Board of Directors (Part I) Meeting in Public

Wed 05 April 2023, 09:30 - 12:45

Boardroom, Northampton General Hospital

NHS
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 050423 (1).pdf (2 pages)

09:30 - 10:00
30 min

2. Staff Story: Responding to Industrial Action

Information *Heidi Smoult*

10:00 - 10:00
0 min

3. Minutes of the Previous Meeting held on 3 February 2023 and Action Log

Decision *Rachel Parker*

3.1 Draft NGH Public Trust Board Minutes - Feb 2023.pdf (9 pages)
3.2 Action Log Updated Post 030223 Part I Board.pdf (1 pages)

10:00 - 10:10
10 min

4. Interim Chair's Report

Information *Rachel Parker*

4.1. Interim Chief Executive's Report

Information *Heidi Smoult / Palmer Winstanley*

4.1 CEO Board Report April 2023 final.pdf (4 pages)

10:10 - 10:50
40 min

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

Assurance *Chief Operating Officer / Executive Directors*

5.0 a IGR cover paper.pdf (2 pages)
5.0 Group Upward Reporting to April-23 Board.pdf (12 pages)
5. March 23 IGR.pdf (78 pages)
5. Finance Report M11_Board.pdf (5 pages)

10:50 - 11:20
30 min

6. CQC Final Report: Inspection of Maternity Services

Receive / Assurance *Debra Shanahan / Ilene Machiva / Nerea Odongo*

BREAK 11:10-11:20

6. NGH CQC Final Report Update April 2023.pdf (4 pages)
6. APPENDIX 1 INS2-13835087781 - RNS01 Northampton General Hospital - 2023-02-16 (1).pdf (21 pages)
6. APPENDIX 2- NGH CQC Action Plan Final.pdf (8 pages)

11:20 - 11:40
20 min

7. Trust Response to the Kirkup Report

Assurance *Executive Leads*

- 7. Trust Board Paper - NGH Kirkup Report Update April 2023.pdf (5 pages)

11:40 - 12:00
20 min

8. Our Strategic Priorities for 2023-24

Decision *Karen Spellman*

- 8. Strategic Priorities NGH Board 5.4.23 Cover Sheet - for merge (2).pdf (3 pages)
- 8. Slides Priorities Group Boards April 23 FV.pdf (23 pages)

12:00 - 12:20
20 min

9. Staff Survey: Results and Response

Information / Assurance *Paula Kirkpatrick*

- 9. NGH Board staff survey response paper April 2023.pdf (4 pages)

12:20 - 12:30
10 min

10. Group Governance Arrangements: Review of Pilot, Board meetings 'in common' and Terms of Reference

Decision *Richard May*

- 10. Group Governance report 050423.pdf (3 pages)
- 10. Appendix A Committee evaluation report F&P 2023.pdf (3 pages)
- 10. Appendix B Annual Committee Evaluation.pdf (3 pages)
- 10. Appendix C CIC Finance and Performance Committee Terms of Reference Revised Draft March 2023.pdf (5 pages)
- 10. Appendix D CQSP CiC Draft TOR.pdf (6 pages)
- 10. Appendix E CIC People Committee Terms of Reference Draft Revised March 2023.pdf (5 pages)

12:30 - 12:35
5 min

11. Fit and Proper Persons Annual Declaration

Decision *Rachel Parker*

- 11.0 Fit and Proper Persons report.pdf (2 pages)

12:35 - 12:40
5 min

12. Annual Self-Certification and new NHS Provider Licence

Decision *Richard May*

- 12. NGH Board 050423 Self Cert report.pdf (7 pages)

12:40 - 12:45
5 min

13. Appointments

Decision *Rachel Parker*

- 13. Appointments.pdf (2 pages)

12:45 - 12:45
0 min

14. Questions from the Public (Received in Advance)

Discussion *Alan Burns*

12:45 - 12:45
0 min

15. Any Other Business and close

Discussion *Alan Burns*

Dedicated to excellence

NHS
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Board of Directors (Part I) Agenda

Meeting	Board of Directors (Part I) Meeting in Public
Date & Time	Wednesday 5 April 2023, 09:30-12:45
Location	Boardroom, Northampton General Hospital

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	Interim Chair	09:30	-	Verbal
2	Patient/Staff Story: impacts of industrial action	Interim Chief Executive	09:30	Discussion	Present-ation
3	Minutes of the Previous Meeting held on 3 February 2023 and Action Log	Interim Chair	10:00	Approve Receive	Attached Attached
4	4 Interim Chair's Report 4.1 Interim Chief Executive's Report	Interim Chair Interim Chief Executive	10:00	Information Information	Verbal Attached
Operations					
5	Board Committee summaries / Integrated Governance Report (IGR)	Interim Chief Executive / Executive Directors	10:10	Assurance	Attached
6	CQC Final Report: Inspection of Maternity Services	Director of Nursing, Midwifery and AHPs	10:50	Receive / Assurance	Attached
	BREAK		11:10		
Strategy and Culture					
7	Trust Response to the Kirkup Report	Director of Nursing, Midwifery and AHPs	11:20	Assurance	Attached
8	Our Strategic Priorities for 2023-24	Interim Director of Integration and Partnerships	11:40	Approve	Attached
9	Staff Survey 2022: Results and Response	Group Chief People Officer	12:00	Information and Assurance	Attached

Governance					
10	Group Governance Arrangements: Review of Pilot, Board meetings 'in common' and Terms of Reference	Trust Board Secretary	12:20	Approve	Attached
11	Fit and Proper Persons Annual Declaration	Interim Trust Chair	12:30	Approve	Attached
12	Annual Self-Certification and new NHS Provider Licence	Trust Board Secretary	12:35	Approve	Attached
13	Appointments	Interim Trust Chair	12:40	Approve	Attached
14	Questions from the Public (Received in Advance)	Chair	12:45	Information	Verbal
15	Any Other Business and close	Chair	12:45	Information	Verbal
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: Friday 9 June 2023, 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	Friday 03 February 2023, 09:00 – 11:20
Location	Boardroom, Northampton General Hospital

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
	Deborah Needham	Interim Group Chief Executive
	Natasha Chare	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
	Paula Kirkpatrick	Group Chief People Officer
	Helen Lidbetter	Deputy Director of Nursing and Quality (Deputy for Debra Shanahan)
	Elena Lokteva	Non-Executive Director
	Hemant Nemade	Medical Director
	Professor Andre Ng	Associate Non-Executive Director
	Karen Spellman	Interim Group Director of Integration and Partnerships
	Becky Taylor	Group Director of Transformation and Quality Improvement
	Anette Whitehouse	Non-Executive Director
	Palmer Winstanley	Chief Operating Officer
In Attendance	Richard Apps	Director of Corporate Governance (KGH)
	Christina Mallinder	Urgent Care Matron (Item 2)
	Richard May	Trust Board Secretary (KGH)
	Ruth Smith	Chief of Staff, Chief Executive's Office (Item 2)

	Dr Sarah Vince	A&E Consultant (Item 2)

Apologies for Absence	Debra Shanahan	Director of Nursing and Quality
	Heidi Smoult	Hospital Chief Executive
	Simon Weldon	Group Chief Executive

Agenda Item	Discussion	Action Owner
1	**Welcome, Apologies and Declarations of Interest** The Chair welcomed Board Members and guests to the meeting and noted apologies for absence as listed above. He extended a particular welcome to colleagues attending their first Board meetings (Natasha Chare and Anette Whitehouse) and congratulated Hemant Nemade on his substantive appointment as Medical Director. There were no declarations of interest relating to specific Agenda items.	
2	**Patient and Staff Story: Winter Pressures** The Board welcomed colleagues to describe their experiences of the severe and ongoing operational pressures the hospital was experiencing in an Emergency Department designed for 45 patients but often with over 140 patients in attendance. Dr Sarah Vince, A&E Consultant, informed the Board that the recent winter period had been the toughest she had experienced in 17 years, pushing staff and teams to the limits of their endurance and providing a sub-optimal environment for patients; around 100-120 patients attended each evening, and a lack of beds often delayed admission to Wards and resulted in patients sitting in chairs for up to 48 hours; this was far below the standard of care that Dr Vince and colleagues had been trained to provide. Staff and teams had been required to adopt new ways of working to provide care in this environment, for example drug rounds, and the department had been forced to restrict visiting due to the overcrowding. The department became inefficient when it was overly full, with the lack of cubicles preventing patients being seen and preventing important procedures such as electrocardiograms, which could not be carried out in waiting areas. Resuscitation capacity had been overwhelmed almost every day, leading to clinicians feeling they could never make good decisions, only ‘least worst’ ones. The team spirit amongst staff was good, and teams worked very well together, continuing to provide the best possible care and undertake effective triage to prioritise the most unwell patients, as	

	evidenced in that there had been no increase in the volume or severity of Serious Incidents reported during the period. The hospital's volunteers provided invaluable support, providing refreshments and activities, whilst the provision of new oxygen supplies in waiting areas and the work of Frailty Co-Ordinators also assisted. Christina Mallinder, Urgent Care Matron, described measures teams had taken to create extra spaces for patients to maintain dignity, and identified examples of service improvements such as the work of Patient Flow Co-Ordinators to support complex discharges. Despite the pressures, most feedback from patients and relatives had been positive and empathetic, expressing gratitude for the care provided in such challenging circumstances. Nursing and Health Care Assistants vacancies were high despite a welcome inflow of overseas nurses; several colleagues cited burnout and an inability to provide the levels of care they wished to and inability to complete training due to work pressures, as reasons for leaving. There were similar challenges with Junior Doctor recruitment and retention. Ruth Smith described her experience of the department as a relative, following the recent admission of a relative; she described an environment which staff were always compassionate and keen to assist, but often lacked the capacity to provide the attention required. Staff were always apologetic about the length of waits, and the care provided was of high quality despite the challenging environment. The Interim Group Chief Executive advised that she was truly sorry for the experiences described and for the cancellation of operations and appointments required as the hospital lacked capacity to care for every patient requiring a bed. 27-28 December had been especially challenging for Northampton and Kettering Hospitals, both of which declared Critical Internal Incidents. The Chair and Board of Directors thanked Sarah, Amanda and Ruth for attending and for the honesty and frankness with which they had described their recent experiences, extending their thanks to all colleagues and teams whose efforts had ensured the most unwell patients had continued to be identified and treated. The Board committed to ensuring it would continue to focus on minimising delays to recruitment and on health and wellbeing measures to support staff, and would ensure that the Integrated Care System carried out a timely and robust review, to ensure key learning was identified and implemented in preparation for future peak demand periods, and to ensure that the 2023/24 operating plans provided for a safe and effective urgent department.	

3	**Minutes of the Previous Meeting held on 24 November 2022 and Action Log** The Board **APPROVED** the Minutes of the Meeting held on 24 November 2022 as a correct record. The Board noted the action log.	
4	**Chair's Report** The Chair reported that he had received communication from the ICB Chair requesting increased document sharing and Non-Executive Director involvement in ICB committees; this request was referred to committees for detailed consideration and response.	**RA**
4.1	**Interim Group Chief Executive's Report** The Interim Group Chief Executive provided further information regarding severe winter pressures which culminated in a Critical Internal Incident being declared on 27 December 2022 at both hospitals, thanking staff colleagues for their ongoing dedication and commitment and apologising to patients, particularly those who waited for long periods in ambulances during peak periods, and to those whose appointments and operations had been postponed to enable urgent care to continue to be provided. The Trust participated in thrice-daily calls with ICB partners; following the incident, the local health system would be reviewing how additional community capacity could be made available more quickly in response to future incidents. Pressures within the hospital had reduced, though some escalation beds remained open in the Discharge Lounge and Wards. The Executive Team was working to develop the Operational Plan for 2023/24, which was required to focus on recovering core services, increasing productivity, delivering the NHS Long Term plan and accelerating transformation; in essence, the plan required the trust, and all ICB partners to operate more efficiently and remove costs. The Board of Directors noted the report.	
4.2	**Hospital Chief Executive's Report** The Board of Directors received the Hospital Chief Executive's report which drew attention to the following key headlines:	

	• Critical Incident in response to severe operational pressures (see items 2 and 4.1 above); • Effective planning for recent strike action affecting the Group and ICS; • Effective partnership working contributing to a 4-day length of stay reduction between October 2022 and January 2023, with an increase in supported discharges during January and cohesive team working with social and community colleagues; • Preparation for Pathway to Excellence redesignation in April 2023; • Strong performance against the 28-day faster Cancer Diagnosis standard; • 380 patients were waiting over 52 weeks to be referred to treatment; whilst frustrating for those affected, this was one of the lowest totalled, compared regionally, and • The Draft CQC Maternity Services Inspection report had been received for fact-checking, with the final published report to follow. The forthcoming Well-Led review briefings on 17 February provided an opportunity to ensure the robustness of shared learning from CQC and other external inspection reports. In response to a question, the Board was advised that the Trust was working with its Charity partner to stage a 'thank you' event to recognise colleagues' hard work in response to the severe and ongoing winter pressures.	
5	**Board Committee summaries and Integrated Governance Report (IGR)** Committee Chairs and Executive Leads brought the following highlights and exceptions to the Board's attention (full Committee summaries were set out in the agenda pack): *Group Finance and Performance Committee* The Committee: - Noted continuing concerns regarding diagnostic MRI capacity; NGH had agreed to retain a mobile MRI unit on-site until March 2023 and the business case for Community Diagnostic Centre provision was approved, but capacity gaps remained until 'hub and spoke' centres were operational during 2023/24, giving rise to increased risk of harm caused by delays (assurance level: Limited) - Noted an increasing disconnect between financial planning and operational performance which presented challenges for the preparation of the 2023/24 operational plan. Enhanced financial controls were place in the context of an £11m year-to-date deficit due to continuing under-delivery of efficiency targets and high agency costs, exacerbated by above-projected inflationary non-pay pressures.	

	The Chief Operating Officer provided clarity and assurance in respect of key operational metrics, drawing attention to specific data set out within the IGR document and noting that the Trust had maintained Cancer treatment and elective treatment trajectories despite reductions in activity due to the recent Critical Incident. Whilst more pressure ulcer cases had been reported, harm levels had remained consistent. *Group Transformation Committee* The Committee: - Reviewed the Integrated Care Partnership (ICP) Strategy, raising concern regarding the operationalisation of the strategy to deliver benefits in alignment with the Group's 2023-24 plans; - Raised concerns about the resources required to deliver Group Priorities during 2023/24, wishing to ensure that benchmarking data was appropriately shared across the group (assurance level: Limited), and - Noted ongoing Estates Transformation Delivery work, and a forthcoming series of workshops to test the findings of the external review and develop plans for new ways of working. *Audit Committee* The Committee: - Indicated 'reasonable' assurance in respect of completed internal audits and its satisfaction with progress with the implementation of the annual plan, and - Approved the Going Concern Statement for the preparation of the final 2022/23 accounts. *Group Digital Hospital Committee* The Committee: - Indicated 'Limited' assurance regarding progress with the implementation of the Digital Roadmap, and noted that, as a consequence of senior leadership changes, delays to the establishment of the strategic collaboration group and the need to reassess digital transformation priorities, the committee was undergoing a period of challenge and review and would be reviewing its role, membership and Terms of Reference in response; - Received an updated on the NGH Electronic Patient Record (EPR) procurement, which had reached public tendering (assurance level: Reasonable); and - Approved a proposal to allow System One access to provide options to access GP data was supported	

	(confirmed by electronic resolution following the committee meeting) (assurance level: Reasonable). *Group People Committee* The Committee: - Indicated its assurance in respect of the Trusts' response to recent and ongoing Industrial Action; - Extended its thanks to all staff, and especially those providing wellbeing and psychological support; - Proposed a reduction in the number of IGR metrics from 27 to 15 and aligned group targets for sickness (5% target), vacancy (8% target) and turnover (8.5% target) levels, which were **AGREED** by the Board of Directors; - Received safer staffing reports, indicating 'Limited' assurance due to data gaps; - Noted an overall reduction in employee relations cases, suggesting an increasing number of issues were able to be resolved informally; and - Undertook to review staff mental health initiatives and agency spend at the strategy workshop planned for April 2023. In response to a question, the Board was advised that the Midwifery Workforce Plan included Neonatal and Medical Staff. *Group Clinical Quality, Safety and Performance Committee* The Committee: - Received the IGR, requesting greater harmonisation of metrics across the Group. - Discussed concerns regarding diagnostic performance (see above); - Approved the submission of the Clinical Negligence Scheme for Trusts (CNST) assessments; - Received an update on the unannounced CQC inspection of Maternity Services, the draft report to which was being reviewed; and - Noted positive Standardised Hospital Mortality Indicator data for NGH. In response to a question, the Board was advised that the number of medical prescribing errors was partly attributable to the wider scope of the Ward-based pharmacy project, which had improved the robustness of reporting. Pressure ulcers had increased due to higher acuity and length of stay during the winter peak demand period though (as reported above), there had not been a corresponding increase in harm levels. The Board of Directors noted the Integrated Governance Report.	

6.	**Review of Dedicated to Excellence Strategy Delivery** The Board of Directors considered a report outlining delivery achievements related to the Dedicated to Excellence Strategy for the University Hospitals of Northamptonshire (UHN) Group, launched in July 2021. The report outlined achievements against each of the five Group priorities around Patient, Quality, Systems and Partnerships, Sustainability and People, and noted progress with the implementation of the Group Clinical Strategy though the Cardiac and Cancer Centres of Excellence programmes, and with enabling strategies for digital, academic, nursing and midwifery, people, estates and the Integrated Care System (ICS). The Board of Directors welcomed the achievements outlined in the report, but requested further assurances that these were directly driven by the strategy, rather than being incidental to the Group's operational activities; quantitative evidence of improvements, linked to key metrics, was also required, and should be received at the next meeting, informing the identification of challenging but measurable and achievable objectives for 2023/24. Consideration must also be given to communicating key messages to the organisations as part of this review.	**Becky Taylor**
7.	**Integrated Care Partnership Strategy** The Board of Directors received the approved ICP 10-year Strategy setting out aspirations for our communities to live their best lives; the strategy had been developed by all partners within the local health system, and was underpinned by outcomes and community engagement frameworks based around local places and collaborative working. The strategy would be delivered through a five-year plan and Health and Wellbeing Strategies for North and West Northamptonshire. The Board of Directors noted and endorsed the strategy though, in doing so, raised concerns about its deliverability, given resources pressures facing all ICB/ICP partners, particularly in respect of key enabling work in HR and digital. The Board looked forward to contributing to the ICB five-year plan and Health and Wellbeing Strategy through which the ICP would be delivered, acknowledging that partners must be realistic about which elements of the 10-year strategy could be delivered during 2023-24.The Board noted the work of the Chief Operating Officer and Directors of Adult Services Network to enhance understanding and capability for interventions in public and community health which would reduce 'front door' attendances and admissions into acute hospital care, as part of which it would be important for the Trust and Group to develop 'proxy' public health measures which would demonstrate the effectiveness of work to identify and tackle local health inequalities. There were also key dependencies for the success of the Group's Centres of Excellence initiative for Cancer and Cardiology.	

8.	**Group Board Assurance Framework (BAF)** The Board of Directors received the Group BAF, which had been updated following quarterly review by Committees; the BAF had developed to include clearer links to underpinning corporate risks. Committees had recommenced rolling programmes of 'deep dive' reviews of BAF risks within their areas of responsibility, following which a series of facilitated workshops, led by the Director of Corporate Governance, would be arranged to enable the time and space for the reviews outside of formal meetings.	
9.	**Standing Financial Instructions** Following a recommendation by the Audit Committee, the Board of Directors **APPROVED** changes to the Trust's Standing Financial Instructions as set out in the report.	
10.	**Appointment of Non-Executive Director to the Group Digital Hospital Committee** The Board of Directors **APPROVED** the appointment of Anette Whitehouse to the Group Digital Hospital Committee.	
11.	**Questions from the Public (Received in Advance)** There were no questions from the public.	
12.	**Any Other Business and close** There was no other business.	
13.	**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	Wednesday 5 April 2023, 9.30am
Location	Boardroom, NGH

Action Log

Meeting	Board of Directors (Part I) Meeting in Public
Date & Time	Updated following 3 February 2023 meeting

Minute Ref.	Action	Owner	Due Date	Progress	Status
Mar 22 8	Identification of metrics to assess implementation of Group Communications Framework	SO	Apr 2023	Group Director of Communications and Engagement to update	OPEN
Nov 22 7	East Kent (Kirkup) response: the Board requested the results of further analysis to be presented in 4-6 months providing an assessment of the extent to which all stakeholders could be assured that maternity services were safe and compassionate.	DS / IM	Apr 2023	Agenda item 8	CLOSE
Feb 23 4	Referral of ICB Committee proposal	RA	Apr 2023	Draft response has been prepared for Chair's agreement	OPEN
Feb 23 6	Report to next meeting setting out measurable outcomes for the Dedicated to Excellence Strategy and 23-24 priorities	BT	Apr 2023	Agenda item 9	CLOSE

Dedicated to excellence

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Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	5 April 2023
Agenda item	4.1

Title	Hospital Chief Executive's Report
Presenter	Heidi Smoult, Hospital Chief Executive (and Interim Chief Executive Designate)
Author	Heidi Smoult, Hospital Chief Executive (and Interim Chief Executive Designate)

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

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

Reason for consideration	Previous consideration
For the Board's information.	None

Executive Summary

The NHS nationally continues to face significant pressures in terms of demand and acuity, in addition to significant workforce challenges. This requires NGH as an acute provider, along with partners across our Integrated Care System (ICS) to find new solutions and continue to work collaboratively to ensure we deliver a sustainable future, and solutions to these challenges in the interests of our teams, patients and our community. Our teams have been working across the system in this regard on our planning submission for the year ahead. Whilst we need to ensure we deliver against key safety and performance

measures in the year ahead, we aim to approach the challenge at NGH, across UHN and our ICS with a strong focus on ensuring we also deliver value for money and deliver care in the most safe and efficient way, with a focus on outcomes and patient experience.

Importantly, this challenge will be faced collectively across and within teams, underpinned by quality improvement and transformation. Furthermore, it will be approached with a strong focus on our culture journey and the well-being of our workforce as our most precious resource.

Industrial Action

During the most recent industrial action in March relating to the junior doctor strike, the teams across NGH demonstrated a strong commitment to support the junior doctors' right to strike, whilst maintaining a clear focus on teamwork and safety of each other and our patients. The dedication and commitment shown in the planning ahead of the strike was excellent, which continued throughout the period of the strike. I would like to thank all our teams across NGH for their support and dedication during this time. During this strike, NGH was in the top two for ambulance offloads during the strike days and whilst we had to make the difficult decision to cancel some activity, as well as some long waiting cases, we received recognition from some regional colleagues on the success of our planning for the junior doctor strike.

Fire

On the first day of the junior doctors' strike NGH had a localised fire on site in a non-patient area, which required the fire brigade to attend the site and required preventative evacuation of some patient areas. This was declared as a major incident and the teams across the site demonstrated exceptional supportive teamwork across the whole multi-disciplinary team to keep our patients, staff and site safe.

Patient feedback on the day and following days was positive and staff were supported by our SoS team to ensure we had a strong focus on their wellbeing from the outset and on the day of the incident.

I would like to thank system partners and the fire service for their expertise and support on the day, as well as their positive and collaborative partnership working subsequently.

Operational Position

Whilst our urgent and emergency care pathways remain a significant focus for improvement, we have maintained our cancer position and reduced our backlog from 136 patients over 62 days, to under 90, so already achieving the March '24 target of 95. We have plans in place to meet the operational focus on RTT for 65 week waits and to recover any current 52-week position.

Theatre Utilisation

Our theatres teams have been working really hard over the last six months on improving our performance through our theatres' transformation programme.

In recent weeks there has been a real focus on making sure that we are starting our theatre sessions on time, meaning that we are able to see more patients per session on our list, and making the flow more positive for our staff. This has been a real team effort, with all members of the theatre team having worked to develop a clear set of roles and responsibilities, changes to the IT infrastructure to make it easier to use our IT to best

effect, the theatre porter team ensuring that our patients are ready to go, the transformation team supporting and coaching the team to implement the changes, and the leadership for supporting Plan Study Do Act cycles to rapidly make changes and resolve issues.

This has meant that the number of sessions we are starting on time has doubled across all our theatre areas and we have achieved up to 89% theatre utilisation (when including a turnaround time of 10 mins).

People

As part of our recruitment ambition and workforce planning, we held a recruitment day on 11th March, and we successfully recruited 91 healthcare assistants and 13 registered nurses on the day.

As a key part of our cultural improvement journey and supporting our teams in line with our values, our leadership programme is ready to be launched, which is a fundamental positive step in developing and supporting our people and teams to thrive.

As part of our continuous focus on staff well-being, we are imminently launching our protected space for staff, branded “Our Space” to help support staff health and well-being. Our staff psychological services have supported teams across major incidents, and we continue to work with our organisational development expertise and our equality diversity and inclusion colleagues to continuously strengthen our focus on valuing diversity more broadly, with a focus on improving disability management, workplace adjustments and leadership support.

Pathway to Excellence

Our Pathway to Excellence journey continues its momentum towards reaccreditation with our Nursing Conference on 24th May. The teams have submitted our evidence submission for our reaccreditation process towards the end of March 2023, and we await our survey date to be confirmed.

Estates and Facilities

We are incredibly proud of the work undertaken by our Estates colleagues to deliver our new ED streaming hub and they are now continuing to work on our Minor injuries hub to provide an improved experience for our patients that require emergency care. They are also working on the development of our new discharge lounge to support timely transfer home for those in our care.

Digital

The procurement of the NGH Electronic Patient Record system is progressing, with a strong focus on the importance of clinical engagement. Consequently, the Programme Board has made a decision to extend the procurement by around 8 weeks to widen and further improve clinical engagement. Supplier demonstrations and site visits will take place in June/July and then the Full Business Case will be written and submitted for approval through our governance processes.

The milestone of 100,000 patient records digitised and available in the EDMS (electronic document management system) was reached in March.

Dedicated to Excellence Awards
Dedicated to Excellence Awards were held on 16th March to recognise and celebrate the achievements of some of our teams, amazing staff, volunteers and fundraisers across the UHN Group. The awards received over 450 nominations from staff, public and patients across 15 categories. The awards were a real pleasure to judge and present at, and importantly, an opportunity to thank all our staff for everything they do each and every day for our patients, communities and each other.

IP7 Pacific Biopsies – Imperial Prostate Diagnosis

NGH has been chosen to be one of the first hospital sites to be a Urology Centre for the Cancer Research UK Sponsored Imperial led PACIFIC RCT research trial.

Final of the BJN National Nurse of the Year Award

Kerry Messam, Deputy Lead Nurse for Specialist Palliative and End of Life Care at Northampton General Hospital, is in the finals of the British Journal of Nursing (BJN) Awards 2023. I would like to congratulate Kerry for this wonderful recognition of her dedication and commitment to our patients.

Retirement of our Chair

Our Chair, Alan Burns retired at the end of March 2023. I would like to take this opportunity to formally thank Alan for his strategic leadership and commitment to NGH and UHN and acknowledge the difference Alan has made on our journey to excellence. I would personally like to thank Alan for his support and leadership to the whole hospital executive team and board.

Appointment of our Director of Nursing (DoN)

We are delighted to have recruited a substantive DoN into post at NGH, and Nerea Odongo joins us on 3rd April 2023.

I would like to take this opportunity to thank Debbie Shanahan for her hard work, dedication and teamwork since fulfilling the interim DoN position. Debbie has been a fundamental part of the executive team during this time and has been a dedicated nurse and nurse leader in NGH for a significant time.

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

Dedicated to excellence

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Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	5 April 2023
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.	Board Committees, March 2023

Executive Summary

Board Committee summaries and the Integrated Governance Report for March 2023 are enclosed. Committee Chairs and Executive Leads will be invited to draw the Board's attention to other significant items considered at meetings, indicating the degree of assurance the committee is able to provide in each case.

Appendices

- Board Committee summaries, February-March 2023
- Integrated Governance Report, March 2023
- Finance Report, Month 11 (28 February 2023 – to follow)

Risk and assurance
The IGR should inform, and be informed by, consideration of the Board Assurance Framework.
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

Northampton General Hospital Board of Directors Meeting: 5 April 2023

AGENDA ITEM 5

Group Strategic Development Committee: 16 February 2023

Group Digital Hospital Committee: 9 March 2023

Group Transformation Committee: 13 March 2023

Group Finance and Performance Committee: 27 February and 28 March 2023

Group People Committee: 30 March 2023

Group Clinical Quality, Safety and Performance Committee: 24 February and 31 March 2023

Audit Committee: no meeting since last Board meeting

Group Strategic Development Committee Report to the Board of Directors	Date of reporting group's meeting: 16th February 2023

Reporting Director: Jon Evans

Agenda Item	Description and summary discussion	Decision / Actions and timeframe	Assurance level *
Project Oversight and Assurance of Major Developments across UHN - Proposed Formation of Programme	The Committee heard that the Executives are reviewing project governance and management currently and the Director of Strategy proposed to bring an update to a future SDC. The Committee APPROVED the concept of the report, noting that it required some amendments.	Amendments to be circulated ahead of April SDC	Reasonable Assurance
KGH Energy Centre and Electrical Infrastructure	With the support of the Chair and the Lead Governor the team had gone through a selection process to identify a preferred supply chain partner to deliver the construction works and to help the hospital deliver the full business case. Assurance was indicated following a very thorough process. It was noted that the project would require close joint working and would be of continuing interest of KGH Governors.	-	Reasonable Assurance
Community Diagnostic Centres Business Case	The Committee noted the latest position and identified key communications messages as part of the next phases towards implementation	-	Reasonable Assurance
KGH New Hospital Programme Budget	It was noted that at the next SDC meeting there would be a paper presenting the New Hospitals Programme budget and the energy and electrical budgets, and that all budgets will continue to be monitored via the Trust's Capital Committee which meets on a monthly basis.	To be presented at April SDC	Reasonable Assurance

Group Digital Hospital Committee Upward Report to Boards of Directors	Date of reporting group's meeting: 9 March 2023

Reporting Group Chair: Alice Cooper

Agenda Item	Description and summary discussion	Decision / Actions and timeframe	Assurance level *
	Following the appointment of the new Group CDIO, Natasha Chare in February the decision was taken to suspend the normal standing agenda for the March meeting, and focus on activities to reset the focus and priorities of the Group Digital team, and also to allow focus on other areas for development of the Team and Committee which had commenced in late 2022, and had also been discussed at the Digital Boards development exercise conducted at the March Group Board Development Session. The March meeting therefore included a far broader list of attendees than would attend the Committee typically, (in order to gather a wider range of views), and focussed on these areas, rather than on the pure assurance on progress of the Group Digital Strategy as has been typical of other meetings. It is planned to use two additional workshop sessions for committee attendees in April to consider a) A full deep-dive of the Digital Risk position, and b) The proposed changes to the ways of working for the Committee and the Group Digital Team in terms of structure, membership, engagement methods, and other governance matters.	Committee Workshops booked for April 2023.	N/A
5	**Update on Digital Prioritisation** The Group CDIO updated on the process that has been conducted so far to refocus the Digital team's activity on current (circa next 12m) organisational priorities from the Digital Strategy, and the draft outputs from this discovery and engagement process. This including clarity on what projects could therefore not be prioritised at present, and next steps to finalise these outcomes.	Next version to be returned to next committee	Substantial
6	**Reflection Exercise on Committee Effectiveness** An interactive discussion and feedback exercise was conducted to gather views on how the Committee was functioning at present, and what would be areas for improvement going forward, including in areas such as membership and scope.	Consideration by Chair in March/April	N\A Discussion item
8	**Plans for Digital Communication and Engagement with Clinical/Operational areas** Initial proposals for the structure of the the Committees and governance and engagement mechanisms that relate to the work of the Group Digital Team were started for feedback and discussion.	Consideration by GDIO & Chair in March/April	N\A Discussion item

Group Transformation Committee Report to the Board of Directors	Date of reporting group's meeting: 13th March 2023

Reporting Non-Executive Director: Jill Houghton (NGH Chair)

Agenda Item	Description and summary discussion	Decision / Actions and timeframe	Assurance level *
Strategic Priorities 23/24	As part of the Integrated Business Planning for 23/24 and in order to set objectives for the coming year, the team has reviewed the strategic priorities as set out in the Dedicated to Excellence strategy. The Committee considered that 3-5 year goals were too vague, and that annual programmes with measurable and achievable targets would be required. The Committee noted the update and AGREED that at present it had LIMITED ASSURANCE on this item because there was a significant amount of work yet to be done and that it was work in progress.	On Board Agenda: item 9	Limted Assurance
Productivity and efficiencies	It was noted that significant productivity challenges faced both hospitals in 23/24 . The Committee noted increasingly complex health needs and acuity since COVID, which gave additional workforce pressures to safely manage them. It was reiterated that the communications around this was vitally important. In summary it was noted that the Group was confident it had an evidence-based plan in place to deal with the challenges, and that there would need to be a balance of operational, clinical and financial risk to deal with them. The Committee NOTED the update and that it had at present LIMITED ASSURANCE as it was unsure how deliverable the plans would be.	-	Limited Assurance
Updates from SDG on 23/24 Programme Delivery	A programme delivery update from the strategic delivery group on the delivery of transformation programmes was given. The Strategic Delivery Group (SDG), which reported into the Group Transformation Committee, had been discussing and setting up the priority programmes that the corporate teams would be supporting for next year through a process of engagement with the divisional leadership teams.	SDG updates to become a monthly standing item on GTC	-

Group Finance and Performance Committee Report to the Board of Directors	Date(s) of reporting group's meeting(s): 27 February 2023

Reporting Non-Executive Director: Rachel Parker

Agenda Item	Description and summary discussion	Decision / Actions and timeframe	Assurance level *
IGR - Diagnostics	Concerns were highlighted to the Committee relating to MRI capacity at KGH and Endoscopy capacity at NGH. There would be additional investment from the CDC for MRI/CT over the next year.	-	Limited
The 2023/24 Annual Operational and Financial Planning/Annual Plan	The draft plan was an updated version from the plan shared at the recent NED and Executive meeting. The draft plan was submitted 23 February 2023. The final plan would be shared at the March Committee and April Trust Board. There were concerns again highlighted regarding diagnostic targets. The Committee requested more information on the efficiency programmes.	Update to the March-23 Committee	Limited
Estates Compliance Report	At NGH the fire risk had reduced following a huge amount of work over the last 3 years. At KGH a new Safety Hub software had been procured to enable staff health and safety training at KGH. An Interim Estates H&S manager had been appointed to start in March. A Group Catering Procurement Business Case would be presented to the March Committee.	To be presented at the March-23 Committee	Reasonable
Cardiac MRI - KGH	The cardiac MRI was now at operating capacity. There had been time delays however these did not incur a financial cost. The lessons learnt were included in the paper.	-	Limited
New Hospital Programme – Car Parking Procurement Plan	There had been agreement to partner with a 3rd party to develop a business case to design and agree a new multi storey car park on site. It was a key part of the redevelopment master plan. The KGH Committee attendees APPROVED the New Hospital Programme Car Parking Procurement Plan.	-	Substantial

Group Finance and Performance Committee Report to the Board of Directors	Date of reporting group's meeting: 28 March 2023

Reporting Non-Executive Director: Rachel Parker

Agenda Item	Description and summary discussion	Decision / Actions and timeframe	Assurance level *
Catering Procurement Business Case	The Committee was presented the catering procurement business case. The business case was made of two parts, part one which related to the procurement of a catering provider, and the second part which focused on digital meal ordering. Savings had been forecasted and these were detailed in the business case. The Committee had a robust discussion, noting the benefits however also making sure certain patient groups would not be excluded. The Committee approved the business case.	Approved	Substantial
Portakabin Purchase Decision (KGH)	There was £3m of capital spend awarded to KGH from the Discharge Unit Capital Fund to purchase areas on site that KGH was currently renting which would then be used to improve flow through ED. This included the Naseby extension, ED pod, rapid assessment unit and the multi-faith prayer room. The Trust would save £368k/year by purchasing them. The CFO was comfortable with the finances. The KGH attendees approved the business case.	Approved	Substantial
2023/24 Annual Operational and Financial Planning/Annual Plan	The Committee was had an in-depth presentation of the plan. The Group had received notification that there would another submission of the plan therefore further work would be required. There was national pressures to reduce the deficits. The Committee highlighted the need to discuss efficiencies in more detail and whether the 4% efficiency planning assumption target was achievable. The Committee approved the plan as it was presented to the Committee, noting it would be further updated.	Update to the Apr-23 Committee	Reasonable
Strategic Priorities	The Committee approved the updates to the System & Partnerships and the Sustainability priorities.	Approved – on Board Agenda	Substantial
Terms of Reference	The Committee approved the Terms of Reference, with the amendment to include the Group Director of Operational Estates & Facilities role.	Approved – on Board Agenda	Substantial
Estates Compliance report	The Committee received an update on the fire at NGH. The Committee complimented the professional response which was in line with all plans and processes.	-	Substantial
IGR - Diagnostics	The Committee continued to note the ongoing issues with diagnostics and that the Group was an outlier in this area.	-	Substantial
Review of Committee Effectiveness	The Committee agreed that it was on the correct trajectory and would recommend continuation of the Committee in Common to the Board.	Approved – on Board Agenda	Substantial

Group People Committee Report to the Board of Directors	Date of reporting group's meeting: 30 March 2023

Reporting Non-Executive Director: Paula Kirkpatrick

Agenda Item	Description and summary discussion	Decision / Actions and timeframe	Assurance level *
Terms of Reference	The Committee approved the Terms of Reference subject to minor amendments to clarify members and attendees.	On Board Agenda	n/a
Our Strategic Priorities for 23/24	The Committee noted that the target related to the staff survey results being within the top 20% to be ambitious therefore the focus would be shifted to whether the individual would recommend either Trust as a place to work and/or receive treatment. A stretch target for these had been identified. The programmes of work were over the next 4 years and there was a direct read across with the People Plan.	-	Reasonable Assurance
Safe Staffing Report	Each Trust provided an update to the Committee. The use of SPC charts within the report to enable clearer presentation of the data was suggested and this would be looked at in the next Performance People Committee. An update on roster publication was shared and there was agreement that work needed to be done on going back to basics of the roster system with the ward leaders. There was also discussions on forecasting upcoming leavers and work being done on time to hire with the QI team coming in to support this.	-	Limited Assurance
Industrial Action	The committee noted, and expressed its gratitude for, the activities related to the strike actions that our HR business colleagues had supported to ensure we had sufficient staff on the days affected.	-	N/a

Clinical Quality, Safety and Performance Committee in Common Upward Report to Boards of Directors	Date of reporting group's meeting: 24 February 2023 (1 of 2)
Reporting Director: Jill Houghton	

Agenda Item	Description and summary discussion	Decision / Actions and timeframe	Assurance level *
Fire Compartmentation	The committee received an update from the Group Director of Estates and Facilities on fire compartmentation works at KGH, which had been raised at the January committee meeting. The committee noted that following successful funding bids, fire compartmentation works would be completed in March 2023 and a business case for further work was being written. The committee confirmed that it had received substantial assurance on this matter.	n/a	Substantial assurance
Sub group reports	The committee received and noted upward reports from Information Governance, Assurance and Risk, Quality Governance and Health and Safety sub groups. The committee noted and supported the amalgamation of the Information Governance and Data Governance Groups into a new Data Security and Protection Group and the new governance structure for this group. The committee highlighted the need for regular sub group reporting to the committee and noted the requirement for further work to ensure all relevant sub groups reported to this committee.	n/a	Reasonable assurance
Maternity	The committee received and noted the joint Maternity Safety report, NGH Maternity Serious Incidents update, KGH Maternity Safety and Serious Incident Q3 briefing, KGH MBRRACE Q4 perinatal mortality report and KGH Saving Babies Lives Care Bundle. The committee noted for CNST that NGH had achieved compliance with two Maternity Safety Actions - Safety Action 2: 'Are you submitting data to the Maternity Services Data Set to the required standard?' and Safety Action 7 'Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?'. Partial compliance was declared for the remaining eight Safety Actions. £87,588 requested in additional funding to support implementation of Safety Actions 1, 3 and 10. The committee was informed of 2 pre-term deaths at KGH and reviews had been undertaken of 2 maternal deaths; no failure in care had been found.	n/a	Substantial assurance

Clinical Quality, Safety and Performance Committee in Common Upward Report to Board of Directors	Date of reporting group's meeting: 24 February 2023 (2 of 2)

Reporting Director: Jill Houghton

Agenda Item	Description and summary discussion	Decision / Actions and timeframe	Assurance level *
UEC	The committee received urgent and emergency care performance standards reports from both trusts. The committee noted that both organisations were recovering from the December 2022 critical incidents and that bed occupancy was high at both trusts.	n/a	Substantial assurance
Infection Prevention and Control, Safeguarding and Complaints	The committee received and noted reports on IPC, safeguarding and complaints. There were no specific comments from the committee on these items.	n/a	Substantial Assurance
Mortality and Morbidity	The committee received and noted the mortality reports for both trusts. The committee noted KGH alerts for respiratory and septicaemia, the Medical Examiner rollout to all GP practices from April, ME workload pressure for KGH and NGH reviews of admissions to ICU from wards.	n/a	Substantial assurance
External Inspection and Assurance	The committee received and noted comprehensive updates on the KGH CYP improvement programme, NGH Maternity Service CQC report and a verbal update on the NGH HTA mortuary inspection.	Maternity CQC report at agenda item 7	Substantial assurance
KGH IT outages	The committee received assurance from the KGH Digital Director regarding IT outages at KGH and the digital incident management process. The committee received assurance that Datix entries were being reviewed and processes were in place to deal with the IT outages.	n/a	Substantial assurance
Integrated Governance Report	The committee received the Integrated Governance Report and commented on the increased number of pressure ulcers at NGH, noting that action was being taken. Diagnostic waits were discussed as these are a major concern at both organisations; it was noted that additional capacity is coming online however, targets would still not be met at KGH. The committee discussed the planning for strikes and was assured that there was robust planning at both sites to ensure patient safety comes first. Committee members commented that complete alignment on items on the IGR was needed.	n/a	Reasonable assurance

Clinical Quality, Safety and Performance Committee in Common Upward Report to Board of Directors	Date of reporting group's meeting: 31 March 2023 (1 of 2)		
Reporting Director: Jill Houghton			
Agenda Item	**Description and summary discussion**	**Decision / Actions and timeframe**	**Assurance level ***
Committee Terms of Reference	The committee reviewed its terms of reference highlighting the need for a focus on quality to be emphasised in section 2.6 and to confirm that section 3 contains a complete list of subgroups that are required to report into the committee from both trusts	n/a	Substantial assurance
Committee self evaluation	Feedback from the annual committee self-evaluation was noted. The committee recommends to the Board the continuation of the Clinical Quality, Safety and Performance Committee in Common.	Recommendation of continuation of committee in common	Substantial assurance
Sub group reports	The committee received and noted upward reports from NGH and KGH Quality Governance subgroups, KGH Safeguarding Steering Group, KGH and NGH Patient Experience subgroups, KGH and NGH Assurance and Risk Committees and NGH and KGH Health and Safety subgroups. The committee requested that where limited assurance was reported by subgroups, that the actions to be taken by the subgroups are provided in their upward reports.	n/a	Reasonable assurance
Strategic Priorities	The committee discussed the Dedicated to Excellence strategic priorities. The committee highlighted the overlap between its agenda and that of the Group Transformation Committee, particularly in relation to GIRFT, which the Transformation Committee chairs have asked the Director of Transformation to review.	n/a	Limited assurance
Integrated Governance Report	The committee received the IGR noting that while c-difficile and pressure ulcers remain a challenge at NGH, action plans and mitigations are in place. The committee was made aware of a never event which had occurred in NGH's Emergency Department and received substantial assurance that the patient had suffered no long term harm due to this, though staff had been impacted. The committee expressed concern regarding the quality of data provided by the IGR and emphasised the need for further work on this and would like a deadline for the alignment of data in the IGR.	n/a	Limited assurance

Clinical Quality, Safety and Performance Committee in Common Upward Report to Board of Directors	Date of reporting group's meeting: 31 March 2023 (2/2)

Reporting Director: Jill Houghton

Agenda Item	Description and summary discussion	Decision / Actions and timeframe	Assurance level *
Joint Urgent & Emergency Care Report	The committee was pleased to receive the first joint Urgent and Emergency Care report and commended the joint work of the Chief Operating Officers in producing this, and from which the committee was provided with reasonable assurance. Challenges relating to the estate which were impacting ambulance handovers at NGH were noted by the committee.	n/a	Reasonable assurance
Maternity Safety	The committee received and noted the joint Maternity Safety report and received reasonable assurance from this though noted that digital issues were creating challenges for the services at both trusts.	n/a	Reasonable assurance
Mortality and Morbidity	The committee received and noted the mortality reports for both trusts from which the committee received reasonable assurance.	n/a	Reasonable assurance
Patient Safety	The committee received the Q3 KGH patient safety report and requested that in future, reporting to the committee was aligned between trusts. The committee received reasonable assurance on the Patient Safety Incident Response Framework which was supported by an external review of governance arrangements on patient safety. The committee also received a verbal update on the latest industrial action, the learning from which would used in planning for the next scheduled industrial action. Strong team work between hospitals was acknowledged during the latest industrial action.	n/a	Reasonable assurance
Clinical Collaboration Updates	The committee received updates on the Cardiology and Head and Neck clinical collaborations. The committee noted positive progress on both collaborations but can only report limited assurance due to the lack of metrics.	n/a	Limited assurance.

*The Committee will indicate the level of assurance it is able to provide to the Boards of Directors using the following definitions:

Substantial Assurance	There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)
Reasonable Assurance	There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance.
Limited Assurance	There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed
No Assurance	Management cannot clearly articulate the matter or issue; something has arisen at Committee for which there is little or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing

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

NHS
University Hospitals of Northamptonshire
NHS Group

IGR

March 2023

Dedicated to excellence

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).

Summary Table

Committee Name	Group Name	Metric Name	Site	Variation
Integrated Governance Report (IGR)	Patient	All	All	All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
KGH	Patient	Patient safeguarding	01/01/23	0		23	92	160			Consistently Anticipated to Meet Target
NGH	Patient	Patient safeguarding	01/02/23	126		24	91	158			Consistently Anticipated to Meet Target
KGH	Patient	Number of complaints	01/02/23	0		8	37	67			Consistently Anticipated to Not Meet Target
NGH	Patient	Number of complaints	01/02/23	22	0	7	24	42			Consistently Anticipated to Not Meet Target
KGH	Patient	% Patients satisfaction score - Trustwide	01/02/23	91.00%	95.00%	81.08%	88.47%	95.87%			Not Consistently Anticipated to Meet Target
NGH	Patient	% Patients satisfaction score - Trustwide	01/02/23	89.40%	95.00%	83.27%	88.02%	92.78%			Consistently Anticipated to Not Meet Target

% Patients satisfaction score - Trustwide

Committee Name: All

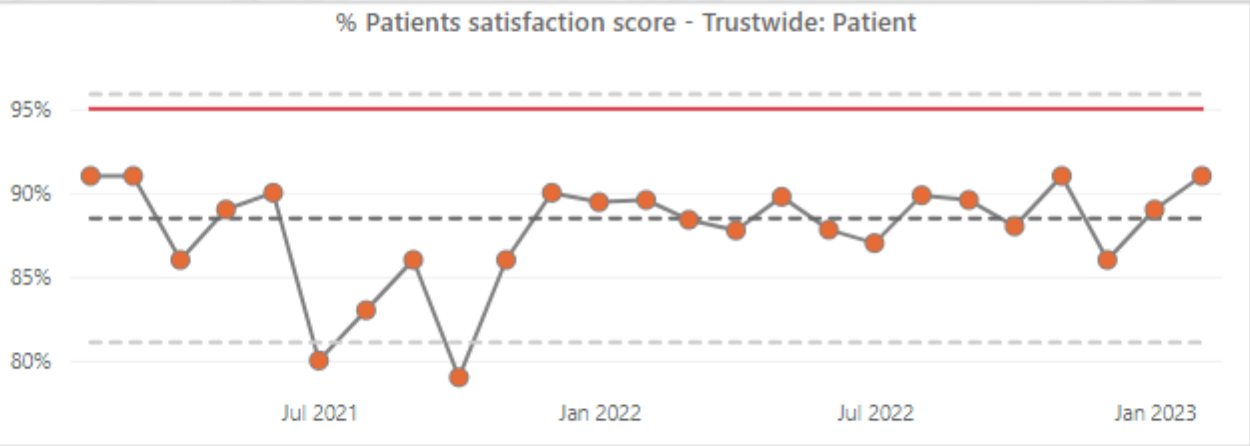
GroupName: Patient

MetricName: % Patients satisfaction score - Trustwide

01/04/2019 – 01/03/2023

91.00%	95.00%	89.40%	95.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses.	Increase in the overall satisfaction score	Although improved this has not been sustained and is variable month on month	Monthly reports sent to departments to share findings and themes of feedback responses	Continue to work with low/no responding areas to increase participation and promote FFT and how we gather patient feedback. Actions should be taken from themes and addressed.
NGH	01/02/23	The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses.	A slight decrease in satisfaction scores from 90.6% in January to 89.4% in February. February's performance is still above the mean average for the reporting period.	The previous month was an exceptional month for performance so a slight decrease was expected and is not considered as being significant.	Continuation of the provision of regular Patient Experience performance reports for review and actions where relevant..	Continuation of the provision of regular Patient Experience performance reports for review and actions where relevant. Performance to be continuously monitored and escalated to the relevant areas as required should the score drop significantly.

Number of complaints

Committee Name: All

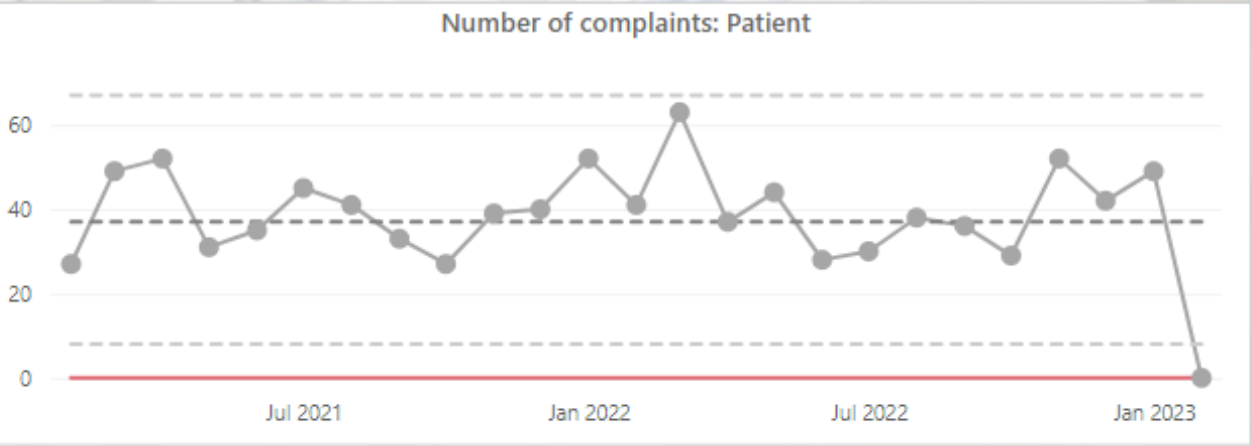
GroupName: Patient

MetricName: Number of complaints

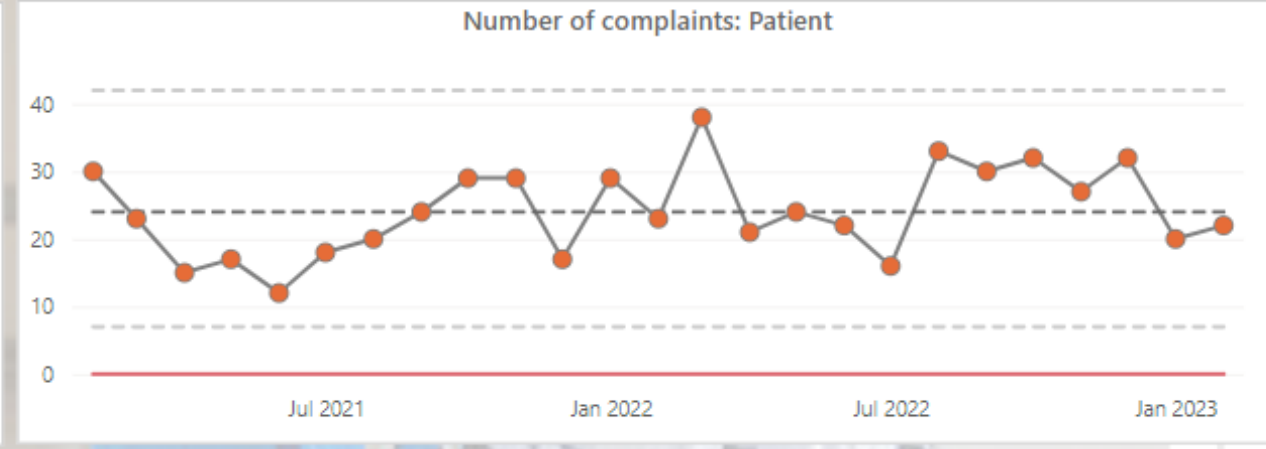
01/04/2019 – 01/03/2023

0		22	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/02/23	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.	There has been an increase in the number of complaints received when compared to January.	What this does not reflect is the continued complexity in the complaints received.	None required.	None required.

Patient safeguarding

Committee Name: All

GroupName: Patient

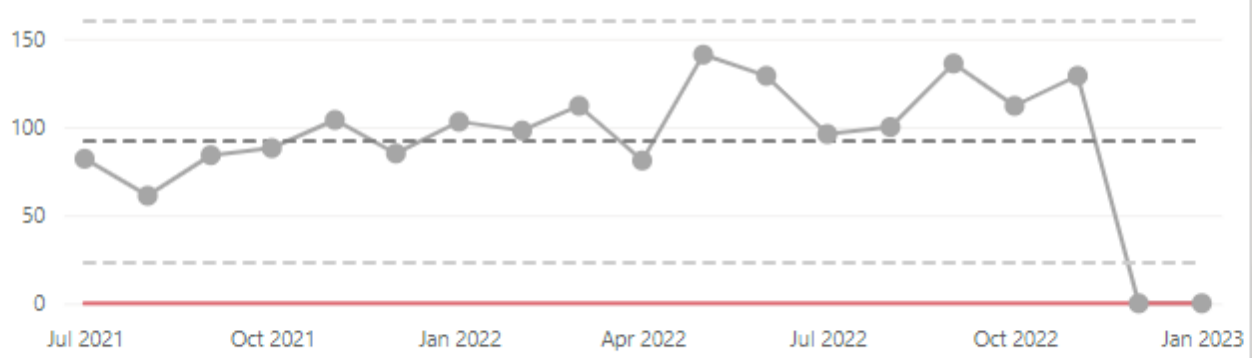
MetricName: Patient safeguarding

01/04/2019 – 01/03/2023

0		126	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

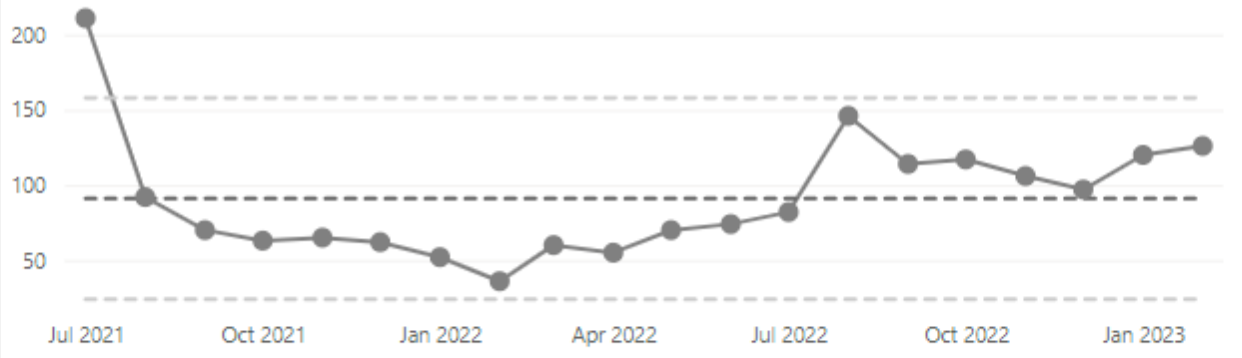
Kettering General Hospital

Patient safeguarding: Patient



Northampton General Hospital

Patient safeguarding: Patient



Summary Table

Committee Name: Integrated Governance Report (IGR)

Group Name: People

Metric Name: All

Site: All

Variation: All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
KGH	People	Turnover rate	01/02/23	9.22%	8.50%	9.43%	10.1%	10.78%			Consistently Anticipated to Not Meet Target
NGH	People	Turnover rate	01/02/23	8.10%	8.50%	8.14%	8.67%	9.21%			Not Consistently Anticipated to Meet Target
NGH	People	Vacancy rate	01/02/23	10.63%	8.00%	7.73%	9.28%	10.83%			Not Consistently Anticipated to Meet Target
KGH	People	Vacancy rate	01/02/23	11.67%	8.00%	7.3%	9.46%	11.61%			Not Consistently Anticipated to Meet Target
KGH	People	Sickness and absence rate	01/02/23	4.97%	5.00%	3.66%	5.65%	7.64%			Not Consistently Anticipated to Meet Target
NGH	People	Sickness and absence rate	01/02/23	5.45%	5.00%	4.62%	6.1%	7.57%			Not Consistently Anticipated to Meet Target
NGH	People	Appraisal completion rates	01/02/23	76.04%	85.00%	61.78%	72.96%	84.14%			Consistently Anticipated to Not Meet Target
KGH	People	Appraisal completion rates	01/02/23	81.61%	85.00%	77.73%	81.19%	84.65%			Consistently Anticipated to Not Meet Target
KGH	People	Mandatory training compliance	01/02/23	91.27%	85.00%	87.39%	90.08%	92.78%			Consistently Anticipated to Meet Target
NGH	People	Mandatory training compliance	01/02/23	86.55%	85.00%	71.24%	82.11%	92.99%			Not Consistently Anticipated to Meet Target
KGH	People	People pulse 'how are you doing' measure	01/07/22	40.00%			40%				Consistently Anticipated to Meet Target
NGH	People	People pulse 'how are you doing' measure	01/07/22	41.00%			32.75%				Consistently Anticipated to Meet Target
KGH	People	Quarterly People pulse advocacy questions	01/07/22	55.00%			55%				Consistently Anticipated to Meet Target
NGH	People	Quarterly People pulse advocacy questions	01/07/22	57.00%			56%				Consistently Anticipated to Meet Target

Quarterly People pulse advocacy questions

Committee Name: All

GroupName: People

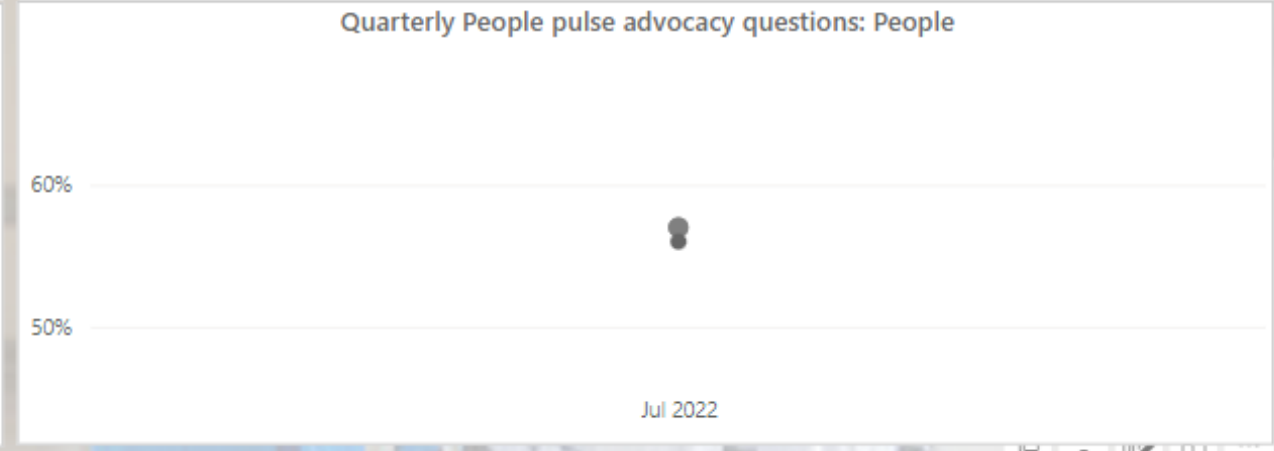
MetricName: Quarterly People pulse advocacy questions

01/04/2019 – 01/03/2023

55.00%		57.00%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital



People pulse 'how are you doing' measure

Committee Name: All

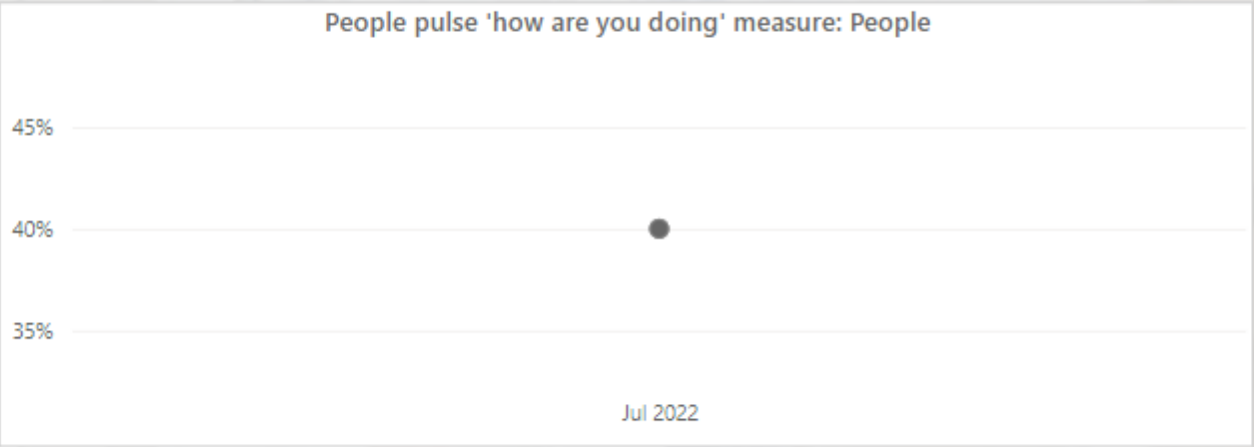
GroupName: People

MetricName: People pulse 'how are you doing' measure

01/04/2019 – 01/03/2023

40.00%		41.00%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital

Mandatory training compliance

Committee Name: All

GroupName: People

MetricName: Mandatory training compliance

01/04/2019 – 01/03/2023

91.27%	85.00%	86.55%	85.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	% of staff compliant with their mandatory training	The % of staff compliant with their Mandatory training profile.	Compliance has remained consistent since May 2022 above 90%. Key focus areas remain resuscitation, and ensuring that IG meets the national bench marking	Ongoing targeting and focus shared with mangers and individuals	Flexible access and opportunity to meet competencies supports operational pressures and time to release staff minimized
NGH	01/02/23	% of staff compliant with their mandatory training	% of staff complaint with their mandatory training profile	IPC's compliance remains below 80% but has increased from previous data. Manual Handling also remains low but is improving with the new trainer in post.	Additional sessions are being provided by the MH trainer and we have additional sessions through to the end of March provided by an external trainer. Work is being carried out to reduce DNA's as this not helping to clear the backlog.	Staff shortages impact on the ability to release. Consideration to the data of non compliance so that these can be addressed in priority.

Appraisal completion rates

Committee Name: All

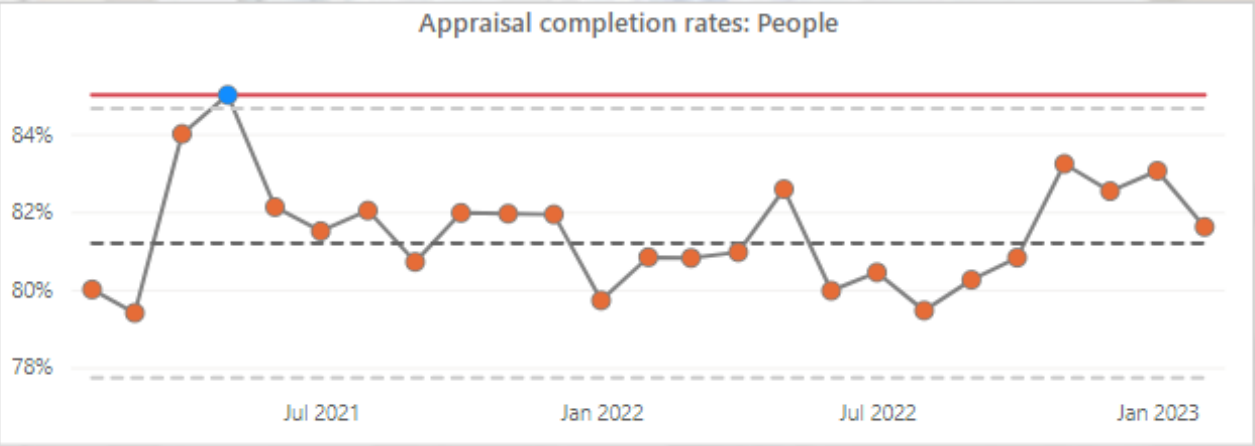
GroupName: People

MetricName: Appraisal completion rates

01/04/2019 – 01/03/2023

81.61%	85.00%	76.04%	85.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	% of staff having completed their appraisal	The % of staff having a documented appraisal on ESR in the past 12 months	The compliance remains below the benchmark, but is impacted at this time with the current Trust acuity and operational pressures. Paper based systems continue to impact. A digital resource is required but is taking time to procure and ensure fit for purpose offering scoped for development to fit Trust directions.	Ongoing targeting of managers and individuals and progress towards a digital solution.	Operational pressures and paper based systems
NGH	01/02/23	% of staff having completed their appraisal	The % of staff that have a documented appraisal recorded on ESR in the past 12 months	The compliance remains below the benchmark, but is impacted at this time with the current Trust acuity and operational pressures. Paper based systems continue to impact. A digital resource is required but is taking time to procure and ensure fit for purpose offering scoped for development to fit Trust directions.	Targeted approach to managers and individuals and ongoing development working towards a digital solution	Operational pressures and paper based systems

Sickness and absence rate

Committee Name: All

GroupName: People

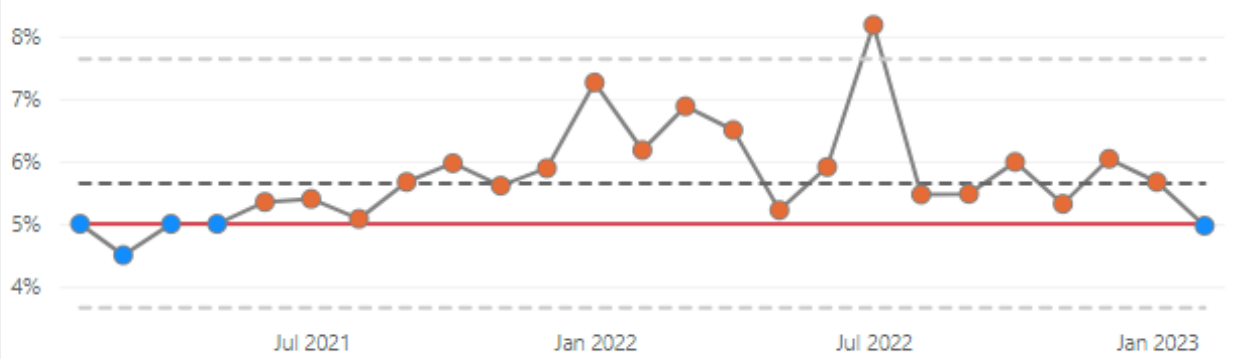
MetricName: Sickness and absence rate

01/04/2019 – 01/03/2023

4.97%	5.00%	5.45%	5.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

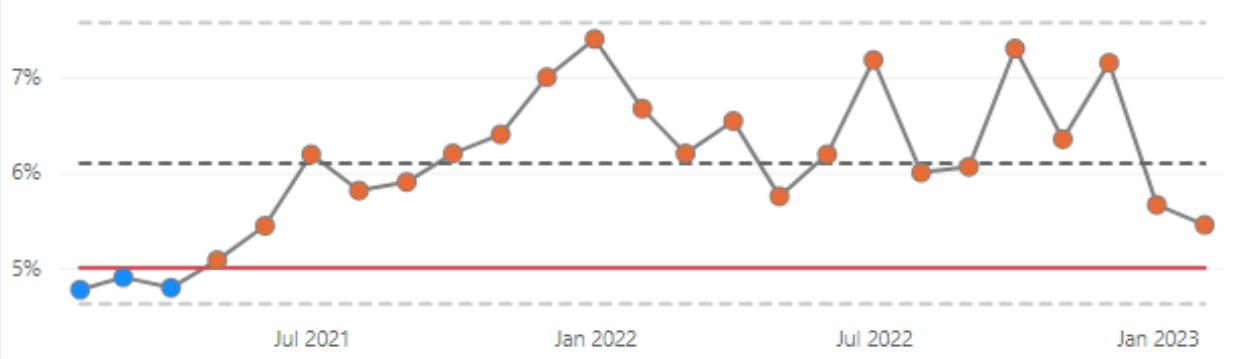
Kettering General Hospital

Sickness and absence rate: People



Northampton General Hospital

Sickness and absence rate: People



Sickness and absence rate

Committee Name: All

GroupName: People

MetricName: Sickness and absence rate

4.97%	5.00%	5.45%	5.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	% of Staff absent	Currently has dropped below the adjusted target of 5%. Results are within the statistical boundary. Mean absence sitting at 4.97%. This is the lowest on target value since April 2021.	* Short term absences relate to COVID-Flu / Gastroenteritis * Long term absence (over 28 days) relates mental health conditions (anxiety, depression) * Flexible working and workplace adjustments for LTCs not being applied in timely way or service requirements prevent adjustments leading to sickness extensions. * Management support monitoring and completing return to works inconsistently being applied * RCN national strikes in January and February likely to have cause increased sickness absences. * Unplanned absence biggest cause of additional workforce pressures / agency spend	* Targeting areas with high sickness absence (hot spots) * Actively managing attendance against absence triggers * Sickness Management Working Party set up with Heads of People Services to review disability, LTC management and workplace adjustment implementation challenges and intervention strategy across the system. * Managing unavailability important part of reducing agency spend * Partnership working with unions	* Developing group harmonised attendance management policy and review of the NHSE sickness management toolkit to support managers and enhance the systematic approach to sickness management across the UHN group. * Providing Group wide Health & Wellbeing Conversations training for managers from January-March 2023 to support prevention of mental and physical health deterioration and proactive management of conditions in the workplace– total of 195 managers have attending with substantial proportion from KGH. * HRBPs Providing active support to Family Medicine through implementing the Health Passport scheme with managers which has seen significant reductions in sickness rates to below target level. * Automation of daily sit rep returns to support division and managers

Sickness and absence rate

Committee Name: All

GroupName: People

MetricName: Sickness and absence rate

4.97%	5.00%	5.45%	5.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/02/23	% of Staff absent	Not meeting Trust target on attendance of 5%, mean absence reported at 5.45%. Results are within statistical common cause. However these rates are at their lowest since June 2021 indicating a slow recovery process and evidence of interventional impact that both NGH and KGH sickness rates are mirroring.	Issues: * Short term absences relate to COVID-Flu / Gastroenteritis * Long term absence (over 28 days) relates mental health conditions * Flexible working and workplace adjustments for LTCs not being applied in timely way or service requirements prevent adjustments leading to sickness extensions. * Management support monitoring and completing return to works inconsistently being applied * Unplanned absence biggest cause of additional workforce pressures / agency spend	* Targeting areas with high sickness absence (hot spots) * Actively managing attendance against absence triggers * Sickness Management Working Party set up with Heads of People Services to review disability, LTC management & workplace adjustment implementation challenges. * Managing unavailability important part of reducing agency spend * Partnership working with unions * Developing group harmonised attendance management policy and review of the NHSE sickness management toolkit to support managers and enhance the systematic approach to sickness management across the UHN group.	* Integrated multidisciplinary team approach to assessing and implementing outcomes from OH management referrals with staff psychology and SoS service which streamlines adjustment recommendations and provides HRBPs with clearer guidance for their leadership support. * Providing Group wide Health & Wellbeing Conversations training for managers from January-March 2023 to support prevention of mental and physical health deterioration and proactive management of conditions in the workplace– total of 195 managers have attending with substantial proportion from KGH. * Occupational Health provide sickness absence training support for the "Functional Skills Programme for Managers emerging managers' training workshops including proactive adjustments advice and management advice process. * Health & wellbeing Service providing a Single Point of Access service for self -referrals responding to individuals and teams with a range of issues that impact on capacity to work with a highly individualised, person-centred expert care. Supporting individuals to remain in the workplace or return to work with reasonable adjustments as soon as able. Provides advice and liaison with managers, external care providers, occupational health and human resources. * H&WB Service offers clinical team reflective practice sessions which provide a compassionate reflective space for staff to identify and process professional challenges, reducing burnout, empathy fatigue and increasing job satisfaction, ultimately reducing the likelihood of sickness absence.

Vacancy rate

Committee Name: All

GroupName: People

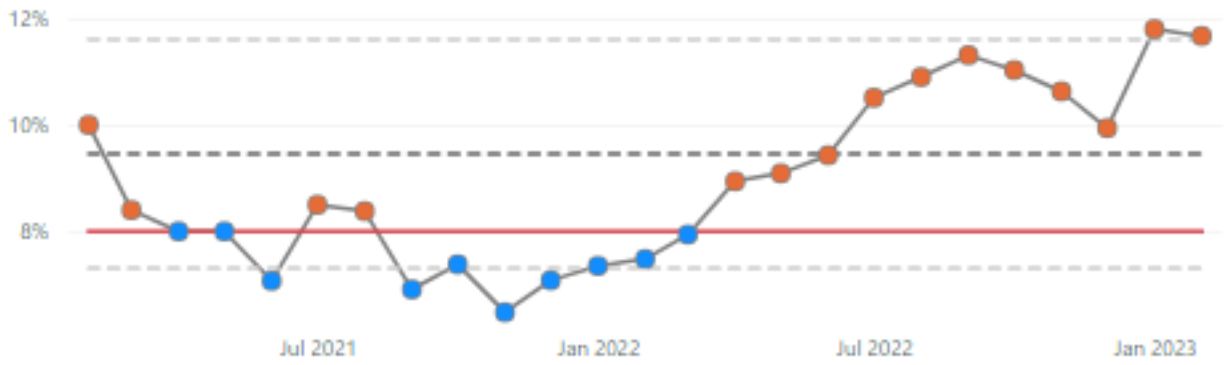
MetricName: Vacancy rate

01/04/2019 – 01/03/2023

11.67%	8.00%	10.63%	8.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

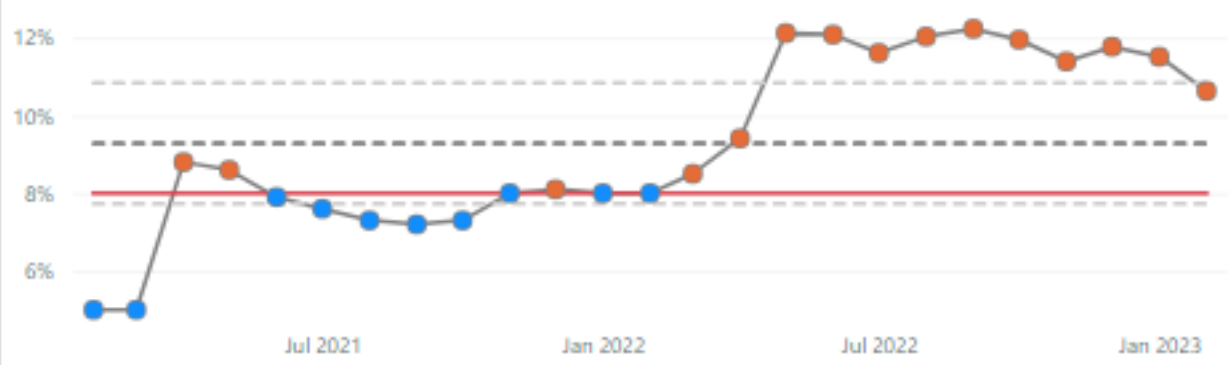
Kettering General Hospital

Vacancy rate: People



Northampton General Hospital

Vacancy rate: People



Vacancy rate

Committee Name: All

GroupName: People

MetricName: Vacancy rate

11.67%	8.00%	10.63%	8.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	% difference between budgeted establishment and actual establishment	% difference between budgeted establishment and actual establishment	Metric is experiencing special cause variation - trend is showing a negative performance below the mean of 11.67% below 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 each month is causing pressures as existing staff seek to support, induct and train.	Ongoing targeted campaigns via social media and Best of Both Worlds for specific vacancies will continue to support an improved performance in 2023. An increase in establishment is having an impact on vacancies but this may be mitigated by the new hospital vacancy approval process. Recruitment and Education are working closely with Divisional leadership to ensure the pressures are managed and new starters supported in their new roles, a new trust induction format has been launched to support this.
NGH	01/02/23	% difference between budgeted establishment and actual establishment	The value tells us that the 11.85% of budgeted posts are currently vacant.	Particular staff group hotspots for vacancy rates are AHPs, Additional Clinical Services (HCAs), Additional Professional Scientific and Technical and Estates and Ancillary. Factors impacting these particular areas relate to a shortage of staff nationally. and for non qualified staff comparability of pay rates to other industry sectors in the job market.	A recruitment event took place in March 2023 resulting in a total of 92 job offers being made for HCAs, 11 RNs, 6 MSWs and 2 Midwives. A further 14 interviews have also been arranged for a range of AHPs. A further international recruitment campaign for nurses has been partially funded by NHSE with a total of 40 internationally educated nurses to be onboarded by August 2023 and interviews are already arranged. An overseas programme for AHPs is underway and NHSE funding has been obtained for an overseas midwifery recruitment programme and includes funding for a Midwifery Retention Manager who is now in post. A transformation programme to look at QI for the recruitment and specifically onboarding process is in the process of being developed with the aim of reducing candidate attrition and improving time to hire. Efforts to repurpose resources to the development of attraction strategies has also been mapped out subject to approval.	Weekly meetings are in place to monitor recruitment activities for each Division in a way in which they are mapped to long terms agency use and to ensure that any delays are unblocked and minimised. Time to Hire reporting is broken down into each stage of the recruitment process and monitored accordingly enabling targeted intervention and support as and when required.

Turnover rate

Committee Name: All

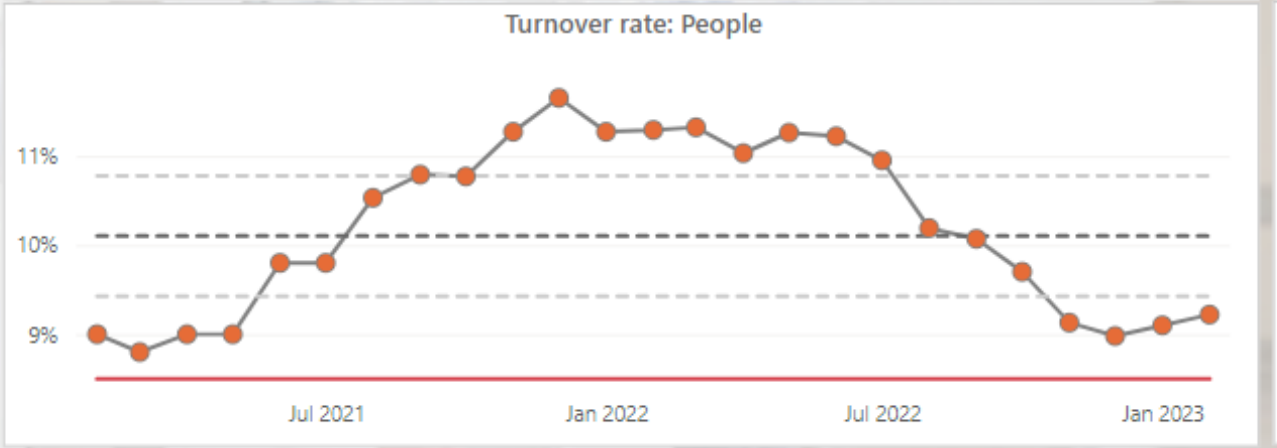
GroupName: People

MetricName: Turnover rate

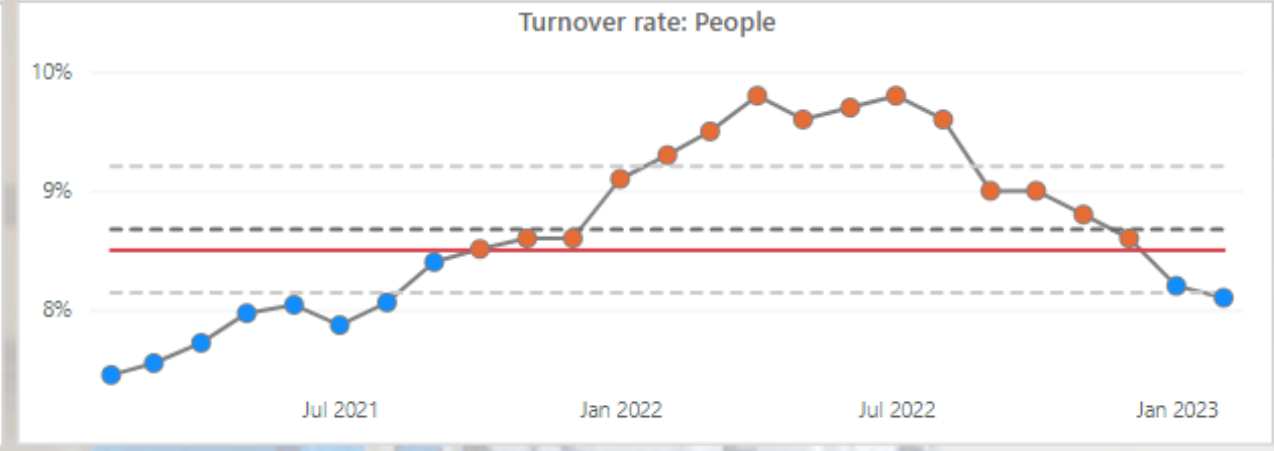
01/04/2019 – 01/03/2023

9.22%	8.50%	8.10%	8.50%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Turnover rate

Committee Name: All

GroupName: People

MetricName: Turnover rate

9.22%	8.50%	8.10%	8.50%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	% of staff leaving the organisation over a 12 month rolling period	% of staff leaving the organisation over a 12 month rolling period	Turnover rates are showing common cause variation and are at 9.22% against a Trust target of 11%	Turnover has been decreasing since January 2022 but this month has seen another increase. The metric continues to be under the Trust target and reducing. The local labour market has returned to normal activity and increased competition within this market and turnover rates still need to be closely monitored for specific staff groups.	Work is being undertaken to review exit interviews to ensure feedback is being acted upon and to assess the quality of the data and response rate. Divisions are being asked to review any areas of concern following staff leaving. 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. Further work will be planned following the results of the National Staff Survey.
NGH	01/02/23	% of staff leaving the organisation over a 12 month rolling period	Trust turnover decreased slightly during the month of February.	Issues relate to a tired post pandemic workforce and the risk of those nearing retirement age wishing to retire.	Age profiling to conduct analysis into retirement forecast. Midwifery Retention Manager is in post. Career pathway conversations available in conjunction with Practice Development and learning and development opportunities available including apprenticeships for existing staff. A range of Health and Wellbeing initiatives are available including financial wellbeing support and self rostering is being piloted in a number of clinical areas in order to try to better facilitate flexible working opportunities and support work/life balance.	Range of Health & Well-being initiatives in place. Career development opportunities to continue to be developed and promotion of agile/flexible working and retire and return options to retain workforce.

Quality

KGH | NGH

Committee Name: Integrated Governance Report (I...

GroupName: Quality

1	0	10
Exec comments KGH	Exec comments NGH	Total No. of Metrics

Site	MetricName	Value
KGH	30 day readmissions	8.02%
KGH	Hospital-acquired infections	6
KGH	Never event incidence	0
KGH	New harms	24.63%
KGH	Number of medication errors	85
KGH	Safe Staffing	88.92%
KGH	Serious or moderate harms	9
KGH	Serious or moderate harms – falls	0.00
KGH	Serious or moderate harms – pressure ulcers	0.21
KGH	SHMI	109.10

Metric	Comment
Mortality	1349 Adult in-patients died in KGH between 1st April 2022 – 10th February 2023. 100% Reviewed by KGH Medical Examiner Office. Every bereaved relative is offered a review with the Consultant ME. 96 Patients identified for an additional SJR Review, of which 80 have been completed. 113 Community Deaths have been reviewed through the ME Process to date 10th February 2023, 12 out of 33 GP surgeries have joined the process so far.

Quality

KGH | NGH

Committee Name: Integrated Governance Report (I...

GroupName: Quality

0	4	10
Exec comments KGH	Exec comments NGH	Total No. of Metrics

Site	MetricName	Value
NGH	30 day readmissions	14.36%
NGH	Hospital-acquired infections	8
NGH	Never event incidence	1
NGH	New harms	0.00%
NGH	Number of medication errors	113
NGH	Safe Staffing	0.00%
NGH	Serious or moderate harms	30
NGH	Serious or moderate harms – falls	0.11
NGH	Serious or moderate harms – pressure ulcers	3
NGH	SHMI	91

Metric	Comment
Infection Prevention & Control	6 patients developed CDI in February,Post-infection reviews and review meetings for every HOHA and COHA case continue. The Matron for IPC is delivering the comprehensive CDI Reduction plan to reduce the incidence of CDI within the organisation that is a standing agenda item on the IPSG agenda and monitored through this group. 8 patients developed a Gram-negative bacteraemia (GNB) this month. No issues for E.coli and Klebsiella species, the Trust remains below trajectory for these 2 Gram-negative bacteraemias. However the Trust has reached the year end ceiling of 10 patients for a Pseudomonas aeruginosa bacteraemia therefore a thematic review has been completed and will be presented at IPSG in March.
Complaints	Response rate is 97% including agreed extension of time requests. When extension of time requests are excluded the response rate is 74%.
Pressure Ulcers	The value tells us that there was a decrease in the numbers of pressure ulcers for the month of February 2023 The TVN team and Deputy Directory of Nursing are currently working with 8 wards to aid in reducing the numbers of harms. The TVN are visiting these areas to provide bespoke training to staff and supporting them with their action plan for there areas.
Falls	There was 0.11 moderate, severe and catastrophic falls/1000 bed days in February 2023. This is a reduction of 0.04 compared to the previous month of January 2023. In total there was 1 moderate harm fall and 1 severe harm fall. Both incidents are being reviewed through the IGR process.

Summary Table

Committee Name	Group Name	Metric Name	Site	Variation
Integrated Governance Report (IGR)	Quality	All	All	All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
NGH	Quality	New harms	01/02/22	0.00%	2.00%	0%	0%	0%			Consistently Anticipated to Meet Target
KGH	Quality	New harms	01/02/23	24.63%		18.27%	23.72%	29.17%			Consistently Anticipated to Not Meet Target
NGH	Quality	Serious or moderate harms	01/02/23	30	0	7	22	37			Consistently Anticipated to Not Meet Target
KGH	Quality	Serious or moderate harms	01/02/23	9	8	-1	7	15			Not Consistently Anticipated to Meet Target
KGH	Quality	Serious or moderate harms – falls	01/02/23	0.00	0.18	0.47	0.47	0.47			Not Consistently Anticipated to Meet Target
NGH	Quality	Serious or moderate harms – falls	01/02/23	0.11	0.06	0.28	0.28	0.28			Not Consistently Anticipated to Meet Target
KGH	Quality	Serious or moderate harms – pressure ulcers	01/02/23	0.21	0.69	0.99	0.99	0.99			Not Consistently Anticipated to Meet Target
NGH	Quality	Serious or moderate harms – pressure ulcers	01/02/23	3	0	-5	3	11			Not Consistently Anticipated to Meet Target
NGH	Quality	Number of medication errors	01/02/23	113	0	5	58	110			Consistently Anticipated to Not Meet Target
KGH	Quality	Number of medication errors	01/02/23	85		36	79	122			Consistently Anticipated to Not Meet Target
KGH	Quality	Hospital-acquired infections	01/02/23	6	7	1	9	17			Not Consistently Anticipated to Meet Target
NGH	Quality	Hospital-acquired infections	01/02/23	8	7	-1	7	15			Not Consistently Anticipated to Meet Target
KGH	Quality	SHMI	01/02/23	109.10	107	111.2	111.2	111.2			Not Consistently Anticipated to Meet Target
NGH	Quality	SHMI	01/02/23	91	100	92	95	97			Consistently Anticipated to Meet Target
NGH	Quality	Safe Staffing	01/02/22	0.00%	96.00%	0%	0%	0%			Consistently Anticipated to Not Meet Target
KGH	Quality	Safe Staffing	01/02/23	88.92%	96.00%	84.95%	91.44%	97.93%			Not Consistently Anticipated to Meet Target
KGH	Quality	30 day readmissions	01/02/23	8.02%	12.00%	9.8%	17.85%	25.9%			Not Consistently Anticipated to Meet Target
NGH	Quality	30 day readmissions	01/02/23	14.36%	12.00%	12.6%	14.31%	16.01%			Consistently Anticipated to Not Meet Target

Summary Table

Committee Name	Group Name	Metric Name	Site	Variation
Integrated Governance Report (IGR)	Quality	All	All	All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
KGH	Quality	Never event incidence	01/02/23	0	0	0	0	1			Not Consistently Anticipated to Meet Target
NGH	Quality	Never event incidence	01/02/23	1	0	-1	0	1			Not Consistently Anticipated to Meet Target

New harms

Committee Name: All

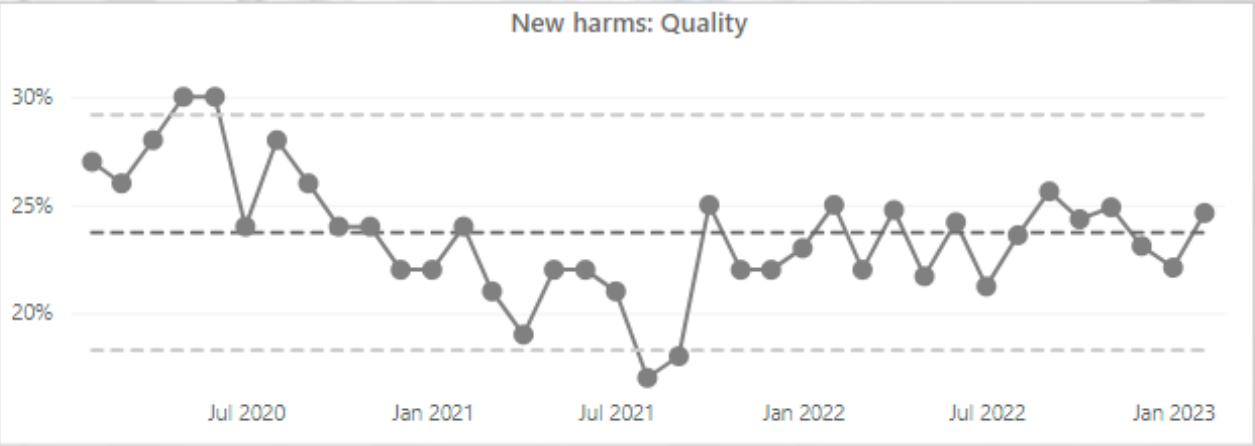
GroupName: Quality

MetricName: New harms

01/04/2019 – 01/03/2023

24.63%		(Blank)	2.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	Patients experiencing a new harm (low, moderate, severe, catastrophic and patient death as a result of a Patient Safety incident) reported as a percentage of ALL incidents reported	Common cause variation with no assurance available due to lack of definition of a target. Recommend to the Committee to remove this metrics as no evidence to define	Common cause variation with no assurance available due to lack of definition of a target. Recommend to the Committee to remove this metrics as no evidence to define.	At a national level the NHS uses these reports to identify and take action to prevent emerging patterns of incidents on via patient safety alerts. At a local level these reports are used to identify and target areas of risk emerging through deficiencies in policy, practice process or therapeutics.	For the time period stated the highest 'harm level' reported is for low harm incidents at 95.85%. Low level harms are investigated by the clinical area. The quarterly Patient Safety report presented to the Quality and Safety Committee provides full detail of incident reporting and analysis and themes.

Serious or moderate harms

Committee Name: All

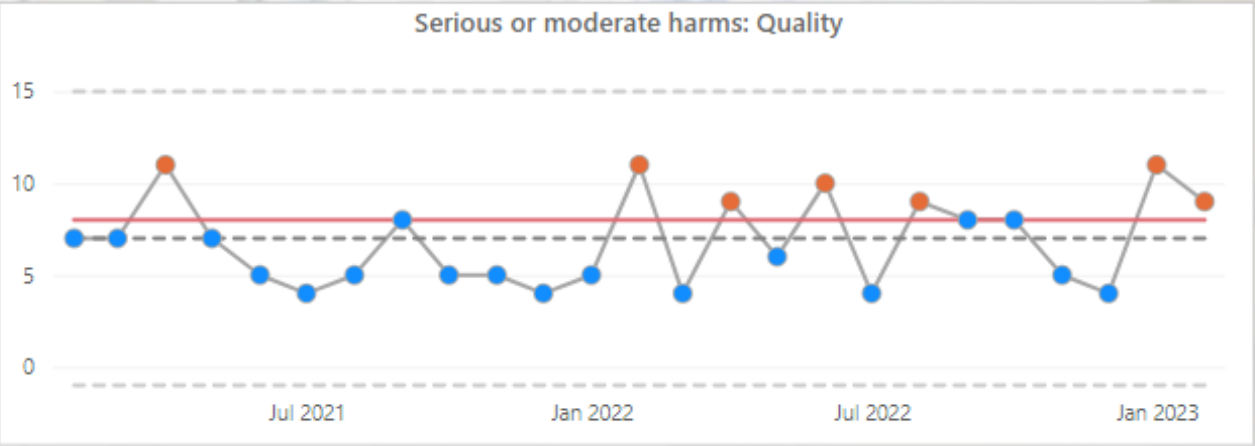
GroupName: Quality

MetricName: Serious or moderate harms

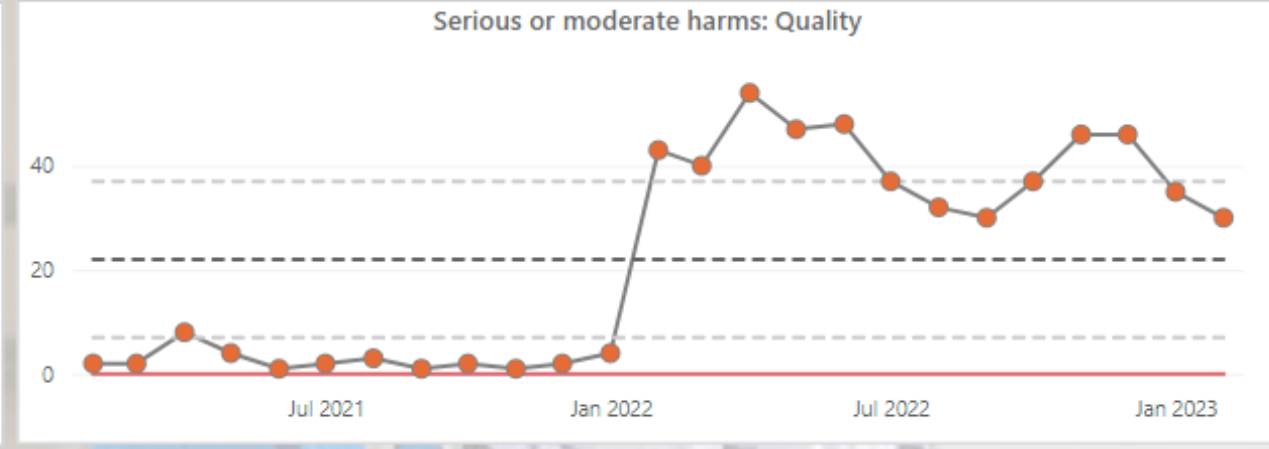
01/04/2019 – 01/03/2023

9	8	30	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Serious or moderate harms

Committee Name: All

GroupName: Quality

MetricName: Serious or moderate harms

9	8	30	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	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 24.63% of all incidents with a patient harm incurred and 1.02% of all incidents reported.
NGH	01/02/23	Patients experiencing moderate, severe, catastrophic harm or patient death as a result of a patient safety incident.	The number of Moderate and above harms recorded on Datix	Number of moderate and above harms meeting serious incident criteria are increasing leading to a backlog of overdue investigation reports whilst continuing to declare serious incidents.	Incidents are considered in the twice weekly Incident Review Group meeting and declared if they meet the SI Framework 2015 criteria	Serious incidents are investigated using root cause analysis techniques and include recommendations and actions aiming to mitigate against future occurrences

Serious or moderate harms – falls

Committee Name: All

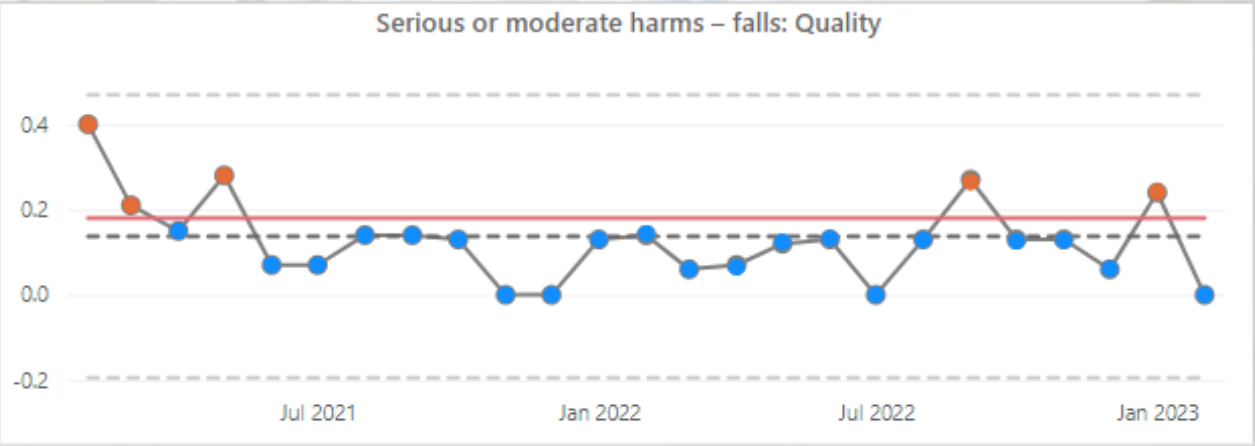
GroupName: Quality

MetricName: Serious or moderate harms – falls

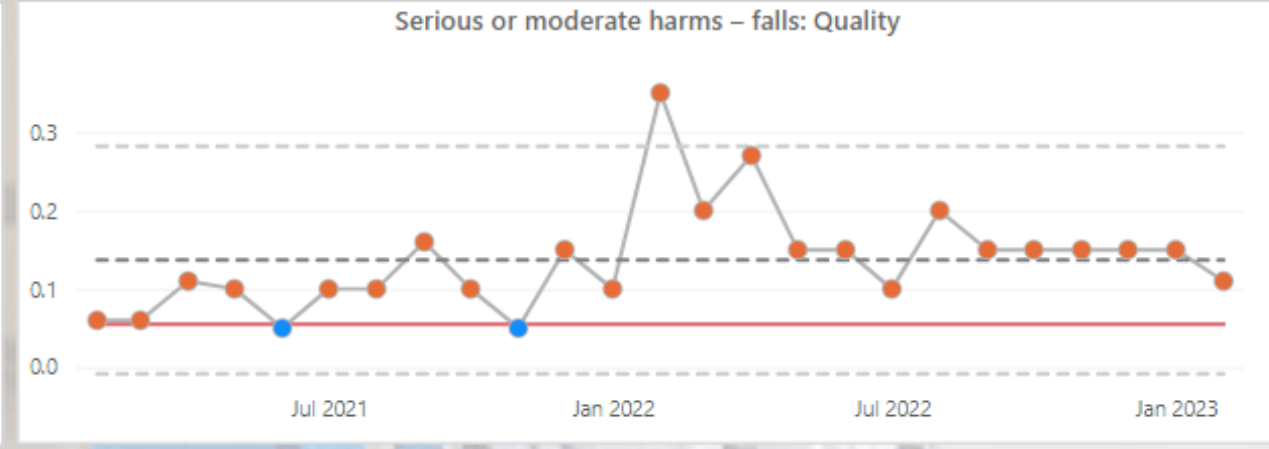
01/04/2019 – 01/03/2023

0.00	0.18	0.11	0.06
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	Patients experiencing falls with moderate harm or above per 1000 bed days.	The chart is showing common cause variation with variable assurance.	There were no falls with moderate or above harm in February	Three weekly focus on falls as part of the Friday Harm Free Care Meetings	Significant work has been undertaken over the last year, with a revision of paperwork and mandatory training for relevant staff. All falls with harm are reviewed by the Falls Prevention Lead and Practice Development Team in conjunction with the clinical area and reviewed by SIRG.
NGH	01/02/23	Patients experiencing falls with moderate harm or above per 1000 bed days.	Unable to view IGR dashboard There was 0.11 moderate, severe and catastrophic falls/1000 bed days in February 2023. This is a reduction of 0.04 compared to the previous month of January 2023.	In total there was 1 moderate harm fall and 1 severe harm fall.	Both incidents are being reviewed through the IGR process.	Trust training Learning from incidents through Falls MDT Trust wide action plan for improvement

Serious or moderate harms – pressure ulcers

Committee Name: All

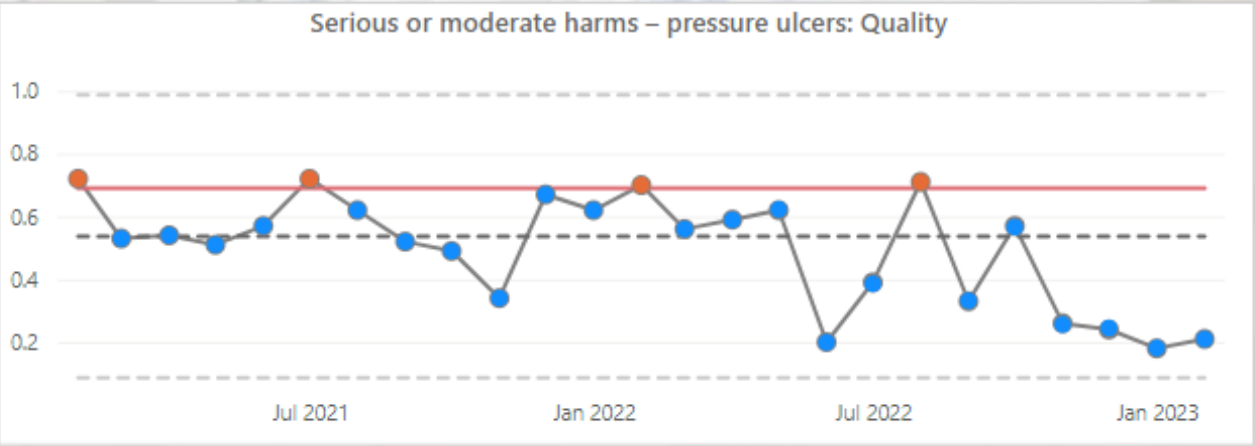
GroupName: Quality

MetricName: Serious or moderate harms – pressure ulc...

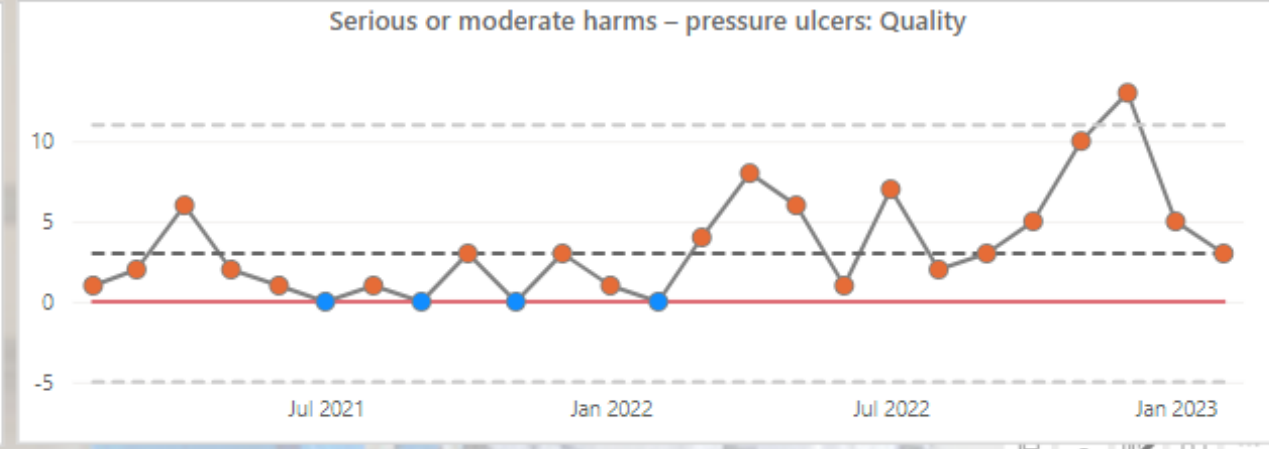
01/04/2019 – 18/02/2023

0.21	0.69	3	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Serious or moderate harms – pressure ulcers

Committee Name: All

GroupName: Quality

MetricName: Serious or moderate harms – pressure ulcers

0.21	0.69	3	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	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 with positive low assurance. 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	01/02/23	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 value tells us that there was a decrease in the numbers of pressure ulcers for the month of February 2023	there continues to be high acuity of patients and length of stay in ED.	The TVN team and deputy Directory of Nursing are currently working with 8 wards to aid in reducing the numbers of harms. The TVN are visiting these areas to provide bespoke training to staff and supporting them with their action plan for there areas.	Wards visits continue. One TVN to visit daily to offer support. Email sent for bespoke training on each area. Tissue Viability team have implemented a new body map, inspected dressings available and are working with IPC and Medical Devices to review mattresses.

Number of medication errors

Committee Name: All

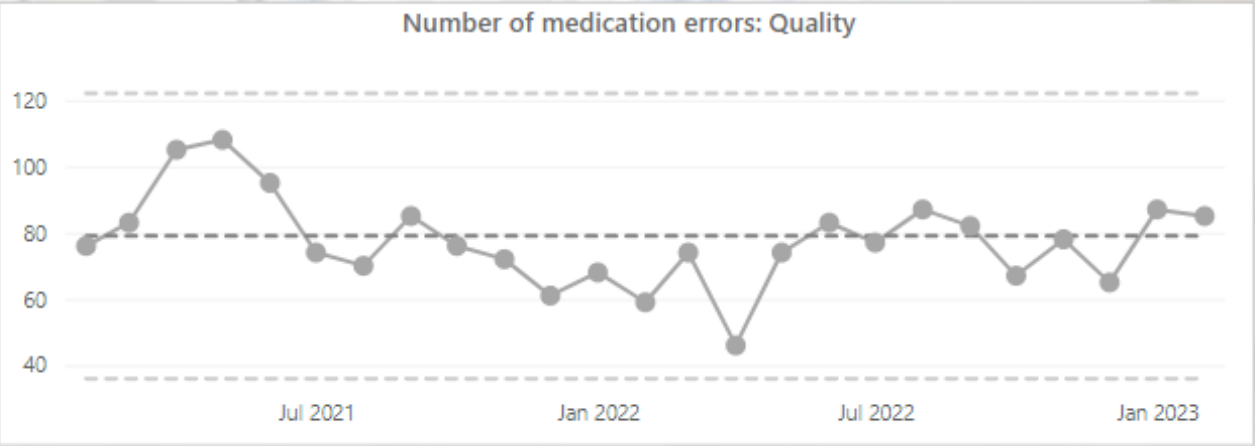
GroupName: Quality

MetricName: Number of medication errors

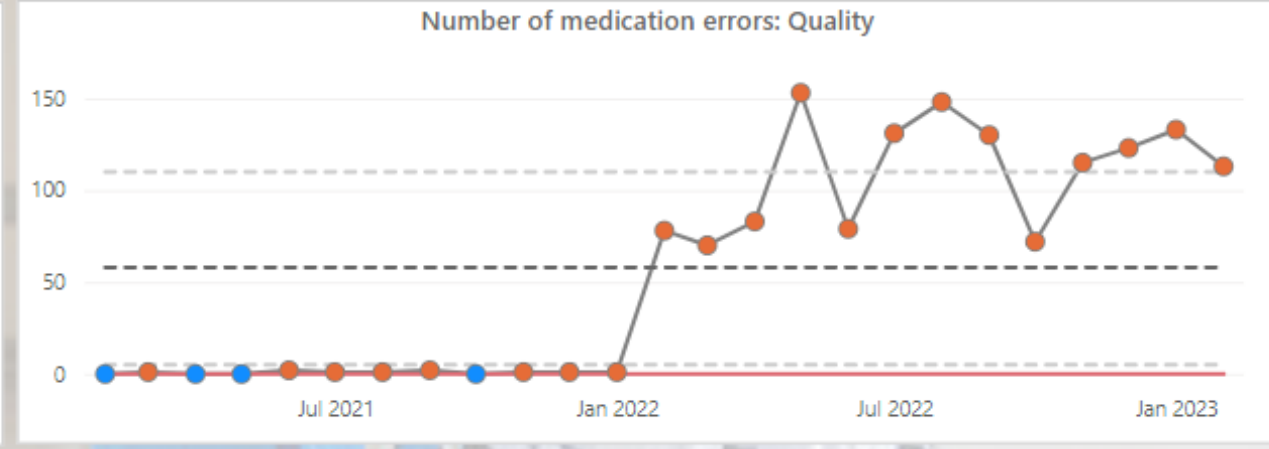
01/04/2019 – 01/03/2023

85		113	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Number of medication errors

Committee Name: All

GroupName: Quality

MetricName: Number of medication errors

85		113	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	Medication incidents reported irrespective of subclass of incident (prescribing, dispensing, administering) and irrespective of harm or level of harm.	The Chart shows common cause variation with no agreed target. Historically the Trust had taken a proactive approach to encouraging incident reporting. Historically the Trust had a target of exceeding 120 medication incident reports per month	A 'low' reporting rate from an organisation should not be interpreted as a 'safe' organisation, and may represent under-reporting. Subsequently, a 'high' reporting rate should not be interpreted as an 'unsafe' organisation, and may actually represent a culture of greater openness.	The reporting of incidents to a national central system (The National Reporting and Learning System (NRLS)) helps protect patients from avoidable harm by increasing opportunities to learn from mistakes where things go wrong. At a national level the NHS uses these reports to identify and take action to prevent emerging patterns of incidents on a national level via patient safety alerts. At a local level these reports are used to identify and target areas of risk emerging through deficiencies in policy, practice process or therapeutics.	For the time period stated, no harm or near misses equate to 78.82% of all medication incidents reported. The remaining were low harm incidents 94.44% and one Moderate harm which is being reviewed and is likely to be downgraded following review.
NGH	01/02/23	Medication incidents reported irrespective of subclass of incident (prescribing, dispensing, administering) and irrespective of harm or level of harm.	Reporting of medication incidents is encouraged across NGH. There is no target set for this but high reporting with no / low harm is considered a good reporting culture. In H1 of 2022/23 98-99% of medication incidents reported were no or low harm incidents.	Low reporting may represent an under reporting culture and high reporting a culture of greater openness. Medication incidents are stratified by harm and further analysed to support analysis. Variable rates of reporting may indicate that reporting is deprioritised during times of pressure or may relate to seasonal changes.	Incidents reported nationally (via NRLS) and locally for learning. Reporting contributes to patient safety alerts allowing us to learn from mistakes. Themes and trends are monitored through local medicines governance to inform local actions and work programme.	Continue to encourage reporting and review any / levels of harm. Monitor themes and trends. Liaise through MSO (Medicines Safety Officer) network. Response to alerts and sharing of learning locally.

Hospital-acquired infections

Committee Name: All

GroupName: Quality

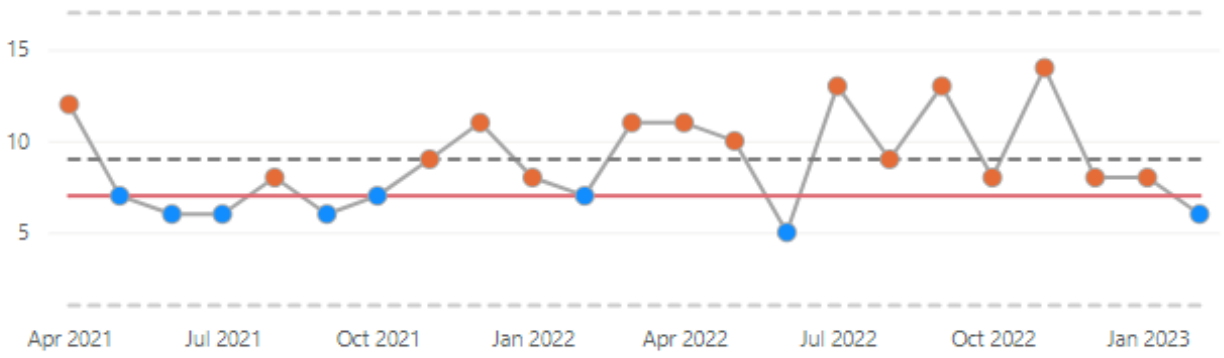
MetricName: Hospital-acquired infections

01/04/2019 – 01/03/2023

6	7	8	7
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

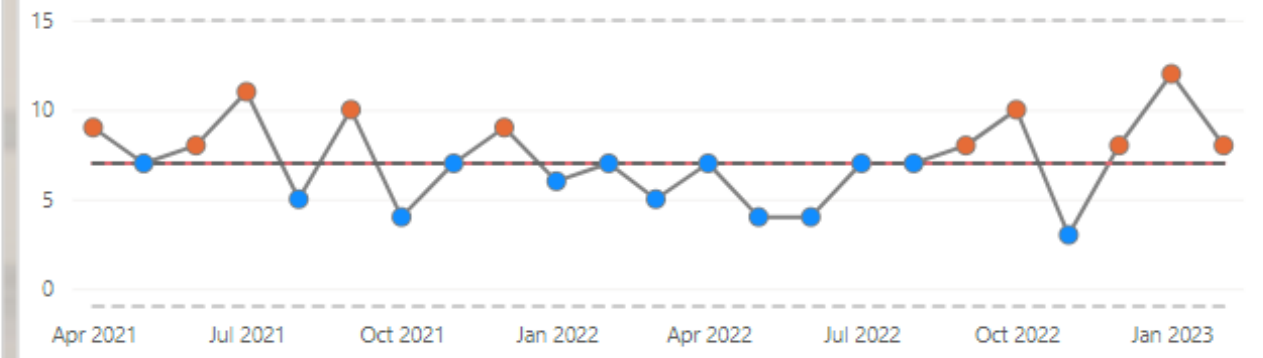
Kettering General Hospital

Hospital-acquired infections: Quality



Northampton General Hospital

Hospital-acquired infections: Quality



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	Patients experiencing a Gram-negative Hospital Onset Healthcare Associated (HOHA) or Community Onset Healthcare Associated (COHA) infection, defined as: E.coli, Pseudomonas aeruginosa and Klebsiella species.	The chart is showing common cause variation and variable assurance.	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. E-Coli occurrences are above the trajectory set by the ICB.	The Trust was to be visited in December by the Regional IPC team to review processes, however this had been delayed until March 2023.	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	01/02/23	Patients experiencing a Gram-negative Hospital Onset Healthcare Associated (HOHA) or Community Onset Healthcare Associated (COHA) infection, defined as: E.coli, Pseudomonas aeruginosa and Klebsiella species.	8 patients developed a Gram-negative bacteraemia (GNB) this month.	No issues for E.coli and Klebsiella species, the Trust remains below trajectory for these 2 Gram-negative bacteraemias. However the Trust has reached the year end ceiling of 10 patients for a Pseudomonas aeruginosa bacteraemia therefore a thematic review has been completed and will be presented at IPSG in March.	The IPC Team continue to progress the GNB section of the HCAI Reduction Plan with no issues for escalation. A Post Infection Review occurs for each patient to develop a GNB and learning is highlighted to IPC Operational Group.	The GNB trajectory is monitored via the monthly IPC Report to IPC Steering Group and CQEG..

SHMI

Committee Name: All

GroupName: Quality

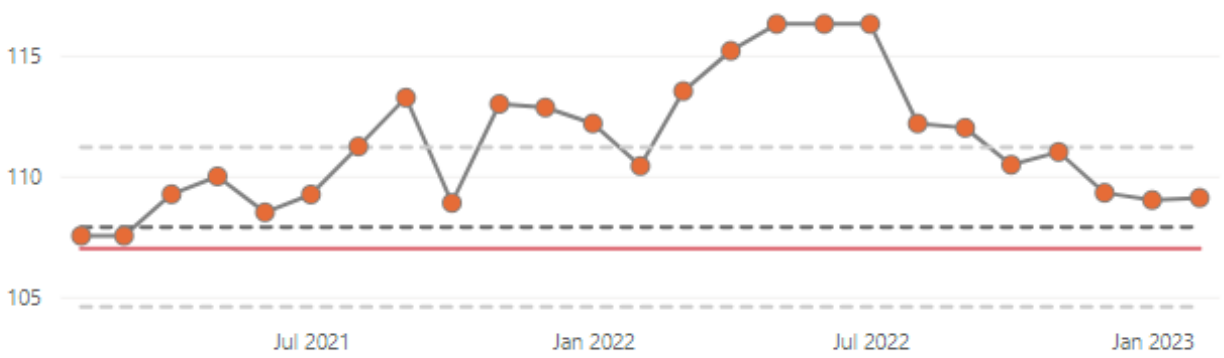
MetricName: SHMI

01/04/2019 – 01/03/2023

109.10	107	91	100
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

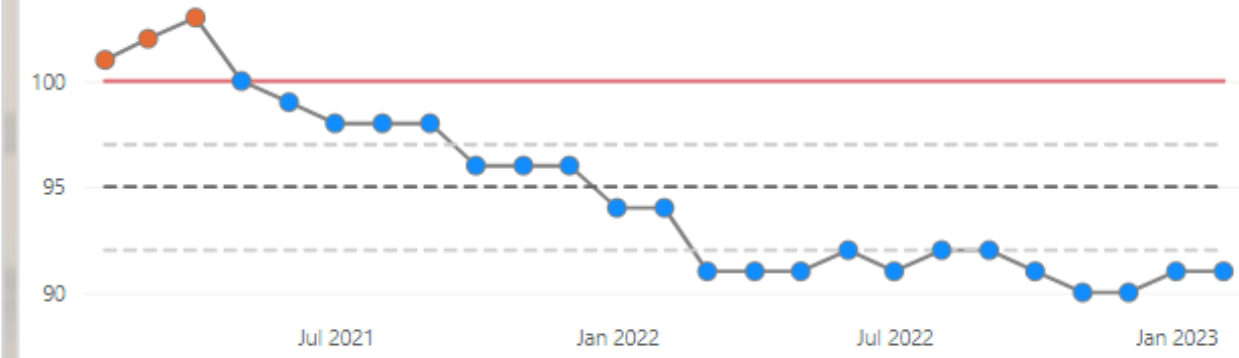
Kettering General Hospital

Summary Hospital-level Mortality Indicator: Quality



Northampton General Hospital

Summary Hospital-level Mortality Indicator: Quality



SHMI

Committee Name: All

GroupName: Quality

MetricName: SHMI

109.10	107	91	100
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	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 July 22 data covers period March 21 - February 22	109.01 - 'as expected'	SHMI higher than expected in the Pneumonia group (136.42), as is Septicaemia (except in labour) at 122.78.	Significant work from both the Coding and Mortality Review Teams continues to review and address the fluctuating SHMI. SHMI Mortality deep-dive was presented in June 2022. Metric has been within 'as expected' banding for 7 consecutive months.	Nil - Alerts are early warning indicators. KGH currently within 'as expected' banding when compared Nationally (Data via NHS England & supported by Dr Foster HSMR / SMR figures).

SHMI

Committee Name: All

GroupName: Quality

MetricName: SHMI

109.10	107	91	100
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/02/23	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 July 22 data covers period March 21 - February 22	Value lies comfortably within the "as expected" range	Nil	Nil	Nil

Safe Staffing

Committee Name: All

GroupName: Quality

MetricName: Safe Staffing

01/04/2019 – 01/03/2023

88.92%	96.00%	(Blank)	96.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	Combined day & night shift fill rate % for registered & non-registered Nursing, midwifery & AHP staff. Reported nationally to NHSE in accordance with National Quality Board guidance.	The value tells us that combined Nursing & Midwifery fill rates reduced in February to 88.92%. This value is comprised of registered and non-registered staff groups. Registered fill rates were 85% on the Day shift and 90% on the Night shift. Non-registered fill rates were 82% on the Day shift and 107% on the Night shift.	The non-registered Day shift fill rate, although slowly improving, continues to be a challenge. In comparison the Night shift fill rate is in excess of 100% (this includes additional duties). This fill rate is likely to reflect the enhanced pay rate on the night shift. In addition, HCA vacancies rose in February which will lead to unfilled shifts.	The effective & compassionate rostering meetings continue with positive impact including reduced sickness, working day and other leave unavailability. Annual leave is demonstrating improved 'steady state' approval control within acceptable rates. Monthly assessment centres continue to have strong interest in working for KGH - over 100 candidates are attending the March event.	Operational mitigation continues via the staffing cell; utilising redeployment if necessary and controlled temporary staffing measures in accordance with risk.

30 day readmissions

Committee Name: All

GroupName: Quality

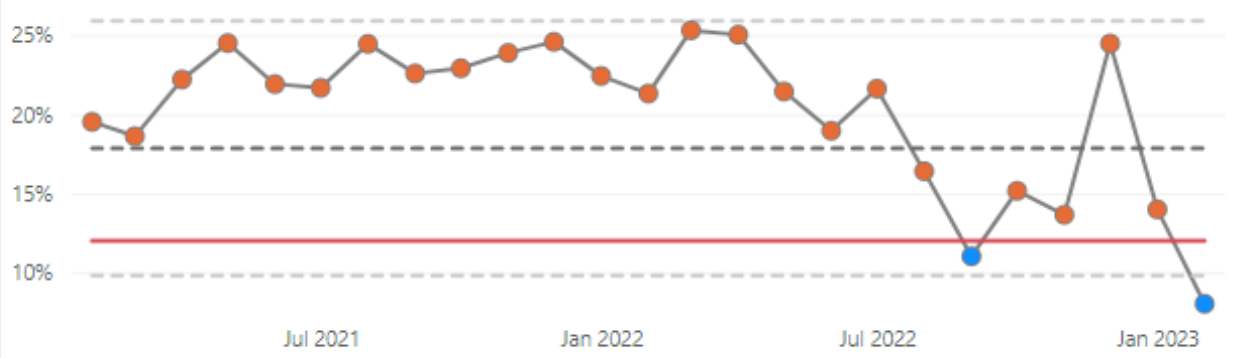
MetricName: 30 day readmissions

01/04/2019 – 01/03/2023

8.02%	12.00%	14.36%	12.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

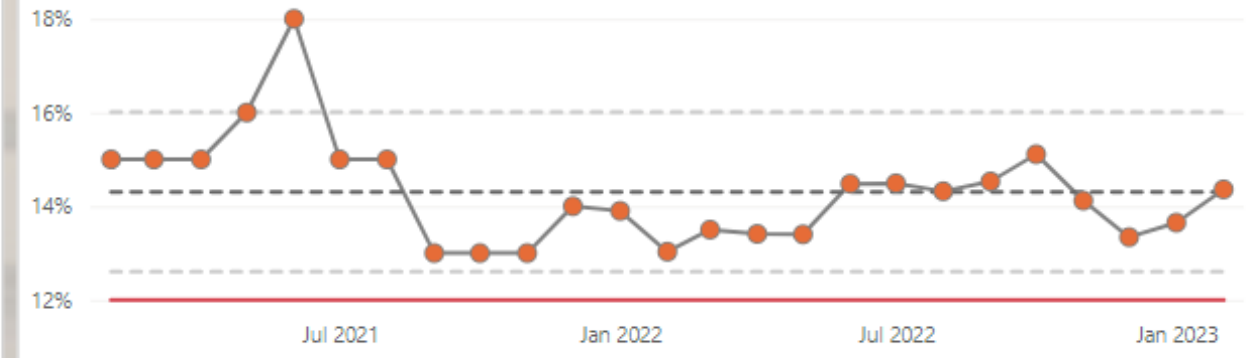
Kettering General Hospital

30 day readmissions: Quality



Northampton General Hospital

30 day readmissions: Quality



Never event incidence

Committee Name: All

GroupName: Quality

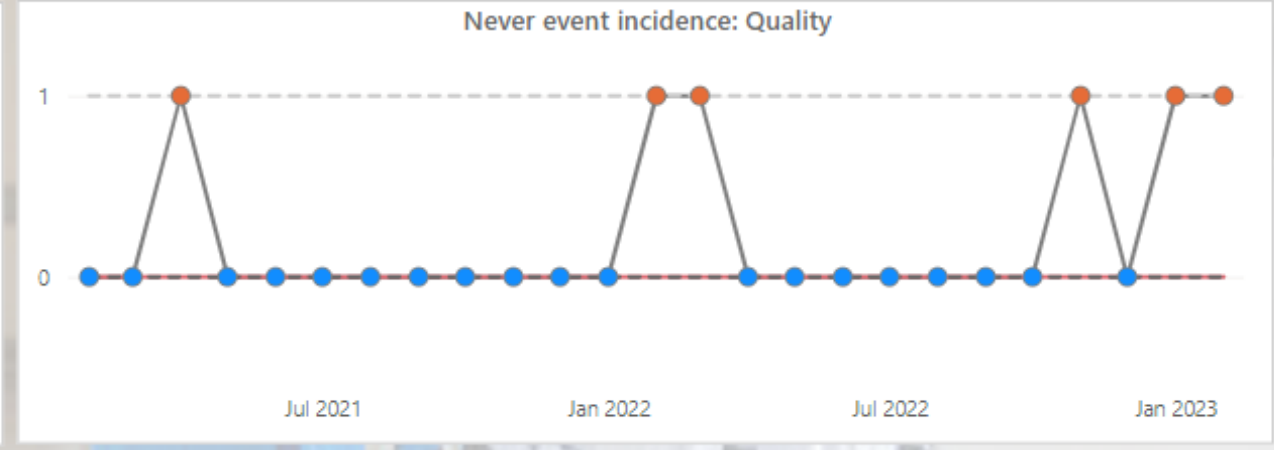
MetricName: Never event incidence

01/04/2019 – 01/03/2023

0	0	1	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Northampton General Hospital



Never event incidence

Committee Name: All

GroupName: Quality

MetricName: Never event incidence

0	0	1	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	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	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	01/02/23	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	The number of Never Events declared in the reporting period	There was one Never Event declared in February 2023. The never event was a fascia iliac block applied to the wrong side to a patient who had suffered a neck of femur fracture	Incidents are considered in the twice weekly Incident Review Group meeting and if appropriate and they meet the criteria set out in the Never Event List 2018 they will be considered for Never Event status.	Declarations of serious incidents meeting the Never Event status are investigated using root cause analysis techniques and include recommendations and actions aiming to mitigate against future occurrences.

Sustainability

KGH | NGH

Committee Name: Integrated Governance Report (I...

GroupName: Sustainability

5 Exec comments KGH

0 Exec comments NGH

11 Total No. of Metrics

Site	MetricName	Value
KGH	A&E activity (& vs plan)	101.40%
KGH	Bank and Agency Spend (M)	3.47
KGH	Capital Spend (M)	1.23
KGH	CIP Performance YTD (M)	0.68
KGH	Elective day-case activity (& vs plan)	99.60%
KGH	Elective inpatient activity (& vs plan)	79.60%
KGH	Headcount actual vs planned (substantive / agency / bank)	4,772
KGH	Maternity activity (& vs plan)	0.00%
KGH	Non-elective activity (& vs plan)	130.80%
KGH	Outpatients activity (& vs plan)	91.40%
KGH	Surplus / Deficit YTD (M)	-0.52

Metric	Comment
Non Pay	Non-Pay is £8.4m overspent to plan, largely attributable to Drugs, Supplies & Utilities inflation. Teleradiology & additional diagnostic capacity has also contributed to the adverse variance, along with other smaller Non-Pay pressures such as additional security & IRTP visa renewals.
YTD Position	The Trust saw a YTD deficit (M1-11) of £16.2m, which is £10.7m adverse to Plan. The expected run-rate improvement is now evident within the financial plans across H2, as this has reduced from a YTD planned deficit of £7.5m back in M6 to a £5.5m planned deficit in M10. The deterioration in performance is due to the financial position not improving in line with plan expectations, as expenditure run-rate has remained in line with prior months and the actual position includes significant inflationary pressures which exceed national planning assumptions or funding.
Income	The YTD position is £6.2m above plan driven by £4.7m Non-Clinical Income & £1.5m Patient Care Income. Non-Clinical overperformances are due to additional funds from Health Education England, Cancer Alliance, Charitable Funds, ICAN reimbursement, IECCP Programme, Car Parking & Capital Grant Funding. Patient Care Income variance is driven primarily by additional System Support Funding.
M5 Position	The YTD position is a £16.2m deficit which is £10.7m adverse to plan. The expected run-rate improvement is now evident within the financial plans across H2, as this has reduced from a YTD planned deficit of £7.5m back in M6 to a £5.5m planned deficit in M11. The deterioration in performance is due to the financial position not improving in line with plan expectations, as expenditure run-rate has remained in line with prior months and the actual position includes significant inflationary pressures which exceed national planning assumptions or funding.
Pay	YTD Pay is £8.9m adverse to plan. Key pressures within Pay such as escalation, absence and vacancy cover including premium cost of agency continue to impact on the expected reductions in line with the planned financial improvements.

Summary Table

Committee Name: Integrated Governance Report (IGR)

Group Name: Sustainability

Metric Name: All

Site: All

Variation: All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
KGH	Sustainability	Outpatients activity (& vs plan)	01/02/23	91.40%		79.91%	130.83%	181.75%			Consistently Anticipated to Meet Target
NGH	Sustainability	Outpatients activity (& vs plan)	01/02/23	95.93%		78.04%	109.86%	141.67%			Consistently Anticipated to Meet Target
NGH	Sustainability	Elective day-case activity (& vs plan)	01/02/23	105.29%		64.73%	93.39%	122.06%			Consistently Anticipated to Meet Target
KGH	Sustainability	Elective day-case activity (& vs plan)	01/02/23	99.60%		77.67%	146.02%	214.37%			Consistently Anticipated to Meet Target
KGH	Sustainability	Elective inpatient activity (& vs plan)	01/02/23	79.60%		68.17%	94.56%	120.95%			Consistently Anticipated to Meet Target
NGH	Sustainability	Elective inpatient activity (& vs plan)	01/02/23	123.45%		57.33%	97.75%	138.16%			Consistently Anticipated to Meet Target
NGH	Sustainability	Non-elective activity (& vs plan)	01/02/23	152.05%		90.03%	114.55%	139.06%			Consistently Anticipated to Meet Target
KGH	Sustainability	Non-elective activity (& vs plan)	01/02/23	130.80%		81.03%	122.25%	163.47%			Consistently Anticipated to Meet Target
KGH	Sustainability	A&E activity (& vs plan)	01/02/23	101.40%		90.07%	102.98%	115.89%			Consistently Anticipated to Meet Target
NGH	Sustainability	A&E activity (& vs plan)	01/02/23	101.54%		80.11%	95.03%	109.96%			Consistently Anticipated to Meet Target
KGH	Sustainability	Headcount actual vs planned (substantive / agen...	01/02/23	4,772		4425	4581	4738			Consistently Anticipated to Meet Target
NGH	Sustainability	Headcount actual vs planned (substantive / agen...	01/02/23	5,957		5847	5960	6073			Consistently Anticipated to Meet Target
NGH	Sustainability	Capital Spend (M)	01/02/23	3.00	5.23	9.81	9.81	9.81			Not Consistently Anticipated to Meet Target
NGH	Sustainability	Bank and Agency Spend (M)	01/02/23	5.03	1.12	6.5	6.5	6.5			Consistently Anticipated to Meet Target
NGH	Sustainability	CIP Performance YTD (M)	01/02/23	0.25	1.42		0				Consistently Anticipated to Not Meet Target
KGH	Sustainability	Capital Spend (M)	01/02/23	1.23	2.82	3.48	3.48	3.48			Not Consistently Anticipated to Meet Target
NGH	Sustainability	Surplus / Deficit YTD (M)	01/02/23	-1.17	-0.02	1.9	1.9	1.9			Not Consistently Anticipated to Meet Target
KGH	Sustainability	Bank and Agency Spend (M)	01/02/23	3.47	1.49	3.94	3.94	3.94			Consistently Anticipated to Meet Target

Summary Table

Committee Name	Group Name	Metric Name	Site	Variation
Integrated Governance Report (IGR)	Sustainability	All	All	All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
KGH	Sustainability	Surplus / Deficit YTD (M)	01/02/23	-0.52	0.38	3.86	3.86	3.86			Not Consistently Anticipated to Meet Target
KGH	Sustainability	CIP Performance YTD (M)	01/02/23	0.68	1.21	1.07	1.07	1.07			Consistently Anticipated to Not Meet Target

Outpatients activity (& vs plan)

Committee Name: All

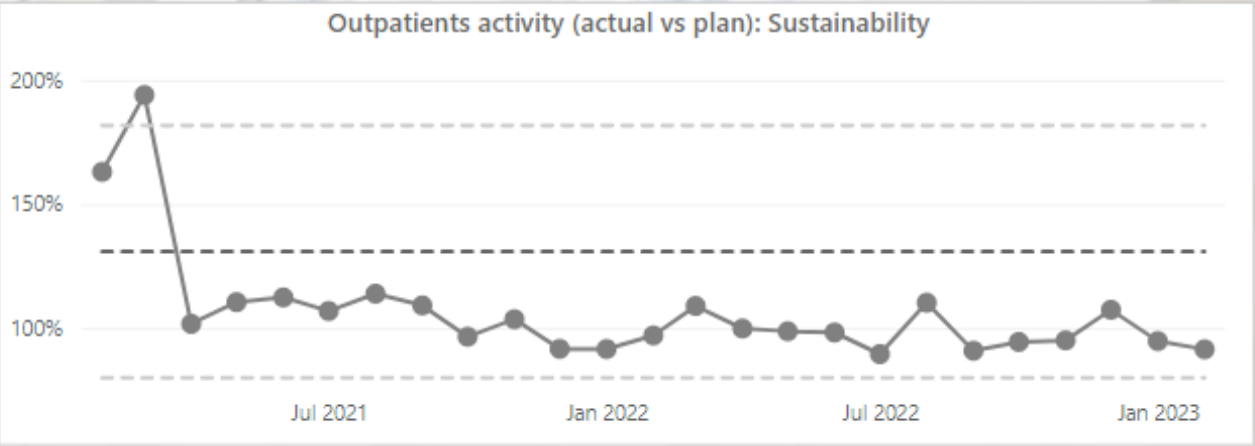
GroupName: Sustainability

MetricName: Outpatients activity (& vs plan)

01/04/2019 – 18/02/2023

91.40%		95.93%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	This is the total number of outpatient appointments in the month (face to face and virtual, new and follow up)	The Trust has under delivered in February against the outpatient target at 91.4% in month	The year to date position is still showing a deficit against plan at 96.19%. There were some clinics cancelled in February due to the RCN Industrial action	Weekly reporting on activity and outpatient efficiency looking forward being reported to the Trust's Patient Access Board as well as monthly Divisional Workforce, Activity and Finance meetings. Activity planning discussions are taking place currently to plan ahead for 23/24	Divisions to look at specialty level opportunities to increase activity to reduce overall year deficit Additional clinics are being added for multiple specialties.
NGH	01/02/23	This is the total number of outpatient appointments in the month (face to face and virtual, new and follow up)	Data shows that we are delivering at 96% against the plan for January (39769 vs 41,455)	Activity was lower in February compared to January due to it being a shorter month (43,747 patients seen in Jan) OPD activity has not been cancelled thus far due to industrial action, however we expect to lose significant OPD activity next month with the start of the junior doctors strike	Weekly monitoring in place with Divisional PTL's and a weekly Access Board meeting where activity vs plan is a standing agenda item. Outpatient improvement project will recommence in the New Year with a Regional focus on DNA's	Weekly monitoring in place with Divisional PTL's and a weekly Access Board meeting where activity vs plan is a standing agenda item. Outpatient improvement project has recommenced with a Regional focus on DNA's

Outpatients activity (& vs plan) 2

Committee Name: All

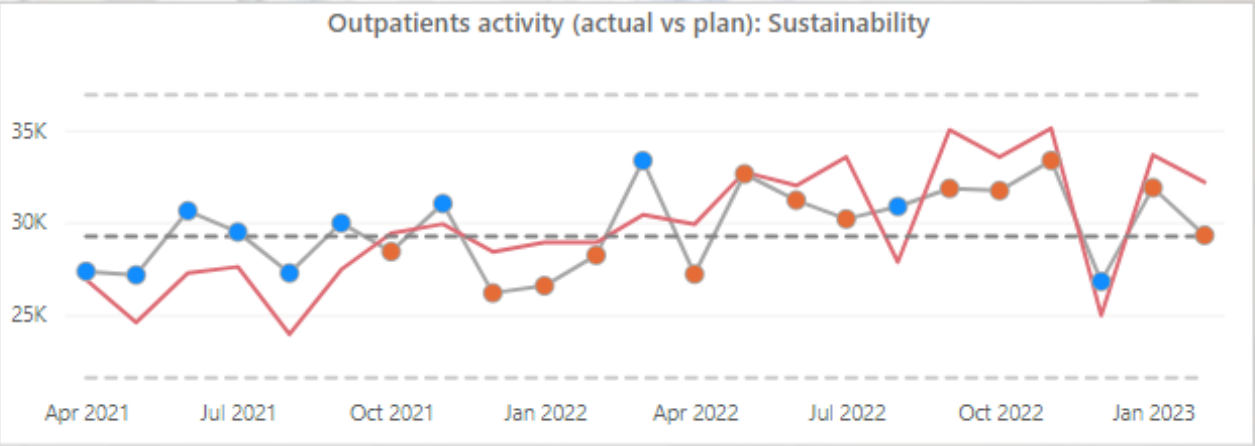
GroupName: Sustainability

MetricName: Outpatients activity (& vs plan) 2

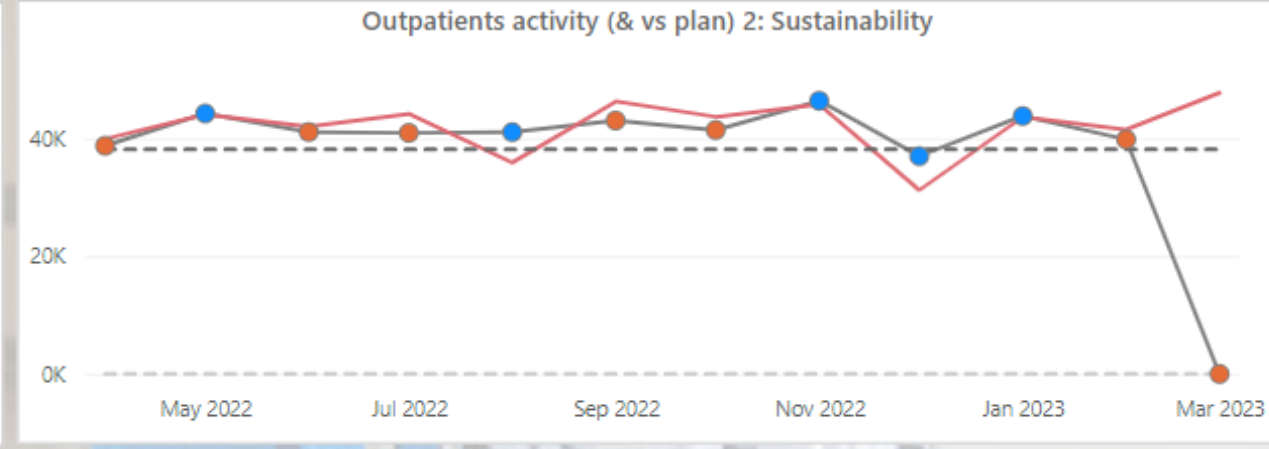
01/04/2019 – 01/03/2023

29,305	32181	39,769	41455
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	This is the total number of outpatient appointments in the month (face to face and virtual, new and follow up)	The Trust has under delivered in February against the outpatient target at 91.4% in month	The year to date position is still showing a deficit against plan at 96.19%. There were some clinics cancelled in February due to the RCN Industrial action	Weekly reporting on activity and outpatient efficiency looking forward being reported to the Trust's Patient Access Board as well as monthly Divisional Workforce, Activity and Finance meetings. Activity planning discussions are taking place currently to plan ahead for 23/24	Divisions to look at specialty level opportunities to increase activity to reduce overall year deficit Additional clinics are being added for multiple specialties.
NGH	01/02/23	This is the total number of outpatient appointments in the month (face to face and virtual, new and follow up)	Data shows that we are delivering at 96% against the plan for January (39769 vs 41,455)	Activity was lower in February compared to January due to it being a shorter month (43,747 patients seen in Jan) OPD activity has not been cancelled thus far due to industrial action, however we expect to lose significant OPD activity next month with the start of the junior doctors strike	Weekly monitoring in place with Divisional PTL's and a weekly Access Board meeting where activity vs plan is a standing agenda item. Outpatient improvement project will recommence in the New Year with a Regional focus on DNA's	Weekly monitoring in place with Divisional PTL's and a weekly Access Board meeting where activity vs plan is a standing agenda item. Outpatient improvement project has recommenced with a Regional focus on DNA's

Elective day-case activity (& vs plan)

Committee Name: All

GroupName: Sustainability

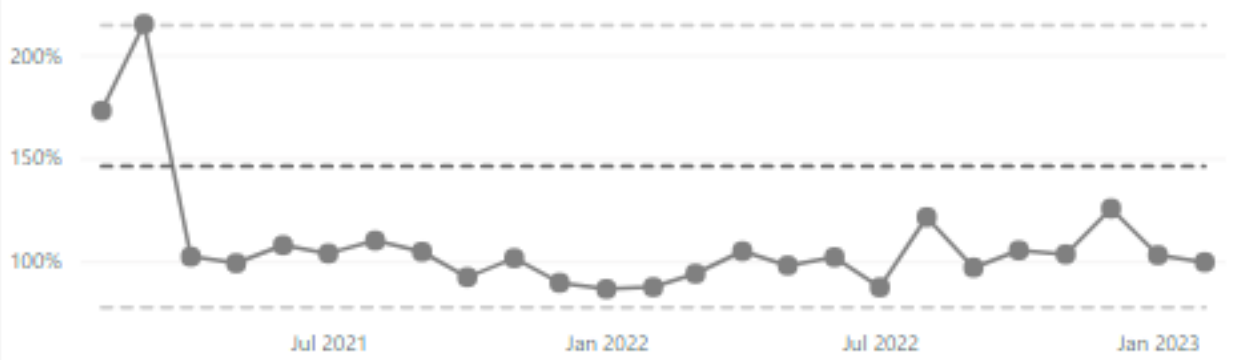
MetricName: Elective day-case activity (& vs plan)

01/04/2019 – 01/03/2023

99.60%		105.29%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

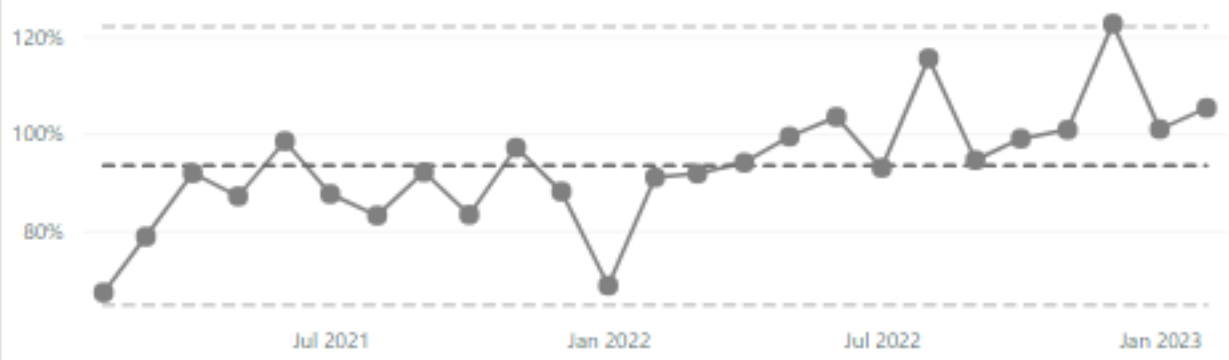
Kettering General Hospital

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



Northampton General Hospital

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



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	Elective day case activity actuals v plan	The chart tells us that day case activity is at 99.6% of plan for February	Day case activity was affected by the RCN industrial action	Weekly Reset and Access 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 wherever possible to minimise disruption
NGH	01/02/23	Elective day case activity actuals v plan	Data shows that we are delivering at 105% (3981 patients vs 3781 target) against the plan for Feb 23	Performance was pleasing despite the ongoing challenges with theatre staffing.	Theatre transformation programme in place and improvements in utilisation rates and start and finish times already being seen with month on month improvements	Weekly theatre transformation meetings in place chaired by COO / DCOO. Robust cancelation escalation process in place to ensure all actions are taken before any list is taken down. Driving down late starts and late finishes in theatre. A step change in utilisation of theatre lists has been seen in 2023 thus far

Elective day-case activity (& vs plan) 2

Committee Name: All

GroupName: Sustainability

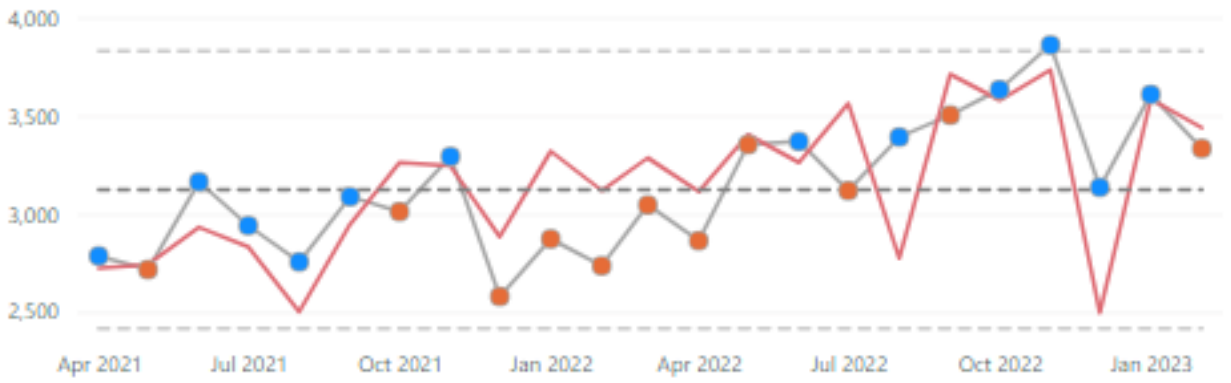
MetricName: Elective day-case activity (& vs plan) 2

01/04/2019 – 01/03/2023

3,333	3439	3,981	3781
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

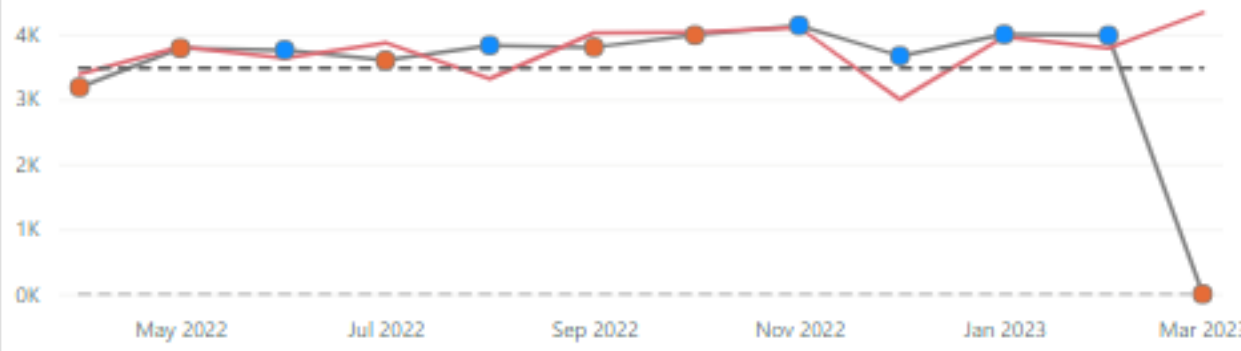
Kettering General Hospital

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



Northampton General Hospital

Elective day-case activity (& vs plan) 2: Sustainability



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	Elective day case activity actuals v plan	The chart tells us that day case activity is at 99.6% of plan for February	Day case activity was affected by the RCN industrial action	Weekly Reset and Access 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 wherever possible to minimise disruption
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Elective inpatient activity (& vs plan)

Committee Name: All

GroupName: Sustainability

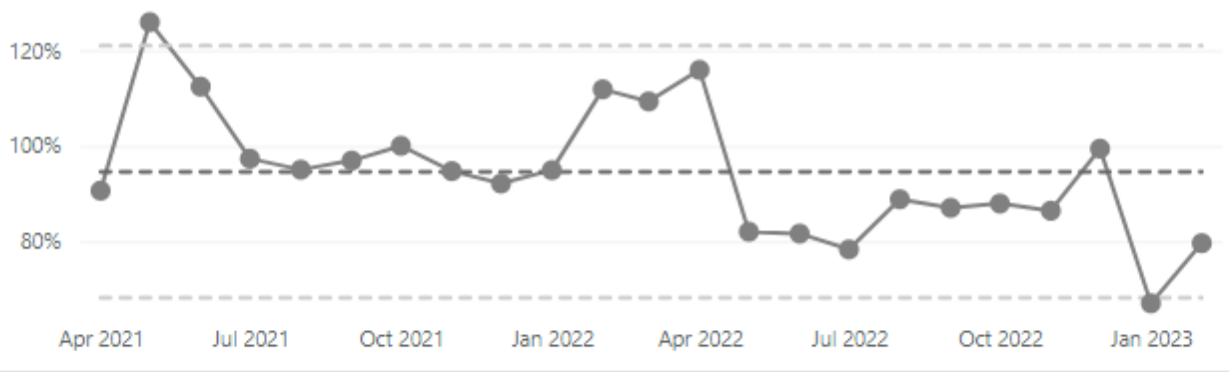
MetricName: Elective inpatient activity (& vs plan)

01/04/2019 – 01/03/2023

79.60%		123.45%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital

Elective inpatient activity (actual vs plan): Sustainability



Northampton General Hospital

Elective inpatient activity (actual vs plan): Sustainability

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	Elective inpatient activity actuals v plan	The chart tells us that inpatient activity is at 79.6% of plan for February	Inpatient activity was affected by the RCN industrial action	Weekly Reset and Access 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 wherever possible to minimise disruption
NGH	01/02/23	Elective inpatient activity actuals v plan	The Trust saw 123% (379 vs 307 target) of its Elective activity vs plan during Feb 23	Performance was pleasing despite the ongoing challenges with theatre staffing and the ongoing Industrial action which saw us able to continue without cancelling elective activity	Further Industrial action over coming months will see the challenges continue esp Junior Docs strike in March which will see a reduction in elective surgery. Multiple requests for mutual aid from numerous Trusts esp Urological cancer from Worcester and H&N cancer surgery from Leicester will add to the challenges	Weekly theatre transformation meetings in place chaired by COO / DCOO. Robust cancelation escalation process in place to ensure all actions are taken before any list is taken down. Driving down late starts and late finishes in theatre. A step change in utilisation of theatre lists has been seen in December and January

Elective inpatient activity (& vs plan) 2

Committee Name: All

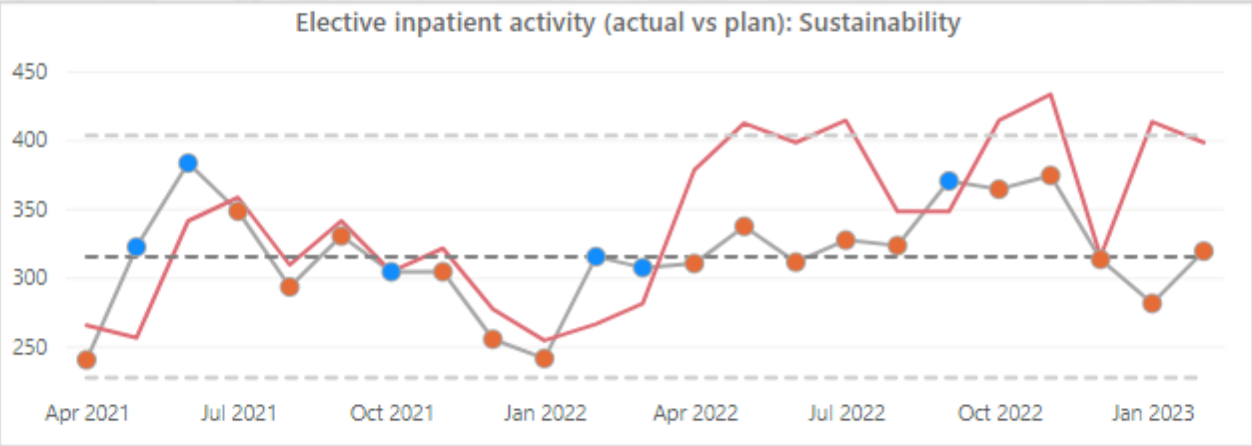
GroupName: Sustainability

MetricName: Elective inpatient activity (& vs plan) 2

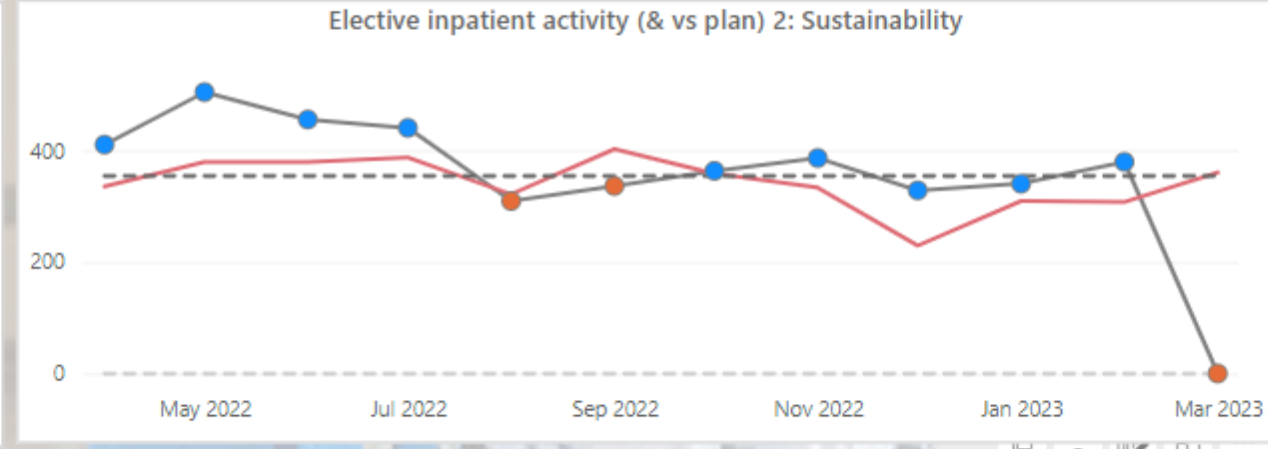
01/04/2019 – 01/03/2023

319	398	379	307
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	Elective inpatient activity actuals v plan	The chart tells us that inpatient activity is at 79.6% of plan for February	Inpatient activity was affected by the RCN industrial action	Weekly Reset and Access 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 wherever possible to minimise disruption
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Non-elective activity (& vs plan)

Committee Name: All

GroupName: Sustainability

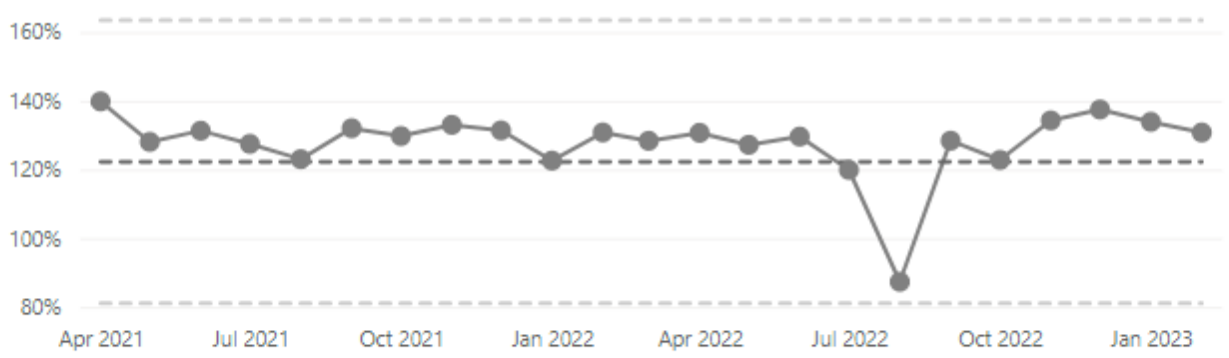
MetricName: Non-elective activity (& vs plan)

01/04/2019 01/03/2023

130.80%		152.05%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

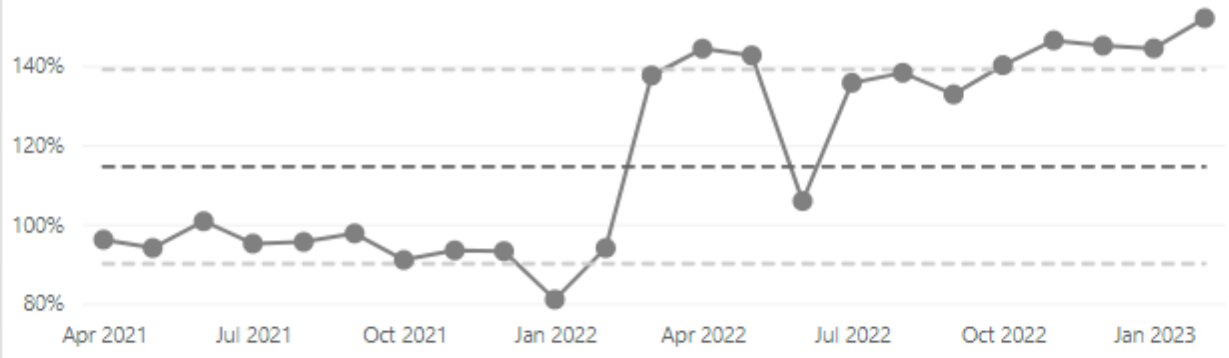
Kettering General Hospital

Non-elective activity (actual vs plan): Sustainability



Northampton General Hospital

Non-elective activity (actual vs plan): Sustainability



Non-elective activity (& vs plan) 2

Committee Name: All

GroupName: Sustainability

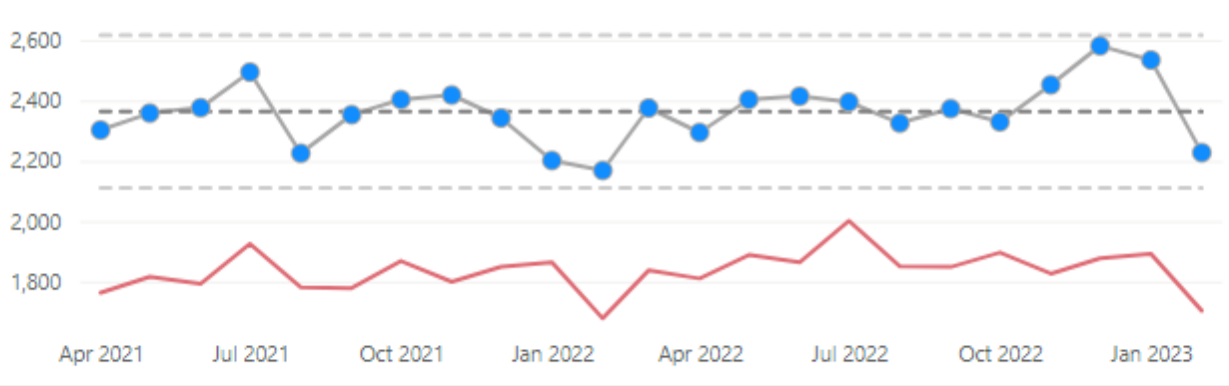
MetricName: Non-elective activity (& vs plan) 2

01/04/2019 – 01/03/2023

2,227	1703	5,477	3602
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

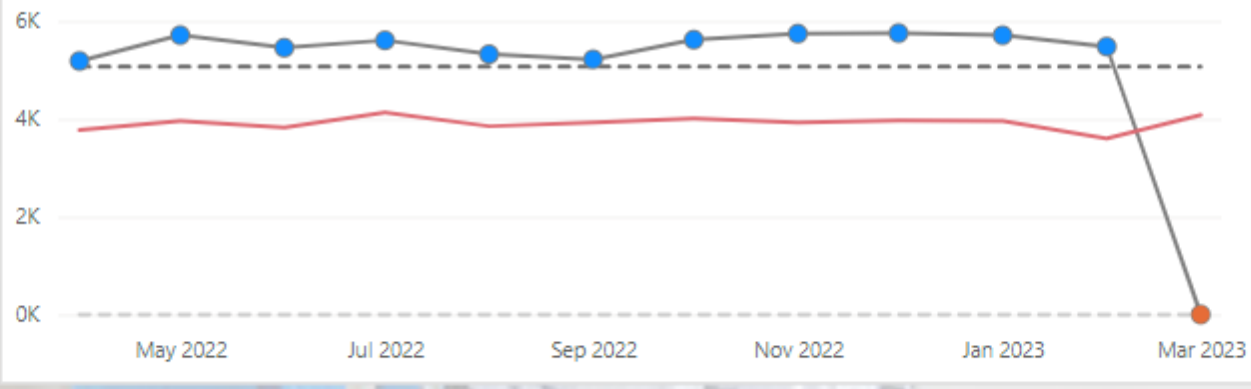
Kettering General Hospital

Non-elective activity (actual vs plan): Sustainability



Northampton General Hospital

Non-elective activity (& vs plan) 2: Sustainability



A&E activity (& vs plan)

Committee Name: All

GroupName: Sustainability

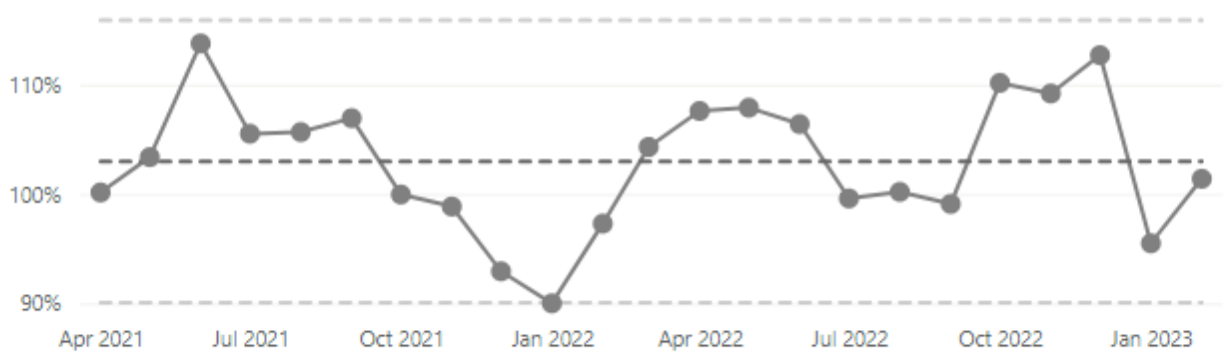
MetricName: A&E activity (& vs plan)

01/04/2019 – 01/03/2023

101.40%		101.54%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

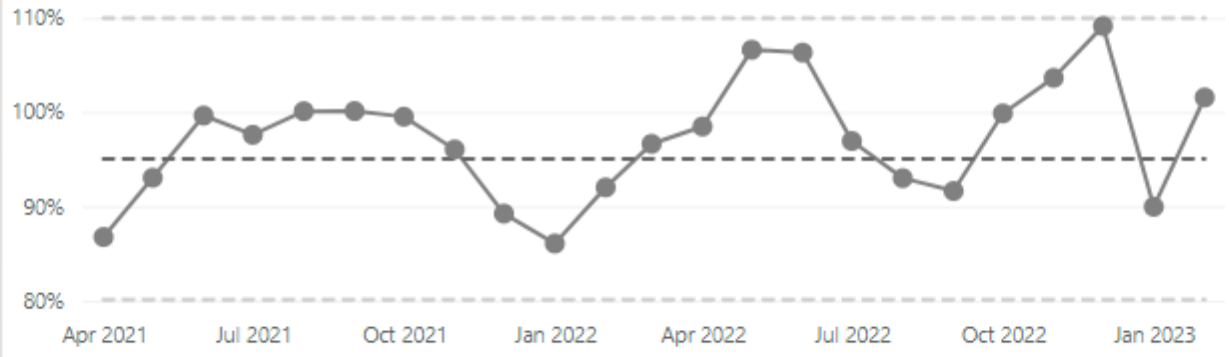
Kettering General Hospital

A&E activity (actual vs plan): Sustainability



Northampton General Hospital

A&E activity (actual vs plan): Sustainability



A&E activity (& vs plan)

Committee Name: All

GroupName: Sustainability

MetricName: A&E activity (& vs plan)

101.40%		101.54%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	A&E attendances	A slight decrease in the total number of attendances during February.	Despite seeing further reduced numbers, safety concerns remain in respect to overcrowding in the current ED estate due to the volume of attendances at peak times of the day, combined with Trust capacity to move confirmed admits from ED	To meet with GP/EMAS colleagues to promote use of SDEC pathway; to maximise referral process and reduce unnecessary ED attendances for patients attending with medical concerns 4-hour task and finish group established; which will include targeted work on increasing flow out of ED to speciality SDECs Introduce notify process for ED Ambulatory Majors patients triaged directly for MSDEC	Trustwide full escalation protocol with implementation of Rapid transfer protocol. Move of patients against confirmed and predicted discharges from base wards to support capacity pressures in ED.
NGH	01/02/23	A&E attendances	ED activity vs plan is very variable with significant increases and decreases against the plan month by month	As we enter into the living with covid era there has been a significant change in NEL activity as is seen by the fact that the activity vs plan is literally swinging over and under month on month. Impacts are the increase in paediatrics attendances, increases in SDEC services so large numbers of pts either direct access to SDEC who would previously of attended ED and been streamed	ongoing development and embedding of EMAS and primary care direct access to SDEC to reduce ED attendances and burden. Gynae SDEC is increasing their criteria so will have enhanced direct access for patients	Increased streaming at front door of ED, continued work with EMAS and primary care to further embed direct access to SDEC.

A&E activity (& vs plan) 2

Committee Name: All

GroupName: Sustainability

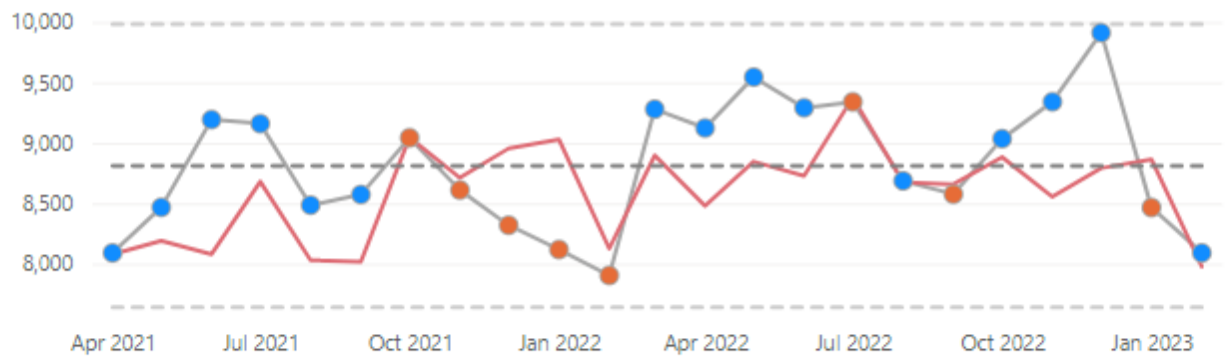
MetricName: A&E activity (& vs plan) 2

01/04/2019 – 01/03/2023

8,090	7978	10,657	10495
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

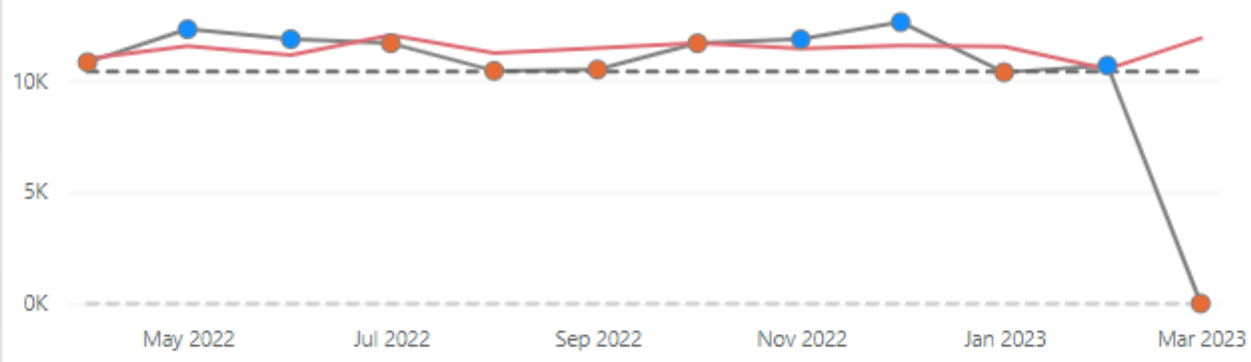
Kettering General Hospital

A&E activity (actual vs plan): Sustainability



Northampton General Hospital

A&E activity (& vs plan) 2: Sustainability



A&E activity (& vs plan) 2

Committee Name: All

GroupName: Sustainability

MetricName: A&E activity (& vs plan) 2

8,090	7978	10,657	10495
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	A&E attendances	A slight decrease in the total number of attendances during February.	Despite seeing further reduced numbers, safety concerns remain in respect to overcrowding in the current ED estate due to the volume of attendances at peak times of the day, combined with Trust capacity to move confirmed admits from ED	To meet with GP/EMAS colleagues to promote use of SDEC pathway; to maximise referral process and reduce unnecessary ED attendances for patients attending with medical concerns 4-hour task and finish group established; which will include targeted work on increasing flow out of ED to speciality SDECs Introduce notify process for ED Ambulatory Majors patients triaged directly for MSDEC	Trustwide full escalation protocol with implementation of Rapid transfer protocol. Move of patients against confirmed and predicted discharges from base wards to support capacity pressures in ED.
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Headcount actual vs planned (substantive / agen...

Committee Name: All

GroupName: Sustainability

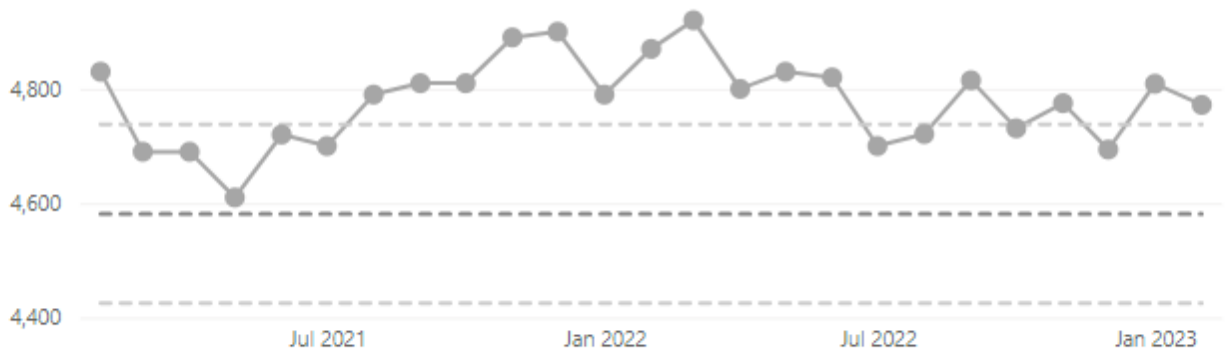
MetricName: Headcount actual vs planned (substantive ...

01/04/2019 01/03/2023

4,772		5,957	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

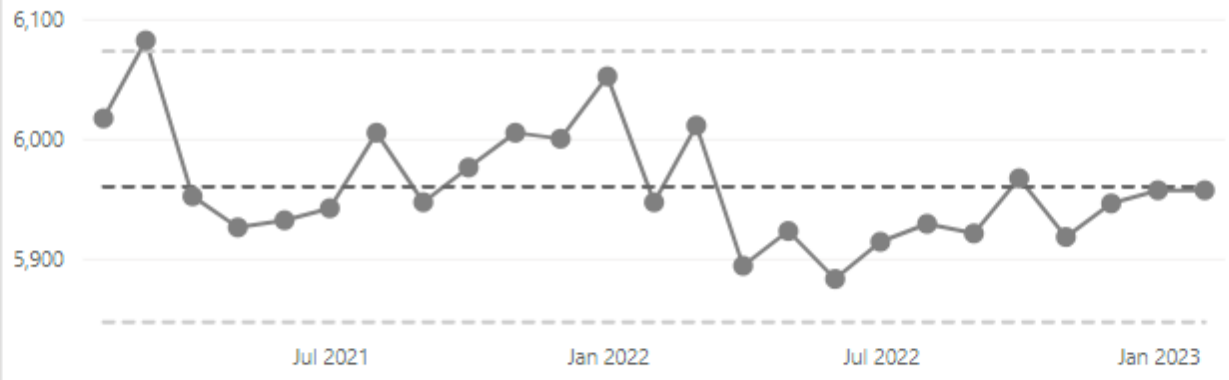
Kettering General Hospital

Headcount actual vs planned (substantive / agency / bank): Sustainability



Northampton General Hospital

Headcount actual vs planned (substantive / agency / bank): Sustainability



Capital Spend (M)

Committee Name: All

GroupName: Sustainability

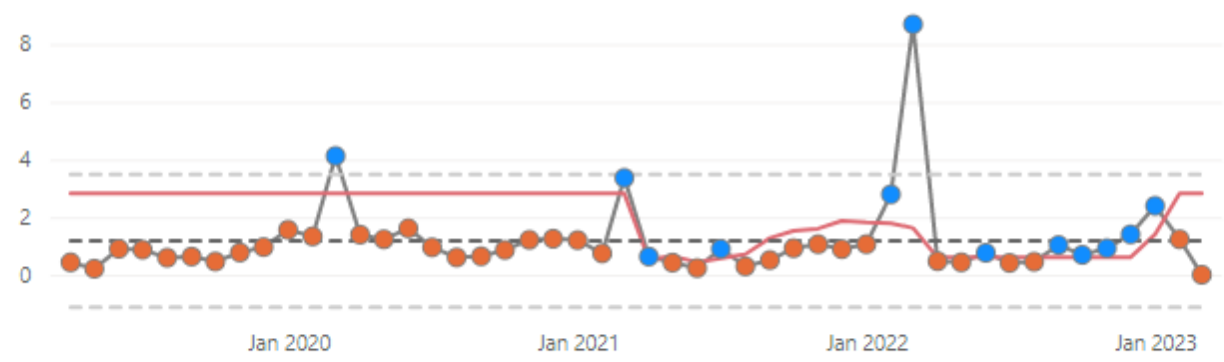
MetricName: Capital Spend (M)

01/04/2019 – 01/03/2023

1.23	2.82	3.00	5.23
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

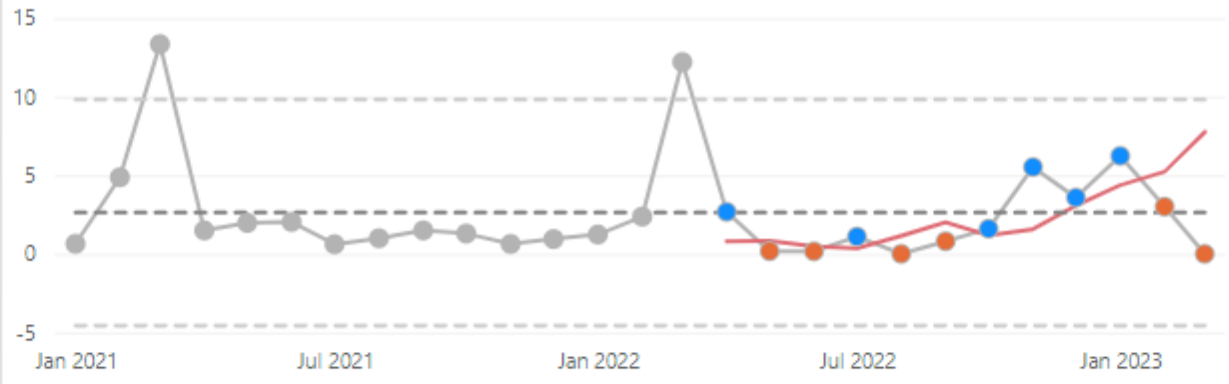
Kettering General Hospital

Capital Spend (M): Sustainability



Northampton General Hospital

Capital Spend (M): Sustainability



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	22/23 Plan vs Actual Capital expenditure	Total CAPEX in February is £1.2m resulting in total expenditure of £10.2m YTD, reflecting delivery of 48% of the programme to date. The total value of outstanding capital orders raised to date is £10m, hence £20.2m of the capital programme is contractually committed. The expectation is that capital funds will be fully spent by yearend.	Detailed forecast reviews has been undertaken throughout the last three motnhs which identified forecast underspends and mitigation plan were approved to offset this. Additional national funding has also being awarded at short notice which is being managed to ensure it is spent by year end.	Vesting is an option for some specific equipment if delivery to the hospital cannot be made by 31st March.	Oversight of all forecast plans continue to ensure orders have been placed, and expenditure can be reported appropriately (including the use of vesting) for year end.
NGH	01/02/23	22/23 Plan vs Actual Capital expenditure	Capital commitments and expenditure have accelerated in Q4 as work on de-carbonisation has progressed.	Work to manage spend by year end is expected to result in the capital spend achieving plan.	Mitigations to slippage progressed	Brokerage between schemes for in-year spend

Bank and Agency Spend (M)

Committee Name: All

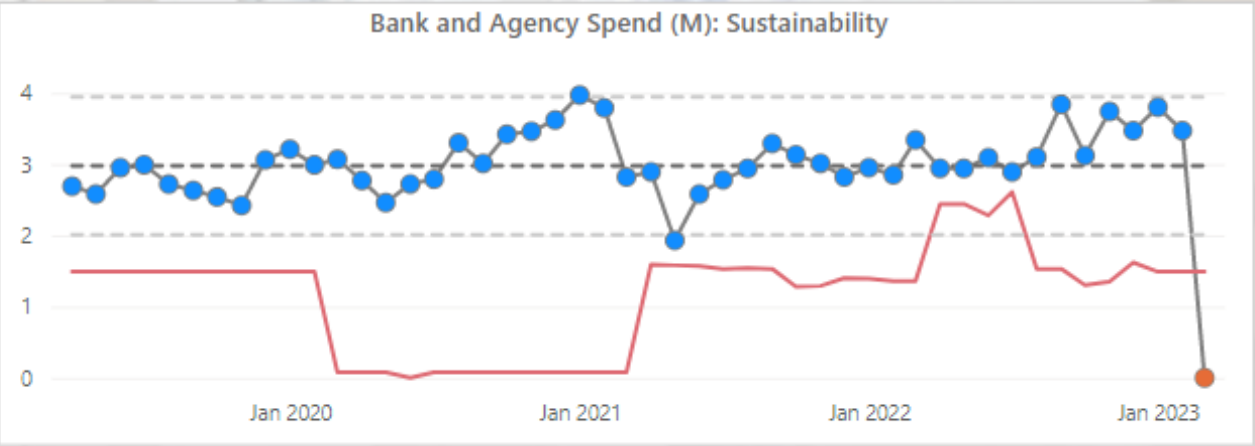
GroupName: Sustainability

MetricName: Bank and Agency Spend (M)

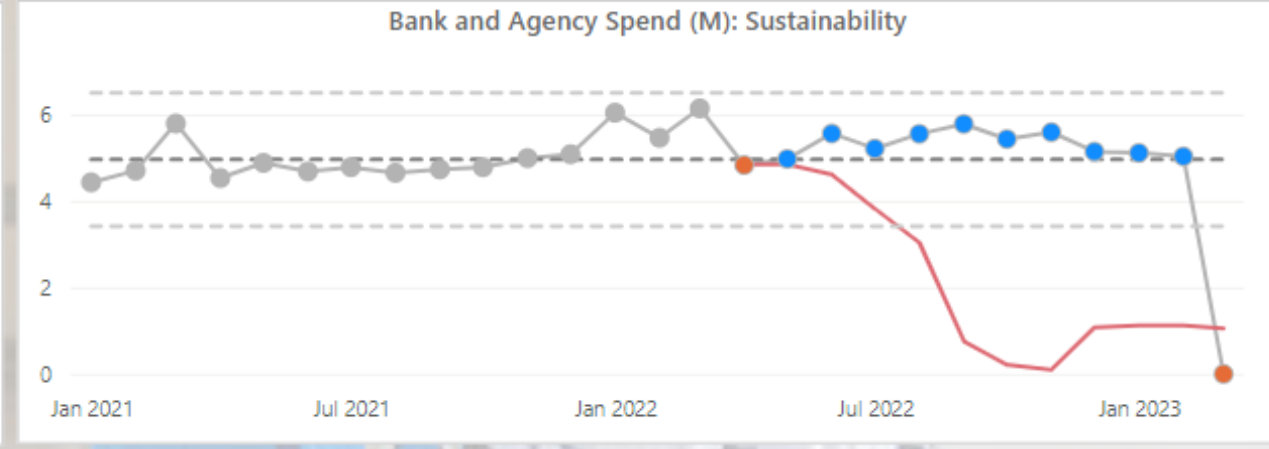
01/04/2019 – 01/03/2023

3.47	1.49	5.03	1.12
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	22/23 Bank & Agency Costs vs Plan	Overall bank and agency spend is adverse to plan due to continued sickness and operational pressures. As a result, there has not been a reduction in temporary staffing costs and the agency cap has been exceeded.	Locum and nursing agency spend usage continues in Medicine and Surgery as a result of operational pressures and opening escalation areas, vacancies and staff unavailability including sickness. There is high levels of agency usage in Corporate, Digital and Estates & Facilities Divisions.	Agency spend is reviewed through workforce meetings. Reviews of Corporate, Digital and Estates agency costs have began to identify opportunities for reducing spend.	All Divisions to review workforce requirements and define and implement recruitment plans to reduce premium pay costs. Agency spend will be reviewed through weekly Hospital Vacancy Panels as part of the workforce and pay enhanced oversight.
NGH	01/02/23	22/23 Bank & Agency Costs vs Plan	Overall bank & agency expenditure is over double the plan year to date, due to efficiencies and schemes to reduce temporary staffing not yet being effectively implemented.	Operational circumstance has seen costs increase, rather than decrease, particularly in agency. Growth in nursing usage is linked to vacancies and sickness levels remaining, whilst costs of Medical agency continue to rise. Support Service areas are also showing increased spend.	To review agency spend through agency review meetings	To review recruitment plans and any other barriers stopping the removal of agency

CIP Performance YTD (M)

Committee Name: All

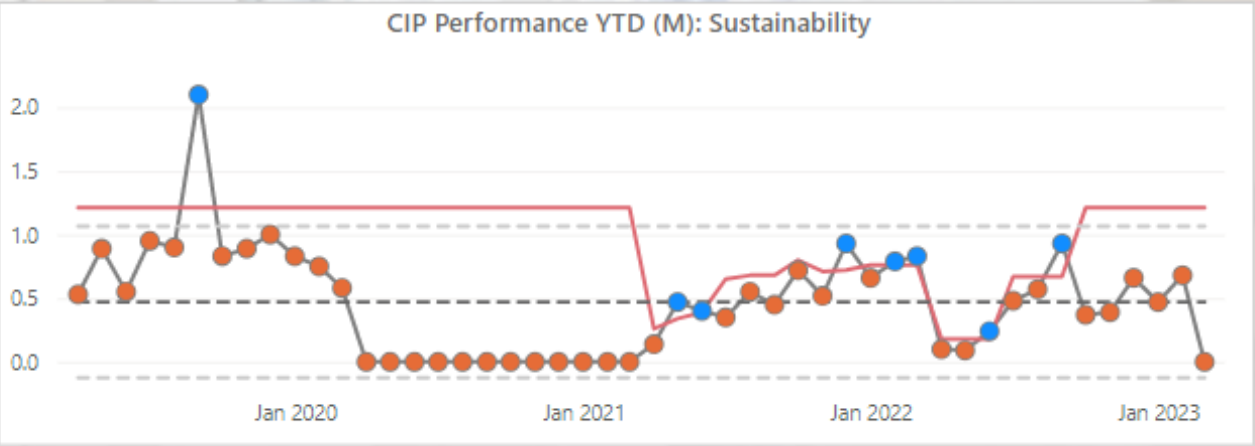
GroupName: Sustainability

MetricName: CIP Performance YTD (M)

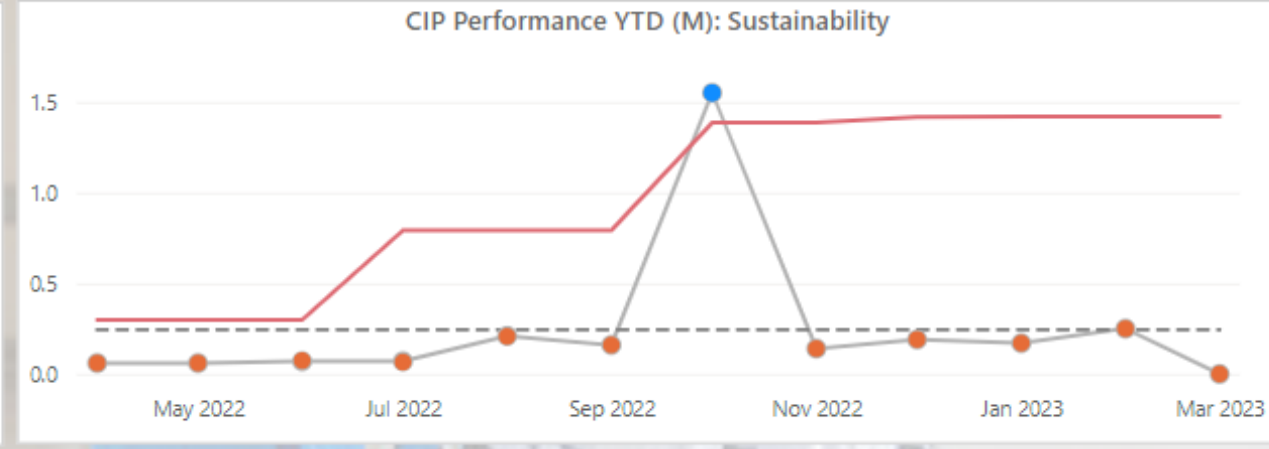
01/04/2019 – 01/03/2023

0.68	1.21	0.25	1.42
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	22/23 Efficiency Plan vs Actual delivery	Efficiency delivery to date is £4.9m with a shortfall of £3.6m to plan. this is primarily due to the non achievement of cash releasing system transformation plans expected of £3.1m to date, with the balance due to Trust under performance of 0.5m.	The divisional efficiency forecast is expecting a £1.2m shortfall to plan, largely due to Estates & Procurement targets not being achieved. System transformation schemes are expecting nil achievement for the year resulting in a £3.7m gap.	Efficiency performance has been monitored through the Trust Efficiency Steering Group.	Divisions continue to pursue new efficiency opportunities.
NGH	01/02/23	22/23 Efficiency Plan vs Actual delivery	The Trust is significantly behind it's efficiency target, achieving approximately 28%	This is due to not yet being able to reduce agency expenditure (a key element) due to operational and other pressures	Schemes are being reviewed, and any potential barriers to cost reduction being assessed	Schemes are being reviewed, and any potential barriers to cost reduction being assessed

Surplus / Deficit YTD (M)

Committee Name: All

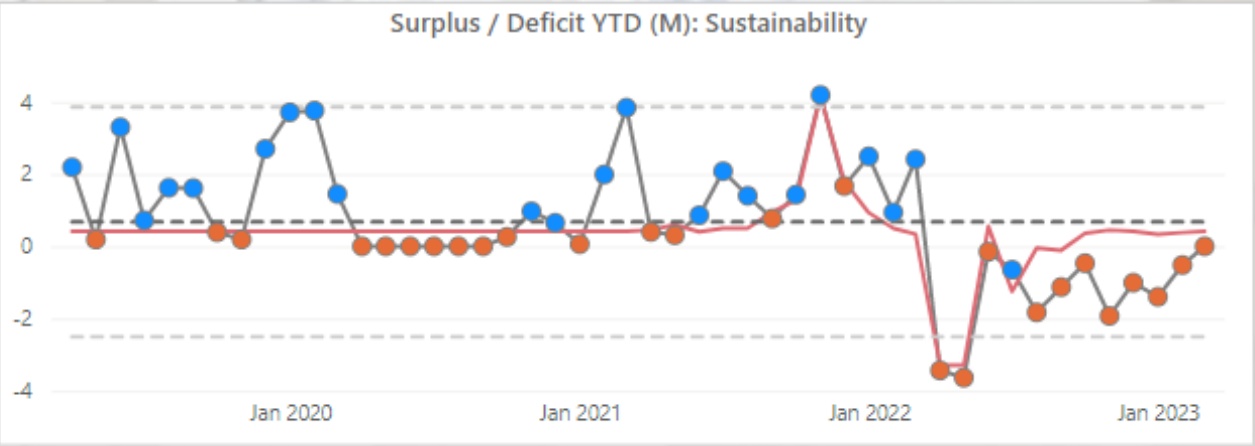
GroupName: Sustainability

MetricName: Surplus / Deficit YTD (M)

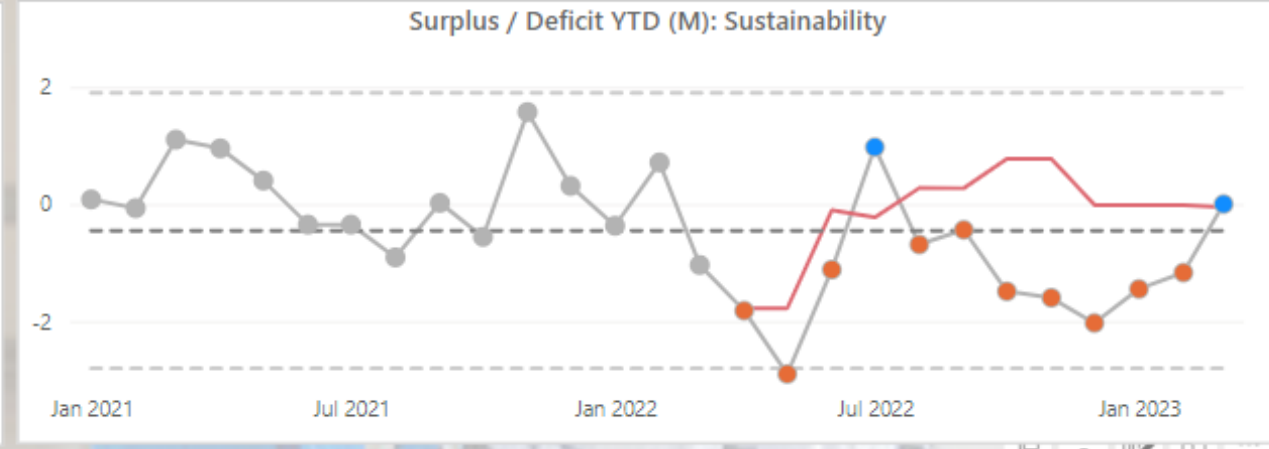
01/04/2019 – 01/03/2023

-0.52	0.38	-1.17	-0.02
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Surplus / Deficit YTD (M)

Committee Name: All

GroupName: Sustainability

MetricName: Surplus / Deficit YTD (M)

-0.52	0.38	-1.17	-0.02
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	Surplus / Deficit in relation to the 22/23 Plan	The YTD position is a £16.2m deficit which is £10.7m adverse to plan. The adverse performance is due to the financial position not improving in line with plan expectations, as expenditure run-rate has remained in line with prior months and the actual position includes significant inflationary pressures which exceed national planning assumptions or funding	The deterioration in performance is due to the financial position not improving in line with plan expectations, as expenditure run-rate has remained in line with prior months and the actual position includes significant inflationary pressures which exceed national planning assumptions or funding.	Efficiency delivery continues to be monitored through the Trust Efficiency Steering Group, but Group efficiency targets (£3.8m) are not expected to be achieved. HMT continue to look for other opportunities to reduce the remaining financial plan improvement gap of £6m.	Divisions continue to look for further financial efficiencies. Workforce discussions continue to take place to define and implement recruitment plans and reduce premium pay costs including agency costs. There are ongoing discussions to review covid capacity and opportunities to step down escalation areas and reduce associated expenditure. Workforce and agency spend will be reviewed in the Hospital Vacancy panels.
NGH	01/02/23	Surplus / Deficit in relation to the 22/23 Plan	The Month 11 financial position is a deficit of £13.7m, £11.9m off a planned deficit of £1.8m.	The primary driver causing the Trust to be off plan is the under delivery of efficiencies. In addition to high efficiency targets in H2 we have also impacted by significant operational pressure in Urgent Care.	Divisional reviews and efficiencies to continue to be monitored closely	Review of potential invest to save impacts and barriers to removing

Summary Table

Committee Name: Integrated Governance Report (IGR)

Group Name: Systems and Partnerships

Metric Name: All

Site: All

Variation: All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
KGH	Systems an...	62-day wait for first treatment	01/01/23	51.40%	85.00%	51.98%	73.49%	95.01%			Not Consistently Anticipated to Meet Target
NGH	Systems an...	62-day wait for first treatment	01/01/23	48.90%	85.00%	52.99%	68.1%	83.21%			Consistently Anticipated to Not Meet Target
KGH	Systems an...	Cancer: Faster Diagnostic Standard	01/01/23	86.00%	75.00%	77.41%	84.8%	92.18%			Consistently Anticipated to Meet Target
NGH	Systems an...	Cancer: Faster Diagnostic Standard	01/01/23	78.67%	75.00%	75.12%	80.83%	86.54%			Consistently Anticipated to Meet Target
KGH	Systems an...	6-week diagnostic test target performance	01/02/23	47.43%	99.00%	60.28%	76.19%	92.11%			Consistently Anticipated to Not Meet Target
NGH	Systems an...	6-week diagnostic test target performance	01/02/23	64.31%	99.00%	69.62%	79.31%	88.99%			Consistently Anticipated to Not Meet Target
NGH	Systems an...	RTT over 52 week waits	01/02/23	734	0	83	240	397			Consistently Anticipated to Not Meet Target
KGH	Systems an...	RTT over 52 week waits	01/02/23	165		6	35	63			Consistently Anticipated to Not Meet Target
NGH	Systems an...	RTT median wait incomplete pathways	01/02/23	13.50	10.9	11.19	11.19	11.19			Not Consistently Anticipated to Meet Target
KGH	Systems an...	RTT median wait incomplete pathways	01/02/23	13.00		12.35	12.35	12.35			Consistently Anticipated to Meet Target
KGH	Systems an...	Theatre utilisation	01/02/23	87.00%	85.00%	65.68%	72.33%	78.97%			Consistently Anticipated to Not Meet Target
NGH	Systems an...	Theatre utilisation	01/02/23	78.00%		60.62%	73.92%	87.22%			Consistently Anticipated to Meet Target
NGH	Systems an...	Bed utilisation	01/12/22	87.67%		79.6%	83.62%	87.64%			Consistently Anticipated to Meet Target
KGH	Systems an...	Bed utilisation	01/02/23	97.06%		86.46%	92.1%	97.74%			Consistently Anticipated to Meet Target
NGH	Systems an...	Stranded patients (7+ day length of stay)	01/02/23	368	0	307	331	355			Consistently Anticipated to Not Meet Target
KGH	Systems an...	Stranded patients (7+ day length of stay)	01/02/23	266		207	250	292			Consistently Anticipated to Not Meet Target
NGH	Systems an...	Super-Stranded patients (21+ day length of stay)	01/02/23	147	0	107	140	172			Consistently Anticipated to Not Meet Target
KGH	Systems an...	Super-Stranded patients (21+ day length of stay)	01/02/23	83		62	90	117			Consistently Anticipated to Not Meet Target

Summary Table

Committee Name	Group Name	Metric Name	Site	Variation
Integrated Governance Report (IGR)	Systems and Partnerships	All	All	All

Site	Group	Metric	Latest Date	Value	Target	LCL	Mean	UCL	Variation	Assurance	Assurance
KGH	Systems an...	Patients with a reason to reside	01/02/23	72.69%		64.88%	69.96%	75.04%			Consistently Anticipated to Meet Target
NGH	Systems an...	Patients with a reason to reside	01/02/23	67.64%	95.00%	59.38%	66.53%	73.67%			Consistently Anticipated to Not Meet Target

62-day wait for first treatment

Committee Name: All

GroupName: Systems and Partnerships

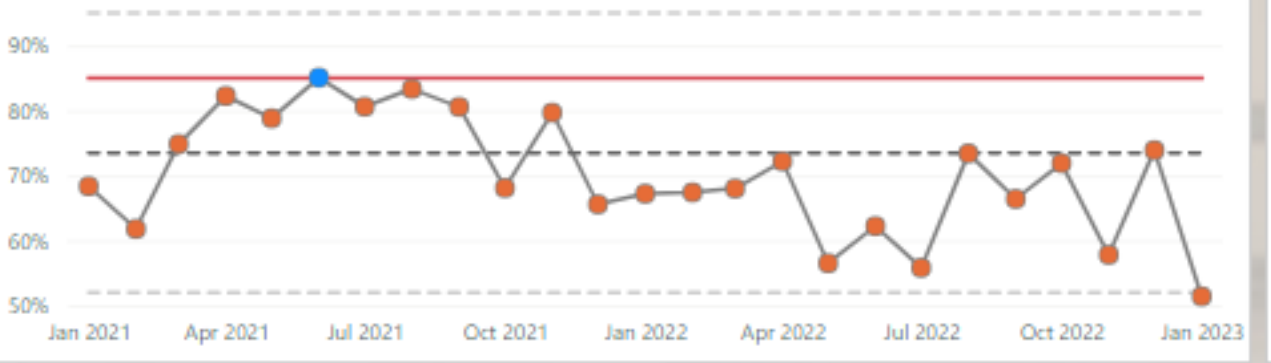
MetricName: 62-day wait for first treatment

01/04/2019 – 01/03/2023

51.40%	85.00%	48.90%	85.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

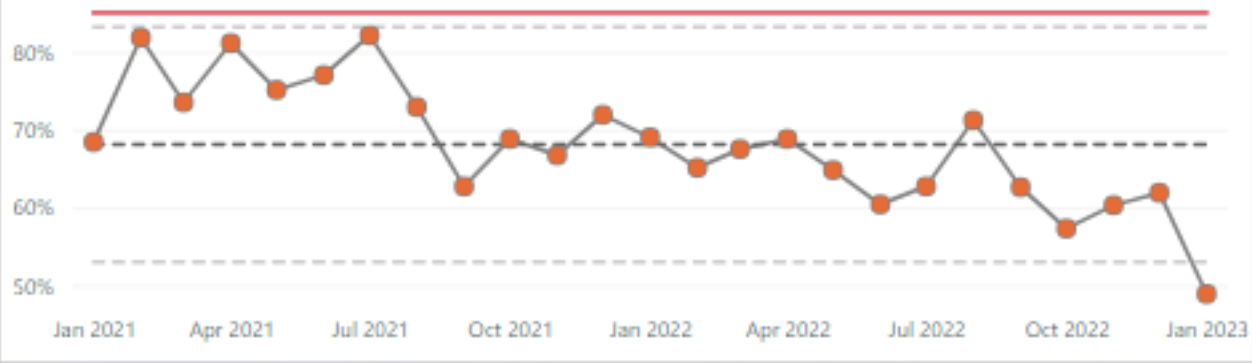
Kettering General Hospital

62-day wait for first treatment: Systems and Partnerships



Northampton General Hospital

62-day wait for first treatment: Systems and Partnerships



62-day wait for first treatment

Committee Name: All

GroupName: Systems and Partnerships

MetricName: 62-day wait for first treatment

51.40%	85.00%	48.90%	85.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/01/23	% of patients whose treatment in initiated within 63 days of urgent referral	The Trust did not achieve the standard of 85%. Performance for January of 57.8%	Continued high volume of patient choice relating to 1st OPA and diagnostics. Workforce issues in Breast delaying diagnostics and multiple MDT discussions continue. A number of breaches were due to rescheduling of surgery because of winter pressures and bed availability. Robotic Nephrectomies redirected to UHL from NGH due to commissioning may incur further delays due to length of waiting lists at UHL.	Cancer recovery action plan discussed and updated weekly by division Weekly calls take place with tertiary centres for next steps of patients. ICB looking into specialist commisioning of Nephrectomies Weekly attendance from radiology and histology at twice weekly PTLs to expediate pathways Radiology tracked now in post and attends twice weekly PTLs	We continue to hold the twice weekly Confirm and Challenge meetings, we 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. Easing of the workforce issues in Breast and communication with the team has facilitated introduction of MDT streamlining which continues to progress. Discussions taking place.
NGH	01/01/23	% of patients whose treatment in initiated within 63 days of urgent referral	The Trust did not meet the standard reaching 48.9% against the 85% standard. 109.5 treatments occurred of which 56 breached. Skin was the only site to achieve the standard	As patients past 62 days on the pathway (legacy) have remained high the possibility of recovering the 62 day standard remains a challenge. The national ask for 23/24 is to reduce long waiters. The Trust has seen a static position for the past 6 months and only as of March 23 are seeing a reduction in numbers, whether this will be sustained remains to be seen.	Actions to improve our patient outcomes, experience and performance remain the same month on month unless we identify a specific outlier in terms of a pathway, the challenge is to embed and sustain the pathway changes teams have made over the past two years: • The delivery of Cancer diagnostics and treatments remain with the Divisions. The Cancer Team continue to focus on holding to account these teams for delivery of sustained improvement plans through the escalation policy and corporate ptl. • Avoidable breaches due to outpatient capacity, diagnostic waits, surgical and oncology waits are re-occurring themes locally and nationally. The divisions continue to work on solutions to reduce waits in these areas. • Robust management of minimum dataset and MDT acceptance of patients being referred from tertiary centres • Working with Primary Care to reduce inappropriate referrals • Reduction in patients on their pathway longer than 62 days	Weekly site and corporate PTL Trust escalation policy Weekly performance report sent to COO, MD highlighting areas of concern All teams focused on reducing legacy, cancer remains a priority Use of national funds to streamline pathways Implementation of national best practice timed pathways

Cancer: Faster Diagnostic Standard

Committee Name: All

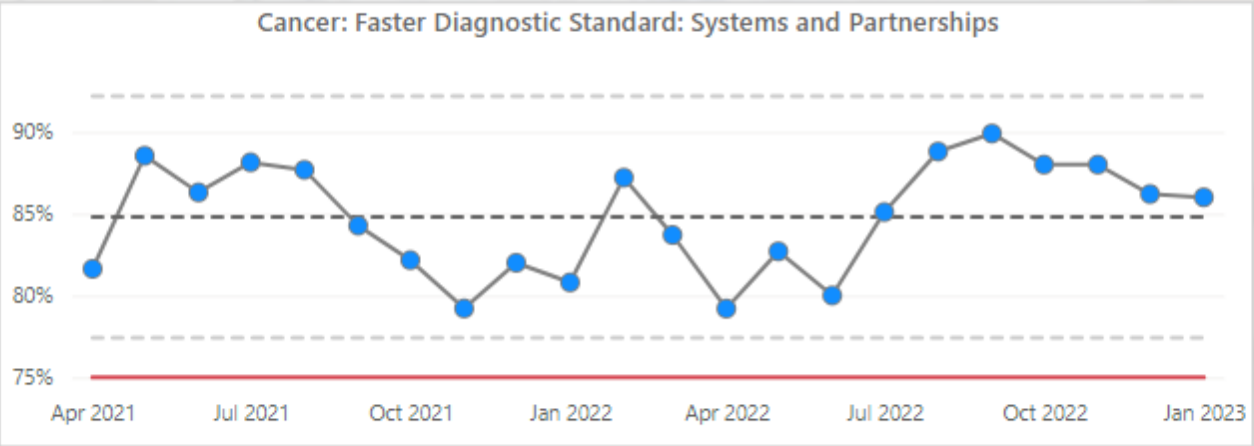
GroupName: Systems and Partnerships

MetricName: Cancer: Faster Diagnostic Standard

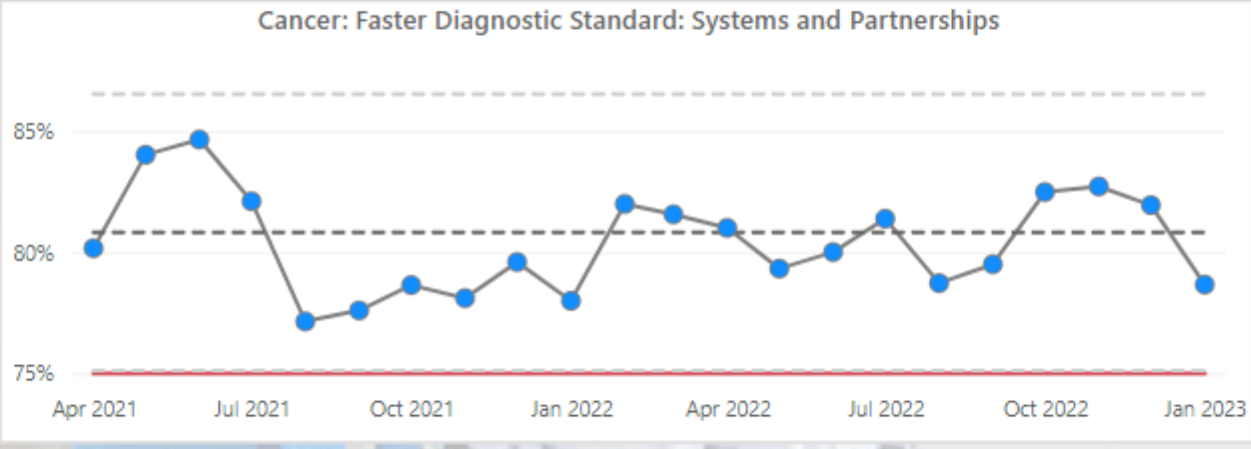
01/04/2019 – 01/03/2023

86.00%	75.00%	78.67%	75.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/01/23	% of patients diagnosed in less than 28 days	The Trust achieved the faster diagnosis standard at 86%	The Trust continues to meet the Faster diagnosis standard. Gynaecology continues to sustain performance against the standard.	Divisions to continue to monitor performance against the standard Increased PTL meetings continue to maintain focus and performance	Patients discussed twice weekly with histopathology and radiology to ensure timely booking and reporting of investigations.
NGH	01/01/23	% of patients diagnosed in less than 28 days	The Trust surpassed the standard reaching 78.7% against the 75% standard	None, standard surpassed	Weekly Site and Corporate PTL meetings with oversight of all patients, using Trust escalation policy to identify patients at risk of breach. Use of best practice timed pathways	Site and Corporate PTL Trust Escalation Policy Weekly Cancer Performance Report identifying areas of concern, which are shared with Divisional Management teams at weekly access board

6-week diagnostic test target performance

Committee Name: All

GroupName: Systems and Partnerships

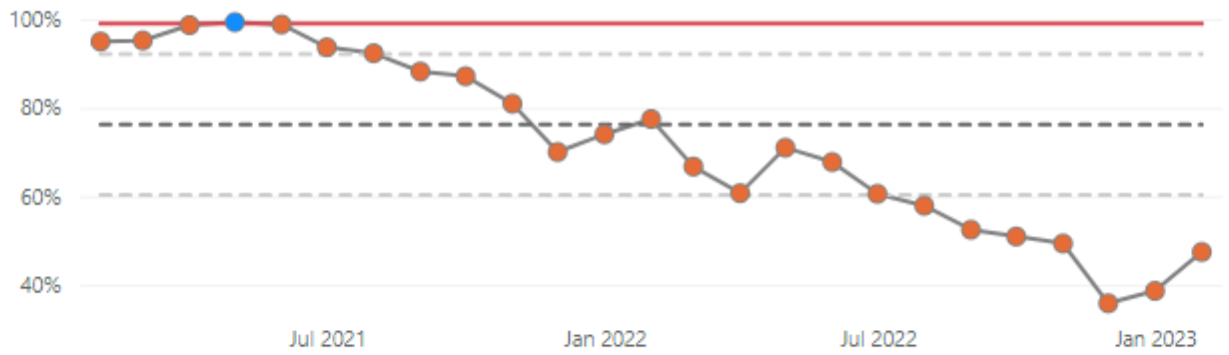
MetricName: 6-week diagnostic test target performance

01/04/2019 – 01/03/2023

47.43%	99.00%	64.31%	99.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

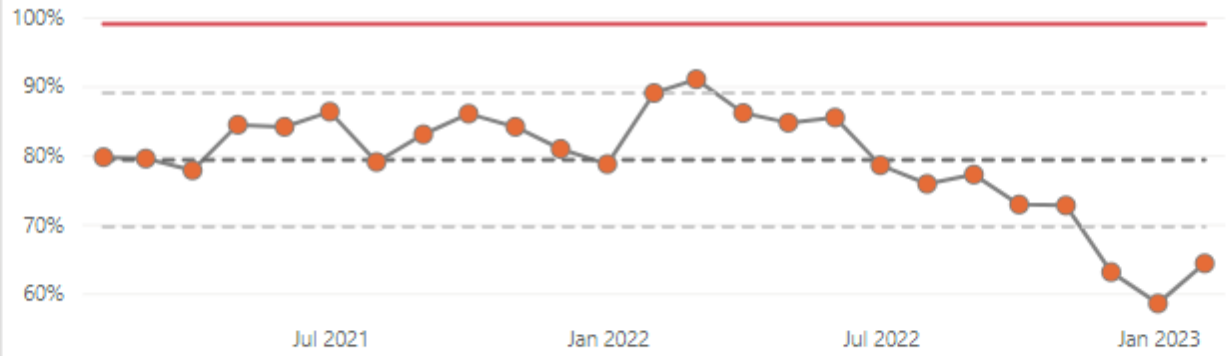
Kettering General Hospital

6-week diagnostic test target performance: Systems and Partnerships



Northampton General Hospital

6-week diagnostic test target performance: Systems and Partnerships



6-week diagnostic test target performance

Committee Name: All

GroupName: Systems and Partnerships

MetricName: 6-week diagnostic test target performance

47.43%	99.00%	64.31%	99.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	% of patients not seen within six weeks	Unvalidated performance for February 2023 has seen a second month of improvement to 47%.	- Increased overall demand for tests from GPs and internally - Continued high demand for cancer, inpatient and other urgent requests which are prioritised over routine requests. - Vacancies as well as sickness and long term leave. - Skill mix within the modalities impacting on specific tests capacity	WLI's have been approved for Neuro in March. This will see an additional 60 patients seen over the weekend Early release of CDC Capacity will be made available to both NOUS and Echo in March. PTL validation continues with Endo modalites to ensure good levels of accuracy	Weekly updates on performance and actions at PAG meeting chaired by DCOO and HoA HoA meeting with all modality leads weekly for DM01 Access Radiology PTL meeting with HoA and DD of Radiology to ensure patients delayed are escalated and managed
NGH	01/02/23	% of patients not seen within six weeks	Performance has improved from last month from 58% to 64%.	Constraints/Pressures from previous month are ongoing: • Sickness and equipment issues impacted. • High volume of referrals. • MRI and echo continue to be challenged however have seen an improvement with additional capacity. • Increased Inpatient, Cancer and Urgent care demand across all modalities. • Continued emergency pressures and Covid-19 demand. • Volume of cancer inpatient demand & urgent care work has impacted on the backlog clearance. • KGH cardiac MRI capacity still a constraint • Skill mix within the modalities to meet demand of tests needed • Endoscopy unit maintenance	• Focused work to prioritise long waits and reduce 13WW • Support from IS for MSK MRI continues Three Shires • Additional MRI capacity through Van for Feb/March • CDC capacity from April - Risk as potential slippage in start • Additional weekend work is being completed where feasible • Echo Insourcing case approved - Implementation now in place and Xyla lists commenced • MSK/U/S additional sessions being offered out to clinicians • PET-CT capacity in place now providing additional CT capacity	standing agenda item at Access Committee and Weekly diagnostic PTL

RTT over 52 week waits

Committee Name: All

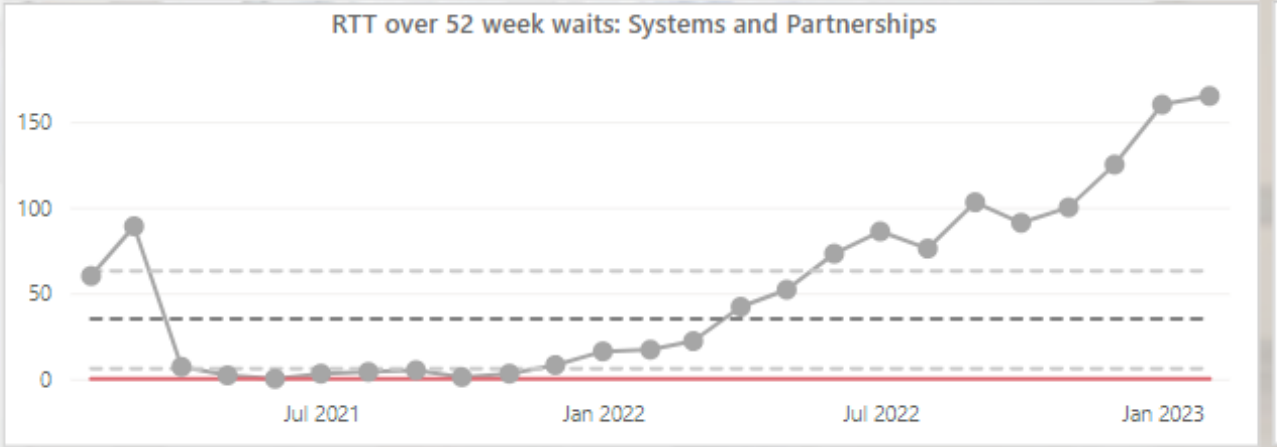
GroupName: Systems and Partnerships

MetricName: RTT over 52 week waits

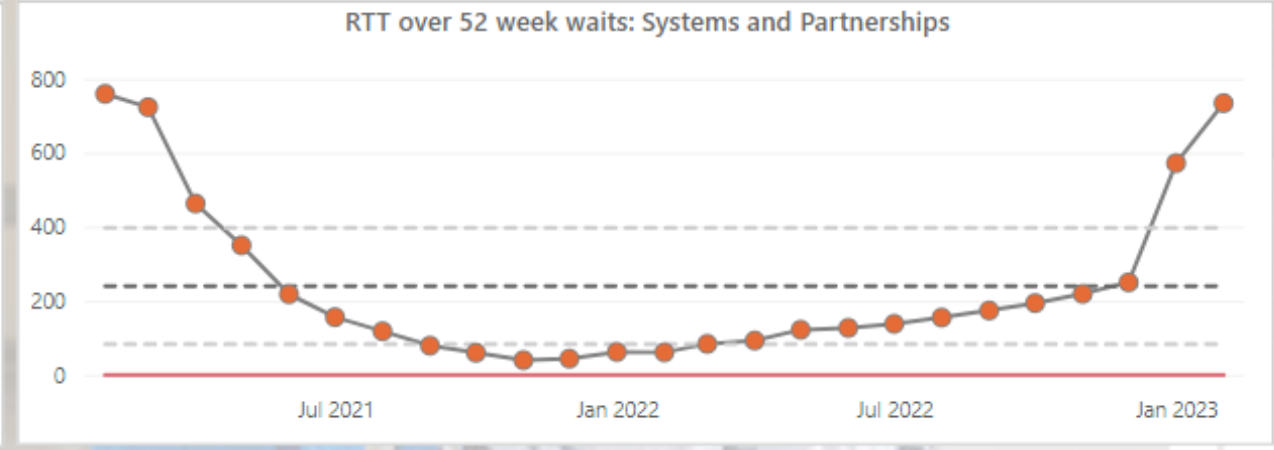
01/04/2019 – 01/03/2023

165		734	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



RTT over 52 week waits

Committee Name: All

GroupName: Systems and Partnerships

MetricName: RTT over 52 week waits

165		734	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	No. of patients waiting greater than 52 weeks from referral to treatment (RTT)	Unvalidated position for February saw 176 patients over 52 weeks. This is an increase from the 160 validated position at the end of January 2023	• Residual patients who chose to defer treatment over Christmas and New Year continue to engaged with and dates negotiated. Patient Choice is often a root cause to the longer waiting patients, especially for school aged children. • Continued capacity problems with Respiratory Medicine resulting in patients waiting longer for their first appointment. Additional WLI clinics have been agreed to support reducing this although ongoing sustainable capacity issue remain. • Increased leave being taken before March 2023. These figures will continue to be impacted with each round of IA. March will see three consecutive days of IA from JrDr. While the trust will not be standing down activity in advance of these dates, it is anticipated to cause an impact.	Weekly PTL meetings are conducted to review all patients on the Surgical Waiting list over 40 weeks. This is attended by several lines of management and operational support including RTT Management, HoA, DDs and Waiting List Management. This ensures any delays can be progressed as well as decision made on patients suitable next steps. The 52w+ PTL is validated weekly to ensure accurate reflection and national reflection of the trust.	Continued review of activity against plans in weekly PAG meetings PTL meetings continue where pathways and confirmed and challenged Radiology requests are expedited through Head of Service to avoid delays in booking and reporting.

RTT over 52 week waits

Committee Name: All

GroupName: Systems and Partnerships

MetricName: RTT over 52 week waits

165		734	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
NGH	01/02/23	No. of patients waiting greater than 52 weeks from referral to treatment (RTT)	734 over 52+ for Feb	- Continued impact of IA with cancellation of activity in March due to Junior doctors Strike - The Trust has seen an increase in the number of patients waiting over 52+ for treatment due to theatre staffing issues and cancellations, UEC pressures, Increased demand in theatre and urgent cases and is reflective of an increased referral rate and demand and reduced clearance. - ENT, T&O, Gynaecology remain our most challenged specialties having seen a significant increase in the number of referrals over the past year compared to 2021. - ENT has seen a significant increase in number of 52+ and continues to be constrained.. The directorate has a number of patients waiting for outpatients over 35 weeks which is a risk re. long waiting position and has seen a 55% increase in referrals have also supported UHL with Mutual Aid all long waiting patients which needed to be prioritised impacting on internal long waits position and contributing to deteriorating position. Additional capacity to support reduction in backlog has been agreed with locums and audiologists. - Critical Incident and OPEL 4 status has resulted in activity being stood down and PTL's being stood down which has impacted greatly on position and resultant backlog contributing to the above position. - Theatre maintenance and seasonal reduction in activity have also impacted - Administrative staffing issues in H&N impacting • Covid-19 sickness and Operational Pressures continue. • Cancer/urgent patients demand increasing and are prioritised impacting ability to clear long waiters.	- ENT met with COO,DCOO and HOA agreement to source additional locums and Audiologists to support outpatient waits • Weekly monitoring in place with Divisional PTL's and a weekly Access Board meeting where 52+weeks is a standing agenda item. • Weekly RTT meeting with H&N attended by DCOO, Head of Access and DM with directorate team • Patients requiring outpatient within ENT being reviewed by Lead Clinician to understand whether they can be placed onto PIFU • Additional ODP's in theatre in place - Focused work on long waiters to deliver 0 78+	• Harm reviews completed on any patient who waits more than 52 weeks for treatment. • 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

Committee Name: All

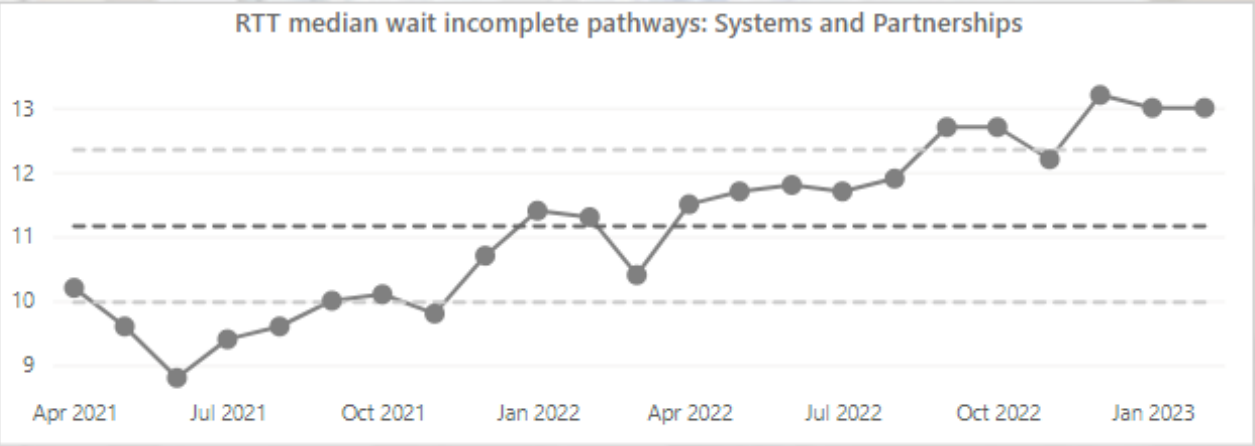
GroupName: Systems and Partnerships

MetricName: RTT median wait incomplete pathways

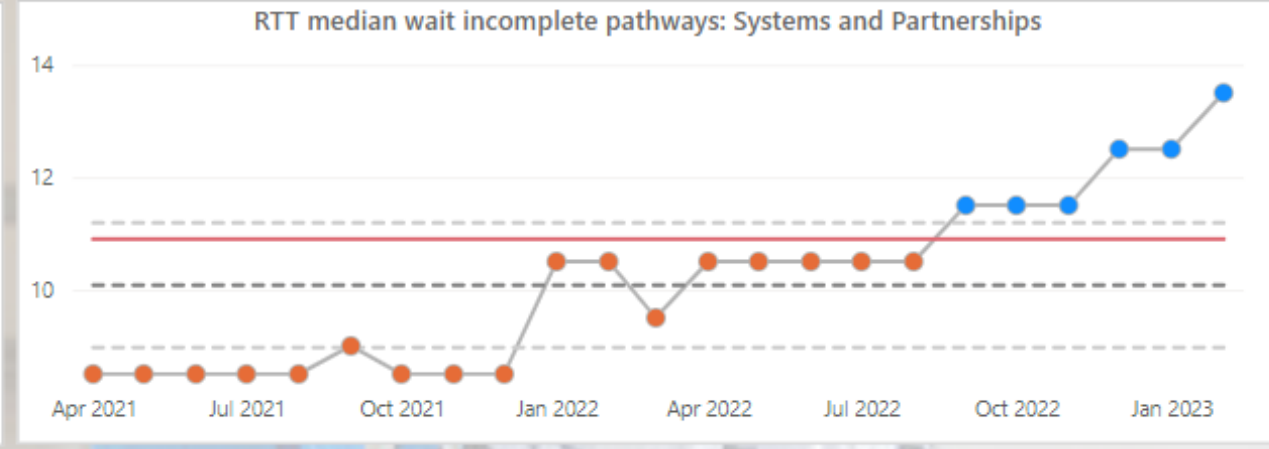
01/04/2019 – 01/03/2023

13.00		13.50	10.9
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



RTT median wait incomplete pathways

Committee Name: All

GroupName: Systems and Partnerships

MetricName: RTT median wait incomplete pathways

13.00		13.50	10.9
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	% of patients waiting more than 18wks for treatment (incomplete pathways)	Median RTT waiting time has remained stable between the last two months ate 13.0 weeks	Delays caused by capacity issues with specialties like Pediatrics, Resp Medicine and Neurology are seeing patients wait in excess of 30 weeks for their 1st appointment. Patient choice in the treatment of longest waiting admitted pathway patients. Capacity within Oral Surgery and specialist treatments Cancer increased demand resulting in large amounts of capacity being priorities for these patients	Theatre Utilisation Board continues to meet to address untilisation and productivity of theatres PTL meetings are continuing and being used to ensure patients are at the right point in their pathway to progress as quickly as possible. Validation of the PTL continues with the RTT validation team to ensure the validity of the PTL	.
NGH	01/02/23	% of patients waiting more than 18wks for treatment (incomplete pathways)	Increase in Median waits reflective of increased 52+ waits	- Constrained ENT capacity with increased level of Demand as per size of waiting list and 52+	Same as size of waiting list and 52+ Weekly monitoring at PTL and standing agenda item and Access Committee Continued efforts to increase use of A&G, triage and Virtual consultation and PIFU to support the position.	Weekly monitoring at PTL and standing agenda item and Access Committee Continued efforts to increase use of A&G, triage and Virtual consultation and PIFU to support the position.

Theatre utilisation

Committee Name: All

GroupName: Systems and Partnerships

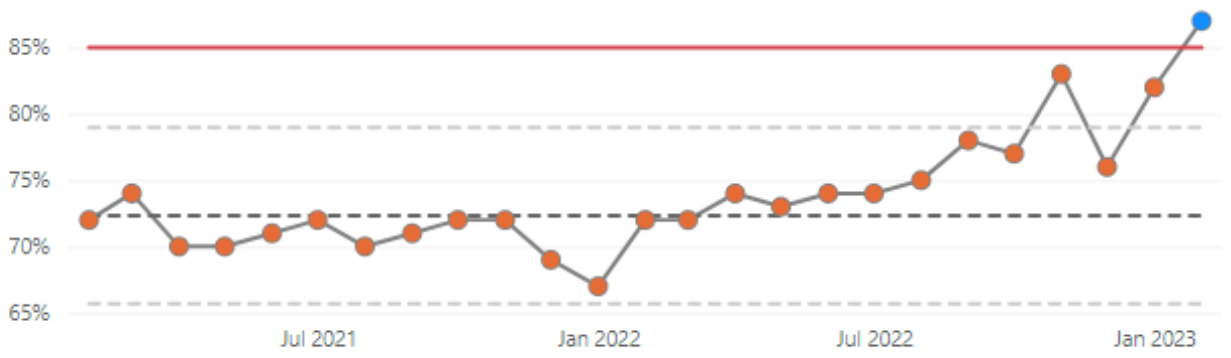
MetricName: Theatre utilisation

01/04/2019 – 01/03/2023

87.00%	85.00%	78.00%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

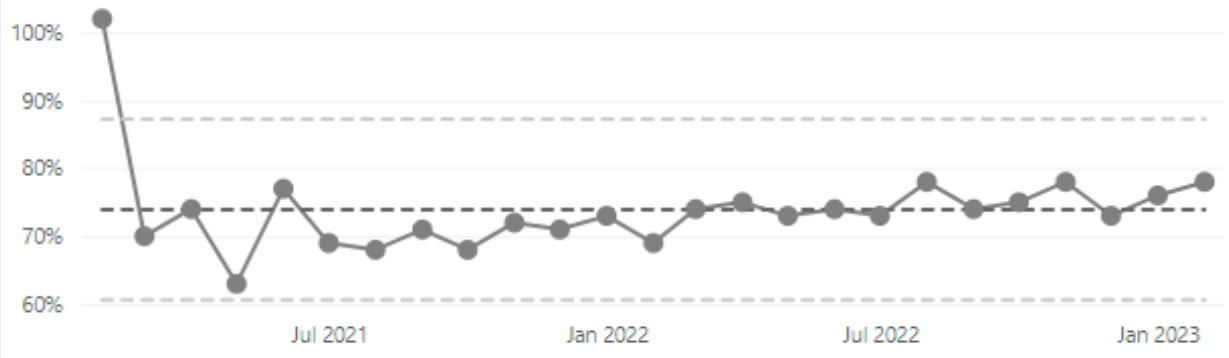
Kettering General Hospital

Theatre utilisation: Systems and Partnerships



Northampton General Hospital

Theatre utilisation: Systems and Partnerships



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	Theatre utilisation % against 85% national target	The chart tells us that theatre utilisation was at 87% in February	Theatre utilisation was affected by a high number of late cancellations of patients due to choice and late pre-assessment processes as well as the RCN industrial action	Daily monitoring of booking levels by the WL Office and a focus on theatre starting times to ensure patients are not cancelled due to running out of time	Relaunched 642 and theatre scheduling meetings with improved booking practice. New accommodation for Pre-Assessment Service identified in early December for increased face to face appointments -further delays to estates work to increase this further.
NGH	01/02/23	Theatre utilisation % against 85% national target	Theatre Utilisation shows 76%.	Nexus system unable to retrieve historic timing of operations for consultants, CCS unable to retrieve this data from Nexus. Nexus needs to be upgraded. Inadequate Pre Op slots to cope with demand therefore difficulty in back filling lists.	6-4-2 weekly meetings - confirm and challenge Planning meetings with consultants Work in progress with CCS regarding utilisation figures of lists	Weekly utilisation meeting Consultants to put timings of operations on waiting list cards / ICE.

Bed utilisation

Committee Name: All

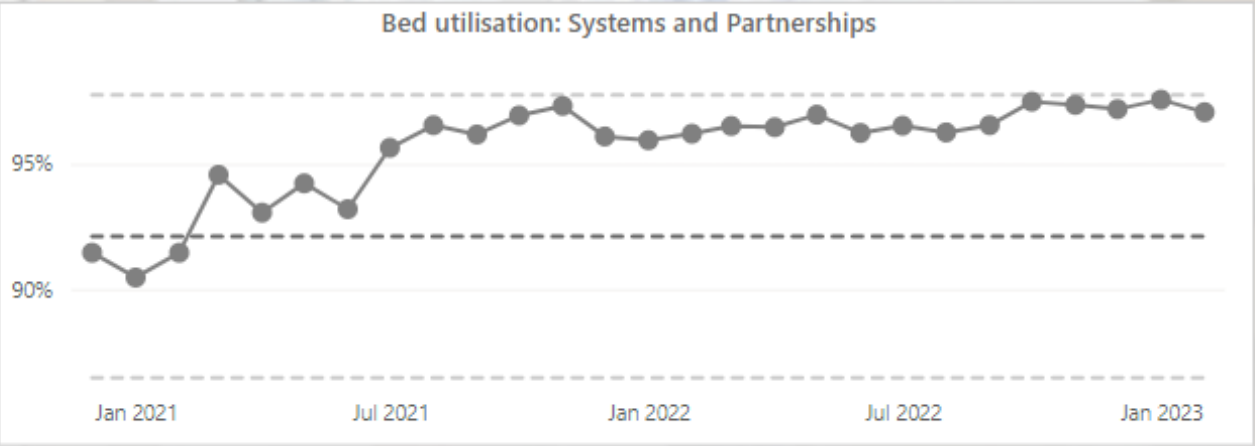
GroupName: Systems and Partnerships

MetricName: Bed utilisation

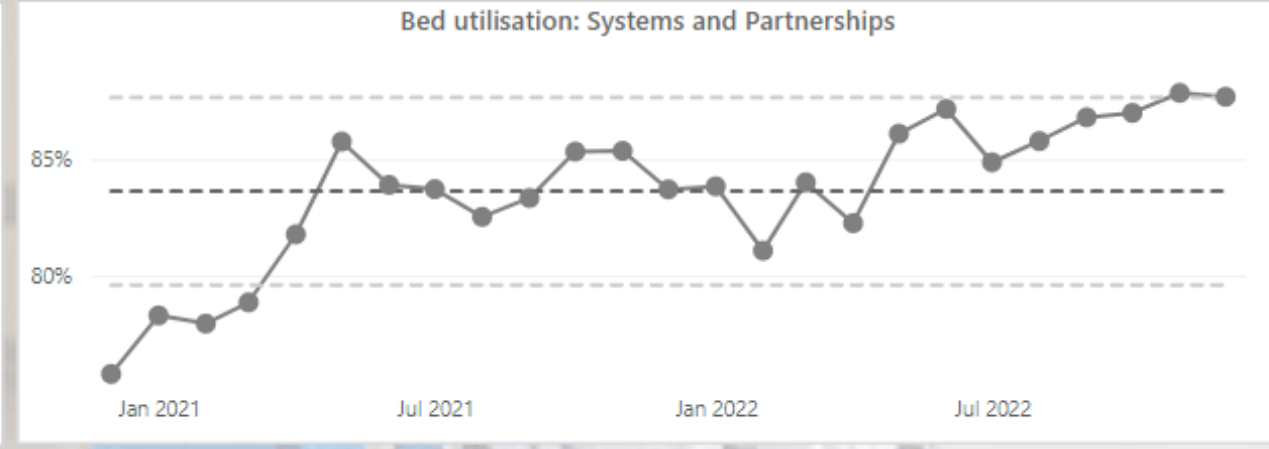
01/04/2019 – 01/03/2023

97.06%		87.67%	
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	% General and acute beds utilised - excluding maternity	As per last month bed utilisation remains consistently high in February above 97%.	From mid December the Trust has been on Critical Incident and pre-emptively opened capacity to support ambulance strike on 21/12. This resulted in the full capacity protocol being instigated, and at one point 70 additional beds over winter capacity were opened and all elective wards were occupied by emergency patients. Following de-escalation from this additional capacity elective activity has resumed business as usual meaning we remain at a utilisation of over 97% which is to be expected at this time of year.	Recommended national bed utilisation levels are 85% to support patients getting in to the right bed without delay. Utilisation over this, in particular over 95%, impedes timely flow and will result in patients being bedded in non ideal areas resulting in multiple bed moves. Bed modelling predicts continued 95%+ utilisation and this will require escalation capacity to manage peaks and impediment to flow and experience due to multiple moves.	Winter schemes provided additional pathway 1, 2 and 3 capacity being implemented by ASC and NHFT. MADE events planned as required & pre-bank holidays.

Stranded patients (7+ day length of stay)

Committee Name: All

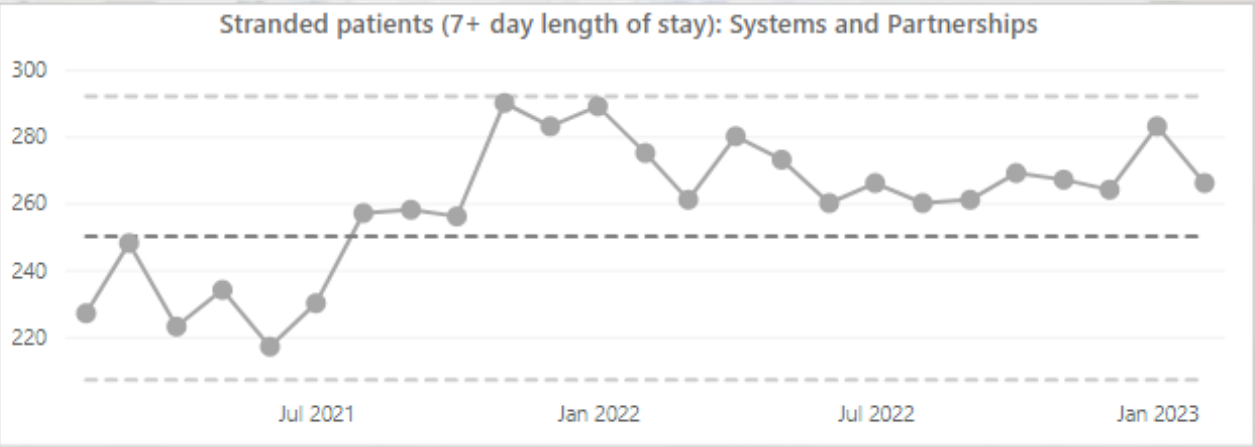
GroupName: Systems and Partnerships

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

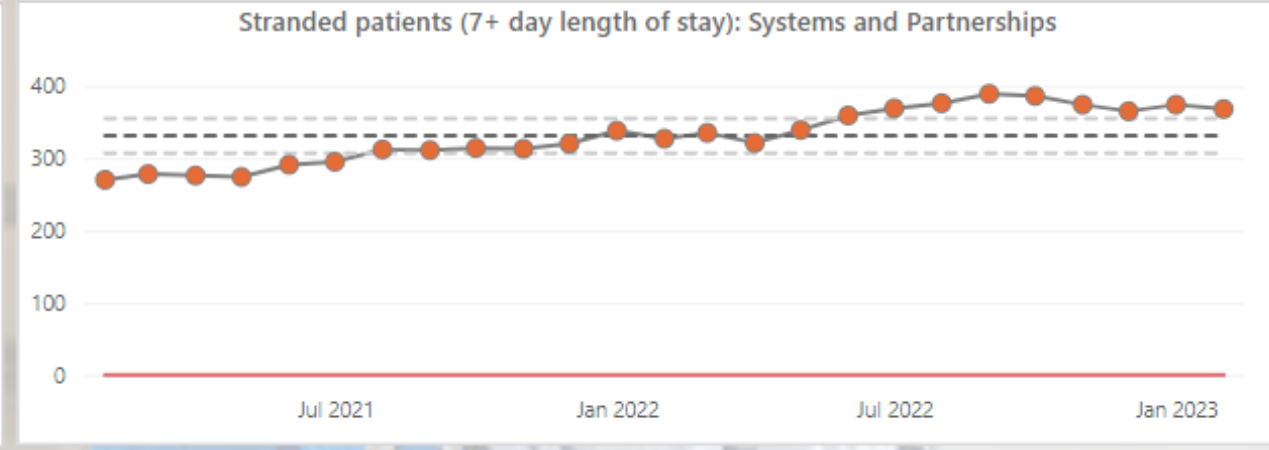
01/04/2019 – 01/03/2023

266		368	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Stranded patients (7+ day length of stay)

Committee Name: All

GroupName: Systems and Partnerships

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

266		368	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	Number of patients with a LoS > 7 days	The number of stranded patients has remained stable as a monthly snapshot over the last 5 months with a sharp spike in January. Similar pattern to January 2022 which would be reasonable when aligned to the increase in activity and acuity over the winter / cold weather. Our aim is to get it to less than 250.	Emergency demand over Christmas and early January resulted in super surge escalation capacity being required, and as a result over this period we saw an increase in the number of stranded patients. From the 12th Jan onwards this has reduced as the impact of the focus internally and from system partners took effect.	The Newton supported Patient Flow Dashboard has been launched which provides real time data on LoS and sits alongside the complex discharge dashboard. This data access will support our operational teams focus in the key issues and support reducing the number of stranded patients.	Sustaining high quality board rounds with clear actions Ensure delays expedited incl diagnostics. Max use of SDEC services. Involvement of senior nurses and matrons to support senior decision making at board rounds
NGH	01/02/23	Number of patients with a LoS > 7 days	Slight increase in stranded this is multifactorial and whilst there is an increase in stroke prevalence which has direct increase in stranded and super stranded numbers stranded numbers have remained relatively static.	the number of patients discharged within 48 hous has overall increased despite this we still continue to have a large number of stranded and super stranded patients. some of this are due to specialist services such as oncology, renal and stroke with longer LOs associated with these services. some are related to delays in accessing social and community care/beds with a circa of 60 pts a each day waiting for supported discharges across the pathways.	continued work and emphasis on board rounds, ensuring treatment plans are progressed with any internal delays escalated are being embedded across all wards. continued work across the trust for ensuring transfer of care forms are completed in a timely way to further reduce delays in supported discharges.	Weekly review of every patient waiting longer than 7 days is part of rolling weekly confirm and challenge which the ward sister directly feeds into

Super-Stranded patients (21+ day length of sta

Committee Name: All

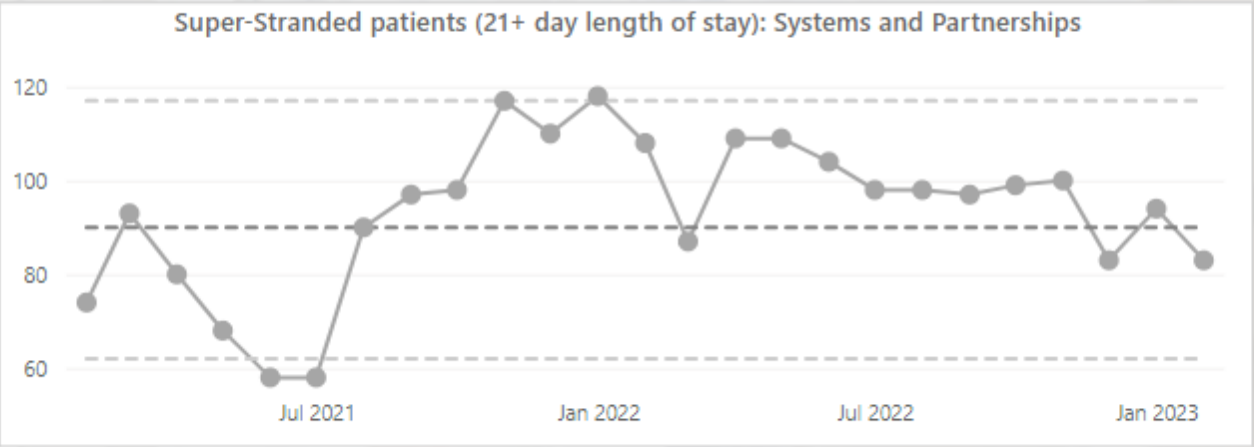
GroupName: Systems and Partnerships

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

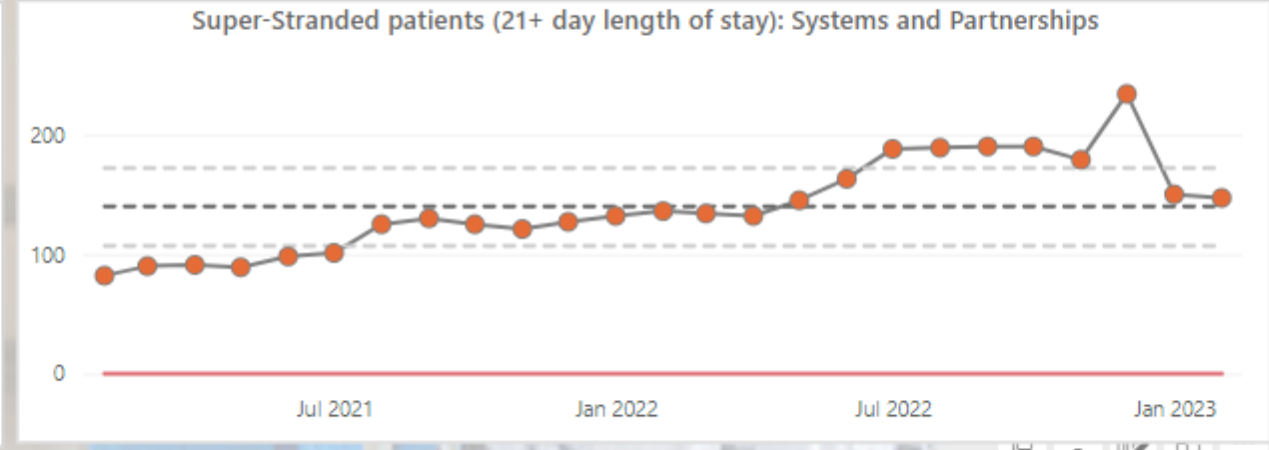
01/04/2019 – 18/02/2023

83		147	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Kettering General Hospital



Northampton General Hospital



Super-Stranded patients (21+ day length of sta

Committee Name: All

GroupName: Systems and Partnerships

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

83		147	0
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	Number of patients with a LOS> 21 days	The number of Super Stranded (LoS>21 days) had reduced significantly at the beginning of December and has started to rise by the beginning of January and has plateaued but remained below our previous 5 month average of 95.5.	Emergency demand across December and early January resulted in super surge escalation capacity being required, and as a result over this period an increase in the number of super stranded patients. From the 12th Jan onwards this is reducing as the impact of the focus internally and from system partners is seen.	The Newton supported Patient Flow Dashboard has been launched which provides real time data on LoS and sits alongside the complex discharge dashboard. This data access will support our operational teams focus in the key issues and support reducing the number of stranded patients.	Sustaining min delays with supported discharge quality SBAR submission Working closely with system partners to expedite delays 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. Allocated actions for all senior dc co-ordinators on a daily basis to keep focus on these patients.
NGH	01/02/23	Number of patients with a LOS> 21 days	reduction in number of super stranded	Super stranded numbers are compounded by the fact that we hold the regional beds for stroke, oncology and haematology and renal services all of these tend to push the LOS up due to the nature of their illness. Stroke in particular has had significant increase in presentations and admissions with difficulty access stroke rehab beds in the community. Significant delays associated with acute confusion/delirium pts due to no community bed capacity. this has been repeatedly flagged to ICB and the promise of bedded solution last July did not materialise - had very limited criteria for acceptance and now has ceased accepting.	Continued work with stakeholders across the system to reduce delays associated with supported discharges. Continued to push teams to utilise VW or NGH@home as means of expediting discharge in particular for those on IVAB's. Ward staff had refresher training on completing transfer of care forms with good attendance. A full stakeholder pathway review is underway to really identify what the bottle necks are in the stroke pathway.	Ongoing daily full attendance at HUB with all system partners to agree pathways for patients requiring supported discharges. continued work across the system with focus on frailty admission avoidance and reduced LOS

Patients with a reason to reside

Committee Name: All

GroupName: Systems and Partnerships

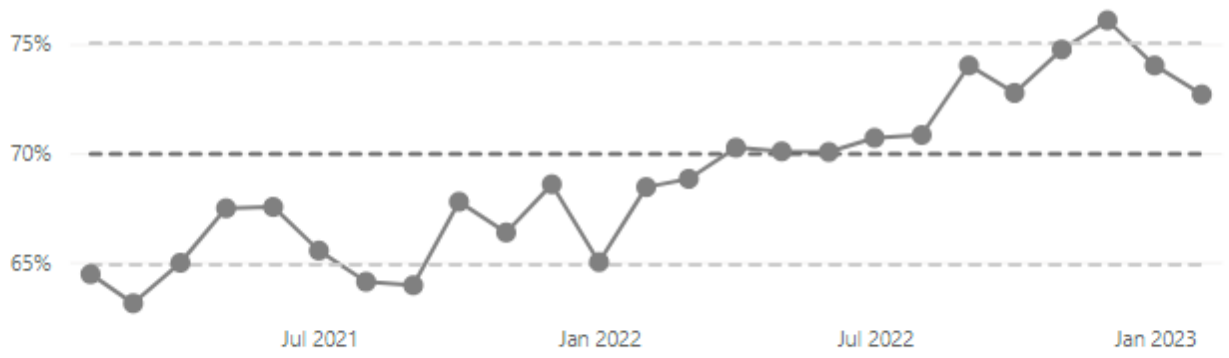
MetricName: Patients with a reason to reside

01/04/2019 – 18/02/2023

72.69%		67.64%	95.00%
KGH: Current Value	KGH: Current Target	NGH: Current Value	NGH: Current Target

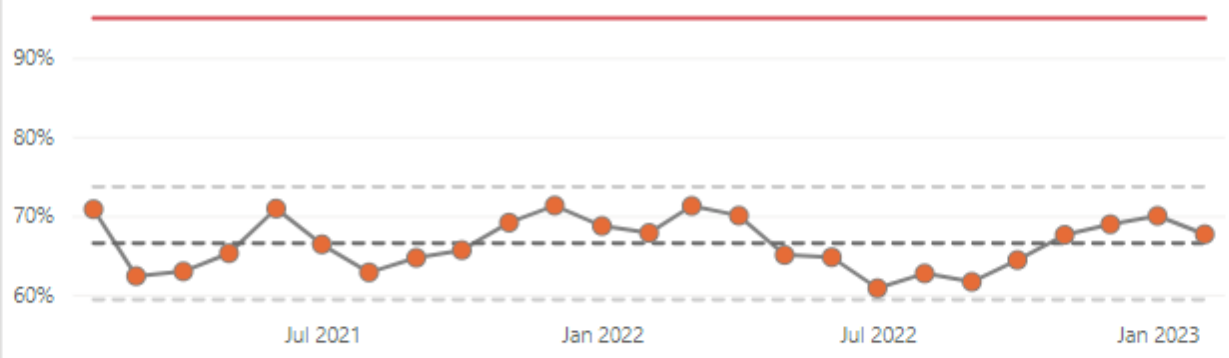
Kettering General Hospital

Patients with a reason to reside: Systems and Partnerships



Northampton General Hospital

Patients with a reason to reside: Systems and Partnerships



Site	Date	Background	What the chart tells us	Issues	Actions	Mitigations
KGH	01/02/23	Number of patients who have a reason to reside in hospital based on national reason to reside criteria	An increasing proportion of patients since April 2021 are being identified as having a reason to reside with a increase in the proportion to 74% in the last month reflecting increased acuity and drive to discharge those with no reason to reside	26% of patients (approx. 120-130) do not have a reason to reside, with approx. 70-80 of these awaiting supported care discharge, and a further 20-30 patients in the process of identifying the supported discharge package required. The remaining 10-20 are in our gift to ensure are discharged expediently	Continued focus on those patients not requiring supported discharge (pathway 0) with the aim to have <8 by the 18.00 every day Ensuring the process to allocate a supported package has minimal delays and is identified while a patient has a reason to reside Continued work with partners to ensure a continual flow of supported discharges take place and identify gaps in provision	Gaps in complex P1 and P3 provision identified and Adult Social Care identifying provision as part of winter funding - ongoing sustainable provision required. Rehab capacity is a bottleneck.

NGH Board, 6 April 2023
Finance Performance

Month 11 (February 2023)
FY 2022/23

Executive Summary

Income and Expenditure - Year to Date

The YTD position is a £13.7m deficit compared to a planned deficit of £1.8m, resulting in an adverse position of £11.9m.

Income and Expenditure - In Month

The 'in-month' financial position for Month 11 reports a deficit of £1.2m, against a break-even, an adverse variance of £1.2m.

This £1.2m month 11 variance is in-line to the monthly run-rate variance, due to some non-recurrent income offsetting the planning assumptions of ICAN delivering expenditure reduction opportunities in the latter half of 22-23.

At NGH, the monthly overspend level has remained static; some prior period non-recurrent income balancing out non-recurrent expenditure. There continues to be spend on agency and temporary staffing to cover vacancies, staff sickness and operational pressures.

In non pay is inflationary pressures continue to impact.

Capital and Cash

NGH has YTD actual capital spend of £14.2m, with a further £10.6m capital orders raised resulting in a total commitment of £24.8m. Capital funding to be spent is £28.3m, with some commitment falling into 2023/24. Cash Balance at the end of February is £11.5m.

2022/23 M11 Summary – Year to Date

Description	NGH Trust Position				NGH M11 Position		
	22-23 Annual Plan	Year To Date			In Month		
		Plan	Actuals	Variance	Plan	Actuals	Variance
	£m	£m	£m	£m	£m	£m	£m
Total Income	449.2	408.7	412.2	3.5	37.1	38.3	1.2
Total Pay	(309.0)	(281.5)	(294.5)	(13.0)	(25.3)	(26.6)	(1.3)
Total Non Pay	(138.1)	(125.7)	(128.5)	(2.9)	(11.5)	(12.7)	(1.2)
OPERATING DEFICIT	**2.1**	**1.5**	**(10.8)**	**(12.3)**	**0.3**	**(0.9)**	**(1.2)**
Capital Charges	(6.5)	(5.6)	(5.2)	0.4	(0.5)	(0.5)	0.0
Trust Surplus/(Deficit)	**(4.4)**	**(4.1)**	**(16.0)**	**(11.9)**	**(0.2)**	**(1.4)**	**(1.2)**
System Support Funding	2.5	2.3	2.3	-	0.2	0.2	-
I&E Surplus/(Deficit)	**(1.9)**	**(1.8)**	**(13.7)**	**(11.9)**	**(0.0)**	**(1.2)**	**(1.2)**

NGH Finance Year-to-Date

The YTD position of £13.7m deficit is £11.9m adverse to plan.

Income – £3.5m favourable (excluding decarbonisation grant) from other sources of income, including non-recurrent VAT review & £0.6m income from local authority to reimburse iCAN.

Pay – The £13.0m adverse key driver is £4.3m under-delivery against the efficiency target to date. £2.5m of Agency expenditure addressing flow issues. Total agency spend of £25.3m also due to vacancy cover at premium costs.

Non-pay – £2.9m adverse due to £1.1m under-delivery on the efficiency target. Plus professional fees, training and recruitment costs; some of this income backed for projects e.g. Electronic Document Management Service.

NGH Finance In-month

The in month position is a £1.2m deficit which is £1.2m adverse to plan.

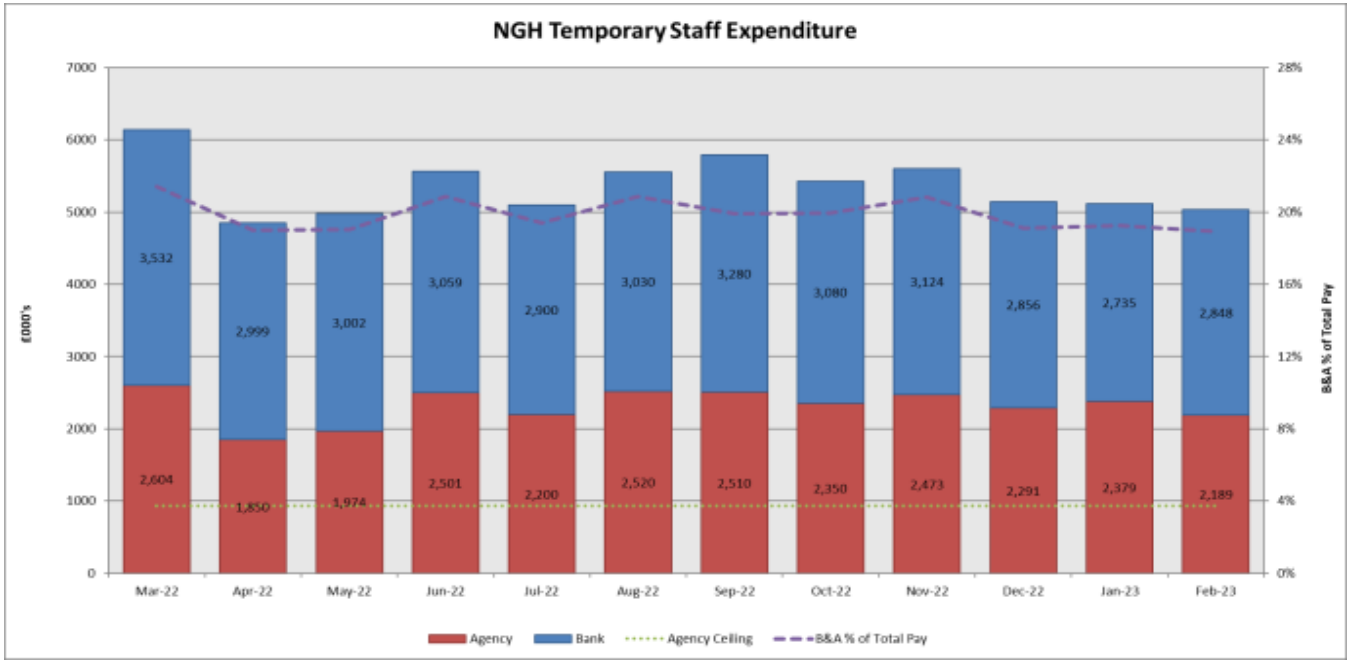
Income – £1.2m favourable this month due to training income, CDC funding, plus a catch up in a few salary recharges of staff costs.

Pay – £1.3m adverse, with very similar spend patterns to recent months. Key driver is £0.6m under-delivery against the efficiency target to date. Ongoing costs to manage flow c. £0.3m per mth and the premia on high level of Bank & Agency (19% of pay)

Non-pay – £1.2m adverse in month is higher than recent months due to training costs (offset in income), plus one-off revenue impact of scoping work for the Urgent Treatment Centre.

NGH - Pay: Temporary Staffing

NGH Temporary Staff Costs M11									
	Agency			Bank			Overall Temporary Saff		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Staff Type	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Senior Medical	244	758	(514)	425	738	(313)	668	1,496	(827)
Junior Medical	105	241	(136)	(62)	280	(342)	43	521	(478)
Qualified Nursing	114	362	(248)	310	980	(670)	425	1,342	(918)
Unqualified Nursing	(19)	426	(445)	(134)	477	(611)	(153)	903	(1,056)
Other Staff	116	403	(287)	65	373	(308)	181	775	(594)
Total	**560**	**2,189**	(1,629)	**604**	**2,848**	(2,244)	**1,164**	**5,037**	(3,873)



In Month 11 Temporary Staff expenditure was £5.04m, 18.9% of Total Pay.

The higher proportions shown in the graph March 2022, include Vaccination Centre work which ceased in November 2022.

Agency spend at £2.2m per month is over double the rate required in the £11.2m p.a.
agency ceiling proposed by NHSI.

The most significant change in February figures is an accrual release of £0.1m following improved information on junior locums employed in recent months.

A significant amount of this temporary staffing spend covers vacancies, with additional shifts for enhanced care or improve flow also providing pressure on the pay budgets.

Statement of Financial Performance - NGH

The key movements from the opening balance are:

Non Current Assets

- M11 Capital additions of £6.0m, consists of PSDS Decarbonisation spend of £2.5m, MESC spend of £2.2m which includes £1.8m of endoscopy equipment, Estates block spend of £0.7m of which £0.2m relates to UPS installation and Digital spend of £0.6m.
- Depreciation in M11 is as plan.

Current assets

- Inventories - £0.5m. Decrease in Pacing stock holding.
- Trade and Other Receivables – £3.1m due to: Increases in NHS Receivables (£0.4m), Trade Receivables (£0.1m), NHS Income Accruals (£0.2m), VAT reclaim (£0.7m), Non-NHS Debtors (£2.0m) and Other Debtors (£0.1m). Decreases in Prepayments (£0.5m).
- Salary overpayments – Increase in month with an overall balance of £0.47m. Year to date overpayments are £0.40m which is slightly more than the same period last year (£0.37m). The number of occurrences is also greater (187 compared to 152).
- Cash – Decrease of £0.9m

Current Liabilities

- Trade and Other Payables – 1.8m due to: Increases in PDC Dividend (£0.5m), Capital Creditors (£4.0m) and Receipts in Advance (£0.6m). Decreases in Trade Payables (£0.7m) and Accruals (£2.6m).
- Provisions £0.1m – release of Income related provision unutilised.

Non Current Liabilities

- Finance Lease Payable - £0.1m. Nye Bevan and Car Park lease repayment (£0.1m). ROU assets (-£0.05m).
- Loans over 1 year. Repayment of Salix Loan.

Financed By

- PDC Capital – Emergency Capital (£2.7m), Digital Supporting Care at Home (£0.4m), ME2 Digital Histopathology (£0.2m) and Medical Equipment – Breast Screening (£0.2m).
- I & E Account - £1.3m surplus in month.

SOFP

TRUST SUMMARY BALANCE SHEET
MONTH 11 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	218.1	218.1	0.0	218.1	9.6
IN YEAR REVALUATIONS	0.0	0.0	0.0	0.0	0.0	0.0
IN YEAR MOVEMENTS	0.0	8.5	14.4	6.0	28.9	28.9
LESS DEPRECIATION	0.0	(13.4)	(14.6)	(1.2)	(16.0)	(16.0)
NET BOOK VALUE	208.5	213.2	217.9	4.8	231.0	22.5
CURRENT ASSETS						
INVENTORIES	6.7	7.0	6.4	(0.5)	6.9	0.2
TRADE & OTHER RECEIVABLES	17.7	17.2	20.3	3.1	22.0	4.3
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	12.4	11.5	(0.9)	4.0	(6.1)
TOTAL CURRENT ASSETS	35.4	37.6	39.2	1.6	33.8	(1.6)
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	30.1	40.0	41.7	1.8	44.2	14.1
FINANCE LEASE PAYABLE under 1 year	1.3	1.3	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	2.2	2.1	(0.1)	2.1	(0.2)
TOTAL CURRENT LIABILITIES	33.9	43.7	45.4	1.7	47.8	13.9
NET CURRENT ASSETS / (LIABILITIES)	1.5	(6.1)	(6.2)	(0.1)	(14.0)	(15.5)
TOTAL ASSETS LESS CURRENT LIABILITIES	210.0	207.0	211.8	4.7	217.0	7.0
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	7.1	14.4	14.4	(0.1)	13.9	6.8
LOANS over 1 year	0.7	0.5	0.4	(0.1)	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	16.8	16.7	(0.1)	16.2	6.6
TOTAL ASSETS EMPLOYED	200.4	190.3	195.1	4.8	200.8	0.4
FINANCED BY						
PDC CAPITAL	268.5	268.5	272.0	3.5	273.3	4.8
REVALUATION RESERVE	47.8	47.6	47.6	0.0	47.6	(0.2)
I & E ACCOUNT	(115.9)	(125.8)	(124.5)	1.3	(120.1)	(4.2)
FINANCING TOTAL	200.4	190.3	195.1	4.8	200.8	0.4

Dedicated to excellence

NHS
Northampton General Hospital
NHS Trust

Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	5th April 2023
Agenda item	6
Title	CQC Final Report Update: Inspection of Maternity Services
Presenter	Ilene Machiva – Deputy Director of Midwifery
Author	Ilene Machiva – Deputy Director of Midwifery

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	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
Receipt of, and provision of assurance around CQC Final Report	Group Clinical Quality, Safety and Performance Committee, 31 March 2023

Summary

The Final CQC Report was received by the Trust on Friday 17th February 2023 following the focused CQC inspection on the Maternity Service on 30th November 2022. The overall rating for Safe and Well-Led remained unchanged - 'Requires Improvement'. The CQC has identified 'Must do' and 'Should Do' actions' for the Maternity services. An action plan has been developed and is in progress.

The Board of Directors is requested to receive the final report and indicate its assurance in respect of the Trust's action plan.

Appendices

Appendix 1 – CQC final report
Appendix 2 – Action Plan

Risk and assurance

Assurance around Maternity CQC Final Report

Financial Impact

N/A

Legal implications/regulatory requirements

N/A

Equality Impact Assessment

Delivery of the action plan will lead to positive impacts for children, young people and families.

Paper

INTRODUCTION

The Maternity services at Northampton General Hospital were subject to a focused CQC Inspection on the 30th November 2022. The Final CQC Report was received by the Trust on Friday 17th February 2023. The overall rating for Safe and Well-Led remained unchanged at 'Requires Improvement'.

The CQC gave the following reasons for keeping the rating for the focused inspection as 'Requires Improvement':

- Not all midwives and medical staff had completed level 3 safeguarding training or training in infection prevention and control
- Staff did not consistently complete checks of specialist equipment and there were some out of date and missing items on emergency trolleys
- Staff did not always fully and accurately completed records in relation to antenatal appointment and birthing plans
- The service did not always have enough staff to care for women and keep them safe or to support their choices in birthing options
- Infection, prevention and control was not always followed to reduce the risk of infections, from the environment and the use of PPE

However:

- The service had enough staff to care for women and keep them safe. Staff had undertaken mandatory training in some key areas and skills. They worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well
- The service managed safety incidents well and learned lessons from them
- Staff understood the service's vision and values, and work was in progress to support the culture of the unit to promote these.

The report further identifies detailed findings that informed the overall rating that the Trust was given.

The CQC requested an action plan of the 'Must Do' and 'Should Do' actions that the Trust is going to take to meet the Health and Social Care Act 2008, associated regulations and any other legislation that have been identified that the Trust is in breach of. The Action Plan was submitted on the 24th March 2023, and is attached (Appendix 1) of the report. There are six 'Must Do Actions' and four 'Should Do Actions' identified in the report.

Must Do Actions and Should Do Actions

The Maternity service with the support of wider Trust colleagues, have made significant progress in addressing both the 'must do and should do' actions as evidenced in the table below and the attached action plan. There are agreed timelines with wider stakeholders to achieve the actions that remain outstanding.

Action the trust MUST take to improve:

- The Trust must ensure the premises used by the service provider is safe to use for their intended purpose and are used in a safe way. 12 (2) (d)
- The Trust must ensure the reduction of the risk of, and preventing, detecting and controlling
- the spread of, infections, including those that are health care associated;12 (2) (h)
- The Trust must follow appropriate guidance in the proper and safe management of medicines; 12 (2)(g)
- The Trust must ensure the security of the unit is reviewed in line with national guidance. Regulation 12

- The Trust must ensure staff complete mandatory, safeguarding and maternity specific training in line with the Trust's own target. Regulation 12(1)(2).
- The Trust must ensure staff complete regular skills and drills training, especially in relation to birthing pool evacuation. Regulation 12(1)(2) (c)

Action the trust SHOULD take to improve:

- The trust should ensure there are the required staff to implement a robust system in maternity triage to include escalation process, monitoring and documentation.
- The trust should ensure the required staffing to enable women to have a choice of birthing options which include the Barratts birthing unit and home birthing.
- The trust should ensure the culture of the service continues to be addressed to ensure staff are listen to and measures put in place to improve the wellbeing of staff.
- The trust should ensure systems were in place to ensure audits were consistently reviewed and actions taken to address any identified concerns

Key

	Must Do Actions	Current Position	Actions	Completion Date
1.	The Trust must ensure the premises used by the service provider is safe to use for their intended purpose and are used in a safe way. 12 (2) (d)		All equipment checklist in the maternity service aligned, across all clinical areas. Ward managers as part of daily tasks reviewing all checklist to confirm that equipment checks have been completed	Completed
2.	The Trust must ensure the reduction of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;12 (2) (h)		Cleaning schedules for Robert Watson to be reviewed. Meeting planned for DDOM and Head of Hotel Services for w/c 03.04.23. Maternity Teams participating in Trust wide event 'Take your Gloves Off Compliance levels with National Standards Efficacy audits on Sturtridge identified as below expected standard and included onto the Estates and Domestic action plan for actioning. Intrapartum matron participating in Audits, to support improvement and embedding changes with the Teams on Sturtridge	01/05/23
3.	The Trust must follow appropriate guidance in the proper and safe management of medicines; 12 (2)(g)		A medicines management database is being developed by the Midwifery Matrons to support tracking of actions from themes that arise from the pharmacy spot checks.	03/04/23
4.	The Trust must ensure the security of the unit is reviewed in line with national guidance. Regulation 12		Quotations for required work with maternity security obtained and currently going through the procurement process	01/08/23
5.	The Trust must ensure staff complete mandatory, safeguarding and maternity specific training in line with the Trust's own target. Regulation 12(1)(2).		Current compliance levels for level 3 safeguarding children and adults below the Trust target of 85% Different training opportunities being made available to both midwives and obstetricians as noted in the action plan	01/07/23
6.	The Trust must ensure staff complete regular skills and		Pool evacuation drill added to the Training week with first session completed on 15th March	Completed

	drills training, especially in relation to birthing pool evacuation. Regulation 12(1)(2) (c)		2023. Baby Abduction Drill in place with a drill completed in December 2022, and March 2023, with plans to repeat drills every 6 months.	
	Should Do Actions	**Current Position**	**Actions**	**Completion Date**
1.	The Trust should ensure there are the required staff to implement a robust system in maternity triage to include escalation process, monitoring and documentation		Maternity escalation policy currently under review to align with Regional Opel status escalation process Core Team of midwives identified to support with the embedding of the Birmingham Symptom Specific Obstetric Training System (BSOTS) Triage process BSOTS training for clinical teams in progress and near completion Delay in launch of BSOTS due to delays with printing of documentation tools	01/02/23
2.	The Trust should ensure the required staffing to enable women to have a choice of birthing options which include the Barratts birthing unit and home birthing		Workforce strategy being developed to support reduction in vacancy factor and improved retention Recruitment retention midwife in post to support with improved retention	01/08/23
3.	The Trust should ensure the culture of the service continues to be addressed to ensure staff are listen to and measures put in place to improve the wellbeing of staff.		Building Tomorrow Together Work in progress and will inform the Maternity Strategy Leadership development days, planned including Kings' Fund Leadership training Culture awareness training planned for Q1 2023/24 Monthly meetings between lead PMA and the maternity leadership team to discuss things from staff feedback, and identify shared solutions	01/06/23
4.	The Trust should ensure systems were in place to ensure audits were consistently reviewed and actions taken to address any identified concerns		Clinical audit forward plan agreed for 2023/24 which feeds into and includes the Trust priorities and links with NICE guidance and National Audit reports Maternity Service Audit Lead included in incident action planning to ensure that requested audits are relevant and robust and link with other workstreams as appropriate All audits where compliance is not shown have an action plan agreed and re-audits undertaken to establish the effectiveness of the actions	Completed

The attached action plan (Appendix 1) has been developed and will form part of the Maternity Quality Improvement Plan.

Care Quality Commission

Northampton General Hospital NHS Trust

Northampton General Hospital

Inspection report

Cliftonville
Northampton
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Date of inspection visit: 30 November 2022
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Northampton General Hospital

Requires Improvement 

We inspected the maternity service at Northampton General Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

The inspection was carried out using a post-inspection data submission and an on-site inspection where we observed the environment, observed care, conducted interviews with patients and staff, reviewed policies, care records medicines charts and documentation. Following the site visit, we conducted interviews with senior leaders and reviewed feedback from women and families about the trust.

We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We analysed the results to identify themes and trends.

Northampton General Hospital is the main site for maternity services for the trust. It comprises of a central birth suite which was midwife lead, a labour ward with maternity theatres and a close observation unit. Post and antenatal wards, day assessment unit, and maternity triage.

A higher proportion of mothers (16%) were in the second most deprived decile at booking compared to the national average. There were 75% white women, with 12% Asian or Asian British and 6% Black or Black British women. There was also an increasing community presence of an Afghanistan community.

Maternity services delivered 4,019 babies between January and December 2021.

We did not rate this hospital at this inspection. The previous rating of requires improvement remains.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Requires Improvement ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Northampton General Hospital.

Our rating of this service stayed the same. We rated it as requires improvement because:

- Not all midwives and medical staff had completed level 3 safeguarding training or training in infection prevention and control.
- Staff did not consistently complete checks of specialist equipment and there were some out of date and missing items on emergency trolleys.
- Staff did not always fully and accurately completed records in relation to antenatal appointment and birthing plans.
- The service did not always have enough staff to care for women and keep them safe or to support their choices in birthing options.
- Infection, prevention and control was not always followed to reduce the risk of infections, from the environment and the use of PPE.

However:

- The service had enough staff to care for women and keep them safe. Staff had undertaken mandatory training in some key areas and skills. They worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well.
- The service managed safety incidents well and learned lessons from them.
- Staff understood the service's vision and values, and work was in progress to support the culture of the unit to promote these.

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement

Mandatory training

The service provided mandatory training in key skills to all staff, but not all staff were up to date with mandatory training.

The service had a maternity services training strategy it was version controlled and in date. It had an up to date training needs analysis which outlined the specific maternity training requirements for each staff group and the frequency of the training.

A weeklong learning programme had been developed which encompassed different days of training. This covered refresher training, new requirements or training as a result of incidents. The training feedback from was positive, staff felt the protected time enabled them to focus on the training. This programme was still being rolled out to all staff, which meant we found gaps in some areas.

The trust target for mandatory training was 85%.

Nursing and midwifery staff had not always kept up to date with their mandatory training. We saw overall compliance with mandatory training was 79.7%, which was below the trust target. Infection prevention and practice training compliance was 43.5% for midwifery staff and fire safety training was 74.5%. However, compliance rates were above 85% for the mandatory training modules, covering safeguarding for children, equality and diversity, Governance and record keeping and moving and handling.

Medical staff had not always kept up to date with their mandatory training. Medical staff overall compliance with training targets was 69.7%, which did not meet the trust target. Medical staff compliance was below target for safeguarding adults' level 1 (72%), equality and diversity (78%), fire safety training (56%), infection prevention and practice (44.9%), manual handling (66.7%) and health and safety (72%).

The service had identified 45 staff to be trained in Advanced New-born Life Support and 97% of these had completed the initial course with 73% completing the annual update.

Midwifery staff completed basic life support training and 81.9% of midwifery staff had completed this. Only 77.5% of medical staff had completed adult basic life support training. This meant the trust could not be assured the staff on all shifts were suitably trained and up to date.

Staff completed regular skills and drills training. These relate to onsite training sessions on topics which may have been identified from incidents or as a refresher. Information provided by the service showed 85% of staff had completed a maternity specific multidisciplinary training day. However, we found gaps in relation to Birthing pool evacuation.

The service offered women the use of three birthing pools in the Barratts Birthing centre and a birthing pool on the Sturridge labour ward. We asked the trust to provide training data for birthing pool evacuation. After the inspection the service told us pool evacuation training was a module in the point of care simulations which had been suspended during the COVID-19 pandemic and again in April 2022. The service told us they had introduced a pool evacuation training video in the PROMPT (PRactical Obstetric Multi-Professional Training), training day and plan to reinstate simulations in 2023. The figures shared with us reflect 78% of midwives and 81% of maternity support workers have participated in these training sessions. However, face to face training had not been completed since the beginning of the pandemic. Therefore, the trust could not be assured staff were competent in the event of sudden deterioration of women in the birthing pool who required evacuation.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff were offered training on how to recognise and report abuse and they knew how to apply it. However not all staff have completed it.

Maternity

The service offered level 3 online safeguarding children training to staff. We looked at the content and saw it included expected areas including child sexual exploitation and female genital mutilation (FGW). Arrangements were in place for women with, or at risk of, FGM. Any identified issues were referred to an obstetric consultant and the safeguarding team.

The face to face training included scenario-based training, from incidents or new items which could relate to the service. The service provided a schedule throughout 2023 to cover level 3 safeguarding training sessions with a range of topics and external speakers.

Level 3 safeguarding children training was provided to staff in line with national intercollegiate (2019) guidelines. However, not all nursing and midwifery staff received specific training for their role on how to recognise and report abuse. Only 45.8% of eligible midwifery staff had completed safeguarding adults' level 3 training. However, 88.1% had completed safeguarding children level 3 training.

Not all medical staff received training for their role on how to recognise and report abuse. Medical staff did not complete level 3 safeguarding adults training and compliance with level 3 children's training was 58.7%.

This meant the trust could not be assured the staff on all shifts were suitably trained and up to date with safeguarding requirements.

After the inspection the trust told us following discussions with the Integrated Care Board (ICB) their aim was to meet their target of 85% training in Adult Safeguarding Level 3 by 1st April 2023 and were on trajectory to achieve this. We will review this on our next inspection to ensure compliance has been met.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were designated safeguarding midwives, however, staff told us there was a lack of defined roles and responsibilities. This meant there was a reliance on the safeguarding midwives to deal with all safeguarding referrals which meant they lacked the capacity to address them all. This meant there was a risk some safeguarding concerns could be missed due to capacity or lack of knowledge.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service met with social services monthly to discuss unborn babies, review cases and share concerns.

The safeguarding team and the specialist team for ethnic minorities (BAME-black, Asian and minority ethnic, specialist team) worked together to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

There was a new baby abduction policy. Staff received a copy and were required to sign off they had read and understood the policy. A near miss of a baby abduction in May 2022, investigated August 2022, prompted the renewed policy. Since the introduction of the new policy, there had been no simulations to ensure staff understanding of the policy or that it was embedded into daily practice. This meant the trust could not be assured that the staff know how to respond in the event of the risks around baby abduction.

We raised concerns about baby abduction with the senior management team. The service sent us a letter dated 22 December 2022, confirming the immediate actions they had taken. A baby abduction drill was undertaken on 16th December 2022. The drill concluded that the staff demonstrated good knowledge of immediate actions required following an abduction as well as ongoing actions. However, this drill did not include external stakeholders, staff articulated who they would call. The service plans to complete a full multi-agency drill in February 2023.

Maternity

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Measures were not always in place for equipment and control measures to protect women, themselves and others from infection. Ward areas were not always clean, and some furnishings were not well-maintained.

Cleaning records were not up-to-date and demonstrated some areas were not cleaned regularly.

We reviewed the cleaning audits for the last 3 months for Robert Watson and the Labour ward. The average of these audits was 98% and 97% respectively, however, during our inspection we found areas which were not clean and equipment which had not been maintained or repaired.

We identified a shower on the Robert Watson ward contained mould and other areas had dust and dirt not removed from general cleaning. Fridge temperatures checks were not consistently done, and this meant items stored in them could be at risk of not being effective or safe to use. We found pool equipment was stored under the sink, in the labour birthing pool room, this placed the items at a higher risk of infection. We found damaged chairs on both wards which would impact the effectiveness of cleaning.

The service could not be assured staff cleaned equipment after contact with women. When women were discharged from Robert Watson ward there was no system to inform the cleaning staff the area required cleaning. On a busy ward this placed a risk of areas not being cleaned between women using the same space.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). For example, we saw blood and urine samples handled without gloves. Babies having their nappies changes by the midwife, not wearing a disposable apron and gloves. This meant there was a higher risk of transference in relation to infections.

We raised concerns about infection, prevention and control at the end of the inspection to the leadership team. After the onsite inspection the service sent us a letter dated 7 December 2022, confirming the immediate actions they had taken. An environmental cleanliness audit on Labour ward and Robert Watson was completed on the 1st December 2022. The service took actions to address the areas found and a daily hand hygiene and PPE audit are now in place. Fridge temperature checks were put in place and being monitored. In addition, we were told the mould in the shower had been removed.

Environment and equipment

Equipment used in emergency situations was not always checked, however, the design, maintenance and use of facilities, premises kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Although staff carried out daily safety checks on specialist equipment, we found the required items within the trolleys did not always correlate with the checklist.

On Robert Watson ward the obstetric emergency trolley and the eclampsia emergency tray, had missing items against the checklist, in addition it also contained items not on the list. These inconsistencies could have had an impact on women's care as staff relied on the items within the trolleys in an emergency or daily use.

The resuscitaire on Robert Watson and transitional care both had missing items, reflecting the items had not been cross-referenced with the checklists provided. We also identified a large number of items available but not listed on the checklist, which impacted on the storage of essential items which were required in line with policy.

We raised concerns about the checking of emergency equipment during the inspection to the leadership team.After the onsite inspection the service sent us a letter dated 7 December 2022, confirming the immediate actions they had taken. The service confirmed the trolley checklist on Robert Watson, had been brought in line with the rest of the maternity unit. Information about the changes were shared with staff as part of the 'Take Five communication tool' during handovers.

Most equipment we reviewed was in date for servicing. For example, all equipment we reviewed had been serviced within the last year and displayed labels to confirm this.

The service had suitable facilities to meet the needs of women's families. The Barratts midwifery-led unit women had access to birthing pools, birth balls and stools to support movement in labour. However, it was identified these facilities were not always accessible due to staffing levels.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff did not always identify and quickly acted upon women at risk of deterioration

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately.

The triage system used was based on an evidence-based triage system. This system was developed to better assess and treat pregnant women who attend hospital with pregnancy related complications or concerns. The service had set the timeframe to be seen by a midwife as 15 minutes recommended by the evidence triage system tool.

The service had a maternity assessment centre where women could telephone the department to obtain advice. The triage telephone was located in the antenatal clinic. This was a conscious decision to have the telephone removed from the physical triage, which reduced the bias on any actions agreed in response to the caller's needs.

On 17 October 2022, the triage unit was moved to be within the same geographical footprint of the labour unit. When women arrive in triage, the service's standard was to be seen by a midwife within 15 minutes. The midwife completed some initial screening of blood pressure, pulse, and temperature. The women were then RAG rated (red amber green), which provided timescales and priority when women should be seen, depending on the urgency of their concern or symptoms.

An audit had been completed in May 2022 prior to the triage move. The audit identified that 100% arrival time was recorded, however the time seen by the midwife was recorded on 94% of occasions, and the doctor 73%. This meant the times women waited was not always recorded to ensure they were seen within the required timeframes. All women had an initial assessment including palpation and auscultation of the fetal heart on arrival. The audit showed for palpation was 88% and auscultation of the fetal heart 94%. The outcome of the audit noted, incomplete documentation of time seen by a doctor and the full initial assessment to include palpation and auscultation.

Maternity

On the day of the inspection we reviewed the recording of the times women had arrived, been seen by a midwife and the times seen by the doctor. The records between 7.00pm and midnight showed women waited an average of 30 minutes before being seen by a midwife. Average waiting for a doctor was an hour. Between the hours of 8.00am and midday, the times to see a midwife varied from 20 minutes to an hour. The recording of the time seen by the doctors was inconsistently recorded.

The service was about to launch the full implementation of the Birmingham symptom specific obstetric triage system (BSOTS) method of triage assessment and was developing training for staff in using the system. However, no audit had been completed following the relocation of the triage unit. This meant there was a risk the measures were not in place to support the staffing requirement to meet the planned timeframes. The delay of women being seen in triage, could have had an impact of the care they receive to support their care and the care of the baby.

The service told us they planned to put in place a new audit for the triage system, to consider the embedding of system and any waiting times, however, we were not given a timeframe for this.

The new-born and infant physical examination (NIPE) screens babies for specific conditions, ideally within 72 hours of birth. The service audited the completion of NIPE examinations and in quarter 2 achieved 95% compliance. Those who had not received a NIPE their details were examined and any possible action to reduce a reoccurrence was considered.

The service used a nationally recognised tool called the Modified Early Obstetric Warning Score (MEOWS) to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any women whose condition was deteriorating.

The outcome of a serious incident in 2021 identified concerns over whether the MEOWS scores had been measured and acted upon appropriately. An audit was completed in May 2022, which reflected the actions taken to prompt the use of MEOWS, this included training, shared outcomes of the audit and support for future workstreams.

A further audit was completed in June 2022 and noted MEOWS were now being used routinely for all maternity inpatient patients. Further actions from this audit identified the need to align all relevant guidelines and paperwork to ensure clarity in the escalation process. We found this area of routinely recording MEOWS had improved and continued to be monitored.

The governance team reflected on this work and the improvements which continued to be made in this area. This ensured safety measures were in place and enabled escalation processes to be instigated to address the risk.

Staff knew about and dealt with any specific risk issues. Cardiotocography (CTG) was used during pregnancy to monitor fetal heart rate and uterine contractions. The service told us all staff were required to complete a competency test before they were recorded as passing the training. Overall compliance with CTG training and competency test was 94%.

The service had access to centralised CTG monitoring system at the nurse's station to support reviews. In addition to this 'fresh eyes' were completed by midwives to maintain an object overview of any CTG readings.

The service provided training in intermittent auscultation (IA). This was the technique of listening to and counting the fetal heart rate for 1 minute following a contraction during active labour for low risk women. Overall compliance with IA training was 62% but the service provided information that showed they had plans to improve compliance from December 2022, however no date of planned completion was identified.

Maternity

Staff in maternity theatres used the World Health Organisation (WHO) Surgical Safety Checklist which was a tool aimed at decreasing errors and adverse events in theatres and to improve communication and teamwork. We reviewed the WHO surgical safety checklist and found them to be completed correctly.

Staff completed risk assessments for each woman antenatally, on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. For example, staff completed carbon monoxide monitoring at the point of booking. We reviewed the recording of carbon monoxide monitoring and found completion in the last 3 months as follows: August 68%, September 80% and October 68%. Smoking can have an impact on the growth of the baby and these figures are below the required levels as indicted under the Saving Babies lives agenda. To support this area, the service had initiated an action plan and had recruited a band 4 Maternity Tobacco Dependency Advisor to support promotion and training in this area.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of deteriorating mental health during pregnancy. Staff screened women for depression using the 'Whooley questions.' The questions are a screening tool which was designed to try and identify symptoms that may be present in depression. There was a referral process to ensure support was accessible for women who identified with possible mental health needs.

Women who chose to birth outside of guidance were provided with support and face to face meetings with theprofessional midwifery advocate (PMA). This enabled them to discuss risks and choices and complete birth plans together.

We observed the handovers in each of the wards. The details shared included all necessary key information to keep women and babies safe. Staff used the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover information. We saw woman's language or communication needs were discussed to ensure they were able to share important information or to obtain any related consent.

There was a pharmacist present during handover on labour ward, this was to support any drug requirements or discuss current issues. This addition to the handovers was as a result of work completed on medicines datix issues.

A communication folder was used to ensure the sharing of information or any required actions for that shift. The unit used a method called, 'take 5' this was a system to reflect any new paperwork requirements or initiatives.

At the time of our inspection the Maternity Voices Partnership (MVP) raised concern around delays in the induction of labour, which was in the process of being audited and reviewed to identify next steps. Other ongoing developments were around the promotion to use the Barratts birthing centre and accessible home births.

Midwifery Staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Maternity

Managers calculated and reviewed the number of midwives, maternity support workers and registered general nurses, needed for each shift in accordance with national guidance. There was a planned ongoing recruitment approach. One of the tools used to consider staffing levels was red flags.

A red flag event was a warning sign that something may be wrong with midwifery staffing, based on the National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. The service told us the system for reporting red flags changed from LMNS Red Flag data to Birthrate Plus Acuity.

During November there had been 10 red flag events. There had been 10 incidents reported for cancelled Elective Caesarean sections in the 6 months prior to our inspection. The service told us they were unable to capture the data for red flags due to the labour ward coordinator not being supernumerary which was not in in line with best practice. It was anticipated the service would be collating future red flags via the Birthrate Plus Acuity App, which had been introduced in November 2022. We did not have access to data to show how this had impacted the service since its introduction. This meant the service could not be assured of all the possible staffing issues which may have occurred and not been recorded during this period of transition.

The service last completed a staffing and acuity review in December 2021 for midwifery staff. This stated a requirement of 197.44 (WTE) band 3 to 8 across maternity services to meet the planned needs of women. The service told us they did not, at the time of our inspection, report planned versus actual data. The service was waiting the updated version of Birthrate plus to review their staffing.

The service shared with us the Northampton General Hospital and another NHS trust Joint Safe Staffing Report for July and August 2022, which was a joint report looking at the overarching workforce for NGH and another NHS trust. The report reflected an increase in the overall vacancy rate to 14%. Recruitment was ongoing but continued to be a challenge. The staffing vacancies were covered by bank staff. We reviewed the data which showed fill rates were not always accurate. During October 2022 the obstetric staffing requirement was only 46.87% filled. Within antenatal only 77% were filled. This meant these areas had reduced staffing to provide the required level of care.

Sickness in July 2022 was reported at 10% due to multiple factors, one being the omicron variant of COVID 19; this had since reduced to 5.5%. Midwifery vacancy rate was at 27.18 whole time equivalent (WTE), recruitment to these posts was anticipated to be achieved through student midwifes and 9international midwives.

We saw the last midwifery staffing paper sent to trust Board was on 30th March 2022; however, the director of nursing had reported to the Joint People Committee on a regular basis with regard to staffing. Due to the changes in management in maternity, a revised paper was due to be submitted to the board in January 2023, in line with the Maternity Incentive scheme requirements.

The service had recruited a maternity recruitment and retention midwife who will support the workforce strategy, look at returning midwives, new recruits along with exit interviews to understand the maternity workforce situation.

The service had a home birthing team along with a community team. However, in the last 6 months the home birthing team had been disbanded due to staff vacancies. The opportunities for women to birth at home had either not been accessible or restricted. The service had recently set up a volunteer pool of midwives who wished to be part of the home birthing arrangements, to enable them to expand their offer to women.

Maternity

The service had a range of specialist midwives to support different areas. We spoke with the bereavement midwife who shared with us the support networks on offer for women who have lost a baby. At the time of our inspection the service was 8.00am to 5.00pm Monday to Friday, this was not in line with the Ockendon (2022) recommendations, however, recruitment was underway to increase the bereavement support to 7 days.

We saw that initially there were 4 teams to provide continuity of care. However, during COVID 19 and the staffing pressure these teams were disbanded with the exception of the team who support women with cultural needs. This team had established positive links with the different communities especially the Afghan community.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women and babies safe.

Medical workforce Consultant obstetricians last year split into obstetrics and Gynaecology This was a clinically led decision to move to this model. Senior consultants reflected this as a strong approach to having the right people who are really engaged with the maternity agenda., Consultants were on site between 8.00am and 22.00pm, 7 days per week, there was a twilight shift and on call arrangements. There was a buddy system in place to provide cover and support for annual leave.

There was a consultant statement of purpose in respect of the roles and responsibilities from the Royal College of Obstetricians and Gynaecologists (RCOG), which was to be followed by the middle grade doctors should they need to escalate a siltation which required a consultant to attend. There had been some tensions with regard to the escalation process with junior doctors and consultants on Delivery Suite, however this had been identified and improvements had been made.

There had been some instability in the senior midwifery side, due to sickness at matron level, which had impacted on the doctor midwife relationship. However, following the senior midwife appointments staff told us they had noted some improvements.

The service had no consultant vacancies. The service told us they had a plan in place to increase consultant staffing from 10 to 12. The service used locum medical staffing when required to fill rota gaps; this supported the out of hours rota gaps that had been a long-standing staffing concern in the service.

Records

Staff did not always keep detailed records of women's care and treatment. Records were not always clear up to date. or easily available to all staff providing care.

Women's notes were not always comprehensive, the service had two recording systems which made it difficult to navigate having all the information easily accessible.

Maternity

We reviewed 7 records across labour and post-natal. These records showed details which should have been completed during antenatal appointments were either missing or completed by the women. These included the birth plan of the midwife or consultant. Carbon testing was not completed consistently and some records in relation to fetal movements at 25 weeks had not been completed.

When using paper records the patient sticker was not always attached, this was not in line with trust policy and meant should a page be separated from the file it would be difficult to know who the record belonged to.

The multiple systems did not talk to one another. As one was paper the other an electronic system call. For example, we reviewed a record which required a woman to receive an anaesthetic review, however we saw the checklist had not been completed on either system, this meant the trust could not be assured the review had been completed.

The service had identified this as a risk through the maternity service data set. There was a digital strategy support by the LMNS in moving to fully electronic records and the project had already engaged staff in the requirements and introduction. However, there was no specified time frame for this or any measures in place to consider how to provide consistency of record keeping, until the digital system is implemented.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines well.

Staff completed general medicine records accurately and kept them up to date. However, we reviewed the medicines records for the controlled drugs (CD) on Labour ward and found recording errors. For example, Pethidine had only been signed by one midwife, which was not in line with trust policy.

We saw the controlled drug book had not been checked for 5 days; however, this had been picked up by the trust audit and reported as an incident. We saw 6 epidural medicines had been administered with no administration time recorded or the required sign off, which had not been identified in the audit. This meant the service could not be assured the required checks were consistently completed for controlled drugs.

Staff did not complete maternity specific medicines management training. The service told us this was being developed and would be in place by the end of January 2023. However, all new midwives starting work in the service were required to complete a medicines management session during their orientation.

The service told us they had been working with staff to raise awareness of medicine errors and how to address these. A quality improvement project had been launched, using a maternity assessment admission check list in September 2022 to raise awareness, which in turn showed an increase in incident reporting which helped identify training needs. However, we saw there was no significant decrease with the incident reporting around medicines, which meant the changes and improvements had not been embedded to consistently reduce ongoing errors.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Maternity

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

There was a daily review of the incidents reported to consider the level of harm and the appropriate person to review and action. This ensured any trends or areas of increased risk were managed swiftly. Various quality projects were initiated from the datix reviews. For example, the work on medicines.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if, and when, things went wrong. Governance reports included details of the involvement of women and birthing people in investigations and monitoring of how duty of candour had been completed.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people. Clinical governance meetings were held quarterly and looked at all the data and any outcomes from incidents. For example, the use of MEOWS and the SBAR tool for monitoring women and ensuring detailed handovers. Following training and posters to remind staff, this area had improved.

Staff were given the opportunity to develop areas of learning following incidents. The trust recognised leaders within their sphere of expertise in midwifery and maternity and invested in a fellowship programme to support the development of leadership and clinical practice. The ward sister was given protected time to develop a project, which looked at the streaming of women above 20 weeks, who present at the ED (emergency department). The project looked at how midwifery could teach practitioners in ED the risks to look for and guided actions. The outcomes of the project were to set up a delivery room in ED and provide training in the use of MEOWS and the SBAR tools. This had created better outcomes for the women, as needs where being identified swiftly and the correct support obtained. The learning from this project had been shared across the trust and will be publicised in a journal as improved practice.

There was evidence that changes had been made following guidance and consistent auditing.

The national guidance when supporting women with Postpartum haemorrhage (PPH), was changed from syntometrine to oxytocin.

The service made this change, but through audit noticed an increase in major obstetric haemorrhages (MoH). The service returned to using syntometrine for all women except those that have contraindications for syntometrine.

Managers investigated incidents thoroughly. We reviewed 2 serious incident investigation reports and found a detailed chronology was completed with care and service delivery problems considered and learning identified. Women and their families were involved in these investigations and meeting minutes showed where families had declined a Healthcare Safety Investigation Branch (HSIB) investigation of an incident that affected them. The weekly serious incident group meeting fed up to the quality and safety committee and to the trust board. Managers monitored incidents that were open over 60 days and we saw action plans in place to address these to a conclusion.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Maternity

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.

The service was led by an associate director of nursing, deputy director of midwifery and a head of midwifery. The triumvirate was supported by divisional managers and in addition to clinical governance. There was a clear line of reporting into the executive directors and board. There was a governance group in place and regular directorate governance meetings were held. Relevant information was escalated to the trust quality and safety committee.

There was a new leadership structure in place within maternity. We heard how the new structure would work, which included clear lines of reporting, dedicated non-clinical time to attend regular meetings and clear roles and responsibilities.

Leaders told us they felt supported and had direct access to the board level executive and non-executive director safety champions, as well as regular bi-monthly meetings where risks and issues were escalated.

The service leaders had links with the Maternity Voices Partnership (MVP) and during the inspection we spoke with the MVP chair. The trust leaders, safety champions and the MVP had developed a good relationship and had developed resources to support black, Asian and minority ethnic groups and language needs. Offering a virtual library and support groups.

The director of midwifery met with the board maternity safety champion every month. The maternity board safety champion was well-sighted on issues relating to the quality and safety of the service and a strong advocate for the service at board level.

Vision and Strategy

The service did not have a specific vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was an overarching strategy for the Northampton General Hospital trust, however, there was not a maternity specific vision and strategy.

There was a workforce strategy which was looking at a range of areas to increase staff flexibility across the unit. This included on call arrangements, flexibility around contracts and rotational working to develop and enhance skills. This would be supported by the data from the birth rate plus data to ensure acuity can support the needs of women using the service.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.

Maternity

Women, relatives and carers knew how to complain or raise concerns and information was clearly displayed in visitor areas. The service received 7 complaints in the 3 months prior to our inspection. We reviewed all 7 complaints, three of which referred to the care provided, 1 referenced the lack of options on home birthing and another referred to staffing levels. All the complaints had been investigated and responses provided in line with the services policy.

The service had been on a cultural journey, recognising 12 months previously action needed to be taken to address the culture within the hospital and especially the maternity unit. In February 2022, the service engaged the support of a speak up guardian and the chief executive officer (CEO) also held some connect and share sessions to provide staff with an open forum to discuss their concerns. One area which had been identified was around the rotas and differing contracts, which had been picked up under the workforce strategy.

Within maternity staff raised issues with us of a culture of feeling bullied by senior staff. Senior leaders were open about these issues and the impact these situations had on the workforce. Staff we spoke with felt although there had been the opportunities to speak up in open forum, actions from these meetings had not been addressed and many staff still felt their concerns had not be listen to or addressed. Senior managers reflected with us, how they were still on the cultural journey and further work was required to address the concerns by staff.

The workforce team had undertaken work to ensure midwives who had been recruited from abroad were supported with their transition to their new place of work and culture. The service provided pastoral support to identify cultural nuances and themes from these sessions had led to the development of post OSCE (objective standard clinical examination) international nurse transition (POINT). The idea of the programme was to support international nurses during transition to the trust by providing a robust induction programme. The programme aimed to develop their confidence and autonomy, break down any fear of hierarchy to make international nurses feel included and welcome.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities. However, they had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a meeting structure in place which meant senior leaders and managers had regular opportunities to discuss operational issues. Leaders and managers were clear on the links to trust wide groups and committees to escalate risks and issues. There were also clear links to the Local Maternity and Neonatal System (LMNS) and the integrated care board. Prior to October 2022 the Governance department consisted of a Deputy Director of Governance leading the Governance Department with a Head of Governance and teams beneath them. One of these teams focussed on Clinical Governance (incident investigations) and liaised and supported maternity with incident investigations. This was an informal arrangement and was never included on an organogram due to ongoing discussions around processes. Both the trust clinical governance team and maternity governance team were experiencing significant staffing challenges which had prevented investigations from moving forward, however processes were being realigned to ensure both teams worked collaboratively, and this was reflected in the December 2022 organogram.

Clinical governance meetings were held quarterly. We looked at meeting minutes for the last 3 meetings; they covered topics including safety concerns, incidents, training, feedback, risks, issues, and learning.

We reviewed minutes of the last 3months, from a range of governance and managerial meetings. All had standard agenda's, follow up actions and covered risk, workforce, performance, relevant dashboards estates and external visits.

In relation to supporting women with home births, it was noted some women made a choice to birth outside of guidance. A free birth guideline had been developed and was going through the trust ratification process. All women who required support with decision making on birthing options had an opportunity to, 'meet the matron' run by the PMA (Professional Midwifery Advocate) team. This team provided support with birthing plans and post-natal support to parents who had been unhappy with their experience.

In the 12 months prior to our inspection, the Barratts birthing unit had officially closed two days in September 2022. However, access to using the unit was based on staffing. The service told us they planned daily staffing for the Barratts unit however, these roles were not ringfenced. Therefore, when labour became busy staff could already be allocated to the care of a labouring woman. This meant opportunities to utilise the birthing unit were restricted. Safety aspects were considered which meant it was not always safe for two midwives to be in the unit in isolation, this had led to the unit not being used for its delivery purpose. Recently the unit had been used to support women in early labour or preparation for a caesarean. The management told us they plan to promote the use of the unit to women of low risk, along with a more robust staffing plan.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. However, systems and processes to identify trends were not always in place for all aspects of the service. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

We reviewed the service's maternity quality dashboard. The dashboard provided target figures to achieve some indicators such as midwife to birth ratio and term admissions. We saw these were consistently monitored and actions were taken to reduce the risks.

The dashboard reported on clinical outcomes such as mode of delivery and trauma during delivery. A separate dashboard reflected time from knife to skin different grades relating to caesarean sections. The total elective rate for caesarean sections was 51.4% in Q1, 15.4%. in Q2 and the emergency rate was 25.4% in Q1 and 24.2% in Q2. The trust average for C sections was 39%, the National average was 35%, therefore the trust was above this average, no rational was provided to support the increase.

The service had a risk register in place. We reviewed the risk register and saw risks were identified by a red, amber green (RAG) rated system. We found the risk register had clear updates, and evidence of risk scores reducing, and all risks were progressing within the risk reduction target timelines set by the service.

One red rated risk related to continuity of care as required by NHSE (National Health Service England). Initially there were 4 teams, however these were suspended during COVID 19. With only 1 team maintained; this team supported ethnic groups. The managers planned to review this risk and consider how this requirement could be met in the coming months.

Managers and staff used outcomes from events to drive improvements. The trust had received 2 final reports from the Healthcare Safety Investigation Branch (HSIB) in the 6 months prior to our inspection. There were some general recommendations, and the service had identified these areas and implemented actions. For example, the use of MEOWS. The service was aware they were behind with their serious incident investigations, with their oldest being open for over 1 year. They had accessed support from the LMNS and recruited a consultant to help progress these investigations. A report was shared with the trust board each quarter, which included details of the deaths reviewed and the consequent action plans. Action plans were reviewed to ensure action was taken and embedded.

Maternity

The service participated in relevant national clinical audits, submitting data to the regional maternity dashboard. This meant the service could benchmark against other services in the region and contribute to system wide improvements. The service worked with other trusts in the region to review incidents and share learning.

Outcomes for women were positive, consistent and met expectations, such as national standards. Leaders benchmarked the service against the most recent 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK' (MBRRACE-UK) report and the recommendations discussed at the quality assurance committee meeting.

The service completed a range of audits in relation to Saving Babies lives care bundle V2. These were completed by the fetal surveillance midwife. We reviewed this data, however noted that it had not been completed for the 2 months prior to our inspection. The service told us this was due to a change in staff roles and recognised this needed to recommence as part of the auditing process, however, there was no specified timescale for this.

We reviewed the trust response to a saving babies lives survey which collected information on the progress of trusts to full implementation of the saving babies lives care bundle in October 2022. We noted that the reduced fetal movement survey had not consistently been completed, with completion during August at 88%, September 98% and October 75%. This along with carbon monoxide testing data not consistently being recorded could impact on early identified risk and consideration of appropriate actions.

Managers and staff carried out a programme of repeated audits to check improvement over time. The service had an audit programme in place, recently the audit list had been reviewed and the service had a forward plan to agree future priorities with the management team. However, some systems and processes were not, at the time of our inspection, in place to identify issues or trends in care delivery. For example, the number of women who would had chosen the birthing centre or home birth however had these denied. The audit of triage ahead of the evidence-based triage system implementation, to ensure all the required measures were in place.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had a range of dashboards and action logs which were used to monitor data on a local and national level. We saw these were used in a range of senior meetings to review and consider actions ahead of reporting any requested changes or risks to the trust board.

Maternity and Neonatal Safety Champions Meeting were held monthly. We reviewed the last 3 meetings and found that improvements were discussed in response to feedback, incidents, or complaints. The service used an action log, to monitor and review aspects of the meeting.

In relation to fetal growth restriction, it was noted the detection rates were low at 34%, a project was in place to review and address this area. The monitoring of reduced fetal movement had improved to 95%. Intrapartum fresh eyes monitoring was consistently at 95%

The service provided data on their recording to the national MBRACE survey. Details were addressed within governance meetings to ensure timelines were met and any investigations and learning followed up.

Maternity

Engagement

Leaders and staff actively and openly engaged with women, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.

Maternity voices partnership (MVP) engagement meetings were scheduled quarterly, however additional meetings and drop-in sessions are arranged to address any immediate issue.

The MVP had established service user coffee mornings and the use of a virtual library. MVP meetings were arranged at different locations and times to provide the opportunity for different groups to attend.

We reviewed minutes from meetings and reviewed the actions plans which we identified were either completed or in progress. The MVP chair felt the trust were responsive and actions were driven by feedback from service users. For example, the promotion of home births was responded to with email communication being disseminated to staff to promote this option of delivery.

The service held a wide range of engagement meetings with the different grades of staff. Some of these were held face to face and others through emails, briefings and letters. We also saw engagement, which was service specific, these involved working groups for induction of labour, digital strategy or pieces of work that required action.

The service produced a newsletter for staff in September 2022, which reflected the changes to maternity and the opportunity to discuss any issues. The newsletter was launched along with a meeting held face to face and accessible via teams. The meetings and newsletter reflected the key priorities in maternity and to provided staff with updates and information about the National, Regional or Trust agenda.

The newsletter reflected changes to triage, workforce development, new staff, career opportunities and thanks to staff members. The service plans to hold these events every quarter to ensure engagement and the sharing of information.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services, however levels of completed training was below the trust's targets. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The meet the matron clinic had been recognised as a celebration point in the Ockenden (2022) report. We saw the PMA team met with over 600 women and or partners to support them with outside of guidance birthing plan, options available and post-natal issues.

The continuity of care team who supported people with cultural needs had established a relationship with the local Afghan community. To support them when requiring an interpreter, they had taught the women to say the word, 'interpreter' when they contacted the triage telephone support line. This meant the caller would know immediately the person required the support of language line, before they could explain their reason for the call.

Maternity

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure the premises used by the service provider is safe to use for their intended purpose and are used in a safe way. 12 (2) (d)
- The trust must ensure the reduction of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;12 (2) (h)
- The trust must follow appropriate guidance in the proper and safe management of medicines; 12 (2)(g)
- The trust must ensure the security of the unit is reviewed in line with national guidance. Regulation 12
- The trust must ensure staff complete mandatory, safeguarding and maternity specific training in line with the Trust's own target. Regulation 12(1)(2).
- The trust must ensure staff complete regular skills and drills training, especially in relation to birthing pool evacuation. Regulation 12(1)(2) (c)

Action the trust SHOULD take to improve:

- The trust should ensure there are the required staff to implement a robust system in maternity triage to include escalation process, monitoring and documentation.
- The trust should ensure the required staffing to enable women to have a choice of birthing options which include the Barratts birthing unit and home birthing.
- The trust should ensure the culture of the service continues to be addressed to ensure staff are listen to and measures put in place to improve the wellbeing of staff.
- The trust should ensure systems were in place to ensure audits were consistently reviewed and actions taken to address any identified concerns.

Our inspection team

During our inspection of maternity services at Northampton General Hospital we spoke with 24 staff including leaders, midwives and administration staff.

We visited all areas of the unit including central delivery suite, the Barratts birth unit, maternity triage, day assessment, and Robert Watson postnatal ward. We reviewed the environment, 7 records and equipment checks whilst on site. Following the inspection, we reviewed data we had requested from the service to inform our judgements.

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors, along with two specialist advisors with expertise in midwifery.

The inspection was overseen by Carolyn Jenkinson Head of Hospital Inspection as part of the national maternity services inspection programme.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/ what-we-do/how-we-do-our-job/what-we-do-inspection

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Northampton General Hospital
NHS Trust

Key

BLUE – Complete
GREEN – In progress and on track
AMBER – Behind schedule – corrective plan in place
RED – Behind schedule – no corrective plan in place. Deadline not met

CQC 'Must Do' & 'Should Do' Action Plan

	Agreed Action	By When	Led By Whom	Evidence of compliance	Date completed	RAG
Trust Must Do Actions						
1.	The Trust must ensure the premises used by the service provider is safe to use for their intended purpose and are used in a safe way. 12 (2) (d)	01/01/23	GH (Intrapartum Matron) LL (Inpatient Matron) CF (HoM)	All equipment checklist in the maternity service aligned, across all clinical areas. Ward managers as part of daily tasks reviewing all checklist to confirm that equipment checks have been completed Importance of correct check, and correct equipment being put in the emergency trollies, shared as part of the 'take five' and safety huddles on every shift 11am Maternity safety briefing huddle implemented, and confirmation of equipment checks and any equipment issues raised at huddle	01/01/23	
2.	The Trust must ensure the reduction of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;12 (2) (h)	01/05/23	LL (Inpatient Matron) GH (Intrapartum Matron) CF (HoM) HS (ADN IPC)	IPC team completed weekly environmental cleanliness audits on Labour Ward and Robert Watson to ensure standards were being maintained, until 16th December 2022, when the functional risk areas scores were achieved. Environmental Audits now being completed in line with Trust guidance (Compliance document embedded)		

	Agreed Action	By When	Led By Whom	Evidence of compliance	Date completed	RAG
				IPC Team completed Hand Hygiene and PPE (combined audit tool) audits and then handed back to Maternity Matrons to continue monitoring in line with Trust requirements on 12/12/22. Where scores were below the Trust compliance threshold of 90%. One to one refresher was provided at the time of audit. (Compliance document embedded) The IPC Team provided PPE refresher training to over 50 members of the maternity team in the 2 weeks following the visit and provided cascade PPE training to four Practice Development Midwives / Matrons to continue this training Maternity Teams participating in Trust wide event 'Take your Gloves Off'. The Trust has signed up to the NHSE Regional Take Your Gloves Off Campaign which focuses on 12 key tasks where gloves are not required and this messaging is being shared across the Trust including Maternity in March and April 2023. Cleaning schedule for Robert Watson Ward does sit within the FR2 category, the cleaning frequencies and schedules have been reviewed and are correct for this Functional Risk Rating and area. National Standards Efficacy audits were completed in December 2022 and March 2023 for Sturtridge and Robert Watson and scored 88.4% and 93.5%, respectively. The audit failures on Sturtridge had already been identified and included onto the Estates and Domestic action plan for actioning. Intrapartum matron participating in Audits, to support		

	Agreed Action	By When	Led By Whom	Evidence of compliance	Date completed	RAG
				improvement and embedding changes with the Teams on Sturtridge Estates and Domestic action plan in progress and is reviewed monthly at the maternity Governance meeting with areas of concerns escalated to the Maternity Risk meeting, and Maternity safety Champion meetings.		
3.	The Trust must follow appropriate guidance in the proper and safe management of medicines; 12 (2)(g)	COMPLETED 03/04/23 03/04/23 COMPLETED COMPLETED	AB (Obstetric Pharmacist) AD (Clinical Director) CF (HoM)	Maternity Pharmacy Team in post and embedded into the Team and the workings of the maternity services Pharmacy staff will be making random spot checks of the CD books in maternity to ensure CDs are signed in/out by two members of staff. Any discrepancies will be escalated to the midwifery team. Locally, midwives involved with drug errors are supported to complete a reflection in line with Trust medicines policy. A medicines management database is being developed by the Midwifery Matrons to support tracking of actions from themes that arise from the pharmacy spot checks. The Medicines Safe and Secure Audit frequency has been increased from 3 monthly to 1 monthly on Labour Ward since December 2022. As of 1/4/23, the pass mark for this audit will be increased to 19/20 across the Trust. Any ward that does not reach this target will also be reassessed the following month (i.e. Balmoral/Robert Watson/Maternity Day Unit/Transitional Care/ANC may also revert to the monthly process if needed). All new midwives receive a medicines management introduction session led by a pharmacist – these		

	Agreed Action	By When	Led By Whom	Evidence of compliance	Date completed	RAG
		COMPLETED		sessions are part of the induction timetable that the Practise Development Team (PD) team put together. The maternity pharmacy team are also supporting the PD team to put together the annual refresher medicines management questions for midwives.		
		COMPLETED		The maternity pharmacy team keep an ongoing Datix database to record all datix incidents submitted and identify trends		
		COMPLETED		Maternity Pharmacy Team attend the patient safety meetings when to discuss specific incidents relating to critical medications, including the Maternity Risk add Governance meetings		
		COMPLETED		Named Consultant obstetric lead reviews medication incidents. Obstetric Lead meets with the Obstetric pharmacist to discuss trends from the incident reports and agree required measures to improve practise Tools implemented to support in clinical practise with medicines management such as the RCOG VTE sticker introduced for use in the drug charts to aid enoxaparin dosing		
		COMPLETED		Medications safety folders implemented in each ward area. Folders include medicine administration templates, SoPs, discharges process, and administration guidance. Ipads in use in the clinical areas to support ease of access to medicines management information		
		COMPLETED		Obstetric Pharmacist presentations on induction days for obstetric, midwifery and nursing staff when they join the service at NGH		

	Agreed Action	By When	Led By Whom	Evidence of compliance	Date completed	RAG
				A Medicine of the Month training poster will also be rolled out monthly- the first one should be posted in the next week or two. This will contain some clinical learning points and questions for a specific drug each month.		
4.	The Trust must ensure the security of the unit is reviewed in line with national guidance. Regulation 12	01/08/23	WI (Deputy Security Manager) CF (HoM)	Review of security in the Unit review completed, and areas for improvement identified. Plan to upgrade maternity CCTV and digital views in progress Quotations for required work with maternity security obtained Shared with clinical leads		
5.	The Trust must ensure staff complete mandatory, safeguarding and maternity specific training in line with the Trust's own target. Regulation 12(1)(2).	01/07/2023	JC/RS (Named Midwife for Safeguarding) JH (Associate Director of Safeguarding) CF (HoM) AD (CD)	Current compliance Safeguarding Adult Level 3 83.14% Current compliance Safeguarding Children Level 3 73.15% Staff allocated to the safeguarding study day, with dates planned throughout the year. To support increasing the training compliance, the Safeguarding Maternity Team is offering a 1-hour session for staff who are out of date in their training level 3 children's safeguarding. To assist in accumulating the required 8 hours of training compliance, colleagues will be required to attend eight 1-hour sessions for compliance to be signed off. Drop-in sessions planned at current established training sessions all meetings to support opportunistic Safeguarding Level 3 training. Corporate Safeguarding exploring the implementation of a Safeguarding Passport to support ongoing		

	Agreed Action	By When	Led By Whom	Evidence of compliance	Date completed	RAG
				capturing of safeguarding training hours over any 3 year period for all staff.		
6.	The Trust must ensure staff complete regular skills and drills training, especially in relation to birthing pool evacuation. Regulation 12(1)(2) (c)	COMPLETED	RD (Consultant Midwife)	Pool evacuation drill added to the Training week with first session planned for 15th March 2023 Baby Abduction Drill in place with a drill completed in December 2022, and March 2023, with plans to repeat drills every 6 months. Action plan developed from the recommendations from abduction drill, and recommendations be shared with teams and reviewed in the Maternity Risk Meetings	15/03/23	
Trust Should do Actions						
1.	The Trust should ensure there are the required staff to implement a robust system in maternity triage to include escalation process, monitoring and documentation.	01/02/23	CF (HoM) AD (CD) GH (Intrapartum Matron) MG (Obstetric Lead for LW)	Maternity escalation policy currently under review to align with Regional Opel status escalation process Core Team of midwives identified to support with the embedding of the Birmingham Symptom Specific Obstetric Training System (BSOTS) Triage process BSOTS training for clinical teams in progress and near completion		
2.	The Trust should ensure the required staffing to enable women to have a choice of birthing options which include the Barratts birthing unit and home birthing.	01/08/23	IM (DDoM)	Workforce strategy being developed to support reductor in vacancy factor and improved retention Recruitment ongoing to reduce vacancy Recruitment retention midwife in post to support with improved retention Staff engagement work in progress to support agile working methods that will support the service to offer more choice to women and families when they present to the service		

	Agreed Action	By When	Led By Whom	Evidence of compliance	Date completed	RAG
				Homebirth and Birthing Unit pathways currently being supported by opt in working pattern by the midwives while the workforce work is ongoing		
3.	The Trust should ensure the culture of the service continues to be addressed to ensure staff are listen to and measures put in place to improve the wellbeing of staff.	01/06/23	IM (DDoM)	Better Together Tomorrow Work in progress and will inform the Maternity Strategy Band 7 development days in progress led by the Trust OD Team Kings Fund Leadership days planned for all Midwives Band 7 and above and Obstetric consultants in Quarter 1 2023/24 Monthly meetings for the Lead PMA midwife, deputy director of midwifery, head of midwifery and HR Business partner with action log shared with Director of Nursing as Board Safety Champion Staff Listening event planned for May 2023		
4.	The Trust should ensure systems were in place to ensure audits were consistently reviewed and actions taken to address any identified concerns	COMPLETED	RD (Consultant Midwife) KJ (Obstetric Governance Lead) EP (QI Lead) IM (DDoM) AD (CD)	• Clinical audit forward plan agreed for 2023/24 which feeds into and includes the Trust priorities and links with NICE guidance and National Audit reports • Maternity Service Audit Lead included in incident action planning to ensure that requested audits are relevant and robust and link with other workstreams as appropriate • All audits where compliance is not shown have an action plan agreed and re-audits undertaken to establish the effectiveness of the actions • Designated Consultant Obstetric Audit Lead and Maternity Service Audit Lead (reporting to the Quality Improvement Lead Midwife)		

	Agreed Action	By When	Led By Whom	Evidence of compliance	Date completed	RAG
				• Fortnightly audit presentation sessions to disseminate and discuss findings from audits • All audits included on the Trust audit database and progress monitored by the divisional Clinical Audit and Effectiveness Facilitator • All audits now have a senior clinical lead to ensure facilitation and championing of actions • Findings from audits feed into the Maternity quality improvement plan		

Dedicated to excellence

Northampton General Hospital NHS Trust

Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	5 April 2023
Agenda item	7
Title	Trust Response to the Kirkup Report
Presenter	Ilene Machiva – Deputy Director of Midwifery
Author	Ilene Machiva – Deputy Director of Midwifery

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	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
Assurance on Trust Actions following the publication of Reading the Signals Report by Dr Bill Kirkup	Board of Directors, November 2022

Summary

- 'Reading the Signals' by Dr Bill Kirkup was published on 19th October 2022, following a review of Maternity and Neonatal services in East Kent commissioned in February 2020.
- The Trust has reviewed its current position against the main observations made by Dr Kirkup and a benchmarking exercise has been undertaken.
- Areas for improvement aligned with each of the four recommendations have been detailed in this report.

The Board of Directors is requested to note the latest position and indicate its assurance in respect of the Trust's response.

Appendices

None

Risk and assurance

Assurance around Maternity CQC Final Report

Financial Impact

N/A

Legal implications/regulatory requirements

N/A

Equality Impact Assessment
N/A

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

Paper

INTRODUCTION

'Reading the Signals' by Dr Bill Kirkup was published on 19th October 2022, following a review of Maternity and Neonatal services in East Kent Hospitals, commissioned in February 2020. The report details that over time the Trust provided clinical care that was 'suboptimal', with multiple missed opportunities that should have led to problems being acknowledged and tackled effectively. The headline findings of the report are far reaching and extend further than the focus of Maternity services. Of the 65 cases reviewed, in which a baby died, the panel found that 45 of these could have had a different outcome, if care had been given to a nationally recognised standard. The systems delivering this level of care were found not to be able to identify areas of poor performance, offer compassion or kindness, demonstrate a common purpose in their work, or deal with challenge in an appropriate manner.

Key themes of the report include:

- Team working
- Professionalism
- Compassion
- The importance of a learning culture
- Hearing the voice of patients

In summary the report identified four key areas where change and improvement is required:

- Monitoring safety performance – finding signals among noise
- Standards of clinical behaviour – technical care is not enough
- Flawed teamworking – pulling in different directions
- Organisational behaviour – looking good while doing badly

The report did not suggest a long list of recommendations, on the basis that previous reviews adopting that approach have not had the desired outcomes for improvement (or sustainability). Therefore, the National focus for responding to the East Kent and Ockenden findings will be addressed within the National Single Point Delivery Plan for Maternity Services – due to be published Early 2023.

NGH has reviewed its current position against the main recommendations made by Dr Kirkup and a benchmarking exercise has been undertaken. Progress against identified areas of improvement are documented in the next section of the report.

EAST KENT RECOMMENDATIONS	TRUST ACTIONS
Team Working & Professionalism	• OD Team supporting leadership on cultural work in maternity services at NGH through the 'Building Tomorrow Together' work, which paused briefly in December 2022, but has recommenced in February 2023. The work has clearly defined priorities that support team working, and key deliverables with identified priorities. The priorities, are grouped into: ➢ Workforce strategy (all staff groups) ➢ Leadership ➢ Governance ➢ Community ➢ Digital ➢ National drivers informing the delivery of maternity services ➢ Issue management (relates to issues that arise in the maternity services) • Work has been completed to support multidisciplinary team (MDT) training during Training Week. This approach supports multidisciplinary teams working together to train together. Training compliance figures evidence a sustained improvement with overall compliance with PROMPT training. Further work is still required to reach the expected standard in line with CNST • Psychological safety and human factors are embedded into the MDT training. Senior members of the midwifery and Obstetric staff are being supported to access the Human Factors training. This work is in progress. • Town Hall and Unit meetings in place to support shared understanding of developments in the service, and to support the staff voice to be heard
Compassion	• Further work is required to support continued co-production of maternity services with our service users. A 15 steps Challenge is planned for Quarter 1 of 2023/ 24 to assess quality in the maternity services from a service user perspective. This will be supported by the Maternity Voices Partnership and Healthwatch • The MVP has recently recruited into the role Diversity and Inclusion lead, to support the system (including NGH) to access hard to reach groups of women, and facilitate their voice being heard when planning the maternity services • Meet the Matron clinics in place with feedback of themes to clinical teams with the Lead midwives. Women can self-refer to this service, or they are referred by the clinicians providing care to them in their pregnancy • PMA sessions, as well as discussion of themes from Professional Midwifery Advocate (PMA) sessions shared with the MDT team during training week • Monthly meetings between HoM/DDoM/HR Business Partner with the Lead Professional Midwifery Advocate (PMA) to share themes coming from PMA sessions. An action log has been developed which will be shared with midwives and MSWs in the service, sharing actions that have been taken because of the feedback and themes from the PMA engagement. One of the first outputs from these meetings is a listening event which is planned for Q1 2023/24 • 2 new PMAs currently undergoing PMA training. This will support an improved midwife to PMA ratio, and PMA support for the service users
The importance of a learning culture	• Immediate learning from any incidents is shared with staff on an individual basis, and through the MDT huddles at staff handovers. Learning from incidents SIs and Datix themes shared by the Patient Safety Midwives as part of their presentation on training week, in a Maternity Messages newsletter shared with all staff, and through individual feedback

	• The maternity Governance team participate in the training week, sharing learning from serious incident investigations and HSIB investigations • ATAIN and PMRT reviews in progress with reports that are shared with clinical leads. Recommendations in practise from these reports are shared with clinical trams • A sustained learning environment is important for ensuring a learning culture. This is supported through Maternity Service Audit Lead joining in incident action planning to ensure that requested audits are relevant and robust and link with other workstreams as appropriate • In recognition of the new leadership team and current staffing and operational challenges, the Trust has been transparent in demonstrating their key priorities and welcomes scrutiny and support from ICB, region and national teams. Maternity Round tables led by the ICB with input from the Regional Chief Midwife have been in place to support the maternity services, and were stood down in January 2023, due to the progress the maternity services have demonstrated in relation to Governance processes • The Quadrumvirates (Obstetric Clinical Director, Lead Neonatologist, Head of Midwifery and Directorate Manager) from NGH will be one of the first quadrumvirates in the Region to participate in the Regional Perinatal Culture Leadership Development programme. This will support MDT working across the services and ensure continued patient safety and a shared understanding of what is required to support a safe perinatal service through joined up working • Maternity services are engaging with wider stakeholders, such as the university of Northampton to learn from the experience of student midwives in the service, and use the feedback to improve the learning environment of our future workforce • The Maternity services is currently in the process of arranging Kings Fund leadership days for the senior midwives in the service (Band 7 upwards) and cultural awareness training for the wider Team planned for Q1 2023/24
Hearing the voice of patients	• MVP in place. Further work is required to support continued co-production of maternity services with our service users. A 15 steps Challenge is planned for Quarter 1 of 2023/ 24 to assess quality in the maternity services from a service user perspective. This will be supported by the Maternity Voices Partnership and Healthwatch • MVP has recently recruited into the role of Diversity and Inclusion Lead across the system (including NGH) to access hard to reach groups of women, and facilitate their voice being heard when planning the maternity services • 2022 CQC Maternity survey, there was a 56.11% response rate from women who use the maternity services at NGH, and this was higher than the national average of 47%. NGH results were better than most Trusts for one question, no questions were worse than other Trusts, and NGH results were the same as other Trusts for fifty questions. The response rates can be taken to demonstrate the women's willingness to work with us to improve the Maternity services an NGH • The maternity services engage with women requesting care outside our evidence-based guidance through Meet the Matrons clinic. Individualised plans for care for women are developed in collaboration with the woman to support a safe birth

As the Reading the Signals Report investigation report importantly highlights the repeated problems were systemic. These included poor professional behaviour within and between Teams, particularly a failure to work as a cohesive team with a common purpose. The Team at NGH through the Building Tomorrow Together work is focusing on joined MDT approach to service development with the woman and her family at the centre of the care given. This project aims to provide an engagement strategy to drive retention, implement and embed inclusion and ensure learning and development is robust and led by the clinical teams

The focus for the Trust continues to be to review the Trust's current position against the main observations made by Dr Kirkup. Consideration will also be given to the recommendations from the Ockenden 1 and 2 reports. These will help to inform ongoing actions on the Maternity quality Improvement plan (QIP) which is currently being developed.

Reference

https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report

Dedicated to excellence

Northampton General Hospital NHS Trust

Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	5th April 2023
Agenda item	8

Title	Our Strategic Priorities for 2023/24
Presenters	Karen Spellman, Interim Group Director of Integration and Partnerships Denise Kirkham, Co-Chair of the Group People Committee Andre Ng, Co-Chair of the Group Clinical Quality, Safety and Performance Committee Rachel Parker, Interim Trust Chair and Co-Chair of the Group Finance and Performance Committee
Authors	Karen Spellman, Interim Group Director of Integration and Partnerships Rebecca Taylor, Group Director of Transformation and QI Paula Kirkpatrick, Group Chief People Officer Debra Shanahan, Director of Nursing, Midwifery Hemant Nemade, Medical Director Palmer Winstanley Chief Operating Officer Jon Evans, Group Chief Finance Officer Stuart Finn, Interim Group Director of Estates and Facilities

This paper is for			
x 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				
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
The purpose of this paper is to review and discuss the recommended changes to our longer term (4-year) goals to deliver our Dedicated to Excellence strategic priorities. To note the 23/24 deliverables and metrics as agreed by each of the responsible committees.	The Dedicated to Excellence strategic priorities were confirmed as still valid at the Board Development session held on the 20th January 2023 The revised strategic priorities were discussed at the Group Transformation Committee; 13th March 23. In March 2023, the Group Finance and Performance , People and Clinical Quality, Safety and Performance Committees will be considering the following; • A review of progress of the 21/23 delivery programmes • Agreement to recommend to Boards the 4-year goals and associated 23/24 deliverables and metrics • How the committees will ensure ongoing visibility during 23/24 *Committee Co-Chairs will be requested to provide feedback from these discussions.*

Executive Summary

As part of our Integrated Business Planning for 23/24 and in order to set our objectives for the coming year, we have reviewed the strategic priorities as set out in our Dedicated to Excellence strategy.

Board committees (in common) have;

- Reviewed progress made on overall deliverables and metrics for 21/23 to include what we have achieved, what has not been achieved and why
- Recommended changes to our longer term 4-year goals
- Recommended a set of programmes of work and metrics for 23/24

The purpose of the paper is to provide assurance to the Board of the review undertaken and set out for each of our strategic priorities the recommended changes to the original 3-5 year goals as set out in 2021, for approval. Ambitions 4-year goals are recommended. The 23/24 programmes of work and metrics to support delivery are included.

The Board is asked to;

- Receive a summary of each committees' deliberations and recommendations as per the March committee cycle
- Review and **approve** the recommended changes to our longer term 4-year goals to deliver our Dedicated to Excellence strategic priorities, and
- Note the 23/24 deliverables and metrics as agreed by each of the responsible committees.

Appendices

Attached paper (slides)

Risk and assurance
The identification of strategic priorities and 2023/24 deliverables is fundamental to the management of risks of the Group Board Assurance Framework, which are aligned to the Group Dedicated to Excellence Strategy and its enabling and supporting strategies.
Financial Impact
Specific financial targets set out under the ‘Sustainability’ priority in the attachment.
Legal implications/regulatory requirements
No direct implications
Equality Impact Assessment
The delivery of our strategic aims will deliver positive impacts in respect of all Protected Equality Characteristics.

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

NHS
University Hospitals of Northamptonshire
NHS Group

Developing our Priorities for 23/24

Boards of Directors, 5-6 April 2023

Dedicated to excellence

Introduction

As part of our Integrated Business Planning for 23/24 and in order to set our objectives for the coming year, we have reviewed the strategic priorities as set out in our Dedicated to Excellence strategy. The purpose of the review for 23/24 planning has been to ensure our strategic priorities are reviewed and updated to reflect the work we are doing collectively across both hospitals and specific priorities for each hospital. When we set out our Dedicated to Excellence Strategy, we agreed 5 strategic priorities, goals and success measures. The 5 strategic priorities were confirmed as current at the joint Board Development session on the 20th January 2023.

A key aim of our strategic planning is to create a single forward focused view of our priorities and goals that can be used to communicate and engage staff about what we are trying to achieve. By planning our strategic priorities and defining goals, the specific deliverables and KPIs can then be determined at organisational level. Our strategic priorities create a single focus that we can align our enabling strategies and organisational delivery around; ensuring that everyone is working to things that matter the most for our patients and staff. Each of our strategies and the integrated business planning process running in both hospitals will be aligned to these strategic priorities.

We have made progress in delivering some of the agreed programmes of work, however we recognise that we have not delivered on all the delivery programmes defined from 2021-2023. Part of the reason for this is that we have not kept the priorities alive and tracked delivery against all regularly throughout the year and some of our goals and focus for delivery were not fully defined. In some instances, no clear delivery plans or key performance indicators were set. There will be several reasons for this, and we have instead made progress in other evolving areas that have been local priorities for each hospital in delivering our overall Dedicated to Excellence strategy. We should also acknowledge that there have been a number of competing and challenging national and local priorities and any strategy must remain agile and evolves with challenges and opportunities that arise.

Strategic planning is an ongoing process and re-confirming our strategic priorities will help us to prioritise and align our resources to best manage risk at local and strategic level as we move into 2022/23. At a Hospital and clinical service level there may be a different level of focus depending on key metrics, for example, one service through their Integrated Business Planning may focus more on priorities aligned to the patient priority if they are already achieving operational standards. Another service may have greater clinical risk and focus on quality metrics.

The committee responsible for each strategic priority has reviewed in detail the progress to date against the 21/23 deliverables and metrics to include what has been achieved, what has not been achieved and why. The longer term 3-5 year goals have been updated and revised 4-year goals are recommended. These are ambitious goals and the 23/24 programmes of work to support delivery, as set by each committee, are detailed in the slides below.

The purpose of this paper is to provide the Board assurance of the review that has been undertaken, to recommend changes to our longer term 4-year goals and to detail the deliverables and metrics for 23/24.

As we move to delivery in 23/24, we now need to embed our strategic priorities, 4-year agreed goals and focus for delivery programmes throughout our two hospitals including risk assurance, local performance monitoring, more robust project reporting through our Divisional assurance processes to HMTs and the Committees.

Our Priorities

Our five strategic priorities are described below as set out in our Dedicated to Excellence strategy. The 3-5 year goals and success measures were defined in 2021 and the specific delivery focus for 21/22 is included below and were continued for focus in 22/23.

	Clinical Quality Safety & Performance Committee		Finance and Performance Committee		People Committee
	Patient *Excellent patient experience shaped by the patient voice*	**Quality** *Outstanding quality healthcare underpinned by continuous, patient-centred improvement and innovation*	**Systems and partnerships** *Seamless, timely pathways for all people's health needs, together with our partners*	**Sustainability** *A resilient and creative university hospital Group, embracing every opportunity to improve care*	**People** *An inclusive place to work where people are empowered to be the difference*
Our 3-5 year goals and success measures	• Top 10% nationally in the inpatient and cancer surveys • Positive feedback in local patient feedback and surveys	• 0 avoidable harm • Standardised Hospital Mortality Index (SHMI) score that is best in peer group • 100% of teams achieve MDT accreditation plus • No unwarranted clinical variation	• All cancer patients treated in 62 days unless clinically inappropriate • Exceed planned and emergency care standards • Maximum 85% bed occupancy	• Double the number of patients who can participate in research trials • Eliminate our carbon footprint by 2040 • No unwarranted financial variation	• Top 20% in national staff survey • Improvement in diversity measures • Positive feedback in staff pulse survey
Our focus for 21/23	• Improving accessibility and consistency of compassionate patient communications	• Reducing harm caused to our patients caused by delays • Reducing harm from medication errors • Reducing clinical variation	• All cancer patients treated in 62 days unless clinically inappropriate • Ensuring our patients have a reason to reside in hospital • No patients required to wait 52 weeks for elective treatment	• Reduction in temporary staffing spend • Reduction in food waste	• Increase in staff survey scores for the themes of supporting staff and staff engagement

Summary of UHN goals and success measures

University Hospitals of Northamptonshire NHS Group

The following details the 3-5 year goals and success metrics as set out in 2021 to deliver or Dedicated to Excellence strategy and the agreed changes to the metrics for the next 4 years from 23/24 onwards.

People 3-5 year goals set out in 2021

PP1: Top 20% in national staff survey

PP2: Improvement in diversity measures

PP3: Positive feedback in staff pulse survey

2023/24 Updates: 4 year goals set out from April 23

PP1: Above average national staff survey advocacy scores

PP2: Improvement in diversity measures

Patient 3-5 year goals set out in 2021

P1: Top 10% nationally in the inpatient and cancer surveys

P2: Positive feedback in local patient feedback and surveys

2023/24 Updates: 4 year goals set out from April 23

P1: Top 10% nationally in the inpatient and cancer surveys

P2: Positive feedback in local patient feedback and surveys

P3: Improved complaints performance rates

Quality 3-5 year goals set out in 2021

Q1: 0 avoidable harm

Q2: Standardised Hospital Mortality Index (SHMI) score that is best in peer group

Q3: 100% of teams achieve MDT accreditation plus

Q4: No unwarranted clinical variation

2023/24 Updates: 4 year goals set out from April 23

Q1: Aspire to no avoidable harm

Q2: Mortality indices that are best in peer group (SHMI / HSMR / SMR)

Q3: 100% of wards and outpatients achieve Assessment & Accreditation

Q4: Reducing clinical variation:

- GIRFT - 85% BADS day case
- Cardiology – Improvement in Cardiology-specific SHMI
- Cancer – Improvement in overall cancer survival rates / Presentation at stage 1 & 2 diagnosis

Dedicated to excellence

Summary of UHN goals and success measures

University Hospitals of Northamptonshire NHS Group

Systems & Partnerships 3-5 year goals set out in 2021

SP1: All cancer patients treated in 62 days unless clinically inappropriate
SP2: Exceed planned and emergency care standards
SP3: Maximum 85% bed occupancy

2023/24 Updates: 4 year goals set out from April 23

SP1: All cancer patients treated in 62 days unless clinically inappropriate
SP2: Deliver planned and emergency care standards
SP3: Maximum 92% bed occupancy

Sustainability 3-5 year goals set out in 2021

S1: Double the number of patients who can participate in research trials
S2: Eliminate our carbon footprint by 2040
S3: No unwarranted financial variation

2023/24 Updates: 4 year goals set out from April 23

S1: Double the number of patients who can participate in research trials
S2: Continue progress towards eliminating our carbon footprint by 2040
S3: Demonstrable improvement in underlying financial performance and effective use of resources, to median benchmark levels or better

Dedicated to excellence

People priority – Review 21-23

3-5 year metrics

		2019	2022
PP1:	Top 20% in national staff survey for staff engagement (out of 125)	NGH: 90th KGH: 71st	NGH: 100th KGH: 121st
PP2:	Improvement in diversity measures	NGH: 14.3 KGH:14.4	NGH: KGH
PP3:	Positive feedback in staff pulse survey	NGH: N/A KGH: N/A	NGH: 6.0 KGH: 6.2

2021/22 and 2022/23: plans and metrics

				Metrics	
Categories	**Initiative**	**What did we want to achieve?**	**What did we achieve?**	**Where were we?**	**Where are we now?**
Developing a 'new offer' for front-line staff working for the Group	**Review provision of 'basic needs' and wellbeing offer for staff**	The wellbeing and 'basic needs' offer for staff developed, communicated and implemented. ✓	Aligning and branding health & wellbeing offer across group	**Turnover** (May 21) NGH: 8.6 KGH: 7.8	**Turnover** (Jan 23) NGH: 8.2 KGH: 9.1
Developing our people	**Upskill line managers to more confidently have development conversations**	A training programme developed with managers and staff, based on best practice, to equip managers with techniques to support staff in feedback and development conversations and built into the Group's training offer for managers. Expectations and standards developed and set with staff and managers about responsibilities for development and communicated to all staff ⏳	Line management development programme designed and piloted	**Staff survey score** 'q9b: My immediate manager gives me clear feedback on my work. (2019) NGH: 58.2% KGH: 61.1%	**Staff survey score (as previous) - 2022:** NGH: 58.2% KGH: 58.5%
Inclusion	**Build in proactive and positive processes to drive inclusive behaviour and thinking**	Inclusion action plan for 2021/22 has been developed and implementation underway. A training programme for managers developed focusing on unconscious bias, and developing cultural competence to address challenging conversations ⏳	EDI strategy document completed.	**Staff survey (2019)** Q15: Career progression NGH: 52.4% KGH: 56.0% Discrimination – other staff NGH: 10.4% KGH: 7.1%	**Staff survey (2022)** Development NGH: 51.2% KGH: 50.7% Discrimination NGH: 12.2% KGH: 12.7%
Staff engagement and empowerment	**Develop a pulse survey to regularly measure staff feedback**	A pulse survey developed to track how staff feel and feedback from the survey is regularly reviewed to further develop training, health and wellbeing offers, and inclusion plans. ✓	Pulse survey implemented and fully rolled out. Response rates above target	**Pulse survey response rate** (Sep 2021) target 5%	**Pulse survey response rate** (2023) 17%
	Create an organisational and leadership culture of empowerment	Leadership and organisational culture centred around empowerment developed jointly with group transformation team. OD and leadership development to deliver that culture, and embedding into staff awards, appraisals, and processes. ⏳	Group values launched. 'Be the change' culture programme designed.	**Number of QI projects (Q4 20/21)** NGH: 11 KGH: 27	**Number of QI projects (Q3 22/23)** NGH: 40 KGH: 15

People priority – Looking forward

4 year metrics (to 26/27)

University Hospitals of Northamptonshire NHS Group

PP1: Above average national staff survey advocacy scores

PP1.1 I would recommend my organisation as a place to work (target 60%)

PP1.2 If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (target 65%)

PP2: Improvement in specific diversity measures

PP2.1 In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues? All colleagues (target 8%)

PP2.2 In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues? REACH colleagues (target 15%)

*10 metrics sit underneath as agreed to deliver the People Plan – see slide 34

Leads;

Paula Kirkpatrick, Deborah Manger, Denise Kirkham

The People priority covers the major programmes which will make a positive impact for our workforce over the next 4 years. It is underpinned in greater detail by the People plan, which sets out further programmes and metrics supporting our workforce.

People priority

Programme of work	Objective(s)	How does this contribute to top aims/metrics?	Delivery metrics	How will we measure this	Baseline	Target / trajectory	Dependencies / risks to delivery
Developing our people	- Development of UHN values based leadership competency framework - Development of UHN leadership strategy - New UHN appraisal - Aligned statutory and mandatory training	Increase in manager related staff survey scores (PP1) Increase in EDI related staff scores (PP1, PP2)	• No managers going on leadership management programme • Appraisal completion rates • MAST compliance	• Course enrolment data • Appraisal rates • MAST compliance	N/A Appraisal KGH 81% NGH 73% MAST KGH 90% NGH 82%	No completing leadership development interventions Appraisal 85% (5% improvement in year) MAST 85% (KGH maintain 90%)	Releasing time from operational or clinical delivery to attend leadership programme

People priority							
Programme of work	**Objective(s)**	**How does this contribute to top aims/metrics?**	**Delivery metrics**	**How will we measure this**	**Baseline**	**Target / trajectory**	**Dependencies / risks to delivery**
Improving health and wellbeing	Aligned offer across both Trusts	Improvement in staff survey score (PP1)	• Improved attendance	Sickness absence	• KGH 5.65% • NGH 6.1%	By end 23/24 KGH 5%, NGH 5.5% Target 5%	Covid
Dedicated to Excellence – Culture change – inclusion and empowerment	Improved staff experience through an improved culture Improvement in inclusion	Increase in improvement related staff survey scores (PP1) – expect delay to year 2 Increase in EDI related staff scores (PP1, PP2)	No. excellence ambassadors recruited Discovery phase to set further delivery metrics	Recruitment figures Tbd depending on discovery output Staff engagement scores	0 N/A Engagement KGH 6.0 NGH 6.2	Target: 50 N/A Engagement KGH 6.2 NGH 6.3	Funding constraints
Clinical and Corporate services collaboration across the Group	Establish framework for People Team to support clinical collaboration People Policy Harmonisation **People Partnering and OD and Inclusion objecti ves within people plan**	Support maintenance of PP1, PP2 through clinical collaboration processes	Package of support for workforce data, team readiness for change diagnostic, workforce planning (including writing JD/PSs) and contractual consultation where appropriate as part of collaboration	All People Policies harmonised across the group.	6 people policies harmonised as at Jan 2023	April 2025	Industrial relations climate

People priority							
Programme of work	**Objective(s)**	**How does this contribute to top aims/metrics?**	**Delivery metrics**	**How will we measure this**	**Baseline**	**Target / trajectory**	**Dependencies / risks to delivery**
Delivering a sustainable workforce	Reducing reliance on agency Improving availability of staff	Improvement of PP1 and PP2 by improving resourcing and day to day experience of staff	• Reduced number of agency shifts • Reduced vacancy through improved workforce planning	Agency cost Vacancy rate Time to hire	• KGH £11M • NGH £27M • KGH 9.5% • NGH 9.3% • KGH 68 days • NGH 88 days	KGH £9.5M NGH £12M Vacancy 8% TTH KGH 65 days NGH 70 days	Staff engagement Labour market

Patient priority – review of 21-23

3-5 year metrics

2019/20	2021/22
IP (2019) NGH: 12% KGH: 40% Patient satisfaction (IGR) NGH: 91% KGH:91% (Apr 21)	IP (2021) NGH:15% KGH:17% Patient satisfaction (IGR) NGH:90% KGH:89% (Dec 22)

P1: Top 10% nationally in the inpatient and cancer surveys

P2: Positive feedback in local patient feedback and surveys

2021/22 and 2022/23: plans and metrics

					Metrics	
Categories	**Initiative**	**What did we want to achieve?**		**What did we achieve?**	**Where were we**	**Where are we now**
Patient experience	**Patient pathway mapping**	A mapping will be undertaken of the entire patient pathway to identify issues or areas for improvement. This will then be used to refine and test proposed initiatives	☑	PEM tool used in ENT collaboration	No standard tool in place across the Group	ENT example available for other collabs
Improving staff to patient communication	**Training on the delivery of information**	A training programme will be developed to build skills and confidence in honest and personalised communication developed with patients and staff and built into the UHN training and inductions. An assessment process focused on compassionate and effective communications rollout will have begun.	⏳	Developed a patient story with the lead for Med Ed shown at Dr training programmes	**Inpatient survey score on 12 communication Qs** NGH: 7.3 KGH: 7.4 *2019 – national avg. 7.3*	**Inpatient survey score on 12 communication Qs** NGH: 7.5 KGH: 7.5 *2021 – national avg. 7.8*
	Increased clarity of patient letter information	A letter template and tone will be developed in partnership with GPs and patients for all appropriate letter types, built into IT systems and available in email format. This will be rolled out with training. Contact details for patients to contact for help included on letters.	⏳	Awaiting digital Healthcare Communications project - new implementation date Aug-23	Not measured	Not measured
Improving staff to patient communication	**Establish staff groups to explore patient communication**	Each Trust will have launched monthly communication discussion groups in selected wards or services, encouraging staff to share and reflect on positive or challenging experiences of patient communication to aid staff learning and generate compassionate thinking	⏳	Shared decision making councils in place at NGH and being developed at KGH	**Inpatient survey score on 12 communication Qs** NGH: 7.3 KGH: 7.4 *2019 – national avg. 7.3*	**Inpatient survey score on 12 communication Qs** NGH: 7.5 KGH: 7.5 *2021 – national avg. 7.8*
	Reduction of any unnecessary or duplicate paperwork	A plan will be developed and agreed for electronic paperwork as part of the Patient Information system being rolled-out across both Trusts. Rollout will have begun of the redistribution of Paperwork responsibilities of frontline staff to wider teams where possible.	⏳	Awaiting digital Healthcare Communications project - new implementation date Aug-23	Not measured	Not measured
Improving quantity and quality of information	**Develop and roll-out 'KGH NGH Patient Journal' (paper/ app)**	UHN will have identified whether an App format is an identified patient need or if other formats are more appropriate. If appropriate, a review of the Northamptonshire Shared Patient Record and other off-the-shelf apps will have taken place against requirements. If no existing apps meet requirements or the Shared Patient Record needs developing to incorporate this, a specification will have been developed.	☑	Patient journal approach developed and rolled out	**Inpatient survey score on 12 communication Qs** NGH: 7.3 KGH: 7.4 *2019 – national avg. 7.3* **Complaints (Q1-3 19/20)** NGH: 425 KGH: 460	**Inpatient survey score on 12 communication Qs** NGH: 7.5 KGH: 7.5 *2021 – national avg. 7.8* **Complaints** (Q1-3 22/23) NGH: 414 KGH: 316

Patient priority – Looking forward

4 year metrics (to 26/27)

P1: Top 10% nationally in the inpatient and cancer surveys
P2: Positive feedback in local patient feedback and surveys
P3: Improved complaints performance rates

- Leads: Jayne Skippen, Deborah Shanahan, Chris Welsh, Andre Ng

23/24: plans and metrics

Patient priority							
Programme of work	**Objective(s)**	**How does this contribute to top aims/metrics?**	**Delivery metrics**	**How will we measure this**	**Baseline**	**Target / trajectory**	**Dependencies / risks to delivery**
Patient feedback digital system	Improve visibility of patient feedback and enable action to improve	Improved feedback from patients	• Patient feedback received digitally	Outputs from digital system – exact measure to be defined during implementation	N/A – would be provided by the system	N/A – would need defining once system to collect in place	- Funding for procurement
Complaints process & compliance	Align with the new national Ombudsman work and improve processes and ensure learning from themes of complaints	Improving complaints performance	• Aligned process & standards across UHN • Track learning from complaints • Reduction in complaints by complaint theme focus	Standard UHN complaints process in place	Not in place	In place	
				Learning from complaints themes	Tbc following approach development	Tbc following approach development	An approach will be developed through the CQSPCiC
				Complaints performance-no. of complaints per month-IGR	KGH 37 (Mean 21/23 NGH 24 (Mean 21/23)	TBC	

Patient priority							
Programme of work	**Objective(s)**	**How does this contribute to top aims/metrics?**	**Delivery metrics**	**How will we measure this**	**Baseline**	**Target / trajectory**	**Dependencies / risks to delivery**
Clinical collaboration	Ensure patient engagement in all clinical collaboration work Ensure all clinical collaborations have list of issues to be solved / metrics / deliverables focussed on patient experience / outcomes from the service that are tracked	Improved patient feedback (P1)	• Patient representation on each of the clinical collaborations • Clinical collaboration achievements in support of resolving agreed patient experience / outcome issues	Patient reps on clinical strategy development groups	3 (in ENT, Cardiology, Cancer)	In all collaborating specialties	Resourcing of patient engagement teams
				Delivery of patient experience metrics outlined in individual service strategies	Varies by specialty	Achievement of experience metrics outlined in individual strategies	
Outpatients	Outpatient communication improvement through the outpatients transformation programme - Digital letters - Improved phone contact	Improved feedback from patients (P2)	• Patient feedback on communication in FFT • Call drop-rates in Outpatients • First-time resolution in call metrics	Outpatients Friends and Family communication scores	Jan-23: 96% - KGH 94% - NGH	95%	Reliant on delivery of digital solution
				Outpatient call answering & resolution rate	Oct-22: 78% calls answered and resolved first time	90%	Risk to delivery given current level of admin vacancies
Improving equality for people of Northamptonshire	Ensure all programmes of work have a focus on improving health inequalities and ensure services are provided in the best place	Improved patient feedback (P2)	• Consistent approach to embedding health inequalities in programmes • All clinical collaborations and transformation programmes have a focus on health inequalities (EIA)	Number of EIAs completed against major programmes	0	100% major programmes (to be defined)	Digital solutions

Quality priority – Review of 21-23

3-5 year metrics

	2019/20	2022/23
Q1: 0 avoidable harm	KGH: 27% (Feb 21)	KGH: 22% (Jan 23)
Q2: Standardised Hospital Mortality Index (SHMI) score that is best in peer group	109/103 (Apr21)	109/90 (Dec22)
Q3: 100% of teams achieve MDT accreditation plus	Not measured	Redefined metric
Q4: No unwarranted clinical variation		

2021/22 and 2022/23: plans and metrics

Categories	Initiative	What did we want to achieve?	What did we achieve?	Metrics: Where were we	Metrics: Where are we now
Enhanced patient monitoring systems	**Ensuring the embedding, and full utilisation of flow systems, electronic observation systems and NEWS2 scoring**	A common electronic observation system in place, with a consistent approach to capturing real-time, reliable observations for all adult patients and paediatrics. Alerts generated automatically to prompt staff.	Electronic observation system in progress	Not measured	Not measured
More robust planning	**Review, revise and roll out enhancements to 'safety huddles' practice to identify patients most at risk**	A UHN-wide approach to 'safety huddles' developed based on best practice. Effective and time-efficient 'safety huddles' held daily by selected MDTs at designated times, paired with appropriate staff training, rolled out across UHN	Improved through other methods - Deteriorating patient task list (NGH-awarded high commendation in HSJ Patient Safety awards) - SBAR KGH for deteriorating patients - Call 4 concern -Patients/carers can speak up (KGH shortlisted for HSJ Patient Safety award)	N/A	N/A
Refined and streamlined escalation procedures	**Create consistent approach to escalation with comprehensive escalation trigger parameters, a universal language and staff training that embeds escalation practices**	Roll-out will have begun for revised escalation processes and protocols across UHN, in line with proposed changes to electronic monitoring and safety huddles. Training developed for staff in the processes and protocols and delivery of this started. Visual aids based on NEWS2 present in all clinical areas. Tracking of metrics in place to monitor responses to NEWS2 scores.		N/A	N/A
Medicines management	**Roll out EPMA system across both trusts (part of wider EPR delivery) Invest in ward based pharmacists across both Trusts**	An electronic prescribing system linked with medication administration systems rolled-out across the two Trusts. Investment plans and a timeline for recruitment and introduction of ward-based and PTWR pharmacists in place.	EPMA rollout delayed in NGH. Ward based pharmacists introduced across UHN. Benefits realisation of business case implementation-reported through Benefits realisation framework reporting (6 monthly through FPC CiC)	**Number of medication errors** (Jan 2022 – IGR): NGH: 78 KGH: 68	**Number of medication errors** (Jan 2023 – IGR) NGH: 133 KGH: 86
Accreditation plus	**Develop MDT team accreditation scheme across all hospital areas**	A standardised MDT accreditation developed and rolled out across all clinical areas in UHN. Accreditation routinely takes place across both hospitals.	Standardised MDT accreditation was not progressed. Both KGH and NGH have focused on the ward accreditation schemes	N/A	Ward A&A progressed at both KGH and NGH
UHN-wide clinical variation and effectiveness programme	**Identify clinical variation, investigate the causes and develop a plan to reduce variation within these specialities, with an initial focus on cardiology**	An established UHN-wide clinical variation and effectiveness programme led by the clinical senate, with an agreed framework. A targeted programme of work in place within cardiology team and two additional specialties reviewed.	In progress. Development of GIRFT metrics across each Trust. Focus to be developed for 23/24	Not measured	GIRFT metrics

Quality priority – Looking forward

4 year metrics (to 26/27)

University Hospitals of Northamptonshire NHS Group

Q1: Aspire to no avoidable harm
Q2: Mortality indices that are best in peer group (SHMI / HSMR / SMR)
Q3: 100% of wards and outpatients achieve Assessment & Accreditation
Q4: Reducing clinical variation:
- GIRFT - 85% BADS day case
- Cardiology – Improvement in Cardiology-specific SHMI
- Cancer – Improvement in overall cancer survival rates / Presentation at stage 1 & 2 diagnosis

Leads: Hemant Nemade, John Jameson, Chris Welsh, Andre Ng

23/24: plans and metrics

Quality priority							
Programme of work	**Objective(s)**	**How does this contribute to top aims/metrics?**	**Delivery metrics**	**How will we measure this**	**Baseline**	**Target / trajectory**	**Dependencies / risks to delivery**
Deteriorating patient	Improve monitoring and responses to deteriorating patients	Reduction of avoidable harm from delays in responding to deteriorating patients	• CQUIN 07-30% of unplanned critical care unit admissions having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes • Compliance rates to set observation frequencies	CQUIN reporting Data from e-Vitals	100% (NGH Q2 22/23) 94% (KGH Q2 22/23) >96% KGH NGH not available across the Trust	30% (CQUIN target-NHSE) >95%	Digital implementation
Medicines management/digital patient records	Implementation and rollout of EPMA system	Reduction in medication errors (avoidable harm)	• EPMA and EPR implemented in all wards	EPMA rollout reporting	KGH wards only NGH-no EPMA or EPR	All UHN wards-EPMA and EPR	Digital implementation

Quality priority							
Programme of work	**Objective(s)**	**How does this contribute to top aims/metrics?**	**Delivery metrics**	**How will we measure this**	**Baseline**	**Target / trajectory**	**Dependencies / risks to delivery**
Cardiology centre of excellence	Delivery of the Cardiology centre of excellence	Reduces clinical variation and outcomes in cardiology patients	• Achievement of objectives in Cardiology CoE 1 year plan • NICOR national audit • 72 hour NSTEMI standard for both sites	Cardiology Strategy quarterly review updates	NSTEMI: NGH 50%, KGH 95%	90% across group	Clinical and operational pressures
Cancer centre of excellence	Delivery of the Cancer centre of excellence	Reduces clinical variation and improves outcomes in cancer patients	• Achievement of objectives in Cancer CoE 1 year plan	Cancer CoE Strategy quarterly review updates	Objectives to be defined (performance metrics included Systems & Partnerships, patient survey under Patient)	To be defined	Clinical and operational pressures
GIRFT	GIRFT programmes	Reduce clinical variation in BADS procedures	• Achieve 85% Day Case rates for BADS procedures • Delivery of HVLC cases per list	Day case rates	Nov-22 71% - NGH 80% - KGH	85%	Clinical and operational pressures
				Cases per list (Ophth, T&O, Gynae, Uro, Gen Surg, ENT)	ENT – 2.7 GenSurg – 2.0 Uro – 2.7 Gynae – 3.3 Ophth – 4.3 T&O – 2.6	Targets need developing based on case mix	Clinical and operational pressures
A&A	Increase areas who have A&A accreditation	Increasing wards and outpatients achieving accreditation	• Number of wards with A&A accreditation	Number of wards at each level of accreditation	Current number at each level	Improved number of wards at top 2 levels of accreditation by 10%	Accreditation team staffing
Implementation of Patient safety strategy	To deliver the national patient safety strategy	Q1:Aspire to no avoidable harm Q2: Mortality indices that are best in peer group	• PSIRF metrics	PSIRF metrics	As per PSIRF baseline-in line with implementation process	Full roll out in line with national timelines	Digital implementation Recruitment System engagement

Systems & Partnerships priority – Review of 21-23

3-5 year metrics

	2019/20	2022/23
SP1: All cancer patients treated in 62 days unless clinically inappropriate	82% (KGH) / 81% (NGH)	57% (KGH)/ 60% (NGH)
SP2: Exceed planned and emergency care standards		
SP3: Maximum 85% bed occupancy	81% (KGH)/ 93% (NGH)	97%(KGH) / 87% (NGH)

2021/22 and 2022/23: plans and metrics

Initiative		What did we want to achieve?	What did we achieve?	Metrics: Where were we	Metrics: Where are we now
Demand and capacity modelling to identify structural cancer and RTT deficits		UHN will have a model of activity and workforce across all acute pathways, at Trust and Group level illustrating current and future emergency, elective, diagnostic and cancer demand and capacity. The model will have been used to develop plans for 21/22 and refined following the 21/22 planning round to further enhance. Relevant staff will have received training to engage with and own the model.	Group capacity and demand modelling has been commissioned and the following have been completed; elective, theatres, outpatients, diagnostics and urgent and emergency care.	No group capacity and demand modelling	The modelling has been handed over to Group HI and incorporated in 23/24 planning, strategic estates development, Community Diagnostic Centre
Sustainable delivery of cancer and elective pathways beginning with phase three plans	Cancer Outpatients Elective	Phase 3 plan delivered, with the actions within the plan achieving the trajectories outlined in the plan. Where there has been challenges in delivery, effective escalation and resolution of issues collectively as a Group. Lessons on the deliver of the plan reflected on collectively. Delivery will be subject to the impact of Covid over the winter period.	• We are exceeding the cancer faster diagnosis standard for our patients 75%). • Our theatre productivity has been increasing with a record month for productivity in both hospitals in November 22. We have some of the best elective care delivery in region and have provided mutual aid to support neighbouring providers to tackle their long waits	**Cancer 28 day standard** KGH 81% ,NGH 80% (April 21) **Theatres utilisation** NGH: 73% (Jan 22) KGH: 72% (Feb 22)	**Cancer 28 day standard** KGH 86%, NGH 79% (Jan 23) **Theatres utilisation** NGH: 83% KGH: 78% (Nov 22)
iCAN programme		A shared and agreed understanding of the issues which result in patients being in hospital without a reason to reside. A designed set of solutions both in hospital and in the community to address the identified issues, which is adopted in trial areas and there is a plan to roll-out further.	There has been a 7 day reduction in the time between when an over 65 patient is medically optimised for discharge and when they leave our hospitals.	**Patients with a R2R (Dec 20)** NGH: 74.85% KGH: 68.1% **Bed utilisation (Dec 20)** NGH: 75.78% KGH: 91.45%	**Patients with a R2R (Dec 22)** NGH: 68.9% KGH: 76.09% **Bed utilisation (Dec 22)** NGH: 87.67% KGH: 97.18%

Systems & Partnerships priority – Looking forward

4 year metrics (to 26/27)

- SP1: All cancer patients treated in 62 days unless clinically inappropriate
- SP2: Deliver planned and emergency care standards
- SP3: Maximum 92% bed occupancy

Leads: Fay Gordon, Palmer Winstanley, Rachel Parker, Damien Venkatasamy

23/24: plans and metrics

Systems & Partnerships priority							
Programme of work	**Objective(s)**	**How does this contribute to top aims/metrics?**	**Delivery metrics**	**How will we measure this**	**Baseline**	**Target / trajectory**	**Dependencies / risks to delivery**
Community Diagnostic Centres	Providing diagnostic capacity in community settings, increased access for outpatient referrals and cancer pathways.	Supports SP1, SP2	• Annual plan diagnostic activity delivery- Performance against the 6 week wating time standard (DM01) • Delivery against CDC business case KPIs	DM01 CDC business case benefits realisation	Activity plan	85% (DM01) CDC KPIs	• Digital connectivity • Recruitment challenges • Managing DNA rates
Outpatients transformation	Transforming our outpatient services, optimising our clinical pathways, streamlining our admin and improving communication with our patients	Delivering planned care standards	• Annual plan outpatient first activity delivery • Outpatient New:FU ratio • Aligned outpatient pathways across UHN	IGR Outpatient programme reporting	Activity plan KGH: 2.11 NGH: 2.33 None aligned	Activity plan KGH: 1.85 NGH: 2.10 10 specialties aligned	• Digital implementation • Clinical and operational pressures

Systems & Partnerships priority							
Programme of work	**Objective(s)**	**How does this contribute to top aims/metrics?**	**Delivery metrics**	**How will we measure this**	**Baseline**	**Target / trajectory**	**Dependencies / risks to delivery**
Theatre productivity	Delivery of the theatre productivity programme	Improved utilisation of theatres supports delivery of elective care activity standards	• Theatres utilisation • Annual plan elective care activity delivery	Theatres utilisation (inc turnaround)	Feb-23: 86% - KGH 89% - NGH	95%	• Theatre staffing
				Elective activity compared to 19/20	Activity plan	Activity plan	• Theatre staffing • System plans for bed occupancy
Cancer centre of excellence- Clinical Collaboration	Delivery of the cancer centre of excellence	Supports SP1 and SP2	• Annual plan cancer trajectory delivery	Cancer waiting times performance Cancer CoE objectives reported through Quality priority	62 days Jan 23 KGH 51% NGH49% FDS Jan 23 KGH 86%, NGH 79%	62 days-85% FDS 75%	• Diagnostic capacity • System pathway review/redesign to include referral patterns/criteria
Virtual wards	Delivery of the Northamptonshire virtual ward programme	Improved use of virtual wards reduces length of stay for patients, contributing towards delivery of emergency care standards	• Annual plan virtual ward delivery	System VW business case monitoring	240	356	• System plans for virtual wards
Urgent and emergency care	Delivery 76% ED Quality Standard		• Annual plan A&E performance delivery	76% (national ask)	NGH – 60% KGH-from May 23	76%	• System plans for bed occupancy Delivery • Internal flow plans for bed occupancy
				92 Bed Occupancy	NGH – 100% KGH 100%	92%	• System plans for bed occupancy Delivery • Internal flow plans for bed occupancy

Sustainability priority – Review of 2021/23

3-5 year metrics

	2019/20	2022
S1: Double the number of patients who can participate in research trials	KGH: 938 NGH:716	KGH 1738 NGH 934 (22/23 YTD at Feb 23)
S2: Eliminate our carbon footprint by 2040	Not defined	Not defined
S3: No unwarranted financial variation	Not defined	Not defined

2012/22 and 2022/23: plans and metrics

				Metrics	
Categories	**Initiative**	**What did we want to achieve?**	**What did we achieve?**	**Where were we**	**Where are we now**
Medical establishment review	**Reset medical establishment as appropriate; plan developed to convert any temporary spend to permanent staff**	A developed and agreed framework in place to review medical establishment across the Group. The medical establishment review process carried out and changes to budgets signed off in top 3 priority specialities as defined by clinical senates and review of bank and agency spend. Medical e-rostering in place at both NGH and KGH with rosters developed and in use. Action plans underway to convert locum to agency spend or recruit to fill gaps.	Medical establishment reviews commenced at each Trust	Not measured	To be developed
Development of a single costing system	**Establishing a group to align costing principles, categorisations, coding and standards across KGH, and NGH**	A single costing system embedded across the Group which aligns costing principles, categorisations, coding and standards across all organisations. A process to analyse areas of cost variation developed and causes of cost variation across the Group identified. Initiatives developed to address variation and an action plan in place to address them	Single upgrade in progress to finance and procurement systems. Established Productivity & Efficiency Committee across UHN to review variation	Separate costing systems in KGH and NGH	Implemented from end March 23
Reducing the carbon footprint – food waste & desflurane use	**Reduce food waste and the impact of medical gasses**	• Regular tracking of food waste as a Group. Implemented changes to food ordering, production or delivery as defined in action plans • Established programme of engagement with anaesthetists across the Group to reduce desflurane usage and switched from desflurane to other volatiles where possible • Business case for digital patient ordering system submitted and plans for implementation started	Food Waste group in place. Individual ward level plans being developed and trialed. Both Trusts are now under the national target of 5%. Average usage circa 1%. Work continues to review/target other harmful aesthetic gases	**Desflurane usage (Dec 20):** NGH: 1.83% KGH: 17.8%	**Desflurane usage (Dec 22):** NGH: 0% KGH: 6.5%
Corporate cost review	**Conduct a review to understand and compare current corporate costs across the Group**	• A thorough review of the Group's corporate costs until February and benchmarking of these across finance, human resources, estates and facilities and digital departments. A corporate costs strategy developed and aligned with the Group CFO, CPO, CDIO and Director of E&F • Quick wins identified through the review implemented	Review across Estates & facilities completed – recommendations being taken forward	No corporate service reviews undertaken	Estates & facilities in delivery

Sustainability priority – looking forward

4 year metrics (to 26/27)

S1: Double the number of patients who can participate in research trials
S2: Continue progress towards eliminating our carbon footprint by 2040
S3: Demonstrable improvement in underlying financial performance and effective use of resources, to median benchmark levels or better

Leads: Stuart Finn, Jon Evans, Rachel Parker, Damien Venkatasamy

2023/24 plans and metrics

Sustainability priority							
Programme of work	**Objective(s)**	**How does this contribute to top aims/metrics?**	**Delivery metrics**	**How will we measure this**	**Baseline**	**Target / trajectory**	**Dependencies / risks to delivery**
Sustainability Group	• Create a Group approach to Sustainability	To monitor and drive delivery of trust Green Plans	Delivery of agreed Green Plan objectives and action plans	Green Plans have agreed actions in place	• Green Plans actions • National carbon reporting	• Green Plans actions • National carbon reporting targets	• Site/activity growth • Capital investment • Sufficient staff resource

Sustainability priority							
Programme of work	**Objective(s)**	**How does this contribute to top aims/metrics?**	**Delivery metrics**	**How will we measure this**	**Baseline**	**Target / trajectory**	**Dependencies / risks to delivery**
Green plans	• Delivery of each Trust's Green plan recommendations • Improved oversight of system Green plan	Delivery of carbon footprint reduction	Delivery of Green Plan objectives and action plans	Green Plans have agreed actions in place	• Green Plans actions • National carbon reporting	• Green Plans actions • National carbon reporting targets	• Site/activity growth • Capital investment • Sufficient staff resource
Decarbonisation	• Development of a decarbonisation plan for each site • Delivery of Public Sector Decarbonisation Scheme at NGH and new energy scheme at KGH	Delivery of carbon footprint reduction	• Delivery of decarbonisation plan objectives and action plans • On time delivery of Public Sector Decarbonisation Scheme at NGH and KGH	• Track through Group Sustainability meeting • Reporting to Group SDC	• National carbon reporting • Programme delivery of energy schemes to SDC	• National carbon reporting targets • Programme delivery of energy schemes to SDC	• Site/activity growth • Capital investment • Sufficient staff resource

Sustainability priority							
Programme of work	**Objective(s)**	**How does this contribute to top aims/metrics?**	**Delivery metrics**	**How will we measure this**	**Baseline**	**Target / trajectory**	**Dependencies / risks to delivery**
Use of resources	• Delivery of annual plan • Benchmarking product. / efficiency – model hospital & post covid analytics • Internal improvement in productivity	Enables effective use of resources	• Variance from financial plan • Cost per weighted activity unit	• IGR metric • Model Health System	Annual plan 19/20: NGH: £3,337 KGH: £3,765	Annual plan Target tbd	Operational and clinical pressures Recruitment challenges resulting in high agency spend Low operational productivity and low visibility of productivity data
Efficiencies programmes	To support a robust programme of deliverable efficiencies schemes	Enables effective use of resources	• Variance from savings plan	Finance data from efficiencies PMO	N/A	4%	Operational and clinical pressures Challenges ensuring that schemes deliver cost out savings Challenge identifying schemes for delivery
Clinical collaboration	To enable clinical collaboration through removal of financial barriers to collaboration : - Alignment of budgets to services as management structures align - Visibility to clinical leads of the budgets for their service across both Trusts	Enables effective use of resources	• Reduction of any financial barriers to clinical collaboration	Collaboration benefits realisation	N/A	To be agreed	Alignment of budget management across services

Next steps

Priority programmes and success metrics set & agreed at Boards

Programme leads to complete delivery plans (Asana)

Strategic Portfolio Office to support set-up of programmes

Metrics & highlight reports to go to committees in regular cycle

Strategic Portfolio Office / Health Intelligence to support programme reporting & dashboard creation

Ongoing monitoring

- The executive leads to identify named SRO leads for each programme of work, to define programmes and ensure appropriate delivery plans are in place
- The Strategic Portfolio Office will work with Health Intelligence to ensure Divisions, Hospitals, Committees have visibility of performance metrics and programme progress
- Develop a communication plan to communicate what we are trying to achieve clearly and embed our priorities
- Progress will be monitored throughout 23/24 through divisional performance meetings, HMTs, and Board committees; reporting to include delivery against plans and success metrics
- A six monthly progress update will be made to Trust boards

Dedicated to excellence

NHS
Northampton General Hospital
NHS Trust

Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	5 April 2023
Agenda item	9
Title	Staff Survey 2022: Results and Response
Presenter	Paula Kirkpatrick, Group Chief People Officer
Author	Paula Kirkpatrick, Group Chief People Officer

This paper is for

Approval	☐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

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
Our staff survey results are a key part of our Dedicated to Excellence strategy and People Plan	Group People Committee, March briefing sessions and joint Board Development 3rd March 2023

Executive Summary

The national NHS staff survey results have been published and the results for our Trusts showed a deterioration in outcomes. As a result, Boards and Trust leadership teams are undertaking a number of actions (including a cultural improvement programme and leadership and management development) in KGH and NGH to improve colleague experience of working in our organisations and fulfilling our Dedicated to Excellence objective of being an inclusive place to work where colleagues are empowered to make a difference. The Board of Directors is requested to note the receipt of, and indicate its assurance in respect of the response to, the 2022 Staff Survey.

Appendices

Our staff survey results can be found here:
https://cms.nhsstaffsurveys.com/app/reports/2022/RNS-benchmark-2022.pdf

Risk

BAF risk UHN01 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.

Financial Impact

The financial impact of our proposed cultural improvement programme is c.£500K which was previously agreed by the Board of Directors.

Legal implications/regulatory requirements

N/A

Equality Impact Assessment

Our Workforce Race and Disability Equality Standards are contained within the benchmarked survey report.

Situation

The national NHS staff survey results have been published and the results for our Trusts showed a deterioration in outcomes. As a result, Boards and leadership teams are undertaking a number of actions (including a cultural improvement programme and leadership and management development) in KGH and NGH in order to improve colleague experience of working in our organisations and fulfilling our Dedicated to Excellence objective of being an inclusive place to work where colleagues are empowered to make a difference.

Background

The survey is one of the world's largest workforce surveys, with the results aligned to the seven elements of the national People Promise. The People Promise sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

The People Promise elements are underpinned by two key indicators of organisational health - engagement and morale.

Assessment

The results of the national staff survey were not where we would want them to be.

Nationally the results for 2022 show improvements in two of the Promise's seven elements – We are a team and We are always learning - with a greater proportion of staff feeling supported by their line manager and having opportunities to develop in their careers. Scores for a further four of the elements and the staff engagement theme have remained more constant.

The full results for NGH can be found here:

https://cms.nhsstaffsurveys.com/app/reports/2022/RNS-benchmark-2022.pdf

Participation

2,723 colleagues completed the survey (48% of our workforce) which was an increase from last year when 2,414 colleagues participated in the survey (response rate of 42%). The national median response rate was 44%.

Results

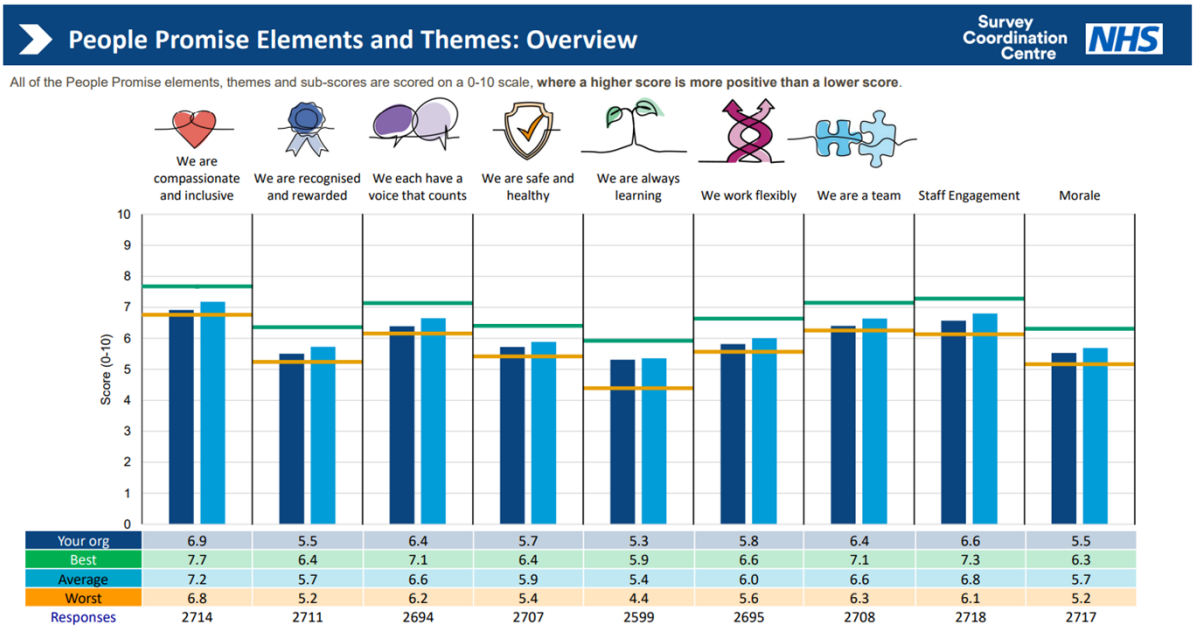
Year on year, NGH improved in one area (We are a team), remained the same in four areas and dropped in four areas. Taking into account national changes, NGH tracked the same in five areas, performed better than nationally in two areas:

- Up 0.1 in we are a team (no change nationally)
- Only dropped 0.1 for Morale (national dropped 0.2)

NGH performed worse against the national picture in 2 areas:

- ‘We are always learning’ saw no change but nationally went up 0.2
- Staff engagement dropped 0.1 against no change nationally

NGH has seen improvements in three of the four race equality measures within the survey, with a positive decrease of 5.8% in discrimination from manager/team leader. However, disability equality measures have shown an increase in disabled staff receiving abuse/bullying and harassment from the public and feeling pressured to come to work.



Context

The survey was carried out after a long and difficult summer which followed the end of the well documented most challenged time for the NHS and our colleagues. Services were under pressure to address the backlog following the pandemic and covid continued to impact in our hospitals with summer infections.

Even with this context our survey results are disappointing given the number of actions and initiatives taken and supported during the past year, including increased listening to our staff (with examples such as 'Connect, Explore, Improve'), further development of our wellbeing offers, development of our academic strategy and our focus on diversity and inclusion (e.g. Inclusive Recruitment Champions, Cultural Ambassadors).

The results articulate that we have much work to do in ensuring colleagues feel recognised, rewarded and respected for their contribution towards caring for our patients at a strategic and operational level.

We have committed to investing in our culture and leadership – we need to accelerate that work to deliver high quality, safe care for our patients.

People Pulse, January 2023

Our People Pulse results in January 2023 showed a deterioration in both our organisations. Response rates were down (17% of staff completed the survey in NGH compared to 25% in July 2022, though the numbers participating were slightly higher than in January 2022). It

should be noted that nationally response rates were expected to be lower due to the proximity to the closing date of the national staff survey.

Compared with national benchmarking NGH has seen a decrease in all three sub-sets (advocacy, motivation and involvement) but little change in the overall staff engagement score.

The Quarter 4 Pulse results for both Trusts tell a similar story to the National Staff Survey results and highlight the challenging position both KGH and NGH face.

Areas for improvement

This is a time of change for the Trust with the work we are actively engaged in with regards to our clinical ambitions and the alignment of support services across both KGH and NGH. The results give us an opportunity to not only identify how we will improve colleagues' experience but also to make positive changes to enable us to be the very best we can for our patients and their families.

In 2022, in response to the 2021 national staff survey, we identified four key areas to make improvements in: Teamwork, Respect, Leadership & Management and Reward & Recognition. This year our colleagues tell us they feel tired and burnt out, work pressure is a problem and they want to feel empowered, respected and valued. The workload pressure on staff as the NHS addresses the backlog coupled with feelings of burnout is causing staff to feel frustrated they cannot deliver the level of care they aspire to. Maintaining a focus on our four key priority areas is the right approach to address the concerns of our colleagues.

Culture change is a long-term commitment and these four priorities remain the right ones. It is clear we need to embrace our values, ensuring that each colleague is treated with respect. We are committed to taking the actions we need to take to make NGH a place where colleagues feel supported, valued, empowered to improve their environment and services.

Recommendation(s)

A full analysis of our results has been shared within the Trust and at the joint Board Development Session on 3rd March 2023 we dedicated time to the staff survey results. We confirmed our commitment to carrying out the NHS culture and leadership programme in our hospitals commencing with the discovery phase in spring. We are committed to improving the culture in our organisations, inclusive of the investment in time and money we will need to commit to our improvement programme, acknowledging that evidence demonstrates this will be a three-to-five-year programme.

The Board of Directors is requested to note the receipt of, and indicate its assurance in respect of the response to, the 2022 Staff Survey.

Dedicated to excellence

NHS
Northampton General Hospital
NHS Trust

Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	5 April 2023
Agenda item	10

Title	Group Governance Arrangements: Review of Pilot, Terms of Reference and Boards 'in common'
Presenter	Richard May, Trust Board Secretary
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 review the effectiveness of committees in common following the 'pilot' meetings, held during January - March 2023, and informed by self-evaluation exercises undertaken by the committees.	Boards of Directors (KGH and NGH), November 2022 and February 2023 KGH Board of Directors: considering on 6 April 2023 Group Finance and Performance Committees, 28 March 2023 and Group Clinical Quality, Safety and Performance Committees, 31 March 2023: to receive self-evaluation outputs and recommend revised Terms of Reference for approval (subject to feedback from the 31 March 2023 meeting, at Appendices C-D)

To agree revised Committee Terms of Reference	Group People Committees, 30 March 2023 (revised draft Terms of Reference: Appendix E)

Executive Summary

(1) Committees in Common

The Boards resolved, at their November 2022 meetings, to resume 'in-common' working for the quality and finance Board Committees, on an initial 1-3 month pilot. The committees held monthly 'in-common' meeting between January to March 2023, receiving the outputs of self-evaluation exercises at their March meetings.

Feedback from Committees' members and attendees is set out in the enclosed reports, and provides a positive assessment of development, improvement and readiness to confirm this model of working.

Committees in Common are a recognised governance approach that enables collaborations between organisations to take decisions together on projects that cross boundaries without compromising the integrity of their own statutory requirements. Legally, these are Committees of both Boards, meeting together with a common agenda and work plan, but with discretion to meet separately in exceptional circumstances, should the need arise.

The Group People Committees have established and embedded 'in common' working and will be reviewing their Terms of Reference on 30 March 2023. These are presented for the Board's ratification at **Appendix E** enclosed. The Committees will complete their annual self-evaluation during April-May 2023; the outputs of all committee self-evaluations will be received by the Audit Committees.

The Board is requested to reflect upon the effectiveness of these meetings from committee members and attendees and to **APPROVE:**

(1) The continuation of 'in-common' format for the Group Finance and Performance and Group Clinical Quality, Safety and Performance Committees, in accordance with agreed Terms of Reference;
(2) Revised Terms of Reference, endorsed by the Group Finance and Performance Committees in common and subject to endorsement by the Group People and Group Clinical Quality, Safety and Performance Committees in common at their meetings on 30-31 March 2023 respectively, and set out at **Appendices C-E** enclosed;
(3) The abolition of the Quality Governance Committee and Finance and Performance Committees (noting the discretionary option to hold stand-alone committees within the proposed Terms of Reference), and
(4) Consequential changes required to the Trust's Scheme of Delegation to take account of the decisions in (1)-(3) above.

(2) Boards meeting in common

Outline implementation plans for Group working, previously received by the Board, provided for the Boards of Directors to meet together from July 2023. Following

recent leadership changes, and in response to the outcomes of the independent external review of the Group model and self-assessment against the CQC Well-led domain, the Board is recommended to **DEFER** implementation of this matter, with a further review to take place by 31 December 2023.
Appendices
Appendix A: report to the Group Finance and Performance Committees, 28 March 2023 Appendix B: report to the Group Clinical Quality, Safety and Performance Committees, 31 March 2023 Appendix C: Group Finance and Performance Committees in common Revised Terms of Reference (for approval) Appendix D: Group Clinical Quality, Safety and Performance Committees in common Revised Terms of Reference (for approval, subject to amendment following Committee consideration on 31 March 2023) Appendix E: Group People Committee in common Revised Terms of Reference (for approval, subject to amendment following Committee consideration on 30 March 2023)
Risk and assurance
The successful embedding of in-common working is a key enabler for the delivery of all group strategies, in mitigation of strategic risks set out on the Group Board Assurance Framework.
Financial Impact
No direct implications
Legal implications/regulatory requirements
As set out in the Executive Summary above. The Committees in Common will be legally-constituted Committees for the KGH and NGH Boards of Directors. The Board of Directors is required to ratify changes to Terms of Reference of its committees in accordance with Standing Orders.
Equality Impact Assessment
Neutral

Cover sheet

Meeting	Group Finance and Performance Committee
Date	28 March 2023
Agenda item	10 (Board of Directors Appendix A)

Title	Committee Self Evaluation
Presenter	Richard May, Trust Board Secretary
Author	Victoria Wallace, Deputy Trust Board Secretary Kirsty Noble, Executive 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
For the Committee to note and discuss the feedback from its self-evaluation survey.	None.

Executive Summary

The Terms of Reference for the Committees of the Boards of Directors of the University Hospitals of Northamptonshire Group require annual self-evaluations to be undertaken to review effectiveness and ensure continuous improvement and learning. This year's survey has been carried out following the restoration of 'in common' meetings since January 2023 of this Committee and the Group Quality, Safety and Performance Committee on an initial three-month trial basis and will inform the Boards' review of the pilot at meetings in April 2023 whilst identifying areas for shared good practice, development and improvement.

The committee's survey received eight responses. An analysis of the feedback received is available here. The following qualitative feedback was received:

Committee Focus

- Queries tend to only come from a couple of committee members rather than everyone.
- The move to joint committee has taken several months to bed in, but it has certainly improved the level of input from all involved
- Really strong Committee in common, clear NED and Exec ownership of the agenda with separation of trust specific business together with the benefits of collaborative working

Committee/Team working

- Sometimes there's a perception that items that come to the committee where it feels like responsibility is not taken for the actions and they repeatedly come back for assurance. This is very few areas, but thought it was worth raising.
- Greater executive ownership of BAF risks would benefit the assurance the committee receives

Meeting effectiveness

- Generally discussion is around clarification rather than challenge, though again, it is just a couple of committee members that provide challenge rather than a wide variety of members, therefore if they are not there, items may not receive enough challenge.
- Agenda are very long and complicated and there is not enough time to drill down into some areas and data that could have been challenged was not.

Leadership and Chairing

- The chairs are not on site; therefore they are not visible within the organisation - however, they are both very approachable and make themselves available when required, therefore this is not an issue.
- The co-chairs work very well together and share convening duties by rotation without issue which is evidence of high trust and effectiveness

Group Committees in Common (CIC)

- The CIC has definitely improved communication/ transparency across the organisations - it has helped having joint feedback on the same topic so that comparisons can be drawn etc. And having consistency in reporting is very helpful.
- Going really well and should continue.

Recommendations and Next Steps

The Committee is invited to receive, note and discuss the feedback from the evaluation survey and identify any specific actions and development areas in response.

Appendices
None
Risk and assurance
Failure to put in place robust, efficient and clearly understood governance arrangements will detrimentally impact the Group's ability to deliver its priorities as set out in the Group Board Assurance Framework.
Financial Impact
None
Legal implications/regulatory requirements
The NHS Foundation Trust Code of Governance 2014 and UK Code of Governance state as a main principle that the Board should undertake annual evaluation of its own performance and that of its committees.
Equality Impact Assessment
Neutral

Cover sheet

Meeting	Group Clinical Quality, Safety and Performance Committee
Date	31 March 2023
Agenda item	10 (Board of Directors Appendix B)

Title	Committee Self Evaluation
Presenter	Richard Apps, Director of Governance
Author	Richard May, Interim Group Company Secretary Victoria Wallace, Deputy 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
For the Committee to note and discuss the feedback from its self-evaluation survey.	None.

Executive Summary

The Terms of Reference for the Committees of the Boards of Directors of the University Hospitals of Northamptonshire Group require annual self-evaluations to be undertaken to review effectiveness and ensure continuous improvement and learning. This year's survey has been carried out following the restoration of 'in common' meetings since January 2023 of this Committee and the Group Finance and Performance Committee on an initial three-month trial basis, and will inform the Boards' review of the pilot at meetings in April 2023 whilst identifying areas for shared good practice, development and improvement.

The committee's survey received eight responses. An analysis of the feedback received is available here. The following qualitative feedback was received:

Committee Focus

- Moving to in common seems to be going well.
- Director pairs from trusts are providing assurance.
- Membership and attendees need to be clarified going forward to maximise the use of everyone's time.
- Attendees seem very motivated and informed on what is being considered.
- There has historically been a lack of interest in non-clinical safety issues, which should have received more time and attention in the committee. That has been improving more recently, however.

Committee/Team working

- Executives could be more focussed and confident using the Board Assurance Framework as a tool for their areas of responsibility.
- Late and missing papers are noted by there remain repeat offenders.
- Generally, a well chaired meeting seeking assurances.

Meeting effectiveness

- There are so many board committees now it is impossible to avoid overlap. There should be a review and reduction of the number of committees to enable clarity and avoid duplication or risk of things being missed.
- Oversight has not always been equal between clinical and non-clinical assurances thereby impacting on effectiveness.
- The committee seems to meet a bit too often.

Leadership and Chairing

- Chair/convenor has changed with the move to in common meetings but there is clarity of responsibility for each trust from a Non-Executive Director point of view.
- Excellent.

Feedback was also submitted highlighting the need for Chairs to ensure they are sufficiently visible within their respective hospitals.

Group Committees in Common

- It has taken some time but there is clarity now and the in common model is working well. Executive ownership of the assurance and upward reporting of the subgroups is a vital next step.
- Only the second meeting so still being developed.
- Understandably, it's a work in progress.
- Unsure.

Recommendations and Next Steps

The Committee is invited to receive, note and discuss the feedback from the evaluation survey and identify any specific actions and development areas in response.

Appendices
None
Risk and assurance
Failure to put in place robust, efficient and clearly understood governance arrangements will detrimentally impact the Group's ability to deliver its priorities as set out in the Group Board Assurance Framework.
Financial Impact
None
Legal implications/regulatory requirements
The NHS Foundation Trust Code of Governance 2014 and UK Code of Governance state as a main principle that the Board should undertake annual evaluation of its own performance and that of its committees.
Equality Impact Assessment
Neutral

GROUP FINANCE & PERFORMANCE COMMITTEE
TERMS OF REFERENCE

Context

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

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

1 . PURPOSE AND AMBITION

To oversee an aligned and integrated approach across the group, so as to ensure consistency in operational and financial management, including the efficient use of resources through optimal allocation of capital and resources.

Improve operational and financial outcomes by identifying and understanding unwarranted variances as a driver for transformational change, thus enabling better patient care, experience and outcome.

To work with the Northamptonshire Integrated Care System (ICS) to ensure financial sustainability of the group through collaborative working.

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

2. AUTHORITY

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

3. MEMBERSHIP AND ATTENDANCE

Chairs of Committee	Non-Executive Director (KGH) Non-Executive Director (NGH) *Chairs shall convene meetings on an alternating basis*
Members	Non-Executive Director (KGH) Non-Executive Director (NGH)
	Group Chief Financial Officer
	Director of Group Financial Performance & Deputy Group Chief Finance Officer
	Chief Operating Officer (KGH)
	Chief Operating Officer (NGH)
	Director of Finance (or equivalent) (KGH)
	Director of Finance (or equivalent) (NGH)
	Group Director of Strategy
	Group Director of Integration and Partnerships
	Group Director of Operational Estates
Attendees	Nominated Governor (KGH) and Deputy
	Others by invitation to discuss pertinent issues/topics
	Meeting Administrator

Notes on membership and attendance:

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

4. MEETINGS AND QUORUM

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

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

4.3 The Committee shall meet not less than four times per year.

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

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

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

5. SUPPORT ARRANGEMENTS

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

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

6. DECLARATION OF INTERESTS

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

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

7. DUTIES

7.1 To monitor current performance, the development and implementation of the group's medium to long term financial strategy, ensuring that the group strategic objectives/priorities are focused on, with the aim of achieving optimal financial outcomes for the individual Trusts, Group and the ICS.

7.2 To oversee the development and management of the Trust's capital programmes including scrutiny of prioritisation processes, forecasting and remedial action.

7.3 To review the long term financial model (LTFM) and seek assurance that the LTFM aligns with the wider System plans.

7.4 To identify and understand unwarranted variation in operational and financial performance across the Trusts and through benchmarking, identify ways to normalise these.

7.5 To monitor the alignment of systems, processes & reporting across both Trusts to ensure that agreed operational and finance metrics are being delivered.

7.6 To oversee and approve major investment decisions across the group in furtherance of the group strategic priorities (specific approval levels are set out in the Trusts' Scheme of Delegation); including the financial risk evaluation, measurement and management scrutiny of any such investment programmes

7.7 To oversee the measurement and monitoring of the financial impact of collaboration programmes, ensuring the delivery of the group objectives

7.8 To inform the development and delivery of group transformation and efficiency schemes via the Group Transformation Committee, ensuring that the right resources are available and that the balance between quality and efficiency is maintained.

7.9 To ensure that robust processes are followed to evaluate, scrutinize and monitor investments to confirm benefits realisation arising from collaboration, transformation, efficiency and productivity programmes.

7.10 To develop and monitor the group approach to working with System partners including the Integrated Care System (ICS) approach and development and agreement of annual ICS/ICB operating plans.

7.11 To monitor and scrutinise the Group's procurement plans, ensuring they drive value for money across purchasing and supplies.

7.12 To monitor and scrutinize operational estates compliance, risks and actions against key infrastructure components, carbon footprint, project management etc, working with the Group Strategic Development Committee to ensure a complementary approach to, and managing the business as usual impacts of, major infrastructure developments.

7.13 To review and monitor strategic risks to both organisations within the Committee's area of responsibility, as set out on the Group Board Assurance Framework.

8. STANDING AGENDA THEMES

	Description
1	Welcome, apologies and declarations of interest
2	Minutes of the previous meeting
3	Action Log
4	Integrated Governance Report
5	Financial Performance: Revenue and Capital
6	Group Board Assurance Framework (quarterly)
7	Transformation
8	Investments (Business Cases) • Group • Other significant investments
9	Estates • NGH • KGH
10	Updates from sub-groups
11	Items for Escalation to the Board

12	Any Other Business

9. REPORTING

9.1 The Committee will provide a Chairs' assurance report to the Boards of Directors following each meeting.

10. PROCESS FOR MONITORING EFFECTIVENESS OF THE COMMITTEE

10.1 These terms of reference may be amended to reflect changes in circumstances that may arise. This Committee in Common is recognised as undertaking a role to support and enable the delivery of the Group Finance Plan and its associated plans and policies and, as such, solutions considered may be iterative and designed to evolve over time. Together both Trust Boards will implement and review the Terms of Reference, not less than once per year.

10.2 The Committee will carry out an annual review of its performance and function in satisfaction of these Terms of Reference and report to the Boards on any consequent recommendations for change.

11. REVIEW

Reviewed: March 2023
Agreed:
Next Review: March 2024

BOARDS OF DIRECTORS, 5-6 APRIL 2023: APPENDIX D

Group Clinical Quality, Safety and Performance Committee

Terms of Reference

Membership	**KGH** • 2 Non-Executive Directors (including Co-Chair and Convenor) • Hospital CEO • Medical Director • Director of Nursing • Chief Operating Officer • Director of Governance **NGH** • 2 Non-Executive Directors (including Co-Chair and Convenor) • Hospital CEO • Medical Director • Director of Nursing • Chief Operating Officer • Director of Governance
Quorum	• Four members from each organisation (one of whom should be a Non-Executive Director)
In Attendance (at the Convenor's discretion)	**Both Trusts** • Trust Board Secretary (or representative) • Clinical quality and safety leads to attend and present reports (by invite) **KGH** • Nominated Governor and Deputy
Frequency of Meetings	• Up to 12 scheduled meetings per year, plus extraordinary meetings at the Chairs' discretion.

	• Chairs may convene meetings of the constituent Trust Committee to consider Trust-specific matters.
Accountability & Reporting	• Accountable to KGH & NGH Trust Boards • Approved minutes available to all Trust Board members • Exception reports to be presented to Boards of Directors
Date of Approval by Committee in Common	January 2023
Date of Approval by KGH & NGH Trust Boards	*February 2023*
Review Date	*February 2024*

Group Clinical Quality, Safety and Performance Committee

Terms of Reference

1. Context

Kettering General Hospital (KGH) Foundation Trust and Northampton General Hospital (NGH) are working together under a Group Management Model to strengthen acute care service provision across Northamptonshire, under the leadership of a jointly appointed Chair and CEO for both Trust Boards. A common approach of working across both organisations and emphasis on acute pathway transformation and quality improvement is recognised as a priority. The approach of working as a Group Model across both organisations maintains the statutory duties and responsibilities of two separate Trust Boards.

2. Purpose, Objectives and Duties

The Committee's overarching purpose is to assure the Boards, patients, visitors and staff of the UHN Group that services at Kettering and Northampton General Hospitals are safe and that they conform to, and surpass, the required quality and safety standards required within a culture of learning and continuous improvement.

In fulfilling this purpose, the Committee will

1. Oversee the delivery of Group Strategic priorities covering the Quality and Patient elements as expressed in the Group Clinical Strategy and Academic Strategies (and their successor documents);
2. Provide a forum for shared learning enabling the identification, review and monitoring of unwarranted variation in quality and performance across both Trusts to ensure that they are understood and investigated with any associated analysis and actions.
3. Enable hospital-level and group assurance, commissioning sub-group/trust-only working on issues of specific concern/priority and receiving exception reports from sub-groups specified in section 3 below
4. Develop, review and maintain oversight of key metrics providing integrated group reporting by exception
5. Monitor the Trusts' systems and processes in place in relation to compliance with the CQC and other relevant regulatory compliance standards and external sources of assurance, including the receipt of draft and final reports and recommendations and oversight of action plans and other statutory undertakings,
6. Ensure that there is an effective mechanism of integrated governance, risk management and control, receiving the Group Board Assurance Framework and assurance in respect of corporate risks in order with agreed schedules and escalation procedures
7. Oversee the development of robust integrated quality systems for quality planning, quality improvement and quality assurance

8. Evaluate transformational change for agreed acute countywide service provision against agreed key KPI's and improve clinical outcomes for patients. Ensure that quality and service outcomes are an integral part of the redesigned acute clinical pathway(s).

9. Oversee the safe transition and integration of quality and performance for service provision into a new architecture and transition from individual organisation to the group model approach at both pace and scale, providing assurance to the Group Transformation Committee in respect of quality and safety implications of collaboration proposals

10. Oversee the development and delivery of recovery plans to drive overarching performance and quality improvements for acute care provision.

11. Share learning, enable participative/collegiate contributions to be timely and enable better-informed discussions and considerations for acute clinical service priorities and transformation, aligned with local system (Integrated Care System) requirements and national imperatives.

12. Seek assurance for timely alignment of key enablers (finance, workforce/HR, digital and estate) for countywide service provision to enable acute clinical service transformation to be progressed with neither organisation becoming compromised during the process.

13. Approve the annual Quality Report (KGH) and Quality Account (NGH) on behalf Boards of Directors.

3. Accountability and Reporting Arrangements

The Committee in Common – QSP will provide assurance to both Trust Boards through the Co-Chairs of the Committee on its proceedings after each meeting through a highlight report.

Two Non-Executive Co-Chairs will be appointed (one from each Trust Board) , one of whom shall convene each meeting.

The Committee in Common will only operate within the parameters of the responsibilities delegated to it by both Trust Boards and as described in these Terms of Reference. Each Board will record the delegation within their Scheme of Reservation & Delegation.

The Convenor will report any specific concerns regarding the effectiveness of the risk management framework to the Audit Committee.

The Chairs will liaise with other Board Committees to ensure co-ordinated and comprehensive oversight of cross-cutting issues via the annual work plan, including (but not confined to) safe staffing, quality and safety implications of operational performance trends and clinical engagement in digital transformation.

The Committee shall receive exception reports from sub-groups responsible for specific aspects of quality and safety within the trusts:

KGH	**NGH**
Quality Governance Steering Group	Clinical Quality and Effectiveness Group
Health and Safety Steering Group	Health and Safety Group
Patient Experience Steering Group	Patient and Carer Experience Group
Radiation Protection Committee	Radiation Protection Committee
Safeguarding Steering Group	Safeguarding Committee

Assurance, Risk and Compliance Group	Assurance, Risk and Compliance Group
Other Groups established by the Committees in pursuance of their purpose and duties as specified in sections (1) and (8) of these Terms of Reference.	

4. Declaration of interests

All members and attendees must declare actual or potential conflicts of interest relevant to the work of the Committee and this shall be recorded in the minutes accordingly and added to the Conflict of Interest Register of individual Trusts.

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

5. Quorum, and required frequency of attendance

Four members from each organisation (one of whom should be a Non-Executive Director) will constitute a quorum.

The Director of Governance will monitor compliance with the Terms of Reference and will bring any non-compliance to the attention of the relevant Board of Directors.

The agenda and supporting papers for meetings will be circulated to all members at least five working days before the date the meeting will take place. Extraordinary meetings may also be called giving at least five working days' notice before the meeting can take place.

Members of the Committee in Common are required to attend a minimum of 80% of the meetings held and not be absent for two consecutive meetings without prior permission of the Chair. Members of the Committee in Common can nominate a deputy but not for more than two consecutive meetings without prior permission of the Chair.

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

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

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

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

6. Administration

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

- Review of the Terms of Reference in line with requirements
- Maintain agenda against work planner/cycle of business

- Agreement of the agenda with the Chairs/Convenor and attendees and collation of papers;
    - Circulation of agendas and supporting papers to Committee members at least five working days prior to the meeting
    - Other members of the Committee should request agenda items to the Chairs or Convenor for the meeting
    - Taking and issuing the minutes and preparing action lists in a timely way;
    - Keeping a record of matters arising and issues to be carried forward.
    - Maintain an on-going list of actions, specifying members responsible, timescales and keeping track of these actions
    - Drafting of minutes for approval by the Convenor within five working days of the meeting and then distributed as outlined above within ten working days
- Keeping an accurate record of attendance

Other Trust Board members from either organisation may request or be required to attend meetings of the Committee when matters concerning their responsibilities are to be discussed or they are presenting papers submitted to the Committee.

7. Requirement for Review

These terms of reference may be amended in consultation with both Trust Boards, to reflect changes in circumstances that may arise. This Committee in Common is recognised as undertaking a role to support and enable collaboration of clinical service delivery and as such solutions considered may be iterative and designed to evolve over time. Together both Trust Boards will implement and review annually the Terms of Reference.

8. PROCESS FOR MONITORING EFFECTIVENESS OF THE COMMITTEE

The Convenor will seek feedback on the effectiveness of committee meetings following each meeting during the period of Board governance review.

The Committee will undertake an annual self-evaluation of its effectiveness and report the outcomes to the Audit Committees and Boards of Directors. The secretary will monitor the frequency of the Committee meetings and the attendance records to ensure attendance figures are complied with. The Terms of reference to be reviewed at least annually.

Agreed: ***Boards of Directors, 5-6 April 2023***

GROUP PEOPLE COMMITTEE
TERMS OF REFERENCE

1. Context

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

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

1. PURPOSE AND AMBITION

1.1 Purpose:

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

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

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

2. AUTHORITY

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

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

2.3 The committee will be accountable for diversity and inclusion steering groups in both Trusts.

3. MEMBERSHIP AND ATTENDANCE

Chairs of Committee	Non-Executive Director (KGH) Non-Executive Director (NGH) Each Trust will appoint a Chair. The Committee shall designate one of the Chairs to Convene meetings.
Members	Non-Executive Director (KGH) Non-Executive Director (NGH)
	Hospital Chief Executives
	Group Chief People Officer
	Trust Directors of People (or equivalent)
	Directors of Nursing, Midwifery and Allied Health Professionals
	Chief Operating Officers
	Medical or Deputy Medical Directors
	Staff Side representatives (2)
Attendees	Nominated Governor (KGH) and Deputy
	Others by invitation to discuss pertinent issues/topics
	Meeting Administrator
	Staff Side Representatives
	Group Head of HR and OD
	Freedom to Speak Up (FTSU) Guardians
	Guardians of Safe Working

Notes on membership and attendance:

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

4. MEETINGS AND QUORUM

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

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

4.3 The Committee shall meet not less than six times per year. Twice-yearly Strategy Sessions will be held at which assessments of progress against the People Plan priorities will be considered as well as an in-depth review of specific matters identified by the Committee.

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

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

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

5. SUPPORT ARRANGEMENTS

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

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

6. DECLARATION OF INTERESTS

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

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

7. DUTIES

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

7.2 Monitor the People Plan Delivery Plan implementation and progress in realising the plans, especially the reductions in the direct cost to the Trust of temporary (agency) workers.

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

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

7.5 To ensure that the Group values are embedded and demonstrated within the culture of both Trusts.

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

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

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

8. STANDING AGENDA THEMES

1.	Integrated Governance Report, focusing on shared workforce metrics
2.	People Plan Implementation
4.	Group Board Assurance Framework
5.	Reports from Sub-Groups aligned to People Plan themes
6.	Staff engagement and feedback
7.	Freedom to Speak Up Guardians' Reports (Quarterly)

9. REPORTING

9.1 The Committee will provide an assurance report to Boards following each Business Meeting.

9.2 The Committee will receive assurance reports from the sub-groups, which it may establish to progress Group People Plan priorities.

10. PROCESS FOR MONITORING EFFECTIVENESS OF THE COMMITTEE

10.1 These terms of reference may be amended in consultation with both Boards of Directors, to reflect changes in circumstances that may arise. This Committee in Common is recognised as undertaking a role to support and enable the delivery of the Group People Plan and its associated plans and policies and, as such, solutions considered may be iterative and designed to evolve over time. Together, both Boards of Directors will implement and regularly review the Terms of Reference, to ensure they are fit for purpose in meeting the continuing business needs of the Group.

11. REVIEW

Agreed: *March/April 2023 (Committee/Boards)*
Next Review: March 2024

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Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	5 April 2023
Agenda item	11

Title	Fit and Proper Persons Annual Declaration
Presenter	Rachel Parker, Interim Trust Chair
Author	Richard May, Interim Group Company 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
For the Board of Directors to accept the Chair's assurance that all Board Members continue to meet the Fit & Proper Persons requirements	None

Executive Summary

Colleagues whose roles are subject to the Group Fit and Proper Persons Policy have submitted yearly declarations satisfying Care Quality Commission (CQC) Registration requirements for the Trust to be able to demonstrate that all Directors are of good character and meet the CQC's Fit and Proper Persons Regulation.

Completed Declaration Forms will be retained on individuals' files by the Trust Board Secretary.

The Trust Secretary has also undertaken the following checks, from which no issues have emerged:

- Individual Insolvency Register;
- Companies House Register of Directors, and of Disqualified Directors;
- Web search

The Trust Chair is ultimately responsible for discharging the requirements placed on the Trust to ensure that all Directors meet the fitness test and do not meet any of the "unfit" criteria.

No concerns about relevant Directors' fitness or ability to carry out their duties or information about a Director not being of good character are required to be brought to the Board's attention. The Interim Trust Chair is therefore able to provide the Board with assurance that all members of the Board of Directors continue to meet the Fit & Proper Persons requirements.

RECOMMENDATION

The Board is asked to accept the assurance that all Members continue to meet the Fit & Proper Persons requirements.

Appendices
None
Risk and assurance
No direct implications of the Board Assurance Framework.
Financial Impact
None.
Legal implications/regulatory requirements
As set out above.
Equality Impact Assessment
Neutral

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Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	5 April 2023
Agenda item	12

Title	Annual Self-Certification in respect of conditions equivalent to the NHS Provider Licence and issue of new NHS Provider Licence
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
The Board of Directors is asked to approve the positive confirmation for each of the licence conditions set out in the report, and note the issue of a new NHS Provider Licence, which will apply to NHS Trusts from 1 April 2023.	The Audit Committee has been consulted on the draft self-certification; no objections were received.

Executive Summary

NHS Trusts are currently exempt from holding a provider licence, but they are required to comply with conditions equivalent to the licence that NHSE/I have

deemed appropriate (Conditions G6 (3) and FT4 (8), applying during 2022/23).

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

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

The Group Chief Finance Officer and Interim Group Director of Governance have determined that a positive confirmation can be given, and provided a rationale, for each of the required conditions: FT4 and G6.

The Board of Directors is asked to **APPROVE** the positive confirmation for each of the licence conditions.

New NHS Provider Licence

Following consultation, NHS England launched the new NHS Provider Licence on 27 March 2023 which, for the first time, requires NHS Trusts to be licensed. The new provider licence aims to support effective system working; enhances the oversight of key services provided by the independent sector; address climate change; and make a number of necessary technical amendments, including a reduction in future self-certification reporting requirements. Further information is set out in a briefing note prepared by NHS Providers, which is available on the 'Documents' section of the Board portal to accompany this agenda item. The new licence conditions are available to view here PRN00191-nhs-provider-licence-v4.pdf (england.nhs.uk), along with details regarding consultation responses: NHS England » NHS Provider Licence: consultation response.
The new licence is expected to be received by the Interim Chief Executive shortly.

Appendices

NHS Providers Briefing Note (available to Board Members in the 'Documents' section of the Board portal)

Risk and assurance

The self-certification statements signed off by the Board must set out any risks and mitigation planned for each statement if applicable.

Financial Impact

No direct financial implications.

Legal implications/regulatory requirements

The National Oversight Framework bases its oversight on the NHS provider licence and therefore Trusts are legally subject to the equivalent of certain provider licence conditions including G6 and FT4.

Equality Impact Assessment
Neutral

NGH Annual Self- Certification 2022-2023

1. Introduction

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

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

2. Requirements

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

· The provider has taken all necessary precautions required to comply with the licence, NHS Acts and NHS constitution (Condition G6 (3)).

· The provider has complied with required governance arrangements (Condition FT4 (8)).

· The CoS conditions only apply to Foundation Trusts; therefore, the Trust is not required to self-certify under the CoS7 condition.

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

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

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

2.1 Condition FT4 - Declaration

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

Rationale for rating: The Trust has in place, a scheme of delegation, standing orders, and a set of standing financial instructions. It has all statutory governance requirements in place and is subject to internal and external audit on the robustness of its arrangements. The Trust was subject to a CQC Well-led inspection in 2019 and is rated as Requires Improvement for well-led overall.

Rating: Confirmed

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

Rationale: The Board receives advice on compliance with existing guidance and information on new guidance issued by regulators, in reports from the Interim Group Director of Corporate Governance. The Trust undertook a self-review of the CQC Well-Led domain during 2022-23.

Rating: Confirmed

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

·Rationale: The Board has an established a governance structure. All Committees are supported by terms of reference which are regularly reviewed & approved by Board. The Annual Governance Statement, contained within the Annual Report, sets out developments each year. Executive Director responsibilities are set out in job descriptions and effective appraisal processes are in place to support Board members. The Audit committee is the principal committee providing oversight and approves the Annual Report and Annual Governance Statement under delegated authority from the Board.

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

Rating: Confirmed

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

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

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

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

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

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

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

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

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

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

Rating: Confirmed

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

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

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

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

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

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

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

Rationale:

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

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

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

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

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

Rating: Confirmed

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

Rationale: The Trust has systems in place to ensure that staff employed at every level are appropriately qualified for their role. The Board and its committees receive data on staffing figures regularly and the impact of staffing issues on delivery of its NHS contracts. The Trust reports monthly on Clinical staff fill-rates and safe staffing reports. The Dedicated to Excellence Strategy, Group People Plan and annual operating plan include objectives for the short-term and long-term staffing needs of the Trust.

Rating: Confirmed

2.2 Condition G6 - Declaration

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

a. identify risks to compliance with the licence, NHS acts and the NHS Constitution

b. guard against those risks occurring.

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

Rating: Confirmed

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Cover sheet

Meeting	Board of Directors (Part I) Meeting in Public
Date	5 April 2023
Agenda item	13

Title	Appointments
Presenter	Rachel Parker, Interim Trust Chair
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
Appointments to the roles of Trust Vice-Chair and Senior Independent Director and to Committee positions are reserved to the Board under the terms of the Trust's Standing Orders.	None

Executive Summary

Following the appointment of Rachel Parker to the position of Interim Trust Chair (an NHS England appointment) and other recent changes in Board composition and the allocation of duties and responsibilities, the Board is invited to:

(1) Appoint Denise Kirkham to the roles of Interim Trust Vice-Chair and Senior Independent Director;

(2) Appoint Anette Whitehouse to the Group Transformation Committee to replace Rachel Parker; (3) Appoint Anette Whitehouse to the position of Non-Executive Safeguarding Lead to replace Jill Houghton, and (4) Appoint a third Non-Executive Director to the Audit Committee.
Appendices
None
Risk and assurance
No direct implications for specific risks on the Group Board Assurance Framework.
Financial Impact
None
Legal implications/regulatory requirements
As set out in ‘reason for consideration’ section above.
Equality Impact Assessment
Neutral