Board of Directors (Part I) Meeting in Public

Thu 28 July 2022, 09:30 - 13:00

ZOOM Link

Northampton General Hospital NHS Trust

Agenda

09:30 - 09:30
0 min

1. Welcome, Apologies and Declarations of Interest

Information *Alan Burns*

1. NGH Board Part I Agenda 280722.pdf (2 pages)

09:30 - 10:00
30 min

2. Staff Story

Information *Palmer Winstanley*

10:00 - 10:00
0 min

3. Minutes of the Previous Meeting held on 27 May 2022 and Action Log

Decision *Alan Burns*

3.0 Draft NGH Public Trust Board Minutes - May 2022.pdf (12 pages)
3. Action Log Updated Post 260522 Part I Board.pdf (1 pages)

10:00 - 10:10
10 min

4. Chair's Report (verbal)

Information *Alan Burns*

4.1. Group Chief Executive's Report

Information *Mark Smith*

4.1 GCEO Board Report July 2022.pdf (3 pages)

4.2. Hospital Chief Executive's Report

Information *Heidi Smoult*

4.2 HCEO Board Report July 22.pdf (4 pages)

10:10 - 10:40
30 min

5. Integrated Governance Report (IGR) and Board Committee summaries

Information *Hospital Chief Executive and EDs*

5. IGR cover paper.pdf (2 pages)
5.0 IGR Board - Committee Summaries - July 2022.pdf (13 pages)
5. REVISED PUBLISHED June 2022 UHN IGR.pdf (49 pages)
5.0 Finance Report M3_Board.pdf (6 pages)

10:40 - 11:00
20 min

6. 2022/23 Operational Plan

Information *Jon Evans / Karen Spellman*

- 6.0 a NGH Cover Sheet 22-23 ICB Operational Plan Board.pdf (2 pages)
- 6.0 b 2223 System Operating Plan Summary - KGH and NGH Boards.pdf (7 pages)

11:00 - 11:10
10 min

11:10 - 11:25
15 min

7. Operational Focus (including Activity against 2022-23 Plan)

Information *Palmer Winstanley*

- 7.0 a Cover paper Activity.pdf (2 pages)
- 7.0 b 2022 July - COO Update.pdf (7 pages)

11:25 - 11:55
30 min

8. Theatres productivity and the Trust Care Co-ordination System

Information *Palmer Winstanley / Becky Taylor*

- 8.0 a Theatres Productivity NGH Board Cover Sheet.pdf (2 pages)
- 8.0 b 220728 Board Theatres and Trust CCS.pdf (11 pages)

11:55 - 12:05
10 min

9. Freedom to Speak Up Annual Report

Information *Ellie Southgate*

- 9.0 20220728 Agenda item 9 FTSU Annual Report to NGH Board.pdf (9 pages)

12:05 - 12:35
30 min

10. Annual Report of the Northamptonshire Health Charity Fund Requested by NGH Trustees

Information *Debra Shanahan*

- 10.0 a NGH Cover Sheet NHCF.pdf (2 pages)
- 10.0 b NHCF Charity NGH Board presentation 28 July 2022.pdf (7 pages)

12:35 - 12:45
10 min

11. Group Board Assurance Framework

Decision *Richard May*

- 11.0 a NGH Cover Sheet 280722 Group BAF.pdf (4 pages)
- 11.0 b Appendix A _Group BAF _19July2022.pdf (13 pages)

12:45 - 12:55
10 min

12. Trust’s responses to the Ockenden reports (2020 and 2022) Follows work in progress May update

Information *Debra Shanahan*

- 12.0 a Board Ockenden 2 paper snapshot position.pdf (4 pages)
- 12.0 b Appendix 1.pdf (4 pages)
- 12.0 c Appendix 2.pdf (3 pages)

12:55 - 12:55
0 min

13. Appointments to Committees

Decision *Alan Burns*

- 13.0 a Appointments NGH 280722.pdf (2 pages)
- 13.0 b Appendix NGH TERMS OF NOMINATION.pdf (2 pages)

12:55 - 13:00
5 min

14. Questions from the Public (Received in Advance)

Discussion *Alan Burns / Mark Smith*

Question received from Mr Wilkins (see agenda front sheet)

13:00 - 13:00
0 min

15. Any Other Business and close

Discussion *Alan Burns*

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Northampton General Hospital NHS Trust

Board of Directors (Part I) Agenda

Meeting	Board of Directors (Part I) Meeting in Public
Date & Time	Thursday 28 July 2022, 09:30-13:00
Location	Video Conference

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.

Item	Description	Lead	Time	Purpose	P/V/Pr
1	Welcome, Apologies and Declarations of Interest	Chair	09:30	-	Verbal
2	Staff Story	Chief Operating Officer	09:30	Discussion	Present-ation
3	Minutes of the Previous Meeting held on 27 May 2022 and Action Log	Chair	10:00	Approve	Attached
4	4 Chair's Report 4.1 Group Chief Executive's Report 4.2 Hospital Chief Executive's Report	Chair Group CPO Hospital CEO	10:00	Information Information Information	Verbal Attached Attached
Operations					
5	Integrated Governance Report (IGR) and Board Committee summaries	Hospital Chief Executive and Executive Directors	10:10	Assurance	Attached
6	2022/23 Operational Plan	Group Chief Finance Officer & Director of Integration and Partnerships	10:40	Receive and Ratify	Attached
	BREAK		11:00		
7	Operational Focus (including Activity against 2022-23 Plan)	Chief Operating Officer	11:10	Assurance	Attached
8	Theatres productivity and the Trust Care Co-ordination System	Chief Operating Officer & Group Transformation and QI Director	11:25	Presentation	Attached

Strategy and Culture					
9	Freedom to Speak Up (FTSU) Annual Report	FTSU Guardian	11:55	Receive	Attached
Governance					
10	Report on the activities of the Northamptonshire Health Charity (NHCF)	Interim Director of Nursing and Quality	12:05	Receive	Attached
11	Group Board Assurance Framework	Trust Board Secretary	12:35	Approve	Attached
12	Trust's responses to the final Ockenden report (2022)	Interim Director of Nursing and Quality	12:45	Assurance	Attached
13	Appointments	Trust Chair	12:55	Approve	Attached
14	Questions from the Public (Received in Advance) Mr. Charles Wilkins has asked the following question to the Group Chief People Officer: 'Following the issue of a Jobs Protection Agreement in 2021, why has the Trust made a U-turn on redundancies in the ICT department as part of its restructure, and how can it justify potentially making committed members of its workforce redundant, who have worked tirelessly during the COVID-19 pandemic and during the biggest cost of living crisis in 40-years?'	Chair	12:55	Information	Verbal
15	Any Other Business and close	Chair	13:00	Information	Verbal
16	**Resolution to Exclude the Public and the Press:** The Board is asked to approve the resolution that: Representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.				
Date of Next Meeting: Thursday 29 September 2022, 9.30am					

P = Paper, P* = Paper to follow, V = Verbal, S = Slides (to be added to agenda pack)

Minutes of the meeting

Meeting	**Board of Directors (Part I) Meeting in Public**
Date & Time	Thursday 26 May 2022, 09:30 –12:30
Location	Video Conference

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	Alan Burns	Chair
	Simon Weldon	Group Chief Executive
	Andy Callow	Group Chief Digital Information Officer
	Jon Evans	Group Chief Finance Officer
	Stuart Finn	Interim Group Director of Operational Estates
	Jill Houghton	Non-Executive Director
	Denise Kirkham	Non-Executive Director
	Elena Lokteva	Non-Executive Director
	Matt Metcalfe	Medical Director
	David Moore	Non-Executive Director
	Professor Andre Ng	Associate Non-Executive Director
	Rachel Parker	Non-Executive Director
	Mark Smith	Group Chief People Officer
	Heidi Smoult	Hospital Chief Executive
	Karen Spellman	Director of Integration and Partnerships
	Becky Taylor	Group Director of Transformation and Quality Improvement
	Palmer Winstanley	Chief Operating Officer
In Attendance	Richard Apps	Director of Integrated Governance (KGH)
	Polly Grimmett	Director of Strategy (KGH)

	Dr Rabia Imtiaz	Interim Medical Director (KGH) (Item 7)
	Richard May	Trust Board Secretary (KGH)
Apology for Absence	Debra Shanahan	Interim Director of Nursing and Quality

Agenda Item	Discussion	Action Owner
1	**Welcome, Apologies and Declarations of Interest** The Trust Chair welcomed Board Members, guests and observers to the meeting and noted apologies for absence as listed above. There were no declarations of interests relating to specific agenda items.	
2	**Patient Story: Maternity Safety** The Board viewed a video during which Sharon described her experiences of the Trust's maternity services, and particularly the midwifery Continuity of Carer Team, which compared positively to her cousin's experience of information having to be regularly repeated where care responsibility passed between individuals. The Board thanked Sharon for her story and acknowledged the valuable work of the continuity of carer team, which the Trust would be continuing to support and resource given the added value of the service, particularly as a means of addressing national and local health inequalities in pregnancy relating to race and ethnicity. The Board that a new Head of Midwifery had joined the Trust and would be reviewing team structures to ensure these levels of continuity could be maintained within the service.	
3	**Minutes of the Previous Meeting held on 30 March 2022 and Action Log** The Board **APPROVED** the Minutes of the Meeting held on 30 March 2022 as a correct record, subject to an amendment for clarity regarding safeguarding training within item 5.0 (Integrated Governance Report: Quality Governance Committee). The Board noted open and closed actions on the Action Log.	
4	**Chairs Report** The Chair congratulated Becky Taylor following her substantive appointment to the role of Group Director of Transformation and Quality Improvement. The Board was advised that the University of Leicester had increased its position by 23 places on the Research Excellence Framework, with its research in Clinical Medicine ranked second in	

	the UK. The Board commended the University on this achievement, noting strong performance in cardio-vascular research as a contributing factor, which would assist in ensuring the successful implementation of a centre for excellence for Cardiology as part of the Group Clinical and Academic Strategies. The Chair advised that the final 2022/23 operating, financial and workforce plans for the Trust and Integrated Care System (ICS) had yet to be agreed in the context of returning towards business as usual operating models following the input of additional resources during the peaks to the COVID pandemic. The revised submission deadline for the ICS plan was 20 June 2022. The Board noted that the Trust had been identified on a list of providers which had not implemented an electronic patient record in a recent news article; whilst these were issues with securing funding streams for local delivery, the Board was confident its programme would progress during the current financial year. The Board of Directors noted the Chair's report.	
4.1	**Group Chief Executive's Report** The Group Chief Executive drew the Board's attention to a number of contextual items influencing the preparation of the 2022/23 operational, financial and workforce plans for the Trust, Group and ICS, specifically: • Strong NHS and Trust performance through the recent Easter Bank Holiday; the Group Chief Executive thanked those that worked during that period at the hospitals were under significant strain; • Falling COVID numbers which, along with changes in infection prevention and control guidance, allowed the Group to pivot towards more normal modes of delivery. The likely relaxation of central controls and reporting requirements was particularly welcome in this regard; • A window for delivery, especially in relation to cancer and elective treatment, prior to the next winter; • The likelihood of challenging productivity and efficiency targets requiring a co-ordinated ICS (system) response, and • The requirement for system digital transformation to accelerate connectivity and use data to drive operational insight, whilst securing funding for the electronic patient record (EPR) programme at NGH. The Group Chief Executive advised that the last staff Pulse Survey attracted a 24% response rate across the group, providing positive feedback and areas in which the trusts could do better, which were summarised in the report. Particular attention was drawn to the impacts of increases in the cost of living upon staff, in response to which the Boards must focus on practical solutions as part of the	

	Group response to the national Staff Survey. Colleagues had also requested clearer messaging around collaboration and what it meant to them; to this end, the Board noted that a successful first engagement workshop had been held to explore the opportunities that collaboration on cardiology could offer. The Board of Directors noted the report.	
4.2	**Hospital Chief Executive Report** The Hospital Chief Executive presented her report, drawing attention to the following specific items: • Recent staff surveys continued to demonstrate the need for cultural changes in a number of areas, with work underway with teams to prepare a cultural change programme. NGH was using Connect, Explore and Improve sessions, briefings, newsletters and visits to connect with teams, explore challenges collectively and focus on the need to improve together; • The Trust held a Nursing, Midwifery and Nursing Associate Conference on 10 May 2022 with around 150 nursing colleagues, as part of the launch of re-accreditation of Pathway to Excellence; the event was extremely positive, exemplifying pride in working for NGH and demonstrating the extensive amount of improvement work underway through shared decision-making councils and other areas; • Demand for urgent care pathways and flow through the hospital continued to present challenges, with work underway to address long-standing issues in a number of areas, informed by external benchmarking and feedback; for example, a recent Getting it Right First Time audit had identified a deficit of eight major incident area cubicles, which were contributing directly to ambulance handover delays. The Trust had introduced patient flow co-ordinators since the last meeting, focussed on minimising internal delays which unnecessarily increased lengths of stay, reducing average length of stay by three days since their introduction; • The Trust had successfully bid to have a National Institute of Health and Care Research Clinical Research Facility, which would commence in Autumn 2022; • The Trust was launching a ‘name the (surgical) robot’ competition with local primary schools. The Board discussed the work and impacts of the National Discharge Programme, noting that all key strands, covering inpatient and out-of-hospital care, needed to be aligned, with appropriate system oversight and data access, to enable real transformation. The Board commended reducing length of stay and admission rates in the context of increased A&E attendances over the past three months.	

	In response to a question, the Board was advised that all internal work was complete prior to the opening of the new ICU, with testing and commissioning work underway; it was anticipated that the facility would be patient-ready by 30 June 2022. The Board of Directors noted the report.	
Operations		
5	**Integrated Governance Report (IGR)** The Group Chief Digital Information Officer presented an update on progress with the establishment of common metrics for the UHN Group, advising that 57 of 89 had been defined; it was anticipated that the full suite of metrics would be available in September 2022. Revised reporting periods had been agreed to improve the timeliness and quality of data and supporting narratives, with work also ongoing to improve data visualisation. Whilst gaps remained in the document, the Board was assured that the Trusts continued to rely upon over 150 reports providing 'real time' data to supports business as usual operations. The Hospital Chief Executive introduced the April 2022 IGR and committee summaries and invited Committee Chairs and Executive Leads to bring the following exceptions to the Board's attention: *Quality Governance Committee* - The degree of assurance provided by the committee was limited by the weight of papers presented – committee members would be working with lead executives to address this, including a review of associated key metrics; - The Committee noted that maternity staffing continued to be an issue and noted plans to address this as part of the Trust's response to the Ockenden report and recommendations; - The Committee received an update on security management and was assured in respect of the Trust's arrangements, commending a number of significant improvements over the past 6-9 months; - The Trust was achieving sustained improvement in respect of its mortality rates and was currently the best performer in its peer group. *Group Clinical Quality, Safety and Performance Committee* The Board noted that the Trust was participating in the Building Tomorrow Together programme to facilitate cultural change within maternity services. *Finance and Performance Committee*	

	- The Trust had achieved a year-end financial surplus position of £0.4m (revenue), and had achieved capital expenditure to within £0.5m of plan; this was particularly commendable, given the amount of capital received during the year which required schemes to progress at short notice; - The Committee was updated on the £26m decarbonisation scheme, £10.8m of which was projected to be spent during 2022/23 - a programme lead would be joining on 30 May 2022, and there were particular challenges regarding supply chain availability. The committee would receive a further report in June, which would include the identification of quantifiable environmental and financial business benefits; - The Committee noted improved operational performance despite increasing demand, thanking the Chief Operating Officer and teams for the leadership and work to achieve this. The Trust's performance against the two-week wait cancer standard remained the highest in the region. This performance had been recognised by regulators at the recent quarterly review meeting. *Group People Committee* - Key metrics continued to be closely monitored; there was particular concern at continuing underperformance in appraisal completion, in response to which the committee had requested oversight of revisions to internal processes at its next meeting; - The most recent People Pulse survey of staff wellbeing continued to give rise to concerns in respect of recurring themes around line management quality, reward and recognition, with increasing evidence from this survey and other sources around the impacts of the increasing cost of living; - The Committee had created a task and finish group to progress workforce aspects of the 2022/23 planning submission, having particular regard to productivity; - The Committee acknowledged the positive work being undertaking to address safer staffing issues to reduce sickness, vacancy rates and the number of patient harms, and - Over 100 offers of employment had been made following a successful recent recruitment event. *Group Digital Hospital Committee* - The Committee had noted with the concern the projection that the Electronic Patient Record for NGH would not be available for use by clinicians until early 2025, challenging digital teams to identify more immediate gains and interim solutions for collaboration before this date;	

	- The Committee was updated on the projected 'go live' date for the Northamptonshire Shared Care Record, which continued to be delayed and was currently projected for summer 2022, noting that the programme team had challenged itself to resolve issues with a view to implementation by 30 June, and - The Committee was pleased to approve the business case for the continuation of the Automation Accelerator business plan, including the roll-out of a centre of excellence to assist the group and generate business more widely across the NHS. The Board noted a strategic weakness within the ICS regarding the availability and quality of actionable data to inform operations; resolving this was a crucial challenge ahead of the 2022/23 winter period. The Chief Digital Information Officer undertook to share his presentation to the recent Integrated Care Board (ICB) meeting. *Collaboration Programme Committee* - The Committee received reports providing overviews of progress with the implementation of the group clinical, digital and academic strategies, commending specific achievements such as the recruit target for patients into research of 3,000 being exceeded; - The Committee reviewed the latest thinking on key areas of focus for the ICS, evaluating which the UHN Group wished to be most closely involved in, and/or lead; the committee's feedback would inform the next stage of drafting the ICS strategy; and - The Committee reviewed the initial findings of the external review of estates, which identified potential improvements and efficiencies. The next steps would require the establishment of the risk appetite to address the issues raised, given the scale of organisational and cultural change likely to be required. *Audit Committee* The Committee approved the following items within its Terms of Reference and Delegated Powers: - Revised Terms of Reference providing for alignment of agenda and work plans with KGH (see item 12 below); - Internal Audit Annual Report and Opinion 2021/22 and delivery plan for 2022/23; TIAA annual report conclusion opinion. The Committee received the draft annual report and noted significant year-end accounting issues.	**Andy Callow**

	The Committee noted work underway to align the Board Assurance Frameworks and Corporate Risk Registers across the group. The Committee received the internal audit progress report, recommending the clearer identification of executive leads to ensure the timely completion of corrective actions in response to internal audit recommendations. The **Board of Directors** noted the Integrated Governance Report (IGR).	
6	**Final NHCP/ICB Plan Submission 2022/23** The Board of Directors noted the latest position regarding the 2022/23 ICS submission and was advised that, following submission on 28 April 2022 with a projected system deficit of £46 million, a further submission had been requested by 20 June 2022, which would be likely to require a lower deficit and clearer trajectories towards a breakeven position. Assumptions and projections regarding activity, productivity and staffing levels would be required to be revisited in order to deliver the national target of 104% of 2019/20 activity levels within a reduced financial envelope; proposals would be discussed in detail at a forthcoming development session for Non-Executive Directors, taking place on 10 June 2022. The Board noted the latest position, re-emphasising the need to justify additional investment since 2019/20 in terms of realised business benefits, and to the crucial impact of reducing the number of 'super stranded' patients experiencing unnecessarily long lengths of stay, which would not only derive patient benefit but reduce staffing and financial pressures.	
Strategy & Culture		
7	**Group Clinical Strategy** Following the agreement of a Group Clinical Ambition by Boards in November 2021, the Board of Directors received a presentation providing an overview of the process for the development, and recommending the approval, of the Group Clinical Strategy. The presentation set out: - Factors influencing the case for change, including an ageing population which was growing faster than the national average, a lack of joined-up services and difficulties in recruiting staff in some areas; - Patient experiences of existing problems arising from poor service collaboration, and how these could be addressed; - A summary of engagement on the draft strategy with over 600 internal and external stakeholders; - Themes arising from engagement, demonstrating widespread enthusiasm for the principle with specific	

	questions and concerns around scope, terminology and the practicalities of cross-site working for staff and patients; and - Changes made in response to feedback, including new sections on zero carbon and mental health. The strategy set out four key objectives: (1) Work with health and care partners to prevent ill-health and reduce hospitalisation; (2) Develop Centres of Excellence across all services, starting with cardiology and cancer; (3) Ring-fence elective capacity to reduce waiting list and variation between sites, and increase efficiency, and (4) Build on our University Hospital status to become a hub for innovation and research. Following adoption, the Group would continue the strong engagement and co-design that had informed development to date, commencing with feedback to stakeholders via a number of channels during June and July, focussing on developing clinical strategies and implementing changes over the next 12 months. The Board welcomed the strategy, noting examples of collaboration which were already generating positive impacts such as the surgical robot and therapists' pool for the ICS. Key enablers for success were noted in respect of digitisation, estates, organisational development, governance and leadership, with assurance provided that colleagues were enthusiastic about positive changes notwithstanding the continuing impacts of COVID and operational pressures. Staff and patient access to services would be key to reducing local health inequalities, aligned to the ICS Improving Outcomes framework. Following discussion, the Board of Directors **APPROVED** the Group Clinical Strategy.	
8	**Staff Survey Response** The Board of Directors considered a report summarising the Staff Survey results for the UHN Group trusts and setting out actions, planned and underway, in response. The results showed a deterioration in response rates across both trusts and outcomes in several categories, with themes emerging around leadership and management, team working, respect and reward and recognition. The Board and leadership were undertaking actions in response to the survey, principally to better understand the factors underlying staff dissatisfaction and scope the introduction of a cultural improvement programme for the group. The Boards of Directors were devoting their April and June 2022 Development Sessions to the issue and there was a shared commitment and determination to achieving and embedding meaningful change.	

	The Board noted the latest position.	
Governance		
9	**Ockenden Review of Maternity Services: Response to the Full Report** The Board of Directors considered a report providing an update on outstanding actions from the first Ockenden report (2020) into maternity services and the Shrewsbury and Telford Hospital, and an initial assessment of the Trust's position in relation to the actions and recommendations set out in the final Ockenden report, published in March 2022. As at 16 May 2022, the Trust had delivered 20 out of 25 actions from the first report, with the five outstanding actions on track to be delivered by proposed completion dates. All actions from the first report would be carried over and amalgamated with new actions into a single action plan. The final report contained 15 immediate and essential actions and 92 sub-actions for every NHS Maternity Services provider to implement; the Trust had begun a full gap analysis against each, informed by a site visit by NHS England and Improvement on 12 April 2022, led by the Regional Chief Midwife (Midlands), which identified points for celebration and consideration as specified in the report. Work to analyse and prioritise the Trust's response continued, and would be reported to the Quality Governance Committee and Board, including an assessment against CQC standards at the next meeting. The Board acknowledged that the Ockenden report provided sad and distressing reading but that it should be welcomed as an opportunity to learn and improve. The Trust continued to experience staffing, leadership and cultural barriers within its Maternity Services; however, the introduction of a new Head of Midwifery and organisational development programme, with the ongoing support of the Regional Chief Midwife, Freedom to Speak Up Guardian and Non-Executive Maternity Safety Champion, would enable the impetus for improvement to be sustained. Following discussion, the Board of Directors noted the latest position, indicating its assurance in respect of the Trust's maternity services arrangements arising from the response to the first report and independent site visit, with work in progress in response to the full report.	**Debra Shanahan**
10	**Board Assurance Frameworks (BAF): 2021/22 Q4 Review** The Board of Directors received BAFs for the Trust and Group and noted that the Audit Committees of both Trusts had recently completed 'deep dive' reviews, as a consequence of which work was underway to consolidate three BAFs into a single Group	

	overview – outputs from this work would be presented at the next meeting following consultation with lead Executives and Committees. The Board indicated its support for the ongoing review, noting that ICS risks would need to be reflected in the resulting product and that 'business as usual' risk management must be maintained alongside the development work. General and specific feedback was provided in respect of current BAF risks, highlighting inconsistencies of approach between the trusts in respect of the process for identifying corporate risks and their reflection on the BAF, and the 'extreme' status of many of the risks presented. The Board was assured that these issues were included in the scope of the review. Following discussion, the Board of Directors noted the latest position.	
11	**Annual Self-Certification in respect of conditions equivalent to the NHS Provider Licence** The Board of Directors considered and **APPROVED** positive confirmation for each of the conditions equivalent to the NHS Provider Licence, as set out in the accompanying report.	
12	**Audit Committee Terms of Reference and Scheme of Delegation** The Board of Directors considered and **APPROVED:** (1) Changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation to effect the delegation of authority to approve: (i) the Trust's Annual Report and Annual Accounts to the Audit Committee, and (ii) the Trust's Quality Account to the Quality Governance Committee. (2) Revised Audit Committee Terms of Reference set out at Appendix 1 attached, and (3) Consequential amendments to the Terms of Reference of the Quality Governance Committee to effect the change approved at (1)(ii) above.	
13	**Elective Collaborative Committee** The Board of Directors considered and **APPROVED:** (1) The establishment of the Elective Collaborative Committee in Common with the Kettering General Hospital NHS Foundation Trust;	

	(2) Committee Terms of Reference as set out at Appendix 2 to the report and (3) The appointment of Elena Lokteva to the Committee as the Trust's Non-Executive Director representative.	
15	**Nomination of Partner Member to the Integrated Care Board** The Board of Directors considered and: (1) **APPROVED** the nomination of the Group Chief Executive, Simon Weldon, to the position of Partner Member of the Integrated Care Board, and (2) **AUTHORISED** the Trust Chair to review the nominations and raise any objections on the Trust's behalf.	
16	**Questions from the Public (Received in Advance)** There were no questions from the public.	
17	**Any Other Business and close** The Hospital Chief Executive advised that Non-Executive Directors would be invited to a forthcoming clinical conference regarding the Cancer Centre of Excellence.	
18	**Exclusion of the Press and Public** The Board of Directors **RESOLVED** to exclude the press and other members of the public from the remainder of the meeting (a Private Meeting followed this meeting), due to the confidential nature of the business to be transacted.	

Next meeting

Date & Time	28 July 2022 – 09:30
Location	MS Teams

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Northampton General Hospital
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Action Log

Meeting	Board of Directors (Part II) Meeting in Public
Date & Time	Updated following 26 May 2022 meeting

Minute Ref.	Action	Owner	Due Date	Progress	Status
Mar 22 6	Quality Governance Committee to review metrics related to discharge	PW	May 2022	Complete	CLOSE
Mar 22 8	Identification of metrics to assess implementation of Group Communications Framework	MS	Tbc	Subject to recruitment of Group Director of Communications and Engagement	NOT YET DUE
May 22 5	Circulate ICB digital presentations slides	ACA	May 2022	Complete	CLOSE
May 22 9	Report on Trust's response to recommendations of the full Ockenden Report	DS	July 2022	On Agenda	CLOSE

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Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	Thursday 28 July 2022
Agenda item	4.1

Title	Group Chief Executive Board Report
Presenter	Mark Smith, Group Chief People Officer
Author	Simon Weldon, Group Chief Executive

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

Group priority				
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
For the Board's receipt and information	None

Executive Summary

As I write, the country and the NHS is dealing with a significant heatwave. I would like to begin my report by thanking all the staff who have worked during this period and particularly because of the buildings they have had to work in. We know that our A&E buildings were, in large part, built a generation ago and are no longer fit for purpose; we know that it is a real struggle to keep our wards cool in a normal summer let alone a heatwave and we know that our fragile infrastructure is strained in these conditions. So I would like to offer a particular thank you to those

staff who work to support and maintain our buildings; never an easy task at the best of times and much harder in the current circumstances.

In addition to these challenges I want to draw attention again to a lack of urgent care treatment facilities in the west of the county. The lack of such a facility means that patients seeking care for routine issues funnel into a space in NGH A&E that is too small and becomes quickly overcrowded. Recently, the department had a day where it saw 506 attendances; the previous high water mark was 350. Attendances are at 108% of 2019 activity. This is an unsustainable and unsafe position. We need a new urgent treatment facility and preferably one that is on site. It is recognised by everyone in our system that this situation requires a solution but sadly, money is still the obstacle and that means we face this winter with the facilities we have.

In our meetings today, we will begin to consider our performance in the year to date particularly in respect of activity vs plan and our theatre utilisation. Both of these are important measures and it is right that we report on them and debate them in public. The first of these – activity against plan – is a marker of how well the hospital is delivering its planned programme of elective care. The second – theatre utilisation – allows us to debate how efficiently we are using our resources. On the latter, Boards will have sight today of a tool that allows us to look in much greater detail at our day by day use of each of our theatres. We will also be able to look at how well each specialty makes use of the theatre space that is allocated to it. This is a capability that we have not had before and will support our theatre transformation plans, led by our COOs, with a robust evidence base.

Our ability to deliver our programme of planned care at the level we want to is effected by a number of factors. Principal among these is the impact of non-elective activity and in particular, the impact of Covid. Over the last month, we have seen cases rise again in both hospitals. As ever, we know this rise reflects an increased number of cases in the community. This has impacted our planned care programme of work as inevitably, sickness rates among staff have increased. We have had to reintroduce mask wearing in all areas in both hospitals and I would like to take this opportunity to ask everyone to support this and to focus on the basic disciplines of good infection control practice – they really do make a difference and it is only by our common support of these measures that we get the current level of infections under control

The other key factor that effects our ability to deliver planned care is the flow through our hospitals. I have reported here previously that both hospitals are part of the national programme on discharge and we had our latest review meeting with the national team recently. Both hospitals have a goal to improve discharges in the area where patients can go home with no further support required from a care agency. Both hospitals are making good progress on addressing this challenge but we know there is more that can be done. However, both hospitals are continuing to struggle to reduce the number of patients who require support from a care function in order to leave hospital. I am pleased to report that partners across the Integrated Care System have agreed a proposal to consolidate all community beds under NHFT and also to support additional beds being opened. This proposal does have the potential to increase flow through both hospitals. It is

really good that partners are working together in this way but I do need to caution that this programme on its own is unlikely to be sufficient to deliver the level of flow that we need to manage through winter so continued work is required to make sure all pathways are operating at the level we need them to.

Finally, I'd like to end this report by noting the launch of the Dedicated to Excellence hour this month. We know from our staff surveys that colleagues say they have good ideas almost every week but there are too many difficulties in implementing those ideas. So this month, every team will have £1000 to spend on their local ideas. The premise is simple – to encourage local innovation. I hope we can all get behind this and I look forward to us reporting back on progress in the September Boards.

I could not end this report without acknowledging that this is the last Board for Mark Smith our Chief People Officer. Mark has led the people function with distinction in Northamptonshire in one guise or another for seven years! His leadership has been instrumental in supporting and developing staff in many ways and I would like to pay a particular tribute to the work that he and his teams did throughout Covid – the support offer to staff was exemplary. I also know he will be missed by his many colleagues – he has truly been part of the fabric of both hospitals and the wider Northamptonshire community. I know we will all want to join together to wish him and his family well as they embark on their new life adventure.

Appendices
None
Risk and assurance
N/A
Financial Impact
N/A
Legal implications/regulatory requirements
N/A
Equality Impact Assessment
Neutral

Dedicated to excellence

NHS
Northampton General Hospital
NHS Trust

Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	28 July 2022
Agenda item	4.2

Title	Hospital Chief Executive's (CEO) Report
Presenter	Heidi Smoult, Hospital CEO
Author	Heidi Smoult, Hospital CEO

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

Group priority				
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
For the Board's receipt and information.	None

Executive Summary

Hospital and System Flow - Urgent Care Pathway

At the time of writing this report, both hospitals across the county were under significant pressure due to a number of factors, including rising COVID numbers, higher acuity of patients coming into hospital and significant and increasing delays for patients waiting for care packages resulting in increasing numbers of patients remaining in hospital that have no reason to be in an acute setting.

Our teams across the hospital have done a significant amount of work to ensure we are focussing internally on what and how can improve flow of patients that do not need any care

or support when leaving hospital. Consequently, we have seen a reduction in length of stay for these patients and it is important to acknowledge the hard work done by our teams in this area, which is being overshadowed by the complexity of the overall picture of patients being delayed leaving hospitals requiring care.

We continue to be part of the national discharge programme to look at sustainability and improvement across the system, which provide a really focussed opportunity to collaboratively ensure all partners work together on the system pressures we face. As a trust, we continue to focus on improving flow for patients who do not require a care package when leaving hospital. However, we are not confident we have sufficient plans to address the system challenge we face to manage the continued delays in those waiting for care packages and the impact these delays have on patients waiting for care across the system. We continue to work collaboratively across the system on the work.

As updated previously, the results of our Getting it Right First Time (GIRFT) review in ED demonstrate that our emergency department physical capacity is insufficient for the number of attendances, which adds to the pressures being seen and impact on ambulance delays. We continue to work with system partners on finding a solution for an urgent treatment centre (UTC) in the west of the county, but we remain in a position where we do not have a system solution.

Financial position

Our financial position is challenged, largely due to under-recovery of Elective Recovery Fund (ERF) as the Trust did not fully meet the required thresholds despite achieving very good operational performance. In addition, unachieved Pay Efficiencies continues to be a key focus to improving the financial position.

Looking ahead, the financial challenge becomes even greater as we have to continue to balance an increased financial ask (following a revised plan submission in June 2022), workforce constraints amidst a very challenging operational landscape, which is dependent on us achieving elective activity outlined in our system plan. Our ability to deliver the elective plan will inevitably be compromised if the sustained pressure remains on urgent care without any significant improvements in system flow.

Cancer performance

Whilst we continue to strive to improve the experience for patients with cancer or suspected cancer, as a county we are recognised as being 7th best nationally for our backlog of cancer patients waiting. We continue to strive to improve this, but it is essential we recognise the hard work of our teams have put in to achieve this.

Regional and National comparisons for April have recently been published setting the context for performance as below:

- 62 day - we achieved 68.8%, fourth in the region, national average 65.2%
- 28 day faster diagnosis we achieved 81%, first in the region, national average 70.8%
- 2ww we achieved 93.8%, only site in the region to achieve this and first with standard met, national average 79.1%
- 31 days we achieved 91%, fourth in the region, national average 92.8%

Cancer Centre of Excellence

On 12th July we had a collaborative event across KGH, NGH and system partners to launch the start of our ambition set out in the Group Clinical Strategy. I was honoured to be able to host Professor Sir Mike Richards to join us to provide objective perspective at the start of our journey. It was a successful day bringing together many clinical, operational, HR, strategy and administrative colleagues. This provided an invaluable opportunity for us to work across the whole system to make a significant difference to people across our county, from prevention, diagnosis, treatment and overall experience.

Intensive Care Unit – Opening

The new ITU/HDU successfully opened on 27th June 2022 after the completion of the build programme and validation and training of staff. The unit has 16 rooms on the ground floor with state-of-the-art equipment and 5 of these are isolation rooms. The upper floor contains staff facilities and areas which will support the training and development of staff both now and for the future. Prior to operational and clinical occupation of the new unit, we launched the unit by celebrating the benefits this facility brings with past and current employees to view the building. We also invited the media in prior to opening and had press coverage to ensure we shared the news with people across the county.

The completion has been completed despite COVID and all of the challenges that has brought, the issues with the Prime Contractor funding stream being put at risk, all whilst being delivered on a live working site.

I would like to thank the states team, led by Tony O'Donovan for their leadership during this major build. Estates colleagues have been supported through with collaborative working between clinical colleagues, our Procurement team, Finance team and the communications team.

Restaurant opening

The newly refurbished restaurant was reopened in June 2022 following a major overhaul to the front of house areas, making the environment more welcoming for our patients and teams across NGH. It has a new stand-alone coffee bar, and offers well priced, nutritious meals sourced from local suppliers.

As part of the opening a 3-month trial is being undertaken, allowing the area to be open 24/7, with the stand-alone coffee bar offering food and drink for staff and visitors alike who are on site overnight. A delivery service to wards areas where staff cannot attend is also on offer. It is hoped to extend this service after the trial period if it makes a difference to our teams to provide a space for them to go out of hours ensuring their wellbeing is a priority and ability to have access to food and drink.

National recognition

NGH have been shortlisted for two HSJ Patient Safety awards and been shortlisted to the last 8 for Macmillan Professionals Excellence Awards. Well done to the teams involved in this work.

Maternity Update

Our maternity service continues to be under pressure due to increased demand and acuity, impact of covid on women and our teams, alongside ongoing staffing shortages in maternity being a national issue. We continue to ensure there are processes in place to manage

escalation and mitigation of risks within the trust and working with colleagues in the LMNS and across the region, as necessary.

We continue with our OD work and ensure staff have the support to raise concerns. In order to strengthen this, we imminently plan to have engagement sessions with all staff in maternity to ensure they have the opportunity to share ideas, raise concerns and directly link with me and the wider executive team and divisional teams.

I am delighted to say we now have our Head of Midwifery in Post and have also appointed a Deputy Director of Midwifery who will join us in due course.

Appendices
None
Risk and assurance
No direct implications from this information report.
Financial Impact
No direct implications from this information report.
Legal implications/regulatory requirements
No direct implications from this information report.
Equality Impact Assessment
Neutral

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Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	28 July 2022
Agenda item	5

Title	Integrated Governance Report (IGR)
Presenters	Heidi Smoult, Hospital Chief Executive Executive Directors and Board Committee Chairs
Author	Richard May, Trust Board Secretary

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

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

Reason for consideration	Previous consideration
To enable the Board of Directors to be assured around organisational performance on an exception reporting basis.	NGH and KGH Board Committees, July 2022

Executive Summary

Board Committee summaries and the Integrated Governance Report for June 2022 are enclosed. Committee Chairs and Executive Leads will be invited to draw the Board's attention to other significant items considered at meetings.

The Group Governance report within the Private (Part II) Agenda for this meeting includes an update on the development of metrics as part of the Group IGR.

Appendices

Board Committee summaries

Integrated Governance Report, April 2022 Finance Update: Month 3 (30 June 2022)
Risk and assurance
The IGR should inform, and be informed by, consideration of the Board Assurance Framework at Agenda Item 11.
Financial Impact
As set out in the report.
Legal implications/regulatory requirements
No direct implications arising from this assurance report.
Equality Impact Assessment
No direct implications arising from this assurance report.

BOARD COMMITTEE SUMMARIES

28 JULY 2022 – AGENDA ITEM 5

Quality Governance Committee: 24 June and 22 July
Finance and Performance Committee: 29 June and 27 July
Group People Committee: 27 June and 25 July
Group Digital Hospital: 7 July
Collaboration Programme: 20 June and 18 July
Audit: 20 June
Strategic Development: 14 July

NGH Quality Governance Committee Committee Summary to Public Trust Board	Dates of committee meetings: 24 June 2022

Committee Chair: Andre Ng

Agenda Item	Description and summary discussion	Decision / Actions	Review Date
Quality Report – maternity update	Maternity staffing – Concerns regarding reducing staffing levels identified, which the Committee are monitoring.	n/a	n/a
Quality Report – Medical update	The Clinical Morbidity and Mortality meetings (M&M) needed a focus.	n/a	n/a
Quality Report – academic strategy	The Committee received an update on the implementation of the Academic Strategy. A bid had been submitted, in partnership with Leicester University and the University Hospital Leicester to become a biomedical centre (BRC bid). This had been awarded.	n/a	n/a
IGR	The IGR was noted, however felt there was more detail and assurance in the Quality Reports, which would be retained until the new IGR was fully developed.	n/a	n/a
Quality Report – medication errors	The Chief Pharmacist delivered an update on Pharmacy's work to reduce medication errors and the Committee ENDORSED the Medicine Optimisation Strategy.	n/a	n/a

NGH Quality Governance Committee Committee Summary to Public Trust Board	Dates of committee meetings: 22 July 2022
Committee Chair: Andre Ng	

Agenda Item	Description and summary discussion	Decision / Actions	Review Date
	TO FOLLOW 22 JULY MEETING		

Finance and Performance Committee Committee Summary to Public Trust Board	Date of committee meetings: 29 June 2022

Committee Chair: Denise Kirkham (Deputy for Rachel Parker)

Agenda Item	Description and summary discussion	Decision / Actions	Review Date
Finance Report	The month 02 performance was £1.1m worse than plan. The Committee was advised that the £16.7m plan referred to in the report did not take into account the updated recent 2022/23 system plan submission; the projected deficit against this revised plan was around £1.9m. Inflation was higher than assumed in 2022/23 with plans in a number of areas, including utilities.	n/a	
IGR	The Trust had its record number of attendees of 506. There had been a rise in bed occupancy. The number of 'stranded' patients remained consistent, whilst the number of 'super stranded' patients experienced lengths of stay of over 21 days was increasing. For cancer, the 2-week wait standard had been achieved in May and June.	n/a	
Discharge Review of Pathways 1-3	An update was received by the Committee. There had been an increase in waiting times for pathways. The Committee requested oversight of other organisations' situations and was advised that an update would be submitted to the August Committee. The Group Executive Director of Transformation and Quality Improvement advised that there was a piece of work to create a system dashboard.	Action	August
Estate Compliance Report	An update was provided on the PSDS 3 decarbonisation Project. The Trust was working through the commercial position and further work was needed with Capsticks on this. A paper was presented to HMT to look at the contract and framework. An update would be included in the Estates Compliance report to the July Committee.	Action	July

Finance and Performance Committee Committee Summary to Public Trust Board	Date of committee meetings: 27 July 2022

Committee Chair: Denise Kirkham (Deputy for Rachel Parker)

Agenda Item	Description and summary discussion	Decision / Actions	Review Date
	TO FOLLOW 27 JULY 22 MEETING		

Group People Committee in common Committee Summary to Public Trust Board	Date of Committee meeting: 27 June 2022

Reporting Committee Co-Chair and NGH Convenor: Denise Kirkham

Agenda Item	Description and summary discussion	Decision / Actions	Review Date
Developing the UHN 2022/23 Board Assurance Framework BAF alignment exercise	The Director of Governance talked about the aims and context of risk management and the work across the group to revise the board assurance frameworks (BAF).The discussions were on the work across the group on risk management and the proposal for a new single people orientated risk, which would subsequently be reflected in each Trust's corporate risk register (CRR). It was proposed to create a single Group BAF to consolidate and replace existing Trust BAFs. The Committee NOTED and ENDORSED the Board Assurance Framework BAF alignment exercise and proposed Group People Plan risk. A revised draft would be submitted to the Business Meeting and Boards of Directors in July 2022 for formal approval	Action	July
People Committee Work Programme	The updated work plan was shared with the Committee. The CPO set out a proposal to the Committee to meet formally six times per year in future, with two half-day developmental workshops in the intervening months. The Committee welcomed and supported the proposal and accompanying workplan, though concern was expressed at the number of items proposed for the May and June meetings.	n/a	n/a

Group People Committee in common Committee Summary to Public Trust Board	Date of Committee meeting: 25 July 2022		
Reporting Committee Co-Chair and NGH Convenor: Denise Kirkham			
Agenda Item	**Description and summary discussion**	**Decision / Actions**	**Review Date**
	TO FOLLOW 25 JULY 2022 MEETING	-	-

Dedicated to excellence

Group Digital Hospital Committee in common Committee Summary to Board of Directors	Date of Committee meeting: Extraordinary meeting 24 June 2022 7 July 2022		
Committee Chair: Alice Cooper (KGH Non-Executive Director) Reporting Director: David Moore			
Agenda Item	**Description and summary discussion**	**Decision / Actions**	**Review Date**
Capital Programme	At the 24th June extraordinary committee meeting, the committee received an update on the position summary for the NGH EPR business case and noted that due to delays in approval, this would be a three year rather than a two year programme. The committee noted with concern the risks of skills leaving the Trust due to this delay. Committee members were keen for the EPR business case to be taken through the relevant approval process as soon as possible.	For Board decision	28 July
Frontline Digitisation	At the 24th June extraordinary meeting, the committee discussed potential options for shortening the NGH EPR timeline and received an update from the programme manager on accelerating the EPR programme.	-	-
Group Digital Strategy Review	The committee received an update on the Digital Strategy which had been in place for over a year and would be reviewed every 6 months. While the aspiration remained to be the most digital hospital Group in England, the target to achieve this by July 2023 was no longer realistic due to factors outside the organisation's control which needed to be considered.	-	-
Group Digital Strategy Theme updates	The committee received updates on the 8 Digital Strategy themes and noted that: • Implementation of some digital schemes was reliant on approval of TIF funding and completion of the capital planning process. • Volunteers had been trained to support digital technology on wards. • EDMS was going to plan at NGH and there were indications that this was being used by clinicians. Adoption rates would continue to be monitored. • Progress on the EPR was noted. The business case was awaiting approval; several activities were dependant on this to be able to progress. • The ICS Digital Strategy was approaching approval.	-	-

Group Digital Hospital Committee in common Committee Summary to Board of Directors	Date of Committee meeting: Extraordinary meeting 24 June 2022 7 July 2022

Committee Chair: Alice Cooper (KGH Non-Executive Director) Reporting Director: David Moore

Agenda Item	Description and summary discussion	Decision / Actions	Review Date
Feedback from CCIOs on clinical engagement	The committee received an update on clinical engagement in the implementation of clinical systems, which highlighted the need to enhance clinical engagement in digital. It was suggested that time should be budgeted for clinical engagement and between 2-4 doctors should be employed by IT for every 1000 doctor users. The need for digital and clinical strategies to be aligned was highlighted. While the committee agreed with these proposals, it is mindful of the funding constraints.	-	-
Digital restructure update	An in-depth review of Digital staffing issues, including the recruitment and retention of staff, will be undertaken.	-	-
Board Assurance Framework	The committee endorsed the proposed changes to the Board Assurance Framework which incorporated the relevant Digital KGH and NGH risks into one.	-	-

Collaboration Programme Committee in common Committee Summary to Trust Board	Dates of Committee meetings: 20 June 2022

Reporting Director: David Moore

Agenda Item	Description and summary discussion	Decision / Actions	Review Date
System Operating Plan	The Group Chief Finance Officer provided an update on the planning submission. Members heard that a plan for finance, operations and workforce will be submitted for the third time in response to a national request regarding the finances. The Group Chief Finance Officer reported on the national context. The view from NHSE finance was that the impact of coping in particular with productivity levels should be minimal and therefore not a reason to affect deployment of resources. The Committee noted that the fact there is a system finance submission that everyone has signed off was to be welcomed. The Committee discussed that it will need to turn attention to a multi-year planning process next year and that Non-Executive Directors will need to engage in this task together.	For Boards' ratification	29 July 22 (on agenda)
NMAHP Strategy	The Interim Director of Nursing and Quality provided an overview of the Nursing, Midwifery and Allied Health Professionals strategy called Ignite Our Voice. The Committee was updated on the five key priorities linking to the group values of dedicated to excellence and it was provided an overview of key quality metrics. The Committee discussed developing its workforce, focusing on the 5 key priorities and an overview of governance within both organisations.	-n/a	-
Sustainability Priority Update	The Group Director of Operational Estates provided an update on the group priorities for sustainability. It was noted that one of its focus areas is 'to reduce our carbon footprint by reducing the impact from our use of medical gases and by reducing food waste'. On Energy and infrastructure, the Committee was informed about a Net Zero funding grant in which a £20.6m bid was successful to be put towards infrastructure projects. The Committee agreed the importance of this work and noted that a business case will be presented to Board in July 2022.	-n/a	-

Collaboration Programme Committee in common Committee Summary to Trust Board	Dates of Committee meetings: 18 July 2022

Reporting Director: David Moore

Agenda Item	Description and summary discussion	Decision / Actions	Review Date
Cardiology Roadmap	The KGH HCEO introduced the cardiology centre of excellence strategy. It was noted that the aim of the strategy was to ensure there is equity for patients across the whole of the county and ensure they have access to the right services at the right hospital. This will mean that cardiology services will still be provided across both hospitals but that there will be some specialist services bases at one hospital. The CPC wanted to reconfirm its commitment to the strategy but also highlight some of the operational and cultural issues that are being faced within the cardiologists group.	n/a	
Theatre Efficiencies Pilot	The Group Director of Transformation and QI provided an overview of the theatre productivity programme; a key programme in both KGH and NGH to help achieve the Trusts' elective ambition. The Committee was also updated on a pilot being run with Palantir which is a solution that helps better manage waiting lists and data scheduling ie. How this fits in with the Trusts overall day-to-day productivity programme.	n/a	-
Review of CPC ToR	The Director of Integrated Governance provided an overview on a revised Terms of Reference for the Committee which has been prepared following a meeting with the Director of Transformation and QI and Ms Cooper, Non-Executive Director. Some of the key changes included • proposing that it is renamed the 'Dedicated to Excellence Delivery Committee'; • reflecting a focus on Group Strategy delivery (previously the focus was on formation and development), • bringing Transformation within the Committee's remit, • increasing the number of Non-Executive Members from one to two per Trust (with other Non-Execs to continue to be invited), and • providing for a designated Non-Exec (Liisa) to convene transformation sections of the agenda.	n/a	-

Audit Committee Summary to Trust Board	Date of Committee meeting: 20 June 2022

Committee Chair: David Moore

Agenda Item	Description and summary discussion	Decision / Actions	Review Date
Cyber Security update	The Committee received a 'deep dive' on Cyber Security.	n/a	n/a
Counter fraud	Audit Committee wished to bring to the Board's attentioncompletion of the Counter Fraud Functional Standard Return and low staff awareness survey response	n/a	n/a
Board Assurance Frameworks and Corporate Risk Registers Review	Approval of design principles of risk management strategy	n/a	n/a
Accounts and External Audit	The Committee wished to share the considerable improvement in the quality of the accounts and the External Audit. The Committee APPROVED the Accounts 2021-22, Annual Report 2021/22 and Annual Governance Statement	n/a	n/a
Internal Audit	The Committee APPROVED the Trust Letter of Representation.	n/a	n/a

Group Strategic Development Committee Summary to Trust Board	Date of Committee meeting: 14 July 2022

Committee Chair: Alan Burns

Agenda Item	Description and summary discussion	Decision / Actions	Review Date
KGH Programme Highlight Report	Four key business cases have been submitted earlier than planned on the advice of the MP and minister with responsibility. Discussions have been taking place with developers on a potential town presence, requesting an update to the KGH Private Board meeting The Committee discussed the Community Diagnostics Centre (CDC). It noted that whilst there was not a SOC created for this work a set of options would be shared with members. The Committee noted that the CDC had not been through a clear governance process in the group and it encouraged the team to take a paper to both KGH and NGH Private Boards at the end of the month. The Committee discussed car parking proposals -It agreed to start the procurement process and bring developments to Boards in Autumn 2022.	Healthcare on the Highstreet work to be taken to Private Board at the end of July for communication and discussion	July Board
Receipt of approved business cases	The infrastructure team noted that the business cases had been submitted and will be reviewed in due course, with the exception of the main scheme which would be on hold until funding has been received in the autumn.	Noted approval	July Board (KGH)
NGH Energy Centre	On Energy and infrastructure, the Committee was informed about a Net Zero funding grant in which a £20.6m bid had been successful to be put towards infrastructure projects. The Committee was informed that the bid will need to go through technical submission and challenge, and that a variation to the contract of its current energy contract with Vital would be the preferred option. In terms of governance oversight of this work, the Chair suggested that the report is taken to the NGH Performance and Finance Committee and then to Private NGH board to endorse the plan and guarantee a full understanding of the risk. It may also need to go to Quality and Safety Committee to understand from the point of view of the care risk.	NGH Energy Centre discussion to be taken to Private NGH Board to endorse plan	Sep 2022

NHS
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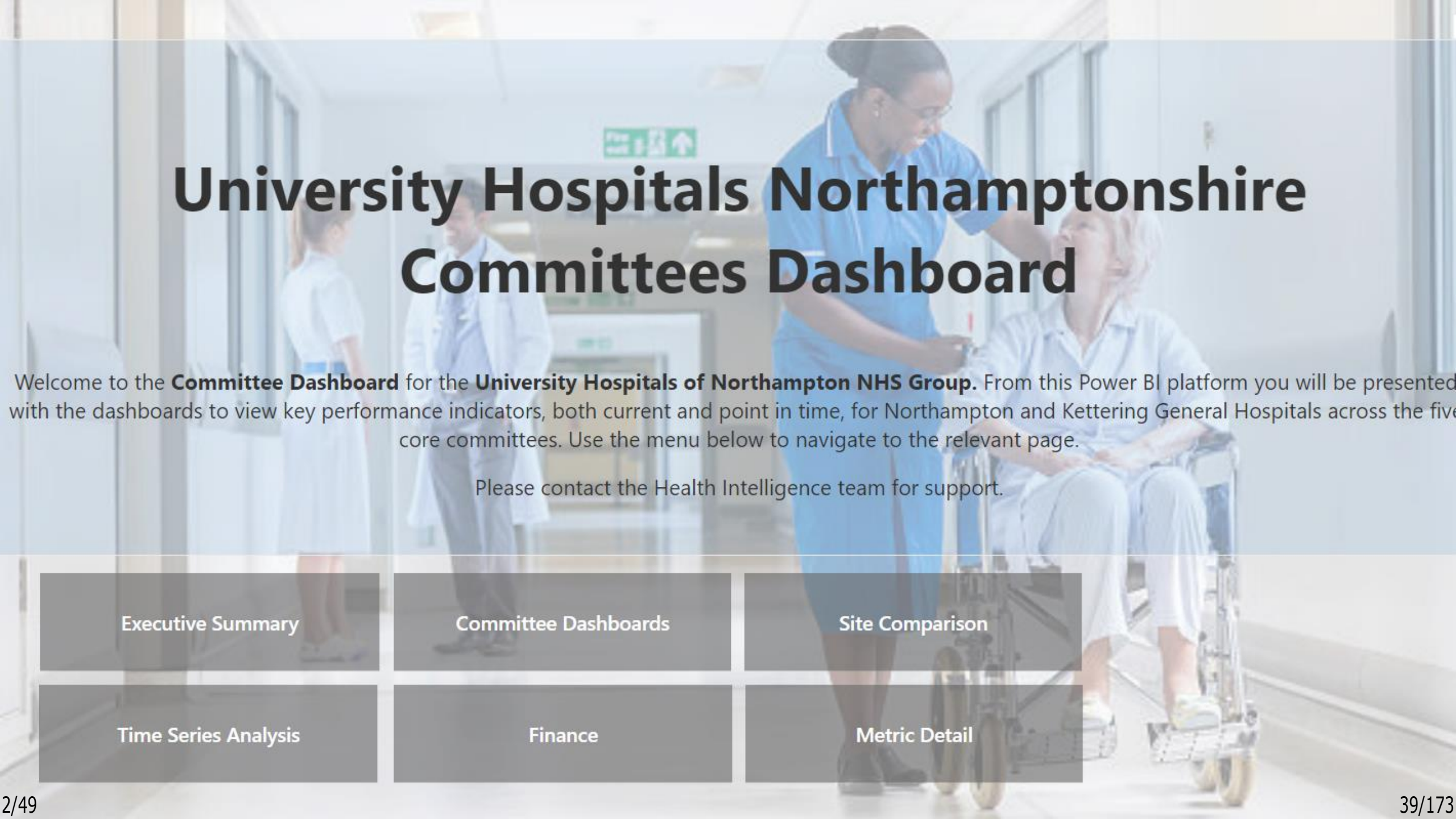
NHS Group

Integrated Governance Report

June 2022

Dedicated to excellence



University Hospitals Northamptonshire Committees Dashboard

Welcome to the **Committee Dashboard** for the **University Hospitals of Northampton NHS Group.** From this Power BI platform you will be presented with the dashboards to view key performance indicators, both current and point in time, for Northampton and Kettering General Hospitals across the five core committees. Use the menu below to navigate to the relevant page.

Please contact the Health Intelligence team for support.

Executive Summary | Committee Dashboards | Site Comparison

Time Series Analysis | Finance | Metric Detail

Metric Categorisation Information

On this dashboard, metrics have been categorised to indicate whether or not they have met their Target, and whether this is likely to be consistent based on statistical analysis of historic results.

- **'Target Met (Consistent)'** = The target has been met and is likely to be consistently met going forwards according to historic values.
- **'Target Met (Inconsistent)'** = The target has been met, however with analysis of past results it may not be met next month.
- **'Target Not Met (Inconsistent)'** = The target has been met and is likely to be consistently met going forwards according to historic values.
- **'Target Not Met (Consistent)'** = The target has been met and is likely to be consistently met going forwards according to historic values.

Statistical analysis method: standard deviation analysis of historic values per metric. If the target is met by two standard deviations above/below the mean then this means new metric results are statistically 95% likely to meet the target. NB: this is purely statistical analysis and does not consider real-world information.

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.

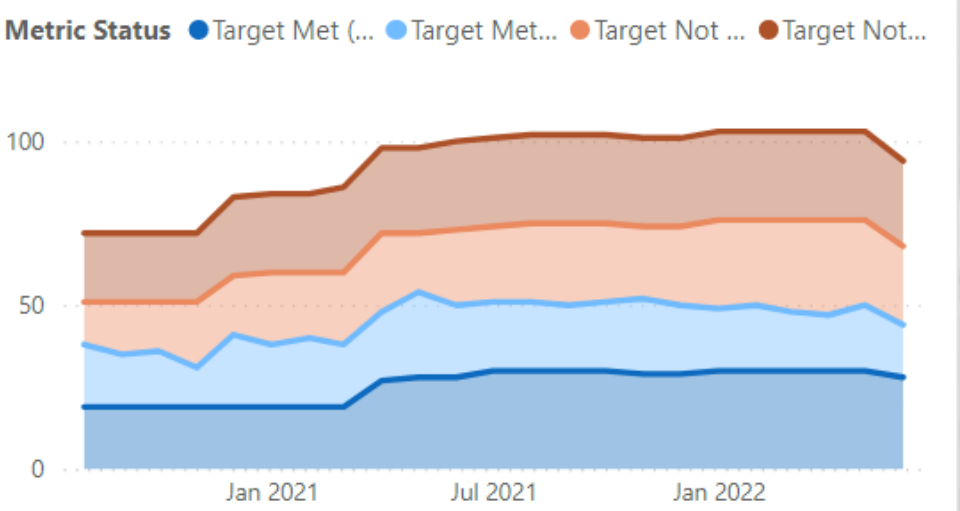
Variance Icons: **Orange** indicates concerning variation requiring action (e.g.: trending away from target). **Blue** indicates potential improvement. **Grey** indicates no significant change (common cause variation).

*** This icon signifies there is further information on this topic. Click on the arrow to navigate to a page with more information.

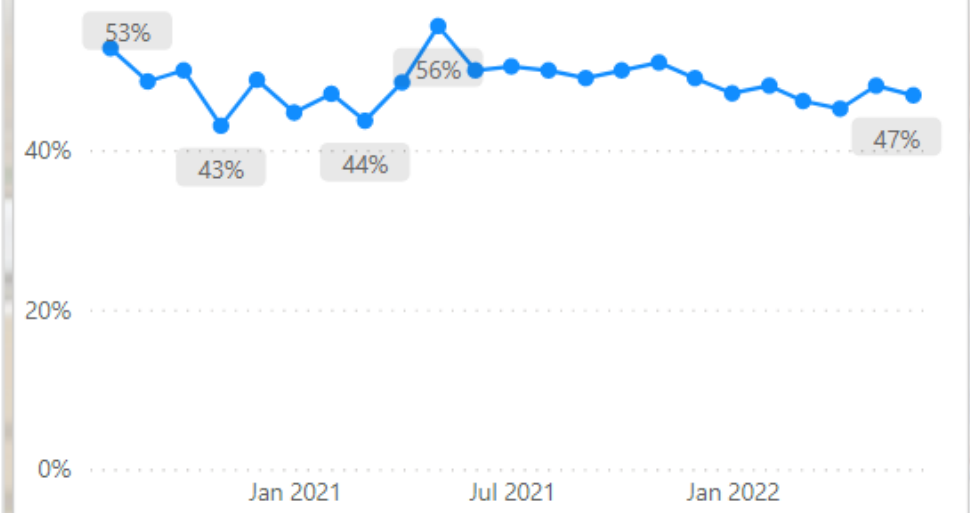
Executive Summary

29	20	27	26	(Blank)
No. Metrics Met (Consistent)	No. Metrics Met (Inconsiste...	No. Metrics Not Met (Incons...	No. Metrics Not Met (Consi...	No. Metrics Met (Consistent)

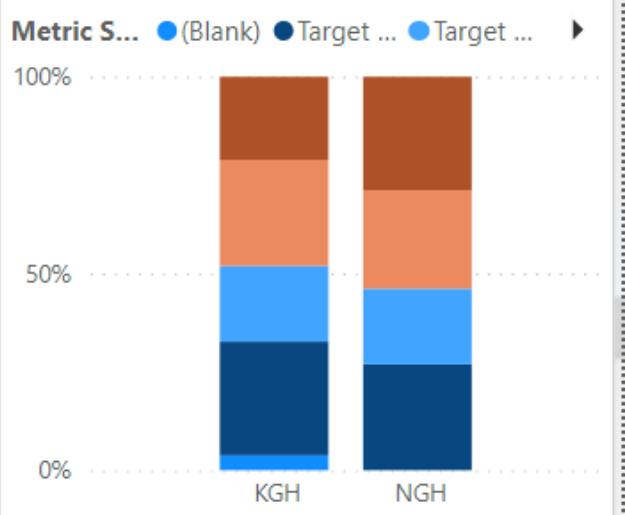
Metric Status Over Time (excl. No Target)



Percentage of Metrics Met Over Time (excl. No Target)

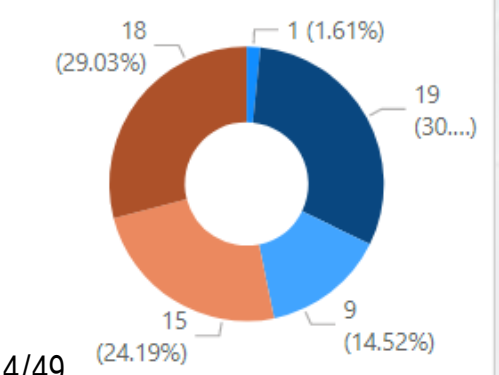


Current Metric Status by Site

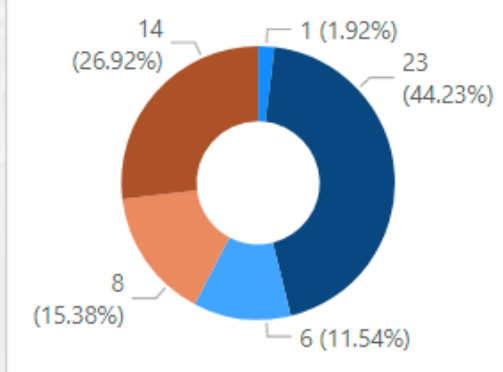


Current Metric Status per Committee

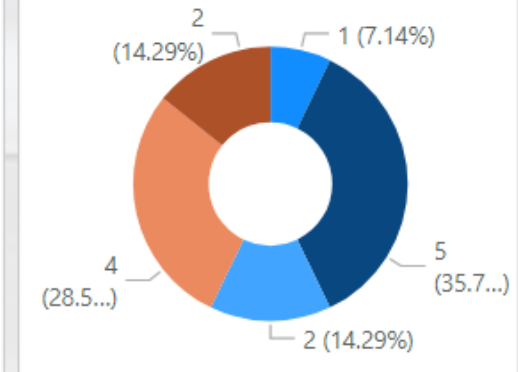
IGR



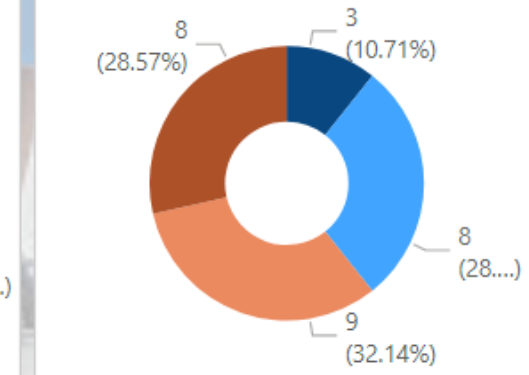
FPC



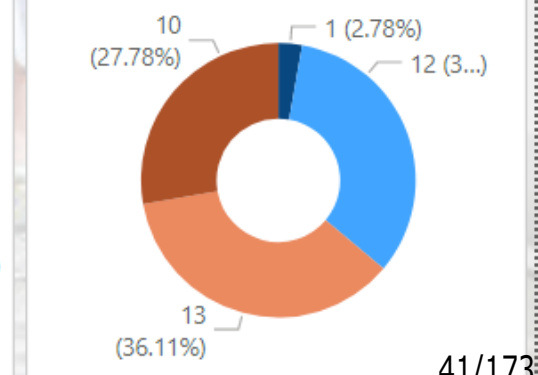
JPC



Joint QSC



Trust QSC

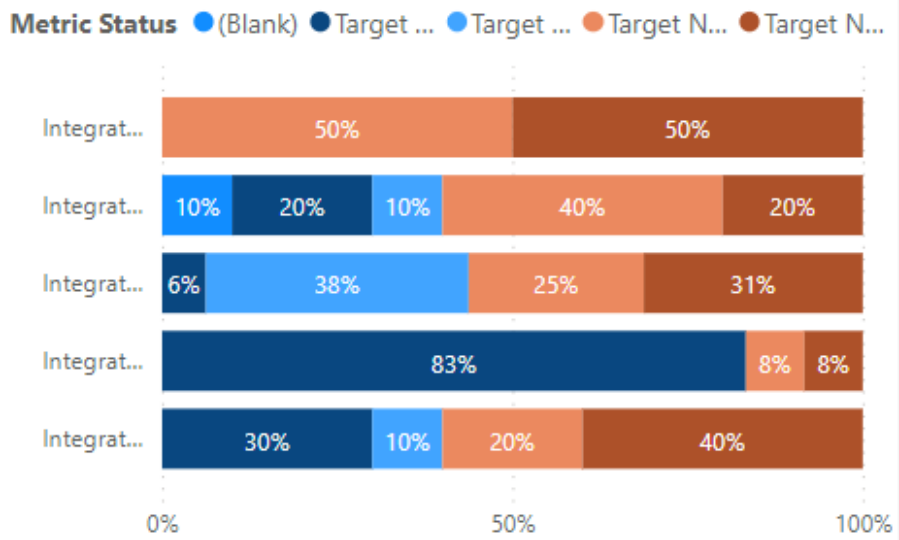


Integrated Governance Report (IGR)

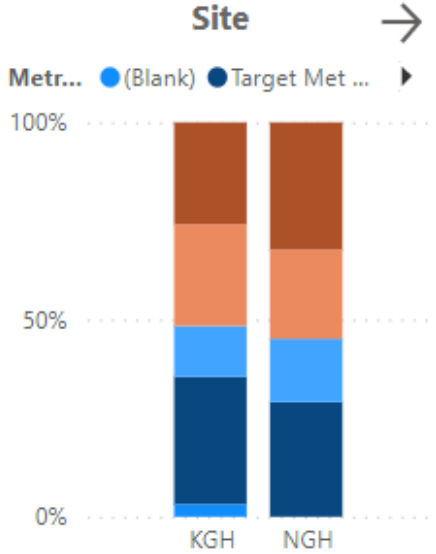
University Hospitals of Northamptonshire NHS Group

19	9	15	18	(Blank)
No. Metrics Met (Consistent)	No. Metrics Met (Inconsiste...	No. Metrics Not Met (Incons...	No. Metrics Not Met (Consi...	No. Metrics w. No Target

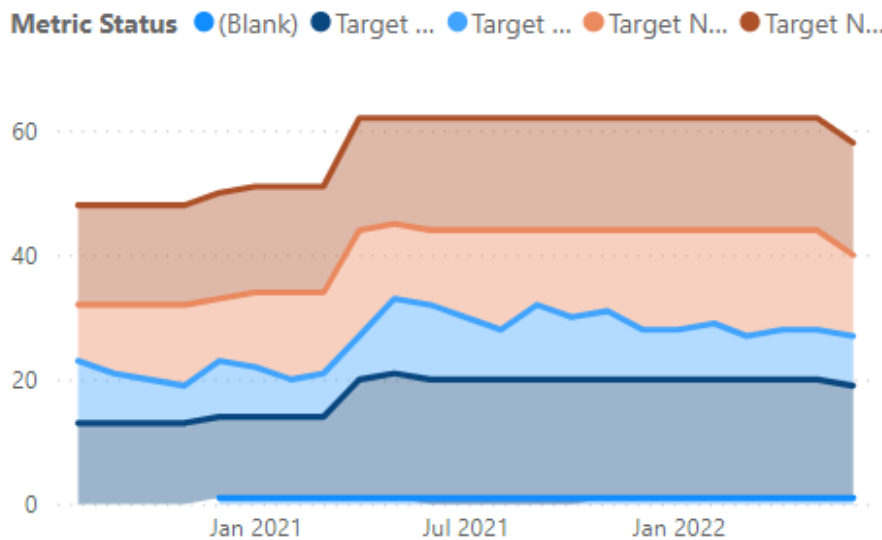
Current Metric Status by Group Metric Category



Current Metric Status by Site



Metric Status Over Time (Excl. Metrics w. No Target)



Quality

Patient | People | Quality | Sustainability | Systems & Partnerships

Site	Metric	Latest Value
KGH	% Patients satisfaction score - Trustwide	87.8%
NGH	% Patients satisfaction score - Trustwide	88.2%
KGH	% Patients satisfaction score - inpatients	85.92%
NGH	% Patients satisfaction score - inpatients	91.4%
KGH	% Patients satisfaction score - A&E	74.78%
NGH	% Patients satisfaction score - A&E	78.3%
KGH	% Patients satisfaction score - maternity	90.63%
NGH	% Patients satisfaction score - maternity	94.4%
NGH	% Patients satisfaction score - outpatients	91.6%
KGH	% Patients satisfaction score - outpatients	95.11%
NGH	Number of complaints	22
KGH	Number of complaints	37
KGH	Complaints response performance	54%
NGH	Complaints response performance	93.8%
KGH	Ambulance handover	14
NGH	Ambulance handover	186

Metric	Comment
Complaints:	Complaints performance remains below target . A review of the data has demonstrated that this is attributed to two issues. The first is the quality of the response, which means that comprehensive responses are not received by the Complaints Team to finalise before responding to the complainant. The second is the timelines of these investigations being returned to the Complaints team. A number of initiatives have been put in place to support both the Complaints Team and the Divisions.

Committee Name
- Select all
- Integrated Governance Report (IGR)
- Joint Finance and Performance Committee (FPC)
- Joint People Committee (JPC)
- Joint Quality and Safety Committee (QSC)
- Trust Quality and Safety Committee (QSC)

Group
- Select all
- Patient
- People
- Quality
- Sustainability
- Systems and Partnerships

SITE
- Select all
- KGH
- NGH

Variation
- Select all
- Common Cause

Clear Filters

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance
KGH	Patient	% Patients satisfaction score - Trustwide	01/06/22	87.8%	95%	80.41%	88.3%	96.19%		
NGH	Patient	% Patients satisfaction score - Trustwide	01/06/22	88.2%	95%	84.16%	88.65%	93.14%		
NGH	Patient	Number of complaints	01/06/22	22	0	-0.57	24.04	48.65		
KGH	Patient	Number of complaints	01/06/22	37	0	11.38	38.52	65.65		

% Patients satisfaction score - Trustwide

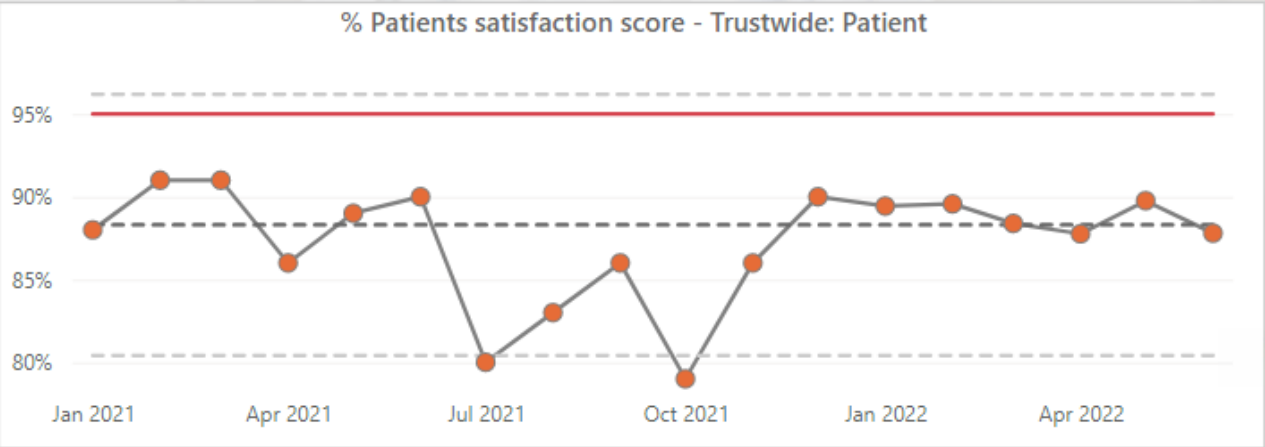
Group Metric Category: All

MetricName: % Patients satisfaction score - Trustwide

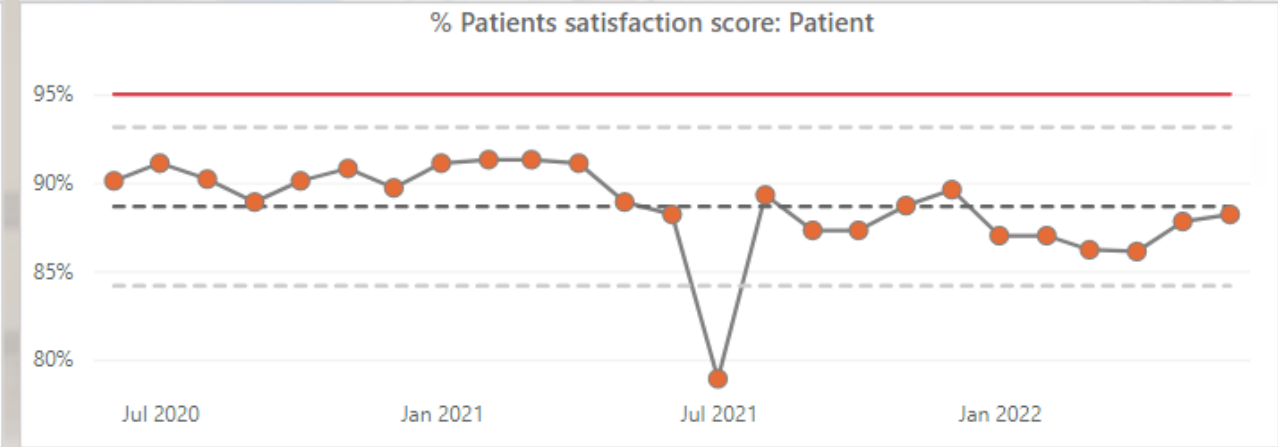
01/05/2020 – 01/06/2022

87.80%	95%	88.20%	95%
KGH: Value	KGH: Target	NGH: Value	NGH: Target

Kettering General Hospital



Northampton General Hospital



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH					
KGH	The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses.	Slight reduction in the overall satisfaction score trust wide. Surgery division see a reduction in overall satisfaction scores, they also see a substantial reduction in the number of responses. significant reduction in ophthalmology OPD	Ward/department required to continue to promote the survey, in addition to text messaging in place, poster and QR codes.	continue promotion of FFT with wards and departments. new guide sheet produced and awards for most improved returns and satisfaction scores.	
NGH					
NGH		Variation: Common cause - no significant change Assurance: Variation indicates consistently (F)alling short of the target			

Number of complaints

Group Metric Category: All

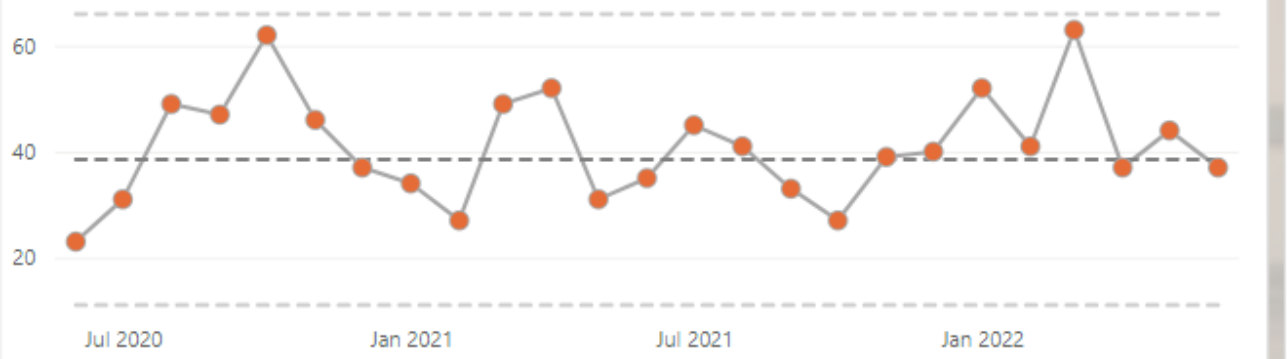
MetricName: Number of complaints

5/1/2020 – 6/1/2022

37.00		22.00	0
KGH: Value	KGH: Target	NGH: Value	NGH: Target

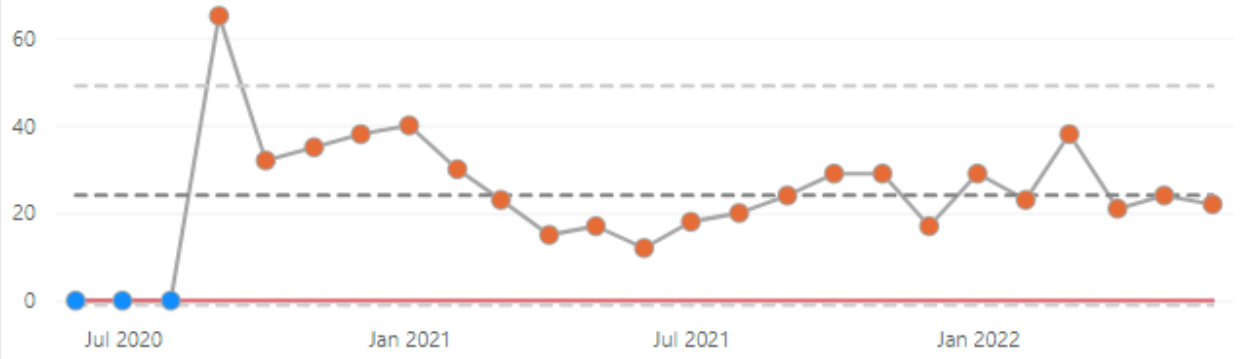
Kettering General Hospital

Number of complaints: Patient



Northampton General Hospital

Number of complaints: Patient



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH					
KGH	Number of complaints received in month. This is the number of complaints that proceeded to a formal investigation. Any complaints that were locally resolved withdrawn or escalated to the patient safety team would not be included in this figure, this figure can be provided if required.	Slight reduction in number of formal complaints for the month			
NGH					
NGH	Number of complaints received in month. This is the number of complaints that proceeded to a formal investigation. Any complaints that were locally resolved withdrawn or escalated to the patient safety team would not be included in this figure, this figure can be provided if required.	Variation: Common cause - no significant change Assurance: Variation indicates inconsistently hitting passing and falling short of the target			

Patient | People | Quality | Sustainability | Systems & Partnerships

Site	Metric	Latest Value
KGH	Number of volunteers	221
NGH	Number of volunteers	364
KGH	Overseas recruitment	0
NGH	Overseas recruitment	13
NGH	Turnover rate	9.7%
KGH	Turnover rate	11.22%
KGH	Vacancy rate	9.43%
NGH	Vacancy rate	12.08%
KGH	Sickness and absence rate	5.91%
NGH	Sickness and absence rate	6.19%
NGH	Appraisal completion rates	76.78%
KGH	Appraisal completion rates	79.97%
NGH	Mandatory training compliance	86.67%
KGH	Mandatory training compliance	90.54%

Metric	Comment
Appraisal	Appraisal rates are showing common cause variation but has fallen this month to 79.97% (against a target of 85%) despite a focus on reminders to managers. Work is ongoing to support areas of concern and to develop tools across the Group to support improvement. We continue to offer Appraisal Light as an option to enable more focused, regular performance/wellbeing discussions and will personailise contact to staff to focus on the need for appraisel conversations.
Stat/Man training	Compliance has maintained this period to 90.54% and remain above target (85%). All areas of the Trust are reporting greater than 85%. IG has been a focus with achievement of the National reporting bench mark of >95%. all areas other than Resus report at >85%. Sustained reminders and contacts with indoividual staff is making a difference.
Absence	Sickness absence shows common cause variation (currently 5.91%; target 4%) and continues to be one of the main challenges for the Trust in managing staff availability. An improvement in late spring is now reversed as the next wave of covid impacts absence rates which started to rise in June. Our range of support measures continues for those needing psyhological, emotional, financial or other support and the HR team are supporting managers with data to enable them to target their interventions.
Turnover	Turnover is showing special cause variation with rates above target at 11.22% (target 11%). We have had a specific project to address HCA retention and our wider staff experience action plan to address some of the issues raised in the staff survey will address concerns such as team work, recognition and leadership. Individual departments and Directorates are developing plans to respond to local challenges e.g. in Estates and Facilities and Therapies.
Vacancy	Vacancy rates show special cause variation, currently at 9.43% against a target of 7%. We are challenged in the recruitment of some specialist skills such as Pharmacists and Therapy Staff. These roles along with HCAs and certain Facilities roles are identified in our Recruitment strategy for particular focus with campaigns and recruitment events planned.

Committee Name
- Select all
- Integrated Governance Report (IGR)
- Joint Finance and Performance Committee (FPC)
- Joint People Committee (JPC)
- Joint Quality and Safety Committee (QSC)
- Trust Quality and Safety Committee (QSC)

Group
- Select all
- Patient
- People
- Quality
- Sustainability
- Systems and Partnerships

SITE
- Select all
- KGH
- NGH

Variation
- Select all
- Concern (High)
- Improvement (High)
- Common Cause

Clear Filters

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance
NGH	People	Mandatory training compliance	01/06/22	86.67%	85%	61.6%	82.04%	102.47%		
KGH	People	Mandatory training compliance	01/06/22	90.54%	85%	86.74%	89.82%	92.91%		
NGH	People	Appraisal completion rates	01/06/22	76.78%	85%	52.07%	71.82%	91.57%		
KGH	People	Appraisal completion rates	01/06/22	79.97%	85%	77.45%	81.13%	84.82%		
NGH	People	Sickness and absence rate	01/06/22	6.19%	3.8%	4.56%	5.64%	6.72%		
KGH	People	Sickness and absence rate	01/06/22	5.91%	4%	3.77%	5.58%	7.4%		
KGH	People	Vacancy rate	01/06/22	9.43%	7%	6.8%	9.06%	11.32%		
NGH	People	Vacancy rate	01/06/22	12.08%	9%	6.02%	7.85%	9.67%		
NGH	People	Turnover rate	01/06/22	9.7%	10%	7.86%	8.27%	8.67%		
KGH	People	Turnover rate	01/06/22	11.22%	11%	9.58%	10.21%	10.85%		

Mandatory training compliance

Group Metric Category: All

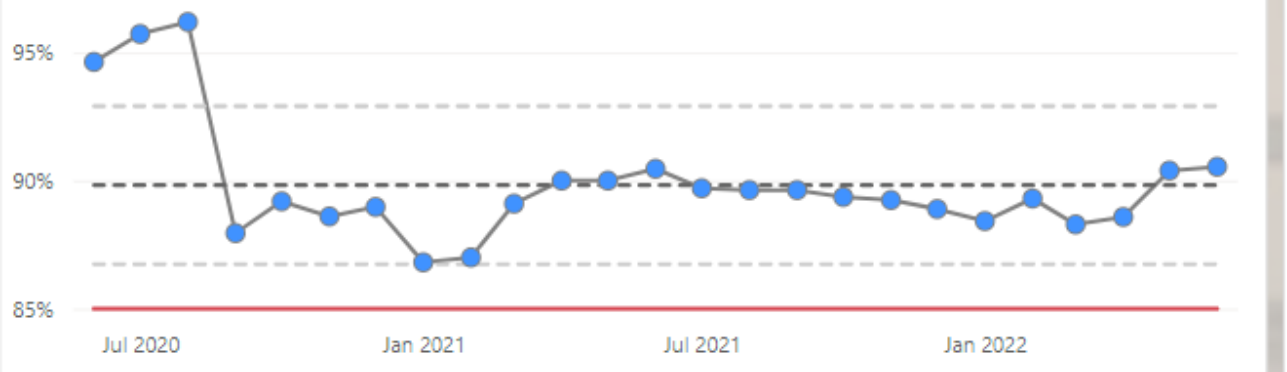
MetricName: Mandatory training compliance

5/1/2020 – 6/1/2022

90.54%	85%	86.67%	85%
KGH: Value	KGH: Target	NGH: Value	NGH: Target

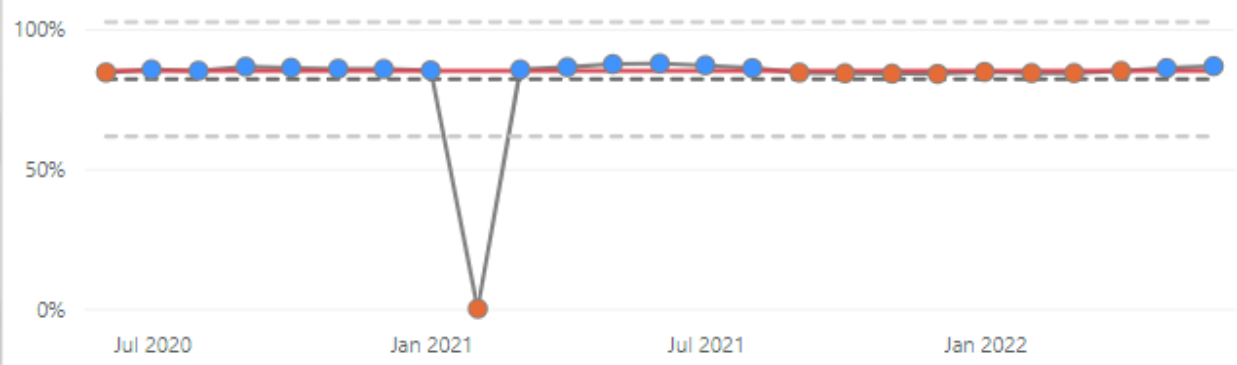
Kettering General Hospital

Mandatory training compliance: People



Northampton General Hospital

Mandatory training compliance: People



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	% of staff compliant with their mandatory training	Compliance has maintained this period to 90.54% and remain above target (85%). All areas of the Trust are reporting greater than 85%. IG has been a focus with achievement of the National reporting bench mark of >95%. all areas other than Resus report at >85%.	Workforce pressures make it very difficult to release staff for face to face resus training.	Continue with personal support and reminders to individuals. Newly trained trainers who are providing local delivery of resus training to offer access to local training.	90.54% of staff compliant - maintain focus
NGH	% of staff compliant with their mandatory training	Variation: Special cause of improving nature or lower pressure due to (H)igher values Assurance: Variation indicates inconsistently hitting passing and falling short of the target	This month's training rates are at 86.60% which is above the trust target of 85%. Manual handling compliance has increased to 80.52% with work on-going. Further support is being given to areas that are showing low compliance to understand reasons and to work with these areas to provide solutions.		

Appraisal completion rates

Group Metric Category: All

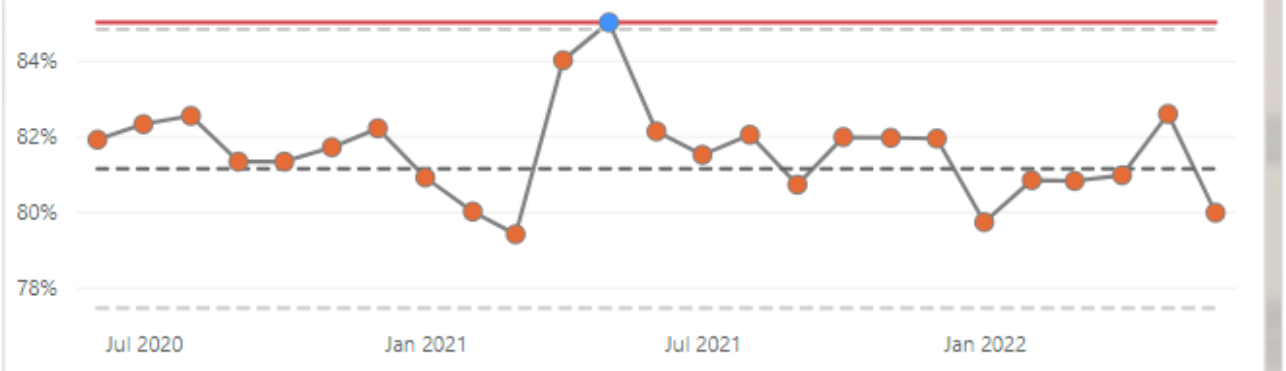
MetricName: Appraisal completion rates

5/1/2020 – 6/1/2022

79.97%	85%	76.78%	85%
KGH: Value	KGH: Target	NGH: Value	NGH: Target

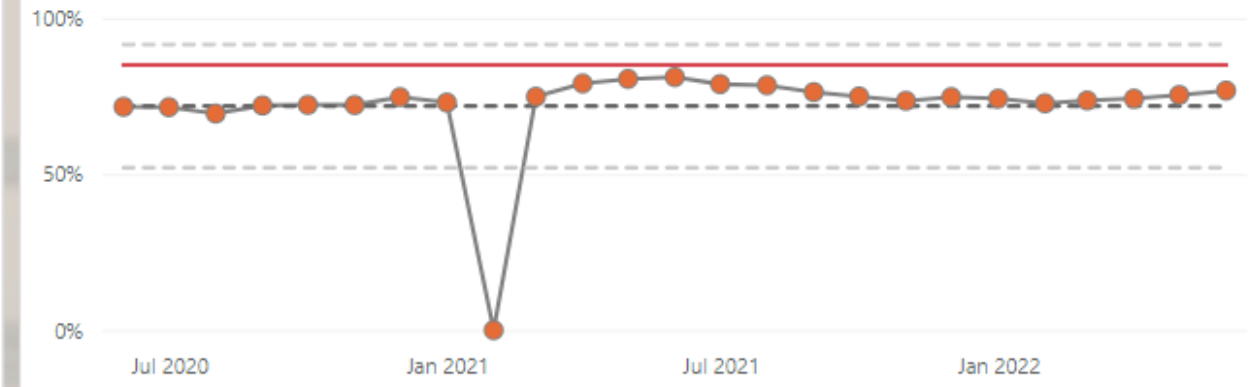
Kettering General Hospital

Appraisal completion rates: People



Northampton General Hospital

Appraisal completion rates: People



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	% of staff having completed their appraisal	Appraisal rates are showing common cause variation but have fallen this month to 79.97% (against a target of 85%)	Workforce pressures are making it difficult for managers and staff to find time for appraisal conversations.	Work is ongoing to support areas of concern and to develop tools across the Group to support improvement. We continue to offer Appraisal Light as an option.	79.97% of staff compliant with appraisals - increase and sustain focus
NGH	% of staff having completed their appraisal	Variation: Special cause of improving nature or lower pressure due to (H)igher values Assurance: Variation indicates inconsistently hitting passing and falling short of the target	This month's appraisal rate is at 76.61% against the 85% target. Working with the Automation team we have created a robot which will automatically take the information from the Appraisal spreadsheet and record this in ESR. This means that instead of minimising the number of separate data sheets that can be received and actioned, managers can send their individual appraisal data straight to the inbox as well as their appraisal co-ordinator. A test is being planned for this month with which will determine when it goes live.		

Sickness and absence rate

Group Metric Category: All

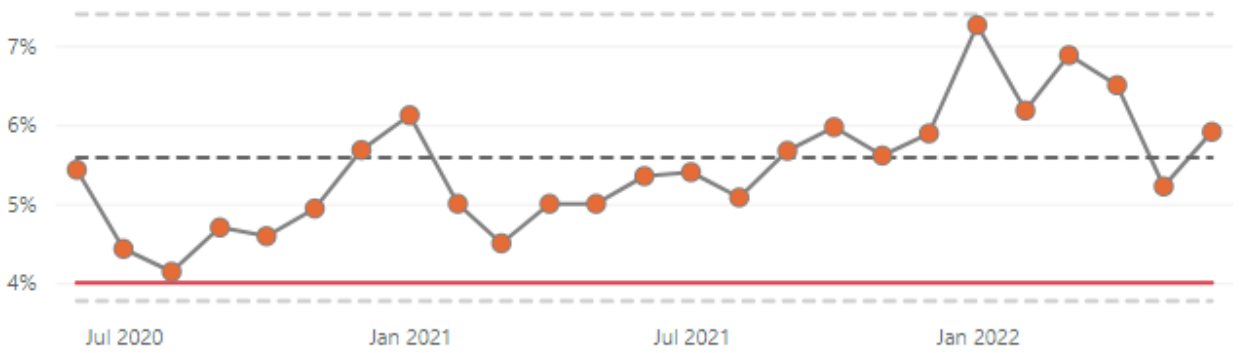
MetricName: Sickness and absence rate

5/1/2020 – 6/1/2022

5.91%	4%	6.19%	3.8%
KGH: Value	KGH: Target	NGH: Value	NGH: Target

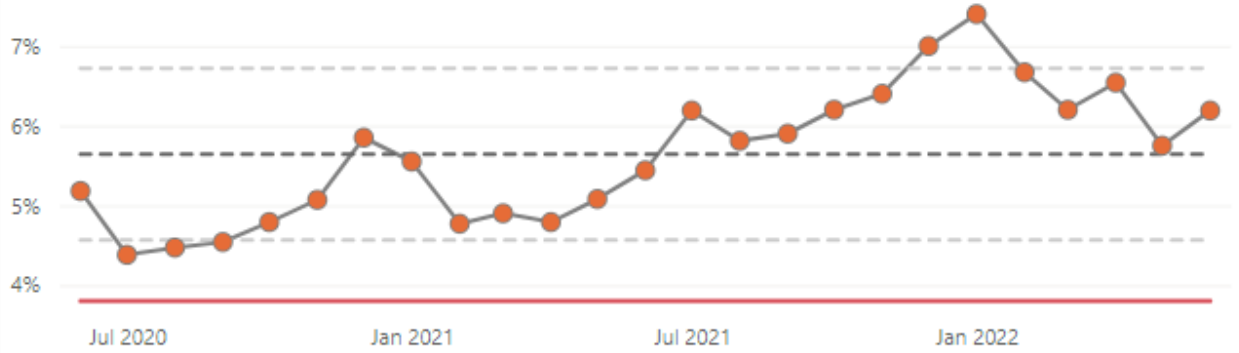
Kettering General Hospital

Sickness and absence rate: People



Northampton General Hospital

Sickness and absence rate: People



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	% of Staff absent	Sickness absence shows common cause variation (currently 5.91%; target 4%) and continues to be one of the main challenges for the Trust in managing staff availability.	The improvement seen in late spring is now reversed as the next wave of covid impacts absence rates which started to rise in June.	Our range of support measures continues for those needing psychological, emotional, financial or other support and the HR team are supporting managers with data to enable them to target interventions.	5.91% sickness rate overall - increase focus
NGH					
NGH	% of Staff absent	Variation: Special cause of concerning nature or higher pressure due to (H)igher values Assurance: Variation indicates consistently (F)alling short of the target	Sickness absence shows common cause variation (currently 6.21%; target 3.8%) . Both short and long term absence are a concern.	Our range of support measures continues for those needing psychological, emotional, financial or other support	we continue to work in partnership with KGH and wider system partners in delivering some of these services.

Vacancy rate

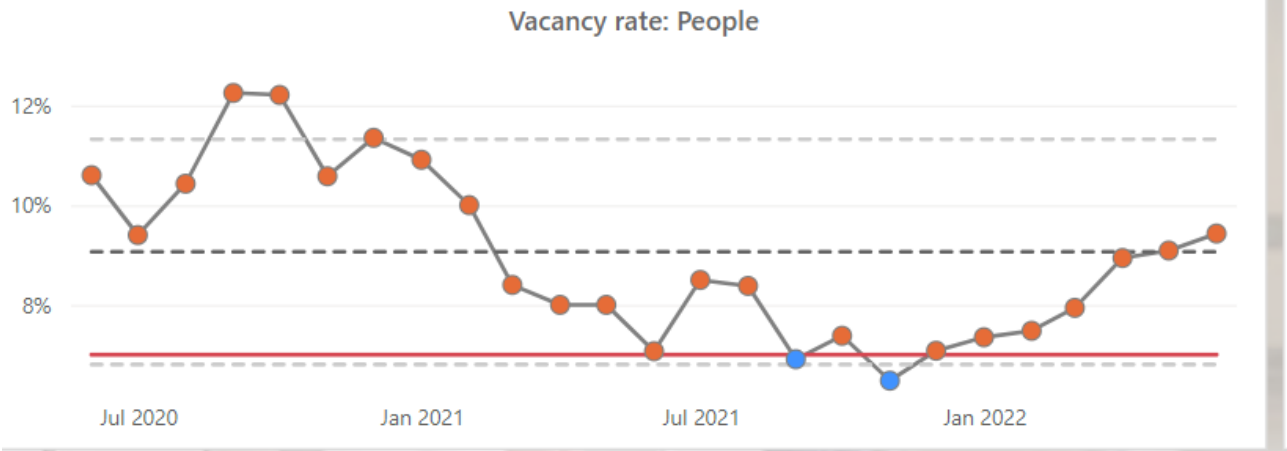
Group Metric Category: All

MetricName: Vacancy rate

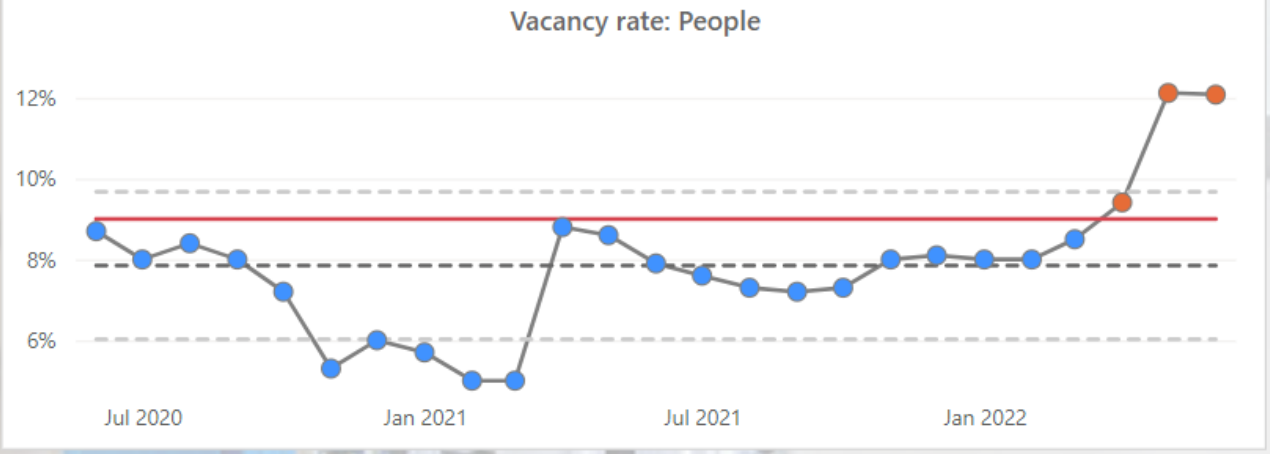
5/1/2020 – 6/1/2022

9.43%	7%	12.08%	9%
KGH: Value	KGH: Target	NGH: Value	NGH: Target

Kettering General Hospital



Northampton General Hospital



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH					
KGH	% difference between budgeted establishment and actual establishment	Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean at 9.40% against the Trust target of 7%	High vacancy in some staff groups especially HCA, therapists, facilities and some medical specialties. The high number of new starters in the organisation is causing pressures as existing staff seek to support.	Ongoing targeted campaigns for specific vacancies will be continuing to support an improved performance in 22/23. An increase in turnover following Covid-19 is having an impact on vacancy rates.	Recruitment and Education teams are working closely with Divisional leadership to ensure the pressures are managed and new starters are supported in their new roles.
NGH					
NGH	% difference between budgeted establishment and actual establishment	Variation: Special cause of concerning nature or higher pressure due to (H)igher values Assurance: Variation indicates inconsistently hitting passing and falling short of the target	Vacancies have seen an increase of 3.5% between March 22 and June 22 and currently stands at 12.35% against a target of 9%. Recruitment initiatives for HCAs and Portering have been undertaken resulting in a 160 HCAs and 53 porters going through clearance.		

Turnover rate

Group Metric Category: All

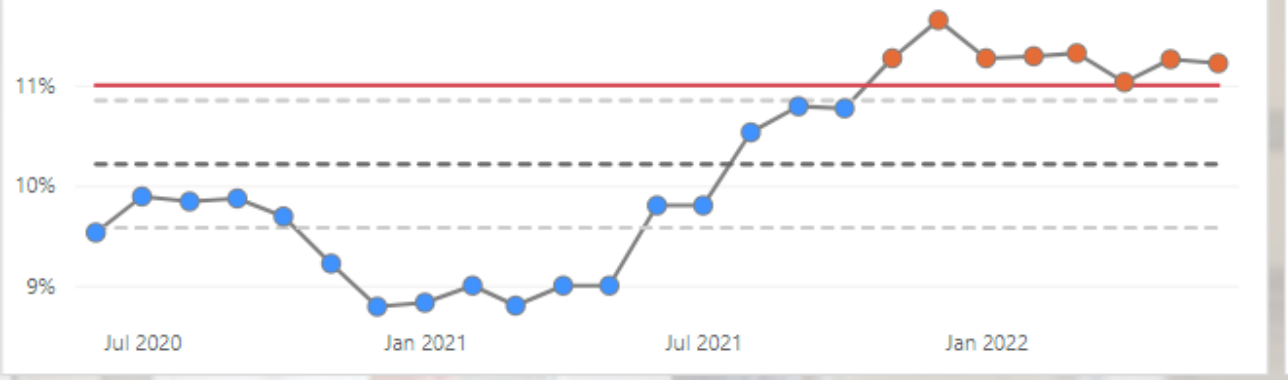
MetricName: Turnover rate

5/1/2020 – 6/1/2022

11.22%	11%	9.70%	10%
KGH: Value	KGH: Target	NGH: Value	NGH: Target

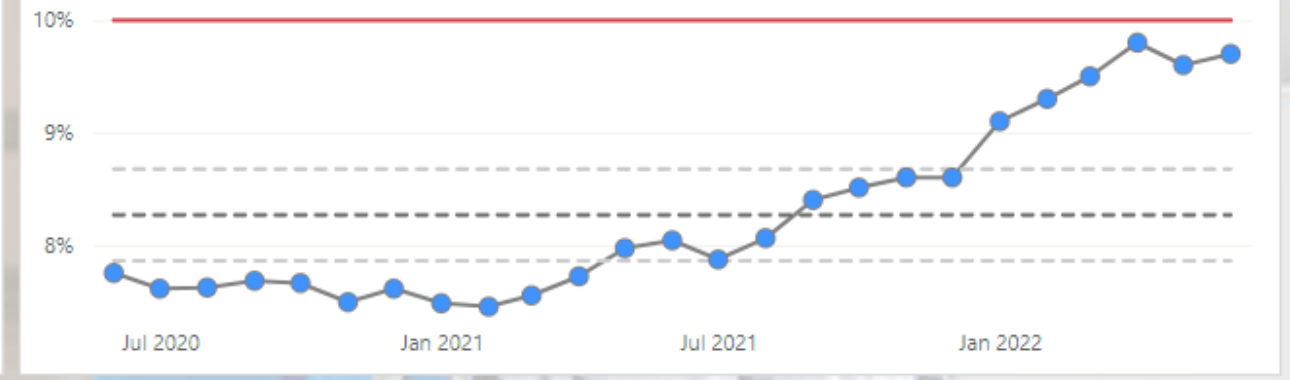
Kettering General Hospital

Turnover rate: People



Northampton General Hospital

Turnover rate: People



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	% of staff leaving the organisation over a 12 month rolling period	Turnover rates are showing Common Cause Variation and are at 11.20% against the Trust target of 11%	Turnover has been increasing since March 2021. The metric is still within common cause variation but is slightly outside of the Trust target. During Covid-19 we saw a reduction in turnover rates. Now that the labour market is returning to normal activity and society is living with Covid-19 people are reviewing their decisions to delay moving roles/retirement.	Work is being undertaken to review exit interviews to ensure feedback is being acted upon. Divisions are being asked to review any areas of concern following staff leaving. A deep dive into HCA recruitment and retention has been undertaken with several listening events and resulting feedback to formulate actions and a strategy to support this staff group.	Engagement with staff is still critical to understand staff views and reasons for leaving. The Staff Survey and Pulse Survey results have been received with Divisional Plans to improve and support staff experience.
NGH	% of staff leaving the organisation over a 12 month rolling period	Variation: Special cause of concerning nature or higher pressure due to (H)igher values Assurance: Variation indicates inconsistently hitting passing and falling short of the target	Turnover has been increasing month on month between August 21 and June 22 but remains below Trust target of 10% at 9.65%. Turnover has increased to higher levels than pre covid as the economy recovers and people who have delayed retirements are now choosing to retire.	Staff support and engagement	activities continue as part of our people plan strategy

Patient | People | Quality | Sustainability | Systems & Partnerships

Site	Metric	Latest Value
KGH	Serious or moderate harms	13
NGH	Serious or moderate harms	48
KGH	Serious or moderate harms – falls	0.13
NGH	Serious or moderate harms – falls	5
KGH	Serious or moderate harms – pressure ulcers	0.2
NGH	Serious or moderate harms – pressure ulcers	1
KGH	Number of medication errors	68
NGH	Number of medication errors	79
NGH	Hospital-acquired infections	0
KGH	Hospital-acquired infections	5
KGH	MRSA	1
NGH	MRSA	1
KGH	C Diff	1
NGH	C Diff	10
NGH	SHMI	91.6
KGH	SHMI	116.3
NGH	HSMR	90
KGH	HSMR	102.7
NGH	30 day readmissions	14.48%
KGH	30 day readmissions	18.96%
KGH	Never event incidence	0
NGH	Never event incidence	0

Metric	Comment
Falls:	In June there were two reported falls with moderate harm. A patient sustained a fractured humerus on Poplar which will continue as a local level investigation. A further patient sustained a fractured neck of femur on DDU which has been declared as a serious incident. All falls for June 2022 was 3.1 per 1000 bed days which is below the National Average.
Pressure Ulcers:	In June, the Trust reported two category two pressure ulcers against a current ceiling of seven and one unstageable pressure ulcer against a ceiling of 2 (Cat 3,4 and Unstageable inclusive). 2022-23 will be the first year that the Trust has included unstageable pressure ulcers. Ceilings for category two and category 3, 4 and unstageable include a 10 % reduction from 2021-22. It is recognised that this may not always be achieved on a month by month basis, however it is recommended that that this remains place for the first six months (31 October 2022) of the financial year and evaluated once six data points have been recorded at which time the committee may take a view that an adjustment is required if this proven to be too ambitious a target. To achieve this target, close monitoring of the data continues through the weekly review meeting which take place every Friday. From this, targeted improvement work led by the Divisions and supported by the Practice Development and Quality teams is being put in place on wards where a requirement for improvement is identified.
Infection Prevention & Control	Metrics agreed by KGH/NGH for IPC are: Hospital Acquired Infections - Defined as Patients experiencing a Gram negative hospital acquired infection: E-Coli, Pseudomonas aeruginosa and Klebsiella species = 5 in June 2022 COVID-19 % HOPA/HODA = 14.5 in June. There is no Nationally set ceiling - therefore no ceiling should be applied There have been seven COVID-19 outbreaks in June resulting in 20 HODA and 11 HOPA: Ashton Ward, Cranford Ward, Lamport Ward, Harrowden A, Sir Thomas Moore, Barnwell B and Pretty B. There has been one incidence of an MRSA bacteraemia on Harrowden A Ward. A full root cause analysis is being undertaken.

Committee Name
- Select all
- Integrated Governance Report (IGR)
- Joint Finance and Performance Committee (FPC)
- Joint People Committee (JPC)
- Joint Quality and Safety Committee (QSC)
- Trust Quality and Safety Committee (QSC)

Group
- Select all
- Patient
- People
- Quality
- Sustainability
- Systems and Partnerships

SITE
- Select all
- KGH
- NGH

Variation
- Select all
- Concern (High)
- Improvement (Low)
- Common Cause

Clear Filters

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance
NGH	Quality	Serious or moderate harms	01/06/22	48	0	0.38	11.24	22.1		
KGH	Quality	Serious or moderate harms	01/06/22	13	8	0.95	7.16	13.37		
KGH	Quality	Serious or moderate harms – falls	01/06/22	0.13	0.18	-0.19	0.14	0.47		
NGH	Quality	Serious or moderate harms – falls	01/06/22	5	0.06	-1.59	1.96	5.51		
KGH	Quality	Serious or moderate harms – pressure ulcers	01/06/22	0.2	0.69	0.15	0.58	1.02		
NGH	Quality	Serious or moderate harms – pressure ulcers	01/06/22	1	0	-3.96	2.36	8.68		
NGH	Quality	Number of medication errors	01/06/22	79	0	-9.87	19.28	48.43		
KGH	Quality	Number of medication errors	01/06/22	68	0	32.01	76.03	120.06		
NGH	Quality	Hospital-acquired infections	01/06/22	0	0	-2.87	1.56	5.99		
KGH	Quality	Hospital-acquired infections	01/06/22	5	7	2.76	8.27	13.78		
KGH	Quality	SHMI	01/06/22	116.3	100	103.55	107.09	110.63		
NGH	Quality	SHMI	01/06/22	91.6	100	94.51	96.92	99.32		
KGH	Quality	30 day readmissions	01/06/22	18.96%	12%	12.43%	18.46%	24.49%		
NGH	Quality	30 day readmissions	01/06/22	14.48%	12%	12.35%	14.75%	17.14%		
KGH	Quality	Never event incidence	01/06/22	0	0	-0.55	0.16	0.87		
NGH	Quality	Never event incidence	01/06/22	0	0	-0.61	0.28	1.17		

Serious or moderate harms

Group Metric Category: All

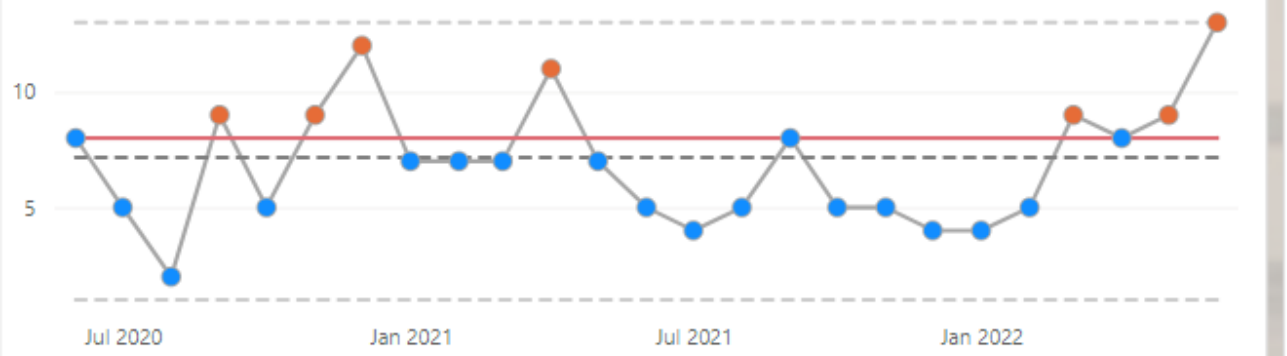
MetricName: Serious or moderate harms

5/1/2020 – 6/1/2022

13.00	8	48.00	0
KGH: Value	KGH: Target	NGH: Value	NGH: Target

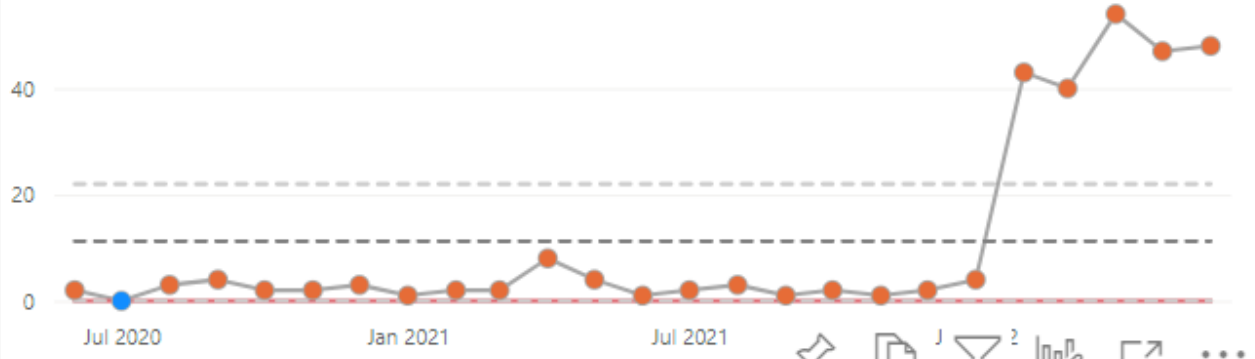
Kettering General Hospital

Serious or moderate harms: Quality



Northampton General Hospital

Serious or moderate harms: Quality



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Patients experiencing moderate, severe, catastrophic harm or patient death as a result of a patient safety incident.	The chart is showing common cause variation with variable assurance. The ceiling was set on the average based on Dec-19-Mar-22 numbers and may require revision.	KGH has an average reporting number of 6.85 for the time period Dec-19-Mar-22. 2020-2021 average reporting was 7.25. 2021-22 average reporting number was 6. KGH propose to set the ceiling at 8 pending review. Caution must be applied as harms levels can change pending investigation which may take several months.	The Trust recognises that there will be incidents that do not meet the Serious Incident reporting threshold. Where moderate harm has occurred, such incidents fall within the scope of the Policy For The Reporting And Management Of Serious Incidents, Never Events And Investigations Into Moderate Harm Incidents and its guidance, in terms of provision of root cause analysis investigations and evidence of assessment of harm and duty of candour by the Serious Incident Review Group (SIRG).	For the time period stated, moderate, severe, catastrophic harm or patient death as a result of a patient safety incident equate to 6.40% of all incidents with a patient harm incurred.
NGH	Patients experiencing moderate, severe, catastrophic harm or patient death as a result of a patient safety incident.	Variation: Special cause of concerning nature or higher pressure due to (H)igher values Assurance: Variation indicates consistently (F)alling short of the target			

Serious or moderate harms – falls

Group Metric Category: All

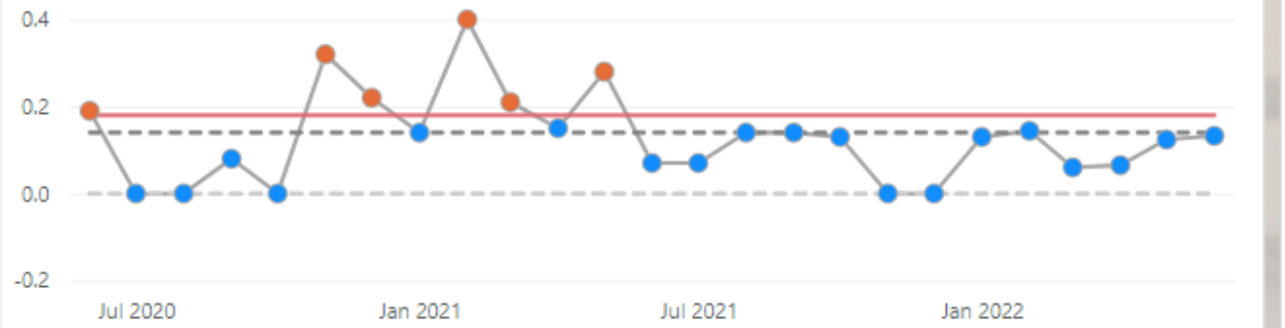
MetricName: Serious or moderate harms – falls

5/1/2020 – 6/1/2022

0.13	0.18	5.00	0.06
KGH: Value	KGH: Target	NGH: Value	NGH: Target

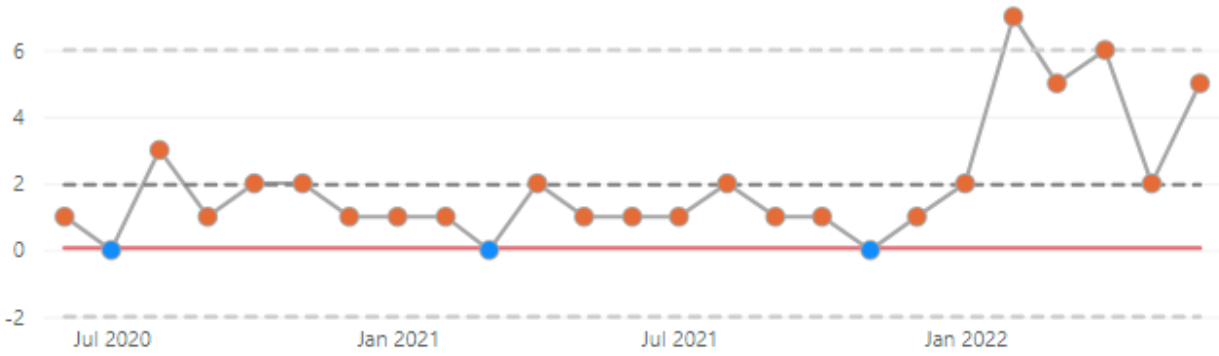
Kettering General Hospital

Serious or moderate harms – falls: Quality



Northampton General Hospital

Serious or moderate harms – falls: Quality



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Patients experiencing falls with moderate harm or above per 1000 bed days.	The chart is showing variable assurance, however demonstrating positive low variation since June 2020.	KGH have worked to a ceiling of 0.18 for many years. An agreed ceiling between KGH and NGH is required. KGH has recently aligned with NGH reporting methodology excluding near miss falls (patient lowered by staff or self) from all falls reporting.	The Trust continues with weekly harm free care meetings reviewing falls and pressure ulcer incidents and improvement actions.	Significant work has been undertaken over the last year, with a revision of paperwork and mandatory training for relevant staff.
NGH	Patients experiencing falls with moderate harm or above per 1000 bed days.	Variation: Common cause - no significant change Assurance: Variation indicates inconsistently hitting passing and falling short of the target			

Serious or moderate harms – pressure ulcers

Group Metric Category: All

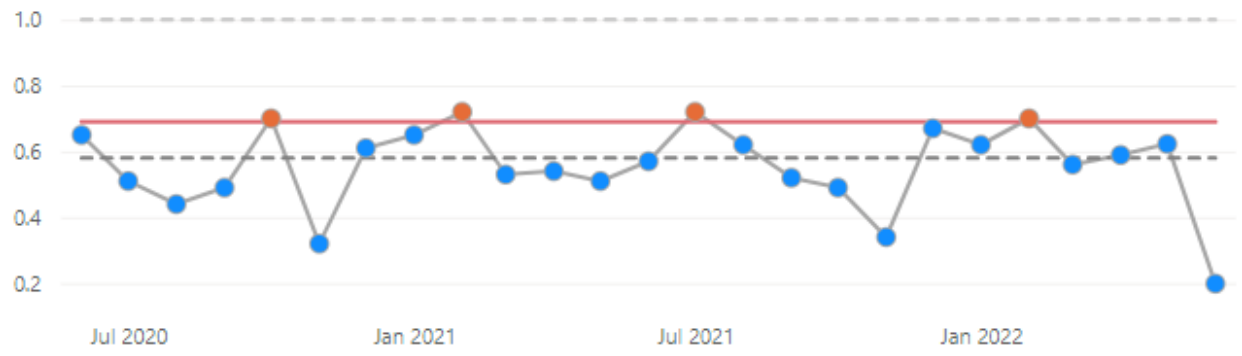
MetricName: Serious or moderate harms – pressure ulcers

5/1/2020 – 6/1/2022

0.20	0.69	1.00	0
KGH: Value	KGH: Target	NGH: Value	NGH: Target

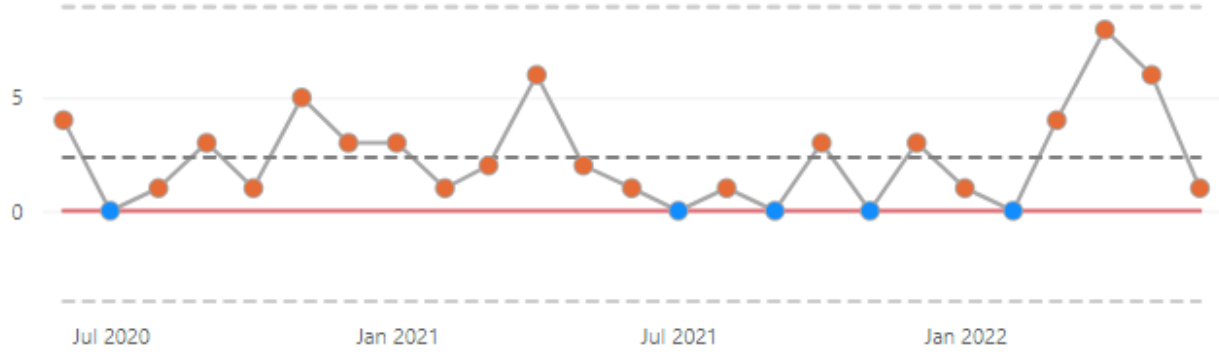
Kettering General Hospital

Serious or moderate harms – pressure ulcers: Quality



Northampton General Hospital

Serious or moderate harms – pressure ulcers: Quality



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Patients experiencing pressure tissue damage category 2, 3, 4 or unstageable developed or worsened in hospital per 1000 bed days. Not including moisture associated skin damage or deep tissue injury	The chart is showing common cause variation. The ceilings have been revised based on a reduction of 10% across all levels of categories.	With the development of the IGR, the defined metric has been agreed as: Patients experiencing pressure tissue damage category 2, 3, 4 or unstageable developed or worsened in hospital per 1000 bed days. (Not including moisture associated skin damage or deep tissue injury).	The SSKIN Risk Assessment and Care Plan are established and in use across the Trust. Compliance with this is now being monitored through the 'Perfect Ward' system.	The Tissue Viability Nurse reviews all Category 2 and above pressure ulcers, providing validation and education.
NGH	Patients experiencing pressure tissue damage category 2, 3, 4 or unstageable developed or worsened in hospital per 1000 bed days. Not including moisture associated skin damage or deep tissue injury	Variation: Common cause - no significant change Assurance: Variation indicates inconsistently hitting passing and falling short of the target			

Number of medication errors

Group Metric Category: All

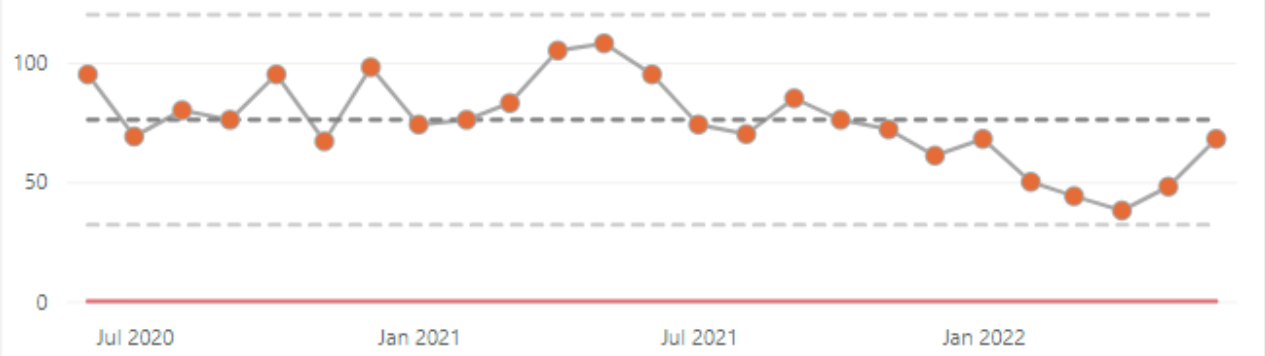
MetricName: Number of medication errors

5/1/2020 – 6/1/2022

68.00	0	79.00	0
KGH: Value	KGH: Target	NGH: Value	NGH: Target

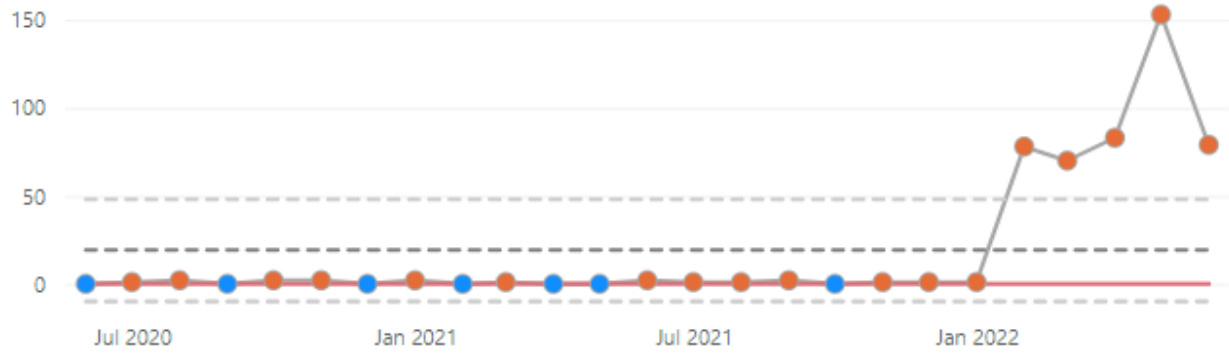
Kettering General Hospital

Number of medication errors: Quality



Northampton General Hospital

Number of medication errors: Quality



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Medication errors irrespective of subclass of incident (prescribing, dispensing, administering) and all levels of harm.	The Trust's attitude to Medication Safety. Increased reporting indicates a greater awareness of medicines safety issues and a desire to improve			
NGH	Medication errors irrespective of subclass of incident (prescribing, dispensing, administering) and all levels of harm.	Variation: Special cause of concerning nature or higher pressure due to (H)igher values Assurance: Variation indicates inconsistently hitting passing and falling short of the target			

Hospital-acquired infections

Group Metric Category: All

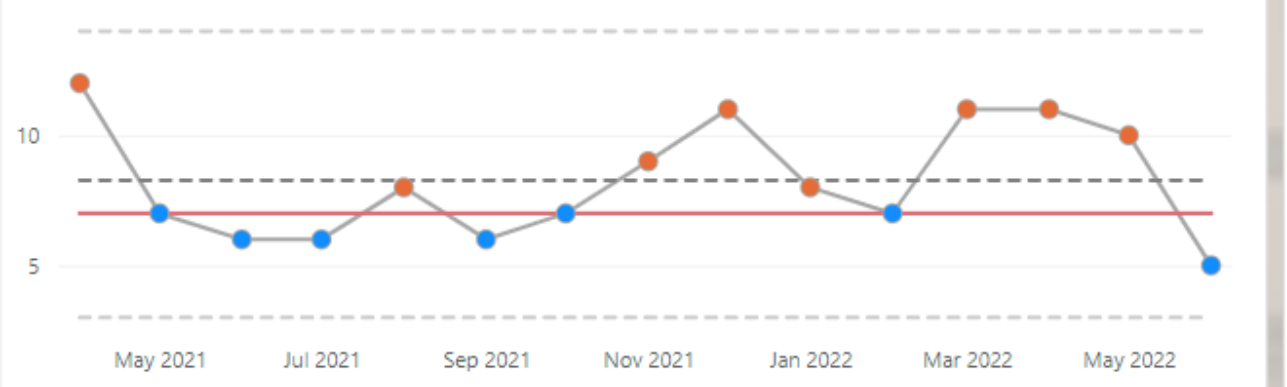
MetricName: Hospital-acquired infections

5/1/2020 – 6/1/2022

5.00	7	0.00	0
KGH: Value	KGH: Target	NGH: Value	NGH: Target

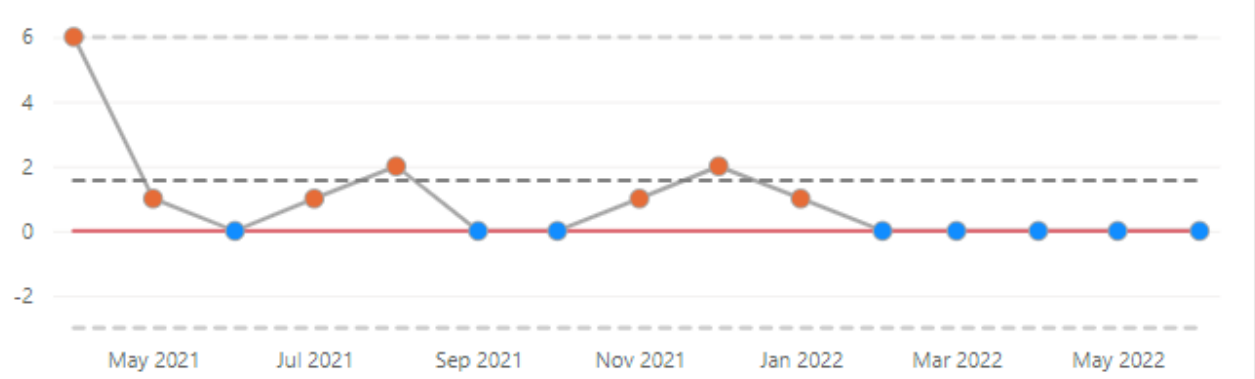
Kettering General Hospital

Hospital-acquired infections: Quality



Northampton General Hospital

Hospital-acquired infections: Quality



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Patients experiencing a Gram negative Hospital Onset Hospital Acquired (HOHA) or Community Onset Hospital Acquired (COHA) infection, defined as: E-Coli, Pseudomonas aeruginosa and Klebsiella species.	The chart is showing common cause variation and variable assurance.	2021-22 was completed with 59 E. Coli cases (26 HOHA and 33 COHA) being reported which was below the ceiling set by the CCG of 68. 2022-23 to date (April-June) has seen 20 cases (11 HOHA and 9 COHA) reported against the first quarter ceiling of 14 with a final annual ceiling of 55 set by the CCG.	The IPC team are working to support the reduction of Gram-Negative infections as part of the wider HCAI reduction plan for 2022-2023, which is monitored through the Infection Prevention Steering Group.	All HOHA cases are investigated by the IPC team and, depending on the source of the bacteraemia, a post infection review is complete to look for any lapses in care.
NGH	Patients experiencing a Gram negative hospital acquired infection, defined as: E-Coli, Pseudomonas aeruginosa and Klebsiella species.	Variation: Common cause - no significant change Assurance: Variation indicates inconsistently hitting passing and falling short of the target			

SHMI

NHS University Hospitals of Northamptonshire NHS Group

Group Metric Category: All

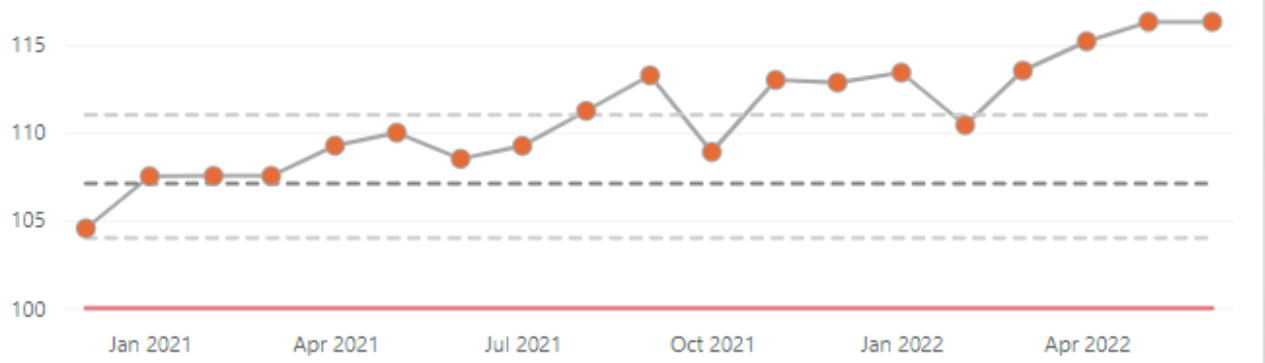
MetricName: SHMI

5/1/2020 – 6/1/2022

116.30	100	91.60	100
KGH: Value	KGH: Target	NGH: Value	NGH: Target

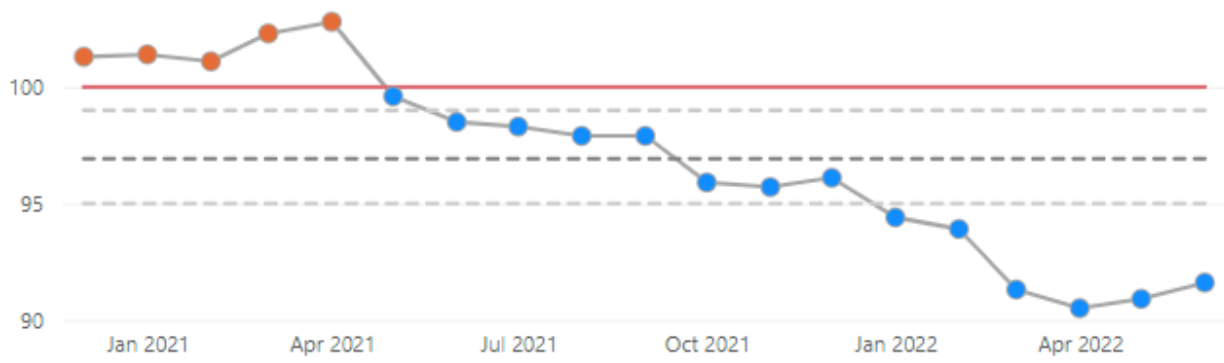
Kettering General Hospital

Summary Hospital-level Mortality Indicator: Quality



Northampton General Hospital

Summary Hospital-level Mortality Indicator: Quality



SHMI

Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Summary Hospital-Level Mortality Indicator (SHMI) is an indicator of healthcare quality that measures whether the number of deaths in hospital, or within 30 days of patients leaving hospital, is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. A higher score means more deaths; a lower score, fewer. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. SHMI takes into account more variables particularly co-morbidities and the emergency/elective split of admissions. SHMI records deaths up to 30 days post discharge, combining national HES data with data from the Office of National Statistics. The death is attributed to last admitting Trust and includes all diseases in diagnostic groups and all palliative care patients. The SHMI is produced and published quarterly. SHMI data covers the Mortality period which is 5 months behind. So Jun 22 data covers period Feb 21 to Jan22.	SHMI for KGH is 116.3 (above expected) as reported Jun 22. This is covering the period - February 21 - January 22.	- SHMI is above expected in Acute Bronchitis (137.20) & Pneumonia groups (131.06). - If Covid Pneumonia is excluded SHMI falls in 'as Expected range'. - The Expected deaths (based on case complexity) for KGH are considerably lower than the Peers prompting review of coding & Data Quality. - KGH provider spells with palliative care admissions and percentage of palliative care deaths remain higher than the national average. - SHMI for Acute Myocardial Infarction lowest in the region (74.66)	All Death are reviewed by Medical Examiners and no death is deemed avoidable for the reported period. However, we are conducting a Deep Dive into Mortality to address rising SHMI and identify areas for improvement including review of: - Leadership & Governance: - Enhancing Quality & Safety: - Learning & Training - Data Quality & Coding:	All Death are reviewed by Medical Examiners and no death is deemed avoidable for the reported period. In addition SJR & Panel reviews takes place where required. Further escalation to SIRG reviews of all cases of potential resulting in full investigation and lessons learned. Any key messages/lessons learned shared through departmental M&M, Junior Dr Forum and Patient Safety Lessons learned forum. Learning from Death Group and Deteriorating patient Group have been set up
NGH		Variation: Special cause of improving nature or lower pressure due to (L)ower values Assurance: Variation indicates consistently (P)assing the target			

30 day readmissions

Group Metric Category: All

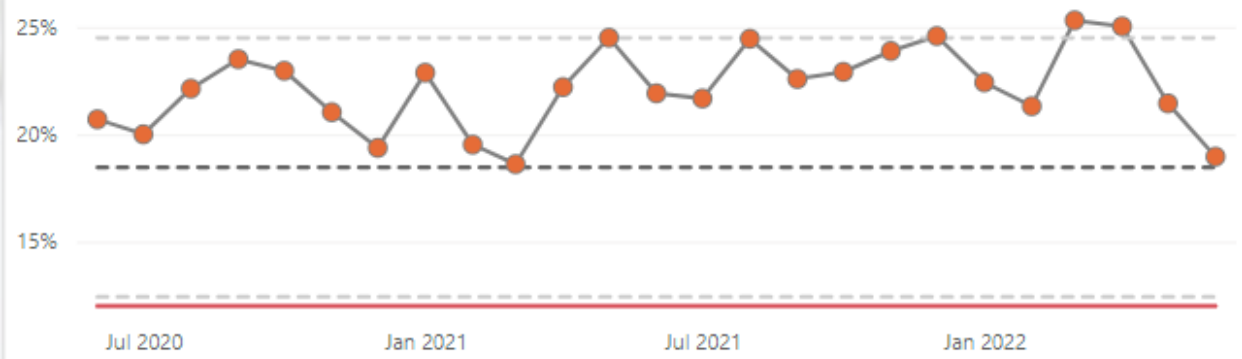
MetricName: 30 day readmissions

5/1/2020 – 6/1/2022

18.96%	12%	14.48%	12%
KGH: Value	KGH: Target	NGH: Value	NGH: Target

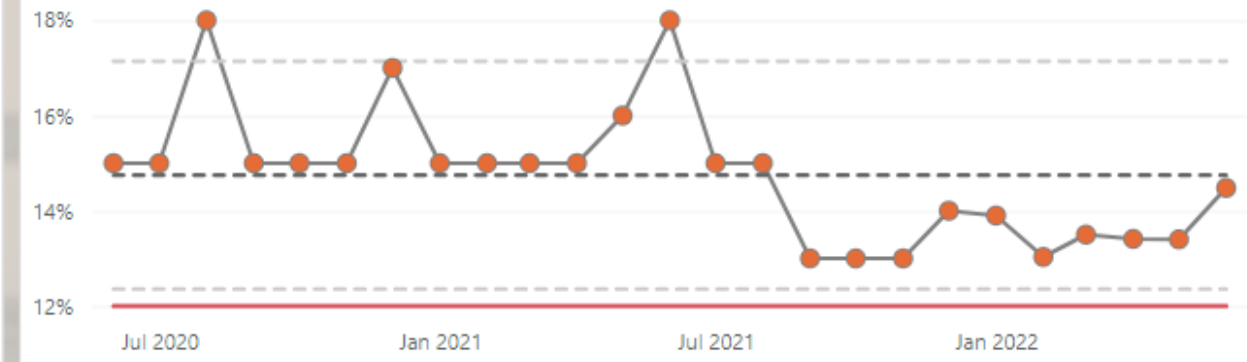
Kettering General Hospital

30 day readmissions: Quality



Northampton General Hospital

30 day readmissions: Quality



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Number of patients readmitted within 30 days of discharge	Readmissions have reduced consistently over the last 4 months to 19% still above target of 12%	Readmissions still remain above target	ongoing work with partners to strengthen discharge pathways and identify issues/ actions via discharge governance meeting	
NGH		Variation: Special cause of improving nature or lower pressure due to (L)ower values Assurance: Variation indicates consistently (F)alling short of the target			

Never event incidence

Group Metric Category: All

MetricName: Never event incidence

5/1/2020 – 6/1/2022

0.00	0	0.00	0
KGH: Value	KGH: Target	NGH: Value	NGH: Target

Kettering General Hospital

Never event incidence: Quality

Northampton General Hospital

Never event incidence: Quality

Never event incidence

Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Number of Never Events Reported. A never event is the "kind of mistake that should never happen" in the field of medical treatment where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.	The chart show common cause variation with variable assurance.	The Trust has experienced five Never Events since March 2021 after a period of showing low positive assurance from January 2020. 2021/4779 [WEB126862] – Medicine Division. Reported on 02/03/2021. Unintentional connection of a patient requiring oxygen to an air flowmeter. Low Harm. 2021/8904 [WEB128830] – Surgery Division. Reported on 26/04/2021. Wrong site surgery. Lucentis injection administered into the incorrect eye. Moderate harm. 2021/12906 [WEB130772] – Surgery Division. Reported on 21/06/2021. Wrong site surgery. Intravitreal Injection administered to the eye of the wrong patient as scans recorded with the previous patients' details. No harm. 2021/16393 [WEB132549] – Reported on 09/08/2021 Surgery Division. Oral medication was administered into a vascular access device. Low harm. 2021/21740 [WEB135321] – Reported on 25/10/2021 Family Health Division. Oral medication was administered into a vascular access device. Low harm.	All Never Events are investigated using robust Root Cause Analysis. Learning is shared in the Incident Learning Bulletins, Patient Safety Hot Topics and on the Trust Learning from Investigations page on K-Net.	There has been a Trust wide review to ensure that Air ports are removed where not needed, or are capped off to prevent inadvertent connection. A trust review has been made to review all imaging practices to ensure patients and imaging are linked. An external review by the Clinical Senate for Ophthalmology has been undertaken. Information regarding the root cause of the two medication incidents has been widely shared and the availability of enteral syringes reviewed.
NGH	Number of Never Events Reported. A never event is the "kind of mistake that should never happen" in the field of medical treatment where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.	Variation: Common cause - no significant change Assurance: Variation indicates inconsistently hitting passing and falling short of the target			

Patient | People | Quality | Sustainability | Systems & Partnerships

Site	Metric	Latest Value
KGH	Income YTD (£000's)	31881
NGH	Income YTD (£000's)	37607
NGH	Pay YTD (£000's)	-26646
KGH	Pay YTD (£000's)	-20567
KGH	Non Pay YTD (£000's)	-10010
NGH	Non Pay YTD (£000's)	-9967
NGH	Bank and Agency Spend (£000's)	-5556
KGH	Bank and Agency Spend (£000's)	-3092
KGH	Beds available	515
NGH	Beds available	689.97
KGH	Theatre sessions planned	348
NGH	Theatre sessions planned	2508
KGH	A&E activity (& vs plan)	106.4%
NGH	A&E activity (& vs plan)	106.3%
NGH	Non-elective activity (& vs plan)	105.87%
KGH	Non-elective activity (& vs plan)	129.6%
KGH	Elective inpatient activity (& vs plan)	80%
NGH	Elective inpatient activity (& vs plan)	120.83%
KGH	Elective day-case activity (& vs plan)	102%
NGH	Elective day-case activity (& vs plan)	103.58%
NGH	Outpatients activity (& vs plan)	95.11%
KGH	Outpatients activity (& vs plan)	98.18%

Metric	Comment
M3 Position:-	The Trust saw an adjusted I&E deficit of £0.15m in M3 against a planned surplus of £0.55m, resulting in a £0.7m adverse variance. The unfavourable position is due to unachieved ERF and non pay inflationary pressures.
YTD Position:-	The Trust saw an adjusted I&E deficit of £7.23m YTD against a planned deficit of £6.04m, resulting in a £1.19m adverse variance. Underspends within pay have partially offset an under achievement on M3 ERF targets and increased non pay inflationary pressures.
Income:-	YTD has seen a £1.4m underperformance against plan. This is largely due to unachieved ERF targets. The activity position has not yet been verified, and it was deemed prudent to only assume 25% ERF income recovery at this time.
Non Pay:-	YTD is £1.0m adverse to Plan YTD largely due to increased inflationary pressures within utilities & supplies being partially offset by underspends within drugs & supplies due to lower than planned activity.
Pay:-	YTD is £1.1m favourable to plan. Key pressures remain due to continued covid sickness cover, increased Corporate, Digital and Estates agency usage and premium payments for medical vacancies which are being offset by underspends due to vacancies across all Divisions.

Committee Name
- Select all
- Integrated Governance Report (IGR)
- Joint Finance and Performance Committee (FPC)
- Joint People Committee (JPC)
- Joint Quality and Safety Committee (QSC)
- Trust Quality and Safety Committee (QSC)

Group
- Select all
- Patient
- People
- Quality
- Sustainability
- Systems and Partnerships

SITE
- Select all
- KGH
- NGH

Variation
- Select all
- Concern (Low)
- Neither (High)
- Neither (Low)
- Common Cause

Clear Filters

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance
KGH	Sustainability	Bank and Agency Spend (£000's)	01/06/22	-3092	-2375	-2889.06	-1993.3	-1097.54		
NGH	Sustainability	Bank and Agency Spend (£000's)	01/06/22	-5556	0.08	-5977.07	-4795.77	-3614.47		
KGH	Sustainability	A&E activity (& vs plan)	01/06/22	106.4%		91.39%	102.71%	114.04%		
NGH	Sustainability	A&E activity (& vs plan)	01/06/22	106.3%		73.05%	86.33%	99.6%		
NGH	Sustainability	Non-elective activity (& vs plan)	01/06/22	105.87%		74.96%	90.33%	105.69%		
KGH	Sustainability	Non-elective activity (& vs plan)	01/06/22	129.6%		116.92%	129.68%	142.44%		
NGH	Sustainability	Elective inpatient activity (& vs plan)	01/06/22	120.83%		46.42%	82.09%	117.76%		
KGH	Sustainability	Elective inpatient activity (& vs plan)	01/06/22	80%		69.63%	100.76%	131.89%		
NGH	Sustainability	Elective day-case activity (& vs plan)	01/06/22	103.58%		58.11%	82.72%	107.32%		
KGH	Sustainability	Elective day-case activity (& vs plan)	01/06/22	102%		81.59%	156.52%	231.44%		
KGH	Sustainability	Outpatients activity (& vs plan)	01/06/22	98.18%		82.36%	139.64%	196.93%		
NGH	Sustainability	Outpatients activity (& vs plan)	01/06/22	95.11%		79.2%	107.26%	135.32%		

Bank and Agency Spend (£000's)

Group Metric Category: All

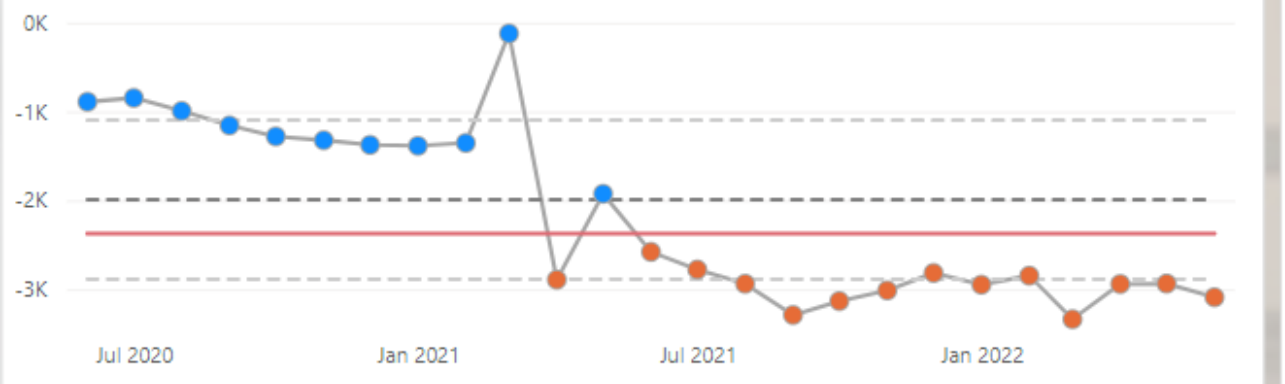
MetricName: Bank and Agency Spend (£000's)

5/1/2020 – 6/1/2022

-3,092.00	-2375	-5,556.00	0.08
KGH: Value	KGH: Target	NGH: Value	NGH: Target

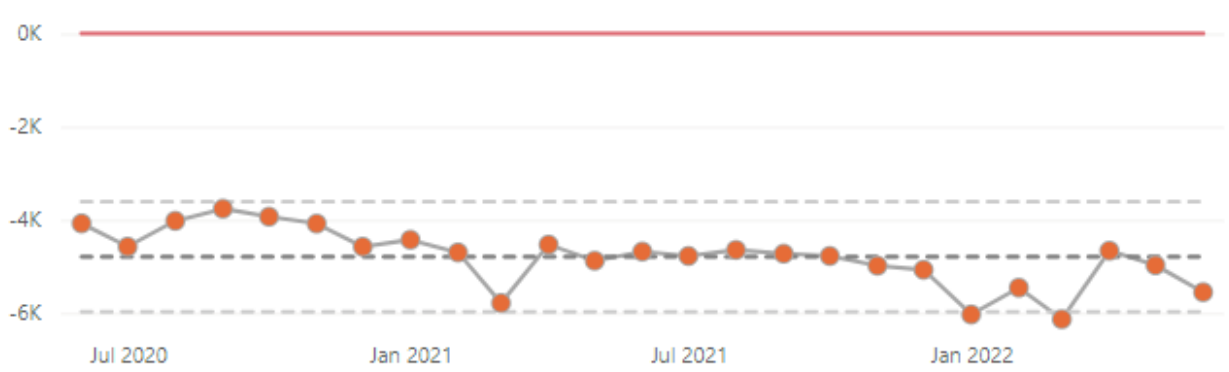
Kettering General Hospital

Bank and Agency Spend (£000's): Sustainability



Northampton General Hospital

Bank and Agency Spend (£000's): Sustainability



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	22/23 Bank & Agency Costs vs Plan	Bank & agency pay is £1.5m adverse to plan YTD (£1m bank and £0.5m agency).	Increased agency usage above plan wthin Corporate, Estates and Digital is a concern.	Review all agency usage to ensure recruitment plans are in place.	Review all agency usage to ensure recruitment plans are in place.
NGH	22/23Bank & Agency Costs vs Plan and comparison to the NHSE/I Agency Ceiling of £10.8m				

A&E activity (& vs plan)

Group Metric Category: All

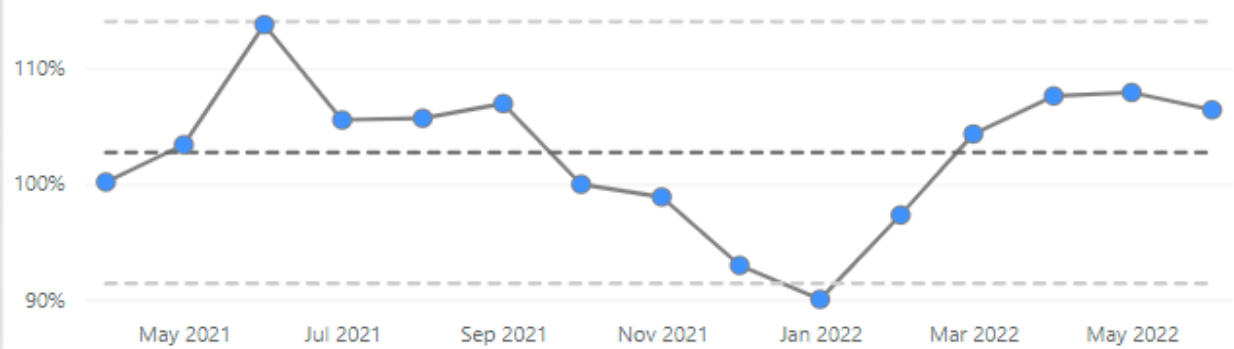
MetricName: A&E activity (& vs plan)

5/1/2020 – 6/1/2022

106.40%		106.30%	
KGH: Value	KGH: Target	NGH: Value	NGH: Target

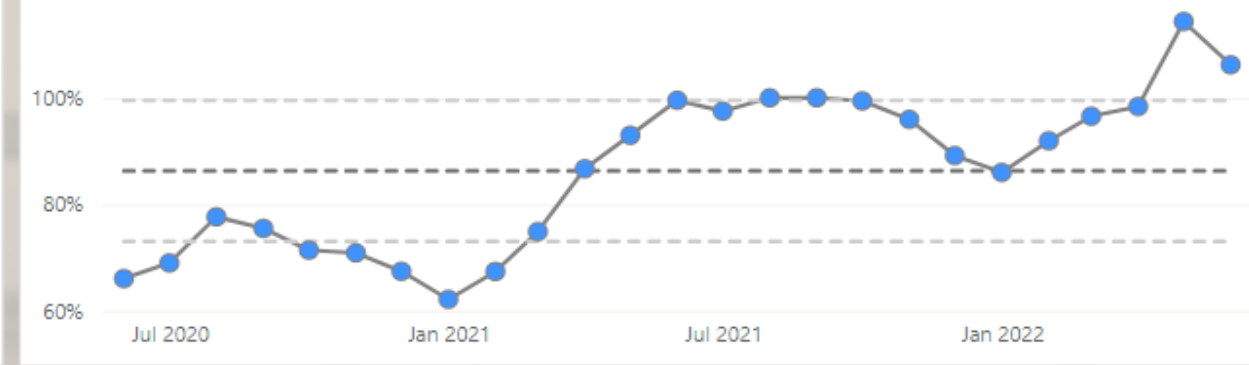
Kettering General Hospital

A&E activity (actual vs plan): Sustainability



Northampton General Hospital

A&E activity (actual vs plan): Sustainability



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	A&E attendances	The chart tell us that ED attendances in June = 9293, and in the last 6 months we have seen a 14.5% increase in attendance figures	Challenges with overcrowding in waiting areas remains, with an average daily attendance >300 per day during June, on some days we have seen activity >350 creating enormous pressure on our Emergency Department to safely manage the patient footfall.	Ongoing collaborative work with EMAS and CUCC via working group Working with EMAS to increase the number of direct EMAS conveyances to MSDEC, and/or stream directly from ED at the point of arrival as appropriate Anticipated opening of our new front door w/c 11th July Launch of our new Ambulatory Majors process to support effective streaming and management of patients; whilst maximising use of our ED footprint. External comms work to promote 111 pathways as an alternative for patients who would ordinarily attend ED	1. Safety Huddles in the department with NIC/DIC/Flow coordinator and Site team 2. Escalation policies in place 3. Maximising use of streaming pathways
NGH	ED attendances	continues to be increased number of attendances	Continued high number of attendances, space limitations due to covid restrictions, significant increase in paediatric attendances with no increase in medical staffing for the stand alone unit means during periods of high paeds ED demand staffing has to be moved from main ED to support.	ongoing work further enhancing SDEC utlisation. Continued work with EMAS and primary care to enable direct access to SDEC.	conversion rate has reduced from 19.52% June 2021 to 14.28% June 2022. this indicates that the continued development of SDEC and streaming is effective and admission avoidance focus is not just evident for this month but sustained for the previous 4 months.

Non-elective activity (& vs plan)

Group Metric Category: All

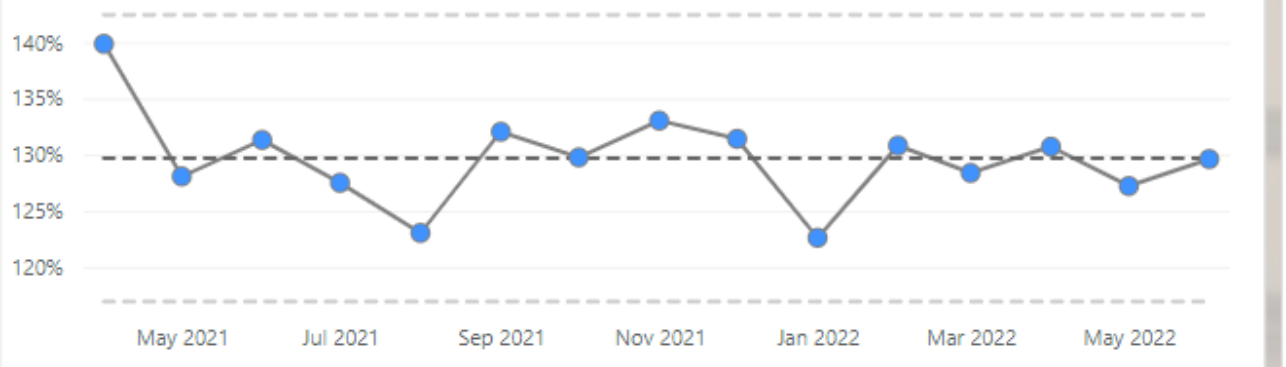
MetricName: Non-elective activity (& vs plan)

5/1/2020 – 6/1/2022

129.60%		105.87%	
KGH: Value	KGH: Target	NGH: Value	NGH: Target

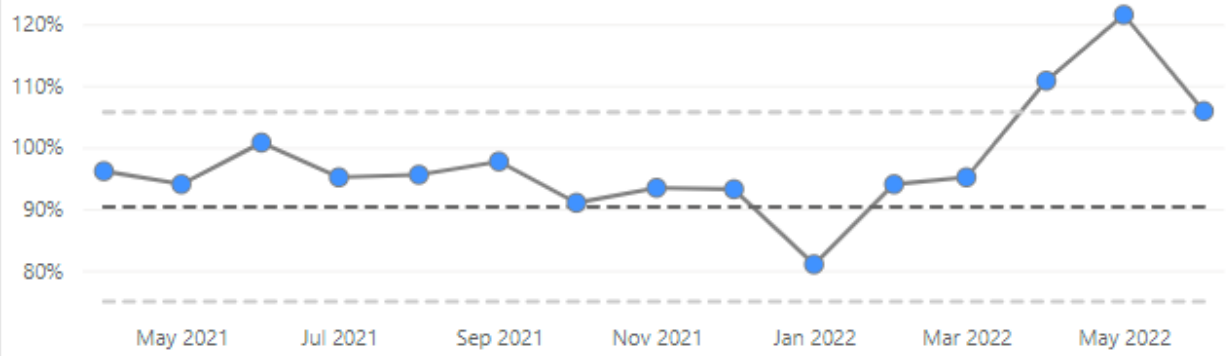
Kettering General Hospital

Non-elective activity (actual vs plan): Sustainability



Northampton General Hospital

Non-elective activity (actual vs plan): Sustainability



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Non-elective activity is all the patients admitted to inpatient areas with a non-elective/emergency admission method.	The data demonstrates a 129.6% delivery of actual vs plan - actual 2414 vs 1863 plan.	There is work to do to understand the ssumptions that amke up the lan and triangulate against a significant decrease in the ED conversion rate to a mean of 22% in 2022 to date compared to a mean of 32% in 2019.	Deep Dive into the data to establish the assumptions and actions to be develped as appropriate. Work continues to support robust bed modelling.	Non-elective activity vs pan to be monitired through divisional and trust governance.
NGH	Non-elective activity is all the patients admitted to inpatient areas with a non-elective/emergency admission method.				

Elective inpatient activity (& vs plan)

Group Metric Category: All

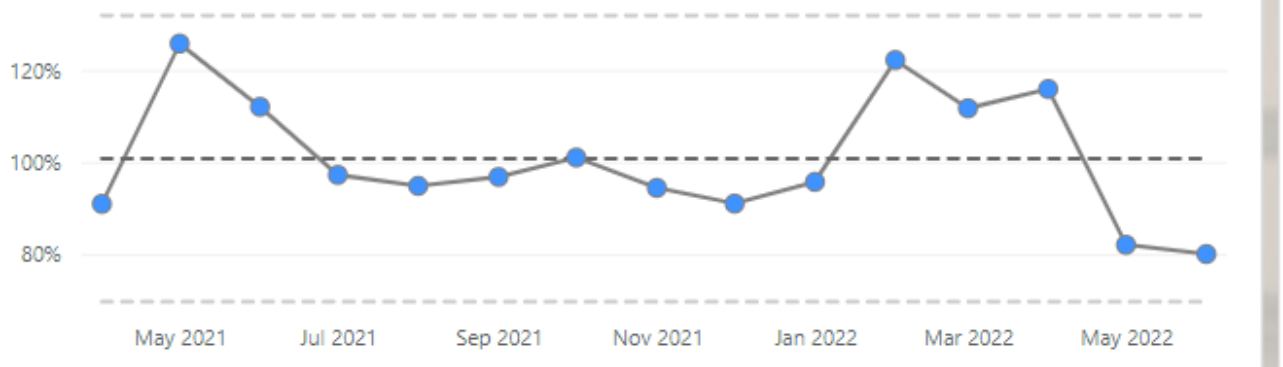
MetricName: Elective inpatient activity (& vs plan)

5/1/2020 – 6/1/2022

80.00%		120.83%	
KGH: Value	KGH: Target	NGH: Value	NGH: Target

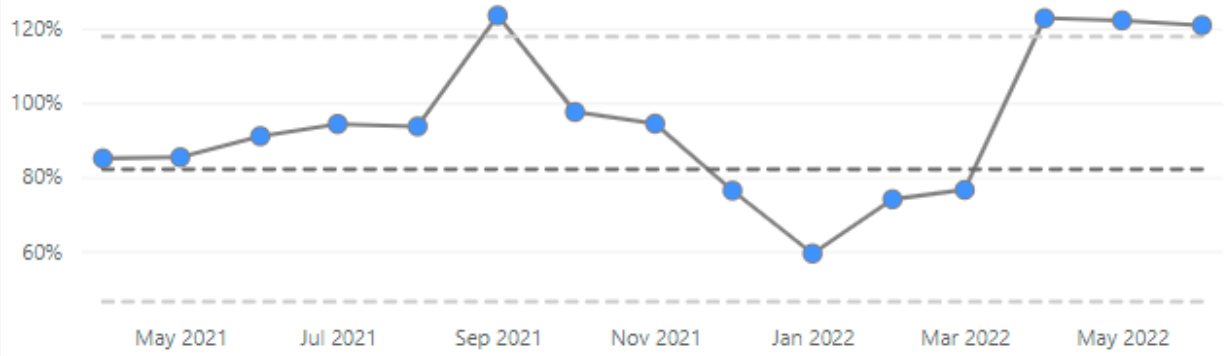
Kettering General Hospital

Elective inpatient activity (actual vs plan): Sustainability



Northampton General Hospital

Elective inpatient activity (actual vs plan): Sustainability



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Elective inpatient activity actuals v plan	The chart tells us that inpatient activity is at 80% of plan for June (though when combined with day cases, the Trust is achieving 100% of elective plan)	Elective inpatient and day case activity has been adversely affected by Covid infections amongst staff (including surgeons), theatre and anaesthetic staff availability and a significant increase in trauma activty, particularly affecting Trauma and Orthopaedics	Weekly Reset meeting examines specialties where activity is below plan and requires actions to be taken - chaired by Deputy COO. Detailed analysis of activity by HRG requested of Health Intelligence to ensure coding is maximising opportunity in counting activity.	Backfilling of lists takes place wherever possible with alignment of unavailability through staffing with Covid-affected lists wherever possible to minimise disruption
NGH	Elective inpatient activity actuals v plan	The Trust saw 121% of its Elective day case activity vs plan during June 22	A 5 month increase in activity has enabled us to meet the target	Weekly monitoring in place with Divisional PTL's and a weekly Access Board meeting where acivity vs plan is a standing agenda item	

Elective day-case activity (& vs plan)

Group Metric Category: All

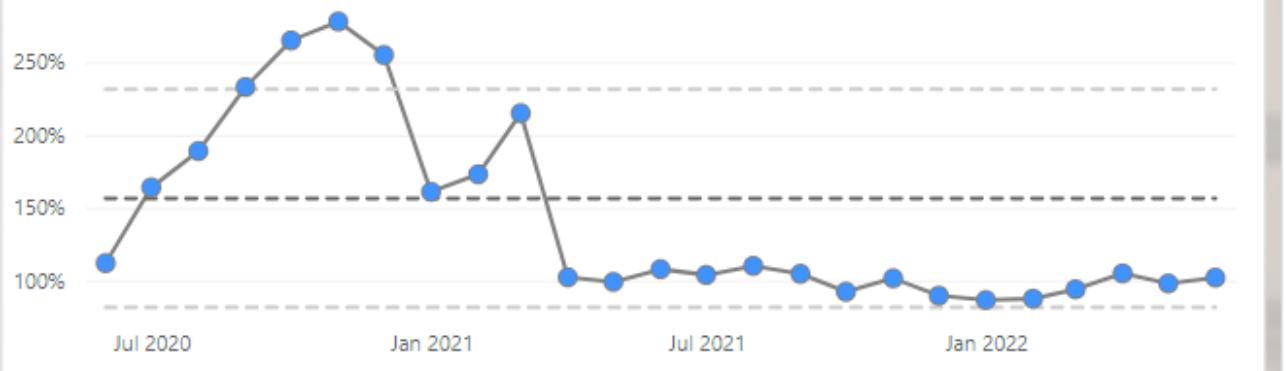
MetricName: Elective day-case activity (& vs plan)

5/1/2020 – 6/1/2022

102.00%		103.58%	
KGH: Value	KGH: Target	NGH: Value	NGH: Target

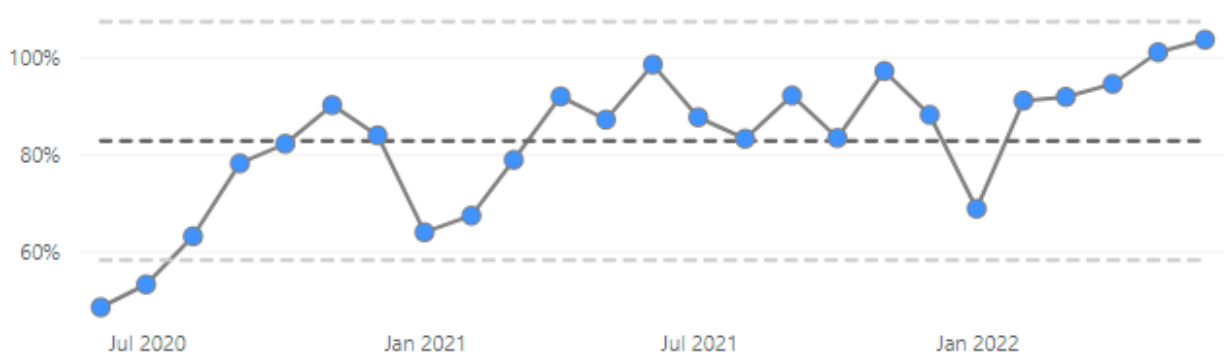
Kettering General Hospital

Elective day-case activity (actual vs plan): Sustainability



Northampton General Hospital

Elective day-case activity (actual vs plan): Sustainability



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Elective day case activity actuals v plan	The chart tells us that day case activity is at 102% of plan for June (though when combined with inpatients, the Trust is achieving 100% of elective plan)	Elective inpatient and day case activity has been adversely affected by Covid infections amongst staff (including surgeons), theatre and anaesthetic staff availability and a significant increase in trauma activty, particularly affecting Trauma and Orthopaedics	Weekly Reset meeting examines specialties where activity is below plan and requires actions to be taken - chaired by Deputy COO. Detailed analysis of activity by HRG requested of Health Intelligence to ensure coding is maximising opportunity in counting activity.	Backfilling of lists takes place wherever possible with alignment of unavailability through staffing with Covid-affected lists wherever possible to minimise disruption
NGH	Elective day case activity actuals v plan	The Trust saw 105% of its Elective day case activity vs plan during June 22	A 4 month increase in activity has enabled us to meet the target	Weekly monitoring in place with Divisional PTL's and a weekly Access Board meeting where acivity vs plan is a standing agenda item	

Outpatients activity (& vs plan)

Group Metric Category: All

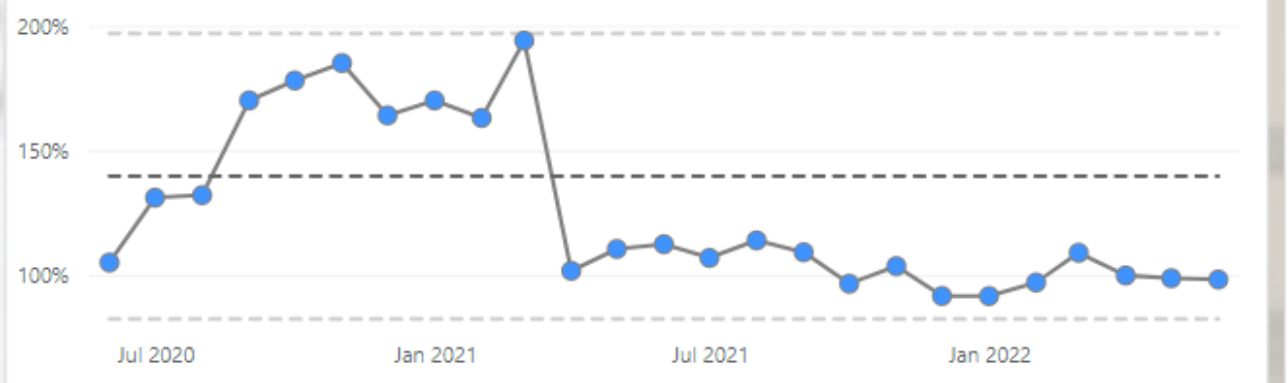
MetricName: Outpatients activity (& vs plan)

5/1/2020 – 6/1/2022

98.18%		95.11%	
KGH: Value	KGH: Target	NGH: Value	NGH: Target

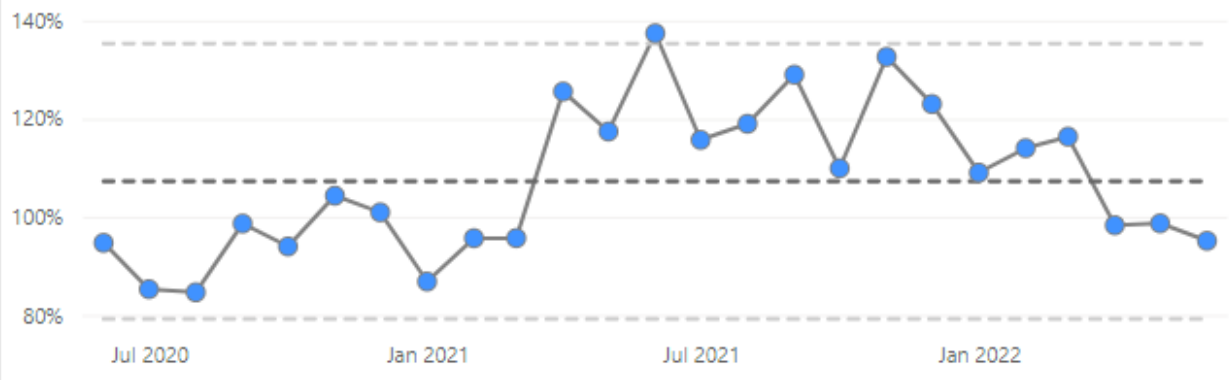
Kettering General Hospital

Outpatients activity (actual vs plan): Sustainability



Northampton General Hospital

Outpatients activity (actual vs plan): Sustainability



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	This is the total number of outpatient appointments in the month (face to face and virtual, new and follow up)	The Trust saw 98% of its planned outpatient activity in June 2022	Across the Trust we had 524 appointments taken place less than the plan. Within this number there were patient cancellations, hospital cancellations due to short notice sickness including covid that resulted in appointments being reduced at very short notice and not necssarily being able to reprovide those in month	Weekly reporting on activity to the Trust's Reset Group, with outpatient efficiency looking forward being reported to the Trust's Patient Access Board	Divisions to look at specialty level opportunities to increase activity
NGH	OPD activity v plan	The Trust saw 93% of its planned outpatient activity vs plan during June 22	Loss of clinic capacity due to increasing sickness due to COVID and an increased cancellation and DNA rate from patients as we enter holiday periods	Weekly monitoring in place with Divisional PTL's and a weekly Access Board meeting where acivity vs plan is a standing agenda item	

Patient | People | Quality | Sustainability | Systems & Partnerships

Site	Metric	Latest Value
NGH	Two week wait	94.4%
KGH	Two week wait	95.1%
NGH	31-day wait for first treatment	90.67%
KGH	31-day wait for first treatment	96.4%
KGH	62-day wait for first treatment	56.5%
NGH	62-day wait for first treatment	64.8%
NGH	Cancer: Faster Diagnostic Standard	79.33%
KGH	Cancer: Faster Diagnostic Standard	82.7%
KGH	6-week diagnostic test target performance	68%
NGH	6-week diagnostic test target performance	85.44%
KGH	Unappointed outpatient follow ups	0
NGH	Unappointed outpatient follow ups	14275
NGH	Virtual outpatient appointments	23.77%
KGH	Virtual outpatient appointments	34%
KGH	RTT over 52 week waits	73
NGH	RTT over 52 week waits	127
NGH	RTT median wait incomplete pathways	10.5
KGH	RTT median wait incomplete pathways	11.7

Metric	Comment
Cancer :-	As a trust we continue to exceed the 28 Day Faster Diagnosis, the 31 Day target, and have met the 2- week standard for 2 months with June provisional position also showing achievement. 62 day and screening targets continue to be a challenge, particularly in Urology, Colorectal, Head & Neck and Gynaecology services. A full recovery action plan has been developed and is being discussed through the governance routes. A sustained recovery is dependent on some key pathway improvements, in particular: diagnostic imaging and pathology reporting turn-round times; actioning decisions from MDTs; adherence to agreed national pathways. There are specific site issues such as implementing the urology 1-stop which are hindering recovery. Some of these are process changes but others will require resources and the impact of these are reflected in the recovery timescales. To ensure oversight and to expedite delays a bi-weekly Confirm and Challenge meetings which are chaired by the Deputy Chief Operating Officer take place.
Referral to Treatment (RTT) :-	At the end of June 2022 there were 73 patients who had waited 52 weeks for their treatment, against a target of 100 in our IBP submission. 14 of these were patients who have been transferred from UHL as part of the offer of mutual aid, 12 of these patients have been waiting 104 weeks or more. We will continue to offer UHL mutual aid to support as the drive to achieve a max wait of 78 wks by March 23. The national expectation is that by end July no patients should wait over 104wk, this has been ameliorated to no 104wks breaches due to capacity but accepting patients who are complex or have chosen to wait to be treated beyond end July. For all patients whom we will not be treating by the end of July, a number are patient choice and UHL have confirmed the remaining are complex according to the regional definition and signed off as such by their surgical lead clinician. Over the last year the waiting lists has grown, this has been driven by an increased demand (referrals) and because capacity has not yet returned to pre pandemic levels. We have recently mobilised a project to improve theatre productivity and outpatient delivery which will support treating more patients and stabilising the waiting list. The Patient Access Board continues to meet weekly to monitor and maintain oversight of all waiting list management.
Urgent Care :-	Attendances to our Emergency and Urgent care services are back to pre-pandemic levels, yet despite this our conversion rate to admission remains good as does our 60-minute ambulance hand over performance. Our bed occupancey remains over 98%, and as a result we regularly open escalation areas for additonal capactiy, and for 4 days in July super surge capacity was required to enable us to manage the demand peak. The number of patients with a length of stay (LOS) greater that 21 days continues to be higher than target, although this has reduced (104 June, from Jan peak of 120). Safe and timely discharge is one of our top priorities and therefore we continue to focus our efforts on our ward and discharge processes and have seen some results with LOS reducing on some of our wards. Oversight of this work is governed by the Hospital discharge steering group that meets weekly and is chaired by the COO. We are also working closely with our system partners to review pathways and reduce the length of time a patient

Patient | People | Quality | Sustainability | Systems & Partnerships

Site	Metric	Latest Value
KGH	Unappointed outpatient follow ups	0
NGH	Unappointed outpatient follow ups	14275
NGH	Virtual outpatient appointments	23.77%
KGH	Virtual outpatient appointments	34%
KGH	RTT over 52 week waits	73
NGH	RTT over 52 week waits	127
NGH	RTT median wait incomplete pathways	10.5
KGH	RTT median wait incomplete pathways	11.7
KGH	Size of RTT waiting list	26316
NGH	Size of RTT waiting list	29786
KGH	Theatre utilisation	77%
NGH	Theatre utilisation	77.39%
NGH	Bed utilisation	87.15%
KGH	Bed utilisation	96.23%
KGH	Stranded patients (7+ day length of stay)	260
NGH	Stranded patients (7+ day length of stay)	359
KGH	Super-Stranded patients (21+ day length of stay)	104
NGH	Super-Stranded patients (21+ day length of stay)	163
NGH	Patients with a reason to reside	64.73%
KGH	Patients with a reason to reside	70.05%

Metric	Comment
	The national expectation is that by end July no patients should wait over 104wk, this has been ameliorated to no 104wks breaches due to capacity but accepting patients who are complex or have chosen to wait to be treated beyond end July. For all patients whom we will not be treating by the end of July, a number are patient choice and UHL have confirmed the remaining are complex according to the regional definition and signed off as such by their surgical lead clinician. Over the last year the waiting lists has grown, this has been driven by an increased demand (referrals) and because capacity has not yet returned to pre pandemic levels. We have recently mobilised a project to improve theatre productivity and outpatient delivery which will support treating more patients and stabilising the waiting list. The Patient Access Board continues to meet weekly to monitor and maintain oversight of all waiting list management.
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Diagnostics :-	June's unvalidated performance is currently at 66% against the national target of 99.1%, a declining position from 71% In May. The driver for this underperformance is due to four challenged modalities, MRI, CT, u/s and echo. Revised demand and capacity plans have been develop based on improved demand data which showed demand has significantly outstripped previous assumptions, with 21% increase in CT, 16% MRI and 24% u/s. The latest C&D trajectories show that CT (with some internal additional capacity) and echo will recover performance during 2022. U/S requires additionality which the service provide on an ad hoc bases but this is not sustainable and therefore additional mitigation is required. MRI requires additional capacity which will require significant resourcing. This is being discussed with execs and the relivant committees. We have established a weekly diagnostic access meeting with modality leads and the Head of Access to discuss plans and pressures within the service. This continues to have had a positive impact on performance with oversight monitored via the Patient Access Group. There is still considerable work to do to ensure our processes are robust and implemented consistently.

Committee Name
- Select all
- Integrated Governance Report (IGR)
- Joint Finance and Performance Committee (FPC)
- Joint People Committee (JPC)
- Joint Quality and Safety Committee (QSC)
- Trust Quality and Safety Committee (QSC)

Group
- Select all
- Patient
- People
- Quality
- Sustainability
- Systems and Partnerships

SITE
- Select all
- KGH
- NGH

Variation
- Select all
- Concern (High)
- Concern (Low)
- Improvement (High)
- Improvement (Low)
- Neither (High)

Clear Filters

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance
KGH	Systems and Partner...	62-day wait for first treatment	01/05/22	56.5%	85%	57.43%	76.08%	94.73%		
NGH	Systems and Partner...	62-day wait for first treatment	01/05/22	64.8%	85%	48.97%	70.48%	91.98%		
NGH	Systems and Partner...	Cancer: Faster Diagnostic Standard	01/05/22	79.33%	75%	69.66%	77.97%	86.28%		
KGH	Systems and Partner...	Cancer: Faster Diagnostic Standard	01/05/22	82.7%	75%		83.82%			
KGH	Systems and Partner...	6-week diagnostic test target performance	01/06/22	68%	99%	66.6%	83.1%	99.61%		
NGH	Systems and Partner...	6-week diagnostic test target performance	01/06/22	85.44%	99%	67.36%	77.75%	88.14%		
KGH	Systems and Partner...	RTT over 52 week waits	01/06/22	73		-9.76	14	37.76		
NGH	Systems and Partner...	RTT over 52 week waits	01/06/22	127	0	135.1	304.12	473.14		
KGH	Systems and Partner...	RTT median wait incomplete pathways	01/06/22	11.7		9.1	10.41	11.72		
NGH	Systems and Partner...	RTT median wait incomplete pathways	01/06/22	10.5	10.9	8.41	10.06	11.71		
KGH	Systems and Partner...	Theatre utilisation	01/06/22	77%		65.71%	72.92%	80.12%		
NGH	Systems and Partner...	Theatre utilisation	01/06/22	77.39%		51.26%	72.47%	93.69%		
NGH	Systems and Partner...	Bed utilisation	01/06/22	87.15%		75.69%	81.33%	86.97%		
KGH	Systems and Partner...	Bed utilisation	01/06/22	96.23%		83.87%	90.8%	97.72%		
NGH	Systems and Partner...	Stranded patients (7+ day length of stay)	01/06/22	359	0	268.13	296.28	324.43		
KGH	Systems and Partner...	Stranded patients (7+ day length of stay)	01/06/22	260		197.11	245.26	293.4		
NGH	Systems and Partner...	Super-Stranded patients (21+ day length of stay)	01/06/22	163	0	90.97	108.92	126.88		
KGH	Systems and Partner...	Super-Stranded patients (21+ day length of stay)	01/06/22	104		58.24	88.39	118.53		
NGH	Systems and Partner...	Patients with a reason to reside	01/06/22	64.73%	95%	43.38%	57.32%	71.27%		
KGH	Systems and Partner...	Patients with a reason to reside	01/06/22	70.05%		63.47%	68.91%	74.36%		

62-day wait for first treatment

Group Metric Category: All

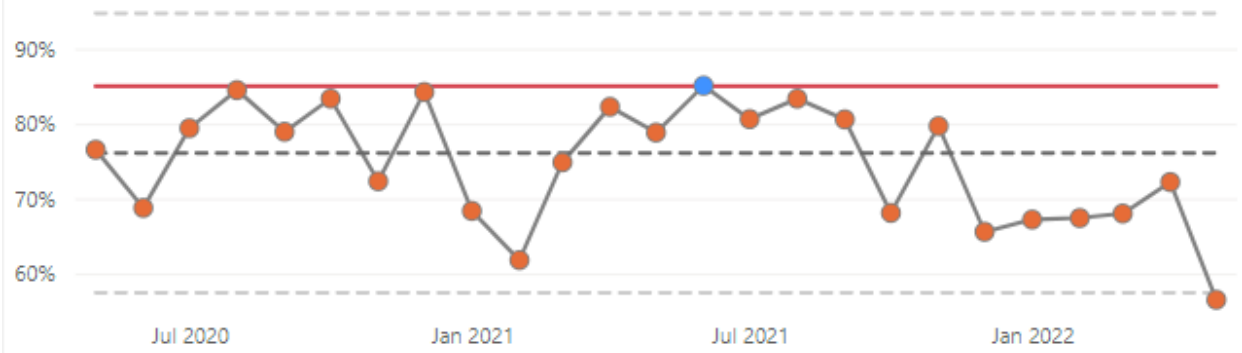
MetricName: 62-day wait for first treatment

5/1/2020 – 6/1/2022

56.50%	85%	64.80%	85%
KGH: Value	KGH: Target	NGH: Value	NGH: Target

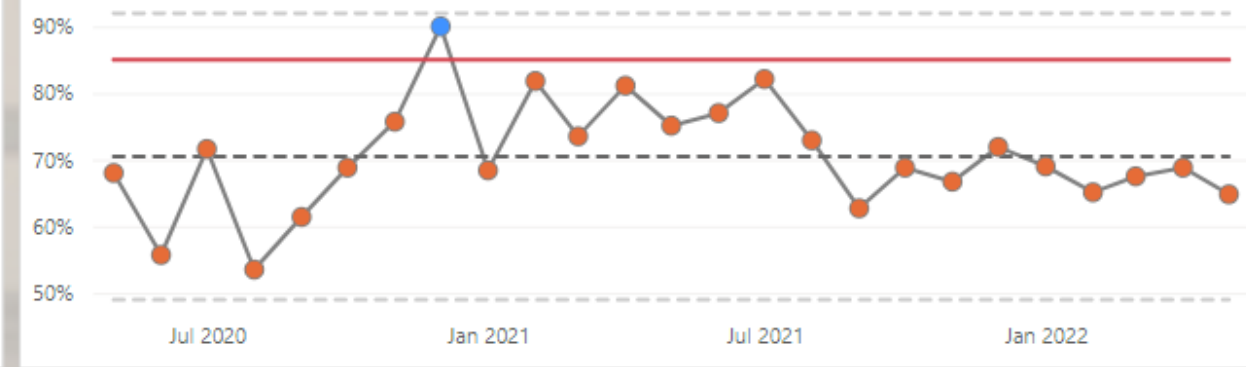
Kettering General Hospital

62-day wait for first treatment: Systems and Partnerships



Northampton General Hospital

62-day wait for first treatment: Systems and Partnerships



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	% of patients whose treatment in initiated within 63 days of urgent referral	The Trust did not meet the national standard of 85% for patient treated within 62 days. Performance for May was 56.5%	We continue to have patients waiting at tertiary centres for robotic surgery. Insufficient capacity for Nephrectomy Diagnostic capacity (LATP) An increase in patient choice during the diagnostic phase of the pathways.	We continue to hold the weekly Confirm and Challenge meetings, we have increased this to twice weekly and now discuss every patient passed breach date and up to day 31 of their pathway. This is chaired by the cancer management team and the DCOO. Weekly PTLs with PPMs and cancer trackers continue.	Cancer recovery action plan in place and reviewed weekly at Access Board. Surgery have increased PTL meeting to twice weekly HON for cancer continues to contact patients who are delaying pathways in order to offer reassurance and encourage to attend as well increasing support from CNS team. Review of performance against timed pathways
NGH		Variation: Common cause - no significant change Assurance: Variation indicates inconsistently hitting passing and falling short of the target			

Cancer: Faster Diagnostic Standard

University Hospitals of Northamptonshire NHS Group

Group Metric Category: All

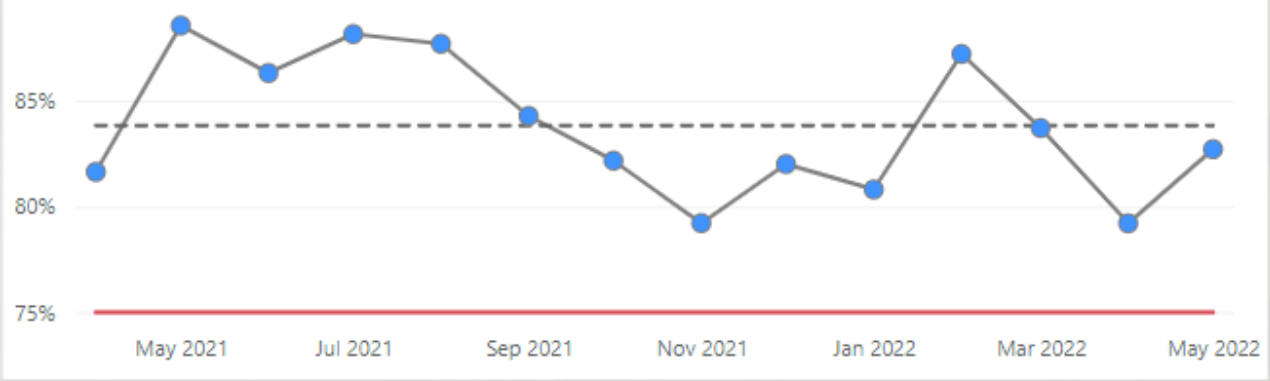
MetricName: Cancer: Faster Diagnostic Standard

5/1/2020 – 6/1/2022

82.70%	75%	79.33%	75%
KGH: Value	KGH: Target	NGH: Value	NGH: Target

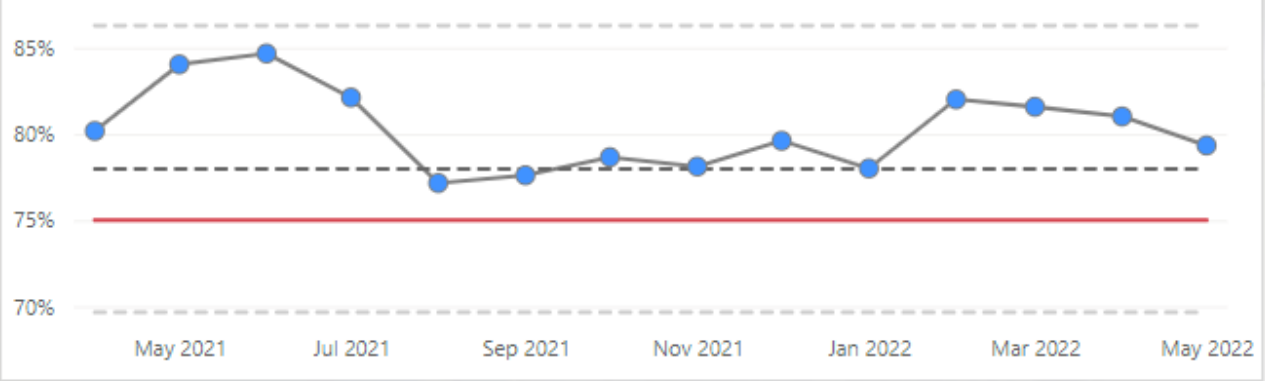
Kettering General Hospital

Cancer: Faster Diagnostic Standard: Systems and Partnerships



Northampton General Hospital

Cancer: Faster Diagnostic Standard: Systems and Partnerships



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	% of patients diagnosed in less than 28 days	The Trust met the standard of 75% at 82.7%	1-stop urology clinics remains outstanding	Increased PTL meetings to maintain focus and performance One stop Gynaecology to be reviewed to ensure fully embedded	One stop clinics developed in key pathways: Breast, Haematuria, Gynaecology and Prostate
NGH		Variation: Special cause of improving nature or lower pressure due to (H)igher values Assurance: Variation indicates inconsistently hitting passing and falling short of the target			

6-week diagnostic test target performance

Group Metric Category: All

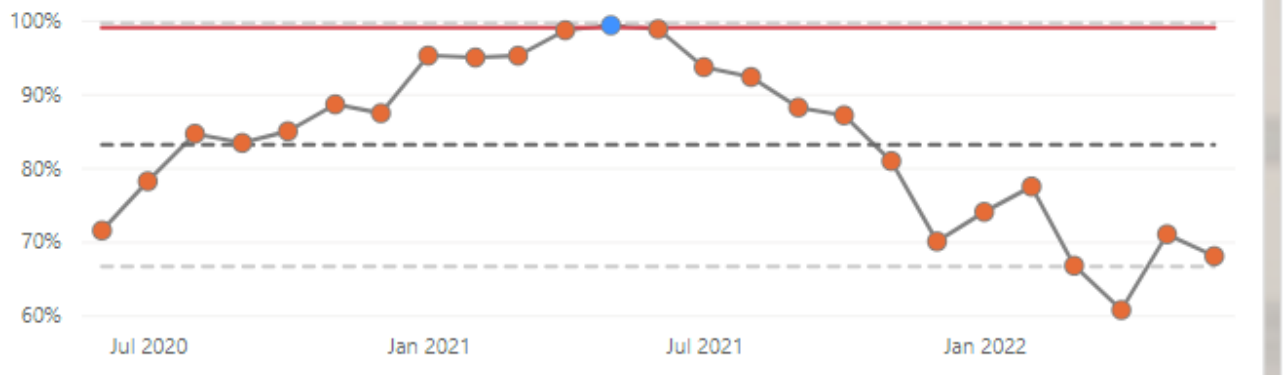
MetricName: 6-week diagnostic test target performance

5/1/2020 – 6/1/2022

68.00%	99%	85.44%	99%
KGH: Value	KGH: Target	NGH: Value	NGH: Target

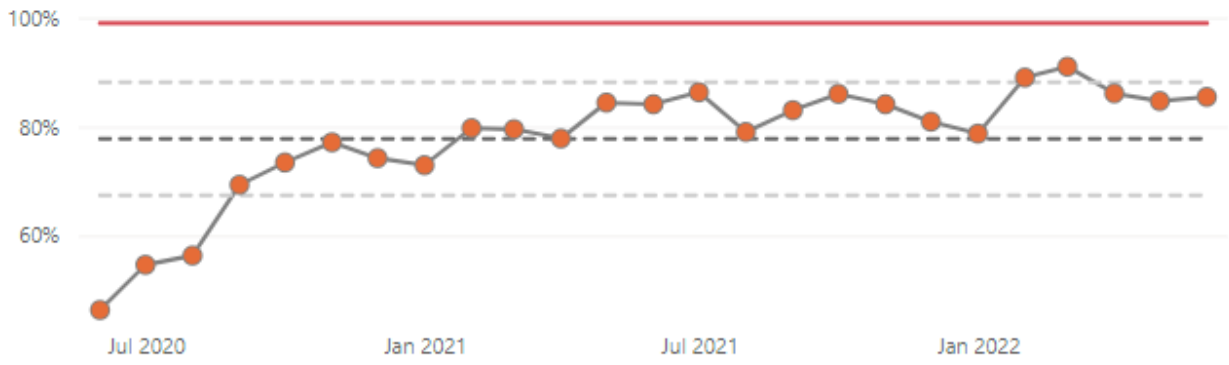
Kettering General Hospital

6-week diagnostic test target performance: Systems and Partnerships



Northampton General Hospital

6-week diagnostic test target performance: Systems and Partnerships



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	% of patients not seen within six weeks		Significant increase in Urgent and 2WW requests resulting in majority of capacity being used to facilitate these needs and extended delays for routine requests. General increase in demand that exceeds plans originally suggested. Capacity remains a struggle within modalitys as the demand exceeds the ability to deliver. Data Quality is a point of concern as there are varying methods of recording and as such accurate reporting has been challenging.	Revised capacity and demand work has been done with the updates reflecting the inflation in demand as well as the increaed DNA. Work continues to identify methods of sourcing and securing additional capcity modalities where there has been particular struggles with delivery (MRI, US, CT, Cardiac Investigations). Bi Weekly Recovery meetings held with DCOO to ensure dedicated oversigt to recovery plans. Weekly DM01 Access meeting with Head of Access continue as well as PTL meetings with Modality leads . Weekly meetings with HI to support in accurate reporting lead by Head of Access	Weekly Access meetings allow for all modality leads to provide weekly updates and escallations of issues being faced. Work will start for a revision of current reports for DM01 to allow better access to data for modalities.
NGH	% of patients not seen within six weeks	Breast, Skin and Testicular were the only sites who achieved the 62 day standard in May.			• Weekly diagnostic PTL on-going. • Weekly Access Committee in place issues escalated to Deputy COO/COO as required

RTT over 52 week waits

Group Metric Category: All

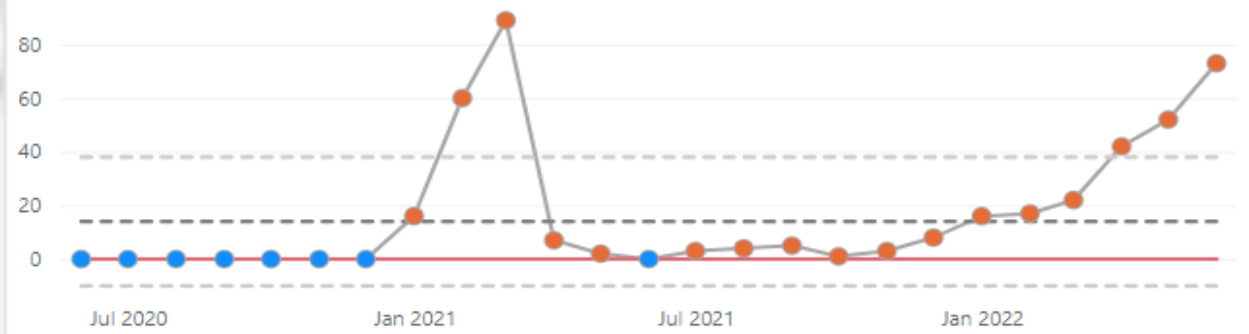
MetricName: RTT over 52 week waits

5/1/2020 – 6/1/2022

73.00		127.00	0
KGH: Value	KGH: Target	NGH: Value	NGH: Target

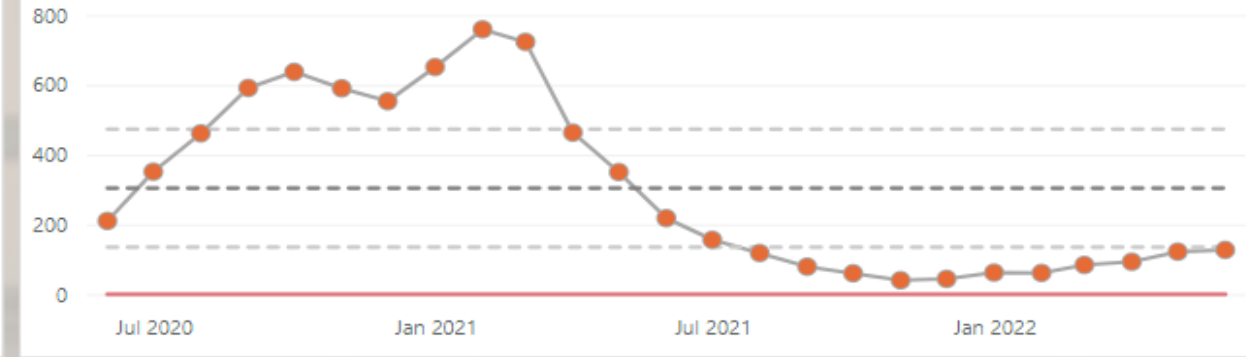
Kettering General Hospital

RTT over 52 week waits: Systems and Partnerships



Northampton General Hospital

RTT over 52 week waits: Systems and Partnerships



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	No. of patients waiting greater than 52 weeks from referral to treatment (RTT)	At the end of June 2022 there were 73 patients who had waited 52 weeks for their treatment, against a target of 100 in our IBP submission. 14 of these were patients who have been transferred from UHL as part of the offer of mutual aid, 7 of these patients have been waiting 104 weeks or more. We will continue to offer UHL mutual aid to support as the drive to achieve a max wait of 78 wks by March 23	The trust continues to recieve patient's from UHL as part of a Mutual Aid agreement. There has been a regional ask to have patients treated as priority which has reduced capacity for allocation of capacity to other patients with long waits.	Surgical division have been asked to establish processes around Hospital Cancellations to ensure longest waiting patients are not cancelled where possible. Weekly validation of the 52w+ PTL continues to ensure patients are listed as they should be and actions are escalated where needed. This included audits of clock stops as there have been a number of "pop-ons" due to clocks being stopped incorrectly. PTL meeting continue to ensure oversight of patients waiting with next steps being expidited where needed. Theatre Utilisation plans being consided to maximise both theatre time and touch time. Clinical Harms reviews are required for all patients who have waited in excess of 52 weeks. Quantitative reports are shared via Patient Access and Operational Management Group detailing completed, outstanding and outcomes (harm rating).	Patients are viewed and discussed at weekly Patient Acccess Board chaired by DCOO. Forward view being used to provide oversight of patients who need next steps in advance of reaching 52 weeks.
NGH	No. of patients waiting greater than 52 weeks from referral to treament (RTT)	127 patients are currently waiting more than 52 weeks for treatment	NGH has now taken 92 long waiting patients (most >than 104 weeks) from UHL. These are being managed on top of our own actvity due to their wait times. Most pressured areas are T&O, ENT and Cardiology	Weekly monitoring in place with Divisional PTL's and a weekly Access Board meeting where 52+weeks is a standing agenda item	

RTT median wait incomplete pathways

Group Metric Category: All

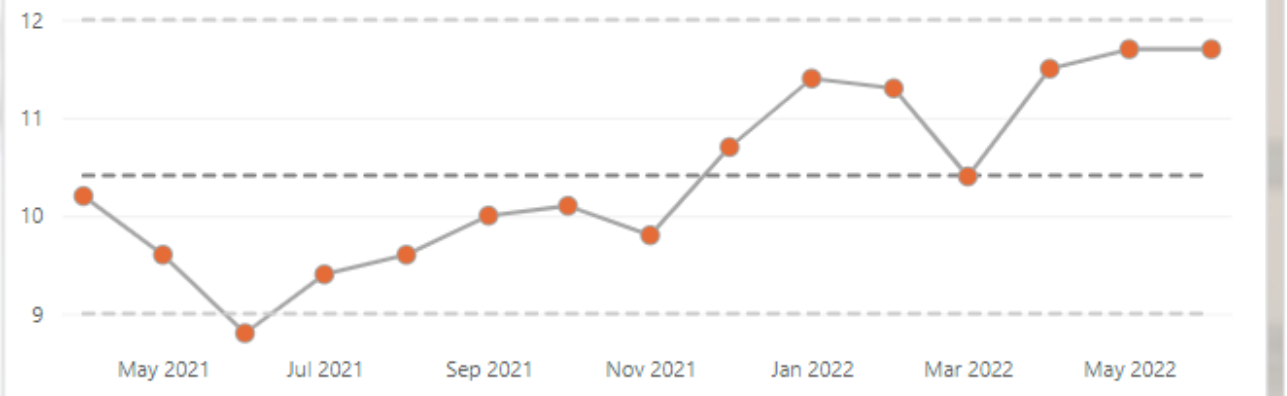
MetricName: RTT median wait incomplete pathways

5/1/2020 – 6/1/2022

11.70		10.50	10.9
KGH: Value	KGH: Target	NGH: Value	NGH: Target

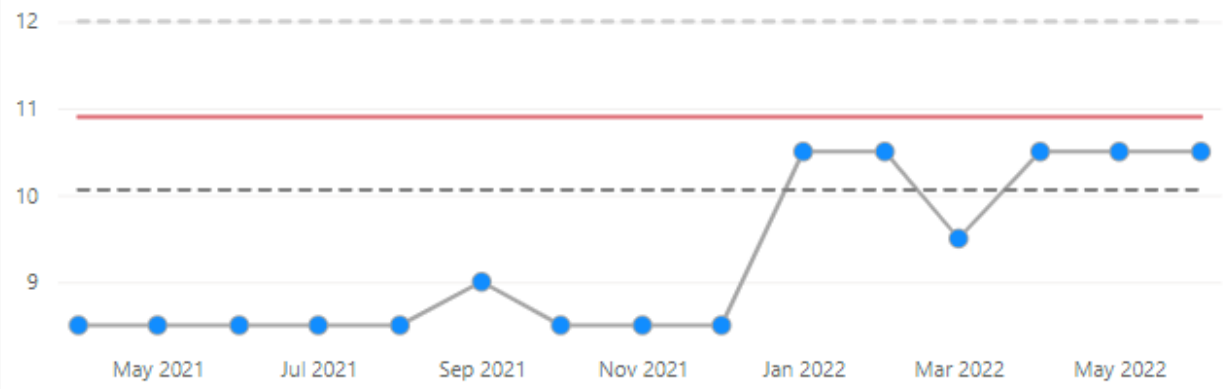
Kettering General Hospital

RTT median wait incomplete pathways: Systems and Partnerships



Northampton General Hospital

RTT median wait incomplete pathways: Systems and Partnerships



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	% of patients waiting more than 18wks for treatment (incomplete pathways)		There has been an increase in demand that exceeds plan based on 19/20 data. Due to capacity limitations there has been a longer wait from referral to first appointment, this has caused delays especially for those who require surgery as treatment. There a Patients are choosing to delay treatment due to social reason.	The PTL continues to be monitored via the weekly Patient Access Meeting chaired by the DCOO. PTL meetings with specialties are used to monitor patients awaiting treatment, especially those with long waits. Health Inteligence have been asked to support with better visualisation of RTT applicable activity as a subset of overall activity plans set for 22/23.	
NGH	Median wait for patients is a trial metric from NHSEI that NGH are trialling. The target set is 10.5 weeks which is being maintained	Target is being consistently met			

Theatre utilisation

Group Metric Category: All

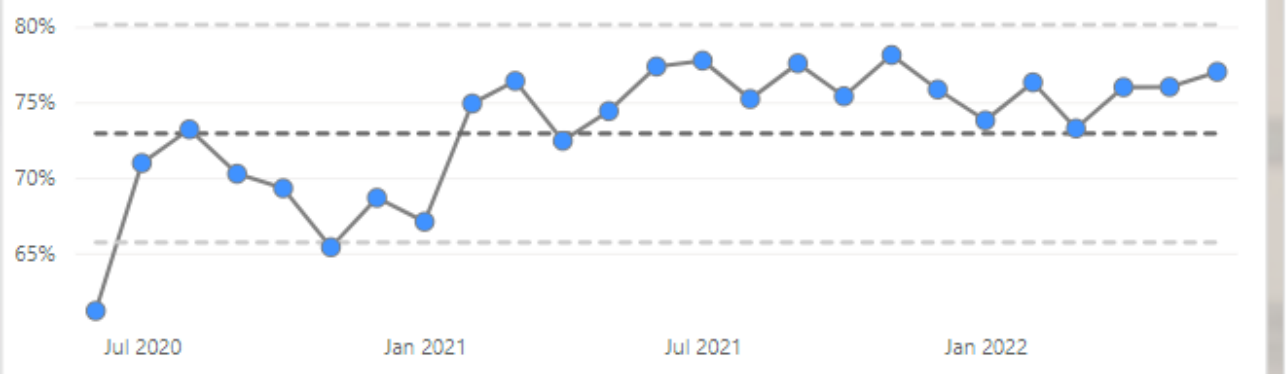
MetricName: Theatre utilisation

5/1/2020 – 6/1/2022

77.00%		77.39%	
KGH: Value	KGH: Target	NGH: Value	NGH: Target

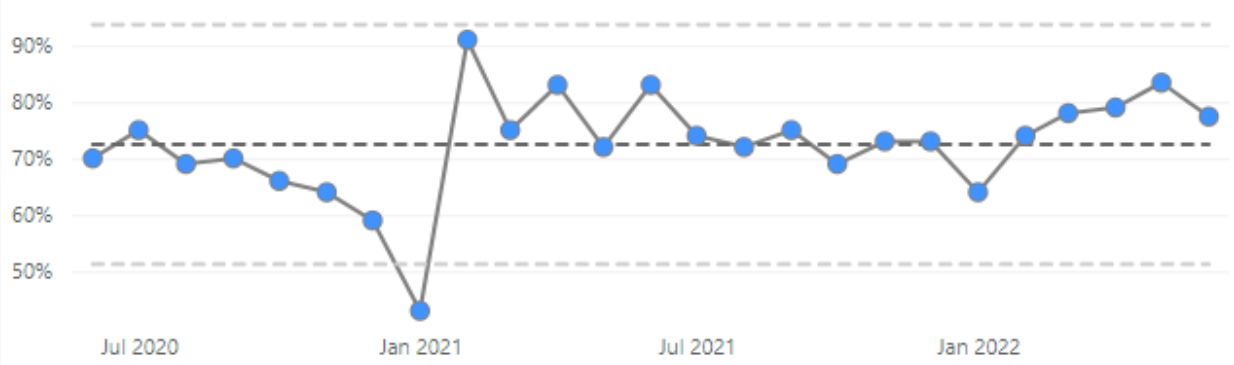
Kettering General Hospital

Theatre utilisation: Systems and Partnerships



Northampton General Hospital

Theatre utilisation: Systems and Partnerships



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Theatre utilisation % against 85% national target	This chart tells us the % of time within theatre sessions that is actively used to treat patients	77% is below the 85% standard. The main causes ar eunder-booked lists and late-notice cancellations by patients	New Divisional Director leading work to improve scheduling of lists to increase utilisation rates above standard	Relaunching of 642 process to ensure processes are followed with timely booking of patients and pre-assessment
NGH	Theatre utilisation % against 85% national target	Theatre Utilisation is at 77.4% against the target of 85%	Lack of informatics to monitor utilisation in real time Cultural change required to drive the theatre lists Team Leaders are constantly in the staffing numbers. Theatre lists lost due to insufficnet staff (ODP's anaesthetists nurses)	- 6-4-2 Theate meeting held weekly - Theatre dashboard in progress - Monthly Divisional Theatre Productivity meeting with Transformation support - OD support in theatre working with Matrons and theatre teams	- Introduction of Palantir - Theatre Dashboard

Bed utilisation

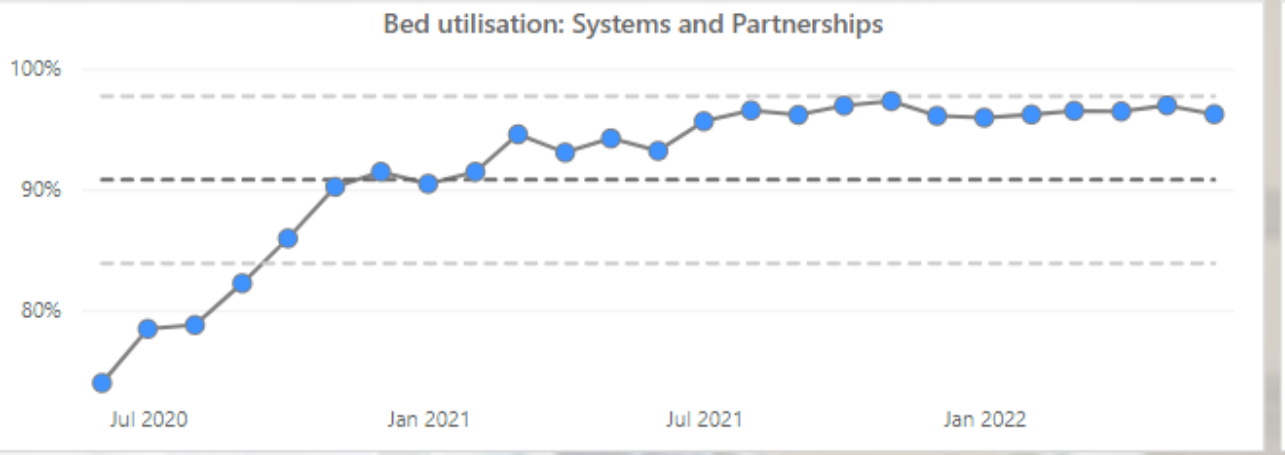
Group Metric Category: All

MetricName: Bed utilisation

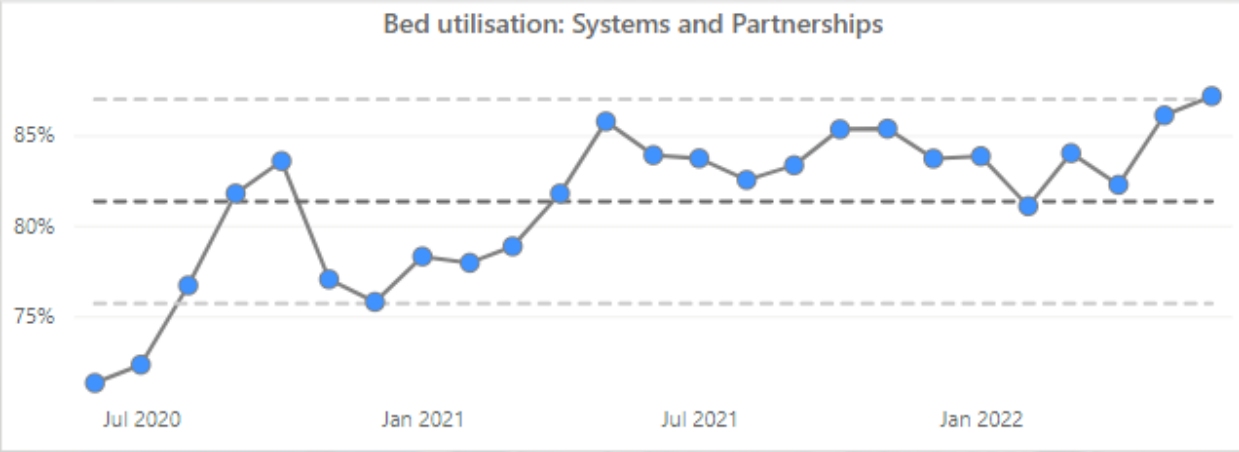
5/1/2020 – 6/1/2022

96.23%		87.15%	
KGH: Value	KGH: Target	NGH: Value	NGH: Target

Kettering General Hospital



Northampton General Hospital



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	% General and acute beds utilised - excluding maternity	The chart tells us that bed utilisation has increased in line with the increase in elective and non- elective activity	Bed utilisation data is not reflecting the additional escalation capacity opened in response to surges of non-elective activity	Focus on simple pathway zero patients as part of board rounds twice daily Regular 3x per week discharge meetings at ward level discussing every patient	Additional discharge reviews at ward level every day for every patient when capacity is constrained and bed utilisation is high
NGH					

Stranded patients (7+ day length of stay)

Group Metric Category: All

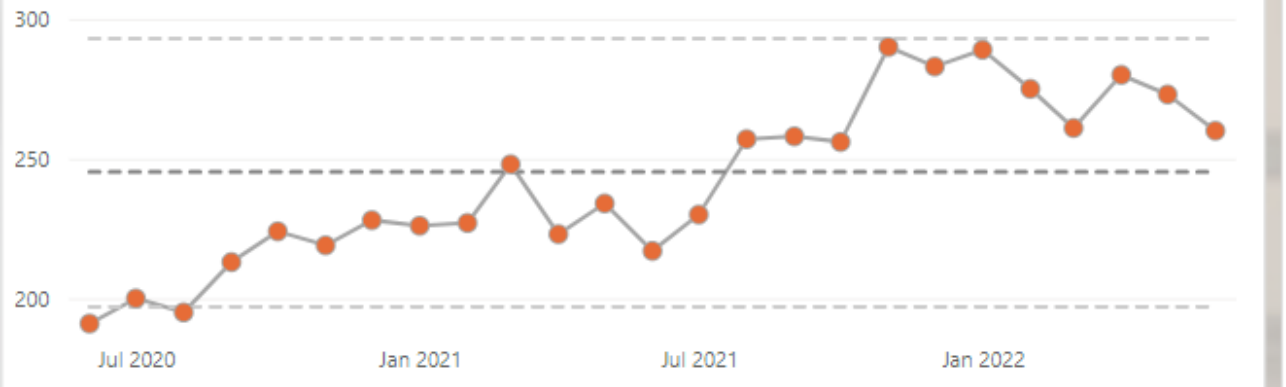
MetricName: Stranded patients (7+ day length of stay)

5/1/2020 – 6/1/2022

260.00		359.00	0
KGH: Value	KGH: Target	NGH: Value	NGH: Target

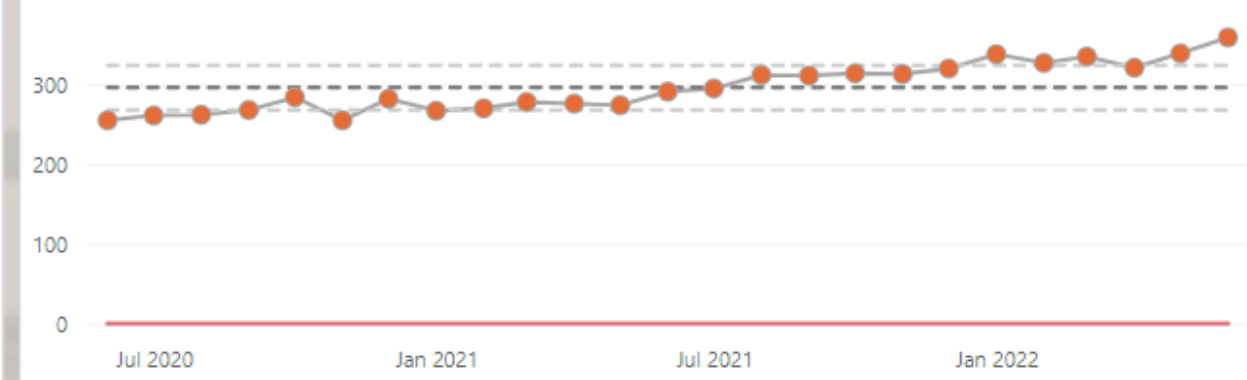
Kettering General Hospital

Stranded patients (7+ day length of stay): Systems and Partnerships



Northampton General Hospital

Stranded patients (7+ day length of stay): Systems and Partnerships



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Number of patients with a LoS > 7 days	The chart tells us that Stranded numbers continue to reduce	Reducing the number of stranded patients relies on consistent well led board rounds with senior medical leadership. Current staffing constraints across both medical and nursing staff present challenges to maintaining consistency however currently we continue to see a reduction.	Twice daily board rounds Access to all diagnostics booked on that day for echo & radiology plus inpatient trauma and endoscopy lists held on shared teams folder to aid decision making focus on pathway zero patients	Involvement of senior nurses and matrons to support senior decision making at board rounds when numbers begin to rise
NGH	359	increase in stranded feeds into increase in super stranded	Dificulty accessing supported discharges, care homes reluctant to take back patients exposed to covid.	Patient flow coordinators are focussed on treatment plans for all patients ensuring that internal delays are escalation and reduced. Pathway 0 patients discharged have increased by 15% since implementation.	Virtual wards are due to be launched for Nye Bevan end of July this should further reduce the number of stranded patients.

Super-Stranded patients (21+ day length of st...

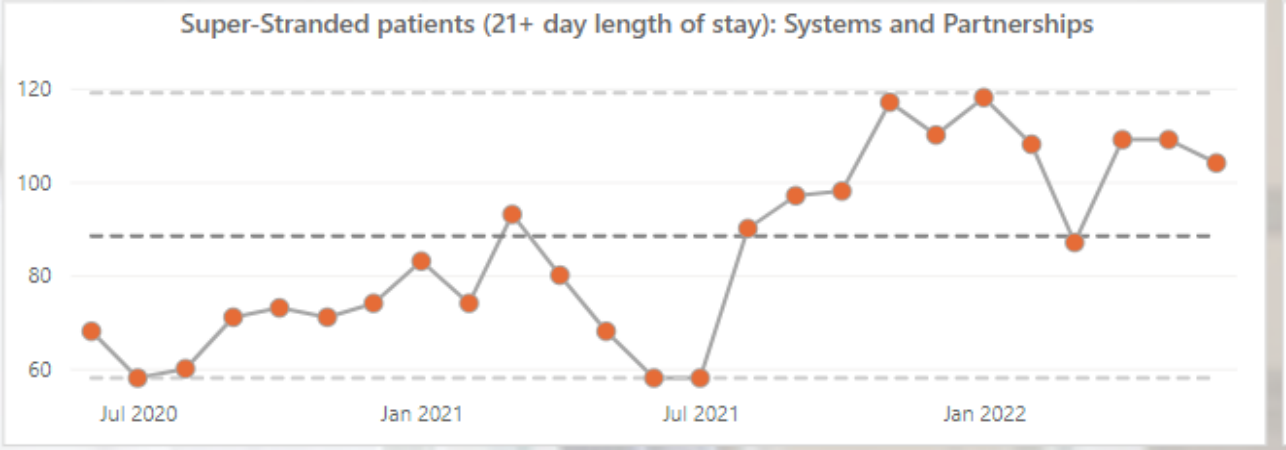
Group Metric Category: All

MetricName: Super-Stranded patients (21+ day length of ...

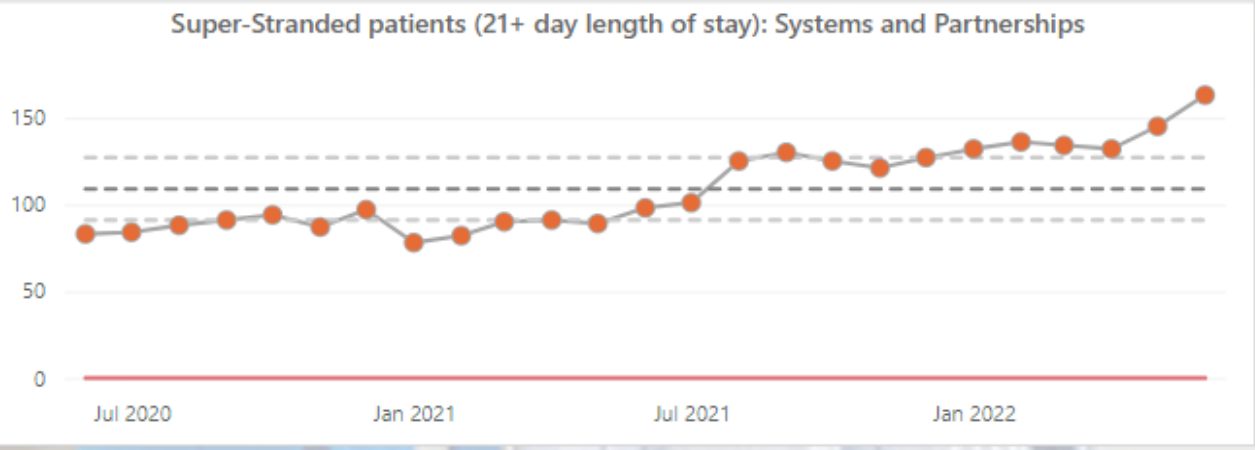
5/1/2020 – 6/1/2022

104.00		163.00	0
KGH: Value	KGH: Target	NGH: Value	NGH: Target

Kettering General Hospital



Northampton General Hospital



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Number of patients with a LOS> 21 days	The chart tells us that Super Stranded numbers continue to reduce	Reliance on external partners to provide resources - placements and packages of care for these complex patients cessation of national discharge funding has placed further constraints on these resources Delirium beds further delayed by covid outbreak in provider home pushing the start date back to the end of July Increase in short term care provision from ASC north not demonstrating reduction in SS numbers waiting for care	Reviews of all Super Stranded patients 3 x per week with super complex review of selected patients 1 x per week with partners Daily updates with OOC providers Continued close working with ASC to identify patients to occupy SCC beds where care at home not available due to lack of resource	Increase in reviews to daily when required Esclations to ASC director with particulaly complex cases Use of alternative capacity where appropriate and available
NGH	average of 164	month on month increase in super stranded numbers	Significant issues in relation to end of national funding for supported discharges so spend reverted back to council. Severe capacity issues and increase in number of stroke, NOF pts all of whom drive up LOS as frequently require supproted discharge to specialist rehab beds in addition to the capacity issues with council	ongoing disucssions with ASCW re plans for additional capacity. Joint review with NHFT for patients waiting on rehab beds occurs weekly. Acute confusion beds are commissioned and aiming to be online end of July.	Weekly full review of all super stranded patients with system partners. patient flow coordinators now in place to drive forward treatment plans so internal delays are minimised. Ongoing discussions re HUB with view of full review late August with system partners. NGH@home commenced with limit of 20 visits per day this has been attained.

Patients with a reason to reside

Group Metric Category: All

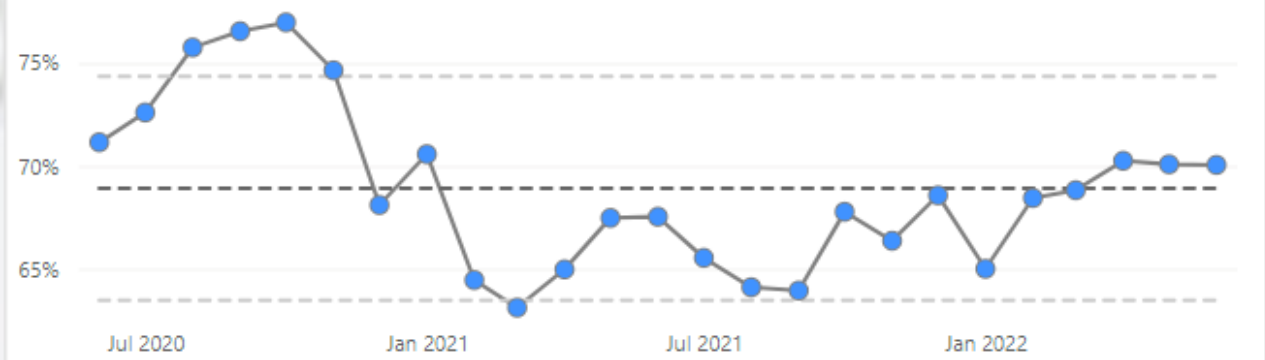
MetricName: Patients with a reason to reside

5/1/2020 – 6/1/2022

70.05%		64.73%	95%
KGH: Value	KGH: Target	NGH: Value	NGH: Target

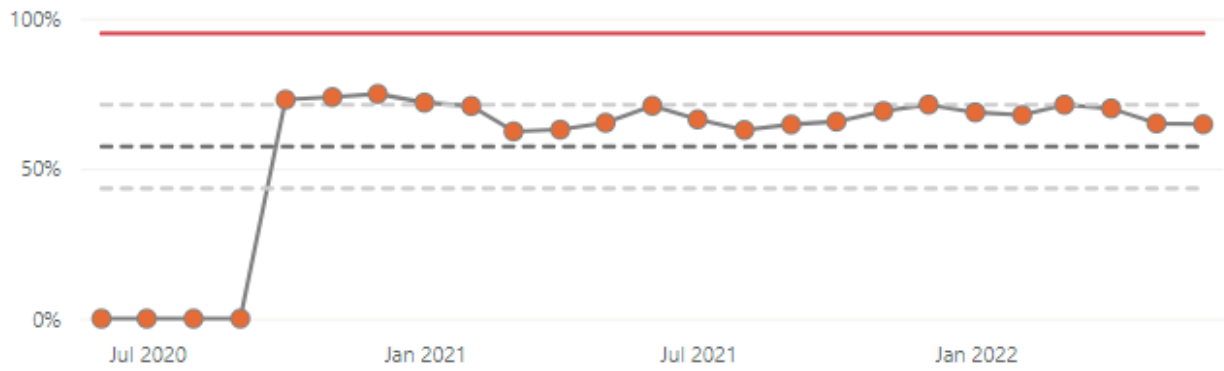
Kettering General Hospital

Patients with a reason to reside: Systems and Partnerships



Northampton General Hospital

Patients with a reason to reside: Systems and Partnerships



Site	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	Number of patients who have a reason to reside in hospital based on national reason to reside criteria	The chart tells us that the number of patients with a reason to reside is increasing	Reliance on wards to update patient flow accurately daily at every ward round but lack of knowledge regarding reason to reside results in high numbers of patients either with nothing recorded or incorrectly coded	Experienced discharge co-ordinator employed with an education / training focus to support at ward level Continued work on board rounds as part of FG8 ican led within the divisions	Patient flow updated during discharge meetings to reflect true reason to reside codes
NGH					

NGH Board
Finance Performance

Month 3 (June 2022)
FY 2022/23

Executive Summary

In Month 3 the Trust financial performance is a deficit of £5.8m, which is £2.2m worse than plan. The primary driver of this position is non-delivery of performance to access Elective Recovery Funding (ERF) as well as under-delivery of Pay efficiencies.

The Month 3 performance is measured against the revised £1.9m deficit plan for 22/23, which will require delivery on ERF, efficiencies, improved workforce usage, system change and other key assumptions (minimal Covid and a light winter) to deliver on the plan. However the movement in plan from £16.7m deficit to £1.9m deficit only required a £0.2m reduction in expenditure in month 3, with the significant improvements phased in from month 5 onwards (see graph on following slide).

KEY VARIANCES - MONTH 3:

Income - £0.1m adverse variance in-month. The variance in-month is driven by:

- £0.1m adverse in reimbursed vaccine centre income
- Recognition of 3 months ERF income (£0.6m) (25%) that is not subject to performance delivery and will not be 'clawed back'

Pay - £1.1m adverse variance in-month. The variance in-month is driven by:

- £0.3m due to lack of Pay CIP being delivered
- £0.2m continuing premium cost temporary medical staffing
- £0.2m of Q1 invoices for agency RN presenting in June
- £0.2m bank bonuses and Sunday enhancements
- £0.1m agency management project costs for RTT validation

Non-Pay - £0.1m favourable variance in-month. The main variances in-month are driven by:

- £0.1m lower building engineering costs in Q1

Cash - The Trust continues to have a healthy cash position, with a balance at the end of the month of £19m.

Capital – Spend at Month 3 is £0.5m with commitments of £2.6m. The total capital plan is £30.4m which includes a recently awarded £1.8m for Endoscopy development and will require £2.7m emergency capital funding.

2021/22 M3 I&E Summary

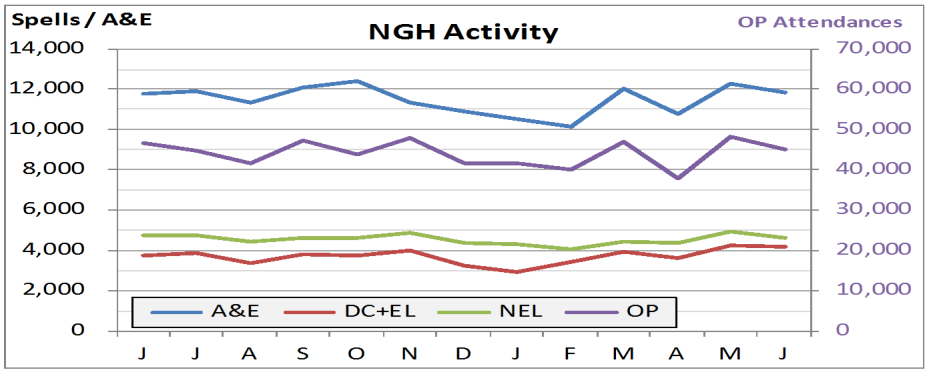
Description	NGH Year To Date			NGH In Month		
	Plan £m's	Actual £m's	Variance £m's	M3 Plan £m's	M3 Actual £m's	Variance £m's
Total Income	109.5	107.5	(2.0)	37.0	37.0	(0.1)
Total Pay	(77.0)	(78.3)	(1.3)	(25.6)	(26.6)	(1.1)
Total Non Pay	(35.3)	(34.1)	1.2	(11.6)	(11.5)	0.1
Operating (Deficit)	**(2.8)**	**(4.9)**	**(2.2)**	**(0.2)**	**(1.2)**	**(1.0)**
Capital Charges	(1.5)	(1.5)	(0.0)	(0.5)	(0.5)	(0.0)
Trust Surplus /	**(4.3)**	**(6.5)**	**(2.2)**	**(0.6)**	**(1.7)**	**(1.0)**
System Support Fundir	0.6	0.6	0.0	0.6	0.6	0.0
I&E Surplus / (Deficit)	**(3.7)**	**(5.8)**	**(2.2)**	**(0.0)**	**(1.0)**	**(1.0)**

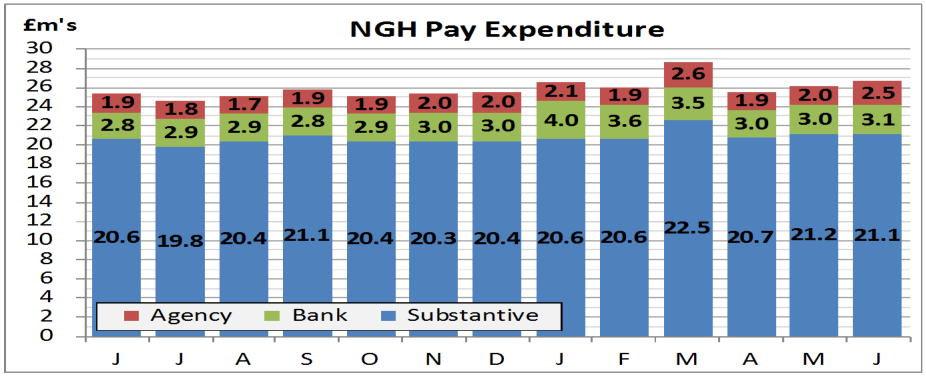
In Month 3 the Trust financial performance is a deficit of £5.8m, which is £2.2m worse than plan. The primary driver of this position is non-delivery of performance to access Elective Recovery Funding (ERF) (-£2.0m) as well as under-delivery of efficiencies.

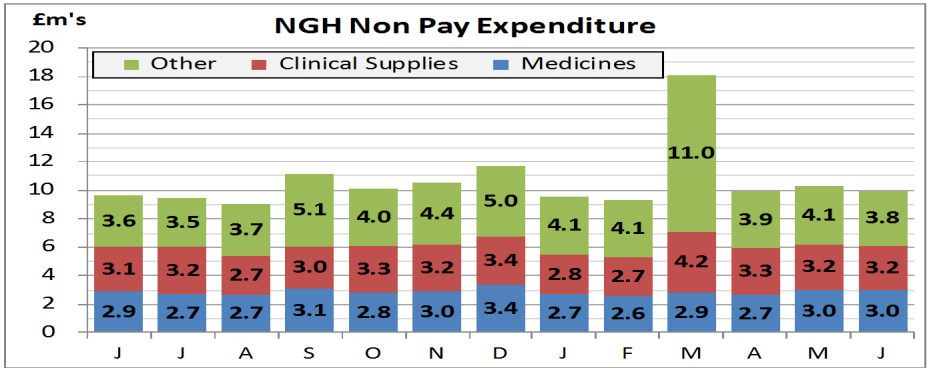
KEY VARIANCES - YEAR TO DATE:

- **Income £2.0m Adverse to plan**
  - Elective recovery fund (ERF) income has now been included in the YTD at 25% (the amount excluded from clawback if targets are not met) This is £0.7m against a YTD plan of £2.7m. Analysis indicates performance is marginally above 100% of 19/20 on a weighted basis (maximum value £0.4m YTD), but with baseline adjustments still to be finalised (NHSEI stated this will happen in Q2). Due to this uncertainty no income is assumed to have been earned.
- **Pay total costs are now £1.3m over plan**
  - Substantive staff costs are continuing to rise and additional enhancements were seen in June due to a 5th Sunday in the month (£0.1m)
  - Agency and bank costs have not yet started to reduce. In Month 3 there were also additional agency costs relating to Q1 (£0.2m), and with Digital overspending by £0.2m
  - Non-delivery of Temporary staff costs savings worth £0.7m pressure in the Q1 pay position
- **Non-Pay £1.2m favourable to plan**
  - Mainly due to lower spend in April. May & June activity increases brought Non Pay in closer to plan in May and June
  - Favourable variance is predominantly due to assumptions on insourcing expenditure that have not yet been contracted for, so costs not incurred

Summary - Activity & Expenditure – Monthly Trend







Highlights / Key Issues

Activity

Another strong month for Daycase & Elective work over 7% higher than any 2 months in 21/22 when activity was boosted by weekend WLIs and insourcing contracts. A&E attenders averaging c.400 per day again in June, plus Non Elective spells also at some of the highest level seen in the last 12 months.

Pay

The temporary staffing cost of £2.5m agency and a marginal increase in bank spend over the long June bank holidays.

With unavailability of staff still running high and above budgeted levels, this reduction in temporary staffing is an area of targeted efficiency in 22/23.

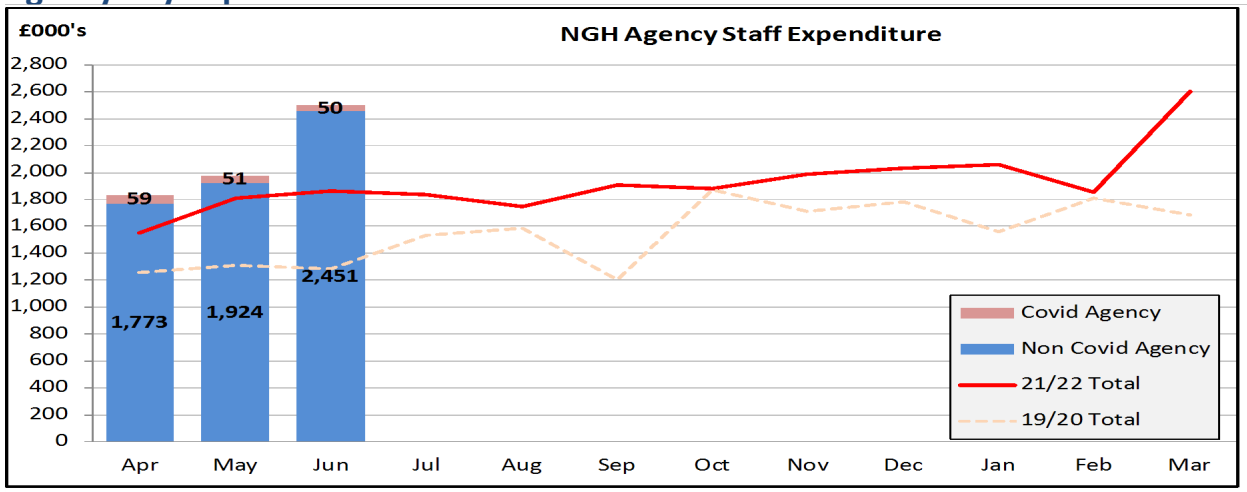
The small increase in temporary staff spend, compared to 21/22 is mainly the accounting of pay award and N.I. increases with no significant gain overall in permanent contracted staff.

Non Pay

Still maintaining a lower spend in Other non-pay, due to lower requirement for insourcing and expenditure on premises and energy being lower in the summer.

The expenditure on clinical supplies is still relatively low compared to the elective output, but is temporarily lowered this month with the accounting for 'right of use assets', IFRS16 being updated for Q1, and effectively lowering the clinical supply spend by £0.23m in M3.

Agency Pay Expenditure

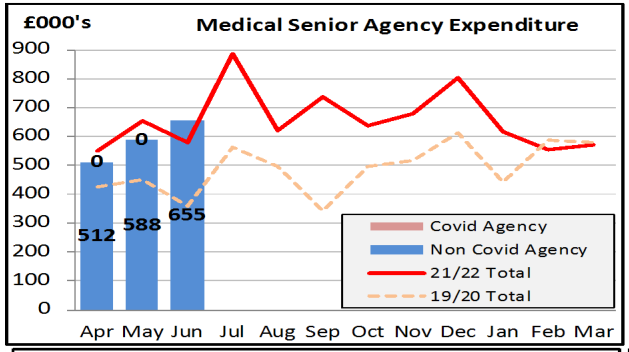


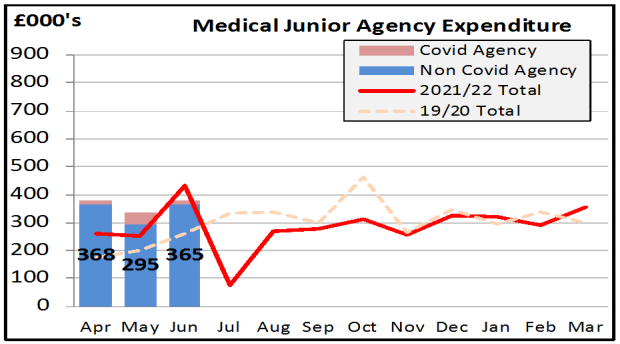
Monthly Agency spend of £2.50m in June, the second highest reported month in recent years.

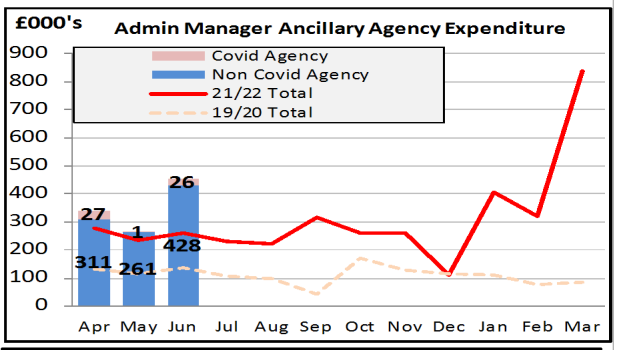
The graphs include a 19/20 spend, in addition to 21/22, to provide a marker for agency spend in the last pre-pandemic year.

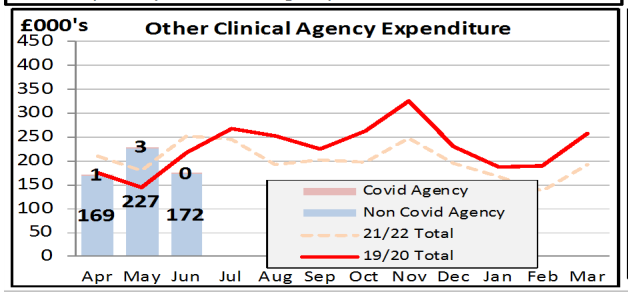
June figures included a £0.2m catch up of agency RN invoices unaccounted for April & May. Adjustments in processes have been made to help mitigate such accounting corrections in future.

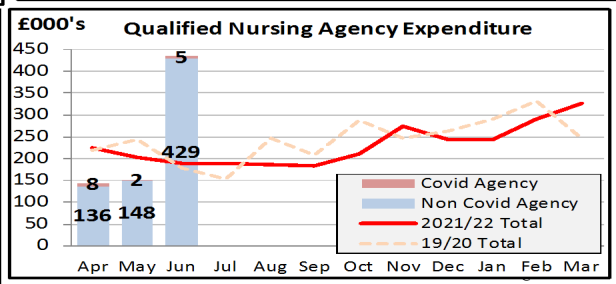
Month 3 was still a high spend month with agency management support for RTT validation project work.

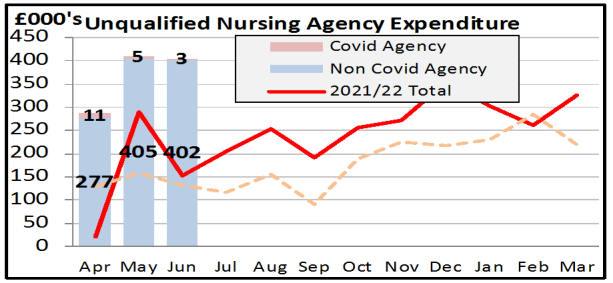












Statement of Financial Performance

The key movements from the opening balance are:

Non Current Assets

- Opening NBV has increased by £8.7m, this is the application of the new IFRS16 accounting standard and the recognition of Right of Use (ROU) assets on the balance sheet.
- M3 movements for capital additions of £0.3m, includes a £0.1m Charitable Funds purchase of an operating table to work in conjunction with the surgical robot purchased last financial year.
- M3 depreciation includes the cumulative Qtr 1 effect of the leased assets now recognised on balance sheet.

Current assets

- Inventories - £0.1m. Increases in Pathology, Pacing/Excluded devices and Supplies Trading offset by decrease in Pharmacy.
- Trade and Other Receivables – £2.1m due to: Increases in NHS Income Accruals (£1.5m), VAT reclaim (£0.9m) and Other debtors (£0.2m). Decreases in NHS Receivables (£0.3m) and Prepayments (£0.2m).
- Salary overpayments have increased slightly this month with an overall balance of £0.36m. Year to date overpayments are £0.13m which is consistent with the same period last year though the number of occurrences are less (63 compared to 71).
- Cash – Decrease of £3.7m.

Current Liabilities

- Trade and Other Payables - £1.1m due to: Decreases in Trade Payables (£0.4m), NHS Payables (£2.7m), accrual for potential repayment of 75% ERF funding now included in receipts in advance, Tax, NI and Pension Creditor (£0.4m), Other Creditors (£0.3m). Increases in PDC Dividend (£0.5m), Accruals (£1.1m) and Receipts in Advance (£1.1m).
- Provisions £0.1m – release of HR provision utilised for legal fees & redundancy payment.

Non Current Liabilities

- Finance Lease Payable - £8.2m. Recognition of Right of Use (ROU) assets under IFRS16 as finance leases (£8.7m), Nye Bevan and Car Park lease repayment (£0.1m), Qtr 1 ROU asset repayments (£0.4m).
- Loans over 1 year. Repayment of Salix Loan.

Financed By

- I & E Account - £1.0m deficit in month

SOFP

TRUST SUMMARY BALANCE SHEET
MONTH 3 2022/23

	Balance at 31-Mar-22 £m	Current Month Opening Balance £m	Current Month Closing Balance £m	Current Month Movement £m	Forecast end of year Closing Balance £m	Forecast end of year Movement £m
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	208.5	208.5	217.3	8.7	217.3	8.7
IN YEAR REVALUATIONS	0.0	0.0	0.0	0.0	0.0	0.0
IN YEAR MOVEMENTS	0.0	0.4	0.7	0.3	30.7	30.7
LESS DEPRECIATION	0.0	(2.3)	(3.9)	(1.6)	(16.0)	(16.0)
NET BOOK VALUE	208.5	206.6	214.0	7.4	231.9	23.4
CURRENT ASSETS						
INVENTORIES	6.7	6.8	6.9	0.1	6.7	0.0
TRADE & OTHER RECEIVABLES	17.7	16.1	18.2	2.1	15.7	(2.0)
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	10.1	22.3	18.7	(3.7)	9.4	(0.6)
TOTAL CURRENT ASSETS	35.4	46.2	44.7	(1.5)	32.8	(2.6)
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	30.1	43.9	42.8	(1.1)	31.1	1.0
FINANCE LEASE PAYABLE under 1 year	1.3	1.2	1.3	0.0	1.3	0.0
SHORT TERM LOANS	0.3	0.3	0.3	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	2.3	2.3	2.3	(0.1)	1.2	(1.1)
TOTAL CURRENT LIABILITIES	33.9	47.8	46.6	(1.2)	33.9	(0.1)
NET CURRENT ASSETS / (LIABILITIES)	1.5	(1.6)	(1.8)	(0.3)	(1.1)	(2.6)
TOTAL ASSETS LESS CURRENT LIABILITIES	210.0	205.0	212.2	7.2	230.9	20.9
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	7.1	6.9	15.1	8.2	15.1	8.0
LOANS over 1 year	0.7	0.6	0.6	(0.0)	0.4	(0.3)
PROVISIONS over 1 year	1.9	1.9	1.9	0.0	1.9	0.0
NON CURRENT LIABILITIES	9.6	9.4	17.6	8.2	17.4	7.8
TOTAL ASSETS EMPLOYED	200.4	195.6	194.6	(1.0)	213.4	13.1
FINANCED BY						
PDC CAPITAL	268.5	268.5	268.5	0.0	272.9	4.5
REVALUATION RESERVE	47.8	47.8	47.8	0.0	47.8	0.0
I & E ACCOUNT	(115.9)	(120.6)	(121.7)	(1.0)	(107.3)	8.6
FINANCING TOTAL	200.4	195.6	194.6	(1.0)	213.4	13.1

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Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	28th July 2022
Agenda item	6

Title	22/23 ICB Operational Plan Submission
Presenter	Karen Spellman Director of Integration and Partnerships Jon Evans Group Chief Finance Officer
Author	Karen Spellman Director of Integration and Partnerships Jon Evans Group Chief Finance Officer

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

Group priority				
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
• This paper is presented to note the summary of the revised final System Operating Plan for 22/23 submitted on 20 June 2022 • Note the plans to deliver elective performance, reduction in long waits and improvement in cancer waits summary of the final financial position • The Board is asked to accept and note the final plan submission made by the System	The final submission was shared and discussed at a joint Divisional Away Day (17th June) and NED development session 10th June. The detailed final submission was approved at the Finance and Performance Committee 29th June.

Executive Summary

This paper presents the summary of the final revised ICB system Operational Plan submission made on the 29th June 2022. This is in line with 2022/23 Operational Planning Guidance published by NHS England and Improvement (NHSEI) on 24th December 2021 and feedback given on the plan submission made on the 28th April 2022.

The paper summarises the system position, as the Trust contributed to an overall system plan rather than agree and submit one as a standalone body.

Following feedback on the 28th April submission, final operational plans are to deliver on;

- Elective performance and 104% of 19/20 levels of activity
- Financial performance, to get to breakeven but be clear on assumptions and risks
- Address issues needed to deliver Winter (e.g. Ambulance Handovers, delayed discharges etc)

The system has submitted a revised plan that delivers a breakeven financial position and proposes to meet elective performance at 104% of 19/20 levels of activity.

The proposals get us to a plan for 22/23 but does not address the wider sustainability and productivity challenges upon us and work is ongoing across the system on a longer term plan to identify and address these issues.

The Board of Directors is asked to;

- Note the summary position for elective recovery, finance and performance across the system, and
- Ratify the plan following approval and submission

Appendices

The summary plan submission is included in the appendices

Risk and assurance

Risks to plan delivery are included in the paper

Financial Impact

The paper detail the finance plan submitted

Legal implications/regulatory requirements

There are no legal/regulatory implications of the proposed course of action

Equality Impact Assessment

The system strategic plans for addressing health inequalities has been incorporated into the system elective recovery narrative plan.

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

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NHS Group

22-23 Operating Plan

19th July 2022

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Context

- The planning round process for 2022/23 was completed with a final resubmission on the 20th June 2022.
- As with other years, the submissions comprised multiple elements, namely:
  - Activity & Performance
  - Workforce
  - Finance (System & Providers)
  - Narrative

Triangulation between all elements is expected

Nationally, the 2022/23 planning round is intended to be the final year of single year planning returns with a move to a multi-year, ICS aligned planning process from 2023/24.

National Context

- Following the original submission on the 28th April, there has been feedback across all systems on balancing performance, capacity and resourcing / money
- There is a clear productivity drag nationally as a result of increases in workforce but lower clinical activity, compared to pre-pandemic levels

On the Operational Plan specifically…

- A clear ask to get to delivery on:
  - Elective performance and 104% of 19/20 levels of activity
  - Financial performance, to get to breakeven **but** be clear on assumptions and risks
  - Address the issues needed to deliver Winter (e.g. Ambulance Handovers, delayed discharges etc)
- National escalation for systems has reiterated the importance of delivering on all fronts, with an approach movement on unresolved issues as quantified assessment of risks, rather than accepting non-delivery
- Not agreeing a breakeven I&E plan would result in restrictions on accessing capital funds, in particular Digital

National Context

Challenge to wider NHS in planning / delivery ask

- Deficits from 2019/20 have been funded, historic deficits are not relevant as they have been written off
- Assumption Covid levels are low, drag on productivity should also be minimal. So costs and inefficiency of running clinical services should be back to pre-pandemic levels as a start point
- Workforce increases added in last two-years either need to deliver increased clinical activity or be removed
- No / negligible funding for growth in urgent care, targeted funding for elective care (based on delivery of increased activity volumes) no other funding beyond inflation and targeted investment bids

System and Local Context

University Hospitals of Northamptonshire NHS Group

System decision making

- The system has collectively agreed a financial plan with all parties taking comparable risk. We have done so in a way where relationships have remained intact and difficult decisions surfaced
- It gives UHN a major challenge to deliver on, but also recognises that providers start in different places with different pressures in the past two years

Changes from April

- Previous (April) iteration of plan gave some tolerance for movement, but this proposal removes all of that and so adds clear risk to delivery, which we need to clearly articulate and quantify
- Delivery is credible but requires all assumptions to e delivered in order to achieve breakeven
- We are still proposing to deliver on:
  - Elective performance at around 104% of 19/20 levels of activity
  - Reduction of RTT waiting lists, ensuring no patients are waiting in excess of 104 weeks for treatment
  - Recovery of cancer waits to improve performance to similar levels delivered pre-pandemic
  - Financial performance, to get to a position close to breakeven
  - Supporting a level of increased investment to support mandated areas (MHIS / BCF) and internally
- What is proposed will get us to the point for this financial year, but not sustainable into 23/24

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System Finance Plan

- System has submitted a plan of breakeven, to be delivered through a combination of:
  - Rephasing (and where possible reducing) investments, delaying their start
  - Reducing temporary staffing costs, in line with national expectations on the reintroduction of caps
  - Reducing overall pay costs, to a level closer to pre-pandemic levels, see note re the ‘productivity challenge’
- The improvement required to meet this is c£35m and this will be split consistently and across all system partners
- UHN will improve its financial plan by c£20m
- CCG surplus (c£14m), from a combination of delayed investment and additional system funding (£7m), would be redistributed to UHN on a one-off basis

Beyond 22/23 Planning

- The proposals get us to a plan for 22/23 but do not address the wider sustainability and productivity challenges upon us, in particular:
  - delaying investment which will have an impact in 23/24; but also
  - we have major decisions to make on the alignment of resources in the system
- We need to commission a longer term plan to begin identifying and addressing these issues
- The scale and pace of integration and the benefits that can be delivered through this needs to accelerate, in particular on those programmes already agreed as priorities (e.g. Pathway 2)
- We clearly have a pivotal role to lead this integration, internally and as a major system partner

Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	28 July 2022
Agenda item	7

Title	Operational Focus (including Activity against 2022-23 Plan)
Presenter	Palmer Winstanley – Chief Operating Officer
Author	Palmer Winstanley – Chief Operating Officer

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

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Executive Summary

This report provides an overview and assurance to the Board on progress for:

1. **Ambulance handover & Discharge progress**: Ambulance handovers reached a peak in April 2022. Work both in NGH ED and on wards has shown a reduction in admissions % coupled with increases in discharges on Pathway 0 from the wards. Once the COVID wave passed in April, the Trust was able to establish flow and vastly reduce delays. However, with an increase in COVID, coupled with social and community care delays increasing, there has been a steady rise from 60 patients waiting for beds on average in April, to almost 150 in July. This is severely restricting the ability for NGH to flow through a depleted bed base with COVID adding pressure.

2. **Elective/cancer delivery**:

   - The Trust continues to perform well against Cancer treatment standards. NGH hit two of the four targets, however of the two missed, the Trust remains in the top 4 in the region across all domains, and the legacy patients (waiting over 62 days) has reduced month on month meaning we are now 2nd in the country as a system.
   - Elective Care: internally performing very well. We have been providing mutual aid to UHL (Leicester). We had a trajectory of zero 52 weekers by end of July, however we have now accepted 92 patients from UHL therefore having a knock effect on our position. All those waiting over 78 and 104 weeks are UHL patients. 92 of the 135 52 weekers are UHL, with some NGH tipping over due to capacity being used up.

3. **Activity v plan:** Despite the pressure highlighted in pathways playing into the bed base, NGH continues to achieve almost 100% of 19/20 levels of activity. There are some specialties much lower due to theatre vacancy, sickness and ongoing recruitment issues in ODP's. DC rates is performing well. Diagnostic is the biggest risk as Non-Elective work continues to require capacity at 140% of expected plan (110% attendances at ED on 19/20 levels). Working being done to source more MRI onsite in the short/medium term ahead of a Community Diagnostic Centre being created.

4. **SHMI update**: During the past 12-15 months SHMI (Standardised Hospital Mortality Rate) has fallen from a peak of 102-103 to 90-92, well below the "target" level. Over the past 2 years, our HSMR (Hospital Standardised Mortality Ratio) has dramatically fallen from alerting in the "above expected range", with a peak of deaths in Winter 2019-20 and Spring 2020, to the "below expected" range. Over the past 2 years, our crude mortality rate has been consistently below the national average. In 2019-20 we had a significant "widened gap" between our weekend vs weekday non-elective mortality rates. This was highlighted by mortality review 13 of December 2019 deaths. This discrepancy has now resolved.

Appendices

Slide deck shows metrics and detailed narrative updates.

Risk and assurance

Two main risk to focus on from this update:

1. **Pathways delays:** this is preventing NGH from dealing with any other peaks in demand or other pressures such as COVID waves.
2. **Diagnostics:** A lack of capacity due to high non-elective activity means less for cancer and elective work, therefore work being done to source extra capacity.

Both of these risks will impact on the Trust's Elective position and quality outcomes.

Financial Impact

A decrease in Elective work would prevent NGH from accessing the Elective Recovery Fund for 2022/23/

Legal implications/regulatory requirements

N/A

Equality Impact Assessment

N/A

NGH Trust Board Operational Update July 2022

NGH Executive Team

28 July 2022

University Hospitals of Northamptonshire NHS Group

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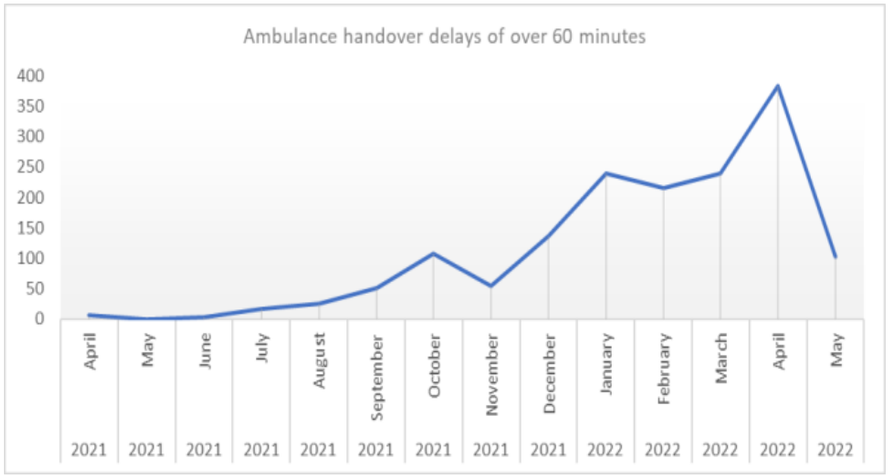
1. Ambulance Handover, Pathways & Discharge
2. Elective & Cancer Deliver
3. Elective Recovery Activity v Plan
4. Mortality Update

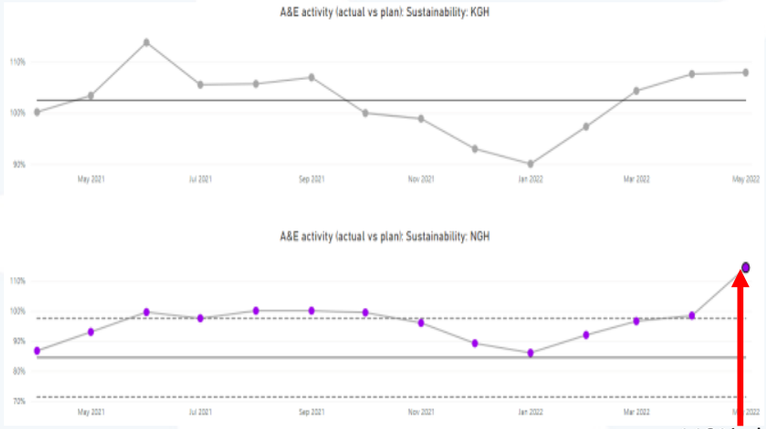
Focus Area 1: Ambulance Handover, Pathways & Discharge

Data

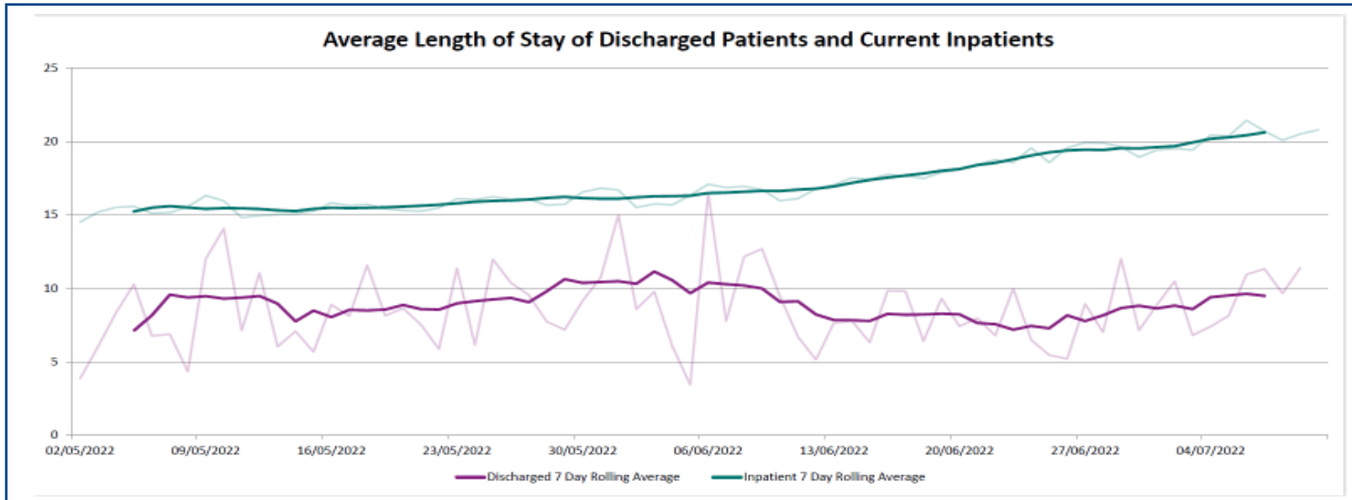


Northampton:

- Ambulance delays have peaked in April 22, however June saw a small increase along with July to date.
- Issue is twofold:
  - Firstly Q1 ED attendances are over 110% of 19/20 levels. 19/20 saw largest day with 22/23 Q1 seeing a new record of 506.
  - Secondly pathway delays have increased by double from 60-70 up to 150
- Significant work been done on pathway 0 patients to ensure the hospital remains safe.
- Emerging issue in July is increasing COVID numbers again increasing the patient moves.



113% above plan



- Purple line shows that NGH is consistently decreasing LoS for those patients we are discharging.
- The green line shows the current LoS of inpatients, indicating that all patient left in beds are dramatically increasing their LoS on average. This is shown in Pathways 1,2,3 growing from 60-70 in March 22, to 140 in Jul 22.
- This data shows that the work being done on P0 patients is having an impact whilst the numbers of patients waiting to leave on pathways is having a 5 day LoS impact.

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Focus Area 3: Systems & Partnerships - Discharge

Are we any good?

606 Total NEL and EL Beds at NGH			
88 EL & ITU	518 NEL Beds		
88 EL & ITU	130 MFFD P1,2 or 3	374 NEL Beds	
88 EL & ITU	130 MFFD P1,2 or 3	50 P0 TBC	324 NEL Beds

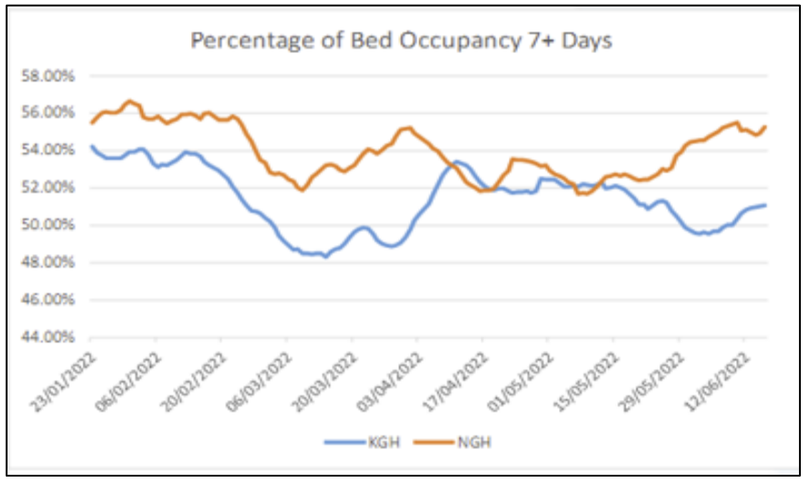
Nationally, Model Hospital shows that top quartile LoS is 9.4 days and top quartile is 8.1

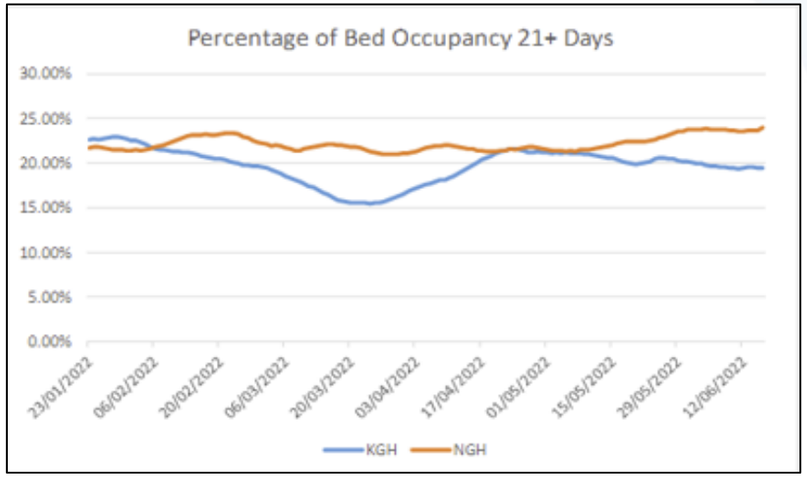
LoS on 42 discharges per day was 12.3, however on new 46/day is 11.3 days

LoS on 46 discharges/day is 8.1 days – Top quartile

LoS on 46 discharges/day is 7.04 days – 5th in the country

This shows that with the bed base that's left to operate in, NGH are turning round patients in an effective manner.





- Extensive work across the urgent and emergency care spectrum at NGH showing significant changes in LoS showing a consistent 3 day decrease in LoS with:
  - IV antibiotic trials have shown a sustained decrease in LoS on trial wards moving from IV to oral, or community IV.
  - Patient flow co-ordinators reduced LoS across medicine by 3 days on implementation.
  - Diagnostics have ensured all MRI and CT completed within 24 hours, previously 2 days.
  - Frailty unit started and successfully discharging over 50% of patients per day.
  - Same Day emergency Care (SDEC) continues to be one of the top performers nationally.
  - ED has lowered consistently their admission % from 20% to 16/17%

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MFFD (Medically Fit For discharge; P1, 2 or 3 (Pathways 1, 2 or 3); P0 (Pathway Zero)

LoS (Length of Stay)

Focus Area 2: Elective & Cancer

CANCER

Standard	%	Target	Regional position	National Average
Two Week Wait	94.4	✔93%	3rd	83%
28 Day Faster Diagnosis	79.3	✔75%	2nd	70.8%
31 Day	90.7%	✖96%	2nd	91.8%
62 Day	64.8%	✖85%	2nd	61.5%

- 1721 referrals were received for May compared to 1357 for the same month pre covid which is a 26.8% increase in referrals. 48.1% of patients were seen in 7 days or less.
- The Trust has 80 patients waiting over 62 days (legacy) a 17.5% reduction from last month. This is 5.7% of our overall PTL. 23 patients have their treatment planned and 6 patients are with our tertiary providers.
- Diagnostic wait continue to rise as a result of the NEL work. Working to secure extra MRI capacity ahead of the Community Diagnostic Hubs (CDH) creation. This would in turn release CT staff to extend days.

ELECTIVE CARE

Standard	Total	Target	Comment
104 Weekers	22	✖ 0	All UHL Patients
52 Weekers	132	✖ 10	

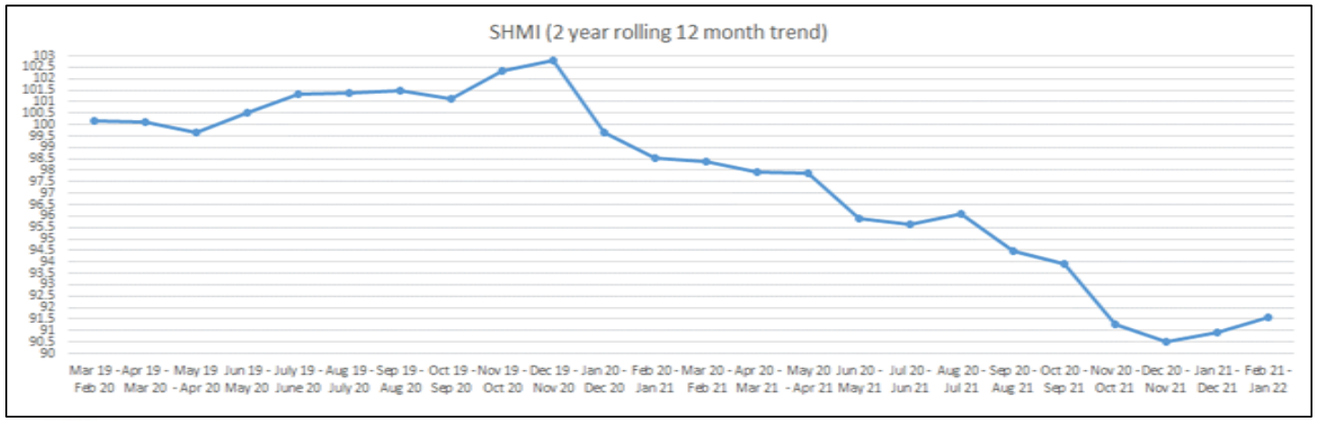
- NGH and KGH have been asked to provide mutual aid to University Hospital Leicester to support treating long waiting patients. Both Trusts are accepting in total 300 IPT transfers from Leicester. For the purposes of 22/23 plans this will equate to 150 each, all of which will have waited longer than any of our current patient cohort.
- NGH have accepted 92, and KGH 35 so far..
- 104 Weekers:
  - 23 patients - 22 ENT and 1 Urology. Directorates have been asked to prioritise these to clear by the end of the month however due to capacity, sickness and operational pressures this is at risk.
- 52 Weekers:
  - T&O (74), Gynae (24) & ENT (13)
  - T&O is capacity and sickness. May & June has seen high levels of consultant sickness coupled with excess emergency levels through May.
  - Gynae & ENT are excess UHL patients.

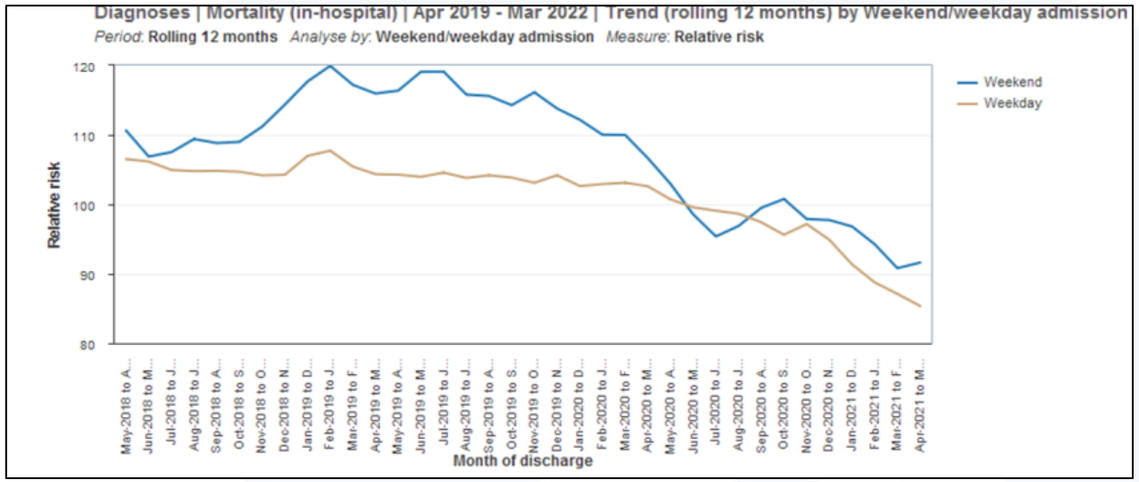
Focus Area 3: Elective Recovery Activity v Plan (Q1)

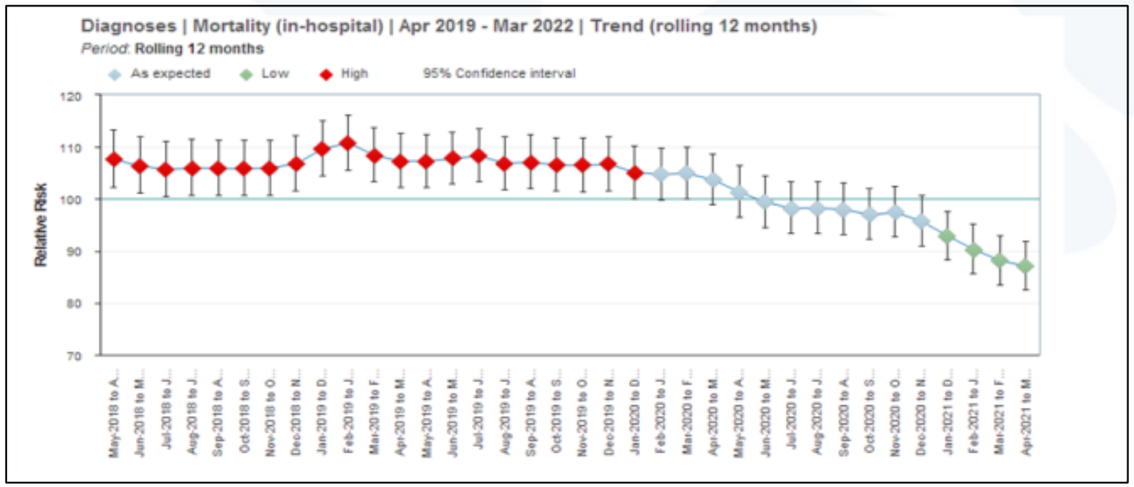
Elective	Day Case	Outpatients	Diagnostic
↓ (97%) -35 on plan 1056	↑ (101%) +112 on plan 10,826	↓ 1st (97%) -1078 on plan 36,983 ↑ FUp (100%) +444 on Plan 88,896	↓ (94%) -991 on plan 17,757
Key variance • Head & Neck at 81% of plan • Trauma & Orthopaedics at 83% of plan • General Surgery at 93%of plan Theatre list losses due to staffing issues with ODP's, anaesthetists and surgeons through A/L, COVID, fatigue (no take up of extra lists) and vacancies are the main drivers.	**Key variance** • Head & Neck at 79% of plan • Trauma & Orthopaedics at 91% of plan • General Surgery at 90% of plan • Obs & Gynae at 75% of plan • Oncology at 107% of plan	**Key variance** • Oncology & Clinical Haematology at 91% • Head & Neck at 88% • General Surgery 93% Most services are performing at >100% for F2F appointments but have seen a drop off of NON F2F appointments since COVID restrictions were reduced with most services recording 70-80% of non F2F activity.	**Key variance** • MRI and ECHO are most pressured services at 95% and 91% respectively but are only at 68% and 71% against 6 week target • Flexisig at 50% of plan but national move away from this has seen most trusts seeing a marked decrease nationally. • Colonoscopy at 79% and Gastroscopy at 75% however 6weeks target is being met
Actions • Further Insourcing discussions underway to support the position. • 92 of 150 UHL patients accepted for treatment via mutual aid • Foot and ankle orthopaedic locum appointed to support the single handed consultant in this area • Substantive appointment of H&N consultant will see H&N figures improve from the end of July	**Actions** • Further Insourcing discussions underway to support the position. • 92 of 150 UHL patients accepted for treatment via mutual aid • Foot and ankle orthopaedic locum appointed to support the single handed consultant in this area • Substantive appointment of H&N consultant will see H&N figures improve from the end of July	**Actions** • Continued validation of unappointed patients ensures we are now only seeing the patients that need to be seen • Weekly performance meetings with all divisions regarding elective performance and PTL meetings in place for all specialties. • Activity vs Plan is now standing agenda item at Access Board so Divisions know where they have to increase their activity to meet the plan	**Actions** • Weekly monitoring in place via Diagnostic PTL, issues escalated to COO as required • Options regarding additional MRI capacity being explored for both trusts via diagnostics bids to region and use of CDC monies • Community Diagnostic Centre case ongoing • Locum Cardiologist in place to support DSE backlog clearance • Additional CT capacity being put in place with use of PET CT scanner for routine CT scans at evenings and weekends • £1.7mil received from successful bid to create to endo rooms and decontamination facility at Danetre
Expected Impact June performance increase to 98% in June and expect a further 2% increase in the coming months	**Expected Impact** Already seeing improvement in June with performance at 105% for the month	**Expected Impact** Follow up activity needs to fall by 25% to meet national target but validation has removed 100,000 patients so only leaves patients who need to be seen so the opportunity is less for UHN.	**Expected Impact** Without investment in additional MRI capacity we will see only modest increases in performance. Echo capacity is a national problem with physiologists in high demands and low availability

Focus Area 6: SHMI

•SHMI (Summary Hospital-level Mortality Indicator) is a national metric of all hospital deaths + deaths within 30 days of discharge.
•During the past 12-15 months SHMI has fallen from a peak of 102-103 to 90-92, well below the “target” level.
•Over the past 2 years, our HSMR (Hospital Standardised Mortality Ratio) has dramatically fallen from alerting in the “above expected range”, with a peak of deaths in Winter 2019-20 and Spring 2020, to the “below expected” range.
•Over the past 2 years, our crude mortality rate has been consistently below the national average.
••In 2019-20 we had a significant “widened gap” between our weekend vs weekday non-elective mortality rates. This was highlighted by mortality review 13 of December 2019 deaths. This discrepancy has now resolved.
•A clinical improvement paper, for presentation at CQEG and QGC in July, has explored in more depth some of the organisational changes and quality initiatives that have likely contributed to our improved mortality performance.
•The paper has concluded that: *Clinical improvement initiatives and changes to service provision aimed at improving the quality of care provided to patients out of hours, and in particular at weekends, are likely to have had the greatest impact on the dramatic reduction in our hospital mortality performance from a peak HSMR during 2019-20 to present day.*







University Hospitals of Northamptonshire NHS Group

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NHS
Northampton General Hospital
NHS Trust

Cover sheet

Meeting	NGH Trust Board
Date	28th July 2022
Agenda item	8

Title	Theatres productivity and the Trust Care Co-ordination System
Presenter	Becky Taylor, Group Director of Transformation and Quality Improvement Palmer Winstanley, Chief Operating Officer
Author	Becky Taylor, Group Director of Transformation and Quality Improvement

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

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

Reason for consideration	Previous consideration
This paper outlines our theatre productivity programme and highlights the Trust CCS (Care Co-ordination System) tool that supports greater waiting list and theatre scheduling management	N/A

Executive Summary

Improving the productivity of our operating theatres is a key transformation programme to support us to achieve our elective recovery trajectory and targets in the 22/23 plan.

Our theatres teams in both hospitals have worked extremely hard throughout the pandemic to ensure that we keep our cancer surgery operating and minimise the disruption to elective care, and as a result of their dedication and effort our waiting list performance is amongst the best in the country.

In order to continue to improve the waiting times for our patients in Northamptonshire, we have a theatres productivity programme.

A key enabler of this programme is the Trust CCS (Care Co-ordination System), which is a valuable tool to support the visibility of theatres performance, scheduling and booking, for which we are two pilot Trusts supported by an NHSE programme and a demonstration of the tool will be covered.

The Trust CCS tool will support waiting list management and validation, and improving our theatres booking and scheduling, aiming to have completed roll out to all surgical specialties by the end of September.

Appendices

N/A

Risk and assurance

This paper outlines the transformation programme and tool that mitigates risks to the delivery of our elective activity plan for 22/23 and current risks to the availability of high quality data to support our operating theatres.

Financial Impact

Improving the productivity of theatres has a material impact on our ability to achieve the elective activity targets for 22/23 and so access the Elective Recovery Fund (ERF) for the system.

Legal implications/regulatory requirements

N/A

Equality Impact Assessment

The increased visibility of our waiting list across the system will provide us with greater opportunities to ensure that we are able to equitably manage the delivery of elective care in Northamptonshire.

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

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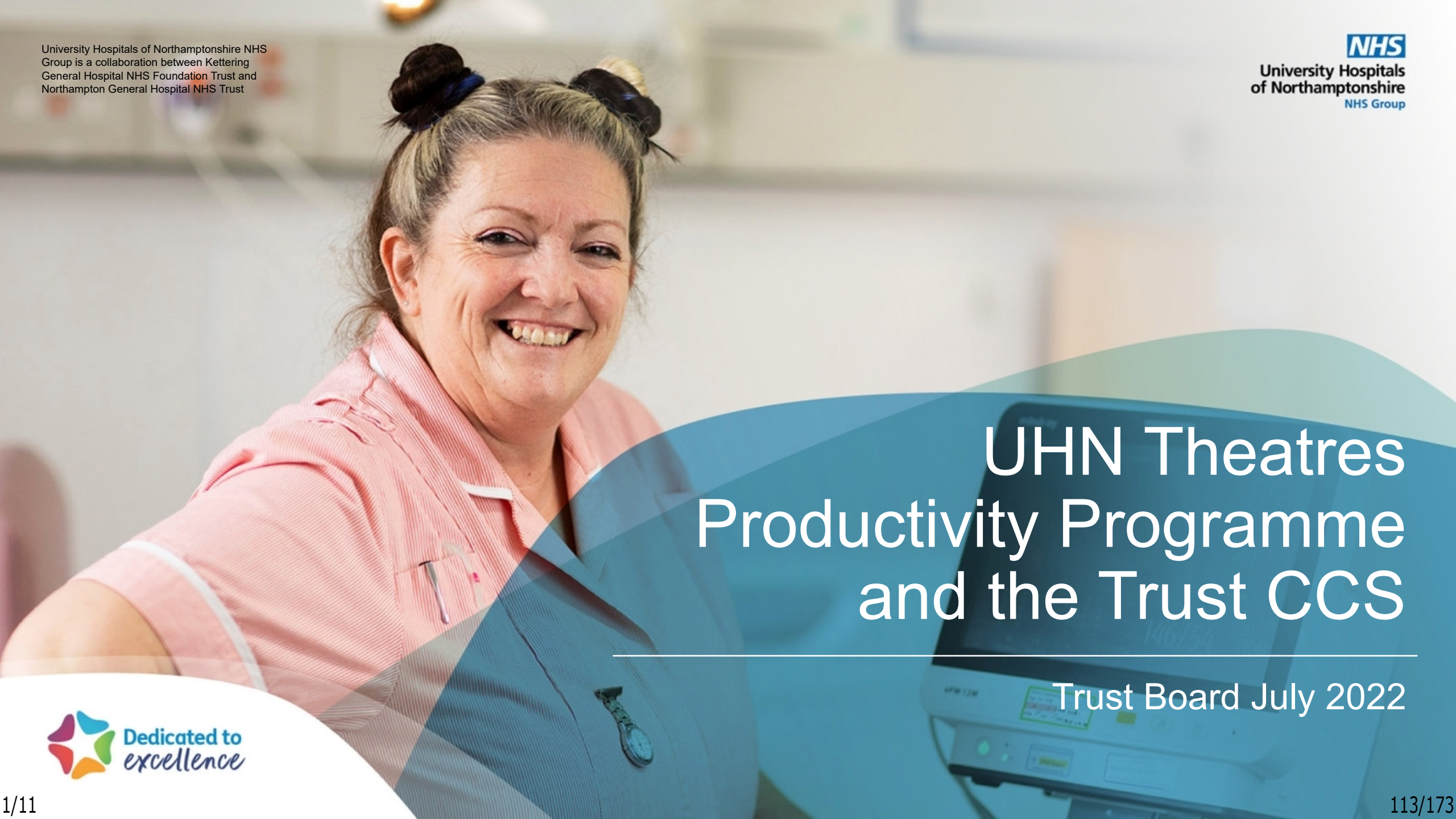

UHN Theatres Productivity Programme and the Trust CCS

Trust Board July 2022

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Theatres productivity programme

- Improving the productivity of our operating theatres is a key transformation programme to support us to achieve our elective recovery trajectory and targets in the 22/23 plan.

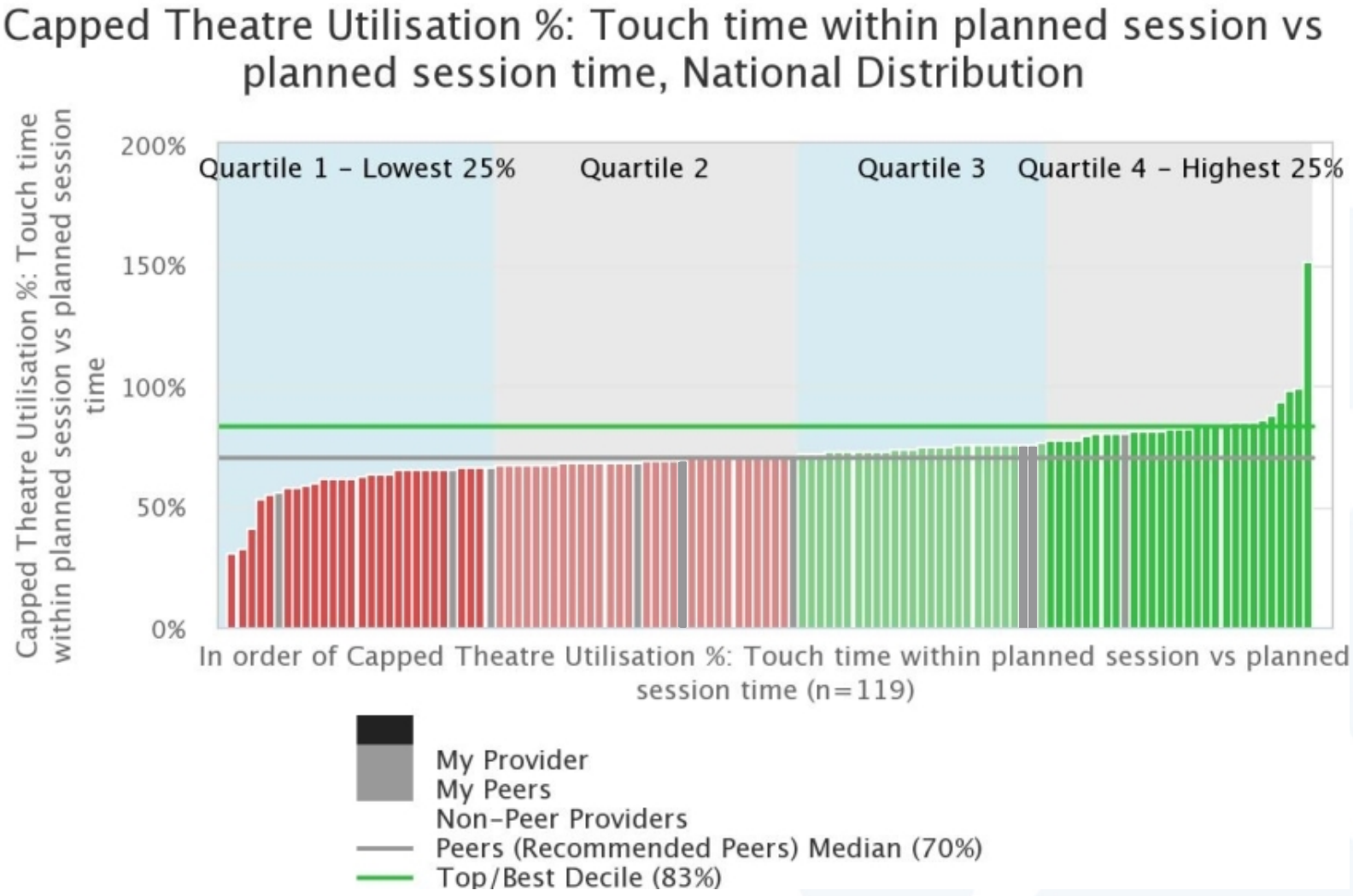
- Our theatres teams in both hospitals have worked extremely hard throughout the pandemic to ensure that we keep our cancer surgery operating and minimise the disruption to elective care, and as a result of their dedication and effort our waiting list performance is amongst the best in the country.

- In order to continue to improve the waiting times for our patients in Northamptonshire, we have a theatres productivity programme.

- A key enabler of this programme is the Trust CCS (Care Co-ordination System), which is a valuable tool to support the visibility of theatres performance, scheduling and booking, for which we are two pilot Trusts supported by an NHSE programme.

Theatres productivity: the national picture

- There is a national target of 85% for theatres productivity, which represents top decile performance nationally.
- There are 9 Trusts nationally achieving the 85% target

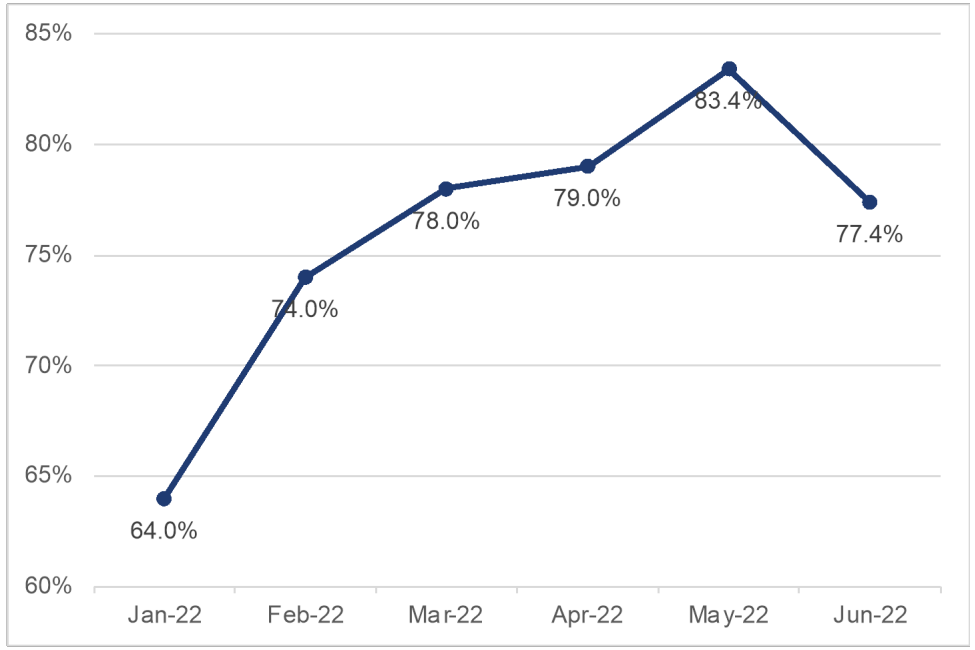


Theatres productivity current performance and targets

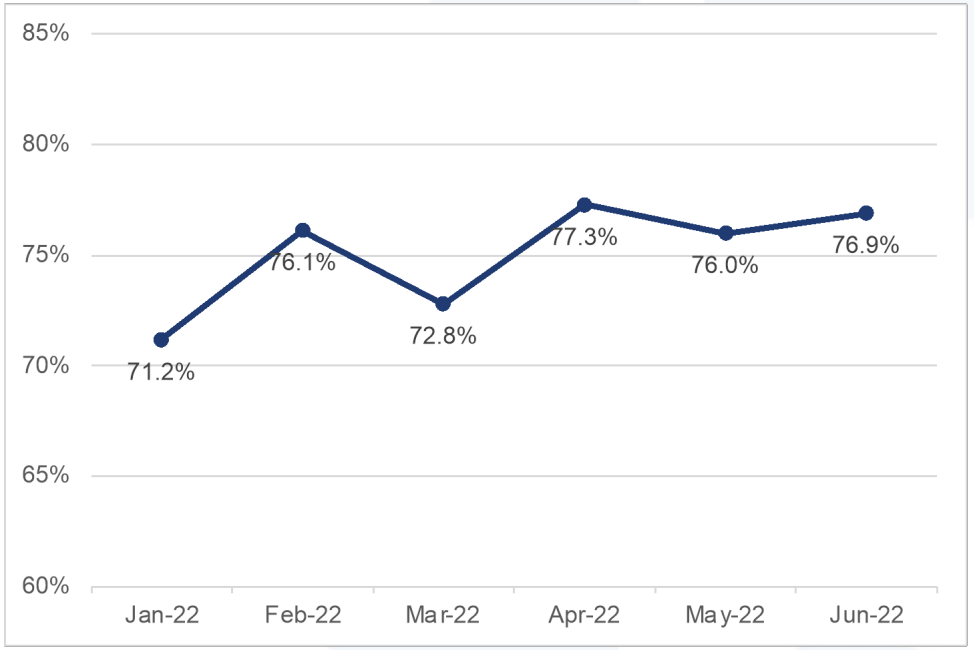
Increasing theatres productivity is a key programme supporting the delivery of our elective activity plans for the year. Both hospitals have an improvement trajectory for theatres performance.

The national target is 85%, and both hospitals have a trajectory for improvement towards this target through the year to support the delivery of the submitted 22/23 elective activity plan.

NGH theatres utilisation – June 2022



KGH theatres utilisation – June 2022



Improving theatres productivity programme

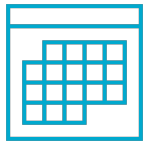
University Hospitals of Northamptonshire NHS Group

What's the vison for the programme
To provide excellent elective care in the right timescales to meet the needs of the local population and support the delivery of the elective plan. Improving the the delivery of the elective pathway through ensuring that our theatres are efficiently utilised, by improving each element of the pathway from decision to list through to recovery, ensuring our staff are supported and making the experience for patients better.

The right patients

with the right pre-operative assessments

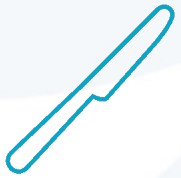
booked in the right theatre sessions



with the right staff

with the right skills

with the right equipment



that runs smoothly on the day

supported by the right systems with the right visibility of data

managed and led by the right leadership team

and delivered by a team with the right culture

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Challenges being addressed by the theatres programme

	The right patients with the right pre-op assessments	Booked in the right theatre sessions	With the right staff with the right skills
KGH	The pre-op assessment team have lost two clinic rooms so there is not enough space to pre-assess patients		A number of experienced staff have left during Covid leaving an inexperienced staff base who have required extensive competency training
Both	Digital preoperative assessment solutions need implementing to support pre-op teams and reduce the need for in-person pre-op The current processes to validate the waiting lists are manual and time consuming for the team	The 6-4-2 process (6 weeks the timetable is locked down, 4 weeks the list is planned, 2 weeks the list order is locked down) needs revitalising and refreshing post-Covid	Covid rates are increasing and this is having a knock-on impact on staffing availability for both theatres staff and surgeons, resulting in reduced capacity and late cancellations of sessions
NGH			There is a 50% vacancy rate for ODPs which is causing challenges to be able to staff lists

The Trust CCS supports clinical prioritisation and management of the inpatient waiting list and list of patients with completed pre-ops

The Trust CCS supports the 6-4-2 scheduling process through providing forward visibility of sessions, highlighting those where staffing isn't available and those that are under-booked

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Challenges being addressed by the theatres programme

	Supported by the right systems with the right data	Managed and led by the right leadership team	And delivered by a team with the right culture
KGH	There have been challenges with the Bluspier system in correctly assigning the right times to operation lengths		
Both	Better visibility of theatre capacity, performance, and in particular forward-looking booking data to support the 6-4-2 process has been unavailable to teams to manage the process	During Covid the roles and responsibilities were rightly changed to deal with the pressures, but leadership and accountability for the theatres lists now needs resetting as we return to full governance and managing performance to achieve the elective target	Team morale within theatres is low due to a combination of vacancies, sickness and pressure of working through Covid.
NGH	The cancellation options within Nexus have historically been too numerous to be useful		

The Trust CCS supports creating a single view of data from multiple systems to help manage performance, including staffing, waiting list and theatres data.

Improving Elective Care Co-ordination for Patients: Trust CCS Programme at UHN

July 2022

NHSE Trust CCS Pilot Overview

Executive Overview

Provides an overview of key metrics across the trust, including Waiting list shape/size and utilisation over time. Can be used to assess comparative performance across the trust

6-4-2 Leads , Executive Board, Ops managers

Waitlist Overview

A near real-time, statistical overview of the entire in-patient waiting list filterable to specialties & consultants

- Service Managers
- Pathway Managers
- Clinicians

Waitlist Cleaning

Automated, customisable alerts that flag issues like duplicate procedures & TCI dates in the past to quickly clean your waitlist

- Admissions
- Waitlist Managers

Scheduling

Efficiently book patients into theatre sessions referencing data from 5+ different sources in a single, collaborative space

- Admissions
- Medical Secretaries
- Clinicians

Theatres Management

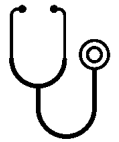
A wrapper around the 6-4-2 process that provides information from 5+ sources in one place & a single portal to collaborate on actions

- Theatres team
- Specialty Service Managers

Progress so far – key stats of the programme

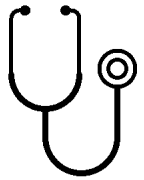
- Introduction and training sessions held with three pilot specialties
  - NGH: Head & Neck, Urology, T&O
  - KGH: Head & Neck, General Surgery, Urology
- 3 patients clinically reprioritised
- 40 patients removed from waitlist
- 17 sessions had additional cases added
- 48 requests to add more patients to theatre lists
- Reviewed theatre sessions have resulted in 2% increase in utilisation compared to sessions not reviewed




Next steps and roll-out plan

- Launching the full 6-4-2 theatre scheduling management system in August
- Accelerated timeline aims to roll-out to all surgical specialties by end September
- In order to support engagement, currently undertaking resource planning to ensure that all specialties receive dedicated training and support throughout
- Progress to be reported through Committees to Board
- Initial work underway to include data to implement the Outpatients Waiting List application which will support management of outpatient first and follow-up waiting lists



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Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	28 July 2022
Agenda item	9 - Freedom to Speak Up Annual Report

Title	Freedom to Speak Up Annual Report
Presenter	Eleanor Southgate, Freedom to Speak up Guardian, Northampton General Hospital NHS Trust
Author	Eleanor Southgate, Freedom to Speak up Guardian, Northampton General Hospital NHS Trust

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

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

Reason for consideration	Previous consideration
The report provides assurance that processes are in place to support staff to raise concerns which are pertinent to patient and staff safety. The Committee is asked to note and comment on the content of the report and accept this paper for information and assurance.	The report constitutes the annual update to the Committee.

Risk and assurance
The report provides assurance of processes in place to support staff to raise concerns which are pertinent to patient and staff safety.
Financial Impact
None
Legal implications/regulatory requirements
There is a legal requirement under the Health and Social Care Act to appoint a Freedom to Speak Up Guardian.
Equality Impact Assessment
There is no potential for, or evidence that, the proposed decision / document will disrupt equality of opportunity for all or promote good relations between different groups. There is no potential for, or evidence that, the proposed decision / document will affect protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics).

Northampton General Hospital NHS Trust Freedom to Speak Up Annual Report 2021-22, with 2022-23 Q1 Report

Introduction

- Freedom to Speak Up promotes and encourages the raising of concerns from NHS workers, sub-contractors and volunteers to ensure patient safety is maintained at all times and to make the health service a better place to work.
- In February 2015, the recommendations of the Freedom to Speak Up Review were published. A number of recommendations were made in order that a more consistent approach to whistleblowing across the NHS could be delivered, including the requirement for all organisations to appoint a Freedom to Speak Up Guardian.
- 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.

Freedom to Speak Up (FTSU) annual report: cases heard April 2021- March 2022

Overview

- The numbers of cases reported via the Freedom to Speak Up (FTSU) programme for 2020/21 were 47.
- According to the 2020/21 report of the National Guardian's Office, the average number of cases for a medium-sized trust is 26 cases per quarter.[1]

Spread of cases over FY 2021/22

Quarter	Cases reported in quarter	Cases reported in same quarter of previous FY
Q1	5	7
Q2	14	8
Q3	12	14
Q4	16	13

Content of cases reported

Category	Q1	Q2	Q3	Q4	Total 2021/22	Total 2020/21
Patient safety / quality	1	7	5	9	**22**	15
Staff safety / training	1	8	2	7	**18**	13
Bullying and harassment	4	7	9	10	**30**	22
Systems, processes or policies	1	1	2	8	**12**	16
Environment/ infrastructure	0	1	0	0	**1**	1
Culture	0	1	1	14	**16**	4
Leadership	0	1	1	14	**16**	4
Use of resources	0	0	0	0	**0**	3
Detriment suffered	0	0	0	3	**3**	0

- 22 cases (47% of all cases in 2021/22) identified issues with patient safety / quality 47% (38% in 2020/21).

[1] Annual-Speaking-Up-Data-Report-2020-21.pdf (nationalguardian.org.uk) – *NB- Data for 2021-22 is yet to be released by the National Guardian's Office*

- 18 cases (38% of all cases in 2021/22) identified issues with staff safety / training (31% in 2020/21).
- 30 cases (64% of all cases in 2021/22) identified issues with bullying and harassment (52% in 2020/21).
- 12 cases (38% of all cases in 2021/22) identified issues with systems, processes or policies (26% in 2020/21).
- One case (2% of all cases in 2021/22) identified issues with environment / infrastructure (2% in 2020/21).
- 16 cases (34% of all cases in 2021/22) identified issues with culture (10% in 2020/21).
- 16 cases (34% of all cases in 2021/22) identified issues with leadership (10% in 2020/21).
- No cases in 2021/22 identified issues with use of resources (3% in 2020/21).
- Three cases (6% of all cases in 2021/22) identified issues with detriment (there were no cases identified as involving detriment in 2020/21).

It should be noted that the current Freedom to Speak Up Guardian came into post in February 2022. As a result, the assignment of categories to case is subject to as a result of individual bias change from this point on (in Q4).

Agent to which cases are reported

Source	**Q1**	**Q2**	**Q3**	**Q4**	**Total 2021/22**	**Total 2020/21**
FTSU Guardian	4	12	11	15	**42**	39
CQC	1	0	0	0	**1**	2
GOSW	0	0	0	0	**0**	0
Ambassador	0	2	1	1	**4**	1
DATIX	0	0	0	0	**0**	0
Other	0	0	0	0	**0**	0

Source of concerns raised by staff group in the last year

Staff group	**Q1**	**Q2**	**Q3**	**Q4**	**Total 2021/22**	**Total 2020/21**
Doctor	0	3	0	1	**4**	5
Registered nurses and midwives	1	4	4	7	**16**	14
Allied health professionals (AHP)	0	2	2	4	**8**	6
Health care assistants (HCA)	0	0	0	0	**0**	1
Admin, cleaning & maintenance / ancillary staff	1	4	5	0	**10**	9
Corporate	2	1	0	4	**7**	3
Other	1	0	1	0	**2**	4
Total	**5**	**14**	**12**	**16**	**47**	42

Activity since new Guardian in post (from February 2022)

Improving culture

- Introduction to the FTSU programme is now a part of the induction for all trust staff.
- In collaboration with the Hospital Chief Executive Officer (HCEO), the Director of Human Resources and the Equality, Diversity and Inclusion (ED&I) Lead, there has been the development and delivery of the Connect, Explore, Improve initiative for improving culture and supporting the creation of working environments that value speaking up.
- Facilitation of the delivery of a programme of initiatives, opportunities and events, in collaboration with the HCEO and the ED&I Lead, that create safe spaces for speaking up (e.g. Connect sessions and Connect, Explore, Improve Safety and Improvement Huddles).
- Work has commenced, with HR and Organisational Development, and under the Connect, Explore, Improve initiative, to develop and deliver a programme of opportunities and events that offer staff the skills for promoting and sustaining local level speaking up.
- Working with HR and the EDI Lead, the FTSU programme has collaborate on action taken to support staff who have faced detriment as a result of speaking up. This has included personalised introduction to Health and Wellbeing Support Services and culturally sensitive support delivered by the EDI Team.

Data management and analysis

- Completion of a review of FTSU data management system has led to the development and implementation of a revised template for recording and analysing data.
- Development and implementation of new questions for capturing more accurate demographic information (i.e. ethnic background, protected characteristic and membership of staff representation network are now recorded in-line with how the individual chooses to self-identify). This has helped to better identify barriers to speaking up and is already supporting the development of a FTSU Action Plan that is more responsive to local needs.
- Development and launch of a log of outcomes and learning achieved through the FTSU programme has greatly aided trust-wide communication and operationalisation of revised policy.
- Engagement with Divisional Governance meetings over the next few months will support the development of a map increase the reach of this learning. Research for the development of a robust policy to support the operationalisation process is also now underway.

Values ambassadors

- Establishment of regular values ambassadors' forum meetings and use of this meeting for co-production of the FTSU Action Plan and Guide to Speaking Up is well embedded (e.g. structured feedback sessions for the development of supporting resources for the FTSU programme).
- Training for a new cohort of values ambassadors has been delivered.
- Refresher training for existing values ambassadors has now been delivered.
- Guided discussion at the values ambassadors' forum meeting regarding the demographic data of the group and their spread across the hospital has informed our understanding of how reflective the group is of the staff population.
- An agenda item at the next forum will deliver the co-production of a recruitment campaign for developing a diverse value ambassador group and plan action so that the values ambassador group is truly support all of our staff, volunteers, students and contractors.
- Work has progressed, in collaboration with the Organisational Development Team, to develop a seminar series for values ambassadors, to offer the cohort evidence-based skills for supporting speaking up and reducing and preventing unprofessional behaviour in their work environment.[2]
- Continue working closely with the ED&I Lead and the staff network leads to identify patterns of bullying, harassment and discrimination in relation to specific protected characteristics, whilst maintaining confidentiality.

Activity in preceding year

[2] Illing JC, Carter M, Thompson NJ, Crampton PES, Morrow GM, Howse JH, *et al. Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision making in the NHS.* Final report, NIHR Service Delivery and Organisation programme; 2013.

- All data submissions were made before the required deadline.
- Attended the Midlands Regional FTSU Network Meetings held virtually.
- Reviewed all Case Review Reports published to date by the National Guardians Office and the recommendations made.

Improvements for our staff and patients

Thanks to staff that have spoken up, the following improvements have been made since February 2022:

Improving support for and communication with junior doctors

- Following a discussion facilitated by the FTSU programme, areas for improved communication and support for locally employed doctors have been identified.
- Improvements in the speaking-up culture for this staff group have been made, including proactive engagement to encourage the raising of all manner of concerns with clinical leaders and the Medicine Division Leadership Team,.
- This insight has also been shared with senior leaders and consideration of how to improve the planning and booking of leave across medical staff rotations is underway.

Strengthening the policy around midwifery preceptorship

- Thanks to concerns raised by a midwife regarding having their preceptorship approval process finalised, midwifery leadership have reviewed and strengthened their policy to ensure a standardised application of this process occurs and that those having completed their preceptorship training receive recognition.

Development of HR policy to guide staff exclusion

- Through sharing concerns raised through the FTSU programme, HR Business Partners have developed more robust and comprehensive policy covering all aspects of the staff exclusion process. This will support and protect both the trust, the manager and the employee in future such circumstances.

Supporting the Maternity Services Strategic Organisational Development Plan

- Through regular meetings with Maternity Services Leadership and the Project Lead, the FTSU programme has supported the Organisational Development Plan for Maternity Services with insight to inform the planning for staff engagement and co-production.
- Through raising the themes of concerns from Maternity Services with senior leaders a mechanism has been developed to link staff involved in a Serious Incident with SoS services.

Triangulation of information to inform strategic planning

- The triangulation of information, delivered through the FTSU programme, has helped to identify where improvements in policy, procedure and responsive guidance is needed trust-wide.

Patient confidentiality policy

- The FTSU programme has helped to bring about a strengthening and reinforcement of the patient confidentiality policy to consider all working environments, including the work-from-home setting.

Delivering recruitment and employment standards

- Working with HR, the FTSU programme has helped to identify and support areas of the trust where managers need HR engagement and guidance to meet recruitment and employment standards. This will protect the trust, managers and staff and has enhanced policy related to both recruitment and substantive and bank employment.

Grievance procedure

- The FTSU programme has supported members of staff who are engaged in a grievance, both with their engagement with HR and to understand and access support to return to work.

Safeguarding

- Management of a concern, raised through the FTSU programme, has helped to significantly strengthen engagement and communications with internal and external safeguarding agents.
- The same case has introduced leaders to the trust's various safeguarding risk assessments and policies.

Further work required

The following areas of work have been prioritised, to develop the FTSU programme at NGH:

- Complete the Board self-assessment using the NHSE/I tool.
- Promote and encourage leaders to complete the e-learning for leaders, produced by the NGO and HEE, to 'support their understanding of the benefits and drivers of fostering a healthy speaking up corporate culture'.[3]
- Review and operationalise the relevant recommendations from the NGO's case review reports and implement the tool to support gap analysis for the improvement of speaking up arrangements.[4]
- Complete the refresh of the FTSU strategy, supporting resources and policy.
- Further develop ambassador role and increase numbers.

Freedom to Speak Up (FTSU) Q1 2022-23 report: cases heard April – July 2022

Overview

- Within the quarter being reported, 26 Freedom to Speak Up cases were received. This is an increase on the previous quarter (an increase of 10).

Route to Freedom to Speak Up Guardian and status

- All of the 26 cases were reported to the Guardian directly.

- Of the 26 cases:
    - 15 remain open with ongoing investigations/ or report write up underway;
    - nine have been referred to HR or are within an HR process, and
    - two have been closed.

Source of concerns

Please note the classification of staff group is in-line with the National Guardian's Office reporting requirement.

Source of concerns raised by staff group:

Staff group	**Number of concerns raised**
Doctors	1
Registered nurses and midwives	17
Allied health professionals (AHP)	2
Health care assistants (HCA) and Midwifery Support Workers (MSW)	2
Admin, cleaning & maintenance / ancillary staff	2

[3] HEE elfh Hub (e-lfh.org.uk)
[4] https://nationalguardian.org.uk/wp-content/uploads/2021/12/Learning_from_Case_Reviews.pdf

Corporate	2

Anonymity and detriment

- No one raising a concern wished to remain anonymous.
- There were five cases in which the individual indicated they are or have been suffering detriment as a result of speaking up, either currently or in the past.

Categorisation of concerns

Category	**Number of cases in which the issue is raised**
Patient safety / quality	18
Staff safety / training	23
Bullying and harassment	16
Systems, processes or policies	22
Environment/ infrastructure	11
Culture	19
Leadership	21
Use of resources	5
Detriment suffered	5

- Please note the categorisation of the concerns is in-line with the National Guardian's Office reporting requirement.
- This notes that 'A case may include elements of patient safety/quality, bullying or harassment, worker safety or wellbeing and/or other inappropriate attitudes or behaviours (as well as other matters). Please use all categories that apply for each case.'[5]
- It should be noted that the current Freedom to Speak Up Guardian came into post in February 2022. As a result, the assignment of category to case is subject to change from this point on (in Q4) as a result of individual bias.

Concerns reported by Division:

Division	**Quarter 1**
Medicine	4
Surgery	2
WCOHCS	15
CSS	0
Corporate	5
Unknown	0

[5] National Guardian's Office, *National Guardian's Office Guidance: Recording Cases and Reporting Data* (2022)

Recommendation

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

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Northampton General Hospital
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Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	28 July 2022
Agenda item	10

Title	Report on the activities of the Northamptonshire Health Charity (NHCF)
Presenters	Debra Shanahan, Interim Director of Nursing and Quality and Trustee to the NHCF Keith Brooks, Managing Director, NHCF
Author	Richard May, Interim Trust Board Secretary

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

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

Reason for consideration	Previous consideration
The Terms of Nomination require the submission of reports on the NHCF's activities on an annual basis.	Reports submitted to Board of Directors in July each year.

Executive Summary
The NHCF acts as trustee for the Trust's charitable funds. Keith Brooks from the NHCF will attend the meeting to present a review of the Charity's activities during the past year, as set out in the **attached** slides. The presentation is for the Board's receipt, information and consideration.

Appendices
Presentation: Reflecting on the activities of the charity during the last year
Risk and assurance
No direct implications
Financial Impact
No direct implications
Legal implications/regulatory requirements
As set out in ‘Reason for consideration’ above
Equality Impact Assessment
The charity’s activities generate positive equality impacts, as specified in the presentation.

Presentation to NGH Board

28th July 2022

Reflecting on the activities of the charity during last year

Presented by Keith Brooks

NORTHAMPTONSHIRE Health Charity

Help us today to improve lives tomorrow!

Brief initial reflections on the past year

- Commenced the financial year with formal merger with the KGH charity
- Grant making during the year prioritised supporting staff and patient facilities in accordance with the specific needs the trusts had identified.
- Launch of the NHFT delivered Stronger Together programme seeking to provide additional mental health support for Health and Social care staff across the county. One of the first NHSCT “Stage 2” projects
- Noticeable effects of continued restricted visiting on donations received by the charity at all sites.

The Financials for the year

	KGH Funds		NGH Funds		NHFT Funds		Core activity		Total	
	2020/21	**2021/22**	*2020/21*	**2021/22**	*2020/21*	**2021/22**	*2020/21*	**2021/22**	*2020/21*	**2021/22**
	£000	*£000*	*£000*	*£000*	*£000*	*£000*	*£000*	*£000*	*£000*	*£000*
Income										
Donations & other grants	*216*	568	*253*	337	*50*	103	*394*	57	913	1,065
ANHSC Grants	*303*	0	*45*	121	*31*	44	*328*	0	707	165
Legacies	*219*	189	*176*	137	*0*	0	*0*	5	395	331
Fundraising	*28*	66	*19*	66	*12*	3	*51*	42	110	177
Investments	*0*	0	*27*	44	*0*	0	*48*	52	75	96
Total income	***766***	***823***	***520***	***705***	***93***	***150***	***821***	***156***	***2,200***	***1,834***
Expenditure										
Fundraising costs	*23*	12	*3*	3	*1*	3	*145*	279	172	297
Grants paid	*421*	199	*795*	505	*125*	102	*47*	311	1388	1117
Support costs	*33*	0	*0*	0	*0*	0	*111*	167	144	167
Total expenditure	*477*	211	*558*	508	*87*	105	*315*	757	1704	1581
	289	612	*36*	197	*(2)*	45	*(139)*	(601)	496	253

Some of the specific initiatives linked to NGH …

Swan room created on Creaton Ward

Funding refurbishment of side room to provide improved environment for end of life care.

New furniture provided for on call rooms

Funding the provision of new furniture for the doctors on call rooms to make a more welcoming environment in which to rest

Refurbishment of porters staff area

Funding porters rest room refurbishment using Covid grant funding received from Barclaycard.

Artwork provision for the new children's emergency department

Funding wall graphics which I think look really good.

Our achievements…

- the trust specific charity sub committees have provided valued support .
- Relaunched specific fundraising events working within constraints of the continued effect of Covid.
- Have been appointed charity of the year for Northamptonshire Chamber of Commerce

NORTHAMPTONSHIRE Health Charity
Help us today to improve lives tomorrow!

- Share video used for the bid

Our asks for the future…

- Need for a good list of cases for need, items for specific units, wards and departments
- Help with updating and inducting our list of fund advisors who are so essential to effective charity operation
- Encourage links with staff, specifically encourage events like Spring into fitness, and please encourage those wanting to undertake a specific challenge
- Please kept the charity informed about the Trusts development plans and seek to identify where we can help

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Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	28 July 2022
Agenda item	11

Title	Group Board Assurance Framework (BAF)
Presenter	Richard May, Trust Board Secretary (Interim)
Author	Richard May, Trust Board Secretary (Interim)

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

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

Reason for consideration	Previous consideration
To consider a proposal to create a single Group BAF, consolidating and replacing the Trust's BAF.	Board of Directors, May 2022 Format and templates endorsed by the Audit Committee, June 2022 Individual BAF risks considered and endorsed by Board Committees (Trust and Group), July 2022 To be presented to the Kettering General Hospital Board of Directors on 29 July 2022

Report

This report sets out proposals to approve a revised Group Board Assurance Framework (BAF), first adopted in July 2021, replacing the NGH and KGH BAFs.

In Qtr. 4 2021/22, Audit Committees, which have delegated authority from the Boards to oversee the Trust's risk management processes, completed full 'deep dive' reviews of both NGH and KGH BAFs.

From the feedback, a group Risk Management review was commissioned and is being undertaken, encompassing a refresh of the BAF, Corporate Risk Register and Risk Management processes across the group. A key component of this is a single integrated BAF report, which will overcome duplication and confusion from similar risks describing the same issues across the Group and provide clearer alignment with Group objectives and delivery strategies. Each Trust will retain a Corporate Risk Register which will inform the Group BAF and provide oversight of key cross-cutting risks at an organisational level.

Board Committees have reviewed risks relevant to their respective areas of responsibility, including scores and risk appetites, agreeing the following risks, for inclusion in the Group BAF:

Group UHN01 – Group People Plan

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.

To replace – NGH114

Risk that the Trust fails to promote a culture that puts patients first

Group UHN02 – Group Clinical Strategy

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.

To replace – NGH109

Risk of not meeting regulators' minimum standards, local and national performance standards

And NGH110

Risk of Avoidable Harm

Group UHN03 – Group Nursing, Midwifery, and Allied Health Professionals Strategy

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.

Group UHN04 – Integrated Care System (ICS) Strategy

Failure to deliver the NHCP Integrated Care System Partnership may result in an impact on the quality of service provided across the group.

Group UHN05 – Group Strategic Estates Plan

Failure to deliver the group Strategic Estates programme may result in care delivery from poor clinical environments, cost inefficiencies, patient safety incidents and statutory non-compliance attributable to some degree to substandard existing estate, and lost opportunities for integrated care delivery at place, resulting in serious incidents, possible prosecution and associated reputational damage.

To replace: NGH111

Risk of Failures relating to failing infrastructure due to ageing estate.

Group UHN06 – Group Academic Strategy

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.

Group UHN07 – Group Digital Strategy

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.

Replaces NGH112

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.

Group UHN08 – Group Medium Term Financial Plan

Failure to deliver a Group Medium Term Financial Plan results in an inability to deliver Trust, Group and system objectives.

Replaces NGH115

Risk that the Trust fails to have financial control measures in place to deliver its 22/23 financial plan

NGH116

Risk that the Trust fails to fully deliver the financial efficiency programme

NGH117

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.

BAF risks UHN01-08 are set out on a new template, which has been redesigned in response to Audit Committees' feedback and enables clearer alignment between risk controls, assurances, and actions to address identified gaps, whilst prompting risk owners to identify circumstances in which strategic risks materialize and become issues. Audit Committees endorsed the revised template at their June 2022 meetings.

Concurrent workstreams and next steps

Complementary work is continuing to review and align risk management frameworks across the Group, comprising the development of a single Risk Management Strategy and template for Ward to Board reporting; the outputs from this work will be presented to Audit Committees in September 2022.

Subject to agreement of the Group BAF, a 'deep dive' review schedule will be put in place to enable regular confirm and challenge by responsible committees. We will also be aligning key performance metrics as part of work to develop a Group Integrated Governance Report.

Following endorsement of the process and content by Committees, the Board of Directors is recommended to **APPROVE:**

(1) The inclusion of revised Group BAF Risks 01-08 above onto a single Group BAF, consolidating and replacing existing NGH risks 109-112 and 114-117;
(2) The referral of the following risk to the Corporate Risk Register to be managed operationally: NGH113 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, and
(3) The abolition of the NGH BAF with immediate effect.

Appendices
Appendix A: Group Board Assurance Framework
Risk and assurance
As set out in the report.
Financial Impact
No direct implications
Legal implications/regulatory requirements
Duty to identify and manage risks / CQC Well-Led
Equality Impact Assessment
Neutral

Group Board Assurance Framework

19th July 2022

University Hospitals of Northamptonshire NHS Group

Ref	Group Priority	Scrutinising Committee	Risk Title	Initial Risk Level (July 2022)	Current Risk Level (July 2022)	Movement (from Initial)	Residual Risk Level	Risk Appetite	Summary Updates
UHN01	People	Group People Committee	Failure to deliver the group People Plan leads to reduced staff engagement, empowerment and lack of inclusion which would impact negatively on staff satisfaction, recruitment and retention resulting in detriment to patient care.	**16**	**16**	→	**12**	**Moderate**	
UHN02	Quality	Quality & Safety Committee (KGH) Quality Governance Committee (NGH)	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**	
UHN03	Patient	Quality & Safety Committee (KGH) Quality Governance Committee (NGH)	Failure to deliver the group Nursing, Midwifery and Allied Health Processionals (NMAHP) Strategy may result in inequity of clinical voice, failure to become a truly clinically led organisation and centre of excellence for patient care	**12**	**12**	→	**8**	**Low**	
UHN04	Systems and Partnership	Quality & Safety Committee (KGH) Quality Governance Committee (NGH) Performance, Finance & Resources (KGH) Finance & Performance (NGH)	Failure of the Integrated Care Board (ICB) to deliver transformed care that will result in an impact on the quality of service provided across the group	**16**	**16**	→	**12**	**High**	
UHN05	Sustainability	Group Strategic Development Committee Performance, Finance & Resources (KGH) Finance & Performance (NGH)	Failure to deliver the group Strategic Estates programme may result in care delivery from poor clinical environments, cost inefficiencies, patient safety incidents and statutory non-compliance attributable to some degree to substandard existing estate, and lost opportunities for integrated care delivery at place, resulting in serious incidents, possible prosecution and associated reputational damage	**12**	**12**	→	**6**	**High**	
UHN06	Quality	Quality & Safety Committee (KGH) Quality Governance Committee (NGH)	Failure to deliver the long-term Group Academic Strategy may result in University Hospitals Northamptonshire's (UHN) ability to attract high calibre staff and research and education ambitions. Recognition of impact on financial income to the Group	**12**	**12**	→	**4**	**Low**	
UHN07	Sustainability	Group Digital Hospital Committee	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**	
UHN08	Sustainability	Performance Finance & Resources Committee (KGH) Finance and Performance Committee (NGH)	Failure to deliver a Group Medium Term Financial Plan results in an inability to deliver Trust, Group and system objectives.	**16**	**16**	→	**12**	**High**	

Principal Risk No:	**UHN01**	**Risk Title:**	Failure to deliver the group People Plan leads to reduced staff engagement, empowerment and lack of inclusion which would impact negatively on staff satisfaction, recruitment and retention resulting in detriment to patient care. Brings together: KGH004 If we fail to improve **staff morale** there is a consequential impact on staff retention, impacting on patient experience and care. KGH005 Failure to have correct **skill mix and competency** may have adverse effect in wards clinical areas and corporate support services on quality of care and safety of patients and staff. KGH012 Failure to deliver patient focused care may lead to **poor patient experience** and reputational risk. This may cause the Trust to perform poorly against national and local patient experience surveys affecting reputation as hospital of choice for our local population and beyond. NGH114 Risk that the Trust fails to promote a **culture** that puts patients first.
		Materialising in [any/several] of the following circumstances:	The Group People Committee will determine circumstances in which it considers the risk to have materialised, having regard to key qualitative and quantitative evidence including: (1) Declines in Staff and People Pulse Survey key indicators in respect of response rates, morale, wellbeing and advocacy (2) Key metrics relating to sickness absence, turnover, vacancies and statutory and mandatory training/appraisal completions in special cause variation for at least three consecutive reporting periods (3) Key metrics relating to safe staffing a (4) Customer experience performance/concerns referred from quality committees (5) Cumulative qualitative and anecdotal evidence identified in the course of business as usual activities e.g. Non-Executive site visits/presentations to Committee/regular communication mechanisms. (6) Corporate Risks (below) materialise.

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

Corporate Risk Register Links:

NGH CRR:	Linked Corporate risks: NCRR: 2439; 1348; 1764; 2135; 2270; 2494; 2635; 1188; 2003; 2579	**KGH CRR:**	Linked Corporate risks: KCRR002, KCRR017, KCRR045, KCC051

Initial Risk Score		Current Risk Score		Residual Risk Score		Risk Appetite
16 (Extreme)		16 (Extreme)		12 (High)		Moderate
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	4	4	4	4	3	People

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
1	People Planning Pledge: We support people plans for our patient services with effective attraction and retention plans that support new roles, new ways of working and career pathways (L/I)	- International Recruitment Target of 200 surpassed - Supporting Clinical Collaborations with OD/HR interventions in place e.g. digital, finance, HR, cardiology, cancer project plans - MOU in place to support people working across trusts	Collaborative Bank		Implementation of Collaborative Bank	Group Head of Planning and Process	Sep 22
2	People Processes Pledge: Colleagues are able to access systems to enhance their work experience and flexibility	Harmonised employment contract in place	Aligned processes not in place across Group		(1) Review of Time to Hire (2) Harmonise Bank Rates (paused for reasons specified in People Pack) (3) Centralise agency management	Group Head of Planning and Process	(1) Aug 22 (2) Tbc (3) Aug 22
3	People Development Pledge: We support colleagues to build a career providing opportunity for people joining us from any level and background to progress	- Statutory and Mandatory Training Compliance has approved: see People Pack - Deliver leadership and management development	Increase appraisal compliance Group-wide leadership and management programme		(1) People Pack actions to improve appraisal compliance (2) Implement Group wide leadership and management programme	Group Head of People Development	(1) Dec 22 (2) Aug 22
4	People Partnering Pledge: We work with one another, reflecting, learning and ensuring feedback is heard and actioned, leading to a reduction in formal employee relations management	- People Pulse response rate for 2022 exceeding 20% target reported in People Pack - Embed pulse feedback into performance reviews			(1) Increase up take in staff survey response rate (2) Policy harmonisation project completion	Group Head of People Partnering	(1) Oct 22 (2) Dec 22

		- Improving People Performance policy agreed, subject to group union ratification					
5	OD and inclusion: We bring our dedicated to excellence values to life, improving the way we work with each other, particularly focusing on empowerment and inclusion	- Delivering EDI Strategy: completed actions set out in People Pack and work plan (report on Agenda)			Development of Cultural Change Programme: Group Board Development Event to progress	Group Head of OD and Inclusion	Oct 22
6	Health and Wellbeing Pledge: We provide bespoke health and wellbeing spaces and access to health assessment and psychological support for all our people	- Delivery of SOS and Psychological Support services - Delivery of financial wellbeing initiatives e.g. Wagestream,VivUp, Blue Light Card			Prepare staff for pension changes	Group Head of Health and Wellbeing	Sep 22

Current Controls		Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
7	Volunteering Pledge: We have a large volunteer base and aspire to have the largest volunteer base across the NHS with volunteer's representative of the local population providing opportunities for our community	- Have 600 active volunteers across group (exceeded, including those in recruitment pipeline) - Younger cohort of volunteers, as set out in People Pack - Deliver health and wellbeing initiatives through volunteering service e.g. WeCare Café, Wellbeing 2 you.			Plans to engage with schools ahead of 22/23 academic year and respond to changing needs e.g. distribution of ice creams and drinks during heatwave	Group Head of Volunteering	Sep 22
8	STRUCTURAL: Group People Committee	Routine group People Committee updates – alignment progress reports (internal) Standing mandatory reporting, regular workforce metrics reports, exception reporting in place (Internal)		People Pledge metrics / dashboards reporting to group people committee and to Divisional Performance Reviews. People Committee oversight of delivery of the HR restructuring programme.	IGR Development	Chief People Officer	30.09.2022

Principal Risk No:	**UHN02**	**Risk Title:**	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.					
		Materialising in any/several of the following circumstances:						
Date Risk Opened:	June 2022	**Risk Classification:**	Quality, Operational Infrastructure, Financial	**Risk Owner:**	Medical Directors and Director of Strategy and Strategic Estate	**Scrutinising Committee:**	Quality and Safety Committee (KGH) Quality Governance Committee (NGH)	
Corporate Risk Register Links:								
NGH CRR:	Linked to Corporate Risk			**KGH CRR:**	Linked to Corporate Risk KCRR015 - No sustainable capacity for urgent care hub due to no source of funding.			

Initial Risk Score		Current Risk Score		Residual Risk Score		Risk Appetite
12 (High)		12 (High)		8 (High)		Low
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	3	4	3	4	2	Quality

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
1	The Clinical Strategy is managed through the Joint Strategic Collaboration Group and Joint Clinical Senate, with individual Trust Clinical Leadership meetings providing a further point of reference and point for resolving tactical issues.	Progress of work shared and reviewed at Trust Clinical Leadership Meetings (Internal) Final Strategy approved at May public Boards (Group) (Internal)		Final strategy not shared with Health & Wellbeing	Final strategy to be approved at Health and Wellbeing Boards in alongside our detailed engagement activity report.	Director of Strategy and Strategic Estate	31.07.2022
2	The Collaboration Programme Committee oversees progress on behalf of both Boards.	Plans and progress presented at Collaboration Programme Committee (Internal)					
3	Detailed plan for subsequent phase of work that will focus on the integration of specific services.	Schedule of service strategy developments (Group) (Internal) Oversight being monitored through Asana Project Software (Group) (Internal)	Bed & Theatre capacity demand analysis has been completed which will support service strategy development but not completed in outpatients and diagnostics		Agreement of proposed detailed analysis of demand and capacity across outpatient and diagnostics , which in turn will support further strategy development.	Director of Strategy	31.07.2022
4	Clinical Strategy shared at Integrated Care Board	Integrated Care Board oversight (Group) (internal)	Links between the Group Clinical Strategy and wider Integrated Care System plan are not yet fully established.		Elective Collaborative to agree how we will develop group service strategies that are aligned with ICS strategies	Director of Strategy	31.07.2022
5			Lack of patient and public engagement		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	Director of Strategy / Director of Nursing (KGH / NGH)	30.06.2023
6			Implementation of projects will require additional resource as yet unidentified		Additional resource agreed for additional strategy and transformation support for implementation of recruitment (Group)	Director of Strategy and Director of Transformation	30.09.2022

Principal Risk No:	**UHN03**	**Risk Title:**	Failure to deliver the group Nursing, Midwifery and Allied Health Processionals (NMAHP) Strategy may result in inequity of clinical voice, failure to become a truly clinically led organisation and centre of excellence for patient care					
		Materialising in any/several of the following circumstances:	N,M,AHP reduced engagement with patient centred initiatives focused on improving safety and quality of care N,M,AHP reduced engagement with professional projects that enhance our working environment and improve morale N,M,AHP are not offered, engage or attend development, training and education opportunities NGH is not able to demonstrate Pathway to Excellence compliance for re-designation					
Date Risk Opened:	April 2021	**Risk Classification:**	Quality, Operational, Infrastructure	**Risk Owner:**	Directors of Nursing and Midwifery	**Scrutinising Committee:**	Quality & Safety Committee (KGH) Quality Governance Committee (NGH)	
Corporate Risk Register Links:								
NGH CRR:	Linked to Corporate Risk NCRR 1188			**KGH CRR:**	Linked to Corporate Risk			

Initial Risk Score		Current Risk Score		Residual Risk Score		Risk Appetite
12 (High)		12 (High)		8 (High)		Low
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	4	4	3	4	3	Patient

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
1	NGH and KGH have a shared Nursing, Midwifery & AHP professional strategy (IGNITE) monitored via hospital Nursing and Midwifery Boards/Nurse Executive Meeting.	NGH in progress for Pathway to Excellence re-accreditation (June 22) (Internal)	Reporting and monitoring not aligned across both sites (Group)		KGH to set up a formal Nursing, Midwifery and AHP Clinical Advisory Group (CPAG) to enable reporting of strategic & professional progress including the N,M,AHP Strategy (Group)	KGH DoN	31.07. 22
2	There is a Director of Nursing and Midwifery and a Deputy who have jointly led the development of the NMHAP strategy at NGH and KGH.	The NMAHP is linked to our People, Academic and Clinical Strategies (Internal) Ignite strategy oversight at NMHAP (Internal) Establishment of a quarterly joint NMAHP Board (Internal)		Lack of established strategy review groups (Group) (internal)	Establish joint strategy review group to meet quarterly (Group)	KGH & NGH DoN	31.09.22
3	Workstream leads and working groups identified to define progress against objectives.	Each Trust has a Strategy Group Meeting where each Workstream Lead provides an update on progress (internal)		Lack of established strategy review groups (Group) (internal)	Establish joint strategy review group to meet monthly (Group)	KGH & NGH DoN	31.09.22
4	Reporting structure agreed to be joint Quality Governance Steering Group (QGSC).	Reports to joint Quality Governance Steering Group (QGSG), Collaboration Programme Committee (CPC) and Board (internal)					
5	KGH Strategy / Pathway Lead proactively managing the implementation of the IGNITE strategy	Recruitment to this post by reassigning establishment within Corporate Nursing budget (internal)	KGH do not have secured funding to commence P2E journey (KGH)		KGH to explore funding sources for P2E journey (KGH)	KGH DoN	31.07.22
6	Dedicated communication programme to support the implementation of IGNITE	Strategy/Pathway Lead to plan monthly communication updates via different media avenue (internal)	Ongoing communication required to increase visibility and ownership of strategy with all staff (Group)		Strategy to be celebrated through International Nurses Day, Midwives Day & AHP Day 2022 (Group)	KGH & NGH DoN	31.07.22

Principal Risk No:	**UHN04**	**Risk Title:**	Failure of the Integrated Care Board (ICB) to deliver transformed care that will result in an impact on the quality of service provided across the group					
		Materialising in any/several of the following circumstances:						
Date Risk Opened:	June 2022	**Risk Classification:**	Quality Finance	**Risk Owner:**	Director of Integration and Partnerships	**Scrutinising Committee:**	Quality and Safety Committee (KGH) Quality Governance Committee (NGH) Performance, Finance and Resources Committee (KGH) Finance and Performance (NGH)	
Corporate Risk Register Links:								
NGH CRR:	Linked to Corporate Risk NCRR1309			**KGH CRR:**	Linked to Corporate Risk KCRR014, KCRR011			

Initial Risk Score		Current Risk Score		Residual Risk Score		Risk Appetite
16 (Extreme)		16 (Extreme)		12 (High)		High
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	4	4	4	4	3	Systems and Partnership

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
1	The development and delivery of the Northamptonshire Integrated Care System (ICS) has been led through the Health and Care Partnership Board attended by the Group Chair and CEO.	ICS transition steering group in place to monitor progress and delivery of the ICS transition reporting to the HCP Board/shadow ICB (Internal / External) Progress reported through to the shadow ICB (Internal / External) Case for change, design and leadership of Elective Collaborative presented to Board in January 22	 Clarity on how the future arrangements dock into those of the Group	Confidence in system architecture to deliver change for the 22/23 winter period	Review and increase Group engagement to include NEDS and EDs on existing and emerging ICS architecture. Full proposal for Elective Collaborative to be developed for implementation from July 22	DoS&P DoS, DoI&P	Ongoing 01.07.2022
2	Transition arrangements in place between CCG and ICB	The shadow ICB came into form in April 22 (External) Transition plan has been agreed by ICB and all system partners (Internal / External) Readiness to Operate Statements for April 2022 have been assessed and returned to NHSE/I.	Fully established ICB Governance structure with clarity on Group membership.				
3	A blueprint of the building blocks of the ICS has been agreed, workstreams leads, groups and plans continue to be developed.	Director of ICS Transition in place for system Group ICS working group providing updates to Boards via CPC Two Board development sessions delivered to ensure a clear course for shaping and leading the emerging ICS and operating model.	Workstreams leads, groups and plans not fully developed. Lack of Strategic plan for delivery of ICS	 Develop strategic plan for Group delivery of ICS	Provide leadership to system, workstreams to develop Collaboratives, Place, Clinical Model, and enablers e.g., Digital, People, Estates, Finance Provide leadership to system, workstreams to develop Collaboratives, Place, Clinical Model, and enablers e.g., Digital, People, Estates, Finance	DoS&P	Ongoing
4	A revised target date of 1 July 2022 has been agreed nationally for the new statutory arrangements for ICSs to take effect and for ICBs to be legally established, subject to the passage of the legislation through Parliament.	The Bill has now been passed and the 1st of July date confirmed (External)	.				

Principal Risk No:	**UHN05**	**Risk Title:**	Failure to deliver the group Strategic Estates programme may result in care delivery from poor clinical environments, cost inefficiencies, patient safety incidents and statutory non-compliance attributable to some degree to substandard existing estate, and lost opportunities for integrated care delivery at place, resulting in serious incidents, possible prosecution and associated reputational damage , replacing: NGH111: Risk of Failures relating to failing infrastructure due to aging estate. KGH007: Suitable hospital estate and provision of hard and soft facilities management services.
		Materialising in any/several of the following circumstances:	(1) Linked corporate risks materialising (see below) (2) Risks related to strategic estates programmes materialising, as defined in programme risk registers.

Date Risk Opened:	01 April 2022	**Risk Classification:**	Quality Finance Infrastructure	**Risk Owner:**	Director of Strategy and Strategic Estate	**Scrutinising Committee:**	Strategic Development Committee Finance & Performance Committee (NGH) Performance, Finance & Resources Committee (KGH)

Corporate Risk Register Links:

NGH CRR:	Linked to Corporate Risk NCRR: 1174; 1177; 1701; 1702;1738; 2041; 2264; 2440	**KGH CRR:**	Linked to Corporate Risk KCRR015, KCRR026, KCRR030, KCRR036

Initial Risk Score		**Current Risk Score**		**Residual Risk Score**		**Risk Appetite**
12 (High)		12 (High)		6 (Moderate)		High
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
3	4	3	4	3	2	Sustainability

	Current Controls	**Plan Delivery Assurance/ Group IGRs (Internal / External)**	**Control Gaps**	**Assurance Gaps**	**Further planned actions to mitigate gaps**	**Action Owner**	**Due date**
1	The Group Clinical Strategy has started and this will define the clinical requirements of both sites for the future.	Group now has a Strategic Development Committee in place (Internal)					
2	Kettering Hospital now have a full Development Control Plan as part of its HIP2 programme. Northampton Hospital have a site masterplan.	Kettering HIP2 SOC has been submitted and a Local Development Order has been signed with Kettering Planning Authority (Internal / External)	 NGH do not have a Development Control Plan		KGH outline business case to be submitted to July Board NGH Development Control Plan to commence	DofS&SE DofS&SE	31.07.2022 01.09.2022
3	These foundations will come together to start to form the Group Strategic Estates Plan.			The Group requires a joint Strategic Estates Plan that supports delivery of the Group Clinical Strategy	Group Strategic Estates Plan to be commissioned in Autumn 2021 following completion of the Group Clinical Strategy. Community Diagnostic Hub business case to be submitted May 22	DofS&SE DofS&SE	01.06.2022 31.05.2022
4	A System Estates Board is in place across the ICS with all Health and Care partners.			The System Estates Strategy is not strategic and needs further development			
5	Health and Safety Policies and Procedures / Fire Safety	Health & Safety Groups and annual reports / fire safety inspections etc					
6	Back-up systems	Regular testing schedules					
7	Annual Maintenance Plans		Group-wide backlog maintenance works of over £70m				

Principal Risk No:	UHN06	Risk Title:	Failure to deliver the long-term Group Academic Strategy may result in University Hospitals Northamptonshire's (UHN) ability to attract high calibre staff and research and education ambitions. Recognition of impact on financial income to the Group
		Materialising in any/several of the following circumstances:	Sustainability of 5-year project

Date Risk Opened:	April 2021	Risk Classification:	Quality Finance	Risk Owner:	Medical Directors and Directors of Strategy	Scrutinising Committee:	Quality & Safety Committee (KGH) Quality Governance Committee (NGH)

Corporate Risk Register Links:			
NGH CRR:	Linked to Corporate Risk NCRR1839, NCRR1445	KGH CRR:	Linked to Corporate Risk

Initial Risk Score		Current Risk Score		Residual Risk Score		Risk Appetite
12 (High)		12 (High)		4 (Moderate)		Low
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
4	2	4	3	4	1	Quality

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
1.	The Academic Strategy is managed through the Academic Strategy Programme Board which reports into the Joint Quality Committee and Collaboration Programme Committee (CPC)	The Academic Strategy and the supporting Business Case has been approved by both Hospitals (Internal / External) Quarterly Update / deep dive at CPC and non-executives on delivery of academic strategy –	No Communication and engagement plan yet developed to maximise the opportunities of the academic strategy (Group)	Due to trust pressures inconsistent meetings of the subcommittees (Group)	Academic Strategy Communications Plan	Heads of Comms (KGH / NGH)	31.07.22
2.	Subgroups manage the following workstreams: • Medical Education (ME)	(ME) Professorial and associate professorial posts advertised, good applicants for some specialities chosen, none in others where national shortage recognised. Reviewed and refreshed planned academic appointments clustering appointments in key specialities in the first instance (Internal) (ME) Agreed approach with UoL (Internal / External) (ME) New University Hospital of Northamptonshire branding agreed and used on new Job Adverts for Clinical Academic Posts (Internal) (ME) Clinical Academic Posts new recruitment pack and British Medical Journal microsite (Internal)		(ME & R) Ability to appoint to Clinical Academic positions- risk limited interested and/ or poor-quality candidates, putting the Academic Strategy at risk (Group)	UoL partnership for Bio Medical Research Centre. Joint advertising	Director of Strategy	31.07.2022
	• Estates (E)	Academic Programme Board oversight (Internal)	(E) Accommodation – teaching space. With rising student numbers, there are no current firm plans to manage the demands on the estate (Group)		The Estates Subgroup to develop short term and long-term potential solutions across the group. Outcome of Integrated Business Case submitted for a short-term solution at NGH.	Operational Director of Estates	31.12.2022
		Academic Programme Board oversight (Internal)	(E) 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 (NGH)		The Estates Subgroup to develop short term and long term potential solutions across the group to manage growing cohorts. A refurbishment plan to be completed at CRIPPS to address student feedback.	Operational Director of Estates	31.12.2022

	Current Controls (Likelihood/Impact)	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
	• Research (R)	(R) Successful in Clinical Research Facility Bid for Bio Medical Research Centre (internal / external)	(R) Research council covers 80% of costs FEC (full economic costing) whereas Commercial / Pharmaceutical Trials are set or fixed costings & financially more beneficial		(R) To manage a Business Case, a Finance Group is required to track business benefits, income and expenditure.	Director of Finance (KGH / NGH)	31.12.2022
			(R, E) 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. This is outstanding for KGH.	The Estates Subgroup to develop short term and long term potential solutions across the group to manage growing cohorts.		Operational Director of Estates	31.12.2022
	• Finance (F)	(F) Monthly finance reporting to Academic Strategy Programme Board and quarterly to Joint Quality Committee – now happening	(F) No strategic lead for academic strategy finance (F) Financial resource for submission of research grants (joint research office)		Finance to discuss support	Director of Finance (KGH / NGH)	31.12.2022
	• Innovation- in development (IN)	Academic Programme Board oversight (Internal)					
	• Academic partnership with University of Leicester (UoL)	Partnership meetings with University of Leicester (UoL) and University of Northampton (UHN) held separately to deliver our joint academic activities, review progress against the Partnership plans and manage risks Internal / External) UoL have signed a Partnership Agreement that sets out the criteria for working between the Group and UoL (Internal / External). The UoL NED has been included within the KGH constitution (Internal / External).					
3	Governance in place to manage Academic partnerships	Academic Programme Board oversight (Internal)					
4	UHN membership of Clinical Research Facility (UoL Partnership) and Biomedical Research Centre steering groups/committees to develop partnership with UoL and UHL under the main body of National Institute for Health and Care Research	July 2021 launch of University Hospitals of Northamptonshire NHS Group.					

Principal Risk No:	**UHN07**	**Risk Title:**	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 Consolidating: KGH BAF 009 Delivery of the digital strategy and NGH BAF 112 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
		Materialising in any/several of the following circumstances:	a) inability to make management and operational decisions effectively b) a significant impact on the quality and level of safety of patient care c) A deterioration in staff satisfaction and feedback (due to a reduced ability to do their jobs effectively and efficiently). d) Cyber security of [level of severity] causes disruption to key systems / significant data loss

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

Corporate Risk Register Links:			
NGH CRR:	Linked to Corporate Risk **1482, 1684, 1733, 2747**	**KGH CRR:**	Linked to Corporate Risk **009, 038, 039, 008**

Initial Risk Score		**Current Risk Score**		**Residual Risk Score**		**Risk Appetite**
20 (Extreme)		20 (Extreme)		15 (Extreme)		High
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
5	4	5	4	5	3	Sustainability

	Current Controls	**Plan Delivery Assurance/ Group IGRs (Internal / External)**	**Control Gaps**	**Assurance Gaps**	**Further planned actions to mitigate gaps**	**Action Owner**	**Due date**
1	Group Digital Roadmap	Monitored bi-monthly at Group Digital Hospital Committee (Group) (Internal).					
2	Group Digital Strategy	Regular updates and reporting on digital strategy to Group Digital Hospital Board Committee (Group)(Internal). Group Digital Operational Meetings in place (Group) (internal). Weekly EPR Operations meeting in place at both Trusts, with escalation to Group Digital Hospital Committee as necessary (Group) (Internal) Weekly Digital programmes meeting in place at both Trusts, with escalation to Group Digital Hospital Committee as necessary (Group) (Internal)	(1) Capacity and capability to implement Theme 5: Providing insight to support decision-making, including: • Deployment and use of data visualisation tooling across the Group (2) Constraints linked to financial restrictions and internal budgetary constraints, and externally required procurement and funding bid processes and requirements.	Recognised benchmarking – against HIMSS EMRAM (Healthcare Information and Management Systems Society) or the emerging Minimal Digital Foundations (MDF) assessment. Formal assessment of What Good Looks Like – framework developed by NHS Transformation (formerly NHSX) to measure ICS (Integrated Care System) digital maturity against 7 success measures.	HIMSS EMRAM (Electronic Medical Record Adoption Model) Assessments – external validation (2022) or MDF assessment Board development session Digital Boards with NHS Providers	GCDIO GCDIO / DoG	30.09.22 Tbc
3	Clinical Chief Information Officers (CCIO) in place across the Group	Monitored bi-monthly at Group Digital Hospital Committee (Group) (Internal). Medical CCIOs in place for KGH and NGH.	No Clinical Chief Information Officers (CCIO) in post for Nursing, Midwifery, AHP and Clinical Scientists Chief Nursing Information Officers for each site – none in post June 2022		Recruit to CCIO post – due to start 1st July 2022 CCIO to determine team structure including how continue to support nursing directorate	GCDIO	01.07.22 TBC
4	Self-assessment against digital maturity frameworks: 'What good looks like' framework and HIMSS EMRAM	Group self-assessment November 2021 (what good looks like) Group self-assessment HIMSS EMRAM April 2022					

Current Controls		Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
5	EPR programmes	Programme Management / Group Digital Hospital Committee etc (Group)(internal)	No business case approval for NGH EPR Procurement of NGH EPR Business case to be approved for extension of KGH EPR to meet MDF standards		**NGH EPR:** NGH EPR Programme: Business Case for NGH EPR to be approved by national teams and secure national funding NGH EPR Procurement to be concluded KGH EPR business case to be taken through local, regional and national approval process to secure local and national funding	NGH DD/ GCDIO KGH DD/ GCDIO	30.11.23 31.03.23
6	BAU (business as usual) Infrastructure Plans/ Monitoring in place	Infrastructure improvement incorporated into Group Digital Strategy and monitored through GDHC KPI (key performance indicators) on operational performance of systems – site specific		Review Group Reporting and monitoring of underlying infrastructure performance	Wider network review National assessment of Support People (Success Measure 4) underway Group-wide KPIs and operational reporting suite	DDs GCDIO DDs	31.12.21 30.09.22 31.12.22

Principal Risk No:	**UHN08**	**Risk Title:**	Failure to deliver a Group Medium Term Financial Plan results in an inability to deliver Trust, Group and system objectives, specifically: (a) Failure to deliver Revenue Plans results in deficits and an inability to finance investments (b) Failure to deliver efficiency and productivity changes result in revenue deficits (c) Failure to generate sufficient cash to finance required capital investment (d) Non-delivery of transformation and efficiency targets results in non-delivery of external funds e.g. Elective Recovery, discretionary capital. *Consolidates/replaces the following:* (KGH011 Delivery of control total and meeting the trajectory to live within our financial means.) (NGH116 Risk that the Trust fails to fully deliver the financial efficiency programme) (NGH115 Risk that the Trust fails to have financial control measures in place to deliver its *22/23* financial plan) (NGH117 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)
		Materialising in any/several of the following circumstances:	- Financial performance (income and expenditure) is materially worse than Plan - Insufficient cash to continue day to day operations; - Materially lower transformation, efficiency and productivity performance compared to Plan - Qualified external audit opinions - Significant control weaknesses identified by Internal Audit - Failure to deliver capital plan elements causes detriment to programme delivery outside agreed tolerances.

Date Risk Opened:	April 2021	**Risk Classification:**	Financial Operational	**Risk Owner:**	Chief Finance Officer	**Scrutinising Committee:**	Performance Finance and Resources Committee (KGH) Finance and Performance Committee (NGH)

Corporate Risk Register Links:

NGH CRR:	Linked to Corporate Risk NCRR 2343; 2345	**KGH CRR:**	Linked to Corporate Risk KCRR015

Initial Risk Score		Current Risk Score		Residual Risk Score		Risk Appetite
16 (Extreme)		16 (Extreme)		12 (High)		High
Consequence	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Group Priority**
5	5	4	4	4	3	Sustainability

	Current Controls	Plan Delivery Assurance/ Group IGRs (Internal / External)	Control Gaps	Assurance Gaps	Further planned actions to mitigate gaps	Action Owner	Due date
1	Business planning process, alignment of activity, workforce and finances	Planning submissions subject to board and board committee scrutiny (internal)					
2	Group Performance Management framework, including areas where not on track.	Performance management framework and meetings (Internal)					
3	Management of capital and working capital.	Performance management framework and meetings (Internal)					
4	Workforce Management meetings (Workforce)	Finance & Performance Committee minutes (Internal)(NGH))					
5	Efficiency/Productivity reporting	Group Transformation and Quality Improvement Committee (internal)					
6	Elective recovery monitoring						
7	Finance & Performance meetings	Finance & Performance Committee minutes (Internal) System Finance meeting minutes (External) System collaboration and joint working including Group representation (Group CFO, DoFs & NEDs) at System Finance Committee minutes		Group policy on planning, reporting and reforecasting	Development of a policy on planning, reporting and reforecasting	CFO/DoS	31.01.2022

8	Hospital Management Team meetings	Hospital Management Team minutes (Internal)					
9	Group Executive meetings	Group Executive meeting minutes (Internal)					
10	External review of underlying deficit and improvement opportunities	22/23 plans have an underlying financial position, which will continue to be managed (Internal/ External)			Agree definition of financial sustainability	CF0	30.11.2021
11			Scope and priorities of Group Financial Strategy not yet finalised.	Group Financial Strategy not in place.	Development of Group Financial Strategy	CFO	31.08.2022
12			Structure and processes in development for Group transformation, investment controls and opportunity identification / delivery		Implementation of Group Transformation structure	CGEO	31.10.2021
13			Lack of control over discretionary spending				
14			Group Financial Structure		Agreement of Group Senior Finance structure	CFO	31.10.2021

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Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	28 July 2022
Agenda item	12

Title	Trust's responses to the final Ockenden report (2022)
Presenter	Debbie Shanahan, Interim Director of Nursing and Quality
Author	Emma Perkin, Matron for Quality Improvement

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

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

Reason for consideration	Previous consideration
As requested at the last meeting, this report enables the Board to seek and obtain assurance in respect of the Trust's Maternity Safety arrangements	None

Executive Summary

In March 2022, the final Ockenden report was published with the Findings, Conclusions and Essential Actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust.

This report demonstrates the performance of maternity services at Northampton General Hospital (NGH) against the Immediate and Essential Actions (IEAs) outlined in the report to improve safety in maternity services across England.
There are 15 IEAs, within which are further actions
The first IEA, Workforce Planning and Sustainability, is broken into two principles;
- Financing a safe maternity workforce
- Training.

In total there are 109 actions.
4 actions are neither a Trust nor System responsibility.
5 actions are awaiting national clarification.
The responsible handler has been identified for all of the remaining actions.
A red, amber, green (RAG) classification system has been used to evidence progress against the actions.
65 actions are green
22 actions are amber
2 actions are red
11 actions are awaiting feedback from the responsible handler.

The Ockenden report also required Maternity Services to urgently review their position regarding Midwifery Continuity of Carer (MCoC). In response to this, NGH has taken the decision to pause further roll-out, but to continue with the current team in place.

Appendices

Appendix 1 Ockenden benchmark tool
Appendix 2 Risk Assessment for MCoC (SBAR)

Risk and assurance

As set out in the repot and appendices.

Financial Impact

As set out in the repot and appendices.

Legal implications/regulatory requirements

As set out in the repot and appendices.

Equality Impact Assessment

As set out in the repot and appendices.

Paper

Situation

This paper will provide a position against the IEAs within the final Ockenden report and to update the Board on the status of Continuity of Carer.

Background

The Final Ockenden report was published in March 2022 into the findings, conclusions and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust was published in March 2022. This follows on from the first report published in December 2020.

Within the first report there were seven Immediate and Essential Actions (IEA) to improve care and safety in maternity services. Maternity services at Northampton General Hospital NHS Trust have previously presented their compliance and action plans in relation to these IEAs and outstanding actions will be incorporated into the final action plan

The final report has fifteen IEAs to improve care and safety in maternity services across England. In response to these, there has been a request to submit a final IEA returns Snapshot. This report aims to provide an overview of compliance at NGH.

Maternity services were also required to urgently review their position regarding Continuity of Carer (MCoC) based on an evaluation of safe staffing requirements. In response to this, NGH has taken the decision to pause further roll-out, but to continue with the current team in place.

Assessment

There is a total of 109 IEAs, of these, 4 IEAs are neither a Trust nor a system responsibility.

5 IEAs are awaiting further clarity from national teams, and maternity services at NGH have not benchmarked against these.

The remaining IEAs have been allocated to the appropriate professional(s) within the Trust for their response, following discussion and allocation with the Clinical Director and Head of Midwifery. Whilst this is a snapshot review, maternity services at NGH have ensured there is evidence to support the self-assessment.

Maternity services at NGH have assessed themselves as compliant in 65% of the IEAs, 22% of the IEAs are amber, 2% of the IEAS are red, and response is waited for 11% of the IEAs.

The two IEAs that are red are:

- 13.2 *Bereavement care must be available 7 days a week for both women and families who suffer pregnancy loss.*

- 14.4 *85% of births less than 27 weeks gestation should take place at a maternity unit with an onsite NICU*. (2021 compliance is 73%; this is network performance, not NGH individual performance).

The benchmarking assessment tool will be updated as more responses are received. The senior management team within maternity services are developing an action plan around the IEAs for which NGH are non-compliant.

Midwifery Continuity of Carer (MCoC) position
The Ockenden report also required Maternity Services to urgently review their position regarding Midwifery Continuity of Carer (MCoC), based on an evaluation of safe staffing requirements. In response to this, NGH has taken the decision to pause further roll-out, but to continue with the current team in place.

Please refer to Appendix 2 to demonstrate the risk assessment process underpinning this decision

Recommendation(s)

It is recommended that maternity services at NGH continue to work towards being compliant in all the IEAs. Action plans for those IEAs that are not currently achieved will be developed.

Midlands Ockenden Final IEA returns Snapshot

Trust and LMNS stated position against the 15 IEAs

Reference Number	IEA 1: WORKFORCE PLANNING AND SUSTAINABILITY	Identified Gaps with actions	Responsible	Evidence	RAG All Yellow Highlighted awaiting national clarification
Principle 1: Financing a safe maternity workforce					
P1.1	Funding for maternity and neonatal services requires multi-year settlement to ensure workforce are enabled to deliver consistently safe maternity and neonatal care across england		NOT A TRUST OR SYSTEM RESPONSIBILITY		
P1.2	Recommendations from Health and Social Care Committee Report: The safety of maternity services in England must be implemented		HOM		
P1.3	If minimum staffing levels not agreed nationally, staffing should be agreed locally by LMNS. Staffing levels must account for: increased acuity, complexity of women, vulnerable families and additonal mandatory training to meet CNST and CQC requirements	Birthrate plus needs to be relaunched, last completed 2020	HOM	Birthrate plus report and implementation plan	
P1.4	Staffing level to include locally calculated uplift representative of 3 previous years' data for ALL absences inc sickness, annual leave, maternity leave and mandatory training		HOM	?sandra neale has this info	
P1.5	Accuracy of BirthRate Plus must be reviewed nationally by all regulatory bodies. As a minimum these must include NHSE, RCOG, RCM and RCPCH		NOT A TRUST OR SYSTEM RESPONSIBILITY		
Principle 2: Training					
P2.1	Proportion of maternity budgets must be ring-fenced for training in every maternity unit		FINANCE	Email confirmation from finance	
P2.2	Trusts must implement robust preceptorship programme for newly qualified midwives (NQMs), which supports RCM (2017) position statement for supernumeray status and protected learning time		PD LEAD MIDWIFE	Training package utilised for all preceptors	
P2.3	ALL NQMs must remain in hospital setting for minimum 12 months post qualification.				
P2.4	ALL trust labour ward coordinators must attend a fully funded and nationally recognised labour ward coordinator education module	Suitable course identified, awaiting places	PD LEAD MIDWIFE	All labour ward co-ordinators have attended course	
P2.5	Newly appointed labour ward coordinators should receive an orientation package to reflect individual needs and opportunity to focus on personal and professional development				
P2.6	ALL trusts must develop core team of senior midwives trained in high dependency maternity care. There should be one HDU trained midwife on each shift, 24/7				
P2.7	ALL trusts must develop succession planning programme to develop for midwifery leaders and senior managers. To include gap analysis of all leadership and management roles.		HOM	Leadership courses and gap analysis in place. Training opportunities and discussions picked in individual appraisals (appraisal paperwork)	
P2.8	Sustainable training programme across the country must be estalished for Maternal Medicine Networks	Engaged with maternal medicine network through maternal medicine lead	NETWORK	Engagement with training programme once defined. ?AD details for training info from Oxford / Leicester	
IEA 2: SAFE STAFFING					
2.1	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below minimum	Policy in place	HOM	Policy	
2.2	If agreed staffing levels across maternity services are not achieved day-to-day, this must be escalated to services' senior management team, obstetric leads, chief nurs, medical director, patient safety chamption and LMNS	Policy in place	HOM	Policy, daily huddle sheets, daily LMNS huddle	
2.3	Is risk assessment and escalation protocol in place for competing workload (as agreed at board level where there is no separate consultant rotas for Obs and Gynae)	N/A	CD	Obstetric consultants do not cover gynae when on call	
2.4	If staffing does not meet safe minimum requirement for ALL shifts within Midwifery Continuity of Carer (MCoC) then systems must review and suspend existing provision and further roll out of MCoC - MCoC reinstatement should not be agreed until robust evidence is available to support reintroduction	CoC team suspended apart from the team covering socially deprived and BAME communities	HOM	Minutes - weekly marenity senior team and escalation to board	
2.5	Job plans must demonstrate that consultants and locally employed doctors have additional time for maternity training. This will be in addition to generic trust mandatory training and reviewed as appropriate.	Within consultant job plans, Difficult to release junior doctors due to staffing, plan ij	CD	Consultant job plans, workforce planning document	
2.6	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support transition into leadership and management roles		HOM		
2.7	Evidence of a a bi-directional robust pathway between midwifery staff in the community setting and those based in hospital.		HOM		
2.8	RCOG guidance should be followed for management of locums		CD	Induction pack, HR checks prior to commencing, confirmation of	
2.9	Trust must demonstrate that there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	Available in hospital but mainly labour ward, need action plan for expansion	PD LEAD MIDWIFE		
2.1	Labour ward coordinator role should be recognised as specialist job role with appropriate job description and person specification		HOM	JD and person spec	
IEA 3: ESCALATION AND ACCOUNTABILITY					
3.1	Can trust demonstrate that there is a developed and maintainable conflict of clinical opinion policy to support staff members escalating clinical concerns	Escalation policy in place and communication to all staff about escalation		Policy, letter	
3.2	If a middle grade or trainee obstetrician is managing the maternity service without direct consultant presence there must be an assurance mechanism demonstrating competency for the role	Trainees competency part of eportfolio, documentation of non-trainees to be addressed	CD	Non-trainee competency assessment for out of hours work alone	
3.3	Local guidelines should detail when consultant obstetrician and midwifery manager on-call should be informed of activity within maternity unit.	Policy in place	HOM	Policy	
3.4	Clear local guidelines must be in place for when consultant obstetricians' attendance is mandatory within maternity unit.	Policy in place	HOM	Policy and audit	
IEA 4: CLINICAL GOVERNANCE-LEADERSHIP					
4.1	Trust boards must have oversight of quality and performance of maternity services		Directorate management team	Board minutes	
4.2	Is there evidence of regular progress, exception reporting and assurance reviews developed by trust board and maternity department		Directorate management team	Minutes of maternity governance/assurance meeting	
4.3	Director of Midwifery and Clinical Director for obstetrics must be operationally responsible and accountable for maternity governance		HOM/CD	Minutes of maternity governance, etc	
4.4	Clinicians with responsibility for maternity governance must have jobs plans which evidence sufficient time to engage with their management responsibilities	Will be in place when implement new job plans	CD	Job plans	

4.5	Individuals leading maternity governance teams must be trained in human factors, causal analysis and family engagement	No family engagement training	HOM/Governance	Evidence of training	
4.6	Maternity services must have co-leads for developing guidelines and performing audits. This should be a consultant midwife or equivalent and obstetric lead		HOM/CD	Clinical effectiveness midwife, maternity services audit lead, clinical effectiveness consultant	
4.7	National Maternity Self-Assessment tool must be completed by appreciative enquiry and comprehensive report inc. governance structures and remedial plans must be shared with trust board		HOM	Completed Jan 2021 but not by appreciative enquiry. Shared with trust board	
4.8	Patient safety specialist must be in place with specific dedication to maternity services	No specific role ?part of governance midwife	HOM		
IEA 5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATION AND COMPLAINTS					
5.1	Incident investigations must demonstate meaningful lessons for families and staff. These should be taught and implemented in practice in a timely manner.	Actions are meaningful but not timely - need action plan	Governance Matron/Head of Governance		
5.2	Complaints themes and trends must be monitored by maternity governance team		Governance Matron/Head of Governance	Dashboard, Maternity Governance report	
5.3	Lessons learnt from clinical incidents must inform local multidisciplinary training plan		PD LEAD MIDWIFE	Example of SI in training	
5.4	Actions following serious incident investigation which involve a change in practice must be audited		audit lead	SI actions and audit	
5.5	Change in practice arising from an SI investigation must be evidenced within 6 months after incident occurred	Investigations and reports delayed, early learning	governance Matron/Head of Governance	Sis and time of completed action	
5.6	Complaints which meet SI threshold must be investigated accordingly		Governance Matron/Head of Governance	Complaints with suspected amissions in care have timeline and discussed at ROHG -	
5.7	Service users must be involved in developing complaints response processed that are caring and transparent		Complaints	email	
5.8	Language used in investigation reports must be easy to understand for families inc. medical terms	Maternity investigators write reports	Governance Matron/Head of Governance	Training	
IEA 6: LEARNING FROM MATERNAL DEATHS					
6.1	All maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies		Coroner	Confirmation from coroner	
6.2	Following a maternal death, a joint investigation of all services involved in care must include representation from all applicable hospitals and clinical settings		HSIB	HSIB referrals	
6.3	Joint review must have an independent chair and be aligned to local and regional staff, and seek external clinical opinion where required.		HSIB		
6.4	Learning must be implemented within 6 months of the completion of the investigation and must be shared across the LMS		HOM	Joint SIAM meetings, futures platform	
IEA 7: MULTIDISCIPLINARY TRAINING					
7.1	Staff who work together must train together		PD LEAD MIDWIFE	MDT training weeks attendance	
7.2	Regular multidisciplinary training skills drills for management of obstetric emergencies including but not limited to: haemorrhage, hypertension, cardiac arrest and deteriorating patient		PD LEAD MIDWIFE	MDT training programme	
7.3	Emotional and psychological support for staff, both individually and within teams must be in place	Working on immediate support	PMA LEAD	PMA access, Trust SOS, clinical psychologist	
7.4	Multidisciplinary training must integrate the local handover tools such as SBAR into teaching programmes		PD LEAD MIDWIFE	MDT training programme	
7.5	It is mandatory for clinicians NOT to work on labour wards or provide intrapartum care without havng appropriate CTG and emergency skills training		fetal surveillance midwife	email confirmation	
7.6	System should be in place to ensure CTG and emergency skills training is completed and up to date for all staff		fetal surveillance midwife	training database	
7.7	Staff should attend regular mandatory training, and job planning should ensure all staff can attend		CD	job plans	
7.8	Clinicians must NOT work on labour ward without appropriate CTG and emergency skills training		CD	training database	
7.9	Annual human factor training must be mandated for all staff working in maternity setting and content must be agreed with LMNS. To include: - Principles of psychological safety - Upholding civility in the workplace	Some human factors included already but specific session being added	PD LEAD MIDWIFE	MDT training programme	
IEA 8: COMPLEX ANTENATAL CARE					
8.1	LMS, Maternal Medicine Networks and trusts must ensure that women have access to preconception care	Await reponse	Lead Obstetrican with a specilaist interest in maternal medicine		
8.2	Women with pre-exisiting medical disorders inc. but not limited to cardiac disease, epilepsy, diabetes and chronic hypertension must have preconception care with a specialist in managing women's condition				
8.3	Women identified with chronic hypertension must be seen in specialist consultant clinic. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with NICE Hypertension and Pregnancy Guidance (2019)	await response	lead obstetrician with a specilaist interest in maternal medicine		
8.4	NICE Diabetes and Pregnancy Guidance (2020) must be followed when managing all pregnant women with pre-existing and gestational diabetes	Await audit	Lead Obstetrician with a specilaist interest in Diabetes		
8.5	Evidence of joint discussion when considering and planning deliery for women with diabetes must be documented in maternity records. Clinicians should provide the woman with relevant evidence-based advice and national recommendations	Await reponse	Lead Obstetrician with a specilaist interest in Diabetes		
8.6	Trusts must provide services for women with multiple pregnancies in line with NICE guideline Twin and Triplet pregnancies 2019	Guideline in NICE guidance, but no core MDT team consisting of named specialist	Fetal Medicine		
IEA 9: PRETERM BIRTH					
9.1	LMNS, commissioners and trusts must work collaboratively to ensure sytems are in place for management of women at high risk of preterm birth		Preterm consultant lead/fetal surveillance midwife	attendance at network meetings	
9.2	Senior clinicians must be involved in conselling women at high risk of preterm birth, especially if pregnancy is at threshold of viability	preterm guideline	Preterm consultant lead	guideline	
9.3	Local and tertiary neonatal teams must be part of discussions so women and partners are aware of risks and chances of survival	preterm guideline	Neonatal lead	guideline	
9.4	Audit process for all in utero transfers and cases where a decision is made NOT to transfer to Level 3 neonatal unit must be in place		fetal surveillance midwife	audit	
9.5	Women and partners must receive expert advice about the most appropriate fetal monitoring and mode of delivery dependent on gestation of pregnancy	Preterm guideline			
9.6	Trusts must implement SBLCB v 2 (2019)	Implemented but audits not all compliant	Fetal surveillance midwife	Audits	
IEA 10: LABOUR AND BIRTH					
10.1	Women who birth outside a hospital setting must receive accurate advice regarding transfer times to obstetric unit. If planned to birth outside hospital, written information should be provided in agreement with local ambulance trust	Is this included in info leaflets re home birth?	HOM/ EMAS/ Community Matron	not given written information and no agreement with ambulance trust currently	
10.2	All women should receive full clinical assessment when in early or established labour. This should include review of risk factors and complications which might change recommended place of birth.		Intrapartum matron	email	
10.3	Evidence of regular multidisciplinary team skill drills which correspond with training needs analysis plan	Some skillsdrills but not regular	PD lead midwife	Skills drills attendance sheets	
10.4	Evidence of yearly operational risk assessments within midwifery led units		HOM	ask bobby and kim	
10.5	All maternity units must have pathway for induction of labour (IOL) Processes which identify clear, safe pathways if IOL is delayed should be demonstated	IOL guideline	Intrapartum matron	Guideline	

10.6	All women should be part of decision making process and be enabled to make informed decision regarding place of birth		HOM	PCPs, meet matron clinic	
10.7	Centralised CTG monitoring systems are mandatory in obstetric units				
	IEA 11: OBSTETRIC ANAESTHESIA				
11.1	Pathway for outpatient postnatal anaesthetic follow-up must be available in every trust. Conditions which require further follow-up include, but are not limited to, postdural puncture headache, accidental awareness, intraoperative pain and conversion to general anaesthesia, neurological injury and failur of labour analgesia		Anaesthetics	email	
11.2	Anaesthetists are required to be proactive in recognising when a woman would benefit from explanation and opportunity for questions to improve overall experience and reduce risk of long term psychological consequences	A new service is developing for hypnosis and anxiety management for expectant mothers who may have had a previous traumatic event	Anaesthetics	email	
11.3	Anaesthetic departments must review documentation of maternity patient records and improve where necessary in line with GMC recommendations		Anaesthetics	email	
11.4	Resources must be readily available for anaesthetic professional bodies to determine consensus on good anaesthetic record		**NOT A TRUST OR SYSTEM RESPONSIBILITY**		
11.5	Obstetric anesthesia staffing guidance should include role of consultants, SAS doctors and doctors in training		Anaesthetics	email. Labour ward handbook	
11.6	Obstetric anesthesia staffing guidance should include full range of obstetric anaesthesia workload		Anaesthetics	email. Labour ward handbook	
11.7	Obstetric anesthesia staffing guidance should include participation by anaesthetists in maternity multidisciplinary ward rounds	Await audit evidence	Anaesthetics	Audit,	
11.8	Obstetric anesthesia staffing guidance should ensure maintenance of safe services by outlining need for prospective cover		Anaesthetics	email	
	IEA 12: POSTNATAL CARE				
12.1	Trusts must ensure that women readmitted to postnatal ward and unwell postnatal women have timely consultant review. Evidence of a system to ensure consultant review of these women, including those on non-maternity ward, must be in place	Guideline	CD	Audit - request audit from audit lead	
12.2	Unwell postnatal women must be seen daily as a minumum	Guideline	CD	Audit	
12.3	Postnatal readmissions MUST be seen within 14 hours of readmission or urgently if required	Guideline		Audit - confirm cons review	
12.4	Staffing levels must be appropriate for activity and acuity of care on postnatal ward both day and night, for both mothers and babies.		HOM	review workforce report/BR+	
	IEA 13: BEREAVEMENT CARE				
13.1	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care		Bereavement midwives	Database. Compliance with NBCP	
13.2	Bereavement care must be available 7 days a week for both women and families who suffer pregnancy loss	Specialist midwife available 8-4, Monday to Friday.	HOM/ DM/ DVM		
13.3	Adequate numbers of staff must be trained to take post-mortem consent so counselling can take place within 48 hours of birth		Bereavement midwives	email	
13.4	Trusts must have developed a system to ensure families are offered follow-up appointments following perinatal loss or poor neonatal outcome		Bereavement midwives	database. Compliance with NBCP	
13.5	Compassionate, individualised, high quality bereavement care must be delivered to ALL families who have experienced perinatal loss		bereavement midwives		
13.6	Evidence of guidance such as National Bereavement Care Pathway		Bereavement midwives	Compliance report	
	IEA 14: NEONATAL CARE				
14.1	Must be clear pathways for provision of neonatal care		Paediatrics	Guidance on intranet	
14.2	Work to expand neonatal critical care, nenonatal cot numbers, development of workforce and enhance experience of families must progress at pace following recomendations from the Neonatal Critical Care Review (2019)		**NOT A TRUST OR SYSTEM RESPONSIBILITY**		
14.3	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including designation of each unit and level of care provided		Paediatrics	Guidance on intranet	
14.4	85% of births at less than 27 weeks gestation should take place at a maternity unit with an onsite NICU	This is network performance report, not an NGH individual report	paediatrics	Neonatal network dashboard	
14.5	Neonatal ODNs must allow staff within providers units the opportunity to share best practice and education to ensure units are not operating in isolation from their local support network		Paediatrics	email N Barnes	
14.6	Each ODN must report to commissioners annually what measures are in place to prevent units from working in isolation		paediatrics	email N Barnes	
14.7	During course of neonatal resuscitations, neonatal providers must ensure there are processes in place to allow telephone instructions and advice to be given		Paediatrics	email	
14.8	If consultant is not immediately available, there must be mechanism for real-time dialogue to take place between consultant and resuscitating team if required		Paediatircs	email	
14.9	Practitioners must ensure that once airway is established, appropriate early consideration is given to increasing inflation pressure, if required Pressures above 30cmH20 in TERM babies Pressures above 25cmH20 in PRE-TERM babies		Paediatrics	Induction pack for new neonatal doctors. Email	
1410	Neonatal providers must have sufficient numbers of appropriately trained consultants, middle grade doctors or ANNPs and nurses available in every type neonatal unit to deliver safe care 24/7	5 WTE consultants, should be 6 .Plan in place. Funding secure to uplift the number of middle grade Doctors and	Paediatrics	email, report	

14.11	Care that is outside agreed pathway must be monitored by quarterly exception reporting and reviewed by providers and network. The activity and results of reviews must be reported to commissioners and LMNS quarterly.	data not currently submitted to commisioners or the LMNS	Paediatrics	exception reporting with EMNODN	
	IEA 15: SUPPORTING FAMILIES				
15.1	Care and consideration of mental health and wellbeing of mothers, their partners and the family must be integral to maternity service provision		HOM	email Helen Elligot	
15.2	Robust mechanisms for identification of psychological distress must be in place, and clear pathways for women and families to access support		perinatal mental health team		
15.3	Access to timely emotional and psychological support should be without need for formal mental health diagnosis	Await reponse	perinatal mental health team		
15.4	Complex psychological support should be delivered by specialist psychological practitioners who have expertise in maternity care	Await reponse from SPHMS service manager	perinatal mental health team		
15.5	Maternity care providers must actively engage with local community, MVP, women with lived experience, to deliver informed services		Lead PMA	minutes of meetings, attendance at MVP zoom sessions	

Continuity of Carer

Executive Summary

S Situation	The publication of the Final Ockenden report (30th March 2022) recommends under Essential Action 2. Safe Staffing - that all Trusts must review and suspend, if necessary, the existing provision and further roll out of Midwifery Continuity of Carer unless they can demonstrate staffing meets safe minimum requirements on all shifts.
B Background	Currently Maternity services at NGH have 1 Midwifery Continuity of Carer (MCoC) team providing care for women of a BAME background and those women living in the postcode areas NN1, NN3 and NN4; the areas with a high index of multiple deprivation. This ensures that women who are most likely to experience adverse outcomes are targeted as a priority. Outcomes improve for women who are at both low and high risk of medical and obstetric complications and the benefits of MCoC are also experienced by women with complex social problems, socio economic deprivation and those from BAME backgrounds. These are the women who are at higher risk of maternal and fetal death and morbidity and experience more failures in care. The MCoC teams at NGH target these groups of women thereby reducing their risk of adverse outcomes. To remove the MCoC pathway for these women would potentially increase their risks. Following the publication of the Final Ockenden report, Trusts have been asked to immediately assess their staffing position and make one of the following decisions for their maternity service: Option 1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision. Option 2. Trusts that cannot meet safe minimum staffing requirements for further roll out of CoC but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide

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	services to existing women on MCoC pathways and suspend new women being booked into MCoC provision. Option 3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision
A Assessment	The 1 MCoC team currently have 8.8 WTE Midwives (which includes 0.6 maternity leave and 0.6 long-term sickness). This results in working with caseloads of up to 36 women per year. 7.6 WTE facilitates Midwives working with the correct caseloads. Based on the number of women currently booked onto a MCoC pathway, stepping down the MCoC teams would in effect release 7.6 WTE Midwives to work in the acute Maternity service equal to 30 11.5 hour shifts per week, but would remove the bespoke care provided to an identified highest risk patient group. MCoC team has a midwife for labour cover on all shifts and a midwife on-call for the night duty for all their caseload and are frequently used for escalation. In addition, currently, there is no provision for community midwives to provide out of hours support to the maternity service (consultation pending). Further to this, homebirth services are currently suspended due to dissolving of the homebirth team. This provision urgently needs relaunching, and it is anticipated that the current MCoC team could support this service, as the only team with the 24 hour on-call element built into their role. The small gain of actual unit shifts would be negated by the potential safety risk involved in removing MCoC to a vulnerable patient group and to the morale of the staff providing such care. Whilst anecdotal, it is anticipated that the suspension of this team would be detrimental to midwifery retention and recruitment. Through analysis of Birthrate plus data for January, February, and March we can demonstrate green acuity on Delivery suite is on average 83% of occasions, red acuity is declared less than 1% of all entries and 1:1 care in labour is always achieved. Better Births (2015) identified that an ongoing, supportive relationship between women and their maternity care provider improves outcomes and experiences of care.

	There remains an expectation for Trusts to submit MCoC updated LTP and staffing risk assessments by June 2022 and the National ambition remains that MCoC will be the default model of care once safe staffing is assured across Maternity services. Stepping down MCoC now would cause huge disruption in a team of midwives who are invested in the concept of MCoC and have worked hard to establish their teams to be in a position of supporting vulnerable families and the Maternity service hand in hand. The experience they are building is invaluable for future work force development and plans. To realistically recommence MCoC following complete removal at this stage would prove to be very challenging and the motivation of the staff to start again would also be extremely difficult. This model mirrors that which is proposed at Kettering General, and therefore would provide consistency across the partnership.
R Recommendation	Based on the staffing review and level of risk to patients currently on a MCoC pathway • NGH Maternity services aim to continue to support the existing 1 MCoC team to provide continuity to our most vulnerable women accessing Maternity care in its current format • Review of safe staffing and service delivery weekly by the Maternity management team. • Continue to work on the MCoC Long-term Plan (LTP) building blocks, in support of further roll out of MCoC teams in line with safe staffing • Review and monitor quality outcomes via bespoke MCoC dashboard monthly through Governance workstream. • Maintain partnership working with the LMNS • Report MCoC LTP progress / challenge via Trust and LMNS boards

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Dedicated to excellence

NHS
Northampton General Hospital
NHS Trust

Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	28 July 2022
Agenda item	13

Title	Appointments
Presenter	Alan Burns, Trust Chair
Author	Richard May, Trust Board Secretary

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

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

Reason for consideration	Previous consideration
To appoint Board Members to fill vacancies.	None

Executive Summary

The Board of Directors is invited to **APPROVE** the:

1. Appointment of Elena Lokteva to the Group People Committee and the Group Digital Hospital Committee, and
2. Appointment of Heidi Smoult to the position of Trustee of the Northamptonshire Health Charitable Fund in accordance with the Terms of Nomination, proposed for the Board's **APPROVAL,** at Appendix A **attached.**

Appendices
Appendix A: Terms of Nomination as Trustee of Northamptonshire Health Charitable Fund
Risk and assurance
No direct implications for the Board Assurance Framework
Financial Impact
No direct financial implications
Legal implications/regulatory requirements
The appointment of Non-Executive Directors to Committees is reserved to the Board of Directors under the terms of the Trust's Standing Orders.
Equality Impact Assessment
Neutral

Kettering General Hospital
NHS Foundation Trust

Appendix

TERMS OF NOMINATION AS TRUSTEE OF NORTHAMPTONSHIRE HEALTH CHARITABLE FUND

Background

The NHCF charity will act as trustee for the charitable funds on behalf of Kettering General Hospital NHS Foundation Trust (KGH), Northampton General Hospital NHS Trust (NGH), and Northamptonshire Healthcare FT (NHFT).

The NHCF charity Board of Trustees includes 2 nominated trustees from each hospital.

Each hospital will have a sub-committee of the NHCF Board with the 2 nominated he trustees being members of the sub-committee with one trustee being chair of that committee.

The sub-committee will also have members drawn from KGH staff and governors (but not having trustee status).

Each NGH Fund has an approved Fund Advisor who has authority to request expenditure up to £5,000. The NGH sub-committee has approval for expenditure up to £25,000 and all expenditure above £25,000 requires full NHCF Board of Trustees approval.

Role of the Trustee

The NGH sub-committee will have responsibility to oversee all expenditure incurred by NGH Funds as well as approving the spend above the fund advisors delegated limits as stated above. In doing so the members of the sub-committee must have due regard to the objectives of the individual funds, the overall NHCF charity objectives, Charity Commission regulations and general laws. The trustee must also be aware of any impact decisions made by the sub-committee have on NGH FT and for example, check that NGH Policies on Procurement have been adhered to by the Fund Advisor e.g. ensuring capital expenditure has the pre-approval from the KGH Investment Committee, and that funding for Medical Equipment has been subject to approval by the Medical Equipment Committee.

The nominated trustee has dual roles both as member of the NGH sub-committee and as trustee of the NHCF charity. The trustee must therefore be cognisance of the potential conflicts of interest as trustee.

Whilst acting in the role as member of the NGH Sub-Committee the interests of the NGH funds and the NGH NHS Trust when making decisions is paramount.

Whilst attending NHCF Board meeting the wider objectives of the charity must be reflected in their decision making but also making representations to the Board as a member of the NGH sub-committee when decisions are being made on the allocation of general funds to Northamptonshire projects. It is expected the trustee will be an active trustee and take an interest in other aspects of the NHCF such as supporting fundraising, investment performance and financial controls.

The trustee also has a responsibility to attend all NHCF Board and sub-committee meetings as well as any urgent non-diarised meeting requests or reasonable communications from the Chair of the Board or Charity Director.

The trustee is also required to regularly feedback to the NGH Board information on key NHCF Board and Sub-Committee decisions and provide an annual report to the Board detailing the activities of the NHCF charity including arranging presentation of the NHCF Annual Report and Accounts (by the NHCF Director).

The trustee is also bound by the Constitution of the NHCF charity.

Length of Term of Appointment

The term of the appointed is for up to 4 years, reviewable at any earlier stage at the Trust's Board's discretion, and in accordance with Section 12 the NHCF Constitution.

Circumstances in which NGH may terminate the appointment include, but are not limited to:

- Cessation of Term of Office as a Non-Executive Director of the Trust;
- The appointed is no longer a NGH employee;
- Change of duties of the staff member that may make the duties of the nominated trustee incompatible with their NGH role
- Ill health
- Disciplinary proceedings
- Job pressures
- Member unable to comply with the duties contained above for any other reason.

Nominated Trustee Details:

Nominated Trustee

Name:……

Period of appointment:…….

Declaration by the Trustee:

I have read and understood the terms of this nomination by NGH NHS Trust and declare I will perform the duties as above and all trustee duties contained in the NHCF Constitution

Signed
(trustee):……

Date:…….