

# Public Trust Board

Thu 25 November 2021, 09:30 - 12:00

ZOOM



Northampton General Hospital  
NHS Trust

## Agenda

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09:30 - 09:30

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### 1. INTRODUCTORY ITEMS

#### 1.1. Introduction and Apologies

Information

Alan Burns

#### 1.2. Declarations of Interest


Information

Alan Burns

#### 1.3. Minutes of meeting 30 September 2021

Decision

Alan Burns

 1.3 NGH Public Trust Board Minutes - September 2021.pdf (24 pages)

#### 1.4. Matters Arising and Action Log

Decision

Alan Burns

 1.4 Action Log Public Board.pdf (1 pages)

#### 1.5. Patient Story

Information

Sheran Oke

#### 1.6. Chairman's Report

Information

Alan Burns

#### 1.7. Group Chief Executive's Report

Information

Simon Weldon

 1.7 NGH Group CEO Board report November 2021 v0.3.pdf (2 pages)

#### 1.8. Hospital Chief Executive's Report

Information

Heidi Smoult

 1.8 HCEO Board Report.pdf (5 pages)

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### 2. PERFORMANCE


#### 2.1. Integrated Performance Report

Information

Heidi Smoult

 2.1 a NGH Cover Sheet and full report Nov.pdf (4 pages)

 2.1 b NGH Performance Report November (October Reporting Period).pdf (62 pages)

 2.1 c Finance Report M7\_Board\_v2.pdf (6 pages)

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## 2.2. IPR Metrics Update

Information *Andy Callow*

- 2.2 a NGH Public Board - IGR Metrics and Reporting D01.pdf (2 pages)
- 2.2 b Public Board Nov 2021 - IGR Metrics and reporting D01.pdf (12 pages)

## 2.3. H2 Financial Plan

Information *Jon Evans*

- 2.3 a NGH Cover Sheet - Board - H2 Planning.pdf (4 pages)
- 2.3 b H2 NGH Planning.pdf (24 pages)

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# 3. STRATEGY & CULTURE

## 3.1. Dedicated to Excellence Group Strategy 6 month review

Information *Simon Weldon*

- 3.1 a NGH Cover Sheet 6 months of Dedicated to Excellence.pdf (2 pages)
- 3.1 b 6 months of Dedicated to Excellence.pdf (14 pages)

## 3.2. Group Clinical Ambitions: Towards our Clinical Strategy

Decision *Matthew Metcalfe*

- 3.2 a NGH Board paper clinical strategyv2.pdf (7 pages)
- 3.2 b Group Clinical Ambitions November 2021 FINALv2.pdf (125 pages)

## 3.3. Digital strategy update

Information *Andy Callow*

- 3.3 a NGH Public Board Nov 2021 - Digital Strategy Update D01.pdf (2 pages)
- 3.3 b Review of Group Digital Strategy Nov 2021 D01.pdf (14 pages)
- 3.3 c Group Digital Strategy F03.pdf (21 pages)

## 3.4. Academic Strategy

Information *Matthew Metcalfe & Kay Faulkner*

- 3.4 2111 Academic Strategy.pdf (7 pages)

## 3.5. Assessment & Accreditation Board Approval for Blue Status

Information *Sheran Oke*

- 3.5 Public Trust Board Assessment and Accreditation November 2021\_final.pdf (8 pages)

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# 4. GOVERNANCE

## 4.1. Board Assurance Framework

Information *Claire Campbell*

- 4.1 a Board BAF report Final - Nov 21.pdf (2 pages)
- 4.1 b Appendix 1 Board Assurance Framework Report Board Nov 2021.pdf (6 pages)
- 4.1 c Appendix 2 Group BAF Risks @091121.pdf (10 pages)
- 4.1 d Appendix 3 NGH BAF Risks - Nov 2021.pdf (11 pages)

## 4.2. Freedom To Speak Up Bi-Annual Report

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*Information*


*Claire Campbell*

 4.2 Q2 and Bi- annual report Board FTSU Nov 2021.pdf (5 pages)

### **4.3. Strategic Development Committee ToR**

*Decision*

*Claire Campbell*

 4.3 a SDC Trust Board Nov 21.pdf (2 pages)

 4.3 b Strategic Development Committee CiC TOR revised November 2021.pdf (3 pages)

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## **5. CLOSING ITEMS**

### **5.1. Questions from the Public (Received in Advance)**

*Discussion*

*Alan Burns*

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## **6. ANY OTHER BUSINESS**

*Discussion*

*Alan Burns*

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## Minutes of the meeting

Meeting	Public Trust Board
Date & Time	30 September 2021 – 09:30am
Location	ZOOM

### Purpose and Ambition

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


Attendance	Name and Title		
Present	Mr A Burns	Chairman	
	Mr S Finn	Group Director of Estates & Facilities	
	Ms H Smoult	Hospital CEO	
	Mr S Weldon	Group CEO	
	Ms D Kirkham	Non-Executive Director	
	Ms T La Thangue	Group Communications and Engagement Director	
	Mr M Metcalfe	Medical Director	
	Ms K Spellman	Director of Strategy & Partnerships	
	Ms A Gill	Non-Executive Director	
	Ms S Oke	Nursing Director	
	Ms J Houghton	Non-Executive Director	
	Mr J Evans	Group Finance Director	
	Mr A Callow	Chief Information Officer	
	Mr M Smith	Chief People Officer	
	Ms C Campbell	Director of Corporate Development Governance and Assurance	
	Mr D Moore	Non-Executive Director	
In Attendance	Ms K Palmer	Executive Board Secretary (Minute taker)	
Apologies	Ms R Parker	Non-Executive Director	
Item	Minute reference	Discussion	Action
<b>1.0 INTRODUCTORY ITEMS</b>			

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1.1	21/22 054	<b>Introductions and Apologies inc Quorum</b>  Apologies were noted from the above.	
1.2	21/22 055	<b>Declarations of Interest</b>  There was no Declarations of Interest.	
1.3	21/22 056	<b>Minutes of meeting 29 July 2021</b>  The minutes of the Public Trust Board held on 29 July 2021 were presented and <b>APPROVED</b> as a true and accurate recording of proceedings subject to amendment raised by Mr J Evans which to the finance update under 21/22 044 with <i>unacceptable</i> to <i>acceptable</i> .	
1.4	21/22 057	<b>Matters Arising and Action Log</b>  The Matters Arising and Action Log were considered and noted  <b>Action Log Items 127 &amp; 128 – included with report pack.</b>  The Board <b>NOTED</b> the Matters Arising & Action Log.	

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1.5	21/22 058	<p><b>Staff Story</b></p> <p>Ms Oke advised that there had been an emphasis the last 2 years on enriching the nursing workforce whilst reducing dependency on temporary work force. This had included a push on employment of internationally educated nurses.</p> <p>Ms K Spazzolino talked through the processes and role the Trust played supporting our international nurses. Ms Spazzolino delivered the presentation.</p> <div data-bbox="555 616 614 678" data-label="Image">  </div> <p>Internationally Educated Nurse Rec</p> <p>Mr L Roginson also provided an update within the presentation in regard to welcoming and onboarding of the international nurses.</p> <p>Ms R Valamboor Unnikrishnan shared her story as an International Educated Nurse. It could be viewed below.</p> <p><a href="#">Link</a></p> <p>Ms K Spazzolino remarked that it was important to listen and learn from these stories as it improved experiences for future cohorts.</p> <p>Mr Burns thanked the team for the video.</p> <p>Ms Houghton thanked colleagues for the presentation. The team had done a fantastic job in welcoming the large number of international nurses. She welcomed Ms R Valamboor Unnikrishnan and asked if there was anything that could be done better. She noted in the presentation it had taken a whole year to receive a NMC pin number through for a member of staff and this concerned her. Ms Houghton also queried whether the Trust had a preceptorship package and asked for an update on midwives.</p> <p>Mr Moore remarked that there had been a presentation at People Committee which had highlighted concerns regarding accommodation. He asked for an update on this.</p> <p>Ms Gill thanked the team thanks for sharing their experiences. She asked whether there was anything else that could be done to support from a Health &amp; Wellbeing perspective. Ms Gill also queried what level of learning was shared with international Doctors.</p>	
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		<p>Ms Oke explained that the NMC pin number challenge was a blip that had been experienced nationally. It was no longer an issue. She confirmed that the Trust did do preceptorship and was an ongoing process from their OSCE training. The bid for international midwives had been submitted with UHL and the University of Warwick. She hoped for success in that. In regard to international doctors, work continued on this as it was mutually beneficial.</p> <p>Mr Finn commented that there were 208 rooms on site. The longer-term plan for accommodation was being worked on, in the meantime work had been done with the University. Mr Roginson confirmed the team had worked with the accommodation office to utilise the nurse's home as much as possible. There was a turnover after 2 months and the team had sought external accommodation for them. This had worked well so far.</p> <p>Mr Burns stressed the importance that these nurses see a future here. He wondered what the opportunities for further education was and were they easily accessible.</p> <p>Mr Smith agreed that it was important to also look at overseas doctors and there was a piece of work underway to address this.</p> <p>Ms Smoult had met with HR and medical education to discuss overseas doctors. The Trust needed to learn from the international nurse's programme.</p> <p>Ms R Valamboor Unnikrishnan remarked that in the past it had been hard to study and work at the same time in India. It was positive that in the UK the nurses could study to get the diploma with the option for a further top up. This was useful for them.</p> <p>Mr Weldon thanked the whole team for coming along. It was important to stick with this for the long term. He referred to the presentation and discussion that it was a beautiful blend of all cultures. This was a tribute to the programme and its success to date.</p> <p>The Board <b>NOTED</b> the Staff Story.</p>	
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1.6	21/22 059	<p><b>Chairman's Report</b></p> <p>Mr Burns advised that this was Ms Smoult's first Trust Board in her substantive post.</p> <p>Mr Burns informed the Board that it would be later joined by Dr Llewyn who was a Non-Executive Director from KGH who had a background of being the Director of Public Health. She was there to discuss the inequalities paper.</p> <p>Mr Burns commented that interviews for Non-Executive Directors had been scheduled for 10 November. He thanked all involved.</p> <p>Mr Burns stated that the ICS Chair was in post and the ICS CEO interview was scheduled for 27 October with shortlisting for the post next week. The appointment will allow some material changes.</p> <p>Ms Burns remarked that the ICS was to appoint 5 Non-Executive Directors and if Trust Board members required any further information on this to contact him.</p> <p>The Board <b>NOTED</b> the Chairman's Report.</p>	
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1.7	21/22 060	<p><b>Group Chief Executive's Report</b></p> <p>Mr Weldon advised that it had been Organ Donation week. He thanked all that had contributed to support the vital work. There had been a family member of a patient who had shared their story. The family member had lost their daughter and she explained to the team the benefits of the recipient of her daughter donations. He encouraged all to sign up to #leavethemcertain.</p> <p>Mr Weldon advised that the NHS had a significant settlement for 2<sup>nd</sup> half of year up to 2024-2025. It was startling that £1 in every £3 comes to NHS. When this is reflected on, this was a significant amount of what we pay in taxes. Mr Weldon noted that the consequence of this was the expectations on the NHS. This included what was going to be delivered for patients and a call to arms. He remarked that the pandemic had worsened the waiting list position nationally. The ask was that for the next 6 months the NHS eliminated the 104 week waits. This required all to work together to do. He stated that Northamptonshire did not have as large backlog as other systems in midlands do therefore it was likely the Trust would be asked to help. The operational teams at NGH had done a stellar job keep going. He thanked all for this.</p> <p>Mr Weldon advised that there was key challenges around performance as stated in the national announcement. The Trust needed to continue to ensure that the 62 day cancer delivery was met and to stabilise the waiting list. The Trust had started in a good position.</p> <p>Mr Weldon discussed the financial challenges. He did not want to focus on H2. The H2 guidance had not yet been published and H2 started tomorrow. The Trust would need to run an accelerated planning process. This was a risk. The medium term actions the Trust needed referred back to Mr Burns' points in regard to the ICS. These leaders were integral to how the ICS would be shaped. The majority of the current finance programme in Northamptonshire sat in the acute hospitals. The Trust needed to respond to what it could do to improve and what conversation were needed with the system. He had welcomed the recent change in tone in terms of finance.</p> <p>Mr Weldon commented that the longer term contribution was the clinical strategy which had a clinical focus. It protected quality, delivery and addressed the financial challenge.</p> <p>Mr Weldon publicly noted and thanked HRH Princess Anne to opening the Paediatric A&amp;E. She also spent time with Sister Donna who would be retiring after 35 years' service. Mr Weldon also wish her a happy</p>	
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		<p>retirement. As HRH Princess Anne had walked away there had been a spontaneous cheer. He believed that her visit had helped staff feel that their contribution had been recognised.</p> <p>Mr Moore noted the use of a sustainable financial position and challenged what that was. It had been answered in context of the system. It also included how much it cost to run an acute hospital, the sustainability and the abstract numbers to deliver the care. The financial strategy would help with that.</p> <p>Mr Weldon stressed that this was why the ICS was so important. It had changed the way conversations are had. There was the CFO group who had gotten in to the task on what was needed to run Northamptonshire as a system. There was also the ICB body who were integral in agreeing the financial strategy.</p> <p>Mr Evans agreed. The focus of conversations since he had joined included what could be done in the acute hospitals to deliver efficiently and productively. There were discussions on what sustainability was in the general sense. Mr Evans advised that there was also a big piece of work on a programme of change across systems 4 key workstreams.</p> <p>The Board <b>NOTED</b> the Group Chief Executives Report.</p>	
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1.8	21/22 061	<p><b>Hospital Chief Executive's Report</b></p> <p>Ms Smoult remarked that it had been an incredible first month. She thanked Ms Doyle's leadership prior to her starting in post. She also thanked the executive team as they had been a huge support.</p> <p>Ms Smoult advised that in her first month she had tried to get out into the Trust and try understand on what to work at NGH as well as experience the care. Her aim was to make NGH a better place to work and better place to receive care.</p> <p>Ms Smoult stated that she had conversations across many teams which had touched on the challenges, the opportunities and the great work. The achievements needed to be recognised and communicated. She would be working on this as it was important to connect with the teams effectively.</p> <p>Ms Smoult referred to the different types of challenge. This included building a strong relationship across the ICS. She had spent time with the Head of Social on what can be done to improve the patients journey.</p> <p>Ms Smoult noted the continued pressure in ED and the impact on staff wellbeing along with the experience of patients. She noted that there was good OD work happening however more still to do. She acknowledged that in backdrop the Trust needed to keep elective work going. In July the Trust was first for 2ww and 62 days in the region.</p> <p>Ms Smoult remarked that the visit by HRH Princess had been positive. It had been an Honour to meet her and for the teams to experience that.</p> <p>Ms Smoult commented that there had been the launch of the Nursing &amp; AHP strategy. It had been a privilege to walk around to meet the teams and hear about their great work.</p> <p>Ms Smoult reported that the Trust had managed to retain the SNAP rating in stroke. This recognised the care provided by the stroke team which had also been achieved by collaborative working. Ms Smoult praised the Urology team for the PENNA award. She had also recently attended the Pride awards which she also praised its importance.</p> <p>Ms Smoult remarked that it had been an honour to be here as CEO. Her priorities included addressing the delays with discharges. She would work with Mr Metcalfe and the MDT to look at what underpinned this. Both an obvious perspective and also in accountability.</p>	
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		<p>It was an opportunity to talk about this from a multi-faceted perspective. She also noted that Maternity was a nationally pressured service and she would spent a lot of time there trying to under pick what was happening.</p> <p>Mr Burns queried whether there were any issues related to fuel. Ms Smoult explained that it had been discussed and working patterns looked at to mitigate the risk. There was no significant issue on care.</p> <p>The Board <b>NOTED</b> the Hospital Chief Executive's Report.</p>	
<b>2.0 PERFORMANCE</b>			

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2.1	21/22 062	<p><b>Integrated Governance Report</b></p> <p>Mr Burns asked the Board that items to be discussed needed to be raised as an exception.</p> <p>Ms Smoult stated that challenges at the front door continued. There was continued demand and a reduced bed base. This was an ongoing issue nationally. The Trust was working on Board rounds which included changes to improve flow. There was also a significant amount of work ongoing for iCan. She was also meeting weekly with Mr Metcalfe to discuss oversea recruitment.</p> <p>Ms Smoult noted that Cancer performance was an improving picture, and she congratulated the team for their hard work. She highlighted maternity pressures and the need to focus on these from a safety perspective.</p> <p><u>Quality Governance Committee – Ms J Houghton</u> Ms Houghton reported that the complaints panel had met and that the panel had been set up in regard to the recommendations from the ‘do no harm’ report. The ongoing theme was communication. She stated that the PALS office had moved to the front of hospital. This would improve communication.</p> <p>Ms Houghton remarked that the Committee had highlighted the missing health information and IT issues. There was a comprehensive IGR metrics report shared with the Committee.</p> <p>Ms Oke advised in regard to the COVID19 response. There was a continued focus on the situation. The number of hospital acquired COVID19 was low and was higher in the community. The IPC BAF was in place to mitigate and allow normal activity.</p> <p>Mr Metcalfe informed the Board that there had been rapid progress with the academic strategy. It had already showed positive benefits in the recruitment and retention of staff. The partnership with UHL had been well received. The Trust had also received positive feedback from the Royal college of physicians.</p> <p>Mr Callow apologised for the delay in the data. He has written to all Board colleagues to advise what was happening. Ms Smoult confirmed that this was a live discussion and had not impacted on safety.</p> <p>Mr Moore asked when ITU would open as this was a large part of capacity plan in to winter. Mr Finn explained that handover was planned for December. The team would work on how it would be staffed. He hoped patients would be in the early part of the new</p>	
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		<p>year. He noted that the plans were fragile. This had been agreed with contractor.</p> <p>Ms Kirkham queried the data as it showed never events as no data received. She asked did this mean zero. Mr Metcalfe confirmed that there had been zero never events.</p> <p>Ms Kirkham noted the FFT results in A&amp;E and the issues with patient concerns with attitude, behaviours and waiting times. She asked if this data had been triangulated with the assessment and accreditation data. She was pleased to see discharge on Ms Smoult's radar as there had not been much progress made over the last 2 years.</p> <p>Ms Smoult explained that FFT was impacted by a number of factors. There was OD support work going in. The Trust needed to make sure communication with patients continued. She had spoken to the divisional teams on behaviours and values. The approach to discharge was multifaceted.</p> <p>Ms Houghton had discussed in the Committee a visit to ED for herself and Mr Moore. They would be conducting a visit today and would report back.</p> <p><u>Finance &amp; Performance Committee – Mr J Evans</u> Mr Evans advised that the Group Finance &amp; Performance had met this month. The areas of discussion were RESET and IGR Metrics. There had been concern on the operational performance data, therefore the conversation was not as detailed as it could have been.</p> <p>Ms Fawcus commented that handover in A&amp;E had seen a rise in conveyances with the query of COVID19. This was a logistical issue. The Trust was working on different options in A&amp;E.</p> <p>There had been a routine update on estates to the Committee on compliance. There had been a paper submitted in regard to application for a grant from the Public Sector Decarbonisation Scheme. This had been submitted however was not committal. It was part of a competitive process and non-return payable. It was related to infrastructure equipment and would reduce the Trusts carbon admission. There was an obligation to be net 0 by 2040 and this was a key enabler.</p> <p>Mr Evans reported that the end of month had reported a deficit of £0.3m, this was a variance to plan of £0.6m. This was a major driver in the move in donations to access ERF. It was an allowable variable to plan. He noted that elective recovery and urgent care had required extra resource and capacity of approximately</p>	
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		<p>and extra £1m. The costs were being offset by a reduced level of COVID19 expenditure.</p> <p>Ms Fawcus stated that there was a transformation programme against urgent care. The Trust was undergoing a 2<sup>nd</sup> week of give it a go week. The Frailty move was key in the programme and would align to all other work.</p> <p>Mr Moore remarked that £3m had been spent on the iCan programme. He asked what it delivered to NGH. Ms Fawcus advised that the first agreed programme frailty had opened its unit at NGH. This had improved the experience for these patients and discharged them quicker. This was one of the key projects to deliver before winter. The Frailty education programme had improved the experience of patients who come but also so can manage patients better in system. She hoped that this reduced conveyances.</p> <p>Mr Weldon commented that this was the first time the system had agreed on a transformation programme.</p> <p>Mr Weldon and Ms Smoult would lead a seminar on iCan to give an opportunity to discuss in totality. He aimed to do this by November.</p> <p><b>ACTION</b></p> <p><u>Group Digital Committee – Mr A Callow</u> Mr Callow reported that that there had been a deep dive in to cyber security. The Trust was performing very well and the systems in place were good. The Committee had received an update on the progress on achieving digit aspiration funding for the NGH EPR programme. The Trust would continue to work through those hurdles following feedback from the regional team.</p> <p>Mr Callow discussed the laboratory used by NGH, KGH and UHL. There was concerns on the supplier and the collective needed to agree what happened next.</p> <p>Mr Callow commented on Health Intelligence and the potential firebreak in effect to focus on a core set of data. An advert went out for head of health intelligence yesterday.</p> <p><u>CPC Update – Mr S Weldon</u> Mr Weldon advised that first on agenda was the People Plan strategy and CPC had considered the progress made on the people plan.</p> <p>Mr Weldon noted that looking forward he expect CPC to start to consider the result of the people pulse survey. There was a meeting later this month look at planning guidance.</p>	<p><b>Mr Weldon &amp; Ms Smoult</b></p>
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		<p><u>Audit Committee – Mr D Moore</u> Mr Moore advised that the Committee had discussed the BAF. It had encouraged the formulation of group risk and there was a number of principle risks that required further review.</p> <p>The Committee had also discussed fraud prevention. Moore stated that there was a paper on Maverick transactions and there would be a zero-tolerance approach.</p> <p>Mr Moore informed the Committee that following the Annual report from the external auditors, a lessons learnt paper detailing corrective action had been presented with a further update in 6 months. At the December Audit Committee there would be a deep dive cyber security and clinical audit.</p> <p>Mr Evans delivered further information on the maverick transactions. He advised that the maverick transactions related to colleagues who not complied with internal process for example advance purchase and was not a fraud issue. He was comfortable seeing the past position and there were now significant steps in the process to reduce this.</p> <p><u>People Committee – Ms A Gill</u> Ms Gill reported that there had been an update from Medical education. There had been improvements made in the GMC survey results. There was a lot of work going on and the results were heading in the right direction. The Group had also shared learning.</p> <p>Ms Gill stated that KGH had shared a lessons learnt paper on the international nurses' arrival to the Trust. The Committee had heard about what happened, the actions and the future positive impact. The Committee had also received an update on the winter vaccination programme and the EDI strategy.</p> <p>Ms Gill commented that in regard to people performance, absence was trending and the Committee had asked for a further breakdown with benchmarking information. The Committee had also discussed the IGR metrics.</p> <p>Mr Smith noted the possible mandatory requirement for NHS staff to have the COVID19 vaccine. There would be a further update in October and Trust would need to look at possible implication.</p> <p>Mr Smith remarked in regard to the pay award there could be industrial action come from that.</p>	
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		<p>Mr Smith informed the Committee that October was black history month and there was a lot of events planned for the 18 October.</p> <p>Ms Smoult stressed the importance of the pulse survey as it gave a wealth of information.</p> <p>The Board <b>NOTED</b> the Integrated Governance Report.</p>	
<b>2.2</b>	<b>21/22 063</b>	<p><b>Proposed Group IGR metrics</b></p> <p>Mr Burns remarked that there was a wide variation that come to the two Trust Boards. The Group needed to find a way to produce an integrated report. It was noted that the Trust was part of a group and should be able to think about the metrics in this way. He stressed that less is more.</p> <p>Mr Burns stated that too much information becomes useless. There needed to be a given focus that could be changed time to time and be supplemented with special issues. The report did not need SPC charts that showed random variation.</p> <p>Mr Callow thanked his colleagues for the good conversations at the Committees. He hoped to provide an update to CPC in October with the first joint IGR January 2021.</p> <p>The Board <b>NOTED</b> the Proposed IGR Metrics.</p>	

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2.3	21/22 064	<p><b>Elective Recovery Update – Reset &amp; Theatre Efficiencies</b></p> <p><u>Reset – Ms J Fawcus</u> Ms Fawcus advised that the RTT backlog was reducing, and the trajectory showed that it was due to be cleared as planned. The Trust was delivering the outpatient target, despite an increase in attendees. There had been challenges in electives. The Trust had received new guidance through yesterday on how theatres could be used to improve theatre throughput.</p> <p>Mr Burns remarked that this was a good plan and was well placed. The Trust was likely to be asked to help others.</p> <p><u>Theatres Efficiencies – Mr A Callow</u> Mr Burns noted that Theatres was the Trust's biggest capital asset, therefore its usage was very important</p> <p>Mr Callow advised that the report was a conclusion from a recent piece of work. Their model had 4 measures. The report describes what the elements are. The data had been extracted from model hospital and NGH and KGH were not where they should be. The target was for 85% utilisation.</p> <p>Ms Fawcus advised that there were theatre productivity plans in place. This was to help with reduction in late starts, early finishes and reduce DNA's. There were issues with theatre staff vacancies and sickness which was impacting on ability. She noted that there was a lot of opportunities to improve.</p> <p>Mr Callow noted the improvements to the dashboard. He stated that my preOP was well utilised at NGH and he was looking how to apply the principle across group.</p> <p>Mr Moore remarked that a significant variable in operating theatres was the surgeon who did the operation. He challenged why this was not about surgeon productivity.</p> <p>Ms Kirkham concurred. She asked to understand what the scale of DNA's was on the day.</p> <p>Ms Gill touched on Health &amp; Wellbeing. There was a high chance theatre staff were being overworked at times with pressure increasing. She referred to a recent article in the HSJ where at another Trust a letter was sent to the CEO stressing that staff were overworked and unsafe in theatres. She wanted reassurance there was plans in place here for this not to happen.</p>	
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		<p>Mr Burns believed that the team needed to be wary of late and early finishes. He noted the importance of making sure that the WHO checklist was being perused.</p> <p>Mr Metcalfe explained that it was not the surgeon was not the primary driver of productivity. There were many factors and this included the turnaround time, portering, the anaesthetist etc. These were all important variables. He agreed the importance of following the WHO guidelines with productivity and safety going hand in hand. Mr Metcalfe discussed the cluster of never events, which were predominately in Theatres which had occurred whilst clearing the COVID19 back logs. In the past late cancellation would have been able to be back filled at short notice now cannot be done.</p> <p>Mr Burns highlighted that NGH was near the bottom of the graph therefore there was a lot needed to be done.</p> <p>Ms Smoult advised that it was an important piece of work. The variation needed to be understood more. Mr Burns would like this to be a regular feature at Trust Board.</p> <p>Mr Callow explained that model hospital helped drill down in to speciality. Now that the Trust had improved the way surface data was presented it would prompt further discussion</p> <p>Mr Weldon welcomed the work done on this. This linked to the conversation about IGR reports. He invited the committees when agreeing the IGR to think about this. It was noted that the ERF was expected to be linked to this and he expected incentives put in system to show how this was improving.</p> <p>Mr Weldon commented that the evidence suggested considerable room for the Trust to improve. The use of theatres needed to be more productive. He asked when discussing the clinical strategy that this was considered.</p> <p>Mr Smith referred back to the Health &amp; Wellbeing point raised by Ms Gill. He confirmed that dialogue continued to happen to understand pressure they face</p> <p>The Board <b>NOTED</b> the Elective Recovery Update – Reset &amp; Theatre Efficiencies.</p>	
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		<p><b>Winter Modelling</b></p> <p>Mr Callow shared his screen to present the Winter Modelling update that was included with the report pack.</p> <p>Mr Burns remarked that it was going to be a difficult winter.</p> <p>Mr Moore noted that it was great to see capacity planning done in this way. He highlighted that target occupancy was 90% however he had been led to believe that 85% meant a safe hospital. He queried the difference. Mr Moore also referred to page 153 and the assumption of home monitor for COVID19 via a docla. He asked how many had been rolled out.</p> <p>Ms Houghton echoed Mr Moore's comment as it was great piece of work done across the Group. The paper had an emphasis on what can be done as an acute and there was no mention of partner involvement. She believed that social care and community nursing referrals are up, and patients are being turned down. There was pressure to get patients discharged as if patient stayed inappropriately, they would become deconditioned.</p> <p>Mr Metcalfe stated that the Trust needed to reduce patients with moderate to severe COVID19. The use of a docla had managed to keep out a ward worth of patients.</p> <p>Mr Weldon thanked all for their contribution on getting to this point. This was system-based working and had been shared with system colleges to ensure there was one version of truth. Mr Weldon referred back to occupancy and explained that the simulation showed that every % above 80%, the number of duress goes up. The duress was caused by occupancy in the hospital.</p> <p>Mr Weldon commented that the risk to super stranded patients go up and there needed to be a creative solution. There needed to be a way of spending money to allow the Trust to mitigate the risks described. He expected to come back to this. There was a high level of risk as the Trust goes into winter and Trust would work with colleagues to mitigate the risk.</p> <p>Ms Fawcus remarked that the first risk was pathway capacity and there were significant gaps in the community. The report can expand on this risk further to reference this.</p> <p>Ms Smoult praised the plan as it could be flexed if required if uncomfortable with element or the model informs otherwise going forward.</p>	
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		<p>Mr Burns believed that it was good to be able to alter the inputs and it was good to get the model sensitive. He challenged how much was it worth to NGH to not have more than 30 super stranded patients. The system solution was very important.</p> <p>The Board <b>NOTED</b> the Winter Modelling Update.</p>	
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		<p><b>Health Inequalities Analysis</b></p> <p>Mr Callow shared his screen to present the report within the report pack.</p> <p>Ms Fawcus advised that work had been done on how the Trust breaks down the waiting list in to cohorts and how COVID19 had impacted these cohorts. There were some patients who had waited longer and it was queried whether this had impacted on their outcomes.</p> <p>Ms Fawcus stated that there had been a conversation at the Elective Care Board. Mr Callow was to form a working group to discuss this at a system level.</p> <p>Ms Gill noted sharing patient tracking across system and would this help understand quality of access. Mr Callow confirmed that the Elective Care Board had approved the concept of a system PTL.</p> <p>Ms Kirkham referred to the 14.5% statistic of not known. This skewed the data. She asked that from the initial review of information, what it told the Board.</p> <p>Ms Houghton remarked that this was an interesting piece of work and how could it align with prevention. She referred to the GP's in primary care and what they were doing to reach out to patients to stop presenting late. The End-of-life delivery board had been looking at advanced care plans and it was noted that Corby were unlikely to have one, therefore in reinforced health and inequalities across the piece.</p> <p>Mr Burns reminded the Board that not all patients had NN postcodes. This was a system problem for data purposes. It was also important to recognise that the NHS pay a lot of private tariff.</p> <p>Mr Callow stated that this was only scratching the surface. This was the first time the Trust had a decent go at indexes of deprivation. There were some many ways this could be looked at the Trust would prioritise what it could do.</p> <p>Mr Burns noted the importance of this. This was important for an acute trust. He requested a further update.</p> <p>The Board <b>NOTED</b> the Health Inequalities Analysis.</p>	
		<p><b>3.0 STRATEGY &amp; CULTURE</b></p>	

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3.1	21/22 065	<p><b>Assessment &amp; Accreditation</b></p> <p>Ms Oke presented the Assessment &amp; Accreditation report. This report had been live for several years and was a way of reporting internal assurance. The staff appreciated the tool as it created a lot of competitiveness and pride.</p> <p>Ms Oke advised that in March 2020 the tool had been paused as the country went in to the pandemic and the Trust had pulled out standard 5 in regards to IPC to focus on. In May 2021 the Trust recommenced in the updated format. Since May there had been 16 wards assessed. There were 4 wards that have had a 3<sup>rd</sup> consecutive green and would come to the panel in October for blue status. There were 2 wards assessed as red and 3 wards assessed as amber.</p> <p>Ms Oke referred to Section 4 of the report. At the time of writing the report standard 9 (Pain), standard 2 (patients feeling safe) and standard 12 (EOL care) are highly scored with standard 1 (evidence of a safety culture) scoring low. There would be a themed analysis of the points under each standard.</p> <p>Ms Oke commented that the team was developing a multi-professional tool, and this was being explored with organisations who already have this embedded at their Trust. She would bring back a proposal by the end of the year. Mr Metcalfe was glad that progress had been made on multi-disciplinary assessment &amp; accreditation. The best possible care was delivered by a multi-disciplinary team.</p> <p>Ms Gill stated that it was good to see this come back as she was a fan of the programme. There was a direct correlation between this and good patient care. She highlighted previous concerns with patient property and the impact this had on patient experience. She asked if this could be part of the criteria. Ms Oke was happy to consider this.</p> <p>Ms Kirkham stated that this good to see the progress. She referred to the two red wards and what steps were being taken to address this Ms Oke advised that the ward was given immediate feedback. If the assessors saw something of immediate risk or danger it would be addressed at the time.</p> <p>The Board <b>NOTED</b> the Assessment &amp; Accreditation Report.</p>	
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3.2	21/22 066	<p><b>Dedicated to Excellence Group Strategy Delivery: People Plan</b></p> <p>Mr Smith presented the People Plan and he shared his screen with the Trust Board.</p>  <p>People Plan Report - Trust Board Slides</p> <p>Ms Gill remarked that in light of concerns and challenges, would the Trust consider fast tracking innovative workforce roles.</p> <p>Mr Moore commented on the people plan metrics being on one page. This was important. He queried that the pulse survey had an 8% response rate and whether this was correct.</p> <p>Mr Smith confirmed to Ms Gill that he was building a small team to lead that piece of work. In regard to metrics, it was being agreed what is it was that was intended to be measured. He confirmed that the pulse survey response had now exceeded to 16% and the target had been 10%. It was noted that nationally the response rate was 50% and that was where the Trust aspired to be.</p> <p>Mr Weldon stated that there was good engagement considering it was a soft launch. The Trust needed to do something about it and demonstrate that it made a difference. The power lays in being able to understand the whole hospital metrics but also the feelings at an individualised level.</p> <p>Mr Weldon advised that there was an opportunity tomorrow to talk about this and what made a difference. He stressed that it was not always the big things that made a difference.</p> <p>The Board <b>NOTED</b> the Dedicated to Excellence Group Strategy Delivery: People Plan</p>	
<b>4.0 GOVERNANCE</b>			

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4.1	21/22 067	<p><b>Emergency Preparedness Annual Report</b></p> <p>Ms Fawcus advised that the Board was asked to note the completion of EPRR Core Standards self-assessment and approve the proposed overall assessment of Fully Compliant. There had also been a deep-dive in to medical gasses and oxygen systems which the Trust was fully compliant with.</p> <p>Mr Moore remarked that pre-COVID19 there had been discussions to test run the whole hospital on backup generators. He asked whether this would be done and would it work. Mr Finn confirmed that it was still in the plan and would hope it would be successful. The final piece of work was only done last month as he wanted to make sure that the network cable had been upgraded. The date would need to be set.</p> <p>Mr Burns commented that it was important to test the full system under load. Mr Finn clarified that the whole site was covered under load and that this was switch of at front end.</p> <p>The Committee <b>NOTED</b> the Emergency Preparedness Annual Report.</p>	
4.2	21/22 068	<p><b>Infection Prevention Annual Report</b></p> <p>Ms Oke advised that this had been at Quality Governance Committee. There had been a productive discussion. The report was structured as previously. The Trust had continued to follow IPC related guidance and had worked hard with our health hospital.</p> <p>Ms Oke reported significant reduction in patients with cdiff and MSSA bacteraemia as well.</p> <p>Ms Oke commented that on 11 March 2020 the pandemic was been declared. There were 2854 patients with a positive diagnosis. This impacted on the way staff managed care for patients.</p> <p>Ms Oke stated that the IPC BAF at the beginning had 28 new lines of enquiries which had been reported to Board and Quality Governance Committee to provide assurance as required.</p> <p>Ms Oke advised that appendix 4 outlines the forward plan and priorities.</p> <p>The Board <b>NOTED</b> the Infection Prevention Annual Report.</p>	

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4.3	21/22 069	<p><b>Safeguarding Annual Report</b></p> <p>Ms Oke advised that the Safeguarding Annual Report had been discussed at Quality Governance Committee. It had paid tribute to the safeguarding team through a very difficult year. The team had worked on site and remained visible supporting the clinical area.</p> <p>Ms Oke commented that there had been an external review in maternity services which had shown robust governance process in place.</p> <p>Mr Burns stated that this was an area which had expressed concern in past and needed continued focus on.</p> <p>The Board <b>NOTED</b> the Safeguarding Annual Report.</p>	
4.4	21/22 070	<p><b>WDES Report 2020/2021</b></p> <p>Mr Smith advised that the strategy had been approved in July and data was being presented to the Trust Board. There had been some improvement and some deterioration seen.</p> <p>Mr Smith remarked that colleagues with disabilities clearly had a disparity noted. He was pleased to announce that the DAWN network was up and running. The Trust to ensure all protected characteristics are reviewed.</p> <p>The Board <b>NOTED</b> the WDES Report 2020/2021.</p>	
4.5	21/22 071	<p><b>Strategic Development Committee</b></p> <p>Ms Campbell advised that this had been agreed in principle at KGH yesterday. She was asking the Board to approve reconstitution of this committee; it was previously a KGH only Committee. The Committee common was to meet in shadow form and full ToR would be presented in November.</p> <p>Mr Burns believed that the Committee was to meet every 2<sup>nd</sup> month. He would be looking at the Non-Executive Director roles across the Committees to make sure a reasonable amount of time was being asked of them.</p> <p>The Board <b>APPROVED</b> the reconstitution of the Strategic Development Committee.</p>	
<b>5.0 CLOSING ITEMS</b>			

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5.1	21/22 072	<b>Questions from the Public (Received in Advance)</b>  There were no questions received from the Public.	
<b>6.0 ANY OTHER BUSINESS</b>			
6.1	21/22 073	<p>Mr Burns advised that this was Ms Fawcus' last Trust Board. She had an impact across the Group, both at KGH and NGH and would be missed.</p> <p>Ms Smoult thanked Ms Fawcus on behalf of the people for the big impact she had. She really admired her values and approach. The Trust Board should recognise the positive impact she has had at NGH and how she also leads. She wished her all the best.</p> <p>Mr Weldon discussed the recent half marathon which Ms Fawcus, Mr Metcalfe and Ms Spellman ran. The noted their success as they had raised £2k. Ms Fawcus had fell over however still finished the race. This was reflective of the work done as COO and Director of Ops. She had been knocked down but got back up again. He hoped the Trust could maintain all the work done with iCan.</p>	

#### Next meeting

<b>Date &amp; Time</b>	25 November 2021 – 09:30
<b>Location</b>	MS Teams

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Public Trust Board Action Log							Last update	04/11/2021
Item No	Month of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Updates
Actions - Slippage								
Actions - Current meeting								
128	Sep-21	21/22 062	Integrated Governance Report	Mr Weldon and Ms Smoult would lead a seminar on iCan to give an opportunity to discuss in totality. He aimed to do this by November.	Mr Weldon & Ms Smoult	Nov-21	On agenda	**Update Matters Arising**
Actions - Future meetings								



## Cover sheet

Meeting	Public Trust Board
Date	25 November 2021
Agenda item	1.7

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

This paper is for			
<input type="checkbox"/> Approval	<input type="checkbox"/> Discussion	<input type="checkbox"/> Note	<input type="checkbox"/> 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				
<input type="checkbox"/> Patient	<input type="checkbox"/> Quality	<input type="checkbox"/> Systems & Partnerships	<input type="checkbox"/> Sustainability	<input type="checkbox"/> 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

As we meet today, we will be considering both current challenges and also the potential future that of acute hospital services in Northamptonshire. I would like to comment on both in my report today.

The causes of the current demands on our emergency care pathway require careful consideration and action across all parts of our system if we are to address them. Before making some observations on what we can do I would again like to pay tribute to all staff who are working in the emergency care pathway across the county. You see people at their most fragile and vulnerable and daily you rise to the challenge of meeting those needs. I know how much the services that you

provide mean to people and on behalf of them and indeed all of us, I want to say thank you.

I said that we need to take action across the system if we are address the demand we are seeing. I want to draw out three areas for action. First, there is more that we can and do ourselves. I commend the work that both Executive Teams have been doing on Board rounds. These interventions provide visible support to wards that are dealing with increasingly complex discharge issues, they allow us to reflect on and improve our practice and they help us identify the key areas where further community support is needed. Secondly, we continue to be marked out as a system as having high levels of delayed discharges. The non-elective demand issue is nationwide but where we in Northamptonshire are different is in this place. We need to come again to the conversation about how we change that. I know that no system partner wants to see the level of delays we have in our hospitals; I also know that we have not been able to sustainably solve this problem. We have to use the auspices of the emerging ICS to drive a different conversation – there are beds and resources available in our community but we are not able to use them. Consequently, as we are now, we have an asynchronous clinical risk in our system on a daily basis. Thirdly, we have been asked to consider what further investment we need to help improve patient pathways and I think rapid consideration now needs to be given to what support would further help decompress our emergency departments.

We will also consider today the clinical strategy for the future development of acute hospital services in Northamptonshire. I would like to make three points in relation to the document. First, this is about acute services in Northamptonshire – we have to now start framing how we deliver services through that lens. We have real and significant opportunities to improve what we can do for patients but they will not be delivered by doing more of the same, in the same way. I vividly recall Bernadette's story from our last Board. Whilst I am glad we have addressed that issue it is but one change. There are many more Bernadette's out there and we need to solve their issues. Secondly, this document is not the final word and should not be read as such. Whilst we can and should present our ideas about how acute services should be improved we need to engage with our communities on how the ideas contained in this document should be delivered. Thirdly, the strategy will continue to evolve; I expect us to come back to it on an annual basis to mark our progress and refresh our ambition. Finally, I want to commend the work to the Board: there are some really interesting and exciting ideas contained here and we need to get behind them, support them, improve them and crucially deliver them. I also want to thank our Medical Directors, Matt and Rabia, for their clinical leadership of the work and one of our Director of Strategy, Polly, for her stewardship of the work you see here.

## Appendices

### Risk and assurance

### Financial Impact

### Legal implications/regulatory requirements

### Equality Impact Assessment

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

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## Cover sheet

Meeting	Public Trust Board
Date	25th November 2021
Agenda item	1.8

Title	Hospital CEO Report
Presenter	Heidi Smoult, Hospital CEO
Author	Heidi Smoult, Hospital CEO

This paper is for			
<input type="checkbox"/> Approval	<input type="checkbox"/> Discussion	<input checked="" type="checkbox"/> Note	<input type="checkbox"/> 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				
<input checked="" type="checkbox"/> Patient	<input checked="" type="checkbox"/> Quality	<input checked="" type="checkbox"/> Systems & Partnerships	<input checked="" type="checkbox"/> Sustainability	<input checked="" type="checkbox"/> People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

Reason for consideration	Previous consideration
HCEO activities and hospital highlights for the previous month	Reported bi-monthly to public Board

### Executive Summary

I would like to commence my report by acknowledging the continued pressures that the NHS currently faces and thank all teams at NGH for their continued hard work, dedication and commitment to delivering excellence for people who receive our care and treatment. I would also like to thank all staff for their commitment to supporting each other during such pressures and ensuring we focus on safety and patient experience. The staff awards this evening will be a truly excellent opportunity to recognise some of the teams and individual excellence we have here at NGH.

The current pressures on the NHS combine a number of factors, including pressures in emergency care, in particular the attendances in A&E, as well as maintaining elective care

and treatment, combined with the pressures in adult social care due to recruitment challenges. These pressures are compounded by the reduced bed capacity as a result of covid-19 IPC requirements, where we have different pathways of care, dependent on covid-19 status. These system pressures require us all to lead in a truly collaborative way across the system and ensure we are all leading to utilise our collective capacity in the most effective way for the people of Northamptonshire. I am pleased to note that NGH colleagues are working proactively with system colleagues to this effect. I am personally working closely with Adult social care colleagues in West Northamptonshire.

1. Board round initiative: empowering our teams: achieving the best outcome for every patient

At the last board meeting I highlighted one of my initial priorities as HCEO to be a focus on flow and discharges at NGH. I am delighted to confirm that we have initiated an executive led initiative to focus on strengthening the quality of our board round process on each ward. Whilst I have personally sponsored this work with Matt Metcalfe, the initiative has been led by Rob Hicks, Deputy Medical Director and supported by Debbie Shanahan (Deputy Director of Nursing), Liz Sargeant (National Discharge Lead) and Marcella Irvine (Head of Therapies) to recognise the multi-disciplinary nature of board round effectiveness. The programme commenced on 1 November and is fully supported by the whole executive team and they will all attend board rounds across the hospital in three phases to ensure we cover all the wards.

The board round initiative is focussing on empowering our teams: achieving the best outcome for every patient. I would like to thank all my executive and divisional colleagues for their dedication to this work.

Why do we believe it is so important?

- Executive visibility and support: the opportunity to meet as a clinical team involving doctors, nurses, therapists and pharmacists improves the communication between teams and helps us to provide the best care for patients.

- By having a clear diagnosis and plan for every patient means that each person in a hospital bed will have

clearer and more consistent information about what is happening to them.

- Documenting a clear diagnosis triggers a clear investigation and management plan. An effective board round sets a plan for every patient with clear tasks for all team members every day.

- Accurate recording of information on ibox will help with planning flow and discharges out of the hospital.

The 3 aims of this work are:

- Improve effective team working on the board round
- Accurate patient diagnosis
- Prevent wasted days in hospital

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There is a large evidence base which shows that wasted days and extended time for people in hospital any longer than necessary when unwell or once recovered is likely to cause harm in terms of impact on a person's function. This is most noticeable in older people and frailer younger people. If we can reduce this harm, the amount of care people need on discharge will reduce, which is why this work is ensuring we are working closely with system colleagues to underpin the work with education from social care on pathways out of hospital.

At NGH we have very higher rates of people in hospital 7 days when benchmarked against other hospitals. This work is to concentrate on what we do at NGH, and ensure we treat every person in our care as though they were our family or friend, and ensure they are only residing in hospital when they meet the criteria to reside.

We will update the board on progress and associated data at the next board meeting.

## 2. Royal College of Physicians (RCP) Visit

Professor Goddard and his team visited NGH and spoke with trainees and consultants within medicine. Overall, the feedback was positive and highlighted areas where we can continue to work to improve. Their first meeting with a group of trainees reported being very well supported during COVID-19 and described this support as 'phenomenal'. This was both from consultants and from the executives and they felt that this created an atmosphere of everybody being 'there for each other'. They also noted the psychological support that was started during the pandemic has been continued and that has been appreciated.

The trainees were particularly grateful to Dr Binns for all that she has done over the past year to support them and be an advocate for their needs. Professor Goddard formally acknowledged his personal thanks for all that Dr Binns and the other College Tutors have done.

Areas for continued focus and improvement include the impact of IMY3 training posts taking trainees away from specialities and into geriatric medicine and the level of consultant staffing within respiratory medicine, care of the elderly and acute medicine. During the visit these areas were discussed and ways of improving recruitment, such as SAS doctors who may then be able to go down the CESR route. Professor Goddard acknowledged some of the work that is underway in these areas, such as Dr Mohsin Zaman working specifically on trying to support those going through the CESR programme. Matt Metcalfe and I are working with divisional colleagues and consultants to progress this area, in particular the sustainability and recruitment. Our academic links and clinical strategy being presented to the board today will be beneficial in moving these areas forward.

## 3. RCM Awards

I am very proud and delighted to inform the board today that NGH is the only trusts to be receive RCM award in two categories. Our midwifery teams have been recognised for their dedication and commitment to providing excellence in two areas.

Claire Dale and Anne Richley won the award for their hard work and dedication during the pandemic. They won - Excellence in Maternity Care during a Global Pandemic

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- Fatima Ghaouch and Sam Tennyson won an award for their excellent work and dedication in their inclusion work. They won - RCM Race matters

#### 4. HEE-EM review

HEE-EM review visit for Surgery took place on 11th November following previous concerns being raised. The verbal feedback was that there had been a "remarkable turnaround" and given the previous level of concerns HEE-EM had their findings were nothing short of "remarkable". We look forward to receiving their written report.

I would like to personally thank the teams working in these areas for their hard work and dedication to improving the areas previously raised as a concern.

#### 5. Chief Operating Officer appointment

As the board is aware, we have been through a recent recruitment process for our COO appointment and delighted to confirm we offered the post to an excellent candidate following interviews on 11th November. I feel they will offer an excellent addition to the executive team at NGH. The appointment has not been formally announced at the time of writing this paper, but the recruitment process is underway.

In the meantime, I would like to thank Matt Metcalfe for his unrelenting support since I have been in post and that he has kindly agreed to cover the post of interim COO until the successful candidate commences in post, which we hope will be in January. Matt will remain the executive medical director and interim COO. Hemant Nemade has kindly agreed to act into the role of Medical Director supporting Matt during this time.

#### 6. HSE Visit

On 16 and 17 November the Health and Safety Executive (HSE) are doing an announced visit of NGH covering three areas, which include:

- IPC – Covid
- MSK
- Violence and Aggression

I would like to thank Claire Campbell, Tracey Robson, Paul Shead and Sheran Oke for their teamwork in collating all the required information.

Initial feedback from the visit was that no improvement notices were required. Some helpful observations and recommendations were made to improve support to and monitoring of aspects of Health and Safety, which will be followed up in writing.

#### Appendices

None

#### Risk and assurance

Board Round initiative and external reviews provide assurance and identifies potential organisational risks and areas for improvements and learning.

#### Financial Impact

None known

#### Legal implications/regulatory requirements

Palmer  
11/24/2023 11:45 AM

Potential risk of not achieving the regulatory standards and compliance with Health and Safety Legislation, HEEM and RCP requirements

Equality Impact Assessment

Neutral

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## Cover sheet

Meeting	Public Trust Board
Date	25 November 2021
Agenda item	2.1

Title	Integrated Performance Report
Presenter	HCEO
Author	Jamil Iqbal

This paper is for			
<input type="checkbox"/> Approval	<input type="checkbox"/> Discussion	<input type="checkbox"/> Note	<input checked="" type="checkbox"/> 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				
<input checked="" type="checkbox"/> Patient	<input checked="" type="checkbox"/> Quality	<input checked="" type="checkbox"/> Systems & Partnerships	<input checked="" type="checkbox"/> Sustainability	<input checked="" type="checkbox"/> People
Excellent patient experience shaped by the patient voice	Outstanding quality healthcare underpinned by continuous, patient centred improvement and innovation	Seamless, timely pathways for all people's health needs, together with our partners	A resilient and creative university teaching hospital group, embracing every opportunity to improve care	An inclusive place to work where people are empowered to be the difference

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

Executive Summary
<p>This paper sets out performance against both national &amp; local key quality and performance metrics.</p> <p>Areas of focus are detailed as:</p> <ul style="list-style-type: none"> <li>Complaints responded to within agreed timescales</li> <li>Friends &amp; Family Test % of patients who would recommend: A&amp;E</li> <li>Friends &amp; Family Test % of patients who would recommend: Inpatient/Day</li> </ul>

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case

- Friends & Family Test % of patients who would recommend: Outpatients
- Mixed Sex Accommodation
- Never event incidence
- Number of Serious Incidents (SI's) declared during the period
- MRSA > 2 Days
- HOHA and COHA (C-Diff > 2 Days)
- MSSA > 2 Days
- VTE Risk Assessment
- Harmful Falls per 1000 occupied bed days (Exc. Maternity and Pead's)
- Fire Drill Compliance
- Fire Evacuation Plan
- Stranded Patients (avg) as % of bed base
- Super Stranded Long Stay Patients (avg) as % of bed base
- Length of stay - All
- Percentage of discharges before midday
- % Day case Rate
- Mortality: HSMR
- Mortality: SHMI
- Unappointed Follow Ups
- A&E: Proportion of patients spending less than 4 hours in A&E
- Ambulance handovers that waited over 30 mins and less than 60 mins
- Ambulance handovers that waited over 60 mins
- Operations: Number of patients not treated within 28 days of last-minute cancellations - nonclinical reasons
- Cancer: Faster Diagnosis Standard
- Cancer: Number of Legacy Patients
- Cancer: Percentage of patients treated within 31 days
- Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days – drug
- Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days – radiotherapy
- Cancer: Percentage of patients for second or subsequent treatment treated within 31 days – surgery
- Cancer: Percentage of patients treated within 62 days of Consultant Upgrade
- Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers
- RTT Median wait incomplete pathways
- RTT over 52 weeks
- Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test
- Stroke patients spending at least 90% of their time on the stroke unit
- Sickness Rate
- Turnover Rate
- Percentage of all trust staff with mandatory training compliance
- Percentage of all trust staff with mandatory refresher fire training compliance
- Percentage of staff with annual appraisal

## Appendices

None
Risk and assurance
None
Financial Impact
None
Legal implications/regulatory requirements
None
Equality Impact Assessment
There is no evidence that the proposed action will promote/have a negative impact on equality of opportunity

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

**Notes:**

The cover page must not exceed two pages of A4 in total

Delete guidance notes

Palmer, Kirsty  
11/24/2021 12:14:24

Paper

Situation
None
Background
None
Assessment
None
Recommendation(s)
None

Notes:

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

Delete guidance notes

Palmer Kirsty  
11/24/2021 12:14:24



# Integrated Performance Report

November 2021

Reporting Period: October 2021

Palmer Kirsty  
11/24/2021 12:14:24

# Overview

Palmer Kirsty  
11/24/2021 12:14:24

# Medical Director's Overview

## **Mortality**

Both HSMR and SHMI indices are below the expected range at 94 and 96 respectively.

## **Deteriorating patients**

Work continues to support wards to understand their own areas for improvement and the patient safety team provide support and share learning trust wide. The data will be aggregated to support divisional scorecards for exploration in assurance meetings.

## **VTE assessment compliance**

There is an agreed approach to replacing the ePMA and pharmacy systems such that both are live in March 2023, and offer alignment opportunities across the group. The procurement process for both is underway. In the meantime a VTE nurse has been recruited and starts next month. She is experienced in the role and will support our journey towards VTE exemplar status.

## **Board rounds**

The executive team buddies with other senior leaders in the hospital are supporting board rounds with an emphasis on accurate working diagnosis, facilitating progression of pathways and ensuring reason to reside. This is supported by the project team at iCAN

## **Patient Safety Strategy**

There is some delay recently announced to the national roll out of this. The trust remains entirely supportive of the direction of travel set out therein, and will proceed with the programme of preparatory work as originally planned.

## **HEE-EM review visit for surgical training**

The school of surgery repeat visit, prompted by concerns over training from a previous review, occurred on the 11th November. The review team considered the improvements made to represent a "outstanding turnaround" and "remarkable achievement".

# Director of Nursing & Midwifery's Overview

## **1. Positive stories:**

- Maternity services have won 2 Royal College of Midwifery Awards; Excellence in Maternity Care in a Global Pandemic / Race matters
- IPC Team presented three posters at the national IPC Conference in September on mouth care, COVID theatre pathways and Clinically Appraised Topic days and in October one of the team accepted a DON fellowship within the Trust.

## **2. Friends & Family Test:**

Feedback received in October showed a slight improvement in the feedback received for the Emergency Department, rising to 76.4% satisfaction within A&E. The majority of comments related to waiting times, communication and care. A patient listening event is being planned for December, patients that have attended ED will be invited to discuss their experience and ideas for how the service can improve. Outpatient areas have continued to see an increase in satisfaction in October achieving 93.1%.

## **3. Complaints:**

All complaints are triaged upon receipt and a decision made as to the most appropriate route through which the complaint should be handled / investigated. Where possible, and in agreement with the complainant, the Complaints team will try to locally resolve some complaints. However, for complaints, which meet the criteria for a potential incident / safeguarding, these are escalated to either Governance or the Trust's Safeguarding team. All such actions are agreed with the complainant from the outset. The complaints timeframe has now returned to the Trust's normal process of agreeing between 20-40 working days with those who raise a complaint formally. The team are working through the complaints from 20/21 with support. It has been identified that the complaints received recently are significantly more complex in terms of the contents. The Trust compliance rate response rate for complaints, reported in September was 97% with 92% achieved in October.

## **4.1 Infection Prevention & Control Service:**

During September and October there were 6 reported cases of Clostridium difficile Toxin A & B identified as hospital onset, 4 in September and 2 in October, the IPC Team reviewed each patient and no lapses in care have been identified for these patients. The IPC Team have developed a C.diff Reduction Action Plan that includes actions around antibiotic stewardship. There were 3 reported cases of MSSA BSI and 1 case of MRSA BSI reported during September and October. Post infection Review meetings have been held and local learning identified.

## **4.2 Covid Response:**

The IPC team continues to focus on leading and supporting the Trust in managing the COVID pandemic and in the safe management of reset for elective and cancer activity. The IPC COVID Board assurance framework has been reviewed, progress has been made with particular attention being made to fit testing compliance and increasing the provision of our domestic support team. There were 0 COVID patient outbreaks in September and 3 in October and 10 patients developed a hospital acquired COVID infection. The IPC Team relaunched the IPC Link Leaders meetings and training sessions and the Matron for IPC presented the learning from COVID outbreaks at Grand Round.

## **4.3 CPE:**

There was an outbreak of CPE on Finedon ward affecting 3 patients in October. Outbreak Control Meeting were joined by UKHSA, NHSE and CCG IPC Leads and control measures were put in place effectively, to date no further cases have been identified. The new CPE admission screening tool and care plan is being developed by the IPC Team and CPE screening for all patients admitted to high-risk areas including Finedon ward continues.



# Chief People Officer's Overview

Palmer, Kirsty  
11/24/2021 12:14:24

# Chief Operating Officer's Overview

## Urgent Care

- Overall performance against the ED standard was 72.02% compared to Oct 2020 performance of 78.37%.
- Attendances for October were the highest recorded for the previous 12 months with 12,390 attendances compared to 8893 in October 2020
- The conversion rate for NEL admissions has continued to reduce despite increase in attendances with October 21 seeing the lowest conversion rate for the previous 12 months that of 16.80%.
- Ambulance conveyances slightly reduced for October to 2775 with a conversion rate of 22.98%.
- SDEC attendances increased to the highest number of attendances for the previous 12 months with a total of 1,240 attendances compared to October 2020 985 attendances.
- Ambulance handovers have been exceptionally challenging for the month of October with 117 over 60 minute delays in offloading the ambulance. This is a multifactorial issue with the significant increase in attendances, the reduction of physical space that ED has had to reconfigure due to covid, the need to continually reassess what area of ED is able to have covid patients and ed block in terms of bed admission waits.
- Flow from Urgent Care has been problematic given the rise in Covid inpatient numbers. This also impacted on our ability to step down from critical care and the use of all escalation areas

## Stranded Patient Metric

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

## Cancer Waiting Times

- For September the Trust met 3 of the 8 cancer waiting standards of which the Trust is performance managed against, this is disappointing compared to previous months, but not unexpected due to the rise in referrals, demand through ED and annual leave of key staff during August all affecting the diagnostic and treatment waits
- The Trust continues to meet and exceed the 28 Faster Diagnosis Standard reaching 77.6% against the 75% standard.
- For the month of September 1689 patients were referred on the 2ww pathway by their GP, prior to covid in the same month the referrals were 1370,
- Referrals in September 2021 were 24.2% more than in August and have put a considerable strain on all diagnostic and treatment pathways.

## Elective Access

- The median RTT wait for October was 8.5 weeks, we are consistently well below the target set by NHSE
- The number over 52+ weeks for October month end was 60 this is a reduction from previous month of 79.
- Challenges remained in September with emergency pressures, staffing all theatre capacity due to sickness, self-isolation and limited uptake of bank & agency. T&O and Cardiology are two specialties that remain challenged.

## Diagnostics

- Increased capacity at Danetre and use of private providers in place to support routine referrals. Additional weekend work is being completed where feasible.
- Outsourcing of circa 500 u/s to Healthshare to support demand and clear backlog

# SPC Charts Explained

Palmer Kirsty  
11/24/2021 12:14:24

- ▶ Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.
- ▶ SPC is a good technique to use when implementing change as it enables you to understand whether changes you are making are resulting in improvement — a key component of the Model for Improvement widely used within the NHS.
- ▶ SPC is widely used in the NHS to understand whether change results in improvement. This tool provides an easy way for people to track the impact of improvement projects.

Palmer Kirsty  
11/24/2021 12:14:24

- ▶ Variation icons: **Orange** indicates concerning special cause variation requiring action; **Blue** indicates where improvement appears to lie, and **Grey** indicates no significant change (common cause variation). Assurance icons:
- ▶ **Blue** indicates that you would consistently expect to achieve a target.
- ▶ **Orange** indicates that you would consistently expect to miss the target.
- ▶ **Grey** icons tells you that sometimes the target will be met and sometimes missed due to random variation

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

Palmer Kirsty  
11/24/2021 12:14:24

# Caring

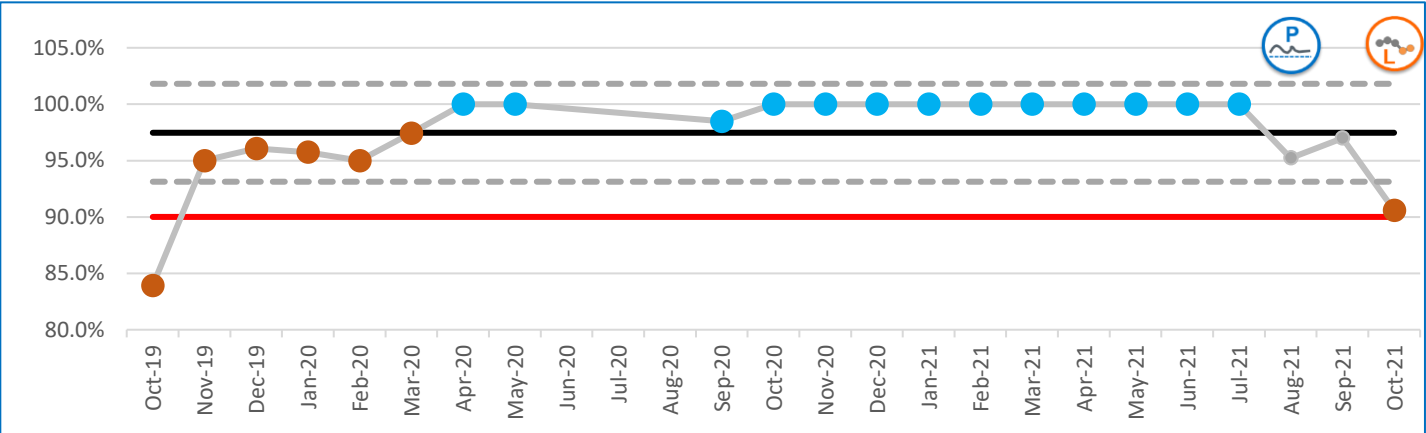
Palmer Kirsty  
11/24/2021 12:14:24

# Caring Key Performance Indicators

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Complaints responded to within agreed timescales	Oct 21	90.6%	90.0%			97.5%	93.1%	101.8%
Friends & Family Test % of patients who would recommend: A&E	Oct 21	76.4%	88.0%			83.1%	78.8%	87.3%
Friends & Family Test % of patients who would recommend: Inpatient/Davcase	Oct 21	90.6%	95.7%			91.7%	88.4%	95.1%
Friends & Family Test % of patients who would recommend: Outpatients	Oct 21	93.1%	94.0%			92.5%	89.9%	95.0%
Mixed Sex Accommodation	Oct 21	2	0			1	-2	4



# Caring - Complaints responded to within agreed timescales



Oct-21
90.6%
Variation
Special cause of concerning nature or higher pressure due to (L)ower values
Target
>= 90.0%
Target Achievement
Not Met

Background:

Palmer Kirsten  
11/24/2022 10:24 AM

Complaints performance – Providing a written response to a complaint within an agreed timescale

What the chart tells us:

Variation indicates consistently (P)assing the target

Issues:

No issues as target met

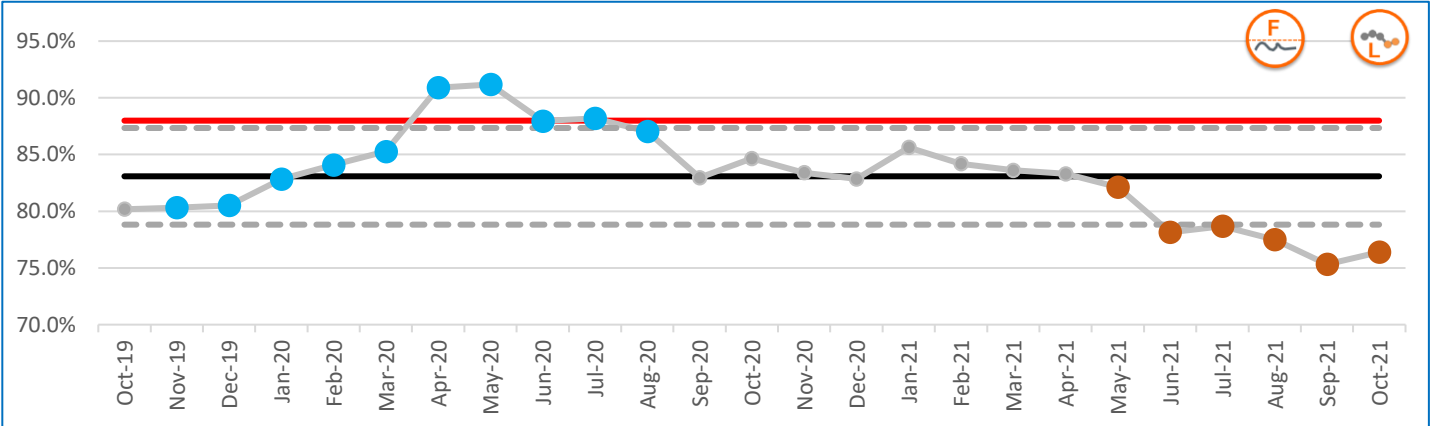
Actions:

No actions as target met

Mitigations

No mitigations as target met

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



Oct-21
76.4%
Variation
Special cause of concerning nature or higher pressure due to (L)ower values
Target
>= 88.0%
Target Achievement
Not Met

Background:

Palmer Kirsty  
11/24/2021 11:14:08 AM

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

What the chart tells us:

Variation indicates consistently (F)alling short of the target

Issues:

ED has seen a decline in satisfaction scores over a period.

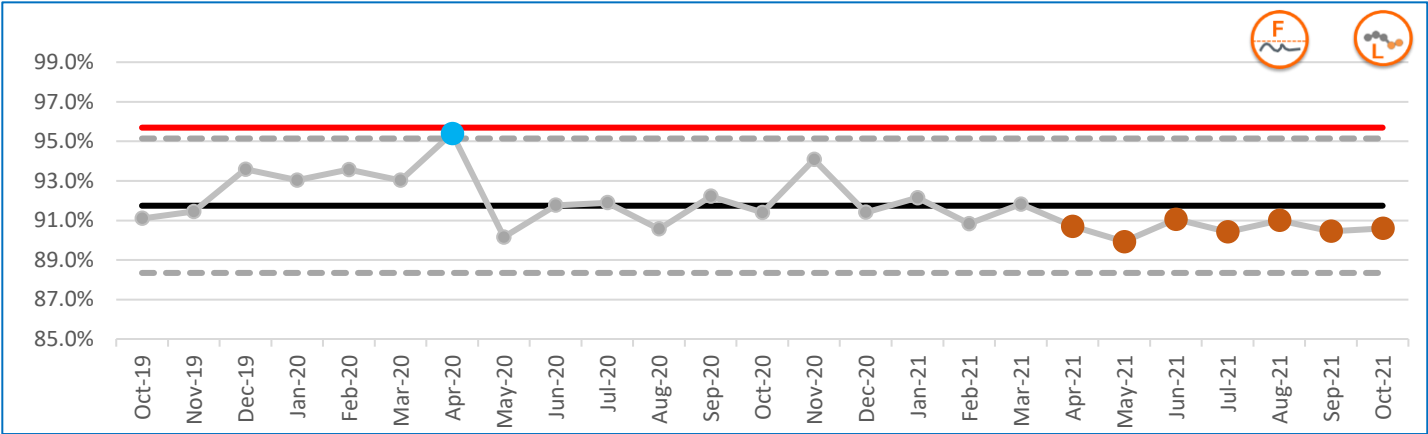
Actions:

To better understand the experiences of patients and to coproduce changes, a focus group is being established with patients that have recently attended ED or Springfield.

Mitigations

Comments within the FFT indicate patients have concerns with communication related to attitude and behaviour and waiting times. The CQC National Urgent Care survey also highlights issues with communication around waiting times.

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



Oct-21
90.6%
Variation
Special cause of concerning nature or higher pressure due to (L)ower values
Target
>= 95.7%
Target Achievement
Not Met

Background:

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

What the chart tells us:

Variation indicates consistently (F)alling short of the target

Issues:

Inpatient & Day case areas are showing special cause variation for a consistent depreciation in the scores. Comments from patients are often related to ED.

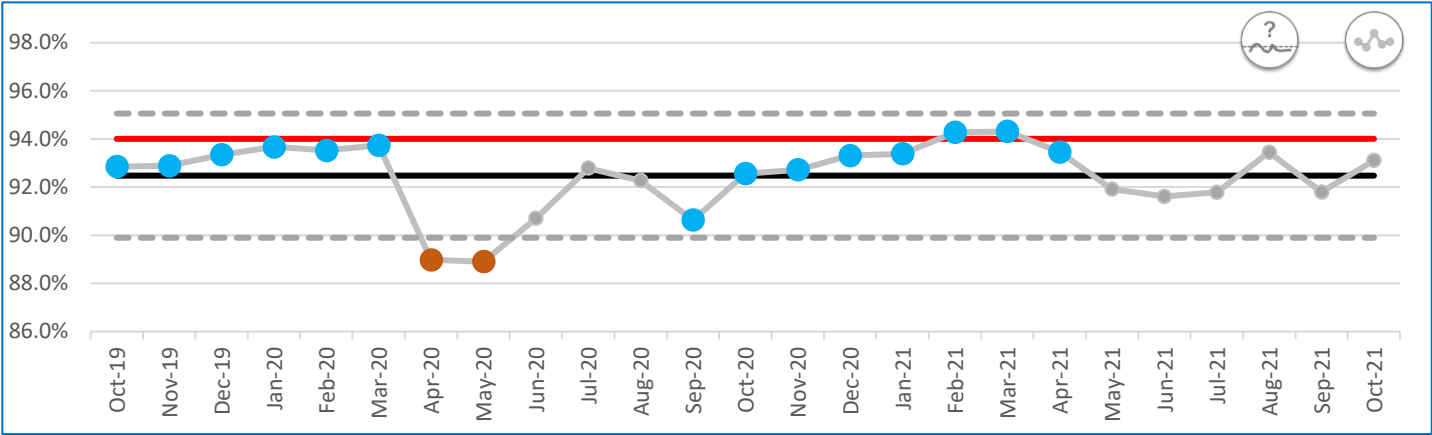
Actions:

Feedback cards will be offered to patients that have attended ED to allow for their experiences to be split out from ED and the Ward. It is hoped that this will provide more accurate feedback for the wards to work with when designing improvements.

Mitigations

Inpatients, the target is 89.5% and the score for October was 85.2%. For Day Case the target is 98% and the October score was 94.3%

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



Oct-21
93.1%
Variation
Common cause - no significant change
Target
>= 94.0%
Target Achievement
Not Met

Background:

Palmer Kirsty  
11/24/2023 11:41 AM

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

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

Following a series of significant improvement scores, Outpatient scores now remain consistently around the average and not achieving target.

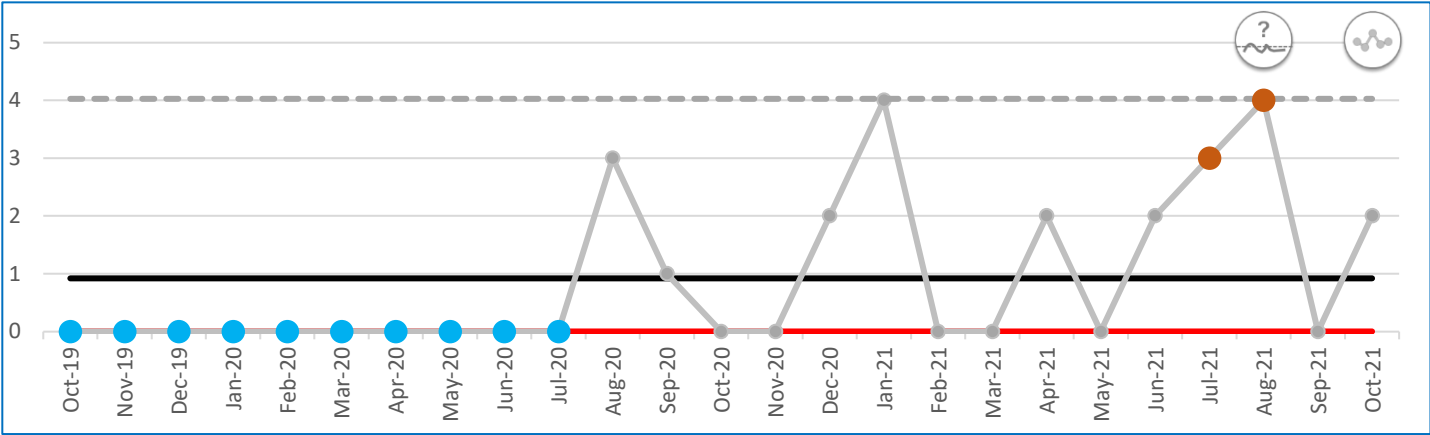
Actions:

An Outpatient Survey has been created to support a review of Outpatient services by the Transformation Team. This will inform a large piece of work to radically improve Outpatient Services.

Mitigations

Although they are marginally below target, significant progress continues to be made which can largely attributed to patients' satisfaction with e-clinics and telephone consultations.

# Caring - Mixed Sex Accommodation



Oct-21
2
Variation
Common cause - no significant change
Target
0
Target Achievement
Not Met

Background:

Palmer Kirsty  
11/24/2021 12:44 PM

Number of Mixed Sex Accommodation

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

With the restrictions due to covid the ability to move patients between ITU and HDU has been significantly reduced. Likewise the ability to step patients down is also challenging if side rooms are required.

Actions:

Three times a day the step downs for ITU/HDU are looked at with site actively trying to map patients out to appropriate bed base. IPC and site review 3x a day patients covid status, beds closed and side room requirements.

Mitigations

No mitigations as target met

# Safe

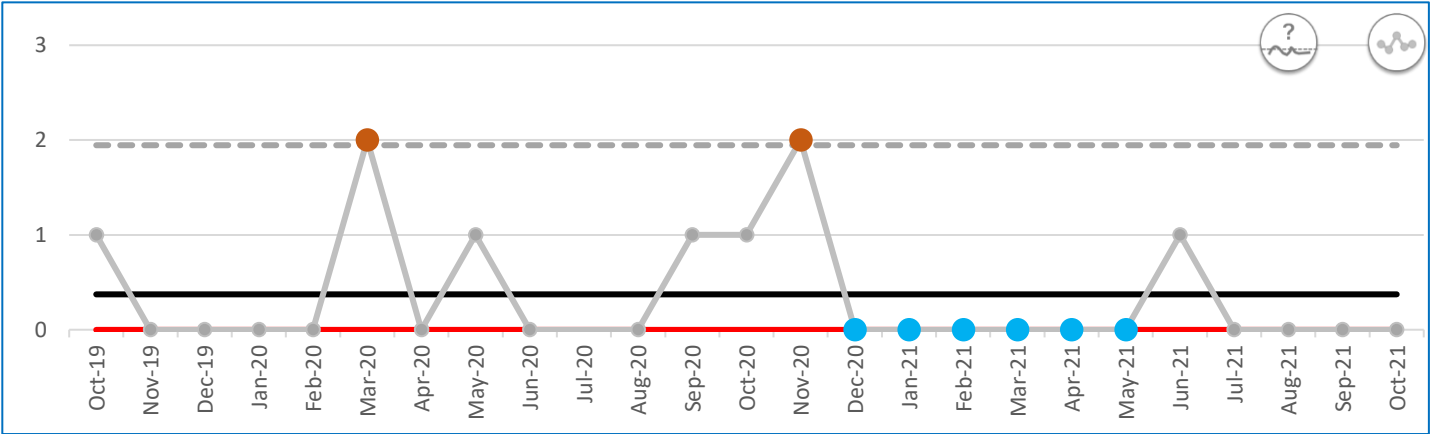
Palmer Kirsty  
11/24/2021 12:14:24

# Safe Key Performance Indicators

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Never event incidence	Oct 21	0	0			0	-1	2
Number of Serious Incidents (SI's) declared during the period	Oct 21	5	0			5	-4	14
MRSA > 2 Days	Oct 21	1	0			0	-1	1
HOHA and COHA (C-Diff > 2 Days)	Oct 21	2	4			3	-1	8
MSSA > 2 Days	Oct 21	1	1			1	-1	4
VTE Risk Assessment	Oct 21	93.1%	95.0%			92.4%	88.4%	96.4%
Harmful Falls per 1000 occupied bed days (Exc. Maternity and Paed's)	Oct 21	0.1%	0.1%			0.1%	-0.1%	0.4%
Fire Drill Compliance	Oct 21	96.4%	85.0%			87.0%	73.0%	101.1%
Fire Evacuation Plan	Oct 21	100.0%	85.0%			93.4%	87.1%	99.7%



# Safe - Never event incidence



Oct-21
0
Variation
Common cause - no significant change
Target
0
Target Achievement
Met

Background:

Palmer Kirsty  
11/24/2021 12:11:24

Never event incidence

What the chart tells us:

Variation indicates  
inconsistently hitting passing  
and falling short of the target

Issues:

No issues as target met

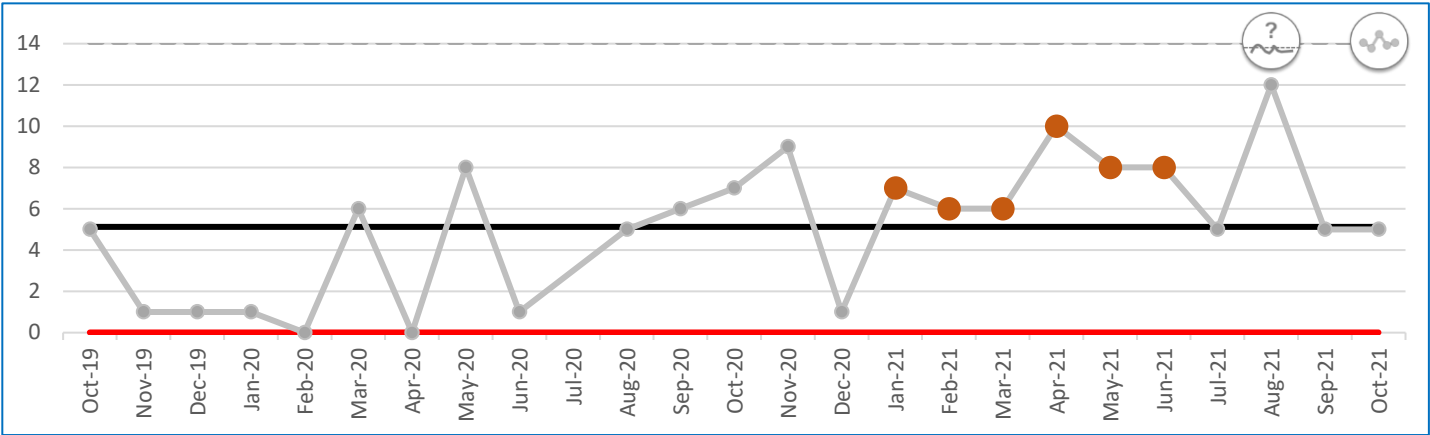
Actions:

No actions as target met

Mitigations

No mitigations as target met

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



Oct-21
5
Variation
Common cause - no significant change
Target
0
Target Achievement
Not Met

Background:

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

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

September increase in SIs was due to an increase in Covid reporting

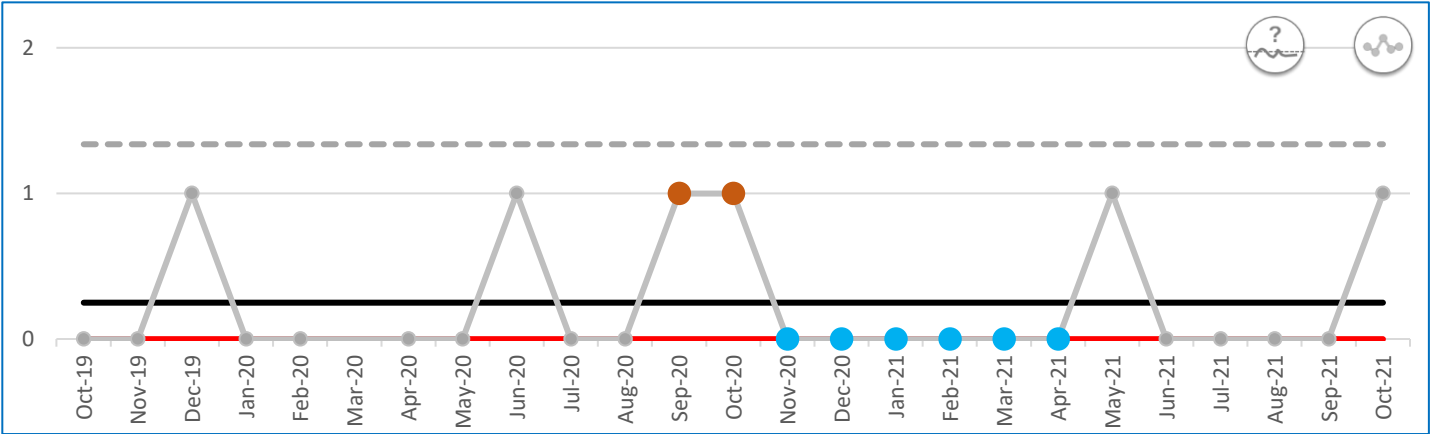
Actions:

Incident report continues to be supported through the Trust including Datix training on reporting incidents.  
Moderate and above incidents are supported through a PCRf submission to RoHG for decision as to next steps

Mitigations

See actions

# Safe - MRSA > 2 Days



Oct-21
1
Variation
Common cause - no significant change
Target
0
Target Achievement
Not Met

Background:

Palmer Kirsty  
11/24/2021 12:14:14

MRSA > 2 Days

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

One incidence of an MRSA bacteraemia. This has been investigated and a post infection review has been completed. The isolate may be a contaminant as the patient was not acutely unwell and improved with Tazocin (which MRSA is not sensitive to). The staff member who took blood cultures had not had competency updated.

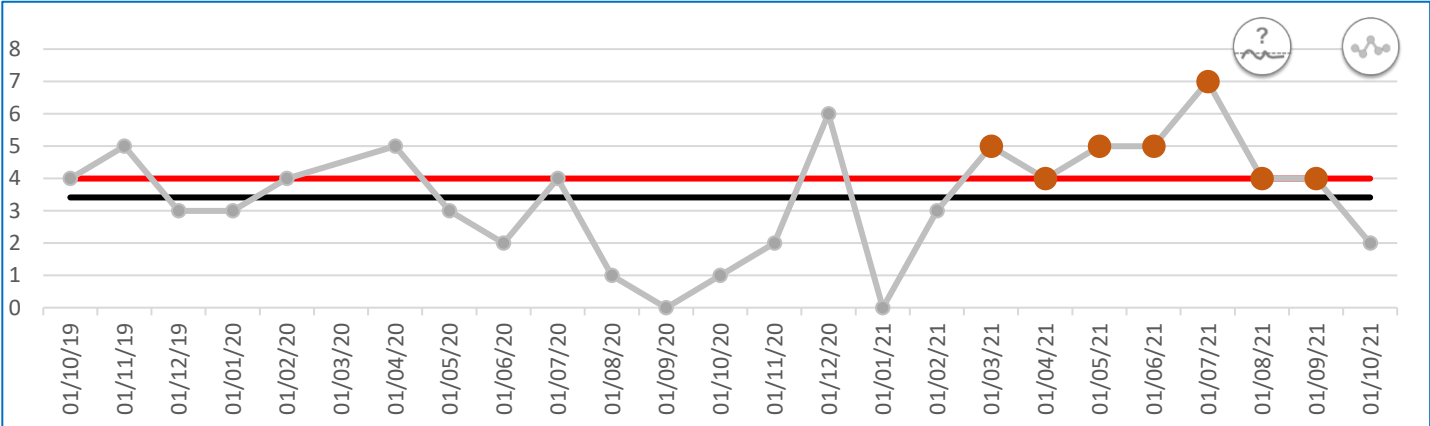
Actions:

Practice Development to ensure all staff on the ward who take blood cultures have undertaken blood culture training and complete assessments annually. Octenisan and ANTT assessments also to be undertaken by ward staff.

Mitigations

Weekly hand hygiene, Octenisan and PPE audits to be undertaken by IPC.

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



Oct-21
2
Variation
Common cause - no significant change
Target
<= 4
Target Achievement
Met

Background:

Palmer Kiroro  
11/24/2020

Reduce the number of attributed Clostridium against CCG ceiling based on 2019-20 ceiling as no ceiling set for 2020-21.

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

No issues as target met

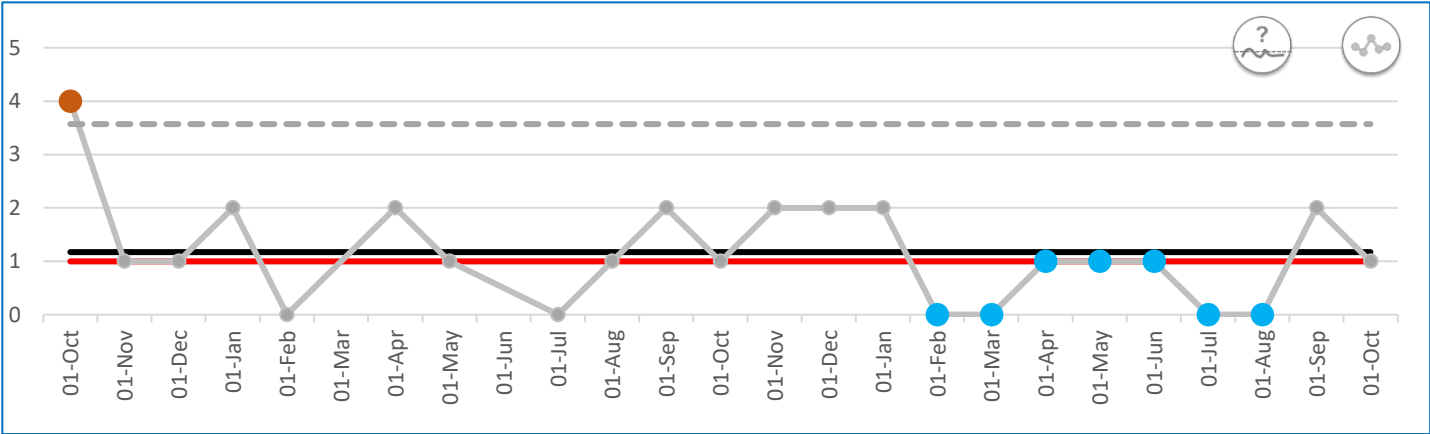
Actions:

No actions as target met

Mitigations

No mitigations as target met

# Safe - MSSA > 2 Days



Oct-21
1
Variation
Common cause - no significant change
Target
<= 1
Target Achievement
Met

Background:

Palmer Kirsty  
11/24/2021 12:14 PM

MSSA > 2 Days

What the chart tells us:

Variation indicates  
inconsistently hitting passing  
and falling short of the target

Issues:

No issues as target met

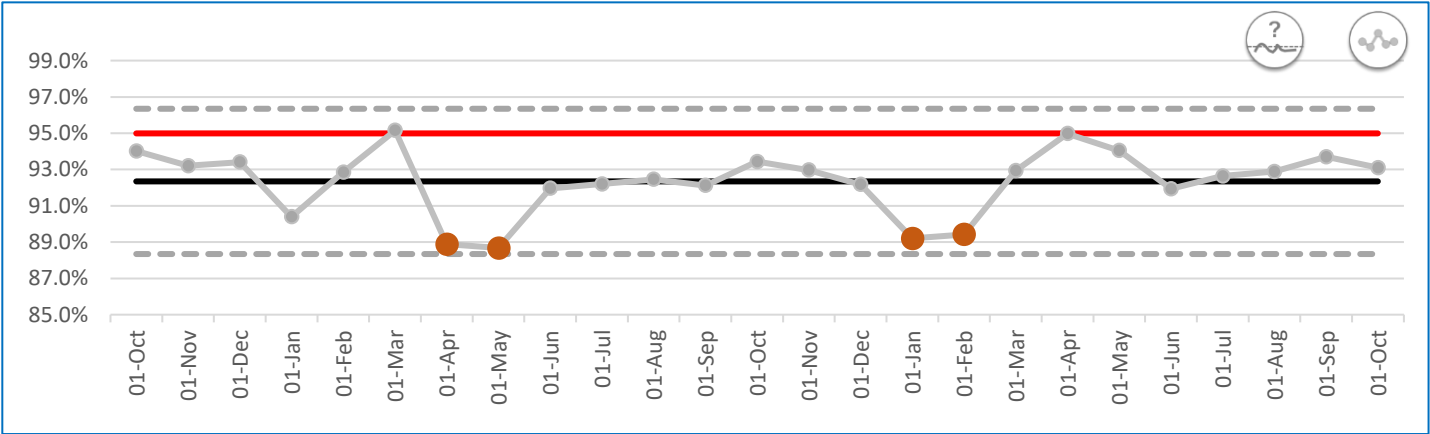
Actions:

No actions as target met

Mitigations

No mitigations as target met

# Safe - VTE Risk Assessment



Oct-21
93.1%
Variation
Common cause - no significant change
Target
>= 95%
Target Achievement
Not Met

Background:

Palmer Kirsty  
11/24/2021 12:16:24

VTE Risk Assessment

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

No issues provided

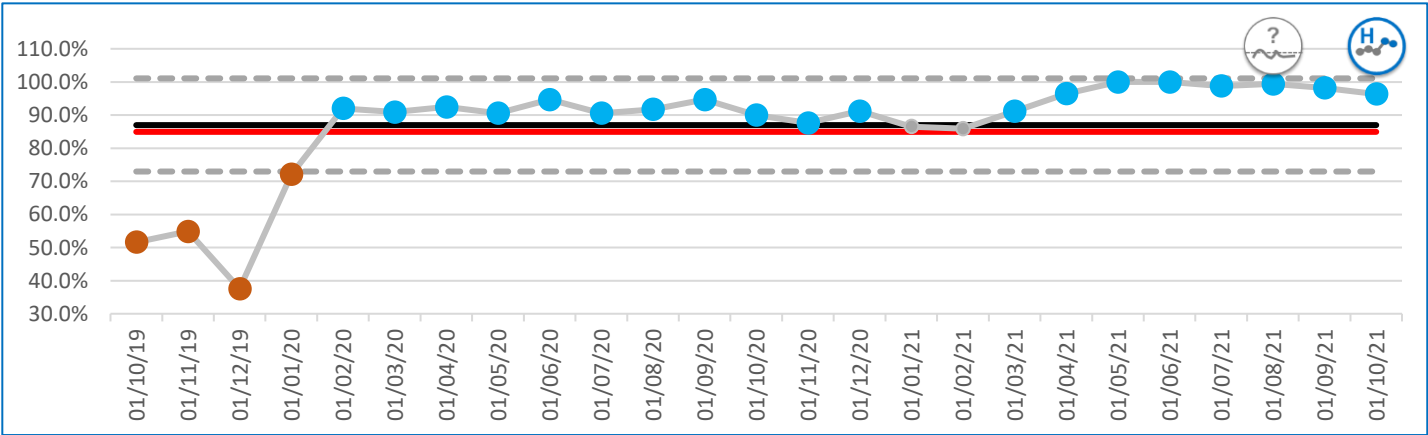
Actions:

Implementation of Journey to Exemplar criteria action plan and weekly MDT reviews of RCA.

Mitigations

The completion of VTE risk assessment is addressed through integrated assessment and prescription charts with ward pharmacists supporting compliance and audit

# Safe – Fire Drill Compliance



Oct-21
96.4%
Variation
Special cause of concerning nature or higher pressure due to (H)igher values
Target
85.0%
Target Achievement
Met

Background:

Palmer Kirsty  
11/24/2021 12:11:24

Fire Drill Compliance

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

No issues as target met

Actions:

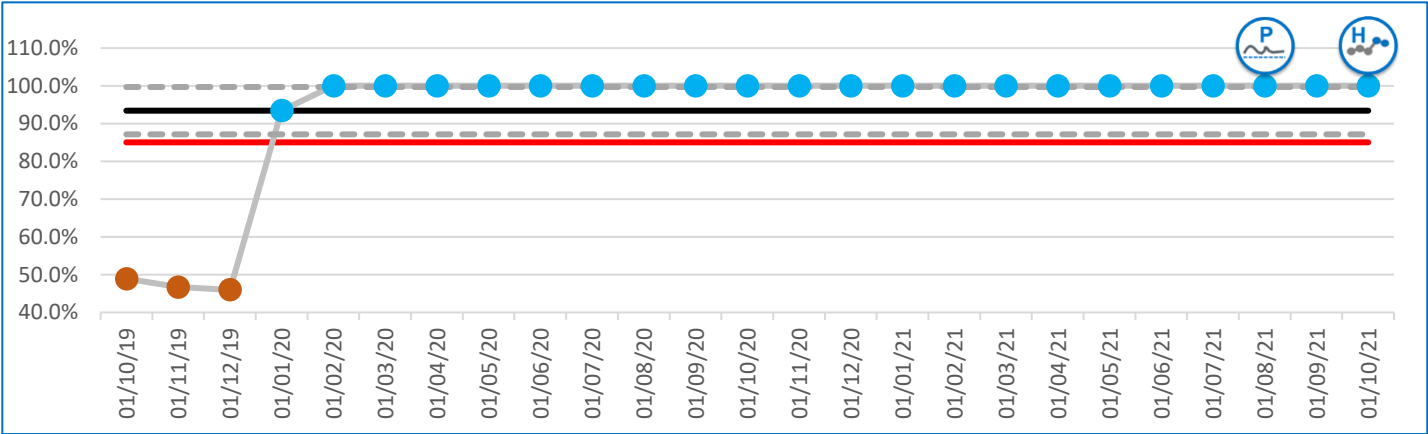
No actions as target met

Mitigations

No mitigations as target met



# Safe – Fire Evacuation Plan



Oct-21
100.0%
Variation
Special cause of concerning nature or higher pressure due to (H)igher values
Target
85.0%
Target Achievement
Met

Background:

Palmer Kirsty  
11/24/2021 12:11:24

Fire Evacuation Plan

What the chart tells us:

Variation indicates consistently (P)assing the target

Issues:

No issues as target met

Actions:

No actions as target met

Mitigations

No mitigations as target met

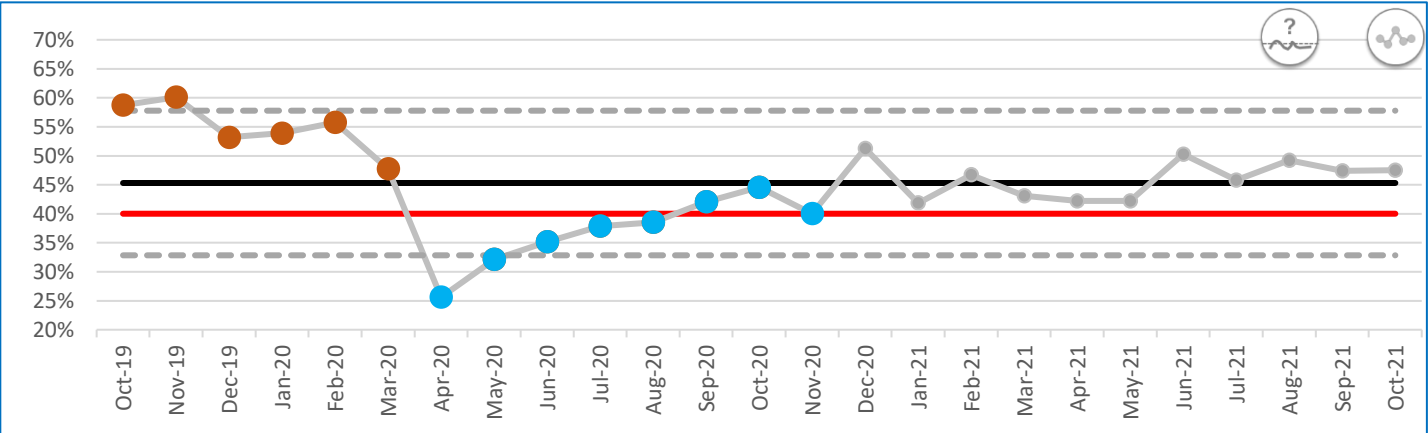
# Effective

Palmer Kirsty  
11/24/2021 12:14:24

# Effective Key Performance Indicators

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Stranded Patients (avg) as % of bed base	Oct 21	47.5%	40.0%			45.3%	32.9%	57.8%
Super Stranded Long Stay Patients (avg) as % of bed base	Oct 21	18.9%	25.0%			16.4%	10.5%	22.3%
Length of stay - All	Oct 21	4.0	4.2			4.1	3.2	5.1
Percentage of discharges before midday	Oct 21	16.0%	25.0%			16.9%	14.6%	19.2%
% Day Case Rate	Oct 21	86.2%	80.0%			86.3%	83.2%	89.5%
Mortality: HSMR	Oct 21	94	106			107	103	111
Mortality: SHMI	Oct 21	96	109			99	97	102
Unappointed Follow Ups	Oct 21	19149	0			36979	19890	54068

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



Oct-21
47.5%
Variation
Common cause - no significant change
Target
<= 40.0%
Target Achievement
Not Met

Background:

Palmer Kirsty  
11/24/2021 12:14:28 PM

Percentage of patients with a LoS > 7 days

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

Stranded numbers have remained static this is due to a combination of internal and external constraints e.g. a significant constraint on the number of care hours available for supported discharges(impact of staff isolating, sickness & vacancies). Internally the combination of medical leave, staff isolation & sickness has also impacted.

Actions:

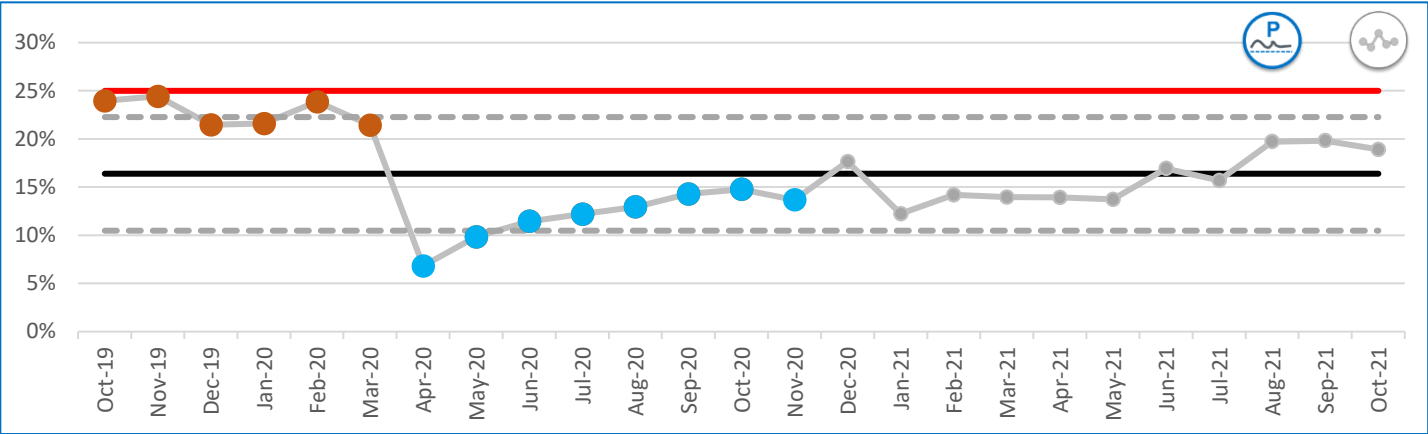
Significant work around board rounds with executive support and attending daily board rounds. Trust wide emphasis on patients not reaching 7 days and identifying those patients that can be discharged independently of any support for board rounds.

Agreement from WASS that patients with a LOS of less than 7 days can have a restart of package of care.

Mitigations

Daily Matron & senior divisional team support on wards to check, challenge & unblock delays – real focus on patients next steps

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



Oct-21
18.9%
Variation
Common cause - no significant change
Target
<= 25.0%
Target Achievement
Met

Background:

Palmer Kirsty  
11/24/2021 12:04:34

Percentage of patients with a LoS > 21 days

What the chart tells us:

Variation indicates consistently (P)assing the target

Issues:

Significant pressure within social care with extensive delays in obtaining packages of care or residential placement. Patients frequently shift between being MOFD and not MOFD

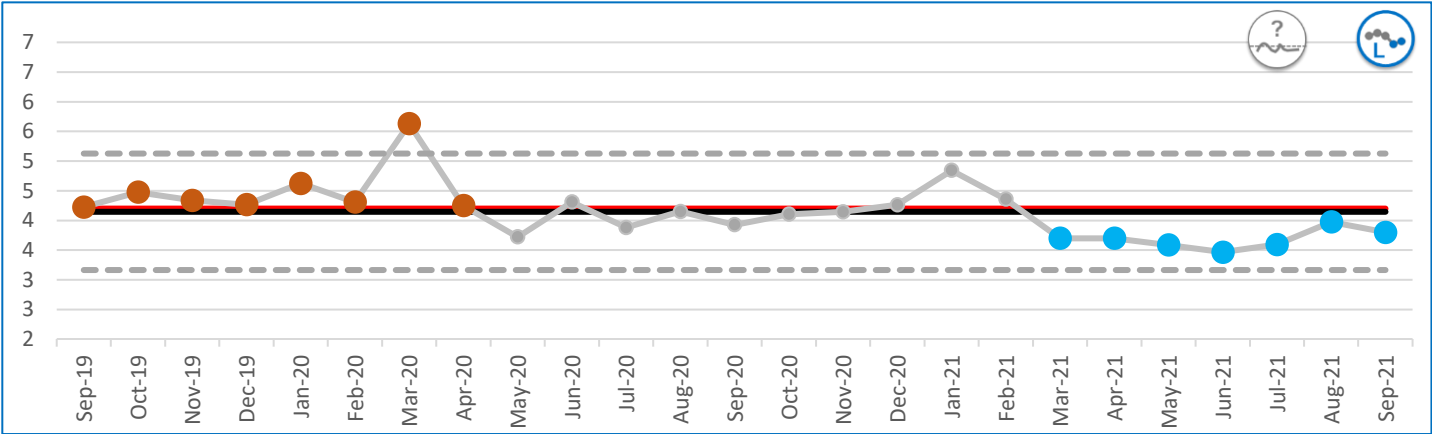
Actions:

A daily multisystem hub is held which focuses on what is required to safely discharge the patient. Liz Sargent form ECIST leads this hub. Significant work with our social care partners to reduce paper work delays to DCS. Wards are trialling John Hopkins deconditioning tool with real focus on 7 days and less and preventing deconditioning and increased care needs

Mitigations

No mitigations as target met

# Effective - Length of stay - All



Oct-21
4.0
Variation
Special cause of improving nature or lower pressure due to (L)ower values
Target
<= 4.2
Target Achievement
Met

Background:

Palmer Kirsty  
11/24/2021 12:14:34

Length of stay - All

What the chart tells us:

Common cause - no significant change

Issues:

No issues as target met

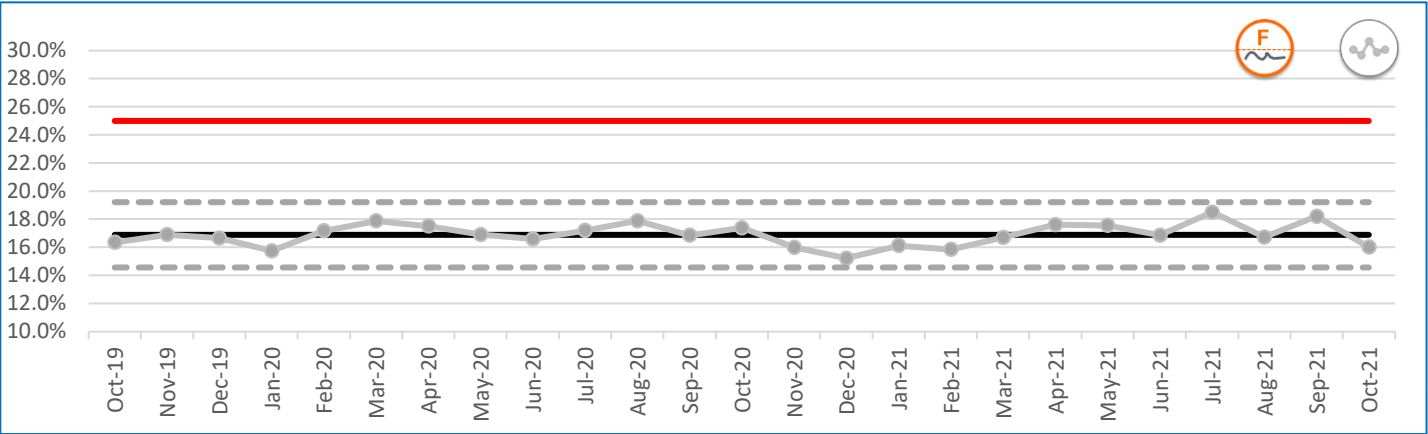
Actions:

No actions as target met

Mitigations

No mitigations as target met

# Effective - Percentage of discharges before midday



Oct-21
16.0%
Variation
Common cause - no significant change
Target
>= 25.0%
Target Achievement
Not Met

Background:

Palmer Kirsty  
11/24/2021 1:28:47 PM

Percentage of discharges before midday

What the chart tells us:

Variation indicates consistently (F)alling short of the target

Issues:

No physical discharge lounge. Transport delays have increased significantly predominately driven by increase in OP activity.

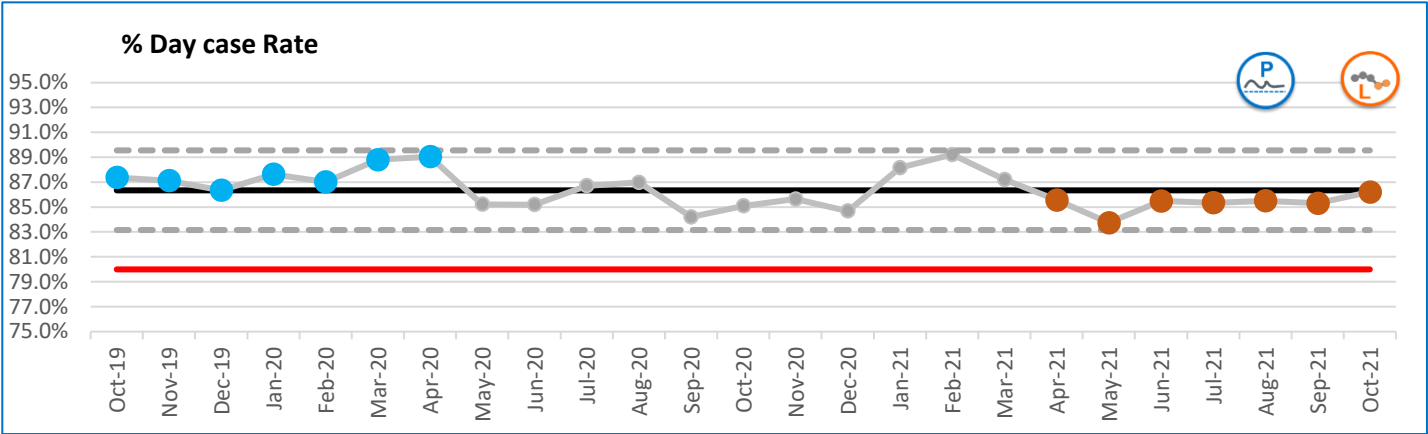
Actions:

A revised chart outlining transport criteria has been developed to be used by the wards when ordering transport. Board round work has focus on ensuring that next steps occur for patients , discharge preparation occur prior to the day of discharge.

Mitigations

Additional private ambulance crews are used to support discharges. Discussions with the CCG to agree alternative transport solution.

# Effective - % Day case Rate



Oct-21
86.2%
Variation
Special cause of concerning nature or higher pressure due to (L)ower values
Target
>= 80.0%
Target Achievement
Met

Background:

Palmer Kirsty  
11/24/2021 12:04 PM

Daycases as percentage of all Elective activity

What the chart tells us:

Variation indicates consistently (P)assing the target

Issues:

No issues as target met

Actions:

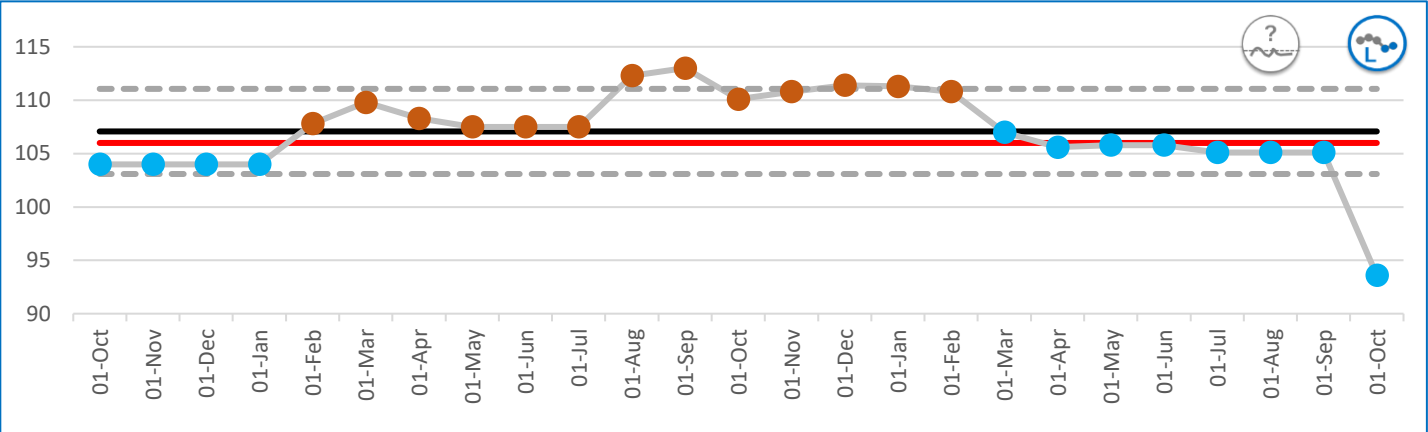
No actions as target met

Mitigations

No mitigations as target met



# Effective - Mortality: HSMR



Oct-21
94
Variation
Special cause of improving nature or lower pressure due to (L)ower values
Target
<= 106
Target Achievement
Met

Background:

Palmer Kirsty  
11/24/2021 12:11:24

Mortality: HSMR

What the chart tells us:

Variation indicates  
inconsistently hitting passing  
and falling short of the target

Issues:

No issues as target met

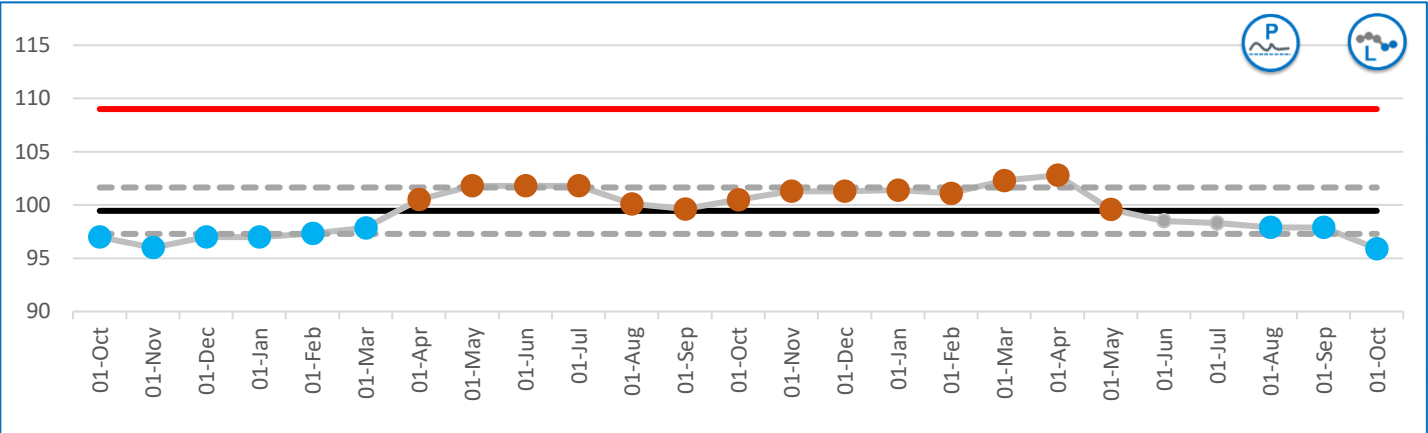
Actions:

No actions as target met

Mitigations

No mitigations as target met

# Effective - Mortality: SHMI



Oct-21
96
Variation
Special cause of improving nature or lower pressure due to (L)ower values
Target
<= 109
Target Achievement
Met

Background:

Palmer Kirsty  
11/24/2021 12:11:24

Mortality: SHMI

What the chart tells us:

Variation indicates consistently (P)assing the target

Issues:

No issues as target met

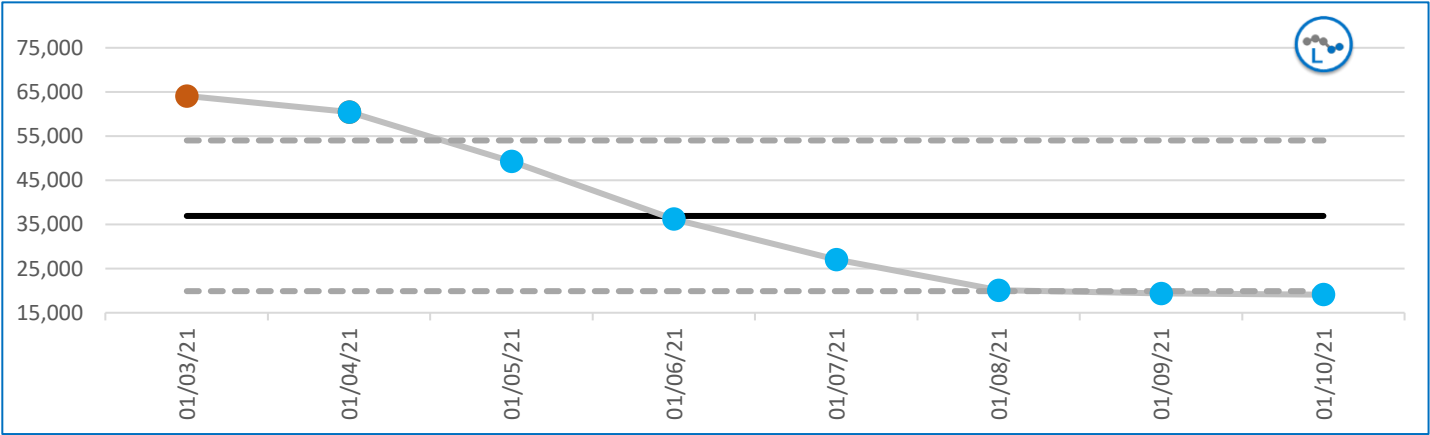
Actions:

No actions as target met

Mitigations

No mitigations as target met

# Effective - Unappointed Follow Ups



Oct-21
19,149
Variation
Special cause of improving nature or lower pressure due to (L)ower values
Target
No Target
Target Achievement

Background:

Unappointed Follow Ups

Palmer Kirsty  
11/24/2021 12:41:24

What the chart tells us:

We have reduced the number of unappointed follow ups by 70% - 40000 patient episodes have been validated manually from CaMIS. Work is ongoing in terms of validation.

Issues:

Validation has plateaued due to increased referrals and lots of patients waiting for appointments in the future (these are not a worry but mask the patients who are past their to be seen date

Actions:

Directorate teams asked to focus on the patients who have exceeded their date to be seen as a priority. This to be completed within 4 weeks
























Mitigations

Harm review process will continue. Administration training programme and support to prevent future recurrence









# Responsive

Palmer Kirsty  
11/24/2021 12:14:24

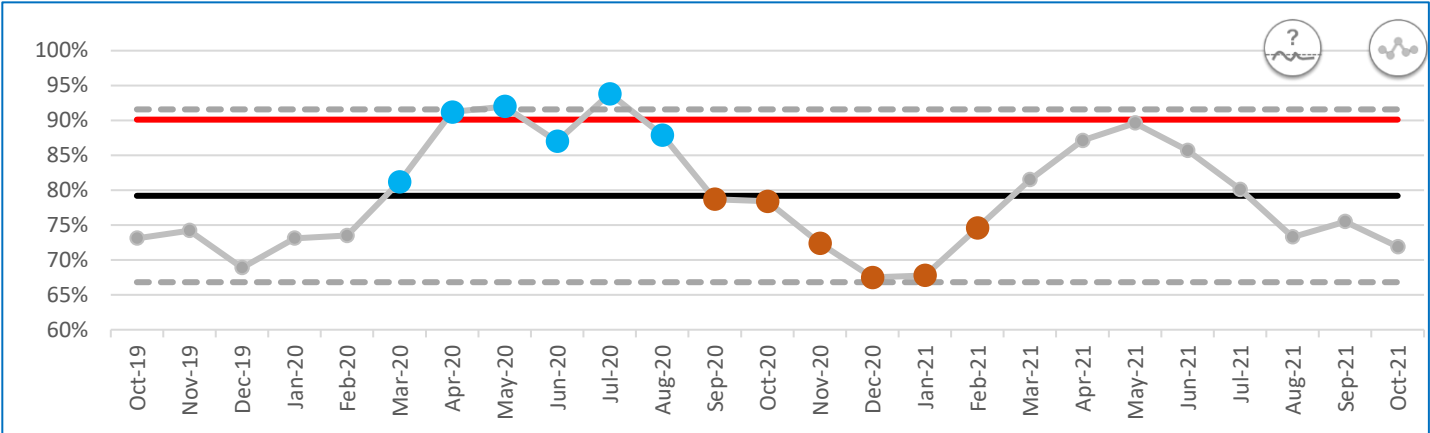
# Responsive Key Performance Indicators

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
A&E: Proportion of patients spending less than 4 hours in A&E	Oct 21	71.9%	90.1%			79.2%	66.8%	91.6%
Ambulance handovers that waited over 30 mins and less than 60 mins	Oct 21	351	25			150	4	296
Ambulance handovers that waited over 60 mins	Oct 21	108	10			49	-48	146
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Oct 21	0	0			2	-3	7
Cancer: Faster Diagnosis Standard	Sep 21	77.6%	75.0%			73.6%	61.0%	86.2%
Cancer: Number of Legacy Patients	Sep 21	69	0			92	29	155
Cancer: Percentage of patients treated within 31 days	Sep 21	92.4%	96.0%			95.3%	87.6%	103.0%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Sep 21	97.4%	98.0%			98.0%	92.6%	103.3%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Sep 21	95.8%	94.0%			95.4%	87.0%	103.8%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Sep 21	92.9%	94.0%			86.6%	52.8%	120.3%
Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Sep 21	85.5%	85.0%			80.9%	49.4%	112.4%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Sep 21	62.7%	85.0%			70.9%	44.0%	97.9%

# Responsive Key Performance Indicators

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT Median wait incomplete pathways	Oct 21	8.5	10.9			10.2	8.3	12.2
RTT over 52 weeks	Oct 21	60	118			282	102	462
Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Oct 21	86.0%	99.1%			77.7%	63.2%	92.2%
Stroke patients spending at least 90% of their time on the stroke unit	Oct 21	75.8%	80.0%			75.9%	47.9%	104.0%

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



Oct-21
71.9%
Variation
Common cause - no significant change
Target
>= 90.1%
Target Achievement
Not Met

Background:

Palmer Kirsty  
11/24/2021 11:11:24

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

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

Performance against the 4hr standard remains challenging. Workforce issues and attendances particularly at night have impacted on department process & flow.

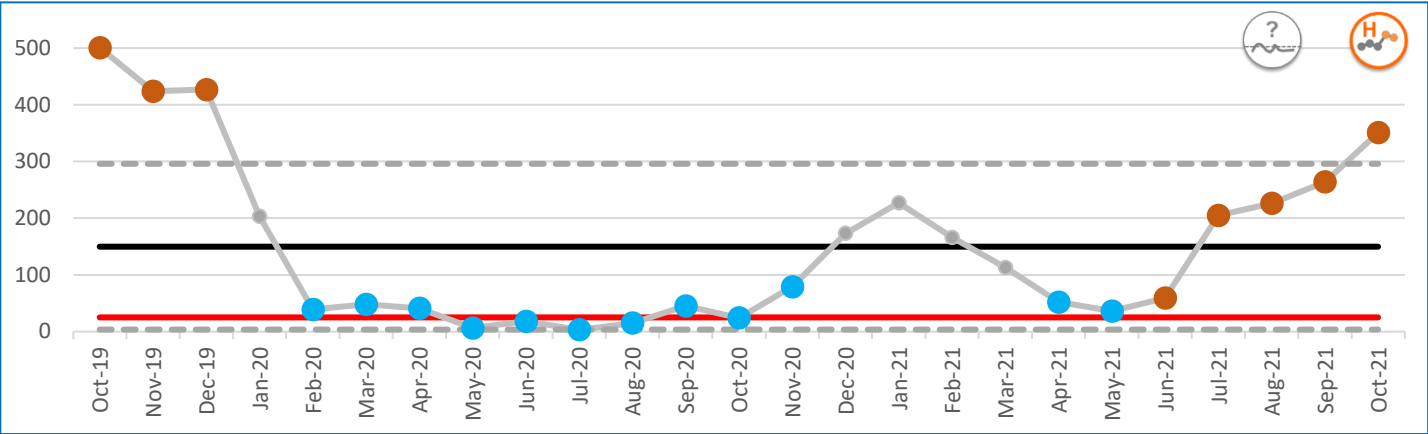
Actions:

ED Consultants have adjusted their rota to better support the evening & night shift demand. The Medical Consultant rota has also been adjusted to support patient assessment in ED until 1am. SDEC & Springfield opening times expanded with further expansion planned in winter.

Mitigations

OOH Service working collaboratively with the ED team to stream patients at night.

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



Oct-21
351
Variation
Special cause of concerning nature or higher pressure due to (H)igher values
Target
<= 25
Target Achievement
Not Met

Background:

Palmer Kirsty  
11/24/2021 4:11 PM

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

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

The majority of ambulance delays are typically during the evening when peak activity is now occurring. This has been further compounded in October by an increase in Covid conveyances. Significant difficulty offloading covid pts due to capacity and IPC.

Actions:

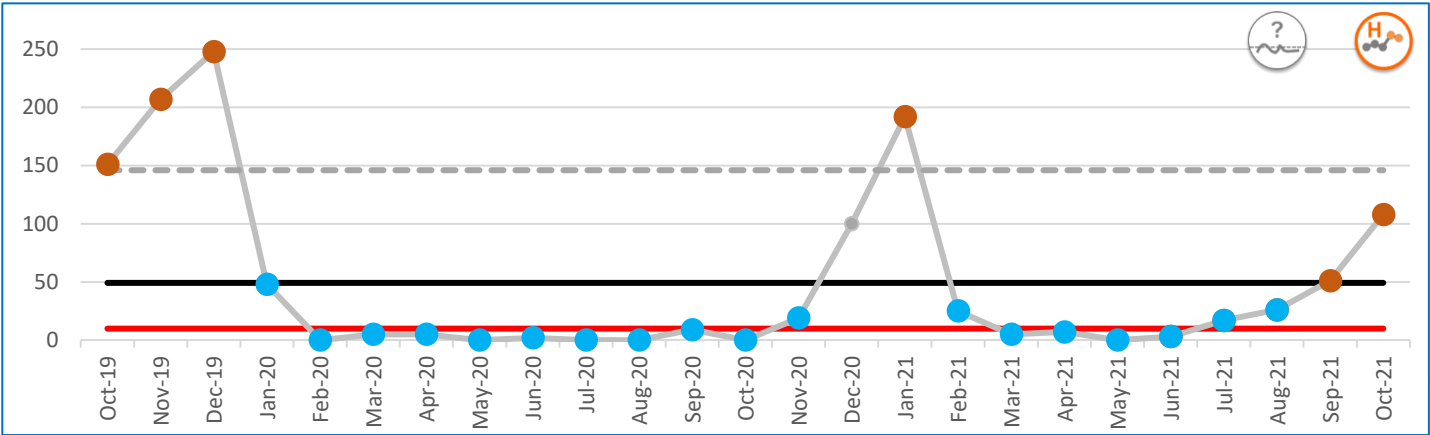
Senior flow nurse allocated to the ambulance assessment areas to unblock delays. Streaming to SDEC & Springfield. EMAS direct referral to SDEC. Patient booking via 111 to be rolled out in October which will signpost patients to alternatives rather than ED.

Mitigations

Clinical Site Manager supports during peak times.



# Responsive - Ambulance handovers that waited over 60 mins



Oct-21
108
Variation
Special cause of concerning nature or higher pressure due to (H)igher values
Target
<= 10
Target Achievement
Not Met

Background:

Ambulance handovers that waited over 60 mins

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

The majority of ambulance delays are typically during the evening when peak activity is now occurring. This has been further compounded in September by an increase in Covid conveyances.

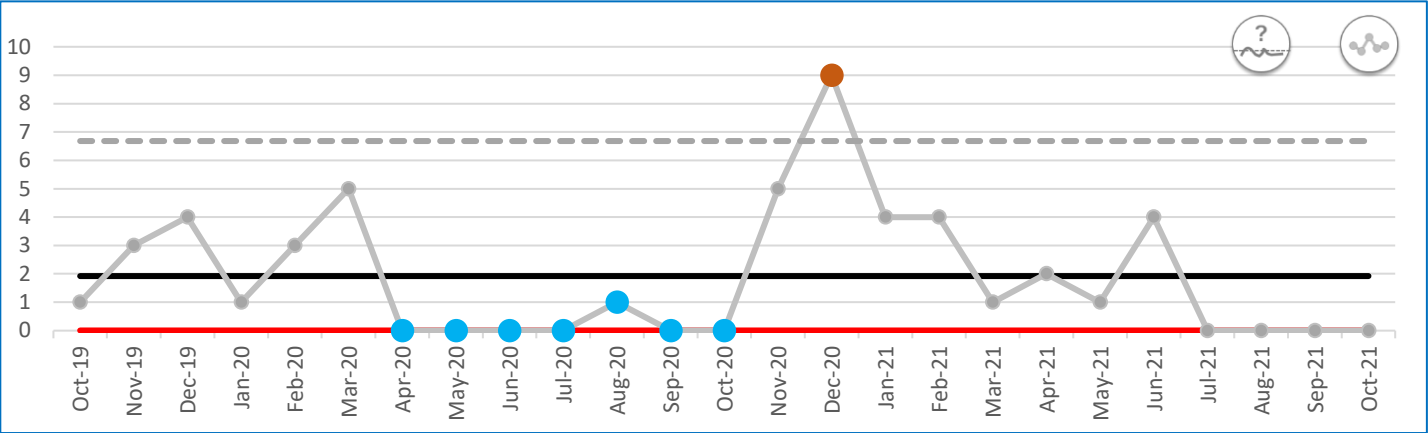
Actions:

Senior flow nurse allocated to the ambulance assessment areas to unblock delays. EMAS direct referral to SDEC. Urgent care looking at alternative areas for covid offloading

Mitigations

Clinical Site Manager supports during peak times. Any ambulance offload delay of 60+ minutes has a consultant review in the ambulance and is triaged with priority for offloading based on clinical need

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



Oct-21
0
Variation
Common cause - no significant change
Target
0
Target Achievement
Met

Background:

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

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

No issues as target met

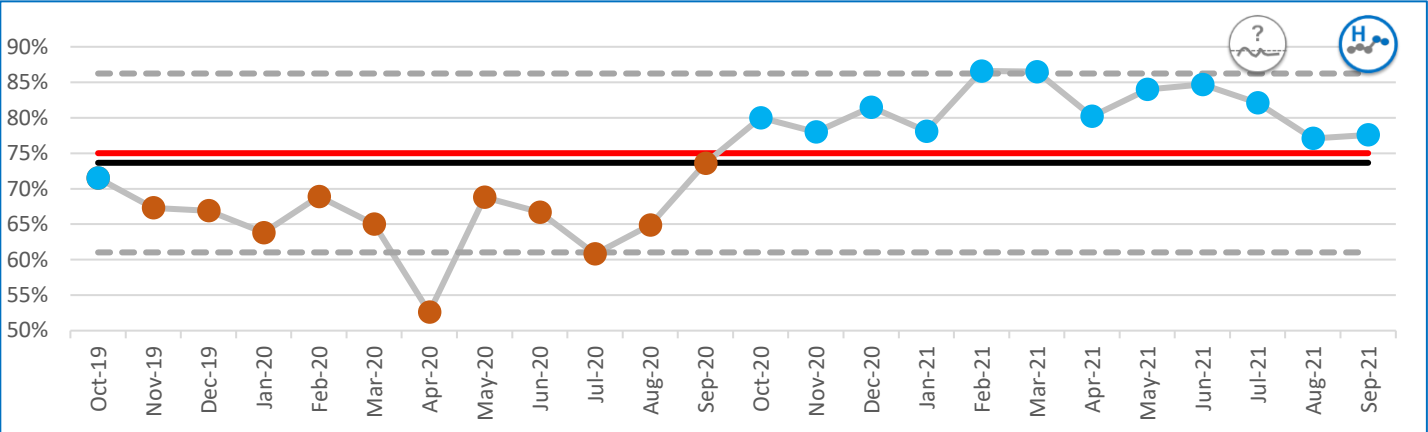
Actions:

No actions as target met

Mitigations

No mitigations as target met

# Responsive - Cancer: Faster Diagnosis Standard



Sep-21
77.6%
Variation
Special cause of improving nature or lower pressure due to (H)igher values
Target
>= 75.0%
Target Achievement
Met

Background:

Cancer: Faster Diagnosis Standard

Palmer Kirsty  
11/24/2021 12:04:24

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

No issues as target met

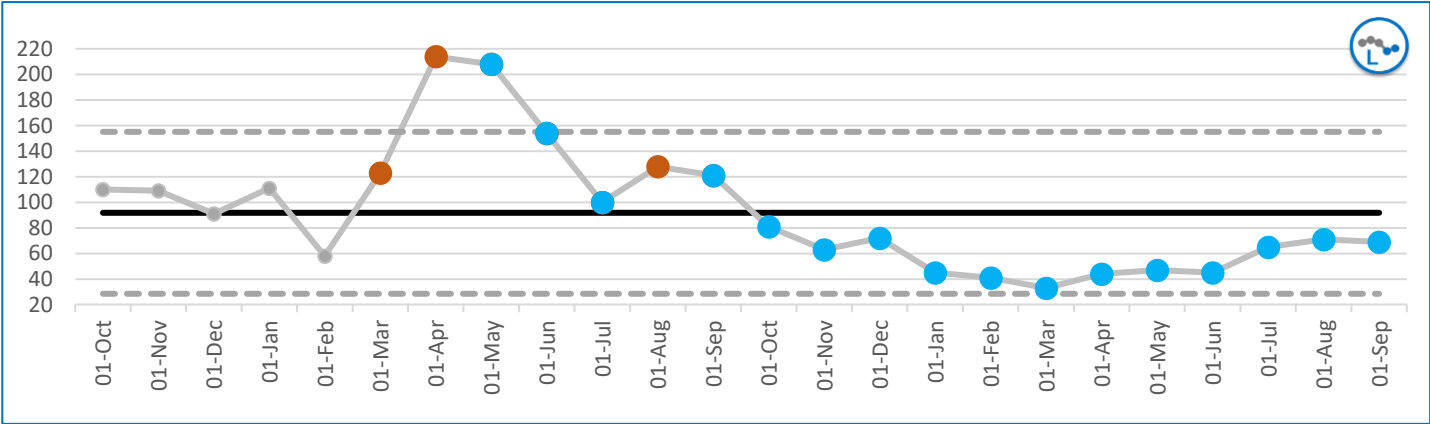
Actions:

No actions as target met

Mitigations

No mitigations as target met

# Responsive - Cancer: Number of Legacy Patients



Sep-21
69
Variation
Special cause of improving nature or higher pressure due to (L)ower values
Target
No Target
Target Achievement

Background:

Palmer Kirsty  
11/24/2021 12:14:24

Cancer: Number of Legacy Patients

What the chart tells us:

The peak in legacy patients that occurred during covid has stabilised for many months, legacy in August started to increase due to absence of key staff and patients delaying next steps but has stabilised in September

Issues:

Increase in 2ww referrals, Delays at tertiary providers, complex patient pathways, patient choice, diagnostic capacity

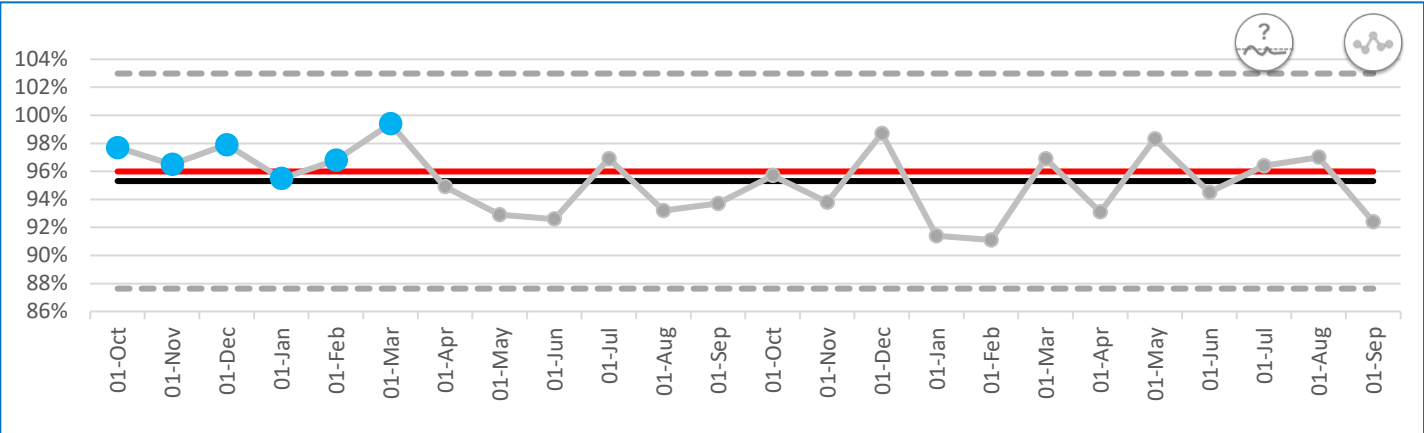
Actions:

Daily PTL review with check & challenge led by Deputy COO & Deputy Medical Director. Patients being clinically escalated to teams in order to flex capacity where possible.

Mitigations

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

# Responsive - Cancer: Percentage of patients treated within 31 days



Sep-21
92.4%
Variation
Common cause - no significant change
Target
>= 96.0%
Target Achievement
Not Met

**Background:**

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%

**What the chart tells us:**

Variation indicates inconsistently hitting passing and falling short of the target

**Issues:**

The Trust did not meet the 31-day standard, reaching 92.4% against the 96% standard. 131 treatments occurred but of these 13 patients breached. 11 of the breaches were avoidable due to capacity and 2 were unavoidable, 1 due to patient choice and 1 due to fitness. This is reflected regionally as a challenge. 38% of the breaches were in the gynaecology pathway

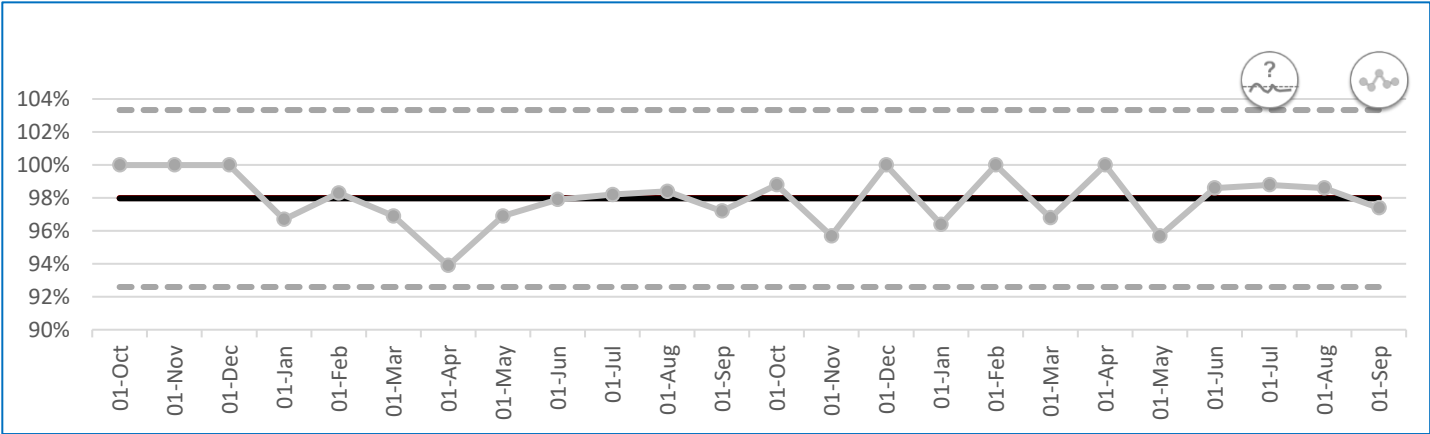
**Actions:**

The gynaecology team are expecting to see an improved position from October onwards. This will significantly impact on the trusts ability to meet these standard moving forwards.

**Mitigations**

All sites are required to review and flex their surgical capacity in order to plan treatments within the 31-day target. Oncology is required to do the same, although this can be challenging for some modalities as Radiotherapy takes 3 weeks planning.

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



Sep-21
97.4%
Variation
Common cause - no significant change
Target
>= 98.0%
Target Achievement
Not Met

Background:

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%.

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

The Trust did not meet the subsequent drug standard reaching 97.4% against the 98% standard. 78 patients were treated of which two breached both due to patient choice and were unavoidable breaches.

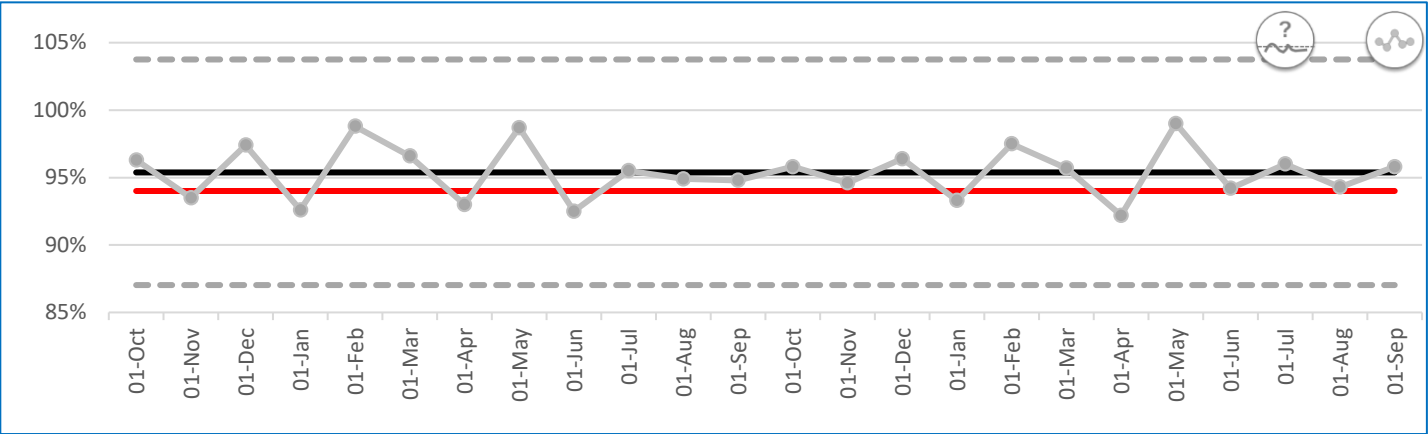
Actions:

Both breaches were unavoidable, therefore, no actions required by the Trust

Mitigations

Oncology to robustly manage the PTL in order to plan and treat patients within the 31 day target, overseen by the cancer team weekly tracking.

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



Sep-21
95.8%
Variation
Common cause - no significant change
Target
> = 94.0%
Target Achievement
Met

Background:

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%.

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

No issues as target met

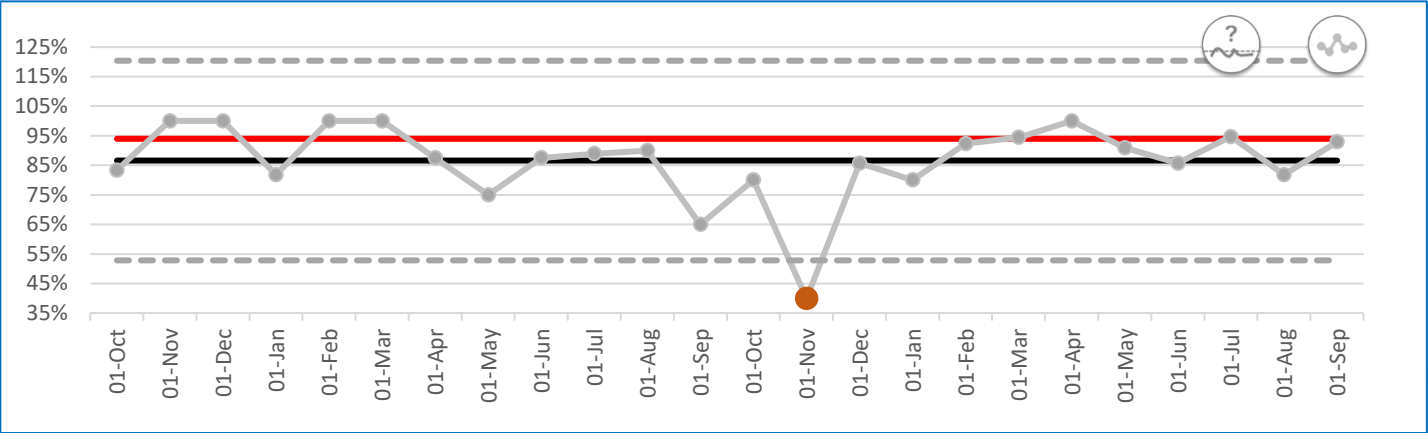
Actions:

No actions as target met

Mitigations

No mitigations as target met

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



Sep-21
92.9%
Variation
Common cause - no significant change
Target
> = 94.0%
Target Achievement
Not Met

Background:

Palmer Trust  
11/24/2023 14:47

Patients should experience a maximum wait of 31 days for a second or subsequent surgical treatment. The operational standard for this measure is 94%.

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

The Trust has not met the subsequent surgery standard reaching 92.9% against the 94% standard. 14 patients were treated of which one breached

Actions:

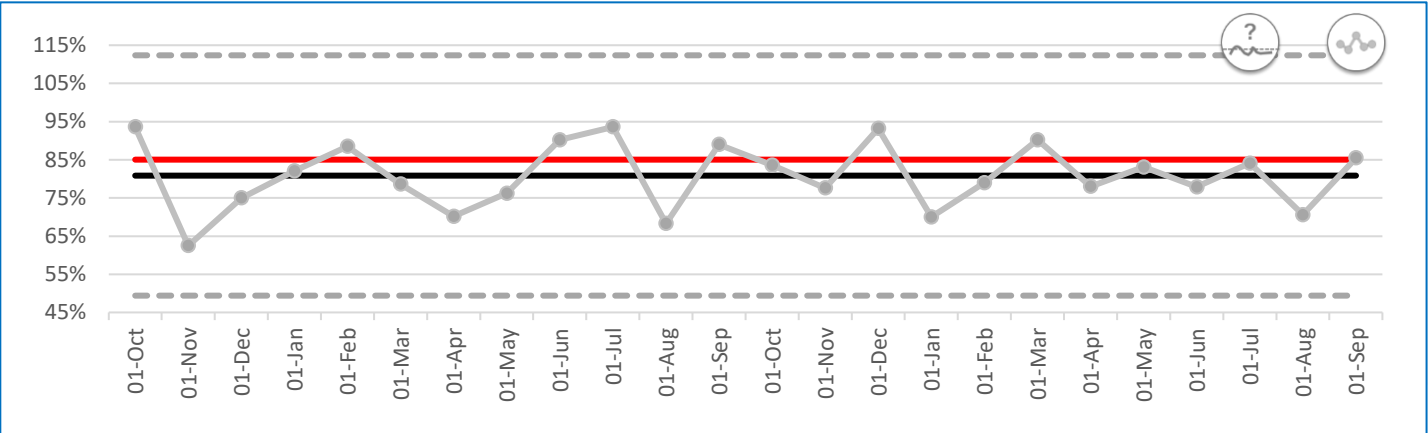
The one breach was complex surgery requiring two specialties, this proved challenging to secure in target

Mitigations

All teams continue to flex surgical capacity where this is possible



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



Sep-21
85.5%
Variation
Common cause - no significant change
Target
>= 85.0%
Target Achievement
Met

**Background:**

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

**What the chart tells us:**

Variation indicates inconsistently hitting passing and falling short of the target

**Issues:**

No issues as target met

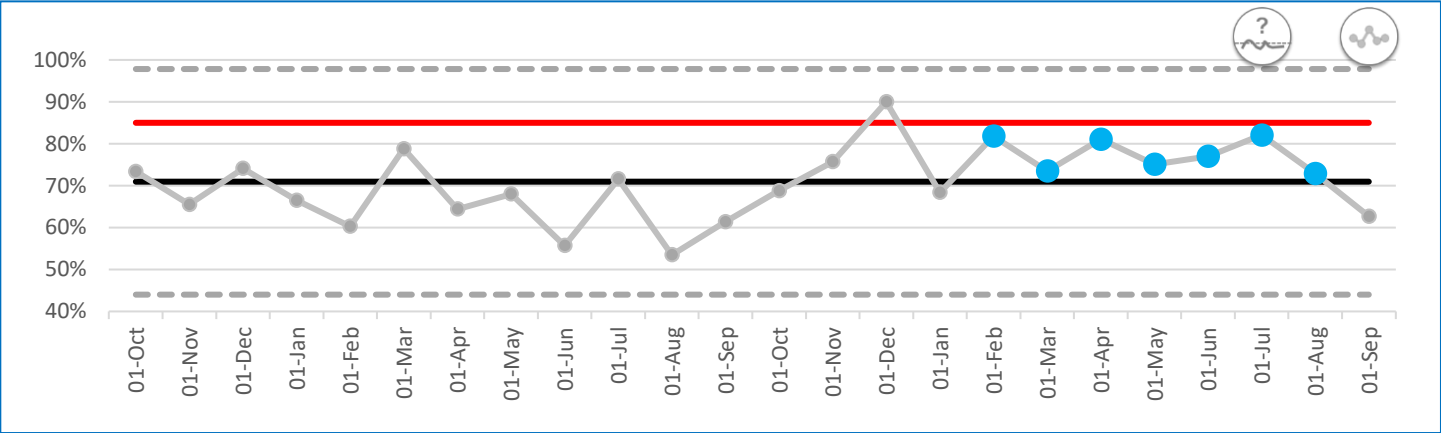
**Actions:**

No actions as target met

**Mitigations**

No mitigations as target met

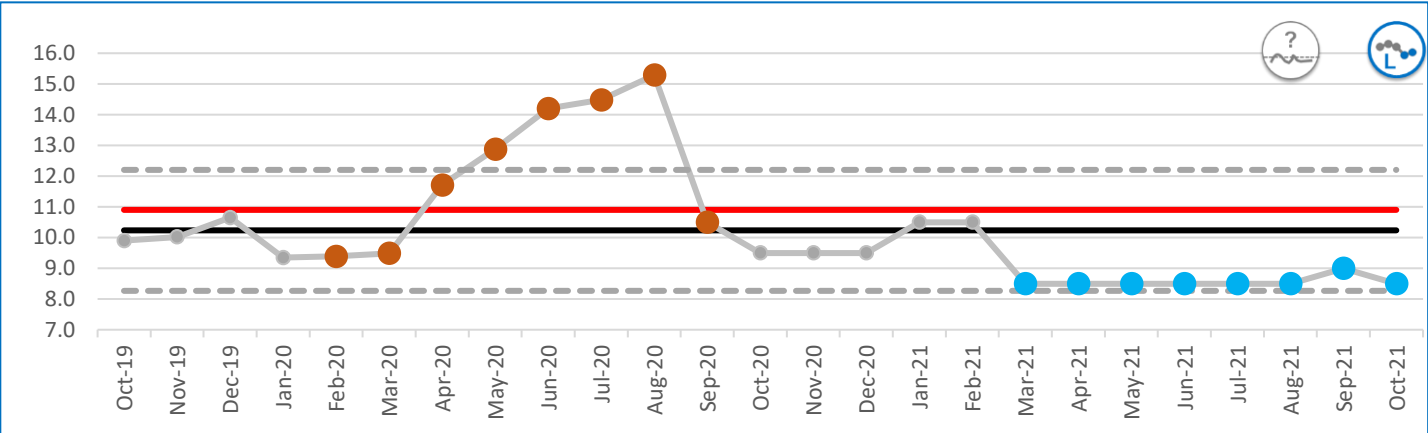
Responsive - Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers



Sep-21
62.7%
Variation
Common cause - no significant change
Target
>= 85.0%
Target Achievement
Not Met

Background:	What the chart tells us:	Issues:	Actions:	Mitigations
<p>Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers</p> <p>Palmer Kirsty 11/24/2021 12:18</p>	<p>Variation indicates inconsistently hitting passing and falling short of the target</p>	<p>Whilst the trust maintained the number of treatments in September undertaking 92.5, 34.5 of these breached, this has resulted in performance of 62.7% compared to the 85% standard.</p> <p>Skin and Upper GI were the only sites who achieved the 62-day standard.</p> <p>20.5% of the breaches in September breached within a week of target, 6 of the 8 were avoidable delays due to capacity for surgery, outpatients, diagnostics and specialist histology.</p> <p>Of the 39 patients, 13 had unavoidable breaches had the 26 avoidable delays been resolved the Trust would have achieved 62 days in September.</p>	<p>Challenge is to embed and sustain these improvements:</p> <ul style="list-style-type: none"><li>The delivery of Cancer diagnostics and treatments remain with the Divisions. The Cancer Team continue to focus on holding to account these teams for delivery of sustained improvement plans through the escalation policy and corporate PTL.</li><li>Avoidable breaches due to outpatient capacity, diagnostic waits, surgical and oncology waits are re-occurring themes locally and nationally. The divisions are working on solutions to reduce waits in these areas.</li><li>Robust management of minimum dataset and MDT acceptance of patients being referred from tertiary centres</li><li>Working with Primary Care to reduce inappropriate referrals</li></ul> <p>The recovery of the 62-day standard is reliant on a significant reduction in legacy patients. Of the 62 legacy in total below 17 patients have their treatment planned. 6 patients are with our tertiary providers.</p> <p>We have 13 patients waiting 104+ days, 4 patients have their treatment planned and 2 are with our tertiary provider.</p> <p>The corporate PTL continues to focus on all legacy including 2ww, screening and upgrades and those patients that have the potential to breach in the next 21 days, this has been extended by a week to ensure those patients are identified that can be escalated to individual teams in order to expedite treatment if dated out of time.</p>	<p>Cancer Services utilising the site and corporate PTL meetings in order to identify patients that require flex of capacity in order to treat in time, if dated outside of target</p>

# Responsive - RTT Median wait incomplete pathways



Oct-21
8.5
Variation
Special cause of improving nature or lower pressure due to (L)ower values
Target
<= 10.9
Target Achievement
Met

Background:

Palmer Kirsty  
11/24/2021 12:44:24

RTT Median wait incomplete pathways

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

No issues as target met

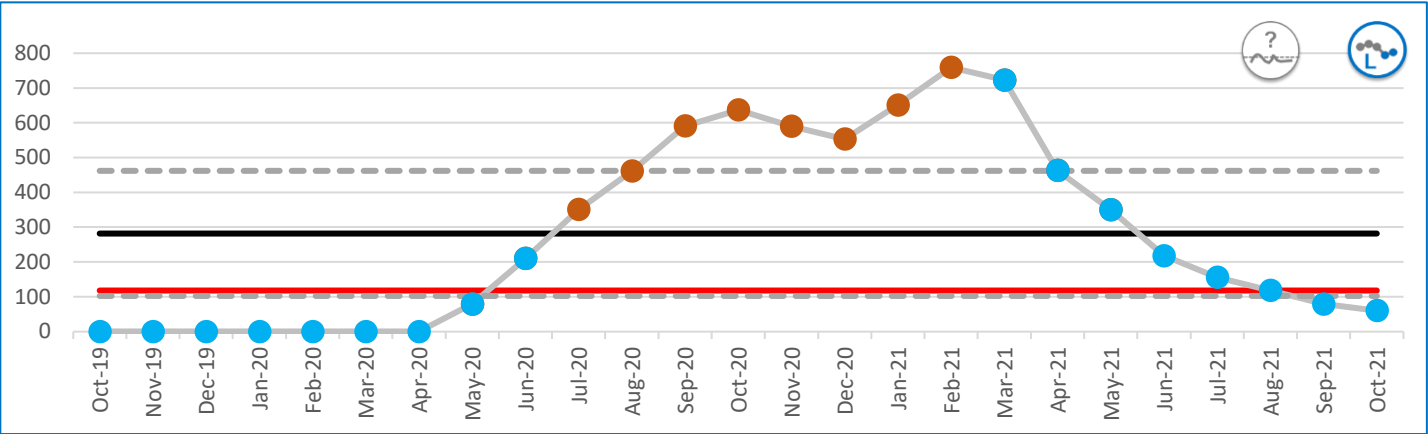
Actions:

No actions as target met

Mitigations

No mitigations as target met

# Responsive - RTT over 52 weeks



Oct-21
60
Variation
Special cause of improving nature or lower pressure due to (L)ower values
Target
0
Target Achievement
Not Met

Background:

Palmer Kirsten  
11/24/2023 10:14 AM

Number of patients waiting over 52 weeks for first definitive treatment at month end

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

Continue to work to trajectory. Continued issues with emergency pressures resulting in cancellations and running theatre sessions due to staff sickness & staff isolating. Volume of cancer work impacts on available slots for RTT patients. T&O and Cardiology remain the two challenged specialties.

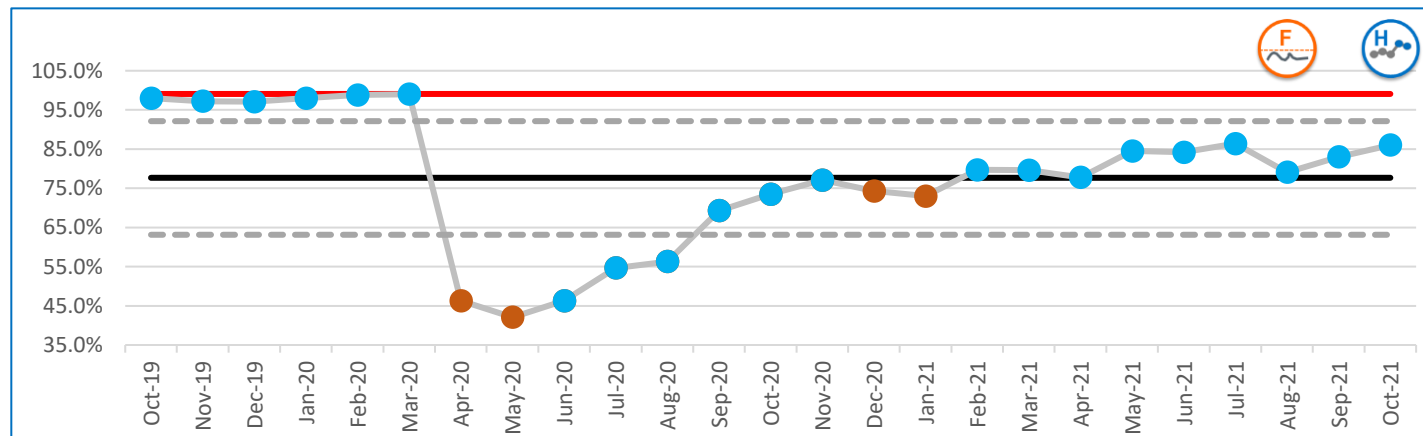
Actions:

Trajectory monitored through weekly Access Committee.  
Weekly PTL meetings by specialty, issues to unblock escalated to Deputy COO/COO.

Mitigations

Insourcing & additional inhouse sessions at weekends. Independent sector capacity to be utilised.

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



Oct-21
86.0%
Variation
Special cause of improving nature or lower pressure due to (H)higher values
Target
>= 99.1%
Target Achievement
Not Met

Background:

Palmer Kirsty  
11/24/2021 12:04:24

% of patients not seen within six weeks

What the chart tells us:

Variation indicates consistently (F)alling short of the target

Issues:

High volume of general referrals, continued increase in cancer diagnostic work, inpatient and urgent care demand. Complex Echos (Dopamine Stress Echo's) remain the only challenge in Cardiology and recovery plan in place. MRI is also still challenged and options for additional capacity being explored.

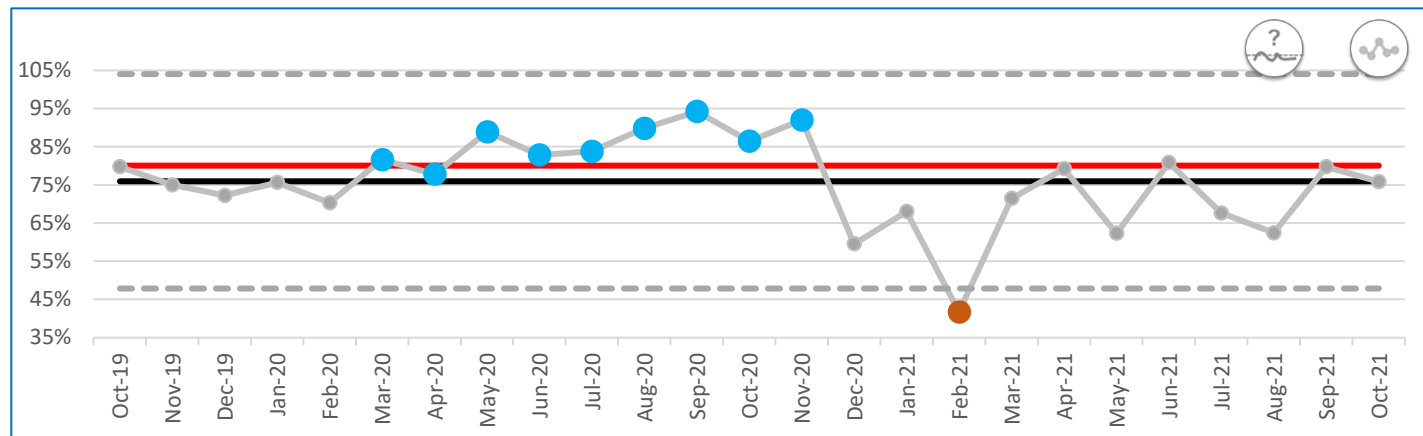
Actions:

Trajectory monitored through weekly Access Committee, actions from weekly PTL escalated as required to ensure delivery of trajectory by December 2021  
Additional capacity at NGH & Danetre in place.

Mitigations

Further external diagnostic capacity agreed for ultrasound . Contract now in place for external company to provide 500 U/S scans for NGH and this will commence throughout November and December. Validation work undertaken to support improvement.

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



Oct-21
75.8%
Variation
Common cause - no significant change
Target
>= 80.0%
Target Achievement
Not Met

### Background:

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

### What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

### Issues:

October has seen an increase in the number of stroke patients, demand has been higher than available capacity. Also community capacity to support discharge has been constrained.

### Actions:

Hyperacute stroke ward has now moved from a 12 bedded ward to a 21 bedded ward.











### Mitigations

Eleanor Ward has moved to a 21 bedded unit in September 2021

# Well Led

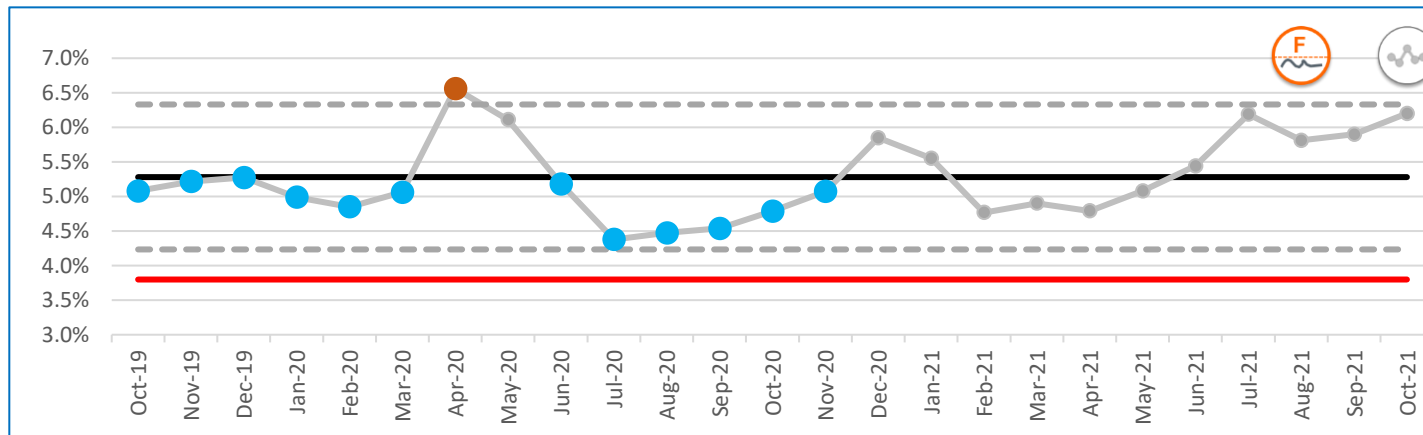
Palmer Kirsty  
11/24/2021 12:14:24

# Well Led Key Performance Indicators

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Sickness Rate	Oct 21	6.2%	3.8%			5.3%	4.2%	6.3%
Turnover Rate	Oct 21	8.5%	10.0%			8.0%	7.4%	8.5%
Percentage of all trust staff with mandatory training compliance	Oct 21	84.1%	85.0%			86.1%	84.1%	88.1%
Percentage of all trust staff with mandatory refresher fire training compliance	Oct 21	76.6%	85.0%			77.6%	55.2%	100.1%
Percentage of staff with annual appraisal	Oct 21	74.9%	85.0%			73.5%	50.5%	96.5%



## Well Led - Sickness Rate



Oct-21
6.2%
Variation
Common cause - no significant change
Target
<= 3.8%
Target Achievement
Not Met

### Background:

Palmer Kirsty  
11/24/2021 12:14:24

Sickness Rate

### What the chart tells us:

Variation indicates consistently (F)alling short of the target

### Issues:

Covid related absence continues to contribute to the overall sickness absence rate.

The impact of the pandemic on work and personal lives and on health/wellbeing – and the significant challenges now being faced in reset/winter/wave3 – likely to cause increased absence.

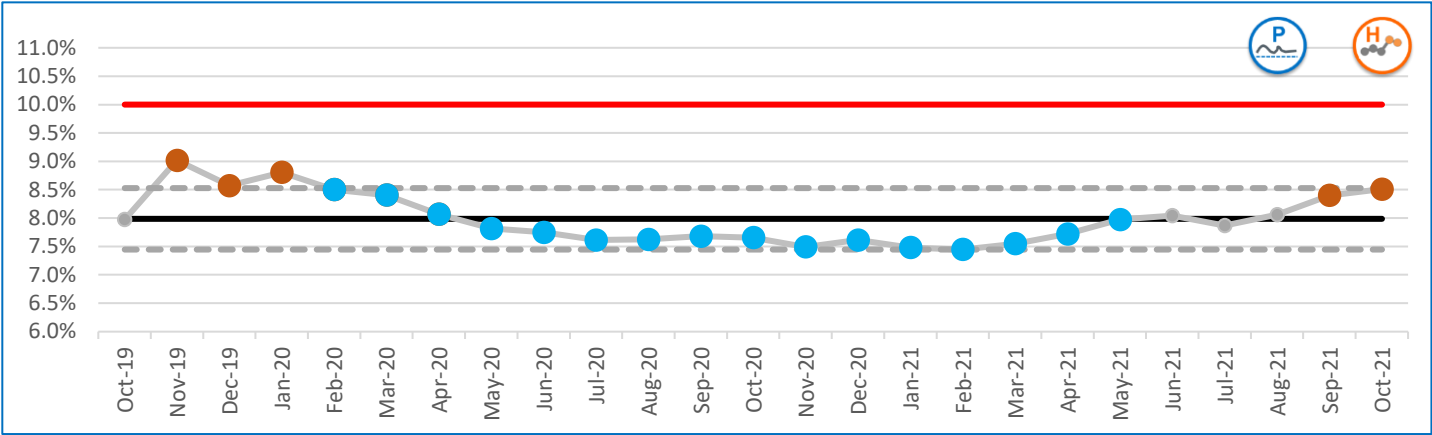
### Actions:

HR Business Partners continue to work closely with Divisions to identify preventative and supportive management of sickness absence.

### Mitigations

Psychological PPE recommendations given to wards, teams and individuals  
Support communications “Talking Matters” Series  
signposting to IAPT & Samaritans  
Additional psychologist resource being recruited  
Enhancements to H&WB offer - signposting to in house & NCC wellbeing activities

# Well Led - Turnover Rate



Oct-21
8.5%
Variation
Special cause of concerning nature or higher pressure due to (H)higher values
Target
<= 10%
Target Achievement
Met

Background:

Palmer Kirsty  
11/24/2021 12:11:24

Turnover Rate

What the chart tells us:

Variation indicates consistently (P)assing the target

Issues:

No issues as target met

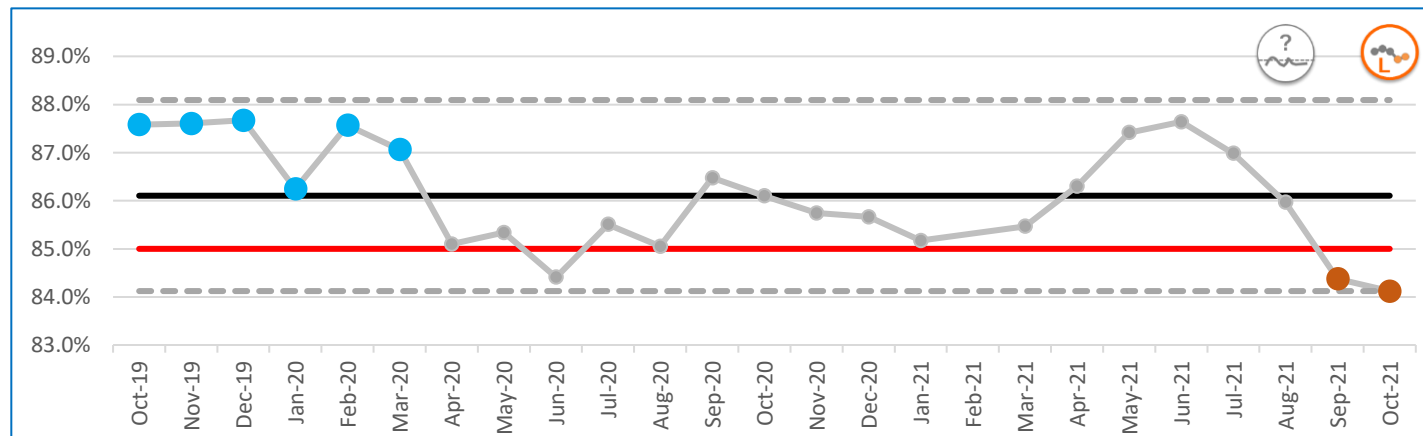
Actions:

No actions as target met

Mitigations

No mitigations as target met

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



Oct-21
84.1%
Variation
Special cause of concerning nature or higher pressure due to (L)ower values
Target
>= 85%
Target Achievement
Not Met

### Background:

Percentage of all trust staff with mandatory training compliance

### What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

### Issues:

The ability to adapt mandatory training to online courses and remote learning has been a pivotal factor in maintaining mandatory training compliance throughout the pandemic

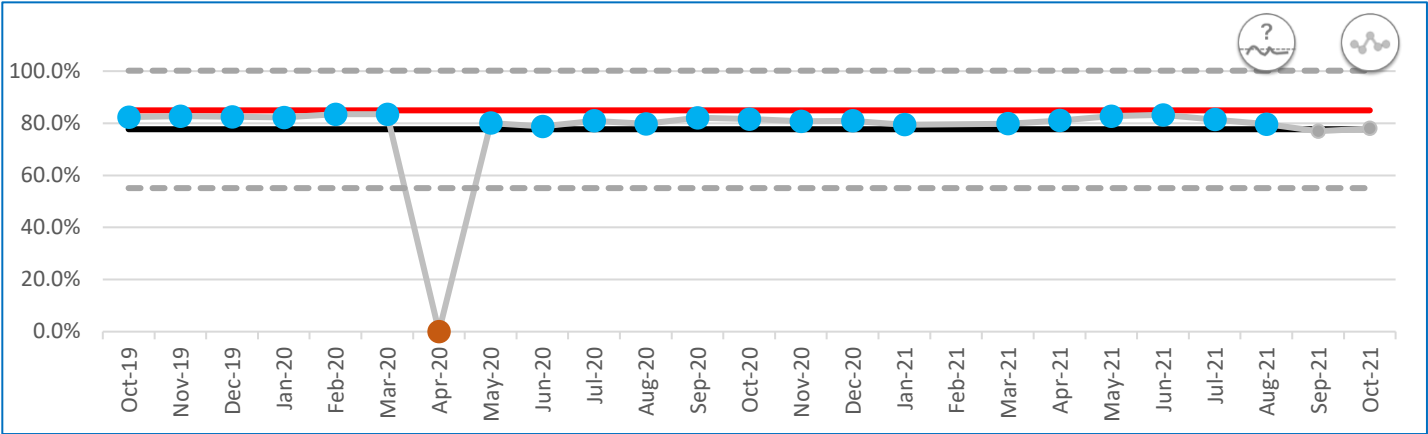
### Actions:

Where possible more courses are reverting to face to face training in order to cater for differing learning styles to enhance the learning experience. Work continues to align courses to the CSTF which includes reviewing refresher periods.

### Mitigations

Courses continue to be provided via E-Learning. More courses are being added to 'My ESR' to enhance ease of access. Comms are being sent out to demonstrate how training compliance can be proactively tracked by staff. A new E-learning provider has been engaged and comm is being issued to support staff.

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



Oct-21
76.6%
Variation
Common cause - no significant change
Target
>= 85.0%
Target Achievement
Not Met

Background:

Palmer Kirsty  
11/24/2021 14:14:44

Percentage of all trust staff with mandatory refresher fire training compliance

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

COVID—this has had a large impact on the way we can currently provide training. Whilst restrictions are easing, there is still a large reliance on T&D to organise the training sessions required, which we as a Fire Team attend to deliver training.

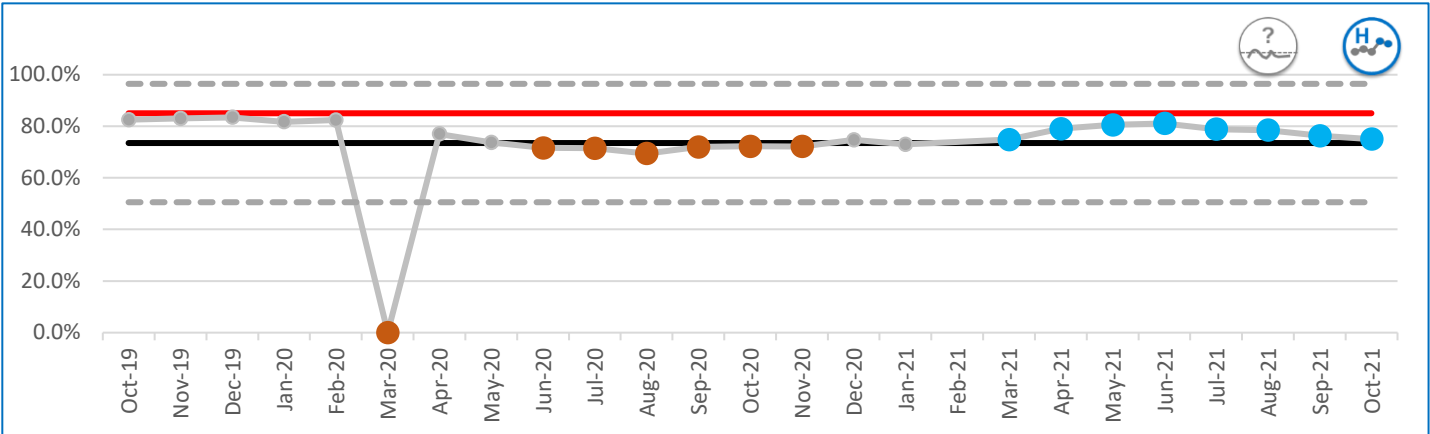
Actions:

To mitigate the reduced face-to-face training, we have developed an online package that auto marks. We also have online induction training, although there are now increased face-to-face inductions taking place. Refresher training has now recommenced for volunteers. This remains the same as previous months

Mitigations

We assess around 150 to 200 staff per month via our assessment sheets. We do rely on our T&D department to forward details of staff who require training, which we then arrange and deliver. It does seem that during the Pandemic training has not been at the forefront of thinking, but this is now improving somewhat.

# Well Led - Percentage of staff with annual appraisal



Oct-21
74.9%
Variation
Special cause of concerning nature or lower pressure due to (H)igher values
Target
>= 85.0%
Target Achievement
Not Met

Background:

Palmer Kirsty  
11/24/2021 12:24 PM

Percentage of staff with annual appraisal

What the chart tells us:

Variation indicates inconsistently hitting passing and falling short of the target

Issues:

Work to recover annual appraisal compliance rates to pre-pandemic level continues to be a challenge.

Actions:

Appraisal reporting, training and support provided to managers

Mitigations

‘Appraisal light’ format continues to be available to managers to reduce administrative burden in a way that maintains the aim of the appraisal process whilst increasing compliance.

# NGH Board Finance Performance

## Month 7 (October 2021) FY 2021/22

Palmer Kirsty  
11/24/2021 12:14:24



## Executive Summary – Year to Date

The year to date financial position is £0.5m adverse to plan, including a H1 variance of £0.2m and the remainder arising from draft H2 plans. The H2 plan is in its final stages of development and is presented under separate cover; it has been developed on a high level basis to ensure the Trust (alongside other System partners) achieve a breakeven position for the full year plan.

At the time of finalising the M7 reporting, the plan had not yet been finalised therefore not all of the available funding has been allocated to the position. This will be adjusted in month 8 and should support an improvement to the reported YTD position.

The key parts of the M7 YTD position are as below.

### **Income – £6.5m favourable variance YTD / £0.1m in-month**

- YTD position is driven by ERF income of £4.9m, an over-performance of £1.1m.
- In-month low reimbursement income (-£0.2m) was offset by rental income (£0.1m), Ockenden YTD funding (£0.1m) and continued project funding.

### **Pay - £5.8m unfavourable variance YTD / £0.2m in-month**

- Agency expenditure of £12.6m is now above our annual ceiling of £11.2m.
- In-month, in addition to agency over plan, higher than average arrears (£0.1m) due to late payment for starters and a Job Plan review.
- Work is on-going with the Medical Division to fully understand resource required across all areas and to target areas for agency use reduction.

### **Non-Pay - £1.1m unfavourable variance YTD / £0.1m in-month**

- £2.3m H1 overspend on insourcing costs to deliver the elective recovery activity which has generated some income overperformance in H1.
- £2.0m favourable against the clinical non pay budgets for H1, as activity lagged behind 19/20 levels, with other overspend on non-pay costs having offsetting income overperformance such as RPA costs, Consultancy cost for EPR.
- In-month the minor overspend is due to insourcing and international recruitment.

**Efficiencies** delivery is on target at £6.1m but has been delivered largely (80%) via non-recurrent pay savings.

**Capital** spend to date is £9.9m. We are yet to receive the final NHSEI approval for the £2.0m Emergency Capital funding and remain in active discussion with the NHSEI regional team about this. The regional team have confirmed that they do not see any reason why the approval should not be forthcoming although it may be delayed. **Given the requirement to spend this by the end of the financial year and in order to avoid delays, we recommend that the Board approves plans to proceed at risk with these schemes.**

## 2021/22 M7 I&E Summary

	NGH In-Month			NGH Year To Date		
Description	Plan £m's	Actual £m's	Variance £m's	Plan £m's	Actual £m's	Variance £m's
Total Income	36.1	36.2	0.1	245.7	252.2	6.5
Total Pay	(25.0)	(25.2)	(0.2)	(168.9)	(174.7)	(5.8)
Total Non Pay	(11.0)	(11.1)	(0.1)	(74.0)	(75.0)	(1.1)
<b>Operating (Deficit)</b>	<b>0.1</b>	<b>(0.2)</b>	<b>(0.2)</b>	<b>2.8</b>	<b>2.4</b>	<b>(0.4)</b>
Capital Charges	(0.4)	(0.4)	0.0	(3.1)	(3.2)	(0.1)
<b>I&amp;E Surplus / (Deficit)</b>	<b>(0.3)</b>	<b>(0.6)</b>	<b>(0.2)</b>	<b>(0.3)</b>	<b>(0.8)</b>	<b>(0.5)</b>

**NGH Finance Overview** – In month reporting a £0.6m deficit, £0.2m adverse to plan.

### Income - £0.1m favourable in month

- Mainly related to recognising confirmed YTD income in October.
- This includes Ockenden income (£0.1m), rental income (£0.1m), and continued project cost funding providing a favourable variance this month, offset by lower re-imbursement income from the Vaccination Centre.

### Pay - £0.2m adverse in month

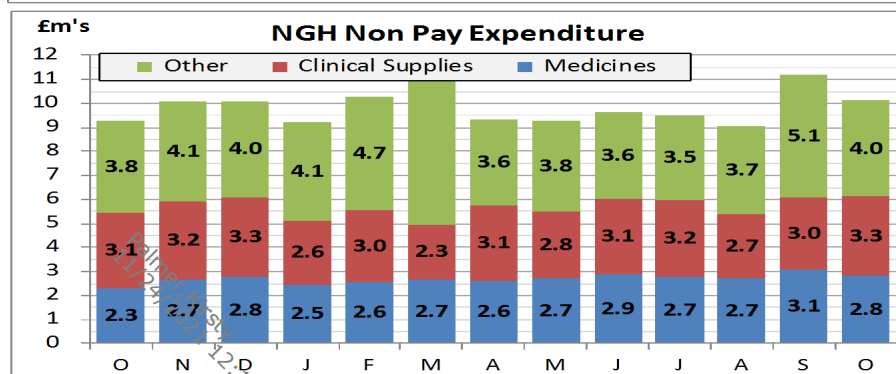
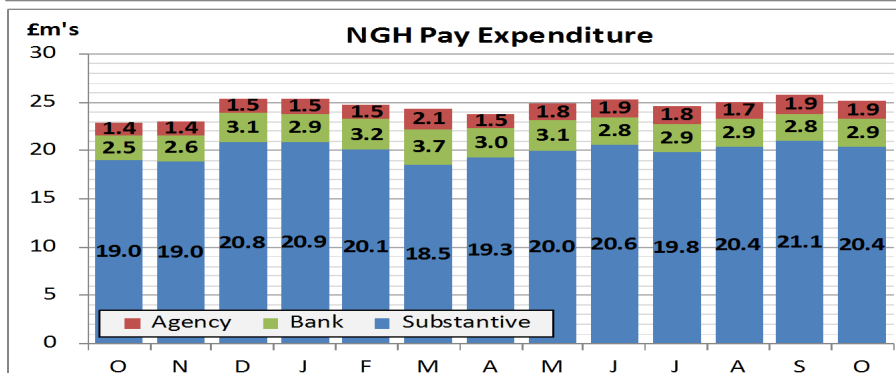
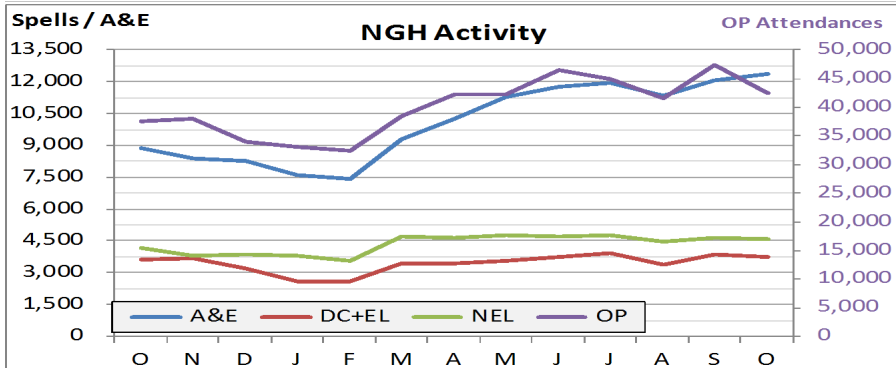
- £0.1m of this relates to a higher than average number of back payment being processed, for junior doctors and changes in consultant job plan.
- Additionally enhanced pay arrangements, across a number of areas, is placing nearly another £0.1m increase in cost this month.
- Agency expenditure is £0.1m above plan due to an increase number of HCAs and medical staff in urgent care.
- Bank staff expenditure is running £0.1m favourable, due to a lower than anticipated activity at the mass vaccination centre.

### Non-pay - £0.1m adverse in month

- Marginal variances in month, some non recurrent items, such as cardiac monitoring and medical visa expenditure totalling £0.1m.
- Slight increase, £0.1m, in insourcing expenditure in imaging, respiratory and endoscopy.
- International nursing recruitment numbers were 2 higher than the 16, presenting a small non pay pressure.
- Some project management support in corporate areas for electronic patient record, £0.1m.
- Lower than average, £0.1m, building and engineering expenditure, due to capitalisation of costs from month 6.



# Summary - Activity & Expenditure – Monthly Trend



## Highlights / Key Issues

### Activity

A&E average attenders for October continued at 400 per day, the highest level yet. Outpatient attenders declined 6% from the peak seen in September. Day Case & Elective activity displayed a marginal increase considering the 21 working days in October, compared to 22 in September this year.

### Pay

Expenditure continues at circa £25.0m per month, with no significant movements in bank & agency spend yet in 21/22. Work is ongoing to establish how much increase in the monthly run-rate we expect to see later in the year. However, funding has been agreed for winter to recognise potential increases in run rate.

### Non Pay

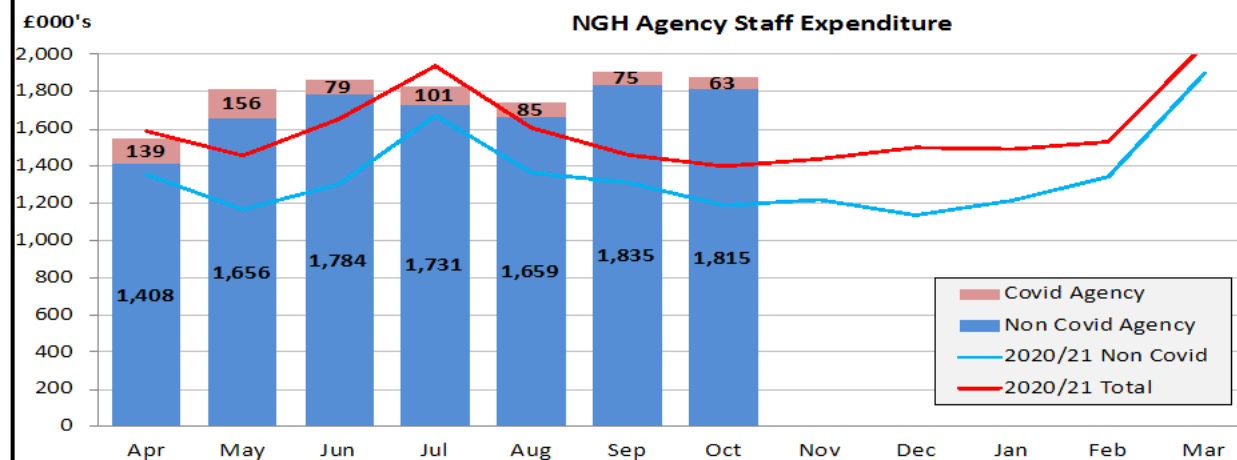
Clinical expenditure increased in month with an increase on Q2 run-rate in Heart Centre, Pacing and Audiology.

'Other Non Pay' is still showing an increase on the M1-M5 run rate, due to some marginal increases in insourcing, plus project management support for developments such as electronic patient record.



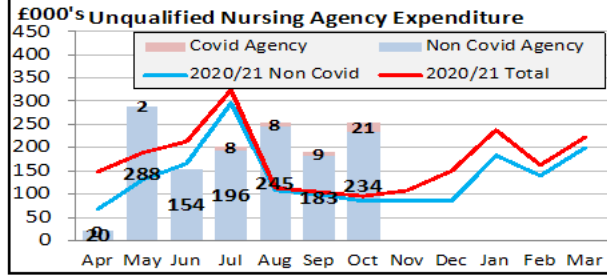
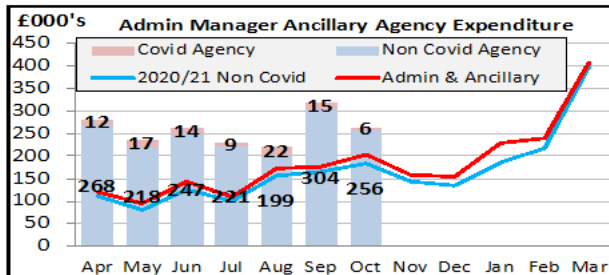
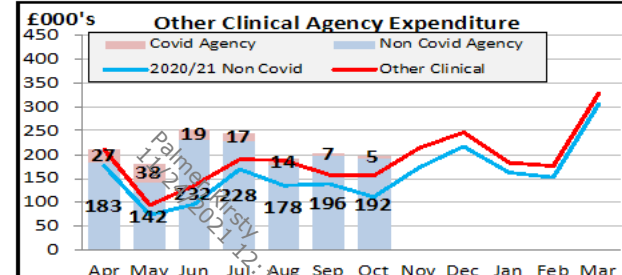
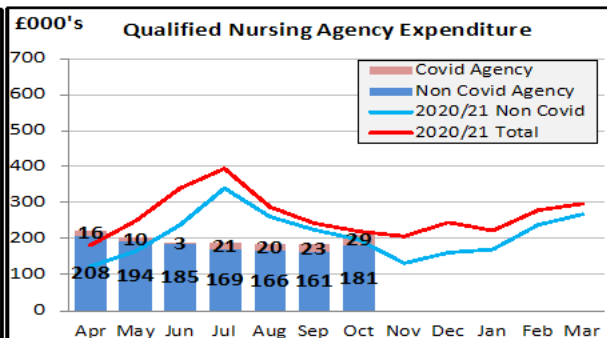
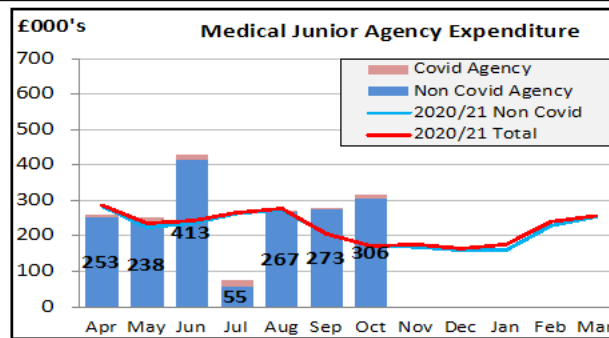
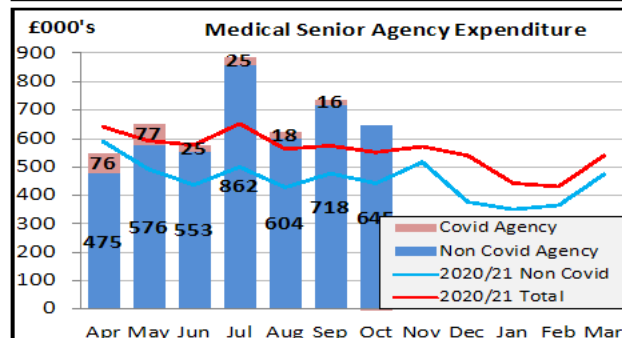
# Agency Pay Expenditure

NGH Agency Staff Expenditure



Monthly Agency spend of £1.9m is the second highest month on record, which brings the total agency spend to £12.6m (including COVID expenditure). This exceeds the set ceiling of £11.2m.

The number of agency staff operating in NGH has increased to 262wte in October, with key drivers continuing to be operational pressures in Urgent Care, sickness and vacancy cover. Work is on-going to put in place action plans as far as possible.



Northampton General Hospital

NHS Trust

# Statement of Financial Performance

The key movements from the opening balance are:

## Non- Current Assets

- Capital additions includes transfer of DHSC Covid donated assets (£0.4m).
- Depreciation includes the Finance Lease revaluation revision.

## Current Assets

- Inventories - increase primarily due to change in funding of Excluded devices. Pacing increase of £0.8m.
- Trade & Other Receivables – decrease in NHS Receivables & Income accruals of £2.8m following receipt of ERF funding from CCG
- Cash – Increase of £3.1m, receipt of Pay Award funding from CCG

## Current Liabilities

- Trade and Other Payables – Increase in Receipts in Advance £3.8m. Nov 21 - Jan 22 Health Education England Funding received in advance £3.2m. Decrease in Tax, NI and Pension Creditor £1.9m – returning to normal level after Pay Award.
- Provisions – Release of Provision held for Reparation for failed EPMA following the issuing of a Credit Note £0.2m. HR Provisions utilised/released have been offset with new provisions arising.

## Financed by

- I & E Account - £0.1m deficit in month

## TRUST SUMMARY BALANCE SHEET MONTH 7 2021/22

	Balance at 31-Mar-21 £m	Opening Balance £m	Current Month Closing Balance £m	Movement £m	Forecast end of year Closing Balance £m	Movement £m
<b>NON CURRENT ASSETS</b>						
OPENING NET BOOK VALUE	188.8	188.8	188.8	0.0	188.8	0.0
IN YEAR REVALUATIONS	0.0	0.0	0.0	0.0	0.0	0.0
IN YEAR MOVEMENTS	0.0	8.7	10.4	1.8	19.1	19.1
LESS DEPRECIATION	0.0	(6.3)	(7.3)	(1.0)	(12.3)	(12.3)
<b>NET BOOK VALUE</b>	<b>188.8</b>	<b>191.2</b>	<b>191.9</b>	<b>0.7</b>	<b>195.5</b>	<b>6.7</b>
<b>CURRENT ASSETS</b>						
INVENTORIES	6.3	6.3	7.2	0.9	6.3	0.0
TRADE & OTHER RECEIVABLES	16.0	21.1	17.9	(3.2)	21.3	5.2
NON CURRENT ASSETS FOR SALE	0.0	0.0	0.0	0.0	0.0	0.0
CLINICIAN PENSION TAX FUNDING	1.0	1.0	1.0	0.0	1.0	0.0
CASH	25.4	17.9	21.1	3.1	1.5	(23.9)
<b>TOTAL CURRENT ASSETS</b>	<b>48.8</b>	<b>46.3</b>	<b>47.1</b>	<b>0.8</b>	<b>30.1</b>	<b>(18.7)</b>
<b>CURRENT LIABILITIES</b>						
TRADE & OTHER PAYABLES	34.8	36.6	38.7	2.1	22.3	(12.5)
FINANCE LEASE PAYABLE under 1 year	1.2	1.2	1.2	0.0	1.3	0.0
SHORT TERM LOANS	0.2	0.2	0.2	0.0	0.3	0.0
STAFF BENEFITS ACCRUAL	0.0	0.0	0.0	0.0	0.0	0.0
PROVISIONS under 1 year	2.5	1.7	1.5	(0.2)	2.5	0.0
<b>TOTAL CURRENT LIABILITIES</b>	<b>38.7</b>	<b>39.8</b>	<b>41.7</b>	<b>1.9</b>	<b>26.3</b>	<b>(12.4)</b>
<b>NET CURRENT ASSETS / (LIABILITIES)</b>	<b>10.0</b>	<b>6.5</b>	<b>5.5</b>	<b>(1.0)</b>	<b>3.7</b>	<b>(6.3)</b>
<b>TOTAL ASSETS LESS CURRENT LIABILITIES</b>	<b>198.8</b>	<b>197.7</b>	<b>197.4</b>	<b>(0.3)</b>	<b>199.3</b>	<b>0.4</b>
<b>NON CURRENT LIABILITIES</b>						
FINANCE LEASE PAYABLE over 1 year	8.3	7.7	7.6	(0.1)	7.1	(1.3)
LOANS over 1 year	0.8	0.6	0.6	(0.1)	0.7	(0.1)
PROVISIONS over 1 year	1.6	1.6	1.6	0.0	1.6	0.0
<b>NON CURRENT LIABILITIES</b>	<b>10.7</b>	<b>9.9</b>	<b>9.8</b>	<b>(0.2)</b>	<b>9.3</b>	<b>(1.3)</b>
<b>TOTAL ASSETS EMPLOYED</b>	<b>188.1</b>	<b>187.8</b>	<b>187.6</b>	<b>(0.1)</b>	<b>189.9</b>	<b>1.8</b>
<b>FINANCED BY</b>						
PDC CAPITAL	259.6	259.6	259.6	0.0	261.8	2.2
REVALUATION RESERVE	42.1	42.1	42.1	0.0	42.1	0.0
I & E ACCOUNT	(113.6)	(114.0)	(114.1)	(0.1)	(114.0)	(0.4)
<b>FINANCING TOTAL</b>	<b>188.1</b>	<b>187.8</b>	<b>187.6</b>	<b>(0.1)</b>	<b>189.9</b>	<b>1.8</b>



## Cover sheet

Meeting	Trust Board
Date	25/11/2021
Agenda item	2.2

Title	IPR Metrics Update
Presenter	Andy Callow, Group Chief Digital Information Officer
Author	Andy Callow, Group Chief Digital Information Officer

This paper is for			
<input type="checkbox"/> Approval	<input type="checkbox"/> Discussion	<input type="checkbox"/> Note	<input checked="" type="checkbox"/> 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				
<input checked="" type="checkbox"/> Patient	<input checked="" type="checkbox"/> Quality	<input checked="" type="checkbox"/> Systems & Partnerships	<input checked="" type="checkbox"/> Sustainability	<input checked="" type="checkbox"/> 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
Provide the Board with an update on the revised set of Metrics	September 2021 Board

Executive Summary
<p>As two hospitals, we agreed in September 2021 that we need an effective way of managing performance and attaining assurance across the Group by monitoring our key metrics using the IGR / IPR process.</p> <p>We are aiming for all committee and Board reporting to be run off a common dataset with high-level measures being included in the IGRs for Boards, and Committees receiving a greater detail of measures. There are two stages to developing these measures:</p>

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

These two stages have now been completed during the September 2021 Board Committee cycle and through the Collaboration Programme Committee in October 2021.

Through this process, 89 metrics were agreed, with 45 of those proposed in the IGR, with committee reports taking other sets of data. The first iteration of this set of reports will be provided to the January 2022 Board.

The IGR will be iterated following publication in January 2022, augmented by a formal review of the metrics will take place after 6 months of the first iteration.

### Recommendations

The committees have agreed the initial batch of metrics, and the board is recommended:

- To receive assurance on the committee's work to date on agreeing metrics
- To note the progress on 'production' of the new IGR to the January committee cycle
- To note that once delivered there will be an iterative review by committees as the new report 'beds-in'
- To note the formal review at the 6 month point

### Appendices

Public Board Nov 2021 - IGR Metrics and reporting D01

### Risk and assurance

There is risk that a delay to the creation of the new IGR using the Group metrics means that effective assurance of the hospital performance is not provided. This could be mitigated to some extent by using the current set of IPR/IGR metrics.

### Financial Impact

Being able to effectively track the sustainability of the organisation is at risk without a fit for purpose IGR.

### Legal implications/regulatory requirements

N/A

### Equality Impact Assessment

N/A

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11/24/2021 12:14:24



# UHN Group IGR Metrics and reporting

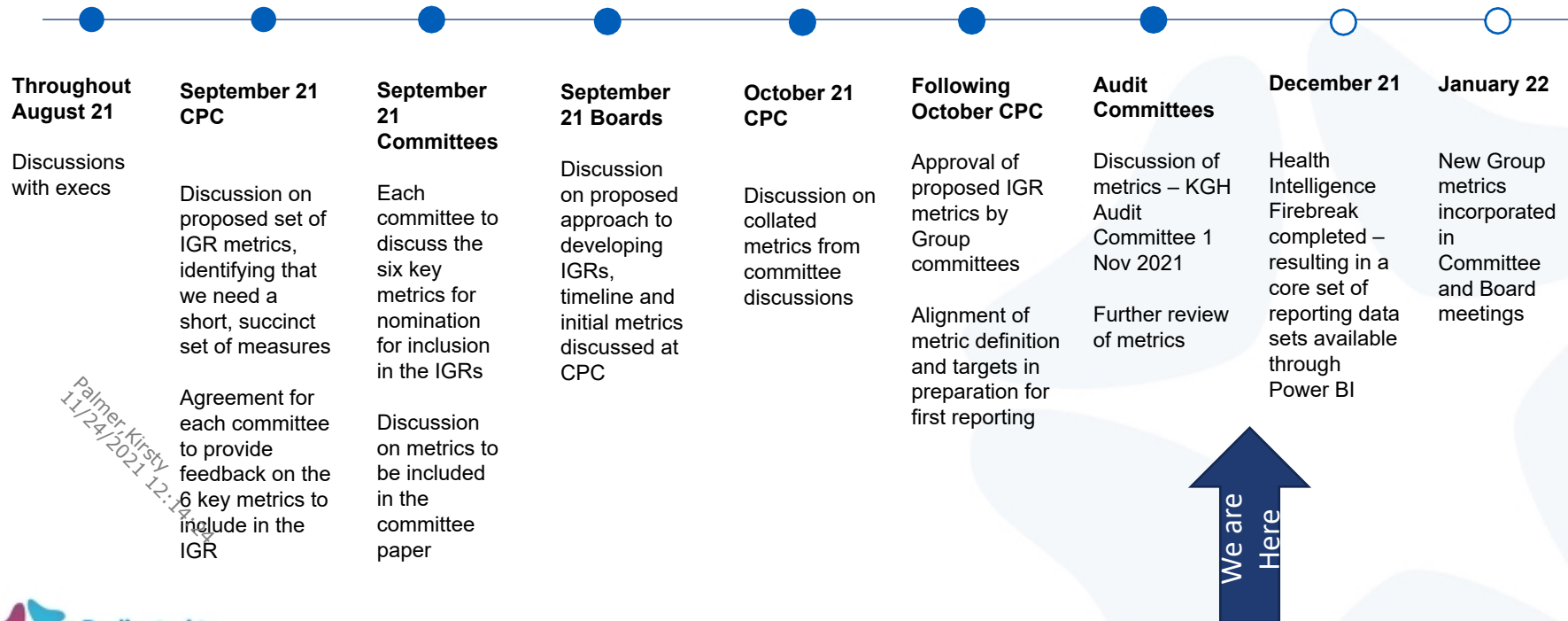
Public Board November 2021

Presented By: Andy Callow, Group CDIO

# Metrics and reporting across the Group to committees and Boards

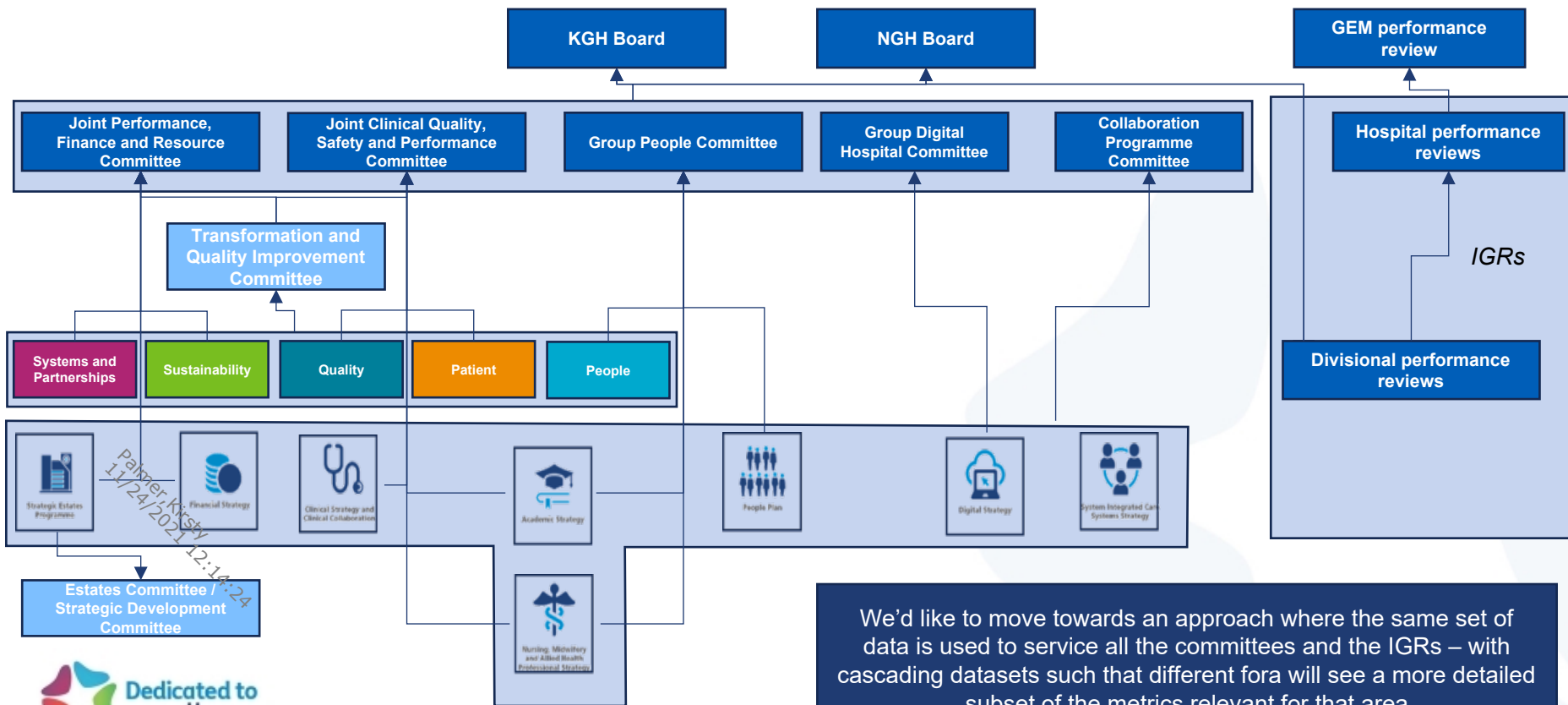
- ▶ As two hospitals, we need an effective way of managing performance across the Group, monitoring our key metrics – using the IGR / IPR process:
  - ▶ The current process needs to be stabilised
  - ▶ There needs to be an agreed set of metrics across the group going forwards that aligns to the Group priorities and reflects the important measures for the Group
  - ▶ The SPC chart format is best practice and has been agreed by our Boards as our agreed methodology (where appropriate)
- ▶ We are aiming for all committee and Board reporting to be run off a common dataset – with high-level measures being included in the IGRs for Boards, and Committees receiving a greater detail of measures. There are two stages to developing these measures:
  1. Agreeing the key metrics committees would like to see in the Group IGR for review at Boards
  2. Agreeing the key metrics committees would like to see in individual committees
- ▶ Conversations took place during the September 2021 Board Committee cycle and through the Collaboration Programme Committee in October 2021 to agree a first set of metrics against the two stages above. This report provides an update on progress.

# Timeline for agreeing consolidated Group reporting for committees and Boards





# Formal Reporting across the Group



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

# Revised Indicator Set

Patient	Indicator
	% of patients who would recommend
	% of patients who would recommend - inpatient
	% of patients who would recommend - A&E
	% of patients who would recommend - maternity
	% of patients who would recommend - outpatients
	Patient pulse feedback on communication
	Number of complaints
	Complaints response performance
	Patient safeguarding
Quality	New harms
	Serious or moderate harms
	Serious or moderate harms – falls
	Serious or moderate harms – deteriorating patient
	Serious or moderate harms – pressure ulcers
	Serious or moderate harms – VTE
	Number of medication errors
	Hospital-acquired infections
	Covid-19
	MRSA
	C Diff
	SHMI
	HSMR
	SMR
	Safe Staffing
	MDT assessment and accreditation
	30 day readmissions
	Never event incidence
	Maternity bundle measures
	Dementia screening
	QI projects undertaken
	Thromboprophylaxis risk assessment tool on admission

Sustainability	Indicator
	Income YTD (£000's)
	Pay YTD (£000's)
	Non Pay YTD (£000's)
	Surplus / Deficit YTD (£000's)
	CIP Performance YTD (£000's)
	Bank and Agency Spend (£000's)
	Capital Spend
	Beds available
	Theatre sessions planned
People	Headcount actual vs planned (substantive / agency / bank)
	A&E activity activity (& vs plan)
	Non-elective activity (& vs plan)
	Elective inpatient activity (& vs plan)
	Elective day-case activity (& vs plan)
	Outpatients activity (& vs plan)
	Maternity activity (& vs plan)
	Quarterly People pulse advocacy questions
	Quarterly People pulse engagement questions
	People pulse 'how are you doing' measure
	People pulse response rates
	People pulse number of actions
	People pulse completion rate of actions
	Mandatory training compliance
	Appraisal completion rates
	Sickness and absence rate
	Vacancy rate
	Turnover rate
	WRES
	WDES
	Temporary staffing FTEs
	Overseas recruitment
	Formal procedures
	Roster publication performance
	Time to hire
	Speed of query resolution
	Satisfaction with query resolution
	Excellence values in survey results
	Number of volunteers
	Number of volunteering hours
	Satisfaction with volunteers
	Safe Staffing (*measure viability to be explored)

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

Revised list of candidate metrics arising out of September 2021 Committee Cycle

Previous number of metrics: 57  
Current number of metrics: 89

# Board & Committee Proposals:

	IGR	Joint FPC	Joint QSC	Trust QSC	Joint PC
Total Metrics	45	32	26	33	25

Although the total number of candidate metrics has increased, the total proposed for the IGR itself has reduced.

Palmer Kirsty  
11/24/2021 12:14:24

# Board & Committee Proposals: IGR

		Total	45
Group priority	Measure	IGR	..T
Quality	Serious or moderate harms – deteriorating patient	✓	
Quality	Serious or moderate harms – pressure ulcers	✓	
Quality	Number of medication errors	✓	
Quality	Hospital-acquired infections	✓	
Quality	SHMI	✓	
Quality	Safe Staffing	✓	
Quality	MDT assessment and accreditation	✓	
Quality	30 day readmissions	✓	
Quality	Never event incidence	✓	
Sustainability	Surplus / Deficit YTD (£000's)	✓	
Sustainability	CIP Performance YTD (£000's)	✓	
Sustainability	Bank and Agency Spend (£000's)	✓	
Sustainability	Capital Spend	✓	
Sustainability	Headcount actual vs planned (substantive / agency / bank)	✓	
Sustainability	A&E activity activity (& vs plan)	✓	
Sustainability	Non-elective activity (& vs plan)	✓	
Sustainability	Elective inpatient activity (& vs plan)	✓	
Sustainability	Elective day-case activity (& vs plan)	✓	
Sustainability	Outpatients activity (& vs plan)	✓	
Sustainability	Maternity activity (& vs plan)	✓	
People	Quarterly People pulse advocacy questions	✓	
People	People pulse 'how are you doing' measure	✓	
People	Mandatory training compliance	✓	
People	Appraisal completion rates	✓	
People	Sickness and absence rate	✓	
People	Vacancy rate	✓	
People	Turnover rate	✓	
Systems and Partnerships	62-day wait for first treatment	✓	
Systems and Partnerships	Cancer: Faster Diagnostic Standard	✓	
Systems and Partnerships	6-week diagnostic test target performance	✓	
Systems and Partnerships	RTT over 52 week waits	✓	
Systems and Partnerships	RTT median wait incomplete pathways	✓	
Systems and Partnerships	Theatre utilisation	✓	
Systems and Partnerships	Composite urgent care bundle - number of measures hit out of 7	✓	
Systems and Partnerships	Bed utilisation	✓	
Systems and Partnerships	Stranded patients (7+ day length of stay)	✓	
Systems and Partnerships	Super-Stranded patients (21+ day length of stay)	✓	
Systems and Partnerships	Patients with a reason to reside	✓	

**45 Metrics proposed for  
Board IGR**

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# Board & Committee Proposals: Group FPC

		Total	32
Group priority	Measure	Joint FPC	✓
Sustainability	Income YTD (£000's)	✓	
Sustainability	Pay YTD (£000's)	✓	
Sustainability	Non Pay YTD (£000's)	✓	
Sustainability	Surplus / Deficit YTD (£000's)	✓	
Sustainability	CIP Performance YTD (£000's)	✓	
Sustainability	Bank and Agency Spend (£000's)	✓	
Sustainability	Capital Spend	✓	
Sustainability	Beds available	✓	
Sustainability	Theatre sessions planned	✓	
Sustainability	Headcount actual vs planned (substantive / agency / bank)	✓	
Sustainability	A&E activity activity (& vs plan)	✓	
Sustainability	Non-elective activity (& vs plan)	✓	
Sustainability	Elective inpatient activity (& vs plan)	✓	
Sustainability	Elective day-case activity (& vs plan)	✓	
Sustainability	Outpatients activity (& vs plan)	✓	
Sustainability	Maternity activity (& vs plan)	✓	
Systems and Partnerships	Two week wait	✓	
Systems and Partnerships	31-day wait for first treatment	✓	
Systems and Partnerships	62-day wait for first treatment	✓	
Systems and Partnerships	Cancer: Faster Diagnostic Standard	✓	
Systems and Partnerships	6-week diagnostic test target performance	✓	
Systems and Partnerships	Unappointed outpatient follow ups	✓	
Systems and Partnerships	Virtual outpatient appointments	✓	
Systems and Partnerships	RTT over 52 week waits	✓	
Systems and Partnerships	RTT median wait incomplete pathways	✓	
Systems and Partnerships	Size of RTT waiting list	✓	
Systems and Partnerships	Theatre utilisation	✓	
Systems and Partnerships	Composite urgent care bundle - number of measures hit out of 7	✓	
Systems and Partnerships	Bed utilisation	✓	
Systems and Partnerships	Stranded patients (7+ day length of stay)	✓	
Systems and Partnerships	Super-Stranded patients (21+ day length of stay)	✓	
Systems and Partnerships	Patients with a reason to reside	✓	

32 Metrics proposed

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# Board & Committee Proposals: Group QSC

		Total	26
Group priority	Measure	Joint QSC	
Patient	% of patients who would recommend	✓	
Patient	Patient pulse feedback on communication	✓	
Patient	Number of complaints	✓	
Patient	Patient safeguarding	✓	
Quality	New harms	✓	
Quality	Serious or moderate harms	✓	
Quality	Serious or moderate harms – falls	✓	
Quality	Serious or moderate harms – deteriorating patient	✓	
Quality	Serious or moderate harms – pressure ulcers	✓	
Quality	Serious or moderate harms – VTE	✓	
Quality	Number of medication errors	✓	
Quality	Hospital-acquired infections	✓	
Quality	Covid-19	✓	
Quality	MRSA	✓	
Quality	C Diff	✓	
Quality	SHMI	✓	
Quality	Safe Staffing	✓	
Quality	MDT assessment and accreditation	✓	
Quality	30 day readmissions	✓	
Quality	Never event incidence	✓	
Quality	Maternity bundle measures	✓	
Quality	Dementia screening	✓	
Quality	QI projects undertaken	✓	
Systems and Partnerships	RTT median wait incomplete pathways	✓	
Systems and Partnerships	Composite urgent care bundle - number of measures hit out of 7	✓	
Systems and Partnerships	Bed utilisation	✓	

26 Metrics proposed

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# Board & Committee Proposals: Trust QSC

	Total	33
Group priority	Measure	Trust QSC
Patient	% of patients who would recommend	✓
Patient	% of patients who would recommend - inpatient	✓
Patient	% of patients who would recommend - A&E	✓
Patient	% of patients who would recommend - maternity	✓
Patient	% of patients who would recommend - outpatients	✓
Patient	Patient pulse feedback on communication	✓
Patient	Number of complaints	✓
Patient	Complaints response performance	✓
Patient	Patient safeguarding	✓
Quality	New harms	✓
Quality	Serious or moderate harms	✓
Quality	Serious or moderate harms – falls	✓
Quality	Serious or moderate harms – deteriorating patient	✓
Quality	Serious or moderate harms – pressure ulcers	✓
Quality	Serious or moderate harms – VTE	✓
Quality	Number of medication errors	✓
Quality	Hospital-acquired infections	✓
Quality	Covid-19	✓
Quality	MRSA	✓
Quality	C Diff	✓
Quality	SHMI	✓
Quality	HSMR	✓
Quality	SMR	✓
Quality	Safe Staffing	✓
Quality	MDT assessment and accreditation	✓
Quality	30 day readmissions	✓
Quality	Never event incidence	✓
Quality	Maternity bundle measures	✓
Quality	Dementia screening	✓
Quality	QI projects undertaken	✓
Quality	Thromboprophylaxis risk assessment tool on admission	✓
People	Safe Staffing (*measure viability to be explored)	✓
Systems and Partnerships	Cancer: NGH internal metric (* to be explored)	✓

33 Metrics proposed

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# Board & Committee Proposals: Group PC

	Total	25
Group priority	Measure	Joint PC
Sustainability	Headcount actual vs planned (substantive / agency / bank)	✓
People	Quarterly People pulse advocacy questions	✓
People	Quarterly People pulse engagement questions	✓
People	People pulse 'how are you doing' measure	✓
People	People pulse response rates	✓
People	People pulse number of actions	✓
People	People pulse completion rate of actions	✓
People	Mandatory training compliance	✓
People	Appraisal completion rates	✓
People	Sickness and absence rate	✓
People	Vacancy rate	✓
People	Turnover rate	✓
People	WRES	✓
People	WDES	✓
People	Temporary staffing FTEs	✓
People	Overseas recruitment	✓
People	Formal procedures	✓
People	Roster publication performance	✓
People	Time to hire	✓
People	Speed of query resolution	✓
People	Satisfaction with query resolution	✓
People	Excellence values in survey results	✓
People	Number of volunteers	✓
People	Number of volunteering hours	✓
People	Satisfaction with volunteers	✓

25 Metrics proposed

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# Next steps and Recommendations

## Next Steps

- Development of shared definitions for IGR metrics and alignment of targets through Firebreak process.
- Begin building into PowerBI dashboards
- Development of the Group IGR, for first use at January 2022 Boards
- The IGR will be iterated following publication in January 2022, augmented by a formal review of the metrics will take place after 6 months of the first iteration.

## Recommendations

- The committees have agreed the initial batch of metrics, and the board is recommended:
  - To receive assurance on the committee's work to date on agreeing metrics
  - To note the progress on 'production' of the new IGR to the January committee cycle
  - To note that once delivered there will be an iterative review by committees as the new report 'beds-in'
  - To note the formal review at the 6 month point

## Cover sheet

Meeting	Trust Board
Date	25 <sup>th</sup> November 2021
Agenda item	2.3

Title	2021/22 H2 Planning
Presenter	Jon Evans, Group Chief Finance Officer Karen Spellman, Group Director of Strategy & Integration
Author	Jon Evans, Group Chief Finance Officer Karen Spellman, Group Director of Strategy & Integration Mark Smith, Chief People Officer Matt Metcalfe, Medical Director and Acting COO

This paper is for			
<input checked="" type="checkbox"/> Approval	<input type="checkbox"/> Discussion	<input type="checkbox"/> Note	<input type="checkbox"/> 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				
<input type="checkbox"/> Patient	<input type="checkbox"/> Quality	<input checked="" type="checkbox"/> Systems & Partnerships	<input checked="" type="checkbox"/> Sustainability	<input type="checkbox"/> 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
<ul style="list-style-type: none"> <li>Note that the Group Board received the draft 2021/22 H2 planning submission for review and approval in respect of financial, people and activity plans at its Development Day meeting on 5<sup>th</sup> November 2021, and</li> </ul>	

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<ul style="list-style-type: none"> <li>• Ratify the approval of the hospital group's final plans for October 2021 – March 2022, as set out in the report that have been included within the System level planning submission on 18<sup>th</sup> November</li> <li>• Approve the Trust level financial planning submission as set out in the report to be submitted by the Chief Finance Officer to NHSEI on 25<sup>th</sup> November 2021</li> <li>• Note the risks within the plan and mitigations presented within the paper</li> </ul>	
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## Executive Summary

### Situation

This paper presents the Trust's final plans for October 2021 – March 2022 (H2) which have been incorporated into the system level planning submission on 18<sup>th</sup> November 2021 in line with 2021/22 H2 Operational Planning Guidance published by NHS England and Improvement (NHSEI) on 30<sup>th</sup> September 2021. The NGH Trust Operational plan will be presented to the Finance and Performance Committee on 24<sup>th</sup> November 2021.

The NGH Trust Finance plan (which is presented within this paper) will be submitted to NHSEI on 25<sup>th</sup> November 2021 in line with NHSEI timelines, and will also be presented to the Trust Finance and Performance Committee on 24<sup>th</sup> November 2021 for approval. This will be the basis on which the financial performance of the Trust will be assessed through H2.

Draft plans for the Trust were presented and supported by the Board on Friday 5<sup>th</sup> November, and have also been approved by Chief Executives as part of the System submission on 10<sup>th</sup> November.

Our plan is an ambitious and realistic approach for the remaining six months of 2021/22, with a focus on our people and ensuring that our plans are supporting the health and wellbeing of staff. The principle risk to recovering elective waiting times and our staff recovery is any further waves of COVID and increased demand during the winter period.

### Assessment

Our system submission is made up of four parts:-

- Activity plan including elective recovery
- Workforce People Plan
- Finance Plan

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- Narrative document to support the technical submissions above

The activity plans have been modelled and assumptions have been tested and supported by both NGH and KGH Boards at the Board Development session, and represents a realistic delivery plan.

The financial plan for NGH for 21/22 is breakeven, as part of the NHCP system plan surplus of +£1.3m. This is a combination of H1 actual performance (-£0.2m) and H2 plan (+£0.2m).

All NHCP system partners have agreed a breakeven or better plan for the 2021/22 financial year

The workforce plan includes assumes the continued recruitment of international nurses and substantive HCA's, with an associated reduction of bank and agency staff, and expansion of the workforce through agreed investments. At System level, a workforce planning summit was held to stress test workforce plans and identified key risks including the risk that COVID will adversely impact on plans to recruit international nurses, and the continued impact of sickness absence and the health and wellbeing of staff.

The key challenges to delivering the plan we have submitted as a group are:-

- The potential of further COVID surges alongside the risk of winter pressures and non-elective demand being higher than anticipated will inevitably cause disruption to plans and impact on the health and wellbeing of staff
- Demand and elective referral rates continuing to increase above the current rate due to increased numbers of patients accessing primary care
- Staffing levels impacting on ability to provide capacity including staff fatigue, recruitment and retention, and staff shortages in specialty areas such as ODPs and anaesthetists

As part of the plans, NHSE/I have approved additional funding of £10.9m capital and £1.1m revenue across the System as part of the Targeted Improvement Fund (TIF). This is for digital and operational schemes to support elective recovery across the System. The impact of these schemes has been built into both the activity and financial plans.

## Appendices

## Risk and assurance

## Financial Impact

The financial implications are described within the paper. This paper provides details of the system and trust level financial plans for H2 2021/22.

Legal implications/regulatory requirements
There are no legal implications in this paper.
Equality Impact Assessment
There is no evidence of any impact upon equality within this paper.

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

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# 2021/22 H2 Planning

## Northampton General Hospital NHS Trust

### November 2021

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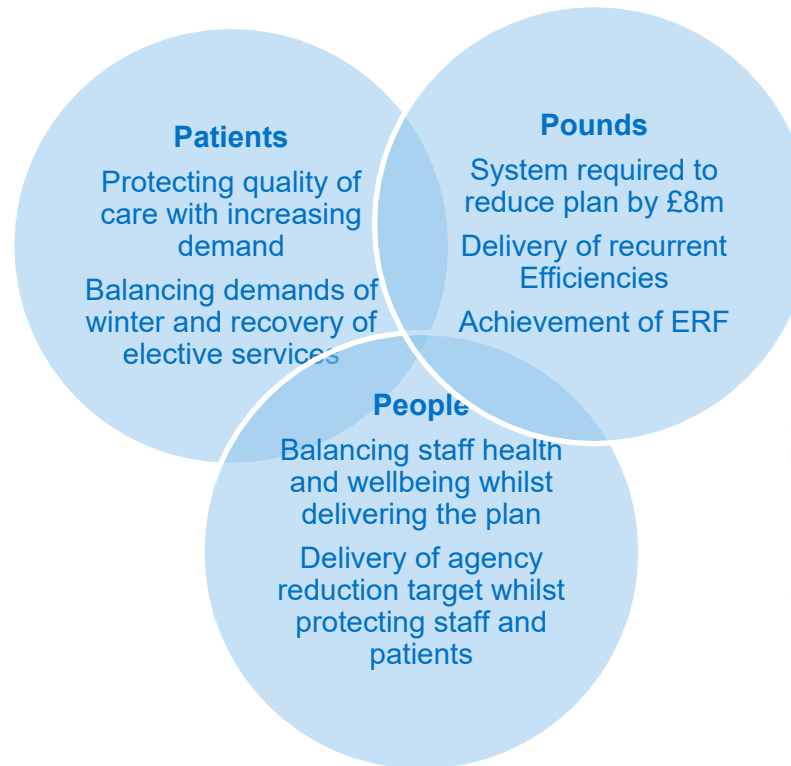
# Introduction

- ▶ The H2 2021/22 plans cover the period from October 2021 to March 2022. The Trust plans form part of the system wide planning submission which was submitted on Thursday 18th November.
- ▶ Draft plans for the Trust were presented and approved in principle to the Board on Friday 5th November. This paper summarises the final plan submitted as part of the System submission.

## Planning Guidance Priorities

- ▶ The six areas set out in NHSE/I's priorities and operational planning guidance for 2021/22, published in March 2021, remain the priorities for the second half of the financial year (H2):
  - ▶ supporting the health and wellbeing of staff and taking action on recruitment and retention
  - ▶ delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
  - ▶ building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
  - ▶ expanding care capacity to improve access, local health outcomes and address health inequalities
  - ▶ transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (EDs), improve timely admission to hospital for ED patients and reduce length of stay
  - ▶ working collaboratively across systems to deliver on these priorities
- ▶ In addition, there will continue to be a focus on the five priority areas for tackling health inequalities and delivering sustained progress against the ambitions of the NHS long term plan

# The balancing three drivers



## Key themes to consider

- How will we balance the welfare of our staff against the national backdrop of recovering elective waiting times and delivering winter plans?
- How will we deliver our system finance strategy and efficiencies?
- How do we ensure that the quality of care our patients receive at the front line is excellent, with a tired workforce and multiple priorities?
- How do we manage and balance risk across these three drivers?

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# Requirements for H2 Planning

**The guidance aims to return – or exceed – elective activity to pre-pandemic levels. The ambition is for systems to;**

- ▶ Eliminate waits of over 104 weeks by March 2022 except where patients choose to wait longer ('P5' and 'P6' patients)
- ▶ Hold or where possible reduce the number of patients waiting over 52 weeks and stabilise waiting lists around the level seen at the end of September 2021
- ▶ Completed RTT pathway activity above a 2019/20 threshold of 89% (system level = access to ERF)
- ▶ Return the number of people waiting for longer than 62 days to the level we saw in February 2020 (based on overall national average) by March 2022
- ▶ Outpatient transformation: Minimum of 12 A&G requests per 100 outpatients with a month-on-month increase in referral optimisation, PIFU in place for 5 specialities – 1.5% by December and 2% by March, Remote outpatients at least 25%

## Finance Requirements

- ▶ System delivery of breakeven over the year
- ▶ Increased efficiency ask @ 0.82% (c£1.1m before any local pressures)
- ▶ To understand / model:
  - ▶ Funding of winter plan capacity
  - ▶ ERF income and costs of capacity
  - ▶ On-going pressures from H1
  - ▶ Efficiency and / or cost reduction delivery in H2
  - ▶ Spend on COVID-19 versus allocations

# Finance Plan

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## Context

- ▶ Planning for 2021/22 H2 has not been a **traditional planning process**:
  - **It is a system plan**, which we all need to provide contributions to and agree collectively the best outcome for the overall system
  - It is an **in-year planning process**
  - **Time scales to develop plans have been truncated**, meaning that there has been no ability to run a bottom-up process engaging divisional teams beyond major movements
- ▶ Both hospitals have been required to develop and agree a financial plan as part of an overall system plan. This is one system plan, which will be monitored and performance managed at system level.

## Summary

- ▶ The NHCP system has agreed a plan for 2021/22 at a surplus of +£1.3m, with **NGH having a breakeven plan** as part of this. This is a combination of H1 actual performance (-£0.2m) and H2 plan (+£0.2m)
- ▶ All NHCP system partners have agreed a breakeven or better plan for the 2021/22 financial year

## Approach taken / assumptions

### ▶ Key inputs in deriving H2 revenue plans are as follows:

- Roll forward H1 run rate / financial performance
- Adjust for changes in block funding (reductions for national efficiency and reductions in covid funding)
- Adjust for known one-off items in H1
- Adjust for additional spend expected in H2 (run rate changes from approved investments started in-period H1 and increase in run rate in Q2 due to increased activity volumes)
- Adjust for expected movement in efficiency delivery
- Adjust for agreed winter investments
- Adjust for additional income from NCCG

**Assumptions have been applied consistently across KGH and NGH**

**Movements shown in following waterfall bridges**

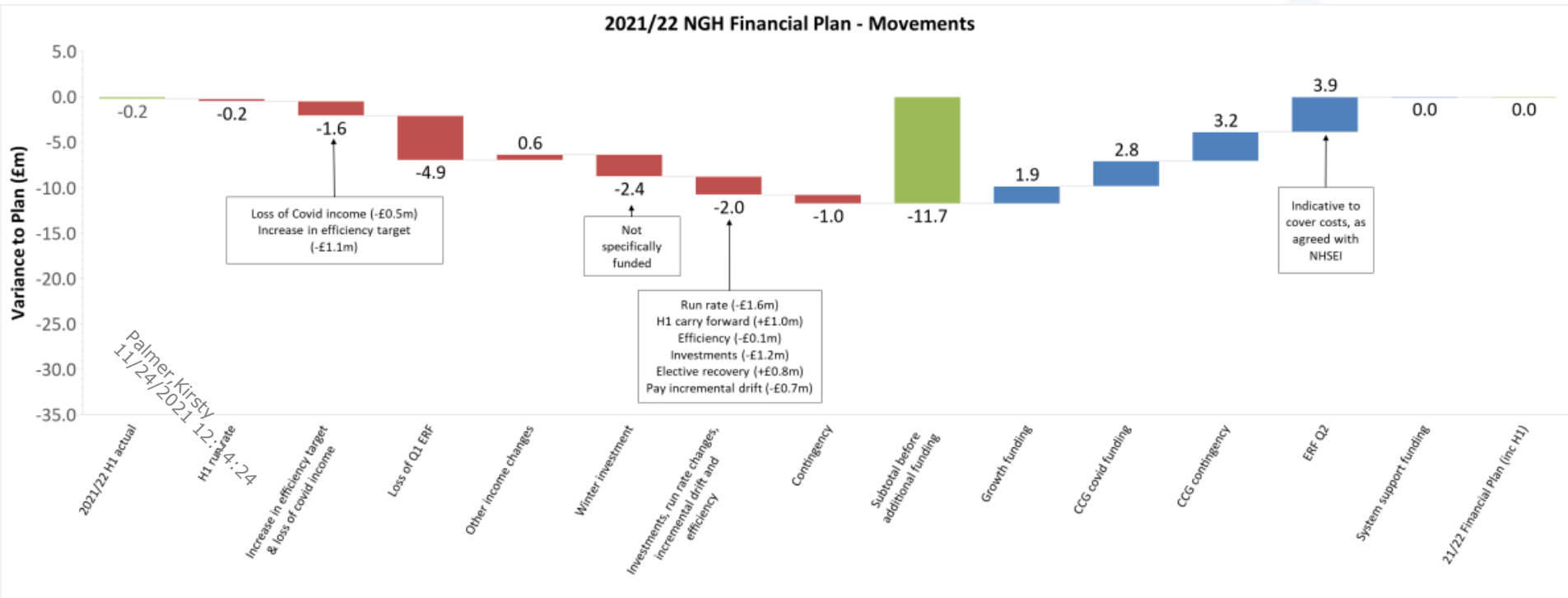
## Key assumptions in H2 plan

- ▶ The planned financial position in H2 is a surplus of +£0.2m, so **breakeven overall in 2020/21**
- ▶ **Changes from draft plan presented to the Group Development away day** are as follows:
  - Additional cancer related SDF income (+£0.6m)
  - Contingency (-£1.0m)
  - Additional growth funding (+£1.9m)
  - Addition system income (+£0.6m)
  - Additional income to maintain elective recovery (ERF) capacity (+£3.9m)
- ▶ ERF funding has been confirmed by regional NHSEI Finance team
- ▶ Additional funding to support Hospital Discharge Programme is awaiting confirmation and has not been included in the Trust's position
- ▶ **No income from NCCG or other main commissioner is assumed in the plan that has not been specifically agreed**

# Financial plan

## Movements - NGH total

- Planned breakeven position, +£0.2m in H2



# Financial plan

## Approach taken on key issues

### ▶ Budgets

Internal budgets will remain unchanged from those loaded to the ledger in H1, other than for the following changes:

- Increase in budgets to cover higher than planned costs of high-cost drugs and devices
- Creation of budgets to cover winter investments
- Change in income targets to account for changes in block contract values, assumed ERF delivery and funding from NCCG

### ▶ Efficiency delivery

NGH assumes no change in run rate of delivery on H1, at £5.2m delivery in H2

### ▶ Alignment of non-pay with activity plans

Non-pay increased above H1 spend to match Q2 levels, due to increased activity levels delivered in this period and assumed to continue into H2.

Using H1 spend alone would understate expected costs as spend and activity levels were lower in Q1.

## Approach taken / assumptions

### ▶ Key items assumed in these outputs:

- No increase in headcount other than defined investments
- No additional consultancy spend
- Maintaining investment in elective recovery as made in H1, not increased / reduced
- Maintaining covid related spend, not reduced in line with funding
- No ERF income earned / received
- No additional inflation above H1
- Pay award / inflation as in H1

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## Risks and opportunities

- ▶ Potential financial improvements include:
  - Lower than planned spend for winter if staffing is not available, but with corresponding operational impacts of less capacity for resilience (Med)
  - Receipt of funding for winter costs - TBC regionally / nationally (Med)
  - Delivery of ERF conditions / funding for costs of capacity - TBC regionally / nationally (Low)
  - Release of Annual Leave accrual (£3.5m at NGH) to test what can be released. Have been advised by NHSEI not to release accrual to date. Expected to be managed nationally (Low / Med)
- ▶ Risks include:
  - Higher than planned cost inflation (assumed in run rate, per national guidance) (Low)
  - Continued increase in substantive recruitment, with no corresponding reduction in temporary staffing, over and above discrete investments planned for (Low)

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## Capital and cash

- ▶ NGH teams have positively confirmed that they expect to deliver capital spend in line with plan, namely:
  - NGH expected spend of £18.9m
- ▶ There are no anticipated cash issues as a result of this plan. Cash forecasts will be completed on a monthly basis and any concerns, including actions to mitigate risks, will be reported through to the relevant Board Committee

There should, given the aggregate system financial position and cash /invoicing profile agreed with NCCG, be no need for national cash support but close attention to this is required.

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# Financial plan

## I&E Summary - NGH

NGH 21/22 Financial Plan	Half 1	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Half 2	Full Year
	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	
Northamptonshire Nene CCG	171,929	28,358	28,358	28,358	28,358	28,358	28,358	170,147	342,076
Other Patient Care income	29,038	5,006	4,908	4,906	4,908	4,907	4,908	29,545	58,583
Other Operating Income	12,887	2,040	4,630	3,610	3,335	3,335	3,335	20,284	33,171
OOE Reimbursement	2,153	357	357	357	107			1,178	3,331
<b>TOTAL Income</b>	<b>216,008</b>	<b>35,761</b>	<b>38,253</b>	<b>37,231</b>	<b>36,708</b>	<b>36,600</b>	<b>36,601</b>	<b>221,154</b>	<b>437,162</b>
Pay Costs Substantive	121,174	20,253	20,304	20,438	20,725	20,435	20,386	122,541	243,715
Pay Costs Bank	17,553	2,959	3,037	3,224	2,976	2,974	2,976	18,147	35,699
Pay agency	10,710	1,801	1,849	2,020	2,020	2,020	2,020	11,730	22,440
Non-Pay Costs	64,310	11,020	11,020	10,586	10,860	10,586	11,980	66,052	130,362
Interest costs	2,630	439	439	439	439	439	439	2,636	5,266
<b>TOTAL Expenditure</b>	<b>216,376</b>	<b>36,472</b>	<b>36,649</b>	<b>36,707</b>	<b>37,020</b>	<b>36,455</b>	<b>37,802</b>	<b>221,106</b>	<b>437,482</b>
Normalisation	120	33	33	33	33	33	33	200	320
<b>Surplus / (Deficit) post normalisation</b>	<b>(248)</b>	<b>(678)</b>	<b>1,637</b>	<b>557</b>	<b>(279)</b>	<b>178</b>	<b>(1,167)</b>	<b>248</b>	<b>0</b>

# Elective Recovery, Performance and Winter Planning

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# Activity Plan Development

- ▶ Activity plans have been modelled for elective and non-elective activity and assumptions have been tested and agreed by both NGH and KGH Boards at a joint Board Development session on the 5th November.
- ▶ On approval of the Targeted Investment Fund (TIF) schemes, the elective and outpatient impact of these schemes has been modelled which will improve productivity and efficiency of services to deliver elective recovery activity.
- ▶ The non-elective activity model reflects current actual data trends and underlying assumptions increasing the number of anticipated non-elective admissions.
- ▶ The impact of Primary Care Winter Access Fund (WAF) proposals have not been included within the activity submission -. If successful, funding will be provided by NHSE/I for proposals to increase primary care capacity and potentially reduce A&E attendances during winter.

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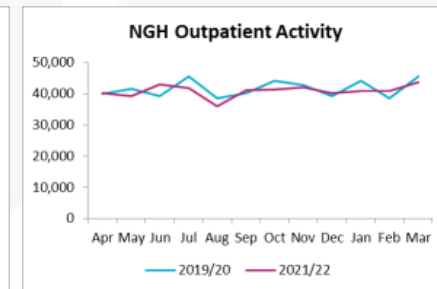
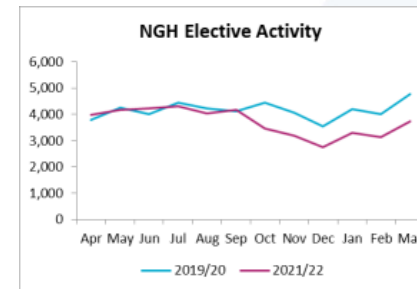
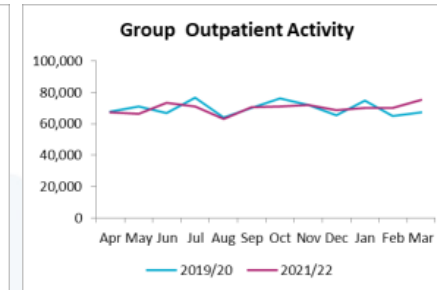
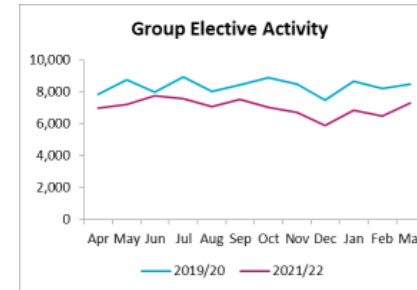
# Elective Recovery and Performance

## What we are planning to achieve with the H2 plans:-

- ▶ Maintain position of no patients waiting over 104 weeks for treatment, and to maintain the current level of patients waiting 52 weeks
- ▶ Maintain the number of people waiting for longer than 62 days for cancer to the current level which is below the level seen in February 2020
- ▶ Maintain current outpatient capacity
- ▶ Support outpatient transformation by planning to increase the number of patients on a Patient Initiated Follow-Up (PIFU) pathway to 2% of all outpatient pathways by March 2022

## However the H2 plans will not enable us to:-

- ▶ Stabilise waiting lists around the level seen at the end of September 2021- the plan has a 2% increase month on month of incomplete RTT pathways – this is based on current demand and capacity.
- ▶ Achieve completed RTT pathway activity above a 2019/20 threshold of 89% at system level to enable us to access additional ERF funding



## Assumptions

- Elective activity plan has assumed a continuation of the activity levels delivered in July/August as a % 2019/20 activity for each month for the remainder of the year.
- A 1% productivity improvement has been applied in Jan – Mar 2022 for elective theatre-based work.

# Approved TIF Schemes

- NHSE/I have now approved the following additional funding part of the Targeted Investment Fund (TIF) to support elective recovery:-
  - Digital - £9.9m capital funding
  - Other - £0.2m capital funding (KGH only)
- Increased activity has been built into final planning submissions
- The delivery of these projects and therefore the anticipated impact has been phased due to procurement and implementation timelines

Approved TIF Schemes	Anticipated Delivery Date
Accelerating the uptake of PHR	December 2021
Deployment of Digital Productivity tools	January 2022
Out pt system PTL	March 2022
Improve room booking system-OP	May 2022
Patient self check in and information system	June 2022
Outpatient Digital Efficiencies Tools & RPA	March 2022
Pre-op e-consent solution	July 2022
2 way clinical communication tool	March 2022
Additional Outpatient Capacity – Corby Community Hospital	January 2021

# Elective Recovery and Performance

## Risks and Mitigations

### Risks

- Increasing demand and elective referral rates
- Winter pressures and non-elective demand being greater than planned impacting on bed capacity, theatres availability and staff resources
- COVID-19 surges impacting on capacity both through non-elective demand and staff availability
- Staffing levels impacting on ability to provide capacity including staff fatigue, recruitment and retention, and staff shortages in specialty areas such as ODPs and anaesthetists

### Mitigations

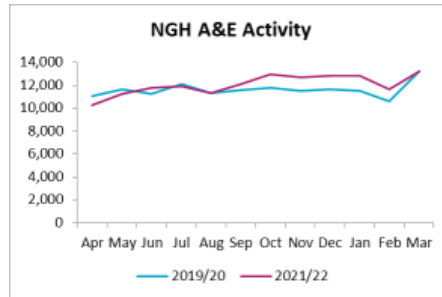
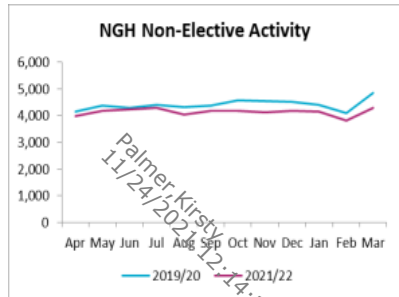
- Ring fenced elective beds and protect elective capacity through schemes to manage NEL capacity demand by avoiding admissions and reducing length of stay
- Continued review of Infection Prevention Controls (IPC)
- Theatre efficiencies built into the model from Q4 onwards and further opportunities being reviewed
- Continued working with Independent Sector Providers across the system

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# Non-Elective modelling and Winter Planning

- ▶ Non-elective and A&E activity figures within the H2 plans have been based on the most likely scenario of the winter bed capacity model signed off by the Board. This model produced a bed capacity gap of up to 47 beds at NGH (based on 90% occupancy)
- ▶ In order to respond to the predicted demand, the Trust has developed a number of winter schemes, however NGH continue to have a bed gap despite the schemes.
- ▶ As a group we continue to work with our partners to develop plans to manage demand and facilitate timely discharge and whilst some of these plans are well developed others are unlikely to be delivered due to significant recruitment challenges particularly in Adult Social Care.



## Non-Elective Activity Plan Assumptions

The forecast is based on the winter planning most likely scenario.

The NGH model has been updated to align with the current activity trend as follows:-

- ED Attendances – 107.5% of 2019/20
- 24% Conversion rate
- 27% Admissions not via ED

## A&E Activity Plan Assumptions

The forecast is based on the winter plan most likely scenario, that has previously been signed off by the Board (September 21).

# Non-Elective modelling and Winter Planning Risks and Mitigations

## Risks

- **Remaining gap in bed capacity**
- **Pathway capacity:** Gaps in care hours due to ASC inability to recruit staff – leading to protracted LOS and delays in discharge
- **IPC:** Impact of COVID-19, flu and other winter viruses
- **Risk of COVID-19 outbreaks** in the hospitals, reducing bed availability and thereby compromising flow
- **Staffing:** COVID-19 isolation/Staff moral/resilience and sickness
- **Increase in COVID-19 inpatients**
- **Paediatric and Critical Care capacity** may be insufficient to meet demand

## Further Mitigations

- Increased use of surgical, medical and frailty SDEC with extended opening hours and GP/EMAS direct referral
- Walter Tull ward will become an assessment unit at NGH and patients will be streamed from ED or have direct referrals from EMAS and GPs
- Board round transformation work to improve simple discharges and length of stay with new PDNA process
- Support mechanisms for staff continue to be in place
- Continuing screening of patients at the front door for flu and COVID; and training and communication re. IPC

# Supporting staff wellbeing and workforce plan

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# Supporting the health & wellbeing of staff

**To support staff's health and wellbeing the following actions have been put in place:-**

- ▶ Access to reflective spaces and support services (Care Spaces and Recovery Spaces)
- ▶ Direct access to psychological support through our SOS teams, 1:1 therapy and indirect psychological support to teams and managers
- ▶ Working with system level initiatives including NHCP "Stronger Together" programme who support our ICU and other clinical teams with regular face to face interventions
- ▶ Health and Wellbeing support service providing preventative health and wellbeing campaigns and support
- ▶ Encouraging staff to take annual leave to enable staff to recover
- ▶ Health and wellbeing conversations as part of the annual appraisal process

## Plan Summary

- In H2 the total workforce is planned to increase from 6029 to 6143
- With an increase in substantive staff from 5202 to 5404

## Assumptions

- Plan for end of December 2021 and March 2022 is based on previous quarter outturn plus investments
- Agency utilisation will see a slight and gradual reduction in H2 as international nurses drop out of their supernumerary phase
- Additional HCA substantive recruitment replacing bank and agency HCA numbers

## Risks

- COVID-19 adversely impact upon ability to on-board planned international nursing recruits
- Potential continuation of unfunded workforce costs relating to COVID-19 demand and the vaccination centre or increase – impact of booster programme and ongoing vaccination activities

## Mitigations

- For difficult to fill roles such as consultants' recruitment through agency long lines is in place and using permanent recruitment agencies to extend advertising reach.
- Work associated with reset, increased activity, backlog work and difficult to fill posts are being supported with financial incentives for staff, with reviews of attraction strategies in place.
- Workforce planning summit held with operational planning, finance and workforce colleagues to stress test workforce plans and identify key risk areas

## Cover sheet

Meeting	Trust Boards
Date	25 November 2021
Agenda item	3.1

Title	Six months of Dedicated to Excellence
Presenter	Simon Weldon, Group CEO
Author	Becky Taylor, Group Director of Transformation & Quality Improvement

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

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

Reason for consideration	Previous consideration
Six month update due	N/A

### Executive Summary

We are delighted to present our first 6 month update on our progress against our Dedicated to Excellence strategy, which demonstrates some of the highlights from our first six months of delivery. We are really proud of all that has been accomplished and hope today that we can celebrate the hard work and dedication that has gone into driving forward progress on this, amongst some challenging and uncertain times. The update demonstrates some of the excellent achievements which have delivered a range of benefits for our patients and staff.

We also outline some of our commitments for the remainder of 21/22 in support of

our collaboration, and take the opportunity to consider how far we have come, and reflect on the work we must now undertake.

#### Appendices

##### 1. Slide deck

#### Risk and assurance

N/A

#### Financial Impact

N/A

#### Legal implications/regulatory requirements

N/A

#### Equality Impact Assessment

N/A

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

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# Six months of Dedicated to Excellence

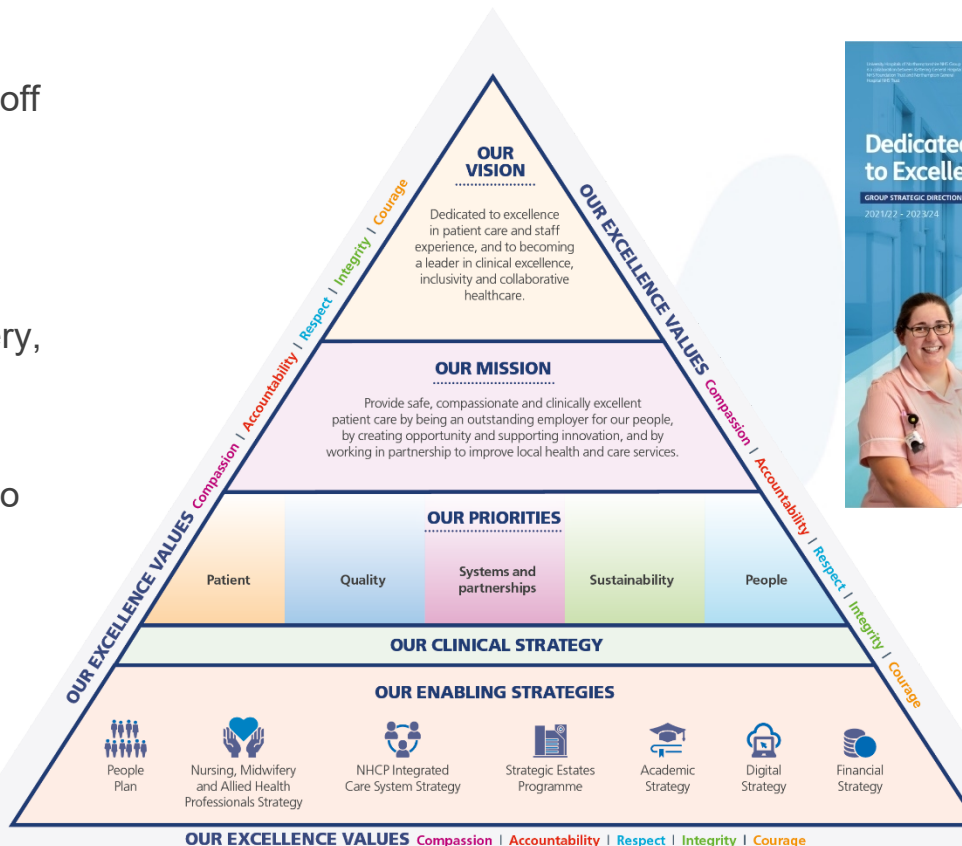
November 2021





# We developed our Dedicated to Excellence strategy

- ▶ Our Group Dedicated to Excellence strategy was developed and signed off at January 2021 Boards
- ▶ Our strategy outlined our vision and mission, our Group priorities, the strategic initiatives supporting delivery, and our Excellence values
- ▶ This paper outlines our first update to the Boards on delivery



# We achieved University Hospital status and launched the Group and the strategy in July



UNIVERSITY OF  
**LEICESTER**



University of  
Northampton



University Hospitals  
of Northamptonshire  
NHS Group



# We've been embedding our values through our Group briefings and values fortnights

- ▶ Our staff have made pledges about our five new values, with campaigns for each of our values on launch
- ▶ Each of our Group briefings now embeds and includes one of our values



**OUR EXCELLENCE VALUES** Compassion | Accountability | Respect | Integrity | Courage

# Our Group priorities and initial focus were outlined in our strategy

## Our Group priorities

### Patient

*Excellent patient experience shaped by the patient voice*

### Quality

*Outstanding quality healthcare underpinned by continuous, patient-centred improvement and innovation*

### Systems and partnerships

*Seamless, timely pathways for all people's health needs, together with our partners*

### Sustainability

*A resilient and creative university teaching hospital Group, embracing every opportunity to improve care*

### People

*An inclusive place to work where people are empowered to be the difference*

## Our 3-5 year goals and success measures

- Top 10% nationally in the inpatient and cancer surveys
- Positive feedback in local patient feedback and surveys

- 0 avoidable harm
- Standardised Hospital Mortality Index (SHMI) score that is best in peer group
- 100% of teams achieve MDT accreditation plus
- No unwarranted clinical variation

- All cancer patients treated in 62 days unless clinically inappropriate
- Exceed planned and emergency care standards
- Maximum 85% bed occupancy

- Double the number of patients who can participate in research trials
- Eliminate our carbon footprint by 2040
- No unwarranted financial variation

- Top 20% in national staff survey
- Improvement in diversity measures
- Positive feedback in staff pulse survey

## Our current Group focus

- To improve the clarity, consistency and compassion of our communications to our patients and families
- To involve our patients in all major change and collaboration programmes

- To reduce harm caused to our patients through delays in responding to deteriorating patients
- To reduce harm caused to our patients through medication errors
- To reduce the chance that our patients need to be readmitted
- To implement a Group nursing, ward and MDT accreditation system

- To treat all cancer patients within 62 days unless clinically inappropriate and minimise waiting times for planned surgeries
- To ensure the right type of care is available in the community so you only come into hospital if you need to, and if you need to come in, that your stay in hospital is as short as possible

- To reduce our spend on temporary staffing
- To reduce improve our carbon footprint by reducing the impact of our use of medical gasses and reducing food waste
- To increase the number of our patients who participate in research trials

- To improve the support for our staff from line managers, leaders and the Group
- To implement a People pulse survey to support the People priority





# Our Group priorities and transformation programmes to support them are beginning to deliver

Patient	Quality	Systems and partnerships	Sustainability	People
<ul style="list-style-type: none"> <li>Involving patients in shaping collaboration and transformation</li> <li>Improving feedback from patients on our communication with them</li> </ul>	<ul style="list-style-type: none"> <li>Reducing harm from medication errors</li> <li>Reducing harm for deteriorating patients</li> <li>Reducing chance of readmission</li> <li>Implementing accreditation as a quality measure</li> </ul>	<ul style="list-style-type: none"> <li>Achieving 62 day cancer performance</li> <li>Reducing waiting times for planned surgery</li> <li>Reducing the number of patients in hospital with no reason to reside</li> </ul>	<ul style="list-style-type: none"> <li>Reducing our spend on temporary staffing</li> <li>Improving our carbon footprint by reducing our food waste and use of medical gasses</li> <li>Increasing the number of our patients who participate in research trials</li> </ul>	<ul style="list-style-type: none"> <li>Improving the support for our staff from line managers, leaders and the Group</li> <li>Implementing People pulse as a measurement</li> </ul>

- ▶ The **Patient Engagement Model** has been co-developed with patients, to put patients at the heart of our collaboration and transformation programmes, which has been tested and developed through the ENT collaboration
- ▶ A **patient journal** has been developed with the Paediatrics teams, improving patient experience and providing greater ownership of care to patients

- ▶ **Electronic medicines management (EPMA)** has been fully rolled out in KGH, with NGH contract being awarded in Jan 22
- ▶ **Nursing and ward accreditation** approaches in both hospitals compared and identified areas to align both approach and methodology for data capture
- ▶ Implemented a **deteriorating patient task bundle** for all NGH patients with a high NEWS score, reducing time taken to complete the bundle from 22 hours to 9 hours (within the target of 12 hours)

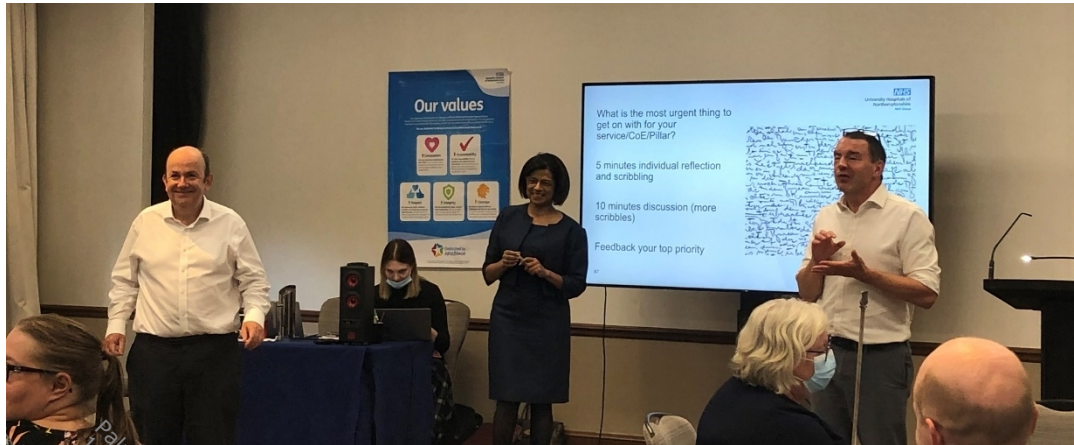
- ▶ Our **Integrated Care Across Northamptonshire (iCAN)** programme is accelerating in delivery, with a current focus on board rounds and discharge
- ▶ An **Outpatients transformation programme** is being developed across the Group, including transforming our digital outpatient solutions
- ▶ A **theatre performance programme** has been developed across the Group to improve theatre efficiency, focussing on late starts and effective booking

- ▶ **Temporary staffing** usage across the Group has been reviewed and a programme set out to address differences in pay rates, strengthen processes and ensure there are plans in place for areas that are hard to recruit to
- ▶ Through the research and innovation work, **increased opportunities for research trials** have led to an increase in the number of patients involved in trials

- ▶ The **People pulse survey** has been launched, with 1,600 staff members, around 17%, completing the survey. Embedding of the survey throughout the organisation is being rolled out.
- ▶ **Leadership visibility** and support from executives has been increased through Let's talk events and resuming walkabouts post-Covid
- ▶ **Health and wellbeing initiatives** have been renewed and regularly receive positive feedback from staff



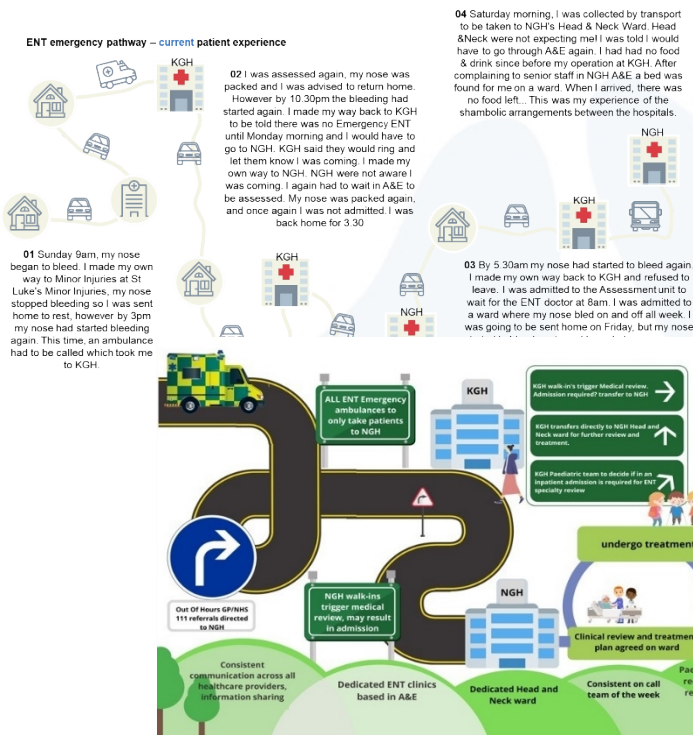
# Together we've been setting out our future clinical strategy



- ▶ Our clinical ambition has been developed together with our clinicians, with our first clinical conference held as a UHN Group
- ▶ We have set out our ambitions for the future of acute services in Northamptonshire with two centres of excellence, and four pillars
- ▶ Our ambition also outlines the enablers that will be required to deliver

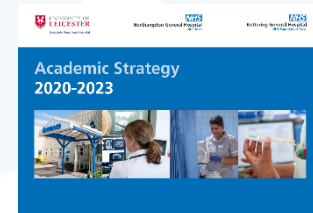
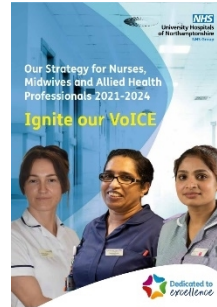
# Our clinical collaboration is redesigning our services to improve care for our patients

- ▶ Our first wave clinical specialties of ENT, breast and cardiology have been working closely together to develop shared services
- ▶ The re-design of ENT services has been inspired by Bernadette's story and that of other patients using our services
- ▶ The new ENT model went live in July, moving emergency weekend services to NGH
- ▶ Lessons learned from the experience of ENT have been shared with clinical leaders to inform future collaboration



# We've developed our enabling strategies to support us to achieve our ambitions

- ▶ Our Group People plan sets out seven pledges to our staff
- ▶ Ignite our VoICE sets out five priorities for our nurses, midwives and AHPs
- ▶ Our Group Digital strategy sets out eight themes to support becoming the most digital hospital Group
- ▶ Our Academic strategy outlines eight priorities to improve care through excellence in research and innovation



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# Each of our strategies have begun delivering exciting improvements for our Group

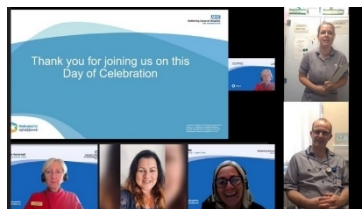
## People

- ▶ Launched our UHN People Pulse survey, receiving over 1,600 responses in September, hearing from our staff what matters to them
- ▶ Equality, diversity and inclusion work recognised nationally
- ▶ Volunteering service managed across the Group, more than doubling the number of active volunteers



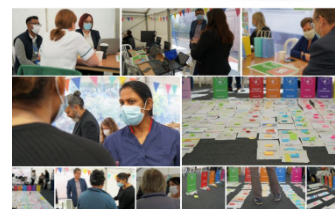
## Nursing, Midwifery and AHPs

- ▶ Ignite our VoICE strategy developed through strong engagement with staff
- ▶ Launch day celebrated our nursing and midwifery achievements
- ▶ Shared Decision Making Councils presentations and posters shared best practice in NGH and planned to be expanded to KGH



## Digital

- ▶ All of our staff are now on NHS.net accounts, allowing Teams and calendar sharing across the Group
- ▶ Northamptonshire shared care record to go live with GP data in Nov 21, NGH & NHFT data in Jan 22, KGH data in Mar 22
- ▶ NGH EPR programme launched
- ▶ 'Paper picnics' held to identify priorities for digitisation



## Academic

- ▶ Achieved University Hospitals status through our partnership with University of Northampton and University of Leicester
- ▶ Recruitment underway to 9 new UHN research posts
- ▶ Bid submitted for a joint NIHR Clinical Research Facility



# With our strategic direction set, we've laid the foundations for delivery

## Leadership

- ▶ We have made a number of joint appointments to strengthen and drive Group working
- ▶ Mrinal Supriya (ENT), Salam Musa (Breast Surgery) and Dave Sharman (Cardiology) take on Group Clinical lead roles for our first wave collaboration specialties
- ▶ Heidi Smoult joins us as Hospital Chief Executive for NGH
- ▶ Jon Evans joins us as Group Chief Financial Officer
- ▶ Theresa La Thangue joins us as Group Communications and Engagement Director
- ▶ Becky Taylor joins us as Group Transformation and Quality Improvement Director
- ▶ Karen Spellman, Polly Grimmett and Stuart Finn have moved to Group roles for Integration and Partnerships, StrategiStrategy and Operational Estates, respectively

## Measurement, reporting and monitoring

- ▶ We are strengthening our measurement and reporting on delivery
- ▶ The Group IGR metrics have been reviewed and aligned with the Group priority metrics and measurements to improve tracking of delivery and embed within the Group
- ▶ Our Group Health Intelligence function is rolling out a series of key dashboards using Power BI built from a common cloud platform, which will be available to all leaders across the organisation from January 22
- ▶ Project management software is being procured across the Group to provide oversight and a single place for reporting on all strategies and transformation programmes

## Transformation and Quality Improvement

- ▶ We are transitioning to a shared and consistent approach across the Group for transformation and quality improvement
- ▶ All transformation programmes are now programmes operating across the Group
- ▶ A Group approach to efficiencies is being developed for 22/23
- ▶ Transformation and efficiencies governance has been aligned to the Group priorities and transformation programmes to increase oversight and assurance of delivery
- ▶ Transformational plans for divisions will be consolidated, providing a single plan per specialty covering all projects within a division

# Our next six months will be about accelerating delivery and ensuring we are making an impact

Patient	Quality	Systems and partnerships	Sustainability	People
<ul style="list-style-type: none"> <li>Developing <b>communications training</b> for our staff in collaboration with our patients, and building this into mandatory training</li> <li>Implementing a <b>Patient feedback pulse survey</b> so that in both hospitals we are able to get feedback from our patients in real-time</li> <li><b>Patient engagement</b> with all transformation programmes and with our clinical strategy ambitions</li> </ul>	<ul style="list-style-type: none"> <li>Implementing a <b>shared ward and nursing accreditation scheme</b> so all wards in KGH and NGH have a common approach</li> <li>Designing a <b>consistent approach to pro-actively improving quality</b> across the Group based on proactive identification of risks through data</li> <li>Implement shared learning from NGH on <b>managing deteriorating patients</b> in KGH so there is a common patient task list bundle across both hospitals</li> </ul>	<ul style="list-style-type: none"> <li>Focus on <b>iCAN programme</b>, embedding improved board rounds on all wards, implementing a new discharge process and establishing our frailty hubs, collectively meaning 144 more patients are treated at home rather than hospital, and freeing up 48 acute beds</li> <li>Accelerating our <b>Outpatients transformation programme</b>, implementing an end-to-end digital platform and trialling in pilot specialities</li> <li>Making a step-change in booking effectiveness for <b>theatres</b> and reducing late starts, increasing our theatres utilisation by 5%</li> </ul>	<ul style="list-style-type: none"> <li>Implementation of key changes to the <b>temporary staffing</b> process to improve oversight and align pay, and targeted work to reduce our reliance on agency in areas that are hard to recruit, saving £1m</li> <li>Development and mobilisation of a <b>Group efficiencies plan</b> for 22/23</li> <li>Implementation of a <b>digital ordering system</b> for patients' food</li> </ul>	<ul style="list-style-type: none"> <li><b>Making it easier to work across the Group</b>, aligning policies to enable ease of collaboration for teams working cross-Hospital</li> <li><b>Embedding the People pulse survey</b> throughout the organisation, with divisions and services having visibility of their own results and taking local action</li> <li><b>Embedding the Group values within appraisals</b> and people processes</li> </ul>

## Reporting and monitoring

- Metrics** associated with Group priorities and delivery against **programme plans** for transformation programmes will be monitored through a **strengthened governance** framework overseeing the Group priority and transformation programme

# Our commitments to our patients and staff in the next six months

## For our patients:

- ▶ **Patients will be engaged** with all our collaboration and transformation programmes
- ▶ Our patients will be able to **order food digitally** when they are staying with us
- ▶ When arranging and attending an **outpatient** appointment, patients will have access to a **digital platform** to book their own appointments
- ▶ When patients stay with us, we will be **clear about what will happen when they are discharged** and we will **support people to get home quicker**
- ▶ When our most frail patients arrive at A&E, there will be a **dedicated hub to support patients** and help get them home rather than being admitted
- ▶ **Patient care records** will be available for clinicians to view your record when you need to visit us, no matter which organisation in Northamptonshire you have been seen in

## For our people:

- ▶ All our staff able to work across both hospitals, including:
  - ▶ A **joint car parking system** with automatic numberplate recognition allowing staff to work across both hospitals
  - ▶ **Single swipe access cards** that work across both hospitals
  - ▶ **Ability to easily collaborate** on files and on Teams using Office 365
  - ▶ **Aligned HR policies** so processes are the same in both hospitals
- ▶ **Our values will become a core part of our HR processes**, including our development and appraisal process
- ▶ **Feedback from our staff** will be discussed in all performance meetings, so that we can take quick action on the things that matter most
- ▶ **Aligned pay** across the Group

# Our reflections as joint chairs of CPC

## What has gone well?

- ▶ The achievement of University Hospitals status is a major landmark for our Group
- ▶ Making collaboration a reality between the two hospitals and beginning to change the mindset to working collectively together to make things better
- ▶ There is good and accelerating progress on our enabling strategies of people, digital and estates to make some practical changes to make things better for our staff and patients on a day-to-day basis
- ▶ Agreeing the first whole system transformation programme with our partners on iCAN

## What could we reflect on for the next six months?

- ▶ How do we go further, faster and be prepared to take some risks to increase the pace of change?
- ▶ How do we culturally start to feel more comfortable with change?
- ▶ We now have an opportunity to accelerate the Outpatients programme through procurement of a digital solution, which we need to grasp and ensure we can move at pace

## Cover sheet

Meeting	Public Trust Board
Date	25 November 2021
Agenda item	3.2

Title	Group Clinical Ambitions: Towards our Clinical Strategy
Presenter	Medical Director and Director of Strategy
Author	Director of Strategy

This paper is for			
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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

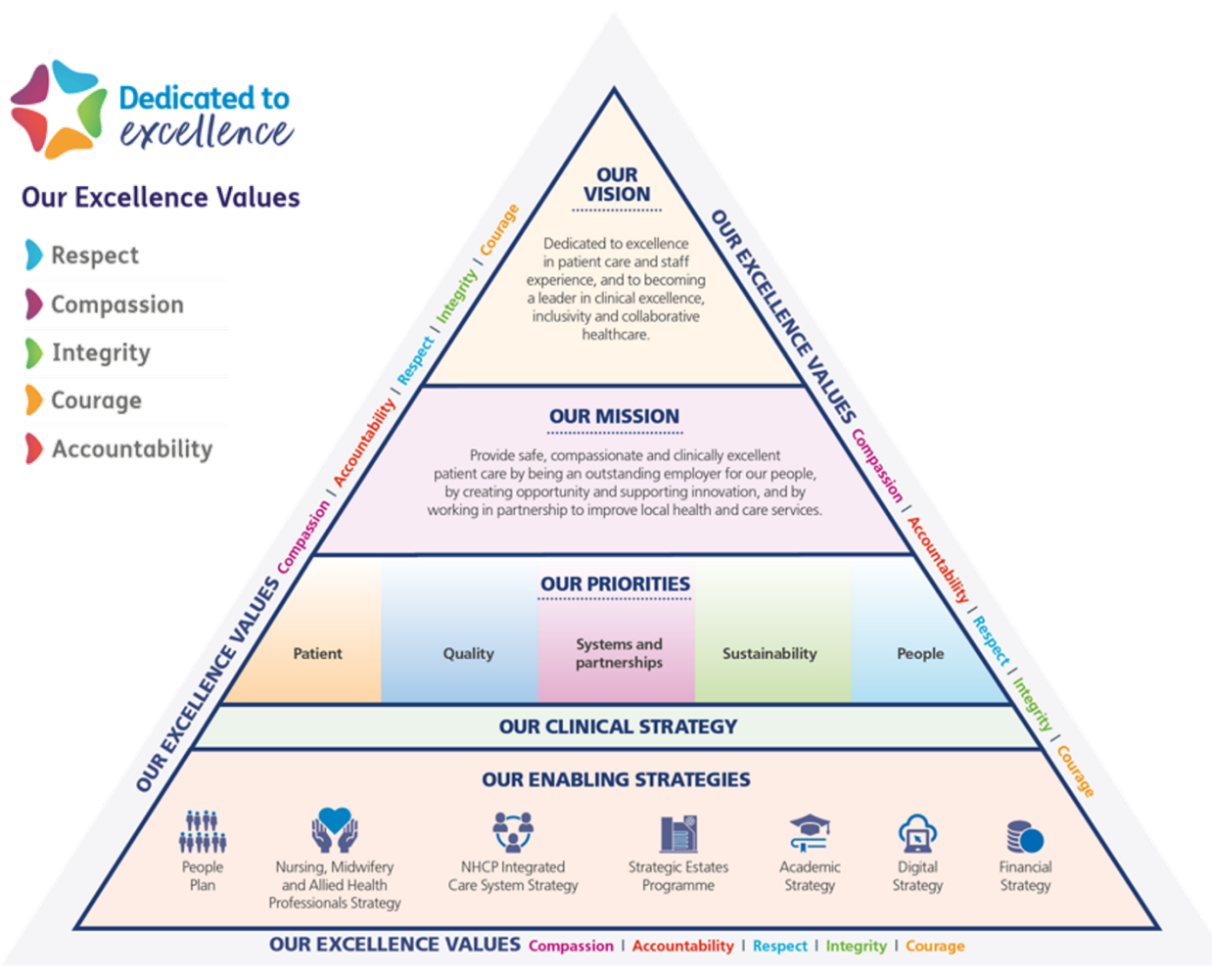
Group priority				
<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Quality	<input type="checkbox"/> Systems & Partnerships	<input checked="" type="checkbox"/> Sustainability	<input type="checkbox"/> People
Excellent patient experience shaped by the patient voice	Outstanding quality 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 receive the recommendations of the senior clinical teams on the priority areas of focus to deliver improved patient outcomes and sustainable clinical services.	Collaboration programme Committee

Executive Summary
<p><b>Situation</b></p> <p>In 2021 Kettering and Northampton Hospitals came together as University Hospitals of Northamptonshire, and agreed a group management structure with a shared Chairman, Chief Executive and various other executive posts. We have agreed five key priorities for our Group, and have already approved a number of enabling strategies to help us deliver against those priorities.</p>



Our group *dedicated to excellence* strategy sets out our values, vision, mission and group priorities – this identified a group clinical strategy as a key strategic initiative



The principle strategy and purpose, is to agree how we will work across the group and with our system partners, to respond to some of the challenges we face in delivering excellence in clinical care for our patients now and in the future.

This paper sets out the key things we think we need to do to deliver this ambition. We are eager to engage with our patients, local public and system partners on our ideas and ambitions, in order that we can further refine them and agree an acute hospital Clinical Strategy for Northamptonshire that we can start to implement in early 2022.

## Background

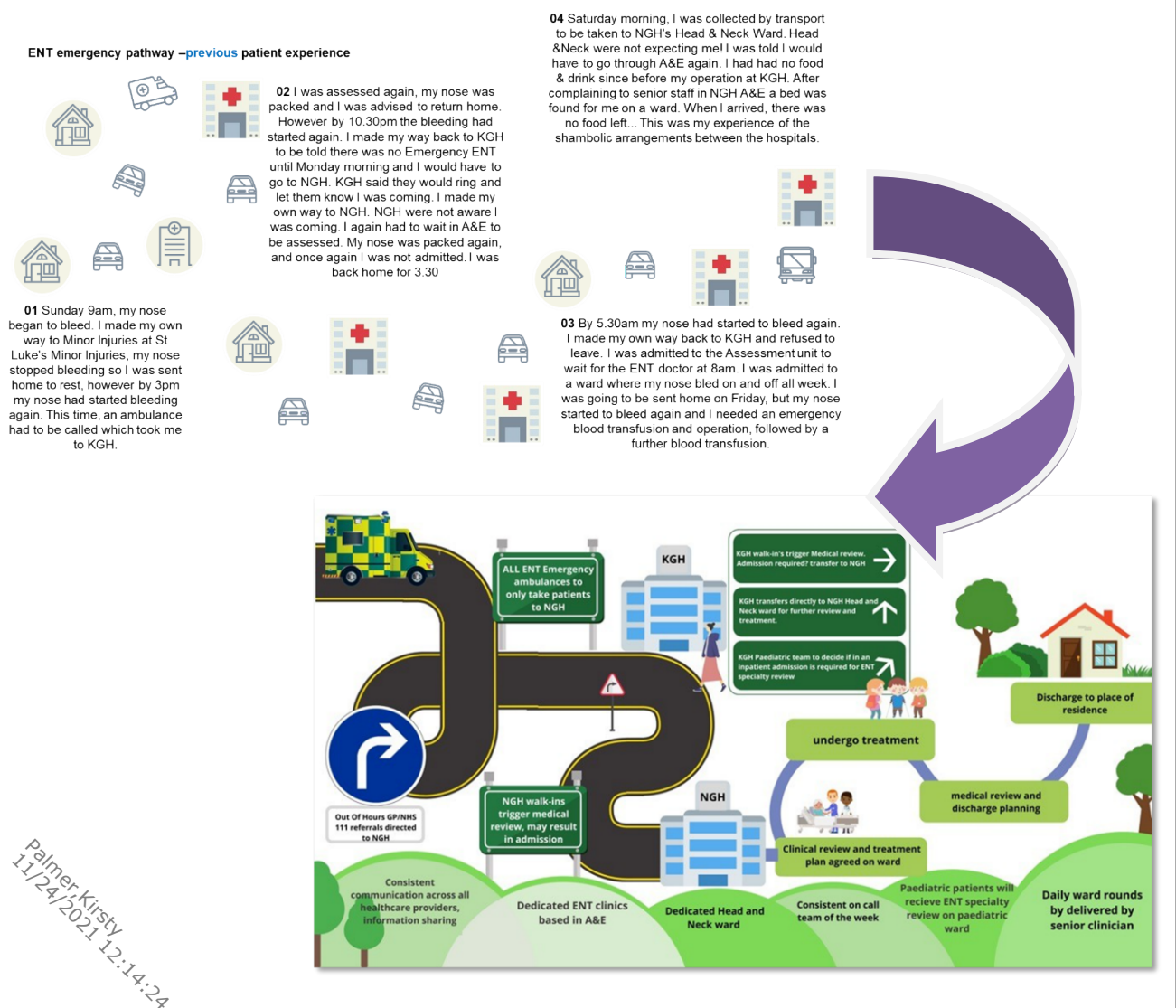
Many of our clinical teams have been working together across the organisations for some time to deliver care to patients; stroke, vascular, heart attack and some on-call out of hours arrangements are all provided singularly across our hospitals.

The opportunity of coming together more formally as a group however, provides the opportunity to dramatically improve the care we are providing for all our patients, deliver

innovative services with our local health and care partners, and establish excellent places to work for our staff.

Our senior clinical teams from across the Group, have been working together throughout 2021 to establish how we might capitalise on this opportunity, and this document sets some key initial areas where they all agree we can build on some of the strengths we already have in the group and expand them across the two hospitals, tackle some of the key challenges we have now, and prepare ourselves for the needs of our population in the future. This however is just the start of our clinical journey across the Group. Our teams will be continuing to work together and with our system partners, to expand the ambitions and detail and to agree for every clinical area a future strategy that delivers sustainable robust excellence in clinical services.

As an example of how working together can improve the care and experience our patients receive, our initial collaboration in ENT has led to the implementation of a new model of emergency care, that has eliminated the poor patient experience arising from a disjointed pathway with multiple handovers, and has created a single team approach with shared governance and treatment protocols. Patient experience and patient outcomes have improved as a result.





## Assessment

We have a number of challenges in how we are delivering acute hospital care now, and in how we need to deliver it to meet the future needs of our patients. For example, we know:

- That some of our clinical services vary across our hospitals, and not all patients are getting the same access to the same high quality services.
- Some of our patients are having to wait too long for diagnosis and treatment, and that some of these waiting times are inequitable across the county and do not meet the needs of some of our more vulnerable local populations.
- That in some services we struggle to recruit and retain the right levels of highly specialised staff, and that there are national shortages of many of these staff.

We also know

- Our local population is set to grow faster than the national average
- That some of our population live in areas with lower than national average life expectancy, and have poor health outcomes
- That we need to recover health services back to pre-pandemic levels, but build on the innovative ways of working that were developed as a response to the pandemic.

To respond to these challenges, we are setting out our initial priority areas for focus as:

1. Developing **two centres of excellence** in the county, with cardiology being based in Kettering General Hospital and cancer in Northampton General Hospital, but with consistent access to these by all patients in the county.

Both services will continue to be delivered across the two hospital sites, with care delivered close to patients homes as clinically appropriate, but with a co-location of specialist services where this can be shown to drive up clinical quality, patient safety and patient experience. The centres of excellence will be national exemplars, delivering best practice clinical care, an increase in research and trials that we can offer patients and be attractive places to come and work.

2. We want to **protect elective beds** to reduce cancelled operations, reduce long waiting times and increase efficiency.

Whilst in Northamptonshire we offer some of the lowest waiting times nationally, for patients waiting for planned treatment, we are committed to reducing this further as some patients still wait too long for diagnosis and treatment. By protecting elective capacity, we will eliminate cancelled operations that result from emergency pressures and we will have the ability to co-locate our specialist surgeons and theatre staff to work together in an efficient and supportive environment.

3. We will work alongside and with all our **health and care partners**, to deliver seamless pathways.

Many of our patients experience disjointed pathways of care when they move between primary, community and hospital services. We are committed to working with our partners to deliver care and services as close to patients homes as possible without

needing a hospital visit, but when specialist hospital services are required then this should be a smooth transition with the patient at the centre of the care provided. We have agreed with our system partners that we will work with them on four priority areas; Frailty, Mental Health, Childrens and Young People and Elective Care. With these and every clinical area however we are committed to working with partners to put the patient journey at the centre of all we do.

4. We want to address specialties that are currently **unsustainable and fragile** at one or both of our hospitals, to develop more robust services that we can reliably offer patients.

We have identified a small number of services that have a small workforce and are finding it difficult to recruit additional specialist staff due to the volume or complexity or workload, or due to national shortages of these specialist staff. This makes the service unreliable for our patients and unsatisfactory for training and developing our staff. We will be working across our group and with other local hospitals to develop solutions for these in order that we can ensure our patients can reliably get high quality services and outcome.

Whilst these areas represent where we think our first areas of clinical priority are across the Group, we will not stop on our work. Our clinical teams are continuing to work together on expanding the clinical collaboration and setting our further ambitions for how we think we can improve the care and experience our patients receive, and develop excellent places to work. Our journey to excellence will continue to be refined and developed throughout 2022.

We are eager to engage with our patients, local public and system partners on our priority ideas and ambitions as set out in this document , in order that we can further refine them and agree an acute hospital Clinical Strategy for Northamptonshire that we can start to implement in early 2022.

A comprehensive engagement programme will be created, under the Government's OASIS communications framework. The programme will begin with a thorough stakeholder mapping exercise to ensure all relevant partners and stakeholders are captured appropriately, before developing a detailed communications and engagement programme to ensure all audience groups are communicated to in a timely manner and effective engagement is enabled.

## Recommendation

That NorthamptonTrust Board of Directors approves the group to begin a conversation with our local patients, stakeholders and wider staff groups, on the ambitions and priority areas identified by our senior clinical teams and set out in this document.

## Appendices

Working Towards a Group Clinical Strategy: Our Clinical Ambitions

## Risk and assurance

The risk of not delivering clinical sustainability are detailed in the Board Assurance Framework.

#### Financial Impact

None as a direct result of this approval. Investment decisions and strategies to build sustainability will be subject to separate financial due diligence processes once

#### Legal implications/regulatory requirements

None identified

#### Equality Impact Assessment

None as a direct result of this approval; this documents sets out how we intend to improve equality of access to high quality services across the county. A full equality impact assessment will be undertaken as part of any service change.

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# Paper

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

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

**Notes:**

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

Delete guidance notes

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# Working Towards a Group Clinical Strategy: Our Clinical Ambitions

November 2021





# Foreword

Our two organisations – Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust – are committed to providing safe, compassionate and clinically-excellent care for local people in Northamptonshire. For our workforce, we strive to offer a supportive culture that empowers teams to learn, develop and innovate in partnership with the wider system.

We face, however, a range of challenges in delivering this commitment, from difficulties in our ability to recruit some specialist staff, to a population growing and ageing above the national average. We recognise that in order to deliver our ambition and respond to the challenges we have, we need close collaboration between our two organisations. Working as a Group, we have far greater opportunity to realise benefits for our patients and staff than we could as separate hospital Trusts. By integrating our clinical services to share staff, skills and resources we are well placed to respond to ever increasing service demand. We believe that collaboration, between us and our other local healthcare partners will be an opportunity to improve the quality of our services and reduce variation across our hospitals, whilst finding sustainable ways to manage and tackle staffing shortages. This will mean we can provide local people with the rapid access to the high quality, specialist care that they require, and that our staff are proud to deliver.

This document sets out our ambitions for our clinical services, the clinical rationale underpinning our proposed changes, and how we would propose to implement these changes. It describes our proposals to build on our existing collaborations to establish clinical centres of excellence in the county, protect elective capacity so our patients do not experience cancelled operations and longer waiting times, and become a hub for research and innovation. All our clinical services across the two organisations would collaborate to share expertise and best practice. All of our clinical services would move towards a single team operating, in the main, across both hospital sites. We will of course continue to deliver local services such as the Emergency Departments and consultant-led maternity services on both hospital sites. Where clinically appropriate, some of our services would be delivered in community settings away from the main hospitals, taking care closer to home and integrating with relevant community and primary care services. For some highly specialist care, where it delivers proven better outcomes for patients, such as heart attacks and specialist cancer surgery, we propose delivering these services on just one of our hospital sites.

Our ambitions and plans have arisen from a engagement with a wide range of our senior clinical leads. We realise however, we are at the beginning of our clinical collaboration journey. Following publication of this document, we will therefore engage widely with local communities, our staff and our health and care partners to gather feedback on our proposals before we publish our full clinical strategy and implementation plan in April 2022. Thank you for taking the time to read this clinical ambitions document and we look forward to further developing our proposals with you.

**Mr Matthew Metcalfe, Medical Director, Northampton General Hospital NHS Trust**  
**Dr Rabia Imtiaz, Acting Medical Director, Kettering General Hospital NHS Foundation Trust**



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<b>2</b>	<b>Our case for change</b>	<b>24</b>
<b>3</b>	<b>Our proposals for transformation</b>	<b>35</b>
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<b>5</b>	<b>Roadmap to implementation</b>	<b>60</b>
<b>6</b>	<b>Next steps</b>	<b>62</b>

**Appendices**

- 1 Centre of Excellence: cancer (detailed proposals)*
- 2 Centre of Excellence: cardiology (detailed proposals)*
- 3 Protecting our elective pathway(detailed proposals)*
- 4 Emergency and integrated acre across Northamptonshire(detailed proposals)*
- 5 Women and children’s services(detailed proposals)*
- 6 Diagnostics (detailed proposals)*

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# Executive summary



# Our Group and our case for change

## Our Group

Our Group is made up of two hospital Trusts in Kettering and Northampton. We provide acute services principally for the population of Northamptonshire, and some specialist services for a wider population. We are part of the Northamptonshire Integrated Care System (ICS) where we collaborate with health and care partners to prevent ill-health and deliver more integrated services for patients.

We are already successfully collaborating across our hospital sites in many clinical areas and are proud of our recent successes improving clinical quality and patient care. We have also recently become an academic university hospital group and want to build our academic and research reputation whilst taking the opportunity to re-build our hospitals to support the delivery of high-quality services as part of the National Hospital Programme.

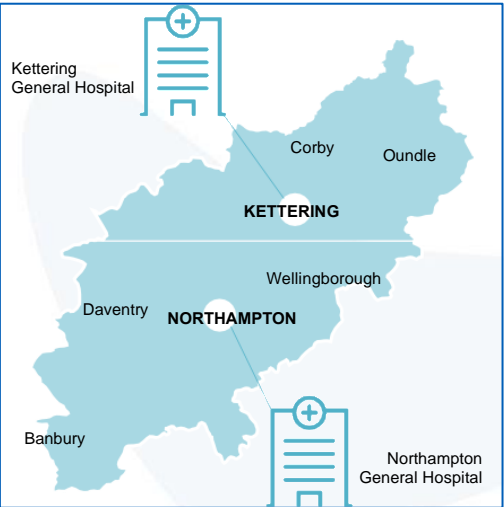
## Our case for change

Our local population is older than, and growing faster than, the national average so the demand for good quality care and support will increase over the coming years. Some of our local populations have significantly poorer health outcomes and life expectancy than the national average, and many of these people do not get the access to the care they need in a timely way. In some instances, and with some conditions, people are being admitted to hospital when, with the right services, these patients could be managed in their homes and communities without the need for a hospital stay. Some patients are also staying longer in hospital than is medically necessary.

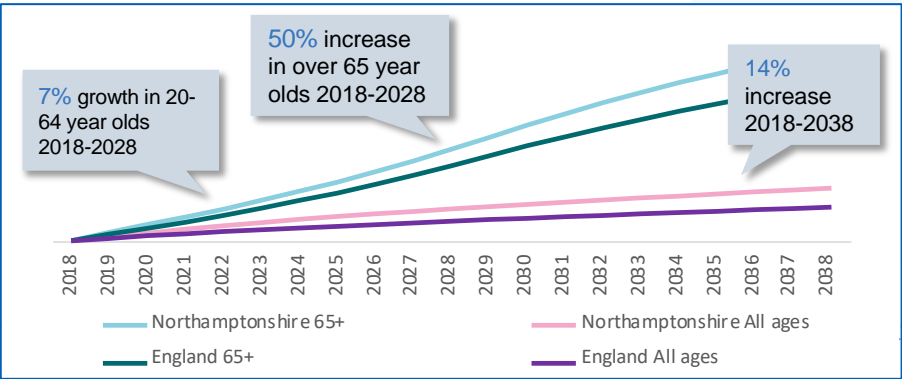
It is essential that in all clinical specialties we work well with our health and care partners and our local communities, to address these issues and tackle health inequalities, ensuring everyone has the same level of access to facilities and are supported to live well. Where patients do require hospital care then the pathways and communication between system partners should be seamless and transparent for those patients.



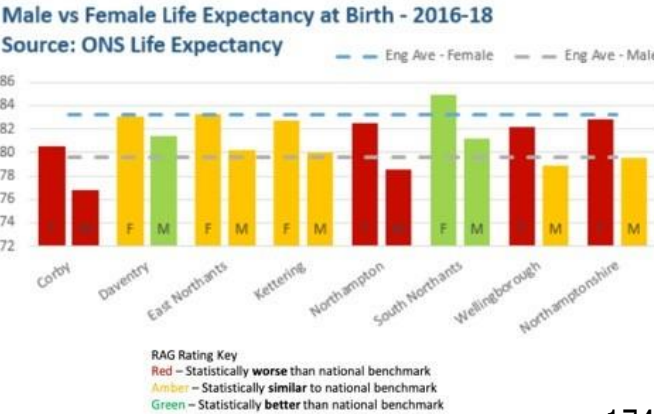
## Our local area



## Our population is growing and ageing faster than the national average



## Life expectancy is lower than the national average in most areas of Northamptonshire



# Our case for change (continued)

## Our case for change

We have more to do across our Group to consistently deliver clinical best practice and meet national quality guidelines, with some of our services “requiring improvement” or in lower quartile performance when compared to national benchmarks. There is also inequity in access to services and quality between our two hospitals, with some patients waiting significantly longer to access care simply because of where they live.

In line with other NHS Trusts, we find it difficult to retain and recruit clinical staff to some specialties and there is a national shortage of staff in some areas. Workforce shortages drive a reliance on bank/agency staff which impacts on the quality and cost of our services. Some of our services are fragile, with few consultants and low volumes in some specialties, which leads to an unsustainable service delivery for our patients.

We know that we need to change the way we deliver services to improve quality and efficiency. Our financial position, and that of the wider NHS, is under pressure but we know we also need to invest in transformation of services to meet the needs of the future. We also need to tackle pressures on elective waiting lists across the local area, driven by the COVID pandemic.

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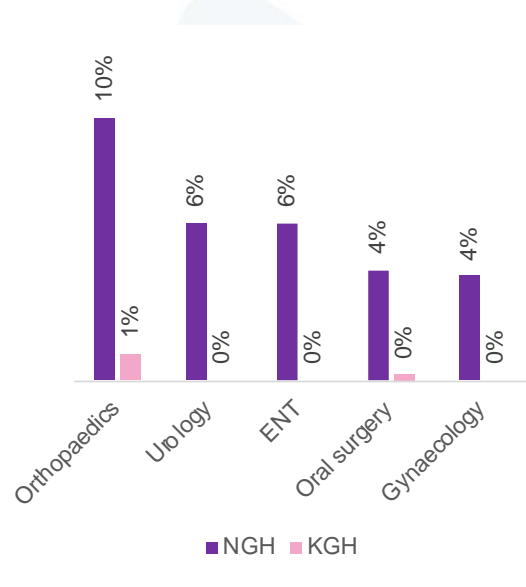


University Hospitals of  
Northamptonshire

NHS Group

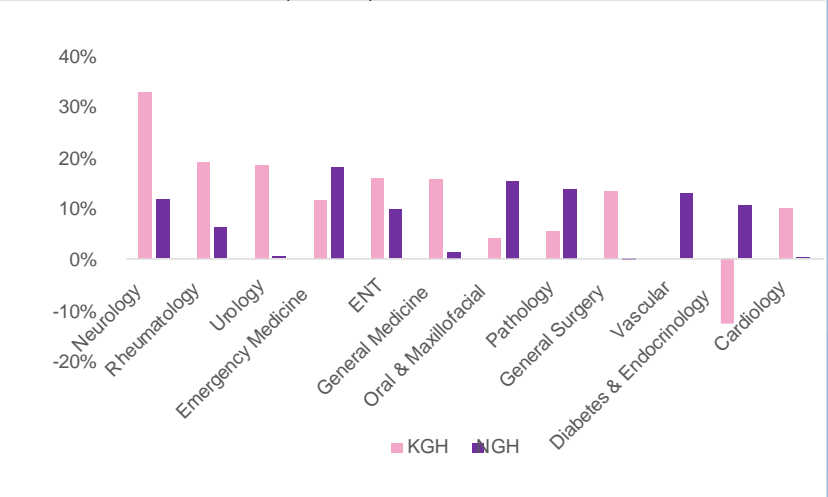
For some specialties there are significant difference in % of patients waiting over 52 weeks for planned care

RTT 52 week wait against national target of 0% for specialties with > 4%point difference  
NHS England, RTT Waiting Times (Mar 2021)



## Our organisations are struggling to attract and retain clinical staff with significant vacancy rates

Vacancy Rates by specialty for March 2021  
KGH & NGH Human Resources (Mar 2021)



## Both our organisations are rated by the CQC as ‘requires improvement’

### CQC Ratings

KGH 2020, NGH 2019

	KGH	NGH
Overall	Requires Improvement	Requires Improvement
Safe	Requires Improvement	Requires Improvement
Effective	Requires Improvement	Good
Caring	Good	Good
Responsive	Requires Improvement	Good
Well-led	Good	Requires Improvement

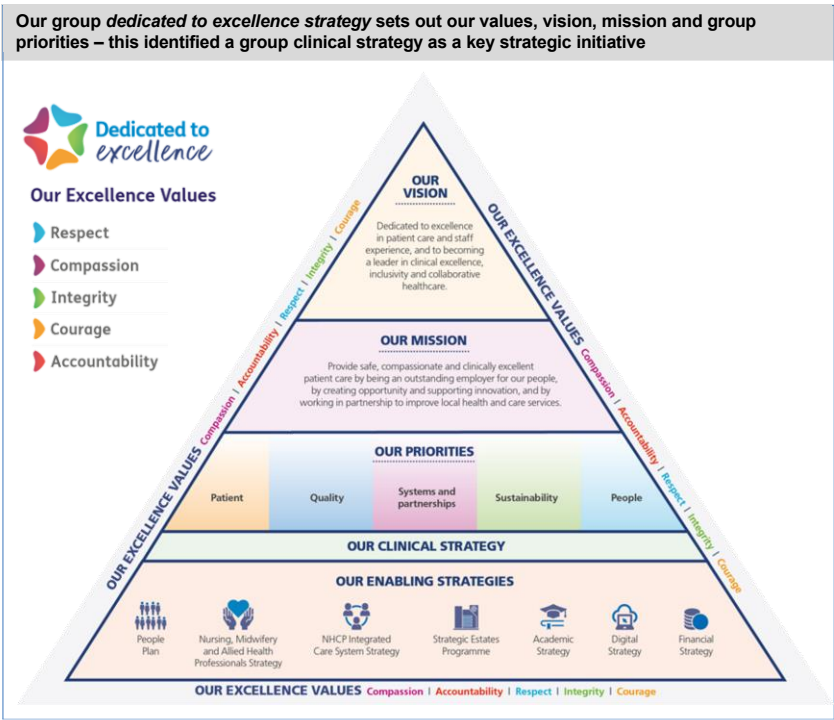
# Our proposals for transformation

## Our proposals for transformation

In 2021 we developed an overall Group strategy which has guided the development of this Group document: ‘*Our clinical ambitions*’. Developing this document involved many of our senior clinical teams across the Group throughout the summer of 2021. Our proposals for transforming care set out in detail the thoughts of our senior clinical staff on what we need to do to tackle the challenges we have set out in the ‘case for change’ as well as working towards providing outstanding care for our patients. In all cases this involves improved collaboration across the two hospitals and with our community partners to strengthen services, improve care for patients and improve opportunities for staff. We are enthusiastic to share our proposals with patients and our local partners, to hear what they think about our plans and build upon this feedback to further strengthen our ambitions.

We recognise that we are on a journey to excellence. This document sets out what we see as some of our priority areas to strengthen and improve, as they reflect some of the key areas where our local population will require care and treatment over the coming years. Clinical collaboration across the Group and the system however will continue wider than just these areas, and we will engage with partners and wider stakeholders to develop thinking on improving services for patients and our staff in a range of other services over the coming months.

### Our Group strategy



### What the Group vision means for the clinical strategy

- The Group will be **known for safe, compassionate and clinically excellent care**: working in partnership as a **system leader** of integrated acute care and a **hub for innovation and research**.
- Integrated services will deliver **consistently exemplar outcomes** for our patients across Northamptonshire, providing timely, seamless care, **minimising disruption to our patients' lives**. Patients will only come in when they need specialist acute services.
- Our staff across the Group will work collaboratively together, and with system partners, to deliver **cutting edge treatments** and produce **high quality research** - enabling the Group to become an outstanding employer able attract and retain leading experts.
- Patients and staff across the county are **proud of their local NHS**.

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# Our proposals for transformation (continued)

We have identified four core ambitions where we would like to initially focus. For these four areas we have developed clinical ambitions that we believe would address the challenges specific to these areas, transform and improve care for patients and provide attractive places for staff to come and work. The four core ambitions are:

1. Work with our partners to **prevent ill-health and reduce hospitalisation**, changing the way care is provided along the care pathway
2. Propose developing **two centres of excellence** in the county, building on our established strengths in each hospital, with cardiology being based in Kettering General Hospital and cancer in Northampton General Hospital, but with consistent access to these services by all patients in the county.
3. **Protect elective beds** to reduce cancelled operations, reduce long waiting times and increase efficiency.
4. Propose **building on our University Hospital status**, becoming a hub for innovation and research, attracting high calibre talent and growing the number of clinical trials our patients can access.

To deliver our ambitions, we will explore options for the specialties that are currently **unsustainable and fragile** at one or both of our hospitals, to develop more robust services that we can reliably offer patients.

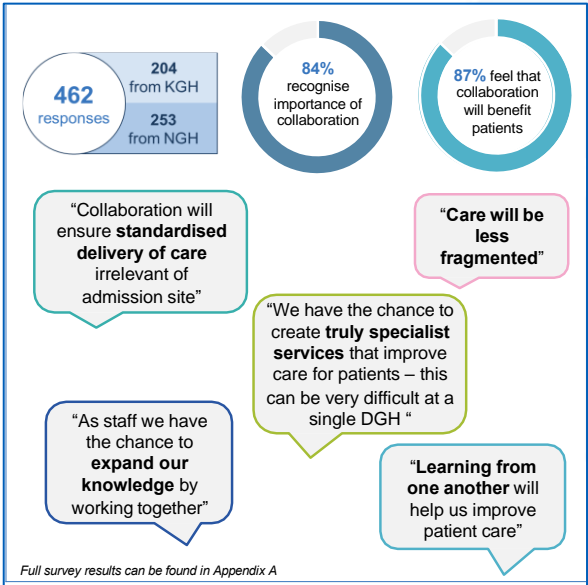
We know we cannot make these all of changes as individual hospitals and we will need to work together and with our system partners to agree and implement our proposals. This will be the beginning of our journey to clinical excellence.



## Our clinical ambitions



## Staff survey results (2021) demonstrate support for collaboration



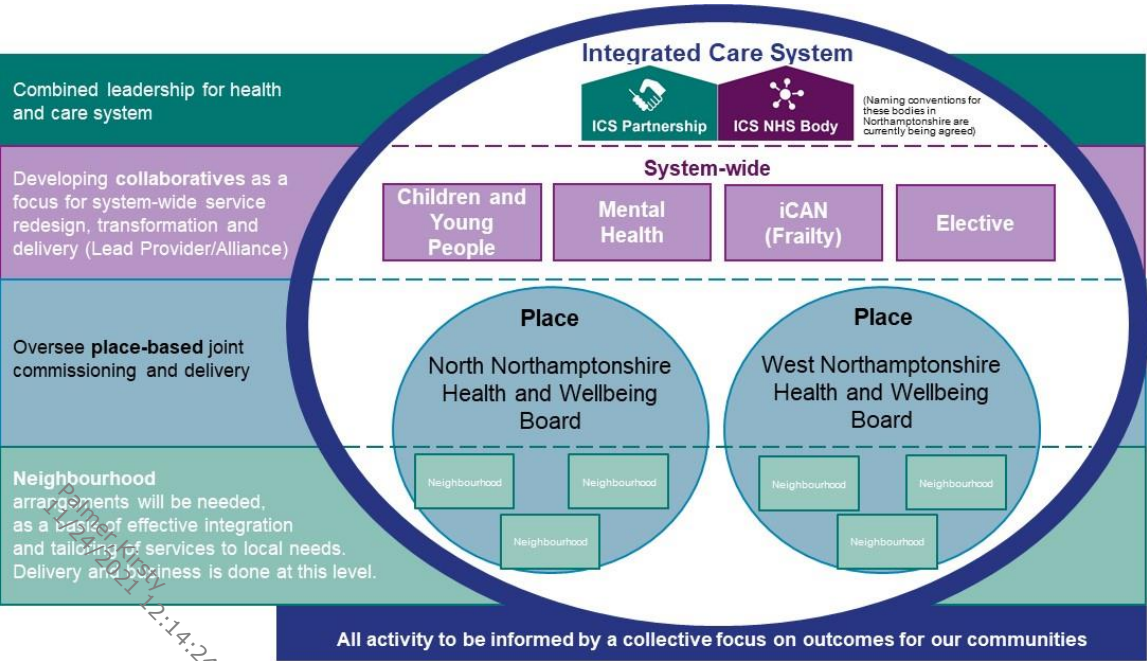


# We are working with health and care partners to change the way care is delivered along the care pathway

## Our transformation priorities

Transformation in our ICS will initially be formed around delivering our four priority collaboratives; Children & Young People, Mental Health, Integrated Care Across Northamptonshire (iCAN, covering frailty) and Elective Care. We will come together with local organisations and providers to join up and redesign service to improve outcomes. We will take a whole pathway approach to transformation working across organisations and services.

Key will be designing and delivering services to meet the needs of our communities at place and neighbourhood level. The aim is to deliver integrated care locally connecting primary care, broader health and care services, including the voluntary sector in local areas with more care delivered out of hospital.



## Elective collaborative

We will work collaboratively with our system partners to develop integrated pathways that support the transformation and delivery of greater out of hospital care. Patients will access the right clinician in the right place. This will include, for example, community integrated diagnostic hubs, transformed outpatient services and a system patient list to manage our capacity.

## Mental health, learning disability and autism

The Mental Health, Learning Disability and Autism Collaborative ('MHLDA') goal is to reduce health inequality, improve social impacts and enabling this population to embrace their chosen life in the community, as an equal contributor to our County. Across the Group will work with partners to ensure we support the development of integrated seamless pathways so that people who attend acute hospitals and emergency departments with mental health, learning disability or autism are treated rapidly and receive the aftercare required.

## Children and young people

We will develop our out of hospital integrated children's service to support our children, young people and their families to provide the best quality service that will be integrated, holistic, offer choice and enable shared decision-making.

## iCAN

The focus will be on improving outcomes for older people in Northamptonshire through alternatives in the community to the Emergency Department and by reducing admissions and length of stay in hospital. We will do this through a community hub model where services are integrated around local communities to help people remain well for longer and provide better self-care support.

In the Group, we will develop our frailty units to provide seamless pathways across the community hubs to provide frailty assessment units and prevent hospital admissions and facilitate discharges.

# We have an ambition to establish a cancer Centre of Excellence for Northamptonshire

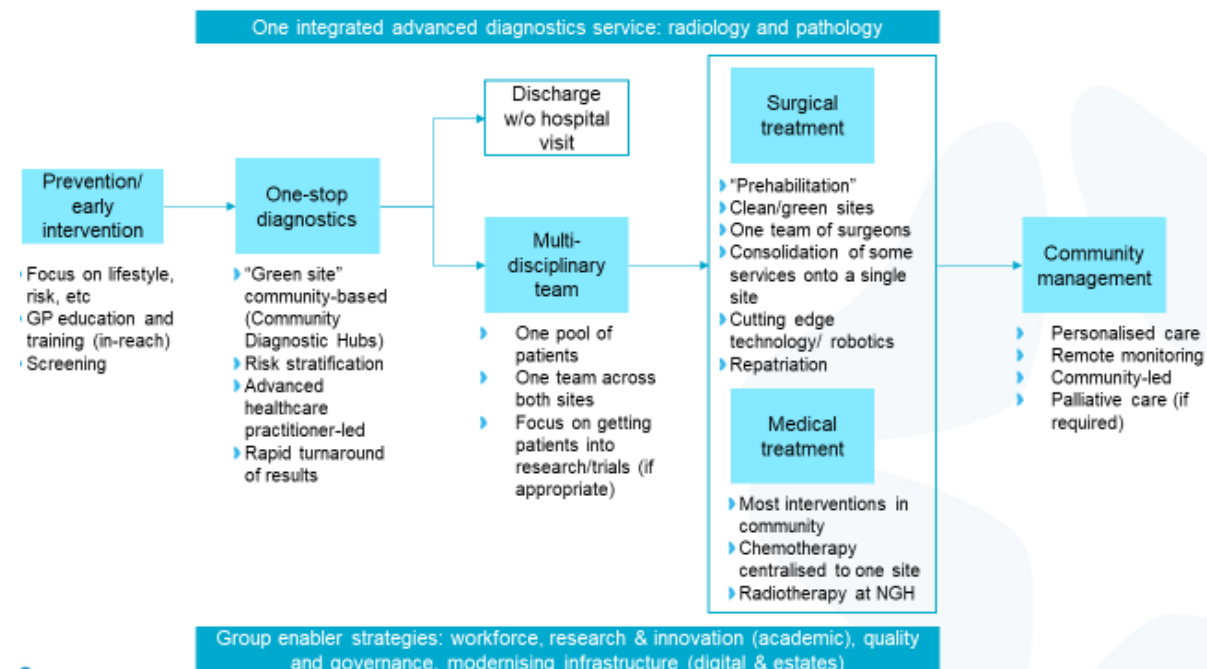
## Our ambition for a cancer Centre of Excellence

The cancer Centre of Excellence would be an **integrated service** that the Group is known for nationally, owing to **excellent outcomes and patient experience, complexity of caseload and extensive research output.**

The Centre of Excellence would **attract and retain leading experts**, offering **outstanding career and development opportunities** and providing a sustainable service that supports growth and innovation.

The Group would collaborate with system partners to explore new ways of working to increase the **accessibility and early diagnosis of cancer care**

## Our proposed acute cancer pathway



## As a Cancer Centre of Excellence, we would commit to...

- ✓ Achieving top 10% nationally for a number of patient experience and outcome metrics, including cancer patient experience survey results
- ✓ Ensuring every cancer patient has the opportunity to participate in a clinical trial where available and clinically appropriate
- ✓ Offering more Northamptonshire patients the chance to be seen and treated by our team if that is what they choose [repatriating some of the activity that is currently sent out of area]
- ✓ Delivery of constitutional standards: 28 day diagnostic standard, maximum 62 day wait to first treatment from urgent GP referral, maximum one-month wait from decision to treat to treatment.

# We have an ambition to establish a cardiology Centre of Excellence for Northamptonshire

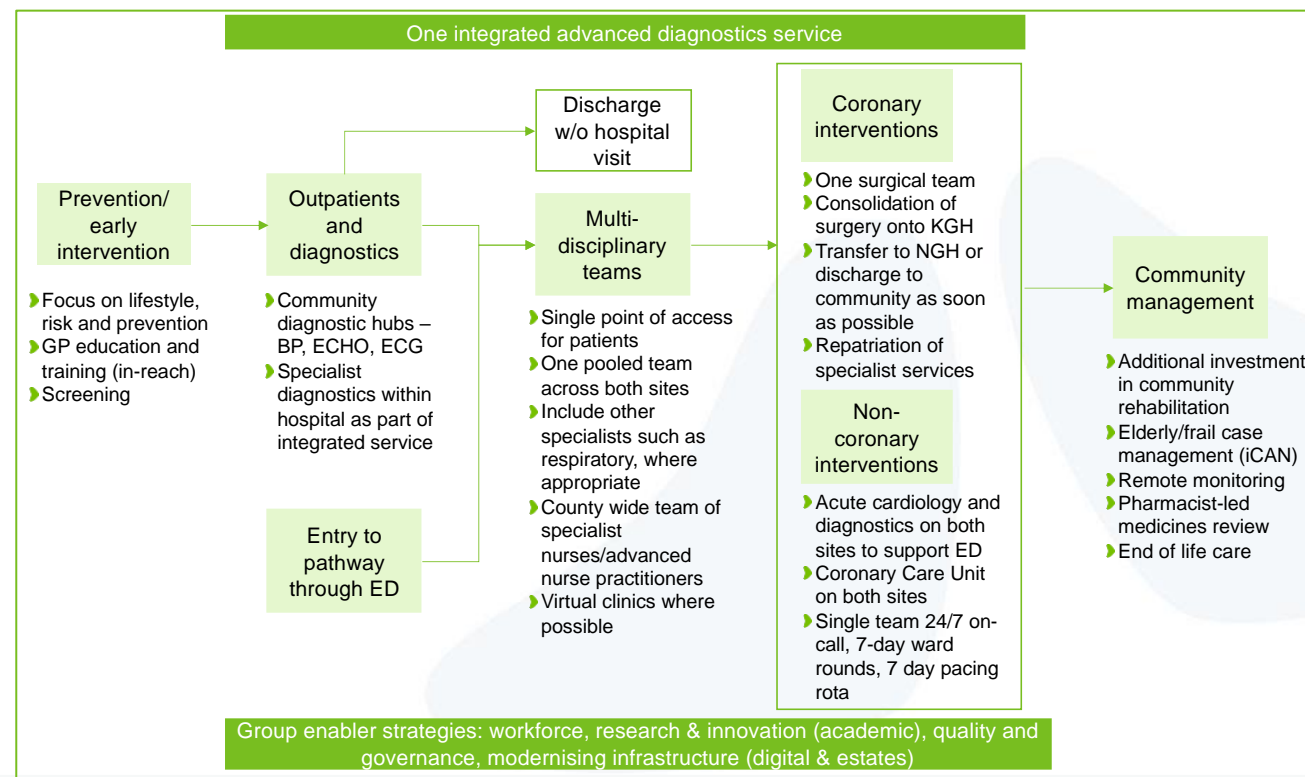
## Our ambition for a cardiology Centre of Excellence

The cardiology Centre of Excellence would be an integrated service that the Group would be known for nationally owing to **exemplary outcomes, excellent patient and staff experience**, and **complexity of caseload**.

The cardiology service would be known for its **extensive research capability, scholarship and academia, attracting and retaining leading experts** in the field.

The cardiology service would work **closely and integrate with colleagues in the community** to improve cardiovascular health and disease prevention for our local population.

## Our proposed cardiology pathway



## As a Cardiology Centre of Excellence, we would commit to...

- ✓ Delivering national quality standards for PCI as set out by Getting it Right First Time (GIRFT) and BCIS (British Cardiovascular Intervention Society)
- ✓ Delivering national quality standards for pacing as set out by Getting it Right First Time (GIRFT) and the National Institute for Cardiovascular Outcomes Research (NICOR)
- ✓ No duplication of complex procedures across sites, to improve quality and performance
- ✓ Single cross site studies which would allow for greater population recruitment
- ✓ Offering more Northamptonshire patients the chance to be seen and treated by our team if that is what they choose
- ✓ Work in partnership with North West Anglia Foundation Trust to improve access to specialist cardiac services to all our PPCI catchment area



# Our ambition is to ensure elective patients consistently get timely, equitable access to high quality care and experience

## Our ambition for elective care

The Group will work collaboratively to provide **dedicated elective capacity** protected from the pressures of emergency services, committed to providing **timely and equitable access to care, minimising infection rates** and **reducing length of stay** in hospital.

Elective care across the Group will offer exemplar **standardised best practice patient pathways** in line with national recommendations which minimise **unwarranted clinical variation**, and maximise **day surgery** and **one stop pathways**.

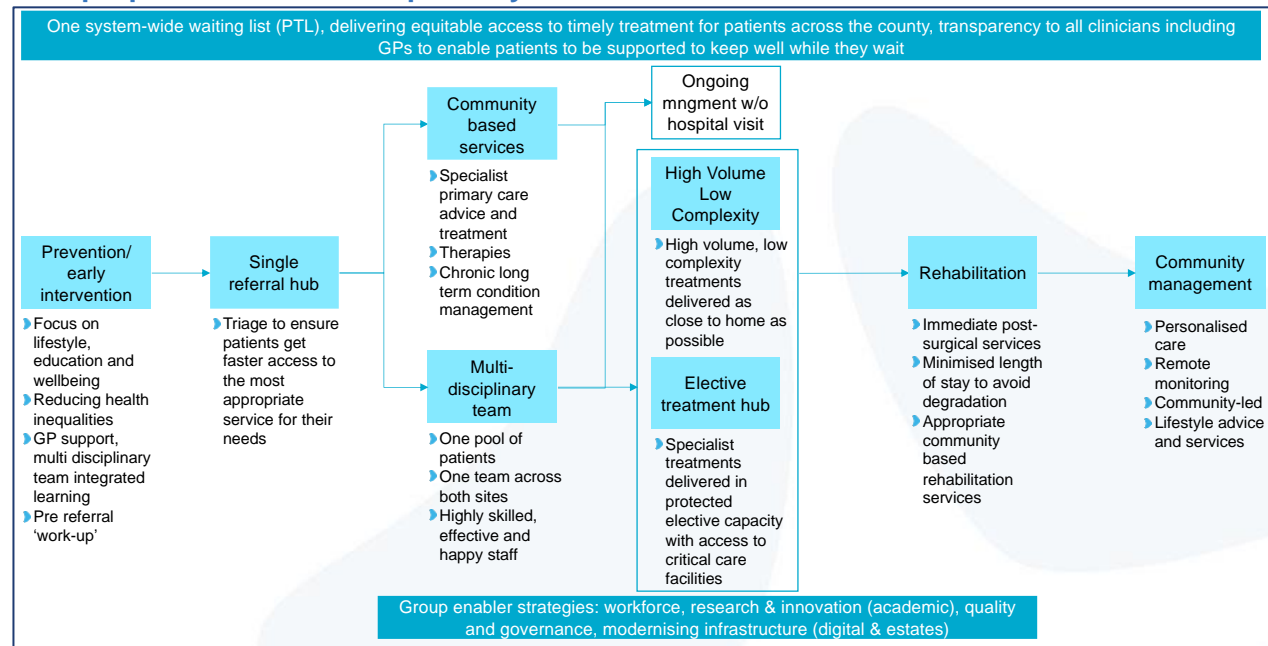
The Group is committed to delivering more care on a **day surgery** pathway, with more assessment, diagnosis and treatment being offered in a **one-stop** pathway, **in the community or virtually** to minimise disruption to patient's lives.

The elective care team would work as one across the Group, providing a positive and fulfilling working environment that **attracts and retains a range of multi-disciplinary staff**, offering **outstanding careers and development opportunities**.

The Group will collaborate with system partners to set up an **Elective Care Collaborative**, providing seamless pathways for patients, working to keep patients well in their homes and providing advice and care as close to their homes as possible.



## Our proposed elective care pathway



## As a lead provider for the Elective Care Collaborative in Northamptonshire, we commit to...

- ✓ Working to deliver top decile performance in GIRFT and model health benchmarked analysis
- ✓ Eliminating any differences in equitable access to care related to health inequalities
- ✓ Delivery of constitutional standards: zero patients waiting over 52 weeks, 92% of patients waiting less than 18 weeks for treatment and all patients waiting less than 6 weeks for a diagnosis
- ✓ Delivering the same service and experience in the county regardless of provider



# We have developed proposals for emergency and integrated care over the next few years

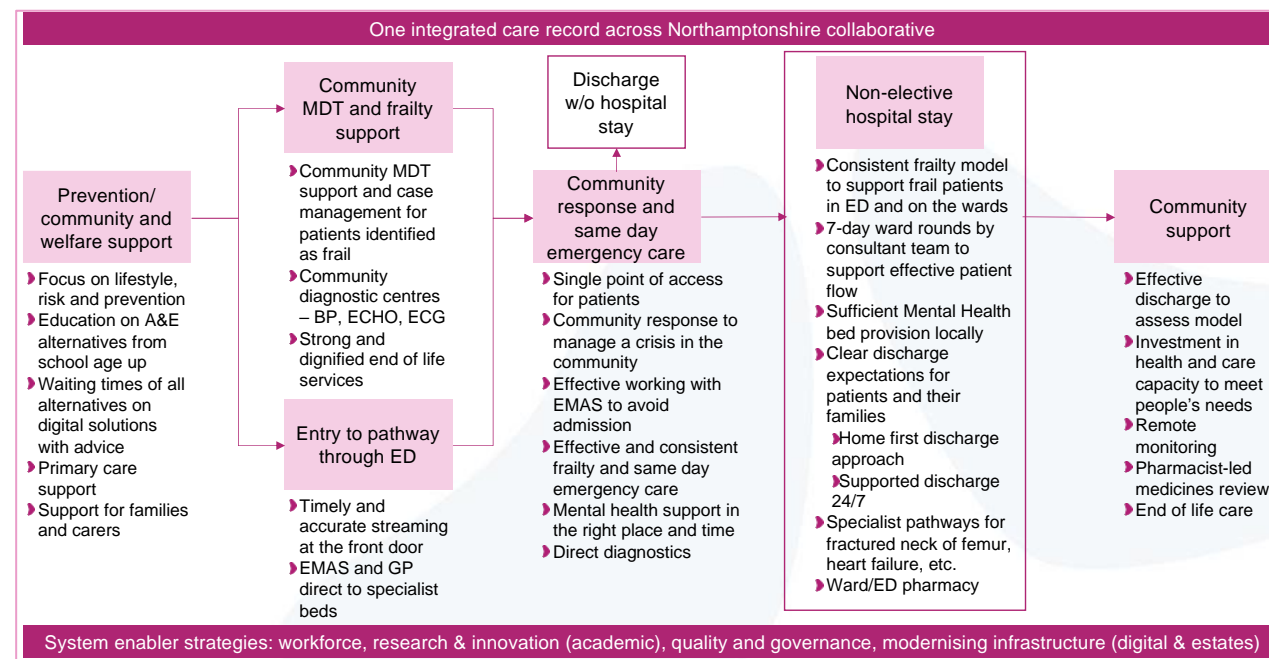
## Our ambition for emergency and integrated care services

Emergency and integrated care services will provide an integrated service that the Northamptonshire system will be known for nationally for delivering the **best outcomes for patients, organisations and our staff – putting patients at the centre of all we do.**

As we develop further models of integrated care across Northamptonshire with our system partners, we will **support people to choose well**, ensuring no one is in hospital without a need to be there, **ensure people can stay well**, and **ensure people can live well**, by staying at home if that is right for them.

Our emergency departments will be the **departments of choice** for staff across the East Midlands. We will embed **continuous development and learning** for staff, with **a diversity of skilled roles** all working together in a **single team**. Our vacancy rates will be low and we will excel in our staff and GMC surveys.

## Our proposed emergency pathway



## As an emergency and integrated care service, we commit to...

- ✓ No avoidable harm in emergency care, and no site specific variation in emergency care.
- ✓ Outstanding CQC rating at both departments
- ✓ No patients waiting over 12 hours in our emergency departments
- ✓ Work in partnership with our Northamptonshire Health and Care Partnership colleagues to provide seamless care for our most frail patients
- ✓ Embed the Home First principles and Discharge to Assess within the county
- ✓ Supporting people to access the right care in the right place, first time
- ✓ A single model for frailty across the county

# Implementing our proposals would address the issues in our case for change

<i>Case for change</i>	<i>How our plans would address the case for change</i>
<b>1. Meeting the needs of a growing and aging population</b>	<ul style="list-style-type: none"> <li>✓ Working closely with system partners to deliver seamless care particularly for patients with complex conditions</li> <li>✓ Closer collaboration for frailty and older people's services</li> </ul>
<b>2. Strengthening fragile services</b>	<ul style="list-style-type: none"> <li>✓ Clinical integration would allow best practice to be shared across the Group</li> <li>✓ Moving to single teams and/or single site working would allow us to use our staff and equipment as efficiently and effectively as possible</li> <li>✓ Collaboration would combine the depth and breadth of our collective expertise allowing us to increase specialist service provision</li> </ul>
<b>3. Retaining and recruiting talent</b>	<ul style="list-style-type: none"> <li>✓ Establish the Group as an attractive place to work offering a broad career portfolio to our staff with increased clinical research opportunities and complex service provision</li> <li>✓ Integrated teams would increase rota resilience and reduce workloads, reducing reliance on temporary staffing and improving staff wellbeing</li> <li>✓ By working together, we would have the scale to explore and pilot new roles and workforce models</li> </ul>
<b>4. Implementing clinical best practice</b>	<ul style="list-style-type: none"> <li>✓ Develop Centres of Excellence across all our services over time, building on the excellence that already exists, developing our services to become nationally known for excellent outcomes and patient experience.</li> <li>✓ Increased provision of ringfenced beds on both sites and, in the longer term, aim to establish a dedicated elective unit(s) separate from emergency care</li> </ul>
<b>5. Reducing avoidable admissions and length of stay</b>	<ul style="list-style-type: none"> <li>✓ Working closely with our health and care partners through iCAN, which is focused on improving outcomes for older people in Northamptonshire, would reduce admissions and length of stay in hospital.</li> </ul>
<b>6. Reducing elective waiting lists</b>	<ul style="list-style-type: none"> <li>✓ Improving the quality of our services and increasing provision of specialist care would reduce patients being transferred out of area with corresponding length waiting times</li> <li>✓ The Group would work to establish a community diagnostic hub which would reduce waiting times for diagnostics</li> <li>✓ We would work collaboratively to protect our elective capacity, providing timely care, minimising infection rates and reducing length of stay in hospital</li> </ul>
<b>7. Improving our financial position</b>	<ul style="list-style-type: none"> <li>✓ Reducing vacancy rates and staff turnover would reduce expenditure on expensive agency staff</li> <li>✓ Consolidation and single- team working would allow us to use our resources efficiently</li> <li>✓ Implementing clinical best practice would reduce duplication and avoid waste</li> </ul>

# Key enablers

## Enablers

We know there are several enablers that will be critical to delivery of the clinical strategy. Our clinical strategy would be supported by our Group enabler strategies:

- ▶ We have a robust digital plan in place that we would accelerate where possible.
- ▶ We have plans in place to recruit and retain a high quality and motivated workforce. Staff also highlight culture and communication as important if we are to achieve collaboration at pace.
- ▶ We would be supported by our academic strategy.
- ▶ We would have new estate at Kettering and Northampton from which to deliver our services.

Our enablers would be underpinned by a programme of transformation and quality improvement

Top three priority enablers as voted for by clinicians (workshops 2021)					
Enablers	Diagnostics	Cancer	Women & Children's	Elective	Emergency
Capital investment in the right facilities	3		3	2	
Digital	1	2	2	1	1
Organisational Development and communications	2	3	2	2	2
Integrated workforce		1	1	1	2
Support structures			3		3
Reporting					



# Implementation and next steps

## Roadmap to implementation

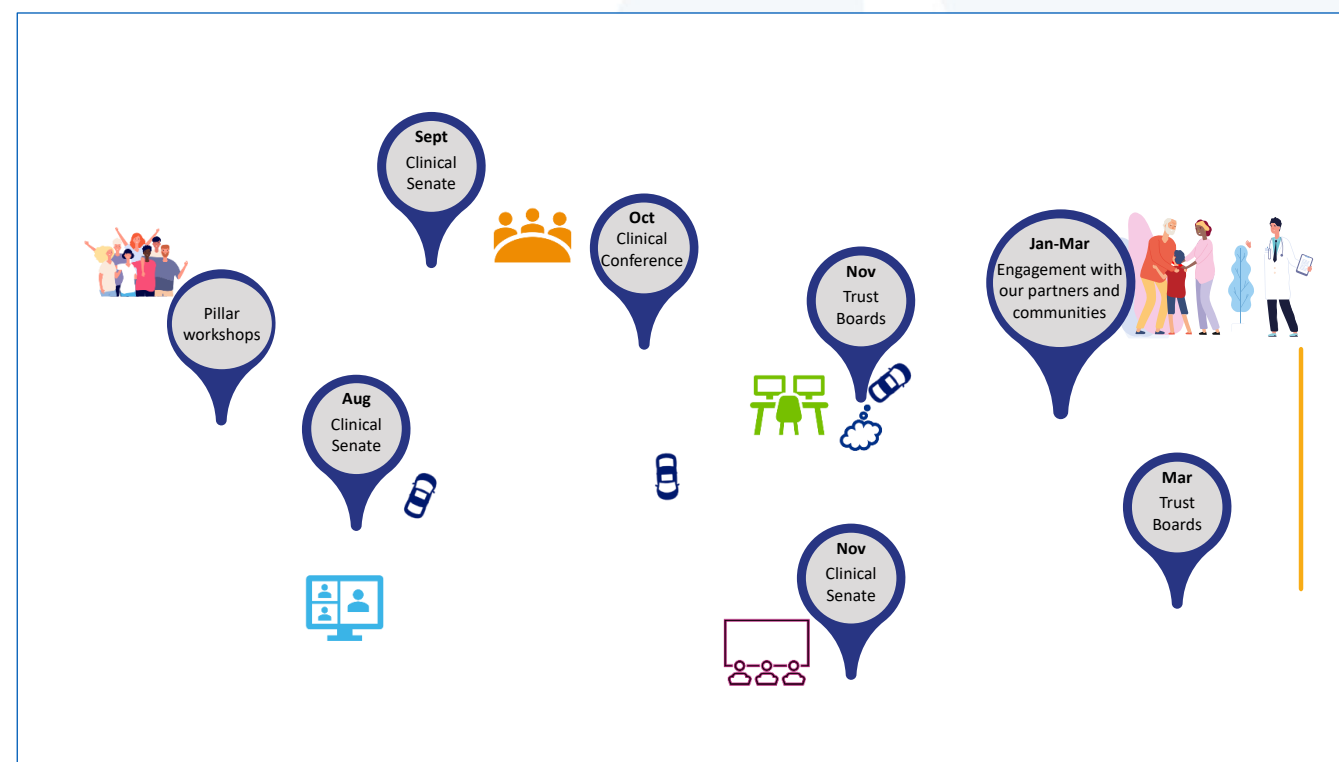
We cannot do everything at once and therefore we propose a set of immediate priorities for the next year:

- ▶ Establish Centres of Excellence for our services, starting with cancer and cardiology
- ▶ Protect elective capacity by increasing provision of ringfenced beds focussing on orthopaedics, general surgery, urology, ophthalmology and ENT
- ▶ Build on our University Hospital status by significantly expanding research in our two centres of excellence: cancer and cardiology
- ▶ Strengthen the most fragile services by establishing single services with single leadership to develop and implement sustainability plans for the future
- ▶ Subject to engagement, prioritise financial investments in a dedicated cardiac MRI at KGH, a specialist cancer robot and co-located head and neck estate at NGH

Integration with services outside of our hospitals will also be key to successful delivery of our strategy and to meet our challenges. We believe that implementing our proposals will transform services for patients and look forward to discussing these with local people, our staff and our health and care partners.

## Next steps

This clinical ambition document will be taken for Board sign-off in November 2021, followed by a period of engagement on the proposals. We will then embark on a two-month engagement journey to discuss and iterate our proposals before publishing our clinical strategy and implementation plan in April 2022.



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# Our plans for engagement

## Clinical ambitions document May-Nov 2021

- Data gathering
- Engagement with UHN clinicians
- Initial discussions with partners
- Proposal formulation
- Clinical ambitions document published

## Engagement Nov 2021 – Feb 2021

### Key audiences for early engagement:

- Staff
- Patients, carers and public
- Northamptonshire Health and Care Partnership
- Health overview and scrutiny committees
- Politicians (local and national)

Other audiences to be identified via comprehensive stakeholder mapping.

### Channels for engagement:

- Regular face-to-face briefings
- Regular online Q&A
- Dedicated digital channels including social media, web pages and intranet page
- Newsletters
- Media releases

Regular measurement and evaluation process to manage inaccurate reporting across internal and external channels

Engagement feedback document to be considered at Trust Board in March 2022

## Clinical strategy Mar 2021

- Revised clinical strategy
- Detailed implementation planning and prioritisation
- Clinical strategy and implementation plan published in April 2022

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# We will engage widely with our partners and local communities

The communications and engagement framework will be designed within the Government's OASIS model.

## Objective/aim

- ▶ Inform all those involved, within the Group and wider externally
- ▶ Ensure engagement from all involved
- ▶ Develop cohesion
- ▶ Garner support for suggested direction of travel

## Strategy and ideas

Engagement with internal audiences will be based on the 'no surprises' principle, with a comprehensive plan developed to ensure all internal audiences are communicated to in a timely manner via appropriate channels.

The external communications strategy will be determined by the stakeholder mapping exercise, with a range of channels available – face-to-face meetings, written briefings, digital channels (including social media) and media engagement – utilised as appropriate. Again, 'no surprises' will be the determining principle guiding external communications and engagement.

## Implementation

Communications and engagement with key internal audiences is already underway and this process will be expanded to ensure all key staff are involved and informed as appropriate. It is anticipated much of the initial communications activity will be primarily face-to-face, to ensure appropriate two-way communication and engagement, with opportunities to gather feedback and views as the plan progresses. Other channels, such as a regular drumbeat of newsletters and fora, will be considered, alongside dedicated digital channels, with existing channels used for wider engagement with colleagues, in line with development and implementation milestones. External communication initially will serve to ensure key stakeholders are informed appropriately, and media (traditional and digital) engagement plans are in place to allay concerns with a schedule of timely communications to ensure accuracy of messaging.

## Scoring and evaluation

The communications plan will be designed to flex in line with feedback and scoring, ensuring messages are landing appropriately with audiences. With the dominant communication channel being face-to-face, qualitative feedback will be obtained from audiences as engagement occurs. Additionally scoring and evaluations methods will include:

- ▶ Pulse surveys
- ▶ Social media engagement rates
- ▶ Media evaluation
- ▶ Audience consultation



# 1

## Our Group



# Our Group is made up of two hospital Trusts in Kettering and Northampton

Our group is made up of Kettering General Hospital (KGH) NHS Foundation Trust and Northampton General Hospital (NGH) NHS Trust and was formed in 2020.

We deliver acute services from two main sites: Kettering General Hospital and Northampton General Hospital. We also provide care at a number of satellite locations including in Corby, Wellingborough, Irthlingborough and GP facilities.

Both our hospitals are acute hospitals providing 24-hour emergency care. We offer a full range of district general hospital care as well as some specialist services: KGH provides emergency cardiac care for the county and NGH provides specialist cancer and stroke care for the county. In total we have around 1,390 beds with 600 at KGH and 790 at NGH.

We serve a population of approximately 900,000 people across the county and employ over 9,000 staff, making us one of the largest employers in Northamptonshire.





# We are part of the Northamptonshire Integrated Care System (ICS) where we collaborate with partners

**Integrating care is a strategic priority at both a regional and national level given the recognised benefits to quality of care and patient experience.**

## **NHS Long Term Plan and move to ICSs**

The NHS Long Term Plan (LTP) sets out how integration of care across organisational boundaries is critical to overcoming the challenges health and care systems are facing.

With the move to ICSs, system partners will be required to work together to deliver 'triple integration' of primary and specialist care, physical and mental health services and health with social care. There will be increased support for integration between trusts to embed cultures of compassion, inclusion and collaboration across the NHS.

The *Integration and Innovation* white paper released in February 2021 accelerates the shift to ICSs by setting out the government's legislative proposals. These proposals intend to remove the barriers to integration including transactional bureaucracy, and ensure systems are more accountable and responsive to their populations.

## **Northamptonshire Health and Care Partnership**

The Northamptonshire Health and Care Partnership (NHCP) is clear that working together and differently will help 'empower people to choose well, stay well and live well'.

As we move to establish our ICS NHS Body and ICS Health and Care Partnership by April 2022, system partners continue to develop plans for greater collaboration and integration across Northamptonshire in line with the White Paper: *Integration and Innovation; working together to improve health and social care for all*.

As part of our leadership within the ICS system, we will need to ensure we:

- ▶ Have a purpose and ambition that is closely aligned to the purpose and ambition of the ICS
- ▶ Enable clinical collaboration both across the Group and with services locally, integrating services at place level
- ▶ Are a strong leader in the system, providing collective leadership in all discussions and decisions regarding local clinical collaboration across the ICS
- ▶ Build relationships with wider providers across and outside our own ICS

There is an opportunity for our Group to be a key system leader, **leading and delivering integrated services** in the ICS, taking an active role to work with our system partners in both preventative and proactive care.

In line with the national and regional strategic direction, we recognise the **importance of collaboration** both within the group and with the wider system in order to deliver outstanding patient care.

# Our two Trusts are already collaborating in many clinical areas and are proud of our recent successes

We are already implementing Group-enabling strategies, and many of our clinical teams are already collaborating - but given the fragility of some of our services and the scale of the challenges we face - we know we need to go further, faster.

Many of our clinical teams are already collaborating, which we know is delivering benefits for our patients and our staff

Specialties which already collaborate include:

- ▶ Cancer
- ▶ Maternity & neonates
- ▶ Pathology
- ▶ Imaging
- ▶ Cardiology
- ▶ Head & neck
- ▶ Stroke
- ▶ Renal
- ▶ Nuclear medicine

Collaboration in head and neck services and cardiology has dramatically improved the patient experience

Patients on a ward at KGH on a Friday, transferred via ambulance to NGH and back on a Monday. No sharing of care records and disjointed care.

Single team working across both sites delivering seamless care and equitable access for patients.



Collaboration in cardiology has allowed the Group to establish a heart attack centre for the county

Patients can now access:

24/7 cardiac outreach nurse service

7 day a week PCI service for patients with minor heart attacks

7 day a week Consultant led service

Specialist service for complex pacing devices and cardiac imaging

As a result, patients no longer have to travel to other specialist centres for life-saving treatment. This service means that patients have a reduced length of stay in hospital and improved rates of recovery from a heart attack.

## Respondents to the all-staff survey (2021) spoke with pride about current clinical collaboration

'We already work together to share care of our patients, a **group clinical strategy** will ensure we are even more joined up and able to deliver even better care'

'The collaboration we're doing on **head & neck services** is something to be proud of. The drive for our Head & Neck clinical lead to develop an integrated service is something we need to replicate'

'Our county wide **stroke service** I feel has been hugely successful – this should be mirrored in other departments'

Full survey results can be found in Appendix A

# We have recently become an academic university hospital and want to build our academic and research reputation

Our ambition to achieve international recognition as an academic centre that promotes and delivers better health service, provision and health outcomes to our patients

The Academic Strategy sets out how we will:

- ▶ Attract, retain and develop the country's top talent. Putting our staff and patients at the heart of its development by improving the training and development we offer
- ▶ Enable us to work more effectively with our health and care partners to collectively improve access, quality and consistency across local patient pathways and services
- ▶ Establish robust estates and digital infrastructure to support innovative clinical education and research
- ▶ Foster a culture of inclusivity and learning, with strong leadership championing the strategy
- ▶ Increase the number of patients included in clinical trials and success of funding from research networks, grant giving bodies and commercial sources



Our vision for the Academic Strategy is to **improve patient care through excellence in education and research**. We will achieve our vision by delivering the following eight objectives:

- ▶ Partnering with University of Leicester to become a University Teaching Hospital Group
- ▶ Foster a culture of learning, research and innovation with strong leadership championing the strategy
- ▶ Provide a multi-professional clinical academic programme and improved training and development offer for staff
- ▶ Increase opportunities and resources for innovation and research to be incorporated at the core of our work and clinical practice
- ▶ Build academic, research and digital infrastructure to support and grow innovative clinical education and an increased research portfolio
- ▶ Increase success of research funding from research networks, grant giving bodies and commercial sources
- ▶ Develop closer alignment with all our University partners
- ▶ Develop and promote the academic brand



# We also have an opportunity to re-build our hospitals to support the delivery of high-quality services

## Our current estate

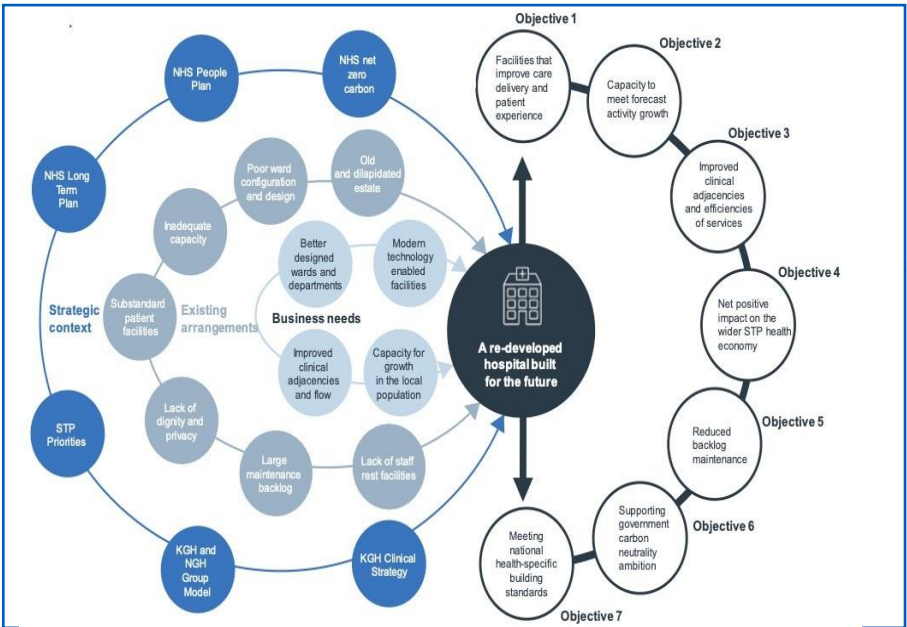
Both hospitals have an aging estate that does not provide the experience we would like for our patients or for our staff. Our clinical services are not able to always be co-located next to each, other meaning staff and patients sometimes have to travel across our hospital sites. In some cases patients are cared for in cramped environments with limited natural light or privacy and dignity. For our staff, they often have to work in less efficient ways to treat patients effectively and keep patients safe.

## Our Estates Strategy

We will need to find ways to improve the current estate we have, and a Group Estate Strategy will follow to deliver the Group clinical strategy:

- Kettering Hospital** submitted a Strategic Outline Case in January 2021 for a large re-build of the hospital incorporating a new ED and new wards, theatres, critical care and day services. This scheme is part of the national New Hospitals Programme and is on track to deliver by 2030.
- Northampton General Hospital** will open a new state-of-the-art critical care unit in January 2022 and opened a designated children's emergency department and new main entrance in 2021. There are plans currently being developed to effectively deliver a whole hospital rebuild.

Our plans for KGH



Our new main entrance at Northampton Hospital



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# 2

## Our case for change



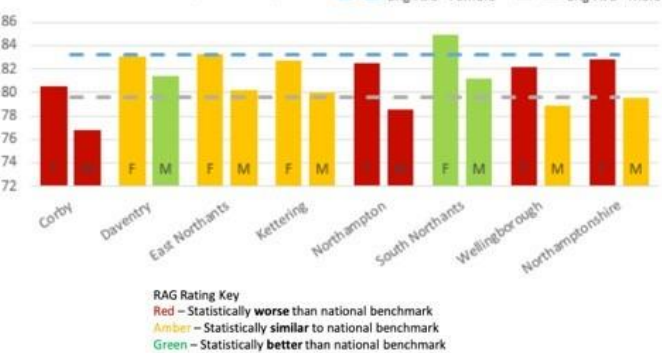


# Our local population is older than the national average with poor outcomes in some areas

Life expectancy is lower than the national average in most areas of Northamptonshire

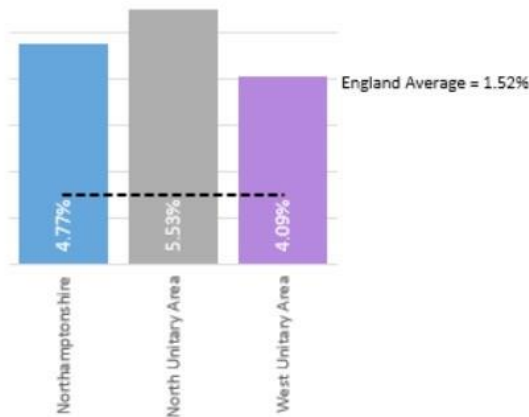
Male vs Female Life Expectancy at Birth - 2016-18

Source: ONS Life Expectancy

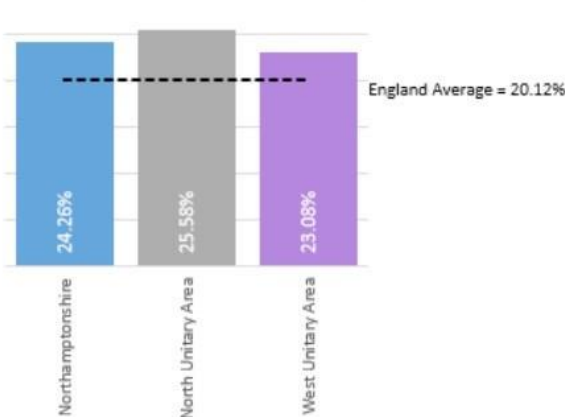


The old and young population are increasing faster than the national average

0-19 Population Change - 2019 to 2029



65+ Population Change - 2019 to 2029



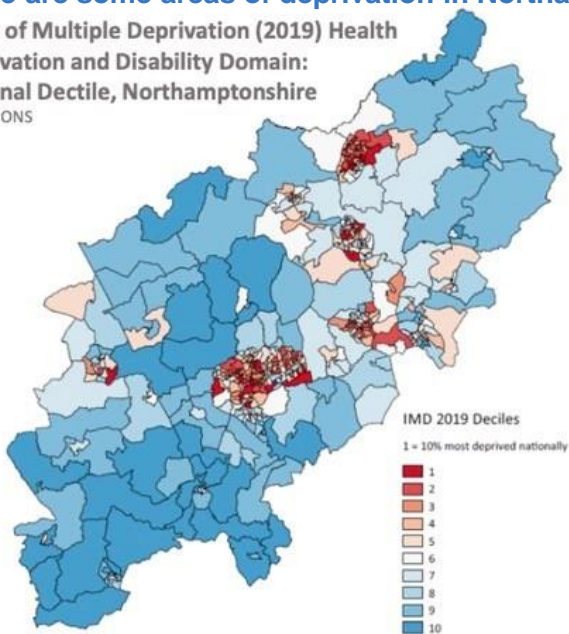
There are some areas of deprivation in Northamptonshire

Index of Multiple Deprivation (2019) Health

Deprivation and Disability Domain:

National Decile, Northamptonshire

Source: ONS



There are poor outcomes in some areas. Across Northamptonshire, 90% of adult disease can be attributed to just 10 risk factors

Health & Wellbeing in Northamptonshire  
JSNA Feb 2020



59 deaths from COPD per 100,000

Worse than England avg.



10% - adults with long-term mental health problems

Worse than England avg.



68% adults overweight or obese

Worse than England avg.



46 deaths from cardiovascular disease considered preventable per 100,000

Similar to England avg.



80 deaths from cancer considered preventable per 100,000

Similar to England avg.

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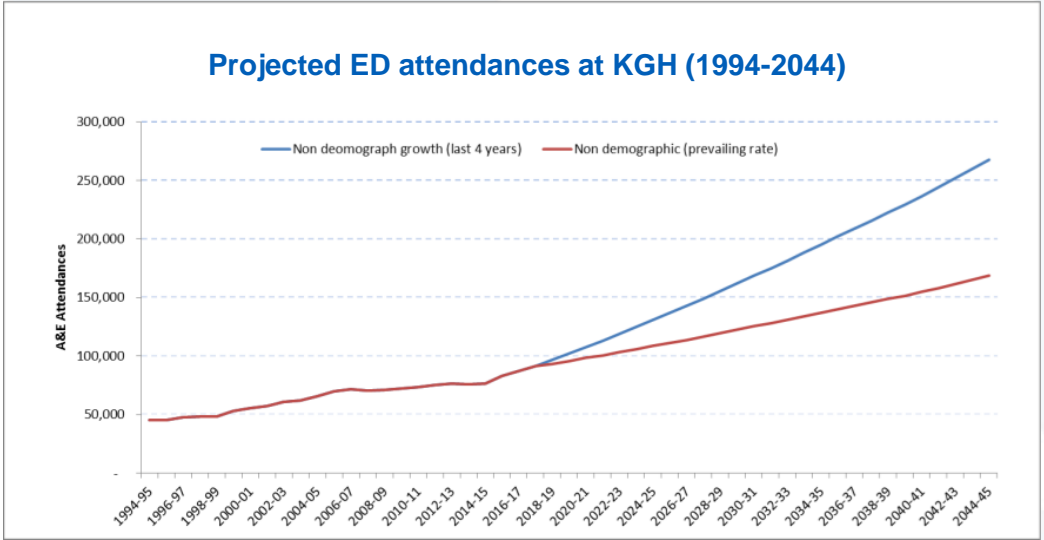
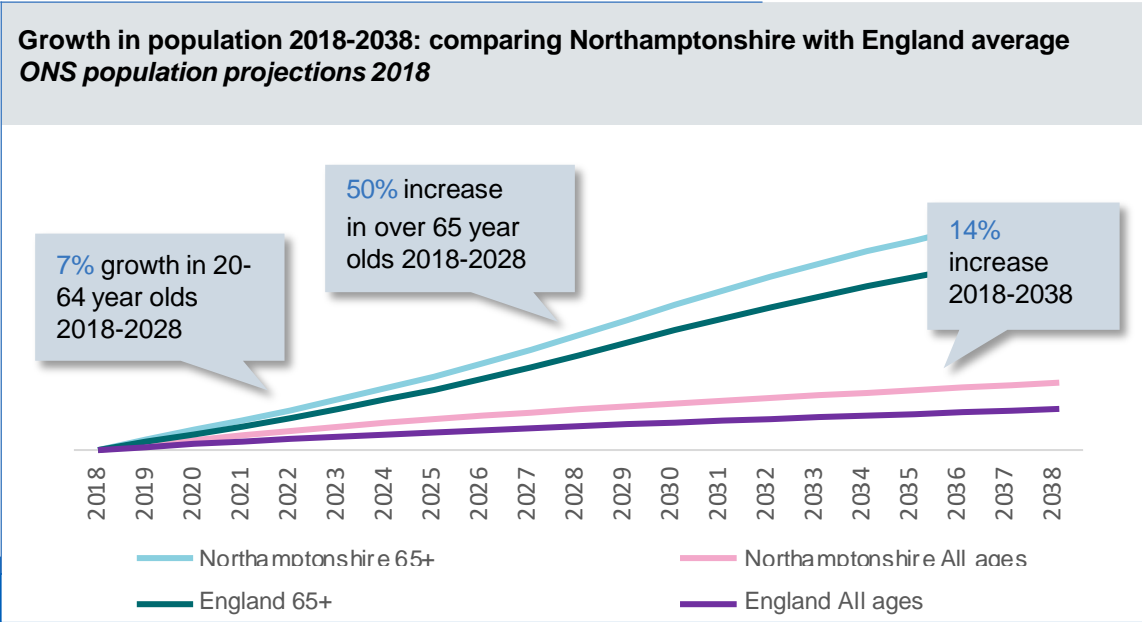
# The local population is growing and aging and will need more care; we also need to address health inequalities

Our population is growing and ageing faster than the national average, increasing the demands on our clinical teams. The Northamptonshire population is projected to increase by 14% between 2018 and 2038. This includes a 50% increase in people aged over 65 (and we already have the highest percentage of over 65s in the country). An ageing population will increase the proportion of our patients with frailty and complex comorbidities.

In North Northamptonshire, a government-backed plan could also see 33,000 new homes built, primarily likely to be for young families, increasing demand for maternity and paediatric services.

The Northamptonshire Health Care Partnership (NHCP) has identified the growing population and increasing disease prevalence linked to unhealthy lifestyles as key drivers for change across the system.

We will work with our system partners to ensure our healthcare services are ready to meet the future needs of our population.



# People are being admitted to hospital when it could be avoided and are staying longer in hospital than they should

Our 2018 CQC local system review found patient experience for people aged 65+ was varied and sometimes unsatisfactory.

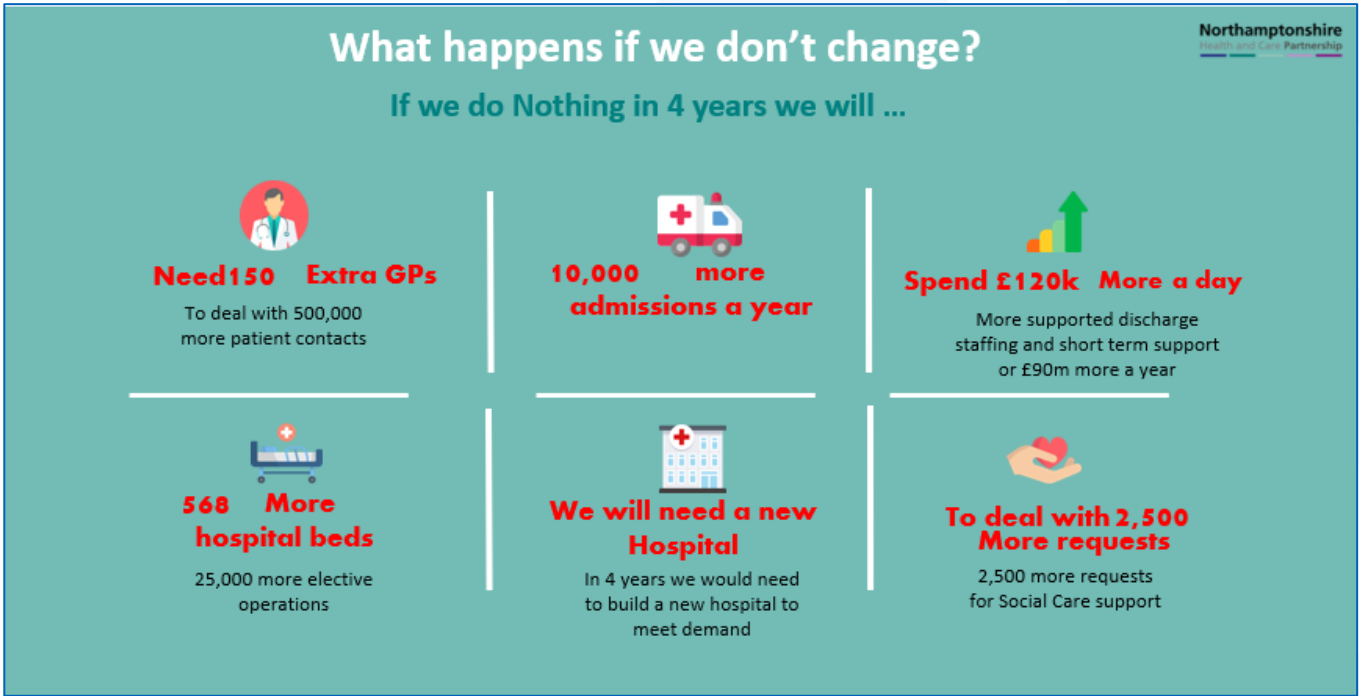
Compared to our peers, in Northamptonshire we:

- ▶ admit almost 9% more people aged 65+ a day to hospital (8 out of 90 daily admissions)
- ▶ have 12% more stranded patients: 113 out of 900 on average, one in three patients in acute beds and one in two in community beds no longer need to be there
- ▶ are twice as likely to admit patients from the community and three times as likely from care homes.

Someone who needs care for a variety of conditions could be receiving services from five or six different organisations with very little coordination between them, which is confusing, wastes resources, and leaves no one taking overall responsibility for the individual's care. It also puts them at higher risk of an emergency department attendance or admission when things go wrong.

This is not what people want. It does not achieve the best outcomes for them. It is not the quality of care our organisations want for our residents. And with rising demand for health and care services in Northamptonshire and an underlying system deficit of £117m as of June 2021, it is not sustainable.

Indeed, if we do not act now, in four years needs will have increased so much that we will not be able to support our population.



Source: iCAN Business Case, July 2021



# We have more to do to implement clinical best practice as many of our services “require improvement”

Overall, we have been rated as “Requires Improvement” by the CQC and our clinical strategy needs to underpin our efforts to improve this rating. Areas that “require improvement” include:

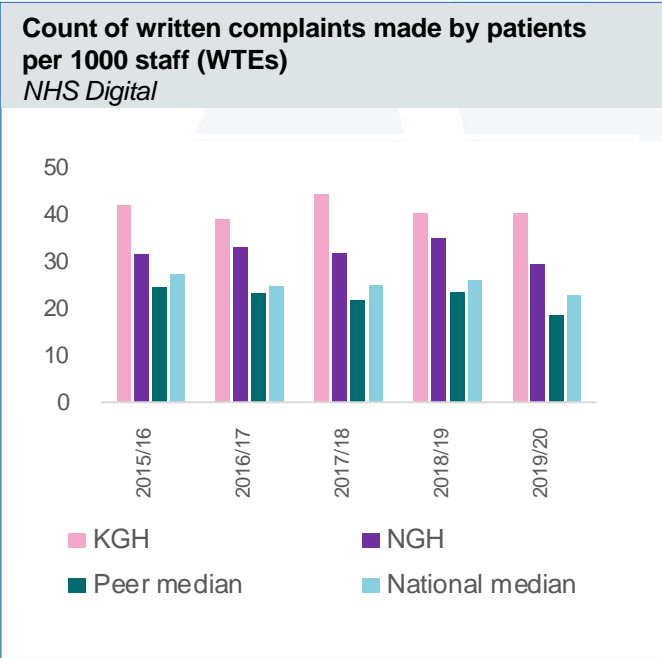
- ▶ Urgent and Emergency Care (KGH)
- ▶ Medical care (KGH & NGH)
- ▶ Maternity (NGH)
- ▶ Children and Young People (KGH)

Workforce challenges are one of the key issues raised by CQC.

## Both our organisations are rated by the CQC as ‘requires improvement’

CQC Ratings KGH 2020, NGH 2019		
	KGH	NGH
Overall	Requires Improvement	Requires Improvement
Safe	Requires Improvement	Requires Improvement
Effective	Requires Improvement	Good
Caring	Good	Good
Responsive	Requires Improvement	Good
Well-led	Good	Requires Improvement

## Our number of patient complaints consistently exceeds national and peer median



Both Trusts were in the **bottom three** when compared with East Midlands Cancer Alliance peers for the patient survey question “Overall how would you rate your care?”  
*National Cancer Survey 2019*




## We are below national median on a number of our friends and family scores

Friends & Family Test scores NHS England (March 2021)			
	KGH	NGH	National median
A&E score - % positive	85%	84%	87%
Inpatient scores - % positive	95%	92%	95%
Maternity scores - birth % positive	Not enough responses (<5)	92%	95%

There are consistently high complaints for ED at NGH and ophthalmology, urology and paediatrics at KGH

# We also need to follow the national direction of travel and national quality guidelines

We have identified a number of key national strategies and guidelines that have been considered in developing our clinical ambitions

<div> <div> Diagnostics: Recovery and Renewal 2020 </div> <div>  <ul style="list-style-type: none"> <li>Split of emergency and elective</li> <li>Community diagnostic hubs to provide highly productive elective diagnostic centres</li> <li>Increase in advanced practitioner radiographer and assistant practitioner roles to address staff shortages.</li> </ul> </div> </div>	<div> <div> Royal College of Surgeons: Future of Surgery </div> <div>  <ul style="list-style-type: none"> <li>Increase in preventative surgery</li> <li>Increase in day-case surgery with focus on preoperative and follow up care undertaken using telemedicine and digital platforms.</li> </ul> </div> </div>	<div> <div> NHS Long Term Plan recommendations </div> <div> <ul style="list-style-type: none"> <li><b>Cancer:</b> by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% to 75% of cancer patients.</li> <li><b>W&amp;C:</b> Children’s mental health services are expected to grow to deliver integrated mental and physical health care. Where possible care will be delivered closer to home for children and their families.</li> <li><b>Elective:</b> supports separation of urgent from planned services. Sets the ambition for the NHS to avoid up to a third of outpatient appointments.</li> <li><b>Emergency:</b> every acute hospital with a type 1 A&amp;E department will move to a comprehensive model of Same Day Emergency Care 12 hrs a day, 7 days a week. Need for appropriate triage and location for urgent mental health services.</li> <li><b>Diagnostics:</b> networks to improve access to more complex tests and enable rapid transfer of clinical images</li> <li><b>Discharge to assess</b> for all patients all of the time.</li> </ul> </div> </div>
<div> <div> Royal College of Physicians: Outpatients the Future </div> <div>  <ul style="list-style-type: none"> <li>Move to flexible, one-stop-shops, see-and-treat clinics and patient-initiated-follow-ups.</li> <li>Services should optimise the staff skill mix rather than always relying on consultant-led care</li> </ul> </div> </div>	<div> <div> GIRFT Recommendations </div> <div> <p>Including but not limited to:</p> <ul style="list-style-type: none"> <li><b>GIRFT elective recovery programme:</b> standardised pathways at system level and establishing fast track surgical hubs while 85% of all elective surgery should be on a day surgery pathway.</li> <li><b>GIRFT radiology 2020:</b> hot/ cold splits of activity, staff working at the top of their license, robust clinical pathways supported by clinical decision making tools.</li> <li><b>GIRFT cardiology 2021;</b> introducing 7-day on-call, 7-day pacing services and extended access to diagnostics</li> </ul> </div> </div>	

# There is inequity in access and quality between our two hospitals

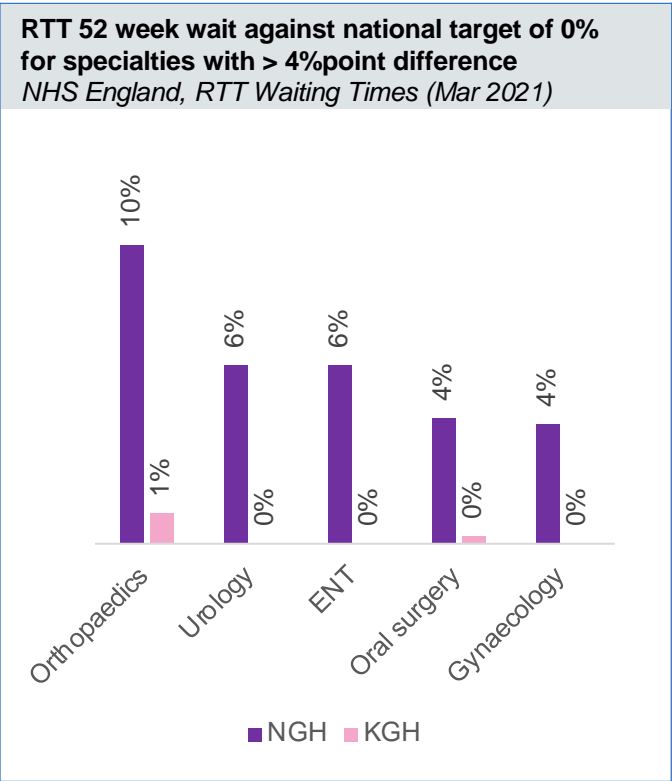
There is variation in the quality of access and quality between our hospitals. For some specialties there are significant differences in the time it takes for patients to receive treatment following a referral; for other specialties there is a variation in how long patients on average spend in hospital once they're admitted; and some specialist treatments are simply not accessible to some patients.

The pandemic nationally has exacerbated health inequalities in populations, with many patients with underlying or deteriorating health even less likely to access the care they need in the right way. We will implement tools to analyse how effective our services are at reaching those of greatest need, and make changes to ensure we eliminate health inequality of access to our services.

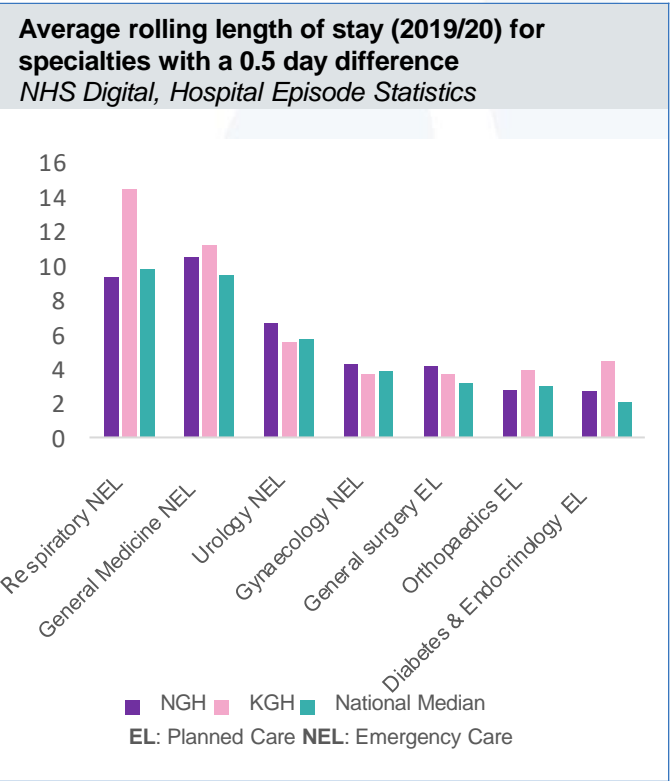
The Northamptonshire Health Care Partnership has set an ambition to ensure everyone has access to the best care wherever they live in the county. We are committed to delivering against this.

Our survey of staff identified reducing variation in quality variation across our hospitals as a top priority.

For some specialties there are significant differences in % of patients waiting over 52 weeks for planned care



...and in others the length of stay varies by over half a day between the trusts



Survey respondents identified that one of the biggest opportunities for collaboration was to begin to reduce the **clinical quality variation** across sites.

# We find it difficult to retain and recruit to some specialties with a national shortage of staff in some areas

There is a national picture of staff shortages and healthcare providers are increasingly collaborating to address this. The Health Foundation predicts that by 2031 there will be a 375,000 FTE gap between staff in post and future demand. This modelling has not taken account of the pandemic impact which may worsen staffing shortages. The Kings Fund acknowledge that staffing shortages were already widespread before the pandemic hit leading to excessive workload and high levels of stress for staff in post.

We have identified areas where national workforce shortages particularly impact on our services:

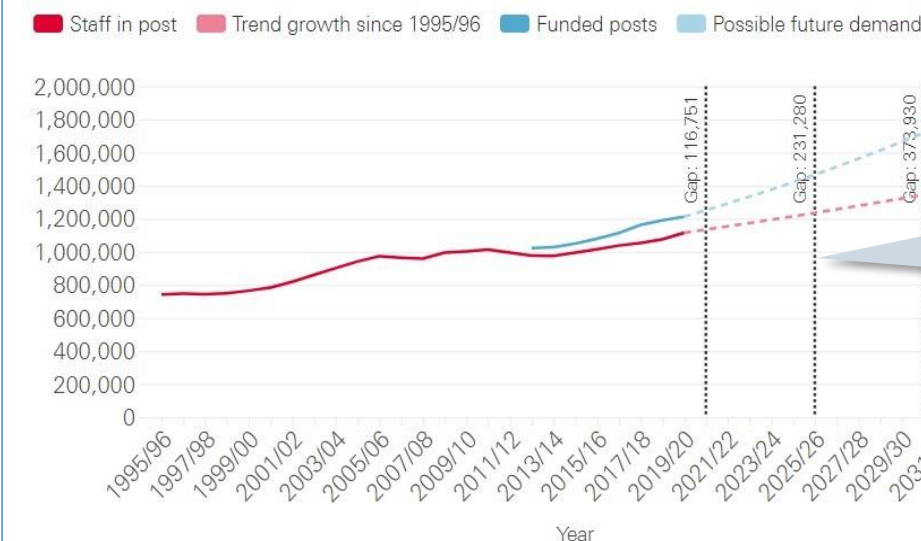
- ▶ Interventional and breast radiology
- ▶ Emergency care; all medical grades
- ▶ Microbiology and blood sciences
- ▶ Specialist cardiology nurses
- ▶ Physiotherapists and occupational therapists
- ▶ Cardiologists
- ▶ Respiratory consultants
- ▶ Theatre staffing
- ▶ Cancer nursing specialists
- ▶ Fetal medicine (at KGH)

The close location of tertiary centres also mean that staff have other attractive employment options.



**The Health Foundation (2020) 'Going into COVID-19, the health and social care workforce faced concerning shortages'**

Potential future shortfall in workforce supply in the NHS in England



Potential gap of 374,000 FTE staff by 2031-32, which does not account for any impacts of the pandemic

NHS workforce shortages in England set to double in next 5 yrs

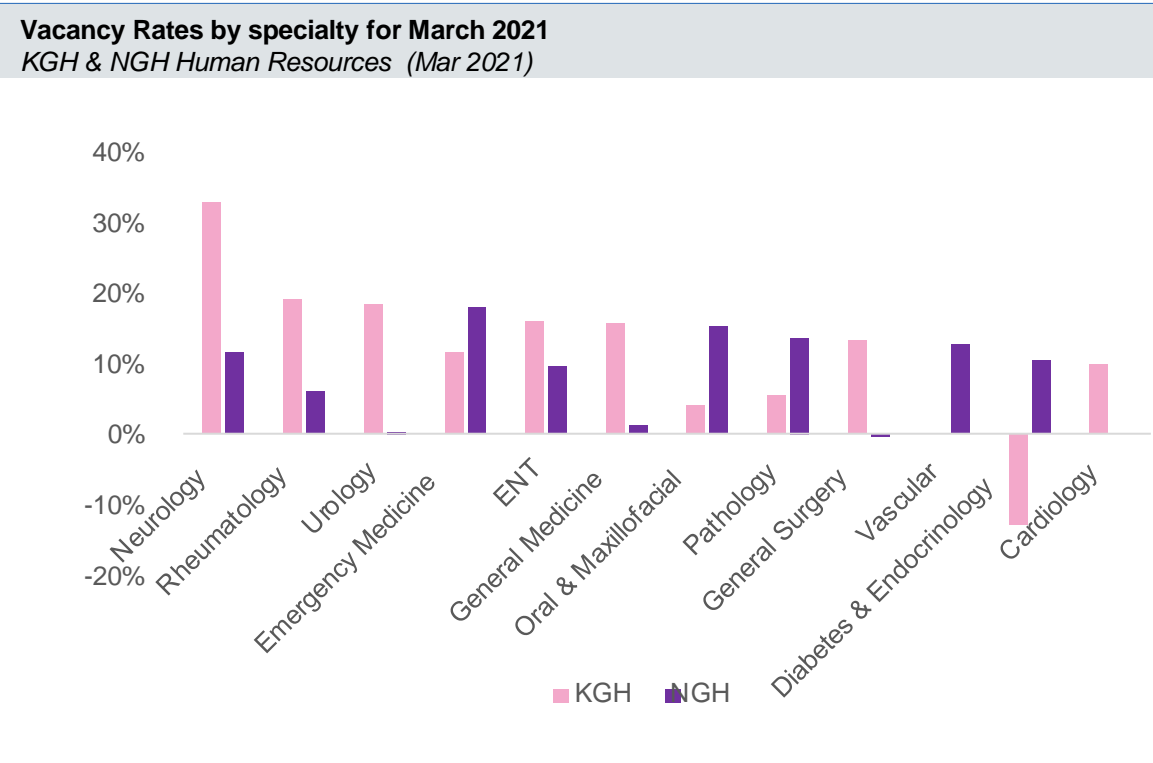
“Before the pandemic, **staffing shortages were endemic**, chronic excessive workloads commonplace and levels of stress, absenteeism and turnover worryingly high”

*Kings Fund (2021) A plan for the NHS and Social Care*

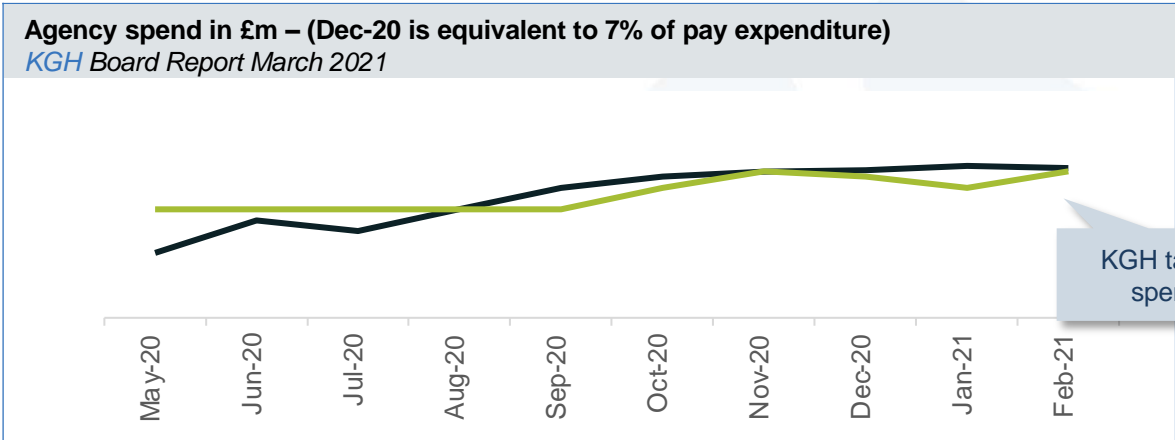


# Workforce shortages drive a reliance on bank/agency staff which impacts on quality (and cost) of services

In common with the wider NHS, our organisations are struggling to attract and retain clinical staff with significant vacancy rates



There is a heavy reliance on agency and substantive staff overtime which creates a significant financial pressure.



“Temporary staff require a level of orientation and supervision that substantive staff – already under pressure – may find difficult to provide. When the proportion of temporary staff becomes too great, this **impacts the quality of care** provided”

*Royal College of Nursing (2017) Safe and Effective Staffing*

“**Staff shortages** identified as the most important factor in determining chronic excessive workload – **a key contributor to staff burn out**”

*Health and Social Care Committee (2021) Workforce Burnout*

The Model Hospital data places NGH approximately **10% below** their peer median in terms of overall substantive WTE medical staff. KGH is **12% below** their peer median by this measure.

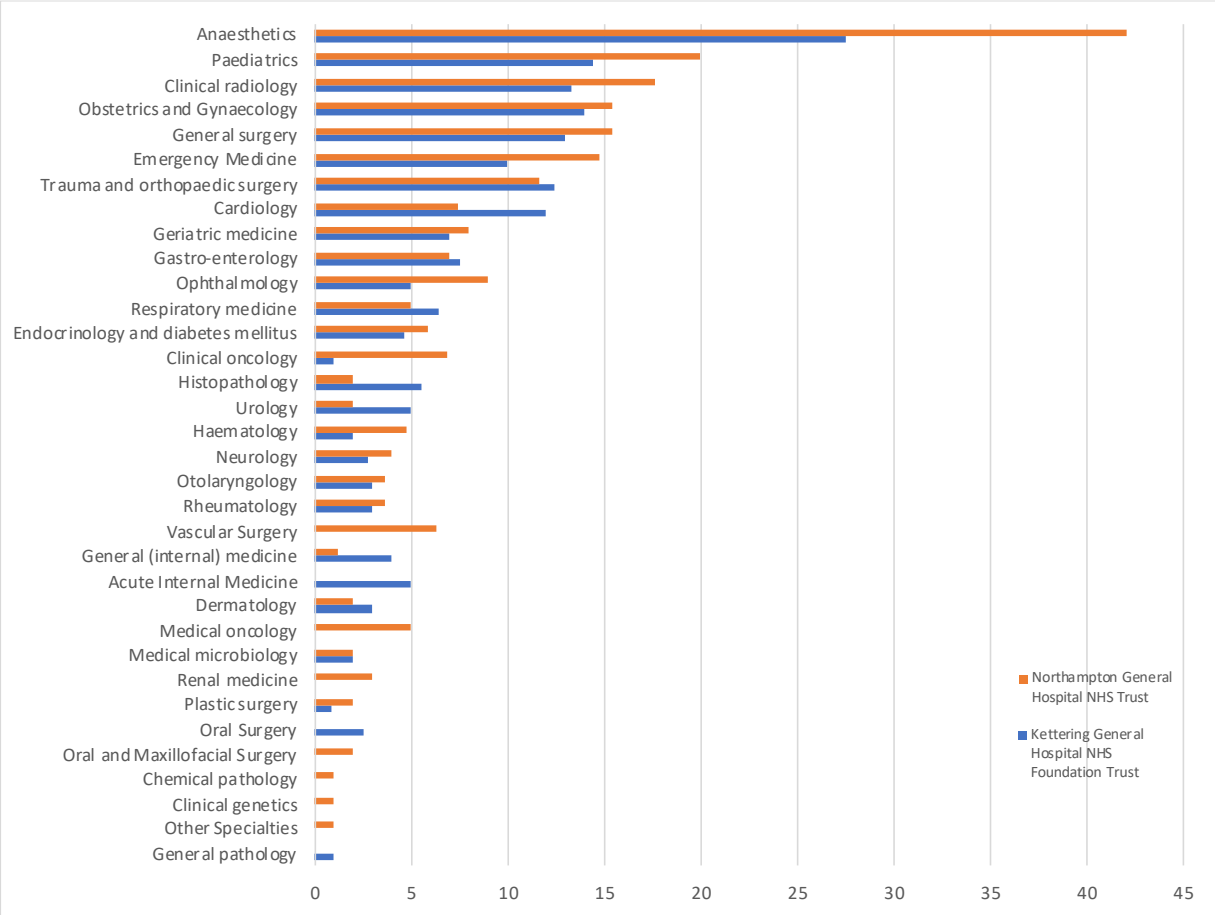
# Some of our services are fragile with few consultants in some specialties, and/or small volumes of patients

We have few consultants in some specialties and there are insufficient levels of activity:

- ▶ **Neurology:** significant pathway improvement opportunities at both sites (driven by workforce challenges)
- ▶ **Geriatric medicine:** the volume of work in this specialty is one that is not only likely to continue to grow significantly, but will also increasingly require specialist skills that interconnect with all other specialisms of care. Nationally there are not enough geriatricians to support this service in the future which results in general adult physicians needing to cover.
- ▶ **Surgery:** concerns about workforce sustainability of smaller specialist services including plastics, head and neck, hand surgery and spine surgery
- ▶ **Plastics:** fragile service with inpatients already seen at University Hospitals Leicester
- ▶ **Gastroenterology:** activity at NGH is in smallest quartile nationally with high costs and poor waiting list performance
- ▶ **Microbiology:** workforce shortages at NGH leading to unsustainability
- ▶ **Renal:** workforce shortages at KGH requiring a Group approach
- ▶ **Haematology:** workforce shortages for a high demand service

These services are not currently resilient or able to adapt to changing conditions. There are challenges to delivering high quality services efficiently and effectively, and our ability to attract staff in these areas

Number of WTE consultants, by specialty, by site



Source: NHS Workforce statistics, May 2021 (excludes Associate Specialists and Staff Grades)

# We need to change the way we deliver services to improve quality and efficiency against a difficult financial position

The Northamptonshire Health System has an estimated underlying deficit of £90m, based on 2020/21 financial year. As part of this, Kettering General Hospital NHS Foundation Trust has a deficit of £45m and Northampton General Hospital NHS Trust has a deficit of £42m, so the two Trusts are contributing to the majority of this deficit.

Many services, often those with low clinical output and workforce challenges, are comparatively expensive to run when compared to other Trusts.

Opportunities have been identified through the Getting it Right First Time (GIRFT) programme:

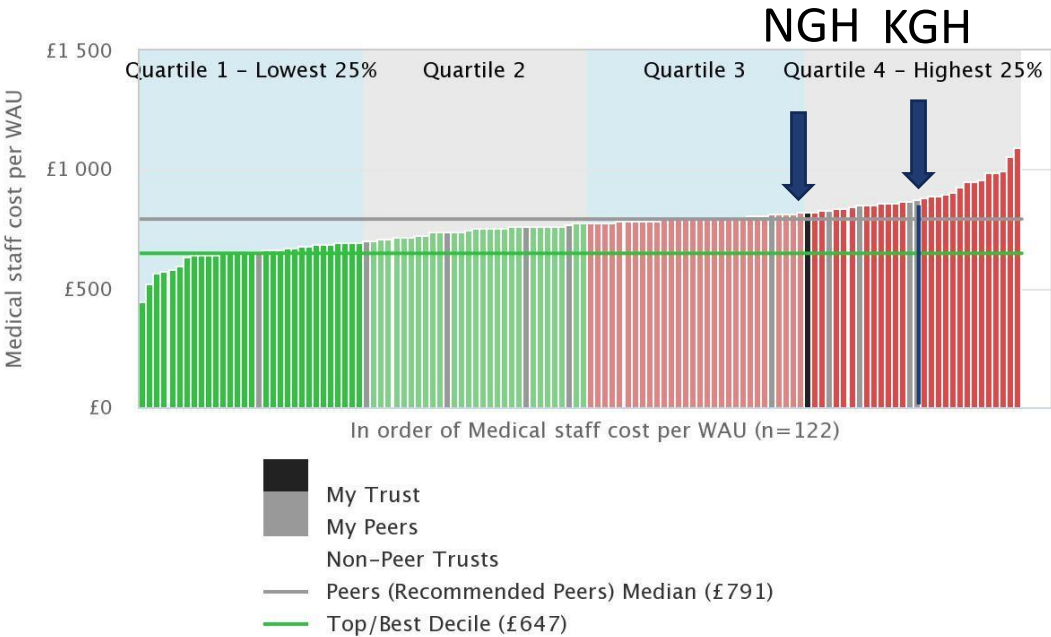
- re-admission rates are high in many specialties
- there are opportunities to improve daycase rates
- there are high lengths of stay for general surgery and orthopaedics
- GIRFT have identified opportunities for efficiencies in orthopaedics, ENT and breast surgery

GIRFT also recommended the Trusts collaborate to develop a dedicated elective hub.

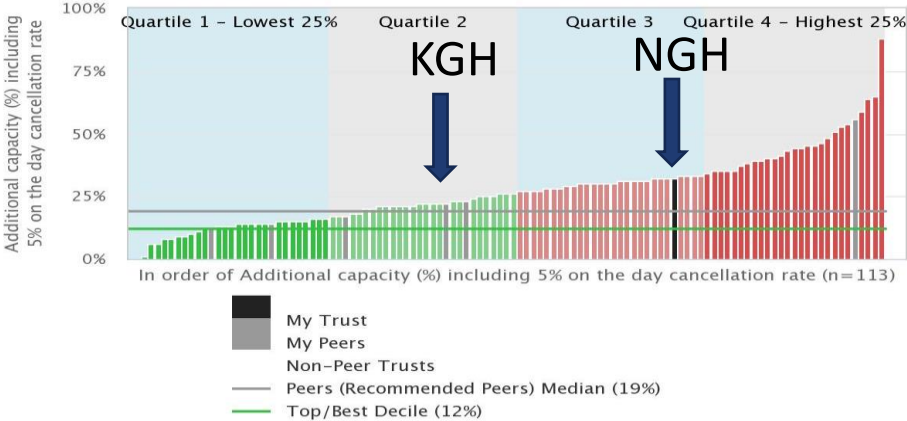
Model Hospital data (2019/2020) shows that, compared to peers:

- Kettering General Hospital has comparably high medical staff costs
- Kettering General Hospital has higher nursing staff costs
- Northampton General Hospital has comparably high medical staff costs
- Northampton General Hospital has similar to average nursing staff costs

Medical staff cost per WAU, National Distribution



Additional capacity (%) including 5% on the day cancellation rate, National Distribution





# 3

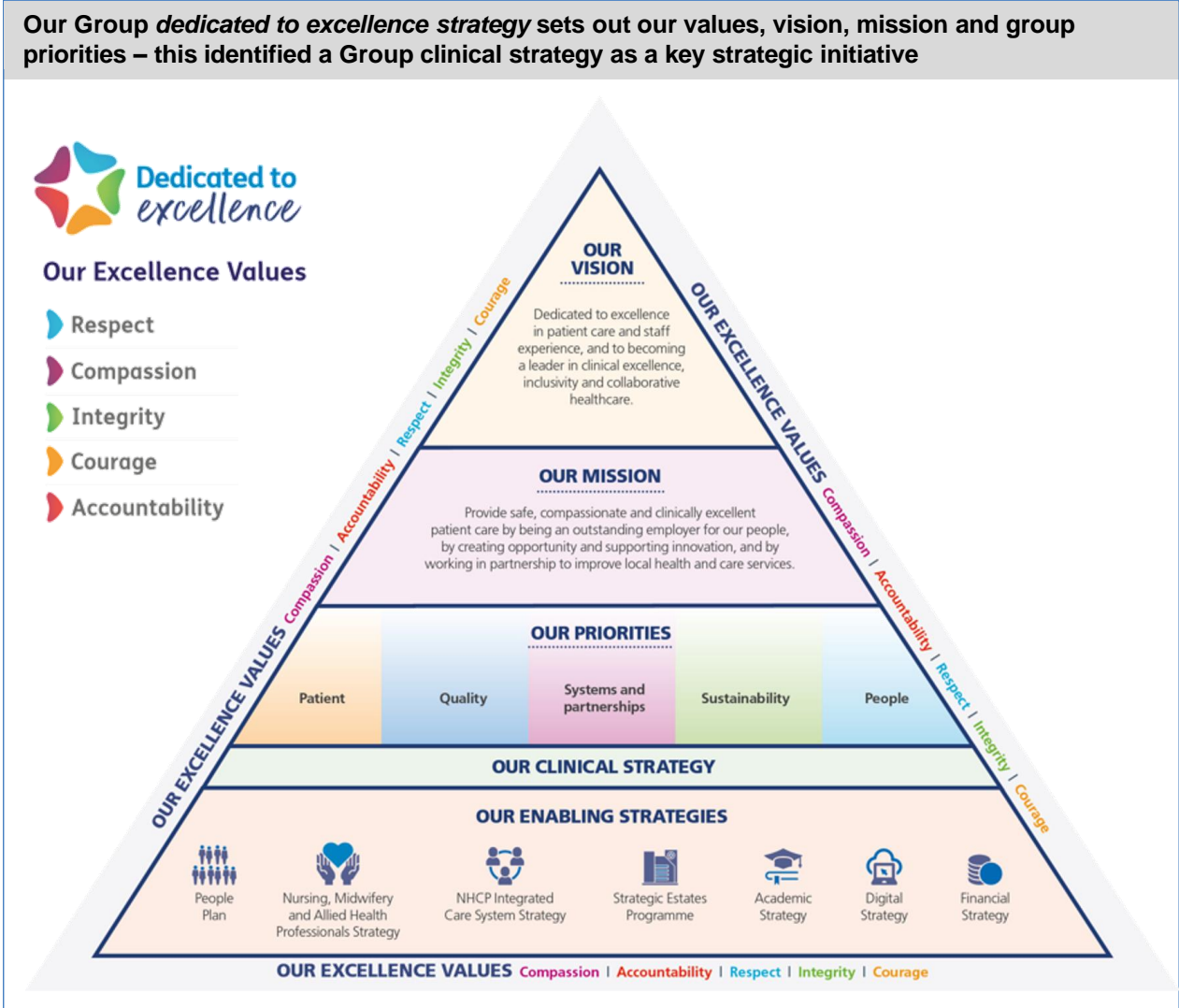
## Our proposals for transformation

# We have developed a Group strategy which is guiding the development of our clinical strategy

In January 2021, Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust boards approved our Group strategy. This sets out our shared vision, mission and values, all ‘dedicated to excellence’.

The Group strategy also outlines the Group priorities and programmes of work required to deliver against these.

One of these programmes of work or ‘strategic initiatives’ was to **develop a Group clinical strategy and clinical collaboration**.



## Our Strategic Initiatives



People Plan



Clinical Strategy and Clinical Collaboration



Nursing, Midwifery and Allied Health Professional Strategy



NHCP Integrated Care System Strategy



Strategic Estates Programme



Academic Strategy



Digital Strategy



Financial Strategy

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# We have explored what our Group vision means for the clinical strategy

## OUR GROUP VISION STATEMENT

Dedicated to outstanding patient care and staff experience by becoming a university hospital group and a leader in clinical excellence, inclusivity and collaborative healthcare.

## OUR GROUP MISSION STATEMENT

Provide safe, compassionate and clinically excellent patient care by being an outstanding employer for our people, creating opportunity and supporting innovation and working in partnership to improve local health and care services.

## What the Group vision means for the clinical strategy

- The Group will be **known for safe, compassionate and clinically excellent care**: working in partnership as a **system leader** of integrated acute care and a **hub for innovation and research**.
- Integrated services will deliver **consistently exemplar outcomes** for our patients across Northamptonshire, providing timely, seamless care, **minimising disruption to our patients' lives**. Patients will only come in when they need specialist acute services.
- Our staff across the Group will work collaboratively, and with system partners, to deliver **cutting edge treatments** and produce **high quality research**, enabling the Group to become an outstanding employer able attract and retain leading experts.
- Patients and staff across the county are **proud of their local NHS**.

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# We have developed clinical ambitions and proposals that would transform care for patients

To achieve our Group vision, we propose that our clinical collaboration focus on four core ambitions:

- 1. Working with our partners to **prevent ill-health and reduce hospitalisation**, changing the way care is provided along the care pathway
- 2. We propose developing **two centres of excellence** in the county, building on our established strengths in each hospital, with cardiology being based in Kettering General Hospital and cancer in Northampton General Hospital, but with consistent access to these services by all patients in the county.
- 3. We want to **protect elective beds** to reduce cancelled operations, reduce long waiting times and increase efficiency.
- 4. We propose **building on our University Hospital status**, becoming a hub for innovation and research, attracting high calibre talent and growing the number of clinical trials our patients can access

To deliver our ambitions, we will propose solutions for the specialties that are currently **unsustainable and fragile** at one or both of our hospitals, to develop more robust services that we can reliably offer patients. We know we cannot make these all of changes as individual hospitals, and we will need to work together and with our system partners to agree and implement our proposals.

## Our clinical ambitions

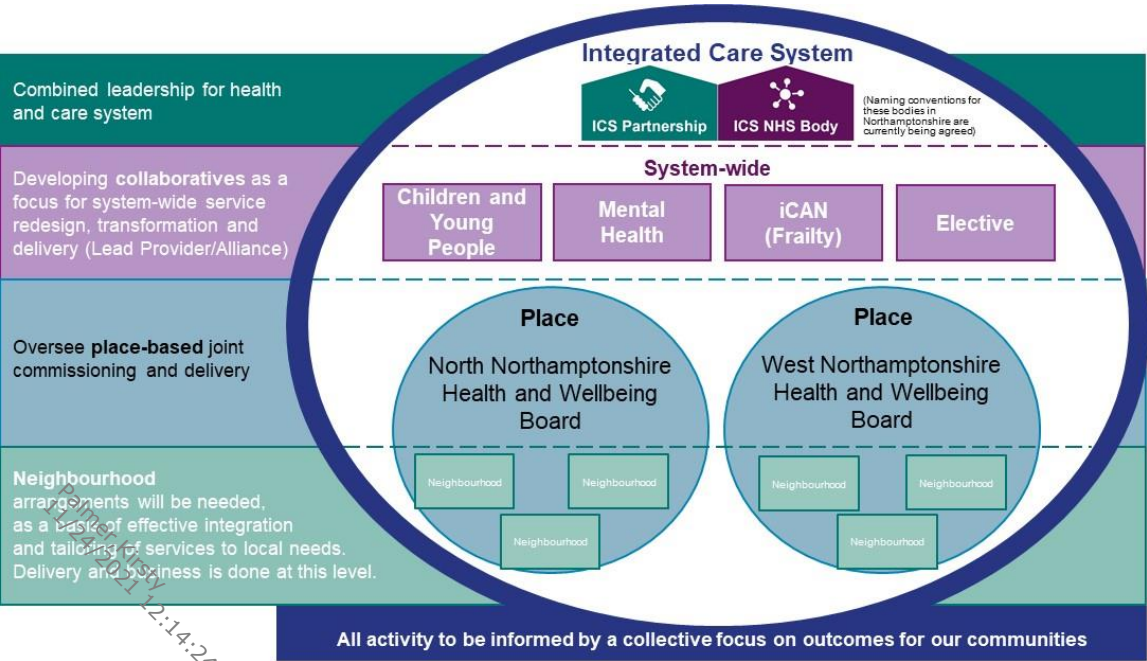


# We are working with health and care partners to change the way care is delivered along the care pathway

## Our transformation priorities

Transformation in our ICS will initially be formed around delivering our four priority collaboratives; Children & Young People, Mental Health, iCAN (frailty) and Elective Care. We will come together with local organisations and providers to join up and redesign service to improve outcomes. We will take a whole pathway approach to transformation working across organisations and services.

Key will be designing and delivering services to meet the needs of our communities at place and neighbourhood level. The aim is to deliver integrated care locally connecting primary care, broader health and care services, including the voluntary sector in local areas with more care delivered out of hospital.



## Elective collaborative

We will work collaboratively with our system partners to develop integrated pathways that support the transformation and delivery of greater out of hospital care. Patients will access the right clinician in the right place. This will include for example, community integrated diagnostic hubs, transformed outpatient services and a system patient list to manage our capacity.

## Mental health, learning disability and autism

The Mental Health, Learning Disability and Autism Collaborative ('MHLDA') goal is to reduce health inequality, improve social impacts and enabling this population to embrace their chosen life in the community, as an equal contributor to our County. Across the Group will work with partners to ensure we support the development of integrated seamless pathways so that people who attend acute hospitals and emergency departments with mental health, learning disability or autism are treated rapidly and receive the aftercare required to recover.

## Children and young people

We will develop our out of hospital integrated children's service to support our children, young people and their families to provide the best quality service that will be integrated, holistic, offer choice and enable shared decision-making.

## iCAN

The focus will be on improving outcomes for older people in Northamptonshire through alternatives in the community to the Emergency Department and by reducing admissions and length of stay in hospital. We will do this through a community hub model where services are integrated around local communities to help people remain well for longer and provide better self-care support.

In the Group, we will develop our frailty units to provide seamless pathways across the community hubs to provide frailty assessment units and prevent hospital admissions and facilitate discharges.

# We propose developing centres of excellence, starting with cardiology and cancer

We propose developing Centres of Excellence across all our services over time, building on the excellence that already exists with the first Centres of Excellence in cancer and cardiology. This is an opportunity to expand and develop our services to become nationally known for excellent outcomes and patient experience.

Our **cancer Centre of Excellence** would provide a fully integrated system wide service ensuring equity of care across Northamptonshire. We propose consolidating most cancer surgery at Northampton General Hospital, to improve outcomes and quality. We would broaden the complexity of our case load to offer patients highly specialised treatments including precision medicine, the next generation of robotic surgery and artificial intelligence assisted diagnostics.

Our **cardiology Centre of Excellence** would focus our more specialist services at Kettering General Hospital with a single team (with a single clinical leadership) operating across both sites. We would offer a single point of access for patients and work closely with health and care partners to prevent cancer and identify cancer earlier, including the development of one-stop diagnostics centres. We would build and grow specialist services such as electrophysiology provision, offering exemplary outcomes to everyone in Northamptonshire

## Our clinical ambitions



# Our Centres for Excellence would deliver our key principles for excellent care

- ▶ **Integrated, seamless care for patients:** so that people get the care they need when they need it without having to re-tell their story, supported by multi-disciplinary team working wherever possible
- ▶ **As close to home as possible:** so that people don't need to travel further than necessary to access services, saving the time and inconvenience
- ▶ **Delivered equitably across the county:** so that everyone has equal opportunity to access high quality services
- ▶ **Focus on prevention and early detection:** so that people don't become ill and don't progress to more severe illness
- ▶ **Supports research and innovation:** so that we can offer the latest treatments to improve health outcomes and contribute to the development of new treatments and technologies
- ▶ **Attract and retain high quality staff:** so that we can provide the highest quality service for patients
- ▶ **Deliver cutting edge treatment, as quickly as possible:** so that people don't need to wait long for treatment, reducing worry and improving health outcomes
- ▶ **Fit for purpose facilities and estate:** so that services can be delivered as efficiently as possible with improved quality in areas such as infection control
- ▶ **Best use of available resources:** so that we can provide the best service we can with the resources that we have



# We have an ambition for a cancer Centre of Excellence for Northamptonshire

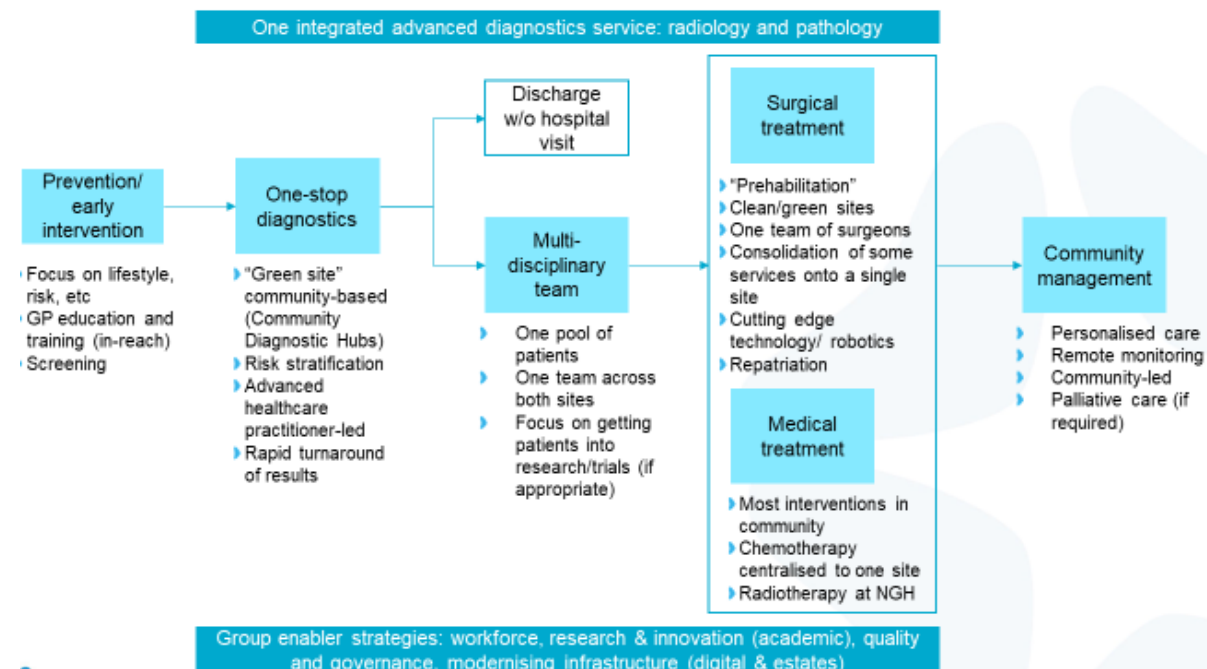
## Our ambition for a cancer Centre of Excellence

The cancer Centre of Excellence would be an **integrated service** that the Group is known for nationally owing to **excellent outcomes and patient experience, complexity of caseload and extensive research output**.

The Centre of Excellence would **attract and retain leading experts**, offering **outstanding career and development opportunities** and providing a sustainable service that supports growth and innovation.

The Group would collaborate with system partners to explore new ways of working to increase the early diagnosis and **accessibility of cancer care**

## Our proposed acute cancer pathway



## As a Cancer Centre of Excellence, we would commit to...

- ✓ Achieving top 10% nationally for a number of patient experience and outcome metrics, including cancer patient experience survey results
- ✓ Ensuring every cancer patient has the opportunity to participate in a clinical trial where available and clinically appropriate
- ✓ Offering more Northamptonshire patients the chance to be seen and treated by our team if that is what they choose [repatriating some of the activity that is currently sent out of area]
- ✓ Delivery of constitutional standards: 28 day diagnostic standard, maximum 62 day wait to first treatment from urgent GP referral, maximum one-month wait from decision to treat to treatment.

# We have an ambition for a cardiology Centre of Excellence for Northamptonshire

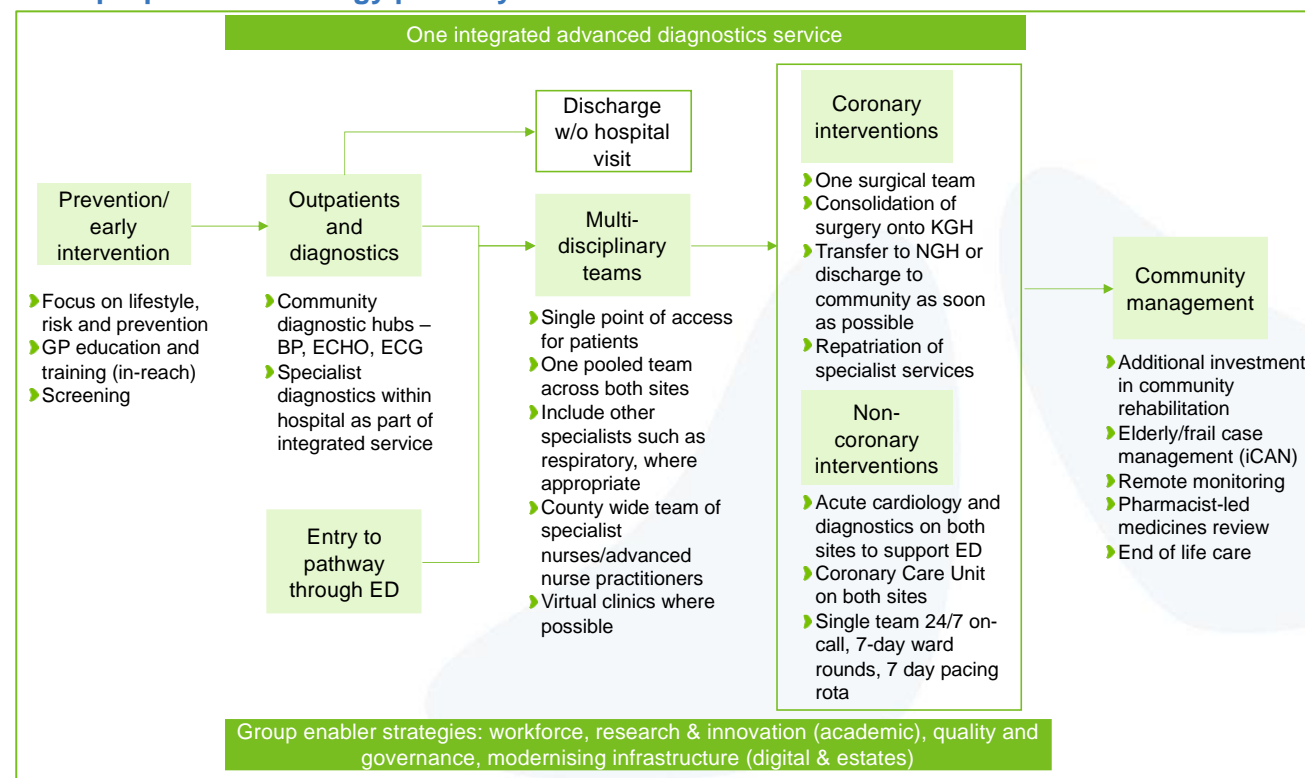
## Our ambition for a cardiology Centre of Excellence

The cardiology Centre of Excellence would be an integrated service that the Group would be known for nationally owing to **exemplary outcomes, excellent patient and staff experience**, and **complexity of caseload**.

The cardiology service would be known for its **extensive research capability, scholarship and academia, attracting and retaining leading experts** in the field.

The cardiology service would work **closely and integrate with colleagues in the community** to improve cardiovascular health and disease prevention for our local population.

## Our proposed cardiology pathway



## As a Cardiology Centre of Excellence, we would commit to...

- ✓ Delivering national quality standards for PCI as set out by Getting it Right First Time (GIRFT) and BCIS (British Cardiovascular Intervention Society)
- ✓ Delivering national quality standards for pacing as set out by Getting it Right First Time (GIRFT) and the National Institute for Cardiovascular Outcomes Research (NICOR)
- ✓ No duplication of complex procedures across sites, to improve quality and performance
- ✓ Single cross site studies which would allow for greater population recruitment
- ✓ Offering more Northamptonshire patients the chance to be seen and treated by our team if that is what they choose
- ✓ Work in partnership with North West Anglia Foundation Trust to improve access to specialist cardiac services to all our PPCI catchment area

# Our ambition is to ensure elective patients consistently get timely equitable access to high quality care and experience

## Our ambition for elective care

The Group will work collaboratively to provide **dedicated elective capacity** protected from the pressures of emergency services, committed to providing **timely and equitable access to care, minimising infection rates** and **reducing length of stay** in hospital.

Elective care across the Group will offer exemplar **standardised best practice patient pathways** in line with national recommendations which minimise **unwarranted clinical variation**, and maximise **day surgery** and **one stop pathways**.

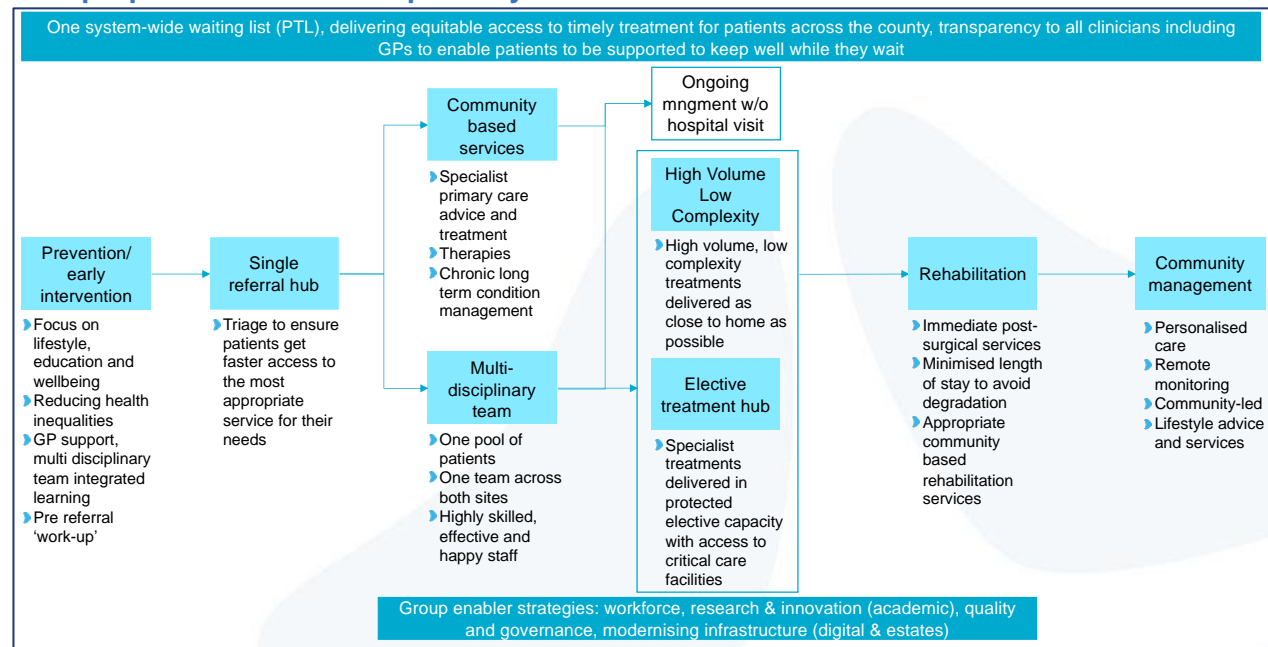
The Group is committed to delivering more care on a **day surgery** pathway, with more assessment, diagnosis and treatment being offered in a **one-stop** pathway, **in the community or virtually** to minimise disruption to patient's lives.

The elective care team would work as one across the Group, providing a positive and fulfilling working environment that **attracts and retains a range of multi-disciplinary staff**, offering **outstanding careers and development opportunities**.

The Group will collaborate with system partners to set up an **Elective Care Collaborative**, providing seamless pathways for patients, working to keep patients well in their homes and providing advice and care as close to their homes as possible.



## Our proposed elective care pathway



## As a lead provider for the Elective Care Collaborative in Northamptonshire, we commit to...

- ✓ Working to deliver top decile performance in GIRFT and model health benchmarked analysis
- ✓ Eliminating any differences in equitable access to care related to health inequalities
- ✓ Delivery of constitutional standards: zero patients waiting over 52 weeks, 92% of patients waiting less than 18 weeks for treatment and all patients waiting less than 6 weeks for a diagnostics
- ✓ Delivering the same service and experience in the county regardless of provider

\*10% is a commitment in the Group's dedicated to excellence strategy; the working group suggested 25% target – the Group to confirm

# We have developed proposals to improve integrated care pathways over the next few years

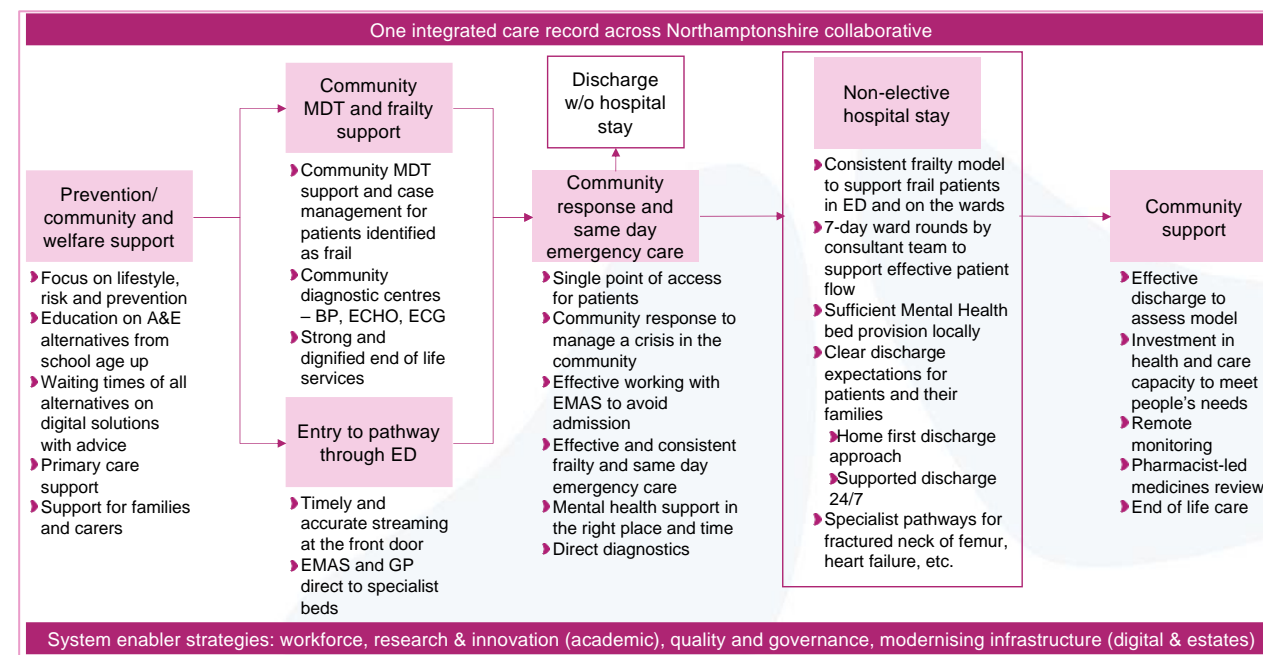
## Our ambition for emergency and integrated care services

Emergency and integrated care services will provide an integrated service that the Northamptonshire system will be known for nationally for delivering the **best outcomes for patients, organisations and our staff – putting patients at the centre of all we do.**

As we develop further models of integrated care across Northamptonshire with our system partners, we will **support people to choose well**, ensuring no one is in hospital without a need to be there, **ensure people can stay well**, and **ensure people can live well**, by staying at home if that is right for them.

Our emergency departments will be the **departments of choice** for staff across the East Midlands. We will embed **continuous development and learning** for staff, with **a diversity of skilled roles** all working together in a **single team**. Our vacancy rates will be low and we will excel in our staff and GMC surveys.

## Our proposed emergency pathway



## As an emergency and integrated care service, we commit to...

- ✓ No avoidable harm in emergency care, and no site specific variation in emergency care.
- ✓ Outstanding CQC rating at both departments
- ✓ No patients waiting over 12 hours in our emergency departments
- ✓ Work in partnership with our Northamptonshire Health and Care Partnership colleagues to provide seamless care for our most frail patients
- ✓ Embed the Home First principles and Discharge to Assess within the county
- ✓ Supporting people to access the right care in the right place, first time
- ✓ A single model for frailty across the county



# We would build on our University Hospital status, becoming a hub for innovation and research, attracting high calibre talent

## OUR CLINICAL AMBITIONS

**Our ambition is to build on our University Hospital status and create a culture of innovation across our Group. Our teams would be supported to expand clinical research so that we can offer our patients access to cutting edge treatments.**

As set out in our *Group Academic Strategy*, we are committed to learning and developing our services so we can provide the best possible care for our patients.

We will be ambitious in our plans in order to attract and retain high calibre, motivated and innovative staff who are best placed to deliver excellent patient outcomes.

Whilst all our services will be supported to increase their research activity, we would strive to **significantly expand research in our two centres of excellence: cancer and cardiology.**



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# To deliver these ambitions, we will increasingly collaborate across the hospitals, starting with our most fragile services

## We would strengthen our collaboration with wider partners

Due to national policy, some specialties already work in wider clinical networks on a regional basis. Pathology and radiology are examples of this. Strengthening our collaboration across the group in these areas would strengthen our position within these networks and enable greater investment and opportunity from the networks into the county.

Many of our patients need to travel to Leicester, Coventry or other specialist centres for specialist treatments, but these vary depending on which hospital the consultant works at. We will work consistently as a Group to establish single pathways to these centres and improve the seamless journeys of our patients into these tertiary centres.

In some specialties, we would immediately go further and establish single teams, some of whom we propose would operate from a single site.

## We would move faster to single leadership and teams in some services

This is because of a number of reasons including:

1. It is a fragile specialty which due to workforce constraints or low activity volume, is unsustainable in its current form
2. There is significant variation in quality across sites with opportunity to collectively improve care through working collaboratively
3. There is existing collaboration with proven benefits to patients which clinical teams wish to strengthen

**Where in the best clinical interests of patients, services may be consolidated on a single site, and where clinically safe they should be delivered as close to patients homes as possible and away from acute hospital sites**

**There are different  
models of  
collaboration**

### **Single team service**

*A single team  
operating across  
both sites*

### **Networked service**

*Services on both sites  
adopting a single way  
of working and model  
of care*

### **Single site service**

*A single team  
operating  
predominantly from  
one site*

*Over time, all services would move to single team*

# We know we could not make these changes as individual hospitals

We believe that working together will help us better overcome the challenges we face and unlock greater opportunities for improving patient care and staff experience.

We have the opportunity to combine our expertise and experience to provide outstanding patient care at the right place and in the right time.

We are already a University Hospital Group and have the ambition to attract high calibre clinicians to join our teams delivering cutting edge clinical research and treatment for our patients. This would improve access to best practice care in Northamptonshire, and mean more patients can receive treatment in county, nearer to their homes.

Collaboration will reduce the current inequity in care and access to hospital services across Northamptonshire

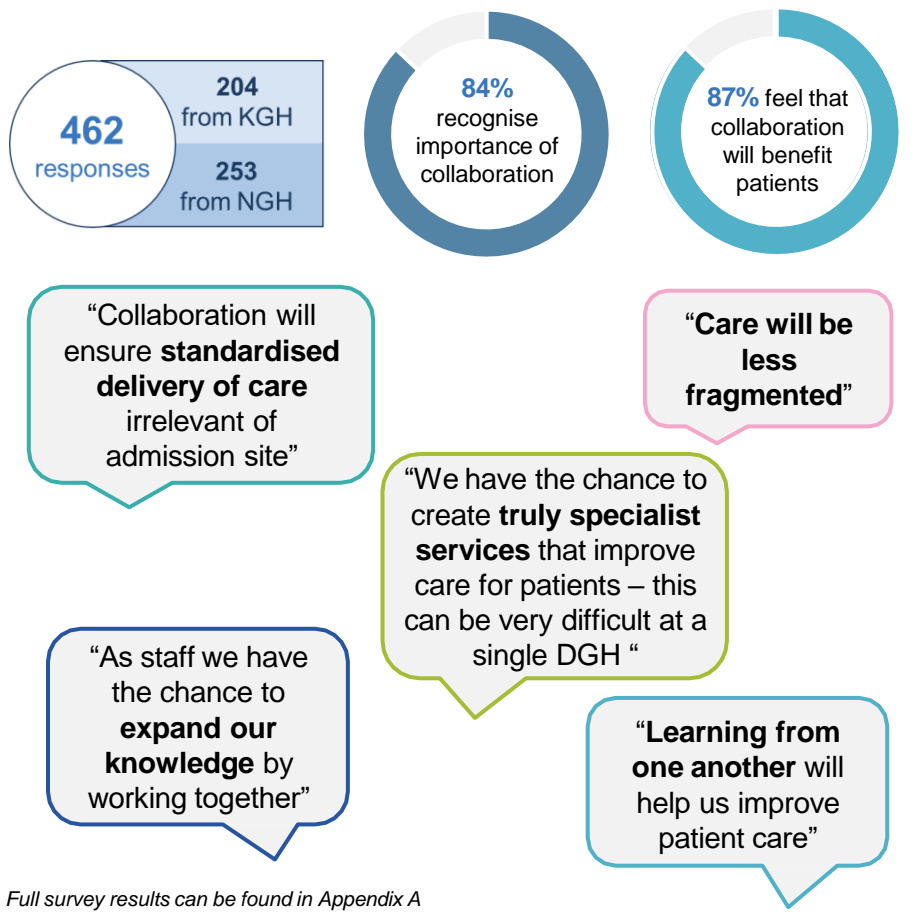
We are committed to working with our system partners to transform care across our county with a focus on prevention and proactive services.

When people become ill we will ensure they can quickly access the care and support they need in the right place at the right time.

We will harness the latest digital technologies to deliver care in the most appropriate and convenient location for our patients.



All-staff survey results (2021) demonstrate support for collaboration and understanding of how this will deliver our dedicated to excellence vision and mission





# Implementing our proposals would address the issues in our case for change

Case for change	How our proposals would address the case for change
<b>1. Meeting the needs of a growing and aging population</b>	<ul style="list-style-type: none"> <li>✓ Working closely with system partners to deliver seamless care particularly for patients with complex conditions</li> <li>✓ Closer collaboration for frailty and older people's services</li> </ul>
<b>2. Strengthening fragile services</b>	<ul style="list-style-type: none"> <li>✓ Clinical integration would allow best practice to be shared across the Group</li> <li>✓ Moving to single teams and/or single site working would allow us to use our staff and equipment as efficiently and effectively as possible</li> <li>✓ Collaboration would combine the depth and breadth of our collective expertise allowing us to increase specialist service provision</li> </ul>
<b>3. Retaining and recruiting talent</b>	<ul style="list-style-type: none"> <li>✓ Establish the Group as an attractive place to work offering a broad career portfolio to our staff with increased clinical research opportunities and complex service provision</li> <li>✓ Integrated teams would increase rota resilience and reduce workloads, reducing reliance on temporary staffing and improving staff wellbeing</li> <li>✓ By working together, we would have the scale to explore and pilot new roles and workforce models</li> </ul>
<b>4. Implementing clinical best practice</b>	<ul style="list-style-type: none"> <li>✓ Develop Centres of Excellence across all our services over time, building on the excellence that already exists, developing our services to become nationally known for excellent outcomes and patient experience.</li> <li>✓ Increase provision of ringfenced beds on both sites and, in the longer term, aim to establish a dedicated elective unit(s) separate from emergency care</li> </ul>
<b>5. Reducing avoidable admissions and length of stay</b>	<ul style="list-style-type: none"> <li>✓ Work closely with our health and care partners through iCAN, which is focused on improving outcomes for older people in Northamptonshire and reducing admissions and length of stay in hospital.</li> </ul>
<b>6. Reducing elective waiting lists</b>	<ul style="list-style-type: none"> <li>✓ Improving the quality of our services and increasing provision of specialist care would reduce patients being transferred out of area with corresponding length waiting times</li> <li>✓ The Group would work to establish a community diagnostic hub which would reduce waiting times for diagnostics</li> <li>✓ We would work collaboratively to protect our elective capacity, providing timely care, minimising infection rates and reducing length of stay in hospital</li> </ul>
<b>7. Improving our financial position</b>	<ul style="list-style-type: none"> <li>✓ Reducing vacancy rates and staff turnover would reduce expenditure on expensive agency staff</li> <li>✓ Consolidation and single- team working would allow us to use our resources efficiently</li> <li>✓ Implementing clinical best practice would reduce duplication and avoid waste</li> </ul>

# 4

## Enablers

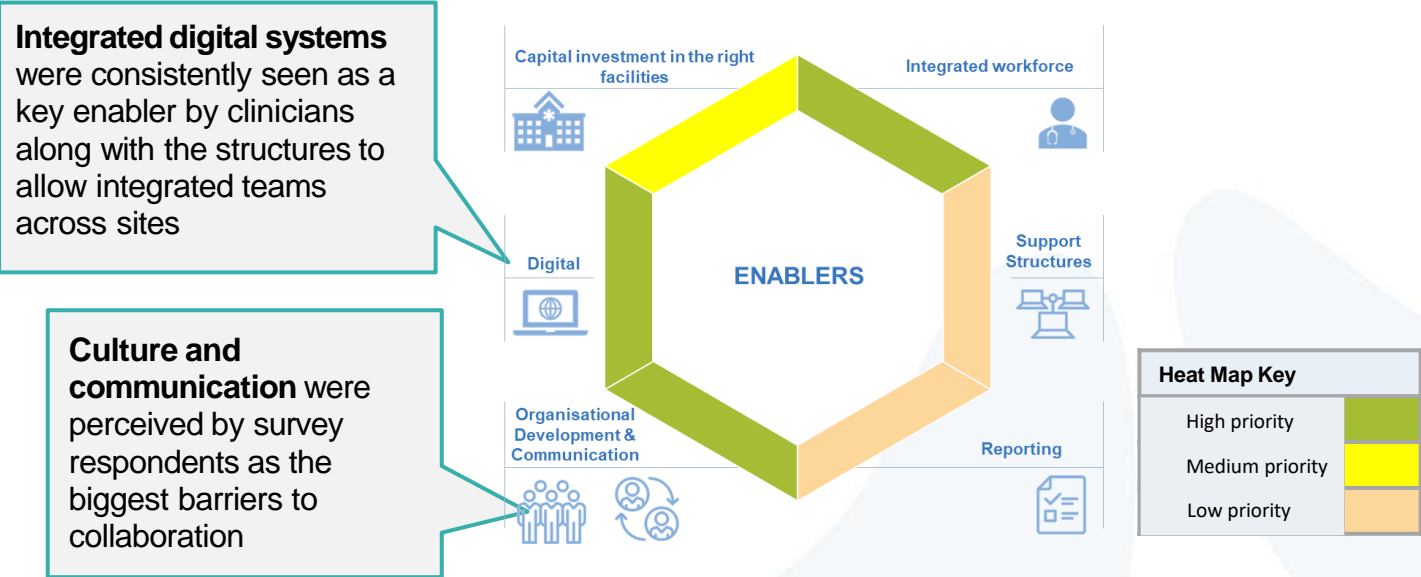
# We know there are a number of enablers that would be critical to delivery of the clinical strategy

Clinicians were asked to select the top three enablers that would be crucial for them to deliver the clinical ambitions. These discussions, in addition to the all-staff survey results, were used to create a heat map.

Whilst all six of the enablers were deemed critical, it was felt that organisational development and communication, digital and integrated workforce were the three highest priority ones.

**All-staff survey results 2021**  
 The top 3 themes from the qualitative feedback ( in order of prevalence) were:

- Culture** – need to remove the ‘us vs them’ mentality
- Communication about the change** – need regular honest communications to overcome fear of change
- Digital** – need shared systems to allow easy communication and seamless patient care



Top three priority enablers as voted for by clinicians (workshops 2021)					
Enablers	Diagnostics	Cancer	Women & Children's	Elective	Emergency
Capital investment in the right facilities	3		3	2	
Digital	1	2	2	1	1
Organisational Development and communications	2	3	2	2	2
Integrated workforce		1	1	1	2
Support structures			3		3
Reporting					



# Our clinical strategy would be supported by changes in digital, workforce, research and education and estates

- ▶ We need the right facilities to accommodate **consolidation of services** (clinical and back office)
  - ▶ We need to address our **critical infrastructure risks** to provide a fit-for-purpose care setting
  - ▶ We need to expand our **community facilities** to deliver care outside the acute setting, where appropriate
- 
- ▶ We need robust **data sharing** to allow easy comparison of care across the system
  - ▶ At a system level we need a **shared care record** and **integrated care systems** so our staff and patients can move seamlessly between sites
    - ▶ We need integrated digital systems to enable collaboration e.g. joint MS Teams, joint address books
  - ▶ We need to ensure we have a system- wide **culture of clinical collaboration**
- 
- ▶ We need to provide **change management support** to our teams
  - ▶ We need to continue **engaging with our staff and patients** throughout implementation of the strategy
    - ▶ We need comprehensive leadership development programme to grow a pipeline of group and system leaders
    - ▶ We need to market our Group to raise our organisational profile

## Capital investment in the right facilities



## Digital



## Organisational Development & Communication



## Integrated workforce



## Support Structures



## Reporting



# ENABLERS

Heat Map Key	
High priority	Green
Medium priority	Yellow
Lower priority	Orange

- ▶ We need **structures and policies** in place that enable cross-site working
  - ▶ We need to deliver **shared training** and development opportunities, bringing in system partners where appropriate
  - ▶ We need to begin **shared workforce planning** to ensure we have the capacity to deliver our group ambitions
  - ▶ We need to carry out a Group **skill-mix review** –esp. opportunities for new Group roles or system-wide roles
- 
- ▶ We need shared **clinical governance** to oversee implementation of clinical integration
  - ▶ Over time we need to **integrate our back office** structures and systems (HR, IT, Finance)
- 
- ▶ We need a shared **reporting process and metrics** to allow like for like comparison and to highlight future collaboration opportunities
  - ▶ We need to establish a **shared quality improvement process** to tackle unwarranted variation

# We have a robust digital plan in place that we would accelerate where possible

We aspire to be the most Digital Hospital Group in England by July 2023. Of particular relevance to the Clinical Strategy are our commitments to:

- ▶ Implement **single sign-on** across all sites for our staff
- ▶ **Implement the Northamptonshire Care Record (NCR)**, fully supporting the digital strategy for the Northamptonshire Integrated Care System (ICS)
- ▶ Work together and with partners to **enable digital care for patients** across the Northamptonshire Health Economy in a joined-up and integrated care system
- ▶ **Hold virtual appointments** for our patients where safe and appropriate.
- ▶ **Virtually monitor our patients' condition**
- ▶ **Join our records up** so our patients have access to their records across the health system
- ▶ Have a **Group Electronic Patient Record** so that our two hospitals can share the same record, viewable from any location on any device
- ▶ Develop **dashboards that are intuitive and staff can use** to revolutionise decision-making
- ▶ Develop **universal NHS.net and Office 365 accounts** across all sites for our staff

## 6 | Our five promises for our staff and patients

### Our patients, their families and carers

#### We will:

- ✓ Join our patient records up so our patients have access to their health record across the whole health system
- ✓ Put our patients in control of their care, making it easy for our patients to receive care in a way that works for them
- ✓ Invest in technology that helps us to monitor our patients' condition wherever they are, meaning our patients can be cared for at home
- ✓ Make sure our systems are simple for our patients to use and provide support if people are struggling
- ✓ Protect our patients' data and information

### Our staff

#### We will:

- ✓ Work with our staff to understand solutions can be designed to improve our workplace a better place
- ✓ Reduce the number of different systems our staff need to use to do their jobs
- ✓ Make sure our staff have the appropriate software
- ✓ Make sure our NHS.net and Office 365 are joined up across the Group so we can work together more effectively
- ✓ Provide amazing training and support

## 7 | Our themes within the Digital strategy

 Empowering our patients, their families and carers

 Supporting our staff

 Doing the basics to have a solid foundation to build on

 Delivering clinically-led solutions

 Providing insight to support decision making

 Working with our health and care partners

 Connecting our systems

 Collaborating for a Shared Purpose



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# We have a robust people plan in place to support the development of our workforce

A focus on people as a core priority across the Group will ensure that we feel empowered and supported working within both Trusts. This will allow us to not only continue to provide excellent patient care, but also to ensure that we can provide an excellent experience for ourselves and our colleagues as an outstanding employer and create an inclusive place to work.

We will continue to improve our support for colleague health and wellbeing and ensure that people working within the Group feel supported and valued regardless of their background or circumstances.

We aim to empower people to voice suggestions and make improvements in how we deliver care together, ensuring our patients and service users receive the care they would wish to receive.

We will build compassionate leadership at all levels and ensure that leaders and managers are supported to lead, engage and develop their teams, in line with the staff survey feedback we have received.



## Our People pledges

Health & Wellbeing	We will provide bespoke health and wellbeing spaces and access to health assessment and psychological support for all our people
People Planning	We will support people plans for our patient services with effective attraction and retention plans that support new roles, new ways of working and career pathways.
People Partnering	To consider how we work with one another, reflecting, learning and ensuring feedback is heard and actioned, leading to a reduction in formal employee relations management
People Development	We will support colleagues to build a career providing opportunity for people joining us from any level and background to progress
People Processes	Colleagues will be able to access systems to enhance their work experience and flexibility
Organisational Development & Inclusion	To bring our dedicated to excellence values to life, improving the way we work with each other, particularly focusing on empowerment and inclusion
Volunteering	We aspire to have the largest volunteer base within the Group across the NHS with volunteers that are representative of the population of Northamptonshire providing opportunities for our community.



# We already have plans in place to recruit and retain a high quality and motivated workforce

## Our Group strategic priority

An inclusive place to work where people are empowered to make a difference

## Our ambition

Seeing an improvement in the feedback we receive from our colleagues, leading to being in the top 20% of acute Trusts with the national NHS staff survey

## Commitments

- ▶ Dedicated car parking and travel plan reviews across both sites
- ▶ Access to psychological support internally and within the county
- ▶ Physical places on site to work out, rest and relax, with refreshments
- ▶ Staff inclusion networks, leading to change and support increasing diversity in senior roles and development opportunities
- ▶ Increased International Recruitment to support current vacancies
- ▶ Development programmes which are consistent and enhance your career
- ▶ A resolution of a contractual query within 48 hours
- ▶ Having the largest number of volunteers in the NHS supporting across varied roles
- ▶ A shared temporary staffing service with access to additional experiences
- ▶ Consistent policies across both Trusts



## Ignite our Voice strategy

- ▶ Enhance staff development, diversity and inclusivity through our innovative Leadership programmes and fellowships
- ▶ Nurses, Midwives and AHPs will be supported to lead on research in clinical academic pathways
- ▶ Nurses, Midwives and AHPs have received training, coaching and support to lead Quality Improvement focussed on reducing harm and enhancing patient experience
- ▶ We will ensure all clinical areas will have progressed towards achieving the highest level of attainment in our respective accreditation programmes and develop a multi-professional approach





# Staff also highlight culture and communication as important if we are to achieve collaboration at pace

Addressing our culture and ensuring we communicate regularly with our teams came out as key priorities to address from our all-staff survey

## Key themes

- **Culture:** needing to remove the 'us vs them' mentality
- **Communication:** need for regular open communication with staff and patients

...we need to address the concerns of our staff through a comprehensive communications and change management process



## All-staff survey results (2021) – culture and communication identified as the key barriers to collaboration currently

'An **us and them** culture'

'There's a **competitive edge** to collaboration'

'Staff working on the shop floor not being consulted – **we need to be part of the development**'

'Need to understand if this will lead to **job losses**'

'**Culture** – one hospital told it is not good enough, the other perceived as snooty and superior'

'We need to remove the '**we are better than you**' attitude'

'Need an **open dialogue**'

'**History of competition** between the two trusts – this is a chance to develop a partnership and feeling of togetherness'

"We currently have two separate identities – **needs to be one identity**"

'This vision can only work with the **staff on board**'

'Staff are anxious about **travel times and job losses** – need more listening to Trust employees'

# We have recently become an academic university hospital and want to build our academic and research reputation

Our ambition to achieve international recognition as an academic centre that promotes and delivers better health service and provision and health outcomes to our patients

The Academic Strategy sets out how we will:

- ▶ Attract, retain and develop the country's top talent. Putting our staff and patients at the heart of its development by improving the training and development we offer
- ▶ Enable us to work more effectively with our health and care partners to collectively improve access, quality and consistency across local patient pathways and services
- ▶ Establish robust estates and digital infrastructure to support innovative clinical education and research
- ▶ Foster a culture of inclusivity and learning, with strong leadership championing the strategy
- ▶ Increase the number of patients included in clinical trials and success of funding from research networks, grant giving bodies and commercial sources



Our vision for the Academic Strategy is to **improve patient care through excellence in education and research**. We will achieve our vision by delivering the following eight objectives:

- ▶ Partnering with University of Leicester to become a University Teaching Hospital Group
- ▶ Foster a culture of learning, research and innovation with strong leadership championing the strategy
- ▶ Provide a multi-professional clinical academic programme and improved training and development offer for staff
- ▶ Increase opportunities and resources for innovation and research to be incorporated at the core of our work and clinical practice
- ▶ Build academic, research and digital infrastructure to support and grow innovative clinical education and an increased research portfolio
- ▶ Increase success of research funding from research networks, grant giving bodies and commercial sources
- ▶ Develop closer alignment with all our University partners
- ▶ Develop and promote the academic brand

# We also have an opportunity to re-build our hospitals, to support the delivery of high-quality services

## Our current estate

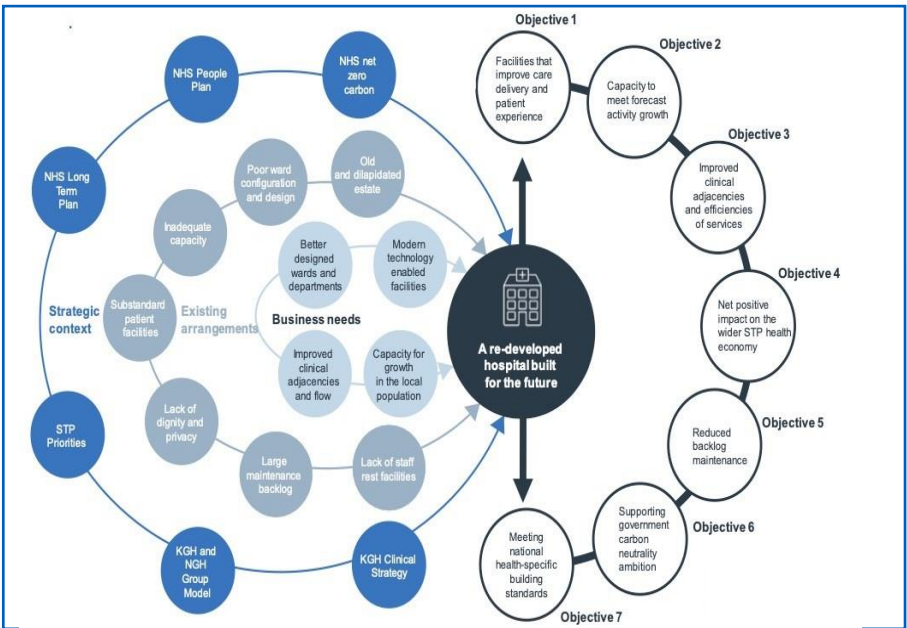
Both hospitals have an aging estate that doesn't provide the experience we would like for our patients or for our staff. Our clinical services are not able to always be co-located next to each other meaning staff and patients sometimes have to travel across our hospital sites, In some cases patients are cared for in cramped environments with limited natural light or privacy and dignity. For our staff, they often have to work in less efficient ways to treat patients effectively and keep patients safe.

## Our Estates Strategy

We will need to find ways to improve the current estate we have, and a Group Estate Strategy will follow to deliver the Group clinical strategy:

- **Kettering Hospital** submitted a Strategic Outline Case in January 2021 for a large re-build of the hospital incorporating a new ED and new wards, theatres, critical care and day services. This scheme is part of the national New Hospitals Programme and is on track to deliver by 2030.
- **Northampton General Hospital** will open a new state-of-the-art critical care unit in January 2022 and opened a designated children's emergency department and new main entrance in 2021. There are plans currently being developed to effectively deliver a whole hospital rebuild.

Our plans for KGH



Our new main entrance at Northampton Hospital

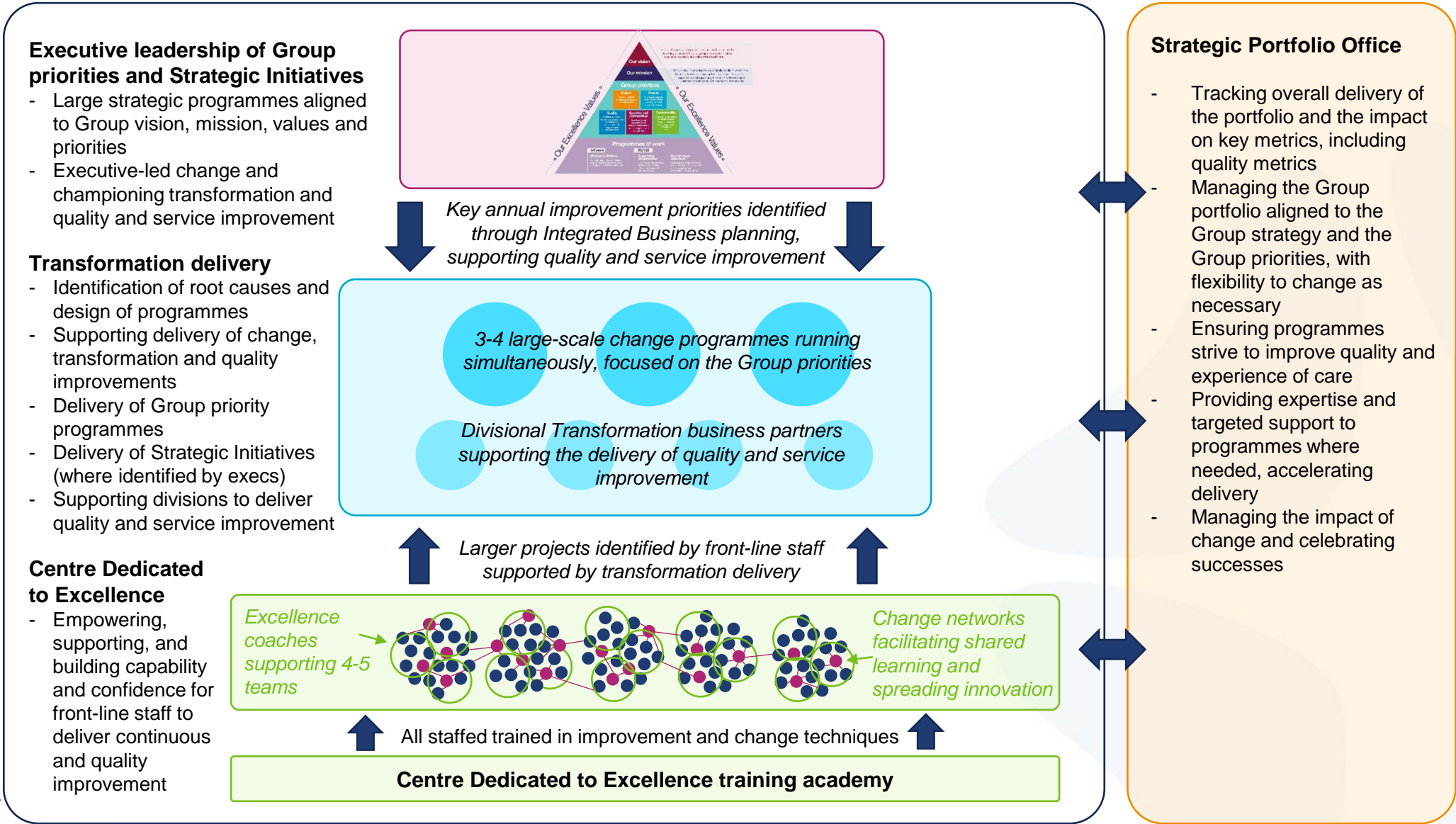


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# The Group Transformation and Quality Improvement team would drive forward these strategic priorities



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# 5

## Roadmap to implementation



# We cannot do everything at once so propose immediate priorities

- **Work with our partners** to reduce ill-health and reduce avoidable hospitalisation, including implementing the iCAN programme, developing community diagnostic hubs and creating an elective collaborative.
- Establish **two Centres of Excellence** in cancer and cardiology, starting by consolidating some services onto a single site and bringing staff together into a single team. This would improve outcomes for patients and reduce cancer waiting times.
- Protect elective capacity by **increasing provision of ringfenced beds**, with services working to develop shared protocols and pathways in line with national guidance focussing on orthopaedics, general surgery, urology, ophthalmology and ENT. This would reduce waiting times for patients and ensure equity of access across Northamptonshire.
- Building on our University Hospital status by **significantly expanding research in our two centres of excellence: cancer and cardiology**. This would benefit patients taking part in research and help us to attract and retain high quality staff.
- **Establish single leadership models** to begin to address the problems faced by some of our most fragile services including:
  - ✓ Neurology
  - ✓ Microbiology
  - ✓ Specialist paediatrics
  - ✓ Specialist cancer
  - ✓ Plastics
  - ✓ Specialist cardiology
  - ✓ Respiratory
- **Subject to engagement, prioritise financial investments**
  - ✓ Dedicated cardiac MRI at Kettering General Hospital
  - ✓ Specialist cancer robot at Northampton General Hospital
  - ✓ Co-located head and neck estate at Northampton General Hospital



# 6

## Next steps

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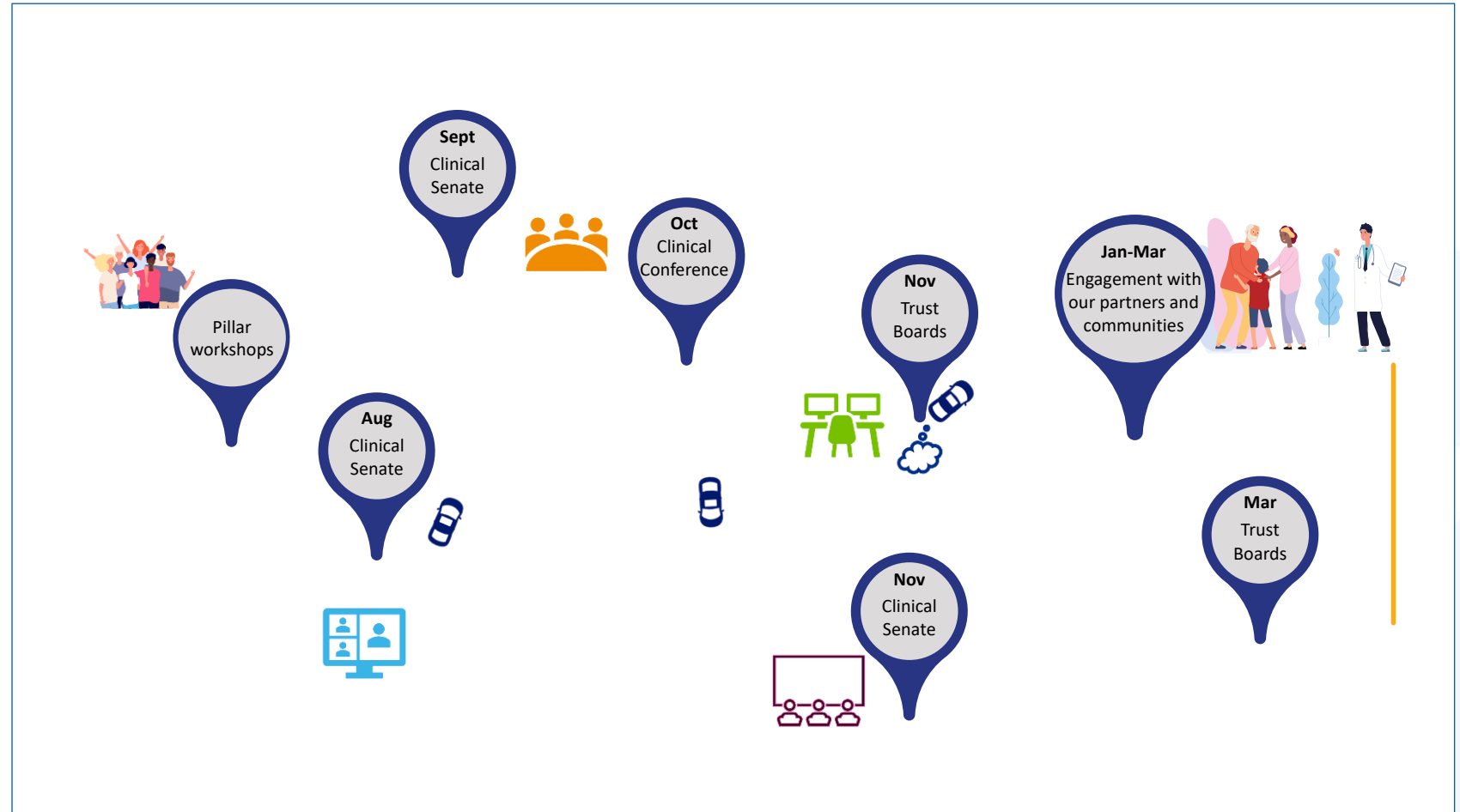
# This clinical ambition document will be taken for Board sign-off in November 2021, followed by extensive engagement

## Next steps

This clinical ambition document will be taken for Board sign-off in November 2021, followed by a period of engagement on the proposals.

We will then embark on extensive engagement to discuss and iterate our proposals before publishing our clinical strategy and implementation plan in April 2022.

Following this, we will enter the implementation planning phase, supporting teams to fully implement our ambitions.



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# Our plans for engagement

## Clinical ambitions document May-Nov 2021

- Data gathering
- Engagement with UHN clinicians
- Initial discussions with partners
- Proposal formulation
- Clinical ambitions document published

## Engagement Nov 2021 – Feb 2021

### Key audiences for early engagement:

- Staff
- Patients, carers and public
- Northamptonshire Health and Care Partnership
- Health overview and scrutiny committees
- Political leaders (local and national)

Other audiences to be identified via comprehensive stakeholder mapping

### Channels for engagement:

- Regular face-to-face briefings
- Regular online Q&A
- Dedicated digital channels including social media, web pages and intranet page
- Newsletters
- Media releases

Regular measurement and evaluation process to manage inaccurate reporting across internal and external channels

Engagement feedback document to be considered at Trust Board in March 2022

## Clinical strategy Mar 2021

- Revised clinical strategy
- Detailed implementation planning and prioritisation
- Clinical strategy and implementation plan published in April 2022

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# We will engage widely with our partners and local communities

The communications and engagement framework will be designed within the Government's OASIS model.

## Objective/aim

- ▶ Inform all those involved, within the Group and wider externally
- ▶ Ensure engagement from all involved
- ▶ Develop cohesion
- ▶ Garner support for suggested direction of travel

## Strategy and ideas

Engagement with internal audiences will be based on the 'no surprises' principle, with a comprehensive plan developed to ensure all internal audiences are communicated to in a timely manner via appropriate channels.

The external communications strategy will be determined by the stakeholder mapping exercise, although the range of channels available – face-to-face meetings, written briefings, digital channels (including social media) and media engagement – will be utilised as appropriate. Again, 'no surprises' will be the determining principle guiding external communications and engagement.

## Implementation

Communications and engagement with key internal audiences is already underway and this process will be expanded to ensure all key staff are involved and informed as appropriate. It is anticipated much of the initial communications will be primarily face-to-face, to ensure appropriate two-way communication and engagement, with opportunities to gather feedback and views as the plan progresses. Other channels, such as a regular drumbeat of newsletters and fora, will be considered, alongside dedicated digital channels, with existing channels used for wider engagement with colleagues, in line with development and implementation milestones. External communication initially will serve to ensure key stakeholders are informed appropriately, and media (traditional and digital) engagement plans are in place to allay concerns with a schedule of timely communications to ensure accuracy of messaging.

## Scoring and evaluation

The communications plan will be designed to flex in line with feedback and scoring, ensuring messages are landing appropriately with audiences. With the dominant communication channel being face-to-face, qualitative feedback will be obtained from audiences as engagement occurs. Additionally scoring and evaluations methods will include:

- ▶ Pulse surveys
- ▶ Social media engagement rates
- ▶ Media evaluation
- ▶ Audience consultation



# Centre of Excellence: Cancer

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# Cancer services are currently provided on both sites, with several specialist services provided outside of county

Cancer care is currently provided at both hospital sites, with some specialist services on a single site

Cancer Services @ KGH	Cancer Services @ NGH
<ul style="list-style-type: none"><li>› Diagnostics</li><li>› Oncology (medical)</li><li>› Haematology (malignant and non-malignant)</li><li>› Chemotherapy (NGH-based oncologists)</li><li>› Immunotherapy</li><li>› Systemic Anti Cancer Treatments (SACT)</li><li>› Supportive treatment e.g. blood transfusions</li><li>› Breast screening</li><li>› Surgical cancer treatment</li><li>› Total Lung Health checks</li><li>› Bowel cancer screening unit</li></ul> <p>KGH currently provide the Bowel Cancer Screening Service for Leicestershire, Northamptonshire and Rutland area</p>	<ul style="list-style-type: none"><li>› Diagnostics</li><li>› Oncology (medical)</li><li>› Haematology (malignant and non-malignant)</li><li>› Chemotherapy</li><li>› Immunotherapy</li><li>› Systemic Anti Cancer Treatments (SACT)</li><li>› Supportive treatment e.g. blood transfusions</li><li>› Breast screening</li><li>› Surgical cancer treatment (inc. all head and neck)</li><li>› Direct emergency admissions for patients undergoing chemo treatment</li></ul> <p>NGH provides radiotherapy, chemotherapy and brachytherapy for KGH, NGH and MKUH</p>

- › Northamptonshire Breast Service working across KGH and NGH with a single rota and pooled clinical capacity to deliver one stop clinics
- › Surgery is provided by two completely separate teams, chemotherapy is a single team working across two sites
- › Some specialist services provided at Leicester (pelvic, lung, upper GI), Oxford (brain), Nottingham (sarcoma)



# Local and national strategies set the strategic context for our proposals for cancer services

There are several national, regional and local strategies and guidelines that have been considered as part of the joint clinical strategy design. The below provides a summary of the key recommendations

## NATIONAL

- ▶ **NHS Long Term Plan:** sets the ambition that by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% to 75% of cancer patients. The NHS will also continue pioneering precision medicine such as CAR-T cancer therapies.
- ▶ **Health and Care white paper:** supports greater integration across local health and care organisations through the establishment of integrated care systems
- ▶ **Diagnostics: Recovery and Renewal 2020:** recommends implementation of rapid diagnostic centres (RDCs) to offer a single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer.

## GROUP/ REGIONAL

- ▶ **East Midlands Cancer Alliance:** evidence suggests access to and provision of robotic surgery provides a number of benefits and can offer safer surgical procedure and smooth recovery for patients. Supporting partners to scope demand and benefits for robotic surgery across the region.
- ▶ **Group Nursing, Midwifery, Allied Health Professional Strategy 21-24:** ambition to become the first group hospital accredited as Pathway to Excellence – a positive practice environment that allows nurses to flourish because of job satisfaction, professional growth, development, respect and appreciation.
- ▶ **Group Digital Strategy:** ambition to implement a shared electronic patient record, ambition to enable staff to virtually monitor patient's and deliver care through virtual appointments where safe and appropriate
- ▶ **Group Academic Strategy:** ambition to achieve international recognition as an academic centre that promotes and delivers better health service and provision and health outcomes to our patients

## LOCAL

- ▶ **The KGH Clinical Strategy 2020:** against a background of great performance historically, KGH are delivering against more stringent cancer targets. Strategy to address these includes a delivery plan for radiology services and overall increase in hospital capacity.
- ▶ **The NGH Strategy 2019-24:** acknowledges the challenges with meeting national cancer targets and sets the ambition to deliver high quality and timely cancer pathways. NGH want to deliver cutting edge cancer care by introducing robotic surgical techniques for cancer surgery and improving patient experience with the build of Maggie's centre.



# Our case for change shows that there are several issues that we must address

As well as responding to the recommendations of key strategies, there are several other drivers for change that services are facing. These are addressed within our proposals for cancer services.

## There is growing demand for services

- ▶ Northamptonshire population is projected to increase by 14% 2018-2038. In 20-64 year olds there is projected to be a 7% increase, in the 65yrs+ there is projected to be a 50% increase [1].

## Patients are not always satisfied with our service

- ▶ National Cancer Survey 2019 – ‘Overall how would you rate your care?’ both Trusts were in the bottom three when compared with East Midlands Cancer Alliance peers.
- ▶ Patients are moved between teams and information is transferred, meaning care is not seamless

## We can become a centre for academic excellence

- ▶ According to the National Cancer Survey 2018 – only 16% of patients at KGH and 20% of patients at NGH were invited to participate in cancer research following their diagnosis (national average is 30%)
- ▶ Increasing research trials across the group will help us to attract and retain staff.

## We need to invest in new technology and ways of working

- ▶ Opportunity for the Group to improve care and patient outcomes by focusing on specialist areas e.g. robotic surgery
- ▶ Opportunity to improve patient experience by sharing best practice and adopting new models such as PIFU

## Further integration with community partners would improve outcomes

- ▶ Need to provide timely accessible care for patients across the county (at home/ in community) which requires greater integration with system partners
- ▶ Integration could improve front of pathway e.g. diagnostics in community and back of pathway e.g. supported discharge and community monitoring

## Delivery of emergency care has a continuing impact on planned care

- ▶ Need to consider the delivery of hot and cold sites, to ensure planned care can continue despite pressures on emergency care
- ▶ Operating as two teams restricts our opportunity to move patients between sites

## We have difficulty recruiting and retaining staff

- ▶ High staffing vacancies for oncology and haematology & poor retention of staff
- ▶ Recruitment challenges for medical staff leading to poor levels of timely access to advice and treatment at KGH
- ▶ Challenge recruiting cancer nurse specialists [3]
- ▶ Challenges in junior doctor satisfaction and support and training

## We have insufficient volume of activity in some services

- ▶ As individual hospitals, we have insufficient activity to deliver the most specialist services
- ▶ Lower throughput can have an impact on outcomes and staff retention

Sources: [1] [ONS Population Projections 2018-2028](#) [2] KGH Clinical Strategy Jan 2020, [3] NGH Clinical Service Model Reviews 19/20 [4] National Cancer Survey Results by Trust

# We have an ambition to develop a cancer Centre of Excellence for Northamptonshire

## Our ambition for a cancer Centre of Excellence

The cancer Centre of Excellence would be an **integrated service** that the Group is known for nationally owing to **excellent outcomes and patient experience, complexity of caseload and extensive research output**.

The Centre of Excellence would **attract and retain leading experts**, offering **outstanding career and development opportunities** and providing a sustainable service that supports growth and innovation.

The Group would collaborate with system partners to explore new ways of working to increase the **accessibility of cancer care**

## As a Cancer Centre of Excellence, we would commit to...

- ✓ Achieving top 10%\* nationally for a number of patient experience and outcome metrics, including Cancer patient experience survey results
- ✓ Ensuring every cancer patient has the opportunity to participate in a clinical trial where available and clinically appropriate
- ✓ Offering more Northamptonshire patients the chance to be seen and treated by our team if that is what they choose [repatriating some of the activity that is currently sent out of area]
- ✓ Delivery of constitutional standards: 28 day diagnostic standard, maximum 62 day wait to first treatment from urgent GP referral, maximum one-month wait from decision to treat to treatment.

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\*10% is a commitment in the Group's dedicated to excellence strategy; the working group suggested 25% target –to confirm

# The cancer Centre for Excellence would deliver our key principles for excellent care

- › **Integrated, seamless care for patients:** so that people get the care they need when they need it without having to re-tell their story, supported by multi-disciplinary team working wherever possible
- › **As close to home as possible:** so that people don't need to travel further than necessary to access services, saving the time and inconvenience
- › **Delivered equitably across the county:** so that everyone has equal opportunity to access high quality services
- › **Focus on prevention and early detection:** so that people don't become ill and don't progress to more severe illness
- › **Supports research and innovation:** so that we can offer the latest treatments to improve health outcomes and contribute to the development of new treatments and technologies
- › **Attract and retain high quality staff:** so that we can provide the highest quality service for patients
- › **Deliver cutting edge treatment, as quickly as possible:** so that people don't need to wait long for treatment, reducing worry and improving health outcomes
- › **Fit for purpose facilities and estate:** so that services can be delivered as efficiently as possible with improved quality in areas such as infection control
- › **Best use of available resources:** so that we can provide the best service we can with the resources that we have

# To deliver the cancer Centre of Excellence, we would pursue four themes, underpinned by three enablers

Themes			
Research and innovation	Treatment and care	Modernising infrastructure	Sustainability
<ul style="list-style-type: none"> <li>Access to clinical trials</li> <li>Preventing cancers</li> <li>Detecting cancers</li> <li>Pathways</li> <li>Digital</li> </ul>	<ul style="list-style-type: none"> <li>Integrated care models</li> <li>Risk stratified pathways</li> <li>Collective expertise</li> <li>Repatriation of activity</li> </ul>	<ul style="list-style-type: none"> <li>Redevelopment</li> <li>Co-location</li> <li>Investing in clinical capacity/ green sites</li> <li>Diagnostics</li> <li>Genomic medicine</li> <li>Information</li> <li>Digital technology</li> </ul>	<ul style="list-style-type: none"> <li>Operational flexibility</li> <li>Stage migration</li> <li>Prevention/ screening/ cessation</li> </ul>

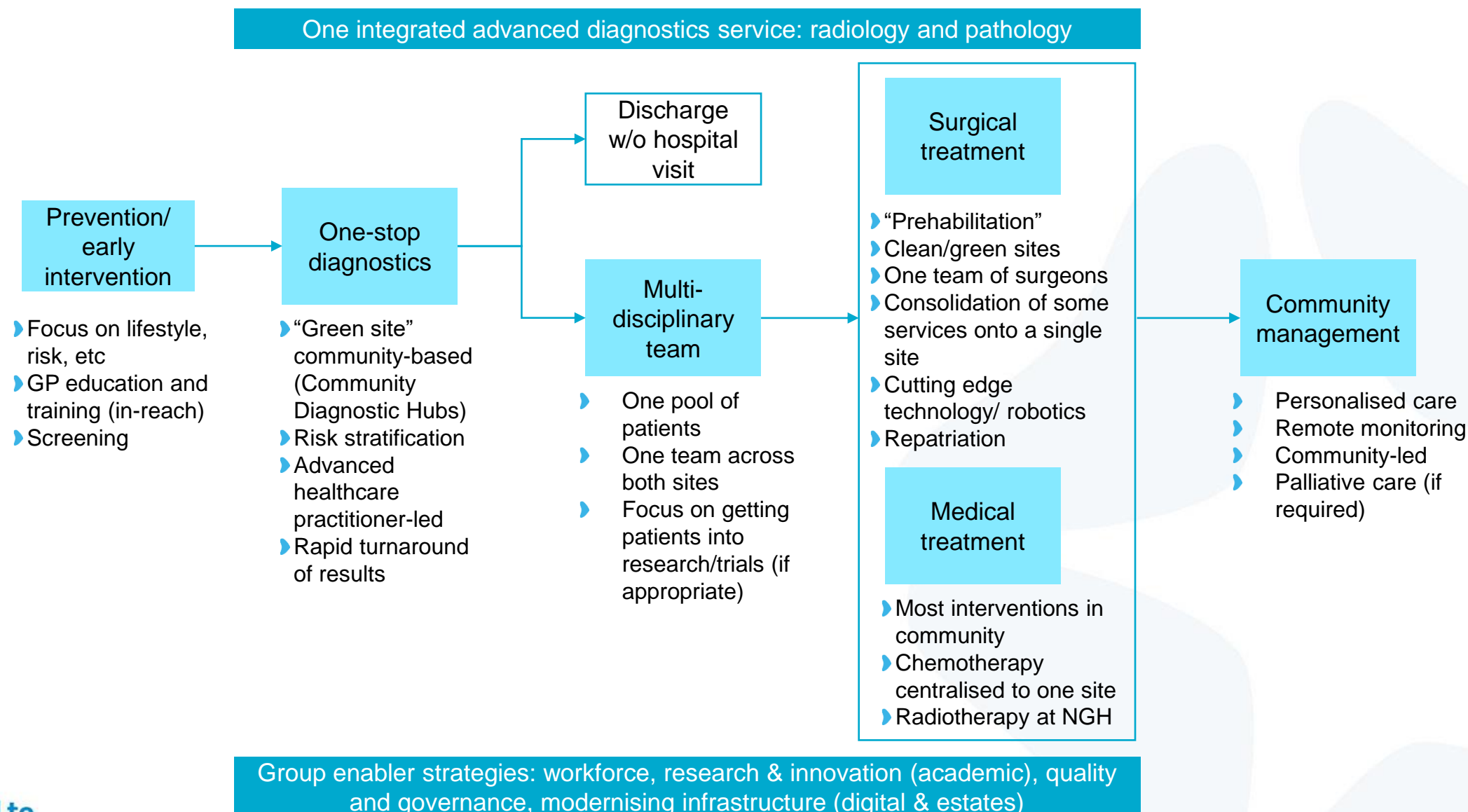
Enablers

**Workforce:** education and training, expert workforce for future, new roles and technology, recruitment

**Quality and governance:** patient safety and experience, regulation, safety innovation, system leadership

**Efficiency and transformation:** early risk assessment, enhance referral communication, enhance triage

# These themes would improve care along the whole cancer pathway over the next 3-5 years



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# There are key enablers that would be required to support the successful implementation of the cancer proposals over 3-5 years



## Workforce

- ▶ Skills mix review
- ▶ Organisational/team development



## Quality and governance

- ▶ Single system leadership
- ▶ Synchronised governance
- ▶ Agreed common pathways



## Research and innovation (academic)

- ▶ New academic post in cancer
- ▶ Successful delivery of our new NIHR Biomedical Research Centre
- ▶ Establishing Cancer research board to develop academic, research and commercial collaborations.



## Modernising infrastructure (estates & digital)

- ▶ Investment in technology/robotics
- ▶ Development of community diagnostic hubs
- ▶ Single patient record

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# Our proposals would mean some changes to how and where we provide cancer services

Our proposals would mean some changes to how and where we provide cancer services for local people in Northamptonshire over the next five years with the aim of improving clinical outcomes of treatment

Cancer Services @ KGH	Cancer Services @ NGH
<ul style="list-style-type: none"><li>▶ Diagnostics</li><li>▶ Oncology (medical)</li><li>▶ Haematology (malignant and non-malignant)</li><li>▶ Chemotherapy (NGH-based oncologists)</li><li>▶ Immunotherapy</li><li>▶ Systemic Anti Cancer Treatments (SACT)</li><li>▶ Supportive treatment e.g. blood transfusions</li><li>▶ Breast screening</li><li>▶ Total Lung Health checks</li><li>▶ Bowel cancer screening unit</li></ul> <p>KGH currently provide the Bowel Cancer Screening Service for Leicestershire, Northamptonshire, and Rutland area</p>	<ul style="list-style-type: none"><li>▶ Diagnostics</li><li>▶ Oncology (medical)</li><li>▶ Haematology (malignant and non-malignant)</li><li>▶ Chemotherapy</li><li>▶ Immunotherapy</li><li>▶ Systemic Anti Cancer Treatments (SACT)</li><li>▶ Supportive treatment e.g. blood transfusions</li><li>▶ Breast screening</li><li>▶ Robotic cancer treatment</li><li>▶ Specialised cancer services</li><li>▶ Direct emergency admissions for patients undergoing chemo treatment</li></ul> <p>NGH provides radiotherapy, chemotherapy and brachytherapy for KGH, NGH and MKUH</p>
<ul style="list-style-type: none"><li>▶ Single point of access for patients</li><li>▶ One clinical team for Northamptonshire operating across both sites. Surgical care provided mainly from NGH.</li><li>▶ Single integrated clinical leadership and management structure with one governance route with ability to make decisions on behalf of both organisations</li></ul>	

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# In the first year, we would take some initial steps to deliver our proposals (1/2)

Area	Changes	How we will know we succeeded	Benefit
Prevention/ early intervention	<ul style="list-style-type: none"> <li>Expansion of Total Lung Checks to whole county and therefore equal access</li> </ul>	<ul style="list-style-type: none"> <li>Total Lung Checks rolled out across county</li> </ul>	<ul style="list-style-type: none"> <li>Prevention of lung cancer</li> </ul>
One-stop diagnostics	<ul style="list-style-type: none"> <li>One-stop diagnostic operational at one community diagnostic hub (CDH)</li> </ul>	<ul style="list-style-type: none"> <li>Consistently meet faster diagnosis standards for all patients</li> </ul>	<ul style="list-style-type: none"> <li>Faster access to diagnostics resulting in better outcomes for patients</li> </ul>
Multi-disciplinary teams	<ul style="list-style-type: none"> <li>Joint clinics (pool of patients) for all pathways</li> </ul>	<ul style="list-style-type: none"> <li>Single PTL</li> <li>Merged operations team</li> <li>Similar waiting times for both sites</li> </ul>	<ul style="list-style-type: none"> <li>Equity of access for patients</li> <li>More efficient use of resources</li> </ul>
Treatment (surgical):	<ul style="list-style-type: none"> <li>Aim to consolidate breast surgery (subject to engagement)</li> <li>Aim to consolidate head &amp; neck surgery (subject to engagement)</li> </ul>	<ul style="list-style-type: none"> <li>All breast surgery coded to single site</li> <li>All head and neck surgery coded to single site</li> </ul>	<ul style="list-style-type: none"> <li>Improved outcomes as teams undertake a greater volume of procedures and more attractive to recruit</li> </ul>
Treatment (medical):	<ul style="list-style-type: none"> <li>MDT delivery of chemotherapy (single team)</li> <li>Pilot a community chemotherapy clinic</li> </ul>	<ul style="list-style-type: none"> <li>Proportion of chemotherapy delivered outside of hospital in "green" site</li> </ul>	<ul style="list-style-type: none"> <li>Sick patients do not have to travel to hospital for treatment</li> <li>Reduced risk of infection</li> </ul>

# In the first year, we would take some initial steps to deliver our proposals (2/2)

Area	Changes	How we will know we succeeded	Benefit
Workforce	<ul style="list-style-type: none"> <li>Undertake skills mix/roles review</li> </ul>	<ul style="list-style-type: none"> <li>New roles for nurses/AHPs in place at both sites</li> </ul>	<ul style="list-style-type: none"> <li>More attractive place for staff to work and therefore improved recruitment and retention</li> </ul>
Research and innovation (academic)	<ul style="list-style-type: none"> <li>Cancer academic post in place</li> <li>Single research team and academic appointments for cancer</li> </ul>	<ul style="list-style-type: none"> <li>At least 22% of patients at both sites to be invited to take part in cancer research</li> </ul>	<ul style="list-style-type: none"> <li>More attractive place to work – improve recruitment and retention</li> <li>Support the development of new treatment and technologies</li> <li>Improve access to new treatment and technologies for patients</li> </ul>
Quality and governance	<ul style="list-style-type: none"> <li>Align governance across both sites</li> <li>Develop an end of life strategy with system partners</li> </ul>	<ul style="list-style-type: none"> <li>Merged overarching cancer board</li> <li>Joint harm reviews (with CCG)</li> <li>Single MDT leadership for an additional tumour site (gynae)</li> </ul>	<ul style="list-style-type: none"> <li>Safer services from joint learning</li> <li>More joined up care for patients</li> </ul>
Modernising infrastructure (estates and digital)	<ul style="list-style-type: none"> <li>Procure and establish referral assessment system (RAS) for:                             <ul style="list-style-type: none"> <li>Urology (repatriate)</li> <li>Colorectal</li> </ul> </li> <li>Introducing robotic surgery at NGH</li> </ul>	<ul style="list-style-type: none"> <li>Robotic platform at NGH business case agreed</li> </ul>	<ul style="list-style-type: none"> <li>Robotic surgery available for local people in Northamptonshire</li> </ul>

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# Centre of Excellence: Cardiology

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# Cardiology services are currently provided on both sites, with PPCI and a coronary care unit at KGH

Cardiology services are provided at both hospital sites, with some specialist services at Kettering General Hospital

## Cardiology services @ KGH

- › Acute cardiology
- › Rapid access chest pain unit
- › Cardiac rehabilitation services
- › Coronary care unit
- › Cardio-respiratory diagnostics
- › Cardiovascular MRI
- › Adult congenital heart disease (ACHD) clinics
- › Kettering Cardiac Centre
  - › Pre-assessment clinics
  - › Outpatients and diagnostics
  - › Planned procedures including percutaneous coronary intervention (PCI), implantable cardioverter-defibrillator (ICD) and permanent pacemakers (PPM)
  - › 24 hour Primary Percutaneous Coronary Intervention (PPCI) emergency service (Northamptonshire and surrounding areas)

*Services requiring co-location with acute cardiology*  
*Emergency Department – mostly unselective*

## Cardiology services @ NGH

- › Acute cardiology
- › Rapid access chest pain clinic
- › Cardiac rehabilitation services
- › Myocardial perfusion scintigraphy (MPS)
- › Adult congenital heart disease (ACHD) clinics
- › Northampton Heart Centre
  - › Pre-assessment clinics
  - › Outpatients and diagnostics
  - › Planned procedures including percutaneous coronary intervention (PCI), implantable cardioverter-defibrillator (ICD) and permanent pacemakers (PPM)
- › Cardiothoracic surgical clinic (visiting surgeons from Oxford)

*Services requiring co-location with acute cardiology*  
*Emergency Department – mostly unselective*  
*Vascular surgery*



# Local and national strategies set the strategic context for our proposals for Group cardiology

There are several national, regional and local strategies and guidelines that have been considered as part of the joint clinical strategy design. The below provides a summary of the key recommendations

## NATIONAL

- ▶ **NHS Long Term Plan:** identifies cardiovascular disease (CVD) as the single biggest area where the NHS can save lives over the next decade. CVD is largely preventable through lifestyle changes and there is a need to increase early detection and treatment of CVD. People with heart failure and heart valve disease will be better supported by multi-disciplinary teams within primary care networks.
- ▶ **Getting it right first time (GIRFT) Cardiology report (2021):** clinical cardiology networks should be established shaped by function and need rather than geography and all hospitals should be able to provide extended access to diagnostics, 24/7 on-call rotas for consultant cardiologists with 7-day ward rounds are recommended for acute medical admissions and a 7-day pacing (cardiac rhythm management (CRM)) service, there should be an emphasis on multidisciplinary teams within hospitals and across cardiology networks and digital transformation will be key to transform outpatient care and improve communication..
- ▶ **The Future of Cardiology, British Cardiovascular Society (2020):** cardiology services should be delivered on the basis of networks or systems of care that are fully and seamlessly integrated from community to tertiary care. As default, diagnostics should be delivered in an integrated community diagnostic hub run by secondary care in partnership with primary care. Virtual consultation should become the norm in both primary and secondary care.

## GROUP

- ▶ **Group Nursing, Midwifery, Allied Health Professional Strategy 21-24:** ambition to become the first group hospital accredited as Pathway to Excellence – a positive practice environment that allows nurses to flourish because of job satisfaction, professional growth, development, respect and appreciation.
- ▶ **Group Digital Strategy:** ambition to implement a shared electronic patient record, ambition to enable staff to virtually monitor patient's and deliver care through virtual appointments where safe and appropriate
- ▶ **Group Academic Strategy:** ambition to achieve international recognition as an academic centre that promotes and delivers better health service and provision and health outcomes to our patients

## LOCAL

- ▶ **The KGH Clinical Strategy 2020:** ambition to create a single cardiology service to improve care and outcomes for patients across Northamptonshire. Focus on raising clinical standards to a consistently high level across the county and expand the service to treat more patients. Integrate service with system partners to deliver proactive and preventative care.
- ▶ **The NGH Clinical Service Reviews:** Ambition to create and deliver a single countywide integrated cardiology service agreed by clinical and operational stakeholders. The service will consistently deliver excellence in quality of care and patient experience. Pooled resources will improve waiting times and reduce readmission rates and bed days for heart failure patients through enhanced discharge to community services.



# Our case for change shows that there are several issues that we must address

As well as responding to the recommendations of key strategies, there are several other drivers for change that services are facing. These are addressed within our proposals for cardiology services.

## There is growing demand for our services

- ▶ In Corby CCG, the **prevalence of heart failure is higher** than the national average \*0.91% compared to 0.76% in England) [2]
- ▶ Heart failure rates are expected to rise with the increase in the over 65s population. There is expected to be a 50% increase in the 65yrs+ population in Northamptonshire between 2018 and 2038 [3].

## There are differences in the services available across the county

- ▶ Patients across NGH and KGH do not have equal access to high quality cardiology and cardiac services.
- ▶ Sub optimal pathways resulting in extended length of stay and adverse readmission rates e.g. **Acute Coronary patients** wait longer in NGH over weekend for PCI.
- ▶ Variable access to **cardiac rehab** support - none at NGH, planning to start at both sites.

## There is an opportunity to provide more specialist services locally

- ▶ There is an opportunity to build and sustain specialist services such as **electrophysiology** provision and grow existing specialist services such as **C-MRI**.
- ▶ Increasing access to specialist service provision will enable the Group to deliver improved patient outcomes and offer attractive career opportunities for leading experts.



## We have difficulty recruiting and retaining our staff

- ▶ There is a **national shortage** of specialist nursing and physiologists for catheter labs and ECHO
- ▶ Recruitment is challenged by the geography of KGH/ NGH, located close to leading teaching hospitals
- ▶ Retention is challenged by high workload and National shortage
- ▶ Terms and conditions are different between the two sites
- ▶ A reduction in job plans for NGH consultants has decreased capacity in the medical workforce leading to an increased waiting list and poor RTT (waiting list) performance

## Some of estate not fit for purpose

- ▶ Not all estate is fit for purpose (for example, there is no BSE-accredited ECHO department at NGH and not enough offices)

## We need to do more multidisciplinary and network working to improve outcomes and patient experience

- ▶ We currently have two separate teams on our two sites
- ▶ The cardiology GIRFT report calls for the establishment of cardiology networks, greater access to diagnostics, 24/7 on-call rotas for consultant cardiologists with 7-day ward rounds and a greater emphasis on multi-disciplinary working
- ▶ The NHS long term plan emphasises the need for enhanced care for cardiovascular disease and prioritises more effectively integrated services

Sources: [1] [Northamptonshire JSNA](#), [2] The KGH Clinical Strategy 2020, [3] [ONS Population Projections 2018-2028](#)

# We have developed a vision for a cardiology Centre of Excellence for Northamptonshire

The cardiology Centre of Excellence would be an integrated service that the Group would be known for nationally owing to **exemplary outcomes, excellent patient and staff experience**, and **complexity of caseload**.

The cardiology service would be known for its **extensive research capability, scholarship and academia, attracting and retaining leading experts** in the field.

The cardiology service would work **closely and integrate with colleagues in the community** to improve cardiovascular health and disease prevention for our local population.

## As a Cardiology Centre of Excellence, we would commit to...

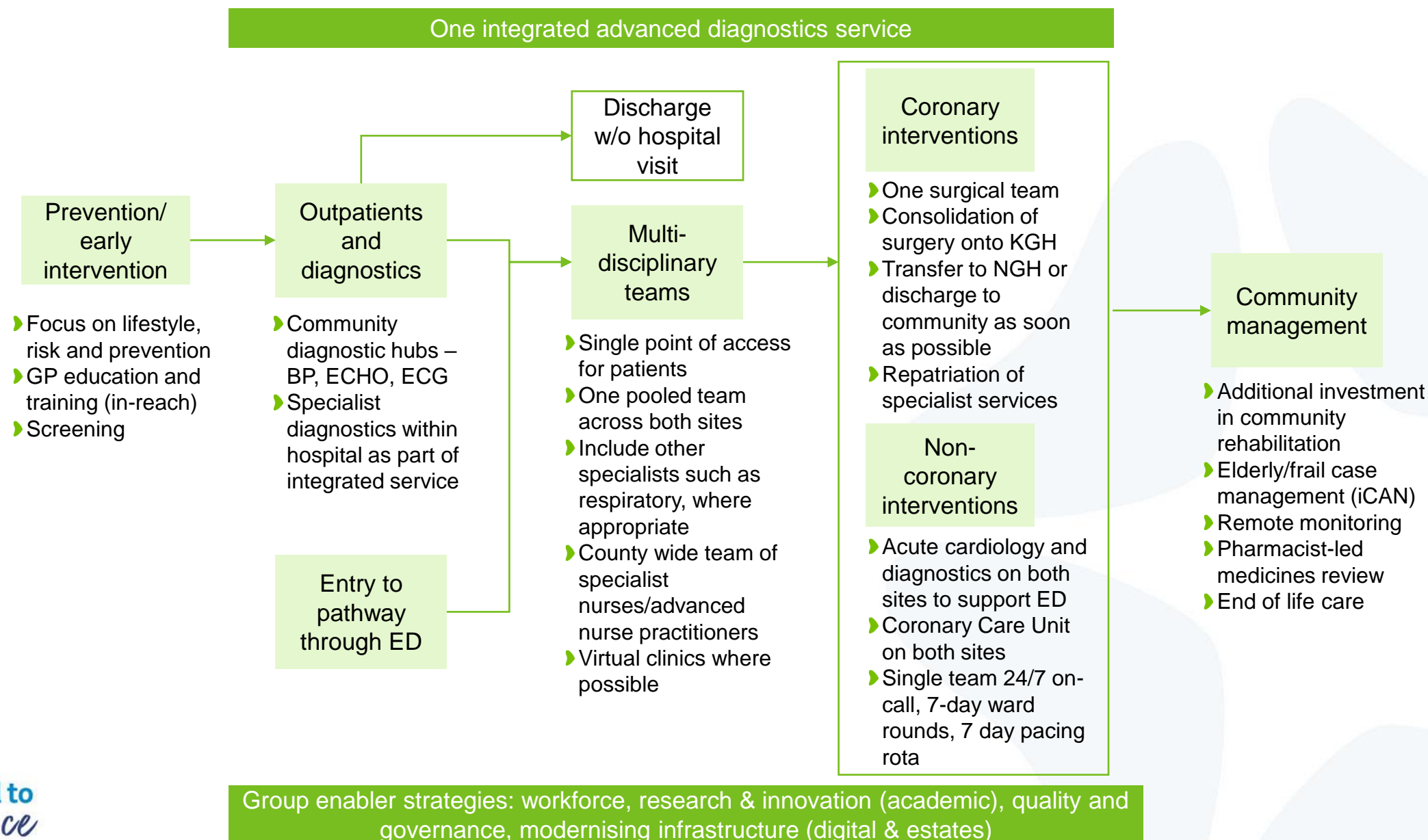
1. Delivering national quality standards for PCI as set out by Getting it Right First Time (GIRFT) and BCIS (British Cardiovascular Intervention Society)
2. Delivering national quality standards for pacing as set out by Getting it Right First Time (GIRFT) and the National Institute for Cardiovascular Outcomes Research (NICOR)
3. No duplication of complex procedures across sites, to improve quality and performance
4. Single cross site studies which will allow for greater population recruitment
5. Offering more Northamptonshire patients the chance to be seen and treated by our team if that is what they choose
6. Work in partnership with North West Anglia Foundation Trust to improve access to specialist cardiac services to all our PPCI catchment area

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# The cardiology Centre for Excellence would deliver our key principles for excellent care

- **Integrated, seamless care for patients:** so that people get the care they need when they need it without having to re-tell their story, supported by multi-disciplinary team working wherever possible
- **As close to home as possible:** so that people don't need to travel further than necessary to access services, saving the time and inconvenience
- **Delivered equitably across the county:** so that everyone has equal opportunity to access high quality services
- **Focus on prevention and early detection:** so that people don't become ill and don't progress to more severe illness
- **Supports research and innovation:** so that we can offer the latest treatments to improve health outcomes and contribute to the development of new treatments and technologies
- **Attract and retain high quality staff:** so that we can provide the highest quality service for patients
- **Deliver cutting edge treatment, as quickly as possible:** so that people don't need to wait long for treatment, reducing worry and improving health outcomes
- **Fit for purpose facilities and estate:** so that services can be delivered as efficiently as possible with improved quality in areas such as infection control
- **Best use of available resources:** so that we can provide the best service we can with the resources that we have

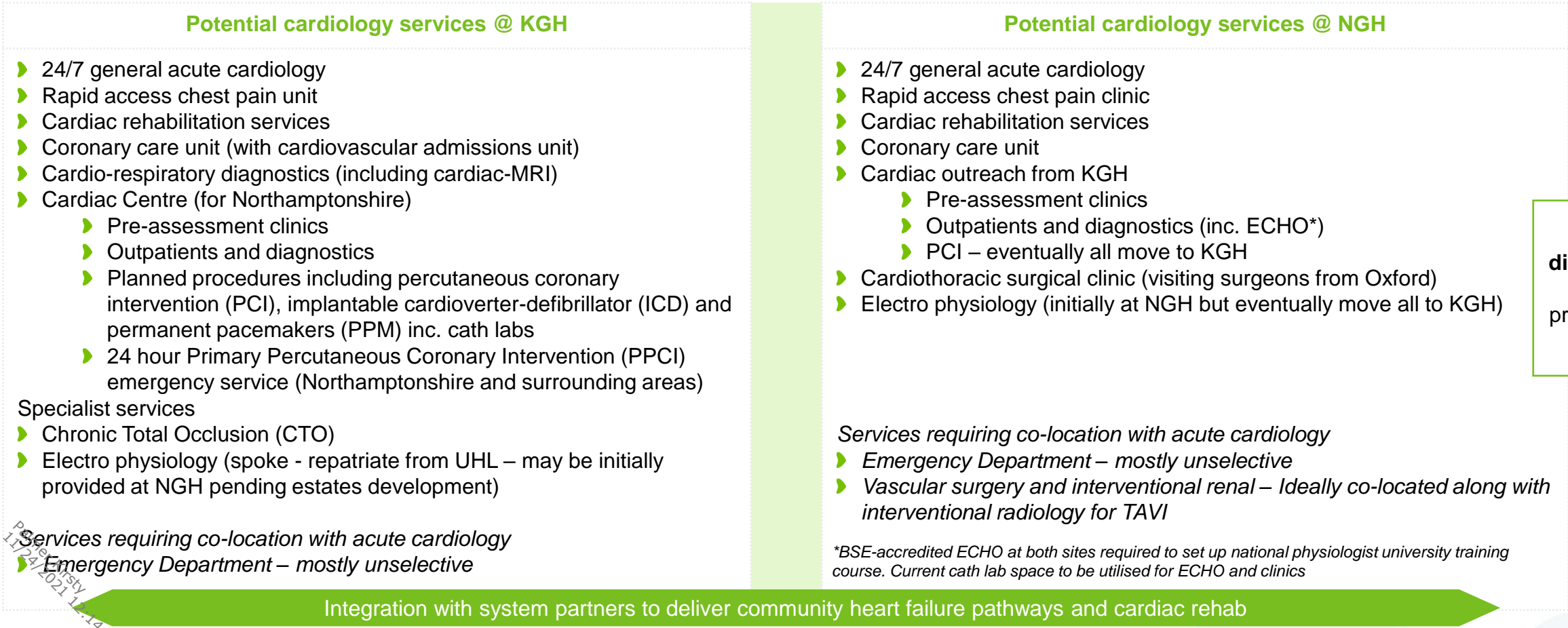
# We would improve care along the cardiology pathways over the next 3-5 years



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# Our proposals would mean some changes to how and where we provide cardiac services

- Single point of access for patients
- One site service with outreach provided on the second site. Single team operating across both sites.
- Single integrated clinical leadership and management structure with one governance route with ability to make decisions on behalf of both organisations.





# There are key enablers required to support the successful implementation of the proposals over 3-5 years

## Workforce



- › Organisational/team development
- › New appointments to both organisations automatically to facilitate cross-site working
- › Alignment of workforce conditions, including parity of pay between sites, ensuring we are able to retain staff
- › Establish team of county wide specialist nurses/advanced nurse practitioners therefore upskill to deliver cardiac assessments
- › Provide career path and progression for all advanced healthcare practitioners (AHPs)
- › Further develop international recruitment programme for middle grade and hospital specialists in cardiology



## Quality and governance

- › Establish safe and effective way of transferring patients between sites
- › Establish joint multidisciplinary team, morbidity and mortality conferences (M&Ms) and joint quality committees
- › Work closely with EMAS on pre-hospital pathways
- › Establish cardiology network
- › Single team/governance, Joined MDT and M&Ms



## Modernising infrastructure (digital & estates)

- › Intra-hospital transport
- › Cardiovascular assessment space near CCU at KGH. Four to five cath labs would be required at NGH
- › Investment to support diagnostic images being swapped between sites
- › Single patient record between sites and with primary care

## Research and innovation (academic)

- › Expand patients involved with trials (e.g. C-MRI)
- › In-house training of staff with University (e.g. physiologists) – cardiac physiology school





# In the first year, we would take some initial steps to deliver our proposals (1/2)

Area	Changes	How we will know we succeeded	Benefit
Prevention/ early intervention	<ul style="list-style-type: none"> <li>› Sign off vision and work programme</li> <li>› Appoint dedicated consultant to lead</li> </ul>	<ul style="list-style-type: none"> <li>› Work programme being successfully implemented</li> <li>› Countywide integrated heart failure service</li> </ul>	<ul style="list-style-type: none"> <li>› Prevention of cardio-vascular disease</li> <li>› Equity of access to services for patients across Northamptonshire</li> </ul>
Outpatients and diagnostics	<ul style="list-style-type: none"> <li>› Single pool of patients/single point of access</li> <li>› Identify pathways and workforce for community diagnostics centre</li> </ul>	<ul style="list-style-type: none"> <li>› Single patient tracking list (PTL)</li> <li>› Merged operations team</li> <li>› Similar waiting times for both sites</li> </ul>	<ul style="list-style-type: none"> <li>› Faster access to diagnostics resulting in better outcomes for patients</li> <li>› Equity of access for patients</li> </ul>
Multi-disciplinary teams	<ul style="list-style-type: none"> <li>› Extended advanced healthcare practitioner (AHP) roles</li> </ul>	<ul style="list-style-type: none"> <li>› Established MDTs</li> <li>› Procedures undertaken by AHPs</li> </ul>	<ul style="list-style-type: none"> <li>› More efficient use of resources</li> </ul>
Coronary interventions	<ul style="list-style-type: none"> <li>› Iterate proposals to consolidate PCI at KGH</li> <li>› Establish joint on call rota for PPCI</li> <li>› Deliver a 7-day cardiac pacing service on both sites</li> <li>› Deliver 5-day TOE cover across sites</li> <li>› Appoint Group electrophysiologist to support repatriation of electrophysiology in year 2</li> </ul>	<ul style="list-style-type: none"> <li>› All PCI coded to KGH</li> <li>› Clinicians on-call from both sites for PPCI</li> <li>› Electrophysiologist appointed</li> </ul>	<ul style="list-style-type: none"> <li>› Meet the NSTEMI 72-hour target – currently not met at NGH</li> <li>› Reduced intensity of workload for consultants</li> <li>› Deliver consistent service for all local people</li> <li>› Provide more services closer to local communities</li> </ul>
Non-coronary interventions	<ul style="list-style-type: none"> <li>› Develop medical physics specialty technical support</li> </ul>	<ul style="list-style-type: none"> <li>› Technical support outsourced</li> </ul>	<ul style="list-style-type: none"> <li>› Better use of resources</li> </ul>
Community monitoring	<ul style="list-style-type: none"> <li>› Implement remote community monitoring for heart failure</li> </ul>	<ul style="list-style-type: none"> <li>› Heart failure patients monitored remotely</li> </ul>	<ul style="list-style-type: none"> <li>› Convenience for patients</li> <li>› Earlier identification of issues</li> </ul>

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# In the first year, we would take some initial steps to deliver our proposals (2/2)

Area	Changes	How we will know we succeeded	Benefit
Workforce	<ul style="list-style-type: none"> <li>Align working and pay rates between KGH and NGH</li> <li>Create pooled workforce</li> <li>Resolve cross-contracting between hospitals</li> </ul>	<ul style="list-style-type: none"> <li>Pay rates and working conditions aligned for all staff</li> </ul>	<ul style="list-style-type: none"> <li>More flexible working, increased rota resilience and greater provision of training and research opportunities</li> </ul>
Research & Innovation	<ul style="list-style-type: none"> <li>Plan to establish physiologist academic course</li> <li>Appoint academic lead</li> </ul>	<ul style="list-style-type: none"> <li>Course established</li> </ul>	<ul style="list-style-type: none"> <li>Access to highly trained staff and novel equipment/approaches</li> </ul>
Quality and governance	<ul style="list-style-type: none"> <li>Nominate lead clinicians for Midlands cardiology network workstreams</li> <li>Single team/governance structure</li> </ul>	<ul style="list-style-type: none"> <li>Clinical leads for network workstreams in place</li> <li>Governance in place</li> </ul>	<ul style="list-style-type: none"> <li>Better outcomes and more joined-up care for patients</li> </ul>
Modernising infrastructure (digital & estates)	<ul style="list-style-type: none"> <li>Agree option for transport between hospitals</li> <li>Develop proposals to establish cath labs at KGH</li> <li>Implement dedicated cardiac MRI (current business case)</li> <li>Retain telephone clinics</li> <li>Implement system to allow scans to be read on both sites</li> </ul>	<ul style="list-style-type: none"> <li>Way forward for transporting patients agreed</li> <li>Proposals for establishing cath labs at KGH agreed</li> <li>Scans available across sites</li> </ul>	<ul style="list-style-type: none"> <li>Quicker access to dedicated diagnostic equipment</li> <li>Quicker access to scans / no need to re-scan</li> <li>More convenient access for patients who prefer telephone appointment</li> </ul>

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# Protecting our elective pathway

# A full range of elective services for adults are currently provided on both sites

The elective pathway provided for each specialty by each site, includes outpatient appointments either face to face or virtually, diagnostic services, pre-operative assessment, outpatient treatments, day case examinations and treatment, surgery and inpatient stays.

## Elective Services available @ KGH & NGH

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>• General surgery</li><li>• Head &amp; neck</li><li>• ENT</li><li>• T&amp;O</li><li>• Urology</li><li>• Pain services</li><li>• Endoscopy</li><li>• Audiology</li></ul> | <ul style="list-style-type: none"><li>• Gastroenterology</li><li>• Ophthalmology</li><li>• Breast</li><li>• Vascular services</li><li>• Plastics</li><li>• Colorectal</li><li>• Gynaecology</li></ul> |
|---|---|

*Most inpatient elective services require co-location with critical care facilities*

*Some sub-speciality procedures are only undertaken on one site or another. For example T&O spinal surgery only takes place at KGH.*

Both organisations work closely with the two Independent sector providers in the county, with some NHS services and procedures being undertaken in collaboration between the NHS and the independent sector to maximise the use of available capacity.

### NGH

Provide the regional specialist vascular surgery services  
Some services are also provided from Danetre Hospital in Daventry

### KGH

Provide a range of outpatient and diagnostic tests in satellite locations closer to patients' homes:

- Corby Health complex and GP surgery
- Nene Park in Irthlingborough
- Isebrook Hospital in Wellingborough
- Kettering town centre

# Local and national strategies set the strategic context for our proposals for Group elective care

There are several national, regional and local strategies and guidelines that have been considered as part of the joint clinical strategy design. The below provides a summary of the key recommendations.

## NATIONAL

- **NHS Long Term Plan:** supports separation of urgent from planned services. Sets the ambition that redesigned hospital support should help the NHS avoid up to a third of outpatient appointments, saving patients 30 million trips to hospital.
- **Royal College of Surgeons - Future of Surgery:** anticipates an increase in preventative surgery that will increasingly focus on quality of life. Day-case surgery will continue to increase with more importance placed on preoperative and follow up care which will be undertaken using telemedicine and digital platforms.
- **Royal College of Physicians:** recommend move away from routine first and follow up care to flexible, one-stop-shops, see-and-treat clinics and patient-initiated-follow-ups. Services should optimise the staff skill mix rather than always relying on consultant-led care. The ultimate objective should be reducing the number of steps in a patient's pathway.
- **GIRFT Elective Recovery High Volume Low Complexity (HVLC) Programme:** standardised procedure level pathway at system level and establishing fast track surgical hubs. 85% of all elective surgery should be on a day surgery pathway in dedicated facilities away from unplanned care.
- **Recovering from the pandemic:** Nationally it is reported that there are currently over £5m people waiting for treatment, with approximately 80% of those waiting for a diagnosis, and over 384k waiting over a year. There are an unknown number who have also yet to come forward for treatment. Recovering this position and treating these patients is one of the four key priorities for the NHS in 2021/22, but we must use innovative ways and digital technologies to do this in the most effective ways.

## GROUP

- **NGH/KGH Group Digital Strategy:** ambition to implement a shared electronic patient record, ambition to enable staff to virtually monitor patient's and deliver care through virtual appointments where safe and appropriate
- **Group Nursing, Midwifery, Allied Health Professional Strategy 21-24:** ambition to become the first group hospital accredited as Pathway to Excellence – a positive practice environment that allows nurses to flourish.
- **Group Academic Strategy:** ambition to achieve international recognition as an academic centre that promotes and delivers better health service and provision and health outcomes to our patients
- **Northamptonshire Health and Care Partnership:** develop musculoskeletal hub

## LOCAL

- **The KGH Clinical Strategy 2020:** ambition to deliver seven day services and opportunity to collaborate with NGH to provide county-wide services and provide access to a larger, more sustainable workforce with greater flexibility. Expected to improve access to a wider range of services for patients.
- **The NGH Strategy 2019-24:** sets an ambition is to build dedicated elective centre with KGH that is easily accessible for all patients.

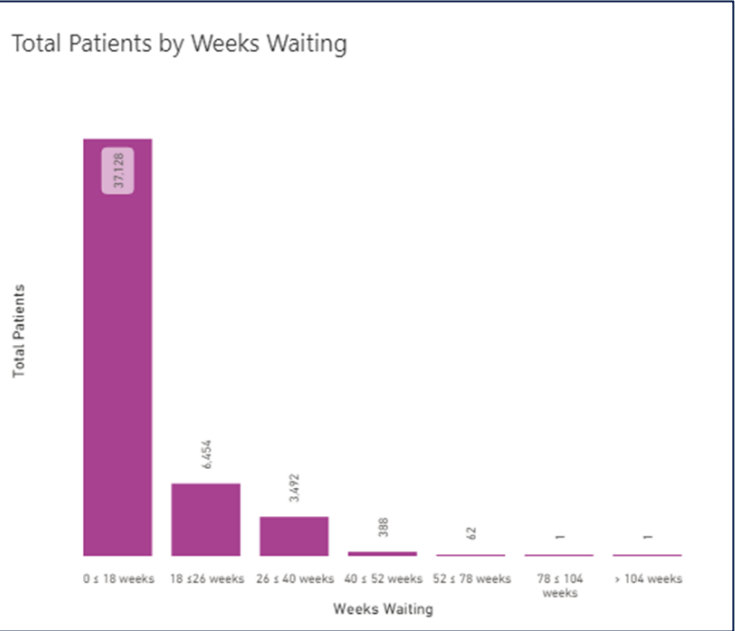


# Our current waits for treatments are low, but we must act now to ensure we continue to meet the needs of our patients

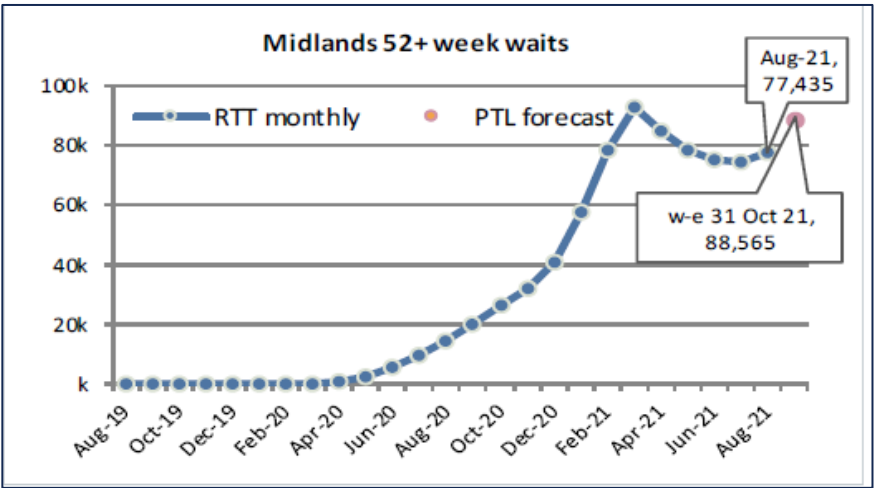
- Nationally and regionally elective waiting times have grown significantly as a result of the COVID pandemic. This was due to:
- staff being redeployed to respond to the pandemic
  - increased infection control and social distancing standards resulting in a drop in efficiency of those patients who can be treated in the same amount of clinical time
  - many patients' clinical priority did not warrant urgent treatment during the pandemic

However demand is significantly increasing and many patients may yet come forward, so we need to work with our primary care colleagues to implement innovative ways of keeping patients well in their communities, managing conditions effectively through joint models of care to ensure those that do need to access acute hospital services and get to the right clinician at the right time with no undue delay.

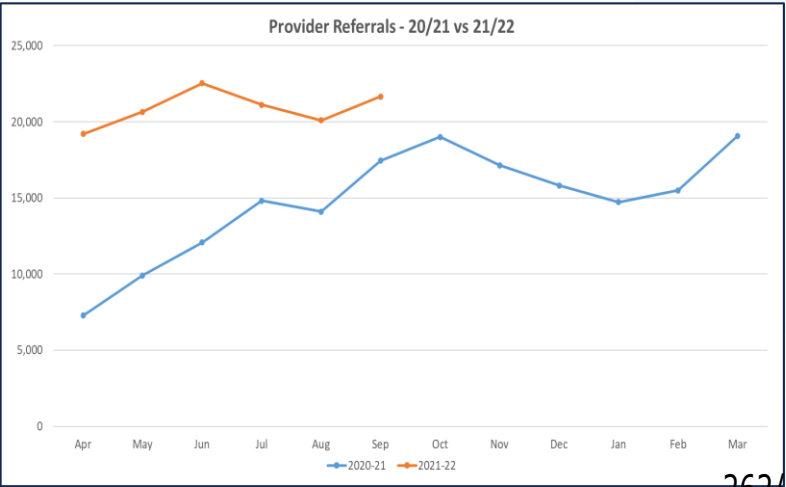
Patients waiting for elective treatments in Northamptonshire, currently have some of the lowest waiting times in the UK



There are significant numbers of people waiting over 52 weeks in the Midlands



Referrals are growing leading to increasing pressures on waiting lists





# Our case for change shows that there are several issues that we must address

As well as responding to the recommendations of key strategies, there are several other drivers for change that services are facing. These are addressed within our proposals for elective services.

## There is growing demand for our services

- Northamptonshire population is projected to increase by 14% 2018-2038. In 20-64 yr olds there is projected to be a 7% increase, in the 65yrs+ there is projected to be a 50% increase [1].
- Referrals for elective treatment have increased since pre-pandemic levels.

## There is an opportunity to deliver care differently

- The delivery of many outpatient appointments has been virtual in the past 18 months. Whilst it is clinically appropriate that some of these return to face to face, we should, where possible, embed these new ways of working as more convenient for our patients.
- Innovative use of emerging technology should be capitalised such as remote monitoring or new theatre techniques.
- Care as close to home and 'health on the high street' should be a strategy we follow where possible.



## There is not equitable access to elective surgery across Northamptonshire

- Health inequalities of those accessing our services and getting treating according to underlying health need, is not fully understood but is likely to not be equitable.
- Non-elective activity redirects focus away from elective cases, and disrupts theatre lists.
- Elective activity is cancelled due to bed pressures leading to poorer patient experience and poorer outcomes. Cancellations also impact of the efficiency and productivity of the services.

## There are opportunities to streamline pathways

- Opportunity for pathway standardisation to reduce unwarranted clinical variation
- Integrated working with system partners to increase provision of care closer to home
- Streamlined pathways to minimise disruption to patients' lives

## We have difficulty recruiting and retaining our staff

- National workforce challenges with theatre staffing are also echoed locally. Both Trusts are unable to fully staff all their theatre capacity.
- Opportunity to adopt new workforce models, in line with the AHP strategy
- Opportunities to improve training and research offerings through collaboration (in line with academic strategy)

## We can improve efficiency and quality by implementing GIRFT recommendations

- Opportunities identified in many areas:
  - theatre efficiencies, start times and turnaround times
  - day case rates in ENT, general surgery, breast and orthopaedics
  - Length of stay in general surgery and urology

# Our ambition is to ensure our elective patients consistently get timely equitable access to high quality care and experience

The Group will work collaboratively to provide **dedicated elective capacity** protected from the pressures of emergency services, committed to providing **timely and equitable access to care, minimising infection rates** and **reducing length of stay** in hospital.

Elective care across the Group will offer exemplar **standardised best practice patient pathways** in line with national recommendations which minimise **unwarranted clinical variation**, and maximise **day surgery** and **one stop** pathways.

The Group is committed to delivering more care on a **day surgery** pathway, with more assessment, diagnosis and treatment being offered in a **one-stop** pathway, **in the community or virtually** to minimise disruption to patient's lives.

The elective care team would work as one across the Group, providing a positive and fulfilling working environment that **attracts and retains a range of multi-disciplinary staff**, offering **outstanding careers and development opportunities**.

The Group will collaborate with system partners to set up an **Elective Care Collaborative**, providing seamless pathways for patients, working to keep patients well in their homes and providing advice and care as close to their homes as possible.



## As a Lead Provider for the Elective Care Collaborative in Northamptonshire, we commit to...

- ✓ Working to deliver top decile performance in GIRFT and Model Health benchmarked analysis
- ✓ Eliminating any differences in equitable access to care related to health inequalities
- ✓ Delivery of constitutional standards: Zero patients waiting over 52 weeks, 92% of patients waiting less than 18 weeks for treatment and all patients waiting less than 6 weeks for a diagnostics.
- ✓ Delivering the same service and experience in the county regardless of provider.

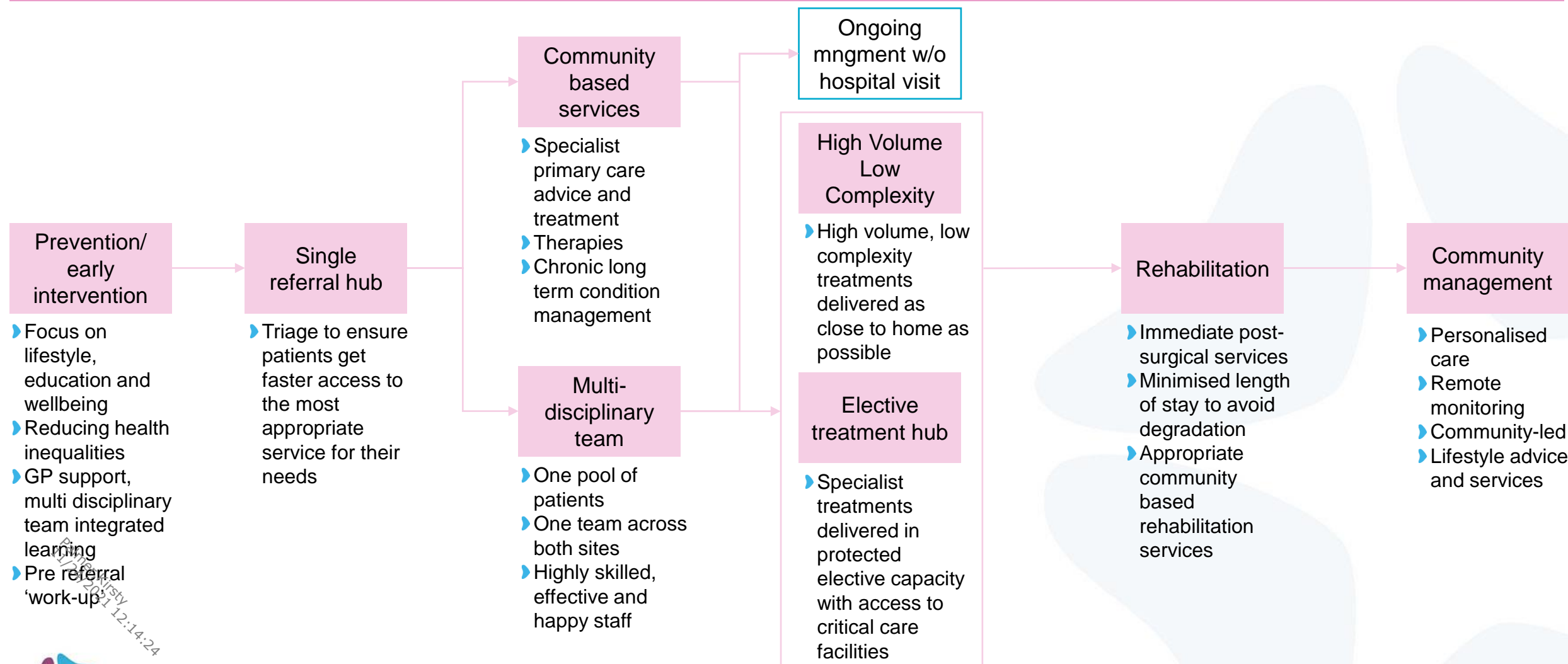
\*10% is a commitment in the Group's dedicated to excellence strategy; the working group suggested 25% target – the Group to confirm

# The Group elective proposals would deliver our key principles for excellent care

- ▶ **Integrated, seamless pathways for patients:** so that people get the care they need, when they need it, by professionals working together across primary community and acute settings
- ▶ **As close to home as possible:** so that people don't need to travel further than necessary to access services, saving the time and inconvenience
- ▶ **Focus on pre-hospital care:** so that people know how to keep well, and can access advice and services in their communities without needing to wait for a hospital appointment
- ▶ **Digital innovation:** so that patients can be treated in any setting with digital care records and test results available, and so patients are able to engage in their own treatment journey through the use of technology
- ▶ **Attract and retain high quality staff:** so that we can provide the highest quality service for patients
- ▶ **Fit for purpose estate:** so that services can be delivered as efficiently as possible, with improved quality and experience in areas such as infection control
- ▶ **Best use of available resources:** so that we can provide the best service we can with the resources that we have

# A single system approach would improve care along the whole elective pathway over the next 3-5 years

One system-wide waiting list (PTL), delivering equitable access to timely treatment for patients across the county, transparency to all clinicians including GPs to enable patients to be supported to keep well while they wait



Group enabler strategies: workforce, research & innovation (academic), quality and governance, modernising infrastructure (digital & estates)

# In the first year, we would take some initial steps to deliver our proposals

Area	Changes	How we will know we succeeded	Benefit
Prevention/early intervention	<ul style="list-style-type: none"> <li>Understand the current impact of health inequalities on elective care in the county</li> </ul>	<ul style="list-style-type: none"> <li>Strategy to reduce health inequalities in place</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in health inequalities</li> </ul>
Single referral hub	<ul style="list-style-type: none"> <li>Implement a systemwide waiting list (PTL) to support delivery</li> </ul>	<ul style="list-style-type: none"> <li>Single waiting list (PTL) implemented</li> </ul>	<ul style="list-style-type: none"> <li>Equity of access for patients</li> <li>More efficient use of resources</li> </ul>
Community based services	<ul style="list-style-type: none"> <li>Develop community based pathways such as chronic pain and rheumatology, and set-up some community based services such as pre-op and ophthalmology away from the acute sites</li> </ul>	<ul style="list-style-type: none"> <li>Community based services set-up</li> </ul>	<ul style="list-style-type: none"> <li>Access closer to home for patients</li> <li>More efficient use of estates</li> </ul>
Elective treatment hub	<ul style="list-style-type: none"> <li>Pilot a dedicated protected elective hub on one site and engage with patients and stakeholders on the benefits</li> <li>Co-locate low volume sub-specialties where this is in the best interests of patients</li> <li>Develop a strategy for fragile services or subspecialties such as plastics</li> </ul>	<ul style="list-style-type: none"> <li>Single elective hub (pilot) established</li> <li>Low volume specialties co-located</li> </ul>	<ul style="list-style-type: none"> <li>Separation of elective and emergency work means fewer cancelled operations and shorter waiting lists</li> <li>Co-locating specialties improves quality as staff are able to specialise more</li> </ul>
Workforce	<ul style="list-style-type: none"> <li>A joint strategy for the recruitment and retention of theatre staff</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in vacancies and turnover for theatre staff</li> </ul>	<ul style="list-style-type: none"> <li>Attract and retain high quality staff</li> <li>More efficient use of theatres and equipment</li> </ul>
Quality and governance	<ul style="list-style-type: none"> <li>Launch the system Lead Provider Collaborative for Elective Care, with an agreed set of system objectives to cover the next 2 years</li> </ul>	<ul style="list-style-type: none"> <li>Lead Provider Collaborative launched</li> </ul>	<ul style="list-style-type: none"> <li>Improved efficiency and reduced waiting times for patients</li> </ul>

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# Emergency and integrated care across Northamptonshire



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# Emergency care services are currently provided on both sites, and at the urgent care centre in Corby

The hospitals are working with partners to reduce emergency hospital visits through the iCAN programme. An Emergency Department is provided at both sites

## Emergency and integrated care services @ KGH

### *Emergency care services*

- ▶ Emergency department
- ▶ Same day emergency care

### *Other emergency care services*

- ▶ Urgent care centre at Corby

### *Integrated care services for frail patients*

- ▶ Frailty unit
- ▶ Community services provided by NHFT
- ▶ Primary care services provided by primary care
- ▶ Social care services commissioned by North Northamptonshire Council

## Emergency and integrated care services @ NGH

### *Emergency care services*

- ▶ Emergency department
- ▶ Same day emergency care
- ▶ Emergency eye department

### *Integrated care services for frail patients*

- ▶ Frailty hub
- ▶ Community services provided by NHFT
- ▶ Primary care services provided by primary care
- ▶ Social care services commissioned by West Northamptonshire Council

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# Local and national strategies set the strategic context for our proposals for emergency and integrated care

There are several national, regional and local strategies and guidelines that have been considered as part of the joint clinical strategy design. The below provides a summary of the key recommendations

## NATIONAL

- ▶ **NHS Long Term Plan:** identifies genuinely integrating care in our communities as a priority, including creating true integrated teams of GPs, community health and social care staff, expanding community health teams to keep people at home and increase support to care homes. Emergency care models building on the success of Urgent Treatment Centres and focussing on increasing usage of same day emergency care.
- ▶ **NHS Ageing Well programme:** the NHS ageing well programme identifies the development of person-centred services that enable people to age well, supporting people who are identified as frail to manage their health and wellbeing according to their needs
- ▶ **Home First policy:** the Home First approach is about supporting patients at home or in an intermediate care service. This is often implemented alongside a Discharge to Assess model, whereby home is the default pathway and the assessment is completed at home, with ongoing support services for up to 6 weeks.

## GROUP / SYSTEM

- ▶ **Northamptonshire Health and Care Partnership iCAN programme:** the integrated care across Northamptonshire programme outlines our ambition for deliver a refreshed focus and way to improve the quality of care and achieve the best possible health and wellbeing outcomes for older people across our county, supporting them to maintain their independence and resilience for as long as possible. Ensuring to Choose Well which services we use for frail patients, Stay Well and Live Well.
- ▶ **Group Digital Strategy:** ambition to implement a shared care record across Northamptonshire, enabling truly integrated care, supporting the delivery of our frailty model.

## LOCAL

- ▶ **The KGH Clinical Strategy 2020:** ambition to provide acute frailty services 70 hours a week and ensure frailty patients receive a comprehensive geriatric assessment. Focus on same day emergency care model, treating a greater number of patients without an overnight.
- ▶ **The NGH Clinical Service Reviews:** Ambition to create and deliver integrated services agreed by clinical and operational stakeholders. The service will consistently deliver excellence in quality of care and patient experience, including enhanced discharge to community services

# Our case for change shows that there are several issues that we must address

As well as responding to the recommendations of key strategies, there are several other drivers for change that services are facing. These are addressed within our proposals for cardiology services.

## There is growing demand for our services

- ▶ Our population is growing, with a 14% increase over the next 20 years
- ▶ There is expected to be a 50% increase in the 65yrs+ population in Northamptonshire between 2018 and 2038 [3].

## There is an opportunity to look after people at home rather than in hospital

- ▶ Patients across NGH and KGH do not have equal access to integrated multi-disciplinary care that supports frail patients.
- ▶ Case reviews have identified that we could better support people in the community to avoid their health reaching a crisis point.
- ▶ When people do reach a crisis point, better availability of services in the community would prevent an emergency department admission.
- ▶ For those who do come to ED, we can reduce the chance of being admitted to hospital by ensuring the right services are in place and known about

## Our patients could be supported to be discharged home quicker

- ▶ Across KGH and NGH, a high proportion of our beds are occupied by patients who have been in hospital for more than 14 and more than 21 days.
- ▶ Around 35% of our patients have no clinical reason to reside in a hospital bed and are waiting for either KGH and NGH or system partners to support them to be discharged.

## We have difficulty recruiting and retaining our staff

- ▶ There is a national shortage of emergency care staff to support our patients in ED.
- ▶ Recruitment is challenged by the geography of KGH/ NGH, located close to leading teaching hospitals
- ▶ Retention is challenged by high workload and National shortage
- ▶ Terms and conditions are different between the two sites
- ▶ A national shortage of care staff reduces capacity to support our patients in the community, meaning we need to best support our patients to be independent.

## We need to do more multidisciplinary and network working to improve outcomes and patient experience

- ▶ We currently have two separate teams on our two sites
- ▶ There could be greater integrated working with our health and social care partners operating in a multi-disciplinary manner to care for our most frail patients
- ▶ The NHS long term plan emphasises the need for enhanced care for people living with frailty and prioritises more effectively integrated services

# We have developed a vision for emergency and integrated care in Northamptonshire

Emergency and integrated care services will provide an integrated service that the Northamptonshire system will be known for nationally for delivering the **best outcomes for patients, organisations and our staff – putting patients at the centre of all we do.**

As we develop further models of integrated care across Northamptonshire with our system partners, we will **support people to choose well**, ensuring no one is in hospital without a need to be there, **ensure people can stay well**, and **ensure people can live well**, by staying at home if that is right for them.

Our emergency departments will be the **departments of choice** for staff across the East Midlands. We will embed **continuous development and learning** for staff, with **a diversity of skilled roles** all working together in a **single team**. Our vacancy rates will be low and we will excel in our staff and GMC surveys.

## As an emergency and integrated care service, we commit to...

- ✓ No avoidable harm in emergency care, and no site specific variation in emergency care.
- ✓ Outstanding CQC rating at both departments
- ✓ No patients waiting over 12 hours in our emergency departments
- ✓ Work in partnership with our Northamptonshire Health and Care Partnership colleagues to provide seamless care for our most frail patients
- ✓ Embed the Home First principles and Discharge to Assess within the county
- ✓ Supporting people to access the right care in the right place, first time
- ✓ A single model for frailty across the county

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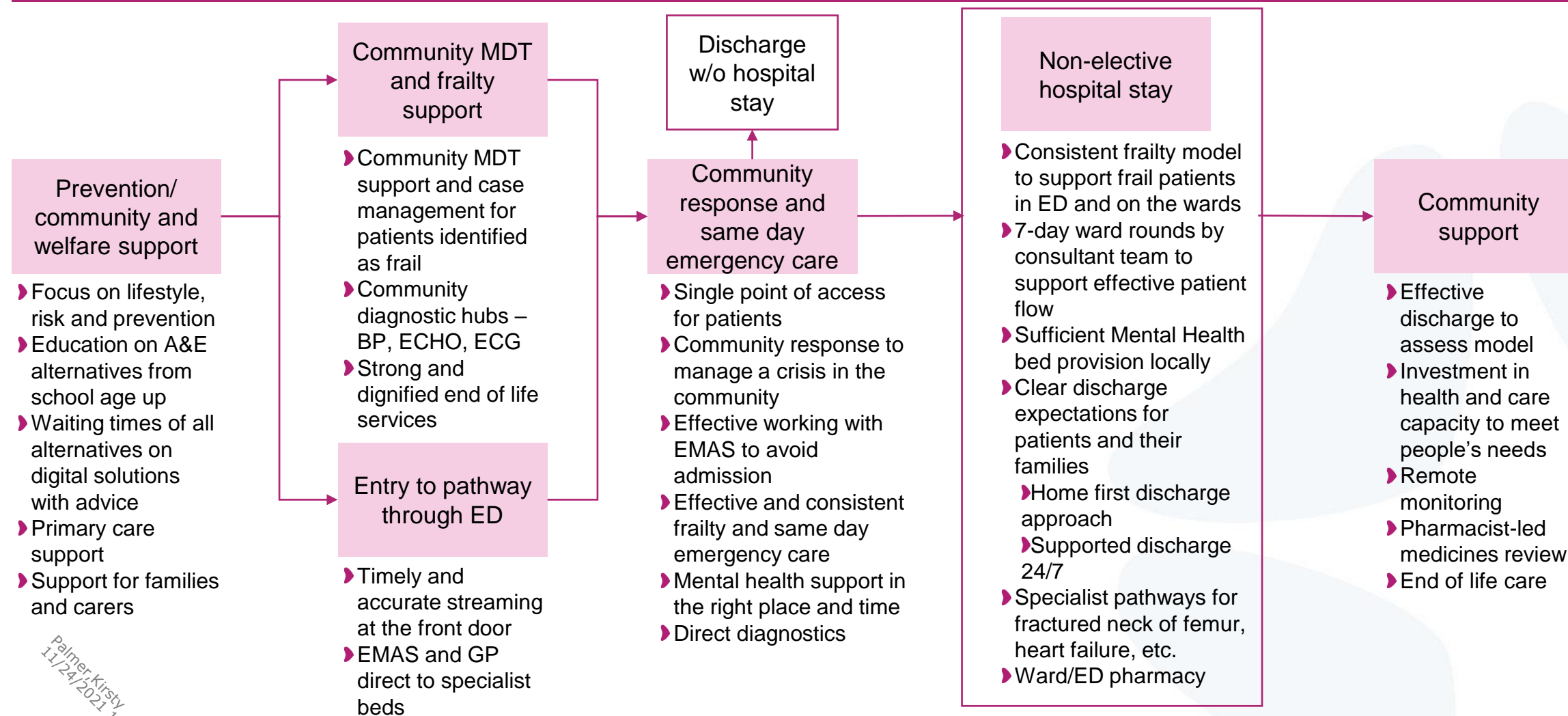
# Emergency and integrated care services will deliver our key principles for excellent care

- › **Integrated, seamless care for patients:** so that people get the care they need when they need it without having to re-tell their story, supported by multi-disciplinary team working wherever possible
- › **Keeping people at home where possible:** so that people don't get admitted to hospital or for onward care when not necessary, keeping people independent and resilient
- › **Delivered equitably across the county:** so that everyone has equal opportunity to access high quality, integrated services
- › **Focus on support in the community:** so that people are supported to stay well and are supported in the community
- › **Attract and retain high quality staff:** so that we can provide the highest quality service for patients
- › **Deliver the right care in the right place, first time:** so that people are looked after in the most appropriate care setting for their needs
- › **Fit for purpose facilities and estate:** so that services can be delivered as efficiently as possible in our communities and capacity is ring-fenced for frailty services in our acute hospitals
- › **Best use of available resources:** so that we can provide the best service we can with the resources that we collectively have as a system



# We will improve integrated care pathways over the next 3-5 years

## One integrated care record across Northamptonshire collaborative



System enabler strategies: workforce, research & innovation (academic), quality and governance, modernising infrastructure (digital & estates)



# There are key enablers required to support the successful implementation of the strategy over 3-5 years

## Workforce



- › Organisational/team development
- › Consistent frailty model across both organisations
- › System-wide workforce planning
- › Investment in county wide community services to support patients in the community
- › Support the development of the care workforce in the system
- › Develop a true multi-professional approach

## Research and innovation (academic)



- › Expand patients involved with trials
- › In-house training of staff with University, expand the frailty training being provided across the system



## Quality and governance

- › Establish safe and effective admission avoidance and discharge pathways
- › Establish joint multi-professional teams and system governance
- › Work closely with EMAS, NHFT and the local authorities on pre-hospital pathways
- › Develop the integrated care across Northamptonshire collaborative

## Modernising infrastructure (digital & estates)



- › Single patient record between all system partners
- › Community hubs to support care in the community
- › Appropriate ring-fenced estate for frailty hubs

# Women and children's services

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# Women and children's services are currently provided on both sites, with a midwife-led unit at NGH

Both KGH and NGH provide maternity and paediatric services. Women who choose to give birth at NGH women have the choice of three birth settings: midwife-led birth centre, labour ward, home birth. At KGH have the choice of two birth settings: labour ward or home birth. There are plans to construct a midwife-led unit at KGH in the near future.

## Women's and Children's @ KGH

### Women's

- Labour ward and home births
- Antenatal and postnatal care
- Local (Level 2) Neonatal Unit (LNU)
- Fetal Health Unit
- Gynaecology (emergency and elective)

### Children's

- Paediatrics medical inpatient and outpatient
- Paediatrics ED & PAU
- Community paediatrics

**Births 2020/21: 3,207**

## Women's and Children's @ NGH

### Women's

- Labour ward, midwife led birth centre & home births
- Antenatal and postnatal care
- Local (Level 2) Neonatal Unit (LNU)
- Fetal Health Unit
- Gynaecology (emergency and elective - incl. Northamptonshire Gynaecological Cancer Centre)

### Children's

- Paediatrics medical inpatient and outpatient
- Paediatrics ED & PAU
- Community paediatrics

**Births 2020/21: 4,200**

- ▶ Northamptonshire Maternity Services is a partnership with NGH, KGH and Northamptonshire Healthcare Foundation NHS Trust (NHFT).
- ▶ Both Trusts are part of the East Midlands Neonatal Operational Development Network (EMNODN).
- ▶ Both Trusts are working as part of the LMNS Partnership Programme, which includes maternity & neonatal digital transformation and transforming Neonatal Care, and with the NHCP Children & Young People Transformation Board.

# Local and national strategies set the strategic context for our proposals for women and children's services

There are several national, regional and local strategies and guidelines that have been considered as part of the joint clinical strategy design. The below provides a summary of the key recommendations

## NATIONAL

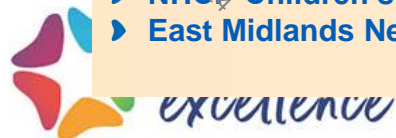
- ▶ **NHS Long Term Plan (2019):** women should receive continuity of the person caring for them during pregnancy, during birth and postnatally. Children's mental health services are expected to grow to deliver integrated mental and physical health care. Where possible care will be delivered closer to home for children and their families.
- ▶ **Better Births (2016, 2021):** women should have continuity of carer and 'should make decisions about the support they need during birth and where they would prefer to give birth whether this is at home, in a midwife unit or in an obstetric unit'.
- ▶ **Saving Babies Lives Care Bundle (2019):** services should offer choice and personalised care for women and promote availability of continuity of carer.
- ▶ **Ockenden Report (2020):** there must be robust pathways for dealing with complex pregnancies. Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.
- ▶ **Royal College of Paediatrics Facing the Future (2010):** consultant cover is present and readily available in peak hours 7 days a week. Trusts should reduce the number of inpatient sites and increase the no. of consultants to improve senior cover.
- ▶ **Neonatal Critical Care Transformation Review (2017-date):** plans to address issues in neonatal workforce and capacity

## GROUP

- ▶ **Group Nursing, Midwifery, Allied Health Professional Strategy 2021-24:** ambition to become the first group hospital accredited as Pathway to Excellence – a positive practice environment that allows nurses to flourish because of job satisfaction, professional growth, development, respect and appreciation.
- ▶ **Group Digital Strategy:** ambition to implement a shared electronic patient record, ambition to enable staff to virtually monitor patient's and deliver care through virtual appointments where safe and appropriate
- ▶ **Group Academic Strategy:** ambition to achieve international recognition as an academic centre that promotes and delivers better health service and provision and health outcomes to our patients

## LOCAL

- ▶ **The KGH Clinical Strategy 2020:** ambition to set up new clinics and hubs in the community. Ambition to provide a comprehensive maternity service alongside NGH incl. sub-specialising care between the two services and working under congruent policies and procedures. Increase access to gynaecology service, enhance facilities and adopt new workforce models
- ▶ **The NGH Strategy 2019-24:** build a dedicated paediatric emergency facility at NGH.
- ▶ **Local Maternity and Neonatal Strategy:** providing continuity of care across Northamptonshire, with a focus on prenatal and postnatal care
- ▶ **NHCP Children's & Young People Transformation Board:** Bringing together partners across health, care and education to improve outcomes for children and young people
- ▶ **East Midlands Neonatal Network:** Ensuring that babies and their families receive high quality care which is equitable and accessible for all



# Our case for change shows that there are several issues that we must address

As well as responding to the recommendations of key strategies, there are several other drivers for change that services facing. These are addressed within our proposals for children and women’s services.

## There is growing demand for our services

- ▶ Northamptonshire population is projected to increase by 14% 2018- 2038. In 20-64 year olds there is projected to be a 7% increase [1].
- ▶ In North Northamptonshire, govt-backed plans could see 33,000 new homes built likely to be for primarily young families, increasing demand for maternity and paediatric services [2].

## Our services are not joined up leading to poor patient experience

- ▶ There is a lack of integration with community services
- ▶ Transition between child and adult services is not always seamless and in some cases a total gap with some subspecialties running to 16 but adult services start at 18.

## There is some quality and efficiency improvements we need to make

- ▶ Day case rates and length of stay needs to improve for gynaecology.
- ▶ Paediatrics at KGH are not efficient in outpatients clinics



## There is variation in service across Northamptonshire

- ▶ **Obstetrics:** there is obstetric clinical variation across Northamptonshire [3]
- ▶ **Paediatrics:** there are different services available across the county (e.g. end of life, allergy)

## We need to do more to prevent ill health during pregnancy

- ▶ The number of mothers smoking at birth is higher than the England average in both Northampton and Kettering.
- ▶ Smoking is the single biggest modifiable risk factor for poor birth outcomes and a major cause of inequality in child and maternal health outcomes [2].

## Some of our estates and facilities are not fit for purpose

- ▶ Both NGH and KGH estates shortfall for neonatology, maternity and gynaecology. In neonatology this has been highlighted in GIRFT (2021) and an NHS Neonatal Critical Care Transformation Review (2019).
- ▶ The development of integrated community centres provide an opportunity to deliver services more locally

## CQC Performance

**Maternity**  
KGH: Good (2019)  
NGH: Requires Improvement (2019)

**Services for children & you**  
KGH: Requires Improvement (2018)  
Northampton: Good (2017)

## Friends and Family Test

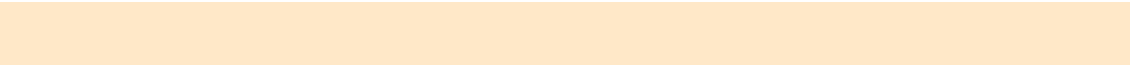
% of people likely to recommend the provider’s maternity services to friends or family

KGH	100%
NGH	96.9%
National median	98.7%

Sources: [1] [ONS Population Projections 2018-2028](#) [2] KGH Clinical Strategy Jan 2020, [3] NGH Clinical Service Model Reviews 19/20, [4] CQC.org.uk [5] Model Hospital



# We have developed a vision for Children and Women's services in Northamptonshire



Our ambition for paediatrics is to **continue to provide inpatient services on both sites** whilst **improving the resilience of our sub specialist services**. We will also **develop our integrated approach with community based services** so that there are no boundaries for patients.

Our ambition is for women's services is to be **a centre of excellence**. We will seek to **address health inequalities**, achieve the **best outcomes for women**, have the **best trained staff** in the country and be **leaders in research and education**.

**We are working with partners to develop a joint vision and commitments for children and women's services in Northamptonshire.**

- Community health services
- Local authority partners
  - Social services
  - Education

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# Children and women's services will deliver our key principles for excellent care

- **Integrated, seamless care for patients:** so that people get the care they need when they need it without having to re-tell their story, supported by multi-disciplinary team working wherever possible
- **As close to home as possible:** so that people don't need to travel further than necessary to access services, saving the time and inconvenience
- **Delivered equitably across the county:** so that everyone has equal opportunity to access high quality services
- **Focus on prevention and early detection:** so that people don't become ill and don't progress to more severe illness
- **Supports research and innovation:** so that we can offer the latest treatments to improve health outcomes and contribute to the development of new treatments and technologies
- **Attract and retain high quality staff:** so that we can provide the highest quality service for patients
- **Deliver cutting edge treatment, as quickly as possible:** so that people don't need to wait long for treatment, reducing worry and improving health outcomes
- **Fit for purpose facilities and estate:** so that services can be delivered as efficiently as possible with improved quality in areas such as infection control
- **Best use of available resources:** so that we can provide the best service we can with the resources that we have

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# We propose collaborating across the two hospital sites to support our more specialised paediatric services

Ambition	Services to include	Rationale for collaboration	Benefits for patients
There is an ambition for some highly specialised services to be provided county-wide on one site, by one consultant team.	<ul style="list-style-type: none"><li>Immunology</li><li>Rheumatology</li><li>Pain</li><li>Chronic fatigue</li><li>Medically unexplained symptoms (MUS)</li></ul>	<ul style="list-style-type: none"><li>There is not enough demand throughout the county to warrant such highly specialist consultants on both sites for these services.</li></ul>	<ul style="list-style-type: none"><li>Reduce patient travel times – currently have to travel out of area</li></ul>
Some services, where there are concerns about sustainability, will be prioritised to set up a networked service, with the same pathways and protocols and regular joint working/ group posts.	<ul style="list-style-type: none"><li>Oncology</li><li>Palliative care &amp; end of life</li><li>Gastroenterology</li><li>Haemoglobinopathy (further work required on one consultant team)</li><li>HIV</li><li>Endocrinology</li><li>Nephrology</li><li>Epilepsy</li><li>Cardiology</li><li>Allergy</li></ul>	<ul style="list-style-type: none"><li>These are areas where there is low case load / workforce challenges that collaboration could support e.g. joint consultant role for gastroenterology</li><li>These are specialties with high demand, where capacity is pressured. Networked working would support demand management and reduce workforce pressures</li></ul>	<ul style="list-style-type: none"><li>Equity of access across the county</li><li>Increased access to more specialist input</li><li>Workforce sustainability</li></ul>

# In the next two years, we would take steps to support our more specialised paediatric services

Area	Changes	How we will know we succeeded	Benefit
Acute management/treatment	<div><div>▶ Build sub-specialty services (Year 1)</div><div><div>▶ Gastro: recruit group post for countywide service</div><div>▶ Asthma: single team and recruit specialist nurse and consultant</div><div>▶ Cystic fibrosis: dedicated post and develop specialist centre for training registrars</div><div>▶ Haemoglobinopathy: develop MDT service with co-located clinic at Nene Park</div><div>▶ Neurology: develop county-wide epilepsy pathway and transition service</div></div><div><div>▶ Build sub-specialty services (Year 2)</div><div><div>▶ Repatriate immunology and rheumatology</div><div>▶ Single team for end of life</div><div>▶ Ambulatory cancer care at both sites</div><div>▶ Align pathways for diabetes and endocrine</div><div>▶ Integrate eating disorders service with community</div></div></div></div>	<div><div>▶ Year 1</div><div><div>▶ Gastroenterology available at both sites</div><div>▶ Establish haemoglobinopathy service at Nene Park</div><div>▶ Neurology non-stop clinics established</div></div><div><div>▶ Year 2</div><div><div>▶ End of life support provided consistently across county</div><div>▶ All oncology ambulatory care provided locally</div><div>▶ Single pathway/tertiary provide for diabetes and endocrine</div><div>▶ Integrated eating disorder service established</div></div></div></div>	<div><div>▶ Equity of access for patients</div><div>▶ More efficient use of resources</div><div>▶ Improved outcomes for patients</div><div>▶ More resilient acute paediatric services</div></div>

# We have developed some initial proposals for collaboration in gynaecology alongside a proposed ambulatory centre of excellence

The ambition is for Gynaecology to be provided in both acute sites by networked teams with the **same protocols and pathways**, delivering equity of care for all patients across the county. Short term ambitions and priorities are to align models of care and services provided and collaborate to drive improvements and excellence across the Group. This would include aligning ways of working (e.g. nurse-led model), reviewing and aligning pathways and offering joint training.

Initial proposals for collaboration are:

- › Development of nurse practitioners for urogynaecology, early pregnancy care and termination of pregnancy service
- › Align pathways including endometriosis and ambulatory gynaecology
- › Repatriation and development of more specialised services including paediatric and adolescent gynaecology, infertility, and advanced endometriosis treatment (including robotic surgery)
- › Develop a 7-day service for ultrasound gynaecology across Northamptonshire
- › Implement a 7-day gynaecology Same Day Emergency Care (SDEC) service
- › Establish a specialist counselling service in partnership with primary care

To do this we would need to:

- › Establish joint training, research and project teams
- › Develop joint governance including M&M meetings and joint pathways

A key ambition is around improving accessibility to our services. Ambulatory gynaecology services would increasingly be **delivered closer to home** with a **nurse-led model** minimising disruption to our patients lives. We will also increase access through self referral.

In the next 2-3 years, we propose developing **Women's Health Hubs** with our partners, providing outpatient appointments and minor procedures in a 'one-stop' environment, co-located with community services. These centres of excellence would deliver high performance against national targets, high quality estates and equipment, high patient satisfaction and patient choice. This is dependent on recommendations of national women's health strategy currently in development and consideration of patient and staff travel times. Further work will be undertaken to develop this proposal.



# We are continuing to work to develop our proposals for fetal medicine

There are several drivers for change for fetal medicine..	<ul style="list-style-type: none"><li>There are currently challenges around the fetal medicine workforce at KGH.</li><li>KGH currently have an SLA with Leicester that isn't fulfilling needs, due to Leicester's capacity constraints and there are also challenges with Oxford (NGH).</li><li>There is a strategic driver to continue to meet RCOG / Public Health fetal medicine access standards (access to fetal medicine sub-specialist within 5 days)<sup>[1]</sup></li><li>There is growing demand for the fetal medicine service</li></ul>
... and potential opportunities for collaboration that would address these challenges.	<ul style="list-style-type: none"><li>There are workforce opportunities for collaboration, for example, joint recruitment. A Group role would increase attractiveness of the role.</li><li>There are opportunities to align the offer within the group and deliver equity of care across the county</li></ul>
The next steps for developing these collaboration opportunities further will be detailed clinical engagement.	<ul style="list-style-type: none"><li>There will be further discussion with the team of fetal medicine specialists to understand what the service could look like in the future across the county.</li></ul>

[1] Royal College of Obstetricians and Gynaecologists (2016) [Providing Quality Care for Women](#)

# Diagnostics

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# Diagnostic services are currently provided on both sites, with vascular interventional radiology at NGH

Both KGH and NGH provide a full range of diagnostic services.

Diagnostics @ KGH	Diagnostics @ NGH
<ul style="list-style-type: none"><li>› Pathology including:<ul style="list-style-type: none"><li>› Andrology</li><li>› Biochemistry</li><li>› Blood transfusion</li><li>› Cellular pathology</li><li>› Haematology</li><li>› Immunology</li><li>› Microbiology</li><li>› Phlebotomy</li><li>› Mortuary</li></ul></li><li>› Radiology: CT, MRI, X-RAY, Ultrasound (non-obstetric &amp; obstetric), breast imaging, nuclear medicine, non-vascular interventional radiology, DEXA.</li><li>› Endoscopy</li><li>› Satellite services</li><li>› Private services</li></ul> <p><i>Cardiology diagnostics in Cardiology Centre of Excellence detailed proposal</i></p>	<ul style="list-style-type: none"><li>› Pathology including:<ul style="list-style-type: none"><li>› Biochemistry</li><li>› Blood transfusion</li><li>› Cellular pathology</li><li>› Haematology</li><li>› Immunology</li><li>› Microbiology</li><li>› Phlebotomy</li><li>› Mortuary</li></ul></li><li>› Radiology: XRAY, CT, MRI, Ultrasound (non-obstetric &amp; obstetric), vascular and non-vascular interventional radiology, fluoroscopy, DEXA, PET-CT, nuclear medicine, breast imaging.</li><li>› Endoscopy</li><li>› Satellite services</li><li>› Private services</li></ul> <p><i>Cardiology diagnostics in Cardiology Centre of Excellence detailed proposal</i></p>

- › Vascular interventional radiology is provided at NGH as a county wide service.
- › Nuclear medicine run by NGH since Feb 2021.
- › Both KGH and NGH are in the ME2 pathology network and EMRAD

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# Local and national strategies set the strategic context for our plans for diagnostic services

There are a number of national, regional and local strategies and guidelines that have been considered as part of the joint clinical strategy design. The below provides a summary the key recommendations

## NATIONAL

- ▶ **NHS Long Term Plan:** sets ambition for pathology networks by 2021 to improve access to more complex tests, diagnostic imaging networks by 2023 to enable the rapid transfer of clinical images from care settings close to the patient. The plan introduces more stringent cancer standards for cancer (28-day diagnosis) which diagnostics will be required to help deliver.
- ▶ **Diagnostics: Recovery and Renewal 2020:** recommends split of emergency and elective where possible. Community diagnostic hubs should provide highly productive elective diagnostic centres for cancer, cardiac, respiratory and other conditions. Major expansion in the workforce is required and increase in roles such as advanced practitioner radiographer and assistant practitioner.
- ▶ **GIRFT Radiology 2020:** Recommendations include hot/ cold splits of activity, staff working at the top of their license, review of the efficiency and management of MDTs, robust clinical pathways supported by clinical decision making tools such as iRefer.
- ▶ **Cancer Alliance 2019/20:** Priorities include: implementation of faster diagnosis standard, improvements in cancer screening programmes and delivery of rapid diagnostic centres.

## REGIONAL

- ▶ **Midlands & East 2 Pathology Network Update:** ambition to create a single operating model for Pathology across ME2 to release benefits for workforce, procurement, logistics and consistent clinical pathways, allowing patients to move seamlessly between Trusts.
- ▶ There are a number of regional networks and groups that our proposals must align to: **East Midlands Imaging Network (EMRAD), Regional Radiology Group and Regional Pathology Group** for example
- ▶ **NGH/KGH Group Digital Strategy:** ambition to implement a shared electronic patient record, ambition to enable staff to virtually monitor patient's and deliver care through virtual appointments where safe and appropriate
- ▶ **Group Academic Strategy:** ambition to achieve international recognition as an academic centre that promotes and delivers better health service and provision and health outcomes to our patients

## LOCAL

- ▶ **The KGH Clinical Strategy 2020:** establish an imaging hub in the community to scan routine patients. Increase in-house capacity to focus on urgent diagnostics and interventional radiology to diagnose and treat patients more quickly. Improve cancer diagnosis and treatment in line with national standards.
- ▶ **The NGH Strategy 2019-24:** ambition to establish an imaging hub in the community in partnership with KGH to provide a range of diagnostic services. This will help manage increasing demand and support colleagues in Primary Care Networks.

# Our case for change shows that there are several issues that we must address

As well as responding to the recommendations of key strategies, there are several other drivers for change that services are facing. These are addressed within our proposals for diagnostic services

## Growth in demand

- › Northamptonshire population is projected to increase by 14% 2018-2038. In 20-64 yr olds there is projected to be a 7% increase, in the 65yrs+ there is projected to be a 50% increase [1]
- › Demand for radiology services is predicted to grow by 8% by 2024 placing additional pressures on services [2]
- › Growth in endoscopy demand in addition to national driver for age extension of bowel cancer screening
- › Increase in one-stop-shop services pressures on diagnostic services
- › Estates will, and are already, constraining growth required to meet this demand

## Digital advancements

- › Emerging role of AI in decision making (NHS LTP)
- › Radiology services nationally will need to make better use of digital technologies and future advances in artificial intelligence that will become vital tools for imaging teams [2]
- › Different ways of working embracing digital technologies

## Capacity: workforce

- › Workforce impacted by national shortages e.g. radiologists and in pathology. Lack of substantive workforce sustainability e.g. IR and breast radiology [3]
- › KGH & NGH have some gaps in radiologist and radiographer capacity, impacted by delays in overseas recruitment due to COVID
- › Opportunity to adopt flexible working contracts and remote working for some parts of the radiology and pathology service [2]

## Networks

- › Need for off-site diagnostic hub. Limited estate capacity at NGH for pathology and radiology.
- › Collaboration between KGH and NGH will support discussions with regional imaging networks, supporting care provided outside of the East Midlands.

## Opportunities to increase services

- › Targeted healthy lung checks (THLC) are currently provided by a third party provider. There is an opportunity to bring this in-house.
- › Neither hospital currently provides 7 day endoscopy services

## CQC Performance

Diagnostic Imaging  
KGH: Good (2019)  
Northampton: Good (2017)



## Diagnostic Waiting Times

**NGH:** Prior to COVID, Trust was variably meeting 6 week referral target of 99%. Current metric (Nov 2020) is 77% [6]

**KGH:** Prior to COVID, Trust was meeting 6 week referral target of 99%. Current metric (Dec 2020) is 87%. [7]

Sources: [1] [ONS Population Projections 2018-2028](#) [2] KGH Clinical Strategy Jan 2020, [3] NGH Clinical Service Model Reviews 19/20, [4] CQC [5] Royal College of Radiologists support and wellbeing report 2021 [6] [NGH Board of Directors report, Jan 2021](#) [7] [KGH Board of Directors report, Jan 2021](#)

# We have developed a vision for a diagnostic services for Northamptonshire

## SHORT TERM

- ✓ Diagnostic services across the Group will work in a collaborative, integrated way developing **shared pathways and protocols, joint access policy** (in development) to enhance care across the county. Both organisations would work together to share capacity in order to reduce waiting times for patients.
- ✓ Diagnostics services will develop services in order to minimise disruption to patients lives, **delivering care closer to home** and **increasing one-stop services**.
- ✓ Diagnostics will **strengthen links with both Leicester and Northampton Universities** in line with the Group academic strategy to increase delivery of high-quality research and improve recruitment and retention.

## LONG TERM

- ✓ Services will embrace **new technologies such as AI** to increase **efficiency and effectiveness of care**, supported by a seamless shared IT system with the Group and wider system partners.
- ✓ Diagnostic services will collaborate to develop **shared strategies for procurement of equipment and required expansion of estate**.
- ✓ Diagnostic services across the Group will **share waiting lists and reporting lists** where appropriate.



# We have developed proposed clinical priorities for diagnostics (1/3)

*There are five services within diagnostics that have been identified as priorities, because of the positive impact that collaboration is expected to deliver in terms of easing workforce pressures, standardising diagnostic care and expanding patient access to specialist expertise. The five services are imaging, interventional radiology, nuclear medicine, pathology and endoscopy.*

*The ambition for all 5 services is for teams across NGH and KGH to work closely together to develop and implement shared pathways and protocols. Longer term this will be the basis for moving towards sharing waiting and reporting lists.*

Priority Specialty	Drivers for Collaboration	Ambition
Imaging	<p><b>STRATEGIC DRIVERS</b></p> <ul style="list-style-type: none"> <li>› NHS Long Term Plan: diagnostic imaging networks by 2023</li> <li>› Diagnostics: Recovery and Renewal: community diagnostic hubs</li> </ul> <p><b>GROWTH IN DEMAND</b></p> <ul style="list-style-type: none"> <li>› Increased demand for imaging as population grows and estate capacity is already constrained particularly at NGH. Collaboration could allow resource to be maximised across both sites to better meet patient demand</li> </ul> <p><b>WORKFORCE CHALLENGES</b></p> <ul style="list-style-type: none"> <li>› Gaps across the group in radiologist and radiography capacity caused by national shortages and delays in overseas recruitment</li> <li>› Overseas recruitment is time and resource intensive therefore collaboration on recruitment could increase efficiency of this process for both organisations</li> </ul> <p><b>EFFICIENCY OPPORTUNITIES</b></p> <ul style="list-style-type: none"> <li>› Working together will avoid duplication of expensive kit and services on both sites</li> </ul>	<p><b>The ambition is for imaging to be maintain service on both acute sites by a networked team working to the same protocols and pathways. The Group will work together to establish a community diagnostic hub.</b></p> <ul style="list-style-type: none"> <li>› The group will work together to rapidly address capacity constraints particularly at NGH. This will reduce waiting times for patients, allowing them quicker access to treatment.</li> <li>› Group ambition to achieve joint QSI accreditation; combining expertise and resource will expedite process to achieve accreditation.</li> <li>› The Group imaging services will embrace the emerging role of digital technologies and artificial intelligence to improve quality and efficiency of services.</li> <li>› Group imaging will share best practice and learning to increase delivery of one-stop services to improve patient experience and streamline their care.</li> </ul> <p><b>Workforce ambitions:</b></p> <ul style="list-style-type: none"> <li>› The Group will work together to explore and expand alternative workforce roles to ease capacity pressure. This will include recruiting 2-3 clinical fellows at a Group level who can be appointed into substantive posts.</li> <li>› The Group will integrate training to jointly offer a wider range of courses; the Group will also develop a Group-wide support network for those on a consultant trajectory. The scale provided through collaboration will expand the support and development network offered to staff.</li> <li>› Overseas recruitment will be progressed at a Group level e.g. joint interview days, to reduce administrative burden of the recruitment process on both organisations.</li> <li>› The Group will introduce rotating radiographers (specialist areas or lower banding) who will facilitate cross-site learning and sharing ways of working.</li> </ul> <p><b>Service location ambitions:</b></p> <ul style="list-style-type: none"> <li>› PET-CT will continue to be delivered solely at NGH (nationally commissioned service).</li> <li>› Cardiac MRI will continue to be delivered solely at KGH (subject to Cardiology proposals.)</li> </ul>

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# We have developed proposed clinical priorities for diagnostics (2/3)

Priority specialty	Drivers for Collaboration	Ambition
<b>Interventional radiology</b>	<p><b>WORKFORCE CHALLENGES</b></p> <ul style="list-style-type: none"> <li>Significant workforce pressures including lack of substantive workforce sustainability.</li> <li>No KGH out of hours cover for non-vascular IR currently. NGH offers an ad hoc 1 in 2 rota. Challenges with out of hours cover results in patients being sent to Leicester for care.</li> </ul> <p><b>EXISTING COLLABORATION</b></p> <ul style="list-style-type: none"> <li>Vascular IR is already consolidated on NGH</li> </ul>	<p><b>The ambition is for non-vascular IR to continue be provided on both acute sites by networked teams working to the same protocols and pathways. Vascular IR will continue to be provided on a single site (NGH).</b></p> <p><b>Non-vascular IR will work collaboratively across the group to provide a shared rota for out of hours cover.</b> The teams will work together to provide joint training and secondment opportunities; sharing expertise to increase career opportunities for staff.</p> <p>The Group will continue to explore and build on alternative roles within IR, including recruiting clinical fellows at a group level who can be appointed to substantive posts. This collaboration will help to ease workforce pressures across the Group.</p> <p><b>Vascular IR</b> (inpatient and complex) will continue to be provided on a single site (NGH). There is potential to expand OP services at KGH to provide day case vascular IR procedures. Rare complex cases will continue to be referred elsewhere as they require access to cardiothoracic surgery.</p>
<b>Nuclear medicine</b>	<p><b>EXISTING COLLABORATION</b></p> <ul style="list-style-type: none"> <li>Nuclear Medicine currently run for the group by NGH, this is a temporary arrangement and a great example of current collaborative working.</li> </ul> <p><b>EFFICIENCY OPPORTUNITIES</b></p> <ul style="list-style-type: none"> <li>Underutilised Nuclear Medicine department at KGH</li> </ul>	<p><b>The ambition is for Nuclear Medicine to continue to be provided on both sites, building on the existing collaborative working this service would be delivered by <u>a single team</u> working to the same protocols and pathways.</b></p> <p>Nuclear medicine will be delivered across both sites by a single team, ensuring capacity across the Group is fully maximised. Note: there may be some challenges re single team given NGH radiographers dedicated to NM, KGH radiographers are not.</p>

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# We have developed proposed clinical priorities for diagnostics (3/3)

Priority specialty	Drivers for Collaboration	Ambitions
Pathology	<p><b>STRATEGIC DRIVERS</b></p> <ul style="list-style-type: none"> <li>▶ NHS Long Term Plan: pathology networks by 2021</li> </ul> <p><b>GROWTH IN ONE-STOP SERVICES</b></p> <ul style="list-style-type: none"> <li>▶ Increase in demand for pathology services</li> <li>▶ Similar ways of working required between the trusts to enable one-stop services</li> </ul> <p><b>WORKFORCE CHALLENGES</b></p> <ul style="list-style-type: none"> <li>▶ Pathology workforce challenges caused by national shortages</li> <li>▶ Opportunity to adopt flexible working contracts and remote working. Implementing this is critical to addressing workforce pressures. Collaboration will enable more rapid roll out of these new ways of working via economies of scale.</li> <li>▶ Microbiology, Histopathology and Blood Sciences are having challenges recruiting medically qualified staff nationwide</li> </ul>	<p><b>The ambition for Pathology is for both trusts to continue work together collaboratively within the ME2 Network.</b></p> <p>The priorities and objectives highlighted in the ME2 include:</p> <ul style="list-style-type: none"> <li>▶ A staffing strategy to include resolving operational issues with staffing, appointing joint posts and delivering joint training</li> <li>▶ Adopting consistent processes to reduce unwarranted variation</li> <li>▶ Digital pathology/diagnostics implementation</li> <li>▶ Common performance and risk management dashboard</li> </ul> <p><b>The Group will have shared on-call provision for Microbiology</b> these discussions are already in train and this will address the current fragility of this service.</p> <p>The Group will collaborate to develop <b>shared ambitions for future use of molecular pathology</b> in line with national recommendations.</p>
Endoscopy	<p><b>MANAGING DEMAND</b></p> <ul style="list-style-type: none"> <li>▶ Growth in endoscopy demand in addition to national driver for age expansion of bowel cancer screening</li> <li>▶ This will incur further challenges meeting diagnostic targets</li> </ul> <p><b>WORKFORCE CHALLENGES</b></p> <ul style="list-style-type: none"> <li>▶ Challenges around consultant and nursing numbers. Alternative roles have been developed, however this hasn't closed the gap.</li> </ul> <p><b>SERVICE PROVISION</b></p> <ul style="list-style-type: none"> <li>▶ Neither KGH or NGH provide 7 day endoscopy services (24/7 OOH provision is provided).</li> </ul>	<p><b>The ambition for Endoscopy is to be provided on both acute sites by networked teams working to the same protocols and pathways, with integration of specialist services.</b></p> <p>The Group will have joint meetings and regular contact to share learnings and work together to deliver equity of service across the county including services offered in the community.</p> <p>This will build on the successful existing collaboration around bowel cancer screening.</p> <p>There is opportunity for further integration of specialist endoscopy services, e.g. EUS (currently key-man risk at NGH) and ERCP (pressured at both trusts), as these services require specialist expertise and equipment, Opportunities include single site service or networked waiting list.</p> <p>The Group will collaborate to discuss jointly delivering 7 day services and new technologies such as Spyglass. This would require significant investment.</p>

# Our ambition is to deliver diagnostic services closer to home

There is a clear ambition to deliver diagnostics services outside of the acute setting, closer to patients’ homes. This will improve access and patient experience. Delivering services in the community could release capacity in the acute setting which is currently constrained.

Collaboration is an opportunity to explore the development of **Community Diagnostic Hubs** across the county.

<b>The ambition to deliver care closer to home could be achieved by delivery of Community Diagnostic Hubs</b>	<p>The Group will collaborate to develop a strategy and delivery plan for Community Diagnostic Hubs (CDH).</p> <p><b>Initial ambitions for CDH include:</b></p> <ul style="list-style-type: none"><li>› To include GP services (including primary care cancer pathway) and outpatient services such as fracture clinic.</li><li>› Diagnostics provision that could be included: CT, MRI, ultrasound and bloods. The hubs could also offer therapy provision.</li></ul>
<b>There are a number of potential opportunities for location of the CDH(s)</b>	<ul style="list-style-type: none"><li>› There is potentially an opportunity to establish a CDH in locations where KGH currently provides satellite services: Nene Park, Isebrook &amp; Corby. Alternatively a CDH could be delivered from a large hub in a central location to provide services county-wide.</li></ul>
<b>There are benefits of delivering diagnostic care closer to home for patients and the trusts..</b>	<ul style="list-style-type: none"><li>› Delivering care closer to home will improve patient experience and minimise unnecessary visits to the acute site.</li><li>› NGH currently has limited space on site (2 CTs and MRI needed). CDH would support reducing estate pressure.</li><li>› A CDH supports delivery of the GIRFT recommendation to split elective and emergency activity. This allows better protection of elective services during periods of high emergency demand such as was seen during the pandemic.</li></ul>
<b>However there a number of challenges and considerations with CDH that the Group must take into account.</b>	<ul style="list-style-type: none"><li>› Currently no significant funding route has been announced</li><li>› Any CDH would have to be staffed from existing workforce. This may increase workforce pressures although reducing estate capacity pressures.</li></ul>

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## Cover sheet

Meeting	Trust Board
Date	25/11/2021
Agenda item	3.3

Title	Digital Strategy Update
Presenter	Andy Callow, Group Chief Digital Information Officer
Author	Andy Callow, Group Chief Digital Information Officer

This paper is for			
<input type="checkbox"/> Approval	<input type="checkbox"/> Discussion	<input type="checkbox"/> Note	<input checked="" type="checkbox"/> 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				
<input checked="" type="checkbox"/> Patient	<input checked="" type="checkbox"/> Quality	<input checked="" type="checkbox"/> Systems & Partnerships	<input checked="" type="checkbox"/> Sustainability	<input checked="" type="checkbox"/> 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 Group Digital Strategy is reviewed every 6 months	N/A

Executive Summary
<p>The Group Digital Strategy was approved by both Boards at the end of March 2021.</p> <p>The Strategy includes 8 themes; within each theme are three key priorities and a number of measures of achievement to be monitored at the 12 month and 36 month points.</p> <p>Since the strategy was approved a lot of detailed work has taken place to put the measures in place for each of the 96 achievement targets specified.</p>

The strategy included a commitment to do a systematic review of the Strategy every 6 months and sign off any changes

This review has not identified any changes to the themes, ambitions or priorities and progress has been made on every theme within the strategy.

In the process of defining the KPIs, some of the 96 targets have been modified:

- 3 targets are now complete
- 4 targets require a new baseline as the target date has now passed – most notable being the delivery of an aligned PAS across the group due to national funding/procurement requirements
- 12 targets have had their summary text revised

A fully marked-up version (F03) of the Group Digital Strategy is included in the Appendices.

There is an acknowledgement that the communication of progress can be improved, particularly to the clinical body. Discussions are taking place with the medical directors and the comms team on how to share progress most effectively.

The Digital team will monitor other strategies as they develop (e.g. Group Clinical Strategy) and keep the Digital Strategy under review to ensure alignment.

The Board is asked to:

- Note the update and achievements to date

#### Appendices

- Review of Group Digital Strategy Nov 2021 D01
- Group Digital Strategy F03

#### Risk and assurance

Risks associated with the Group Digital Strategy are monitored through the Group Digital Hospital Committee and the associated operational groups.

Risk of not delivering the Group Digital Strategy is managed through the BAF.

#### Financial Impact

Financial impact of each element within the strategy are tracked individually and reporting collectively at the Group Digital Hospital Committee

#### Legal implications/regulatory requirements

N/A

#### Equality Impact Assessment

Individual elements within the Group Digital Strategy will have equality impact assessments completed.

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

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# Public Board: Digital Strategy Review

Presented By: Andy Callow

November 2021

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



# Introduction

- The **Group Digital Strategy** was approved by both Boards at the end of March 2021.
- The Strategy includes **8 themes**; within each theme are three key priorities and a number of measures of achievement to be monitored at the 12 month and 36 month points.
- Since the strategy was approved a lot of detailed work has taken place to put the measures in place for each of the **96 achievement targets** specified.
- The strategy included a commitment to do a systematic review of the Strategy every 6 months and sign off any changes
- This slide deck provides the Board with a summary of progress.

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# Executive Summary

- To date **no changes to the themes, ambitions or priorities have been identified.**
- Progress has been made on every theme within the strategy.
- In the process of defining the KPIs, some of the 96 targets have been modified:
  - 3 targets are now complete
  - 4 targets require a new baseline as the target date has now passed – most notable being the delivery of an aligned PAS across the group due to funding/procurement requirements
  - 12 targets have had their summary text revised

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# Progress Update on the 8 Digital Strategy Themes



**Empowering our patients, their families and carers**



**Supporting our staff**



**Doing the basics to have a solid foundation to build on**



**Delivering clinically-led solutions**



**Providing insight to support decision making**



**Working with our health and care partners**



**Connecting our systems**



**Collaborating for a Shared Purpose**

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# Format for Theme Updates

## Theme N: Name of Theme

### Our ambition for this theme

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### Our priorities

- 1 Ut enim ad minim veniam, **quis nostrud** exercitation ullamco laboris nisi ut aliquip ex ea commodo consequat
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- 3 Excepteur sint **occaecat cupidatat non proident**, sunt in culpa qui officia deserunt mollit anim id est laborum.

### Progress to date

KPI (due March 2022)	Status
1.1.1. Maternity patients have access to the patient health record through system-wide portal	Delayed – but project now kicked off
1.1.2. Patients can select their communication format preference (e.g. email, letters etc).	On track
1.2.2. Of patient groups suitable for virtual monitoring 50% are utilising this technology	On track
1.3.1 25% of volunteers are trained to provide digital support to patients	On track
1.3.2. Patient self-check-in facility for Outpatients	On track
March 2022 KPIs largely on track. 1.1.1 – is delayed, initial implementation date is sighted as December which feels unrealistic given delay CCG contract signature but delivery for March feel more achievable. For awareness.	

Ambition statement from the strategy (no changes)

Priorities from the strategy (no changes)

Update on progress towards achieving priorities

Summary of theme from KPI tracker

# Theme 1: Empowering our patients, their families and carers



## Our ambition for this theme

We want to design services around our patients' and their families needs that give them control of appointments. To provide communications in formats of their choice. To have access to their records to share as they see fit and feel that their needs are known by all who are for them.

We will make appropriate use of remote monitoring technology to support care from the comfort of their own home. We will provide technology and support to our patients to help access our systems if they need it.

We want to keep improving our environment to improve the inpatient experience, such as electronic meal ordering and patient entertainment, taking opportunities presented of the new building works taking place.

## Our priorities

- 1 We will **join our records up** so our patients have access to their records across the health system
- 2 We will **hold virtual appointments** for our patients where that is safe and appropriate. We will be able to **virtually monitor our patients' conditions**
- 3 We will **improve the patient experience**, making sure **our systems are simple** to use, we **provide support if people are struggling** and **improve inpatient experience**

## Progress to date



Contract signed for **Patient Knows Best** patient website. Pilot areas Advanced Care Planning and Maternity. This platform will be the route that patient records, letters and appointment booking will be managed through. Working with NHS Digital to use NHS Login through the NHS App

Common **virtual consultation platform eClinic now in place across the Group**. Monitoring uptake and reaching out to services not yet using the system.

Doccla remote monitoring continues to be well received, mainly for Covid patients. Extending to pregnant covid patients. Pilot areas Pulmonary rehab. **Additional funding received to add further 250 patients.**

Project underway to deliver questionnaires to patients prior to follow up appointment to help **reduce unnecessary follow ups**. Anticipating Go-live April 2022.

Digital letter/hybrid mail project commencing end of 2021.

25% of volunteers are trained to provide **digital support to patients** at NGH.

KPI (due March 2022)	Status
1.1.1. Maternity patients have access to the patient health record through system-wide portal	Delayed – but project now kicked off
1.1.2. Patients can select their communication format preference (e.g. email, letters etc).	On track
1.2.2. Of patient groups suitable for virtual monitoring 50% are utilising this technology	On track
1.3.1 25% of volunteers are trained to provide digital support to patients	On track
1.3.2. Patient self-check-in facility for Outpatients	On track

March 2022 KPIs largely on track. 1.1.1 – is delayed, initial implementation date is sighted as December which feels unrealistic given delay CCG contract signature but delivery for March feel more achievable. For awareness.

# Theme 2: Supporting our staff



## Our ambition for this theme

We want our digital systems to transform the workplace, making it a better and more efficient place to work. We will do the hard work to design our systems and processes to make things easier for our staff.

We will have a single sign-on service for our staff. Our people will have the appropriate hardware and software to do their job and feel confident about using our digital systems.

Our approach to training and support for staff will be continuous and adaptive, using data to target the support to staff to help them to make the most of our systems.

## Our priorities

- 1 We will develop **universal NHS.net and Office 365 accounts** across all sites for our staff
- 2 We will make sure that staff have the **appropriate kit and software** that they need to do their jobs
- 3 We will provide amazing **training and support** for our staff and ensure that we are **building digital literacy**

## Progress to date

**All email is now transferred to NHS.Net** across the Group. This now enables sharing calendars across UHN. Next steps will be to complete the move of all NGH staff to the NHS.Net version of MS teams by the end of November.

NGH project for migration to Office 365 underway, with 50% network storage migrations completed. Planning commencing for NGH migration to Office 365. This will result in **improved document collaboration** across the Group (working on a single document rather than email "version hell").

Implementation of TCAMs system underway enabling community pharmacists to see medicine information for discharged patients.

Linking of network credentials to HR system project underway. This will help improve access to systems for starters and **reduce the risk of unauthorised system access** for leavers. Due to go live April 2022.

**Agreed minimum specification of desktop hardware now in place across UHN.** Assessment of current state against specification taking place across UHN and replacement schedule being put in place.

KPI (due March 2022)	RAG
2.1.1. All staff on NHS net accounts by Q3 2021	On track
2.2.1. Consistent rolling user device hardware replacement programme established by Q3 2021 with regular review process in place to establish user device needs	KPI in review
2.3.1. All staff have access to digital training and support which utilises a range of learning techniques including virtual and face to face	Determining baseline
2.3.2. Number of service desk calls that could have been resolved using self-help (or are first time fixes over the phone) are reduced by 25% by Q1 2022	KPI in review
2.3.3. IT SLAs are standardised across the Group	On track



# Theme 3: Doing the basics to have a solid foundation to build on



## Our ambition for this theme

We want to be ambitious and drive our Trusts forward, but we need to build great foundations to build on.

We need to ensure that our connectivity is universally available and our staff have the tools they need to do their jobs.

We are trusted with our patients' data and our systems need to be safe and secure. We will always consider confidentiality, integrity and availability of our data to embed a culture of data protection by design.

We will continue to enact our cloud-first policy to make the best use of today's technology.

## Our priorities

- 1 We will focus on **cyber security and data security** to ensure our patients' records are safe and secure
- 2 We will seek to be one of the truly **cloud-first Hospital Groups** in England
- 3 We will work to ensure our **network and connectivity keeps pace** with our growing digital needs

## Progress to date

Improved wifi coverage on track across UHN for Aug 2022. **More controllers and access points installed already across both sites** as part of a rolling programme of works. This will also include improvements to the public and staff personal device parts of the network.

**Business Continuity rehearsal completed in May 2021.**

Schedule in place for this to be repeated at least annually.

Good progress on the migration of all Windows servers to supported versions. 90% of migration completed at KGH, 60% at NGH. Trajectory to complete at KGH by Dec 2021 and NGH Aug 2022.

Cloud-first statement agreed for NGH (KGH's cloud-first policy been in place since Oct 2020). **17% of KGH servers already migrated to Cloud.** NGH trajectory for 20% of servers to be migrated by March 2022.

Upgrade of network cores and firewalls planned for April/May 2022. NGH data centre essential hardware refresh being planned (last refresh as part of cloud-first policy)

KPI (due March 2022)	RAG
3.1.1. 0 Serious Security Incidents each year	On track (currently 0)
3.1.2 Standardised Cyber reporting	Await baseline
3.1.3. Business Continuity rehearsal based on testing scenarios & tabletop exercise by Q2 2021	On track
3.1.4. +97% of servers fully patched at all times by Q2 2021	Await baseline
3.2.1. NGH Cloud-first policy in place by Q2 2021	Complete
3.2.2. No more new software hosted in our data centres from Q1 2022 in line with NGH Cloud First Intent	Await baseline
3.2.3. 20% of services hosted in the cloud by Q4 2021 where possible or appropriate.	Await baseline
3.3.1. The number of calls to the service desk for poor Wi-Fi and slow connectivity drops by 50% by March 2022	In review
3.3.2. Independent assessment of wired and wireless LAN taken place and all remediations / action plan complete by March 2022	On track



# Theme 4: Delivering clinically-led solutions



## Our ambition for this theme

We will understand the needs of clinicians in order to give them excellent tools that work for them and give them back time to care. Our paperless systems will not just be aligned but will bring together relevant clinical information into a hub for ease of access by clinicians and improve workflows for clinicians, including minimising additional data capture.

We will work with our clinicians through the Group Clinical Strategy and Clinical Collaboration work to understand patient pathways in our services and design digital solutions to enhance care.

We will make use of the advanced technology and data available to us to help support decisions about clinical care and we will become nationally renowned for the environment we create to allow our clinical research to thrive.

## Our priorities

- 1 We will have a **Group Electronic Patient Record** so that our two hospitals can share the same record, viewable from any location on any device
- 2 We will **spend time with our clinicians** to understand how our staff are using systems and how our systems could better help
- 3 We will **help deliver innovative research projects**, supporting our ambition to become a teaching hospital

NGH EPR Programme launched. Working through national Digital Aspirant funding process to help fund replacement and alignment of Patient Administration system and other EPR components. Outline Business Case on agenda for Treasury Investment Committee in Jan 2022. In parallel and funded internally, procurements for **Electronic Document Management System (EDMS) and Electronic Prescribing and Medicine Administration (EPMA) are underway**. Planning for sequencing and replacement of the pharmacy system underway **[Pledge 3 from the Clinical Collaboration Conference]**.

KGH EDMS programme continues to roll out across the Trust. **35% of inpatient discharges now have scanned historical patient records.**

Working across the Group and with UHL to determine next steps for Laboratory Information Management System.

111 Streaming and Redirection **live in EDs.**

“Paper Picnic” held at KGH, with colleagues from across the Group, System and wider, looking at the various pieces of paper used in patient journeys, starting with nursing. This is helping to inform the **prioritisation of the clinical areas to be migrated** to electronic processes using clinical narrative. Three documents chosen for Phase One.

Digital team actively arranging shadowing sessions with clinical teams.

KPI (due March 2022)	RAG
4.2.1. System in place to gather digital, innovative ideas from across the Group.	On track
4.2.2. Embedded use of user research and service designers to improve introduction and use of clinical systems	Confirmed
4.3.1. Provision of access to pseudonymised data and analytical support to research projects	In review

# Theme 5: Providing insight to support decision-making



## Our ambition for this theme

We want to revolutionise the way decisions are taken in our Group and across our health system. We will start with being clear about what data is relevant for making decisions and build a consistent structure that supports this.

We will adapt and provide increased insight and analysis, getting to the point where our teams are anticipating the questions colleagues may ask.

We need to make it easy for all staff to have information at their fingertips and for it to be easier for clinicians involved in research being able to analyse data for better care and prevention.

## Our priorities

- 1 We will **understand what data is needed** to support patient care so that when we are creating data, it provides value
- 2 We will develop **dashboards that are intuitive and staff can use** to revolutionise decision-making
- 3 We will **improve the consistency and data quality** across the sites, including standardising the way we report our data

## Progress to date

Firebreak agreed across UHN to give teams more time to implement a series of key dashboards using Power BI. Team working with operational and strategic staff to test out initial versions. **Theatre dashboard now live** and in use, other dashboards to follow. Progress in migrating key data feeds into a common cloud platform across the Group.

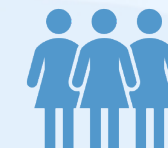
Key departures in the senior leadership across Health Intelligence have led to the acceleration of the recruitment and appointment of a Group Head of Health Intelligence, reporting to the Group CDIO. **Successful candidate to commence in January 2022.**

Winter modelling, H1 and H2 modelling, alignment of IGR/Committee metrics key deliverables during this period.

Preparation work for use of artificial intelligence in Clinical Coding underway, seeking to explore if coding endoscopy procedures can be automated, giving the coding team **more time to focus on more complex coding** and audit the automated elements. Iterative builds taking place now, with completion of project expected in April 2022.

KPI (due March 2022)	RAG
5.1.1. Agreed consistent board, committee and operational reporting frameworks and what data is required by Q2 2021	On track
5.2.1. Power BI is available to all staff and all staff have been trained to use it	Confirmed – baselining in progress
5.2.2. Group Data Warehouse established. 30% of clinical systems ingested.	On track
5.3.1. Data Quality Improvements Programmes established at both Trusts, ensuring that data is extracted and processed with the consistent application of validated business rules by Q2 2021	Determining baseline measures

# Theme 6: Working with our health and care partners



## Our ambition for this theme

We need to work better with our local health and care partners to make sure that our systems talk to each other.

We want it to be easy for our staff to make sure our patients get the care in the community they need. We will create a single shared system to manage putting care packages in place that all our partners use, rather than relying on unconnected systems and processes.

We will work to make sure we are supporting the four transformation aims of the Northamptonshire Health and Care Partnership, including implementing the Northamptonshire Care Record (NCR) and supporting the Integrated Care In Northamptonshire (ICAN) programme.

## Our priorities

- 1 **Implement the Northamptonshire Care Record (NCR)**, fully supporting the digital strategy for the Northamptonshire Integrated Care System (ICS)
- 2 We will fully support the development of the **ICS Digital Strategy**, and the delivery of the digital requirements of **four transformation priorities**, starting with ICAN
- 3 We will contribute to the **creation of an ICS-wide dataset** that can support decision-making across the system and population health management

## Progress to date

Northamptonshire Care Record (**NCR**) **due to go live Nov 2021**, with GP data being the first data set available, followed by NGH and NHFT data in January 22 and KGH data in March 22. In KGH staff will access the NCR via single sign on interface from Medway in the context of a patient, no additional password or user account will be required. NGH staff will access the NCR via an individual user account and password until the NGH PAS is replaced or it can be integrated with single sign on to EDMS. **[Pledge 1 from Clinical Collaboration Conference]**

Work has commenced on creating an **ICS Digital Strategy**, through the ICS Digital Transformation Board.

**Access to SystmOne by the Community stroke team** to interact with GP records. Live at KGH. Go live at NGH planned by Dec 2022.

Initial Northamptonshire Analytics Reporting Platform (**NARP**) **dashboards to be available from November 2021**. This will provide access to patient level data within the business intelligence tool for the purposes of direct care, including GP data, national COVID information for initial self service analytics + including national data sets with standardised dashboards. This will also support pseudonymised data usage, **supporting easier use for research**. As the data in the NCR grows, so will the data available to analyse through the NARP.

KPI (due March 2022)	RAG
6.1.1. All our patient's records linked to the NCR by Q4 2021 and available for sharing. NCR view integrated with existing systems	Delayed (see workstream updates)
6.2.1. ICS Digital Strategy approved	On track
6.3.1. Implementation and use of the Northamptonshire Analytics Reporting Platform (NARP) at Trust and ICS level	On track

# Theme 7: Connecting our systems



## Our ambition for this theme

We need our systems to be as joined up as we will be. We want our staff to be able to experience a friction-free experience when working in any Trust location, though use of a staff “digital passport”.

We have a large collection of unconnected clinical systems, each with its own overhead of training, support, supplier management and release maintenance. We will seek to reduce the number of systems, following the principle of once for both, and ensure that there is greater interoperability between the systems that remain.

We will build on our work as a Robotic Process Automation (RPA) Centre of Excellence to release efficiencies. We will be the first Trusts to transform Clinical Coding through the application of machine learning

## Our priorities

- 1 Implement **single sign-on** across all sites for our staff
- 2 Reducing the **number and variety of stand-alone clinical systems** that are in use across the Group
- 3 Supporting the **alignment and consolidation of back office and corporate systems**

## Progress to date

NGH RPA Centre of Excellence “The Automation Accelerator” funded by NHSX as one of two centres in England continues to develop its service offering. 21 automations are live, 6 in NGH:

- Pathology Patient Records Merging
- O2 Monitoring
- NHS.net provisioning
- NHS.net de provisioning
- New starters into CAMIS
- Excel to database automation

Digital teams are supporting clinical collaboration as it evolves. Interim measures in place via Virtual Desktops to allow **access to systems across the Group**. Enabled systems:

- Medway (KGH)
- Somerset Cancer (Both)
- Images via EMRAD (Both)
- Careflow Connect (Both)
- Chemocare (NGH)
- Aria Radiotherapy (NGH)
- Home Oxygen Therapy (NGH)

A technology policy review is taking place across UHN, starting with IG policies. Plan is to tackle 2 policies per month over the next 6 months.

Digital teams are supporting the work to **align workforce systems across the Group**. Currently teams are reviewing tender documentation

We are on track to have a **single sign on solution** evaluated and proof of concept demonstrated by end of March **[PLEDGE 2 at the Clinical Collaboration Conference]**

KPI (due March 2022)	RAG
7.1.1. Single sign on solution evaluated and identified. Proof of concept demonstrated	On track
7.2.1. 5% reduction in number of clinical systems used across the Group by Q4 2021	Baselines being confirmed
7.3.2. Agree strategy to align single costing system and financial system	Baselines being confirmed



# Theme 8: Collaborating for a shared purpose



## Our ambition for this theme

We want to make the most of working together as a Group. We have a wealth of experience and talent in our two current Hospital Digital teams, and together we will be able to go much further and faster.

We want to create a shared culture in our Digital portfolio, better support, training and development, and make the Group Digital team the best place to work. We will value behaviours of collaboration over individual brilliance.

Working on the principle of “Once for Both”, we will become a national exemplar on how NHS teams organise themselves to do great work.

## Our priorities

- 1 We will develop our **shared Digital portfolio**, helping our staff to understand what we do, and providing clarity on the roles and structure
- 2 We will **enhance our professionalism** and ensure our teams are equipped with the right skills to meet our users needs
- 3 We will create a **supportive and co-operative culture** that **puts the Group first**, making the most of our **individual strengths**

## Progress to date

Shared **service desk platform for the Group has been agreed**. KGH have completed upgrade, with NGH planned for Jan 2022. The platform will deliver increased reporting metrics on performance and incidents.

**British Computer Society membership arranged for the Group**. Launch event w/c 8 Nov. Audit of training materials/platforms completed and shared across all the Digital Directorate.

**Commenced Senior Digital Leadership restructure consultation** (Phase 1) 25 October 2021. This will establish group Heads of Service for the various areas within the Digital Directorate:

- ICT
- Clinical Systems
- Health Intelligence
- Clinical Coding
- Digital Transformation and Innovation
- CCIO/Digital Clinical Influence

Each Head of Service will design and develop service structures and run consultations as Phase 2.

KPI (due March 2022)	RAG
8.2.1. Regular show and tells in place by Q3 2021 – once a quarter	On track
8.2.2. Shared learning forums in place by Q3 2021	On track
8.2.3. Access to professional development tools by Q4 2021 and 50% of staff take up the opportunity	Baselining underway
8.3.1. For 100% of procurements to be joint from Q1 2021	Baselining underway
8.3.2. Completion of review of Group digital contracts for efficiency, consistency and utilisation by Q3 2021	Baselining underway

# Summary and Recommendation

- **Summary**

- Progress on all items have been provided to the Group Digital Hospital Committee at each meeting since the Digital Strategy was approved in March 2021.
- Good progress has been made on all eight themes. There is an acknowledgement that the communication of progress can be improved, particularly to the clinical body. Discussions are taking place with the medical directors and the comms team on how to share progress most effectively.
- A paper was presented to GDHC 11 November 2021 giving details on updates to the Digital Strategy related to the target monitoring, as a result of the extensive benchmarking process that has taken place to define the tracking metrics.
- The most significant item to require change in the Strategy is the delivery of an aligned PAS (patient administration systems) in place across the Group by 31 March 2022. Due to the Digital Aspirant funding process timescales, this will not be possible. The contract should be in place at this time, with planning for implementation well under way. It will be 31 March 2023 before the aligned PAS is live.

- **Recommendation**

- Note the update and achievements to date
- Monitor other strategies as they develop and keep the Digital Strategy under review.





# Group Digital Strategy March 2021 – March 2024

Version F02: Published March 2021

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# 1 | Foreword from the Group Chief Digital Information Officer

As we've developed our ambitions as a teaching hospital Group, time and time again the need for digital approaches has come up. To paraphrase Satya Nadella, the CEO of Microsoft "Every organisation is a technology organisation" and the health system is no different.

But what is digital? Digital is NOT rebadged IT, it is about working to *apply the culture, processes, business models & technologies of the internet era to respond to people's raised expectations* [Tom Loosemore].

That's what is important about this strategy, it sets out our plans for the next few years to ensure that the digital approach is applied across all aspects of our Group, so that our patients receive the excellent care they deserve and our staff are supported by tools that meet their needs.

We are starting from a challenging position where lots of our processes are paper-based and the electronic systems we have don't talk to each other very well. That situation cannot continue.

Our ambition is to be the Most Digital Hospital Group in England by July 2023. Achieving that would mean clinicians are given excellent tools that give them back time to care, patients are in control of their treatment, managers have instant information to drive decision-making and all staff have access to amazing training and support. This strategy sets the path to get there.



Andy Callow  
**Group CDIO**



## 2 | Our Group

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

In 2020 Kettering General Hospital and Northampton General Hospital announced the formation of a Group Hospital Model. Over the last year we have made some important steps towards working ever more closer together, including the appointment of a Group CEO, CFO, CDIO and CPO.

In January 2021, both Boards approved our **Group vision, mission and values**, which describe our ambitions for the Group, including our strapline “Dedicated to Excellence” and our values describe how we want our behaviours to be in the future.

**Our Group Strategy** outlines our Group priorities that will be supported through the development and delivery of a series of **strategic initiatives**; one of these is a Group Digital Strategy.



### Our Excellence Values

- Respect
- Compassion
- Integrity
- Courage
- Accountability

### Our Group Strategy



### Our strategic initiatives

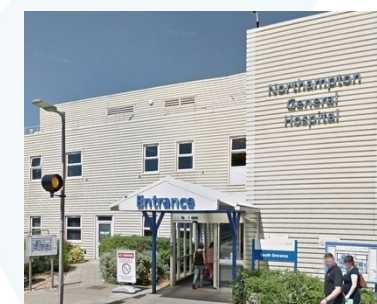


**NHS**  
Kettering General Hospital  
NHS Foundation Trust



**Kettering General Hospital (KGH) NHS Foundation Trust**

**NHS**  
Northampton General Hospital  
NHS Trust



**Northampton General Hospital (NGH) NHS Trust**



## 2 | National context

Digital has an incredible potential to transform the way that the NHS delivers care and supports its staff. Digital solutions provide an opportunity to help meet some of the key priorities for the NHS. In recent years, innovations in digital technology have supported the rise of virtual outpatient appointments, the use of Robotic Process Automation (RPA) is beginning to ease the burden on repetitive tasks, and machine learning is revolutionising the way we are able to understand the wealth of data that the NHS collects.

There have been a number of key documents and initiatives published nationally that emphasise the importance of digital in the future of care delivery and how organisations should work to design digital into care delivery:

### The NHS Long term plan five digital transformation priorities:

- 1 Empowering people:**  
People will be empowered, and their experience of health and care will be transformed, by the ability to access, manage and contribute to digital tools, information and services.
- 2 Supporting health and care professionals:**  
The information technology revolution in the NHS also needs to make it a more satisfying place for our staff to work
- 3 Supporting clinical care:**  
Patients, clinicians and the carers working with them will have technology designed to help them, through digitisation of records, EPRs and modern IT infrastructure.
- 4 Improving population health:**  
Shared care records and population health management solutions will support ICSs to understand the areas of greatest health need and match NHS services to meet them
- 5 Improving clinical efficiency and safety:**  
Digital technology can support the NHS to deliver high quality specialist care more efficiently, including digitising diagnostic images, and the use of wearable technology.

### Next steps for digital in Integrating Care Systems:

- 1 Build smart digital and data foundations:**  
Building shared infrastructure, contracts and platforms across systems, creating data and digital literacy of the whole workforce. Having a system-wide digital transformation plans to complement organisational plans that outlines the three-year journey that will benefit the citizens who live in the system.
- 2 Connect health and care services:**  
Develop a shared care record that safely joins records across health and social care, supplemented by following national standards for digital, data and interoperability. Tools and services are in place to work collaboratively across a system.
- 3 Use digital and data to transform care:**  
Redesigning care pathways to make use of digital solutions to join care up and improve outcomes. Building cross-system data and analytical functions to enable data-driven decision-making at every level.
- 4 Put the citizen at the centre of their care:**  
Develop citizen-centred digital channels and services with personalised advice, enhanced by remote monitoring solutions.

### NHS service design principles:

- 1 Put people at the heart of everything you do**
- 2 Design for the outcome**
- 3 Be inclusive**
- 4 Design for context**
- 5 Design for trust**
- 6 Test your assumptions**
- 7 Make, learn, iterate**
- 8 Do the hard work to make it simple**
- 9 Make things open, it makes things better**

## 2 | Our current digital services

In the most recent NHS Digital Maturity assessment, KGH and NGH scored below the average, with scores of 55 and 70, respectively. We want to take advantage of coming together as a Group to make improvements to our digital maturity and create a shared infrastructure on which to build.

There are currently over 220 clinical IT systems in use across the Trust, many of which aren't interoperable, making it difficult for our clinicians to have access to the right information at the right time.

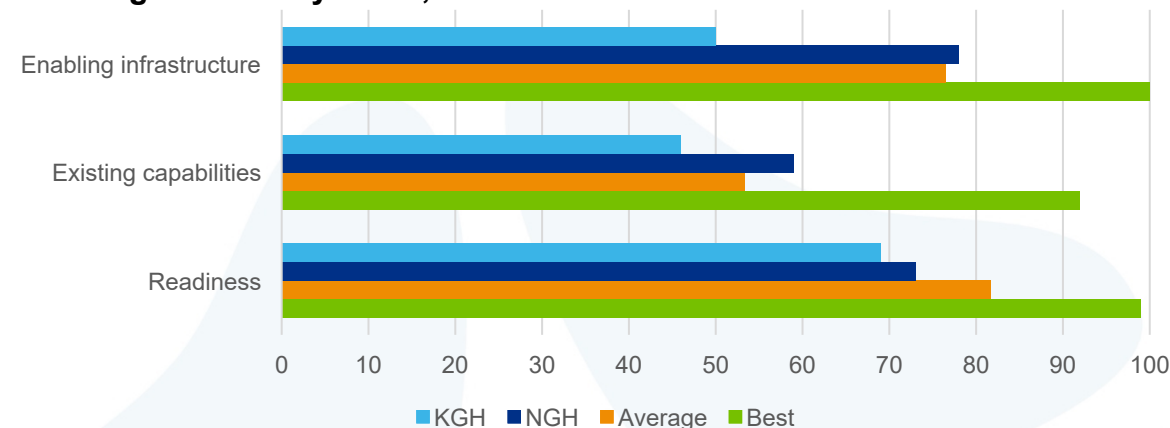
In a survey to all staff as part of the development of the strategy, our staff told us that we aren't doing so well at supporting them digitally, scoring an average of 2.2 out of a possible 5 across a range of different areas.

However we have some great work that we can build on. The KGH EPR programme will ensure that there is a robust clinical system in place, and the NGH EPR programme will be able to learn from this experience and together we will work towards the single patient record our patients expect and our clinicians need.

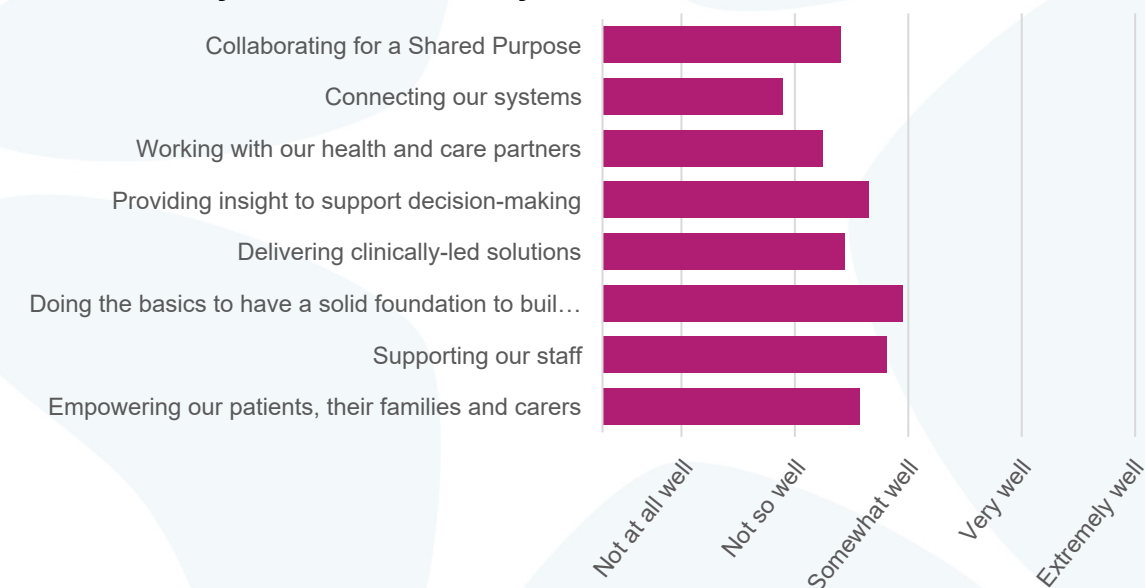
We have seen great innovation in response to the Covid-19 pandemic which has seen a substantial increase in virtual outpatient appointments and the roll-out of a number of remote patient monitoring technologies which have supported care.

Our programme with Northamptonshire Health and Care Partners (NHCP) is developing the Northamptonshire Care Record (NCR), which will help us to share access to health and care records beyond our Group and across the county.

**NHS digital maturity index, 2017**



**How well do you feel we currently do in these areas?**





### 3 | Developing the digital strategy – engagement with our staff and patients

From December 2020 to March 2021, more than 460 people engaged, through:

- All staff survey
- Patient survey
- Focus groups with patients
- Workshop for senior leaders within the organisations
- GDHC Committee workshops
- Workshops with the clinical senates
- Junior doctor meetings
- Group briefings
- Newsletters

## ”What do we want from excellent Digital services?”



  
Kettering General Hospital  
NHS Foundation Trust

**NHS**  
Northampton General Hospital  
NHS Trust



Dedicated to  
excellence

# We aspire to be the most Digital Hospital Group in England by July 2023

We will work together and with partners to enable digital care for patients across the Northamptonshire Health Economy in a joined-up & Integrated Care System



We will obtain external validation to confirm our position. By July 2023 we aim to be **ranked #1** in the “What Good Looks Like measure of Digital Transformation” (this is an emerging NHSX standard, aligned with ICS development).

Also by July 2023, we aim to achieve the highest levels of Healthcare Information and Management Systems Society (HIMSS) accreditation:

- Electronic Medical Record Adoption Model (EMRAM) Level 7
- Outpatient Electronic Medical Record Adoption Model (O-EMRAM) Level 7
- Analytics Adoption Model for Analytics Maturity (AMAM) Level 7



## 4 | We will know we've achieved this ambition when...

### Patients say:

"I can make appointments using my device"  
"My care can be monitored from my home"  
"I can have video consultations"  
"I know my information is safe"  
"As a patient I only need to say things once"  
"I see no paper notes or forms being used in my care"

#### Summarised as:

- Control of my care
- Control of my time
- Control of my information



### Managers say:

"I understand the performance of my service compared to other Trusts"  
"I have access to the information I need to help inform my decision making"  
"I trust the analysis I see and can create and answer queries on the data"

#### Summarised as:

- Trusted data
- Comparative data
- Actionable data



### All staff say:

"I can go anywhere in the Group and have a great internet connection"  
"The software and kit I have helps me to do my best work"  
"I have all the training I need to use the systems I need"  
"When I have a software or hardware problem, it gets fixed rapidly"

#### Summarised as:

- Universal connectivity
- Great kit
- Amazing support and training



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NHS Foundation Trust

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NHS Trust

### Clinicians say:

"I can provide better care because of the information systems we have"  
"I understand what care my patients need and can direct my time to those most in need"  
"As a clinician I can view records for my patients from any site"  
"As a clinician, I have a single-sign-on two-factor authentication to access the systems I need on either site"

#### Summarised as:

- Any record
- Any location
- Any device



**Dedicated to excellence**

## 5 | Our design principles for Digital



### ✓ Putting users' needs first

We need to get better at thinking about things from the user's point of view, whether that is our staff, our patients or their families/carers. This means User Research methods and skills to understand what people are trying to do and how they are trying to do it, and then designing our systems and solutions in a way that puts them first.



### ✓ Designing for simplicity

We want our systems to be simple and easy-to-use. The best digital systems and solutions are intuitive, simple and make sense to users without needing in-depth training. We want there to be as few different systems that our patients and staff need to use as possible. We should be doing the hard work to make it easy for them.



### ✓ Working in an agile way

We know that working flexibly and using agile principles will allow us to make rapid progress, whilst remaining flexible when needs change. We want to make sure that we are able to hear feedback from our staff and patients and change our course appropriately to match their needs and priorities. This will allow us to learn and iterate as we go. On this we will work to the best practice of Government Digital Services, NHS Digital and NHSX.



### ✓ Doing things once across the Group

We will take every opportunity to provide solutions, processes, suggestions, and learning once for both hospitals. We want to build links between both Trusts to build on our individual strengths, whilst making sure that we don't duplicate. Just imagine how much faster we'll improve things if we are doing things once for both hospitals!



### ✓ Communicating and engaging throughout

We want to make sure that as we are developing new solutions we will engage with both our patients and staff and the wider community to involve them in our design and roll-out process. Beyond that, we know that it's really important for people to know what is available, what is coming, and when – in non-technical language.

## 6 | Our five promises for our staff and patients

### Our patients, their families and carers

#### We will:

- ✓ Join our patient records up so our patients have access to their health record across the whole health system
- ✓ Put our patients in control of their care, making it easy for our patients to receive care in a way that works for them
- ✓ Invest in technology that helps us to monitor our patients' condition wherever they are, meaning our patients can be cared for at home
- ✓ Make sure our systems are simple for our patients to use and provide support if people are struggling
- ✓ Protect our patients' data and information



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### Our staff

#### We will:

- ✓ Work with our staff to understand how digital solutions can be designed to improve care and make our workplace a better place to work
- ✓ Reduce the number of different systems and log-ons our staff need to use to do their jobs
- ✓ Make sure our staff have the appropriate kit and software
- ✓ Make sure our NHS.net and Office365 accounts are joined up across the Group so our staff can work together more effectively
- ✓ Provide amazing training and support to our staff





## 7 | Our themes within the Digital strategy



Empowering our patients, their families and carers



Supporting our staff



Doing the basics to have a solid foundation to build on



Delivering clinically-led solutions



Providing insight to support decision making



Working with our health and care partners



Connecting our systems



Collaborating for a Shared Purpose



# 7 | Theme 1: Empowering our patients, their families and carers



## Our ambition for this theme

We want to design services around our patients' and their families needs that give them control of appointments. To provide communications in formats of their choice. To have access to their records to share as they see fit and feel that their needs are known by all who are for them.

We will make appropriate use of remote monitoring technology to support care from the comfort of their own home. We will provide technology and support to our patients to help access our systems if they need it.

We want to keep improving our environment to improve the inpatient experience, such as electronic meal ordering and patient entertainment, taking opportunities presented of the new building works taking place.

## Our priorities

- 1 We will **join our records up** so our patients have access to their records across the health system
- 2 We will **hold virtual appointments** for our patients where that is safe and appropriate. We will be able to **virtually monitor our patients' conditions**
- 3 We will **improve the patient experience**, making sure **our systems are simple** to use, we **provide support if people are struggling** and **improve inpatient experience**

## How we will measure improvement

Within one year (by 31.03.2022)		Within three years (by 31.03.2024)	
1	<ul style="list-style-type: none"><li>Maternity patients have access to the patient health record through system-wide portal.</li><li>Patients can select their communication format preference (e.g. email, letters etc).</li></ul>		<ul style="list-style-type: none"><li>All patients have access to their digital records from their smartphone and can share it with health professionals. No paper notes/forms will be used in direct patient care.</li><li>Patients can reschedule <b>outpatient</b> appointments through self-service</li></ul>
2	<ul style="list-style-type: none"><li>25% of outpatient appointments are virtual</li><li>Of patient groups suitable for virtual monitoring 50% are utilising this technology</li></ul>		<ul style="list-style-type: none"><li>1M virtual consultations have occurred, 50% of outpatient clinics are virtual</li><li>Of patient groups suitable for virtual monitoring, 85% are utilising this technology</li></ul>
3	<ul style="list-style-type: none"><li>25% of volunteers are trained to provide digital support to patients</li><li>Self-check-in <b>kiosks</b> installed to Outpatients facilitating patients self-check in</li></ul>		<ul style="list-style-type: none"><li>50% volunteers are trained to provide digital support to patients</li><li>Self-check-in <b>kiosks</b> installed to Emergency Department facilitating patients self-check in</li><li>We will have <b>refreshed enabled</b> our electronic inpatient entertainment and meal ordering.</li></ul>

# 7 | Theme 2: Supporting our staff



## Our ambition for this theme

We want our digital systems to transform the workplace, making it a better and more efficient place to work. We will do the hard work to design our systems and processes to make things easier for our staff.

We will have a single sign-on service for our staff. Our people will have the appropriate hardware and software to do their job and feel confident about using our digital systems.

Our approach to training and support for staff will be continuous and adaptive, using data to target the support to staff to help them to make the most of our systems.

## Our priorities

- 1 We will develop **universal NHS.net and Office 365 accounts** across all sites for our staff
- 2 We will make sure that staff have the **appropriate kit and software** that they need to do their jobs
- 3 We will provide amazing **training and support** for our staff and ensure that we are **building digital literacy**

## How we will measure improvement

Within one year (by 31.03.2022)		Within three years (by 31.03.2024)	
1	<ul style="list-style-type: none"><li>All staff on NHS net accounts by Q3 2021</li></ul>		<ul style="list-style-type: none"><li>Online collaboration is the norm for all staff and emailing attachments has fallen by 95%</li></ul>
2	<ul style="list-style-type: none"><li>Consistent rolling hardware replacement programme established by Q3 2021 with regular review process in place to establish user device needs.</li></ul>		<ul style="list-style-type: none"><li>Number of service desk calls related to old or non-functioning kit and software is reduced by 75%</li></ul>
3	<ul style="list-style-type: none"><li>All staff have access to digital training and support which utilises a range of learning techniques including virtual and face to face</li><li>Number of service desk calls that could have been resolved using self-help (or are first time fixes over the phone) are reduced by 25% by Q1 2022</li><li>IT SLAs are standardised across the Group</li></ul>		<ul style="list-style-type: none"><li>Digital literacy programme embedded into staff roles - within all appraisals and staff induction by Q3 2022</li><li>Digital literacy programme heralded nationally as exemplar (e.g. awards, national body recognition) by Q2 2023.</li><li>We will extend our service desk support hours to reflect demand by Q2 2022</li><li>No more than 1% of service desk calls outstanding without a resolution after 31 days of the call being made</li></ul>

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# 7 | Theme 3: Doing the basics to have a solid foundation to build on



## Our ambition for this theme

We want to be ambitious and drive our Trusts forward, but we need to build great foundations to build on.

We need to ensure that our connectivity is universally available and our staff have the tools they need to do their jobs.

We are trusted with our patients' data and our systems need to be safe and secure. We will always consider confidentiality, integrity and availability of our data to embed a culture of data protection by design.

We will continue to enact our cloud-first policy to make the best use of today's technology.

## Our priorities

- 1 We will focus on **cyber security and data security** to ensure our patients' records are safe and secure
- 2 We will seek to be one of the truly **cloud-first Hospital Groups** in England
- 3 We will work to ensure our **network and connectivity keeps pace** with our growing digital needs

## How we will measure improvement

Within one year (by 31.03.2022)		Within three years (by 31.03.2024)	
1	<ul style="list-style-type: none"><li>0 Serious Security Incidents each year. Standardised Cyber reporting</li><li>Business Continuity rehearsal based on testing scenarios &amp; table top exercise by Q2 2021</li><li>+97% of servers fully patched at all times by Q2 2021</li></ul>		<ul style="list-style-type: none"><li>Achieve Cyber Essentials Plus accreditation.</li><li>A disaster recovery test is completed across the group every year.</li><li>100% of servers and clients are fully patched within 30 days of a patch release by Q4 2022</li></ul>
2	<ul style="list-style-type: none"><li>NGH Cloud-first policy in place by Q2 2021</li><li>No more new software hosted in our data centres from Q2 2021 in line with Group Cloud First Intent</li><li>20% of services hosted in the cloud by Q4 2021</li></ul>		<ul style="list-style-type: none"><li>50% of services in the cloud by Q2 2022</li><li>100% of services hosted in the cloud by Q4 2023 with minimal viable data centre footprint</li></ul>
3	<ul style="list-style-type: none"><li>The number of calls to the service desk for poor Wi-Fi and slow connectivity drops by 50% by March 2022</li><li>Independent assessment of wired and wireless LAN taken place and all remediations / action plan complete by March 2022</li><li>Network availability across both sites at 99.9+% by March 2022</li></ul>		<ul style="list-style-type: none"><li>Latest Wi-Fi (at least Wi-Fi 6) is rolled out inside and outside the Trust. Independent surveys tell us that coverage and quality is great.</li><li>Distributed working is seamless and as quick as working on-site. All systems and services are available remotely by Q3 2023.</li><li>Network availability across both sites 99.97+% by Q2 2022</li></ul>

# 7 | Theme 4: Delivering clinically-led solutions



## Our ambition for this theme

We will understand the needs of clinicians in order to give them excellent tools that work for them and give them back time to care. Our paperless systems will not just be aligned but will bring together relevant clinical information into a hub for ease of access by clinicians and improve workflows for clinicians, including minimising additional data capture.

We will work with our clinicians through the Group Clinical Strategy and Clinical Collaboration work to understand patient pathways in our services and design digital solutions to enhance care.

We will make use of the advanced technology and data available to us to help support decisions about clinical care and we will become nationally renowned for the environment we create to allow our clinical research to thrive.

## Our priorities

- 1

We will have a **Group Electronic Patient Record** so that our two hospitals can share the same record, viewable from any location on any device
- 2

We will **spend time with our clinicians** to understand how our staff are using systems and how our systems could better help
- 3

We will **help deliver innovative research projects**, supporting our ambition to become a teaching hospital

## How we will measure improvement

Within one year (by 31.03.2022)		Within three years (by 31.03.2024)	
1	<ul style="list-style-type: none"><li>Aligned PAS (patient administration systems) contract in place across the Group</li></ul>	<ul style="list-style-type: none"><li>By Q3 2022 our hospitals will be able to share critical patient information through a shared EPR (electronic patient record)</li><li>Sharing of the full patient record by Q3 2023</li><li>No paper in use in any clinical interaction. All clinical procedures are closed-loop</li></ul>	
2	<ul style="list-style-type: none"><li>System in place to gather digital, innovative ideas from across the Trust.</li><li>Embedded use of user research and service designers to improve introduction and use of clinical systems</li></ul>	<ul style="list-style-type: none"><li>Clinical system usage analysis in place and being used to adapt practice and processes</li><li>At least two hackathon days have been hosted each year (digital innovation events)</li><li>Clinicians consistently give a Net Promoter Score for clinical systems of over 80</li></ul>	
3	<ul style="list-style-type: none"><li>Provision of access to pseudonymised data and analytical support to research projects</li></ul>	<ul style="list-style-type: none"><li>All research projects have digital team involvement.</li><li>Our data and analytical support for research projects will be nationally recognised/ renowned (e.g. national body recognition given)</li></ul>	

# 7 | Theme 5: Providing insight to support decision-making



## Our ambition for this theme

We want to revolutionise the way decisions are taken in our Group and across our health system. We will start with being clear about what data is relevant for making decisions and build a consistent structure that supports this.

We will adapt and provide increased insight and analysis, getting to the point where our teams are anticipating the questions colleagues may ask.

We need to make it easy for all staff to have information at their fingertips and for it to be easier for clinicians involved in research being able to analyse data for better care and prevention.

## Our priorities

- 1 We will **understand what data is needed** to support patient care so that when we are creating data, it provides value
- 2 We will develop **dashboards that are intuitive and staff can use** to revolutionise decision-making
- 3 We will **improve the consistency and data quality** across the sites, including standardising the way we report our data

## How we will measure improvement

Within one year (by 31.03.2022)		Within three years (by 31.03.2024)	
1	<ul style="list-style-type: none"><li>Agreed consistent board, committee and operational reporting frameworks and what data is required by Q3 2021</li></ul>		<ul style="list-style-type: none"><li>All transformational activities to improve pathways and/ or software systems, use (and informed by) analytics to understand patient and clinician journeys.</li><li>Consistent Net Promoter Score of 80+</li></ul>
2	<ul style="list-style-type: none"><li>Power BI is available to all staff and all staff have been trained to use it</li><li>Group Data Warehouse established. 30% of clinical systems ingested.</li></ul>		<ul style="list-style-type: none"><li>100% of clinical systems ingested onto the Group Data Warehouse and all data visualisations accessed through Power BI platform by Q1 2023</li></ul>
3	<ul style="list-style-type: none"><li>Data Quality Improvements Programmes established at both Trusts, ensuring that data is extracted and processed with the consistent application of validated business rules by Q2 2021.</li></ul>		<ul style="list-style-type: none"><li>Data Quality Improvements Programmes embedded at both Trusts by Q4 2022</li><li>Using new technologies and consistent processes in Clinical Coding across the Group to reduce manual coding effort by Q2 2022</li></ul>



# 7 | Theme 6: Working with our health and care partners



## Our ambition for this theme

We need to work better with our local health and care partners to make sure that our systems talk to each other.

We want it to be easy for our staff to make sure our patients get the care in the community they need. We will create a single shared system to manage putting care packages in place that all our partners use, rather than relying on unconnected systems and processes.

We will work to make sure we are supporting the four transformation aims of the Northamptonshire Health and Care Partnership, including implementing the Northamptonshire Care Record (NCR) and supporting the Integrated Care In Northamptonshire (ICAN) programme.

## Our priorities

- 1 **Implement the Northamptonshire Care Record (NCR)**, fully supporting the digital strategy for the Northamptonshire Integrated Care System (ICS)
- 2 We will fully support the development of the **ICS Digital Strategy**, and the delivery of the digital requirements of **four transformation priorities**, starting with ICAN
- 3 We will contribute to the **creation of an ICS-wide dataset** that can support decision-making across the system and population health management

## How we will measure improvement

Within one year (by 31.03.2022)		Within three years (by 31.03.2024)	
1	<ul style="list-style-type: none"><li>All our patients records linked to the NCR by Q2 2021 and available for sharing. NCR view integrated with existing systems</li></ul>		<ul style="list-style-type: none"><li>Full patient record will be included in the NCR</li><li>Personalised pre-elective support/guidance and rehabilitation materials available via NCR</li><li>All appointments from all providers visible in one place to patients by Q2 2023</li></ul>
2	<ul style="list-style-type: none"><li>ICS Digital Strategy approved</li><li>Tactical solution for frailty assessments by Q23 2021 as part of ICAN programme – 80% GP practices sharing via system one</li></ul>		<ul style="list-style-type: none"><li>Digital solution developed, implemented and integrated to support ICAN programme</li><li>Support for the ICS Transformation Priorities</li></ul>
3	<ul style="list-style-type: none"><li>Implementation and use of the Northamptonshire Analytics Reporting Platform (NARP) at Trust and ICS level</li></ul>		<ul style="list-style-type: none"><li>Demonstratable use of the NARP for Population Health decisions by Q2 2022</li><li>Fully embedded Northamptonshire Control Tower by Q2 2023, supporting system-wide decision making</li></ul>



# 7 | Theme 7: Connecting our systems



## Our ambition for this theme

We need our systems to be as joined up as we will be. We want our staff to be able to experience a friction-free experience when working in any Trust location, though use of a staff “digital passport”.

We have a large collection of unconnected clinical systems, each with its own overhead of training, support, supplier management and release maintenance. We will seek to reduce the number of systems, following the principle of once for both, and ensure that there is greater interoperability between the systems that remain.

We will build on our work as a Robotic Process Automation (RPA) Centre of Excellence to release efficiencies. We will be the first Trusts to transform Clinical Coding through the application of machine learning

## Our priorities

- 1 Implement **single sign-on** across all sites for our staff
- 2 Reducing the **number and variety of stand-alone clinical systems** that are in use across the Group
- 3 Supporting the **alignment and consolidation of back office and corporate systems**

## How we will measure improvement

Within one year (by 31.03.2022)		Within three years (by 31.03.2024)	
1	<ul style="list-style-type: none"><li>Single sign on solution evaluated and identified. Proof of concept demonstrated.</li></ul>		<ul style="list-style-type: none"><li>No more than 5 log-ons per user by Q3 2022</li><li>Single log-on per user by Q2 2023</li></ul>
2	<ul style="list-style-type: none"><li>5% reduction in number of clinical systems used across the Group by Q4 2021</li></ul>		<ul style="list-style-type: none"><li>20% reduction in the number of clinical systems used across the Group by Q4 2022</li><li>30% reduction in the number of clinical systems used across the Group by Q4 2023</li></ul>
3	<ul style="list-style-type: none"><li>Agree strategy to align the separate workforce systems across the Group by Q1 2021</li><li>Agree strategy to align single costing system and financial system</li></ul>		<ul style="list-style-type: none"><li>Implement a Group workforce deployment system and phase 1 of a Group costing system by March 2023. Alignment of Occupational Health Systems. Scanned Personnel files and Digital Passport. Leading implementor of the national ESR programme.</li><li>Implemented single costing system and single financial system</li><li>Implement CRM system to manage employment queries across the Group</li></ul>

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# 7 | Theme 8: Collaborating for a shared purpose



## Our ambition for this theme

We want to make the most of working together as a Group. We have a wealth of experience and talent in our two current Hospital Digital teams, and together we will be able to go much further and faster.

We want to create a shared culture in our Digital portfolio, better support, training and development, and make the Group Digital team the best place to work. We will value behaviours of collaboration over individual brilliance.

Working on the principle of “Once for Both”, we will become a national exemplar on how NHS teams organise themselves to do great work.

## Our priorities

- 1 We will develop our **shared Digital portfolio**, helping our staff to understand what we do, and providing clarity on the roles and structure
- 2 We will **enhance our professionalism** and ensure our teams are equipped with the right skills to meet our users needs
- 3 We will create a **supportive and co-operative culture** that **puts the Group first, making the most of our individual strengths**

## How we will measure improvement

Within one year (by 31.03.2022)		Within three years (by 31.03.2024)
1	<ul style="list-style-type: none"><li>Provide clarity to the organisations and our digital teams on structure and roles by Q2 2021</li></ul>	<ul style="list-style-type: none"><li>Fully embedded Group delivery functions in place by Q4 2022</li></ul>
2	<ul style="list-style-type: none"><li>Regular show and tells in place by Q3 2021</li><li>Shared learning forums in place by Q3 2021</li><li>Access to professional development tools by Q4 2021</li></ul>	<ul style="list-style-type: none"><li>People are so keen to join the organisation that there are no ‘hard to fill’ roles within the digital portfolio – all vacancies are over-subscribed</li></ul>
3	<ul style="list-style-type: none"><li>For 100% of procurements to be joint from Q1 2021</li><li>Completion of review of Group digital contracts for efficiency, consistency and utilisation by Q3 2021</li></ul>	<ul style="list-style-type: none"><li>All common software contracts co-terminating or consolidated <b>where possible</b></li><li>We have no examples of ‘gotchas’ where a Group solution should have been considered by Q2 2023</li></ul>

# 8 | Engagement, governance and tracking of strategy delivery

We have comprehensive tracking and assurance in place for the delivery of the Group Digital Strategy

## KGH and NGH Trust Boards

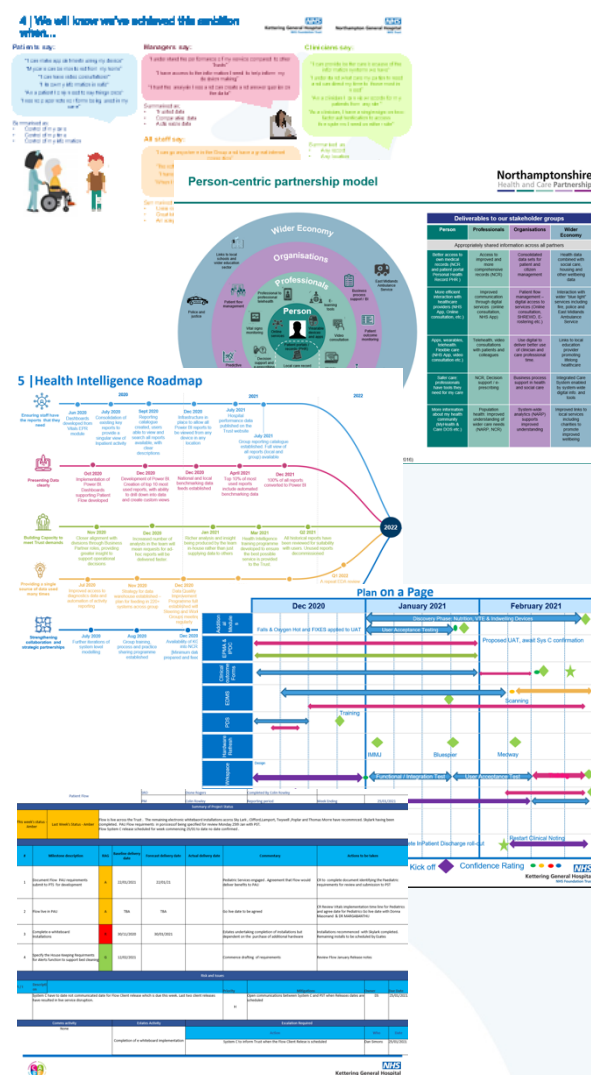
Receive an update on the Digital Strategy delivery at each meeting. Systematic review the progress of the strategy every 6 months and sign off changes.

## Group Digital Hospital Committee

Oversees the strategic aspects of the NGH and KGH Group's digital, technology and information agenda. Roadmap reviewed at every meeting (every other month).

## Operational Meetings

Monitor the detailed delivery of the roadmap. A number of meetings are in place at individual Trusts, as well as the Group Digital Operational meeting.



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

## Patient focus groups

We will involve our patients, their families and carers through focus groups when developing and designing digital solutions.

## Staff focus groups

We will use existing staff forums and set up focus groups to gather feedback and ideas, and gain input into the development of digital solutions.

## Dedicated to Excellence newsletter

We will share updates in a 'Dedicated to Excellence' newsletter to keep our staff up to date with progress, next steps and raise awareness of how to get involved.

## Cover sheet

Meeting	Public Board
Date	25 November 2021
Agenda item	3.4 Academic Strategy Update

Title	Update on Academic Strategy
Presenter	Matt Metcalfe
Author	Matt Metcalfe/ Kay Faulkner

This paper is for			
<input type="checkbox"/> Approval	<input type="checkbox"/> Discussion	<input checked="" type="checkbox"/> Note	<input type="checkbox"/> 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				
<input type="checkbox"/> Patient	<input type="checkbox"/> Quality	<input type="checkbox"/> Systems & Partnerships	<input checked="" type="checkbox"/> Sustainability	<input type="checkbox"/> 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
One year into the approved Academic Strategy, this paper gives an update on progress and success.	

Executive Summary
<p>The paper gives an overview of progress against the Academic Strategy. Key achievements to date are:-</p> <ul style="list-style-type: none"> <li>• Partnership agreement with University of Leicester</li> <li>• Agreement of a partnership with University of Northampton to cover: Research, Education, Estates, People, Sustainability.</li> <li>• Launch of University Hospitals of Northamptonshire July 21</li> </ul>

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- Largest ever cohort of medical students on placement at UHN
- Joint bids with University of Leicester and University Hospitals Leicester for NIHR key infrastructure- Biomedical Research Centre (BRC) & Clinical Research Facility (CRF)
- Agreement of 10 Clinical Academic posts across UHN
- Establishment of Academic Strategy Programme Board to manage delivery across the group
- Recruitment of expanded Research and Medical Education Teams to support growth in activity.

## Appendices

None

## Risk and assurance

### Key risks for the Academic Strategy

- Recruitment to the Clinical Academic Posts given national shortages in some areas. The link with the BRC and the CRF will add to the attractiveness of these posts.
- Student accommodation for future cohorts of medical students- there is a lack of space on the hospital estate to manage with the uplift in student numbers. An Estates sub group is working through the requirements for the future and solutions.
- Teaching space for Medical Students- due to COVID-19 and the uplift in Medical Student numbers, the availability of teaching space is challenging. An Estates subgroup is working through the requirements for the future and solutions

## Financial Impact

The Group has invested significant funding to support new posts, with an increase in income from increased placements and commercial trials. Recruitment has been delayed this year that includes longer than expected time for the Royal College to approve the Clinical Academic posts.

## Legal implications/regulatory requirements

None

## Equality Impact Assessment

A PPI Strategy for Research is in development for the Group. A key deliverable of the PPI Strategy Research will be to increase the diversity of patients accessing Clinical Trials across the Group.

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

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# Paper

## Situation

This paper provides an overview of the approved Academic Strategy, progress to date, financial overview and risks. Significant progress has been made in our partnership with University of Leicester and University Hospitals Leicester to support increased numbers of Medical Students, expand our research base and become part of National Institute of Health Research national infrastructure. This will directly impact on our ability to recruit and retain our workforce as a University Hospital Group.

An Academic Strategy Programme Board, chaired by the Medical Directors, meets monthly to review progress, KPI's, risks and financial overview.

## Background

In November 2020, the Academic Strategy was approved by both Hospital Boards. The Academic Strategy, is supported by a Business Case that details the investments required to deliver the Academic Strategy. By February 2021, the Business Case was approved by both hospitals. The Group has appointed an Associate Director of Research, Innovation and Education to lead on the delivery of the Academic Strategy. In July 2021, we became University Hospitals of Northamptonshire NHS Group, our first milestone in the delivery of the Academic Strategy.

## Group Academic Strategy: Our Objectives



Our ambition is to achieve international recognition as an academic centre that promotes and delivers better health service and provision and health outcomes to our patients

How will we achieve this?

Partnering with University of Leicester to become a **University Teaching Hospital**

Foster a **culture of learning, research and development** with strong leadership championing the strategy

Build **academic, research and digital infrastructure** to support and grow innovative clinical education and an increased research portfolio

Increase **success of research funding** from research networks, grant giving bodies and commercial sources

Develop closer alignment with **all our University Partners**

Provide a **multi professional clinical academic programme** and improved training and development offer for staff

Increase **opportunities and resources for innovation and research** to be incorporated at the core of our work and clinical practice

Develop and promote the **academic brand**

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For our Patients	For our Workforce	For UHN
<ul style="list-style-type: none"> <li>➤ <b>Access to new treatments</b> through clinical trials</li> <li>➤ Opportunity to <b>Be Part of Research</b> to inform new diagnostics and treatments</li> </ul>  <ul style="list-style-type: none"> <li>➤ Supporting the <b>workforce of the future</b> - student placements</li> </ul>	<ul style="list-style-type: none"> <li>➤ <b>Contribution to new knowledge</b> through research</li> <li>➤ Creation of <b>clinical academic careers</b></li> <li>➤ Growing numbers of <b>research active workforce from Masters to PhDs</b></li> <li>➤ <b>Employer of choice</b> post qualifying</li> </ul>	<ul style="list-style-type: none"> <li>➤ <b>Lower mortality rates</b></li> <li>➤ Improved <b>recruitment and retention</b> of clinical workforce</li> <li>➤ Efficiencies from <b>access to new screening and treatments</b></li> <li>➤ <b>Increased income</b> from clinical trials</li> <li>➤ <b>UHN credible hospital group</b> to be research active and a research leader</li> </ul>

We are investing in 10 Clinical Academics which will grow our research capability and capacity. We are focussing these investments in the following areas.

## Research Themes

Working in partnership with University of Leicester, Leicester Biomedical Research Centre and Leicester NIHR Clinical Research Facility

 <p><small>Created by Leicester Biomedical Research Project</small></p> <p><b>Diabetes</b></p>	 <p><small>Created by Leicester Biomedical Research Project</small></p> <p><b>Respiratory</b></p>	 <p><small>Created by Leicester Biomedical Research Project</small></p> <p><b>Cancer</b></p>	 <p><small>Created by Leicester Biomedical Research Project</small></p> <p><b>Stroke</b></p>	 <p><small>Created by Leicester Biomedical Research Project</small></p> <p><b>Big Data/ AI</b></p>
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To deliver the Academic Strategy our Academic Partnerships are critical to us. We are working with our University of Leicester and University of Northampton to enable us to deliver the Academic Strategy. Regular partnership meetings are in place with both Universities that help shape joint opportunities for collaborative working. In addition, we are working in partnership with University Hospitals Leicester to create a common Research Framework to support the joint posts we are investing in and to streamline our research processes. This will enable us to become more efficient and to enable us to work on joint initiatives such as the Biomedical Research Centre and the National Institute of Health Research Clinical Research Facility.

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## Assessment

A set of Key Performance Indicators have been established to monitor our success in the implementation of the Academic Strategy.

### Placements

- Largest ever cohort of Medical Students in 21/22
- 128 Students during 2021/22

### Research

- YTD October 2021 Research Participants 1443
- 13 commercial Trials open

### People

- Expanded Research teams – Joint posts
- Expanded Medical Education Teams
- 3 NMAHPs on Regional Clinical Academic Programmes
- 10 Clinical Academic posts – to be in post by April 2022
- 24 Honorary Titles with Uni of Leics

### Partnerships

- University Hospital Status achieved
- Joint NIHR Infrastructure bids submitted
  - BioMedical Research Centre
  - Clinical research Centre
- Shared Governance for Research- roll out April 22

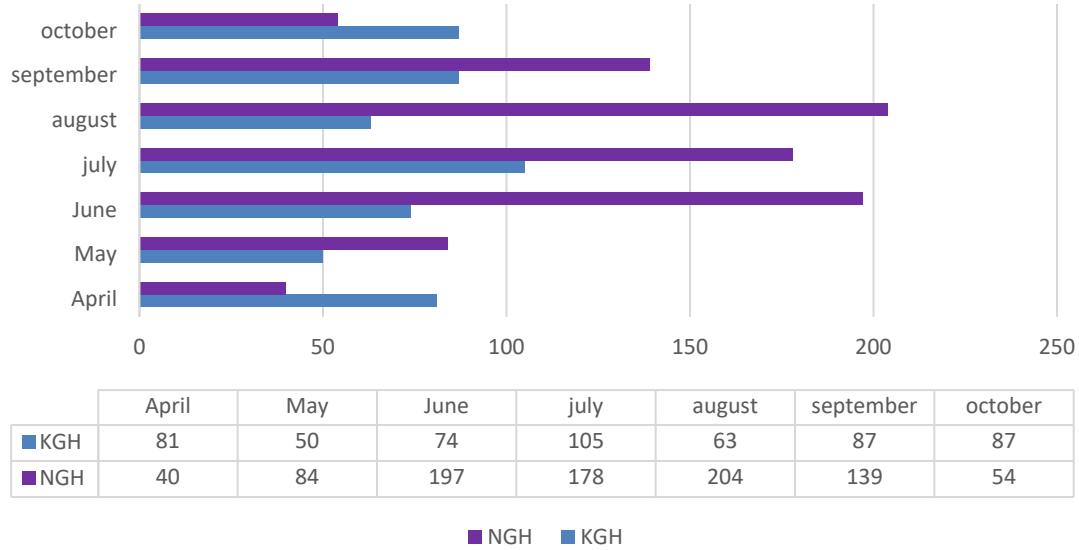
## Placements

We have taken our largest ever cohort of Medical Students this academic year 21/22 and this will rise to a total of 148 by 2024/25, a rise of 52 students from our baseline. We are continuing to invest in our workforce who deliver Clinical Education and in our Technology Enhanced Learning. Feedback from the University of Leicester after a recent visit is very positive about the student placement experience. We are tracking annual feedback and end of block placement feedback.

## Research & Innovation

Key Performance Indicators manage our success of delivery of the Academic Strategy. For Research, we are monitoring the numbers of patients who are recruited into Clinical Trials and numbers of Commercial Trials. Commercial Trials are important to us, not only to help find new diagnostics and treatments, but also to bring in revenue to support our Research Teams.

## University Hospitals Northamptonshire : YTD Patient Recruitment



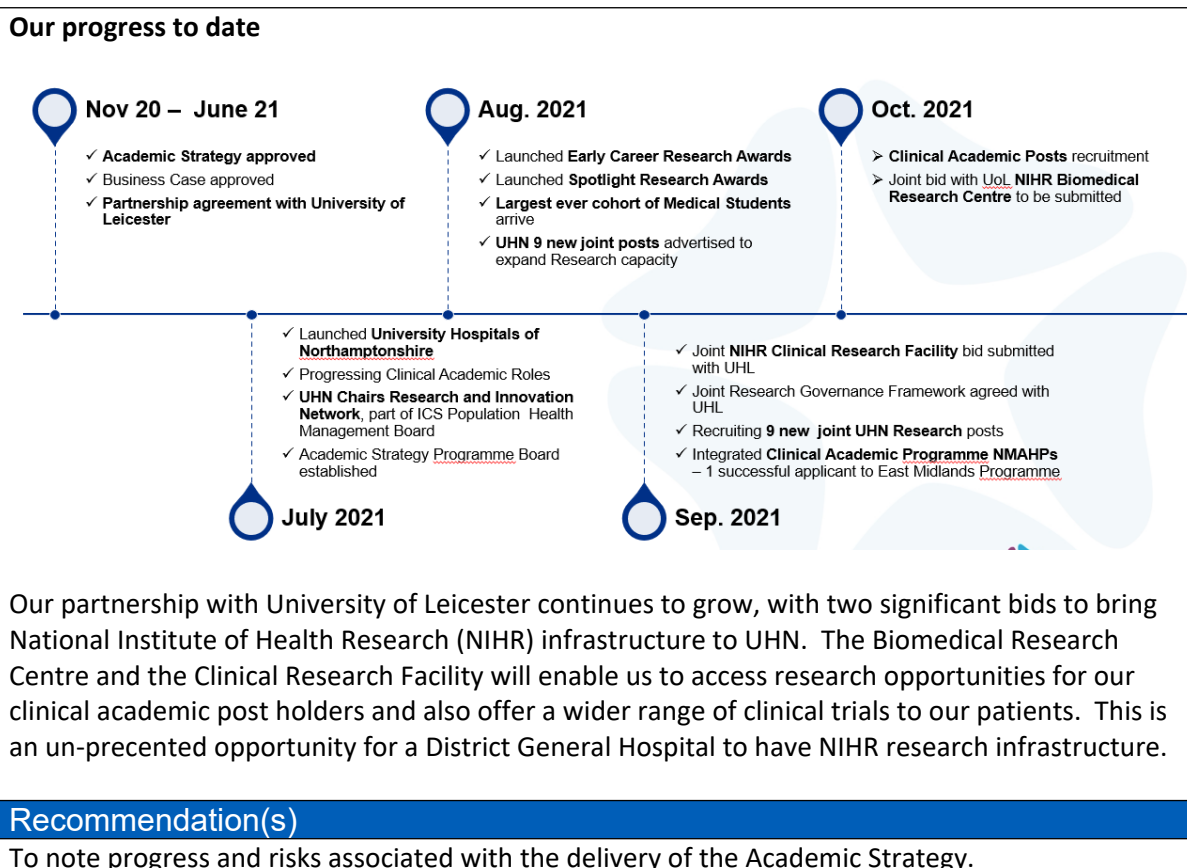
Our baseline recruitment data is 2,617 and our current performance mid-year is 1,443. This is set against challenging conditions to reopen Clinical Studies after we closed all non-Urgent Public Health Trials to support research into Covid-19. We are a top recruiter for the RECOVERY trial, which is the worlds largest clinical trial that looks at how existing treatments can be used to treat Covid-19.

We have also trademarked our first innovation and have agreed to Licence this product, called eezyCD® . Each day across Health and Social care where there are Controlled Drug Liquids, such as morphine, a daily stock check is required. Until now the only way of performing a daily stock check would be to measure the liquid with a conical flask or syringes which in turn causes residual waste, continual exposure of the liquid to the environment and time incurred by Nurses to complete the stock check.

The business benefits are:-

- Time saved on wards by reducing the time to complete a daily stocktake- potential over £1million savings across Acute Trusts alone.
- Impact on residual waste of the Controlled Drug and reduction in the use of syringes.
- Compliance with Controlled Drug management policies for Health and Social Care settings.

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## Notes:

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

Delete guidance notes

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## Cover sheet

Meeting	Public Trust Board
Date	25 <sup>th</sup> November 2021
Agenda item	3.5

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

This paper is for			
<input checked="" type="checkbox"/> Approval	<input type="checkbox"/> Discussion	<input type="checkbox"/> Note	<input type="checkbox"/> 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				
<input type="checkbox"/> Patient	<input checked="" type="checkbox"/> Quality	<input type="checkbox"/> Systems & Partnerships	<input type="checkbox"/> Sustainability	<input type="checkbox"/> 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 Approval for Dedicated to Excellence Status	None

Executive Summary
The purpose of this paper is to recommend Dryden Ward and Althorp Ward for 'Dedicated to Excellence' status following at least 3 consecutive Green Assessment and Accreditation visits and a successful Nursing and Midwifery Care Excellence Panel.
Appendices
<ul style="list-style-type: none"> <li>Appendix 1 – The 15 Standards &amp; RAG Criteria</li> <li>Appendix 2 - Nursing and Midwifery Care Excellence Panel and Essential Elements of the Application Report</li> </ul>
Risk and assurance

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Quality Care Standards
Financial Impact
None
Legal implications/regulatory requirements
Ward and clinical areas requirements to comply with Trust Quality and Safety standards and Care Quality Commission (CQC) guidance
Equality Impact Assessment
None

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

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## Introduction

The Nursing and Midwifery Assessment and Accreditation process recommenced in May 2021 after a period of suspension due to COVID-19. This paper recommends to the Board that Dryden and Althorp be recognised as 'Dedicated to Excellence' wards.

## Context

The Nursing and Midwifery Assessment and Accreditation Process has been in place within the Trust for a number of years and has provided assurance to our patients, staff, Divisions, Trust Board and regulators that optimal standards of nursing care are being delivered consistently and reliably by our health care workforce. It has become valued by our staff who strive for 'Nursing and Midwifery Care Excellence' status and as a beacon for best practice.

The Assessment and Accreditation framework has been developed to align with the Care Quality Commission's Core standards and incorporates the 6Cs; Compassion in Practice Values (NHS England, 2020) which were developed to underpin the culture and practice of all organisations that deliver care. The 6Cs continue to provide a set of common values that help to create consistency across our organisation. The Assessment and Accreditation standards also reflect the Trust's vision and values and recognises the Allied Health Professional contribution to ward/ department success.

The framework is designed around fifteen standards, each standard is sub-divided into the following elements: Environment, Care and Leadership and incorporates national performance indicators as well as local indicators, developed from lessons learned arising from complaints, concerns, adverse and quality improvement work.

The assessment process is undertaken by the Lead Nurse, for Quality Assurance, who acts as a quasi-external assessor. Each ward is assessed against the fifteen standards with each standard being RAG rated individually and when combined, an overall ward RAG rating produced. The re-assessment of the wards is dependent on the overall improvement and subsequent RAG (**Appendix 1**).

For a ward/area to be recommended for consideration to a panel for Dedicated to Excellence Status they must have achieved Green status on 3 consecutive occasions thus demonstration sustainability in delivering high standards of care. The ward/area will then formally apply for 'Dedicated to Excellence' Status. This application is outlined in **Appendix 2**, the panel then, after review of the written portfolio and presentation session will decide whether to support the application to Board for 'Dedicated to Excellence' status

The Quality Assurance Lead Nurse and Director of Nursing, Midwifery and Patient Services review and revise the Assessment and Accreditation tool annually. Elements of the tool that are no longer current or are consistently being met may be removed and elements may be added that reflect new internal and external standards. The revised tool will be prepared for use in Q1 each year. The Quality Assurance Lead Nurse will communicate all changes to the tool to the clinical areas and the Director of Nursing, Midwifery and Patient Services must approve all changes to the framework which is agreed by Nursing and Midwifery Board.

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

One of our objectives under our Quality pillar for our Group Hospital is to develop an enhanced Assessment and Accreditation tool for the multidisciplinary team (MDT). It is envisaged that this will build upon this well-embedded nursing excellence framework and develop a more cohesive approach, with an enhanced MDT focus which will commence in the new year.

## Situation

### Dryden Ward

Dryden Ward is a 26 bedded, mixed sex ward specialising in Cardiology. The ward cares for patients from across the county of Northamptonshire and often also cares for patients within General Medicine.

#### Accreditation Standards

Dryden ward were due to attend Dedicated to Excellence (formally, Best Possible Care status) Panel in 2020 however owing to the pandemic, this was delayed.

Dryden ward was initially assessed as Amber in May 2018 and subsequently as Green on 4 consecutive occasions. **See Table 1.**

**Table 1**

Standard Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Overall Rating
May 18																
Oct 18																
April 19																
Dec 19																
May 21																

The Dryden Ward team presented formally to the panel in October 2021 as to why they should receive 'Dedicated to Excellence' Blue ward, status and their plans for sustainability. The panel received an extensive report with evidence developed around key performance indicators. The Ward Sister was challenged on elements of the report and the presentation, and provided assurance to the panel. The panel were also invited to visit the ward to see the improvements "in action" and to speak to staff on duty.

### Althorp Ward:

Althorp Ward is an 18 bedded, mixed sex, elective General Surgical ward. Since the beginning of 2021 the ward has been caring for patients across specialities including; head and neck, general surgery and trauma and orthopaedics.

#### Accreditation Standards

Althorp ward were due to be reassessed in 2020 however owing to the pandemic, this was postponed.

Althorp ward was assessed as Green in June 2021 following two previous Green assessments. **See Table 2.**

**Table 2**

Standard Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Overall Rating
Oct 17																

Awarded BPC Status															
Oct 18															
Dec 19															
June 21															

The Althorp Ward team presented formally to the panel in October 2021 as to why they should receive ‘Dedicated to Excellence’ Blue ward, status and their plans for sustainability. The panel received an extensive report with evidence developed around key performance indicators. The Ward Charge Nurse was challenged on elements of the report and the presentation, and provided assurance to the panel. The panel were also invited to visit the ward to see the improvements “in action” and to speak to staff on duty.

### Recommendation

Following successful presentations to Nursing and Midwifery Care Excellence Panel on 12<sup>th</sup> October 2021, the recommendation from the panel is that the Trust Board awards Dryden and Althorp Wards ‘Dedicated to Excellence’ status.

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## **Appendix 1-** The 15 Care Standards & RAG Criteria

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

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

Assessment Outcome	Criteria for Outcome	Reassessment Timeframes
Red	6 red standards	Reassess in 2 months
Amber	3-5 red standards	Reassess in 4 months
Green	2 red standards and 8 or more green standards Standard 5 & 15 must be green	Reassess in 6 months
Dedicated To Excellence Ward	3 consecutive green assessments	Reassess in 12 months

## **Appendix 2 - Nursing and Midwifery care Excellence Panel and Essential Elements of the Application Report.**

The Nursing and Midwifery care Excellence Panel review will consist of the following elements:

- Examination of a portfolio of evidence submitted by the ward. Ward team presentation to panel with a focus on achievements and sustainability.
- Panel questions to ward team post presentation/at interview.
- Panel visit to ward

The panel will be chaired by the Director of Nursing and will include:

- Chief Executive
- Associate Directors of Nursing
- Non-Executive Directors
- Matrons (from other divisions than the ward applying for 'Dedicated to Excellence' status)
- Representation from the University of Northampton (UON)
- Representation from the CCG( Deputy Director of Quality) /NHSI/NHSE
- Representation from a Patient Family Partner

Panel decision options:

- To recommend the ward/area to the Trust Board for 'Dedicated to Excellence' Status.
- To refuse to recommend the ward/area to the Trust Board for 'Dedicated to Excellence' status.
- To defer the decision for a set timeframe

The final decision to grant 'Dedicated to Excellence' status will be made by the Trust Board.

Wards that achieve 'Dedicated to Excellence' status will be reassessed in 12 months. If green status is maintained the ward/area will submit a Board Report as a portfolio of evidence.

The final decision to maintain 'Dedicated to Excellence' status will be made by the Trust Board.

### Essential Elements of Portfolio of Evidence

<b>Please provide supporting evidence within your portfolio. The evidence must cover a period no less than 12 months</b>	<b>Panel Comments</b>
<b>1.</b> Structure of the team	
<b>2.</b> Recognition	
<b>3.</b> Patient Experience	
<b>4.</b> Complaints and PALS concerns numbers and themes	
<b>5.</b> Number of incidents (Datix) and themes	

<b>6. Safeguarding</b> <ul style="list-style-type: none"> <li>• Numbers</li> <li>• Themes</li> </ul>	
<b>7. Serious Incidents – Numbers and themes</b>	
<b>8. Incidents of Pressure Ulcers and themes</b>	
<b>9. Infection Prevention</b> <ul style="list-style-type: none"> <li>• MRSA bacteraemia's/acquisitions</li> <li>• Clostridium difficile</li> <li>• CRUTI</li> <li>• Other?</li> <li>• HHOT</li> <li>• Environmental audits</li> </ul>	
<b>10. Falls with harms</b> <ul style="list-style-type: none"> <li>• Numbers</li> <li>• Themes</li> </ul>	
<b>11. Nursing Quality Care Indicators and themes</b>	
<b>12. Training data</b> <ul style="list-style-type: none"> <li>• Mandatory</li> <li>• Role Specific</li> </ul>	
<b>13. Appraisal rates</b>	
<b>14. Leaving hospital</b> <ul style="list-style-type: none"> <li>• Systems and processes for safe and timely discharge from hospital</li> </ul>	
<b>15. Quality Improvement initiatives</b> <ul style="list-style-type: none"> <li>• Collaborative involvement</li> </ul>	
<b>17. Ward testimonies</b>	
<b>18. Finance</b> <ul style="list-style-type: none"> <li>• Budget statements</li> </ul>	
<b>19. Roster Metrics</b> <ul style="list-style-type: none"> <li>• Sickness/absence rates</li> <li>• Use of temporary staffing</li> </ul>	
<b>20. Presentation</b> <ul style="list-style-type: none"> <li>• How the ward will sustain 'Dedicated to Excellence' Status</li> </ul>	

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## Cover sheet

Meeting	Public Trust Board
Date	25 <sup>th</sup> November 2021
Agenda item	4.1

Title	Board Assurance Framework Quarter 2
Presenter	Claire Campbell- Director of Corporate Development, Governance & Assurance
Author	Claire Campbell- Director of Corporate Development, Governance & Assurance

This paper is for			
<input type="checkbox"/> Approval	<input type="checkbox"/> Discussion	<input type="checkbox"/> Note	<input checked="" type="checkbox"/> 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				
<input checked="" type="checkbox"/> Patient	<input checked="" type="checkbox"/> Quality	<input checked="" type="checkbox"/> Systems & Partnerships	<input checked="" type="checkbox"/> Sustainability	<input checked="" type="checkbox"/> 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
<ul style="list-style-type: none"> <li>Note and agree the changes made to the review of the BAF</li> <li>Consider if the Board is gaining sufficient assurance that controls and actions in place are mitigating risks described</li> </ul>	Previous BAF iterations presented quarterly to Trust 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.

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 Q2 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. 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. All linked corporate risks have been reviewed and updated as required.

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.

All changes made are identified in red ink for ease of identification.

#### Appendices

Appendix 1- Summary of changes in Q2

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)

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

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# Board Assurance Framework Report

Q2 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 Q2 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. All linked corporate risks have been reviewed and updated as required.

## 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.

All changes made are identified in red ink for ease of identification.

## 4. Changes to the BAF in Q2 2021/22

### 4.1 Group Strategic Risks:

The following changes have been made since the previous report:

- 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- reports to People Committee
  - Current controls: No change
  - Assurance of control: Updated
  - Gaps in control: No change
  - Gaps in assurance: No change
  - Actions updated: Slippage of due dates for actions 2,3 and 4 noted. Two actions completed and two new actions added.
  - Risk Score: 16- No change

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- 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. Reports to Quality Governance Committee
  - Current controls: No change
  - Assurance of Control: No change
  - Gaps in control: No change
  - Gaps in assurance: No change
  - Actions updated: Action owners identified. Slippage noted for due date for action 1.
  - Risk Score: 12- No change
  
- c. GSI03: Failure to deliver the group Nursing, Midwifery and Allied Health Professionals Strategy may result in inequity of clinical voice, failure to become a truly clinically led organisation and centre of excellence for patient care. Reports to Quality Governance Committee
  - Current controls: Updated with additional controls added.
  - Assurance of Control: No change
  - Gaps in control: Updated with a reduction of gaps in control.
  - Gaps in assurance: No change
  - Actions updated: Action owners identified. Slippage noted in due dates.
  - Risk Score: reduced from 16 to 12. Residual score reduced from 12 to 8.
  
- 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. Reports to Quality and Finance Committee
  - Current controls: Updated with additional controls added.
  - Assurance of Control: Updated with additional assurances added
  - Gaps in control: No change
  - Gaps in assurance: No change
  - Actions updated: Two actions completed. Five actions added or wording updated.
  - Risk Score: 16- No change
  
- 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. Reports to Quality Governance Committee
  - Current controls: No change
  - Assurance of Control: Updated with an additional assurance added
  - Gaps in control: No change
  - Gaps in assurance: No change
  - Actions updated: Slippage noted in due date for action 2. Action owners identified and two new actions added.
  - Risk Score: 12- No change

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- 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. Reports to Quality Governance Committee
- Current controls: Updated and expanded
  - Assurance of Control: Updated with additional assurance added
  - Gaps in control: No change
  - Gaps in assurance: Updated with additional gaps in assurance added relating to accommodation.
  - Actions updated: Two actions completed. Three new actions added.
  - Risk Score: increased from 8 to 12 with potential to increase further if accommodation issues are not resolved as required for an increased in student intake and the expansion of the research and medical education team
- 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. Reports to Group Digital Hospital Committee
- Current controls: Updated with additional assurance added
  - Assurance of Control: Update of one assurance
  - Gaps in control: No change
  - Gaps in assurance: Reduction in gaps in assurance
  - Actions updated: One action completed. Slippage noted in due date for action 4 and one action added.
  - Risk Score: 20- no change
- 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. Reports to Finance and Performance Committee
- Current controls: Updated with additional controls added
  - Assurance of Control: Updated with additional assurances added
  - Gaps in control: Updated with additional gap added
  - Gaps in assurance: No change
  - Actions updated: All actions revised and updated
  - Risk Score: Reduced and amended in terms of consequence score (5 to 4) from 25 to 16. Changes to national finance arrangements and funding allocations mean that the link, and so risk, between financial strategy and improvement to underlying financial deficit is considered to be lower than initially scored. Funding allocations are now routinely allocated on a fair share system basis, not linked to individual organisation's performance. There are support mechanisms in place to ensure adequate access to cash for business as usual purposes (e.g. payroll) and an ability, where evidence based, to agree a deficit plan and ensure adequate funding arrangements are in place to meet performance, quality and safety needs. Residual score changed from 15 to 12.

## 5. Group Risk score:

Total Risk score for Group Risks has decreased from 125 to 116 for 8 risks.

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## 4.2 NGH Strategic Risks:

- a. NGH 109: Risk of not meeting regulators minimum standards, local and national performance standards. Reports to Quality Governance Committee and Finance & Performance Committee
  - Current controls: Updated with additional control added
  - Assurance of Control: Updated with additional assurance added
  - Gaps in control: Updated with additional gap added
  - Gaps in assurance: No change
  - Actions updated: Actions reviewed and updated
  - Risk Score: 15- No change
- b. NGH 110: Risk of Avoidable Harm. Reports to Quality Governance Committee
  - Current controls: Updated with additional control added
  - Assurance of Control: Updated with additional assurance added
  - Gaps in control: No change
  - Gaps in assurance: Additional gap added
  - Actions updated: Two new actions added
  - Risk Score: 10- No change
- 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. Reports to Finance & Performance Committee
  - Current controls: No change
  - Assurance of Control: Updated with additional assurance added
  - Gaps in control: Updated with one gap removed
  - Gaps in assurance: Additional gap added
  - Actions updated: One new action added
  - Risk Score: 20- No change
- 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. Reports to Digital Hospital Committee
  - Current controls: No change
  - Assurance of Control: No change
  - Gaps in control: No change
  - Gaps in assurance: No change
  - Actions updated: Action updated regarding delivery of migration; situation has improved from 40 to 27 devices awaiting upgrades
  - Risk Score: 20- No change
- 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. Reports to Board and all Board Committees

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- Current controls: Updated
  - Assurance of Control: Updated and additional assurances added
  - Gaps in control: No change
  - Gaps in assurance: No change
  - Actions updated: Action 3 updated to reflect the widening of the vaccination programme.
  - Risk Score: 15- No change
- f. NGH 114: Risk that the Trust fails to promote a culture that puts patients first  
Reports to Quality Governance Committee
- Current controls: Additional control added
  - Assurance of Control: Updated and a control removed
  - Gaps in control: No change
  - Gaps in assurance: No change
  - Actions updated: No change
  - Risk Score: 8- No change
- g. NGH 115: Risk that the Trust fails to have financial control measures in place to deliver its 2021/22 financial plan. Reports to Finance and Performance Committee
- Current controls: No change
  - Assurance of Control: No change
  - Gaps in control: No change
  - Gaps in assurance: Updated and additional assurance gap added
  - Actions updated: Action 1- slippage on due date noted. Action 3 completed.
  - Risk Score: 15- reduced from 25 to 15. Reduction due to changes to national finance arrangements and funding allocations.
  - Risk owner updated
- h. NGH 116: Risk that the Trust fails to fully deliver the financial efficiency programme  
Reports to Finance and Performance Committee
- Current controls: No change
  - Assurance of Control: No change
  - Gaps in control: No change
  - Gaps in assurance: Updated and additional assurance gap added
  - Actions updated: Detail linked to risk owners updated.
  - Risk Score: 25- No change
  - Risk owner updated
- 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. Reports to Finance and Performance Committee
- Current controls: No change
  - Assurance of Control: No change
  - Gaps in control: No change
  - Gaps in assurance: No change
  - Actions updated: Detail linked to risk owners updated.

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- Risk Score: 15- No change
- Risk owner updated

## **6. Risk Score**

Total Risk score for NGH Risks has decreased from 153 to 143 for 9 risks.

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# Board Assurance Framework

## Group Strategic Initiative Risk Report

### BAF Risks in Order of Severity (9<sup>th</sup> November 2021)

Ref	Group Priority	Risk Title	Initial Risk Level (July 21)	Current Risk Level (Nov 2021)	Movement (from Initial)	Residual Risk Level	Risk Appetite	Comments
GSIO7	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	
GSIO1	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	
GSIO8	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	16	↓	12	High	Reduced score from 25 to 16 Reduced residual score from 15 to 12
GSIO4	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	
GSIO3	Patient	Failure to deliver the group Nursing, Midwifery and Allied Health Professionals Strategy may result in inequity of clinical voice, failure to become a truly clinically-led organisation and centre of excellence for patient care	16	12	↓	8	Low	Reduced score from 16 to 12 Reduced residual score from 12 to 8
GSIO2	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	
GSIO5	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	
GSIO6	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	12	↑	4	Low	Increased score from 8 to 12

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
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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: April 2021		Risk Classification: Operational Infrastructure		Risk Owner: Chief People Officer		Scrutinising Committee: People Committee			
Underlying Cause/Source of Risk: Linked Corporate risks:  NCRR 2439; 2586; 1348; 1598; 1764; 2135; 2732; 1573; 2188; 2270; 2494; 2635; 1188; 2003; 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) People Plan 6-month progress report presented at CPC and Trust Boards (internal)					
Gaps in Controls				Gaps in Assurance					
HR structures not aligned to People Plan. 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 – leadership structure in place 2. Align current workstreams to People Pledges. 3. Develop detailed pledge delivery plans. 4. People metrics dashboard in development for JPC performance pack and management reviews 5. Agreed change support programme. 6. Deputy Director of People to be recruited for additional support 7. Fully embed the People Pulse survey, outcomes and action at Trust level				1. Chief People Officer 2. Directors of People 3. Chief People Officer 4. Chief People Officer 5. 6. Chief People Officer 7. Chief People Officer/Directors of People		1. 31.12.21 2. 30.01.22 3. Completed 4. 30.11.21 5. Completed 6. 31.12.21 7. 28.02.22			

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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: April 2021		Risk Classification: Quality Operational Infrastructure Financial		Risk Owner: Medical Directors and Directors of Strategy		Scrutinising Committee: 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. Theresa LaThangue 2. Polly Grimmett		1. 01.12.21 2. 01.02.22			

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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: April 2021		Risk Classification: Quality Operational Infrastructure		Risk Owner: Directors of Nursing and Midwifery		Scrutinising Committee: Quality & Safety Committee			
Underlying Cause/Source of Risk: Linked Corporate risks:  NCRR 1188  KCRR033				Initial score		Current score		Residual score	
				16 (Extreme)		12 (High)		8 (High)	
				Consequence	Likelihood	Consequence	Likelihood	Consequence	Likelihood
				4	4	4	3	4	2
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.  NMAHP Strategy was launched in September 2021 by both DoN  Joint NMAHP Board planned for December 2021 where our Ignite Strategy will be reviewed.  Workstream leads and working groups identified to define progress against objectives.  Reporting structure agreed to be joint QGSC.				NGH in progress for Pathway to Excellence re-accreditation (June 22) (Internal)  Regular reporting to NMB (Internal)  Reports to joint QGSC and CPC and Board (Internal)					
Gaps in Controls				Gaps in Assurance					
Ongoing communication required to increase visibility and ownership of strategy with all staff. Strategy to be launched.				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. Fiona Barnes 2. Sheran Oke/ Fiona Barnes		1. March 2022 2. 22.12.21			

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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: April 2021		Risk Classification: Quality Finance		Risk Owner: Directors of Strategy		Scrutinising Committee: Quality Governance Committee Finance & Performance Committee			
Underlying Cause/Source of Risk: Linked Corporate risks:  NCCR1309 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.  A blueprint of the building blocks of the ICS has been agreed, workstreams leads, groups and plans are being developed.  Readiness to Operate Statements for April 2021 have been assessed and returned to NHSE/I.  ICS weekly transition steering group ion place to monitor progress and delivery of the ICS transition reporting to the HCP Board  Group ICS working group providing updates to Boards				Northamptonshire Health and Care Partnership delivery plan to achieve 'maturing ICS' status has been submitted and signed off by NHSE/I  Workplans in place for ICS design blueprint workstreams-reviewed at weekly ICS Transition Steering Group and HCP Board  Director of ICS Transition in place for system					
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 ICS working Group established to report through to Boards 4. Two Board development sessions to be delivered by due date to ensure a clear course for shaping and leading the emerging ICS and operating model. 5. Develop strategic plan for Group delivery of ICS 6. Provide leadership to system, workstreams to develop Collaboratives, Place, Clinical Model, and enablers e.g. Digital, People, Estates, Finance 7. Case for change, design and leadership of Elective Collaborative				1. DoS&P  2. DoS&P  3. DoS&P 4. DoS&P/GCEO  5. DoS&P 6. DoS, CFO, CDIO, MDs, DoNs, CPO, GDT&QI  7. DoS, DoS&P		1. Completed  2. Ongoing  3. Completed 4. 31.12.21  5. 15.12.21 6. 31.03.22  7. 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: April 2021		Risk Classification: Quality Finance Infrastructure		Risk Owner: KGH Director of Strategy & NGH DoE		Scrutinising Committee: Strategic Development Committee Finance & Performance Committee			
Underlying Cause/Source of Risk: Linked Corporate risks:  NCRR 258; 1174; 1177; 1701; 1702; 1703; 1738; 1986: 2041; 2264; 2683; 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) Kettering has a Strategic Development Committee in place					
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. 3. Community Diagnostic Hub business case to be submitted March 22 4. A Group Strategic Estates Delivery Committee to be implemented.				1. KGH Director of Strategy 2. KGH Director of Strategy  3. KGH Director of Strategy 4. KGH Director of Strategy		1. 31.03. 22 2. 30.12.21  3. 31.03.22 4. 31.03.22			

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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: April 2021		Risk Classification: Quality Finance		Risk Owner: Medical Directors and Directors of Strategy		Scrutinising Committee: Quality Governance Committee			
Underlying Cause/Source of Risk:  NCRR1839; 1445;				Initial score		Current score		Residual score	
				8 (High)		12 (High)		4(Moderate)	
				Consequence	Likelihood	Consequence	Likelihood	Consequence	Likelihood
				4	2	4	3	4	1
Current Controls				Assurance of Controls					
The Academic Strategy is managed through the Academic Strategy Programme Board which reports into the Joint Quality Committee. Sub Groups manage the following workstreams: -  <ul style="list-style-type: none"><li>Estates</li><li>Finance</li><li>Medical Education</li><li>Research</li><li>Innovation- in development</li></ul> Partnership meetings with University of Leicester and University of Northampton held separately to deliver our joint academic activities, review progress against the Partnership plans and manage risks.				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) July 2021 launch of University Hospitals of Northamptonshire NHS Group. The UoL NED has been included within the KGH constitution (Internal / External). Joint bids for National Institute for Health Research Infrastructure have been submitted with Uni of Leicester and University Hospitals of Leicester for a Biomedical Research Centre and Clinical Research Facility.					
Gaps in Controls				Gaps in Assurance					
Royal College (RC) approval for the clinical academic posts is taking considerably longer than expected.  To manage the Business Case, a Finance Group is required to track business benefits, income and expenditure.  Monthly finance reporting to Academic Strategy Programme Board and quarterly to Joint Quality Committee.				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. Accommodation – teaching space. With rising student numbers, there are no current firm plans to manage the demands on the estate. The Estates Subgroup are working on short term and long-term potential solutions across the group.  Accommodation- Student living space. With rising student numbers there is pressure on the current estate and at NGH poor feedback from the Medical Students staying onsite at CRIPPS. The Estates Sub Group are working at short term and long term potential solutions across the group to manage growing cohorts. A refurbishment plan will be completed at CRIPPS by Jan 22 to address student feedback.  Accommodation- expanding Research and Medical Education team space. With expanding teams to manage an increased portfolio, there is pressure on office space for delivery teams. The Estates Subgroup are working at short term and long term potential solutions across the group.					
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. Clinical Academic Posts new recruitment pack and BMJ microsite ready 4. Academic Strategy Communications Plan 5. Update at CPC in November				3. Geraldine Harrison 4. Teresa La Thangue 5. Matt Metcalfe / Kay Faulkner		1. Completed  2. Completed 3. November 2021 4. November 2021 5. November 2021			

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: April 2021		Risk Classification: Quality Infrastructure Finance		Risk Owner: Group Chief Digital Information Officer		Scrutinising Committee: Group Digital Hospital Committee			
Underlying Cause/Source of Risk: Linked Corporate risks:  NCRR 1482; 1684; 1733; 2747.  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.  Self-Assessment of What Good Looks Like completed for GDHC (Nov 2021).				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 (Oct 2020) and NGH (Sept 2021)					
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				HIMSS and What Good Looks Like Benchmarking  Reporting and monitoring of underlying infrastructure performance					
Further Planned Actions				Action Owner		Due Date			
1. HIMSS EMRAD Assessments 2. Review of Group Cloud-First Policies 3. Board development session Digital Boards with NHS Providers 4. Wider network review 5. National assessment of Support People (Success Measure 4) underway				1. Group CDIO 2. N/A 3. Group CDIO/ DoGs  4. Digital Directors (KGH & NGH) 5. Group CDIO		1. 31.03. 22 2. Completed 3. TBC 4. 31.12. 21 5. 31.03.22			

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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: April 2021		Risk Classification: Financial Operational		Risk Owner: Chief Finance Officer		Scrutinising Committee: Finance and Performance Committee			
Underlying Cause/Source of Risk: Linked Corporate risks:  NCRR 2343; 2345  KCRR015				Initial score		Current score		Residual score	
				25 (Extreme)		16 (Extreme)		12 (High Risk)	
				Consequence	Likelihood	Consequence	Likelihood	Consequence	Likelihood
				5	5	4	4	4	3
Current Controls				Assurance of Controls					
Business planning process, alignment of activity, workforce and finances Group Performance Management framework, including areas where not on track. Management of capital and working capital. Workforce Management meetings (Workforce) Group Transformation and Quality Improvement Committee (Efficiency/Productivity) Elective recovery monitoring Finance & Performance meetings Hospital Management Team meetings Group Executive meetings External review of underlying deficit and improvement opportunities				Planning submissions subject to board and board committee scrutiny Performance management framework and meetings System collaboration and joint working including Group representation (Group CFO, DoFs & NEDs) at System Finance Committee minutes Finance & Performance Committee minutes Hospital Management Team minutes Group Executive meeting minutes System Finance meeting minutes					
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 Lack of control over discretionary spending 22/23 operational and financial planning guidance and priorities not yet known other than an expectation for improvement in underlying system financial, with movement to a 'sustainable' position in a 2–3-year timeframe Group financial structure				Group policy on planning, reporting and reforecasting					
Further Planned Actions				Action Owner		Due Date			
1. Alignment of the Groups financial objectives and Plan 2. Review of centralisation of controls 3. Alignment of internal financial controls 4. Development of Group Financial Strategy 5. Agreement of Group Senior Finance structure 6. Implementation of Group Transformation structure 7. Agree definition of financial sustainability 8. Development of a policy on planning, reporting and reforecasting				1. CFO 2. CFO 3. HCEO’s 4. CFO 5. CFO 6. GCEO 7. CFO 8. CFO/ DoS		1. March 22 2. Nov 21 3. March 22 4. March 22 5. Oct 21 6. Oct 21 7. Nov 21 8. Jan 22			

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Movements on Board Assurance Framework (since previous report)		Rationale for change
ADDITIONS	None	
INCREASESES	GS106- Increased from 8 to 12	Increase in gaps in assurance
DECREASESES	GS103- Reduced from 16 (Extreme) to 12 (High)	Reduction in Gaps in control
	GS108- Reduced from 25 (Extreme) to 16 (Extreme)	Amended in terms of both the consequence score and overall score reduction due to changes to national finance arrangements and funding allocations.
CLOSURES/ AMALGAMATED	None	

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
GDT&QI	Group Director of Transformation and Quality Improvement
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

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# Board Assurance Framework Summary

## BAF Risks in Order of Severity (9<sup>th</sup> November 2021)

Ref	Group Priority	Risk Title	Initial Risk Level (April 2021)	Current Risk Level (Nov 2021)	Movement (from Initial)	Residual Risk Level	Risk Appetite	Comments
NGH116	Sustainability	Risk that the Trust fails to fully deliver the financial efficiency programme	25	25	→	10	High	Score reduction due to changes to national finance arrangements and funding allocations
NGH112	Sustainability	Risk of failure in ICT infrastructure and/or a successful cyber security attack may lead to a loss of service with a significant patient care and reputational impact.	20	20	→	16	High	
NGH111	Sustainability	Risk of Failures relating to failing infrastructure due to aging estate.	20	20	→	15	High	
NGH115	Sustainability	Risk that the Trust fails to have financial control measures in place to deliver its 2021/22 financial plan	25	15	↓	5	High	
NGH113	All	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	20	15	↓	10	Low	
NGH 109	Quality	Risk of not meeting regulators minimum standards, local and national performance standards	15	15	→	10	Low	
NGH117	Sustainability	Risk that the Trust fails to manage its capital programme within the capital resource limit or fails to secure sufficient funding for infrastructure and equipment improvements	15	15	→	10	High	
NGH110	Quality	Risk of Avoidable Harm	10	10	→	5	Low	
NGH114	Quality	Risk that the Trust fails to promote a culture that puts patients first	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
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3. System discharge work with external support from ECIST and iCAN programme and <b>Exec led Daily Board rounds</b> 4. <b>Establishment of Urgent and emergency care Board</b> 5. <b>Recruitment of substantive COO</b>		3. Ongoing 4. December 21 5. <b>TBC</b>
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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: CRR reference risks: 1303; 1411,1478, 1776, 1782, 1867, 1879, 1911, 1955, 1972, 2150, 2187, 2195, 2216, 2219.				Initial score		Current score		Residual score	
				10		10		5	
				Consequence	Likelihood	Consequence	Likelihood	Consequence	Likelihood
				5	2	5	2	5	1
Current Controls				Assurance of Controls					
<ul style="list-style-type: none"><li>Monthly review of Dr Foster information and alerts</li><li>Learning from Deaths Group</li><li>Audit plan</li><li>Incident and SI reporting policy</li><li>Monthly Clinical Quality and Effectiveness Group</li><li>Monthly Quality Governance committee</li><li>Countywide Patient safety M&amp;M meetings</li><li>Review of Harm Group weekly</li><li>Dare to Share- currently suspended</li><li>FIT Group</li><li>MASH referral system</li><li>NGH Safeguarding Team</li><li>IP Steering Group</li><li>IPC Team</li><li>Maternity Dashboard</li><li>Saving Babies Lives – National Initiative</li><li>Maternity and Neonatal Safety Champion Role</li><li>Integrated risk assessment and prescription chart introduced</li><li>Mandated use of Deteriorating Patient Toolkit on iBox</li><li>Weekly Exec led Risk and Quality Briefings</li></ul>				<ul style="list-style-type: none"><li>Reports from Mortality review to CQEG and QGC (L1)</li><li>HSMR &amp; SHMI data (L3)</li><li>CQEG reports to Quality Governance committee (L1)</li><li>Quality reports to Quality Governance and Trust Board (L1)</li><li>Quality Governance reports to Trust Board (L2)</li><li>Dr Foster data reports (L3)</li><li>Results from Clinical audit (L1)</li><li>Review of Harm Group monitoring implementation for SI action plans (L1)</li><li>National Learning and reporting system data (L3)</li><li>Incident report to Quality Governance committee (L1)</li><li>Delivery of infection control trajectory requirements at end of 2019/20 (L1)</li><li>Reports to FIT Group (L1)</li><li>IPC Assurance Framework (L3)</li><li>IPC ESF (L3)</li><li>Maternity report to QGC (L1)</li><li>Maternity Forum (L1)</li><li>Maternity and Neonatal Safety Champion Meeting (L1)</li></ul>					
Gaps in Controls				Gaps in Assurance					
<ul style="list-style-type: none"><li>NICE-/ VTE compliance remains inconsistent</li><li>Recurrent themes of harm identified requiring thematic approach to redress.</li><li>System Safeguarding resources and infrastructure</li><li>Dare to share events to be re established</li></ul>									
Further Planned Actions				Action Owner		Due Date			
<div>1. EPMA system review and introduction</div> <div>2. Re-establishment of Dare to Share events</div> <div>3. Report to QGC re impact of Covid 19 pandemic on SI reporting processes</div>				<div>1. Matt Metcalfe</div> <div>2. Matt Metcalfe</div> <div>3. Matt Metcalfe</div>		<div>1. TBC</div> <div>2. November 2021</div> <div>3. November 2021</div>			

Principal Risk No: 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							
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: CRR reference risks; 258, 1174, 1177, 1701, 1702, 1703, 1738, 1986, 1414, 2440,2441,2655.				Initial score		Current score		Residual score	
				20		20		15	
				Consequence	Likelihood	Consequence	Likelihood	Consequence	Likelihood
				5	4	5	4	5	3
Current Controls				Assurance of Controls					
<ul style="list-style-type: none"><li>Health and Safety committee</li><li>Fire safety committee</li><li>Estates Compliance group</li><li>Facilities Governance group</li><li>Water safety group</li><li>Resilience planning group</li><li>Business continuity plan</li><li>Training and scenario exercises undertaken</li><li>Annual capital programme</li><li>Medical Gas committee</li><li>Ventilation group</li><li>Asbestos group</li><li>Fire Safety Task and Finish Group</li><li>Assurance &amp; Risk Committee</li><li>Additional screening/ doors in Covid areas</li><li>Oxygen monitoring system and dashboard for capacity monitoring</li></ul>				<ul style="list-style-type: none"><li>H&amp;S reports to Quality Governance committee (L1); QGC reports to Trust Board (L2); F &amp; P reports to Trust Board (L2)</li><li>Resilience planning group reports to Assurance, risk &amp; compliance group (L1)</li><li>Assurance, risk and compliance group reports to QGC (L1)</li><li>Capital Group reports to F&amp; P committee (L1)</li><li>Annual Audit of high risk and statutory systems; ventilation, asbestos, electrical, medical gas, electrical, lifts, pressure systems, water</li><li>PLACE audits (L3); H&amp;S risk assessments (L1)</li><li>Fire safety inspections (L3); Annual external review of water hygiene (L3)</li><li>HSE inspection(L3)</li><li>ERIC self- assessment returns (L1)</li><li>Premises Assurance model self- assessment (L1);</li><li>Internal Audit report- Limited assurance opinion – Health and Safety (L3)</li><li>Back log maintenance programme in place based on risk assessment (L1)</li><li>National PAM (Premises Assurance Model) dashboard completed in September 2021 (L3)</li></ul>					
Gaps in Controls				Gaps in Assurance					
<ol style="list-style-type: none"><li>Large Backlog maintenance risk requires greater funding than is available</li><li>Estates strategy currently being reviewed for alignment in light of revised Clinical Strategy, KGH collaboration work and STP/HCP outputs.</li><li>Reduced capital plan due to financial constraints.</li><li>Review of internal assurance against key estates elements shows short fall.</li><li>Limited access to clinical areas to carry out maintenance and compliance work.</li></ol>				<ul style="list-style-type: none"><li>Increased level of internal audits and checks.</li></ul>					
Further Planned Actions				Action Owner		Due Date			
<ol style="list-style-type: none"><li>Review Estates strategy to align with KGH, STP/HCP and Clinical strategy commenced in December 20</li><li>Review Estates strategy to align with KGH, STP/HCP and Clinical strategy. Group Ops / Strategic now done via split roles. Clinical Strategy for Group due November 21. Estates to follow in 2022.</li><li>Seek additional routes to Capital funding to reduce backlog and align with Estates strategy &amp; Masterplan and Clinical strategy - regular conversations with NHSIE lead continue</li></ol>				<ol style="list-style-type: none"><li>Stuart Finn</li><li>Stuart Finn</li><li>Stuart Finn</li></ol>		<ol style="list-style-type: none"><li>Oct 2021</li><li>March 2022</li><li>Ongoing</li></ol>			

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:  CRR reference risks 1733, 1984, 1482, 1684, 2020, 2151, and 2170.				Initial score		Current score		Residual score	
				20		20		16	
				Consequence	Likelihood	Consequence	Likelihood	Consequence	Likelihood
				4	5	4	5	4	4
Current Controls				Assurance of Controls					
<ul style="list-style-type: none"><li>• Reporting to Digital Hospital committee</li><li>• Elective access policy and Data quality SOPs in place</li><li>• Microsoft Advanced Threat Detection (ATP) alerts</li><li>• Intrusion Prevention blocking and alerts from the Trust’s boundary firewalls</li><li>• Anti-Virus in place.</li><li>• Microsoft Patching – All Trust workstations and Servers are patched.</li><li>• SPAM Emails are automatically quarantined. Any SPAM that is not quarantined is manually blocked when reported</li><li>• Weekly Care Cert meetings held between NGH and KGH.</li><li>• Web Filtering –blocks malicious and non-Trust related web traffic.</li><li>• Enhanced Anti-Ransomware protection.</li><li>• Tape backups (off-line backups) – The Trust now backs up data to tape and secure cloud storage regularly</li></ul>				<ul style="list-style-type: none"><li>• Reports to Digital Hospital Committee (L1)</li><li>• Minutes from IT committee (L1)</li><li>• Application of additional Sophos updates(L2)</li><li>• Digital Strategy updated (L1)</li><li>• Data Quality Audits. (L1)</li><li>• Blocked Activity reported to IT Committee (L1)</li><li>• Free NHS WiFi</li></ul>					
Gaps in Controls				Gaps in Assurance					
Further Planned Actions				Action Owner		Due Date			
1. Windows to migrate from Windows 7				1. Dave Smith		1. 27 Devices left awaiting supplier upgrades in 21/22. Security patching in place until 22/23			

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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: April 2021		Risk Classification: Compliance, operational, quality, infrastructure, financial		Risk Owner: COO		Scrutinising Committee: 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					
<ul style="list-style-type: none"><li>• Covid Incident management plan</li><li>• Provision to revise medical rotas to ensure staffing supports activity, recruitment of volunteer workforce, redeployment of staff to areas of greatest need</li><li>• Digital solutions for Outpatient work where appropriate/ workforce permits</li><li>• Critical Care Plan - Enhanced triage of patients to ensure best use of available experience as required</li><li>• Capacity/ cohort plan for elective activity</li><li>• Use of private provider bed stock for additional capacity</li><li>• National Guidance and webinars</li><li>• Gold, Silver and Bronze Command structures and processes in line with Major Incident Policy</li><li>• IPC Cell/ Workforce Bronze cell and staff support network</li><li>• Identified Covid expenditure</li><li>• SCG Command Structure under CCG during pandemic waves</li><li>• Covid 19 Strategy</li><li>• Resources – command structure flexes resource delivery according to demand</li><li>• Covid reset management plan</li><li>• System Discharge Group- iCan</li><li>• Regional Calls – CEO, MD, DN, COO – weekly</li><li>• Demand and Capacity plans completed for RTT and Cancer for all Specialties</li><li>• Insourcing / Outsourcing in place for several specialties to support demand as required</li></ul>				<ul style="list-style-type: none"><li>• Decision risk log (L1)</li><li>• Incident log (L1)</li><li>• Actions from System meetings (L2)</li><li>• Gold meeting action log (L1)</li><li>• Silver meeting action log (L1)</li><li>• Weekly Bronze meetings action log (L1)</li><li>• On site staff testing (L1)</li><li>• SOS team/ NGH Our Space (L1)</li><li>• Repository of all Covid information on the Shared drive (L1,2 &amp; 3)</li><li>• Actions from System meetings (L2)</li><li>• Trust Board reports (L1)</li><li>• Covid scorecard (L3)</li><li>• Weekly Trust wide Access Committee (cancer, diagnostics and elective care) (L1)</li><li>• System wide Elective care board (L2)</li><li>• System wide Urgent care board (L2)</li><li>• H2 plans developed, modelled and submitted (L1)</li></ul>					
Gaps in Controls				Gaps in Assurance					
<ul style="list-style-type: none"><li>• Increase in COVID positive staff not available to work</li><li>• Workforce gaps leading (especially theatres) leading to lost capacity</li><li>• Tertiary providers under immense pressure to support Cancer activity</li></ul>									
Further Planned Actions				Action Owner		Due Date			
1. H2 Planning and monitoring with feedback to Trust Board				1. Carl Holland		1. Ongoing			
2. Focus on staff well-being, from SOS services, protected time back to recover, home working where possible, thank you handouts				2. Executive		2. Ongoing			
3. Staff and population booster and child vaccination programme underway to protect staff and patients over winter				3. Chris Pallot		3. Ongoing			



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: CRR reference risks 1955, 1867, 2003				Initial score		Current score		Residual score	
				8		8		4	
				Consequence	Likelihood	Consequence	Likelihood	Consequence	Likelihood
				4	2	4	2	4	1
Current Controls				Assurance of Controls					
<ul style="list-style-type: none"><li>• Patient and Carer experience and engagement Group with the following reporting:<ul style="list-style-type: none"><li>○ Dementia Group</li><li>○ End of Life Group</li><li>○ Disability Partnership forum</li><li>○ Learning and Disability Group</li></ul></li><li>• PALS and Complaints team</li><li>• Link with Health watch Northampton</li><li>• Regular performance reviews by Division including patient experience KPIs</li><li>• Patient Experience Manager</li><li>• Safeguarding policies and training</li><li>• Guidelines that identify how we manage patients with protected characteristics</li><li>• Patient Involvement Strategy</li><li>• Volunteer Strategy</li><li>• Use of electronic devices/ letters to loved ones to connect families</li><li>• Volunteer support via drop off points, delivery service including prescriptions</li><li>• Response volunteers linked to ward areas.</li><li>• Visiting recommenced</li></ul>				<ul style="list-style-type: none"><li>• Complaints report to Quality Governance committee (L1)</li><li>• Complaint Review Panel (L1)</li><li>• Quality Governance reports to Trust Board (L2)</li><li>• NHS Choices feedback (L3)</li><li>• CQC inspection (L3)</li><li>• F&amp;F tests results (2019) (L3)</li><li>• Patient story to the Board (L1)</li><li>• Board to Ward visits (L1)</li><li>• National Survey results: Cancer; Urgent Care; Inpatient; Paediatric &amp; Young people and Outpatient surveys (L3)</li><li>• PLACE audits (L3)</li><li>• Assessment and Accreditation scheme reports to Board (L1)</li><li>• Divisional Quality Governance reports to CQEG (L1)</li><li>• Pathway to Excellence (L3)</li><li>• Maternity Voices Partnership attend Maternity Safety meetings (L2)</li></ul>					
Gaps in Controls				Gaps in Assurance					
<ul style="list-style-type: none"><li>• Opportunity for collaborative working with patients and carers to improve and inform service development</li></ul>									
Further Planned Actions				Action Owner		Due Date			
<div>1. Review of Patient Information- content and mode of delivery</div> <div>2. Reinstate Board to Ward visits virtually</div> <div>3. Work with Northamptonshire Healthwatch, carers and volunteers commenced</div>						<div>1. Ongoing</div> <div>2. December 2021</div> <div>3. Ongoing</div>			

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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: Group Chief Financial Officer Hospital Director of Finance		Scrutinising Committee: Finance & Performance			
Underlying Cause/Source of Risk:  CRR reference risks; 2343, 2344, 2346.				Initial score		Current score		Residual score	
				25		15		5	
				Consequence	Likelihood	Consequence	Likelihood	Consequence	Likelihood
				5	5	5	3	5	1
Current Controls				Assurance of Controls					
<ul style="list-style-type: none"><li>Finance and Performance committee</li><li>Divisional performance reviews</li><li>Audit arrangements</li><li>SFOs SFIs &amp; SOD</li><li>Policies and procedures</li><li>Financial and accounting systems</li><li>Counter Fraud plan</li><li>Purchasing and Supplies Strategy &amp; Policies</li><li>Financial Assurance oversight by NHSE/I</li><li>HCP System Finance Director meetings</li></ul>				<ul style="list-style-type: none"><li>Monthly report to Finance and Performance committee (L1)</li><li>Finance and Performance committee Report to Board (L2)</li><li>Finance KPIs (L1)</li><li>Audit committee reports to Trust Board (L2)</li><li>Outcome of NHSE/I accountability meetings (L3)</li><li>NHSE/I rating for Single Oversight Framework (L3)</li><li>Internal Audit (L3)</li><li>External Audit (L3)</li></ul>					
Gaps in Controls				Gaps in Assurance					
<ul style="list-style-type: none"><li>Pay spend above plan</li><li>Agency expenditure is currently above the set target for 2021/22.</li></ul>				<ul style="list-style-type: none"><li>Uncertainty around the funding arrangements for 2021/22 e.g. ERF (Elective Recovery Fund)</li><li>Timeliness of the financial plan - H2 plan being finalised in Month 7</li></ul>					
Further Planned Actions				Action Owner		Due Date			
1. Review with Medicine Division to agree a reasonable recovery plan- In progress 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. Heidi Smoult/ Bola Agboola 3. Jon Evans		1. December 2021 2. Ongoing 3. Completed			

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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: Group Chief Financial Officer Hospital Director of Finance Group Director of Transformation and QI		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					
<ul style="list-style-type: none"><li>Finance and Performance committee</li><li>Efficiencies Undertaking meetings</li><li>Group transformation programme</li><li>Hospital Management Team</li></ul>				<ul style="list-style-type: none"><li>Finance report to Finance and Performance committee</li><li>Includes progress on delivery and forecast plans (L1)</li><li>Report to Board (L2)</li><li>Internal audit (L3)</li><li>External Audit (L3)</li></ul>					
Gaps in Controls				Gaps in Assurance					
<ul style="list-style-type: none"><li>Current operational pressures may impact on capacity to deliver the savings programme</li><li>Reorganisation of the PMO team may cause disruption to the programme</li></ul>				<ul style="list-style-type: none"><li>The Trust has not fully delivered its Efficiency programme recurrently historically</li></ul>					
Further Planned Actions				Action Owner		Due Date			
1. Efficiencies undertaking meeting to be chaired by Group Director of Transformation and QI 2. Identify and monitor delivery of the group transformation programme to be monitored through Group Transformation and QI meeting.				1. Becky Taylor 2. Jon Evans/Karen Spellman/ Becky Taylor		1. Ongoing 2. Ongoing			

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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: Group Chief Financial Officer Hospital Director of Finance		Scrutinising Committee: Finance and Performance Committee			
Underlying Cause/Source of Risk:  CRR reference risks; 2345				Initial score		Current score		Residual score	
				15		15		10	
				Consequence	Likelihood	Consequence	Likelihood	Consequence	Likelihood
				5	3	5	3	5	2
Current Controls				Assurance of Controls					
<ul style="list-style-type: none"><li>Capital Committee</li><li>Finance and Performance committee</li><li>5-year capital plan</li><li>Purchasing and Supplies Strategy</li><li>Leasing strategy in place/ IFRS16</li><li>Hospital Management Team Meetings</li><li>Business Case process</li></ul>				<ul style="list-style-type: none"><li>Finance report to Finance and Performance committee</li><li>Includes progress on capital planning and expenditure plus forecast expenditure (L1)</li><li>Report to Board (L2)</li><li>Internal audit (L3)</li><li>External Audit (L3)</li></ul>					
Gaps in Controls				Gaps in Assurance					
<ul style="list-style-type: none"><li>The Trust has a large backlog maintenance programme and the estate is ageing</li><li>Affordability of additional capital</li><li>Ability to fully utilise Trust’s CRL for the year if slippage occurs</li></ul>				<ul style="list-style-type: none"><li>Additional access to capital limited in infrastructure incidents</li></ul>					
Further Planned Actions				Action Owner		Due Date			
<ul style="list-style-type: none"><li>1. Continue to work with System partners and bid for any available capital</li><li>2. Closely monitor delivery of the ITU Build to plan</li><li>3. Continue to manage capital needs in a prioritised manner</li></ul>				<ul style="list-style-type: none"><li>1. Jon Evans/ Bola Agboola</li><li>2. Stuart Finn</li><li>3. Bola Agboola</li></ul>		<ul style="list-style-type: none"><li>1. Ongoing</li><li>2. Ongoing</li><li>3. Ongoing</li></ul>			

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Movements on Board Assurance Framework (since previous report)		Rationale for change
ADDITIONS	None	
INCREASESES	None	
DECREASESES	115- Reduced from 25 (Extreme) to 15 (Extreme)	Overall score reduction due to changes to national finance arrangements and funding allocations.
CLOSURES/ AMALGAMATED	None	

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

GCEO	Group Chief Executive Officer
GCFO	Group Chief Finance Officer
GCPO	Group Chief People Officer
GCDIO	Group Chief Digital Information Officer
GDT&QI	Group Director of Transformation and Quality Improvement
HCEO	Northampton Hospital CEO
MD	Kettering / Northampton Medical Director
DoN	Director of Nursing
COO	Chief Operating Officer
DoE&F	Director of Estates and Facilities
DoS	Director of Strategy
DoCDG&A	Director of Corporate Development, Governance & Assurance

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## Cover sheet

Meeting	Public Trust Board
Date	25 <sup>th</sup> November 2021
Agenda item	4.2

Title	FTSU Q2 and Bi- Annual 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			
<input type="checkbox"/> Approval	<input type="checkbox"/> Discussion	<input checked="" type="checkbox"/> Note	<input checked="" type="checkbox"/> 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				
<input type="checkbox"/> Patient	<input type="checkbox"/> Quality	<input type="checkbox"/> Systems & Partnerships	<input checked="" type="checkbox"/> Sustainability	<input checked="" type="checkbox"/> 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.	Papers presented quarterly to People Committee and Bi- annually to Trust Board.

Executive Summary
The report provides the background to the introduction of Freedom to Speak Up and progress made to develop clear systems and process at Northampton General Hospital. It provides information on concerns raised in the first two quarters of this financial year. It also provides detail of case content, open and closed cases and outcomes and sources of concerns raised.



The report provides an overview of the Trust Guardians role and activity year to date and outlines key publications for the National Guardians Office.
<b>Appendices</b>
None
<b>Risk and assurance</b>
There is a legal requirement under the Health and Social Care Act to appoint a Freedom to Speak Up Guardian.
<b>Financial Impact</b>
None
<b>Legal implications/regulatory requirements</b>
There is a legal requirement under the Health and Social Care Act to appoint a Freedom to Speak Up Guardian.
<b>Equality Impact Assessment</b>
Increase in staff trained from the REACH network as Values Ambassadors should increase accessibility for relevant staff.

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

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## 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 Quarter 2 (July- September 2021)

Within Quarter two, 14 cases were reported. This is big increase on quarter one when 5 cases were reported in total. No cases were raised anonymously, and one case was reported in confidence. Most cases reported related to attitudes and behaviours of line managers and patient and staff safety issues.

Twelve cases were reported to the Guardian direct and two reported via Values Ambassadors which is a positive step. No cases reported resulted in disadvantageous and/ or demeaning treatment as a result of speaking up (referred to as detriment).

In this quarter a number of staff were encouraged and agreed to meet with relevant Executives to discuss the issues raised in more detail and for individuals to hear how staff were feeling first hand.

## 3. Freedom to Speak Up Cases Quarters 1 & 2 (April- September 2021)

### 3.4 Content of cases reported:

Category	Q1	Q2	Total
Patient safety/ quality	1	5	6
Staff safety/ Training	1	5	6
Bullying and harassment	4	7	11
Systems, processes or policies	1	1	2
Environment/ infrastructure	0	1	1
Workplace culture	0	1	1
Leadership	0	1	1
Use of resources	0	0	0

Noting most cases raised contain more than one issue.

### 3.5 Cases reported to:

Source	Q1	Q2	Total
FTSU Guardian	4	12	16
CQC	1	0	1
GOSW	0	0	0
Ambassador	0	2	2
DATIX	0	0	0
Other	0	0	0

### 3.6 Staff Groups reporting:

Staff group	Q1	Q2	Total
Doctor	0	3	3
Nurse & Midwife	1	4	5
AHP	0	2	2
HCA	0	0	0
Admin, clerical & Maintenance/ Ancillary	1	5	6
Corporate	2	0	2
Other (including anonymous)	1	0	1
Total	5	14	19

The number of cases raised by Admin, clerical & Maintenance/ Ancillary has increased and is now the highest reporting group, whereas previously this has been nurses and midwives.

### 3.7 FTSU Reported by Division:

Division	Quarter 1	Quarter 2
Medicine	2	6
Surgery	0	3
WCOHCS	0	4
CSS	1	0
Corporate	1	1
Unknown	1	0

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#### **4. Trust Guardian Role – Activity to date**

- Refresh of the FTSU Strategy and revision of deadlines due to Covid 19 impact: this work has commenced and will complete next month, linked to the national publication of the NGO strategic framework.
- Two further training courses for staff from the networks took place in September to further develop the Ambassador role and increase accessibility as well as an additional Maternity Ambassador. The Trust now has 30 trained Values Ambassadors, 14 of which have applied from the REACH and other staff networks.
- Complete refresh of the Intranet information regarding FTSU and Values Ambassadors

#### **5. National Guardians Office (NGO)**

##### **5.1 Changes to reporting**

The National Guardian's Office receives quarterly data returns from all FTSU Guardians. The mandated return was recently changed with 'Worker safety' was added as a category (in addition to the existing 'patient safety/quality' and 'bullying and harassment' categories). The guidance has also amended the wording from the term 'detriment' and replaced this with 'disadvantageous and/or demeaning treatment', though the term detriment is still used in brackets to avoid any confusion.

##### **5.2 WRES Experts and NGO**

The WRES team has continued to work closely with the NGO over the past few months, as part of their ambition that the FTSU speaking up culture works for everyone, regardless of their background, role, or ethnicity. Locally- the FTSU Guardian maintains data (where possible) regarding ethnicity of background of individuals raising concerns. Of cases raised in the first two quarters- 6 of 19 cases raised by staff from an ethnic minority group. 2 are unknown.

##### **5.3 NGO Strategic Framework**

The NGO introduced a Strategic Framework which sets out the intention to obtain greater assurance about speaking up cultures and the quality and consistency of how the Freedom to Speak Up Guardian role is implemented.

##### **5.4 National Guardian post**

After five years in post, the National Guardian Henrietta Hughes stepped down from the post in September to take up the Chair of a charity, the Institute of Integrated Systemic Therapy – Childhood First. An open competitive national recruitment process was commenced.

##### **5.5 Case Review**

The National Guardian Office published a case review report in October which analyses the themes and learning for the whole health sector from their review of the speaking up culture at Blackpool Teaching Hospitals. This was commenced following receipt of information indicating that a speaking up case may not have been handled following good practice. The information received also suggested black and minority ethnic workers had comparatively worse experiences when speaking up. The findings will be added to the gap analysis review for the Trust.

#### **6. Recommendations:**

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

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## Cover sheet

Meeting	Public Trust Board
Date	25 <sup>th</sup> November 2021
Agenda item	4.3

Title	Strategic Development Committee Terms of Reference: Committee in Common with Kettering General Hospital (KGH)
Presenter	Claire Campbell- Director of Corporate Development, Governance and Assurance
Author	Richard May, Trust Board Secretary KGH

This paper is for			
<input checked="" type="checkbox"/> Approval	<input type="checkbox"/> Discussion	<input type="checkbox"/> Note	<input type="checkbox"/> 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				
<input type="checkbox"/> Patient	<input type="checkbox"/> Quality	<input checked="" type="checkbox"/> Systems & Partnerships	<input type="checkbox"/> Sustainability	<input type="checkbox"/> 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 approve these Terms of Reference to give effect to the previous Boards' of NGH and KGH Resolutions to create a committee in common of both Trusts.	NGH and KGH Boards held September 2021

### Executive Summary

Following NGH submission of an expression of interest for inclusion in the next phase of the government's Hospital Infrastructure Programme (HIP3) and the KGH Director of Strategy assuming the role of Group Director of Strategic Estates, NGH Board at its meeting on 30 September 2021, resolved to approve the constitution of

a Strategic Development Committee as a Committee in Common with KGH.

These Terms of Reference were approved at the Strategic Development Committee held 18<sup>th</sup> November 2021 and are now presented to the Trust Board for ratification. They will be presented to KGH Board for ratification on the 30<sup>th</sup> November 2021.

#### Appendices

Appendix 1 - Revised Terms of Reference

#### Risk and assurance

No direct implications relating to the Board Assurance Framework

#### Financial Impact

None

#### Legal implications/regulatory requirements

None

#### Equality Impact Assessment

Neutral

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

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## STRATEGIC DEVELOPMENT COMMITTEE TERMS OF REFERENCE

### 1 Context

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

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

### 2. PURPOSE

- 2.1 The Committee will oversee the modernisation of the Trusts' estates to ensure that they are key enablers to deliver clinical service ambitions.

### 2. AUTHORITY

- 2.1 The Committee is established by the Boards of Directors to fulfil the purpose set out above and has the authority to take decisions in pursuance of this purpose, subject to the provisions of the Trusts' Schemes of Delegation and Standing Financial Instructions.

### 3. MEMBERSHIP AND ATTENDANCE

<b>Chair</b>	Trust Chair (KGH and NGH)
<b>Members</b>	Two KGH Non-Executive Directors
	One NGH Non-Executive Director
	Group Chief Finance Officer
	Director of Strategy (KGH) / Group Director of Strategic Estates
<b>Attendees</b>	Senior Clinical Representatives
	Key internal and external programme leads (Programme Management Office)
	Group Director of Operational Estates and Facilities
	Admin Support
	Nominated KGH Governor representative (and Deputy)
	NHSE/I Regional Estates Lead (by invitation)
	NHSE/I Cash and Capital (by invitation)

### 4. MEETINGS AND QUORUM

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- 4.1 The quorum for meetings shall be three Members, including the Trust Chair and/or a Non-Executive Director from each Trust. Members shall be entitled to nominate deputies to attend in their place
- 4.2 Meetings will be scheduled on a bi-monthly basis on dates to be agreed with the Trust Chair.
- 4.3 Virtual meetings, subject to minimum quoracy requirements, will have full authority to take decisions; meetings will be recorded, and Minutes/Action Logs produced, in the normal way.
- 4.4 In urgent and exceptional circumstances where it is not possible to convene a meeting via video conference, decision items may be
  - circulated to voting members of the body for comment and approval, or:
  - taken by Chair's action, in liaison with the Group Chief Executive and Lead Executive Director for the matter concerned from both Trusts.

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

## **5. SUPPORT ARRANGEMENTS**

- 5.1 The Corporate Governance Teams will provide administrative support to the Committee.

## **6. DECLARATION OF INTERESTS**

- 6.1 All members must declare any actual or potential conflicts of interest relevant to the work of the Committee, which shall be recorded in the Minutes accordingly.
- 6.2 Members should exclude themselves from any part of a meeting in which they have a material conflict of interest. The Chair will decide whether a declared interest represents a material conflict of interest.

## **7. DUTIES**

The duties and responsibilities of the Committee are as follows:

1. To have oversight of the development and delivery of the Group's' strategic estates strategy, and the projects/programmes that underpin this, including strategic estates projects from both Trusts.
2. To act as a strategic point of alignment for future estates development within the Trusts and across the wider health and social care economy and ensure coherence with all other major programmes across the Group.
3. To monitor and oversee the relationship and partnering with key estates infrastructure suppliers, ensuring that all future works meet the needs of the Trusts and that the contract is being managed effectively.
4. To establish and oversee a single integrated decision-making framework for strategic estates investment and prioritisation to make appropriate recommendations to the Trust Boards.
5. To develop and oversee internal and external communications to ensure transparency, visibility and to ensure compliance with relevant legislation.
6. To oversee and act as the authorisation body for schemes progressing through the three-stage business case process (SOC, OBC and FBC), culminating in final recommendations

made to Boards of Directors to proceed with contract award for construction work.

7. To approve contracts that support the progression of works through to completion of FBC (full business case) up to a value of £5 million, where expenditure remains within secured budget.
8. To provide oversight of projects within delivery programmes through:
  - Scrutiny of programme implementation.
  - Acting as a point of escalation for risks to delivery and supporting mitigations.
  - Ensuring the right resources are in place for successful delivery of these projects.
  - Ensuring effective stakeholder participation and engagement
  - Monitoring programme benefits, and ensuring these are in line with expected benefits laid out at the start of the projects, escalating this where necessary, and
  - Ensuring lessons learned are incorporated into future projects, and learnings are disseminated across the Trusts.

## 8. STANDING AGENDA ITEMS

1.	Welcome, Apologies for Absence, Declarations of Interest
2.	Agree Minutes from Previous Meeting and Action Log
3.	Programme Level Update
4.	Project Updates
5.	Financial Overview
6.	Key Risks

## 9. REPORTING

- 9.1 The Committee will submit a summary report to the Boards of Directors following each meeting.
- 9.2 The Committee will receive Highlight reports from the Group strategic projects Infrastructure, and from the Strategic Stakeholder Group.

## 10. PROCESS FOR MONITORING EFFECTIVENESS OF THE COMMITTEE

- 10.1 The Committee will carry out an annual review of its performance and function in satisfaction of these Terms of Reference and will submit an annual report to the Audit Committees and Boards of Directors providing assurance that it is effectively fulfilling its purpose.

## 11. REVIEW

**Agreed:** *November 2021*

**Review date:** *November 2022*

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