UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 30 July 2020

09:30

Via ZOOM
Northampton General Hospital

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

AGENDA

NHS
Northampton General Hospital
NHS Trust

PUBLIC TRUST BOARD

Thursday 30 July 2020
09:30 via ZOOM at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr A Burns	**Verbal**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal**
	3.	Minutes of meeting 28 May 2020	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Patient & Staff Vlogs	Receive	Ms S Oke Mr M Metcalfe	**Verbal.**
	6.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	7.	Chief Executive's Report	Receive	Mr S Weldon	**C.**
PERFORMANCE					
	8.	Integrated Performance Report	Assurance	Executive Directors	**D.**
GOVERNANCE					
	9.	Board Assurance Framework	Approval	Ms C Campbell	**E.**
	10.	Covid-19 Reset	Assurance	Mrs D Needham Mr C Pallot Mr M Smith	**F.**
	11.	NGH Improvement Plan	Assurance	Ms C Campbell	**G.**
	12.	Group Governance Paper	Assurance	Mr S Weldon	**H.**
STRATEGY & CULTURE					
	13.	Equality, Diversity and Inclusion – BAME Staff Support	Assurance	Mr M Smith	**I.**
ANNUAL REPORTS					
	14.	Freedom To Speak Up Annual Report	Assurance	Ms C Campbell	**J.**
	15.	National Inpatient Survey Feedback 2019	Assurance	Ms S Oke	**K.**

Time	Agenda Item		Action	Presented by	Enclosure
GOVERNANCE continued					
	16.	Questions from the Public (Received in Advance)	Information	Mr A Burns	**Verbal.**
11:30	**17.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held 24 September at 09:30 on 2020 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Minutes of the Public Trust Board

Thursday 28 May 2020
09:30 by ZOOM teleconference

Present		
	Mr A Burns	Chairman (Chair)
	Dr S Swart	Chief Executive Officer
	Mrs D Needham	Chief Operating Officer and Deputy CEO
	Mr M Metcalfe	Medical Director
	Ms S Oke	Director of Nursing, Midwifery and Patient Services
	Mr P Bradley	Director of Finance
	Ms J Houghton	Non-Executive Director
	Mr J Archard-Jones	Non-Executive Director
	Ms A Gill	Non-Executive Director
	Mr D Moore	Non-Executive Director
	Prof T Robinson	Associate Non-Executive Director
	Ms R Parker	Non-Executive Director
	Ms D Kirkham	Associate Non-Executive Director
In Attendance		
	Ms C Campbell	Director of Corporate Development Governance and Assurance
	Mr S Finn	Director of Facilities and Capital Development
	Mr T Richard-Noel	Next NED Scheme
	Ms K Palmer	Executive Board Secretary
Apologies		
	Mr C Pallot	Director of Strategy and Partnerships
	Mr M Smith	Chief People Officer

TB 20/21 001 **Introductions and Apologies**

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

TB 20/21 002 **Declarations of Interest**

No new Declarations of Interest were noted.

TB 20/21 003 **Minutes of the Public Trust Board held on 26 March 2020**

The minutes of the Public Trust Board held on 26 March 2020 were presented and **APPROVED** as a true and accurate recording of proceedings subject to amendments raised by Prof Robinson.

TB 20/21 004 **Matters Arising and Action Log Public Trust Board**

The Matters Arising and Action Log were considered and noted.

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

TB 20/21 005 **Chairman's Report**

Mr Burns advised that work was ongoing with the group governance agenda The NEDs had been involved in a workshop to discuss the previous day. The transition would start next month.

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

TB 20/21 006 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart advised that COVID19 was the focus for the Trust and would likely be so for the foreseeable future. It was a challenging situation for a combination of issues and the Trust had received an exceptional response from the workforce.

Dr Swart stated that her biggest concern going forward with the workforce. The Trust was providing the best it could do in regards to testing and PPE. This would continue to be important.

Dr Swart commented that the Trust had lost a number of patients and the death rate was similar to that of the national picture. The Trust had sadly lost one of their own team.

She noted that teamNGH continued. The Trust had a new Head of Midwifery and Dr Swart remarked that this had been positive.

Dr Swart referred to what would be the new 'normal' for the NHS nationally, regionally and locally. She queried what would be done differently. The work with social care was important however noted that there was tension here. Dr Swart believed that all partners needed to be involved.

Dr Swart thanked all staff across the hospital for their continued hard work despite being stretched operationally.

Mr Burns on behalf of the Board formally thanked all staff for going that extra mile. The Board also shared their deep regret in respect to the staff member who had died as a result of the virus.

Ms Houghton referred back to the new Head of Midwifery. She was pleased to have this good news and had noticed a difference since the person had been in post. There was a new perspective and the Head of Midwifery's national contacts would be of benefit to the Trust.

Mr Archard-Jones asked about staff testing in relation to information that if you already had a positive COVID19 test and then received a further positive COVID19 test you were not to self-isolate. He remarked that this was very confusing. Dr Swart explained she had also questioned this. She had been sent an article which claimed a person was less likely to be infectious the second time they had a positive COVID19 test. If the area the staff is in was high risk it may be requested that the member of staff wore a mask.

Ms Gill asked what were the operational implications of the expected sickness rate for the remainder of the year. Dr Swart advised that these were considerable and would be brought into the reset discussions. The Trust had been able to cope at current as the whole hospital was not open. There may need to be a different level of expectation set. Mr Burns commented that annual leave also needed to be added in to this. The Trust needed to control the rate it did things.

Dr Swart stated that she had attended a system call yesterday. There was considerable pressure in regards to reset. The Trust was asked to commit to a level of activity. It was important that the trust to not commit to what it couldn't achieve. The Trust needed to be clear in the stance as it moves forward.

Mr Moore noted the track and trace that had been introduced by the

government. He asked did the staff swabbing results at NGH get fed into this. Dr Swart advised that this had been picked up by the Strategic Commissioning Group. It was the responsibility of local government to organise. She commented that the Trust has been asked to introduce antibody tests by the end of the week. Dr Swart however confirmed that these results would not be included in the track and trace scheme.

Mr Moore asked if he was to receive a positive result how would he be informed. It was clarified that the Trust would telephone him.

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

TB 20/21 007 Integrated Performance Report

Dr Swart introduced the Integrated Performance Report. Each Director would deliver an update.

Ms Oke presented the Director of Nursing update.

Ms Oke advised that the 'relatives helpline' for family members to call for an update on their loved one had been set up and was receiving 60 calls a day. There were also electronic devices now available on all wards to enable patients to communicate directly with friends/family. Ms Oke reported that 'Letters to Loved Ones' had also been implemented. There had also been a new generation of volunteers from across the organisation.

Ms Oke commented that as part of the reset programme there would be work done on how to obtain patient feedback.

Ms Oke informed the Board as her role as DIPC the Trust had complied with national guidance and had provided adequate PPE for staff. Mr Burns queried whether the Trust was confident it could push the system enough to deliver the correct levels of PPE. Ms Oke remarked that her confidence level varied. PPE equipment was talked about as part of the reset and also with KGH. Ms Oke complimented the fantastic procurement team on site.

Ms Gill asked if the oversea nurses had arrived. Ms Oke explained that the Philippians and Indian government had had gone into lockdown. There was also staff that had travelled home prior to lockdown who could not return at current. The Trust was awaiting the arrival of 60 nurses

Mrs Needham shared the Chief Operating Officer update with the Board.

Mrs Needham advised that in April the majority of activity had been paused. The numbers of A&E attendees reduced by between 60-70% and emergency admissions also decreased. The last 7-10 days there has been an increased number of emergency activity especially with illness not related to COVID19.

Mrs Needham commented that the information on the SPC charts looked different and this was due to the numbers of patients rapidly discharged in April which brought occupancy levels down to 60% which was the lowest Mrs Needham had ever known.

Mrs Needham reported that diagnostics had been paused and this had impacted the list of patients over 62 days without a diagnosis. The number of legacy patients was currently at 266. This number was usually lower than 100.

Mrs Needham remarked that the 2ww referrals had started to increase and as the Trust starts to see these patients it would be able to establish whether any

harm had been caused by this delay.

She informed the Board that the Trust was currently working with KGH regarding sharing of diagnostics with Endoscopy noted to be the major gap. There had been some Endoscopy work started however was not at the same level as before and was down 50% from previously. The activity was reduced due to social distancing requirements and use of PPE.

Ms Houghton referred to page 25 of the report pack and the mention of a large number of patients throughout April and May who refused to attend to have diagnostics and/or treatment. She asked the reasons behind this. Mrs Needham clarified that some of these patients were scared of the risk of infection and therefore their treatment had been paused on the waiting list.

Ms Houghton queried the 'SPC Chart – #NoF – Fit Patients Operated on Within 36 Hours' and the 5 not done in 36 hours due to lack of time. Mrs Needham explained that additional ITU beds were housed in main theatres therefore there was less theatre space available. In April there had also been an increased level of trauma. The Trust had to prioritise the time on the list and this could become quite complex.

Ms Gill asked what message is being sent to staff in terms of reassurance. Mrs Needham stated that there was daily communication sent to all staff. She had also recently signed of social distancing information which would be circulated to staff.

Mr Moore queried whether the number of empty beds included Three Shire beds. He was informed it did not. The Trust currently had 162 empty beds. Mrs Needham stated that the Trust was not utilising all the beds at Three Shires as it needed the medical staff at NGH. Mr Moore asked if the Trust maximised Three Shires and Mrs Needham believed that it did. She hoped that as COVID19 activity reduced more work could be done at Three Shires and it was a key part of the reset plan.

Ms Kirkham stated that she read the daily briefing and had noticed the numbers of stranded and super stranded patients increase, along with the available beds decrease. She remarked that there appeared to be flow issues and that it had happened quite quickly. Mrs Needham advised that every patient has to have a swab and then the patients' needs to be held until the swab is received back, also testing does not happen overnight therefore all of this impacted on flow. The nursing homes were also reluctant to take patients back.

Ms Kirkham asked for the number of beds on the closed wards. Mrs Needham clarified that Victoria and Compton Ward hoped to be kept closed until winter with another ward opening as a frailty unit.

Mr Bradley shared the Director of Finance update.

Mr Bradley advised that this was the first report since the new block contract for 2020/21 had been initiated; this has now been extended to the end of October 2020. The block payment was based on the run-rate from M9 in the last financial year and then topped up with COVID19 related costs and to cover loss of other income.

Mr Bradley reported that Non-COVID operational activity was down as expected leading to a £9.7m shortfall in clinical income. It was noted that COVID spend for the month was £2.4m.

Mr Bradley stated that Pay and Non-pay were underspent by £0.6m. When COVID spend of £2.4m was excluded, this meant an underspend of £3.0m which was not unexpected given the reduction in operational activity and consequent underachieved income of £9.7m.

Mr Bradley remarked that agency spend was similar to before. The nurse agency spend had decreased however medical agency spend had remained high. Due to sickness certain posts had to be extended as if this had not happened the Trust would have experienced significant issues. There had been big spending reported in Oncology however this vacancy had now been filled.

Mr Burns touched on the reimbursement of COVID19 costs. He also challenged what would now be considered good if not measured by payment by results.

Ms Parker queried how the COVID19 costs are captured. Mr Bradley stated that these were classed as excess costs related to COVID19. He noted a large amount of the base cost was covered in the block contract. One of the biggest costs was related to staff and patient testing. A separate cost centre and email address had been created. The Trust would now be looking at the costs related to the reset. The Capital spend in the month was £1.5m mainly related to COVID19 expenditure and this was discussed in greater detail at the Finance & Performance Committee. The processes around Capital spend approval and reimbursement keeps changing as NHSE/I introduced frequent changes with a response received in 7 days.

Mr Moore remarked that without PBR what performance indicators would be place.

Dr Swart delivered the Chief People Officer update on behalf of Mr Smith,

Dr Swart advised that there was an emphasis on getting staff back to work safely. With staff testing, track and trace and the summer holidays staff absence was likely to increase.

Ms Gill thanked the HR team for their phenomenal work in terms of the support they had put in place.

Mr Metcalfe presented the Medical Director update to the Board.

Mr Metcalfe advised that it had been planned for VTE to be recorded on EMPA however prior to COVID19 there had been complications with this. The VTE assessment was now recorded on paper and integrated into the admissions clerking proforma. There were regular Audits of prophylaxis have confirmed good compliance which is particularly important for COVID19 patients given the high risk of thrombotic episodes and complications. The Quality Governance Committee would receive regular updates on this.

Mr Metcalfe reported that as part of a review of the “governance lite” arrangements instituted during phase 1 of the COVID19 response, review of harm meetings and limited investigations of harm incidents had now been resumed.

Mr Metcalfe commented that as anticipated the HSMR had increased as had the crude mortality. This was associated with a spike in deaths of patients admitted on a Sunday. A Trust-wide mortality review would be undertaken. The

SHMI was still as expected.

Ms Houghton found the update to be helpful. She asked when the Mortality Committee would be reintroduced. Mr Metcalfe clarified that it had been reintroduced in light form and would invite Ms Houghton to attend the next meeting.

Mr Moore requested a research update as to what NGH was doing. Mr Metcalfe advised that clinical research staff had not been deployed to the front line. The Trust had opened every COVID related study it could. Mr Metcalfe was diverting resource to support the Research & Development Team. As part of the reset programme the Trust was part of the second largest research project.

Mr Archard-Jones queried the delegation of 'do not resuscitate' to the Junior Doctors. Mr Metcalfe explained that the medical staff were thinly spread and needed this support. The senior consultants would review as soon as possible. He stated that senior nurses had also been given this responsibility.

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

TB 20/21 008 COVID19 NGH response

Mrs Needham presented the COVID19 NGH response.

Mr Burns commented that he had found the information within this document to be very impressive.

Mrs Needham advised that the report pulled all the information into one document to formalise the response. She referred the Board to appendix one and summarised the contents. Each Bronze cell has highlighted areas of work they had undertaken as part of the response. This included; use of private sector for operations, expansion of critical care beds into main theatres, virtual outpatients, staff testing on site and estates working on wards to support IPC.

Mrs Needham remarked that teamNGH had stepped up to the challenge with little negativity. There are many staff who have changed the way they work or the role they do. Mrs Needham was very impressed with the positivity and can do attitude of the Workforce.

Ms Parker asked whether there had been talks with KGH as to whether have one as the COVID19 Trust and the other as non-COVID19. Mrs Needham stated that there was a meeting with KGH on the 15 June 2020. She remarked that there had been some discussion of having a hot/cold site, but this had not progressed any further at present

Mr Burns queried the cost of Three Shires. Mrs Needham remarked that this cost was being met centrally until the end of June 2020 and further guidance would be issued centrally on future funding.

Ms Houghton mentioned that at the Quality Governance Committee risk of virtual clinics had been discussed. Mrs Needham commented that all risks needed to be thought about and balanced, including foot fall on site, social distancing and the need to diagnose patients face to face. It was noted that for most specialities the virtual appointments was much quicker for the patients.

The Board **NOTED** the COVID19 NGH response

TB 20/21 009 **Reset Plan**

Mrs Needham presented the Reset Plan. The Trust was working closely with KGH on this.

Mrs Needham advised that the government had asked the Trust to start to reintroduce some routine work whilst still adhering to social distancing measures and the use of PPE. She noted that this was in itself a challenge. There was talk of the new NHS from 2021 and this was the Trust's opportunity to work closer with system colleagues and make ambitious changes.

Mrs Needham stated that the Trust needed to be mindful that it was still working under a national level 4 incident regime managing the response to COVID19.

Mrs Needham remarked that the regulators think the Trust would be back up to 100% activity by the autumn however her view was it would be more likely be at 40-60%.

Mrs Needham reported that the regional modelling suggested a June peak which would be the same activity as the April peak and then further along an Autumn super peak.

Mrs Needham highlighted that the paper detailed the governance on how the Trust was leading the reset. The areas of focus for the bronze cells are noted in the appendix. She stressed that the key challenges would be restarting routine elective work whilst trying to separate positive and negative patients. There would be restarting of governance lite following from the freedom of fewer or no meetings, and this had been embraced. There needs to be a middle ground achieved here.

Mrs Needham advised that she had seen a change in leadership, especially clinical leaders who had stepped up to the challenge and this did not want to be lost.

Mrs Needham commented that the plan was aligned with KGH and the Trusts had weekly reset meetings. There would be some differences, the detail of these would be discussed and debated weekly. The Trust did not want inequity for patients in the County.

Ms Gill asked how confident was Mrs Needham that partners would take the same approach. Mrs Needham remarked that this was variable across the system partners. Her area of concern was the increased number of super stranded patients and this would be a struggle if the autumn peak happened. Mrs Needham informed the Board that there had been executive conversations with those at KGH as to if other partners could not provide in the community what could the two Trust's provide or support with.

Dr Swart stated that the Trusts have a shared set of ambitions.

Mr Moore referred back to the 40-60% comment by Mrs Needham. He noted that this was not good to hear and therefore was even more important to use outsourcing.

Mr Moore asked why another outbreak was believed to be happening in the Autumn. Mrs Needham explained that this was linked to the schools going back and more people returning to work as lockdown is relaxed

Mr Burns asked if the modelling had been shared with staff. Mrs Needham

advised that there was communication daily and next week any relevant information would be included within the communication to staff. There was also vlogs on the Facebook page.

Mr Richard-Noel queried how the Trust was preparing for the potential large influx of patients in the Autumn. Mrs Needham believed that the reset would prepare the Trust for this. The Trust needed to work with system partners again. Especially to reduce the bed occupancy.

Mr Burns believed that the plan was good and the external work was as important. It was important to embrace system partners to make for a better environment. The Trust must do its best to hold control as it reopens services and encouraged advising staff of what was expected to happen.

The Board **NOTED** the Reset Plan.

TB 20/21 010 **Infection Prevention & Control Board Assurance Framework**

Ms Oke presented the Infection Prevention & Control Board Assurance Framework.

Ms Oke advised that on 4 May 2020 NHS England/Improvement published an Infection Prevention & Control Framework. It was not compulsory to complete the framework however, it was provided to enable organisations to self-assess the Trust compliance with Public Health England (PHE) guidance. This would be looked at even more closely as the Trust moved into the reset.

Ms Oke reported that the Infection Prevention & Control Team had completed the self-assessment, the key areas of focus would be on auditing the Trust's current practice including; Audit of patient notes regarding 'streaming' and Audit of PPE compliance across the organisation.

Ms Oke stated that the outcome of these audits would be shared as part of future Infection Prevention & Control reports, then fed up to the Quality Governance Committee.

The Board **NOTED** the Infection Prevention & Control Board Assurance Framework.

TB 20/21 011 **Future Risks to COVID19**

Ms Oke and Mr Metcalfe presented the Future Risks to COVID19.

Mr Metcalfe advised that the paper illustrated the way in which the COVID19 strategic and corporate risks were likely to complicate the reset process for the delivery of clinical services as we progress through response phases. He remarked that many of these had been discussed through the course of the meeting.

Mr Metcalfe stressed the importance of monitoring the availability and welfare of the workforce. Ms Oke concurred.

Mr Richard-Noel queried the BAME percentage at NGH and COVID19. Mr Metcalfe clarified that it was similar to that of the national picture. He stated that 1900/5000 staff were BAME. In terms of how this staff group had engaged with the Trust has been exemplary. These staff felt supported by the organisation.

Ms Gill commented that the Equality & Diversity Lead had established a proactive BAME group. She had done a ZOOM call with the group, Mr Smith

and Dr Swart to seek assurance on how best support them. The feedback had been positive.

Mr Burns remarked that the number of positive tests appeared to be increasing. Mr Metcalfe explained that this was due to how the information was collected. On the daily silver call it appeared that there were outbreaks in specific clinical teams and this became more complicated with the medical workforce. At the peak there was between 15-20% absence. For example there was only one Haematology Consultant in at one point to see patients and that was a concern. There were contingency plans put in place.

Ms Parker shared her concern that there appeared to be a perfect storm brewing due to only 40% activity, Track & Trace, Autumn peak and asymptomatic staff testing. She challenged whether the Trust was prepared. Mr Metcalfe concurred, the Trust was in unknown territory and this was of a concern.

Dr Swart agreed that this was complicated and the Trust were putting plans in place. It was important that the Board was aware of the scale of the challenge.

Ms Gill referred to page 121 of the report pack and the narrative that there had been an outbreak of COVID19 on one of our wards identified when 3 patients tested positive after admission with non-COVID19 symptoms. She asked how this risk had been minimised. Mr Metcalfe explained that it was difficult to test patients twice as the patients could not always be held before a second test. The patients however are kept to a minimum to reduce cross infection. Further outbreaks of COVID19 would be a big challenge to the reset.

Mr Burns suggested an online seminar in mid-July to update and share ideas moving forward. The Board agreed with this and Mr Burns asked Ms Campbell to look at.

Action: Ms Campbell

The Board **NOTED** the Future Risks to COVID19.

TB 20/21 012 Any Other Business

There was no other business to discuss.

Date of next meeting: Public Trust Board - Thursday 30 July 2020 at 09:30 in the Board Room at Northampton General Hospital.

Public Trust Board Action Log **Last update** **23/07/2020**

Item No	Month of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Updates
Actions - Slippage								
Actions - Current meeting								
122	May-20	TB 20/21 011	Future risks to COVID19	Mr Burns suggested an online seminar in mid-July to update and share ideas moving forward. The Board agreed with this and Mr Burns asked Ms Campbell to look at.	Ms Campbell	Jul-20	On agenda	**Update in Matters Arising**
Actions - Future meetings								
120	Jan-20	TB 19/20 100	Agency Staff Governance	Mr Burns asked for an update at a future Board.	Ms Oke/Ms Curtis	TBC	TBC	**update for **July Board** - Progress has been made on identifying recurring agency costs, particularly those that are long term. Prior to the pandemic a reduction in cost was noted with some additional positive forecasts. For those posts where there was not an alternative solution identified it was recognised that the market was very difficult. The Director of HR continued to monitor and seek any solutions. Unfortunately further action was temporarily suspended owing to Covid. As part of the reset process the Director of HR is reviewing the current position and along with the Director of Finance will be reinstating the review process in August. With regards to the employment of Health Care Assistants, recruitment has continued throughout the pandemic meaning that once through the recruitment process vacant posts in core areas will be filled. An HCA pool is currently being tested which will support the employment of 'bank only' trained HCA staff.

Report To	**Public Trust Board**
Date of Meeting	**30 July 2020**

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

This paper is for: (delete as appropriate)

		☐ Note	
		For the intelligence of the Board without the in-depth discussion as above	

Executive summary

In this, my first report as Group Chief Executive, I want to talk about my thinking to date on the Group and the opportunities it can bring. However, before turning to that, I want to reflect on the last couple of months and on what lies ahead in the remainder of the year.

From a hospital perspective, it is clear that we are emerging from the initial phase of the pandemic. Both hospitals have endured the most testing of times. Our staff have been magnificent. We have been supported with great generosity by our communities. Yet we know we have to continue to build our resilience to face a further wave of Covid. As I write, the latest data shows that the coronavirus infection rate in the borough of Northampton remains above the national rate (455.6 per 100,000) and regional average at 535.2 per 100,000.

The rate of infection is increasing, and the number of positive tests is also increasing within the borough. Action is being taken to address this situation by partners across the system and I append the latest advice to this report.

The message is clear: the virus is very much still with us and we need to maintain a constant state of vigilance and readiness to respond. More than that, we need to now prepare for the winter that is ahead. Work is in hand on this: not only do we need to secure the correct level of non-elective capacity; we need to maintain access to Covid free elective capacity. On the former, our partnership with local government will be critical. Their support during the first phase of the pandemic has been essential and it will be again as we face a second wave. On the latter, the access to independent sector capacity will be key. On elective work more generally, I would encourage everyone who needs treatment to seek it: all local partners will be emphasising this message and we will play our part in the

communications that are planned across Northamptonshire to assure patients that our hospitals are safe places.

As we consider how best to establish the Group, it can be easy to think only about the complexity and difficulties that are involved. I want to encourage an optimistic outlook. I had the occasion to review some of the early comments on what some of the senior leaders thought and I attach the word cloud of those comments here:

The dominant themes in the comments are obvious: opportunities, patients and staff. I think this is the spirit in which we must approach this task. So, the work now begins: I am beginning the process of appointing to joint posts and there will soon be an expectation to articulate plans and arrangements for the emergent hospital group. This includes a shared vision and values, supported by strategic priorities. These will articulate what the Group plans to offer patients, staff, the wider health and care economy, and other partners, among others.

It is worth noting that staff morale, health and wellbeing have been directly affected by significant pressures during the pandemic, and there is clearly a need to enthuse and re-energise the collective workforce. Not only does the decision to form a group enable significant improvements to be made in the quality of care provided collaboratively, but it represents a major opportunity to look beyond immediate operational challenges and develop a fresh, aspirational and exciting vision for the future. Before, I conclude I would like to acknowledge the excellent progress that both hospitals have made in respect of their estate: in Northampton, funding has been secured to build a new ITU and for upgrades to the electrical system. In Kettering, the outline business case for the Urgent Care Hub has been submitted and masterplanners appointed to start the process of developing the strategic outline case for the wider rebuild of the hospital. This progress is very welcome and I would like to thank everyone involved.

Finally, I'd like to end today by acknowledging the contribution of two people: first, I would like to pay my own tribute to my predecessor in Northampton, Dr Sonia Swart. She led the Trust with distinction over many years and in her wider career made a lifetime contribution to the NHS. I wish her very well in her retirement and know she will continue to contribute to the development of leadership in the NHS. Secondly, I would like to thank Nicci Briggs for her service as Kettering Director of Finance. She has made a massive contribution to the life of the Trust. She started as a finance business partner 10 years ago and leaves us as a Director of the Board. I think that is a fantastic journey and I know that she has taken that focus on developing staff in her own team. Beyond that, we all know about Dragons Den and her passion for frontline staff led innovation. Those projects funded by the Den, I think will be her proudest legacy and rightly so. I wish all the very best.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with*

	Kettering General Hospital 5. *Create a great place to work, learn and care to enable excellence through our people* 6. *Become a University Hospital by 2020 becoming a centre of excellence for education and research*
Risk and assurance	Risks arising from the Group Model will be identified and managed via both Trusts risk registers
Related Board Assurance Framework entries	All
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Financial Implications	To be advised as the group model develops
Legal implications / regulatory requirements	None

Actions required by the Board

The Board is asked to:

- Note the paper

UNIVERSITY OF LEICESTER
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NHS
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Appendix 1:

- Limit contact with others outside of your household or bubble
- Work from home if you can
- Keep 2 metres from others at all times, use a face covering where you are less than 2 metres apart
- Avoid using public transport or car sharing, wear face coverings if you cannot avoid these
- If you have COVID-19 symptoms, stay at home, self-isolate and get a test
- Avoid meeting those outside of your household or bubble in an indoor space
- Wash your hands regularly and thoroughly for 20 seconds each time
- Do not share items with others outside of your household or bubble
- If you have COVID-19 symptoms, do not go to work, either work from home or report sick, self-isolate and get a test
- Even if you only have mild COVID-19 symptoms, get a test
- If you are contacted by test and trace and asked to self-isolate, stay at home for 14 days

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NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**30 July 2020**

Title of the Report	**Integrated Performance Report**
Agenda item	**8**
Presenter of Report	Executive Directors
Author(s) of Report	Sean McGarvey (Head of Information) Directors

This paper is for: (delete as appropriate)

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

Executive summary

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

Each Director has provided a summary.

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

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

Actions required by the Trust Board

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

Corporate Scorecard – Integrated Performance Report

Date: July 2020
Reporting Period: June 2020

Northampton General Hospital NHS
NHS Trust

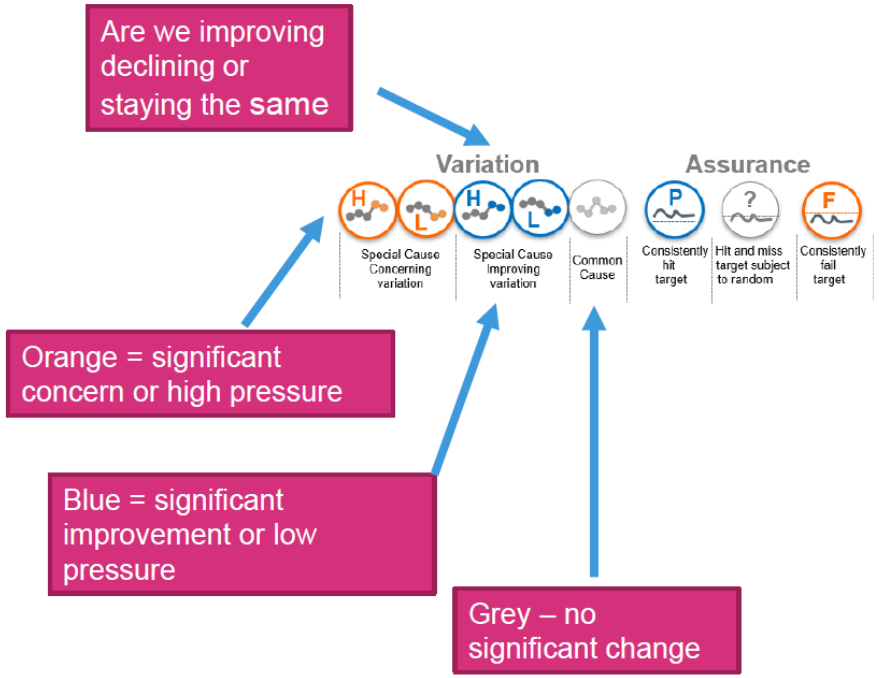
Pilot SPC Charts

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

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

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

High level key - variation



High level key - assurance

Domains: Caring, Effective & Safe

Domain	Metric	Target	Variation	Assurance	Chart
Caring	Complaints responded to within agreed timescales	90%	No Update due to Covid-19		
Caring	Friends & Family Test % of patients who would recommend: A&E	86%			
Caring	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	96%			
Caring	Friends & Family Test % of patients who would recommend: Maternity - Birth	97%			
Caring	Friends & Family Test % of patients who would recommend: Outpatients	94%			
Caring	Mixed Sex Accommodation	0	L	?	

Domain	Metric	Target	Variation	Assurance	Chart
Effective	Length of stay - All	4.2	?	?	
Effective	Percentage of discharges before midday	25%	L	F	Page 9
Effective	# NoF - Fit patients operated on within 36 hours	80%	?	?	
Effective	Maternity: C Section Rates	29%	?	?	
Effective	Mortality: HSMR	106	?	?	
Effective	Mortality: SHMI	109	?	P	
Effective	Stranded Patients (ave.) as % of bed base	40%	Outside Control Limits	?	Page 10
Effective	Super Stranded Long Stay Patients (ave.) as % of bed base	25%	Outside Control Limits	?	Page 11

Domain	Metric	Target	Variation	Assurance	Chart
Safe	HOHA and COHA (C-Diff > 2 Days)	3	?	?	
Safe	MSSA > 2 Days	1	?	?	
Safe	VTE Risk Assessment	95%	Outside Control Limits	?	Page 26
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	60	?	?	
Safe	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	98%	?	?	

Section:	Indicator:	Target:	May-20	Jun-20	Chart
Caring	Compliments	N/A	No Update due to Covid-19		

Section:	Indicator:	Target:	May-20	Jun-20	Chart
Effective	Patient Ward Moves Overnight (22:00 - 06:59)	=0	411	421	
Effective	Readmissions within 30 days of previous reporting month	<=12%	13.8%	5.4%	
Effective	% Daycase Rate	>=80%	89%	85%	

Section:	Indicator:	Target:	May-20	Jun-20	Chart
Safe	Never event incidence	0	0	0	
Safe	Number of Serious Incidents (SI's) declared during the period	N/A	4	1	
Safe	MRSA > 2 Days	0	0	1	
Safe	New Harms	<=2%	No Update due to Covid-19		
Safe	Appointed Fire Wardens	>=85%	100.0%	100.0%	
Safe	Fire Drill Compliance	>=85%	90.5%	94.7%	
Safe	Fire Evacuation Plan	>=85%	100.0%	100.0%	

Domains: Responsive

Domain	Metric	Target	Variation	Assurance	Chart
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	90%			
Responsive	Average Ambulance handover times	00:15:00			
Responsive	Ambulance handovers that waited over 30 mins and less than 60 mins	25		F	Page 12
Responsive	Ambulance handovers that waited over 60 mins	10			
Responsive	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	L		
Responsive	Delayed transfer of care	23			
Responsive	Average Monthly DTOCs	23	Outside Control Limits		Page 13
Responsive	Average Monthly Health DTOCs	7			
Responsive	Cancer: Percentage of patients treated within 31 days	96%			

Domain	Metric	Target	Variation	Assurance	Chart
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%			
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%			
Responsive	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%			
Responsive	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%		F	Page 14
Responsive	Cancer: Percentage of patients treated within 62 days of referral from screening	90%			
Responsive	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	85%			
Responsive	RTT over 52 weeks	0	Outside Control Limits		Page 16
Responsive	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	99%	Outside Control Limits	F	Page 17
Responsive	Stroke patients spending at least 90% of their time on the stroke unit	80%	No Update Due to Covid-19		
Responsive	Suspected stroke patients given a CT within 1 hour of arrival	50%			

Section:	Indicator:	Target:	Apr-20	May-20	Chart
Responsive	RTT median wait incomplete pathways	<=10.9	11.6	13.1	Page 15
Responsive	Cancer: Faster Diagnosis Standard	>=63%	53%	69%	

Section:	Indicator:	Target:	May-20	Jun-20	Chart
Responsive	Unappointed Follow Ups	=0	5,871	5,774	

Domains: Well Led

Domain	Metric	Target	Variation	Assurance	Chart
Well Led	Income YTD (£000's)	0%	Outside Control Limits	?	Page 19
Well Led	Surplus / Deficit YTD (£000's)	0%	Outside Control Limits	?	Page 20
Well Led	Pay YTD (£000's)	0%	Outside Control Lilts	?	Page 21
Well Led	Non Pay YTD (£000's)	0%	L	?	
Well Led	Bank & Agency / Pay %	7.5%	Outside Control Limits	F	Page 22
Well Led	CIP Performance YTD (£000's)	0%	No Update due to Covid-19		
Well Led	Sickness Rate	3.8%	Outside Control Limits	?	Page 24

Domain	Metric	Target	Variation	Assurance	Chart
Well Led	Staff: Trust level vacancy rate - All	9%	No Update due to Covid-19		
Well Led	Staff: Trust level vacancy rate - Medical Staff	9%			
Well Led	Staff: Trust level vacancy rate - Registered Nursing Staff	9%			
Well Led	Staff: Trust level vacancy rate - Other Staff	9%			
Well Led	Turnover Rate	10%		P	
Well Led	Percentage of all trust staff with mandatory training compliance	85%	No Update due to Covid-19		
Well Led	Percentage of all trust staff with role specific training compliance	85%			
Well Led	Percentage of staff with annual appraisal	85%			
Well Led	Job plans progressed to stage 2 sign-off	90%			

Section:	Indicator:	Target:	May-20	Jun-20	Chart
Well Led	CIP Performance - Recurrent	N/A	No Update due to Covid-19		
Well Led	CIP Performance - Non Recurrent	N/A			
Well Led	Percentage of all trust staff with mandatory refresher fire training compliance	>=85%			

Directors view – Director of Nursing

Performance:

Friends & Family Test
At present, no FFT data is required to be submitted to NHSE due to the pandemic. The Trust continues to collect locally through SMS messaging and automated voice calls, we are one of the few trusts across the country to maintain this service. Feedback will be reviewed as a period of time, separate to normal data collection months to prevent the skewing of data.

Actions to date:
During the Pandemic the Patient Experience team has reviewed the patient feedback data and continued to support PAL's, Complaints and the Volunteers in proactively supporting our patients.

Complaints Service:
Our Complaints Service has recommenced in line with national guidance. Some complaints have been managed through the Covid 19 period however, the team will now be focusing on the 'suspended' letters.

Electronic Devices for patients:
NGH was one of the first hospitals to roll out iPads to the isolation wards, packed with video calling apps and entertainment. The Patient Experience team have issued over 70 devices to date. Video calls are supported by the Volunteers since April, this has significantly improved the process. We are reviewing future options to further utilise the iPads to capture and enhance patient experience.

Letters to Loved Ones
We have set up an email address where loved ones can send letters and photos and the patient experience team and PNS team print them off during the week and they are delivered by volunteers. The volunteers print and deliver the letters at the weekend. To date, over a thousand letters have been received and delivered to patients within NGH.

To my friend Letters
The letters to loved ones has been extended to include letters to anyone within the hospital that may be feeling lonely and isolated without visitors. Ten have been received to date and issued to a number of patients in the hospital with the support of the hospital chaplain.

Directors view – Chief Operating Officer / DCEO

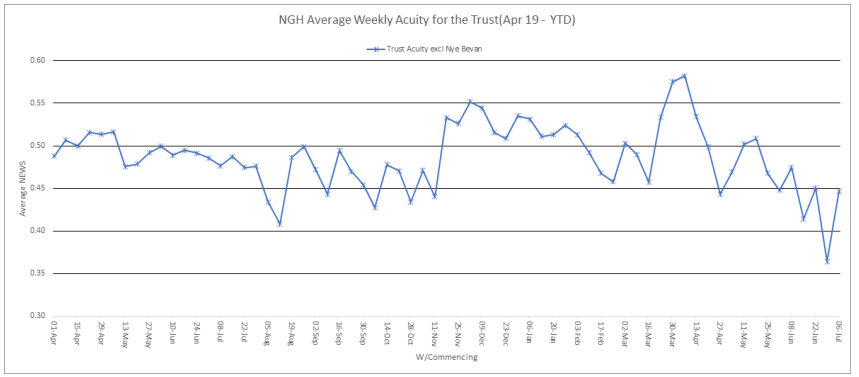
Performance - A&E 4hrs

- Performance deteriorated in June, this is the first month we have seen a deterioration. July performance has improved significantly.
- Emergency activity increased in June and again in July.
- Acuity of patients has started to increase after seeing a gradual decrease over the last month as show in the adjacent graph.
- Stranded & super stranded patient numbers have increased although bed occupancy is stable below 85%.

Cancer waiting times

- 62 day performance increased slightly in month.
- Breast & colorectal are the pathways with the largest backlog.

Actions being taken:
2 x weekly PTL meetings being undertaken with a focus on all patients over 62 days.
Bronze cancer cell in place as part of reset.
Daily NHSE/I calls with all regional Trusts to support an increase in diagnostic capacity.
Additional CT colon being sourced to support the colorectal pathway.



RTT – Average wait time

- The average wait to be seen in May was 13.1 weeks, this has increased from April and has increased again into June.

There are currently 79 patients waiting over 52 weeks to be seen.

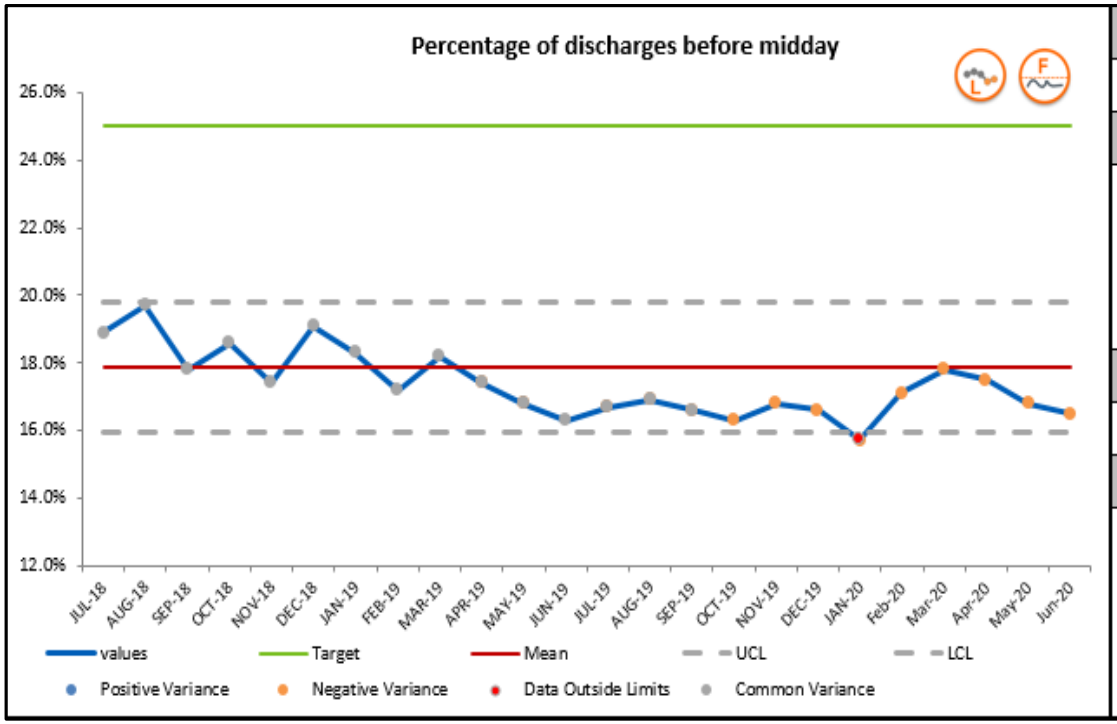
Diagnostics – 6 weeks

- Performance has decreased significantly to 46% due to all routine diagnostic procedures being placed on hold during the covid-19 pandemic.

Actions being taken:
Additional capacity (internal & external) is in place to manage the demand.
Daily NHSE/I regional provider calls in place to support recovery.
Recovery will be slow due to the need to use PPE & socially distance which will make processes slower.
Elective & Outpatient/diagnostic bronze cell in place as part of reset.

Please note variability in all performance metrics which is due to the covid-19 pandemic

SPC Charts – Discharges by Midday



Jun-20
17%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
25%
Target Achievement
Metric is consistently failing the target

Context:

The focused work as part of discharge transformation prior to covid-19 was ceased in April 2020 as occupancy in the organisation decreased.

The continued presence of Covid 19 within the organisation is still having an effect on underperformance in this area.

The reduction in elective surgery in the Trust is also be having some effect as historically there was good turnover of discharges before midday from surgical wards.

There has been no Discharge Suite Facility in the last month where early birds will have been transferred to and therefore identified as a morning discharge.

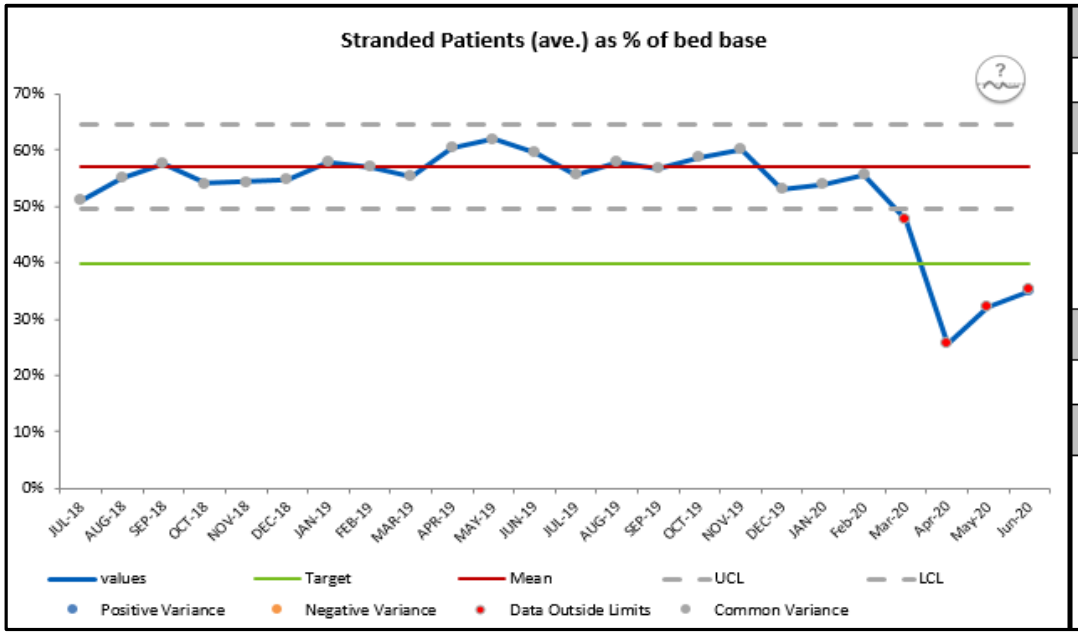
Reduced presence of friends and family to collect the patient as they may be shielding and therefore increased reliance on Hospital transport pushes the time of discharges back.

Actions:

Actions being taken in the next month

- Ongoing work with the Bronze Discharge Cell specifically looking at patients with no reason to reside on a daily basis, supported by AND's and matrons.
- Discharge Support Band 7 trial started at the beginning of July to enhance work of Complex discharge team and to support with simple discharges on wards.
- EMAS now attending bed meetings twice a day to forecast and plan to ensure early discharge patients have transport booked the day before.

SPC Charts – Stranded patients (avg.) as a % of bed base



Jun-20
35.1%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
40%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:

Prior to Covid-19, the discharge transformation workstream had started to see some benefit in reducing the number of stranded (7+ days in hospital) patients.

From March into April, the focus across all partners in health and social care was to discharge patients and to reduce the occupancy in preparation for the anticipated admissions with covid-19.

Since May the numbers of stranded patients have started to increase but still remain significantly lower than pre covid-19.

Bed occupancy remains lower than 85%.

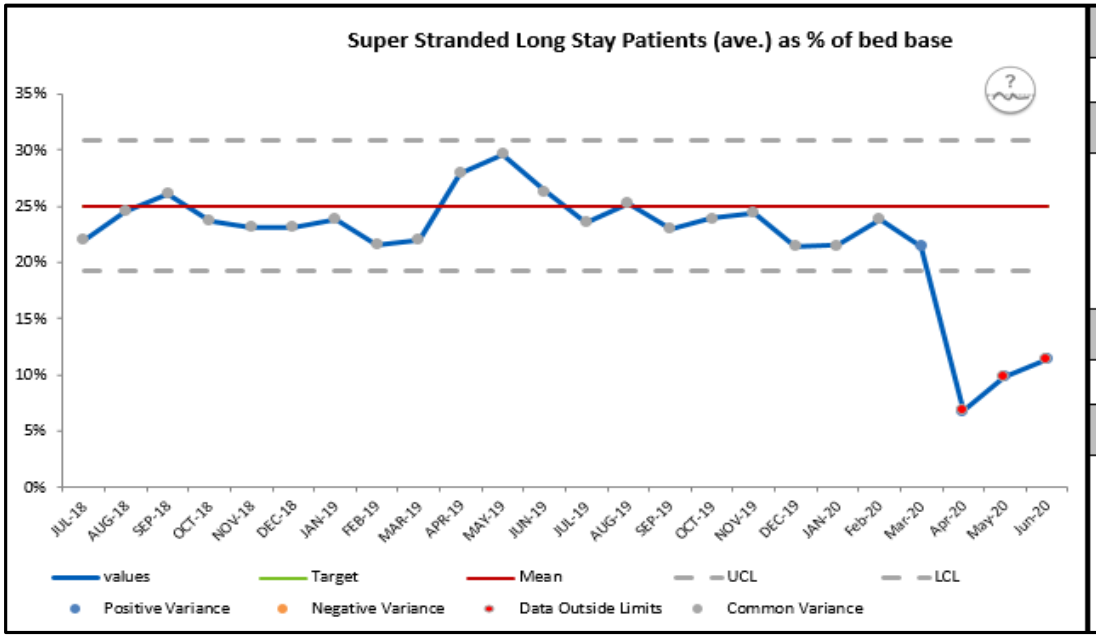
Some issues affecting discharge are:

- Reduced bed base in the community hospitals and an increased LOS, less throughput for acute patients.
- Low discharge numbers of COVID patients who remain very frail post infection.
- Some risk aversion to discharge patients.

Actions:

- NGH Discharge Cell has been established. Led by Director of Nursing and Dep COO, 4 areas of work including providing care in the community, reason to reside, TTO process & role of the discharge nurses.
- Frailty unit, a dedicated clinical space is now in place and functioning, the overall aim to see, assess and stream patients and reduce referrals for inpatient beds.
- A business case is being developed to recruit substantive Acute Medicine Consultants to support a more robust clinical challenge of medical admissions from the assessment areas and ED and also release some speciality physicians to undertake ward & outpatient work.
- Shielding matrons and senior nursing staff to conduct ward reviews each day virtually to support flow.
- Review of referred patients by ED to see if they meet the 'reason to reside' criteria.
- Daily discharge call with health & social care colleagues has been reinstated.
- Longer term discharge programme going into assessment phase in August (Integrated care across Northamptonshire – iCAN)

SPC Charts – Super Stranded patients (avg.) as a % of bed base



Jun-20
11.4%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
25%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Actions:

- NGH Discharge Cell has been established. Led by Director of Nursing and Dep COO, 4 areas of work including providing care in the community, reason to reside, TTO process & role of the discharge nurses.
- Frailty unit, a dedicated clinical space is now in place and functioning, the overall aim to see, assess and stream patients and reduce referrals for inpatient beds.
- A business case is being developed to recruit substantive Acute Medicine Consultants to support a more robust clinical challenge of medical admissions from the assessment areas and ED and also release some speciality physicians to undertake ward & outpatient work.
- Shielding matrons and senior nursing staff to conduct ward reviews each day virtually to support flow.
- Review of referred patients by ED to see if they meet the 'reason to reside' criteria.
- Daily discharge call with health & social care colleagues has been reinstated.
- Longer term discharge programme going into assessment phase in August (Integrated care across Northamptonshire – iCAN)

Context:

Prior to Covid-19, the discharge transformation workstream had started to see some benefit in reducing the number of super stranded (21+ days in hospital) patients.

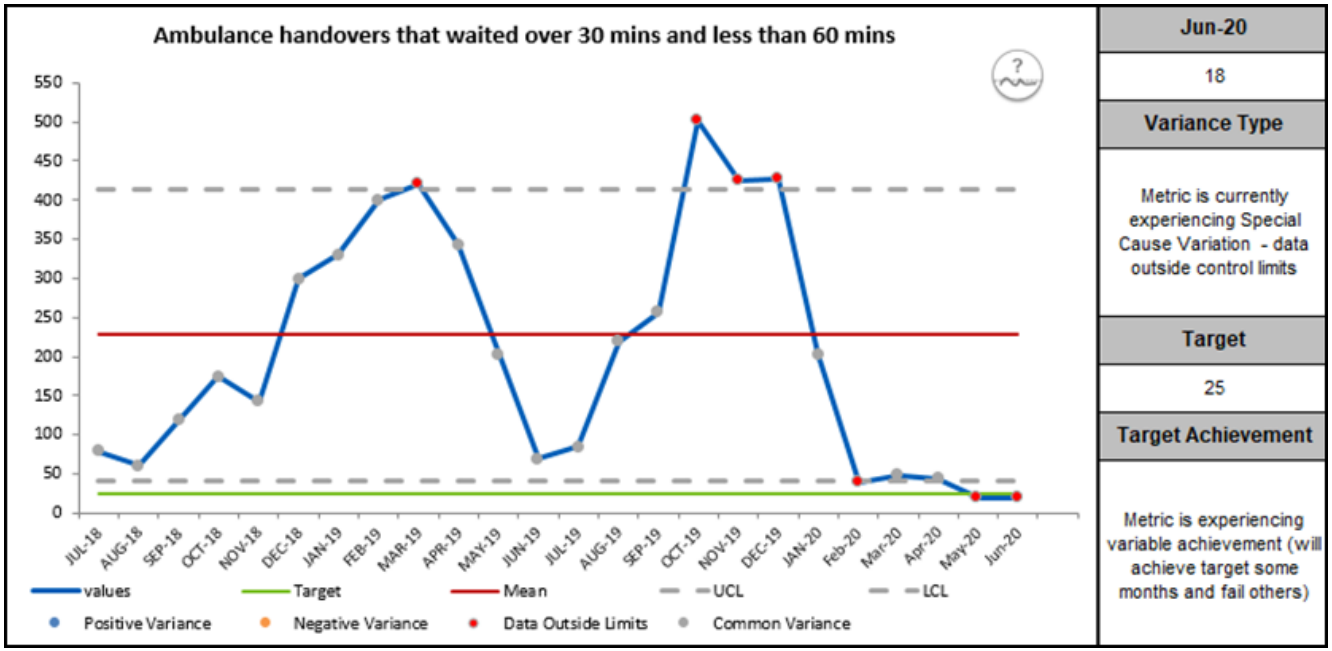
From March into April, the focus across all partners in health and social care was to discharge patients and to reduce the occupancy in preparation for the anticipated admissions with covid-19.

Since May the numbers of super stranded patients have started to increase but still remain significantly lower than pre covid-19.

Bed occupancy remains lower than 85%.

Some issues affecting discharge are:
• Reduced bed base in the community hospitals and an increased LOS, less throughput for acute patients.
• Low discharge numbers of COVID patients who remain very frail post infection.
• Some risk aversion to discharge patients.

SPC Charts – Ambulance handovers that waited over 30 minutes and less than 60 minutes



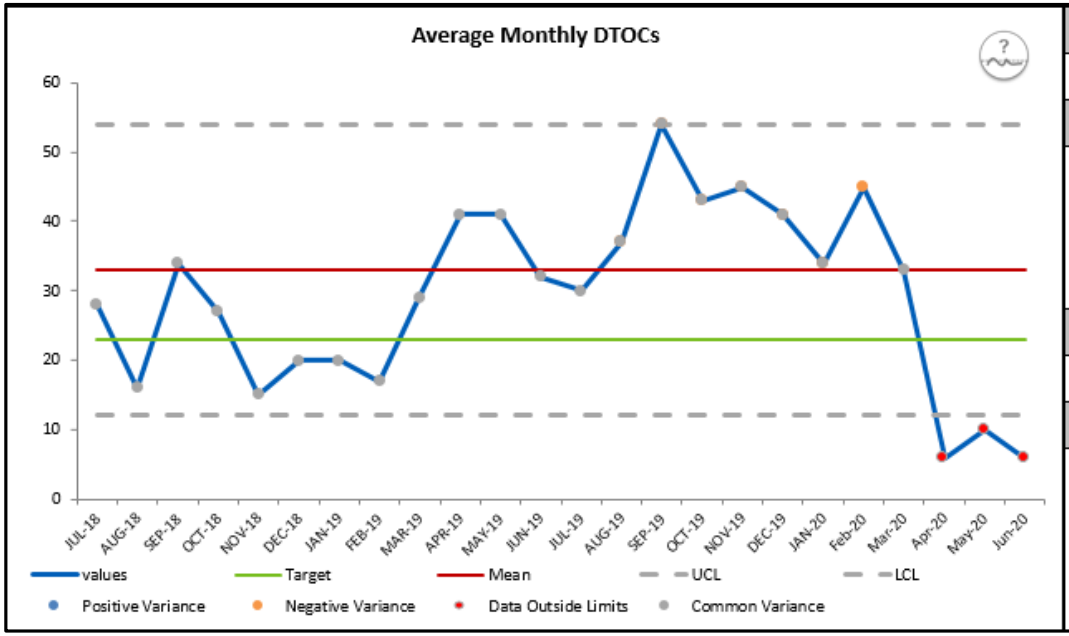
Jun-20
18
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
25
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:

Handover delays during June remained at a minimal level.

The majority taking place on one day due to overcrowding in the A&E department and the inability to safely off load and socially distance.

SPC Charts – Average monthly DTOCs



Jun-20
6
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
23
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Actions This Month:

The numbers of patients who are delayed transfers of care (DTOC) remain significantly lower than pre covid 19.

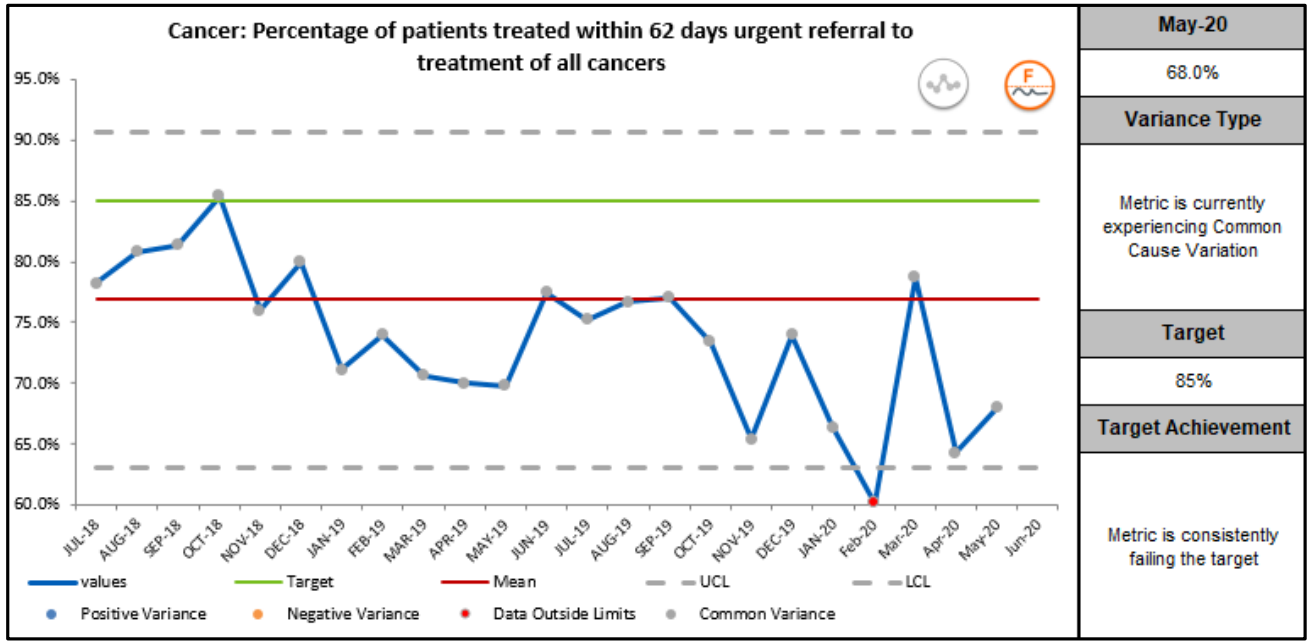
Changes and training provided to care homes regarding swabbing on discharge & isolation of patients has proved positive.

Daily Tracking Meetings are in place for all medically fit patients with no reason to reside. Supported by AND's and matrons on each ward.

Actions:

- NASS are increasing their brokerage team to help expedite discharges.
- Daily discharge call with health & social care colleagues has been reinstated.
- Longer term discharge programme going into assessment phase in August (Integrated care across Northamptonshire – iCAN)

SPC Charts – Cancer: Percentage of patients treated within 62 days



May-20
68.0%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is consistently failing the target

Context:

The Trust continues to be challenged in meeting the 62 day standard which is a result of the increasing backlog incurred due to the peak of the Covid 19 pandemic, with cessation of key elements of the pathway and patient initiated choice to delay. This is compounded by the challenges that existed pre-covid.

Whilst pathways are starting to be re-introduced, the backlog, reduction in capacity due to social distancing measures and use of PPE will not deliver improved performance for sometime, this is acknowledged nationally with exploration of diagnostic centres to support trusts with backlogs of patients.

The Trust undertook 62.5 treatments during May with a performance of 68% against the 85% standard, a reduction in treatments continued as last month, the 62 day performance did see a 3.6% improvement on April.

Actions:

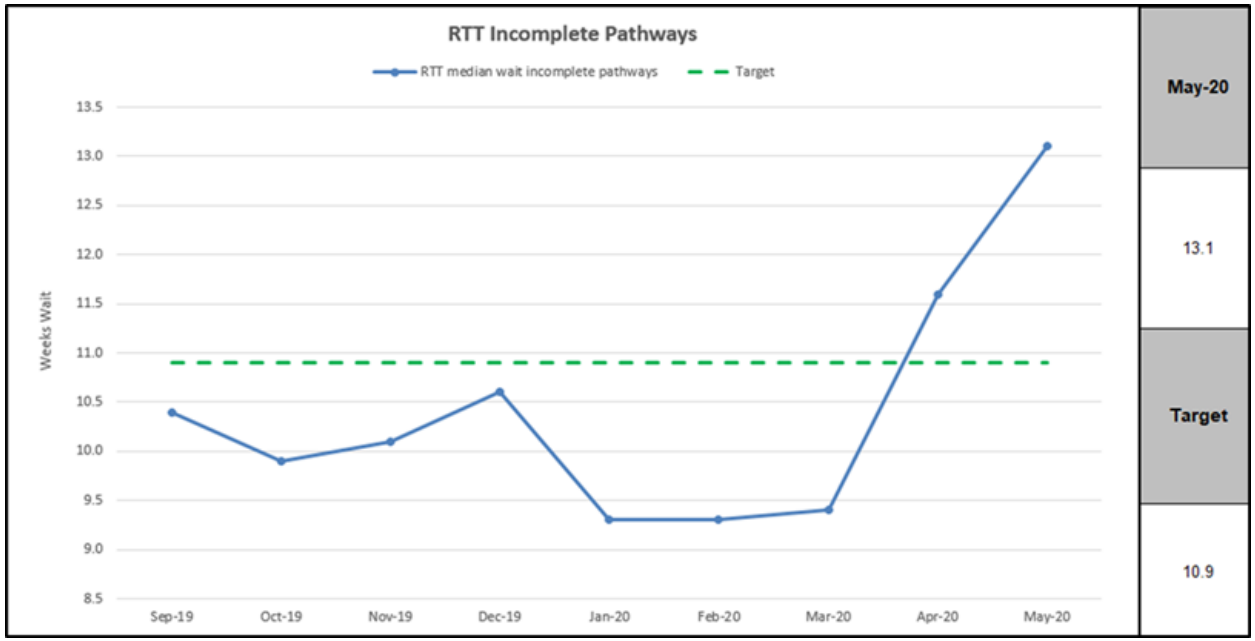
The cancer task and finish group continue to meet weekly in order to drive the restoration of cancer services. Supplemented by national and regional feedback received by the Cancer Management team.

Daily regional calls with NHSE/I to understand plans around endoscopy and radiology capacity, regional diagnostic hubs being explored.

All tumour sites have refreshed recovery action plans.

Weekly cancer reset group continues to drive forward transformation and recovery of services with an increased focus on diagnostics.

Charts – RTT Average Wait Incomplete Pathways



Actions:

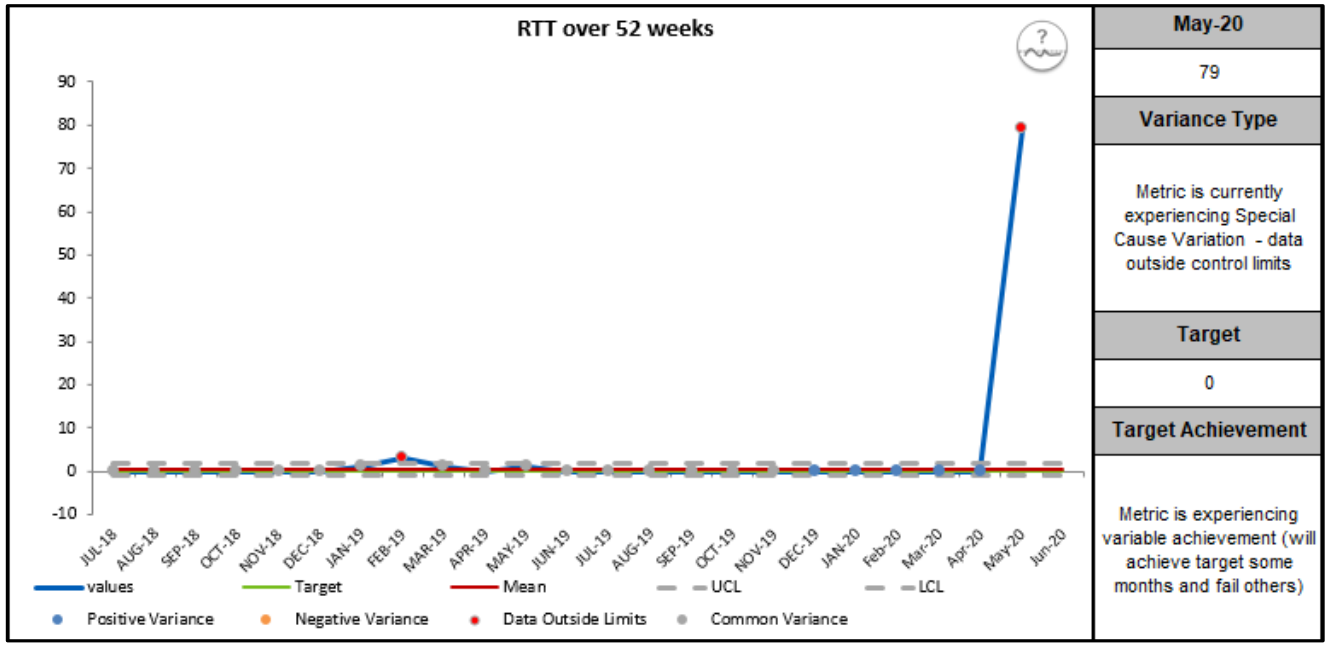
- Nationally led validation of PTLs programme commencing, NGH will take part in this.
- Strategic (gold) agreement to ensure cancer & clinically urgent patients are seen and treated first, recognising that the wait time for routine patients will increase whilst social distancing & the use of PPE is still required.
- Additional lists are in place for outpatients and elective activity.

Context:

Whilst all routine outpatient activity was ceased from April to June 2020 due to covid-19 , the average waiting time has increased, whilst validation of the PTLs has taken place, the time waiting has increased significantly & also increased again into June & July.

Clinically urgent & cancer appointments take priority over routine procedures

Charts – RTT Incomplete Pathway 52 week breaches



May-20
79
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:

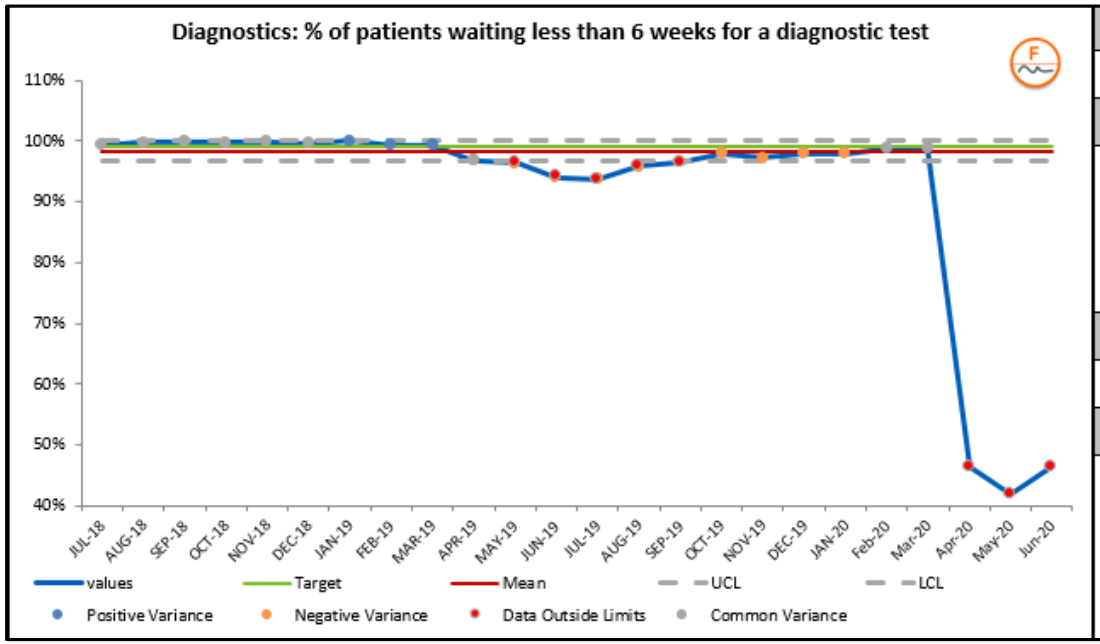
Whilst all routine outpatient activity was ceased from April to June 2020 due to covid-19, the number of patients waiting over 52 weeks has increased in May & also increased again into June & July.

Clinically urgent & cancer appointments take priority over routine appointments and procedures.

Actions:

- Nationally led validation of PTLs programme commencing, NGH will take part in this.
- Strategic (gold) agreement to ensure cancer & clinically urgent patients are seen and treated first, recognising that the wait time for routine patients will increase whilst social distancing & the use of PPE is still required.
- Additional lists are in place for outpatients and elective activity.

Charts – Diagnostic 6 week waits



May-20
42.0%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
99%
Target Achievement
Metric is consistently failing the target

Context:

All routine diagnostic activity was ceased from April to June 2020 due to covid-19.
The number the number of patients waiting over 6 weeks for a diagnostic test is significantly higher than pre covid.
take down elective work during the pandemic we have seen a huge fall in the percentage of patients
The performance was back to target in April, but has now decreased to 46.3% of patients having their diagnostic test done within the 6 week standard.

Actions:

- Plans are in development in all specialties that now have significantly increased diagnostic waits
- Teams have been asked to explore insourcing and outsourcing options with external providers
- Full validation of all patients is taking place to ensure all breaches are accurate and patients still require a diagnostic test.
- Strategic (gold) agreement to ensure cancer & clinically urgent patients are seen and treated first, recognising that the wait time for routine patients will increase whilst social distancing & the use of PPE is still required.
- Additional lists are in place for outpatients and elective activity.

Directors view – Director of Finance

The Trust ended the month of June 2020 with a break-even financial position which includes £25.3m block funding, £4.0m top-up funding and £2.8m additional top-up funding to cover excess COVID spend. Year to date non-recurrent top-up funding is £15.5m.

COVID spend for the month is £3.0m (Month 2: £2.0m) and includes pay cost of £1.3m and non-pay cost of £1.7m. The increase in spend is largely driven by testing costs, purchase of sanitising gel, remote management of patients and backfill for staff sickness absence.

Non-COVID operational activity is starting to pick up resulting in a block funding gap of £6.0m (reduced from £8.7m in month 2). In addition, as a result of the increasing activity A&E, Daycase and Non elective activity up c. 20%), there has been an increase in pay and non-pay spend due to closed wards reopening as well as an increase in the use of temporary staff costs. In addition, bank holiday enhancements as well as an accrual for unused Q1 leave for nursing staff of £0.5m resulted in increased pay costs in June.

The current block funding arrangement is expected to continue until at least August and potentially until the end of the year. We understand there are plans to change the reimbursement regime for COVID funding and this may be provided as block funding, with organisations expected to manage within the allocated block. However this is yet to be confirmed and we expect an update from NHSE/I by the end of the month.

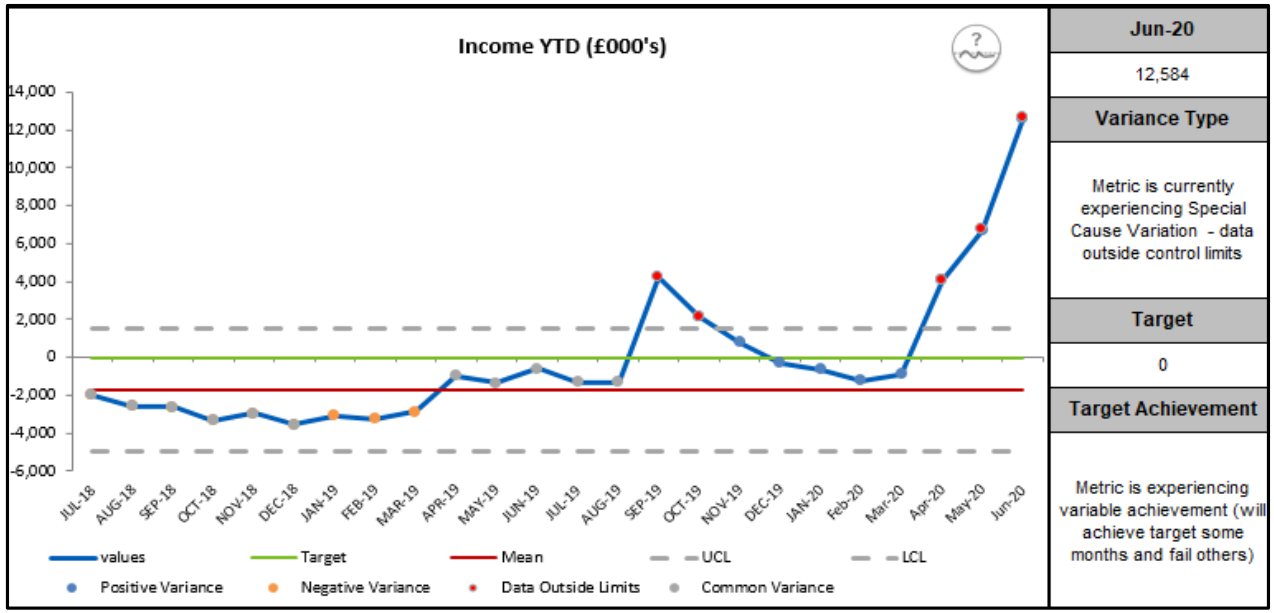
Other income is down by £0.53m due to loss of catering, car parking and other income.

Divisional performance continues to reflect an adverse position to plan as a result of reduced activity, although this is mitigated by the block funding received centrally. As the Divisions continue to work to address backlog, it is expected that the income gap will become smaller and costs will increase. The importance of strong financial governance and control continues to be reiterated as the Divisions work through challenging operational conditions.

The Capital spend in the month is £3.4m mainly relating to Information Technology and Estates spend.

Cash balance at the end of the month is £31.9m as NHSE/I currently provide additional funding for the following month in advance.

SPC Charts – Income YTD



Jun-20
12,584
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

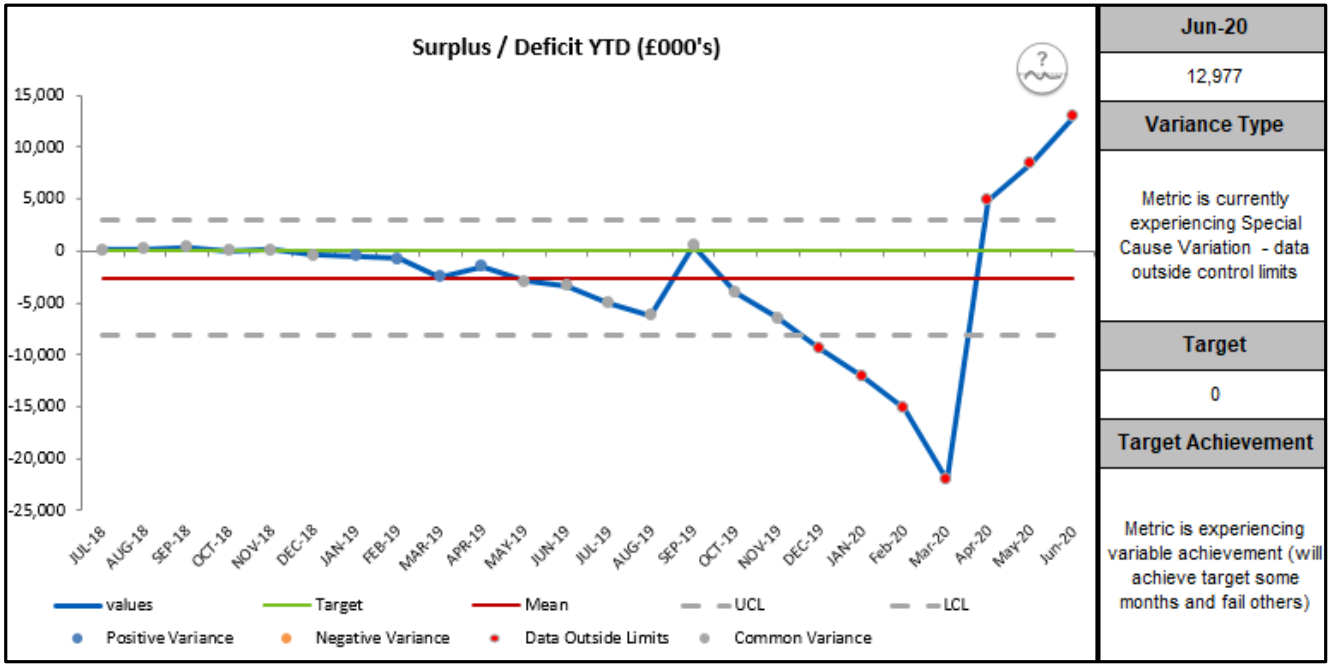
Actions:

Context:

Clinical income, if paid for via PbR would show a £24.1m year to date. The chart shows the impact of the block and top up payments received to ensure the Trust breaks even.

- A&E activity continued to rise, with a couple of individual days in June approaching 'normal' levels. From April to June we have seen a 45% increase in A&E attendances, which remains 110 per week below Jan/Feb activity levels.
- Planned activity started to see an element of recovery after the extremely low levels of April and May due to the impact of COVID-19 prioritisation.
- However, Day Case and Elective activity year-to-date is achieving only 37% of expected levels, with First Outpatient appointments at 55%
- Outpatient activity overall (Firsts, Follow-up and OPROCs) are 27% below plans, but 43% below PbR value as some activity has been converted to non-face-to-face.
- NEL discharges have continued increasing, up by 20% from April, now averaging approximately 900 per week. Only 10-15% below levels seen in January and February.
- The adjustment to block value has been derived at CCG level, adjusting the PbR calculated position to the block values received. Currently £24.1m year-to-date.

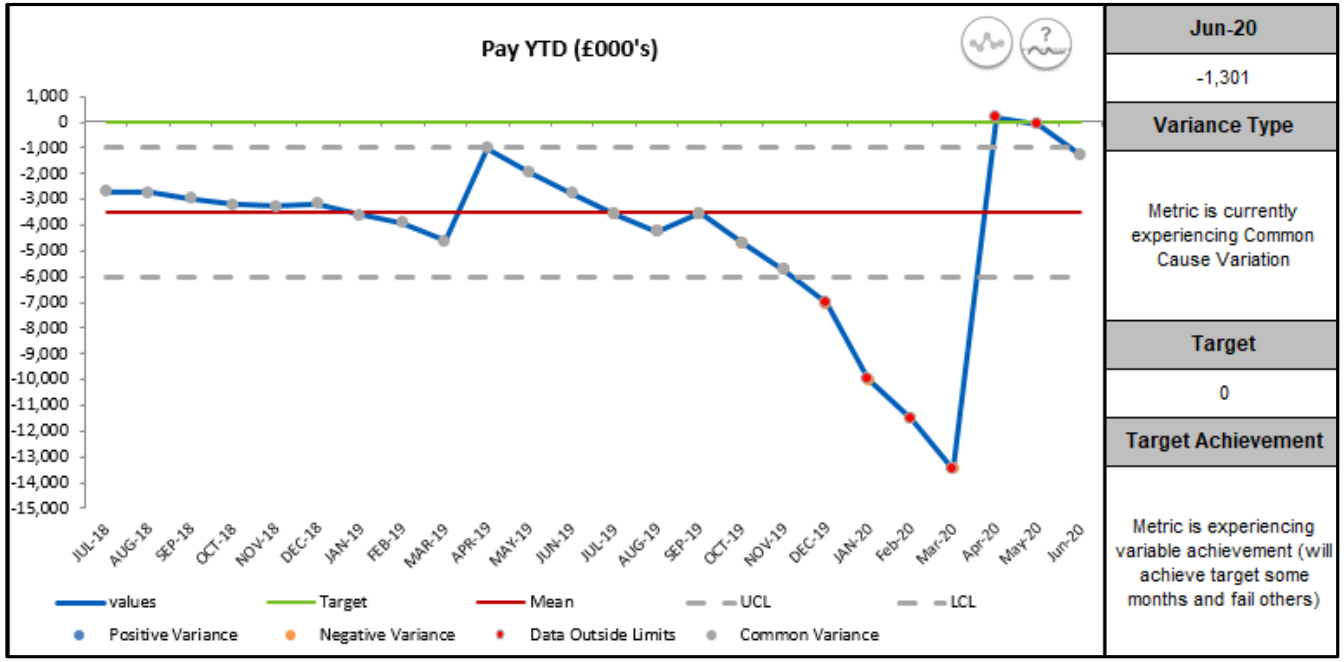
SPC Charts – Surplus/Deficit YTD



Jun-20
12,977
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

See Directors view for comments

SPC Charts – Pay YTD



Jun-20
-1,301
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

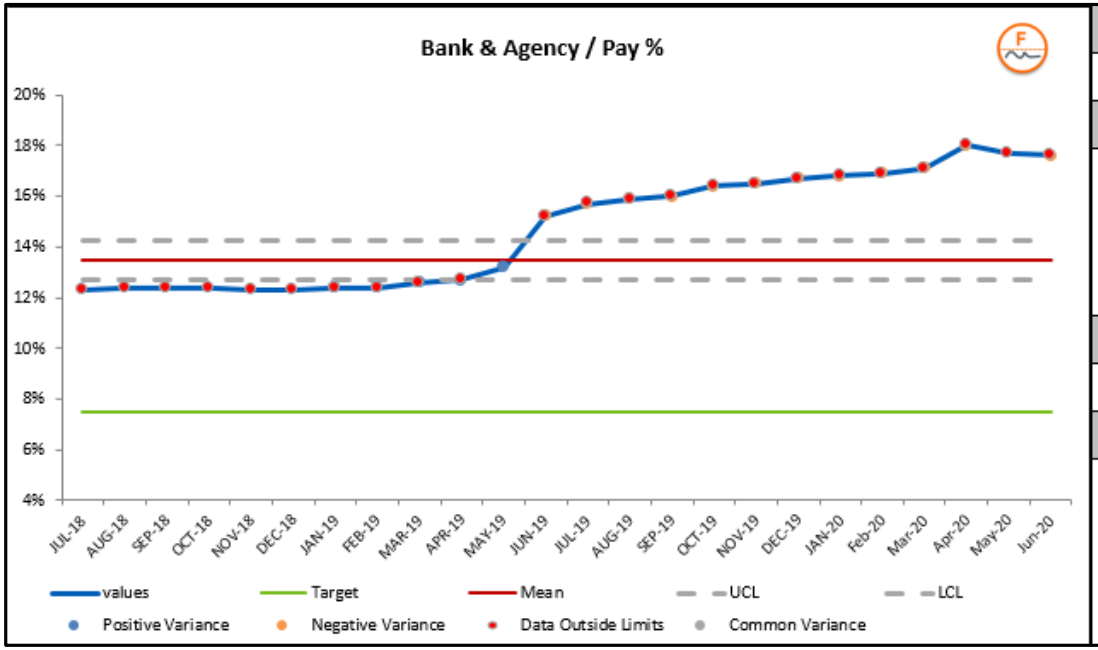
Actions:

Context:

In Month 3 pay expenditure was £23.1m against a plan of £22.0m; resulting in a £1.1m adverse variance to plan in month

- £1.26m of pay costs in Month 3 have been attributed to COVD-19 response including £1.16m of temporary staff costs for either backfill for higher sickness absence or additional shifts due to operational pressures.
- Overall pay costs increased by £1.03m from the previous month. In month 3 an accrual has been included for unused annual leave as a result of COVID-19 during Q1 for nursing staff (RNs and HCAs). This provision of £508k (calculated using annual leave average at 8.8% vs 14.6% allowance for Q1) has been included within nursing substantive pay costs.
- As well as this there has been a further increase in COVID-19 pay costs (£193k increase from Month 2) including an increase in expenditure on student nurses (£62k increase), clinical assistants (£43k increase).
- Other pay costs continue to increase across all staff groups as routine operational activity begins to increase with increased non-elective and A&E activity resulting in an increased number of beds opening during the month.
- Pay budget includes a non-recurrent CIP target of £523k as recognition that a number of established posts are vacant at any one time. The budget also includes an additional activity budget of £687k. This was part of the cost response to both 2019/20 run rate and 2020/21 activity growth which is currently held centrally.

SPC Charts – Bank & Agency spend



Jun-20
17.6%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
7.5%
Target Achievement
Metric is consistently failing the target

Context:

- NHS Improvement issued a maintained expenditure limit of £11.208m for the financial year 2020/21, against an exit run-rate (2019/20) of £18.598m.
- The most significant increases seen in agency expenditure in Quarter 1 has come in Nursing.
- Agency Qualified Nursing increased 15wte in June. Some of the booking reasons highlighted include 'High Acuity' , 'Approved Unavailability', increased cover for sickness and annual leave.

Actions:

Directors view – Chief People Officer

Vacancy rates

The overall Trust vacancy factor for June 2020 is 8.73%, which is a decrease on the figure of 10.07% reported for May 2020 and is below the 9% target. The vacancy factor for medical staff is 11.34%, which is a decrease on the figure of 13.03% reported for May 2020. There are a total of 70 medical vacancies of which 63 have candidates in clearance. There are a total of 170 Deanery doctors in clearance for the August rotation. The nursing & midwifery vacancy factor for May 2020 is 8.68% which is an increase on the figure of 8.23% reported for May 2020 but remains below the Trust target of 9%. The nurse vacancy factor is expected to reduce further as a result of the Trusts overseas nurse recruitment programme recommencing with the arrival of 30 nurses during August 2020. Despite the delays brought about as a result of the travel restrictions associated with Covid, none of the overseas candidates to whom a position at the Trusts was offered have yet dropped out of the recruitment process. Overall time to hire from authorisation to advertise to start date is an average of 11.45 weeks for June 2020

Turnover

Turnover decreased since May 2020 to 7.75%, which is below the Trust target of 10%. Nursing & Midwifery turnover remains stable at 5.61%. Medical & Dental turnover for June 2020 stands at 10.54%. The staff group of Additional Professional Scientific and Technical staff remains the area of highest turnover at 13.43%.

Attendance

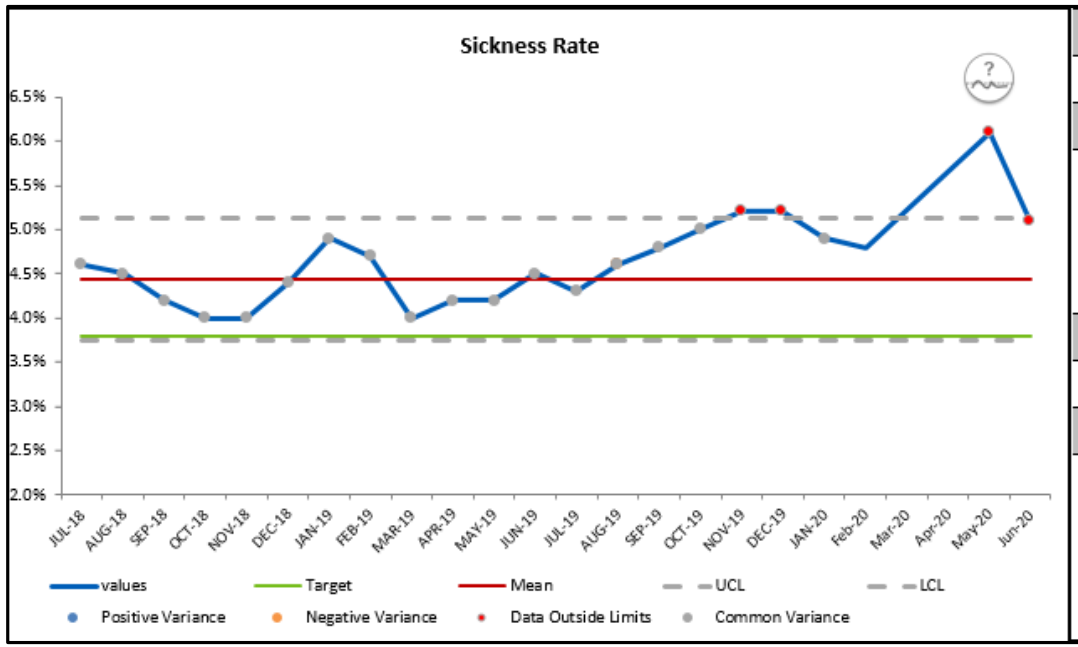
The Trusts sickness absence rate for June 2020 as reported through ESR is 5.18% which is a reduction from May's figure of 6.11%.
A proportion of this absence is due to Covid-19 and this absence is monitored and reported on daily basis via the Roster system. The management of sickness absence and Covid-19 absence is being supported by HR Business Partners and Occupational Health and ways of supporting staff back into work are being identified on a case by case basis. Work is also being undertaken to support those staff who have been shielding to return to work. The top two reasons for non-covid related absence are Stress and Anxiety and Musculoskeletal.

Competence

The overall appraisal compliance percentage for the month of June 2020 is 71.4%, which is a decrease on the figure of 73.61% reported for May 2020. As part of the Covid response incremental progression was automatically awarded to staff through April, May and June 2020 and was not subject to the completion of an appraisal. From July 2020, incremental progression will revert to being reliant on confirmation that a successful appraisal has taken place.

The overall statutory and mandatory training position for the month of June 2020 is 84.4%, which is a decrease on the figure of 85.36% reported for May 2020. All statutory and mandatory training continues to be available via e-learning and initial discussions are now underway regarding the re-provisioning of the other training delivery methods, which were temporarily suspended as part of the Covid response.

SPC Charts – Sickness Rate



Jun-20
5.1%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
3.8%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Medical Director's view

Overview

This last month has seen the appointment of Daniel Sedgewick to the post of chief registrar with a background in Emergency Medicine, whose leadership portfolio includes a review of the medical establishment at the trust and establishing the junior doctor workforce onto electronic rostering.

This month we also welcome Toyosi Adeniji as the inaugural BAME clinical fellow at the trust. In her role Toyosi will lead the establishment of an international medical graduate group , undertake regular polling of BAME junior doctors and advocate an inclusive culture with the senior leadership team at the trust.

Incidents

There has been a significant uptick in clinical incident reporting in proportion to increasing bed occupancy and clinical activity at the trust. There has not been an increase in moderate or severe harm reported incidents. The increase brings incidents back within the confidence intervals for common cause variation from the last two months of low SCV.

Mortality

There are no new CUSUM or outlier alerts this month. A trust wide mortality review of deaths in December 2019 has been resumed after pausing during covid-19. The NGH mortality team are meeting this month with the KGH team to align processes for review and reporting to quality committees. The medical examiners are collating their scrutiny of covid-19 deaths to identify themes for learning and for assurance.

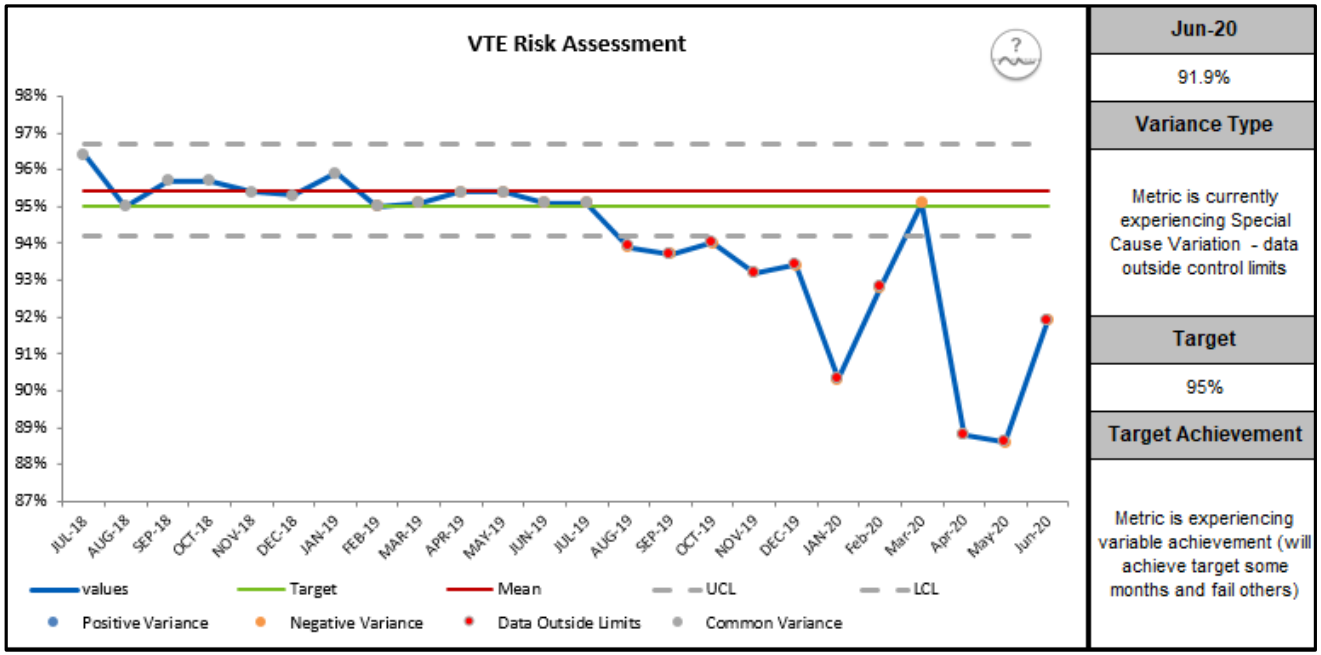
VTE prophylaxis

The ePMA upgrade mandating VTE first assessment ahs been furthe r developed by the supplier to address the performance issues necessitating business continuity with paper charts. This is expected to be received to the trust for testing in August with rollout this calendar year.

Research

The trust remains the second highest recruiting centre nationally for the covid-19 RECOVERY trial, and has opened 5 additional covid-19 studies. It is also moving into reset phase to resume the non-covid portfolio of studies resumed. The appointment of a senior academic manager to support the ambition across the group will be appointed before the board in September.

SPC Charts – VTE Risk Assessment



Jun-20
91.9%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
95%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:
Assessment on paper clerking proformas during covid-19 outbreak co-inciding with ePMA upgrade issues. Audit of these point prevalence based, and limited by IPC regulations for covid-19.

Actions completed:
The prescription of prophylaxis is scrutinised by ward based pharmacy teams and is completed for patients.

Actions:
Audit (point prevalence) supported by ward pharmacists
Re-introduction of ePMA system

Report To	**Trust Board**
Date of Meeting	**July 30th 2020**

Title of the Report	**Board Assurance Framework annual review & Q1 2020- 21**
Agenda item	**9**
Presenter of the Report	Claire Campbell, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Claire Campbell, Director of Corporate Development, Governance and Assurance

This paper is for: (delete as appropriate)

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

1. Executive summary

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

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

This report includes the annual review of the BAF risks and their content and describes the updated Q1 position in relation to the risks associated to delivery of corporate objectives described on the BAF.

2. Assurance

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

3. Population of the BAF

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

4. Update to the BAF during Q1 2020/21

General changes made are as follows:

- The full review of the BAF risks and content has been undertaken, with risk titles simplified where possible, the date of the next full review is planned for 31/3/21. Dates risks opened have been updated to 30/6/20.
- All CRR references have been reviewed and updated

The following updates have been made to the Risks assigned to the Board committees:

a. BAF Risk 1.1: Risk of failure to meet regulators minimum fundamental standards to avoid enforcement action, intervention or suspension of services- Quality Governance Committee

- No Change to the risk title
- Existing Controls: During the pandemic there has been a marked reduction in regulators oversight, external visits and a suspension of Governance meetings and other activities which constitute controls and positive assurances of control. Ward accreditation is currently suspended and CQC relationship meetings are held virtually. The CQC have introduced a new Emergency Support Framework (ESF) to support Trusts.
- Positive Assurance of Control: No changes
- Actions updated: NGH Improvement plan updated the action as recommenced monthly reporting via QGC. Robust management of delays in SI completion has been completed as there are currently no outstanding SIs. One CAS alert remains outstanding. Otherwise, all other actions remain as prior to Covid 19 pandemic, dates have been further extended. A virtual meeting is to be held with the CQC relationship manager in month regarding the recently implemented ESF.
- Score: No change.

b. BAF Risk 1.2: Risk of Failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties- Finance & Performance

- No change to risk title
- Existing Controls: Controls updated
- Positive Assurance of Control: Reset Plan added.
- Gaps in assurance: The following added –Capacity reduced in electives, OP and diagnostics
- Actions updated: One new action added and due dates revised.
- Score: No change

c. BAF Risk 1.3: Risk of failing CQUIN standards leading to lost opportunity to improve service quality and financial risk of due to loss of funding associated with CQUIN attainment- Quality Governance Committee

- NHS England have confirmed that the operation of the 2020/21 CQUIN scheme (both CCG and specialised) for Trusts will remain suspended for all providers for the remainder of the year. This risk has therefore been removed for the current year.

d. BAF Risk 1.4: Risk of avoidable harm to patients resulting in adverse publicity and public confidence in NGH as hospital of choice- Quality Governance Committee. The risk title has been updated to "Risk of avoidable harm to patients and the associated loss of public confidence".

- Risk Owner: Revised to include DON due to risk of patient harm from nosocomial infection.
- Existing Controls: Controls updated to include infection prevention meetings and team.
- Positive Assurance of Control: IPC Assurance Framework added.
- Gaps in control: Dr Foster dater replaced with HSMR outlier. Delayed review of mortality and outbreaks of nosocomial infection added.
- Actions updated: Completion of work to mandate use of deteriorating patient care plan due date extended further to September. Discussions with HSIB completed and closed. Two new actions relating to nosocomial infection added.
- Score: Score increased from 10 to 15.

e. BAF Risk 1.5: Risk that Trust fails to deliver high quality services across all wards and clinical departments at all hours on each day of the week resulting in skills and capacity constraints impacting on patient safety and experience- Quality Governance Committee. The risk title has been updated to "Risk that Trust fails to deliver high quality services in all clinical areas 24/7. The risk to capacity and capability is dealt with in section 3.

- Existing controls: Updated and nurse staffing hub removed due to reduction in Covid 19 patients.
- Gaps in assurance: No change.
- Actions updated: Further extension of due dates of actions 1 & 2. Quality strategy is on July 2020 QGC agenda.
- Score: No change.

f. BAF Risk 1.6: Inability to recruit adequate numbers of nursing staff- Quality Governance Committee/ Workforce Committee

- No change to risk title.
- Existing controls: Nurse staffing hub removed due to reduction in Covid 19 patients.
- Gaps in control: No change.
- Actions update: Cultural awareness and pastoral enhancement is now up and running and remains ongoing for the next cohort of staff arriving in August. The Safe Care Electronic tool has now been implemented- action completed.
- Score: No change made

g. BAF Risk 1.7: Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failure- Quality Governance Committee/ Finance & Performance Committee

- No change to risk title
- Existing controls: No change
- Gaps in control: Lack of additional central funding from NHSE/I for urgent estates works to reduce the risk from Covid pandemic.
  Actions updated: Recruit into key estates vacancies, permanent appointment to the vacant Deputy Director of Estates and Facilities made and will commence in post Oct 2020, Interim cover secured in the meantime- action completed. Deliver action plans against key estates elements to improve assurance and reduce risks, this work continues and is reported via Facilities Governance meeting, key risks reported at ARC, monthly report at FPC. Movement in assurance levels will be discussed at specific groups e.g. Water Safety Group, Fire Safety Group, Ventilation Group, etc. some of these meetings were stepped down in recent months due to pandemic but are starting again. The date has been extended to September. Seek additional routes to Capital funding to reduce backlog and align with Estates strategy & Masterplan and Clinical strategy – ongoing
  Emergency funding for new ITU building, emergency fire works and electrical works has been confirmed.
- Score: No change made

h. BAF Risk 1.8: Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust- Finance & Performance

- No change to risk title
- Existing controls: No changes
- Gaps in control: Two further gaps added regarding gaps in data and clinical applications teams
- Actions update: Three new actions added
- Score: No change

i. BAF Risk 1.9: The risk of the Trust being unable to deliver an appropriate response to Covid 19 in terms of quality of care, capacity and timeliness with consequential impact on patient and staff safety, patient experience and staff wellbeing.

- No change to risk title
- Risk Owner: Changed to DCEO
- Existing Controls and positive assurances updated to reflect reduction in frequency of local and regional meetings.
- Gaps in control: PPE stocks and plan for restoration of services removed. An additional gap of timely information to inpatients added.
- Actions update: Actions updated.
- Score: Score reduced from 25 to 15

j. BAF Risk 1.10: NEW Risk of the Trust being unable to deliver a recovery plan post covid-19 with consequential impact on patient and staff safety, patient experience and staff wellbeing.
This new risk reflects the potential risk to the organisation post Covid 19. Further work is required to develop the controls as the reset programme is implemented with actions to be identified.

k. BAF Risk 2.1: Risk that the Trust fails to promote a culture which puts patients first- Quality Governance Committee. The risk title has been updated to" Risk that the Trust fails to provide an excellent patient experience".

- Existing controls: PALs helpline for family feedback now closed as now can contact wards directly;

Actions update: Date further extended for actions 1 & 2. Two additional actions added.
- Score: No change.

l. BAF Risk 3.1: Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future- Workforce Committee
- No change to risk title
- Existing controls: No change
- Actions update: Action 1 completed , action 4 date has been extended for a further month
- Score: No change

m. BAF Risk 3.2: Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future- Workforce Committee
- No change to risk title
- Existing controls: No change
- Actions update: No change
- Score: No change

n. BAF Risk Score 3.3: Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optimal culture- Workforce Committee
- No change to risk title
- Existing controls: No change
- Actions update: No change
- Score: No change.

o. BAF Risk 4.1:Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire Health and Care Partnership will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access- Finance & Performance
- No change to risk title
- Existing controls: No change
- Actions update: No change
- Score: The score has been downgraded from 16 to 12 due to the move to a block contract

- BAF Risk 5.1: Risk that the Trust fails to have financial control measures in place to deliver its 2020/21 financial plan- Finance & Performance Committee
- No change to risk title- updated last month to reflect new financial year
- Existing controls: Controls have been updated.
- Actions update: Action due dates to be advised
- Score: No change.

p. BAF Risk 5.3: Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements Finance & Performance Committee
- No change to risk title
- Gaps in control: Additional gap in control added – ineffective regional and national Covid 19 related capital bids regime, the outcome remains unknown
- Actions update: Action 2- advised of successful application for the emergency capital bid- date extended until monies received. Additional action Action due dates updated to reflect new financial year and new action added relating to emergency capital bids.
- Score: Score increased from 20 to 25 to reflect additional gap

Risk Score: The risk score has increased overall in this quarter from 203 for 15 risks to 236 for 16 risks.

The BAF is attached (Appendix 1).

Work remains outstanding with regards to the actions associated with the pledges which require further review to ensure risks have been appropriately linked; to ensure no new risks are identified as a result of the actions, including a review of Pledge 6 and identification of risks associated with this work.

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

Actions required

The Board is asked to:

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

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.			
BAF Risk No.1.1 Risk of failure to meet regulators minimum fundamental standards to avoid enforcement action, intervention or suspension of services			
Risk Classification: Compliance	**Risk Owner:** DCD,G & A	**Scrutinising Committee:** Quality Governance Committee	
Date Risk Opened: 30/6/20	**Date of next full review of BAF:** 31/3/21		
Changes since last review:			
Underlying Cause/ Source of Risk: CRR reference risks: 731,1303;1553; 1665; 1782; 1867;1879;1902; 1911; 1303; 2178	**Initial score**	**Current score**	**Target score**
	15 (5x3)	15 (5x3)	5 (5x1)

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

Gaps in Controls

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

Further Actions	**Responsible Person/s**	**Due Date**
1. NGH Improvement Plan reviewed monthly in QGC	1. Claire Campbell	Ongoing
2. HEE/GMC action plans in progress	2. Matt Metcalfe	September 2020
3. Robust management of delays in CAS alerts	3. Claire Campbell	September 2020
4. Full capacity protocol instigated- Overflow stroke beds agreed to be monitored	4. Debbie Needham	September 2020
5. Virtual meeting to be held with CQC Relationship manager regarding the ESF	5. Claire Campbell	July 2020

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

BAF Risk No. 1.2 Risk of failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties

Risk Classification: Operational	**Risk Owner:** COO	**Scrutinising Committee:** Finance & Performance Committee
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/3/21**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks: 1303; 1782; 1795; 1867; 1911; 1902;1930 1971;2132; 2341;
Multiple sources of risk exacerbated by high demand and high patient acuity.

Initial score	Current score	Target score
20 (4x5)	16 (4x4)	8 (4x2)

Existing Controls	Positive Assurance of Controls
1. Performance management framework policy 2. Bed meetings and safety huddle daily with escalation processes in place 3. Symphony IT monitoring system in use for A&E 4. A&E delivery Board 5. Cancer Improvement Group meeting monthly 6. County wide Cancer Board meets monthly 7. Somerset reporting cancer 8. Twice weekly tracking for DTOC 9. Elective Care Board CCG Monthly 10. Weekly performance meeting in place 11. Twice weekly virtual cancer PTL meeting 12. Targeted support from regional NHSE/I to all Trusts in the region for cancer 62 days (Diagnostics) 13. Additional performance metrics now in place in relation to Covid-19	• Performance metrics at corporate, divisional and directorate level (L1) • Integrated performance report to Trust Board and committees (L1) • A&E received rating of Good in CQC inspection 2019 (L3) • Benchmarking against other Trusts. (L3) • Winter Plan. (L1) • Reset plan (L1)

Gaps in Controls

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

Further Actions	Responsible Person/s	Due Date
1. Full covid response remains in place 2. Reset has commenced with 43% of theatres back in place but with reduced utilisation 3. Specific reset for OP, discharge, elective & cancer 4. Further outsourcing of routine work to private sector including endoscopy 5. System discharge work with external support 6. Zoning bronze cell in place	1-6 Debbie Needham	1. To continue – March 2021 2. Moving to 85% by October 3. Reset – ongoing through to 2021 4. Ongoing 5. Dec 2021 6. September 2020

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

BAF Risk No.1.4 Risk of avoidable harm to patients and the associated loss of public confidence

Risk Classification: Quality	**Risk Owner:** MD/DON	**Scrutinising Committee:** Quality Governance Committee
Date Risk Opened: 30/6/20	**Date of next full review of BAF:31/3/21**	
Changes since last review:		

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

Existing Controls	**Positive Assurance of Controls**
1. Monthly review of Dr Foster information and alerts 2. Mortality Review Group 3. Audit plan 4. Incident and SI reporting policy 5. Monthly Clinical Quality and Effectiveness Group 6. Monthly Quality Governance committee 7. Countywide Patient safety M&M meetings 8. Review of Harm Group weekly 9. Dare to Share alternate monthly 10. FIT Group 11. MASH referral system 12. NGH Safeguarding Team 13. IP Steering Group 14. IPC Team	• Reports from Mortality review to CQEG and QGC (L1) • HSMR & SHMI data (L3) • CQEG reports to Quality Governance committee (L1) • Quality reports to Quality Governance and Trust Board (L1) • Quality Governance reports to Trust Board (L2) • Dr Foster data reports (L3) • Results from Clinical audit (L1) • Review of Harm Group monitoring implementation for SI action plans (L1) • National Learning and reporting system data (L3) • Incident report to Quality Governance committee (L1) • Safety thermometer metrics via DoN report (L2) • Delivery of infection control trajectory requirements at end of 2019/20 (L1) • Reports to FIT Group (L1) • IPC Assurance Framework (L3)

Gaps in Controls

1. HSMR outlier
2. NICE-/ VTE compliance remains inconsistent
3. Recurrent themes of harm identified requiring thematic approach to redress.
4. System Safeguarding resources and infrastructure
5. Delayed review of mortality
6. Outbreaks of nosocomial Covid 19 infection

Further Actions	**Responsible Person/s**	**Due Date**
1. Completion of work to digitise and mandate use of Deteriorating Patient Care Plan	1. Dr Hardwick	1. September 2020
2. Mortality review of deaths – Winter 2019	2. Matt Metcalfe	2. October 2020
3. IPC reviews of nosocomial full SI process to be completed	3. Sheran Oke	3. September 2020
4. Clear guidance on consequence related to nosocomial outbreaks to be communicated	4. Sheran Oke	4. August 2020

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

BAF Risk No.1.5 Risk that Trust fails to deliver high quality services in all clinical areas 24/7

Risk Classification: Quality	**Risk Owner:** MD/DON	**Scrutinising Committee:** Quality Governance Committee
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/3/21**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks 979, 1188, 1445, 1665, 1764, 2188, 2219, 2359. Insufficient clinical staffing to provide 24/7 service.	**Initial score**	**Current score**	**Target score**
	12 (4x3)	8 (4x2)	8 (4x2)

Existing Controls	**Positive Assurance of Controls**
1. Reports to Clinical Quality and Effectiveness Group (CQEG) – 7 day services 2. CQEG reports to QGC 3. Job planning processes 4. Review of clinical models in line with Trust 60 bedded unit 5. Safe Nursing & Midwifery Staffing Report 6. Quality Account & process 7. Quality Strategy 8. Assessment and Accreditation report to Board on standards of nursing care- currently suspended	• Associate Medical Director report to CQEG (L1) • Quality Governance report to Trust Board (L2) • Clinical Collaboration work to ensure robust services county wide across both acute Trusts (L1) • Self-assessments (Assurance Framework return) undertaken biennially against 7 day services criteria (L1 • Mortality review reports to QGC and Trust Board (L1) • Safer staffing metrics (L1) • Delivery of Quality Priorities (L1)

Gaps in Controls
1. Weekend capacity of medical staffing
2.

Further Actions	**Responsible Person/s**	**Due Date**
1. Medical rota revision 2. Plan to roll out ERostering 3. Revision/ update of Quality Improvement Strategy	1. Geraldine Harrison 2. Fiona Poyner 3. Matt Metcalfe/ Sheran Oke	1. 31/12/2020 2. 31/12/2020 3. 31/7/2020

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.		
BAF Risk No.1.6 Inability to recruit adequate numbers of nursing staff		
Risk Classification: Quality	**Risk Owner:** DON	**Scrutinising Committee:** Quality Governance & Workforce
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/3/21**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks; 979, 1188, 1665, 1879,1962,1967,2219, 2334 National shortage of Nursing and Midwifery qualified staff.	**Initial score**	**Current score**	**Target score**
	25 (5x5)	15 (5x3)	10 (5x2)

Existing Controls	**Positive Assurance of Controls**
1. Nursing recruitment and retention plan including both UK and overseas recruitment programmes. 2. Three times daily safety/staffing huddles led by senior nursing team /Staffing escalation protocol 3. Nursing Talent Academy providing career pathway 4. Monitoring standards of care through the Assessment and Accreditation process reporting to Board 5. Patient and Carer Engagement and Experience Group 6. Safeguarding policies/ staff training 7. Nurse Staffing Recruitment and Retention Group 8. Nursing and Midwifery strategy 9. Quality Governance Committee 10. Workforce committee	• Nursing recruitment monthly recruitment pipeline tracker (L1) • Monthly reports from Workforce committee to Trust Board (L2) • Report to workforce committee (L1) • Quality Governance report to Trust Board (L2) • Incident reporting (L1) • Staff satisfaction survey (L3) • Patient feedback (L3) • Acuity and skill mix reviews (Bi- annual) (L1) • Open and Honest Care report (L1) • Safety thermometer (L1) • Patient harm data (Including falls, pressure ulcers)d incidence and benchmarking (L1) • Nurse fill rate (L1)

Gaps in Controls
1. Vacancy rates of qualified nursing staff

Further Actions	**Responsible Person/s**	**Due Date**
1. NHS Recruitment & Retention collaboration 2. Assessment & Accreditation roll out to Paeds, Maternity & Theatres	1. Fiona Barnes 2. QA Matron & PNS	1. Sept 2020 2. Dec 2020

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

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

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

Underlying Cause/ Source of Risk:	**Initial score**	**Current score**	**Target score**
CRR reference risks; 258, 1174, 1177, 1287, 1699, 1701, 1702, 1703, 1738, 1373, 1893, 1986, 1414. Failure of multiple estates components or systems due to age, accessibility and lack of funding	20 (5x4)	20 (5x4)	10 (5x2)

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

Gaps in Controls

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

Further Actions	**Responsible Person/s**	**Due Date**
1. Recruit into key estates vacancies	1. Stuart Finn	1. Oct 20
2. Deliver action plans against key estates elements to improve assurance and reduce risks	2. Stuart Finn	2. September 20
3. Review Estates strategy to align with KGH, STP/HCP and Clinical strategy	3. Stuart Finn	3. Oct 20
4. Seek additional routes to Capital funding to reduce backlog and align with Estates strategy & Masterplan and Clinical strategy	4. Stuart Finn	4. Ongoing

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

BAF Risk No. 1.8 Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust

Risk Classification: Infrastructure	**Risk Owner:** COO	**Scrutinising Committee:** Finance & Performance
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/3/21**	
Changes since last review:		

Underlying Cause/Source of Risk: CRR reference risks 1733, 1984, 1482, 1684, 2020, 2151, and 2170. Cyber risks, Information security and aging ICT infrastructure.	**Initial score**	**Current score**	**Target score**
	20 (4x5)	20 (4x5)	8 (4x2)

Existing Controls	**Positive Assurance of Controls**
1. IT reporting to Finance and Performance committee 2. Elective access policy and Data quality SOPs in place 3. Microsoft Advanced Threat Detection (ATP) alerts 4. Intrusion Prevention blocking and alerts from the Trust's boundary firewalls 5. Anti-Virus in place. 6. Microsoft Patching – All Trust workstations and Servers are patched. 7. SPAM Emails are automatically quarantined. Any SPAM that is not quarantined is manually blocked when reported 8. Weekly Care Cert meetings held between NGH and KGH. 9. Web Filtering –blocks malicious and non-Trust related web traffic. 10. Enhanced Anti-Ransomware protection. 11. Tape backups (off-line backups) – The Trust now backs up data to tape regularly	• Reports from IT to Finance and Performance committee (L1) • Minutes from IT committee (L1) • Application of additional Sophos updates(L2) • IT strategy updated (L1) • Data Quality Audits. (L1) • Blocked Activity reported to IT Committee (L1) • Free NHS WiFi

Gaps in Controls

1. IT Team vacancies/ Ability for users to plug old equipment into network/ Limited knowledge of staff regarding cyber security and Potential for incorrect data input due to human error
2. Gaps in data team with SOP's/process and testing.
3. Gaps in Clinical Applications team daily service checks to provide assurance that all clinical systems are functioning as expected.

Further Actions	**Responsible Person/s**	**Due Date**
1. Training	1. Dave Smith	1. Mar 2021
2. Network access control (plug in USB)	2. Dave Smith	2. Oct 2020
3. Windows to migrate to Windows 7 (2529 completed- 1162 remain)	3. Dave Smith	3. Nov 2020
4. USB Port control	4. Dave Smith	4. Ongoing
5. Additional external assurance (DCIO) for data/information	5. Deborah Needham	5. Oct 2020
6. New kitemark process	6. Hugo Mathias	6. Aug 2020
7. New Daily service checks process for clinical systems	7. Dave Smith	7. Ongoing

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

Existing Controls	**Positive Assurance of Controls**
1. Covid Incident management plan 2. Revision of medical rotas to ensure staffing supports activity, recruitment of volunteer workforce, redeployment of staff to areas of greatest need 3. Digital solutions to allow continuation of Outpatient work where appropriate/ workforce permits 4. Critical Care Plan - Enhanced triage of patients to ensure best use of available experience 5. Maintain 75% bed occupancy 6. Capacity/ cohort plan 7. Use of private provider bed stock for additional capacity 8. National Guidance and webinars 9. Gold, Silver and Bronze Command structures and processes in line with Major Incident Policy 10. IPC Cell 11. Workforce Bronze cell and staff support network 12. Dedicated Covid 19 cost centre and coding to capture lost elective activity 13. Bi-Weekly System Strategic Command Group CEO 14. System Critical Care Group 15. System Discharge Group 16. SCG Command Structure under CCG 17. Regional Calls – CEO, MD, DN, AO – weekly 18. Twice weekly system Gold DCEO 19. Covid 19 Strategy 20. Resources – command structure flexes resource delivery according to demand	• Decision risk log (L1) • Incident log (L1) • Actions from System meetings (L2) • Twice weekly Gold meeting action log (L1) • Daily Silver meeting action log (L1) • Weekly Bronze meetings action log (L1) • Covid 19 Strategic response meetings (L1) • On site staff testing (L1) • SOS team/ NGH Our Space (L1) • Repository of all Covid information on the Shared drive (L1,2 & 3)

Gaps in Controls

- Cyber Security
- Plan for return to 'normal' unmet need of Covid patients in the community.
- Timely information relating to inpatients

Further Actions	**Responsible Person/s**	**Due Date**
1. Additional vigilance in area of cyber security with assurance provided	Hugo Mathias	Aug 2020
2. Continue with Bronze, Silver, Gold until national incident has been stood down	Deborah Needham	Aug 2020

NEW

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.				
BAF Risk No. 1.10 Risk of the Trust being unable to deliver a recovery plan post covid-19 with consequential impact on patient and staff safety, patient experience and staff wellbeing.				
Risk Classification:	**Risk Owner:** COO/DCEO	**Scrutinising Committee:** Board and all committees		
Date Risk Opened: 20/07/20	**Date risk expected to be removed from BAF: Dec 2020**			
Changes since last review:				
Underlying Cause/ Source of Risk: CRR reference risks: 1482,2287, 2305, 2307, 2313, 2334, 2336, 2341, 2359 Global pandemic relating to Covid 19 affecting the Northamptonshire healthcare system. In recovery, backlogs of activity and reduced capacity.		**Initial score** 20 (5 x 4)	**Current score** 20 (5 x 4)	**Target score** 10 (5x2)

Existing Controls	**Positive Assurance of Controls**
1. Covid reset management plan 2. Digital solutions to allow continuation of Outpatient work where appropriate/ workforce permits 3. Maintain 75% bed occupancy 4. Capacity/ cohort plan for elective activity 5. Use of private provider bed stock for additional capacity 6. National Guidance and webinars 7. Gold, Silver and Bronze Command structures and processes in place with reporting twice weekly 8. System Discharge Group 9. Regional Calls – CEO, MD, DN, COO – weekly	• Actions from System meetings (L2) • Twice weekly reset meeting minutes (L1) • SOS team/ NGH Our Space (L1) • Repository of all recovery information on the Shared drive (L1,2 & 3) • Trust board reports • Covid scorecard

Gaps in Controls

- Demand & capacity plan

Further Actions	**Responsible Person/s**	**Due Date**
TBC		

Principal Risk 2 – Failure to deliver patient focussed care may lead to reputational risk and poor patient experience. this may cause the Trust to perform poorly against national and local patient experience surveys affecting reputation as hospital of choice for our local population and beyond.

BAF Risk No. 2.1 Risk that the Trust fails to promote a culture which puts patients first

Risk Classification: Patient Experience	**Risk Owner:** DON	**Scrutinising Committee:** Quality Governance
Date Risk Opened: 30/07/20	**Date of next full review of BAF: 31/03/21**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks 1955, 1867, 2003 Multiple sources of risk exacerbated by high demand and high patient acuity.	**Initial score**	**Current score**	**Target score**
	12 (4x3)	8 (4x2)	4 (4x1)

Existing Controls	**Positive Assurance of Controls**
1. Patient and Carer experience and engagement Group with the following reporting: • Dementia Group • End of Life Group • Disability Partnership forum • Learning and Disability Group 2. PALS and Complaints team 3. Link with Health watch Northampton 4. Regular performance reviews by Division including patient experience KPIs 5. Patient Experience manager 6. Safeguarding policies and training 7. Appointment of Head of Diversity & Inclusion 8. Guidelines that identify how we manage patients with protected characteristics 9. Patient Involvement Strategy 10. Volunteer Strategy 11. Use of electronic devices/ letters to loved ones to connect families 12. The Knitted Hearts initiative for deceased patients and their families; 13. Volunteer support via drop off points, delivery service including prescriptions 14. Response volunteers linked to ward areas.	• Patient satisfaction survey (L3) • Complaints report to Quality Governance committee (L1) • Complaint review Panel (L1) • Quality Governance reports to Trust Board (L2) • NHS Choices feedback (L3) • CQC inspection (L3) • F&F tests results (2019) (L3) • Patient story to the Board (L1) • Board to Ward visits (L1) • National Survey results: Cancer; Urgent Care; Inpatient; Paediatric & Young people and Outpatient surveys (L3) • PLACE audits (L3) • Assessment and Accreditation scheme reports to Board (L1) • Divisional Quality Governance reports to CQEG (L1) • Pathway to Excellence (L3)

Gaps in Controls

1. Opportunity for collaborative working with patients and carers to improve and inform service development

Further Actions	**Responsible Person/s**	**Due Date**
1. Undertake a co design service development to enhance collaborative working	1 & 2: Rachel Lovesey	1. Oct 2020
2. Enhance the role/ profile of patient experience champions locally		2. Sept 2020
3. Findings of patient survey to be disseminated to Divisions for local implementation	3.Sheran Oke	3. Oct 2020
4. Review of Patient Information- content and mode of delivery	4. Sheran Oke	4. Dec 2020

Principal Risk 3 – Failure to develop, value and support our staff may lead to poor standards of care, poor staff training and difficulty in recruiting and retaining high calibre staff.		
BAF Risk No. 3.1 Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future		
Risk Classification: Human Resources	**Risk Owner:** CPO	**Scrutinising Committee:** Workforce
Date Risk Opened: 30/07/20	**Date of next full review of BAF: 31/03/20**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks 2075, 1188, 979, 1764, 1893, 2219 National workforce shortages of clinical staff	**Initial score**	**Current score**	**Target score**
	10 (5x2)	10 (5x2)	5 (5X1)

Existing Controls	**Positive Assurance of Controls**
1. People Plan 2019 -2020 2. Nurse Recruitment and retention strategy 3. Recruitment policies and procedures 4. Workforce Plan submitted to LWAB 5. Sickness Absence management policy 6. Occupational Health Service 7. Bank staff service 8. E-rostering 9. Apprenticeship scheme 10. Regular skill mix reviews in Nursing 11. Northamptonshire Branding- Best of Both Worlds campaign 12. Weekly Agency meeting 13. Alternative pension contribution policy	• Workforce report to workforce committee (L1) • Workforce committee reports to Trust Board (L2) • Nurse Recruitment plan and retention report to Workforce Committee (L1) • Staffing data report to Workforce Committee and Quality Governance Committee (L1) • Patient survey (L3) • Staff survey (L3) • Medical Trainee survey (L3) • Internal Audit – Sickness Absence audit (L3) • OH Annual Report (L1)

Gaps in Controls

1. Difficulties in recruiting to vacancies due to national shortages
2. Challenges moving forward with the domestic supply of nurses with educational and placement issues following the pandemic
3. Trust has red flags related to Medical Trainee survey reports
4. Opening of escalation areas dilutes capacity with current issues regarding covid and non-covid treatment areas

Further Actions	**Responsible Person/s**	**Due Date**
1. Establishing the system People Board	1. Mark Smith	Completed
2. Restart Oncology work in response to medical trainee comments	2. Bronwen Curtis	1. Aug 2020
3. Rebasing our international recruitment profile and domestic supply for nursing colleagues	3. Mark Smith and Sheran Oke	2. Sept 2020
4. Review workforce capacity based on national guidance for colleagues i.e. colleagues shielding	4. Bronwen Curtis	3. Aug 2020

Principal Risk 3 – Failure to develop, value and support our staff may lead to poor standards of care, poor staff training and difficulty in recruiting and retaining high calibre staff.		
BAF Risk No. 3.2 Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future		
Risk Classification: Human Resources	**Risk Owner:** CPO	**Scrutinising Committee:** Workforce
Date Risk Opened: 3/06/20	**Date of next full review of BAF: 31/03/21**	
Changes since last review:		

Underlying Cause/Source of Risk:	**Initial score**	**Current score**	**Target score**
Operational pressures impact on staff training and development	8 (4x2)	12 (4x3)	4 (4x1)

Existing Controls	**Positive Assurance of Controls**
1. People Plan 2019-2020 2. Study leave policy 3. Appraisal policy 4. Statutory and mandatory training policy 5. Leadership and Management development programmes for leaders 6. Practice Development Team for Nursing staff 7. Director of Medical Education for medical staff 8. Consultant Foundation programme 9. Continuing professional development and in house training programmes for staff. 10. Nursing and Midwifery Committee	• Workforce report to workforce committee (L1) • Workforce Committee reports relating to revalidation and Medical Education (L1) • Workforce committee reports to Trust Board (L2) • Line managers receive compliance rates for appraisal (L1) • Staff survey results relating to training and development (L3) • Nursing revalidation report (L1) • Divisional scorecards and Performance Review process (L1)

Gaps in Controls

1. Underperformance against target on Statutory & Mandatory training for specific staff groups – pause on data publication during pandemic
2. Apprenticeship Levy attainment remains challenging
3. Organisational Pressures in releasing colleagues time to develop at the moment

Further Actions	**Responsible Person/s**	**Due Date**
1. Talent Management development	1. Mark Smith	1. Dec 2020
2. Implementation of People Plan 2019-2020	2. Mark Smith	2. Dec 2020
3. Deep dive reports into staff group compliance with training upon commencement of reporting in Q2	3. Mark Smith	3. Sept 2020

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

BAF Risk No. 3.3 Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optional culture

Risk Classification: Human Resources	**Risk Owner:** CPO	**Scrutinising Committee:** Workforce
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/03/21**	
Changes since last review:		

Underlying Cause/Source of Risk: CRR reference risks: 2003	**Initial score**	**Current score**	**Target score**
	15 (3x5)	15 (3x5)	6 (3x2)

Existing Controls	**Positive Assurance of Controls**
1. Workforce committee 2. Equity and Diversity Steering Group 3. Staff networks including BAME, LGBTQ and Disability 4. Freedom to Speak up Policy and process 5. Bullying and Harassment Policy 6. Grievances at Work policy. 7. Health and Wellbeing Plan/Strategy 8. People Plan 2019-2020 9. Diversity & Inclusion Manager post 10. Development of TRiM training and our Support Our Staff (SOS) team	• Organisational Development updates to Workforce Committee, includes staff engagement and staff survey results(L1/ L3) • Equality and Human Rights Group (staff) reports to Workforce Committee and Trust Board (L1/ L2) • Web based incident reporting system available for staff (L1) • Staff survey (L3) • Guardian of Safe working hours report to Workforce Committee and annually to Trust board (L1) • Freedom to Speak Up Guardian Report to Workforce Committee and Trust Board (L1) • Workforce committee reports to Trust Board (L2) • Staff Friends and Family Test (L3) • Health & Wellbeing reports to workforce Committee (L1) • Sickness rate (L1) • Approval of People Plan by Trust Board (L1)

Gaps in Controls

1. Trust results in staff survey relating to bullying and harassment require improvement
2. Introduction of Workforce Race Equality Standards (WRES) action plan

Further Actions	**Responsible Person/s**	**Due Date**
1. Health & Well- Being Strategy to be developed across the Group Model	1. Mark Smith	1. Sep 2020
2. People Plan Implementation	2. Mark Smith	2. Dec 2020
3. WRES Acton plan completed and implement	3. Mark Smith	3. Aug 2020

Principal Risk 4 – Failure to develop a sustainable future for Northampton General Hospital through delivery of high quality effective services in collaboration with partner organisations

BAF Risk No. 4.1 Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire HCP will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access.

Risk Classification: Partnerships	**Risk Owner:** DoS&P	**Scrutinising Committee:** Finance & Performance
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 31/7/20**	
Changes since last review:		

Underlying Cause/Source of Risk: CRR reference risks 1309, 2006
Northamptonshire HCP fail to deliver service and financial sustainability for NGH and local providers

Initial score	Current score	Target score
16 (4x4)	12 (4x3)	4 (4x1)

Existing Controls	Positive Assurance of Controls
1. Board and Executive updated monthly on progress of the Health and Care Partnership 2. Executive oversight 3. Collaboration Steering Board and associated governance framework 4. Monthly updates to the Board via CEO report 5. Non Exec Directors attend NED countywide and Chairs meetings 6. Integrated Business Planning Group/ Strategic planning group 7. County wide Finance Directors Group 8. Chair & CEO are members of HCP Board 9. DoS&P is senior responsible officer for the Unified Acute Model work stream and MSK work stream of HCP 10. Significant partnerships described in Annual Plan 11. Annual contract negotiation and service planning processes leading to a Board approved contract and annual plan 12. Regulatory oversight of the annual planning process 13. Establishment of the Group Model with Kettering General Hospital giving additional opportunities for service sustainability and collaboration	• New Trust strategy in place with aligned estates strategy in progress reports to Trust Board (L1) • Estates strategy and master plan in place with plans for Health and Well Being Campus being delivered alongside external partners (L1) • Service line reports (SLR) (L1) • Medium term financial sustainability plan (L1) • HCP Board in place update reports to Trust Board (L2) • Plans delivered for collaboration with partners in respect to: Rheumatology; Dermatology; Stroke, MSK (L2) • Plans in development for; Plastics; Ophthalmology; Urology; ENT; Cardiology • Reports on all collaboration schemes to Collaboration Steering Model Board (L2) • Annual capacity and demand analysis and associated contract agreements • Service sustainability reviews undertaken as part of annual planning process (L1) • Partnership in place with UHL NHS Trust for oncology services (L1)

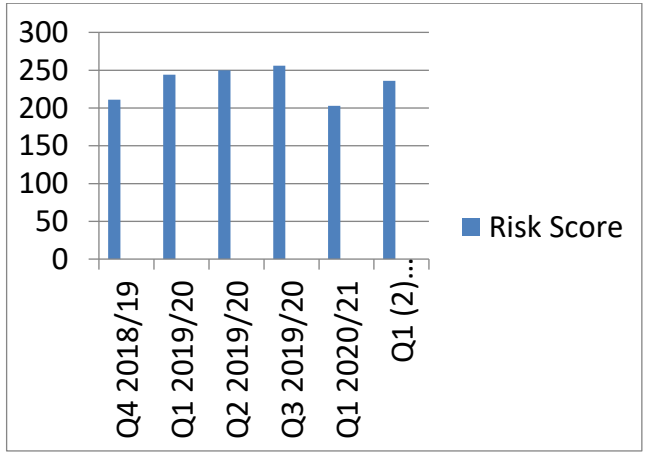
Gaps in Controls
1. Trust capacity issues have led to outsourcing and loss of market share;
2. Out of hospital work-streams fail to deliver reductions in activity;
3. Challenging relationships with local partners in context of health economy financial challenges;
4. Reduction in funding of adult social care leading to increased admissions;
5. Lack of Resource to support implementation of scheduled care programme is a risk;
6. Resistance to collaboration within some of clinical workforce due to capacity.

Further Actions	Responsible Person/s	Due Date
1. Implementation of Group model	1. Trust Board	1. July 2020
2. Annual Planning process- delivering internal clinical sustainability reviews and use to inform future divisional clinical strategy design during 2020/21	2. Chris Pallot 3. Chris Pallot	2. 31/12/2020
3. Annual Planning - align processes with KGH to ensure single unified approach	4. Chris Pallot	3. 31/03/21
4. Continue to explore options to integrate tertiary services, e.g. Head & Neck on a regional basis	5. Chris Pallot	4. 31/03/21
5. Integration with new Unitary Authorities and Primary Care Networks		5. 31/03/21

Principle Risk 5: Failure to deliver financial stability may affect the quality of services and the future sustainability and viability of the Trust					
BAF Risk No. 5.1 Risk that the Trust fails to have financial control measures in place to deliver its 2020/21 financial plan					
Risk Classification: Finance	**Risk Owner:** DoF	**Scrutinising Committee:** Finance & Performance			
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 31/7/20**				
Changes since last review:					
Underlying Cause/Source of Risk: CRR reference risks; 2343, 2344, 2346. Requirement to return to financial balance in the medium term.			**Initial score** 25 (5x5)	**Current score** 10 (5x2)	**Target score** 5 (5x1)
Existing Controls			**Positive Assurance of Controls**		
1. Finance and Performance committee 2. Divisional performance reviews 3. Audit arrangements 4. SFOs SFIs & SOD 5. Policies and procedures 6. Financial and accounting systems 7. Counter Fraud plan 8. Purchasing and Supplies Strategy & Policies 9. Financial Assurance correspondence with NHSE/I (monthly) 10. HCP Finance Director meetings			• Monthly report to Finance and Performance committee (L1) • Finance and Performance committee Report to Board (L2) • Finance KPIs (L1) • Audit committee reports to Trust Board (L2) • Outcome of NHSE/I accountability meetings (L3) • LCFS rated Green (L3) • NHSE/I rating for Single Oversight Framework (L3) • Internal Audit (L3) • External Audit (L3)		
Gaps in Controls 1. Pay spend above plan and activity below plan 2. Agency expenditure is currently above the set target for 2020/21.					
Further Actions			**Responsible Person/s**		**Due Date**
1. Transformation & efficiency programme changes to be implemented- once out of pandemic 2. System financial plans submitted to support LTP but currently on hold 3. Underlying financial position report received to be presented in July to Finance & Performance Committee 4. Balance sheet review paper to July Finance & Performance Committee			1. Chris Pallot 2. Phil Bradley 3. Phil Bradley 4. Phil Bradley		1. TBA 2. TBA 3. July 2020 4. July 2020

Principle Risk 5: Failure to deliver financial stability may affect the quality of services and the future sustainability and viability of the Trust					
BAF Risk No. 5.3 Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements					
Risk Classification: Finance	**Risk Owner:** DoF	**Scrutinising Committee:** Finance & Performance			
Date Risk Opened: 30/06/20	**Date of next full review of BAF: 31/03/21**				
Changes since last review:					
Underlying Cause/Source of Risk: CRR reference risks; 2345 Insufficient Capital funds to meet Trusts requirements			**Initial score** 10 (5x2)	**Current score** 25 (5x5)	**Target score** 10 (5x2)
Existing Controls			**Positive Assurance of Controls**		
1. Capital Committee 2. Finance and Performance committee 3. 5 year capital plan 4. Purchasing and Supplies Strategy 5. Leasing strategy in place/ IFRS16 6. Hospital Management Team Meetings 7. Business Case process			• Finance report to Finance and Performance committee • Includes progress on capital planning and expenditure plus forecast expenditure (L1) • Report to Board (L2) • Internal audit (L3) • External Audit (L3)		
Gaps in Controls 1. The Trust has a large backlog maintenance programme and the estate is ageing. 2. Affordability of additional capital 3. Additional access to capital limited in infrastructure incidents 4. Ineffective and lengthy regional and national Covid 19 related capital bids regime					
Further Actions			**Responsible Person/s**		**Due Date**
1. Submit additional bids wherever possible e.g. electrical infrastructure, IT and Paediatric ED 2. Emergency capital bid in train for a new ITU / HDU, electrical infrastructure and fire and safety works on the current critical care floor 3. Covid related Capital bid for additional ward capacity to maintain social distancing and zoning of hospital			1. Phil Bradley 2. Stuart Finn/ Phil Bradley 3. Phil Bradley		1. 31/3/21 2. Q2 2020/21 3. Q2 2020/21

	Movements on Board Assurance Framework (since previous report)
ADDITIONS	1.10 Risk of the Trust being unable to deliver a recovery plan post covid-19 with consequential impact on patient and staff safety, patient experience and staff wellbeing.
INCREASES	1.4 Score increased from 10 to 15 due to increase in nosocomial infections.
	5.3 Score increased from 20 to 25 due to delays in Covid related capital bid outcomes
DECREASES	1.9 Score decreased from 25 to 15 due to a decrease in gaps in assurance
	3.1 Score decreased from 15 to 10 due to mitigations in place
	4.1Score decreased from 16 to 12 due to the move to a block contract
CLOSURES/ AMALGAMATED	1.3 Risk removed as CQUIN scheme suspended for 2020/21



Graph shows risk score of 236 for 16 Risks

Consequence Score/ Domain	Likelihood Score/Domain				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost certain
5 Catastrophic		3.1; 5.1;	1.1; 1.4; 1.6; 1.9;	1.7; 1.10;	5.3;
4 Major		1.5; 2.1;	3.2; 4.1;	1.2:	1.8;
3 Moderate					3.3;
2 Minor					
1 Negligible					

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

BAF risks in order of severity:

5.3	Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements	25
1.7	Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failures	20
1.8	Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust	20
1.10	Risk of the Trust being unable to deliver a recovery plan post covid-19 with consequential impact on patient and staff safety, patient experience and staff wellbeing.	20
1.2	Risk of failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties	16
1.4	Risk of avoidable harm to patients and the associated loss of public confidence	15
1.6	Inability to recruit adequate numbers of nursing staff	15
1.9	The risk of the Trust being unable to deliver an appropriate response to Covid 19 in terms of quality of care, capacity and timeliness with consequential impact on patient and staff safety, patient experience and staff wellbeing.	15
3.3	Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optional culture	15
3.2	Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future	12
4.1	Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire Health and Care Partnership (Northamptonshire's Sustainability and Transformation programme) will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access.	12
3.1	Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future	10
5.1	Risk that the Trust fails to have financial control measures in place to deliver its 2019/20 financial plan	10
1.5	Risk that Trust fails to deliver high quality services in all clinical areas 24/7	8
2.1	Risk that the Trust fails to promote a culture which puts patients first	8

Executive Leads

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

CQC Fundamental standards

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

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

Report To	**Public Trust Board**
Date of Meeting	**30 July 2020**

Title of the Report	**Post Covid Reset**
Agenda item	**11**
Presenter of Report	Deborah Needham, Chief Operating Officer and Deputy Chief Executive Mark Smith, Chief People Officer Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Deborah Needham, Chief Operating Officer and Deputy Chief Executive Mark Smith, Chief People Officer Chris Pallot, Director of Strategy and Partnerships

This paper is for: (delete as appropriate)

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

Executive Summary

This report provides an update to the Board on activities that are taking place across the Trust to reset services following the pandemic. It details activity and performance levels during past months along with measures that have been taken to support our staff and manage our site. It provides an in-depth review of our position in relation to cancer services and how we intend to recover performance along with a case study on outpatients.

The conclusions drawn are that whilst every effort is being made to deliver services at pre-Covid levels, enhanced measures to safely managing the care of our patients, protect our staff and ensure adequate distancing is in-place mean that our capacity is reduced. This will inevitably require the adoption of new practices, and the continuation of others (such as the use of private sector capacity) to continue to recover from the pandemic.

From an assurance perspective, the appendix contains a position statement that both Northampton and Kettering General Hospitals provided to regulators following a request from the Chief Executive of the NHS.

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

Actions required by the Trust Board

The Trust Board is asked to note the contents of this paper and the work underway at the Trust to reset services.

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Northampton General Hospital NHS Trust
Post Covid-19 Reset

Chris Pallot, Director of Strategy and Partnerships
Deborah Needham, Chief Operating Officer and Deputy Chief Executive
Mark Smith, Chief People Officer

We put patient safety above all else
We aspire to excellence
We reflect, we learn, we improve
We respect and support one another

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Contents

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RESET - Highlights

Service	Activity level	Regional level	Comments
Breast Screening	**100%**	3.7%	Screening invites continue with age range of patients in line with national guidance
Bowel Screening	**60%**	22.7%	Cleared by 31 July 2020
Antenatal Screening	**100%**		Maintained
Cervical	**100%**		Cleared by 31 July 2020
Cancer faster diagnosis	**52%**	Unknown	
Endoscopy	**60%**	30%	Cleared by 30 November 2020 with current capacity. System capacity being sought
Outpatients	**80%**	Unknown	
Elective activity	**35%**	44%	Plans in place to increase from 27 July 2020
Day case activity	**35%**	41%	Plans in place to increase from 27 July 2020
Diagnostics - Radiology	**Direct access 45%**	45%	

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Structure of the Reset and Performance

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Overview

- On the 29 April 2020 Simon Stevens (NHS Chief Executive) set out the second phase of NHS response to Covid-19.
- This phase of reset and recovery requested the NHS to begin to step up non Covid-19 urgent services as soon as possible. Any restart needs to be “safe”.
- The overall reset programme is being jointly led by the Director of Strategy & Partnerships and Chief Operating Officer/Deputy CEO.
- The Trust initiated a twice weekly reset group lead by the Silver Commander with clinical and operational leads for each of the reset programmes.
- As we move into month 4 of 2020/21 and in anticipation of phase 3 we have taken stock of the current position and set out the reset priorities going forward.
- We have reset urgent treatments, screening services, cancer, diagnostics and are undertaking some routine outpatients, direct access and elective treatments.
- The ability to reset is restricted by capacity constraints from creation of emergency capacity at the expense of elective/ outpatient areas, availability of staff and the requirement to create Covid-19 safe environments.
- The Trust fast adoption of new technologies and ways of working has allowed us to maintain 80% of pre Covid-19 outpatient activity.

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Operational Structure of the Reset

DIAGNOSTICS (CSS name change)
Reports in Reset as a division
LEAD: Davis Thomas/Julie Mason

CANCER (W/C & Cancer name change)
Remains in reset and reports in as part of the division
LEAD: Owen Cooper/ Sandra Neale

EMERGENCY CARE (name change)
Lead changes to division & reports in as a division
LEADS: Fiona Poyner/Mary Visser
(lead changed)

ELECTIVE CARE
Lead remains and reports in as a division
LEAD: Matt Tucker/ Gregor Kerr

OUTPATIENT CARE
Remains in reset
LEADS: Mary Visser/Julie Mason

INPATIENT CAPACITY / DISCHARGE
Remains in reset
LEAD: Carl Holland

ZONING
New to reset
LEAD: Sandra Neale

LEADERSHIP
Remains in Reset
LEAD: Mark Smith

STAFF WELLBEING & EXTERNAL SUPPORT
Remains in Reset
LEAD: Bronwen Curtis

ESTATE & FACILITIES
Remains in reset
LEAD: Stuart Finn

COMMUNICATIONS
Remains in reset
LEAD: Sally Watts

CORPORATE & CLINICAL GOVERNANCE
Remains in Reset
LEAD: Claire Campbell

CHILDRENS
Becomes BAU (issues reported via division)
Lead: Lalith Chandrakantha

WFH
Becomes BAU
LEAD: Sandra Neale

FINANCIAL GOVERNANCE
Becomes BAU
LEAD: Phil Bradley

INFORMATION TECHNOLOGY
Becomes BAU
LEAD: Hugo Mathias

PROCUREMENT
Becomes BAU
LEAD: Allan Rivans

IPC
BECOMES BAU
LEAD: Ros Pounds

MATERNITY
Becomes BAU (issues reported via division)
Lead: Sue Lloyd

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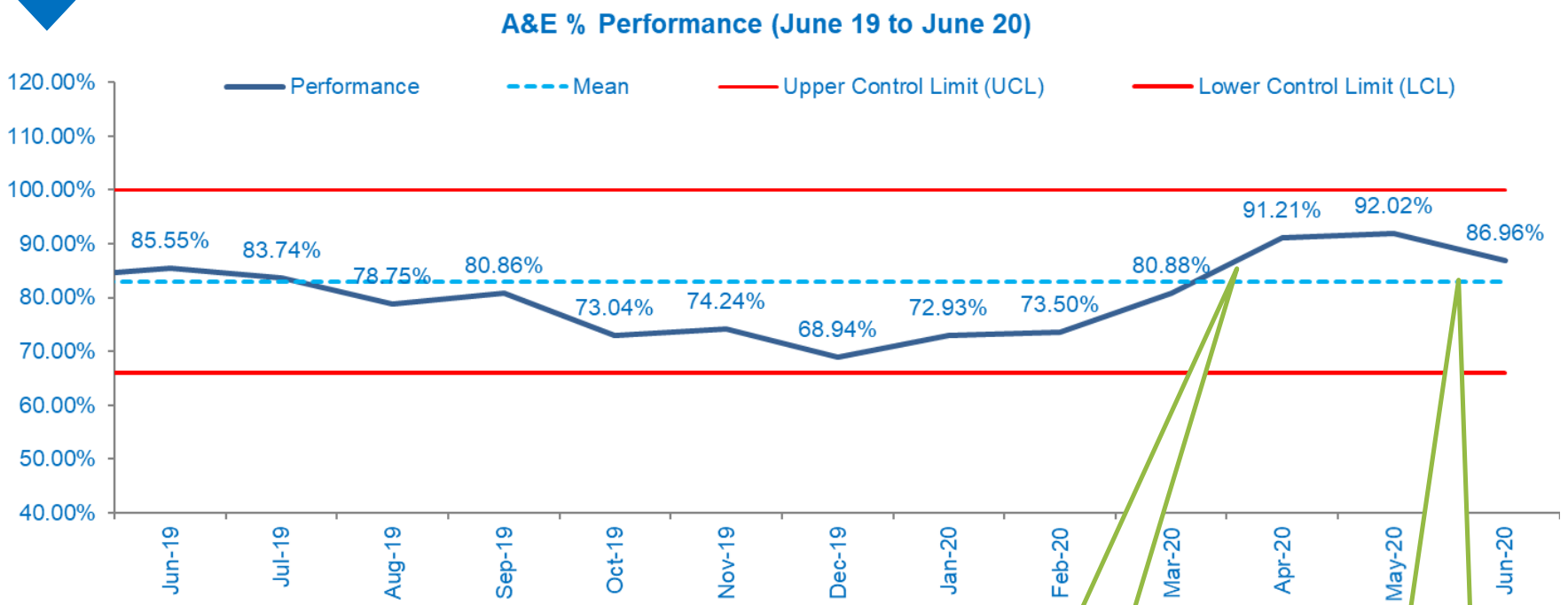
Emergency Department Performance



- Performance has increased in July and is 94.6% (at 21 July 2020).
- There has been a gradual increase in A&E attendees since the significant reduction in April 2020.
- The average daily attendance continues to be 25% lower than attendees pre Covid-19.

Emergency Department performance improves as attendances decrease as a result of patients avoiding the hospital due to Covid-19 risks

Emergency Department performance decreases as attendances start to increase

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Elective and Daycase

- Elective activity is at 35% pre Covid-19 levels compared to 44% regionally
- Day case activity is at 35% pre Covid-19 levels compared to 41% regionally
- Wait times have increased by 3.6 weeks between March and May and 7 weeks between March and June
- The Trust declared 79 52-week breaches in May
- Capacity on site restricted due to theatre staff and anaesthetist capacity being utilised for Covid-19 response
- 50% reduction in theatre lists for planned elective surgery with each 30% less efficient than pre Covid-19

Next Steps

- All category 1 patients treated at Three Shires Hospital (TSH)/NGH with some capacity for category 2/3 patients
- Two theatres opened in main suite, plus gynaecology theatres for elective operating to repatriate from TSH
- Orthopaedics relocated to TSH in place with some also at Ramsay Horton
- Althorp designated as the green surgical ward and is bubbled from the end of July 2020

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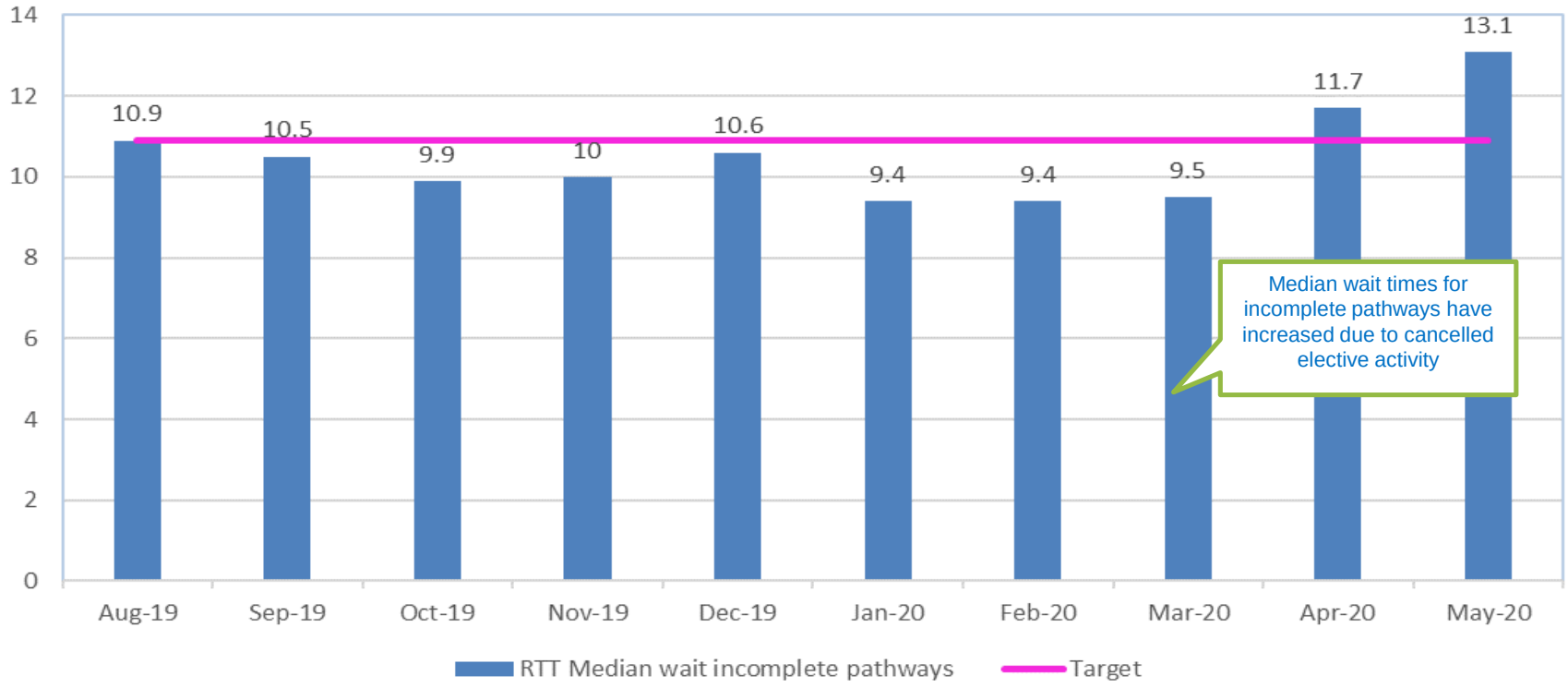
Referral to Treatment (RTT) Performance



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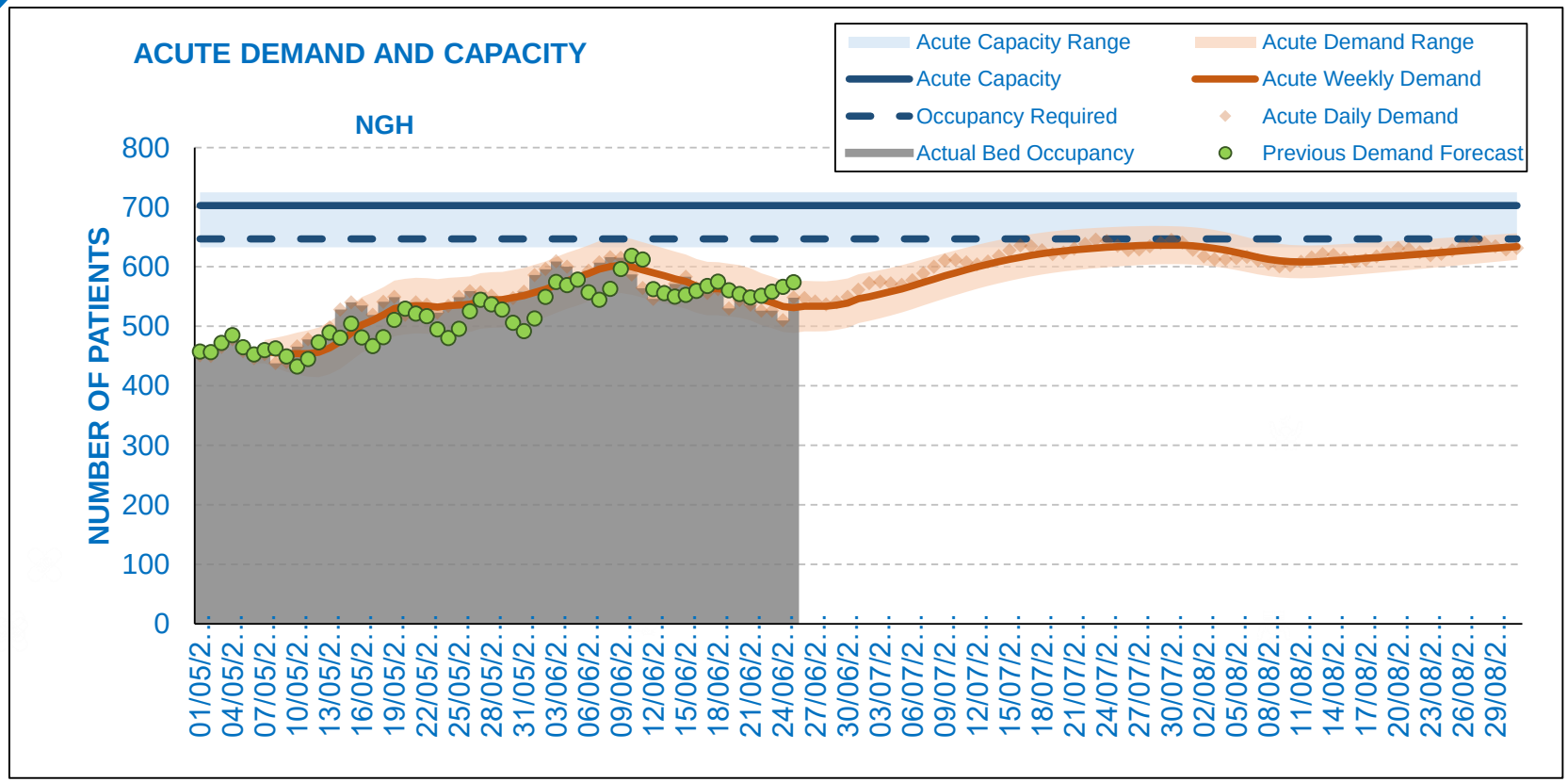
Acute Capacity and Demand



- To maintain a low bed occupancy (75%), the requirement would be to have 160 empty beds
- The current demand is tracking lower than predicted

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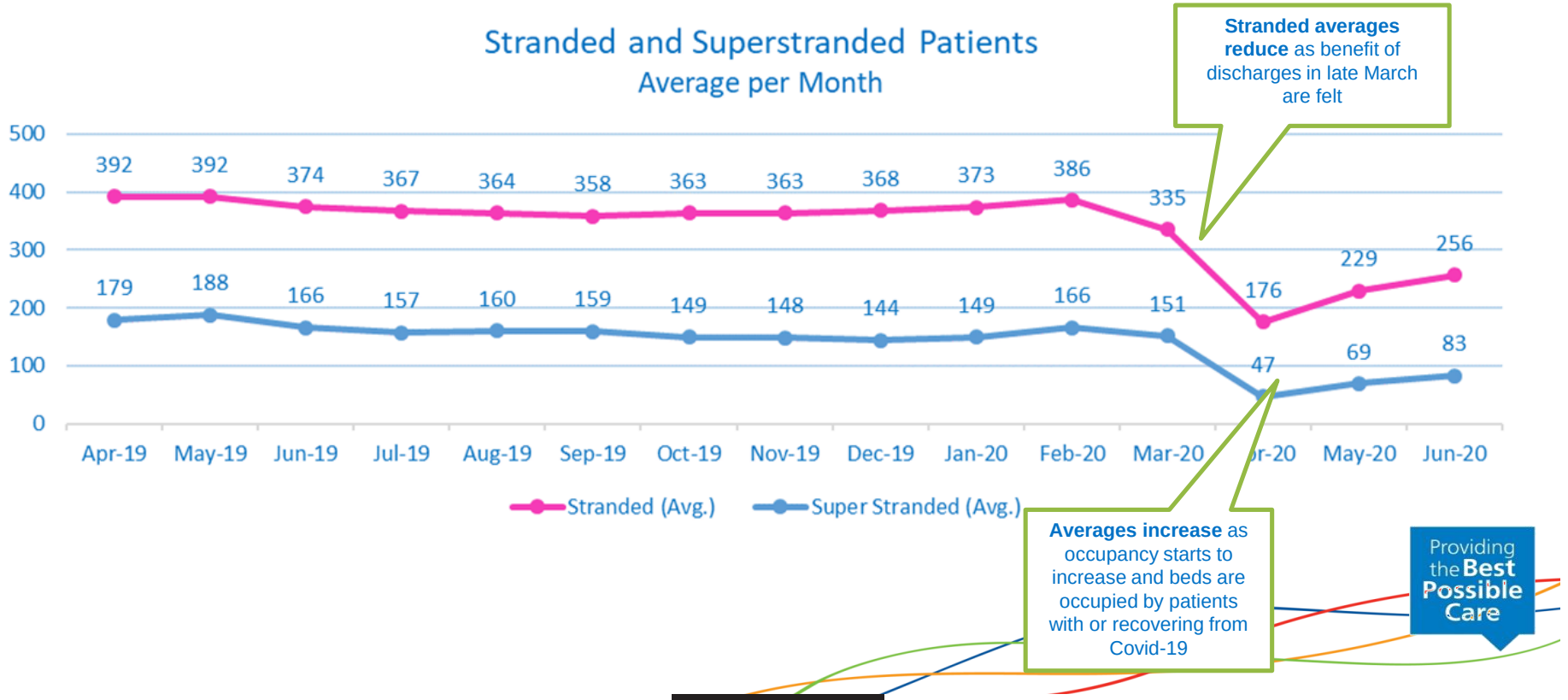
Stranded and Super Stranded Monthly Average

- Average numbers for stranded and super stranded decreased to their lowest in April 2020 as the Trust felt the benefit of the increased number of discharges carried out in late March to prepare the hospital for Covid-19.
- A lower number of Covid-19 patients than expected combined with lower numbers attending the Emergency Department and a pause on elective activity resulted in a marked decrease in % occupancy and long stay patients.
- An increase is shown in May as the Trust saw increases in the number of patients attending the Emergency Department combined with longer lengths of stay for patient's recovering from or still being treated for Covid-19.



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Diagnostics

- Delivering all 2WW capacity, inpatient capacity and urgent direct access activity
- Radiology direct access capacity restricted by requirement to maintain Covid-19 safe areas. Mobile/modular units for MRI and CT have been requested via a national process
- A system approach is required to high footfall services such as phlebotomy which were transferred to TSH but are now back on-site temporarily
- Direct access activity at 45% pre Covid-19 levels which matches regional levels
- Backlog is the total waiting list and shortfall is estimate of current capacity vs forecast activity

Radiology Modality	Backlog	shortfall
B - Breast		2579
C - CT	1807	9789
M - MRI	851	4504
R - Plain Film	145	24010
U - Ultrasound	3025	7891
Obs Ultrasound		3659
X - Dexa	208	0

Next Steps

- Increased weekend lists for MRI and CT
- Evening and weekend lists for plain film
- Additional ultrasound sessions at Daventry
- Exploring use of Three Shires and Woodlands capacity
- A system approach is being sought for high footfall services such as phlebotomy

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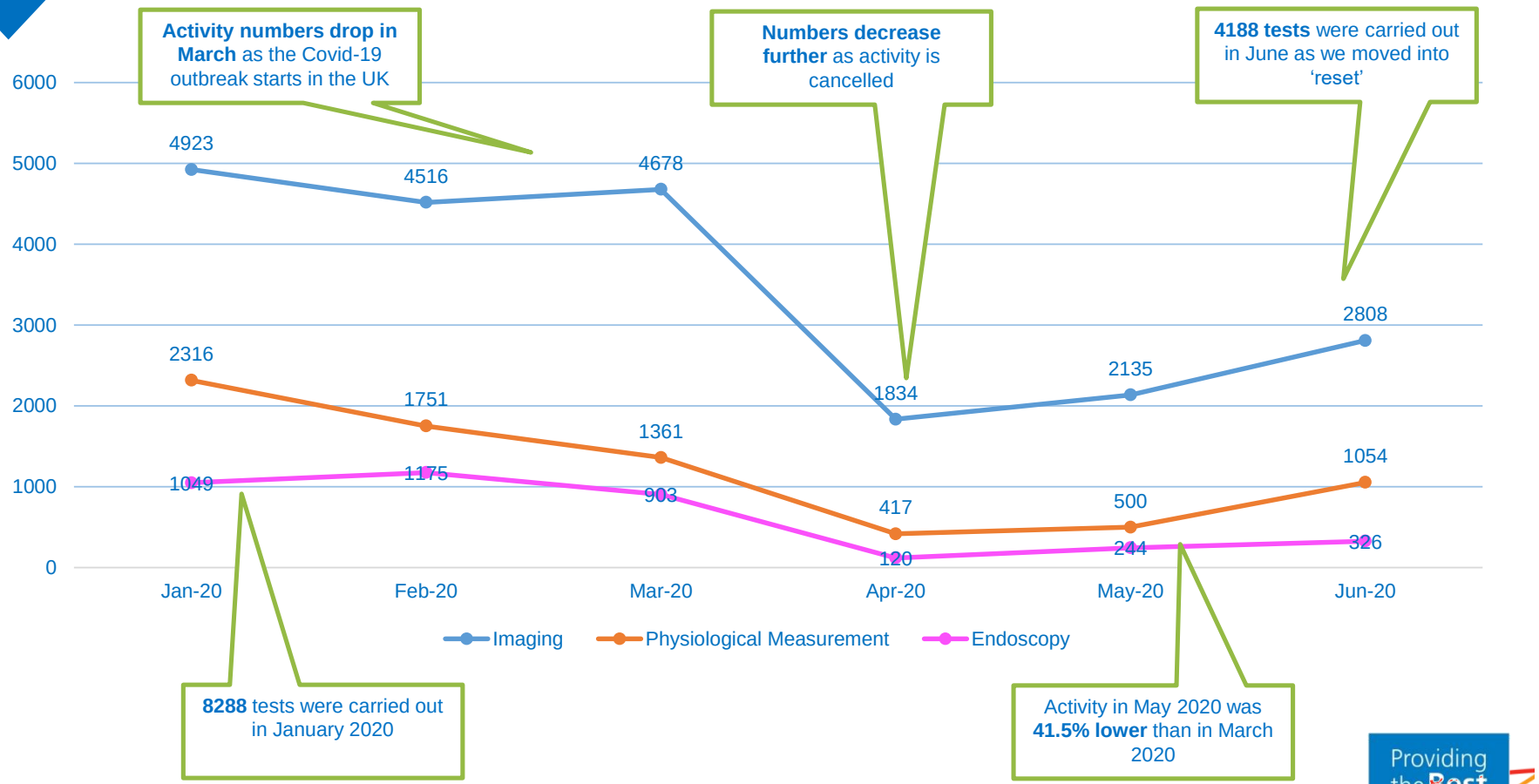
Diagnostics - Activity



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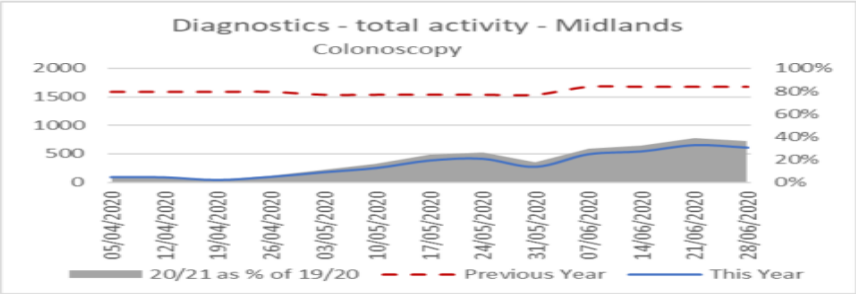
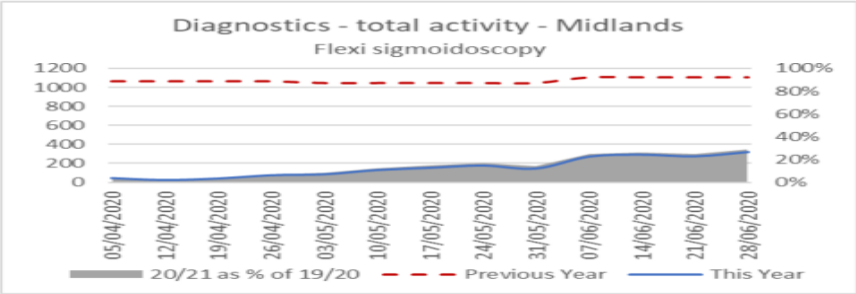
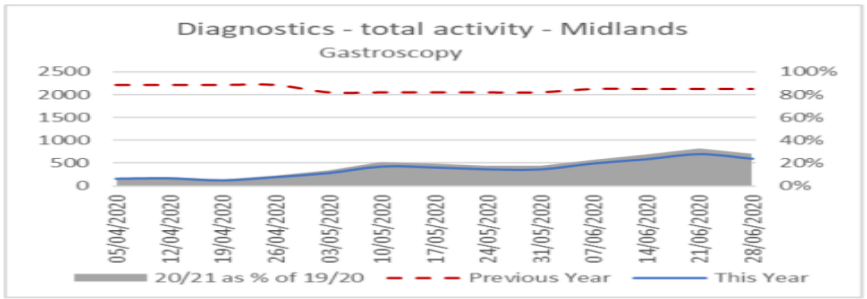
Endoscopy

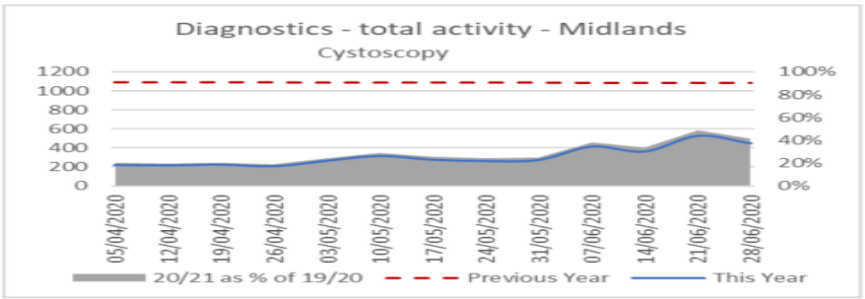
Regional Assumptions

- Lack of endoscopy capacity is a key risk to recovery
- Endoscopy capacity reduction is up to 70% in some Trusts due to a range of restrictions
- Current capacity is in-sufficient to enable a speedy recovery
- Patient choice is a significant limitation, compounded by self-isolation requirements of 14 days in the independent Sector
- Workforce is a key limiting factor









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Endoscopy

- **Backlog –** 700-800 patients (including Urology)
- **Capacity** – Additional 12 lists per week due to pause in bowel scope but list sizes reduced by 50% due to ventilation, cleaning, PPE. In total operating at 60% pre Covid-19 capacity
- **Demand** – reduced 16% during Covid-19 but now back to 99% of pre Covid-19 with the exception of bowel scope screening (paused nationally)
- Endoscopy capacity reduced due to PPE restrictions that could impact activity by 40%

Next Steps

- Expected to take 12-15 weeks to clear current backlog (five weeks to clear 2 week wait backlog). Additional capacity will be required to sustain pre Covid-19 waiting times
- Senior clinical triaging, risk assessing and prioritising all referrals
- Additional capacity for surgical endoscopy sourced in TSH. NGH utilising insourcing an external provider to support Saturday lists for minimum of eight points
- Established system endoscopy reset group facilitating collaborative working across the county
- The local position is much better than both the region and national position

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Outpatients

- Activity at 80% of pre Covid-19 levels with over 80% delivered virtually/telephone

Next Steps

- Trust implementing a referrals assessment service (RAS) in partnership with KGH
- Face to face clinics, where clinically indicated for routine patients re-commence 27 July
- Aim is to reduce patient footfall in each acute site by 50%-75%:
  - Increased use of Consultant Connect
  - RAS to establish common referral process for primary care across the county
  - Convert face to face to virtual for majority of activity
  - Patient testing and screening for face to face and altered physical environment to allow distancing
- Reset solutions require cultural and transformational change, continued partnership with the external partners and the rapid expansion of off-site and virtual clinics supported by enhanced digital solutions

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Cancer

- During the pandemic and following national guidance high volume (colonoscopy, upper GI endoscopy and bronchoscopy), elective surgery and palliative chemotherapy were paused at the main site
- Imaging (MRI and CT) continued throughout the pandemic for suspected cancer cases
- Elective surgery and colonoscopy were transferred to BMI Three Shires with cases requiring ITU remaining at NGH
- Cancer surgical first definitive treatment capacity at 100% of pre Covid-19 levels (March v June)
- 2WW referrals are nearing pre Covid-19 levels but patient choice affecting decisions to attend hospital
- Patient choice affecting cancer pathway performance

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Cancer Target Performance

Cancer waits - 31 days	Target	Jan-20	Feb-20	Mar-20	Apr-20
Cancer: Percentage of patients treated within 31 days - from diagnosis to first definitive treatment	96%	95.4%	96.7%	99.4%	94.9%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	81.8%	100%	100.0%	87.5%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%	96.7%	98.3%	96.9%	93.9%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%	92.5%	98.8%	96.5%	93.0%
Cancer waits - 62 days	**Target**	**Jan-20**	**Feb-20**	**Mar-20**	**Apr-20**
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	66.4%	60.2%	78.7%	64.4%
Cancer: Percentage of patients treated within 62 days of referral from screening	90%	93.5%	91.6%	87.0%	86.9%
Cancer: Faster Diagnosis Standard	70%	63.8%	68.9%	65.0%	52.6%

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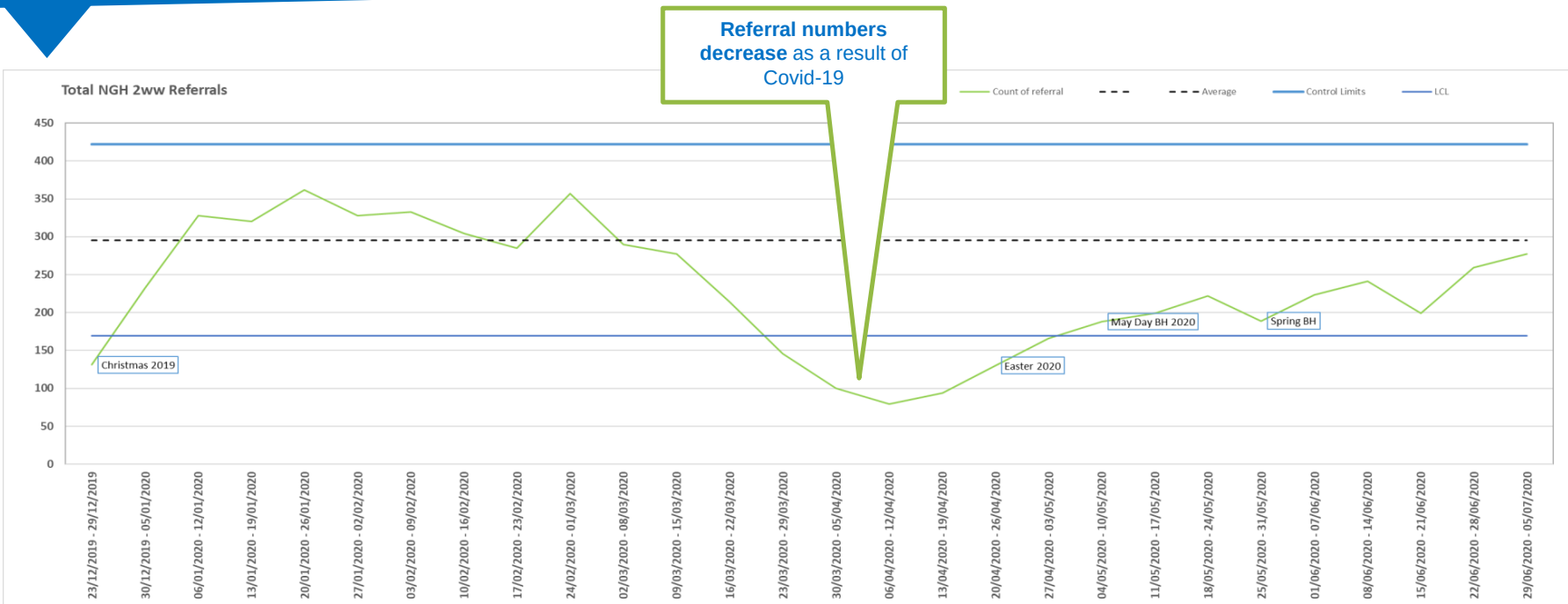
Cancer – Two Week Wait Referrals



- All patients remain active on the PTL under national safety netting guidance
- Clinical Nurse Specialists continue to proactively contact patients on their caseload to undertake a "wellness call". Telephone contacts have dramatically increased across all tumour sites
- Macmillan Information Centre undertakes over 150 patient's wellness calls a month of to those referred on 2ww
- Cancer task and finish group established to drive forward restoration of cancer services

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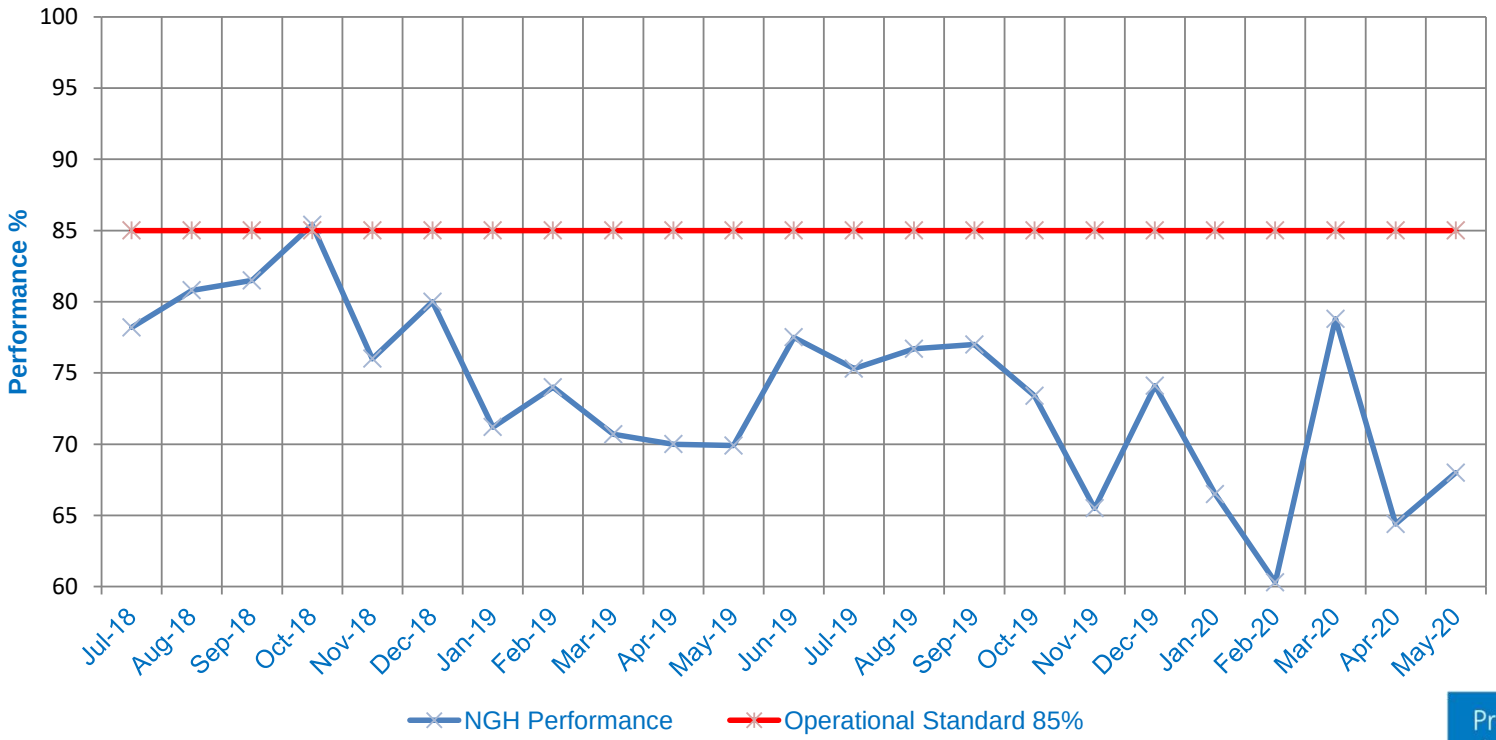
Cancer – 62 Day Performance

62 Day First Treatment Performance



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Cancer: First Definitive Treatments

Radiotherapy oncological treatments: March - June 2020

Month	Chemoradiotherapy	Teletherapy (Beam Radiation excl. Proton Therapy)	Total
Mar	6	8	**14**
Apr	5	9	**14**
May	4	9	**13**
Jun	7	14	**21**
Total	**22**	**40**	**62**

Surgical treatments: March - June 2020

Month	Surgery
Mar	82
Apr	55
May	52
Jun	46
Total	**235**

- Radiotherapy Oncology treatments have not reduced during Covid-19 and increased significantly in June 2020 due to demand
- Surgical treatments decreased during Covid-19

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Cancer: Breaches by Tumour Site

Tumour Site as at 15.07.2020	Without a Cancer Diagnosis	With a Cancer Diagnosis	Total number patients whose breach date has passed
Brain	0	0	0
Breast	8	6	14
Colorectal	57	5	62
Cancer Unknown Primary	0	0	0
Gynaecology	11	4	15
Haematology	1	2	3
Head and Neck	1	3	4
Lung	5	4	9
Other	0	0	0
Paediatric	0	0	0
Sarcoma	1	0	1
Skin	3	2	5
Upper GI	34	2	36
Urology	11	5	16
Grand Total	132	33	165

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Cancer: Actions During Covid-19

Cancer remained a priority for the Trust with the continuation of:

- Receipt of referrals from GP's and safety netting of those patients
- Clinical triage of all referrals
- Virtual or face to face appointments
- Diagnostics that were not ceased on a national level
- Robust tracking and escalation of patients
- Focus on legacy patients already in the system
- Reporting of data locally and nationally
- MDT meetings-virtual
- Prioritisation of patients in line with national guidance for treatments on site and through a third party provider
- Site and twice weekly PTL meetings
- On-going Clinical Nurse Specialist support to clinicians and patients

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Cancer: Next Steps

A reset group has been established which meets weekly to review progress against the eight areas identified to support the recovery of cancer, each division, cancer management team and all support services are represented. Areas of focus were identified as follows:

- Individual tumour site recovery plans
- Streamlining MDT meetings
- Stratified pathways
- Diagnostics
- National pathways - Lung and Prostate
- Demand and Capacity Modelling
- Supported self-management
- 2ww including triage of referrals

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Cancer: National Directives

In July Trusts were asked by NHS England and Improvement to focus on reducing their backlog levels as follows:

Phase 1

- All patients waiting 104 days and over including endoscopy, to be seen within six weeks by the 21 August 2020
- In addition, the number of patients waiting over 60 days should be reduced by 20% within six weeks with a trajectory in place for full recovery; high risk non cancer surveillance patients must also be included

A daily call with NHSEI for systems in the region has started to take place to offer mutual support and discuss risks and system based solutions

All tumour sites have been asked to produce a trajectory which will be monitored weekly by the cancer reset group and a twice weekly return is being submitted on progress against the reduction levels

Phase 2

- Systems will be asked to share longer term system solution plans that include screening and surveillance and sustainability. These plans should include a phase one exit strategy, returning to BAU but with improvements over and above pre Covid-19 waiting times where these were previously below national standards

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Site Implications

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Site Implications

Area	Issue	Solution
Inpatient Areas	• Covid positive separation	• Strict barrier and infection control • Gold ward– Althorp • Zoning including green bubbles • Trust overview & site management
Endoscopy/Diagnostics	• Limited physical capacity to expand • Loss of 50% capacity	• Modular build requested • Extended sessions • Use of independent sector • Daily support calls with NHSE/I
Outpatients	• Social distancing challenged in all areas	• Virtual appointments as default for FU patients • Referrals assessment service
Theatres	• Covid-19 positive and negative separation • Efficiency reduced • Staff constraints	• Orthopaedics to Three Shires and Horton • Cancer cases repatriated • MDSU Covid-19 positive • Strict patient criteria – pre admission isolation

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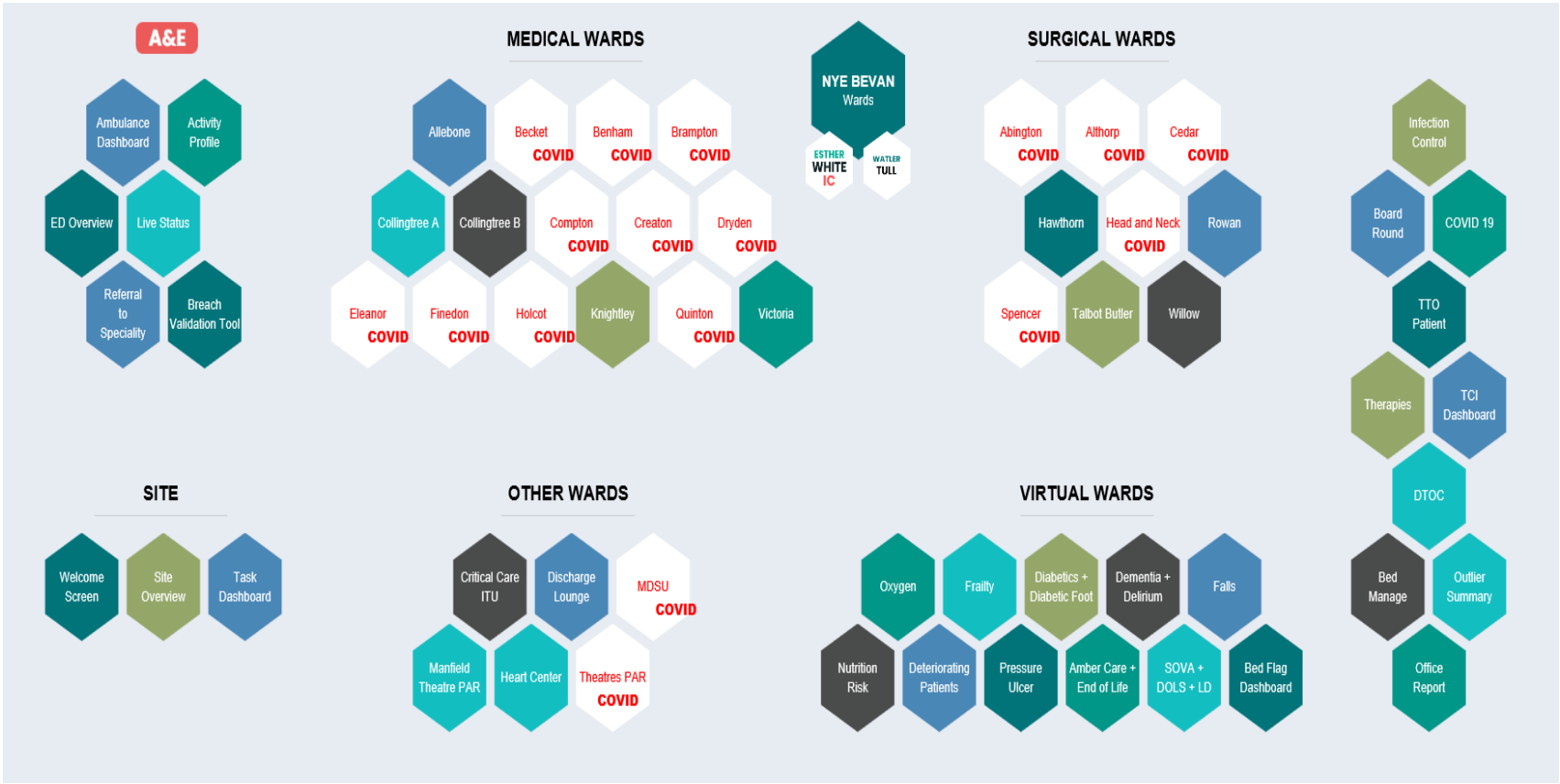
Site Implications: Real Time Overview



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Staff Welfare and Support

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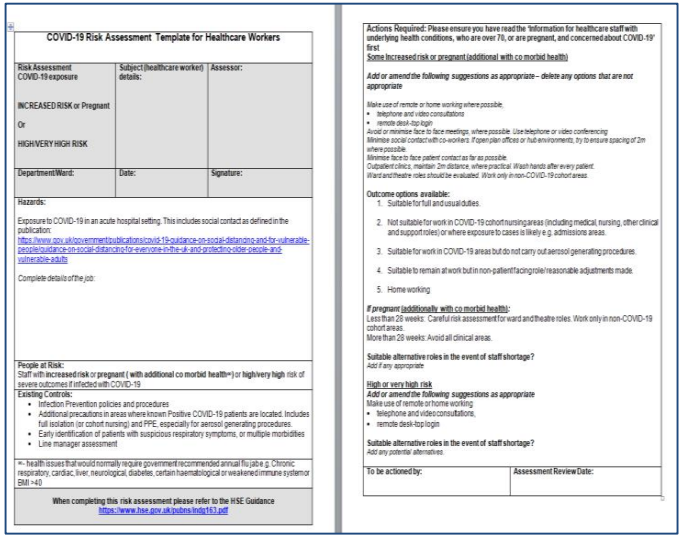
Staff Health and Wellbeing – Diversity & Inclusion

Protecting our BAME Staff

As you will be aware there is emerging evidence that is currently being reviewed by Public Health England which shows that black, asian and minority ethnic (BAME) communities are disproportionately affected by Covid-19. This concerning evidence suggests that the impact may also be higher among men and those in the higher age brackets. The reasons for this are not yet fully understood, but the health inequalities present for BAME communities have long been recognised.



COVID-19 Risk Assessment Template for Healthcare Workers

Risk Assessment COVID-19 exposure INCREASED RISK or Pregnant Or HIGH VERY HIGH RISK	Subject (healthcare worker) details:	Assessor:
Department/Ward:	Date:	Signature:

Hazards:

Exposure to COVID-19 in an acute hospital setting. This includes social contact as defined in the publication: https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults

Complete details of the job:

People at Risk:
Staff with increased risk or pregnant (with additional co morbid health*) or high/very high risk of severe outcomes if infected with COVID-19

Existing Controls:
- Infection Prevention policies and procedures
- Additional precautions in areas where known Positive COVID-19 patients are located. Includes full isolation (or cohort nursing) and PPE, especially for aerosol generating procedures
- Early identification of patients with suspicious respiratory symptoms, or multiple morbidities
- Line manager assessment

*- health issues that would normally require government recommended annual flu jab e.g. Chronic respiratory, cardiac, liver, neurological, diabetes, certain haematological or weakened immune system or BMI >40

When completing this risk assessment please refer to the HSE Guidance https://www.hse.gov.uk/pubns/indg163.pdf

Actions Required: Please ensure you have read the 'information for healthcare staff with underlying health conditions, who are over 70, or are pregnant, and concerned about COVID-19' first
Some Increased risk or pregnant (additional with co morbid health)

Add or amend the following suggestions as appropriate – delete any options that are not appropriate

Make use of remote or home working where possible;
- telephone and video consultations
- remote desk-top login

Avoid or minimise face to face meetings, where possible. Use telephone or video conferencing
Minimise social contact with co-workers. If open plan offices or hub environments, try to ensure spacing of 2m where possible.
Minimise face to face patient contact as far as possible.
Outpatient clinics, maintain 2m distance, where practical. Wash hands after every patient.
Ward and theatre roles should be evaluated. Work only in non-COVID-19 cohort areas.

Outcome options available:
1. Suitable for full and usual duties.
2. Not suitable for work in COVID-19 cohort nursing areas (including medical, nursing, other clinical and support roles) or where exposure to cases is likely e.g. admissions areas.
3. Suitable for work in COVID-19 areas but do not carry out aerosol generating procedures.
4. Suitable to remain at work but in non-patient facing role/reasonable adjustments made.
5. Home working

If pregnant (additionally with co morbid health):
Less than 28 weeks: Careful risk assessment for ward and theatre roles. Work only in non-COVID-19 cohort areas.
More than 28 weeks: Avoid all clinical areas.

Suitable alternative roles in the event of staff shortage?
Add if any appropriate

High or very high risk
Add or amend the following suggestions as appropriate
Make use of remote or home working
- telephone and video consultations;
- remote desk-top login

Suitable alternative roles in the event of staff shortage?
Add any potential alternatives

To be actioned by:	Assessment Review Date:

Risk Assessments

A total of 1983 members of staff have been identified at BAME and lists of these staff have been provided to managers to enable them to make contact and identify any action and support that may be required.

- Of the 1983 members of staff identified over 80% of colleague have now been met with. There needs to be an assessment of lessons learnt from the RA feedback
- Next steps include conducting welfare risk assessments for all colleagues

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RESET - What Next – Our Cell

STAFF, STAFF WELFARE AND VOLUNTEERS

1 Maximise Staffing Levels
- Enabling attendance
- Support alternatives
- Streamlining
- Multi-sourcing

→ **Current Staff**
- Guidance on UHC/pregnancy
- Schooling
- Childcare
- Contact programme
- FAQs
- Staff swabbing

New Staff
- 3 year medical students
- 1/2/3 nurses
- Returners
- HCA recruitment
- Honorary contracts
- Redeployment register

→
- 1000 plus challenge
- Re-aligning the workforce
- "ways of working" – agile/flexible

2 Staff Wellbeing
- Access to things that matter and work
- Indirect and direct support
- Professional advice

→
- OH advice
- Wellbeing support
- Kindness
- FTSU link
- Car parking
- Accommodation
- Water bottles
- SOS
- Ourspace

→
- Managing the complexity
  - ➢ Covid-19/bau
  - ➢ Restart
  - ➢ Transformation
- SOS brief
- Health & Wellbeing centre
- Social capital

3 Volunteers
- Retain and value existing
- Focus
- Train new
- Assign hotspots
- National helpline

→
- Patient support
- Kindness support

→
- Integration of kindness / volunteers

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What Next – Workforce RESET Plans

Improving ‘’attendance” – focus on enabling the safe and supported return to work of those people who are needed to deliver patient care as reset is restricted by the number of staff not here

- Improving absence analysis and information given to managers
- Supporting managers in ‘changing the conversation’
- Understanding the longer term absences and those not returning as planned from self isolation
- Preparing for any new guidance on those shielding

Refocus on causes of transmission and staff role in mitigating this – responds to outbreaks, examples of poor practice, social distancing, test and trace etc

- Joint work between IPC,OD, governance and comms to remind of causes, mitigations and how to access support
- Will include masks once guidance issued
- Working with ‘hotspots’

Supporting those working from home

- Exploring modules that can be undertaken remotely- resilience first one completed

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What Next – Workforce RESET Plans

Psychological safety

- SoS team expansion – significant demand on this team
- Working as part of system to identify support
- Supporting divisions as they bring back staff and manage reintegration

Leadership through difficult times

- Draft framework complete – next step is to merge with transformation programmes
- 'Key points for leaders' ready to share

Supporting reset

- Division reset conversations in place
- Alignment between OD and transformation team
- Antibody testing and test and trace support
- Supporting the change in conversations
- Picking up the things that were 'paused' e.g. mandatory training, case work

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Outpatients Case Study

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Data Capture – Snapshots Through Timeline

On 30/03/20 – 2130 patients received text messages regarding changes to their planned appointments – 34 were cancelled, 213 remained as face to face due to clinical need with 1882 converted to virtual sessions

On14/04/20 – 777 referrals in the system not yet triaged and 70 Advice & Guidance requests

10 specialties continued to self manage all OPA communications and clinic changes (Cardiology, Nephrology, Gastroenterology, Respiratory Medicine, Orthopaedics, Paediatrics, Obstetrics & Gynaecology, Maternity and Oncology & Haematology)

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Conversion of Planned Activity

Example of converted OPA activity for the period 14/05/20 – 28/05/20

Speciality	No. of Sessions	No. Converted to Virtual	No. Cancelled	No. Remaining Face to Face	% of Planned Activity Converted to Virtual Sessions
Ophthalmology	196	182	0	14	**92.8%**
General Surgery	40	40	0	0	**100%**
Dermatology	56	56	0	0	**100%**
Vascular Surgery	25	25	0	0	**100%**
Diabetic Medicine	24	23	0	1	**95.8%**
Rheumatology	39	31	8	0	**79.4%**
ENT	22	21	0	1	**95.4%**

None of these services operated virtual sessions prior to COVID19

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Referral Reduction by Speciality

Year	2020							
Month	January		February		March		April	
Referred To Specialty Name	No of Referrals	%GT No of Referrals	No of Referrals	%GT No of Referrals	No of Referrals	%GT No of Referrals	No of Referrals	%GT No of Referrals
OPHTHALMOLOGY	317	4.14%	339	4.43%	214	2.80%	2	0.03%
DERMATOLOGY	371	4.85%	252	3.29%	124	1.62%		
PAEDIATRICS	269	3.51%	276	3.61%	126	1.65%		
GYNAECOLOGY	242	3.16%	206	2.69%	149	1.95%	13	0.17%
GASTROENTEROLOGY	265	3.46%	183	2.39%	116	1.52%	8	0.10%
ENT	164	2.14%	129	1.68%	126	1.65%		
GENERAL SURGERY	146	1.91%	109	1.42%	88	1.15%	58	0.76%
CARDIOLOGY	167	2.18%	100	1.31%	108	1.41%	1	0.01%
TRAUMA AND ORTHOPAEDICS	201	2.63%	117	1.53%	48	0.63%		
UROLOGY	167	2.18%	111	1.45%	77	1.01%	1	0.01%
BREAST SURGERY	230	3.00%	106	1.38%	15	0.20%		
NEUROLOGY	129	1.68%	60	0.78%	73	0.95%		
AUDIOLOGY	23	0.30%	87	1.14%	95	1.24%		
PAIN MANAGEMENT	92	1.20%	66	0.86%	27	0.35%		
RESPIRATORY MEDICINE	67	0.88%	69	0.90%	32	0.42%	3	0.04%
CLINICAL HAEMATOLOGY	78	1.02%	50	0.65%	35	0.46%		
ENDOCRINOLOGY	50	0.65%	53	0.69%	29	0.38%	6	0.08%
RHEUMATOLOGY	6	0.08%	37	0.48%	88	1.15%		
PLASTIC SURGERY	46	0.60%	46	0.60%	30	0.39%		
MAXILLO FACIAL SURGERY	48	0.63%	38	0.50%	17	0.22%		
ORTHOPTICS	30	0.39%	30	0.39%	25	0.33%		
GERIATRIC MEDICINE	26	0.34%	30	0.39%	13	0.17%		
DIABETIC MEDICINE	22	0.29%	23	0.30%	19	0.25%	1	0.01%
ORAL SURGERY	22	0.29%	23	0.30%	15	0.20%		
CHEMICAL PATHOLOGY	27	0.35%	17	0.22%	7	0.09%		
PAEDIATRIC OPHTHALMOLOGY	19	0.25%	5	0.07%	23	0.30%		
PAEDIATRIC RESPIRATORY MEDICIN	8	0.10%	10	0.13%	5	0.07%		
PAEDIATRIC GASTROENTEROLOGY	7	0.09%	5	0.07%	6	0.08%		
PAEDIATRIC PLASTIC SURGERY	5	0.07%	4	0.05%	3	0.04%		
VASCULAR SURGERY	3	0.04%						
NEPHROLOGY			1	0.01%				
OBSTETRICS	1	0.01%						
Total	**3,248**	**42.42%**	**2,582**	**33.73%**	**1,733**	**22.64%**	**93**	**1.21%**

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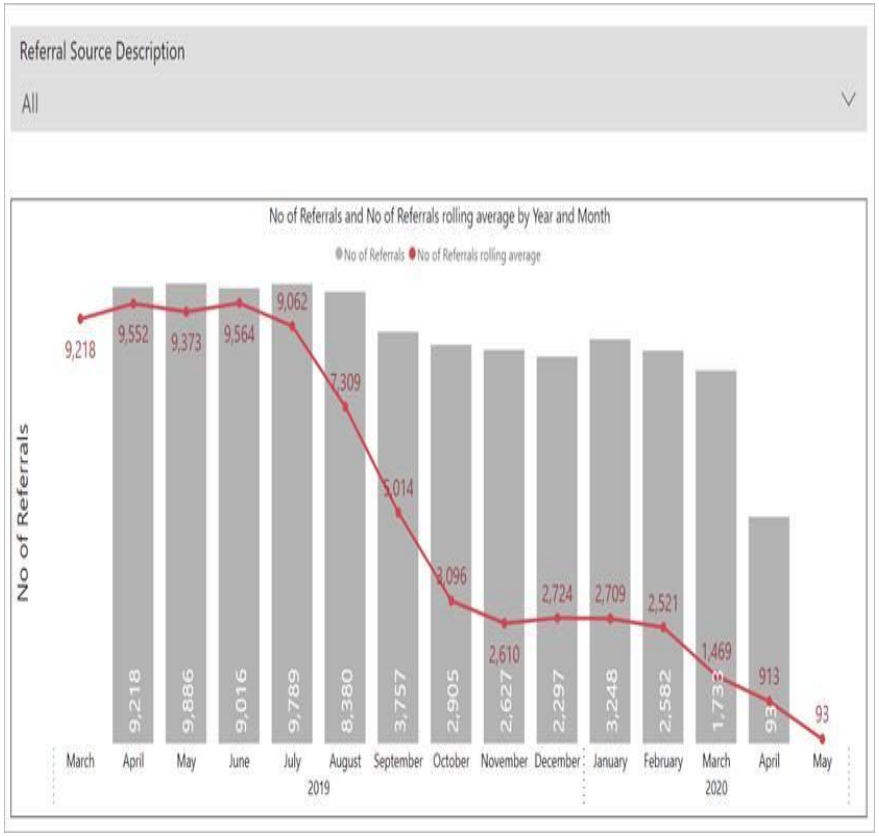
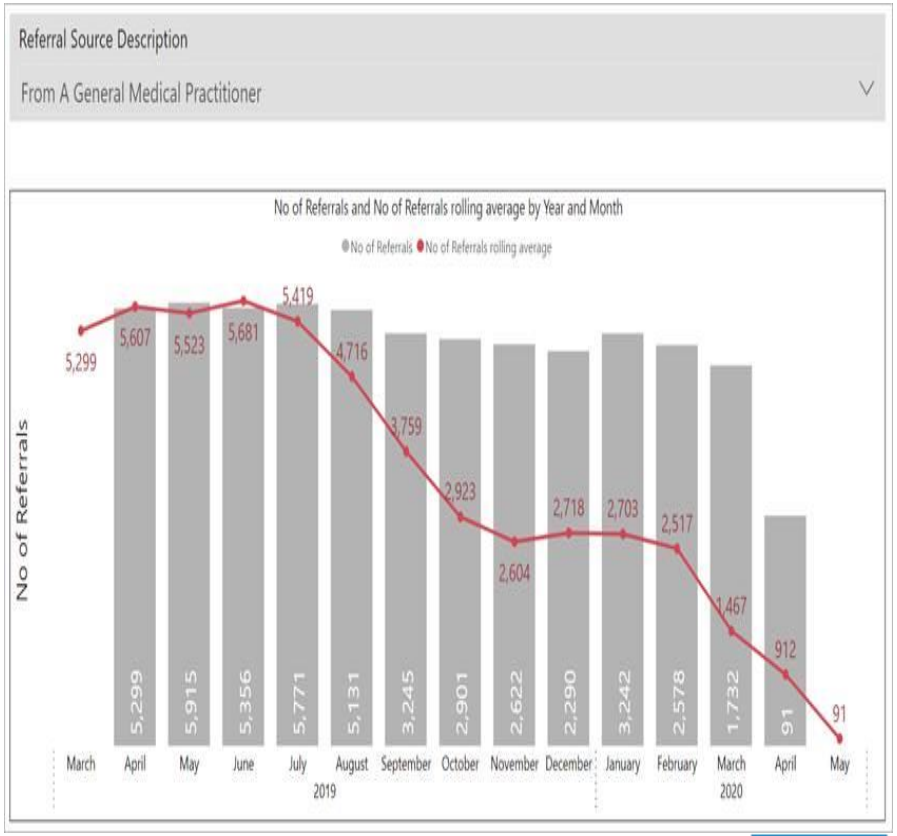
Referral Reduction by Referrer





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Outpatient Reset

To work in collaboration with our Primary Care and external providers, developing system based solutions to achieve the reduction of patient footfall into both Acute Trusts by 50% – 75%

How?

- *Increase use of Consultant Connect and Advice & Guidance*
- *Referral Assessment/Triage to be in place & where possible to establish a common referral process for Primary Care with clear guidance and engagement*
- *Converting Face to Face (f2f) activity to virtual for the majority of OPA activity*
- *Patient Testing/Screening processes for F2F activity aswell as physical environments allowing for social distancing*

The aspiration is for virtual clinic activity to restart by 01/08/20

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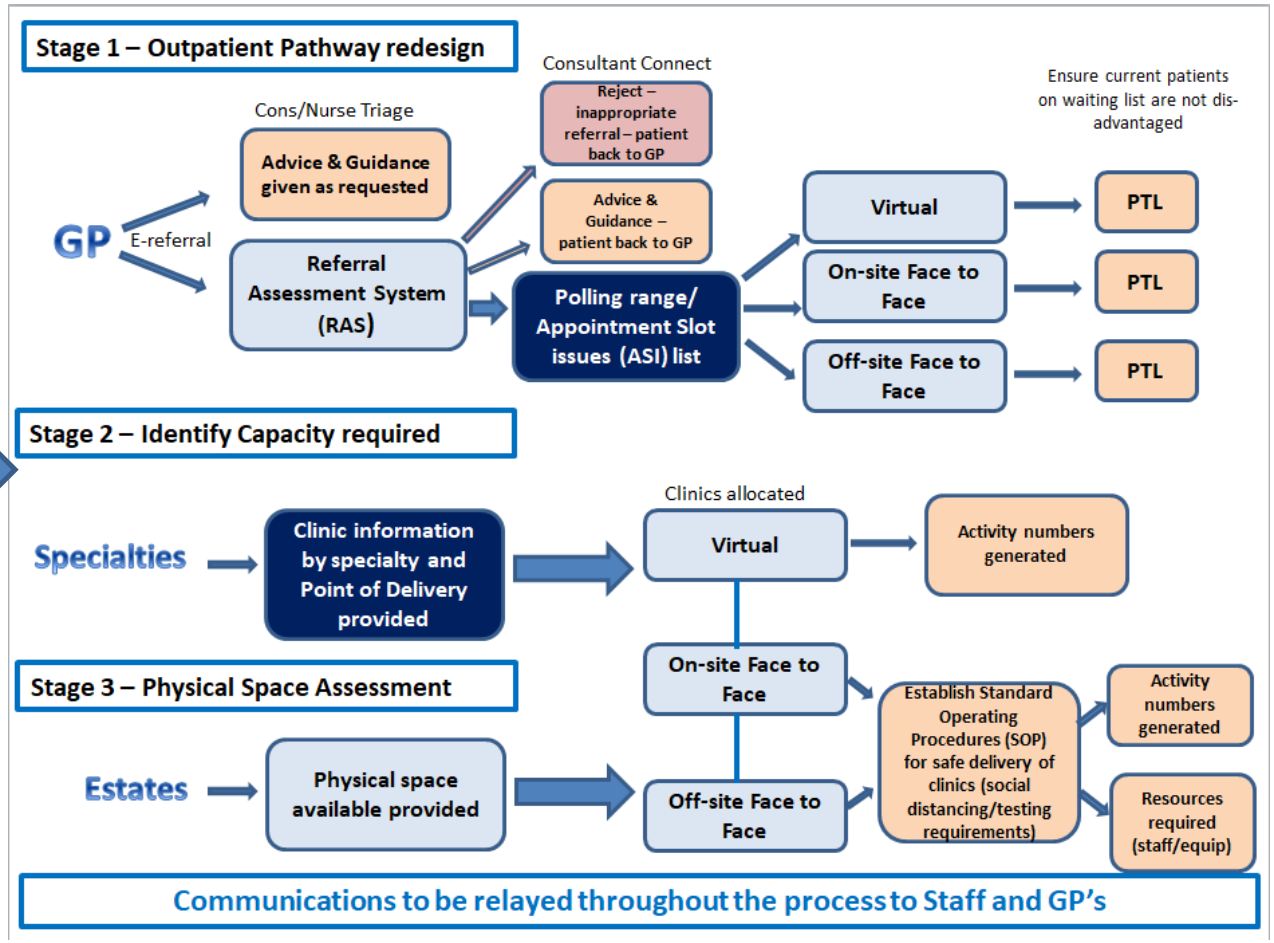
Outpatient Reset

Patient choice offered and incorporated at all points prior to the start of this pathway



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Appendix 1

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Service Line Summary

Breast Screening

- 100% delivery of high risk screening and familial screening
- Reset capacity restricted without additional equipment and staffing. Currently two mobile units, third requested. Estimated time to recover is six months
- Age extension paused nationally and additional six months to complete each cohort of patients

Bowel Screening

- Bowel screening (60-75 years) restarted and 138 patient backlog to be cleared by end of July 2020 (KGH is the hub)
- Bowel scope screening (55-60 years) restart dependent on screening hub guidance and is currently paused

Other Screening & Immunisation Programmes

- Antenatal and Newborn screening services have been maintained throughout the pandemic
- Cervical screening services (colposcopy) operating at pre Covid-19 level. All two week wait and high grade patients seen within timescales. 15 patient backlog for low grade referrals, cleared by end of July

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Service Line Summary

Abdominal Aortic Aneurysm Screening

- Reset commenced on 15 July 2020 in readiness to recommence screening high risk males from 31 July 2020
- Cohort of patients to be invited was collated during the pandemic
- Venues for the commencement which are Covid-19 secure have been identified at Daventry and Irthlingborough outpatient departments. Each venue has been risk assessed
- Plans to return to full routine screening by 31 August 2020 being determined
- Current backlog for 2019/20 cohort is 144 patients and 197 from the 2020/21 cohort had been invited prior to service suspension
- All 2019/20 will be screened upon recommencement. Estimated 50% of the whole 2020/21 cohort will be screened by 31 March 2021
- National extension to service specification to additional six months to clear the 2020/21 backlog

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Service Line Summary

Maternity

- Maternity outpatients were relocated to the Day Surgery Unit and maintained, activity levels did not alter during the pandemic. Indeed in April 2021 527 patients were seen compared to 55 in April 2019

- Community antenatal appointments relocated to the hospital but many appointments were managed over the telephone

- Our home birth services restarted at the end of May 2020

- No change to elective caesarean sections

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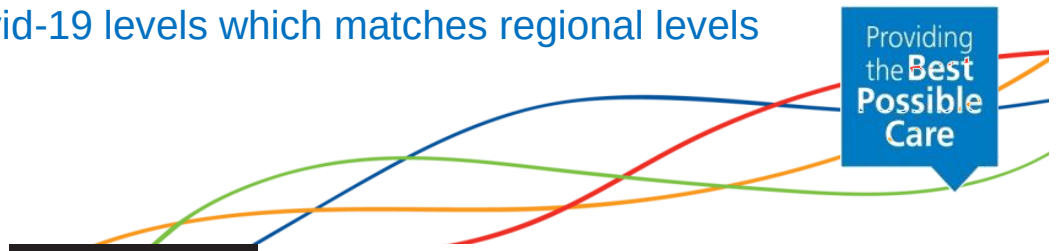
Service Line Summary

Diagnostics

- Delivering all 2WW capacity, inpatient capacity and urgent direct access activity
- Radiology direct access capacity restricted by requirement to maintain Covid-19 safe areas so will require mobile units in order to catch up demand by end of March. Mobile/modular units for MRI and CT have been requested via a national process
- Endoscopy capacity reduced due to PPE restrictions that could impact activity by 40%
- A system approach is required to high footfall services such as phlebotomy which were transferred to TSH but are now back on-site temporarily
- Direct access activity at 45% pre Covid-19 levels which matches regional levels



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Likely Timelines

- The current financial arrangements last until 31 July 2020
- Expectation that block contract will last until 31 March 2021 but some moves to system management of the quantum
- The Trust is still awaiting confirmation from NHSI/E for;
  - Covid-19 capital expense including critical care and emergency department
  - additional mobile capacity including diagnostic PODs
  - Independent sector support
  - Numerous NHSI/E short notice requests made for capital expenditure
- It is likely any new financing arrangements will include activity and performance expectations (the Trust has to submit weekly activity returns)
- The Trust is working up an activity plan that will be delivered based on the current reset plans with the following assumptions;
  - Must be Covid-19 ready/Covid-19 safe
  - Social distancing restrictions
  - Capital restrictions
  - Patient choice impact understood

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Trusts Response to Simon Stevens Phase 2 Letter

- BOTH TRUSTS RECEIVED A LETTER FROM SIMON STEVENS WITH EXPECTATIONS REGARDING PHASE 2 OF NHS COVID-19 RESPOSE FOR DELIVERY BY 15 JUNE 2020
- THIS PACK SHOULD PROVIE ASSURANCE THAT BOTH TRUSTS HAVE DELIVERED AGAINST THESE EXPECTATIONS

Requirements in Simon Stevens Phase 2 letter		NGH status	KGH status
URGENT & ROUTINE SURGERY AND CARE	Provide urgent outpatient and diagnostic appointments at pre Covid-19 levels	URGENT OP AND DIAGNOSTIC AT PRE-COVID LEVELS. GP DIRECT ACCESS IN-PLACE FOR URGENTS ONLY	URGENT DIAGNOSTICS (INC GP DIRECT ACCESS) AT PRE-COVID 19 LEVELS AND OUTPATIENTS WHERE URGENT TAKEN PLACE VIRTUALLY
	Ensure that urgent and time critical surgical and non surgical procedures can be provided at pre Covid-19 levels of capacity	CATEGORY 1 PATIENTS CANCER PATIENTS ARE ALL BEING ADMITTED AT THREE SHIRES HOSPITAL. FROM 22 JUNE – PHASE 2 RESET LIVE WITH GYNAE THEATRES OPENING FOR ELECTIVE COVID FREE CASES, DAYCASES AND TWO ALL DAY SESSIONS A WEEK TO MANAGE THOSE WHO CAN NOT GO TO TSH	ALL CATEGORY 1 PATIENTS TREATED AT WOODLANDS/ KGH WITH SOME CAPACITY FOR CATEGORY 2 PATIENTS. CURRENT RESET PLANS TO MAXIMISE 4 THEATRES A DAY AT WOODLANDS AND 5 SESSIONS AT KGH FOR CATEGORIES 1-4 PATIENTS
	In absence of face to face appointments clinicians should proactively contact their high risk patients and ensure ongoing care plans are delivered	WHEREVER POSSIBLE CONTACT IS VIA VIRTUAL OP. ALL HIGH RISK PATIENTS HAVE BEEN CONTACTED IN-LINE WITH HM GOVERNMENT SHIELDING REQUIREMENTS TO BE OFFERED SUPPORT AND ADVICE	VIRTUAL OP APPOINTMENTS HAVE BEEN INITIATED FOR HIGH RISK PATIENTS AND ALL THOSE WAITING FOR ELECTIVE PROCEDURES ARE BEING CONTACTED
	Where additional capacity is available, restart routine electives, prioritising long waiters first. Make full use of all contracted independent sector hospital and diagnostic capacity	AS ABOVE, THREE SHIRES BEING USED BY NGH WITH A RESET PROGRAMME IN-PLACE FOR OTHER ELECTIVES	WOODLANDS CAPACITY IS BEING UTILISED FOR ELECTIVES AND DIAGNOSTICS. IN ADDITION THE TRUST HOPES TO UTILISE 5 THEATRE SESSIONS A DAY ON SITE FOR FURTHER ELECTIVE CAPACITY AND USE OF DIAGNOSTIC RENTAL CAPACITY

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NHS Trust

Requirements in Simon Stevens Phase 2 letter		NGH status	KGH status
CANCER	Maintain access to essential cancer surgery and other treatment throughout the Covid-19 pandemic	THIS HAS BEEN DELIVERED AT NGH IN PARTNERSHIP WITH TSH	DELIVERED IN PARTNERSHIP WITH WOODLANDS
	Local systems and Cancer Alliances must continue to identify ring-fenced diagnostic and surgical capacity for cancer, and providers must protect and deliver cancer sugary and cancer treatment by ensuring that cancer surgery hubs are fully operational	IN-PLACE AS PER THE ABOVE.	IN PLACE AS ABOVE
	Referrals, diagnostics (including direct access diagnostics available to GPs) and treatment must be brought back to pre-pandemic levels at the earliest opportunity to minimise potential harm, and reduce the scale of the post pandemic surge in demand. Urgent action should be taken by hospitals to receive new 2WW referrals and provide 2WW outpatient and diagnostic appointments at pre Covid-19 levels in Covid-19 protected hubs/ environments	2WW AND URGENT APPOINTMENTS AT PRE-COVID LEVELS. SOME FACE TO FACE AND OTHERS VIRTUALLY. DIAGNOSTICS DELIVERING ALL 2WW BUT NUMBERS MUCH REDUCED	2WW AND URGENT ACCOMODATED VIRTUALLY AND FACE TO FACE IS NECESSARY. DIAGNOSTIC DELIVERING ALL 2WW BUT CAPACITY REDUCED
CARDIOVASCULAR DISEASE, HEART ATTACKS AND STROKE	Hospitals to prioritise capacity for acute cardiac surgery, cardiology services for PCI and PPCI	PCI REMAINS IN-PLACE AT NGH. NO OTHERS DELIVERED FROM THIS LIST	PCI AND PPCI IN PLACE AND ACTIVITY IS ABOVE PRE COVID LEVELS
	Secondary care to prioritise capacity for urgent arrhythmia services plus management of patients with severe heart failure and severe valve disease	SERVICE REMAINS AVAILABLE	SERVICE AVAILABLE THROUGHOUT
	Hospitals to prioritise capacity for stroke services for admission to hyperacute and acute stroke units, for stroke thrombosis is and for mechanical thrombectomy	STROKE SERVICE HAS REMAINED FULLY OPERATIONAL THROUGHOUT	STROKE SERVICES PROVIDED BY NGH
MATERNITY	Providers to make direct and regular contact with all women receiving antenatal and postnatal care, explaining how to access maternity services for scheduled and unscheduled care, emphasising the importance of sharing any concerns so that the maternity team can advise and reassure women of the best and safest place to receive care	DELIVERED THROUGHOUT THE PANDEMIC	ALL WOMENT ARE HAVING THE SAME AMOUNT OF NORMAL CONTACT, SOME VIRTUAL. WE HAVE WRITTEN TO ALL WOMENT RE. CHANGES TO SERVICE. WE USE OUR FACEBOOK PAGE AND TRUST WEBSITE TO DISEMINATE INFORMATION. WE HAVE SET UP A COVID HELPLINE FOR WOMEN TO ACCESS. WE HAVE PUT PIECES IN LOCAL PRESS AND OUR MVP TO ENSURE WOMEN ARE AWARE THEY CAN STILL ACCESS ALL SERVICES
	Ensure obstetric units have appropriate staffing levels including anaesthetic cover	DELIVERED THROUGHOUT THE PANDEMIC	DELIVERED THROUGHOUT THE PANDEMIC

Requirements in Simon Stevens Phase 2 letter		NGH status	KGH status
SCREENING AND IMMUNISATIONS	Ensure as a first priority that screening services continue to be available for the recognised high risk groups, as identified in individual screening programmes	MOST SCREENING SERVICES AT PRE COVID-19 LEVELS EXCEPT FOR AAA SCREENING WHICH IS SUSPENDED AS ELECTIVE AAA REPAIR IS PAUSED. BREAST SCREENING OPERATING FOR CLINICALLY URGENT CASES ONLY	ALL SCREENING PROGRAMMES BACK TO PRE COVID-19 LEVELS WITH THE EXCEPTION OF BREAST SCREENING. RUNNING AT 25%-50% FOR JUNE WITH EXPECTION BACK TO 100% BY END OF JULY
	Increase the delivery of diagnostic pathways (including endoscopy) to catch up with the backlog of those already in an active screening pathway, followed by the rescheduling of any deferred appointments	ENDOSCOPY AVAILABLE BUT AT MUCH REDUCED CAPACITY. ESTIMATED 50% LOSS OF CAPACITY DUE TO IPC AND SOCIAL DISTANCING REQUIREMENTS	ENDOSCOPY PROVISION FOR URGENT, 2WW PLUS SCREENING. DIAGNOSTICS URGENT (INC URGENT GP DIRECT ACCESS), CANCERS AND PLANS TO EXPAND CAPACITY TO DELIVER PRE COVID LEVELS AND RECOVER BACKLOG BY END MARCH
	Antenatal and Newborn Screening Services must be maintained because this time critical	DELIVERED THROUGHOUT THE PANDEMIC	DELIVERED THROUGHOUT THE PANDEMIC
OUTPATIENTS	Referral streaming of new OP appointments is important to ensure they are being managed in appropriate setting, this should be coupled with an Advice and Guidance provision so that patients can avoid a referral if there primary care can access specialist advice virtually	DELIVERED THROUGHOUT THE PANDEMIC	TRUST HOPING TO COMMENCE REFERRALS ASSESSMENT SERVICE BEFORE END OF JUNE AND VIRTUAL ADVICE AND GUIDANCE PROVISION AVAILABLE THROUGHOUT THE PANDEMIC
	All NHS secondary care providers now have access to video consultation technology to deliver some clinical care without the need for in-person contact. As far as practicable, video or telephone appointments should be offered by default for all outpatient activity without a procedure, and unless they are clincial or patient choice reasons to change to replace to with in-person contact. Trusts should also use remote appointments - including video consultations - as a default to triage their elective backlog. They should implement a 'patient initiated follow up' approach for suitable appointment	DELIVERED THROUGHOUT THE PANDEMIC	DURING PANDEMIC OVER 80% OF OP ACTIVITY HAS BEEN VIRTUAL. TRUST IS WORKING ON THE SYSTEMS AND PROCESSES TO IMPLEMENT 'PATIENT INITIATED FOLLOW UP'

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Appendix 3

We put patient safety above all else
We aspire to excellence
We reflect, we learn, we improve
We respect and support one another

Providing the Best Possible Care

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Health & Wellbeing Activities During Covid-19

- Salute the NHS-Boost boxes were delivered to all wards/departments 3 times a week
- Thank you letters & activity books for children/grandchildren/siblings of members of TeamNGH
- Facebook live events with exec team (150 people taking part)
- Food bank donations to the Hope Centre co-ordinated by members of TeamNGH – paying back the kindness we've received
- Free car parking for staff implemented
- Welfare calls for long term sickness absence & Covid-19 absence
- Counselling referrals for mental ill health – reasons : anxiety/stress & other
- Self-referrals for skin problems – due to increase in hand care in clinical areas
- Addition of evening on call service for telephone support during Covid-19
- Addition of weekend working for Covid-19 telephone support
- We have had x50 clinical staff resident at our off site accommodation
- Colleagues have developed a ' reflection' book leaving positive uplifting messages for each other
- Northamptonshire Health Charity, colleagues and external providers have donated artwork, books, magazines, biscuits, colouring in books and pens to 'Our Space'.
- We have an 'our space' bear mascot 'Olga', donated by the public
- 'Our Space' was launched and although relocated continues to be utilised and is used for SOS support

Providing the Best Possible Care

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Supporting Our Staff – Health & Wellbeing

Our SoS Team and Trends

- 7 day a week service and responding within 12 hours to initial requests for support
- 1:1s are averaging one a day
- Requests have come from those:
  - Shielding
  - home working
  - clinical and non-clinical staff that are working on site
- Since the start of the Covid-19 peak first need for referral for further psychological support was on 14 April 2020. Referrals currently being made through SoS to volunteer counsellors in the absence of formal psychological support within the Trust
- The trends are highlighted in the next slide

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Noticeable SoS Trends

	Themes		Support Given in May
Early on in the peak	• Psychological impact of the clinical picture people were facing (young deaths, number of deaths, patients can't do anything for, traumatic incidences) • Fear around PPE – understanding what should be worn and general around catching it	Wearing of psychological badges	• Managers have been encouraged to start and end the day with a psychological debrief • Buddy systems have been set up for teams to support each other throughout the shift • Coffee and chat sessions are being run for all areas by SoS team to give individuals and teams • SoS slot on BAME virtual network meeting on 7th May. Follow up SoS sessions have been offered • Opportunity to talk about how they are feeling using March on Stress approach. 1:1 SOS are taking place for staff that have requested it or where managers have asked for further support for a team member • Wellbeing telephone calls from Occupational Health and counsellors currently volunteering from Child Health • 1:1 SoS support either face to face or virtually • Virtual resilience training has been designed and will be launched June 2020 • 2 roundtable conversations have taken place to resolve conflict in working relationships
In the peak	• Fear being expressed from those being asked to work in different areas in the hospital • Increased number saying they are suffering from anxiety • Previous mental health diagnosis being triggered where symptoms have returned and are worse. This has included incidences where people have said they have had suicidal thoughts return • Feelings of fear and guilt from those self-isolating, shielding or home working • Young or new to the role staff appear to have been more susceptible to anxiety		
Later on in the peak	• Feelings of guilt of who they may have infected from those that have received +ve results from asymptomatic testing • Colleagues of those receiving a +ve asymptomatic result feeling fearful • Impact of poor behaviour from another team member that was being felt before the start of Covid-19		
Start of reset	• Feeling of pressure to reset but still feeling the pressure of covid-19 – practically, emotionally and physically		

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Associate Teaching Hospital

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NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**30th July 2020**

Title of the Report	**NGH Improvement Plan**
Agenda item	**11**
Presenter of Report	Ms Claire Campbell, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Ms Jemma Moody, Compliance Governance Manager

This paper is for:

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

Executive summary

- Further to publication of the final reports, the Trust has developed an improvement plan to address the 'must' and 'should' actions listed in the reports.
- The Trust received three requirements notices. Two in relation to the proper and safe use of medicines (Medicine and Maternity) and one in relation to receiving and acting on complaints (Maternity).
- All actions have been completed for the three requirement notices and the supporting evidence of completion is in place.
- 14 out of the 39 actions in the Improvement Plan have been fully completed with supporting evidence.
- 34 actions have been closed since January 2020 (Last Trust Board Meeting)
- 45 actions are outstanding and remain on track for completion by the deadline date.
- All outstanding actions have had at least a 3 month extension due to covid-19.
- 33 actions are not completed yet.
- 12 actions have been signed off as complete but the evidence of completion is required (detail in the report)

Related strategic pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable excellence through our people*

Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: **Yes** Failure to meet statutory requirements can lead to improvement notices, and prosecution and in extremes withdrawal of Trust services
Related Board Assurance Framework entries	All
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? **No** Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No**
Financial Implications	Some actions will require additional funds e.g. business cases and capital projects. Failure to meet requirements can lead to fines.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: **Yes** **CQC Fundamental Standards** The Trust has been issued with three requirement notice following the CQC inspection. Two in relation to Regulation 12 (2) (g): The proper and safe use of medicines. One in relation to Regulation 16 (2): Receiving and acting on complaints.

Actions required by the Trust Board:

The Board is asked to:

- Accept this report as part of the assurance process, showing the Trust has and is taking action to address the concerns raised in the CQC reports and undertakings requirements.
- Challenge any areas of concern or where it is felt that progress is not occurring in a timely manner, or evidence of completed action is not forthcoming.

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NGH Improvement Plan

1. Introduction

The CQC completed a use of resources, core service and well-led inspection of the Trust on 4th June 2019, 11th -13th June 2019 and 24th -25th July 2019 respectively. Three services were reviewed as part of the core service inspections, Urgent and Emergency Service, Medical Care (including older people's care) and Maternity. This was the first time the Trust has had a use of resources inspection as part of the updated CQC inspection methodology.

The final reports were published on 24th October 2019. Three reports were published:

- Provider report
- Evidence appendix (to support the provider report)
- Use of resources report

The reports are available on the CQC website https://www.cqc.org.uk/provider/RNS/reports

2. Progress against actions

2.1 NGH Improvement Plan (Update)

Following the publication of the reports, the 'must' and 'should' actions from the reports, have been transposed and used to form the detail of the NGH Improvement Plan. The Trust was issued with three requirement notices. The current version of the plan is provided in *Appendix A*. Actions have been provided, to show how the Trust will complete each of the 'must' and 'should' concerns raised in the reports. A deadline date, evidence of completion and a score for the likelihood of completion are also included.

The likelihood score is rated from 1 (rare- not going to happen) to 5 (almost certain) to mirror the likelihood scoring within the Trusts risk assessment processes. Only one action is currently scored as unlikely (15.3) this is due to the lack of available capital funding, to make the necessary changes to the paediatric ED layout.

The improvement plan was approved at Public Trust Board on 28th November 2019. The process for confirming closure of actions , is for the Lead Executive to 'sign off' on receipt of the required evidence and for the Executive team to ratify, prior to the monthly Quality Governance Committee meeting. An update will also be provided to Public Trust Board on a bi-monthly basis.

Report Month	Total actions remaining	Number closed in month	Number outstanding (on track)	Number overdue
November 2019	126	30	96	0
December 2019	96	17	79	0
January 2020	79	24	55	0
February 2020	55	5	50	0
March 2020	50	6	44	0
June 2020	54	5 since March 2020	43	0
July 2020	45 (including 12 for evidence)	9	33	0

2.2 List of actions closed in month
Detail is provided in the NGH Improvement Plan (see Appendix A)

2.2.1 January 2020 - July 2020 closures

Action number	Concern	Action/s
9	**The trust should consider an external review of its governance structure and systems**	9.1 Refresh well- led Board knowledge 9.2 Identify basic specification of need
12	**The trust should take steps to assure itself that the interventions in progress to address bullying and poor behaviour are having an impact at pace**	12.3 Incorporate 'Civility Saves Lives' into Respect and Support programme
13	**The trust should consider commissioning a more detailed analysis of the drivers of its deficit to inform those elements that are within its gift to be able to address both directly and indirectly**	13.1 Work with NHSE/I to agree process to complete this (using their expertise and knowledge)
17	**The service should take action so medical staff are compliant with the trust target for safeguarding children level three training**	17.1 Mandatory training compliance of all staff groups is reviewed at every Urgent Care Governance meeting 17.2 Clinical Director for Urgent Care will remind all medical staff of their need to complete the training
18	**The service should take action to improve the median time from arrival to treatment**	18.1 Implement winter actions
19	**The service should check medical staff are up to date with mandatory, safeguarding and mental capacity training**	19.1 Use of Netconsent software to check and force compliance 19.2 Provide additional sessions of 'bundles' of mandatory training for trust grade staff
20	**The service should check catering staff are following infection prevention and control protocols**	20.1 Induction training for new starters 20.2 Infection Prevention representation at Catering Meetings regarding PPE 20.3 Infection Prevention Mandatory training - 3 yearly for non-clinical staff 20.4 Environment audits and Catering audits are carried out when infection is identified 20.5 Domestic monthly cleaning audits include host/hostess staff - hand hygiene etc observed 20.6 A review of catering procedures and working practices will be carried out by Infection control and the Catering management team

21	**The service should keep all confidential patient records securely**	21.4 Data Quality, Security and Protection team to complete spot audits of compliance on wards and departments (Oct 2019 and March 2020). Findings to be shared at Assurance, Risk and Compliance meeting) 21.5 Assessment & Accreditation will incorporate criteria regarding the safe storage of health records.
22	**The service should introduce local procedures for invasive procedures in non-theatre settings**	22.1 LocSSIP documents reviewed and updated
23	**The service should manage medical outliers so they are seen in a timely manner**	23.1 Inpatients cared for on outlying wards have a designated medical team to review patients. This is monitored and audited twice weekly by reviewing the medical plans in the patient's medical records 23.2 Ward staff escalate any issues regarding medical reviews at the x3 daily Site meetings. 23.3 Number of medical outliers to be communicated daily via Sitrep (Whats app)
25	**The service should review clinical guidelines to check they are current**	25.1 Netconsent to ensure guidelines reviewed in line with policy 25.2 Use of PDG report to show reduction in overdue guidelines
27	**The service should consider reviewing environment and facilities for inpatient outliers staying on the Heart Centre**	27.1 Complete review of Heart Centre environment and facilities
30	**The service should ensure women can access the service when they need it and receive the right care promptly and that waiting times from referral to treatment and arrangements to admit, treat and discharge women are in line with national standards**	30.7 Business case to reconfigure Labour Ward which will make a dedicated Triage area and provide easier access to obstetric care. It will also reduce attendances / waiting times on the Maternity Day Unit.
32	**The service should ensure managers are planning the service for the long term. For example, to enable planning and organisation of services so they met the needs of the local population within the local expected population growth**	32.1 Develop Long Term Plan in conjunction with the Local Maternity System 32.3 Engagement in East Midlands Clinical Network as well as other Regional / National events and meetings 32.4 Monthly report to Divisional Management Board on forecasted activity based on bookings 32.5 Business case to be submitted to reconfigure Sturtridge Labour Ward – non clinical rooms changed into clinical rooms, dedicated Triage area consisting of 4 rooms which could be used as further birthing

		rooms at times of high activity 32.6 Business case to be submitted for midwifery staffing to be submitted to ensure sufficient staff are available for the higher level of activity / acuity forecast. 32.7 Ensure sufficient midwifery staff in post to meet the Continuity of Carer agenda as per Better Births
35	**The NHS trust should continue focusing on building internal capacity and capability to deliver trust wide workforce and service productivity improvements**	35.1 Support the transformation of the quality function 35.2 Integrate productivity improvements in OD interventions
39	**The NHS trust should progress implementation of its five-year estates maintenance plan.**	39.4 Put in place a new Facilities Governance committee and structure

2.3 Updates on actions which are overdue

None for July 2020

2.4 Changes to actions

All outstanding actions have had at least a 3 month extension due to covid-19.

2.5 Evidence

Evidence to close actions will be provided by the action owner to the relevant Executive Lead, they will review prior to sign off of the action. Evidence will be collated by the Compliance Team. The Team will complete a final review of the evidence and raise any concerns with the Executive Lead. If evidence is not sufficient to demonstrate completion, the action will be re-opened. Any gaps in the evidence at time of writing are included in the table below.

Action number	Action	Gaps in evidence
8.8	**Closure of salary overpayment issue via audit committee**	Action signed off as completed. Evidence of completion required via Audit Meeting Minutes.
9.2	**Identify basic specification of need**	Action signed off as completed. Evidence of completion required.
12.3	**Incorporate 'Civility Saves Lives' into Respect and Support programme**	Action signed off as completed. Evidence of completion required. ***This is difficult as awaiting staff survey 2020 as evidence.***
15.4	**Review pathways for use of PAU and increased activity**	Action signed off as complete. Awaiting evidence that PAU pathways have been reviewed and show evidence of improved patient flow.
19.1	**Use of Netconsent software to check and force compliance**	NetConsent is in place and is able to enforce compliance with Policies and IG training. Awaiting Evidence.
19.2	**Provide additional sessions of 'bundles' of mandatory training for trust grade staff**	Action signed off as complete. Evidence of completion required – dates, training bundle, and attendance records.
20.6	**A review of catering procedures and working practices will be**	Action signed off as completed. Evidence of completion required.

	carried out by Infection control and the Catering management team	
21.4	**Data Quality, Security and Protection team to complete spot audits of compliance on wards and departments (Oct 2019 and March 2020). Findings to be shared at Assurance, Risk and Compliance meeting)**	Action signed off as complete. Awaiting evidence of data protection audit results.
21.5	**Assessment & Accreditation will incorporate criteria regarding the safe storage of health records.**	The A&A programme has been placed on 'hold' due to Covid19 and will not be recommenced in its same format for a number of months. Inability to achieve current action as A&A timetable is dependent on the outcome of the wards previous assessment, i.e. as ward may not be required to have an assessment for 6 months.
22.1	**LocSSIP documents reviewed and updated**	Action signed off as completed. Evidence of completion to be provided once minor amendments made to policy post approval at procedural document group in February 2020
23.1	**Inpatients cared for on outlying wards have a designated medical team to review patients. This is monitored and audited twice weekly by reviewing the medical plans in the patient's medical records**	Completed and in place. Evidence of completion required.
32.3	**Engagement in East Midlands Clinical Network as well as other Regional / National events and meetings**	Action signed off as complete. Awaiting evidence of East Midlands Clinical Network Minutes.

2.6 Updates from external reporting to CQC/ NHSE/I

No updates to report for July 2020 in relation to feedback from CQC or NHSE/I.

The TIAA (Trust Internal Auditors) reviewed the governance arrangements over the monitoring, assessment and evaluation of evidence for the Improvement Plan. They have reviewed the evidence relating to the three requirement notices and produced a report in April 2020 which was approved 2nd June 2020. Overall assurance assessment showed ***'Reasonable Assurance'.*** Due to COVID-19 and the subsequent unavailability of key staff it was not possible to test evidence supporting the implementation of the 'should' actions that were classified as completed by the Trust. All three 'must' actions were reported to the Trust Board as 'implemented'. The review by internal audit did not identify any significant issues.

3. Assessment of Risk

The Trust has been issued with three requirement notices by CQC. A requirement notice is issued when a service is found to be in breach of one of the fundamental standards of care; the standards below which care must never fall. These fundamental standards are linked to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Trust must be able to demonstrate it has taken action to address these breaches. If not, there is the potential for further enforcement action to be taken against the Trust (warning notice) or prosecution

(with qualifications). Please refer to section 2.6 for detail on updates provided to the CQC to show progress with the actions associated with the requirement notices.

The summary detail of the three requirement notices is provided in the table below. Further detail can be found in the improvement plan (appendix A)

Core service	Regulation	Brief detail	Progress update
Medical care (including older people's care)	**Regulation 12 (2) (g): The proper and safe use of medicines**	Staff not always ensuring the proper and safe management of medicines	All actions completed and supporting evidence in place
Maternity	**Regulation 12 (2) (g): The proper and safe use of medicines**	Staff not always following systems and processes when prescribing, administering, recording and storing medicines	All actions completed and supporting evidence in place
Maternity	**Regulation 16 (2): Receiving and acting on complaints.**	Information on how to make a complaint was not seen at the time of the inspection	All actions completed and supporting evidence in place

4. Agreed governance reporting framework

The Improvement Plan will be presented to Executive meetings and the Quality Governance Committee on a monthly basis. Bi-monthly updates will be presented at Public Trust Board.

The process for confirming closure of actions will be for the Lead Executive to sign off on receipt of the required evidence and for the Executive team to ratify prior to the Quality Governance Committee.

5. Recommendations

The Board is asked to:

- Accept this report as part of the assurance process, showing the Trust has and is taking action to address the concerns raised in the CQC reports
- Challenge any areas of concern or where it is felt that progress is not occurring in a timely manner, or evidence of completed action is not forthcoming.

NGH Improvement Plan
(Incorporating CQC Inspection Report outcomes published October 2019/ NHSE/I Undertakings actions)

03/03/2020
vs

21/07/2020

No	Concern: Medicine Division Requirement notice	Action	Deadline	Progress/ Comments
1	The trust must ensure the proper and safe management of medicines. Staff must follow current national practice to check patients receive the correct medicines. The service must have systems to ensure staff are aware about safety alerts and incidents. Staff must store and manage all medicines and prescribing documents in line with the provider's policy. (Regulation 12 (2) (g): The proper and safe management of medicines).	1.1 Implementation of Task and Finish Group chaired by Medical Director	01/08/2019	Completed
		1.2 Medicines Optimisation Work plan updated to include CQC recommendations (post inspection)	02/08/2019	12/02/2020 Safety alert issued via NetConsent last week for staff and via weekly staff comms update. 21/12/2019 Update from Chief Pharmacist advise safety alerts already shared across the Trust but exploring the use of Netconsent for this as well. Help raise profile and enable audit of staff accessing documents. Also provide historic reminders of key messages Completed
		1.3 Ongoing enhanced audits monitored through medicines governance structure	31/12/2019	20/12/2019 Update from Chief Pharmacist- Audit form approved August 2019 - changes made after 3 months of use and discussions at MOSG. Completed Audits remain ongoing
		1.4 Safe & Secure Controlled Drug audit carried out on a monthly basis	31/12/2019	20/12/2019 Update from Chief Pharmacist- Audits are completed monthly for areas of poor compliance (normally done quarterly). CD Audit form has been updated. Plan is to combine CD and MM audits, completed jointly by Nursing and Pharmacy from April 2020 Completed Audits remain ongoing

No	Concern: Womens Childrens, Oncology & Haematology and Cancer Services Division Requirement notice	Action	Deadline	Progress/ Comments
2	Staff must follow systems and processes when safely prescribing, administering, recording and storing medicines. The service must ensure medicines are in date and medicine waste and returns are stored securely. Infusions that require protection from light must be stored appropriately. Staff must ensure medicines stored in the medicine trolley are stored in their original boxes to ensure expiry dates and names of medicines are visible. Staff must ensure action is taken to address repeated high room temperature values, where the recommended storage conditions for medicines have been exceeded. (Regulation 12 (2) (g): The proper and safe management of medicines).	2.1 Implementation of Task and Finish Group chaired by Medical Director	01/08/2019	Completed
		2.2 Medicines Optimisation Work plan updated to include CQC recommendations (post inspection)	31/10/2019	Completed
		2.3 Ongoing enhanced audits monitored through medicines governance structure	31/12/2019	20/12/2019 Update from Chief Pharmacist- Audit form approved August 2019 - changes made after 3 months of use and discussions at MOSG. Completed Audits remain ongoing
		2.4 Safe & Secure Controlled Drug audit carried out on a monthly basis	31/12/2019	20/12/2019 Update from Chief Pharmacist- Audits are completed monthly for areas of poor compliance (normally done quarterly). CD Audit form has been updated. Plan is to combine CD and MM audits, completed jointly by Nursing and Pharmacy from April 2020 Completed Audits remain ongoing
		2.5 Approve business case for maternity pharmacist	31/12/2019	20/12/2019 Chief Pharmacist email - confirm Exec team approve business case and recruitment will commence Jan 2020, with view to providing service from April 2020. 18/12/2019 Supporting evidence saved- business case and emails re taking case to Dec 2019 Finance Committee 05/12/2019 Action updated to Approve business case for maternity pharmacist (previous action Appoint maternity pharmacist)
3	The maternity service must ensure information and guidance about how to complain is widely available to everyone who uses the service. (Regulation 16: (2) Receiving and acting on complaints).	3.1 4Cs information leaflets and posters to be displayed in all areas	31/12/2019	06/01/2020 Completed. Audits will remain ongoing. No concerns with compliance. Evidence also included of attendance at Meet the Matrons clinic - 3 months of data. Women are accessing this service to discuss their care 18/12/2019 S.Oke advise spot audits will be available for CQC engagement meeting Jan 2020 05/12/2019 Leaflets and posters on display. Meet the Matron posters are also on display in all areas of maternity. Flyers to support the availability of the above are also now included within the mothers discharge pack
		3.2 'Meet the Matron' posters displayed in all areas- so service users can raise concerns	31/12/2019	06/01/2020 Audits provided which show posters on display and evidence of clinics taking place 05/12/2019 Meet the Matron posters are available in all areas of maternity
		3.3 Use of Big Word translation services	31/12/2019	6/01/2020 Information available in ward areas. Currently included in maternity's 'Stork Talk' newsletter to remind staff. HOM continues to monitor use of interpreters 05/12/2019 Message relayed through safety huddles, information also available in ward areas. Currently included in maternity's 'Stork Talk' newsletter to remind staff. HOM is monitoring use of interpreters
		3.4 Develop poster which contains information in other languages for women and families in whom English is not their first language	31/12/2019	06/01/2020 Poster on display at hospital. Information booklets available in Romanian. Polish, Lithuanian and Bengali (most common languages). Provided to women at booking appointment by Community Midwife. Evidence of completion changed to Copy of poster 05/12/2019 Information also provided by midwives at booking appointment by community midwife. New poster under design to signpost, leaflets being translated into other languages (most commonly used)

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
4	a) The trust should review its board assurance framework to ensure it provides adequate assurance b) he trust should consider tabling the board assurance framework monthly and consider how current gaps in assurance are highlighted. This consideration should inform debate on the sufficiency of the actions taken to close these gaps, and the associated timelines	4.1 BAF to be reviewed by Board- benchmarked against CQC advised exemplar document and revised format to be agreed. This will assist in improving assurance, highlight gaps in assurance and timely actions as a result.	31/12/2019	Completed
		4.2 Board to consider frequency of reporting of BAF.	26/09/2019	20/12/2019 Evidence of completion changed to Board development programme (from Board paper). Frequency of reporting discussed as part of presentation for 4.1 Completed- Board agreed to leave as quarterly reporting in line with other Trusts.
		4.3 BAF content reviewed and links to strategy pledges included	28/11/2019	Completed
		4.4 BAF presented in revised format	28/11/2019	Completed

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
5	The trust should review its risk register so staff can easily track changes to risk or mitigation and improve clarity on how the existing controls relate to the risk as stated in the risk register	5.1 Revised report format for ARC, Board and its committees	31/10/2019	Completed
		5.2 Training refresh for all ARC members on risk, including mitigation, and controls	31/07/2020	10/07/2020 - No update for 5.2 relating to training. With DCIQ coming in we would expect the training to be after this. 08/06/20 - 4 month extension to deadline due to COVID-19. Due to timing of meetings. 09/03/2020 SH confirm with SB that CaC had agreed to change of date (on behalf of CIC). To change date from 31/03/2020 to 30/04/2020. This will enable training to cover Datix Cloud. 12/02/2020 Date for completion changed to 31/03/2020 (from 29/02/2020). For presentation at March 2020 ARC meeting 13/01/2020 Link to training provided. 31/12/2019 Video presentation due at ARC Dec 2019 - lack of presentation software on the day. Expected Jan 2020 or Feb 2020. Date changed to end of Feb 2020 (from 12/12/2019). Link to online training to be provided. 18/12/2019 Email sent to action owner asking if amended date required as training not yet provided at ARC
		5.3 Deep dives into Divisional Risk Registers	31/10/2019	Completed
		5.4 Introduction of Datix Cloud to improve risk management processes	01/09/2020	10/07/2020 - go live date is aimed at 1 September – some modules are being user tested now 08/06/20 - 5 month extension to deadline due to COVID-19. 10/02/2020 Datix Cloud IQ launch planned for April 2020. Training to be provided to staff and ARC members on new risk

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
6	The trust should consider how it could improve the effectiveness of its medicines audit processes	6.1 Action is covered by Medicines Optimisation Action Plan (part of the Medicines Optimisation Strategy 2016-2020). The action plan is monitored through Medicines Optimisation Strategy Group which reports to CQEG	31/12/2019	Completed
		6.2 See also entry and actions for action 1	31/12/2019	Completed

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
7	The trust should consider its methods of assurance relating to the segregation of clinical waste	7.1 The Infection Prevention Team carried out a six week audit of all wards, departments, Outpatient areas and Theatres looking in every bin, the results of which were fed back to senior staff	30/09/2019	Completed/Audit results available
		7.2 Focus on findings of these audit results with a view to improving compliance	31/12/2019	Completed. Audit results shared with Ward Manager, Matron and Infection Prevention Steering group & IPC Operational group on a monthly basis
		7.3 Established a rolling audit programme to carry out a detailed Infection Prevention audit	31/12/2019	Completed. Audit rolling plan developed and implemented
		7.4 A screensaver has been produced and displayed across the Trust	30/09/2019	Completed. Screensaver developed and launched across the Trust

		7.5 Key issues are raised at the Infection Prevention Operational Group, Link Nurse Meetings and Infection prevention Steering Group	31/12/2019	Completed Minutes available from Infection Prevention Steering Group & IPC Operational Group on a monthly basis
		7.6 Weekly walk arounds with Claire Topping, Sustainability Manager	31/12/2019	Completed. Weekly walk rounds completed by Sustainability Manager & IPC team. Findings shared with Ward Manager and Infection Prevention Steering Group & IPC Operational group on a monthly basis

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
8	a) The trust should review the effectiveness of its audit committee b) The trust should consider the observations in relation to the audit committee to ensure that only realistic and deliverable internal audit recommendations are agreed in future, and that internal audit recommendations, as far as is practicable, are implemented within agreed timescales.	8.1 Agree Committee membership and Lead Executive	24/09/2019	Completed
		8.2 Meeting with Committee Chair and Lead Exec to discuss issues raised in CQC report and Committee effectiveness review	10/10/2019	Completed
		8.3 Revise committee reporting matrix	15/10/2019	Completed
		8.4 Agreed to include committee self-assessment at the end of each meeting	18/12/2019	09/06/2020 - Evidence provided by Claire Campbell. 20/12/2019 Require final version of minutes from Audit meeting (will be available after March 2020 meeting)
		8.5 Agreed to include actions from clinical audit and compliance with Clinical audit bi- annually	15/10/2019	Completed
		8.6 Ensure only realistic and deliverable IA recommendations are agreed in future and monitor delivery against agreed timescale	30/09/2020	08/06/20 - 6 month extension to deadline due to COVID-19. not been receiving reports from Internal audit/ or not responding to them during Covid 12/02/2020 Action remains ongoing as Internal Audit reviews are identified
		8.7 Ensure Audit committee takes a zero tolerance to longstanding issues and seeks resolution	30/09/2020	
		8.8 Closure of salary overpayment issue via audit committee (Cross reference with action no 14.)	18/12/2019	20/12/2019 Exec email- discussed at Audit Committee and Finance and Performance. Require final version of minutes from Audit meeting (will be available after March 2020 meeting)

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
9	The trust should consider an external review of its governance structure and systems	9.1 Refresh well- led Board knowledge	29/02/2020	09/06/2020 - Evidence provided by Claire Campbell. 03/03/2020 Discussed at Board of Directors on 27/02/2020. Evidence of completion required. 12/02/2020 Postponed from January 2020 Board meeting as ran out of time. To now take place in Feb 2020. Date changed from 30/01/2020 to 29/02/2020. All other actions to be moved back one month. 20/12/2019 Exec email- actions relating to 9.1 and 9.2 postponed as Dec 2019 Board overran. To now take place in Jan 2020 (changed from 19/12/2019). All other actions to be moved back one month.
		9.2 Identify basic specification of need	29/02/2020	03/03/2020 Discussed at Board of Directors on 27/02/2020. Evidence of completion required. 12/02/2020 Postponed from January 2020 Board meeting as ran out of time. To now take place in Feb 2020. Date changed from 30/01/2020 to 29/02/2020. All other actions to be moved back one month. 20/12/2019 Exec email- actions relating to 9.1 and 9.2 postponed as Dec 2019 Board overran. To now take place in Jan 2020 (changed from 19/12/2019). All other actions to be moved back one month.
		9.3 Commission external review via competitive quotes	30/07/2020	08/06/20 - 4 month extension to deadline due to COVID-19. 12/02/2020 See action 9.1- date for completion changed to 31/03/2020 (from 29/02/2020) 20/12/2019 See action 9.1- date for completion changed to 29/02/2020 (from 31/01/2020)
		9.4 Undertake governance review	31/09/2020	08/06/20 - 4 month extension to deadline due to COVID-19. 12/02/2020 See action 9.1- date for completion changed to 31/05/2020 (from 30/04/2020) 20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)
		9.5 Provide evidence to NHSE/I	31/09/2020	08/06/20 - 4 month extension to deadline due to COVID-19. 12/02/2020 See action 9.1- date for completion changed to 31/05/2020 (from 30/04/2020) 20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
10	The trust should consider the structure, management and oversight arrangements for its quality improvement function	10.1 Collective transformation resource reviewed	01/04/2020	18/12/2019 Transformation Resource paper to be presented at Finance and Performance meeting 19/12/2019 Completed
		10.2 Recommendations of review to be presented to Trust Board	01/04/2020	13/01/2020 Discussed and recommendations approved at Dec 2019 Finance and Performance meeting (Committee of Board)

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
11	The trust should continue to engage all its partners in operational and strategic decision making	11.1 To publish the new strategy and retain evidence of consultation with partners.	01/11/2019	13/01/2020 Strategy includes how partners were consulted and input used Completed
		11.2 Continue to engage partners in large scale strategic changes	01/11/2019	13/01/2020 Evidence of completion added in- Examples of work with partners Completed and remains ongoing
		11.3 Continue to engage partners in strategic operational issues and decision making	01/11/2019	13/01/2020 Evidence of completion added in- Examples of work with partners Completed and remains ongoing

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
12	The trust should take steps to assure itself that the interventions in progress to address bullying and poor behaviour are having an impact at pace	12.1 Review impact of current programme	31/10/2019	Completed. Feedback responded to from staff in the People's Plan
		12.2 Targeted interventions in 'hotspots'	31/12/2019	06/01/2020 Freedom to Speak Up/HR/OD linkage created. Targeted interventions plans are in place or being progressed for 'hotspot' areas (Oncology, Cardiology and Maternity) Evidence of completion changed from Staff Survey 2020 to Example of targeted intervention work in 'hotspot' area
		12.3 Incorporate 'Civility Saves Lives' into Respect and Support programme	30/06/2020	16/06/20 - no Staff Survey 2020 as cancelled due to covid 08/06/20 - 3 month extension to deadline due to COVID-19. 8/6/20 - BC reports action now completed, awaiting evidence. 09/03/2020 Action owner confirm action complete subject to exec sign off next week. To amend deadline from 29/02/2020 to 31/03/2020. Refocus of respect and support approach complete. New programme incorporating Civility Saves Lives, GMC Professional Standards and previous Respect and Support campaign agreed ready for rollout Executive sign off planned for 17/03/20 06/02/2020 Two pilots run in Oncology 06/01/2020 Piloting GMC professional standards in January 2020 to incorporate Civility Saves Lives for roll out from February 2020. Completion date changed from 31/12/2019 to 29/02/2020

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
13	The trust should consider commissioning a more detailed analysis of the drivers of its deficit to inform those elements that are within its gift to be able to address both directly and indirectly	13.1 Work with NHSE/I to agree process to complete this (using their expertise and knowledge)	01/07/2020	13/07/2020 - The STP engaged Deloitte to carry out a review of the underlying deficit position and the report agrees with the Trust underlying deficit position. The current COVID block funding regime also means that some of the underlying tariff underfunding will now be addressed. Therefore feel this recommendation is closed. 08/06/20 - 3 month extension to deadline due to COVID-19. 04/03/2020 Working with systems colleagues a review into the drivers of the deficit is to be commissioned during march 2020 and completed in May 2020.

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
14	The trust has plans to introduce an electronic solution between the human resources function and payroll to seek to address the issue of staff overpayments. The trust should consider requesting an internal audit function review of the planned electronic solution, in order that any control weaknesses can quickly be identified and addressed.	14.1 Request an internal audit review and address weaknesses	01/09/2020	17/07/2020 - 2 months extension agreed for the adult due to covid. 08/06/20 - 3 month extension to deadline due to COVID-19. 05/06/2020 - There has been no change to this since last updated. It is ready to implement however awaiting confirmation of the IT functionality. 09/03/2020 Remain on track for completion date 13/02/2020 Electronic solution designed and process agreed Await confirmation of functionality before implementation

No	Concern: Urgent and Emergency Services Quality "Should" actions	Action	Deadline	Progress/ Comments
15	The service should continue to re-assess the layout of the paediatric emergency department to ensure it meets the Children and Young People in Emergency Care Settings 2012 standards	15.1 Set up working group to establish with Paediatrics and Estates to review the current working practices that our Paediatric area has to meet these standards.	30/08/2020	16/07/2020Senior Medical & Nursing team from ED and Paediatrics have regular meetings in last 3 years , which happens usually once in 3-4 months , to discuss the referral pathways and any issues if causing problems in transfer of care. They have been working together with better communication and support to each other. The last meeting was on June 2020. After the Covid, ED has proposed referral pathways of children to PAU to Paediatrics to share the workload equally between the teams and to work along with the Infection Control policy. They are waiting for the outcome from Paediatrics, hopefully in next 2 weeks. - 10/7/20 - Tony O'Donovan reports there are plans being drawn up for Quinton to be adapted to take the Paediatric ED. There are some layout issues which need to be resolved as well as funding for the changes if this is given the go ahead. 11/06/20 Area identified adjacent to AE. As part of covid reset plans being developed (Quinton ward). Origional plans now ceased due to covid and social distancing measures being put into place. 08/06/20 - 5 month extension to deadline due to COVID-19. 06/03/2020 The space that had been initially identified has been assessed as unsuitable and therefore other options are now being considered. The space has been identified and plans are being worked up by estates. The urgency of developing these plans has been discussed at the Trust estate meeting which is chaired by the COO. We are expecting plans to be available in the next 4 weeks to enable a further discussion
		15.2 Develop options paper looking at expanding or relocating the department. Seek potential options for capital funding.	30/08/2020	10/7/20 - Tony O'Donovan reports there are plans being drawn up for Quinton to be adapted to take the Paediatric ED. There are some layout issues which need to be resolved as well as funding for the changes if this is given the go ahead. 11/06/20 Plans being progressed 08/06/20 - 5 month extension to deadline due to COVID-19. 06/03/2020 The space that had been initially identified has been assessed as unsuitable and therefore other options are now being considered. The space has been identified and plans are being worked up by estates. The urgency of developing these plans has been discussed at the Trust estate meeting which is chaired by the COO. We are expecting plans to be available in the next 4 weeks to enable a further discussion 10/02/2020 See action 15.1 09/01/2020 See update for action 15.1. Change of completion/ review date to March 2020 (from 31/12/2019) 04/12/2019 Update from S.Finn Initial long term, high level plans have been produced but funding has not been identified to allow the scheme to progress at this time.
		15.3 Complete works to change the department	31/12/2020	10/7/20 - Tony O'Donovan reports there are plans being drawn up for Quinton to be adapted to take the Paediatric ED. There are some layout issues which need to be resolved as well as funding for the changes if this is given the go ahead. 11/06/20 Linked with 15.1 08/06/20 - 9 month extension to deadline due to COVID-19. 10/02/2020 See action 15.1

		15.4 Review pathways for use of PAU and increased activity	31/12/2019	16/07/2020 - wording for evidence required changed from increased activity to improved patient flow to reflect reflect the excellent work that is on-going via our liaison with the Paediatricians to make sure that the right patients are going as rapidly as possible to PAU/the ward. 09/03/2020 Remains outstanding due to annual leave 14/02/2020 SB liaise with DN PA to try and resolve issues around closure of action 29/01/2020 Evidence of compliance provided - concerns raised by TD. SB email DN for confirmation of sign off 09/01/2020 Email from D.Needham. Pathways from A&E to PAU in place. Evidence of
16	The service should make arrangements so patient group directions are regularly checked and updated on the trust internal website	16.1 This action is included within the Medicines Optimisation action plan (part of the Medicines Optimisation Strategy 2016- 2020).	31/12/2019	20/12/2019 Further supporting evidence added in. Action complete 18/12/2019 Supporting evidence added re amendments to PGD process
		16.2 Include process in revised Medicines Management Policy	30/07/2020	08/06/20 - 4 month extension to deadline due to COVID-19. 07/02/2020 Process for PGDs will be included in review of Medicines Management Policy (due for update March 2020). Once policy approved, Pharmacy will audit against it and will add to 20/21 Medicines Optimisation Plan 18/12/2019 Supporting evidence added re amendments to PGD process 05/12/2019 Action changed to 'Include process in revised Medicines Management Policy'. Date revised to 31/03/2020 (from 31/12/2019) Previous action was 'See also entry for action 1
17	The service should take action so medical staff are compliant with the trust target for safeguarding children level three training	17.1 Mandatory training compliance of all staff groups is reviewed at every Urgent Care Governance meeting	29/02/2020	12/02/2020 Data is included in monthly governance reports and discussed in more detail where required. Training data is also emailed monthly by Training and Development to key leads in the directorate. 13/01/2020 Compliance Governance Manager review plan. No current update available at time of writing report. Extend date of completion by 1 month to 29/02/2020 (from 31/12/2019). Compliance team will raise at Urgent Care Governance meeting on 16/01/2020 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
		17.2 Clinical Director for Urgent Care will remind all medical staff of their need to complete the training	29/02/2020	29/01/2020 E-mail from TD confirming medical staff are reminded to complete mandatory training. Action closed. 13/01/2020 Compliance Governance Manager review plan. No current update available at time of writing report. Extend date of completion by 1 month to 29/02/2020 (from 31/12/2019). Compliance team will raise at Urgent Care Governance meeting on 16/01/2020 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
		17.3 The Safeguarding Team provide regular updates of who needs to completed training and this will be monitored for medical staff who are not completing the training and are repeatedly on the list	01/08/2020	14/07/20 - 1 month evidence received for those needing to do training. 08/06/20 - 4 month extension to deadline due to COVID-19. 09/03/2020 Plan to achieve by deadline date 13/02/2020 Joint working between QI and L&D to identify non-compliance. Currently working with safeguarding to ensure availability of training 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
18	The service should take action to improve the median time from arrival to treatment	18.1 Implement winter actions	31/12/2019	01/02/2020 Evidence of completion provided. Action closed down. 28/01/2020 Evidence of completion confirmed as Winter action plan and paper to Board. Winter action plan needed as evidence (will be sent over 30/01/2020 post progress meeting today) 09/01/2020 Email from D. Needham. In progress- ET updated weekly. Evidence of completion required, Action completed
		18.2 Appoint PMO lead for Urgent Care and Winter	12/11/2019	Completed
		18.3 Review Heat activity 18.3 Re-define programme 18.3 Re-launch	30/07/2020	11/06/20 - All transformation ceased in light of covid. New discharge plan as part of Reset being planned additional work taking place with external partners. 08/06/20 - 4 month extension to deadline due to COVID-19. 10/03/2020 Dep COO request extension for one month so COO can advise current position. Date for completion changed from 29/02/2020 to 31/03/2020 10/02/2020 New workstreams agreed and being led by COO/MD/DofN 29/01/2020 Evidence of completion confirmed as Agreement of workstreams 09/01/2020 Email from D. Needham. Meeting planned for PMO, DofN, Med Dir and COO to relaunch. Winter actions taken priority. Completion date changed to 29/02/2020 (from 31/12/2019)
		18.4 Rapid improvement project with IDT	09/12/2019 (and ongoing)	05/02/2020 Evidence provided. Time to PDNA currently monitored via SPA. Project in progress to utilise real time data from IBox. Trust has implemented an internal PDNA Hub. 03/02/2020 SB link with relevant leads to source evidence 09/01/2020 Email from D.Needham. Action is completed. Evidence of completion required

No	Concern: Medical Care Quality "Should" actions	Action	Deadline	Progress/ Comments
19	The service should check medical staff are up to date with mandatory, safeguarding and mental capacity training	19.1 Use of Netconsent software to check and force compliance	01/07/2020	17/07/2020 - Netconsent does not cover all training (only IG and policy management-we a
		19.2 Provide additional sessions of 'bundles' of mandatory training for trust grade staff	01/07/2020	16/07/2020 - awaiting evidence. 29/06/202
20	The service should check catering staff are following infection prevention and control protocols	20.1 Induction training for new starters	30/04/2020	23/01/2020 Evidence of completion provided. 06/01/2020 Email from S.Finn. IPC mandatory training and bespoke food hygiene induction training is in place for all new starters and existing staff. Action completed. Evidence of completion required 04/12/2019 Catering and IPC meeting held 29 Nov 19 to discuss and agree actions. Documentation including HASAP (Hazard and Critical Control Process) has been shared with IPC who are reviewing. Next meeting to be arranged in Jan 20
		20.2 Infection Prevention representation at Catering Meetings regarding PPE	30/04/2020	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn PPE is issued to all food handlers/production staff. Ward hostesses uniforms are issued and protective aprons and gloves available. Staff are trained in food hygiene procedures which include PPE. Staff records evidence training and issue of PPE. Action completed. Evidence of completion required. 04/12/2019 As above
		20.3 Infection Prevention Mandatory training - 3 yearly for non-clinical staff	30/04/2020	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required. 04/12/2019 This is in place for all catering staff and monitored via mandatory training results and at appraisals. Every 'food handler' also complete 'Food Hygiene' course
		20.4 Environment audits and Catering audits are carried out when infection is identified	30/04/2020	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn. Audits and inspections are in place and carried out regularly. Post infection audits and inspections are carried out by IPC and include ward kitchens. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required 04/12/2019 IPC have been asked to comment
		20.5 Domestic monthly cleaning audits include host/hostess staff - hand hygiene etc observed	30/04/2020	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required. 04/12/2019 This is in place as part of the cleaning audits. The ward kitchens are scored separately as part of the audit and include the ward host/hostess
		20.6 A review of catering procedures and working practices will be carried out by Infection control and the Catering management team	30/04/2020	10/03/2020 This action has been completed. W. Foster has written to A. Head to confirm that the procedures have been reviewed and are suitable and in place. A. Head will provide copy of the email as evidence on return form leave 16/03/20 23/01/2020 Email from W Foster. Dates being organised between IPC and Hotel Services 06/01/2020 Email from S.Finn. BW arranging follow-up meeting with IPC. 04/12/2019 Catering and IPC meeting held 29 Nov 19 to discuss and agree actions. Documentation including HASAP (Hazard and Critical Control Process) has been shared with IPC who are reviewing. Next meeting to be arranged in Jan 20
21	The service should keep all confidential patient records securely	21.1 The Trust have invested in lockable trollies in order to store patient records securely	30/09/2019	Completed
		21.2 Lockable cupboards are available for the safe storage of patient records	30/09/2019	Completed
		21.3 Annual Information Governance mandatory training for all staff	31/12/2019	09/06/20 This requirement has been completed, and the DSP toolkit assertion has been submitted .3/01/2020 Further email confirmation of the below received 05/12/2019 Completed As part of the Data Security and Protection Tool kit, the trust met the 95% Mandatory Information Governance training requirement for 2019 and are working towards this requirement in time for the March 2020 submission
		21.4 Data Quality, Security and Protection team to complete spot audits of compliance on wards and departments (Oct 2019 and March 2020). Findings to be shared at Assurance, Risk and Compliance meeting)	01/08/2020	16.07.2020 - shared the findings with the DGG and also confirmed it in the minutes for ARC this month . Awaiting evidence. 09/06/20 In total, 29 wards have been audited by the DQSP team with a set of 26 questions asked to give assurance of IG compliance. The findings were due to be reported to the DGG but these have been postponed due to COVID, the next DGG is in June and this will be presented then. 09/06/2020 - SS e-mailed for new deadline estimate. 08/06/20 - 4 month extension to deadline due to COVID-19. 09/03/2020 Verbal update from Dep DofN Waiting for outcome of further audit to be completed March 2020 13/02/2020 High level findings from Oct 2019 DSP audit shared at ARC 13/02/2020. A number of screensavers have been issued as result of findings from spot audits. Acceptable Use Policy also being updated and taken to February 2020 PGD meeting. 14/01/2020 Action amended to read Data Quality, Security and Protection team to complete ...... Date of audit completed changed to Oct 2019 Evidence provided for audit completed Oct 2019. Results discussed at Data Governance Group.

		21.5 Assessment & Accreditation will incorporate criteria regarding the safe storage of health records.	01/04/2020	04/06/20 - Assessment & Accreditation will incorporate criteria regarding the safe storage of health records – in regards to this action the A&A programme has been placed on 'hold' due to Covid19 and will not be recommenced in its same format for a number of months. However, the new wording is in place and we are looking at ways to self/peer assess clinical areas to enable A& A to recommence in the next couple of months. 09/03/2020 Email from Dep DofN to reword action. Wording changed to Assessment & Accreditation will incorporate criteria regarding the safe storage of health records (from All areas need to demonstrate compliance as part of the Ward Accreditation Assessment). Due to inability to achieve current action as A&A timetable is dependent on the outcome of the wards previous assessment, i.e. as ward may not be required to have an assessment for 6 months. 12/02/2020 All evidence provided waiting confirmation of closure from action owners 07/01/2020 Evidence of related documents used for Assessment and Accreditation provided 05/12/2019 On track, being included in ward Assessment & Accreditation process, not as yet
22	The service should introduce local procedures for invasive procedures in non-theatre settings	22.1 LocSSIP documents reviewed and updated	29/02/2020	03/03/2020 Policy discussed and approved at Feb 2020 PDG meeting. Minor changes needed then will be uploaded to intranet. Final version required for evidence of completion. 05/02/2020 LocSSIPs policy is going to PDG in February 2020. Date for completion changed to 29/02/2020 (from 01/02/2020) 05/12/2019 Date changed from 01/01/2020 to 01/02/2020 due to current progress with workstream
		22.2 Relaunch of LocSSIPs - training and comms	30/09/2020	08/06/20 - 3 month extension to deadline due to COVID-19. 05/02/2020 Existing LocSSIPs being updated to new Trust format. Education being provided to teams as these are updated 31/12/2019 Email from Mi.Metcalfe. Work programme has increased. New Clinical Lead for this. Plan to revise the template for the Trust and do base line audit of documents in existence and staff awareness. Re-launch planned for June 2020. Completion date changed to 30/06/2020 (from 01/05/2020) 05/12/2019 Date changed from 01/04/2020 to 01/05/2020 due to progress with action 22.2
		22.3 Audit of compliance	31/01/2021	08/06/20 - 3 month extension to deadline due to COVID-19. 31/12/2019 See comment for 22.2. Completion date changed to 31/10/2020 (from 01/09/2020) 05/12/2019 Date changed from 01/08/2020 to 01/09/2020 due to progress with action 22.1
23	The service should manage medical outliers so they are seen in a timely manner	23.1 Inpatients cared for on outlying wards have a designated medical team to review patients. This is monitored and audited twice weekly by reviewing the medical plans in the patient's medical records	29/02/2020	10/02/2020 Completed and in place. Evidence of completion required.06/01/2020 Email f
		23.2 Ward staff escalate any issues regarding medical reviews at the x3 daily Site meetings.	31/10/2019	28/01/2020 D Needham advise evidence of completion can change to What's App messages 23/01/2020 Example Daily Safety Sheet notes provided for Oct 19, Dec 19 and Jan 20. Site Team to provide relevant Whats App messages as well. This is the format of notes from meeting. 13/01/2020 Evidence of completion required Completed and ongoing review quarterly .
		23.3 Number of medical outliers to be communicated daily via Sitrep (Whats app)	31/10/2019	23/01/2020 Evidence provided of example x6 daily Trust position- Sitrep. Recent change to now include medical outliers in this as well as info going out via Whats app. Also sample What's app message 13/01/2020 Evidence of completion required Completed and ongoing review quarterly
24	The service should consider how it manages private and NHS patients for cardiology procedures to ensure equity of access	24.1 East Midlands Clinical Senate review completed August 2019- Terms of reference included private practise arrangements	31/08/2019	Completed
		24.2 Action plan developed linking multiple reports/ workstreams in Cardiology	13/09/2020	15/06/2020 - E-mail reply from MV - Can you please extend it a further three months to allow us to work through reset and then we may have already addressed some of these actions? 09/06/20 - Mary Visser e-mailed for update 08/06/20 - 3 month extension to deadline due to COVID-19. 10/03/2020 Key leads involved in workstream met for handover. Cross referencing with recommendations from national audits etc has been done against Senate recommendations. Dir manager to met with clinical lead to progress next steps. 03/03/2020 Associate medical director request an update on progress. SB will be completed by deadline of 13/03/2020 12/02/2020 Some delays in collating information. Completion date changed to 13/03/2020 (from 16/02/2020) 13/01/2020 Compliance Governance Manager involved in this workstream. Meeting planned for 07/01/2020 (cancel due to Trust pressures) rebooked for 16/01/2020
25	The service should review clinical guidelines to check they are current	25.1 Netconsent to ensure guidelines reviewed in line with policy	01/07/2020	13/07/202- In addition to NetConsent and PDG , the Divisions track their policies/ procedural documents on a monthly basis and report through CQEG to the Medical DIrector. Any areas of concern are escalated to QGC. There are Reports to CQEG that demonstrate this. Following doscussion with the Meidcal Director it is felt that there are robust process in place to support the updating of existing documents and development of new documents . Therefore this action can close. 09/06/20- Net Consent has been amended to send reminders out to all authors 6mths ahead of when their policy is due for updating to allow sufficient time for the documents to be reviewed and updated Awaiting evidence of sample reminders. 09/06/20 - CC e-mailed for deadline date update. 08/06/20 - 3 month extension to deadline due to COVID-19. 03/06/20- Net Consent has been amended to send reminders out to all authors 6mths ahead of when their policy is due for updating to allow sufficient time for the documents to be reviewed and updated.
		25.2 Use of PDG report to show reduction in overdue guidelines	01/07/2020	09/06/20 Regular reports provided and monthly report presented to PDG with current posiiton of documents . PDG reports evidence received. 09/06/20 - CC e-mailed for deadline date update. 08/06/20 - 3 month extension to deadline due to COVID-19. 04/06/20 Regular reports provided and monthly report presented to PDG with current posiiton of documents 03/03/2020- PDG continues to submit reports to CQEG in relation to the documents that have been approved and those that are overdue. This is a long term action, including rationalisation of procedural documents. 10/02/2020 Monthly report provided to CQEG which demonstrates the progress in
26	The service should consider reviewing storage and security of substances subject to control of substance hazardous to health (COSHH)	26.1 All storage areas reviewed during core service inspection and security risks removed	30/06/2019	08/01/2020 Email from F. Barnes. DofN complete further spot check on door codes before Christmas (late evening and night shift). None found. Completed (spot audit to review ongoing compliance planned late November 2019)
27	The service should consider reviewing environment and facilities for inpatient outliers staying on the Heart Centre	27.1 Complete review of Heart Centre environment and facilities	31/03/2020	29/01/2020 Evidence of completion provided. Escalation documents taken from the Weekend Plan in relation to use of Heart Centre for outliers 09/01/2020 Email from D.Needham. Undertaken as part of escalation areas review previously. Action completed. Evidence of completion required.
28	The service should consider addressing cultural issues across some medical wards	Covered within action 12	31/12/2019	Covered within action 12
29	The stroke services to consider improving compliance with completion of VTE assessments	29.1 To monitor stroke service VTE compliance via thrombosis committee and implement actions if compliance has not improved	30/07/2020	08/06/20 - 4 month extension to deadline due to COVID-19. 10/02/2020 Action owner confirmed data is captured by ward. Will provide for relevant wards related to stroke service.

No	Concern: Maternity Services Quality "Should" actions	Action	Deadline	Progress/ Comments
30	The service should ensure women can access the service when they need it and receive the right care promptly and that waiting times from referral to treatment and arrangements to admit, treat and discharge women are in line with national standards	30.1 Continue monitoring access to maternity services by 10+0 weeks and 12+6 weeks	31/10/2019	Completed
		30.2 Monitor access to scan appointment within 72 hours for women with reduced/static growth	30/11/2019	Completed Currently monitoring is in place, to be added to dashboard as from December
		30.3 Review midwifery ultrasonography scan clinics to ensure adequate capacity	31/12/2019	06/01/2020 Email from DofN to confirm completed. Evidence provided. 05/12/2019 MDU midwife currently completing QI project reviewing demand to baseline match capacity developing a better triage system
		30.4 MESC bid for ultrasound machine for Labour Ward to prevent overnight referrals to MDU / Midwife Scan clinics	30/07/2020	16/07/2020 -we are still awaiting response regarding whether bid for US machine successful. 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Awaiting bid outcome, continue to monitor waiting times and report 72 hour breeches to governance 11/02/2020 Awaiting outcome 08/01/2020 Continue to await feedback on bid
		30.5 Seek further funding / training for more midwives to be trained in 3rd Trimester scanning	31/03/2020	06/01/2020 No requirement at present to train additional midwives. As per 30.3 - 2 midwives will complete training in April 2020. Funding currently available via HEE if situation changes - next course September 2020. Action completed. 05/12/2019 Two midwives have to date commenced the training scanning programme. Funding currently available via HEE. Currently exploring how places can be accessed going forward as next programme is Sept 20
		30.6 Monitor Triage waiting times on Maternity Dashboard – monthly report to Directorate / Divisional Governance Group.	31/10/2019	Completed (see evidence for 30.2)
		30.7 Business case to reconfigure Labour Ward which will make a dedicated Triage area and provide easier access to obstetric care. It will also reduce attendances / waiting times on the Maternity Day Unit.	30/07/2020	16/07/2020 - Business case for triage not supported. Will continue to raise safety issues. Discussed at maternity safety champions meeting and business case was not supported due to mitigation. 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Continue to monitor triage waiting times, these are poor, triage on MDU is an issue, 19% had first assessment within 15 mins (Jan' 20) Support for business case will address concern 11/02/2020 Executive Team support case– Options currently being developed by Facilities
31	The service should formally monitor delayed discharges and how frequently induction of labours or elective caesarean sections are delayed (or cancelled) so the service can analyse and monitor trends to inform future plans	31.1 Develop audit proforma for delayed/cancelled IOL and elective caesarean sections	01/08/2020	08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Audit proforma is being used, sections are now datixed and are reported on the huddle sheets. Figures to be reported as below 13/02/2020 Cancelled electives being monitored through Datix and IOL though audit . Figures to be included in Risk Management report and Clinical effectiveness report and escalated as appropriate 06/01/2020 Audit proforma developed and circulated to all staff - December 2019 Every induction to be audited as well as cancelled electives, To continue and feedback through Divisional Governance meetings 05/12/2019 Supported by snapshot audit, every induction audited as well as cancelled electives, To continue and feedback through Divisional Governance meetings
		31.2 Reasons for delayed discharges discussed and documented at the Maternity Safety Huddle	01/08/2020	08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 As per 31.1. Audit proforma being used 13/02/2020 Maternity huddle sheets being used daily and well embedded in service 05/12/2019 This is currently under development and on track to deliver by stated deadline
		31.3 Monthly report to Directorate Governance Group and Divisional Governance Group	01/08/2020	08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020

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		31.4 Business case for pharmacy support to assist with delayed discharges for take home medications	01/08/2020	08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Pharmacy post out to advert 11/02/2020 Please refer to 2.5 06/01/2020 Business case supported and recruitment underway 05/12/2019 Please refer to No.2.5 Business case has been completed and due for submission in Dec 19
32	The service should ensure managers are planning the service for the long term. For example, to enable planning and organisation of services so they met the needs of the local population within the local expected population growth	32.1 Develop Long Term Plan in conjunction with the Local Maternity System	01/04/2020	01/03/2020 Action completed. Discussed at strategy meeting- 5 year LMS plan has been submitted 13/02/2020 Feedback still awaited 05/12/2019 Long Term Plan developed, awaiting feedback
		32. 2 Develop integrated Business Plan for Maternity Services	01/04/2020	06/01/2020 Email from DofN to confirm action completed. 05/12/2019 Plan has been developed and has been presented to the Divisional Team meeting
		32.3 Engagement in East Midlands Clinical Network as well as other Regional / National events and meetings	01/08/2020	16/07/2020 - – East Midlands network meetings have always been well attended and this continues. We ensure representation at the board meetings and smaller breakout and subspeciality meetings, awaiting evidence. 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Service attends relevant events. Evidence to follow. 13/02/2020 The service continue to engage and be involved in these events 05/12/2019 Trust team has attended and engaged in events, sharing findings and outcomes with
		32.4 Monthly report to Divisional Management Board on forecasted activity based on bookings	01/08/2020	16/07/2020 - projected figures are now included in the divisional reports – May 2020 gove
		32.5 Business case to be submitted to reconfigure Sturtridge Labour Ward – non clinical rooms changed into clinical rooms, dedicated Triage area consisting of 4 rooms which could be used as further birthing rooms at times of high activity	01/08/2020	16/07/2020 – business cases not supported for maternity triage or increased midwifery staffing due to mitigation. 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Executive Team support case- options awaited from Facilities 11/2/20 Executive Team support case– Options currently being developed by Facilities 05/12/2019 Business case submitted awaiting outcome
		32.6 Business case to be submitted for midwifery staffing to be submitted to ensure sufficient staff are available for the higher level of activity / acuity forecast.	01/08/2020	16/07/2020 – business cases not supported for maternity triage or increased midwifery staffing due to mitigation. 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Continue to await outcome for submitted business case 11/02/2020 Business case submitted awaiting outcome 05/12/2019
		32.7 Ensure sufficient midwifery staff in post to meet the Continuity of Carer agenda as per Better Births	01/08/2020	16/07/2020 – business cases not supported for maternity triage or increased midwifery staffing due to mitigation. 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Linked with action 32.6 11/02/2020 – Discussed at Maternity Safety Champions meeting, minuted. Business case for additional staff submitted awaiting outcome 05/12/2019 Safety champions meetings occur bi monthly, all discussion minuted

No	Concern: Use of resources 'Should' Actions	Action	Deadline	Progress/ Comments
33	The NHS trust should continue working to ensure optimisation of its substantive medical workforce and reduce reliance on agency staff.	33.1 Reinforce medical agency committee	31/12/2019	09/03/2020 Evidence of completion provided 04/03/2020 SB review evidence. Contact LL to see if meeting held- request evidence of completion. 14/01/2020 Email from L.Ludgrove to advise meeting today did not go ahead due to lack of attendance. Reschedule to next week. Agenda and TofR to be provided. 08/01/2020 Monitoring meetings refreshed. New fortnightly meetings to start from 14/01/2020. Attendance to include Execs to support strategic decision making on reducing medical agency spend.
		33.2 Review medical recruitment strategy	30/08/2020	08/06/20 - 3 month extension to deadline due to COVID-19. 09/03/2020 Project initiated to determine correct medical establishment. Date amended from 03/04/2020 to 31/05/2020 to progress the medical establishment review 13/02/2020 Senior level review meeting in place concerned with agency cost reduction, substantive recruitment and shift to Bank where possible
34	This NHS trust should continue working to achieve further efficiencies from collaborative working with partners in its clinical and support services	34.1 Continue to seek opportunities to collaborate on the delivery of clinical and support services with partners within Northants and Leicestershire	31/10/2019	14/01/2020 See supporting evidence for Action 11 Completed Ongoing through the life of the new strategy and Long Term Plan
		34.2 Continue to pursue opportunities with KGH through the Unified Acute Model workstream of the HCP	31/10/2019	14/01/2020 See supporting evidence for Action 11 Completed Ongoing through the life of the new strategy and Long Term Plan
35	The NHS trust should continue focusing on building internal capacity and capability to deliver trust wide workforce and service productivity improvements	35.1 Support the transformation of the quality function	30/06/2020	16/06/20 - Evidence received - NOC & Team structure. 08/06/20 - 3 month extension to deadline due to COVID-19. 08/06/20 - BC reports action completed. Awaiting evidence. 09/03/2020 Leadership role assigned and focus of new team agreed Recruitment to vacant posts in progress. No further significant support needed 06/01/2020 Integration on plan for Quarter 1 20/21. HR and OD support in place
		35.2 Integrate productivity improvements in OD interventions	30/06/2020	16/06/2020 - Evidence received for oncology intervention plan. 08/06/20 - 3 month extension to deadline due to COVID-19. 08/06/20 - BC reports action completed. Awaiting evidence. 09/03/2020 Work in progress against key elements of plan with next steps identified 06/01/2020 Oncology plan fully integrated
		35.3 Introduce talent management	31/08/2020	08/06/20 - extension to deadline due to COVID-19. 08/06/20 - BC - 35. 3 was paused due to Covid19 but will be revised shortly to reflect current position Completion date can be revised to 31/8/20 09/03/2020 Rollout to other divisions launched as well as pipeline identification for non clinical areas 06/02/2020 Surgery due for completion February 2020
36	The NHS trust should ensure the improvements that they make in pathways results in achieving better performance against constitutional operational standards	36.1 Cancer recovery plan in place	30/07/2020	08/06/20 - 4 month extension to deadline due to COVID-19. 10/03/2020 Intensive support team (IST) have been working with us for 3 weeks now with very positive feedback on our cancer board, processes and cancer PTL structure. They are going to support us with some demand and capacity work for our most challenged cancer sites as well as helping to review our cancer access policy and 'straight to test processes' A full action plan will be developed once the IST diagnostic has been completed 10/02/2020 Recovery plans in place for individual tumour sites, support being provided by the IST (NHSI) starting on 14th February 2020 09/01/2020 Email from D.Needham. Recovery plan is in place. Completion date amended to 31/03/2020 (from 31/12/2019). Action not yet signed off Review date (31/12/2019)
		36.2 AE plan in place as per actions 18 and 23	30/07/2020	08/06/20 - 4 month extension to deadline due to COVID-19. Link in with 18 & 23. 10/02/2020 New work streams agreed and being led by COO/MD/DoN 09/01/2020 Email from D.Needham. Recovery plan is in place. Completion date amended to 31/03/2020 (from 31/12/2019) Action not yet signed off.
37	The NHS trust should ensure existing cost improvement initiatives achieve the expected reduction of its expenditure run-rate and overall cost base.	37.1 Development of a recurrent savings plan	30/07/2020	13/07/2020 - The Trust, at this time, does not need to make cost savings. This action should be closed? 08/06/20 - 4 month extension to deadline due to COVID-19. 04/03/2020 The 2019/20 CIP target should be achieved in its totality, though a large percentage will be non recurrent
38	The NHS trust should develop a plan to return to finance balance on recurrent basis	38.1 Development of System 3 year financial strategy	30/07/2020	13/07/2020 - The Trust, at this time, does not need to make cost savings. This action should be closed? 08/06/20 - 4 month extension to deadline due to COVID-19. 04/03/2020 The system finance group will move on to the development of this workstream over the next few months 12/02/2020 This is superseded by the issued financial improvement trajectories and system working relating to transformation and block contracts. We know that the major cause of our deficit is the underfunding of the tariff. (links with
		38.2 Development of a LTFM to see if this is possible	30/07/2020	13/07/2020 - The Trust, at this time, does not need to make cost savings. This action should be closed? 08/06/20 - 4 month extension to deadline due to COVID-19. 04/03/2020 The LTFM will be an integral part of 38.1
39	The NHS trust should progress implementation of its five-year estates maintenance plan.	39.1 Continued recruitment into newly created Estates maintenance posts. Some key roles already filled.	01/09/2020	08/06/20 - 3 month extension to deadline due to COVID-19. 04/06/2020 - Interim Dep Dir of E&F in place and 'head hunters have been asked to assit in recruitment. 2 x candidtaes were interviewed 2/06/20 Agency staff are being used to fill trade staff vacancies in Estates - new adverts have been opened for permenant roles Target date of June 2020 will not be met. 10/03/2020 Deputy Director of Facilities & Head of Estates interview on 10/03/20 – originally 6 shortlisted for interview but 5 withdrew. An interim has been interviewed and is due to start end of March. Senior Maintenance Manager advert closed and 2 applicants selected for interview end of March. Suitable interims continue to prove difficult to source. 06/01/2020 Further posts have been filled - during Dec 19/Jan 20 (fire officer and mechanical maintenance engineer). Senior maintenance manager & electrical maintenance manager interviews due end of Jan 2020. Deputy director role advert closes end of Jan 2020.
		39.2 Implementation of new CMMS (computer maintenance management system)	01/08/2020	04/06/2020 Review completed which supports the use of the existing system. Progress has been delayed due to vacancies but new interim Dep Dir of E&F has been tasked to complete implementation. Target date of Aug 20 will not be achievable and a new date will be set following further meetings in June 10/03/20 Independent review completed which confirmed existing system is fit for purpose. A number of recommendations were made as part of the report which are being reviewed. 06/01/2020 Independent review starting 7 Jan 20 04/12/2019 An independent review of the existing system has been arranged. This will include recommendations and action plan to implement the system and utilise the reporting function.
		39.3 Development of key maintenance compliance reports from CMMS to be presented at Facilities Governance committee	01/08/2020	04/06/2020 Review completed which supports the use of the existing system. Progress has been delayed due to vacancies but new interim Dep Dir of E&F has been tasked to complete implementation. Target date of Aug 20 will not be achievable and a new date will be set following further meetings in June 10/03/20 Independent review completed which confirmed existing system is fit for purpose. A number of recommendations which included reporting were made as part of the report which are being reviewed. 06/01/2020 Independent review starting 7 Jan 20 04/12/2019 An independent review of the existing system has been arranged.
		39.4 Put in place a new Facilities Governance committee and structure	30/09/2019	Completed

NGH Improvement Plan
(Incorporating CQC Inspection Report outcomes published October 2019/ NHSE/I Undertakings actions)

09/06/2020
V7

21/07/2020

No	Concern: Medicine Division Requirement notice Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date Completed	Evidence of completion	Likelihood of completion	Progress/ Comments
1	The trust must ensure the proper and safe management of medicines. Staff must follow current national practice to check patients receive the correct medicines. The service must have systems to ensure staff are aware about safety alerts and incidents. Staff must store and manage all medicines and prescribing documents in line with the provider's policy. (Regulation 12 (2) (g): The proper and safe management of medicines).	Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	1.1 Implementation of Task and Finish Group chaired by Medical Director	01/08/2019	01/08/2019	1.1 Updated Medicines Optimisation workstream	5- Almost certain	Completed
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	1.2 Medicines Optimisation Work plan updated to include CQC recommendations (post inspection)	02/08/2019	31/10/2019	1.2 Papers of Task and Finish Group- updates provided to CQEG	5- Almost certain	12/02/2020 Safety alert issued via NetConsent last week for staff and via weekly staff comms update. 21/12/2019 Update from Chief Pharmacist advise safety alerts already shared across the Trust but exploring the use of Netconsent for this as well. Help raise profile and enable audit of staff accessing documents. Also provide historic reminders of key messages Completed
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	1.3 Ongoing enhanced audits monitored through medicines governance structure	31/12/2019	03/12/2019	1.3 Audit results/ report and meeting minutes	5- Almost certain	20/12/2019 Update from Chief Pharmacist- Audit form approved August 2019 - changes made after 3 months of use and discussions at MOSG. Completed Audits remain ongoing
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	1.4 Safe & Secure Controlled Drug audit carried out on a monthly basis	31/12/2019	03/12/2019	1.4 Audit results/ report and meeting minutes	5- Almost certain	20/12/2019 Update from Chief Pharmacist- Audits are completed monthly for areas of poor compliance (normally done quarterly). CD Audit form has been updated. Plan is to combine CD and MM audits, completed jointly by Nursing and Pharmacy from April 2020 Completed Audits remain ongoing

No	Concern: Womens Childrens, Oncology & Haematology and Cancer Services Division Requirement notice Undertakings Section 4 (both action 2 and 3)	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
2	Staff must follow systems and processes when safely prescribing, administering, recording and storing medicines. The service must ensure medicines are in date and medicine waste and returns are stored securely. Infusions that require protection from light must be stored appropriately. Staff must ensure medicines stored in the medicine trolley are stored in their original boxes to ensure expiry dates and names of medicines are visible. Staff must ensure action is taken to address repeated high room temperature values, where the recommended storage conditions for medicines have been exceeded. (Regulation 12 (2) (g): The proper and safe management of medicines).	Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	2.1 Implementation of Task and Finish Group chaired by Medical Director	01/08/2019	01/08/2019	2.1 Updated Medicines Optimisation workstream	5- Almost certain	Completed
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	2.2 Medicines Optimisation Work plan updated to include CQC recommendations (post inspection)	31/10/2019	31/10/2019	2.2 Papers of Task and Finish Group- updates provided to CQEG	5- Almost certain	Completed
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	2.3 Ongoing enhanced audits monitored through medicines governance structure	31/12/2019	03/12/2019	2.3 Audit results/ report and meeting minutes	5- Almost certain	20/12/2019 Update from Chief Pharmacist- Audit form approved August 2019 - changes made after 3 months of use and discussions at MOSG. Completed Audits remain ongoing
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	2.4 Safe & Secure Controlled Drug audit carried out on a monthly basis	31/12/2019	03/12/2019	2.4 Audit results/ report and meeting minutes	5- Almost certain	20/12/2019 Update from Chief Pharmacist- Audits are completed monthly for areas of poor compliance (normally done quarterly). CD Audit form has been updated. Plan is to combine CD and MM audits, completed jointly by Nursing and Pharmacy from April 2020 Completed Audits remain ongoing
		Matthew Metcalfe	Maxine Foster/ Christine Ainsworth	2.5 Approve business case for maternity pharmacist	31/12/2019	20/12/2019	2.5 Submitted business case	4- Likely	20/12/2019 Chief Pharmacist email - confirm Exec team approve business case and recruitment will commence Jan 2020, with view to providing service from April 2020. 18/12/2019 Supporting evidence saved- business case and emails re taking case to Dec 2019 Finance Committee 05/12/2019 Action updated to Approve business case for maternity pharmacist (previous action Appoint maternity pharmacist)

3	The maternity service must ensure information and guidance about how to complain is widely available to everyone who uses the service. (Regulation 16: (2) Receiving and acting on complaints).	Sheran Oke	Christine Ainsworth/Lorraine Ryan	3.1 4Cs information leaflets and posters to be displayed in all areas	31/12/2019	31/12/2019	3.1 Three spot audits to confirm leaflets and posters on display	5- Almost certain	06/01/2020 Completed. Audits will remain ongoing. No concerns with compliance. Evidence also included of attendance at Meet the Matrons clinic - 3 months of data. Women are accessing this service to discuss their care 18/12/2019 S.Oke advise spot audits will be available for CQC engagement meeting Jan 2020 05/12/2019 Leaflets and posters on display. Meet the Matron posters are also on display in all areas of maternity. Flyers to support the availability of the above are also now included within the mothers discharge pack
		Sheran Oke	Christine Ainsworth/Lorraine Ryan	3.2 'Meet the Matron' posters displayed in all areas- so service users can raise concerns	31/12/2019	31/12/2019	3.2 Record of when Senior Midwifery Team walk arounds completed	5- Almost certain	06/01/2020 Audits provided which show posters on display and evidence of clinics taking place 05/12/2019 Meet the Matron posters are available in all areas of maternity
		Sheran Oke	Christine Ainsworth/Lorraine Ryan	3.3 Use of Big Word translation services	31/12/2019	31/12/2019	3.3 Briefing to staff to remind them to use Big Word	5- Almost certain	6/01/2020 Information available in ward areas. Currently included in maternity's 'Stork Talk' newsletter to remind staff. HOM continues to monitor use of interpreters 05/12/2019 Message relayed through safety huddles, information also available in ward areas. Currently included in maternity's 'Stork Talk' newsletter to remind staff. HOM is monitoring use of interpreters
		Sheran Oke	Christine Ainsworth/Lorraine Ryan	3.4 Develop poster which contains information in other languages for women and families in whom English is not their first language	31/12/2019	31/12/2019	3.4 Copy of poster	5- Almost certain	06/01/2020 Poster on display at hospital. Information booklets available in Romanian. Polish, Lithuanian and Bengali (most common languages). Provided to women at booking appointment by Community Midwife. Evidence of completion changed to Copy of poster 05/12/2019 Information also provided by midwives at booking appointment by community midwfe. New poster under design to signpost, leaflets being translated into other languages (most commonly used)

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
4	a) The trust should review its board assurance framework to ensure it provides adequate assurance b) The trust should consider tabling the board assurance framework monthly and consider how current gaps in assurance are highlighted. This consideration should inform debate on the sufficiency of the actions taken to close these gaps, and the associated timelines	Claire Campbell	Claire Campbell	4.1 BAF to be reviewed by Board- benchmarked against CQC advised exemplar document and revised format to be agreed. This will assist in improving assurance, highlight gaps in assurance and timely actions as a result.	31/12/2019	26/09/2019	4.1 Board development programme	5- Almost certain	Completed
		Claire Campbell	Claire Campbell	4.2 Board to consider frequency of reporting of BAF.	26/09/2019	26/09/2019	4.2 Board development programme	4- Likely	20/12/2019 Evidence of completion changed to Board development programme (from Board paper). Frequency of reporting discussed as part of presentation for 4.1 Completed- Board agreed to leave as quarterly reporting in line with other Trusts.
		Claire Campbell	Claire Campbell	4.3 BAF content reviewed and links to strategy pledges included	28/11/2019	28/11/2019	4.3 Board paper	4- Likely	Completed
		Claire Campbell	Claire Campbell	4.4 BAF presented in revised format	28/11/2019	28/11/2019	4.4 Board paper	4- Likely	Completed

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
		Claire Campbell	Simon Hawes	5.1 Revised report format for ARC, Board and its committees	31/10/2019	31/10/2019	5.1 Reports to ARC, Board and its committees	4- Likely	Completed

5	The trust should review its risk register so staff can easily track changes to risk or mitigation and improve clarity on how the existing controls relate to the risk as stated in the risk register	Claire Campbell	Simon Hawes	5.2 Training refresh for all ARC members on risk, including mitigation, and controls	31/07/2020		5.2 Training presentation	4- Likely	10/07/2020 - No update for 5.2 relating to training. With DCIQ coming in we would expect the training to be after this. 08/06/20 - 4 month extension to deadline due to COVID-19. Due to timing of meetings. 09/03/2020 SH confirm with SB that CaC had agreed to change of date (on behalf of CIC). To change date from 31/03/2020 to 30/04/2020. This will enable training to cover Datix Cloud. 12/02/2020 Date for completion changed to 31/03/2020 (from 29/02/2020). For presentation at March 2020 ARC meeting 13/01/2020 Link to training provided. 31/12/2019 Video presentation due at ARC Dec 2019 - lack of presentation software on the day. Expected Jan 2020 or Feb 2020. Date changed to end of Feb 2020 (from 12/12/2019). Link to online training to be provided. 18/12/2019 Email sent to action owner asking if amended date required as training not yet provided at ARC
		Claire Campbell	Simon Hawes	5.3 Deep dives into Divisional Risk Registers	31/10/2019	31/10/2019	5.3 ARC minutes	4- Likely	Completed
		Claire Campbell	Simon Hawes	5.4 Introduction of Datix Cloud to improve risk management processes	01/09/2020		5.4 Training presentation on new module	4- Likely	10/07/2020 - go live date is aimed at 1 September – some modules are being user tested now 08/06/20 - 5 month extension to deadline due to COVID-19. 10/02/2020 Datix Cloud IQ launch planned for April 2020. Training to be provided to staff and ARC members on new risk module once created

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
6	The trust should consider how it could improve the effectiveness of its medicines audit processes	Matthew Metcalfe	Karin Start	6.1 Action is covered by Medicines Optimisation Action Plan (part of the Medicines Optimisation Strategy 2016-2020). The action plan is monitored through Medicines Optimisation Strategy Group which reports to CQEG	31/12/2019	03/12/2019	6.1 Action Plan & most recent report to CQEG	5- Almost certain	Completed
		Matthew Metcalfe	Karin Start	6.2 See also entry and actions for action 1	31/12/2019	03/12/2019	6.2 See above - action 1	5- Almost certain	Completed

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
7	The trust should consider its methods of assurance relating to the segregation of clinical waste	Sheran Oke	Wendy Foster/ Claire Topping	7.1 The Infection Prevention Team carried out a six week audit of all wards, departments, Outpatient areas and Theatres looking in every bin, the results of which were fed back to senior staff	30/09/2019	30/09/2019	7.1 Audits completed over 6 weeks	5- Almost certain	Completed Audit results available
		Sheran Oke	Wendy Foster/ Claire Topping	7.2 Focus on findings of these audit results with a view to improving compliance	31/12/2019	05/12/2019	7.2 Action plans from audits/ improvement work	5- Almost certain	Completed. Audit results shared with Ward Manager, Matron and Infection Prevention Steering group & IPC Operational group on a monthly basis
		Sheran Oke	Wendy Foster/ Claire Topping	7.3 Established a rolling audit programme to carry out a detailed Infection Prevention audit	31/12/2019	05/12/2019	7.3 Rolling audit programme	5- Almost certain	Completed. Audit rolling plan developed and implemented
		Sheran Oke	Wendy Foster/ Claire Topping	7.4 A screensaver has been produced and displayed across the Trust	30/09/2019	30/09/2019	7.4 Screensaver	5- Almost certain	Completed. Screensaver developed and launched across the Trust
		Sheran Oke	Wendy Foster/ Claire Topping	7.5 Key issues are raised at the Infection Prevention Operational Group, Link Nurse Meetings and Infection prevention Steering Group	31/12/2019	05/12/2019	7.5 Minutes from IPOG, Link nurse meetings and IPSG	5- Almost certain	Completed. Minutes available from Infection Prevention Steering Group & IPC Operational Group on a monthly basis
		Sheran Oke	Wendy Foster/ Claire Topping	7.6 Weekly walk arounds with Claire Topping, Sustainability Manager	31/12/2019	05/12/2019	7.6 Notes from weekly walk arounds and any actions to be taken	5- Almost certain	Completed. Weekly walk rounds completed by Sustainability Manager & IPC team. Findings shared with Ward Manager and Infection Prevention Steering Group & IPC Operational group on a monthly basis

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
	a) The trust should review the effectiveness of its audit committee	Claire Campbell	Claire Campbell	8.1 Agree Committee membership and Lead Executive	24/09/2019	24/09/2019	8.1 Named attendees and Lead Exec	5- Almost certain	Completed
		Claire Campbell	Claire Campbell	8.2 Meeting with Committee Chair and Lead Exec to discuss issues raised in CQC report and Committee effectiveness review	10/10/2019	10/10/2019	8.2 Meeting outcomes as agreed below	5- Almost certain	Completed
		Claire Campbell	Claire Campbell	8.3 Revise committee reporting matrix	15/10/2019	15/10/2019	8.3 Revised reporting matrix	5- Almost certain	Completed
		Claire Campbell	Claire Campbell	8.4 Agreed to include committee self-assessment at the end of each meeting	18/12/2019	18/12/2019	8.4 Minutes of December 2019 meeting	4- Likely	09/06/2020 - Evidence provided by Claire Campbell. 20/12/2019 Require final version of minutes from Audit meeting (will be available after March 2020 meeting)

8	b) The trust should consider the observations in relation to the audit committee to ensure that only realistic and deliverable internal audit recommendations are agreed in future, and that internal audit recommendations, as far as is practicable, are implemented within agreed timescales.	Claire Campbell	Claire Campbell	8.5 Agreed to include actions from clinical audit and compliance with Clinical audit bi- annually	15/10/2019	15/10/2019	8.5 Revised reporting matrix	4- Likely	Completed
		Claire Campbell	Claire Campbell	8.6 Ensure only realistic and deliverable IA recommendations are agreed in future and monitor delivery against agreed timescale	30/09/2020		8.6 TIAA Recommendation tracker	3 - Possible	08/06/20 - 6 month extension to deadline due to COVID-19. not been receiving reports from Internal audit/ or not responding to them during Covid 12/02/2020 Action remains ongoing as Internal Audit reviews are identified
		Claire Campbell	Claire Campbell	8.7 Ensure Audit committee takes a zero tolerance to longstanding issues and seeks resolution	30/09/2020		8.7 Audit Committee minutes	3 - Possible	08/06/20 - 6 month extension to deadline due to COVID-19. not been receiving reports from Internal audit/ or not responding to them during Covid
		Claire Campbell	Claire Campbell	8.8 Closure of salary overpayment issue via audit committee (Cross reference with action no 14.)	18/12/2019	18/12/2019	8.8 Minutes of December 2019 meeting	3 - Possible	20/12/2019 Exec email- discussed at Audit Committee and Finance and Performance. Require final version of minutes from Audit meeting (will be available after March 2020 meeting)

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
9	The trust should consider an external review of its governance structure and systems	Claire Campbell	Claire Campbell	9.1 Refresh well- led Board knowledge	29/02/2020	27/02/2020	9.1 Presentation	4- Likely	09/06/2020 - Evidence provided by Claire Campbell. 03/03/2020 Discussed at Board of Directors on 27/02/2020. Evidence of completion required. 12/02/2020 Postponed from January 2020 Board meeting as ran out of time. To now take place in Feb 2020. Date changed from 30/01/2020 to 29/02/2020. All other actions to be moved back one month. 20/12/2019 Exec email- actions relating to 9.1 and 9.2 postponed as Dec 2019 Board overran. To now take place in Jan 2020 (changed from 19/12/2019). All other actions to be moved back one month.
		Claire Campbell	Claire Campbell	9.2 Identify basic specification of need	29/02/2020	27/02/2020	9.2 Specification document	4- Likely	03/03/2020 Discussed at Board of Directors on 27/02/2020. Evidence of completion required. 12/02/2020 Postponed from January 2020 Board meeting as ran out of time. To now take place in Feb 2020. Date changed from 30/01/2020 to 29/02/2020. All other actions to be moved back one month. 20/12/2019 Exec email- actions relating to 9.1 and 9.2 postponed as Dec 2019 Board overran. To now take place in Jan 2020 (changed from 19/12/2019). All other actions to be moved back one month.
		Claire Campbell	Claire Campbell	9.3 Commission external review via competitive quotes	30/07/2020		9.3 Supplier engaged	4- Likely	08/06/20 - 4 month extension to deadline due to COVID-19. 12/02/2020 See action 9.1- date for completion changed to 31/03/2020 (from 29/02/2020) 20/12/2019 See action 9.1- date for completion changed to 29/02/2020 (from 31/01/2020)
		Claire Campbell	Claire Campbell	9.4 Undertake governance review	31/09/2020		9.4 Governance review completed	4- Likely	08/06/20 - 4 month extension to deadline due to COVID-19. 12/02/2020 See action 9.1- date for completion changed to 31/05/2020 (from 30/04/2020) 20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)
		Claire Campbell	Claire Campbell	9.5 Provide evidence to NHSE/I	31/09/2020		9.5 Outcome evidence	4- Likely	08/06/20 - 4 month extension to deadline due to COVID-19. 12/02/2020 See action 9.1- date for completion changed to 31/05/2020 (from 30/04/2020) 20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)

No	Concern: Trustwide Quality "Should" actions Undertakings Section 5	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
10	The trust should consider the structure, management and oversight arrangements for its quality improvement function	Matthew Metcalfe	Phil Bradley	10.1 Collective transformation resource reviewed	01/04/2020	03/12/2019	10.1 Completed review 10.1 New organogram for QI resource	4- Likely	18/12/2019 Transformation Resource paper to be presented at Finance and Performance meeting 19/12/2019 Completed
		Matthew Metcalfe	Phil Bradley	10.2 Recommendations of review to be presented to Trust Board	01/04/2020	19/12/2019	10.2 Completed review	4- Likely	13/01/2020 Discussed and recommendations approved at Dec 2019 Finance and Performance meeting (Committee of Board)

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
11	The trust should continue to engage all its partners in operational and strategic decision making	Chris Pallot	Chris Pallot	11.1 To publish the new strategy and retain evidence of consultation with partners.	01/11/2019	01/11/2019	11.1 New strategy 11.1 Responses from partners	5- Almost certain	13/01/2020 Strategy includes how partners were consulted and input used Completed
		Chris Pallot	Chris Pallot	11.2 Continue to engage partners in large scale strategic changes	01/11/2019	01/11/2019	11.2 Examples of work with partners	5- Almost certain	13/01/2020 Evidence of completion added in- Examples of work with partners Completed and remains ongoing

		Chris Pallot	Chris Pallot	11.3 Continue to engage partners in strategic operational issues and decision making	01/11/2019	01/11/2019	11.3 Examples of work with partners	5- Almost certain	13/01/2020 Evidence of completion added in- Examples of work with partners Completed and remains ongoing

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
12	The trust should take steps to assure itself that the interventions in progress to address bullying and poor behaviour are having an impact at pace	Mark Smith	Bronwen Curtis	12.1 Review impact of current programme	31/10/2019	31/10/2019	12.1 Summer of engagement feedback	5 - Almost certain	Completed. Feedback responded to from staff in the People's Plan
		Mark Smith	Bronwen Curtis	12.2 Targeted interventions in 'hotspots'	31/12/2019	31/12/2019	12.2 Example of targeted intervention work in 'hotspot' area	4 - Likely	06/01/2020 Freedom to Speak Up/HR/OD linkage created. Targeted interventions plans are in place or being progressed for 'hotspot' areas (Oncology, Cardiology and Maternity) Evidence of completion changed from Staff Survey 2020 to Example of targeted intervention work in 'hotspot' area
		Mark Smith	Bronwen Curtis	12.3 Incorporate 'Civility Saves Lives' into Respect and Support programme	30/06/2020	08/06/2020	12.3 Staff survey 2020	4 - Likely	16/06/20 - no staff survey 2020 as cancelled deu to covid 08/06/20 - 3 month extension to deadline due to COVID-19. 8/6/20 - BC reports action now completed, awaiting evidence. 09/03/2020 Action owner confirm action complete subject to exec sign off next week. To amend deadline from 29/02/2020 to 31/03/2020. Refocus of respect and support approach complete. New programme incorporating Civility Saves Lives, GMC Professional Standards and previous Respect and Support campaign agreed ready for rollout Executive sign off planned for 17/03/20 06/02/2020 Two pilots run in Oncology 06/01/2020 Piloting GMC professional standards in January 2020 to incorporate Civility Saves Lives for roll out from February 2020. Completion date changed from 31/12/2019 to 29/02/2020

No	Concern: Trustwide Quality "Should" actions Undertakings Section 2	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
13	The trust should consider commissioning a more detailed analysis of the drivers of its deficit to inform those elements that are within its gift to be able to address both directly and indirectly	Phil Bradley	Bola Agboola	13.1 Work with NHSE/I to agree process to complete this (using their expertise and knowledge)	01/07/2020	13/07/2020	13.1 Copy of agreed process	3 - Possible	13/07/2020 - The STP engaged Deloitte to carry out a review of the underlying deficit position and the report agrees with the Trust underlying deficit position. The current COVID block funding regime also means that some of the underlying tariff underfunding will now be addressed. Therefore feel this recommendation is closed. 08/06/20 - 3 month extension to deadline due to COVID-19. 04/03/2020 Working with systems colleagues a review into the drivers of the deficit is to be commissioned during march 2020 and completed in May 2020. 12/02/2020 This is superseded by the issued financial improvement

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
14	The trust has plans to introduce an electronic solution between the human resources function and payroll to seek to address the issue of staff overpayments. The trust should consider requesting an internal audit function review of the planned electronic solution, in order that any control weaknesses can quickly be identified and addressed.	Mark Smith	Adam Cragg	14.1 Request an internal audit review and address weaknesses	01/09/2020		14.1 Internal audit report and action plan	4 - Likely	17/07/2020 - 2 months extension agreed for the adult due to covid. 08/06/20 - 3 month extension to deadline due to COVID-19. 05/06/2020 - There has been no change to this since last updated. It is ready to implement however awaiting confirmation of the IT functionality. 09/03/2020 Remain on track for completion date 13/02/2020 Electronic solution designed and process agreed Await confirmation of functionality before implementation

No	Concern: Urgent and Emergency Services Quality "Should" actions	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
		Deborah Needham	Tristan Dyer/ Head of Estates	15.1 Set up working group to establish with Paediatrics and Estates to review the current working practices that our Paediatric area has to meet these standards.	30/08/2020		15.1 Minutes from Working Group	5- Almost certain	16/07/2020Senior Medical & Nursing team from ED and Paediatrics have regular meetings in last 3 years , which happens usually once in 3-4 months , to discuss the referral pathways and any issues if causing problems in transfer of care. They have been working together with better communication and support to each other. The last meeting was on June 2020. After the Covid, ED has proposed referral pathways of children to PAU to Paediatrics to share the workload equally between the teams and to work along with the infection Control policy. They are waiting for the outcome from Paediatrics, hopefully in next 2 weeks. - 10/7/20 - Tony O'Donovan reports there are plans being drawn up for Quinton to be adapted to take the Paediatric ED. There are some layout issues which need to be resolved as well as funding for the changes if this is given the go ahead. 11/06/20 Area identified adjacent to AE. As part of covid reset plans being developed (Quinton ward). Origional plans now ceased due to covid and social distancing measures being put into place. 08/06/20 - 5 month extension to deadline due to COVID-19. 06/03/2020 The space that had been initially identified has been assessed as unsuitable and therefore other options are now being considered. The space has been identified and plans are being worked up by estates. The urgency of developing these plans has been discussed at the Trust estate meeting which is chaired by the COO. We are expecting plans to be

15	**Undertakings Section 4** The service should continue to re-assess the layout of the paediatric emergency department to ensure it meets the Children and Young People in Emergency Care Settings 2012 standards	Deborah Needham	Tristan Dyer/ Head of Estates	15.2 Develop options paper looking at expanding or relocating the department. Seek potential options for capital funding.	30/08/2020		15.2 Options paper	5- Almost certain	10/7/20 - Tony O'Donovan reports there are plans being drawn up for Quinton to be adapted to take the Paediatric ED. There are some layout issues which need to be resolved as well as funding for the changes if this is given the go ahead. 11/06/20 Plans being progressed 08/06/20 - 5 month extension to deadline due to COVID-19. 06/03/2020 The space that had been initially identified has been assessed as unsuitable and therefore other options are now being considered. The space has been identified and plans are being worked up by estates. The urgency of developing these plans has been discussed at the Trust estate meeting which is chaired by the COO. We are expecting plans to be available in the next 4 weeks to enable a further discussion 10/02/2020 See action 15.1 09/01/2020 See update for action 15.1. Change of completion/ review date to March 2020 (from 31/12/2019) 04/12/2019 Update from S.Finn Initial long term, high level plans have been produced but funding has not been identified to allow the scheme to progress at this time. A short term solution has been identified and is currently being costed. A paper will be presented to ET for approval in Jan 20
		Deborah Needham	Tristan Dyer/ Head of Estates	15.3 Complete works to change the department	31/12/2020		15.3 Completion of works	2 - Unlikely	10/7/20 - Tony O'Donovan reports there are plans being drawn up for Quinton to be adapted to take the Paediatric ED. There are some layout issues which need to be resolved as well as funding for the changes if this is given the go ahead. 11/06/20 Linked with 15.1 08/06/20 - 9 month extension to deadline due to COVID-19. 10/02/2020 See action 15.1
		Deborah Needham	Tristan Dyer/ Owen Cooper	15.4 Review pathways for use of PAU and increased activity	31/12/2019	31/12/2019	15.4 PAU pathways reviewed and evidence of improved patient flow.	4- Likely	16/07/2020 - wording for evidence required changed from increased activity to improved patient flow to reflect reflect the excellent work that is on-going via our liaison with the Paediatricians to make sure that the right patients are going as rapidly as possible to PAU/the ward. 09/03/2020 Remains outstanding due to annual leave 14/02/2020 SB liaise with DN PA to try and resolve issues around closure of action 29/01/2020 Evidence of compliance provided - concerns raised by TD. SB email DN for confirmation of sign off 09/01/2020 Email from D.Needham. Pathways from A&E to PAU in place.
16	**Undertakings Section 4** The service should make arrangements so patient group directions are regularly checked and updated on the trust internal website	Matthew Metcalfe	Karin Start	16.1 This action is included within the Medicines Optimisation action plan (part of the Medicines Optimisation Strategy 2016- 2020).	31/12/2019	20/12/2019	16.1 Action plan 16.2 Most recent report taken to CQEG	4- Likely	20/12/2019 Further supporting evidence added in. Action complete 18/12/2019 Supporting evidence added re amendments to PGD process
		Matthew Metcalfe	Karin Start	16.2 Include process in revised Medicines Management Policy	30/07/2020		16.2 Revised Medicines Management Policy	5- Almost certain	08/06/20 - 4 month extension to deadline due to COVID-19. 07/02/2020 Process for PGDs will be included in review of Medicines Management Policy (due for update March 2020). Once policy approved, Pharmacy will audit against it and will add to 20/21 Medicines Optimisation Plan 18/12/2019 Supporting evidence added re amendments to PGD process 05/12/2019 Action changed to 'Include process in revised Medicines Management Policy'. Date revised to 31/03/2020 (from 31/12/2019) Previous action was 'See also entry for action 1
17	**Undertakings Section 4** The service should take action so medical staff are compliant with the trust target for safeguarding children level three training	Mark Smith	Tristan Dyer	17.1 Mandatory training compliance of all staff groups is reviewed at every Urgent Care Governance meeting	29/02/2020	12/02/2020	17.1 Governance report and governance meeting minutes	4 - Likely	12/02/2020 Data is included in monthly governance reports and discussed in more detail where required. Training data is also emailed monthly by Training and Development to key leads in the directorate. 13/01/2020 Compliance Governance Manager review plan. No current update available at time of writing report. Extend date of completion by 1 month to 29/02/2020 (from 31/12/2019). Compliance team will raise at Urgent Care Governance meeting on 16/01/2020 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
		Mark Smith	Tristan Dyer	17.2 Clinical Director for Urgent Care will remind all medical staff of their need to complete the training	29/02/2020	29/01/2020	17.2 Email sent to medical staff	4 - Likely	29/01/2020 E-mail from TD confirming medical staff are reminded to complete mandatory training. Action closed. 13/01/2020 Compliance Governance Manager review plan. No current update available at time of writing report. Extend date of completion by 1 month to 29/02/2020 (from 31/12/2019). Compliance team will raise at Urgent Care Governance meeting on 16/01/2020 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
		Mark Smith	Tristan Dyer	17.3 The Safeguarding Team provide regular updates of who needs to completed training and this will be monitored for medical staff who are not completing the training and are repeatedly on the list	01/08/2020		17.3 Training information over 3 months and identification of medical staff on the list more than once	4 - Likely	14/07/20 - 1 month evidence received for those needing to do training. 08/06/20 - 4 month extension to deadline due to COVID-19. 09/03/2020 Plan to achieve by deadline date 13/02/2020 Joint working between QI and L&D to identify non-compliance. Currently working with safeguarding to ensure availability of training 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
		Deborah Needham	Claire Dannatt	18.1 Implement winter actions	31/12/2019	31/12/2019	18.1 Winter action plan 18.1 Board paper in relation to winter plan	5- Almost certain	01/02/2020 Evidence of completion provided. Action closed down. 28/01/2020 Evidence of completion confirmed as Winter action plan and paper to Board. Winter action plan needed as evidence (will be sent over 30/01/2020 post progress meeting today) 09/01/2020 Email from D. Needham. In progress- ET updated weekly. Evidence of completion required, Action completed
		Deborah Needham	Deborah Needham	18.2 Appoint PMO lead for Urgent Care and Winter	12/11/2019	12/11/2019	18.2 PMO lead identified and commenced	5- Almost certain	Completed

18	Undertakings Section 1 The service should take action to improve the median time from arrival to treatment	Deborah Needham	Deborah Needham	18.3 Review Heat activity 18.3 Re-define programme 18.3 Re-launch	30/07/2020		18.3 Agreement of workstreams	5- Almost certain	11/06/20 - All transformation ceased in light of covid. New discharge plan as part of Reset being planned additional work taking place with external partners. 08/06/20 - 4 month extension to deadline due to COVID-19. 10/03/2020 Dep COO request extension for one month so COO can advise current position. Date for completion changed from 29/02/2020 to 31/03/2020 10/02/2020 New workstreams agreed and being led by COO/MD/DofN 29/01/2020 Evidence of completion confirmed as Agreement of workstreams 09/01/2020 Email from D. Needham. Meeting planned for PMO, DofN, Med Dir and COO to relaunch. Winter actions taken priority. Completion
		Deborah Needham	Deborah Needham	18.4 Rapid improvement project with IDT	09/12/2019 (and ongoing)	09/12/2019	18.4 Time to PDNA reduced	4 - Likely	05/02/2020 Evidence provided. Time to PDNA currently monitored via SPA. Project in progress to utilise real time data from IBox. Trust has implemented an internal PDNA Hub. 03/02/2020 SB link with relevant leads to source evidence 09/01/2020 Email from D.Needham. Action is completed. Evidence of completion required

No	Concern: Medical Care Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
19	The service should check medical staff are up to date with mandatory, safeguarding and mental capacity training	Mark Smith	Sally Shocklidge/ Becky Samson	19.1 Use of Netconsent software to check and force compliance	01/07/2020	09/06/2020	19.1 Information provided on Netconsent	4 - Likely	17/07/2020 - Netconsent does not cover all training (only IG and policy management-we are working on self service but this will not force compliance so no further action possible at this time. 29/06/2020 - 19.1 is about Net Consent, which is in place and is able to [illegible] training records
		Mark Smith	Sally Shocklidge/ Becky Samson	19.2 Provide additional sessions of 'bundles' of mandatory training for trust grade staff	01/07/2020	16/07/2020	19.2 Dates training bundle provided and attendance records	4 - Likely	29/06/2020 - 19.2 prior to covid-19 cluster days were being run and dates had been issued for the year. All staff including trust grade staff could attend these. It states this in the progress as completed. 09/06/2020 - SS e-mailed for new deadline estimate. 08/06/20 - 3 month extension to deadline due to COVID-19. 09/03/2020 Plan to achieve by deadline date
20	The service should check catering staff are following infection prevention and control protocols	Stuart Finn	Wendy Foster/ Brian Willet	20.1 Induction training for new starters	30/04/2020	06//01/2020	20.1 Induction training	5- Almost certain	23/01/2020 Evidence of completion provided. 06/01/2020 Email from S.Finn. IPC mandatory training and bespoke food hygiene induction training is in place for all new starters and existing staff. Action completed. Evidence of completion required 04/12/2019 Catering and IPC meeting held 29 Nov 19 to discuss and agree actions. Documentation including HASAP (Hazard and Critical Control Process) has been shared with IPC who are reviewing. Next meeting to be arranged in Jan 20
		Stuart Finn	Wendy Foster/ Brian Willet	20.2 Infection Prevention representation at Catering Meetings regarding PPE	30/04/2020	06/01/2020	20.2 Meeting minutes	5- Almost certain	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn PPE is issued to all food handlers/production staff. Ward hostesses uniforms are issued and protective aprons and gloves available. Staff are trained in food hygiene procedures which include PPE. Staff records evidence training and issue of PPE. Action completed. Evidence of completion required. 04/12/2019 As above
		Stuart Finn	Wendy Foster/ Brian Willet	20.3 Infection Prevention Mandatory training - 3 yearly for non-clinical staff	30/04/2020	06/01/2020	20.3 See 20.1	5- Almost certain	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required. 04/12/2019 This is in place for all catering staff and monitored via mandatory training results and at appraisals. Every 'food handler' also complete 'Food Hygiene' course
		Stuart Finn	Wendy Foster/ Brian Willet	20.4 Environment audits and Catering audits are carried out when infection is identified	30/04/2020	06/01/2020	20.4 Audits/ report and meeting minutes where presented	5- Almost certain	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn. Audits and inspections are in place and carried out regularly. Post infection audits and inspections are carried out by IPC and include ward kitchens. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required 04/12/2019 IPC have been asked to comment

		Stuart Finn	Wendy Foster/ Brian Willet	20.5 Domestic monthly cleaning audits include host/hostess staff - hand hygiene etc observed	30/04/2020	06/01/2020	20.5 Audits/ report and meeting minutes where presented	5- Almost certain	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required. 04/12/2019 This is in place as part of the cleaning audits. The ward kitchens are scored separately as part of the audit and include the ward host/hostess
		Stuart Finn	Wendy Foster/ Brian Willet	20.6 A review of catering procedures and working practices will be carried out by Infection control and the Catering management team	30/04/2020	10/03/2020	20.6 Completed review	5- Almost certain	10/03/2020 This action has been completed. W. Foster has written to A. Head to confirm that the procedures have been reviewed and are suitable and in place. A. Head will provide copy of the email as evidence on return form leave 16/03/20 23/01/2020 Email from W Foster. Dates being organised between IPC and Hotel Services 06/01/2020 Email from S.Finn. BW arranging follow-up meeting with IPC. 04/12/2019 Catering and IPC meeting held 29 Nov 19 to discuss and agree actions. Documentation including HASAP (Hazard and Critical Control Process) has been shared with IPC who are reviewing. Next meeting to be arranged in Jan 20
21	The service should keep all confidential patient records securely	Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.1 The Trust have invested in lockable trollies in order to store patient records securely	30/09/2019	30/09/2019	21.1 Confirmation email from Senior member of Nursing team	5- Almost certain	Completed
		Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.2 Lockable cupboards are available for the safe storage of patient records	30/09/2019	30/09/2019	21.2 Confirmation email from Senior member of Nursing team	5- Almost certain	Completed
		Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.3 Annual Information Governance mandatory training for all staff	31/12/2019	05/12/2019	21.3 Relevant section from Data Protection Toolkit submission	5- Almost certain	09/06/20 This requirement has been completed, and the DSP toolkit assertion has been submitted .3/01/2020 Further email confirmation of the below received 05/12/2019 Completed As part of the Data Security and Protection Tool kit, the trust met the 95% Mandatory Information Governance training requirement for 2019 and are working towards this requirement in time for the March 2020 submission
		Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.4 Data Quality, Security and Protection team to complete spot audits of compliance on wards and departments (Oct 2019 and March 2020). Findings to be shared at Assurance, Risk and Compliance meeting)	01/08/2020	17/07/2020	21.4 Data Protection Audit results	5- Almost certain	16.07.2020 - shared the findings with the DGG and also confirmed it in the minutes for ARC this month . Awaiting evidence. 09/06/20 In total, 29 wards have been audited by the DQSP team with a set of 26 questions asked to give assurance of IG compliance. The findings were due to be reported to the DGG but these have been postponed due to COVID, the next DGG is in June and this will be presented then. 09/06/2020 - SS e-mailed for new deadline estimate. 08/06/20 - 4 month extension to deadline due to COVID-19. 09/03/2020 Verbal update from Dep DofN Waiting for outcome of further audit to be completed March 2020 13/02/2020 High level findings from Oct 2019 DSP audit shared at ARC 13/02/2020. A number of screensavers have been issued as result of findings from spot audits. Acceptable Use Policy also being updated and taken to February 2020 PGD meeting. 14/01/2020 Action amended to read Data Quality, Security and Protection team to complete ...... Date of audit completed changed to Oct 2019 Evidence provided for audit completed Oct 2019. Results discussed at Data Governance Group. 05/12/2019 On Track - Spot audits of 12 wards have been carried out so far this financial year. The findings are to be published at the next Data Governance Group Meeting which feeds into the Assurance Risk and
		Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.5 Assessment & Accreditation will incorporate criteria regarding the safe storage of health records.	01/04/2020	09/03/2020	21.5 Relevant Assessment and Accreditation document	5- Almost certain	04/06/20 - Assessment & Accreditation will incorporate criteria regarding the safe storage of health records – in regards to this action the A&A programme has been placed on 'hold' due to Covid19 and will not be recommenced in its same format for a number of months. However, the new wording is in place and we are looking at ways to self/peer assess clinical areas to enable A& A to recommence in the next couple of months. 09/03/2020 Email from Dep DofN to reword action. Wording changed to Assessment & Accreditation will incorporate criteria regarding the safe storage of health records (from All areas need to demonstrate compliance as part of the Ward Accreditation Assessment). Due to inability to achieve current action as A&A timetable is dependent on the outcome of the wards previous assessment, i.e. as ward may not be required to have an assessment for 6 months. 12/02/2020 All evidence provided waiting confirmation of closure from action owners 07/01/2020 Evidence of related documents used for Assessment and Accreditation provided 05/12/2019
		Matthew Metcalfe	Michelle Metcalfe	22.1 LocSSIP documents reviewed and updated	29/02/2020	18/02/2020	22.1 Completed documents	5- Almost certain	03/03/2020 Policy discussed and approved at Feb 2020 PDG meeting. Minor changes needed then will be uploaded to intranet. Final version required for evidence of completion. 05/02/2020 LocSSIPs policy is going to PDG in February 2020. Date for completion changed to 29/02/2020 (from 01/02/2020) 05/12/2019 Date changed from 01/01/2020 to 01/02/2020 due to current progress with workstream

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22	The service should introduce local procedures for invasive procedures in non-theatre settings	Matthew Metcalfe	Michelle Metcalfe	22.2 Relaunch of LocSSIPs - training and comms	30/09/2020		22.2 Education/ Comms provided and timelines	4 - Likely	08/06/20 - 3 month extension to deadline due to COVID-19. 05/02/2020 Existing LocSSIPs being updated to new Trust format. Education being provided to teams as these are updated 31/12/2019 Email from Mi.Metcalfe. Work programme has increased. New Clinical Lead for this. Plan to revise the template for the Trust and do base line audit of documents in existence and staff awareness. Re-launch planned for June 2020. Completion date changed to 30/06/2020 (from 01/05/2020) 05/12/2019 Date changed from 01/04/2020 to 01/05/2020 due to progress with action 22.2
		Matthew Metcalfe	Michelle Metcalfe	22.3 Audit of compliance	31/01/2021		22.3 Audit forward programme and outcome of audit	4 - Likely	08/06/20 - 3 month extension to deadline due to COVID-19. 31/12/2019 See comment for 22.2. Completion date changed to 31/10/2020 (from 01/09/2020) 05/12/2019 Date changed from 01/08/2020 to 01/09/2020 due to progress with action 22.1
23	The service should manage medical outliers so they are seen in a timely manner	Deborah Needham	Divisional Director for Medicine	23.1 Inpatients cared for on outlying wards have a designated medical team to review patients. This is monitored and audited twice weekly by reviewing the medical plans in the patient's medical records	29/02/2020	10/02/2020	23.1 Twice weekly audits	5- Almost certain	10/02/2020 Completed and in place. Evidence of completion required. 06/01/2020 Email from D. Needham. Each outlying ward has nominated consultant. Audits completed within the division by the management team. Date of completion amended to 29/02/2020 (from 31/12/2019). Not yet signed off by exec lead. 31/12/2019 Review date of 31/12/2019
		Deborah Needham	Divisional Director for Medicine	23.2 Ward staff escalate any issues regarding medical reviews at the x3 daily Site meetings.	31/10/2019	31/10/2019	23.2 What's app messages	5- Almost certain	28/01/2020 D Needham advise evidence of completion can change to What's App messages 23/01/2020 Example Daily Safety Sheet notes provided for Oct 19, Dec 19 and Jan 20. Site Team to provide relevant Whats App messages as well. This is the format of notes from meeting. 13/01/2020 Evidence of completion required Completed and ongoing review quarterly .
		Deborah Needham	Divisional Director for Medicine	23.3 Number of medical outliers to be communicated daily via Sitrep (Whats app)	31/10/2019	31/10/2019	23.3 Examples of Sitrep communications	5- Almost certain	23/01/2020 Evidence provided of example x6 daily Trust position- Sitrep. Recent change to now include medical outliers in this as well as info going out via Whats app. Also sample What's app message 13/01/2020 Evidence of completion required Completed and ongoing review quarterly
24	The service should consider how it manages private and NHS patients for cardiology procedures to ensure equity of access	Matthew Metcalfe	Mary Visser	24.1 East Midlands Clinical Senate review completed August 2019- Terms of reference included private practise arrangements	31/08/2019	31/08/2019	24.1 Completed report	5- Almost certain	Completed
		Matthew Metcalfe	Mary Visser	24.2 Action plan developed linking multiple reports/ workstreams in Cardiology	13/09/2020		24.2 Action plan	5- Almost certain	15/06/2020 - E-mail reply from MV - Can you please extend it a further three months to allow us to work through reset and then we may have already addressed some of these actions? 09/06/20 - Mary Visser e-mailed for update 08/06/20 - 3 month extension to deadline due to COVID-19. 10/03/2020 Key leads involved in workstream met for handover. Cross referencing with recommendations from national audits etc has been done against Senate recommendations. Dir manager to met with clinical lead to progress next steps. 03/03/2020 Associate medical director request an update on progress. SB will be completed by deadline of 13/03/2020 12/02/2020 Some delays in collating information. Completion date changed to 13/03/2020 (from 16/02/2020) 13/01/2020 Compliance Governance Manager involved in this workstream. Meeting planned for 07/01/2020 (cancel due to Trust pressures) rebooked for 16/01/2020. Progress has also been made with using this approach in Breast- method can now be transferred to Cardiology. Completion date changed from 31/12/2019 to 16/02/2020. 18/12/2019 Action plan in place to address concerns from Senate visit. Meeting held 17/12/2019 to identify relevant reports for Cardiology- further meeting planned 07/01/2020
25	The service should review clinical guidelines to check they are current	Matthew Metcalfe	Caroline Corkerry	25.1 Netconsent to ensure guidelines reviewed in line with policy	01/07/2020	09/06/2020	25.1 Sample of reminders sent out using Netconsent	3 - Possible	13/07/202- In addition to NetConsent and PDG , the Divisions track their policies/ procedural documents on a monthly basis and report through CQEG to the Medical DIrector. Any areas of concern are escalated to QGC. There are Reports to CQEG that demonstrate this. Following doscussion with the Meidcal Director it is felt that there are robust process in place to support the updating of existing documents and development of new documents . Therefore this action can close. 09/06/20- Net Consent has been amended to send reminders out to all authors 6mths ahead of when their policy is due for updating to allow sufficient time for the documents to be reviewed and updated Awaiting evidence of sample reminders. 09/06/20 - CC e-mailed for deadline date update. 08/06/20 - 3 month extension to deadline due to COVID-19. 03/06/20- Net Consent has been amended to send reminders out to all authors 6mths ahead of when their policy is due for updating to allow sufficient time for the documents to be reviewed and updated. 03/03/2020- Procedural Document Group meet monthly and overdue document list is brought to the meeting to gain support from attendees to address any overdue documents within the sphere of control. Net Consent continues to send reminders to document authors in advance of the expiry

		Matthew Metcalfe	Caroline Corkerry	25.2 Use of PDG report to show reduction in overdue guidelines	01/07/2020	09/06/2020	25.2 PDG reports	4- Likely	09/06/20 Regular reports provided and monthly report presented to PDG with current positon of documents . PDG reports evidence received. 09/06/20 - CC e-mailed for deadline date update. 08/06/20 - 3 month extension to deadline due to COVID-19. 04/06/20 Regular reports provided and monthly report presented to PDG with current positon of documents 03/03/2020- PDG continues to submit reports to CQEG in relation to the documents that have been approved and those that are overdue. This is a long term action, including rationalisation of procedural documents. 10/02/2020 Monthly report provided to CQEG which demonstrates the progress in reducing the number of overdue documents. This will be a long term action.
26	The service should consider reviewing storage and security of substances subject to control of substance hazardous to health (COSHH)	Sheran Oke	Fiona Barnes	26.1 All storage areas reviewed during core service inspection and security risks removed	30/06/2019	30/06/2019	26.1 Senior staff visited areas and ensured door codes removed 26.1 Spot audit of compliance to be completed by Health and Safety team late November 2019	5- Almost certain	08/01/2020 Email from F. Barnes. DofN complete further spot check on door codes before Christmas (late evening and night shift). None found. Completed (spot audit to review ongoing compliance planned late November 2019)
27	The service should consider reviewing environment and facilities for inpatient outliers staying on the Heart Centre	Debbie Needham	Fay Gordon	27.1 Complete review of Heart Centre environment and facilities	31/03/2020	09/01/2020	27.1 Completed review	4- Likely	29/01/2020 Evidence of completion provided. Escalation documents taken from the Weekend Plan in relation to use of Heart Centre for outliers 09/01/2020 Email from D.Needham. Undertaken as part of escalation areas review previously. Action completed. Evidence of completion required.
28	The service should consider addressing cultural issues across some medical wards	Mark Smith	Bronwen Curtis	Covered within action 12	31/12/2019	31/12/2019	See action 12	See action 12	Covered within action 12
29	The stroke services to consider improving compliance with completion of VTE assessments	Matthew Metcalfe	Amanda Bisset	29.1 To monitor stroke service VTE compliance via thrombosis committee and implement actions if compliance has not improved	30/07/2020		29.1 Copy of meeting minutes and associated actions (if relevant)	4- Likely	08/06/20 - 4 month extension to deadline due to COVID-19. 10/02/2020 Action owner confirmed data is captured by ward. Will provide for relevant wards related to stroke service.

No	Concern: Maternity Services Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
30	The service should ensure women can access the service when they need it and receive the right care promptly and that waiting times from referral to treatment and arrangements to admit, treat and discharge women are in line with national standards	Sheran Oke	Sue Lloyd / Trish Ryan	30.1 Continue monitoring access to maternity services by 10+0 weeks and 12+6 weeks	31/10/2019	31/10/2019	30.1 Maternity Dashboard 30.1 Minutes of Directorate Governance Meetings	5- Almost certain	Completed
		Sheran Oke	Sue Lloyd / Trish Ryan	30.2 Monitor access to scan appointment within 72 hours for women with reduced/static growth	30/11/2019	30/11/2019	30.2 Datix Incidents / Trends 30.2 Minutes of Maternity Risk Group Meeting / Directorate Governance Group Meeting	5- Almost certain	Completed Currently monitoring is in place, to be added to dashboard as from December
		Sheran Oke	Sue Lloyd / Trish Ryan	30.3 Review midwifery ultrasonography scan clinics to ensure adequate capacity	31/12/2019	31/12/2019	30.3 Service review presented to the Directorate Management Board	5- Almost certain	06/01/2020 Email from DofN to confirm completed. Evidence provided. 05/12/2019 MDU midwife currently completing QI project reviewing demand to baseline match capacity developing a better triage system
		Sheran Oke	Sue Lloyd / Trish Ryan	30.4 MESC bid for ultrasound machine for Labour Ward to prevent overnight referrals to MDU / Midwife Scan clinics	30/07/2020		30.4 Completed bid.	4- Likely	16/07/2020 -we are still awaiting response regarding whether bid for US machine successful 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Awaiting bid outcome, continue to monitor waiting times and report 72 hour breeches to governance 11/02/2020 Awaiting outcome 08/01/2020 Continue to await feedback on bid
		Sheran Oke	Sue Lloyd / Trish Ryan	30.5 Seek further funding / training for more midwives to be trained in 3rd Trimester scanning	31/03/2020	06/01/2020	30.5 Additional training places available for midwives	4- Likely	06/01/2020 No requirement at present to train additional midwives. As per 30.3 - 2 midwives will complete training in April 2020. Funding currently available via HEE if situation changes - next course September 2020. Action completed. 05/12/2019 Two midwives have to date commenced the training scanning programme. Funding currently available via HEE. Currently exploring how places can be accessed going forward as next programme is Sept 20
		Sheran Oke	Sue Lloyd / Trish Ryan	30.6 Monitor Triage waiting times on Maternity Dashboard – monthly report to Directorate / Divisional Governance Group.	31/10/2019	31/10/2019	30.6 Maternity Dashboard 30.6 Minutes of Directorate/Divisional Governance Group	5- Almost certain	Completed (see evidence for 30.2)
		Sheran Oke	Sue Lloyd / Trish Ryan	30.7 Business case to reconfigure Labour Ward which will make a dedicated Triage area and provide easier access to obstetric care. It will also reduce attendances / waiting times on the Maternity Day Unit.	30/07/2020	17/07/2020	30.7 Completed business case	3 - Possible	16/07/2020 - Business case for triage not supported. Will continue to raise safety issues. Discussed at maternity safety champions meeting and business case was not supported due to mitigation. 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Continue to monitor triage waiting times, these are poor, triage on MDU is an issue, 19% had first assessment within 15 mins (Jan' 20) Support for business case will address concern 11/02/2020 Executive Team support case- Options currently being developed by Facilities 05/12/2019

31	The service should formally monitor delayed discharges and how frequently induction of labours or elective caesarean sections are delayed (or cancelled) so the service can analyse and monitor trends to inform future plans	Sheran Oke	Trish Ryan	31.1 Develop audit proforma for delayed/cancelled IOL and elective caesarean sections	01/08/2020		31.1 Audit proforma	5- Almost certain	08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Audit proforma is being used, sections are now datixed and are reported on the huddle sheets. Figures to be reported as below 13/02/2020 Cancelled electives being monitored through Datix and IOL though audit . Figures to be included in Risk Management report and Clinical effectiveness report and escalated as appropriate 06/01/2020 Audit proforma developed and circulated to all staff - December 2019 Every induction to be audited as well as cancelled electives, To continue and feedback through Divisional Governance meetings 05/12/2019 Supported by snapshot audit, every induction audited as well as cancelled electives, To continue and feedback through Divisional Governance meetings
		Sheran Oke	Trish Ryan	31.2 Reasons for delayed discharges discussed and documented at the Maternity Safety Huddle	01/08/2020		31.2 Maternity Safety Huddle sheets	5- Almost certain	08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 As per 31.1. Audit proforma being used 13/02/2020 Maternity huddle sheets being used daily and well embedded in service 05/12/2019 This is currently under development and on track to deliver by stated
		Sheran Oke	Trish Ryan	31.3 Monthly report to Directorate Governance Group and Divisional Governance Group	01/08/2020		31.3 Monthly reports / Minutes of Directorate / Divisional Governance Group	5- Almost certain	08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Results of Feb 2020 audit will be presented at March 2020 Maternity governance meeting 13/02/2020 Monitoring and reporting as outlined and concerns escalated as needed 05/12/2019 To commence Feb 2020
		Sheran Oke	Trish Ryan	31.4 Business case for pharmacy support to assist with delayed discharges for take home medications	01/08/2020		31.4 Approved business case	3 - Possible	08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Pharmacy post out to advert 11/02/2020 Please refer to 2.5 06/01/2020 Business case supported and recruitment underway 05/12/2019 Please refer to No.2.5 Business case has been completed and due for submission in Dec 19
32	The service should ensure managers are planning the service for the long term. For example, to enable planning and organisation of services so they met the needs of the local population within the local expected population growth	Sheran Oke	Sue Lloyd	32.1 Develop Long Term Plan in conjunction with the Local Maternity System	01/04/2020	01/03/2020	32.1 Long Term Plan submitted to NHSE/I	5- Almost certain	01/03/2020 Action completed. Discussed at strategy meeting- 5 year LMS plan has been submitted 13/02/2020 Feedback still awaited 05/12/2019 Long Term Plan developed, awaiting feedback
		Sheran Oke	Sue Lloyd	32. 2 Develop integrated Business Plan for Maternity Services	01/04/2020	06/01/2020	32.2 Integrated Business Plan	5- Almost certain	06/01/2020 Email from DofN to confirm action completed. 05/12/2019 Plan has been developed and has been presented to the Divisional Team meeting
		Sheran Oke	Sue Lloyd	32.3 Engagement in East Midlands Clinical Network as well as other Regional / National events and meetings	01/08/2020	16/07/2020	32.3 Minutes from Network meetings	5- Almost certain	16/07/2020 – East Midlands Network meetings have always been well attended and this continues. We ensure representation at the board meetings and smaller breakout and subspecialty meetings, awaiting evidence. 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Service attends relevant events. Evidence to follow. 13/02/2020 The service continue to engage and be involved in these events
		Sheran Oke	Sue Lloyd	32.4 Monthly report to Divisional Management Board on forecasted activity based on bookings	01/08/2020	16/07/2020	32.4 Reports and minutes of Divisional Management Board meetings	5- Almost certain	16/07/2020 - projected figures are now included in the divisional reports – May 2020 governance report evidenced. 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Updated evidence provided of meeting reports 13/02/2020 Work is ongoing
		Sheran Oke	Sue Lloyd	32.5 Business case to be submitted to reconfigure Sturtridge Labour Ward – non clinical rooms changed into clinical rooms, dedicated Triage area consisting of 4 rooms which could be used as further birthing rooms at times of high activity	01/08/2020	17/07/2020	32.5 Business Case submitted in line with trust process	3/4 (outcome dependent)	16/07/2020 – business cases not supported for maternity triage or increased midwifery staffing due to mitigation. 08/06/20 - 4 month extension to deadline due to COVID-19 01/03/2020 Executive Team support case- options awaited from Facilities 11/2/20 Executive Team support case– Options currently being developed by Facilities 05/12/2019 Business case submitted awaiting outcome
		Sheran Oke	Sue Lloyd	32.6 Business case to be submitted for midwifery staffing to be submitted to ensure sufficient staff are available for the higher level of activity / acuity forecast.	01/08/2020	17/07/2020	32.6 Business case submitted in line with trust process	5 (outcome dependent 4)	16/07/2020 – business cases not supported for maternity triage or increased midwifery staffing due to mitigation. 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Continue to await outcome for submitted business case 11/02/2020 Business case submitted awaiting outcome 05/12/2019 Safe staffing review using Birthrate plus - Business case submitted awaiting outcome
		Sheran Oke	Sue Lloyd	32.7 Ensure sufficient midwifery staff in post to meet the Continuity of Carer agenda as per Better Births	01/08/2020	17/07/2020	32.7 Minutes of the Maternity Safety Champions Meetings	5- Almost certain	16/07/2020 – business cases not supported for maternity triage or increased midwifery staffing due to mitigation. 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Linked with action 32.6 11/02/2020 – Discussed at Maternity Safety Champions meeting, minuted. Business case for additional staff submitted awaiting outcome 05/12/2019 Safety champions meetings occur bi monthly, all discussion minuted

No	Concern: Use of resources 'Should' Actions	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments

33	**Undertakings Section 4** The NHS trust should continue working to ensure optimisation of its substantive medical workforce and reduce reliance on agency staff.	Mark Smith	Louise Ludgrove	33.1 Reinforce medical agency committee	31/12/2019	12/12/2019	33.1 Minutes of meeting	4 - Likely	09/03/2020 Evidence of completion provided 04/03/2020 SB review evidence. Contact LL to see if meeting held- request evidence of completion. 14/01/2020 Email from L.Ludgrove to advise meeting today did not go ahead due to lack of attendance. Reschedule to next week. Agenda and TofR to be provided. 08/01/2020 Monitoring meetings refreshed. New fortnightly meetings to start from 14/01/2020. Attendance to include Execs to support strategic decision making on reducing medical agency spend.
		Mark Smith	Louise Ludgrove	33.2 Review medical recruitment strategy	30/08/2020		33.2 Strategy in place	4 - Likely	08/06/20 - 3 month extension to deadline due to COVID-19. 09/03/2020 Project initiated to determine correct medical establishment. Date amended from 03/04/2020 to 31/05/2020 to progress the medical establishment review 13/02/2020 Senior level review meeting in place concerned with agency cost reduction, substantive recruitment and shift to Bank where possible
34	**Undertakings Section 2** This NHS trust should continue working to achieve further efficiencies from collaborative working with partners in its clinical and support services	Chris Pallot	Chris Pallot	34.1 Continue to seek opportunities to collaborate on the delivery of clinical and support services with partners within Northants and Leicestershire	31/10/2019	31/10/2019	34.1 Evidence of collaboration work with relevant groups- e.g emails/ proposals for joint working	4 - Likely	14/01/2020 See supporting evidence for Action 11 Completed Ongoing through the life of the new strategy and Long Term Plan
		Chris Pallot	Chris Pallot	34.2 Continue to pursue opportunities with KGH through the Unified Acute Model workstream of the HCP	31/10/2019	31/10/2019	34.2 Workstream model 34.2 Business cases e.g MSk and Stroke	4 - Likely	14/01/2020 See supporting evidence for Action 11 Completed Ongoing through the life of the new strategy and Long Term Plan
35	**Undertakings Section 4** The NHS trust should continue focusing on building internal capacity and capability to deliver trust wide workforce and service productivity improvements	Mark Smith	Bronwen Curtis	35.1 Support the transformation of the quality function	30/06/2020	08/06/2020	35.1 HR/ OD support plan	3 - Possible	16/06/20 - Evidence received - NOC & Team structure. 08/06/20 - 3 month extension to deadline due to COVID-19. 08/06/20 - BC reports action completed. Awaiting evidence. 09/03/2020 Leadership role assigned and focus of new team agreed Recruitment to vacant posts in progress. No further significant support needed 06/01/2020 Integration on plan for Quarter 1 20/21. HR and OD support in place
		Mark Smith	Bronwen Curtis	35.2 Integrate productivity improvements in OD interventions	30/06/2020	08/06/2020	35.2 Oncology Intervention plan	3 - Possible	16/06/2020 - Evidence received for oncology intervention plan. 08/06/20 - 3 month extension to deadline due to COVID-19. 08/06/20 - BC reports action completed. Awaiting evidence. 09/03/2020 Work in progress against key elements of plan with next steps identified
		Mark Smith	Bronwen Curtis	35.3 Introduce talent management	31/08/2020		35.3 Talent Management rollout plan	4 - Likely	08/06/20 - Extension to deadline due to COVID-19. 08/06/20 - BC - 35.3 was paused due to Covid19 but will be revised shortly to reflect current position Completion date can be revised to 31/8/20 09/03/2020 Rollout to other divisions launched as well as pipeline identification for non clinical areas 06/02/2020 Surgery due for completion February 2020 06/01/2020 Launch Jan 2020 with focus on directorate/divisional
36	**Undertakings Section 1** The NHS trust should ensure the improvements that they make in pathways results in achieving better performance against constitutional operational standards	Debbie Needham	Owen Cooper	36.1 Cancer recovery plan in place	30/07/2020		36.1 Most recent version of recovery plan	3- Possible	08/06/20 - 4 month extension to deadline due to COVID-19. 10/03/2020 Intensive support team (IST) have been working with us for 3 weeks now with very positive feedback on our cancer board, processes and cancer PTL structure. They are going to support us with some demand and capacity work for our most challenged cancer sites as well as helping to review our cancer access policy and 'straight to test processes' A full action plan will be developed once the IST diagnostic has been completed 10/02/2020 Recovery plans in place for individual tumour sites, support being provided by the IST (NHSI) starting on 14th February 2020 09/01/2020 Email from D.Needham. Recovery plan is in place. Completion date amended to 31/03/2020 (from 31/12/2019). Action not yet signed off Review date (31/12/2019)
		Debbie Needham	Debbie Needham Sheran Oke Matthew Metcalfe	36.2 AE plan in place as per actions 18 and 23	30/07/2020		36.2 AE plan	3- Possible	08/06/20 - 4 month extension to deadline due to COVID-19. Link in with 18 & 23. 10/02/2020 New work streams agreed and being led by COO/MD/DoN 09/01/2020 Email from D.Needham. Recovery plan is in place. Completion date amended to 31/03/2020 (from 31/12/2019) Action not yet signed off.
37	**Undertakings Section 2** The NHS trust should ensure existing cost improvement initiatives achieve the expected reduction of its expenditure run-rate and overall cost base.	Phil Bradley	Robert Mayes	37.1 Development of a recurrent savings plan	30/07/2020		37.1 Savings plan	5- Almost certain	13/07/2020 - The Trust, at this time, does not need to make cost savings. This action should be closed? 08/06/20 - 4 month extension to deadline due to COVID-19. 04/03/2020 The 2019/20 CIP target should be achieved in its totality, though a large percentage will be non recurrent Part of budget setting for 20/21
38	**Undertakings Section 2** The NHS trust should develop a plan to return to finance balance on recurrent basis	Phil Bradley	Phil Bradley	38.1 Development of System 3 year financial strategy	30/07/2020		38.1 STP financial strategy	3- Possible	13/07/2020 - The Trust, at this time, does not need to make cost savings. This action should be closed? 08/06/20 - 4 month extension to deadline due to COVID-19. 04/03/2020 The system finance group will move on to the development of this workstream over the next few months 12/02/2020 This is superseded by the issued financial improvement trajectories and system working relating to transformation and block contracts. We know that the major cause of our deficit is the underfunding of the tariff. (links with action 13.1)
		Phil Bradley	Phil Bradley	38.2 Development of a LTFM to see if this is possible	30/07/2020		38.2 LTFM	3 - Possible	13/07/2020 - The Trust, at this time, does not need to make cost savings. This action should be closed? 08/06/20 - 4 month extension to deadline due to COVID-19. 04/03/2020 The LTFM will be an integral part of 38.1 12/02/2020 This development continues and will involve our system partners

39	Undertakings Section 4 The NHS trust should progress implementation of its five-year estates maintenance plan.	Stuart Finn	James Stewart	39.1 Continued recruitment into newly created Estates maintenance posts. Some key roles already filled.	01/09/2020		39.1 Recruitment plan and updates as posts are filled	5- Almost certain	08/06/20 - 3 month extension to deadline due to COVID-19. 04/06/2020 - Interim Dep Dir of E&F in place and 'head hunters have been asked to assit in recruitment. 2 x candidtaes were interviewed 2/06/20 Agency staff are being used to fill trade staff vacancies in Estates - new adverts have been opened for permenant roles Target date of June 2020 will not be met. 10/03/2020 Deputy Director of Facilities & Head of Estates interview on 10/03/20 – originally 6 shortlisted for interview but 5 withdrew. An interim has been interviewed and is due to start end of March. Senior Maintenance Manager advert closed and 2 applicants selected for interview end of March. Suitable interims continue to prove difficult to source. 06/01/2020 Further posts have been filled - during Dec 19/Jan 20 (fire officer and mechanical maintenance engineer). Senior maintenance manager & electrical maintenance manager interviews due end of Jan 2020. Deputy director role advert closes end of Jan 2020.
		Stuart Finn	James Stewart	39.2 Implementation of new CMMS (computer maintenance management system)	01/08/2020		39.2 Confirmation email new CMMS in place and in use	5- Almost certain	04/06/2020 Review completed which supports the use of the existing system. Progress has been delayed due to vacancies but new interim Dep Dir of E&F has been tasked to complete implementation. Target date of Aug 20 will not be achievable and a new date will be set following further meetings in June 10/03/20 Independent review completed which confirmed existing system is fit for purpose. A number of recommendations were made as part of the report which are being reviewed. 06/01/2020 Independent review starting 7 Jan 20 04/12/2019 An independent review of the existing system has been arranged.
		Stuart Finn	James Stewart	39.3 Development of key maintenance compliance reports from CMMS to be presented at Facilities Governance committee	01/08/2020		39.3 Maintenance compliance reports and copy of meeting minutes	5- Almost certain	04/06/2020 Review completed which supports the use of the existing system. Progress has been delayed due to vacancies but new interim Dep Dir of E&F has been tasked to complete implementation. Target date of Aug 20 will not be achievable and a new date will be set following further meetings in June 10/03/20 Independent review completed which confirmed existing system is fit for purpose. A number of recommendations which included reporting were made as part of the report which are being reviewed. 06/01/2020 Independent review starting 7 Jan 20 04/12/2019 An independent review of the existing system has been arranged. This will include recommendations and action plan to implement the
		Stuart Finn	James Stewart	39.4 Put in place a new Facilities Governance committee and structure	30/09/2019	30/09/2019	39.4 Governance structure and terms of reference for meetings	5- Almost certain	22/01/2020 Evidence of completion provided 06/01/2020 Review meeting arranged for 9 Jan 2020 This action can be closed as committee and structure is in place Evidence of completion required 04/12/2019 Facilities Governance structure is in place. Trust Governance team have been asked to review the structure to ensure it is sufficient. Date for review TBC Completed (since initial version of action plan- update provided as above)

Report To	**Trust Board**
Date of Meeting	**30th July 2020**

Title of the Report	Collaboration Programme Committee (CPC)Terms of Reference
Agenda item	**12**
Presenter of Report	Claire Campbell, Director of Corporate Development, Governance & Assurance & Richard Apps, Director of Governance Kettering General Hospital NHS Foundation Trust
Author(s) of Report	Claire Campbell, Director of Corporate Development, Governance & Assurance & Richard Apps, Director of Governance Kettering General Hospital NHS Foundation Trust
Purpose	To obtain Board approval at NGH and KGH of the Terms of Reference for the Collaboration Programme Committee.

Executive summary

The Collaboration Steering Committee (CSC) was established as a Committee of both NGH and KGH Boards and held its inaugural meeting in May 2019 with executive membership from both Trusts. Its role was to drive the collaborative strategy across both Trusts, agree clinical models of care, and establish operating models, where clinical services are delivered across both Trusts.

The CSC has spent the last year developing shared clinical models, fostering and enhancing collaborative relationships. It has driven the first three clinical collaborations and established joint Clinical Director posts for each. The CSC has also focussed on back office collaboration, focussing on maximising the potential of the Digital and HR functions.

In order to develop and deliver the aims of the collaboration and to steer the Committee through delivery of the Group model ambitions, it proposed that the CSC is re-purposed with a Non-Executive Director from each Trust to join as co-Chairs, and rename the revised meeting and its Terms of Reference as the Collaboration Programme Committee (CPC).

This paper presents the Terms of Reference for the Collaboration Programme Committee (CPC) as proposed by the Directors of Governance and considered in the Board workshop 14th July 2020.

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Corporate Objective 4: Transform our services to deliver better care and value with long term sustainability.
Risk and assurance	There is a risk that without a robust and properly resourced collaborative governance framework may result in stakeholders not fully supporting or understanding the collaboration and will likely result in non-achievement of the Group objectives and the

	associated Trusts strategic objectives. All risks associated with the Group model will sit on respective organisations Risk Registers and will be considered by the Collaboration Programme Committee.
Related Board Assurance Framework entries	4.1
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? **(N)** Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **(N)**
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper? No- in line with Trusts Standing Orders/ Constitution

Actions required by the Board

The Board is asked to:

- To approve the Terms of Reference of the Collaboration Programme Committee

Collaboration Programme Committee

Terms of Reference

Context

1. Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust ('the Boards') formed a Group Model on the 1st July 2020.

Purpose

2. The Collaboration Programme Committee (CPC) will develop and deliver the aims of the Group and steer the delivery of the Group Model ambitions.

3. The CPC will advise the Boards of Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust on all matters relevant to identifying and sharing best practice at pace.

4. The CPC will identify opportunities to improve outcomes for patients through innovative practice and partnerships.

5. The CPC will agree and confirm areas of common interest and priorities for joint work, within strategic objectives agreed by the Boards.

Authority & Accountability

6. The Committee is accountable to the Board of each Trust and is authorised by the Boards to investigate any activity within its terms of reference.

7. It is also authorised to:

- seek any information it requires from any employees and all employees are directed to co-operate with any request made by the Committee.
- ensure the engagement of all Board members in the formation and execution of group strategy
- agree and implement appropriate action to ensure the Committee's work plan supports, and addresses deviations from, the strategic objectives agreed by the Boards.

8. The CPC is a formal joint committee of both NGH & KGH and shall have the authority to make recommendations in relation to those matters delegated to it as described in these Terms of Reference for each Trust Board to ratify.

9. The CPC does not usurp or replace any existing statutory accountabilities of member organisations. Individual member organisations retain their statutory accountabilities to their respective regulatory and oversight bodies.

Roles and Duties

10. The Committee will implement the strategic objectives of the Group Model as agreed by the Boards, specifically:

Strategic Financial and Operational Planning

- The CPC will;
    - Drive the delivery of the Group strategy, including finance, IT, estates, and commercial development
    - Develop new working models for corporate functions where appropriate
    - Develop and execute a group communications strategy
    - Determine the framework that supports each provider's organisational objectives and targets
    - Identify, review and mitigate group risks
    - Ensure alignment to the wider HCP plans
    - Determine the right level of public engagement or consultation is undertaken to ensure public and patient views on proposals
    - Ensure interdependencies with other providers and specialist commissioned services are considered.
    - Ensure governance links to the policy framework of each organisation making clear the monitoring and audit of agreed policies.
    - Monitor and report on benefits realisation
    - Provide recommendations to each Trust on any investment requirements (Capital and Revenue)

Clinical Collaboration

- The CPC will;
    - Identify and progress clinical collaboration workstreams.
    - Agree, recommend, for Boards' approval (where required), and oversee processes which benchmark clinical outcomes and productivity across the Group supporting the implementation of best practice solutions
    - Oversee service transformation and pathway redesign
    - Oversee the development of any required policies, standard operating procedures or guidelines that underpin the areas of collaboration.

Membership

- One NED from each organisation (alternating Chair)
- Group Chief Executive
- Group Executive Directors
- NGH Executive Directors
- KGH Executive Directors

Quoracy

11. The following roles must be represented for the meeting to be quorate: Non-Executive Director, Group Chief Executive, Group Executive Director, three Executive Directors from each Trust

12. Where a member cannot attend, they can send a suitably and duly nominated deputy to attend in their absence and be considered within the quorum.

13. Other individuals can attend by invitation, particularly when the Committee is discussing an agenda item that is the responsibility of that role.

14. Additional representation will be invited dependant on the topics requiring greater stakeholder insight and/or engagement.

Reporting arrangements.

15. A brief report will be submitted to the following Board meetings drawing attention to significant developments, highlighting areas where further assurance is required and matters requiring Board decisions.

16. The Committee's agendas and meeting papers will be made available to all Board members of the respective Boards.

17. The Committee will review its work annually to highlight key issues in the delivery of the Groups Strategies and their management, as well as the effectiveness of the Committee.

Conduct of Business

18. The CPC shall meet on a monthly basis, rotating sites between both organisations. Where an additional meeting is required outside of the established meeting pattern it shall be for the Chair(s) to convene the meeting, with the agreement of leads from each Trust.

19. Papers will be circulated one week in advance, to enable organisations to consider the implications for their own organisations in advance of the meeting. Where this is not possible, any later circulation must be agreed with the Chair(s) in advance.

20. The CPC is a private meeting of the Trusts.

21. Where any member of the CPC has concerns about the way in which the CPC is addressing a matter, or where he/she disagrees with a decision of the CPC, he/she may at any time refer that matter to the Board of the parent organisations at NGH & KGH.

22. The CPC shall be supported and administered by a secretary to the committee, jointly resourced by each Trust.

23. The Directors of Governance shall advise the Chair(s) of the CPC on the CPC's compliance with these terms of reference and with other relevant governance requirements and shall generally provide support to the CPC as required .

Decision making

24. When taking decisions members of the CPC will work constructively and pragmatically to reach a consensus position where all agree; voting arrangements will not apply to the decision making of the CPC.

25. Decision making member organisations shall ensure that their own constitutions and schemes of reservation and delegation provide members of CPC with sufficient authority to take decisions on matters presented to the CPC on behalf of their organisations.

26. Where a recommendation has been made by the CPC outside its delegated authority, it shall be reported to the Board/Boards of Directors for formal approval, as appropriate.

Conflicts of Interest

27. Members are required to state for the record any interest relating to any matter to be considered at each meeting. These conflicts will be recorded in the minutes, and where necessary an individual may be asked to withdraw from the meeting for that part of the agenda.

28. Should the Chair of the meeting have a conflict of interest which necessitates his or her absence from the meeting, the role of Chair should be undertaken by the alternate Chair. Where neither alternate Chair is available, the Group Chief Executive shall reside.

Review Date

29. These terms of reference shall be formally reviewed in July 2021 and thereafter annually.

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Report To	**TRUST BOARD**
Date of Meeting	**30 July 2020**

Title of the Report	**Equality, Diversity & Inclusion – BAME Support and Workforce Annual Report 2019/2020**
Agenda item	13
Presenter of Report	Mark Smith, Chief People Officer
Author(s) of Report	Sarah Kinsella, Corporate HR Officer Leanna Dennis, BAME Network Chair Tim Brown, Equality, Diversity and Inclusion Manager
Purpose	Assurance that the equality agenda including the public sector equality duty in accordance with the Equality Act 2010 is being implemented for staff across the Trust

Executive summary

The Public Sector Equality Duty requires the Trust to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out its activities. To ensure transparency, and to assist in the performance of this duty, the Equality Act 2010 (Specific Duties) Regulations 2011 require the Trust to publish information to demonstrate compliance with the Public Sector Equality Duty.

The Equality and Human Rights Workforce Annual Report for 2019/2020 as part of this paper demonstrates the Trust's current position and provides assurance of actions taken to date, however it is acknowledged that there are many actions which we will undertake the address our Trust performance in this area.

On 2 June, in response to a commission from the Department of Health and Social Care, Public Health England (PHE) published its review, Disparities in the risk and outcomes of COVID-19. On 16 June PHE followed up its initial descriptive report with 'Beyond the data: understanding the impact of COVID-19 on BAME groups', a summary of its stakeholder engagement and literature review. The report puts forward that the relationship between ethnicity and health, and the disproportionate impact of COVID-19 on BAME groups is likely to be the result of a combination of factors including social and economic inequalities, racism, discrimination and stigma, differing risks at work and inequalities in the prevalence of conditions such as obesity, diabetes, hypertension and asthma. A number of the

recommendations requested by stakeholders included in PHE's second report are of direct relevance to the NHS's work to address the impact of COVID-19 including better representation of BAME communities among staff at all levels, risk assessments for BAME workers, producing culturally sensitive education and prevention campaigns and ensuring that COVID-19 recovery strategies address inequalities to create long-term change. This paper outlines initial steps on how these are being addressed and planned for within our Trust. Our response is underpinned by three principles of protecting, supporting, and engaging our staff.

The presentation provided at the Board of Directors meeting highlights the Trusts current position, from the Annual Report, however it also includes the Trust welfare Risk Assessment outcomes, introduced in response to the COVID-19 situation to protect colleagues, the welfare risk assessments are now being conducted throughout the Trust but were initially focused on colleagues vulnerable to the virus including BAME colleagues. The Trust Workforce Race Equality Standard position is also outlined in the presentation. The presentation focuses on support which the Trust had put in place for BAME colleagues, our BAME network and the work which the network has supported to date across three work streams including:

- Visibility
- Talent and Leadership
- Behaviours, IT Social Media/ IT/Profile Raising

More recently the network has supported increasing our BAME FTSU champions, supporting colleagues during COVID-19 including the Fit Test process and risk assessments and developing our Black Lives Matter video.

Moving forward, Equality, Diversity and Inclusion will be focused upon as part of the group People Plan being developed across our Trust and KGH, however the presentation brings forward a number of actions which will be implemented in the short term, including more representative recruitment panels, development opportunities, the establishment of role models including a BAME Clinical Fellow to be appointed and support for colleagues experiencing discrimination. There are Board specific actions which colleagues are requested to support, which include the introduction of reverse mentoring, a Non-Executive to support our BAME network and regular Board reporting and discussions focused on this agenda particularly to review progress on action and outcome of our initial desired WRES outcomes.

Please Note – as part of the Equality & Human Rights Commissions response to COVID-19, in England, planned compliance activity on the specific duties for this year were suspended, including the publication of our annual report. However, where possible, those bodies who could meet the obligations were encouraged to do so. As the Trust was in a position to produce its workforce annual report the decision was taken to do so.

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	The Trust's workforce equality agenda for staff is monitored through the Equality and Diversity Staff Group.
Related Board Assurance Framework entries	BAF 2.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? No, whilst there is a focus in this paper on BAME colleagues, other protected characteristics actions are reviewed by the Equality, Diversity and Inclusion Manager including the formation of other staff networks

	Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No**
Legal implications / regulatory requirements	Public Sector Equality Duty Equality Act 2010 Equality Act 2010 (Gender Pay Gap Information Regulations 2017) NHS Constitution Equality Delivery Scheme (EDS2) Workforce Disability Equality Standard (WDES) Workforce Race Equality Standard (WRES)

Actions required by the Committee

The Trust Board is asked to endorse the content of the Annual Report, note the action taken to date with reference to welfare Risk Assessments and the work of our BAME network, whilst supporting the actions within the Board presentation.

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Northampton General Hospital
NHS Trust

Equality, Diversity & Inclusion

Workforce Annual Report

April 2019 to March 2020

Providing the Best Possible Care

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Associate Teaching Hospital

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Northampton General Hospital
NHS Trust

Equality, Diversity and Inclusion

Workforce Annual Report

April 2019 to March 2020

Our Vision and Values

Our Vision is: To provide the best possible care for our patients

Our Values are:

- We put patient safety above all else
- We aspire to excellence
- We reflect, we learn, we improve
- We respect & support each other

Contents

Executive Summary

The Equality, Diversity and Inclusion Workforce Annual Report for 2019/2020 reviews the work Northampton General Hospital (NGH) has undertaken to promote equality, celebrate diversity create an inclusive workforce during April 2019 to March 2020.

During this time we have started to develop the NGH People Plan, which is focussed on 4 areas - CARE (Culture, Achievement, Resourcing, Environment) to enable us to deliver the best possible care.

The area of 'culture' will have key links to diversity and inclusion together with respect and support, civility saves lives, freedom to speak up, leadership behaviour and how we welcome and include employees who are joining the organisation. We look forward to embedding these plans during the coming year.

In the summer of 2019 we launched our Black, Asian and Minority Ethnic (BAME) Staff Group and the NHS Rainbow Badge initiative. Work also took place during early 2020 to set up an LGBT Staff Network Group and a Disability Network Group led by our newly appointed Head of Equality, Diversity & Inclusion.

Following the outbreak of COVID-19 in 2020 the focus of the work of the Trust changed dramatically and many of our normal day to day activities were paused to deal with the pandemic. Throughout this time we remained conscious of the need to continue to be a diverse and inclusive employer to support our staff through this challenging time.

During 2020/2021 we look forward to finalising the NGH People Plan and creating a great place to work, learn and CARE for the people of Team NGH.

Dr Sonia Swart
Chief Executive

Alan Burns
Chairman

Introduction

We believe that Equality, Diversity & Inclusion is central to what we do. We understand the importance of creating a fairer society where everyone has the opportunity to fulfil their potential, whilst recognising and valuing difference and ensuring everyone feels valued and included.

We aim to support our staff in a responsive and appropriate way to meet the diverse needs of the different groups and individuals we employ, because well supported staff can deliver better care for our patients.

To achieve this we want to ensure that our staff are not subject to any form of discrimination or unequal treatment. All staff can expect to be treated with equal respect and dignity regardless of their background or circumstances. Dignity and respect are at the foundation of the work we do at the Trust, supported by our value of 'We Respect and Support Each Other'.

It is important to us that we eliminate discrimination in the way we recruit, train and support our workforce and advance equality of opportunity.

Further information regarding Equality, Diversity and Inclusion can be found on our website at https://www.northamptongeneral.nhs.uk/About/Equality-and-diversity-information/Equality-Diversity-Inclusion.aspx

A summary of some of our achievements during 2019/2020 can be found on the next page.

2019/2020 Summary

Head of Equality, Diversity & Inclusion
We appointed a dedicated member of staff to work with staff and patients

Rainbow Badges
We signed up to the NHS Rainbow Badge initiative. Over 1,000 staff have now signed up and made a pledge

Staff Network Groups
We held our first Black, Asian and Minority Ethnic Staff Group

Staff Network Groups
Work has started to set up a Disability and a LGBT+ Staff Network Group

Workforce Race Equality Standard (WRES)
Data collection undertaken and analysed to enable action planning on areas for improvement

Workforce Disability Equality Standard (WDES)
First data collection undertaken and analysed

Faith & Belief
Managers supported to enable them to better understand staff needs in relation to their religion or beliefs

Health & Wellbeing
Activities continued to support staff to look after their own health and wellbeing

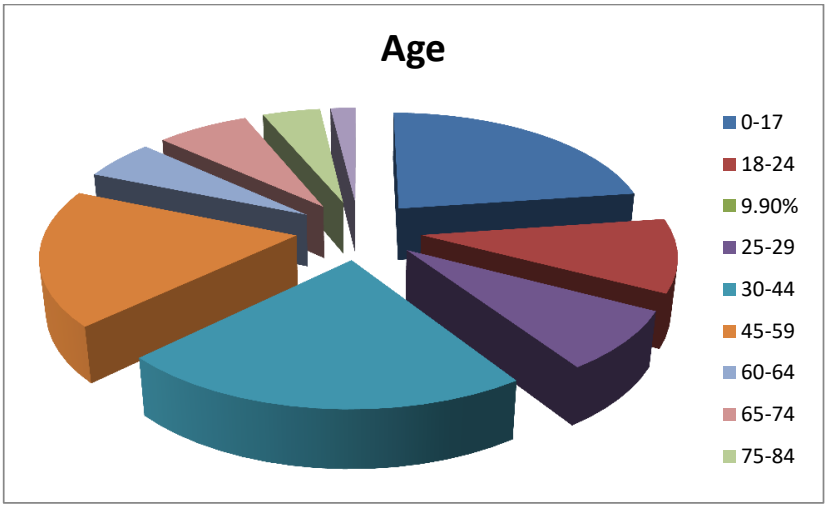
Our Population

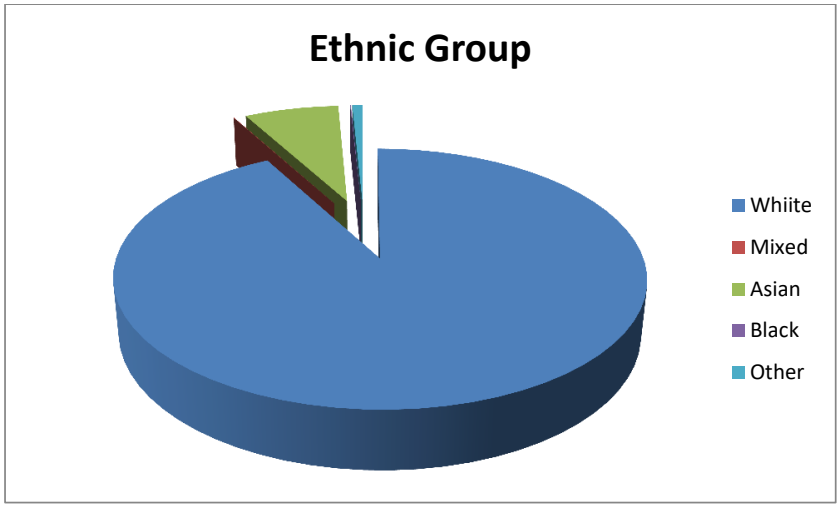
Northampton General Hospital NHS Trust provides general acute services for a population of 380,000 and hyper-acute stroke, vascular and renal services to people living throughout whole of Northamptonshire, a population of 692,000. The Trust is also an accredited cancer centre and provides cancer services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire.

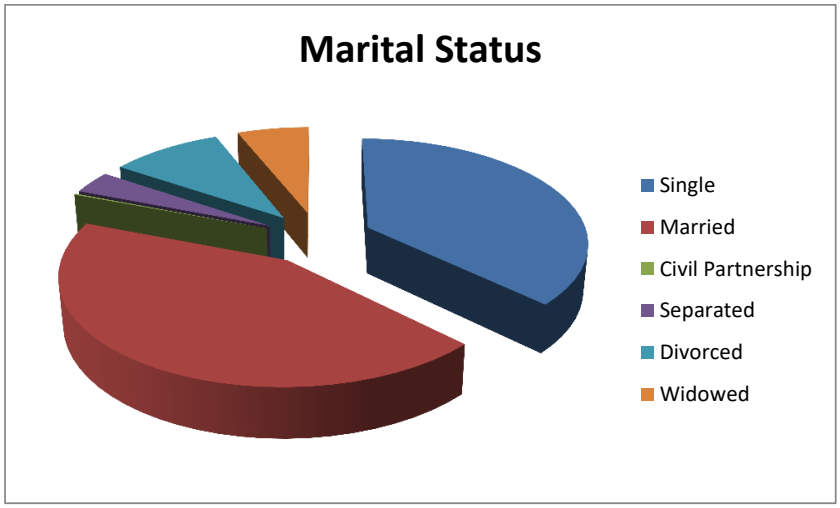
The principal activity of the Trust is the provision of free healthcare to eligible patients. We are a hospital that provides the full range of outpatients, diagnostics, inpatient and day case elective and emergency care and also a growing range of specialist treatments that distinguishes our services from many district general hospitals. We also provide a very small amount of healthcare to private patients.

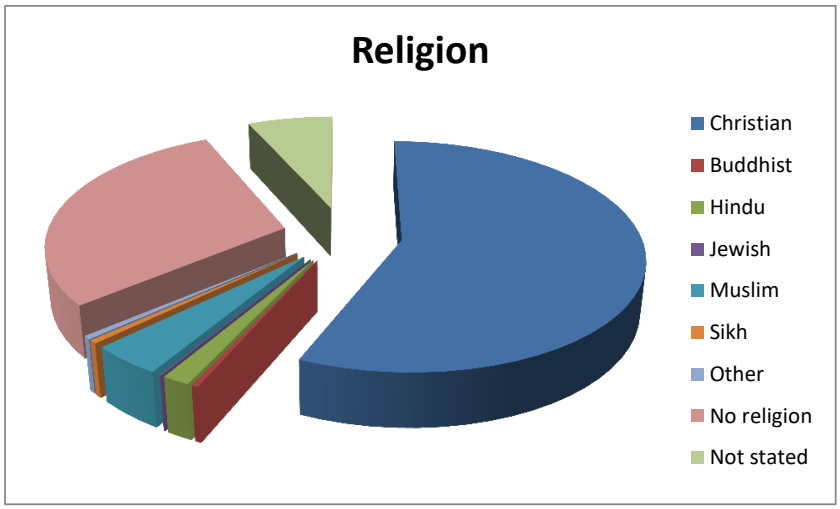
Northampton Population (2011 Census)

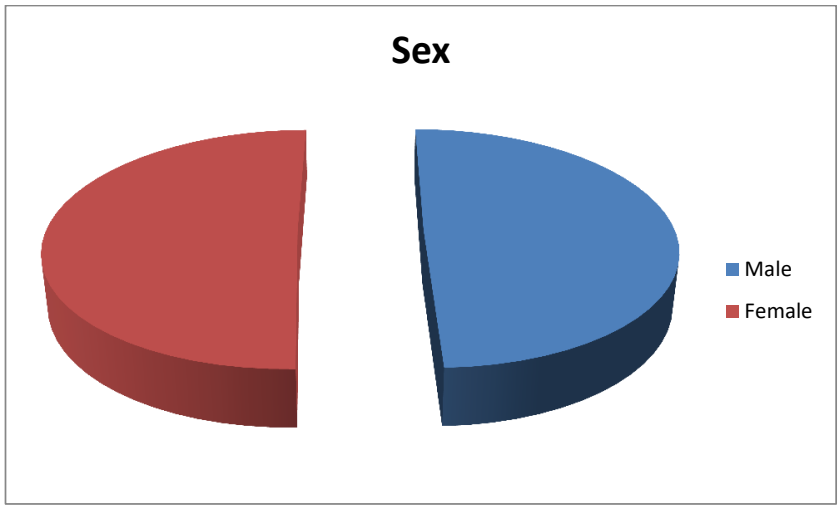
Age Group	Ethnic Group	Marital Status	Religion	Sex
0-17 22.8%	White 84.5%	Single 37.2%	Christian 56.6%	Male 49.5%
18-24 9.9%	Mixed 3.2%	Married 43.5%	Buddhist 0.4%	Female 50.5%
25-29 8.0%	Asian 6.5%	Civil Partnership 0.2%	Hindu 1.6%	
30-44 22.2%	Black 5.1%	Separated 3.5%	Jewish 0.1%	
45-59 18.4%	Other 0.7%	Divorced 9.5%	Muslim 4.2%	
60-64 5.5%		Widowed 6.1%	Sikh 0.5%	
65-74 7.0%			Other 0.5%	
75-84 4.4%			No religion 29.4%	
85+ 1.9%			Not stated 6.7%	


Age
0-17
18-24
9.90%
25-29
30-44
45-59
60-64
65-74
75-84


Ethnic Group
Whiite
Mixed
Asian
Black
Other

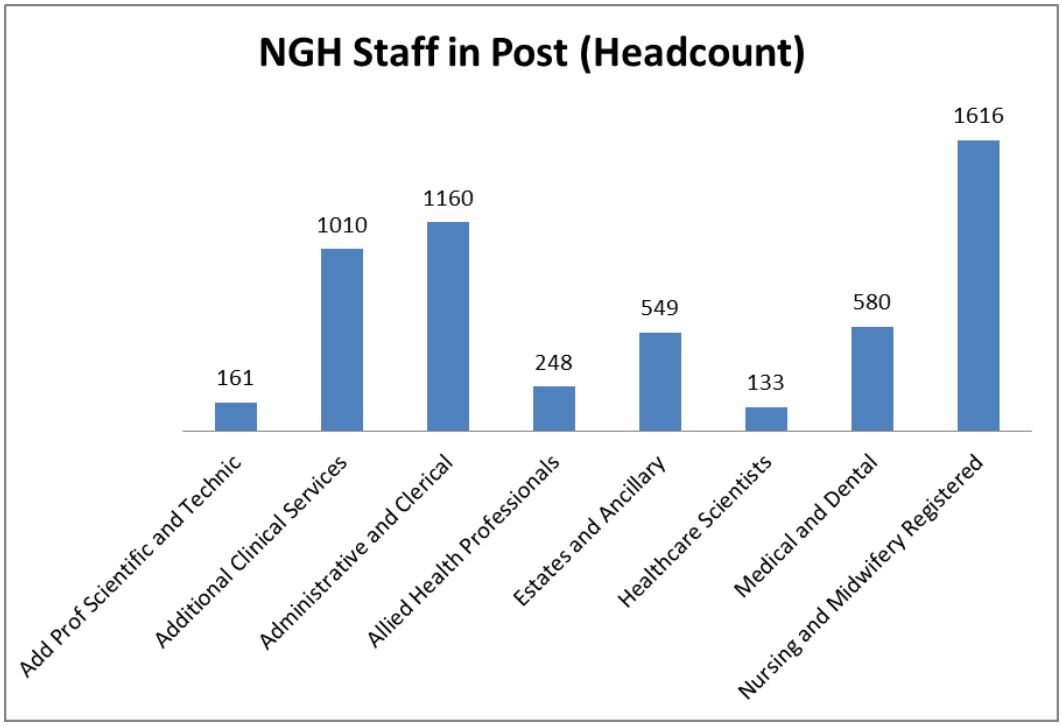

Marital Status
Single
Married
Civil Partnership
Separated
Divorced
Widowed



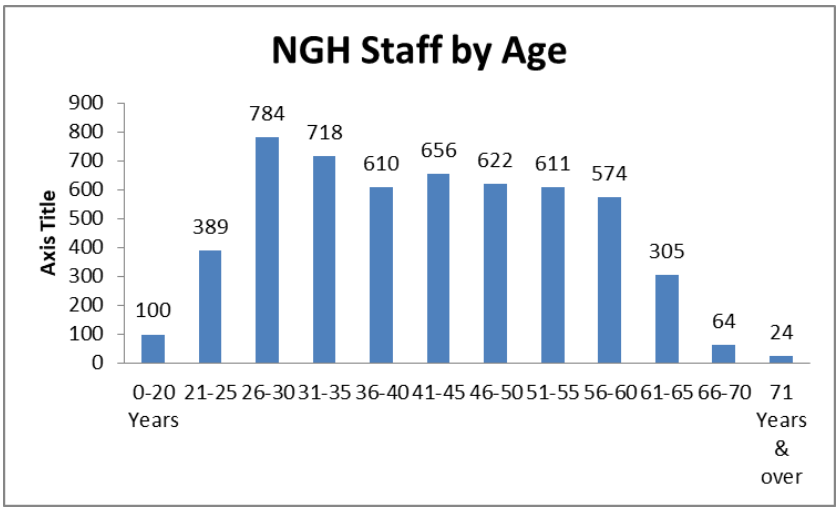


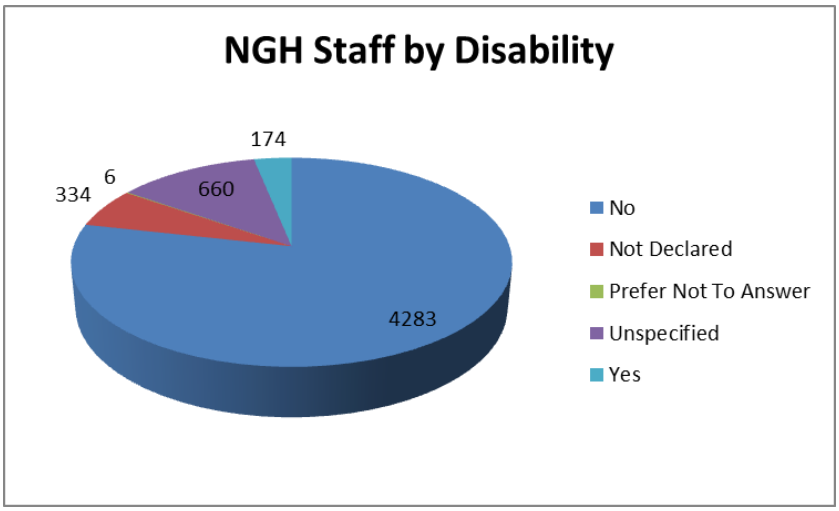
Our People

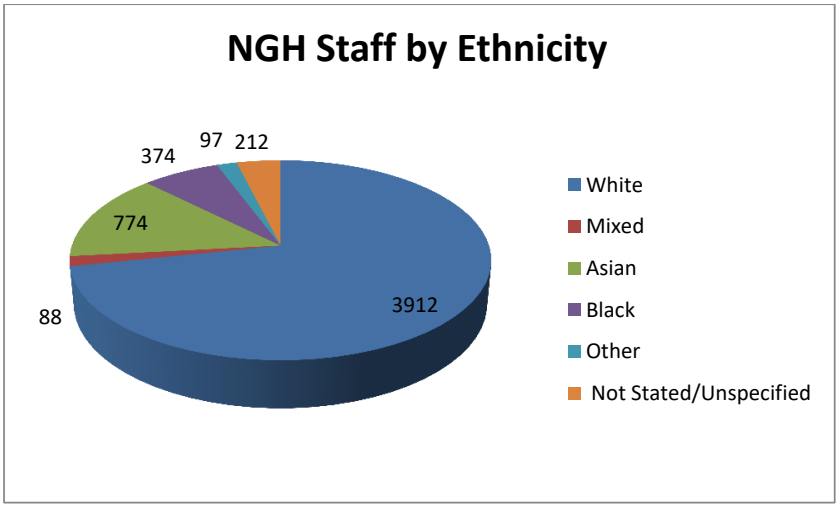
The Trust employs 4801.35 whole time equivalent (wte) members of staff, a headcount of 5457 people, (as at 31 March 2020).

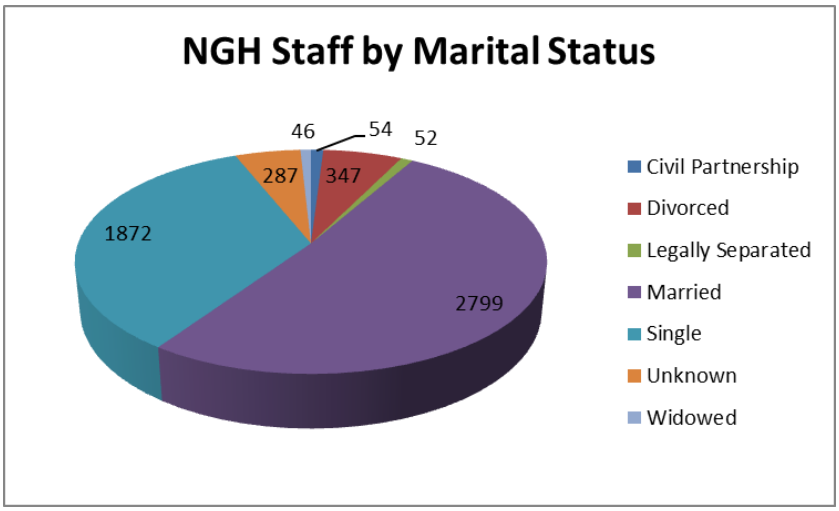


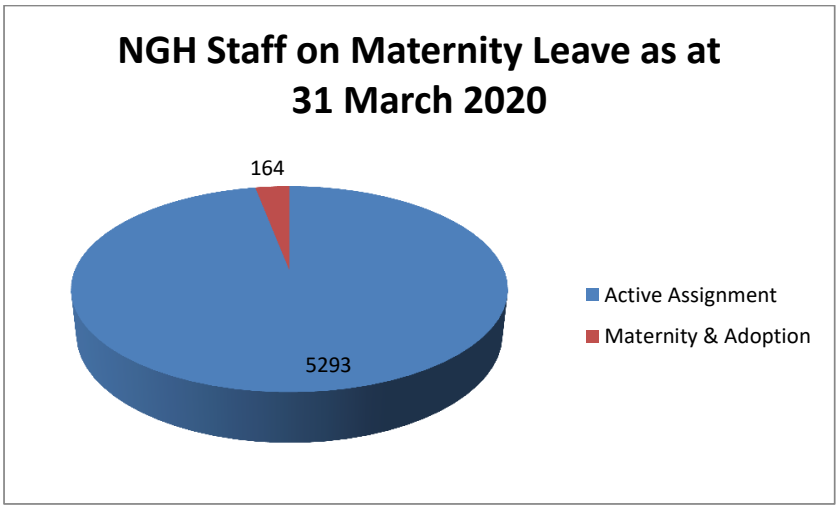
The breakdown of our staff can is detailed on the graphs below by the protected characteristics that data is recorded for.

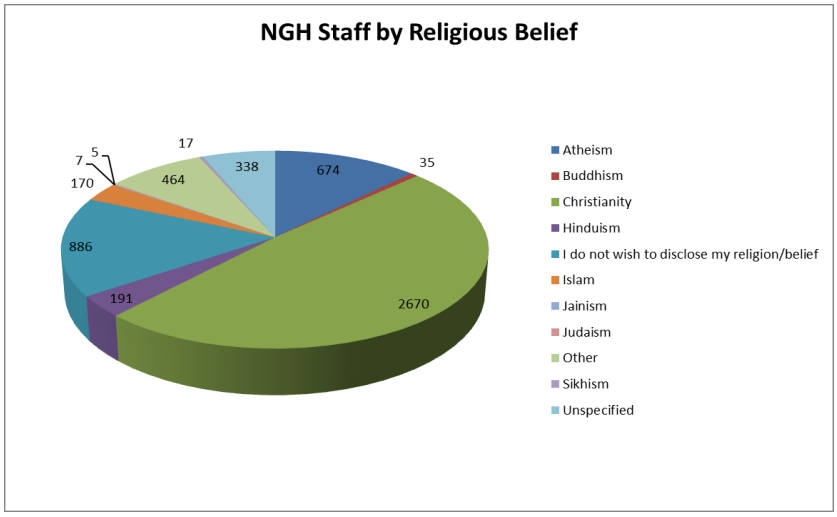


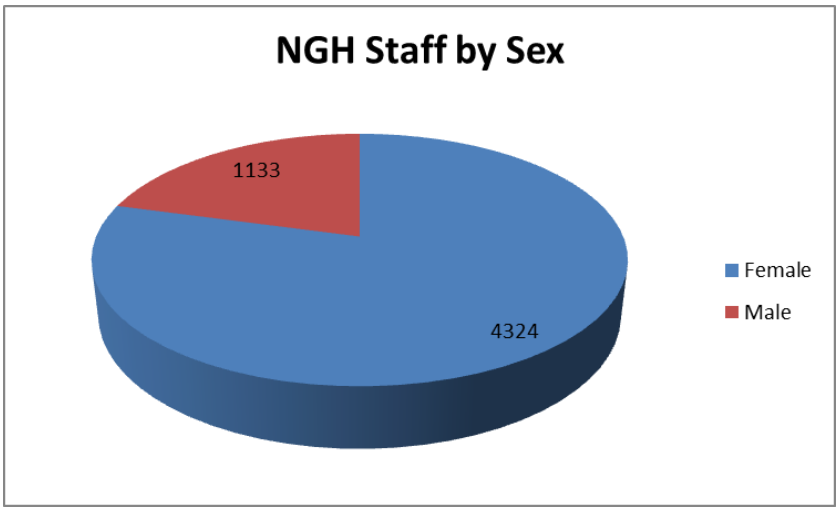


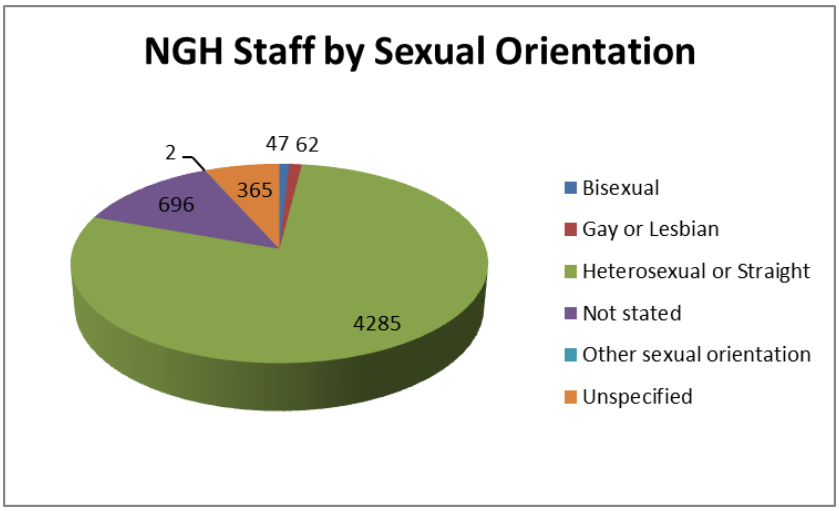



NGH Staff by Marital Status
46
54
52
287
347
1872
2799
Civil Partnership
Divorced
Legally Separated
Married
Single
Unknown
Widowed


NGH Staff on Maternity Leave as at 31 March 2020
164
5293
Active Assignment
Maternity & Adoption


NGH Staff by Religious Belief
17
7
5
338
674
35
170
464
886
191
2670
Atheism
Buddhism
Christianity
Hinduism
I do not wish to disclose my religion/belief
Islam
Jainism
Judaism
Other
Sikhism
Unspecified





Our Activities

Rainbow Badges

In 2019 we signed up to the NHS Rainbow Badge initiative, with the badges being officially launched at NGH in July 2019.

The Rainbow Badge initiative gives our staff a way to show that we and our organisation is open, non-judgemental and inclusive for patients, their families and our staff, who identify as LGBT+ (lesbian, gay, bisexual, transgender, the + simply means that we are inclusive of all identities, regardless of how people define themselves.)

By choosing to wear the Badge, staff are sending a message that “you can talk to me” They aren’t expected to have the answers to all issues and concerns but they are a friendly ear, and will know how to signpost to the support available. Staff who chose to wear a badge don’t have to identify as LGBT+ they just have to be willing to listen.

Simple visible symbols, such as the Rainbow Badge, can make a big difference for those unsure of both themselves, and of the reception they will receive if they disclose their sexuality and/or gender identity.

Evidence shows that patients and staff are often discriminated against due to their sexuality (Stonewall):

1. One in 7 (14%) LGBT people avoid seeking healthcare for fear of discrimination
2. Almost one in four (23%) have witnessed discriminatory or negative remarks against LGBT people by healthcare staff
3. Nearly 1 in 5 (18%) LGBT people are not open with work colleagues about sexual orientation
4. Almost one in 5 (18%) have been target of negative comments or behaviour by colleagues due to their sexuality
5. Almost a quarter of NHS staff have heard colleagues making negative remarks about LGBT people.

Since launching the badge over 1,000 staff have signed up and made a pledge to be a listening ear to those that need it.

Staff Network Groups

In the summer of 2019 we held our first meeting of our Black, Asian & Minority Ethnic (BAME) Staff Group.

This was followed in early 2020 with work to set up a disability staff network group and a LGBT+ (lesbian, gay, bisexual, transgender +) group as well.

The overall aims of our staff network groups is to:

- To promote positive working experiences for staff
- Provide a safe platform to express views
- To feedback to the Trust on issues that affect those staff
- To feedback on strategic issues and initiatives
- To promote access to opportunities for training and development for staff.

NHS Equality, Diversity & Human Rights Week – 13 to 17 May 2019

The 13 – 17 May 2019 was the eighth NHS Equality, Diversity and Human Rights Week (#EQW2019).

Co-ordinated by NHS Employers, #EQW2019 is a national platform to highlight creating a fairer and more inclusive NHS for patients and staff.

The theme was once again **diverse, inclusive, together** to continue to reflect the move across the health and social care sector towards collaboration and integration. Working together makes the NHS stronger, we meet standards, enable change and collectively invest in the creation of a diverse and inclusive NHS workforce to deliver a more inclusive service and improved patient care.

We asked our staff to think about what they do on a day to day basis to make the Trust to be a diverse, inclusive and together organisation.

Support for Staff becoming a Parent

During 2019/2020 we continued to provide support for staff becoming a parent to ensure that they are aware of their rights and entitlements. In addition to our Maternity, Paternity, Adoption and Shared Parental Leave Procedure we have a dedicated member of staff who can provide support and advice to individuals, who are applying for these types of leave, and their managers.

Workshops are run for staff who are pregnant to provide additional support and information. For other parenting leave such as adoption or shared parental leave individuals are seen on a one to one basis.

During the 12 month period that this report covers:

- 200 members of staff commenced maternity leave
- 30 members of staff commenced paternity leave
- 1 member of staff commenced shared parental leave.

Supporting Our Staff to Breastfeed

As a fully accredited Baby Friendly Hospital, we aim to help our staff to continue to breastfeed, if that is their wish, by promoting breastfeeding to our pregnant staff through our Maternity Workshops.

Breastfeeding has lots of benefits for a new mother and for their baby as well and we want staff to feel that they can continue breastfeeding when they return to work.

Support for Our Retiring Staff

Each year we run pre-retirement seminars for staff that are looking to retire within one to four years' time. The seminars help staff to prepare and plan for their retirement and covers aims and concerns, financial matters, inflation, taxation, investments, wills and equity release.

In addition staff can also join the NHS Retirement Fellowship, which is a social, leisure, educational and welfare organisation for current and retired NHS and Social Care staff and their partners.

More than 17% of our workforce are over the age of 55, so these seminars prove useful for many of our staff.

Equality Analysis

We continued to analyse our policies and procedures, to ensure they meet our public sector duties and give 'due regard' to ensure that everyone who works here or uses our services are treated fairly, equally and free from discrimination.

From April 2019 to March 2020 we analysed 73 procedural documents.

Equality & Diversity Group – Workforce

Our Equality and Diversity Staff Group (EDSG) continued to meet on a quarterly basis. The purpose of the group is to champion and steer the work of the hospital so that we are in full and positive compliance of equality and human rights legislation, regulations and codes of practice including NHS and Department of Health standards.

The aim of the group is twofold, firstly to lead, advise and inform on all aspects of policy making, and employment including various engagements related to equality and inclusion legislation and policy direction. The second EDSG aim is to lead and monitor progress on the development of the Equality Objectives/Four Year Plan. The two main objectives link to the Equality Delivery System (ED2) outcomes relating to the workforce:

1. A representative and supported workforce –

"We will improve our staff satisfaction rates as reported in the annual staff survey. We will make year on year improvements on our staff survey results, aiming to achieve top 20% of acute Trusts for staff engagement. We will improve the experiences and treatment between White staff and BME staff at the Trust by progressing the Workforce Race Equality Standard (WRES) and monitoring outcomes."

2. Inclusive leadership -

"We will improve our leadership and management capability."

The key actions for each objective are linked to the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap reporting and the staff survey results.

During 2020/2021 we will be reviewing our key actions to ensure that they are fit for purpose, meet the needs of the Trust, and continue to link to our analysis and findings from our most recent staff survey results and our findings from the annual WRES, WDES and Gender Pay Gap Reporting exercises.

Workforce Race Equality Standard (WRES)

We undertook our fifth WRES exercise in 2019 and it was submitted to NHS England and published on our website in September 2019.

There was improvement in some areas from 2018, such as an increase in the number of Black, Asian & Minority Ethnic (BAME) staff who work for us, along with an increase in the likelihood that a BAME applicant would be appointed following shortlisting.

Deteriorations from the previous year were seen for BAME staff reporting bullying, harassment or discrimination and a reduction in the number of BME staff who believe we provide equal opportunities for career progression or promotion.

The National WRES Report was released in January 2020 and when comparing our results to the national results we have more positive results for some of the indicators. The areas where our results are below that of the national results is for the same areas where we have deteriorated since 2018.

Our WRES Data Reports can be found on our Trust website.

Workforce Disability Equality Standard (WDES)

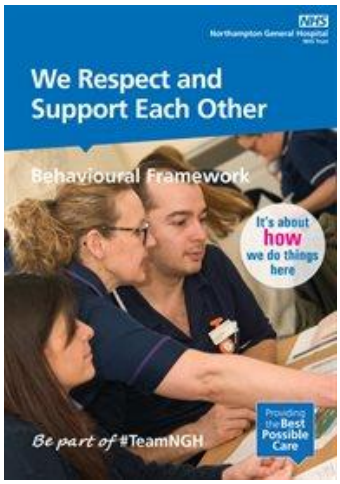
2019 saw the introduction of the Workforce Disability Equality Standard (WDES). This is a set of key indicators which we will be measured against, from the data we hold for staff, to compare the experiences and treatment of our disabled staff compared to our non-disabled staff.

As this is the first time the data has been collected we are not able to make a historical comparison to assess if there have been improvements or deteriorations, so this will be undertaken the next time the data is collected.

The National WDES Report was released in March 2020 and when comparing our results to the national results we have more positive results for some of the indicators, such as the number of disabled staff entering a formal capability process when compared to non-disabled staff and the percentage of staff who felt adequate reasonable adjustments had been made to enable them to carry out their work.

The areas where we had less positive results than those nationally were around bullying, harassment or discrimination and disabled staff who believe we provide equal opportunities for career progression or promotion.

Our WDES Data Reports can be found on our Trust website.

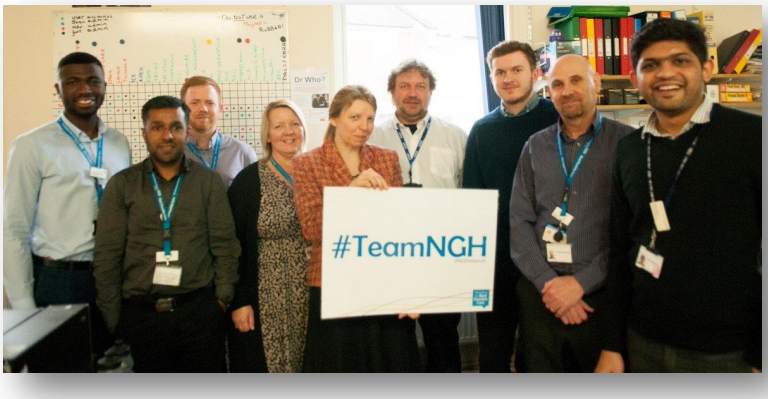


Gender Pay Gap Reporting

As per the Equality Act 2010 (Gender Pay Gap Information Regulations 2017) we compiled our data for the third time, since the regulations came into effect. In February 2020 the approved report was published on our website and submitted to the Government. Although we are not legally required to produce a written report it was agreed we would do this to give context to the data. The report can be found on our website:

https://www.northamptongeneral.nhs.uk/About/Equality-and-diversity-information/Equality-Diversity-Inclusion.aspx

There has been a deterioration when comparing it to the results of the previous year and we will be looking at the results more closely during 2020/2021 to see what we can do to reduce the gap.



Staff Survey 2019 Equality & Diversity Results

The 2019 annual National NHS Staff Survey took place during October to December 2019 and 2,027 members of staff returned the survey. Of the 11 themes there was deterioration in seven and five stayed the same.

The overall Equality & Diversity theme deteriorated in 2019 from 8.9 in 2018 to 8.8 out of 10.

Within the Staff Survey there are four specific questions about equality and diversity. The first question is in relation to the percentage of staff believing that we act fairly in relation to career progression and promotion. This result has deteriorated from 83.5% in 2018 to 80.7% in 2019. We are also below average when compared to other acute trusts by 3.7%.

The question relating to personally experiencing discrimination at work in the last 12 months from patients/service users, their relatives or other members of the public has deteriorated from 8.5% in 2018 to 9.8% in 2019. The national average when compared to other acute trusts is 6.8%.

The same question, but relating to discrimination from managers, team leaders or other colleagues was 10.2% in 2018 and has increased slightly to 10.4%. We are also worse than the national average which is 7.5%

There was a slight improvement for the final question that asks if adequate adjustments have been made in order to enable staff to carry out their work. Our 2018 result was 76% rising to 76.3% in 2019. We are also better than the national average for acute trusts which is 73.4%.

The survey has highlighted some areas of concern and we will be working with our teams to analyse the results more deeply in order to continue our work in ensuring all our staff are focused on our values, by displaying positive behaviours, high quality care striving for continuous improvement and meaningful staff engagement to sustainably improve staff satisfaction at work.

Disability Confident Scheme Certification

We continue to be certified as a Disability Confident Employer (formally Positive about Disabled People 'Two Ticks' Scheme) and as a result of this we commit to:

- Get the right people for our organisation - which includes providing fully inclusive and accessible recruitment processes, offering interviews to disabled people who meet the minimum criteria for the job and making reasonable adjustments as required.

- Keep and develop our staff - which includes supporting our staff to manage their disabilities or health conditions.

Along with ensuring that our recruitment processes are accessible and fair, we also encouraged our existing staff, that have a disability, to make us aware so that we could meet with them and discuss what support could be provided, if required. Knowing which of our staff have a disability also enables us to record the number of disabled staff that we have and the nature of their disability, in line with the Data Protection Act.

It is our ultimate goal is to attain the next level of certification, which is a Disability Confident Leader.

Faith and Belief

As one of the largest employers in Northampton our staff have many different religious beliefs, some of which have specific festival periods or Holy Days throughout the year.

Although there is no right that guarantees staff time off to attend religious services, we do recognise that it is good practice to accommodate requests where possible. To support with this we have been making our managers aware of key dates for religious observance and providing them with information to help them better understand the needs of our staff in relation to their religion or beliefs.

The hospital has two chaplains and a team of 12 volunteer pastoral visitors. The chaplains regularly visit the wards and are always happy to offer support or a 'listening ear'. Hospital Chaplains have a duty of care not only for the patients, but also the whole hospital community, including staff, visitors and friends.

A Hospital Chaplain is always available to support people in their religious and spiritual journey. The Chapel is always open and can offer a refuge and sanctuary for prayer, reflection and meditation for staff, patients and visitors.

Health and Well Being for Staff

The working environment of an acute Trust is demanding and can be pressurised, therefore promoting a culture of health and wellbeing in our organisation has never been more important. Our staff are our biggest asset, they are committed to patient care and their physical and emotional wellbeing is key.

Over the past 12 months we have promoted a range of opportunities for staff to improve and invest in their health and wellbeing. We have provided practical options for staff to participate in, with the emphasis of providing them with visible and tangible initiatives to highlight the importance the hospital places on the wellbeing of our staff.

During the Trust response to COVID-19 our efforts focused on the mental well-being of staff and how we could support them to enable them to continue to deliver the best possible care to our patients and to look after themselves and their colleagues.

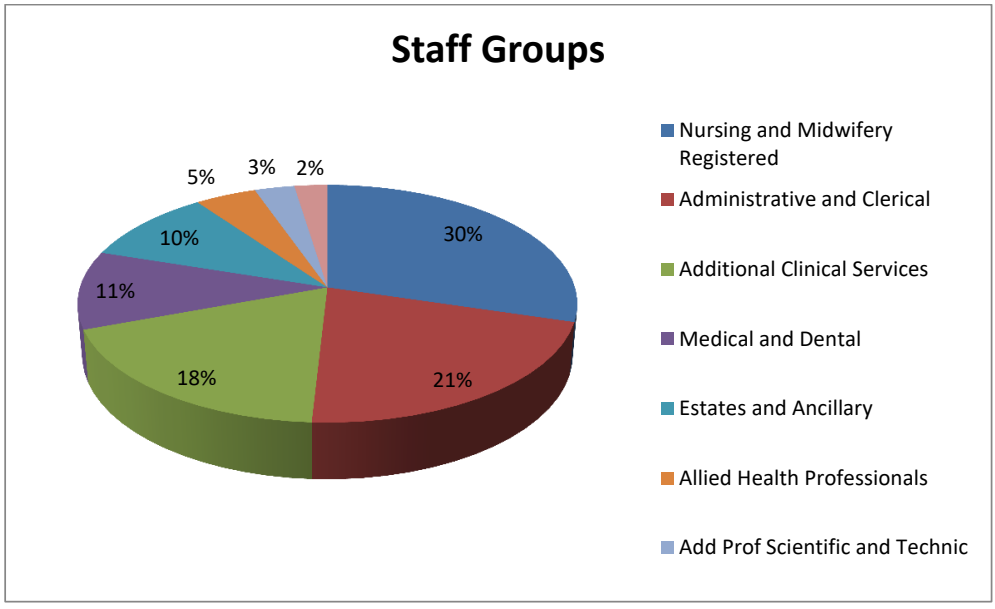
Live Life... Live Well

Our Workforce Data

As at 31 March 2020 the Trust employed 5457 members of staff, which was a whole time equivalent of 4801.35 people.

By Staff Group breakdown is as follows:

Staff Group (as at 31/3/20)	Headcount	%
Nursing and Midwifery Registered	1616	29.61
Administrative and Clerical	1160	21.26
Additional Clinical Services	1010	18.51
Medical and Dental	580	10.63
Estates and Ancillary	549	10.06
Allied Health Professionals	248	4.54
Add Prof Scientific and Technic	161	2.95
Healthcare Scientists	133	2.44
Total	**5457**	**100%**



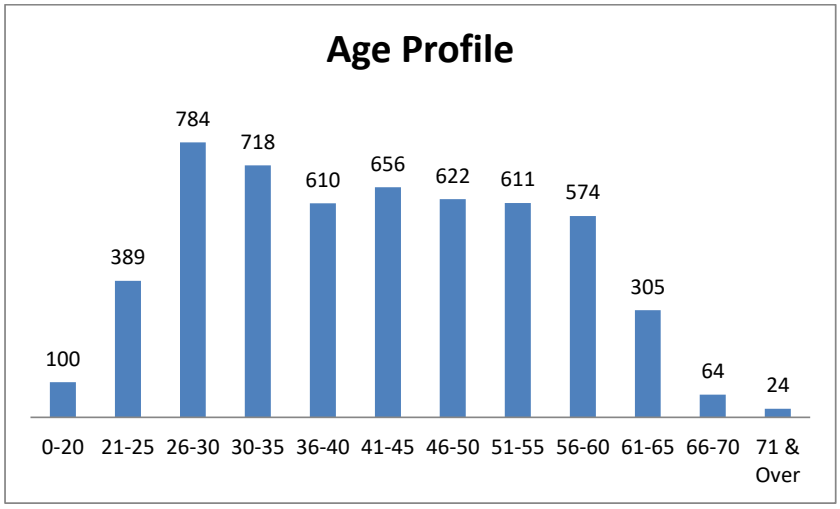
Age

Age - Trust Profile

The overall age profile for the Trust is shown in the table below:

Age Profile (as at 31/3/20)	Headcount	%
0-20	100	1.83
21-25	389	7.13
26-30	784	14.36
30-35	718	13.15
36-40	610	11.18
41-45	656	12.02
46-50	622	11.39
51-55	611	11.20
56-60	574	10.52
61-65	305	5.59
66-70	64	1.19
71 & Over	24	0.44
Total	**5457**	**100%**

The highest percentage of staff employed by the Trust are in the age ranges of 26-30 and 30-35. The lowest percentage of staff employed are in the age ranges of 71 and over and 66-70.



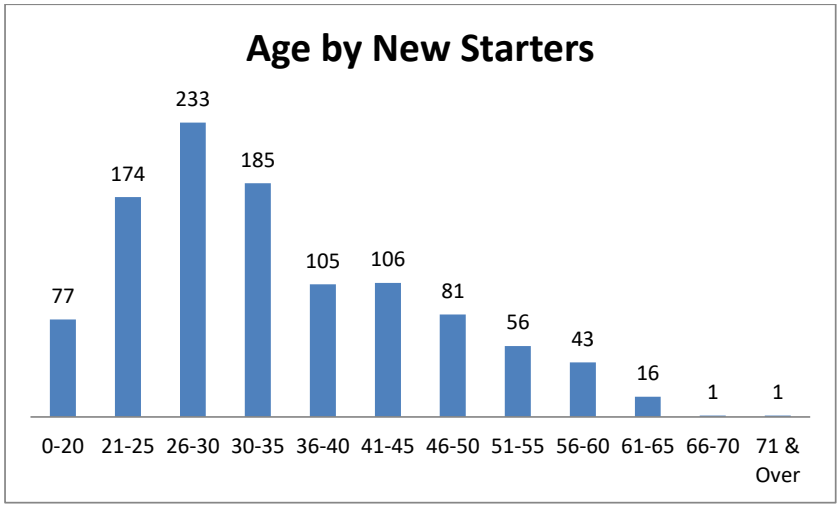
Age by Pay Band

Band	Age Group	Total	%	All Staff %
Bands 4 and Below	Under 20	100	4.23%	1.83%
	21-25	210	8.89%	7.11%
	26-30	267	11.30%	14.39%
	31-35	256	10.83%	13.16%
	36-40	244	10.33%	11.18%
	41-45	217	9.18%	12.02%
	46-50	258	10.92%	11.40%
	51-55	286	12.10%	11.20%
	56-60	289	12.23%	10.52%
	Over 61	236	9.99%	7.19%
	Total	**2363**	100.00%	
Bands 5-7	Under 20	0	0.00%	1.83%
	21-25	147	6.42%	7.11%
	26-30	394	17.21%	14.39%
	31-35	349	15.25%	13.16%
	36-40	272	11.88%	11.18%
	41-45	323	14.11%	12.02%
	46-50	256	11.18%	11.40%
	51-55	225	9.83%	11.20%
	56-60	209	9.13%	10.52%
	Over 61	115	5.02%	7.19%
	Total	**2289**	100.04%	
Band 8 and Above including VSM	Under 20	0	0.00%	1.83%
	21-25	0	0.00%	7.11%
	26-30	7	3.11%	14.39%
	31-35	19	8.44%	13.16%
	36-40	20	8.89%	11.18%
	41-45	39	17.33%	12.02%
	46-50	42	18.67%	11.40%
	51-55	47	20.89%	11.20%
	56-60	35	15.56%	10.52%
	Over 61	16	7.11%	7.19%
	Total	**225**	100.00%	
Medical & Dental	Under 20	0	0.00%	1.83%
	21-25	32	5.52%	7.11%
	26-30	117	20.17%	14.39%
	31-35	94	16.21%	13.16%
	36-40	74	12.76%	11.18%
	41-45	77	13.28%	12.02%
	46-50	66	11.38%	11.40%
	51-55	53	9.14%	11.20%
	56-60	41	7.07%	10.52%
	Over 61	26	4.48%	7.19%
	Total	**580**	100.00%	

Age by New Starters

Between 1 April 2019 and 31 March 2020 there were 1078 new starters at the Trust, which represents 19.75% of the workforce.

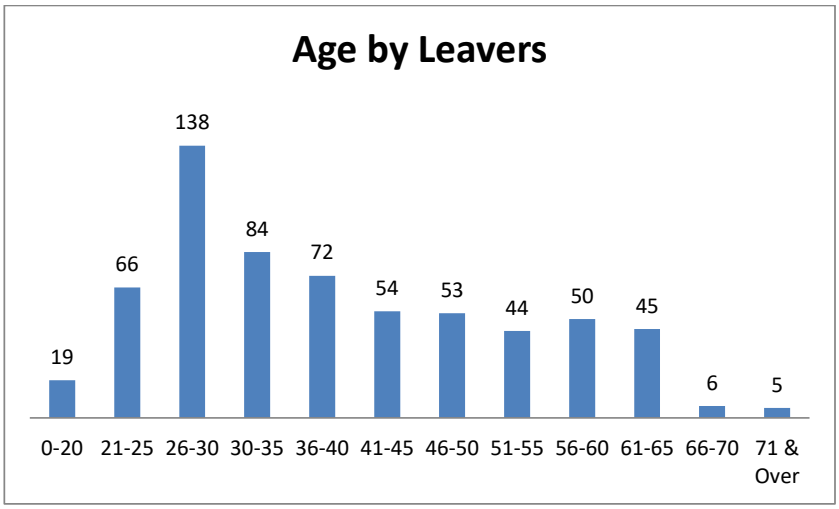
Age Profile of New Starters (as at 31/3/20)	Headcount	%
0-20	77	7.14
21-25	174	16.14
26-30	233	21.62
30-35	185	17.16
36-40	105	9.74
41-45	106	9.83
46-50	81	7.51
51-55	56	5.19
56-60	43	3.99
61-65	16	1.48
66-70	1	0.10
71 & Over	1	0.10
Total	**1078**	**100%**



Age by Leavers

Between 1 April 2019 and 31 March 2020 there were 636 leavers from the Trust, which represents 11.65% of the workforce.

Age Profile of Leavers (as at 31/3/20)	Headcount	%
0-20	19	2.99
21-25	66	10.38
26-30	138	21.7
30-35	84	13.21
36-40	72	11.32
41-45	54	8.49
46-50	53	8.33
51-55	44	6.92
56-60	50	7.86
61-65	45	7.07
66-70	6	0.94
71 & Over	5	0.79
Total	**636**	**100%**



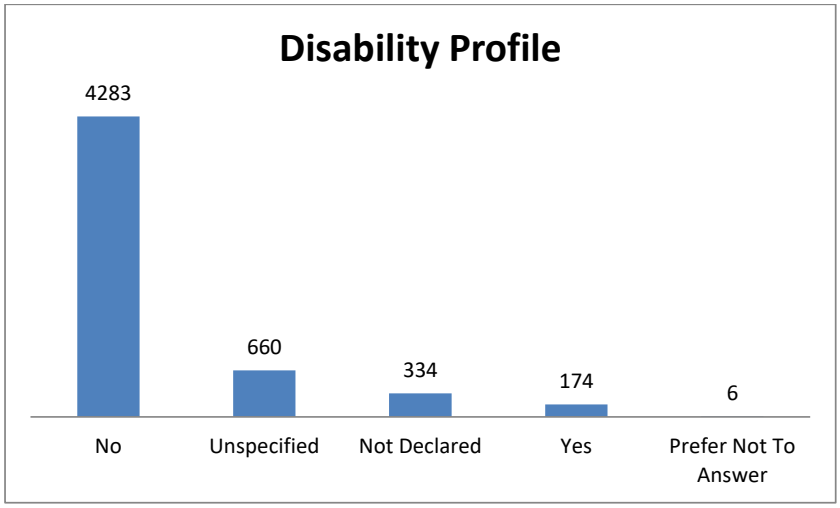
Disability

Disability - Trust Profile

The overall disability profile for the Trust is shown in the table below:

Disability Profile (as at 31/3/20)	Headcount	%
No	4283	78.49
Unspecified	660	12.09
Not Declared	334	6.12
Yes	174	3.19
Prefer Not to Answer	6	0.11
Total	**5457**	**100%**

The highest percentage of staff employed by the Trust have declared they do not have a disability. The lowest percentage of staff employed have indicated they would prefer not to answer or have declared they have a disability.



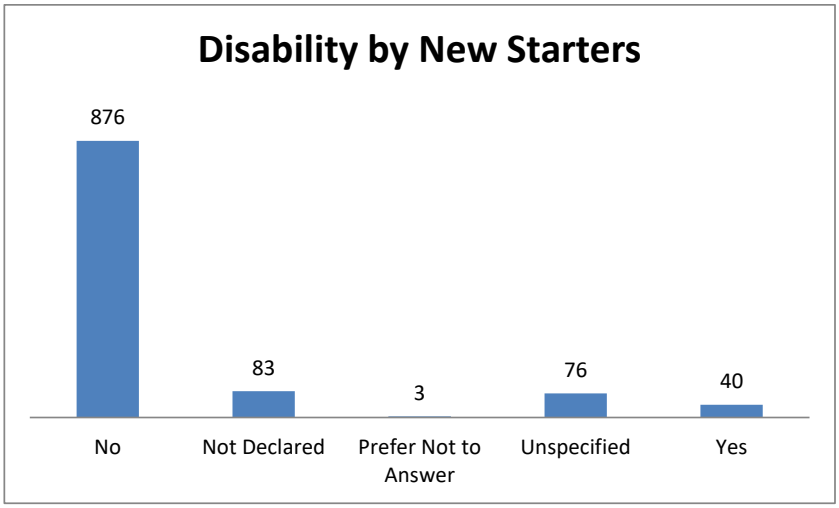
Disability by Pay Band

Band	Disability	Total	%	All Staff %
Bands 4 and Below	No	1908	80.75%	78.50%
	Not Declared	83	3.51%	6.12%
	Prefer Not to Answer	2	0.08%	0.11%
	Unspecified	284	12.02%	12.10%
	Yes	86	3.64%	3.17%
	Total	**2363**	**100%**	
Bands 5-7	No	1815	79.29%	78.50%
	Not Declared	123	5.37%	6.12%
	Prefer Not to Answer	4	0.17%	0.11%
	Unspecified	267	11.66%	12.10%
	Yes	80	3.49%	3.17%
	Total	**2289**	**100%**	
Band 8 and Above including VSM	No	175	77.78%	78.50%
	Not Declared	9	4.00%	6.12%
	Prefer Not to Answer	0	0.00%	0.11%
	Unspecified	40	17.78%	12.10%
	Yes	1	0.44%	3.17%
	Total	**225**	**100%**	
Medical & Dental	No	385	66.38%	78.50%
	Not Declared	119	20.52%	6.12%
	Prefer Not to Answer	0	0.00%	0.11%
	Unspecified	69	11.90%	12.10%
	Yes	7	1.21%	3.17%
	Total	**580**	**100%**	

Disability by New Starters

Between 1 April 2019 and 31 March 2020 there were 1078 new starters at the Trust, which represents 19.75% of the workforce.

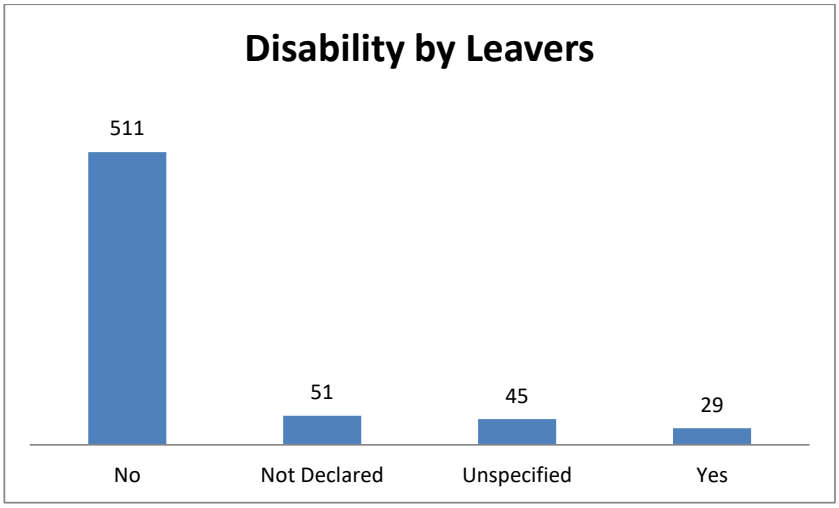
Disability Profile of New Starters (as at 31/3/20)	Headcount	%
No	876	81.26
Not Declared	83	7.70
Prefer Not to Answer	3	0.28
Unspecified	76	7.05
Yes	40	3.71
Total	**1078**	**100%**



Disability by Leavers

Between 1 April 2019 and 31 March 2020 there were 636 leavers from the Trust, which represents 11.65% of the workforce.

Disability Profile of Leavers (as at 31/3/20)	Headcount	%
No	511	80.34
Not Declared	51	8.02
Unspecified	45	7.08
Yes	29	4.56
Total	**636**	**100%**



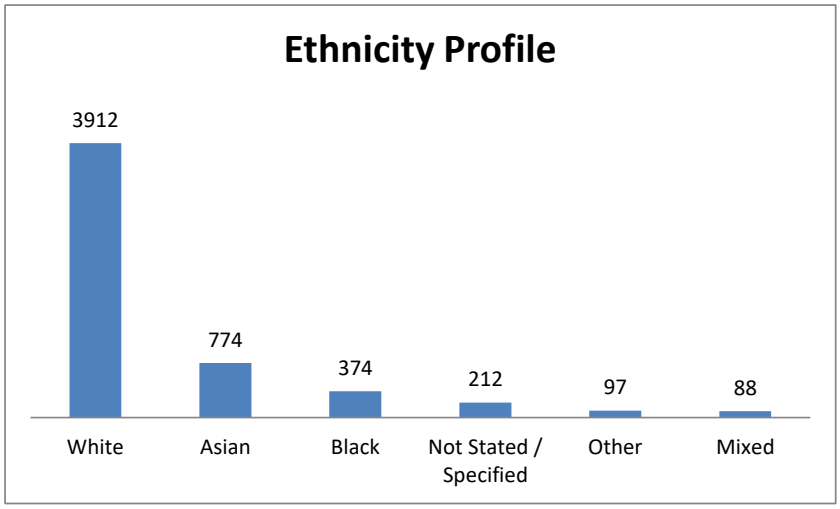
Ethnicity

Ethnicity - Trust Profile

The overall ethnicity profile for the Trust is shown in the table below:

Ethnicity Profile (as at 31/3/20)	Headcount	%
White	3912	71.70
Asian	774	14.18
Black	374	6.85
Not Stated / Specified	212	3.88
Other	97	1.78
Mixed	88	1.61
Total	**5457**	**100%**

The highest percentage of staff employed by the Trust are White. The lowest percentage of staff employed are Mixed or Other.



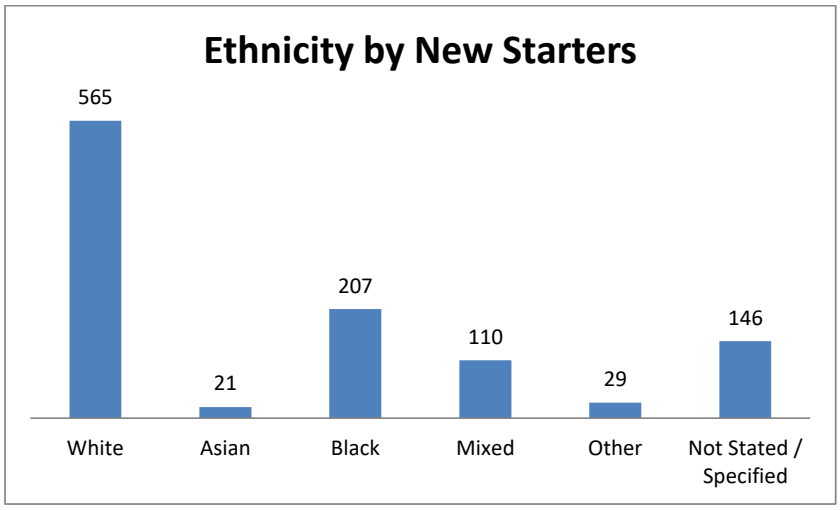
Ethnicity by Pay Band

Band	Disability	Total	%	All Staff %
Bands 4 and Below	White	1955	82.74%	71.70%
	Asian	161	6.81%	14.18%
	Black	134	5.67%	6.85%
	Mixed	39	1.65%	1.61%
	Not Stated / Specified	48	2.03%	3.88%
	Other	26	1.10%	1.78%
	Total	**2363**	**100%**	
Bands 5-7	White	1564	68.33%	71.70%
	Asian	388	16.95%	14.18%
	Black	198	8.65%	6.85%
	Mixed	33	1.44%	1.61%
	Not Stated / Specified	69	3.01%	3.88%
	Other	37	1.62%	1.78%
	Total	**2289**	**100%**	
Band 8 and Above including VSM	White	193	85.78%	71.70%
	Asian	13	5.77%	14.18%
	Black	8	3.56%	6.85%
	Mixed	2	0.89%	1.61%
	Not Stated / Specified	5	2.22%	3.88%
	Other	4	1.78%	1.78%
	Total	**225**	**100%**	
Medical & Dental	White	200	34.49%	71.70%
	Asian	212	36.55%	14.18%
	Black	34	5.86%	6.85%
	Mixed	14	2.41%	1.61%
	Not Stated / Specified	90	15.52%	3.88%
	Other	30	5.17%	1.78%
	Total	**580**	**100%**	

Ethnicity by New Starters

Between 1 April 2019 and 31 March 2020 there were 1078 new starters at the Trust, which represents 19.75% of the workforce.

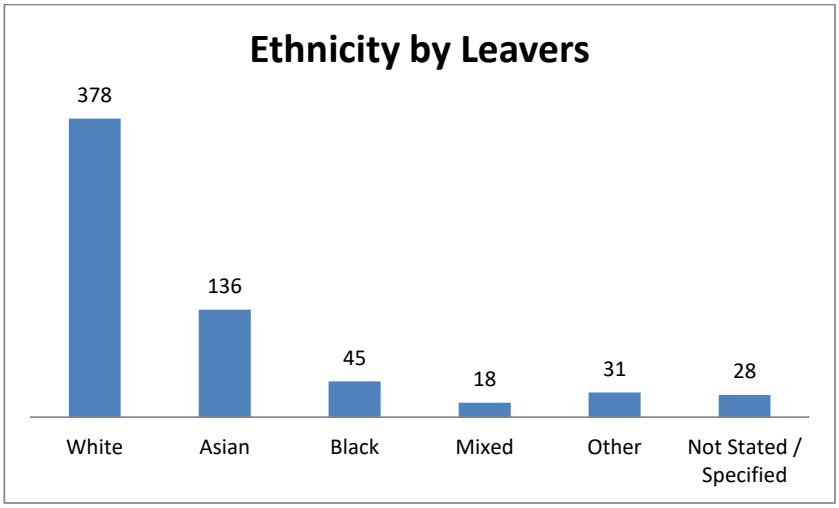
Age Profile of New Starters (as at 31/3/20)	Headcount	%
White	565	52.42
Asian	21	1.95
Black	207	19.20
Mixed	110	10.20
Other	29	2.69
Not Stated / Specified	146	13.54
Total	**1078**	**100%**



Ethnicity by Leavers

Between 1 April 2019 and 31 March 2020 there were 636 leavers from the Trust, which represents 11.65% of the workforce.

Ethnicity Profile of Leavers (as at 31/3/20)	Headcount	%
White	378	59.44
Asian	136	21.38
Black	45	7.08
Mixed	18	2.83
Other	31	4.87
Not Stated / Specified	28	4.40
Total	**636**	**100%**



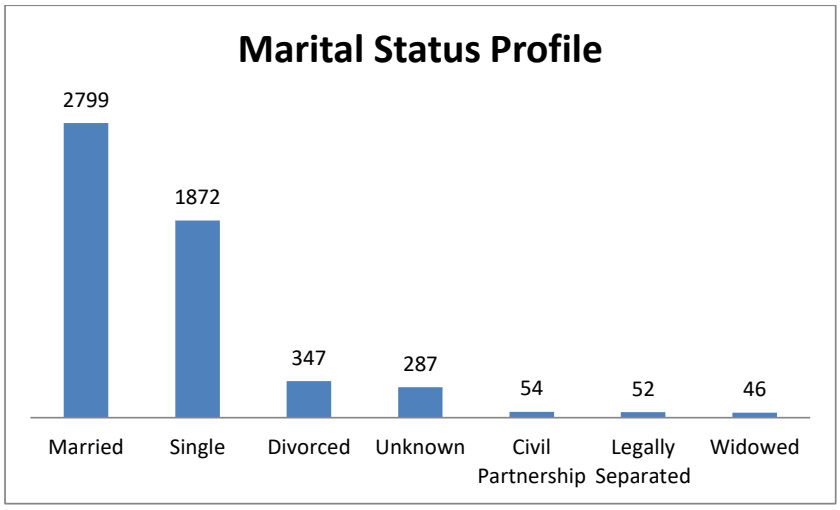
Marital Status

Marital Status - Trust Profile

The overall marital status profile for the Trust is shown in the table below:

Marital Status Profile (as at 31/3/20)	Headcount	%
Married	2799	51.30
Single	1872	34.30
Divorced	347	6.36
Unknown	287	5.26
Civil Partnership	54	0.99
Legally Separated	52	0.95
Widowed	46	0.84
Total	**5457**	**100%**

The highest percentage of staff employed by the Trust are married. The lowest percentage of staff employed are widowed or legally separated.



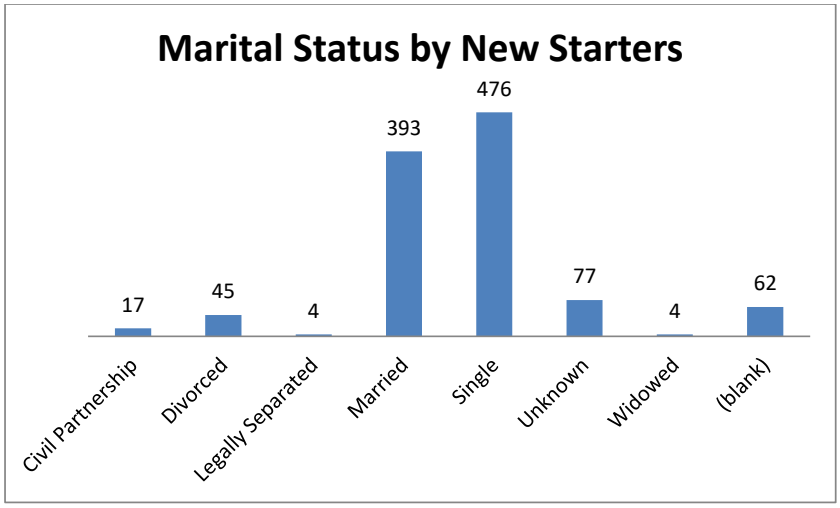
Marital Status by Pay Band

Band	Disability	Total	%	All Staff %
Bands 4 and Below	Civil Partnership	34	1.44	0.99
	Divorced	194	8.21	6.36
	Legally Separated	37	1.57	0.95
	Married	1065	45.06	51.3
	Single	932	39.44	34.3
	Unknown	54	2.29	5.26
	Widowed	47	1.99	0.84
	Total	**2363**	**100%**	
Bands 5-7	Civil Partnership	17	0.74	0.99
	Divorced	126	5.5	6.36
	Legally Separated	13	0.57	0.95
	Married	1262	55.14	51.3
	Single	793	34.64	34.3
	Unknown	67	2.93	5.26
	Widowed	11	0.48	0.84
	Total	**2289**	**100%**	
Band 8 and Above including VSM	Civil Partnership	3	1.33	0.99
	Divorced	16	7.11	6.36
	Legally Separated	1	0.45	0.95
	Married	153	68	51.3
	Single	41	18.22	34.3
	Unknown	10	4.44	5.26
	Widowed	1	0.45	0.84
	Total	**225**	**100%**	
Medical & Dental	Civil Partnership	0	0	0.99
	Divorced	11	1.9	6.36
	Legally Separated	1	0.17	0.95
	Married	319	55	51.3
	Single	106	18.28	34.3
	Unknown	141	24.31	5.26
	Widowed	2	0.34	0.84
	Total	**580**	**100%**	

Marital Status by New Starters

Between 1 April 2019 and 31 March 2020 there were 1078 new starters at the Trust, which represents 19.75% of the workforce.

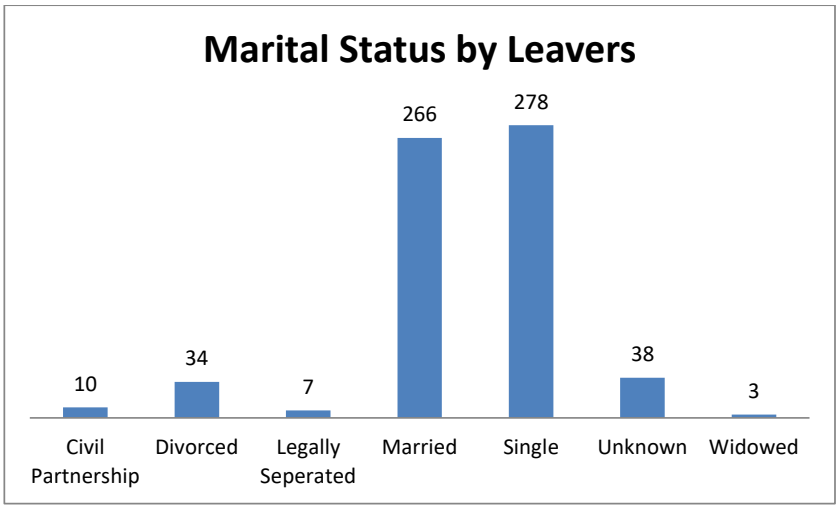
Marital Status Profile of New Starters (as at 31/3/20)	Headcount	%
Civil Partnership	17	1.58
Divorced	45	4.17
Legally Separated	4	0.37
Married	393	36.46
Single	476	44.16
Unknown	139	12.89
Widowed	4	0.37
Total	**1078**	**100%**



Marital Status by Leavers

Between 1 April 2019 and 31 March 2020 there were 636 leavers from the Trust, which represents 11.65% of the workforce.

Marital Status Profile of Leavers (as at 31/3/20)	Headcount	%
Civil Partnership	10	1.57
Divorced	34	5.35
Legally Separated	7	1.10
Married	266	43.72
Single	278	43.71
Unknown	38	5.97
Widowed	3	0.47
Total	**636**	**100%**



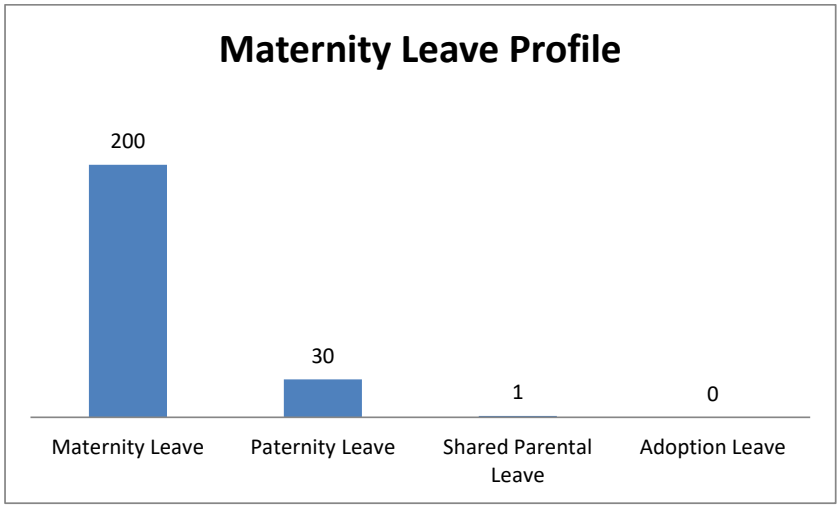
Maternity

Maternity Status - Trust Profile

The overall maternity status profile for the Trust, including paternity leave and shared parental leave is shown in the table below:

Marital Status Profile (as at 31/3/20)	Headcount	% of Trust Staff
Maternity Leave	200	3.67
Paternity Leave	30	0.55
Shared Parental Leave	1	0.02
Adoption Leave	0	0.00
Total	**231**	**4.24**

The highest percentage of staff on parenting leave are on maternity leave.



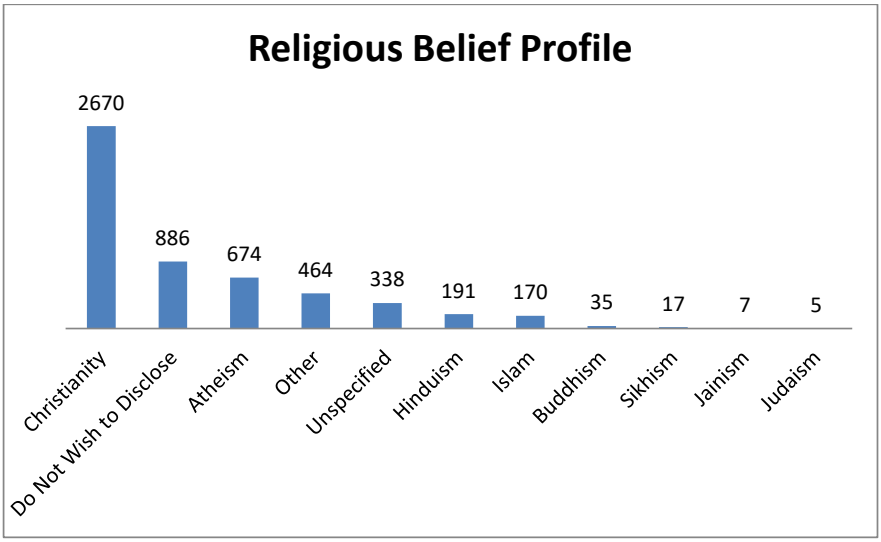
Religious Belief

Religious Belief - Trust Profile

The overall religious belief profile for the Trust is shown in the table below:

Religious Belief Profile (as at 31/3/20)	Headcount	%
Christianity	2670	48.93
I Do Not Wish to Disclose	886	16.24
Atheism	674	12.35
Other	464	8.50
Unspecified	338	6.19
Hinduism	191	3.50
Islam	170	3.12
Buddhism	35	0.64
Sikhism	17	0.31
Jainism	7	0.13
Judaism	5	0.09
Total	**5457**	**100%**

The highest percentage of staff employed by the Trust are Christian. The religious beliefs of the lowest percentage of staff employed are Judaism and Jainism.



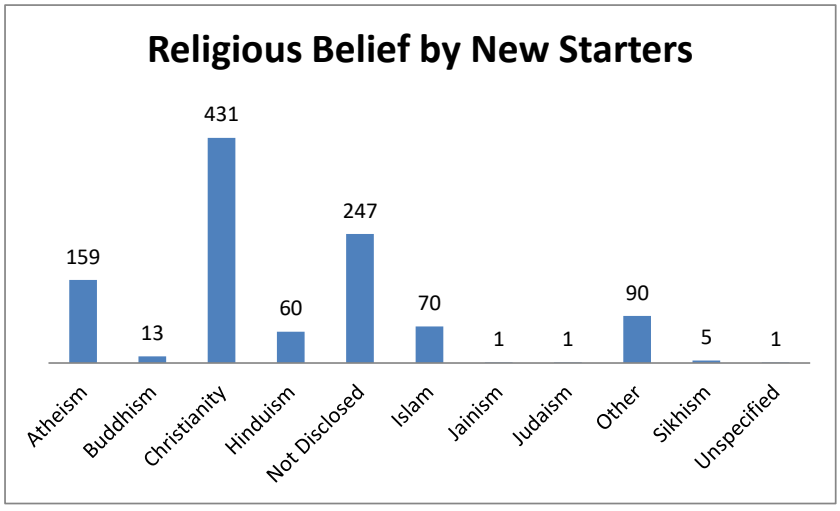
Religious Belief by Pay Band

Band	Religious Belief	Total	%	All Staff %
Bands 4 and Below	Atheism	324	13.71	12.35
	Buddhism	11	0.47	0.64
	Christianity	1178	49.86	49.93
	Hinduism	32	1.34	3.50
	Not Disclosed	372	15.75	16.24
	Islam	38	1.61	3.12
	Jainism	1	0.04	0.13
	Judaism	0	0.00	0.09
	Other	262	11.09	8.50
	Sikhism	5	0.21	0.31
	Unspecified	140	5.92	6.19
	Total	**2363**	100.00%	
Bands 5-7	Atheism	274	11.97	12.35
	Buddhism	7	0.31	0.64
	Christianity	1247	54.47	49.93
	Hinduism	63	2.75	3.50
	Not Disclosed	347	15.16	16.24
	Islam	40	1.75	3.12
	Jainism	3	0.13	0.13
	Judaism	2	0.09	0.09
	Other	175	7.65	8.50
	Sikhism	6	0.26	0.31
	Unspecified	125	5.46	6.19
	Total	**2289**	100.00%	
Band 8 and Above including VSM	Atheism	30	13.34	12.35
	Buddhism	1	0.44	0.64
	Christianity	123	54.68	49.93
	Hinduism	5	2.22	3.50
	Not Disclosed	28	12.44	16.24
	Islam	3	1.33	3.12
	Jainism	1	0.44	0.13
	Judaism	0	0.00	0.09
	Other	16	7.11	8.50
	Sikhism	1	0.44	0.31
	Unspecified	17	7.56	6.19
	Total	**225**	100.00%	
Medical & Dental	Atheism	46	7.93	12.35
	Buddhism	16	2.76	0.64
	Christianity	122	21.03	49.93
	Hinduism	91	15.69	3.50
	Not Disclosed	139	23.97	16.24
	Islam	89	15.34	3.12
	Jainism	2	0.34	0.13
	Judaism	3	0.52	0.09
	Other	11	1.90	8.50
	Sikhism	5	0.86	0.31
	Unspecified	56	9.66	6.19
	Total	**580**	100.00%	

Religious Belief by New Starters

Between 1 April 2019 and 31 March 2020 there were 1078 new starters at the Trust, which represents 19.75% of the workforce.

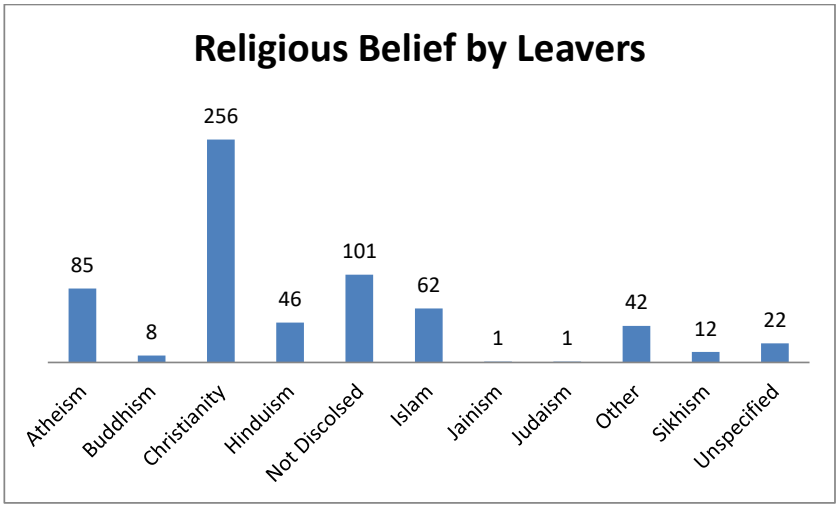
Religious Belief Profile of New Starters (as at 31/3/20)	Headcount	%
Atheism	159	14.75
Buddhism	13	1.21
Christianity	431	39.99
Hinduism	60	5.57
Not Disclosed	247	22.91
Islam	70	6.49
Jainism	1	0.09
Judaism	1	0.09
Other	90	8.35
Sikhism	5	0.46
Unspecified	1	0.09
Total	**1078**	**100%**



Religious Belief by Leavers

Between 1 April 2019 and 31 March 2020 there were 636 leavers from the Trust, which represents 11.65% of the workforce.

Religious Belief Profile of Leavers (as at 31/3/20)	Headcount	%
Atheism	85	13.36
Buddhism	8	1.26
Christianity	256	40.25
Hinduism	46	7.23
Not Disclosed	101	15.88
Islam	62	9.75
Jainism	1	0.16
Judaism	1	0.16
Other	42	6.60
Sikhism	12	1.89
Unspecified	22	3.46
Total	**636**	**100%**



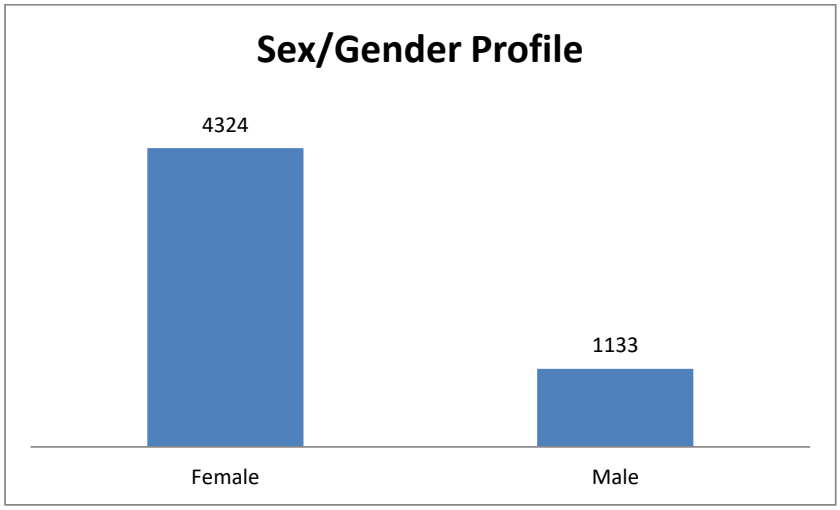
Sex/Gender

Sex/Gender - Trust Profile

The overall sex/gender profile for the Trust is shown in the table below:

Sex/Gender Profile (as at 31/3/20)	Headcount	%
Female	4324	79.24
Male	1133	20.76
Total	**5457**	**100%**

The highest percentage of staff employed by the Trust are female.



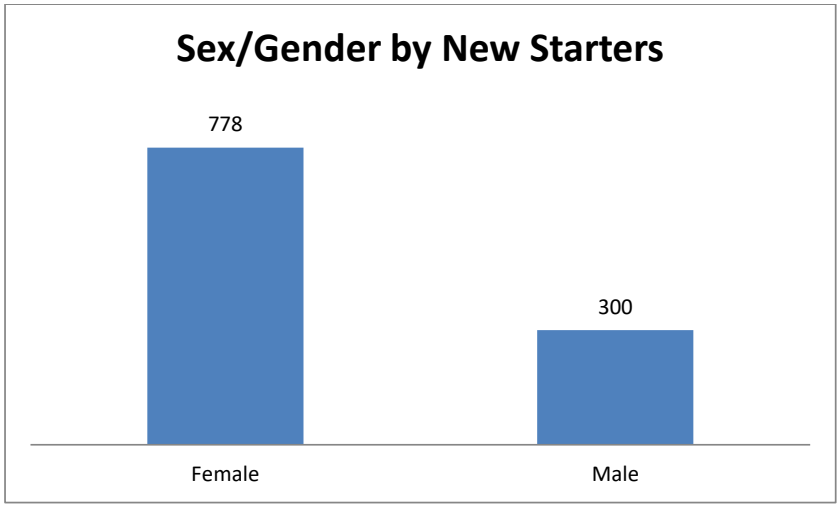
Sex/Gender by Pay Band

Band	Disability	Total	%	All Staff %
Bands 4 and Below	Female	1918	81.17	79.24
	Male	445	18.83	20.76
	Total	**2363**	**100%**	
Bands 5-7	Female	1992	87.02	79.24
	Male	297	12.98	20.76
	Total	**2289**	**100%**	
Band 8 and Above including VSM	Female	164	72.89	79.24
	Male	61	27.11	20.76
	Total	**225**	**100%**	
Medical & Dental	Female	250	43.10	79.24
	Male	330	56.90	20.76
	Total	**580**	**100%**	

Sex/Gender by New Starters

Between 1 April 2019 and 31 March 2020 there were 1078 new starters at the Trust, which represents 19.75% of the workforce.

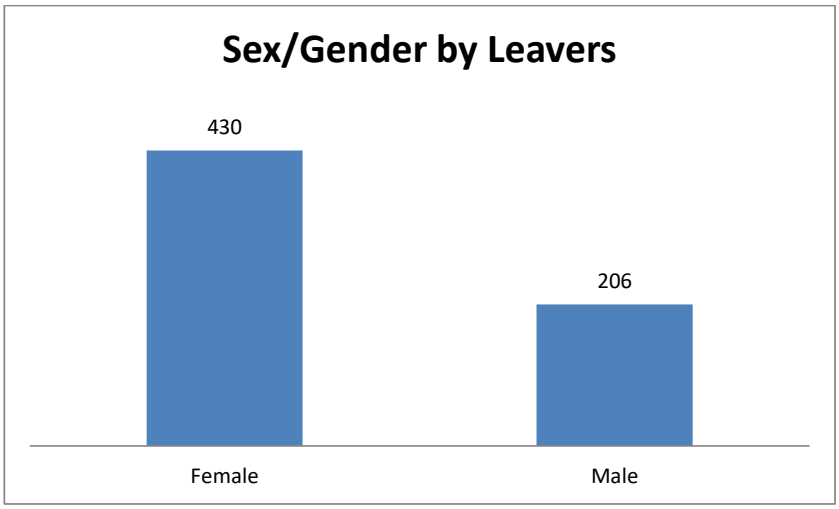
Sex/Gender Profile of New Starters (as at 31/3/20)	Headcount	%
Female	778	72.17
Male	300	27.83
Total	**1078**	**100%**



Sex/Gender by Leavers

Between 1 April 2019 and 31 March 2020 there were 636 leavers from the Trust, which represents 11.65% of the workforce.

Sex/Gender Profile of Leavers (as at 31/3/20)	Headcount	%
Female	430	67.61
Male	206	32.39
Total	**636**	**100%**



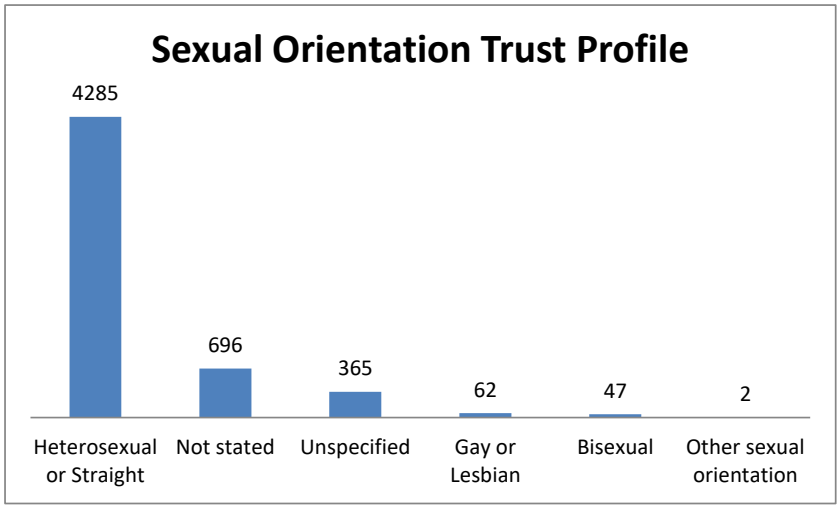
Sexual Orientation

Sexual Orientation - Trust Profile

The overall sexual orientation profile for the Trust is shown in the table below:

Sex/Gender Profile (as at 31/3/20)	Headcount	%
Heterosexual or Straight	4285	78.52
Not Stated	696	12.75
Unspecified	365	6.69
Gay or Lesbian	62	1.14
Bisexual	47	0.86
Other Sexual Orientation	2	0.04
Total	**5457**	**100%**

The highest percentage of staff employed by the Trust are heterosexual or straight. The sexual orientation of the lowest percentage of staff employed is other sexual orientation and bisexual.



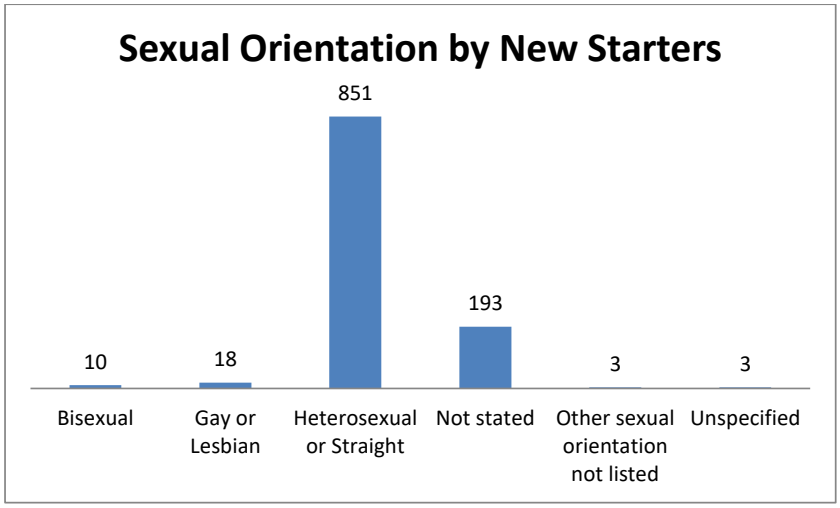
Sexual Orientation by Pay Band

Band	Disability	Total	%	All Staff %
Bands 4 and Below	Bisexual	24	1.02	0.86
	Gay or Lesbian	28	1.18	1.14
	Heterosexual or Straight	1911	80.88	78.52
	Not stated	247	10.45	12.75
	Other sexual orientation	2	0.08	0.04
	Unspecified	151	6.39	6.69
	Total	**2363**	**100%**	
Bands 5-7	Bisexual	22	0.96	0.86
	Gay or Lesbian	26	1.14	1.14
	Heterosexual or Straight	1816	79.33	78.52
	Not stated	288	12.58	12.75
	Other sexual orientation	0	0	0.04
	Unspecified	137	5.99	6.69
	Total	**2289**	**100%**	
Band 8 and Above including VSM	Bisexual	0	0	0.86
	Gay or Lesbian	5	2.22	1.14
	Heterosexual or Straight	180	80.00	78.52
	Not stated	22	9.78	12.75
	Other sexual orientation	0	0	0.04
	Unspecified	18	8.00	6.69
	Total	**225**	**100%**	
Medical & Dental	Bisexual	1	0.17	0.86
	Gay or Lesbian	4	0.69	1.14
	Heterosexual or Straight	378	65.17	78.52
	Not stated	139	23.97	12.75
	Other sexual orientation	0	0	0.04
	Unspecified	58	10.00	6.69
	Total	**580**	**100%**	

Sexual Orientation by New Starters

Between 1 April 2019 and 31 March 2020 there were 1078 new starters at the Trust, which represents 19.75% of the workforce.

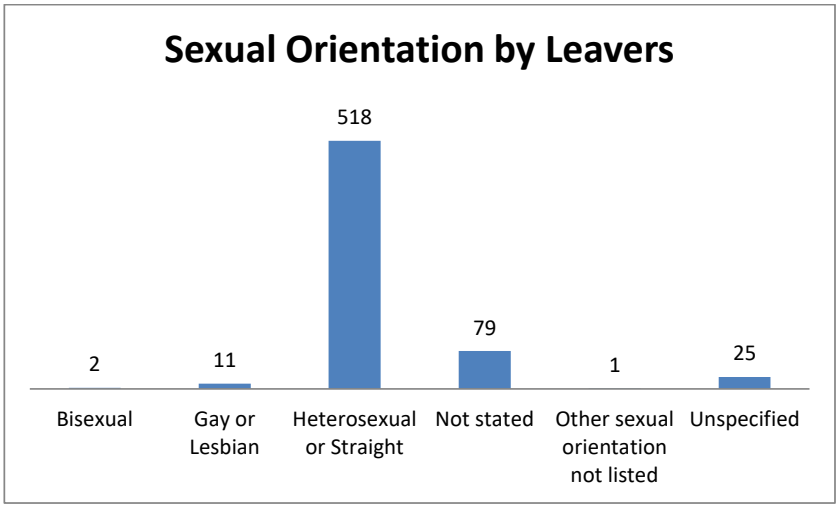
Sex/Gender Profile of New Starters (as at 31/3/20)	Headcount	%
Bisexual	10	0.93
Gay or Lesbian	18	1.67
Heterosexual or Straight	851	78.94
Not stated	193	17.90
Other sexual orientation	3	0.28
Unspecified	3	0.28
Total	**1078**	**100%**



Sexual Orientation by Leavers

Between 1 April 2019 and 31 March 2020 there were 636 leavers from the Trust, which represents 11.65% of the workforce.

Sex/Gender Profile of Leavers (as at 31/3/20)	Headcount	%
Bisexual	2	0.31
Gay or Lesbian	11	1.73
Heterosexual or Straight	518	81.45
Not stated	79	12.42
Other sexual orientation	1	0.16
Unspecified	25	3.93
Total	**636**	**100%**



Northampton General Hospital

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- Find us on Facebook
- Follow us on Twitter @nghnhstrust
- Follow us on Instagram

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30th July 2020**

Title of the Report	**Freedom to Speak Up Annual Report & Quarter 4 Report**
Agenda item	14
Presenter of Report	Claire Campbell Director of Corporate Development, Governance and Assurance/ Freedom to Speak up Guardian
Author(s) of Report	Claire Campbell Director of Corporate Development, Governance and Assurance/ Freedom to Speak up Guardian

This paper is for:

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

Executive summary

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

It provides information on concerns raised in quarter 4, as well as 2019/20. It also provides detail of case content, open and closed cases and outcomes and sources of concerns raised.

Comparisons with 2018/19 data is made where available.

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

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 4. *Create a great place to work, learn and care to enable excellence through our people*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks
Related Board Assurance Framework entries	BAF – please enter BAF number(s) BAF 1 BAF 2

Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Financial Implications	None
Legal implications / regulatory requirements	There is a legal requirement under the Health and Social Care Act to appoint a Freedom to Speak Up Guardian.

Actions required by the Board

The Board is asked to:

- Note and comment on the content of the report
- Accept this paper for information and assurance.

FREEDOM TO SPEAK UP ANNUAL REPORT (INCORPORATING Q4 REPORT)

1. INTRODUCTION

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

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

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

2. FREEDOM TO SPEAK UP CASES (JANUARY- MARCH 2020)

Within the quarter being reported, 17 Freedom to Speak Up cases were received. This is a decrease on the previous quarter (26).

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

Cases reported by/ to:
11 cases were reported to the Guardian direct
1 case was received by the Board
3 cases were reported to the CQC
2 cases were received by Ambassadors

Of the above cases;
- 7 remain open with ongoing investigations/ or report write up underway
- 4 referred to HR or within an HR process
- 1 referred to Fraud

Source of concerns raised by staff group:
- Doctor x1
- Nurse x 2
- Midwife x 7
- AHP's x 3
- Admin x 0
- Cleaning/ Catering/ Maintenance/ Ancillary staff x 2

- Corporate x 0
- Other x 2 (unknown)

10 individuals wished to remain anonymous.

0 cases where the individual indicated they are suffering detriment as a result of speaking up.

3. FREEDOM TO SPEAK UP CASES (APRIL 2019 - MARCH 2020)

The numbers of cases reported via the Freedom to Speak Up policy for 2019/20 were 71. This is a big increase on the previous year when 22 cases were reported in total.

Cases reported each quarter were as follows:
Quarter 1- 12 cases (2018/19- 3 cases)
Quarter 2- 16 cases (2018/19 2 cases)
Quarter 3- 26 cases (2018/19 1 case)
Quarter 4- 17 cases (2018/19 16 cases)

The increase in Quarter 3 could be partly related to raising awareness due to October being National Freedom to Speak Up month.

Content of cases reported:

Category	**Q1**	**Q2**	**Q3**	**Q4**	**Total 2019/20**	**2018/19**
Patient safety/ quality	5	6	9	10	**30**	**5**
Staff safety/ Training	2	2	0	1	**5**	**2**
Bullying and harassment	6	10	19	6	**41**	**9**
Systems, processes or policies	6	1	4	4	**15**	**7**
Environment/ infrastructure	1	0	0	0	**1**	**1**
Workplace culture	2	1	0	0	**3**	**7**
Leadership	4	1	0	1	**6**	**5**
Use of resources	1	0	0	1	**2**	**2**

- 30 cases identified issues with patient safety/ quality 42% (2018/19- 41%)
- 5 cases identified issues with staff safety/ Training 7% (2018/19- 9%)
- 41 cases identified issues with bullying and harassment 57% (2018/19- 54%)
- 15 cases identified issues with systems, processes or policies 21% (2018/19- 32%)
- 1 case identified issues with environment/ infrastructure 1% (2018/19- 4%)
- 3 cases identified issues with workplace culture 4% (2018/19- 32%)
- 6 cases identified issues with leadership 8% (2018/19- 23%)
- 2 cases identified issues with use of resources 3% (2018/19- 9%)

Case reported to:

Source	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
FTSU Guardian	11	14	20	11	**56**
CQC	1	0	1	2	**3**
GOSW	0	2	2	0	**4**
Ambassador	0	0	1	3	**4**
DATIX	0	0	1	0	**1**
Other	0	0	1	1	**2**

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

Staff group	Q1	Q2	Q3	Q4	Total	2018/19
Doctor	2	2	5	1	**10**	**1**
Nurse	2	4	4	2	**12**	**3**
Midwife	2	1	3	7	**13**	**4**
AHP	1	2	2	3	**8**	**2**
Pharmacist	1	0	0	0	**1**	**N/A**
Admin	0	3	6	0	**9**	**1**
Cleaning/ Catering/ Maintenance/ Ancillary staff	0	2	0	2	**4**	**2**
Corporate	0	0	4	0	**4**	**1**
Board Members	0	0	0	0	**0**	**0**
Other (Anonymous)	4	2	2	2	**10**	**5**
Total	**12**	**16**	**26**	**17**	**71**	**19 (3 Qtrs)**

In 2018/19 the data stored nationally did not enable the current Guardian to identify staff groups for Quarter 1. Therefore this has only been collated for three of the four quarters of 2018/19.

0 cases where the individual indicated they are suffering detriment as a result of speaking up in 2019/20 (2018/19- 1 case).

4. TRUST GUARDIAN ROLE- ACTIVITY IN PREVIOUS YEAR

- Worked with the Guardian of Safe Working to support each other's guardian roles and identify solutions to the challenges faced at a local level. Now provide a joint presentation to Junior Doctors "Meet the Guardians"
- Provided training to specific departments on request regarding Freedom to Speak Up
- Launched the Values Ambassador training with OD team –
- Work closely with OD team regarding further session for all trained Ambassadors and ongoing support.
- All data submissions were made before the required deadline (Q4 delayed nationally due to Covid 19)
- Completed the National Guardians Office Annual Survey for FTSU Guardians
- Planned and delivered activities for FTSU Month with communications team for October 2019 which included screen savers, introducing the Ambassadors, a personal message via video from the FTSU Guardian and increase in Twitter usage with the hashtag #speakuptome utilised nationally
- Attended KPMG- Ethics Champions Panel session in September on behalf of the National Guardians Office to promote the role of FTSU Guardians in the NHS and learn from non NHS organisations systems
- Attended the East Midlands Regional FTSU Network Meetings- latterly virtually
- Developed Trust FTSU strategy and presented to November Board Development. Final document was approved by the Workforce Committee in January 2020. Delivery dates to be reviewed due to Covid 19.
- Presented and discussed Trusts FTSU self-assessment (NHSE/I Guidance for Boards July 2019) at Board development- document content approved.
- Reviewed all seven Case Review Reports published to date by the National Guardians Office and the 102 recommendations made. These were reviewed and a gap analysis undertaken by the FTSU Guardian. This was reported to the Workforce Committee to ascertain what lessons can be learnt to improve FTSU systems and processes, to encourage staff and embed FTSU into the organisational culture. Actions identified were included in the Trust self-assessment/ Strategy development.

- Training- agreed inclusion of FTSU in staff induction and review of training in line with revised training guidance to ensure embedding into Trust practice- this has yet to commence due to Covid 19.
- Identified as a speaker for the Midlands Regional Integration and Development Event- unfortunately this was cancelled and replaced with a shorter virtual event led by the National Guardians Office

5. NATIONAL GUARDIANS OFFICE

5.1 Freedom to Speak Up Index Report

The Freedom to Speak Up Guardian Surveys run over the last couple of years have indicated that a positive speaking up culture is associated with higher performing organisations, as rated by the CQC. The annual NHS staff survey contains several questions that serve as helpful indicators of the speaking up culture in trusts. Working with NHS England, the NGO have brought four questions together into a 'Freedom to Speak Up (FTSU) index'.

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

The survey questions that have been used to make up the FTSU index are:

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

The Trusts who have the highest index scores by type of trust and the most improved trust have shared examples of their freedom to speak up arrangements. The report contains examples of their experience and how learning has been gained from speaking up.

Nationally the median FTSU score has improved since 2015. With Acute Trusts improving the median as follows:

Trust Type	2015	2016	2017	2018
Acute Trusts	75%	76%	76%	77%

Currently NGH scores 78% (2018 data), the same as KGH, with NHFT scoring 85%.

5.2 Speaking up in the NHS in England 2018/19

This report published in January 2020 revealed that over the last year cases of speaking up to guardians have risen by 73%, compared to 2017/18. Of the 12,000 cases raised between 1 April 2018 and 31 March 2019, guardians reported that almost a third included an element of patient safety/quality of care, and just over forty per cent included an element of bullying/harassment.

Other trends that the report draws from the data that guardians in trusts are providing to the National Guardian's Office are that the percentage of anonymous cases is falling, down to 12 per cent in 2018/19 compared to 18 per cent in 2017/18.

- Between 1 April 2017 and 31 March 2019, 19,331 cases were raised to Freedom to Speak Up (FTSU) Guardians in trusts and foundation trusts.
- 12,244 cases were raised to FTSU Guardians in trusts and foundation trusts between 1st April 2018 and 31st March 2019.
- The total number of cases raised in 2018/19 was 73% higher than that raised in the 2017/18 reporting period
- The number of cases raised in Q4 of 2018/19 was 38% higher than that raised in Q1 of the same year
- In 2018/19:
  - More cases (3,728, 30% of the total) were raised by nurses than other professional groups.
  - 1,491 cases (12%) were raised anonymously, compared to 18% of cases the previous year.
  - 3,523 cases (29%) included an element of patient safety/quality of care
  - 4,969 cases (41%) included an element of bullying/harassment

6. FURTHER WORK REQUIRED

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

- Review of the Trusts self- Assessment and implement areas for development which include the development of an overarching strategy and improvement plan and improved communications with respect to Freedom to Speak up.
- Identify training opportunities/programme within induction for all Trust staff to raise the profile of FTSU in the Trust
- Refresh the FTSU Strategy and revise deadlines due to Covid 19 impact
- Further develop the Ambassador role and increase numbers

7. RECOMMENDATIONS

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

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

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Report To	**Public Trust Board**
Date of Meeting	**30th July 2020**

Title of the Report	**National Inpatient Survey 2019- Results**
Agenda item	**15**
Presenter of Report	Sheran Oke, Director of Nursing, Midwifery and Patient Services
Author(s) of Report	Rachel Lovesy, Head of Patient Experience & Engagement

This paper is for: (delete as appropriate)

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

Executive summary

The 2019 National Inpatient Survey was published on 2nd July 2020. The Trust had a response rate of 43.42%.

Of the 12 sections contained within the survey, the Trust scored 'about the same as other Trusts for 10 sections and 'worse than' the national average in 2 sections.

There were 63 questions within the survey, of which the Trust scored 'about the same as other Trusts in 56 questions and Worse than most Trusts in 7 questions

The paper notes the actions which are already in place to drive improvement and highlights further actions needing to be undertaken

Progress will be reported and monitored through the Patient & Carer Experience & Engagement Group (PCEEG).

The Board are asked to note and discuss the results from the Inpatient Survey for 2019 and the action going forward.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a great place to work, learn and care to enable excellence through our people*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks No

Related Board Assurance Framework entries	BAF – please enter BAF number(s)
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	None
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper- No

Actions required by the Trust Board

The Board are asked to note and discuss the results from the Inpatient Survey for 2019 and the action going forward.

CQC National Inpatient Survey of Adult Inpatients- 2019 Results

1. Survey Overview

The National Inpatient Survey is an annual, mandatory requirement from the CQC. The survey comprises of questions which are all based on areas which have been determined by research conducted by the Picker Institute as issues which are the most important to patients. The survey is sent to patients who have attended the hospital during a particular month; in 2019 this month was June. Results from the survey were released in July 2020, 143 acute and specialist NHS trusts participated with 76,915 responses. Consideration should be given when reviewing the results given the changing landscape of the NHS between the time of patients being within the hospital (June 2019) and the results being released.

This report details the findings from the 2019 survey, including a comparison with national performance, a comparison with 2018 and an overview of the lowest scoring questions.

2. Trust Results 2019

In total, 521 patients responded to the survey, giving the Trust a **response rate of 43.42%,** this is slightly lower than the **national response rate of 45%**

National Methodology
The national methodology identifies an '**expected range**' to determine if NGH is performing 'about the same', 'better' or 'worse' compared with most other trusts.

The National Inpatient Survey 2019 is comprised of 12 sections with 63 questions distributed between the sections as illustrated in the table below.

Sections	Number of questions per section	Rating for the sections
S1. The Accident & Emergency Department (answered by emergency patients only)	2	about the same
S2. Waiting list or planned admissions (answered by those referred to hospital)	3	about the same
S3. Waiting to get to a bed on a ward	1	about the same
S4. The hospital and ward	12	about the same
S5. Doctors	3	worse
S6. Nurses	5	about the same
S7. Your care and treatment	12	about the same
S8. Operations and procedures (answered by patients who had an operation or procedure)	3	about the same
S9. Leaving hospital	17	about the same
S10. Feedback on care and research	3	about the same
S11. Respect and dignity	1	about the same
S12. Overall experience	1	worse

Of the 12 sections NGH performed 'the same as' in 10 and 'Worse than' the national average in two sections, these were:

- Doctors
- Overall Experience

From the 63 questions in the survey

NGH's results were better than most trusts for **0** questions.
NGH's results were about the same as other trusts for **56** questions.
NGH's results were worse than most trusts for **7** questions.

4 questions out of the 63, received a score of 9 or above indicating high levels of satisfaction:

- Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?
- Did nurses talk in front of you as if you weren't there?
- Did you ever share a sleeping area with patients of the opposite sex?
- Were you given enough privacy when being examined or treated?

7 questions out of the 63 scored worse than most trusts

- When you had important questions to ask a doctor, did you get answers that you could understand?
- Did you have confidence and trust in doctors treating you?
- How much information about your condition or treatment was given to you?
- Did you feel you were involved in decisions about your discharge from hospital?
- Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?
- Were you ever bothered by noise at night from other patients?
- Overall… I had a very good experience

Comparison with 2018's survey

NGH's results were significantly higher this year for **0** questions.
NGH's results were lower this year for **5** questions

Of the 5 questions where the Trust scored lower than last year, 4 of the 5 questions demonstrated statistically significant depreciation in score yet still were within the national average, indicating the potential decline in score for these questions nationally.

- From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward? (About the same)
- In your opinion, were there enough nurses on duty to care for you in hospital? (About the same)
- Were you given enough privacy when discussing your condition or treatment? (About the same)
- If you needed attention, were you able to get a member of staff to help you within a reasonable time? (About the same)

There were no statistically significant differences between last year's and this year's results for **56** questions.

NGH received 11 questions which scored 5 or below, all falling within the national averages.

- How would you rate the hospital food? (About the same)
- Did you find someone on the hospital staff to talk to about your worries and fears? (About the same)
- Did a member of staff tell you about medication side effects to watch for when you went home? (About the same)
- Did a member of staff tell you about any danger signals you should watch for after you went home? (About the same)

- During this hospital stay, did anyone discuss with you whether you would like to take part in a research study? (About the same)
- During your hospital stay, were you ever asked to give your views on the quality of your care? (About the same)
- Did you see, or were you given, any information explaining how to complain to the hospital about the care you received? (About the same)

3. Priority areas

It is evident from the 2019 survey that there are 3 prominent areas that require improvement:

- Communication
- Doctors
- Discharge – patient involvement and information

In addition, noting that there are multiple layers to the survey which require focus from a number of different areas within the hospital, for example pharmacy and patient drug information, healthcare professionals ensuring that patients are informed of their health status and involved in their safe discharge

The approach taken to improve our patients experience needs to build upon work already started including a breadth of functions, from the staff experience of the culture of the organisation, through to tailored division led actions with clear reporting functions and progress assessments

4. The way forward

4.1 National Survey Triangulation – Action Plans

In late 2019, work was undertaken to review all of the most recent 2018 national surveys to identify key areas of focus across the hospital. From this, actions plans were created by the Director of Nursing, Medical Director, Director of Estates & Facilities, Head of Clinical Pharmacy and Patient Experience. Due to the pandemic, the programme has been placed on hold, however the plans have been reviewed against the results from the 2019 Inpatient Survey to identify any gaps and where further actions need to be added. The following areas are already included within the triangulation at present:

- Noise at Night from the patients
- Understanding answers from Doctors

Progress against the plans will continue to be monitored through local surveys and reports will be presented and discussed at the Patient & Carer Experience & Engagement Group (PCEEG).

4.2 Supporting our staff – Cultural Change

It has long been acknowledged that the experience of staff has a direct impact on the experience of patients. Following the staff surveys results for 2019 it is evident that focus needs to be given to the culture of the organisation and the impact that it has on the staff experience. It is likely that any improvement on the experience of staff, how supported and nurtured feel by the organisation will have a direct impact on the care they provide to patients. There are particular aspects of the survey that require further understanding from a behavioural aspect, such as, why do patients not have confidence and trust in our doctors? The Organisational Development team are key to understanding this further and to supporting the staff to overcome some of these issues. Discussions will take place with the OD team to develop a plan of action in terms of the staff survey and aspects of the Inpatient survey that this impacts on.

4.3 Divisional Led Improvements

In addition to the Triangulation action plans, the results from the survey will be shared with each Divisional leadership triumvirate to outline the various issues which have been identified. The expectation is for each of the Divisions to drive improvements supported with an action plan detailing what they are going to do within their respective areas to improve and sustain a positive patient experience. This will also outline the governance channels within each Division to oversee the plans. A nominated lead from within the Division will attend PCEEG. Progress will be monitored through local surveys.

4.4 Changes during the pandemic

It should be noted that during the pandemic a number of changes have been made to the ward environment which are likely to have a positive impact on areas such as Noise at Night, with partitions built in a number of ward areas. Noise at Night from patients has been a consistent area of low satisfaction for patients within NGH and despite many measures being put into place the open environment has often been considered as one of the reasons for this being a persistently poor experience for patients.

4.5 Hospital Reset

As the hospital resets following the pandemic it is critical that patient feedback is used within reset plans to ensure changes made do not replicate previously dysfunctional processes. Feedback on subject areas is being directly fed into plans, for example, Inpatient Survey feedback is being reviewed within the Pharmacy reset and discharge cells, with a particular focus on the information given to patients at the point of discharge. The team are currently reviewing local survey data to understand whether ward based pharmacists have made an impact on patient experience within this area.

4.6 Quality Improvement

It is critical that the feedback received is linked into the work of the Quality Improvement programme and Transformation Team and projects are identified that can support the improvement work required.

5.0 Further actions for this year

5.1 Local Survey Review – 2020 Lead: Head of Patient Experience By 12/20

A review is being undertaken into the local surveys that we conduct within the trust, including the hospital's own version of the inpatient survey. This will allow wards to focus individually on areas of patient dissatisfaction. Reports will also be developed to allow for the monitoring of progress and to ensure that the wards that have a particular issue, are tasked with making improvements. These will be monitored alongside the Divisional Led action plans as a measure of whether progress is being made.

5.2 Concerns/ Complaints Information Lead: Head of PALS/Complaints By 11/20

Ways to ensure that our patients are aware of how to escalate concerns regarding their experience using either PALS or the complaints channels will be reviewed and relaunched making the best use of available technology.

5.3 Medical Leadership **Lead: Director Medical Education** **By 12/20**

The Director of Medical Education now represents the medical workforce at PCEEG and will identify, lead and support changes in patient experience with the medical teams. This is vitally important given the patient feedback this year. This will support the work which is already in place led by the Medical Director

6. The future of the National Inpatient Survey

Nationally the Inpatient Survey requires a review, this includes the questions asked, the methods of response and the sampling month. At present it has been indicated that the sample month will move to November. As the questions will change, 2019 was the last year that it will run in its current format and surveys moving forward will be incomparable.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

A G E N D A

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PUBLIC TRUST BOARD

Thursday 30 July 2020
09:30 via ZOOM at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr A Burns	**Verbal**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal**
	3.	Minutes of meeting 28 May 2020	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Patient & Staff Vlogs	Receive	Ms S Oke Mr M Metcalfe	**Verbal.**
	6.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	7.	Chief Executive's Report	Receive	Mr S Weldon	**C.**
PERFORMANCE					
	8.	Integrated Performance Report	Assurance	Executive Directors	**D.**
GOVERNANCE					
	9.	Board Assurance Framework	Approval	Ms C Campbell	**E.**
	10.	Covid-19 Reset	Assurance	Mrs D Needham Mr C Pallot Mr M Smith	**F.**
	11.	NGH Improvement Plan	Assurance	Ms C Campbell	**G.**
	12.	Group Governance Paper	Assurance	Mr S Weldon	**H.**
STRATEGY & CULTURE					
	13.	Equality, Diversity and Inclusion – BAME Staff Support	Assurance	Mr M Smith	**I.**
ANNUAL REPORTS					
	14.	Freedom To Speak Up Annual Report	Assurance	Ms C Campbell	**J.**
	15.	National Inpatient Survey Feedback 2019	Assurance	Ms S Oke	**K.**

Time	Agenda Item		Action	Presented by	Enclosure
GOVERNANCE continued					
	16.	Questions from the Public (Received in Advance)	Information	Mr A Burns	**Verbal.**
11:30	**17.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held 24 September at 09:30 on 2020 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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