals and thresholds as well as looking at different specialities. She noted the possibility of looking at consultant connect. Ms Fawcus stated that some of this would be picked up at the system elective care board and it was part of the sustainability plan.

Mr Burns highlighted that some GP's had limited appointments and not all GPs

were opening at the same time. There needed to be an exercise of understanding and there needed to be a careful balance.

Ms Spellman advised that there was a real opportunity through the system elective care board. The Trust needed to focus on the longer term. She stated that a colleague at KGH was the Chair which should help drive the agenda.

Mr Weldon referred to the national perspective. There had been discussion about the financial impact and the actions needed to be taken. There had been finance set aside to support elective recovery and how to access this would part of the planning guidance.

Mr Weldon believed this was a good paper. It was important to understand what was going on and that validation was essential. He commented that all were challenged to make sure the Trusts waiting list was validated. The Trust needed be confident in the data.

Mr Weldon discussed how the Trust was going to bounce back. The Trust needed to keep track of activity data as this would be key. As the Trust reported activity, it must pay attention to the trends. The Board should give thought on what information was reported alongside the metrics. He believed it would be beneficial for the Board to have further information to continue the debate.

Mr Burns concurred. As the planning guidance comes out and update on the process to May Board was essential as was the plan against the resources. The plan would need to detail what was achievable against staff welfare concerns and to strike a balance against recovery. The Trust Board and Committees needed to consider and arrive at firm conclusion what the Trust wanted to strike as a balance by the May Trust Board.

The Board **NOTED** the Facing the challenge of elective recovery.

TB 20/21 097 **Staff Survey**

Mr Smith presented the Staff Survey.

Mr Burns remarked that in regards to a CQC rating, the single biggest indicator was the staff survey results. This was crucial for the Trust to get the balance between staff and the patients correct. This was a central piece of information.

Mr Smith commented that on the 23 March across system Prof M West had ran a session and he had said the same. The staff survey was a clear indicator of performance in all areas.

The Staff Survey presentation was shared with the Board. The presentation was also included in the report pack. Mr Smith delivered the presentation to the Board.

Mr Smith summarised that there was significant work to be undertaken. The people plan contained outputs from the staff survey, in addition to feedback from a number of workshops.

Ms Kirkham queried what were the staff thoughts on the results and how did the Trust perform against others. Mr Smith clarified that NGH was at the national average. The ambition was to be even better. There would be work done to look at areas that were doing well and the areas that required improvement. Mr Smith had done an update in the staff briefing and the information had been worked through the divisional meetings which had shown an even greater breakdown. In the divisional meetings the information was division specific. The Director of HR had discussions with the groups in the top ten and bottom ten. The lessons learnt would be shared.

Ms Houghton asked if the Trust would do regular survey of their own. She also queried whether the Trust knew the hot spots for bullying and harassment. If these were known surveys in these areas could focus on the culture in that department. Mr Smith confirmed that the Director of HR had contacted them. These areas are consistently low in many of the staff survey. The team would work with ten areas to make some improvements in relation to how work with one another. A huge focus was on how to launch the values. This will be an integral part and was very important.

Mr Smith advised that in regard to a pulse survey he had contacted the lead for the national people plan, for which pulse surveys are part of the plan. The Trust would get some assistance with these surveys.

Ms Agboola remarked that the staff needed to feel empowered to speak up. This linked to the value campaign. She queried whether the Trust did enough at communicate enough about what it had in place for staff.

Ms Gill asked whether the data was triangulated. Mr Archard-Jones noted that some departments had several issues and management issues were a theme in the past. He asked what was being done to support middle management training.

Mr Smith had asked the two Head of Communications to circulate what was in place for staff so people can see what available. For triangulation of the data, this would be detailed more in the People Plan.

The Board **NOTED** the Staff Survey

TB 20/21 098 **The People Plan**

Mr Smith presented the People Plan.

Mr Smith advised that the People Plan had been presented in draft form to the January Trust Board. It took into account feed from a number of workshops. It had been circulated to the Committees, ICS, key stakeholders, across group and the People Board. He had received 10 pages of feedback on the draft plans.

Mr Smith informed the Board of the key changes. There was now 7 themes instead of 6. The new theme was a People Partnering theme. This brought in following feedback on how the People Plan would be embedded. The people partners will enable this.

Mr Smith state that inclusion and OD was encapsulated throughout the plan. The Health and Wellbeing element looked at how the Trust enhanced the current models. He informed the Board that it had been agreed for free parking for staff to continue in 2021. There would also be a stronger together hub created between NGH, KGH, NHFT and NHCF to provide psychological support. This would be beneficial for all involved.

Mr Smith reported that the People Plan discussed AHPs and the medical establishment, as well as volunteers noting the variety of roles volunteers have taken on more recently.

Mr Smith stated that there would be a leadership development programme which included a pathway and prospectus across the group. It was noted that technology across the group was also an important enabler for the People Plan.

Mr Smith informed the Board that the April People Committee would look at the metrics in the plan.

Ms Gill commented that the behaviour of leaders was key and asked how they were going to be held accountable for delivering this. The biggest impact was the line manager.

Ms Houghton advised that there had been a good discussion at Quality Governance Committee around a draft strategy for nursing midwifery and AHP's. This strategy was more of a professional strategy that 1000 staff had developed. She had asked about alignment with the digital and people plan. The Committee was assured all were aligned.

Mr Moore stressed that the Board made sure that the message was circulated down to staff as the Trust progressed with implementation.

Mr Archard-Jones believed that it was a good plan and was supportive of the plan. He still looked for assurance on how to improve middle management and help with their development. Mr Smith explained that the People Committee had discussed human factors training which educated people on how they can do things differently.

Mr Smith drew the Committee page 272 and page 278 of the report pack which detailed the people pledges. This is what the Board will hold Mr Smith to account on. Mr Burns reminded the Trust Board that this was a whole board responsibility.

Ms Fawcus commented that as a leader she would be held to account and would work to the values as well. She had met with the HR Director to agree her top 3 priorities. The Trust had divisional assurance days which she wanted to revamp and to hold divisional teams to account. There would be clarity on what the expectations were.

Ms Doyle stated that when under pressure how we communicate with our line manager and vice versa needed to have set expectations. There needed to be honest and courageous conversations. The most important element was the support required and if problems still occurred then the problem would need to be addressed.

Mr Weldon congratulated Mr Smith and his team for the large piece of work. There needed to be focus on how can change 'you' to 'we'. He would like people to think what they could do to the support implementation of the people plan. Mr Weldon would bring the two Executive Teams together. The Trust needed to be a place where people felt it was a great place to work and an inspiring place to be. If we want to come to work this will cascade into the organisation. The other commitment was to be willing to meet staff in their world and listen to why they feel way they do. He noted the importance of understanding individual communities. The Board needed to commit a time to debate this.

Mr Burns agreed with this response. He thanked all staff who had contributed and the team who had put the People Plan together.

The Board **NOTED** The People Plan.

TB 20/21 099 **Group Digital Strategy**

Mr Callow presented the Group Digital Strategy.

Mr Callow advised that the strategy had been presented to the Board Committees. The Board Committees had recommended approval by the Board. The strategy had looked at what had been done well in the digital realm. He noted NGH's involvement in the robotic process.

Mr Callow reported that to maintain service security it would start small with the

electronic patient record programme.

Mr Callow commented that the Trust was still classed as digitally immature and it was an ambitious strategy to reverse this. He was confident of the progress to date. There was targets given in each of the themes.

Mr Callow discussed how he would make it happen. There was a core set of principles, which the Trust will work to. These were the user needs of the patients, staff and clinicians.

Mr Callow stated that there was 8 themes selected. The importance of patient experience who during the pandemic these patients had felt assured by telephone conversations and wanted access to their records. This would be built on. The significance of giving staff the tools they love them as this would help patient care. The visibility of patient records for a patients care journey across many settings was also a key item in the strategy. A group electronic patient record will address this.

Mr Burns believed that this was a remarkably ambitious strategy. He had met with NHS X in terms of NGH's thinking moving forward. That was a representation of quality of work at the Trust and this was beginning to be seen by the rest of the system.

Ms Gill advised that the strategy had been discussed at the People Committee and everyone had felt energised. The Committee noted the fantastic technology currently in place from education and that the digital strategy could open up more opportunities.

Ms Parker referred to the ambition to be most digital hospital group and she queried what needed to be met to confirm this goal had been achieved. Mr Smith agreed with the question as the implementation of strategy was his biggest concern. Mr Callow clarified that theme 3 picked up on the foundational work that needed to be done and targets had been included for year one and year three.

Mr Callow commented that in regard to the being the most digital hospital group ambition this would be confirmed by looking at external measures, but most important the net promoter scores from clinicians. It was important to make difference on the ground.

Mr Callow's biggest concern was moving to group electronic patient record. He was informed that NGH were in receipt of SEED funding. The Trust needed to make sure it breaches that affordability gap.

Mr Callow stated that the longer-term big targets were to move on to single log on. Mr Burns asked what Board could do to help this. Mr Callow believed that as the group moved to an electronic patient record, it needed to be aware that this was a hard piece of work and the Board need to hold their nerve. He noted that any support was appreciated.

Mr Burns believed that the ambition was impressive and mostly had the equipment to deliver the strategy. There was a lot going on and the teams are energised by this.

The Board **NOTED** the Group Digital Strategy.

TB 20/21 100 Equality, Diversity and Inclusion – BAME Staff Support

Mr Smith presented the Equality, Diversity and Inclusion – BAME Staff Support.

Mr Smith shared the screen with the Board and delivered the presentation. The

presentation was also included in the Board pack.

Ms Agboola lent her support to all work that had been done. The last 2 years had seen a lot of progress and the Board should pause to celebrate the progress made. The reverse mentoring, she had found really useful, as it was educational to be in other people's shoes.

Ms Oke was passionate about this topic. The shared decision making council and international council had done a vast amount of work to support this.

Mr Callow remarked that inclusion needed to be embedded in all the Trust did.

Ms Kirkham felt strongly on this and it was good to see a focus on what had been done differently. There needed zero tolerance towards and the People Committee were in agreement with this.

Mr Smith explained that the issue was that there needed to be protected time given to colleagues for this. An independent review had been conducted and a strategy would be developed.

Mr Metcalfe queried the development of BAME midwifery leaders starting at a Band 6A as this could be too high. This should include B5 nurses.

Mr Weldon believed that it would be good to have our BAME leads as part of the conversation at Trust Board.

Mr Burns commented that the Diversity agenda across the board needed to be developed. He thanked the network for all their hard work.

The Board **NOTED** the Equality, Diversity and Inclusion – BAME Staff Support.

TB 20/21 101 Terms of Reference for Ratification

Ms Campbell presented the Joint People Committee Terms of Reference (ToR).

Mr Burns advised that the ToR been through CPC or gone through the relevant Committees.

- Group Finance & Performance Committee Terms of Reference
- Quality Governance Committee
- Finance & Performance Committee
- Hospital Management Team

The Board **APPROVED** the Terms of Reference for Ratification.

TB 20/21 102 Questions from the Public (Received in Advance)

'Does the Trust have a partnership with any organisation, public or 3rd sector, to deliver a rapid discharge service for all its patients? If it does ,how is the service measured and do they consider it to be safe , efficient and effective'

Ms Fawcus advised that the Trust had many agencies that supported with discharge. There was one company, care home select who helped with rapid discharge and the Trust did not hold the contract, this was held by Northampton CCG. The data they provide us is on the number of referrals, length of stay, patient experience and feedback. There was no finance information given about that contract.

TB 20/21 103 Any Other Business

Mr Finn advised that the HSJ environmental sustainability had highly commended NGH on their carbon risk reduction and single use plastic.

Mr Smith referred to a query made during the Board. He confirmed that 96% BAME risk assessment had been completed. He would follow the 4% up.
Action: Mr Smith

Mr Burns commented that it was good to have a plan and follow it. The Board had laid out clear plans and the methodology behind the plans to ensure that the plan was on target. The Board had discussed what needed to be done between now and the May meeting.

Date of next meeting: Public Trust Board - Thursday 27 May 2021 at 09:30 via ZOOM at Northampton General Hospital.

Public Trust Board Action Log							Last update	13/05/2021
Item No	**Month of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
Actions - Current meeting								
128	Mar-21	TB 20/21 103	BAME risk assessment	Mr Smith referred to a query made during the Board. He confirmed that 96% BAME risk assessment had been completed. He would follow the 4% up.	Mr Smith	May-21	On agenda	**Update Matters Arising**
Actions - Future meetings								
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.	Mr Holland	TBC	On Track	

Report To	**May Public Board**
Date of Meeting	**27 May 2021**

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

This paper is for: (delete as appropriate)

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

Executive summary

Group Chief Executive Update: May 2021

Covid-19 update – looking forward

As the Board meets, we are at an important inflection point. Thanks to the tireless efforts of all staff in so may roles across the health and care system, we can now start to talk about our hospitals being having no Covid patients within them. Clearly, that is not a moment to be complacent but reaching that position does allow us to begin planning for what we will deliver this year. Planning this year is unusual in that we are only focussed currently on what we will deliver in the first half of the year. So Board discussions will be focussed on delivery up to the end of September and there will then be a further planning process for the second half of the year. The discussions will require us to successfully balance three imperatives: restoring services for our public, particularly elective services; caring for our staff and improving our efficiency and reducing our costs.

Integrated Care System

Having received Integrated Care System designation in April, we are continuing to develop our plans for Northamptonshire's emerging system in the context of the recently published White Paper. Among other things, the White Paper sets out proposals which will foster greater collaboration and partnership in the system with the intention of providing a significantly more joined up experience for our patients. This presents an exciting opportunity to improve outcomes for our local population through working more closely together.

As a Hospital Group, we are committed to working across the system to put in place the core components of the ICS by April 2022. In order to achieve this goal, we are with partners, starting the process of designing the key elements of the system and the interactions between them. This will include the overall design of the system and which activities are best undertaken once across the County and which should be more local. The ICS will set out how providers of care in the NHS, Local Authority and others can best work together to meet the needs of our population. We will be building on the wider range of good work that is already underway by partners across the County.

International Nurse's Day

To celebrate International Day of the Midwife on 5 May and International Nurse's Day on 12 May, I spent time with Nurses and Midwives across both KGH and NGH. It was a privilege and honour to spend time talking with colleagues who demonstrated what is means to provide patient led care every day, and particularly during the COVID-19 pandemic. Many of our nursing colleagues were re-deployed over the pandemic and I am grateful for their skills, resilience and passion for patient care in areas that they did not normally work in. It was wonderful to see people share their reasons for being a nurse over social media and to celebrate and honour the role they play in our clinically led organisations.

I thought I would share one example of what I saw on that day. Pictured below is Mairead, who is the Ward Sister on Hawthorn. She is standing in front of the team's egg-cellent board, obviously themed on Easter. The boards are part of our Pathway to Excellence Programme and are visual reminders of how we live our values and put into practice our aspirations. It will not surprise you to learn that the team won an award for the creativity of their board. But the more important point is the fact that Mairead has brought together a new team and led them so well that they are now fully recruited and thriving. It was fantastic to hear her leadership journey and to remind myself again how pivotal our ward leaders are in ensuring great care.

NGH Estate

The last few months have seen a number of exciting key estates capital projects nearing the final leg of their programmes. I was able to visit these new buildings and infrastructure upgrades in May to see how far these works have progressed.

- Our new main entrance will deliver fantastic new facilities for our visitors and staff and, has been funded via a commercial structure which means it will not affect our limited capital allocation. Whilst it looks like there is still much to do, the opening date is still on track for the end of June.

- All the modules are now in place for our new ICU building and work continues at pace inside to hand over to our clinical teams in August (ready to take patients by end of September). This state of the art building will be everything a modern clinical facility should be and more. Our Estates and clinical teams have worked closely with designers to deliver a building based on lessons learned from the pandemic and, through clever design they have been able to include eight additional level one beds and an additional six rooms for Radiology.

- The long standing challenges around a dedicated Paediatrics ED will now be addressed through the new extension to ED. Working in and around a live ED department in the middle of a pandemic has presented its challenges but, building works are nearing completion in May.

- Much work continues behind the scenes too. Circa £8m has been invested into new back up emergency generators and high voltage supplies to ensure the site has a robust and resilient infrastructure. The majority of those upgrades are now complete which will ensure the safety of our patients, visitors and staff.

Our teams have been able to deliver these works at a phenomenal pace during an extraordinarily challenging year; all the works will have a direct impact on staff, patients and visitors to our site. I would like to place on record my thanks to Stuart and his team for all they have done to get us to this point.

Related Group Priority	Which Group Priority does this paper relate to? 1. Patient: Excellent patient experience shaped by the patient voice 2. Quality: Outstanding quality healthcare underpinned by continuous, patient-centred improvement and innovation

	3. System & Partnerships: Seamless, timely pathways for all people's health needs, together with our partners 4. Sustainability: A resilient and creative university teaching hospital Group, embracing every opportunity to improve care 5. People: An inclusive place to work where people are empowered to be the difference
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks None
Related Board Assurance Framework entries	BAF – ALL
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	Estates work within available Capital funding
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper None

Actions required by the Board:

The Board is asked to: Note the report.

Report To	**Public Trust Board**
Date of Meeting	**27 May 2021**

Title of the Report	**Hospital CEO Report**
Agenda item	**8**
Presenter of Report	Eileen Doyle
Author(s) of Report	Eileen Doyle

This paper is for: (delete as appropriate)

☐ Approve	☐ Receive	x Note	☐ Assurance
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Executive summary

The paper outlines HCEO key issues and activities in the past month.

Related Group Priority	Which Group Priority does this paper relate to? 1. Patient: Excellent patient experience shaped by the patient voice 2. Quality: Outstanding quality healthcare underpinned by continuous, patient-centred improvement and innovation ALL
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks
Related Board Assurance Framework entries	BAF – ALL
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? N If yes please give details and describe the current or planned activities to address the impact.

	Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? N If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	Will be worked through as yet there may be costs associated with any in/out sourcing
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper The Health and Social Care Act means the Trust has a statutory requirement to meet the standards of Quality and Safety as described by the Care Quality Commission who act as regulators in this respect.

As numbers of COVID cases in the hospital drop significantly, we turn our attention to recovering from the most recent, and to date serious wave of the pandemic so far. The success of the vaccination program coupled with lock down restrictions has undoubtedly led to a decrease in serious illness from the virus presenting to hospital. At the time of writing this report, we have two patients with a positive diagnosis in the hospital having spent several of the previous seven days with zero cases.

A worrying trend, however, is that the number of attendances to the Emergency Department each day is increasing. Some days they are exceeding 400, higher than winter and this is placing massive strain on the department and the hospital as a whole. We are working with our primary care partners to get some degree of balance back into the system so that those seeking care get back into the habit of contacting their GP Practice in the first instance rather than using ED as a default facility. In general, the percentage of patients admitted has not greatly changed and in fact has come down a little, so that would suggest that there are many who could and should be treated outside of the acute hospital.

On a positive note, the clinical teams are making good progress in terms of the over 52 week backlog and there is a focused effort on clearing the waits across all specialties including diagnostics with plans being put in around extra capacity for the next three to six months. However, we need to be aware that the numbers of referrals across the board are dramatically increasing so far in Q1 and this will present us with a significant problem in terms of capacity, both for recovery and the clearance of backlogs but also the position going forward. We are about to submit final operating plans which are based on our capacity to deliver activity volumes (Q3 of last year plus current known adjustments for reduction in endoscopy rooms etc). We will be clear that not only will these need to be adjusted if the increase continues and a further submission done, but also we will need to be ready to tailor our services in such a way as it meets the demand.

Endoscopy remain in Day Theatres which means we still have a reduction in day case activity for the moment, but assuming there are no problems with the installation of the new ventilation unit, all of the facilities should be up and running in their normal locations by the middle of June.

Unappointed follow ups (those who need an appointment) are being worked through, cleansed where they are incorrect or have been treated/discharged and appointments made for patients who need them. The numbers are high and so this is a big logistical and clinical exercise and it will take a little while to clear the numbers. COVID has played a significant part in the delays as you might expect, but there are other referrals which were not closed or cleansed both pre and post covid which we need to ensure are dealt with appropriately. In the future it will be

imperative that these are completed at the time. Processes are being revised and the rules of housekeeping clinic appointments (or cashing up in old speak) are being worked through with the teams so that firstly we don't find ourselves in this position without full visibility on it again, but as importantly, if there is a rising tide of unappointed patients, we can spot the trend in a more timely manner and intervene as necessary earlier.

Further information on all of the performance indicators and ongoing work around the above is detailed in the executive narrative accompanying the IPR.

At the end of April we undertook a review in the new CQC Transitional Approach which involved a number of senior staff. Although no formal feedback will be received, the verbal discussions were generally positive at the end of the process. However, with a recent unannounced visit to KGH we have increased our focus on reviewing action plans and progress since the last inspection including Sis, falls assessment processes on the wards and general compliance around risk t ensure we are safe and sighted on any issues which may be present so appropriate action is taken in a timely way.

As ever, it is thanks to the staff across all of the areas in the hospital for continuing to work so hard and with such commitment. We all hope that we have turned a corner with COVID admissions but we know that we in a precarious position especially with the increasing numbers of variants of concern across the UK. We will continue to work in the hope that the vaccines will prevent us seeing the numbers in the hospital that we did in the new year and that we can get back to treating other patients who need the skill and expertise of our staff and services.

Eileen Doyle
Hospital Chief Executive NGH
May 2021

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**27 May 2021**

Title of the Report	**Integrated Performance Report**
Agenda item	**9**
Presenter of Report	Miss J Fawcus (Chief Operating Officer); Mr M Metcalfe (Medical Director); Mr M Smith (Chief People Officer); Mrs B Agboola (Director of Finance); Mrs S Oke (Director of Nursing)
Author(s) of Report	Adrian Marsden, Head of Information

This paper is for: (delete as appropriate)

☐ Approve	X Receive	☐ Note	☐ Assurance
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Executive summary
The integrated performance report highlights via SPC charts any adverse variances in performance relating to national performance targets, financial performance, Quality & workforce metrics.
Each Director has provided a summary.

Group Priority	ALL
Risk and assurance	Provides assurance on risk
Related Board Assurance Framework entries	BAF – All
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Financial Implications	NA
Legal implications / regulatory requirements	None

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

Integrated Performance Report

Date: May 2021
Reporting Period: April 2021

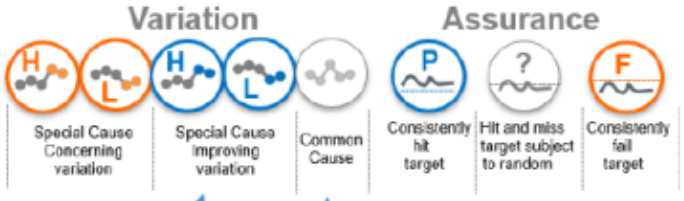
SPC Charts

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

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

High level key - variation

Are we improving declining or staying the same



Orange = significant concern or high pressure

Blue = significant improvement or low pressure

Grey – no significant change

High level key - assurance

Can we reliably hit the target

Orange = system change required to hit target

Blue = will reliably hit the target

Hit and miss the target

Key Performance Indicators

Domain	Metric	Target	Actual in Month Performance	Variation	Chart	Narrative
Caring	Complaints responded to within agreed timescales	90%	100%		P1	This metric continues to show Special Cause Variation, the trend is showing a positive performance above the mean
Caring	Friends & Family Test % of patients who would recommend: A&E	86%	83%	Insufficient Data Points	P2	The Friends & Family Test recommenced nationally on the 1st of December 2020 with the change from Recommendation Rates to Satisfaction Scores. New targets have been set locally from April 2021
Caring	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	96%	0%	Insufficient Data Points		The inpatient and day case Satisfaction scores have remained between 90%-95%. This is within normal variation. On comparing the figures since April, satisfaction scores average around 92%
Caring	Friends & Family Test % of patients who would recommend: Outpatients	94%	95%	Insufficient Data Points	P3	Monitoring of this target recommenced in April 2021 following suspension through the COVID pandemic
Caring	Mixed Sex Accommodation	0	2		P4	The metric shows common cause variation there were two reported breaches in month

Key Performance Indicators

Domain	Metric	Target	Actual in Month Performance	Variation	Chart	Narrative
Effective	Stranded Patients (ave.) as % of bed base	40%	42%		P5	Performance remains above the target of 40%, the metric is showing common Cause Variation
Effective	Super Stranded Long Stay Patients (ave.) as % of bed base	25%	14%		P6	The metric is below target and shows Special Cause Variation, the trend is showing a positive performance below the mean
Effective	Length of stay - All	4.2	3.7		P7	The target was delivered in April 21, the metric is showing Common Cause Variation and month on month achievment is variable
Effective	Readmissions within 30 days of previous reporting month	12%		Metric suspended		Monitoring of this metric is suspeded whilst review is undertaken
Effective	Percentage of discharges before midday	25%	18%		P8	Performance remains below target in April 21, the trend is showing a negative performance below the mean
Effective	% Daycase Rate	80%	86%		P9	The metric is consistently achieved
Effective	Failed Daycases as a % of Planned Daycases	0%				Monitoring of this metric is suspeded whilst review is undertaken
Effective	# NoF - Fit patients operated on within 36 hours	80%	0%			
Effective	Maternity: C Section Rates	29%	36%		P11	The metric is showing Special Cause Variation, the trend is showing a negative performance above the mean
Effective	Mortality: HSMR	106.0	106		P12	The metric is showing Special Cause Variation - trend is showing a negative performance above the mean
Effective	Mortality: SHMI	109.0	103		P13	The metric is showing Common Cause Variation - trend is showing a negative performance above the mean

Key Performance Indicators

Domain	Metric	Target	Actual in Month Performance	Variation	Chart	Narrative
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	90%	87%		P14	The metric is showing Special Cause Variation, the trend is showing a negative performance below the mean
Responsive	Ambulance handovers that waited over 30 mins and less than 60 mins	25	52		P15	There were 52 handovers between 30 and 60 minutes, this shows continued reduction in line with reduced Covid activity and seasonal variations
Responsive	Ambulance handovers that waited over 60 mins	10	7		P16	There were 7 breaches of the target, this shows continued reduction in line with reduced Covid activity and seasonal variations
Responsive	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	2		P17	There were 2 breaches of this target in April 21
Responsive	Cancer: Faster Diagnosis Standard	70%	87%		P18	There are insufficient data points to show as SPC
Responsive	Cancer: Number of Legacy Patients	0	35		P19	There are insufficient data points to show as SPC
Responsive	Cancer: Percentage of patients treated within 31 days	96%	97%		P20	The target is not consistently met
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%	97%		P21	Target delivered in line with trajectory
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%	96%		P22	Target delivered in line with trajectory
Responsive	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	94%		P23	Target delivered in line with trajectory
Responsive	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	85%	90%		P24	Target delivered in line with trajectory
Responsive	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	74%		P25	Trajectory of improvement from Aug 20, but not yet an assured system
Responsive	RTT Median wait incomplete pathways	10.9	8.5		P26	The trend is showing a positive performance below the mean
Responsive	RTT over 52 weeks	0	463		P27	The number over 52+ weeks for April continues to follow a downward trajectory, focus continues on backlog and patients with extednded waits
Responsive	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	99%	78%		P28	Previous improvement in performance has now plateaued
Responsive	Stroke patients spending at least 90% of their time on the stroke unit	80%	79%		P29	The percentage of patients spending at least 90% of their time on a stroke unit was below the 80% threshold

Key Performance Indicators

Domain	Metric	Target	Actual in Month Performance	Variation	Chart	Narrative
Safe	Never event incidence	0	0		P30	There were 0 never events in month
Safe	MRSA > 2 Days	0	0		P31	There were 0 MRSA > 2 Days incidence in month
Safe	HOHA and COHA (C-Diff > 2 Days)	3	2		P32	There were 2 C-Diff > 2 Days incidence in month
Safe	MSSA > 2 Days	1	1		P33	There was 1 MSSA > 2 Days incidence in month
Safe	VTE Risk Assessment	95%	95%		P34	The trust is in a significantly improved position following improvement work. The approach to sustaining in the short to medium term is to incorporate assessment review into the board round checklist, and in the longer term to mandate assessment through ePMA.
Safe	Harmful Falls per 1000 occupied bed days (Exc. Maternity and Paeds)	0%	13%		P35	The number of incidents reported per 1000 bed days remains constant, although there has been an increase in those graded upon report as being of moderate severity or above. This has not
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	120				Metric under review with Deputy COO
Safe	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	98%				Metric under review with Deputy COO

Key Performance Indicators

Domain	Metric	Target	Actual in Month Performance	Variation	Chart	Narrative
Well Led	Income YTD (£000's)	0	0		P36	No Data
Well Led	Surplus / Deficit YTD (£000's)	0	0		P37	No Data
Well Led	Pay YTD (£000's)	0	0		P38	No Data
Well Led	Non Pay YTD (£000's)	0	0		P39	No Data
Well Led	Bank & Agency / Pay %	0	0		P40	No Data
Well Led	Salary Overpayments - Number YTD	0	23		P41	No Data
Well Led	Salary Overpayments - Value YTD (£000's)	0	31		P42	No Data
Well Led	Maverick Transactions	0	0		P43	No Data
Well Led	Waivers which have breached	0	0		P44	No Data
Well Led	Job plans progressed to stage 2 sign-off	90%	0%			No Data
Well Led	Sickness Rate	4%			P45	
Well Led	Staff: Trust level vacancy rate - All	9%	0%			No Data
Well Led	Staff: Trust level vacancy rate - Medical Staff	9%	0%			No Data
Well Led	Staff: Trust level vacancy rate - Registered Nursing Staff	9%	0%			No Data
Well Led	Staff: Trust level vacancy rate - Other Staff	9%	0%			No Data
Well Led	Turnover Rate	10%	8%		P46	Turnover continues to be lower than 10% target and has been stable throughout the pandemic Increase in Turnover within Medical Staff and Healthcare Scientists have seen increases in Turnover that have taken them beyond 10% target.
Well Led	Percentage of all trust staff with mandatory training compliance	85%	86%		P47	
Well Led	Percentage of all trust staff with mandatory refresher fire training compliance	85%	81%			
Well Led	Percentage of all trust staff with role specific training compliance	85%	80%			
Well Led	Percentage of staff with annual appraisal	85%	79%		P48	Appraisal rates continue to be below Trust target of 85%

Directors view – Medical Director

Incidents

The number of incidents reported per 1000 bed days remains constant, although there has been an increase in those graded upon report as being of moderate severity or above. This has not translated to an increase in investigations as the review of harm process has downgraded some on the basis of outcome. There are some themes which have been identified, mostly relating to the Covid pandemic. Work continues with the division to close the overdue actions (which rose unavoidably during the pandemic).

VTE assessments

The trust is in a significantly improved position following improvement work. The approach to sustaining in the short to medium term is to incorporate assessment review into the board round checklist, and in the longer term to mandate assessment through ePMA.

Focus on Surgery Trainees

Training and workload issues affecting surgical junior doctors are being addressed through a comprehensive improvement plan, supported by the approval of a business case for additional doctors allowing separation of speciality on call rotas.

Dedicated ward pharmacists

There has been an excellent response to the advertisement of these posts to support better medicines management and patient care in the Emergency Department and assessment areas. Appointments will be made in June and the service will be operational ahead of the coming Winter supporting quality of care and operational performance.

Research and Innovation

The trust is prioritising the reset of high priority non-covid studies. An invention supporting the safe administration of controlled drugs by a member of our pharmacy team is being developed commercially with support from Innovate UK. This is a first for the trust.

Medical Support Workers

The trust currently employs 16 MSWs (qualified doctors without current GMC licence to practice) as part of a HEE scheme. We are currently evaluating their experience and the utility to the departments they have been supporting. HEE funding for these posts has been extended to March 2022 and we are seeking to recruit more. One option supported by HEE is to employ medically qualified refugees, and we are currently exploring this option with a view to support as possible.

Directors view – Director of Nursing - 1

Friends & Family Test:

The Friends & Family Test recommenced nationally on the 1st of December 2020 with the change from Recommendation Rates to Satisfaction Scores. New targets have been set locally from April 2021 in line with the new Satisfaction Scores and replacing the recommendation rates. These will begin to be uploaded with April's data and each month moving forward. At present, the hospital is still not collecting via postcards, however each ward now has an electronic tablet which contains a link to the FFT survey on it. In addition to this, the hospital has now set up a number of FFT surveys via QR codes which are included within mini postcards and posters. The hospital continues to collect the majority of the FFT feedback through SMS text messages and automated calls.

The inpatient and day case Satisfaction scores have remained between 90%-95%. This is within normal variation. On comparing the figures since April, satisfaction scores average around 92%

Complaints:

The complaints timeframe has temporarily changed three times over the last the last year in order to allow our clinical staff the time to provide care to our patients during the pandemic. At present we are working to the temporary 60 working days (having previously gone from 30/40 (normal) to 60, to 130 and back down to 60). The Complaints team are working hard to get the complaints process back on track to normal timeframes. They are ensuring to communicate with the patients. The Trust compliance rate response rate for complaints, reported in February was 100%.

Infection Prevention & Control Service:

During March and April there were 8 reported cases of Clostridium difficile Toxin A & B identified as hospital onset, 4 in March and 4 in April, one potential lapse in care has identified around the antibiotic prescribing for the patient and the IPC Team are currently reviewing this with the Consultant Microbiologist and Clinical Team and a full post infection review is being undertaken. There was 1 reported case of MSSA BSI reported during March and April and the Trust remained below trajectory for both hospital-onset MSSA bacteraemia and C.difficile at the year end.

Covid Response:

The IPC team continues to focus on leading and supporting the Trust in managing the Covid pandemic and in the safe management of reset for elective and cancer activity. The IPC Board assurance framework has been reviewed, progress has been made with particular attention being made to PPE training and increasing the provision of our domestic support team. During March and April there were 7 Covid-19 patient outbreaks reported, 6 in March and 1 in April. The contributory theme was asymptomatic carriage by staff undetected due to poor uptake with lateral-flow testing (LFT). Therefore in April the IPC team focused on LFT in April, through a communication campaign to dispel myths around LFT, providing ward and departmental level uptake data to support managers to encourage increased update and developing a smarter way of uploading results. Consequently, a significant increase in testing was noted throughout April and ten staff tested positive during the month which was detected rapidly through LFT and no patients developed COVID as a result.
Daily outbreak meetings with attendance of the CCG, PHE and NHSE/I were stood down on 14.4.21 following no active outbreaks.

Directors view – Director of Nursing -2

CPE:

Following an outbreak of Carbapenemase-Producing Enterobacterales (CPE) on Critical Care an Outbreak Control Group convened from 25.2.21 to 9.4.21 to contain and control the outbreak and prevent future outbreaks from occurring. The likely root cause of the outbreak was patients being patriated from the network into Critical Care surge capacity at the peak of the pandemic at a time when there were some gaps in CPE admission screening and the normal isolation on admission to the unit process was not possible due to responding to COVID-19 capacity.

Nine patients isolated CPE and a further nine were identified as contacts, were isolated, screened rigorously as per the PHE CPE framework and did not isolate CPE. 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 have been obtained
3. Revision of CPE screening process to include screening of all admissions to the unit, this has been commenced and is monitored weekly by the IPC Team, and a Trustwide CPE Policy has been revised and is currently out for consultation.

The NHSE/I IPC lead for Midlands visited the Trust on 19.3.21 to review the systems and processes in place for preventing and managing CPE on Critical Care. She identified some additional areas for focus. The report has been circulated to Board members, actions highlighted were captured in the CPE and COVID NHSE/I review action plan that was monitored through the Outbreak Group and IPSG. All actions have been completed and the supporting evidence returned to NHSE/I. The Trust remains green on the NHSE/I matrix following the visit and the management of this outbreak.

Directors view – Chief Operating Officer

Urgent Care

It is positive to note continued improvement in the ED 4hr standard. However there are key points to note:

- Attendances have increased significantly - March saw 9,326 and April 10,264
- The conversion rate for ED admissions was 20.44%, so whilst attendances have increased these patients are being streamed to SDEC or Springfield
- Ambulance conveyances have increased again but a reduced conversion rate of 31.80% is noted
- Ambulance handover delays also continue to reduce with further changes in the handover process introduced
- Streaming pathways from ED saw 1494 patients streamed to SDEC & Springfield. The opening hours of these areas have been extended to support
- SDEC conversion rate in April was 13%. This is a key indicator that the right patients are being streamed to SDEC Stranded Patient Metrics

Stranded Patient Metrics

Average Stranded patient numbers for April was 276. The internal Discharge & Flow Programme was launched in April. This programme has external national support to help drive transformation & improvement

Super stranded (21+ days in hospital) patient numbers for April 2021 was 91 on average. There are two focussed workstreams focussed on reducing this sustainably - the internal Discharge programme and the iCAN Discharge to Assess workstream which has a winter 2021 timeline

Directors view – Chief Operating Officer

Cancer

In March 6 of the 8 cancer waiting standards were achieved. This is a further improvement on February.
There was an increase of 68% in first treatments delivered in March compared to February. The ongoing prioritisation of legacy patients being treated, combined with some challenges in March around capacity, including diagnostic waits has resulted in 62 day performance of 73.5%, with 31.5 patients breaching the standard.
We continue to meet and exceed the 28 Faster Diagnosis Standard achieving 86.5% against the 75% standard. All Trusts will be measured against the national standard from quarter 3.
2WW referrals in March increased by 31% compared to February referral numbers. If sustained this will impact on the diagnostic and RTT recovery plans.

RTT

52wk recovery plan was signed off in April with a trajectory to achieve by the end of December 2021
Patients >52, 45 & 40 reduced throughout April
Elective Orthopaedics resumes on 1st June
The Day Surgery Unit fully reopens in June
Important to note however the following:
1. Routine GP referrals have increased by 18% and the overall PTL size has increased by 4% in April
2. The Cancer referral increase of 31% in March if sustained may impact on capacity available for routine work

Diagnostics

A trajectory to achieve against the 1% standard has been agreed & signed off in May. Given the following challenges the trajectory is to achieve the standard by the end of January 2022:

- MRI & CT capacity challenges given the increased urgent care attendances and cancer referrals
- Additional Mobile solutions are being considered for both MRI & CT
- The ECHO service has been relocated in May and will be running with external support over 7 days from June but the backlog remains high. There is work ongoing to right size the capacity for this service

Chief People Officer Report

Within the People directorate we are working through mapping our agreed People Plan pledges and metrics to monitor delivery across the Group model, there is positive performance in the attached report with regards to our vacancy and turnover position being lower than target. We will be rebasing these metrics in line with the 2021/22 planning submissions inclusive of the new posts required to support service delivery. We have areas of challenge within the attached metric which are being actioned, specifically with regards to absence management and our continued focus on Health and Wellbeing of our colleagues. Within our People Development pledge we will be working through increasing compliance with statutory and mandatory training and our appraisals.

There has been progress with regards to our people collaboration across the group, including the development of joint leadership programmes commencing on the 25th May 2021, policy reviews and the consistency of tracking employee relations activity. We require a focus on employee relations activity given the number of cases and the complexity of the cases being supported in our Trust and across the Group, learning from recent cases has also shown issues with regards to application of our policy and in some cases poor management practice and advice. Taking into account the Dame Harding requirements following recommendations made based on a serious case review our disciplinary policy will be amended before the end of June, a presentation on this will be provided at our June Joint People Committee development session and at our July public Board meeting. It is also planned to share our Equality, Diversity and Inclusion progress at our July Board in July, demonstrating the work being undertaken with the Trust and Group, given our challenges in this area articulated within our staff survey results.

Directors view – Director of Finance

We have submitted a breakeven plan for the first half of the year which includes £26.2m top up support funding. The full plan for the year is ongoing and is expected to be completed when NHSEI issues further guidance.

Against the submitted plan, the Trust achieved a surplus of £0.95m, which is £0.05m better than plan.

The Month 1 favourable variance has been achieved by a non-pay underspend against plan, offset by agency staff costs.

The activity figures show an increase in spells and attendances for April, and are reported above plan. Activity will impact Elective Recovery Fund (ERF) income. This has been included as plan for April as figures will not be finalised by NHSE/I until June, following validation and assessment of the System position. ERF plans are also currently under review by NHSE/I.

Agency spend in Month 1 is £1.5m, which is down by £0.5m from previous month. However, more work is required in order to achieve the agency ceiling of £11.2m for the year. Some of the actions to manage this include reinstating the bi-weekly agency performance meetings and carrying out a workforce stress test exercise.

Capital allocation for the year is £18.9m. The Month 1 spend was £1.5m with a further £7.1m committed spend which equates around 46% of the annual allocation.

Cash balance at the end of the month is £35.2m and we continue to monitor the cash position to ensure staff and suppliers are paid as and when due.

Income and Expenditure Analysis

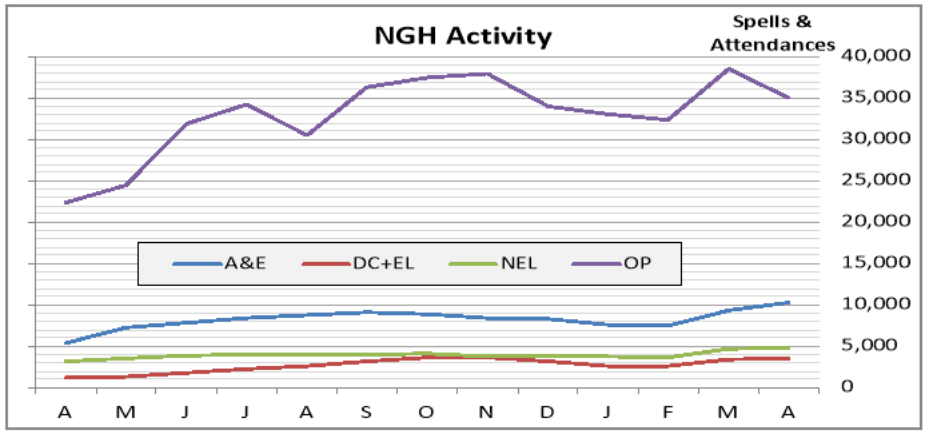
NGH 21/22 I&E	Half 1 Plan £000's	Recent Months: Actual Feb-21	Recent Months: Actual Mar-21 *	Apr-21 Plan £000's	Apr-21 Actual £000's	Apr-21 Variance £000's
Northamptonshire Nene CCG	129,098	21,288	20,633	21,516	21,516	()
Other Patient Care income	27,676	4,622	4,968	4,613	4,494	(119)
Other Operating Income	11,506	2,761	2,629	1,918	1,915	(3)
Plan & Retrospective Top Up	41,375	7,651	7,821	7,588	7,703	115
TOTAL Income	**209,655**	**36,321**	**36,051**	**35,712**	**35,628**	**(7)**
Pay Costs Substantive	(135,379)	(23,243)	(22,398)	(22,385)	(22,308)	77
Pay agency	(7,318)	(1,529)	(2,054)	(1,220)	(1,547)	(328)
Non-Pay Costs	(64,644)	(11,312)	(10,866)	(10,742)	(10,423)	319
Interest costs	(2,514)	(318)	(417)	(419)	(419)	
TOTAL Expenditure	**(209,855)**	**(36,402)**	**(35,735)**	**(34,842)**	**(34,697)**	**68**
Normalisation	200	9	30	33	18	(15)
Surplus / (Deficit) post normalisation	**(0)**	**(72)**	**346**	**903**	**949**	**46**

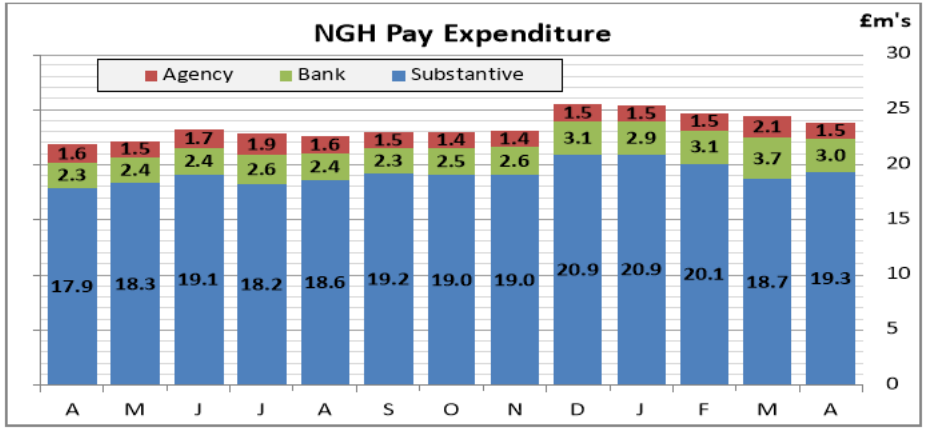
***Mar-21 is expressed excluding significant non-recurrent year-end adjustments.**

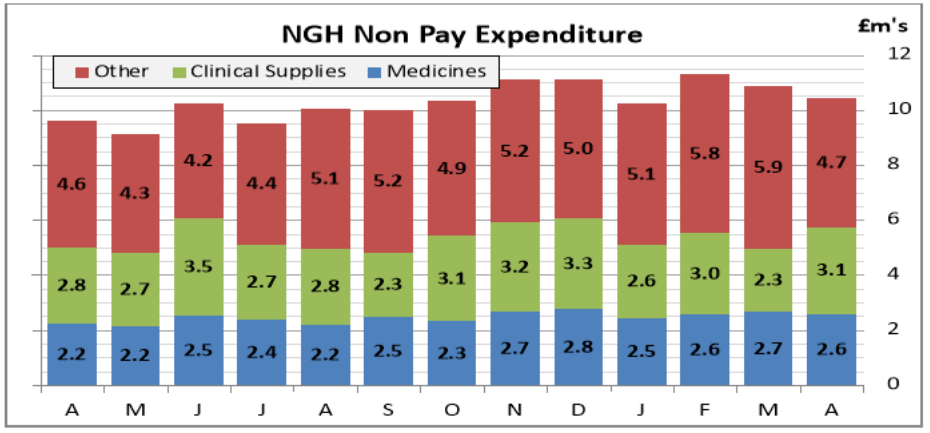
Commentary:

- The Trust has developed and submitted a Half 1 breakeven plan for 2021/22.
- April 2021 plan was for £903k surplus; this has been surpassed by £46k. A £949k surplus reported in month.
- Expenditure was marginally above plan with agency spend reduced to £1.2m, compared to £1.5m in Feb-21.
- Non-pay returned a £319k favourable variance. This is largely due to the theatre reset, with lower orthopaedic elective work taking place in April. We expect non-pay costs to increase as theatre activity increases.
- Other Patient Care Income is under plan due to fluctuating income streams such as injury claim income, Overseas patients and income from other Trusts. We expect these to hit plan across the year.
- Top Up re-imbursement income is higher in month due to a higher expenditure on PCR testing.

Activity & Expenditure Trend







Commentary:

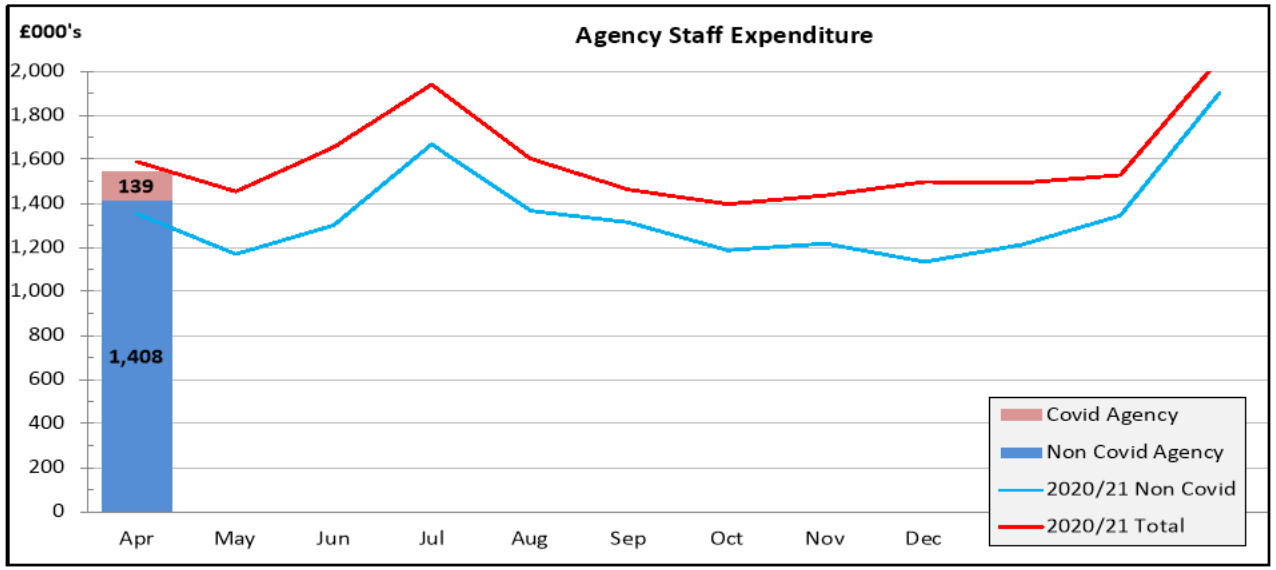
- Activity is showing a marked increase in numbers for April.
- The 10,262 April A&E attendances are 1,100 higher than the previous peaks seen in Sep-20 and Mar-21.
- The 3,476 Daycase plus Elective spells are just 5% lower than the Oct -20 / Nov-20 numbers that were boosted by significant insourcing, plus T&O electives working out of BMI Three Shires. These numbers should be surpassed in June as the Theatres are reset for elective recovery.
- The Non Elective spells of Mar-21 & Apr-21 are nearly 15% higher than any month in recent history.

- These higher levels of activity have been managed without a marked increase in pay expenditure in April. Substantive and Bank levels are on par with autumn 2020.
- Bank costs since Feb-21 include £0.3m of Vaccination Centre Staff.
- Substantive costs Dec-21 to Feb-21 were inflated as the Trust recognised and accounted for the unused annual leave accumulating in 2020/21.

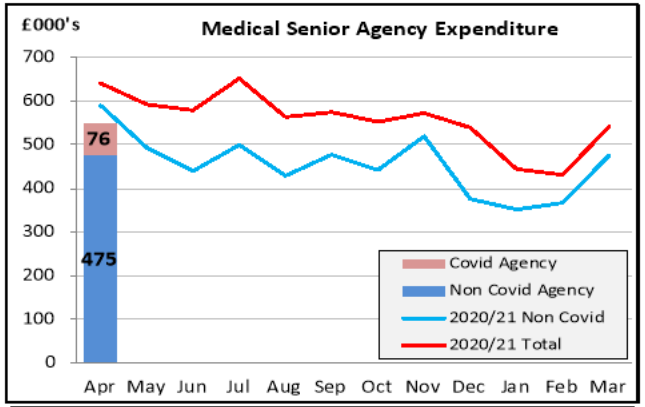
- Where increased activity does become evident in expenditure is the clinical supplies increasing to £3.1m in Apr-21, following increased activity levels in April

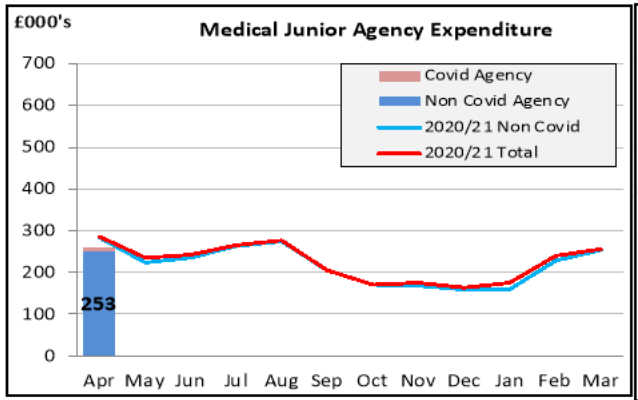
- Other Non Pay has returned to under £5m per month following increased levels of expenditure in Q4.

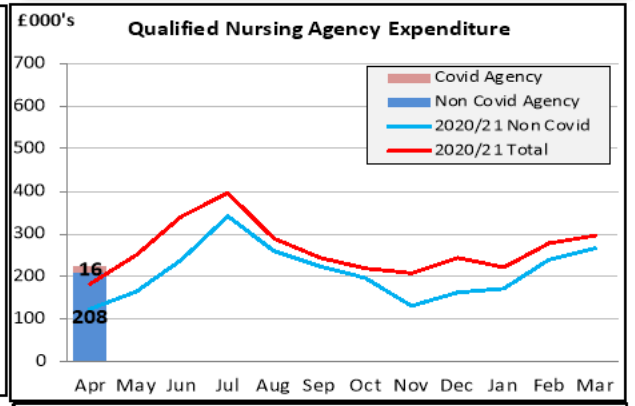
Agency Spend

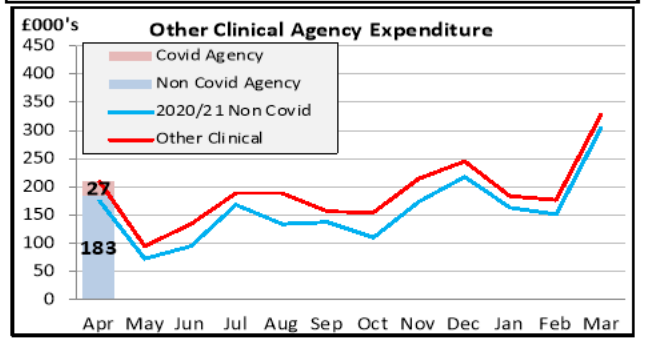


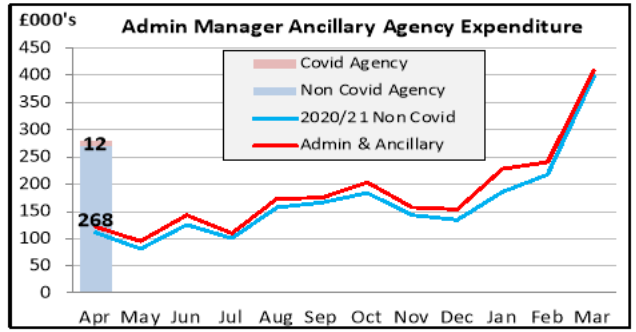
- NGH is challenged again in reducing agency expenditure to £11.2m in 21/22.
- 2020/21 expenditure totalled £19.1m, with £3m being for directly attributable COVID reasons.
- Apr-21 agency spend is down on the year-end peak in March, but is still equal to Jan-Feb level.
- HCA agency spend has benefitted from some accrual release in month.
- Agency management has continued at a high level with investment into IT staffing projects.

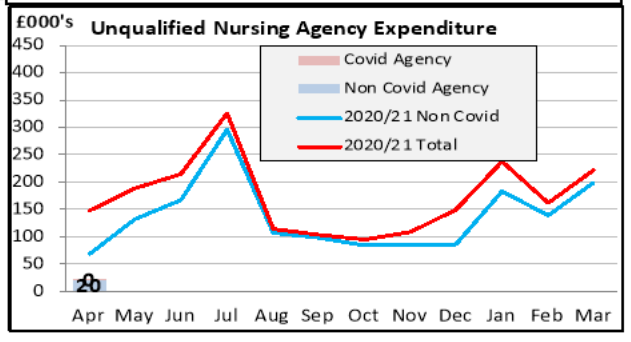






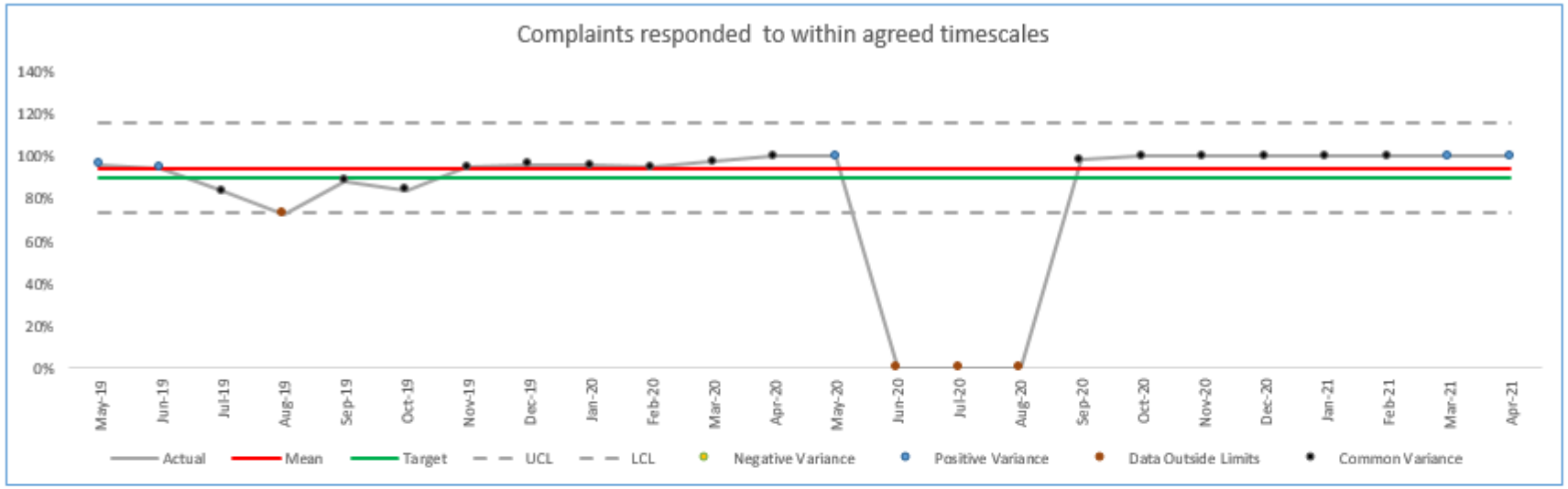






TRUST SUMMARY BALANCE SHEET MONTH 1 2021/22						
	Balance at 31-Mar-21 £000	Current Month			Forecast end of year	
		Opening Balance £000	Closing Balance £000	Movement £000	Closing Balance £000	Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	187,241	187,241	187,241	0	187,241	0
IN YEAR REVALUATIONS	0	0	0	0	0	0
IN YEAR MOVEMENTS	0	0	1,514	1,514	19,075	19,075
LESS DEPRECIATION	0	0	(1,090)	(1,090)	(13,359)	(13,359)
NET BOOK VALUE	187,241	187,241	187,665	424	192,957	5,716
CURRENT ASSETS						
INVENTORIES	6,310	6,310	6,340	30	6,310	0
TRADE & OTHER RECEIVABLES	16,048	16,048	17,183	1,135	21,282	5,234
CLINICIAN PENSION TAX FUNDING	966	966	966	0	966	0
CASH	25,428	25,428	35,227	9,799	1,500	(23,928)
TOTAL CURRENT ASSETS	48,752	48,752	59,716	10,964	30,058	(18,694)
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	36,939	36,939	48,107	11,168	25,434	(11,505)
FINANCE LEASE PAYABLE under 1 year	1,206	1,206	1,194	(12)	1,254	48
SHORT TERM LOANS	246	246	246	0	274	28
PROVISIONS under 1 year	2,477	2,477	1,925	(552)	2,477	0
TOTAL CURRENT LIABILITIES	40,868	40,868	51,472	10,604	29,439	(11,429)
NET CURRENT ASSETS / (LIABILITIES)	7,884	7,884	8,244	360	619	(7,265)
TOTAL ASSETS LESS CURRENT LIABILITIES	195,125	195,125	195,909	784	193,576	(1,549)
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	8,323	8,323	8,235	(88)	7,069	(1,254)
LOANS over 1 year	763	763	703	(60)	669	(94)
PROVISIONS over 1 year	1,585	1,585	1,585	0	1,585	0
NON CURRENT LIABILITIES	10,671	10,671	10,523	(148)	9,323	(1,348)
TOTAL ASSETS EMPLOYED	184,454	184,454	185,386	932	184,253	(201)
FINANCED BY						
PDC CAPITAL	259,588	259,588	259,588	0	259,804	216
REVALUATION RESERVE	39,313	39,313	39,313	0	39,313	0
I & E ACCOUNT	(114,447)	(114,447)	(113,515)	932	(114,864)	(417)
FINANCING TOTAL	184,454	184,454	185,386	932	184,253	(201)

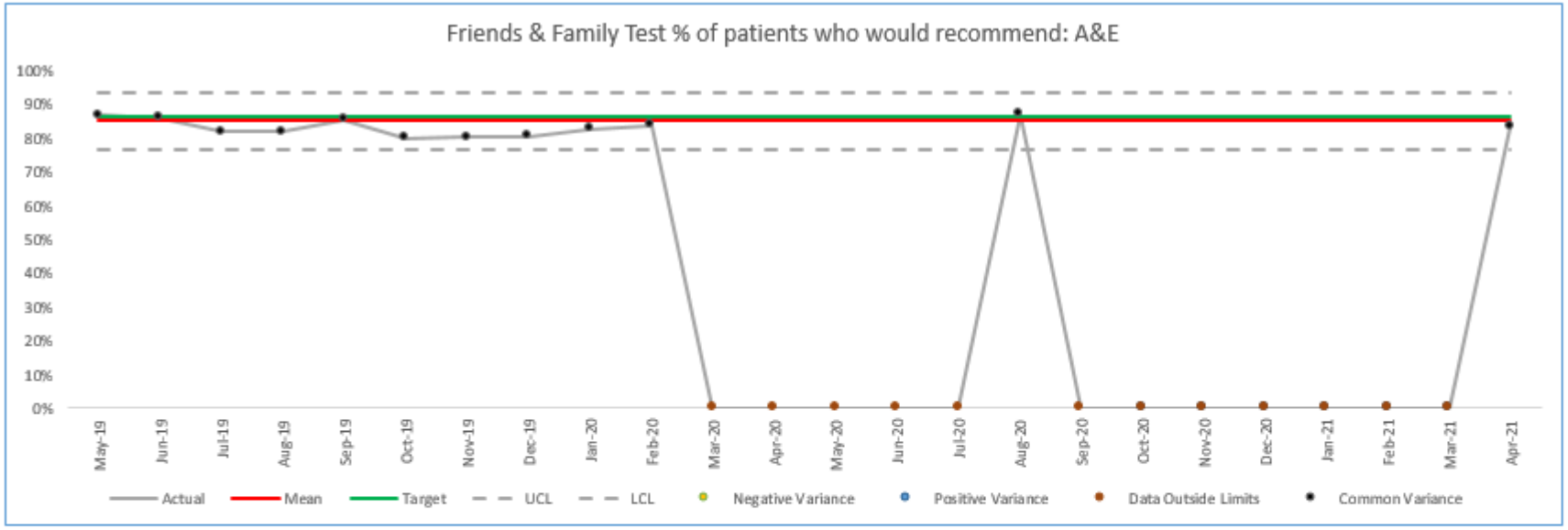
Complaints responded to within agreed timescales



Apr-21
100%
Variance Type
Special Cause Variation - trend is showing a positive performance above the mean
Target
90%
Target Achievement
Metric is consistently achieving the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Complaints performance – Providing a written response to a complaint within an agreed timescale	Special Cause Variation - trend is showing a positive performance above the mean the metric continues to be delivered, the metric was suspended from July to September 20 due to Covid	The metric is delivering at 100% and is now an assured system	Review and possible recalculation of control limits	The complaints timeframe has temporarily changed three times over the last the last year in order to allow our clinical staff the time to provide care to our patients during the pandemic. At present we are working to the temporary 60 working days. The Complaints team are working hard to get the complaints process back on track to normal timeframes. They are ensuring to communicate with the patients. The Trust compliance rate response rate for complaints, reported in February was 100%.

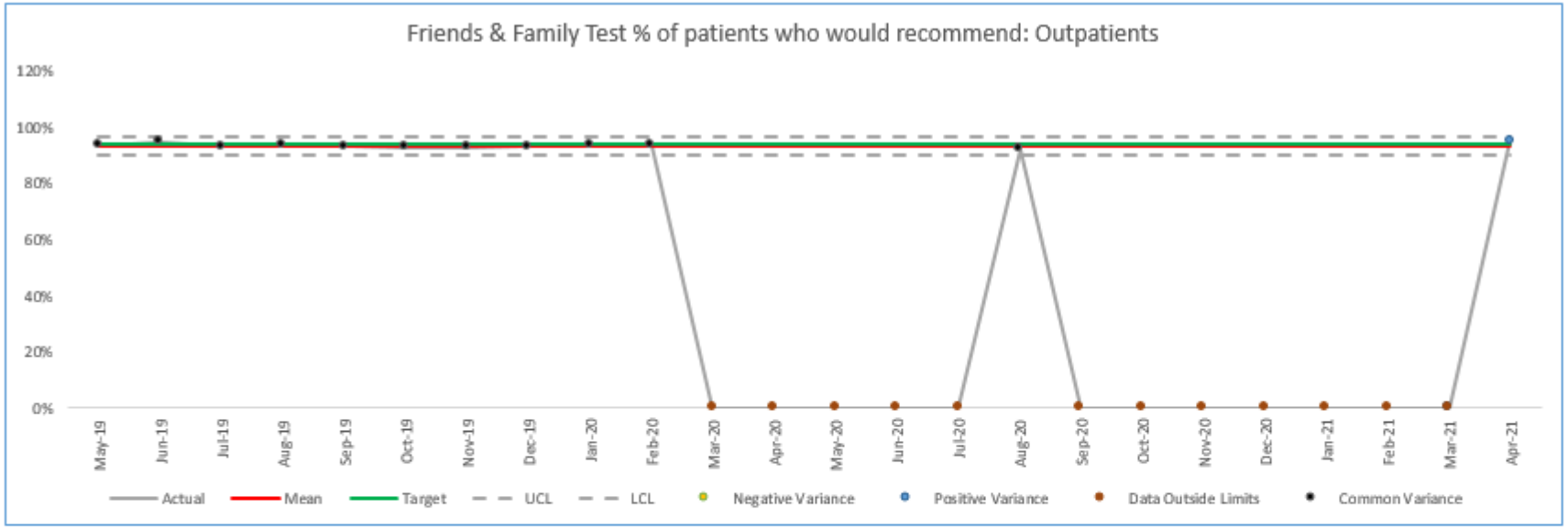
Friends & Family Test % of patients who would recommend: A&E



Apr-21
83.29%
Variance Type
Special Cause Variation - trend is showing a negative performance below the mean
Target
86%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Friends & Family Test % of patients who would recommend: A&E	Monitoring of this target was suspended in June 20 and recommenced in April 2021 following Covid	None highlighted	Monitoring in place from April 2021.	N/A

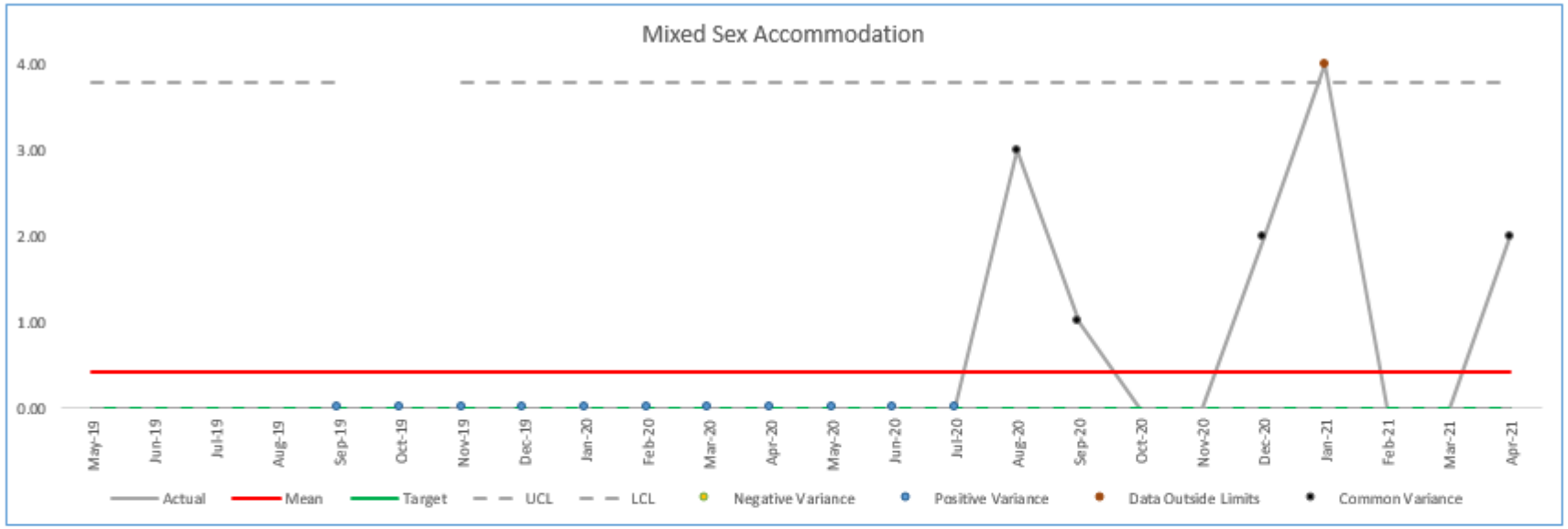
Friends & Family Test % of patients who would recommend: Outpatients



Apr-21
95%
Variance Type
Insufficient Data Points
Target
86%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Friends & Family Test % of patients who would recommend: Outpatients	Monitoring of this target was suspended in June 20 and recommenced in April 2021 following Covid	None highlighted	Monitoring in place from April 2021.	N/A

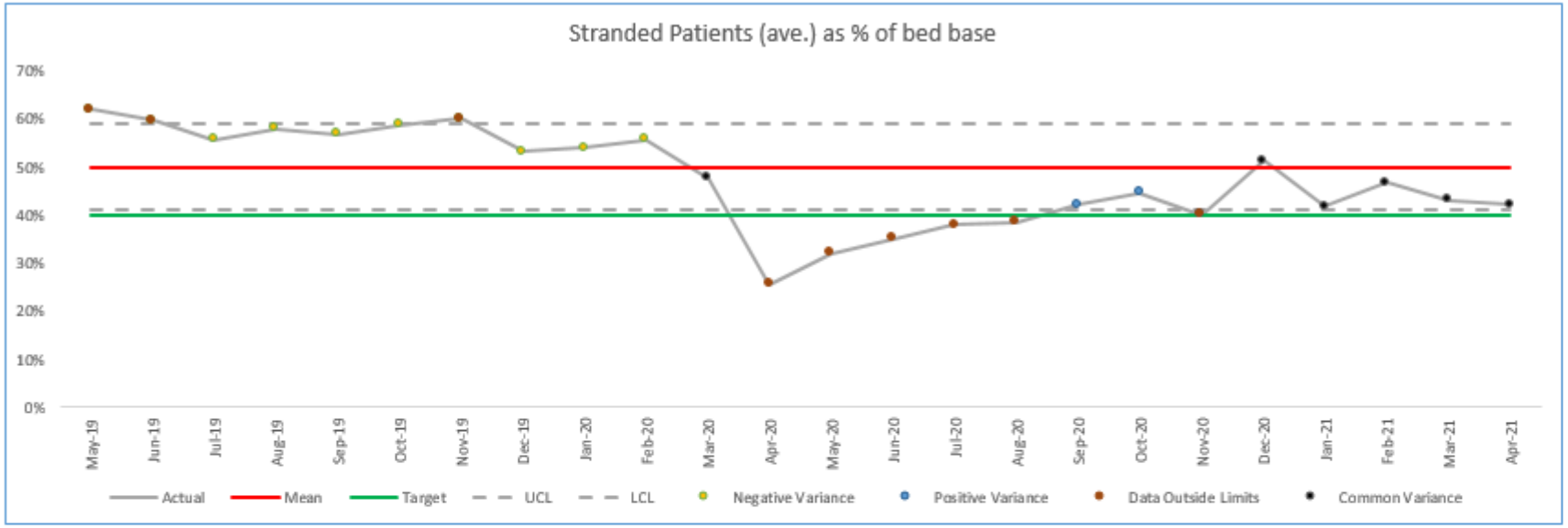
Breaches in mixed-sex accomodation



Apr-21
2
Variance Type
Common Cause Variation
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Number of Mixed Sex Accommodation	There were two reported breaches in month	None highlighted	N/A	N/A

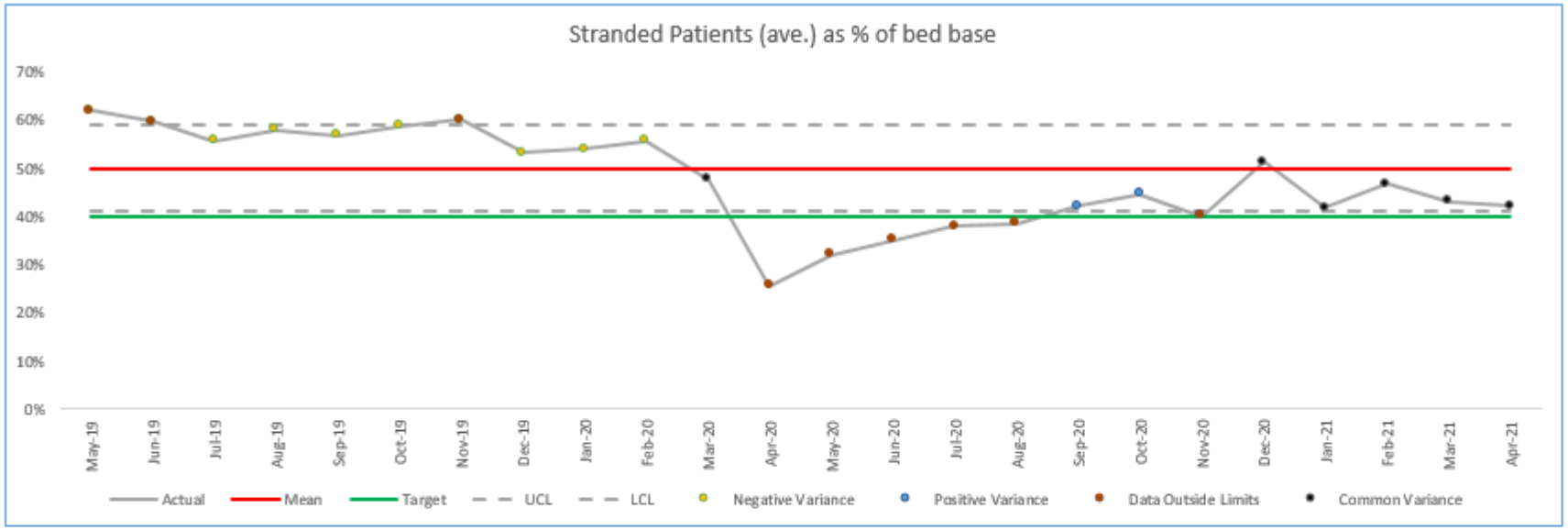
Stranded Patients (ave.) as % of bed base



Apr-21
42%
Variance Type
Common Cause Variation
Target
40%
Target Achievement
Metric is consistently failing the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Percentage of patients with a LOS > 7 days	Performance remains above the target of 40%	Number of acutely unwell patients who have stayed longer than 7 days Internal discharge processes and delays	Ongoing work with the Reason to Reside Discharge Cell as a part of the iCAN Programme Flow & Grip Pillar Discharge bronze with all wards to focus on all patients with no reason to reside commenced in March Internal discharge & flow transformation programme was launched in April	Daily meeting with system partners

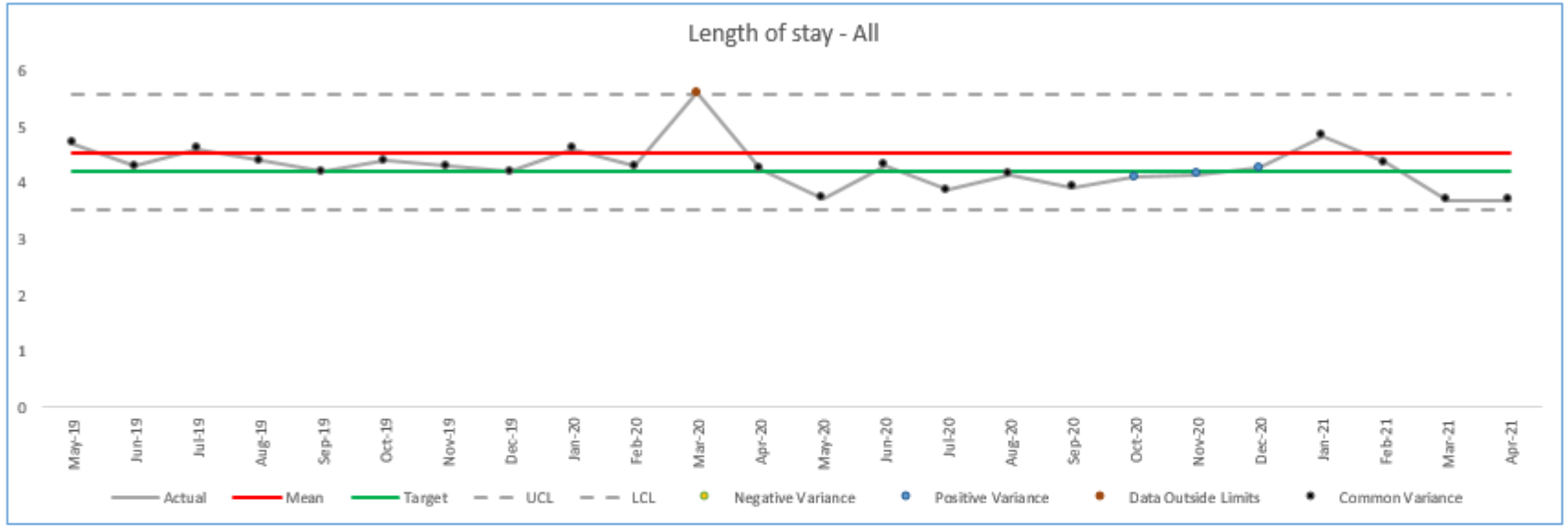
Stranded Patients (ave.) as % of bed base



Apr-21
42%
Variance Type
Common Cause Variation
Target
40%
Target Achievement
Metric is consistently failing the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Percentage of patients with a LOS > 7 days	Performance remains above the target of 40%	Number of acutely unwell patients who have stayed longer than 7 days Internal discharge processes and delays	Ongoing work with the Reason to Reside Discharge Cell as a part of the iCAN Programme Flow & Grip Pillar Discharge bronze with all wards to focus on all patients with no reason to reside commenced in March Internal discharge & flow transformation programme was launched in April	Daily meeting with system partners

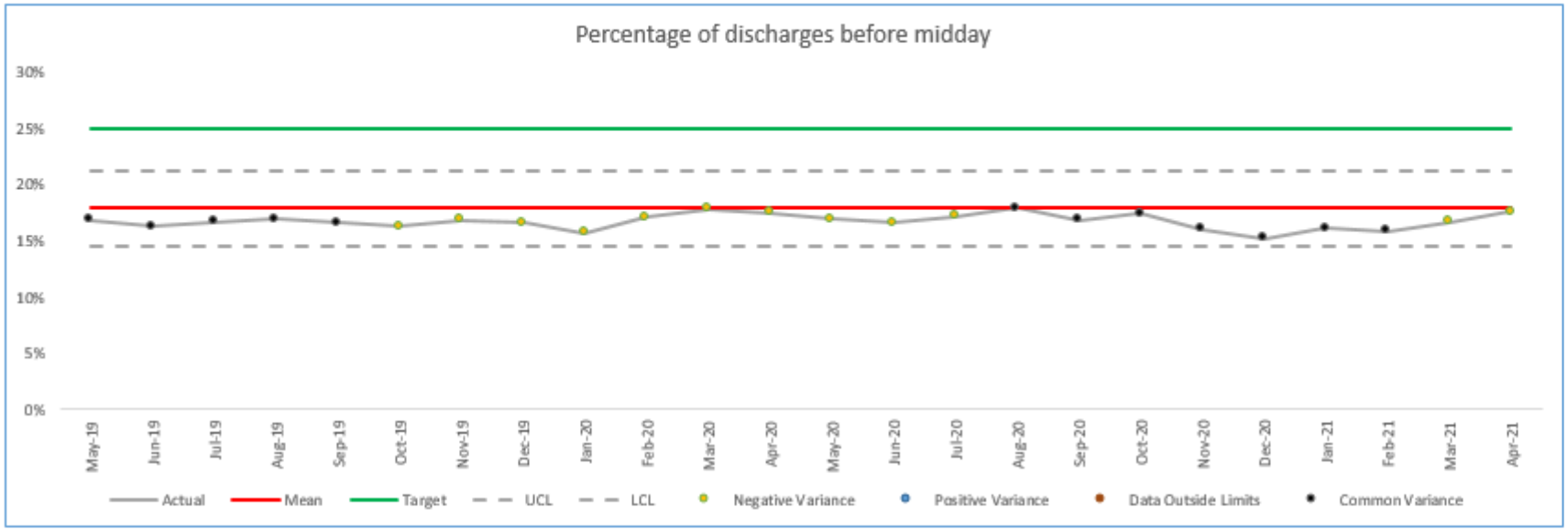
Length of stay - All



Apr-21
3.70
Variance Type
Common Cause Variation
Target
4.30
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Length of stay - All	The target was delivered in April 21, from June 20 to February 21 performance was significantly impacted by Covid, the target has been delivered in March and April, this attributed to a reduction long stay Covid patients coupled with the revovery of elective activity	None highlighted	N/A	Internal discharge and flow transformation programme

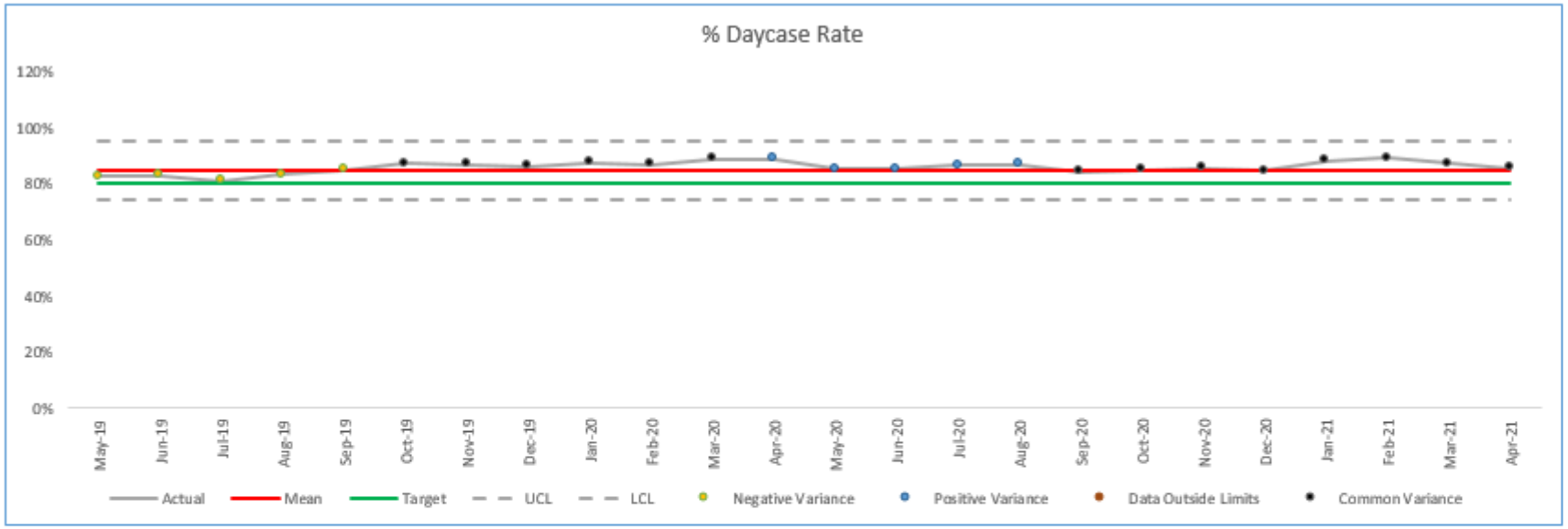
Percentage of discharges before midday



Apr-21
18%
Variance Type
Special Cause Variation - trend is showing a negative performance below the mean
Target
25%
Target Achievement
Metric is consistently failing the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Percentage of discharges before midday	Performance remains below target in April 21	None highlighted	Continued work through the Ican prorogramme and support from the intensive support team to fully implement the national discharge policy	Internal discharge and flow transformation programme

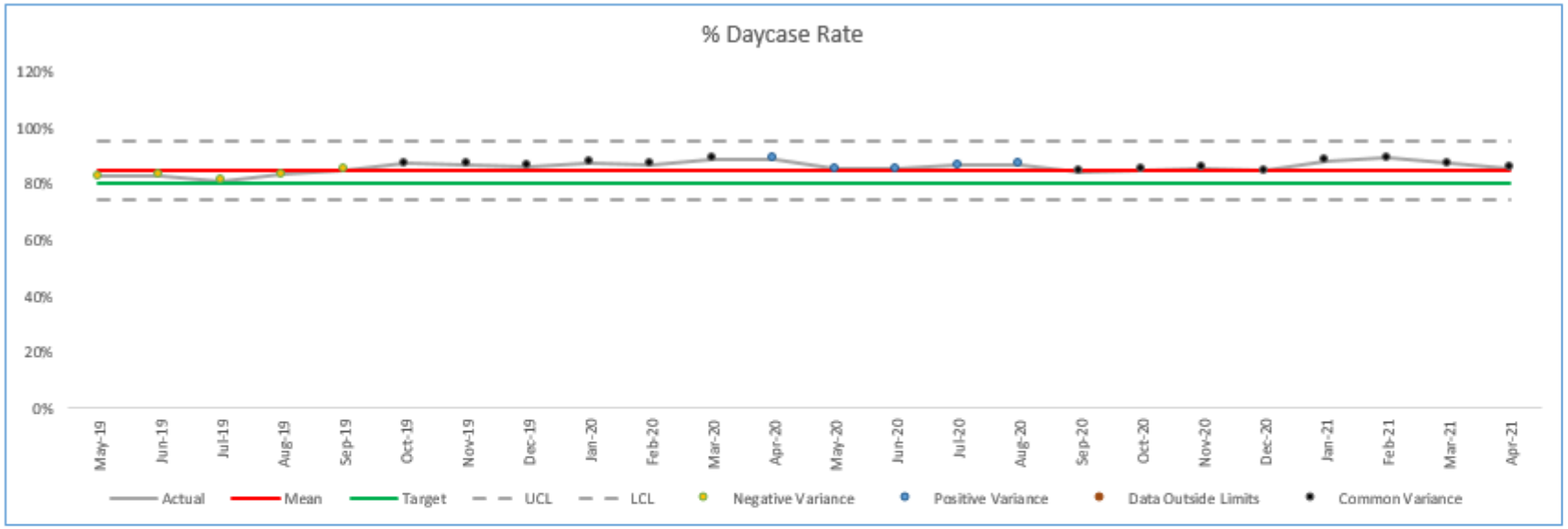
% Daycase Rate



Apr-21
86%
Variance Type
Common Cause Variation
Target
80%
Target Achievement
Metric is consistently achieving the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Daycases as percentage of all elective activity	Metric is consistently achieving the target	None highlighted	Additional theatre capacity will come on line in June when endoscopy relocates to their original unit	N/A

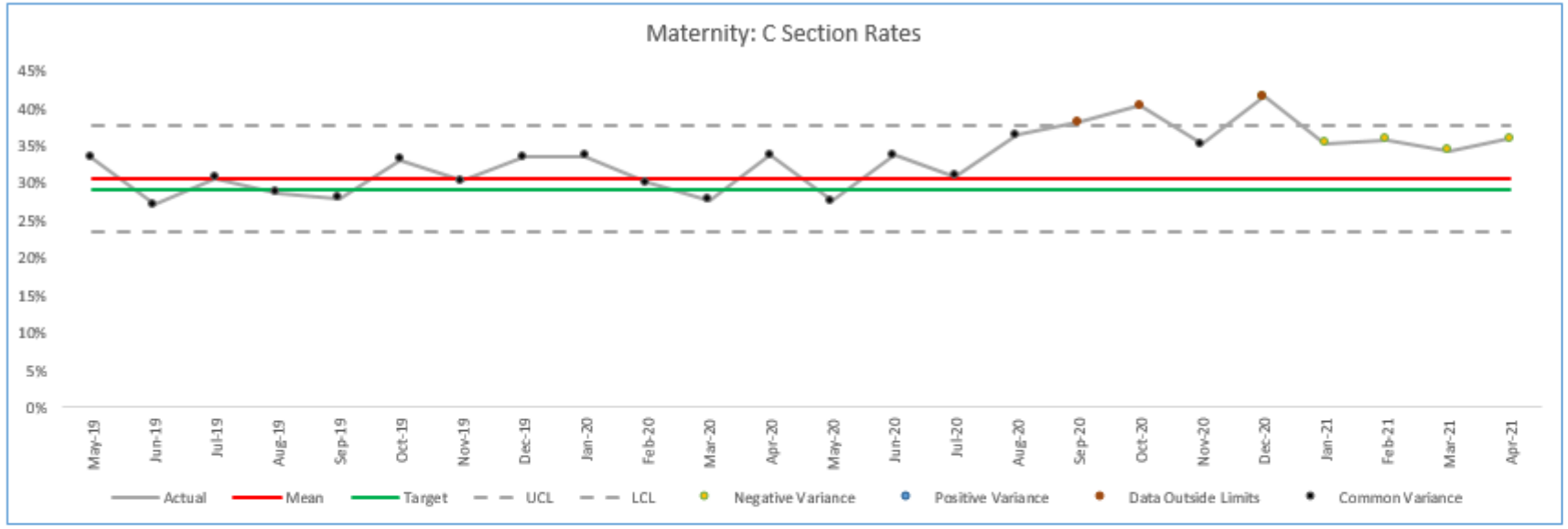
% Daycase Rate



Apr-21
86%
Variance Type
Common Cause Variation
Target
80%
Target Achievement
Metric is consistently achieving the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Daycases as percentage of all elective activity	Metric is consistently achieving the target	None highlighted	Additional theatre capacity will come on line in June when endoscopy relocates to their original unit	N/A

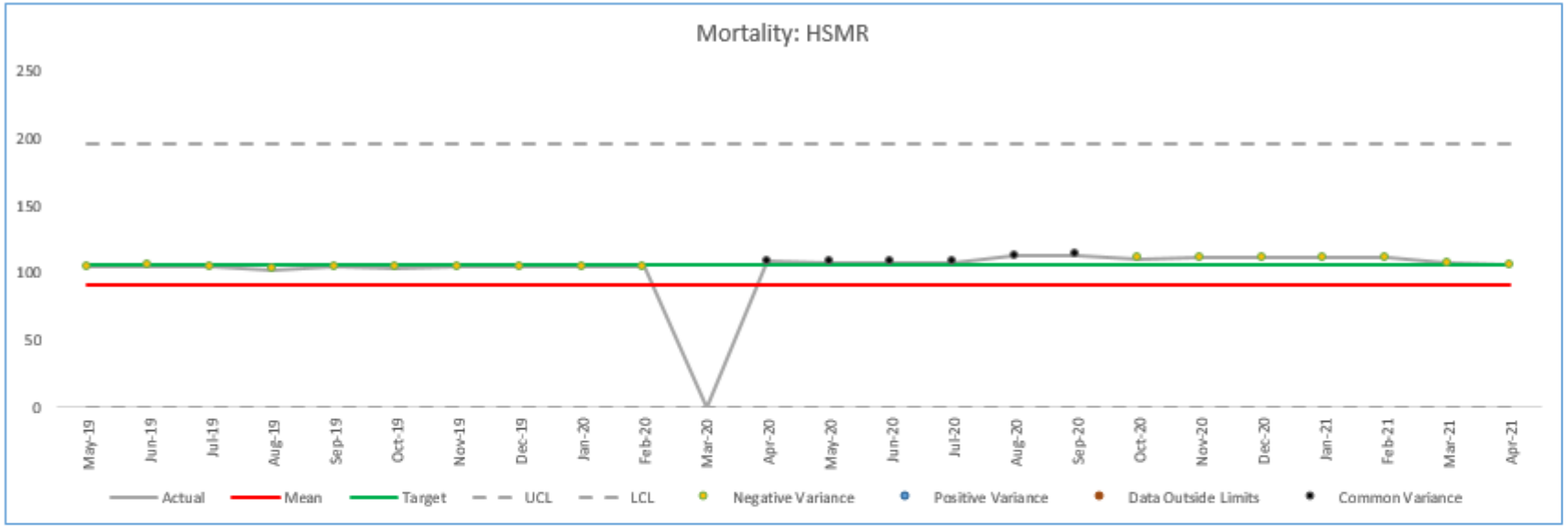
Maternity: C Section Rates



Apr-21
36%
Variance Type
Special Cause Variation - trend is showing a negative performance above the mean
Target
29%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Maternity: C Section Rates	Performance remains above target in April 21	None highlighted	N/A	N/A

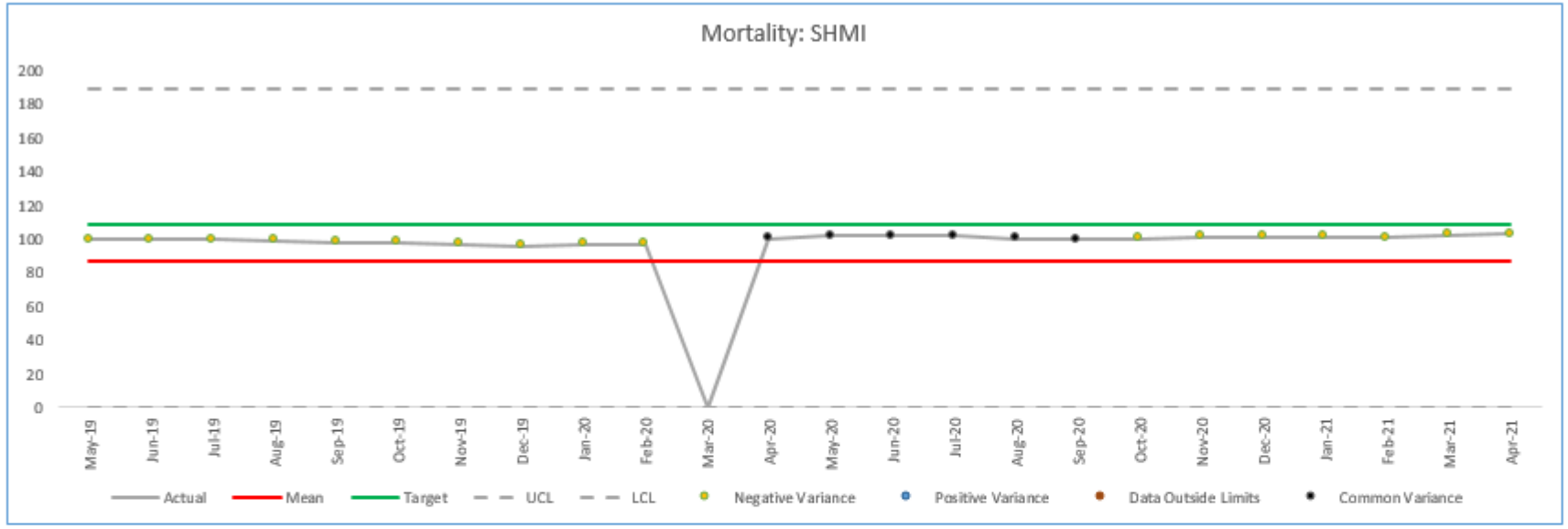
Mortality: HSMR



Apr-21
105.60
Variance Type
Special Cause Variation - trend is showing a negative performance above the mean
Target
106.00
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Mortality: HSMR	Performance is per target in April 21	None highlighted	N/A	N/A

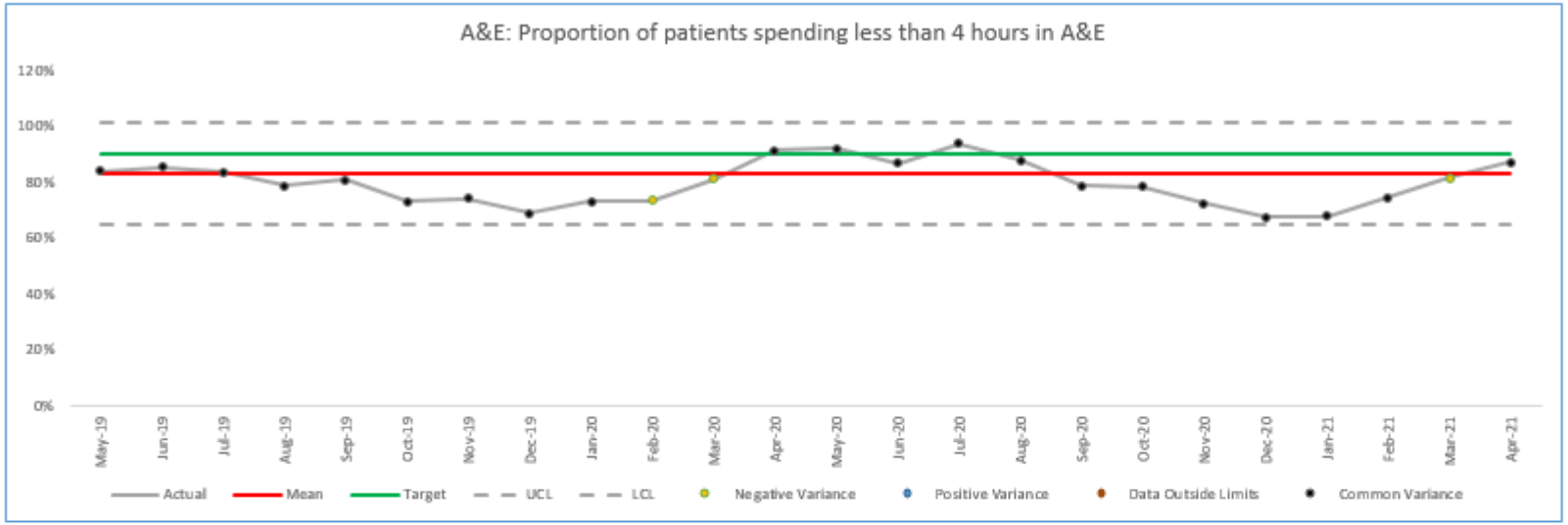
Mortality: SHMI



Apr-21
102.80
Variance Type
Special Cause Variation - trend is showing a negative performance above the mean
Target
109.00
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Mortality: SHMI	Performance is below target in April 22	None highlighted	N/A	N/A

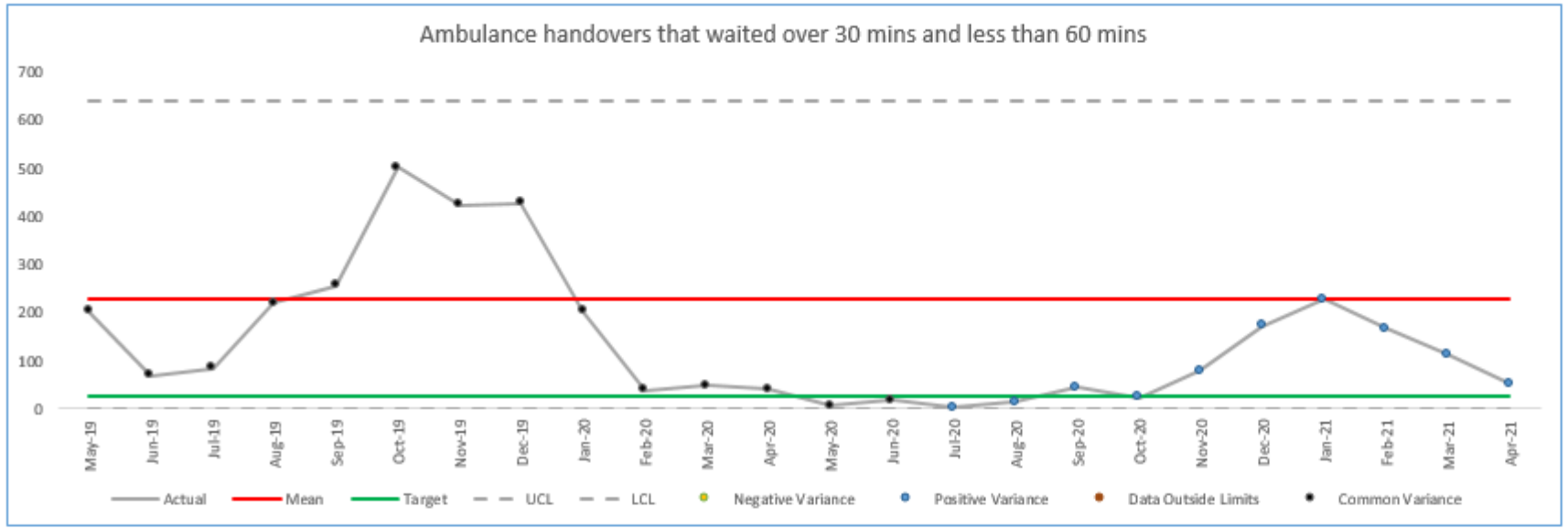
A&E: Proportion of patients spending less than 4 hours in A&E



Apr-21
87%
Variance Type
Special Cause Variation – trend is showing a negative performance below the mean
Target
90%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
A&E: Proportion of patients spending less than 4 hours in A&E	Although still be low target there is a continued upward trend in performance, this is attributed to a reduction in Covid activity and seasonal change	Challenge of flow through ED Volume of attendances High acuity within ED Staffing challenges compounded by sickness following staff receiving Covid vaccine	Continuation of pathways to stream patients to alternative services including SDEC and Springfield Continuation of fit2sit for all appropriate patients Paramedic pathways into SDEC ED Doctor rota has been realigned to map to times of high inflow e.g. SpR shift from 4-2am has been put in place as well as an extra Consultant shift in the evening Springfield opening hours have been extended Internal Discharge & Flow programme launched in April	Reverse corridor boarding to support flow when required SDEC inreach into ED to support

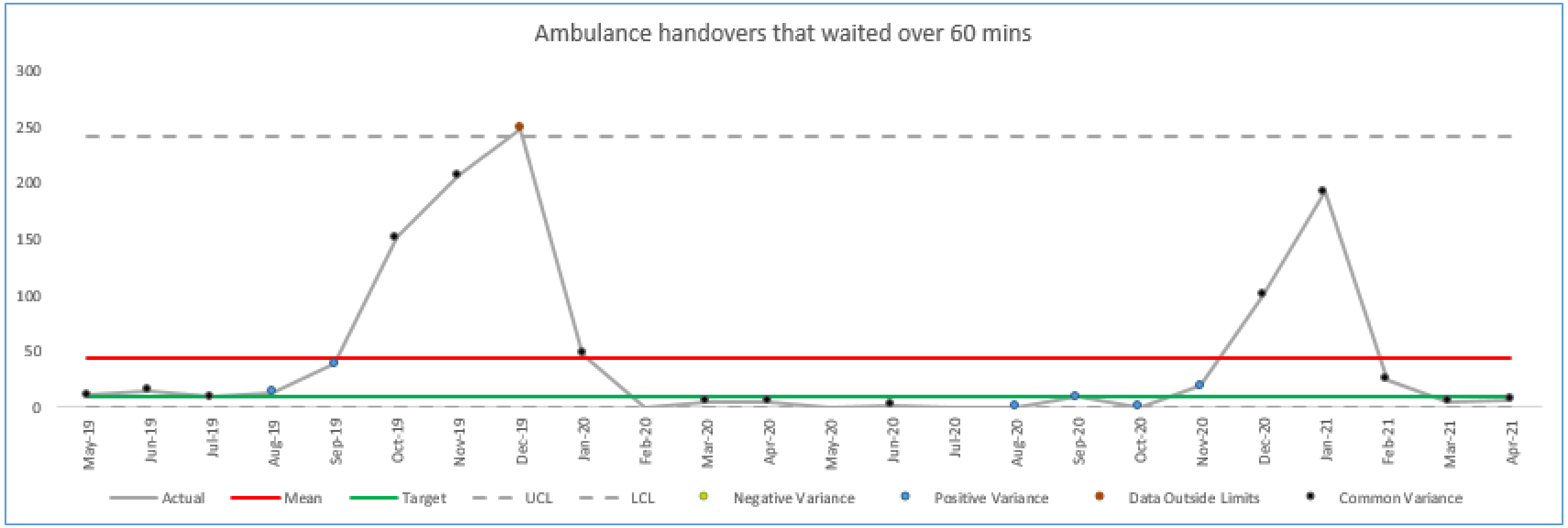
Ambulance handovers that waited over 30 mins and less than 60 mins



Apr-21
52
Variance Type
Special Cause Variation - trend is showing a negative performance above the mean
Target
25
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Total number of Ambulance handovers that exceed a wait of 30+ minutes within A&E	There were 52 handovers between 30 and 60 minutes, this shows continued reduction in line with reduced Covid activity and seasonal variations	Inflow of ambulances and outflow at peak times	Ambulance streaming on arrival and direct access to SDEC Revised processes to improve internal ED flow Missed opportunities audit completed by ECIST	Escalation SOP and protocols in place

Ambulance handovers that waited over 60 mins



Apr-21
7
Variance Type
Common Cause Variation
Target
10
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:

Total number of Ambulance Handovers that exceed a wait of 60+ minutes within A&E

What the chart tells us:

There were 7 breaches of the target, this shows continued reduction in line with reduced Covid activity and seasonal variations

Issues:

Inflow of ambulances and outflow at peak times

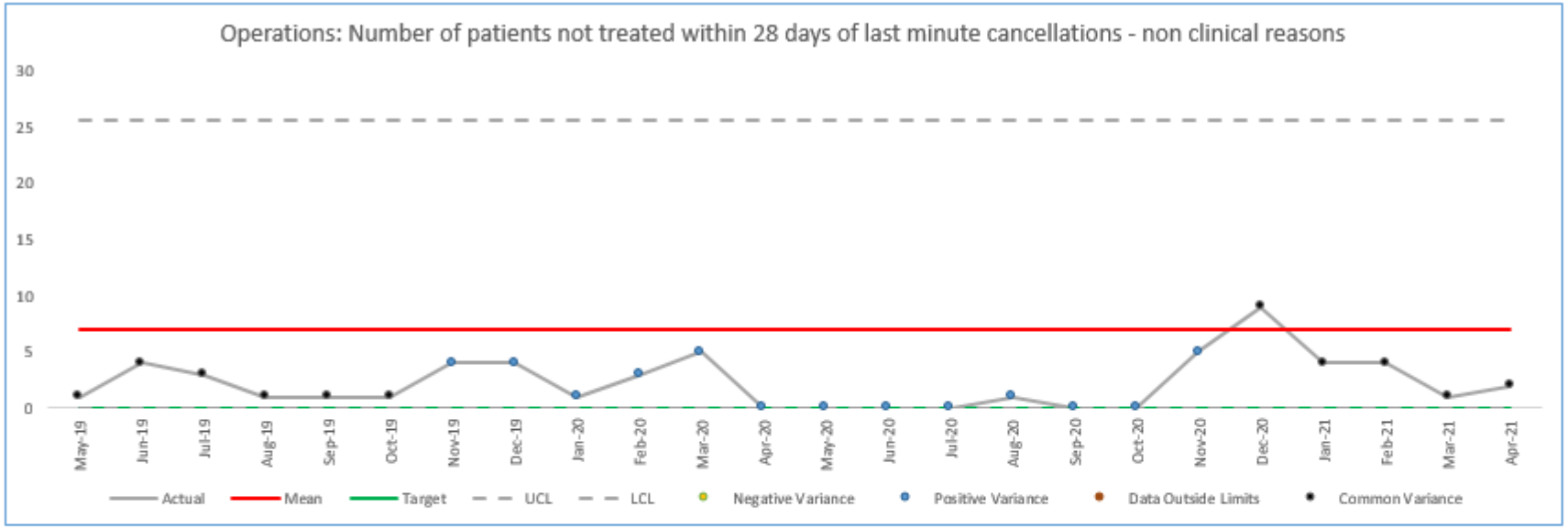
Actions:

Ambulance streaming on arrival and direct access to SDEC
Revised processes to improve internal ED flow
Missed opportunities audit completed by ECIST

Mitigations

Escalation SOP and protocols in place

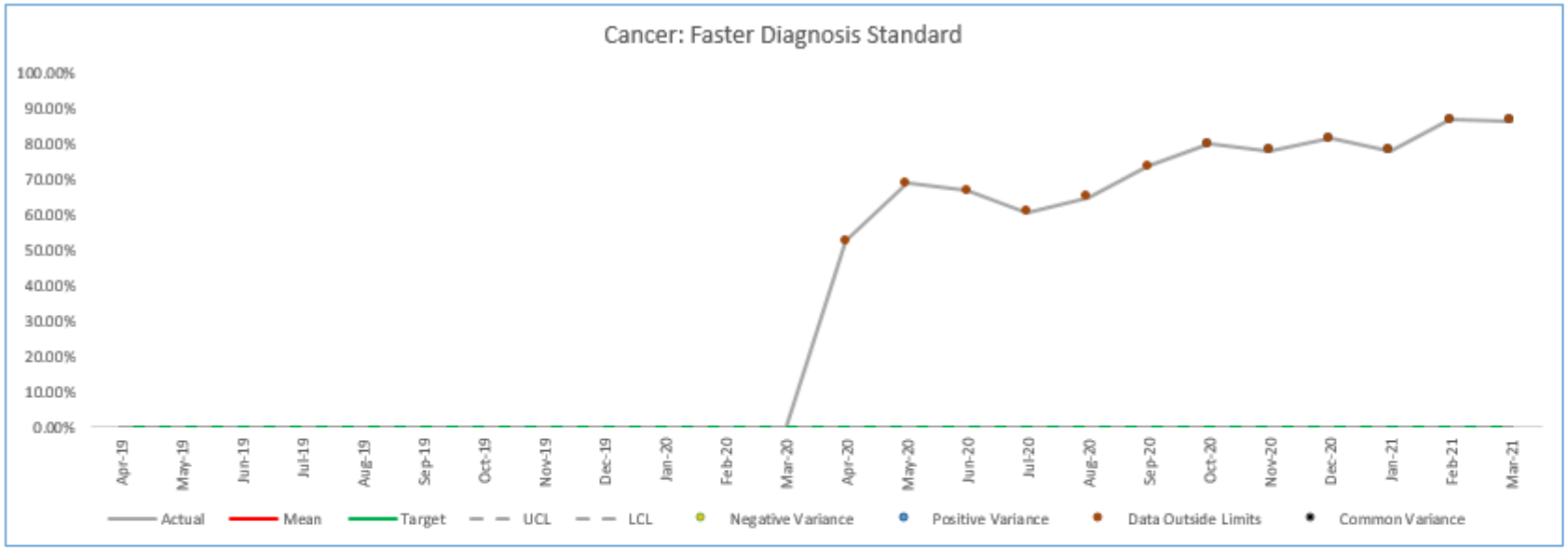
Operations: Number of patients not treated within 28 days of last minute cancellations - non



Apr-21
2
Variance Type
Common Cause Variation
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	There were 2 breaches of this target in April 21	These were not escalated appropriately	Deputy COO to review the escalation policy	Deputy COO and Head of Informatics will review processes between Operations and Informatics

Cancer: Faster Diagnosis Standard

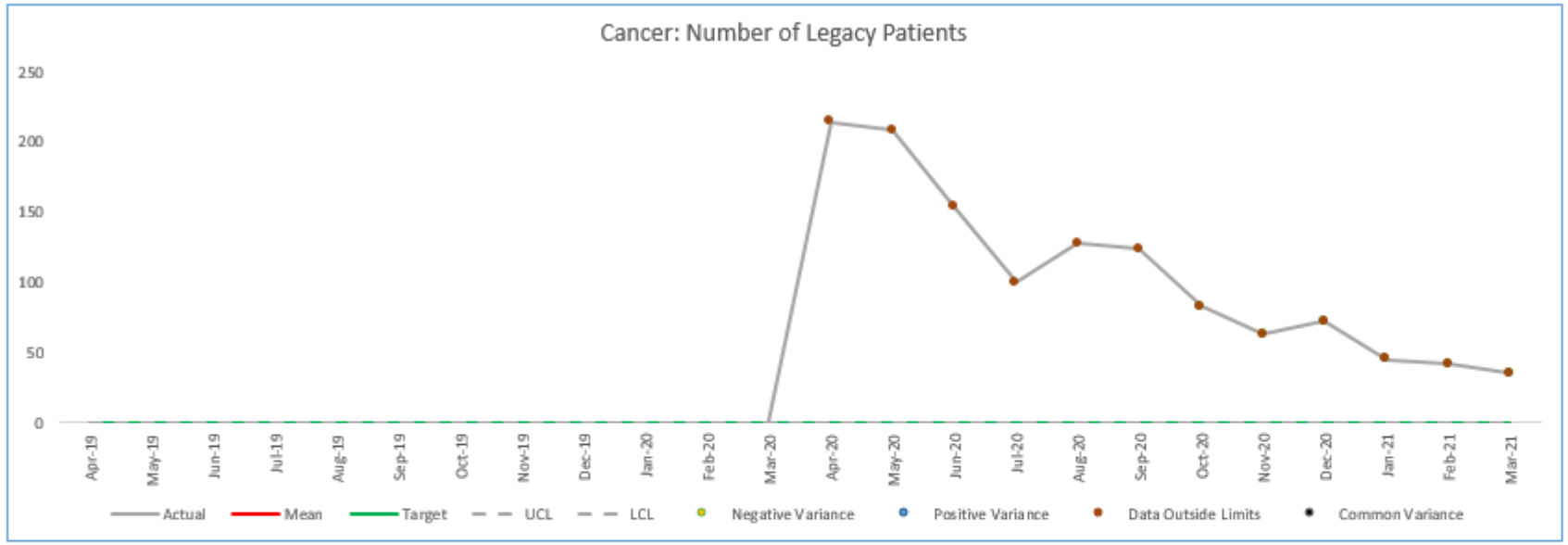


Mar-21
87%
Variance Type
Target
70%
Target Achievement

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Cancer: Faster Diagnosis Standard	There are insufficient data points to show as SPC	None highlighted	H1 Trajectories developed and monitored through Weekly RESET Meeting, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

Caroline April 06/24/2021 14:54:01

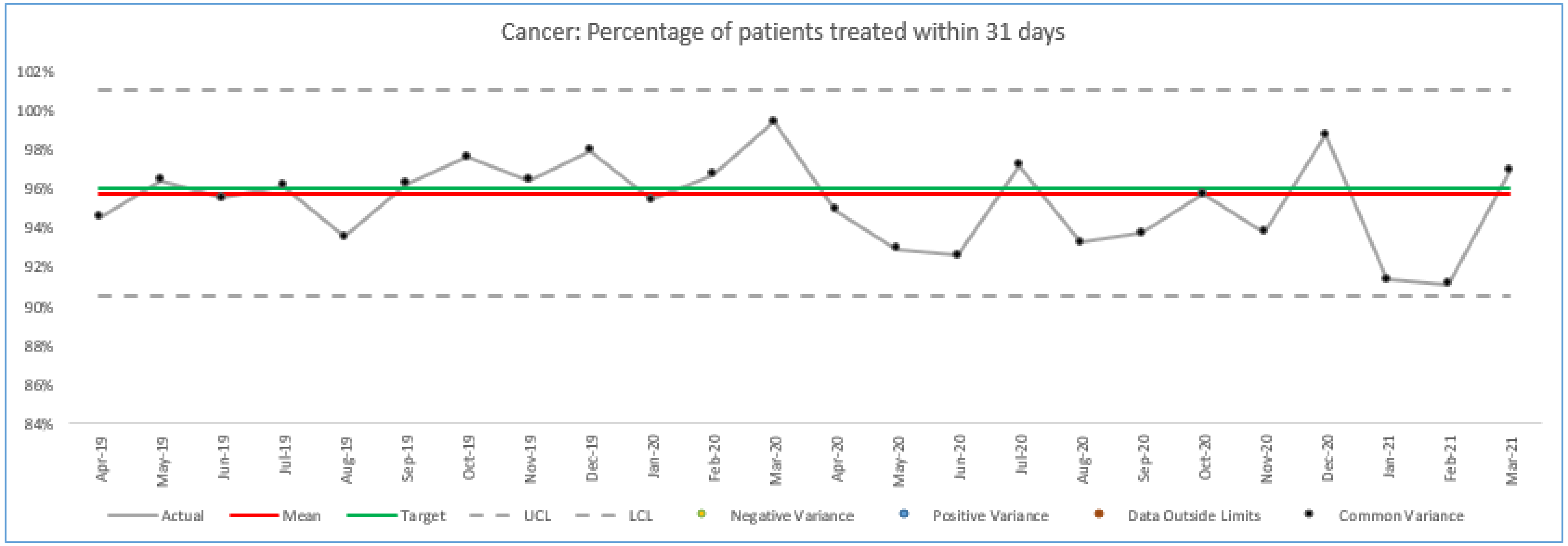
Cancer: Number of Legacy Patients



Mar-21
35
Variance Type
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Cancer: Number of Legacy Patients	There are insufficient data points to show as SPC	None highlighted	H1 Trajectories developed and monitored through Weekly RESET Meeting, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

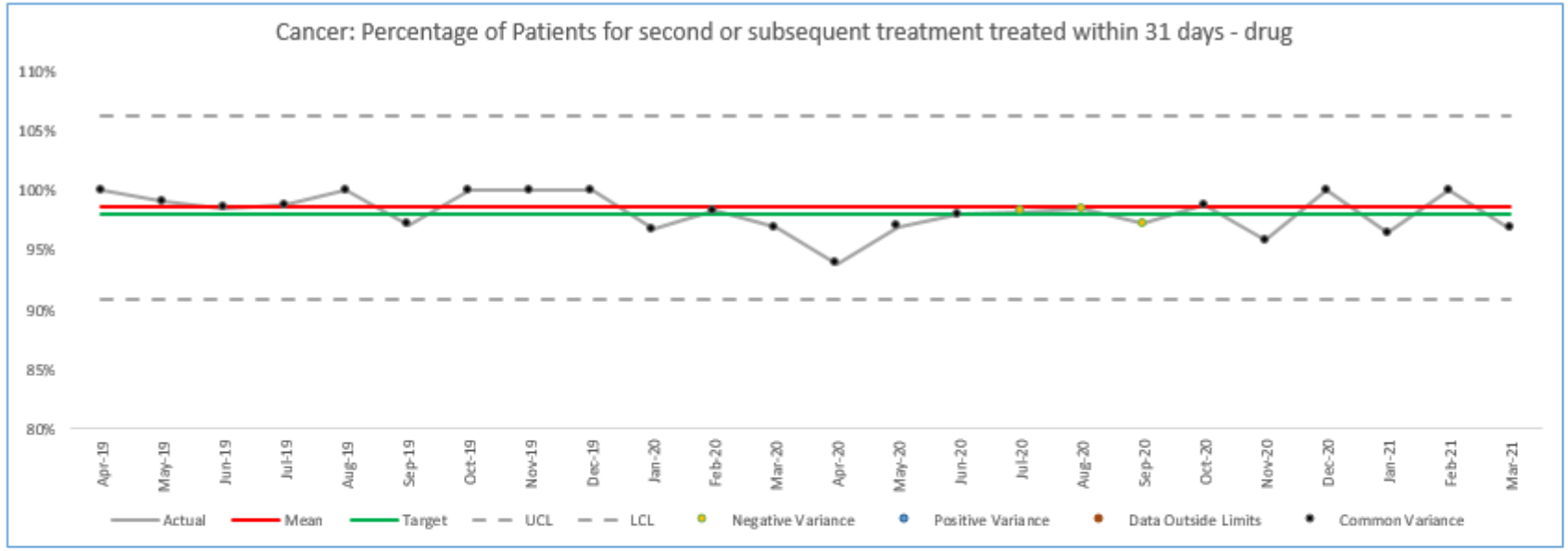
Cancer: Percentage of patients treated within 31 days



Mar-21
97%
Variance Type
Special Cause Variation - trend is showing a negative performance below the mean
Target
96%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

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	The target is not consistently met	None highlighted	H1 Trajectories developed and monitored through Weekly RESET Meeting, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

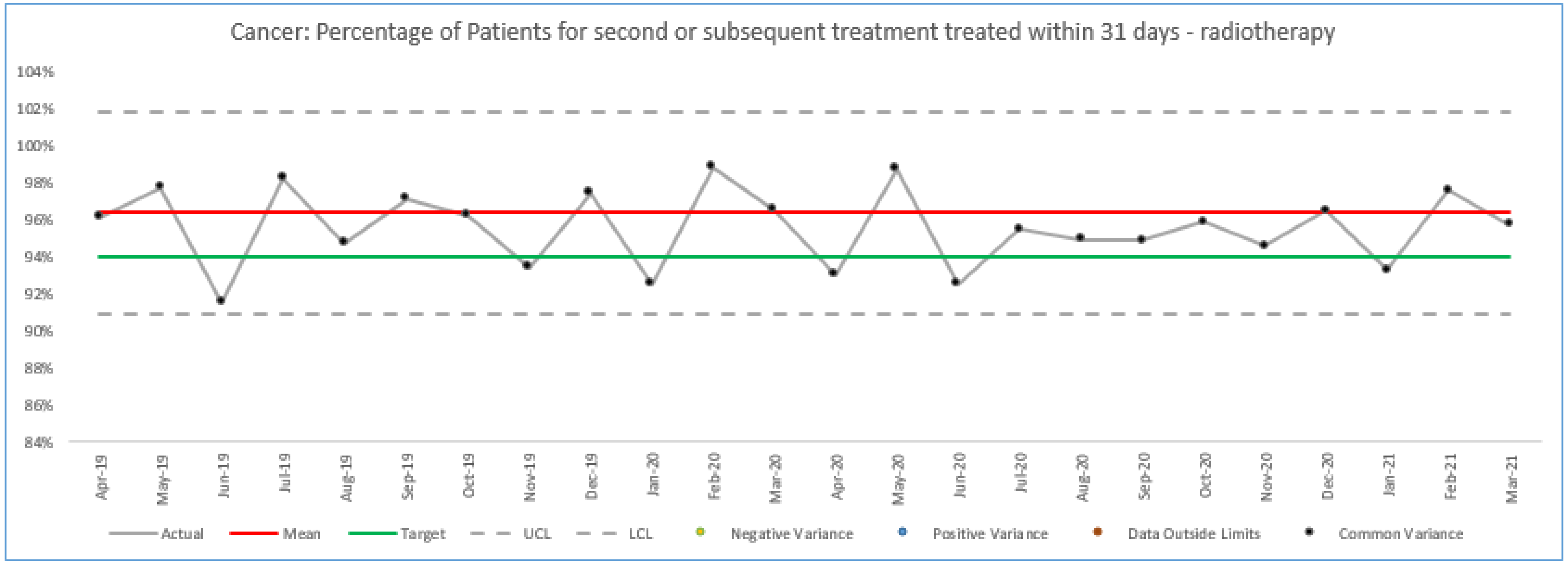
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug



Mar-21
97%
Variance Type
Special Cause Variation - trend is showing a negative performance below the mean
Target
98%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

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%.	Target delivered in line in trajectory	None highlighted	H1 Trajectories developed and monitored through Weekly RESET Meeting, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

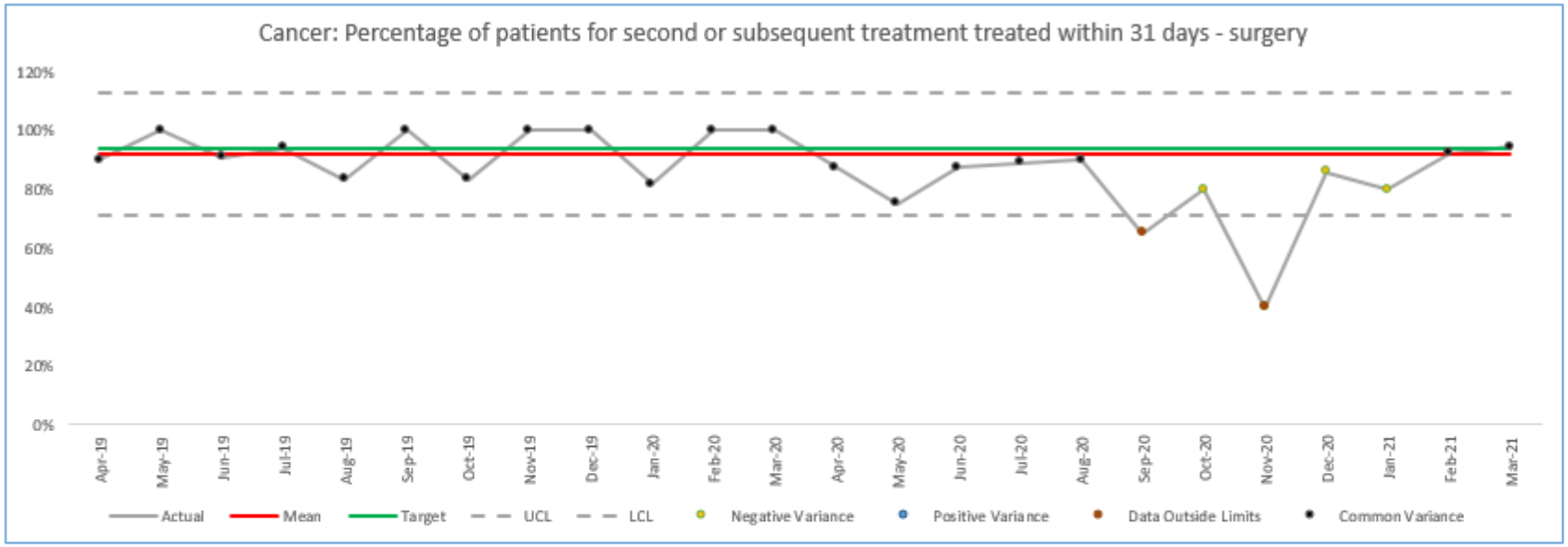
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy



Mar-21
96%
Variance Type
Special Cause Variation - trend is showing a negative performance below the mean
Target
94%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

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%.	Target delivered in line with trajectory	None highlighted	H1 Trajectories developed and monitored through Weekly RESET Meeting, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

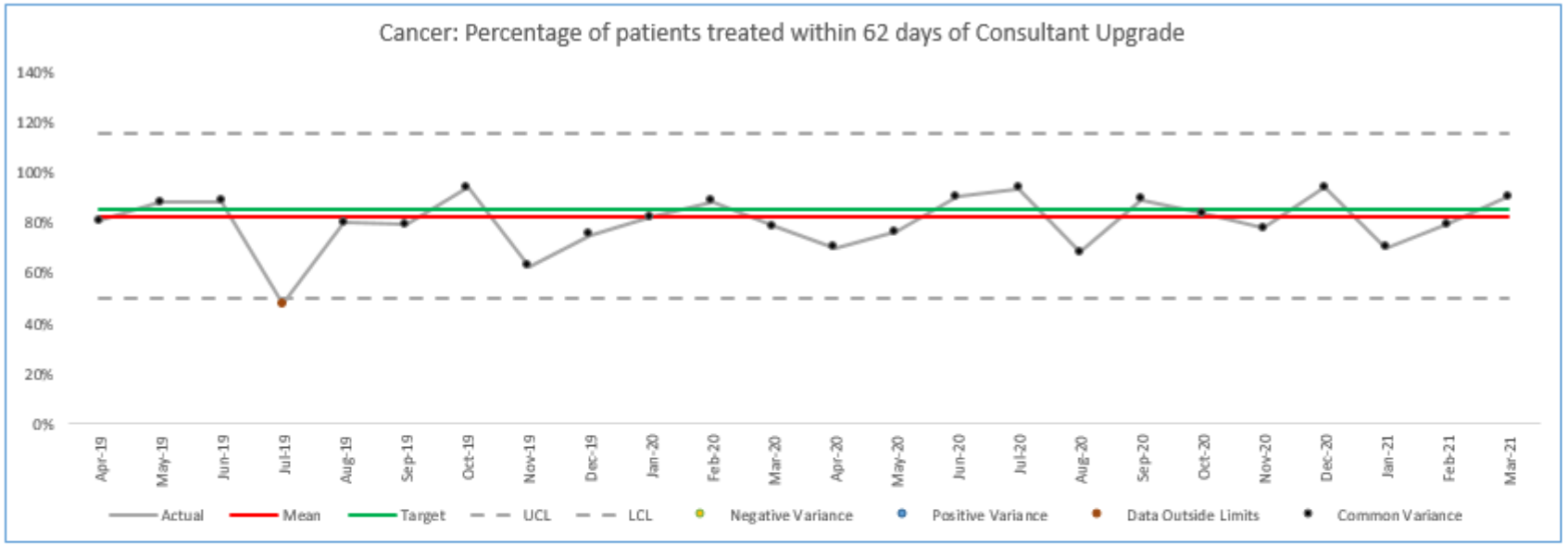
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery



Mar-21
94%
Variance Type
Special Cause Variation - trend is showing a negative performance below the mean
Target
94%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

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%.	Target delivered in line with trajectory	None highlighted	H1 Trajectories developed and monitored through Weekly RESET Meeting, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

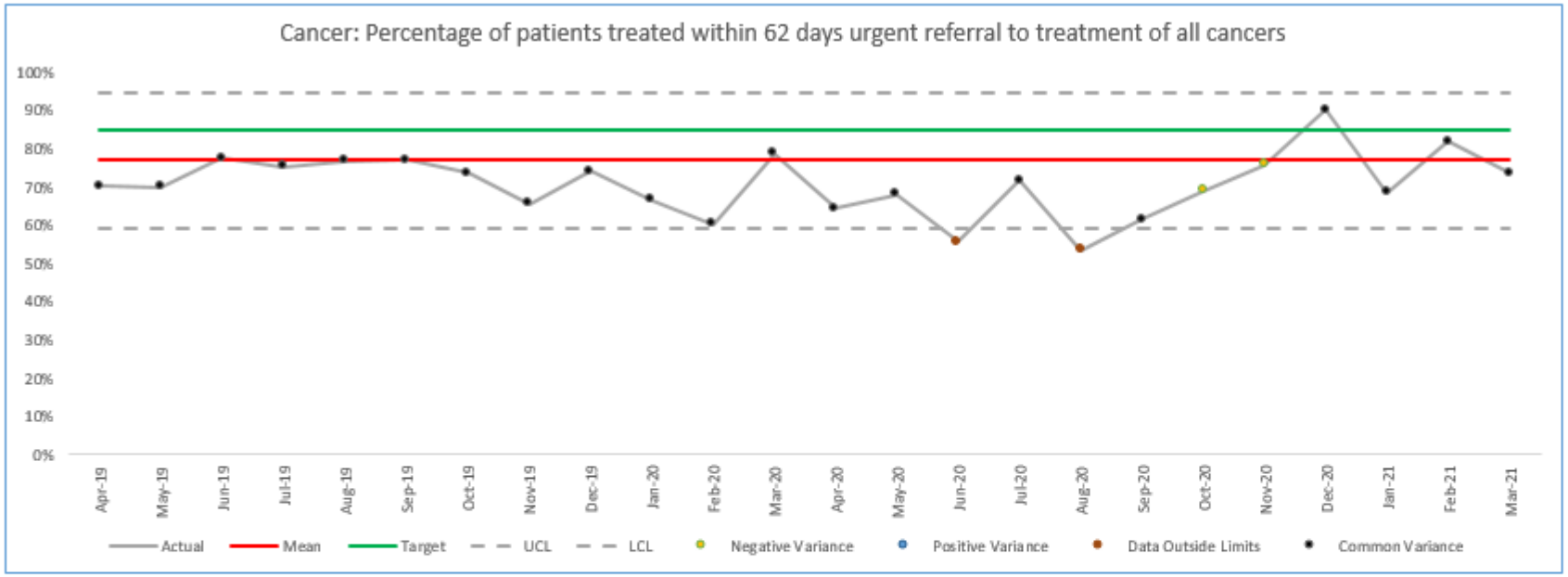
Cancer: Percentage of patients treated within 62 days of Consultant Upgrade



Mar-21
90%
Variance Type
Special Cause Variation - trend is showing a negative performance below the mean
Target
85%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
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.	Target delivered in line with trajectory	None highlighted	H1 Trajectories developed and monitored through Weekly RESET Meeting, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

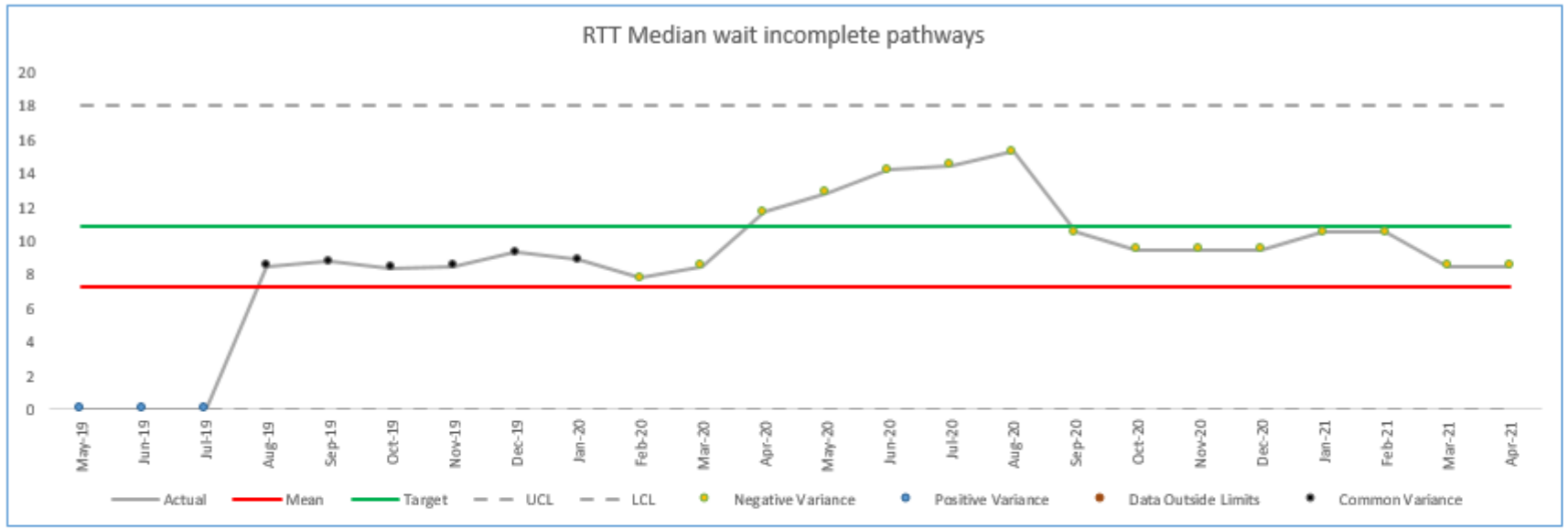
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers



Mar-21
74%
Variance Type
Special Cause Variation - trend is showing a negative performance below the mean
Target
85%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
The operational standard for this requirement specifies that 85% of patients should wait a maximum of 62 days to begin their first definitive treatment following an urgent referral for suspected cancer from their GP.	Trajectory of improvement from Aug 20, but not yet an assured system	Backlog clearance	H1 Trajectories developed and monitored through Weekly RESET Meeting, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

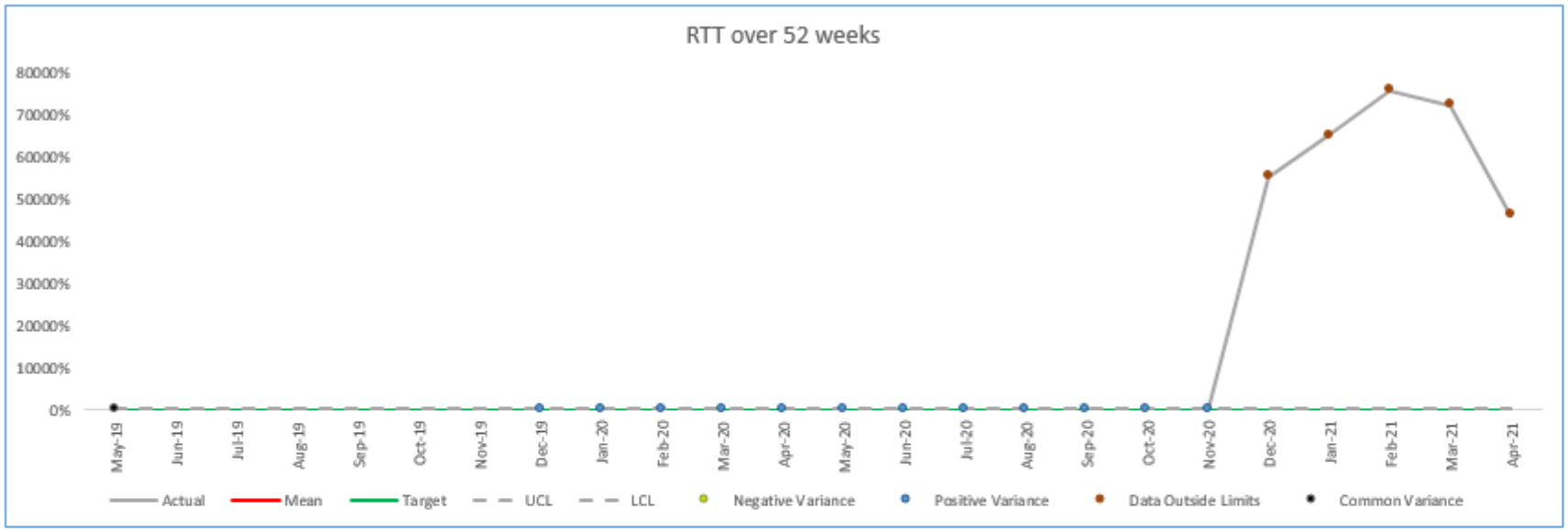
RTT Median wait incomplete pathways



Apr-21
8.50
Variance Type
Special Cause Variation - trend is showing a positive performance below the mean
Target
10.90
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
The Median wait time for patients on an RTT incomplete pathway	The trend is showing a positive performance below the mean	None highlighted	Favourable performance below target	Favourable performance below target

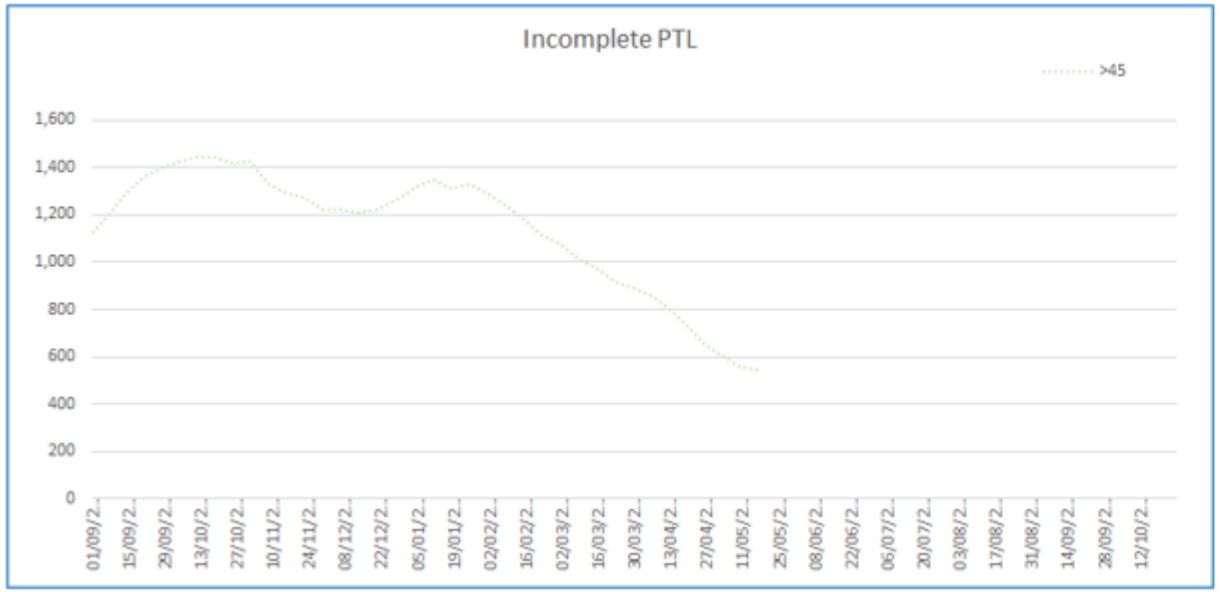
RTT over 52 weeks



Apr-21
463
Variance Type
Insufficient data points to produce SPC
Target
0
Target Achievement
Metric is consistently achieving the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Number of patients waiting over 52 weeks for first definitive treatment at month end	Insufficient data points to produce SPC the metric continues to be delivered, the metric was suspended from July to September 20 due to Covid	None highlighted	Review and possible recalculation of control limits	Weekly PTL - monitoring in place, issues escalated to COO as required

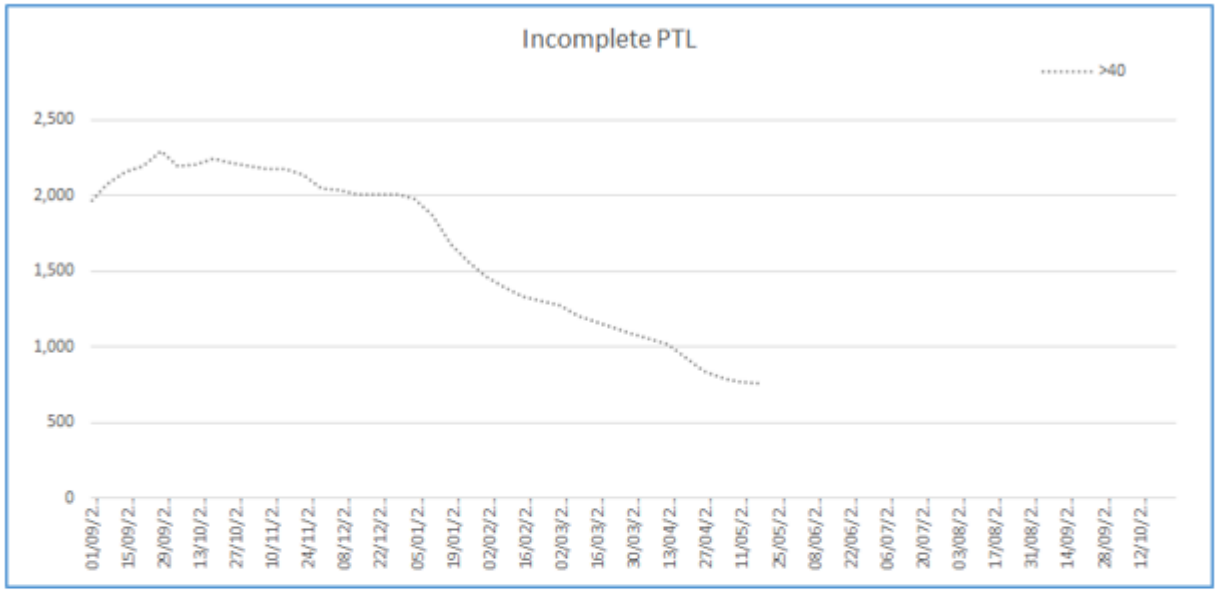
RTT over 45 weeks



Apr-21
544
Variance Type
Insufficient data points
Target
Target Achievement

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Number of patients waiting> 45 weeks for first treatment	The number over 40+ weeks for April continues to follow a downward trajectory, focus continues on backlog and patients with extednded waits	None highlighted	H1 Trajectories developed and monitored through Weekly Access Board, actions from weekly PTL escalated as required to ensure delivery of trajectory by December 2021	Weekly PTL - monitoring in place, issues escalated to COO as required Additional theatres to open in June when Endoscopy will relocate Compton Ward will open as an Elective Orthopedic Ward in June Winter plans and Ward reconfigurations are being developed to right size the bed numbers to the demand and to ensure continued delivery of elective services

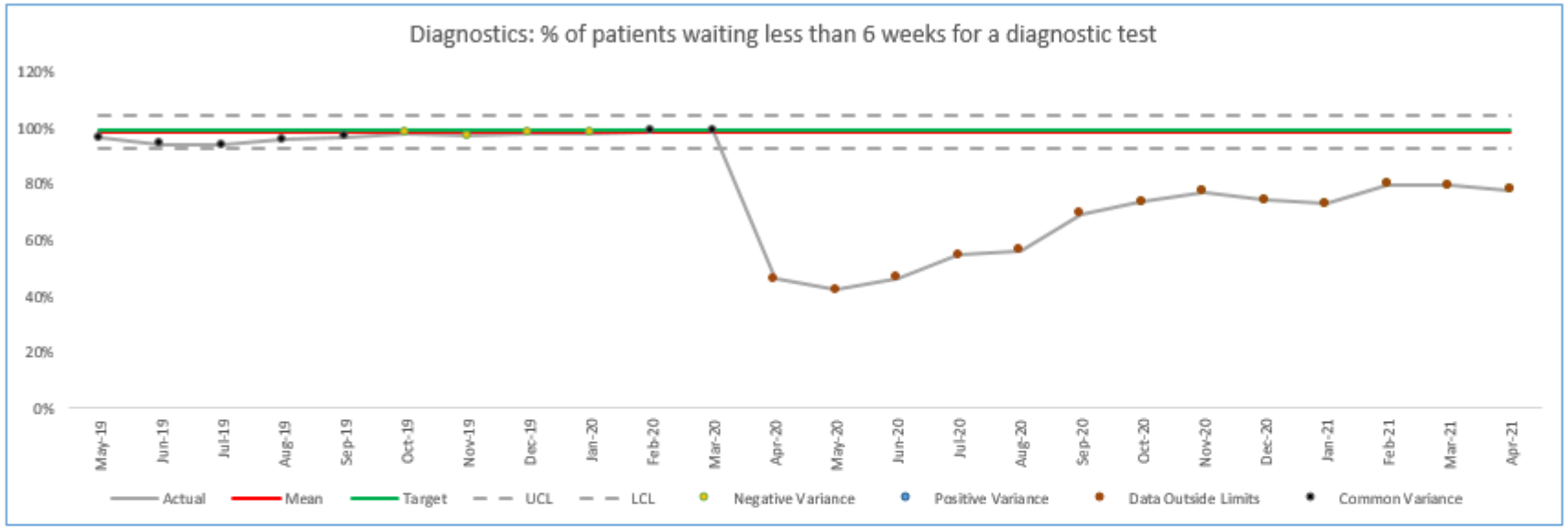
RTT over 40 weeks



Apr-21
761
Variance Type
Insufficient data points for SPC monitoring
Target
Target Achievement

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Number of patients waiting> 40 weeks for first treatment Pending April 05/24/2021 14:54:01	The number over 40+ weeks for April continues to follow a downward trajectory, focus continues on backlog and patients with extednded waits	None highlighted	H1 Trajectories developed and monitored through Weekly Access Board, actions from weekly PTL escalated as required to ensure delivery of trajectory by December 2021	Weekly PTL - monitoring in place, issues escalated to COO as required Additional theatres to open in June when Endoscopy will relocate Compton Ward will open as an Elective Orthopedic Ward in June Winter plans and Ward reconfigurations are being developed to right size the bed numbers to the demand and to ensure continued delivery of elective services

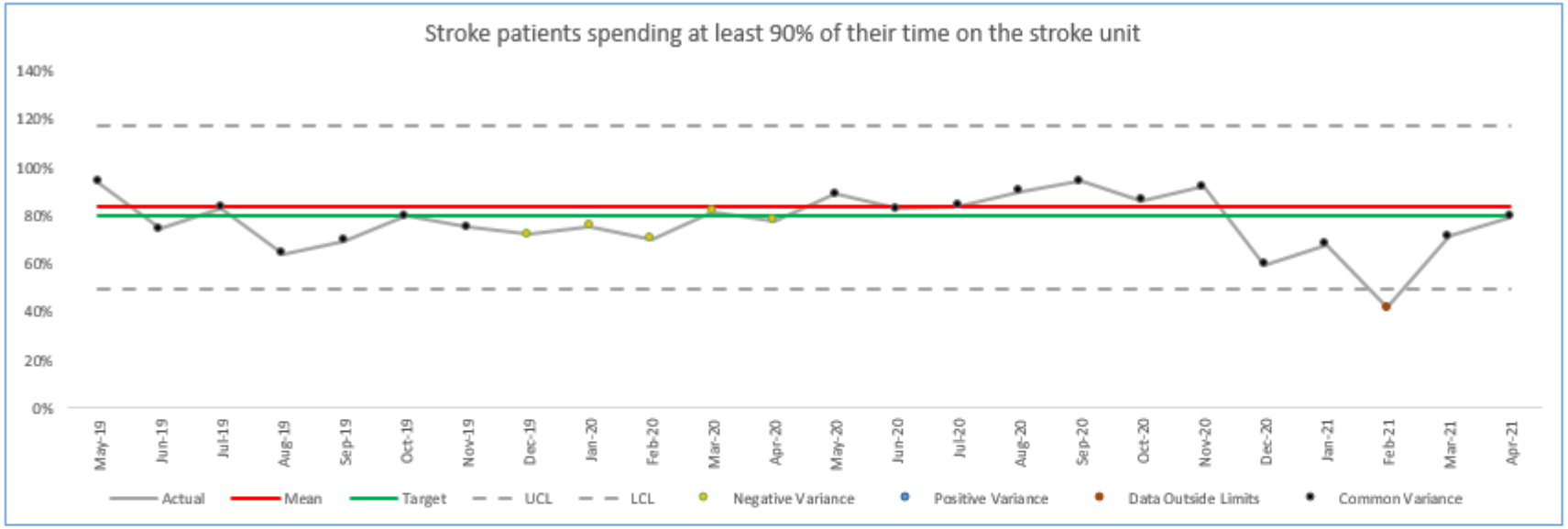
Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test



Apr-21
78%
Variance Type
Special Cause Variation - trend is showing a negative performance below the mean
Target
99%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
% of patients not seen within six weeks	Previous improvement in performance has now plateaued	Reduced capacity through Covid Patient choice Inpatient demand across all modalities Increased emergency attendances through April and May	H1 Trajectories developed and monitored through Weekly Access Board Divisional validations in place for weekly and monthly validation of the DMO1 Evidence appropriate capaccity to meet demand using IMAS modelling	Weekly PTL - monitoring in place, issues escalated to COO as required

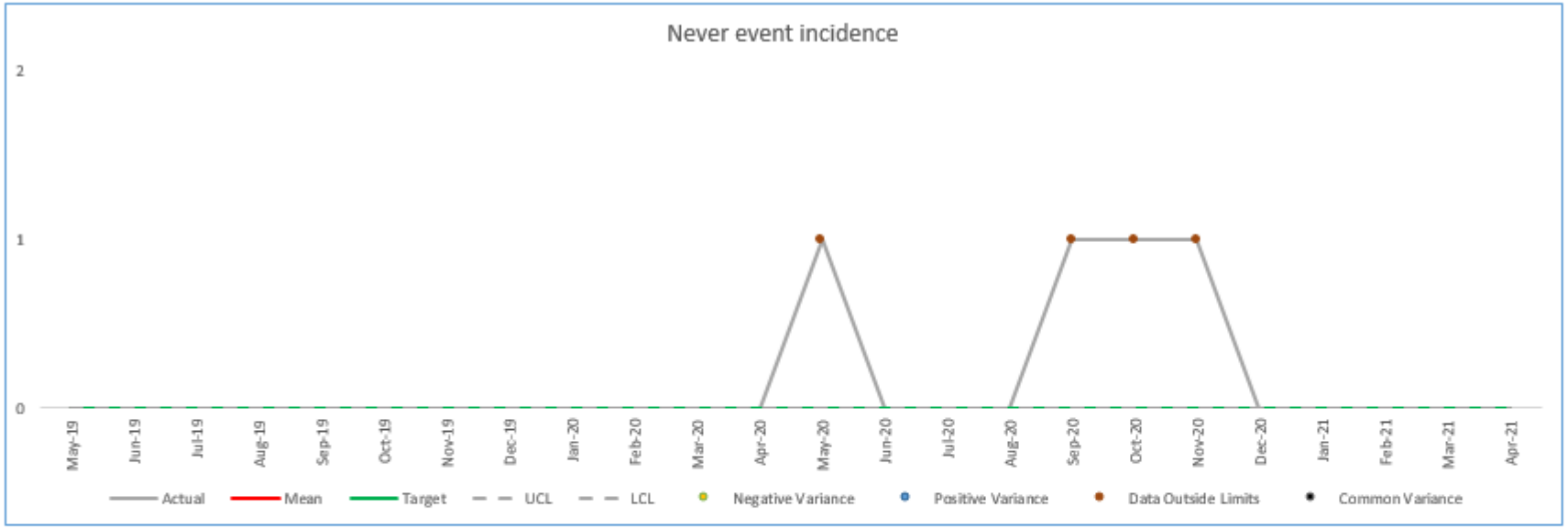
Stroke patients spending at least 90% of their time on the stroke unit



Apr-21
79%
Variance Type
Special Cause Variation - trend is showing a negative performance below the mean
Target
80%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
% of patients spending at least 90% of their time on the stroke unit	The percentage of patients spending at least 90% of their time on a stroke unit was below the 80% threshold	due to Covid outbreaks patients were being manged outside of stroke unit	Relocation of stroke patients to their original unit	N/A

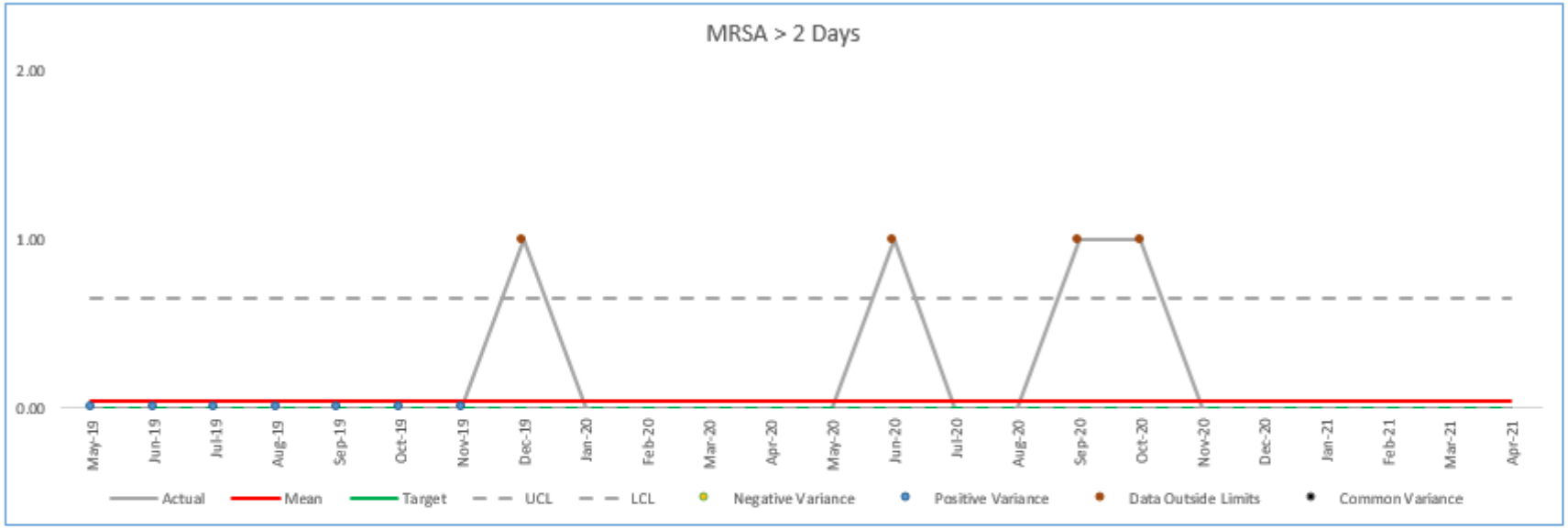
Never event incidence



Apr-21
0
Variance Type
Special Cause Variation - trend is showing a negative performance above the mean
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Never event incidence	There were 0 never events in month	None highlighted	N/A	N/A

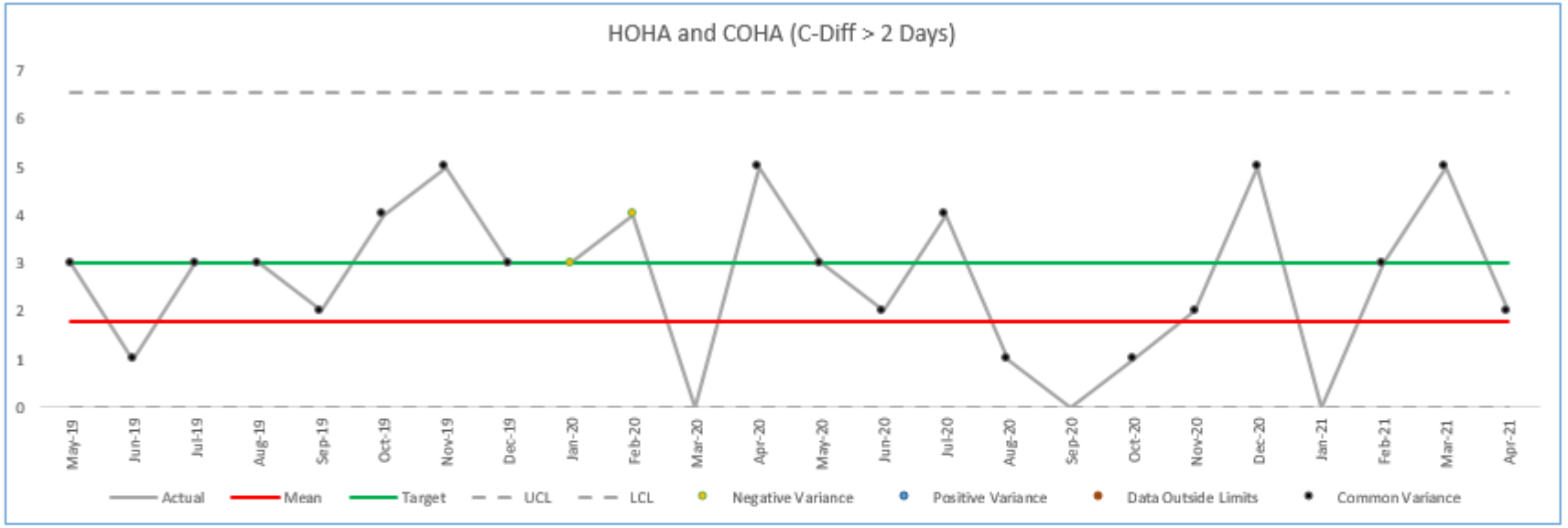
MRSA > 2 Days



Apr-21
0
Variance Type
Special Cause Variation - trend is showing a negative performance above the mean
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
MRSA > 2 Days	There were 0 MRSA > 2 Days incidence in month	None highlighted	N/A	N/A

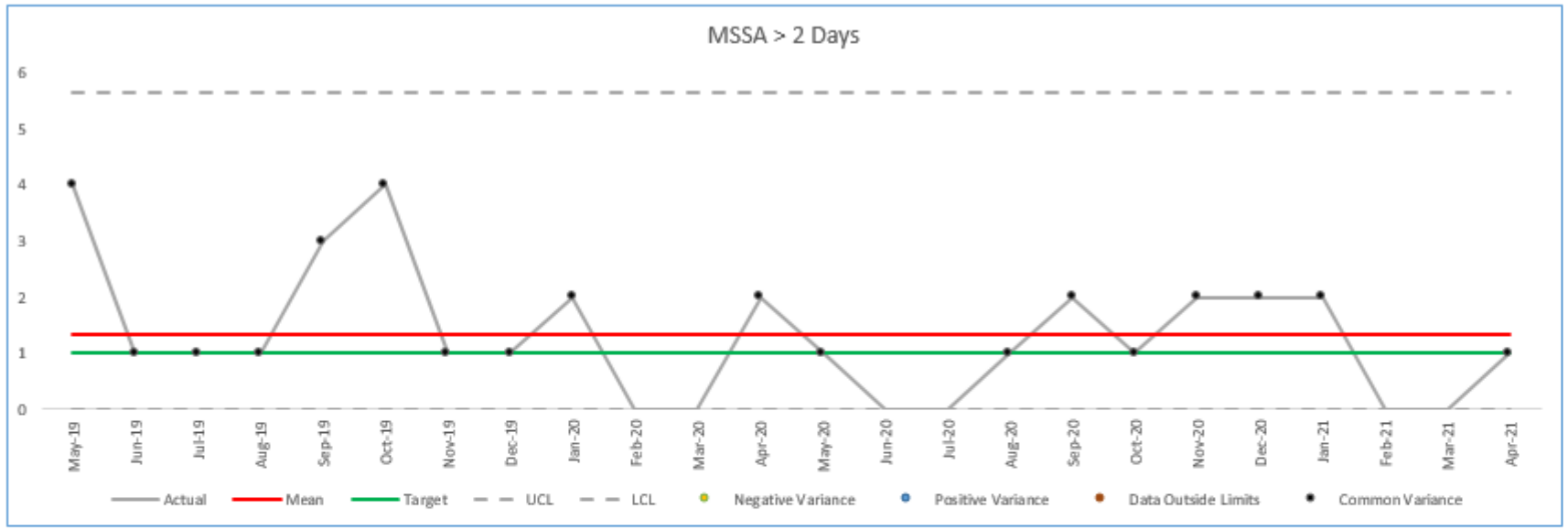
HOHA and COHA (C-Diff > 2 Days)



Apr-21
2
Variance Type
Common Cause Variation
Target
3
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Reduce the number of attributed Clostridium against CCG ceiling based on 2019-20 ceiling as no ceiling set for 2020-21.	There were 2 C-Diff > 2 Days incidence in month	None highlighted	N/A	N/A

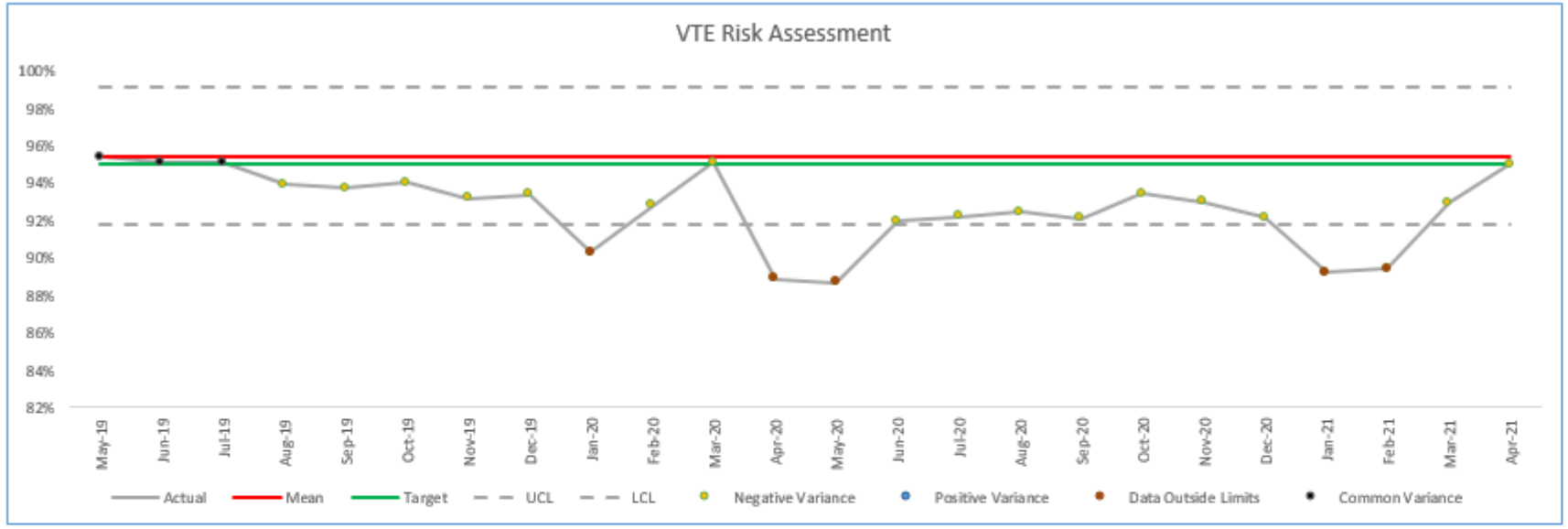
MSSA > 2 Days



Apr-21
1
Variance Type
Common Cause Variation
Target
1
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
MSSA > 2 Days	There was 1 MSSA > 2 Days incidence in month	None highlighted	N/A	N/A

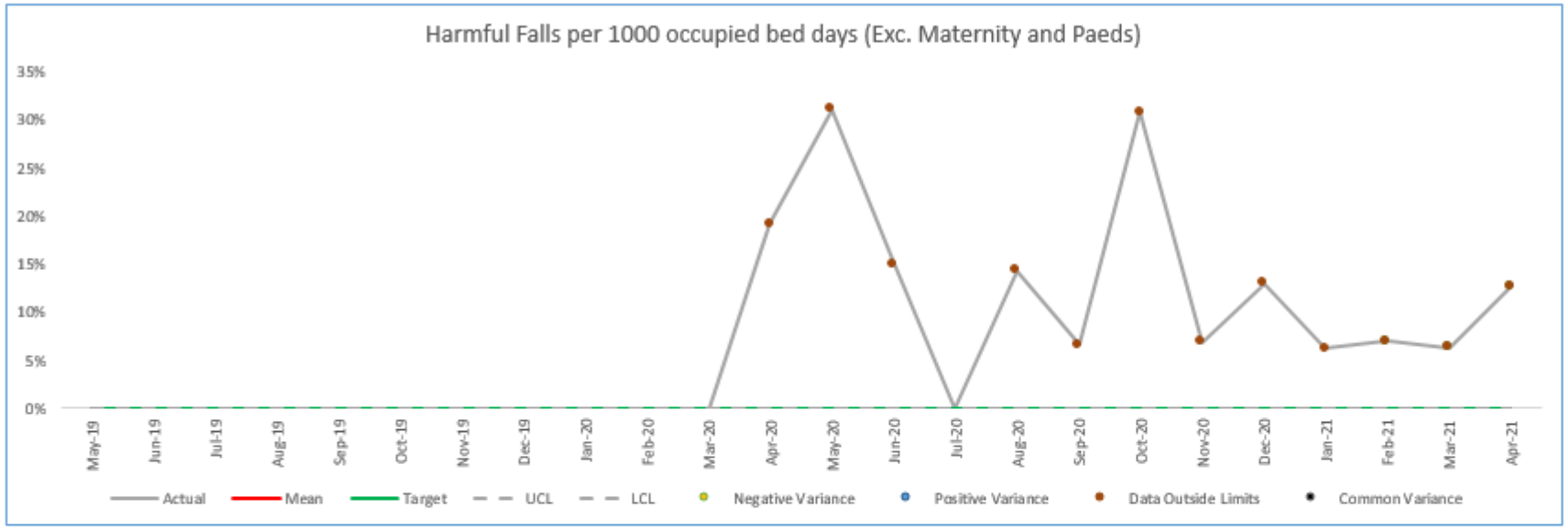
VTE Risk Assessment



Apr-21
95%
Variance Type
Special Cause Variation - trend is showing a negative performance below the mean
Target
95%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
VTE Risk Assessment	The trust is in a significantly improved position following improvement work. The approach to sustaining in the short to medium term is to incorporate assessment review into the board round checklist, and in the longer term to mandate assessment through ePMA.	None highlighted	N/A	N/A

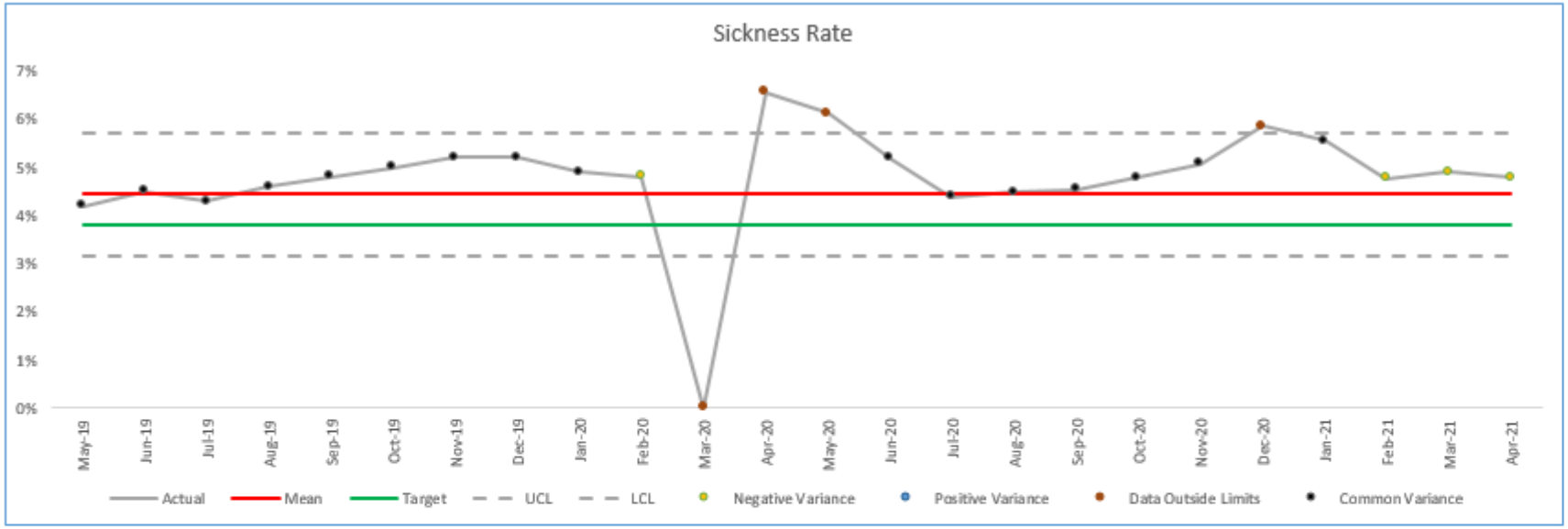
Harmful Falls per 1000 occupied bed days (Exc. Maternity and Paeds)



Apr-21
13%
Variance Type
Special Cause Variation - trend is showing a negative performance above the mean
Target
0%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Patients experiencing falls with moderate harm or above.	The number of incidents reported per 1000 bed days remains constant, although there has been an increase in those graded upon report as being of moderate severity or above. This has not translated to an increase in investigations as the review of harm process has downgraded some on the basis of outcome. There are some themes which have been identified, mostly relating to the covid pandemic. Work continues with the division to close the overdue actions (which rose unavoidably during the pandemic).	None highlighted	N/A	N/A

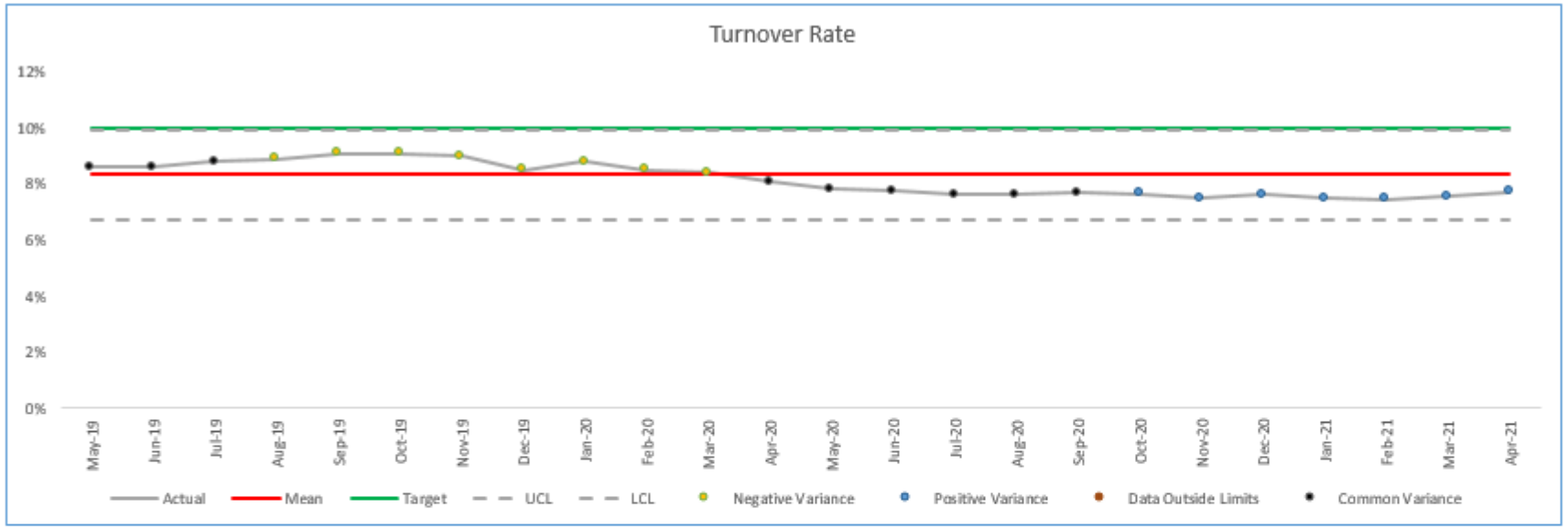
Sickness Rate



Apr-21
4.79%
Variance Type
Special Cause Variation - trend is showing a positive performance above the mean
Target
3.80%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Sickness Rate	Special Cause Variation - trend is showing a positive performance above the mean	None highlighted	N/A	N/A

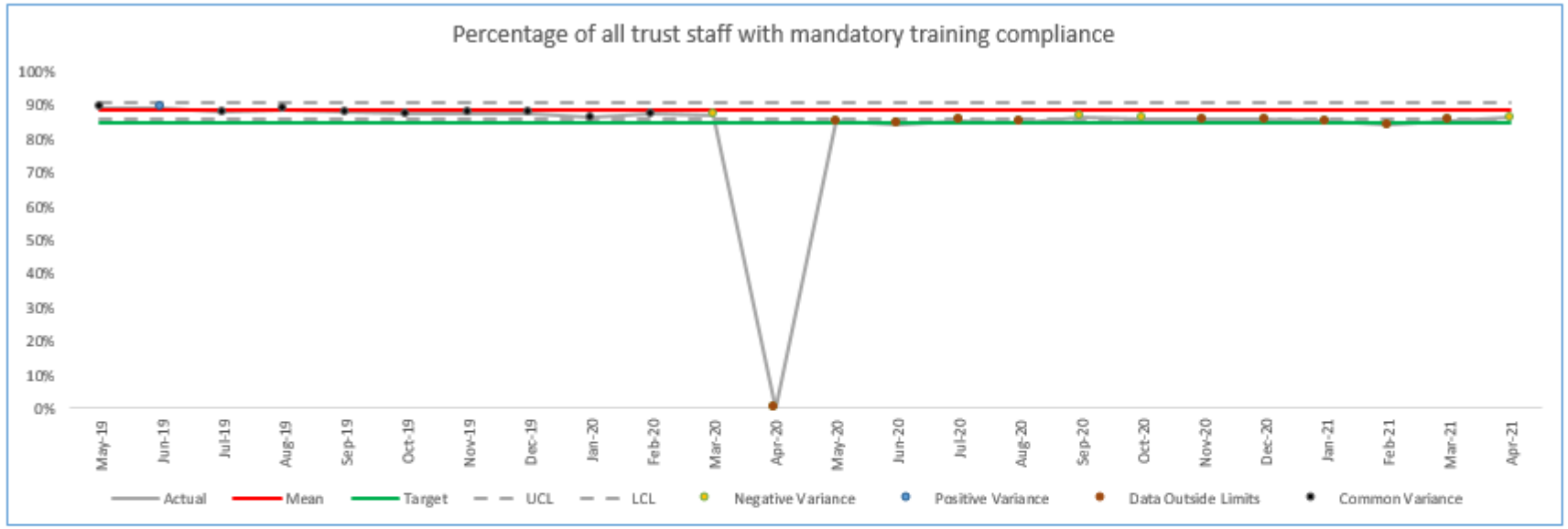
Turnover Rate



Apr-21
8%
Variance Type
Special Cause Variation - trend is showing a positive performance below the mean
Target
10%
Target Achievement
Metric is consistently achieving the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Turnover Rate Paulee April 03/24/2021 14:54:01	Turnover continues to be lower than 10% target and has been stable throughout the pandemic Increase in Turnover within Medical Staff and Healthcare Scientists have seen increases in Turnover that have taken them beyond 10% target.	As a result of fatigue there is a risk of turnover increasing over the next 12 months	Exercise to sensitively scope out staff intentions to be undertake. Continue with staff wellbeing programmes to support staff. Ensure vacancies are minimised to ease pressure on existing staff Undertake further analysis into an increase in turnover within Medical Staffing and Healthcare Scientists.	Analysis undertaken of those eligible to retire over the next 12 months as a result of special class status and factored into a nurse overseas nurse recruitment business case. Potential of post pandemic increase in turnover/retirements raised at regional level.

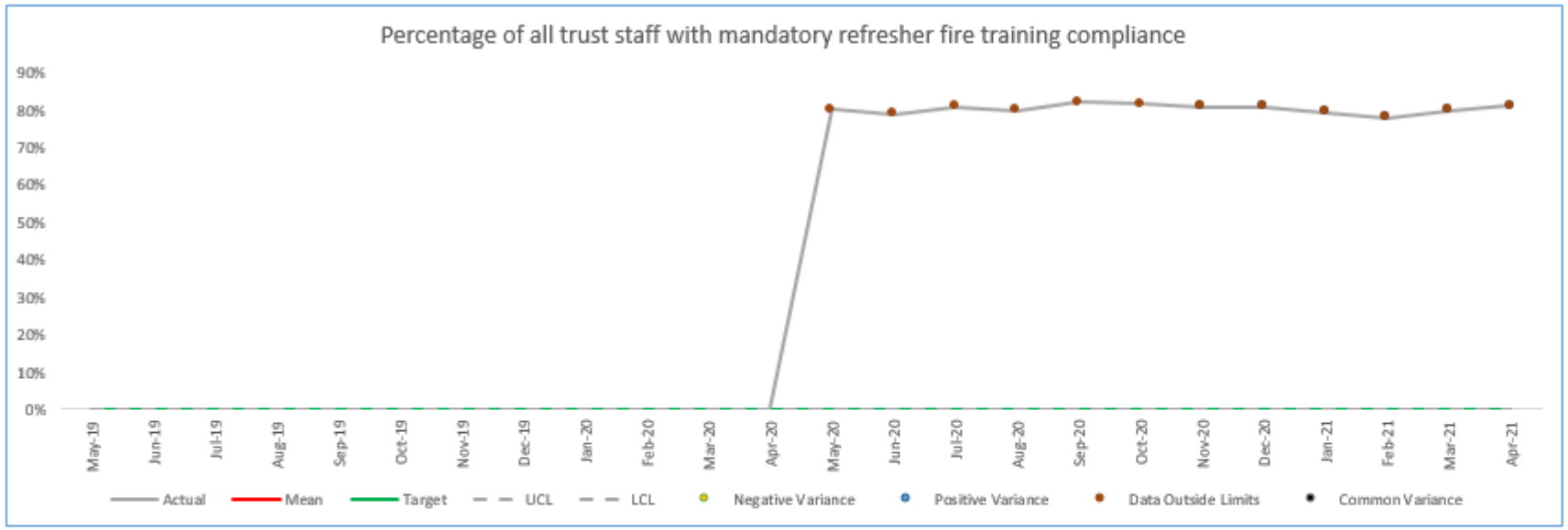
Percentage of all trust staff with mandatory training compliance



Apr-21
84%
Variance Type
Special Cause Variation - trend is showing a negative performance below the mean
Target
85%
Target Achievement
Metric is consistently achieving the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Percentage of all trust staff with mandatory training compliance	Awaited	None highlighted	N/A	N/A

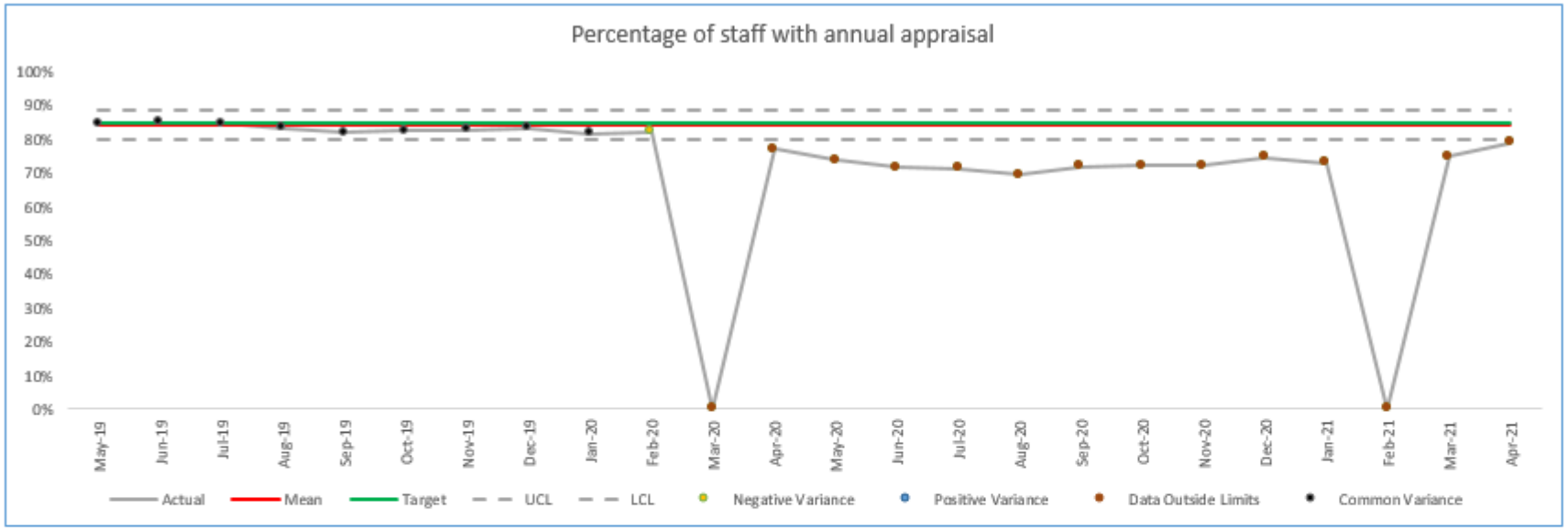
Percentage of all trust staff with mandatory refresher fire training compliance



Apr-21
81%
Variance Type
Insufficient data points to form SPC
Target
85%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Percentage of all trust staff with mandatory refresher fire training compliance	The percentage of all trust staff with mandatory refresher fire training compliance rates continue to be below Trust target of 85%			

Percentage of staff with annual appraisal



Apr-21
79%
Variance Type
Special Cause Variation - trend is showing a negative performance below the mean
Target
85%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Percentage of staff with annual appraisal	Appraisal rates continue to be below Trust target of 85%	A decrease in appraisal compliance has emanated from the pressures brought about as a result of Covid-19	To further promote the utilisation of the Appraisal Light process formulated to ease administrative burden associated with Appraisals	A simplified 'Appraisal Light' process continues to be available to help to facilitate further increases to the compliance percentage.

Report To	**Public Trust Board**
Date of Meeting	**Thursday 27th May 2021**

Title of the Report	**Operational Plan 2021//22**
Agenda item	
Presenter of Report	Karen Spellman, Director of Strategy & Partnerships Bola Agboola Director of Finance
Author(s) of Report	Bola Agboola Director of Finance Karen Spellman, Director of Strategy & Partnership Mark Smith Chief People Officer Polly Grimmett Director of Strategy

This paper is for: (delete as appropriate)

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

Executive Summary

Situation

This paper presents the hospital group's final plans for April – September 2021 (H1), which will be incorporated into the system level final planning submission on 3rd June 2021 in line with 2021/22 Operational Planning Guidance published by NHS England and Improvement (NHSEI) on 25th March 2021. The final system finance plan was submitted on 6th May. The NGH Trust Operational plan will be presented for approval to the Finance and Performance Committee on 26th May 2021.

The financial monitoring return (which is based on the enclosed pack) will be submitted to NHSEI on the 26th of May, in line with NHSEI timelines. This will be the basis on which the financial performance of the Trust will be assessed through H1.

A Quarterly System Review Meeting with NHSEI Midlands on 21st May 2021, highlighted a number of areas of strength with our current performance and plan:

- The way we managed COVID during the last year and had worked proactively to support other hospitals in the region with ensuring patients who required higher levels of intensive support

could get that access promptly was lauded. As was the system roll-out of the vaccination programme which was a national leader.
- The system Health and Wellbeing Plans for our staff were also named as an area of strength in our county.
- Finally, there was praise for the amount of elective work that was maintained throughout the pandemic as this was significantly higher than other systems were able to do. Some of this was due to having a dispersed acute estate that in part meant safe separation of Green and Red pathways, and much of it was due to the positive relationship with our local independent sector partners and the ability to translate that to taking joint decisions to expand the safe range of clinical care that could be delivered on those sites. Breast cancer and colorectal cancer procedures as an example where two services were moved to be supported to work off-site by the installation of digital technology to view high specification images.

Our plan is an ambitious and realistic approach to offering services to the communities we serve in the first six months of 2021/22, with a focus on our people and ensuring that our plans are supporting the health and wellbeing of staff as they recover from the pressures of the past 12 months. The principle risk to recovering elective waiting times and our staff recovery is any further waves of COVID and the possibility of increased flu over winter 21/22.

Assessment
Our system submission is made up of four parts:
- Activity plan including Elective Recovery
- Workforce People Plan
- Finance Plan
- Narrative document to support the technical submissions above.

The elective submission has been through multiple confirm and challenge processes and represents a realistic delivery plan that maintains the health and wellbeing of our staff. Whilst the system has been able to submit a financial breakeven position for H1, it is heavily reliant on the other two streams of workforce and elective. For example, the plan includes a financial amount that will be allocated from the Elective Recovery Fund and is based on delivery of a trajectory improvement in elective care. The elective care improvement is wholly dependent on our staff, so ensuring they are well and have enough rest and support is vital to delivering improved access times for our long waiting patients.

Likewise, our workforce plan includes a strong focus on building up our international nurses through a strong recruitment campaign, and there are associated impacts included within the financial plan on reductions in agency volumes. The current government restrictions on international travel therefore not only place a risk to the workforce submission, but also place a risk to the financial breakeven and could impact on delivering elective activity if our current staffing levels are carrying significant vacancies.

At a system level, a joint Workforce Improvement Meeting has been set-up between Directors and Finance and Workforce in order to ensure risks and opportunities are proactively known, discussed and managed. The system elective care board is in place to manage capacity across the system and ensure all NHS and Independent sector providers are working together to ensure equity of access to care by patients, and all inpatient and daycase capacity in the county is maximised.

The key challenges to delivering the plan we have submitted as a group are:
- The potential of a 3rd wave of COVID and the inevitable disruption to the activity planning and impact on the health and wellbeing of our staff.
- Demand is currently assumed in the planning submission as 100% of 19/20 levels. It is however anticipated that there are many patients who have not accessed primary care during the pandemic and will now begin to do so. Local intelligence is already starting to show increased attendances at primary care and referrals into secondary care as a result of this.
- Delivering cost improvement and efficiency plans in a system with very tired staff.
- Managing a reduction in use of temporary staff to achieve the set agency ceiling, whilst also supporting a reduction in the underlying System financial deficit, currently estimated at £117m
- The resilience of theatre staff to continue to deliver elective activity throughout the year following

a year of a pandemic where they were drafted across and working intensively in ITU's.

- Digital technology is a key enabler and dependency in a variety of ways and the many drivers for digital support presents a bandwidth risk to effective delivery. A system PTL for example is a key mechanism to manage capacity effectively across the system and isn't yet in place. Likewise, we need to establish a much more mature ability to proactively track and monitor theatre throughput across providers, and report consistently on issues such as GIRFT (getting it Right First Time) from independent as well as NHS providers.

There remain some further opportunities we are working across the system to explore:

- There remains some empty theatre capacity at KGH due to limitations with theatre staff, and empty endoscopy facilities at the independent sector. We are working across the Group and system on plans to use this capacity in innovative ways with staff from different organisations coming together to support patients on different organisational waiting lists to get treated.
- Our plans currently do not include previous levels of additional sessions, in order that we assured ourselves we could protect the rest and recuperation of staff. We are currently exploring however through our People Plan and approach different alternatives that may enable this to happen in a safe way.
- GIRFT offers some potential
- Focussed efforts in supporting Divisions with recruitment plans and monitoring agency usage

Related Group Priority	Which Group Priority does this paper relate to? • System & Partnerships • Sustainability
Risk and Assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks – Yes as described in the paper
Related Board Assurance Framework Entries	BAF – please enter BAF number(s) 5.1, 4.1
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	The financial implications are described within the paper
Legal Implications / Regulatory Requirements	Are there any legal/regulatory implications of the paper? (N)

Actions required by the Board

The Board is asked to:

1. Note that the Finance and Performance Committee would have received the 2021/22 submission for review and approval in respect of financial, people and activity planning at its meeting on 26th May 2021 and
2. RATIFY the approval of the hospital group's final plans for April – September 2021, as set out in the report and appendix, for incorporation into the system level final planning submission to NHS England and Improvement by 3 June 2021 and for the full and final submission to be submitted by the Interim Director of Finance within the timeframe specified by NHSEI.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**27th May 2021**

Title of the Report	Assessment and Accreditation of Nursing Excellence
Agenda item	11
Presenter of Report	Sheran Oke, Director of Nursing
Author(s) of Report	Jenny Scott, Lead Nurse Quality Assurance Debbie Shanahan Deputy Director of Nursing

This paper is for: (delete as appropriate)

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

Executive summary

This paper will:

- Provide a background and summary position of Best Possible Care A&A framework
- Describe Best Possible Care A&A framework
- Provide assurance that the quality and safety of nursing care is being reviewed using the new A&A Nursing Excellence framework formally 'Best Possible Care' framework.
- Describe the updates new A&A Nursing Excellence framework relaunch process and how this will be extended beyond ward areas to the Emergency Department, Theatres, Critical Care, Paediatrics and Maternity.

Related Group Priority	1. Quality: Outstanding quality healthcare underpinned by continuous, patient-centred improvement and innovation 2. People
Risk and assurance	Does the content of the report present any risks to the Trust or

	consequently provide assurances on risks – No
Related Board Assurance Framework entries	1.1; 1.2; 1.4 & 2.1
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? N If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? N If yes, please give details and describe the current or planned activities to address the impact.
Financial Implications	None
Legal implications / regulatory requirements	Ward and clinical areas requirements to comply with Trust Quality and Safety standards and Care Quality Commission (CQC) guidance

Actions required by the Board:

The Board is asked to note and approve the content of this report.

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

1.0 Introduction

The Nursing Assessment and Accreditation Process has been in place within the Trust for a number of 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 'blue/Best Possible Care' status and as a beacon for best practice. Owing to the recent pandemic it was not possible for us to continue with our Assessment and Accreditation programme and so the process was paused in March 2020 in the hope that the programme would resume in September 2020. This was not possible, and it became necessary to move the focus of assessment to being able to gain enhanced assurance of Infection Prevention and Control (IPC) practice.

We are now in a position to relaunch our Assessment and Accreditation process, we have updated the tool and have renamed our tool to reflect our future group direction and can see the opportunity to strengthen this further by providing an enhanced multi professional accreditation model with our group partner hospital later in the year.

This paper serves to:

- Provide a background and summary position of Best Possible Care A&A framework
- Describe Best Possible Care A&A framework
- Provide assurance that the quality and safety of nursing care is being reviewed using the new A&A Nursing Excellence framework formally 'Best Possible Care' framework.
- Describe the updates new A&A Nursing Excellence framework relaunch process and how this will be extended beyond ward areas to the Emergency Department, Theatres, Critical Care, Paediatrics and Maternity.

2.0 Assessment and Accreditation for Nursing Excellence

This assessment and accreditation framework has been developed to align with the Care Quality Commission's Core standards (Appendix 1/Table 1), 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 that will be 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.

Reference is made to the Trust Organisational Development function who will work with teams to ensure that the improvements they make are sustainable and lead to a culture of continuous improvement in nursing care. In addition, we recognise that we have several our nursing team who have undertaken the Masters in Quality Improvement with the University of Northampton and therefore can bring this expertise into the workplace.

The renamed 'Assessment and Accreditation for Nursing Excellence' tool formally the 'Best Possible Care' has been updated for 2021/22 to reflect an update on the CQC standards, local learning from incidents and concerns specifically related to Safeguarding training and enhanced Infection Prevention and Control.

The Lead Nurse Quality Assurance has reviewed the A&A Standard Operating Procedure NGH-SOP-21 (Appendix 2) has been ratified by Nursing & Midwifery Board in April 2021.

3.0 The Assessment Process

The Lead Nurse, Quality Assurance undertakes the review acting as a quasi-external assessor, being supported by a Director of Nursing Fellow who has two days a week dedicated to support the programme. 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 1/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 are considered, for example patient mealtimes, doctor's rounds and visiting time. Opinion from patients, staff, 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 Readiness for relaunch of Assessment and Accreditation of Nursing Excellence

An options paper for the relaunch of A&A of Nursing Excellence across the Trust was completed by the Lead Nurse Quality Assurance in February 2021 and presented to Nursing & Midwifery Board in March 2021. This was shared with Divisional ADNs, Matrons and Ward Sisters and the programme will formally be recommenced in May 2021. It has also been shared with the Hospital Management Team.

In readiness, since March, our Wards and Departments have self -assessed themselves, (Appendix 3) which has identified their baseline. The Ward Sisters/Charge Nurses and Department Managers have completed action plans. The Quality Assurance Lead Nurse has commenced informal walk around/ mock visits alongside this from March 2021. Results will not count towards the formal programme however action plans would be further developed, and remedial action put in place in readiness for the relaunch of a formal Assessment and Accreditation of Nursing Excellence programme in May 2021.

When the formal process commences it will begin with Wards and Departments that were last assessed as green and being their third green assessment. At the same time, the Wards and departments that were last assessed as amber will be re assessed. Wards that have never had an assessment, due to closure (of which there are two) will also be scheduled to follow. After these have been completed, all the remaining wards previously assessed in 2019, are scheduled to have assessments throughout summer/autumn/winter 2021. There are currently no red areas in the Trust.

Informal 'mock' visits are planned to take place in May 2021 in Critical Care, Emergency Department and Paediatric wards. These are supported by the Divisional Matrons and ADNs and once completed these areas will be formally assessed along all other areas.

Work has begun to review the existing Theatres Assessment and Accreditation tool to ensure that it reflects recent learning and piloting of the new and updated tool will begin Q4 2021/2022.

The tool for Maternity Services is currently being developed and will incorporate recent maternity National Guidance and learning. The new Maternity tool will begin to be piloted in Q4 2021/2022.

5.0 Assessment and Accreditation Nursing Excellence Recognition

There is an appetite for the Ward and Department Sisters/Charge Nurses to resume A&A and many areas are keen to receive acknowledgement for their hard work and achievements pre pandemic. This is testament to the work that has been done over recent years to embed the programme and the ward teams' commitment to both the demands and benefits of A&A. There is also a need to ensure ongoing monitoring of care quality across the organisation.

Wards that achieve three consecutive green assessments, which will take at least 12 months, will asked to produce a standardised panel document, and be invited to present this to A&A Nursing Excellence Panel. The panel may then 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 will have the ultimate authority to influence a recommendation to the Trust Board.

The QA Lead Nurse on a yearly basis will reassess the blue wards. The process for a A&A nursing excellence Panel is outlined in the SOP (Appendix 2)

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.

Plans for the Future:

Preliminary work has been undertaken to develop an electronic version of the tool and it is hoped that this will improve efficiency of the process. Additionally, the communications team are in discussions with the Lead Nurse for Quality Assurance, to have an intranet page launched to further support, develop staff knowledge, and provide information on A&A

One of our objectives under our Quality pillar for our Group Hospital 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.

Recommendation

The Board as invited to note and support the relaunch of our Assessment and Accreditation tool for Nursing Excellence within the Trust

Appendix 1 – The 15 Care Standards in the BPC 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

Appendix1
Table 2: RAG Criteria

Red	6 red standards	Reassess in 2 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 framework Standard Operating Procedure NGH-SOP-21:

Nursing Excellence Assessment and Accreditation Framework Standard Operating Procedure NGH-SOP- 21

Ratified By: DoN **Date Ratified:** 15th April 2021
Version No: 6 **Reviewed:** February 2021
Review Date: November 2021
Responsibility for Review: Quality Assurance Lead Nurse

CONTENTS

1. Introduction

Delivering high quality, safe and appropriate care to patients is of paramount importance. All Trust staff have a responsibility in delivering the best possible care to patients. As far as possible, the care must be evidence based and appropriate to the needs of the patient.

Measuring the quality of nursing care delivered by individuals and teams is a complex issue. This assessment and accreditation framework aligns with the Care Quality Commission's Core standards (see Appendix 1), incorporates the 6Cs Compassion in Practice values, reflects the Trust's vision and values, and allied health professional contribution to ward/ department success.

The framework is designed around fifteen standards that will be initially used to assess adult inpatient wards 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.

Reference is made to the Trust Organisational Development function who will work with teams to ensure that the improvements they make are sustainable and lead to a culture of continuous improvement in nursing care.

This Standard Operating Procedure (SOP) sets out the process for the implementation and review of the assessment and accreditation process, to ensure that it is consistently applied across the organisation.

2. Purpose

The framework is designed to:

- Support nurses, midwives and clinical teams in practice to understand how they deliver care, identify what works well and where further improvements are required.

- Provide patients, staff, divisions, Trust Board and regulators with assurance that optimal standards of care are being delivered consistently and reliably by health care professionals.

3. Process

Assessment Process

The Quality Assurance Lead Nurse will develop an annual planned program of adult inpatients wards and other clinical areas to be assessed which will be agreed with the Director of Nursing, Midwifery and Patient Services.

All ward areas would be required to self-assess, identify their baseline and put action plans in place against these in the first instance, working alongside the matron for the area. The QA Lead Nurse would commence informal walk-around/mock visits prior to any ward/clinical area being formally assessed. This process will take place prior to the formal assessment process.

The formal assessment will take place unannounced by a Quality Assurance (QA) Lead Nurse.

1. Prior to the visit, the QA Lead Nurse will collate Key Performance Indicator (KPIs) data from various sources such as training and development, the Quality Care Indicator dashboard, the family and friends test and complaints.

2. On the day of the assessment (which, for wards will include a period when meals are served to patients), the ward assessment will cover the following areas and will involve at a minimum, one third of patients and a half of staff on duty.
   - Observation of care given.
   - Observation of the environment.
   - Review of patient documentation.
   - Discussions with patients and carers if present and appropriate.
   - Interviews with staff members (These may extend into the following day).
   - Interview with the ward Sister/Charge Nurse.

3. Each ward will have an assessment completed and will be accredited using a Red, Amber, Green (RAG) rating. Reassessment will take place at a time interval dependent upon the results (see Table 1).

Table 1. Rag Rated Criteria

Red	**6 Red Standards or more**	**Reassess in 2 months**
Amber	**3-5 Red Standards**	**Reassess in 4 months**
Green	**0-2 Red Standards + 8 or more Green standards. (Standard 5 & 15 must be Green)**	**Reassess in 6 months**
Nursing Excellence / Blue Ward	**3 consecutive Green assessments Successful panel review Yearly successful panel review**	**Reassess in 12 months**

4. Ward accreditation assessment may not take place if patient safety is a concern within the Trust.
5. The assessment process may continue into the following day.
6. Immediately following the Ward assessment, the Ward Sister or Charge Nurse is given a brief summary of the visit from the QA Lead Nurse. This will include any immediate or urgent issues that have not been addressed during the visit.
7. The QA Lead Nurse gives formal verbal feedback, supported with a written copy of the assessment ideally within 24 hours of the visit to the Ward Sister or Charge Nurse.
8. Following the formal feedback to the Ward Sister/Charge Nurse, an e -mail is sent to the Ward Sister/Charge Nurse and copied to the Matron, Associate Director of Nursing, Deputy Directors of Nursing and Director of Nursing, Midwifery and Patient Services, summarising the results of the assessment and the feedback given against the standards that are Green, Amber or Red
9. The Ward Sister or Charge Nurse in partnership with the Matron will be given 10 working days from the date of the formal feedback, to formulate a Ward Improvement Plan (Template in Appendix 2). The date for completion of this will be noted on the front sheet of the assessment document.
10. A copy of each assessment and improvement plan will be sent to the Divisional Associate Director of Nursing to approve and endorse in practice and will be stored centrally for a record of progress to be maintained across the whole organisation.
11. Improvement Plans must then form part of every ward team meeting and Ward Sister/Charge Nurse meeting to track progress.
12. The QA Lead Nurse will report into Nursing and Midwifery Board (NMB) and update the Trust Board on a quarterly basis
13. The Ward Sister/Charge Nurse and Matron will have access to an organisational development practitioner who can assist in identifying where support might be required from a range of interventions; outlined in Appendix 3.

4. Management Framework

Red Wards/Clinical Areas:

1. Wards/Clinical areas that receive a Red rating will be given an appropriate level of support to improve their status. The Associate Director of Nursing / Midwifery will review these areas for the division (and other relevant members of staff).
2. The Director of Nursing, Midwifery and Patient Services and the Deputy Director of Nursing will review wards/Clinical areas that receive a Red rating on two or more consecutive assessments.
3. The Ward Sister/ Charge Nurse will meet with the Directorate Matron and clear objectives will be set. If the ward achieves a red rating on two or more consecutive assessments, then sanctions may occur (if there are no extenuating circumstances). Where necessary staff may be managed according to the Trusts Performance Management Policy. (NGH-PO-118)

Amber Wards

4. Wards/Clinical areas that achieve an Amber rating will be given an appropriate level of support to improve their status.
5. The Deputy Director of Nursing and Associate Director of Nursing / Midwifery will review wards/clinical areas that fail to achieve above an Amber rating on three concurrent assessments, unless there are extenuating circumstances, for the division (and other relevant members of staff).
6. The Ward Sister/ Charge nurse will meet with the Directorate Matron and clear objectives will be set.

Green Wards

Wards/clinical areas that achieve eight or more Green standards, with no more than two Red standards will be considered 'Green'. Additionally, Standards 5 &15 (which indicate compliance against key performance parameters) must be Green.

7. The expectation is that wards/clinical areas that achieve a Green rating will continue to have a clear set of improvement objectives and the Ward Sister/ Charge Nurse will meet with the Directorate Matron to continue to develop an improvement plan for these areas and those that require improvement.
8. Wards that achieve Green on three concurrent assessments will asked to produce a standardised panel document and be invited to present this to panel where consideration will be given to them being awarded Blue Ward Accreditation –Nursing Excellence status.
9. The panel will consist of the following members:
   - The Director of Nursing, Midwifery and Patient Services or the Deputy Director of Nursing will chair the panel.
   - Representative from the Trust Executive Board.
   - Representative from the Non-Executive Board.
   - Senior Nurse representation (ADNS and/ or Matron) from another division to that of the ward/clinical area being considered.

   If available:
   - Representative from CCG.
   - Representative from Nurse Education within the University of Northampton.
10. Recognition will also be given annually to the Ward/clinical area that have shown the most improvement.

Non-Progressing Wards/Clinical Areas

- The definition of a non –progressing ward/clinical area is one that has failed to attain a Green rating through the assessment and accreditation process after four assessments unless there are extenuating circumstances.
- Following the identification of a ward/clinical area as non – progressing; based upon the definition provided, the divisional Associate Director of Nursing (ADN) will oversee a six-week

programme of remedial support based on issues identified under Leadership, Environment and Care (Appendix 4).

- Progress will be monitored by the Director of Nursing, Midwifery and Patient services through a monthly report written by the relevant ADN.
- Effectiveness will be measured at the next assessment and failure to demonstrate improvement could result in the management of capability.
- A ward/clinical area will remain Non-progressing Ward/clinical area until they achieve a Green rating.

5. The Nursing Excellence Accreditation Process

The Nursing Excellence (NE) Standardised Framework

1. For a ward/clinical area to achieve NE status, they must at a minimum have achieved Green for three consecutive assessments. This will take at least 12 months.
2. The ward teams will also be required to present to a NE panel. The ward/clinical area team will be asked how they propose to maintain standards and how they will highlight this to the rest of the organisation. The panel will consider the performance indicators of the ward/clinical area, which include; sickness and absence, the number of complaints, risk management issues, nurse bank usage and avoidable harms etc. NE wards will showcase best practice to the rest of the organisation.
3. The Nursing Excellence panel may then recommend the ward/clinical area to the Trust Board for approval of NE status. The Director of Nursing, Midwifery and Patient Services will have the ultimate authority to influence a recommendation to the Trust Board.
4. The ward sister/Charge Nurse may be invited to attend Trust Board as part of the official recognition of their Blue Ward status.
5. The QA Lead Nurse on a yearly basis will reassess NE Wards. If Green status is maintained, the ward will be recommended to panel.
6. NE wards will be reviewed by a review panel on a yearly basis.
7. If the leadership of a ward/clinical area changes or a ward Sister/Charge Nurse leaves the ward after they have obtained three consecutive Green assessments but before the ward/ clinical area has obtained Blue status, the process will be delayed for approximately six months and the ward/clinical area re assessed by the NQ Lead Nurse.

8. Care Recognition

1. Nursing Excellence Ward staff will each receive a certificate and badge from the Director of Nursing, Midwifery and Patient Services and Chief Executive, which states that they are a member of a Nursing Excellence (NE) ward.
2. A ward plaque will be displayed on the entrance to the ward/clinical area, informing patients that they are being cared for on a NE ward.
3. The ward staff will also be recognised at the annual Best Possible Care awards.
4. The Ward Sister/Charge Nurse that has led their area to Blue status will wear a Navy Uniform with Gold piping, earning recognition of their successful leadership within the organisation. As a successful leader 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.

The Assessment and Accreditation Framework needs to remain current and relevant and reflect external standards as well as the Trust Quality Improvement journey.

9. Updating the Assessment and Accreditation Tool

1. The Quality Assurance Lead Nurse and Director of Nursing, Midwifery and Patient Services will revise the Assessment and Accreditation tool annually.

2. Elements of the tool that are no longer current or are consistently being met may be removed.
3. Elements may be added that reflect new internal and external standards.
4. The revised tool will be prepared for use in Q1 each year.
5. The Quality Assurance Lead Nurse will communicate all changes to the tool to the clinical areas.
6. The Director of Nursing, Midwifery and Patient Services must approve all changes to the framework.

10. **References & Associated Documents**

Appendix 1- The Ward assessment Standards in reference to the Care Quality Commission Key Lines of Enquiry
Appendix 2 - Ward Improvement Plan Template
Appendix 3 – Organisational Development support for the Ward assessment and accreditation Scheme
Appendix 4- Divisional checklist for Non-Progressing Wards

Appendix 1 - The Ward Assessment Standards against the Care Quality Commission (CQC) Key Lines of Enquiry (KLOE).

Chief Inspector of Hospitals Five Key Lines of Enquiry	SAFE (People are protected from abuse and avoidable harm)	EFFECTIVE (People's needs are assessed and care, treatment and support achieves good outcomes, promotes a good quality of life and is based on best available evidence)	CARING (Staff involve and treat people with compassion, kindness, dignity and respect)	RESPONSIVE (Services are organised so that they meet people's needs)	WELL LED (Leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation and promotes an open and fair culture)
Trust Standards	**S1** There is evidence of a safety culture on the ward	**E1** People's physical, mental health and social needs are holistically assessed and their care, treatment and support is delivered in line with legislation, standards and evidence-based guidance. The rights of people subject to the Mental Health Act 1983 (MHA) are protected. Nutrition and Hydration – patients are enabled to consume food and fluids to meet their individual needs Pain is controlled to an acceptable standard for the patient. People are told when they need to seek further help or if their condition deteriorates	**C1** Staff understand and respect the personal, cultural, social and religious needs of people and how these may relate to care needs,	**R1** Communication - The communication needs of people with a disability or sensory loss are met and these are recorded, highlighted and shared this information with others when required. End of life care – patients have control over their own health care and independence is promoted	**W1** The clinical area is effectively managed and organised in a way that benefits patients, staff and visitors
	S2 Patients feel safe, secure and supported and the risks to people are assessed, and their safety monitored	**E2** People's care and treatment outcomes are monitored and how they how they compare with other similar services	**C2** Person centred care – every patient is treated as an individual, with compassion at all times staff seek accessible ways to communicate with people	**R2** Patients and carers experience effective communication, sensitive to their individual needs and preferences	**W2** The area can provide assurance against key performance parameters
	S3 The environment is safe for patients, staff and	**E3** Staff have the skills, knowledge and experience to	**C3** People's privacy and dignity is respected and	**R3** People access care and treatment in a timely way	**W3** There a culture of high-quality, sustainable care in

	visitors	deliver effective care, support and treatment	promoted Patients will be supported to meet their hygiene needs to an acceptable level for the patient and in a respectful and considerate way		the area
	S4 Medicines Management – avoidable patient harm in relation to medicines management will be eliminated	**E4** Staff, teams and services work together within and across organisations to deliver effective care and treatment		**R4** People's concerns and complaints are listened to and responded to and used to improve the quality of care	**W4** There are clear responsibilities, roles and systems of accountability to support good governance and management? Staff at all levels clear about their roles and they understand what they are accountable for, and to whom.
	S5 Safety is monitored using information from a range of sources against performance safety goals. Infection Control – Patients are cared for in an environment where the risk of cross infection is minimised	**E5** People identified who may need extra support. This includes: people in the last 12 months of their lives			**W5** There clear and effective processes for managing risks, issues and performance
	S6 Lessons are learned and improvements are made when things go wrong	**E6** Consent to care and treatment always sought in line with legislation and guidance			**W6** The management of information is appropriate and accurate and it is effectively processed, challenged and acted on when necessary
					W7 People who use services, the public, staff and external partners are engaged and involved to support high-quality sustainable services
					W8 There are robust systems and processes for

					learning, continuous improvement and innovation

Appendix 2 - Ward Improvement Plan Template

Nursing Excellence - Ward Improvement Plan

Ward	Date Started	Matron
	Date Completed	Ward Sister/ Charge Nurse

Care Standard	Activity	Responsible	Status	Comments
Care Standard 1 Safety Culture				
Care Standard 2 Patients feels safe, secure and supported				
Care Standard 3 Safe Environment				
Care Standard 4 Medicines Management				
Care Standard 5 Infection Control				
Care Standard 6 Nutrition and Hydration				
Care Standard 7 Skin Integrity				
Care Standard 8 Elimination				
Care Standard 9 Pain Co				

Care Standard 10 Hygiene				
Care Standard 11 Person Centred Care				
Care Standard 12 End of Life Care				
Care Standard 13 Communication				
Care Standard 14 Effective Management				
Care Standard 15 Assurance				

Review Record Review Date	Signature (Ward Sister/Charge Nurse or Representative)	Signature (Matron or Representative)	Comments

Appendix 3 - Organisational Development support for the Ward Assessment and Accreditation

The OD program of support is available to support the Ward Sister/ Charge Nurse and their team by drawing upon emerging research that links patient experience with staff experience and wellbeing. In addition to the assurance and recognition that the Ward accreditation scheme offers, it is anticipated; that by weaving OD interventions into the process the following outcomes will be achieved:

- An increase in the confidence levels of the Ward Sister/ Charge Nurse to lead change in their areas.
- Greater autonomy for those doing the job role to deliver the improvements they identify.
- More cohesive teams and a greater sense of ownership and personal accountability for 'self' and team.
- An increase in pride, energy, and enthusiasm that leads to a better working environment.

The OD team can support in the following ways:

- Provide a simple staff engagement measurement tool prior to any intervention and after the self- assessment process.
- Introduction of a cultural audit to the self and peer assessment process: what do I see, hear, feel to add context to the 15 standards and to ensure that the 'how' we do the 'what' is not missed.
- Introduction/support to the ward sister/charge nurse around the leadership model
- Offer of coaching support to the Ward Sister/Charge Nurse to build confidence in leading a team through change.
- Team exercises as relevant

Appendix 4 - Divisional checklist for Non-Progressing Wards

		Date	Comments
	Element: Environment		
1	Arrange an EDI (estates, domestics and infection prevention nurse) visit		
2	Report any key environmental issues raised to estates		
3	Invite PD team to review the ward/clinical area against Well Led Ward (WOW) and ward principles		
	Element: Care		
4	Invite a Tissue Viability Nurse to review area		
5	Invite Falls Team to review the ward		
6	Invite Safeguarding team representative to review the ward		
7	Invite Infection Prevention & Control (IPC) Nurse to review the ward		
8	Invite the Nutrition Nurse to review the ward		
9	Invite the End of Life Care team to review the ward		
10	Invite P&PD nurse to review and discuss learning opportunities		
	Element: Leadership		
11	Oversee and monitor the Ward Improvement Plan		
12	Arrange for Organisational Development (OD) team to meet with the Ward Sister/Charge Nurse and senior ward team		
13	Arrange a ward Buddy for the Ward Sister/Charge Nurse		
14	Plan for monthly written reports to DoN and ADNs		
15	Consider performance and/or capability		

	management		
16	Consider Management referral to Occupational Health		
17	Consider the learning environment and the placement of students		
18	Consider the involvement of Human Resources (HR)		

Appendix 3 - Ward Self-Assessments April 2021:

Standard / Ward	Self-Assessment April 2021 Overall Rating	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Abington																
Allebone																
Althorp																
Becket																
Benham																
Brampton																
Cedar																
Collingtree A																
Collingtree B																
Creaton																
Dryden																
Eleanor																
Esther White																
Finedon																
Hawthorn																
Head & Neck																
Holcot																
Knightley																
Rowan																
Spencer																
Talbot Butler																
Victoria																
Walter Tull																
Willow																
Total reds		5	0	5	1	5	1	3	6	2	1	2	1	3	2	4

Please Note: information not available for Head and Neck but assessments have been completed.

Outpatients Self- Assessments April 2021

Clinical Area	Self-Assessment April 2021 Overall rating	1	2	3	4	5	6	7	8	9	10
Integrated Surgery											
Medical Day Care Unit											
Chemo Suite											
Pre –Op assess Clinic											
Oncology											
Haematology											

Ophthalmology OPD & Eye Casualty											
Singlehurst											
Maxillo – Facial											
Fracture Clinic											
Total RED		**0**	**1**	**2**	**0**	**0**	**2**	**0**	**0**	**1**	**0**

Appendix 3 –
Table 2 : Outpatient Areas:

Clinical Area	Overall Last Assessment 2019/2020
Integrated Surgery	Feb 2020
Medical Day Care Unit	Jan 2020
Pre –Op assess Clinic	Not assessed
Oncology	Nov 2019
Haematology	Feb 2020
Ophthalmology OPD & Eye Casualty	Jan 2020
Singlehurst	Dec 2019
Maxillo – Facial	Jan 2020
Chemotherapy suite	Not assessed
Fracture Clinic	Not assessed
Endoscopy	Not assessed

Report To	**Public Trust Board**
Date of Meeting	**27th May 2021**

Title of the Report	**Group Nursing, Midwifery and Allied Health Professional Strategy 2021-24**
Agenda item	**12**
Presenter of Report	Sheran Oke and Leanne Hackshall
Author(s) of Report	Sheran Oke and Leanne Hackshall

This paper is for: (delete as appropriate)

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

Executive summary

Currently, Nurses, Midwives and AHP's form the largest professional groups across both Organisations, as part of our Organisation's journey to becoming a Group Hospital our Directors of Nursing articulated their joint ambition to work together to 'ignite the voice' of Nurses, Midwives and Allied Health Professionals to be equal partners in the Clinically-Led Organisation, excel in patient care and be the employer of choice in Northamptonshire. They also wanted to underpin this, through aiming to become the first Group hospital to be accredited as Pathway to Excellence® hospitals in England.

To fulfil this ambition, both Trusts have strategically aligned their Nursing, Midwifery and Allied Health Professional (AHP) workforces by sharing a strategic voice through the launch of the inaugural Nursing, Midwifery and AHP Strategy.

This Strategy has been developed having engaged with over one thousand members of staff spanning three professional groups using a range of methods. Following a thematic analysis five key priorities emerged. These five key Priorities also align with the Pathway to Excellence® Standards which reflect the direction of the group and our commitment to be Dedicated to Excellence through the creation of a positive practice environment.

The Five Themes which emerged were:

- Provide Safe and Quality Care
- Strengthen Leadership
- Value our People
- Develop our Workforce

- Empower and Innovate

Within these themes, the document presents a series of commitments, measures of success and how we will achieve these. These will form the basis of our annual work plans for each organisation encompassing the three professional groups.

The Strategy closely aligns with both the People Plan and the Clinical Strategy whilst also underpinning the need to breakdown professional boundaries to enhance the development of the clinically and professionally led ICS. The Strategy also aligns with the National Work streams of the three professional groups and supports the visions of the NHS Long Term Plan.

The Strategy has been discussed at the Joint Quality Governance and Safety Committee and the Joint Board Development session on April 2021 and has been agreed by both Nursing and Midwifery Board at Northampton General Hospital and the Nursing Executive at Kettering General. It is now being brought to the two Trust Boards for their final approval

The NMAHP Strategy Steering Group will continue to oversee the delivery of these work plans and empower staff in implementing their co-created strategy which provides a road map for the growth and development of Nurses, Midwives and AHP's over the coming years.

The Strategy is being presented at both Trust Boards in May for approval

Related Group Priority	Which Group Priority does this paper relate to? 1. Patient: Excellent patient experience shaped by the patient voice 2. Quality: Outstanding quality healthcare underpinned by continuous, patient-centred improvement and innovation 3. System & Partnerships: Seamless, timely pathways for all people's health needs, together with our partners 4. Sustainability: A resilient and creative university teaching hospital Group, embracing every opportunity to improve care 5. People: An inclusive place to work where people are empowered to be the difference
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks A lack of funding for some aspects will impact on delivery
Related Board Assurance Framework entries	BAF – please enter BAF number(s) 1.1; 1.2; 1.6; 2.1
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? N If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? N If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	Nil at present

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

Actions required by the Trust Board:

The Trust Board is asked to approve the strategy

Nursing, Midwifery and Allied Health Professional Strategy Delivery Plan- 2021-2022

Key Deliverables

Provide Safe & Quality Care

- **Create a supportive and inclusive culture for patient and family partners through our patient to enable their diversity to be celebrated, voice to be heard and acted upon**
- **Drive continual improvements for both quality and safety by reducing avoidable harm to our patients and staff**
- Continue to enhance Care Excellence through our Assessment and Accreditation process and develop MDT Accreditation

Strengthen Leadership

- **Enhance staff development, diversity and inclusivity through our innovative leadership programmes and fellowships**
- Promote role modelling through visible and accessible leaders
- Create reverse mentoring opportunities

Value Our People

- Introduce meaningful recognition which is inclusive of AHP's and support workers
- **Supporting our staff's wellbeing through a comprehensive Programme which recognizes the cost of caring**
- **Ensuring equality and diversity is at the forefront of what we do**

Develop our workforce

- **Explore a professional development prospectus**
- Support the development of NMAHP's to access clinical academic career opportunities and to lead on research
- **Recruitment and retention of NMAHP's who will pioneer care excellence**

Empower and Innovate

- **Ensure NMAHP's are leaders of innovation and transformation through the Shared Decision Making process**
- **Enable digitalization of care which enhances patient experience**
- Deliver care which is based upon Research and evidence from Quality Improvement

Measures of Success

- **Both hospitals will have established patient and family involvement groups**
- **Benchmark & alignment of quality metrics including improvement trajectory and method of achievement & reporting agreed**
- There will be a reduction in the episodes of violence & aggression towards staff
- Effective N&M assessment and accreditation programme across the group

- **6 staff will have enrolled on a Fellowship programme**
- **33% of staff at Band 7 & above will have completed a leadership programme**
- **Establishment of unconscious bias training for Band 7 +**
- Develop and pilot a meaningful visibility programme for senior leaders
- Develop and pilot a reverse mentoring programme

- **All staff will have had a meaningful appraisal that includes a development plan and wellbeing conversation**
- **Revisit, revise and refresh robust induction programmes**
- **All staff from all protected characteristics will say they feel valued as measured in feedback mechanisms**
- Reward and recognition programmes will be in place for all NMAHP staff

- **Establish a joint approach of listening & responding to the voice of our NMAHPs**
- **Work with university to trial different methodologies for student placements**
- **Vacancy and retention rates will have improved local trajectories to be agreed**
- Bench marking professional development offering across the group
- 5% of staff will undertaken a clinical academic opportunity

- **20 Shared Decision Making councils will be in place across group**
- **Increase the number of documentation processes that are completed digitally by 10% (as dictated by the Digital Roadmap)**
- 5% of staff will have completed a research or quality improvement training programme

Focus on Pathway Standard: Safety & Quality

Focus on Pathway Standard: Leadership

Focus on Pathway Standard: Wellbeing

Focus on Pathway Standard: Professional Development

Focus on Pathway Standard: Shared Decision Making

Kettering General Hospital NHS Foundation Trust

Dedicated to excellence

Northampton General Hospital NHS Trust

‘Ignite our Voice’

Vision of Inspiring Care Excellence

Our Strategy for Nurses, Midwives and Allied Health Professionals

2021-2024

Contents

Foreword

It is with great pleasure and pride we introduce ‘Ignite our Voice’ our first joint commitment to the future of Nursing, Midwifery and Allied Health Professionals (AHP). This strategy signals the start of the future for our three professional groups inspired by the ignition of our staff’s voice. Its development would not have been possible without your contribution which has been insightful and invaluable and has fuelled our vision of inspiring care excellence (VoICE) across the group.

The collective voice of our staff is ambitious, forward thinking and patient-centred. The group values are at the core of the VoICE showing our commitment to be ‘dedicated to excellence’. It also reflects our ambition to be the first group hospital in UK to achieve Pathway to Excellence® designation on both sites.

We promise to work with you all to develop and strengthen leadership at every level, with a personal commitment to support you in being the best you can be. It is a priority for us that each of you feels valued and in turn you value and celebrate each other; placing your health and well-being at the centre of our relationships and interactions.

We promise to support you in providing high-quality and safe care to patients and in continuing to improve their experience which is fundamental to our group priorities. Developing and embedding our assessment and accreditation framework will enable us to reward and recognise care excellence. We make a personal commitment to work with you all to continue to develop this multi-professionally.

Our collaboration as part of the group model places us in a unique position to innovate, lead research and inspire improvement through our well established cross professional relationships which will underpin the VoICE. We are excited by the new opportunities these foundations provide and the impact your collaboration will have on continuing to improve outcomes for our patients. Working collaboratively with other providers and external partners will enable us to share services, reduce variations and provide exciting opportunities for new ways of working across traditional boundaries. Enabling new roles to emerge and develop future Nurses, Midwives and Allied Health Professionals.

We make a personal promise and commitment to you all, to keep patients, carers and staff central to our decisions and be your greatest advocates, ensuring we continue to ignite the voice of nurses, midwives and AHP’s is throughout our ambitions. In return, we ask you embrace this strategy and continue to seek opportunities to provide exceptional care to our patients through our VoICE.

As Nurses Midwives and AHP’S we have so much to be proud of and we look forward to further igniting your voice to further embed and deliver your VoICE.

Leanne Hackshall
Director of Nursing and Quality

Kettering General Hospital

Sheran Oke
Director of Nursing, Midwifery and Patient Services

Northampton General Hospital

Our Group and Our Values

Our Group is made up of two hospital Trusts with two main hospital sites and a number of services provided elsewhere. We are proud to serve the people of Northamptonshire and beyond.

Kettering General Hospital (KGH) NHS Foundation Trust

Northampton General Hospital (NGH) NHS Trust

In 2020 Kettering General Hospital and Northampton General Hospital announced the formation of a Group Hospital Model. We have made some important steps to strengthen our collaboration together, including the a number of Shared Group Executive appointments.

In January 2021, both Boards approved the **Group vision, mission and values**, which describe our ambitions and our commitment to be “Dedicated to Excellence”.

The Group vision, mission and values will be supported through the development and delivery of a series of **strategic initiatives**; including the Group Nursing, Midwifery and Allied Health Professionals Strategy. This strategy also aligns with the vision outlined in the Group’s People Plan and the Clinical Strategy. Together with the clinical strategy, this strategy will enable us across the system to develop the Integrated Care System to provide great opportunities to people and enhance patient care.

Dedicated to excellence

Our Excellence Values

- Respect
- Compassion
- Integrity
- Courage
- Accountability

The Group Strategy

Our strategic initiatives

NHS Kettering General Hospital NHS Foundation Trust

Dedicated to excellence

NHS Northampton General Hospital NHS Trust

National Context

Nurses, Midwives and Allied Health Professional form a significant percentage of the workforce in the NHS. We collectively transform health, care and wellbeing for our patients and are essential to the future of patient care. As we look to the future the National Leaders of our three professional groups have made significant commitments to enable us to deliver care high quality care, strengthen our leadership and value our workforce. Our strategy reflects this through our 'Dedication to Excellence'.

"I have three priorities to support delivery of the NHS Long Term Plan and give full recognition to the value of the nursing profession will be to address workforce shortfalls; enhance pride in the profession and strengthen perceptions of nursing and midwifery as high-value careers; and to help nurses and midwives to influence and lead change at every level across the NHS.

Ruth May, NHS England Chief Nurse Officer (CNO)

We need to focus on three key areas; making Allied Health Professions a career of choice, support for undergraduates and new registrants to stay in their chosen profession and continued development of AHPs in terms of advanced practice, leadership and improvement.

Suzanne Rastrick, NHS England Lead AHP

In her new role, the Chief Midwifery Officer will lead the implementation of Better Births through the Maternity Transformation Programme making maternity services in England one of the best in the world delivering safe personalised care to women and their families.

Professor Jacqueline Dunkley- Bent, Chief Midwifery Officer

Developing our Strategy

Throughout the development of the strategy; our key priority was capturing the voices of Nurses, Midwives and Allied Health Professionals to signal the start of sharing a strategic vision.

LISTEN

We have heard the voices of over 1000 Nurses, Midwives and Allied Health Professionals.

LEARN

5 key priorities emerged.

- Provide Safe and Quality Care
- Strengthen Leadership
- Value our People
- Develop our Workforce
- Empower and Innovate

LEAD

Following the co-creation of the strategy our NMAHP's will be empowered to lead.

'As an AHP it is key for us to be heard and lead as equals to the other staff groups'

'Transparent communication is integral to leading the future of our professions'

'Our collaboration across research, innovation and education will enable us to lead safer patient care'

'We need to lead in an inclusive, diverse and supportive culture'

'As an AHP I am excited to engage in new inclusive innovative leadership opportunities'

'Compassion is key to enabling us to leading high quality care'

'I feel empowered to lead with my voice through shared decision making'

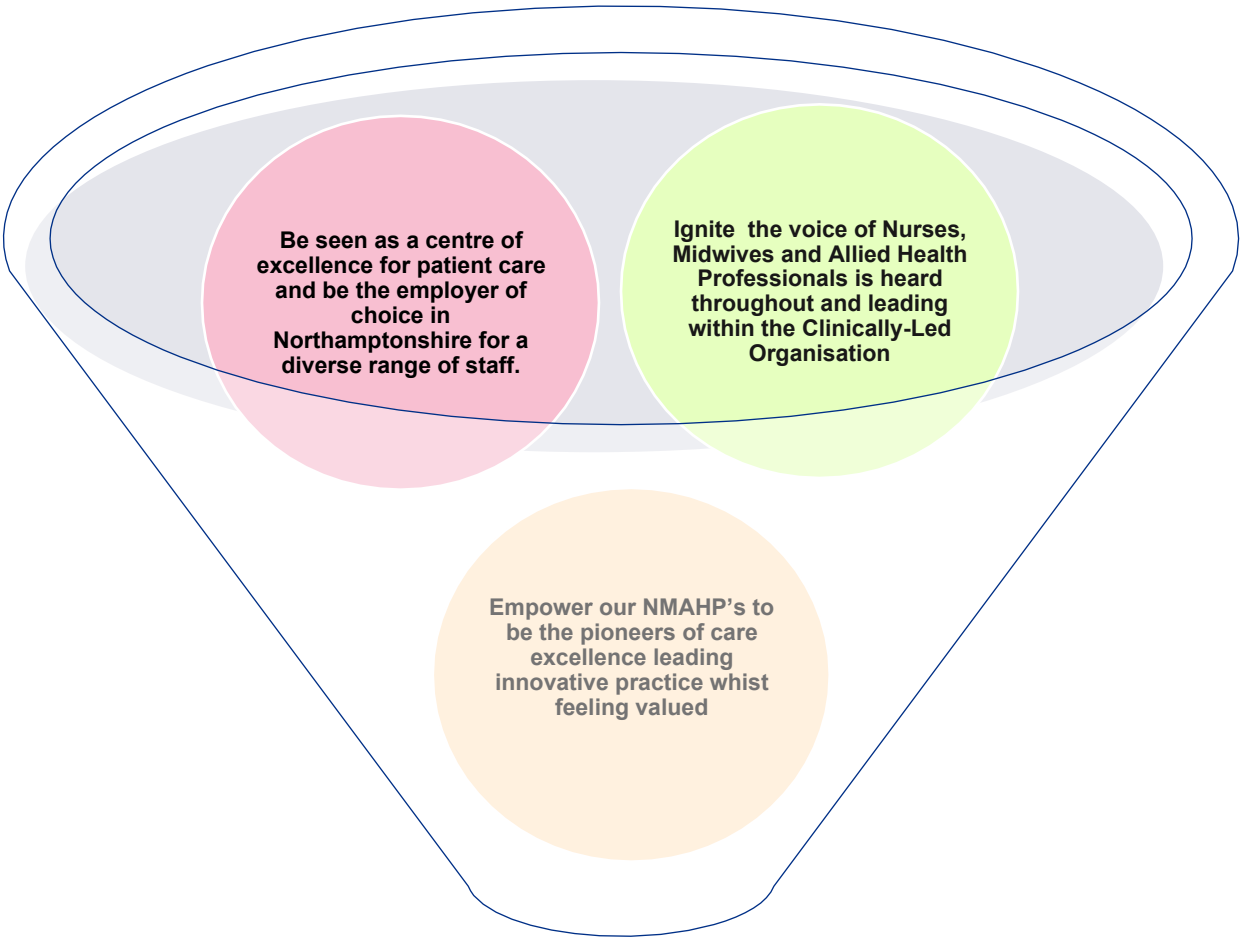
'It is key respect and integrity are at the heart of our day to day culture'

'This is a chance to lead new innovative ways of working'

'This will enable stronger team work across both organisations'

Our Ambition for Nurses, Midwives and Allied Health Professionals

By 2024, we will…



Be the first 'hospital group' to achieve Pathway to Excellence® designation across both sites

Our vision is to be a career defining destination for NMAHP staff where passion, pride and perseverance drive quality care, excellence in practice and compassionate leadership with patients at the heart of all we do.

Our Five Key Priorities

Our five key priorities developed from the thematic analysis in the engagement align with the Pathway to Excellence® standards and will support our Nurses, Midwives and Allied Health Professionals to Inspire, Excel and Transform. Annual work plans will be developed which will drive our work forward and will form the basis of reports to the Trust Board.

Provide Safe and Quality Care

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 COMMITTED TO…

- ✓Being recognised as a trailblazer for Nursing, Midwifery and Allied Health Professional excellence
- ✓Placing patient and carer experience at the heart of everything we do
- ✓Ensuring safety for both staff and patients across the group model
- ✓Delivering care which is compassionate, evidence-based and minimises harm

WE WILL DEMONSTRATE SUCCESS AS…

- Patients will tell us they feel involved in improving safety and quality
- Patients receive safe, compassionate and high quality care
- We will ensure all clinical areas will have progressed towards achieving the highest level of attainment in our respective accreditation programmes and develop a multi-professional approach
- Data will tell us we are reducing harm, promoting excellence and improving quality

Provide Safe and Quality Care

WITHIN OUR WORKPLANS, WE ARE DEDICATED TO …

KEY DELIVERABLES WITHIN THE FIRST 12 MONTHS:

- Create a supportive and inclusive culture for patient and family partners to enable their diversity to be celebrated, voice to be heard, and acted upon
- Drive continual improvements for both quality and safety by reducing avoidable harm to our patients and staff
- Continue to enhance Care Excellence through our Assessment and Accreditation process and develop MDT Accreditation

WITHIN OUR WORKPLANS, WE ARE DEDICATED TO …

KEY DELIVERABLES FOR THE MONTHS 12 TO 36:

- Providing individualised patient focused care
- Establish a culture of excellence amongst all professional groups and across the group hospitals
- Celebrating excellence in care
- Using digital technology which enables effective communication and enhances compassionate, effective care
- Achieving the Pathway to Excellence® Quality and Safety Standards
- Strengthening processes and partnerships to learn from both errors and excellence
- Using shared decision making councils to empower staff and enable transparency to provide high quality and safe care
- Increasing environmental sustainability across the group hospitals

Strengthen Leadership

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 COMMITTED TO…

- ✓ Evolving our leadership development programmes across all staff groups
- ✓ Building an inclusive environment to develop a diverse range of leaders
- ✓ Senior leaders being visible and accessible
- ✓ Creating a diverse range of leadership fellowships

WE WILL DEMONSTRATE SUCCESS AS…

- Nurses, Midwives and AHP's will value the visible, accessible and compassionate support of leaders
- Enhancing the development of a diverse range of leaders to future proof our professions
- Nurses, Midwives and AHP's will participate in and benefit from a leadership development programme
- Continuously evolving leadership development for Nurses, Midwives and AHP's will be designed to promote the inclusivity and progression of our diverse workforce

Strengthen Leadership

WITHIN OUR WORKPLANS, WE ARE DEDICATED TO …

KEY DELIVERABLES WITHIN THE FIRST 12 MONTHS:

- Enhance staff development, diversity and inclusivity through our innovative Leadership programmes and fellowships
- Promote role modelling through visible and accessible leaders
- Create reverse mentoring opportunities

WITHIN OUR WORKPLANS, WE ARE DEDICATED TO …

KEY DELIVERABLES FOR THE MONTHS 12 TO 36:

- Providing a leadership structure enabling clinical and professional opportunities across professional groups
- Celebrating outstanding leadership
- Ensuring visibility and accessibility to Nurse, Midwife and AHP leaders
- Creating new, innovative leadership opportunities
- Agreeing clear and transparent methods of communication
- Supporting Shared Decision Making to enable staff to have a voice
- Developing a future generation of strong and innovative leaders
- Ensuring compassionate leadership is embedded throughout the professional groups
- Achieving the Pathway to Excellence ® Leadership standard
- Developing inclusive leadership at all levels

Value our People

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 COMMITTED TO…

- ✓ Creating a culture driven by meaningful recognition
- ✓ Becoming a diverse, inclusive environment where staff flourish
- ✓ Empowering the voice of Nurses, Midwives and AHP's
- ✓ Being an outstanding employer
- ✓ Recognising the emotional cost of caring on our Nurses, Midwives and AHP's wellbeing

WE WILL DEMONSTRATE SUCCESS AS…

- Nurses, Midwives and AHP's excel within our hospitals where diversity is celebrated and embraced and their views are listened to and valued
- We celebrate and recognise success, innovation and hard work through our various awards programmes
- Nurses, Midwives and AHP's feel empowered through Shared Decision Making councils

Value our People

WITHIN OUR WORKPLANS, WE ARE DEDICATED TO …

KEY DELIVERABLES WITHIN THE FIRST 12 MONTHS:

- Introduce meaningful recognition which is inclusive of AHP's and support workers
- Supporting our staff's wellbeing through a comprehensive Programme which recognizes the cost of caring
- Ensuring equality and diversity is at the forefront of what we do

WITHIN OUR WORKPLANS, WE ARE DEDICATED TO …

KEY DELIVERABLES FOR THE MONTHS 12 TO 36:

- Ensuring the creation of an inclusive culture based around the embedding of our group values
- Creating multi-professional, inclusive talent management opportunities
- Ensuring equal and flexible opportunities for all protected characteristics
- Embedding Shared Decision Making to enable staff to drive decisions
- Promote unconscious bias training
- Continuing the DAISY awards and developing further local recognition schemes
- Showing compassion to our staff as well as our patients
- Enabling staff to work in a sustainable environment
- Ensuring the maturing workforce are supported to transfer their knowledge in to relevant roles
- Introducing an independent coaching scheme for staff provided by retirees
- Achieving the Pathway to Excellence ® wellbeing standard

Develop our Workforce

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 Integrated Care System. We will role model the group value of accountability when developing our staff.

WE ARE COMMITTED TO…

- ✓ Providing clear, innovative and inclusive career pathways
- ✓ Offering a comprehensive Continuing Professional Development prospectus
- ✓ Creating a culture where Nurses, Midwives and Allied Health Professionals are empowered to lead on research at PhD level and follow clinical academic pathways
- ✓ Recruit Nurses, Midwives and Allied Health Professionals who will pioneer excellence in patient care

WE WILL DEMONSTRATE SUCCESS AS…

- Nurses, Midwives and AHP's can equitably access academic pathways which enhance their career progression
- Nurses, Midwives and AHP's will be supported to lead on research in clinical academic pathways
- Nurses, Midwives and AHP's progress and develop their career within the group

Develop our Workforce

WITHIN OUR WORKPLANS, WE ARE DEDICATED TO …

KEY DELIVERABLES WITHIN THE FIRST 12 MONTHS:

- Produce a professional development prospectus
- Support the development of NMAHP's to access clinical academic career opportunities and to lead on research
- Recruitment and retention of NMAHP's who will pioneer care excellence
- Establish clinical and academic mentoring opportunities from pre-registration education

WITHIN OUR WORKPLANS, WE ARE DEDICATED TO …

KEY DELIVERABLES FOR THE MONTHS 12 TO 36:

- Developing career pathways and innovative roles for all staff
- Providing an inclusive learning environment where staff feel supported and empowered to excel through an innovative educational offering
- Ensuring equal access to educational funding and an equitable model for protected learning time
- Empowering internationally recruited staff through programmes which enable transfer of knowledge, understanding of the UK and life in Northamptonshire
- Appointing Education leads and developing academic posts in partnership with HEI's
- Working in partnership with our HEIs to nurture the next generation of NMAHP's
- Achieving the Pathway to Excellence® Professional Development Standard
- Creating new and innovative roles across the ICS for our future workforce which cross professional boundaries
- Providing new opportunities for NMAHP's via the apprenticeship Pathway

Empower & Innovate

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.

WE ARE COMMITTED TO…

- ✓ Offering diverse opportunities to lead innovation and transformation
- ✓ Creating a culture where research, quality improvement and digital transformation is integral
- ✓ Create and support the next generation of inclusive and innovative leaders

WE WILL DEMONSTRATE SUCCESS AS…

- Nurses, Midwives and AHP's will be involved in the development digital innovation programmes which improve and enhance patient care
- Nurses, Midwives and AHP's have received training, coaching and support to lead Quality Improvement focussed on reducing harm and enhancing patient experience
- Nurses, Midwives and AHP's flourish within a positive practice environment built on the Pathway to Excellence ® standards

Empower & Innovate

WITHIN OUR WORKPLANS, WE ARE DEDICATED TO …

KEY DELIVERABLES WITHIN THE FIRST 12 MONTHS:

- Ensure NMAHP's are leaders of innovation and transformation through the Shared Decision Making process
- Enable digitalization of care which enhances patient experience
- Deliver care which is based upon Research and evidence from Quality Improvement

WITHIN OUR WORKPLANS, WE ARE DEDICATED TO …

KEY DELIVERABLES FOR THE MONTHS 12 TO 36:

- Promoting Quality Improvement, Research and Evidence Based Practice training through a range of methodologies
- Enabling our staff to be digitally literate with robust support mechanisms in place
- Working in partnership to share learning from errors and excellence
- Professionalisation of Nursing, Midwifery and Allied Health Professional informatics
- Celebrating success and showcasing projects
- Supporting staff to present and publish both nationally and internationally
- Establishing more interactive patient information resources
- Enabling our NMAHP's to lead on building a partnership with our patients to understand the innovations within our group
- Using innovative methods to enable environmental sustainability

Pathway to Excellence®

By 2024, our vision is to be the first group hospital to achieve Pathway to Excellence® designation across both sites.

In 2018, Northampton General Hospital became the first Trust in the UK to achieve Pathway to Excellence® Designation; a vision which is now shared across Kettering General Hospital. Pathway to Excellence® is a framework commissioned by the American Nurses Credentialing Center (ANCC) to accredit organisations which are 'Positive Practice Environment's'. The CNO for England, Ruth May, also sees Pathway to Excellence® as an integral part of achieving her vision of Nursing & Midwifery Excellence.

Over the coming years we are committed to creating a positive working environment for our Nurses, Midwives and AHP's. This will enable them to flourish because they experience job satisfaction, professional growth and development, respect, and appreciation.

Pathway to Excellence ® has been shown internationally to improve recruitment and retention of staff, improve patient experience and reduce preventable harms. We see this as an integral part of enabling our Nurses, Midwives and Allied Health Professionals to lead on our commitment of being 'Dedicated to Excellence'.

Pathway to Excellence ® comprises of 6 Standards which must be embedded within organisations to achieve designation;

- Shared Decision Making
- Leadership
- Safety
- Quality
- Wellbeing
- Professional Development

Since our 2018 designation, the ANCC have now expanded their survey requirements to include Midwives and Nursing Associates. Across the group model we recognise the importance of also hearing AHP voices and their valued contributions to our hospital therefore, will be working to include these groups as part of both our journey's to achieve

Meaningful Recognition

Meaningful recognition is core to ensuring our staff feel valued and appreciated. As a group hospital we strive to ensure meaningful recognition becomes part of our everyday culture and is inclusive of our Nurses, Midwives and AHP's.

At present, we have introduced the following initiatives across the group model to ensure meaningful recognition.

SMILE AWARDS kgh

The DAISY FOUNDATION™

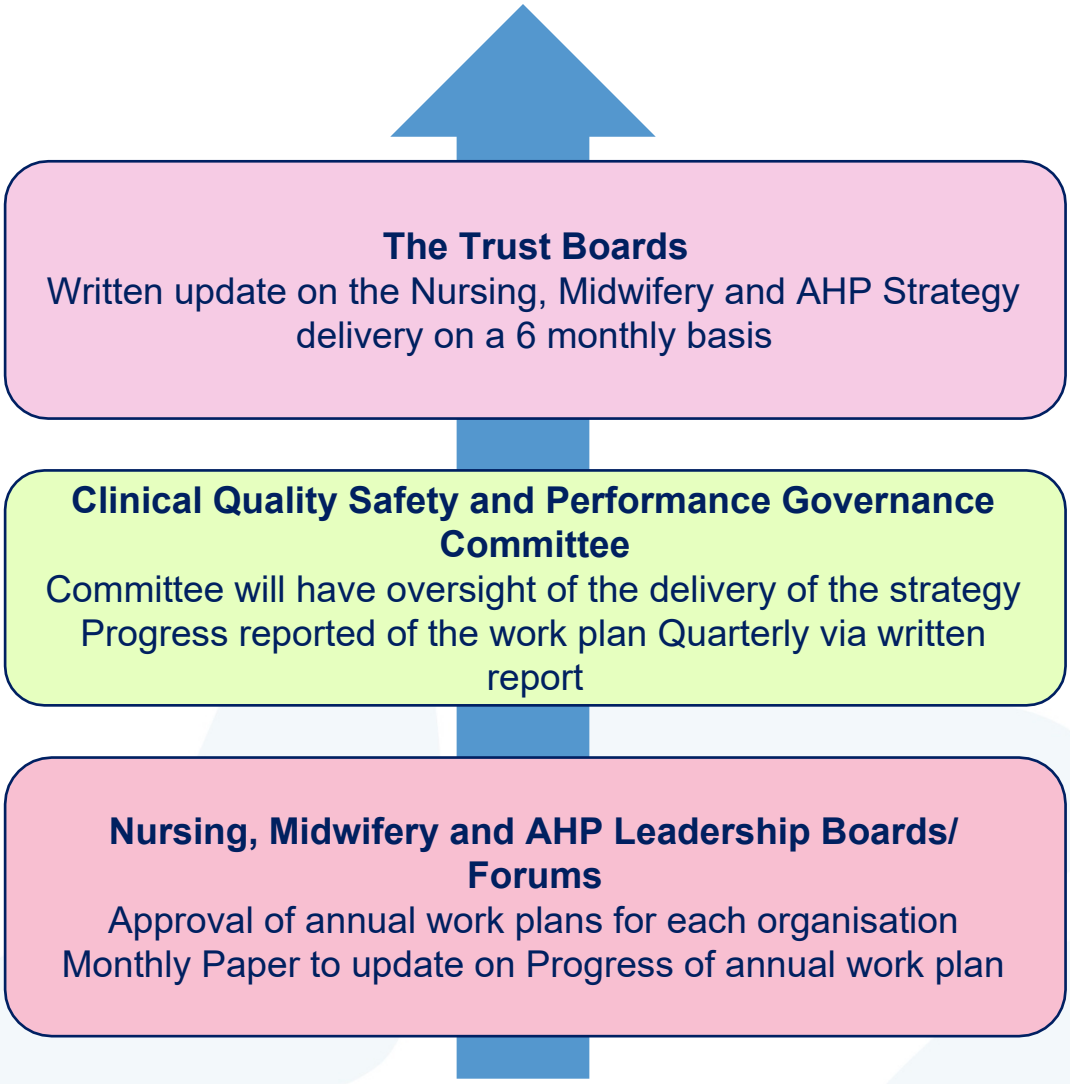
HONORING NURSES INTERNATIONALLY IN MEMORY OF J. PATRICK BARNES

NGH Everyday Hero

We plan to develop further collaborative methods of meaningful recognition to ensure consistency across the professional groups in line with the Group Vision, Mission and Values.

Engagement and Governance

We have comprehensive tracking and assurance in place for the delivery of the Group Nursing, Midwifery and AHP Strategy.



We will make sure that we keep our staff and patients informed and engaged

Strategy Steering Group

The Strategy steering group will continue to lead the implementation of the strategy and delivery of the annual work plans.

We will share updates to keep our staff up to date with progress, next steps and raise awareness of how to get involved.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Board**
Date of Meeting	**27 May 2021**

Title of the Report	**Annual Self-Certification**
Agenda item	**13**
Presenter of Report	Claire Campbell- Director of Corporate Development, Governance & Assurance
Author(s) of Report	Claire Campbell- Director of Corporate Development, Governance & Assurance

This paper is for: (delete as appropriate)

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

Executive summary

NHS Trusts are exempt from holding a provider licence, but they are required to comply with conditions equivalent to the licence that NHSE/I have deemed appropriate (Conditions G6 (3) and FT4 (8)).

The Single Oversight Framework bases its oversight on the NHS provider licence. NHS Trusts are legally subject to the equivalent of certain provider licence conditions and must self- certify under these licence provisions.

The Board is required to carry out an annual self-certification. This provides assurance that NHS Trusts are compliant with the conditions of their licence. There is no longer a requirement to submit the results to NHSE/I; however, these must be published on the Trust website in some form and are subject to audit by NHSE/I on request.

The finance and governance teams have determined that a positive confirmation can be given, and provided a rationale, for each of the required conditions: FT4, G6, CoS7 and Governor Training.

The Finance and Performance Committee have approved the positive confirmation for each of the licence conditions and is now presented to Board for ratification.

The Trust is required to self-certify with Board sign off as well as publish the G6 self-certification declaration by 30th June 2021.	
Related Group Priority	Which Group Priority does this paper relate to? 1. Patient: Excellent patient experience shaped by the patient voice 2. Quality: Outstanding quality healthcare underpinned by continuous, patient-centred improvement and innovation 3. System & Partnerships: Seamless, timely pathways for all people's health needs, together with our partners 4. Sustainability: A resilient and creative university teaching hospital Group, embracing every opportunity to improve care 5. People: An inclusive place to work where people are empowered to be the difference
Risk and assurance	The self-certification statements signed off by the Board must set out any risks and mitigation planned for each statement if applicable.
Related Board Assurance Framework entries	1; 5
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Financial Implications	No direct financial implications
Legal implications / regulatory requirements	The Single Oversight Framework bases its oversight on the NHS provider licence and therefore Trusts are legally subject to the equivalent of certain provider licence conditions including G6 and FT4.

Actions required by the Board:

The Board is asked to:

- Ratify the positive confirmation for each of the licence conditions approved by the Finance & Performance Committee.

1. Introduction

NHS Trusts are exempt from holding a provider licence, but they are required to comply with conditions equivalent to the licence that NHSE/I have deemed appropriate (Conditions G6 (3) and FT4 (8)).

The Single Oversight Framework bases its oversight on the NHS provider licence. NHS Trusts are legally subject to the equivalent of certain provider licence conditions and must self- certify under these licence provisions.

2. Requirements

Providers must self- certify the following NHS provider licence conditions after the financial year end:

- The provider has taken all necessary precautions required to comply with the licence, NHS Acts and NHS constitution (Condition G6 (3)).
- The provider has complied with required governance arrangements (Condition FT4 (8)).
- The CoS conditions only apply to Foundation Trusts; therefore, the Trust is not required to self-certify under the CoS7 condition.

The aim of self- certification is for providers to carry out assurance that they comply with the conditions. Any process should ensure that the Board clearly understands whether or not the provider can confirm compliance. Providers must state “confirmed” or “not confirmed” for each declaration explaining the rationale for the decision.

The Trust is not required to submit the self-certification to NHSE/I, but the Board is required to sign off the certificates and publish the outcome of the self-certification exercise.

The Trust intends to make positive confirmations on all declarations as follows.

2.1 Condition FT4 - Declaration

(1) The Board is satisfied that the Licensee (the Trust) applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

Rationale for rating: The Trust has in place, a scheme of delegation, standing orders, and a set of standing financial instructions. It has all statutory governance requirements in place and is subject to internal and external audit on the robustness of its arrangements. The Trust has considered the Well Led Governance framework through a self-assessment process undertaken by the Board.

Rating: <u>Confirmed</u>

(2) The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time

Rationale: The Board receives advice on compliance with existing guidance and information on new guidance issued by regulators, in reports from the relevant Directors.

Rating: <u>Confirmed</u>

(3) The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.

- **Rationale:** The Board has an established a governance structure. All Committees are supported by terms of reference which are regularly reviewed & approved by Board. The Annual Governance Statement, contained within the Annual Report, sets out developments each year. Executive Director responsibilities are set out in job descriptions and effective appraisal processes are in place to support Board members. The Finance and Performance committee together with the Audit committee are the principal committees of oversight. The Quality Governance committee meets monthly and reviews performance in key areas of patient safety, patient experience and clinical outcomes.

  During 2020/21, the Board agreed the establishment of Group Committees in Common with Kettering General Hospital NHS Foundation Trust to drive key elements of group collaboration in respect of People, Quality and Safety, Finance and Performance and the Digital Hospital. These Committees are formally constituted bodies of both Boards, each of which has delegated specific powers and functions to be exercised by the group committees.

  Rating: <u>Confirmed</u>

(4) The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:

(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively.

(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations.

(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions.

(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern).

(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making.

(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence.

(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) To ensure compliance with all applicable legal requirements.

Rationale: The Trust has sufficient skills and capacity at Board level to undertake financial decision making, management and control. The self-certification provides evidence of the Board's review and assessment of its going concern status. The Annual Governance Statement identifies that the Trust Board is well sighted on the issues and risks.

Rating: <u>Confirmed</u>

(5) The Board is satisfied that the systems and/or processes (above) should include but not be restricted to systems and/or processes to ensure:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided.

(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations.

(c) The collection of accurate, comprehensive, timely and up to date information on quality of care.

(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care.

(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Rationale:

(a) The Trust Board has mix of clinical, quality and performance expertise to provide leadership across the organisation and to take account of all Board accountabilities in relation to quality.

(b) The Trust Board receives regular information via the Integrated Performance Report from the preceding month, on finance, performance and quality, which is subject to more detailed scrutiny by Board Committees as well as the Trust Board.

(c) There are specific reports monthly providing timely and accurate data on quality of care, using a variety of sources.

(d) which enable the Board to take an accurate, timely and accurate account of quality of care, and other reports throughout the year, which provide more comprehensive oversight of quality.

(e & f) The Trust Board concerns itself with quality of care at each Trust Board meeting including starting the substantive agenda with patient, staff and patient stories; The Trust Board and Committees receives intelligence on staff and patient experience through a number of routes during the year - annual staff survey, monthly Friends and Family test, Patient Experience, complaints and serious incident reporting.

Rating: <u>Confirmed</u>

(6) The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

Rationale: The Trust has systems in place to ensure that staff employed at every level are appropriately qualified for their role. The Board and its committees receive data on staffing figures regularly and the impact of staffing issues on delivery of its NHS contracts. The Trust reports monthly on Clinical staff fill-rates and safe staffing reports. The Trust's Operational Plan and Workforce model looks at the short-term and long-term needs of the Trust.

Rating: <u>Confirmed</u>

2.2 Condition G6 - Declaration

The Board is satisfied that the Trust has processes and systems that:

a. identify risks to compliance with the licence, NHS acts and the NHS Constitution
b. guard against those risks occurring.

Rationale: For the purposes of licence condition G6, the Board is satisfied that the Trust took all such precautions as were necessary in order to comply with the conditions of the licence, the NHS acts and Constitution. The Corporate Governance function monitors compliance, and reports to the Board as required (details are available in the Annual Governance Statement).

Rating: <u>Confirmed</u>

3. Actions required by the Board:

The Board is asked to:

- Ratify the positive confirmation for each of the licence conditions approved by the Finance & Performance Committee.

Report To	**Trust Board**
Date of Meeting	**27 May 2021**

Title of the Report	**Board Assurance Framework Q4 2020- 21**
Agenda item	**14**
Presenter of the Report	Claire Campbell, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Claire Campbell, Director of Corporate Development, Governance and Assurance

This paper is for: (delete as appropriate)

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

1. Executive summary

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

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

This report describes the updated Q4 position in relation to the risks associated to delivery of corporate objectives described on the BAF. This is the final review of the year and the revised BAF will be presented to Board and its committees in July 2021. The revised BAF will include risks associated with the delivery of Group priorities and strategies and a revised Risk Appetite which is subject to a separate paper to Board this month.

2. Assurance

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

3. Population of the BAF

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

4. Changes to the BAF during Q4 2020/21

General Changes:

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

- Existing controls: CQC Transitional Monitoring Approach added.
- Assurance of Control: No change
- Gaps in control: Medical Trainee reports gap updated

- Actions updated: HEE/GMC action plan completed. Outcome of the Urgent and Emergency Care Provider collaboration review- advised no formal outcome will be reported. One new action added and completed in relation to the CQC Transitional Monitoring approach that was undertaken in April. No formal outcome will be received as a result of this work.
- Score: No change

b. BAF Risk 1.2: Risk of Failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties- Finance & Performance
- Existing Controls: Updated to reflect reduction in alert level
- Assurance of Control: No change
- Gaps in assurance: No change.
- Actions updated: Updated to reflect the changes to the management of Covid and reduction in numbers of patients seen, the Trust response to the pandemic and the reduction in the UK alert level from 4 to 3. All options continue in relation to use of the independent sector and an internal programme has been set up to support the system discharge work.
- Score: No change

c. BAF Risk 1.4: Risk of avoidable harm to patients and the associated loss of public confidence. Quality Governance Committee.
- Existing Controls: Mandated use of Deteriorating Patient Care Plan added.
- Assurance of Control: No change
- Gaps in assurance: Updated
- Actions updated: Two actions completed relating to Deteriorating Care Plan and IPC reviews. EPMA system deadline extended and updated as Trust seeking an alternative provider.
- Score: Decreased from 15 to 10

d. BAF Risk 1.5: Risk that Trust fails to deliver high quality services in all clinical areas 24/7. Quality Governance Committee.
- Existing controls: No change.
- Assurance of Control: No change
- Gaps in assurance: No change.
- Actions updated: Deadline for medical rota extended due to the dependency on recruitment of acute physicians and overseas recruitment. E Rostering completed.
- Score: No change.

e. BAF Risk 1.6: Inability to recruit adequate numbers of nursing staff- Quality Governance Committee/ People Committee
- Existing controls: No change.
- Assurance of Control: No change.
- Gaps in control: No change
- Actions update: Assessment and Accreditation on track for delivery.
- Score: No change

f. BAF Risk 1.7: Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failure- Quality Governance Committee/ Finance & Performance Committee
- Existing controls: No change
- Assurance of Control: No change
- Gaps in control: No change.
- Actions updated: Action 1, as is business as usual activity has been closed down as reported monthly via ARC and Finance and Performance Committee. Deadline for estates strategy has been extended to October 21 as work needs to align to clinical strategy.
- Score: No change

g. BAF Risk 1.8: Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust- Digital Hospital Committee
- Existing controls: No change.

- Assurance of Control: No change
- Gaps in control: No change.
- Gaps in control: No change.
- Actions update: Deadlines for action 4 extended, all other actions completed.
- Score: No change

h. BAF Risk 1.9: The risk of the Trust being unable to deliver an appropriate response to Covid 19 in terms of quality of care, capacity and timeliness with consequential impact on patient and staff safety, patient experience and staff wellbeing. All Committees
- Existing Controls: No change.
- Assurance of Control: No change.
- Gaps in control: Covid infectivity removed as number of patients has reduced, Covid positive staff numbers have reduced, and work has commenced to return shielding staff to work, with flexible working now business as usual. Winter pressures gap removed.
- Actions update: All actions completed.
- Score: Decreased from 15 to 10, now achieving the target score.

i. BAF Risk 1.10: Risk of the Trust being unable to deliver a recovery plan post covid-19 with consequential impact on patient and staff safety, patient experience and staff wellbeing. All Committees
- Existing Controls: No change
- Assurance of Control: No change.
- Gaps in control: ITU capacity increase and Covid surge removed.
- Actions update: Planning round for 2021/22 added, noting that plans may need to be reviewed/ amended in the event of a further Covid surge.
- Score: Decreased from 15 to 20.

j. BAF Risk 2.1: Risk that the Trust fails to provide an excellent patient experience. Quality Committee.
- Existing Controls: No change.
- Assurance of Control: No change.
- Gaps in control: No change.
- Actions update: Board to ward action deadline extended to June to awaiting changes to Government Guidelines and the potential to reinstate face to face events. National Cancer Collaborative project work completed which supports the work of CNS's working with prostate cancer carers- the project was highly commended.
- Score: No change.

- BAF Risk 3.1: Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and, in the future - People Committee
- Existing controls: No change
- Assurance of control: No change
- Gaps in control: Opening of escalation areas and staff absence removed.
- Actions update: Oncology work action completed. Absence data action- staffing cell now closed so removed. People Plan delivery completed.
- Score: Decreased from 15 to 10 due to reduction of impact of pandemic on workforce capacity.

k. BAF Risk 3.2: Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future- People Committee
- Existing controls: No change
- Assurance of control: No change
- Gaps in control: No change
- Actions update: People Plan Board submission completed.
- Score: No change

l. BAF Risk Score 3.3: Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optimal culture- People Committee

- Existing controls: Group briefings added.
- Assurance of control: References to workforce committee updated
- Gaps in control: No change.
- Actions update: Health & wellbeing elements added to people plan submitted to Trust Board.
- Score: No change.

m. BAF Risk 4.1:Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire Health and Care Partnership will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access- Finance & Performance

- Existing controls: System Corporate Governance workgroup added
- Assurance of control: Updated
- Gaps in control: Covid surge and adult social care funding removed.
- Actions update: One new action added, Planning for 2021/22 in train. Integration of new Unitary Authorities deadline changed to ongoing as work continues.
- Score: No change

n. BAF Risk 5.1: Risk that the Trust fails to have financial control measures in place to deliver its 2020/21 financial plan- Finance & Performance Committee

- Existing controls: No change
- Assurance of control: No change
- Gaps in control: No change
- Actions update: One action added.
- Score: Score reduced from 15 to 5 due to delivery of financial plan with a £303k surplus in year and target score has been achieved.

o. BAF Risk 5.3: Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements Finance & Performance Committee

- Existing controls: New capital funding added.
- Assurance in control: No change
- Gaps in control: Gap in control removed – ability to fully utilise Trusts CRL due to slippage.
- Actions update: Both actions completed, and an additional action added re carry forward of slippage. escalate slippage and bring forward any appropriate 2021/22 schemes.
- Score: Score decreased from 20 to 15 to reflect carry forward of slippage.

Risk Score: The risk score has decreased overall in this quarter from 236 to 206 for 16 risks. The BAF is attached (Appendix 1).

Related Group Priority	ALL
Risk and assurance	The Board assurance framework describes key risks to the Trust's corporate objectives and informs the organisational Annual Governance Statement
Related Board Assurance Framework entries	ALL
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? (N)
Legal implications / regulatory requirements	The Board assurance framework is cross referenced to the Care Quality Commission Standards of Quality and Safety which the organisation has a statutory duty to meet.

Actions required
The Board is asked to:

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

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

BAF Risk No.1.1 Risk of failure to meet regulators minimum fundamental standards to avoid enforcement action, intervention or suspension of services

Risk Classification: Compliance	**Risk Owner:** DCD,G & A	**Scrutinising Committee:** Quality Governance Committee
Date Risk Opened: 30/6/20	**Date of next full review of BAF:** 31/3/21	

Changes since last review:

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

Existing Controls	**Assurance of Controls**
1. Clinical Governance structures and processes 2. Clinical Audit strategy 3. Board to Ward visits 4. Quality metrics in Performance report to Board 5. Divisional Quality Governance reports to Clinical Quality & Effectiveness Committee 6. Quality meetings with commissioners 7. Quality Governance committee 8. Clinical Quality & Effectiveness Group 9. Patient and Carer experience Group 10. ARC reports to QGC 11. Ward Accreditation- currently suspended 12. Virtual CQC Relationship meetings 13. CQC IPC Emergency Support Framework (ESF) 14. Full Hospital Capacity Protocol 15. CQC Transitional Monitoring Approach	• QGC report to Trust Board (L2) • Trusts Quality Improvement scorecards (L1) • Assessment and accreditation reports to Trust Board (L1) • Divisional Quality Governance assurance reports to CQEG (L1) • Compliance reports to QGC (L1) • Peer review & screening QA visits (L3) • Internal audit reports (L3) • ARC reports to QGC(L1) • CQC Insight report – Bi monthly (L3) • CQC Engagement meetings (L3) • IPC ESF (L3) +ve

Gaps in Controls

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

Further Actions	**Responsible Person/s**	**Due Date**
1. HEE/GMC action plans in progress	1. Matt Metcalfe	1. Completed
2. Standard 5- IPC enhanced and updated for ward accreditation	2. Sheran Oke	2. Completed
3. Urgent and Emergency Care Provider Collaboration Review	3. Claire Campbell	3. Completed
4. CQC Transitional Monitoring Approach assessment	4. DoN/MD/DCDG&A	4. Completed

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

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

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

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

Existing Controls	**Assurance of Controls**
1. Performance management framework policy 2. Bed meetings and safety huddle daily with escalation processes in place 3. Silver calls with silver lead and system Silvers every day to provide mutual support to all organisations 4. Symphony IT monitoring system in use for A&E 5. A&E delivery Board 6. Cancer Improvement Group meeting monthly 7. County wide Cancer Board meets monthly 8. Cancer site PTL meetings weekly for all cancer sites 9. Somerset reporting cancer 10. Daily tracking for DTOC 11. Elective Care Board CCG Monthly 12. Weekly performance meeting in place 13. RTT PTL performance meetings weekly for all specialties 14. Targeted support from regional NHSE/I to all Trusts in the region for cancer 62 days (Diagnostics) 15. Additional performance metrics now in place in relation to Covid-19 16. Patient Access Manager in post 17. COVID control room, with bronze and silver cells in place to oversee the local pandemic response with GOLD meetings held as required	• Performance metrics at corporate, divisional and directorate level (L1) • Integrated performance report to Trust Board and committees (L1) • A&E received rating of Good in CQC inspection 2019 (L3) • Benchmarking against other Trusts. (L3) • Winter Plan. (L1) • Reset plan (L1) • Elective Care national support team review of Trust PTL (L3)

Gaps in Controls
1. Report to Board indicates under performance for: Cancer targets (62 days) / A & E /RTT
2. Attendances, admissions, and acuity remain high
3. Outsourcing of elective activity to reduce backlog
4. Social Care reductions impacting on discharge and flow in hospital
5. Key posts in A&E remain difficult to recruit to.
6. Key nursing and medical posts remain difficult to recruit to.
7. Diagnostic capacity reduced

Further Actions	**Responsible Person/s**	**Due Date**
1. Covid response remains in place 2. Reset continues despite COVID challenges and performance monitored and reported monthly to Trust Board. Theatres to return to full capacity by June 21. 3. Further outsourcing of routine work to Independent sector including endoscopy 4. System discharge work with external support from ECIST	1-4 Jo Fawcus	1. Review in 3/12 2. Ongoing 3. Ongoing 4. Ongoing

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.		
BAF Risk No.1.4 Risk of avoidable harm to patients and the associated loss of public confidence		
Risk Classification: Quality	**Risk Owner:** MD/DON	**Scrutinising Committee:** Quality Governance Committee
Date Risk Opened: 30/6/20	**Date of next full review of BAF:31/3/21**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks: 1303; 1411,1478, 1776, 1782, 1867, 1879, 1911, 1955, 1972, 2150, 2187, 2195, 2216, 2219, Multiple sources of risk exacerbated by high demand and high patient acuity.	**Initial score**	**Current score**	**Target score**
	10 (5x2)	10 (5x2)	5 (5x1)

Existing Controls	**Assurance of Controls**
1. Monthly review of Dr Foster information and alerts 2. Mortality Review Group 3. Audit plan 4. Incident and SI reporting policy 5. Monthly Clinical Quality and Effectiveness Group 6. Monthly Quality Governance committee 7. Countywide Patient safety M&M meetings 8. Review of Harm Group weekly 9. Dare to Share alternate monthly 10. FIT Group 11. MASH referral system 12. NGH Safeguarding Team 13. IP Steering Group 14. IPC Team 15. Maternity Dashboard 16. Saving Babies Lives – National Initiative 17. Neonatal Safety Champion Role 18. Integrated risk assessment and prescription chart introduced 19. Mandated use of Deteriorating Patient Care Plan	• Reports from Mortality review to CQEG and QGC (L1) • HSMR & SHMI data (L3) • CQEG reports to Quality Governance committee (L1) • Quality reports to Quality Governance and Trust Board (L1) • Quality Governance reports to Trust Board (L2) • Dr Foster data reports (L3) • Results from Clinical audit (L1) • Review of Harm Group monitoring implementation for SI action plans (L1) • National Learning and reporting system data (L3) • Incident report to Quality Governance committee (L1) • Safety thermometer metrics via DoN report (L2) • Delivery of infection control trajectory requirements at end of 2019/20 (L1) • Reports to FIT Group (L1) • IPC Assurance Framework (L3) • IPC ESF (L3) • Maternity report to QGC (L1) • Maternity Forum (L1)

Gaps in Control

1. NICE-/ VTE compliance remains inconsistent
2. Recurrent themes of harm identified requiring thematic approach to redress.
3. System Safeguarding resources and infrastructure

Further Actions	**Responsible Person/s**	**Due Date**
1. Completion of work to digitise and mandate use of Deteriorating Patient Care Plan	1. Dr Hardwick	1. Completed
2. IPC reviews of nosocomial full SI process to be completed	2. Sheran Oke	2. Completed
3. EPMA system review and introduction	3. Matt Metcalfe	3. Q1 2021/22

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.				
BAF Risk No.1.5 Risk that Trust fails to deliver high quality services in all clinical areas 24/7				
Risk Classification: Quality	**Risk Owner:** MD/DON	**Scrutinising Committee:** Quality Governance Committee		
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/3/21**			
Changes since last review:				
Underlying Cause/ Source of Risk: CRR reference risks 979, 1188, 1445, 1665, 1764, 2188, 2219, 2359. Insufficient clinical staffing to provide 24/7 service.		**Initial score** 12 (4x3)	**Current score** 8 (4x2)	**Target score** 8 (4x2)
Existing Controls		**Assurance of Controls**		
1. Reports to Clinical Quality and Effectiveness Group (CQEG) – 7 day services 2. CQEG reports to QGC 3. Job planning processes 4. Review of clinical models in line with Trust 60 bedded unit 5. Safe Nursing & Midwifery Staffing Report 6. Quality Account & process 7. Quality Strategy 8. Assessment and Accreditation report to Board on standards of nursing care- currently suspended		• Associate Medical Director report to CQEG (L1) • Quality Governance report to Trust Board (L2) • Clinical Collaboration work to ensure robust services county wide across both acute Trusts (L1) • Self-assessments (Assurance Framework return) undertaken biennially against 7 day services criteria (L1 • Mortality review reports to QGC and Trust Board (L1) • Safer staffing metrics (L1) • Delivery of Quality Priorities (L1)		
Gaps in Controls 1. Out of Hours capacity of medical staffing				
Further Actions		**Responsible Person/s**		**Due Date**
1. Medical rota revision 2. Plan to roll out ERostering		1. Fiona Poyner 2. Luke Styant		1. June 2021 2. Completed

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

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

Further Actions	**Responsible Person/s**	**Due Date**
1. Assessment & Accreditation roll out to Paeds, Maternity & Theatres	1. QA Matron & PNS	1. May 2021

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

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

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

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

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

Gaps in Controls

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

Further Actions	**Responsible Person/s**	**Due Date**
1. Deliver action plans against key estates elements to improve assurance and reduce risks	1. Stuart Finn	1. Completed
2. Review Estates strategy to align with KGH, STP/HCP and Clinical strategy commenced in December 2020	2. Stuart Finn	2. Oct 2021
3. Seek additional routes to Capital funding to reduce backlog and align with Estates strategy & Masterplan and Clinical strategy - regular conversations with NHSIE lead continue	3. Stuart Finn	3. Ongoing

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

BAF Risk No. 1.8 Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust

Risk Classification: Infrastructure	**Risk Owner: DCIO**	**Scrutinising Committee: Digital Hospital Committee**
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/3/21**	
Changes since last review:		

Underlying Cause/Source of Risk: CRR reference risks 1733, 1984, 1482, 1684, 2020, 2151, and 2170. Cyber risks, Information security and aging ICT infrastructure.	**Initial score**	**Current score**	**Target score**
	20 (4x5)	20 (4x5)	16 (4x4)

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

Gaps in Controls

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

Further Actions	**Responsible Person/s**	**Due Date**
1. Training	1. Dave Smith	1. Completed
2. Network access control	2. Dave Smith	2. Completed
3. Plug in USB port control	3. Dave Smith	3. Completed
4. Windows to migrate to Windows 7	4. Dave Smith	4. July 2021
5. New Daily service checks process for clinical systems	5. Miriam Jepson	5. Completed

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

BAF Risk No. 1.9 The risk of the Trust being unable to deliver an appropriate response to Covid 19 in terms of quality of care, capacity and timeliness with consequential impact on patient and staff safety, patient experience and staff wellbeing.

Risk Classification:	**Risk Owner:** COO	**Scrutinising Committee:** Board and all committees
Date Risk Opened: 20/04/20	**Date risk expected to be removed from BAF: 31/8/20**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks 1482,2287, 2305, 2307, 2313, 2334, 2336, 2341, 2359 Global pandemic relating to Covid 19 affecting the Northamptonshire healthcare system with high volumes of high acuity patients requiring healthcare.	**Initial score**	**Current score**	**Target score**
	25 (5 x 5)	10 (5 x 2)	10 (5 x 2)

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

Gaps in Controls

- COVID positive staff not available to work and / or shielding

Further Actions	**Responsible Person/s**	**Due Date**
1. Focus on staff well-being, from SOS services, protected time back to recover, home working where possible, thank you handouts	Gold team	Ongoing
2. Staff and population vaccination programme underway to protect staff and patients	Chris Pallot	Completed
3. All staff issued with Lateral flow kits to self-test for COVID	Carl Holland	Completed
4. Enhanced rates programme to support capacity issues	Gold Team	Completed

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.				
BAF Risk No. 1.10 Risk of the Trust being unable to deliver a recovery plan post covid-19 with consequential impact on patient and staff safety, patient experience and staff wellbeing.				
Risk Classification:	**Risk Owner:** COO	**Scrutinising Committee:** Board and all committees		
Date Risk Opened: 20/07/20	**Date risk expected to be removed from BAF: Dec 2020**			
Changes since last review:				
Underlying Cause/ Source of Risk: CRR reference risks: 1482,2287, 2305, 2307, 2313, 2334, 2336, 2341, 2359 Global pandemic relating to Covid 19 affecting the Northamptonshire healthcare system. In recovery, backlogs of activity and reduced capacity.		**Initial score** 20 (5 x 4)	**Current score** **15** **(5 x 3)**	**Target score** 10 (5x2)

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

Gaps in Controls

- End of national contract with Independent sector and activity on offer not sufficient to meet needs

Further Actions	**Responsible Person/s**	**Due Date**
1. Planning round for 2021/22 to be agreed by Board, to include activity.	1. Jo Fawcus	1. June 2021

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

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

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

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

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

Gaps in Controls

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

Further Actions	**Responsible Person/s**	**Due Date**
1. Review of Patient Information- content and mode of delivery	1. Sheran Oke	1. Ongoing
2. Reinstate Board to Ward visits virtually	2. Sheran Oke	2. June 2021
3. Work with Northamptonshire Healthwatch, carers and volunteers commenced	3. Sheran Oke	3. Ongoing
4. Trust working with National Cancer Collaborative to improve patient experience	4. Sheran Oke	4. Completed

Principal Risk 3 – Failure to develop, value and support our staff may lead to poor standards of care, poor staff training and difficulty in recruiting and retaining high calibre staff.				
BAF Risk No. 3.1 Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future				
Risk Classification: Human Resources	**Risk Owner:** CPO	**Scrutinising Committee: People Committee**		
Date Risk Opened: 30/07/20	**Date of next full review of BAF: 31/03/20**			
Changes since last review:				
Underlying Cause/ Source of Risk: CRR reference risks 2075, 1188, 979, 1764, 1893, 2219 National workforce shortages of clinical staff		**Initial score** 10 (5x2)	**Current score** 10 (5x2)	**Target score** 5 (5X1)

Existing Controls	**Assurance of Controls**
1. People Plan 2019 -2020 2. Nurse Recruitment and retention strategy 3. Recruitment policies and procedures 4. Workforce Plan submitted to LWAB 5. Sickness Absence management policy 6. Occupational Health Service 7. Temporary staff service 8. E-rostering 9. Apprenticeship scheme 10. Regular skill mix reviews in Nursing 11. Northamptonshire Branding- Best of Both Worlds campaign 12. Director of HR Agency meeting 13. Alternative pension contribution policy 14. Commencement of the Covid Vaccination programme	• Workforce report to People committee (L1) • People committee reports to Trust Board (L2) • Nurse Recruitment plan and retention report to People Committee (L1) • Staffing data report to People Committee and Quality Governance Committee (L1) • Patient survey (L3) • Staff survey (L3) • Medical Trainee survey (L3) • Internal Audit – Sickness Absence audit (L3) • OH Annual Report (L1)

Gaps in Controls

1. Difficulties in recruiting to vacancies due to national shortages
2. Challenges moving forward with the domestic supply of nurses with educational and placement issues following the pandemic
3. Trust has red flags related to Medical Trainee survey reports

Further Actions	**Responsible Person/s**	**Due Date**
1. Complete Oncology work in response to medical trainee comments	1. Bronwen Curtis	1. Completed
2. Daily recording and reporting of absence data to undertake risk assessment for staffing areas	2. Bronwen Curtis and Sheran Oke	2. Ongoing/daily
3. 2021 to 2024 People Plan being developed in line with national NHS People Plan and group priorities	3. Mark Smith	3. Completed

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

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

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

Gaps in Controls

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

Further Actions	**Responsible Person/s**	**Due Date**
1. Talent Management development 2. The Group People Plan will be submitted to Trusts Board for approval	1. Mark Smith 2. Mark Smith	1. June 2021 2. Completed

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

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

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

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

Existing Controls	**Assurance of Controls**
1. Workforce committee 2. Equity and Diversity Steering Group 3. Staff networks including BAME, LGBTQ and Disability 4. Freedom to Speak up Policy and process 5. Bullying and Harassment Policy 6. Grievances at Work policy. 7. Health and Wellbeing Plan/Strategy 8. People Plan 2019-2020 9. Diversity & Inclusion Manager post 10. Development of TRiM training and our Support Our Staff (SOS) team 11. Regular Group and Trust briefings for all colleagues	• Organisational Development updates to People Committee, includes staff engagement and staff survey results(L1/ L3) • Equality and Human Rights Group (staff) reports to People committee and Trust Board (L1/ L2) • Web based incident reporting system available for staff (L1) • Staff survey (L3) • Guardian of Safe working hours report to People Committee and annually to Trust board (L1) • Freedom to Speak Up Guardian Report to People Committee and Trust Board (L1) • People committee reports to Trust Board (L2) • Staff Friends and Family Test (L3) • Health & Wellbeing reports to People Committee (L1) • Sickness rate (L1) • Approval of People Plan by Trust Board (L1)

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

Further Actions	**Responsible Person/s**	**Due Date**
1. Health and Wellbeing to be an integral element of the group People Plan to be submitted to the Trust Board	1. Mark Smith	1. Completed
2. WRES Action plan completed and implemented	2. Mark Smith	1. July 2021
3. BAME reverse mentoring programme	3. Mark Smith	2. June 2021

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

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

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

Underlying Cause/Source of Risk: CRR reference risks 1309, 2006 Northamptonshire HCP fail to deliver service and financial sustainability for NGH and local providers	**Initial score**	**Current score**	**Target score**
	16 (4x4)	12 (4x3)	4 (4x1)

Existing Controls	**Assurance of Controls**
1. Board and Executive updated monthly on progress of the Health and Care Partnership 2. Executive oversight 3. Collaboration Programme Committee and associated governance framework 4. Non Exec Directors attend NED countywide and Chairs meetings 5. Integrated Business Planning Group/ Strategic planning group 6. Chair & CEO are members of HCP Board 7. System-wide approach to Phase 3 post-covid reset and board level approval of plans 8. Significant partnerships described in Annual Plan 9. Annual contract negotiation and service planning processes leading to a Board approved contract and annual plan 10. Regulatory oversight of the annual planning process 11. Establishment of the Group Model with Kettering General Hospital giving additional opportunities for service sustainability and collaboration 12. System Corporate Governance Workgroup	• New Trust strategy in place with aligned estates strategy in progress reports to Trust Board (L1) • Estates strategy and master plan in place with plans for Health and Well Being Campus being delivered alongside external partners (L1) • Service line reports (SLR) (L1) • Medium term financial sustainability plan (L1) • HCP Board in place update reports to Trust Board (L2) • Joint clinical directors appointed for Breast and ENT with Cardiology to follow • Reports on all collaboration schemes to Collaboration Programme Committee (L2) • Annual capacity and demand analysis and associated contract agreements agreed with Commissioners (L2) • Service sustainability reviews undertaken as part of annual planning process (L1) • Partnership in place with UHL NHS Trust for oncology services (L1)

Gaps in Controls

1. Development of the ICS remains in progress along with the evolution of the two new Unitary Authorities
2. Trust capacity issues have led to outsourcing in some specialities;
3. A risk that Out of hospital work-streams fail to deliver reductions in activity;

Further Actions	**Responsible Person/s**	**Due Date**
1. Continue to explore options to integrate tertiary services, e.g. Head & Neck on a regional basis	1. DoS&P	1. Completed
2. Integration with new Unitary Authorities and Primary Care Networks	2. DoS&P	2. Ongoing
3. Development of Group Clinical Strategy	3. DoS&P	3. Q3 2021/22
4. Planning for 2021/22 in train	4. DoS&P	4. June 2021

Principle Risk 5: Failure to deliver financial stability may affect the quality of services and the future sustainability and viability of the Trust				
BAF Risk No. 5.1 Risk that the Trust fails to have financial control measures in place to deliver its 2020/21 financial plan				
Risk Classification: Finance	**Risk Owner:** DoF	**Scrutinising Committee:** Finance & Performance		
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 31/3/21**			
Changes since last review:				
Underlying Cause/Source of Risk: CRR reference risks; 2343, 2344, 2346. Requirement to return to financial balance in the medium term.		**Initial score** 25 (5x5)	**Current score** 5 (5x1)	**Target score** 5 (5x1)
Existing Controls		**Assurance of Controls**		
1. Finance and Performance committee 2. Divisional performance reviews 3. Audit arrangements 4. SFOs SFIs & SOD 5. Policies and procedures 6. Financial and accounting systems 7. Counter Fraud plan 8. Purchasing and Supplies Strategy & Policies 9. Financial Assurance correspondence with NHSE/I (monthly) 10. HCP Finance Director meetings 11. Progress in agreeing a system break- even plan for Year 1 (2020-21)		• Monthly report to Finance and Performance committee (L1) • Finance and Performance committee Report to Board (L2) • Finance KPIs (L1) • Audit committee reports to Trust Board (L2) • Outcome of NHSE/I accountability meetings (L3) • LCFS rated Green (L3) • NHSE/I rating for Single Oversight Framework (L3) • Internal Audit (L3) • External Audit (L3)		
Gaps in Controls 1. Pay spend above plan and activity below plan 2. Agency expenditure is currently above the set target for 2020/21. 3. Non-recurrent funding is useful for the current year but does not help the underlying position				
Further Actions		**Responsible Person/s**		**Due Date**
1. Plans for 2021/22 in train		1. Bola Agboola		1. June 2021

Principle Risk 5: Failure to deliver financial stability may affect the quality of services and the future sustainability and viability of the Trust				
BAF Risk No. 5.3 Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements				
Risk Classification: Finance	**Risk Owner:** DoF	**Scrutinising Committee:** Finance & Performance		
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/03/21**			
Changes since last review:				
Underlying Cause/Source of Risk: CRR reference risks; 2345 Insufficient Capital funds to meet Trusts requirements		**Initial score** 10 (5x2)	**Current score** 15 (5x3)	**Target score** 10 (5x2)

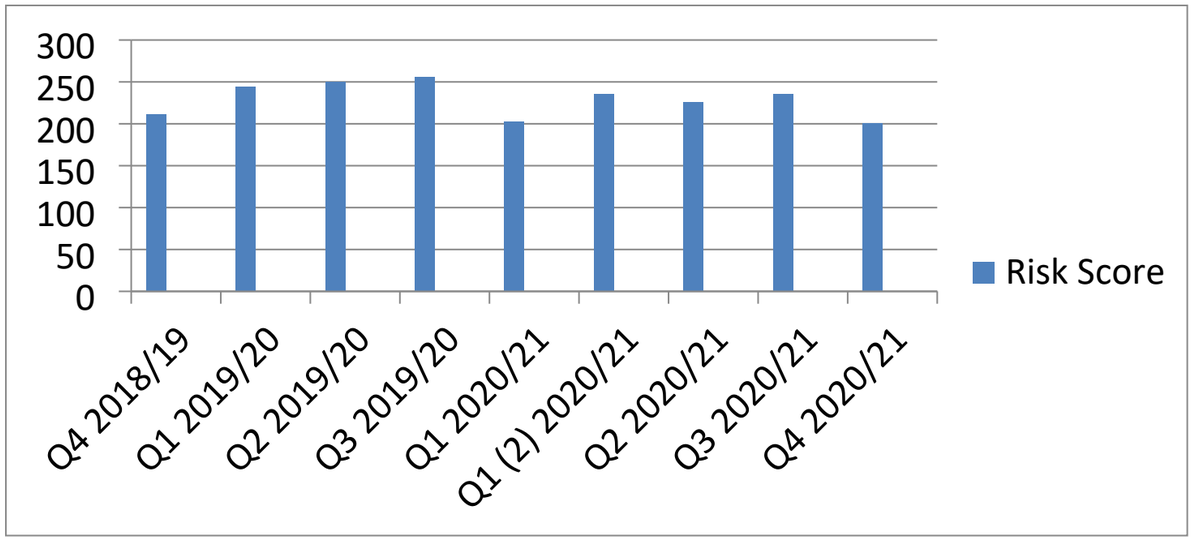
Existing Controls	**Assurance of Controls**
1. Capital Committee 2. Finance and Performance committee 3. 5 year capital plan 4. Purchasing and Supplies Strategy 5. Leasing strategy in place/ IFRS16 6. Hospital Management Team Meetings 7. Business Case process 8. New capital funding approved for the ITU Build, Paeds ED Unit	• Finance report to Finance and Performance committee • Includes progress on capital planning and expenditure plus forecast expenditure (L1) • Report to Board (L2) • Internal audit (L3) • External Audit (L3)

Gaps in Controls

1. The Trust has a large backlog maintenance programme and the estate is ageing. 2. Affordability of additional capital
3. Additional access to capital limited in infrastructure incidents. 4. Ineffective and lengthy regional and national Covid 19 related capital bids regime
4. Inconsistent data requests and treat of removing previously approved capital risking achievement of Trusts CRL.
5. Ability to fully utilise Trust's CRL for the year due to slippage

Further Actions	**Responsible Person/s**	**Due Date**
1. Escalate slippage spend via NHSI Monitoring returns and through Board and FPC 2. Bring forward any appropriate 2021/22 schemes to support CRL utilisation 3. Slippage agreed with NHSE/I to be carried forward to 2021/22	1. Bola Agboola 2. Bola Agboola 3. Bola Agboola	1. Completed 2. Completed 3. Ongoing

Movements on Board Assurance Framework (since previous report)	
ADDITIONS	None
INCREASES	None
DECREASES	1.4 decreased from 15 to 10 due to reduction in gaps in control
	1.9 decreased from 15 to 10 due to a reduction in gaps in control
	1.10 decreased from 20 to 15 due to a reduction in gaps in control and progress made
	3.1 decreased from 15 to 10 due to a reduction in gaps in control
	5.1 decreased from 15 to 5 due to delivery of financial plan
	5.3 decreased from 20 to 15 due to carry forward of slippage
CLOSURES/ AMALGAMATED	None



Graph shows risk score of 201 for 16 Risks

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

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

BAF risks in order of severity:

1.7	Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failures	20
1.8	Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust	20
1.2	Risk of failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties	16
1.1	Risk of failure to meet regulators minimum fundamental standards	15
1.10	Risk of the Trust being unable to deliver a recovery plan post covid-19 with consequential impact on patient and staff safety, patient experience and staff wellbeing	15
5.3	Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements	15
3.3	Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optional culture	15
3.2	Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future	12
4.1	Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire Health and Care Partnership (Northamptonshire's Sustainability and Transformation programme) will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access.	12
1.6	Inability to recruit adequate numbers of nursing staff	10
1.9	The risk of the Trust being unable to deliver an appropriate response to Covid 19 in terms of quality of care, capacity and timeliness with consequential impact on patient and staff safety, patient experience and staff wellbeing.	10
1.4	Risk of avoidable harm to patients and the associated loss of public confidence	10
3.1	Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future	10
1.5	Risk that Trust fails to deliver high quality services in all clinical areas 24/7	8
2.1	Risk that the Trust fails to promote a culture which puts patients first	8
5.1	Risk that the Trust fails to have financial control measures in place to deliver its 2020/21 financial plan	5

Executive Leads

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

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

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**27 May 2021**

Title of the Report	**Group Risk Appetite**
Agenda item	**15**
Presenter of Report	Claire Campbell- Director of Corporate Development, Governance & Assurance
Author(s) of Report	Claire Campbell- Director of Corporate Development, Governance & Assurance

This paper is for: (delete as appropriate)

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

Executive summary

Northampton General Hospital (NGH) Trust Board reviewed the organisations Risk Appetite Framework in September 2019 and amended it to the following Risk Appetite statements:

Assessment	Description of potential effect
Zero Risk Appetite	The Trust Board aspires to avoid risks under any circumstances that may result in reputation damage, financial loss or exposure, major breakdown in services, information with no or negligible potential risk to staff /patients.
Low Risk Appetite	The Trust Board aspires to avoid (except in very exceptional circumstances) risks that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.
Moderate Risk Appetite	The Trust Board is willing to accept some risks in certain circumstances that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.
High Risk Appetite	The Trust Board is willing to accept risks that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.
Very High Risk Appetite	The Trust Board accepts risks that are likely to result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential serious risk of injury to staff / patients.

The definition for Zero risk has been amended from the original statement to add “With no or negligible potential risk to staff /patients” as requested by Board members.

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

Work is in progress to develop and agree group risks to ensure alignment to the Board approved group priorities and consistent use of risk management language. Alignment of both organisations Risk Appetite Statements is part of this work. Risk appetite refers to the amount of risk that Boards are prepared to accept, tolerate, or be exposed to in pursuit of its strategic objectives. The higher the appetite, the greater the autonomy that is granted to the risk owner before the threshold is crossed for escalating issues to the Boards; the lower the appetite the greater the control that the Boards will wish to exercise over its management.

At the joint NGH and KGH Board Development session in April 2021, the Risk Appetite for each organisation was presented and the agreed outcome was then presented to the Collaboration Programme Committee for approval earlier this month. This is now presented to the Trust Board for ratification as follows:

Group Priority	**Risk Appetite**
Patient	Low
Quality	Low
Systems & Partnerships	High
Sustainability	High
People	Moderate

Related Group Priority	Which Group Priority does this paper relate to? 1. Patient: Excellent patient experience shaped by the patient voice 2. Quality: Outstanding quality healthcare underpinned by continuous, patient-centred improvement and innovation 3. System & Partnerships: Seamless, timely pathways for all people's health needs, together with our partners 4. Sustainability: A resilient and creative university teaching hospital Group, embracing every opportunity to improve care 5. People: An inclusive place to work where people are empowered to be the difference
Risk and assurance	Supports the risk management process.
Related Board Assurance Framework entries	All
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Financial Implications	None
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper - None

Actions required by the Board

The Board is asked to:

- Approve the amended Group Risk Appetite Statements.