UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 28 January 2021

09:30

Via ZOOM
Northampton General Hospital

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 28 January 2021
09:30 via ZOOM at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr A Burns	**Verbal.**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal.**
	3.	Minutes of meeting 26 November 2020	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Patient Vlog (Cancer)	Receive	Ms S Oke	**Verbal.**
	6.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	7.	Group Chief Executive's Report	Receive	Mr S Weldon	**C.**
	8.	Hospital Chief Executive's Report	Receive	Mrs D Needham	**D.**
PERFORMANCE					
	9.	Integrated Performance Report	Assurance	Mr C Holland Board Members	**E.**
	10.	Reset and Recovery Phase 3	Assurance	Mr C Holland	**F.**
	11.	Ockenden Report	Assurance	Ms S Oke	**G.**
	12.	COVID19 Vaccination Update	Assurance	Mr M Metcalfe	**H.**
GOVERNANCE					
	13.	Freedom to Speak Up Bi-Annual Report	Assurance	Ms C Campbell	**I.**
	14.	Board Assurance Framework	Assurance	Ms C Campbell	**J.**

Time	Agenda Item		Action	Presented by	Enclosure
	15.	Joint People Committee Terms of Reference	Approval	Ms C Campbell	**K.**
	16.	Emergency Preparedness Annual Report	Assurance	Mr C Holland	**L.**
STRATEGY & CULTURE					
	17.	Strategic Cancer Plan	Assurance	Mr M Metcalfe	**M.**
	18.	Dedicated to Excellence: Group Strategic Direction 21/22 – 23/24	Approval	Mr S Weldon	**N.**
CLOSING ITEMS					
	19.	Questions from the Public (Received in Advance)	Information	Mr A Burns	**Verbal.**
11:50	**20.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on 25 March 2021 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

Minutes of the Public Trust Board

Thursday 26 November 2020
09:30 by ZOOM teleconference

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

TB 20/21 047 Introductions and Apologies

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

Mr Burns advised that Ms A Gill had given her apologies. He welcomed Mr A Callow as Group CDIO.

Mr Burns commented that this was Mr Bradley's last Trust Board as he would be moving on secondment to a regional role. His deputy Ms B Agboola would be acting up.

Mr Burns stated that Prof K Harris was attending from the University of Leicester and would be presenting **agenda item 16 - Academic Strategy.**

Ms R Bolton from NHSE/I was observing as part of her induction programme.

TB 20/21 048 Declarations of Interest

There were no declarations of interest.

TB 20/21 049 Minutes of the Public Trust Board held on 24 September 2020

The minutes of the Public Trust Board held on 24 September 2020 were

presented and **APPROVED** as a true and accurate recording of proceedings subject to the below amendments.

TB 20/21 050 Matters Arising and Action Log Public Trust Board

The Matters Arising and Action Log were considered and noted.

Action Log Item 125

Ms Oke confirmed that the required action to set up a Task & Finish Group had been completed. The BAF action plan had been developed. It was monitored through ISPG and reported up to QGC.

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

TB 20/21 051 Patient & Staff Vlogs

Ms Oke introduced the staff vlog.

Ms Oke advised that the staff vlog came from Ms K Jayadevan who was site manager. She needed to manage discharge safely which was becoming more difficult due to COVID19.

The staff vlog was shared on screen.

Ms Jayadevan worked with the clinical site team as clinical site manager. She started in February 2020. Her primary role was to ensure patient safety was achieved. She had to balance both the emergency and elective demand. She was also the bridge between clinical and operational teams.

Ms Jayadevan worked with nurses, medics and MDTs. She worked alongside many different teams.

Ms Jayadevan noted that this was a challenging job which added to this year was dealing with the pandemic. She had to make sure the patient was in the right place at the right time and this came with a lot of responsibility. There was the added pressure in winter due to A&E attendance and respiratory patients coming in. The Trust needed to maintain flow to make sure it functioned. The most important part of her job was ensuring plans were in place and that was the core of her job.

Ms Jayadevan had learned that you need to act as actions change things. She was hopeful that going forward the Trust continued to maintain the standard of care. She remarked that all hospital staffs core of work was patient safety and the quality of their care.

Ms Jayadevan stressed the need to look after staff and their needs. This included being kind, honest and to display authenticity in their actions. It was really important look after each other and make sure have standards in these challenging times. The staff needed to look after themselves. The health and wellbeing of staff was critical to perform well in your job. This is crucial and asked staff to be open when talking to colleagues if you have problem.

Mr Burns remarked that supporting the staff was essential as this impact on patient care. The hospital had done a lot to provide support and he referred to the SoS Team who had won an award.

Mr Weldon commented that this was a brilliant staff vlog. When he started working in a hospital he visited the site team. He explained that spending time with the site he had learnt a great deal and gained an understanding how they responded to situations. He encouraged the Board to spend time with site team

once out of pandemic.

Mr Weldon stated that Ms Jayadevan was a great advocate for the People Plan. The site team see the health and wellbeing of staff and are often the best barometer of the emotional wellbeing of a hospital. He thanked her as she displayed what a site team can and should be.

Mr Smith had shared at the People Committee a Health and Wellbeing update. He would circulate to all Board members to see the full package of support offered to staff.
Action: Mr Smith

Mrs Needham thanked Ms Jayadevan for her vlog. Mrs Needham had been a site manager and noted that it was a difficult job. The site team did a fantastic job every day and she thanked Ms Jayadevan for openness in the vlog.

Mr Holland spent a large of time with the site team. He remarked that the appointment of Ms Jayadevan had been positive. She showed great professionalism and did an outstanding job.

Mr Burns thanked Ms Jayadevan for sharing her story.

The Board **NOTED** the Patient Vlog.

TB 20/21 052 Chairman's Report

Mr Burns presented the Chairman's Report.

Mr Burns noted the ongoing COVID19 pressures however there was now a light at end of tunnel. He remarked that NGH had a role in the county of the distribution of these. It was crucial to provide a level of vaccination across the county.

Mr Burns commented that at 11:00 areas of England would be told what tier they were placed in which would have an impact on wellbeing.

Mr Burns advised that the interview for the hospital CEO post was scheduled for week beginning 14 December. He had been told by the recruitment panel that the candidates made up excellent field and that there had been lot of interest in the posts due to the development of group model.

Mr Burns stated that there was an ICS away day in December and an update would be given at the January 2021 Trust Board.

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

TB 20/21 053 Group Chief Executive's Report

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

Mr Weldon advised that the Healthcare Partnership part of his report talked about the group mission vision and values. He had taken the engagement work to the HCP last week and it had been well received. There had been a large number of comments about how the group should be and what look the HCP looked forward to about a group. Mr Weldon remarked that the workshop was important and it set up a governance discussion and important questions as to what the ICS would be used for. He believed that it should be about helping create better care for residents of the county over a longer term and how to best address priorities in health care. Mr Weldon welcomed their offer to help shape the mission vision values.

Mr Weldon stated that during the pandemic the staff had been phenomenal. The second wave was harder and many staff were spinning 3 plates. This was managing COVID19, the elective recovery from the first wave and dealing with the rise of winter pressures.

Mr Weldon commented that the Trust was the lead in the implementation of the vaccine. Mr Pallot was taking the lead role in this. He has stepped up and would take a leadership role across the county. The Trust would be at the heart and centre of the vaccination effort. There would be many colleagues involved across the group.

Mr Weldon thanked Mr Bradley for his contribution. He noted that Directors of Finance are responsible for keeping safe organisations safe and recognised Mr Bradley's role in this. Without Mr Bradley's work the Trust would not be contemplating the new ITU, the Trust would not be opening a Childrens ED and would not be opening a new front entrance. He had helped the Trust navigate these tricky issues.

Mr Weldon noted the quality of person who was stepping into the role. He welcomed Ms Agboola and had every confidence in her. He knew she would play an important part in all discussions.

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

TB 20/21 054 Hospital Chief Executive's Report

Mrs Needham presented the Hospital Chief Executive's Report.

Mrs Needham highlighted the key points as the Trust approached winter. She noted the importance of thanking staff. Their unwavering support and hard work in caring for patients. It was a strange time for the NHS.

Mrs Needham stated that people reacted differently to the pressure of the pandemic and this presented challenges. She stated that Health & Wellbeing of staff was at the forefront of our actions. It was very important look after self and each other. He report highlighted what support was offered.

Mrs Needham commented that special days had celebrated recently and these were listed on page 29 of the report pack. She referred to the Best Possible Care Awards which had been done virtually. The staff had felt proud to have been nominated. She shared a special thank you to all the events planned and these would continue.

Mrs Needham discussed COVID19 with the Board. There had been an increase numbers and there was currently 90 patients admitted with a positive COVID19 result. She advised that despite the hospital being busy the Trust had continued with the Phase 3 activity and had also supported other hospitals who were near critical capacity. The Trust had to postpone some routine in outpatient work and she was sorry for the patients who had their treatment postponed. Her main priority above all else was safety.

Mrs Needham reported that there had been a reduction in patient waits over 60 days on a cancer pathway. She had been pleased with this decrease and there was continued focus on this target. Mrs Needham thanked the teams for their hard work.

Mrs Needham highlighted the importance of remembrance street as the Trust turned hospital street into a walkway of poppies. This was a team effort and had

included the involvement of local children.

Mrs Needham shared her excitement on the estates developments detailed in the report. The Trust was making good progress with three largest estate projects.

Mr Burns was concerned at the 50% rise of COVID19 positive patients in a week. This was significant as come to end of lockdown.

Prof Robinson informed the Board that at Quality Governance Committee the flu vaccine had been discussed. It was noted that historically the Trust got a good staff uptake. The uptake at current was 57% and there were actions in place to take to ensure that the Trust got to the usual level. Mrs Needham reminded staff on the importance of having the flu vaccine to both protect their self and patients. The next step was for vaccinators go out to areas to vaccinate staff who had not yet been for their vaccination. The Trust could now see an increase in compliance due to this.

Mr Burns advised that it was a requirement to have the flu vaccination ahead of COVID19 vaccination.

Mr Archard-Jones asked whether staff working from home had impacted on the vaccination numbers. Mrs Needham clarified that staff can still come on to site for their flu vaccination.

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

TB 20/21 055 Integrated Performance Report

Mrs Needham presented the Integrated Performance Report. The performance elements would be discussed within this report and the activity under the reset report.

Mrs Needham discussed the progress against the performance target. She was concerned in regards to the 52 week position as recovery was not happening as planned. There were patients which had come on treatment list which were not originally account for. This had continued to grow but was now seeing a decrease. Mrs Needham would be seeking external views of the Trust's treatment list and process.

Mrs Needham was worried about staff sickness absence and as the Trust goes into difficult winter she expected this to rise. This decreased ability to increase the Trust's internal capacity. This would become a challenge as the Trust progressed in to winter.

Mrs Needham noted that ways of working in the NHS were different now. The NHS not had to work in pandemic before. The routine activity was slow to restart and patients were scared to attend their appointments.

Mr Holland delivered an operational update to the Board.

Mr Holland advised that A&E performance was 78.3% in October. This was 5% higher than last year despite COVID19. The emergency activity had started to climb with 11,793 patient attendances last month which is lower than this time last year however admissions are at 97%. Mr Holland stated that acuity was higher and the Trust had to admit more patients.

Mr Holland commented that ambulance arrivals had continued to climb to 2821 arrivals in October. There was a national focus on ambulance handover times to ensure the crews are back on the road as soon as possible. He was pleased to

report that the Trust remained one of the best for handover times which was noted by NHSEI this week.

Mr Holland remarked that the 4hour performance was not performing as well as he would like. He noted that the Trust was working differently to last year. The Trust was testing every patient for COVID19 and this was being done 24/7. A patient was not move to a base ward until the results had been received. This added delays to the process. This builds in safety to patient admitted and fellow patients.

Mr Holland advised that 111 was now live and patients were being booked in to in SDEC. In December SDEC and Frailty units would move into a purpose built area closer to ED.

Mr Holland commented that bed occupancy was at 94% and 2 wards closed. The Stranded and Super Stranded patient numbers had risen. There was a piece of work being done as part of discharge programme and a winter task force in place to address this. Mr Holland was the Executive lead for iCan and would incorporate early wins from this programme.

Mr Holland reported that Cancer performance had improved. There had been good progress in improving services. He noted that the activity within the report related to September. He confirmed that in November the Trust was meeting the 2ww cancer target, and 28 day faster diagnosis target. The number of patients waiting in excess of 104 days was now reporting 8 versus 69 in July.

Mr Holland stated that elective care RTT median wait for October was 9.5 weeks, a reduction from median wait of 16.5 weeks in June.

Mr Holland informed the Board that there had been an external review of the PTL meetings by the national elective care team. The Trust was 2nd out of all acute hospitals for the validation of that PTL, 16th for data quality and scored lower for capacity.

Mr Holland advised that in regards to 52 weeks the Trust had reported 654 in October against the 124 forecast. He had found this disappointing. It had been compounded by losing theatres to ITU pods, of which 2 pods were open currently. There had been a fall in 52 week patients and yesterday this had reported at 502.

Mr Holland commented that diagnostics continued to improve and he expected performance to be in the 80's% shortly. He noted that most diagnostics were working at greater than 100%.

Mr Archard-Jones asked what had been done to increase capacity in Endoscopy. Mr Holland explained that the Endoscopy hoped to get their two theatres back. The speciality was looking at having a vanguard mobile unit and discussions with Three Shires.

Mr Archard-Jones noted that 2 wards were closed however may need to be opened. He asked how these wards would be staffed. Ms Oke stressed that maintaining patient safety was the key priority. A central staff hub for nurses coordinates this.

Mr Finn advised that two theatres were closed due to ventilation needing to meet new guidance regarding COVID19. He hoped that the new system would be in place by year end.

Mr Moore referred to mention of Three shires. At the Finance & Performance

Committee there had been concern raised around Three Shires. The risk to performance delivery of patient care if the Trust was to lose access to Three Shires. The Board needed to be clear on level of impact and when it would lose access to the Three Shires. Mr Weldon remarked that there was discussion ongoing to help get to place where NHS could assess to volume of work needed to be done in private sector.

Ms Parker referred to Cancer waiting times. The figures appeared good and showed a reduction from July. She noted that a number people are put of going to GP at current and she queried whether the Trust expected these numbers to increase. She also asked if the Trust maintained contact with the patients on the waiting list. Mrs Needham clarified that GP referrals had started to come back in and these were at the same as last year. The Trust was now achieving the 2ww. There was a clinical nurse specialist who kept in regular contact with the patients.

Ms Houghton commented that this was positive to have good news and progress. She was pleased to hear that the Trust was in contact with patients on the PTL list. She was concerned that patients may not want to visit the Trust and queried whether there was a clinical eye on them to ensure patients were seen in the correct priority. Mr Holland explained that for patients on 62 days all had a harm review completed to assess their condition. There had been a big increase in requests from GP's via consultant connect about the disease process.

Mr Weldon remarked that the Board needed to be strategically focused. He had spoken to the Cancer lead. He would like to invite the Cancer lead to present the Cancer strategy for the organisation. Mr Weldon believed that the Board would benefit from hearing from the lead clinician for Cancer. Prof Robinson advised that the Cancer lead had delivered a presentation to the Quality Governance Committee. This was an excellent presentation as it addressed what was being done now and it had planned looking forward. .

Mr Burns noted that it was pleasing to see that the numbers for Cancer had improved. He asked the Board to think about what can be done within the group on Cancer. He was happy for the Cancer lead to deliver a presentation to the Public Trust Board. Mr Burns had requested that the Clinical three leads are to arrange a running order to deliver an update to the Board on their plans for the future, their successes and their difficulties.

Prof Robinson concurred and that the Board must take the benefits offered by the group model.

Mr Bradley delivered a finance update to the Board.

Mr Bradley commented that in October, as part of a system plan, the Trust submitted a £7m deficit plan for M7-M12. This was the financial response to the September reset activity plan based on R=1 and the reintroduction of OP and elective activity. The system plan had not formally been signed off by the Regional team but the Trust did know the Northants system was not being called in to further regional discussions as have other systems.

Mr Bradley stated that the plan for the Northamptonshire system had not yet officially been signed of.

Mr Bradley reported that for October the Trust had projected a £500k deficit, the actual position was £300k deficit so a positive position by £200k.

Mr Bradley delivered a brief update on capital. In the last month the Trust had received the official documentation confirming the funding for both the ITU and

Emergency Electrical works. He advised that the biggest risk to the capital programme was to the ITU project. The delays caused by finding asbestos buried below ground could potentially move up to £3.5m of spend into 2021/22. At this time this had yet to be confirmed but in discussions with the Regional team the Trust had been informed that this capital allocation cannot be carried forward into the new financial year. This will cause a major impact on the 2021/22 capital plan if agreement was not reached to carry forward the unspent allocation. The capital team and Mr Finn was aware.

Mr Moore remarked that the Trust was moving away from the pre-COVID19 deficit and this was good. As the Trust moved out of winter, the focus will be more on expenses. The Trust was running at same price as pre-COVID19 however only at 65% activity.

Mr Smith presented the People update to the Committee.

Mr Smith highlighted the noted reduction in vacancy rate which had been supported by the arrival of oversea nurses. There had been work done with the international nurses across the county on both supporting them and how they can continue to develop once they are with us.

Mr Smith advised that absence figures had increased. There had been an increase in COVID19 absence and absence due to self-isolation. This was managed by the daily huddle.

Mr Smith commented that training figures had dropped. He had worked with colleagues on how to best undertake training in most time efficient way. The team had developed a new appraisal light process.

Mr Smith stated that in regards to health and wellbeing it was important to check in on colleagues and ask how they are.

Mr Smith delivered an update on the staff survey. The return rate for last year was 40%. This year it was at 48% against a target of 50%.

Mr Smith reported that the People Plan was on track for end of January 2021 approval.

Mr Smith discussed the shadow joint People committee and the NGH committee, which had happened in November. It was noted that both had appreciated the flu vaccination, COVID19 testing and lateral throat swabbing updates as well as the plan to roll out the COVID19 vaccination. The Committees had also noted the great work done by the Health and Wellbeing programme as staff continued to come under significant pressure.

Ms Parker remarked that the vacancy rate reduction was excellent and she asked how this had happened in addition to how the Trust compared other hospitals. Mr Smith explained that the oversea nurses was the biggest driver as was the continuation of low turnover rates. The Trust compared very well against other organisations and the ambition was to have the same impact on medical staff and HCAs.

Ms Parker queried that if took oversea nurses were removed would the Trust still track well. Mr Smith confirmed that it would as turnover at NGH was normally good.

Ms Houghton referred to training as at the Quality Governance Committee levels of training in regards to PPE had been discussed. It had been explained how long

training figures could take to input and data shared was not real time. She asked whether there was any way to speed up process. Mr Smith confirmed that the Trust needed to look into for real time reporting.

Ms Oke referred back to the nursing vacancy rate. She noted that Pathway to Excellence gave the Trust a special culture. It makes nurses want to stay and international nurses want to work at the Trust.

Ms Oke delivered the Director of Nursing update.

Ms Oke advised that the complaints process had been reinstated and all complaints in August had been responded to.

Ms Oke discussed the COVID19 response. The IPC team had worked extremely hard during pandemic. In regards to outbreaks there had been daily meetings. The IPC BAF noted the progress made and drew attention to PPE training.

Prof Robinson confirmed that the IPC BAF had undergone a detailed discussion at QGC. It had highlighted concerns with cleaning and PPE training. It was important for the Board to note that when PPE was not adhered, it was called out. There was close attention on this.

Mr Metcalfe presented the Medical Director Update.

Mr Metcalfe stated that he wished to highlight two items to the Board.

Mr Metcalfe advised that his team had begun the implementation of eRoster for medical staff. This would help improve the experience for Junior Doctors and their work life balance.

Mr Metcalfe confirmed to the Trust Board that an agreed way forward for the reintroduction of e-prescribe. This would improve medicine safety as well as deliver step change in VTE and profalyaxis.

Prof Robinson reported that maternity had been a focus of QGC. The Committee had noted the progress in respect to the maternity incentive scheme. The second item to highlight to the Board was the HSE visit which had happened due to a concern earlier in the year. The HSE were satisfied with progress.

Ms Houghton expanded on the maternity incentive scheme. If the Trust achieved the ten standards it received a 10% reduction on premium. This was a very tough thing to achieve and NGH was the only Trust to achieve in the region last year. Ms Houghton highlighted the risk that the Trust may not achieve this year. There may be a risk to our premium cost and a plan was in place.

Ms Parker shared a CPC update with the Board.

Ms Parker advised that there had been a Clinical Collaboration update and progress had been made in breast, head and neck and oncology. These had been impacted by the 2nd wave of COVID19. The CPC had also discussed patient engagement in planning activities. There was to be a fuller update on the mission, vison and values at the December CPC.

Ms Parker stated that each of the Committees went through how each were progressing in regards to the Committees in Common.

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

TB 20/21 056 Reset and Recovery Phase 3

Mr Holland presented the Reset and Recovery Phase 3.

Mr Holland advised that the report showed NGH activity against the Phase 3 plan. The model was based on September to March 2020, with the R=1.

Mr Holland stated that the October referrals were slightly below expected; this meant less patients on the waiting list. There had been over performance in virtual clinics and this was three times what had been predicted.

Mr Holland commented the theatres were performing below the model. There had been a loss in the use of theatres and also the addition of ITU pods. He noted that Endoscopy had been challenged and hoped to use Dantre in the new year. Mr Holland reported that ED was below model levels.

Mr Moore remarked that it was good news to see outpatient video and telephone appointments to be running well. This should continue into the future.

The Board **NOTED** the Reset and Recovery Phase 3.

TB 20/21 057 Winter Plan

Mr Holland presented winter plan.

Mr Holland shared his screen which displayed the Winter Plan presentation included within the report pack.

Mr Burns commented that there was a lot more unpredictably in the plan due to the level of uncertainty.

Mrs Needham apologised that that it was being presented later than usual to the Trust Board. It was to ensure that it was joined up across the system.

The Board **NOTED** the Winter Plan.

TB 20/21 058 Terms of Reference for Joint Committees – Quality & Digital

Ms Campbell presented the Terms of Reference for the Joint Committees of Quality and Digital.

Ms Campbell advised that the joint committees to supported joint working using the Committees in common process.

Ms Campbell stated that both Terms of Reference had been to CPC who had agreed. The Terms of Reference are to be iterative. These were the first iteration and could be further developed in the future.

<u>Quality ToR</u>

Ms Houghton referred to page 92 of the report pack and section on frequency. It stated that the CiC would be scheduled to meet on the same day however this should read as bimonthly. Ms Campbell would make this amendment.

The Board **APPROVED** the Joint Quality Committee ToR.

<u>Digital ToR</u>

Ms Campbell advised that NGH did not have a Digital Committee prior to this however once had been set up at KGH. The proposal to Chair the Committee was the Chair of the KGH Digital Committee.

Ms Campbell thanked to Mr A Callow for his quick turn round of the ToR to CPC.

The Board **APPROVED** the Joint Digital Committee ToR.

Mr Burns was conscious of demands on being placed on the Non-Executive Directors. The Board needed think about support and how get consistency between the joint Committees over a period of time.

Ms Campbell advised that she and Mr Apps had discussed about how to best support the joint Committees. This would be discussed with the relevant administration support.

The Board **APPROVED** the Terms of Reference for Joint Committees – Quality & Digital.

TB 20/21 059 Terms of Reference – Audit Committee

Ms Campbell presented the Terms of Reference for the Audit Committee as per its Annual review and the Board beings the parent Committee for Audit.

The Board **APPROVED** the Terms of Reference – Audit Committee.

TB 20/21 060 Board Assurance Framework

Ms Campbell presented the Board Assurance Framework (BAF).

Ms Campbell advised that she would take the report as read. She reported that there had been changes proposed to that of the timeframe for the target date. It had been agreed that this would be in line with the date of the next full review of the BAF i.e. annually.

Ms Campbell reported that the target scores had been amended. These were for BAF 1.1 and 1.8 which were owned by the People Committee.

Ms Campbell referred to BAF 1.6 on page 112 of the report pack which had a reduced score. The score was now at target level. It was noted that risk 1.10 which related to the recovery plan post-COVID19 had decreased from 20 to 15 due to mitigations in place at time.

Ms Campbell informed the Board that the risk score had decreased overall in this quarter from 236 for 16 risks to 226 for 16 risks.

Mr Weldon commented that draft planning guidance had been released in December which would mean that all committees of the board were to revisit their risk. There may be some added and some removed. Mr Weldon stated that the Board should have a forward facing look as the guidance comes out and bring the BAF back detailing the risks that the board may be thinking about next year. The BAF needed to be looked at in a strategic way.

Ms Houghton noted that the board to ward this year could not happen and asked how this would be managed next year. Ms Oke would like to evaluate how the drop in visit to maternity goes and possibly use this as the model moving forward. Mr Burns remarked that these are likely to be reinstated in April.

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

TB 20/21 061 Fire Plan

Mr Finn presented operational fire plan 2020-2025.

Mr Finn advised that the plan could be flexed as operational issues arise. The plan was managed by fire technical group. There were also regular updates in the estates compliance report to the Finance & Performance Committee.

Mr Finn stated that all fire risk assessments were in place and fire drills were also in place across site.

Mr Finn informed the Board that last week a fire safety audit from TIAA had given reasonable assurance.

Mr Finn advised that on 8 November there had been a fire on ITU. He thanked all staff involved in the evacuation and it had gone well.

Mr Burns remarked that the programme of work needed to be adhered to.

Ms Kirkham commented that fire training had been mentioned at the People Committee and this needed a focus. Mr Finn confirmed that there was a continued focus on fire training and compliance was at 82%.

Mr Moore stated that there had been two recent fire call outs and asked whether there was any association between two. He was informed that there was not.

The Board **NOTED** the Fire Plan.

TB 20/21 062 Academic Strategy

Mr Metcalfe introduced Prof K Harris to the Trust Board

Mr Metcalfe advised to take the strategic document as read and to acknowledge work done across group. The same paper was going to KGH and the strategy document had been approved by Quality Governance Committee.

Mr Metcalfe commented that the Trust wanted to acquire University teach status. By achieving this there would be improved access study participation, improved clinical outcomes, enhanced opportunities for staff, improved staff retention and the potential to build a strong brand. The clinical teams at both hospitals were keen to progress.

Mr Metcalfe had recruited an Associate Director to work across group. They were pulling together detailed work programme.

Prof Harris remarked that the synergy would improve patient care, benefit research, enhance education for staff and would promote staff development. He commented that the University of Leicester was excited

Prof Harris stated that the strong associations the University had with the two Trust's enabled them to develop this model. He paid great tribute to the number of people who had worked behind scenes on this on a remarkably short period of time

Mr Weldon thanked Prof Harris for his presentation and echoed what had been said. He referred to how the group can help progress key work programmes and this was the first big thing to have been achieved by the group. This was strategically important and was a big investment in the future. He also thanked Prof Robinson for his support.

Prof Robinson concurred that Prof Harris had articulated the strategy well. It was important professional groupings take the academic strategy further and it would benefit all staff groups. He believed these to be exciting times.

Mrs Needham agreed and thanked Prof Harris. This would also benefit the

patients and was well supported by the Trust.

Mr Moore remarked that the timeline was great with the completion month of September 2021. He asked were there any risks to meeting that. Mr Metcalfe explained that all risks were mitigated by the commitment and investment the group was making. He had a high level of confidence during the next calendar year and working with the academic partners the group would be able to achieve is.

Ms Kirkham noted that all actions with the strategy puts the Trust into a great position for both staff and patients,

Ms Oke thanked the team for how the nurses and midwives had also become part of strategy.

Prof Harris referred back to the discussion on the timeline and believed that all risks could be mitigated.

The Board **NOTED** the Academic Strategy.

TB 20/21 063 Pathway to Excellence

Ms Oke presented the Pathway to Excellence.

A presentation was shared with the Board which was also included in the report pack.

Mr Burns thanked Ms Oke for the presentation and hoped that the Trust continued to hold the Pathway to Excellence in the future years.

Mr Weldon remarked that this was a fantastic achievement and needed to be built on. He referred to the shared decision making council. There was a need to give people more empowerment and given them local control. This was a mechanism that needed to be supported.

There was a discussion on virtual ward visits to be shared in December. This was a good way to connect back to the front line. If cannot be present staff can still be at heart of debates.

The Board **NOTED** the Pathway to Excellence.

TB 20/21 064 Integrated Care System

Mr Weldon presented the Integrated Care System report.

Mr Weldon commented that the discussion was active. Mr Burns and Mr Weldon were Trust representatives at meeting and put forward their view. The meeting reminded you that this was happening and the group had to be active and participating.

Mr Weldon advised that there was a workshop in December. This workshop would look at the practical side and the forward look. .

Mr Weldon encouraged everyone to go and look at PHE website. There was finger print data that set out the public indices for area and it allowed comparisons with other area. He remarked this was powerful reading. He noted the importance on thinking about the future and what the challenges were. Mr Weldon believed that some were not a surprise and however some were interesting to reflect on. Mr Weldon stated that the Trust had a commitment to shared system working and would appear at every board. He asked for the Boards support and endorsement

of this as it progresses.

Mr Burns had requested NED input. Mr Pallot has asked for the two co-chairs of the CPC board and Mr Burns has asked Mrs Kirkham. There would be an update at the January 2021 Public Trust Board.

Mr Burns remarked that it was positive to see the county looking at solving problems together which could not be solved as individual organisations for 20 years.

The Board **NOTED** the Integrated Care System.

TB 20/21 065 Questions from the Public (Received in Advance)

There were no questions received in advance from the Public.

TB 20/21 066 Any Other Business

Mr Burns again extended his thanks to Mr Bradley and welcomed Mrs Agboola to acting Director of Finance.

There was no other business to discuss.

Date of next meeting: Public Trust Board - Thursday 28 January 2021 at 09:30 in the Board Room at Northampton General Hospital.

Public Trust Board Action Log **Last update** **19/01/2021**

Item No	Month of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Updates
Actions - Slippage								
Actions - Current meeting								
126	Nov-20	TB 20/21 051	Health & Wellbeing	Mr Smith had shared at the People Committee a Health and Wellbeing update. He would circulate to all Board members to see the full package of support offered to staff.	Mr Smith	Jan-21	On Agenda	**Confirmation given that completed**
Actions - Future meetings								
124	Jul-20	TB 20/21 025	Equality, Diversity and Inclusion – BAME Staff Support	The Board requested a further update in 6 months	Mr Smith	Mar-21	On Track	

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

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

This paper is for: (delete as appropriate)

√ Note

Since the Boards last met, our hospitals have had to face the second peak of the Covid pandemic. It is right that we reflect on that in our discussions; the second peak has seen double the number of inpatients compared to wave 1. And that demand has been in addition to trying to maintain elective operations as well as responding to winter pressures. However, I wanted to out say at the outset of those discussions that I know that these challenges we face are mirrored in our communities. Many families have suffered, many people have lost loved ones. On behalf of the Boards and all the staff who work here, I want again to extend my sincerest condolences to everyone who has suffered loss through this pandemic.

Covid-19 update: High demand across Northamptonshire

Covid-19 cases remain high across our community and this is reflected in the number of very poorly patients in both Northampton and Kettering General Hospitals.

Demand is challenging. As well as high numbers of Covid-19 patients, we are dealing with the expected winter pressures, which means our staff are working extremely hard to keep everyone safe.

We have expanded our critical care capacity as well as our overall bed numbers and are working with our partners in the community to increase capacity for patients who are well enough to leave our care.

We are also working with our private sector partners to continue as much urgent and elective work as possible. We have, however, had to reduce some of our non-urgent treatment.

Even with all this hard work, our hospitals are very busy, which means all of us – the whole community - need to do what we can to reduce infections.

Reduce contact with other people as much as possible and continue to follow the advice and guidance to reduce the spread of the virus, particularly:

- Wash your hands more frequently
- Wear a mask
- Maintain social distancing
- Please stick to the rules - reducing contact with other people as much as possible will keep us all safe.

Vaccination hubs at NGH and KGH

I was delighted that in December our hospitals were in the first two waves of the drive to deliver the Covid-19 vaccine. So far, thousands of people have received their initial dose of the Pfier/BioNTech vaccine at the NGH and KGH hubs.

Setting up these hubs so efficiently and effectively at such short notice is a fantastic achievement and I am really proud of the leading role many of our hospital teams are playing in the wider delivery of the vaccine through the growing number of centres across Northamptonshire.

I would urge everyone who is invited to have the vaccine to take up the offer. It is safe and it is the most effective way to protect us all from this virus and, hopefully, start our return to normal life.

Group Strategy

I am delighted that we will be presenting our first-ever joint ambitions for our newly formed hospital Group at this Board meeting. Our three-year strategic aims have been developed following extensive engagement with leaders, staff, governors, patient and carer representatives, partners, and others.

The document sets out our new vision, mission and values, as well as our core strategic priorities and programmes; and it describes how staff, patients and other stakeholders have been involved in shaping our plans for the future.

The conversations which have brought us to this point are just the beginning of many. We will share our ambitions widely, and will continue to engage others in developing and delivering our plans to achieve them.

Thank you to staff

I want to take some time to recognise the emotional and physical toll this pandemic is taking, not just on the frontline teams on wards and in critical care but across both Trusts with our domestic teams, support staff and admin teams all working incredibly hard in challenging circumstances.

During the first wave, last year, we put in place extra support measures for staff, from clinical psychological support to refuge spaces away from the wards.

We are now looking to further expand this support and I would urge all staff to seek help whenever they feel they need it.

The continuing commitment and dedication I have seen has been amazing and I would like to take this opportunity to once again put on record my thanks to you all.

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

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28 January 2021**

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

This paper is for: (delete as appropriate)

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

Executive summary

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

- **Covid-19 update – new national lockdown and launch of the Covid-19 vaccine**
- **Our staff**
- **Performance headlines**
- **Estate**
- **Other activities**
- **Leadership changes**

Related Strategic Pledge	1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a great place to work, learn and care to enable excellence through our people*

Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks
Related Board Assurance Framework entries	BAF – NA
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	NA
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper - No

Actions required by the Trust Board

The Board is asked to note this paper

Hospital Chief Executive's report

Deborah Needham
January 2021

Northampton General Hospital
NHS Trust

Contents

December/January headline

The second national lockdown presents us with renewed challenges and we continue to focus on the best care for our patients alongside giving our staff the support they need to get through these difficult times. I continue to be inspired by the compassion and dedication of everyone at NGH and I would like to thank them for everything they have done – and continue to do.

The new variant has brought with it more challenges and almost all hospitals in England are working above their normal capacity coping with Covid, winter pressures & increased staff sickness.

Health & social care colleagues have worked together across Northamptonshire to operationalise additional capacity in the community & alter some pathways of care whilst internally within NGH we have paused some routine elective operating and outpatient work to enable us to safely staff all of our ward areas

We have never before seen this kind of pressure in our NHS & I truly hope we never see it again. It is imperative now more than ever that we look after ourselves & our staff so that we can continue to look after our patients.

Deborah Needham
Hospital CEO

Covid - 19 Update

Covid continues to dominate our agenda in all that we do both at work and in our own family lives. This, and the expected winter pressures, are putting additional pressure on all hospitals and their staff

- Thankfully, just before Christmas we began delivering our first doses of the long-awaited Covid-19 vaccine in our hospit news and a major step on the road back to normality for us all

- We have delivered more than 9,500 first doses of the vaccine, focusing on the over-80s, care home staff and our own high-risk, frontline teams. NGH was one of the first 50 hubs in England (and, in fact, the world) to start giving the vaccine and are playing a key role in the team leading the county-wide roll-out programme

- As I write this paper the Northamptonshire vaccination centre is planned to be operational from 25th January 2021

* Information as of 15th January 2021

NHS
Northampton General Hospital
NHS Trust

Covid - 19 Update

- We are caring for 228 inpatients at NGH and are operating at 96% bed occupancy – at the height of the first wave we had 131 positive patients and bed occupancy of 45%
- We have now cared for 1,537 Covid positive inpatients since the pandemic began
- To support IPC, each day we continue to have between 700-800 staff working from home
- We have 162 staff self isolating with 51 diagnosed Covid positive *
- We have doubled our ITU capacity to help us treat our most seriously ill patients
- To maintain as much elective work as possible we are expanding our capacity by working with our private sector partners (Three Shires and Woodlands)
- Community beds are now being used for our subacute patients – those that are well enough to no longer need acute care in a hospital setting

* Information as of 21st January 2021

NHS
Northampton General Hospital
NHS Trust

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

On top of national and local help our in-house support continues to play an important role in keeping us all safe, including:

- Psychology support service, offering psychological therapy, consultancy & training for teams & departments
- Team NGH Occupational Health Service
- SoS team: Confidential peer support following incidents
- Organisational development: Round-table events and training
- Health and wellbeing: Lifestyle support, mental health first aid and awareness training and EAP service
- Chaplaincy team: A listening ear to all at Team NGH – a confidential and a non-judgemental space for all staff
- Launched a series of briefings focusing on staff wellbeing to help reduce risk of exhaustion, feelings of responsibility, distress anxiety and fear
- Continued our Big thank You with a “Blue Monday” free prize draw for all staff
- Recognising the importance of clear and timely communications, we launched NGH Covid briefing Live – online sessions with senior staff giving Team NGH the very latest updates and operational changes and taking questions from staff

Covid - 19 Update

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

- Activity for December against the plan:
  - GP referrals – 96%
  - Outpatients – 96%
  - A&E attendees – 71%
  - Non elective inpatient – 87%
  - Day case – 98%
  - Elective inpatient – 137%
  - Diagnostic tests* – 95%

* Average of all modalities

NHS
Northampton General Hospital
NHS Trust

Performance headlines

- Cancer 62 day performance – continues to improve & plan to deliver for January 2021
- Cancer performance – 2ww, 31d, 28 day faster diagnosis all achieving target in the reporting month
- We have 48 patients* waiting over 62 days of which 8 have waited over 104 days
- RTT average wait has remained stable at 9.5 weeks in November with diagnostic performance increasing to 77%
- 65.7% of our patients were seen, treated and discharged/admitted from A&E within 4hrs in December (3% lower than December 2019)
- Our finance position for December is better than plan with a slight increase in temporary staffing spend
- Our overall vacancy continues to decrease and for December is 6%, sickness absence has however increased

* Information as of 21st January 2021

NHS
Northampton General Hospital
NHS Trust

Our estate

We continue to make good progress with our estate developments

- Children's AE – £2.9m building work continues with new unit being fitted out and existing building being refurbished. Expected to be complete by the end of March.

NHS
Northampton General Hospital
NHS Trust

Our estate

Good progress with our estate developments

Our new main entrance is due for handover in June 2021. It will include:

- Significantly improved facilities and retail outlets for staff, patients and visitors
- New main reception and PALS office
- Building modules due to be delivered end of March with handover expected in June 2021.

Our new £1.8m ITU/HDU continues and is due to be completed by July

- Building modules will be installed by the end of March with handover by August
- Additional rooms for Radiology, extra eight-bedded level 1 ward area, improved offices and training facilities for ITU.

PLUS we are investing £7m in our electrical infrastructure, due for completion in March

Other activities

During the last 2 months we have also:

- Launched our Winter Taskforce – dedicated to getting patients back home as soon as they are medically fit enough to leave
- Held two successful MADE events (Multi-Agency Discharge Events) – virtual sessions to support staff working to get our longest stay patients home as soon as possible
- Lateral flow testing (swab testing) has been rolled out to patient-facing staff
- As part of drive to promote IPC, continued with our #CleaningForConfidence campaign and launched #MaskingForAFriend to promote correct use of PPE
- Continued to keep our staff updated with twice weekly bulletins, vlogs & blogs
- Stepped up our virtual visiting and letters service for patients and deliveries from relatives to patients while visiting remains restricted
- Had our very own team of opera singers, led by local soprano Alison Roddy, entertaining patients and staff with carols on Christmas Eve

NHS
Northampton General Hospital
NHS Trust

Leadership changes

This will be my last public Trust Board at NGH and whilst I am sad to be leaving NGH and the people I have worked so closely with over the last 16 years, I am also quietly excited about taking on the role of Hospital CEO at Kettering General Hospital. As we continue our journey in developing the group both hospitals will be working closely together and I firmly believe the benefits of group working will have a significant & positive impact for our staff and the care of our patients.

Eileen Doyle, who has been the interim Hospital CEO at KGH will move over to NGH from March to take on the role of interim CEO until the substantive post is appointed to.

I would like to thank the board & my NGH colleagues for the support & opportunities offered to me throughout my 16 years at NGH & I would like to take the opportunity to wish Eileen well in the CEO role at NGH.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28th January 2021**

Title of the Report	**Integrated Performance Report**
Agenda item	**9**
Presenter of Report	Hospital CEO Executive Directors Non-Executive Directors
Author(s) of Report	Adrian Marsden (Head of Information) Directors

This paper is for: (delete as appropriate)

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

Executive summary

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

Each Director has provided a summary.

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

	document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	NA
Legal implications / regulatory requirements	None

Actions required by the Trust Board

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

Corporate Scorecard – Integrated Performance Report

Date: January 2021
Reporting Period: December 2020

Northampton General Hospital NHS
NHS Trust

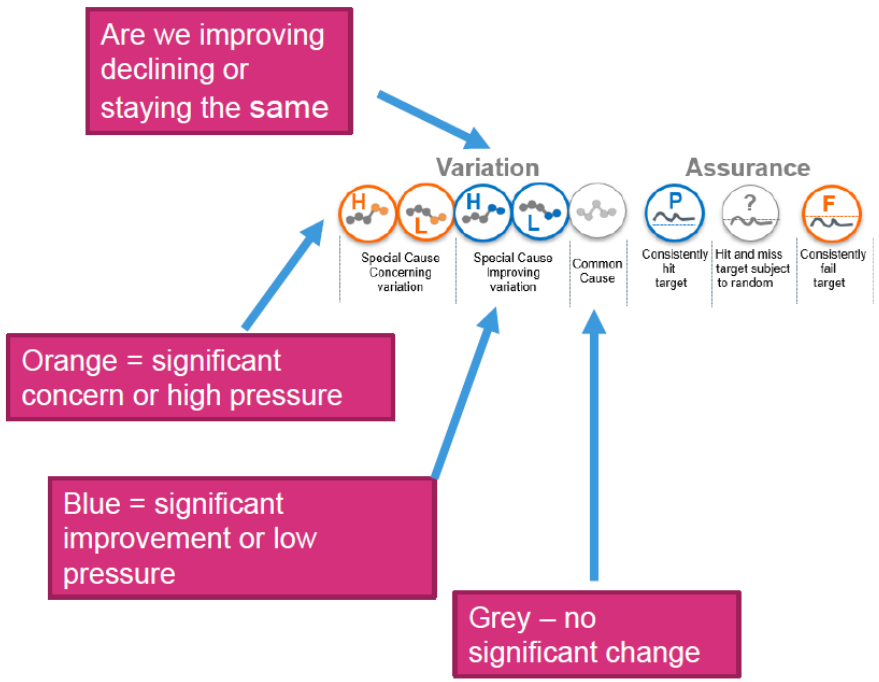
Pilot SPC Charts

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

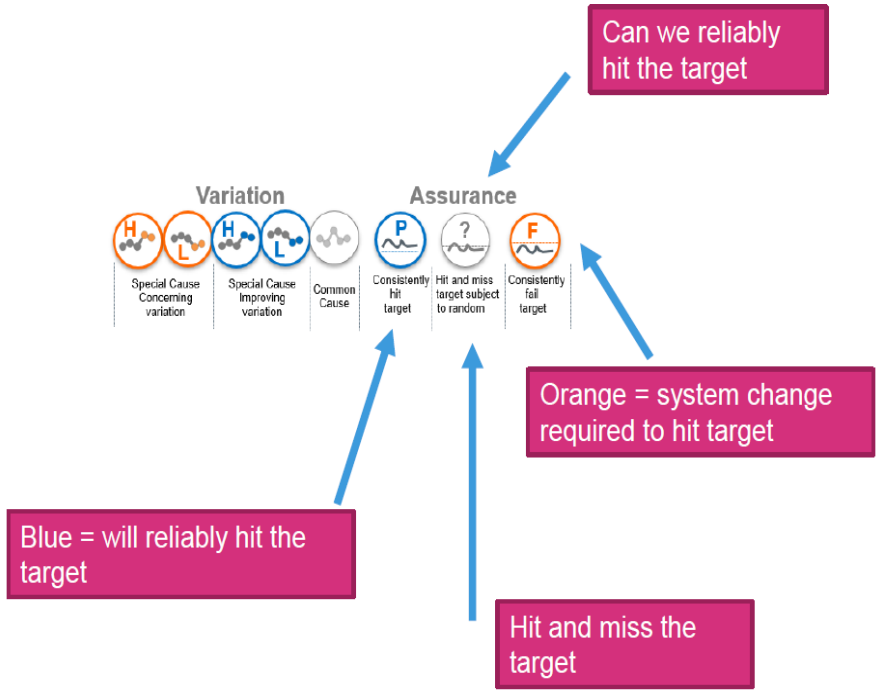
The reports that follow use the key below. A recap of using these descriptions is also included

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

High level key - variation



High level key - assurance



Domain	Metric	Target	Variation	Assurance	Chart
Safe	HOHA and COHA (C-Diff > 2 Days)	3			
Safe	MSSA > 2 Days	1			
Safe	VTE Risk Assessment	95%	Outside Control Limits	F	Page 10
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	60	No Data Available		
Safe	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	98%			

Safe Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Nov-20	Dec-20	Chart
Safe	Never event incidence	0	1	No Data	
Safe	Number of Serious Incidents (SI's) declared during the period	N/A	9	No Data	
Safe	New Harms	<=2%	No Data Available		
Safe	Appointed Fire Wardens	>=85%	100%	100%	
Safe	Fire Drill Compliance	>=85%	90%	No Data Available	
Safe	Fire Evacuation Plan	>=85%	100%		

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

Caring Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Nov-20	Dec-20	Chart
Caring	Compliments	N/A	No Data Available		

Domain	Metric	Target	Variation	Assurance	Chart
Effective	Length of stay - All	4.2			
Effective	Percentage of discharges before midday	25%	Outside Control Limits	F	Page 11
Effective	# NoF - Fit patients operated on within 36 hours	80%	No Data Available		
Effective	Maternity: C Section Rates	29%	Outside Control Limits		Page 12
Effective	Mortality: HSMR	106	Outside Control Limits		Page 13
Effective	Mortality: SHMI	109		P	
Effective	Stranded Patients (ave.) as % of bed base	40%	Outside Control Limits	F	Page 14
Effective	% Daycase Rate	80%	H	P	
Effective	Super Stranded Long Stay Patients (ave.) as % of bed base	25%	Outside Control Limits		Page 15
Effective	Readmissions within 30 days of previous reporting month	12%	No Data Available		

Effective Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Nov-20	Dec-20	Chart
Effective	Patient Ward Moves Overnight (22:00 - 06:59)	0	378	447	

Domain	Metric	Target	Variation	Assurance	Chart
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	90%	Outside Control Limits	F	Page 16
Responsive	Average Ambulance handover times	00:15:00	No Data Available		
Responsive	Ambulance handovers that waited over 30 mins and less than 60 mins	25	L	?	
Responsive	Ambulance handovers that waited over 60 mins	10	Outside Control Limits	?	Page 17
Responsive	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0		?	
Responsive	Average Monthly DTOCs	23	No Data Available		
Responsive	Cancer: Percentage of patients treated within 31 days	96%		?	

Domain	Metric	Target	Variation	Assurance	Chart
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%		?	
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%		?	
Responsive	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	L	F	Page 18
Responsive	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	L	F	Page 19
Responsive	Cancer: Percentage of patients treated within 62 days of referral from screening	90%		?	
Responsive	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	85%		?	
Responsive	RTT over 52 weeks	0	Outside Control Limits	F	Page 20
Responsive	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	99%	Outside Control Limits	F	Page 21
Responsive	Stroke patients spending at least 90% of their time on the stroke unit	80%	Outside Control Limits	?	Page 22
Responsive	Suspected stroke patients given a CT within 1 hour of arrival	50%	L	P	

Responsive Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Oct-20	Nov-20	Chart
Responsive	RTT median wait incomplete pathways	<=10.9	9.5	9.5	
Responsive	Cancer: Faster Diagnosis Standard	>=63%	80.0%	77.9%	

Section:	Indicator:	Target:	Nov-20	Dec-20	Chart
Responsive	Unappointed Follow Ups	=0	8,297	8,869	

Domain	Metric	Target	Variation	Assurance	Chart
Well Led	Income YTD (£000's)	0	Outside Control Limits	?	Page 24
Well Led	Surplus / Deficit YTD (£000's)	0	Outside Control Limits	?	Page 25
Well Led	Pay YTD (£000's)	0	Outside Control Limits	P	Page 26
Well Led	Non Pay YTD (£000's)	0		?	
Well Led	Bank & Agency / Pay %	7.5%	Outside Control Limits	F	Page 27
Well Led	Sickness Rate	3.8%		F	Page 29

Well Led Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Nov-20	Dec-20	Chart
Well Led	Percentage of all trust staff with mandatory refresher fire training compliance	>=85%	80.7%	No Data Available	

Domain	Metric	Target	Variation	Assurance	Chart
Well Led	Staff: Trust level vacancy rate - All	9%	Outside Control Limits	P	Page 30
Well Led	Staff: Trust level vacancy rate - Medical Staff	9%	Outside Control Limits	P	Page 31
Well Led	Staff: Trust level vacancy rate - Registered Nursing Staff	9%	Outside Control Limits	P	Page 32
Well Led	Staff: Trust level vacancy rate - Other Staff	9%	Outside Control Limits	P	Page 33
Well Led	Turnover Rate	10%		P	
Well Led	Percentage of all trust staff with mandatory training compliance	85%	Outside Control Limits	P	Page 34
Well Led	Percentage of all trust staff with role specific training compliance	85%	Outside Control Limits	F	Page 35
Well Led	Percentage of staff with annual appraisal	85%	Outside Control Limits	?	Page 36
Well Led	Job plans progressed to stage 2 sign-off	90%		F	Page 37

Medical Director's view

Overview

Following the approval of the academic strategy and supporting business cases the job descriptions of the associate professor posts are being developed and progressed in collaboration with the University of Leicester as a key enabler of attaining University Hospital status for the group.

Research productivity at NGH, having dipped during an overhaul of governance and structure in 2019/20, has accelerated and through the first 3 quarters of the current reporting year already exceeded trial recruitment for the preceding year (1,875 vs 1,401), a full year effect increase of 78% in rate.

Covid response

In order to meet the second covid peak and in particular the acuity of patients suffering infection at the time of reporting, the capacity of the critical care unit has been increased to 200% of that contracted. The capacity for respiratory support short of invasive ventilation (CPAP and NIV) has been increased from a typical trust level of up to 5 patients at any one time to a maximum capacity of 36 patients. A covid respiratory medical rota has been established to optimise management of patients and use of capacity, and improvements in use of equipment have enabled us to operate comfortably within our oxygen distribution capability. The reduction in elective activity has also enabled a re-distribution of medical staff to support the high demand for supporting covid inpatients. We have re-deployed clinical assistants from our medical students. We are also recruiting medical support workers through a scheme run by HEE-EM.

IMGs

Our programme of support for international medical graduates, led by our BAME clinical fellow and supported by the clinical education team and medical staffing, continues to develop. BAME focussed induction and interview preparation workshops for doctors new to the NHS key achievements over the last quarter. A proposal for a structured period of induction and NHS orientation will be presented to workforce committee in Q4.

Education

Our education team, in addition to re-introducing our clinical assistants, developing a package of IMG support and the "medical education business partner model" are introducing an ever expanding portfolio of virtual learning opportunities, this month taking receipt of some virtual reality headsets.

Directors view – Chief Operating Officer

Performance - A&E 4hrs

- Performance was 65.75% for December 2020 compared to 2019 at 68.94% this is approximately 7% lower than the previous month and related in the main to a significant increase in COVID presentations, delays in ability to transfer patients from ED while waiting on PCR results and need to stream to correct zone.
- There were 8243 Type 1,2 & 3 attendances compared to 2019 = 11665 which is significantly less than pre COVID attendances.
- Conversion rate from ED remains approximately the same as previous month and December 2019, 22.47% conversion rate from ED.
- Ambulance conveyance has increased month on month with an increased acuity and resultant conversion rate. Ambulances = 2918. 2019 = 2515.
- Whilst the numbers attending ED are not as great as previous years the key difference is due to increased Same Day Emergency Care (SDEC) activity we are seeing less patients that typically didn't breach, required minimal input and good turnaround.
- SDEC attendances for December 2020 were 1019 with a conversion rate of 9%- well below national standard of circa 15% conversion rate and an increase from December 19 which seen 955 attendances.
- Additionally the need to stream patients based not just on acuity and skill set required but on IPC has resulted in delays to beds resulting in longer stays in ED.
- For December all 'green' patients are required to have a negative COVID swab prior to leaving ED this compounds delays and breaches.
- Stranded & super stranded patient numbers are at 324 and 97 respectively is higher than the previous month but still down considerably from December 2019 when they were 410 stranded and 131 super stranded. However a focussed piece of work on this cohort in January has already seen the numbers fall to 272 and 75 respectively as of Mid January

Cancer waiting times

- Legacy patients, those on their pathway in excess of 62 days is 46 as of the 19/1/21, compared to 150 in July. Patients waiting in excess of 104 days now 8 versus 69 in July
- 2ww Standard now being achieved in October, November and December 2020, last achieved September 2019
- 62 day performance 75.7% against the 85% standard. This was just under the trajectory of 76.4% but shows an increase of over 15% in 2 month. December's position is currently 0.6% off the National target of 85% which is a massive improvement in 3 months
- All teams made considerable shift in capacity for patients to be seen in 7 days or less for first outpatient
- Cancer improvement programme continues to improve performance with 2ww, 31 days, 28 faster diagnosis and 62 days expected to meet the national target once final validation is complete at the end of January

Directors view – Chief Operating Officer

RTT – Average wait time

- The median wait for November was 9.5 weeks, this is the same as October. Previous months position include; September (10.5 weeks), August (13.5), July (15.5) , June (16.5) and May (14.5).
- The number over 52+ weeks for November was 590 decrease from 637 in October .

The average wait to be seen and number of patients waiting 52+ has continued to be a challenge nationally with the COVID shut down of elective work. There has been an improvement due to the actions completed outlined below, however the current operational pressures Nationally and within the Trust mean the position continues to be a challenge with the current focus being on P1/P2/Cancer/Urgent's, with routine elective activity being cancelled to support flow and the COVID surge.

Actions:

- Phase 3 recovery plans were being progressed with the restoration of elective activity, priority was being given to clinically urgent and cancer patients.
- Insourcing options were being progressed and utilised to provide additional capacity within key surgical and medical specialties.
- Weekly PTL's in place with a focus on 52+ , this continues and a new format for PTL's is being progressed.
- Reset Delivery Group in place as part of Phase 3 recovery.
- NEC's clinical validation programme being progressed to support prioritisation of elective activity. Healthcare Communications being utilised to support administrative validation and responses have now been received.
- Addendum to the access policy has been approved and now live.

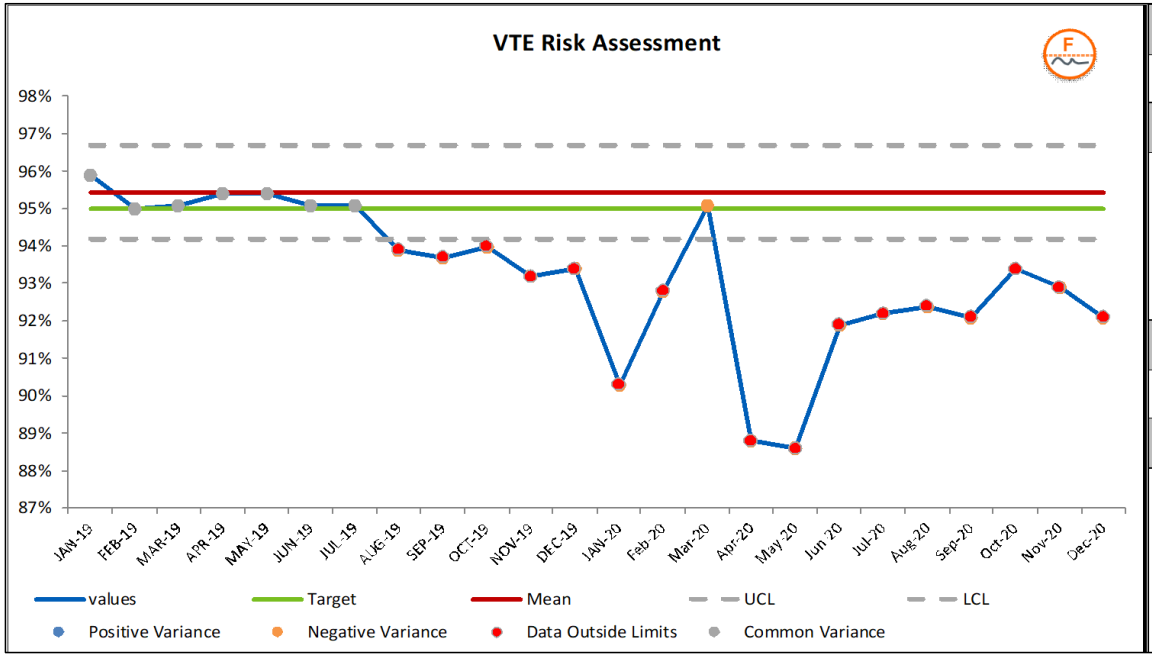
Risk:

- Impact of a covid-19 surge and associated staffing risks
- Currently the Trust has seen significant operational pressures resulting in cancellations of theatre activity to expand ITU capacity to 200% of norm which will impact on position for November and December.

Diagnostics – 6 weeks

- Performance has Increased significantly from 46% to 78% due to all routine diagnostic procedures restarting post COVID phase 1 with all modalities now performing at >100% of pre-COVID activity levels .
- Actions being taken:
- Additional capacity (internal & external) is in place to manage the demand.
- Daily NHSE/I regional provider calls in place to support recovery.
- Work on-going with CCG to develop referral guidelines for GP requesting of MRI to better manage demand
- Routine MRI & CT now being booked within 6 weeks with exception of paediatric sedations and cardiac angiography CT scans
- Additional WLI US lists for MSK and H&N in place.
- Recovery will be slow due to the need to use PPE & socially distance which will make processes slower.
- Some CT capacity may be lost due to increased urgent and non-elective care covid-19 +ve scans requiring the urgent care scanner being designated as a red scanner for at least half a day this increases the demand on the remaining 2 scanners. This may require some routine examinations to be postponed.
- Elective & Outpatient/diagnostic bronze cell in place as part of reset.

SPC Charts – VTE Risk Assessment



Dec-20
92.1%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
95%
Target Achievement
Metric is consistently failing the target

Context:

Lack of functioning ePMA combined with covid IPC movement restrictions have made significantly inhibited both monitoring and improvement actions.

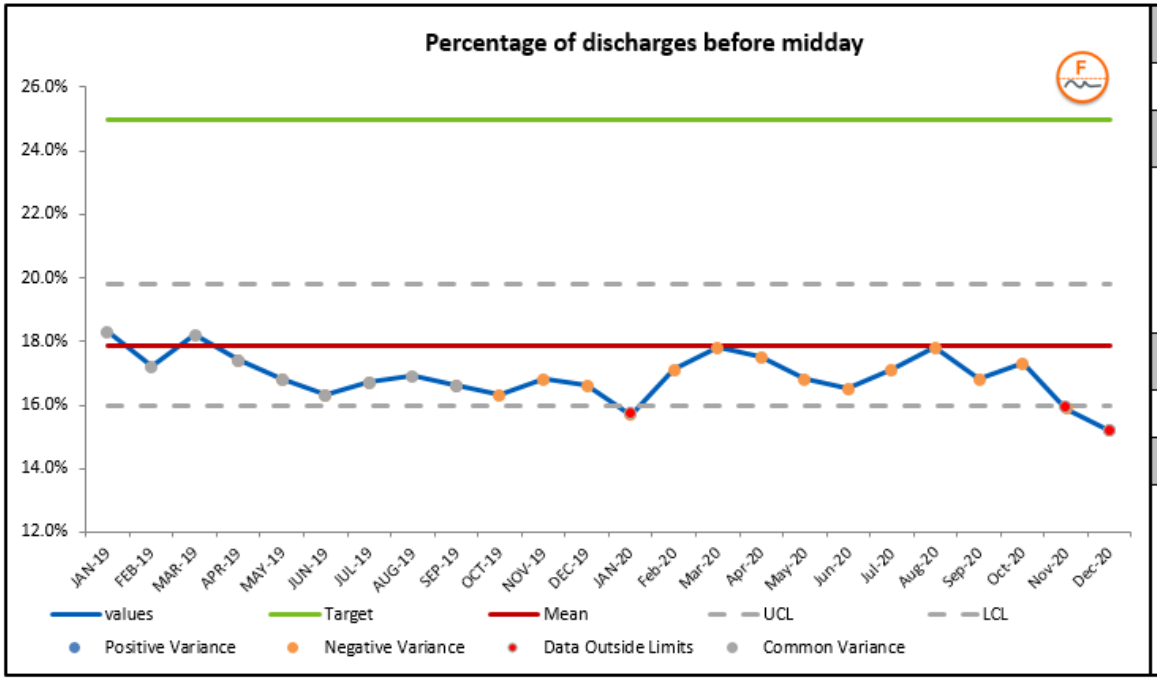
Indirect assurance of compliance is drawn from a spot audit conducted by ward pharmacists confirming that 98% of patients had appropriate and timely prophylaxis prescribed.

The metric represented here is an indirect measure, relying on the doctors completing discharge summaries to capture the information here, often a substantial time (up to weeks) after the time the assessment is recorded.

Actions:

- New prescription charts with integrated assessment forms printed and launched this month. Regular spot audits and feedback to practitioners near real time.
- ePMA project group and oversight exec committee established for re-introduction of further upgrade – on track for delivery end Q4/ beginning Q1
- Medical examiners also checking records and finding significant improvements in compliance

SPC Charts – Percentage of discharges by midday

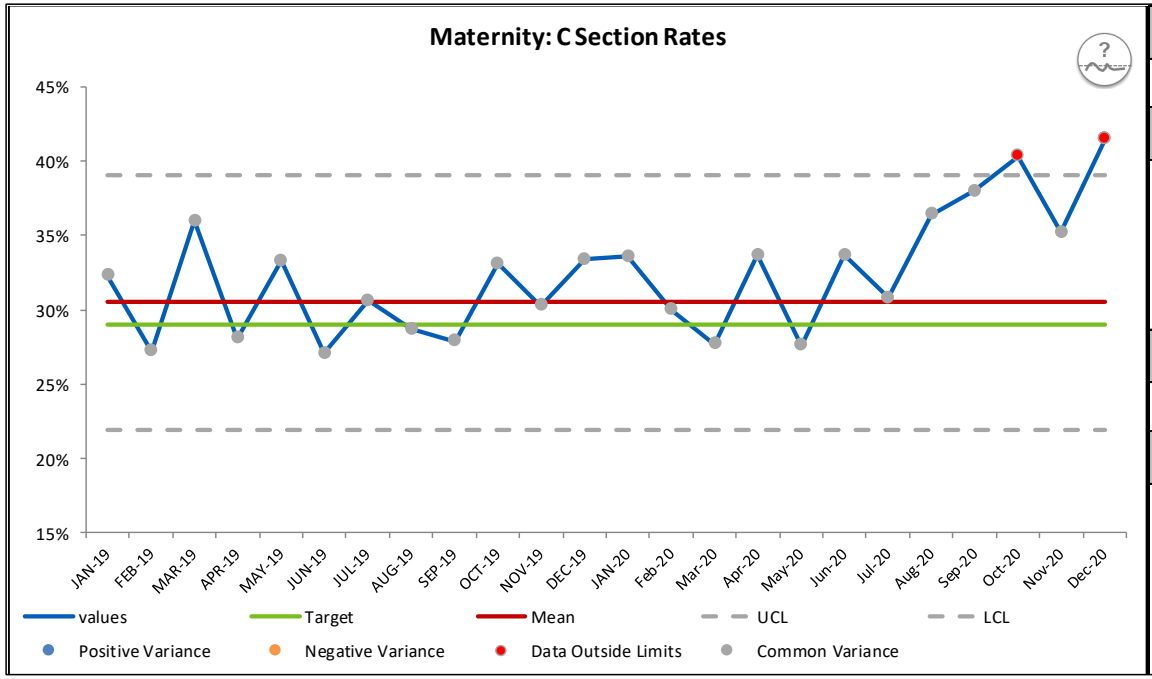


Dec-20
15%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
25%
Target Achievement
Metric is consistently failing the target

Context:
Discharges before Midday deteriorated in November and December. A contributory factor in relation to discharges before noon is the lack of discharge suite which has been converted to paediatric area. In addition the patient transport service only transport 1 patient at a time home due to COVID risks

Actions:
ICAN discharge pillar has completed the diagnostics phase of the programme and is now developing its key work streams to address the challenges identified
Task force of 4 doctors, 1 nurse and a Pharmacist have been introduced to facilitate earlier discharges across the trust 7 days a week 8am till 5pm
Work started with Ian Sturgess from ECIST to focus on rapid discharge of patients with a NEWS score of 3 or less with ward teams
Designated Unit for discharge of COVID positive patients who cannot return home until their COVID isolation period is complete opened at the end of December.

SPC Charts – Maternity C Section



Dec-20
42%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
29%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

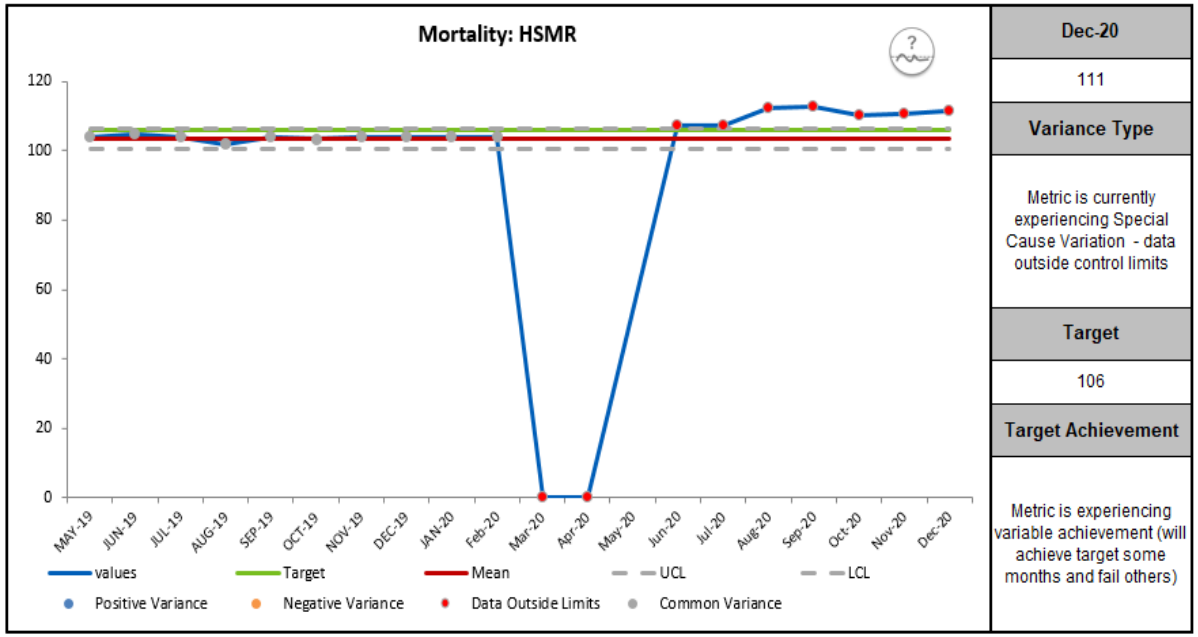
Context: Unexpected rise in C-Section rate over the last 3 months. Not associated with harm (PPH etc) Possibly associated with new fetal monitoring guidance affecting risk assessment . No changes to pathway introduced

Actions:

Case note series review to understand the drivers

Awareness raised with teams

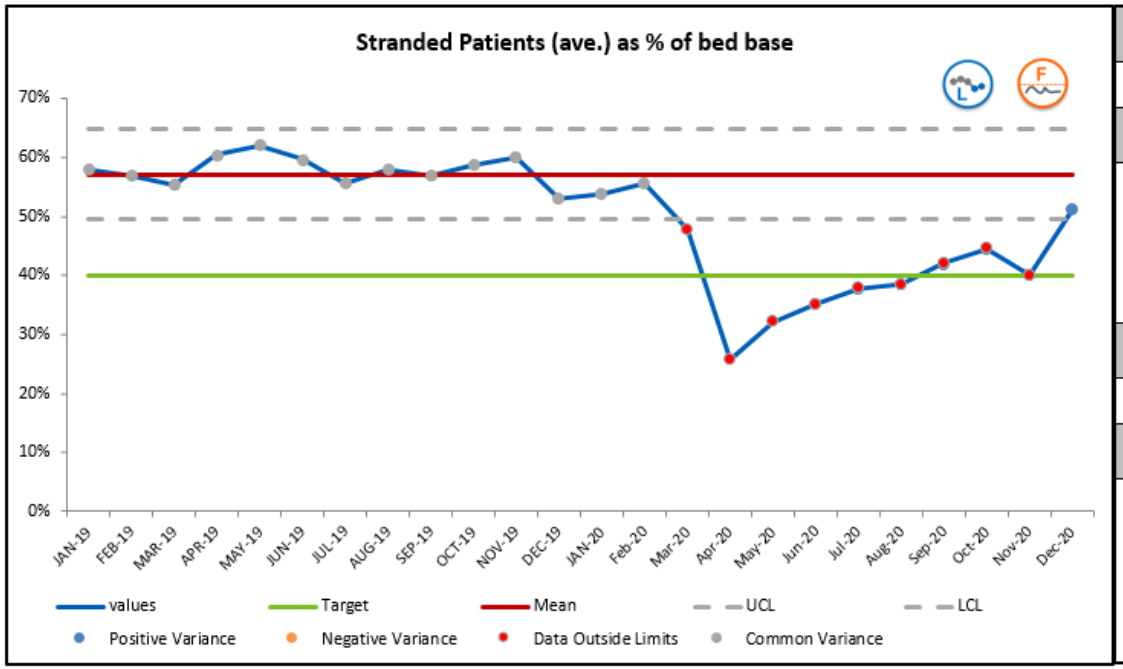
SPC Charts – Mortality HSMR



Context:
The SPC chart will be replace for future board meetings with one for SHMI and another for an adjusted HSMR for the hospice transfer effect previously described.

Actions:
Dr Foster will continue to provide NGH with a COVID-specific package with analysis report and 5 updates for review after 5th iteration so we can identify any future areas of concern as early as possible.
The Mortality team are conducting a trustwide review of all deaths identified with hospital acquired Covid-19 infection ("Review 14"), that have been referred for SJR by the Medical Examiner Team. These reviews will be conducted as part of the routine M&M process, and we aim to have the final report available to highlight key learning themes from the Covid-19 outbreak as soon as achievably possible. Action Plans are to be drawn up to focus on the 3 key workstreams identified above.
Going forward, increased resources and support for patients in the community will result in decreased hospital admissions, and therefore decreased in-hospital mortality. Cancer Services and the Heart Failure service has been identified as a key target area going into 2021.

SPC Charts – Stranded Patients (ave.) as % of bed base



Dec-20
51.2%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance below the mean
Target
40%
Target Achievement
Metric is consistently failing the target

Context:

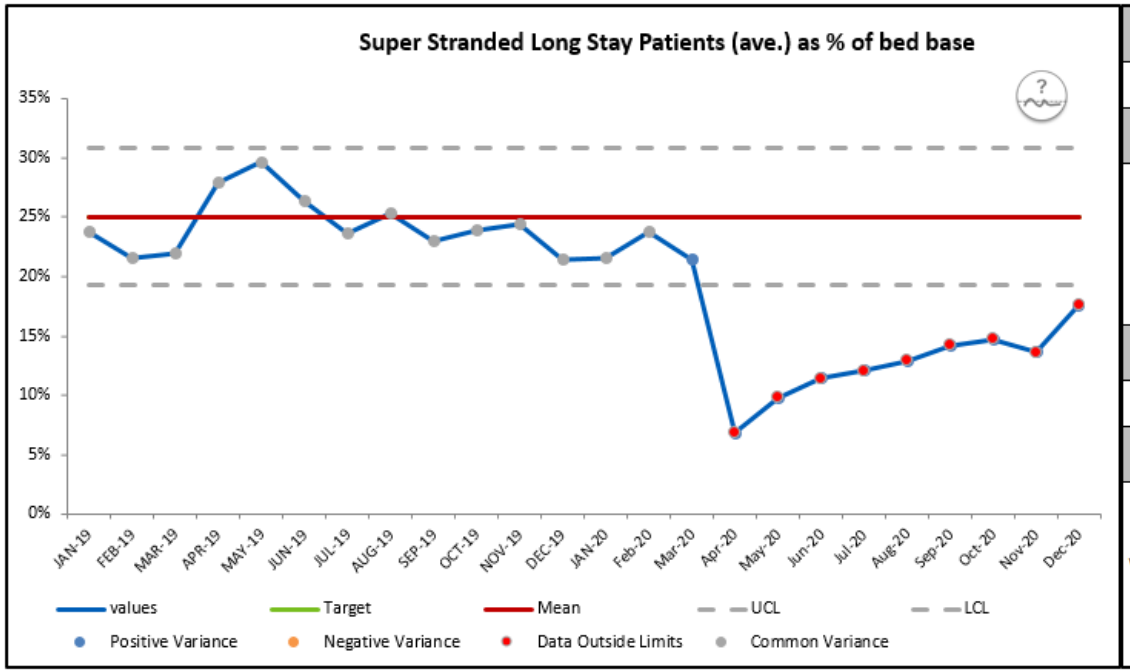
Numbers of stranded patients increased in December.

50% of our patients spend more than 7 days in hospital. The stranded number is further compounded by the lack of community 'red' capacity for patients who have tested positive for COVID but are now fit to be discharged but will not be accepted until 14 days post exposure. Rehab capacity is also reduced due to closure of units to COVID

Actions:

- Ongoing work with the Reason to Reside Discharge Cell as a part of the ICAN Discharge long term project.
- MD, DON and COO leading discharge programme to improve discharge processes over the key winter and COVID period focussing on NEWS of 3 or less, and clinical challenge of reasons to reside for this low acuity group of patients
- Additional capacity is coming on line in December in the form of additional care home beds at Avery, Discharge to assess beds at the specialist care centres and COVID positive beds at 2 care homes.
- Conversion of Rehab units at Danetre and Corby to subacute medicine will take place in January to support patent flow that based on the modelling shows the COVID peak in mid to late January
- Supported by Emergency Care Intensive Support team (ECIST)

SPC Charts – Super Stranded Patients (ave.) as % of bed base



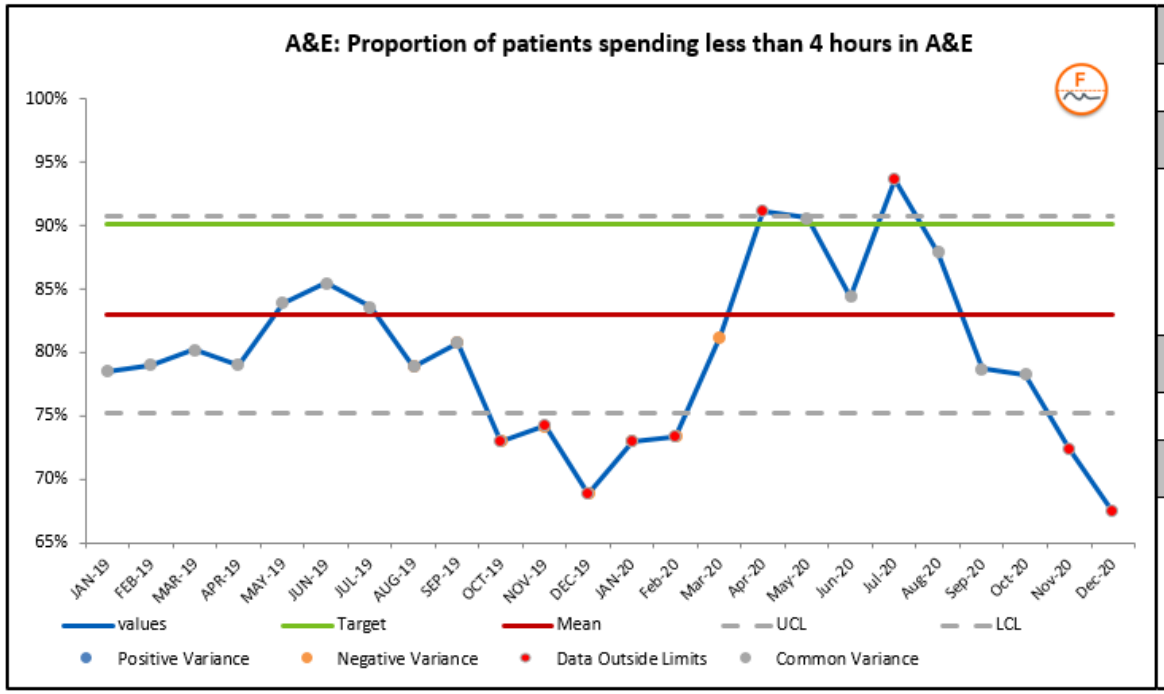
Dec-20
17.6%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
25%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context: The number of superstranded patients increased in December, but remains much lower than the same period last year.
15% of our patients spend more than 21 days in hospital (we have set a target to decrease to 12% of the bed base over winter). The super stranded number is further compounded by the lack of community 'red' capacity for patients who have tested positive for COVID but are now fit to be discharged but will not be accepted until 14 days post exposure. Rehab capacity is also reduced due to closure of units to COVID

Actions:

- Ongoing work with the Reason to Reside Discharge Cell as a part of the ICAN Discharge long term project.
- MD, DON and COO leading discharge programme to improve discharge processes over the key winter and COVID period focussing on NEWS of 3 or less, and clinical challenge of reasons to reside for this low acuity group of patients
- Additional capacity is coming on line in December in the form of additional care home beds at Avery, Discharge to assess beds at the specialist care centres and COVID positive beds at 2 care homes.
- Conversion of Rehab units at Danetre and Corby to subacute medicine will take place in January to support patent flow that based on the modelling shows the COVID peak in mid to late January
- Supported by Emergency Care Intensive Support team (ECIST)

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



Dec-20
67.5%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
90.1%
Target Achievement
Metric is consistently failing the target

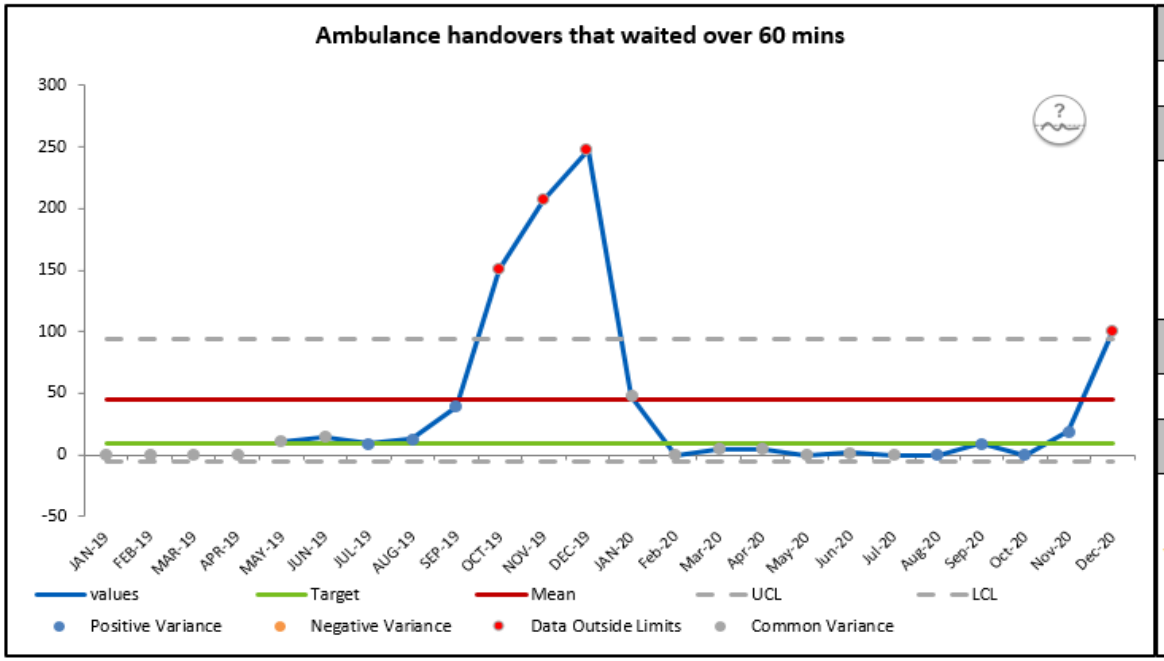
Context:
Lack of internal flow through the department due to Covid positive patients and high demand for covid area.

High acuity within ED.
Increased demand for Medical beds.
Staffing challenged in ED with staff testing positive, shielding or isolating are placing severe pressure on the dept

Actions taken:
Consultant or SPR decision to admit only.
Requests for additional medical and support staff complete.

Actions:
Review of Covid swab pathway.
Lateral Flow tests introduced to provide rapid COVID results
Consultant or SPR decision to admit only.
Rapid transfer for all appropriate patients to assessment units or base wards
Improvement plan being implemented in ED with PMO support

SPC Charts – Ambulance handovers that waited over 60 mins



Dec-20
100
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
10
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:
High demand for patients requiring the Covid area.

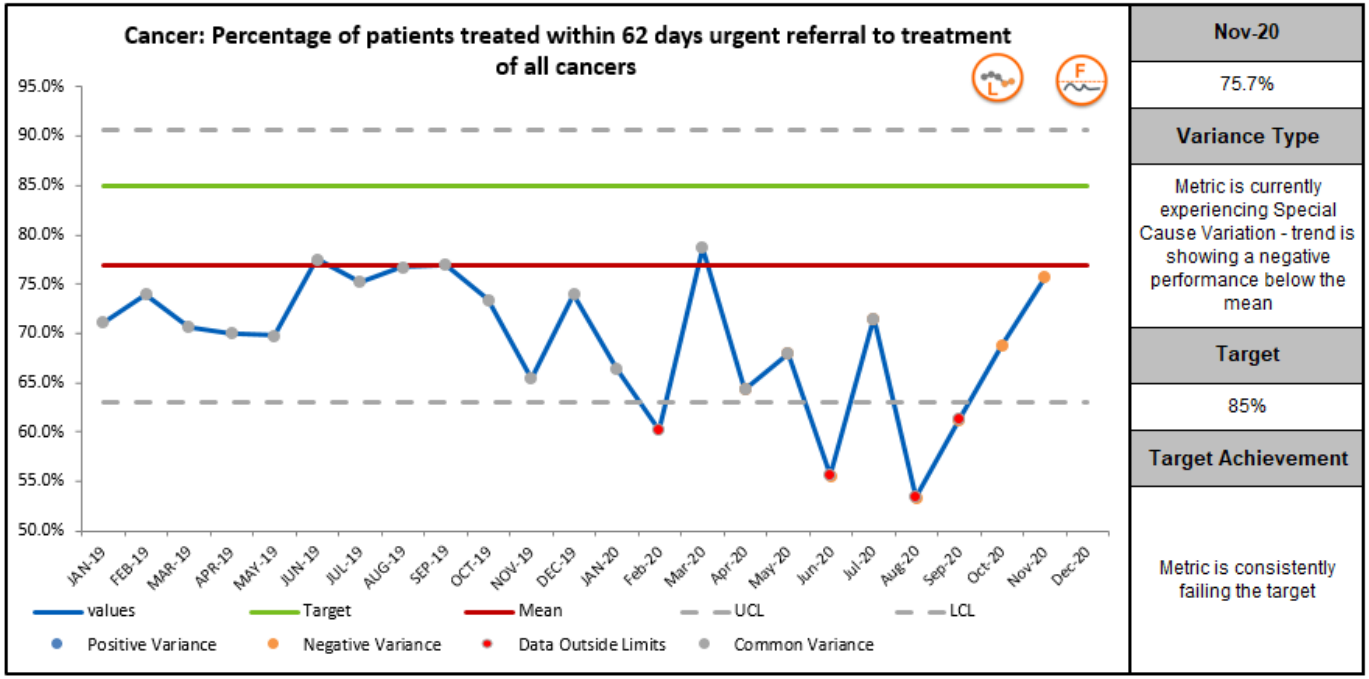
Internal flow constraints due to capacity within the trust and high demand for medical beds.

Staffing challenged in ED with staff testing positive, shielding or isolating are placing pressure on the dept

Cannot offload patents with COVID symptoms into the ED dept if no available cubicles to isolate

Actions:
Identifying fit2sit to ease capacity.
Identify whether patient could use alternative pathway. SDEC, Minors or UTC.
Expedite flow through the department to ensure timely handover from Ambulance.
Halo support whenever Ambulance unable to off load.
Emergency Department Doctor to assess patient to ensure clinically safe and instigate any urgent investigations/treatment
Identifying additional area to support offload challenges (Fracture clinic / ambulatory care)

SPC Charts – Cancer: Percentage of patients treated within 62 urgent referral to treatment of all cancers



Nov-20
75.7%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
85%
Target Achievement
Metric is consistently failing the target

Context:

62 day performance 75.7% against the 85% standard. This was just under the trajectory of 76.4% but shows an increase of over 15% in 2 months. December's position is currently 0.6% off the National target of 85% which is a massive improvement in 3 months

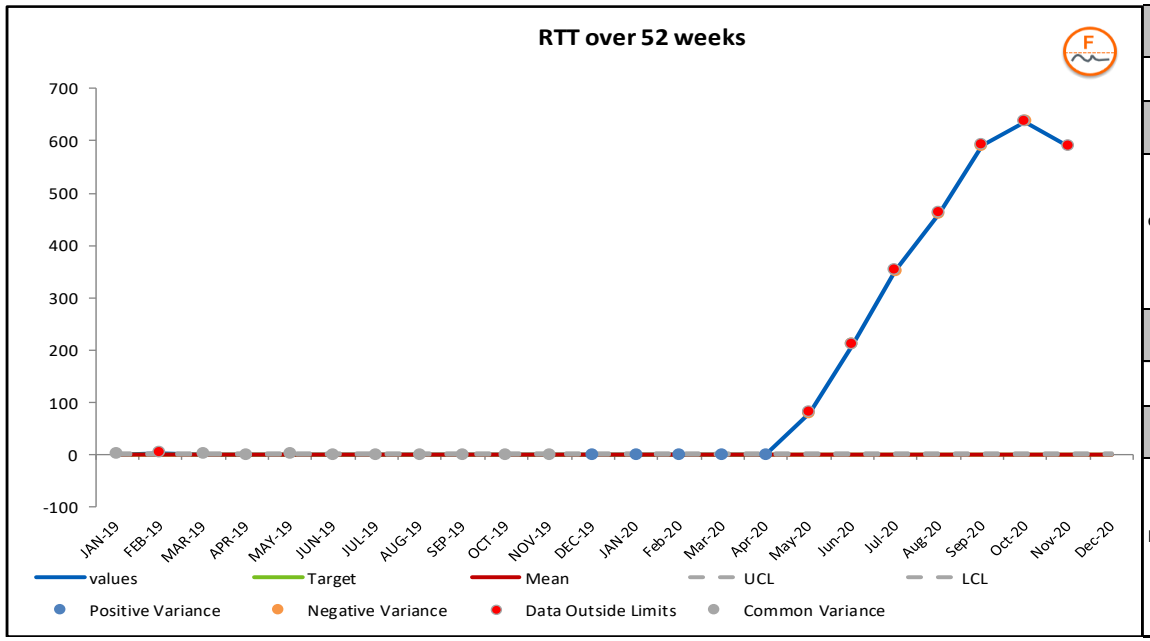
The Trust continues to micro manage patients through their 62 day pathway. Legacy patients continued to reduce finishing the month at 46.

The loss of theatre capacity to create 200% COVID ITU capacity will impact on performance

Actions:

The trust continues to focus on:
Diagnostic request to report in 7 days or less
Histopathology in 7 days or less
First OPA in 7 days or less
Achieving the 28 Day Faster Diagnosis Standard
Reduction in legacy patients
Independent sector hospitals agreed to support our loss of theatre capacity by switching their activity to cancer in January

SPC Charts – RTT over 52 weeks



Nov-20
590
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is consistently failing the target

Actions:

Nationally and within the Trust mean the position continues to be a challenge with the current focus being on P1/P2/Cancer/Urgents with routine elective activity being cancelled to support flow and the COVID surge.

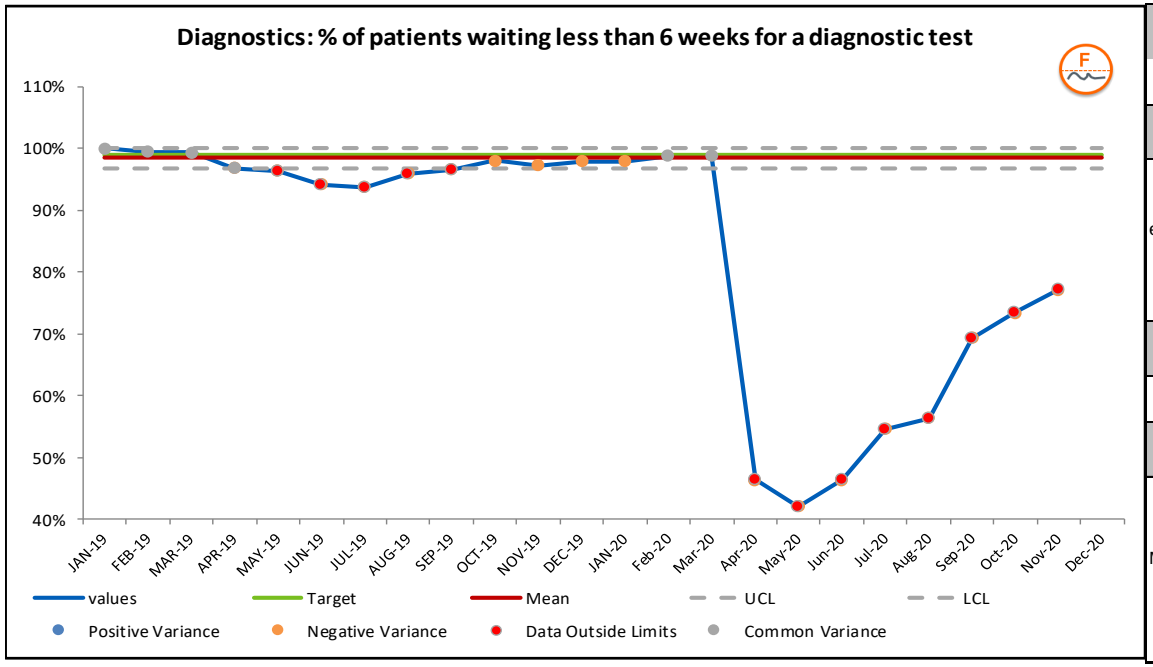
- Independent sector is being utilised to support Cancer work (Breast/Plastics).
- PTL meetings as above.
- Responses have been received in relation to the administrative element of the National Validation Programme and appropriate action is being progressed in line with the addendum to the access policy.
- Addendum to the access policy has been approved and now live.

Context:

The average wait to be seen and number of patients waiting 52+ has continued to be a challenge nationally with the COVID shut down of elective work. There has been an improvement due to the actions completed outlined below, however the current operational pressures Nationally and within the Trust mean the position continues to be a challenge with the current focus being on P1/P2/Cancer/Urgents with routine elective activity being cancelled to support flow and the COVID surge.

The number over 52+ weeks for November was 590 this a decrease from October which was 637. Actions:
- Phase 3 recovery plans were being progressed with the restoration of elective activity, priority was being given to clinically urgent and cancer patients.
- Insourcing options were being progressed and utilised to provide additional capacity within key surgical and medical specialties.
- Weekly PTL's in place with a focus on 52+ , this continues and a new format for PTL's is being progressed.
- Reset Delivery Group in place as part of Phase 3 recovery. A performance monitoring model aligned with KGH designed to provide a weekly view of how we are progressing against our phase 3 submission has been progressed and will form part of this Group.
- NEC's clinical validation programme being progressed to support prioritisation of elective activity. Healthcare Communications being utilised to support administrative validation and responses have now been received.

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



Nov-20
77.2%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
99%
Target Achievement
Metric is consistently failing the target

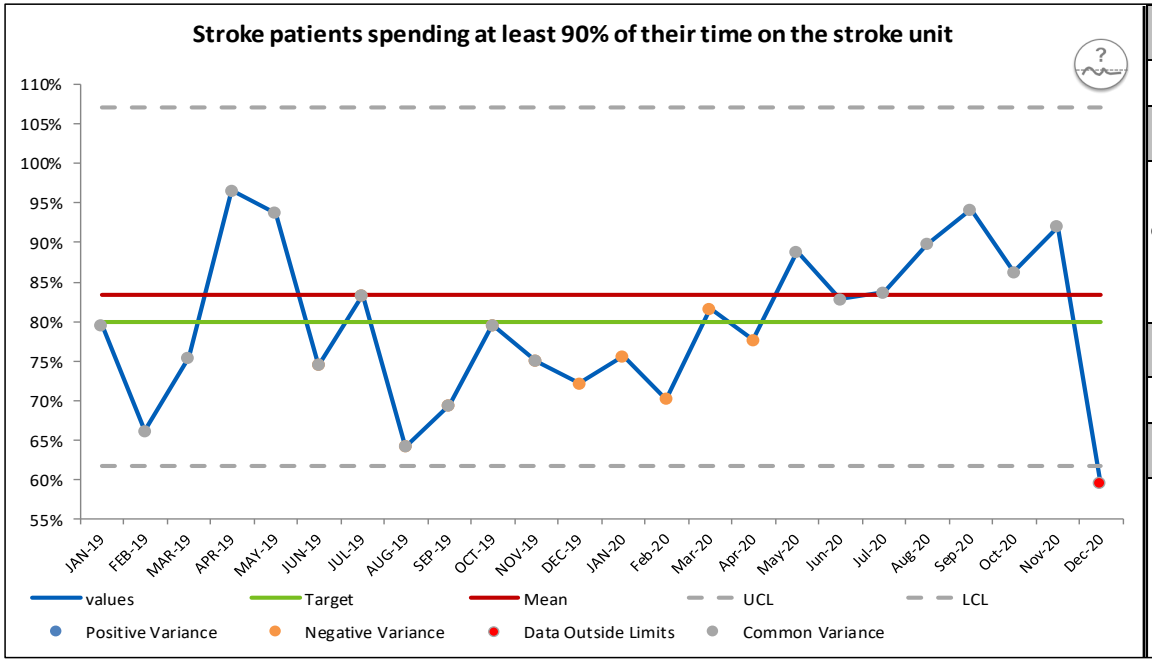
Context:

- As per national guidance to take down elective work during the pandemic we have seen a huge fall in the percentage of patients having their diagnostic test in 6 weeks from 98+ % to a position of **78%** for November
- Services are now operating at >100% of productivity compared with the same time last year
- Recovery slow due to the need to use PPE & socially distance which makes processes slower.

Actions:

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

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



Dec-20
60%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
80%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context: Numbers of patients spending 90% of their time on the stroke unit has reduced significantly due to COVID zoning of patients across the trust and COVID outbreaks which has necessitated movement of patients from 'green' stroke wards to 'red' COVID wards

Actions: Stroke patients being supported by the Stroke team away from their 'normal' ward areas. Site continues to work with IPC to ensure we place patients safely while the COVID numbers continue to rise

Directors view – Director of Finance

The Trust ended December 2020 with a year to date surplus of £27k, which is £2.9m better than the Phase 3 Reset plan.
The in-month surplus of £1.2m is £2.5m better than the Reset plan and is largely due to £3.8m of agreed deficit system funding accrued into the month 9 position, partly offset by an increased leave accrual. The funding support has been provided to ensure that the organisation and the system achieve a breakeven position.

COVID-19 spend for the month is £1.4m (Month 8: £1.2m). An increase of £0.2m in temporary pay expenditure due to COVID-19 sickness, self-isolation and increased staffing requirements to support patients.

Pay expenditure is £25.4m (an increase of £2.3m on November spend). This is mainly due to an accrual of £1.4m for untaken annual leave to reflect the Trust's decision on carried forward and payment for unused leave, as the Trust works to maintain staffing levels. In addition, £0.3m expenditure incurred in December to incentivise staff to cover temporary shifts during a pressurised month as well as spend on medical workforce to support operational demands to manage response to COVID-19.

Agency spend is £1.5m, which is a marginal increase on November, although the details does show a significant increase month-on month in covering medical staff due to COVID-19 sickness/isolation.

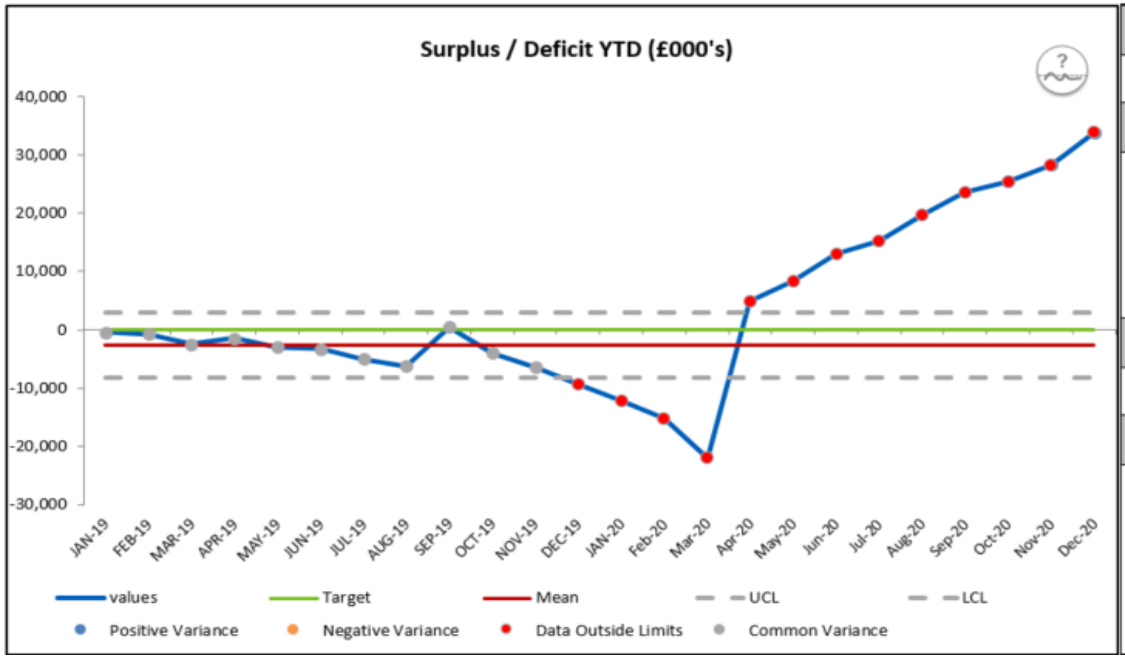
Non-pay spend remained at very similar levels to November. This is in-line with the Reset Plan, although we see a higher spend on insourcing offsetting lower spend on swabbing due to on-site processing.

The increased spend on insourcing helped to maintain activity performance for December in Elective/Daycase, resulting in over 90% of 19/20 levels . Non- elective activity rose to over 3,900 discharges, up from 3,800 in November. Outpatients dropped from November, impacted by emergency pressures and seasonality.

The Total Capital Plan for 20/21 is £40.8m. Capital spend to date is £16.3m, with a further £19.6m of future spend now being committed against the underlying schemes. However, slippage for this financial year is anticipated against a small number of these schemes, primarily the Critical Care building which has been subject to delays mainly due to asbestos removal. The Trust is currently forecasting (in a most likely scenario) to spend £34.7m in 20/21, generating slippage of £6.1m of which Critical Care is £5.6m. This is currently under discussion with system partners and NHSE/I.

Cash balance at the end of the month is £35.7m, lower than last month as capital expenditure increases in final quarter as major schemes progress.

SPC Charts – Surplus/Deficit YTD (£000's)



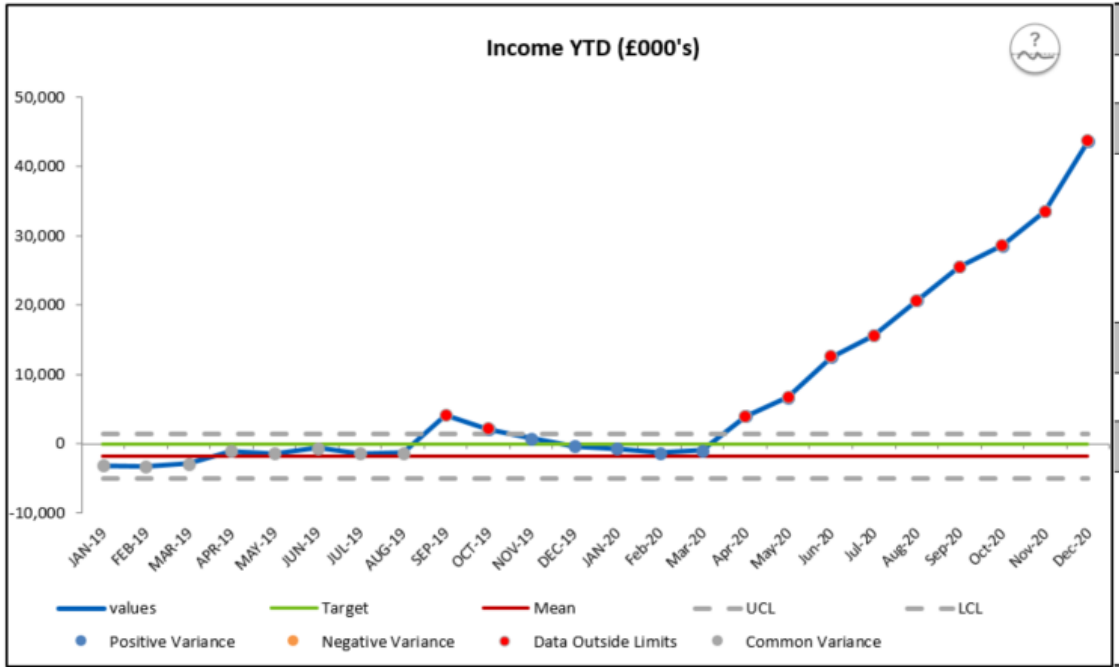
Dec-20
33,952
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:

The Trust reported a YTD breakeven position at the end of December. This is a £1.2m improvement on the Month 8 YTD position, mainly due to the deficit support funding agreed with system partners of £3.8m. This was partly offset by an increased annual leave accrual.

Actions:

SPC Charts – Income YTD (£000's)



Dec-20
43,762
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

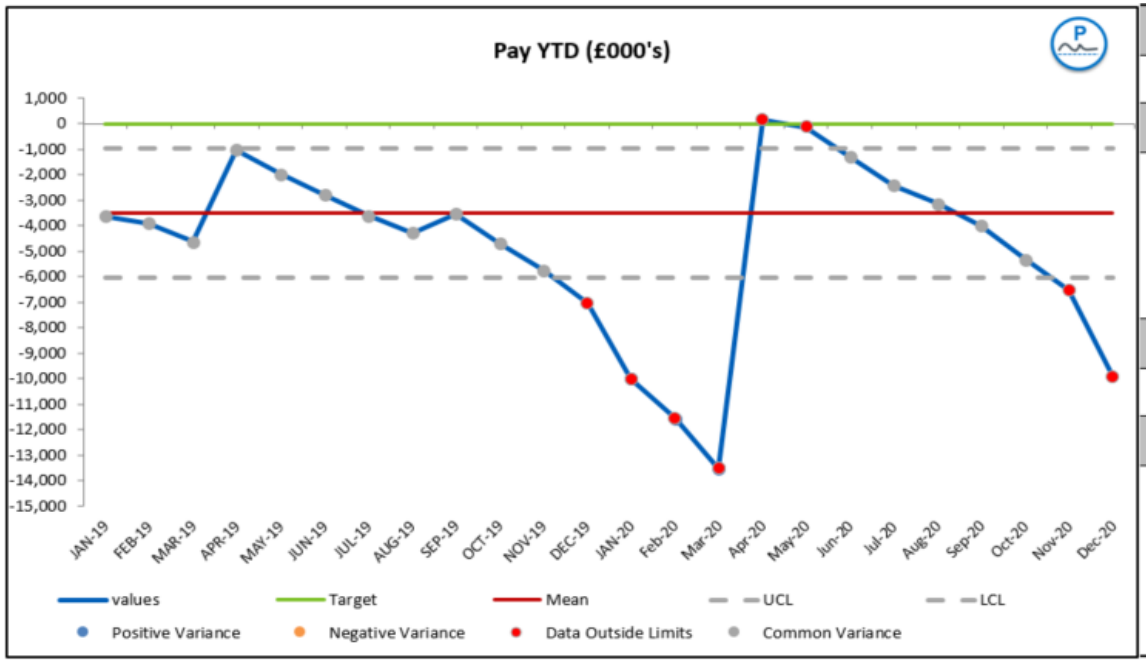
Actions:

Context:

The Trust receives block funding for the majority of its clinical income, including a fixed top-up funding.

As at Month 9 the Trust reported income in-line with the Phase 3 reset plan.

SPC Charts – Pay YTD (£000's)



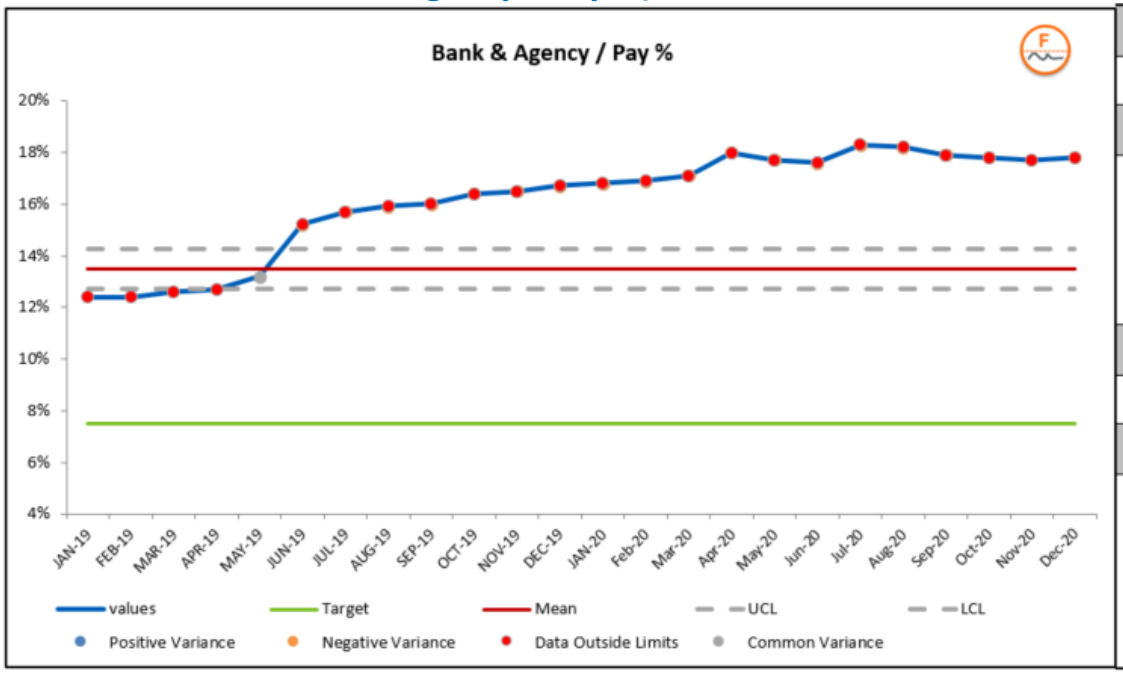
Dec-20
-9,910
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is consistently failing the target

Context:

- The year-to-date Pay variance against original pre-COVID plan accelerated this month due to an accrual £1.4m for untaken annual leave to reflect the Trust's decision on carried forward and payment for unused leave, as the Trust works to maintain staffing levels.
- COVID spend included in the YTD position is £8.9m and relates to pay costs incurred in response to COVID issues such as staff sickness and self isolation.

Actions:

SPC Charts – YTD Bank & Agency / Pay %)



Dec-20
17.8%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
7.5%
Target Achievement
Metric is consistently failing the target

Actions:

Context:

- In Month 9 Temporary Staff expenditure (Bank and Agency) is £4.6m (previous month £4.1m)
- £1.0m of this spend is attributed to COVID related spend (£0.6m in Month 8)
- In December, the level of agency spend has been maintained but there has been an increase in Bank spend. This relates to operational pressures on wards, increased RESET activity and staff having to self-isolate due to COVID.

Directors view – Chief People Officer

Vacancy position

The overall Trust vacancy factor for December 2020 is 6.02%. The vacancy factor for medical staff is 2.68%, which is a decrease for the fourth consecutive month. Medical staff in clearance total 42. Recruitment agencies for hard to recruit residual vacancies are engaged and actively searching for candidates alongside internal resourcing activity. The nursing & midwifery vacancy factor for November and December 2020 is 1.31% and 2.71% respectively. There were no overseas arrivals in the month of December, however a further 12 have arrived in January with a further 10 scheduled to arrive in February. Overall the overseas nurse recruitment programme has on boarded a total of 143 nurses from a planned 159. The planned figure of 159 will be met in March 2021. Overall time to hire for December 2020 is an average of 12.6 weeks from authorisation to start date.

Attendance

The Trusts sickness absence rate for November and December 2020 as reported through ESR was 5.07% and 5.86% respectively. A proportion of this absence is due to Covid-19 and this absence is monitored and reported on daily basis via the Roster system. As at 13 January 2021 there were 225 members of staff absent due to Covid-19 and self isolation. The management of sickness absence and Covid-19 absence is being supported by HR Business Partners and Occupational Health. The top two reasons for non-Covid -19 related absence are Stress and Anxiety and Musculoskeletal.

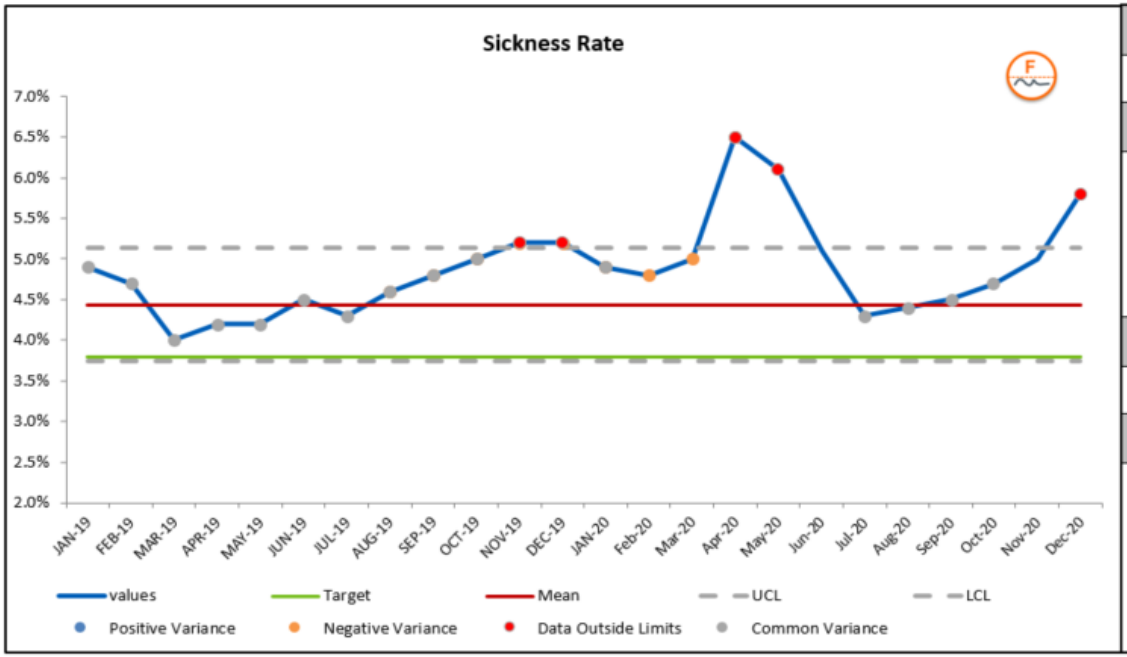
Regular asymptomatic testing has been replaced with the lateral flow testing kits with the exception of those areas that treat immunocompromised patients. PCR swabbing for outbreak areas continues and a team to support IPC has been formulated within HR to assist with the administration of this. There are currently 11 outbreak areas declared that require staff to be tested weekly for the duration of the outbreak and the results reported to PHE. Between 1 November 2020 and 31 December 2020 a total 2940 tests have been undertaken of which 99 were positive Covid cases.

Between 1 November 2020 and 31 December 2020 HR have booked a total of 859 symptomatic staff through the drive through. Of these 221 returned positive results for Covid.

Competence

The overall appraisal compliance percentage for the month of December is 74.80%, which is an increase for the third consecutive month but remains below the 85% target. A simplified 'Appraisal Light' process has been launched to enable and facilitate further increases to the compliance percentage.
The overall statutory and mandatory training position for the month of December 2020 is 85.71%, which and remains above the Trust target of 85%. All statutory and mandatory training continues to be available via e-learning.

SPC Charts – Sickness rate



Dec-20
5.8%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
3.8%
Target Achievement
Metric is consistently failing the target

Context:

- Anxiety and depression plus pregnancy related absences are high.
- As at 21 January 2021 a total of 213 staff were absent due to covid-19.

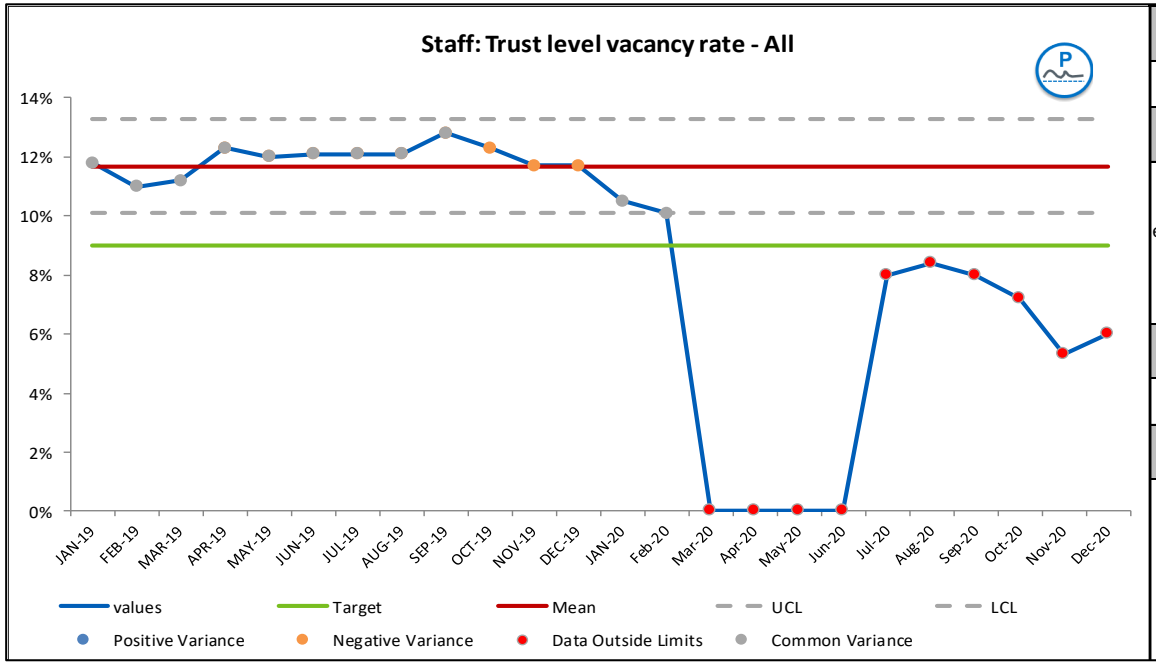
Actions completed:

- Robust sickness management continues with support from the HR Business Partners and HR Advisors.
- A number of OD initiatives to support staff are on-going including the SOS service.

Actions:

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

SPC Charts – Staff: Trust level vacancy rate - all



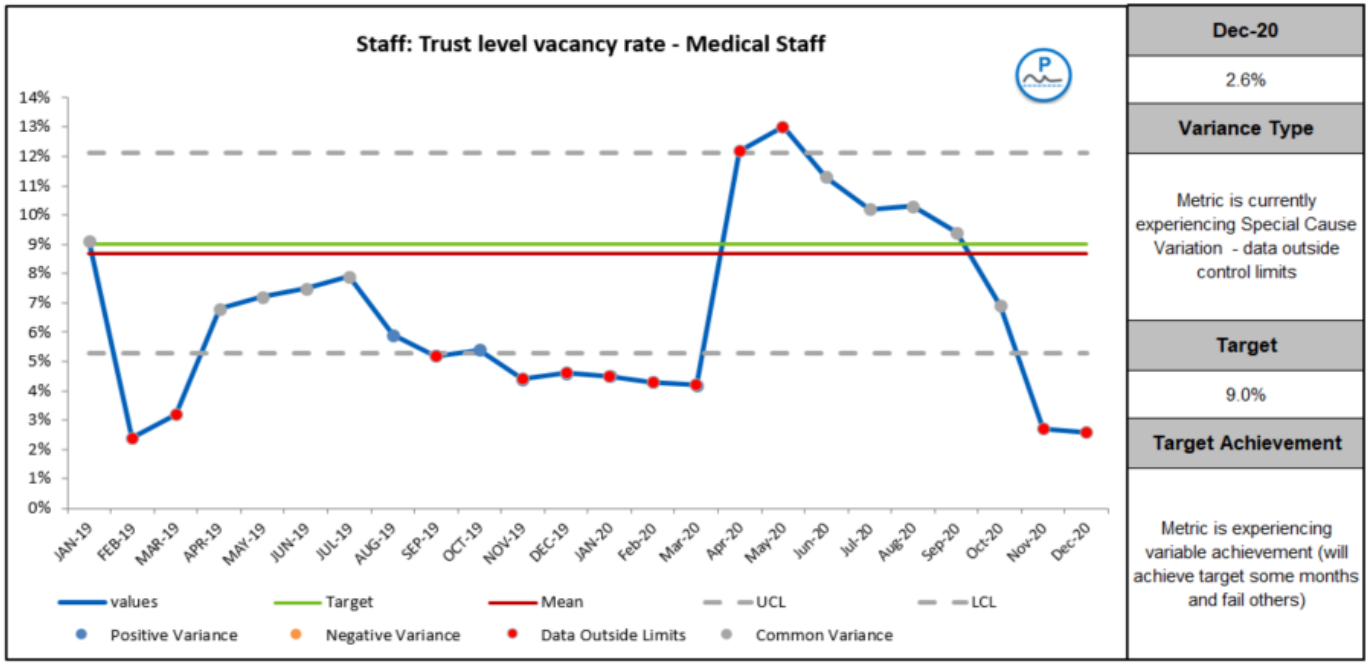
Dec-20
6.0%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
9.0%
Target Achievement
Metric is consistently achieving the target

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

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

Actions
- Funding obtained for a collaborative on-boarding of more overseas nurses with KGH underway
- Continue sourcing candidates and complete interviews for direct and agency candidates in particular for medical staff.

SPC Charts – Staff: Trust level vacancy rate – Medical staff



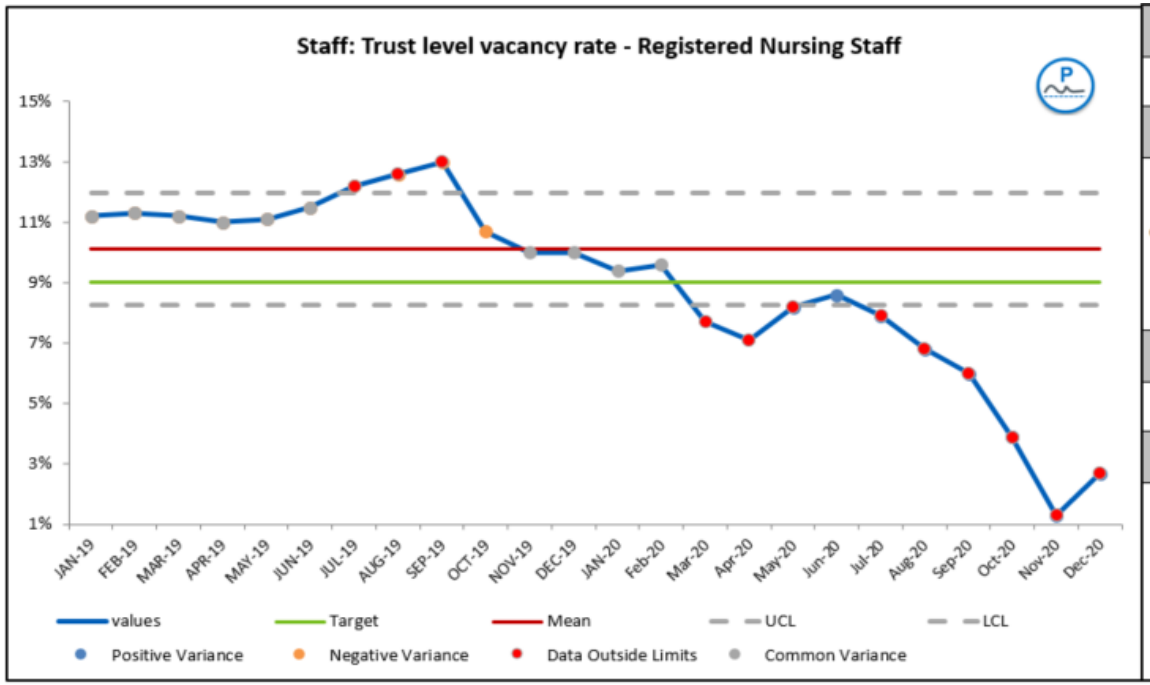
Dec-20
2.6%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
9.0%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:
There is a national shortage of certain specialties which remain persistent hard to recruit roles.

Actions completed:
- High volume of recruitment activity continues resulting in a further decrease in medical vacancy factor.

Actions:
- Collaborative recruitment initiative to look at hard to recruit vacancies to be scoped out with KGH

SPC Charts – Staff: Trust level vacancy rate – Registered nursing staff



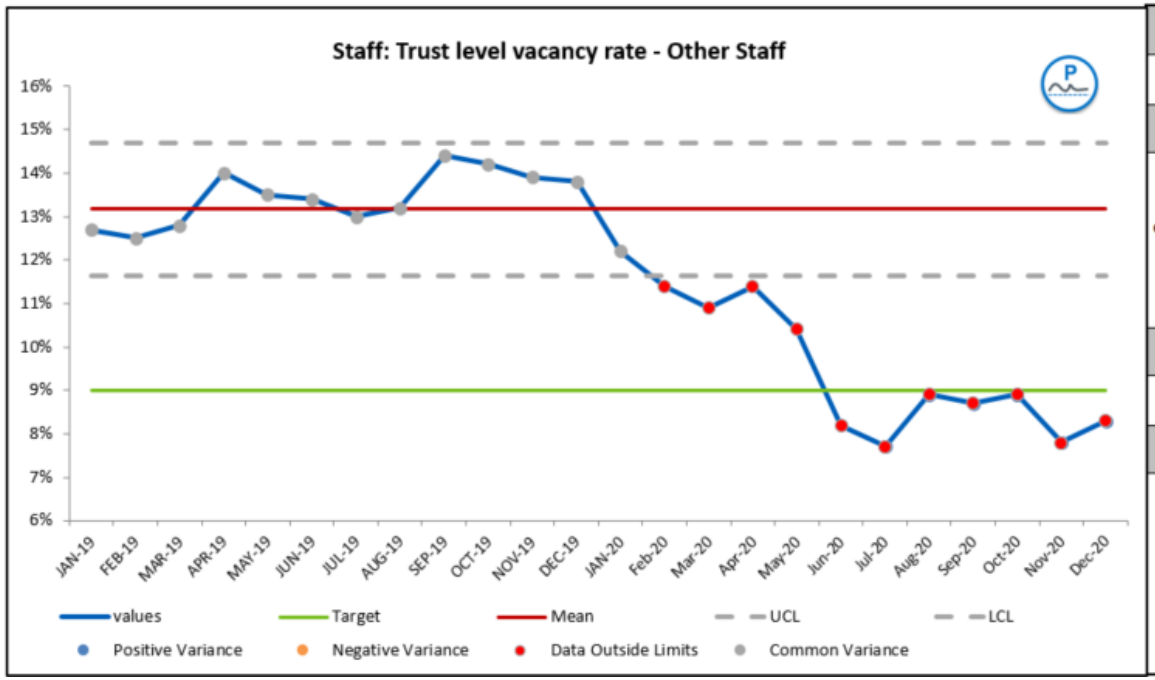
Dec-20
2.7%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
9.0%
Target Achievement
Metric is consistently achieving the target

Context:
There is a national shortage of nursing staff

Actions completed:
- Local recruitment continues – Jan 2021 Overseas recruitment of 12 nurses in January.
- Business case costings for further collaborative bid finalised.
- Establishment of a system level overseas recruitment steering group.
- Further 20 overseas nurses secured from Global Learning each attracting external funding of £7k per nurse

Actions:
- Finalise business case for overseas nurse recruitment for 2021/22
- Establish procurement exercise for collaborative recruitment.
- Recruit to new developed secondment opportunity to have nurse specialist input into nurse recruitment.

SPC Charts – Staff: Trust level vacancy rate – Other staff



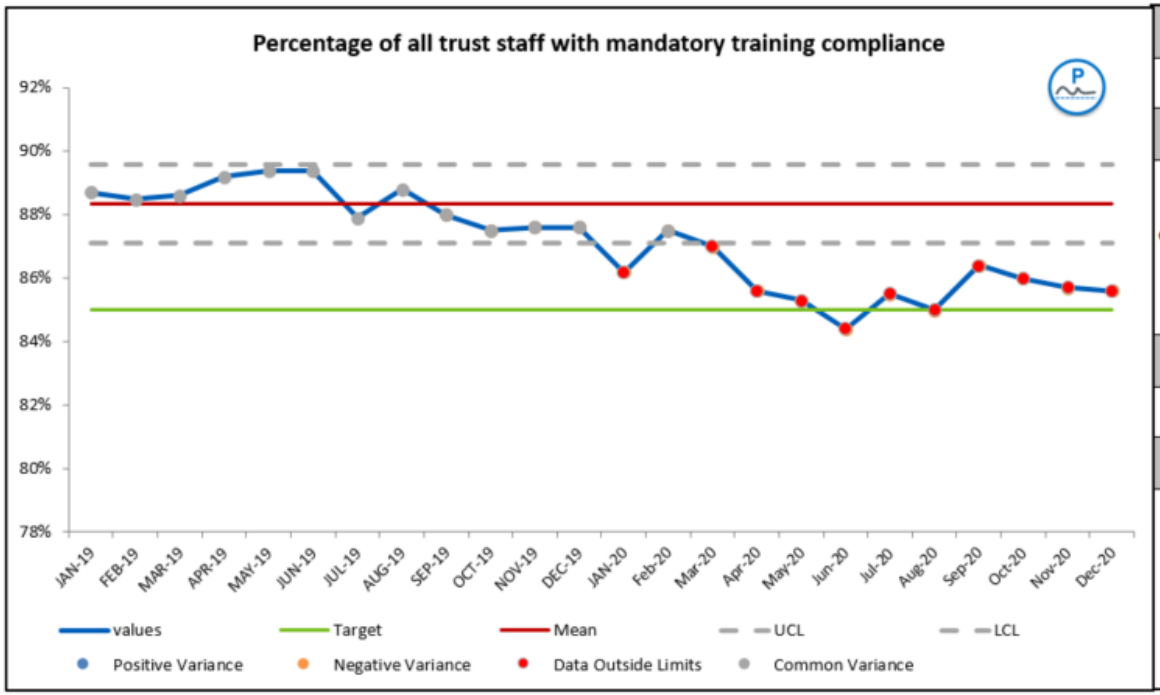
Dec-20
8.3%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
9.0%
Target Achievement
Metric is consistently achieving the target

Context:
There is a national shortage within professional allied specialities

Actions completed:
- Continue high volume recruitment.

Actions:
- Identify hard to recruit vacancies particularly within AHP staff group

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



Dec-20
85.6%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
85.0%
Target Achievement
Metric is consistently achieving the target

Context:

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

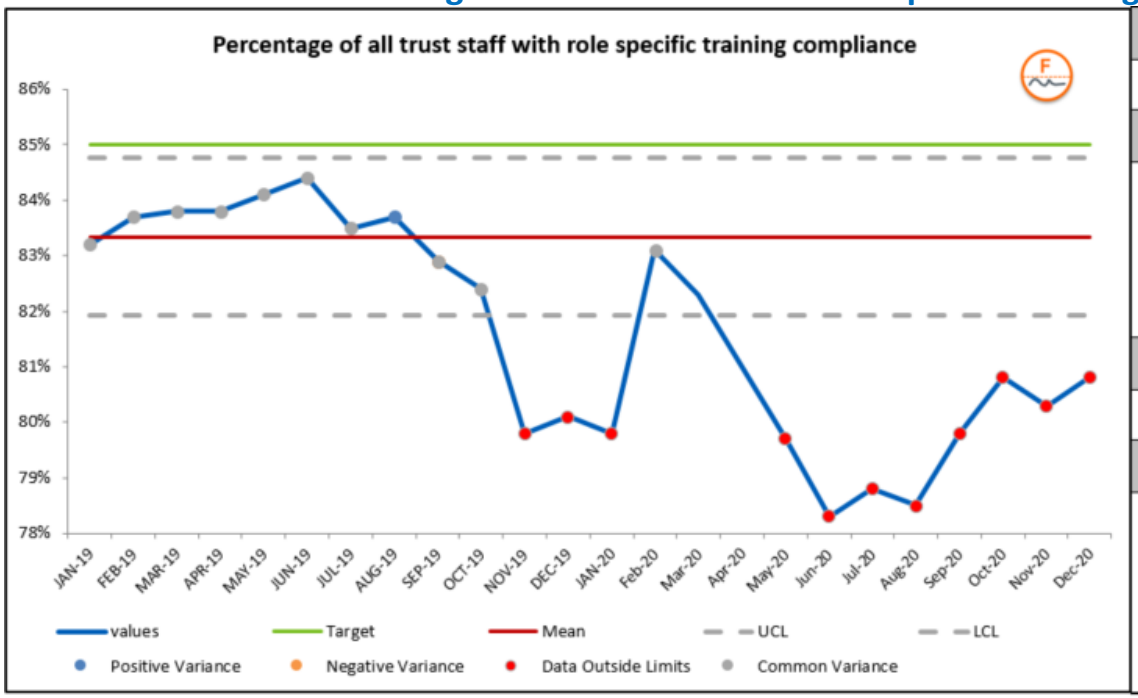
Actions completed:

- E-Learning continues to facilitated.
- Recording and reporting of mandatory training continues.

Actions:

- Continue to facilitate remote mandatory training
- Continue to record and report to divisions

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



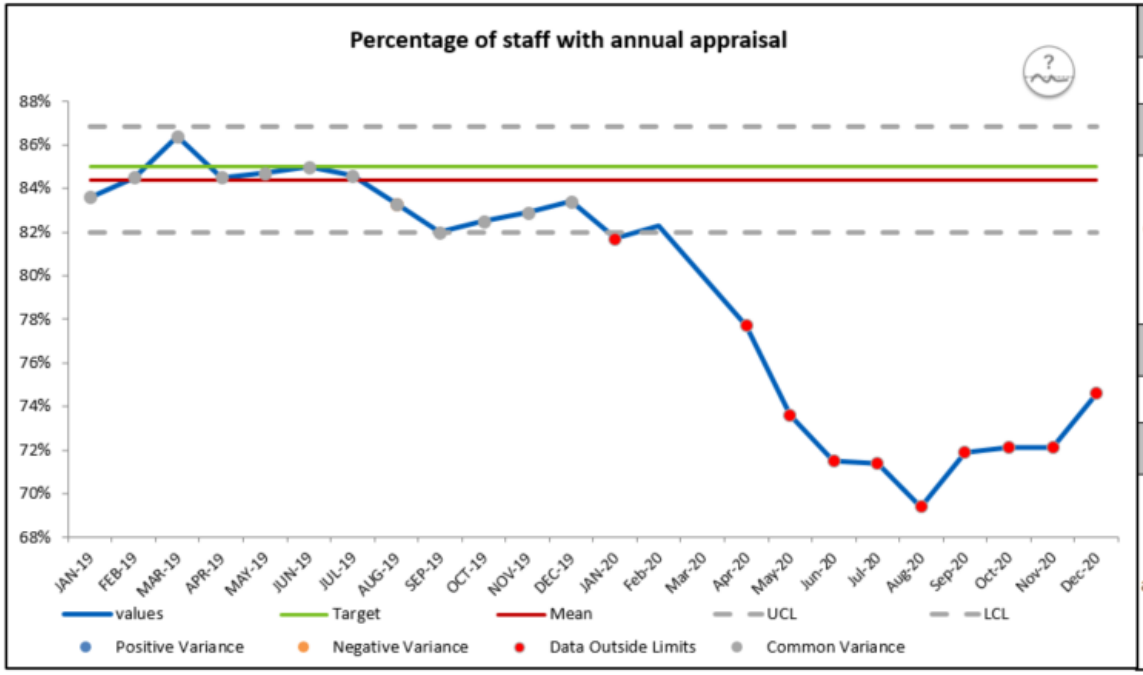
Dec-20
80.8%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
85.0%
Target Achievement
Metric is consistently failing the target

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

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

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

SPC Charts – Percentage of staff with annual appraisal



Dec-20
74.6%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
85.0%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:

Capacity to undertake Appraisals has been impacted by Covid-19

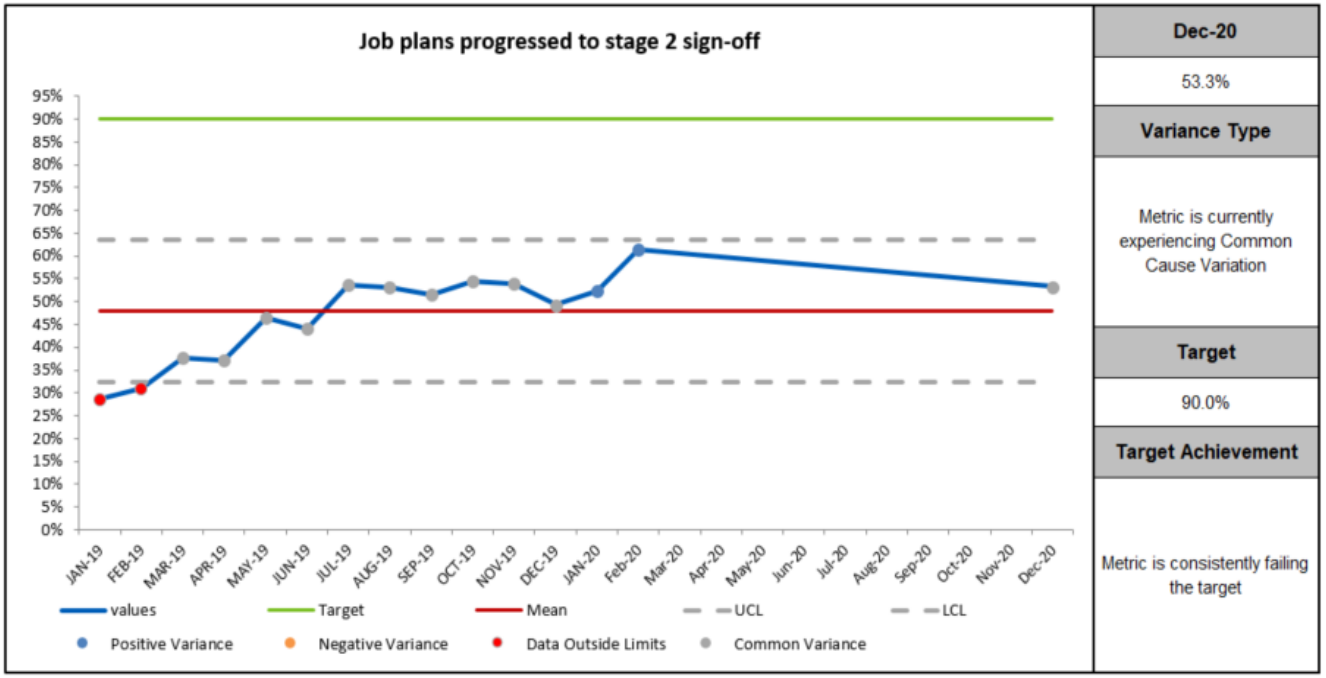
Actions completed:

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

Actions:

- Support and monitor the take up of appraisal light process

SPC Charts – Job plans progressed to stage 2 sign-off



Dec-20
53.3%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90.0%
Target Achievement
Metric is consistently failing the target

Actions:

As aforementioned, Managers and Clinical Directors are supported by the Project team to ensure progress is maintained. Changes to Job Plans are reflected in pay and tracked and reported on a monthly basis.
All job plans awaiting second stage sign off are being notified to the departments to ensure timely progression and expedited to the MD when necessary.

Context:

Job planning data was rebased during April 2020 with the Trust wide lockdown being applied to all clinician's plans. This Decision from the Medical Director was to alleviate pressure on the divisions. For a job plan to be compliant it must have been reviewed within a 12 month period and progressed to second stage sign off – i.e: a job plan that is aligned with the speciality demand and, clinician availability (for the purpose of recording compliance this is the numerator). The denominator will continue to be dynamic as this is attributed to the number of all clinicians within the speciality /division, varying as new consultants either join or leave the speciality workforce and is presented as a rolling 12 month period.

Actions this month:

The job planning process is now being aligned to services migrating to the new medical rostering platform. The project team are working closely with specialties to ensure a higher level of accuracy is being achieved, so that job plans are succinct with real life day to day deliverables. Ophthalmology (pilot for the rostering) despite its current score of 38% actually reflects that those plans still under discussion and in final stages of agreement between the Clinician and Lead.
In September the Surgical Divisional Director requested that all job plans within the division were republished and instructed Clinical Directors and Leads to push ahead with updating plans, this is very much still on-going but due to current pressures will be at a slower pace.

Actions completed in the last month to achieve recovery:
During the last month and those prior where we haven't reported, we have worked continually o amend colleagues who had overpayments or underpayments as a priority aside from the aforementioned programme. We have achieved an accurate reduction and a repayment of many jobs plans by liaising closely with finance managers to work through matters of contention.

Directors view – Director of Nursing

Friends & Family Test:
The FFT recommenced nationally in December 2020 which will be reported as from January 2021, with a slightly revised question looking at the patient's satisfaction of their experience service rather than their recommendation rate. As reported previously the Trust continues to collect feedback locally through SMS messaging and automated voice calls, we are however, not using paper survey cards on the advice of NHSE. We are one of the few Trusts across the country to maintain this service.

Feedback will be reviewed from January 2021, separate to normal data collection months to prevent the skewing of data. The top themes will be reviewed and fedback through the Divisions with any actions highlighted for the patient experience Divisional groups.

Complaints / Compliments:
The NHS Complaints Procedure has opened and significant progress has been made in ensuring that all complaints received are appropriately investigated and responded to. The Trust response rate for complaints registered in December was 100%.

However since December 2020 and wave 2 of the pandemic, clinical staff are finding it hard to respond to complaints, in a timely way, due to clinical commitments. The Trust has increase the response rate for a letter to the complainant to 60 days which is still a challenge for clinical staff.

Infection Prevention & Control Service:
During December there were 6 reported cases of Clostridium difficile Toxin A & B identified as hospital onset on Talbot Butler, Victoria, Allebone and 2 on Critical Care. There has been 2 reported case of MSSA BSI reported during December; sources are osteomyelitis and unknown, post infection review is still in progress. The Vascular Assess Group are reviewing all policies for vascular devices to ensure there are no contradictions as many overlap.

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 December there have been 8 Covid-19 Outbreaks reported across a range of clinical, administrative and specialist teams. Contributory themes include a lack of social distancing, inappropriate doffing of PPE and patient moves. Many of the index cases in the Outbreaks were asymptomatic carriers, therefore the undertaking of the Lateral Flow Testing for staff and swabbing of patients on day of admission, then Day 3, Day 5, and Day7 in line with new national guidance has been implemented. Daily Outbreak meetings occur with attendance of the CCG, PHE and NHSE/I. Regular audits are completed which reflect positive progress made.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28th January 2021**

Title of the Report	**Covid Phase 3 Reset**
Agenda item	**10**
Presenter of Report	Carl Holland, Chief Operating Officer
Author(s) of Report	Carl Holland, Chief Operating Officer Adrian Marsden, Head of Informatics

This paper is for: (delete as appropriate)

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

Executive summary

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

Please note the numbers that are included within the tables should be treated as indicative and are subject to change post coding and validation

Referrals at 96% of Plan

Referrals to the Trust are generally in line with the planned levels,

Outpatients at 96% of Plan

Although the table below suggests a slight under performance (4%), Outpatient attendances at the Trust are also in line with plan, there is a significant over performance against the non-face to face modelling and a mirroring under performance in face to face attendances

Electives at 101% of Plan

Elective activity is at expected levels, this is in part attributed to delivery of Waiting List initiatives and Insourcing and Outsourcing through December

RTT

From the highest position of 650, the number of patients waiting greater than 52 weeks reduced in December from 592 to 542 this is again in part attributed to delivery of Waiting List initiatives and

Insourcing.

Appendix 1 details performance against the 52 week target to weekending 13 December 2020 where 203,000 patients are waiting >52 weeks national and 35,000 in the Midlands.

NEL
There is under performance NEL 0 day LoS & NEL 1 day plus (Non- Covid) activity but significant over performance in NEL 1 day (Covid) activity, the NEL 1 day (Covid) is currently above 200% of wave 1 levels

ED at 71% of plan
The underperformance in core NEL activities is mirrored in ED attendances which are lower than last year but are dominated by COVID presentations and high acuity

Diagnostics
Although the table below suggests under performance in some modalities Diagnostic activities at the Trust are also in line with plan, once all coding is completed it is expected that the position will reflect over performance in all modalities. Currently:
CT – 108%
U/S – 100%
MRI – 96%
Colonoscopy - 99%
Flexi Sig – 80%
Gastroscopy – 86%

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

Actions required by the Trust Board

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

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

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

	Dec 2020									
	NGH			KGH			Group			
RTT	Submitted	Actual	Variance to forecast	Submitted	Actual	Variance to forecast	Submitted	Actual	Variance to forecast	Commentary
The total number of incomplete RTT pathways at the end of the month	32,877	20,386	62%	18,397	15,059	82%	51,274	35,445	69%	The PTL size in each of KGH and NGH, and the Group as a whole, is lower than forecast.
The number of incomplete RTT pathways (patients waiting to start treatment) of 52 weeks or more at the end of the reporting period	42	542	1290%	0	0	-	42	542	1290%	NGH had significantly more 52-week breaches than forecast whereas KGH had zero breaches as forecast. The Group as a whole had more breaches than forecast.
Referrals										
GP Referrals	4,708	4,084	87%	4,016	3,074	77%	8,724	7,158	82%	GP referrals to each of KGH and NGH, and the Group as a whole, are lower than forecast.
Other Referrals	2,073	2,450	118%	3,551	2,917	82%	5,624	5,367	95%	Other referrals are higher than forecast at NGH but lower than forecast at KGH. Overall, other referrals are slightly lower than forecast across the Group.
Total Referrals	**6,781**	**6,534**	**96%**	**7,567**	**5,991**	**79%**	**14,348**	**12,525**	**87%**	Total referrals are slightly lower than forecast at NGH and lower than forecast at KGH. Overall, total referrals are lower than forecast across the Group.
Outpatients										
Consultant-led first outpatient attendances (face-to-face)	5,742	4,412	77%	3,535	3,872	110%	9,277	8,284	89%	Face to face first appointments were lower than forecast at NGH and higher than forecast at KGH, with the Group seeing less patients than forecast
Consultant-led first outpatient attendances (telephone/video)	1,130	3,079	272%	3,135	1,916	61%	4,265	4,995	117%	Telephone first appointments were higher than forecast at NGH and lower than forecast at KGH, with the Group seeing more patients than forecast
Consultant-led follow-up outpatient attendances (face-to-face)	17,191	8,527	50%	6,274	7,616	121%	23,465	16,143	69%	Face to face follow up appointments were lower than forecast at NGH and higher than forecast at KGH, with the Group seeing less patients than forecast
Consultant-led follow-up outpatient attendances (telephone/video)	4,215	11,081	263%	9,212	8,198	89%	13,427	19,279	144%	Telephone follow up appointments were higher than forecast at NGH and lower than forecast at KGH, with the Group seeing more patients than forecast
Total Outpatient Attendances	**28,279**	**27,099**	**96%**	**22,155**	**21,602**	**98%**	**50,434**	**48,701**	**97%**	Overall outpatients appointments were slightly lower than forecast for each of NGH and KGH, and the Group as a whole
Electives										
Day Case spells	3,006	2,960	98%	2,477	2,509	101%	5,483	5,469	100%	Day case activity was slightly lower than forecast at NGH, slightly above forecast at KGH and as forecast for the Group as a whole
Ordinary spells	209	287	137%	315	290	92%	524	577	110%	Ordinary spell (mainly inpatients) activity was higher than forecast at NGH, lower than forecast at KGH and above forecast for the Group as a whole
Total Elective spells	**3,215**	**3,247**	**101%**	**2,791**	**2,799**	**100%**	6,006	6,046	**101%**	Overall elective activity was was slightly above forecast at each of NGH, as forecast at KGH, and slightly above forecast for the Group as a whole
Non Elective										
0 day length of stay	1,740	1,546	89%	900	534	59%	2,640	2,080	79%	0 day length of stay non-elective activity was below plan for NGH, KGH and the Group as a whole.
+1 length of stay - COVID	3	194	6488%	5	230	4600%	8	424	5307%	Covid inpatient non-elective activity was significantly higher than forecast across the Group
+1 length of stay - Non-COVID	2,585	2,041	79%	1,932	1,625	84%	4,517	3,666	81%	Non-covid inpatient non-elective activity was lower than forecast across the Group
Total Non elective admissions	**4,328**	**3,781**	**87%**	**2,837**	**2,389**	**84%**	7,165	6,170	86%	Overall non-elective admissions was lower than forecast across the Group
A&E										
Type 1-4 A&E Attendances	11,665	8,243	71%	8,117	6,329	78%	19,782	14,572	74%	A&E attendances were lower than forecast across the Group
Demand and capacity										
Average number of G&A Beds occupied per day	615	636	103%	474	460	97%	1,089	1,096	101%	Bed occupancy was higher than planned at NGH, lower than planned at KGH and slightly higher than planned across the Group
Average number of G&A Beds available per day	655	655	100%	523	523	100%	1,178	1,178	100%	Bed availability was as planned across the Group
%	94%	97%	103%	91%	88%	97%	92%	93%	101%	% bed occupancy was slightly higher than planned at NGH, slightly lower than planned at KGH and slightly above forecast across the Group
Diagnostic Activity										
Diagnostic Tests - Magnetic Resonance Imaging	1,614	1,546	96%	1,526	1,605	105%	3,140	3,151	100%	MRI activity was slightly below forecast at NGH, above plan at KGH and as forecast across the Group
Diagnostic Tests - Computed Tomography	2,946	3,186	108%	2,555	2,686	105%	5,501	5,872	107%	CT activity was above forecast across the Group
Diagnostic Tests - Non-Obstetric Ultrasound	1,248	1,250	100%	2,499	2,649	106%	3,747	3,899	104%	Ultrasound activity was above forecast across the Group
Diagnostic Tests - Colonoscopy	272	268	99%	95	80	84%	367	348	95%	Colonoscopy activity was below forecast across the Group, particularly at KGH
Diagnostic Tests - Flexi Sigmoidoscopy	82	66	80%	220	151	69%	302	217	72%	Flexible sigmoidoscopy activity activity was below forecast across the Group
Diagnostic Tests - Gastroscopy	240	207	86%	175	139	79%	415	346	83%	Gastroscopy activity was below forecast across the Group
Cancer										
All patients urgently referred with suspected cancer by their GP who received a first outpatient appointment in the given month	1,100	1,145	104%	912	979	107%	2,012	2,124	106%	More patients than forecast were seen following a suspected cancer referral across the Group
Number of patients receiving first definitive treatment following a diagnosis within the month, for all cancers	140	154	110%	105	64	61%	245	218	89%	More patients than forecast were treated for cancer at NGH, with less than expected treated at KGH and across the Group as a whole
Cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral at the end of the reporting period	70	66	94%	60	73	122%	130	139	107%	The cancer backlog was lower than forecast at NGH, but higher than forecast at KGH and across the Group

6) Elective Care Data Pack: 52ww Summary

Northamptonshire Health and Care Partnership

Incomplete - Referral to Treatment - Week Ending 13 Dec 20

England and Regional total are adjusted to remove CRS trial sites from 28/07/19	% waiting <18 weeks			Over 62 weeks		
	w-e 29 Nov 20	w-e 06 Dec 20	w-e 13 Dec 20	w-e 29 Nov 20	w-e 06 Dec 20	w-e 13 Dec 20
Standard	92%	92%	92%	0	0	0
Provider perspective						
ENGLAND	66.3%	67.0%	67.4%	190,544	195,441	203,474
Midlands	63.8%	65.2%	65.4%	31,109	30,934	34,642
Midlands						
Chesterfield Royal Hospital FT	66.7%	67.2%	67.6%	605	663	726
UH Derby & Burton FT	56.7%	57.4%	57.4%	3,725	3,906	4,179
Nottingham University Hospitals Trust	69.2%	69.9%	70.6%	1,206	1,318	1,456
Sherwood Forest Hospitals FT	68.3%	68.7%	68.1%	481	502	517
Shrewsbury and Telford Hospital	59.1%	59.0%	58.4%	1,271	1,357	1,496
The Robert Jones and Agnes Hunt FT	54.5%	54.9%	55.1%	545	585	627
UH North Midlands	66.6%	66.7%	66.4%	2,141	2,282	2,480
Birmingham Women's & Children's Hospital FT	77.1%	78.9%	79.1%	562	595	616
The Royal Orthopaedic Hospital FT	74.3%	74.3%	74.4%	17	19	12
UH Birmingham FT	60.1%	60.5%	60.9%	6,888	7,294	6,803
George Eliot Hospital	64.0%	66.6%	67.2%	798	808	781
South Warwickshire NHS FT	75.5%	76.4%	77.0%	215	241	267
UH Coventry and Warwickshire (CRS trial site)				2,074	2,184	2,303
Sandwell and West Birmingham Hospitals		74.4%	74.7%		653	701
The Dudley Group Of Hospitals FT	83.1%	83.1%	83.4%	29	41	42
The Royal Wolverhampton Hospitals Trust	73.9%	74.6%	75.6%	889	920	976
Walsall Healthcare Trust	74.2%	74.0%	73.8%	58	68	100
Worcestershire Acute Hospitals	55.5%		56.2%	2,611		2,989
Wye Valley	60.0%	61.1%	61.3%	837	850	909
University Hospitals Of Leicester	58.8%	58.6%	58.9%	5,273	5,563	5,797
United Lincolnshire Hospitals Trust	55.5%	56.6%	56.2%	550	573	525
Kettering General Hospital FT	74.5%	74.3%	75.6%	0	0	0
Northampton General Hospital (CRS trial site)				563	571	569

Source: NHSEI Midlands Restoration Report 22 December

Report To	**Public Trust Board**
Date of Meeting	28th January 2021

Title of the Report	Ockenden Report: Maternity Services at the Shrewsbury and Telford Hospital NHS Trust
Agenda item	**11**
Presenter of Report	Sheran Oke, Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Patricia Ryan – Deputy Director of Midwifery / Sue Lloyd Clinical Director

This paper is for:

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

Executive summary

The Okenden Report was published on 10th December 2020 as the result of an investigation into concerns regarding maternity services and care at Shrewsbury and Telford NHS Trust. Within the report 7 Immediate and Essential actions were highlighted that all Trusts were required to benchmark their current position against.

In December 2020, NHSI distributed a tool to support providers to assess and report their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their Trust Boards, Local Maternity System and NHS England and NHS Improvement regional teams.

Trusts have been asked to objectively review their evidence and outcome measures and consider whether they have assurance that that 10 safety actions of the Maternity Incentive Scheme and 7 Immediate and Essential Actions are being met. Trust have also been asked to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards.

Maternity Safety Champions and Non-Executive and Executive leads for Maternity should be involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Following the self-assessment, Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. The self-assessment and assurance tool enclosed is to be submitted to the Northamptonshire LMS and East and West Midlands regional team by 15th January 2021, with a later revised date of the 15th February 2021 in order to complete a gap and thematic analysis which will be reported to the Regional and National Maternity Boards. The evidence to accompany this template has also been delayed for submission to the end of February /March 2021.

The benchmark enclosed has been completed by Deputy Director of Midwifery, Clinical Director, Divisional Director, Consultant Obstetricians and Midwifery Matrons and shared at the Maternity & Neonatal Safety Champions meeting. The following gaps have been identified with what further actions are required both locally and nationally.

Immediate and Essential action 1:

- To consider a separate Maternity Risk Management Strategy.
- To implement the key principles outlined within the Perinatal Clinical Quality Surveillance Model that relate to the providers role.
- Trust Board to receive all maternity SI reports (and a summary of key issues) at least every 3 months.
- Maternity services are to explore with Local Maternity System (LMS) to formalise the criteria for when external clinical specialist opinion from within the region is required for cases that do not fit the HSIB criteria.

Immediate and Essential action 2:

- National clarification is required regarding the role of the independent senior advocate which reports to both the Trust and the LMS board.

Immediate and Essential action 3:

- To commence reporting of training compliance to the LMS in 2021.
- A gap of 1.2 PAs has been identified to provide Consultant Obstetric presence for a post-handover labour ward round in the evening, 7 days a week currently the gap is at weekends of Consultant ward rounds, however there is a Consultant board round at 8pm on weekends to the oncoming night staff. However, additional clarification is required nationally if the intention long-term is for the consultant obstetric led ward round to be conducted with the on-coming night medical staff.

Immediate and Essential action 4:

- Pathways for Maternal Medicine need to be formalised via the Northampton shire LMS and East midlands network We currently refer to Oxford

Immediate and Essential action 5:

- Review of our current processes to ensure that a named consultant is clearly identified on Medway for women with complex pregnancy.
- Audit of women with complex pregnancies to ensure they are referred for Consultant care
- Development of a risk assessment tool for all women for each antenatal contact by all disciplines of staff.
- Digital midwife to be funded and recruited.

Immediate and Essential action 6:

- Classify all SI/HSIB based on foetal monitoring contributory factors and audit each case going forward.
- Develop a role description for the lead obstetrician with responsibility for monitoring foetal wellbeing as set out in Ockenden and funding for one PA for one dedicated Consultant Obstetrician

Immediate and Essential action 7:

- Audit of where women are sourcing information in relation to choice and information
- Report on choices to the Patient Experience Group

Section 2: Midwifery workforce planning:

- Business case for 9.8wte to meet birth rate compliance has been agreed from 1st April 2021; advert currently out on NHS jobs.

Midwifery leadership:

- Consultant Midwife post to be considered to support clinical pathways
- NICE guidance in relation to Maternity.

Gap analysis to be undertaken for non-compliance.

Required actions will be pulled together into an action plan, which will be monitored via QGC and reported to Trust Board.	
Related strategic pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable excellence through our people*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: **Yes** Failure to meet statutory requirements can lead to improvement notices, and prosecution and in extremes withdrawal of Trust services
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? **(No)** Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **(No)**
Financial Implications	Some actions will require additional funds e.g. business cases and capital projects. Failure to meet requirements can lead to fines.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: **Yes** **CQC Fundamental Standards** The Trust has been issued with three requirement notice following the CQC inspection. Two in relation to Regulation 12 (2) (g): The proper and safe use of medicines. One in relation to Regulation 16 (2): Receiving and acting on complaints.

Actions required by the Board:

The Board is asked to:

- Note the information contained in this report and support the financial investment required to progress these safety actions and the requirement to strengthen Maternity Governance.

Maternity Services Assessment and Assurance Tool

Northampton General Hospital

Northamptonshire LMNS

Section 1
Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight. • Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. • External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum foetal death, maternal death, neonatal brain injury and neonatal death. • All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months
Link to Maternity Safety actions: **Action 1:** Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? **Action 2:** Are you submitting data to the Maternity Services Dataset to the required standard? **Action 10:** Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?
Link to urgent clinical priorities: (a) A plan to implement the Perinatal Clinical Quality Surveillance Model (b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	A. A plan to implement the Perinatal Clinical Quality Surveillance Model was published and received by Northampton General Hospital on 21st December 2020. The recommendations are currently being considered by the Trust. A Maternity risk management strategy is being developed which will outline the reporting structure and will include the outlines of Principle 1 and 5 of implementing a revised perinatal quality surveillance model. From January 2021 all Maternity Serious Incidents will be reported bi - monthly to the Trust Board by the Medical Director. There are monthly Maternity and Neonatal Safety Champion meetings with the Executive and Non-Executive Safety Champions which has a standing agenda and the following are tabled and discussed Maternity Dashboard, Serious Incidents/Comprehensive Investigation and HSIB Investigations and moderate harms are discussed. There is a new Maternity Safety Action plan which highlights all the recommendations from National reports. Quarterly PMRT and Term admission reports and Still birth bundle dashboard are reviewed. There is a monthly exception report from this meeting by the Executive and Non-Executive Maternity Safety Champion to the Quality Governance Committee which is a subcommittee of the Trust Board. There is an escalation highlight report from the Maternity and Neonatal Safety Champion meeting to the Quality Governance Committee, which is a sub-committee of the Trust Board. From January 2021 we will incorporate in the performance report an update relating to maternity and neonatal safety and quality. We will need to further develop this. The Quarterly PMRT report is presented at the Mortality meetings chaired by the Executive Medical Director. B. An external clinical specialist opinion from outside the Trust, but within the region, is mandated for cases of Intrapartum foetal death, maternal death, neonatal brain injury and neonatal death. Currently, all term babies (greater than 37 weeks) are referred to HSIB. All HSIB cases are reported to the Trusts Review of Harm Group and in our current guidance they are not automatically declared as serious incidents although this will need to be revised in light of the HSIB letter received December 2020/January 2021 outlining that all HSIB cases are to be declared as Serious Incidents. This guidance is currently being updated. If HSIB refers the case back to the Trust, either because the case does not fit criteria or due to the family not giving consent, the Trust undertakes an internal serious incident investigation. Northampton General Hospital has networked with local Trusts, to request an external clinical opinion on some internal Serious Incident investigations. The Trust also submits data through standardised perinatal mortality reviews, PMRT, on all antenatal/intrapartum stillbirths, neonatal deaths. We are currently reviewing the current PMRT process so as to strengthen the reviews and develop and implement learning through a PMRT action plan. We had an external review of Stillbirths/Neonatal Deaths by an external Consultant Obstetrician / external Head of Midwifery on all case of still birth and neonatal deaths from January 2019 to March 2020.We and are in the process of implementing the recommendations from this review and await the finalised report. C. All maternity SI's are currently reported through the Trust Board via Quality Governance Committee (QGC), a sub-committee Trust Board. As from January 2021 all maternity SI's will be reported through the governance process and Trust Board.

Describe how we are using this measurement and reporting to drive improvement?	The Trust continues to share learning from incidents in variety of ways in order to drive improvement. Following a HSIB or SI or Comprehensive investigation, action plans are monitored through the Trust internal governance process. Actions are implemented, with the intention of mitigating future risks and minimising incidents. For example, learning is shared thorough the mortality and morbidity meetings and included in maternity emergency training scenarios. There are daily Datix reviews and daily safety huddles with Neonatal Teams and weekly Maternity Incident Review meetings where cases are reviewed by Multi-disciplinary Team. There is a weekly Datix report of all incidents that is sent to the Teams with a report on incidents reported and learning for teams and also noting the good practice during the week that have been noted .There is individual feedback to staff on learning and formal letters to all disciplines of staff noting good practice. All 'moderate harms' on Datix are reviewed by the Maternity team, early learning identified and shared and all 'moderate harms' are escalated to the Review of Harm Group which is chaired by Medical Director and has representations from the Corporate Governance team, Divisional Medical Director/Associate Directors of Nursing. It is this group which decide if Maternity Incidents that are of moderate / severe harm meet the criteria for Serious Incidents or a Comprehensive Investigation. All the investigations are led by and written by the Corporate Governance team with input on the subject matter from the Matron/ Consultant Obstetrician. The Corporate Governance team contact the Mother and advise her on the time scales of the investigation and the formal duty of candour is completed. The parents are contacted by the Clinical Governance team who are tasked with all incident investigations for the Trust. The parents are contacted firstly by telephone where they are provided with an apology on behalf of the Trust, given an explanation into the investigation process and asked if they wish to contribute to the investigation and if they have any specific questions, this verbal Duty of Candour is then followed up with a letter from the Head of Governance which will also provide the family with a named contact from both the Clinical Governance team as well as a member of the maternity service. An agreed timescale is discussed with the family during the Duty of Candour telephone call. Families who have adverse outcomes will have an identified senior midwife as a point of contact during the investigation process. The Maternity Services summarise the reports in a close down Serious Incident/Root Cause report and these are shared with all discipline of staff. All the SI /CI Learning from incidents involving problems with foetal monitoring are shared with the Foetal Surveillance Midwife who uses these cases as learning on a weekly basis. The Serious Incidents HSIB investigations and Comprehensive Investigations are presented at Mortality and Morbidity meetings. In terms of continuing assurance, audits are undertaken to ensure improvements following an incident to ensure functioning and efficient processes in practice are embedded within the service .If the monthly audit highlights an issue i.e. example CTG monitoring then the Foetal Surveillance Midwife will progress to weekly audits to ensure full learning embedded.

How do we know that our improvement actions are effective and that we are learning at system and trust level?	The Trust Board has oversight of completed investigations and outcomes via existing corporate governance structures. Initially, learning, recommendations and associated actions are reported at the Maternity Risk meetings and Maternity Governance Group. The Obstetric, Midwifery and Neonatal Safety Champions meet with the Trust Maternity Executive Director and Non-Executive Director on a monthly basis. There is an established and updated agenda and the Maternity action plan, current Serious Incidents and Comprehensive are presented and the maternity dashboard is reviewed to discuss current issues and improvement initiatives within the maternity department. The Still Birth Bundle Dashboard is reviewed and Moderate Harms are reviewed and the outcomes from review of harm group of these harms are discussed. Alongside these governance processes, the Trust has oversight of key measures that align with national ambitions, for example stillbirth rate and neonatal deaths as outlined in the maternity dashboard.
What further action do we need to take?	1a. NGH will continue with the current mechanisms of reporting and oversight. In addition, a separate maternity risk management strategy will be developed and will include the key principles outlined within the Perinatal Clinical Quality Surveillance Model that relate to the providers role. 1b. The Trust is to explore with LMS to formalise the criteria for when external clinical specialist opinion from within the region is required for cases that do not fit the HSIB criteria. 1c. Clarification is needed on how to fulfil the requirement for local specialist opinion to be involved in the investigation of serious incidents for cases referred to and accepted by HSIB. 1d. Clarification is required on the definition of neonatal brain injury.
Who and by when?	1a. Patricia Ryan, Deputy Director of Midwifery, Sue Lloyd Clinical Director Obstetrics April 2021 1b,c and d. LMS board, March 2021
What resource or support do we need?	No resources required.
How will mitigate risk in the short term?	1a. Maternity safety action plan in place with associated papers.

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	Lead PMA runs a weekly clinic for women to attend who have concerns about any aspects of care they have received. Women also attend if support is needed with complex pregnancies and women /midwives need support with individualised birth plans. Women can self-refer and referrals are also made by midwives and obstetricians as well as PALs. Lead PMA works closely with MDT. Feedback when required is disseminated both individually and through team meetings. Pre COVID 2 monthly MVP meetings, 15 steps organised by Health watch using MVP members. During COVID our close working relationship with the MVP has been invaluable to ensure the many changes happening within maternity services. There is a Non-Executive Director for Maternity. Their role includes maintaining oversight of maternity services and specific responsibility for ensuring that women and family voices across the Trust are represented at Board Level. They work collaboratively with Maternity and Neonatal Safety Champions, and attend the monthly meeting.

How will we evidence that we are meeting the requirements?	Monthly meetings are held with the Trust Director for Maternity and the Maternity Safety Champions team. Subjects discussed within the meeting include updates on quality improvement safety initiatives, user feedback, learning from incidents and the maternity safety action plan. The Trust has an active Maternity Voice Partnership (MVP) with a lay chair and associated chair. MVP has 1.6 thousand members. There is a local MVP strategy with agreed terms of reference. There are regular meetings between MVP representatives, the Head of Midwifery and the Senior Maternity Team. The agenda is co-produced and the meeting is chaired by the lay service user. These meetings facilitate timely discussion of current events, for example visiting policy consultation, women's experience feedback; the nature of information provided to women. The meeting will also agree work stream priorities. In addition to the feedback received through our MVP, regular feedback is collated centrally by the patient experience team and includes responses from the Family and Friends Test, complemented by the annual CQC maternity survey, as well as feedback from concerns, compliments or complaints raised. The questionnaire was designed in partnership with our MVP to capture feedback in relation to areas that were identified for improvements in our CQC maternity survey. The results can be viewed and reports generated through an online portal. Feedback about the Q&As from service users has been extremely positive. The MVP Facebook group receives daily requests to join as people hear what an excellent forum it is to get accurate information about maternity services during covid-19. The Continuity Teams who are prioritising BAME women, have worked closely with the Patient Experience Lead and have been actively collecting feedback from these service users relating to the development of information leaflets about the teams. Accessibility to a specific Matron/PMA clinic to voice any concerns, or develop individualised management plans when women choose to go against advice, is well promoted and service is well attended. Service changes have been made based on feedback. Accessibility to clinic and senior midwives is well promoted and service is well attended
How do we know that these roles are effective?	During COVID 19 pandemic the MVP played a pivotal role in relation to the provision of feedback on patient information leaflets, website information, and our virtual parenthood workshops. In partnership with the MVP, regular Matron Clinics are facilitated to capture user feedback and provide a platform for women and their partners to ask questions or have their voice heard. Dates for MVP meetings in 2021 have been planned and circulated and are available on the women's maternity platform. MVP worked with Healthwatch and the lead PMA to do '15 steps' around maternity, which included a '15 step report', followed by actions which were then implemented. During Covid, a virtual 15 steps was facilitated. All women receive a copy of a Personal Care Plan, which was developed in line with Better Births. MVP were closely involved in the development of the plan, which is available in our top five languages. It encourages women to express their thoughts, feelings and questions throughout their care. An easy read version is also available and was taken to the 'Chit Chat Group' for women with a learning disability as part of its development.

	At the end of March, in the true spirit of co-production and partnership working, Northamptonshire MVP and KGH & NGH Maternity Services decided to start running weekly live Q&A sessions for local families. Given the immense pressure everyone was under, it was agreed that it would be the most efficient use of time to co-produce accurate and up-to-date information and gather feedback from families. We also felt that if people could see their midwives faces and hear them answering questions in a live forum it would provide reassurance. On April 3rd we held the first session with 97 attendees, these have been running them weekly and then fortnightly. The calls are hosted by the MVP Chair with senior midwifery staff from both NGH and KGH attending to answer questions. Answers to questions are shared on the MVP Facebook group each week in a series of date-stamped themed posts. Feedback about the Q&As from service users has been extremely positive. The MVP Facebook group receives daily requests to join as people hear what an excellent forum it is to get accurate information about maternity services during covid-19.
What further action do we need to take?	2a. The above described support for families will remain standard practice. In November 2020 MVP set up a new service user group specifically for the Better Birth work streams. A service user will be attached to each stream : • Post-natal Pathway • Perinatal Mental Health • Transforming Neo- natal care • Promoting good practice for safer care • Personalised Care • Continue to work with the users to further develop the website
Who and by when?	2a. Awaiting national guidance. Independent Senior Advocate
What resource or support do we need?	2a. Awaiting national guidance. Independent Senior Advocate
How will we mitigate risk in the short term?	Continue working with the users

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3	A. The practice development midwifery team maintained obstetric emergency skills training from March 2020 as face to face training, 8 staff trained per session as per Covid restrictions. PD team supported the following elements in clinical practice: • Upskilling Midwives to care for immediate post section women • Facilitated Maternity Enhanced Care training sessions which included care of the arterial line, interpretation of blood gases and oxygen therapy • Point of care scenarios in hospital based settings • Supported junior midwives in hospital based settings • PPE risk assessments for Midwives and MSWs • In October 2020 we accessed the PROMPT e-learning package which was localised by producing an MDT, PPH and Eclampsia videos • PROMPT e-learning package is being delivered via Microsoft Teams and the PROMPT e-learning package is in the process of being available of the Moodle platform for staff to access • From January 2021 all Midwives, MSWs, Gynae Theatre staff, Consultant Obstetricians have been allocated date on the monthly training database so as to ensure compliance currently developing an educational dashboard to further monitor compliance Oversight of training compliance is Midwifery Professional Leads meetings quarterly report for maternity Governance and is a standing agenda item on Maternity Governance meeting

	B. At the, twice daily consultant present and led ward rounds are held at 08:00 and 16.30 Monday to Friday. During the week there is a Consultant ward round on Labour Ward which commences at 16:30 -1800 with a Consultant Obstetrician, Consultant Anaesthetist, Labour Ward Co-ordinator, Obstetric Registrar and Anaesthetic registrar. At 20:00 the consultant obstetrician does a board round with the incoming night shift. Weekend and bank holiday consultant led ward rounds are held at 08:00.am and there is currently no formal consultant obstetric ward round in the evening at weekends, there is a board round at 8pm to the oncoming night staff to implement the board round this will require 1.2 PA to support this. C. External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only. Examples include CNST year. CNST MIS refunds have been reinvested within Maternity Services to promote safety
What are our monitoring mechanisms?	A. Current oversight is monitored quarterly at the Maternity Risk Management meeting and is a standing agenda on the maternity governance meeting. B. The service has completed a spot check audit of consultant led labour ward rounds for compliance against the current consultant led ward rounds.
Where will compliance with these requirements be reported?	Educational compliance is monitored at the monthly at the Professional Leads Midwifery Group and is now a standing agenda on the Maternity Governance meetings. In 2021 the LMS will validate training 3 times per year. We are currently producing a Training dashboard for further monitoring.
What further action do we need to take?	3a. To commence reporting of training compliance to the LMS in 2021. 3b. 1.2 PA is required to provide consultant obstetric presence at weekends. Additional clarification is required nationally if the intention long-term is for the consultant obstetric led ward round to be conducted with the on-coming night medical staff. Clarification needed if it is a board or a ward round
Who and by when?	LMS board, March 2021
What resource or support do we need?	Funding 1.2 PA, Consultant Obstetrician
How will we mitigate risk in the short term?	Consultant board rounds at weekends

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	A referral is sent to the lead Cons Obstetrician for Antenatal Clinic and the Antenatal Clinic Manager and the referral is reviewed and the woman is triaged into the appropriate clinic at an appropriate gestation. In the event that a woman with a low-risk pregnancy develops complications a named consultant is identified at the time the complexity is identified. For example, following an abnormal GTT result the care of the woman would be transferred to the obstetric consultant managing diabetes in pregnancy. There is an established Antenatal clinic for Medical Disorders in pregnancy where women with pre-existing Medical problems are referred under a named Lead Consultant Obstetrician. The only exceptions to this referral are women with epilepsy or hypothyroidism – who are not specifically under the Maternal Medicine Lead. Those women are referred to any Obstetrician. Northampton General Maternal Medicine Lead maintains close liaison with Thames Valley Maternal Medicine Network (Tertiary referral Maternal Medicine Centre being Oxford) and East Midlands Maternal Medicine Network (most tertiary referral to Leicester). There is an established referral pathway to Oxford for high risk women who have a defined pathway and there is a Consultant who is the lead for women with medical problems. Though there is no joint antenatal clinic at NGH, however, there is good local support from Haematology, Rheumatology, Neurology, Cardiology, Gastroenterology, Respiratory and Obstetric Anaesthetic team to provide care for women with complex pre-existing medical conditions. Women with Sickle Cell and Thalassaemia in pregnancy are referred to East midlands Sickle Cell and Thalassaemia Network at Leicester. Women with Haemophilia in pregnancy are referred to Regional Haemophilia centre at Oxford.

	There is an ongoing work to develop a SOP for women with cardiac condition in pregnancy. There is a service for GUCH (Grown up congenital heart) clinic which is run by visiting Cardiologist from Oxford. Most women with cardiac condition will be referred to this clinic or Oxford during pregnancy. There is an established pre-conception service for women with pre-existing medical disorder in pregnancy. There is comprehensive perinatal mental health team, with dedicated Perinatal Psychiatrist Consultant Obstetrician and a midwife who run a monthly clinic and who develop multidisciplinary team plans for these women. Data is submitted to the National in Diabetes Audit. There are guidelines in place for epilepsy and there are pathway of care in place for these high-risk women referral to Oxford. The following joint obstetric medical clinics are well established and include diabetes and other endocrine disorders (except hythyroid) seen in pregnancy Mothers who require input outside of these specialties are referred through a well-established pathway to the appropriate Specialist antenatal clinics in Oxford. The Trust is currently compliant with 4 out of the 5 saving babies' lives elements. Element 1 has been re-introduced CO monitoring was re-introduced in December 2020. Although a conversation about smoking and referral to stop smoking services at booking is undertaken 95-100%, the conversation at each antenatal appointment especially the 36 week appointment continues to be embedded in practice and is currently being audited. There is a plan to roll out uterine artery dopplers in March/April.
What are our monitoring mechanisms?	Most multidisciplinary discussions with various specialities are carried out by the Maternal Medicine Lead via Email. Discussions also take place via formal letters. The MDT email discussions are cut/pasted on Medway IT System by the Maternal Medicine Lead. Letters of correspondences are scanned in by Medical Secretary to Medway. This is to ensure that outcome of care is available to other Obstetric Team Members in Emergency. Thames Valley Maternal Medicine Network is now using OARS software for referral. This will document multidisciplinary patient care electronically. There is an ongoing discussion with IT at NGH for implementation of this system. This will help to monitor patient flow and create audit report.
Where is this reported?	Stillbirth bundle dashboard is submitted to Maternity Governance meeting, Midwifery Professional Leads meeting and LMNS. Medical complexity cases reported to the Maternal Medicine Network in the East Midlands
What further action do we need to take?	Developing a risk assessment for all women early in booking so as a booking midwife can ensure that women are referred promptly to high risk clinics pending booking appointment To develop SOP for women with cardiac condition in pregnancy Work continues towards implementing OARS referral system to Oxford and continue to maintain links with both Thames Valley and East Midlands Maternal Medicine Network. The service needs to consider developing a joint Haematology/ Obstetric service East Midlands Pathways for Maternal Medicine need to be formalised via the LMS.

	Audit of women with complex pregnancies to ensure they are referred to Consultant care
Who and by when?	Clinical Director February 2021 noting that ongoing work is occurring across the East Midlands Network
What resources or support do we need?	1. Support from MCEG for audit and developing SOP 2. Support from IT for implementation of OARS 3. Support from Obstetric and Haematology service lead to develop Joint Haem/ Obs clinic
How will we mitigate risk in the short term?	Dedicated obstetric Consultant for Complex pregnancy who triages the referrals

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include on-going review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include on-going review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	At the maternity booking appointment, a risk assessment is completed using a detailed risk assessment form on the Perinatal notes and additionally on Medway system the booking is recorded. The antenatal contacts are documented in the antenatal notes and the Medway system is not utilised again until postnatal. The woman is referred to a named obstetrician as indicated by the risk assessment at each antenatal contact, each woman's risk factors are reviewed, any changes to the woman's risk factors are reflected within their plan of care in the notes and where required the woman is referred to a named consultant obstetrician and or specialist for gestation diabetes. Any changes following the risk assessment should be documented as part of the woman's on going personalised care plan which clinicians are required to discuss and update at each contact. On Medway information System there is a field at every antenatal appointment in which the reviewing clinician can undertakes a risk assessment and completes a review of care and there is the possibility to update the record and change the location of birth at each antenatal contact

What are our monitoring mechanisms and where are they reported?	Monthly spot check audit in place.
Where is this reported?	Compliance reports will be submitted to the monthly Maternity Risk Management meeting /Maternity Governance
What further action do we need to take?	Review of our current processes (paper and digital in process) to ensure that a named consultant is clearly identified on Medway for women with complex pregnancy and in the notes .The maternity services needs to progress and move all discipline of staff using Medway (paper light system) so as the risk assessment can be completed by all disciplines at each point of antenatal contact by Obstetricians /Midwifery sonographers/midwifes in triage/Labour ward etc. The capability of Medway needs to be developed and strengthened so as to support an Information structure to support a fully digitalised system for maternity services and further support safety. Business case and job description completed for this post awaiting banding and financial resource
Who and by when?	Digitalisation of Medway with all disciplines of staff using Medway to support paper light by and paper light by October 2021
What resources or support do we need?	Digital Midwife to lead on the digitalisation of Maternity Services Business Case and Job Description completed awaiting financial approval Awaiting Banding Support from Information Technology.
How will we mitigate risk in the short term?	Risk is controlled as paper risk assessment developed and has been submitted to the publisher to ensure risk assessment at each antenatal contact whilst awaiting the appointment of Digital Midwife to lead and embed digitalisation of maternity services for safety.

Immediate and essential action 6: Monitoring Foetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in foetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring foetal wellbeing –
- Consolidating existing knowledge of monitoring foetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of foetal wellbeing monitoring –
- Ensuring that colleagues engaged in foetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental foetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities: a) Implement the saving babies' lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	
What do we have in place currently to meet all requirements of IEA 6?	1. Foetal Surveillance (FS) Midwife leads on all five elements of Saving Babies' Lives version 2 and is the Foetal Monitoring Lead Midwife 2. New CTG guideline launched October 12th 2020 including foetal physiology, Intermittent Auscultation and human factors to be consistent with Regional Foetal Monitoring Network 3. Weekly MDT remote CTG meetings to discuss and learn from recent CTG cases Serious Incident /HSIB /Comprehensive Investigations' and share best practice. 4. FS Midwife and CD attend Regional Clinical Network Foetal Monitoring meetings – discuss cases and learn from incidents. National recommendations and new developments in the field discussed and reviewed with plans on how to introduce any developments as a region. 5. FS MW participates in review of cases where there are concerns with CTG interpretation and informs the report. 6. Compliant with element 4 of SBLCBv2 7 Projected Plan to implement Uterine Artery Doppler's by March /April 2021
How will we evidence that our leads are undertaking the role in full?	1. Training attendance and compliance, weekly CTG and IA audits, attendance at community hubs. 2. All staff midwifery and medical that provide intrapartum care trained in new guidance and competency assessed. 3. Record kept of attendance at weekly CTG meetings and cases discussed. 4. Minutes of meetings and actions. 5. Findings and actions from case reviews where adverse outcome involving poor CTG interpretation and practice. 6. Ongoing audits – 10 sets of notes per week – of CTG interpretation, fresh eyes, application to practice and escalation. Findings shared with staff, midwives sent letters where areas of good practice recognised and where need for learning is identified.

What outcomes will we use to demonstrate that our processes are effective?	Reduction in Term admissions to NNU following foetal monitoring concerns. Reduction in H.I.E cases Reduction in Intrapartum Still Births.
What further action do we need to take?	1. Appoint a lead obstetrician with dedicated PA for the role. 2 Continue to audit compliance with CTG guideline and Intermittent Auscultation Guideline on a monthly basis and feedback on Audits to all disciplines of staff 4. Establish a local group of CTG champions who work clinically providing Intrapartum care to ensure feedback learning from incidents and the sharing of good practice. CTG champions will be visible in the clinical area to support with escalation and the appropriate management of CTGs.
Who and by when?	1. Clinical director to appoint Lead Obstetrician when funding agreed 4. Foetal Surveillance Midwife to establish group before end of Q1 – March 2021
What resources or support do we need?	1. Funding for 1 PA Session for this role and Job description for this role.
How will we mitigate risk in the short term?	1. Clinical Director attends Regional Foetal Monitoring Groups, MDT CTG meetings and feedback to medical staff regarding findings, opportunities for learning and areas of best practice. Labour Ward Consultant Obstetrician is supporting this currently but not a dedicated role with the job description

Immediate and essential action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected	
Link to Maternity Safety actions: **Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?**	
Link to urgent clinical priorities: a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	
What do we have in place currently to meet all requirements of IEA 7?	Strategies in place to increase the number of leaflets in different languages. Currently have the choices leaflet in different languages available on the website. Maternal requests for Caesarean Sections is part of the Caesarean Section Guideline
Where and how often do we report this?	Women are seen in the Matrons clinic to discuss their choices and women have a personalised care plan which is discussed. The PMA Lead presents the Patient Experience report at the Patient Experience Board meetings.
How do we know that our processes are effective?	Annual auditing of user feedback through the CQC maternity survey ,reduced foetal movement survey of women and quarterly analysis of modified FFT questionnaire which will include questions related to access to information to enable informed choice.
What further action do we need to take?	Continue working with the Culture and Diversity lead and Communications team in the Trust to develop more leaflets and information in other languages and further develop the website informing women of the service Audit of where women are sourcing information for the choices leaflet

Who and by when?	Lead PMA /Community Matron /Quality Matron/Communications Department/Equality and Diversity Manager
What resources or support do we need?	Communications Department to be able to update the website
How will we mitigate risk in the short term?	Midwives use translation services for all contact with women who require an interpreter whilst resources are being developed and introduced on the website. Matrons Clinic for choice is in place

Section 2	
MATERNITY WORKFORCE PLANNING	
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**	
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.	
What process have we undertaken?	Maternity workforce was reviewed using a BR+ model in 2018. A business case for 9.8wte midwives was submitted to the Trust Board in 2019 to ensure compliance with BR+ model. The funding for 9.8wte midwives has been agreed for budget in April 2021, we are currently recruiting for these posts. The Trust Board receive a midwifery safe staffing report on a six monthly basis.
How have we assured that our plans are robust and realistic?	Midwifery workforce business case submitted to meet BR + compliance.
How will ensure oversight of progress against our plans going forwards?	Maternity and Neonatal Champion's Board.
What further action do we need to take?	Out to advert and awaiting to recruit
Who and by when?	As soon as possible
What resources or support do we need?	None.
How will we mitigate risk in the short term?	Escalation Policy and Maternity Safety Huddles

MIDWIFERY LEADERSHIP **Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in** Strengthening midwifery leadership: a manifesto for better maternity care
The RCM publication 'Strengthening midwifery leadership: a manifesto for better maternity care suggests seven steps to strengthen midwifery leadership. 1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service 2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally 3. More consultant midwives 4. Specialist midwives in every trust and health board 5. Strengthening and supporting sustainable midwifery leadership in education and research 6. A commitment to fund on going midwifery leadership development 7. Professional input into the appointment of midwife leaders The service has a number of specialist midwives such as safeguarding lead midwife, antenatal and newborn screening midwifery team, bereavement midwives, diabetic midwives, infant feeding midwives and foetal surveillance midwife. The gap is there is currently no Consultant midwife who would strengthen midwifery leadership and develop and promote research within the service.

NICE GUIDANCE RELATED TO MATERNITY	
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	
What process do we have in place currently?	Approach to NICE guidelines – assessment and implementation The Maternity Clinical Effectiveness Group meetings review local guidelines. The Clinical Effectiveness Chair is a member of the NICE effectiveness committee receives monthly email updates or instruction emails when there are new guideline inclusions or updates and this ensures up to date knowledge of change in evidence and practice. This is then presented at the CE group and a monthly agenda item. The Maternity Clinical Effectiveness Group benchmarks our current service against any new guidance and undergoes a gap analysis. This is then presented to the monthly Governance Group as an agenda item. If the Service is fully compliant with the new or updated NICE Guidance this is confirmed in the minutes. If the Service is not compliant but needs to achieve compliance an action plan is developed by the clinical effectiveness group and agreed with governance. Any delays in completion of action plan are escalated to Governance Compliance with the action plan is then monitored by CE group on a monthly basis and derogation form is completed and guideline process in put place to provide assurance of safety alongside practice development who ensures all practitioners are aware of changes and are clinically prepared and if any training is required this would be put in place. All clinical updates are shared with staff through monthly 'Stork Talk' e-magazine (Maternity Bulletin).

What process do we have in place currently?	Alongside this all updates in guidance are emailed to staff and alert flagged on Maternity Medway. Once disseminated an audit will be completed within 4 week to monitor awareness of update and workability prior to monitoring of compliance. If the service does not follow the guidance (may have evidence that other practise is more relevant etc.), then this should be classed as "agreed noncompliant" and the discussion and decision should be reflected in the Clinical Effectiveness meeting minutes. If the service does not follow the guidance due a resource issue this will then be escalated to a risk review and the gap analysis template reported on the maternity services risk register. This is fed back monthly to trust clinical effectiveness manager for trust board awareness. <u>Documentation and tracking:</u> Completed gap analyses are saved under the relevant guidance folder within the Maternity Clinical Effectiveness shared folder within Clinical Effectiveness Minutes and Maternity Governance Minutes.
Where and how often do we report this?	The Clinical Effectiveness Meetings are held monthly. Within this meeting all guidance reviews are discussed and all NICE publications discussed and allocated if needed. All new NICE guidelines will have a baseline assessment review and benchmark against current practice completed and actioned and held within the trust Clinical Effectiveness Department. This will be updated every month and outstanding actions presented to Maternity Governance.
What assurance do we have that all of our guidelines are clinically appropriate?	The Clinical Effectiveness meeting is a multidisciplinary forum to promote standards in clinical practice and ensure that referenced, evidence-based multidisciplinary maternity guidelines for the clinical management of all conditions are produced. The group's objectives include: • To commission, discuss, edit, ratify, publicise and distribute the maternity guidelines. • To lead the development and implementation of Evidenced Based Practice across the maternity and gynaecology services. • To ensure that guidelines are authored, version controlled and dated, and regularly reviewed at three yearly intervals or when external guidance or seminal research publications dictate that a revision is required. • To ensure that guidelines are reviewed in light of recommendations of The National Institute for Health and Care Excellence (NICE), other relevant bodies and new evidence. Meeting agendas and minutes are produced for the Clinical Effectiveness meetings
What further action do we need to take?	Continue to strengthen and develop shared ownership and membership of the clinical effectiveness group Complete a baseline assessment to show compliance with NICE guidance by February 2021.
Who and by when?	Clinical Effectiveness and Audit Lead Midwife and Clinical Effectiveness Lead Obstetrician, February 2021
What resources or support do we need?	None
How will we mitigate risk in the short term?	Continue to escalate any clinical concerns to Maternity Governance Group.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28 January 2021**

Title of the Report	**Northamptonshire Covid-19 Vaccination Programme**
Agenda item	**12**
Presenter of Report	Matt Metcalfe, Medical Director
Author(s) of Report	Chris Pallot, Programme Director, Vaccination Programme

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

This paper provides an update to the Board on the Covid-19 vaccination programme that commenced on Tuesday 8 December 2021 with Northampton General Hospital being in the first cohort of hospital hubs nationally to commence offering the vaccine.

As at Friday 15 January, 54,235 vaccines have been delivered in the county in the cohorts listed in the paper. 44,671 were first and 9,564 subsequent deliveries.

The two hospitals in the Group were both appointed as Hospital Hubs and intended to focus on vaccinating their own staff via the Occupational Services. Northampton was operational in the first wave with Kettering commencing on 29 December.

National guidance changed for the hospital hubs to include over 80s and Care Home staff. This was because of the need to vaccinate these cohorts due to their priority in the JVCI cohorts and that the hospitals were the first services to go-live.

The paper also provides an update on the Vaccination Centre and the importance of this facility in the overall programme.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback*

Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks
Related Board Assurance Framework entries	BAF – please enter BAF number(s): 1.1, 1.4, 3.1
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) 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 – Vaccination costs are funded centrally
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: No

Actions required by the Trust Board

The Trust Board is asked to note progress made with programme.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board

28 January 2021

Northamptonshire Covid-19 Vaccination Programme

Introduction

This paper provides an update to the Board on the Covid-19 vaccination programme that commenced on Tuesday 8 December 2021 with Northampton General Hospital being in the first cohort of hospital hubs nationally to commence offering the vaccine.

As at Friday 15 January, 54,235 vaccines have been delivered in the county in the cohorts listed in the paper. 44,671 were first and 9,564 subsequent deliveries.

The two hospitals in the Group were both appointed as Hospital Hubs and intended to focus on vaccinating their own staff via the Occupational Services. Northampton was operational in the first wave with Kettering commencing on 29 December.

National guidance changed for the hospital hubs to include over 80s and Care Home staff. This was because of the need to vaccinate these cohorts due to their priority in the JVCI cohorts and that the hospitals were the first services to go-live.

The initial requirement was for vaccines to be delivered as follows:

95% to over 80s and Care Homes
5% to NHS staff

In response the team at NGH opened a dedicated clinic service in Area K to ensure that the over 80s and Care Home staff were serviced separately.

The approach adopted was to contact every patient over 80 already attending the hospital for an outpatient appointment and offer the vaccination. Also all patients with walk-in appointments in radiology or the blood taking unit were offered a vaccination.

On 29th December 2020 the hospital hub at Kettering General Hospital opened, serving the same cohorts as at Northampton.

The number of patients in the over 80 cohort has deceased over the course of the implementation, as the roll-out commenced in primary care. This was expected and a reflection that most patients will prefer to have their service closer to home.

Nationally, the roll-out of the programme has been governed by guidance issued by the Joint Committee for Vaccination and Immunisation (JCVI), these have been followed in Northamptonshire.

Programme Governance

The programme has agreed a governance structure as listed in appendix 1 which ensures clear processes for system and organisational assurance.

In summary the Health and Care Executive Steering Group retains overall responsibility for implementation of the programme across the county and delivery of the overarching objectives.

Each organisation delivering the programme where the vaccinations take place are accountable to clinical safety, oversight and adherence to their policies and protocols on administration of the vaccine.

Prior to go-live at each hospital the Medical Directors signed off the end to end pathway including administrative, delivery and cold-chain protocols which were presented to the relevant clinical governance forums.

Changes to Vaccination Regime

The first vaccine released to the NHS was supplied by Pfizer Biontech. The second from AstraZeneca is now also licenced and being delivered in Northamptonshire but only in a primary care arena.

Both vaccines are delivered via a two dose schedule with the initial programme recommendation being that Pfizer is repeated at day-21 and AstraZeneca day-28.

On this basis, NGH commenced second vaccinations on 30 December, this being 21-days after the initial doses were delivered.

On 31 December the JCVI published a short statement entitled “Optimising the Covid-19 vaccination programme for maximum short-term impact”. This supported a two dose vaccine schedule with a maximum 12-week period between injections to preserve as many vaccines for the wider population as possible. This was confirmed to the NHS and The Green Book was updated (Chapter 14a) in this regard.

The NHS was requested to move all scheduled second vaccinations from 5 January by cancelling appointments but that clinical judgement could be exercised as to the risk this may pose. The decision taken by the Northamptonshire Clinical Leaders Group was that all appointments would be moved from 11 January and that every effort would be taken to move appointments prior to this time.

This was delivered and there are no second doses being undertaken at NGH with all appointments moved to the 12-week point. NHSE are monitoring this very closely at provider level.
This change has given rise to many questions particularly around the scientific evidence to support the move which the Trusts have sought to answer. All four national CMOs have supported the change, it has been published appropriately to provide indemnity to the prescribing clinicians and NHSE have required that it is enacted. To this end the NHS in the county has now implemented the requirement.

Current Targets

The current mandate from NHS England is that all patients in cohorts 1 to 4 of the JCVI list must be vaccinated by mid-February. This is in-line with the Prime Ministers announcement at the commencement of the programme.

For Northamptonshire this equates to:

Over 80s	29,679
75-79 year olds	24,118
70-74 year olds	36,939
Northampton General Hospital	5702
Kettering General Hospital	4663
Northamptonshire Healthcare	4561
Care Home Works and Residents	14,192

Social Care Workers	13,387
Total	**133,241**

N.B. Headcount numbers used for NGH, KGH, NHFT & NHS England figures for other cohorts

This number excludes organisations aligned to healthcare outside of the NHS such as dentists, optometrists, funeral directors. All of these organisations have been written to and asked to confirm their numbers with the expectation that these staff will be offered appointments

Capacity to Deliver

Currently the county has 3 main delivery models for the vaccine, with the associated weekly capacity as listed:

Hospital Hubs
Northampton General Hospital
Kettering General Hospital

Primary Care Networks
16 sites covering the entire registered population of the county

Roving Model (Care Homes and Housebound)

The fourth delivery model will be central to delivering the mandate, the Vaccination Centre at Moulton Park. This is expected to open on 25 January 2021 and when fully operational will have the capacity to vaccinate in excess of 1,500 patients per day.

A full demand and capacity model for the county is in production however assurance has been given that cohorts 1-4 can be vaccinated by mid-February as long as vaccine supplies are timely.

Activity to Date

Until 15 January 2021, the two hospital hubs at KGH and NGH have delivered 11,373 vaccines. NGH has delivered 1,560 second doses which are included in these numbers but this has now ceased.

NHFT were not able to be appointed as a Hospital Hub due to the way in which their pharmacy is established and therefore set up a clinic on the NGH site for their staff. More latterly they have also referred their teams to the hub at KGH to maximise coverage.

75% of the vaccines delivered at the Hospital Hubs have been to healthcare workers. 14% to care home staff and 10% to the over 80s. 1% were classed as “other” and will include colleagues from the Council.

NHSE are sharing information on the cohort penetration for the priority cohorts. At present the focus is on the over 80s and care homes. It is pleasing to note that Northamptonshire has a very high rate of vaccination for the over 80s.

Vaccination in care homes is now accelerating with an aim to deliver this element of the service by the end of January. It is expected the majority of the remaining over 80s will be covered in this manner.

Permission to move to the 75-79 age band is awaited at the time of writing but is expected imminently and will have commenced by the time of the Board meeting.

Key Risks

A separate risk register has been defined for the programme and is included in separate governance processes within each Trust.

The key risks to delivering the activity in this plan are workforce and vaccine supply. To date deliveries to the Hospital Hubs have all taken place as planned with some of the PCNs experiencing late notification of deliveries but all vaccines have arrived as expected. The issue is that the county could move faster if supply was unconstrained.

From a workforce perspective, the rosters for the Vaccination Centre are being populated and require a dedicated team to support the facility based on the numbers of staff needed in a variety of roles at all times. The mitigation has been the on-boarding of additional workforce and rostering teams to ensure everything is in-place. The roster for week one of operation is filled but further detail is provided in the workforce section below.

The Northamptonshire Vaccination Centre

The vaccination centre will be located at Royal Pavilion, Moulton Park in a building that was previously used as office accommodation and is expected to open on 25 January 2021. The location was chosen due to its central position within the county. The AstraZenica vaccine will be administered at this site.

The site will fall under the governance arrangements for NGH and has been registered with the CQC. All clinical pathways and processes have been signed-off by the Medical and Nurse Directors and the Chief Pharmacist.

The ground floor has been converted entirely into clinical space and has three wings. The north wing accommodates 8 vaccination stations, 2 recovery bays, post vaccination waiting area (if needed) and a pharmacy room. The south wing has 6 vaccination stations along with the same additional rooms as the north wing

The east wing has been converted into a clinical storage area and a large pharmacy for the storage and preparation of the vaccines

Upstairs houses the countywide PPE store, office space for the team overseeing the programme and the east wing a dedicated staff rest/welfare area.

Patients will arrive into the main reception having had their booking validated by marshalls outside the facility. They will be streamed into one of the wings where they will complete the pre vaccination checklist with a registered healthcare professional to ensure there are no contraindications.

Each patient will be called into one of the booths where an administrator will complete the vaccination information on the national Pinnacle system. This ensures the batch number, patient details and all demographics are reported in real-time. The vaccine is administered and the patient leaves via the exit at the end of the wing. In time it is expected to deliver one vaccine every 5-minutes in each pod.

All IT equipment has been received and checked alongside a load test for the wi-fi network. The booking, patient management and vaccination systems are all nationally procured and not managed by NGH.

Workforce

The workforce requirements in terms of roles for Vaccination Centres is determined nationally and modelled locally based on the size of each Centre and operating hours. The roles required include Management and Triage, Pharmacy, Vaccinators, HCA's, Administration and Support (ie Flow Co-ordinators). For the Royal Pavilion Centre, the total Workforce requirement is 204 FTE.

The workforce availability to meet this requirement has a number of temporary/volunteer workforce streams as details below. We have calculated a likely headcount requirement of 960 with a maximum requirement of around 1900. A number of the roles in the Centre will be covered by seconded, full time staff (i.e. Management and Triage) which does reduce temporary staffing requirement and therefore these numbers include some contingency.

Stream	**Potential Available Headcount**	**Available from**
Expressions of Interest for existing NHS staff	1192	1154 covered by MOU - immediate subject to training/induction 768 require recruiting
NHS providers	571	Update on numbers and availability expected shortly
Royal Voluntary Service (RVS) - Stewards	444	W/c 18 January. 10 to 14 day lead time for booking confirmation
St John Ambulance	Estimated 400	Update on numbers and availability expected mid-January
TOTAL AVAILABLE	**2607**	

Assumption of Working	**Number of hours per 4 week per person**	**Headcount Requirement**
Maximum based on RVS and SJA minimum commitment	16 hours	1900
Likely number based on experience of NHS bank workers	32 Hours	960
Preferred minimum based on Fixed Term Contracted minimum of 22.5 hours per week	90 hours	340

To illustrate the operational changes to operate a centre of this size using a temporary workforce, the north wing requires 758 shifts to be filled each week. By way of context, this is comparable to the demand for HCA bank shifts across KGH.

This workforce plan is not without its risks and, as indicated, a number of the national workforce streams are not available to supply to us ahead of go-live. They will however, provided supplementary resources to sustain the current plan in the short term as well as meet PCN workforce needs.

We will propose a substantive workforce plan for the medium term, especially due to the uncertainty as to the cessation of the centre (or indeed if it ever will cease if the programme becomes one of annual boosters). We cannot rely on existing NHS staff to be able to, or want to, work additional hours. They will need rest and recuperation and therefore by the spring we need to have a more sustainable workforce utilising fixed term contracts as opposed to bank or volunteers. With the National Protocol now published, we can recruit full and part time vaccinators in line with other Vaccination Centres.

The pandemic has had a detrimental impact on employment in other sectors, such as hospitability and retail which we could utilise. We are already beginning to see an increase in the average number of applications to our vacancies advertised on NHS jobs. Given the correlation with social inequality and health, this approach will support both the health and economy of Northamptonshire. Over the next few weeks we will develop a Recruitment Plan, and additional national funding has been made available to support and accelerate these plans to on board a sustainable workforce.

Summary

This is a programme of work the like the NHS has never seen before due to its scale and pace. It is being delivered as a team which includes all NHS organisations across the county alongside Northamptonshire County Council, Police, Fire, Voluntary and other organisations.

The pace of work will increase and will clearly extend well into 2021. It is possible the programme will become an annual one if boosters are needed (similar to flu) to maintain immunity and at that time consideration will need to be given to extending the reach of the vaccination centres to other sites in the county.

In time more detailed performance information will become available and will be shared with Boards at that time.

Appendix 1

12012021
Northamptonshire Va

Northamptonshire
Health and Care Partnership

Northamptonshire Health and Care Partnership Vaccination Programme

Governance framework

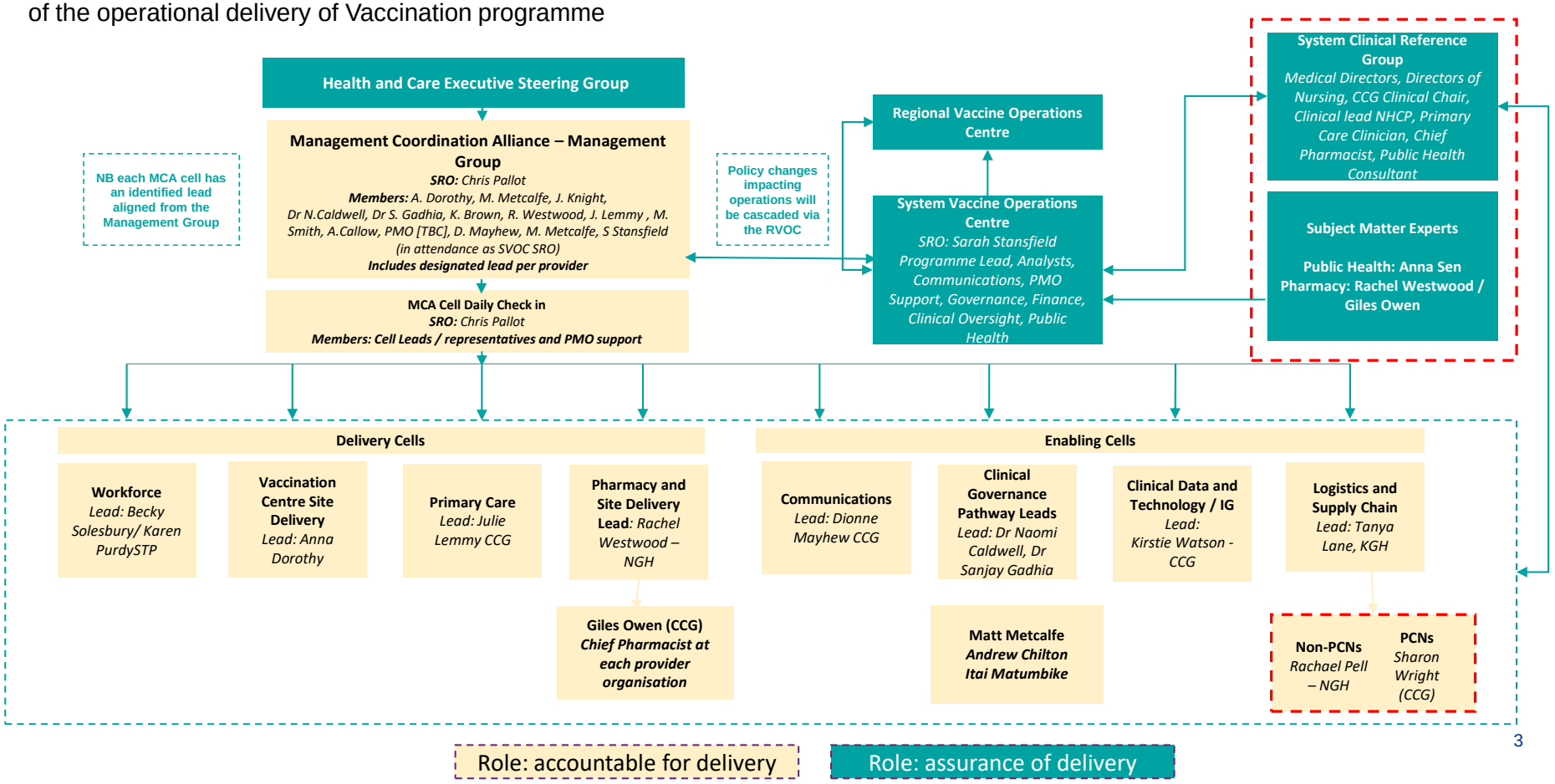
12th January 2021

Northamptonshire
Health and Care Partnership

Governance Framework

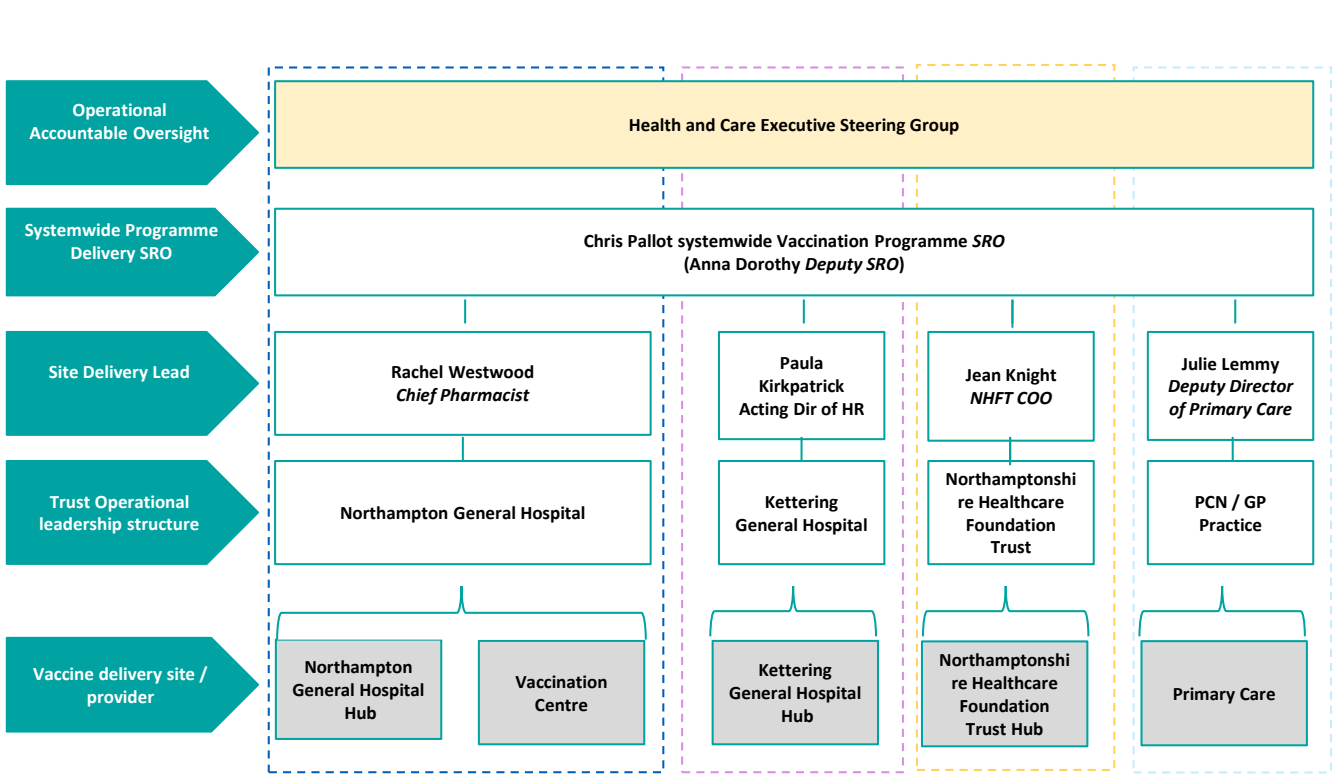
Vaccination Programme – Systemwide Programme Governance

We have set out our systemwide structure and forums below. This framework will provide operational delivery and oversight to / assurance of the operational delivery of Vaccination programme



Vaccination Programme – Operational Responsibility Framework

The Vaccination programme and SRO are operationally accountable to the Health and Care Executive Steering Group, which includes all system CEOs



Accountability

Ultimate accountability for oversight and assurance of operational delivery

Accountable for the safe and effective operational delivery of the systemwide vaccination programme

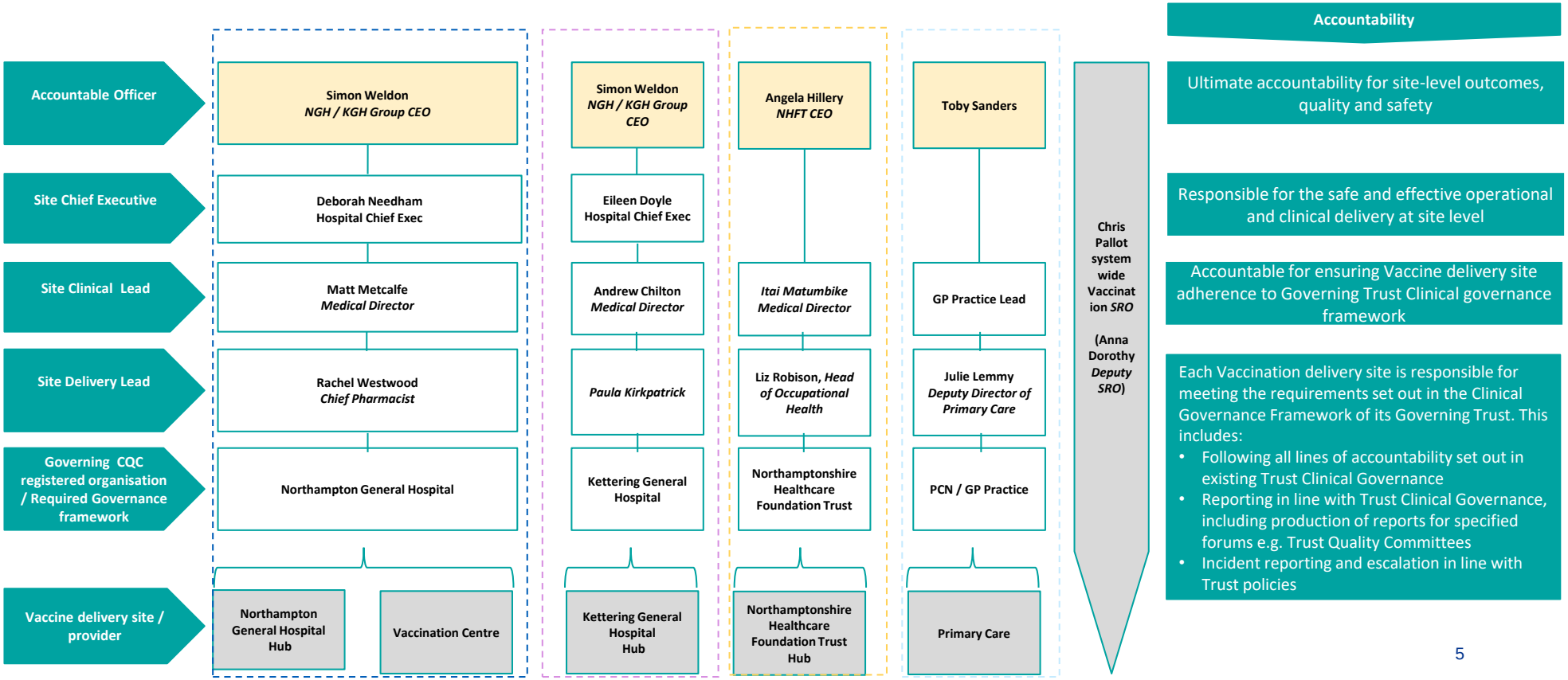
Key MCA Management Group point of contact back in to the Governing Trust for non-clinical escalations , risks, issues and comms

Each Vaccination delivery site is responsible for meeting the requirements set out in Operational policies and SOPs of its Governing Trust. This includes:

- Following all lines of accountability
- Reporting and escalation in line with Trust requirements and as defined by the Operational management structure

Vaccination Programme – Provider Accountability Framework

Individual vaccine provider sites are accountable for adhering to the clinical governance framework of their governing Trust. Ultimate site-level accountability for site-level outcomes, quality and safety is held by the corresponding Trust Accountable Officer, as set out below.

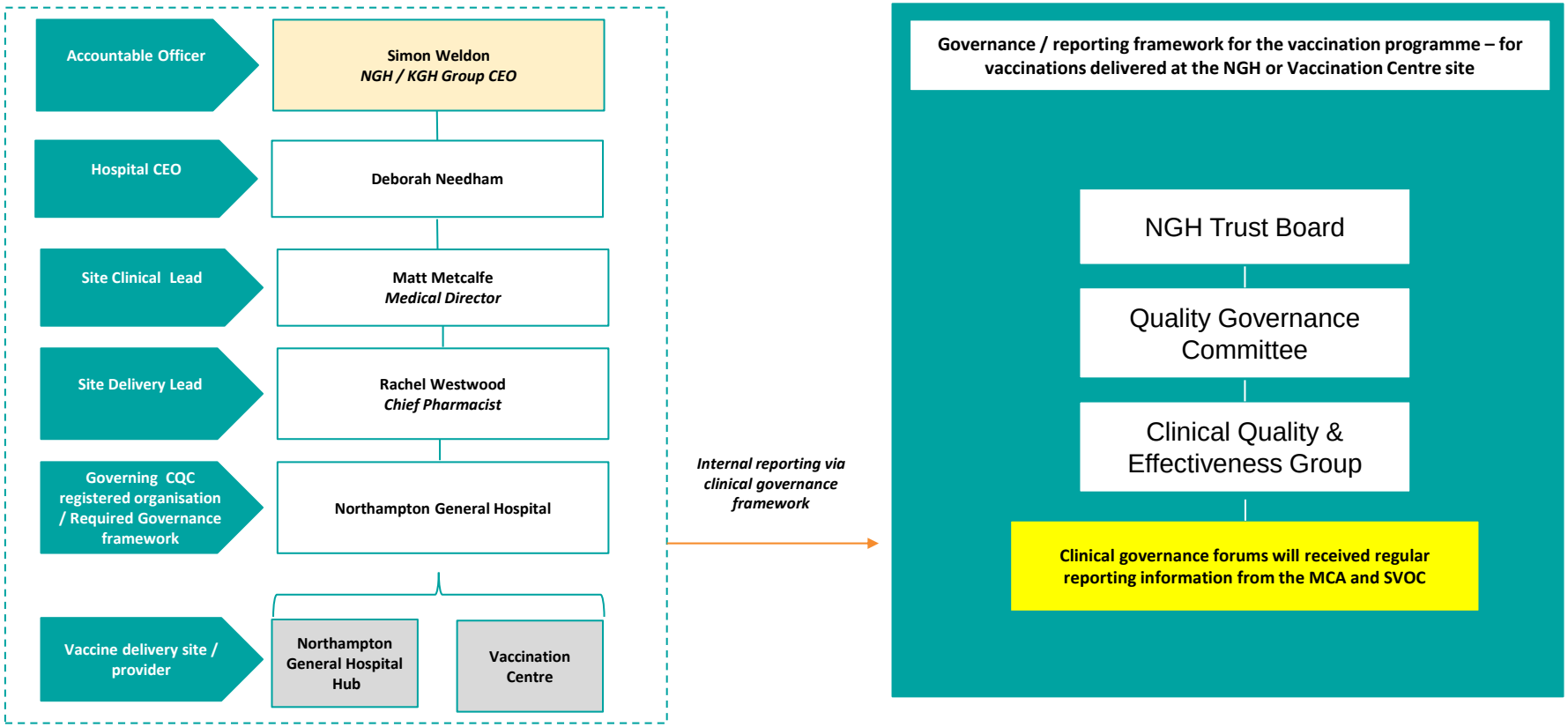


Provider Accountability Framework - Roles and Responsibilities

Role	Responsibility / Accountability
Accountable Officer	Ultimate accountability for vaccination site-level outcomes, quality and safety
Hospital Chief Executive	Responsible for the safe and effective operational and clinical delivery at site level , in line with provider Trust clinical governance and operational frameworks
Medical Directors	Accountable to the Hospital Chief Executive Officer for the end to end clinical safety of the programme. Ensuring all clinical safety aspects are adhered to. Oversight of incidents and investigations. Clinical sign-off of all policies and protocols. Accountable for ensuring vaccine delivery site(s) adherence to Trust Clinical governance framework
Directors of Nursing	Accountable for all aspects of infection prevention across the service operated by their hospital Accountable to the Hospital CEO for adherence to all relevant policies and protocols covering the nursing aspect of the service
Chief Pharmacists	Responsible for ensuring that each Vaccination delivery site meets the requirements set out in the Clinical Governance Framework in relation to the ordering, storage, supply and safe delivery of the vaccine. This includes: • Following all lines of accountability set out in existing Trust Clinical Governance • Reporting in line with Trust Clinical Governance, including production of reports for specified forums e.g. Trust Quality Committees • Incident reporting and escalation in line with Trust policies
Programme Director SRO	Accountable for the operational delivery of the systemwide vaccination programme. Reporting to individual site CEOs for operational performance and to the CCG Accountable Officer for system delivery

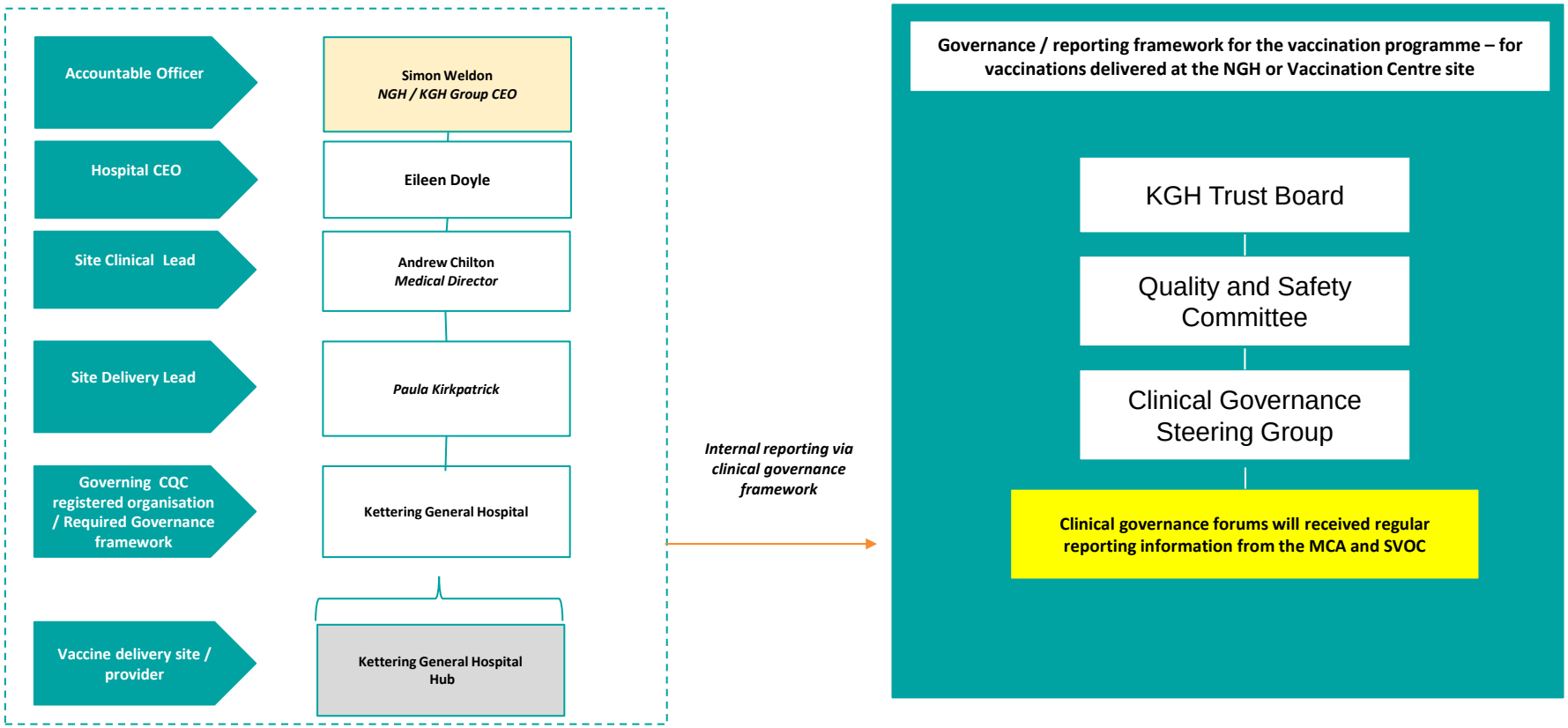
Vaccination Programme – Vaccine Provider Clinical Accountability Framework for **NGH** delivered vaccinations

Individual vaccine provider sites must follow the clinical governance framework of their governing Trust. This includes ultimate site-level accountability for clinical incidents and risks is held by the corresponding Trust Accountable Officer, as set out below.



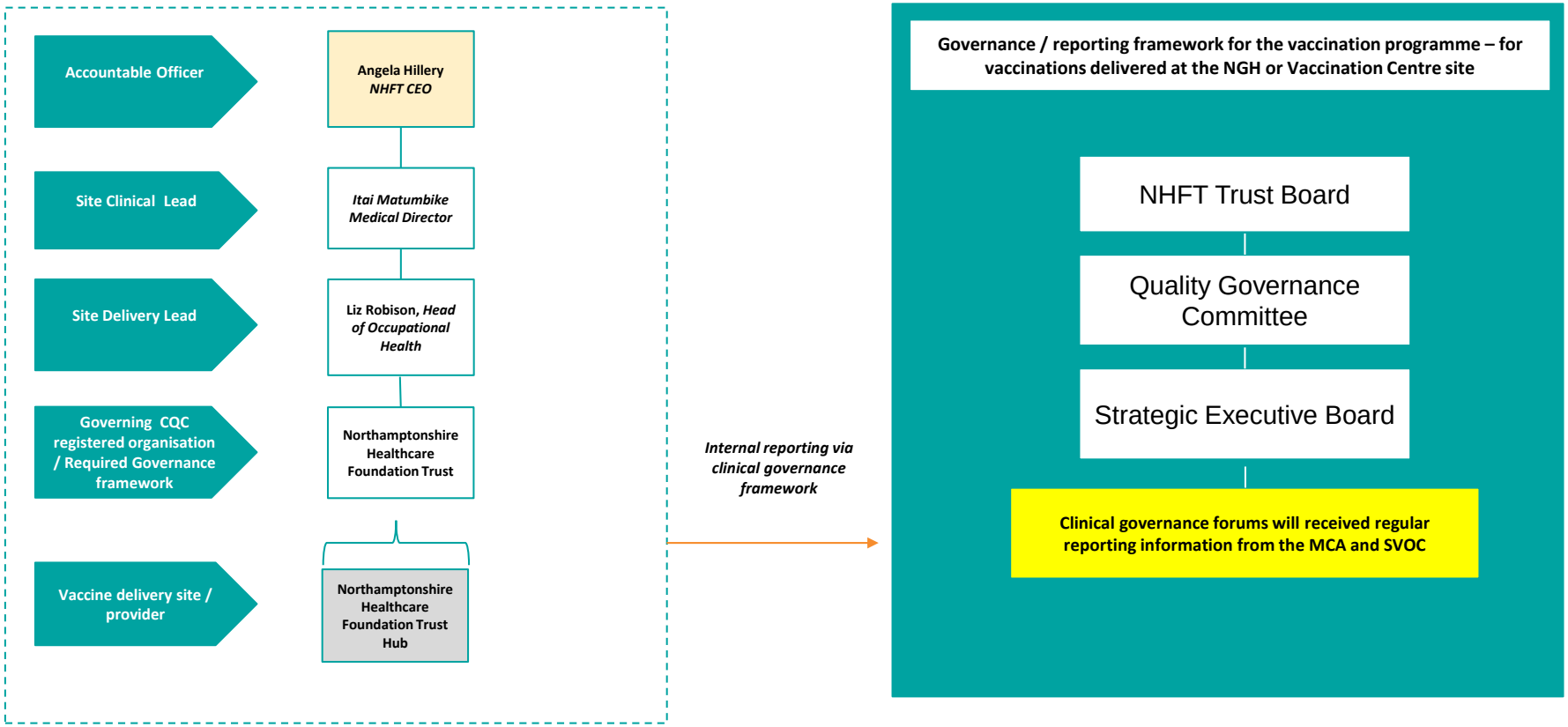
Vaccination Programme – Vaccine Provider Clinical Accountability Framework for **KGH** delivered vaccinations

Individual vaccine provider sites must follow the clinical governance framework of their governing Trust. This includes ultimate site-level accountability for clinical incidents and risks is held by the corresponding Trust Accountable Officer, as set out below.



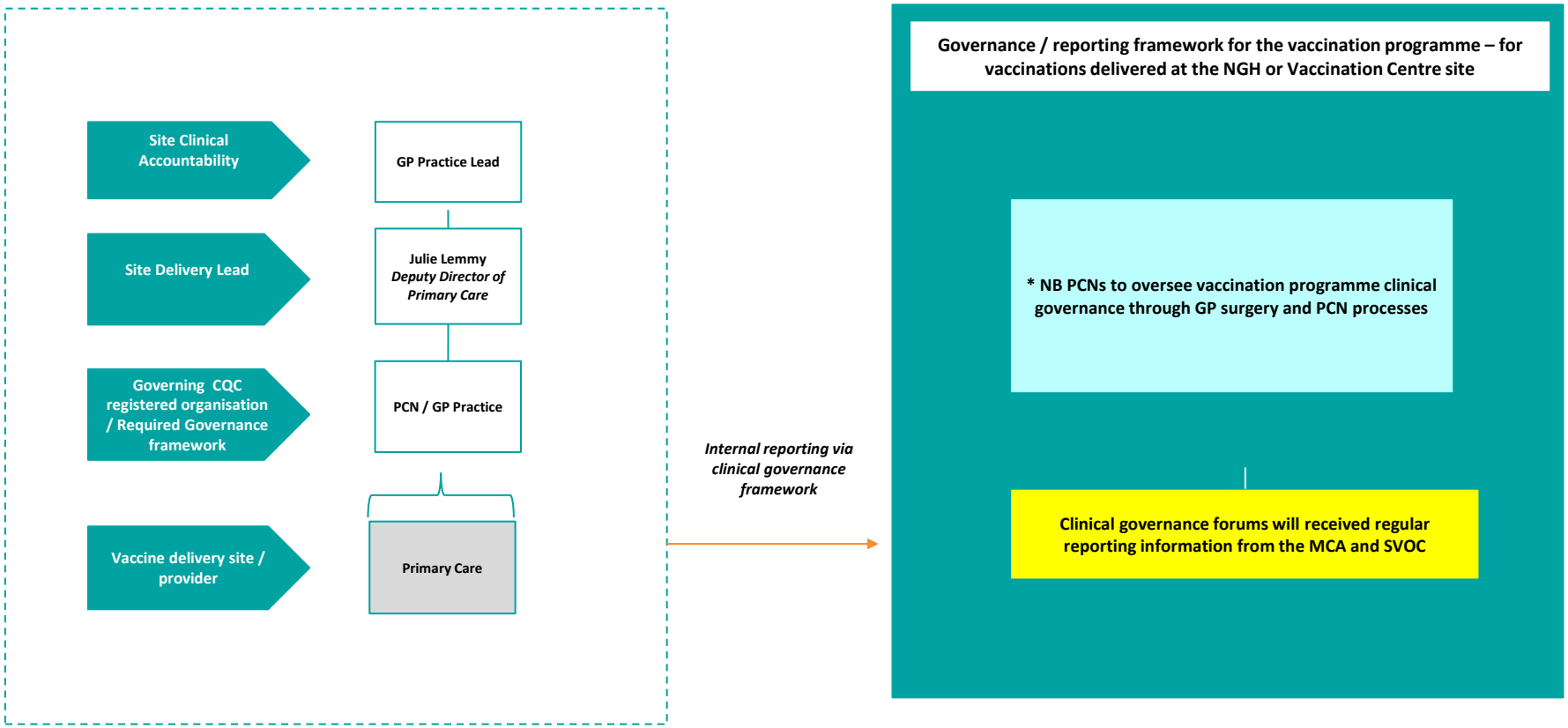
Vaccination Programme – Vaccine Provider Clinical Accountability Framework for **NHFT** delivered vaccinations

Individual vaccine provider sites must follow the clinical governance framework of their governing Trust. This includes ultimate site-level accountability for clinical incidents and risks is held by the corresponding Trust Accountable Officer, as set out below.



Vaccination Programme – Vaccine Provider Clinical Accountability Framework for **PCN** delivered vaccinations

Individual vaccine provider sites must follow the clinical governance framework of their governing Trust. This includes ultimate site-level accountability for clinical incidents and risks is held by the corresponding Trust Accountable Officer, as set out below.



Governance arrangements – Draft to discuss and finalise

Northamptonshire Health and Care Partnership

Governance forum	Purpose	In scope	Out of scope	Accountable to	Assurance of / to
System Vaccination Operations Centre steering group (SVOC)	The SVOC is a service that is Nationally mandated to assure the operational delivery of the Covid-19 vaccine deployment within Northamptonshire. The service is chaired by Sarah Stansfield and reports into the Regional Vaccine Operations Centre. The SVOC is responsible for oversight of MCA delivery of the vaccination programme, as well as assurance to regional and national teams that delivery is in line with the national specification. The SVOC will establish a steering group that meets daily, in the afternoon to follow the daily MCA Cell call (TBC).	• Oversight of programme planning • Clarity and assurance on plan, progress, risks and issues • Liaison with the regional team to support policy, delivery and reporting requests • Ordering of vaccine via PHE • Oversight of incidents • Point of contact for system vaccine queries	• Operational planning (responsibility of the cells) • Undertaking incident RCA (responsibility of the provider organisation) • Alliance stakeholder management (responsibility of the MCA) • Contract monitoring (responsibility of the legal entity holding contracts on behalf of the Alliance)	• RVOC and MG	• SVOC will provide assurance to the RVOC re the MCA delivery of the Northamptonshire vaccination programme
System Clinical Reference Group (CRG)	The CRG is an independent systemwide forum that provides an opportunity to identify and collate systemwide themes and learning to the MG and SVOC. Individual providers are responsible for quality assurance within their delivery model and clinical pathways. The CRG will provide arms-length oversight and assurance of incident root cause analysis and risk themes, in addition to patient experience feedback and outcomes across the system. The CRG meets twice per week (TBC).	• Oversight and assurance of incident root cause analysis and risk themes across the system • Oversight of patient experience feedback and metrics across systemwide providers	• Review and clinical signoff of provider-level care pathways and SOPs (responsibility of each provider via existing clinical governance framework) • Provider-level incident root cause analysis (responsibility of the relevant provider organisation)	• SVOC	• CRG will provide clinically-focussed review and challenge of the systemwide vaccination delivery model, providing feedback directly to delivery cells, with copy to MCA / SVOC (including MCA Management Board site leads)

Governance arrangements – Draft to discuss and finalise

Northamptonshire Health and Care Partnership

Governance forum	Purpose	In scope	Out of scope	Accountable to	Assurance of / to
MCA Management Group (MG)	The MG is accountable for ensuring the safe and effective delivery of vaccination services across Northamptonshire. It ensures that critical decisions are made on key problems that are raised from the delivery cells. The MG will identify any issues, decisions or escalations that require SVOC support Following the MG, decisions and actions will be cascaded back to cells via the CDC to action. A lead contact from each provider organisation will be confirmed from within the Management Group The MG meets twice a week.	• Decision making, issue and risk management as escalated by the CDC • Facilitate seamless working between Alliance partners • Identifying early warning of potential failure to the SVOC • Assurance regarding contract management	• Data collection or data processes (responsibility of the cells) • Day to day management of operational planning and delivery (responsibility of the cells)	• Health and Care steering group	• Assurance of the day to day delivery of the operational cells, including oversight of decisions , escalations, actions, milestones and risks
MCA cell daily check-in (CDC)	The daily check in is an operational group chaired by Chris Pallot and is attended by the cell leads. The CDC ensures that key cell decisions are made and cascaded to the cells, or escalated to the MG for a decision to be made. The CDC is attended by provider representatives who are clinically responsible and accountable for vaccines delivery in their settings, clinical safety and staff accountability. The CDC is supported by PMO capacity that is discharged by the SVOC. The CDC occurs daily in the morning, with potential by exception, to meet again in the afternoon.	• Action-orientated group focussing by exception on decisions required, risks, issues and other escalations • Mobilisation of vaccination sites and accompanying deliverables (as per cell structure) • Day to day management of delivery and inter-dependencies • Daily data collection and processing and onward transmission to the SVOC	• Vaccine ordering (responsibility of the SVOC) • System point of contact (responsibility of the SVOC) • Signing off of care pathways and SOP (responsibility of the CRG)	• MG	• The group will provide assurance of MCA cell delivery to the MCA MG / SRO, to inform SVOC reporting

Northamptonshire
Health and Care Partnership

Appendix 1 - Proposed Draft Terms of Reference

Terms of Reference: System Vaccine Operations Centre Steering Group

Northamptonshire Health and Care Partnership

Purpose / role of the group:

The SVOC **is an operational oversight group** chaired by Sarah Stansfield. It is responsible for measuring, planning and assessing delivery. The SVOC is responsible for oversight and assurance to regional and national teams that delivery of the Northamptonshire Vaccination programme is in line with the national specification.

The SVOC will provide data analytics support to the MG and PMO support. The SVOC steering group review occurs daily, in the afternoon.

Membership:

Name	Organisation/ Role
Sarah Stansfield	SRO
TBC	SVOC Programme Lead
TBC	SVOC Programme Manager x 6
TBC	SVOC Analytics and Reporting

Accountability, Governance and reporting arrangements:

The SVOC is accountable to the Regional Vaccine Operations Centre for deployment of the Covid-19 vaccine across Northamptonshire, in a clinically safe and affordable manner. 08.00–20.00 seven days a week, 365 days a year. Queries within standard hours of operation should be responded to within 24 hours.

The SVOC is responsible for the following:

- Reports of utilisation versus vaccine supply to Regional VOC
- Redistribution within system, any un-utilised supply as per vaccine storage characteristics
- Escalating actions where populations or staff groups have low uptake
- Ordering vaccine quantities from PHE via ImmForm to meet forecast demand
- Provide vaccine stock level reports as required and escalation of low stock/stockpile events to Regional VOC
- Identifying and reporting to the RVOC early warning of potential risks or issues
- Oversight of system-level incidents including incident recovery, post- incident root-cause analysis, with daily feedback to RVOC
- Participation in the event of a national incident with accountability to the Regional VOC/National VOC
- A Systems point of contact for all Covid-19 Vaccination queries and feedback loop to the Regional VOC
- Participation in the daily NVOC battle rhythm If requested by RVOC and responding promptly to daily requests for updates, information and reports as requested by the NVOC
- Ensuring a robust communication plan is in place across the Alliance with consistent messaging deployed and monitored
- Intervening and escalating to the Management Group for rapid action where population or staff groups have low uptake in order to deploy additional communication and clinically lead interventions
- Ensuring robust ordering and receipting mechanisms are in place within provider organisations

Frequency of meetings:

The SVOC steering group reviews daily

Terms of Reference – Management Coordination Alliance Management Group

Northamptonshire Health and Care Partnership

Purpose / role of the group:
The MG is accountable for ensuring the safe and effective delivery of vaccination services across Northamptonshire, including maximising consistency and minimising duplication. It is responsible for ensuring that critical decisions are made on key escalations, risks and issues raised from the MCA delivery cells. Following the MG, decisions and actions will be cascaded back to Management Group to action

Membership:

Role	Name
Vaccination Programme SRO	Chris Pallot
Nursing / Deputy for programme	Anna Dorothy
Medical oversight and NGH Medical Lead:	Matt Metcalfe
Mass Vaccs	Jean Knight
Medical	Dr Naomi Caldwell, Dr Sanjay Gadhia
NAS representative and NCC	Katie Brown
Pharmacy and NGH	Rachel Westwood
Primary Care and CCG	Julie Lemmy
Workforce	Mark Smith/Becky Solesbury
Digital	Andy Callow
Comms	Dionne Mayhew
Governance	Michelle Metcalfe
Operational Lead / PMO	Lisa Riddaway

Accountability, Governance and reporting arrangements:

The MCA Management Group will be accountable to the Health and Care Executive Group for deployment of the Covid-19 vaccinate across Northamptonshire, in a clinically safe and affordable manner. The SRO will be expected to participate in daily battle rhythms as determined by NHS regions. In addition, the MCO must ensure there is sufficient coverage to oversee the Programme during its operational times.

- Ensuring SVOC reporting requirements are met
- Ensuring system wide vaccine deployment KPIs are met and a Go-Live checklist is in place
- Assuring contracts deployed and holding financial oversight of Vaccine associated costs
- Ensuring decision making processes are robust with an accompanying audit trail of key decisions and actions
- Operational planning to ensure all Estates and workforce requirements in place, including implementation of Nationally mandated SOPs.
- Identifying a legal entity to be responsible for delivery partner/subcontractor contracts and to be a party to the NHS England and NHS Improvement contract. The MCO will be responsible for the overall management of the delivery partners/subcontractors.
- Management and oversight of the Programme and care pathway within the relevant STP/ICS footprint
- Ensure effective joint working interfaces between providers, subcontractors, other delivery partners and wider stakeholders across the delivery system.
- Liaise with the System VOC (if not the same organisation) to ensure seamless working between organisations
- Mobilise all vaccination sites and ensure these are set up and run efficiently according to the relevant specification
- Mobilise the supply and logistics to ensure the right amount of vaccines are in the right place at the right time to minimise cold chain incidents and waste
- Ensure security arrangements are in place for the vaccine following delivery to the delivery sites
- Mobilise the workforce through recruitment, training and effective deployment of suitably qualified staff
- Responsibility for drawing down on nationally procured consumables and equipment for all contracted providers
- Liaise with the Lead Employer to ensure seamless working between organisations drawing down on national pools of available workforce
- Identifying and reporting to the SVOC early warning of potential failure so that mitigating action can be taken and learning applied across all areas
- Overall responsibility for data collection, processing, onward transmission and reporting requirements of the System VOC (and onward to Regional VOC and National VOC)
- Ensuring a robust communication plan is in place across the Alliance with consistent messaging deployed and monitored

Frequency of meetings:

- The MG occurs twice a week.

Northamptonshire Health and Care Partnership

Terms of Reference: MCA Cell Daily Check in (CDC))

Purpose / role of the group:

- The daily check in is an operational group chaired by Chris Pallot and is attended by the cell leads. The CDC ensures that key cell decisions are made and cascaded to the cells, or escalated to the MG for a decision to be made. The CDC is attended by provider representatives who are clinically responsible and accountable for vaccines delivery in their settings, clinical safety and staff accountability. The CDC is supported by PMO capacity that is discharged by the SVOC.
- The CDC occurs daily in the morning, with potential by exception to meet again in the afternoon.

Membership:

Role	Name
SRO	Chris Pallot
Deputy SRO	Anna Dorothy
Logistics and Supply Chain Cell Lead	Tanya Lane, KGH
Workforce Lead	Becky Solesbury STP
Clinical Governance Pathway Lead	Dr Naomi Caldwell, Dr Sanjay Gadhia
Clinical Data and Technology / IG Lead	Kirstie Watson, CCG
Pharmacy and NHS Provider Delivery Lead	Rachel Westwood, NGH
Vaccination Centre Site Delivery and Deputy SRO	Anna Dorothy
Primary Care Lead	Julie Lemmy, CCG
Communications Lead	Dionne Mayhew, CCG
PMO support	Lisa Riddaway

Accountability, Governance and reporting arrangements:

The group will provide assurance of MCA cell delivery to the MCA Management Group and SRO. The group will indirectly inform SVOC reporting via reporting and escalations through the Management Group , whilst supporting pre-agreed daily reporting via SVOC submissions

- Daily Cell Check ins will focus on by-exception cell workstream updates and escalations, informed by submission and review of the following information:
  1. Cell highlight reports setting out by exception only:
     i. Key decisions taken or decisions / escalations required
     ii. Risks / issues and proposed mitigation for agreement or further escalation
     iii. Updates against key milestones (with a focus on deviation from plan and course correcting actions)
  2. Programme risk log (where risks not already addressed via the Cell highlight reports)
  3. Programme inter-dependency matrix
  4. Cell Go live checklist
  5. Check in meeting Action tracker (highlighting overdue actions only)
- All workstreams will be represented by cell lead (or nominated deputy) and PMO support
- A log of all Actions, Decisions, Escalations, Risks and Issues will be captured live during the session and shared with Cell Leads, SVOC lead and MCA SRO within 1 hour of meeting close
- Workstreams may be asked to return to an exceptional afternoon meeting where additional support or focus is required. This will be at the discretion of the Chair

Frequency of meetings:

- The MCA Daily cell check in will run daily in the morning, with the option to return to an exceptional afternoon meeting where additional cell-level support or focus is required.

Northamptonshire Health and Care Partnership

Terms of Reference: System Clinical Reference Group

Purpose / role of the group:

- There is a requirement, as indicated by discussions with the RVOC and NVOC that a Clinical Reference Group should be established. The CRG is an independent systemwide forum that provides an opportunity to identify and collate systemwide themes and learning to the MG and SVOC.

Membership:

Role	Name
Chair – Clinical Lead, NHCP	Dr Miten Ruparelia
Deputy Chair – NHS Northants CCG	Dr Joanne Watt
KGH Medical Director	Dr Andrew Chilton
NGH Medical Director	Mr Matt Metcalfe
NHFT Medical Director	Dr Itai Matumbike
CCG Director of Nursing	Mrs Angela Dempsey
KGH Director of Nursing	Ms Leanne Hackshall
NGH Director of Nursing	Mrs Sheran Oke
NHFT Director of Nursing	Mrs Julie Shepherd
Primary Care Clinician	Dr Sanjay Gadhia
Chief Pharmacist	Mrs Rachael Westwood
Consultant in Public Health	Mrs Lucy Wightman

Accountability, Governance and reporting arrangements:

The group will be accountable to the SVOC and will provide independent assurance to the SVOC on the quality and safety of Covid-19 vaccine deployment in Northamptonshire. Escalations will be made to SVOC , with direct feedback reports submitted to MCA-MG and to Care Pathways Cell to facilitate immediate action

Individual providers are responsible for quality assurance within their delivery model and clinical pathways. The CRG will provide arms-length oversight and assurance of incident root cause analysis and risk themes, in addition to patient experience feedback and outcomes across the system.

The CRG will identify and flag any systemwide quality themes that require further scrutiny as well as potential learning

Deliverables

- To agree and review a set of safety and quality metrics that provide real-time view of vaccine deployment efficacy **at a system level**
- To review causes of clinical incidents identified through individual provider clinical governance frameworks, identifying any systemwide themes or recommendations
- To draw on subject matter expertise from Public Health experts as needed to ensure population needs are being made and are reflected within care pathways
- To assure the incident reporting mechanisms and quality and clinical assurance visits undertaken by the CCG

Frequency of meetings:

- The CRG meets once per week

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**28th January 2021**

Title of the Report	**Freedom to Speak Up Bi- Annual Report**
Agenda item	**13**
Presenter of Report	Claire Campbell Director of Corporate Development, Governance and Assurance/ Freedom to Speak up Guardian
Author(s) of Report	Claire Campbell Director of Corporate Development, Governance and Assurance/ Freedom to Speak up Guardian
Purpose	The report provides an update into the work of Trust in respect to Freedom to Speak Up requirements and ongoing work to support this agenda.

Executive summary

The report provides the background to the introduction of Freedom to Speak Up and progress made to develop clear systems and process at Northampton General Hospital.
It provides information on concerns raised in the first two quarters of this financial year. It also provides detail of case content, open and closed cases and outcomes and sources of concerns raised.
The report provides an overview of the Trust Guardians role and activity year to date and outlines key publications for the National Guardians Office.

Related strategic aim and corporate objective	Focus on Quality and Safety Enabling Excellence through our people
Risk and assurance	The report provides assurance that the Trust is meeting its legal duties with respect to Freedom to Speak Up.
Related Board Assurance Framework entries	BAF 1 BAF 2
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) 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)
Legal implications / regulatory requirements	There is a legal requirement under the Health and Social Care Act to appoint a Freedom to Speak Up Guardian.

Actions required by the Board

The Board is asked to:

- The Board is asked to note and comment on the content of the report, and accept this paper for information and assurance.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

FREEDOM TO SPEAK UP BI ANNUAL REPORT NOVEMBER 2020/21

1. INTRODUCTION

In February 2015 the recommendations of "Freedom to Speak Up" (Chaired by Sir Robert Francis QC) were published. The review concluded that there was a serious issue in the NHS that required urgent attention if staff are to play their full part in maintaining safe and effective services for patients.

A number of recommendations were made to deliver a more consistent approach to whistleblowing across the NHS, including the requirement for all organisations to appoint a Freedom to Speak Up Guardian and the development of a single national integrated whistleblowing policy to help normalise the raising of concerns.

The agreed reporting route for Freedom to Speak up at the Trust is the Workforce Committee (quarterly) with a bi-annual report to Trust Board. The Freedom to Speak Up Guardian maintains a case log, to oversee the management and timeliness of investigations and outcomes and ensure the Trust policy is followed.

2. FREEDOM TO SPEAK UP CASES QUARTERS 1 & 2 (April- September 2020)

Within the timeframe being reported, 15 cases were reported. This is big decrease on the previous two quarters when 43 cases were reported in total (26 in quarter 3 and 17 in quarter 4). It should be noted that a decrease was generally noted regionally during the first wave of the Covid 19 pandemic, although nationally this differs. Locally, this could be due to the additional communications and avenues for staff support put into place during this period. In addition NGH did not suffer issues noted elsewhere in relation to PPE availability.

2.1 Content of cases reported:

Category	**Q1**	**Q2**	**Total**
Patient safety/ quality	1	3	**4**
Staff safety/ Training	1	4	**5**
Bullying and harassment	5	6	**11**
Systems, processes or policies	2	3	**5**
Environment/ infrastructure	0	0	**0**
Workplace culture	0	2	**2**
Leadership	0	1	**1**
Use of resources	0	1	**1**

Noting most cases raised contain more than one issue.

2.2 Source of cases reported

Source	**Q1**	**Q2**	**Total**
FTSU Guardian	7	7	**14**
Values Ambassador	0	1	**1**
CQC	0	0	**0**
GOSW	0	0	**0**

2.3 Concern raised by staff group (where known)

Staff group	**Q1**	**Q2**	**Total**
Doctor	1	0	**1**
Nurse/ Midwife	1	2	**3**
AHP	2	3	**5**
Admin, Clerical/ Maintenance/ Ancillary staff	2	2	**4**
Corporate	1	0	**1**
Unknown	0	1	**1**
Total	**7**	**8**	**15**

Of the above cases at time of report;

- 0 remain open with ongoing investigations/ or report write up underway
- 3 referred to HR or within an HR process
- 15 cases closed

1 case was reported where the individual indicated they are suffering detriment as a result of speaking up.

3. TRUST GUARDIAN ROLE- ACTIVITY IN YEAR TO DATE

- From the start of the Covid 19 pandemic the Regional FTSU network held a virtual fortnightly informal check in session, these remain ongoing. The sessions have provided insights to how other organisations were managing and the level and types of cases received.
- The above sessions also enabled the Trusts Guardian to share good practice relating to how other organisations introduced a safe space for staff which NGH introduced as “Our NGH Space”.
- Regionally the top three themes from Covid 19 were lack of PPE, Redeployment and anxiety/ isolation.
- In Q1 the regional focus has been on the experience of BAME staff in terms of risk assessments, the impact of Covid 19 and lack of staff reporting FTSU cases. Please note Guardians are not required to report cases to the National Guardians Office by ethnicity.
- Responded to the National Guardians Office Pulse Surveys.
- During Q1 all Regional Guardians received and responded to an FOI asking for numbers of issues raised in April/May 2019 and 2020.
- The Midlands Network approached the National Guardian to consider adding staff safety to the data requests. This information has been captured at NGH since the current Guardian took up post.
- Quarter 1 and 2 reports updated onto National system
- Training for a further five Values Ambassadors undertaken in Q2, including staff recruited from the BAME network with the support of the network chair. Further staff members identified for a future session.
- FTSU Guardian attended the BAME network meeting to raise the profile of FTSU within the group.

4. NATIONAL GUARDIANS OFFICE (NGO)

4.1 Pulse Surveys

During the Pandemic the NGO has undertaken two Pulse Surveys to find out more about how speaking up was being affected by the COVID-19 pandemic..

The first of survey results were published at the end of April and highlighted the following:

- 31% of Guardians responded
- 57% of Guardians stated that they or some of their team were suffering from ill- health or self-isolating as a result of Covid 19
- 60% of Guardians had been asked to take on other duties to respond to the Covid 19 pandemic
- 39% responding that there was no change in the amount of cases being received and 40% stated numbers of cases had decreased.
- Of the cases received the following themes were noted:
    - 76% re Staff safety and wellbeing
    - 46% re behaviour including bullying and harassment
    - 34% re patient safety and wellbeing
- Most respondents said changes had been made to speaking up arrangements e.g. ceasing of face to face meetings and moving to telephone or virtual meetings

- Mixed views regarding how likely staff were to speak up during the pandemic compared to before with 31% stating staff would be less likely and 28% more likely.

The second survey results were published in May and highlighted the following:

- 81% of Guardians responded
- 16% of Guardians stated that they or some of their team were suffering from ill- health or self-isolating as a result of Covid 19

- 62% of Guardians had been asked to take on other duties to respond to the Covid 19 pandemic
- 29% responding that there was no change in the amount of cases being received and 37% stated numbers of cases had decreased.
- Of the cases received the following themes were noted:
    - 83% re Staff safety and wellbeing – 75% of cases related to PPE
    - 57% re behaviour including bullying and harassment
    - 32% re patient safety and wellbeing
- Most respondents said changes had been made to speaking up arrangements e.g. ceasing of face to face meetings and moving to telephone or virtual meetings
- Mixed views regarding how likely staff were to speak up during the pandemic compared to before with 24% stating staff would be less likely and 31% more likely.

4.2 Freedom to Speak Up Index published in July 2020

The FTSU Index is a key metric for organisations to monitor their speaking up culture. Measuring the effect of culture change can be difficult. The acid test is the view of workers. The NHS Annual Staff Survey can help to give some indication as to whether Freedom to Speak Up is embedded within Trusts detailing whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident.

The index has risen nationally from 75.5 per cent in 2015 to 78.7 per cent in 2019.

The FTSU Index can help identify areas where workers in your organisations feel less supported to speak up and to focus on ways to improve this. This is especially important if the organisation features lower down the FTSU Index.

The Index enables trusts to see at a glance how their FTSU culture compares with others. This will promote the sharing of insights and enable trusts that are struggling to ‘buddy up’ with those that have recorded higher index scores.

- The survey questions that have been used to make up the FTSU index are:
- % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)
- % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)
- % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)
- % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

Currently NGH scores 76.9% (2019 data) compared to previous year which was 78% (2018 data).

5. FURTHER WORK REQUIRED

The following areas of work have been prioritised to further the FTSU agenda at NGH:

- Identify training opportunities/programme within induction for all Trust staff to raise the profile of FTSU in the Trust
- Further work to support to Values Ambassadors and additional training sessions

6. RECOMMENDATIONS

The Board is asked to note and comment on the content of the report, and accept this paper for information and assurance.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Trust Board**
Date of Meeting	**28th January 2021**

Title of the Report	**Board Assurance Framework Q3 2020- 21**
Agenda item	**14**
Presenter of the Report	Claire Campbell, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Claire Campbell, Director of Corporate Development, Governance and Assurance

This paper is for: (delete as appropriate)

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

1. Executive summary

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

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

This report includes the annual review of the BAF risks and their content and describes the updated Q3 position in relation to the risks associated to delivery of corporate objectives described on the BAF.

2. Assurance

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

3. Population of the BAF

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

4. Changes to the BAF during Q3 2020/21

General Changes:

Several deadlines for actions have been extended in response to Covid surge in Trust. References to workforce committee have been updated.

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: No change

- Assurance of Control: No change
- Gaps in control: No change
- Actions updated: HEE/GMC action plan deadline extended. CAS Alert action has been completed. Trust awaits the formal outcome of the Urgent and Emergency Care Provider collaboration review. Two new actions added in relation to recent publication of Okenden Review and the implementation of the Mass Vaccination centre
- 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 and six additions made.
- Assurance of Control: No change
- Gaps in assurance: No change.
- Actions updated: Two additional actions added and zoning policy completed and implemented.
- 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: Integrated risk assessment and prescription chart added.
- Assurance of Control: No change
- Gaps in assurance: No change.
- Actions updated: QGC approved SHMI as key source of assurance, mortality reviews and mortality presentation to Trust Board completed. Three new actions added- Okenden review to Board in January, Never Event Task and finish group and Quality Summit and EPMA systems added.
- Score: No change.

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: Quality Account action completed. Two deadlines extended.
- 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: References to workforce committee updated.
- Gaps in control: No change
- Actions update: Assessment and Accreditation currently suspended, Lead Matron role appointed to and commenced in the New Year. Revised date for action to be confirmed.
- 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: Actions remain on track
- Score: No change made

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

- Scrutinising Committee: named as Digital Hospital Committee but to be confirmed to ensure KGH/ NGH reporting mechanisms are mirrored.

- Lead Director changed from DoF to CDIO
- Existing controls: No change.
- Assurance of Control: No change
- Gaps in control: No change.
- Gaps in control: No change.
- Actions update: Deadlines for actions 3 & 4 extended.
- 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: Updated due to Covid surge and impact on workforce, staff sickness and winter pressures.
- Actions update: Updated with four new actions, staff wellbeing, vaccination programme, Lateral flow testing and pay rates.
- Score: No change.

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: Updated to include increase in ITU capacity and independent sector contracts.
- Actions update: Deadline for review of elective lists extended. Endoscopy action completed. Two new actions added, ongoing negotiation with the independent sector and ITU capacity added.
- Score: Increased from 15 to 20. Increased gaps in control and surge in Covid has impacted delivery of reset planning.

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: Friends and Family testing completed and restarted. Board to ward action deadline extended.
- Score: No change.

k. 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 (updated from Workforce to People)

- Existing controls: Vaccination programme added.
- Assurance of control: References to workforce committee updated
- Gaps in control: Pandemic related staff absence added
- Actions update: Oncology work action deadline extended. Two new actions added daily reporting of absence data and People Plan delivery. Review of workforce capacity reintroduced and updated following 4th national lockdown.
- Score: Increased from 10 to 15 due to impact of pandemic on workforce capacity.

l. 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 (updated from Workforce to People)

- Existing controls: No change
- Assurance of control: References to workforce committee updated
- Gaps in control: No change
- Actions update: Talent management development and People Plan Board submission deadlines extended. Appraisal lite process completed.
- Score: No change

m. 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 (updated from Workforce to People)
- Existing controls: Group briefings added.
- Assurance of control: References to workforce committee updated
- Gaps in control: No change.
- Actions update: Group health and wellbeing interventions completed, health & wellbeing elements into the people plan and WRES action plan deadlines extended. BAME reverse mentoring programme added.
- Score: No change.

n. 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: Amended.
- Actions update: One new action added –development of group clinical strategy.
- Score: No change

o. 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: Agreement of system break added.
- Assurance of control: No change
- Gaps in control: Underlying position added.
- Actions update: Actions updated and system financial plans added.
- Score: No change.

p. 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: Additional gap in control added – ability to fully utilise Trusts CRL due to slippage.
- Actions update: Additional bid submission completed, two new actions added, escalate slippage and bring forward any appropriate 2021/22 schemes.
- Score: Score decreased from 25 to 20 to reflect new funding received

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

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

	organisation has a statutory duty to meet.

Actions required

The Board is asked to:

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

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

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

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

Gaps in Controls

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

Further Actions	**Responsible Person/s**	**Due Date**
1. HEE/GMC action plans in progress	1. Matt Metcalfe	1. March 2021
2. Robust management of delays in CAS alerts	2. Claire Campbell	2. Completed
3. Standard 5- IPC enhanced and updated for ward accreditation	3. Sheran Oke	3. Ongoing
4. Urgent and Emergency Care Provider Collaboration Review outcome awaited	4. Claire Campbell	4. TBC
5. Okenden Review action Plan to Trust Board	5. Sheran Oke	5. January 2021
6. Mass Vaccination Centre Governance structure & implementation	6. Matt Metcalfe/ Claire Campbell	6. February 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. 1.2 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 daily GOLD meeting	• Performance metrics at corporate, divisional and directorate level (L1) • Integrated performance report to Trust Board and committees (L1) • A&E received rating of Good in CQC inspection 2019 (L3) • Benchmarking against other Trusts. (L3) • Winter Plan. (L1) • Reset plan (L1) • Elective Care national support team review of Trust PTL (L3)

Gaps in Controls

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

Further Actions	**Responsible Person/s**	**Due Date**
1. Full Covid response remains in place	1-5 Carl Holland	1. To continue – March 2021
2. Reset continues despite COVID challenges and performance monitored and reported monthly to Trust Board		2. To continue – March 2021
3. Further outsourcing of routine work to private sector including endoscopy		3. Ongoing
4. System discharge work with external support from ECIST		4. To continue – March 2021
5. External validation of our waiting list and cleansing of patients who no longer need to be seen		5. Feb 2021
6. Zoning policy developed and ratified	6. Sheran Oke	6. Completed

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

Underlying Cause/ Source of Risk: CRR reference risks: 1303; 1411,1478, 1776, 1782, 1867, 1879, 1911, 1955, 1972, 2150, 2187, 2195, 2216, 2219, Multiple sources of risk exacerbated by high demand and high patient acuity.	**Initial score** 10 (5x2)	**Current score** 15 (5x3)	**Target score** 5 (5x1)

Existing Controls	**Assurance of Controls**
1. Monthly review of Dr Foster information and alerts 2. Mortality Review Group 3. Audit plan 4. Incident and SI reporting policy 5. Monthly Clinical Quality and Effectiveness Group 6. Monthly Quality Governance committee 7. Countywide Patient safety M&M meetings 8. Review of Harm Group weekly 9. Dare to Share alternate monthly 10. FIT Group 11. MASH referral system 12. NGH Safeguarding Team 13. IP Steering Group 14. IPC Team 15. Maternity Dashboard 16. Saving Babies Lives – National Initiative 17. Neonatal Safety Champion Role 18. Integrated risk assessment and prescription chart introduced	• 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
4. Outbreaks of nosocomial Covid 19 infection

Further Actions	**Responsible Person/s**	**Due Date**
1. Completion of work to digitise and mandate use of Deteriorating Patient Care Plan	1. Dr Hardwick	1. March 2021
2. Mortality review of deaths – Winter 2019	2. Matt Metcalfe	2. Completed
3. IPC reviews of nosocomial full SI process to be completed	3. Sheran Oke	3. February 2021
4. Mortality presentation to Board (Dr Foster & Medical Director)	4. Matt Metcalfe	4. Completed
5. Okenden Review Action Plan to Board	5. Sheran Oke	5. January 2021
6. Never Event Task & Finish Group and Quality Summit	6. Matt Metcalfe	6. Feb 2021
7. QGC approved SHMI as key source of assurance for Mortality	7. Matt Metcalfe	7. Completed
8. EPMA system to be reintroduced	8. Matt Metcalfe	8. Q4 2020/21- 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**	**Current score**	**Target score**
	12 (4x3)	8 (4x2)	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 3. Quality Account to be presented to QGC for approval	1. Fiona Poyner 2. Geraldine Harrison 3. Matt Metcalfe/ Sheran Oke	1. March 2021 2. March 2021 3. 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**	**Current score**	**Target score**
	25 (5x5)	**10** **(5x2)**	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. TBC

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

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

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

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

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

Gaps in Controls

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

Further Actions	**Responsible Person/s**	**Due Date**
1. Deliver action plans against key estates elements to improve assurance and reduce risks	1. Stuart Finn	1. Ongoing
2. Review Estates strategy to align with KGH, STP/HCP and Clinical strategy commenced in December 2020	2. Stuart Finn	2. April 21
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. Mar 2021
2. Network access control	2. Dave Smith	2. Mar 2021
3. Plug in USB port control	3. Dave Smith	3. Mar 2021
4. Windows to migrate to Windows 7	4. Dave Smith	4. Mar 2021
5. New Daily service checks process for clinical systems	5. Miriam Jepson	5. Ongoing

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

Existing Controls	**Assurance of Controls**
1. Covid Incident management plan 2. Revision of medical rotas to ensure staffing supports activity, recruitment of volunteer workforce, redeployment of staff to areas of greatest need 3. Digital solutions to allow continuation of Outpatient work where appropriate/ workforce permits 4. Critical Care Plan - Enhanced triage of patients to ensure best use of available experience 5. 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

- Continued COVID infectivity putting additional pressure on workforce
- COVID positive staff not available to work and / or shielding
- Winter pressures and COVID at the same time creating huge operational challenges

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	Dec 2020 onwards
3. All staff issued with Lateral flow kits to self-test for COVID	Carl Holland	Dec 2020 onwards
4. Enhanced rates programme to support capacity issues	Gold Team	January 2021 onwards

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

Underlying Cause/ Source of Risk: CRR reference risks: 1482,2287, 2305, 2307, 2313, 2334, 2336, 2341, 2359 Global pandemic relating to Covid 19 affecting the Northamptonshire healthcare system. In recovery, backlogs of activity and reduced capacity.	**Initial score**	**Current score**	**Target score**
	20 (5 x 4)	**20** **(5 x 4)**	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
- National request to increased ITU capacity to 200% of baseline will impact significantly on recovery plans
- Covid surge

Further Actions	**Responsible Person/s**	**Due Date**
1. National review of elective waiting lists to ensure all patients still want / need to be seen	1. Carl Holland	1. Feb 2021
2. New Air handling unit on order, endoscopy moved to 3 day case theatres plus plan to open 2 rooms for endoscopy in Daventry	2. Mary Visser	2. Completed
3. Negotiation with Independent Sector for additional capacity continue	3. Matt Tucker/Gregor Kerr	3. Jan 2021
4. Revised plans to support COVID ITU position being developed	4. Gregor Kerr / Jonathan Hardwick	4. Jan 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)

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	4. Sheran Oke	1. Ongoing
2. Friends and Family test to restart	5. Sheran Oke	2. Completed and restarted
3. Re-instate Board to Ward visits virtually	6. Sheran Oke	3. Mar 2021
4. Work with Northamptonshire Healthwatch, carers and volunteers commenced	7. Sheran Oke	4. Ongoing
5. Trust working with National Cancer Collaborative to improve patient experience	8. Sheran Oke	5. Ongoing

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

BAF Risk No. 3.1 Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future

Risk Classification: Human Resources	**Risk Owner:** CPO	**Scrutinising Committee:** People Committee
Date Risk Opened: 30/07/20	**Date of next full review of BAF: 31/03/20**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks 2075, 1188, 979, 1764, 1893, 2219
National workforce shortages of clinical staff

Initial score	Current score	Target score
10 (5x2)	**15 (5x3)**	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
4. Opening of escalation areas dilutes capacity with current issues regarding covid and non-covid treatment areas
5. Staff absence during the pandemic

Further Actions	Responsible Person/s	Due Date
1. Complete Oncology work in response to medical trainee comments	1. Bronwen Curtis	1. March 2021
2. Review workforce capacity based on national guidance for colleagues i.e. colleagues shielding following the 4th January national lockdown announcement	2. Bronwen Curtis	2. Jan 2021
3. Daily recording and reporting of absence data to support staffing cell to undertake risk assessment for staffing areas	3. Bronwen Curtis and Sheran Oke	3. Ongoing/daily
4. 2021 to 2024 People Plan being developed in line with national NHS People Plan and group priorities	4. Mark Smith	4. March 2021

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	1. Mark Smith	1. June 2021
2. The Group People Plan will be submitted to Trusts Board for approval	2. Mark Smith	2. March 2021
3. Introduce an Appraisal lite process	3. Bronwen Curtis	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. 3.3 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 an 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 & Well- Being interventions to be developed across the Group Model	1. Mark Smith	1. Completed
2. Health and Wellbeing to be an integral element of the group People Plan to be submitted to the Trust Board	2. Mark Smith	2. March 2021
3. WRES Action plan completed and implemented	3. Mark Smith	3. July 2021
4. BAME reverse mentoring programme	4. Mark Smith	4. 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;
4. Effect of surges in covid-19 related activity and the associated effect on demand, capacity and workforce availability
5. Reduction in funding of adult social care leading to increased admissions;

Further Actions	**Responsible Person/s**	**Due Date**
1. Annual Planning - align processes with KGH to ensure single unified approach	1. DoS&P	1. 31/12/2020
2. Continue to explore options to integrate tertiary services, e.g. Head & Neck on a regional basis	2. DoS&P	2. 31/03/21
3. Integration with new Unitary Authorities and Primary Care Networks	3. DoS&P	3. 31/03/21
4. Development of Group Clinical Strategy	4. DoS&P	4. Q2/Q3 2021/22

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** **15** **(5x3)**	**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. Transformation & efficiency programme changes to be implemented- once out of pandemic 2. System financial plans submitted to support LTP with 2020/21 plans in the process of being agreed as a break-even plan	1. Karen Spellman 2. Bola Agboola	1. TBA 2. January 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** 20 (5x4)	**Target score** 10 (5x2)

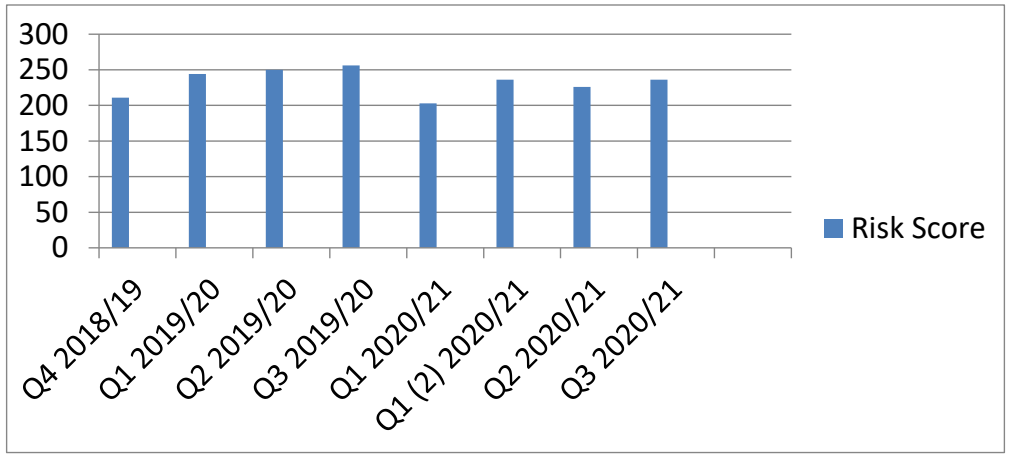
Existing Controls	**Assurance of Controls**
1. Capital Committee 2. Finance and Performance committee 3. 5 year capital plan 4. Purchasing and Supplies Strategy 5. Leasing strategy in place/ IFRS16 6. Hospital Management Team Meetings 7. Business Case process 8. New capital funding approved for the ITU 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. Submit additional bids wherever possible e.g. electrical infrastructure, IT and Paediatric ED	1. Phil Bradley	1. Completed
2. Escalate slippage spend via NHSI Monitoring returns and through Board and FPC	2. Bola Agboola	2. 31/3/2021
3. Bring forward any appropriate 2021/22 schemes to support CRL utilisation	3. Bola Agboola	3. 31/3/2021

	Movements on Board Assurance Framework (since previous report)
ADDITIONS	None
INCREASES	1.10 Increased from 15 to 20 due to impact of Covid surge
	3.1 Increased from 10 to 15 to reflect staff increases in staff absences during the pandemic
	5.1 increased from 10 to 15 to reflect medium term view Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future
DECREASES	5.3 decreased from 25 to 20 to reflect new funding received for ITU and Paeds, but risk remains around fully utilising CRL in 2020/21
CLOSURES/ AMALGAMATED	None



Graph shows risk score of 236 for 16 Risks

Consequence Score/ Domain	Likelihood Score/Domain				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost certain
5 Catastrophic		1.6;	1.1; 1.4; 1.9; 3.1; 5.1;	1.7; 1.10; 5.3;	
4 Major		1.5; 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:

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	20
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
1.10	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	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
1.4	Risk of avoidable harm to patients and the associated loss of public confidence	15
1.9	The risk of the Trust being unable to deliver an appropriate response to Covid 19 in terms of quality of care, capacity and timeliness with consequential impact on patient and staff safety, patient experience and staff wellbeing.	15
3.3	Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optional culture	15
5.1	Risk that the Trust fails to have financial control measures in place to deliver its 2020/21 financial plan	15
3.1	Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future	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
1.5	Risk that Trust fails to deliver high quality services in all clinical areas 24/7	8
2.1	Risk that the Trust fails to promote a culture which puts patients first	8

Executive Leads

CEO	Chief Executive Officer
COO	Chief Operating Officer
MD	Medical Director
DoN	Director of Nursing
DoF	Director of Finance
CPO	Chief People Officer
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

CQC Fundamental standards

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

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

Report To	**Trust Board**
Date of Meeting	**28th January 2021**

Title of the Report	**Group People Committee Terms of Reference**
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 (NGH) and Richard Apps- Director of Integrated Governance (KGH)

This paper is for:

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

Executive summary

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

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

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

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

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

(a) People Committee (Appendix A)

Both KGH and NGH Trust Boards have agreed to establish a joint People Committee. The purpose of the committee will be to support and oversee an aligned and integrated approach to ensure 10,000 colleagues across NGH and KGH are engaged and supported through the successful delivery of the Group People Plan. The Committees ambition is for NGH/KGH to be an inclusive place to work where people are empowered to be the difference.

These Terms of Reference have been approved by the Collaboration Programme Committee; they have been submitted to/received by the Joint People Committee for information with any material feedback to be reported to the Board. They are presented to the Board for ratification.

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

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable excellence through our people* 6. *Become a University Hospital by 2020 becoming a centre of excellence for education and research*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: Not approving these ToR will delay the commencement of key Group initiatives and therefore delay effective governance arrangements, which may result in delays in programme delivery across both Trusts and missed opportunities for collaboration and alignment.
Related Board Assurance Framework entries	All
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	None
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper

Actions required by the Board:

- Approve the Terms of Reference for the Joint People Committee

APPENDIX A - GROUP PEOPLE COMMITTEE
TERMS OF REFERENCE

1. Context

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

As part of collaboration planning, delivery and governance, both Trusts have agreed to establish Committees in Common to provide oversight of the delivery of group objectives in respect of people. The People Committee is therefore Constituted as a Committee in Common of both Boards.

1. PURPOSE AND AMBITION

1.1 Purpose:

The committee will oversee an aligned and integrated approach to ensure 10,000 colleagues across NGH and KGH are engaged and supported through the successful delivery of the Group People Plan.

The committee will escalate items to the Boards, seeking their direction and decision making as required.

1.2 Ambition: NGH/KGH to be an inclusive place to work where people are empowered to be the difference.

2. AUTHORITY

2.1 The Committee has delegated authority from the Trust Boards as set out in the Trusts' Scheme of Delegations. The committee is authorised, subject to the scheme of delegation, to oversee the delivery of the Group People Plan across the Trusts. The committee is charged with providing assurance to the Boards and is authorised to investigate any activity within its Terms of Reference. The committee is required to escalate items to the Boards, where Boards' direction and decision making is required. The committee has authority to review information and report to regulators as required.

2.2 A key relationship for this group will be to the Integrated Care System People Board. Members of the committee are represented on the ICS People Board and therefore communication should be maintained through this route.

2.3 The committee will be accountable for the Diversity and Inclusion Steering Group in both Trusts.

3. MEMBERSHIP AND ATTENDANCE

Chairs of Committee	Non-Executive Director (KGH) Non-Executive Director (NGH) *Rotating Chair*
Members	Non-Executive Director (KGH) Non-Executive Director (NGH)
	Chief People Officer
	Operational Directors of HR (or equivalent)
	Directors of Nursing & Quality
	Chief Operating Officers
	Medical or Deputy Medical Director
	Staff Side representatives (2)
	Staff Network Leads / Diversity and Inclusion Managers
Attendees	Nominated Governor (KGH)
	Others by invitation to discuss pertinent issues/topics
	Meeting Administrator

Notes on membership and attendance:

3.1 The committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate. The Trust Chair(s), Group Chief Executive, Hospital Chief Executives or other executive directors may be invited to attend any meeting of the Committee, particularly when the Committee is discussing areas of the Trusts' operation that are the responsibility of that director. The nominated Governor will attend the meeting as an observer.

4. MEETINGS AND QUORUM

4.1 A quorum of the Committee shall be four members from each organisation, including a Non-Executive Director from each organisation. Members of the Committee in Common can nominate a deputy but not for more than two consecutive meetings without prior permission of the Chair.

4.2 Virtual meetings, subject to minimum quoracy requirements, will have full authority to take decisions; meetings will be recorded, and Minutes/Action Logs produced, in the normal way.

4.3 The Committee shall meet not less than six times per year, in addition to which it will arrange informal development workshops to facilitate staff engagement and policy development.

4.4 In urgent and exceptional circumstances where it is not possible to convene a meeting via video conference, decision items may be

- circulated to voting members of the body for comment and approval, or:
- taken by Chair's action, in liaison with the Chief Executive and Chief People Officer for the matter concerned.

In each case, electronic approvals and decisions will be communicated as soon as they are confirmed, and reported to the next formal meeting for information, specifying the exceptional circumstances.

5. SUPPORT ARRANGEMENTS

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

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

6. DECLARATION OF INTERESTS

6.1 All members must declare any actual or potential conflicts of interest relevant to the work of the Committee, which shall be recorded in the Minutes accordingly.

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

7. DUTIES

7.1 To be assured that the Group People Plan and its supporting policies are effectively implemented and reviewed through the development, agreement and monitoring of delivery plans and associated common performance metrics across the Trusts.

7.2 Monitor the organisational development plan and organisational development strategy implementation and progress in realising the plans, especially the reductions in the direct cost to the Trust of temporary (agency) workers.

7.3 Seek assurance that the people management processes are in place and are being followed.

7.4 Seek assurance that there are mechanisms in place to deliver effective staff engagement and to regularly review staff feedback, including through, but not limited to, the annual staff survey.

7.5 To ensure that the Group values are incorporated and demonstrated within the Trusts.

7.6 Risk assess the organisational development interventions to direct the Committee's activities and feed into Corporate Risk Registers. Provide any required updates to the Board Assurance Frameworks, relevant to the work of the committee, to the Trusts' Audit Committees.

7.7 Approve the annual Medical Revalidation process on behalf of Boards of Directors.

7.8 Receive reports from both Trusts' Freedom to Speak Up Guardians and refer key issues and learning arising to the Board of Directors and relevant Board Committees, as required.

8. STANDING AGENDA THEMES

1.	Integrated Governance Report, focusing on shared workforce metrics
2.	People Plan Implementation
3.	Workforce Compliance & Operational Performance (including: MAST, pre-employment checks, revalidation, pay reports, safe staffing, Occupational Health, Medical Education)
4.	Risk and Board Assurance Framework
5,	Reports from Sub-Groups aligned to People Plan themes
6.	Staff engagement and feedback – from colleagues

9. REPORTING

Reports to Boards:

9.1 The Committee will formally report on a bi-monthly basis to the Boards of Directors with a summary report.

Reports to the Committee:

9.2 There will also be a regular update from the Learning & Education function and a quarterly progress report in relation to Diversity and Inclusion within the Trust.

9.3 The Staff Health & Wellbeing Group will also formally report to the People Committee on a quarterly basis for assurance purposes, however for operational decisions, the Group would escalate to the Hospital Management Teams meetings.

10. PROCESS FOR MONITORING EFFECTIVENESS OF THE COMMITTEE

10.1 These terms of reference may be amended in consultation with both Trust Boards, to reflect changes in circumstances that may arise. This Committee in Common is recognised as undertaking a role to support and enable the delivery of the Group People Plan and its associated plans and policies and, as such, solutions considered may be iterative and

designed to evolve over time. Together both Trust Boards will implement and review the Terms of Reference, not less than once per year.

11. REVIEW

Agreed: January 2021
Next Review: January 2022

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**28 January 2021**

Title of the Report	**Emergency Preparedness, Resilience & Response Annual Report**
Agenda item	**16.**
Presenter of the Report	Carl Holland – Chief Operating Officer
Author(s) of Report	Jeremy Meadows – Head of Resilience and Business Continuity
Purpose	For assurance/information/awareness.

Executive summary

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

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Strategic aim 1 – focus on quality and safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks (**Y**)
Related Board Assurance Framework entries	BAF – please enter BAF number(s) BAF 1
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 /	Are there any legal/regulatory implications of the paper

regulatory requirements	(**N**)

Actions required by the Group

The Group is asked to:

- Note the contents of this paper.
- Discuss and appropriately challenge the contents of this report.
- Identify areas where additional assurance is required.

Emergency Preparedness, Resilience & Response – Annual Report January 2021

1. Introduction

This paper provides a report on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response Framework 2015.

The Trust has a suite of plans to deal with Major Incidents and Business Continuity issues. These conform to the Civil Contingencies Act (2004) and current NHS-wide guidance. All plans have been developed in consultation with regional stakeholders to ensure cohesion with their plans.

The paper reports on the training and exercising programme, EPRR reporting programme, and details the developments of the emergency planning arrangements and plans. The report gives a summary of instances in which the Trust has had to respond to extraordinary circumstances.

It is recognised that a number of key work streams have been put on hold due to the COVID-19 response.

2. Background

The Civil Contingencies Act (2004) outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at a local level. As a category one responder, the Trust is subject to the following civil protection duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance coordination
- Cooperate with other local responders to enhance coordination and efficiency

3. Overview of EPRR

Risk Assessment

The Civil Contingencies Act (2004) places a legal duty on responders to undertake risk assessments and publish risks in a Community Risk Register. The purpose of the Community Risk Register is to reassure the community that the risk of potential hazards has been assessed, and that preparation arrangements are undertaken and response plans exist.

The emergency planning team works closely with other agencies as part of the Northamptonshire Local Resilience Forum to consider these risks to keep the county as safe as possible.

Partnership Working

The Trust works in collaboration with a range of partner agencies through formal standing meetings and ad hoc arrangements. Formal committees of which the Trust is a member include the Northamptonshire Local Health Resilience Partnership and the Northamptonshire Health Resilience Working Group. The Trust is also represented at a number of sub groups of the Northamptonshire Local Resilience Forum. The purpose of these groups is to ensure that effective and coordinated arrangements are in place for NHS emergency preparedness and response in accordance with national policy and direction from NHS England Central Midlands.

Debriefing from Live Events and Exercises

Following live events and exercises, debriefs are undertaken in order to capture learning points. Lessons identified from live events and exercises are subsequently incorporated into major incident and business continuity plans, and are shared with partner organisations.

Communications

Communications is critical in dealing with any adverse incident. The Trust has recently purchased a dedicated web-based system to assist with the notification and call-out process during an incident. As part of the rollout of this system, the resilience team are linking with key areas within the Trust to provide training and ensure ongoing maintenance of contact details. Additionally, work has recently been undertaken to install contingency phones throughout the Trust in order to maintain communication during periods of potential IT/network outage. As part of the Trust's exercise programme, a series of communication cascade exercises will be held throughout the year in order to test the ability of the organisation to contact key staff and other NHS and partner organisations.

4. Governance

Resilience Planning Group

The Trust has a Resilience Planning Group that meets bi-monthly. All standing members of the group are required to attend 4 of the 6 meetings held each financial year and not be absent for two consecutive meetings without the permission of the chair of the group.

The group includes representation from all areas within the Trust and other Directors and Officers of the Trust may be asked to attend at the request of the Chair. External partner agencies will be invited if there are specific agenda items that require multi-health partner involvement.

The group is authorised by the Trust Board to investigate any activity within its terms of reference and to seek any information it requires from any employees and all employees are directed to co-operate with any request made by the Group.

The Group has devolved responsibility from the Chief Operating Officer as the Accountable Emergency Officer for the following elements of the Resilience and Business Continuity workstreams:

- Ensuring that the Trust is compliant with the requirements of the Civil Contingencies Act (2004).
- Ensuring that the Trust can satisfy the requirements of external standards, legislation and statutory requirements.

- Ensuring that the Trust is engaged at a strategic, tactical and operational level with National, Regional and local health and multi-agency resilience agendas specifically: Local Health Resilience Partnership, Northamptonshire Local Resilience Forum and its sub-groups.
- Ensuring appropriate Trust input via Operational and Resilience routes into multi-agency plans, procedures and policies.
- Ensuring that the Trust has a robust and tested Major Incident Plan in place and that staff have been trained in their roles.
- Ensuring that the Trust has a range of emergency plans in place to respond to specific emergency situations such as Pandemic Influenza, Communicable Disease Outbreaks, Mass Casualty and CBRN.
- Ensuring that staff are trained to an appropriate level with respect to role and function in an emergency situation.
- Ensuring that the Trust and all of its Directorates have robust Business Continuity Management plans in place which would enable the continued delivery of key services even whilst responding to an emergency.
- Ensuring that all Divisions are involved in the emergency planning and resilience agenda and that updates, potential risks and new initiatives are shared with respective management teams.
- To provide a forum to exchange information, and promote good practice in emergency planning across the Trust.

5. Planning Sector Reports

The following sections provide an area-by-area report on developments over the past year and planning for the next 12 months.

Corporate Major Incident Response Plan

This plan details the Trust's actions in the event of a major incident (e.g., a rail crash, floods, or a terrorist attack). Such an event will require the hospital to employ a different method of working in order to manage the situation. The plan contains unit-level plans that details the actions required of individual areas to ensure that a trust-wide response is achieved.

The policy is currently under review to incorporate recent changes within the Trust, notably to incorporate the new paediatric ED.

Business Continuity Management Policy

Business Continuity Management is a management process that helps to manage the risks to the smooth running of the organisation or delivery of a service, ensuring that the Trust can continue in the event of a disruption. These risks can be from an external environment (e.g., power failures or severe weather) or from within the organisation (e.g., system failures or loss of key staff). A business continuity event is any incident requiring the implementation of special arrangements in order to maintain or restore services.

The policy comprises of a corporate-level policy supported by service-level plans. These service level-plans detail what would be required for the service to continue; which less-critical services or functions could be suspended and for how long in order to maintain critical services; which other services are required for that service to function; and which services rely on that service being operational.

A Group business continuity exercise is being planned for May to ensure compliance with the Data Security and Protection Toolkit.

EU Exit Business Continuity Plan

The EU Exit Business Continuity Plan has recently been developed in consultation with the Brexit Planning Group with the intention of managing the Trust's response to the potential risks associated with the UK's departure from the EU. The UK formally left the EU at 23:00 on the 31st December 2020. The Government is now focussing on the delivery aspects of the current deal, the future relationship negotiations following the end of the implementation period.

The Resilience Planning Group will continue to monitor the situation.

Adverse Weather Plan

Adverse weather covers conditions such as snow, ice, fog, floods, gales and high winds and heavy storms, which render journeys by road extremely hazardous. The UK Cold Weather alert watch came into operation on 1 November 2020 until 31 March 2021. Throughout this period, senior managers have received alert communications to ensure preparedness across the Trust. This plan details how the Trust would manage an adverse weather event which would result in staff requiring assistance to attend their place of work, and/or requiring overnight accommodation. The resilience team have acquired the services of 4x4 Response UK, an organisation who provide 4x4 vehicles, equipment and trained personnel to support the emergency services in adverse weather and poor road conditions where conventional plans cannot cope.

Additionally, the Trust has arrangements with Northampton Leisure Trust who operate the onsite Cripps Recreation Centre and will provide a 'Snow School' play scheme for 5-13 year olds to allow staff, who would otherwise be required to provide childcare, to work in the event of school closures. Current COVID social-distancing requirements mean that this scheme cannot currently be utilised.

No changes from the national plan was required, therefore, the Trust Cold Weather plan remains in place. This is readily available on the Trust Intranet.

6. Training

A key part of any preparedness arrangements is to ensure that staff are appropriately trained to implement the required response. The Head of Resilience facilitates the delivery of major incident training to staff, in addition to specific sessions as required, and has included;

- Quarterly ED training days which focus on major incident and CBRN responses, including erection of the CBRN decontamination tent and donning the Powered Respiratory Protection suits.
- Loggist training ensures that NGH has sufficiently trained members of staff who can act as loggists during an incident. In addition, sessions have been developed to provide qualified loggists with refresher training in decision logging prior to assisting in the Incident Coordination Centre.
  As part of the training, loggists are encouraged to attend some senior meetings in order to practice the logging of key decisions.
- Staff undertaking strategic, tactical and operational response roles for COVID-19 are gaining first-hand experience of the command and control response structure within the NHS.

It should be noted that a number of training events have been cancelled due to the COVID-19 response. The Trust events will be rescheduled at an appropriate time.

As required by the EPRR Core Standards, all corporate-level training and exercising is based on and referenced to the National Occupational Standards for Civil Contingencies.

7. Exercising

The Trust has a rolling programme of live, table-top, command post and communications exercises that are designed to test and develop our plans. The Trust is required to undertake the following:

- Communications exercise – minimum frequency – every six months
- Table top exercise – minimum frequency – every 12 months
- Live exercise – minimum frequency – every three years

The activation of the Trusts Incident Control Centre in response to a live incident replaces the need to run an exercise, providing lessons are identified and logged, and an action plan is developed.

It is vital to ensure that internal exercises are run in a multi-departmental context in order to provide areas of the Trust with an increased understanding of any potential requirements and realistic expectations in the event of an incident.

Whenever possible, the Trust strives to ensure that testing is held in a multi-agency context in order to provide familiarisation with other organisations and to assist with benchmarking our response with our partners. Exercises provide valuable insight into the operationalisation of our plans and important information regarding the areas of the plans that require further development.

The following exercises have taken place over the past 12 months:

- 17th January 2020: Tactical command training has been delivered to on-call managers. The aim of the session was to provide managers with an update on EPRR arrangements in being able to respond to a major incident and to build their competence. This also included engagement from clinicians to test ED's response in receiving, triaging and treating causalities involved in a major incident.

- 24th January 2020: Data Security Business Continuity Tabletop took place to test the IT department's response to a data security incident.

- 19th February, 6th March & 11th March 2020: Fire Evacuation Tabletop exercises.

- 7th February 2020: Coronavirus Tabletop exercise. Prior to the Trust receiving its first COVID-19 patient, a Trustwide Coronavirus table top exercise was developed to simulate a number of potential scenarios in order to ensure thorough consideration for a host of potential eventualities.

- 17th – 21st March 2020: Exercise Novus Coronet was an NHS England led, national Coronavirus business continuity exercise. The exercise was played over the course of a week, with the simulated demand on the NHS increasing in line with the predicted forecasts.

- 28th May & 23rd June: Alert Cascade call-out test.

Staff who have attended table-top exercises have found them to be enjoyable and informative with lots of new useful information discussed.

It should be noted that a number of exercising and testing events have been cancelled due to the COVID-19 response. The Trust events will be rescheduled at an appropriate time.

8. **Live Incidents**

During 2020, NGH experienced a number of extraordinary incidents. These are detailed below:

- 14th January 2020: Electrical Generator Failure:

At 07:00 the routine 'on load' test for the new site was carried out as planned. Notifications of this routine test were emailed out to site prior to testing giving details of the test and areas that will be affected.

At 07:00, main electrical supplies were isolated; the generator started and supported the load. After approximately 20 minutes, the temporary generator went into fault and electrical power was lost. The Estates team remained present throughout the tests and were able to reinstate the mains supplies and restored power to all areas within 10 minutes. Estates staff visited the Site Office and Main Theatres to inform staff.

Initial investigation of the generator showed a fault had occurred with the battery charger which led to the generators shutting down.

The specialist generator contractor attended site at 11am to investigate the generator. Following initial investigation the contractor replaced the charger and a retest was carried out at 3pm.

During the second test the generators started and worked, testing was carried out for 15 minutes.

An on load re-test was carried out on the 17th January. All emergency supplies were confirmed as working correctly.

A further on load test was successfully carried out on the 18th January. The four temporary generators were tested on full load from 07:00 until 11:00. No faults were found.

What went well:

- Routine testing highlighted a fault under controlled conditions
- Experienced Estates team were able to respond immediately and minimise impact
- Specialist generator contractor attended site within contracted hours
- Estates contingency plan worked well and a temporary generator was delivered, connected and tested
- Regular update communications via Exec and Sit-rep WhatsApp group
- Estates team attended all theatre areas to keep them informed
- Clinical teams in affected areas, led by Divisional Director and Senior Managers, responded well and worked with Estates team
- UPS (battery back-up) systems were tested in each area to give clinical team assurance they were operational

Those in attendance at the debrief were in agreement that the incident was managed appropriately and patient safety was maintained throughout the incident.

- 21st October 2020: Gynae Theatres Formalin Spillage:

A specimen pot containing approximately 5 litres of Formalin 10% was dropped on the floor. This resulted in a significant amount of Formalin spilling on the floor in a small unventilated cupboard.

A 5 litre spillage meets the criteria for fire service attendance. Ventilation systems were isolated within the area. The area was evacuated of patients and staff. Powered ventilation was completed by the fire service, followed by 24 hours of natural ventilation.

Patient safety was maintained throughout the incident. There was no reported harm as a result of the incident.

- 8th November 2020: ITU Fire:

An electrical fire, the result of a low voltage transformer feeding an automatic tap sensor, was detected by staff at approximately 07:00 on the 8th November 2020 within ITU. This led to the activation of the fire alarm by staff. The assessment of risk and the training of staff led to a prompt "Progressive Horizontal Evacuation", as per the local evacuation plan, to the Heart Centre. In total 12 critical care patients were evacuated.

Through the use of a range of call out methods, on-call and off-duty staff responded to support the incident.

A major incident was declared given the potentially dangerous scenario and the areas affected.

The ITU team followed the fire plan and were able to quickly and safely evacuate all occupants.

- 11th November 2020: Allebone Fire.

Contractors were carrying out roof repairs as per planned capital works. Overhearing occurred whilst a new roof covering was being applied. The roof timber under the existing roof covering ignited and the contractors used the predetermined fire precaution measures in place to extinguish the fire. Upon smelling smoke within Allebone ward, the ward receptionist raised the alarm.

The Fire Safety Advisor and a member of the security team went onto the roof and met the project manager for the roof works. A thermal imaging camera was used to identify heat within the roof cavity.

The decision was taken to evacuate Allebone and Eleanor wards. All patients were moved safely as per the department's Fire Plan.

It should be noted that Allebone and Eleanor followed the fire plan and were able to quickly and safely evacuate all occupants. All teams responded appropriately. The Fire Service were very pleased with NGH response and had no concerns.

Debriefs were held after the incidents and action plans for plan development were produced. These incidents have helped the Trust and services to develop their plans to manage such incidents should they occur again in the future.

- COVID-19. March 2020:

An incident team has been established for the management of the hospital since the emergence of the pandemic in March 2020. It was initially envisaged to stay in place for a minimum of three

months but has been in-place throughout. The Incident Coordination Centre (ICC) acts as the single point of contact and is staffed by the Silver Executive lead, administrator and decision loggist.

The Incident Room itself is open at a minimum between 08:00 – 20:00 daily, in reality it may be open for much longer depending on the operational situation in the Trust. The actual hours will be determined by the Hospital CEO and based on the requirements from NHS England Regional Response Centre in line with the national incident level.

The ICC does not replace the Site Office who continue to oversee patient flow. Bed meetings will continue at present. The difference is the Incident Team will continue to manage and support the entire hospital response.

The command structure co-ordinates the entire Trust via the Bronze teams that have been established. It is the central point that external organisations use to contact the Trust and ensure all information requirements of the hospital, and external partners are co-ordinated.

9. EPRR Core Standards Review 2020/21

NHS England requires providers of NHS funded care to provide assurance surrounding their EPRR readiness. This is provided through the annual National Emergency Preparedness, Resilience and Response (EPRR) Core Standards assurance process.

It was recognised that the detailed and granular process of previous years would be excessive whilst responding to COVID-19, as well as seasonal pressures and operational demands. 2020 sees an amended process which focuses on learning from the first wave of COVID-19.

The emergency preparedness, resilience and response (EPRR) annual assurance process letter highlighting the revised format of this year's assurance process is attached for awareness.
APPENDIX 1

The letter sets out the amended process for 2020/21 which focuses on three areas:

1) Progress made by organisations that were reported as partially or non-compliant in the 2019/20 process.

This is not applicable as the Trust was previously rated as fully-compliant.

2) The process of capturing and embedding the learning from the first wave of the COVID-19 pandemic.

As part of the Trust response to the COVID-19 pandemic response it was felt that an interim debrief would be useful. The debrief was held on Friday 25th September 2020 whilst the Trust was still responding to the pandemic, albeit at a reduced level.

The information received will be used to help support the ongoing response, help inform the recovery process, and help set the new environment and way of working going forward.

Any areas of best practice would be shared across all divisions and plans, processes and relevant documents reviewed and updated accordingly to reflect required changes.

An assurance meeting took place on Monday 28th September 2020 including the Chief Operating Officer, Deputy Chief Operating Officer and Head of Resilience with the Head of EPRR and System Resilience from Northamptonshire CCG. A verbal overview of initial learning was provided in the absence of a full debrief report.

3) Inclusion of progress and learning in winter planning preparations.

A winter debrief took place on the 2nd September 2020. It was noted that last winter was immediately followed by the pandemic and there is lots of learning to be had from both. Challenges this year include further COVID peaks, influenza and usual winter pressures. It was agreed that the winter plan will need to be flexible and quickly deployable to meet the changing demand.

The CCG issued a statement of assurance to regional EPRR teams in October. Confirmation of assurance is expected in March 2021.

10. Recommendations

The Board is asked to receive this report as a statement of assurance of the preparedness of the Trust to provide an effective response to a range of incidents and emergencies.

11. Next steps

The past year has been dominated by the response to the COVID-19 pandemic, however it has seen good developments in the Trust's resilience arrangements, particularly relating to IT infrastructure, and remote working. The priorities highlighted above will determine the Emergency Planning and Business Continuity work plan for 2021.

Appendix 1

C0731_EPRR annual assurance letter.pdf

Report To	**Public Trust Board**
Date of Meeting	**Thursday 28 January 2021**

Title of the Report	**Strategic Cancer Plan Presentation**		
Agenda item	**17**		
Presenter of Report	Mr Matthew Metcalfe, Medical Director		
Author(s) of Report	Mr Hemant Nemade, Deputy Medical Director & Consultant Urological Surgeon		
This paper is for: (delete as appropriate)			
	x Receive		
	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it		

Executive summary

The presentation 'Developing our Strategic Cancer Plan' covers the following;

- Our ambition for cancer care for our patients
- How we have continued to deliver cancer care during Covid-19
- A summary of plans for 2021/22 to improve our cancer performance and trajectories
- Proposals for developing our Cancer Strategy as a key strand of the Clinical Strategy

The Trust Board are asked to note and discuss the contents and progress in delivering our cancer priorities and strategic plans for cancer.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks No
Related Board Assurance Framework entries	BAF – please enter BAF number(s) 1.2

Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	None
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper No

Actions required by the Board:

The Trust Board is asked to note and discuss the contents of the presentation noting its implications for the Trust.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Strategic Cancer Plan

Mr. Hemant B Nemade
Deputy Medical Director & Consultant Urological Surgeon
Royal College of Surgeons – Regional Director(East Midlands)

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

Providing the Best Possible Care

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Contents

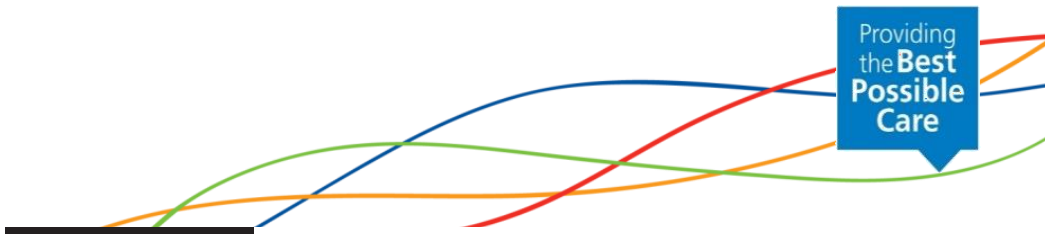
Providing the Best Possible Care

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Our Ambitions

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



UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Our Ambition - Achieving World Class Cancer Outcomes

Spearhead a radical upgrade in prevention and public health

Establish patient experience as being on a par with clinical effectiveness and safety

Drive a national ambition to achieve faster diagnosis

Make the investment required to deliver a modern high-quality service

Transform our approach to support people living with and beyond cancer

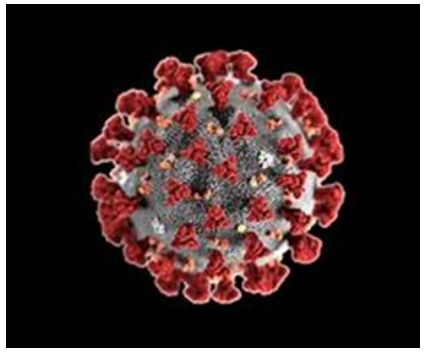
Influence processes for commissioning, accountability and provision

Providing the Best Possible Care

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Response to Covid-19



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

Providing the Best Possible Care

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Response to Covid-19 Phase 1 – Phase 2/3/4

Cancer remains the number 1 priority for the Trust

We are continuing to deliver;

- Receipt of referrals from GP's and safety netting of those patients
- Clinical triage of all referrals
- Virtual or face to face appointments
- Robust tracking and escalation of patients
- Diagnostics that were not ceased on a national level
- Network Approach with EMCA
- Focus on legacy patients already in the system
- New pathways Rapid Colorectal, Lung, Derm Ambulatory care, CUP/RDC Personalised care
- Quality Governance Harm Reviews Quality Surveillance MDT effectiveness
- Prioritisation of patients for treatments on site and through a third party provider
- Safety netting Wellness calls - CNS

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

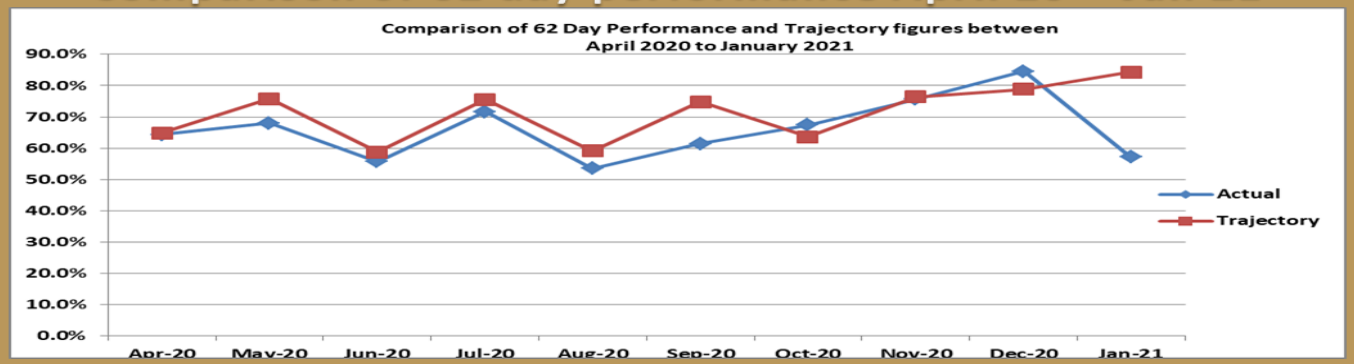
Response to Covid-19 Phase 1 – Phase 2/3/4?

Comparison of 2ww referrals received at NGH last year to this

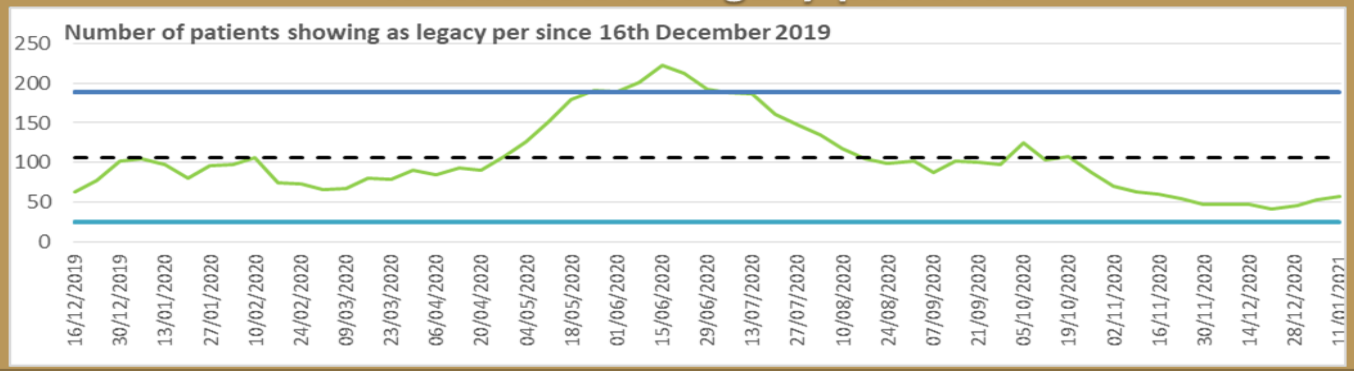
Comparison of 2ww Performance and Trajectory figures

Comparison of 28 Day Faster Diagnosis Performance and

Comparison of 62 day performance April 20 – Jan 21



Reduction in legacy patients



UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Plan for 2021/22 - NGH

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

Providing the Best Possible Care

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Our goal is achievable with system, clinical collaboration and innovation….

Reduce avoidable delays in the cancer pathways, improvements in the organisation of workflows and clinically led transformation of MDT's. Move the patient administration and communication to the patient contact centre.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

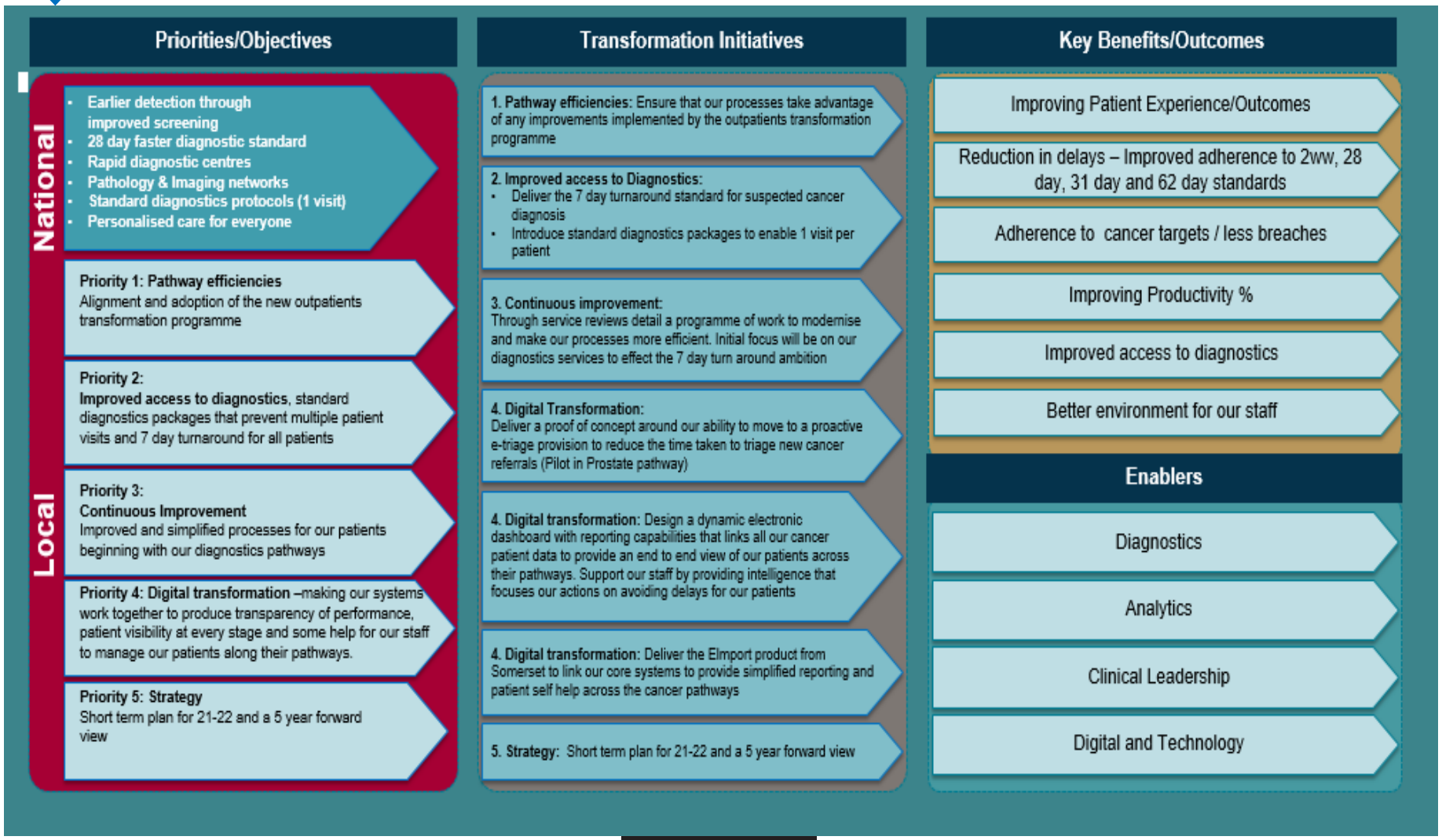
Achieving Our Goal

Achieving our goal does not come without challenges, locally and across the system

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

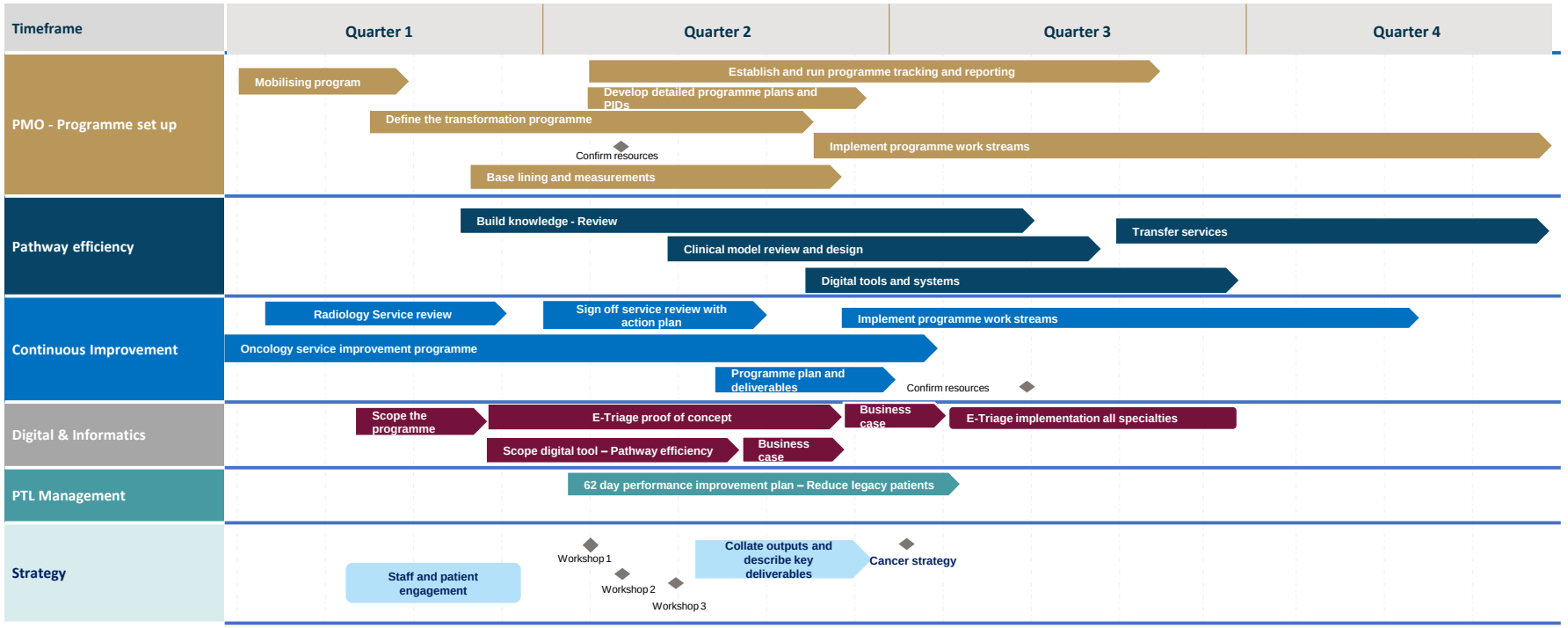
Cancer Plan on a Page



UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Cancer Transformation Timescales



Providing the Best Possible Care

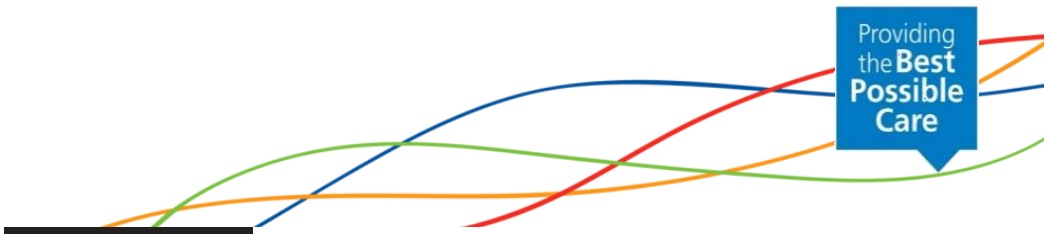
UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Developing Group Cancer Strategy

The Cancer Strategy will form a key pillar of the Group Clinical Strategy to be developed by end of Quarter 2 2021/22

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



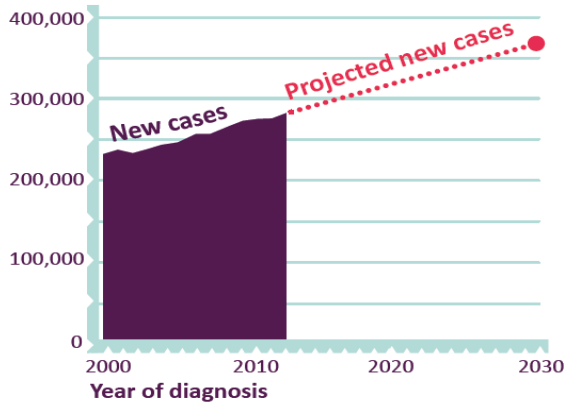
UNIVERSITY OF LEICESTER
Associate Teaching Hospital

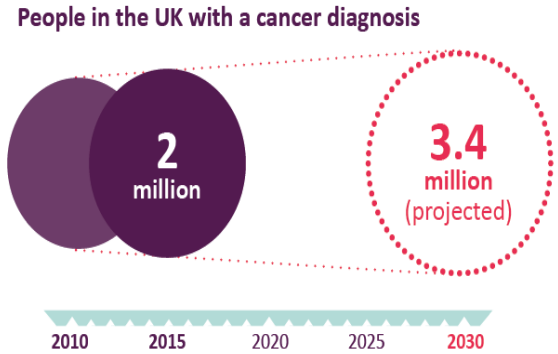
NHS
Northampton General Hospital
NHS Trust

Reason for Change?

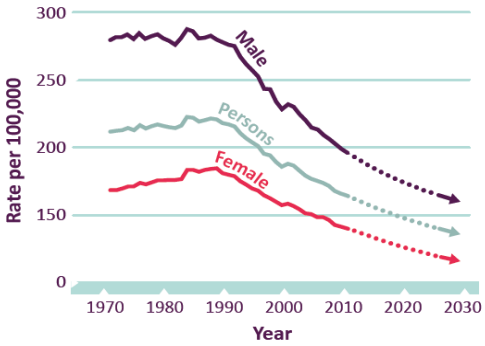
We have a very real and present national context

Projection – Incidences will keep growing





Projection – Cancer mortality



- With no other long term condition 30%
- With 1 other long term condition 22%
- With 2 other long term conditions 18%
- With 3+ other long term conditions 29%

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Reason for Change – Local Context

- Patients do not always receive timely care in the cancer pathways
- Performance has deteriorated during the Covid period and ensuring that pathways remain open and there will continue to be challenges in ensuring care is Covid secure
- There are inconsistencies in performance and there could be improved working to share strengths across the site

Providing the Best Possible Care

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Strategy Design Principles

CO-DESIGN

- System wide strategic effort
- Stakeholder engagement
- Patient voice
- One size fits no-one
- Systems of external accountability
- Devolved decision making

AGILITY

- Collaborative leadership
- Patient 1st
- Adaptable
- Cost effective innovation

PEOPLE

- Pre- and post-treatment are as important as treatment
- Personalised care for everyone
- Continuous improvement in patient experience with a reduction in variation
- Staff wellbeing

AMBITION

- Research and data as drivers of continuous improvement
- Cancer as an exemplar for other conditions
- Continuous improvement in long-term quality of life

PERFORMANCE METRICS

- Patient experience and quality of life
- Underpinning metrics
- Cancer Intelligence
- Dashboards CCG, cancer services, patient experience

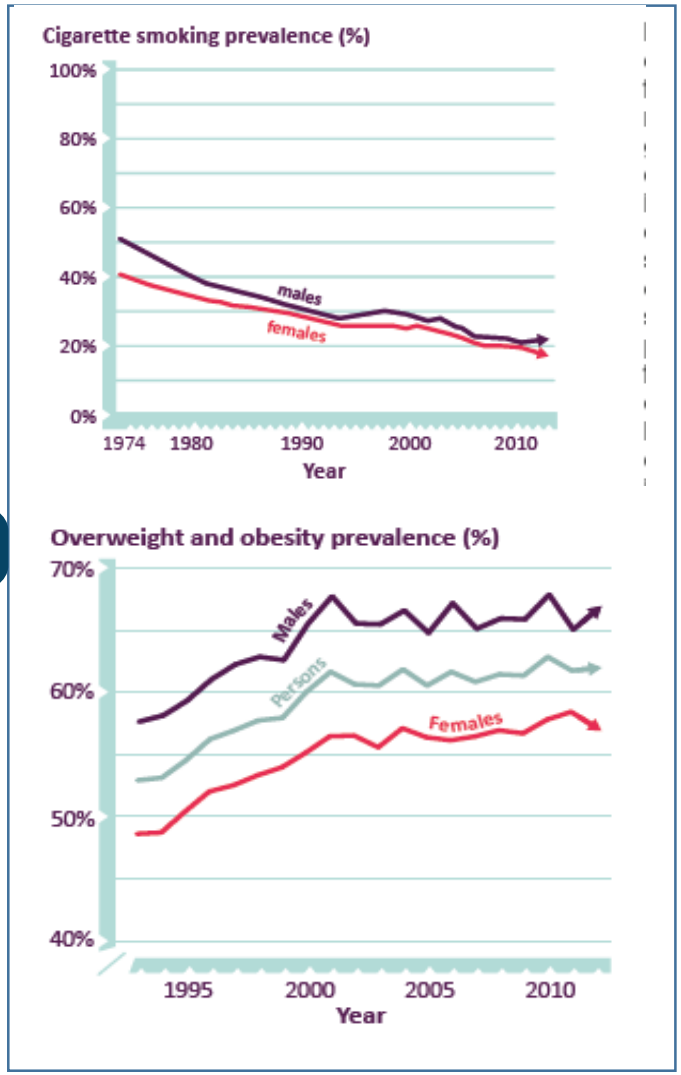
Providing the Best Possible Care

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

How Should we Reduce the Growth in the Number of Cancer Cases?

HOW SHOULD WE REDUCE THE GROWTH IN THE NUMBER OF CANCER CASES?



UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

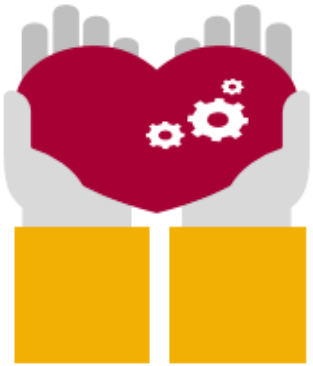
Survival Rates – How do we influence them?

SCREENING

Efficiency -bowel, cervical , breast
Screening leadership
New screening programmes – ovarian , lung
Risk based approaches

TREATMENT

Surgery - Service reconfiguration, timely surgery , measuring surgical outcome and reducing variation
Oncology - access to new drugs, acute oncology services
Enhancing treatment service delivery
Target groups



CANCER REHABILITATION

Cancer rehabilitation
Living with and beyond cancer
Provision of care in the community
Supporting people with cancer to return to work
Early access to palliative care and AHP services
End of life and palliative care

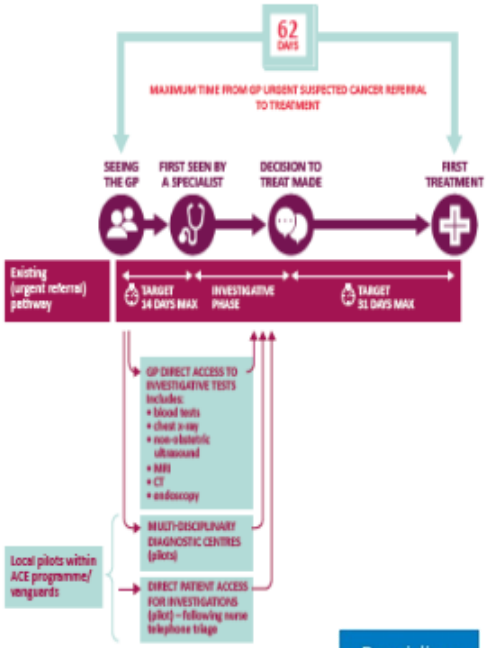
EARLY DIAGNOSIS

Early diagnosis - Public awareness, GP referrals, safety netting, diagnostic capacity, new approaches to diagnostic pathways , measuring performance on early diagnosis

Teachable moment - 'Making Every Contact Count'

RESEARCH & INNOVATION

Supportive environment pull through innovation

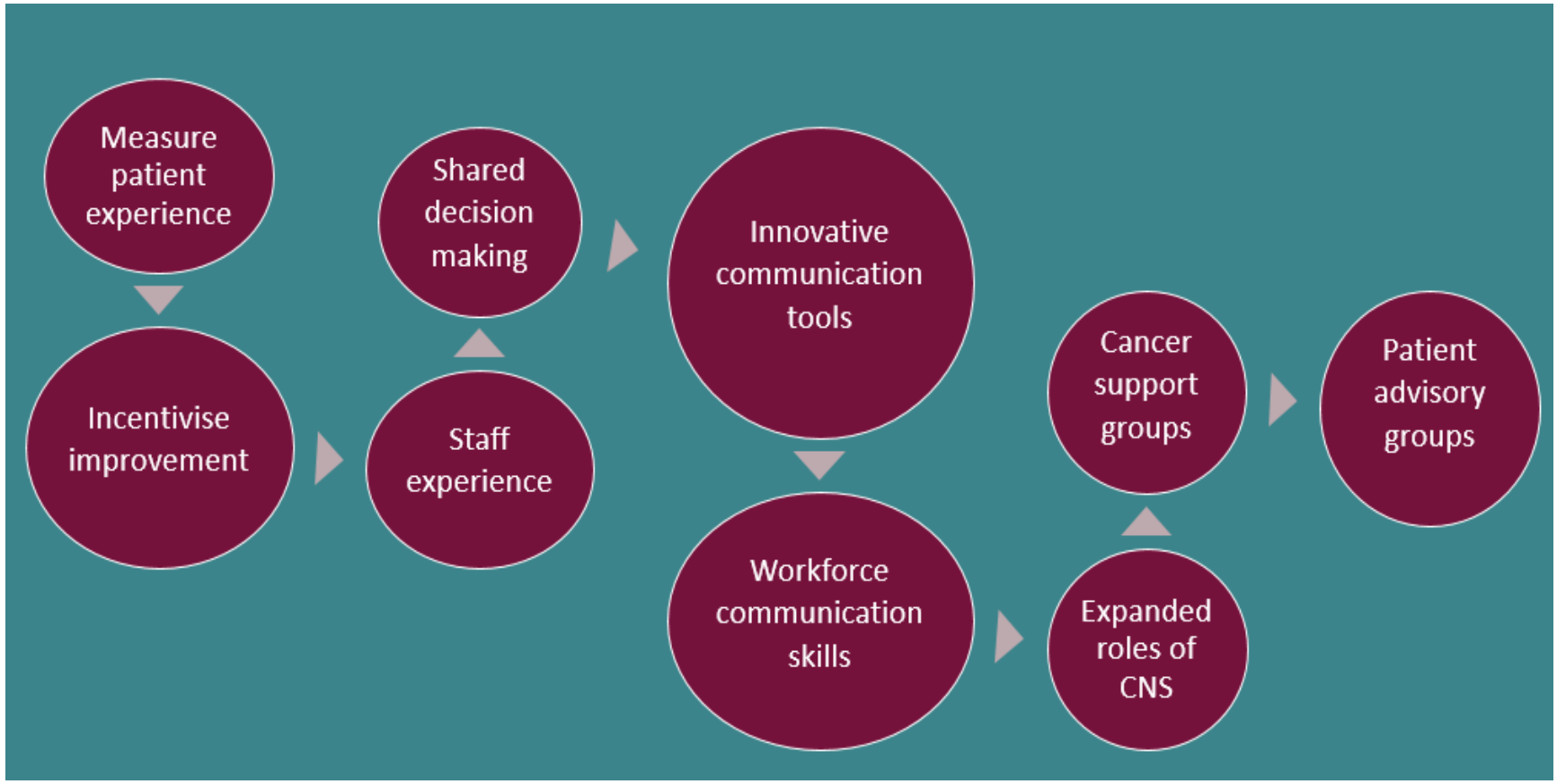


Providing the **Best Possible Care**

UNIVERSITY OF LEICESTER

NHS
Northampton General Hospital
NHS Trust

Improving the Experience of Care, Treatment and Support

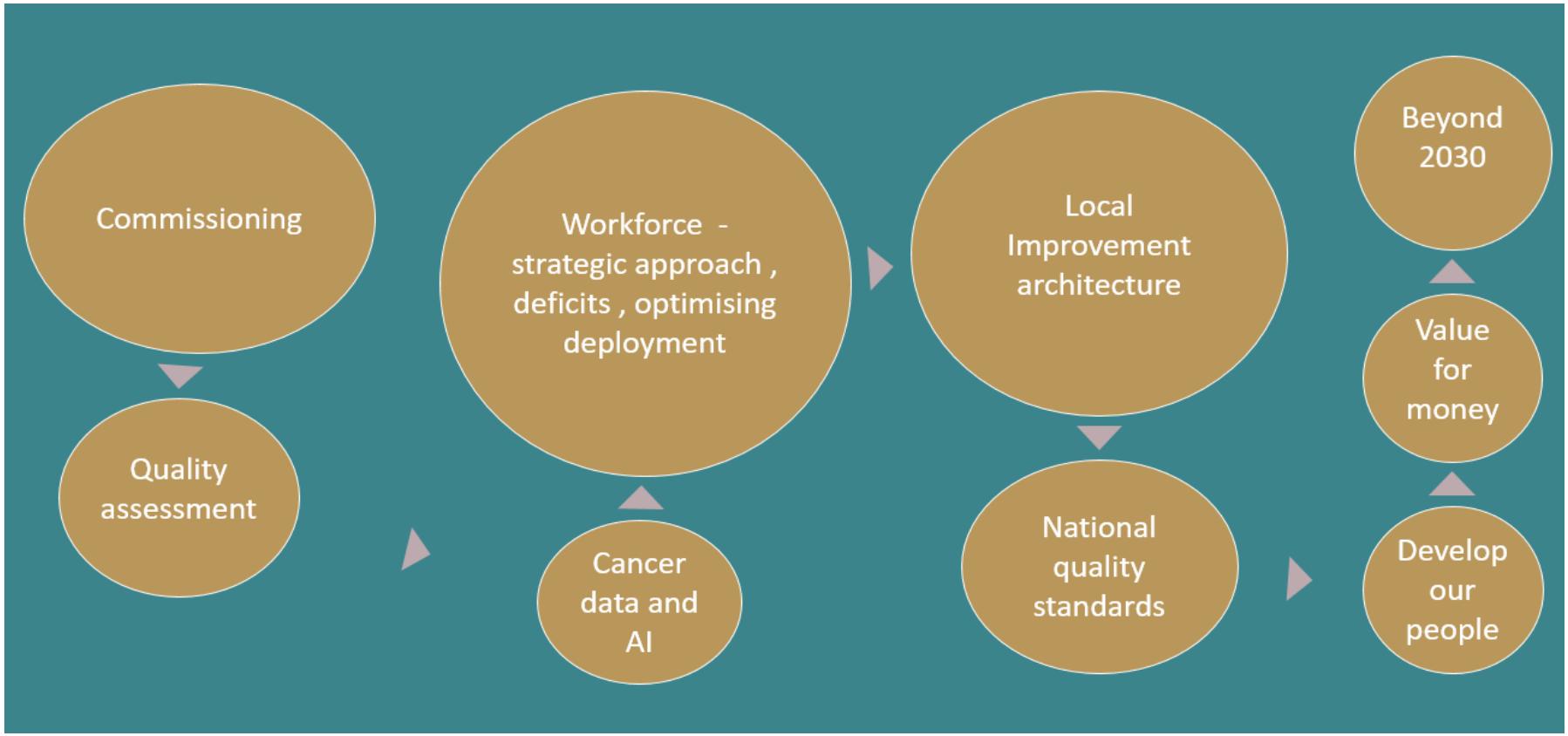


Providing the Best Possible Care

UNIVERSITY OF LEICESTER

NHS
Northampton General Hospital
NHS Trust

Improving the Efficiency and Effectives of Delivery and Drive Implementation



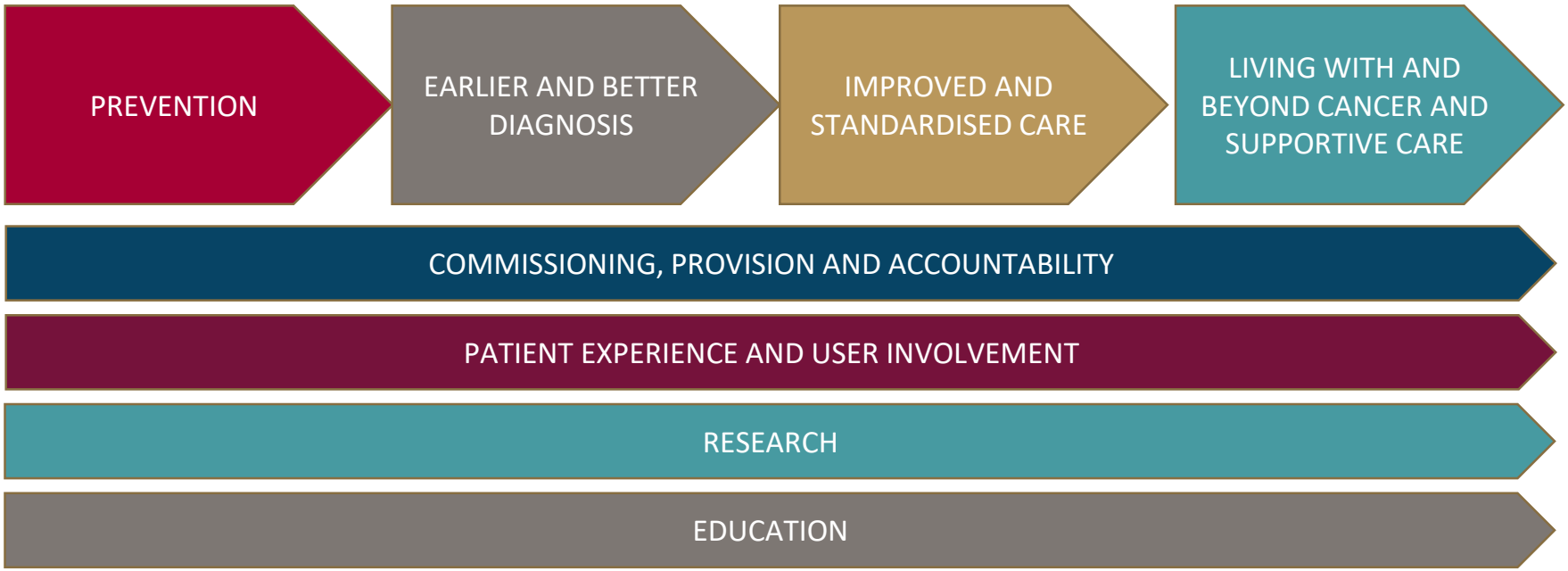
Providing the Best Possible Care

UNIVERSITY OF LEICESTER

NHS
Northampton General Hospital
NHS Trust

Delivering a Joined up Strategy

To deliver a joined up strategy, improve outcomes and meet further demands will require a whole system approach



Providing the Best Possible Care

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28 January 2021**

Title of the Report	**Dedicated to Excellence – Group Strategic Direction 21/22 – 23/24**
Agenda item	**18**
Presenter of Report	Simon Weldon, Group Chief Executive; Alan Burns, Group Chair; Alice Cooper, KGH Non-Executive Director; Rachel Parker, NGH Non-Executive Director
Author(s) of Report	Simon Weldon, Group Chief Executive

This paper is for: (delete as appropriate)

☐ Approve			
To formally receive and discuss a report and approve its recommendations OR a particular course of action			

Executive summary

We are delighted to present our first-ever joint strategic plans for our newly formed hospital Group. Our three-year strategic aims have been developed following extensive engagement with leaders, staff, patient and carer representatives, healthcare partners and others from across both Kettering and Northampton General Hospitals, and the Northamptonshire health and care system.

This paper sets out our new vision, mission and values, as well as our core strategic priorities and programmes; and it describes how staff, patients and other stakeholders have been involved in shaping our plans for the future.

Our vision for the Group is to; “Dedicated to outstanding patient care and staff experience by becoming a university hospital group and a leader in clinical excellence, inclusivity and collaborative healthcare.”

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

Together they describe the future ambition for the Group.

Our Excellence values are that we are dedicated to being consistently excellent in all these areas:
• Compassionate
• Respectful
• Integrity
• Accountable
• Courageous

In order to deliver on our vision and mission, this document also sets out an ambitious strategy which will enable and bring to life the Group vision.

We have developed our core strategic priorities:

- Patient: Excellent patient experience shaped by the patient voice
- People: An inclusive place to work where people are empowered to make the difference
- Quality: Outstanding quality healthcare underpinned by continuous, patient-centred improvement and innovation
- Systems and partnerships: Seamless, timely pathways for all people's health needs, together with our partners
- Sustainability: A resilient and creative University Hospital Group, embracing every opportunity to improve care

We have outlined a comprehensive programme of work to deliver on our goals and ambitions, from our multi-year complex strategic initiatives, our programmes that will support our annual 21/22 focus, to the breakthrough objectives we will support all our staff to help deliver. The document also outlines our framework for transformation and improvement which we will embed throughout the Group.

Progress against the overall delivery of the Group strategy will be overseen by the Collaboration Programme Committee, supported by robust programme management and tracking of the measures outlined in the strategy. The People Committee, and the committee in common sessions of the Quality and Finance Committees will oversee delivery of our core strategic priorities. The Boards will review progress every 6 months.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable excellence through our people* 6. *Become a University Hospital by 2020 becoming a centre of excellence for education and research*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks
Related Board Assurance Framework entries	BAF – please enter BAF number(s) ALL
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N)

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

Actions required by the Board

The Board is asked to:
Formally note and approve the Group strategic direction to support Northampton General Hospital NHS Trust and Kettering General Hospital NHS Foundation Trust in achieving the Group vision, mission and strategic ambition

Engagement sessions that have taken place:

Staff across both organisations and KGH governors:

- Facilitated dialogue sessions with staffside, BAME, disabilities, equalities and COVID shielding groups, as well as the newly formed Joint Staff Reference Group
- Discussions with Governors
- Focused discussions during clinical meetings and committees with medical, nursing, midwifery and AHP staff
- Dedicated time-out sessions led by directors within directorate teams
- All-staff virtual briefings at group and hospital levels
- Updates via newsletters, intranets, staff
- Facebook groups and other social media
- Recordings of events posted onto staff intranets for those interested but unable to attend
- Promotion of the #LetsTalkNow email and hashtag, allowing feedback, challenge and suggestions to be shared directly with programme leaders.
- Joint Board development sessions held with both Boards
- Focussed discussions with People, Quality and Finance Committee members from both Trusts, and in Collaboration Programme Committee on the strategic priorities
- Focussed development of the strategic priorities with both Executive teams

Patient representatives and health and care partners

- Engagement with patient groups
    - including representatives from Healthwatch/Young Healthwatch, Carers Northamptonshire, Kettering Mind and Northamptonshire Association for the Blind - such as the Patient Experience & Involvement Steering Group, the Patient & Carer Experience & Engagement Group, the Patient and Family Partners Group and the Prostate Cancer Support Group
- Discussion session with Northants Healthwatch/Young Healthwatch
- Engagement with health and care partners, including representatives from mental health, primary and community care, commissioners, local authorities and the Local Medical Committee
- Discussions sessions with NGH and KGH volunteers

External stakeholders

- Open, virtual public events
- Media coverage
- Digital communications and engagement using social media and public websites

Enclosure N

Dedicated to Excellence

Group Strategic Direction **21/22 – 23/24**

NHS
Kettering General Hospital
NHS Foundation Trust

NHS
Northampton General Hospital
NHS Trust

Foreword

An introduction from our Group Chair and Chief Executive

We are delighted to present our first ever joint ambitions for our newly formed hospital Group. Our three-year strategic aims have been developed following extensive engagement with leaders, governors, staff, patient and carer representatives, partners, and others from across both Kettering and Northampton General Hospitals, and the Northamptonshire health and care system.

Our aim has been clear from the outset: we wanted to agree an ambitious vision for the Group which transcends organisational boundaries and which achieves benefits for our patients and staff that we would struggle to realise as individual hospital Trusts. We were also determined to involve and engage as many people as possible in the development of our shared goals and plans, despite the backdrop of a pandemic which has seen a major impact on our services, our staff and patients, and how we communicate and engage with people.

For nearly 30 years, our two organisations - Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust - have been competing for the staff, skills and resources we need. In order to provide high quality, sustainable care that is fit for the 21st century and which responds to the evolving healthcare needs of our local communities, we fully recognise the importance of working in partnership together. Our collective response to the pandemic alone has proven the benefits and opportunities that working in collaboration can offer.

This document sets out our new vision, mission and values, as well as our core strategic priorities and programmes; and it describes how staff, patients and other stakeholders have been involved in shaping our plans for the future.

The conversations which have brought us to this point are just the beginning of many. We will share our ambitions widely, and will continue to engage others in developing and delivering our plans to achieve them.

Colleagues from across the hospital Group will be involved in ongoing discussions to find ways to work evermore effectively together, so that we can maximise the value we add as a provider, employer, and health and care system partner.

It has taken significant effort and determination to develop shared strategic intentions for our Group, and we would like to thank everyone who has played a part. In particular, we would like to thank our incredible members of staff, who have been willing to contribute and get involved throughout, despite the significant pressures they have faced over the past year.

As always, we welcome suggestions for improvement as well as other feedback.

You can email us at: **LetsTalkNow.Northants@nhs.net** and you can get involved in discussions on social media. Follow us on Twitter, Facebook or Linked In.

We look forward to hearing from you.

Best Wishes,

Alan Burns
Group Chair

Simon Weldon
Group CEO

Contents

Our commitment to patients, carers and staff

Our mission is to provide safe, compassionate and clinically excellent patient care, by being an outstanding employer for our people, creating opportunities, supporting innovation, and working in partnership to improve local health and care services.

In delivering this mission, we have outlined below a set of promises that we will uphold at all times.

For our patients, their families and carers we will…

- Treat you with care and compassion
- Ensure that the care we provide puts you and your family first
- Strive to provide the highest quality care, and continuously improve our services
- Work to ensure that communication about your care is clear and consistent
- Ensure that we include representation through our patient groups and public forums when designing improvements or changes to the way we provide your care
- Work with our health and care partners across Northamptonshire and beyond so that your care feels joined up

For our staff we will…

- Create an environment and culture that is supportive, compassionate and enables us all to do our jobs effectively
- Improve support for health and wellbeing and ensure everyone feels valued
- Provide an inclusive place to work, taking action to address inequalities
- Ensure key systems and processes will help with our jobs, not hinder them
- Encourage everyone to voice suggestions and provide support to make improvements day-to-day
- Support our managers and leaders to lead, engage and develop their teams
- Ensure everyone is fully engaged and consulted in our plans, and understand the impact on day-to-day work

Our Group

On 10 January 2020 Kettering General Hospital and Northampton General Hospital announced our commitment to working closer together by moving towards a group management model to strengthen health services in Northamptonshire. This shows our collective commitment to greater collaboration between our two hospitals and both senior management teams.

Over the last year we have made some important steps towards working ever more closer together.

- We have begun developing our Group leadership team alongside our Joint Chair, Alan Burns. In July, we appointed Simon Weldon as our Group CEO, followed by Mark Smith as our Chief People Officer in August, and Andy Callow as our Group Chief Digital and Information Officer in December. We have also appointed Deborah Needham as the Hospital CEO of Kettering General Hospital. We are extremely fortunate to have their expertise on board in supporting our Group in the future.
- Clinical colleagues are working collaboratively to bring together our clinical services across the Group. As part of that, we have appointed six joint clinical directors, and some of our services, including Breast Surgery, Cardiology and ENT are beginning to develop collaborative ways of working between our teams at both hospitals.
- During the response to the Covid-19 pandemic, we have demonstrated stronger resilience by working together across both hospitals. Our people have been working more flexibly than ever across both sites, supporting services where the patient need is greatest, and we have been able to make decisions and choices across both hospitals that previously we would not have made together.
- We have been collaborating across the Group to define what we want the future to be. More than 1,000 staff, patient representatives and others have been directly involved in our work to develop our vision, mission and values. Many more have heard about our emerging direction of travel and have had the opportunity to become more actively engaged. The discussion and feedback during engagement events and various other activities has not only been both valuable and enjoyable, but also instrumental in shaping and strengthening our proposals for the future.

As a Group, we face a range of challenges, from consistently providing high quality care with the financial resources we have available, making sure we have the right number of staff with the appropriate skills, and ensuring that we create a hospital Group which is sustainable and fit-for-the-future.

> “We were determined to agree an ambitious vision for the Group, and one which enables us to realise far greater benefits for our patients and staff than we would ever be able to achieve as separate hospital Trusts.”
>
> ALAN BURNS, CHAIR

Key Group facts

Here are some interesting and relevant facts to provide an overview of activities across our hospital Group.

We operate **two hospital sites** which provide services to a **population of around** **900,000** **people** across Northamptonshire

We employ over **9,000** **staff** and are one of the **largest employers in Northamptonshire**

We have a budget of around **£620** **million**

We receive around **£1.4** **million funding** for research, enabling **over 3,000 patients** to participate in trials in 19/20

Every year…

We care for around **92,000** **inpatients**

We care for around **765,000** **outpatients**

We deliver over **8,000** **babies**

We carry out over **140,000** **operations**

Our Emergency Departments care for over **226,000** **people**

Our Hospital Trusts

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

An acute hospital with around 600 beds and a 24-hour Emergency Department (ED). In addition to the full range of district general hospital care, KGH also provides some specialist services including cardiac care for the county. It has inpatient, day case, diagnostic and outpatient facilities with a dedicated children's ward and outpatients.

In 2019/20 teams at the KGH site cared for approximately 90,000 emergency patients and 120,000 patients referred to us for treatment.

Northampton General Hospital (NGH) NHS Trust

An acute hospital with around 790 beds and a 24-hour Emergency Department (ED). In addition to the full range of district general hospital care, NGH also provides some specialist services including cancer and stroke services for the county. It has inpatient, day case, diagnostic and outpatient facilities with a dedicated children's ward and outpatients.

In 2019/20 teams at the NGH site cared for approximately 135,000 emergency patients and 140,000 patients referred to us for treatment.

Together, we will continue to serve our growing population of around 900,000 people across Northamptonshire. This population is varied with a range of needs from our services:

- There are large and growing numbers of people over 70, as well as high numbers of people under 20 and newborns
- Around 70% of our population live in urban areas, whilst 30% live in more rural areas
- Our six boroughs and districts are diverse, with countryside and urban areas, different ages of local populations, and differing levels of affluence
- There are growing levels of ethnic diversity, particularly in more urban areas of the county

Challenges and opportunities

We have undertaken engagement events across the Group, including with both Boards and the KGH governors, patients and staff to identify both the challenges we face as a Group, and the opportunities to work together to make improvements.

Together with analysis, this engagement has directly influenced our strategic direction and plans for the next five years. The themes are outlined below, and we need to improve in all of these areas if we are to make the progress we aspire to as a Group.

PROVIDING CARE

Our current situation

In the last 4 years, demand has increased for our health services, with an increase in both elective and emergency admissions of 8%, 3% more outpatient appointments, and 1% more attendances at A&E. This applies increased pressure on both our staffing and physical capacity to provide high quality care in a timely fashion. Over the same four years, our performance against key access targets has deteriorated, with patients waiting on average 5 weeks longer for planned treatment. There are also new and exciting improvements due to pioneering treatments and technologies, and people are interacting with our services in new ways. There are a number of challenges for us to overcome if we are to provide consistently excellent care to all our patients, their carers and families.

Our challenges

- Our CQC rating is 'Good' for 'Caring' at both Trusts, and whilst a number of our key services are also rated 'Good', both Trusts were rated as 'Requires Improvement' overall. Robust plans are therefore in place to make the necessary improvements.
- Our performance against key standards and targets has diminished in the last four years, with patients on average waiting 5 more weeks for planned care, and around 3% fewer patients are seen within 4 hours in A&E.

Our opportunities

- We have recently announced our intention to achieve University Hospital status through a partnership with Leicester University, which will build on and strengthen our existing research and clinical teams. This will make sure our staff have the latest skills, training and techniques, and provide access for patients to cutting edge treatment and research trials. As a result, this will improve the quality of care we are able to provide and enhance training and development opportunities for staff.
- Some services have been shared across the two hospitals for several years. These have been successfully consolidated and improved to deliver various benefits for patients. However, we could and should aim to develop more county-wide services, which will help us to redesign services to provide the best possible healthcare which is fit for the 21st century. This will allow us to utilise staff more effectively, enabling enhanced services across the county.

PEOPLE

Our current situation

Our Group employs around 10,000 people with a range of roles and skills, and who care for the people of Northamptonshire with skill, compassion and dedication. Making sure that we support and look after our people and address ongoing workforce challenges will continue to be complex and challenging in many ways. We have worked hard in the last year to increase the support we are able to provide our staff in response to the Covid-19 pandemic, including the We Care café and Our Space.

Our challenges

- Both KGH and NGH were below the national average in the NHS staff survey with regard to staff engagement for 2019.
- Despite reductions in the turnover of staff in both organisations, 10.4% of our posts remain vacant, putting pressure on our teams to manage their workload and resulting in additional spending on temporary staffing to cover gaps.
- The most prevalent absences from work are stress / anxiety related, which account for around 25% of all absences.

Our opportunities

- We have an excellent, dedicated and supportive team with clinical and support staff who work together every day to care for our patients. They are supported by our leadership teams, Boards and, at KGH, our Governors.
- We are developing a People Plan as a Group to support the delivery of our people priorities and also the national NHS people plan.
- We have an opportunity to have a consistency of approach to recruitment and development opportunities across the Group, rather than competing for staff.
- In the last year we have put in place a number of initiatives to support our staff. We have an opportunity to build on these initiatives and learn from each other at KGH and NGH about what works best. As a Group we are able to work together to continue to improve the support we are providing staff, allowing us to create new development opportunities and provide different ways of working.
- We have a commitment to improving our culture of inclusion across the Group which has been signed off by both Boards, helping every staff member - regardless of their background or circumstances - feel included, involved and valued.

RESOURCES

Our current situation

Creating the best value from our available finances and meeting our financial obligations to both Trusts continues to be a core part of our commitment as a Group. Making sure we are running the hospitals day-to-day as effectively as possible, whilst securing the investments that we need to create the hospitals of the future, will continue to be a challenge.

Our challenges

- In recent years, both Trusts in the Group have reported a financial deficit, with a combined deficit of £43.6m in 19/20. We continue to work on improving our underlying financial position through improving our productivity of services and reducing the variation we see across the Group in the cost to provide care.
- Our estate is mixed, with many of our buildings aged over 100 years old, and which are increasingly in a poor state of repair.

Our opportunities

- Working together across the Group, there is an opportunity for us to reimagine the way that we provide care across the county, ensuring that our we are providing the best value for money for the funding we receive.
- There are aspects of care provision that are delivered more effectively in each of our hospitals. Coming together as a Group allows us to learn from each other to implement the best of both across the whole Group.

- Kettering is seeking to redevelop the hospital to improve this, and as a Group we will be able to create a strategic estates plan that improves the environment in both our hospitals.

DIGITAL

Our current situation

Digital technology has great potential to transform and improve the care we provide, as well as our day-to-day working experience. It is not something that should be 'on the side' of the work we do, rather being integral to the way we do everything, and will allow us to make progress across all our agenda.

Our challenges

- Our systems and the infrastructure that support them are not joined up, which makes sharing information between our own teams difficult and takes up time that could be used to care for patients.
- A range of different systems currently support our clinical and support services. However, as two separate Trusts we have a number of different systems that struggle to talk to each other which can make things frustrating for both our staff and patients.

Our opportunities

- We have successfully installed an Electronic Patient Record System in Kettering which will allow us to better manage care, and a similar programme is just starting in Northampton. Through these programmes we will ensure that those looking after patients have all the information they need to offer excellent care.
- During the response to the Covid-19 pandemic, a number of our services have been able to provide care remotely and we have used technology to monitor patients at home. There is an opportunity to learn from our experiences and implement other innovative digital solutions.
- We have developed with the Northamptonshire Health and Care Partnership a shared care record that will help us to have a single view of health records across all the different services accessed by patients.

SYSTEM WORKING

Our current situation

The Northamptonshire Health and Care Partnership aims for the people of Northamptonshire to have a positive lifetime of health, wellbeing and care in our community. We are proud partners to other health and care organisations within our local system, and work together on a range of projects and programmes to improve services for the population of Northamptonshire.

Our challenges

- Our financial challenges are mirrored within our local NHS and Local Authority partners. Unless we work together differently, within four years we will no longer be able to properly support the health and care needs of our county's older residents.
- We also know that for those people who move between our services and organisations, it can feel disjointed and there can be delays.

Our opportunities

- We have a strong partnership with our local system partners and we have been supporting each other, particularly during the response to the Covid-19 pandemic. The Northampton Health and Care Partnership aims to become a thriving Integrated Care System by April 2022.
- The creation of two unitary councils in April 2021 provides an opportunity for us to strengthen our overall system relationships and work with the newly formed councils to provide joined-up care.
- We have begun working together on a large transformation programme called iCAN (Integrated Care Across Northamptonshire) which will better support people in our community, simplify moving between services and make sure that people have the right care at the right time in the right services.

Our engagement journey

From the outset we were committed to involving staff, governors and volunteers, patient representatives, healthcare partners and other stakeholders in the development of our vision, mission, values and strategic priorities.

We started by holding a number of workshops with members of the Board and senior leaders across both organisations. This was the first opportunity to consider collectively what we wanted to achieve by working together in partnership as a hospital Group. The message from leaders was very clear – we wanted to agree an ambitious, shared vision and mission, supported by strategic aims, and which motivates colleagues across both organisations towards achieving a common set of goals.

Having agreed on some key principles, draft statements were drawn up, discussed and developed on an iterative basis. Once the proposed statements had received widepsread support from the leadership team, we launched an engagement programme to provide the opportunity for staff, patient representatives, health and care partners, and other stakeholders to contribute. At this point, discussions were extended to include values, having decided that the values we choose for the Group must directly reflect the behaviours which staff, patient representatives and other key stakeholders see as as being the most important, relevant and well embedded across both organisations today. At the same time, we discussed the values we would want to nurture and strengthen if the Group is to become the organisation we collectively want it to be.

As the supporting priorities and specific strategies developed in tandem, discussions about these were included within vision, mission and values engagement sessions. Respective Exective leads also organised and led a variety of focused deliberative sessions to share, test, challenge and refine strategic proposals, for example the Academic, People, and Nursing, Midwifery and AHP strategies.

Over the course of four months, many facilitated discussions were held within open forums, regular meetings and committees, and with targeted groups using an on-line engagement tool, Mentimeter. The COVID pandemic provided a challenging backdrop for the engagement programme, and most discussions were undertaken virtually owing to the travel restrictions and social distancing measures in place.

More than 1,000 people were directly involved in discussions, with staff across both organisations also receiving regular updates about the developing vision, mission and values. Staff and members of the public were invited to attend open events and share information via the #LetsTalkNow email, and activities were also publicised within the media.

During the first month of the programme, the vision and mission statements were shaped significantly through conversations with staff and stakeholders. They evolved on an iterative basis, having been tweaked and updated to reflect comments after each session. By the fifth week, overwhelming support for the emergent vision and mission was clear, as conversations moved from the 'what' we should do and 'why', to 'how' these goals would be implemented.

The Group's chosen core values directly reflect the most common themes shared by staff, patient representatives and other stakeholders during the engagement programme. The top aspirational values we need to nurture have been woven into the vision and mission statements and will form an important part of our Group organsiational development plans.

We engaged:

Staff across both organisations and KGH governors:

- Facilitated dialogue sessions with staffside, BAME, disabilities, equalities and COVID shielding groups, as well as the newly formed Joint Staff Reference Group
- Discussions with Governors
- Focused discussions during clinical meetings and committees with medical, nursing, midwifery and AHP staff
- Dedicated time-out sessions led by directors within directorate teams
- All-staff virtual briefings at group and hospital levels
- Updates via newsletters, intranets, staff Facebook groups and other social media
- Recordings of events posted onto staff intranets for those interested but unable to attend
- Promotion of the #LetsTalkNow email and hashtag, allowing feedback, challenge and suggestions to be shared directly with programme leaders.

Patient representatives and health and care partners

- Engagement with patient groups - including representatives from Healthwatch/Young Healthwatch, Carers Northamptonshire, Kettering Mind and Northamptonshire Association for the Blind - such as the Patient Experience & Involvement Steering Group, the Patient & Carer Experience & Engagement Group, the Patient and Family Partners Group and the Prostate Cancer Support Group
- Discussion session with Northants Healthwatch/Young Healthwatch
- Engagement with health and care partners, including representatives from mental health, primary and community care, commissioners, local authorities and the Local Medical Committee
- Discussions sessions with NGH and KGH volunteers

External stakeholders

- Open, virtual public events
- Media coverage
- Digital communications and engagement using social media and public websites

Values development

During vitual sessions, attendees submitted their views on both core, and aspirational values to create a word cloud which developed live on screen. The larger the word or phrase, the more often it was suggested. In the same session, comments were tested, explored and discussed further and, over the course of the engagement programme, strong themes emerged which reflected the core and aspirant values common across both hospital Trusts.

This word cloud summarises the suggested core values across the Group

This word cloud shows views on the values we should nurture and develop further as a Group

We recognise that many people prefer to 'think visually' rather than to contemplate written word. For this reason we engaged the services of a graphic scribe, who attended a variety of discussion activities and created drawings to reflect the converations underway. The consolidated picture, which draws out the common themes from all sessions, can be seen below.

Dedicated to Excellence

We are delighted to share our Group vision, mission and values. These are a direct product of the extensive engagement we have undertaken with staff, governors, patient representatives, health and care partners, and others.

VISION STATEMENT

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

MISSION STATEMENT

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

OUR EXCELLENCE VALUES

We are dedicated to being consistently excellent in all these areas:

- **Compassionate**
- **Respectful**
- **Integrity**
- **Accountable**
- **Courageous**

> “It is really heartening to see our feedback reflected in the revised vision and mission statements. I feel they are much better, and I’m now interested in how we’re going to do it rather than whether it’s the right thing to be doing.”
>
> STAFF ATTENDEE DURING ONE OF THE ENGAGEMENT SESSIONS

Dedicated to Excellence

Over recent months we have discussed, developed and agreed five core priorities. Everything we do as a Group should contribute to achieving short- or long-term goals within at least one of these priority areas. An overview of each priority is given below, with more detail provided within the following pages.

Our Group priorities

Patient
Excellent patient experience shaped by the patient voice

People
An inclusive place to work where people are empowered to make a difference

Quality
Outstanding quality healthcare underpinned by continuous, patient-centred improvement and innovation

Systems and partnerships
Seamless, timely pathways for all people's health needs, working together with our partners

Sustainability
A resilient and creative University Hospital Group, embracing every opportunity to improve care


“We are clear that transformation within each of the priority areas we’ve identified is essential to achieving our Group ambitions. There isn’t a single priority more important than the others.”
SIMON WELDON, GROUP CEO

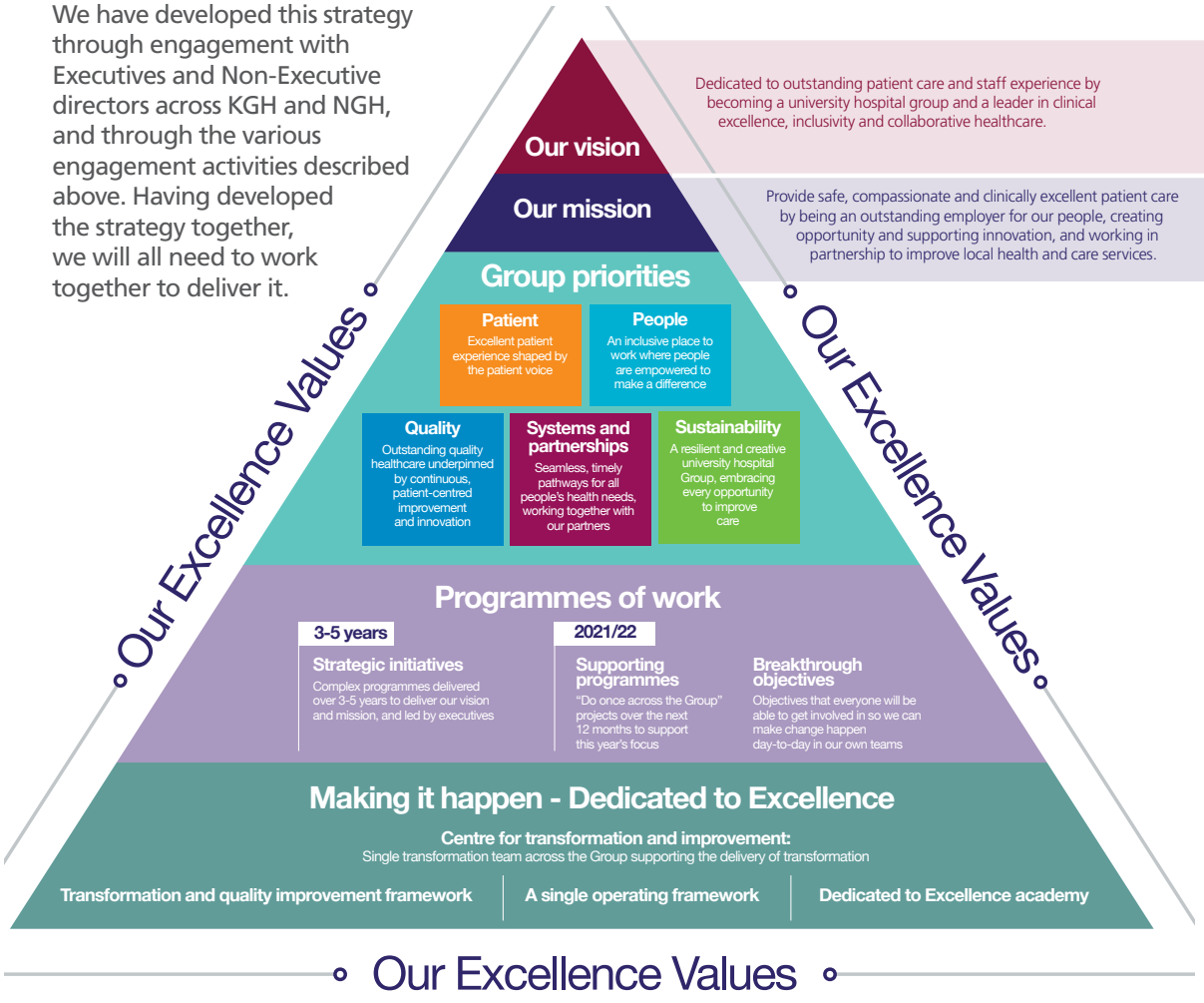
Developing our strategic direction

Joining together as a Group has provided an opportunity to shape our future direction, ensuring we are all committed to, and aligned with, a single vision and mission with shared values and priorities.

Our new shared strategy allows us as a Group to:

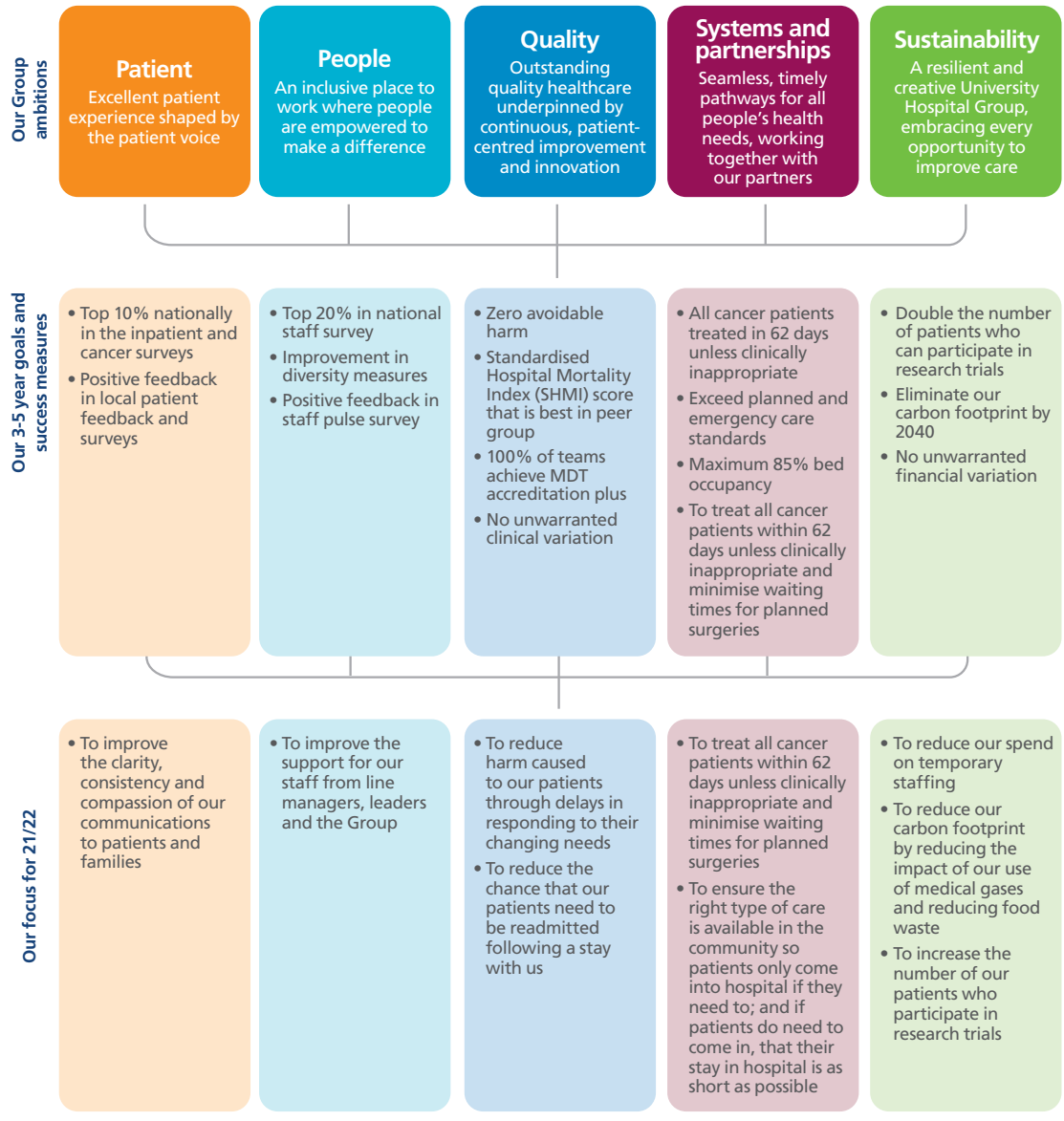
- Have a shared vision, mission and purpose
- Be clear about what the Group priorities are and what we want to achieve
- Prioritise improvements so we work on a small number of important changes at a time
- Know that our transformational activities and strategies will make a difference to the things that matter the most to us
- Identify a small number of metrics that will let us track our progress

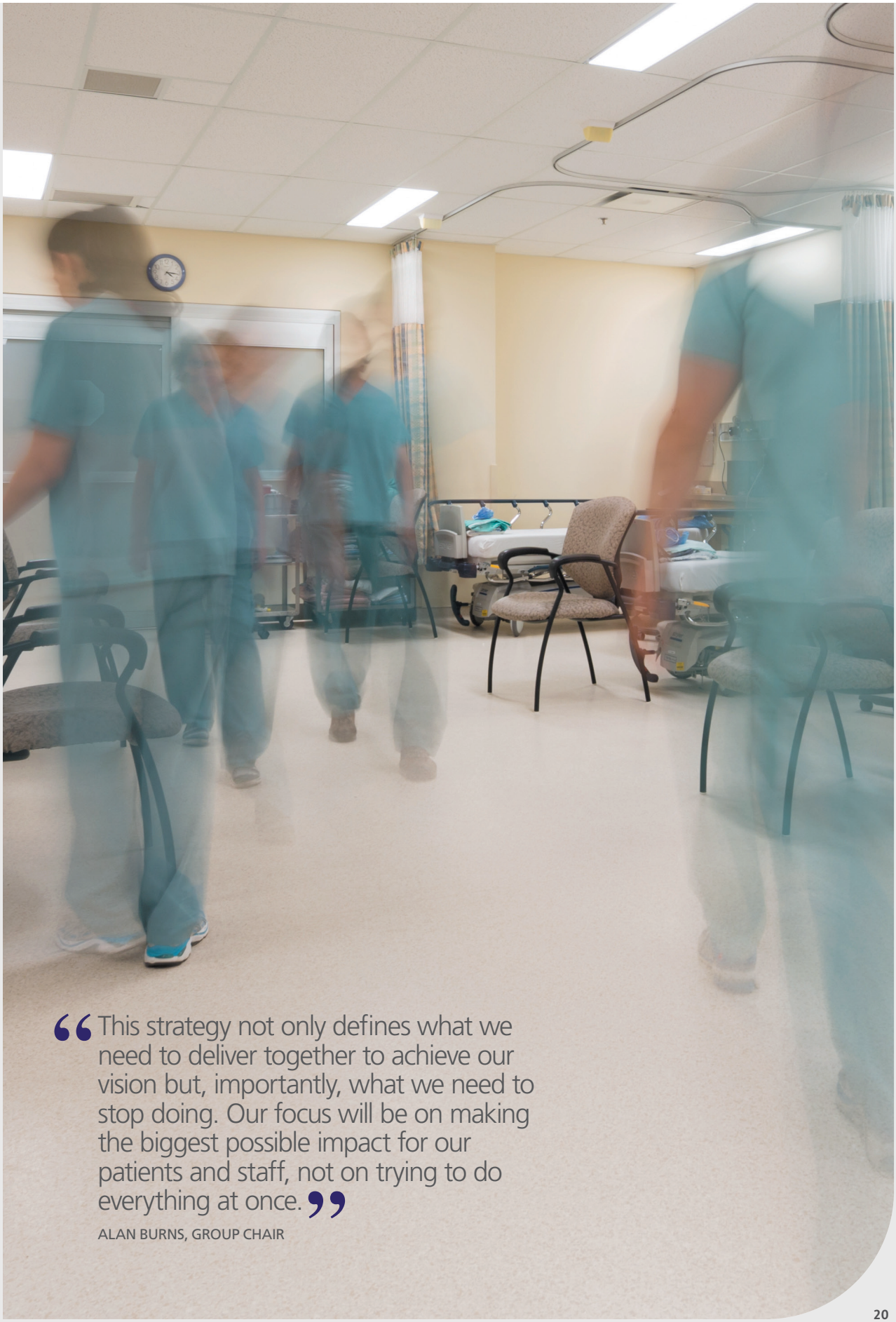
We have developed this strategy through engagement with Executives and Non-Executive directors across KGH and NGH, and through the various engagement activities described above. Having developed the strategy together, we will all need to work together to deliver it.



Our Group Priorities and our focus for 21/22

We have agreed five priorities for the Group. Everything we do across both hospitals should contribute towards achieving at least one of these priorities. They form the long-term objectives of the Group, and each has an ambition and a success measure that we can track. Every year we will analyse our performance as a Group and set an annual focus on the area that will have the biggest impact on our overall goals.





> This strategy not only defines what we need to deliver together to achieve our vision but, importantly, what we need to stop doing. Our focus will be on making the biggest possible impact for our patients and staff, not on trying to do everything at once.

ALAN BURNS, GROUP CHAIR

Patient

Our ambition: Excellent patient experience shaped by the patient voice

What does our ambition mean to us?

We will ensure compassionate patient care through working to provide an excellent patient experience, shaped by engagement with our patients.

We want to be in the top 10% of Trusts in terms of how our patients rate the care we provide.

We will strive to ensure that patient/public representation and engagement is included as part of every major change project.

Our patients, their carers and families tell us that a really important part of how they experience care is how we communicate with them. We want to make sure that we are able to provide clear, consistent and compassionate communication at every step of a patient's care.

How will we measure success?

Success of our work will be measured:

- By being within the top 10% nationally in the inpatient and cancer surveys
- Through regular collections of patient feedback locally

Where are we now?

- Both KGH and NGH are currently below national average in the national inpatient and cancer patient surveys, although there have been recent improvements in scores relating to respect and dignity.
- The area with the most room for improvement is ensuring consistent and compassionate communication with patients

What will support delivery of our 2021/22 focus?

A breakthrough objective for front-line staff, individuals and teams to improve communications with our patients.

Each Trust will launch monthly communication discussion groups, beginning in selected wards and services, encouraging staff to share and reflect on positive or challenging experiences regarding patient communication.

Patient pathway mapping will help us to understand the entire patient pathway, focusing on communication with patients at every step of their journey.

Existing written patient communications will be reviewed to ensure they are as clear as possible.

We will build our skills and confidence in delivering honest and personalised communication through strengthening our training programmes. We will get feedback from patients and families to develop this programme.

Our Digital Strategy will help our systems to work better together. Improving our digital systems will mean our staff will have access to our patients' complete records, rather than our patients needing to tell each new member of staff their story again. It will also provide our staff with new ways to communicate with our patients, whether that is through an app, over the phone or online. Our plan to move towards new Electronic Patient Record systems, in particular, will help us to reduce unnecessary or confusing paperwork and allow us to help our IT systems to talk to each other so all staff can see a patient's record, however they interact with us.

Our 2021/22 focus

To improve the clarity, consistency and compassion of our communications with our patients, carers and families

> “These are all values we would want to see and they reflect our experience as patients. I would, however, like to see more focus placed on communication. Improving how different hospitals and departments share and access patient information with each other would make a major difference to a patient’s care and experience.”

CARER REPRESENTATIVE, PATIENT AND CARER EXPERIENCE AND ENGAGEMENT GROUP

People

Our 2021/22 focus

To improve the support for our staff from line managers, leaders and the Group

Our ambition:

An inclusive place to work where people are empowered to make a difference

What does our ambition mean to us?

A focus on our people as a core priority across the Group will ensure that staff feel empowered and supported. This will allow them not only to provide excellent patient care, but also to ensure that we can provide an excellent staff experience as an outstanding employer for our people, and create an inclusive place to work.

We will continue to improve our support for staff health and wellbeing and ensure that people feel supported and valued regardless of their background or circumstances.

We will empower our people to voice suggestions and make improvements to how we deliver care.

We want to build compassionate leadership at all levels and ensure that leaders and managers are supported to lead, engage and develop their teams.

How will we measure success?

Success of our work will be measured:

- By being in the top 20%
- Improvements in our inclusivity measures
- By seeing an improvement in the feedback we receive from our staff

Where are we now?

- Both NGH and KGH are below the national average in the national staff surveys for staff engagement. However, there have been significant improvements within both Trusts over recent years in both the response rates and the overall scores.
- The most recent staff surveys highlight three main areas where the Group performed less well compared to peers:
  - Staff feeling able or empowered to make improvements
  - Quality of career development
  - Support from managers
  - Health and wellbeing

What will support the delivery of our 2021/22 focus?

- A breakthrough objective to improve both engagement of all staff with improvement and transformational activity, and staff satisfaction with regard to the support provided by managers, leaders and the Group.
- Alongside the development of our People Plan, which will outline our wider people ambition for the next three years, there are some projects we will focus on this year to improve the support we provide to our staff.
- Management and leadership programmes will be developed to strengthen managers' and leaders' compassionate leadership, management and coaching skills. A standard approach to feedback and development will be developed so that everyone is clear about the development and support available to them.
- We have put in place a range of support over the last year to support our staff through the Covid-19 pandemic. We will continue to develop our health and wellbeing offer for staff, including enhanced psychological support. We will also make sure that we are continuing to ask our people what will make a positive difference to their working lives.
- Making sure that everyone, regardless of their background or circumstances, feels included is important to us. We have an inclusion action plan, addressing a range of areas from training and recruitment, through to cultural competence that will make us a more inclusive employer with a more inclusive culture.
- The national staff survey is a really helpful source of information, but it is only completed annually. We want to know how our staff are feeling on a more frequent basis, so we will be setting up a pulse survey so we can be more responsive to how our staff are feeling and how we can support them.
- We have an ambition to make improvement and transformation a part of everyone's day-to-day job and for staff to have the knowledge and support they need, and to feel empowered to make changes happen. Later in this document we discuss how we will approach this, but we will support building a leadership and organisational culture centred around empowerment and improvement. We will continue to celebrate and communicate successes across the Group.

Quality

Our ambition: Outstanding quality healthcare underpinned by continuous, patient-centred improvement and innovation

What does our ambition mean to us?

We will focus on providing safe and clinically excellent care and a positive patient experience, underpinned by continuous improvement and innovation.

We have an ambition to reduce our mortality and avoid harm to our patients. Building on the existing nursing accreditation programmes, we want to have a programme to accredit multi-disciplinary (MDT) teams which are achieving high standards of care and ways of working.

We will aim to embed a culture of continuous quality improvement with patients at the centre, and which will help ensure the quality of care we provide is consistently high.

How will we measure success?

Success of our work will be measured by:

- Having no cases of avoidable harm
- Improving our SHMI score (a national mortality measure) to be the best compared to other similar hospitals
- All of our multi-disciplinary teams having achieved the highest category of accreditation
- Having no unwarranted clinical variation

Where are we now?

- There have been reductions in the number of patients in our inpatient services who have been injured as a result of a fall. However, there are many incidents caused by issues related to delays in responding when a patient's condition deteriorates.
- There is variation in the outcomes that our patients receive from our care. Compared to other hospitals, there is a greater number of patients who need to be readmitted for the same condition after we have discharged them from hospital.
- Our national standardised hospital mortality indicator (SHMI) score on patient mortality is in line with national averages

What will support delivery of our 2021/22 focus?

A breakthrough objective for front-line staff, individuals and teams to identify and respond to deteriorating patients faster.

Each Trust will revitalise existing safety huddles, and teams will meet daily at an appropriate time with a focus on identifying high-risk patients and discussing recent incident data trends so teams have protected time to reflect and improve.

We will implement electric patient monitoring systems for all appropriate patients, which will generate automatic scores indicating patients' current health status. The processes that support escalation processes will be refined to reflect the new systems and help make sure that staff have the training required to interpret and respond to electronic observation scores effectively.

A multi-disciplinary team (MDT) accreditation scheme will be developed which will periodically assess best practice provision of care and ways of working. This will help teams to create plans to improve themselves, as well as identify common themes and challenges across the Group.

A clinical variation and effectiveness programme will be introduced across the Group to regularly identify specialties where comparisons with other hospitals show there is an opportunity to improve. Clinical teams will work together to learn from both hospitals and best practice to make changes.

An EPMA (Electronic Prescribing and Medicines Administration) system will be installed in clinical areas. This system will link with medication administration systems and help to make sure that patients are given the right doses and types of medication.

Our 2021/22 focus

To reduce harm caused to our patients through delays in responding to their changing needs
To reduce the chance that our patients need to be readmitted following a stay with us

Systems and Partnerships

Our ambition: Seamless, timely pathways for all people's health needs, working together with our partners

What does our ambition mean to us?

We will strengthen our involvement in partnership activity to improve local health and care services, and to provide seamless, timely patient pathways.

We will strive to identify and resolve causes of delayed access to care, or delays in discharging our patients from our care when their hospital stay is completed.

We will work together with our partners to make sure that our patients' experience of health and care services in the county is seamless, so that as our patients move between our services, the process is smooth and timely.

How will we measure success?

Success of our work will be measured:

- By all of our cancer patients being treated within 62-days unless it is clinically inappropriate
- By exceeding national standards set for waiting times for planned care treatment and within our A&E departments
- By consistently achieving a maximum of 85% of our beds being occupied

Where are we now?

- Our hospital beds are under pressure, with high bed occupancy. Around a third of inpatients do not have a clinical reason to be in a hospital bed
- Our planned care performance has deteriorated as a result of the Covid-19 pandemic, with increases in average waiting times and the number of patients who are having to wait the longest
- Cancer performance suffered during the Covid-19 pandemic, with the longest delays in endoscopy screening services and GI tumours

What will support delivery of our 2021/22 focus?

A breakthrough objective for front-line staff, individuals and teams to ensure every patient has a clinical reason to reside in hospital, and to get patients home sooner if they don't need to stay.

The iCAN programme with our Northamptonshire health and care partners will design solutions and ways of working across the system that will address inappropriate admissions, improve support within the community and enable more timely and effective discharge planning. These solutions helps us to discharge patients more quickly, either to home or to the most appropriate accommodation. It will also prevent people from being admitted to hospital if they can be safely cared for at home.

A large part of 21/22 will be recovering from the impact that Covid-19 has had on our non-urgent services. We will take steps to recover waiting times where they have slipped as a result of the pandemic, in line with the NHS elective recovery programme, including increasing endoscopy capacity, increasing theatre sessions and ensuring there is additional outpatient clinical capacity.

As a Group we need to understand better the demand for our services and the capacity required, both in terms of physical space and workforce. We will create a Group demand and capacity model for emergency, elective, diagnostic and cancer services which will help us to understand which areas need more capacity and create solutions to resolve them so that your experience with us is smooth.

Our 2021/22 focus

To treat all cancer patients within 62 days unless clinically inappropriate, and minimise waiting times for planned surgeries

To ensure the right type of care is available in the community so patients only come into hospital if they need to, and if patients do need to come in, that their stay in hospital is as short as possible

Sustainability

Our ambition: A resilient and creative University Hospital Group, embracing every opportunity to improve care

What does our ambition mean to us?

A focus on sustainability will allow our hospital Group to be resilient and creative, providing opportunities to innovate.

We want our Group to be fit for the future – this includes making sure we are building the sustainability of our hospital services and exploring opportunities to innovate, whilst working within the financial budget we have available by becoming more productive.

We will strive to attract more permanent staff to the organisation to create a more stable workforce.

We will aim to reduce our carbon footprint in order to adopt more sustainable approaches and fulfil our social responsibility as an organisation.

How will we measure success?

Success of our work will be measured by:

- Doubling the number of patients who are able to participate in research trials
- Eliminating our carbon footprint by 2040
- Having no unwarranted variation from our financial budget

Where are we now?

- We have posted a financial deficit in recent years within both Trusts, which is in part due to spending on medical and agency pay owing to a high number of vacancies for nursing and medical staff
- In common with many other NHS organisations, our services have a carbon footprint to reduce in line with the NHS plan. We have made progress in reducing the impact of our energy usage and the estates plans will further reduce this. The use of desfluranes in medical gases and food waste are large contributors to our carbon footprint
- There are opportunities to be more productive and learn from each other across the Group, but there is not currently a shared costing system and approach to costs

What will support delivery of our 2021/22 focus?

- A breakthrough objective for front-line staff, individuals and teams to reduce food waste and increase productivity.
- We will work to design and implement changes to food ordering, production and delivery and to reduce food waste.
- In line with divisional business planning, areas for improvements to the productivity of services and teams will be identified and delivered to meet productivity improvements required to meet our financial targets.
- We will review the current medical staffing levels across the Group for the number of patients that need to be seen and better align the two, allowing recruitment of permanent staff in those areas that require it.
- Medical e-rostering will be introduced at both NGH and KGH, to help make the rostering process easier and reduce our temporary staffing spend.
- A single costing system will be embedded across the Group which aligns costing principles, categorisations, coding and standards. This will help us to better understand our underlying costs, learn from each other and reduce costs in areas where there are opportunities to do so.
- We will work with anaesthetic teams to reduce desflurane usage and swap desflurane in medical gases to other alternatives where possible, in order to reduce the impact of medical gases on our carbon footprint.
- As we come together in a Group, there are opportunities for some of our corporate functions to collaborate, creating new opportunities for us to do things differently and better. We will review our corporate services to identify how each service can benefit from working together.

Our 2021/22 focus

To reduce our spend on temporary staffing

To reduce our carbon footprint by reducing the impact of our use of medical gases and reducing food waste

To increase the number of our patients who participate in research trials

Programmes of work

The programmes of work we will focus on delivering will be aligned to our Group shared priorities. These are categorised into three types of programme:

- **Strategic initiatives:** complex programmes that will be delivered over multiple years to drive forward our longer-term ambitions, and which will require dedicated Executive leadership.
- **Supporting programmes:** programmes of work to 'do once across the Group' over the next 12 months that will support delivery of our annual focus in each priority area.
- **Breakthrough objectives:** objectives enabling everyone to get involved in making change happen within staff teams, and which underpin delivery of our annual focus. If we all work towards achieving the same small number of objectives, we will be able to make a big difference.

Our Strategic Initiatives

People Plan

Clinical Strategy and Clinical Collaboration

Nursing, Midwifery and Allied Health Professional Strategy

NHCP Integrated Care System Strategy

Strategic Estates Programme

Academic Strategy

Digital Strategy

Financial Strategy

Our focus for 21/22, breakthrough objectives and supporting programmes

Based on analysis of our current performance, we have identified the focus in each of the five areas for 21/22. Focusing on one area of our longer-term objectives will help us to make a real difference in a few key areas in a short space of time.

For each focus, we have developed a set of supporting programmes to help us make the progress required over the next 12 months.

For each breakthrough objective, we will be asking divisions how they plan to contribute towards delivering our annual focus, ensuring that these areas are relevant and achievable at divisional level and within day-to-day staff activities.

Clinical Strategy

We will develop a clinical strategy across the Group that outlines how services will be delivered in the future in order to provide the right model of care for our communities.

Our Clinical Strategy will be developed with clinical staff from across the Group. Together, we will develop the overall clinical vision and agree what we want to achieve, as well as the model of care we need to achieve our ambitions.

Each specialty will develop a service strategy that outlines how services will work best for our patients in the future, making the most of the opportunity of working across the Group and the wider system, the innovative digital solutions and the latest best practice evidence.

The clinical strategy will inform our strategic estates plan and is planned to be developed by Summer 2021.

People Plan

Replace first sentence in this para with: Our people underpin everything we do, and so developing a plan that increases staff numbers and capacity, offers better ways of working, and develops an empowering and inclusive culture, is central to achieving our ambitions. Above and beyond our people focus for 21/22, we are developing a People Plan which will outline our wider ambitions for people over the next 3 years.

Our People Plan is being developed with engagement from our leadership, staff and committees. The NHS staff surveys have been supplemented with local surveys and forums to understand our current opportunities to improve.

Key themes emerging within our People Plan from engagement completed to date include:

- Health and wellbeing
- People planning
- Volunteering
- People development
- People processes
- Organisational development

The strategy will be developed and finalised by Spring 2021.

Digital Strategy

We aspire to be the most Digital Hospital Group in England by July 2023. We will work together and with partners to enable digital care for patients across Northamptonshire.

Our Digital Strategy is being developed through engagement with our staff and patients to understand how Digital can best improve working lives and the care we provide.

Key design principles emerging through engagement are:

- To put patients and staff at the heart of everything we do
- Easy, simple and intuitive systems
- Clinically-led solutions that join up care
- Connected and shared systems that work together
- Innovative and flexible solutions
- Improves information about our services
- Increases accuracy and availability of data

The strategy will be developed and finalised by Spring 2021.

Strategic Estates Programme

Our objective is to develop a holistic estates plan for both Kettering and Northampton General Hospitals to support changes in the way we organise and deliver services.

Our strategic estates programme will outline the future requirements for the Group to improve the environment within which people will receive care, as well as the environment our staff work in.

At Kettering, the hospital is part of the National Hospital Redevelopment Programme, but we need a single strategic plan across the Group. This will be developed alongside the Clinical Strategy to ensure the estate is fit-for-purpose to deliver the care models outlined.

The strategic estates programme will be developed throughout 2021.

Financial strategy

Our objective is to develop a financial strategy for the Group which supports us to achieve the best value for money for our available funding, and which aligns with the NHS financial planning guidance at an organisation, Group and ICS level.

Our financial strategy will be developed in line with the NHS financial and planning guidance, and in partnership with our system finance colleagues.

The strategy will outline how the Group will achieve financial balance and create opportunities to invest in the future, interact with the ICS financial planning processes and how the new Group financial function will operate.

The financial strategy will be developed over Summer 2021.

NHCP Integrated Care System System Strategy

We will work with our partners to contribute towards achieving a thriving Integrated Care System (ICS) by April 2022, including by advancing the integration of care between NHS organisations, Local Authorities, and other partners to share responsibility for managing resources and delivering improvements in health outcomes.

Our ICS strategy will be developed together with our system partners in the Northamptonshire Health and Care Partnership (NHCP) in the coming months, in support of the NHCP vision to provide a positive lifetime of health, wellbeing and care in our community and the delivery of the four main priorities:

- Integrated Care Across Northamptonshire
- Mental Health
- Children and Young People
- Elective Care

Nursing, Midwifery and Allied Health Professional Strategy

We will build on our ambition to excel in patient care and create a positive practice environment for staff by working to become the employer of choice in Northamptonshire for healthcare careers.

Our Nursing, Midwifery and AHP strategy is being developed through lots of engagement with our nursing, midwifery and AHP colleagues. We have a extensive great successes to build on, including the Pathway to Excellence® accreditation in Northampton, and we plan to develop a roadmap for Kettering to become accredited.

In response to engagement undertaken to date, the Nursing, Midwifery and AHP strategy will include:

- Valuing our people
- Strengthening leadership
- Inspiring innovation and transformation
- Developing our workforce
- Ensuring safe and high quality care

The strategy will be developed and finalised by Spring 2021.

Academic Strategy

The aim of the Academic Strategy is to achieve University Hospitals status through partnership with the University of Leicester. This will improve the quality of care we are able to provide patients and the development opportunities we are able to offer our staff.

Our academic strategy has been developed through engagement with our people, staff, leadership and our external partners.

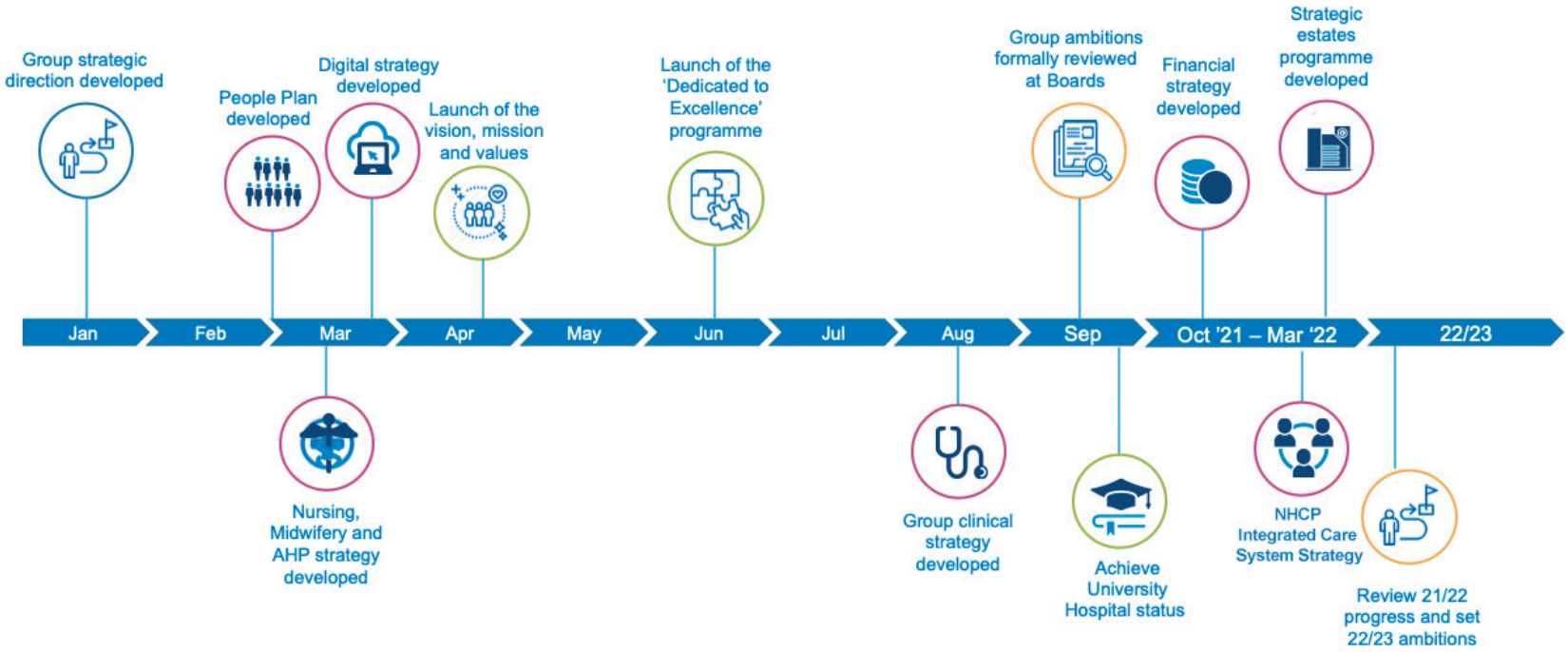
The strategy outlines our objectives:

- Partner with the University of Leicester to become a University Hospitals Group
- Foster a culture of learning, research and development
- Provide a multi-professional academic training and development programme
- Increase opportunities and resources for innovation and research
- Build our supporting infrastructure
- Develop our partnerships with other universities including the University of Northampton

The strategy was approved in Autumn 2020.

Our timeline for developing the Group

We will continue to develop the Group strategy and its constituent parts over the coming year through continued engagement with staff, governors, patient and carer representatives, health and care partners and other stakeholders.



Making Transformation Happen

We have agreed bold ambitions for our Group, and we have developed a shared vision of how things will be in the future. We now need everyone's support and engagement to deliver the transformations proposed and turn ambition into reality.

As we set out together on this journey, we all need to be heading in the same direction. We need to know the individual role we play in reaching our goals, and feel both supported and able to make small changes to make our own and our patients' lives better.

Embedding a Group-wide approach to transformation and improvement, building on the existing strengths and achievements of the KGH KIITE Team and the NGH Transformation and Efficiencies Team, will help us to create a culture of continuous quality improvement.

We want to develop an environment where every member of staff is taking steps towards making KGH and NGH a better place to work and be cared for. We want our priorities to be real, meaningful and relevant to our staff and what we do on a day-to-day basis. We need all staff to understand how what we do daily affects how we perform as a Group.

We will support our staff to have the skills and confidence to make improvements happen and to make a real difference.

Each division, department, team and individual will have their part to play, but we need a common approach. Our framework for transformation and improvement has seven key elements and supports everyone in making change happen, regardless of the role we play.

This will be a journey we need to travel together over the next few years to build a culture of improvement where everyone is empowered to make change happen. There will be plenty of opportunities to get involved and understand more about this in the coming months.

Measuring success

We have set out the ambitions for our hospital Group and we have shared our vision, mission and values. Working together across the two organisations, we will make the best use of our collective resources and remain committed to delivering excellence in all we do. This ambitious strategy will enable us to bring to life the vision for our hospital Group.

This document has outlined how we will align our transformation and improvement activities with our Group priorities. We have also developed plans for measuring our progress towards achieving these priorities, and for monitoring success measures on an ongoing basis.

Monitoring delivery

Each Group strategic priority has a set of success measures in order to track and measure performance. The Group priority success measures will be built into the operational performance monitoring structures within both Trusts and included in reporting packs for committees.

Our business intelligence and analytics teams will support the development of 'board-to-ward' reporting for metrics, which will be accessible by staff on a self-service system and allow teams to understand their own performance and see the impact of their improvements

Our programme teams will monitor delivery, providing robust programme and project management support to appropriately track delivery, and manage risks, issues and dependencies.

Assurance and governance

The NGH and KGH Trust boards have overall responsibility for the delivery of the Group strategy in their respective organisations, with assurance provided through committees in common.

The Collaboration Programme Committee provides oversight and assurance with respect to development and delivery of the Group-wide vision, strategy and priorities.

The People Committee, and the Quality Committee and Finance Committees in their committee in common sessions will oversee delivery of the Group priorities.

Group Strategy delivery oversight

This diagram provides an overview of the governance arrangements we have put in place to ensure we stay on track.

KGH Board

Both Trust Boards retain their sovereign responsibilities whilst delivering the Group's strategies through its committees in common

NGH Board

Committee overseeing overall Group strategy

People Committee

Overall Group strategy and priorities

Committees overseeing Group priorities

Collaboration Programme Committee

People

Quality Committee (in common sessions)

Patient

Quality

Finance Committee (in common sessions)

Systems & partnerships

Sustainability

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 28 January 2021
09:30 via ZOOM at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr A Burns	**Verbal.**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal.**
	3.	Minutes of meeting 26 November 2020	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Patient Vlog (Cancer)	Receive	Ms S Oke	**Verbal.**
	6.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	7.	Group Chief Executive's Report	Receive	Mr S Weldon	**C.**
	8.	Hospital Chief Executive's Report	Receive	Mrs D Needham	**D.**
PERFORMANCE					
	9.	Integrated Performance Report	Assurance	Mr C Holland Board Members	**E.**
	10.	Reset and Recovery Phase 3	Assurance	Mr C Holland	**F.**
	11.	Ockenden Report	Assurance	Ms S Oke	**G.**
	12.	COVID19 Vaccination Update	Assurance	Mr M Metcalfe	**H.**
GOVERNANCE					
	13.	Freedom to Speak Up Bi-Annual Report	Assurance	Ms C Campbell	**I.**
	14.	Board Assurance Framework	Assurance	Ms C Campbell	**J.**

Time	Agenda Item		Action	Presented by	Enclosure
	15.	Joint People Committee Terms of Reference	Approval	Ms C Campbell	**K.**
	16.	Emergency Preparedness Annual Report	Assurance	Mr C Holland	**L.**
STRATEGY & CULTURE					
	17.	Strategic Cancer Plan	Assurance	Mr M Metcalfe	**M.**
	18.	Dedicated to Excellence: Group Strategic Direction 21/22 – 23/24	Approval	Mr S Weldon	**N.**
CLOSING ITEMS					
	19.	Questions from the Public (Received in Advance)	Information	Mr A Burns	**Verbal.**
11:50	**20.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on 25 March 2021 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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