Public Trust Board - 29 July 2021

Thu 29 July 2021, 09:30 - 12:00

MS Teams

Northampton General Hospital NHS Trust

Agenda

09:30 - 09:30
0 min

1. INTRODUCTORY ITEMS

1.1. Introduction and Apologies

Information *Alan Burns*

1.2. Declarations of Interest

Information *Alan Burns*

1.3. Minutes of meeting 27 May 2021

Decision *Alan Burns*

1.3 Public Trust Board 27 May 2021.pdf (12 pages)

1.4. Matters Arising and Action Log

Information *Alan Burns*

Action Log Public Board.pdf (1 pages)

1.5. Staff Story

Discussion *Sheran Oke*

1.6. Chairman's Report

Information *Alan Burns*

1.7. Group Chief Executive's Report

Information *Simon Weldon*

1.7 GCEO Board Report July 2021.pdf (3 pages)

1.8. Hospital Chief Executive's Report

Information *Eileen Doyle*

1.8 HCEO board report July 21.pdf (3 pages)

09:30 - 09:30
0 min

2. PERFORMANCE

2.1. Integrated Performance Report

Information *Eileen Doyle & Board Members*

2.1 a NGH Cover sheet IPR.pdf (2 pages)
2.1 b NGH IPR June21 (002).pdf (64 pages)

2.2. 2021/22 Activity Report

Information *Joanna Fawcus & Jon Evans*

- 2.2 a 2021 22 Activity report front sheet.pdf (3 pages)
- 2.2 b H1 Operational Planning Submission Monitoring Template_June 2021 - Group.pdf (2 pages)

09:30 - 09:30
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BREAK

09:30 - 09:30
0 min

3. STRATEGY & CULTURE

3.1. Diversity and Inclusion Update

Information *Mark Smith*

- 3.1 a Group Cover sheet - EDI Progress Presentation and EDI Strategy for Approval - JPC - Item 6 - 26072021.pdf (3 pages)
- 3.1 b EDI Strategy 2021 _ 24 FINAL.pdf (24 pages)

3.2. ICS decision and Update

Decision *Karen Spellman*

- 3.2 a NGH Cover sheet template ICS Public Board July.pdf (2 pages)
- 3.2 b ICS Board paper Public July 21.pdf (3 pages)

09:30 - 09:30
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4. GOVERNANCE

4.1. Freedom to Speak Up – Quarter 4 and Annual Report

Information *Claire Campbell*

- 4.1 a FTSU Q4 and annual report Board July 2021.pdf (2 pages)
- 4.1 b FTSU Q4 and Annual Report Trust Board 2020 21.pdf (4 pages)

4.2. People Plan Update – People Partnering Pledge

Information *Mark Smith*

- 4.2 a NGH Board Meeting - Item 14 - 29072021.pdf (4 pages)
- 4.2 b UHON Disciplinary Policy FV - Appendix 1.pdf (8 pages)
- 4.2 c UHON - People Partnering Disciplinary Policy and Procedure Paper - Appendix 2.pdf (2 pages)

4.3. Board Assurance Framework

Information *Claire Campbell*

- 4.3 a Board BAF report - July 2021.pdf (2 pages)
- 4.3 b Appendix 1 Board Assurance Framework Report Board July 2021.pdf (4 pages)
- 4.3 c Appendix 2 Group BAF Risks @ 220621.pdf (10 pages)
- 4.3 d Appendix 3 NGH BAF Risks - July 2021.pdf (11 pages)

4.4. Fire Safety Annual Report & Fire Safety Board Compliance Statement

Information *Stuart Finn*

- 4.4 Annual Fire Safety Report FINAL 2021 v.8.1.pdf (23 pages)

09:30 - 09:30
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5. CLOSING ITEMS

5.1. Questions from the Public (Received in Advance)

Discussion *Alan Burns*

09:30 - 09:30
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6. ANY OTHER BUSINESS

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Minutes of the Public Trust Board

Thursday 27 May 2021
09:30 by ZOOM teleconference

Present		
	Mr A Burns	Chairman
	Mr D Moore	Non-Executive Director
	Mr S Weldon	Group Chief Executive Officer
	Ms E Doyle	Interim Hospital Chief Executive Officer
	Mr M Metcalfe	Medical Director
	Ms S Oke	Director of Nursing, Midwifery and Patient Services
	Ms J Houghton	Non-Executive Director
	Prof T Robinson	Associate Non-Executive Director
	Ms R Parker	Non-Executive Director
	Ms D Kirkham	Associate Non-Executive Director
	Ms J Fawcus	Chief Operating Officer
	Ms A Gill	Non-Executive Director
	Mr A Callow	Chief Digital Information Officer
	Mr M Smith	Chief People Officer
	Mrs B Agboola	Interim Director of Finance
In Attendance		
	Ms C Campbell	Director of Corporate Development Governance and Assurance
	Mr S Finn	Director of Estates and Facilities
	Ms K Spellman	Director of Strategy and Partnerships
	Mrs A Pardoe	Executive PA to the Hospital CEO and Chair

TB 21/22 019 **Introductions and Apologies**

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

Mr Burns advised that Mr Archard Jones had resigned from his Non-Executive Director role; Mr Burns expressed thanks and recognition on behalf of the board to Mr Archard Jones for everything he had done during his term.

TB 21/22 020 **Declarations of Interest**

There were no declarations of interest.

TB 21/22 021 **Minutes of the Public Trust Board held on 25 March 2021**

The minutes of the Public Trust Board held on 25 March 2021 were presented and **APPROVED** as a true and accurate recording of proceedings.

TB 21/22 022 **Matters Arising and Action Log Public Trust Board**

The Matters Arising and Action Log were considered and noted.

Action Log Item 128

Mr Smith advised this remains at 96% and they are working to ensure BAME risk assessments are complete; Mr Smith advised this is an ongoing process.

Action Log Item 127

Ms Campbell confirmed that a date is needed to address the EPRR and COVID lessons learned and she will work with Ms Fawcus to agree a suitable date.

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

TB 21/22 023 Patient Story

Ms Oke presented the video of the patient story from John Andrews, she advised it is very pertinent story and requested the Board discuss actions taken.

This story was sobering but very open and broadly supportive of Northampton General Hospital NHS Trust. Ms Houghton commented her concern was that communication remains a major theme within complaints and this story highlights the importance of it. Ms Houghton asked Mr Metcalfe and Ms Oke if this story can be used in clinical meetings for training purposes, Ms Gill echoed this point. Mr Metcalfe also shared these concerns and sentiments and confirmed that this story has already been shared with staff in gastroenterology and endoscopy and he has arranged a follow up meeting to discuss how they will use the learning from it. In Oncology appointment times for new patients are 40-60 minutes which is ample time to communicate properly. Mr Metcalfe noted how this patient was passed onto a CNS (Clinical Nurse Specialists) who are the designated key worker for cancer patients, he stressed that this role is vital to support patients but agreed more should be taken from this story and work is ongoing to do so. Mr Moore agreed and also asked about the plans for the Maggie's Centre and if work is still ongoing, it was confirmed that it is.

Mr Weldon expressed thanks to Mr Andrews for sharing his story and asked – as we are debating how to restore services post pandemic - have we challenged ourselves to deliver the best possible care and in doing so are we looking after our staff and, are we making steps in returning to more normal around finance. This patient is waiting for surgery – what was the position? And concluded there is a series of steps and we need to reflect on. Mr Metcalfe commented that this patient had reached the point of being suitable for curative treatment and surgery and that after a good response to chemotherapy he has been reassessed and down-staged and is now amenable to a curative surgery. Mr Weldon expressed his respect for Mr Andrews for sharing his story and journey. Mr Weldon added we will use his story as a training tool and pick up as an example of asking ourselves if we are doing as much as we can. Mr Weldon also commented that communication is very top of the new group values

The Board **NOTED** the Patient Story.

TB 21/22 024 Chairman's Report

Mr Burns presented the Chairman's Report.

Mr Burns noted there are a number of plans being developed in terms of operational system plans, the beginning of the ICS process and finance plans which cover the first part of the year; we do not know what is required, what will be asked of us or what will be possible in the second half of the year but we need to balance the three aspects of patients, staff and finance.

ICS and the value of having two places (Northampton and Kettering) are important and we have made a generous contribution to ICS. This is new territory and we need to put a lot of effort into doing it right.

Mr Burns was pleased to see the Nursing, Midwifery and Allied Health Professionals Strategy on the agenda for today, this is very important; a lot of work has gone into it and it is a major landmark for staff within these careers.

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

TB 21/22 025 Group Chief Executive's Report

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

Mr Weldon commented there are three questions everyone needs to be able to answer – are we doing the best for patients, the best for staff and making the best use of money; Mr Weldon added that it is down to us to make this less of a competition.

Mr Weldon commented that it was a privilege to be part of Nurses Day at Northampton General Hospital NHS Trust and appreciated spending time with nurses on wards and saw some amazing things; a particular highlight was meeting Mairead on Hawthorn ward and hearing her talk about the importance of ward leadership and the difference it can make. Hawthorn ward recently won an award for Pathway to Excellence and Mr Weldon saw good evidence of the hard work done by all the team with creativity and inspiration.

As we come out of COVID, Mr Weldon is keen to see how we can support Shared Decision Councils in nursing; he encouraged executives to join and support one and is very keen to have representatives come to board and report on what they are doing, Mr Weldon expressed his thanks to all the nursing workforce.

Mr Weldon commented that the estates team are very much unsung heroes; Mr Finn showed him the impressive new boilers on his last visit. It is also fantastic to see how close to fruition the new main entrance is and what a benefit it will be to staff and patients, also the new ITU and Paediatrics ED. Despite a number of challenges these are visible signs of improvement and we should celebrate and thank all estates team who have made it all possible and this is acknowledged via Mr Finn. Mr Burns also commented that although the entrance, Costa Coffee and M&S sound trivial they will have a major impact for staff; he reminded the board of the video of a nurse crying in her car during the first COVID lockdown as she could not get any food after her shift – resources such as these are essential and very important for staff and patients. Mr Finn and the estates team are to be praised for this work and the forward thinking as the unit has been built with the potential to have another storey added if needed. Generators and boilers are less exciting but just as important and these are good example of good investment and future planning.

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

TB 21/22 026 Hospital Chief Executive's Report

Ms Doyle presented the Hospital Chief Executive's Report.

Ms Doyle commented the site is very busy, we are still seeing winter numbers in A&E but staff are coping well. There are no COVID patients in hospital today and things do look to be improving but we must not be complacent.

Ms Doyle advised we are looking after staff in all areas as much as possible.

Reset plans and catch up work are in place. M1 points to us being busier than last year and the plans now based on actuals rather than Q3 last year – referrals are increasing, and we need to keep an eye on these in case the trajectory continues on the same level.

52 week+ figures are still worrying but are now below 400 which shows a great deal of hard work from all teams for which we are grateful.

A&E is very busy; we are currently in the midst of Give It A Go week and there is a real buzz of excitement around the different ways of working. Patients are being assessed on arrival and to get them out the door as soon as safely possible and preferable avoiding admission, all indications so far are good.

Ms Doyle acknowledged we are not where we need to be with cancer, and we know we need to improve this; work is ongoing with tertiary partners to support and improve pathways and speeds for patients.

Generally, though it is more positive picture and things are definitely improving and Ms Doyle is pleased to see the positive vibe.

Prof Robinson commented on the no harm review where the numbers are reducing, which is good news, it is also good news about the COVID patient numbers and asked if we can share anything on vaccination rates and new variants. Ms Doyle advised the system are keeping a close eye on the situation, but we know there are some hot spot areas which are being blitz tested, we have not seen any new variant cases yet onsite. Vaccination programme is going well despite some hiccups with supply and we are on target for working through the age groups.

Mr Weldon commented that we had the QRSM meeting last week where our response was praised by the region, especially the ability of teams to keep things going, yes we have challenges but they are less than other areas and this is a reflection on the management and leadership shown at Northampton General Hospital NHS Trust, we do need to be aware of ongoing issues with IPC vigilance, social distancing, testing and staff vaccinations. The highlights of the QRSM were our overall COVID response and how much elective work Northampton General Hospital NHS Trust were able to keep going.

Mr Smith commented we have done incredibly well in looking after our staff and this is reflected by the Health and Wellbeing Employer of the year award we achieved. We have a lot of colleagues who are keen to progress but some challenge with the theatre staff who have worked so incredibly hard throughout the pandemic and it is important we continue to look after them. Mr Smith advised we talk about staff regularly as well as patients and finances – our staff are our most important asset.

Mr Burns commented the estate is something we cannot control and this has been discussed before. Vaccination coverage is very good and soon we should be able to extend offer to all 18+.

Ms Gill asked about A&E numbers, what the key issues were and when we will be able to break this cycle and see a step change. In terms of urgent care pathways it was commented that GPs need to get back to face to face appointments, it is difficult but it does feel like some has changed; last Monday we have 420 patients through A&E but a low conversion rate of 20% so A&E was not what these patients needed but they came to us first, assuming they couldn't see their GP. We shouldn't be seeing these numbers and they are unsustainable. Ms Doyle commented we had a whole site response and recovered within 24 hours, but the message does need to go out about appropriate attendances. Mr Burns agreed that something has definitely changed since the pandemic with numbers increasing.

Mr Metcalfe commented seeing mid-winter numbers in May is alarming and he has spoken to Primary Care and the CCG regarding the drivers and has been assured that primary care attendances are also up 20% on normal rates; the example given was that of chest pain which doesn't usually need to come to hospital as a GP can usually manage it but this is harder to do with virtual appointments so thresholds are lower but work is ongoing to refine streaming processes in primary care. Mr Burns commented that patients often feel better by going to A&E.

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

TB 21/22 027 **Integrated Performance Report**

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

Ms Doyle advised this report is a work in progress as we are changing how it is done and we are not quite there yet

Mr Metcalfe was delighted to get a good calibre of candidates for the ward-based pharmacists and they will be in post by winter and he is assured they will make an impact.

Mr Metcalfe drew the board's attention to the fact that a simple fix to improve the safe administration of controlled drugs developed by one of our pharmacy team is now moving into commercial mass production with support from Innovate UK and this is a first for Northampton General Hospital NHS Trust

Mr Metcalfe commented about our programme of employing qualified doctors without current GMC licences to practice as Medical Support Workers as part of an HEE scheme; this has worked well so far and we are currently evaluating their experience and the benefits to the departments they work in. HEE funding for this has been extended to March 2022 and we are looking to recruit more.

Ms Oke highlighted that FFT is now measuring patient satisfaction rates which remain between 90 and 95% and this will allow us to do themed analyses.

Whilst it is good news we currently do not have any COVID patients in hospital, Ms Oke stressed the need for readiness if there are any further peaks and it was advised that the IPC BAF was discussed at length in QGC to provide assurance on the work being done. Ms Oke also advised following an RCA it is believed the recent CPE outbreak was brought in during the critical care surge by a patient. There was a visit in March from the regional IPC lead to observe our views and the Trust remains green on NHSI matrix following those outbreaks.

There was a recent meeting with the CQC looking at the 5 KLOES and the questions underneath them regarding assurance to the CQC. There was a good conversation with Ms Oke, Ms Fawcus, Ms Campbell and Mr Metcalfe from which we are not expecting any formal feedback, but this was a very good, positive conversation with a clear focus on IPC for which we provided good evidence. Ms Doyle advised we need to be ready for the CQC as both KGH and NHFT have had recent visits.

Ms Fawcus gave feedback on "Give It A Go" week which was a clinically led initiative and part of the discharge work. NHFT streamed 13 patients on Monday who were sent home. Ambulance assessments are being streamed to Nye Bevan. The focus is on Brampton and Holcot and colleagues from West Northamptonshire are supporting discharge which is clinically led and has support from Ms Taylor (Deputy COO).

There was a significant increase in numbers through Urgent Care in April which we are trying to manage by streaming more patients via SDEC and Springfield. The board were asked to note that Springfield is now open until 2am to cope with the increase in demand, this is an additional unexpected cost, but we need to maintain flow and safety in ED.

On the Monday ED saw 400+ patients, the whole trust pulled together and this momentum was maintained all week; ambulance numbers are also increasing. Ms Fawcus advised we are working with a European agency regarding acute physician appointments.

We have a national expert on discharges (Liz Sargent) working with us 2 days a week, this will feed into iCAN and the national DTA programme. Ms Fawcus commented there is a whole programme on discharge and flow and she is really pleased with the teams – the key to this will be board and ward rounds.

Cancer met 6 of 8 standards but not 62 days, there are some issues including workforce especially in gynaecology however we have now appointed new gynaecology oncologist. We have also recruited a locum oncologist. There are a number of diagnostic issues, but we are achieving the faster diagnosis standards. There is a lot of scrutiny on the legacy backlog with a daily focus both clinical and managerial which is overseen by Ms Fawcus.

There is good news for RTT as we hit the median wait. 52 weeks were 723 and are down to 370 today; this has been fantastic work by the teams to hit the trajectory. Ms Fawcus is also pleased with the position for 45 weeks and 40 weeks and we are working to ensure these don't get to 52 weeks.

Mr Moore asked about the Medical Support Workers – is this part of a programme to get them registered or a stand-alone. Mr Metcalfe advised that HEE approached us after we recruited some 5th years and their programme is similar to this. HEE are keen to see how it develops and evaluate both sides of the experience; we are working up a proposal for when the GMC make it easier for doctors to register to then give them a quicker route in.

Ms Kirkham asked if there was any comment on the C-section rate as this remains over target. Prof Robinson advised maternity services is a significant part of the current QGC agenda including Ockendon report, CNST and performance and we have a thorough view of those issues. Mr Burns agreed that he expects maternity to be the focus of any forthcoming CQC visit. Ms Houghton added that C-section rates are subject to the monthly champion meetings; the figures remain constant and an extensive case note audit has been undertaken which showed that very little could have been changed. Women do have the right to choose to have a C-section under NICE guidance – we can offer support and counselling, but we have to respect their decision and there can be clinical reasons as well. Ms Houghton advised C-section figures are being removed from dashboard as it can be clinical and choice, so it is no longer RAG rated.

Mr Weldon drew the board's attention to the ten new A&E standards on which we will be held to account. QGC will monitor these in June and July and bring them to Board in July, we would do well to reflect in lessons learned and what we may need to do differently.

Mr Smith gave feedback from the People committee in common, some progress has been made with the People Plan to include plans to hold the first joint leadership sessions this week. Mr Smith also added work is being done on employer issues and he will report back after a workshop at People Committee in

June. Mr Smith also stressed that looking at agency costs is very important and was overspent in M1. Mr Smith also commented about work ongoing with the Health and Wellbeing board and the second virtual Wellbeing Festival will take place in June.

Mrs Agboola was pleased to report that the Trust performed better than its forecast financial plan by reporting a surplus of £303k at the end of 20/21. The external audit is ongoing and final accounts are due to be done by the end of June. Mrs Agboola wished to record her thanks to the finance team for all their hard work in getting us to this position.

Mrs Agboola is also pleased to report the M1 financial position of £949k surplus against a draft plan of £903k which means we are £46k better than plan. The draft plan is on the agenda for discussion shortly. Mrs Agboola highlighted there has been an increase in activity with ED attendances and elective activity increasing in April which is good news for patient care. As we continue to be on block for H1 at least, it gives us the opportunity to focus on cost areas. Pay is overspent against our draft plan, mainly as a result of agency being overspent by £328k. However this is offset by non-pay which shows an underspend of £319k; however as activity continues to increase, especially elective activity, non-pay costs will likely increase, which would mean that if we don't control pay costs now, we may end up with overspends against our plan and therefore not be in a position to meet the Half 1 trajectory that we have set. Mrs Agboola advised we therefore need to act swiftly to put in necessary measures to control costs in a way that still provides the excellent quality of care to our patients but removes any unnecessary spend. In particular we need to focus on our agency spend and controls around that, it was noted HR colleagues are working actively to support Divisions with their recruitment plans and reinstating the workforce management meetings that do a deep-dive into agency usage across Divisions, as well as explore opportunities for alternative forms of contracting, rate negotiation etc. Mrs Agboola advised agency spend in the month is £1.5m, which is an improvement of £0.5m from previous month, so shows a movement in the right direction, but stressed we still need to do more to bring this down even further as far as possible.

The Capital plan for the year (which is presented for approval on the next agenda item as part of the financial plan for the year) is £18.9m. The M1 spend is £1.5m with a further £7.1m committed spend and we will need to ensure that we deliver on our capital plan this year.

Ms Gill asked about the drivers for the agency spend and if the investments in health and wellbeing are having a positive impact, how are they impacting sickness rates. Mr Smith commented there has been a reduction in sickness absence post winter and suspects things would have been worse within the interventions we had in place (SOS team) but there is still more work to do; we are now back to seeing stress and musculoskeletal issues as being the most regular reasons for sickness absence alongside Long COVID. There is a recruitment plan, but this has not been borne out in M1 and the monitoring of this will be picked up in SLT next week.

Mr Burns commented the board has been assured there would be a group reviewing agency use pre-Covid and Mr Smith confirmed this is the meeting that is being put back in place now.

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

TB 21/22 028 2021/2022 Planning

Mrs Agboola and Mrs Spellman presented the 2021/2022 Planning Update.

Ms Grimmett Director of Strategy for Kettering General Hospital and system elective care lead also joined the meeting for this section only.

The Northampton General Hospital NHS Trust plan will become part of the system plan when it is submitted in early June. The plan has to be the best we can achieve, and we need to be certain if have we got the balance right in terms of people, patients, and money. Mrs Spellman confirmed this paper presents the final plan for H1 and for the moment, this is all we have been asked on and we are expecting to get further guidance for H2. There is a need to be sure we are being ambitious enough for patients while recognising the need to be realistic.

Elective recovery is a good example of the three circles for us to break even is dependent on elective recovery. The key risks are wellbeing of staff as a great many theatre staff worked flat out during COVID and now the same people are being asked to do the same somewhere else. Mrs Spellman advised there is an elective recovery fund (ERF) to help us get back to our pre-COVID position but this will be delivered at system level and we need to ensure there is a balance across county so we have support each other to achieve at similar levels. Mrs Agboola advised we have improved the plan from first draft by increasing activity and opening more areas, activity will increase month on month and we are expecting to hit target but we must ensure staff are looked after, we must ensure we continue to work closely with the independent sector and we must ensure there is bed availability against emergency admissions. There is a system elective care board in place, and we are working at pace.

Ms Fawcus commented we need to be cognizant of the risks to staff ; currently we have staff not wanting to work extra lists and we are supporting them in that decision. The day surgery unit and theatres will be back up and running soon and we plan to maintain capacity. We are looking to maximise the space available; there will be weekly performance meetings chaired by Ms Fawcus and we will look to maintain the same levels of activity during holiday periods and the divisions are working on summer plans. Mr Holland will manage and monitor these daily. Ms Fawcus noted we can utilise KGH but would also need to send staff, we also plan to continue with use of the independent sector. Ms Fawcus confirmed we are being ambitious , while still supporting staff – ambitious but realistic. There will be regular reviews of capacity and we have an external company working with us on this. Mr Callow advised we are looking to have a shared waiting list in due course.

Mr Smith added that at the People Committee the workforce submission was completed in line with national guidance and assuring we support our staff wellbeing. Mr Smith added there is a lot of other work ongoing especially in terms of equality and diversity where we have a lot of learning to do; new ways of working and new roles and which roles we may need in the future.

Mr Smith commented that we are looking to increase staffing by 500 WTE across both sites and this is scary but important; it is not necessarily about additional recruitment but could be additional payment to staff for doing extra work – what is achievable and realistic. Mr Smith confirmed a review has been completed to assure we can recruit into these positions, there is some nervousness around agency costs which is a counterbalance to finances being so closely watched; however there is a plan to use some agency staff to maintain the pace. It was asked what these posts are, and Mr Smith advised a lot of them are healthcare support workers but also nurse recruitment and international nurse recruitment although he acknowledged the risk of this due to COVID. We are also looking at

retention of staff, we have a lot of staff approaching retirement age and this is something we need to be aware of.

Mrs Agboola advised the financial plan for 2021/22 is split across H1 and H2 and we are today asking for approval of the H1 plan as H2 will be developed further once the H2 Operational Guidance is released. The Group, alongside other system partners have developed a plan for H1 which meets NHSEI's expectations of a breakeven in H1. Mrs Agboola agreed with the earlier comments regarding the challenge of balancing activity, staff and money.

The H1 plan assumes delivery of activity based on current baseline capacity and workforce and includes no assumptions about increased referrals/activity or the impact of a potential third wave of COVID. Other assumptions include: ERF: £6.6m (NGH: 3.8m), Agency target: £7.3m H1 (NGH), Efficiency £6.0m H1 (FY: £10.9m). The H1 financial plan largely triangulates with workforce and activity, however subsequent changes to the activity and workforce plans which are submitted later on in the process but not the finance plans may mean that additional costs arising are not included in the current plan.

Mrs Agboola confirmed we have been working with system partners to develop a full year view which currently stands at a deficit of £117m of which the Group deficit is £107m (NGH: £54m KGH £53m). The key drivers being Pay and WTE increases, hence there is a real push for us to justify increases in spend and WTE and we are having ongoing discussions with NHSE/I.

The Capital plan allocation for NGH for the year is £18.9m of the £40.5m system capital envelope. We have taken this through Capital Committee, FPC and happy to present for Board approval.

The next steps are to develop a clear financial strategy that aims to balance the competing needs of patients, people and pounds; Mrs Agboola confirmed we will be reinstating Workforce management meetings to support recruitment drive as well as apply rigour around temporary staff usage, we will also develop robust Efficiency schemes. To date we have identified £14.2m of the full CIP target (77%) including recurrent and non-recurrent schemes and we now need to focus on delivery. For NGH, H1 target is £6m and we have identified c.80%, although c.50% recurrent, 50% non-recurrent)

Ms Houghton thanked those involved for a comprehensive report and commented there were very robust discussions in both QGC and FPC, this is a very difficult plan and we have articulated the risks well. Ms Houghton is supportive and asked about risk of clinical staff taking early retirement post COVID – are we seeing this and asked for more information around how patients are prioritised.

Ms Gill agreed it is a difficult balance and asked how we can break the cycle; what opportunities does agile working present and what do staff think would be helpful for them.

Mr Finn advised that Cancer services are trialling use of agile spaces as an example of what this can look like and the transformation team are looking at options for virtual clinics being run from places other than treatment rooms and this work is being funded by Estates.

Mr Smith added that agile working plans are still ongoing and what people want is changing but a lot of work is needed around the physical treatment of patients on site and this is tricky, but we are looking at options. In terms of early retirements we have looked into this and at the moment we are basing assumptions on what we know, we are not expecting it yet but due to the psychological impact it may

not happen for another few months, especially if there is a third wave and this is when we will have to increase support for colleagues.

Mr Smith advised that agency spend is being reviewed but this is also about improving resources to make things better. The main thing that would help staff is clarity on what is needed and what the priorities are, we need to clearly articulate these to staff to reassure them.

Mr Moore enhanced Mrs Agboola's point about transformation – this will be key for positive impacts for staff and patients so they need to be the best they can be.

Mr Weldon thanked everyone for their contributions and advised he had received some feedback from the QRSM meeting last week on where we are. In terms of elective recovery in our first submission we were comparatively low – does the revised version improve this to as good or better than our peers. Mr Weldon commented that the sooner we can move to a system PTL the better, but it does need to be a system effort, Mr Callow confirmed this is being worked on. At the present time we are not submitting a community diagnostic hub. In terms of workforce we are one of the best in the region and received unqualified approval from the region. Mr Weldon agreed to share the letter with the board.

Mr Weldon commented we need to think about H2 as well as H1 and work with the system to develop these; we can be reasonably confident about H1 and a system conversation about H2 will be needed soon after Jon Evans comes into post as Group Finance Director.

Ms Grimmett commented that in terms of actual activity there is an improvement from the first draft as we used M1 actuals and NGH improved by 4% on what was predicted; KGH were able to add 3000 cases as theatres were cleared by IPC sooner than expected. The QRSM praised us for elective waiting times and asked if we would be able to help others in the region.

Mr Callow commented a system PTL is priority but there is no date yet, there was an approach to see if we could bring them together but this can't be done, Mr Callow has found some bespoke systems which are being tested with a view to getting sign off as soon as we can, Mr Callow confirmed these are being shared with national colleagues to get a wider view.

Ms Grimmett confirmed we are also working on a plan for diagnostic hubs and mental health facilities through the ICS. Ms Grimmett also chairs the system estate board and is looking at how this can be brought together with all requirements and how we can best use the estate we have.

Ms Fawcus advised we expect to still have some 52 week waits in September but predicting to have these cleared by December and if we can do them quicker we will but that will be based on capacity; it should also be borne in mind that referrals have increased and cancer performance will affect legacy backlog but this is being worked on.

Mr Smith advised in terms of retirements we need to offer consistency; we are the lead employer for the vaccination centre and we are asking for staff to support that as well. We need to ensure we have a good offer for staff

Ms Parker commented this is a good, very clear piece of work and reminded the board that making cancer priority will mean difficult decisions and we may be at that point now

Mr Burns also agreed this is a good plan and stressed the importance of supporting staff and recognised there is still a lot of work to do but is happy to approve the plan with the intention for KGH to approve tomorrow.

The Board **APPROVED** the 2021/2022 Planning Update.

TB 21/22 029 Assessment & Accreditation for Nursing Excellence

Ms Oke presented the Assessment & Accreditation for Nursing Excellence.

Ms Oke presented the report, Assessment and Accreditation has been in place across the Trust for a number of years, it was suspended during COVID but focused on standard 5 – IPC which was a big help during the pandemic.

The time is now right to re-start the process and the assessment tool has been reviewed and refreshed and name has changed to bring it in line with the new group standards and looking to develop a multi-professional tool for nursing excellence across both sites.

Mr Smith advised he is fully supportive of this and keen to see the group values incorporated when the time is right.

Mr Metcalfe is also fully supportive and excited to see this develop into being a full clinical tool.

Ms Gill fully endorses Ms Oke and this presentation and added that those wards who have achieved Blue status have fantastic leadership and innovation.

Ms Houghton agrees this is good news and asked if it covers midwifery and is it linked to Pathway to Excellence, Ms Oke confirmed it is being adjusted to included midwifery, this was delayed by COVID and the title will be amended accordingly.

Mr Burns commented the value is in the rigour of the assessment and encouraging standards to be upheld, they shouldn't drop because of COVID or anything else. This should be encouraged and ensure staff are happy that where it is awarded it is deserved.

The Board **NOTED** the Assessment & Accreditation for Nursing Excellence

TB 21/22 030 Nursing, Midwifery & Allied Health Practitioner Strategy

Ms Oke presented the Nursing, Midwifery & Allied Health Practitioner Strategy.

Ms Oke advised the board are familiar with the strategy and she is very proud to present it. A lot of work has gone into this, staff wanted to have their work recognised and their voices ignited. The strategy does not stand alone but links with the clinical and academic strategies.

Ms Oke asked the Board to approve and advised KGH do so tomorrow.

The Board **APPROVED** Nursing, Midwifery & Allied Health Practitioner Strategy.

TB 21/22 031 Annual Self Certification

Ms Campbell presented the Annual Self Certification.

Ms Campbell advised this is an annual review which we are expected to comply with even though Northampton General Hospital NHS Trust are exempt as we are not a Foundation Trust. This does not need to be submitted to NHSE/I but we do have to publish on the website.

The Board **APPROVED** the Annual Self Certification.

TB 21/22 032 Board Assurance Framework

Ms Campbell presented the Board Assurance Framework.

Ms Campbell advised this is the final version of the BAF in this iteration. The next version will include risks to group priorities, strategies and a revised risk appetite and work is ongoing on this.

Mr Burns was pleased to see the change in framework, it is important to see the same format and language across the group, Mr Burns is also looking for a greater focus in high level risk.

Mr Finn advised the work on fire and reducing of risk scores has now been verified by independent auditor and risk assessment. Mr Burns commented the Board have spent a lot time talking about fire risk and this is a significant achievement which he is pleased to see.

The Board **APPROVED** the Board Assurance Framework.

TB 21/22 033 Group Risk Appetite

Ms Campbell presented the Group Risk Appetite and advised this is coming to Board for ratification.

Ms Campbell advised this should colour all decisions made and remains an active document. This will be an integral part of the new BAF, and risk appetite against each strategic priority will be clear. Ms Campbell noted that good progress has been made.

The Board **APPROVED** the Group Risk Appetite.

TB 21/22 034 Questions from the Public (Received in Advance)

There were no questions received in advance.

TB 21/22 035 Any Other Business

Mr Weldon took the opportunity, as this was Mrs Agboola's last meeting as Interim Director of Finance to thank Mrs Agboola for the work done and the contributions she has made.

Ms Oke advised that last year the board had delegated the timetable for CNST submission to the QGC and asked if this could be done again and this was agreed.

Meeting closed 12.14

Date of next meeting: Public Trust Board - Thursday 29th July 2021 at 09:30 via ZOOM at Northampton General Hospital.

Public Trust Board Action Log							Last update	20/07/2021
Item No	**Month of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
Actions - Current meeting								
Actions - Future meetings								
127	Jan-21	TB 20/21 082	Emergency Preparedness Annual Report	Mr Weldon remarked that the EPRR arrangements had been tested to the max over the past year. This was an important report and he asked the team to work with KGH from a lessons learn point of view. He asked for when the second wave recedes that this was debated.	Ms Fawcus	TBC	On Track	**Update from May Board - Ms Campbell confirmed that a date is needed to address the EPRR and COVID lessons learned and she will work with Ms Fawcus to agree a suitable date**

Cover sheet

Meeting	Public Trust Board
Date	29 July 2021
Agenda item	1.7

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

This paper is for

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

Group priority

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

Reason for consideration	Previous consideration
Outline the reason for consideration	*Outline previous consideration including consultation*

Executive Summary

It is right to begin this report by reflecting on the launch of the group on 1st July. Many people contributed to making the day the success it was and I would like to thank them all for their contributions. But it is also important to remember that days like our launch day signalling a different kind of start; one in which we are better positioned to meet the challenges of the day. As we go into the second half of the year, I would like to reflect on some of those challenges here.

First, delivering for patients. The key national debate on delivery currently is how soon can waiting lists for elective surgery be sustainably recovered? The headlines on this are stark with the national waiting list recently passing 5 million for the first time. There is much that is still unclear at policy level at a national level but while that debate continues, it will be important that as a Group we are able to demonstrate that, given that context, we have done the very best we can to meet patients needs and expectations. We have made good initial progress on some of the headline measures against which we will be judged – reducing 52 week waits – but we need to do more. As the year progresses, I expect to a see increasing scrutiny on theatre efficiency. We will be required to demonstrate that our use of our most expensive assets – our theatres – is as good as we can make it. By September, I expect to be bringing forward new data into our performance reports at Board level to show our position on theatre efficiency and to talk about what we can do to improve it.

Secondly, working together as a system. Many of you have been involved in the work that has been done to date on how we will create our new care system, called the Integrated Care System or ICS for short. Some of these discussions will feel remote from the day to day of care but they do matter. Roughly, this type of system changes come around every 10 years so we live with the consequences of them for some considerable time. And those consequences can have considerable impact for the delivery of patient care. Assuming the legislation currently being debated in Parliament goes through as planned, there are significant opportunities for us to improve the how we organise to deliver care. I'll focus on two here. Firstly, one of the key ideas in the bill is to about breaking down barriers and really acting as a system. So in the future, we could have a seat on an ICS statutory body board – an idea unthinkable in the current system dominated as it has been by purchaser / provider splits. Implementing this idea would really rope us together as a system. Secondly, taking the idea of breaking down traditional barriers further, in that new system, the Group will lead the development of how elective services are organised and delivered (the new term here is an elective collaborative and our role will be as a lead provider) and could take on some of the commissioning responsibilities previously reserved to the CCG. We will continue to be involved in the development of the ICS over the remainder of this financial year and I expect by September to be bringing forward our initial thinking on how an elective collaborative will work.

Finally, we will also talk today about our work on equality and diversity. I want us today to reflect on our progress and learning but also commit to go further in the year ahead. We are fortunate in our Group to be blessed by the service of colleagues from many backgrounds, races and orientations. Today is a day to acknowledge and appreciate the work that they do and for us all to commit to continue to develop our Group to be a more inclusive place to work. I would like to record here a sincere personal note of thanks to my reverse mentor, Rita Onyeibe. During the last year I have been privileged to have a small glimpse into her world and her journey. Those conversations will live long in my memory and on her behalf and all the other colleagues who walk similar paths I pledge to continue my own journey towards inclusiveness.

Launch of University Hospitals of Northamptonshire – 1 July 2021

Appendices

n/a

Risk and assurance

n/a

Financial Impact

n/a

Legal implications/regulatory requirements

n/a

Equality Impact Assessment

n/a

Cover sheet

Meeting	Northampton General Hospital Trust Board
Date	29 July 2021
Agenda item	1.8

Title	Hospital Chief Executive Report for June 2021
Presenter	Eileen Doyle
Author	Eileen Doyle

This paper is for

☐Approval	☐Discussion	☒Note	☒Assurance
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Group priority

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Reason for consideration	**Previous consideration**

Executive Summary

Another busy month at NGH with the continuation of high levels of attendances to the Emergency Department which seems to break previous records week on week. The operational update will show that the numbers of long waiters over 52 weeks continues to decline rapidly as does the mean waits for intervention and any subsequent treatment. We are working hard with our clinical teams to ensure that we can continue with elective surgery and with the support of National GIFRT colleagues to craft a plan which will put us in a more robust position when pressures are high especially over winter periods when historically planned surgery has been disrupted due to lack of bed capacity.

The backlog of unappointed follow ups at NGH has also dropped significantly with around 5% of patients contacted needing further appointments and these have been accommodated to now in existing sessions. Due to the demands in imaging, we have installed a further CT scanner mobile unit on site to help manage the workload.

Stranded and super-stranded went up in month and this has certainly put an immense amount of pressure on the site and beds. There is a continuous effort both within the hospital and also with our partners to decrease the numbers waiting for other interventions, but they remain stubbornly high. There are particular issues in CRT (The Community Reablement Team) where many of our patients transfer to due to the increase in demand and also staffing issues around vacancies, sickness and of course covid isolation. This is likely to get worse as unlocking takes effect and the background incidence of positive covid increases.

During this month, I'm delighted to say that we interviewed and successfully appointed three new Emergency Department Consultants (one a dual post with ITU) all of whom have accepted their offers.

We have also appointed Tracey Robson to be our substantive Hospital HR Director and she will start in her new role in September 2021.

Since our last Trust Board meeting, we have officially opened our fabulous new main entrance and it is certainly proving extremely popular judging by the (socially distanced) queues for the food and coffee outlets. Thanks to our estates and facilities teams who worked so hard to deliver this on time and also to our commercial partners who worked with us to ensure a smooth handover.

Of course, we have moved on from June and at the time of writing this report we are well and truly in the throws of wave 3 of Covid. Only a couple of weeks ago we had less than a handful of inpatients with us and today we have 31 with 2 of those in HDU. We expect this to rise over the coming weeks and will continue services for as long as it is safe and sensible to do so as we are extremely conscious of the impact delays in treatment would have on our patients and services. We have well-rehearsed covid plans and are comfortable with triggering those again. We are stepping up our silver response so that we are agile in our decision making as the need and situation arises. However, our staffing; those positive or isolating is already presenting itself as our major challenge and we anticipate that could become a critical factor over the coming weeks. We will be following the Government guidelines for Health Workers and are standing up a risk assessment group lead by our DIPC which will convene daily to look at those who have been contacted by NHS Test and Trace who are asymptomatic on whether and how they isolate for the following 10 days depending on the forthcoming guidance. We are also working with services at KGH to see how we can best support each other clinically over this time whether it is with planned theatre capacity or critical care demand.

We know we are entering in to a really challenging time over the next couple of months and we cannot underestimate the impact on our staff, many of whom have worked tirelessly during the first 2 waves without much leave or downtime and who are facing another peak in the coming weeks. I know that I speak on behalf of the entire Board when offering our sincere thanks and appreciation to all of our staff

who continue to show immense commitment and professionalism to our patients and each other during such difficult times.

Eileen Doyle- July 2021

Appendices

None

Risk and assurance

Additional pressures of wave 3 COVID

Financial Impact

None

Legal implications/regulatory requirements

Potential risk of not achieving the regulatory standards

Equality Impact Assessment

Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? N

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.

There is no potential that the content of this report will have any negative impact.

Cover sheet

Meeting	Trust Board
Date	29 July 2021
Agenda item	2.1

Title	Trust Integrated Performance Report
Presenter	Eileen Doyle, Chief Executive
Author	Adrian Marsden, Head of Informatics

This paper is for

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

Group priority

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

Reason for consideration	Previous consideration
The Trust Board is asked to note the contents of this paper and note current performance against the key metrics	*Outline previous consideration including consultation*

Executive Summary

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

Areas of focus are detailed as:

- Friends & Family Test % of patients who would recommend: Inpatient/Day case
- Stranded Patients (average.) as % of bed base
- A&E: Proportion of patients spending less than 4 hours in A&E
- Ambulance handovers that waited over 30 mins and less than 60 mins
- Ambulance handovers that waited over 60 mins
- Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers
- RTT over 52 weeks
- RTT over 45 weeks
- RTT over 40 weeks
- Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test
- Stroke patients spending at least 90% of their time on the stroke unit
- Percentage of all trust staff with mandatory refresher fire training compliance
- Percentage of staff with annual appraisal

Appendices

Longer papers should be summarised in the executive summary section and additional information appended.

Risk and assurance

The increased levels of demand in urgent & cancer services means there is a risk to overall delivery of the elective recovery trajectories and H1 activity plan. This is being mitigated by the use of weekend sessions, insourcing and the independent sector.

Financial Impact

The increased activity from higher referrals for Cancer, elective care and Emergency care are impacting on the trust financial position as the organisation works to manage these increasing numbers. Insourcing / outsourcing of services to meet the demand by the use of the Independent sector compounds the issue when we are not on tariff.

Legal implications/regulatory requirements

None

Equality Impact Assessment

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

Integrated Performance Report

Date: July 2021
Reporting Period: June 2021

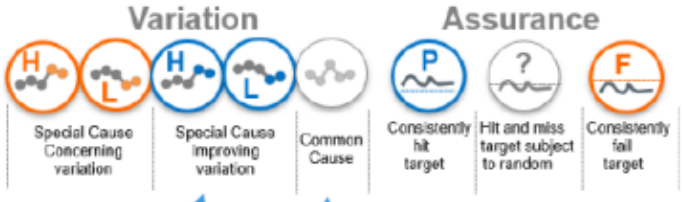
SPC Charts

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

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

High level key - variation

Are we improving declining or staying the same



Orange = significant concern or high pressure

Blue = significant improvement or low pressure

Grey – no significant change

Palmer Kirsty
07/26/2021 10:25:24

High level key - assurance

Can we reliably hit the target

Orange = system change required to hit target

Blue = will reliably hit the target

Hit and miss the target

Medical Director's Overview

- **Clinical Incidents**

There have been 8 serious incidents reported in June 7 of these either relating to covid outbreaks and cases or maternity cases. Ongoing improvement work is led by the infection prevention team and the maternity leadership team respectively. There have been no never events.

- **VTE and ePMA**

The use of the combined VTE assessment and drug charts continues to support improved prophylaxis. Further improvement will be driven through the appointment of a specialist VTE nurse and the introduction of ePMA. Ther eis good progress with developing the tender for ePMA, and now the realistic prospect of a high quality solution across the group as part of the digital strategy.

- **Medical establishment**

The medical examiners across the group have agreed to second a project manager to undertake the medical establishment review previously completed at NGH across the group, and lead the programme of work to address clinical workforce gaps and their sequelae.

- **Academic programme**

The official launch of the University Hospitals of Northants has created a positive stir among the senior medical establishment at NGH, and applicants for senior medical positions are already citing this achievement as a reason to come and work at our hospitals. The medical directors of the group are arranging an academic conference to design a coordinated future of academic functions to maximise benefits for our patients and colleagues. NGH has met it's ambitious trajectory for recruitment to research studies in June following a "reset" from covid studies towards the broader portfolio.

- **BAME clinical fellow**

The BAME clinical fellow work will be augmented and replicated across the group through the appointment of GP trainees with an inclusion leadership components to their job plans focussing on embedding the improved welcome and support offered to our international medical graduates.

Chief People Officer Overview

The report demonstrates the above pressure within the Trust in caring for patients with different needs and the impact the pandemic is starting to have an impact on our people metrics inclusive of our colleague absence and temporary staffing expenditure, specifically in NGH. Whilst there are challenges there are real demonstrations of success, within the international nurse recruitment programme, our continued focus on health and wellbeing inclusive of our county based psychological support services and our system virtual health and wellbeing festival. The link to the festival is attached, our first virtual health and wellbeing festival in 2020 has seen over 14,000 users hits and we anticipate similar if not higher levels this year. www.wellbeingfestival.live

We also launched our University Hospitals Group status this month along with our new Group Dedicated to Excellence values, these are designed not only to support colleagues working within both Trusts, reducing turnover and increasing opportunities for colleagues to develop and learn, but these will also support us in attracting more people to come and work as part of our group.

We have two items from the People Plan at the Public Board meeting this month, showcasing the progress made with regards to EDI and a review of our new disciplinary policy, one of our first Group policies.

Within the HR and OD teams, our focus is on establishing an infrastructure to support the implementation of our People Plan, with a particular focus on the next 12 month deliverable in line with our business plan submissions.

Directors view – Director of Nursing & Midwifery

Maternity: The Trust has submitted evidence by the stated deadline to demonstrate compliance with the identified Ockendon standards and has submitted full compliance with the Clinical Negligence Scheme for Trusts (CNST) Safety Actions.

Nursing, Midwifery and AHP Strategy: The strategy launch is planned for Aug/Sept with infrastructure being identified to support delivery

Friends & Family Test: The Friends & Family Test recommenced nationally on the 1st of December 2020 with the change from Recommendation Rates to Satisfaction Scores. New targets have been set from April 2021. Postcards recommenced collection from June for patients that are not able to use the technology methods that we have introduced. It is expected that this will increase feedback, although it is being encouraged that technological methods should be used where possible. Further posters with QR codes have been established within Gynaecology, Eye Casualty and a number of surgical outpatient departments. These will commence in July. Increasing responses and feedback options ensures the Hospital has the information needed to make changes where needed. The Divisions have established Patient Experience Groups targeted at improving patient experience. Each Division presented to the Patient & Carer Experience & Engagement Group (PCEEG) to outline the work that they aim to take forward. It is expected that over a period of time this will have a direct impact on the ways in which patients experience our services. The inpatient and day case Satisfaction scores have remained between 90%-95%. This is within normal variation. On comparing the figures since April, satisfaction scores average around 92%.

Complaints: All complaints are triaged upon receipt and a decision made as to the most appropriate route through which the complaint should be handled / investigated. Where possible, and in agreement with the complainant, the Complaints team will try to locally resolve some complaints. However, for complaints, which meet the criteria for a potential incident / safeguarding, these are escalated to either Governance or the Trust's Safeguarding team. All such actions are agreed with the complainant from the outset. The complaints timeframe has now returned to the Trust's normal process of agreeing between 20-40 working days with those who raise a complaint formally. There are still a number of complaints ongoing which were allocated a 130 / 60 day timeframe whilst the second wave of the COVID 19 pandemic was ongoing. These complaints are currently being addressed on a priority basis and complainants are being kept informed. The Trust compliance rate response rate for complaints, reported in June was 100%.

Infection Prevention & Control Service: During May and June there were 10 reported cases of Clostridioidies difficile Toxin A & B identified as hospital onset, 5 in May and 5 in June, the IPC Team reviewed each patient and no lapses in care were found. There were 2 reported case of MSSA BSI reported during May and June and 1 patient developed a MRSA bacteraemia from a previous community acquired infective endocarditis infection. There were no lapses in care identified for any of these three patients.

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 May and June there were 0 COVID patient outbreaks reported and 0 patients developed a hospital acquired COVID infection. In May the Social Distancing Cell commenced to disseminate key social distancing guidance, signage, measures to teams across the Trust and support non-clinical areas to continue to use and in June PPE training exceeded 85% compliance and is now being integrated into IPC mandatory training moving forwards. Plans are being developed to manage the anticipated 3rd wave of the virus.

Directors view – Chief Operating Officer

ED 4hr Standard

Overall performance against the ED standard was 86%. It is important to recognise the context the clinical teams operated in throughout June:

- Attendances were 11,788 for June and it is worth noting the continued increase in attendances - April was 10,264 and May 11,277
- Despite the increase in attendances the ED conversion rate was 19.52%
- Streaming from ED to areas such as Springfield & SDEC has continued to increase with 1896 patients streamed
- Ambulance conveyances decreased in June at 2893 compared to 3082 for May and handover issues remain minimal due to the processes now in place and the focus from the operational teams
- Attendances in the evening and night remain high with Springfield open until 2am seven days per week to support this work

Stranded Patient Metric

- Average Stranded patient numbers for June 2021 was 274 an increase from pervious month which was 260
- Super stranded numbers for June increased to an average of 89
- Following the Give It A Go Week at the end of May several further workstreams have been agreed which will focus on transforming the board round processes
- The Frailty Unit will also move to a bigger area with increased short stay beds in July which will facilitate rapid & intense clinical treatment and support to reduce inappropriate admissions

Cancer Waiting Times

- The Trust met 3 of the 8 cancer waiting standards for May
- During May the Trust received 1422 GP referrals which is 18.5% above pre Covid levels. Despite this 54.2% of patients were seen in 7 days or less exceeding the 2ww standard. This is a fantastic achievement by all teams given the sustained increase in referrals
- There was a 29.3% increase in treatments in May compared to April, undertaking 92.5 treatments, of which 23 breached, resulting in 62d performance of 75.1%. There remains ongoing surgical capacity issues within Gynaecology but an improvement trajectory is in place following successful Consultant recruitment
- We continue to meet and exceed the 28 Faster Diagnosis Standard achieving 84% against the 75% standard. All Trusts will be measured against the national standard from Q3
- Board should note the challenged position of the Head & Neck Cancer service at Leicester which NGH & other Trusts in the region are now supporting

Directors view – Chief Operating Officer

Elective Access

- The median RTT wait for June was 8.5 weeks
- The number over 52+ weeks for June was 218 with progress against the trajectories of over 45 & over 40 weeks also continuing despite the challenges across the emergency footprint and increased cancer referrals
- All theatre capacity was fully functioning by the end of June
- The Unappointed follow up issue is managed through a daily task & finish group chaired by the Deputy COO and progress monitored weekly through the Access Committee and no harm has been reported to date

Diagnostics

- Challenges remain across the diagnostic services
- MRI & CT capacity challenges remain given the increased urgent care attendances and cancer referrals
- Mobile MRI scanner secured and onsite from July 2021
- Private sector capacity & pathways agreed and in place to support cancer & elective pathways

NGH Board
Finance Performance

Month 3 (June 2021)
FY 2021/22

Northampton General Hospital NHS Trust

Director of Finance Summary

The year to date financial position is £53k favourable to plan, made up of income over-performance of £2.3m, pay overspend £3.0m, and non-pay underspend of £0.7m.

- **Income performance** is largely driven by ERF reported as £3.9m YTD, which is an over-performance of £1.5m and has been recognised on the basis of the original guidance and subject to overall System achievement. The rules around ERF have recently changed and is likely to have an impact on the Q2 position, currently estimated at around £2.9m. Further work is being done to refine this estimate and will be reported back to FPC.
- **Pay** is overspent by £3.0m YTD arising from increased staff usage to manage operational pressures, costs to achieve ERF, as well as prior year invoices, sickness above budgeted levels. Overall Agency spend year to date is £5.2m, versus budgeted spend of £3.5m.
- A significant portion of the pay overspend relates to medical staff costs which is overspent by over £1m. This relates largely to premium staffing costs to fill vacancies, over-establishment suggested to relate to addressing operational needs including new clinics put on to address backlog, staffing the Springfield Urgent Treatment Centre and SDEC in response to increased A&E attendances ('Give It a Go' week). These issues are being explored further with the Divisions to fully understand the drivers and agree recovery actions as necessary.
- **Non-pay underspend performance** is largely driven by underspend in elective activity due to theatres not fully open prior to June
- **Efficiencies** delivery for Q1 stands at £2.7m which is on plan. However, this is being met largely through non-recurrent pay savings. Work is underway with Divisions to increase the delivery of recurrent CIPs, which have delivered £0.4m against the £1.1m plan for Q1. Also, there remains an unidentified CIPs gap of £1.8m
- **Capital** spend to date is £5.5m, which is in line with the plan. NHSEI have advised that a portion of the already allocated full year capital plan requires further approval via the "Emergency Capital PDC" funding route and we are working with them on this. If unapproved, there is a risk to the capital plan of £2.0m.
- The other risks to achieving the full year plan remain largely around ERF achievement for Q2 given the change in rules, increase in the use of agency given the increase in staff sickness and isolation with COVID Wave 3 and the achievement of our Efficiency target.

We will prepare a forecast analysis in Month 4 based on current trend as well as assess the impact of the identified risks on the financial position.

2021/22 M3 I&E Summary

Description	NGH In-Month			NGH Year To Date		
	Plan £m's	Actual £m's	Variance £m's	Plan £m's	Actual £m's	Variance £m's
Total Income	34.7	36.0	1.4	105.4	107.7	2.3
Total Pay	(24.0)	(25.3)	(1.3)	(71.1)	(74.1)	(3.0)
Total Non Pay	(10.6)	(10.7)	(0.1)	(32.0)	(31.4)	0.6
Operating (Deficit)	**0.1**	**0.0**	**(0.1)**	**2.3**	**2.3**	**(0.1)**
Capital Charges	(0.5)	(0.4)	0.0	(1.4)	(1.3)	0.1
I&E Surplus / (Deficit)	**(0.4)**	**(0.4)**	**(0.0)**	**0.9**	**1.0**	**0.1**

NGH Finance Overview

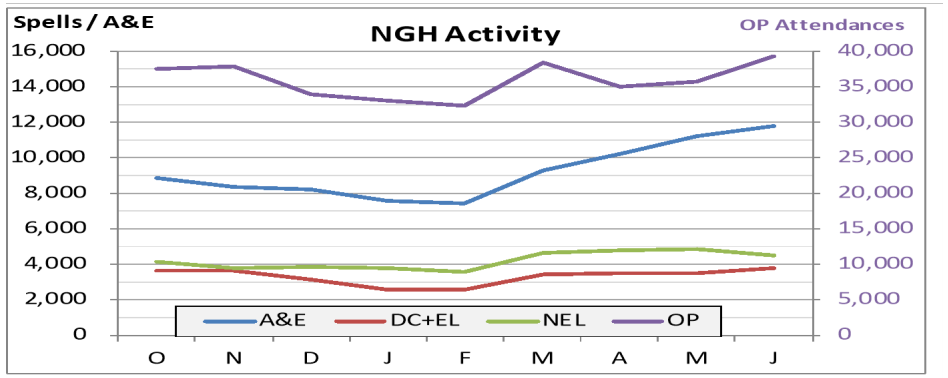
The YTD position of £1.0m surplus is £0.1m favourable against plan.

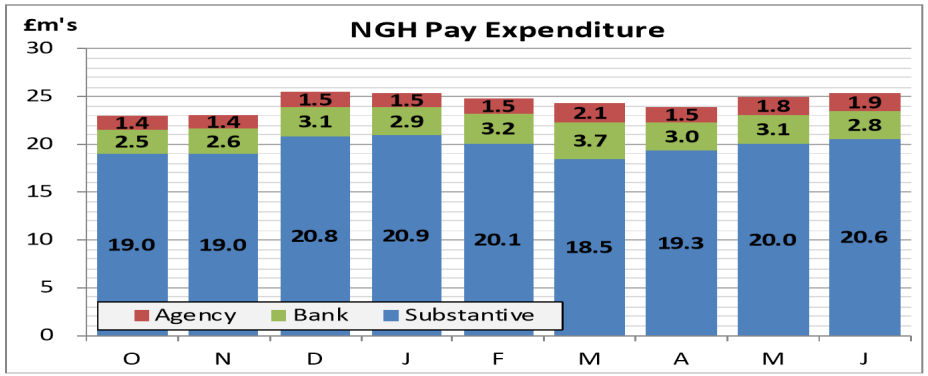
Income – The key driver in income is ERF, which is £1.5m above plan due to Day Case and OP performance

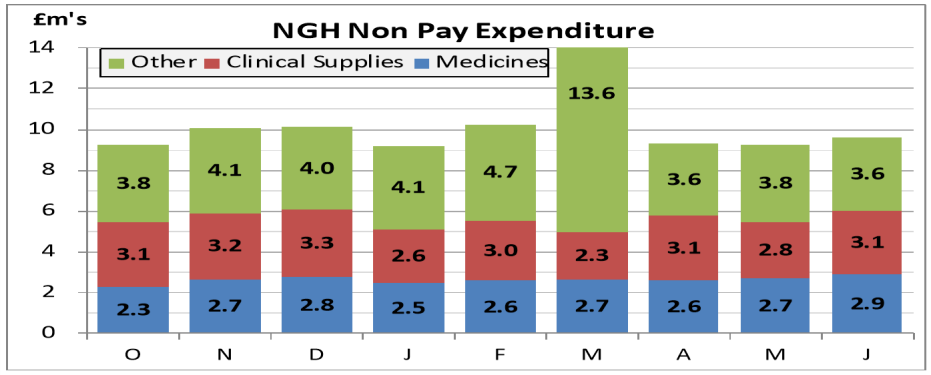
Pay – The £3.0m adverse variance is driven by a much higher agency spend (£5.2m) than plan (£3.5m) driven by cover for vacancies plus additional staffing above establishment to manage operational pressures.

Non-pay – Earlier months underspends are starting to reduce as activity increases. However, June also includes some extra income backed (£0.4m) expenditure causing the slight adverse variance in month.

Summary - Activity & Expenditure – Monthly Trend







Highlights / Key Issues

Activity

A&E attendances continued to increase to just under 12,000 in June. Outpatient activity shows a significant rise in June, although this is influenced by working days, with 22 in June compared to only 19 working days per month in April & May.

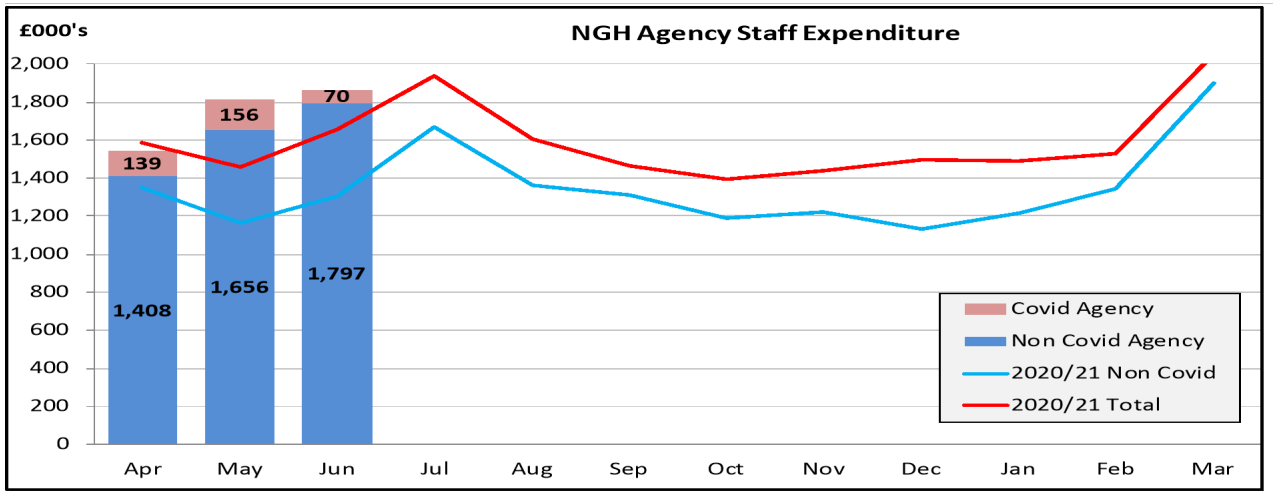
Pay

Agency expenditure continues as a significant risk to plan. The Substantive costs have increased from April 2021 but this is in relation to weekends and bank holiday pay, rather than growth in contracted staff.

Non Pay

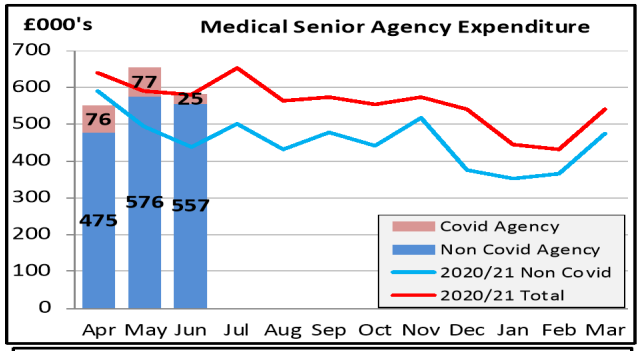
Clinical expenditure growth returning as activity increases, but overall the Trust is underspending against budget.

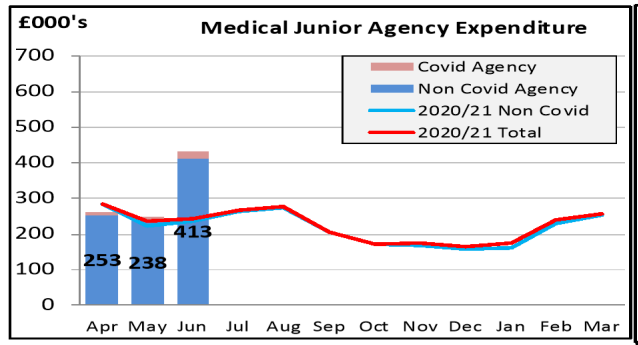
Agency Pay Expenditure

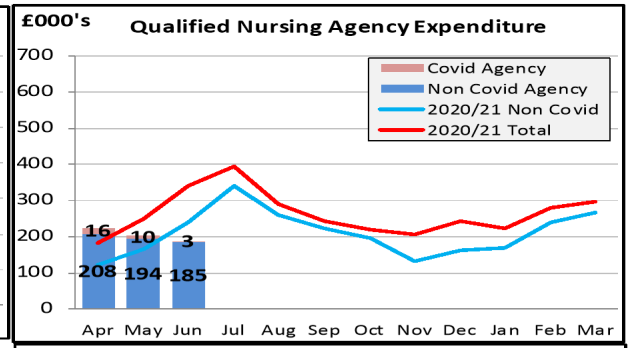


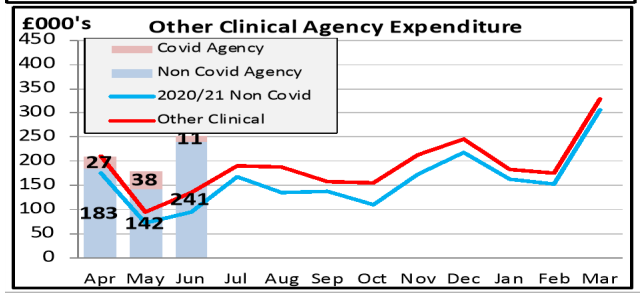
Monthly Agency spend was just under £1.6m for several months until March 2021.

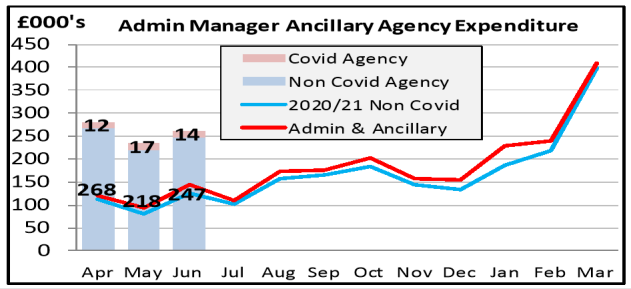
The significant increases seen in June come in Junior Medical Staff and Other Clinical groups for vacancy cover and additional staffing to manage operational pressures and staff additional clinics.

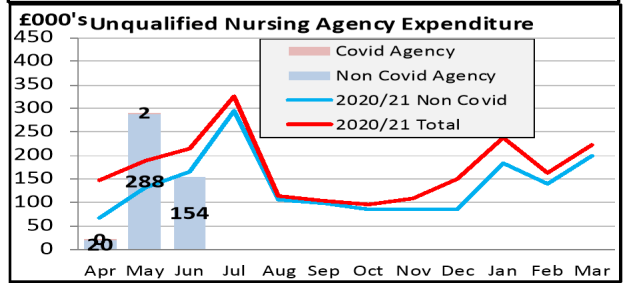












Northampton General Hospital
NHS Trust

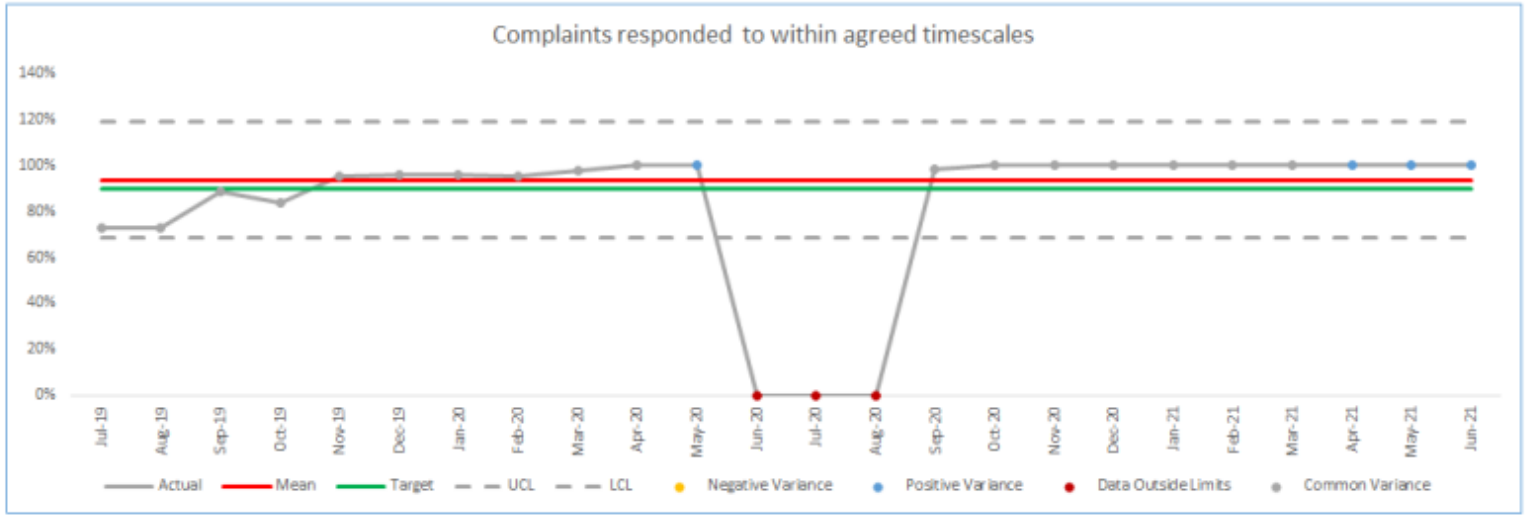
Statement of Financial Performance - NGH

TRUST SUMMARY BALANCE SHEET MONTH 3 2021/22	Balance at 31-Mar-21 £000	Current Month Opening Balance £000	Current Month Closing Balance £000	Current Month Movement £000	Forecast end of year Closing Balance £000	Forecast end of year Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	188,782	187,241	188,782	1,541	188,782	0
IN YEAR REVALUATIONS	0	0	0	0	0	0
IN YEAR MOVEMENTS	0	3,483	5,510	2,027	19,075	19,075
LESS DEPRECIATION	0	(2,179)	(3,271)	(1,092)	(12,334)	(12,334)
NET BOOK VALUE	**188,782**	**188,545**	**191,021**	**2,476**	**195,523**	**6,741**
CURRENT ASSETS						
INVENTORIES	6,310	6,124	6,238	114	6,310	0
TRADE & OTHER RECEIVABLES	16,048	20,141	21,376	1,235	21,282	5,234
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CLINICIAN PENSION TAX FUNDING	966	966	966	0	966	0
CASH	25,428	31,595	26,092	(5,503)	1,500	(23,928)
TOTAL CURRENT ASSETS	**48,752**	**58,826**	**54,672**	**(4,154)**	**30,058**	**(18,694)**
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	34,787	47,865	43,109	(4,756)	24,307	(10,480)
FINANCE LEASE PAYABLE under 1 year	1,206	1,198	1,202	4	1,254	48
SHORT TERM LOANS	246	246	246	0	274	28
STAFF BENEFITS ACCRUAL	0	0	0	0	0	0
PROVISIONS under 1 year	2,477	1,903	1,780	(123)	2,477	0
TOTAL CURRENT LIABILITIES	**38,716**	**51,212**	**46,337**	**(4,875)**	**28,312**	**(10,404)**
NET CURRENT ASSETS / (LIABILITIES)	**10,036**	**7,614**	**8,335**	**721**	**1,746**	**(8,290)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**198,818**	**196,159**	**199,356**	**3,197**	**197,269**	**(1,549)**
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	8,323	8,130	8,029	(101)	7,069	(1,254)
LOANS over 1 year	763	703	701	(2)	669	(94)
PROVISIONS over 1 year	1,585	1,585	1,585	0	1,585	0
NON CURRENT LIABILITIES	**10,671**	**10,418**	**10,315**	**(103)**	**9,323**	**(1,348)**
TOTAL ASSETS EMPLOYED	**188,147**	**185,741**	**189,041**	**3,300**	**187,946**	**(201)**
FINANCED BY						
PDC CAPITAL	259,588	259,588	259,588	0	259,804	216
REVALUATION RESERVE	42,144	39,313	42,144	2,831	42,144	0
I & E ACCOUNT	(113,585)	(113,160)	(112,691)	469	(114,002)	(417)
FINANCING TOTAL	**188,147**	**185,741**	**189,041**	**3,300**	**187,946**	**(201)**

Key Performance Indicators - Caring

Domain	Metric	Target	Actual in Month Performance	Variation	Assurance
Caring	Complaints responded to within agreed timescales	100%	100%	H	P
Caring	Friends & Family Test % of patients who would recommend: A&E	85%	78%		?
Caring	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	91%	91%		F
Caring	Friends & Family Test % of patients who would recommend: Outpatients	93%	92%		?
Caring	Mixed Sex Accommodation	0	2		?

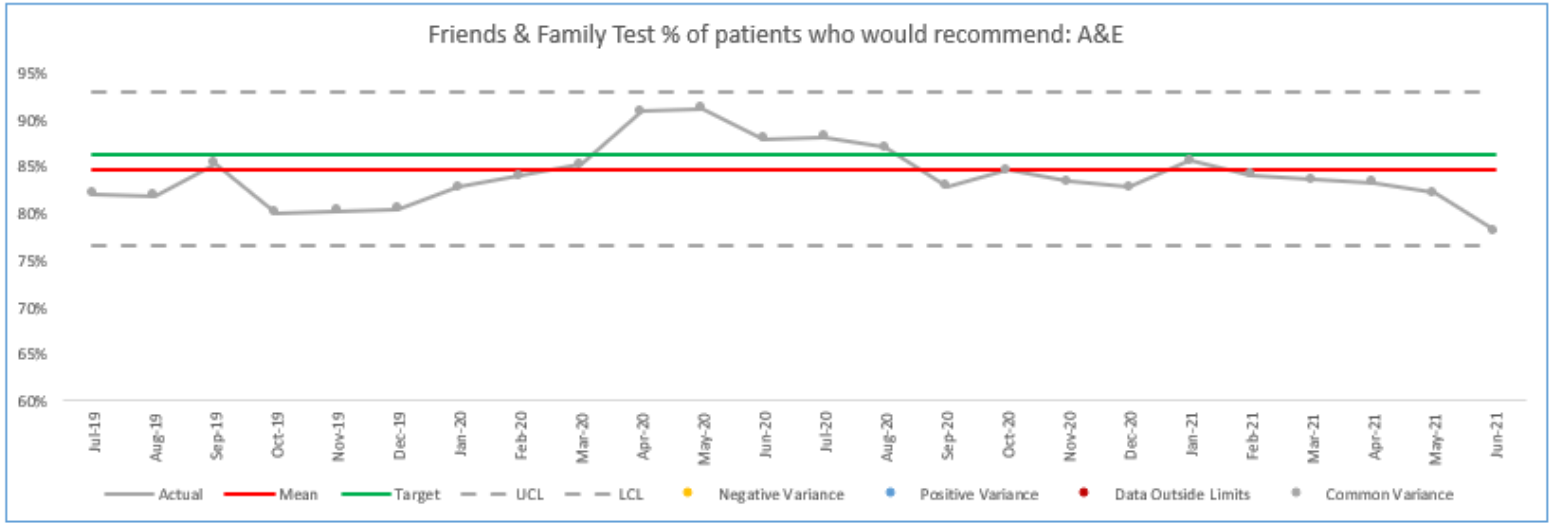
Complaints responded to within agreed timescales



Jun-21
100.0%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance above the mean
Target
90.0%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Complaints performance – Providing a written response to a complaint within an agreed timescale	Metric is Experiencing variable achievement (will achieve target some months and fail others)	There are still a number of complaints ongoing which were allocated a 130 / 60 day timeframe whilst the second wave of the COVID 19 pandemic was ongoing. These complaints are currently being addressed on a priority basis and complainants are being kept informed.	Review and possible recalculation of control limits	All complaints are triaged upon receipt and a decision made as to the most appropriate route through which the complaint should be handled / investigated. Where possible, and in agreement with the complainant, the Complaints team will try to locally resolve some complaints. However, for complaints, which meet the criteria for a potential incident / safeguarding, these are escalated to either Governance or the Trust's Safeguarding team. All such actions are agreed with the complainant from the outset. The complaints timeframe has now returned to the Trust's normal process of agreeing between 20-40 working days with those who raise a complaint formally.

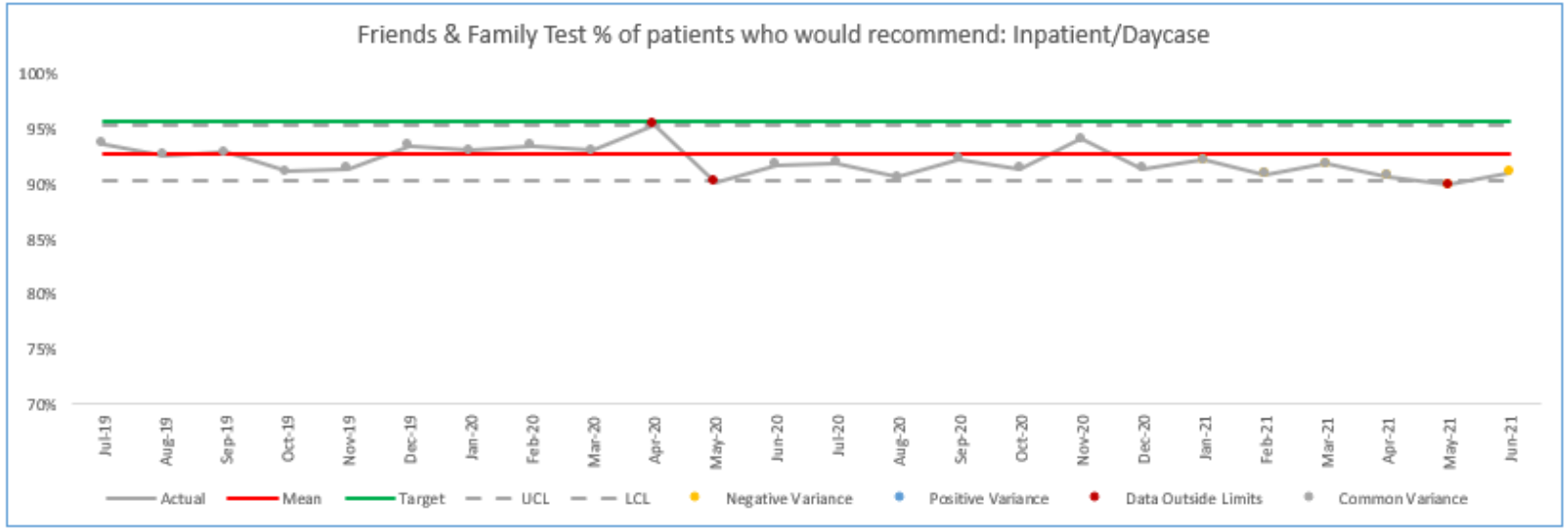
Friends & Family Test % of patients who would recommend: A&E



Jun-21
78.1%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
86.4%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Friends & Family Test % of patients who would recommend: A&E	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Waiting Times in ED Care received Staff and Patient communications	Themed response review specifically to negative scores Closer working with the ED to improve participation	The Friends & Family Test recommenced nationally on the 1st of December 2020 with the change from Recommendation Rates to Satisfaction Scores. New targets have been set locally from April 2021 in line with the new Satisfaction Scores and replacing the recommendation rates.

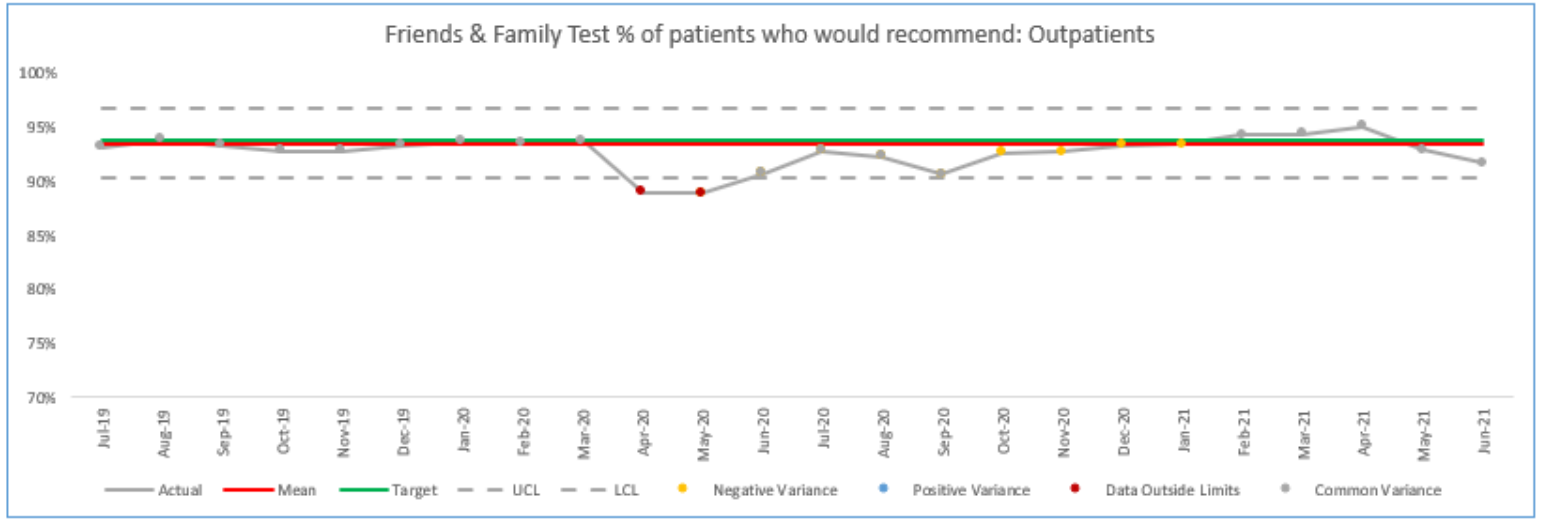
Friends & Family Test % of patients who would recommend: Inpatient/Daycase



Jun-21
91.1%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
95.7%
Target Achievement
Metric is Consistently failing the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Metric is Consistently failing the target	Staff and Patient communications Waiting time for treatment	Themed response review specifically to negative scores Closer working with the Wards and Departments to improve participation	The Divisions have established Patient Experience Groups targeted at improving patient experience. Each Division presented to the Patient & Carer Experience & Engagement Group (PCEEG) to outline the work that they aim to take forward. It is expected that over a period of time this will have a direct impact on the ways in which patients are experiencing our services.

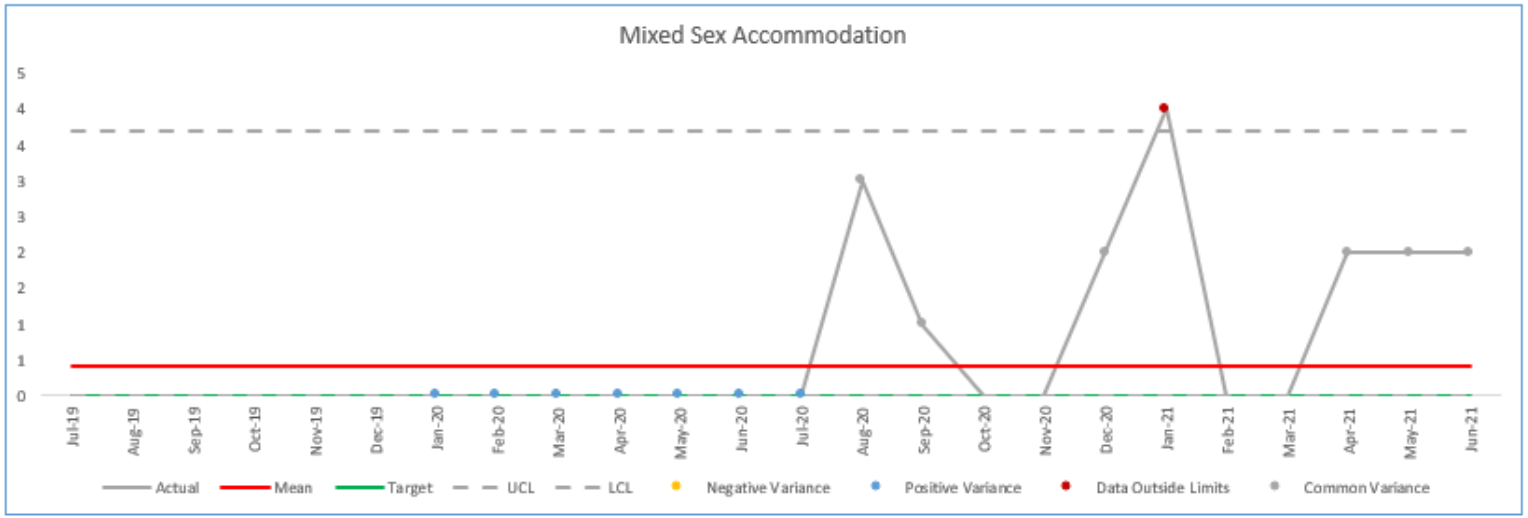
Friends & Family Test % of patients who would recommend: Outpatients



Jun-21
91.6%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93.8%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Friends & Family Test % of patients who would recommend: Outpatients	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Waiting Times in Outpatients Staff and Patient communications	Postcards recommenced collection from June for patients that are not able to use the technology methods that we have introduced. It is expected that this will increase feedback, although it is being encouraged that technological methods should be used where possible. Further posters with QR codes have been established within Gynaecology, Eye Casualty and a number of surgical outpatient departments. These will commence in July.	The Divisions have established Patient Experience Groups targeted at improving patient experience. Each Division presented to the Patient & Carer Experience & Engagement Group (PCEEG) to outline the work that they aim to take forward. It is expected that over a period of time this will have a direct impact on the ways in which patients are experiencing our services.

Mixed Sex Accommodation



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

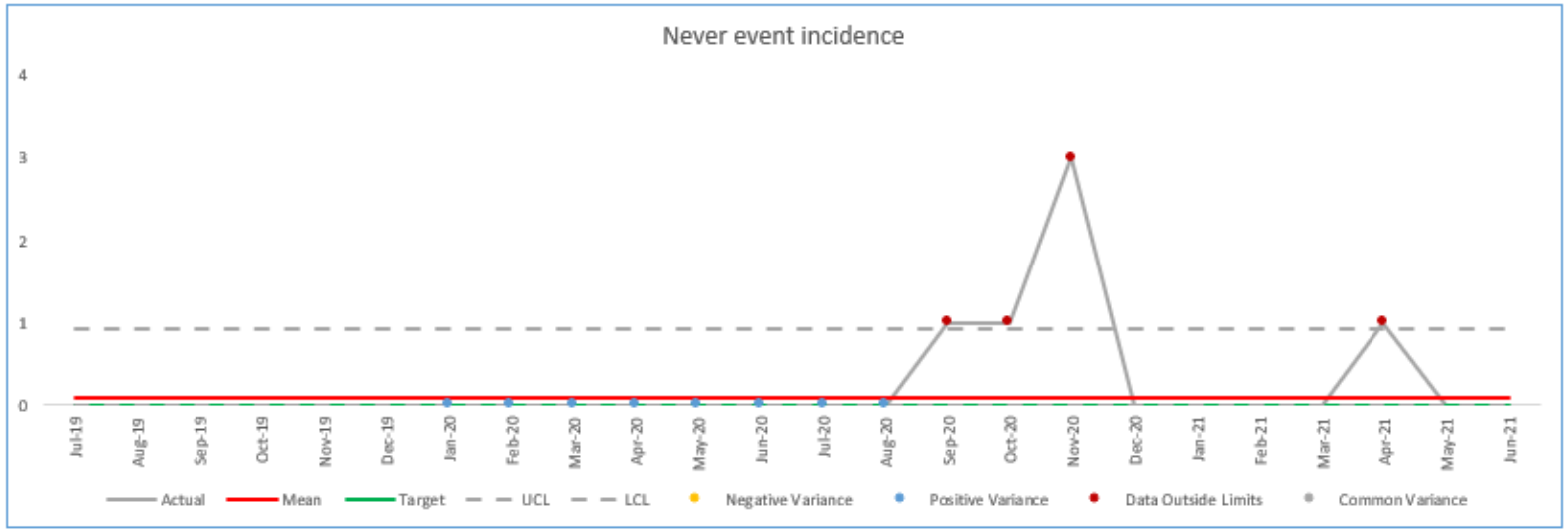
Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Number of Mixed Sex Accommodation	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Activity levels and acuity of patients through COVID	Ongoing investigation through normal process	Reduced number of COVID admissions

Palmer, Kirsty
07/26/2021 10:25:24

Key Performance Indicators - Safe

Domain	Metric	Target	Actual in Month Performance	Variation	Assurance
Safe	Never event incidence	0	0		
Safe	Number of Serious Incidents (SI's) declared during the period	0	8		
Safe	MRSA > 2 Days	0	0		
Safe	HOHA and COHA (C-Diff > 2 Days)	3	2		
Safe	MSSA > 2 Days	1	1		
Safe	VTE Risk Assessment	95%	92%		
Safe	Harmful Falls per 1000 occupied bed days (Exc. Maternity and Paeds)	0.140	0.063		
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Metric Under Review			
Safe	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Metric Under Review			
Safe	Fire Drill Compliance	85%	100%	H	P
Safe	Fire Evacuation Plan	85%	100%	H	P

Never event incidence



Jun-21
0
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)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Never event incidence	Metric is Experiencing variable achievement (will achieve target some months and fail others)	There are no issues highlighted	Continued monitoring of Datix	New patient safety strategy KPIs and dashboard data are not to be used as a performance indicator regarding clinical incidents (roll out April 22)

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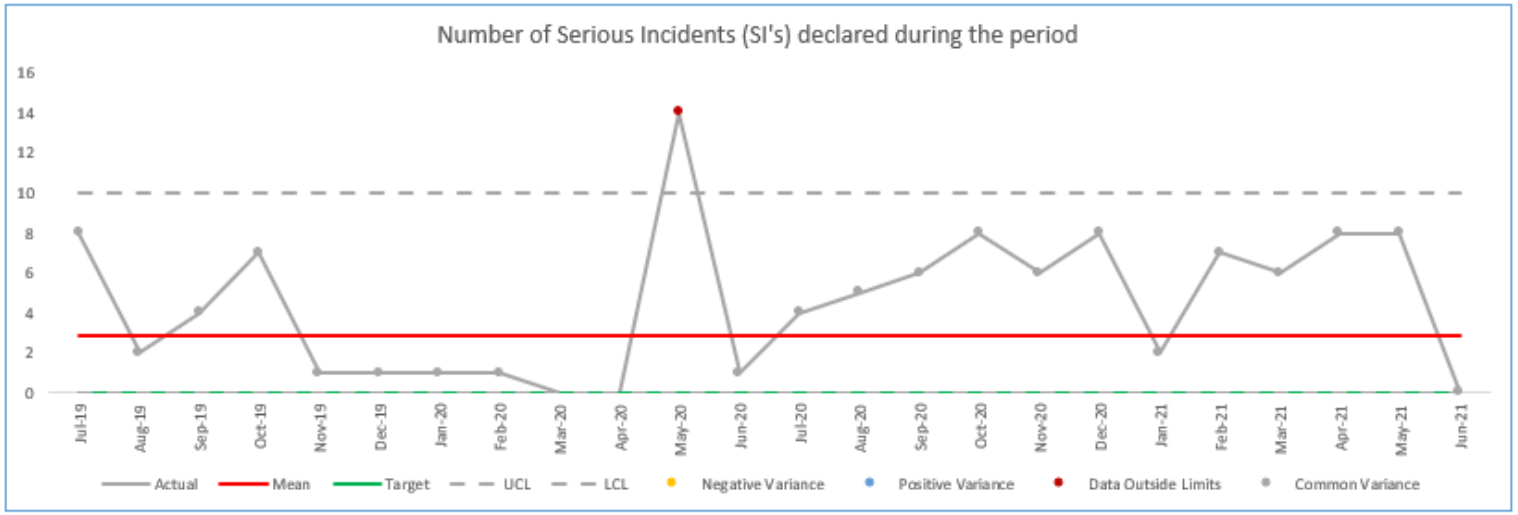
07/26/2021 10:25:24

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



Jun-21
0
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)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Number of Serious Incidents (SI's) declared during the period	Metric is Experiencing variable achievement (will achieve target some months and fail others)	None reported	Continued monitoring of Datix	New patient safety strategy KPIs and dashboard data are not to be used as a performance indicator regarding clinical incidents (roll out April 22)

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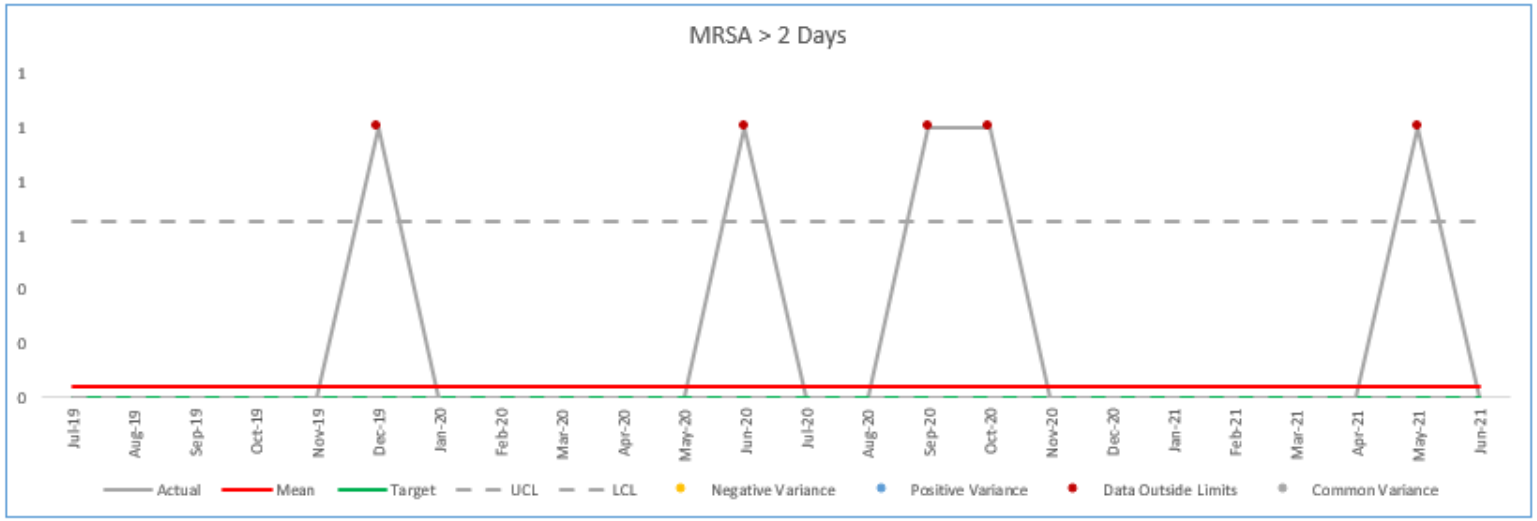
MRSA > 2 Days



Jun-21
0
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)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
MRSA > 2 Days	Metric is Experiencing variable achievement (will achieve target some months and fail others)	No lapse in care Ongoing infection	All instances are investigated through normal routes	Trust wide policy Mandatory training IPSG - Monitoring IPC governance

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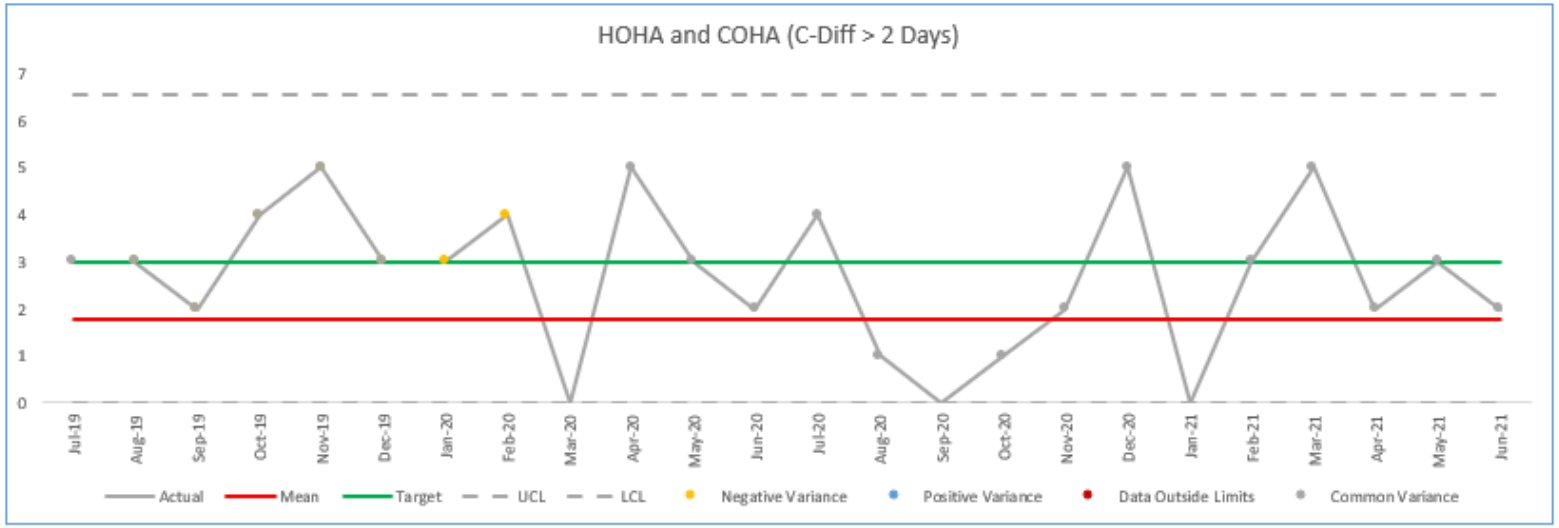
HOHA and COHA (C-Diff > 2 Days)



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

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Reduce the number of attributed Clostridium against CCG ceiling based on 2019-20 ceiling as no ceiling set for 2020-21.	Metric is Experiencing variable achievement (will achieve target some months and fail others)	No lapse in care Treatment through antibiotics	All instances are investigated through normal routes	Trust wide policy Mandatory training IPSG - Monitoring IPC governance

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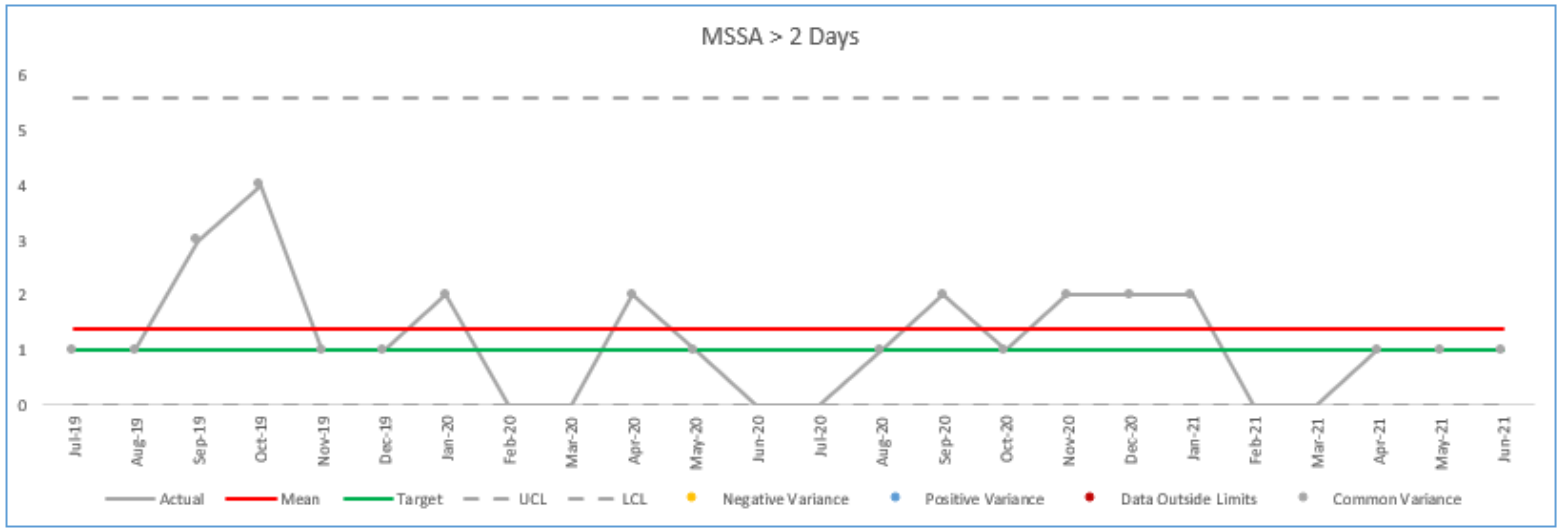
MSSA > 2 Days



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

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
MSSA > 2 Days	Metric is Experiencing variable achievement (will achieve target some months and fail others)	30% of hospital patients have MSSA on their skin. These are mostly endogenous	All instances are investigated through normal routes MRSA Policty updated - all patients to go on octenisan body wash	Trust wide policy Mandatory training IPSG - Monitoring IPC governance

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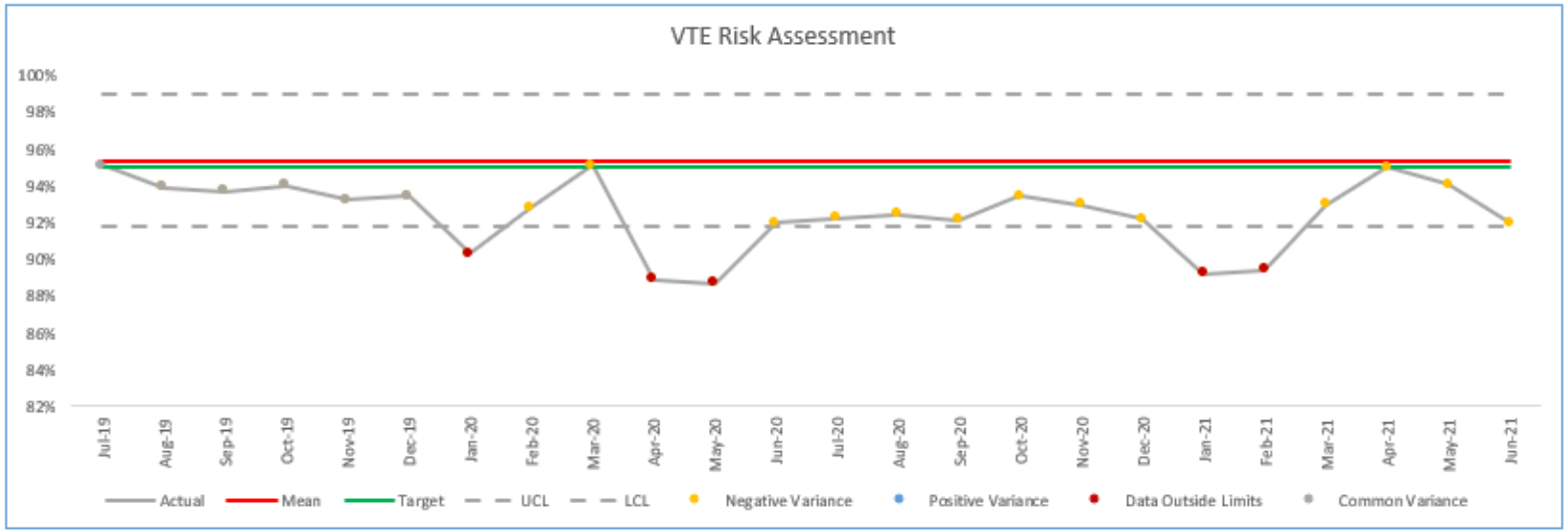
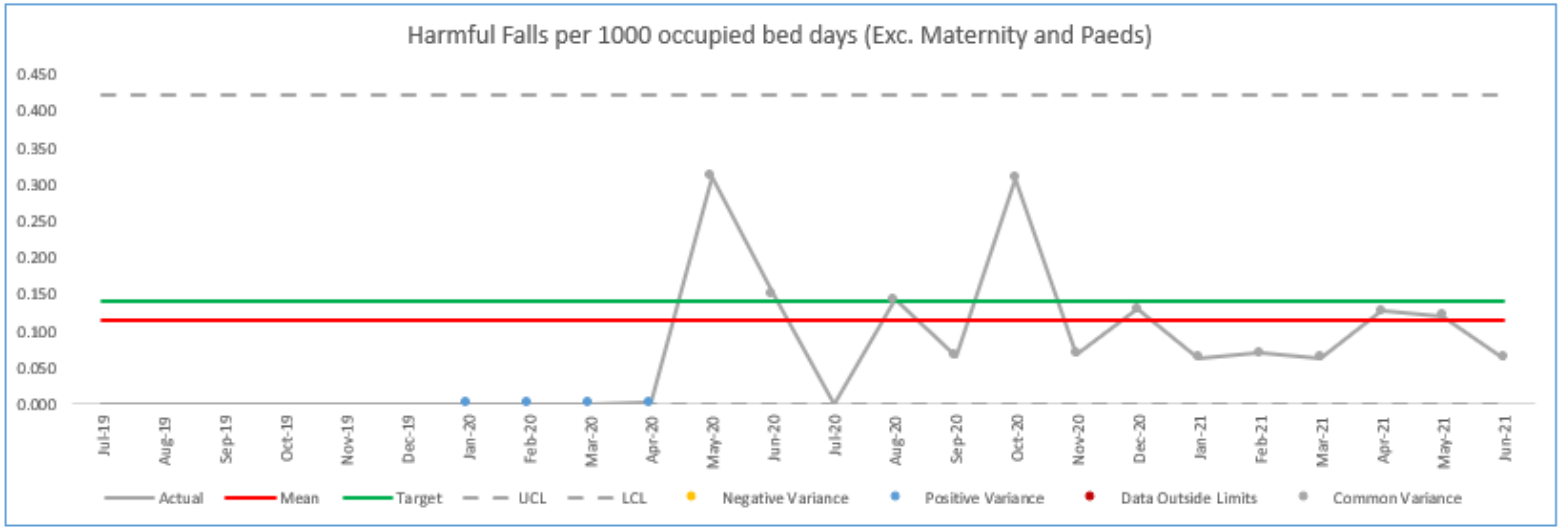
VTE Risk Assessment



Jun-21
92%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
95%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
VTE Risk Assessment	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Accuity of patients through the Covid pandemic	Incorporate assessment review into the board round checklist, and in the longer term to mandate assessment through ePMA	Trust wide policy Mandatory training

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



Jun-21
0.06
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.14
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Patients experiencing falls with moderate harm or above.	Metric is Experiencing variable achievement (will achieve target some months and fail others)	There were two inpatient falls in month, 1 moderate and 1 severe	Ongoing investigation through normal process	Trust wide policy Mandatory training Falls MDT (monthly)

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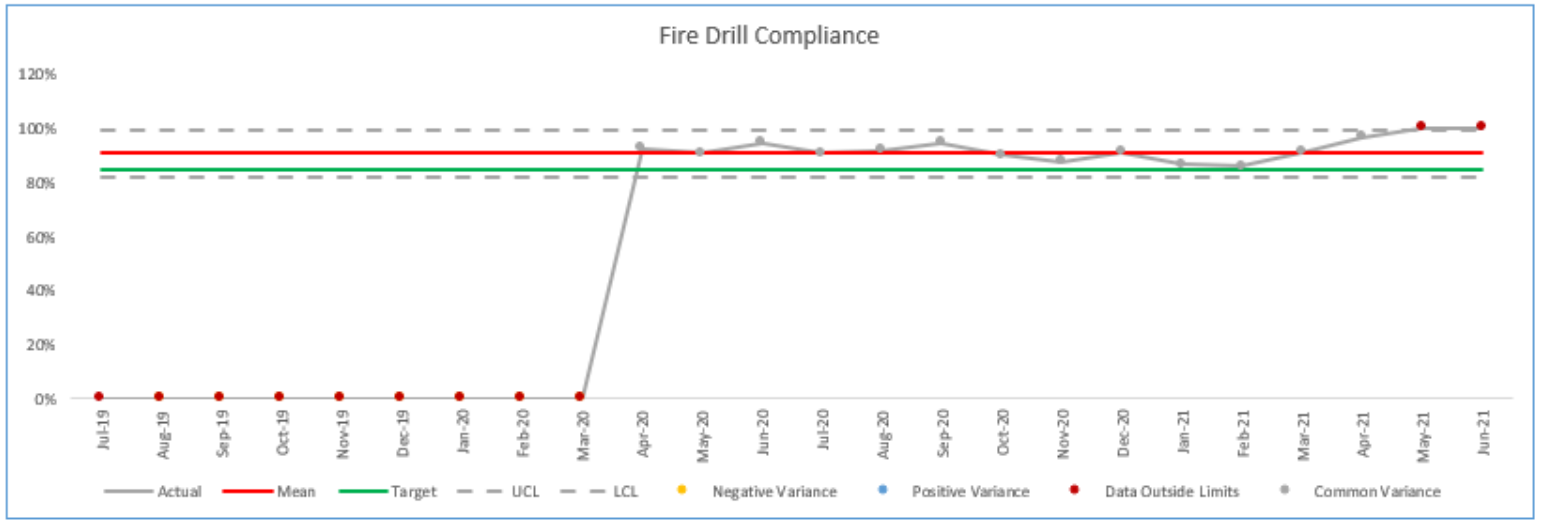
Fire Drill Compliance



Jun-21
100%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
85%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Fire Drill Compliance	Metric is Experiencing variable achievement (will achieve target some months and fail others)	None reported	No further actions required at this point	The metric is delivering above the target

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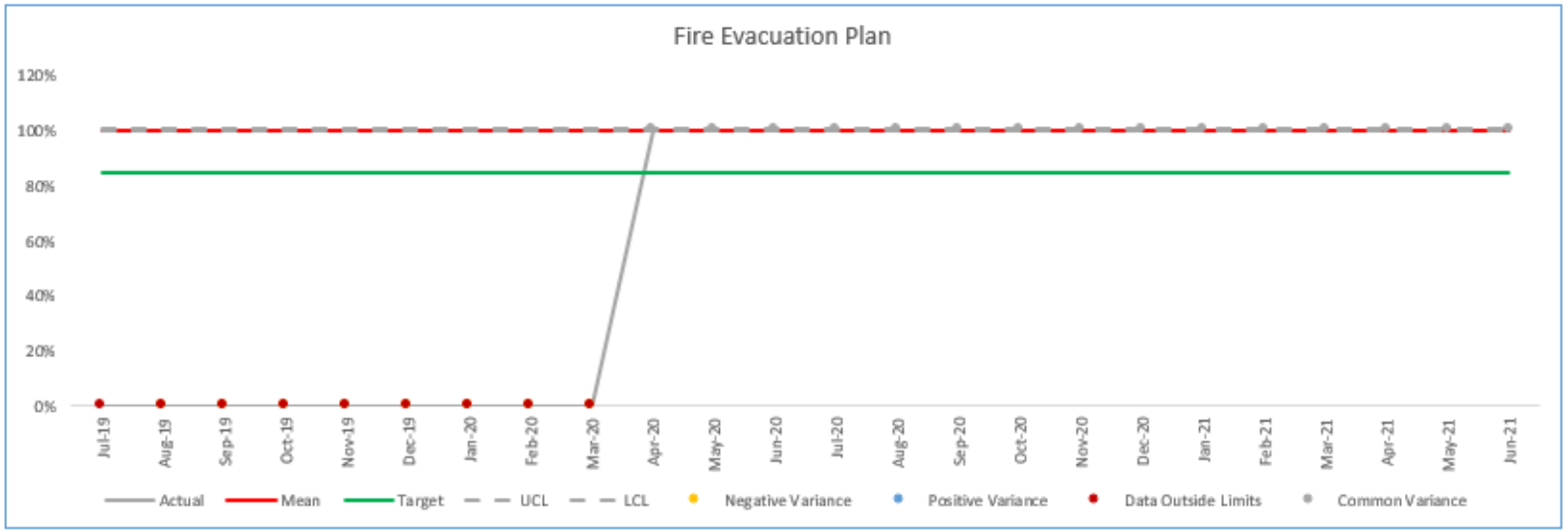
Fire Evacuation Plan



Jun-21
100%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is Consistently achieving the target

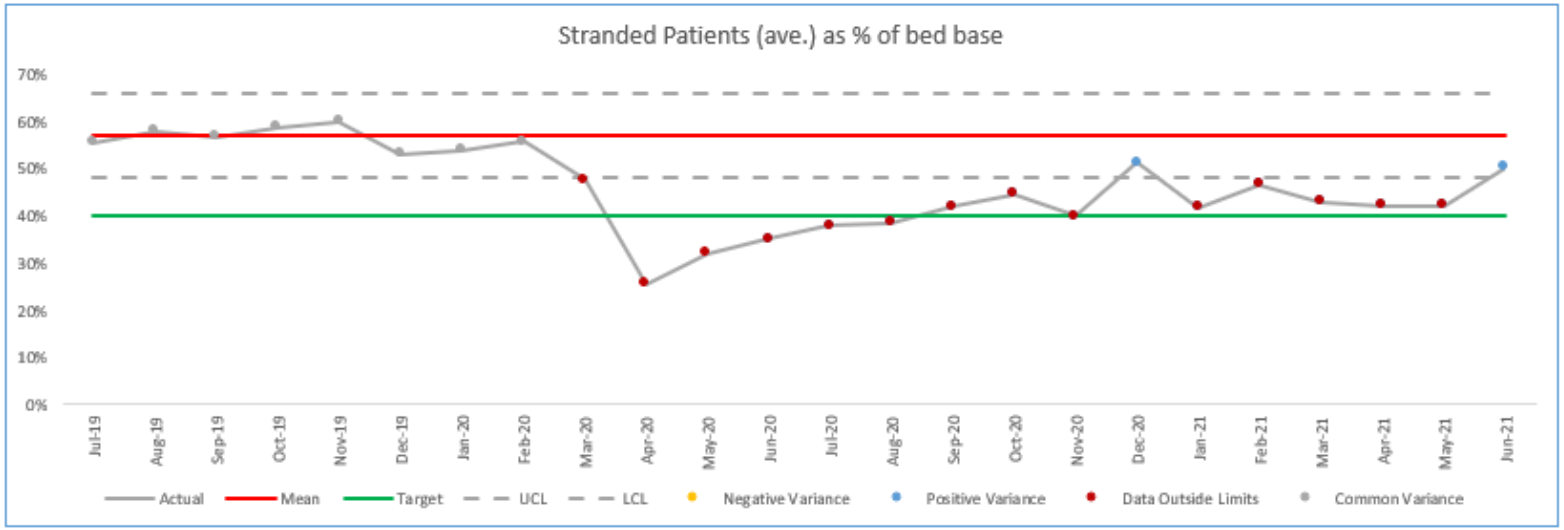
Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Fire Evacuation Plan	Metric is Consistently achieving the target	None reported	No further actions required at this point	The metric is consistently delivering at 100%

Palmer, Kirsty
07/26/2021 10:25:24

Key Performance Indicators - Effective

Domain	Metric	Target	Actual in Month Performance	Variation	Assurance
Effective	Stranded Patients (ave.) as % of bed base	40%	50%		
Effective	Super Stranded Long Stay Patients (ave.) as % of bed base	25%	17%		
Effective	Length of stay - All	4.2	3.5		
Effective	Readmissions within 30 days of previous reporting month	Metric Under Review			
Effective	Percentage of discharges before midday	25%	17%		
Effective	% Daycase Rate	80%	85%		
Effective	Failed Daycases as a % of Planned Daycases	Metric Under Review			
Effective	Mortality: SHMI	100	99		
Effective	Unappointed Follow Ups	0	36,178	Insufficient Data Points	

Stranded Patients (ave.) as % of bed base



Jun-21
50%
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

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Percentage of patients with a LoS > 7 days	Metric is Consistently failing the target	Number of acutely unwell patients who have stayed longer than 7 days Internal discharge processes and delays	Discharge bronze with all wards to focus on all patients with no reason to reside commenced in March Internal discharge & flow transformation programme was launched in April Taskforce approach to review all patients >7days Intensive support for ward board round processes now in place	Daily meeting with system partners

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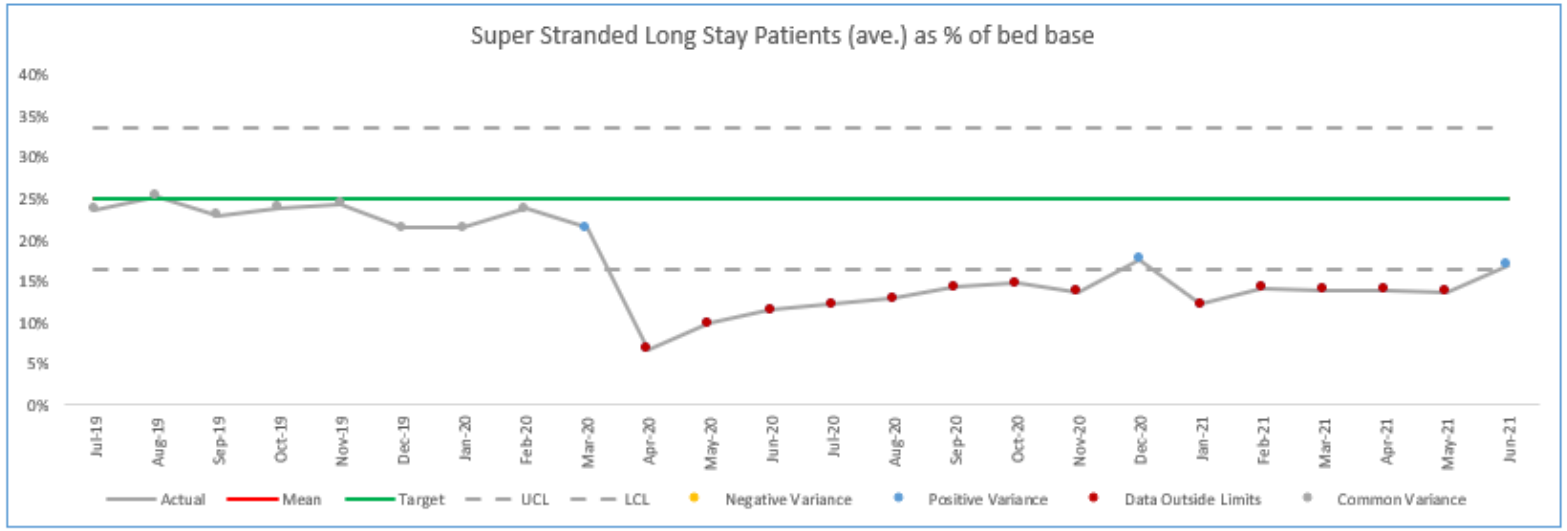
Super Stranded Long Stay Patients (ave.) as % of bed base



Jun-21
17%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance below the mean
Target
25%
Target Achievement
Metric is Consistently achieving the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Percentage of patients with a LOS> 21 days	Metric is Consistently achieving the target	Number of acutely unwell patients who have stayed longer than 21 days Internal discharge processes and delays	Discharge bronze with all wards to focus on all patients with no reason to reside commenced in March Internal discharge & flow transformation programme was launched in April Taskforce approach to review all patients >7days Intensive support for ward board round processes now in place	Daily meeting with system partners

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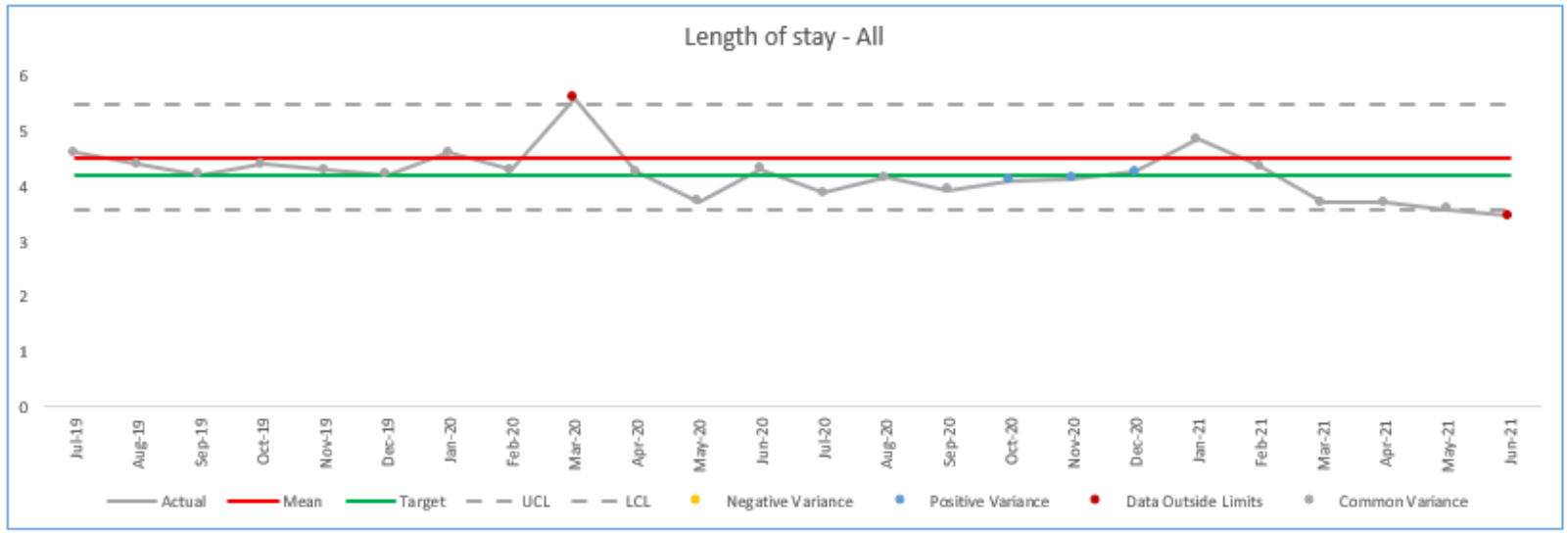
Length of stay - All



Jun-21
3.46
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
4.20
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Length of stay - All	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Internal discharge processes and delays	Discharge bronze with all wards to focus on all patients with no reason to reside commenced in March Internal discharge & flow transformation programme was launched in April Taskforce approach to review all patients >7days Intensive support for ward board round processes now in place	Internal discharge & flow transformation programme

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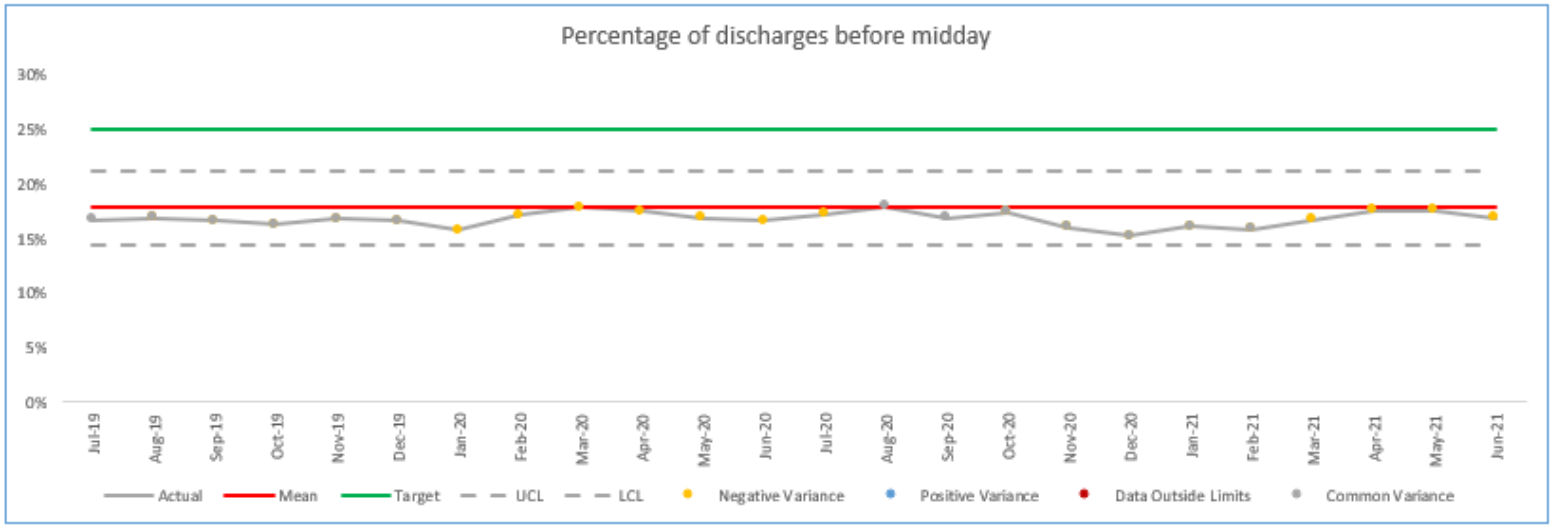
Percentage of discharges before midday



Jun-21
17%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
25%
Target Achievement
Metric is Consistently failing the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Percentage of discharges before midday	Metric is Consistently failing the target	Internal discharge processes and delays	Continued work through the iCAN programme Discharge & Flow programme supporting the team to fully implement the national discharge policy	Internal discharge and flow transformation programme

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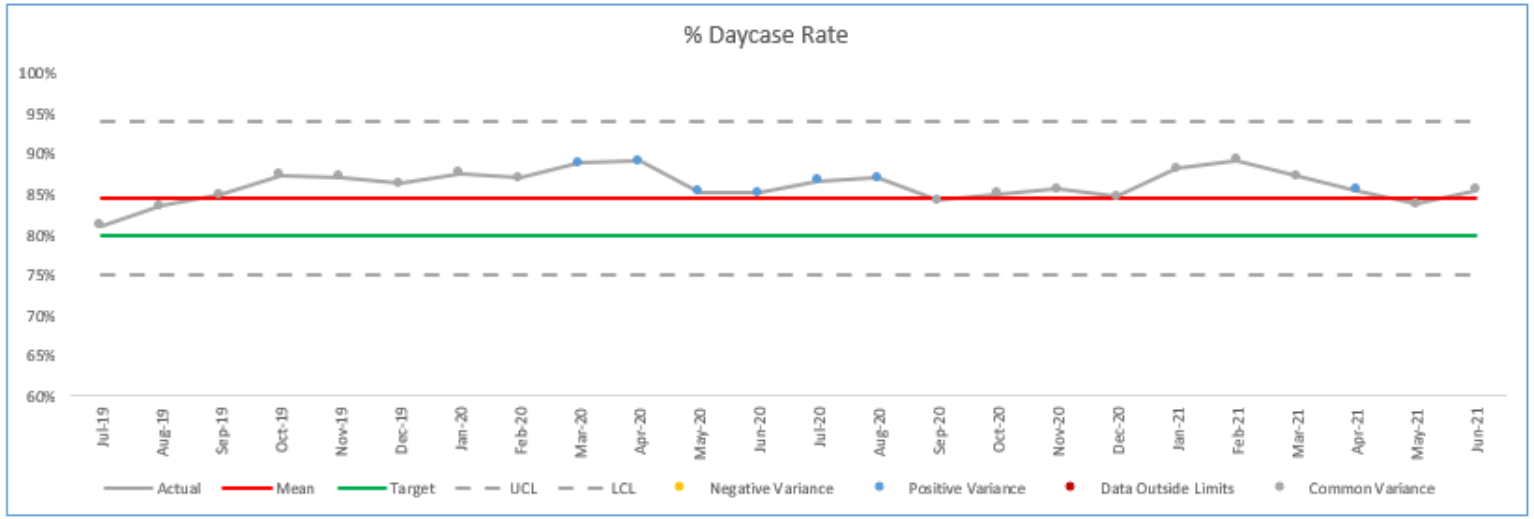
% Daycase Rate



Jun-21
85%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
80%
Target Achievement
Metric is Consistently achieving the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Daycases as percentage of all Elective activity	Metric is Consistently achieving the target	None raised	Additional theatre capacity came on line in mid-June when endoscopy relocated to their original unit	The metric is delivering above target and is now an assured system

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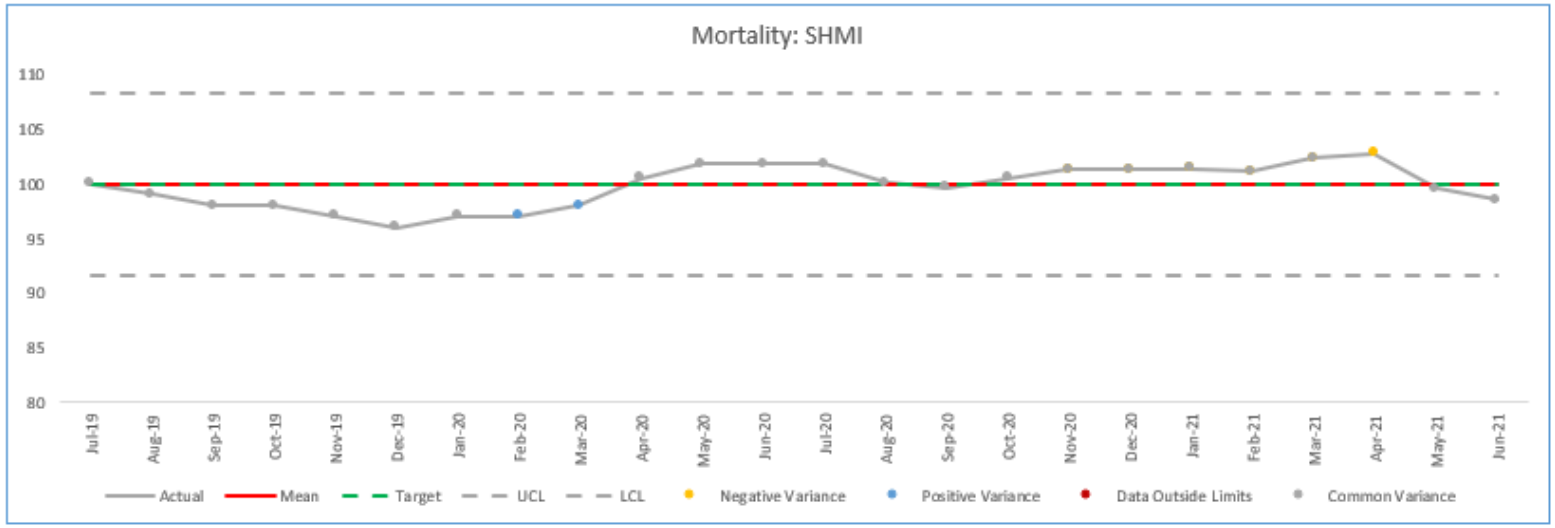
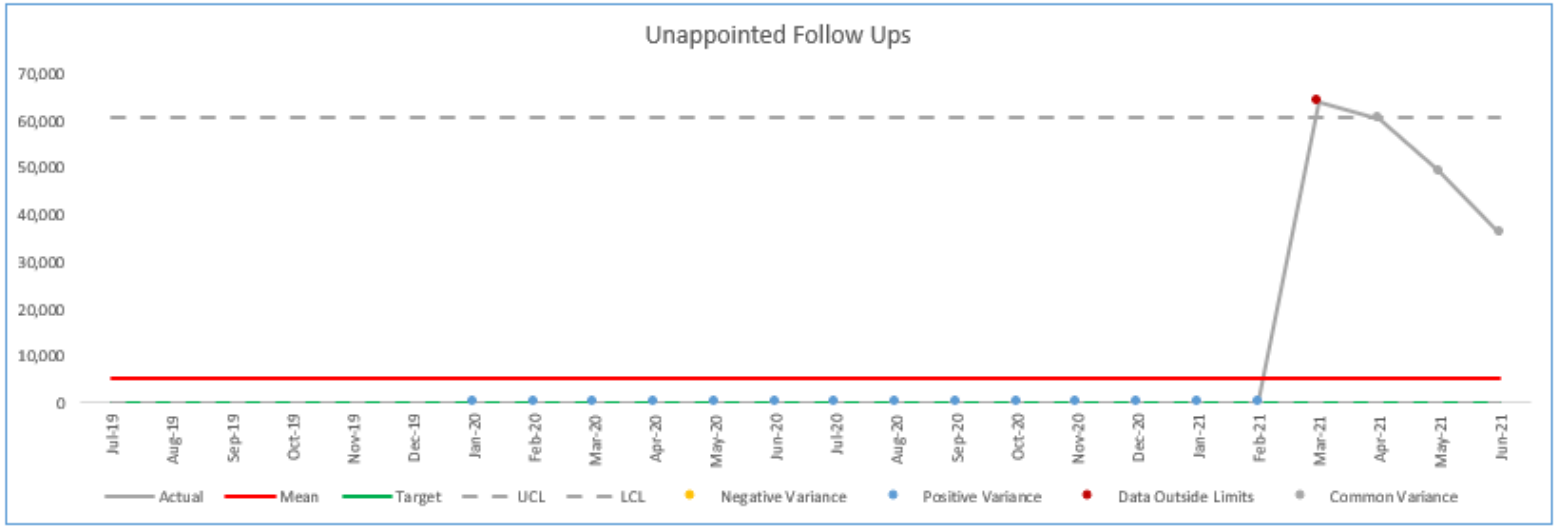
Mortality: SHMI



Jun-21
99
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Mortality: SHMI	Metric is Experiencing variable achievement (will achieve target some months and fail others)	There are no new exceptions reported	Trustwide review 13 –mortality casenote review of December 2019 inpatient deaths –completed & learning shared trustwide Mortality workstreams –these are ongoing and report to the Learning From Deaths Group, chaired by the Medical Director	SHMI -this is reported by NHS digital with 5 months in arrears i.e June reported reflects 12 months to Jan 21 Ongoing monitoring and management through the Trust mortality group and CQEG

Unappointed Follow Ups



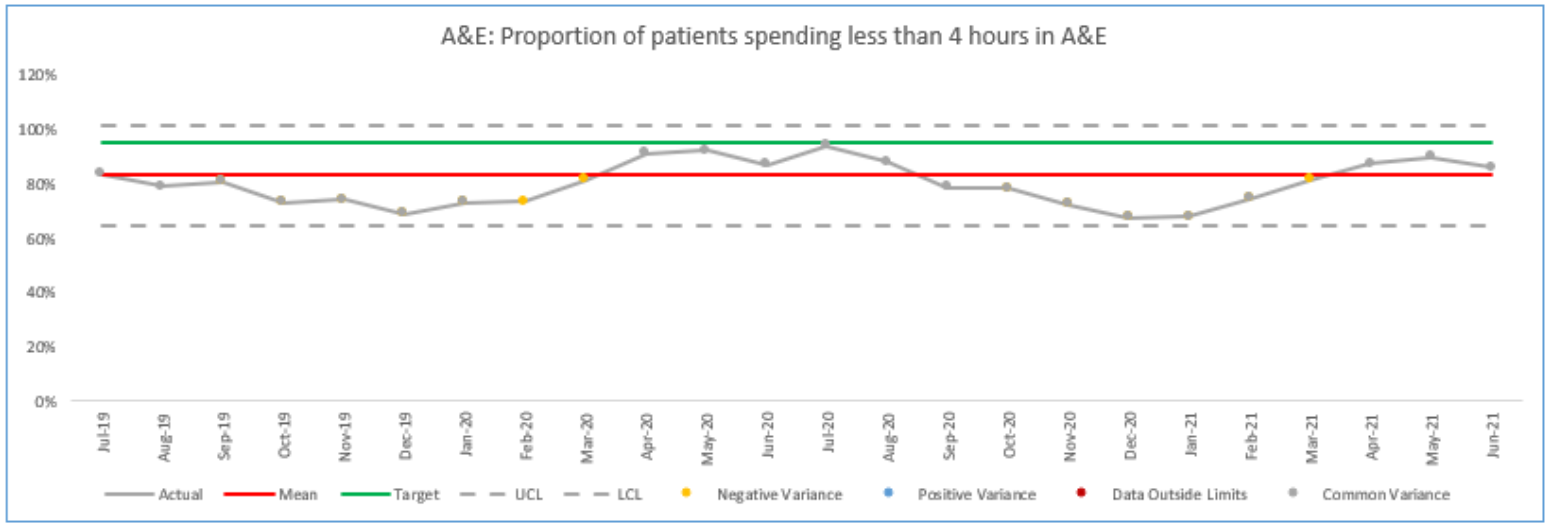
Jun-21
36,178
Variance Type
Insufficient Data points to produce SPC (15 points required)
Target
0
Target Achievement
Insufficient Data points to produce SPC (15 points required)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Unappointed Appointments	Insufficient Data points to produce SPC (15 points required)	There remains a significant amount of historical referrals that require admin validation	Daily monitoring and management of unappointed referrals Weekly agenda Item at the Trust Access Committee. Trust wide task anf finsh group in place	Full validation of all patient pathways affected, 35000 episodes have now been closed off (55%) Only 5% of patients needing an appointment. No harm identified

Key Performance Indicators - Responsive

Domain	Metric	Target	Actual in Month Performance	Variation	Assurance
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	95%	86%	L	F
Responsive	Ambulance handovers that waited over 30 mins and less than 60 mins	25	59	H	F
Responsive	Ambulance handovers that waited over 60 mins	10	3	H	F
Responsive	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	0	H	F
Responsive	Cancer: Faster Diagnosis Standard	75%	84%		P
Responsive	Cancer: Number of Legacy Patients	0	47		?
Responsive	Cancer: Percentage of patients treated within 31 days	96%	98%		?
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%	96%		?
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%	99%		?
Responsive	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	91%		?
Responsive	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	85%	83%		?
Responsive	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	75%	L	F
Responsive	RTT Median wait incomplete pathways	10.9	8.5		P
Responsive	RTT over 52 weeks	0	218	H	F
Responsive	RTT over 45 weeks	0	366	H	F
Responsive	RTT over 40 weeks	0	579	H	F
Responsive	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	99%	84%	L	F
Responsive	Stroke patients spending at least 90% of their time on the stroke unit	80%	81%	L	F

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



Jun-21
86%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
A&E: Proportion of patients spending less than 4 hours in A&E	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Challenge of flow through ED out of hours Volume of attendances	Continuation of pathways to stream patients to alternative services including SDEC and Springfield Continuation of fit2sit for all appropriate patients Paramedic pathways into SDEC ED Doctor rota has been realigned to map to times of high inflow Springfield opening hours have been extended	Reverse corridor boarding to support flow when required SDEC inreach into ED to support

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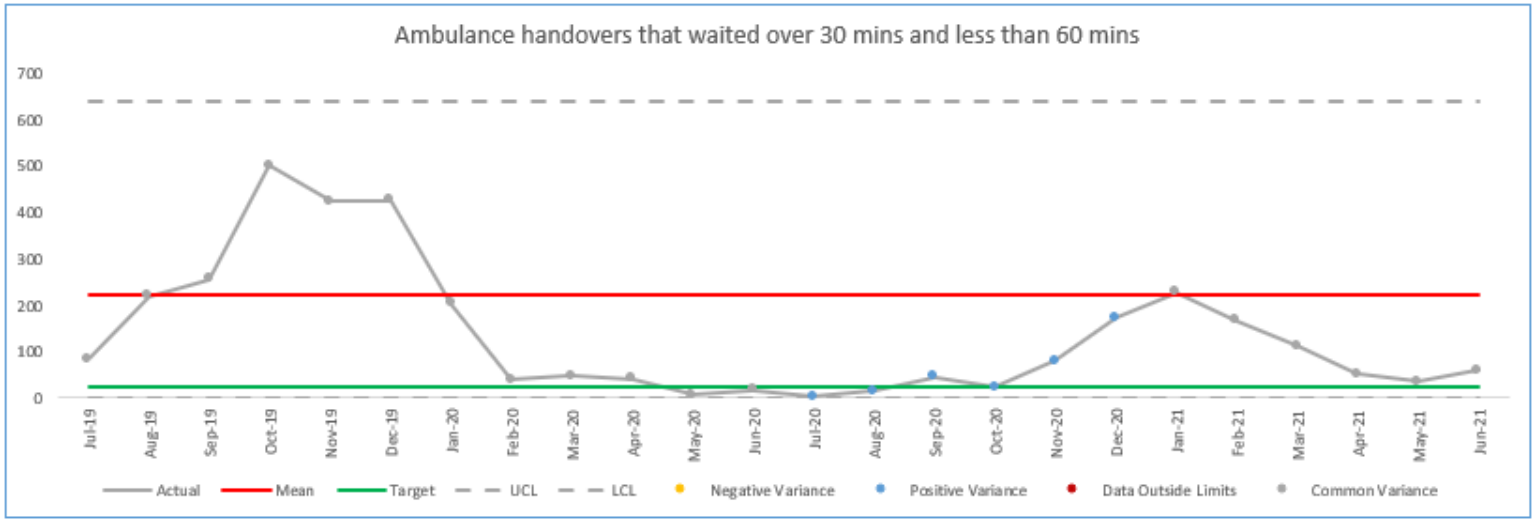
Ambulance handovers that waited over 30 mins and less than 60 mins



Jun-21
59
Variance Type
Metric is currently experiencing Common Cause Variation
Target
25
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Total number of Ambulance Handovers that exceed a wait of 30+ minutes within A&E	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Inflow of ambulances and outflow at peak times	Ambulance streaming on arrival and direct access to SDEC Revised processes to improve internal ED flow Missed opportunities audit completed by ECIST	Escalation SOP and protocols in place

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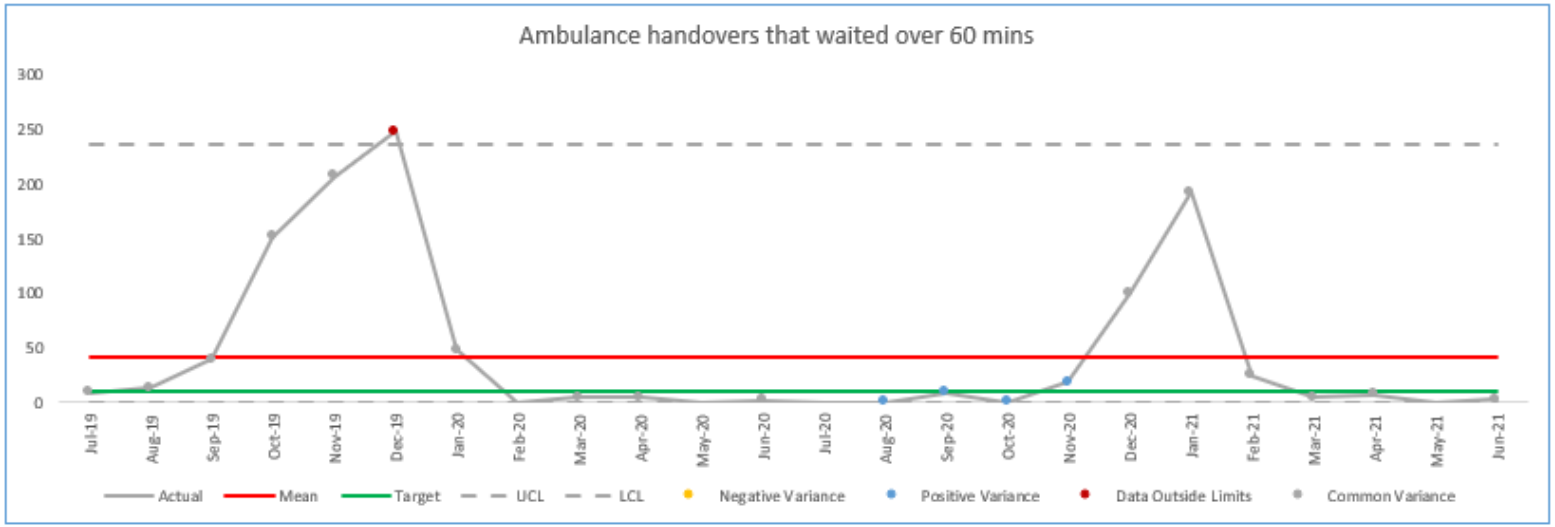
Ambulance handovers that waited over 60 mins



Jun-21
3
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Total number of Ambulance Handovers that exceed a wait of 60+ minutes within A&E	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Inflow of ambulances and outflow at peak times	Ambulance streaming on arrival and direct access to SDEC Revised processes to improve internal ED flow Missed opportunities audit completed by ECIST	Escalation SOP and protocols in place

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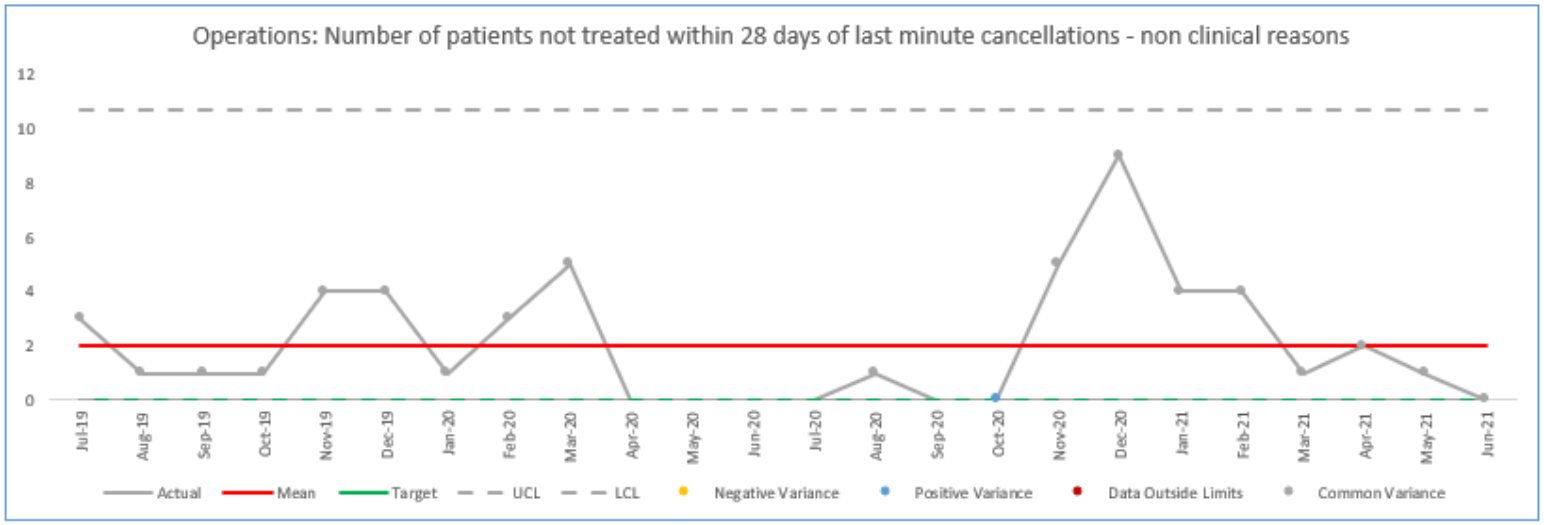
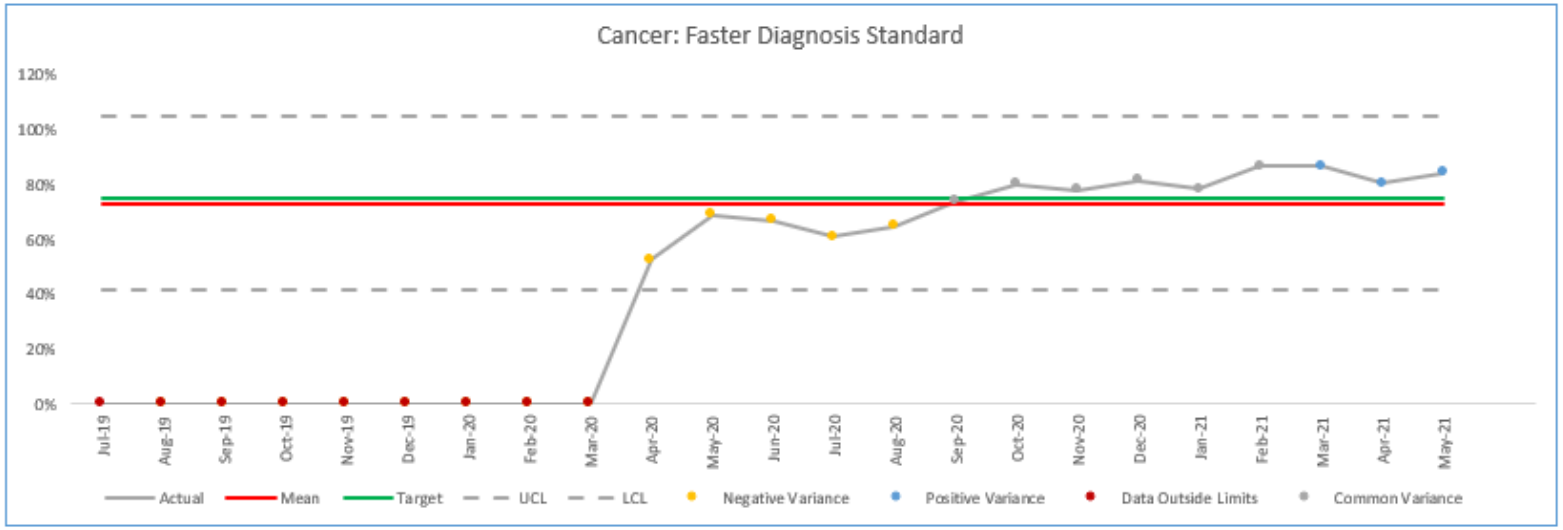
Operations: Number of patients not treated within 28 days of last minute cancellations -



Jun-21
0
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)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Escalation policy requires review and RCA paperwork to be re-issued	SOP review	Revised reporting to be developed in conjunction with the Trust Access Board and Informatics

Cancer: Faster Diagnosis Standard



May-21
84%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance above the mean
Target
75%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Cancer: Faster Diagnosis Standard	Metric is Experiencing variable achievement (will achieve target some months and fail others)	The Trust continues to meet and exceed the 28 Faster Diagnosis Standard reaching 84% against the 75% standard.	H1 Trajectories developed and monitored through Weekly Access Board, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

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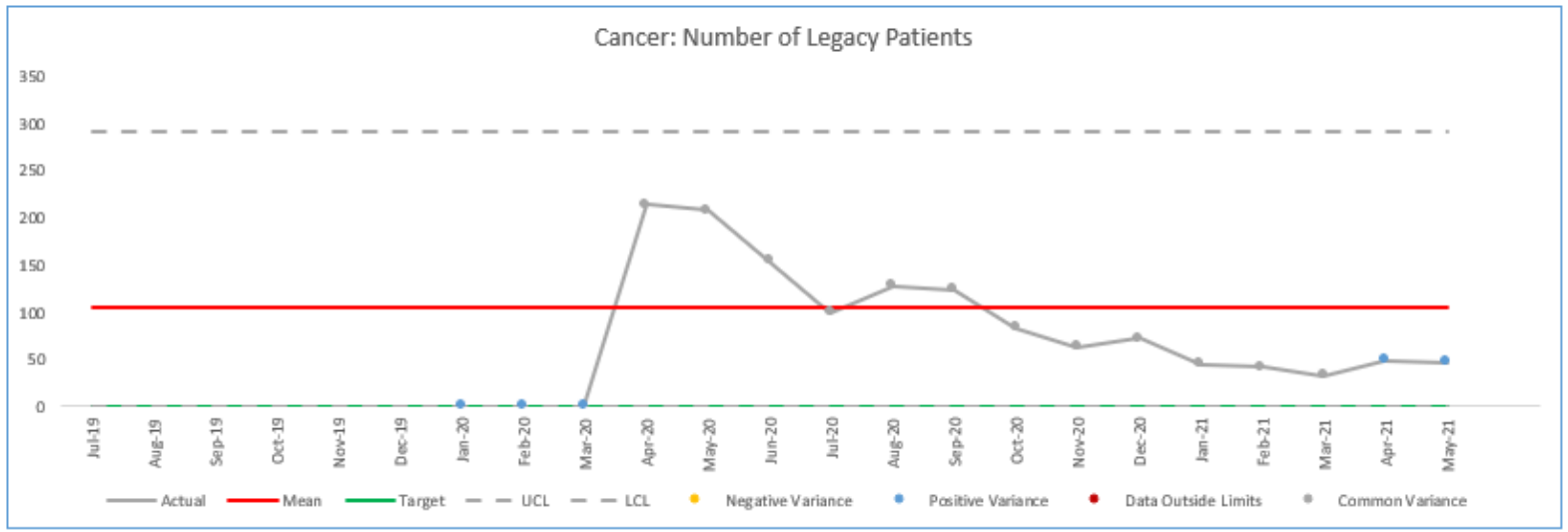
Cancer: Number of Legacy Patients

Chart Area



May-21
47
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance below the mean
Target
0
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Cancer: Number of Legacy Patients	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Management of backlog and legacy patients Complexity of patient pathways	Daily updates & tracking Weekly Access Board now in place which will hold divisional management teams to account Tertiary provider issues escalated via Deputy Medical Director and COO	Weekly PTL - monitoring in place, issues escalated to COO as required

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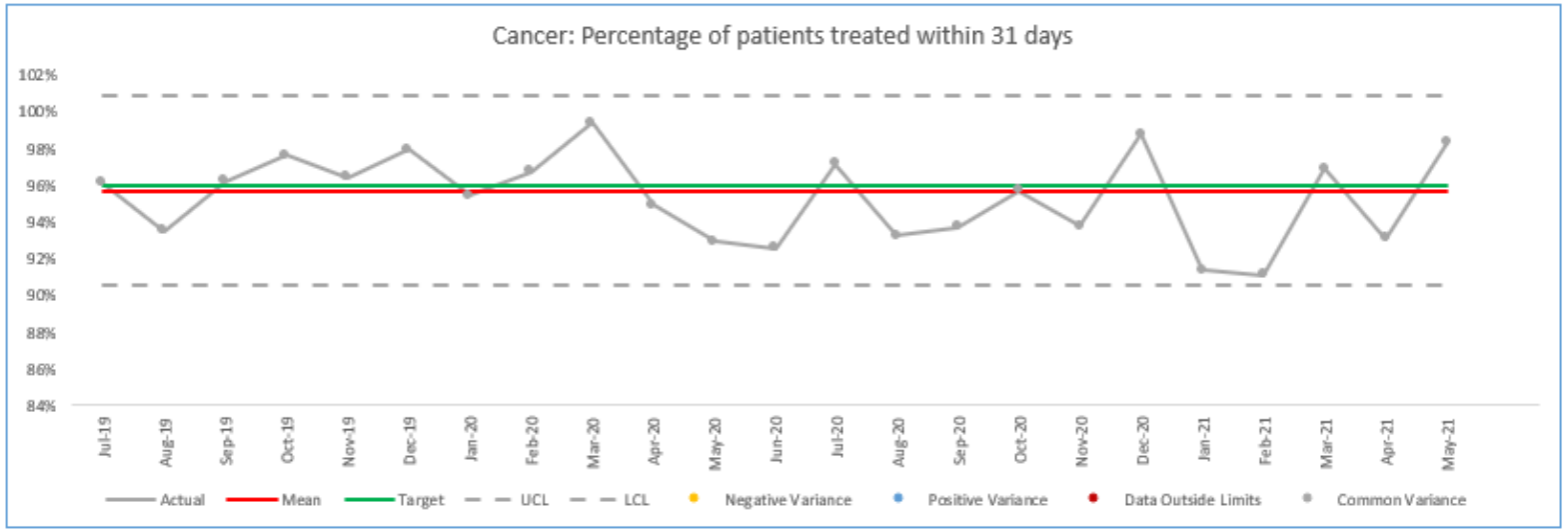
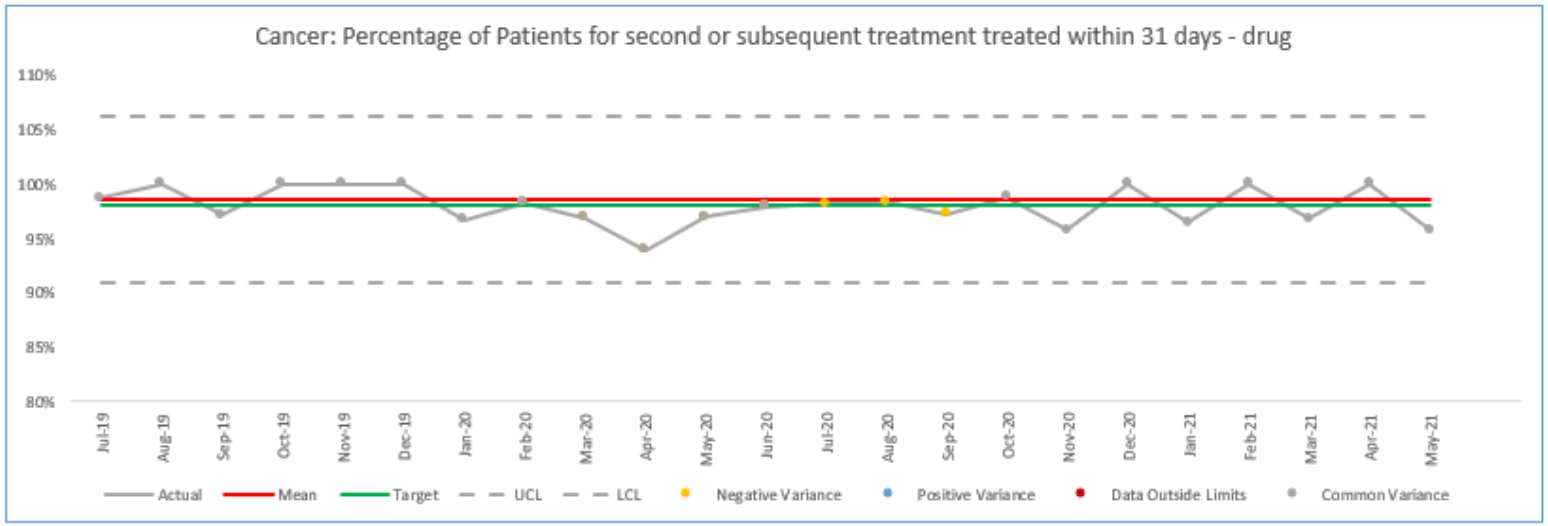
Cancer: Percentage of patients treated within 31 days



May-21
98%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Patients should experience a maximum wait of one month (31 days) between receiving their diagnosis and the start of first definitive treatment, for all cancers. This is measured from the point at which the patient is informed of a diagnosis of cancer and agrees their package of care. The operational standard for this measure is 96%	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Surgical capacity	H1 Trajectories developed and monitored through Weekly Access Board, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

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



May-21
96%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
98%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Patients should experience a maximum wait of 31 days for a second or subsequent treatment. Where that treatment is an anti-cancer drug regimen, the operational standard is 98%.	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Surgical capacity	H1 Trajectories developed and monitored through Weekly Access Board, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

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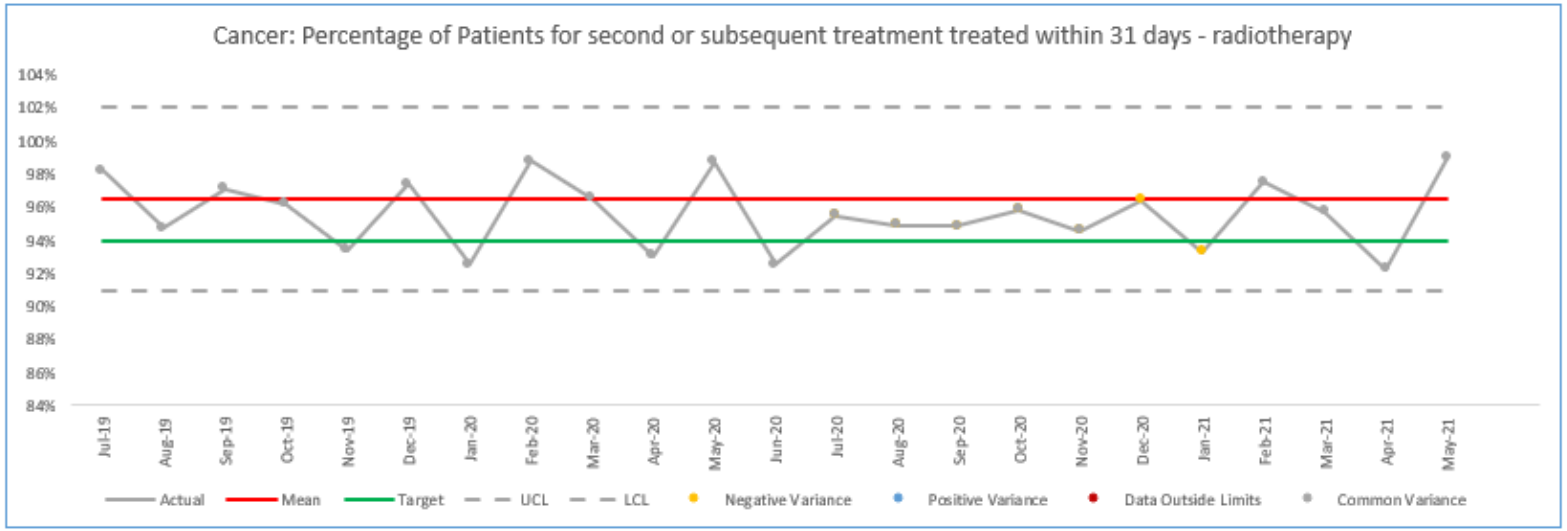
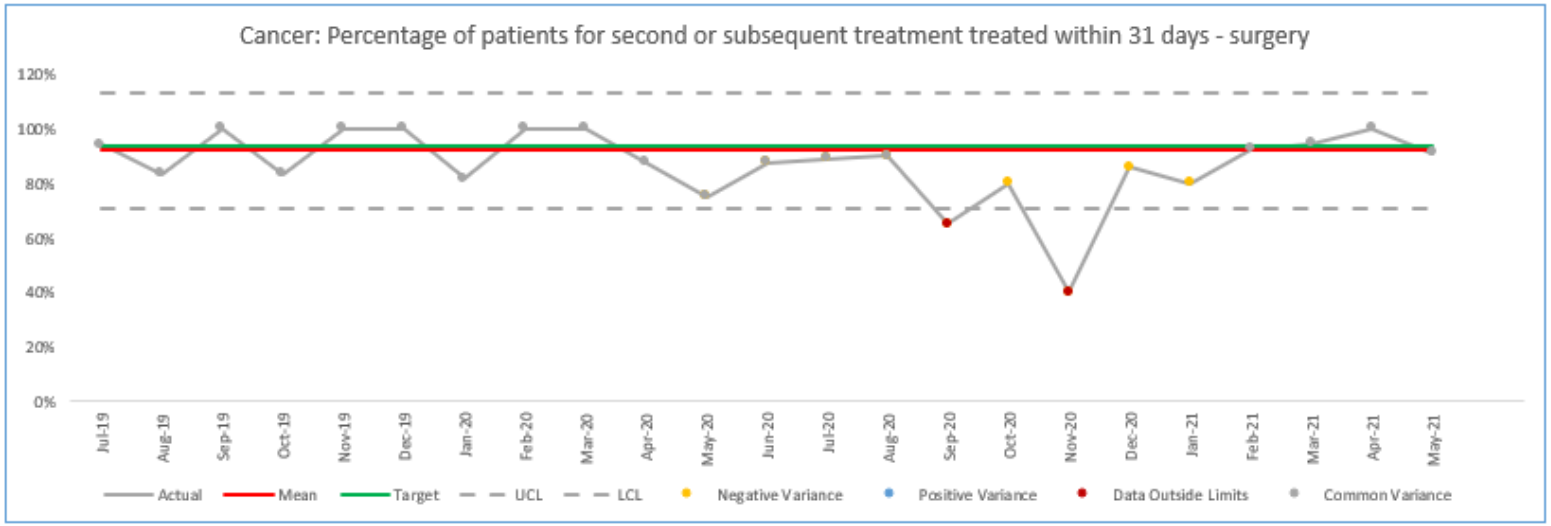
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy



May-21
99%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Patients should experience a maximum wait of 31 days for a second or subsequent treatment if that treatment is a course of radiotherapy. The operational standard for this requirement is 94%.	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Surgical capacity	H1 Trajectories developed and monitored through Weekly Access Board, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

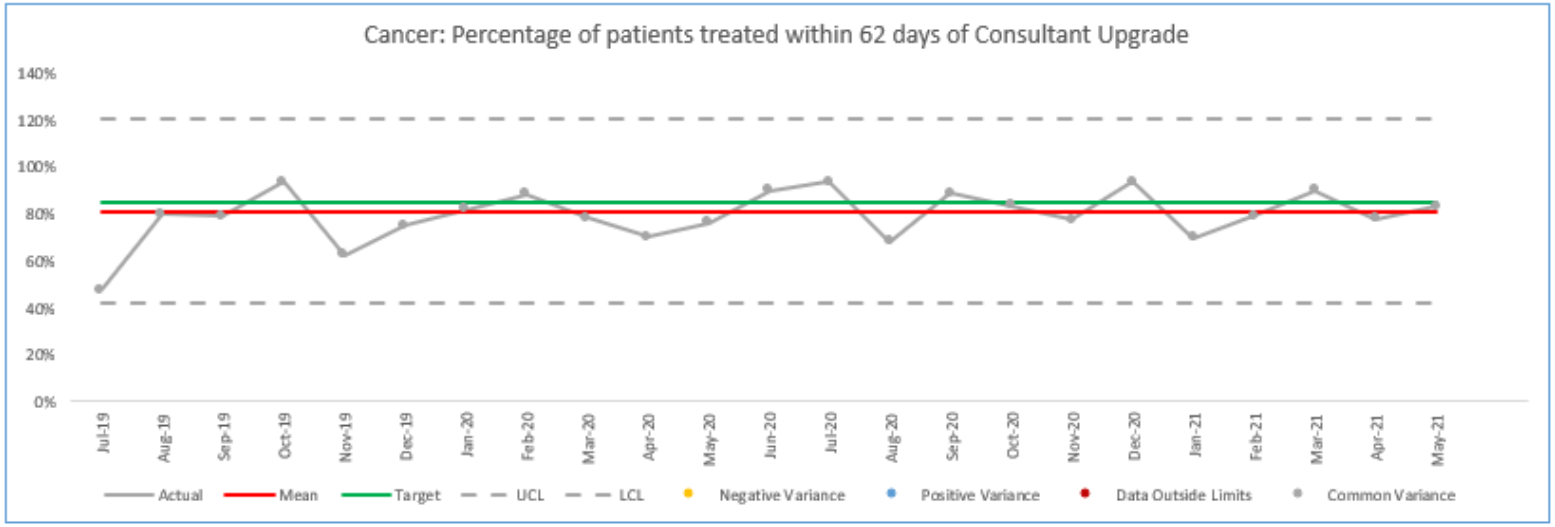
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery



May-21
91%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Patients should experience a maximum wait of 31 days for a second or subsequent surgical treatment. The operational standard for this measure is 94%.	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Surgical capacity	H1 Trajectories developed and monitored through Weekly Access Board, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

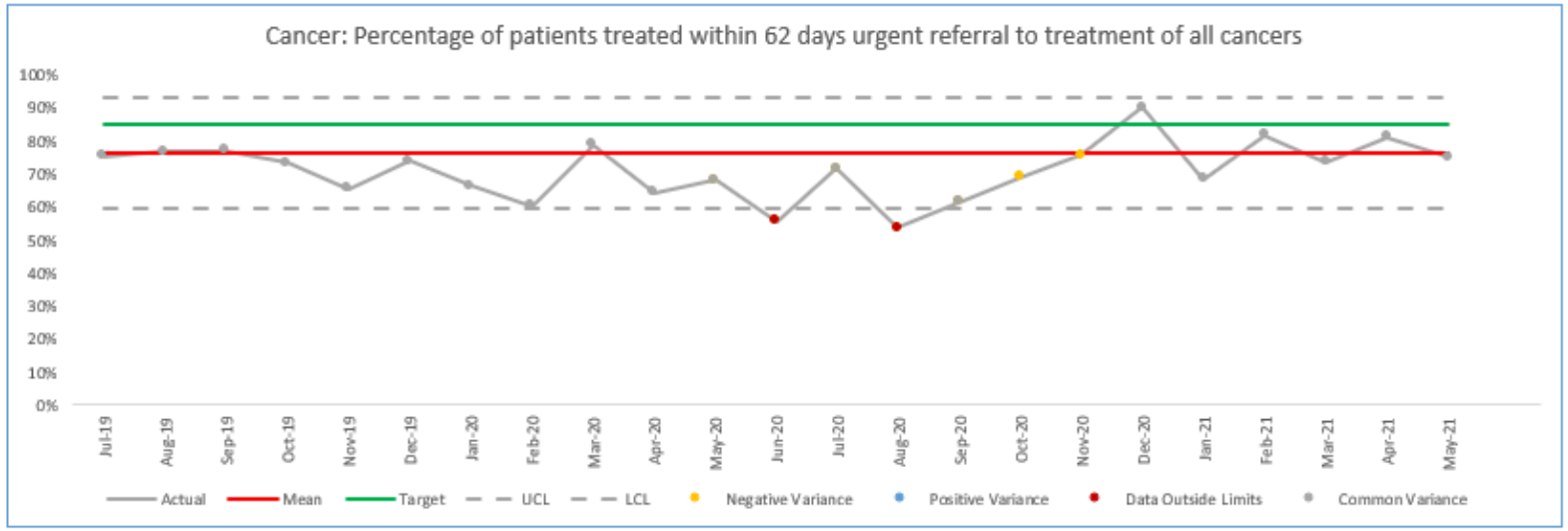
Cancer: Percentage of patients treated within 62 days of Consultant Upgrade



May-21
83%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
An operational standard for the maximum 62-day wait for first treatment for those patients who are upgraded with a suspicion of cancer by the consultant responsible for their care has not been developed.	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Complex pathways Capacity Histology waits at a tertiary provider Capacity for treatment at a tertiary provider.	H1 Trajectories developed and monitored through Weekly Access Board, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

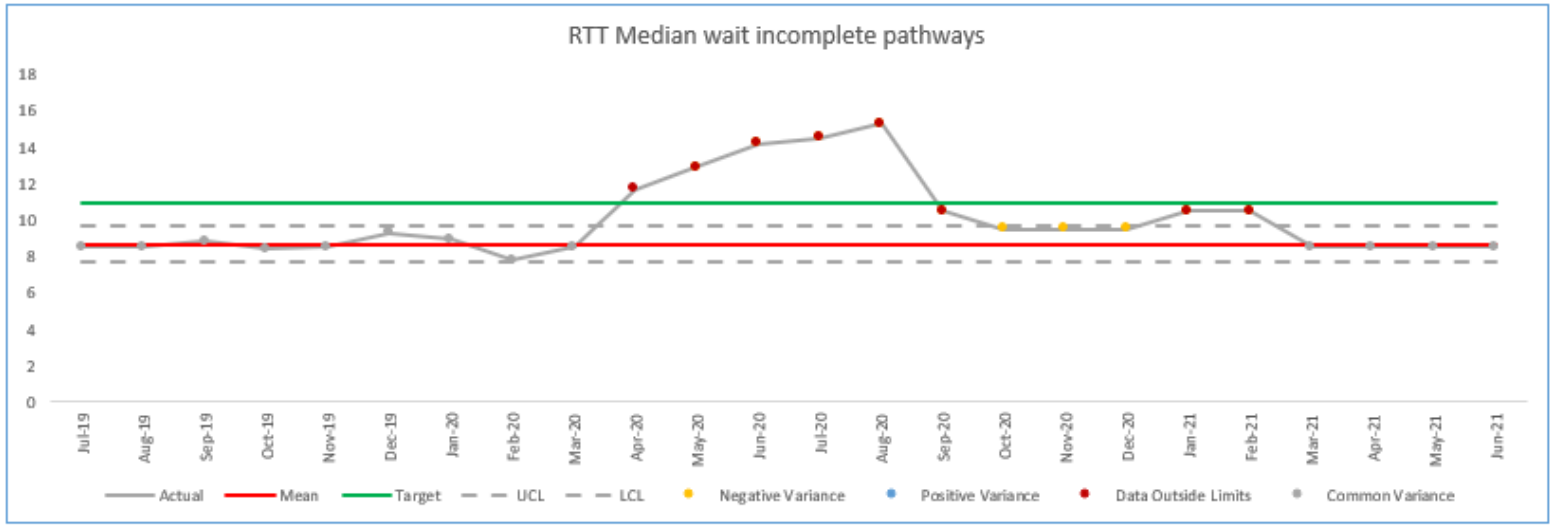
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all



May-21
75%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
The operational standard for this requirement specifies that 85% of patients should wait a maximum of 62 days to begin their first definitive treatment following an urgent referral for suspected cancer from their GP.	Metric is Experiencing variable achievement (will achieve target some months and fail others)	The trust saw a 29.3% increase in treatments in May compared to April, undertaking 92.5 treatments, of which 23 breached, resulting in performance of 75.1% compared to the 85% standard. The increase in referrals from March onwards which continues to be above pre covid levels is adding pressure to all pathways and this is recognised regionally	H1 Trajectories developed and monitored through Weekly Access Board, actions from MDTescalated as required	Weekly PTL - monitoring in place, issues escalated to COO as required

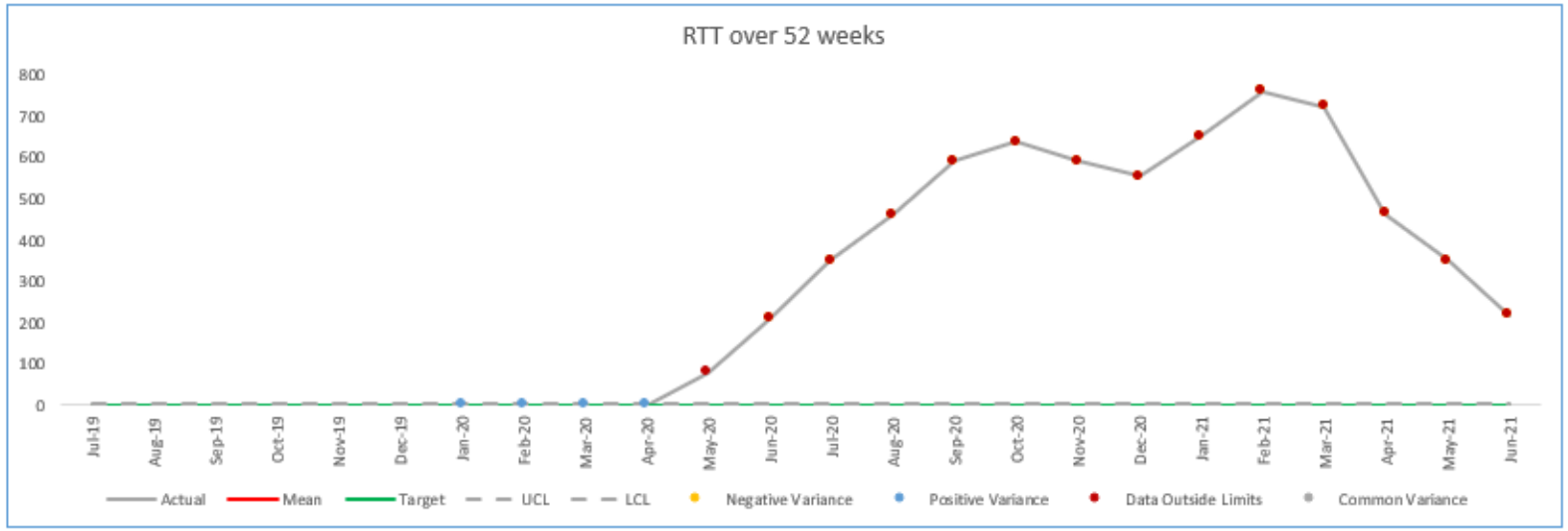
RTT Median wait incomplete pathways



Jun-21
8.5
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10.9
Target Achievement
Metric is Consistently achieving the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
The Median wait time for patients on an RTT incomplete pathway	Metric is Consistently achieving the target	Continued management of extended waits	H1 Trajectories developed and monitored through Weekly Access Committee Actions from weekly PTL escalated as required to ensure delivery of trajectory by December 2020 Weekly PTL - monitoring in place, issues escalated to COO as required Additional theatres opened in June when Endoscopy relocated.	Insourcing to continue at weekends Private sector capacity to be utilised

RTT over 52 weeks



Jun-21
218
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
0
Target Achievement
Metric is Consistently failing the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Number of patients waiting over 52 weeks for first definitive treatment at month end	Metric is Consistently failing the target	The number over 52+ weeks for June continues to follow a downward trajectory, focus continues on backlog and patients with extended waits	H1 Trajectories developed and monitored through Weekly Access Committee Actions from weekly PTL escalated as required to ensure delivery of trajectory by December 2020 Weekly PTL - monitoring in place, issues escalated to COO as required Additional theatres opened in June when Endoscopy relocated.	Insourcing to continue at weekends Private sector capacity to be utilised

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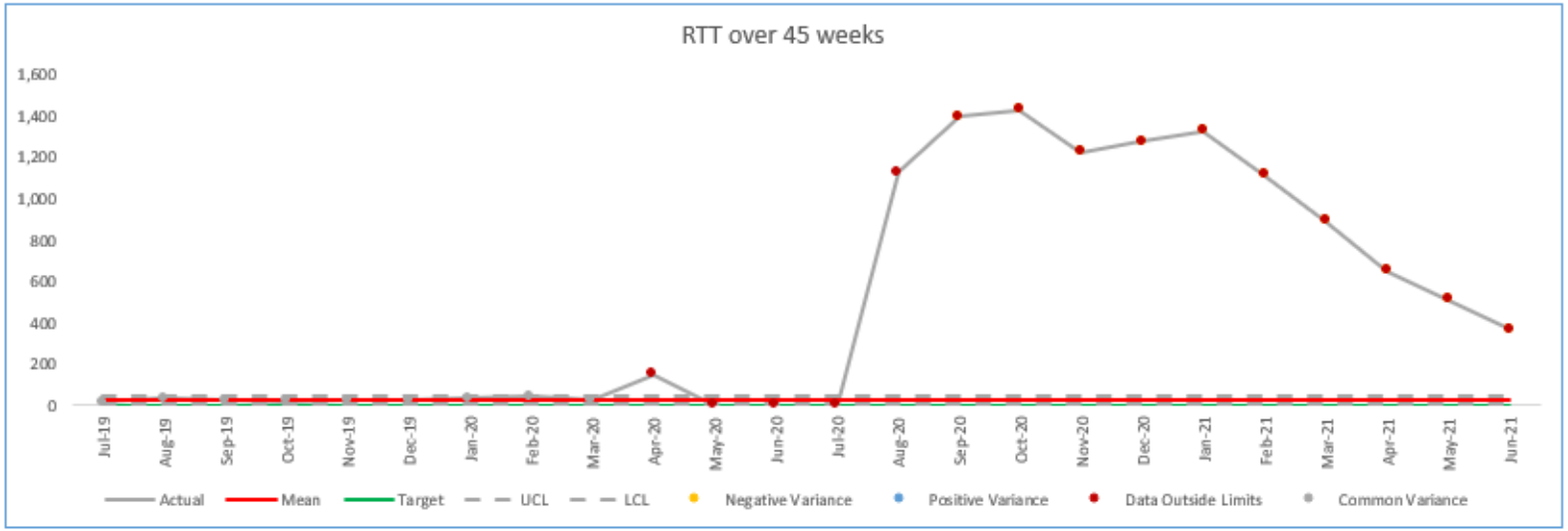
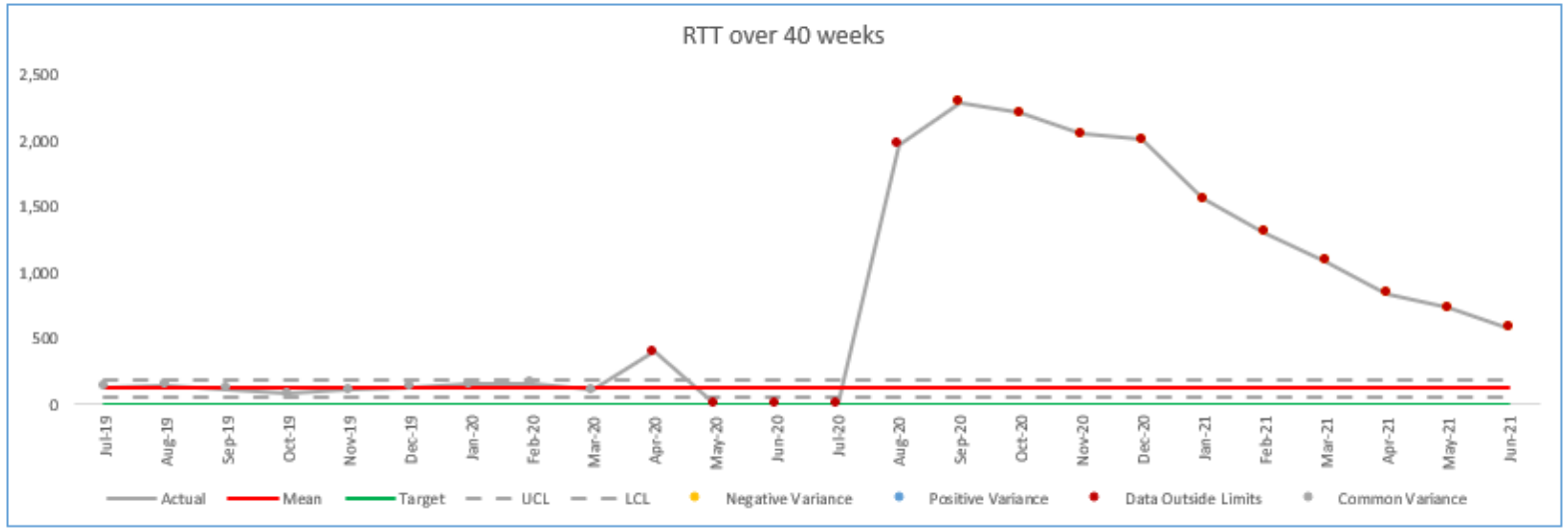
RTT over 45 weeks



Jun-21
366
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
0
Target Achievement
Metric is Consistently failing the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Number of patients waiting over 45 weeks for first definitive treatment at month end	Metric is Consistently failing the target	The number over 45+ weeks for June continues to follow a downward trajectory, focus continues on backlog and patients with extended waits	H1 Trajectories developed and monitored through Weekly Access Committee Actions from weekly PTL escalated as required to ensure delivery of trajectory by December 2020 Weekly PTL - monitoring in place, issues escalated to COO as required Additional theatres opened in June when Endoscopy relocated.	Insourcing to continue at weekends Private sector capacity to be utilised

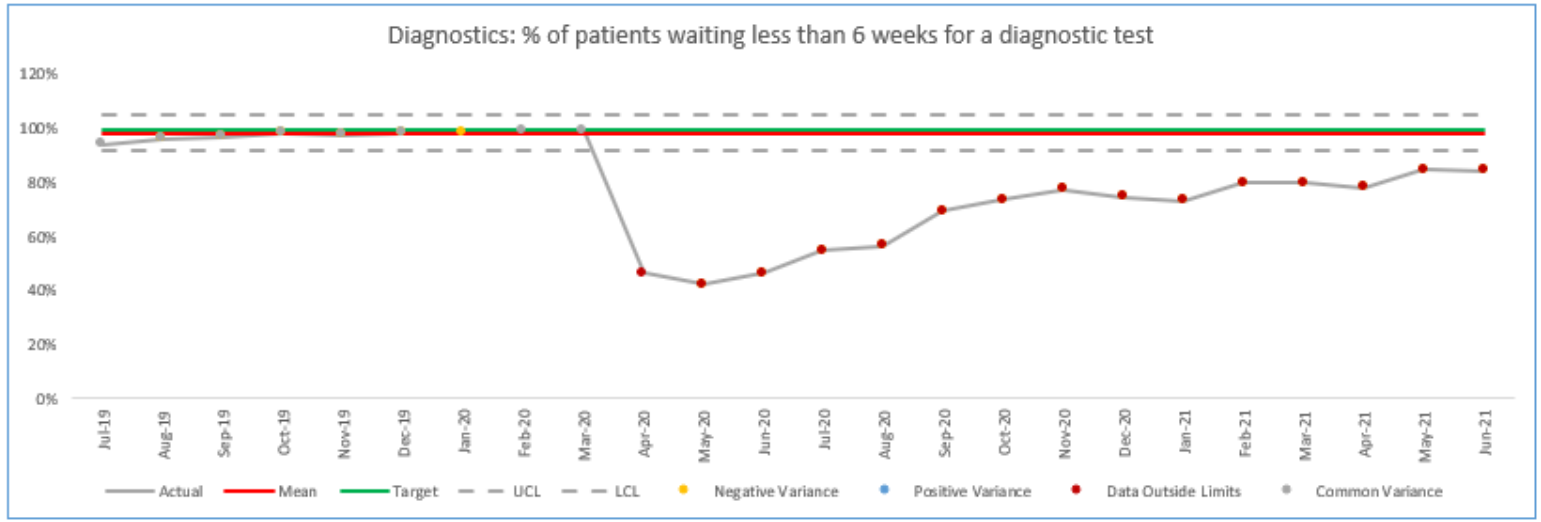
RTT over 40 weeks



Jun-21
579
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
0
Target Achievement
Metric is Consistently failing the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Number of patients waiting over 40 weeks for first definitive treatment at month end	Metric is Consistently failing the target	The number over 40+ weeks for June continues to follow a downward trajectory, focus continues on backlog and patients with extended waits	H1 Trajectories developed and monitored through Weekly Access Committee Actions from weekly PTL escalated as required to ensure delivery of trajectory by December 2020 Weekly PTL - monitoring in place, issues escalated to COO as required Additional theatres opened in June when Endoscopy relocated.	Insourcing to continue at weekends Private sector capacity to be utilised

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



Jun-21
84%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
99%
Target Achievement
Metric is Consistently failing the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
% of patients not seen within six weeks	Metric is Consistently failing the target	Backlog Extended wait times Inpatient activity volumes Urgent care demand	H1 Trajectories developed and monitored through Weekly Access Board, actions from weekly PTL escalated as required to ensure delivery of trajectory by December 2021 Private sector capacity being utilised Additional CT scanner arrived on 18/07 and will be in place initially for three months	Weekly monitoring in place, issues escalated to COO as required

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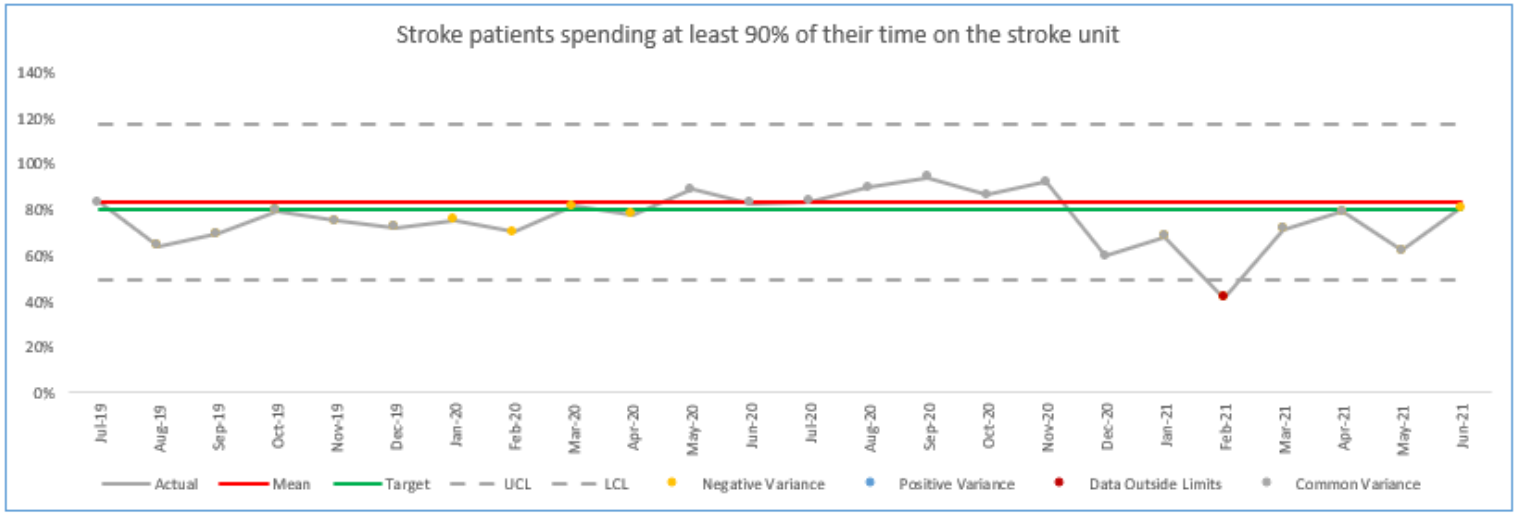
Stroke patients spending at least 90% of their time on the stroke unit



Jun-21
80.8%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
80.0%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
% of patients spending at least 90% of their time on the stroke unit	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Due to COVID pressures patients were being managed outside of the specialist unit	Reloacation of patients post COVID	Reduced COVID admissions will enable patients to be admiited to a appropriate setting

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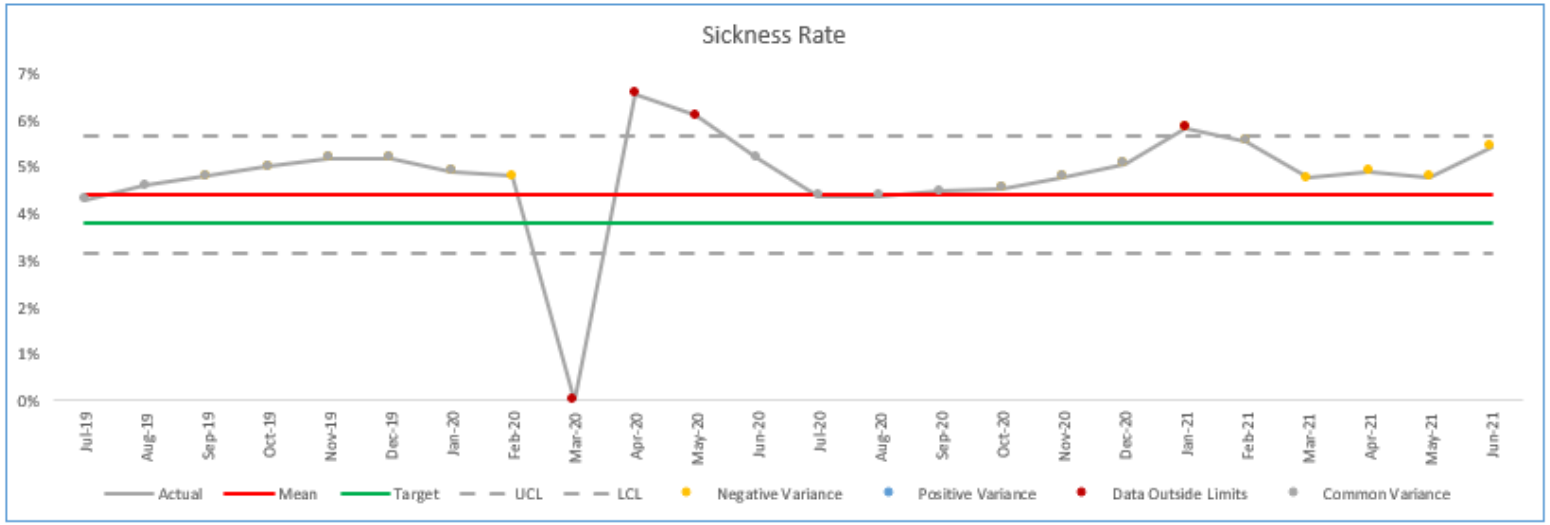
Key Performance Indicators - Well Led

Domain	Metric	Target	Actual in Month Performance	Variation	Assurance
Well Led	Sickness Rate	3.8%	5.4%		
Well Led	Staff: Trust level vacancy rate - All	9.0%	8.0%		
Well Led	Turnover Rate	10.0%	8.0%		
Well Led	Percentage of all trust staff with mandatory training compliance	85.0%	87.4%		
Well Led	Percentage of all trust staff with mandatory refresher fire training compliance	85.0%	82.7%		
Well Led	Percentage of staff with annual appraisal	85.0%	81.1%		

Sickness Rate



Jun-21
5.4%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
3.8%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Sickness Rate	Metric is Experiencing variable achievement (will achieve target some months and fail others)	As a result of fatigue there is a risk of sickness rates increasing over the next 12 months	Health and Wellbeing initiatives Reset planned OD support	Business Partners continue to work closely with Divisions

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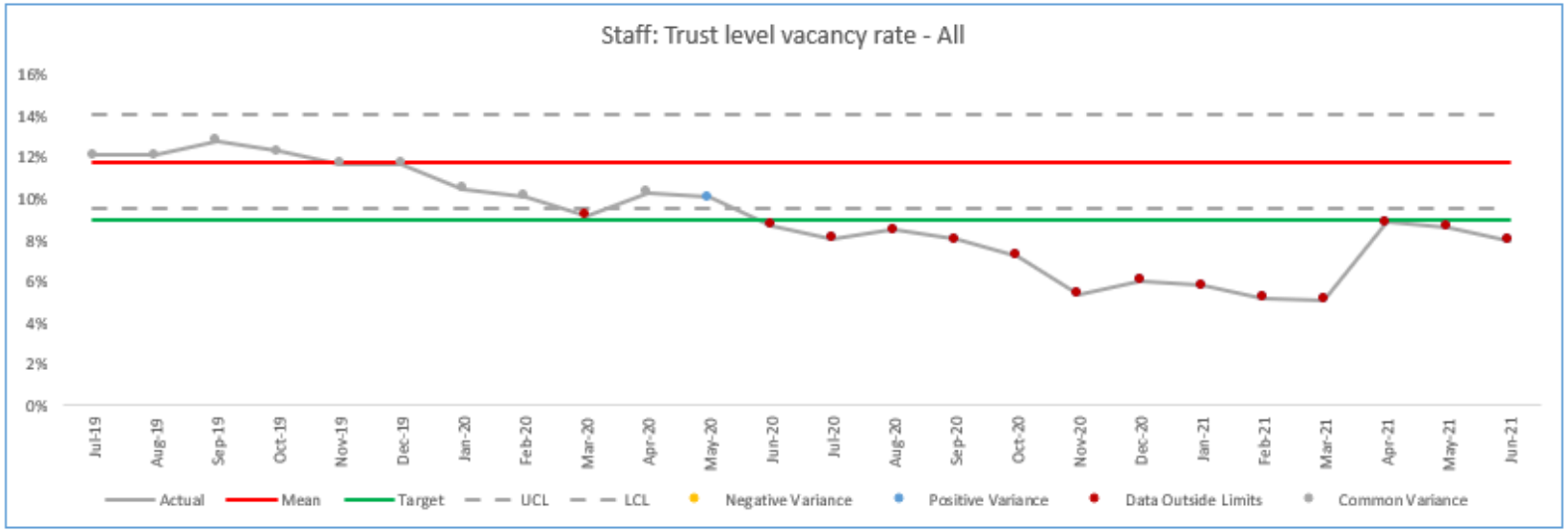
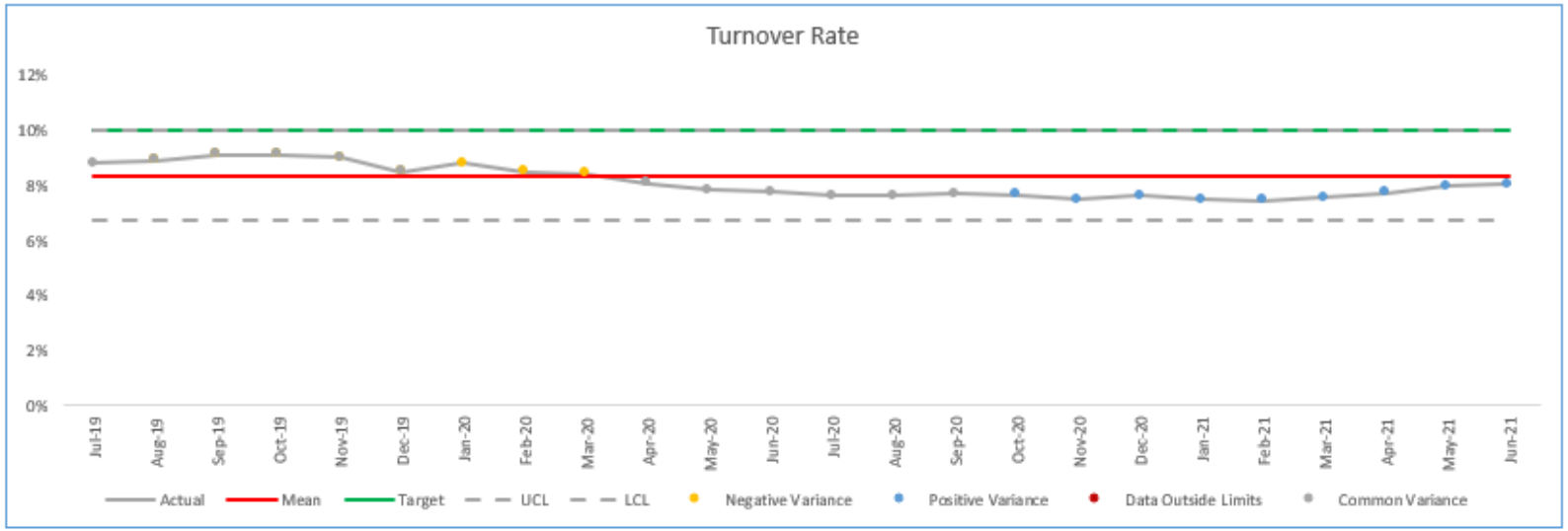
Staff: Trust level vacancy rate - All



Jun-21
8.0%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance below the mean
Target
9.0%
Target Achievement
Metric is Consistently failing the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Staff: Trust level vacancy rate - All	Metric is Consistently failing the target	As a result of fatigue there is a risk of turnover increasing over the next 12 months	Exercise to sensitively scope out staff intentions to be undertake. Continue with staff wellbeing programmes to support staff. Ensure vacancies are minimised to ease pressure on existing staff Undertake further analysis into an increase in turnover within Medical Staffing and Healthcare Scientists.	Analysis undertaken of those eligible to retire over the next 12 months as a result of special class status and factored into a nurse overseas nurse recruitment business case. Potential of post pandemic increase in turnover/retirements raised at regional level.

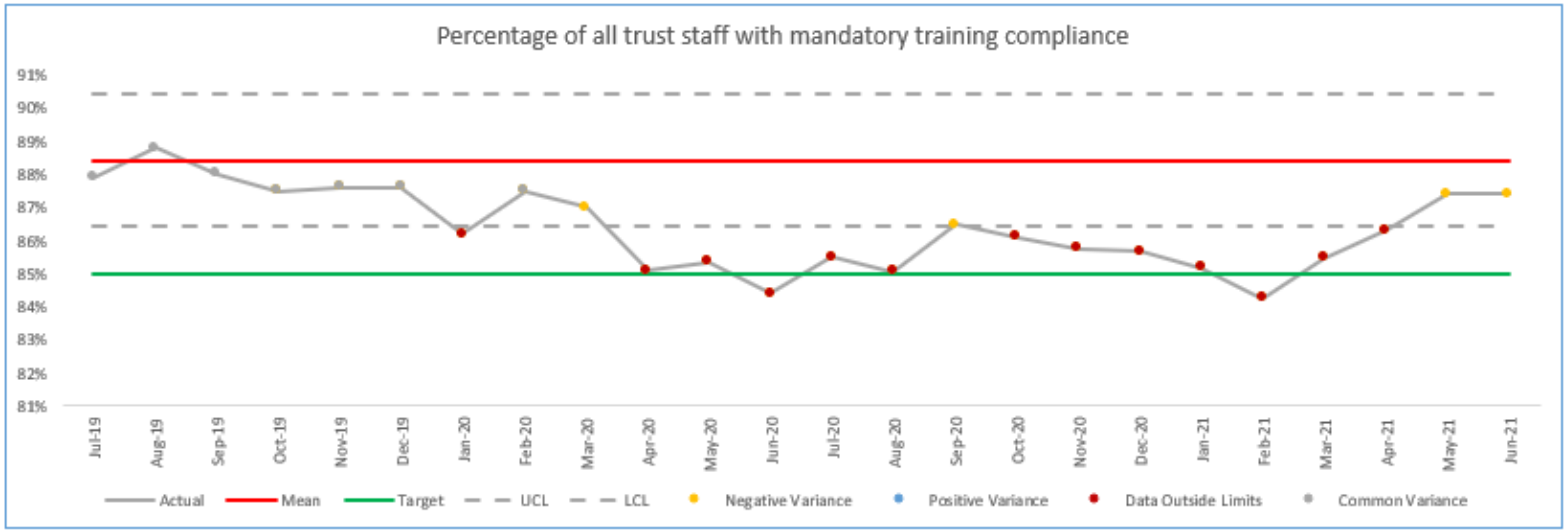
Turnover Rate



Jun-21
8.0%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance below the mean
Target
10.0%
Target Achievement
Metric is Consistently achieving the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Turnover Rate	Metric is Consistently achieving the target	As a result of fatigue there is a risk of turnover increasing over the next 12 months	Exercise to sensitively scope out staff intentions to be undertake. Continue with staff wellbeing programmes to support staff. Ensure vacancies are minimised to ease pressure on existing staff Undertake further analysis into an increase in turnover within Medical Staffing and Healthcare Scientists.	Analysis undertaken of those eligible to retire over the next 12 months as a result of special class status and factored into a nurse overseas nurse recruitment business case. Potential of post pandemic increase in turnover/retirements raised at regional level.

Percentage of all trust staff with mandatory training compliance



Jun-21
87.4%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
85.0%
Target Achievement
Metric is Consistently achieving the target

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Percentage of all trust staff with mandatory training compliance	Metric is Consistently achieving the target	Lack of Face to face training and maintaining quality MT plans	Online training solution	Face to Face training to recommence

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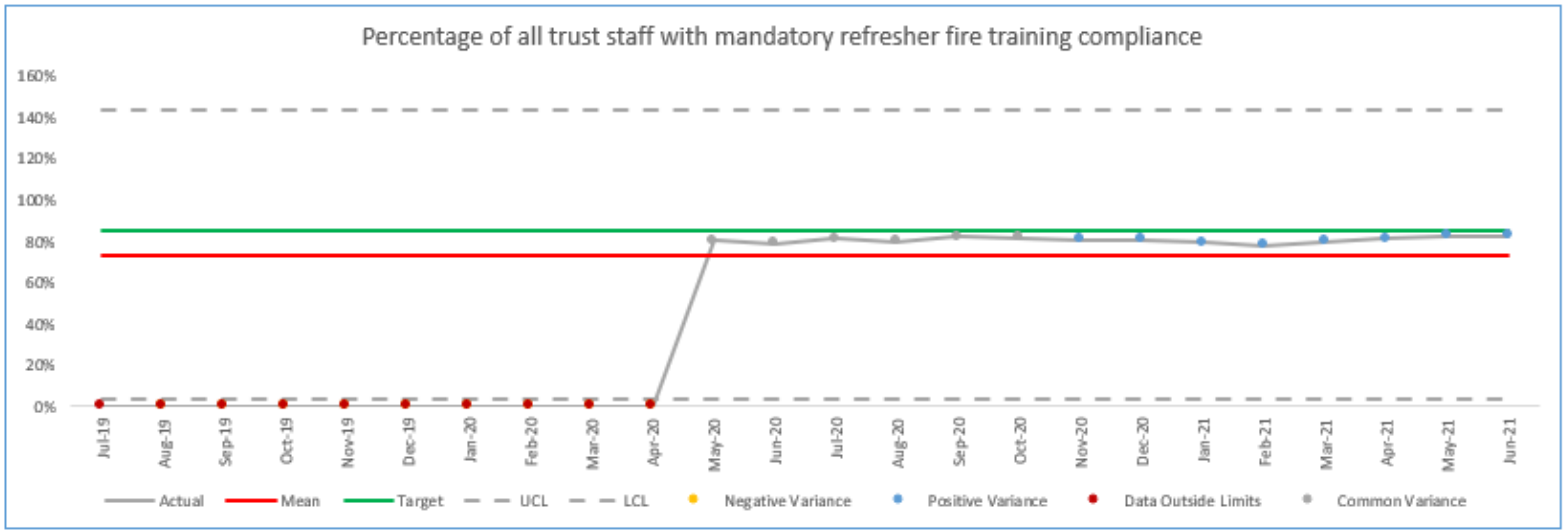
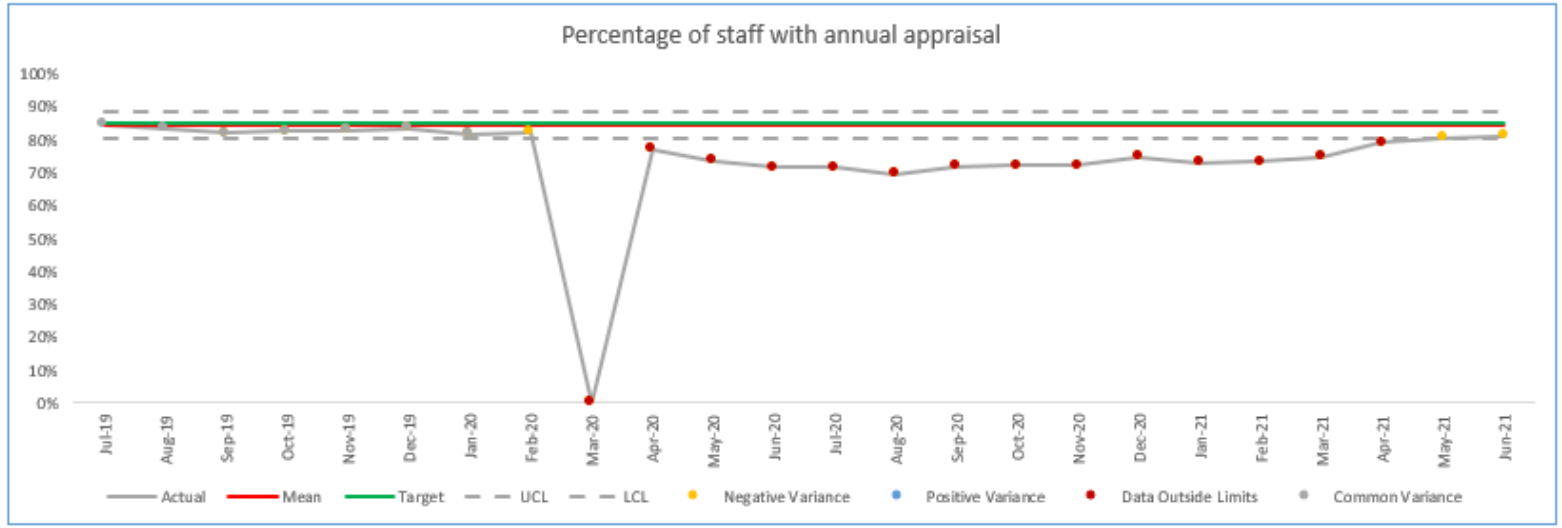
Percentage of all trust staff with mandatory refresher fire training compliance



Jun-21
82.7%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance above the mean
Target
85.0%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Percentage of all trust staff with mandatory refresher fire training compliance	Metric is Experiencing variable achievement (will achieve target some months and fail others)	Lack of Face to face training and maintaining quality MT plans	Online training solution	Face to Face training to recommence

Percentage of staff with annual appraisal



Jun-21
81.1%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
85.0%
Target Achievement
Metric is Experiencing variable achievement (will achieve target some months and fail others)

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
Percentage of staff with annual appraisal	Metric is Experiencing variable achievement (will achieve target some months and fail others)	A decrease in appraisal compliance has emanated from the pressures brought about as a result of Covid-19	To further promote the utilisation of the Appraisal Light process formulated to ease administrative burden associated with Appraisals	A simplified 'Appraisal Light' process continues to be available to help to facilitate further increases to the compliance percentage.

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Cover sheet

Meeting	Public Trust Board
Date	29th July 2021
Agenda item	2.2

Title	2021/22 Activity Report
Presenter	Jo Fawcus, Chief Operating Officer
Author	Carl Holland, Deputy Chief Operating Officer Adrian Marsden, Head of Informatics

This paper is for

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

Group priority

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

Reason for consideration	Previous consideration
The Trust Board is asked to note the contents of this paper and the work underway at the Trust to reset services	*Outline previous consideration including consultation*

Executive Summary

This report sets out the performance against the plan submitted to the requirements of H1 Reset. The headlines for the Board to note are:

- RTT: The number of 52-week breaches of the RTT standard at the end of June continues to fall week by week as we focus on clearing our backlogs and longest waiters. (181 at the time of writing 19th July which is the second lowest in the region) Reviews of Harm continue to be completed for all long waiters and followed up by the Review of Harm Group (RoHG)

- Cancer: June cancer waits are not validated yet, this will not happen until the first week of August. So far 2 of the 3 standards below are being achieved. 62 days- 28.4% reduction in predicted activity- trajectory indicated 109 treatments back to pre covid levels, so far as this is unvalidated 78 treatments have been undertaken. The number of breaches so far for June are 20 compared to the 18 predicted. The reduction in treatments has led to performance being reduced so far, national inter provider transfer rules (IPT) will be applied after validation. 31 day- 30% above predicted activity,2ww- 15.1% above predicted activity. 2 week wait, 31 days and 28 day faster diagnosis targets all being met. NGH has the lowest backlog of any cancer centre in in the region.

- NGH has seen another month of increased referrals (118% increase overall) from primary care as patients present to their GP's with their health concerns. This along with increases in cancer and urgent care presentations is placing significant pressure on the hospital as we attempt to see all cohorts

- Overall Outpatient Activity has shown another significant over performance of 122% against plan. NGH has seen a marked increase in Face to Face consultations (116%) and virtual consultations are over plan at over 132% of plan. We remain committed to the virtual platforms as patients have clearly indicated they like this format

- Day Case and Inpatient activity has exceeded plan at 113% and 107% respectively for June and NGH continues to insource and outsource activity to support this increase and clear the patient backlogs.

- A&E attendances continue to grow at 104% of Plan and 105% on 2019/20. Type 3 and 4 attendances have seen the biggest increases where we are streaming the least urgent cases away from A&E into the urgent care centre and SDEC units.

- 0 day LOS shows a marked increase as we drive to see increased numbers of patients in SDEC Springfield and Nye Bevan Units. Admissions are higher than planned but conversion rates from ED remain low

- With a real focus on clearing the diagnostic backlog both internally with additional capacity and externally by insourcing and outsourcing capacity. All diagnostics modes continue to over perform against plan with the exception of Echo where the focus continues and an increase in performance of 5% on the previous month

Conclusion

June's performance have shown that the H1 and RESET plan are over performing in almost every area against the plan as the Trust works hard to clear its backlogs against a backdrop of increased referrals into the hospital from every area. This is expected to continue into July.

Appendices

Appendix 1- Operational Planning Submission Monitoring Template

Risk and assurance

Financial Impact

The increased activity from higher referrals for Cancer, elective care and Emergency care are impacting on the trust financial position as the organisation works to manage these increasing numbers. Insourcing / outsourcing of services to meet the demand by the use of the Independent sector compounds the issue when we are not on tariff.

Legal implications/regulatory requirements

None

Equality Impact Assessment

There is NO evidence that the proposed action will promote/have a negative impact on equality of opportunity

Total OP	June 2021					Comments
	Planned	Actual	%	2019/20	%	
Total Outpatient attendances (All TFC, Consultant and Non consultant led)	22,239	29,858	134%	27,620	108%	
Total outpatient attendances (All TFC, Consultant and Non consultant led) - Face to face	12,311	17,947	146%	25,445	71%	
Total outpatient attendances (All TFC, Consultant and Non consultant led) - Telephone/Virtual	9,928	11,911	120%	2,075	574%	

OP Transformation	June 2021					Comments
	Planned	Actual	%	2019/20	%	
Total Advice and Guidance requests processed/answered	1,206	1,264	105%	-	-	
Number of patients moved or discharged to a PIFU pathway for the first time	70	68	97%	-	-	

1st OP	June 2021					Comments
	Planned	Actual	%	2019/20	%	
Consultant led first outpatient attendances (Spec acute)	7,349	8,334	113%	8,090	103%	

FU OP	June 2021					Comments
	Planned	Actual	%	2019/20	%	
Consultant-led follow-up outpatient attendances (Spec acute)	17,066	16,899	119%	16,466	115%	

Electives	June 2021					Comments
	Planned	Actual	%	2019/20	%	
Total Elective Admissions	3,256	3,628	108%	4,011	88%	
Total Elective Admissions - Day Case	2,924	3,155	108%	3,619	87%	
Total Elective Admissions - Ordinary	332	373	112%	392	95%	

A&E 1-4	June 2021					Comments
	Planned	Actual	%	2019/20	%	
Type 1-4 A&E Attendances excluding Planned Follow Ups	8,080	9,195	114%	8,080	114%	
Type 1&2 A&E Attendances excluding Planned Follow Ups	8,080	9,195	114%	8,080	114%	

Non-Electives	June 2021					Comments
	Planned	Actual	%	2019/20	%	
Number of Specific Acute non-elective spells in the period	2,757	2,739	99%	2,915	94%	
Number of Specific Acute non-elective spells in the period with a length of stay of zero	965	863	89%	973	89%	0 day LOS spells are the highest they have been since Feb 2020 AND +5% on the previous month as SDEC activity continues to increase. The lower A&E conversion rate means that we NEL admissions are not quite as high as the increase we've seen in attendances (114% of planned)
Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more	1,792	1,876	105%	1,942	97%	
Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more (COVID)	0	6	-	0	-	
Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more (Non-COVID)	1,792	1,870	104%	1,942	96%	

Diagnostics	June 2021					Comments
	Planned	Actual	%	2019/20	%	
Diagnostic Tests - Magnetic Resonance Imaging	1,520	1,776	117%	-	-	
Diagnostic Tests - Computed Tomography	1,110	1,763	159%	-	-	
Diagnostic Tests - Non-Obstetric Ultrasound	2,195	2,861	130%	-	-	
Diagnostic Tests - Colonoscopy	90	178	198%	-	-	
Diagnostic Tests - Flexi Sigmoidoscopy	230	222	97%	-	-	
Diagnostic Tests - Gastroscopy	210	191	91%	-	-	
Diagnostic Tests - Echocardiography	520	132	25%	-	-	

Cancer	June 2021					Comments
	Planned	Actual	%	2019/20	%	
63 Day Waits	35		0%	-	-	
31 Day Treatment	124		0%	-	-	
2 Week Waits	1,044		0%	-	-	

Bed Occupancy	June 2021					Comments
	Planned	Actual	%	2019/20	%	
Average number of occupied G&A beds	476	453	95%	-	-	
Average number of available G&A beds	505	486	96%	-	-	
%	94%	93%	99%	-	-	
Average number of occupied ACC beds	11	9	84%	-	-	Bed occupancy for June averaged at 93.2%, -1.1% on the planned level. Avg LOS for Medicine (Emergency POD and 1+ day LOS) remained similar to the previous month 8.6 vs. 8.7 days in May so still above the modelling assumption of 7.8 days.
Average number of open ACC beds	12	12	100%	-	-	
%	92%	77%	84%	-	-	

Referrals	June 2021					Comments
	Planned	Actual	%	2019/20	%	
Total Referrals	-	12,476	-	-	-	Referrrals increased by 8% in June compared to May, the highest volume since the start of COVID. The majority of the increase was seen in 'Other' referrals with some stand out specialties being T&O (+399) and Ophthalmology (+120)
GP Referrals	-	5,383	-	-	-	
Other Referrals	-	7,093	-	-	-	

NHSi Ref	Total OP	June 2021 Planned	Actual	%	2019/20	%	Comments
E.M.32	Total Outpatient attendances (All TFC, Consultant and Non consultant led)	**59,742**	**73,053**	122%	**77,659**	**94%**	Overall Outpatient Activity has shown another significant over performance of 122% against plan. NGH has seen an increase in Face to Face consultations at over 116% of plan and an even bigger increase in Non face to face to 132% against plan.
E.M.32a	Total outpatient attendances (All TFC, Consultant and Non consultant led) - Face to face	36,758	42,669	116%	39,173	109%	
E.M.32b	Total outpatient attendances (All TFC, Consultant and Non consultant led) - Telephone/Virtual	22,984	30,384	132%	38,486	79%	

NHSi Ref	OP Transformation	June 2021 Planned	Actual	%	2019/20	%	Comments
E.M.33	Total Advice and Guidance requests processed/answered	1,274	1,236	97%	-	-	Advice and Guidance actvity is lower than plan at 97%. >95% of A&G's are responed to within 2 working days as per internal target
E.M.34	Number of patients moved or discharged to a PIFU pathway for the first time	-	-		-	-	

NHSi Ref	1st OP	June 2021 Planned	Actual	%	2019/20	%	Comments
E.M.8	Consultant led first outpatient attendances (Spec acute)	9,418	8,434	90%	10446	81%	Consultant lead outpatient activity is lower than planned at 90% but this is against a backdrop of overall OPD activity overperformin
E.M.8b	Consultant-led first outpatient attendances with procedures (Spec acute)	2,708	2,987	110%	3279	91%	

NHSi Ref	FU OP	June 2021 Planned	Actual	%	2019/20	%	Comments
E.M.9	Consultant-led follow-up outpatient attendances (Spec acute)	23,912	21,789	91%	22731	96%	Consultant lead follow up outpatient actvity is lower than planned at 91% but this is against a backdrop of overall OPD actvity
E.M.9b	Consultant-led follow-up outpatient attendances with procedures (Spec acute)	4,552	6,206	136%	5556	112%	overperforming at 132%

NHSi Ref	Electives	June 2021 Planned	Actual	%	2019/20	%	Comments
E.M.10	Total Elective Admissions	**3,085**	**3,307**	**107%**	**7,297**	157%	Day Case and Inpatient activity has exceeded plan at 113% for June which is a similar >100% the previous month. Total elective admissions overperformed against plan at 107%. NGH continues to insource and outsource activity to support this increase and clear the patient backlogs. Actvity does not match 2019 figures due to COVID distancing and IPC procedures between patients
E.M.10a	Total Elective Admissions - Day Case	2,465	2,794	113%	4,003	85%	
E.M.10b	Total Elective Admissions - Ordinary	620	513	83%	3,294	72%	
E.M.10c	Total Elective Admissions-Day Case-Children under 18 years of age	144	65	45%	709	80%	
E.M.10d	Total Elective Admissions-Ordinary-Children under 18 years of age	47	54	115%	194	109%	

NHSi Ref	A&E 1-4	June 2021 Planned	Actual	%	2019/20	%	Comments
E.M.12	Type 1-4 A&E Attendances excluding Planned Follow Ups	**11310**	**11788**	**104%**	**11084**	**106%**	A&E attendances continue to grow at 104% of Plan and 106% on 2019/20. Type 3 and 4 attendances have seen the biggest increases where we are streaming the least urgent cases away from A&E into the urgent care centre and SDEC units.
E.M.12a	Type 1&2 A&E Attendances excluding Planned Follow Ups	9,840	9,895	101%	9610	103%	
E.M.12b	Type 3&4 A&E Attendances excluding Planned Follow Ups	1,470	1,893	129%	1474	128%	

NHSi Ref	Non-Electives	June 2021 Planned	Actual	%	2019/20	%	Comments
E.M.11	Number of Specific Acute non-elective spells in the period	**3,690**	**4,224**	**114%**	**4,293**	**98%**	0 day LOS shows an increase as we drive to see increased numbers of patients in SDEC, Springfield and Nye Bevan Unit . Admissions are higher than planned but conversion rates from ED remain low and remain in line with 2019/20
E.M.11a	Number of Specific Acute non-elective spells in the period with a length of stay of zero	1,560	1,724	111%	1,781	97%	
E.M.11b	Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more	2,130	2,500	**117%**	2,512	**100%**	
E.M.11c	Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more (COVID)	0	0		0		
E.M.11d	Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more (Non-COVID)	2,130	2,500	117%	2,512	100%	

NHSi Ref	Diagnostics	June 2021 Planned	Actual	%	2019/20	%	Comments
E.B.26a	Diagnostic Tests - Magnetic Resonance Imaging	1,500	1,662	111%	1587	105%	With a real focus on clearing the diagnostic backlog both internally with additional capacity and externally by insourcing and outsourcing capacity. All diagnostics modes continue to over perform against plan with the exception of Echo where the focus continues and an increase in performance of 5% on the previous month
E.B.26b	Diagnostic Tests - Computed Tomography	2,730	3,340	122%	2819	118%	
E.B.26c	Diagnostic Tests - Non-Obstetric Ultrasound	1,980	2,697	136%	1383	195%	
E.B.26d	Diagnostic Tests - Colonoscopy	195	364	187%	407	89%	
E.B.26e	Diagnostic Tests - Flexi Sigmoidoscopy	123	119	97%	85	140%	
E.B.26f	Diagnostic Tests - Gastroscopy	217	261	120%	301	87%	
E.B.26g	Diagnostic Tests - Echocardiography	1,450	917	63%	943	97%	

NHSi Ref	Cancer	June 2021 Planned	Actual	%	2019/20	%	Comments
E.B.32	63 Day Waits	109	78	72%	-	-	Cancer performance is strong despite high number of referrals via the 2WW route 1382 patients seen in June which is 115% of pre Covid levels. 47.5% of patients were seen with 7 days of referral
E.B.31	31 Day Treatment	160	208	130%	-	-	2ww 96.4% (Target 93%)
E.B.30	2 Week Waits	1,200	1,382	115%	-	-	

NHSi Ref	Bed Occupancy	June 2021 Planned	Actual	%	2019/20	%	Comments
E.M.26a	Average number of occupied G&A beds	539	565	105%	-	-	Bed occupancy remains much higher than planned for June. Where we usually see a dig in occupancy during the summer months we contine to see winter numbers of attendances and admissions
E.M.26a	Average number of available G&A beds	601	579	96%	-	-	
E.M.26a	%	**90%**	**98%**	**109%**	-	-	
E.M.26b	Average number of occupied ACC beds	11	10	91%	-	-	
E.M.26b	Average number of open ACC beds	16	16	100%	-	-	
E.M.26b	%	**69%**	**63%**	**91%**	-	-	

NHSi Ref	Referrals	June 2021 Planned	Actual	%	2019/20	%	Comments
MRR	Total Referrals		8,899	-	-	-	total referral are up 1054 on the previous month with the vast majority being GP referrals
MRR	GP Referrals	-	6,097	-	-	-	
MRR	Other Referrals	-	2,802	-	-	-	

Cover sheet

Meeting	Public Trust Board
Date	29th July 2021
Agenda item	3.1

Title	OD and Inclusion – EDI Progress presentations and EDI Strategy
Presenter	Mark Smith, Chief People Officer
Author	Mark Smith, Chief People Officer

This paper is for

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

Group priority

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

Reason for consideration	Previous consideration
For the Board to be appraised on the progress of the EDI actions prior to the July Board cycle and to approve the Group EDI strategy	JPC Development Session in June

Executive Summary

Our Organisational Development and Inclusion People Pledge is:

To bring our dedicated to excellence values to life, improving the way we work with each other, particularly focusing on empowerment and inclusion.

The attached presentations are to provide colleagues with a progress report regarding the work being undertaken within both Trusts within the Group in regard to Equality, Diversity and Inclusion. It is acknowledged that there is much work for both Trusts to undertake in this area based on recent staff survey and WRES and WDES information. An example of this in NGH is whereby recent staff survey data demonstrated an improvement in some areas of EDI, however benchmarked national comparisons had the Trust in the bottom 10 of acute providers.

This report provides a status report as to the action which has been taken to date, showcasing the overall EDI progress, inclusive of the building cultural bridges programme in both Trusts, the development of the EDI networks, along with Board representation and actions to be progressed over the next 12 months. There is a specific reference to progress within the REACH network (previously known as BAME) outlining action taken, including the reverse mentoring programme and again actions to be taken within the next 12 months. There is an update on the actions agreed to by the Boards in 2020 and progress within these, including suggested future actions. Finally, in line with the Group People Plan the EDI Strategy within the Trusts for the Group has been developed, comments received have been considered and incorporated.

The strategy is built around the Equality Delivery System for the NHS – EDS2 and is in line with the Trusts and therefore Groups obligations under the Equality Act 2010. The strategy has also been triangulated with our plans as a Group and those at a system, regional and national level.

Our Equality, Diversity and Inclusion Strategy 2021- 2024 will focus on five goals:

1. Creating a representative and supportive workforce
2. Supporting accurate data collection and usage to measure and reduce inequalities
3. Developing compassionate leadership and accountability
4. Culture change through mainstreaming diversity and inclusion
5. Improving Patient access and experience in and of our services

We will be measuring the impact of the strategy via the EDI steering groups in both hospitals reporting and via the management and committee structures, whilst specifics are detailed within the strategy, some specifics we aim to see in the first year include:

- 5% of colleagues educated as part of the Building Cultural Bridges Programme
- 150 trained inclusive recruitment champions
- An increase in the number of colleagues participating in the reverse mentoring programmes in both Trusts leading to greater insight of experiences and action which can be taken

Ultimately an improvement in our staff survey feedback, in line with the national average in the first instance and WRES and WDES information continuous improvements

Appendices

Dedicated to excellence

KGH and NGH EDI Progress Presentations and Group EDI Strategy

Risk and assurance

Not undertaking work to improve our staff experience from an EDI perspective will have an impact on our ability to deliver the Group People priority and be within the top 20% for staff engagement. We also know that this will have an update on our ability to retain, attract and recruit colleagues to work within the Group.

Financial Impact

The costs of EDI work being undertaken is within the existing budget, allocation of funding for staff networks will be required to achieve progress in this area.

Legal implications/regulatory requirements

There are a number of legal and regulatory requirements, which includes the Equality Act 2010.

Equality Impact Assessment

This work has a direct Equality impact on colleagues within both Trusts and the Group. The EDI Strategy is designed to address Equality, Diversity and Inclusion across the Group, ensuring that all colleagues feel included working with those with protected characteristics.

NHS
University Hospitals of Northamptonshire
NHS Group

Group Equality, Diversity, and Inclusion Strategy 2021-2024

Dedicated to excellence

Contents

Introduction

The Equality, Diversity, and Inclusion Strategy (EDI) is built around the five goals stipulated by the Equality Delivery System for the NHS (EDS2), which looks at service user health outcomes, experience, and access to our services, as well as how representative and supported our workforce is and inclusive leadership.

The EDI Strategy supports the Group's requirement to meet its obligations under the Equality Act (2010) and incorporate the mandatory requirements for the EDS2, Workforce Race Equality Standard (WRES) and the Accessible Information Standards; including the Workforce Disability Equality Standard (WDES)

We have set ourselves five aims based on feedback from our staff, service users and other stakeholders which we are dedicated to achieving and know will be supported by commitment across the Group.

We recognise the significance of this strategy in providing a vision and direction for eliminating discrimination, reducing inequalities for our staff teams, and improving the health outcomes of our service users and carers. We are sensitive to our staff and patients with protected characteristics and will work to ensure they have accessible and supportive services and workplaces.

Information in the strategy was gleaned from a wide range of sources including local and national polices, WRES data, feedback from our respective Equality and Diversity and Inclusion leads, Group wide staff networks, and the findings of the 2020 Staff Survey.

In this strategy we refer to the nine protected characteristics, defined under the Equality Act (2010).

By this we mean treating colleagues or patients based on their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation with any form of discrimination.

We triangulated our plans against the key following local and national policies and strategies.

- Dedicated to excellence: Group Strategic Direction 21/22 -23/24
- Midlands Workforce Race, Equality, and Inclusion Strategy
- Workforce Race and Equality Standard 2020 - Data analysis report for NHS trusts and Clinical Commissioning groups
- Group People Plan 2021-2024
- NHS People Plan: 2020/21
- A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS 2019

This strategy is particularly reflective of regional EDI strategies outlined in the Midlands Race, Equality and Inclusion Strategy, and the following regional strategic priorities, are addressed within this Group strategy.

1. Removing barriers to inclusive and compassionate health and wellbeing support for all
2. Leading with compassion and inclusion
3. Tackling racism and sexism and other types of bullying and harassment and discrimination
4. Eliminating racism in disciplinaries
5. Reward and celebration when good practice is identified
6. Taking a collaborative approach across systems
7. Building Accountability
8. Eliminating racism and bias and discrimination in recruitment and progression

The Group EDI strategy is further underpinned by the newly launched Group People Plan and reflects our aspirations to be a collaborative and inclusive employer and reflect cultural sensitivities and compassion to both our patients, their families, and our colleagues.

This strategy also follows aspirations outlined in the A Model Employer guidance: 2019 and this is integral within the developing compassionate leadership and accountability section, of the strategy.

We believe it is time to start the uncomfortable and, at times, challenging conversations about the nine protected characteristics, to ensure our staff and patients are free from any discriminatory practices.

Through this document we refer to REACH (Race, Ethnicity and Cultural Heritage).

This replaces the terms BAME and BME as an acronym.

Numerous colleagues across the Group contributed to and were instrumental in the development of this strategy including, Carol Verner, Andrew Stewart, Andy Callow, Dr Toyosi Adeniji, Robyn Thorman, Leanna Luxton, Tracey Robson, and Anne-Marie Dunkley and Charlotte Smith, as well as the co-chairs within the Group wide staff networks, HR business partners, and other interested parties.

Group Values Dedicated to Excellence

Compassion

We care about our patients and each other. We consistently show kindness and empathy and take the time to imagine ourselves in other people's shoes.

Integrity

We are consistently open, honest and trustworthy. We can be relied upon, we stand by our values and we always strive to do the right thing.

Respect

We value each other, embrace diversity and make sure everyone feels included. We take the time to listen to, appreciate and understand the thoughts, beliefs and feelings of others.

Courage

We dare to take on difficult challenges and try out new things. We find the strength to speak up when it matters and we see potential failure as an opportunity to learn and improve.

Accountability

We take responsibility for our decisions, our actions and our behaviours. We do what we say we will do, when we say we will do it. We acknowledge our mistakes and we learn from then

Our Vision Statements

Dedicated to outstanding patient care, and colleague experience by becoming a University Hospital Group and a leader in clinical excellence, inclusivity, and collaborative healthcare.

Our Mission Statements

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.

About the 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.

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.

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 new-born
- 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

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:

1. Have a shared vision, mission, and purpose
2. Be clear about what the Group priorities are and what we want to achieve
3. Prioritise improvements so we work on a small number of important changes at a time
4. Know that our transformational activities and strategies will make a difference to the things that matter the most to us and identify a small number of metrics that will let us track our progress

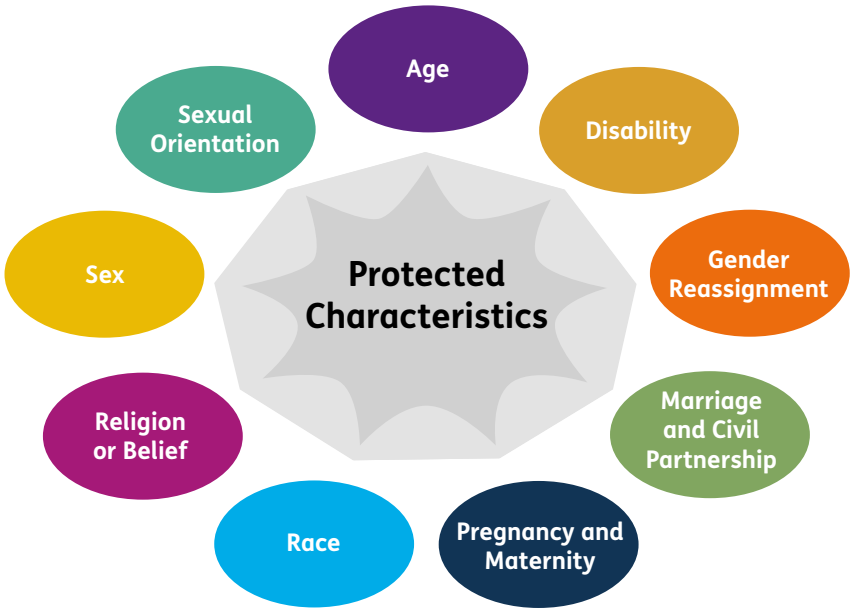
Group staff teams as of 01.01.21

Characteristic	No. KGH	No. NGH	Group Total
Permanent Staff	4711	5457	10,168
REACH Staff	1363	1333	2696
LGBTQ+ Staff	93	156	249
Disabled Staff	128	174	302
Male Staff	820	1133	1953
Female Staff	3514	4324	7838

(We accept that these statistics may not be accurate as some staff may have concerns around anonymity when completing their Equality Impact assessments)

The NHS People Plan sets out practical actions that employers and systems should take, focusing on:

- **Looking after our people** particularly the actions we must all take to keep our people safe, healthy, and well – both physically and psychologically.
- **Belonging in the NHS** highlighting the support and action needed to create an organisational culture where everyone feels they belong.
- **New ways of working and delivering care** emphasising that we need to make effective use of the full range of our people's skills and experience to deliver the best possible patient care.
- **Growing for the future** particularly by building on the renewed interest in NHS careers to expand and develop our workforce, as well as retaining colleagues for longer.



Executive Summary

Equality, Diversity, and Inclusion (EDI) are key to achieving the Group vision of being dedicated to outstanding patient care and colleague experience by becoming a University Hospital Group and a leader in clinical excellence, inclusivity, and collaborative healthcare. The Group ambition is to be regarded as the best place for patient safety, quality and experience and the best place to work.

The Group is committed to the elimination of discrimination, to reducing health inequalities, promoting equality of opportunity and dignity and respect for all our patients, their families, carers, and our colleagues.

Supporting our EDI staff networks which include members with protected characteristics as well our new Youth Peer Network and as is an important part of this strategy as the members feed into Human Resources, Organisational Development and Training and Development colleagues and minimise the potential for Board to Ward gaps to occur.

With this strategy therefore, we have an aspiration to ensure Equality, Diversity, and Inclusion (EDI) is at the heart of everything we do.

We will model accountability and reflect changes to our practice to ensure we reach all our colleagues and model accessibility and inclusion in all we do through having focussed and measurable action plan.

We believe that the Equality, Diversity, and Inclusion agenda is critical to building a future proof workforce that is truly reflective of the diverse communities we serve.
We also believe that in building a diverse workforce, we will increase the talent pool from which we recruit and build services that are responsive to the needs of the local community.

Our Five Goals for the Future

This Equality, Diversity and Inclusion Strategy 2021- 2024 will focus on five goals:

1. Creating a representative and supportive workforce
2. Supporting accurate data collection and usage to measure and reduce inequalities
3. Developing compassionate leadership and accountability
4. Culture change through mainstreaming diversity and inclusion
5. Improving Patient access and experience in and of our services

A selection of EDI achievements so far

We are building upon a selection of our achievements so far in Equality, Diversity, and Inclusion.

Northampton General Hospital

An international shared decision making council has been created to support international nursing staff. The council benefits international nurses to acclimatise to the UK offering them practical support and guidance.

The appointment of a Director of Nursing Clinical Fellow – who supports International medical staff joining the Trust.

The REACH staff network meets monthly and has an Executive sponsor at Board level.

REACH reverse mentoring, pairing directors, and non-executive directors in a 12-month programme of sharing and learning through honest and sometimes difficult conversations about race and inequalities commenced.

Senior Staff being trained in unconscious bias and sharing this knowledge with directors engaged in the reverse mentoring programme.

A menopause library with relevant articles and information has been launched with planned support groups for both staff and partners to explore the impact.

We have launched two new staff networks. Both the LGBTQ+ network and the disability network will give a voice to staff who identify as being a member of these groups.

The distribution of over 1,100 Rainbow Badges enabling staff to show that Northampton General Hospital NHS Trust is open, non-judgemental, and inclusive for patients, their families, and colleagues, who identify as LGBTQ+.

SOS psychological support and wellbeing services, support diversity through matching practitioners based on the situation and individual needs. SOS use diversity leads to inform practices with wellbeing and psychological support services.

Kettering General Hospital

All recruiting managers have undertaken unconscious bias training before taking part in a recruitment panel.

A campaign of "We Declare" was launched to encourage all staff to provide accurate and timely equality and diversity information.

Several staff networks have been relaunched and supported by the EDI lead.

Two new networks have been established, the Gender Equality network and the Young Peer network.

There is an Executive Sponsor at board level for championing EDI issues.

Bullying, harassment and discrimination related to protected characteristics has been addressed through a communications campaign. This provided information on support available, policies, links to the Freedom to Speak Up Guardian; as well as access to counselling.

Equality Impact Assessments have been prioritised to be completed to ensure that our policies, practices, events, and decision-making process do not discriminate or present barriers to anyone from a protected group.

REACH Staff Governors have been recruited to contribute and advise the Board about the experiences of working at the hospital.

Equality of Access Pathways have been developed. These are to support staff with protected characteristics to achieve roles at the most senior level in the organisation.

This will be achieved through experience and training opportunities; and will better promote inclusivity across the Group.

Building Cultural awareness training, has been rolled out to support staff managing unconscious bias in the workplace.

Our Group EDI Priorities for 2021- 2024

Dedicated to excellence

Creating a representative and diverse workforce

Developing an inclusive and diverse workforce is a key strand within our Group People Strategy and hence our EDI strategy.

We want to create an environment that embraces diversity and promotes inclusion. We recognise the importance of providing a safe and caring environment for staff where they can be themselves in work.

We will support colleagues through an attraction strategy ensuring that Equality, Diversity and Inclusion is the golden thread runs through our talent management and career pathways and ensures staff with protected characteristics can apply for and be supported in promotion throughout their careers.

We will support colleagues who have been internationally recruited, ensuring a safe, caring environment in a positive practice environment, promoting a shared decision-making culture. We will actively address all discrimination across protected characteristics with fair and transparent policies.

We will prioritise the wellbeing of our staff and ensure colleagues with protected characteristics are enabled to gain the support including access to appropriate and if required bespoke psychological support needed to work effectively.

We will promote agile and flexible working policies for all our colleagues.

We will work to develop an inclusive organisation, which attracts and engages a diverse workforce, representative of the communities we serve.

Workstream and outcomes

We will understand the potential impact of the decisions we make on colleagues, by protected characteristics, and identifying mitigating steps to reduce or remove adverse impacts.

We will look at development solutions around Unconscious Bias to raise both individual and collective awareness.

We will deliver Disability Confident employer training to support recruiting and retaining and developing colleagues with disabilities.

Harnessing the talents of all communities to provide a high-quality patient care, increased patient satisfaction and better patient safety particularly the ethnic diversity at Board and senior management levels.

We will improve fair access to employment by extending the reach of adverts for band 8A and above roles into places where REACH, disabled and LGBTQ +staff are likely to search for employment opportunities
We will continue to offer on job training via the apprenticeship pathways for relevant entry level roles to attract diversity into and across the Group.

We will further develop wellbeing and psychological resources that meet the needs of our colleagues with protected characteristics by providing diversity and choice in service provision and continuing to promote services such as “Stronger Together “which offers specific psychological support in response to the intense pressures of the coronavirus pandemic.

We will ensure no section of our workforce is disproportionately involved in disciplinary processes and we will work towards ensure there is a level playing field in all our people processes.

We will work towards the development of a shared job description library across the Group People services.

We will undertake to develop into a Menopause Friendly Employer and model new ways of engaging colleagues through our targeted health and well-being initiatives.

We will sign up to committing to being a “Mindful Employer” and sign the charter to demonstrate our transparency towards promoting positive mental health and wellbeing towards both ourselves and our colleagues.

Accurate data collection and usage to measure inequalities

We recognise the need for good data and data analysis to ensure that board, management, and human resources have the knowledge they need to better understand issues and make them more visible, reinforcing organisational and individual accountability for action.

Triangulating this data and improvement plans against tools such as recruitment monitoring, talent development plans, succession plans and equality succession plans provides an overview of progress, indicating whether our existing Equality and Diversity Actions are having a positive impact and where intervention is required.

We will prioritise collecting Equality Impact Assessment information and be sensitive to staff concerns around self-disclosure, whilst ensuring we match resources to our colleague and team needs.

WRES data will allow us to measure the impact of each of the areas of our plan combined with our annual staff survey and we will work towards improving and reducing our data around Bullying and Harassment and Discrimination across the Group.

Workstream and outcomes

In line with the Equality Act (2010) and the NHS Equality Delivery system, we will improve our monitoring and analysis to develop better services and enhance our employment and training opportunities for all colleagues regardless of background.

The development of enhanced reporting and dashboards to track key workforce metrics and support activity management and analysis.

Implement the WRES and WDES action plans locally, enabling greater inclusion and network participation.
We will improve our information on Equality Impact Assessments and increase our numbers of staff completing these to ensure we match our staff needs in terms of access, training, development, and promotion opportunities.

We will focus on ensuring disciplinaries involving REACH colleagues are proportionate and reasonable. We will monitor the numbers to ensure fairness at every opportunity of the process and to ensure we are both an equal opportunity and transparent employer.

We will utilise exit interviews to better understand the experience of leavers and to focus on staff with protected characteristics to examine if a lack of diversity and inclusion are part of their story.

Compassionate Leadership and Accountability

We want our workforce to demonstrate and receive compassionate and inclusive leadership. Compassionate leaders play close attention to the people they lead, and understand the situations they face, respond empathetically, and take thoughtful and appropriate action to help.

Board members and senior leaders will champion equality and diversity and apply a consistently inclusive approach.

We will continue to utilise reverse mentoring at Board level to ensure we work to reduce the Board to ward gap and further work to improve visibility within our leadership teams by supporting colleagues with protected characteristics in applying for senior roles within the Group with our Pathways to Access model.

Board members and senior managers will be encouraged and supported to mentor, guide and advise staff from within our REACH community, to ensure that staff are given specific support to move into senior positions within the Group.

Board members and senior leaders will understand the equality impacts of their decisions and that decisions will advance equality and cohesion rather than adversely affect sections of the population with protected characteristics.

Workstream and outcomes

- We will take a demonstrable zero tolerance towards bullying, harassment and discrimination to ensure all our colleagues feel safe at work
- We will take a demonstrable zero tolerance towards racism in the workplace
- We will take a demonstrable zero tolerance towards sexism in the workplace
- We will take a demonstratable zero tolerance approach towards any incidence of discrimination or harassment relating to sexual orientation or gender identity in the workplace
- We will take a demonstrable zero tolerance to ableism in the workplace

This zero tolerance approach will be incorporated into Trust and Group policies.

Board members and senior leaders to routinely talk about and engage their staff on issues of Equality, Diversity and Inclusion and communicate the benefits.

The Board will have a membership that reflects members with protected characteristics and models diversity at all levels.

The Board will actively recruit Non-Executive Directors from a REACH background to further promote visible diversity.

The Board will appoint sponsors representing all our staff networks and identify and utilise its Health and Wellbeing Guardians for assurance on wellbeing initiatives.

Senior leaders and Board members will have performance objectives, on workforce race equality built into their appraisal process.

We will work towards email signoffs highlighting the preferred personal pronouns of staff (E.g. He/him, she/her or they/them). This will act as a reminder of the importance of gender identity and gender diversity.

Board stories and patient experience will include and engage with patients and families twice yearly with protected characteristics to better represent the diverse community we serve.

We will actively seek to appoint more governors with protected characteristics to ensure we model inclusion and equality in all levels of our workforce.

We will broaden our pathways model alongside leadership training as a development for our staff to move to upwards in the organisation with a clear set of steps to achieve promotion.

We will promote and engage the Board to use reverse mentoring in the following years with other groups with protected characteristics.

Culture change – Mainstreaming Equality, Diversity and Inclusion

We will create a culture where colleagues feel valued and recognised for their important and individual contributions. We will promote an environment where health inequalities can be identified in a safe and transparent way and for the organisation to learn and improve as a result.

We will ensure EDI practices are woven through the staff journey starting at induction and being part of recruitment and retention and included in any promotion opportunities.

We will continue to actively address bullying, harassment and discrimination and racism experienced by our colleagues and patients with protected characteristics and work towards a zero tolerance of inequality.

We will underpin and support our existing and emerging Staff Networks to formalise their work and promote link across the Group and use the members talents and lived experiences to inform and shape policy and practices across the Group.

Workstream and outcomes

We will enhance our internal and external communications to raise awareness of equality and inclusion issues as well as celebrating diversity.

We will recognise and celebrate good practice in EDI workstreams and behaviours where it is identified.

An Equality and Diversity allies programme will be introduced across the Group as another step to broaden the reach of EDI across all teams and departments and contribute to creating a more diverse and inclusive workplace.

We will create a library of lived diversity and inclusion experiences, with articles and documents of colleagues and patients and other professionals with protected characteristics to stimulate cultural change for equality.

We will continue to support and grow our EDI staff networks as a safe way for staff to have peer support and open conversations. Engagement with our staff networks provides the opportunity for the trust leadership to hear lived experiences of staff. We will ensure the Chair and Co-chairs and Governors have protected work time to participate in staff network activities.

All our staff networks will hold a formal constitution and produce agendas' minutes and report into the wider EDI steering group.

We will ensure that our EDI programmes are accessible to all levels of staff.

This will include training in unconscious bias, building cultural bridges and compassionism. This will be implemented from Board to ward throughout the organisation

We will ensure more Freedom to Speak Up champions are recruited to represent colleagues with protected characteristics and to make visible, groups who may have previously felt under-represented or less visible within the Group model.

Improved Patient Access and Experience

We know positive patient experience is achieved through everyone being informed and provided with the opportunity to be involved in decisions about their care.

In decisions about their care, we will continue to develop support for staff on how they can effectively involve and engage all patients and carers.

The goal is to secure a good cross-section of people reporting positive experiences about their care within our services.

We will make sure concerns and complaints about services are handled respectfully and efficiently and will continue to encourage reporting where our standards fall short of expectations.

We will identify any unnecessary variations in access, safety and experience of the Group's services and develop plans to address these.

We will meet the information and communication needs of patients, their families, carers and service users with a disability, impairment or sensory loss by completing the implementation of the Accessible Information Standard (AIS).

We will ensure that people with learning disabilities, autism or both receive treatment, care and support which is safe and personalised and have the same access to services.

We will provide service users and carers who may have specific communication needs a way of communicating in an easy and accessible format.

We will provide service users and carers patient information in an easy and accessible format.

Our NHS People Promise

Implementation

Our Equality Diversity and Inclusion Strategy has been designed to support the above themes from an equality perspective as each have implications for staff with the nine identified protected characteristics. As well as making our Group values comes to life, we intend they include a wide range of both opinions and voices of colleagues and patients within the Group.

The EDI strategy should be seen as the golden thread that runs through all the actions as EDI is built into everything we do. We will monitor progress with Group EDI action plans that will provide a road map to creating a better working environment for our staff (colleagues) and an inclusive welcoming environment for our patients and their families on both the NGH and KGH sites.

The Group EDI leads will manage respective action plans across both sites and multiple services accepting regional variations and ensure there is cross site learning and cross pollination of best practices between EDI teams.

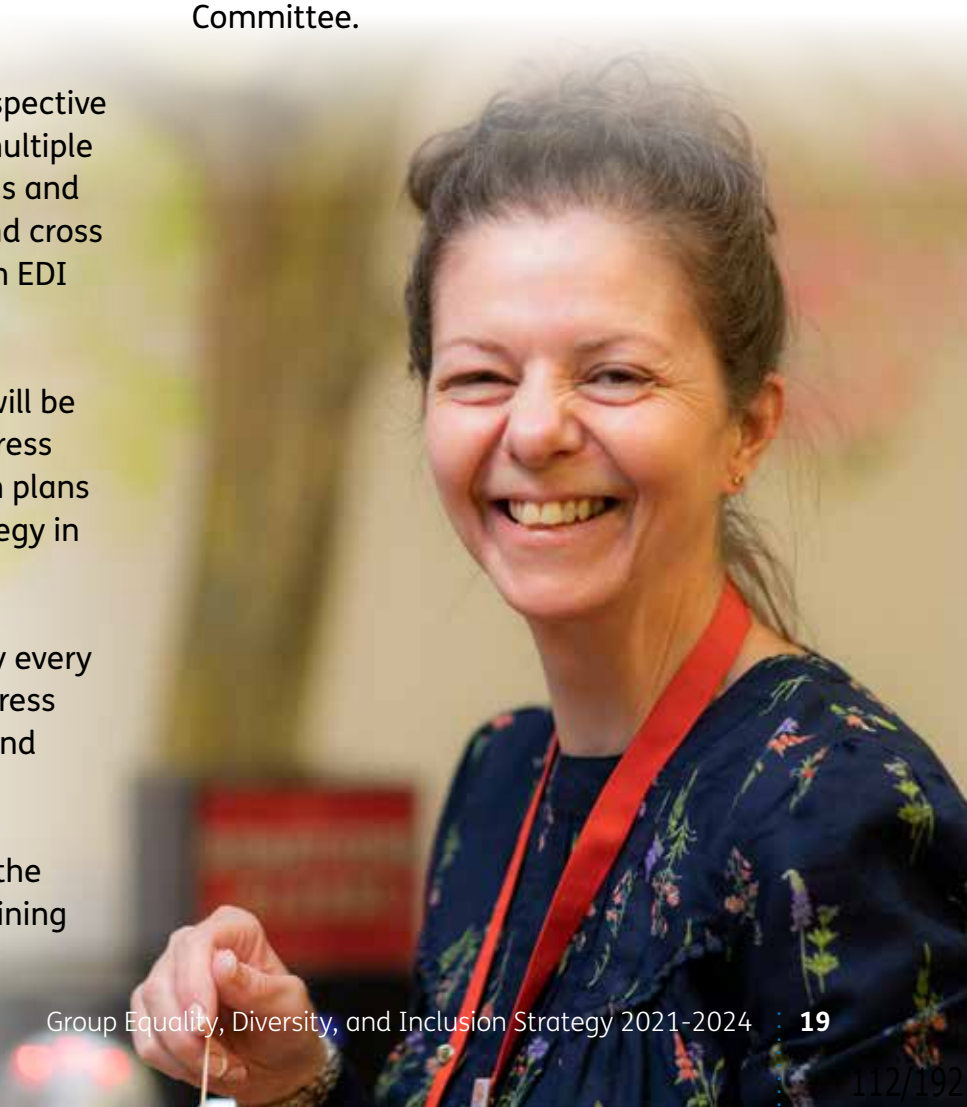
As the strategy spans four years, it will be important to review and report progress annually. This is to ensure the action plans remains live and to update the strategy in line with national developments.

Reviewing and updating the strategy every 12 months will help us monitor progress in line with the developing agenda and respective action plans.

The EDI leads will work closely with the Freedom to Speak Up Guardians, Training and Development and Organisational Development colleagues as well as Human Resource and Health and Wellbeing colleagues on both sites, to ensure the action plans improve the working life of colleagues and our patients and their families.

The EDI leads will work alongside Patient Experience leads in ensuring we promote a safe and respectful environment for both staff and patients.

The Group EDI leads will report alongside Staff Network Chairs and colleagues to the respective EDI steering groups and ensure all progress on the site-based EDI action plans are monitored and variations to time scales escalated accordingly to the People Committee.



Monitoring and Assurance

We will hold regular focus groups across our staff networks and listen to colleagues' experiences against the Group values and ensure we continue to monitor and update our action plans based on their feedback and lived experiences.

Our action plans will have specific and measurable targets which we will be held accountable for meeting to improve our WRES scores.

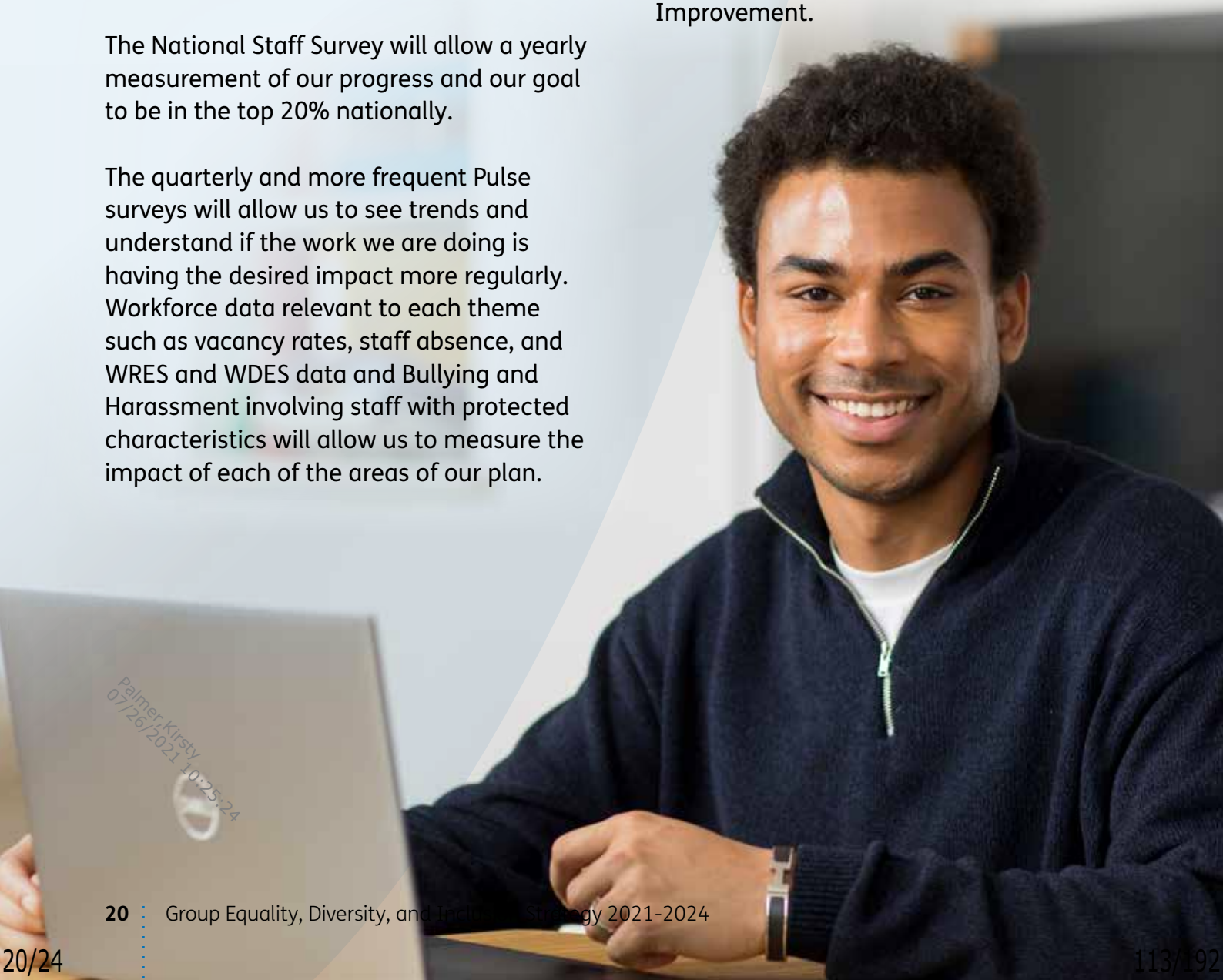
The National Staff Survey will allow a yearly measurement of our progress and our goal to be in the top 20% nationally.

The quarterly and more frequent Pulse surveys will allow us to see trends and understand if the work we are doing is having the desired impact more regularly. Workforce data relevant to each theme such as vacancy rates, staff absence, and WRES and WDES data and Bullying and Harassment involving staff with protected characteristics will allow us to measure the impact of each of the areas of our plan.

The People Committee will oversee the workstream and report to the Board progress against the EDI action plans for each site.

We will report on our progress to be A Model Employer to NHS England.

We will report on our progress on the Midlands Race and Workforce Inclusion strategy to both NHS England and NHS Improvement.



Public Duties

The Public Sector Equality Duty (PSED) that is set out in the Equality Act (2010) requires public authorities, in the exercise of their functions, to have due regard for the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

The PSED also asks organisations to set equality objectives at least every four years.

- To strengthen data collection of the protected characteristics of our service users
- To strengthen data collection of the protected characteristics of our workforce
- To collate and monitor data on the protected characteristics of our service users who make complaints
- To set local equality objectives in our business development plans
- To undertake equality impact assessments on our policies and business development plans to ensure they meet the needs of, and do not disadvantage, service users of any protected characteristics

Equality objectives have helped us to focus our core business surrounding equality and diversity; however, it is acknowledged there is still work to be done and any outstanding actions from the objectives will be translated into this strategy.

The Equality Act (2010) and PSED also requires the Trust to publish equality objectives and related information annually, this is demonstrated via an Annual Equality and Diversity report. These reports include information, disaggregated by service, on the protected characteristics of our workforce and service users. We aim to publish our annual equality report in March each year in line with statutory requirements set out in equality legislation.

Equality Delivery System (EDS) 2 is an assessment tool designed to measure NHS equality performance with an aim to produce better outcomes for people using and working in the NHS and to gather equality evidence that demonstrates compliance with the PSED of the Equality Act (2010)

Gender Pay Gap Information Regulations 2017 requires the Trust to publish six calculations relating to gender pay. The gender pay gap shows the difference in the average pay between all men and women in a workforce.

The Workforce Race Equality Standard (WRES) is a set of nine specific measures that all NHS organisations are required to measure with associated actions demonstrating how trusts are addressing race equality issues across its workforce.

Definitions

Carer	is used to describe any person who provides unpaid practical or emotional support to someone with a disability, addiction, or illness. The person may be a relative, partner, friend, or neighbour. A carer can be of any age and may be a young person aiding a parent or another person. A carer may live with the person they care for or provide support from a distance.
Disability	Having a physical or mental impairment that has a substantial and long-term negative effect on your ability to do normal activities. You meet the disability definition from the day you are diagnosed with a physical or mental impairment.
Diversity	acknowledges and values the full range of differences between people both in the workplace and in wider society.
Equality	is about creating a fairer society where everyone can participate and has the same opportunity to fulfil their potential. Equality is backed by legislation (e.g., Equality Act 2010) designed to address unfair discrimination, harassment, and victimisation.
European healthcare workforce	Qualified nursing, or midwifery professionals, associate nurses, or caring health personnel. Including doctors, nurses, dentists, allied health professionals, ophthalmologists, and surgeons working in Europe.
Inclusion	is about positively striving to meet the needs of different people and taking deliberate action to create environments where everyone feels respected and able to achieve their full potential.
LGBTQ+	Lesbian, Gay, Bisexual, Transgender and Questioning. The plus represents other sexual orientations and gender identities.
Nine Protected Characteristics	age, disability, sex, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation, marriage, and civil partnerships.
REACH	Race, Ethnicity and Cultural Heritage. This replaces the terms BAME and BME as an acronym.
Service user /patient	Is used to describe anyone that is under our care either as an Inpatient, outpatient or within community services.

Additional Sources

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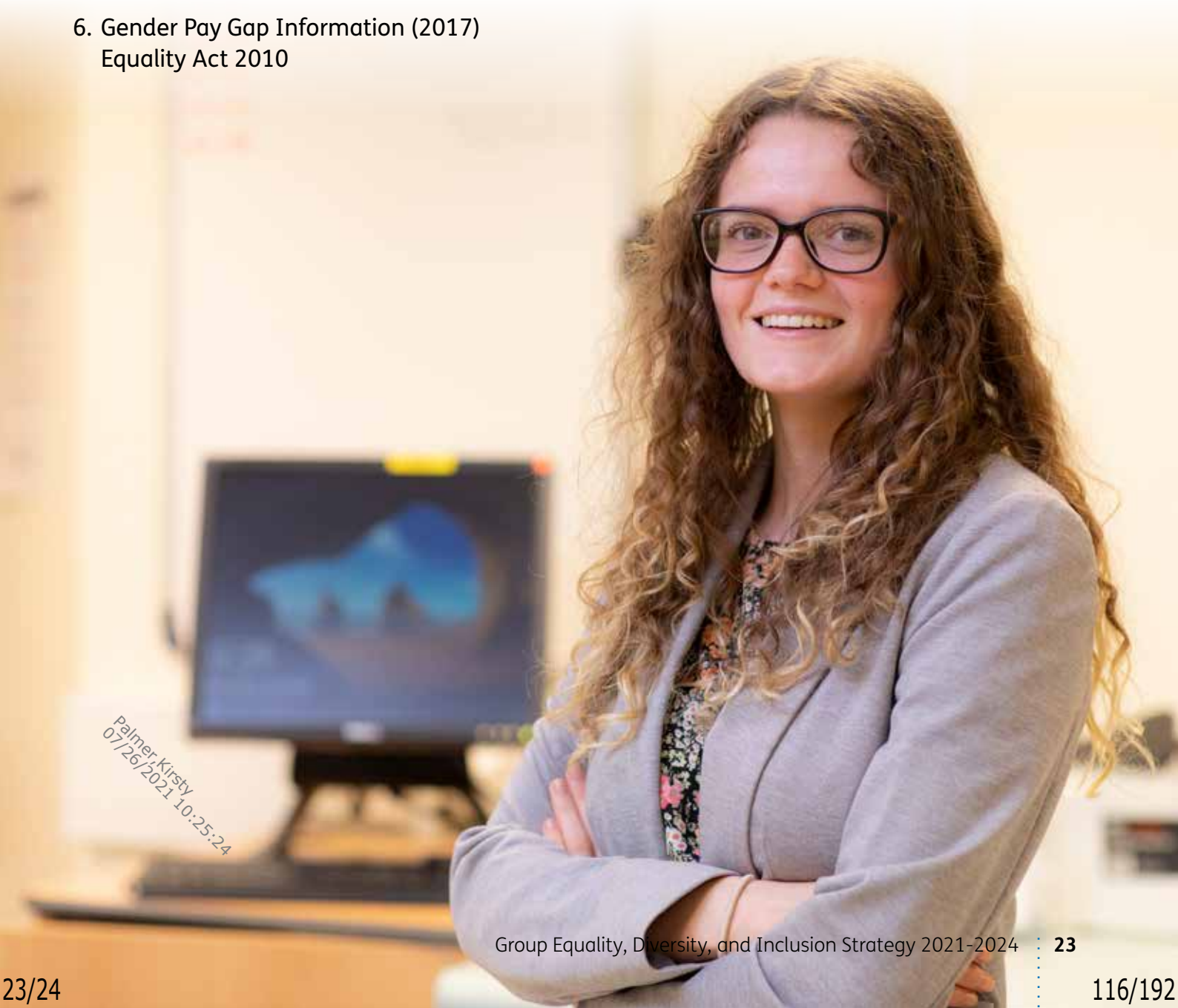
2. Marmot, M. “Fair society, healthy lives: The Marmot Review: strategic review of health inequalities in England post-2010” (2010).
3. Equality Act (2010)
4. Equality Delivery System 2 (EDS2) 2013. The NHS Constitution.
5. Health and Social Care Act (2012)
6. Gender Pay Gap Information (2017) Equality Act 2010
7. Mend the Gap (2020): The independent review of gender pay gaps in medicine in England. Chair Professor Dame Janet Dacre, Lead Researcher – Professor Carol Woodham
8. Human Rights Commission April 2011 updated June 2014 Equality and Human Rights Commission
9. A vision for change – acceptance without exception for trans people (2015) Stonewall



NHS

University Hospitals of Northamptonshire

NHS Group

Designed and produced by
Communications Department

July 2021

Cover sheet

Meeting	NGH Public Trust Board
Date	29th July 2021
Agenda item	3.2

Title	ICS Design Update
Presenter	Karen Spellman, Director of Strategy and Partnerships
Author	Karen Spellman, Director of Strategy and Partnerships

This paper is for

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

Group priority

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

Reason for consideration	Previous consideration
The paper is presented to update the Board on the latest developments in the ICS design model and the items requiring endorsement from Boards	The ICS design blueprint has previously been reviewed and discussed at the Board Development session in June 2021

Executive Summary

The paper sets out the agreements of the ICS design blueprint and a number of design elements that Boards have been asked to endorse. Further work is required during the next phase of the Northamptonshire ICS design to develop the underlying detail of the model and its component parts.

The design elements are set out on slide 3. Recognising the detail of each of the design elements and the membership of the ICS Body and precise remit of the ICS Partnership are still to be fully worked through, the Boards are recommended to **approve** these design elements.

Appendices

Longer papers should be summarised in the executive summary section and additional information appended.

Risk and assurance

The risks of the proposed ICS design model will be developed as the detail of each element of the model is refined

Financial Impact

The financial impact of the ICS design will be reviewed separately

Legal implications/regulatory requirements

The final ICS design model will be dependent on the imminent legislation

Equality Impact Assessment

The equality impact considerations will be reviewed as the ICS design is further developed.

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ICS Design Blueprint and Endorsement

NGH Board 29th July
KGH Board 30th July

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ICS Design Summary

The following illustrates the building blocks of our ICS blueprint that have been agreed at the HCP Board on the 17th June 2021. Further work is required to develop the underlying detail of the model and its component parts but the broad principle of the six design elements are agreed and supported across the system.

Design elements Boards asked to endorse

University Hospitals of Northamptonshire NHS Group

Within the design blueprint, there are a number of elements on which Boards are asked to endorse. This will ensure there is explicit approval to the overall direction of travel, and a clear mandate for developing the model in more detail during the next phase of work.

Recognising the detail of each of the design elements and the membership of the ICS Body and precise remit of the ICS Partnership are still to be fully worked through, the Boards are asked to endorse the following;

• ICS design element	Items requiring endorsement from Boards, ahead of the next phase of work to develop the detail
Collaboratives	1. Collaboratives will be formed around four system priorities. 2. Collaboratives will be commissioned at a system level, and operate system wide, but operate services which are tailored to meet needs at Place and neighbourhood level. 3. Our Collaboratives will operate under one of two Collaboration Models – either an Alliance or a Lead Provider. Further work is required to determine which model will be used for each collaborative, as well as leadership arrangements
Place arrangements and Health and Wellbeing Boards	4. Our ICS will have two places – aligning with the footprints for the new Unitary Authorities. 5. ICSs will require an overall system strategy to be developed by the ICS Partnership. We propose that this will incorporate our two (planned) Joint Health and Wellbeing Strategies – producing a single, system-wide strategic plan for meeting health, care and wider wellbeing needs across the County. 6. Joint commissioning for integrated health and care services will continue to take place at Place level (through Better Care Fund and current joint programmes). The ICS strategic commissioner and Local Authority commissioners will form joint arrangements for each Place in order to undertake this activity.
Neighbourhood (sub-place) arrangements	7. 'Neighbourhood' arrangements will be needed as a basis of effective integration and tailoring of services to local needs. We will support our Places to develop the neighbourhood arrangements which best work for them, as an explicit work stream during the next phase of design work. 8. Our collaboratives will operate services which are tailored to needs at Place and neighbourhood level. They will co-design services in consultation with Place, Sub-Place and general practice representatives.
ICS Statutory Body and ICS Partnership	9. The (small) size of our system means that we have an opportunity to build a Board which includes the most comprehensive possible range of NHS and Local Authority partners. *This means that our ICS statutory Board will be able to take a 'whole system' perspective, and will therefore play a relatively larger role – and our ICS Partnership a relatively smaller role – within our overall system governance arrangements when compared to other, larger systems. The precise membership and ways of working for the ICS statutory body will be determined in the next phase of work.* 10. Our ICS Partnership will be made up from the membership of our two Health and Wellbeing Boards and our ICS statutory Board. 11. The Partnership will meet twice per year, in order to (i) consider progress against our Outcomes Framework over the past year, and (ii) agree a systemwide health and care strategy (or an update to the existing strategy, as appropriate) to improve population outcomes. This then forms the key mandate for the ICS statutory board, our Places and our Collaboratives. 12. The precise remit of the ICS Partnership – and its relationship to other parts of the system - will be developed during the next phase of work. This will include considering whether the ICS Statutory Body Independent Chair should also chair the Partnership Board.

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Cover sheet

Meeting	Public Trust Board
Date	29th July 2021
Agenda item	4.1

Title	Freedom to Speak Up Annual Report & Quarter 4 Report
Presenter	Claire Campbell Director of Corporate Development, Governance and Assurance/ Freedom to Speak up Guardian
Author	Claire Campbell Director of Corporate Development, Governance and Assurance/ Freedom to Speak up Guardian

This paper is for

☐Approval	☐Discussion	☒Note	☒Assurance
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Group priority

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

Reason for consideration	Previous consideration
The Board is asked to note and comment on the content of the report and accept this paper for information and assurance.	Board receives bi- annual report and quarterly reports presented to the People Committee.

Executive Summary

The report provides the background to the introduction of Freedom to Speak Up and progress in the past twelve months to further develop clear systems and process at Northampton General Hospital.

It provides information on concerns raised in quarter 4, as well as 2020/21. It also provides detail of case content, open and closed cases and outcomes and sources of concerns raised.

Comparisons with 2019/20 data is made where available.

The report provides an overview of the Trust Guardians role over the past 12 months. It outlines the further development of the values ambassador roles and links, publications and work with the National Guardians office are also highlighted.

Appendices

FTSU Report – Appendix 1

Risk and assurance

The report provides assurance of processes in place to support staff to raise concerns which are pertinent to patient and staff safety.

Financial Impact

None

Legal implications/regulatory requirements

There is a legal requirement under the Health and Social Care Act to appoint a Freedom to Speak Up Guardian.

Equality Impact Assessment

Increase in staff trained from the REACH network as Values Ambassadors should increase accessibility for relevant staff.

APPENDIX 1

FREEDOM TO SPEAK UP ANNUAL REPORT (INCORPORATING Q4 REPORT)

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 People 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 (JANUARY- MARCH 2021)

Within the quarter being reported, 13 Freedom to Speak Up cases were received. This is a small decrease on the previous quarter (14).

Content of cases reported:
- 6 cases identified issues with patient safety/ quality
- 6 case identified issues with staff safety/ Training
- 6 cases identified issues with bullying and harassment
- 4 cases identified issues with systems, processes or policies
- 1 case identified issues with environment/ infrastructure
- 0 cases identified issues with workplace culture
- 0 case identified issues with leadership
- 1 case identified issues with use of resources

Cases reported by/ to:
11 cases were reported to the Guardian direct
2 cases were reported to the CQC

Of the above cases;
- 3 remain open with ongoing investigations/ or report write up underway
- 9 referred to HR or within an HR process

Source of concerns raised by staff group:
- Doctor x3
- Registered Nurses & Midwives x 4
- AHP's x 0
- HCA x 1
- Admin, Cleaning & Maintenance/ Ancillary staff x 2
- Corporate x 1
- Other x 2 (unknown)

3 individuals wished to remain anonymous.

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

3. FREEDOM TO SPEAK UP CASES (APRIL 2020 - MARCH 2021)

The numbers of cases reported via the Freedom to Speak Up policy for 2020/21 were 42. This is a big decrease on the previous year when 71 cases were reported in total. However, it is in keeping with an average for medium size Trust of 10 cases per quarter.

Cases reported each quarter were as follows:
Quarter 1- 7 cases (2019/20 12 cases)
Quarter 2- 8 cases (2019/20 16 cases)
Quarter 3- 14 cases (2019-20 26 cases)
Quarter 4- 13 cases (2019-20 17 cases)

It should be noted that a decrease has generally been seen regionally during 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, our organisation did not suffer the issues others did in relation to PPE availability.

The increase in Quarter 3 occurred after a Covid wave and an increase in cases regarding policies relating to returning to work and local rules for travelling to work etc.

Content of cases reported:

Category	Q1	Q2	Q3	Q4	Total 2020/21	Total 2019/20
Patient safety/ quality	3	3	3	6	**15**	**30**
Staff safety/ Training	1	4	2	6	**13**	**5**
Bullying and harassment	5	6	5	6	**22**	**41**
Systems, processes or policies	2	3	7	4	**16**	**15**
Environment/ infrastructure	0	0	0	1	**1**	**1**
Workplace culture	0	2	2	0	**4**	**3**
Leadership	0	2	2	0	**4**	**6**
Use of resources	0	1	1	1	**3**	**2**

- 15 cases identified issues with patient safety/ quality 38% (2019/20 42%)
- 13 cases identified issues with staff safety/ Training 31% (7% 2019/20)
- 22 cases identified issues with bullying and harassment 52% (57% 2019/20)
- 16 cases identified issues with systems, processes or policies 38% (21% 2019/20)
- 1 case identified issues with environment/ infrastructure 2% (1% 2019/20)
- 4 cases identified issues with workplace culture 10% (4% 2019/20)
- 4 cases identified issues with leadership 10% (8% 2019-20)
- 3 cases identified issues with use of resources 7% (3% 2019/20)

Case reported to:

Source	Q1	Q2	Q3	Q4	Total 2020/21	Total 2019/20
FTSU Guardian	7	7	14	11	**39**	**56**
CQC	0	0	0	2	**2**	**3**
GOSW	0	0	0	0	**0**	**4**
Ambassador	0	1	0	0	**1**	**4**
DATIX	0	0	0	0	**0**	**1**
Other	0	0	0	0	**0**	**2**

Source of concerns raised by staff group in the last year:

Staff group	Q1	Q2	Q3	Q4	Total 2020/21	Total 2019/20
Doctor	1	0	1	3	**5**	10
Nurse & Midwife	1	2	7	4	**14**	25
AHP	2	3	1	0	**6**	9
HCA	0	0	0	1	**1**	Previously counted below
Admin, clerical & Maintenance/ Ancillary	2	2	3	2	**9**	13
Corporate	1	0	1	1	**3**	4
Other (Anonymous)	0	1	1	2	**4**	10
Total	**7**	**8**	**14**	**13**	**42**	**71**

2 cases where the individual indicated they are suffering detriment as a result of speaking up in (2019/20- 0 cases).

4. TRUST GUARDIAN ROLE- ACTIVITY IN PREVIOUS YEAR

- All data submissions were made before the required deadline
- Completed the National Guardians Office Annual Survey for FTSU Guardians
- Attended the Midlands Regional FTSU Network Meetings- held virtually
- Reviewed all Case Review Reports published to date by the National Guardians Office and the recommendations made.
- Training- agreed inclusion of FTSU in staff induction and review of training in line with revised training guidance to ensure embedding into Trust practice- this has yet to commence due to Covid 19.
- Trained five more Values Ambassadors including colleagues from the REACH (previously BAME) network.
- Provided FTSU training for the REACH Network and Pharmacy staff

5. NATIONAL GUARDIANS OFFICE

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.

a. 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)

b. % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)
c. % 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)
d. % 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).

6. 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
- Refresh the FTSU Strategy and revise deadlines due to Covid 19 impact
- Two further training courses for staff from the REACH Network are planned for September 2021 to further develop the Ambassador role and increase accessibility
- Review proposed refresh of report content with NED Lead, to include feedback from staff on the service and further comparisons with national data

7. RECOMMENDATIONS

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

Cover sheet

Meeting	Public Trust Board
Date	29th July 2021
Agenda item	4.2

Title	People Partnering Pledge – Disciplinary Policy Review
Presenter	Mark Smith, Chief People Officer
Author	Andrew Stewart, Head of Employee Relations

This paper is for

☐Approval	☐Discussion	☐Note	☒Assurance
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Group priority

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

Reason for consideration	Previous consideration
Board awareness of our new Group disciplinary policy and regulatory requirement	Joint People Committee – 17th June 2021

Executive Summary

Our People Plan People Partnering Pledge is:

To consider how we work with one another, reflecting, learning and ensuring feedback is heard and actioned, leading to a reduction in formal employee relations management

One of our key deliverables within the first 12 months for this pledge includes a review and amendment of policies, across the group, to ensure they are inclusive of a just and restorative approach. Based on national case studies and the learning to be taken from these situations, combined with recent examples across both Trusts within the Group, whereby cases could have been managed in a much more just and restorative approach, it has been necessary to review our disciplinary policy. It is a national requirement to share this review with the Board and to place the new policy on both Trust websites.

Both KGH and NGH had undertaken separate reviews of their policies and procedures in line with the recommendations from Baroness Harding's letter received by both Trusts in 2019. It was decided with the formation of the group model between both Trusts that the tone of our policies going forward would be amended to also include the new Group dedicated to excellence values and that a new disciplinary policy would be ratified (in line with the sovereign organisations internal governance processes) by the end of June 2021. It is acknowledged that the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed.

As part of this review the team consisting of managers, HR professionals and staff side colleagues were asked to consider adhering to best practice, applying a rigorous decision-making methodology, ensuring people are fully trained and competent to carry out their role, assigning sufficient resources, decisions relating to the implementation of suspensions/exclusions, safeguarding people's health and wellbeing and board-level oversight.

- We are attempting to accomplish this in a way to promote informal resolution and reduce/mitigate risk of never events happening within the disciplinary process across the group
- We will know that this has worked when we can see an improvement in
    - our WRES and WDES scores relating to our disciplinary processes being proportional based on our workforce profile, and
    - a reduction in our formal disciplinary cases which result in minimum or no further action
- We aim to see an improvement in the above based on reviewing and updating the disciplinary policy in line with
    - best practice
    - just culture
    - our values; Compassion, Accountability, Respect, Integrity and Courage.
    - making sure everyone understands their obligations in the process
    - managers have been appropriately trained as case managers, investigators or as a panel chair and that their training is up to date,
    - a simplified disciplinary process is created so that everyone can understand it
    - ensuring checks and balances have been thoroughly explored prior to going to the formal stages; and
    - mitigating any adverse affects to health and wellbeing by providing additional advise and support to the individuals going through the disciplinary process

The aim of University Hospitals of Northamptonshire NHS Group (Kettering General and Northampton General Hospitals) is to develop and apply local investigation and disciplinary procedures that are informed and underpinned by current best practice. Independence and objectivity is maintained at every stage of the investigation and disciplinary procedure. It is understood that informal management action is often the best route to take in response to a concern or incident provided learning from the incident or circumstances is taken forward =. A comprehensive and consistent decision-making methodology is applied that provides full and careful consideration when determining whether a formal investigation and

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hearing should take place. It is important decisions which could result in formal sanctions, including dismissal, are very well informed, reviewed from multiple perspectives, and never taken by one person alone. People leading these processes should be fully trained and can demonstrate the level of competency required to undertake the role of either case manager, case investigator or panel chair.

In looking at suspensions/exclusions there is clear definition around decision making process i.e.

Decisions to suspend/exclude should be:	Decisions to suspend/exclude should not be:
✓ a measure of last resort	× taken by one person alone
✓ applied when there is full justification for doing so	× taken by anyone who has an identified or perceived conflict of interest
✓ timebound, with review dates firmly set	
✓ proportionate	
✓ with Director level oversight and approval	

As part of the implementation of the policy it is critical that the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Additional advice and support should be gained through Occupational Health as required. Individuals should also be signposted to 24/7 crisis listening support. Staff guidance on being investigated should be created, to set expectations around what will happen as part of the process and where to go to get advice and support as required. Manager guidance to support staff who are being investigated should be created to ensure all communication is timely, comprehensive, unambiguous, sensitive and compassionate.

It is proposed that the Joint People Committee in common across the Group and the Board is provided with information on a regular basis based on numbers of procedures being undertaken, reasons for those procedures, adherence to process and timeliness of case management, justification for any suspensions/exclusions, decision-making relating to outcomes, impact on patient care, colleagues and importantly that any lessons learnt from the situations are taken forward and actioned.

Appendices

Group Disciplinary Policy

Disciplinary implementation action plan

Risk and assurance

Failure to deliver the Group People Plan pledge under People Partnering to ensure learning is taken to enhance colleagues experience in the workplace

Financial Impact

The costs of disciplinary activity is met within existing budgets. It is hoped that with the introduction of this policy with a learning, supportive and restorative approach the effects of the process/policy will be more supportive for colleagues, reducing illness and absence and employment tribunal applications

Legal implications/regulatory requirements

There are a number of legal and regulatory requirements addressed in this policy. The first is to ensure the policy is compliant with best legal practice, particularly the ACAS disciplinary guidance and to ensure the regulatory requirement of reviewing the policy in line with national learning is undertaken

Equality Impact Assessment

This work has a direct Equality impact on colleagues within both Trusts and the Group. This is articulated and will be measured within the Workforce Race Equality and Workforce Disability Equality Standards (WRES ad WDES)

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NHS Group

Disciplinary Policy (UHON-HR01)
NGH-PO-028 / KGH-B.1.A

Ratified By:	Procedural Documents Group (NGH) / Terms and Conditions Meeting (KGH)
Date Ratified:	July 2021
Version No:	1
Supersedes Document No:	6.1 (NGH) 7 (KGH)
Previous versions ratified by (group & date):	PDG August 2011, May 2014, June 2014, February 2015, May 2015, February 2016, September 2017, October 2017, January 2018, July 2018, January 2019, May 2019, July 2020, August 2020 (NGH) July 2010, September 2011, October 2011, February 2012, August 2013, April 2014, Sept 2014, Oct 2016 (KGH)
Date(s) Reviewed:	June 2021
Next Review Date:	July 2023
Responsibility for Review:	Group Chief People Officer
Contributors:	HR Directorate & Partnership Forum Operational Subgroup (NGH) Terms and Conditions, Operational Management Group (KGH) Group People Committee (NGH & KGH)

Compassion Accountability Respect Integrity Courage

1. Introduction

1.1. What this policy covers:

The Trust is committed to ensuring that you are managed in a supportive, consistent, fair and effective manner. Our Disciplinary Policy is designed to help and encourage you to achieve and maintain high standards of conduct, to resolve problems of minor misconduct quickly, fairly and in a supportive manner, while protecting the Trust's interests, patients and staff.

1.2. This policy will outline the procedure to be followed in respect of alleged policy breaches detail disciplinary sanctions that can be applied and their duration make clear the responsibilities of the Trust Board of Directors, managers and individuals in respect of this policy and tell you how you can appeal a decision.

2. Principles

2.1. Where possible, issues of minor misconduct will initially be addressed informally between you and your manager. Formal action will only be taken if this has not led to the necessary improvement or where matters are more serious.

2.2. This policy should not be seen merely as a means of imposing sanctions. The intention is that disciplinary cases are dealt with early on to resolve problems as quickly and fairly as possible and understand where you can go to seek additional advice and support.

2.3. If you are a doctor, please note all investigations are conducted in line with our maintaining high professional standards policy and procedure.

3. Responsibilities

3.1. The Trust Board has overall responsibility for developing and maintaining an open, fair and consistent culture throughout the Trust, where disciplinary issues are dealt with fairly as a just and learning organisation.

3.2. The HR Department is responsible for providing professional HR advice and support to managers on applying this policy and associated procedures. The HR Department will be involved in all formal stages of the disciplinary procedure.

3.3. The Trust is responsible for ensuring that employees know the standards of conduct required in their job and providing you with additional psychological and wellbeing support to go through this process

3.4. Managers are responsible for ensuring their actions taken under this policy are reasonable and fair.

3.5. You are responsible for cooperating with the Trust, in any investigations arising from alleged breaches and other aspects of the disciplinary process.

4. Policy in practice

4.1. The policy has the following stages:

- Stage One – Informal
- Stage Two – Formal
- Stage Three – Appeal

5. Stage One – Informal Process

5.1. Where possible, minor misconduct will be handled informally between you and your manager as part of day-to-day management. The aim of an informal discussion is to:

- advise you how you are demonstrating poor conduct or standards
- confirm that you understand the behavioural standards the Trust expects
- help you make the necessary changes by setting objectives/standards within an agreed timescale
- agree any support you need, in line with a just and learning culture
- agree how progress will be reviewed
- set out the next steps of continued poor conduct or standards.

5.2. The discussion should be dealt with in a timely manner. These informal discussions may take place more than once. There is no right to be accompanied nor to appeal against informal outcomes. However, you can invoke the Trust Grievance Policy if you feel the action taken by your manager is unreasonable. Managers must make a file note that summarises discussions under the previous bullet points. Where this happens, employees must be given a copy and another will be placed on your personal file, dated and marked “informal discussion”.

5.3. The note will remain on your file until your progress against the set objectives is reviewed and if it has improved, your manager will write to you to confirm you have met the required standards. However, should they decide that insufficient improvement has been made, the note will remain on the file and may be considered as part of any future hearing documentation.

6. Stage Two – Formal

6.1. The investigation

6.1.1. For more serious incidents, including potential gross misconduct, informal discussions will not be appropriate and it will be necessary to begin formal proceedings. It may also be appropriate to move to the formal stage where previous informal discussions have not brought about the required changes in behaviour or conduct.

6.1.2. Incidents that require formal investigation must have agreement between a case manager and a representative from the HR department.

6.1.3. Having determined that the formal process is necessary, the HR Department will appoint an case investigator with no previous involvement in respect of the alleged misconduct. The

case investigator will interview you and any witnesses with relevant information and then submit a report to the case manager, advising whether in their judgement there is a case to answer, also recommending whether a formal disciplinary hearing is necessary.

6.1.4. If the case manager and HR decide that there is a formal disciplinary case to answer, you will be told and this will be confirmed in writing within seven calendar days of that decision. The disciplinary hearing should be planned to be held within 28 calendar days of the end of the investigation. The case investigator's report and any statements collated during the disciplinary process will be included in the documentation to be considered at the disciplinary hearing and you will receive a copy.

6.1.5. If the case manager and HR decide that there is no formal case to answer, but further informal action is required you will be informed of this verbally and in writing within seven calendar days. If you have been suspended, you will return to work at the agreed date and time. This will be managed in line with Stage 1 – Informal.

6.1.6. If the case manager and HR decide that there is no case to answer, you will be informed of this verbally and in writing within seven calendar days. If you have been suspended, you will return to work at the agreed date and time. This process will end.

6.2. The disciplinary hearing

6.2.1. The disciplinary panel will consist of three people, including a senior manager who will chair the hearing, and a HR Manger / Business Partner. Where allegations involve professional misconduct or technical issues, a senior professional from an appropriate discipline will be part of the three-person panel. A minimum of seven calendar days' written notice will usually be given to allow you to make arrangements to be accompanied if you wish and to prepare your case. This may be reduced by mutual consent. The letter you receive will give information about:

- the nature of the complaint against you
- the date, time and venue for the meeting and names and job titles of the panel members
- copies of any reports, statements or information relevant to the internal disciplinary process that will be relied on or referred to at the meeting. However, in certain circumstances (e.g. to protect a witness) the Trust reserves the right to withhold information
- the names and positions of any witnesses
- the meeting being of a disciplinary nature and may result in disciplinary action being taken against you
- your right to be accompanied at the meeting by a trade union representative, work colleague, relative or friend not acting in a legal capacity

6.2.2. You should provide a written statement of your case at least five calendar days before the hearing, with any witness statements upon which you intend to rely, giving the names of any witnesses you intend to call. If you or your representative is unable to attend for justifiable

reason, the disciplinary hearing will be rearranged once. At the second attempt, if you still cannot attend, the hearing may still take place, and a decision may be made in your absence.

6.2.3. At the hearing, both parties (you and the presenting manager) will be given an opportunity to present your case, call any witnesses and, in addition to the panel members questions, both parties will also be able to ask questions.

6.2.4. After both cases have been heard, the hearing will be adjourned so the panel can come to a decision. It will decide firstly whether there is a disciplinary case to answer, and secondly, if there is a disciplinary case to answer, what level of sanction should be made. The parties will be recalled and the chair of the panel will inform both of its decision. The outcome will be confirmed in writing within seven calendar days of the hearing. In some circumstances, the panel may need more time to reach a decision.

7. Disciplinary sanctions

7.1. The sanction level will be determined by the severity of the offence and may take into account previous sanctions. Warnings may run concurrently if they are for different reasons. The Trust will normally select one of the following sanctions if the allegations are upheld.

7.2. Informal action

7.2.1. If decide that there is no formal case to answer they may ask that further informal action is required and refer it back to be managed in line with “Stage 1 – Informal Stage”

7.3. Written warning

7.3.1. A written warning will usually be used as the first step of corrective action following conduct offences. The Trust will explain the nature of your unacceptable actions and the conduct or standards required in future. You will be advised in writing that failure to improve conduct or may result in further disciplinary action. The warning will be held on your personal file for 12 months, after which it will no longer be considered live.

7.4. Final written warning

7.4.1. A final written warning is usually issued following a written warning that has not improved conduct, but it may be given after a more serious first offence. You will be advised in writing that failure to improve may result in dismissal. The final written warning will remain on your personal file for up to two years at the discretion of the panel, after which time it will no longer be considered live.

7.4.2. In reaching a decision, a panel may consider previous warnings that have expired only where they are directly relevant to the case being considered and demonstrate a previous pattern of behaviour that has continued.

7.5. Dismissal

7.5.1. Dismissal occurs when your employment is terminated with or without notice. Dismissal without notice is called “summary dismissal” and it will only be used in cases of gross misconduct. The Trust reserves the right to impose a sanction short of dismissal if deemed appropriate. This may include demotion or transfer to a different post. Any such decision will be confirmed to you in writing once you’ve been informed of the outcome.

7.6. Professional bodies

7.6.1. The Trust also reserves the right, if appropriate, to report the matter to the relevant professional body (eg NMC, GMC, HCPC), which may also take additional action.

7.7. Right to be accompanied

7.7.1. You have the right to be accompanied at any formal stage of the disciplinary procedure by a trade union or staff association representative or colleague. Prior to any formal meeting, you should inform the manager or panel with whom you are meeting that you will be accompanied, giving the name of your representative.

7.8. Suspension or restriction of practice

7.8.1. If the Trust believes it is appropriate, it may suspend you from your work or restrict your practice pending further investigation or disciplinary action. Suspension is a neutral act, not a disciplinary sanction. You’ll be suspended on full pay and the Trust will try to keep the period of suspension as short as possible.

7.8.2. Reasons for suspension can include where:

- the alleged action is of a serious nature, potentially constituting gross misconduct
- it is necessary to protect you or others
- an internal or criminal investigation might be compromised if you were to remain at work.

7.8.3. Before deciding to suspend, the manager should seek advice from HR or the on-call manager if out of hours. If a decision to suspend is made, you will be informed verbally and then in writing within seven calendar days. While you are suspended you should not attend work or discuss your case with any colleague other than your representative or colleague you have asked to accompany you at any hearing.

7.8.4. If you need to contact anyone connected to the Trust while suspended, you can contact the HR department, your line manager, union representative or the case investigator. Any reasonable request will not be refused.

7.8.5. Breach of the terms of your suspension may result in additional disciplinary action up to and including dismissal without notice.

8. Stage Three – Appeal

8.1. Following the disciplinary hearing, you may wish to appeal, perhaps because you feel the sanction or finding is unfair, or you believe that the Disciplinary Policy was not applied. If so, notify the Director of HR & OD in writing within seven calendar days of receiving the decision letter.

8.2. An appeal hearing will be arranged, and the process and timescales will mirror those outlined in the disciplinary hearing stages detailed in this policy. The panel members and secretary will have had no prior direct involvement in any aspects of the current issue. The decision of the appeal hearing will be final. An appeal hearing panel can increase a sanction, up to and including dismissal.

9. Definitions of *gross* misconduct

9.1. Gross misconduct is misconduct that is so serious that it fundamentally breaches the contractual relationship between the employee and organisation. When an employee commits an act of gross misconduct, the employer can dismiss them without notice.

9.2. Examples of gross misconduct include:

- theft, fraud or deliberate falsification of records or the Trust documents
- serious or gross negligence resulting in unacceptable loss, damage or injury
- intentional serious breach of the Trust policy or regulations or improper conduct in relation to job responsibilities
- malicious damage to the Trust property
- intentional misuse of confidential information
- fraudulent misuse of the Trust's property or name
- unauthorised entry to computer records or inappropriate use of the Trust data or computing
- equipment, including social media
- serious breaches of health and safety rules
- serious insubordination
- continued failure to follow reasonable management instructions bringing the Trust into disrepute including serious misconduct outside work
- physical violence or bullying
- unlawful discrimination or harassment

9.3. Conviction or being charged with a criminal offence outside the workplace and normal working hours may be deemed as misconduct or gross misconduct, though not automatically. Each case should be considered based on individual circumstances, including the nature of the offence, effect of the charge on the employee's suitability to do the job and their relationship with the Trust, colleagues, patients and those external to the Trust and any sentence incurred.

10. Appendices

IN DEVELOPMENT

Appendix 2. Disciplinary Policy and Procedure Action Plan

Key

Not started		On track		Off track		Completed	

Action	Lead	Deadline	Status
Joint Review group established with HR leads and Unions from both KGH and NGH	Head of Employee Relations	June 2021	
Review of both KGH and NGH policies	Head of Employee Relations	June 2021	
Review of GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' and HCPC guidance	Head of Employee Relations	June 2021	
Review of Imperial NHS Foundation Trust Policy held as an example by NHSE/I	Head of Employee Relations	June 2021	
Review of Yeovil Hospital Health Care HR policy manual held up as exemplar by CQC	Head of Employee Relations	June 2021	
Review of new group trust values	Head of Employee Relations	June 2021	
Agreement for Policy to set standards across NGH and KGH group to include • Review disciplinary panel composition where dismissal is to be considered • Manager guidance about practical application • Staff guidance to manage and set expectation	Head of Employee Relations	End of June 2021	
New joint disciplinary policy published on NGH and KGH websites	Head of Employee Relations	End of July 2021	
Joint training delivered between HR and Unions	Head of Employee Relations and Staff Side Chairs	Nov 2021	
Review appendices • Colleague Guidance & Support to include: Flow chart and defined addition support available for colleagues going through the disciplinary process (At both NGH and KGH). With detail of trade unions at the trust, psychological and wellbeing support and support for staff from different cultural backgrounds • Manager Toolkit to include additional material on how to resolving things informally, supporting colleagues through the process, where to get additional training, awareness on the Just Culture Guide supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents and referrals to counter fraud. A review of template letters / Informal discussion. Manager training on authority to dismiss and a suspension Check List • Training and Implementation to include clearly defined role profiles for case investigator, case	Head of Employee Relations and Deputy Director of HR and OD	August 2021	

manager and HR, Case manager training on authority to dismiss.			
Review 4 online modules online modules provided by NHS Merseycare	Head of Employee Relations	June 2021	
Seek additional support around implementation and senior buy in for 'Just Culture'	Head of Employee Relations	June 2021	
Support the scoping for 'Just Culture' training for the Northamptonshire Healthcare system	Head of Employee Relations	Sept 2021	
Seek funding from system for cultural ambassador programme	Head of Employee Relations	June 2021	
Deliver cultural ambassador programme	NHCP People Board	Dec 2021	
Build trusted working relationship between HR, Managers and Unions at KGH and NGH	All	Ongoing	
Set KPIs around the reduction of formal disciplinary hearings to be reviewed at board	CPO	July 2021	
All decisions to investigate into formal sanctions to be reviewed by Senior HR team	Head of Employee Relations	June 2021	
Review KGH and NGH investigation/fact finding training for line managers	Head of Employee Relations and Deputy Director of HR and OD	Sept 2021	
Review delivery method of training to improve attendance	Head of Employee Relations	Sept 2021	
Developing a competence framework for managers completing formal investigations	Head of Employee Relations and Deputy Director of HR and OD	Sept 2021	
Agree standard investigation report template across NGH and KGH	Head of Employee Relations and Deputy Director of HR and OD	Sept 2021	
Review resource required as part of the People Partnering reconfiguration to allow for • sourcing independent external advice and expertise as required • Scope and build the creation of a staff welfare officer within the wellbeing offering • To create business case to be created bank of independent trained investigators to operate independently of managers and HR (mirroring successful NGH approach)	CPO	Dec 2021	

Cover sheet

Meeting	Public Trust Board
Date	29th July 2021
Agenda item	4.3

Title	Board Assurance Framework Quarter 1
Presenter	Claire Campbell- Director of Corporate Development, Governance & Assurance
Author	Claire Campbell- Director of Corporate Development, Governance & Assurance

This paper is for

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

Group priority

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

Reason for consideration	Previous consideration
• 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	Previous BAF iterations presented quarterly to Trust Board. Board committees received paper last month to approve the revised format and presentation of the BAF and have received their Committee specific risks this month prior to presentation at Board.

Executive Summary

The purpose of the Trust Board Assurance Framework (BAF) is to provide the 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 strategic objectives/priorities.

All Board committees and the Board review the BAF quarterly. Each risk has been assigned to one or more Board committees with an Executive Director Lead assigned to lead the update of each risk.

This report presents work completed to date, with the Board approved revised format which will be used by both NGH and KGH BAF to ensure a consistent approach for Group BAF risks as well as individual Trust BAF risks.

Work on Group risks (defined as those that may potentially affect the realisation of the group priorities), the alignment and subsequent approval by both Trust Boards of a standardised risk appetite criteria and statements and alignment of the BAFs are now completed.

This report presents the recently approved eight Group BAF and nine NGH specific risks. NGH BAF risks from the previous year have been reviewed and updated, ensuring no overlap with the additional agreed Group risks and an audit trail of changes made is provided within the report.

Appendices

Appendix 1- BAF Report

Appendix 2- Group BAF Risks

Appendix 3- NGH BAF Risks

Risk and assurance

The Board assurance framework describes key risks to the Trust's corporate objectives and informs the organisational Annual Governance Statement

Financial Impact

Some actions required may have financial implications

Legal implications/regulatory requirements

Several risks could have impacts on legal or regulatory requirements

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)

Board Assurance Framework Report

Q1 2021/22

1. Introduction

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

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

This report describes the updated Q1 position 2020/21 in relation to the risks associated to delivery of Group objectives described on the BAF and the strategic risks specific to NGH.

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.

4. Changes to the BAF in Q1 2021/22

4.1 Group Strategic Risks:

The following Group Strategic Risks have been added to both the BAF at NGH and KGH:

a) BAF Risk GS101: Failure to deliver the group People Plan may result in reduced staff engagement, empowerment and lack of inclusion which would impact negatively on staff satisfaction, recruitment and retention, and reflect poorly in our staff survey results

- New Group risk: Reports to People Committee
- Risk Score: 16

b) BAF Risk GS102: Failure to deliver the group Clinical Strategy may result in fragmented and inefficient service delivery, fragile service provision, and sub-optimal outcomes of care alongside negatively impacting staff retention, recruitment and morale

- New Group risk: Reports to Quality Governance Committee
- Risk Score: 12

c) GSI03: Failure to deliver the group Nursing, Midwifery and Allied Health Processionals Strategy may result in inequity of clinical voice, failure to become a truly clinically led organisation and centre of excellence for patient care
- New Group risk: Reports to Quality Governance Committee
- Risk Score: 16

d) GS104: Failure to deliver the NHCP Integrated Care System Partnership may result in an impact on the quality of service provided across the group
- New Group risk: Reports to Quality and Finance Committees
- Risk Score: 16

e) GS105: Failure to deliver the group Strategic Estates programme may result in care delivery from poor clinical environments, cost inefficiencies, and lost opportunities for integrated care delivery at place
- New Group risk: Reports to Quality Governance Committee
- Risk Score: 12

f) GS106: Failure to deliver the Group Academic Strategy may result in non-delivery of University Hospital status, reducing the ability to attract high calibre staff and research ambitions
- New Group risk: Reports to Quality Governance Committee
- Risk Score: 8

g) GS107: Failure to deliver the group Digital Strategy may result in poor performance of systems resulting in a lack of consistency and expected levels of quality of patient and staff experience of digital services across the group
- New Group risk: Reports to Group Digital Hospital Committee
- Risk Score: 20

h) GS108: Failure to deliver the group financial strategy, plans and improvement of underlying financial deficit position, may result in an inability to deliver Trust, Group and system objectives
- New Group risk: Reports to Finance and Performance Committee
- Risk Score: 25

Further work is required to populate action owners and completion dates for actions. In addition, scrutinising committee information to be reviewed to ensure all scrutinising committees for NGH and KGH are included as appropriate.

4.2 NGH Strategic Risks:

a) NGH 109: Risk of not meeting regulators minimum standards, local and national performance standards.
- New risk: Risk amalgamates previous BAF risks 1.1 and 1.2. Reports to Quality Governance Committee and Finance & Performance Committee
- Risk Score:15

b) NGH 110: Risk of Avoidable Harm
- Previously BAF risk: 1.4. Reports to Quality Governance Committee
- Risk Score: 10

c) NGH 111: 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
- Previously BAF risk: 1.7. Reports to Finance & Performance Committee
- Risk Score: 20

d) NGH 112: Risk of failure in ICT infrastructure and/or a successful cyber security attack may lead to loss of service with a significant patient care and reputational impact
- Previously BAF risk: 1.8- components of risk removed which are in included in GS107, with residual risk of ICT infrastructure and cyber security attack retained. Reports to Digital Hospital Committee
- Risk Score: 20

e) NGH 113: Risk that the Trust is unable to respond appropriately to further pandemic waves; provide sufficient elective care and other clinical services, including non-elective and possible delays to treatment
- New risk: Risk amalgamates previously BAF risks 1.9 and 1.10. Reports to Board and all Board Committees
- Risk Score: 15

f) NGH 114: Risk that the Trust fails to promote a culture that puts patients first
- Previously BAF risk: 2.1. Reports to Quality Governance Committee
- Risk Score: 8

g) NGH 115: Risk that the Trust fails to have financial control measures in place to deliver its 2021/22 financial plan
- Previously BAF risk: 5.1. Reports to Finance and Performance Committee
- Risk Score: 25

h) NGH 116: Risk that the Trust fails to fully deliver the financial efficiency programme
- Previously BAF risk: 5.2. Reports to Finance and Performance Committee
- Risk Score: 25

i) NGH 117: 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
- Previously BAF risk: 5.3. Reports to Finance and Performance Committee
- Risk Score: 15

4.3 Remaining Previous BAF Risks

a) Previous BAF Risk 1.5: Risk that Trust fails to deliver high quality services in all clinical areas 24/7

- Subsumed into GS102: Failure to deliver the group Clinical Strategy may result in fragmented and inefficient service delivery, fragile service provision, and sub-optimal outcomes of care alongside negatively impacting staff retention, recruitment and morale

b) Previous BAF Risk 1.6: Inability to recruit adequate numbers of nursing staff
- Subsumed into GS101: Failure to deliver the group People Plan may result in reduced staff engagement, empowerment and lack of inclusion which would impact negatively on staff satisfaction, recruitment and retention, and reflect poorly in our staff survey results

c) Previous BAF Risk 3.1: 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
- Subsumed into GS101: Failure to deliver the group People Plan may result in reduced staff engagement, empowerment and lack of inclusion which would impact negatively on staff satisfaction, recruitment and retention, and reflect poorly in our staff survey results

d) Previous BAF Risk 3.2: Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future
- Subsumed into GS101: Failure to deliver the group People Plan may result in reduced staff engagement, empowerment and lack of inclusion which would impact negatively on staff satisfaction, recruitment and retention, and reflect poorly in our staff survey results

e) Previous BAF Risk 3.3: Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optimal culture
- Subsumed into GS101: Failure to deliver the group People Plan may result in reduced staff engagement, empowerment and lack of inclusion which would impact negatively on staff satisfaction, recruitment and retention, and reflect poorly in our staff survey results

5. Risk Score

Total Risk score for both Group and NGH Strategic risks: 283 for 17 risks (8 Group Strategic Risks and 9 NGH Strategic risks). This score has increased from 201 in Q4 2020/21 when there were 16 NGH specific risks on the Trusts BAF.

Board Assurance Framework
Group Strategic Initiative Risk Report
BAF Risks in Order of Severity (5th July 2021)

University Hospitals of Northamptonshire NHS Group

Ref	Group Priority	Risk Title	Initial Risk Level (July 21)	Current Risk Level (July 2021)	Movement (from Initial)	Residual Risk Level	Risk Appetite	Comments
GSI08	Sustainability	Failure to deliver the group financial strategy, plans and improvement of underlying financial deficit position, may result in an inability to deliver Trust, Group and system objectives	**25**	**25**	→	**15**	**High**	
GSI07	Sustainability	Failure to deliver the group Digital Strategy may result in poor performance of systems resulting in a lack of consistency and expected levels of quality of patient and staff experience of digital services across the group	**20**	**20**	→	**15**	**High**	
GSI01	People	Failure to deliver the group People Plan may result in reduced staff engagement, empowerment and lack of inclusion which would impact negatively on staff satisfaction, recruitment and retention, and reflect poorly in our staff survey results.	**16**	**16**	→	**12**	**Moderate**	
GSI03	Patient	Failure to deliver the group Nursing, Midwifery and Allied Health Processionals Strategy may result in inequity of clinical voice, failure to become a truly clinically-led organisation and centre of excellence for patient care	**16**	**16**	→	**12**	**Low**	
GSI04	Systems and Partnership	Failure to deliver the NHCP Integrated Care System Partnership may result in an impact on the quality of service provided across the group	**16**	**16**	→	**12**	**High**	
GSI02	Quality	Failure to deliver the group Clinical Strategy may result in fragmented and inefficient service delivery, fragile service provision, and sub-optimal outcomes of care alongside negatively impacting staff retention, recruitment and morale	**12**	**12**	→	**8**	**Low**	
GSI05	Sustainability	Failure to deliver the group Strategic Estates programme may result in care delivery from poor clinical environments, cost inefficiencies, and lost opportunities for integrated care delivery at place	**12**	**12**	→	**6**	**High**	
GSI06	Quality	Failure to deliver the Group Academic Strategy may result in non-delivery of University Hospital status, reducing the ability to attract high calibre staff and research ambitions	**8**	**8**	→	**4**	**Low**	

Key:	Initial Risk Level	The risk (consequence x likelihood) with controls in place at the time risk initially identified	Current Risk Level	The risk (consequence x likelihood) with controls in place at the time of assessment or review	Residual Risk Level	The risk (consequence x likelihood) once the further planned actions have been achieved

Principal Risk No: GSI01	Failure to deliver the group People Plan may result in reduced staff engagement, empowerment and lack of inclusion which would impact negatively on staff satisfaction, recruitment and retention, and reflect poorly in our staff survey results.

Changes since last review

Date Risk Opened:	**Risk Classification:**	**Risk Owner:**	**Scrutinising Committee:**
April 2021	Operational Infrastructure	Chief People Officer	People Committee

Underlying Cause/Source of Risk:
Linked Corporate risks:

NCRR 2003; NCRR 2579

KCRR002, KCRR017, KCRR029

Initial score		**Current score**		**Residual score**	
16 (Extreme)		16 (Extreme)		12 (High)	
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
4	4	4	4	4	3

Current Controls	**Assurance of Controls**
Group People Plan in Place, extensive engagement. Group People Committee in Common in place. People Committee development sessions aligned to People Plan delivery. Continued engagement through staff for (JNC, Networks, staff reference groups etc)	Routine group People Committee updates – alignment progress reports (internal) Standing mandatory reporting, regular workforce metrics reports, exception reporting in place (Internal) Routine staff voice presentations (Internal) Positive staff side involvement in People Committee (internal)
Gaps in Controls	**Gaps in Assurance**
HR structures not aligned to People Plan. Pledge delivery plans in development. Formal People sessions workplans aligned to pledge delivery to be agreed. Comprehensive support for group HR team required.	People Pledge metrics / dashboards reporting to group people committee and to Divisional Performance Reviews. People Committee oversight of delivery of the HR restructuring programme.

Further Planned Actions	**Action Owner**	**Due Date**
1. Restructuring of HR functions to align to and support People Plan Pledges 2. Align current workstreams to People Pledges. 3. Develop detailed pledge delivery plans. 4. People metrics dashboard in development 5. Agreed change support programme.		1. Leadership structure in place 31.12.21 2. 30.06.21 3. 31.08 21 4. Phase 1 30.07.21, Phase 2 30.09.21 5. 30.06.21

Principal Risk No: GSI02	Failure to deliver the group Clinical Strategy may result in fragmented and inefficient service delivery, fragile service provision, and sub-optimal outcomes of care alongside negatively impacting staff retention, recruitment and morale

Changes since last review

Date Risk Opened:	**Risk Classification:**	**Risk Owner:**	**Scrutinising Committee:**
April 2021	Quality Operational Infrastructure Financial	Medical Directors and Directors of Strategy	Quality and Safety Committee

Underlying Cause/Source of Risk:

No linked Corporate risks.

Initial score		**Current score**		**Residual score**	
12 (High)		12 (High)		8 (High)	
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
4	3	4	3	4	2

Current Controls	**Assurance of Controls**
The Clinical Strategy is managed through the Joint Clinical Reference Group, with individual Trust Clinical Leadership meetings providing a further point of reference and point for resolving tactical issues. The fortnightly Strategic Collaboration Group manages the clinical collaboration and strategy development work against plan and resolves and agreed on the strategic direction of work.	Progress of work will be shared and reviewed at Trust Clinical Leadership Meetings (Internal) Plans and progress will be presented at Collaboration Programme Committee (Internal)
Gaps in Controls	**Gaps in Assurance**
Following completion of an overarching clinical strategy, individual service areas prioritised for more detailed analysis and design will need to be set up and managed as projects. Links between the Group Clinical Strategy and wider ICS plan are not yet fully established.	Comms plan that; 1. fully informs clinical staff across both Trusts of the work, it's objectives and timescales. 2. engages and listens to all staff about their ambitions for the clinical strategy, and how they wish to be engaged in delivering it. Detailed analysis of demand and capacity across services will take place following confirmation of priority areas, which in turn will be based on broad data analysis. Engagement with specific patient groups will take place as detailed design work commences. Initially patient views will be incorporated into the work via historical complaints data and general input from Healthwatch

Further Planned Actions	**Action Owner**	**Due Date**
1. Identification of Comms leads to support development of targeted comms plan. 2. Develop detailed plan for subsequent phase of work that will focus on the integration of specific services.		1. 31.05.21 2. TBC

Principal Risk No: GSI03	Failure to deliver the group Nursing, Midwifery and Allied Health Processionals Strategy may result in inequity of clinical voice, failure to become a truly clinically-led organisation and centre of excellence for patient care

Changes since last review

Date Risk Opened:	**Risk Classification:**	**Risk Owner:**	**Scrutinising Committee:**
April 2021	Quality Operational Infrastructure	Directors of Nursing and Midwifery	Quality & Safety Committee

Underlying Cause/Source of Risk:
Linked Corporate risks:

NCRR 1188

KCRR033

Initial score		**Current score**		**Residual score**	
16 (Extreme)		16 (Extreme)		12 (High)	
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
4	4	4	4	4	3

Current Controls	**Assurance of Controls**
NGH and KGH have separate professional strategies monitored via hospital Nursing and Midwifery Boards. There is a Director of Nursing and Midwifery and a Deputy who have jointly led the development of the strategy at NGH and KGH. The NMAHP is linked to our People, Academic and Clinical Strategies.	NGH in progress for Pathway to Excellence re-accreditation (June 22) (Internal) Regular reporting to NMB internally and to Joint QGSC and CPC and Board (Internal)
Gaps in Controls	**Gaps in Assurance**
Further communication required to increase visibility and ownership of strategy with all staff. Strategy to be launched. Workstream leads and working groups to be identified. Reporting structure to be put in place (agreed to be joint QGSC). Change to board level leadership at KGH - outcome yet to be determined.	KGH to secure funding to commence P2E journey. Reporting and monitoring not aligned across both sites. Establishment of strategy review groups (combined) to meet monthly.

Further Planned Actions	**Action Owner**	**Due Date**
1. Agree funding stream for P2E for KGH 2. Establish strategy review group		1. 07.07. 21 2. 22.07. 21

Principal Risk No: GSI04	Failure to deliver the NHCP Integrated Care System Partnership may result in an impact on the quality of service provided across the group

Changes since last review

Date Risk Opened:	**Risk Classification:**	**Risk Owner:**	**Scrutinising Committee:**
April 2021	Quality Finance	Directors of Strategy	Quality Governance Committee Finance & Performance Committee

Underlying Cause/Source of Risk:
Linked Corporate risks:

KCRR014, KCRR011

Initial score		**Current score**		**Residual score**	
16 (Extreme)		16 (Extreme)		12 (High)	
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
4	4	4	4	4	3

Current Controls	**Assurance of Controls**
The development and delivery of the Northamptonshire Integrated Care System is being led through the Health and Care Partnership Board attended by the Group Chair and CEO. The system architecture to deliver the current plans is in place with representation from the Group and Trust executives.	Northamptonshire Health and Care Partnership delivery plan to achieve 'maturing ICS' status has been submitted and signed off by NHSE/I Approval given by the NHCP Board to procure external provider to support the system to develop a detailed, milestone-based plan which will then be programme managed over the next 13 months as part of the transition to an ICS statutory body for Northamptonshire.
Gaps in Controls	**Gaps in Assurance**
Design and mapping work required across the NHCP to transition to statutory ICS body by April 22. The transition to a safe and legal ICS entity is an initial step, there will need to be clarity on the development horizon and the ambition for the ICS beyond April 22. A series of Board development sessions have been established to shape our ambition for the ICS The CPC may be extended to include the ICS to enable rapid, collaborative decision making and receive broad input from across the programme in order to comprehensively represent the views of the Group	Clarity on the definition and a common system view of the ambition for the ICS arrangements Representation and engagement in current and emerging ICS agenda Clarity on how the future arrangements dock into those of the Group

Further Planned Actions	**Action Owner**	**Due Date**
1. External provider to support the NHCP system to clarify aim for ICS, operating model and delivery plan to enable transition into ICS by April 22. 2. Review and increase Group engagement to include NEDS and EDs on existing and emerging ICS architecture. 3. Monthly reporting through CPC 4. Board development sessions to ensure a clear course for shaping and leading the emerging ICS and operating model.		1. 30.06.21 2. 30.05.21 3. Commence 01.05.21 4. Two sessions by 31.12.21

Principal Risk No: GSI05	Failure to deliver the group Strategic Estates programme may result in care delivery from poor clinical environments, cost inefficiencies, and lost opportunities for integrated care delivery at place

Changes since last review

Date Risk Opened:	**Risk Classification:**	**Risk Owner:**	**Scrutinising Committee:**
April 2021	Quality Finance Infrastructure	KGH Director of Strategy NGH DoE	Strategic Development Committee Finance & Performance Committee

Underlying Cause/Source of Risk:
Linked Corporate risks:

NCRR 1174; NCRR 1177; NCRR 1701; NCRR 1702; NCRR 1703; NCRR 1738; NCRR 2440

KCRR015, KCRR026,KCRR030, KCRR036

Initial score		**Current score**		**Residual score**	
12		12		6	
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
3	4	3	4	3	2

Current Controls	**Assurance of Controls**
Partners have been appointed and commissioned to undertake a Group Estates Strategy, which will set out the combined assets and risks associated with the current Estate. The Group Clinical Strategy has started and this will define the clinical requirements of both sites for the future. Kettering now have a full Development Control Plan as part of its HIP2 programme and Northampton have a site masterplan. These foundations will come together to start to form the Group Strategic Estates Plan. A System Estates Board is in place across the ICS with all Health and Care partners.	Kettering HIP2 SOC has been submitted and a Local Development Order has been signed with Kettering Planning Authority (Internal / External)
Gaps in Controls	**Gaps in Assurance**
A Group Strategic Estates Delivery Committee needs to be set up. Work with the local authorities needs to begin in earnest to make the most of local opportunities.	The System Estates Strategy is not strategic and needs further development. The Group Strategy for Net Carbon Zero needs to be written and ties into the System Green Plan. The Group requires a joint Strategic Estates Plan that supports delivery of the Group Clinical Strategy.

Further Planned Actions	**Action Owner**	**Due Date**
1. Group Green Plan to be agreed by Boards. 2. Group Strategic Estates Plan to be commissioned in Autumn 2021 following completion of the Group Clinical Strategy.		1. 31.03. 22 2. 30.09. 21

Principal Risk No: GSI06	Failure to deliver the Group Academic Strategy may result in non-delivery of University Hospital status, reducing the ability to attract high calibre staff and research ambitions

Changes since last review

Date Risk Opened:	**Risk Classification:**	**Risk Owner:**	**Scrutinising Committee:**
April 2021	Quality Finance	Medical Directors and Directors of Strategy	Quality Governance Committee

Underlying Cause/Source of Risk:

No linked Corporate risks.

Initial score		**Current score**		**Residual score**	
8 (High)		8 (High)		4(Moderate)	
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
4	2	4	2	4	1

Current Controls	**Assurance of Controls**
The Academic Strategy is managed through the Partnership Board with University of Leicester (UoL). This is supported by an Operational Group which has been focussed on meeting the criteria to achieve University Hospital Status.	UoL have signed a Partnership Agreement that sets out the criteria for working between the Group and UoL (Internal / External) The Academic Strategy and the supporting Business Case has been approved by both Hospitals (Internal / External) UoL Council and Executive have approved our progression to University Hospital status (Internal / External) The UoL NED has been included within the KGH constitution (Internal / External)
Gaps in Controls	**Gaps in Assurance**
To support the delivery of the Academic Strategy, we will be establishing sub groups to support our Research and Education activities in partnership with UoL. Royal College (RC) approval for the clinical academic posts is taking considerably longer than expected. To manage the Business Case, we need to have a Finance Group to track business benefits, income and expenditure. Report to PFR in October 21. A plan for the next 12 months has been developed outlining key priorities. New Medical Education Manager in post and Medical Education Partners at NGH to improve U/grad provision for medical students.	No timeline from RC on anticipated approvals. Ability to appoint to Clinical Academic positions- risk limited interested and/ or poor quality candidates, putting the Academic Strategy at risk. NGH Medical Education Team have new people in post. Training and induction underway to ensure team fully operational.

Further Planned Actions	**Action Owner**	**Due Date**
1. New University Hospital of Northamptonshire Branding agreed to be used on the new Job Adverts for Clinical Academic Posts. 2. Working closely with UoL to chase RC to approve JD's. 3. New website to promote Research activities at NGH to demonstrate Research ambitions and success to engage with potential applicants for Clinical Academic Posts. 4. SMART legacy for Diabetes post of £250k makes this position very attractive compared to other Professorial posts in Diabetes. 5. New Induction for U/grad Med Ed students planned for next intake in Sept to address concerns from UoL		1. 05.07.21 launch 2. 3. 05.07.21 4. 5. 30.09.21

Principal Risk No: GSI07	Failure to deliver the group Digital Strategy may result in poor performance of systems resulting in a lack of consistency and expected levels of quality of patient and staff experience of digital services across the group

Changes since last review

Date Risk Opened:	**Risk Classification:**	**Risk Owner:**	**Scrutinising Committee:**
April 2021	Quality Infrastructure Fianance	Group Chief Digital Information Officer	Group Digital Hospital Committee

Underlying Cause/Source of Risk:
Linked Corporate risks:

NCRR 1482; NCRR 1684; NCRR 1733; NCRR 1923; NCRR 2170; NCRR 2432

KCRR009, KCRR038, KCRR039, KCRR008

Initial score		**Current score**		**Residual score**	
20 (Extreme)		20 (Extreme)		15 (Extreme)	
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
5	4	5	4	5	3

Current Controls	**Assurance of Controls**
Group Digital Roadmap delivery progress is monitored regularly at GDHC. CCIOs in place across the Group. CNIOs in place across the Group .	Regular updates and reporting on digital strategy to Group Digital Hospital Board Committee (Internal). Group Digital Operational Meetings in place. Weekly EPR Operations meeting in place at both Trusts, with escalation to GDHC as necessary Health Intelligence Strategy and Cloud-First policy in place at KGH
Gaps in Controls	**Gaps in Assurance**
Workstreams need to be aligned to the 8 themes in the strategy and team objectives defined. Definition and benchmarking of Strategy targets NGH EPR Programme: * Business Case for NGH EPR to be approved * EPR Procurement to be concluded Capacity and capability to implement Theme 5: Providing insight to support decision-making, including: • Deployment and use of data visualisation tooling across the Group	Alignment of management of digital risks across both Trusts HIMSS and What Good Looks Like Benchmarking Cloud-First policy in place at NGH Reporting and monitoring of underlying infrastructure performance

Further Planned Actions	**Action Owner**	**Due Date**
1. Risk review completed. 2. HIMSS EMRAD Assessments 3. Review of Group Cloud-First Policies 4. Board development session Digital Boards with NHS Providers 5. Infrastructure review concluded.		1. 13.05. 21 2. 31.03. 22 3. 31.10. 21 4. TBC 5. 31.10. 21

Principal Risk No: GSI08	Failure to deliver the group financial strategy, plans and improvement of underlying financial deficit position, may result in an inability to deliver Trust, Group and system objectives

Changes since last review

Date Risk Opened:	**Risk Classification:**	**Risk Owner:**	**Scrutinising Committee:**
April 2021	Financial Operational	Chief Finance Officer	Finance and Performance Committee

Underlying Cause/Source of Risk:
Linked Corporate risks:

NCRR 2343; NCRR 2345

KCRR015

Initial score		**Current score**		**Residual score**	
25 (Extreme)		25 (Extreme)		15 (Extreme)	
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
5	5	5	5	5	3

Current Controls	**Assurance of Controls**
Business planning process, alignment of activity, workforce and finances Group Performance Management framework, including for areas where not on track. Management of capital and working capital. Workforce Management meetings (Workforce) Efficiency Steering Groups (Savings) Contingency against underperformance (TBC H2 only) Elective recovery monitoring System collaboration and joint working including Group representation (Group CFO, DoFs & NEDs) at System Finance Committee	Planning submissions subject to board and board committee scrutiny Performance management framework and meetings
Gaps in Controls	**Gaps in Assurance**
Scope and priorities of Group Financial Strategy not yet finalised. Structure and processes in development for Group transformation, investment controls and opportunity identification / delivery Centralisation of controls of over discretionary spending (?) H2 21/22 operational and financial planning guidance and priorities not yet known other than an expectation for improvement in underlying system financial performance (+£20m improvement quoted by NHSEI regional team), with movement to a 'sustainable' position in a 2-3 year timeframe In-year reforecasting process and mitigation plans Budget setting policy (?) Management of education programmes on Financial sustainability Increase capacity to deliver major change projects	

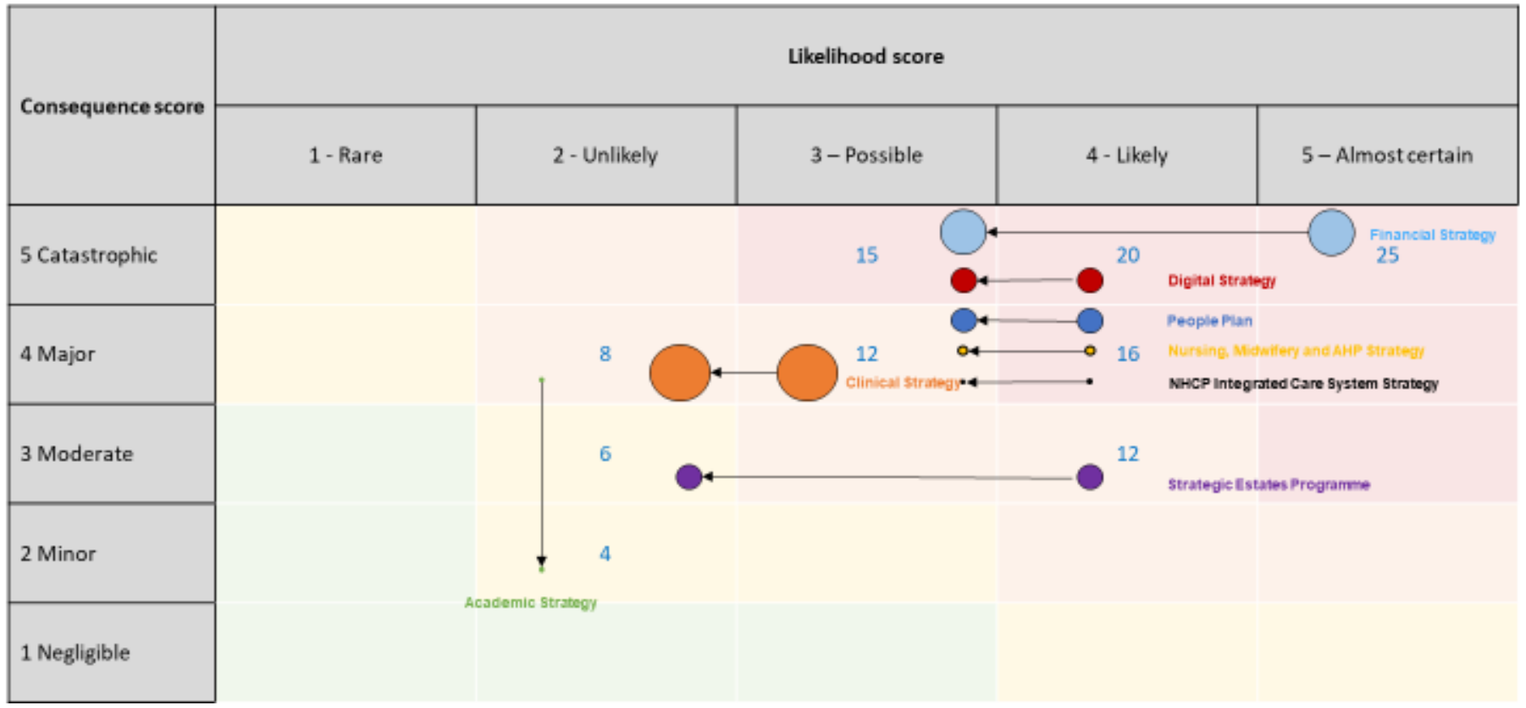
Further Planned Actions	**Action Owner**	**Due Date**
1. GCFO 2. Alignment of Trusts, Group, and system financial objectives and plans. 3. Broad internal and external engagement required		1. Commence 01.06.21 2. 3.

	Movements on Board Assurance Framework (since previous report)
ADDITIONS	None
INCREASES	None
DECREASES	None
CLOSURES/ AMALGAMATED	

Strategic initiative risk heat map

Number of interdependencies • 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Size of the bubble indicates the combined number of interdependencies - those with large bubbles and high risk scoring will require the greater scrutiny and assurance



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

Executive Leads / Action Owners

GCEO	Group Chief Executive Officer
GCFO	Group Chief Finance Officer
GCPO	Group Chief People Officer
GCDIO	Group Chief Digital Information Officer
KHCEO / NHCEO	Kettering / Northampton Hospital CEO
KMD / NMD	Kettering / Northampton Medical Director
KDoN / NDoN	Kettering / Northampton Director of Nursing
KCOO/ NCOO	Kettering / Northampton Chief Operating Officer
N DoE&F	Northampton Director of Estates and Facilities
KDoS / KDoS	Kettering / Northampton Director of Strategy
KDoG / NDoG	Kettering / Northampton Director of Governance

Board Assurance Framework
NGH Strategic Risk Report
BAF Risks in Order of Severity (20th July 2021)

Ref	Group Priority	Risk Title	Initial Risk Level (July 21)	Current Risk Level (July 2021)	Movement (from Initial)	Residual Risk Level	Risk Appetite	Comments
NGH 115	Sustainability	Risk that the Trust fails to have financial control measures in place to deliver its 2021/22 financial plan	**25**	**25**	→	**5**	**High**	
NGH 116	Sustainability	Risk that the Trust fails to fully deliver the financial efficiency programme	**25**	**25**	→	**10**	**High**	
NGH 111	Sustainability	Risk of failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failures	**20**	**20**	→	**15**	**High**	
NGH 112	Sustainability	Risk of failure in ICT infrastructure and/or a successful cyber security attack may lead to loss of service with a significant patient care and reputational impact	**20**	**20**	→	**16**	**High**	
NGH 113	Quality	Risk that the Trust is unable to respond appropriately to further pandemic waves; provide sufficient elective care and other clinical services, including non-elective and possible delays to treatment	**15**	**15**	→	**10**	**Low**	
NGH 117	Sustainability	Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements	**15**	**15**		**10**	**High**	
NGH 109	Quality	Risk of not meeting regulators minimum standards, local and national performance standards	**15**	**15**		**10**	**Low**	
NGH 110	Quality	Risk of avoidable harm	**10**	**10**	→	**5**	**Low**	
NGH 114	Patient		**8**	**8**		**4**	**Low**	

Key:	Initial Risk Level	The risk (consequence x likelihood) with controls in place at the time risk initially identified	Current Risk Level	The risk (consequence x likelihood) with controls in place at the time of assessment or review	Residual Risk Level	The risk (consequence x likelihood) once the further planned actions have been achieved

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

Principal Risk No: NGH 109	Risk of not meeting regulators minimum standards, local and national performance standards		
Changes since last review			
Date Risk Opened: April 2021	**Risk Classification:** Compliance	**Risk Owner:** DCD, G & A and COO	**Scrutinising Committee:** Quality Governance Committee Finance & Performance Committee

Underlying Cause/Source of Risk:	**Initial score**		**Current score**		**Residual score**	
	15		15		10	
CRR reference risks: 731,1303,1553,1665, 1782, 1867,1879,1902,1303; 1782; 1795; 1867; 1911; 1902;1930 1971;2132; 2341.	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
	5	3	5	3	5	2

Current Controls	**Assurance of Controls**
• Clinical Governance structures and processes • Clinical Audit Strategy • Quality metrics in reports to QGC/ Board • Quality meetings with CCG • Quality Governance Committee • Clinical Quality & Effectiveness Group • Patient and Carer Experience Group • Ward Accreditation- currently suspended • Virtual CQC meetings and IPC Emergency Support Framework and Transitional Monitoring Approach • Performance management framework policy • Elective Access Committee held weekly • Bed meetings and safety huddle daily with escalation processes in place • Gold, Silver and Bronze Command structures and processes in line with Major Incident Policy • Symphony IT monitoring system in use for A&E • UEC Ops Board • Cancer Improvement Group meeting monthly • County wide Cancer Board meets monthly & cancer site PTL meetings weekly for all cancer sites • Somerset reporting cancer • Super stranded & stranded Tracking • Elective Care Board CCG Monthly • Weekly performance meeting in place • Monthly Divisional Assurance meetings • RTT PTL performance meetings weekly for all specialties • Targeted support from regional NHSE/I to all Trusts in the region for cancer 62 days (Diagnostics) • Additional performance metrics now in place in relation to Covid-19	• QGC escalation to Trust Board (L2) • Divisional Quality Governance Assurance reports to CQEG (L1) • Assurance Reports to QGC (L1) • Peer Review and QA visits (L3) • Internal Audit Reports (L3) • CQC Insight Reports – Bi- monthly (L3) • Notes of CQC virtual meetings (L3) • IPC ESF (L3) +ve • 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	**Gaps in Assurance**
• Lack of timely surveys related to Medical Trainee reports due to Covid • Report to Board indicates under performance for: Cancer targets (62 days) / A & E /RTT/ Stranded & Superstranded • Attendances, admissions, and acuity remain high	Assessment and Accreditation reports to Trust Board CQC Insight report indicates Trusts composite indicator score is similar to Trusts likely to be rated RI CQC Report (2019) – overall rating of RI

Further Planned Actions	**Action Owner**	**Due Date**
1. Covid response remains in place 2. Reset continues despite COVID challenges and performance monitored, reported monthly to Trust Board. 3. Further outsourcing of routine work to Independent sector including endoscopy 4. System discharge work with external support from ECIST and iCAN programme	1-4 Jo Fawcus	1. Review in 3/12 2. Ongoing 3. Ongoing 4. Ongoing

Principal Risk No: NGH 110	Risk of avoidable harm		
Changes since last review			
Date Risk Opened: April 2021	**Risk Classification:** Quality	**Risk Owner:** MD/DON	**Scrutinising Committee:** Quality Governance Committee

Underlying Cause/Source of Risk:	**Initial score**		**Current score**		**Residual score**	
CRR reference risks: 1303; 1411,1478, 1776, 1782, 1867, 1879, 1911, 1955, 1972, 2150, 2187, 2195, 2216, 2219.	10		10		5	
	Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
	5	2	5	2	5	1

Current Controls	**Assurance of Controls**
• Monthly review of Dr Foster information and alerts • Mortality Review Group • Audit plan • Incident and SI reporting policy • Monthly Clinical Quality and Effectiveness Group • Monthly Quality Governance committee • Countywide Patient safety M&M meetings • Review of Harm Group weekly • Dare to Share alternate monthly • FIT Group • MASH referral system • NGH Safeguarding Team • IP Steering Group • IPC Team • Maternity Dashboard • Saving Babies Lives – National Initiative • Neonatal Safety Champion Role • Integrated risk assessment and prescription chart introduced • Mandated use of Deteriorating Patient Care Plan	• Reports from Mortality review to CQEG and QGC (L1) • HSMR & SHMI data (L3) • CQEG reports to Quality Governance committee (L1) • Quality reports to Quality Governance and Trust Board (L1) • Quality Governance reports to Trust Board (L2) • Dr Foster data reports (L3) • Results from Clinical audit (L1) • Review of Harm Group monitoring implementation for SI action plans (L1) • National Learning and reporting system data (L3) • Incident report to Quality Governance committee (L1) • Safety thermometer metrics via DoN report (L2) • Delivery of infection control trajectory requirements at end of 2019/20 (L1) • Reports to FIT Group (L1) • IPC Assurance Framework (L3) • IPC ESF (L3) • Maternity report to QGC (L1) • Maternity Forum (L1)
Gaps in Controls	**Gaps in Assurance**
• NICE-/ VTE compliance remains inconsistent • System Safeguarding resources and infrastructure • Number of overdue investigations/ reports into SI's	

Further Planned Actions	**Action Owner**	**Due Date**
1. EPMA system review and introduction 2. Weekly Risk & Quality Meetings to address incident backlog	1. Matt Metcalfe 2. Matt Metcalfe/ Sheran Oke/ Claire Campbell	TBC Ongoing

Principal Risk No: NGH 111	Risk of failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failures		
Changes since last review:			
Date Risk Opened: April 2021	**Risk Classification:** Compliance, operational, quality, infrastructure, financial	**Risk Owner:** DE&F	**Scrutinising Committee:** Finance & Performance Committee

Underlying Cause/Source of Risk:	**Initial score**		**Current score**		**Residual score**	
CRR reference risks; 258, 1174, 1177, 1287, 1699, 1701, 1702, 1703, 1738, 1373, 1893, 1986, 1414.	20		20		15	
	Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
	5	4	5	4	5	3

Current Controls	**Assurance of Controls**
• Health and Safety committee • Fire safety committee • Estates Compliance group • Facilities Governance group • Water safety group • Resilience planning group • Business continuity plan • Training and scenario exercises undertaken • Annual capital programme • Medical Gas committee • Ventilation group • Asbestos group • Fire Safety Task and Finish Group • Assurance & Risk Committee • Additional screening/ doors in Covid areas • 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	**Gaps in Assurance**
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.	• National PAM (Premises Assurance Model) dashboard is currently being completed (due by end of July 21)

Further Planned Actions	**Action Owner**	**Due Date**
1. Deliver action plans against key estates elements to improve assurance and reduce risks 2. Review Estates strategy to align with KGH, STP/HCP and Clinical strategy commenced in December 20 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	1. Stuart Finn 2. Stuart Finn 3. Stuart Finn	1. Completed 2. Oct 2021 3. Ongoing

Principal Risk No: NGH 112	Risk of failure in ICT infrastructure and/or a successful cyber security attack may lead to loss of service with a significant patient care and reputational impact.		
Changes since last review			
Date Risk Opened: April 2021	**Risk Classification:** Infrastructure	**Risk Owner:** DCIO	**Scrutinising Committee:** Digital Hospital Committee

Underlying Cause/Source of Risk:	**Initial score**		**Current score**		**Residual score**	
	20		20		16	
	Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
CRR reference risks 1733, 1984, 1482, 1684, 2020, 2151, and 2170.	4	5	4	5	4	4

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

Gaps in Controls	**Gaps in Assurance**
1. IT Team vacancies/ Potential for incorrect data input due to human error 2. Legacy Windows desktop and server software mitigated by extended Microsoft Security patching until March 2023	

Further Planned Actions	**Action Owner**	**Due Date**
1. Windows to migrate to Windows 10, 40 Devices awaiting supplier upgrades in 21/22 2. Windows Server and SQL Server Upgrades, 62 Servers awaiting supplier upgrades in 21/22	1. Dave Smith 2. Dave Smith	1. Security patching in place until March 23 2. Security patching in place until March 23

Principal Risk No: NGH 113	Risk that the Trust is unable to respond appropriately to further pandemic waves; provide sufficient elective care and other clinical services, including non-elective and possible delays to treatment

Changes since last review

Date Risk Opened:	**Risk Classification:**	**Risk Owner:**	**Scrutinising Committee:**
April 2021	Compliance, operational, quality, infrastructure, financial	COO	Board and all Board Committees

Underlying Cause/Source of Risk:

CRR reference risks 1482,2287, 2305, 2307, 2313, 2334, 2336, 2341, 2359

Initial score		**Current score**		**Residual score**	
20		15		10	
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
5	4	5	3	5	2

Current Controls	**Assurance of Controls**
• Covid Incident management plan • Provision to revise medical rotas to ensure staffing supports activity, recruitment of volunteer workforce, redeployment of staff to areas of greatest need • Digital solutions to allow continuation of Outpatient work where appropriate/ workforce permits • Critical Care Plan - Enhanced triage of patients to ensure best use of available experience • Capacity/ cohort plan for elective activity • Use of private provider bed stock for additional capacity • National Guidance and webinars • Gold, Silver and Bronze Command structures and processes in line with Major Incident Policy • IPC Cell/ Workforce Bronze cell and staff support network • Dedicated Covid 19 cost centre and coding to capture lost elective activity • SCG Command Structure under CCG • Covid 19 Strategy • Resources – command structure flexes resource delivery according to demand • Covid reset management plan • Digital solutions to allow continuation of Outpatient work where appropriate/ workforce permits • System Discharge Group • Regional Calls – CEO, MD, DN, COO – weekly • Demand and Capacity plans completed for RTT and Cancer for all Specialties • Additional endoscopy capacity in place	• Decision risk log (L1) • Incident log (L1) • Actions from System meetings (L2) • Gold meeting action log (L1) • 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) • Actions from System meetings (L2) • Twice weekly reset meeting minutes (L1) • Trust Board reports • Covid scorecard
Gaps in Controls	**Gaps in Assurance**
• End of national contract with Independent sector and activity on offer not sufficient to meet needs • Increase in COVID positive staff not available to work	

Further Planned Actions	**Action Owner**	**Due Date**
1. Planning round for 2021/22 to be agreed by Board, to include activity.	1. Jo Fawcus	1. TBC
2. New ICU unit in September will provide capacity to ensure theatres can be used to continue operating and an additional 8 level 1 beds will be available for respiratory patients	2. Stuart Finn / Jo Fawcus	2. September 2021
3. Focus on staff well-being, from SOS services, protected time back to recover, home working where possible, thank you handouts	3. Gold Team	3. Ongoing
4. Staff and population vaccination programme underway to protect staff and patients	4. Chris Pallot	4. Ongoing
5. Review of Hospital rules and IPC requirements post 19th July 21	5. Sheran Oke	5. July 2021

Principal Risk No: NGH 114	Risk that the Trust fails to promote a culture that puts patients first		
Changes since last review			
Date Risk Opened: April 2021	**Risk Classification:** Patient Experience	**Risk Owner:** DON	**Scrutinising Committee:** Quality Governance Committee

Underlying Cause/Source of Risk:	**Initial score**		**Current score**		**Residual score**	
CRR reference risks 1955, 1867, 2003	8		8		4	
	Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
	4	2	4	2	4	1

Current Controls	**Assurance of Controls**

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

Gaps in Controls	**Gaps in Assurance**
• Opportunity for collaborative working with patients and carers to improve and inform service development	

Further Planned Actions	**Action Owner**	**Due Date**
1. Review of Patient Information- content and mode of delivery	1. Sheran Oke	1. Ongoing
2. Reinstate Board to Ward visits virtually	2. Sheran Oke	2. July 2021
3. Work with Northamptonshire Healthwatch, carers and volunteers commenced	3. Sheran Oke	3. Ongoing

Principal Risk No: NGH 115	Risk that the Trust fails to have financial control measures in place to deliver its 2021/22 financial plan		
Changes since last review			
Date Risk Opened: April 2021	**Risk Classification:** Financial	**Risk Owner:** Director of Finance	**Scrutinising Committee:** Finance & Performance

Underlying Cause/Source of Risk:	**Initial score**		**Current score**		**Residual score**	
	25		25		5	
CRR reference risks; 2343, 2344, 2346.	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
	5	5	5	5	5	1

Current Controls	**Assurance of Controls**
• Finance and Performance committee • Divisional performance reviews • Audit arrangements • SFOs SFIs & SOD • Policies and procedures • Financial and accounting systems • Counter Fraud plan • Purchasing and Supplies Strategy & Policies • Financial Assurance oversight by NHSE/I • HCP System Finance Director meetings	• Monthly report to Finance and Performance committee (L1) • Finance and Performance committee Report to Board (L2) • Finance KPIs (L1) • Audit committee reports to Trust Board (L2) • Outcome of NHSE/I accountability meetings (L3) • NHSE/I rating for Single Oversight Framework (L3) • Internal Audit (L3) • External Audit (L3)
Gaps in Controls	**Gaps in Assurance**
• Pay spend above plan • Agency expenditure is currently above the set target for 2021/22.	• Uncertainty around the funding arrangements for 2021/22 e.g. ERF (Elective Recovery Fund)

Further Planned Actions	**Action Owner**	**Due Date**
1. Review with Medicine Division to agree a reasonable recovery plan 2. Monthly assurance meetings with all Divisions to monitor financial performance 3. Board discussion/decision on managing activity backlog against reduced financial envelope	1. Bola Agboola 2. Jo Fawcus/Bola Agboola 3. Jon Evans	1. July 2021 2. Ongoing 3. July/Aug 2021

Principal Risk No: NGH 116	Risk that the Trust fails to fully deliver the financial efficiency programme.		
Changes since last review			
Date Risk Opened: April 2021	**Risk Classification:** Finance	**Risk Owner:** Director of Finance	**Scrutinising Committee:** Finance and Performance Committee

Underlying Cause/Source of Risk: CRR reference risks:	**Initial score**		**Current score**		**Residual score**	
	25		25		10	
	Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
	5	5	5	5	5	2

Current Controls	**Assurance of Controls**
• Finance and Performance committee • Efficiencies Undertaking meetings • Group transformation programme • Hospital Management Team	• Finance report to Finance and Performance committee • Includes progress on delivery and forecast plans (L1) • Report to Board (L2) • Internal audit (L3) • External Audit (L3)
Gaps in Controls	**Gaps in Assurance**
• Current operational pressures may impact on capacity to deliver the savings programme • Reorganisation of the PMO team may cause disruption to the programme	• The Trust has not fully delivered its Efficiency programme recurrently historically

Further Planned Actions	**Action Owner**	**Due Date**
1. Efficiencies undertaking meeting to be chaired by COO 2. Identify and monitor delivery of the group transformation programme	1. Jo Fawcus 2. Jon Evans/Karen Spellman	1. Ongoing 2. Ongoing

Principal Risk No: NGH 117	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		
Changes since last review			
Date Risk Opened: April 2021	**Risk Classification:** Finance	**Risk Owner:** Director of Finance	**Scrutinising Committee:** Finance and Performance Committee

Underlying Cause/Source of Risk:	**Initial score**		**Current score**		**Residual score**	
CRR reference risks; 2345	15		15		10	
	Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**
	5	3	5	3	5	2

Current Controls	**Assurance of Controls**
• Capital Committee • Finance and Performance committee • 5-year capital plan • Purchasing and Supplies Strategy • Leasing strategy in place/ IFRS16 • Hospital Management Team Meetings • Business Case process	• Finance report to Finance and Performance committee • Includes progress on capital planning and expenditure plus forecast expenditure (L1) • Report to Board (L2) • Internal audit (L3) • External Audit (L3)
Gaps in Controls	**Gaps in Assurance**
• The Trust has a large backlog maintenance programme and the estate is ageing • Affordability of additional capital • Ability to fully utilise Trust's CRL for the year if slippage occurs	• Additional access to capital limited in infrastructure incidents

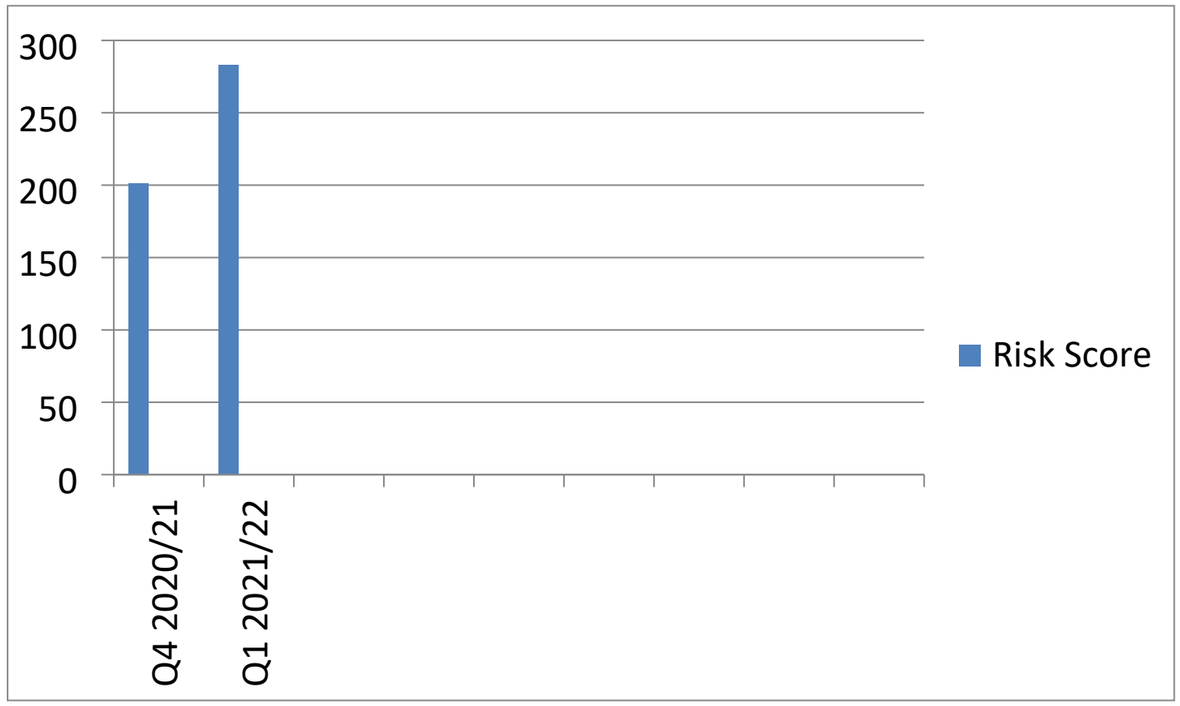
Further Planned Actions	**Action Owner**	**Due Date**
1. Continue to work with System partners and bid for any available capital	1. Jon Evans/ Bola Agboola	1. Ongoing
2. Closely monitor delivery of the ITU Build to plan	2. Stuart Finn	2. Ongoing
3. Continue to manage capital needs in a prioritised manner	3. Bola Agboola	3. Ongoing

Movements on Board Assurance Framework (since previous report)	
ADDITIONS	None
INCREASES	None
DECREASES	None
CLOSURES/ AMALGAMATED	As per report (Appendix 1)

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

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

Graph shows risk score of 283 for 17 Risks



Cover sheet

Meeting	Public Trust Board
Date	29 July 2021
Agenda item	4.4

Title	Annual Fire Safety Assurance Report for Northampton General Hospital NHS Trust
Presenter	Stuart Finn, Director of Estates and Facilities
Author	Stuart Finn, Director of Estates and Facilities

This paper is for

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

Group priority

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

Reason for consideration	Previous consideration
The Board is asked to note the actions taken to deliver fire safety within the Trust during the reporting period April 2020 to March 2021 and give approval for the Group Chief Executive for Northampton General Hospital NHS Trust and Kettering General Hospital NHS Foundation Trust to sign the Annual Statement of Fire Safety Compliance (included at the end of this report)	Annual report FY19/20

Executive Summary

For This annual report has been produced to give the Trust Board an overview of fire safety for the period April 2020 to March 2021 and, to provide assurance that the Trust is meeting its statutory responsibilities.

The report requests Board approval for the Group Chief Executive for Northampton General Hospital NHS Trust and Kettering General Hospital NHS Foundation Trust to sign the Annual Statement of Fire Safety Compliance (included at the end of this report).

Dedicated to excellence

Appendices

Annual Fire Safety Assurance Report

Annual Statement Of Fire Safety Compliance

Risk and assurance

Risk to patient safety through an unmanaged fire as a result of failure to operate safely within the remit of Fire safety. This paper goes some way in showing current status and improvements made in the area during the reporting period.

Financial Impact

Failure to meet statutory obligations under Health and Safety legislation may result in fines.

To maintain fire safe premises and services, continued capital investment, as agreed in the Estates Capital plan, must continue.

Legal implications/regulatory requirements

Continuation of ongoing works to improve Fire Safety across the Trust through Premises, & People. Convergence on compliance across delivery areas and adherence to relevant Fire legislation and guidance.

Equality Impact Assessment

Failure to meet statutory obligations under The Regulatory Reform (Fire Safety) Order, Department of Health Firecode and Health and Safety legislation may result in fines and suspension of services

Annual Fire Safety Assurance Report for Northampton General Hospital NHS Trust

This annual report has been produced to provide the Northampton General Hospital (NGH) NHS Trust Board with an overview for the period April 2020 to March 2021 and, to provide assurance that the Trust is meeting its statutory responsibilities.

All fire safety arrangements and building alterations within the Trust are modelled on the recommendations made by the Department of Health in their Firecode fire safety guidance documents. These are referenced and supported within the Trust's Fire Safety Policy.

The Fire Safety Adviser is tasked with reviewing Fire Safety arrangements. A number of issues around the fire alarm system, fire compartmentation, fire training, the management of fire alarm activations and internal audit including Fire Risk Assessments and Fire Evacuation Planning were identified.

Fire Risk Assessments - The previous fire risk assessments totalled 337 documents. The NGH site has been risk assessed to the 'Public Available Specification' (PAS) 79 (published by British Standards Institution).

There are now 43 fire risks assessments in place for the NGH site and 3 fire risk assessments for premises 'off site'. These include Danetre Site and Two Midwifery Hubs located in the community. These fire risk assessments have been managed by the Fire Safety Advisor (FSA).

The actions identified from the fire risk assessments have been prioritised and are being managed through action plans.

The action plan is in place to track progress against identified issues; the plan is managed through the Trust Fire Safety Group.

Fire Compartmentation - A full conditional survey of the site was completed by a specialist contractor to review condition of the fire compartmentation structures (2018). The Fire Engineer AE (independent to the Trust) reviewed the fire compartmentation positioning and the evacuation strategies adopted in line with each area (March 2021).

Fire Alarm - The Trust has continued to upgrade and renew the site Fire Alarm System. Work throughout the reporting period has included a focus on the effectiveness of the system and a number of corrections/ improvements have been made. These included upgrades to replace obsolete equipment and additional fire panels, due to panels reaching capacity.

Investigations by the contractor, has highlighted that the local area panels of the existing system is nearing capacity and, to continue to add devices will require, considerable further investment.

The current system is 'closed protocol' which restricts the options to work on or extend the system. Changing to an alternative 'open protocol' system will be a complex process but will deliver improved access to the system and the potential to review other systems available on the market.

NB: Definition of 'open' and 'closed' protocol fire alarms.

Fire alarm systems include a variety of different components, all of which communicate with each other. The language that these devices use to communicate is called a 'protocol' – and this is what can be 'open' or 'closed'.

Companies who provide open protocol systems disclose the relevant technical data required for manufacturers to produce compatible devices. These companies can work with any number of different manufacturers, providing customers with a range of different suppliers to choose from.

Companies who produce closed protocol systems don't disclose their technical information, and therefore customers are forced to acquire all of the relevant components from a single source.

The current system continues to operate safely and a full review and feasibility study has taken place during 20/21. The Trust will need to digest the information and decide on the future strategy, future upgrades and how additional capacity is delivered.

The New South Entrance and Retail Unit have a new fire alarm system, which is an 'open protocol' system and is linked to the existing main fire alarm. The Retail area is also protected by a misting fire suppression system due to its proximity to the new Critical Care building.

At the time of the reporting period, the new Paediatric ED area was under construction with the fire alarm linked to the main hospital fire alarm system, to ensure the safety of our patients and staff.

Fire Safety Training - Staff training is a key control measure in reducing risk and it is imperative that staff fully understand their roles and responsibilities should a fire occur. Through programmed fire safety training events during 2020/21 the Fire Safety Training role has delivered an improved training package for staff with a range of delivery methods being undertaken due to COVID.

The Fire Response Team training has been delivered and further practical training sessions to ensure all members of the Fire Response Team have a full working knowledge of the site, with further training scheduled as part of regular refresh of knowledge, understanding and application.

The Site Management Team attend all Fire Alarm activations other than pre-alarms. They have received additional practical training sessions to enable this. These sessions were delivered on a 1:1 basis to ensure they were able to attend.

All areas of the Trust have a Fire Risk Assessment (FRA) and Local Emergency Evacuation Plans (LEEPS) in place and all have been reviewed during the reporting period.

Fire Service engagement - Meetings and on-site inspections/visits with the Northamptonshire Fire & Rescue Service (NFRS) continue and supportive working relationships have been developed strengthening the relationship built in the previous 12 months

'Fire Works' capital Programme - Continued investment in fire safety through the annual capital plan has allowed the Trust to ensure that building/structural fire risks are reduced or mitigated as far as practicable. Cavity barriers and asbestos ceilings continue to be the biggest concern in the structural fire protection of the Trusts buildings especially in "Oxford method" construction. The age of these buildings presents concerns for the condition of the structural fire precautions within them, along with the age of the building led electrical wiring system.

In addition to the fire safety management measures detailed above, the continued extension of the water mist automatic fire suppression system during the year into building works has provided increased fire protection, mitigating some of this risk and providing life safety and business continuity.

The 'Fire Works' has included extensive improvements to the 60 minute fire compartmentation and protection across the Critical Care floor. With the exception of the existing HDU/ITU area which is programmed for after the opening of the new Critical Care unit.

New fire dampers have been installed across the Critical Care floor with the associated fire stopping, this work continues and is programmed for completion within 2021.

During the reporting period, works has continued with construction of new fire escapes, review and delivery of LEEPs and training, live fire drill exercises and improved fire communications across site. This work has improved significantly local awareness of roles and responsibilities and has provided improved assurance that all staff and patients on the Critical Care floor can be evacuated to a place of safety in the event of a fire. Infrastructure works, live fire drills, new FRAs and LEEPs have provided assurance that this has been achieved and witnessed by the Trust Fire Safety Team and the NFRS.

Fires and Fire Evacuations - Two real fire events, which affected the Critical Care floor, in November 2020 tested staff to invoke the emergency procedures. In both scenarios, the post incident debrief with NFRS praised the staff for their positive actions.

Fire Site Plans - Work to update the site fire plans (these are building/construction plans) across the site, annotated with compartment, sub-compartment and high risk areas fire resisting construction and the estimated location of cavity barriers has been completed and has been verified by the independent Authorising \Engineer (fire) AE(F). This work has enabled the programming of fire door maintenance and upgrades to be undertaken and have assisted with the inspection of cavity barriers.

Following a fire safety report submitted to the Trust Board in January 2020 significant investment in fire safety has been made. £2.3m has been invested in passive fire safety measures to address the significant findings of this report and, the prioritised findings from the fire risk assessments. To support the prioritisation of 'Fire Works' and patient safety, £500k of the capital programme on 'fire works' was brought forward into 2020/21 and completed. The flexibility of the capital plan is of utmost importance to reflect the position at the time of available funding and is based upon all of the data and understanding by the Estates Teams. This does result in flexing the plan to suit across the years with funding being variable across years to suit all needs as required by the Capital Plan within funding which is made available to Estates by the process.

Audits and Inspections - The NFRS has been involved and supportive of the 'Fire Works' programme and have visited site on several occasions to inspect alongside regular meetings between NFRS and Head of Estates / Fire Safety Adviser. The Fire AE has conducted compartmentation survey review and a review of the fire safety arrangements in accordance with the HTM. Two external fire risk assessors have undertaken a fire safety review of the entire site under the Regulatory Reform (Fire Safety) Order 2005, (RRO) and

provided recommendations for improvements as part of the fire risk assessment.

Within this reporting period, 110 fire safety actions (Estates Action Plan HTM – 05 Fire safety) have been completed. Estates Action Plan	Total Actions	Completed by 31/03/2021	Percentage completed
HTM 05 Fire	128	102	80%
TIAA	10	8	80%
Critical Care	2	0	Action on hold

TIAA are an organisation commissioned by the Trust to carry out internal audits to provide independent assurance.

During the previous reporting period, TIAA were requested to carry out an audit of fire safety. They undertook and the audit and the report were delivered /October 2020, this has provided recommendations for improvement, which have been delivered via a managed action plan.

At the time of writing this report: all of the fire related TIAA actions have been addressed.

Fire policy	Approved by the Fire Safety Committee. Next review in August 2022
Fire strategy	New 5 year strategy has been developed and shared with Fire committee
Fire Risk Assessments (FRAs)	337 FRA were replaced with 43 fully assessed and validated FRA's on site and 3 FRA's off site. The risk assessment methodology used is in line with the PAS 79 format, which is BSI approved.
Local Emergency Evacuation Plans (LEEPS)	100% compliance. 166 plans in place
Fire drills	100% compliance
Fire wardens	100% compliance. • 190 wardens in place in 2019/20. • 460 2020/21
Fire training	83% and increasing

Fire Safety Team	Trust's Estates team has been expanded. • Compliance and Fire Manager (band 8) • Fire Safety Officer (training) (band 5) • Fire Safety Advisor (band 7) • Two additional roles temporally added to support the delivery of fire risk assessment action plans

Appendices - Annual Fire Safety Assurance Report -

1. Introduction

This report sets out an assurance review of fire compliance for the period April 2020 to March 2021.

Regulatory Reform (Fire Safety) Order 2005, (RRO)

The Regulatory Reform (Fire Safety) Order replaced all existing fire safety legislation applicable to hospitals; the current suite of Fire Code documents addresses the changes brought about by the Order.

The Fire Safety Order, in line with the other Regulatory Reform initiatives, has limited local government involvement and has placed the responsibility for compliance within an employer's duty to '*self-assess'* their own premises and make such modifications as necessary.

The imposed fire risk is managed by the Fire Safety Manager through Trust approved procedures and control measures. The management of fire safety is audited by the Fire and Rescue Authority whose primary role is enforcement and not the provision of prescriptive fire safety advice.

2. Policies, Procedures, Protocols etc.:

The Trust Fire Safety Policy has been approved by the Fire Safety Committee and at PDG and is next due for review in August 2022.

The Fire Safety Guidance Note that gives further guidance on all matters of fire safety is under review and is due in 2021/22. (October 2021)

3. Roles and Responsibilities

HTM 05-01 Responsibility for Managing Fire Safety in Healthcare buildings ultimately lies with Northampton General Hospital NHS Trust as they are the employer under the RRO. The Chief Executive Officer has direct responsibility for Fire Safety and has delegated their duties to the Trust Fire Safety Manager. Under the RRO any other members of staff who have responsibility to any extent are also responsible under the RRO.

Previously the Trust employed one band 5 Fire Officer; (2019/20) the fire safety team was increased to:

- Fire Safety Manager - Deputy Director Estates and Facilities, Head of Estates
- Business Compliance Manager including fire (band 8)
- Fire Safety Advisor (band 7)
- Fire Safety Trainer (band 5)

This change significantly strengthens the resources of the Fire safety Team and enables the delivery of fire compliance across the Trust.
In addition, membership of the Fire Response Team has also been strengthened and now has a consistent approach.

An improved training programme for site management training, including 1:1 for key staff has been delivered by the Fire Safety Officer.

All Fire Response Team members completed part 1 (theory) of their training. A programme for all to receive part 2 (practical session) is currently being implemented.

Fire Wardens Currently there are 460 fire wardens in place, across 190 areas. In December 2019, with staff movements etc. there were only 180 (94.7%) in place. This meant that there were gaps in fire warden coverage.

The Fire Safety Officer undertook a positive action recruitment campaign to promote the role. Through this active approach this has led to a 240% increase in the number of fire wardens trained and in place.

The Fire Safety Officer delivers fire warden training annually. It is a requirement the Fire Wardens undergo a refresher every 3 years.

Throughout this reporting period, the Fire Safety Team this proactive training programme achieved 100% of the site covered with fire wardens.

A register of fire wardens is maintained by the Fire Safety Officer which is distributed monthly to Divisional and Directorate managers, Heads of Departments and Matrons showing compliance. These are also reported to the Fire Committee and the Trust Health and Safety Committee. As an additional level of reassurance, Divisional scorecards were also amended to indicate fire compliance.

4. Fire Alarm activations

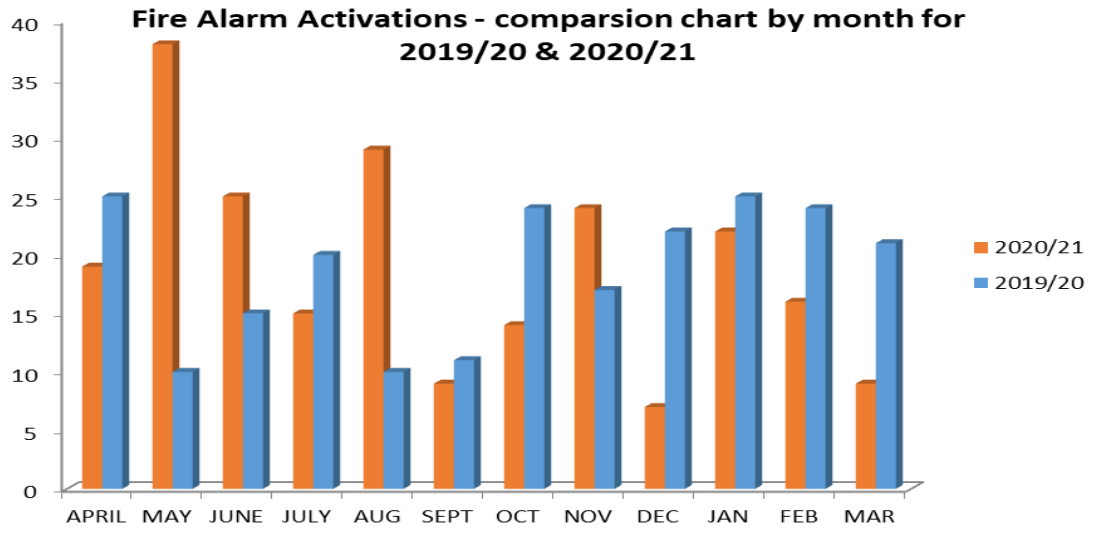
The fire alarm is a comprehensive networked system that provides coverage across the NGH site.

The system includes manual call points (also referred to as 'Break Glass' units) and automatic fire detection (which includes smoke, heat and flame detection).

The fire alarm has two levels of activation to provide early warning, referred to as

- Pre-warning signal
- Fire signal

The chart below shows the number of alarm activations that occurred in 2019/20 and 2020/21 as a comparator.



The fire alarm detection is very sensitive and reacts to changes in temperature. The two spikes in activity in May 2020/21 and August 2020/21 are attributed to 'heat wave' conditions. The Fire Safety team have engineered out 'false alarm' activations caused by high ambient temperature through investment in 'flame detection' which activate on 'flame flicker' from a fire and not heat. The impact on the reduction of false activations in the boiler room will be monitored during 2021/22.

The trend from September to March 2020/21 has been a reduction in fire alarm activations compared to the previous year. This can be attributed to investigation into the cause, engineering solutions to reduce false alarms, staff training and improvements in the fire safety culture within the Trust. (See section 'False Alarms' below for common causes.

5. Incidents:

Fire Incidents (actual fire)			
Year	**No.**	**Location**	**Occurrence**
2014 – 15	5	Sturtridge bin store Cripps Recreation o/s Maxillo Facial o/s South Entrance Car Park 1	External bin store dealt with by Fire Service. Overheated fan bearing. Bin fire successfully dealt with by staff. Fire in bush dealt with by Fire Service. Car fire initially dealt with by staff then Fire Service.
2015 – 16	5	Allebone ward Cripps Recreation Child Health Offices Abington Ward HDU	Overheated fluorescent light. Magicians' volcano. E-cigarette battery in persons pocket. Patient set fire to bedding successfully dealt with by staff. Sparks from electrical socket.
2016 – 17	0		
2017 - 18	1	Balmoral ward	Oil filled radiator caught fire successfully dealt with by staff.

2018 – 19	2	Balmoral Ward Heart Clinic	Staff member placed a towel in the microwave to heat it up for a patient Small Fire Cautery Device, plasma blade set fire to operator's glove.
2019 - 20	5	Paddington ward Rockingham Corridor Becket ward Nye Bevan Car Park Outside A&E	Smoke from dishwasher Cooking left unattended Smoke from Battery Recycling Bin Minor Car Fire - Engine Compartment Waste-Paper Bin
2020 -21	3	ITU Roof – above Nursing Floor Boughton Corridor – Admin Block	Electrical fire in redundant transformer in wall void Contractors working on roof Cooking left unattended

There were two significant fire incidents that during this reporting period.

On 8th November 2020 at 06:58hrs ITU staff reported the smell of burning and witnessed light smoke in the ITU ward. The fire alarm was activated and the immediate area was safely evacuated. The NFRS attended, by which time the fire was out. NFRS conducted an investigation and handed the control of the incident back to the Trust. The Trust had invoked the emergency responses protocols and a 'Major Incident' was declared.

The HDU staff managed the safe evacuation in a very timely manner. This can be attributed to the regular and enhanced evacuation training that has been conducted in the previous 12 months. This enabled all 16 patients to be safely evacuated from the 'fire zone' via the progressive horizontal evacuation method.

The cause was determined to be an electrical short circuit in a redundant transformer located within a wall void behind a sink unit. A programme of checks were immediately conducted by the Estates Electrical team to ascertain if similar risks were present elsewhere on site. A programme of works has been adopted to install a safer solution in the future so to prevent re-occurrence from a similar fault.

On 11th November 2020 at 0930hrs staff in Allebone Ward reported a smell of burning. On further investigation a small fire was detected on the roof. This was in the area that contractors were at work on the replacement roof project. The work activity included the use of naked flame. The process was under the control of a 'hot work' permit and the safe torching principles were been followed. In the contractors effort to avoid potential fumes entering into a local air handling unit vents a 'shield' was used. The shield inadvertently lengthened the flame length and this enabled a fire to develop in an area of the roofing materials a short distance away from the 'safe torch' area. Once located through the use of the contractors' thermal image camera, the fire was quickly extinguished by security staff and the contractors. The fire service attended and undertook an investigation and a check of fire spread. Two ward areas were evacuated as a precaution.

The cause was investigated and a thorough debrief was undertaken with the roofing contractor. Several improvements were made to the work activity and the 'Hot Works' permit. The contractor adopted safer work practices and this led to the remainder of the replacement roof work to be completed without further safety events.

Each fire alarm event is debriefed with an opportunity for the 'lessons learnt' to prevent re-occurrence.

There has been a history of cooking left unattended in Trust staff accommodation kitchens. Different methods have been tried to address the risk and prevent re-occurrence with limited to success. The Fire Safety Team introduced a trial of a 'cooker timing device'. This was successful and has been fitted in kitchens within the administration block.

NB: The cooker timer is limited to 8 minutes and has to be reset manually by the person cooking. If the timer is not reset then the cooker automatically switches off. This prevents fires been caused by cooking left unattended.

False Alarms				
Year	**Unwanted Fire Signals**	**False Alarms**	**Pre-Warnings**	**Misting System**
2014 – 15	21	57	78	0
2015 – 16	31	41	86	2
2016 –17	15	54	147	2
2017 - 18	27	53	125	2
2018 - 19	16	56	132	6
2019 - 20	20	120	97	6
2020 - 21	11	83	141	6

False alarm are activations of the fire alarm system when there is no fire and are divided into two types:

- *False alarm where the fire alarm activates but the Fire Service does not attend*
- *Unwanted fire signal where the alarm activates and the Fire Service attends.*

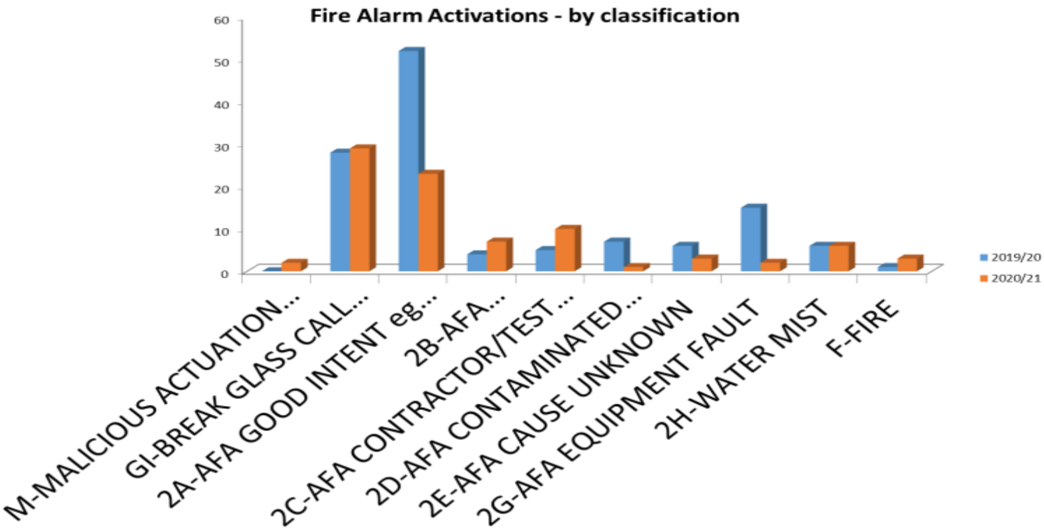
False Alarms have been broken down into the following areas:

Malicious Actuation of Break Glass Point	*2*
Break Glass Point Actuated – Good Intent	*29*
AFA Good Intent e.g. Toast, Fumes, Smoking, Steam	*23*
AFA Electrical / Mechanical Fault	*7*
AFA Contractor / Test Error	*10*
AFA Contaminated Head e.g. flies, dirt	*1*
AFA Cause unknown	*3*
AFA Pre Warning	*141*
AFA Equipment Fault	*2*
Water Mist	*6*

NB: Pre-warnings account for the highest number of fire alarm activations. When a pre-warning occurs, this does not sound the fire alarm. The Fire Response Team receives a signal to respond and investigate the cause, as part of an early warning protocol. Pre-warnings occur when a detector reaches a certain threshold, this could be smoke, fumes, aerosol, dust, this is not sufficient for the detector to go into full alarm. Pre warnings are generally linked to the older devices.

The cause of fire alarm activations in 2019/20 indicated that the 'false alarm – good intent' was recorded as an average of one event a week. In 2020/21 this cause was reduced by over 50%,

this can be attributed through increase compliance in staff training and a positive 'nudge in behaviours'.



The Misting System is interfaced to the fire alarm system to alert the hospital if it actuates. The actuations have been accidental by a person knocking a head and setting the system off or excessive heat in the local area – for example caused by steam leaks.

The Fire Safety Team continue to monitor and record all fire alarm activations and follow up all areas of concerns and trends

Analysis has shown there has been an increase in fire alarm activations both in pre alarm and full alarm from causes: Steam; 47 actuations and Heat Build Up; 23 actuations.

The key findings showed that dual type detectors (heat & smoke) have been fitted in kitchens and roof spaces. Where this has been found, detectors have been adjusted or replaced to more suitable detectors for their environment.

Fire & Rescue Service Attendance to Site in 2019/20 & 2020/21				
Time	**No. of Activations (including Pre-Warnings)**		**No. of Times FRS Attended**	
	2019/20	2020/21	2019/20	2020/21
Between the hours of 08:00 and 20:00	160	179	1	8
Between the hours of 20:00 and 08:00	42	49	22	15
Total fire alarm activations	221	227		
Total fire service attendances			23	23

For the last six years, NFRS have not attended calls from automatic fire alarms to the hospital between the hours of 0800 – 2000hrs. (This part of the NFRS community safety plan). Their stance is that they will not attend during these times unless the Trust confirm that there is a fire. They do not accept the activation of the fire alarm system as confirmation of a fire. NFRS attendance is therefore reliant on the hospital making a direct 999 call to confirm a fire. This could result in a delay in their attendance during the day.

It has been agreed with the NFRS that, should there be fire alarm activation in Block 41 & 42 (includes Critical Care floor and Main Theatres), there will be automatic attendance 24 hour a day. This is to be reviewed in 2021/22 by Trust and NFRS in light of the improvements in fire safety made to date.

6. Risk Assessment:

It is a statutory requirement of the RRO that the Responsible Person has in place a fire risk assessment for all premises for which they have responsibility. The Trust employs a Fire Safety Adviser who, as part of their responsibilities, carries out these assessments using guidance from HTM 05-03, The DCLG 'Green Guide' and PAS 79.

All areas of the Trust have had a new fire risk assessment completed in 2020/21.

As best practice and in line with the industry standard, all of the previous Fire Risk assessments area have been replaced with new fire risk assessments which follow the risk assessment methodology from the PAS 79 (Public Available Specification).

As part of this process, the premises within the Trust have been assessed at high level to identify the priorities for re-inspection, taking into account the recent compartmentation survey results and type of use.

The following risk categories were agreed and align with HTM guidance.

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

During this reporting period the fire safety team undertook a programme of fire audits and the delivery of actions.

In spring 2020, a review of all FRAs has been completed by an external fire specialist.

Following a fire safety report submitted to the Trust Board in January 2020 significant investment in fire safety has been made. £2.3m has been invested in passive fire safety measures to address the significant findings of this report and the prioritised findings from the fire risk assessments. To support the prioritisation of 'Fire Works and patient safety, £500k of the capital programme on 'fire works' was brought forward into 2020/21 and completed.

Fire Safety on the Critical Care Floor - Block 41 & 42

The top floor of Blocks 41 & 42 (Critical Care floor) was of concern to the Fire Safety Team, consequently the Trust FSA carried out full Fire Risk Assessments of theses wards and identified significant issues with fire compartmentation and means of escape (2019, 2020 and 2021).

The significant actions required from the FRA's have been have included additional fire compartmentation, the development of a protected escape route within the corridors in block 41 and 42, the installation of an escape ramp for beds and access for fire service. The improvements have included new fire dampers, (the installation project has continued into 2021/22) during the period from February 2019 to present, significant estates work have continued at pace to reduce the risk. The protected escape corridor and compartmentation project (ongoing into 2021/22) with upgrades to fire safety provision in Creaton and Dryden Wards was completed in November 2020.

The NFRS have been involved and supportive of the programme and have visited site on several occasions to inspect.

This work has provided assurance that all staff and patients on the Critical Care floor can be evacuated to a place of safety in the event of a fire. Infrastructure works, live fire drills, new FRAs and LEEPs have provided assurance that this has been achieved and witnessed by the Trust Fire Safety Team and the NFRS.

With 'Fire Works' on the Critical Care floor planned to continue to November 2020, with new fire dampers, associated fire compartmentation and fire doors (fire door replacement and refurbishment project forecast into 2022/23). Some of this work is dependent on access to the existing ICU/HDU and will be completed post the move to the new CCU. This will collectively provide further levels of assurance and safety

The new ITU / HDU is currently under construction and is due for handover November 2021 which will be followed by a period of training and commissioning.

Post-handover in November 2021 will provide the opportunity to continue the capital 'Fire works' on the Critical care floor and extend into this area.

Other and Existing Mitigations

- The 337 Fire Risk Assessments have been replaced with 43 Fire Risk Assessments which cover all areas of the NGH site. In addition, there 3 fire risk assessments for premises 'off site' that are occupied by NGH staff and are managed by the fire safety team. Within each Fire Risk assessment significant findings of the inspection are recorded, and an action plan created to improve and/or upgrade the fire safety measures in the hospital. The Action Plan is formerly reviewed on a quarterly basis through the Fire Safety Committee.
- Fire wardens carry out fire safety checks which identify fire safety breaches
- There is a maintained automatic water mist fire suppression system that will, when activated, control or extinguish a fire.
- There is in a place a comprehensive fire alarm and automatic fire detection system which will give early warning of any fire incident allowing staff to react in a quick and timely manner. The system has a service and maintenance agreement in place with an approved provider and is tested weekly.
- All members of staff receive refresher fire training annually.
- A Fire Response Team who will attend all fire and false alarm incidents or when the fire alarm has been activated 24/7.
- 21 Evacuation Chairs provided and installed throughout the site, with 'train the trainer' provided to 11 personnel
- Fire Alarm - All historic faults rectified
- Fire Alarm- Cause and Effect register updated
- Fire Extinguisher contract – renew for Chubb FIRE c1400 fire extinguishers on site serviced and maintained
- Fire Safety compliance checks and recommendations submitted to support the new ICU, HDU, Retail Unit and Paediatrics ED building projects
- Liaison with NFRS to support their emergency preparedness and development of a positive working relationship with both the fire safety enforcement team and the operational response team.

7. Maintenance

Fire Alarm System

Increased inspections of the fire alarm system highlighted a number of legacy faults. A new maintenance specialist was commissioned and their additional resource and support has been critical in delivering a fully operational system. The system was fully tested and maintained during the reporting period.

Misting System

An automatic water mist fire suppression system has been installed to cover the Service corridor and plant rooms, the service corridor of Main Theatres; Medical Records; Portering Services; A & E; Resuscitation; FIT stop; Clinical Observation; bin store; corridor outside ITU; Nye Bevan and bin stores.

The system has been fully maintained by a specialist contractor.

Suppression Systems

There are 3 suppression systems on site covering IT Suites, HV switch room and the main cookers in the food production unit. These systems have been fully maintained by a specialist contractor.

Other Maintenance

Both Fire Extinguishers and Emergency Lighting have annual inspections as part of their routine maintenance. This is completed by specialist contractor.

All electrical systems have been tested and inspected by an external specialist contractor. An independent Electrical Authorising Engineer is appointed by the Trust and reviews electrical compliance as part of their 6 monthly audits.

8. Training and Development

	Induction	Refresh of Knowledge	Mandatory	Ward	W/Book	eLearning	Number Trained	% Trust Compliant
2014 - 15	997	965	1048	605	0	772	4387	67.0
2015 – 16	1060	1725	192	719	111	879	4686	78.2
2016 – 17	1064	1250	196	629	943	1022	5104	80.7
2017 – 18	1055	1234	141	543	1063	1264	5300	81.9
2018 – 19	986	904	45	540	1288	1326	5358	82.7
2019 - 20	1092	1028	83	601	1637	737	5471	83.5
2020-21	0*	0*	*	*	1883	2147	4264	80.3

*NB: *Due to the COVID Pandemic induction sessions were ceased from February 2020. With staff working from home and shielding the advisory within the Trust was to cease 'face to face' training. Ward evacuation training has continued and is recorded under 'fire evacuation drill records'. Also since this early 2020 ROK (Refresh Of Knowledge) and the 'mandatory' training have not been delivered in the same way, hence the zero records above in the table. We have adapted to the circumstances and developed new ways of fire safety training delivery.*

An on-line approach via Microsoft Teams has been developed and this has led to training in this way to 234 staff. In addition, there has been a significant increase and 291% increase of staff been trained in fire safety via the E- learning platform. This increase has included ward staff, volunteers and domestic staff.

There are several forums where fire training is undertaken and all the sessions have been adapted to deliver a consistent fire safety core message.

The formal training sessions include:

Induction	Fire Wardens
Refreshers	Fire Response
Midwives	ROK (Refresh of Knowledge)
Volunteers	eLearning
Junior Doctors	Workbooks.

In addition to the programmed training, the Fire Safety Team have supported all departments to arrange more departmental specific on-site training. The Fire Safety team provide additional training as required and support in running tabletop or passive fire drills.

The Fire team have also supported staff with the production or review of their Fire Evacuation Plans.

Staff training figures have continued to increase year on year since 2013.

To facilitate specialist training in the use of Fire Extinguishers, a fire simulator with laser operated extinguishers has been purchased. This has allowed for safe classroom teaching in the use of extinguishers without exposing any of our staff to any hazard or risk. This fire extinguisher training is also supplemented with 'real fire' experience provided by Chubb Fire

Emergency Fire Evacuation Drills

It is a statutory requirement of the RRO and a mandatory requirement of Firecode that all members of staff take part in a fire drill at regular intervals.

Whilst this can be undertaken in staff and outpatients areas it is difficult to achieve within in-patient areas, in these areas a tabletop exercise can and has been undertaken.

Out of a possible 166 areas, 100% are now in date (as at 31/03/2021) following an extensive effort to by the Fire Safety Team to go out to individual wards that were falling behind and help with their specific training needs with recognition that departments are accountable for these works, supported by the Fire Safety Team.

The Fire Safety Officer monitors completion of drills and distributes monthly to Divisional and Directorate managers, Heads of Departments and Matrons showing compliance.

These are reported to the Fire Committee and the Trust Health and Safety Committee and is now also monitored as part of fire

compliance section which has been added to the Divisional Scorecards.

Local Emergency Evacuation Plans
It is a statutory requirement of the RRO that every area has a Local Emergency Evacuation Plan (LEEP) for staff to follow should a fire occur. To enable the plan to be completed there is a template available to download from the Intranet which the manager of the area must complete.

Once completed the plan is sent to the Fire Safety Adviser who will approve it and arrange for it to be uploaded onto the Policy and Procedures section of the Intranet.
The plan is to be reviewed annually to ensure that it is still current.
Out of a possible 166 areas 100% have been reviewed.

The Fire Safety Officer monitors completion of plans and distributes monthly to Divisional and Directorate managers, Heads of Departments and Matrons showing compliance.

These figures are reported to the Fire Committee and the Trust Health and Safety Committee and are monitored as part of fire compliance section which has been added to the Divisional Scorecards.

To assist each department with production of Evacuation plans the Fire Safety Team proactively visited departments to assist respective heads with their review. Where requested, the Fire Safety Team also delivers presentations on site and demonstrates evacuation procedures.

9. Resilience Fire Safety Governance

The Fire Safety Committee meets at quarterly intervals and has a set Agenda covering – Action Plan, Fire Incidents and False Alarms, Staff Training.

The membership of the meeting consists of Deputy Director of Estates and Facilities & Head of Estates, Fire Safety Adviser, Health and Safety Manager, Head of Resilience, Site Management, Nursing representative, Non-Nursing representative, Fire Response Team representative.

The Committee reports to the Trust Health and Safety Committee.

In support of the Fire Safety Group and to enhance our Governance procedures, the Estates team have introduced a formal Technical Team Meeting monthly to discuss and identify technical issues that may need oversight from the Fire Safety Group.

Fire Logbooks and Safety Information Manual
An electronic record (Logbooks) is held centrally for each fire alarm control panel for the recording of any activation, test or fault on that panel.

Fire Safety Information Manuals (Fire Precautions Manual) have been issued to all occupied areas of the hospital.

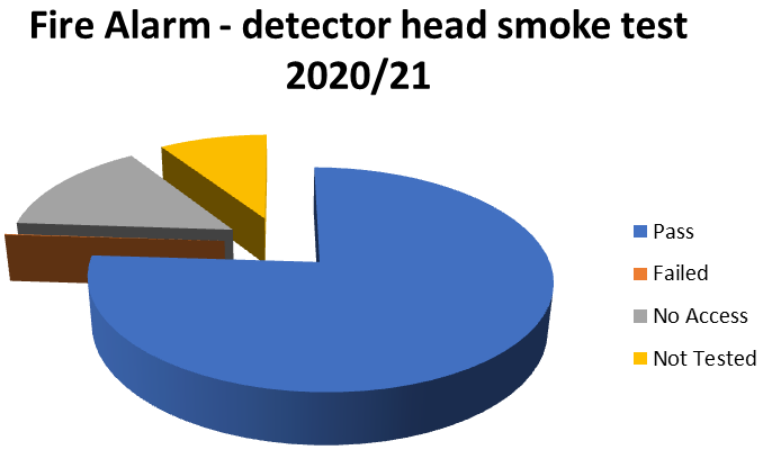
Included in the Manual is a copy of the Fire Safety policy and Fire Policy guidance document with sections on fire extinguishers, staff training, fire drills, fire wardens, hazards in the area and fire risk assessment.

Fire Alarm System
The fire alarm and automatic fire detection system is a fully integrated and functioning part of the fire safety measures in the

hospital. Due to the complexity of the site the current fire alarm system has received substantial investment to reach its current standard however, investment needs to continue to ensure that the system continues to maintain this standard.

Over the last 10 years approximately 50% has been upgraded. However, the system is a closed protocol system and there is limitation to further improvements. The circuits with which the detectors and associated equipment fitted is nearing capacity and there is limited room for expansion.

The fire alarm has a monitoring facility on all the devices, this reports back to the fire alarm panel and the network. If a fault is detected this is investigated and repaired. To comply with BS 5839, the fire alarm engineer contractor undertakes tests of all the detection devices. Below is a pie chart to illustrate that 76% of the units have passed. 9% were not tested and will be tested in the next year. 15% of the detection was not accessible, with challenges associated with COVID, isolation areas and less than 1% of units tested failed.



Work continued during the period to amend and update the cause and effect' register for the fire alarm with particular focus in patient areas, to ensure the correct evacuation or alert signal.

Audit, Surveys & Service Reports

Audit of the fire safety systems is undertaken locally by our Fire Safety team, reporting to the Fire Safety Committee through the production of quarterly reports.

An external Approved Engineer (AE) undertakes two inspections per year, once as a re-assurance visit and the second to undertake an independent full inspection. The AE reports findings to the Fire Safety Committee 6 monthly

NFRS carry out full Fire Safety Audits every two years; however due to other demands for the Fire and Rescue Service to undertake inspections within the Trust following Grenfell and the COVID-19 pandemic there has not been a full inspection since 2014. NFRS have been to site on numerous occasions to support the Fire Safety team. They have indicated that a full inspection will be carried out in the next 12 months.

A Governance review of fire safety was undertaken by Director of Corporate Development, Governance & Assurance in February 2020. The report made 16 recommendations.

Of the 16 recommendations:

- 14 have been completed;
- 2 are on track to complete

Where actions have been closed, evidence of assurance has been provided to the Governance Team.

Service Reports

In addition to Programmed Preventative Maintenance (PPM) carried out by Estates Department, all safety systems undergo comprehensive maintenance undertaken by external specialist contractors.

All results are recorded either through system specific recording systems and action plans or through Estates Computer Aided Facilities Management System (Agility). Follow up and remedials are actioned and recorded accordingly. High risk elements are reported through the Fire Safety Committee.

10. The Forward View (update. Change recommendation made in May 2021)

The key driver was to reduce both the current risks that sit at 25 and improve fire safety and assurance.

Since the ending of this reporting period (31st March 2021) and following the completion of significant fire safety works across site and based on the results of the TIAA audit and independent review of the FRAs, the general fire safety risk that covers the entire site has been be reviewed with the recommendation were made in April 2021 to reduce the risk from 25 to 20. This was approved by the Trust Fire Safety group and subsequently ARC.

The focus for 2020/21:

- Adoption of a 5 year strategy that identifies the fire safety priorities in high risk areas and enables continued improvement year on year.
- With external specialist support, continue to review and re-inspect the entire site on a risk-based approach through thorough Fire Risk Assessment.
- Emergency plans – continue to support departments and assist in reviewing all Local Emergency Evacuation Plans
- Ensure all areas undertake an annual fire drill
- Ensure all areas have in place a fire warden who is carrying out fire safety checks
- Fire training – continue to improve quality of training and increase compliance above from 85% in 2019/20 to 96.4% in 2020/21. .
- Continue on site familiarisation exercises/drills with NFRS
- Plan for 2021/22 a full inter-service major incident exercise with the NFRS to test the Trust's emergency and continuity plans
- Continue Capital investment in fire safety through:
    - Continued phased upgrade of the fire alarm and automatic fire detection system including the recommendations from GAP analysis that brings the system up to an L1 standard and HTM compliance.
    - Continued extension of automatic water mist fire suppression system
    - Completion of fire barrier inspection and remedial works
    - Continued upgrade and extension of emergency lighting
    - Continued upgrade/replacement of fire doors

COVID19

In March 2020, COVID19 began to take hold of the country and NGH took all necessary action to deal with this pandemic and keep staff visitors and patients safe. Some of the actions undertaken did have an impact on our Fire Safety Systems, however the Fire Safety Advisor undertook a risk assessment at that time and deemed the precautions implemented to be acceptable as a temporary measure under the circumstances.

Hoardfast PVC partitions were quickly installed on wards to help reduce the risk of spread of the virus, however the Fire Safety Advisor did inform the Trust that these would need to be removed once COVID19 was under control.

Should it be necessary to keep these partitions permanently then they would need to be replaced with a more suitable alternative that meets the HTM 'fire code' Class '0' rating for circulation areas and escape routes. To date, the Hoard fast has been removed from Dryden, Finedon and Creaton wards. With proposals put forward for the remaining areas to be removed in 2021/22 subject to additional funding (c£100k).

Request for Board Approval

The Regulatory Reform (Fire Safety) Order (RRO) 2005 replaced all existing fire safety legislation applicable to hospitals; the current suite of Fire Code documents addresses the changes brought about by the Order.

The RRO, in line with the other Regulatory Reform initiatives, has limited local government involvement and has placed the responsibility for compliance within an employer's duty to 'self-assess' their own premises and make such modifications as necessary.

Therefore, this report provides assurance for the Board and requests their approval for the Group Chief Executive for University Hospitals of Northampton NHS Group to sign the Annual Statement of Fire Safety Compliance

ANNUAL STATEMENT OF FIRE SAFETY COMPLIANCE

NHS Organisation Code: **RNS**	NHS Organisation Name: **Northampton General Hospital NHS Trust**

I confirm that for the period 1st April 2020 to 31 March 2021, all premises which the Trust owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and;

1	There are no significant risk arising from the fire risk assessments	
OR **2**	The Trust has developed a programme of work to eliminate or reduce as low as reasonably practicable the significant fire risks identified by the fire risk assessment	Y
OR **3**	The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks*****	

* *Where a programme to mitigate significant risk HAS NOT been developed, please insert the date by which such a programme will be available, taking account of the degree of risk*

Date:

4	During the period covered by this statement, has the organisation been subject to any enforcement action by the Fire and Rescue Authority? If yes, outline the details of the enforcement action in Annex A – Part 1	N
5	Does the organisation have any unresolved enforcement action pre-dating this statement? If Yes, outline the details of unresolved enforcement action in Annex A – Part 2	N
6	The organisation achieves compliance with the Department of Health Fire Safety Policy, contained within HTM 05-01, by the application of Firecode or some other suitable method	Y
7	There is a current fire safety policy in place	Y

Fire Safety Manager:	Name: Paul Shead Deputy Director Estates and Facilities, Head of Estates E-mail: Paul.Shead@nhs.net

Dedicated to excellence

Contact Details:	Telephone: 01604 54 4740 Mobile: 07894 327633
Chief Executive:	Simon Weldon Group Chief Executive for University Hospitals of Northampton NHS Group'
Signature of Chief Executive:	
Date:	