# University Hospitals of Northamptonshire NHS Group (UHN): Meeting in Public of the Boards of Directors of Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

*Wed 05 June 2024, 09:30 - 12:00*

**North Northamptonshire Council, The Cube, George Street, Corby, Northants NN17 1**

## Agenda

**09:30 - 09:30**
0 min

### 1. Welcome, apologies and declarations of interest

*John MacDonald*

- UHN Boards Part I Agenda 050624.pdf (2 pages)

**09:30 - 10:00**
30 min

### 2. Patient/Staff Story: Palliative Care

*Presentation* *Pam Smith*

**10:00 - 10:05**
5 min

### 3. Minutes of the previous meeting held on 9 April 2024 and Action Log

*Decision* *John MacDonald*

- 3.1 090424 UHN Public Part I Boards of Directors Draft Minutes.pdf (9 pages)
- 3.2 Action Log Updated Post 090424 Part I Boards.pdf (2 pages)

**10:05 - 10:15**
10 min

### 4. Chair's report (verbal)

*Information* *John MacDonald*

#### 4.1. Chief Executive's report

*Information* *Richard Mitchell*

- 4.1 CEO update public board June 2024.pdf (5 pages)

**10:15 - 10:55**
40 min

### 5. Board Committee Chairs' reports and Integrated Governance Report

*Assurance* *Richard Mitchell / Board Committee Chairs*

- 5. Cover sheet_IGR.pdf (2 pages)
- 5.0 Group Upward Reporting to UHN 050624 Boards.pdf (18 pages)
- 5. IGR.pdf (106 pages)

**10:55 - 11:05**
10 min

### 6. Break

**11:05 - 11:05**
0 min

## 7. KGH New Hospital Enabling Project – Relocation of services from Warren Hill House (moved to private session due to ongoing commercial negotiations)

*KGH Decision* *Polly Grimmett*

**11:05 - 11:25**
20 min

## 8. KGH CQC report (added 31 May)

*Receive / Assurance* *Pam Smith*

- 8. CQC report May 24 response for TB (1).pdf (3 pages)

**11:25 - 11:35**
10 min

## 9. KGH Constitution

*Decision* *Richard Apps*

- 9. UHN report 050624 KGH Constitution.pdf (4 pages)
- 9. Appendix A Schedule of Proposed Changes 2024 review.pdf (5 pages)
- 9. Appendix B - KGH Revised Draft Constitution Board Council June 2024.pdf (61 pages)
- 9. Appendix C KGH draft sop-alleged-breach-governors-code-of-conduct1.pdf (2 pages)
- 9. Appendix D Significant-Transactions-Policy KGH revised draft 2024.pdf (13 pages)

**11:35 - 11:45**
10 min

## 10. Board Assurance Framework (BAF)

*Decision* *Richard Apps*

- 10. Boards BAF Cover Paper_June24.pdf (3 pages)
- 10. Appendix A_Group BAF_29MAY24.pdf (15 pages)
- 10. Appendix B_Corporate risks aligned to BAF risks @ May 2024.pdf (2 pages)

**11:45 - 11:50**
5 min

## 11. Fit and Proper Persons Compliance

*Decision* *John MacDonald*

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

**11:50 - 11:55**
5 min

## 12. Audit Committees Terms of Reference

*Decision* *Richard Apps*

- 12. Cover Sheet AC Terms of Reference 050624.pdf (3 pages)
- 12. KGH Audit Committee Terms of Reference Revised June 2024.pdf (8 pages)
- 12. NGH Audit Committee Terms of Reference Revised April 2024.pdf (7 pages)

**11:55 - 12:00**
5 min

## 13. Questions from the public

**12:00 - 12:00**
0 min

## 14. Any other business and close

# University Hospitals of Northamptonshire NHS Group (UHN): Meeting in Public of the Boards of Directors of Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

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| Meeting | Boards of Directors (Part I) Meeting in Public |
| Date & Time | Wednesday 5 June 2024, 09:30-12:00 |
| Location | North Northamptonshire Council, The Cube, George Street, Corby, Northants NN17 1QG |

| Purpose and Ambition |
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| The Boards are accountable to the public and stakeholders; to formulate the Trusts' strategies; ensure accountability; and to shape the culture of the organisations. The Boards delegate authority to Board Committees to discharge their duties effectively and these committees escalate items to the Boards, where Board oversight, decision making and direction is required. |

| Item | Description | Lead | Time | Purpose | P/V/Pr |
|---|---|---|---|---|---|
| 1 | Welcome, Apologies and Declarations of Interest | Chair | 09:30 | - | Verbal |
| 2 | Patient / Staff Story: Palliative Care | KGH Chief Nurse | 09:30 | Discussion | Present-ation |
| 3 | Minutes of the Previous Meeting held on 9 April 2024 and Action Log | Chair | 10:00 | Decision<br><br>Receive | Attached<br><br>Attached |
| 4 | 4 Chair's Report<br>4.1 Chief Executive's Report | Chair<br>Group Chief Executive Officer | 10:05 | Information<br>Information | Verbal<br>Attached |
| Operations | | | | | |
| 5 | Board Committee Chairs' Reports/ Integrated Governance Report (IGR) | Committee Chairs / Chief Executive and Executive Directors | 10:15 | Assurance | Attached |
| 6 | BREAK | | 10:55 | | |
| 7 | KGH New Hospital Enabling Project – Relocation of services from Warren Hill House – moved to Private meeting due to ongoing commercial negotiations | KGH Director of Strategy | 11:05 | KGH Decision | - |

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| 8 | KGH CQC report | KGH Chief Nurse | 11:05 | Receive / assurance | Attached |
| Governance | | | | | |
| 9 | KGH Constitution | Director of Corporate and Legal Affairs | 11:30 | KGH Decision | Attached |
| 10 | Board Assurance Framework | Director of Corporate and Legal Affairs | 11:35 | Assurance | Attached |
| 11 | Fit and Proper Persons Compliance | Chair | 11:45 | Assurance | Attached |
| 12 | Audit Committees' Terms of Reference | Director of Corporate and Legal Affairs | 11:50 | Decision | Attached |
| 13 | Questions from the Public | Chair | 11:55 | Information | Verbal |
| 14 | Any Other Business and close | Chair | 12:00 | Information | Verbal |
| **Date and venue of Next Meeting:** Friday 2 August 2024 at Northampton University | | | | | |

# Minutes of the Meeting

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| Meeting | Boards of Directors of the University Hospitals of Northamptonshire NHS Group (UHN) comprising Northampton General Hospital (NGH) and Kettering General Hospital (KGH) (Part I) Meeting together in Public |
| Date & Time | Tuesday 9 April 2024, 09:30-12:20 |
| Location | Moulton Community Centre |

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

| Attendance | Name and Title | |
|---|---|---|
| **Present** | John MacDonald | Interim Trust Chair, UHN |
| | Richard Mitchell | Chief Executive, UHN |
| | Richard Apps | Interim Director of Corporate and Legal Affairs, UHN |
| | Professor Natalie Armstrong | Non-Executive Director, KGH |
| | Natasha Chare | Chief Digital Information Officer, UHN |
| | Alice Cooper | Non-Executive Director, KGH |
| | Stuart Finn | Interim Director of Operational Estates, UHN |
| | Fay Gordon | Chief Operating Officer, KGH |
| | Polly Grimmett | Director of Strategy, KGH |
| | Sam Holden | Director of Communications and Engagement, UHN |
| | Jill Houghton | Non-Executive Director, UHN |
| | John Jameson | Medical Director, KGH |
| | Denise Kirkham | Non-Executive Director, NGH |
| | Paula Kirkpatrick | Chief People Officer, UHN |
| | Elena Lokteva | Non-Executive Director, NGH |
| | Deborah Manger | Non-Executive Director, KGH |
| | Andrew Moore | Non-Executive Director, KGH |
| | Deborah Needham | Hospital Chief Executive, KGH |
| | Hemant Nemade | Medical Director, NGH |
| | Rachel Parker | Non-Executive Director, NGH |
| | Ballu Patel | Associate Non-Executive Director, KGH |
| | Trevor Shipman | Non-Executive Director, KGH |
| | Jayne Skippen | Chief Nurse, KGH |
| | Caroline Stevens | Non-Executive Director, NGH |
| | Becky Taylor | Director of Transformation and Quality Improvement, UHN |
| | Damien Venkatasamy | Non-Executive Director, KGH |

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| | Professor Chris Welsh<br>Richard Wheeler<br>Palmer Winstanley | Non-Executive Director, UHN<br>Chief Finance Officer, UHN<br>Interim Hospital Chief Executive, NGH |
| **In Attendance** | Lou Corrigan<br><br>Richard May<br>Tom Swallow<br><br>Mara Tonks | Advanced Nurse Practitioner, Urology, NGH (Item 2)<br>UHN Company Secretary<br>Consultant Urological Surgeon, NGH (Item 2)<br>Director of Midwifery, KGH |
| **Apologies for absence** | Simon Baylis<br>Professor Andre Ng<br>Sarah Noonan<br>Nerea Odongo | Lead Governor, KGH<br>Associate Non-Executive Director, NGH<br>Interim Chief Operating Officer, NGH<br>Chief Nurse, NGH |

| Item | Discussion | Action Owner |
|---|---|---|
| 1 | **Welcome, Apologies and Declarations of Interest**<br><br>The Chair welcomed colleagues to meeting and noted apologies for absence as listed above. There were no declarations of interest relating to specific agenda items. | |
| 2 | **Patient and Staff Story: NGH Urology One Stop Clinic**<br><br>The Boards welcomed Tom Swallow, Consultant Urological Surgeon, and Lou Corrigan, Advanced Nurse Practitioner, to describe the creation of a 'one stop' urology clinic to facilitate earlier diagnosis and treatment plans for patients. The presentation covered the aims, structure and implementation of the initiative, and included positive patient testimony (via audio) regarding their experiences of a 'one stop' service; specifically, patients cited clear and timely pre-appointment information, professional and communicative staff, and efficient procedures. The service remained ambitious and sought to further streamline pathways and advance collaboration with KGH.<br><br>The Boards thanked Tom and Lou for the presentations and welcomed a positive example of innovation driven by empowered clinicians and sustained by executive leadership, as well as the ambition to go further and provide a model of excellence for other specialities. In response to questions, guests provided further detail around benefits for colleagues, particularly the opportunities for consultants to be able to undertake dedicated follow-up through specialist clinics, and identified other factors which had been critical to the initiative's success, including robust test pilots and learning from other models within the NHS. | |
| 3 | **Minutes of the last meeting held on 7 February 2024 and Action Log**<br><br>The Minutes of the meeting of the Boards of Directors of KGH and NGH held on 7 February 2024 were approved as a correct record. The Boards noted actions on the action log which were designated 'complete' or 'not yet due'. | |
| 4 | **Chair's Report** | |

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| | The Chair advised that the advertisement to recruit his successor was currently open, closing on 16 April 2024.<br><br>The Chair drew attention to the draft operating plan for 2024-25, in which a very clear understanding of priorities requiring extra focus was required which would require difficult judgements to be made.<br><br>The Chair expressed regret that the latest national survey results showed declining public confidence in the NHS, which reflected not only increasing waits for treatment but also the quality of experiences during treatment.<br><br>The Boards noted the Chair's report. | |
| 4.1 | **Chief Executive's Report**<br><br>The Chief Executive presented his report, commending the trusts for delivering national urgent and emergency care targets during March 2024, placing them amongst the most improved trusts in the country; this performance needed to be sustained and underpinned by a county-wide strategy. A summit meeting of Integrated Care Board partners was scheduled for June 2024 to progress this work.<br><br>The Chief Executive drew attention to the responses to the 2023 Staff Survey (see also item 9 below), re-emphasising the importance of improving both trusts as places of work and the consequentially beneficial impacts this had on patient care and the patient experience.<br><br>The Chief Executive noted that the trusts were undergoing periods of significant change as they were realigned to meet future need, recognising impacts on individuals directly affected. He extended his thanks to the Trusts' Hospital Chief Executives and to the KGH Medical Director, who would be leaving the organisations, for their contributions to the trusts, group and wider NHS, also paying tribute also to Interim Trusts' Chair John MacDonald, who had confirmed his intention to retire on 30 June 2024.<br><br>Hospital Chief Executives drew attention to the following specific issues relating to each Trust:<br><br>*Kettering General Hospital*<br><br>• The Trust planned to relocate further patients following the discovery of 'RAAC' concrete within its Rockingham Wing, making use of the Thomas Moore Ward; no patient or staff complaints had been received in response to the decants of patients that had been undertaken to date;<br>• The Hospital CEO attended a workshop in February 2024 with senior estates colleagues, providing an opportunity to reflect on actions taken and lessons from the Health and Safety incident in 2022 which resulted in serious injury to a colleague and subsequent prosecution by the Health and Safety Executive. The Trust was moving to embed an improved culture of health and safety within the department, including self-nomination of | |

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| | champions to undergo training with a view to educating others. In response to a question, the Boards were assured that relevant learning and good practice were shared across the UHN group;<br>• The first ROSE (Recognising our staff excellence) awards were held in March 2024 to recognise colleagues, nominated by patients, families and colleagues for their outstanding kindness and support. The Hospital CEO extended her thanks to all who had taken the time to nominate, and her congratulations to the six award recipients.<br><br>*Northampton General Hospital*<br><br>• The Emergency Department again witnessed very high attendances during March therefore achieving the national target of 76% of patients being discharged or admitted within four hours was a particularly commendable achievement;<br>• The Robotic Assisted Surgery team had achieved 500 cases, a significant achievement in a short space of time and testament to the drive and teamwork within theatres;<br>• The new Patient Safety and Incident Response Framework (PSIRF) had gone live and was already highlighting areas in which the trust could triangulate issues to prevent serious incidents;<br>• The Trust hosted an International Open Day showcasing successes in Pathway to Excellence, cementing its position as a pioneer in nursing and midwifery excellence;<br>• Through a targeted approach to recruitment, the number of consultant level vacancies at the trust had reduced from 47 to 19 during the 2023-24 financial year.<br><br>The Boards noted the introduction of 'Martha's Rule' in February 2024, enabling patients and families to seek second opinions where they were concerned about deteriorating conditions and, whilst supportive of the initiative, asked to ensure that this complemented other initiatives whose objectives overlapped such as the KGH call4concern, to avoid confusion and duplication.<br><br>The Boards noted the Chief Executive's reports. | |
| 5. | **Board Committee Summaries and Integrated Governance Report (IGR)**<br><br>The Chief Executive invited Committee Chairs, Convenors and Executive Leads to bring significant items and exceptions to the Boards' attention from the enclosed report, including performance variations set out within the IGR document:<br><br>*Strategic Development Committee*<br><br>Items of 'limited' assurance in respect of the KGH hospital redevelopment principally related to the lack of clarity in respect of processes and funding at national programme team level. Details were specified within the report. | |

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| | *Clinical Quality, Safety and Performance Committee*<br><br>The Committee:<br><br>- Received a report regarding several incidents which had occurred at NGH relating to patients with a background of sickle cell, indicating 'limited' assurance and requesting further work to develop a subregional service in the context of a national shortage of specialists; the Boards were assured that two new consultants had recently joined NGH, one of whom would be designated sickle cell lead;<br>- Received the safeguarding quarterly update and noted the ongoing lack of reporting app at NGH which gave rise to risks to timely incident management and learning;<br>- Noted the switch to a new digital dictation application at NGH on 27 March, indicating 'reasonable' assurance that the business and clinical needs of patients and staff would not be adversely impacted (particularly the risk of loss of records on obsolete servers);<br>- Noted that C-Difficile infections at NGH had decreased<br>- Approved amended Terms of Reference (see item 10 below).<br><br>The Boards expressed concern that complaints performance remained sub-optimal within the trusts and noted that the new PSIRF framework (see above) would enable improved triangulation of feedback from various sources to stimulate sustainable improvements and learning; the quarterly complaints report, received by the committee, had evolved to identify themes, trends and follow-up actions.<br><br>*Finance and Performance Committee*<br><br>The Committee:<br><br>- Received financial reports for Months 10 and 11 (January – February 2024), and noted that the trusts were anticipated to meet their year-end trajectories during Month 12 (March 2024) due to technical accounting adjustment. The Chief Finance Officer confirmed that these had been achieved;<br>- Considered the draft 2024-25 operating plan submission which showed an overall ICB deficit of £81.4m, with around £30m of efficiency savings yet to be identified;<br>- Noted continued challenges to UEC performance and concerns regarding the ICB's engagement with solutions which required engagement and input from across the local health system, specifically reducing the number of 'super stranded' patients spending over 21 days in hospital;;<br>- Noted the latest position following the discovery of 'RAAC' concrete in the KGH Rockingham Wing (to be subject to Private Board discussion)<br><br>*Audit Committees (meeting in common)*<br><br>The Committees:<br><br>- Received the trusts' responses to enquiries from external | |

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| | auditors regarding compliance with auditing standards, indicating 'reasonable' assurance in this regard;<br>- Approved Going concern status and policies for the preparation of the trusts' annual accounts;<br>- Indicated 'reasonable' assurance in respect of the Trusts' responses to recommendations and significant weaknesses identified in external auditors' 2022-23 reports and that, while the trusts' direct influence in respect of some issues such as determining their Oversight Framework segmentation was limited, improved and co-ordinated tracking and monitoring mechanisms were in place.<br><br>The KGH Committee indicated 'substantial' assurance in respect of the Trust's response to a serious health and safety incident from a technical and procedural perspective, retaining concerns regarding evidence of culture change which gave rise to an overall assurance rating of 'reasonable'.<br><br>*People Committee*<br><br>The Committee:<br><br>- Received a report into the drivers of agency spend and would retain this item for monthly consideration, sharing data and updates with the Finance and Investment Committee to ensure an aligned approach;<br>- Noting reducing sickness and vacancy levels across both trusts.<br><br>The Boards asked further questions in respect of measures to understand and reduce temporary staff spend, recognising that the employment of substantive staff was an 'invest to save' measure in reducing longer term bank and agency reliance. The Trusts also needed to continue to review the skills mix of specific roles to enable innovation and improvement to improve quality without unsustainable increases in staffing establishments.<br><br>The Boards noted the IGR and committee summaries which highlighted the need to balance quality, safety, efficiency and safe staffing to achieve deliverable financial and operating plans for 2024-25, and the important role of committees in the development and implementation of these plans. | |
| 6. | **Delivery of Financial Plan 2023/24**<br><br>The Boards considered a report setting out the financial position of the trusts at month 11 (29 February 2024) which, for KGH, showed a £6.1m deficit which was £4m worse than plan and, for NGH, a £17.5m deficit, which was £15.6m worse than plan. Following accounting adjustments and mitigations, both trusts were on track to deliver the year-end positions, agreed with NHS England as part of the revised financial forecast. The capital forecast showed that KGH had spent 53%, and NGH 66%, of allocations at Month 11, requiring significant focus towards year end, noting that a significant proportion of the slippage related to centrally-funded projects such as Community Diagnostic Centres. | |

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| | The Boards of Directors noted the Month 11 position, commended the Chief Finance Officer and colleagues for their delivery of the forecast Month 12 position, and **APPROVED** the recommendation of the Finance and Performance Committee to support the draw down of Revenue Cash Support of £4.765m (KGH Board of Directors) and £8.458m (NGH Board of Directors) for 2024-25 (first quarter). | |
| 7. | **KGH Maternity CQC Report and response**<br><br>The Boards of Directors received the final CQC report following the inspection of the KGH Maternity Service against the Safe and Well-Led domains in October 2023, which resulted in reductions in ratings from 'Good' to 'Requires Improvement' in both domains. The overall rating of the Maternity Services had also been downgraded to 'Requires Improvement'.<br><br>The KGH Board of Directors acknowledged and shared the disappointment of all stakeholders with the reduced rating, and its dissatisfaction with the number of inaccuracies within the draft report and the timeliness of publication so long after the inspection. The standards against which the CQC was inspecting had also been significantly raised. Notwithstanding these concerns, the KGH Board accepted the report's findings and recommendations and reiterated its desire to engage with the CQC and other stakeholders to respond positively to enhance the patient and family experience within the Maternity Service, indicating its assurance in respect of the Trust's response to 'must do' and 'should do' actions, summarised in the report (and specified in detail in the action plan, submitted to the last meeting of the Clinical Quality, Safety and Performance Committee). | |
| 8. | **UHN Procurement Strategy 2023-2028**<br><br>The Boards of Directors received a UHN Procurement Strategy for 2023-2028, recommended for adoption by the Finance and Performance Committee. The strategy sought to position University Hospitals of Northamptonshire as innovative leaders in NHS Procurement through collaboration, continuous improvement and creativity that attracts and retains talent, providing a procurement function that adopts best practice, leading change nationally for the benefit of the Trust, the wider NHS and patients.<br><br>The Boards of Directors welcomed and indicated support for the strategy, requesting consideration for stretching efficiency targets within it and the delivery of engagement across both trusts and particularly with clinicians. This should be aligned to the launch of the strategy and to its ongoing implementation, emphasising the importance of effective procurement to sustainable service delivery, joint exercises where appropriate to drive efficiencies and the responsibilities of all managers and teams to seek best value. Subject to these factors being taken into account, the Boards **APPROVED** the UHN Procurement Strategy for 2023-2028. | **RW / SH** |
| 9. | **National Staff Survey Results 2023** | |

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| | The Boards considered a report summarising the responses to the national NHS Staff Survey, which was carried out in October – November 2023 with the results published in March 2024. The KGH response rate was 56% (2,699 responses), compared to 43% in 2022. The NGH response rate was 60% (3,508 responses), compared to 48% in 2022 and the best response rate in the past five years. The report set out key headlines against each question in the survey, comparing KGH and NGH to national best, worst and average performers, and described engagement with teams to review results and develop local actions in response, aligned to areas of focus and commitment for 2024-25.<br><br>The Boards noted and discussed the report, focussing discussion on extremely concerning data which showed the largest deteriorations in scores for both trusts in the category 'discrimination on the grounds of race.' It was clear that, in spite the Trusts' clear commitments to combatting the issue through the adoption of an anti-racism strategy and statement, there was much more concerted work required to embed cultural change and create more inclusive organisations for colleagues; the data showed that significant pockets of racism remained in the hospitals, which was not acceptable and must be addressed through Board leadership and local accountability by individuals and teams. The Boards noted measures the Trusts were taking to combat discrimination including specific board members' objectives, cultural understanding education to middle and senior leaders, reverse mentoring and an expanded programme of cultural events, requesting regular updates throughout the year regarding their implementation and impacts. Equality, diversity and inclusion objectives for all staff, measures to improve boards' diversity and representativeness and external advice and support should also be considered as part of this package. | **PK** |
| 10. | **University Hospitals of Northamptonshire (UHN) NHS Group: Proposed Governance Operating Model**<br><br>The Boards of Directors considered a report proposing changes to the UHN governance operating model following extensive engagement through board development sessions and consultation with committees. The review had been informed by independent external assessments of the trust's governance arrangement carried out by Deloitte and NHS England, and its proposals were designed to best support integration between the trusts and with UHL. Subject to approval, the new model would be subject to review at three and six months.<br><br>The Board of Directors **APPROVED** the following proposals:<br><br>1) To split the responsibilities of the Finance and Performance Committee into the Finance and Investment Committee and the Operational Performance Committee.<br>2) To establish the Partnership Board as a Joint Committee of KGH, NGH and UHL.<br>3) To disestablish the Group Strategic Development Committee, the Group Digital Hospital Committee, the Group Transformation Committee and the Elective Care Collaborative Committee, designating Trevor Shipman as the KGH HIP2 lead Non-Executive Director.<br>4) To approve updated Terms of Reference for all Committees as | |

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| | set out at Appendices A-E to the report, subject to the additional of reference to monitoring agency spend within the People Committee Terms of Reference, to ensure the effective re-distribution of responsibilities from the disestablished Committees.<br>5) To incorporate delegated duties and responsibilities, agreed as part of recommendation (4) above, into schemes of delegation;<br>6) To increase membership of the Audit Committees to four non-executive directors, and<br>7) To implement the proposals with immediate effect, subject to reviews at three and six months. | |
| 11. | **Appointments to Boards' Committees and Non-Executive Board and lead roles**<br><br>The Boards of Directors **APPROVED** the appointment of Non-Executive Directors to Committees and Non-Executive lead roles as specified in the appendix to the report, subject to the following amendments:<br><br>(1) Caroline Stevens to replace Rachel Parker (NGH) on the Operational Performance Committee<br>(2) Elena Lokteva to replace Caroline Stevens (NGH) on the People Committee. | |
| 12. | **Questions from the public**<br><br>There were no questions from the public. | |
| 13. | **Any Other Business**<br><br>There was no other business. | |

# Action Log

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|---|---|
| Meeting | Boards of Directors (Part I) Meeting in Public |
| Date & Time | Updated following 9 April 2024 meeting |

| Minute Ref. | Action | Owner | Due Date | Progress | Status |
|---|---|---|---|---|---|
| Dec 23<br><br>5ii | The Boards requested the audit committees review data quality within UHN, commissioning specialist external support as required. | RW / RA | May 2024 | 1. Audit Committees to review recommendations from the Internal Audit review of the Integrated Governance Report at April meetings. Complete. Item 5 refers<br>2. Boards' workshop on making data count, facilitated by NHS England, scheduled for 8 May 2024. Complete | CLOSE |
| Feb 24<br>5(i) | The Boards indicated concern in respect of the lapses in financial control highlighted in the report and requested a further report in 3-4 months to provide assurance, via the KGH Audit Committee, that the issues were being addressed and supported by the communication of clear messages to budget holders | RW | Jun 24 | There has been a tightening of procurement controls and a focus on the payroll processes, alongside clear direction to teams and budget managers. This will only be solved through culture change and local ownership with some emerging evidence of this, and will be further supported by development of a robust performance management framework. Ongoing monitoring by Audit Committees | CLOSE |

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| Feb 24 5(ii) | The Board welcomed progress with the head and neck collaboration and invited service representatives to address a future meeting to celebrate progress and identify challenges and learning for future clinical collaborations. | JJ / HN | Aug 24 | Deferred: Patient/Staff Story on this topic requested for the August Boards' meeting | NOT YET DUE |
| Feb 24 8 | Boards to review risk appetites | RA | Tbc | To be scheduled as part of Board Development Programme | OPEN |
| Apr 24 8 | Procurement Strategy: The Boards of Directors requested consideration to be given to stretching efficiency targets within it and the delivery of engagement across both trusts and particularly with clinicians, aligned to the launch of the strategy and to its ongoing implementation, emphasising the importance of effective procurement to sustainable service delivery, joint exercises where appropriate to drive efficiencies and the responsibilities of all managers and teams to seek best value. | RW / SH | Jun 24 | The strategy has featured in the UHN staff sessions for discussion and across internal channels. More internal engagement is planned for later in the year. | CLOSE |
| Apr 24 9 | Staff Survey: The Boards requested regular updates throughout the year regarding the implementation and impacts of anti-discrimination measures. | PK | Jun 24 | Added to Boards' work plan for October 2024 and February 2025 meetings | CLOSE |

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## Cover sheet

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| Meeting | University Hospitals of Northamptonshire NHS Group Public Boards of Directors (Kettering General Hospital / Northampton General Hospital) |
| Date | Wednesday 5 June 2024 |
| Agenda item | 4.1 |

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| Title | Chief Executive Update |
| Presenters | Richard Mitchell, CEO UHN, Debbie Needham, CEO KGH, Palmer Winstanley, Acting CEO NGH |
| Authors | Richard Mitchell, CEO UHN, Debbie Needham, CEO KGH, Palmer Winstanley, Acting CEO NGH |

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

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

| Reason for consideration | Previous consideration |
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| For the Boards' information. | None |

**Executive Summary**

This report is an update for May 2024 on the University Hospitals of Northamptonshire NHS Group and the Northamptonshire Integrated Care Board.

**Appendices**

None

**Risk and assurance**

No direct implications for the Board Assurance Framework.

**Financial Impact**

There is no financial impact

**Legal implications/regulatory requirements**

There is no legal impact

**Equality Impact Assessment**

Neutral

## UHN Staff Survey

The national staff survey results were published in March and we have been working with UHN colleagues to develop our 2024 action plan.

Sixty per cent of colleagues completed the survey and I am grateful to all who shared their views. Many of the comments were positive:

“I thoroughly enjoy my job and role. I always have support from my team and my manager, in fact I have never worked with such a close-knit team and understanding manager who always tries to do their best for every single one of their staff members.”

Some colleagues recognise, like me, there is much more we need to do:

“I would like to understand more about how we will change and what our aims are as an organisation. It feels like things are disjointed and I don't really understand what we are trying to achieve as a team.”

The themes of teamwork, management and leadership, development, inclusion and recognition were in the feedback and based on this, in May we launched the TEAM UHN programme. We have identified four key areas:

**Together: Together we will provide a safe, respectful, compassionate and inclusive culture for all. We will:**

• Amplify staff voices - strengthening our Freedom to Speak Up (F2SU) service and developing our staff networks, including appointing Executive team sponsors to ensure the networks are represented at a senior level.
• Embedding our Tackling Racism Strategy and launching the ‘Rethinking Race’ education programme in the coming weeks.
• Focus on basic needs to make working lives easier – providing nutritious and affordable food options, making sure breaks and leave are taken, and ensuring getting to work is easier and accessible.

**Empower: Empowering our teams through supportive management and leadership. We will:**

• Introduce a new appraisal process to ensure we better support colleagues to develop and excel in their roles.
• Continue to roll out new self-rostering pilots to give colleagues more control over working hours and shifts.
• Launch a new single improvement strategy which empowers colleagues to lead improvement in their areas.

**Achieve: Help colleagues to achieve their goals by providing the right support and opportunities. We will:**

• Add to our extensive learning and development package, including programmes for managers across UHN to develop excellence in leadership and management.
• Increase opportunities for career progression and demonstrate the impact of career development with real examples from our leaders.

• Improve the way we communicate – giving colleagues a clear vision of what we will achieve at a departmental and organisational level.

**Motivate: Motivating our amazing people by recognising and rewarding their achievements. We will:**
• Relaunch our Celebration of Service awards based on total continuous NHS service to ensure colleagues are celebrated. We are collating feedback from this year's celebration to enhance the offering for next year.
• Recognise the amazing achievements of colleagues by improving the way we celebrate good news through new divisional briefs, UHN-wide channels and in the media.
• Improve our annual Excellence Awards to make it easier and more accessible to nominate colleagues for an award at the ceremony in September.

There is lots of good work happening at a local level too, and our divisions and corporate areas have been working through their survey results to agree local action plans. Part of our TEAM UHN programme is a commitment to provide divisions with regular briefs updating on progress.

## Deborah Needham

Today is Debbie Needham's last UHN Public Board meeting. Debbie joined the NHS in 1991, training as a nurse and joined NGH in 2004, working as a General Manager. Since 2014 she has been in an executive director role, most recently as CEO at KGH in 2021. I would like to thank Debbie for her unwavering focus on patients and colleagues and for her support over the last seven months.

Debbie said: "There are many things I am proud of during my time at NGH and KGH, including leading through the pandemic, leading and operationalising the Nye Bevan unit and project managing the Critical Care build and Childrens ED. At KGH, my main priority has been improving our culture and after three years I am proud to see the improvements in our staff survey results. I truly believe that we are an organisation with a much more positive outlook, one which has an open culture and where colleagues feel able to speak out and speak up.

"I care deeply for people and colleagues come first, including my senior leadership team who have excelled in their roles. I have had the privilege to work with some amazing people in our hospitals and I have made friends for life. I am proud to say that I led both hospitals through some very challenging periods throughout the last 20 years.

"There is much to look forward to at UHN.  At KGH a new hospital building is close to being approved and care will continue to evolve to ensure patients receive the care they need in the best place and by the most appropriate professional. Both NGH and KGH are very special places to me and I wish Richard and the senior leadership team all the success in making our hospitals the best place to work and be treated."

## Kettering General Hospital Update – Debbie Needham KGH CEO

### Patient

At the last Board of Directors, I noted that the Care Quality Commission (CQC) had reinspected our Childrens and Young peoples (CYP) service in early December 2023. I am pleased to report the inspection report has been finalised and published. The overall Trust rating remains unchanged and I am pleased to inform the board that the rating for the CYP service has increased from 'inadequate' to 'requires improvement' and this is testament to the leadership of the Chief Nurse, divisional leaders and colleagues across CYP. There is more to do to further improve and our acting Chief Nurse will present the report and associated actions including other service rating changes during the board meeting.

### Quality & Safety

Our Breast unit held an open day for patients, public and colleagues on 11th May. The team showcased a range of services which are delivered at KGH. It was fantastic to see the event supported by local companies who also offered services such as bra fitting and signposting on the day. Over 100 members of the public attended the event and each received a goody bag, sponsored by our charity, and included information on being breast aware, badges, pens and self-help leaflets. On speaking to colleagues at the event, they said it had been a fantastic day with many members of the public suggesting that they had learnt something new and were thankful they had attended.

### People

Over the last two months we have celebrated our people at many events. In April we held our annual long service awards, and an afternoon tea was served to long serving colleagues who had worked at KGH or within the NHS for over 20 years, the longest being 46 years. On national administration professionals day in April, we held an event which was attended by hundreds of colleagues and the celebrations continued in May with national and international recognition days for Nurses, Midwives, AHPs, ODPs and colleagues in our people team. I was pleased to attend the Nursing and Midwifery conference which was led by our senior nursing team and attended by over 80 nurses along with system nursing colleagues and a special member of the public whose wife had been a nurse at KGH for over 40 years before she sadly passed away last year.

I would like to take the opportunity to say a very big thank you to our Medical Director John Jameson who is retiring from the NHS and leaves us at the end of the month. John is very much looking forward to enjoying his hobbies, cycling and motor homing. Along with the senior leadership team, I have thoroughly enjoyed working with John over the last 16 months. He has spent many years in the NHS as a junior doctor, consultant, medical leaders and more recently Medical Director and I wish him a very well deserved, happy and fulfilling retirement.

Finally, as colleagues are aware, this will be my last Board meeting as I will be leaving the organisation at the end of the month. I would like to thank the many people who have provided the opportunities for me to learn and grow and to those who I have worked with over the last 20 years at both KGH and NGH. It has been a privilege to lead both hospitals

and I hope the changes I have been able to make with the executive teams are sustained and continue to benefit both patients and colleagues alike.

## Northampton General Hospital Update – Palmer Winstanley NGH CEO

### Call for Concern

NGH was selected to be in the national breakthrough series collaborative supported by NHS England to pilot projects that demonstrate an improvement in the recognition of early deterioration (Worry and Concern). NGH has been recognised for the work in implementing a system for patients and families to escalate their concerns in relation to acute illness/ deterioration. This builds on the work to provide an understandable and consistent way for families and patients to request urgent review if they feel their loved one's condition is deteriorating and not being responded to.

### Urgent and Emergency Care (UEC) Performance

NGH Emergency Department performance improved significantly in March 2024, resulting in an additional £1m capital to support our UEC plans for the coming year.

### Long Service Awards

We celebrated colleagues who had served between 25 and 51 years at NGH. We are extremely proud of these colleagues.

### Maggie's

Maggie's is a charity which provides free expert care and support in Cancer centres across the UK. They have specialists, psychologists and benefit advisers for those affected. Maggie's board approved the commencement of the NGH centre in May 2024. This follows a significant fund-raising effort due to the supply chain cost escalations as part of Covid. Work is due to start on site in mid-June 2024 with completion being late summer 2025. This supports the strategic objective of NGH being a cancer centre of excellence and will be a massive support to people who are impacted directly and indirectly by cancer.

# Cover sheet

| | |
|---|---|
| Meeting | Boards of Directors (Part I) Meeting in Public |
| Date | 5 June 2024 |
| Agenda item | 5 |

| | |
|---|---|
| Title | Board Committee summaries and the Integrated Governance Report (IGR) |
| Facilitator | Richard Mitchell, UHN Chief Executive |
| Author | Richard May, UHN Company Secretary |

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

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

| Reason for consideration | Previous consideration |
|---|---|
| The Integrated Governance Report (IGR) provides a mechanism to provide a holistic overview to both KGH and NGH's performance to support overarching governance of the respective Trust boards in promotion of assurance and continuous improvement. | The IGR is produced on a monthly basis and is presented at each public Board on a bi-monthly basis.<br><br>Board Committees, April - May 2024 |

| | |
|---|---|
| Board Committee summaries enable the Boards of Directors to be assured around organisational performance on an exception reporting basis. Committee Chairs and Executive Leads will be invited to draw the Board's attention to other significant items considered at meetings, indicating the degree of assurance the committee is able to provide in each case. | |

## Executive Summary

Board Committee summaries and the Integrated Governance Report for April - May 2024 are enclosed. Committee Chairs and Executive Leads will be invited to draw the Board's attention to other significant items considered at meetings, indicating the degree of assurance the committee is able to provide in each case.

Board Members' attention is drawn to an accompanying note setting out the purpose and objectives of the IGR and Committee summaries, which is available in the 'documents' section of the Board portal.

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## Appendices

Board Committee Summaries, April and May 2024
Integrated Governance Report, May 2024
Briefing note (documents section of Board portal only)

## Risk and assurance

The appendices provide key controls and assurances to inform the effective management of strategic risks, set out in the Group Board Assurance Framework.

## Financial Impact

No direct implications relating to this assurance report.

## Legal implications/regulatory requirements

No direct implications relating to this assurance report.

## Equality Impact Assessment

Neutral

# BOARD COMMITTEE SUMMARIES

University Hospitals of Northamptonshire Boards of Directors Meeting: 5 June 2024

AGENDA ITEM 5

UHN/UHL Partnership Board: 23 April 2024

People Committee: 25 April and 23 May 2024

Clinical Quality and Safety Performance: 26 April and 29 May 2024

Audit Committees: 29 April 2024

Finance and Investment Committee:  30 April and 28 May 2024

Operational Performance Committee: 30 April and 28 May 2024

| UHL/UHN Partnership Board<br>Upward Report to Boards of Directors | Date of reporting group's meeting: 23 April 2024 |
|---|---|

**Reporting Group Chair: John MacDonald**

| Agenda Item | Description and summary discussion | Decision / Actions and timeframe | Assurance level * |
|---|---|---|---|
| UHN/UHL Strategy | The Board considered and endorsed a single page statement setting out the purpose (high quality care for all, a great place to work, financially sustainable), focus (nine key workstreams – see below) of UHN/UHL collaboration and key beliefs underpinning the approach: 1. By looking after our people we will improve the quality of care we provide 2. By working together, we can deliver more than the sum of our parts 3. Long term radical change is required, and we are committed to delivering it. The Board asked the Chief Executive to ensure that vertical integration and opportunities for wider partnerships were reflected in the final draft, and that 'financially sustainable' could be clarified to be understood in the context of agreed deficit positions for 2024-25. | - | - |
| Terms of Reference | Received, following Boards' approval; the Partnership Board noted feedback from members on specific elements, which would be taken into account as part of the scheduled three-month review of the revised governance arrangements. | July / August 2024 Boards | - |
| Collaboration Agreement | Endorsed, with comments, for subsequent recommendations to Boards as a final draft at the next meeting. The Board was strongly supportive of establishing a Programme Management Office, with the proviso that its scope and objectives were clear and aligned to the collaboration and to existing Trust programmes. | 30 July Partnership Board | - |
| Collaboration Programme Year One | The Board considered and endorsed Year 1 priorities for the collaboration, developed following Non-Executive and Executive Director development sessions held since February 2024 and comprising eight themes: improving safety rating, fragile services, new hospitals programmes, culture and leadership, shared capacity, productivity, digital roadmap, research and innovation. The appendix to the report set out work in progress for each workstream. Going forward, alignment with medium term strategy and identification of business benefits would be required | - | - |
| Building an approach to a UHL/UHN Group Clinical Strategy | The Board indicated its in-principle support for the development of a UHL/UHN Strategy which built on existing foundations (for example the university academic partnership) and showed how, where and when care could be standardized across the three organisations, and how this would demonstrably benefits patients and colleagues within meaningful timeframes. The strategy must also be informed by robust engagement with clinicians and wider stakeholders and requested a further paper to the next meeting, outlining preferred methodology, linked to the strategy item (above). The anticipated development period for the strategy, incorporating engagement, was 12 months. | 30 July Partnership Board | - |

| UHL/UHN Partnership Board<br>Upward Report to Boards of Directors | Date of reporting group's meeting: 23 April 2024 (2 of 2) | | |
|---|---|---|---|
| **Reporting Group Chair: John MacDonald** | | | |
| **Agenda Item** | **Description and summary discussion** | **Decision / Actions and timeframe** | **Assurance level *** |
| Developing a unified approach to research and innovation | The Board supported a proposal to create, and recruit to, a new role of Director of Research and Innovation for UHN and UHL. The new role would be cost-neutral (and, in the longer term, able to deliver net surplus income) and offered new opportunities for collaborative working across R&I, sharing of best practice, harmonisation of processes, maximising existing resources and delivering important joint objectives where commitments have already been made to funders and regulatory bodies. | - | - |

| Group People Committee<br>Reports to the Boards of Directors | Date of reporting group's meeting: 25 April 2024 (Strategy Workshop) | | |
|---|---|---|---|
| Reporting Group Chairs: Denise Kirkham (NGH), Deborah Manger (KGH, Convenor) | | | |
| **Agenda Item** | **Description and summary discussion** | **Decision / Actions and timeframe** | **Assurance level *** |
| People Priorities | The People Plan Six Month Review presentation was shared and discussed along with priorities for 2024-25 in respect of a Sustainable Workforce, developing the contribution of volunteers, developing our workforce, improving health and wellbeing, culture change, inclusion and empowerment. | - | - |

| Group People Committee<br>Reports to the Boards of Directors | Date of reporting group's meeting: 23 May 2024 (1 of 2) |
|---|---|

**Reporting Directors: Denise Kirkham (NGH), Alice Cooper (KGH)**

| Agenda Item | Description and summary discussion | Decision / Actions and timeframe | Assurance level * |
|---|---|---|---|
| Chief People Officer's Report | Committee recommends to the board that the risk appetite for UHN01 be adjusted to 'low', reflecting the imperative that the aims and objectives are achieved to ensure our ability to attract, recruit, develop and retain colleagues thus able to deploy the right people to the right role at the right time. | For Boards' determination | Reasonable |
| People and Culture | The Committee:<br>1. Noted positively the TEAM campaign across UHN.<br>2. Acknowledged the benefits of the health & well-being strategy resulting in a levelling up within KGH, adopting the best practice from NGH.<br>3. Welcomed the financial support to progress the people promise objectives over the next 12 months. | - | Reasonable |
| Workforce and Temporary Staffing | (1) This and subsequent staffing paper focused discussions on temporary staffing and the drivers for this. Requests were made for:<br>• Detail regarding why the data shows increased usage of temporary staff in subsequent workforce papers.<br>• The data presented to be current.<br>(2) Employee relations, formal cases. When next presented to include data regarding protected characteristics.<br>(3) A review of the policy regarding formal case management to include expected timelines for each stage of the process.<br><br>It was noted that there was planned industrial action for 4-6 June amongst the Healthcare Assistant workforce. Our HR colleagues were thanked for their continued efforts prior to and during the events. | 27/06/2024<br><br>TBC<br>TBC | Reasonable |
| Safer Staffing | (1) It was noted that the audit re safer staffing later in the agenda highlights the safer staffing paper should be presented to the board. A review of the National Quality Board guidance confirms this. It was agreed that the committee would continue to receive the paper until the board has discussed and decided how this paper will be managed in the future.<br>(2) There was continued pressure on vacancy rate and absence. The committee is assured that the staffing is safe albeit resulting in increased pressure on the financial situation, because of bank and agency costs. Both organisations are exploring and exploiting all possible avenues to improve our vacancy rate and absence. | For Boards' discussion | Reasonable |
| Maternity Workforce | 1. Update of BirthRate+ completed at NGH and currently occurring at KGH.<br>2. Community midwives exceeding recommended caseload but have support in place to mitigate risks.<br>3. Continued pressure on vacancy rate and absence (maternity leave in particular). Vacancies of specialist posts is having an impact<br>4. Maternity Incentive Scheme year 6 audit to be completed by March 2025 and expected to be compliant as services have been on previous years. A KGH challenge to this is the lack of clarity regarding consultant obstetrician rest periods; currently planning underway to ensure rest periods are clearly identified.<br>5. The committee is assured that the staffing is safe albeit resulting in increased pressure on the financial situation, because of bank and agency costs. Both organisations are exploring and exploiting all possible avenues to improve our vacancy rate and absence. | March 2025 (Incentive scheme) | Reasonable |

| Group People Committee<br>Reports to the Boards of Directors | Date of reporting group's meeting: 23 May 2024 (2 of 2) |
|---|---|

**Reporting Group Chairs: Denise Kirkham (NGH), Deborah Manger (KGH, Convenor)**

| Agenda Item | Description and summary discussion | Decision / Actions and timeframe | Assurance level * |
|---|---|---|---|
| Guardians of Safe Working (GOSW) | 1. Exception reports have been reviewed and not resulted in any fines.<br>2. Both GOSW work collaboratively with doctors in training and their supervisors.<br>3. A letter from NHS England entitled **'Improving the working lives of doctors in training'** requests action regarding rota management, payroll accuracy, mandatory training and protected learning time and the utilisation of the National Education & Training survey and GMC survey. Lead for this is the Group Head of People Planning and Processes. | 31/7/24 (Payroll) Update 7/8/24 re. rotas | Substantial |
| Group Board Assurance Framework | Committee recommends to the board that the risk appetite for UHN01 be adjusted to low (see CPO report above) | Boards' agenda 5 June 2024 | - |
| Receipt of final Internal audit reports | 1. The committee found these audits to be extremely helpful in guiding decisions regarding assurance.<br>2. Safer staffing – see above<br>3. Mandatory training. National induction and National mandatory training alignment should result in increased compliance and data accuracy.<br>4. Salary management. Overpayments remain a challenge. This alongside the noted national challenges by doctors in training (DIT) receiving their salary payments requires a plan to address UHNs management of salary throughout the workforce. | 3. 31/12/2024<br>4. 31/07/2024 (DIT) | Assurance levels set out in specific internal audit reports |

| UHN Clinical Quality and Safety Committee<br>Upward Report to Board of Directors | Date of reporting group's meeting: 26 April 2024 |
|---|---|

**Reporting Non-Executive Director: Chris Welsh (Convenor)**

| Agenda Item | Description and summary discussion<br><br>The committee: | Decision / Actions and timeframe | Assurance level * |
|---|---|---|---|
| Patient Story | Received a patient story which highlighted systemic gaps in communication which the committee thinks is an endemic problem. The committee agreed to escalate to the Boards of Directors the importance of the implementation of Nuance software, which will help address some of the issues highlighted by this patient story. | Escalate to the Boards. | n/a |
| Subgroup reports | Received upward reports from the NGH Health and Safety Committee, KGH and NGH Assurance and Risk Committees, NGH Clinical Quality and Effectiveness Group, KGH Quality Governance Steering Group and KGH Patient Experience Group. An item of limited assurance relating to NGH Health and Safety Quarterly Audits compliance was discussed and noted. | - | Reasonable |
| Integrated Governance Report | Noted that the number of super-stranded patients is now affecting quality as patients are not in the appropriate setting. This is an issue of particular concern with regards to stroke patients and their rehabilitation. The committee suggests the Operational Performance Committee (OPC) may want to look at super-stranded patients. | Refer super-stranded to OPC | n/a |
| Maternity | Received the joint maternity safety report and quarterly maternity updates in relation to maternity serious incidents, Saving Babies Lives Care Bundle, maternity incentive scheme year 6, perinatal deaths and KGH MBRRACE. | - | Substantial |
| KGH Draft Quality Report | Received and noted the KGH draft Quality Report as part of the consultation on this within the Trust. | - | n/a |

| UHN Clinical Quality and Safety Committee<br>Upward Report to Board of Directors | Date of reporting group's meeting: 26 April 2024 (2 of 2) | | |
|---|---|---|---|
| **Reporting Non-Executive Director: Chris Welsh (Convenor)** | | | |
| **Agenda Item** | **Description and summary discussion**<br><br>**The committee:** | **Decision / Actions and timeframe** | **Assurance level *** |
| Joint Chief Nurses' Exception Report | Received and noted the Chief Nurses' joint exception report. | - | Substantial |
| 2024/25 Planning submission | Discussed how to take forward the 2024/25 planning submission and the quality aspects of this. A further discussion about which took place after the 1st May Board development session. | - | n/a |

| UHN Clinical Quality and Safety Committee<br>Upward Report to Board of Directors | Date of reporting group's meeting: 29th May 2024 (1 of 2) |
|---|---|

**Reporting Non-Executive Director: Chris Welsh (Convenor)**

| Agenda Item | Description and summary discussion<br><br>**The committee:** | Decision / Actions and timeframe | Assurance level * |
|---|---|---|---|
| Items of urgent business | Noted items of urgent business relating to:<br>• An issue that had been identified relating to the review of TIA (transient ischaemic attack) patients. The committee is assured that appropriate remedial action has been taken and will receive a further update at the committee's June meeting.<br>• A visit by the joint advisory group to the KGH endoscopy service. A full report is awaited after the receipt of which the committee will receive a further update and an action plan. | - | Reasonable |
| UHN Paediatric Audiology provision | • Received an update providing oversight of the risks with the UHN paediatric audiology service following a national request to review all trusts' services against accreditation standards.<br>• Noted that both trusts have seen a significant increase in demand for both adult and paediatric audiology services.<br>• Noted that workforce and recruiting audiologists is a challenge.<br>• Confirmed it was reasonably assured that the services are progressing with the required improvements and deliverables, and that services are collaborating. | - | Reasonable |
| Subgroup reports | • Received upward reports from the NGH and KGH Health and Safety Committees, NGH and KGH Assurance and Risk Committees, NGH Clinical Quality and Effectiveness Group, KGH Quality Governance Steering Group, NGH Patient Experience and Carer Engagement Group and NGH and KGH Safeguarding Assurance/Steering Groups.<br>• Noted the challenge in recruiting anaesthetic consultants. | - | Reasonable |
| Urgent and Emergency Care Performance | Noted the continuing emergency care pressures particularly regarding bed occupancy, impact on flow, ambulance handovers and the high number of super stranded patients at both hospitals and the challenge of securing adult social care support, particularly at NGH. | - | Reasonable |

| UHN Clinical Quality and Safety Committee in Common Upward Report to Board of Directors | Date of reporting group's meeting: 29th May 2024 (2 of 2) |
|---|---|

**Reporting Non-Executive Director: Chris Welsh (Convenor)**

| Agenda Item | Description and summary discussion<br><br>The committee: | Decision / Actions and timeframe | Assurance level * |
|---|---|---|---|
| Patient Safety | Received quarterly patient safety reports from both trusts and confirmed the reports provided the committee with reasonable assurance in the management of identifying, responding to and learning from patient safety incidents. | - | Reasonable |
| Board Assurance Framework | Agreed the changes to Board Assurance Framework risks UHN02 and UHN06. | - | Reasonable. |
| Target Operating Model | • Noted the levels of aspiration for the integration of UHN clinical services and actions being taken to deliver the UHN clinical strategy.<br>• Welcomed this work and supported the ambition of services on integration. | - | Reasonable |
| Estates internal audit | Received the estates (fire and water safety) internal audit report for NGH and confirmed it had received reasonable assurance in relation to this. | - | Reasonable |
| Improving together improvement strategy | Supported and approved the Improving Together improvement strategy | August Boards | Reasonable |
| Maternity | Received the joint maternity safety report and NGH MBRRACE exception report and confirmed it had received reasonable assurance that the identification, investigation and learning from all maternity patient safety incidents are being effectively managed and that the maternity services are achieving good compliance against the key national maternity safety indicators. | - | Reasonable |

| UHN Operational Performance Committee<br>Upward Report to Board of Directors | Date of reporting group's meeting: 30th April 2024 | | |
|---|---|---|---|
| **Reporting Non-Executive Director: Trevor Shipman (Convenor)** | | | |
| **Agenda Item** | **Description and summary discussion**<br><br>**The committee:** | **Decision / Actions and timeframe** | **Assurance level *** |
| 2024/25 Operational Planning and Performance | The committee considered the 2024/25 operational metrics and national operating targets. The committee discussed the forthcoming Urgent and Emergency Care summit and highlighted the need to consider the Group's objectives for the summit which is an opportunity to lobby for support. | - | Reasonable |
| Integrated Governance Report & Operational Performance | The committee noted that improved operational performance had been sustained since March. Maintaining this longer term was discussed. The committee discussed challenges regarding theatre availability at NGH and noted that there have been improvements in urology since the urology one stop was introduced. | - | Reasonable |
| Theatres productivity deep dive | The committee received an update on theatres performance and work to improve productivity. An improvement in theatre utilisation and productivity was noted. The committee noted actions to be taken over the coming months to improve theatre utilisation and work being undertaken to address challenges obtaining data for theatre productivity at both hospitals, work on which is ongoing. | - | Reasonable |

| UHN Operational Performance Committee<br>Upward Report to Board of Directors | Date of reporting group's meeting: 28th May 2024 | | |
|---|---|---|---|
| **Reporting Non-Executive Director: Trevor Shipman (Convenor)** | | | |
| **Agenda Item** | **Description and summary discussion**<br><br>**The committee:** | **Decision / Actions and timeframe** | **Assurance level *** |
| Integrated Governance Report & Operational Performance | The committee noted teams across hospitals are working collaboratively to support each other and a weekly meeting is taking place between UHN and UHL to explore further opportunities for mutual support across specialties, to equalise waiting times. Emergency activity continues to be very busy for both organisations, bed occupancy remains a challenge and ambulance handover delays have increased. | - | Reasonable |
| Health intelligence transformation update | • Received an update on the health intelligence transformation programme and welcomed the progress being made on this.<br>• Highlighting the significance of this project, the committee noted that in all areas of improving service delivery, the need for accurate and timely information is required. | - | Reasonable |
| GIRFT – Getting it right first time | • Received an update on the GIRFT/Further Faster programme and the work being undertaken to improve elective productivity.<br>• Noted a significant improvement in theatre productivity at KGH in the last three months.<br>• Noted staffing is a significant challenge for theatre productivity, particularly in relation to anaesthetics. | - | Reasonable |
| Outpatients | Received an update on the re-imagining planned care programme and noted the work that is taking place across the system on the delivery of outpatient care. | | Reasonable |

| NGH Audit Committee<br>Report to the Boards of Directors | Date of reporting group's meeting: 29 April 2024 |
|---|---|

**Reporting Director: Rachel Parker**

| Agenda Item | Description and summary discussion | Decision / Actions and timeframe | Assurance level * |
|---|---|---|---|
| Statement of Internal Controls (Internal Audit) Report | The Committee indicated 'limited' assurance in respect of the receipt of 'limited assurance' completed internal audit reports, on account of the evidence within them that, whilst procedures and processes were in place and robust, these were often not applied consistently or effectively.<br><br>The Committee noted outstanding recommendations from previous internal audits, continuing to indicate 'limited' assurance given the number still outstanding, whilst recognizing that commentary and revised timescales had been agreed in each case. | - | Limited |
| 2024-25 Plans | The Committee approved the Internal Audit and Counter Fraud (Anti-Crime) Work Plans for 2024-25, subject to a review of priority audits relating to the Group People Plan | Approved | - |
| Head of Internal Audit Opinion | The Head of Internal Audit presented his overall opinion of reasonable assurance regarding the Trust's risk management, control and governance processes in place, based on the areas reviewed during the year. | June Audit Committee | Reasonable |
| Financial Governance Report | The Committee **NOTED** the Financial Governance Reports and the assurance level agreed to be **limited** on account of the continuing high levels of 'maverick' transactions reported, particularly within the digital service (£1.6m). | - | Limited |
| Group Board Assurance Framework | The Committee **NOTED** the Group Board Assurance Framework & Corporate Risk Register and the level of assurance agreed to be reasonable in respect of the robustness of the trust's framework and processes. | On Boards Agenda | Reasonable |
| Terms of Reference | The Committee reviewed its Terms of Reference, making recommendations to the Board of Directors | On Boards Agenda | - |

| KGH Audit Committee<br>Report to the Boards of Directors | Date of reporting group's meeting: 29 April 2024 (1 of 2) |
|---|---|

**Reporting Chair: Alice Cooper**

| Agenda Item | Description and summary discussion | Decision / Actions and timeframe | Assurance level * |
|---|---|---|---|
| Statement of Internal Controls (Internal Audit) Report | The Committee received and discussed at length the summary of recent audit work from TIAA, and particularly the findings of the following audits, concluded in the recent period:<br><br>Salary Overpayments (revisit) – Limited Assurance<br>Community Engagement – Limited Assurance<br>Estates: Fire & Water – Limited Assurance<br>Safer Staffing – Reasonable Assurance<br>IGR Production – Limited Assurance<br>Mandatory Training – Reasonable Assurance<br>Safeguarding – Reasonable Assurance<br>Code of Governance Compliance – Substantial Assurance<br><br>We were pleased that for all audits achieving Limited Assurance or below, the responsible member of the Executive team was present to discuss the findings and action plan to remediate. | - | Reasonable |
| Head of Internal Audit's Annual Opinion | The Committee received the Head of Internal Audit Opinion for the Year, considering all work carried out in the Trust in the year. The opinion was as follows.<br>*"TIAA is satisfied that, for the areas reviewed during the year, the Trust has reasonable and effective risk management, control and governance processes in place."* | June 2024 Committee | Reasonable |
| Internal Audit Plan 2024-25 | The Committee also received the IA plan for the coming year and raised a number of questions or suggested variations to the plan, to ensure it is approximately risk based, and includes current areas of high risk for the Trusts. These are to be considered by the CFO and TIAA and brought back to members. | June 2024 Committee | - |
| Anti-Crime | The Committee received and scrutinised the update on recent work from the team, and approved the work plan for the coming year | Approved | Reasonable |
| Financial Governance | The Committee received and scrutinised the report, which it was noted still needs further revision to address clearly the committee's key questions. | June 2024 | Limited |

| KGH Audit Committee<br>Report to the Boards of Directors | Date of reporting group's meeting: 29 April 2024 (2 of 2) |
|---|---|

**Reporting Chair: Alice Cooper**

| Agenda Item | Description and summary discussion | Decision / Actions and timeframe | Assurance level * |
|---|---|---|---|
| Board Assurance Framework (BAF) and Corporate Risks review | The Committee noted, and was assured by, the progress of the reviews of the BAF and the Corporate Risks, whilst acknowledging that these will need to be refreshed shortly to align with strategic objectives for the collaboration partnerships. | On Boards' Agenda | Reasonable |
| External Audit Report | The Committee received assurance that the current auditors have agreed to serve for the 24/25 financial year end, and that an open procurement process would then be timetabled for the following period. Some early concerns were noted by the external auditors regarding the KGH Finance team's ability to meet the audit planning timetable so far, due to staff absences in key finance roles, or to new staff now replacing formerly well-established staff; however, the committee were assured that this matter was being tightly managed by the CFO. | June 2024 | Reasonable |
| Terms of Reference | These were reviewed and a modestly revised version were to be recommended to the Board for approval. | On Boards' Agenda | - |

| UHN Finance and Investment Committee<br>Upward Report to Boards of Directors | Date(s) of reporting group's meeting(s):<br><br>30 April 2024 |
|---|---|

**Reporting Group Chairs: KGH – Damien Venkatasamy, NGH – Rachel Parker**

| Agenda Item | Description and summary discussion | Decision / Actions and timeframe | Assurance level * |
|---|---|---|---|
| Finance report – Month 12 | The Committee **NOTED** the Finance Report Month 12. UHN planned a breakeven position by the end of the year however during Q3 agreed a deficit forecast of £18.41m deficit with NHSE of £18.4m (KGH £2.9m, NGH £15.5m) as part of the overall system forecast deficit of £38.4m. It was reported that 5 systems out of 11 had delivered against their reset target. The revised forecast had been met | - | Reasonable |
| Capital Report | For KGH there was an underspend on System Capital, in part due to management of the potential RAAC related risk and decisions over Right of Use asset costs, whereas NGH was in line with expectations. The Committee expressed concern regarding the pattern of larger amount of spend happening in the final quarter, and that this should be more evenly spread over the year. It was advised that there was a different capital planning approach between the two hospitals, and it had been agreed to align the approaches across UHN, moving towards a 3–5-year planning round | - | Limited |
| 2024-25 Planning Submission | The Committee received the 2024-25 Planning submission, noted the revised projected activity, workforce and financial projections, assumptions and risks within it. | Approved by Boards 1 May 2024 | - |
| Annual Plan Efficiencies – 2023-24 Delivery | Following the adjustments made as part of the reforecasting process, the UHN forecast at target has largely been achieved. The cost avoidance delivery total was £19.5m (productivity from activity growth £11.49m). The cost out delivery total was £35m. Of the total £54.6m actual delivery, £13.9m (26%) were technical adjustments. £32m (59%) of the efficiency savings have been delivered on a recurrent basis. | - | Reasonable |
| Annual Plan Efficiencies – 2024-25 | The Committee considered a report setting out the efficiency requirement for the trusts for 2024-25. Schemes amounting to 45% of the overall target had been identified to date. | Ongoing | Limited |
| Business Case Implementation | The Committee received a report which advised that only 50% of approved businesses cases (during 2022-23 and 2023-24) had been fully implemented. The review identified important learning for the trusts in respect of the clearer identification of business benefits, clearly aligned to key performance metrics, and the need to be realistic in respect of the ability to recruit to specific positions due to local and national limitations. | - | Limited |

| UHN Finance and Investment Committee<br>Upward Report to Boards of Directors | Date(s) of reporting group's meeting(s):<br><br>28 May 2024 | | |
|---|---|---|---|
| **Reporting Group Chairs: KGH – Andrew Moore, NGH – Rachel Parker (Convenor)** | | | |
| **Agenda Item** | **Description and summary discussion** | **Decision / Actions and timeframe** | **Assurance level *** |
| Financial Position: 2024-25 Plan and Month 1 | The Committee noted that the 2024-25 financial and operating plan required resubmission following an NHS England request for a reduced final deficit for the Integrated Care Board for the year. Additional funding had been identified, but the Committee was concerned at the deliverability of the final plan in the context of a large deficit in Month One and the continuing lack of effective data and systems for managing staffing numbers, costs and performance. | For discussion at Part II (Private) meeting 5 June | Limited |
| Efficiencies 2024-25 | The Committee was not assured that the Trusts' efficiency targets would be met given that initiatives generating only one third of the total requirement had been identified in the year to date. The Committee urged the Boards to bring forward transformative proposals towards a position of greater financial stability, and to move towards a medium term approach to financial planning, transformation and savings. | For discussion at Part II (Private) meeting 5 June | Limited |
| UHN Priorities for 2024-25 | The Committee confirmed that its priorities for 2024-25 were to strengthen control systems to enable the balance between quality, safety, productivity, staffing and resourcing to be better understood, underpinned by timely and accurate data and the development of medium term (3-5 year) recovery trajectories towards a position of greater financial sustainability | - | Limited |
| Board Assurance Framework | The Committee did not consider a reduction in the risk score in relation to the Trusts' delivery of a medium term financial plan to be appropriate given continuing concerns regarding the deliverability of annual plan targets and associated efficiencies. | For discussion at Public Board meeting | Limited |
| Business Case – Isham House | KGH Members approved the Business Case for the drawdown of capital funds to utilise Isham House as an enabling project for the Kettering site redevelopment. | For discussion at Part II (Private) meeting 5 JUne | - |
| Energy Centre Full Business Case | The Committee noted that approval of the business case had been delayed due to projected cost increases which had the potential to delay the national approvals process. | June 2024 | - |

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

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

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

NHS
University Hospitals of Northamptonshire
NHS Group

# IGR

May 2024

Dedicated to excellence

# Introducing the IGR

This IGR pack has three main sections in alignment with the Committees the metrics support:

1) Clinical Quality and Safety Committee (pages 4 to 38) covering metrics aligned to our ‘patient’ and ‘quality’ dedicated to excellence values
2) Finance and Investment Committee (pages 39 to 50) covering metrics aligned to our ‘sustainability’ dedicated to excellence values
3) Operational Committee (pages 51 to 91) covering metrics aligned to our ‘sustainability’ and ‘systems and partnerships’ dedicated to excellence values
4) People Committee (pages 92 to 106) covering metrics aligned to our ‘people’ dedicated to excellence values

It is worth noting:

- Only metrics that have a) had data provided and b) have been signed off, will be published – therefore, this could lead to some gaps in reporting.
- Many of our metrics are aggregated as they show the high-level performance of the Trust in this area (e.g. mandatory training). Therefore, there may be higher/ lower levels of performance at local level which will be monitored and acted upon accordingly.

## Metric Categorisation Information

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

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

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

**Assurance Icons**: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. **Grey** icons tells you that sometimes the target will be met and sometimes missed due to random variation.

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

# Clinical Quality and Safety Committee

# Summary Table

Committee Name: All

Group Name: Patient

Metric Name: Multiple selections

Site: All

Variation: All

| Site | Group | Metric | Latest Date | Value | Target | LCL | Mean | UCL | Variation | Assurance | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| KGH | Patient | % Patients satisfaction score - Trustwide | 01/04/24 | 94.00% | 95.00% | 84.25% | 89.88% | 95.5% | | | Not Consistently Anticipated to Meet Target |
| NGH | Patient | % Patients satisfaction score - Trustwide | 01/04/24 | 90.40% | 95.00% | 86.33% | 89.02% | 91.72% | | | Consistently Anticipated to Not Meet Target |
| KGH | Patient | % Patients satisfaction score - inpatients | 01/04/24 | 94.00% | 95.00% | 81.97% | 89.93% | 97.9% | | | Not Consistently Anticipated to Meet Target |
| NGH | Patient | % Patients satisfaction score - inpatients | 01/04/24 | 93.30% | 89.50% | 86.66% | 91.97% | 97.28% | | | Not Consistently Anticipated to Meet Target |
| KGH | Patient | % Patients satisfaction score - A&E | 01/04/24 | 77.00% | 95.00% | 67.51% | 76.99% | 86.46% | | | Consistently Anticipated to Not Meet Target |
| NGH | Patient | % Patients satisfaction score - A&E | 01/04/24 | 79.90% | 88.00% | 69.41% | 77.06% | 84.7% | | | Consistently Anticipated to Not Meet Target |
| NGH | Patient | % Patients satisfaction score - maternity | 01/04/24 | 97.70% | 96.80% | 86.33% | 93.26% | 100.2% | | | Not Consistently Anticipated to Meet Target |
| KGH | Patient | % Patients satisfaction score - maternity | 01/04/24 | 95.00% | 95.00% | 67.72% | 91.67% | 115.62% | | | Not Consistently Anticipated to Meet Target |
| KGH | Patient | % Patients satisfaction score - outpatients | 01/04/24 | 94.00% | 95.00% | 84.87% | 93.65% | 102.42% | | | Not Consistently Anticipated to Meet Target |
| NGH | Patient | % Patients satisfaction score - outpatients | 01/04/24 | 93.50% | 93.80% | 91.57% | 93.27% | 94.96% | | | Not Consistently Anticipated to Meet Target |
| KGH | Patient | Number of complaints | 01/04/24 | 29 | 0 | 13 | 41 | 68 | | | Consistently Anticipated to Not Meet Target |
| NGH | Patient | Number of complaints | 01/04/24 | 36 | 0 | 18 | 35 | 52 | | | Consistently Anticipated to Not Meet Target |
| KGH | Patient | Complaints response performance | 01/04/24 | 68.00% | 90.00% | 7.01% | 44.03% | 81.05% | | | Consistently Anticipated to Not Meet Target |
| NGH | Patient | Complaints response performance | 01/04/24 | 87.00% | 90.00% | 80.36% | 94.29% | 108.22% | | | Not Consistently Anticipated to Meet Target |

# Quality Committee

Exec owners: Jayne Skippen, Nerea Odongo, John Jameson, Hemant Nemade, Fay Gordon, Palmer Winstanley, Becky Taylor

*In reminder, this Committee monitors the 'quality' metrics and the 'patient' metrics within the IGR.*

This cover sheet is designed to **highlight to the Committee saliant messages from the IGR metrics** for this month:

1. Positive trends for Safe staffing for both KGH and NGH. Continual programmes for Recruitment. At NGH, ongoing work around agency reductions plans will be discussed.
2. SHMI remains static and is 'as expected' overall. NGH have indicated that the SHMI methodology will be changing nationally in May 24, which may affect the reporting figures for next month.
3. SMR remains static for Apr 24 and is 'as expected' Trusts continue to work with Clinical Coding, Clinical Leads and Dr Foster representatives.
4. Food Wastage numbers has fallen for this month, but the commentary has indicated the value is still too high and further investigations will continue.

Key **developments with the IGR** itself for the Committee to note:

1. Proposal for the COVID metrics to be removed - tbc
2. Safeguarding, Compliments and Complaints metrics are under review.
3. Safe Staffing Metric – Which Committee should this metric be reported in? People or Quality?

*Worth remembering for all metrics, only metrics that have a) had data provided and b) have been signed off, will be published – therefore, this could lead to some gaps in reporting.*

# % Patients satisfaction score - Trustwide

Committee Name: All

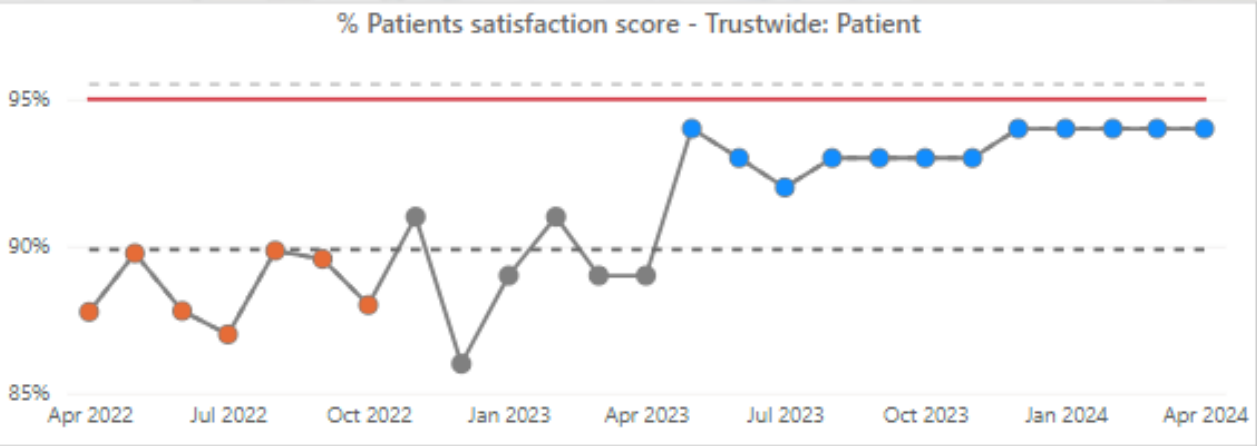
GroupName: Patient

MetricName: % Patients satisfaction score - Trustwide

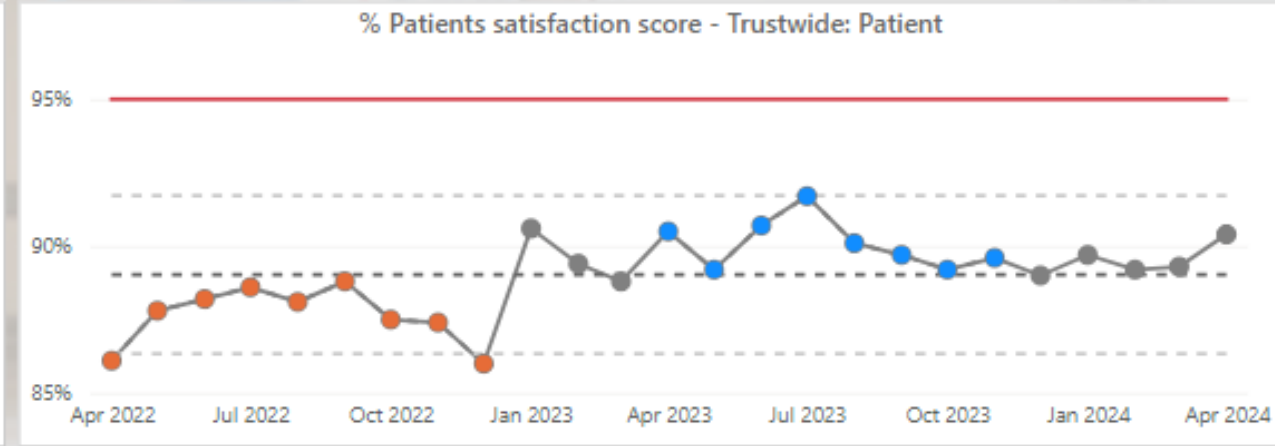
Date: 01/12/2019 – 01/04/2024

| 94.00% | 95.00% | 90.40% | 95.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

## Kettering General Hospital




## Northampton General Hospital




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses. | Our Trustwide satisfaction score remained the same for April when compared with March (94%) however, when compared with LY there was an increase of 4%. As a Trust, we received 5,481 responses to the Friends and Family Test. This was an increase of 97 compared with March and an increase of 3,524 compared with April 2023. | Decreases in satisfaction were recorded in Outpatient Services and Accident & Emergency in April. | Any learning actions identified through the FFT are highlighted in the monthly divisional updates which are discussed in divisional governance meetings. Bi-Monthly, updates on actions and learning from feedback are reported to the Patient Experience & Engagement Steering Group (PESG). | Response rates and satisfaction score information is shared with all Service Leads to ensure relevant actions are in place to better performance. |
| NGH | 01/04/24 | The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses. | Overall Trust wide patient satisfaction scores rose by 1.1% in April from 89.3% to 90.4%. There was also in increase in FFT responses from 6,462 in March to 6,795 in April 2024. | Every service saw an increase in their performance except Outpatient services which was the same as the previous month. | Areas of concern are identified within the regular reporting process to the service leads. The reports also identify where improvements have been made to recognise the areas and teams that have seen an increase in patient experience. | The full detailed performance data is shared at various management levels with the ability to drill down to Divisions, Directorates, locations, and specialties (OPs) |

# % Patients satisfaction score - inpatients

Committee Name: All

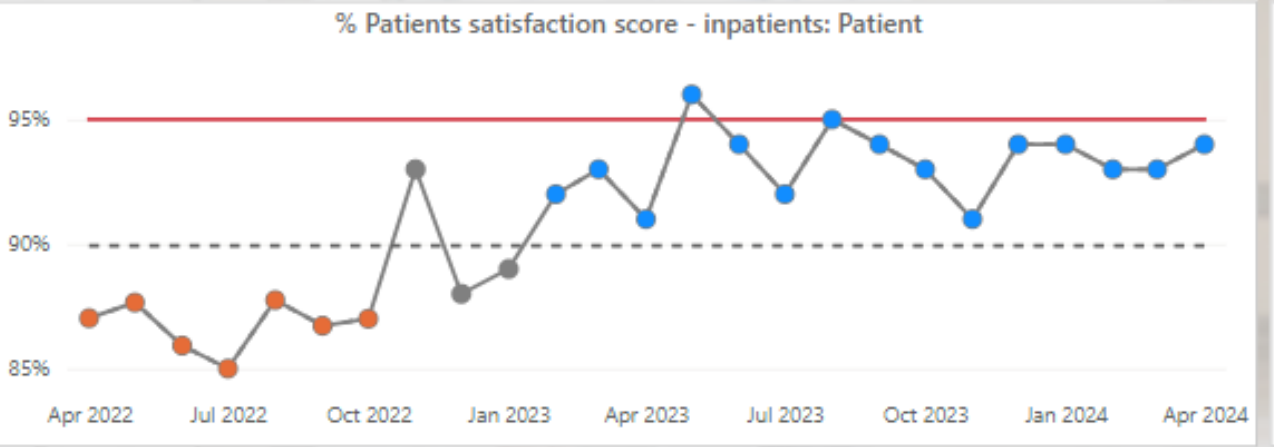
GroupName: Patient

MetricName: % Patients satisfaction score - inpatients

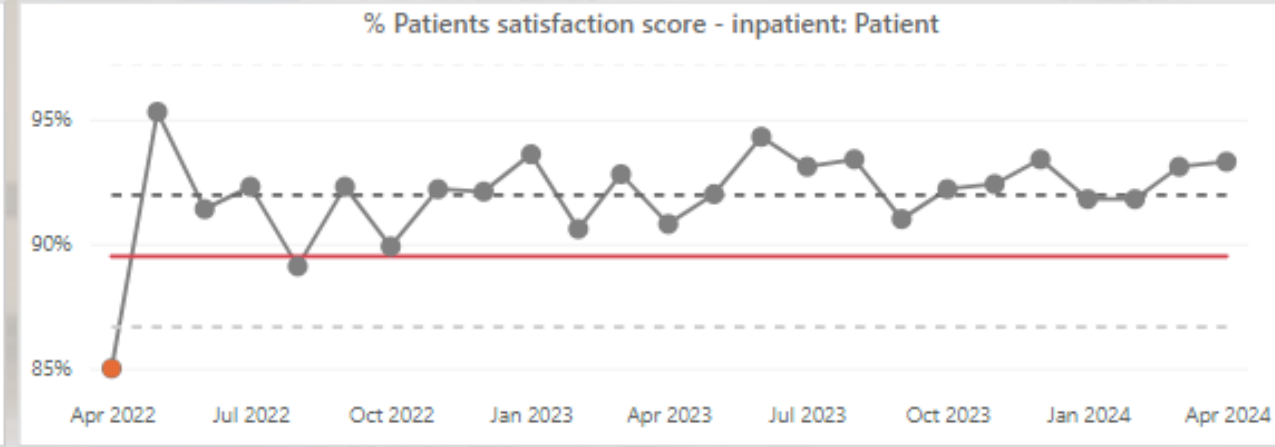
Date: 01/12/2019 – 01/04/2024

| 94.00% | 95.00% | 93.30% | 89.50% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

## Kettering General Hospital




## Northampton General Hospital




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses. | Our Inpatient satisfaction score increased by 1% in April to 94%, when compared with March (93%). In inpatient areas, we received 1,062 responses to the Friends and Family Test. This was a decrease of 227 compared with March however it was an increase of 424 compared with April 2023. | Inpatient areas did not see a decrease in satisfaction score this month. | Any learning actions identified through the FFT are highlighted in the monthly divisional updates which are discussed in divisional governance meetings. Bi-Monthly, updates on actions and learning from feedback are reported to the Patient Experience & Engagement Steering Group (PESG). | Response rates and satisfaction score information is shared with all Service Leads to ensure relevant actions are in place to better performance. |
| NGH | 01/04/24 | The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses. | A very slight increase in patient satisfaction (93.3%) from the previous month (93.1%). | The monthly performance has remained above target continuously since Sept 2022. In April we received 795 FFT responses, an increase of 39 in March. | Ward areas continue to promote the FFT surveys, review their monthly performance and the comments provided by patients & carers. | Continued monthly reporting shared with all areas, Directorates, Divisions and senior leaders. |

# % Patients satisfaction score - A&E

Committee Name: All

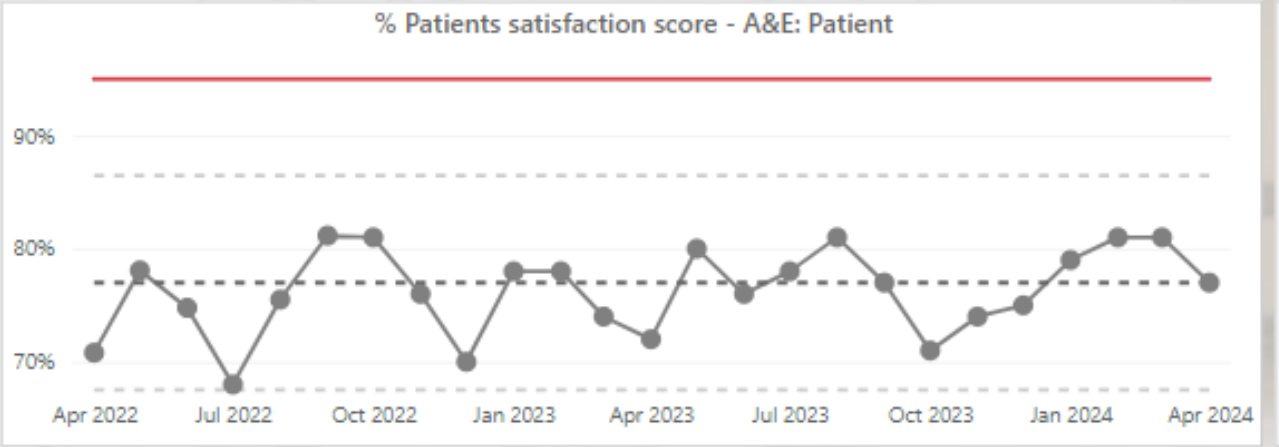
GroupName: Patient

MetricName: % Patients satisfaction score - A&E

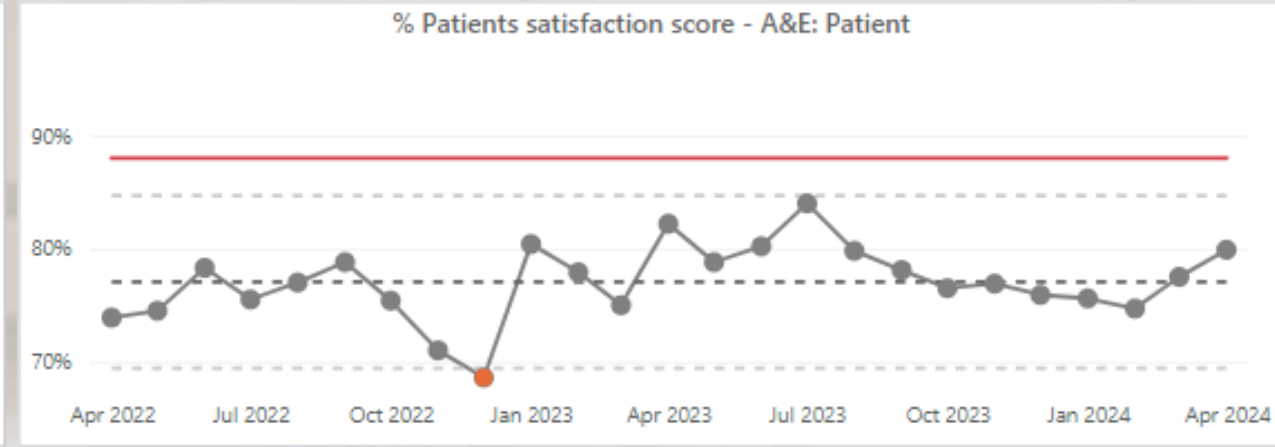
Date: 01/12/2019 – 01/04/2024

| 77.00% | 95.00% | 79.90% | 88.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses. | Our ED satisfaction score decreased by 3% April to 77% when compared with March (81%) however, when compared with LY there was an increase of 5%. In our EDs, we received 450 responses to the Friends and Family Test. This was an increase of 5 compared with March and an increase of 84 compared with April 2023. | The decrease in satisfaction score came from Accident & Emergency (Adult ED). | Any learning actions identified through the FFT are highlighted in the monthly divisional updates which are discussed in divisional governance meetings. Bi-Monthly, updates on actions and learning from feedback are reported to the Patient Experience & Engagement Steering Group (PESG). | Response rates and satisfaction score information is shared with all Service Leads to ensure relevant actions are in place to better performance. |
| NGH | 01/04/24 | The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses. | Patient satisfaction for ED in April 2024 was 79.9% with 1,873 FFT responses being received. | The national drive to improve ED waiting times and times for admission has helped improved the FFT score by 2.4% since the previous month. | Various factors to improve patient experience and increased bed flow into ward areas have been implemented. Patient satisfaction performance within ED discussed at the Divisional P E Meeting. | Springfield opening hours have been extended. The waiting area has been refurbished. Additional personnel deployed within ED. |

# % Patients satisfaction score - maternity

Committee Name: All

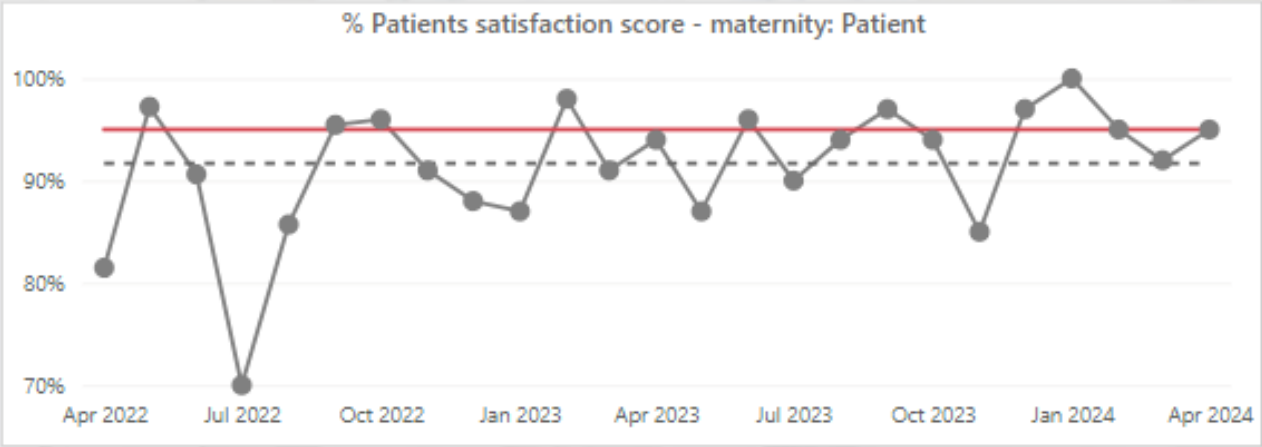
GroupName: Patient

MetricName: % Patients satisfaction score - maternity

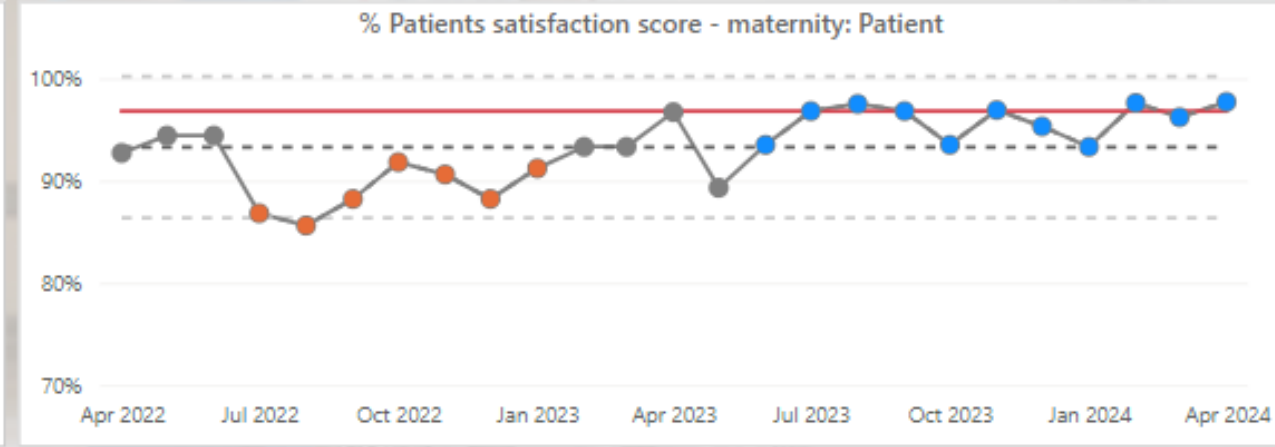
Date: 01/12/2019 – 01/04/2024

| 95.00% | 95.00% | 97.70% | 96.80% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses. | Our Maternity Services satisfaction score increased by 3% for April to 95% when compared with March (92%). In maternity services, we received 302 responses to the Friends and Family Test. This was an increase of 72 compared with March and an increase of 245 compared with April 2023. | No areas within Maternity Services decreased in satisfaction score this month. All areas increased in responses. | Any learning actions identified through the FFT are highlighted in the monthly divisional updates which are discussed in divisional governance meetings. Bi-Monthly, updates on actions and learning from feedback are reported to the Patient Experience & Engagement Steering Group (PESG). | Response rates and satisfaction score information is shared with all Service Leads to ensure relevant actions are in place to better performance. |
| NGH | 01/04/24 | The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses. | Maternity services satisfaction scores rose by 1.5% from March to April 2024 with an increase in FFT responses received (365 in March and 485 in April) | There are still a few sections of maternity services with low FFT responses which are being looked into to obtain a rounded picture of the whole services | Pockets of the service with low satisfaction levels or survey responses are to be reviewed with an aim to increase these. | The Maternity Patient Experience Midwife is working on increasing the spread of the FFT surveys d any particular areas of concern. |

# % Patients satisfaction score - outpatients

Committee Name: All

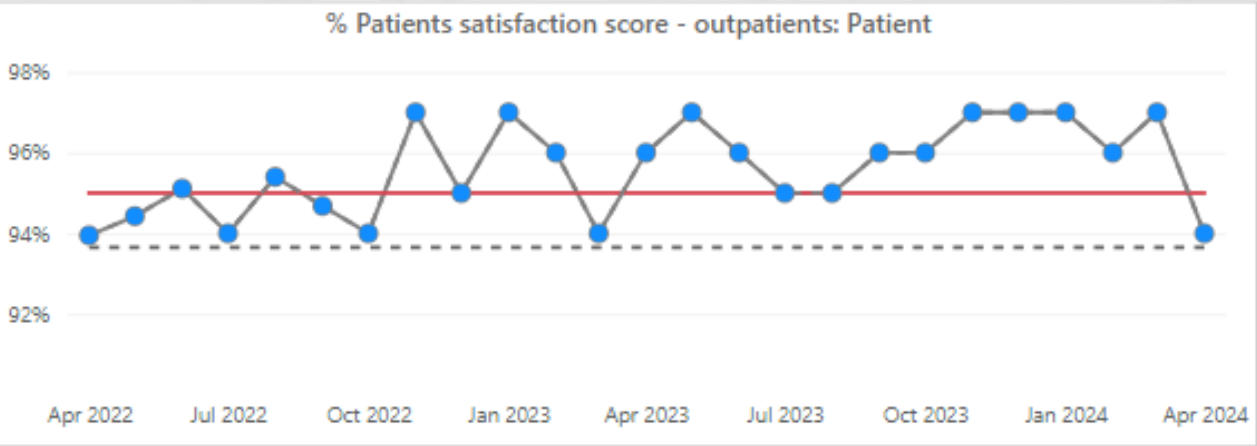
GroupName: Patient

MetricName: % Patients satisfaction score - outpatients

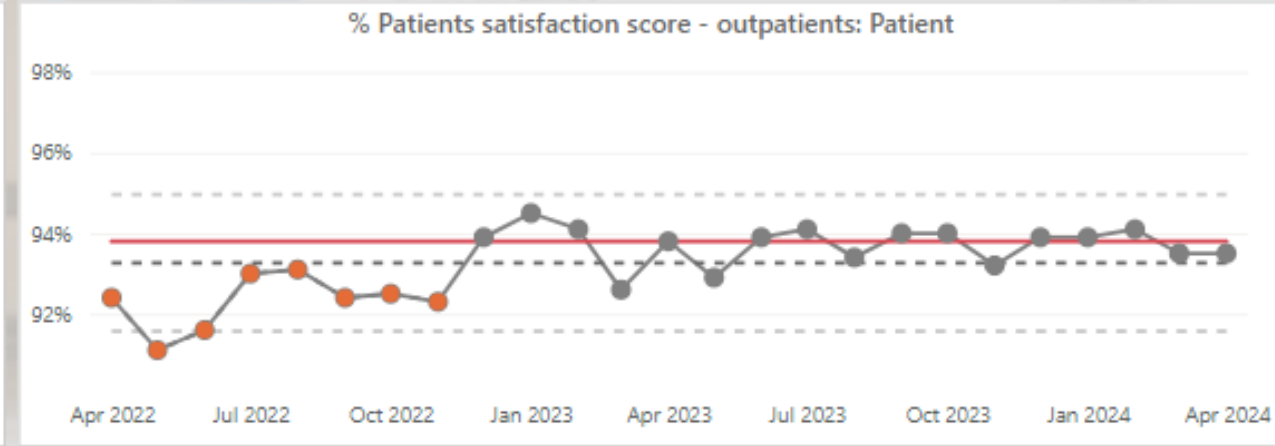
Date: 01/12/2019 – 01/04/2024

| 94.00% | 95.00% | 93.50% | 93.80% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

## Kettering General Hospital




## Northampton General Hospital




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses. | Our Outpatient satisfaction score decreased by 3% to 94% for April when compared with March (97%). In outpatient areas, we received 3,667 responses to the Friends and Family Test. This was an increase of 247 compared with March and an increase of 3,029 compared with April 2023. | Medical SDEC, Nuffield and Frank Radcliffe had a decline in satisfaction score in April 2024. However, all departments increased in responses when compared with last month. | Any learning actions identified through the FFT are highlighted in the monthly divisional updates which are discussed in divisional governance meetings. Bi-Monthly, updates on actions and learning from feedback are reported to the Patient Experience & Engagement Steering Group (PESG). | Response rates and satisfaction score information is shared with all Service Leads to ensure relevant actions are in place to better performance. |
| NGH | 01/04/24 | The satisfaction score is calculated by adding together all the "Very good" and "Good" responses, to obtain a percentage from the overall responses. | Outpatient satisfaction scores have remained stable since around June 2023. | Some outpatient areas have lower than expected FFT survey responses for the volume of attendances. (Point of note: Some areas have a 'survey fatigue' exclusion built in to the process) | Review of specialities and departments that have a low FFT response rate to try to boost the response rates. | Work by the Outpatient Matron focussing on clinics at Danetry Hospital, the Main OPD and the Blood Taking Unit initially prioritised for review. |

# Number of complaints

Committee Name: All

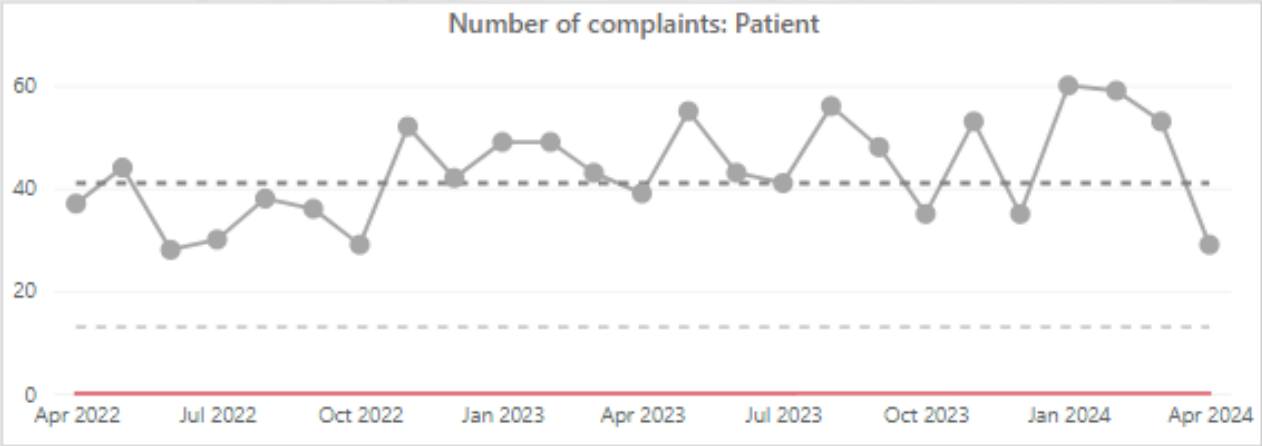
GroupName: Patient

MetricName: Number of complaints

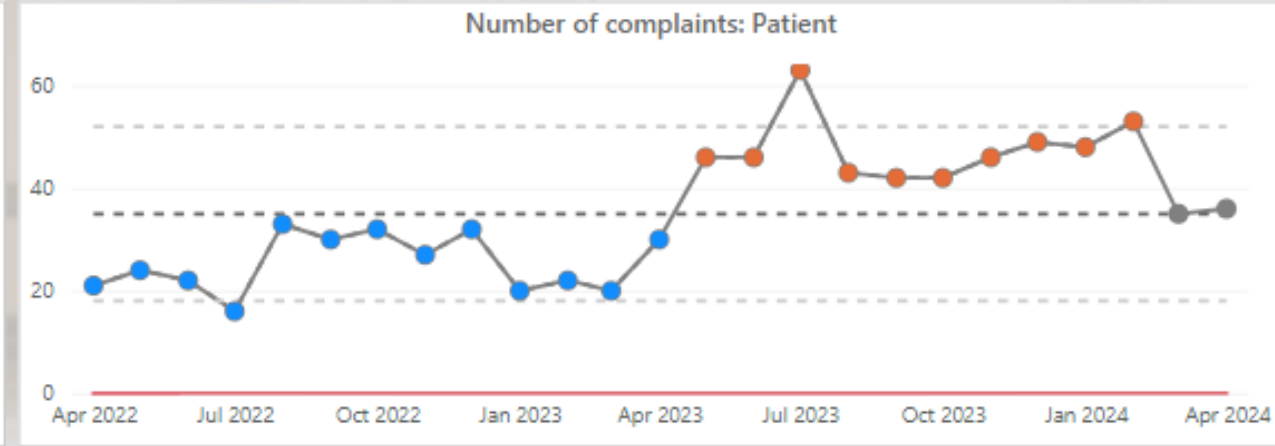
Date: 01/12/2019 – 01/04/2024

| 29 | 0 | 36 | 0 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

## Kettering General Hospital




## Northampton General Hospital




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Number of complaints received in month. This is the number of complaints that proceeded to a formal investigation. Any complaints that were locally resolved withdrawn or escalated to the patient safety team would not be included in this figure, this figure can be provided if required. | 29 complaints logged shows less concerns being made formally, and that more issues being dealt with at the point of the concern | Nil | Continue to monitor and respond to complaints | Nil |
| NGH | 01/04/24 | Number of complaints received in month. This is the number of complaints that proceeded to a formal investigation. Any complaints that were locally resolved withdrawn or escalated to the patient safety team would not be included in this figure, this figure can be provided if required. | 36 Complaints were received in April compared to the 35 received in March and the 53 received in February. This demonstrates that for the last two months the numbers have remained steady. | Whilst the number of complaints has remained steady in the last two months, they continue to be very complex in terms of the content. The top two themes this month relate to Clinical Care and Appointment delays / cancellations. | All complaints are shared with the divisional senior teams when received and a summary is included within monthly reporting. Work is currently ongoing to revise the way in which learning from complaints is captured and the information shared. | The pressures that continue to be experienced across the Trust must be taken into consideration during this period. |

# Complaints response performance

Committee Name: All

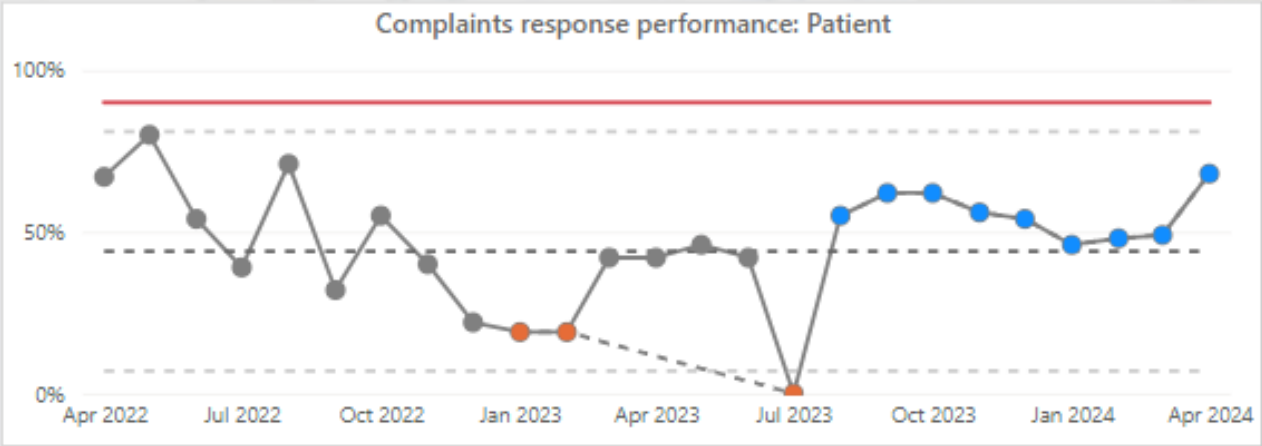
GroupName: Patient

MetricName: Complaints response performance

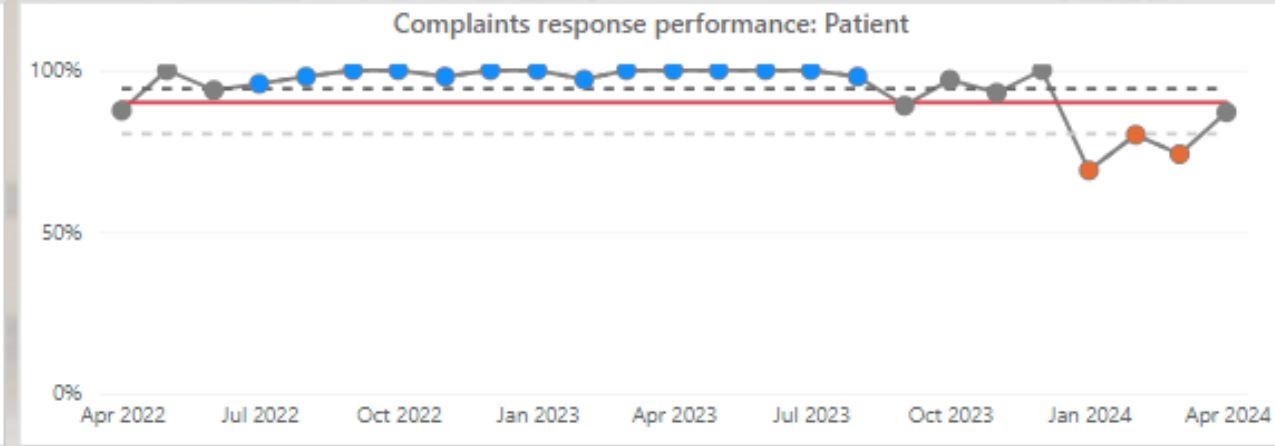
Date: 01/12/2019 – 01/04/2024

| 68.00% | 90.00% | 87.00% | 90.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

## Kettering General Hospital




## Northampton General Hospital




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Complaints performance – Providing a written response to a complaint within an agreed timescale | 68% of complaints due with April where sent out on time, within agreed timeframe to complainant. This is improvement from 49% in March | Nil | Continue to work on overdue cases and improving the performance | Nil |
| NGH | 01/04/24 | Complaints performance – Providing a written response to a complaint within an agreed timescale | The Trust response rate, when extension of times are included is 87% which is within the amber target range. However, when extension of times are excluded the response drops to 47% which is within the red zone for our target. Our target should be 90% or above to achieve green status. | There continues to be a backlog of complaints awaiting a letter of response, which has a detrimental impact on the response rate. Additionally, there remains some challenges with the late receipt of statements and directorate approval of draft letters of response. This has caused an increase in the number of people contacting the Complaints Department requesting their letters of response. | A new process for reviewing complaint response letters is currently being trialled which is a fully digital way of working. It is expected that this will improve the approval process and ensure that responses are released in a timely manner. This is being monitored to demonstrate improvement. | Reduced staffing within the Complaints team, pressures across the organisation have all impacted the Trust response rate. |

# Summary Table

| Committee Name | Group Name | Metric Name | Site | Variation |
|---|---|---|---|---|
| All | Quality | Multiple selections | All | All |

| Site | Group | Metric | Latest Date | Value | Target | LCL | Mean | UCL | Variation | Assurance | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NGH | Quality | Serious or moderate harms | 01/04/24 | 16 | 0 | 13 | 32 | 52 | | | Consistently Anticipated to Not Meet Target |
| KGH | Quality | Serious or moderate harms | 01/04/24 | 5 | 8 | -1 | 7 | 14 | | | Not Consistently Anticipated to Meet Target |
| NGH | Quality | Serious or moderate harms – falls | 01/03/24 | 0.09 | 0.06 | 0.42 | 0.42 | 0.42 | | | Not Consistently Anticipated to Meet Target |
| KGH | Quality | Serious or moderate harms – falls | 01/04/24 | 0.00 | 0.18 | 0.38 | 0.38 | 0.38 | | | Not Consistently Anticipated to Meet Target |
| NGH | Quality | Serious or moderate harms – pressure ulcers | 01/02/24 | 0.50 | 0 | 1.1 | 1.1 | 1.1 | | | Consistently Anticipated to Not Meet Target |
| KGH | Quality | Serious or moderate harms – pressure ulcers | 01/04/24 | 0.26 | 0.69 | 0.83 | 0.83 | 0.83 | | | Not Consistently Anticipated to Meet Target |
| KGH | Quality | Number of medication errors | 01/04/24 | 68 | | 34 | 74 | 113 | | | Consistently Anticipated to Not Meet Target |
| NGH | Quality | Number of medication errors | 01/04/24 | 127 | | 53 | 123 | 193 | | | Consistently Anticipated to Not Meet Target |
| NGH | Quality | Hospital-acquired infections | 01/04/24 | 13 | 7 | 1 | 8 | 15 | | | Not Consistently Anticipated to Meet Target |
| KGH | Quality | Hospital-acquired infections | 01/04/24 | 15 | 7 | -1 | 10 | 21 | | | Not Consistently Anticipated to Meet Target |
| NGH | Quality | MRSA | 01/03/24 | 1 | 0 | -1 | 0 | 1 | | | Not Consistently Anticipated to Meet Target |
| KGH | Quality | MRSA | 01/04/24 | 0 | 0 | 0 | 0 | 1 | | | Not Consistently Anticipated to Meet Target |
| KGH | Quality | C Diff | 01/04/24 | 6 | 3 | -3 | 3 | 9 | | | Not Consistently Anticipated to Meet Target |
| NGH | Quality | C Diff | 01/04/24 | 9 | 4 | -2 | 7 | 16 | | | Not Consistently Anticipated to Meet Target |
| NGH | Quality | SHMI | 01/04/24 | 87 | | 87 | 89 | 91 | | | Consistently Anticipated to Not Meet Target |
| KGH | Quality | SHMI | 01/04/24 | 105.80 | | 110.85 | 110.85 | 110.85 | | | Consistently Anticipated to Not Meet Target |
| KGH | Quality | HSMR | 01/04/24 | 95.00 | 100 | 128.77 | 128.77 | 128.77 | | | Not Consistently Anticipated to Meet Target |
| NGH | Quality | HSMR | 01/04/24 | 91 | 100 | 88 | 90 | 92 | | | Consistently Anticipated to Meet Target |

# Summary Table

| Committee Name | Group Name | Metric Name | Site | Variation |
|---|---|---|---|---|
| All | Quality | Multiple selections | All | All |

| Site | Group | Metric | Latest Date | Value | Target | LCL | Mean | UCL | Variation | Assurance | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NGH | Quality | SMR | 01/04/24 | 91 | | 88 | 89 | 91 | H | F | Consistently Anticipated to Not Meet Target |
| KGH | Quality | SMR | 01/04/24 | 96.40 | | 118.49 | 118.49 | 118.49 | H | | Consistently Anticipated to Not Meet Target |
| KGH | Quality | Safe Staffing | 01/04/24 | 103.36% | 96.00% | 87% | 92.81% | 98.61% | H | ? | Not Consistently Anticipated to Meet Target |
| NGH | Quality | Safe Staffing | 01/04/24 | 105.60% | 96.00% | 97.27% | 102.05% | 106.82% | | F | Consistently Anticipated to Meet Target |
| KGH | Quality | 30 day readmissions | 01/04/24 | 0.00% | 12.00% | 5.59% | 14.47% | 23.36% | L | ? | Not Consistently Anticipated to Meet Target |
| NGH | Quality | 30 day readmissions | 01/04/24 | 13.11% | 12.00% | 8.65% | 13.4% | 18.15% | | ? | Not Consistently Anticipated to Meet Target |
| NGH | Quality | Never event incidence | 01/03/24 | 1 | 0 | 0 | 0 | 1 | H | ? | Not Consistently Anticipated to Meet Target |
| KGH | Quality | Never event incidence | 01/04/24 | 0 | 0 | 0 | 0 | 1 | L | ? | Not Consistently Anticipated to Meet Target |
| KGH | Quality | Food wastage | 01/04/24 | 7.11 | | 9.43 | 9.43 | 9.43 | | | Consistently Anticipated to Meet Target |
| NGH | Quality | Food wastage | 01/04/24 | 7.40 | | 11.94 | 11.94 | 11.94 | | | Consistently Anticipated to Meet Target |

# Serious or moderate harms

Committee Name: All

GroupName: Quality

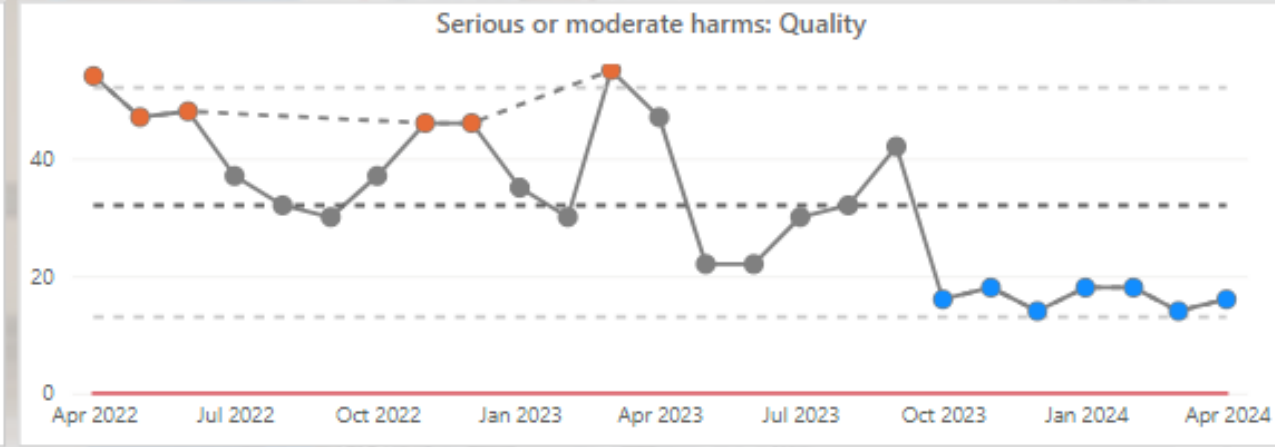
MetricName: Serious or moderate harms

Date: 01/12/2019 – 01/04/2024

| 5 | 8 | 16 | 0 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

## Kettering General Hospital


## Northampton General Hospital




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Patients experiencing moderate, severe, catastrophic harm or patient death as a result of a patient safety incident. | The chart is showing common cause variation with variable assurance. The ceiling was set on the average based on Dec-19-Mar-22 numbers and may require revision | KGH has an average reporting number of 6.85 for the time period Dec-19-Mar-22. 2020-2021 average reporting was 7.25. 2021-22 average reporting number was 6. KGH propose to set the ceiling at 8 pending review. Caution must be applied as harms levels can change pending investigation which may take several months. | The Trust recognises that there will be incidents that do not meet the Serious Incident reporting threshold. Where moderate harm has occurred, such incidents fall within the scope of the Policy For The Reporting And Management Of Serious Incidents, Never Events And Investigations Into Moderate Harm Incidents and its guidance, in terms of provision of root cause analysis investigations and evidence of assessment of harm and duty of candour by the Serious Incident Review Group (SIRG). | For the time period stated, moderate, severe, catastrophic harm or patient death as a result of a patient safety incident equates to 2.49% of all incidents with a patient harm incurred, and 0.48% of all incidents reported. |

# Serious or moderate harms – falls

Committee Name: All

GroupName: Quality

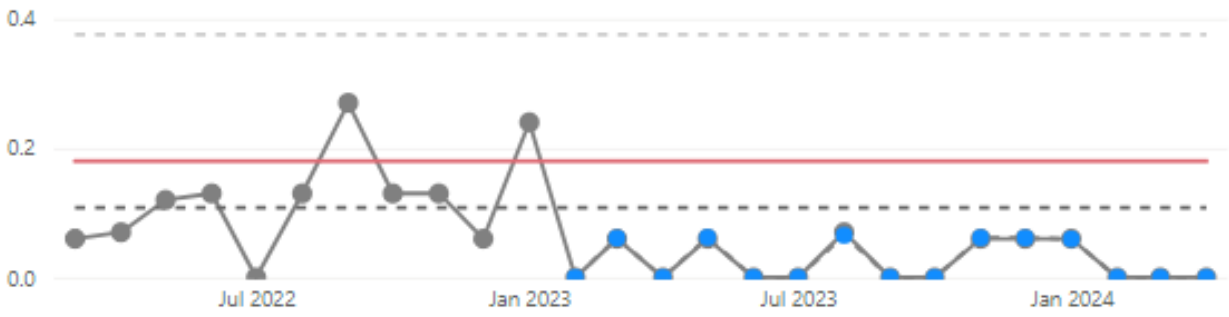
MetricName: Serious or moderate harms – falls

Date: 01/12/2019 – 01/04/2024

| 0.00 | 0.18 | 0.09 | 0.06 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

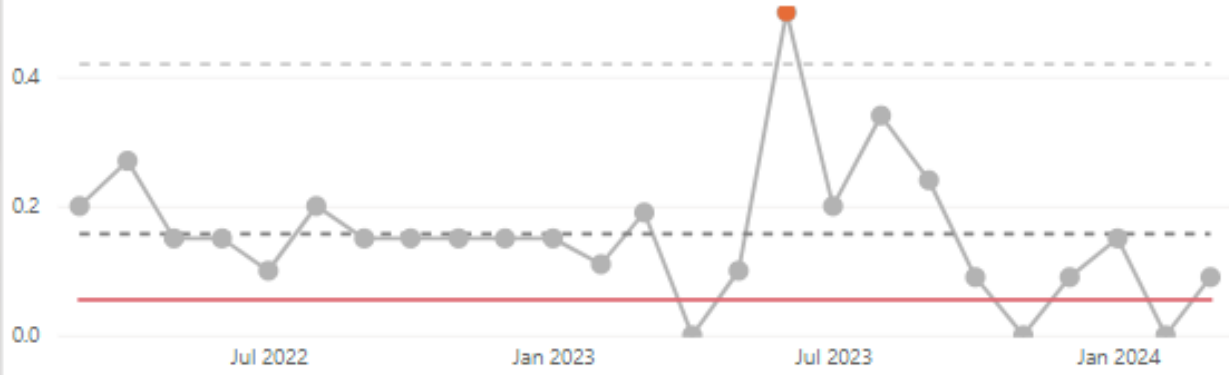
## Kettering General Hospital

Serious or moderate harms – falls: Quality




## Northampton General Hospital

Serious or moderate harms – falls: Quality




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Patients experiencing falls with moderate harm or above per 1000 bed days. | There were no falls with moderate or above harm in April | Three weekly focus on falls as part of the Friday Harm Free Care Meetings.<br>Bi-weekly Harm Free Scrutiny panel meets to review any incidents with harm relating to falls. | Significant work has been undertaken over the last two years, with a revision of paperwork and mandatory training for relevant staff. All falls with harm are reviewed by the Falls Prevention Lead and Practice Development Team in conjunction with the clinical area | |

# Serious or moderate harms – pressure ulcers

Committee Name: All

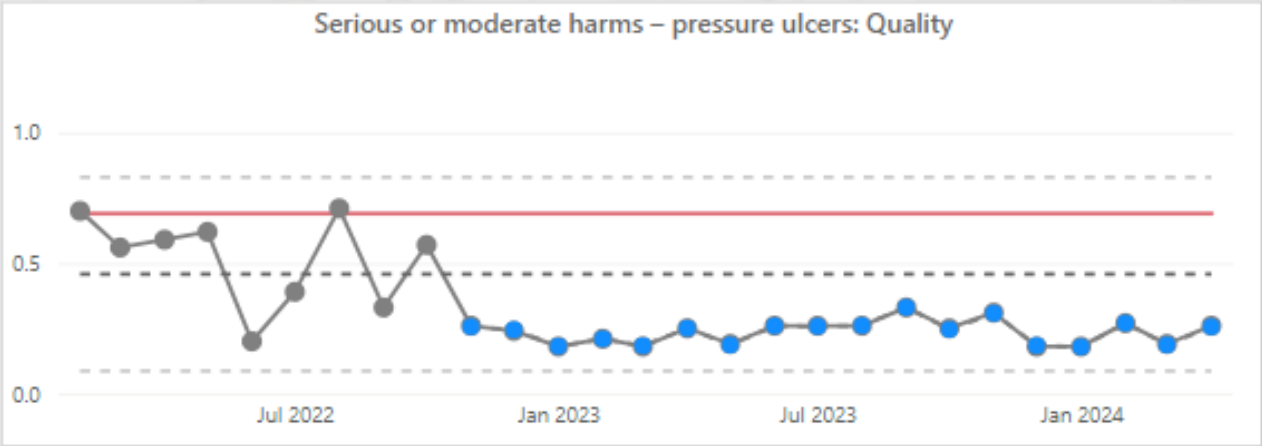
GroupName: Quality

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

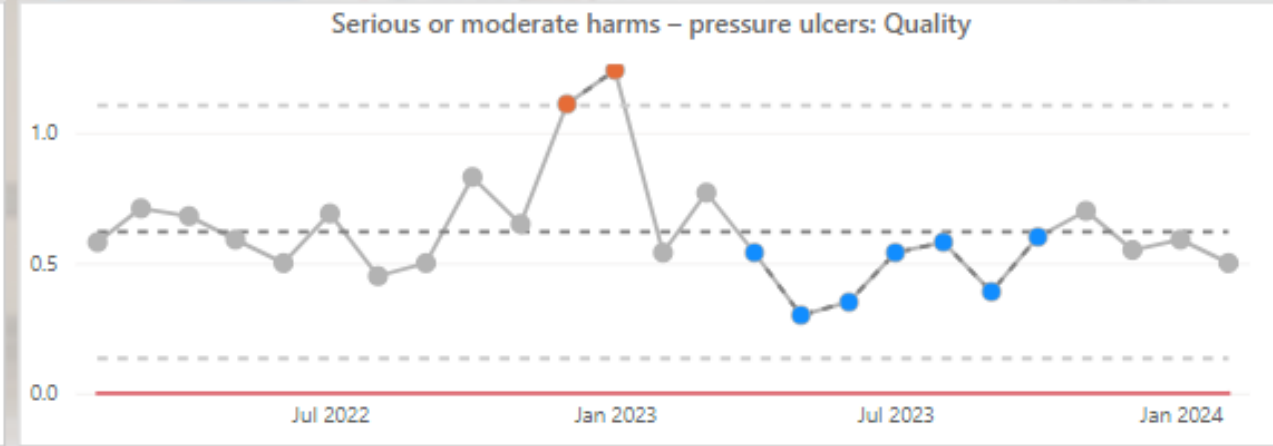
Date: 01/12/2019 – 01/04/2024

| 0.26 | 0.69 | 0.50 | 0 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

## Kettering General Hospital




## Northampton General Hospital




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Patients experiencing pressure tissue damage category 2, 3, 4 or unstageable developed or worsened in hospital per 1000 bed days. Not including moisture associated skin damage or deep tissue injury | The chart is showing common cause variation with positive low assurance. | With the development of the IGR, the defined metric has been agreed as: Patients experiencing pressure tissue damage category 2, 3, 4 or unstageable developed or worsened in hospital per 1000 bed days. (Not including moisture associated skin damage or deep tissue injury). | The SSKIN Risk Assessment and Care Plan are established and in use across the Trust. Compliance with this is now being monitored through the 'Perfect Ward' system. Three weekly focus on pressure ulcers as part of the Friday Harm Free Care Meetings | The Tissue Viability Nurse reviews all Category 2 and above pressure ulcers, providing validation and education. |

# Number of medication errors

Committee Name: All

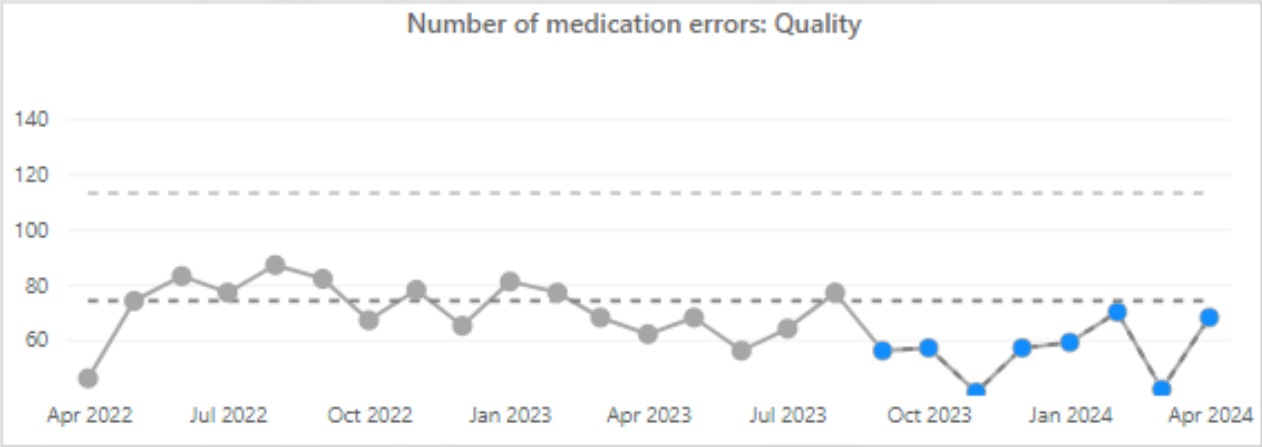
GroupName: Quality

MetricName: Number of medication errors

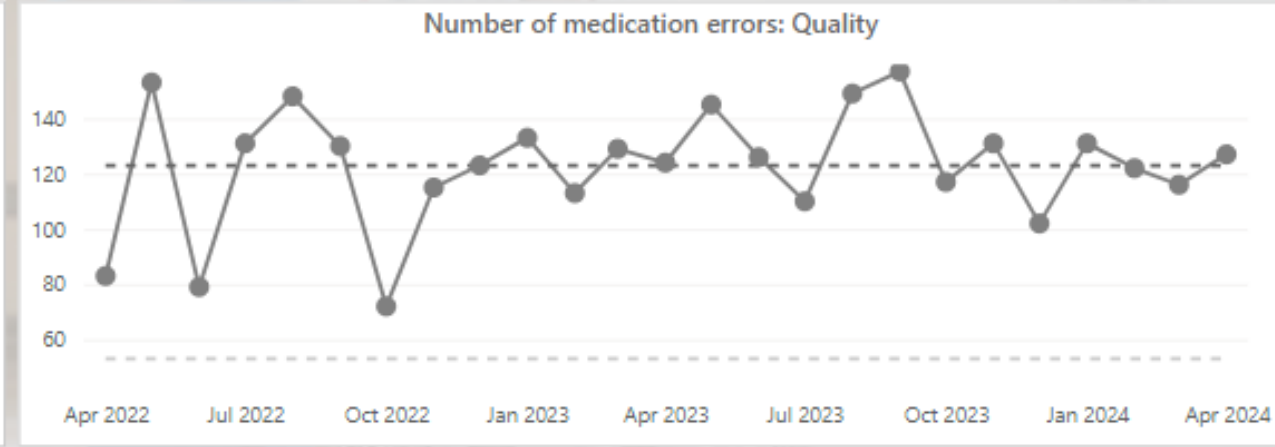
Date: 01/12/2019 – 01/04/2024

| 68 | | 127 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**



# Number of medication errors

Committee Name: All

GroupName: Quality

MetricName: Number of medication errors

| 68 | | 127 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Medication incidents reported irrespective of subclass of incident (prescribing, dispensing, administering) and irrespective of harm or level of harm. | The Chart shows common cause variation with no agreed target. Historically the Trust had taken a proactive approach to encouraging incident reporting. | A 'low' reporting rate from an organisation should not be interpreted as a 'safe' organisation, and may represent under-reporting. Subsequently, a 'high' reporting rate should not be interpreted as an 'unsafe' organisation, and may actually represent a culture of greater openness. | The reporting of incidents to a national central system (The National Reporting and Learning System (NRLS)) helps protect patients from avoidable harm by increasing opportunities to learn from mistakes where things go wrong. At a national level the NHS uses these reports to identify and take action to prevent emerging patterns of incidents on a national level via patient safety alerts. At a local level these reports are used to identify and target areas of risk emerging through deficiencies in policy, practice process or therapeutics. | Therr were no moderate harm incidents reported |
| NGH | 01/04/24 | Medication incidents reported irrespective of subclass of incident (prescribing, dispensing, administering) and irrespective of harm or level of harm. | Medicines incidents continue to be reported at a similar level across the organisation. There are no significant changes in stage of process, degree of harm or themes | No issues highlighted through report. Work commencing on medication incident reports relating to discharge. | Incidents will continue to be reviewed by experienced medication safety team and reported via Medicines Safety and Governance Group (MSGG). Discharge medicines workstream will report findings through MSGG. | Incidents reviewed for trends/actions and feedback for learning. |

# Hospital-acquired infections

Committee Name: All

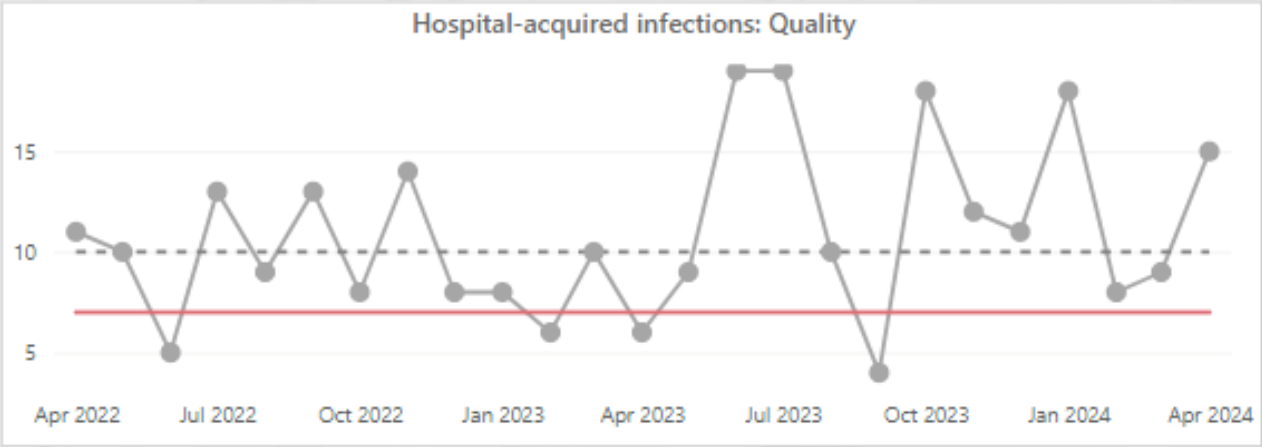
GroupName: Quality

MetricName: Hospital-acquired infections

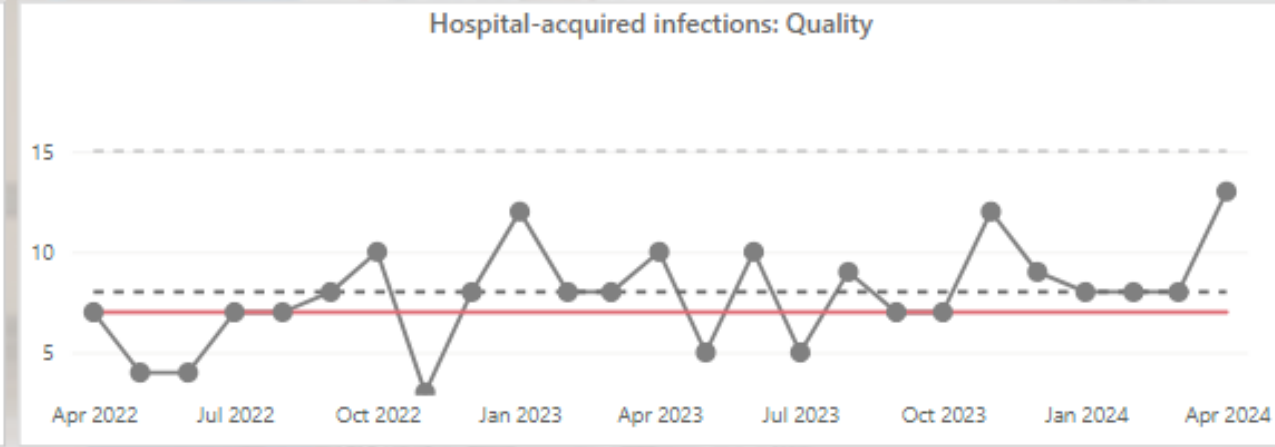
Date: 01/12/2019 – 01/04/2024

| 15 | 7 | 13 | 7 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**



# Hospital-acquired infections

Committee Name: All

GroupName: Quality

MetricName: Hospital-acquired infections

| 15 | 7 | 13 | 7 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Patients experiencing a Gram-negative Hospital Onset Healthcare Associated (HOHA) or Community Onset Healthcare Associated (COHA) infection, defined as: E.coli, Pseudomonas aeruginosa and Klebsiella species. | The chart is showing common cause variation and variable assurance. Patients experiencing a Gram negative Hospital Onset Hospital Acquired (HOHA) or Community Onset Hospital Acquired (COHA) infection, defined as: E-Coli, Pseudomonas aeruginosa and Klebsiella species. E-Coli occurrences. | The NHS Standard Contract 2024/25 for Minimising Clostridioides difficile and Gram-negative bloodstream infections has yet to be published. Therefore ceilings have been set based on 2023/24 figures, which will be revised retrospectively. | Full RCAs are undertaken on all cases followed by a subsequent MDT review. Identified learning is action planned and presented at IPSG | Full RCAs are undertaken on all cases followed by a subsequent MDT review. Identified learning is action planned and presented at IPSG |
| NGH | 01/04/24 | Patients experiencing a Gram-negative Hospital Onset Healthcare Associated (HOHA) or Community Onset Healthcare Associated (COHA) infection, defined as: E.coli, Pseudomonas aeruginosa and Klebsiella species. | 13 patients developed a healthcare associated Gram-negative bloodstream infection this month. | NHSE standard contract for GNB 2024/25 for NGH is as yet unpublished. There were 13 cases in April, all of which were unavoidable at an IPC level for example due to hepatobiliary or intra-abdominal causes. | The IPC Team continue to deliver on the GNB section of the HCAI Improvement Plan and are continuing with three key workstreams in May including world hand hygiene day, blood culture clinics in Urgent Care and catheter prevention ward rounds. | Thematic analysis shows that the majority of the GNBs could not have been prevented e.g. were due to hepatobiliary infections, community onset delayed diagnosis, and gastro/abdominal infections from which there was no learning. The GNB trajectory is monitored via the monthly IPC Report to IPC Steering Group and the monthly CNO report to CQSP and CQEG. |

# MRSA

Committee Name: All

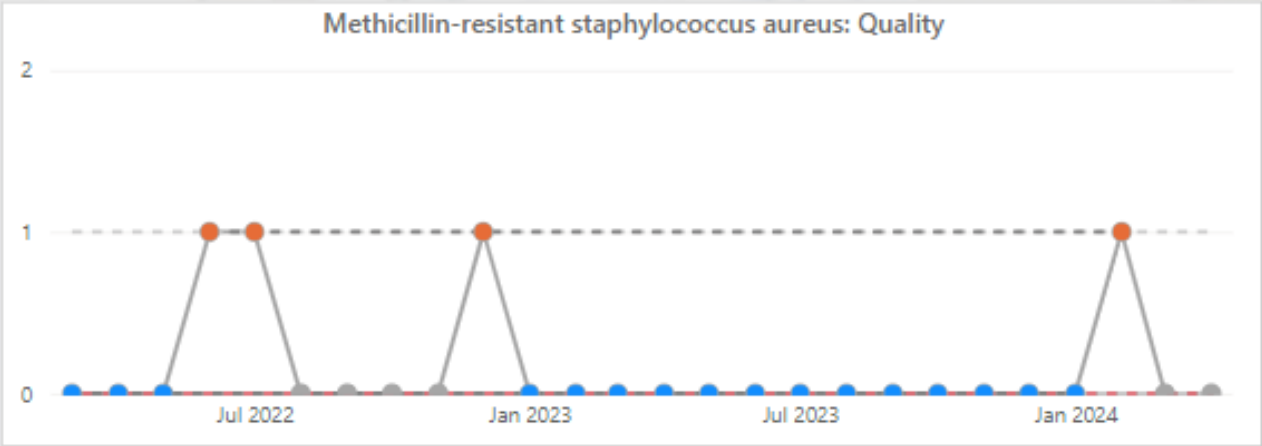
GroupName: Quality

MetricName: MRSA

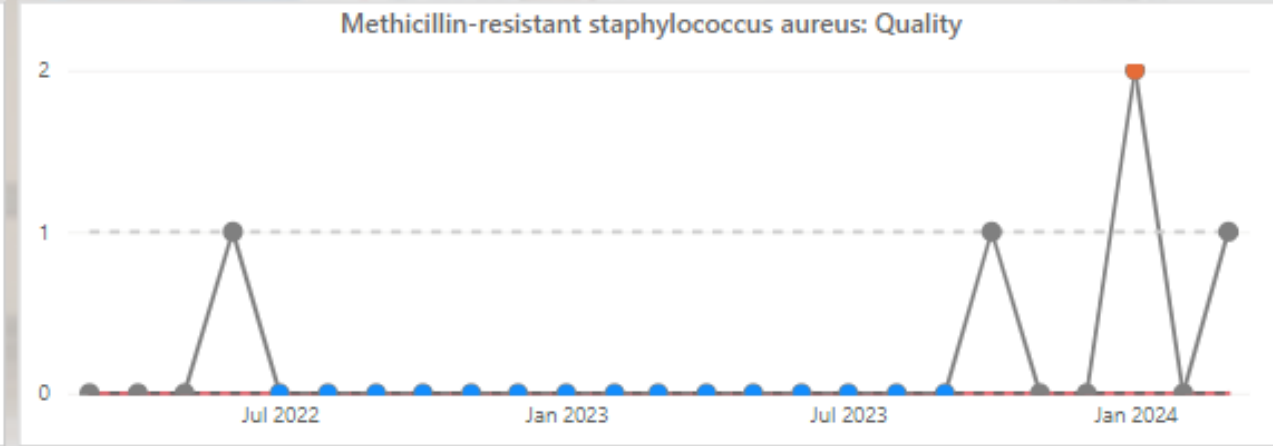
Date: 01/12/2019 – 01/04/2024

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

**Kettering General Hospital**




**Northampton General Hospital**




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Patients experiencing a MRSA Bacteraemia | The chart shows common cause variation with variable assurance | None | All MRSA bacteraemia undergo robust root cause analysis | IPC measures are reviewed and revised in line with National Changes. |

# C Diff

Committee Name: All

GroupName: Quality

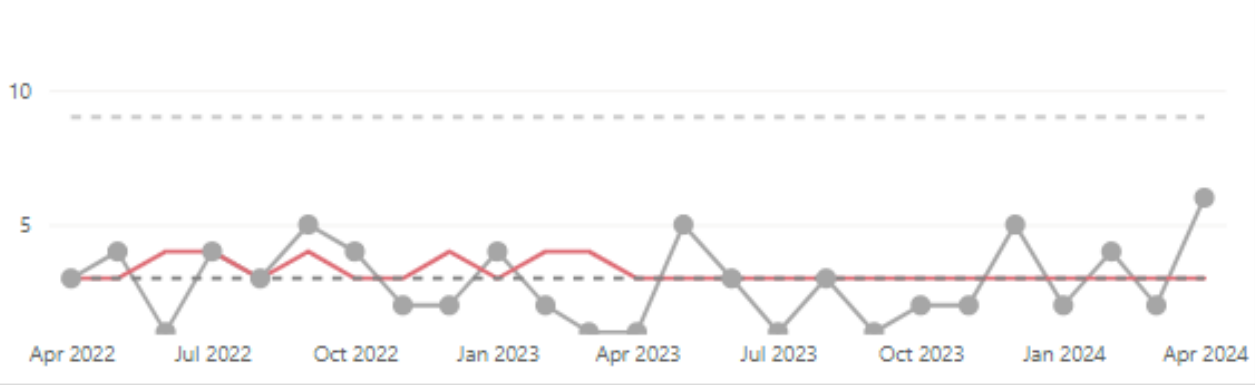
MetricName: C Diff

Date: 01/12/2019 – 01/04/2024

| 6 | 3 | 9 | 4 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

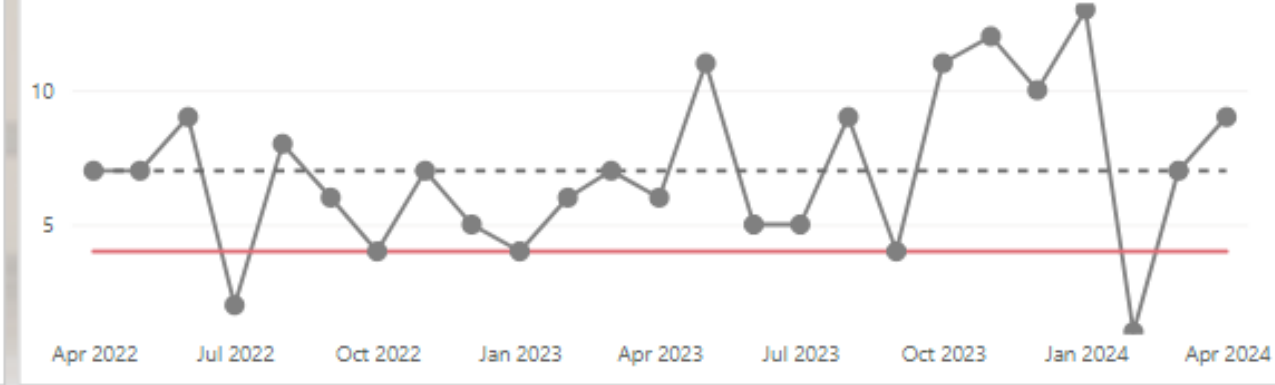
## Kettering General Hospital

Clostridium difficile: Quality




## Northampton General Hospital

Clostridium difficile: Quality



# C Diff

Committee Name: All

GroupName: Quality

MetricName: C Diff

| 6 | 3 | 9 | 4 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Reduce the number of attributed Clostridium difficile against CCG ceiling. The CCG have now set a variable number per month with an annual ceiling of 41 for 2022-23. | The chart is showing common cause variation and variable assurance. | The NHS Standard Contract 2024/25 for Minimising Clostridioides difficile and Gram-negative bloodstream infections has yet to be published. Therefore ceilings have been set based on 2023/24 figures, which will be revised retrospectively. | SIGHT tool being promoted in clinical areas from the IPC team on ward meetings. IPC working with matrons and action plans have been drawn up in clinical areas to assist with auditing and education. Pharmacy are discussing correct prescribing of antibiotics within guidance for CDT patients with medical staff. | IPC daily visits to laboratory to check stool samples and liaising with the clinical areas to ensure all appropriate actions (SIGHT) have been put in place in the area. SIGHT posters given to clinical areas for nursing staff and medical staff. Stool chart audits by IPC on clinical area to ensure SIGHT tool, Isolation and stool sampling is in line with guidance. Actions then given back to clinical area. |
| NGH | 01/04/24 | Reduce the number of attributed Clostridium difficile against CCG ceiling. The CCG have now set a variable number per month with an annual ceiling of 51 for 2022-23. | 9 patients developed healthcare associated CDI this month. | The NHSE standard contract for CDI for NGH 2024/5 is yet to be published. 9 patients developed a healthcare associated CDI this month. Over 50% of 2023/24 cases were due to inappropriate antibiotic prescriptions and 30% were patients that had previously had CDI who received broad-spectrum antibiotics that caused infections. The business case to expand the Antimicrobial Stewardship Pharmacy Team was rejected. | SWARMs and after actions review meetings are completed as required for each HOHA and COHA CDI case using the PSIRF framework. Regular Antibiotic Stewardship rounds continue and data and learning is being fed back via directorate governance meetings. Although the patients have a variety of ribotypes and there has been largely no evidence of cross-infection, a targeted deep clean plan commences in May 2024. New local antimicrobial stewardship guidance is being launched in May. | The CDI position and actions are monitored monthly through IPSG, are raised quarterly via the IPC report to CQEG and CSQP and monthly via the CNO report to CSQP for discussion and oversight. |

# SHMI

Committee Name: All

GroupName: Quality

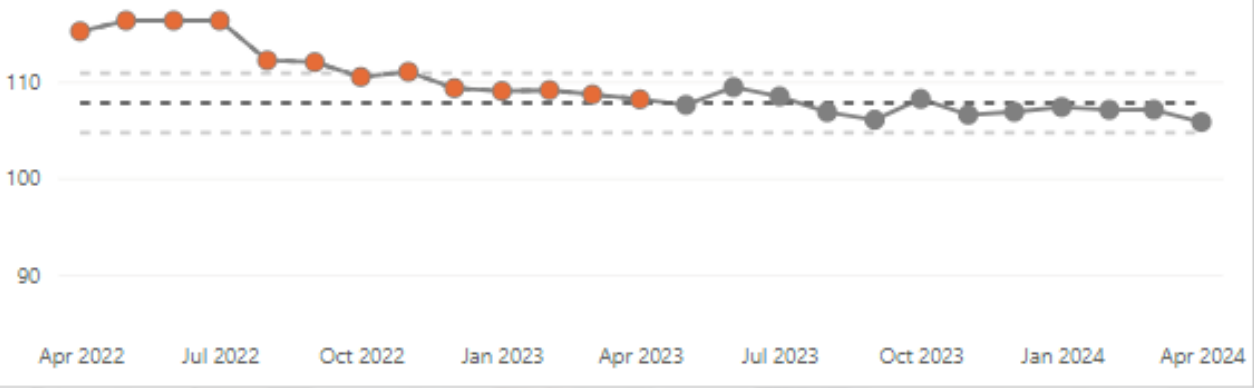
MetricName: SHMI

Date: 01/12/2019 – 01/04/2024

| 105.80 | | 87 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

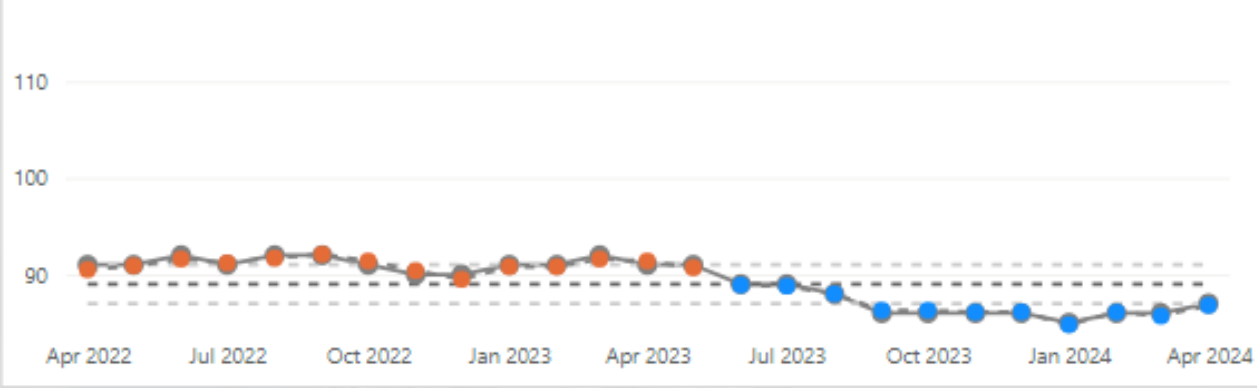
## Kettering General Hospital

Summary Hospital-level Mortality Indicator: Quality




## Northampton General Hospital

Summary Hospital-level Mortality Indicator: Quality



# SHMI

Committee Name: All

GroupName: Quality

MetricName: SHMI

| 105.80 | | 87 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Summary Hospital-Level Mortality Indicator (SHMI) is an indicator of healthcare quality that measures whether the number of deaths in hospital, or within 30 days of patients leaving hospital, is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. A higher score means more deaths; a lower score, fewer. | 105.80 - 'as expected' (Data Period: December 22 - November 23) | SHMI is 'as expected' overall. 0 diagnosis groups 'above expected'. | Analysis and assurance has been provided in Quarter 4 2022/23 as well as Quarter 1 & 2 2023/24 Mortality Dashboards. LFDG continues to monitor all Dr Foster metrics monthly. Metric has been within 'as expected' banding for 14 consecutive months. | 0 - Alerts are early warning indicators and currently no alerts within current data period. KGH currently within 'as expected' banding when compared Nationally (Data via NHS England & supported by Dr Foster HSMR / SMR figures). |
| NGH | 01/04/24 | Summary Hospital-Level Mortality Indicator (SHMI) is an indicator of healthcare quality that measures whether the number of deaths in hospital, or within 30 days of patients leaving hospital, is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. A higher score means more deaths; a lower score, fewer. | SHMI = 86.8, continues in the "below expected" range | SHMI methodology will be changing nationally in May 2024, which may affect our reported figures from next month. This will include a backdated inclusion of deaths from Covid-19 for the first time with this metric. Full explanation given by Telstra Health Consultant at LFDG May 2024 | Nil current | Not applicable |

# HSMR

Committee Name: All

GroupName: Quality

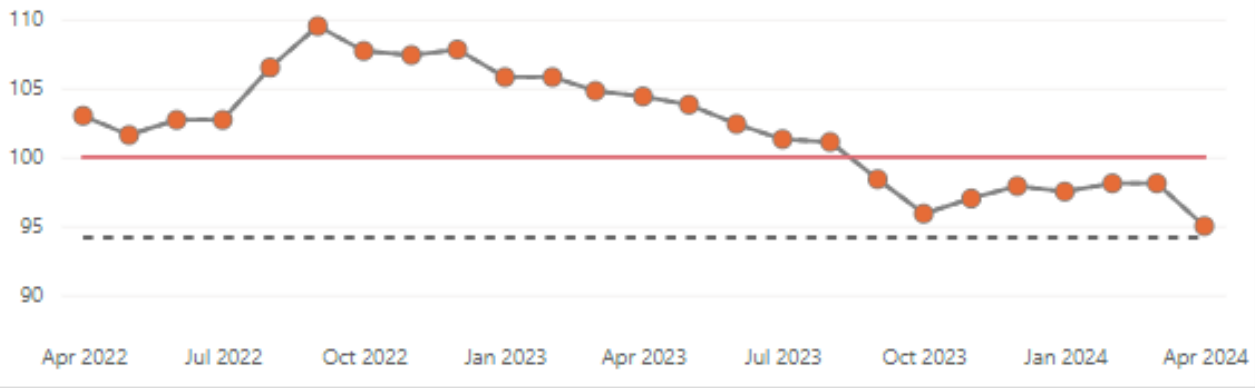
MetricName: HSMR

Date: 01/12/2019 – 01/04/2024

| 95.00 | 100 | 91 | 100 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

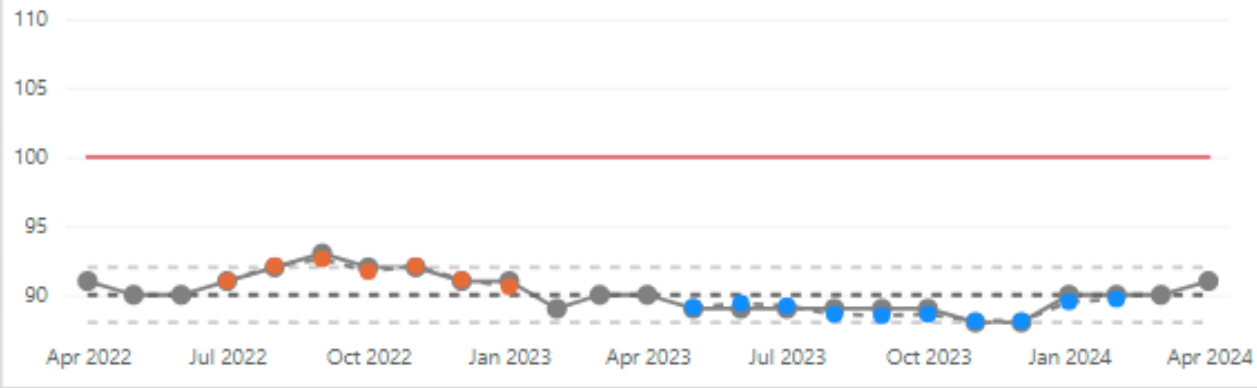
## Kettering General Hospital

Hospital Standardised Mortality Ratio: Quality




## Northampton General Hospital

Hospital Standardised Mortality Ratio: Quality



# HSMR

Committee Name: All

GroupName: Quality

MetricName: HSMR

| 95.00 | 100 | 91 | 100 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. A higher score means more deaths; a lower score, fewer. Statistically, the HSMR is the relative risk of in-hospital mortality for patients admitted within the 56 diagnosis groups that account for 80% of in-hospital deaths. | 95.0 - 'as expected' (January 2023 - December 2023) 1 MONTH LAG | At Trust level for the time period February 2023 to January 2024, there are 9677 superspells within the residual codes, unclassified diagnosis group (6443 superspells for January 24).<br>Although this activity will contribute to the Trust and Hospital wide SMR it can generate a potentially materially different risk and consequently may not show a true Trust position. Furthermore, this activity "residual codes" will be excluded from the HSMR as it is not within the basket of 56 diagnosis groups.<br>Therefore, this report will use a time period of January 2023 to December 2023 for all HSMR / SMR analysis.<br>It will impact less on the SHMI because of the additional time lag applied as standard and so the report will contain basic analysis for the 12-month period to November 23 (as published). | Analysis and assurance of individual diagnosis groups has been provided in the February 2023, Quarter 4 22/23 and Quarter 2 23/24 Mortality Dashboards. The Trust continue to work with Clinical Coding, Clinical Leads and our Dr Foster Representative. | Mortality is monitored closely through the Medical Director's office. Monthly meetings between Mortality, Dr Foster and Clinical Coding continue to be effective and as of September 2023, Learning from Deaths Group is now held monthly with Dr Foster alerts being a standing agenda item. |

# HSMR

Committee Name: All

GroupName: Quality

MetricName: HSMR

| 95.00 | 100 | 91 | 100 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| NGH | 01/04/24 | Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. A higher score means more deaths; a lower score, fewer. Statistically, the HSMR is the relative risk of in-hospital mortality for patients admitted within the 56 diagnosis groups that account for 80% of in-hospital deaths. | HSMR = 90.5, continues in the below expected range | Nil current issues | Nil current actions | Not applicable |

# SMR

Committee Name: All

GroupName: Quality

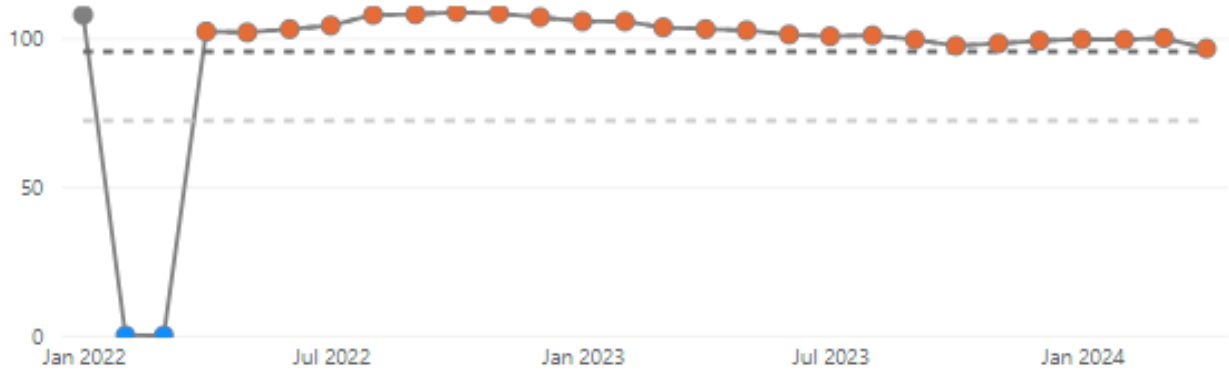
MetricName: SMR

Date: 01/12/2019 – 01/04/2024

| 96.40 | | 91 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

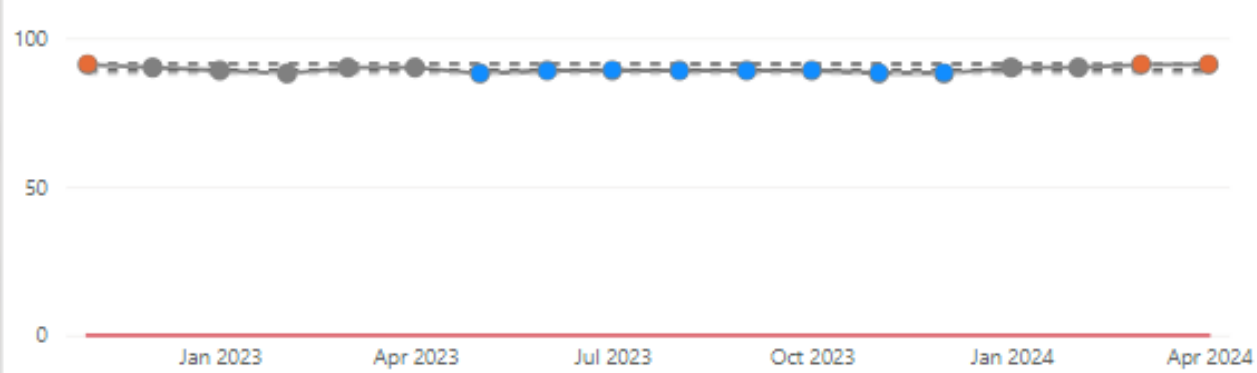
## Kettering General Hospital

Standardised Mortality Ratio: Quality




## Northampton General Hospital

Standardised Mortality Ratio: Quality



# SMR

Committee Name: All

GroupName: Quality

MetricName: SMR

| 96.40 | | 91 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Standardised Mortality Ratio (SMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. A higher score means more deaths; a lower score, fewer. Statistically, the SMR is the relative risk of in-hospital mortality for all patients admitted. | 96.4 - 'as expected' (January 2023 - December 2023) 1 MONTH LAG | At Trust level for the time period February 2023 to January 2024, there are 9677 superspells within the residual codes, unclassified diagnosis group (6443 superspells for January 24).<br>Although this activity will contribute to the Trust and Hospital wide SMR it can generate a potentially materially different risk and consequently may not show a true Trust position.<br>Furthermore, this activity "residual codes" will be excluded from the HSMR as it is not within the basket of 56 diagnosis groups.<br>Therefore, this report will use a time period of January 2023 to December 2023 for all HSMR / SMR analysis.<br>It will impact less on the SHMI because of the additional time lag applied as standard and so the report will contain basic analysis for the 12-month period to November 23 (as published). | Analysis and assurance of individual diagnosis groups has been provided in the February 2023, Quarter 4 22/23 and Quarter 2 23/24 Mortality Dashboards. The Trust continue to work with Clinical Coding, Clinical Leads and our Dr Foster Representative. | Mortality is monitored closely through the Medical Director's office. Monthly meetings between Mortality, Dr Foster and Clinical Coding continue to be effective and as of September 2023, Learning from Deaths Group is now held monthly with Dr Foster alerts being a standing agenda item. |

# SMR

Committee Name: All

GroupName: Quality

MetricName: SMR

Date: 12/1/2019 – 4/1/2024

| 96.40 | | 91 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| NGH | 01/04/24 | Standardised Mortality Ratio (SMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. A higher score means more deaths; a lower score, fewer. Statistically, the SMR is the relative risk of in-hospital mortality for all patients admitted. | SMR = 91.2, continues in the "below expected" range | Nil current issues | Nil actions | Not applicable |

# Safe Staffing

Committee Name: All

GroupName: Quality

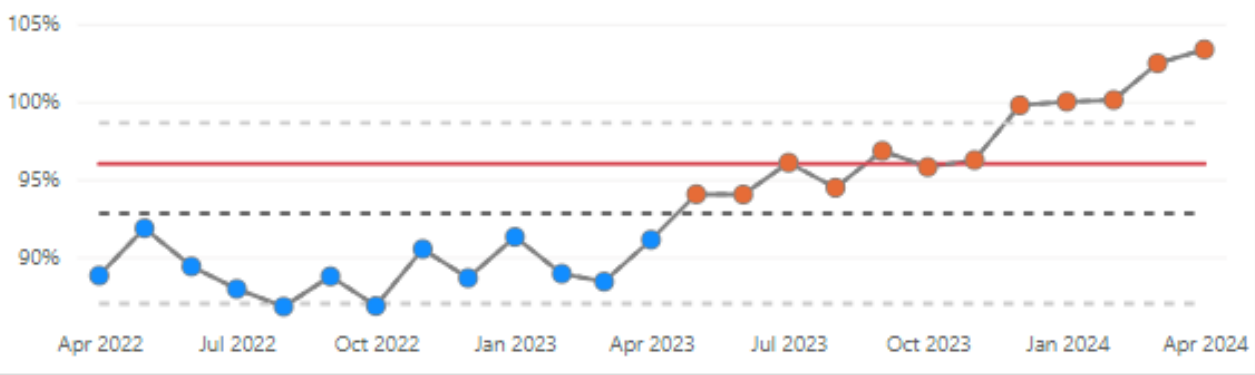
MetricName: Safe Staffing

Date: 01/12/2019 – 01/04/2024

| 103.36% | 96.00% | 105.60% | 96.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

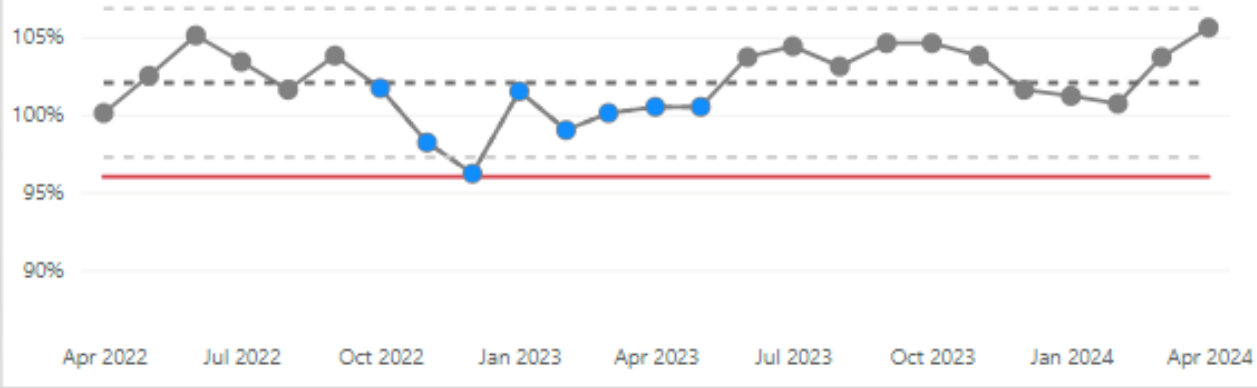
## Kettering General Hospital

Safe Staffing: Quality




## Northampton General Hospital

Safe Staffing: Quality



# Safe Staffing

Committee Name: All

GroupName: Quality

MetricName: Safe Staffing

| 103.36% | 96.00% | 105.60% | 96.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Combined day & night shift fill rate % for registered & non-registered Nursing, midwifery & AHP staff. Reported nationally to NHSE in accordance with National Quality Board guidance. | The value tells us that the overall combined fill rate is at the highest level for the last 2 years which assures us of safe staffing levels for both the registered & non-registered staff groups | No issues | Continue with recruitment & NA deployment planning | Temporary staffing & internal deployment as required monitored & managed via twice daily staffing cell |
| NGH | 01/04/24 | Combined day & night shift fill rate % for registered & non-registered Nursing, midwifery & AHP staff. Reported nationally to NHSE in accordance with National Quality Board guidance. | 105.6% This is the combined day and night shift fill rate % for registered and non-registered nursing staff. Reported nationally to NHSE in accordance with the National Quality board guidance. The value tells us that the combined registered and non-registered nursing and midwifery fill rates are above the current NGH target and but has increased by 1.8% since Nov 23 (103.8%). This means that the actual staffing levels met the planned staffing levels 100.4% of the time in January which has a positive impact on patient safety, quality of care and patient experience. | Despite the decrease in actual staffing fill rates, Nursing and Midwifery continues to be more than 30% unavailability with parenting rates of > 5.7% and sickness rates above 7%, this indicates that the actual staffing fill rates have been supported by temporary staffing measures via bank and agency. The above 100% is a result of enhanced observation of care being in addition to budgeted establishment but essential to providing safe care to patients requiring enhanced levels of care and un-reflected roster templates changes awaiting to be updated. Enhanced care team is now in post and should see a reduction in the use of 1:1. | The monthly roster metric KPI meetings will continue to focus on managing unavailability, there have been improvements in terms of other leave and roster housekeeping however high rates of sickness require a greater focus. The trust wide ongoing work around agency reduction plans will also be introduce at these meetings for discussion and assurance, as well as the weekly recruitment and retention meetings and progress tracker. Agency HCA has now been taken off auto transfer to agency on health roster, these now have to be manually sent once all other avenues of covering shifts explored. | NGH hold twice daily safety huddles to monitor and mitigate staffing concerns and shortfalls where plans are made to provide internal mitigations and redeployment of staff to maintain safety. Temporary staffing is utilised when all opportunity for internal mitigation is exhausted. More recently UHN RAG rating for staffing shortfalls have been agreed and implemented, this has given greater objectivity in relation to evaluation of shortfalls, this has ensured alignment of approach to staffing evaluation across KGH and NGH |

# 30 day readmissions

Committee Name: All

GroupName: Quality

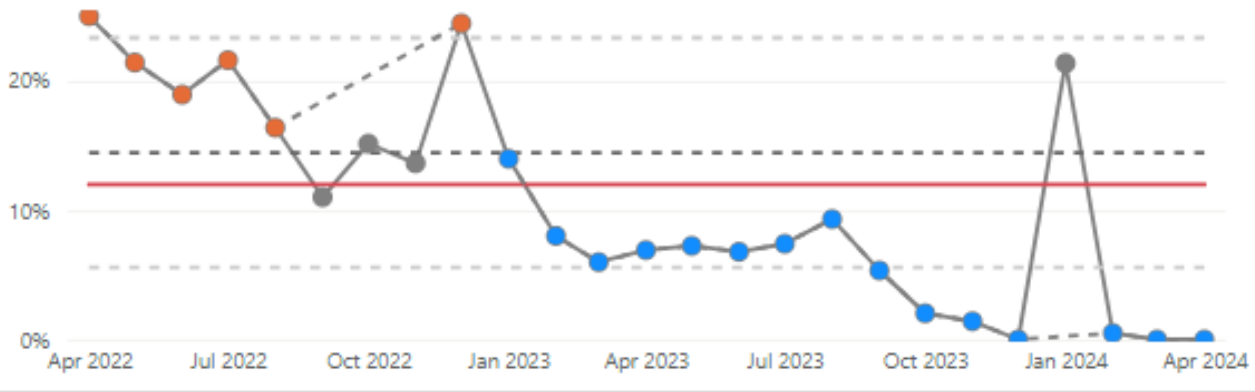
MetricName: 30 day readmissions

Date: 01/12/2019 – 01/04/2024

| 0.00% | 12.00% | 13.11% | 12.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

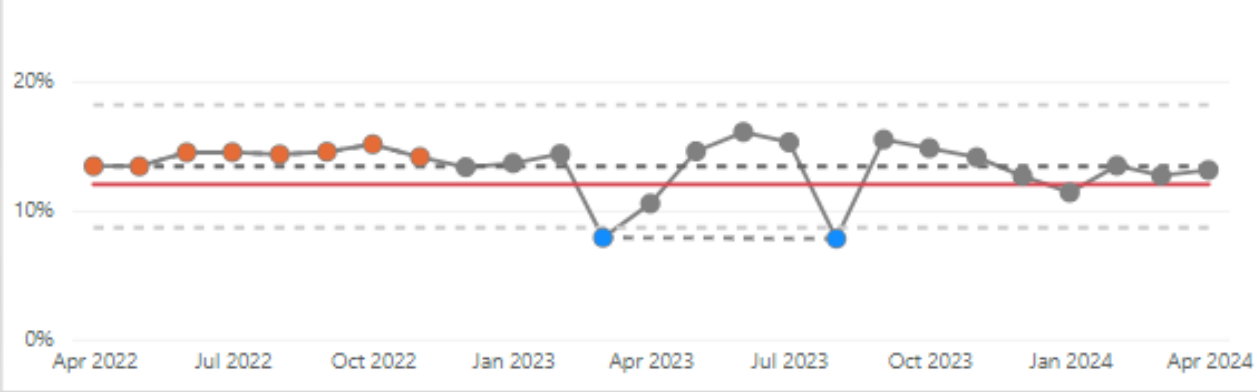
**Kettering General Hospital**

30 day readmissions: Quality




**Northampton General Hospital**

30 day readmissions: Quality




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|

# Never event incidence

Committee Name: All

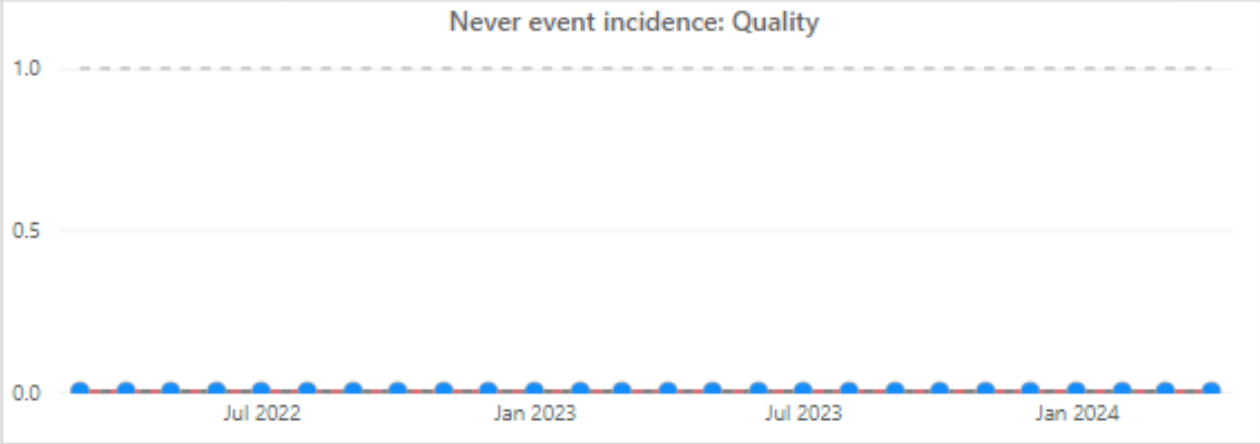
GroupName: Quality

MetricName: Never event incidence

Date: 01/12/2019 – 01/04/2024

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

## Kettering General Hospital




## Northampton General Hospital


| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. As context between 01 April 22 and 31 March 23, 410 never events were reported nationally. National themes are shared across the NHS for learning. | The chart shows that since November 2021 there is a positive assurance with no Never Events reported. | None | None | None |

# Food wastage

Committee Name: All

GroupName: Quality

MetricName: Food wastage

Date: 01/12/2019 – 01/04/2024

| 7.11 | | 7.40 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

## Kettering General Hospital


## Northampton General Hospital


| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | A Group sustainability priority for reduction of the carbon footprint of food waste. Financial savings for Trust. | that food waste has come down slightly | none to report | still looking into food waste data. | Food Waste is slightly down on last months figures staff restaurant has been looking into food waste so figure may be lower because of this but we are still looking into the lower amount. |
| NGH | 01/04/24 | A Group sustainability priority for reduction of the carbon footprint of food waste. Financial savings for Trust. | Overall the value has fallen to below the mean. | Value still too high | Meeting with Chief Nurse has happened for a top down support. Last 3 years data, plus new data shared. Awaiting feedback and actions. | Split on food waste by area has been ongoing in collation for ~ 10 weeks Roughly 1 tonne of food waste is through the restaurant, so is ~ 12.5% of overall waste, allowing a different targeted review, and ~ 750Kg from the CPU. This is being reviewed for impact and understanding |

HEALTHi
informatics | intelligence | insight | integration | improvement

NHS
University Hospitals of Northamptonshire
NHS Group

# Finance and Investment Committee

Dedicated to excellence

# Finance and Investment Committee

Exec owner: Richard Wheeler

*In reminder, this Committee monitors the 'sustainability' metrics within the IGR.*

This cover sheet is designed to **highlight to the Committee saliant messages from the IGR metrics** for this month:

1

UHN submitted a 2024/25 Financial Plan on 02 May, reflecting a projected £60m deficit for the year (KGH £30.5m, NGH £29.5M) Following meetings with the ICB and NHSE, UHN is being asked to review and resubmit the plan improving on this position and work is ongoing to finalise areas for improvement. At month 1, the ytd position is a £9.0m deficit, (£4.3m KGH, £4.7m NGH) which is £1.6m worse than plan. (£0.8m per Trust) These variances include ongoing UEC, inflationary and specific service pressures recognised as risks in the plan, along with an element of late submitted pay costs for 2023/24. Further work is required to identify the full CIP programme from the original submission and to identify additional mitigations to further improve on the planned deficit.

Key **developments with the IGR** itself for the Committee to note:

1

Finance metric alignment (IGR vs F&P) – Work has started in relation to alignment.

*Worth remembering for all metrics, only metrics that have a) had data provided and b) have been signed off, will be published – therefore, this could lead to some gaps in reporting.*

# Sustainability

KGH | NGH

Committee Name: All

GroupName: Sustainability

5 Exec comments KGH

0 Exec comments NGH

22 Total No. of Metrics

| Site | MetricName | Value |
|---|---|---|
| KGH | Theatre sessions planned | 0 |
| KGH | Surplus / Deficit YTD (M) | -4.35 |
| KGH | Pay YTD (M) | 24.22 |
| KGH | Outpatients activity (& vs plan) 2 | 32,465 |
| KGH | Outpatients activity (& vs plan) | 0.00% |
| KGH | Non-elective activity (& vs plan) 2 | 1,712 |
| KGH | Non-elective activity (& vs plan) | 0.00% |
| KGH | Non Pay YTD (M) | 11.05 |
| KGH | Maternity activity (& vs plan) 2 | 0 |
| KGH | Maternity activity (& vs plan) | 0.00% |
| KGH | Income YTD (M) | 32.14 |
| KGH | Headcount actual vs planned (substantive / agency / bank) | 4,949 |
| KGH | Elective inpatient activity (& vs plan) 2 | 317 |
| KGH | Elective inpatient activity (& vs plan) | 0.00% |
| KGH | Elective day-case activity (& vs plan) 2 | 3,712 |
| KGH | Elective day-case activity (& vs plan) | 0.00% |
| KGH | CIP Performance YTD (M) | 0.20 |
| KGH | Capital Spend (M) | 0.69 |
| KGH | Beds available | 504 |
| KGH | Bank and Agency Spend (M) | 3.87 |
| KGH | A&E activity (& vs plan) 2 | 8,938 |
| KGH | A&E activity (& vs plan) | 0.00% |

| Metric | Comment |
|---|---|
| M5 Position | The in-month position is a £4.3m deficit which is £0.8m worse than the £3.5m plan. Variances include £0.1m of efficiency slippage, ongoing UEC, unfunded inflation and other specific service pressures. These were risks that were identified in the compilation of the plan. |
| YTD Position | The ytd position is a £4.3m deficit which is £0.8m worse than the £3.5m plan. Variances include £0.1m of efficiency slippage, ongoing UEC, unfunded inflation and other specific service pressures. These were risks that were identified in the compilation of the plan. |
| Income | Year to date income is £0.1m better than plan . This comprises minor variances across of range of areas, including High Cost Drugs and Devices. |
| Non Pay | Year to date non pay excluding depreciation is £0.1m worse than plan. This includes a level of unfunded inflation identified as a risk in the plan. |
| Pay | Year to date pay costs are £1.0m worse than plan including the impact of ongoing UEC and other unfunded service specific pressures identified as risks in the plan. |

# Sustainability

KGH | NGH

Committee Name: All

GroupName: Sustainability

0 Exec comments KGH

5 Exec comments NGH

17 Total No. of Metrics

| Site | MetricName | Value |
|---|---|---|
| NGH | Theatre sessions planned | 645 |
| NGH | Surplus / Deficit YTD (M) | -3.85 |
| NGH | Pay YTD (M) | 29.25 |
| NGH | Outpatients activity (& vs plan) 2 | 46,411 |
| NGH | Non-elective activity (& vs plan) 2 | 5,889 |
| NGH | Non Pay YTD (M) | 12.19 |
| NGH | Maternity activity (& vs plan) 2 | 883 |
| NGH | Income YTD (M) | 39.65 |
| NGH | Headcount actual vs planned (substantive / agency / bank) | 6,414 |
| NGH | Food Wastage (Cost) | 960 |
| NGH | Elective inpatient activity (& vs plan) 2 | 410 |
| NGH | Elective day-case activity (& vs plan) 2 | 4,231 |
| NGH | CIP Performance YTD (M) | 0.25 |
| NGH | Capital Spend (M) | 1 |
| NGH | Beds available | 711 |
| NGH | Bank and Agency Spend (M) | 3.25 |
| NGH | A&E activity (& vs plan) 2 | 14,296 |

| Metric | Comment |
|---|---|
| M5 Position | The in-month position is a £4.7m deficit which is £0.8m worse than the £3.9m plan. CIP delivery is £0.4m better than plan. Residual variances include ongoing UEC, unfunded inflation and other specific service pressures which were risks that were identified in the compilation of the plan. The position also includes an element of late submitted staffing costs relating to 2023/24. |
| YTD Position | The ytd position is a £4.7m deficit which is £0.8m worse than the £3.9m plan. CIP delivery is £0.4m better than plan. Residual variances include ongoing UEC, unfunded inflation and other specific service pressures which were risks that were identified in the compilation of the plan. The position also includes an element of late submitted staffing costs relating to 2023/24. |
| Income | Year to date income is £0.5m better than plan . This includes an estimated overperformance against the ERF target and a number of minor variances across of range of areas, including High Cost Drugs and Devices. |
| Non Pay | Year to date non pay excluding depreciation is £0.2m worse than plan. This includes a level of unfunded inflation identified as a risk in the plan. |
| Pay | Year to date pay costs are £1.3m worse than plan including the impact of ongoing UEC and other unfunded service specific pressures identified as risks in the plan and an element of late submitted staffing costs relating to 2023/24. |

# Summary Table

Committee Name: All

Group Name: Sustainability

Metric Name: Multiple selections

Site: All

Variation: All

| Site | Group | Metric | Latest Date | Value | Target | LCL | Mean | UCL | Variation | Assurance | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| KGH | Sustainability | Income YTD (M) | 01/04/24 | 32.14 | 29.66 | 41.05 | 41.05 | 41.05 | H | ? | Not Consistently Anticipated to Meet Target |
| NGH | Sustainability | Income YTD (M) | 01/04/24 | 39.65 | 39.65 | 53.76 | 53.76 | 53.76 | | P | Not Consistently Anticipated to Meet Target |
| KGH | Sustainability | Pay YTD (M) | 01/04/24 | 24.22 | 19.55 | 27.26 | 27.26 | 27.26 | H | ? | Not Consistently Anticipated to Meet Target |
| NGH | Sustainability | Pay YTD (M) | 01/04/24 | 29.25 | 29.25 | 38.57 | 38.57 | 38.57 | | P | Not Consistently Anticipated to Meet Target |
| KGH | Sustainability | Non Pay YTD (M) | 01/04/24 | 11.05 | 8.58 | 11.13 | 11.13 | 11.13 | H | ? | Not Consistently Anticipated to Meet Target |
| NGH | Sustainability | Non Pay YTD (M) | 01/04/24 | 12.19 | 12.19 | 13.94 | 13.94 | 13.94 | | P | Not Consistently Anticipated to Meet Target |
| KGH | Sustainability | Surplus / Deficit YTD (M) | 01/04/24 | -4.35 | -0.5 | 4.44 | 4.44 | 4.44 | L | ? | Not Consistently Anticipated to Meet Target |
| NGH | Sustainability | Surplus / Deficit YTD (M) | 01/04/24 | -3.85 | -3.85 | 3 | 3 | 3 | | ? | Not Consistently Anticipated to Meet Target |
| KGH | Sustainability | CIP Performance YTD (M) | 01/04/24 | 0.20 | 0.74 | 1.85 | 1.85 | 1.85 | | ? | Not Consistently Anticipated to Meet Target |
| NGH | Sustainability | CIP Performance YTD (M) | 01/04/24 | 0.25 | 0.25 | 5.81 | 5.81 | 5.81 | | ? | Not Consistently Anticipated to Meet Target |
| NGH | Sustainability | Bank and Agency Spend (M) | 01/04/24 | 3.25 | 3.25 | 7.32 | 7.32 | 7.32 | L | P | Consistently Anticipated to Meet Target |
| KGH | Sustainability | Bank and Agency Spend (M) | 01/04/24 | 3.87 | 1.3 | 4.19 | 4.19 | 4.19 | | P | Consistently Anticipated to Meet Target |
| KGH | Sustainability | Capital Spend (M) | 01/04/24 | 0.69 | 0.6 | 4.57 | 4.57 | 4.57 | | ? | Not Consistently Anticipated to Meet Target |
| NGH | Sustainability | Capital Spend (M) | 01/04/24 | 1 | 1 | -3 | 2 | 7 | | ? | Not Consistently Anticipated to Meet Target |

# Income YTD (M)

Committee Name: All

GroupName: Sustainability

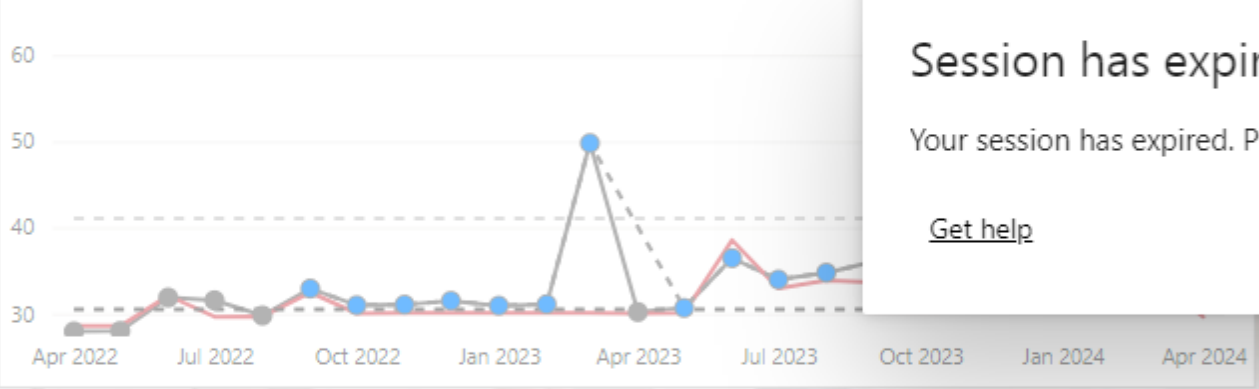
MetricName: Income YTD (M)

Date: 01/12/2019 – 01/04/2024

| 32.14 | 29.66 | 39.65 | 39.65 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

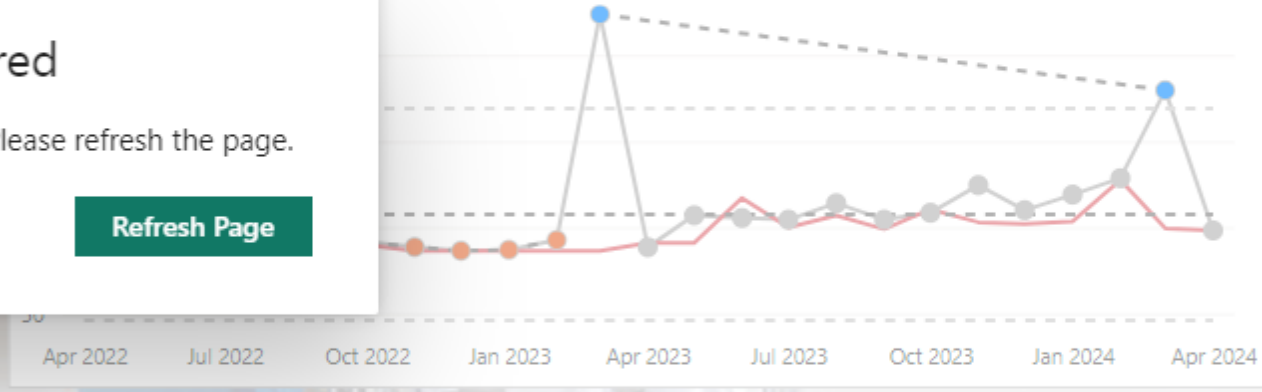
**Kettering General Hospital**

Income YTD (M): Sustainability




**Northampton General Hospital**

Income YTD (M): Sustainability




## Session has expired

Your session has expired. Please refresh the page.

Get help

Refresh Page

# Pay YTD (M)

Committee Name: All

GroupName: Sustainability

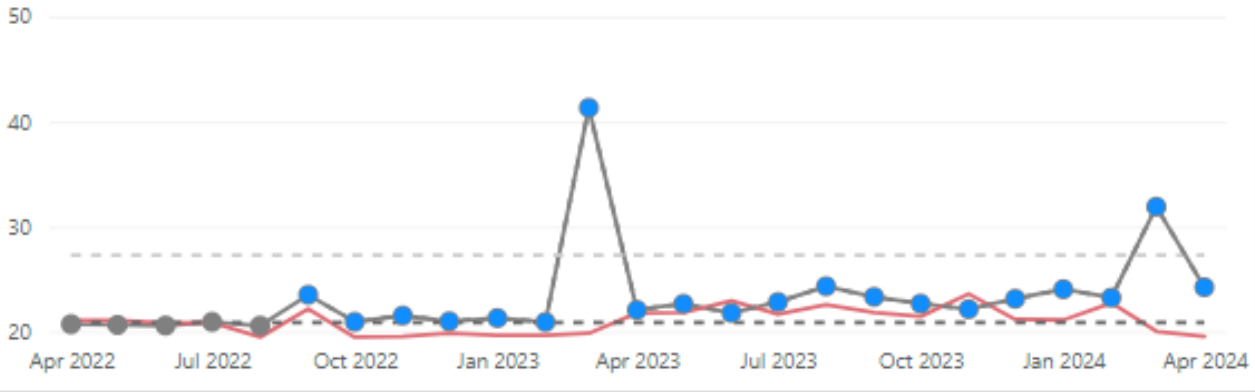
MetricName: Pay YTD (M)

Date: 01/12/2019 – 01/04/2024

| 24.22 | 19.55 | 29.25 | 29.25 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

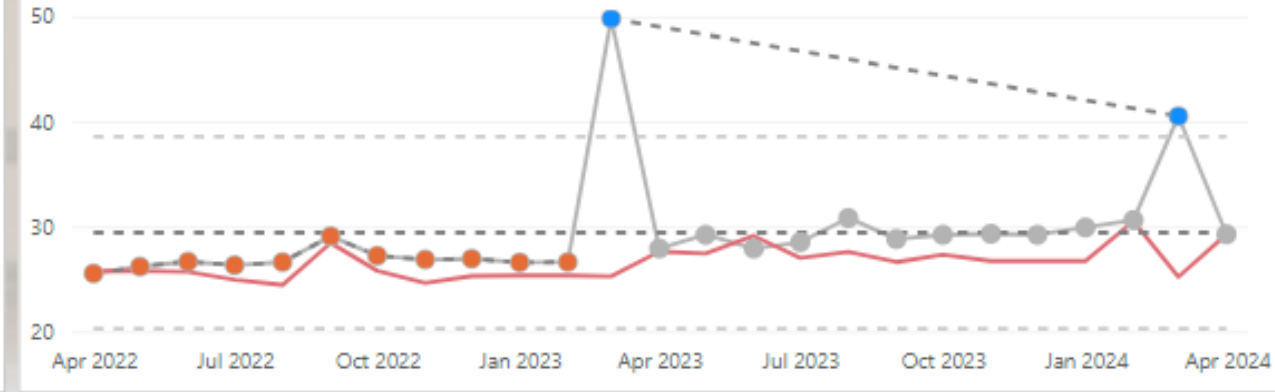
## Kettering General Hospital

Pay YTD (M): Sustainability




## Northampton General Hospital

Pay YTD (M): Sustainability



# Non Pay YTD (M)

Committee Name: All

GroupName: Sustainability

MetricName: Non Pay YTD (M)

Date: 01/12/2019 – 01/04/2024

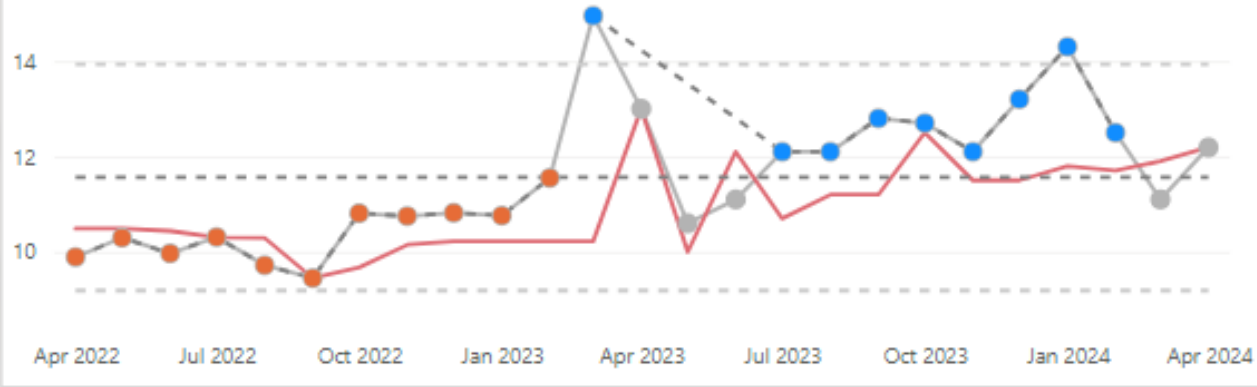
| 11.05 | 8.58 | 12.19 | 12.19 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**

Non Pay YTD (M): Sustainability


**Northampton General Hospital**

Non Pay YTD (M): Sustainability



# Surplus / Deficit YTD (M)

Committee Name: All

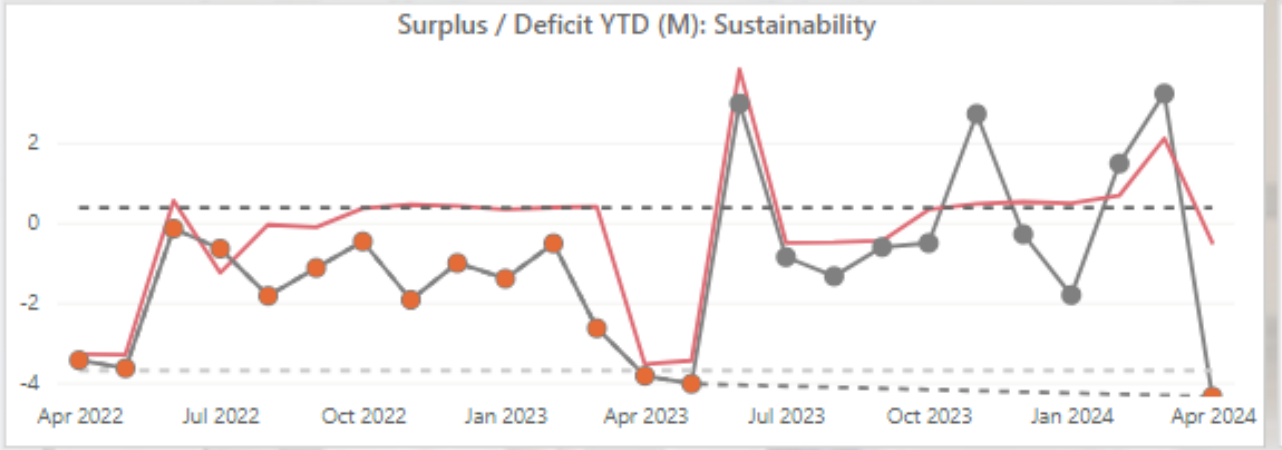
GroupName: Sustainability

MetricName: Surplus / Deficit YTD (M)

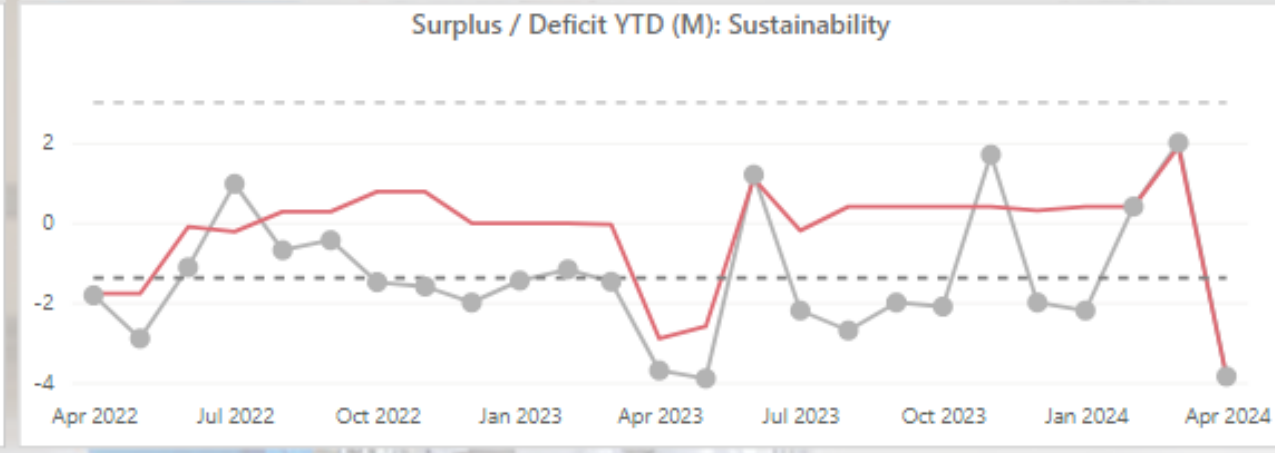
Date: 01/12/2019 – 01/04/2024

| -4.35 | -0.5 | -3.85 | -3.85 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

## Kettering General Hospital




## Northampton General Hospital



# CIP Performance YTD (M)

Committee Name: All

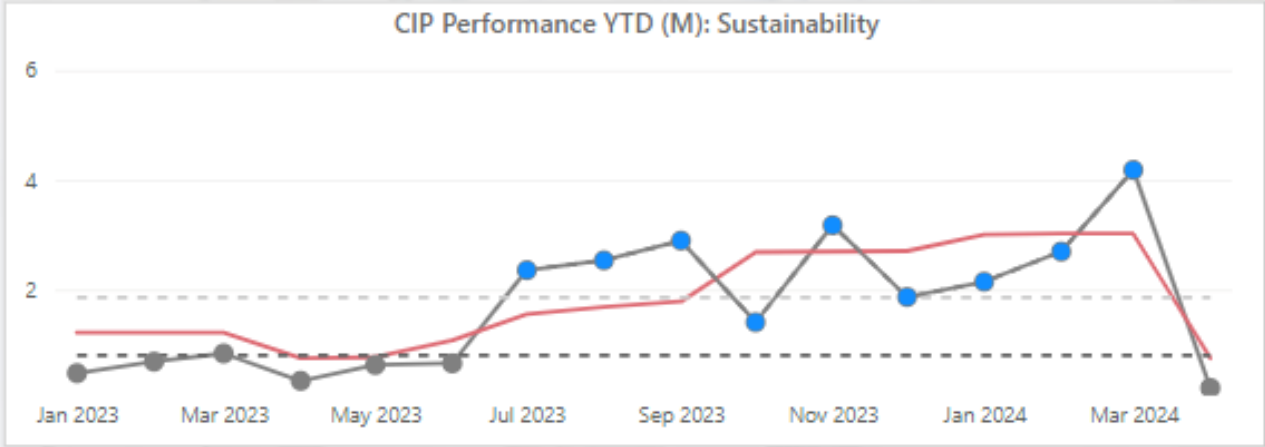
GroupName: Sustainability

MetricName: CIP Performance YTD (M)

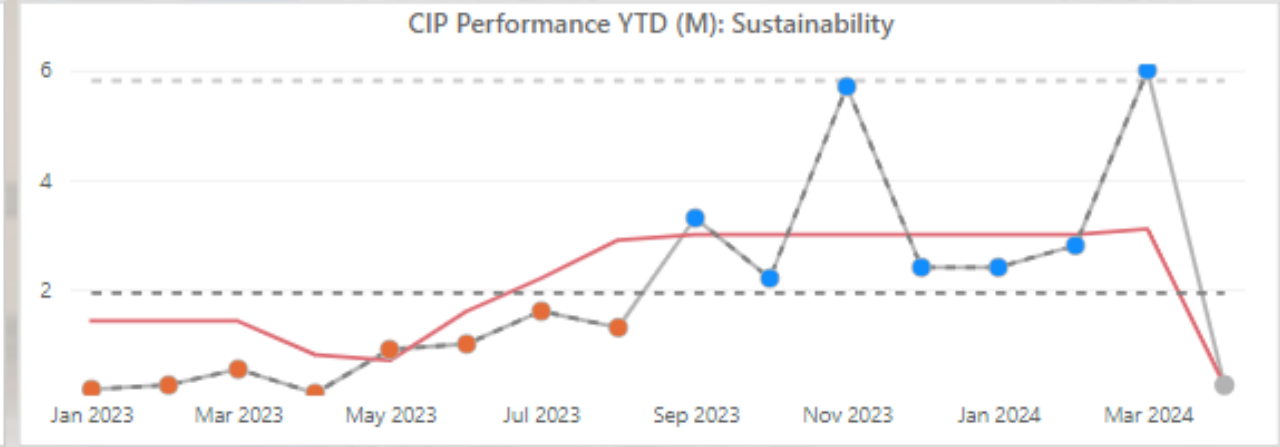
Date: 01/12/2019 – 01/04/2024

| 0.20 | 0.74 | 0.25 | 0.25 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

## Kettering General Hospital




## Northampton General Hospital



# Bank and Agency Spend (M)

Committee Name: All

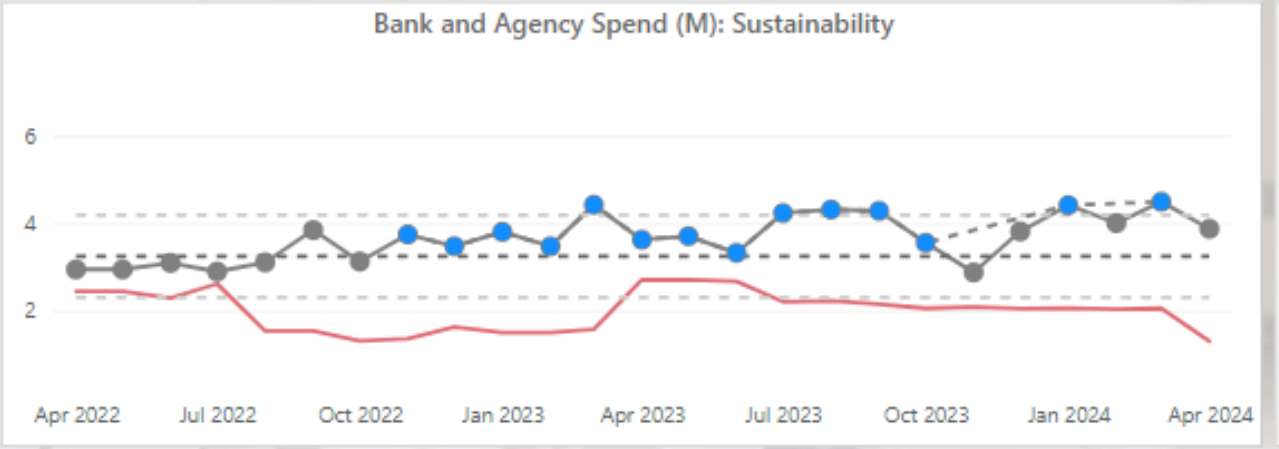
GroupName: Sustainability

MetricName: Bank and Agency Spend (M)

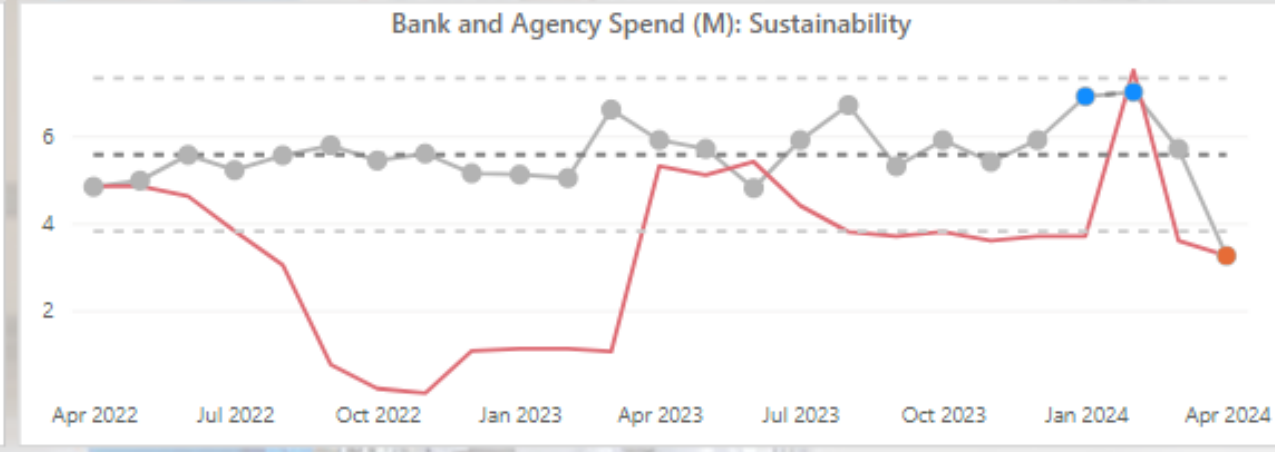
Date: 01/12/2019 – 01/04/2024

| 3.87 | 1.3 | 3.25 | 3.25 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**



# Capital Spend (M)

Committee Name: All

GroupName: Sustainability

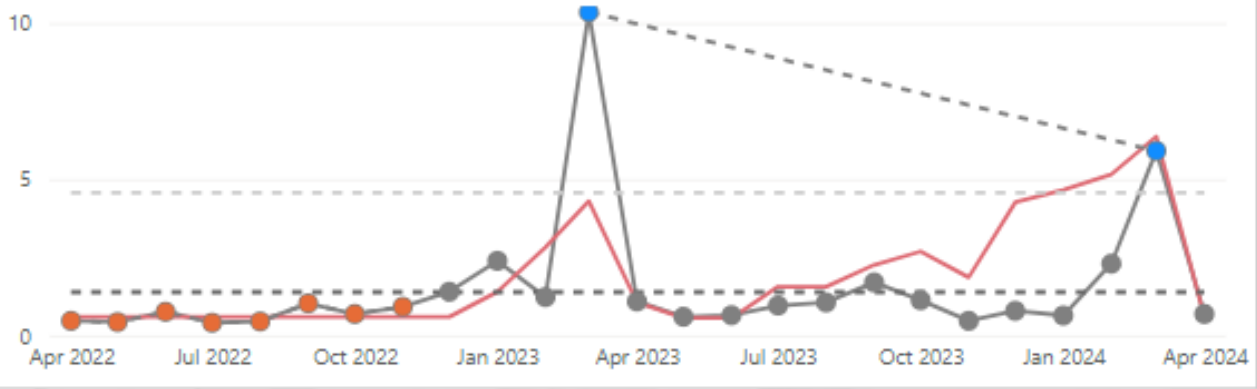
MetricName: Capital Spend (M)

Date: 01/12/2019 – 01/04/2024

| 0.69 | 0.6 | 1 | 1 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

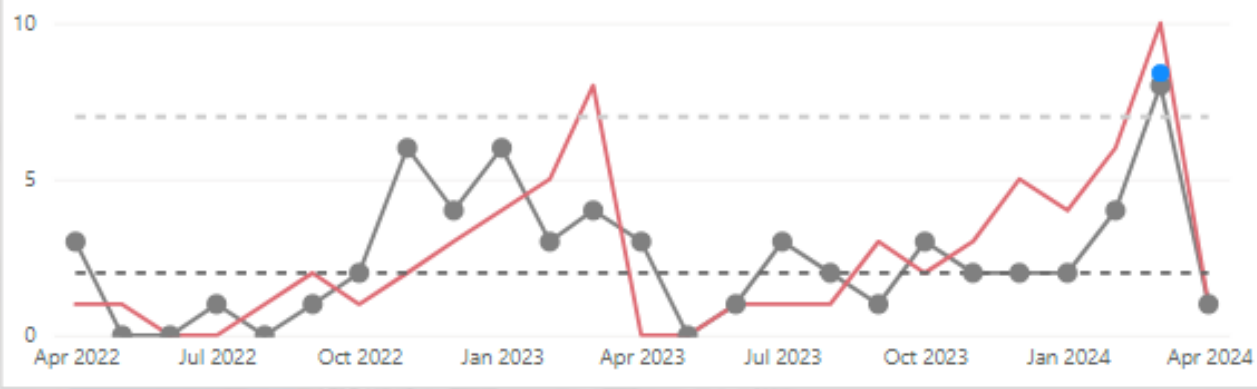
## Kettering General Hospital

Capital Spend (M): Sustainability




## Northampton General Hospital

Capital Spend: Sustainability



# Operational Performance Committee

# Operational Performance Committee

Exec owners: Fay Gordon, Palmer Winstanley

*In reminder, this Committee monitors the 'sustainability' metrics and the 'systems and partnerships' metrics within the IGR.*

This cover sheet is designed to **highlight to the Committee saliant messages from the IGR metrics** for this month:

1. 4hr ED Performance continues to show an upward trend.

2. 6-week diagnostic test target performance is showing a steady trend in improved performance. KGH have indicated continual challenges within Cardiac Radiology, Paediatric MRI, Cardiac Investigations DSE, Neurophysiological and Cystoscopy.

Key **developments with the IGR** itself for the Committee to note:

1. Logic for the Time to Initial Assessment is under review. .

*Worth remembering for all metrics, only metrics that have a) had data provided and b) have been signed off, will be published – therefore, this could lead to some gaps in reporting.*

# Summary Table

Committee Name: All

Group Name: Multiple selections

Metric Name: Multiple selections

Site: All

Variation: All

| Site | Group | Metric | Latest Date | Value | Target | LCL | Mean | UCL | Variation | Assurance | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NGH | Sustainability | Beds available | 01/04/24 | 711 | | 636 | 679 | 722 | | | Consistently Anticipated to Meet Target |
| KGH | Sustainability | Beds available | 01/04/24 | 504 | | 503 | 517 | 531 | | | Consistently Anticipated to Meet Target |
| KGH | Sustainability | Theatre sessions planned | 01/04/24 | 0 | | 128 | 271 | 414 | | | Consistently Anticipated to Meet Target |
| NGH | Sustainability | Theatre sessions planned | 01/04/24 | 645 | | 484 | 602 | 719 | | | Consistently Anticipated to Meet Target |
| NGH | Sustainability | A&E activity (& vs plan) 2 | 01/04/24 | 14,296 | | 9537 | 11744 | 13951 | | | Consistently Anticipated to Meet Target |
| NGH | Sustainability | Non-elective activity (& vs plan) 2 | 01/04/24 | 5,889 | | 5093 | 5717 | 6342 | | | Consistently Anticipated to Meet Target |
| NGH | Sustainability | Elective inpatient activity (& vs plan) 2 | 01/04/24 | 410 | | 237 | 369 | 502 | | | Consistently Anticipated to Meet Target |
| NGH | Sustainability | Elective day-case activity (& vs plan) 2 | 01/04/24 | 4,231 | | 3109 | 3904 | 4700 | | | Consistently Anticipated to Meet Target |
| NGH | Sustainability | Outpatients activity (& vs plan) 2 | 01/04/24 | 46,411 | | 32044 | 43427 | 54809 | | | Consistently Anticipated to Meet Target |
| KGH | Sustainability | A&E activity (& vs plan) 2 | 01/04/24 | 8,938 | | 6140 | 8798 | 11455 | | | Consistently Anticipated to Meet Target |
| KGH | Sustainability | Non-elective activity (& vs plan) 2 | 01/04/24 | 1,712 | | 1616 | 2301 | 2987 | | | Consistently Anticipated to Meet Target |
| KGH | Sustainability | Elective inpatient activity (& vs plan) 2 | 01/04/24 | 317 | | 170 | 307 | 444 | | | Consistently Anticipated to Meet Target |
| KGH | Sustainability | Elective day-case activity (& vs plan) 2 | 01/04/24 | 3,712 | | 1984 | 3232 | 4480 | | | Consistently Anticipated to Meet Target |
| KGH | Sustainability | Outpatients activity (& vs plan) 2 | 01/04/24 | 32,465 | | 22537 | 29970 | 37404 | | | Consistently Anticipated to Meet Target |
| NGH | Systems and Partnershi... | 31-day wait for first treatment | 01/03/24 | 90.50% | 96.00% | 79.94% | 90.49% | 101.03% | | | Not Consistently Anticipated to Meet ... |
| KGH | Systems and Partnershi... | 31-day wait for first treatment | 01/03/24 | 94.40% | 96.00% | 92.44% | 96.49% | 100.54% | | | Not Consistently Anticipated to Meet ... |
| KGH | Systems and Partnershi... | 62-day wait for first treatment | 01/03/24 | 64.60% | 85.00% | 46.68% | 68.82% | 90.97% | | | Not Consistently Anticipated to Meet ... |
| NGH | Systems and Partnershi... | 62-day wait for first treatment | 01/03/24 | 67.00% | 85.00% | 45.47% | 63.15% | 80.83% | | | Consistently Anticipated to Not Meet ... |

# Summary Table

NHS University Hospitals of Northamptonshire NHS Group

| Committee Name | Group Name | Metric Name | Site | Variation |
|---|---|---|---|---|
| All | Multiple selections | Multiple selections | All | All |

| Site | Group | Metric | Latest Date | Value | Target | LCL | Mean | UCL | Variation | Assurance | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NGH | Systems and Partnershi... | Cancer: Faster Diagnostic Standard | 01/03/24 | 87.00% | 75.00% | 76.93% | 82.67% | 88.42% | | | Consistently Anticipated to Meet Target |
| KGH | Systems and Partnershi... | Cancer: Faster Diagnostic Standard | 01/03/24 | 86.50% | 75.00% | 77.87% | 84.64% | 91.4% | | | Consistently Anticipated to Meet Target |
| KGH | Systems and Partnershi... | 6-week diagnostic test target performance | 01/04/24 | 84.70% | 99.00% | 59.64% | 74.08% | 88.53% | | | Consistently Anticipated to Not Meet ... |
| NGH | Systems and Partnershi... | 6-week diagnostic test target performance | 01/04/24 | 87.91% | 99.00% | 64.1% | 73.67% | 83.24% | | | Consistently Anticipated to Not Meet ... |
| NGH | Systems and Partnershi... | Unappointed outpatient follow ups | 01/04/24 | 27,629 | 0 | 18064 | 21077 | 24091 | | | Consistently Anticipated to Not Meet ... |
| KGH | Systems and Partnershi... | Unappointed outpatient follow ups | 01/04/24 | 5,228 | | 8093 | 12976 | 17858 | | | Consistently Anticipated to Not Meet ... |
| NGH | Systems and Partnershi... | RTT over 52 week waits | 01/04/24 | 1,588 | 0 | 726 | 970 | 1215 | | | Consistently Anticipated to Not Meet ... |
| KGH | Systems and Partnershi... | RTT over 52 week waits | 01/04/24 | 384 | 0 | 79 | 141 | 202 | | | Consistently Anticipated to Not Meet ... |
| NGH | Systems and Partnershi... | Size of RTT waiting list | 01/04/24 | 42,405 | 0 | 35011 | 37664 | 40316 | | | Consistently Anticipated to Not Meet ... |
| KGH | Systems and Partnershi... | Size of RTT waiting list | 01/04/24 | 27,890 | | 21398 | 23138 | 24878 | | | Consistently Anticipated to Not Meet ... |
| NGH | Systems and Partnershi... | Theatre utilisation | 01/04/24 | 77.00% | | 71.88% | 76.76% | 81.64% | | | Consistently Anticipated to Meet Target |
| KGH | Systems and Partnershi... | Theatre utilisation | 01/04/24 | 0.00% | | 59.85% | 70.79% | 81.74% | | | Consistently Anticipated to Meet Target |
| NGH | Systems and Partnershi... | Bed utilisation | 01/12/22 | 87.67% | | 79.6% | 83.62% | 87.64% | | | Consistently Anticipated to Meet Target |
| KGH | Systems and Partnershi... | Bed utilisation | 01/04/24 | 98.42% | | 89.27% | 93.79% | 98.31% | | | Consistently Anticipated to Meet Target |
| KGH | Systems and Partnershi... | Stranded patients (7+ day length of stay) | 01/04/24 | 283 | | 219 | 259 | 298 | | | Consistently Anticipated to Not Meet ... |
| NGH | Systems and Partnershi... | Stranded patients (7+ day length of stay) | 01/04/24 | 395 | | 333 | 373 | 414 | | | Consistently Anticipated to Not Meet ... |
| KGH | Systems and Partnershi... | Super-Stranded patients (21+ day length of stay) | 01/04/24 | 97 | 0 | 67 | 92 | 118 | | | Consistently Anticipated to Not Meet ... |
| NGH | Systems and Partnershi... | Super-Stranded patients (21+ day length of stay) | 01/04/24 | 172 | 0 | 125 | 168 | 212 | | | Consistently Anticipated to Not Meet ... |

# Summary Table

Committee Name: All

Group Name: Multiple selections

Metric Name: Multiple selections

Site: All

Variation: All

| Site | Group | Metric | Latest Date | Value | Target | LCL | Mean | UCL | Variation | Assurance | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| KGH | Systems and Partnershi... | Patients with a reason to reside | 01/04/24 | 76.75% | | 66.74% | 71.55% | 76.36% | | | Consistently Anticipated to Meet Target |
| NGH | Systems and Partnershi... | Patients with a reason to reside | 01/04/24 | 70.79% | 95.00% | 62.2% | 67.45% | 72.7% | | | Consistently Anticipated to Not Meet ... |
| KGH | Systems and Partnershi... | Ambulance Handover | 01/04/24 | 358 | | -46 | 79 | 204 | | | Not Consistently Anticipated to Meet ... |
| NGH | Systems and Partnershi... | Ambulance Handover | 01/04/24 | 452 | | -69 | 228 | 525 | | | Not Consistently Anticipated to Meet ... |
| NGH | Systems and Partnershi... | Time to initial assessment | 01/04/24 | 41.76% | | 42.8% | 49.3% | 55.81% | | | Consistently Anticipated to Meet Target |
| KGH | Systems and Partnershi... | Time to initial assessment | 01/04/24 | 68.89% | | 48.49% | 60.14% | 71.79% | | | Consistently Anticipated to Meet Target |
| KGH | Systems and Partnershi... | Average time in department - Admitted | 01/04/24 | 567 | | 438 | 552 | 666 | | | Consistently Anticipated to Meet Target |
| KGH | Systems and Partnershi... | Average time in department - Discharged | 01/04/24 | 205 | | 206 | 227 | 249 | | | Consistently Anticipated to Meet Target |
| KGH | Systems and Partnershi... | 4hr ED Performance | 01/04/24 | 81.40% | | 47.5% | 54.39% | 61.28% | | | Consistently Anticipated to Meet Target |
| NGH | Systems and Partnershi... | 4hr ED Performance | 01/04/24 | 75.10% | | 60.08% | 65.89% | 71.7% | | | Consistently Anticipated to Meet Target |
| NGH | Systems and Partnershi... | Average time in department - Discharged | 01/04/24 | 202 | | 173 | 208 | 244 | | | Consistently Anticipated to Meet Target |
| NGH | Systems and Partnershi... | Average time in department - Admitted | 01/04/24 | 796 | | 623 | 900 | 1177 | | | Consistently Anticipated to Meet Target |

# Beds available

Committee Name: All

GroupName: Sustainability

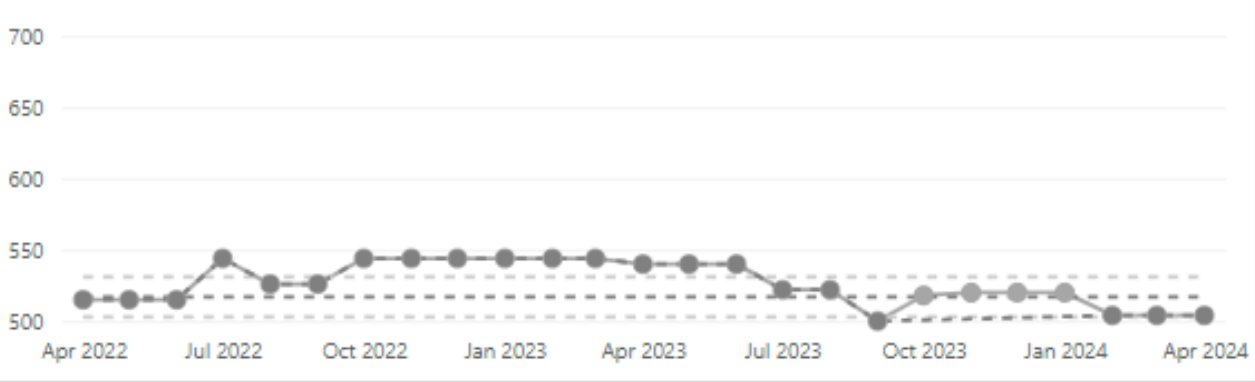
MetricName: Beds available

Date: 01/12/2019 – 01/04/2024

| 504 | | 711 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

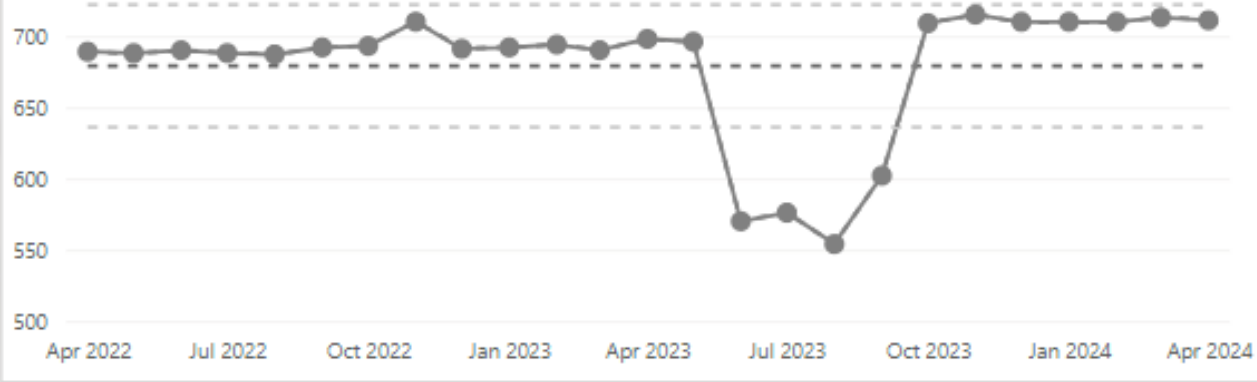
## Kettering General Hospital

Beds available: Sustainability




## Northampton General Hospital

Beds available: Sustainability



# Theatre sessions planned

Committee Name: All

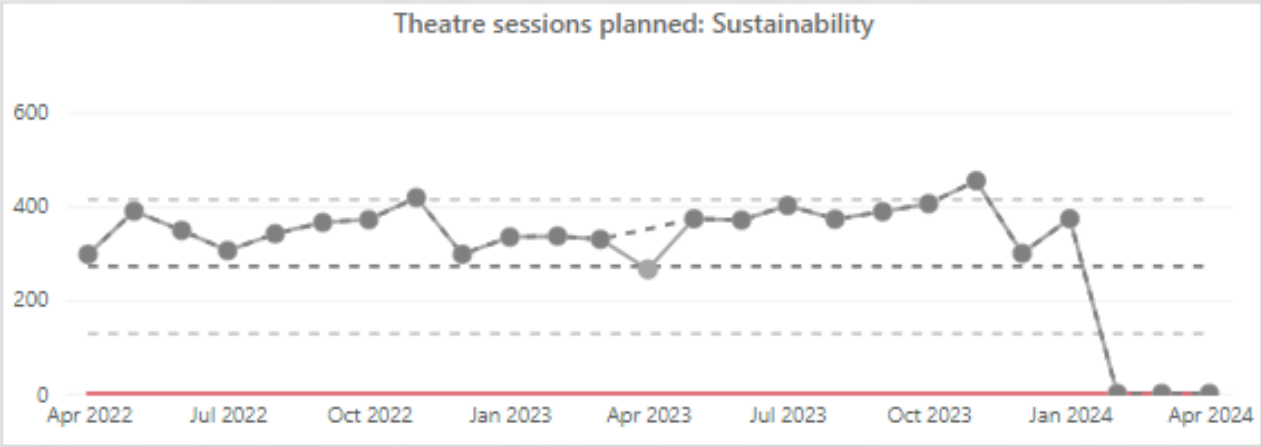
GroupName: Sustainability

MetricName: Theatre sessions planned

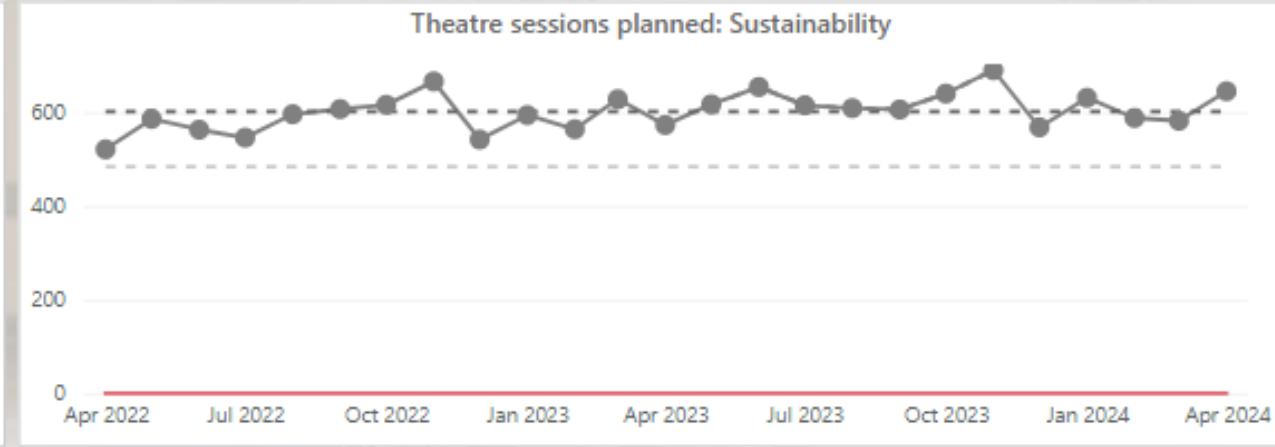
Date: 01/12/2019 – 01/04/2024

| 0 | | 645 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

## Kettering General Hospital




## Northampton General Hospital




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| NGH | 01/04/24 | To monitor number of elective theatre sessions | 645 sessions planned for this month | Lack of Anaesthetists resulting in cancellations of planned lists. | Ongoing substantive and locum recruitment. KGH and MK anaethetists have been asked if willing to work at NGH weekdays.<br>Development of a workforce plan | Use of locum and agency staff. Additional weekend lists for long waiting and cancer patients |

# A&E activity (& vs plan) 2

Committee Name: All

GroupName: Sustainability

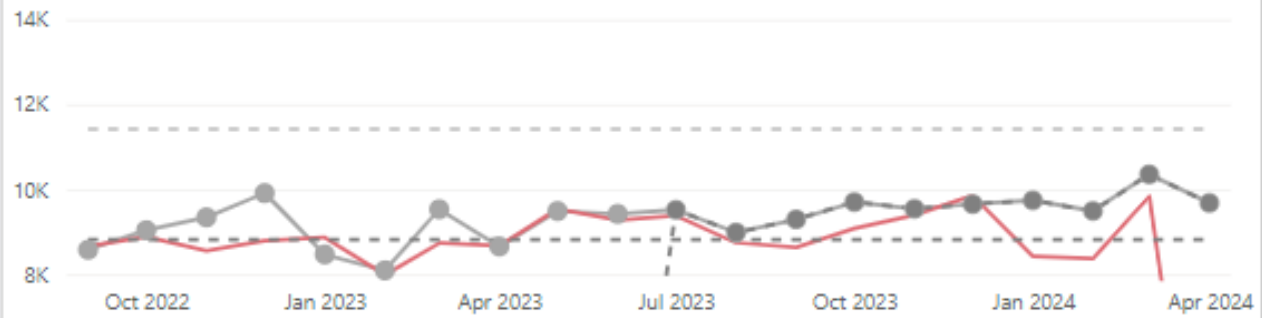
MetricName: A&E activity (& vs plan) 2

Date: 01/12/2019 – 01/04/2024

| 9,679 | | 14,296 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

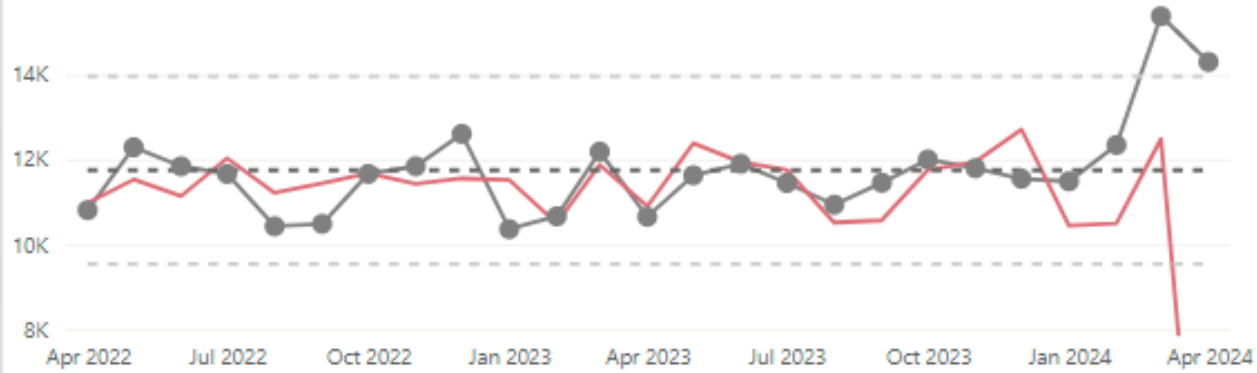
## Kettering General Hospital

A&E activity (actual vs plan): Sustainability




## Northampton General Hospital

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




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| NGH | 01/04/24 | A&E attendances | Target 12,479 achieved 15,349 | Increase in attendances seen | Booking in process changed (all attendances are now booked in before streamed to relevant area's pathways) | Cohorting receptionists (2 receptionist now book in patients) |

# Non-elective activity (& vs plan) 2

Committee Name: All

GroupName: Sustainability

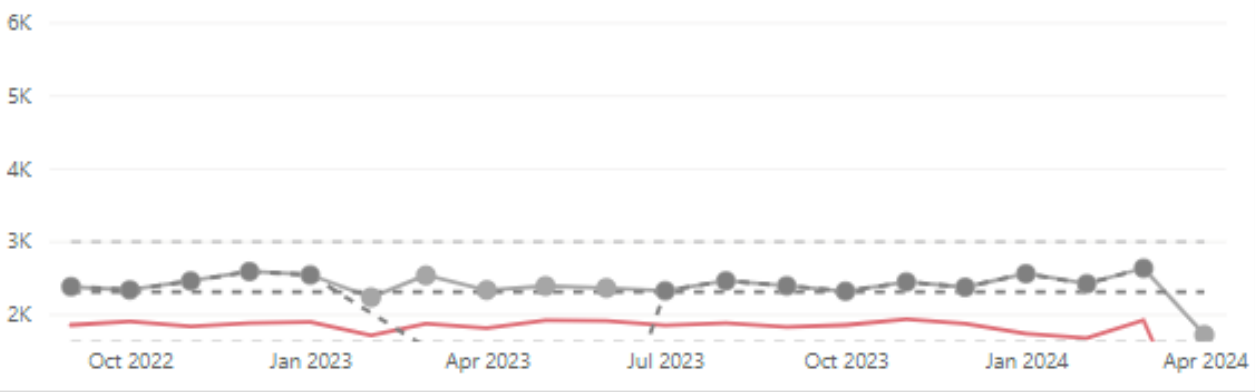
MetricName: Non-elective activity (& vs plan) 2

Date: 01/12/2019 – 01/04/2024

| 1,712 | | 5,889 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

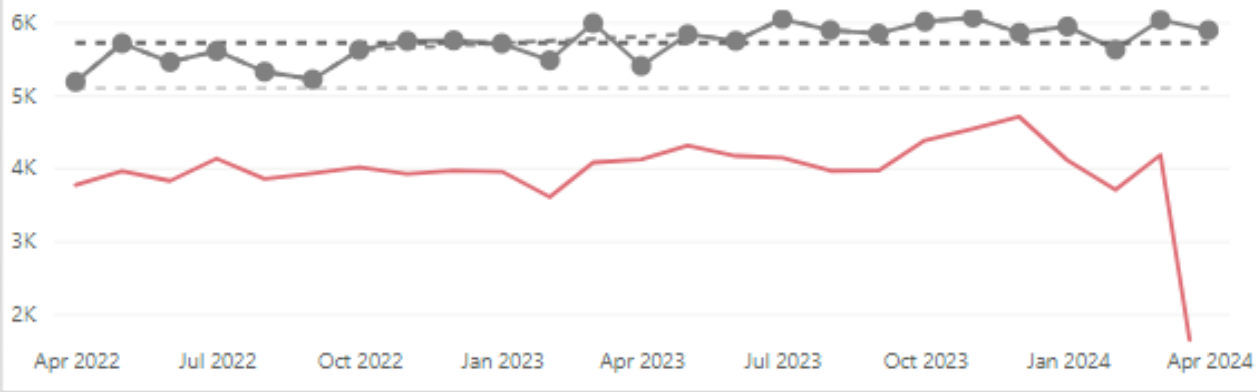
## Kettering General Hospital

Non-elective activity (actual vs plan): Sustainability




## Northampton General Hospital

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



# Elective inpatient activity (& vs plan) 2

Committee Name: All

GroupName: Sustainability

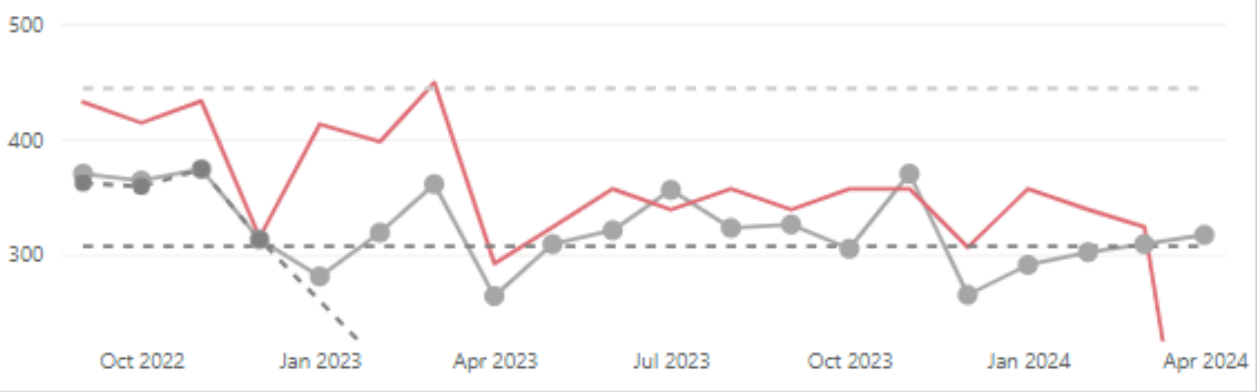
MetricName: Elective inpatient activity (& vs plan) 2

Date: 01/12/2019 – 01/04/2024

| 317 | | 410 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

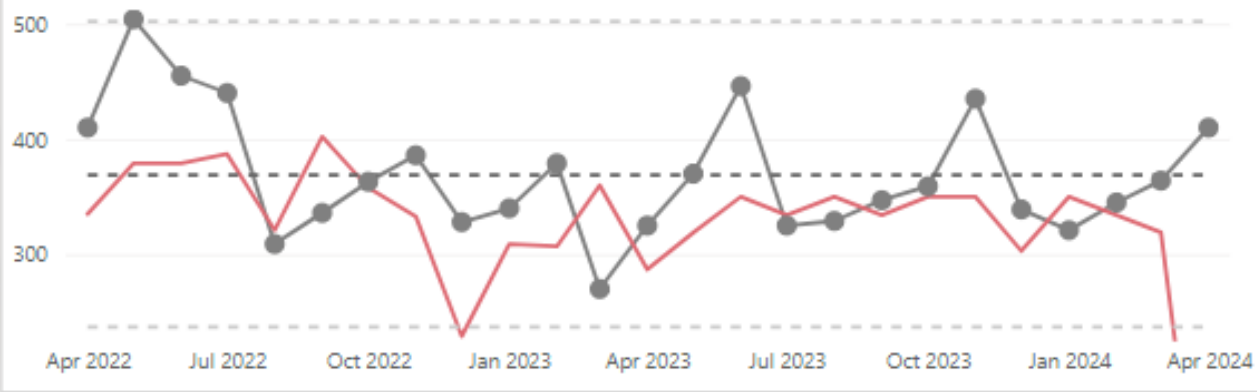
## Kettering General Hospital

Elective inpatient activity (actual vs plan): Sustainability




## Northampton General Hospital

Elective inpatient activity (& vs plan) 2: Sustainability




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| NGH | 01/04/24 | Elective inpatient activity actuals v plan | Data shows that we delivered increased Elective In patient actvity in April (410 vs 364 previous month) | Activity above plan although shortages of Aneasthetists is forcing lists to be cancelled at short notice | Cancer and long waiter lists priortised with transfer of actvity to KGH/Woodlands and Blakelands. Recruitment of consultant anaesthetists coninues with 2 appointed and 2 more out to advert | NGH has ceased to outsource its ENT activity to Athena as of the end of March |

# Elective day-case activity (& vs plan) 2

Committee Name: All

GroupName: All

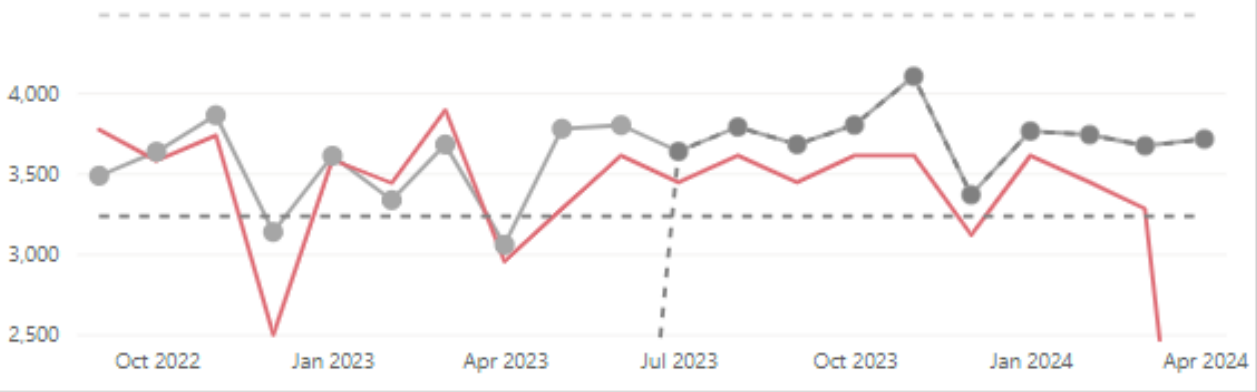
MetricName: Elective day-case activity (& vs plan) 2

Date: 01/12/2019 – 01/04/2024

| 3,712 | | 4,231 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

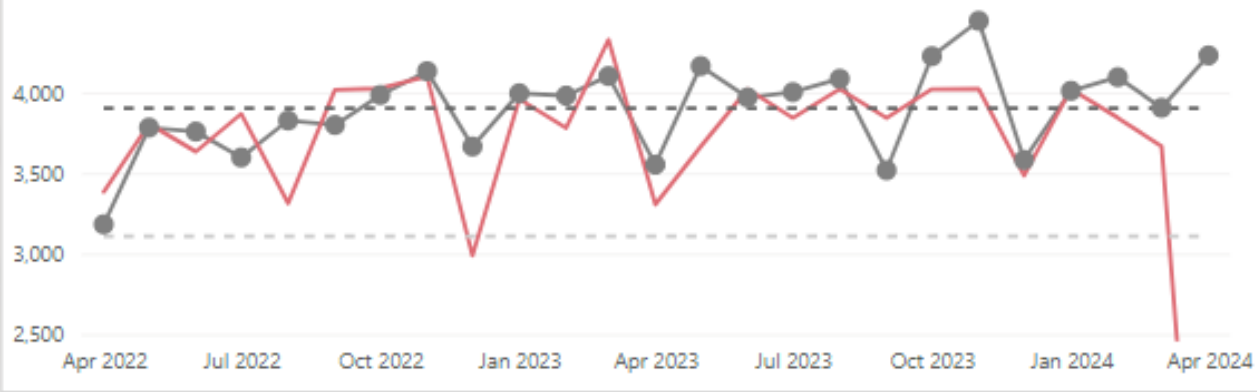
## Kettering General Hospital

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




## Northampton General Hospital

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




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| NGH | 01/04/24 | Elective day case activity actuals v plan | Data shows that we delivered increased Elective Day Case actvity in April (4,231 vs 3,906 previous month) | Activity above plan although shortages of Aneasthetists is forcing lists to be cancelled at short notice | Cancer and long waiter lists priortised with transfer of actvity to KGH/Woodlands and Blakelands. Recruitment of consultant anaesthetists coninues with 2 appointed and 2 more out to advert | NGH has ceased to outsource its ENT activity to Athena as of the end of March |

# Outpatients activity (& vs plan) 2

Committee Name: All

GroupName: Sustainability

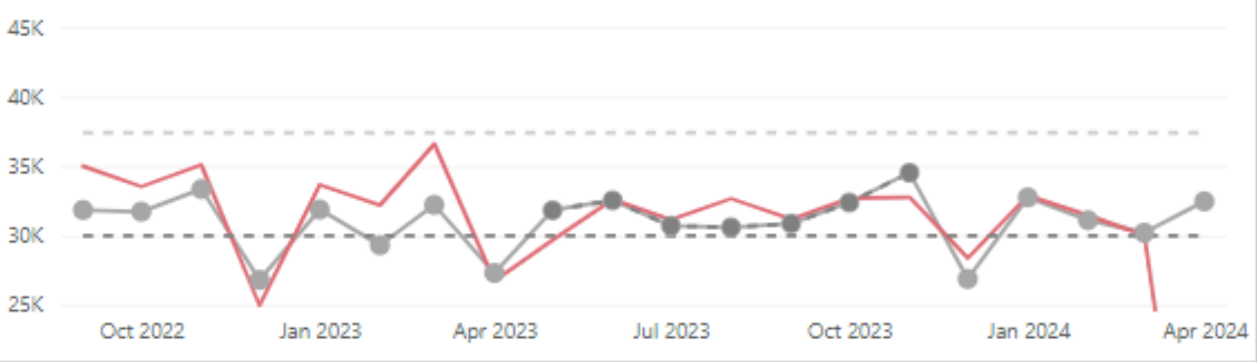
MetricName: Outpatients activity (& vs plan) 2

Date: 01/12/2019 – 01/04/2024

| 32,465 | | 46,411 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

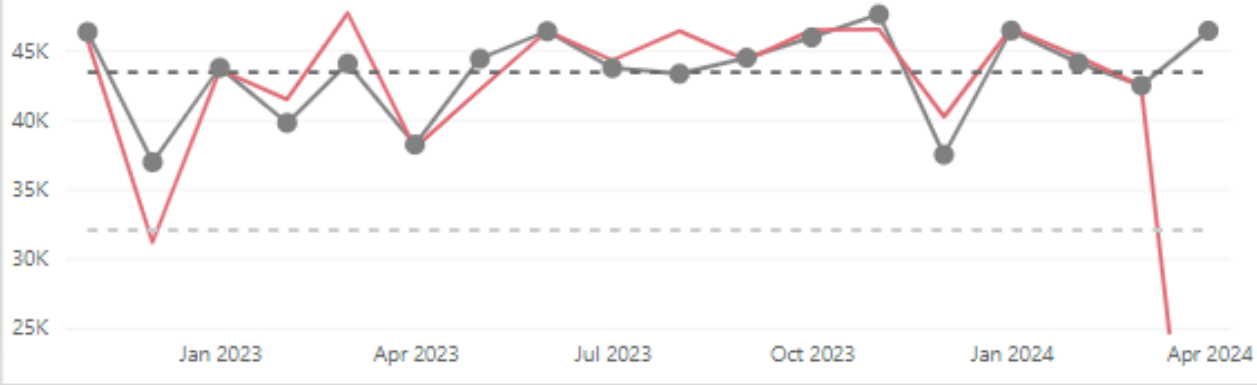
## Kettering General Hospital

Outpatients activity (actual vs plan): Sustainability




## Northampton General Hospital

Outpatients activity (& vs plan) 2: Sustainability




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| NGH | 01/04/24 | This is the total number of outpatient appointments in the month (face to face and virtual, new and follow up) | Data shows that we delivered increase OPD actvity in April (46,411 vs 42,468 previous month) | Performance at plan for NGH | Performance at plan | Outpatient improvement project continues across the group with a Regional focus on DNA's, referral triage, PIFU and patient validation |

# 31-day wait for first treatment

Committee Name: All

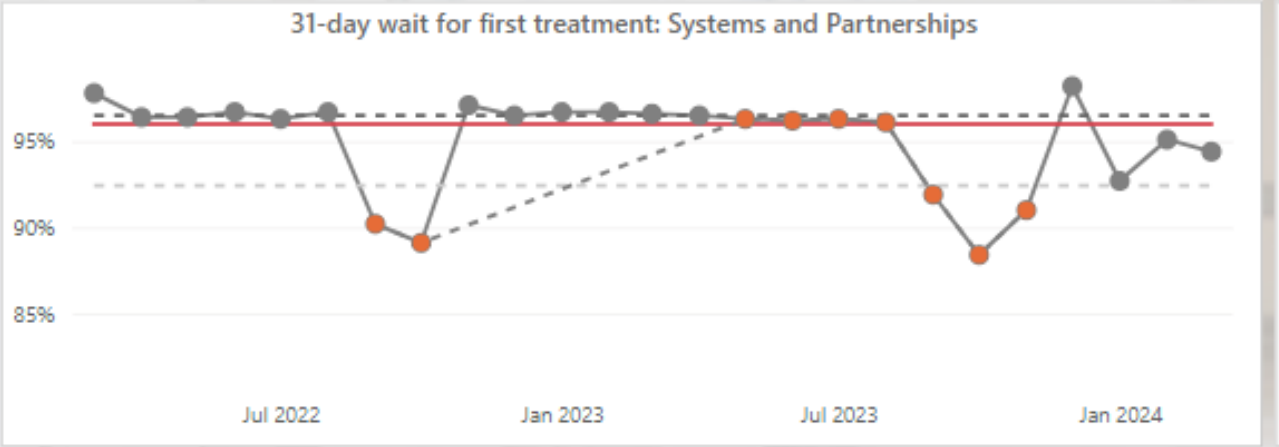
GroupName: Systems and Partnerships

MetricName: 31-day wait for first treatment

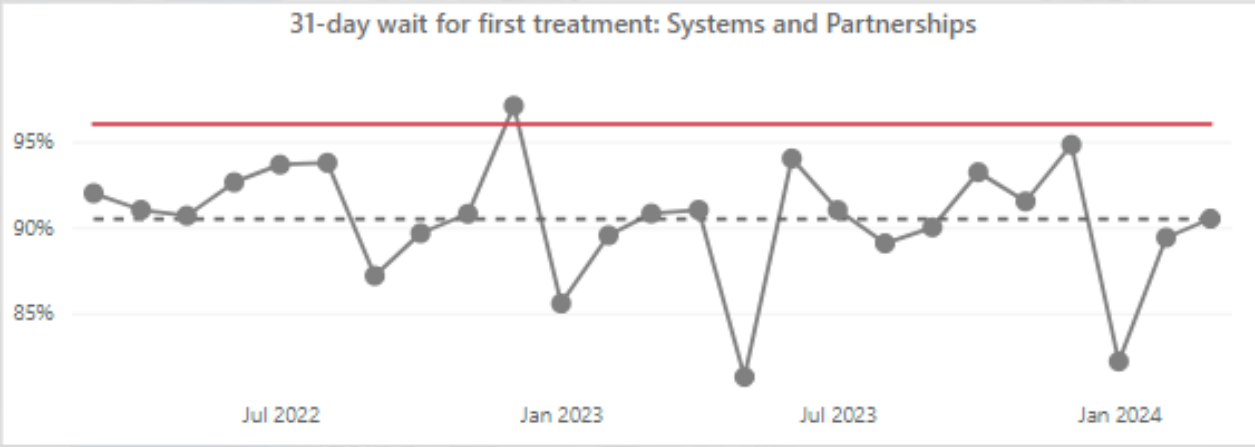
Date: 01/12/2019 – 01/04/2024

| 94.40% | 96.00% | 90.50% | 96.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**



# 31-day wait for first treatment

Committee Name: All

GroupName: Systems and Partnerships

MetricName: 31-day wait for first treatment

| 94.40% | 96.00% | 90.50% | 96.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/03/24 | % of patients whose treatment is initiated within 31 days of the decision to treat | The Trust did not achieve the 31d standard of 96% | The combined performance for the month of March was recorded at 93.6%. The trust treated 156 patients and recorded 10 breaches<br><br>Breach reasons recorded included lack of capacity to treat within 31 days from patient consent. Hospital cancellation, patient fitness and an incidental cancer found post routine surger | The Trust continues to monitor demand for all sites and escalate as appropriate.<br><br>31d and subsequent patient tracking list reviewed weekly by MDT coordinator and trackers.<br><br>Continue to highlight performance and escalate at patient access board<br><br>Discussions have taken place with Gynae team to ensure the waiting list department are aware of breach dates | Cancer trackers continue to highlight potential breaches and blockages to services in order to bring patients forward where capacity allows. |
| NGH | 01/03/24 | % of patients whose treatment is initiated within 31 days of the decision to treat | The Trust did not achieve the 96% standard, reaching 90.5%. | 409 treatments were delivered across first and subsequent pathways of which 39 breached. 5 breached due to oncology capacity or patients needed rescanning, 34 were due to surgical capacity | Individual tumour sites have been asked to develop action plans and trajectories to evidence how they will improve performance over the next 12 months | Separate ptl is shared with each speciality to ensure full visibility of patients dated in/out of target trust escalation policy in order to identify patients not meeting key milestones A weekly list is shared with each speciality of patients dated outside of the target in order to redate the patient in time if possible. |

# 62-day wait for first treatment

Committee Name: All

GroupName: Systems and Partnerships

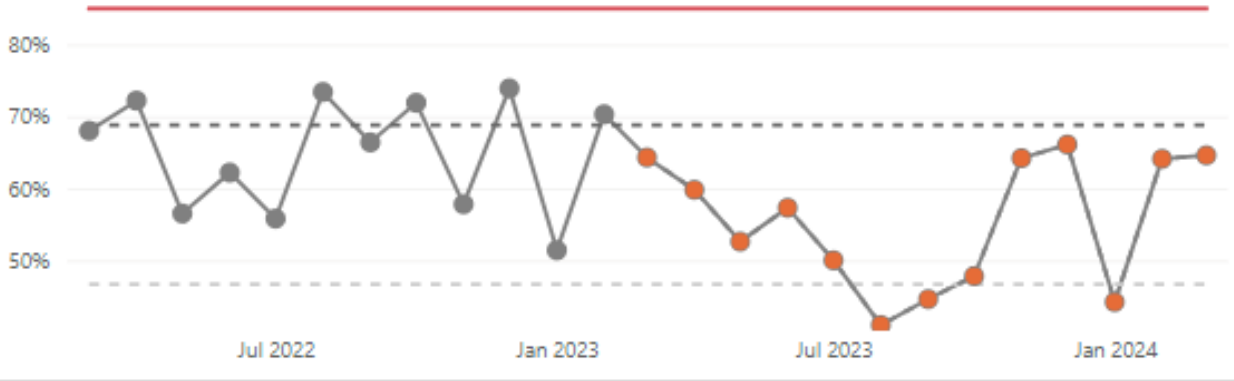
MetricName: 62-day wait for first treatment

Date: 01/12/2019 – 01/04/2024

| 64.60% | 85.00% | 67.00% | 85.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

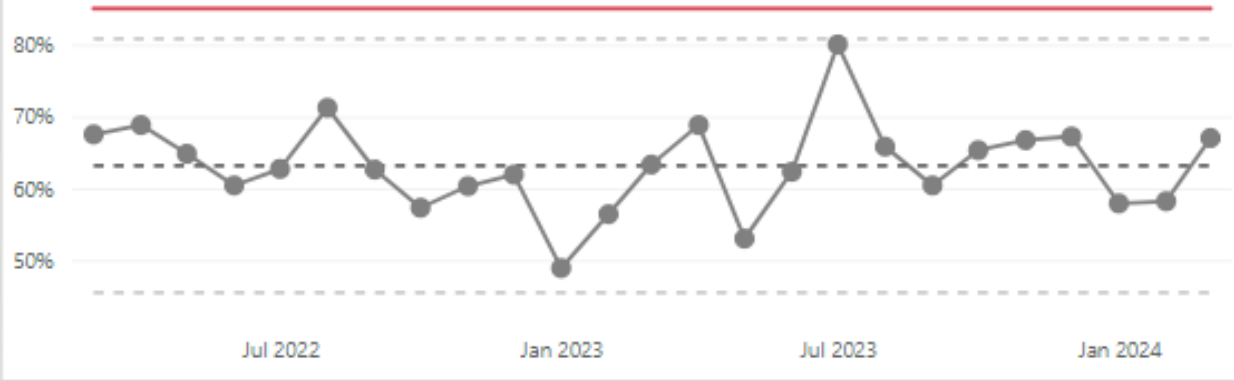
**Kettering General Hospital**

62-day wait for first treatment: Systems and Partnerships




**Northampton General Hospital**

62-day wait for first treatment: Systems and Partnerships



# 62-day wait for first treatment

Committee Name: All

GroupName: All

MetricName: 62-day wait for first treatment

| 64.60% | 85.00% | 67.00% | 85.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/03/24 | % of patients whose treatment in initiated within 63 days of urgent referral | The Trust did not meet the standard of 85%. Performance for the month of March was recorded at 65.7%. | The Trust improved the 62 day performance by 5% this is the third consecutive month an improvement has been recorded.<br><br>The Trust treated 134 patients and 43 breaches were recorded.<br><br>The highest proportion of breaches were recorded within the surgical division. Workforce, surgical capacity, complex pathways - patients requiring additional tests to confirm diagnosis and patient led delays during diagnostics. | No change - Cancer recovery action plan discussed and updated by Head of Nursing Cancer and service and presented weekly at Patient access board.<br><br>Weekly calls take place with tertiary centres for next steps of patients, both NGH and UHL<br><br>Impact of industrial action added to risk register, updated and reviewed regularly and discussed at operational risk management group.<br><br>Discuss with Radiology ways of making the CTC booking process more efficient.<br><br>Training to commence of admin staff to enable booking of CT Colons in order to release clinical staff and increase access to patients<br><br>Attempt to employ overseas pathologist ongoing - awaiting costings from Medica<br><br>Roll out clinical review of PTLs to other sites and ensure this is custom practice to ensure patients are moved though the pathway without delay<br><br>Review of cancer access policy inline with new CWT version 12 changes | We continue to hold the twice weekly Confirm and Challenge meetings, we discuss every patient passed breach date and up to day 31 of their pathway. This is chaired by the cancer management team and the DCOO.<br><br>Patient access board continues weekly where actions to improve cancer performance are highlighted by the divisions and escalated when necessary.<br><br>Booking of MRI to assist RAPID prostate pathway now managed within Urology service (14 slots per week)<br><br>Flexi Cystoscopy now booked within service as part of Haematuria One stop pathway<br><br>Locum secured in Breast to cover long term sickness<br><br>Colposcopy nurse now in post<br><br>Increased activity for LATP and OPA (weekend clinics) continues |

# 62-day wait for first treatment

Committee Name: All

GroupName: All

MetricName: 62-day wait for first treatment

| 64.60% | 85.00% | 67.00% | 85.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| NGH | 01/03/24 | % of patients whose treatment in initiated within 63 days of urgent referral | The national target for 62 days is to achieve 70% by March. The Trust achieved 67%. | 182 treatments were delivered of which 60 breached. 37 of these were multi-factorial, with delayed milestones throughout pathways, 11 were due to surgical capacity and cancellations. Patient choice, fitness, complex routes to diagnostics and outpatient capacity also featured as a delay reason this month. | The trust continues to prioritise cancer, Moving patients to treatment remains the biggest challenge. | Site and corporate ptl's provide full visibility of patient pathways, the trust escalation policy identifies patients not meeting key milestones for services to address, weekly access committee to highlight areas of concern to divisional teams, monthly cancer strategy group overseeing and driving improvements |

# Cancer: Faster Diagnostic Standard

Committee Name: All

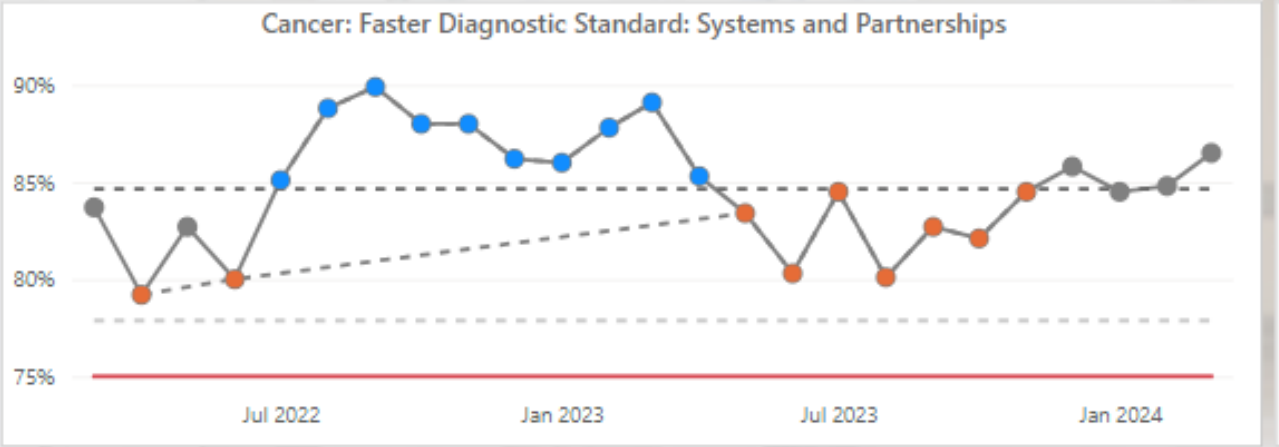
GroupName: Systems and Partnerships

MetricName: Cancer: Faster Diagnostic Standard

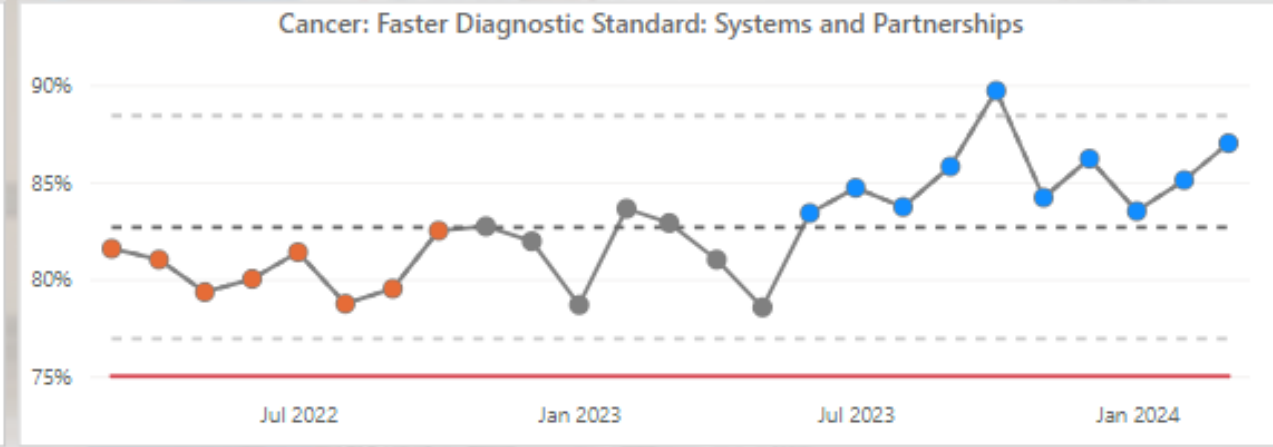
Date: 01/12/2019 – 01/04/2024

| 86.50% | 75.00% | 87.00% | 75.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**



# Cancer: Faster Diagnostic Standard

Committee Name: All

GroupName: All

MetricName: Cancer: Faster Diagnostic Standard

| 86.50% | 75.00% | 87.00% | 75.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/03/24 | % of patients diagnosed in less than 28 days | The Trust achieved the faster diagnosis standard for the month of March at 86.5% | The trust recorded an increase in performance of 2%.<br>KGH continues to be one of the best performing Trusts exceeding the Faster Diagnosis Standard. As a system we are the leading performer in the country. | No changes<br><br>Divisions to continue to monitor performance against the standard<br><br>Increased PTL meetings continue to maintain focus | Patients discussed twice weekly with histopathology and radiology to ensure timely booking and reporting of investigations.<br><br>Reports within Somerset cancer registry enable retrospective tracking to ensure all patients |
| NGH | 01/03/24 | % of patients diagnosed in less than 28 days | The Trust exceeded the standard in March, reaching 87% against the 75% standard. | Standard exceeded no issues | Sustain existing focus on early diagnosis | First seen within 7 days.<br>Diagnostics request to report stretch target 7 days<br>Histology 7 days TAT<br>Trust escalation policy and ptl meetings with oversight of all patients<br>Effective MDT meetings |

# 6-week diagnostic test target performance

Committee Name: All

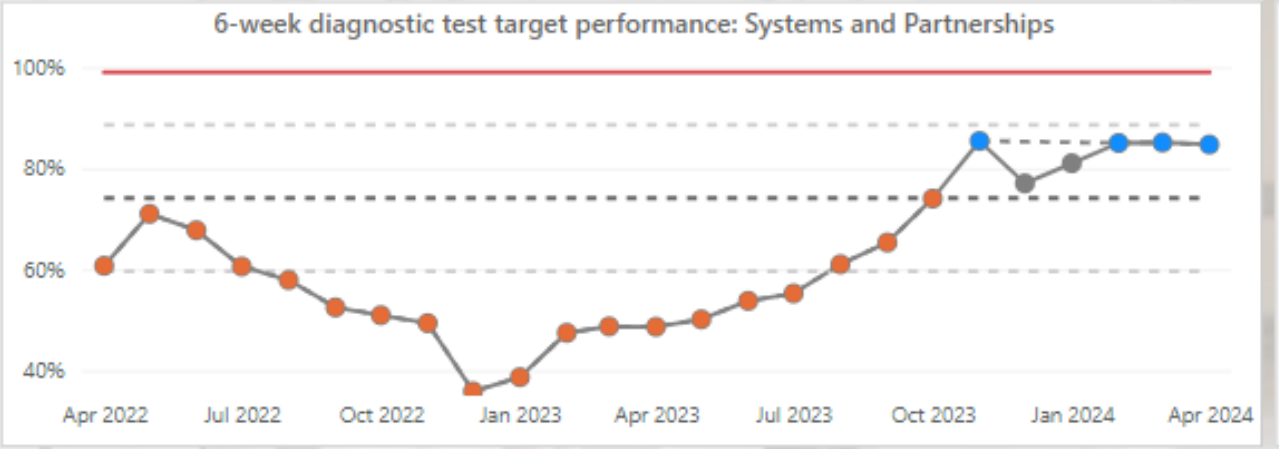
GroupName: Systems and Partnerships

MetricName: 6-week diagnostic test target performance

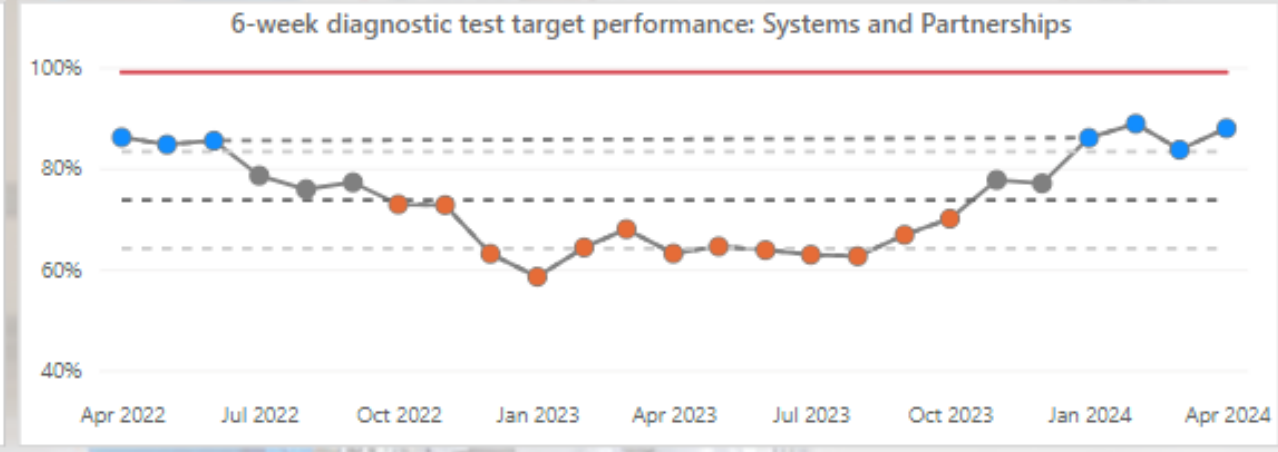
Date: 01/12/2019 – 01/04/2024

| 84.70% | 99.00% | 87.91% | 99.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**



# 6-week diagnostic test target performance

Committee Name: All

GroupName: Systems and Partnerships

MetricName: 6-week diagnostic test target performance

| 84.70% | 99.00% | 87.91% | 99.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | % of patients not seen within six weeks | performance for April 2024 at 84.7%. | Challenges continue within Cardiac Radiology, Paediatric MRI, Cardiac Investigation DSE, Neurophysiological and Cystoscopy. | • Cystoscopy have been tasked with validation of longest waiting patients. This has not been running as efficiently as there has been a lot of sickness in the team. The AD has detailed plans for validation work with support of HoA<br>• Neurophysiology remains challenged however there are plans for 170 patients to be transferred to Woodlands in June to support with patient care<br>• A Cardiac locum has been extended until June month end which will support with allocation of patients who need Cardiac CTs and MRIs. | Weekly PTL meetings with Radiology continue<br>PTL meetings with Cysto to be established<br>Head of Radiology asked to present a recovery plan to DCCO |
| NGH | 01/04/24 | % of patients not seen within six weeks | DM01 month end position increased to 88% | - U/S and Audiology remains constrained,<br>- MRI and CT remain stable U/S has also seen improvement to 80%,<br>- Echoe's are at 90% with TOE's and DSE constrained due to sickness and workforce issues. Locum in place to mitigate. | - Mitigations for Audiology in place to include support from Agency and additional weekend lists with 6 week trajectory to clear backlog by end of June. Insourcing being discussed and yet to be finalised dependant on financial and procurement discussions .<br>- Additional lists for U/S in place at the weekend and Medicare utilised for additional capacity. | - Weekly diagnostic PTL<br>- Standing agenda item at Access Committee<br>- Forward look for all modalties with trajectories to be in place |

# Unappointed outpatient follow ups

Committee Name: All

GroupName: Systems and Partnerships

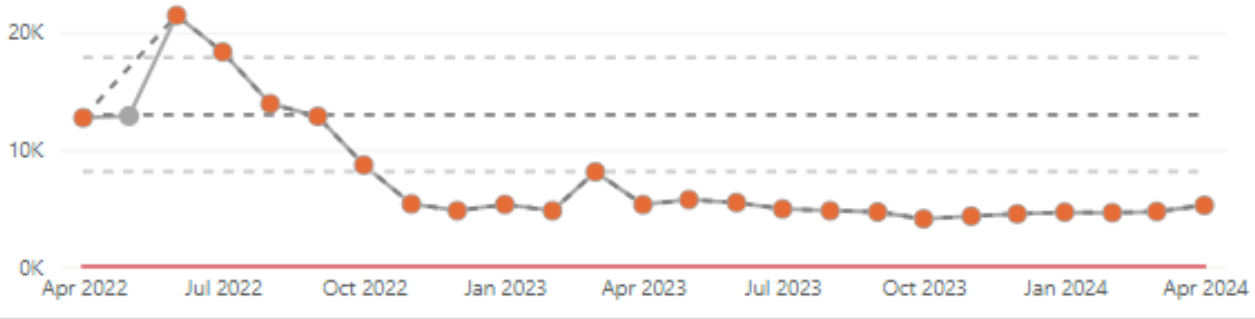
MetricName: Unappointed outpatient follow ups

Date: 01/12/2019 – 01/04/2024

| 5,228 | | 27,629 | 0 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

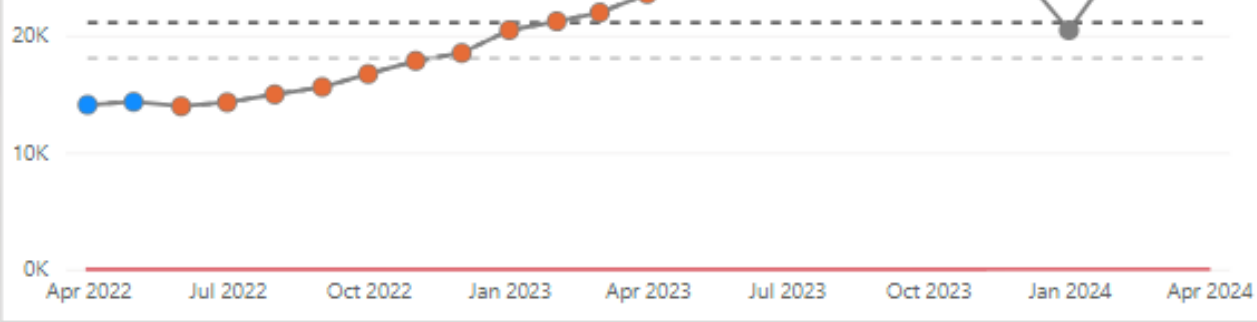
## Kettering General Hospital

Unappointed outpatient follow ups: Systems and Partnerships




## Northampton General Hospital

Unappointed outpatient follow ups: Systems and Partnerships



# Unappointed outpatient follow ups

Committee Name: All

GroupName: Systems and Partnerships

MetricName: Unappointed outpatient follow ups

| 5,228 | | 27,629 | 0 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Count of patients who do not have a booked appointment and are past their due date | Patient 6months or more past their review date has increased from 4753 last month to 5228 in April 2024 | Capacity to meet the needs of those who have been listed to be seen again<br>Systems available to support specialties with accurate sight of patients who need to be seen<br>Pathway management within specialties being difficult to manage due to digital capacity and volumes of patients. | Continues development of digital solutions support both the reporting and management of patients<br>FDS has been deployed and the Outpatient module continues to be developed<br>Weekly circulation of data to divisions for action | Bank support from RTT team to validate 10months+ |
| NGH | 01/04/24 | Count of patients who do not have a booked appointment and are past their due date | Over 6 months has increased to 6,971 from 6,721. This continues to remain an on-going challenge | - Administrative resource<br>- Capacity to deliver FU requirements | -- Over 12 months circulated to divisions to support tracking<br>-Working for the automation of closures including PIFU past review<br>- Implementation of Outpatients CCS to support management<br>- Continued work on the deployment and extended use of PIFU<br>- GIRFT Further Faster program. | - Standing Agenda Item at Access Committee<br>- Project focus through further faster and GIRFT |

# RTT over 52 week waits

Committee Name: All

GroupName: Systems and Partnerships

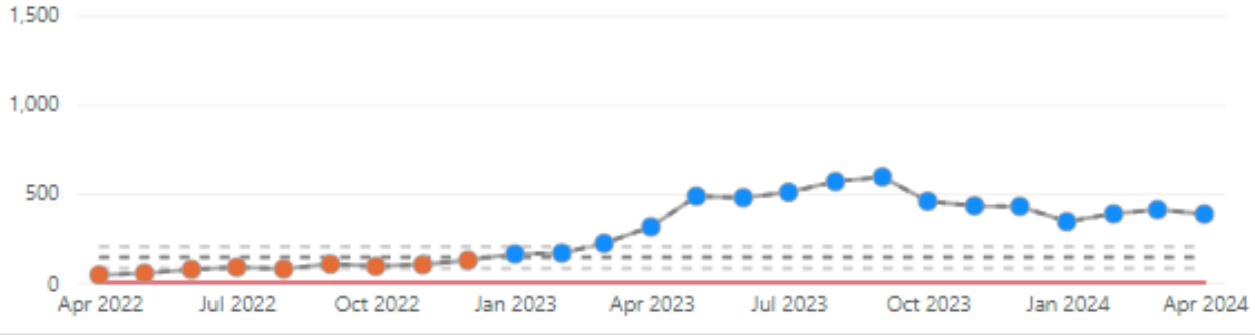
MetricName: RTT over 52 week waits

Date: 01/12/2019 – 01/04/2024

| 384 | 0 | 1,588 | 0 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

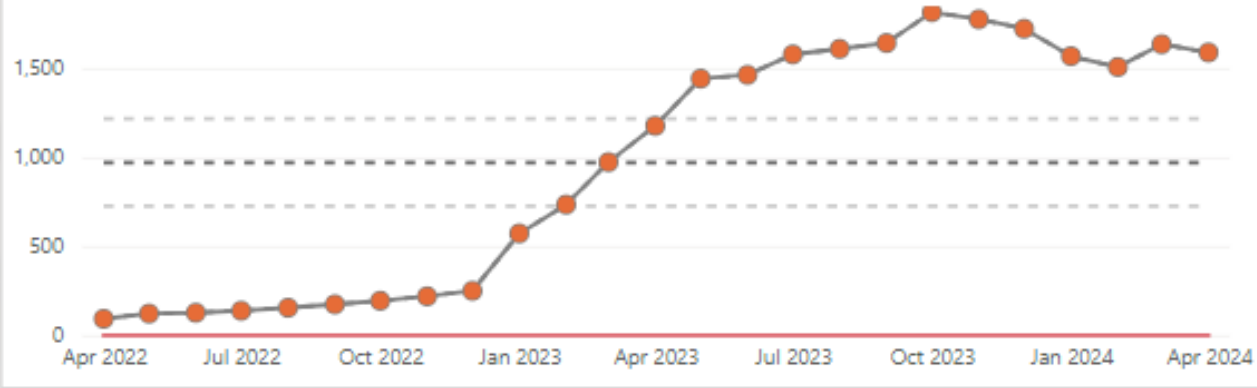
**Kettering General Hospital**

RTT over 52 week waits: Systems and Partnerships




**Northampton General Hospital**

RTT over 52 week waits: Systems and Partnerships



# RTT over 52 week waits

Committee Name: All

GroupName: Systems and Partnerships

MetricName: RTT over 52 week waits

| 384 | 0 | 1,588 | 0 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | No. of patients waiting greater than 52 weeks from referral to treatment (RTT) | 52w+ has seen a decline from 404 at the end of March to 384 at the end of April. | Capacity issues within Neurology and Respiratory services<br>Length of pathways within Orthodontics and Oral Surgery<br>Transfers from NGH | Mitigating Actions:<br>- Continued validation of patients 52w+ on a weekly basis by the RTT Validation team. The deployments of the RTT Validation tool has made this much easier and efficient for this team.<br>- Continued weekly PTL meeting with the RTT Manager and Head of Access for all patients at risk of being 65w+ over the next three months.<br>- Continued application of the Access policy for patients who have disengaged including timely escalation for clinical validation.<br>- Support for Neurology has been approved for the allocation of a locum of whom started 13/05/24. This will add capacity and support with seeing new patients earlier.<br>- Theatre Utilisation is being monitored to ensure maximum usage (80%+) | Continued PTL meetings with HoA for all 65w+cohort patients<br>Continued specialty based PTL meetings |
| NGH | 01/04/24 | No. of patients waiting greater than 52 weeks from referral to treatment (RTT) | 52+ Actuals reduced in April delivering ahead of trajectory. 1,588 against trajectory of 1660 this continues to reduce despite operational pressures. | - Constrained specialties still remain ENT,T&O,Surgery,Urology,Vascular.<br>- Clearance has been impacted by increased clock starts vs Stops Annual leave, Sickness, Cancelled elective activity due to shortage/lack of availability of anaesthetic cover for theatre lists. | - All first outpatients to be booked in 65+ cohort by June 24 and 52+ by December<br>- Utilisation of independent sector capacity for General Surgery, Urology and T&O to support delivery of target. This is on-going.<br>- Support from KGH with long waiters This is on-going<br>- Continued Digital validation of all patients over 12 weeks – to be confirmed<br>- Woodlands agreed to support with May/June/July patients that will breach 78+ for T&O, Surgery and ENT. Accepted patients have now been uploaded onto DMAS.<br>- Daily reports to monitor the 78+ position have been put in place and twice weekly planning meetings chaired by Deputy COO are ongoing. | - Daily monitoring of long waiting patients<br>- Standing Agenda item at Access Committee<br>- PTL weekly<br>- Continued application of Access Policies and Guidance has been useful for management patient pathways where they have disengaged or refused continued care. Weekly PTL meetings ensures pathways are monitored, managed, and escalated. Ambitions are for zero 65w+ waits by Sep24 and zero 52w+ by March 2025 |

# Size of RTT waiting list

Committee Name: All

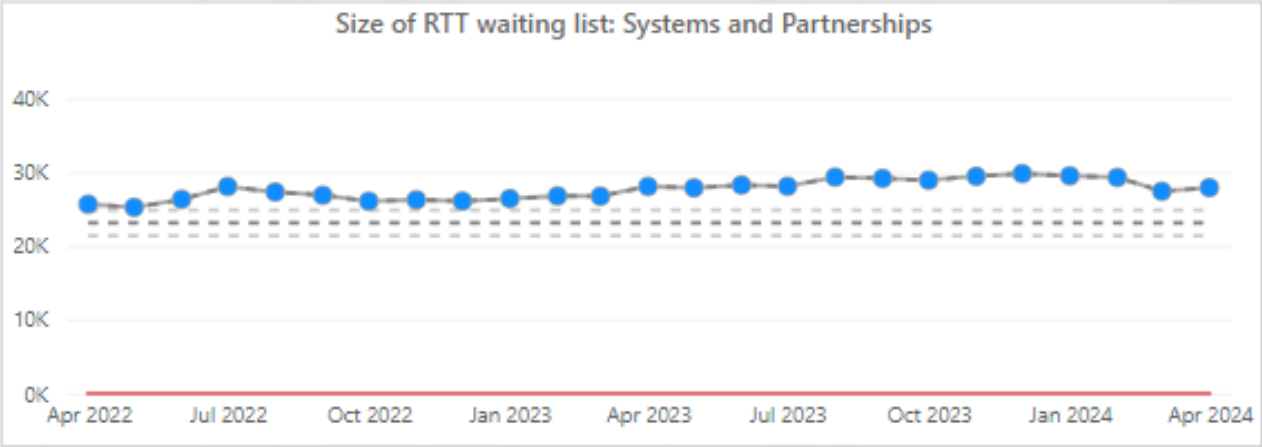
GroupName: Systems and Partnerships

MetricName: Size of RTT waiting list

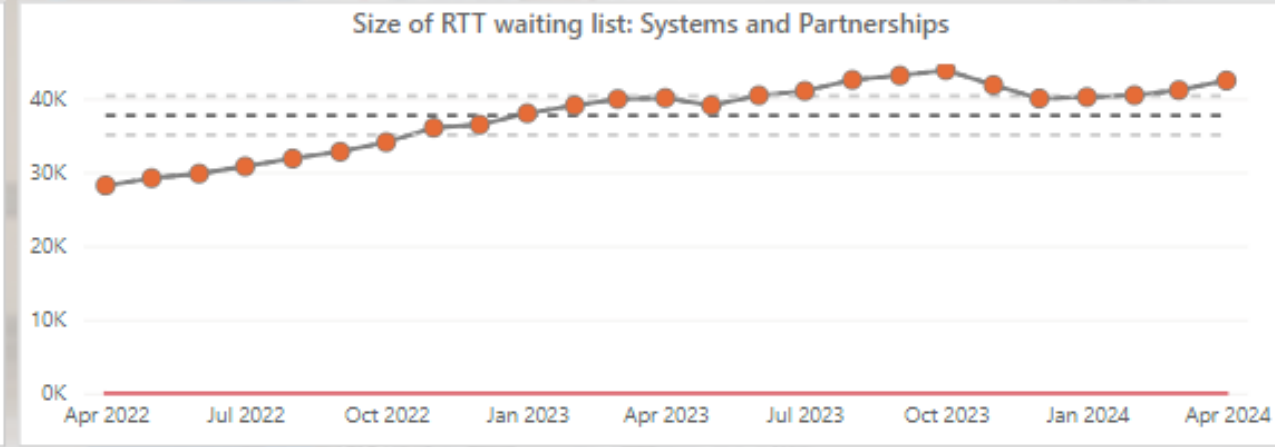
Date: 01/12/2019 – 01/04/2024

| 27,890 | | 42,405 | 0 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**



# Size of RTT waiting list

Committee Name: All

GroupName: Systems and Partnerships

MetricName: Size of RTT waiting list

| 27,890 | | 42,405 | 0 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Count of patients actively waiting against the 18 week RTT target | As per the below the PTL as at April month end 2024 27,890. This has seen an increase from 27,186 from March 2024 | Higher levels of referrals into the trust<br>Challenges with specialties : Pediatrics, Neurology, Respiratory, Ortho and Oral | Closing working relationships with NGH and UHL to support where the challenges have been felt across the trusts<br>Validation continues<br>Transformation department working with ICB and Primary care to review pathways into the trust. | Validation<br>GIRFT Further Faster<br>Daycase and Theater Utilisation management |
| NGH | 01/04/24 | Count of patients actively waiting against the 18 week RTT target | PTL size month end April is 42,205 whilst this is increased from previous month of 41,106 this is still below 43,000 at the start of the year in January. | Clearance has been impacted by increased number of referrals into the Trusts with increased clock starts vs Stops. There has also been Annual leave, Sickness, Cancelled elective activity due to shortage/lack of availability of anaesthetic cover for theatre lists. | • Continued application of Access Policies and Guidance has been useful for management patient pathways where they have disengaged or refused continued care. Weekly PTL meetings ensures pathways are monitored, managed, and escalated. Ambitions are for zero 65w+ waits by Sep24 and zero 52w+ by March 2025<br>• Foundry RTT validation has been implemented and is now in use by the central validation team which should support reduction.<br>• Collaboration with KGH and UHL to review scope for mutual aid and support for challenged specialties in spirit of ensuring equitable waits across the Trusts.<br>• Transformation department working with ICB and Primary care to review pathways into the Trust.<br>• GIRFT Further Faster workstreams in place to support reduction which includes outpatient productivity, Daycase and Theatre Utilisation management.<br>• Validation has remained above 90% with an increase to 95% being validated over 12 weeks. The deployment of the RTT Validation tool has made this much easier and efficient for the team | - Standing agenda item Access Committee<br>- Weekly PTL<br>- CCS tool "Go live April to support PTL and monitoring of waiting list" |

# Theatre utilisation

Committee Name: All

GroupName: Systems and Partnerships

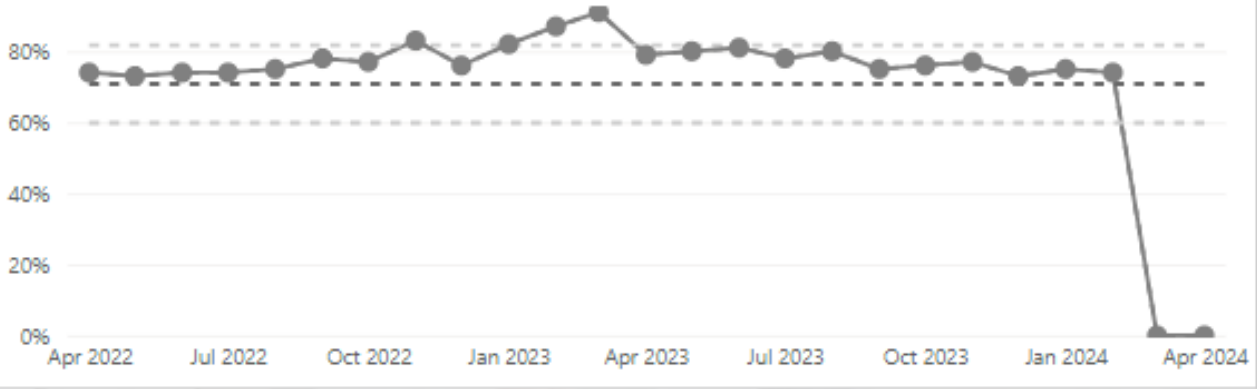
MetricName: Theatre utilisation

Date: 01/12/2019 – 01/04/2024

| 0.00% | | 77.00% | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

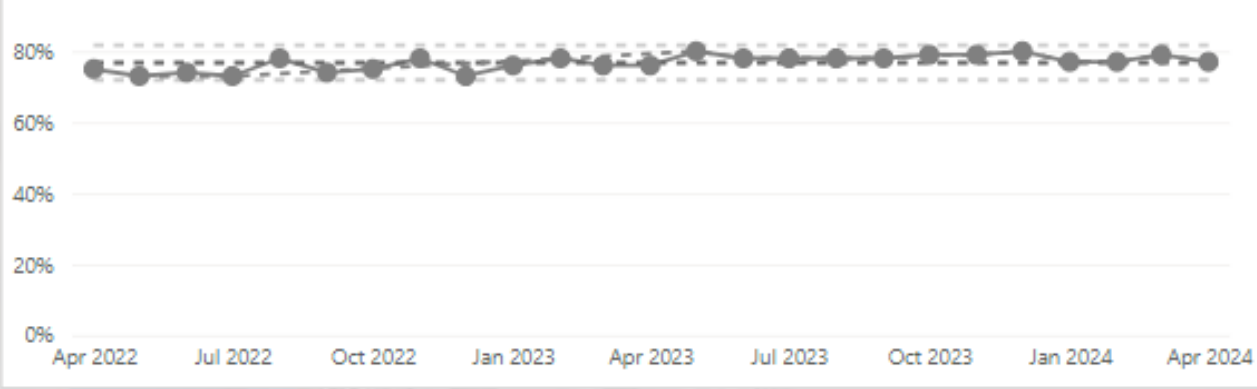
**Kettering General Hospital**

Theatre utilisation: Systems and Partnerships




**Northampton General Hospital**

Theatre utilisation: Systems and Partnerships




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| NGH | 01/04/24 | Theatre utilisation % against 85% national target | Theatre Utilisation - Touch time = 77%<br>Theatre Utilisation - Touch time including turnover = 92% | Sustainment of utilisation.<br>Nexus is not pulling surgeon timings into Palantir.<br>No data to look back at planned V actual utilisation. | 6-4-2 weekly meeting<br>Planning meetings with Consultants.<br>Consultant timings to be manually inputted into Nexus. | Newton investigating surgeons timings. Awaiting Nexus upgrade. |

# Bed utilisation

Committee Name: All

GroupName: Systems and Partnerships

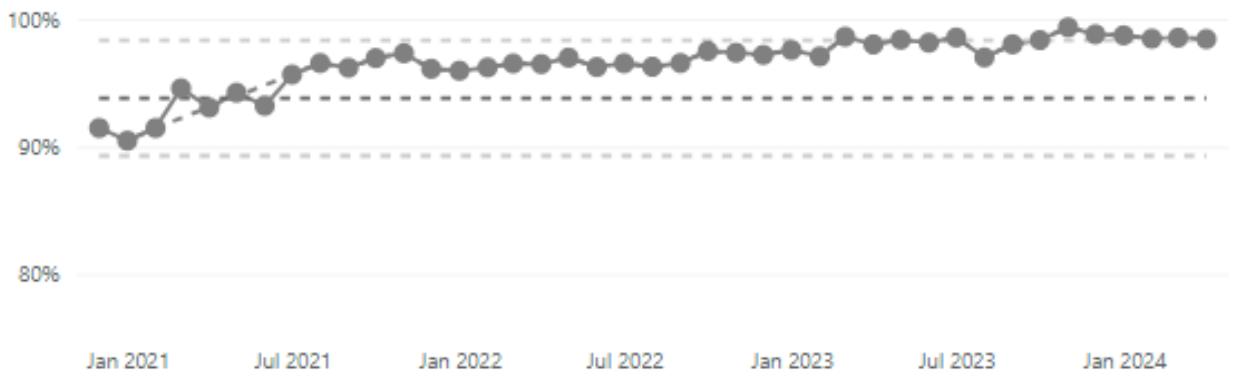
MetricName: Bed utilisation

Date: 01/12/2019 – 01/04/2024

| 98.42% | | 87.67% | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

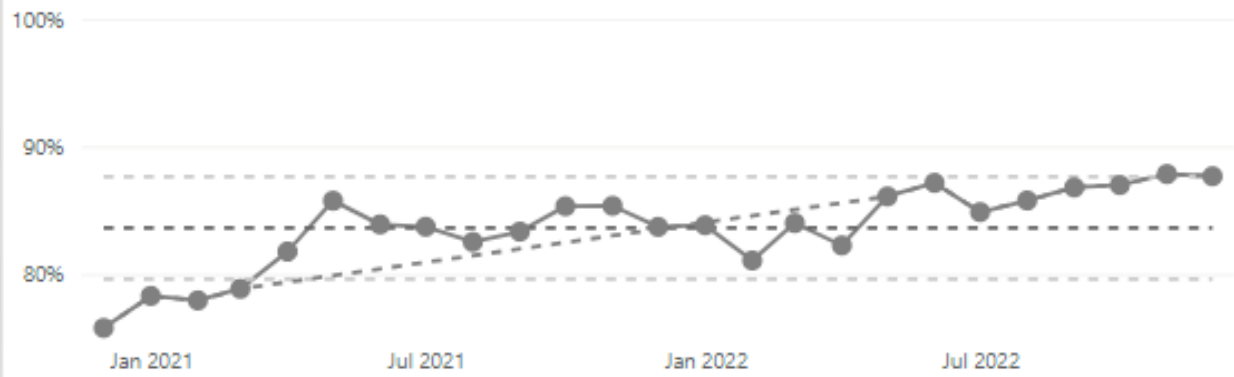
**Kettering General Hospital**

Bed utilisation: Systems and Partnerships




**Northampton General Hospital**

Bed utilisation: Systems and Partnerships




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|

# Stranded patients (7+ day length of stay)

Committee Name: All

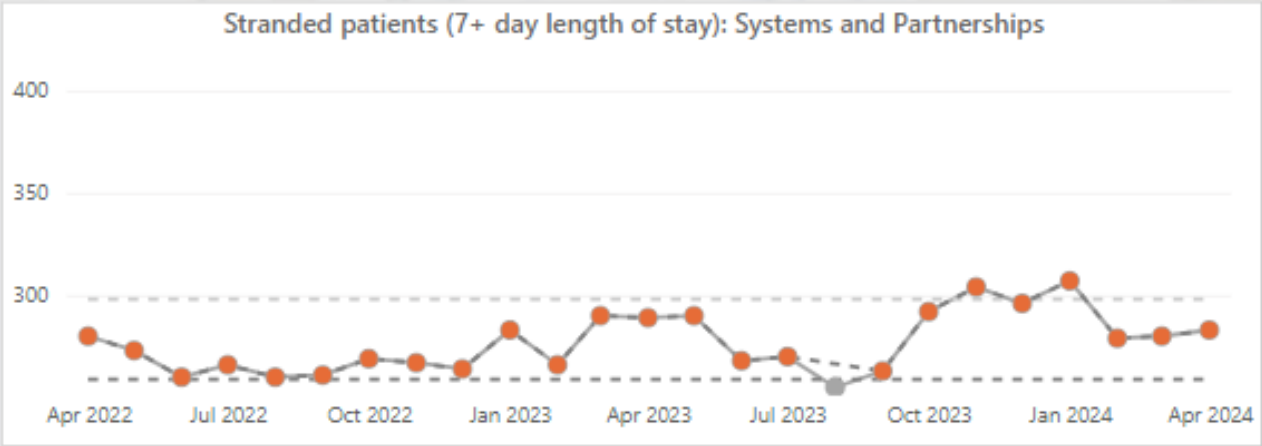
GroupName: Systems and Partnerships

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

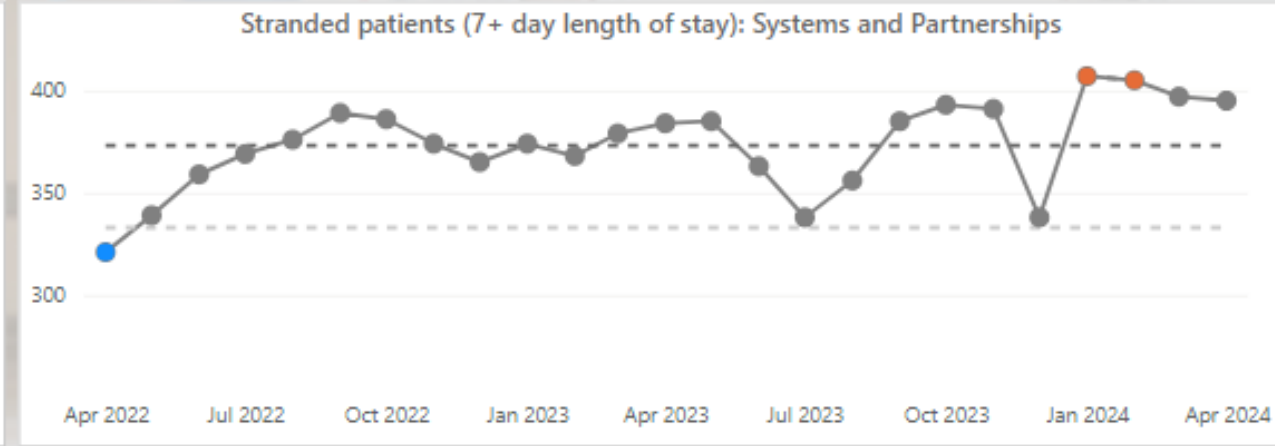
Date: 01/12/2019 – 01/04/2024

| 283 | | 395 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**



# Stranded patients (7+ day length of stay)

NHS University Hospitals of Northamptonshire NHS Group

Committee Name: All

GroupName: Systems and Partnerships

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

Date: 12/1/2019 – 4/1/2024

| 283 | | 395 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Number of patients with a LoS > 7 days | We have seen a significant and sustained increase in stranded patient numbers which over the past 2 months has reduced and remained steady | Medical LoS increased to 10.2 days against plan of 9.5 days, equiv of 21 bed demand increase over plan<br>Emergency admission demand 1.2% higher than planned, equiv of 7 bed demand increase than planned | Continued focus of complex discharge process and minimise delays with allocation of required package - we are sustaining a TAT of <2.5 days for completion and decision on package<br>Ongoing work with NNH ASC to utilise PW 2 beds in Thackley Green specialist care centre to free up community hospital rehab beds & to take a higher level of patient dependency e.g. manageable delirium.<br>Opening 29 sub acute care beds at Spinneyfields care home to compensate for the loss of beds due to RAAC<br>Focus on ensuring effective board rounds with daily completion of actions to generate discharges<br>Criteria led discharge work across surgery moving to nurse led discharge. | Bi Weekly Patient time matters meeting to oversee progress and provide scrutiny and advice<br>Upwards reporting to UEC Delivery Board also Bi weekly<br>Senior nursing support to wards<br>Consideration of external support to review gaps in mitigations |

# Super-Stranded patients (21+ day length of sta[redacted]

Committee Name: All

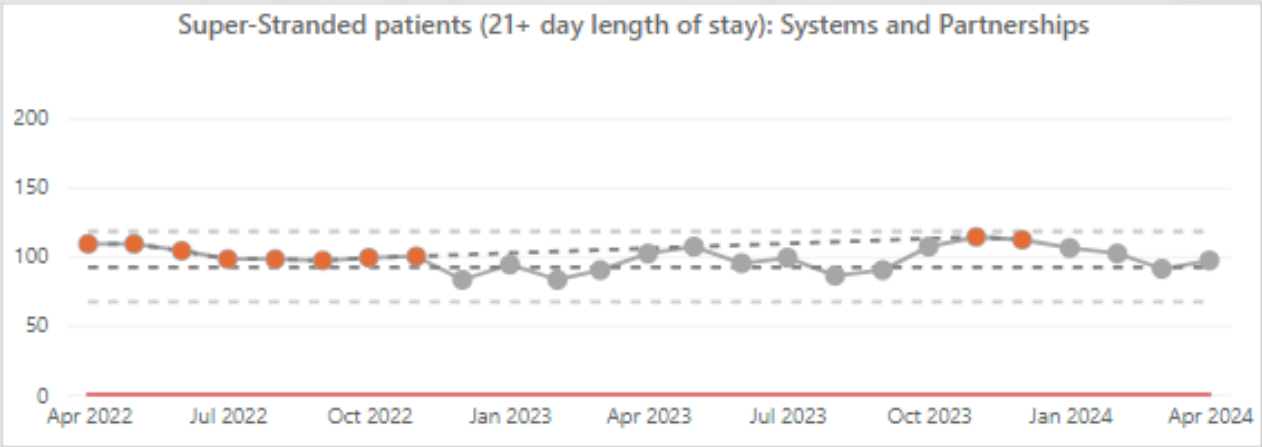
GroupName: Systems and Partnerships

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

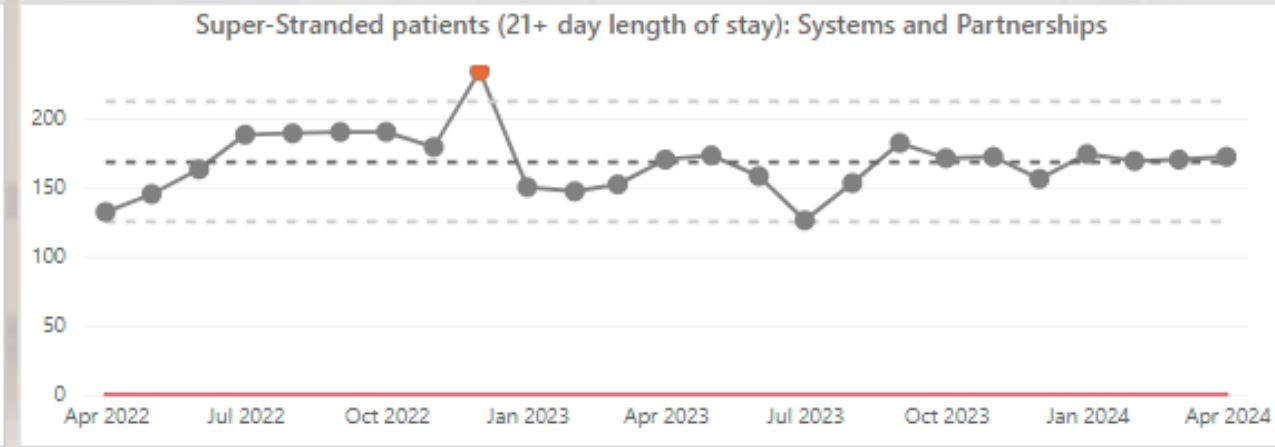
Date: 01/12/2019 – 01/04/2024

| 97 | 0 | 172 | 0 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Number of patients with a LOS> 21 days | continued reduction in number of super stranded patients | Difficulties in discharging patients with acute confusion/delirium/dementia are continuing due to high level of support required. Increase in stroke prevalence is also contributing to increased numbers of patients waiting for stroke specialist community bed provider | continued working with system partners to reduce pathway delays and ensure patients are able to be discharged in timely manner. Areas of focus within the system are stroke pathway, bariatric and acute confusion. Current work underway across the system to deliver additional Dementia and Delirium capacity and additional sub acute beds in Spinneyfields care home to compensate for the loss of beds due to RAAC | Continued flexing in the use of acute renal bed base to facilitate home dialysis has had a positive impact in terms of reducing inpatient delays due to lack of community dialysis capacity. Frailty short stay unit has had a significant reset and refocus with 1/5th of their bed base discharged each day at a minimum. This work is of significant benefit to our vulnerable elderly population. |

# Patients with a reason to reside

Committee Name: All

GroupName: Systems and Partnerships

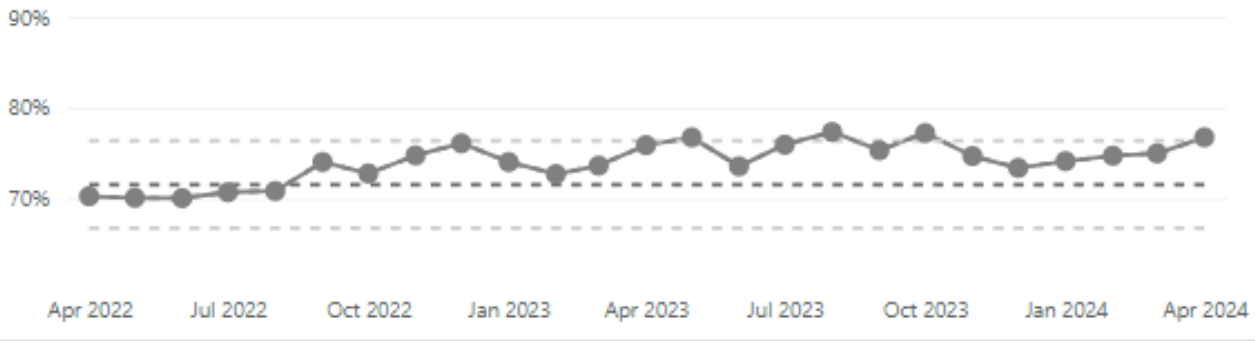
MetricName: Patients with a reason to reside

Date: 01/12/2019 – 01/04/2024

| 76.75% | | 70.79% | 95.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

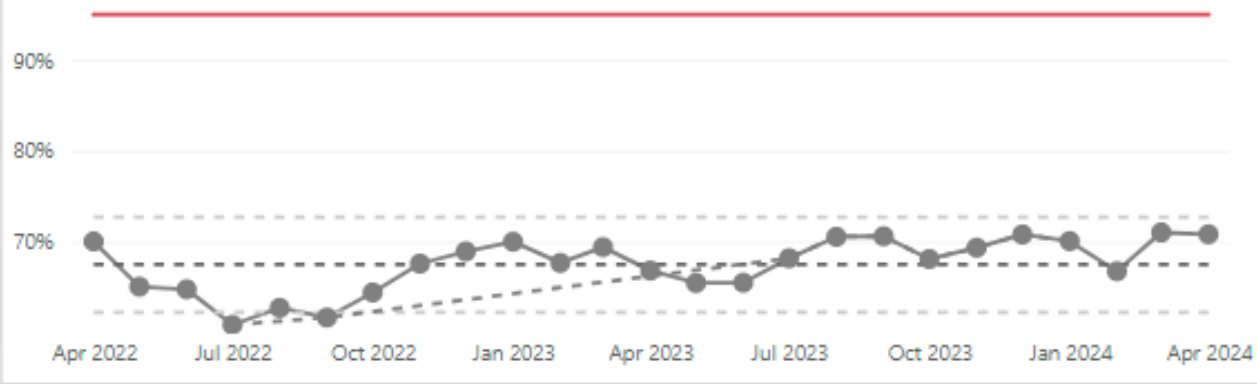
**Kettering General Hospital**

Patients with a reason to reside: Systems and Partnerships




**Northampton General Hospital**

Patients with a reason to reside: Systems and Partnerships



# Patients with a reason to reside

Committee Name: All

GroupName: Systems and Partnerships

MetricName: Patients with a reason to reside

| 76.75% | | 70.79% | 95.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Number of patients who have a reason to reside in hospital based on national reason to reside criteria | NHSE have asked for assurance re board round review and challenge metrics associated with patients whom have no reason to reside/discharge ready. This metric describes that.<br>The percentage of patients whom have a reason to reside has increased which correlates with the current levels of acuity being admitted. | 27% of patients have no reason to reside (approximately 90) and of these 55-60 patients are awaiting supported discharge with biggest delays being in P2 (rehab) and P3 (nursing and residential home) discharges (on average 21 days from no reason to reside to discharge).<br>The remaining 40 are classed as pathway zero and the operational teams focus on a daily basis is to expedite these - on average 80% of these patients are discharged, one of the best performers in the region | System level challenge for patients who have been declined by more than 3 care homes - weekly meeting set up<br>Review of patients awaiting community hospital beds for rehab weekly to identify those that could change to pathway 1<br>Expand screening at the front door to include pathways other than acute medicine<br>Continued work with partners to ensure a continual flow of supported discharges and identify gaps in provision<br>System level work, led by COOs, on improving P2 and P3 pathway flow | Review of Super stranded patients 2 x weekly concentrating on medicine<br>Daily focus on pathway zero patients to ensure same day discharge<br>Review and challenge all patients who have been declined by 3 care homes |

# Ambulance Handover

Committee Name: All

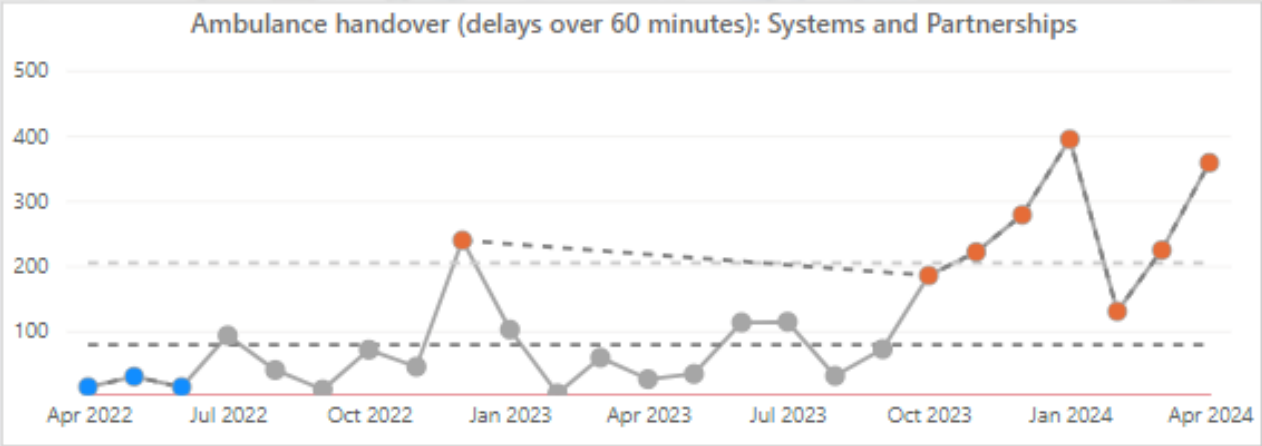
GroupName: Systems and Partnerships

MetricName: Ambulance Handover

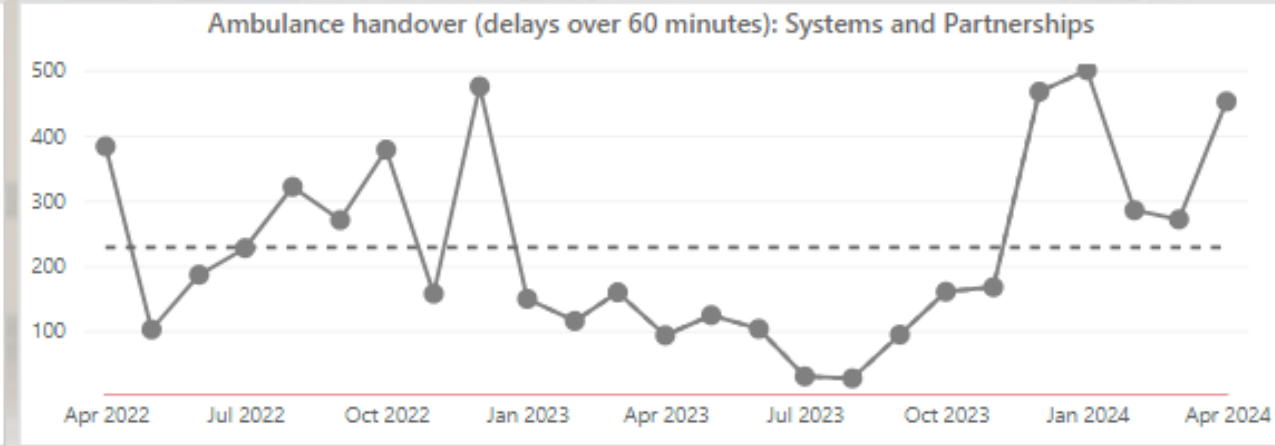
Date: 01/12/2019 – 01/04/2024

| 358 | | 452 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

## Kettering General Hospital




## Northampton General Hospital




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | EMAS ambulance handovers > 60 minutes | The organisation has seen a further increase in the number of black breaches during April. Overall, 358 black breaches were reported, of which 244 were validated as true KGH breaches. | We continue to experience an increase in attendances, further impacted by Trust capacity pressures impacting our ability to offload within 15 mins.<br>We continue to see a surge in arrivals during peak times of the day; | Continue to facilitate physician and nurse assessment for patients where handover is delayed to ensure safety and minimum care standards are maintained.<br>Driving direct access pathway to MSDEC, and further looking to establish EMAS pathway into MSDEC for cardiology.<br>Engaging in NHS England "Access from Primary care task and finish group" EMAS/GP/111/UTC | No incidents of harm identified from the harm reviews undertaken. |
| NGH | 01/04/24 | EMAS ambulance handovers > 60 minutes | Increase of 169 - 60min breaches | A vast increase in attendances seeing on average 80 more patients a day | Ensure patients are reviewed by Senior Clinicians who are unable to be offloaded | Treatment is started at the earliest |

# Average time in department - Admitted

Committee Name: All

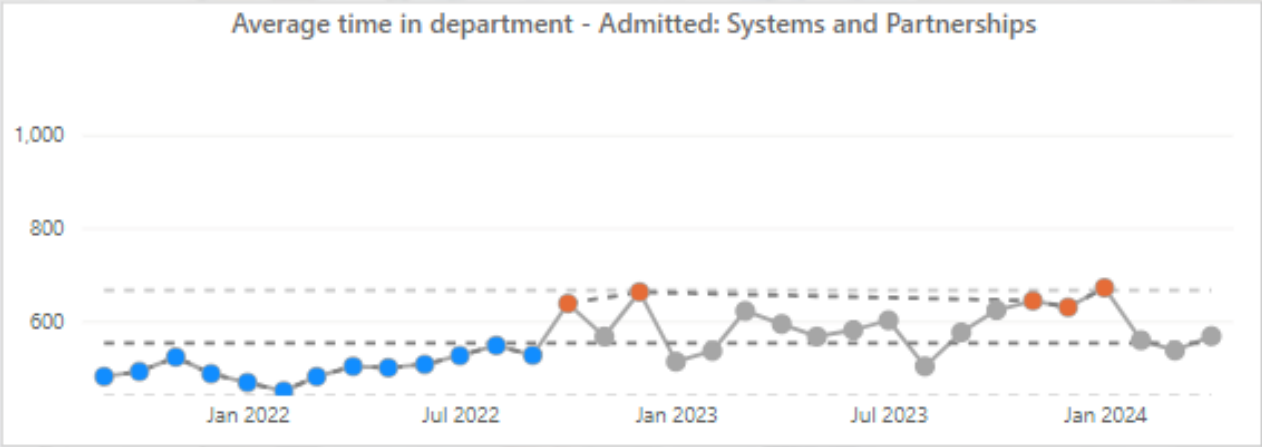
GroupName: Systems and Partnerships

MetricName: Average time in department - Admitted

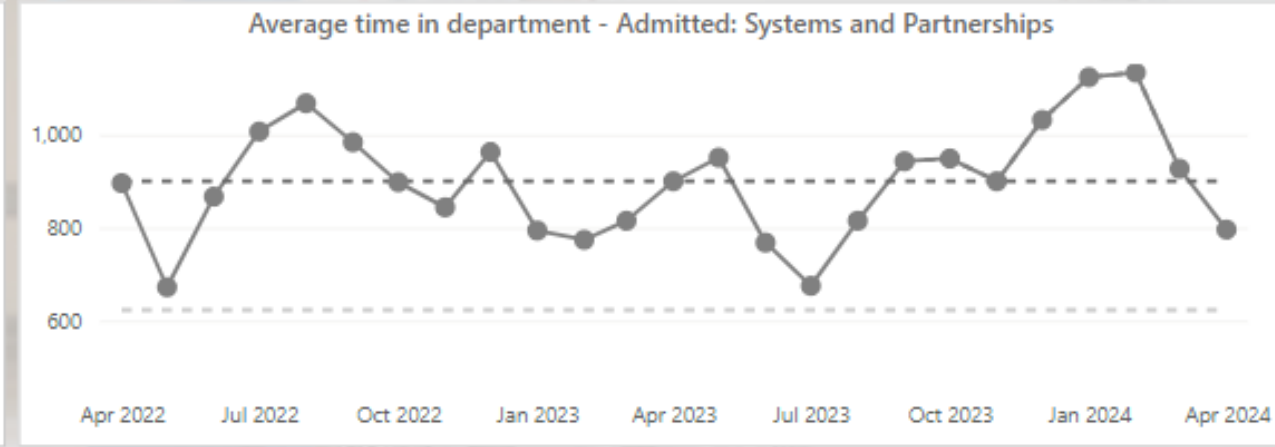
Date: 01/12/2019 – 01/04/2024

| 567 | | 796 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**



# Average time in department - Admitted

Committee Name: All

GroupName: Systems and Partnerships

MetricName: Average time in department - Admitted

| 567 | | 796 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Average time in department for those patients who are admitted to the hospital | The data shows a slight increase from the previous month with average time to discharge for admitted patients. | This is not solely an ED Metric but a Whole System metric and largely impacted by capacity and flow out of ED.<br><br>Admission of MH patients into UC wards due to the unavailability of inpatient beds in the community. | Continue with direct admission into acute medical wards for patients with EDD >48hours<br>Continue with MSDEC in reach to ED in the morning<br>Established a standalone planned care unit with capacity to see returning MSDEC patients<br>Implemented breach validation work to be used to identify pathway improvement<br>Discussions ongoing regarding an A&E cardiology pathway into MSDEC<br>Gynae SDEC opened 24/7 | Use of escalation areas and outlying capacity<br>Rapid transfer protocol |
| NGH | 01/04/24 | Average time in department for those patients who are admitted to the hospital | Continues to decrease - current now 796 | Concerns with poor discharge profile on backend wards | Senior Clinician led boardrounds | Early discharges to facilitate flow |

# Average time in department - Discharged

Committee Name: All

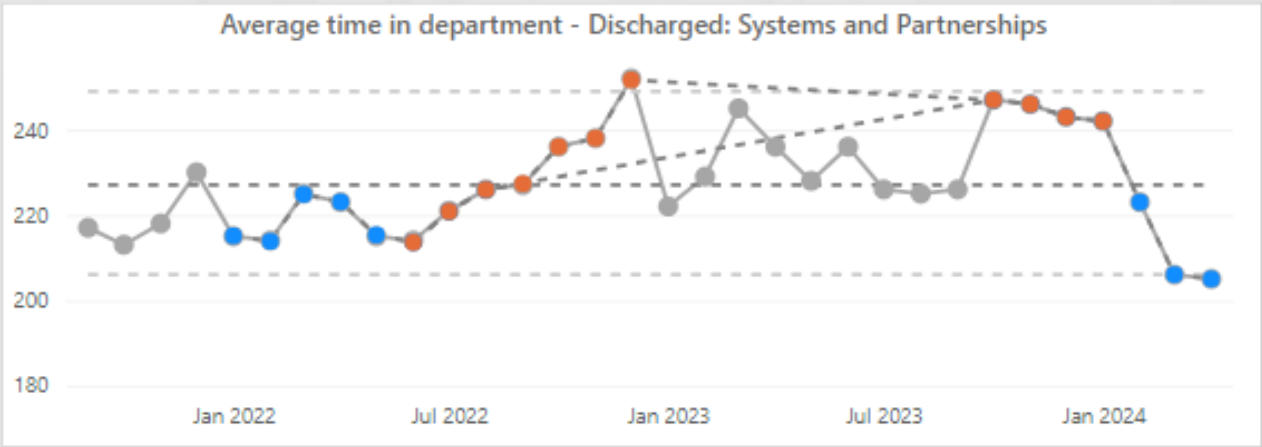
GroupName: Systems and Partnerships

MetricName: Average time in department - Discharged

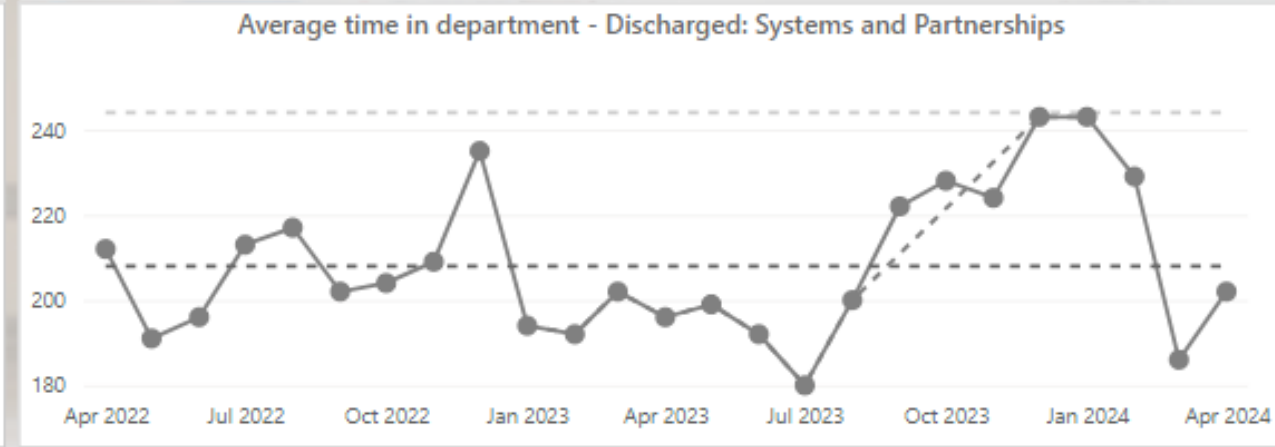
Date: 01/12/2019 – 01/04/2024

| 205 | | 202 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

## Kettering General Hospital




## Northampton General Hospital




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Average time in department for those patients who are not admitted to the hospital | The data shows us that the average time in the department for discharged patient in April was 206 mins – this is within the breach limit of 240 mins for all patients. | Recognised limitations with regards to existing streaming and re-direction pathways available from ED.<br>Timely review of patients further challenged by lack of capacity within the department footprint<br>It is recognised that this current data includes patients against which a confirmed admit has been applied; however, due to lack of Trust capacity these patients have experienced extended lengths of stay before becoming fit to be discharged home. | EDU SOP reviewed and finalised – detailing exclusion criteria and process for handover.<br>PIT room allocated for GP<br>Implemented A&E cardiology pathway into MSDEC – looking to establish EMAS stream<br>GP Stream to PAU established<br>Ongoing Frailty service review – plan to a page for the next step in progress. Present to Divisional SLT w/c 25/4/24. | Use of streaming pathways to MSDEC, MIAMI and in reach in the department to support medical on call for patients who can be discharged on the same day<br>Post take of ED patients |
| NGH | 01/04/24 | Average time in department for those patients who are not admitted to the hospital | Slight increase to 202 | We had extended the opening hours of UTC from 00:00 to 04:00am but now back to closing at 00:00 | Request extending UTC opening to 04:00am | This equates to approximately 88 patients which would be 1 ED Doctors work |

# Time to initial assessment

Committee Name: All

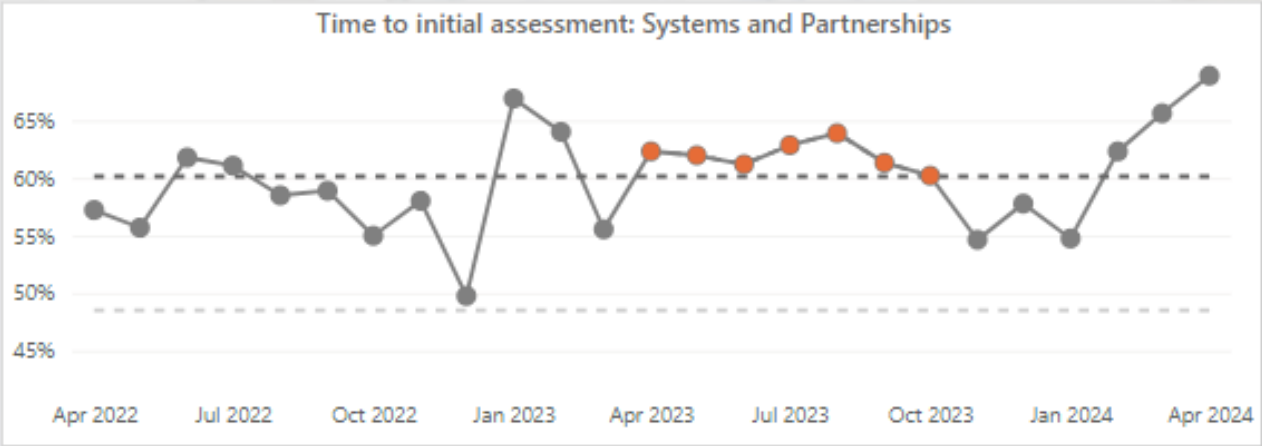
GroupName: Systems and Partnerships

MetricName: Time to initial assessment

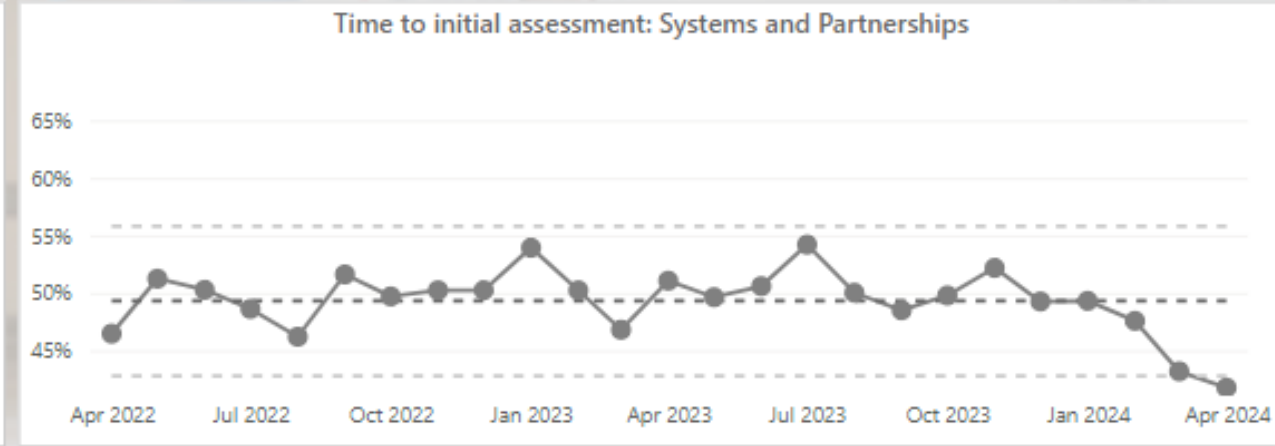
Date: 01/12/2019 – 01/04/2024

| 68.89% | | 41.76% | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | The percentage of patients who had an initial assessment within 15 minutes arriving at the department. | We have a seen a further increase in compliance with TTIA during April 2024.<br><br>This is the highest compliance since Aug 21. | Our ability to complete TTIA within time standard continues to impacted during periods of heightened activity<br>further impacted by nursing numbers inhibiting our ability to increase triage rooms in ED<br>Assessment space available to increase triage rooms limited due to current estate footprint. | Following completion of the Test of change week supported by KPM; clinical teams to review and confirm room allocation to support clinical pathways.<br>Provision of additional triage rooms to support at times of a surge in activity (depending on staffing levels). | Staffing reviewed twice daily via staffing cell with staff re-deployed from other areas to support safe staffing levels.<br><br>MIAMI and resus patients excluded from denominator giving assurance that the metric is appropriately |
| NGH | 01/04/24 | The percentage of patients who had an initial assessment within 15 minutes arriving at the department. | Constant drop to 41.76% | Bedding assessment area's to facilitate ambulance offloads | Requesting the continuation of using a Bank HCA to help with triage | In order to facilitate the 76% 4hr standard we will need this additional resource |

# 4hr ED Performance

Committee Name: All

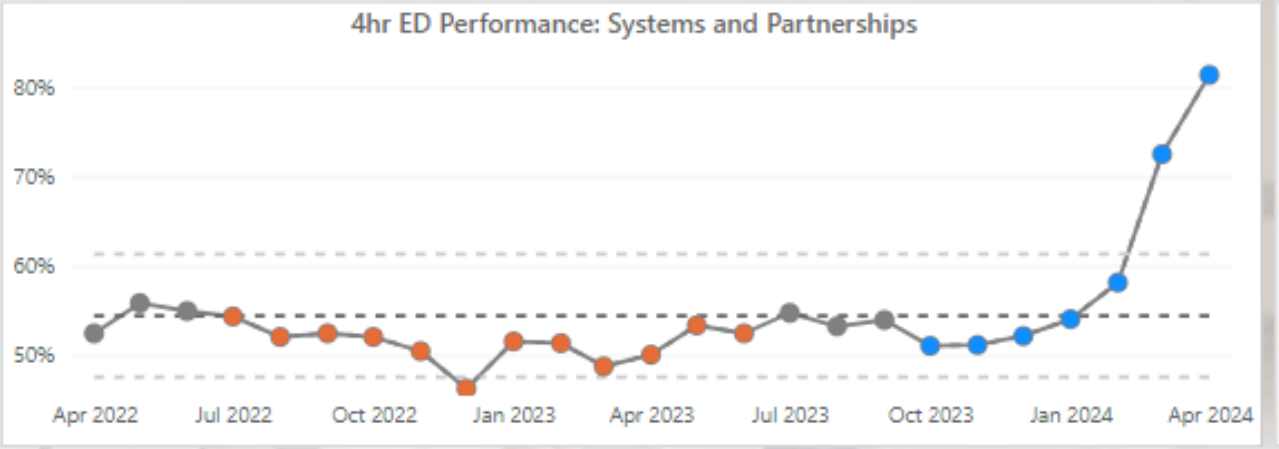
GroupName: Systems and Partnerships

MetricName: 4hr ED Performance

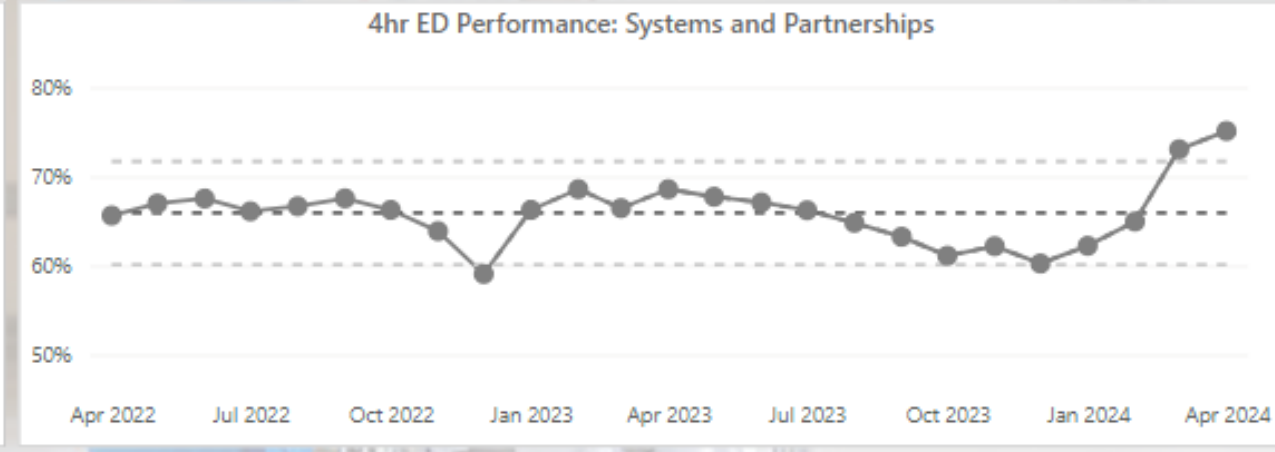
Date: 01/12/2019 – 01/04/2024

| 81.40% | | 75.10% | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**



# 4hr ED Performance

Committee Name: All

GroupName: Systems and Partnerships

MetricName: 4hr ED Performance

| 81.40% | | 75.10% | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | % of emergency patients seen, treated if necessary, and either discharged or admitted, within four hours of arrival in ED | Overall performance = 81.4%. (KGH + CUCC from 25/3/24)? - KGH = 65.6%, Non-admitted = 77.9% | The requirement to embed renewed focus across the system with regards to working to the standard<br>Patients requiring admission with an extended LOS in ED<br>Inability to stream to an SDEC outside of the medicine division directly from triage<br>Restricted pathways to stream and redirect outside of the Trust due to our current governance and workforce structure | EDU SOP reviewed and finalised – detailing exclusion criteria and process for handover.<br>PIT room allocated for GP<br>Implemented A&E cardiology pathway into MSDEC – looking to establish EMAS stream<br>GP Stream to PAU established<br>Engaging in NHS England "Access from Primary care task and finish group" EMAS/GP/111/UTC<br>Ongoing works to the physical estate via Capital projects to support pathways and maximise use of footprint<br>Team visit to Homerton 15/5/24 and a planned visit to Walsall to see their streaming and re-direction models | 2 Hourly In reach by MSDEC<br>Implement rapid flow protocol<br>Appropriate use of operational escalation protocol<br>Weekly focus 4hr group for oversight of performance and monitoring of active workstreams |
| NGH | 01/04/24 | % of emergency patients seen, treated if necessary, and either discharged or admitted, within four hours of arrival in ED | Continues to increase - 75.10% | Capacity, delays in specialty reveiwing their patients, delays with diagnostics and delays with portering out of ED to wards and also from assessment unit to base wards | Professional standards to be shared with all teams i.e. Specialties, extend UTC opening hours to 04:00am | Teams, being constantly reminded about the new 4hr Performance standard and buy in from all teams across the Trust |

# People Committee

# People Committee

Exec owners: Paula Kirkpatrick

*In reminder, this Committee monitors the 'people' metrics within the IGR.*

This cover sheet is designed to **highlight to the Committee saliant messages from the IGR metrics** for this month:

1. Appraisal Completion rates are showing a positive trend. Commentary has indicated a pilot of a new Appraisal form is in progress.
2. Mandatory Training Compliance is above target for both KGH and NGH. Commentary has indicated a focus on key target areas and flexible sessions.
3. Both Trusts are showing an increase in the Number of Volunteering hours. Operational Pressures has been indicated as the key issue.
4. Turnover Rates continues to show a downward trend. Key challenges for NGH relate to staff reaching retirement age and ensuring greater flexibility for working challenges but despite this, the turnover rate remains relatively stable and has achieved target on a regular basis.
.

Key **developments with the IGR** itself for the Committee to note:

1. Cautionary note around aggregated data has been added to the introductory page to the wider IGR pack following feedback regarding mandatory training.
2. WRES and WDES data is picked up in wider People reporting
3. Safe Staffing Metric – Which Committee should this metric be reported in? People or Quality?

*Worth remembering for all metrics, only metrics that have a) had data provided and b) have been signed off, will be published – therefore, this could lead to some gaps in reporting.*

# Summary Table

Committee Name: All

Group Name: People

Metric Name: Multiple selections

Site: All

Variation: All

| Site | Group | Metric | Latest Date | Value | Target | LCL | Mean | UCL | Variation | Assurance | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NGH | People | Mandatory training compliance | 01/04/24 | 89.42% | 85.00% | 86% | 86.93% | 87.85% | | | Consistently Anticipated to Meet Target |
| KGH | People | Mandatory training compliance | 01/04/24 | 92.03% | 85.00% | 88.26% | 90.62% | 92.98% | | | Consistently Anticipated to Meet Target |
| KGH | People | Appraisal completion rates | 01/04/24 | 86.15% | 85.00% | 78.59% | 82% | 85.41% | | | Not Consistently Anticipated to Meet Target |
| NGH | People | Appraisal completion rates | 01/04/24 | 77.11% | 85.00% | 74.61% | 76.69% | 78.77% | | | Consistently Anticipated to Not Meet Target |
| NGH | People | Sickness and absence rate | 01/03/24 | 4.53% | 5.00% | 4.11% | 5.9% | 7.68% | | | Not Consistently Anticipated to Meet Target |
| KGH | People | Sickness and absence rate | 01/04/24 | 5.11% | 5.00% | 3.84% | 5.46% | 7.08% | | | Not Consistently Anticipated to Meet Target |
| KGH | People | Vacancy rate | 01/04/24 | 12.10% | 8.00% | 8.42% | 10.31% | 12.2% | | | Consistently Anticipated to Not Meet Target |
| NGH | People | Vacancy rate | 01/04/24 | 12.91% | 8.00% | 9.48% | 11.1% | 12.72% | | | Consistently Anticipated to Not Meet Target |
| NGH | People | Turnover rate | 01/04/24 | 6.70% | 8.50% | 7.73% | 8.17% | 8.61% | | | Not Consistently Anticipated to Meet Target |
| KGH | People | Turnover rate | 01/04/24 | 7.62% | 8.50% | 9.05% | 9.65% | 10.25% | | | Consistently Anticipated to Not Meet Target |
| KGH | People | Formal procedures | 01/04/24 | 15 | | 3 | 8 | 13 | | | Consistently Anticipated to Meet Target |
| NGH | People | Formal procedures | 01/04/24 | 23 | | | 14 | | | | Consistently Anticipated to Meet Target |
| NGH | People | Roster publication performance | 01/03/24 | 38 | 42 | 33 | 39 | 46 | | | Not Consistently Anticipated to Meet Target |
| KGH | People | Roster publication performance | 01/04/24 | 42 | 42 | 27 | 36 | 44 | | | Not Consistently Anticipated to Meet Target |
| NGH | People | Time to hire | 01/03/24 | 93.00 | 91 | 99.06 | 99.06 | 99.06 | | | Not Consistently Anticipated to Meet Target |
| KGH | People | Time to hire | 01/04/24 | 51.00 | 91 | 80.93 | 80.93 | 80.93 | | | Consistently Anticipated to Meet Target |
| KGH | People | Number of volunteering hours | 01/04/24 | 2,514 | | 1030 | 1379 | 1729 | | | Consistently Anticipated to Meet Target |
| NGH | People | Number of volunteering hours | 01/04/24 | 4,196 | | 2090 | 2808 | 3525 | | | Consistently Anticipated to Meet Target |

# Mandatory training compliance

Committee Name: All

GroupName: People

MetricName: Mandatory training compliance

Date: 01/12/2019 – 01/04/2024

| 92.03% | 85.00% | 89.42% | 85.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**


**Northampton General Hospital**


| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | % of staff compliant with their mandatory training | "% of staff compliant with their mandatory training profiles" | Areas have maintained compliance. Actions plans to support improvement in resuscitation are having an impact. the key clinical areas are showing good compliance and it is the smaller areas that continue to require focus. | Targetting and flexible sessions, accurate DNA tracking | Operational pressures |
| NGH | 01/04/24 | % of staff compliant with their mandatory training | "% of staff compliant with their mandatory training profiles" | Ongoing improvement across all areas | A focus on the key areas with targeted training offerings | Current focus is having an impact. |

# Appraisal completion rates

Committee Name: All

GroupName: People

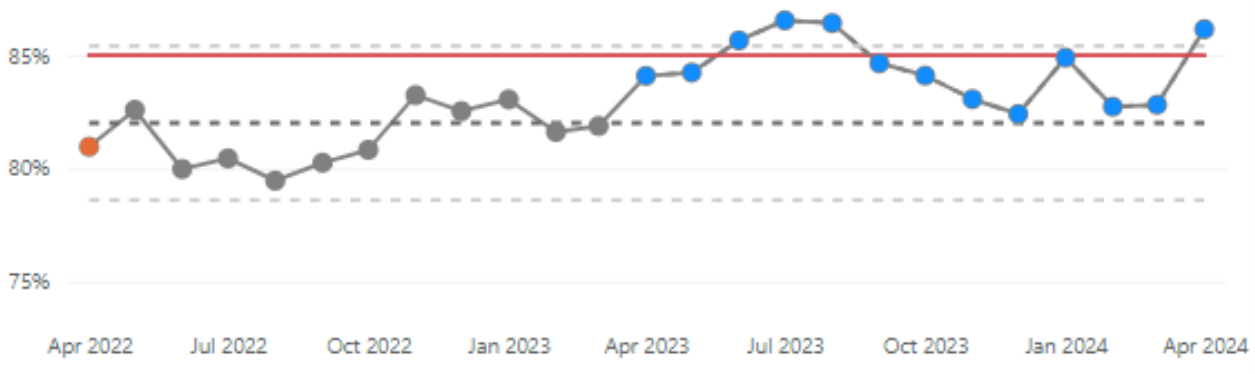
MetricName: Appraisal completion rates

Date: 01/12/2019 – 01/04/2024

| 86.15% | 85.00% | 77.11% | 85.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

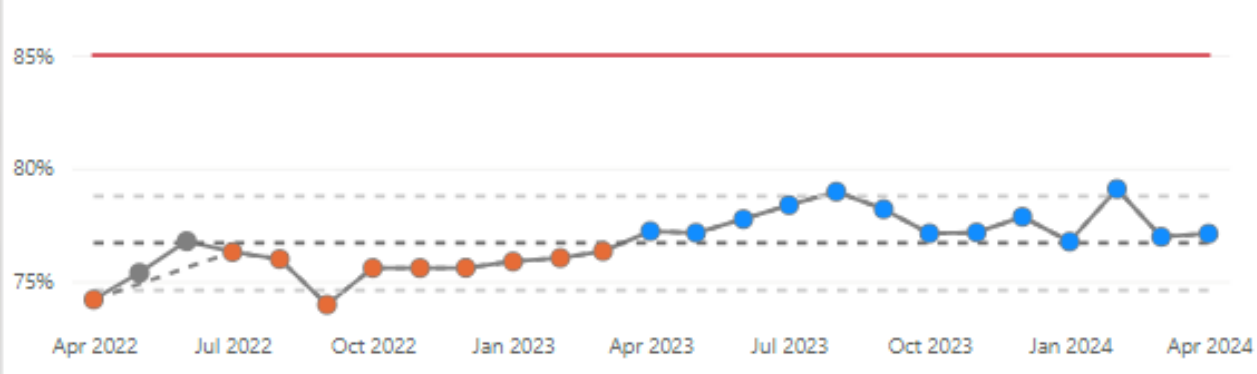
## Kettering General Hospital

Appraisal completion rates: People




## Northampton General Hospital

Appraisal completion rates: People




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | % of staff having completed their appraisal | % of staff who have had a documented appraisal in the past 12 months | Time to complete and process to record impacted by human factors that are a challenge to combat | On going focused targeting of staff member and manager, and ongoing development work. pilot of new appraisal form in progress. | Operational pressures |
| NGH | 01/04/24 | % of staff having completed their appraisal | % of staff who have had a documented appraisal in the past 12 months | Time to complete and process to record impacted by human factors that are a challenge to combat | On going focused targeting of staff member and manager, and ongoing development work. pilot of new appraisal form in progress | Operational pressures |

# Sickness and absence rate

Committee Name: All

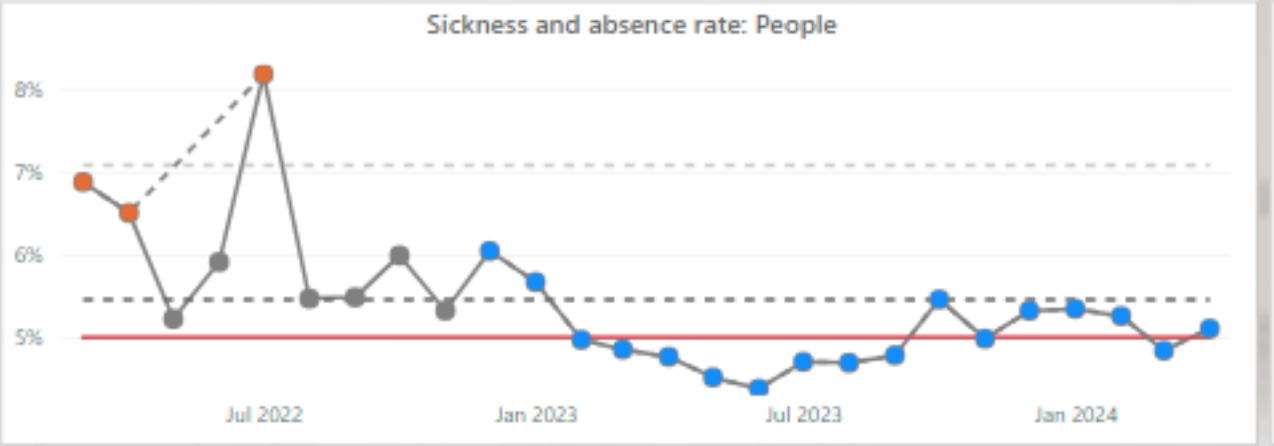
GroupName: People

MetricName: Sickness and absence rate

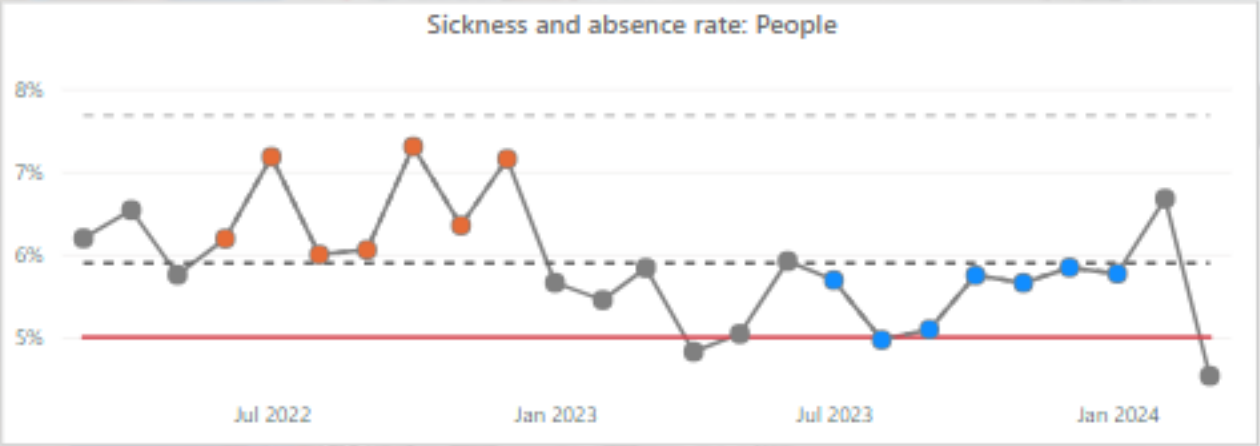
Date: 01/12/2019 – 01/04/2024

| 5.11% | 5.00% | 4.53% | 5.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**



# Sickness and absence rate

Committee Name: All

GroupName: People

MetricName: Sickness and absence rate

| 5.11% | 5.00% | 4.53% | 5.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | % of Staff absent | Over target: Currently is 5.11%, 0.11% above the adjusted target of 5%. Results are within the statistical boundary. Mean absence has increased 0.27% from previous month at 4.84%. Sickness absence rates are 0.34% up in 1 year from April 2023. | * Short term absences relate to Cough/Cold/ COVID-Flu, Gastroenteritis and Anxiety/Depression/stress.<br><br>* Long term absence (over 28 days) is divided between MSK and nervous system conditions.<br><br>* Flexible working and workplace adjustments for LTCs and neurodiverse conditions remain an issues for managers to balance/ understand with their service requirements and leading to sickness extensions.<br><br>* Distressed teams are proactively referring to OH-HWB services for interventional support in high demand clinical areas such Surgery, ED/HDU, Pain Management, Paediatrics and in non-clinical teams such as Porters. | * Targeting areas with high sickness absence (hot spots). High prevalence of very long term sick staff in health care assistant roles. Workforce analysis of impact on retention and recruitment to support and manage HCSW's has been completed. Plan to address at recruitment and through clearance the impact of mental health and role specific challenges through OH-HWB-HRBP processes.<br><br>* Actively managing attendance against absence triggers - in Long term condition/ MSK cases are being actively managed in RTW programme on therapeutic hours and being offered supportive multidisciplinary approaches to their recovery through occupational health assessment, psychological support and long-term condition support peer group attendance.<br><br>* Utilising the UHN Sickness Management, Attendance Policy including Wellbeing at Work preventative SOP to provide guidance and support to managers to preventively manage staff | * Wellbeing at Work policy has been developed as an "umbrella" approach to preventative-proactive management of staff absence and sickness including both physical and psychological wellbeing. This is the overarching strategic change of approach to developing a group harmonised attendance management policy and a preventative systematic approach to sickness management across the UHN group.<br><br>* Managers and employee health-disability toolkit of resources to be developed in collaboration between HRBPs, H&WB services and OD to ensure that there is accountability of both for both roles in managing staff sickness absence-attendance management including where employees may have behavioural as opposed to health related absence and including ACAS case studies and guidance for managers for Mental Health adjustments at work published May 2023 with case examples and recommendations being built into existing training, induction programmes and informational support for managers |

# Sickness and absence rate

Committee Name: All

GroupName: People

MetricName: Sickness and absence rate

| 5.11% | 5.00% | 4.53% | 5.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| | | | | * Management support monitoring and completing return to work meetings and health & wellbeing reviews are inconsistently being applied and can be associated with performance review rather than independent support.<br><br>* National Junior Doctor strike is likely to continue to cause increased sickness absences, distress to medical staff and the system and remain an issue going forward for the Junior Doctors.<br><br>* Unplanned absence biggest cause of additional workforce pressures / agency spend. | attendance based on psychological or physical health needs by engaging an early intervention referral to support services for assessment and treatment.<br><br>* Heads of Service Workstreams Group is focusing on HR policy review group and Sickness Absence-Availability cost efficiency POAP and sub streams of work include:<br>1) Co-ordinated strategy across the People Directorate to improving attendance from recruitment, onboarding to management induction following a preventative framework.<br>2) Managing unavailability with a prevention focused approach, using Wellbeing at Work SOP, utilising the health passport scheme at employment commencement and through career journey engaging HRBPs and managers for early intervention and workplace adaptations to reduce agency and temporary staffing.<br>3) Partnership working with staff side unions and early intervention with their clients.<br><br>* To develop with the medical leadership and medical education team a package of preventative support for doctors at all levels of training and employment to enhance their psychological wellbeing and to engage with estates and facilities services to manage practical impacts of rotational shifts on their wellbeing as per the BMA 5 Priorities for Improving Wellbeing at Work guidance (2024). | to learn from.<br><br>* A review of the HSE managers toolkit for workplace stress management with the NHS Employers sickness absence toolkit to identify gaps in support, systems and process to follow.<br>* Neurodiversity Working Group led by Head of OD in collaboration with Head of H&WB to scope out neurodiverse support pathways for diagnosed and self-diagnosed staff including awareness raising for employees, managers and HRBPs to facilitate early intervention and support where needed.<br><br>* Continue to provide UHN Group wide Health & Wellbeing Conversations training and staff suicide risk management training in a 6 week rolling programme to prevent the impact of mental and physical health deterioration of staff on their service delivery and absences and to engage leaders in their proactive management of staff wellbeing. |

# Vacancy rate

Committee Name: All

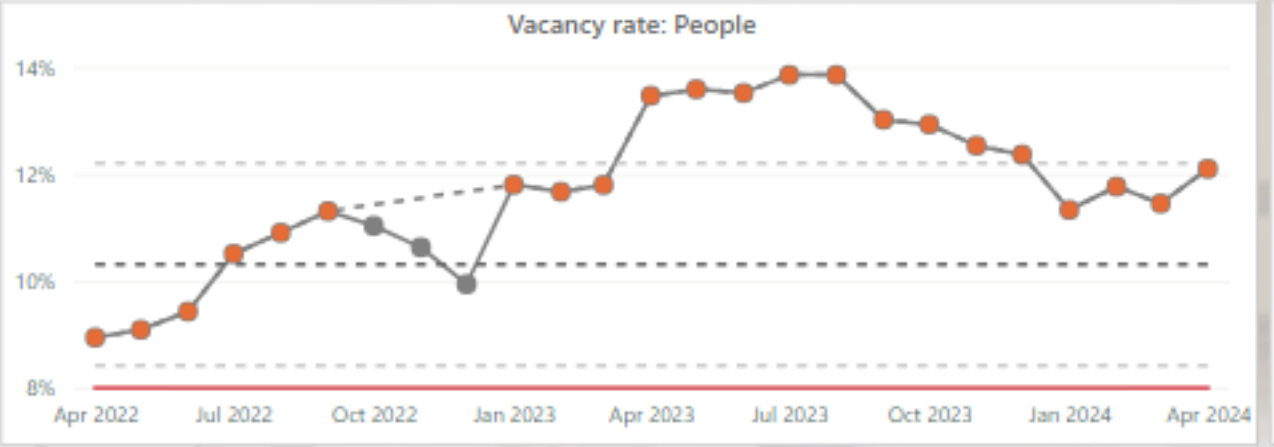
GroupName: People

MetricName: Vacancy rate

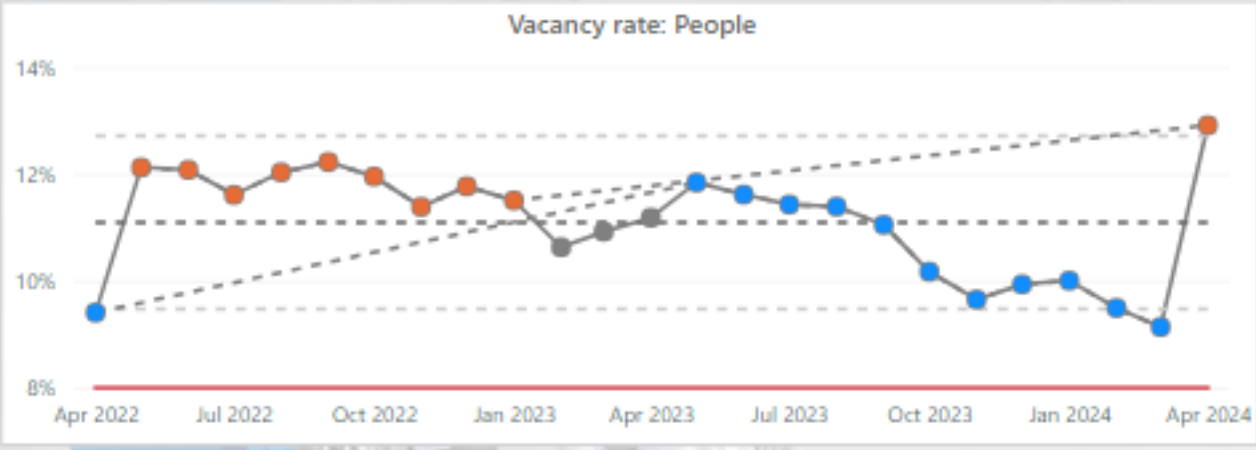
Date: 01/12/2019 – 01/04/2024

| 12.10% | 8.00% | 12.91% | 8.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**



# Vacancy rate

Committee Name: All

GroupName: People

MetricName: Vacancy rate

| 12.10% | 8.00% | 12.91% | 8.00% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| NGH | 01/04/24 | % difference between budgeted establishment and actual establishment | The value tells us the percentage of budgeted posts that are vacant. | Particular staff group hotspots for vacancy rates continue to be AHPs, Additional Clinical Services (HCAs), Additional Professional Scientific and Technical and Estates and Ancillary. Factors impacting these particular areas relate to a shortage of staff nationally. and for non qualified staff comparability of pay rates to other industry sectors in the job market and associated need to develop an attraction strategy. | Integrated business workforce plans for the Group have been submitted and encompass a variety of workforce efficiency schemes. Work Has been undertaken at NGH under the Transformation project to refine recruitment processes and vacancy management including system configuration of Trac, training needs analysis of team, reference management, recruitment in box management and transitioning team to Divisional recruitment support function.<br>As part of developing an attraction strategy, content for a resourcing microsite has been developed and attraction engagement videos are being developed.<br>HCA recruitment events and assessment centres continue across the Group to reduce vacancies and remove agency use at NGH. As part of this career pathways have been developed for HCAs to attract candidates into the roles. | Weekly meetings are in place to monitor recruitment activities for each Division in a way in which they are mapped to long terms agency use and to ensure that any delays are unblocked and minimised. Time to Hire reporting is broken down into each stage of the recruitment process and monitored accordingly enabling targeted intervention and support as and when required. Temporary staffing has now been centralised and an escalated rate SOP being approved to better control the need to fill vacancy gaps as and when the need arises. |

# Turnover rate

Committee Name: All

GroupName: People

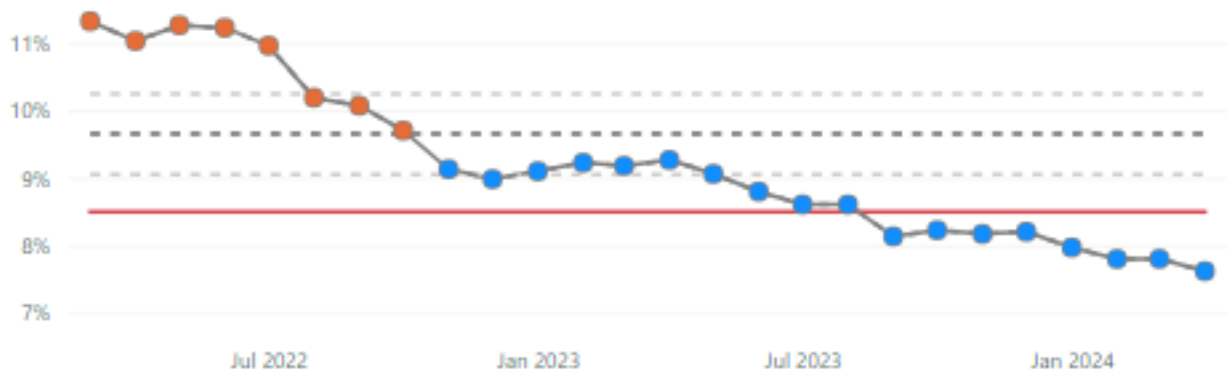
MetricName: Turnover rate

Date: 01/12/2019 – 01/04/2024

| 7.62% | 8.50% | 6.70% | 8.50% |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

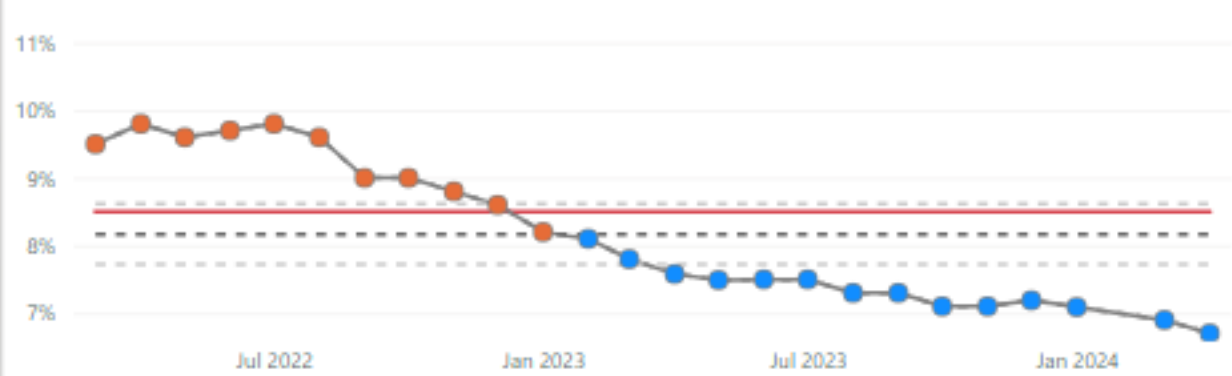
**Kettering General Hospital**

Turnover rate: People




**Northampton General Hospital**

Turnover rate: People




| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| NGH | 01/04/24 | % of staff leaving the organisation over a 12 month rolling period | Number of leavers as a proportion of total headcount. | Issues relate to the risk of those nearing retirement age wishing to retire. Issues also relate to ensuring greater flexibility for working patterns and ensuring staff engagement. Despite these challenges the Trusts turnover rate has remained relatively stable and achieved target on a consistent basis. | Having successfully piloted rolled out in a number of clinical areas in order to try to better facilitate flexible working opportunities and support work/life balance flexible rostering is being rolled as and when the ability to do so presents itself. System wide collaboration is on going.<br>Staff survey results have been widely communicated and Divisions are in the process of being supported to address the key findings from the survey results. | Range of Health & Well-being initiatives in place. Career Development opportunities continue to be developed and promotion of agile/flexible working and retire and return options to retain workforce. Turnover rates are routinely reported on and monitored at Trust, divisional and departmental levels. |

# Formal procedures

Committee Name: All

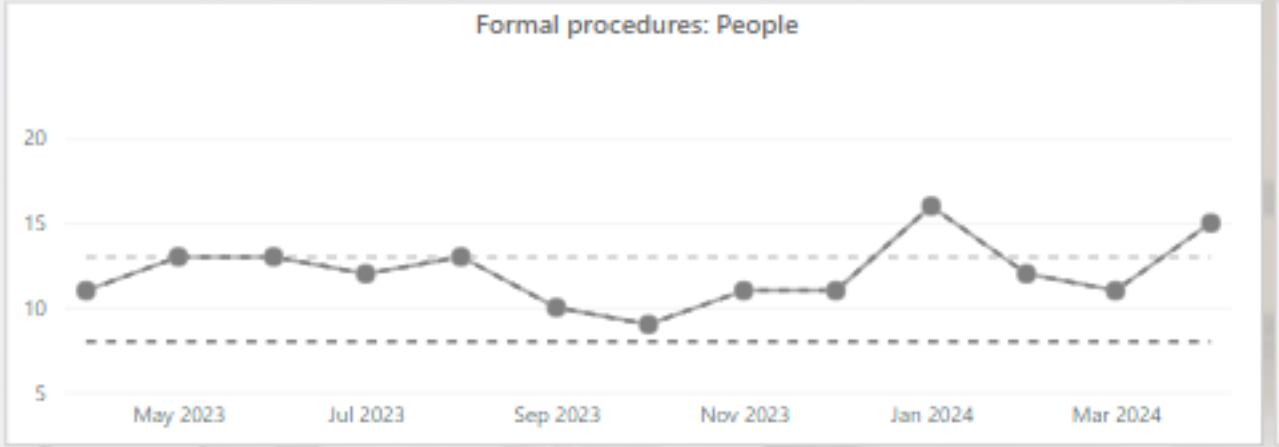
GroupName: People

MetricName: Formal procedures

Date: 01/12/2019 – 01/04/2024

| 15 | | 23 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**


| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Number of formal complaints – active and open | There has been a reduction in open formal cases both in Disciplinary and Grievance from April to May. | A number of cases have been delayed to long term sickness/fitness to attend/engage in formal processes. | Engaging where appropriate with Trade Union representatives to facilitate engagement in formal processes. | Occupational Health Referrals have been made where appropriate to assess individuals capacity to engage with formal processes. |

# Roster publication performance

Committee Name: All

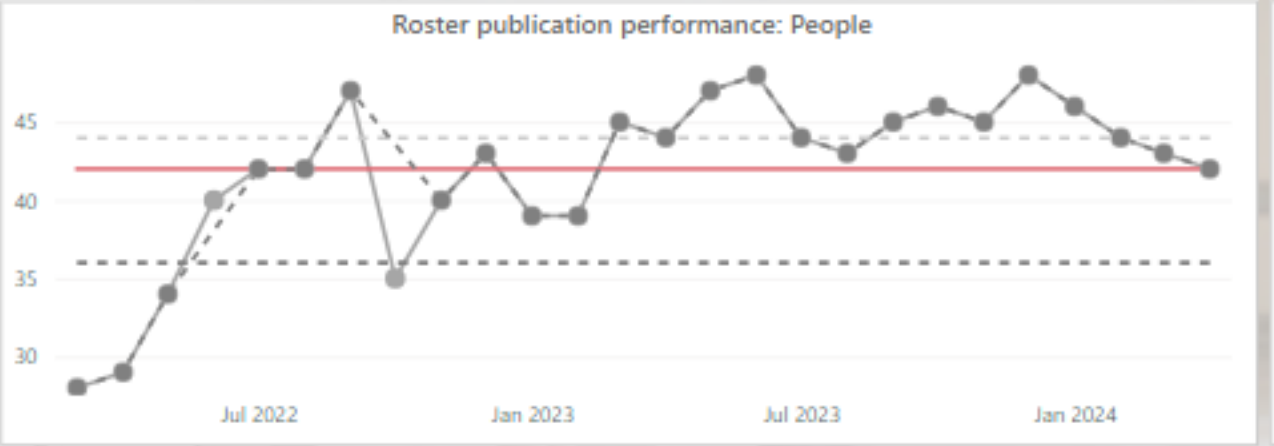
GroupName: People

MetricName: Roster publication performance

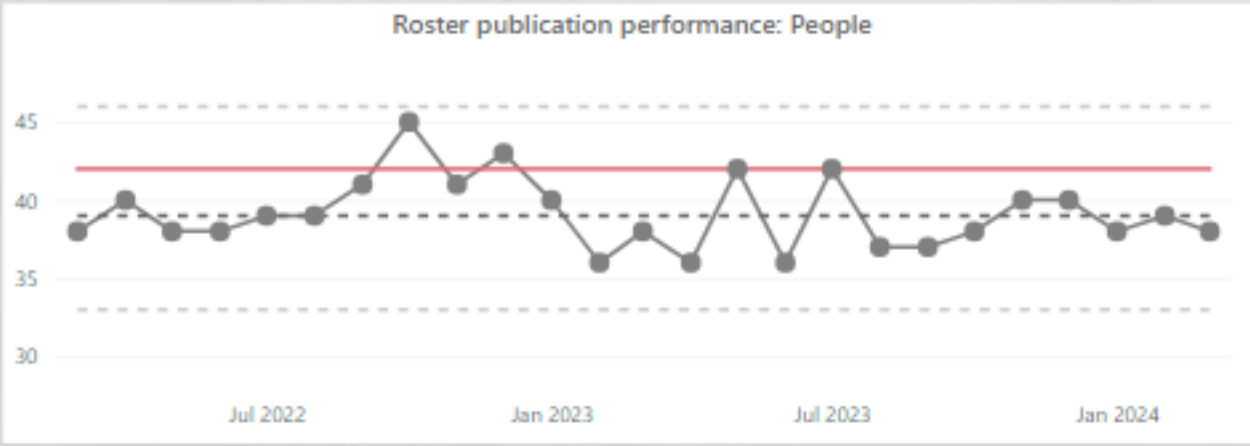
Date: 01/12/2019 – 01/04/2024

| 42 | 42 | 38 | 42 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**




**Northampton General Hospital**



# Time to hire

Committee Name: All

GroupName: People

MetricName: Time to hire

Date: 01/12/2019 – 01/04/2024

| 51.00 | 91 | 93.00 | 91 |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**


**Northampton General Hospital**

# Number of volunteering hours

Committee Name: All

GroupName: People

MetricName: Number of volunteering hours

Date: 01/12/2019 – 01/04/2024

| 2,514 | | 4,196 | |
|---|---|---|---|
| KGH: Current Value | KGH: Current Target | NGH: Current Value | NGH: Current Target |

**Kettering General Hospital**

Number of volunteering hours: People


**Northampton General Hospital**

Number of volunteering hours: People


| Site | Date | Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|---|---|
| KGH | 01/04/24 | Number of volunteering hours | 2514 | Operational pressures | Currently advert supports the Charity | Reduction in Staff which will futher impacted over the next 4 weeks due to annual leave |
| NGH | 01/04/24 | Number of volunteering hours | 4196 | Operational pressures | Concentrate on the retention of current volunteers | |

# Cover sheet

| | |
|---|---|
| Meeting | University Hospitals of Northamptonshire NHS Group (UHN): Boards of Directors of Kettering General Hospital and Northampton General Hospital meeting together in public |
| Date | 5th June 2024 |
| Agenda item | 8 |

| | |
|---|---|
| Title | May 2024 CQC report and response |
| Presenter | Pamela Smith – Deputy Chief Nurse |
| Author | Pamela Smith – Deputy Chief Nurse |

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

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

| Reason for consideration | Previous consideration |
|---|---|
| In December 2023 the CQC undertook an unannounced Comprehensive Inspection where they inspected the following 4 core services;<br>Urgent and emergency care<br>Medical Care<br>Surgery<br>Children and young people's services (CYP)<br><br>The inspection was undertaken against the CQC domains with the exception of Well-Led which was not carried out as part of this inspection.<br>This paper invites the Boards to receive the report and for the KGH Board of Directors to indicate its | CQC inspection reports from:<br>Maternity March 2024<br>CYP April 2023<br>CYP December 2022 |

| | |
|---|---|
| assurance in respect of the Trust's response and action plan, having particular regard to next steps for the service against the CQC 'must' and 'should' Dos. | |

## Executive Summary

The report highlighting the CQC findings relating to the visit undertaken in December 2023 was published on 23rd May 2024. This report followed a 2-day inspection in December 2023 and is available to view here:
https://www.cqc.org.uk/location/RNQ51?referer=widget3

The report outlines the recent inspection visit which undertook a review of the following 4 core services;
Urgent and emergency care
Medical Care
Surgery
Children and young people

All 4 services were reviewed against the domains of Safe, Effective, Caring and Responsive. Well-Led was not reviewed as part of this visit and has been deferred until later in 2024 when it will be undertaken using the new CQC well-led methodology.

The report highlights that improvements in children and young person's services were noted in comparison to the review undertaken in December 2022 where the children and young person's service was rated as "Inadequate". As outcome from this inspection the rating for the Children's and Young Peoples services has now improved to "Requires Improvement".

The overall Ratings for the trust did not change and remains as Requires Improvement.

All divisions have been provided with oversight of the report and work has commenced to focus on action plans relating to all Should Do and Must Dos.

An oversight meeting was to be held by the Deputy CNO on the 31/05/2024 to ensure staff have been informed of the findings and have engaged in the actions required to make improvements. This meeting will track progress and provide support with ongoing plans in readiness for submission to the CQC by the 11th of June.

An overarching Quality Improvement Plan is currently being developed to ensure all MUST and SHOULD do recommendations are embedded by the divisions and services. The plans will be monitored and tracked through the Monthly Journey to Outstanding meetings (Chaired by the Chief Nursing Officer) who will be accountable officer for the plan.

Exceptions on the progress of the Improvement Plan will be reported to the Clinical Quality, Safety and Performance Committee to ensure continuing Board-level oversight.

Challenges were made by the organisation on receipt of the report for factual accuracy and, despite not all challenges being addressed in the final report, the Trust fully accepts the recommendations and fully endorses the final report.

| |
|---|
| **Recommendation** – The KGH Board of Directors is asked to receive, review and note the final CQC report and to indicate its assurance, through the Clinical Quality, Safety and Performance Committee, in respect of the Trust's response, as set out in the associated Quality Improvement plan. |
| Appendices |
| None |
| Risk and assurance |
| Non delivery of National and Local recommendations and improvements in services which compromises our Trust strategic objectives and may result in increased claims, poor patient outcomes/ experience and Trust reputation. |
| Financial Impact |
| Potential for increased/changes to workforce estates and equipment |
| Legal implications/regulatory requirements |
| NA in relation to this inspection |
| Equality Impact Assessment |
| This is applicable to all staff within Kettering General Hospital NHS foundation trust and all who access services and care. |

# Cover sheet

| | |
|---|---|
| Meeting | Boards of Directors of Northampton General Hospital NHS Trust (NGH) and Kettering General Hospital NHS Foundation Trust (KGH) meeting together |
| Date | 5 June 2024 |
| Agenda item | 9 |

| | |
|---|---|
| Title | Review of the KGH Constitution |
| Presenters | Richard Apps, Director of Corporate and Legal Affairs<br>Trevor Shipman, Vice-Chair and Senior Independent Director |
| Author | Richard May, Company Secretary |

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

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

| Reason for consideration | Previous consideration |
|---|---|
| Changes to the Constitution require the approval of the KGH Board and Council of Governors, therefore these proposals will also be submitted to the Council of Governors for consideration at its meeting on 6 June 2024. | None relating to these proposals – last Constitutional changes approved by KGH Board of Directors in November 2020. |

## Executive Summary

The Board of Directors is invited to consider and approve changes to the Trust's Constitution, brought forward following a review undertaken by a Working Group comprising Governors and the Senior Independent Director.

The Constitution is reviewed every three years, and the changes proposed reflect current practice and are designed to clarify and simplify how KGH is governed, resulting in a more logical, accessible and user-friendly document which reflects and promotes good governance and the local, national, legislative and structural contexts in which the Trust operates.

The KGH Board of Directors is recommended to **APPROVE** the revised Constitution, comprising the proposed changes to the Constitution set out in the report and Appendices A-D, and to authorise the Company Secretary to incorporate the approved changes into a revised edition for notification to NHS England, publication on the Trust's website and dissemination within the organisation.

Changes to the Constitution require the approval of the Board and Council of Governors, therefore these proposals will also be submitted to the Council of Governors for consideration at its meeting on 6 June 2024.

## Appendices

Appendix A: Schedule of changes to the Constitution

Appendix B: Revised draft KGH Constitution

Appendix C: Proposed addendum to the Constitution: Process for the removal of a Governor

Appendix D: Proposed addendum to the Constitution: Revised Procedure for the approval of significant transactions

## Risk and assurance

No direct implications relating to risks within the Board Assurance Framework.

## Financial Impact

None.

## Legal implications/regulatory requirements

The requirement to have a Constitution is specified in Schedule 7 to the NHS Act 2006.

## Equality Impact Assessment

Neutral

# Paper

## Situation

A Constitution Review Working Group has reviewed the Trust's Constitution. The Group, comprising Trevor Shipman (Senior Independent Director), Simon Baylis (Lead Governor), Cath Chisholm (Staff Governor), David Harland and Rashmi Shah (Public Governors), supported by the Trust Board Secretary, met on three occasions during March 2024 to discuss and make proposals in respect of a number of changes to the Constitution.

## Background

KGH adopted a Constitution upon attaining Foundation Trust status in 2008, agreeing a number of amendments in November 2020. In approving these changes, KGH committed to three-yearly reviews thereafter.

## Assessment

The Working Group has reviewed the format and content of the Constitution and proposes a number of changes. These are set out in full in the schedule at **Appendix A attached** and the following significant items brought to the Board's attention:

To:

- Provide flexibility for the Trust to hold its Annual Members' Meeting by 31 December each year (Article 10.1)
- Remove restrictions on Governors being members, Governors or Directors of other Foundation Trusts or NHS bodies: the working Group considered this to be an unnecessarily restrictive clause and that membership of multiple organisations could be governed through effective management of declarations of interest (Article 19.2.1).
- Require Governors to confirm acceptance of the Code of Conduct within 30 days of election of appointment to the Council (Article 19.2.9);
- Adopt of a new procedure for the removal of a Governor to ensure equity and the principles of natural justice, full investigation and fair hearing are applied (Article 19.2.23 and Appendix C to this report);
- Clarify the Governors' statutory role and procedure for the appointment of the Trust Chair and Non-Executive Directors (Articles 23.2-23.4)
- Provide grounds upon which Notices of Motion, submitted to the Board of Directors or Council of Governors, can be rejected (Annex 4, paragraph 4.6.2 and Annex 5, Paragraph 3.7iii)
- Clarify provisions for the Chair and Non-Executive Directors to serve third terms of office (Annex 5, paragraph 2.3)
- Make changes for consistency and alignment with NGH Standing Orders to reflect the Boards meeting together (Annex 5, paragraphs 3.11 and 3.17)
- Formally dissolve the Charitable Funds Committee following the transfer of its assets to the Northamptonshire Healthcare Charitable Fund in 2021 (Annex 5, paragraph 4.7.3)

*Mergers and Significant Transactions (Article 42)*

Foundation Trusts have discretion to define Significant Transactions requiring approval of the Council of Governors and adopted, as part of the 2020 review, a definition based on NHS Improvement (now NHS England) which has now been superseded. These criteria related to the percentage impact of the transaction on the Trust's gross assets, income and expenditure.

The current definitions focus on the financial implications of transactions. The working group reviewed similar policies from other trusts and indicated its preference for a revised procedure which did not formally define significant transactions within its Constitution, but instead provides guidance setting out the types of transactions that would be likely to fall within the definition. The revised policy and procedure also provides advice on the types of issues Governors should be seeking assurance on in approving significant transactions (which also require Board of Directors approval). This advice recognises that the Board of Directors remains the statutory decision maker. The Board is therefore recommended to adopt a revised procedure for identifying and approving Significant Transactions by the Board of Directors and Council of Governors (Article 42.3 and Appendix D to this report), which takes these factors into account.

*Composition of the Council of Governors*

The working group recommended no changes to the composition of the Council of Governors at the present time. Noting, however, a number of stakeholder governor positions which have been vacant for long periods, the group undertook to carry out further analysis and engagement to assess the value added by existing Stakeholder Governor seats, and to bring recommendations to the Board and Council in due course.

## Recommendation

The KGH Board of Directors is recommended to **APPROVE** the revised Constitution the proposed changes to the Constitution set out in the report and Appendices A-D, and to authorise the Company Secretary to incorporate the approved changes into a revised edition for notification to NHS England, publication on the Trust's website and dissemination within the organisation.

| SECTION | Page and paragraph | Description of proposed change | Rationale for proposed change |
|---|---|---|---|
| **ARTICLES OF THE CONSTITUTION** | 6, 7.1 | **Amended wording of Clause 7.1:** An individual who is employed by the Trust under a contract of employment with the Trust shall (delete 'may') become or continue as a Member of the Trust upon appointment provided: | To reflect that all colleagues automatically become members of trust unless they opt out (subject to 7.11-7.12 below) |
| **ARTICLES OF THE CONSTITUTION** | 6, 7.2 | **Delete** 'appropriate class of' the Staff Constituency | There is a single Staff Constituency. |
| **ARTICLES OF THE CONSTITUTION** | 6, 7.6 | **New Clause 7.6:** Trust volunteers shall be entitled to join the Staff Constituency, provided that they have been continually engaged by the Trust for at least 12 months. | To reflect current practice. Volunteers may choose to join a Public Constituency instead, where the 12-month restriction doesn't apply. |
| **ARTICLES OF THE CONSTITUTION** | 7, 10.1 | Delete 'no later than 30 September each year' to hold Members' Meeting 'by 31 December' | The Trust can't hold its annual members' meeting until its annual report has been Laid before Parliament; depending on national deadlines, 30 September may not be feasible (though note that 30 September is a statutory deadline for the NGH annual general meeting) |
| **ARTICLES OF THE CONSTITUTION** | Throughout document | Consistency of language – refer to 'Chair' not 'Chairman' and 'Board of Directors' not 'Trust Board' | |
| **ARTICLES OF THE CONSTITUTION** | Throughout document | Consistency of language – refer to 'Governors' not 'Council Members' | To avoid confusion between the roles of Governor and Foundation Trust Member |
| **ARTICLES OF THE CONSTITUTION** | 9, 19.2.1 | Delete 'or a Member, Council Member, Governor or Director of another NHS Foundation Trust or any other NHS body, unless such FT or NHS body is an appointing organisaton, which is appointing them under this Constitution'. Clause to read 'A person may not become a Governor of the Trust, and if already holding office will immediately cease to do so, if they are a director of the Trust.' | This is considered to be an unnecessarily restrictive clause; membership of multiple organisations can be governed through effective management of declarations of interest. |
| **ARTICLES OF THE CONSTITUTION** | Throughout document | Consistency of language – refer to 'they/their' not 'him/his' | In pursuance of the Trust's Public Sector Equality Duty |
| **ARTICLES OF THE CONSTITUTION** | 10, 19.2.9 | **Add '**within 30 days of election or appointment to the Council' (for Governors to confirm acceptance of the Trust's Code of Conduct). | To ensure timely completion and submission of acceptance of the Code of Conduct |
| **A**RTICLES OF THE CONSTITUTION | 10, 19.2.12 | Governors may be 'removed from the Council of Governors, following an approved procedure.' | The working group supported the development of a procedure, which is set out at Appendix C and will form an Addendum to the Constitution |
| **ARTICLES OF THE CONSTITUTION** | 11, 19.4.3 | Add [Chair] 'confirms in writing' [that they are satisfied that a Governor has reasonable grounds for failure to attend meetings]. | To clarify that approval of a dispensation request must be given in writing. |
| **ARTICLES OF THE CONSTITUTION** | 12-13, 23.2-23.4 | **APPOINTMENT AND REMOVAL OF NON-EXECUTIVE DIRECTOS (INCLUDING CHAIR AND DEPUTY CHAIR) Rewording – 'vacant roles will be advertised' (23.2), 'candidates shall be sought to fill vacancies' (23.3) '**At a General Meeting, the Council of Governors shall either appoint the recommended individual or invite the Group to make an alternative recommendation, with accompanying reasons, . (23.4) | Appointment provisions updated to reflect current practice - this is a governor-led process. |
| **ARTICLES OF THE CONSTITUTION** | 14, 26.3 | Delete reference to 'Chief Executive' | CEO advises but is not a member of the committee appointing executive directors. |
| **ARTICLES OF THE CONSTITUTION** | 16, 39.2 | Revised wording: The seal shall not be affixed and attested except under the authority of an Executive Director, in accordance with approved procedure. | Cross references existing procedure. |
| **ARTICLES OF THE CONSTITUTION** | 18, 40 | Delete references to 'Monitor' | Monitor's functions now carried out by NHS England |
| **ARTICLES OF THE CONSTITUTION** | 19, 42.3 | Significant transactions: reference to an amended procedural document and amendment to this article to clarify that the Trust will no longer have a set definition of significant transactions, but rather will treat will case on its merit based on a number of criteria. | The Trust's current definition of a Significant Transaction is based on NHS England guidance |

| SECTION | Page and paragraph | Description of proposed change | Rationale for proposed change |
|---|---|---|---|
| | | | which has been superseded. The working group reviewed similar policies from other trusts and indicated its preference for a revised procedure which did not formally define significant transactions within its Constitution, but instead provides guidance setting out the types of transactions that would be likely to fall within the definition. The revised policy and procedure also , provides advice on the types of issues Governors should be seeking assurance on in approving significant transactions (which also require Board of Directors approval). This advice recognises that the Board of Directors remains the statutory decision maker. |
| **ANNEX 1 – THE PUBLIC CONSTITUENCY** | 20 | Change title of Constituency from 'Rest of UK' to 'Rest of England' | For clarity |
| **ANNEX 4 – COUNCIL OF GOVERNORS STANDING ORDERS** | 24, Foreword | Refer to 'Managing Conflicts of Interest Policy' | To reflect correct policy title |
| **ANNEX 4 – COUNCIL OF GOVERNORS STANDING ORDERS** | 27, 2 | Refer to 'Code of Governance for NHS Provider Trusts' | To reflect correct title of new 2023 Code |
| **ANNEX 4 – COUNCIL OF GOVERNORS STANDING ORDERS** | 27, 3.3 | Delete [Chair's] 'absence *from England and Wales'* | Unnecessary prescription |
| **ANNEX 4 – COUNCIL OF GOVERNORS STANDING ORDERS** | 28, 4.1.4 | Revised wording: 'In addition, the Trust shall hold an annual meeting…' | Reflects current practice |
| **ANNEX 4 – COUNCIL OF GOVERNORS STANDING ORDERS** | 28. 4.3.1 | Delete 'or sent by post to the usual place of residence of such Council Member' | Covered by 'communicated to' |
| **ANNEX 4 – COUNCIL OF GOVERNORS STANDING ORDERS** | 28, 4.3.2 | Delete 'clear' | 28 days' notice is sufficient – 28 'clear days' means 30 days in practice and is a confusing term |
| **ANNEX 4 – COUNCIL OF GOVERNORS STANDING ORDERS** | 29, 4.6.2 | **New paragraph proposed:**<br>**4.6.2** The Chair, having regard to the advice of the Company Secretary, may reject a Motion if it:<br>(a) is not about a matter for which the Trust has a responsibility;<br>(b) is defamatory, frivolous or offensive;<br>(c) requires the disclosure of confidential or exempt information;<br>(d) Would, if carried, commit the Council to a course or courses of action contrary to agreed procedures or outside its authority to act. | This provides a safeguard, noting that the submission off formal Notices of Motion is rare. |
| **ANNEX 4 – COUNCIL OF GOVERNORS STANDING ORDERS** | 30, 4.8.2 | **VOTING: Add** 'or electronic' (ballot) | Making specific provision for electronic ballots |
| **ANNEX 4 – COUNCIL OF GOVERNORS STANDING ORDERS** | 30, 4.8.3 | **VOTING: Reword** 'other than secret (delete paper) ballot' | To reflect that secret ballots maybe be paper or electronic |
| **ANNEX 4 – COUNCIL OF** | 30, 4.9.3 | A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the ~~Directors~~Audit | For consistency with paragraph 4.9.4 |

| SECTION | Page and paragraph | Description of proposed change | Rationale for proposed change |
|---|---|---|---|
| **GOVERNORS STANDING ORDERS** | | Committee. | |
| **ANNEX 4 – COUNCIL OF GOVERNORS STANDING ORDERS** | 30. 4.10 | Reword: These Standing Orders shall be amended in accordance with Clause 41 of this Constitution (above), provided that the amendments do not contravene statutory provisions | To simplify and clarify the process for changing Standing Orders, which is a change to the Constitution itself. |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 39, 1.2 | Delete definitions from glossary: Clinical Governance Risk Management Committee, Commissioning, Funds held on Trust | None of these terms are used in the document so it is not necessary to define them here |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 41, 2.1 | Composition of the Board: The number of directors may be increased with the approval of the Board **and, in the case of Non-Executive Directors, the Council of Governors,** provided always that at least half of the **voting members of the Board**, plus the Chair, comprises NEDs determined by the Board to be independent | Amends in bold to reflect the Governors' statutory role in NED appointments |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 42, 2.2.2 | Delete reference to 'Chief Executive' and refer to Remuneration and Appointments Committee | Correct committee title. CEO isn't a voting member of the remuneration committee. |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 42, 2.2.3 | Grounds for the removal of the Chair and Non-Executive Directors from office:<br>(i) Add 'Board and Board Committee' attendance (over a three month period)<br>(vii) 'irreconcilable' delete 'terminal' breakdown in essential relationships<br>(viii) insert references to Remuneration and Appointments committee for exec directors and Appointments and Remuneration Group for non-execs | (i) Clarify scope<br>(vii) 'terminal' not an appropriate word to use in a hospital setting<br>(viii) to reflect current practice and statutory provisions |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 42, 2.3 | New wording: he ~~Chairman~~Chair and Non-Executive Directors will hold a term of 3 years. If appropriate a further term may be served. Any decision to extend a term beyond six years should subject to rigorous review comprising ~~If appointment for a 3rd term is sought a "particularly rigorous" review is required, with~~ annual appointments thereafter. The Chair and Non-Executive Directors should not remain in post beyond nine years from the date of their first appointment to the Board of Directors, except where a short extension may be appropriate to facilitate effective succession planning and the development of a diverse board, particularly where, on appointment, a chair was an existing non-executive director. The need for such extensions should be clearly explained and should be agreed with NHS England. A Non-Executive Director becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as Chair. | Taken from section 4.3 of the NHS Provider Code of Governance. |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 42-43, 2.4 | New wording: 'The Board shall make a statement within its Annual Report regarding the independent status or otherwise of each Non-Executive Director.'<br><br>Delete paragraph regarding audit committee chair independence. | Reflects current practice |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 44, 2.5 (6) | Add reference to Lead Governor | Reflects Lead Governor's role in Chair's appraisal |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 46, 2.6.2 | New wording: The Trust shall comply with Section B of the NHS Provider Code of Governance in ensuring an appropriate division of responsibilities within the Board of Directors.<br><br>Non-Executive Directors may, ~~at the Trust's expense~~request the Audit Committee to, seek external advice or appoint an external adviser on any material matter of concern provided the ~~decision~~ request to do so is a collective one by the majority of Non-Executive Directors. | Reflects current practice and Audit Committee Terms of Reference |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 46, 3.2(1) | **Notice of Meetings:** Delete 'sent by post…', add 'communicated' | For consistency and clarity |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 47, 3.3 | Revised wording: The agenda and supporting papers will be sent to (Board) members seven days before the meeting. With the Chair's agreement, additional papers may be issued no later than three days before the meeting. | Amend – see document |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING** | 49, 3.7(ii) | Add: ii) The Chair, having regard to the advice of the Company Secretary, may reject a Motion if it:<br>(a) is not about a matter for which the Trust has a responsibility; | This provides a safeguard although, in reality, the likelihood of formal Notices of Motion being |

| SECTION | Page and paragraph | Description of proposed change | Rationale for proposed change |
|---|---|---|---|
| **ORDERS** | | (b) is defamatory, frivolous or offensive;<br>(c) requires the disclosure of confidential or exempt information;<br>(d) Would, if carried, commit the Board to a course or courses of action contrary to agreed procedures or outside its authority to act. | submitted is low. |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 51, 3.11 | Quorum: Add paragraphs:<br>ii. A non-voting executive or **Associate** non-executive director or an officer in attendance for an Executive director (Officer Member) but without formal acting up status does not count towards the quorum.<br>iii. If after 15 minutes from the time appointed for a meeting of the Board of Directors to take place no quorum is present, then there shall be no meeting. Likewise, if during a meeting the Chair, after counting the number of directors present, declares that there is no quorum, the meeting shall stand adjourned to a time arranged by the Chair or to the next ordinary meeting of the Board of Directors. | For consistency with NGH Standing Orders |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 54, 3.17 | Add new section re. Admission of Public and Press<br><br>**Admission of Public and the Press**<br><br>1. The public and representatives of the press shall be entitled to attend all formal meetings of the Trust (Board) but shall be required to withdraw upon the Trust (Board) resolving in accordance with the following:<br><br>*"A body may, by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted……" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960)*<br><br>2. The Chair shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:<br><br>*"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public" (utilising the power given in section 1(8) Public Bodies (Admission to Meetings) Act 1960)*<br><br>3. Nothing in these Standing Orders shall require the Trust (Board **of Directors**) to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board. | For consistency with NGH Standing Orders |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 56, 4.7.2 | Update references to Remuneration and Appointments Committee | To reflect changes to Terms of Reference |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 56, 4.7.3 | Delete reference to Charitable Funds Committee | Assets of the charity were transferred to the Northants Health Charity in April 2021. |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 57, 5.4.7 | Add 'notified in writing by the director concerned' | To clarify that directors must authorise alternative arrangements for delegation in writing. |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING** | 58, 5.6 | Duty to report non-compliance with SO and SFI: new wording: If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, | Appropriate role for the audit committee. |

| SECTION | Page and paragraph | Description of proposed change | Rationale for proposed change |
|---|---|---|---|
| **ORDERS** | | shall be reported to the **Audit Committee**, and to the Board at the next available opportunity. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible. | |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 60, 7.1.5 | Board members' directorships of companies likely or possibly seeking to do business with the NHS **will** be published **on the Trust's website.** | Reflects current practice (TYPO!) |
| **ANNEX 5 – BOARD OF DIRECTORS STANDING ORDERS** | 60, 7.2.2 | These details (register of interests) will be kept up to date by means of an **ongoing** (delete annual) review of the register in which any changes to interests declared will be incorporated **upon notification to the Trust Board Secretary** | Reflects current practice |
| **ANNEX 7 – STANDARDS OF BUSINESS CONDUCT** | 65-67 | Updated references to 2023 Code of Governance and Managing Conflicts of Interest Policy | Reflects updated policy framework |
| **ANNEX 7 – STANDARDS OF BUSINESS CONDUCT** | 67, 6 | Revised wording: In addition, ~~Council Members~~ Governors, ~~in undertaking the role of Council Members of this NHS Foundation Trust~~ shall sign a declaration stating that they have read, understood and agreed to comply with the Kettering General Hospital NHS Trust Foundation Trust's Code of Conduct for Council Governors, agreeing also to inform the Trust Board Secretary if at any time, they become unable to comply with the Code or any part of the Code. | Reflects current practice and removes the need to reproduce sections of the Code here. |
| **ANNEX 7 – STANDARDS OF BUSINES CONDUCT** | 67, 6.1-6.7 | Delete | Covered in (6) above. |

# Kettering General Hospital

# NHS Foundation Trust

# Constitution

**Revised November 2023 – Board of Directors / Council of Governors: 5-6 June 2024**

| Date | Brief Summary of changes |
|---|---|
| June 2024 | Three-yearly review – principal changes described in Board and Council cover papers to 5-6 June meetings |
| | |
| | |

**Table of Contents (subject to review following approval)**

**Paragraph** **Page**

## 1. NAME

1.1 The name of the foundation trust is the Kettering General Hospital NHS Foundation Trust (the Trust).

## 2. PRINCIPAL PURPOSE

2.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

2.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

2.3 The Trust may provide goods and services for any purpose related to:

2.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

2.3.2 the promotion and protection of public health

2.4 The Trust may also carry out activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry out its principal purpose.

## 3 POWERS

3.1 The powers of the Trust are set out in the 2006 Act, subject to any restrictions in the Terms of Authorisation.

3.2 The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

3.3 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

## 4 MEMBERSHIP AND CONSTITUENCIES

The Trust shall have Members, each of whom shall be a Member of one of the following constituencies:

4.1 A Public Constituency

4.3 A Staff Constituency

## 5 APPLICATION FOR MEMBERSHIP

5.1 An individual who is eligible to become a Member of the Trust may do so on application to the Trust (See also paragraph 7).

## 6 PUBLIC CONSTITUENCY

6.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a Member of the Trust.

6.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the Public Constituency.

6.3 The minimum number of Members in each area for the Public Constituency is specified in Annex 1.

6.4 Where a Member of a Public Constituency ceases to live permanently in the area of the Public Constituency of which they are a Member they shall forthwith advise the Trust that they are no longer eligible to continue as a Member and the Secretary shall forthwith remove their name from the register of Members unless the Secretary is satisfied that the individual concerned lives in some other area of a Public Constituency of the Trust.

Where the Secretary is satisfied that such an individual continues to live in the area of a Public Constituency of the Trust the Secretary shall, if the individual so requests, thereafter treat that individual as a member of that other Public Constituency and amend the register of Members accordingly provided the Secretary has given that individual not less than 14 days' notice of its intention to do so.

## 7. STAFF CONSTITUENCY

7.1 An individual who is employed by the Trust under a contract of employment with the Trust shall become or continue as a Member of the Trust upon appointment provided:

7.1.1 they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

7.1.2 they have been continuously employed by the Trust under a contract of employment for at least 12 months.

7.2 Individuals who exercise functions for the purpose of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as Members of the the Staff Constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

7.3 Those individuals who are eligible for Membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

7.4 The minimum number of Members in the Staff Constituency is specified in Annex 2.

7.5 An individual who is:

7.5.1 eligible to become a Member of the Staff Constituency, and

7.5.2 invited by the Trust to become a Member of the Staff Constituency, shall become a Member of the Trust as a Member of the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

7.6 Trust volunteers shall be entitled to join the Staff Constituency, provided that they have been continually engaged by the Trust for at least 12 months.

## 8. PATIENTS' CONSTITUENCY

Not Applicable

## 9. RESTRICTION ON MEMBERSHIP

9.1 An individual who is a Member of a constituency or of a class within a constituency, may not while Membership of that constituency or class continues, be a Member of any other constituency or class.

9.2 An individual who satisfies the criteria for Membership of the Staff Constituency may not become or continue as a Member of any constituency other than the Staff Constituency.

9.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 6 – Further Provisions.

## 10. MEMBERS' MEETING

10.1 The Trust shall hold an annual members' meeting of its Members (called the "Annual Members' Meeting") ~~no later than 30 September~~ each year. The Annual Members Meeting shall be open to the members of the public.

10.2 The Board of Directors shall present the Annual Accounts, and report of the Auditor on them, and the Annual Report, to the Annual Members' Meeting.

10.3 The Trust shall give notice of the Annual Members' Meeting by notice in writing to all Members, and by notice on the Trust's website at least 14 clear days before the date of the meeting.

10.4 The Chair or in his absence the Vice Chair shall preside at all Annual Members' Meetings of the Trust. If the Chair and Vice-Chair are not present, the Governors present shall elect one of their number to be Chair and if there is only one Governor present and willing to act that person shall be Chair. If no Governor is willing to act as Chair or if no Governor is present within fifteen minutes after the time appointed for the Annual Members' Meeting, the Members present and entitled to vote shall choose one of their number to be Chair.

## 11. COUNCIL OF GOVERNORS – COMPOSITION

11.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed Members.

11.2 The composition of the Council of Governors is specified in Annex 4.

11.3 The Council of Governors, other than the appointed Members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Members to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

## 12. COUNCIL OF GOVERNORS - ROLES AND RESPONSIBILITIES

12.1 The roles and responsibilities of the Council of Governors are:

- Advisory – It communicates to the Board the wishes of Members and the wider community
- Guardianship – It ensures that the Trust is operating in accordance with its Statement of Purpose and is compliant with its Terms of Authorisation. In this regard it acts in a trustee role for the welfare of the organisation
- Strategic - It advises on a longer-term direction to help the Board effectively determine its policies

Council Members are to:

12.2 Develop the Membership of the Trust and represent the interests of Members.

12.3 Give the views of the Council of Governors to the Board of Directors for the purposes of the preparation (by the Directors) of the document containing information as to the ~~Trust's forward planning in respect of each financial year to be given to the Independent~~

Regulator.

12.4 Respond to any matter as appropriate when consulted by the Directors.

12.5 Appoint or remove the Chair and the other Non-Executive Directors in accordance with paragraphs 22-23 of this Constitution and the Deputy Chair in accordance with paragraph 25 of this Constitution.

12.6 Decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and Non-Executive Directors in accordance with paragraph 24 of this Constitution.

12.7 Approve the appointment of the Chief Executive in accordance with paragraph 26 of this Constitution.

12.8 Appointments of the Chair, Chief Executive and Non-Executive Directors are to be Approved by the majority of a quorate Council meeting. See also Annex 4 para 4.3.2. and the Terms of Reference of the Appointments and Remuneration Group.

12.9 Consider the annual accounts, any report of the auditor on them and the annual report.

12.10 Appoint or remove the Trust's external auditor.

## 13. COUNCIL OF GOVERNORS – ELECTION OF GOVERNORS

13.1 Elections for elected Council of Governors shall be conducted on a First Past the Post basis and in accordance with the Model Rules for Elections, as may be varied from time to time.

13.2 The Model Rules for Elections, as may be varied from time to time, form part of this Constitution and are published alongside it on the Trust's website.

13.3 A variation of the Model Rules, by the Department of Health shall not constitute a variation of the terms of this Constitution. For the avoidance of doubt, the Trust cannot amend the Model Rules.

13.4 An election, if contested, shall be by secret ballot.

## 14. COUNCIL OF GOVERNORS – TENURE

14.1 An elected Governor may hold office for a period of up to three years, subject to and in accordance with Section 19 below.

14.2 An elected Governor shall cease to hold office if he ceases to be a Member of the constituency or class by which he was elected.

14.3 An elected Governor shall be eligible for re-election at the end of his term, subject to and in accordance with Section 19 below.

## 15. COUNCIL OF GOVERNORS – MEETINGS

15.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraphs 22-23 below) or, in his absence, the Vice Chair (appointed in accordance with the provisions of paragraph 25 below), shall preside at meetings of the Council of Governors.

15.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from all or part of any meeting following appropriate resolution by the Council of Governors made in accordance with its Standing Orders set out in Annex 4 paragraph 4.

## 16 COUNCIL OF GOVERNORS – STANDING ORDERS

16.1 The Standing Orders for the practice and procedure of the Council of Governors, as may be varied from time to time, are attached at Annex 4.

## 17 COUNCIL OF GOVERNORS – CONFLICTS OF INTEREST OF MEMBERS

17.1 If a Council Member has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Council Member shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Council Member declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

## 18 COUNCIL OF GOVERNORS – TRAVEL EXPENSES AND REMUNERATION

18.1 The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust. The roles are not otherwise remunerated.

## 19 COUNCIL OF GOVERNORS – DISQUALIFICATION AND REMOVAL

19.1 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

19.2 ELIGIBILITY TO BE A COUNCIL MEMBER

A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so, if:

19.2.1 They are a Director of the Trust, ~~or a Member, Council Member, Governor or Director of another NHS Foundation Trust or any other NHS body, unless such Foundation Trust or NHS body is an appointing organisation, which is appointing him under this Constitution;~~

19.2.2 Being a Member of one of the public constituencies, they fail to sign a declaration in the form specified by the Council of Governors of the particulars of their qualification to vote as a Member of the Trust, and that they are not prevented from being a Member of the Council of Governors;

19.2.3 A person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

19.2.4 A person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

19.2.5 A person who within the preceding five years has been convicted in the British Isles, or elsewhere, of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them;

19.2.6 They are incapable by reason of mental disorder, illness or injury of managing or administering their property and affairs;

19.2.7 They have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

19.2.8 They are a person whose tenure of office as the Chair or as a Member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

19.2.9 They have failed to sign and deliver to the Trust Board Secretary a statement in the form required by the Council of Governors confirming acceptance of the Trust's Code of Conduct (see Annex 7 of this Constitution) within 30 days of election or appointment to the Council;

19.2.10 They have made a claim against the Trust (or Kettering General NHS Trust where such a claim relates to the period prior to creation of the Trust) and has issued legal proceedings in respect of such claim;

19.2.11 They have failed to undertake any training, which the Council of Governors requires all Council of Governors to undertake;

19.2.12 They are removed from the Council of Governors, following an approved procedure (set out as an Addendum to this Constitution), by a resolution approved by 75% of the remaining Council Members present and voting at a General Meeting on the grounds that:

(a) They have committed a serious breach of the Trust's Code of Conduct, or

(b) They have acted in a manner detrimental to the interests of the Trust, or

(c) They have failed to discharge their responsibilities as a Council Member

19.2.13 If it comes to the notice of the Trust Board Secretary at the time of the Council Member's appointment or later that the Council Member is ineligible to hold office, they shall immediately declare that the person in question is disqualified and notify the Council Member in writing to that effect. Upon receipt of any such notification, that person's tenure of office, if any, shall be terminated and they shall cease to act as a Council Member;

19.2.14 Where a person has been declared disqualified by the Secretary under paragraph 19.1.13 above, they may appeal the Secretary's decision to the Chair, whose decision on the matter will be final;

19.2.15 They refuse a DBS check or on return of a DBS check it is noted that the

Member is no longer eligible under the terms of the Constitution or Standing Orders. Any undisclosed convictions reported under a DBS check will be considered by the Chair with regard to the future eligibility of that Member

**19.3 REQUIREMENT OF COUNCIL MEMBER TO NOTIFY TRUST**

Where a person has been elected or appointed to be a Council Member and he becomes disqualified from office under paragraph 19 of the Trust's Constitution, he shall notify the Secretary in writing of such disqualification.

**19.4 TERMINATION OF OFFICE AND REMOVAL OF COUNCIL MEMBERS**

A person holding office as a Council Member shall immediately cease to do so if:

19.4.1 They resign by notice in writing to the Trust Board Secretary;

19.4.2 They are disqualified under Section 19.1 above;

19.4.3 They fail to attend three successive meetings, unless the Chair is satisfied, and confirms in writing that:

(a) the absences were due to reasonable causes; and

(b) they will be able to start attending meetings of the Trust again within such a period as they consider reasonable;

19.4.4 In the case of an elected Council Member, they cease to be a Member of the constituency or class of the Membership of the Trust by which they were elected;

19.4.5 In the case of a nominated Council Member, the appointing organisation terminates their employment or the individual is no longer eligible to represent the appointing organisation.

**19.5 TERMS OF OFFICE**

19.5.1 Terms of office for all Council Members will be 3 years, for a maximum of 3 terms.

**19.6. VACANCIES AMONGST COUNCIL MEMBERS**

19.6.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

19.6.2 Where the vacancy arises amongst the appointed Council Members, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

19.6.3 Where the vacancy arises amongst the elected Council Members, the Council of Members shall:

(a) call an election within three months or
(b) if the vacancy arises within a period of eighteen months of the previous election, invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat for any unexpired period of the term of office.

**20 BOARD OF DIRECTORS - COMPOSITION**

20.1 The Trust shall have a Board of Directors, which shall consist of Executive and Non-

Executive Directors.

20.2 The Board shall comprise:

(a) The following Non-Executive Directors;

(i A Non-Executive Chair and a minimum of five and maximum of eight Non Executive Directors

(b) The following Executive Directors;

(i) A minimum of five and a maximum of seven Voting Executive Directors.

- One of the Executive Directors shall be the Chief Executive
- The Chief Executive shall be the Accounting Officer
- One of the Executive Directors shall be the Finance Director
- One of the Executive Directors is to be registered Medical Practitioner or a registered dentist (within the meaning of the Dentist Act 1984).
- One of the Executive Directors is to be a registered nurse or registered midwife.

20.3 At least half the Board, excluding the Chair will comprise of Non-Executive Directors.

20.4 The University of Leicester may nominate an individual as a candidate for appointment as a non-executive director, provided that individual qualifies for appointment in accordance with paragraph 21 below. The individual may be appointed only in accordance with the 2006 Act and paragraph 21 of the constitution below.

**21. BOARD OF DIRECTORS – QUALIFICATION FOR APPOINTMENT AS A NON EXECUTIVE DIRECTOR**

A person may be appointed as a Non-Executive Director only if:

21.1 They are a Member of the Public Constituency, or

21.2 Where any of the Trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university, and

21.3 They are not disqualified by virtue of paragraph 27 below.

**22. BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF CHAIR AND OTHER NON EXECUTIVE DIRECTORS**

22.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other Non-Executive Directors.

22.2 Removal of the Chair or another Non-Executive Director shall require the approval of three-quarters of the Members of the Council of Governors and shall follow the process as described in paragraph 23 below.

22.3 The Terms of Office are in accordance with Annex 5.

**23. APPOINTMENT AND REMOVAL OF NON-EXECUTIVE DIRECTORS (INCLUDING CHAIR AND DEPUTY CHAIR)**

23.1 The Appointments and Remuneration Group will identify the balance of individual skills and experience it requires at the time a vacancy arises and, accordingly, draw up a job description and person profile for each new appointment.

23.2 ~~Suitable candidates will be identified by the Board of Directors~~ Vacant roles will be advertised; the Council may, if it considers it appropriate in particular circumstances, engage an external organisation recognised as an expert in this field, to assist it in the whole process (including the work involved in 7.1 above)

**23.3** The Appointments and Remuneration Group, on expiry of the initial Non-Executive Director's current terms of appointment (or a period of 12 months from appointment as a Director of this Foundation Trust whichever is the greater) and on any subsequent vacancy, shall consider whether to recommend to the Council of Governors to reappoint the retiring non-executive or Chair or Deputy Chair. The Group may not make any such recommendation other than for a first renewal of the appointment of a Non-Executive Director or Chair without first taking the steps outlined in 7.1 and 7.2 above. If the Council of Governors does not so appoint, or if the individual does not wish to continue, or if the Committee doesn't not consider the reappointment appropriate then ~~the Board of Directors shall be asked to identify suitable new candidates~~ new candidates shall be sought to fill vacant roles in accordance with the procedures outlined above.

23.4 Suitable candidates identified ~~by the Board of Directors (via their Nomination and Remuneration Committee), together with any comments from the Board~~, will be considered by the Group. The Group shall also take full account of the job description and person profile drawn up by the Board of Directors and shall recommend to the Council of Governors an individual for an appointment. At a General Meeting, the Council of Governors shall either appoint the recommended individual or invite the Group to make an alternative recommendation, with accompanying reasons, .

23.5 The Council of Governors at a General Meeting shall appoint or remove the Chair of the Trust and other Non-Executive Directors.

23.6 a) Where a Member of the Council of Governors wishes to propose a resolution to remove the Chair or a Non-Executive Director (such person in either case being referred to in this paragraph as the "Reviewer"), he shall first send a notice in writing of his intention, reasons and supporting evidence to the Chair or, if his intention is to remove the Chair, to the Senior Independent Director (such person in either case being referred to in this paragraph as the "Investigator").

b) The Investigator shall then carry out a preliminary review of the case. If the Investigator concludes that there is no case to answer, the matter shall go no further and the resolution to remove the Reviewer shall not be proposed. If the Investigator concludes that there is or may be a case to answer, he shall notify the Reviewer and the Council of Governors of the proposal and the nature of the allegation and shall invite the Reviewer to give his account of the matter: he shall then conduct an investigation into the matter.

c) If on the basis of his investigation the Investigator concludes that there is no case to answer, the matter shall go no further and the resolution to remove the Reviewer shall not be proposed. If the Investigator concludes that there is or may be a case to answer, he shall notify the Reviewer and the Council of Governors of that fact and of his recommendation (if any): the proposal to remove the Reviewer shall be put to a meeting of the Council of Governors to be held not sooner than 28 days from the date on which the Investigator notifies the Reviewer and the Council of Governors that in his opinion there is or may be a case to answer. The requirement to give such notice shall not be waived under clause 4.3.3.

d) The Reviewer shall have the right to prepare a written response to be sent to the Members of the Council of Governors in advance of the meeting and at the meeting itself the Reviewer shall have the right to address the Council of Governors in relation to the proposal for his removal but shall not be entitled to attend the rest of the meeting or to witness the proposal, the deliberations of the Council of Governors or their subsequent vote on the matter.

c) Removal of the Chair or other Non-Executive Directors shall require the approval of three quarters of the Members of the Council of Governors, present and voting..

## 24. REMUNERATION OF THE CHAIR AND OTHER NON–EXECUTIVE DIRECTORS

In order to determine the proper level of remuneration and allowances that should be paid to the Chair and other Non-Executive Directors the Council may from time to time and at least every three years shall, consult, at the Trust's expense, with external professional advisers.

## 25. BOARD OF DIRECTORS – APPOINTMENT OF VICE CHAIR

25.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive directors as a Vice Chair.

## 26. BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF THE CHIEF EXECUTIVE AND OTHER EXECUTIVE DIRECTORS

26.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

26.2 The appointment of the Chief Executive shall require the approval of a majority of the members of the Council of Governors, present and voting.

26.3 A committee consisting of the Chair, and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

## 27. BOARD OF DIRECTORS – DISQUALIFICATION

The following may not become or continue as a member of the Board of Directors:

27.1 A person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

27.2 A person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

27.3 A person who within the preceding five years has been convicted in the British Isles (or elsewhere) of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

27.4 A person who is an unfit person within the meaning of the Trust's Provider License

27.5 A person who fails to satisfy the requirements of Regulation 5(3) of the Regulated Activities Regulations..

## 28. BOARD OF DIRECTORS – STANDING ORDERS

The Trust will be administered in accordance with the Standing Orders for the practice and procedure of the Board of Directors, as may be varied from time to time, which are attached at Annex 5.

## 29. BOARD OF DIRECTORS – CONFLICTS OF INTEREST OF DIRECTORS

29.1 If a Director has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Board of Directors, the Director shall disclose that interest to the members of the Board of Directors as soon as he becomes aware of it. The Standing Orders for the Board of Directors shall make provision for the disclosure of interests and arrangements for the exclusion of a Director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

## 30. BOARD OF DIRECTORS – REMUNERATION AND TERMS OF OFFICE

30.1 The Council of Governors at a general meeting shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.

30.2 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

## 31. R E G I S T E R S

31.1 The Trust shall have:

a. A register of Members showing, in respect of each Member, the constituency to which the Member belongs and, where there are classes within it, the class to which they belong;

b. A register of Members of the Council of Governors;

c. A register of interests of the Council of Governors ;

d. A register of Directors; and

e. A register of interests of the Directors.

31.2 The Trust Board Secretary shall be responsible for keeping the registers up to date from information received, and the registers may be kept in either paper or electronic form.

## 32. REGISTERS – INSPECTION AND COPIES

32.1 The Trust shall make the registers specified in paragraph 31 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

32.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the trust, if the member so requests.

32.3 So far as the registers are required to be made available:

32.3.1 they are to be available for inspection free of charge at all reasonable times; and

32.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

32.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

## 33. DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

33.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

33.1.1 a copy of the current constitution;

33.1.2 a copy of the current authorisation;

33.1.3 a copy of the latest annual accounts and of any report of the auditor on them;

33.1.4 a copy of the latest annual report;

33.1.5 a copy of the latest information as to its forward planning; and

33.1.6 a copy of any notice given under section 65 of the 2006 Act.

33.2 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

33.3 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

## 34. A U D I T O R

34.1 The Trust shall have an auditor.

34.2 The Council of Governors shall appoint or remove the Auditor at a general meeting of the Council of Governors.

## 35. AUDIT COMMITTEE

35.1 The Trust shall establish a committee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

## 36. ACCOUNTS

36.1 The Trust must keep proper records in relation to the accounts.

36.2 The Regulator may, with the approval of the Secretary of State, give directions to the Trust as to the content and form of its accounts.

36.3 The accounts are to be audited by the Trust's auditor.

36.4 The Trust shall prepare in respect of each financial year annual accounts in such form as the Regulator may, with the approval of the Secretary of State, direct.

36.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

## 37 ANNUAL REPORT AND FORWARD PLANS and NON-NHS WORK

37.1 The Trust shall prepare an Annual Report and send it to the Regulator.

37.2 The Trust shall give information as to its forward planning in respect of each financial year to the Regulator.

37.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

37.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

37.5 Each forward plan must include information about:

37.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on; and

37.5.2 the income it expects to receive from doing so.

37.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 37.5.1. the Council of Governors must:

37.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose of the performance of its other functions, and

37.6.2 notify the Directors of the Trust and its determination;

37.7 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purpose of health service in England may implement the proposal only if more than half of the members of Council of Governors of the Trust voting approve its implementation.

## 38. MEETING OF COUNCIL OF GOVERNORS TO CONSIDER ANNUAL ACCOUNTS AND REPORTS

38.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

38.2 The annual accounts

38.3 Any report of the auditor on them

38.4 The annual report

38.5 The Trust may hold a meeting of the Council of Governors, convened for the purposes of paragraphs 38.1-38.4, consecutively with the Annual Members' Meeting.

## 39. INSTRUMENTS

39.1 The Trust shall have a seal

39.2 The seal shall not be affixed and attested except under the authority of an Executive Director, in accordance with approved procedure. ~~the Board of Directors.~~

## 40. INTERPRETATION AND DEFINITIONS

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this constitution shall bear the same meaning as in the 2006 Act.

References in this Constitution and its Annexes to legislation shall be deemed to incorporate references to such legislation as amended, re-enacted or replaced from time to time.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

**The 2012 Act** is the Health and Social Care Act 2012

**Corporate Governance** - Systems and processes for ensuring proper accountability, probity and openness in the conduct of an organisation's business.

**Council** means the Council of Governors, formally constituted in accordance with this Trust's Constitution.

**Council Member** means a person elected or appointed to the Council of Governors.

**Executive Director** means a person appointed to the Board of Directors.

**Member** means a person registered as a member of a constituency

~~**Monitor** is the body corporate known as Monitor as provided by Section 61 of the 2012 Act, or its successors.~~

**Non-Executive Director** is a person appointed by a meeting of the Council of Governors and will be a member of the Board of Directors. Initially Non-Executive Directors of the applicant NHS Trust will automatically become Non-Executive Directors of the Foundation Trust. This includes the Chair of the Trust.

**Terms of Authorisation** are the terms of authorisation issued under Section 35 of the 2006 Act.

**Voluntary organisation** is a body, other than a public or local authority, the activities of which are not carried on for profit.

The **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25 (5) of Schedule 7 to the 2006 Act.

## 41.CHANGES TO THE CONSTITUTION.

41.1 Any proposed changes to the Constitution of the Trust shall be agreed by more than half of the members of the Board of Directors, present and voting, and more than half of the members of the Council of Governors, present and voting, in accordance with their respective Standing Orders contained in Annexes 4 and 5. The changes, so agreed provisionally, shall be notified to the Independent Regulator of NHS Foundation Trusts. For the avoidance of doubt, the Regulator's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

41.2 Amendments made under paragraph 41.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act as amended.

41.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

41.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment;

41.3.2 the Trust must give the members present at the Annual Members' Meeting an opportunity to vote on whether they approve the amendment; and

41.3.3 if more than half of the members present and voting at the Annual Members' Meeting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

**42. Mergers and Significant Transactions**

42.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

42.2 The Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors of the Trust present and voting at the meeting of the Council of Governors approve entering into the transaction.

42.3 The Trust will set out the ~~description of, and~~ process for the identification and approval of, Significant Transactions, within a procedural document to be made available on the Trust's website as an addendum to this Constitution.

## ANNEX 1- THE PUBLIC CONSTITUENCY

Members in each Constituency shall elect Members (in accordance with Annex 4) to represent them on the Council of Members.
The areas identified in Sections (A)-(D) represent Electoral Wards of the North Northamptonshire Council.

| (A) KETTERING | (B) CORBY | (C) EAST NORTHAMPTONSHIRE | (D) WELLINGBOROUGH | (E) WEST NORTHAMPSTONSHIRE | (F) REST OF ENGLAND |
|---|---|---|---|---|---|
| Desborough<br>Rothwell and Mawsley<br>Clover Hill<br>Northall<br>Windmill<br>Wicksteed<br>Ise<br>Burton and Broughton | Corby Rural<br>Corby West<br>Kingswood<br>Lloyds<br>Oakley | Rushden Pemberton West<br>Rushden South<br>Higham Ferrers<br>Raunds<br>Irthlingborough<br>Thrapston<br>Oundle | Earls Barton<br>Hatton Park<br>Croyland and Swanspool<br>Brickhill and Queensway<br>Finedon<br>Irchester | All Electoral Wards of the West Northamptonshire Council | All electoral areas in England save for those specified in Columns A-E |
| **MINIMUM NUMBER OF MEMBERS** | | | | | |
| 50 | 50 | 50 | 50 | 50 | 50 |
| **NUMBER OF GOVERNORS** | | | | | |
| 4 | 4 | 4 | 4 | 1 | 1 |

## ANNEX 2 – THE STAFF CONSTITUENCY

| Class | Minimum number of Members | Number of Governors |
|---|---|---|
| All staff | 120 | 8 |

## ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

**The Council of Governors consists of: -**

Members appointed by partnership organisations and Members elected by:

(a) Members of the Public in each of the Constituencies defined in Annex 1 of this Constitution; and by

***(b)*** Individuals within each class of the Staff Constituency defined in Annex 2 of this Constitution**.**

More than half of the Members of the Council of Governors shall be elected by those in (a) above.

**Membership of the Council of Governors is detailed below**:

| | | |
|---|---|---|
| **Primary Care** | 1 | To represent key<br>NHS health economy partners |
| **Principal Local Councils**<br>• North Northamptonshire Council<br>• West Northamptonshire Council | <br>1<br>1 | To represent key local non-NHS health economy |
| **Principal Universities**<br>For the time being;<br>• The University of Leicester and<br>• The University of Northampton | <br><br>1 | To ensure strong teaching and research partnership and to represent other University interests |
| **Voluntary Sector** | 2 | To ensure a voice for the voluntary sector who often work in partnership with the Trust |

| | | |
|---|---|---|
| **MIND** | 1 | To reinforce the representation of patients' views and interests |
| **Healthwatch** | 1 | To reinforce the representation of patients' views and interests |
| **TOTAL APPOINTED MEMBERS** | 8 | |

## ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

| Elected Members | | Role |
|---|---|---|
| **Staff Elected Members to represent:** | | |
| All staff | 8 | To represent all staff (The Trust will take the necessary steps to ensure equitable representation from the broadest range of staff roles and professions) |
| **Total Elected Staff Members** | **8** | |

| Public Elected Members to represent: | | Role |
|---|---|---|
| Kettering | 4 | Representing the public who are resident in the Electoral Wards of the North Northamptonshire Council specified in Annexe 1, Column A above |
| Corby | 4 | Representing the public who are resident in the Electoral Wards of the North Northamptonshire Council specified in Annexe 1, Column B above |
| Wellingborough | 4 | Representing the public who are resident in the Electoral Wards of the North Northamptonshire Council specified in Annexe 1, Column C above |
| East Northants | 4 | Representing the public who are resident in the Electoral Wards of the North Northamptonshire Council specified in Annexe 1, Column D above |
| West Northamptonshire | 1 | Representing the public who are resident in the areas specified in Annexe 1, Column E above |
| Rest of England ~~the UK~~ | 1 | Representing the public who are resident in the areas specified in Annexe 1, Column F above |
| **Total Public Elected Members** | **18** | |

| **Total Membership of Council of Governors:** | |
|---|---|
| Appointed Members | 8 |
| Staff Members | 8 |
| Public Members | 18 |
| **Total** | **34** |

# KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST

# ANNEX 4

# COUNCIL OF GOVERNORS STANDING ORDERS

## ANNEX 4 – COUNCIL OF GOVERNORS STANDING ORDERS

### FOREWORD

The Kettering General Hospital NHS Foundation Trust (The "Trust") is a public benefit corporation established in accordance with the Chapter 5 of the National Health Service Act 2006.

As such, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In its latter role the Trust is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held on behalf of patients.

These Standing Orders (SOs) are for the regulation of the Trust's Council of Governors proceedings and business.

The Trust's Managing Conflicts of Interest Policy lays down certain procedures where there is concern about possible conflicts of interest of Governors.

The Trust believes that public service values lie at its heart. High standards of corporate and personal integrity based on recognition that patients come first, is a fundamental value of the Trust. Members are expected to observe the Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (see paragraph 9 of the Council of Governors Standing Orders).

Everything done by the Trust should be able to stand the test of scrutiny, public judgment on propriety, and professional codes of conduct.

There should be sufficient transparency about the Trust's activities to promote confidence between the Trust and its staff, patients and the public.

# ANNEX 4 – COUNCIL OF GOVERNORS STANDING ORDERS

**Contents**

## ANNEX 4 – COUNCIL OF GOVERNORS STANDING ORDERS

### 1. INTERPRETATION

**1.1** Any expression to which a meaning is given in the National Health Service Act 2006 has the same meaning in this interpretation and in addition:

**"TRUST"** means the Kettering General Hospital NHS Foundation Trust.

**"MEMBER"** means a person registered as a Member of a constituency in terms of paragraph 4 of this Trust's Constitution.

**"GOVERNOR"** means a person elected or appointed to the Council of Governors in terms of paragraph 10 of this Trust's Constitution.

**"DIRECTOR"** means a person appointed to the Board of Directors in terms of paragraphs 20-23 of this Trust's Constitution.

**"CHAIR"** is the person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The Chair shall be deemed to include the Non-Executive Director appointed by the Council of Governors to take on the Chair's duties if the Chair is absent from the meeting or is otherwise unavailable.

**"COUNCIL"** means the Council of Governors, formally constituted in accordance with this Trust's Constitution.

**"BOARD"** means the Board of Directors, formally constituted in accordance with this Trust's Constitution and consisting of the Chair, and Non-Executive Directors, appointed by the Council of Governors, and the Executive Directors, appointed by the Non-Executive Directors and (except for his own appointment) by the Chief Executive.

**"COMMITTEE OF THE COUNCIL"** means a committee appointed by the Council of Governors with specific Terms of Reference, Chair, and Membership approved by the Council.

**"MOTION"** means a formal proposition to be discussed and voted on during the course of a meeting.

**"OFFICER"** means an employee of the Trust.

**"BUDGET"** means a resource, expressed in financial terms, approved by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.2 Save as permitted by law, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they shall be advised by the Chief Executive and Director of Finance).

## ANNEX 4 – COUNCIL OF GOVERNORS STANDING ORDERS

### 2. GENERAL INFORMATION

The purpose of the Council of Governors Standing Orders is to ensure that the highest standards of Corporate Governance and conduct are applied to all Council meetings and associated deliberations. The Council shall at all times seek to comply with the Code of Governance for NHS Provider Trusts that is founded on "The Combined Code": https://www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance .

**2.1** All business shall be conducted in the name of the Trust.

**2.2** The Board of Directors shall appoint trustees to administer separately charitable funds received by the Trust and for which they are accountable to the Charity Commission.

**2.3** A Governor who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal civil liability which is incurred in the execution or purported execution of his or her function as a Member save where the Member has acted recklessly. On behalf of the Council of Governors, and as part of the Trust's overall insurance arrangements the Board shall put in place appropriate insurance provision to cover such indemnity.

### 3. COMPOSITION OF THE COUNCIL OF GOVERNORS

**3.1** The composition of the Council of Governors shall be in accordance with para 11 of the Trust's Constitution.

**3.2** The Chair or Vice Chair of the Trust will preside over meetings of the Council of Governors, such persons being appointed and removed by the Council in accordance with the provisions of paragraphs 21 to 23 of the Constitution. If the Chair and Vice Chair are both absent, another Non-Executive Director or the Lead Governor shall be appointed by the Council to preside.

**3.3** **Duties of Deputy Chair** - Where the Chair of the Trust has died or has otherwise ceased to hold office or where they have been unable to perform his/her duties as Chair owing to illness, absence or any other cause, references to the Chair shall, so long as there is no Chair able to perform his/her duties, be taken to include references to the Deputy Chair.

### 4. MEETINGS OF THE COUNCIL OF GOVERNORS

**4.1** **Meetings held in Public**

**4.1.1** Meetings of the Council of Governors must be open to the public subject to the provisions of paragraph 4.1.2 below.

**4.1.2** The Council of Governors may resolve to exclude members of the public from any meeting or part of a meeting on the grounds that:

(i) Publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

(ii) There are special reasons stated in the resolution and arising from the nature of the business of the proceedings.

**4.1.3** The Chair may exclude any member of the public from the meeting of the Council if they are interfering with or preventing the reasonable conduct of the meeting.

**4.1.4** Meetings of the Council of Governors shall be held not less than four times each year at times and places that the Council of Governors may determine. In addition, the Trust shall hold ~~These shall include~~ an annual meeting to receive the Annual Accounts, any report by the Auditor and the Annual Report.

**4.1.5** The Council may invite the Chief Executive and other appropriate Directors, to attend any meeting of the Council to enable Members to raise questions about Trust affairs.

**4.1.6** Public Meetings may be recorded at the Chair's discretion, subject to prior notification and recording not being disruptive to proceedings.

### 4.2 Calling Meetings

Notwithstanding 4.1.4 above, the Chair may, in exceptional circumstances, call a meeting of the Council of Governors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by a majority of the Governors, or if without so refusing the Chair does not call a meeting within fourteen days after requisition to do so, then the Governors may forthwith call a meeting provided they have been requisitioned to do so by more than 50% of Council Members.

### 4.3 Notice of Meetings

**4.3.1** Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, shall be communicated to every Council Member, ~~or sent by post to the usual place of residence of such Council Member~~, so as to be available at least five clear days before the meeting. Lack of service of the notice on any Council Member shall not affect the validity of a meeting subject to paragraph 4.3.3.

**4.3.2** Where a resolution is to be proposed to remove the Chair or a Non-Executive Director, not less than 28 days' notice of such resolution shall be given. The requirement to give such notice shall not be waived under clause 4.3.3.

**4.3.3** Save in respect of a notice required under 4.3.2, the Chair may waive the requirement for notice under 4.3.1 on the receipt of written agreement of at least 50% of Council Members.

**4.3.4** In the case of a meeting called by Governors in default of the Chair, the notice shall be signed by those Council Members calling the meeting and no business shall be transacted at the meeting other than that specified in the notice. Failure to serve such a notice on more than three quarters of Council Members will invalidate the meeting. A notice will be presumed to have been served at the time at which the notice would be delivered by electronic mail, or in the ordinary course of the post.

### 4.4 Setting the Agenda

**4.4.1** The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council and shall be addressed prior to any other business being conducted.

**4.4.2** A Governor desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

4.5.1 Hybrid meetings, comprising a mixture of attendance in person and by remote means, subject to minimum quoracy requirements, will have full authority to take decisions; meetings will be recorded, and Minutes/Action Logs produced, in the normal way.

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

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

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

**Petitions**

4.5.4 Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next meeting of the Council of Governors. The petition shall be received and responded to in accordance with a protocol to be approved by the Council.

**4.6 Notices of Motion**

**4.6.1** A Governor desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the Meeting to the Chair, who shall insert in the Agenda for the Meeting.. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to section 4.3 of these Standing Orders.

**4.6.2** The Chair, having regard to the advice of the Company Secretary, may reject a Motion if it:

(a) is not about a matter for which the Trust has a responsibility;

(b) is defamatory, frivolous or offensive;

(c) requires the disclosure of confidential or exempt information;

(d) Would, if carried, commit the Council to a course or courses of action contrary to agreed procedures or outside its authority to act.

**4.6.3** A motion or amendment, once moved and seconded, may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

**4.6.4** Notice of motion to amend or rescind any resolution (or the general substance of any resolution), which has been passed within the preceding six calendar months, shall bear the signature of the Members who give it and also the signature of four other Members. When the Council has disposed of any such motion it shall not be competent for any Governor, other than the Chair, to propose a motion to the same effect within six months; however the Chair may do so if they consider it appropriate.

**4.6.5** The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

**4.6.6** When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move;

(a) An amendment to the motion.
(b) The adjournment of the discussion or the meeting.
(c) The appointment of an ad hoc committee to deal with a specific item of business.
(d) That the meeting proceeds to the next business.

(e) That the motion be now put.

Such a motion, if seconded, shall be disposed of before the motion that was originally under discussion or about to be discussed. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

In the case of motions under (d) and (e), to ensure objectivity, motions may only be put by a Governors who has not previously taken part in the debate.

### 4.7 Chair's Ruling

Statements of Governors made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

### 4.8 Voting

**4.8.1** Decisions at meetings shall be determined by a majority of the votes of the Governors present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

**4.8.2** All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper or electronic ballot may also be used if a majority of the Governors present so request.

**4.8.3** If at least one-third of the Governors present so request, the voting (other than by secret ~~paper~~ ballot) on any question may be recorded to show how each Governor present voted or abstained.

**4.8.4** If a Governor so requests, his/her vote shall be recorded by name upon any vote (other than by paper or electronic ballot).

**4.8.5** In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

### 4.9 Suspension of Standing Orders (SOs)

**4.9.1** Except where this would contravene any statutory provision or guidance issued by the Independent Regulator any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of Governors are present and that a majority of those present vote in favour of suspension.

**4.9.2** A decision to suspend SOs shall be recorded in the minutes of the meeting.

**4.9.3** A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the ~~Directors~~ Audit Committee.

**4.9.4** The Trust's Audit Committee shall review every decision to suspend SOs.

### 4.10 Variation and Amendment of Standing Orders

These Standing Orders shall be amended in accordance with Clause 41 of this Constitution (above), provided that the amendments do not contravene statutory provisions. ~~only if;~~

~~notice of motion has been given; and~~

~~no fewer than half the total of the Council Members vote in favour of amendment; and~~

~~at least two-thirds of the Council Members are present; and~~

~~the variation proposed does not contravene a statutory provision~~

~~approval for change will take no affect until it has been agreed by the Trust Board and notified to the Independent Regulator of NHS Foundation Trusts~~

### 4.11 Record of Attendance

The names of the Governors present at the meeting shall be recorded in the minutes.

### 4.12 Minutes

**4.12.1** The Minutes of the proceedings of the meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next meeting.

**4.12.2** No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

**4.12.3** Minutes shall be circulated in accordance with the Council of Governors's wishes. The Minutes of the meeting shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of Section 4.1 of these Standing Orders

### 4.13 Quorum

**4.13.1** No business shall be transacted at a meeting of the Council of Governors unless at least one of third of the current membership (excluding vacancies) of the Council is present. Should a meeting not be quorate the meeting would be adjourned for 21 days or such other period as the Chair shall notify to the Governors, at which time whoever attended the reconvened meeting would constitute a quorum. Meetings which are inquorate may proceed at the Chair's discretion, though no formal resolutions may be passed. In exceptional circumstances, Motions may be circulated for electronic approval between meetings in accordance with the provisions of Standing Orders 4.5.1-4.5.3 above. In such cases, the details will be recorded in the Minutes of the Meeting at the next available opportunity.

**4.13.2** If a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

### 4.14 Membership of the Council

**4.14.1** The Council will review its membership at least every three years to ensure it remains appropriate **5**

## ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

### 51 Committees

The Council of Governors may agree from time to time to establish committees or sub-committees to advise the Council of Governors in the performance of its duties. To ensure clarity of purpose the constitution and Terms of Reference of these committees, or sub-committees are approved by the Council. Decision-making cannot be delegated to committees or sub-committees.

### 5.2 Delegation

The Council of Governors may not delegate its duties to any committee or sub-committee or individual Council Member or to any other person or group of persons.

## 6. COMMITTEES AND SUB-GROUPS – FURTHER PROVISIONS

**6.1**
The Council of Governors may appoint committees and groups of the Council consisting wholly of persons who are Governors to advise the Council in performing its duties. Non- Members may attend such committees if appropriate under the Committee's Terms of Reference but they shall have no vote.

**6.2** A committee or group so appointed may appoint sub-committees consisting wholly of persons who are Governors. Non-Members may attend such bodies if appropriate under the Committee's Terms of Reference but they shall have no vote.

**6.3** These Standing Orders, as far as they are applicable, shall apply also, with appropriate alteration, to meetings of any committees, groups or sub-committees so established by the Council.

**6.4** Each such committee, group or sub-committee shall have such Terms of Reference and remit and be subject to such conditions (as to reporting back to the Council) as the Council shall decide. Such Terms of Reference are to be read in conjunction with the Constitution.

**6.5** The Council of Governors shall approve the membership to all committees/sub committees/groups that it has formally constituted and shall determine the Chair of each committee/s sub-committee.

## 7. CONFIDENTIALITY

**7.1** A Member of the Council of Governors or an attendee on a committee of the Council shall not disclose a matter dealt with, or brought before, the Council of Governors without its permission or until the committee shall have reported to the Council or shall otherwise have concluded on that matter.

**7.2** A Member or a Non-Member in attendance at a committee shall not disclose any matter dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee resolves that it is confidential.

## 8. DECLARATION OF INTERESTS AND REGISTER OF INTERESTS

### 8.1 Declaration of Interests

Governors are required to comply with the Trust's Managing Conflicts of Interest, Gifts and Hospitality and Commercial Sponsorship and to declare interests that are relevant and material to the Council. All Council Members should declare such interests on appointment and on any subsequent occasion that a conflict arises.

8.1.1 Interests regarded as "relevant and material" are:

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

(b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

(c) Significant share holdings (more than 5%) in organisations likely or possibly seeking to do business with the NHS.

(d) A position of authority in a charity or voluntary organisation in the field of

health and social care.

(f) Any connection with a voluntary or other organisation contracting for NHS services.

(g) Employment or Membership within any Health and Social Care provider or NHS Trust.

**8.1.2** If a Council Member has any doubt about the relevance of an interest, he should discuss it with the Chair and Trust Board Secretary, who shall advise him whether or not to disclose the interest.

**8.1.3** At the time Council Members' interests are declared, they should be recorded in the Council of Governors minutes and entered on a Register of Interests of Council Members to be maintained by the Trust Board Secretary. Any changes in interests should be declared at the next Council meeting following the change occurring.

**8.1.4** Members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report.

**8.1.5** During the course of a Council meeting, if a conflict of interest is established, the Governor concerned shall withdraw from the meeting and play no part in the relevant discussion or decision.

**8.1.6** There is no requirement for the interests of Governors' spouses or partners to be declared. [Note however that regulations require that the interest of Members' spouses or partners, if living together, in contracts should be declared].

**8.2 Register of Interests**

**8.2.1** The Trust Board Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Council Members.

**8.2.2** Details of the Register will be kept up to date and reviewed annually.

**8.2.3** The Register will be available to the public.

## 9. COMPLIANCE - OTHER MATTERS

**9.1** Governors shall comply with Standing Financial Instructions prepared by the Chief Finance Officer and approved by the Board of Directors.

**9.2** Council Members must behave in accordance with the seven Nolan Principles of Behaviour in Public Life (and the Trust's Code of Conduct as amended from time to time as detailed in Annex 7 to the Trust's Constitution)

## DISPUTE RESOLUTION

**10.3** The Council of Governors and the Board of Directors are committed to developing and maintaining constructive and positive relationships. The aim, at all times, is to resolve any potential or actual differences of opinion quickly, through discussion and negotiation.

**10.3.1** Should an issue not be resolved through informal means, , the Chair will call a joint meeting ("Resolution Meeting") of equal numbers of Governors and Directors, to take place as soon as possible, but no later than twenty days following the date of the request by the Chair. The Resolution Meeting will be held in private. The aim of the Resolution Meeting will be to achieve resolution of the conflict. The Chair shall have the right to appoint, in their absolute discretion, an independent facilitator to assist the process. Every reasonable effort must be made to reach resolution;

**10.3.2** If the Resolution fails to resolve the conflict, the dispute will be referred back to the Board of Directors, who shall make the final decision.

**10.3.3** Where the dispute involves the Trust Chair, the Trust Chair's role and duties within this section shall be undertaken by the Senior Independent Director.

**10.3.4** Nothing in this procedure shall prevent the Council, if it so desires, from informing the Independent Regulator that, in the Council's opinion, the Board has not responded constructively to concerns of the Council or that the Trust is not meeting the Terms of its Authorisation.

## 11. COUNCIL PERFORMANCE

The Chair shall, at least annually, lead a performance assessment process for the Council to enable the Council to review its roles, structure, composition and procedures taking into account emerging best practice.

## 12. CHANGES TO STANDING ORDERS

Changes to the Council of Governors Standing Orders shall be agreed by the Board of Directors and Council of Governors and notified to the Independent Regulator of NHS Foundation Trusts.

## 13. LEAD GOVERNOR

13.1 The Council shall appoint a Lead Governor to facilitate direct communication between the Trust and the Independent Regulator (as set out in the ' Code of Governance for NHS Providers' (2023)), and any other duties which may be determined by the Council within a role description. The Lead Governor's term of office shall be determined by the Council upon appointment, but shall not expire no later than the expiry of their Term of Office as a Governor.

13.2 The Council shall appoint a Deputy Lead Governor to perform the duties described in 13.1 above in the Lead Governor's absence.

# KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST

# ANNEX 5

# BOARD STANDING ORDERS

## Contents

## Contents

## Contents

## ANNEX 5 – BOARD STANDING ORDERS

### SECTION A

### 1. Interpretation and Definitions for Standing Orders

**1.1** Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board).

**1.2** Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and in addition:

**"ACCOUNTING OFFICER"** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

**"TRUST"** means Kettering General Hospital NHS Foundation Trust.

**"BOARD"** means the Board of Directors, formally constituted in accordance with the Constitution and consisting of the Chair, and Non-Executive Directors, appointed by the Council of Governors, and the Executive Directors, appointed by the Non-Executive Directors and (except for their own appointment) by the Chief Executive.

**"BUDGET"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

**"BUDGET HOLDER"** means the Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

**"CHAIR OF THE BOARD (OR TRUST)"** is the person appointed by the Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

**"CHIEF EXECUTIVE"** means the chief officer of the Trust.

~~**"CLINICAL GOVERNANCE AND RISK MANAGEMENT COMMITTEE"** means a committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the quality of healthcare for which the Kettering General Hospital NHS Foundation Trust has responsibility.~~

~~**"COMMISSIONING"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.~~

**"COMMITTEE OF THE BOARD"** means a committee or sub-committee appointed by the Board of Directors with specific Terms of Reference, Chair and membership approved by the Board.

**"COMMITTEE MEMBERS"** means persons formally appointed by the Board to sit on or to chair specific committees.

## ANNEX 5 – BOARD STANDING ORDERS

**"CONTRACTING AND PROCURING"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

**"FINANCE DIRECTOR"** means the Chief Financial Officer of the Trust.

**"DIRECTOR"** means a person appointed to the Board of Directors in terms of paragraphs 20-23 of the Constitution.

~~**"FUNDS HELD ON TRUST"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept as trust funds. Such funds may or may not be charitable.~~

**"COUNCIL"** means Council of Governors, formally constituted in accordance with the Constitution meeting in public and presided over by the Chair.

**"COUNCIL MEMBER"** means a person elected or appointed to the Council of Governors in terms of paragraph 10 of the Constitution.

**"NOMINATED OFFICER"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

**"OFFICER"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

**"SECRETARY"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and Independent Regulator's guidance.

**"SFIS"** means Standing Financial Instructions.

**"SOs"** means Standing Orders.

**"DEPUTY CHAIR"** means the Non Executive Director appointed by the Council of Governors to take on the Chair's duties if the Chair is absent for any reason.

**"SENIOR INDEPENDENT DIRECTOR"** means a Non Executive Director appointed by the Board in consultation with the Council of Governors who may act as the Deputy Chair.

~~**"MONITOR"** means the Independent Regulator for NHS Foundation Trusts established under the Health and Social Care (Community Health and Standards) Act 2003 to regulate NHS Foundation Trusts, or its successors.~~

## ANNEX 5 – BOARD STANDING ORDERS

### SECTION B – STANDING ORDERS

### 1. INTRODUCTION

#### 1.1 Statutory Framework

The Kettering General Hospital NHS Foundation Trust (the Trust) is a public benefit corporation that was established in accordance with the provisions of Chapter 5 of the National Health Service Act 2006.

The functions of the Trust are conferred by this legislation.

As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to NHS England.

The Regulatory Framework requires the Board of Directors to adopt Standing Orders for the practice and procedure of the Board of Directors.

The Board of Directors will conduct business in as open a way as possible and will:-

1. Observe the Nolan Principles of Public Life of selflessness, integrity, objectivity, accountability, openness, honesty and leadership;

2. At all times seek to comply with the Code of Governance for NHS Provider Trusts; and the UK Corporate Governance Code.

#### 1.2 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee or sub-committee or appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit". Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). This document should be read in conjunction with the Constitution.

### 2. THE BOARD OF DIRECTORS: COMPOSITION, APPOINTMENT OF DIRECTORS AND SECRETARY AND INDEMNITY ARRANGEMENTS

#### 2.1 Composition of the Membership of the Board of Directors

The Composition of the Board shall be in accordance with Clause 20 of this Constitution.

The number of Directors may be increased, with the approval of the Board and, in the case of Non-Executive Directors, the Council of Governors, provided always that at least half the voting members of the Board, including ~~excluding~~ the Chair, comprises Non-Executive Directors determined by the Board to be independent.

The Board of Directors will be supported by the Secretary who will attend Board meetings in that capacity.

## 2.2 Appointment and removal of Chair and Members of the Board of Directors

**2.2.1** The Chair and Non-Executive Directors are appointed/removed by the Council of Governors in accordance with paragraphs 22-23 of this Trust's Constitution.

**2.2.2** In accordance with paragraph 26 of this Trust's Constitution, via the Remuneration and Appointments Committee, the Non-Executive Directors shall appoint the Chief Executive (which appointment shall be approved by the Council of Governors). This committee consisting of the Chair, and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

**2.2.3** The Chair and Non-Executive Directors may be removed from office in the following circumstances (subject to the procedures laid down in paragraphs 22-23 of this Trust's Constitution) :

i. It is no longer in the interests of the NHS for the appointment to continue;
ii. Non-attendance at Board and Board Committee meetings for a period of 3 months unless the absence was due to a reasonable cause and they will be able to attend meetings again within a period considered reasonable by the Chair;
iii. If they do not properly comply with the requirements of the ~~Constitution with regard to pecuniary interests in matters and discussion at meetings of the Trus~~ the Trust's Managing Conflicts of Interest Policy;
iv. If an annual appraisal or sequence of appraisals is unsatisfactory;
v. If they no longer enjoy the confidence of the Board;
vi. If they lose the confidence of the Council of Governors or the local community in a substantial way;
vii. If the Chair fails to ensure that the Board monitors the performance of the Trust in an effective way;
viii. If they fail to deliver work against pre-agreed targets incorporated within their annual objectives;
ix. If there is a irreconcilable breakdown in essential relationships e.g. between the Chair and Chief Executive or between a Non-Executive Director and the rest of the Board;
x. When a new Chair is appointed to a Board they will be expected to review the objectives of all Board members. They may at the end of their term of office make recommendation to the Remuneration and Appointments Committee (Executive Directors) or Appointment and Remuneration Group of the Council of Governors (Non-Executive Directors) regarding their continued appointment;
xi. If they are no longer eligible to be a Member of the Public Constituency
xii. See also paragraph 27 of this Trust's Constitution – Board of Directors - disqualification.

## 2.3Terms of Office of the Chair and Members of the Board of Directors of Directors

The Chair and Non-Executive Directors will hold a term of 3 years. If appropriate a further term may be served. Any decision to extend a term beyond six years should subject to rigorous review comprising annual appointments thereafter. The Chair and Non-Executive Directors should not remain in post beyond nine years from the date of their first appointment to the Board of Directors, except where a short extension may be appropriate to facilitate effective succession planning and the development of a diverse board, particularly where, on appointment, a chair was an existing non-executive director. The need for such extensions should be clearly explained and should be agreed with NHS England. A Non-Executive Director becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as Chair.

## 2.4 Independence of Directors and Appointment and Powers of Deputy Chair

The Board shall ~~approve a formal declaration process to enable it to assess~~ make a statement within its Annual Report regarding the independent status or otherwise of each Non-Executive Director.

~~The process shall apply to all proposed new appointees and annually to those already appointed. The Chief Executive and Chairman of the Audit Committee shall review the declarations and shall report the outcome to the Trust Board.~~

~~The declaration of the Chairman of the Audit Committee, himself a Non-Executive Director under the terms of this Trust's Constitution, shall be reviewed and the outcome reported to the Board by the Trust Chairman and the Chief Executive. The Board shall then determine the status of each Non-Executive Director.~~

The Board shall, in consultation with the Council of Governors, appoint one of the Independent Non-Executive Directors as the 'Senior Independent Director'. The Board shall normally, but not necessarily, appoint the Deputy Chair to this position, as defined in paragraph 25 of this Constitution (Appointment of Non-Executive Directors).

For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Council of Governors shall, in accordance with paragraph 25 of this Trust's Constitution, appoint one of the Non-Executive Directors to be Deputy Chair.

Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair.

### 2.5 Role of Board Members

The Board will function as a corporate decision-making body, Executive Directors and Non-Executive Directors will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

#### (1) Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

#### *(2)* Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. They are the **Accounting Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accounting Officer Memorandum for NHS Foundation Trust Chief Executives.

#### (3) Finance Director

The Finance Director shall be responsible for the provision of financial advice to the Trust and to its Members and for the supervision of financial control and accounting systems. They shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

#### (4) Non-Executive Directors

The Role of the Non-Executive Directors will include the following:

- Challenge and help develop proposals on strategy.
- Scrutinise the performance of management in meeting agreed goals and objectives.

- Monitor the reporting of performance.
- Ensure the integrity of financial and clinical outcome information.
- Ensure financial and clinical quality controls and systems of risk management are robust and defensible.
- Determine appropriate levels of remuneration of Executive Directors.
- Be involved in succession planning for Board members.
- Ensure effective dialogue with the Council of Governors.

**(5) Chair**

The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall work closely with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

**(6) Senior Independent Director**

The Board shall appoint a Senior Independent Director in consultation with the Council of Governors, who may act as the Deputy Chair. The Senior Independent Director, working with the Lead Governor, may meet with the other members of the Board without the Chair present on at least an annual basis in order to evaluate and appraise the performance of the Chair.

They may also act as an alternative contact point for officers or members with concerns which have failed to be resolved or would not be appropriate through the normal channels of the Chair, Chief Executive or Finance Director.

**(7) Board Secretary**

The Board shall appoint a Secretary who, under the direction of the Chair, shall ensure effective information flows within the Board and Council and their Committees, between Directors and Council Members, and between senior management and Non- Executive Directors. The Secretary shall also advise the Board and Council on all governance matters and shall facilitate induction and professional development as required.

## 2.6 Corporate Role of the Board

(1)All business shall be conducted in the name of the Trust.

(2)All funds received in trust shall be held in the name of the Trust as corporate trustee.

~~The Board shall approve a formal Letter of Understanding between the Chairman and Chief Executive setting out, as clearly as possible, a division of their responsibilities. The Letter shall be reviewed and modified, as the Board shall, from time to time, decide.~~ The Trust shall comply with Section B of the NHS Provider Code of Governance in ensuring an appropriate division of responsibilities within the Board of Directors.A Director, or Officer of the Trust, who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal civil liability which is incurred in the execution or purported execution of his or her function as a Director save where the Director has acted recklessly. On behalf of the Directors, and as part of the Trust's overall insurance arrangements the Board of Directors shall put in place appropriate insurance provision to cover such indemnity.

Non-Executive Directors may, at the Trust's expense request the Audit Committee to, seek external advice or appoint an external adviser on any material matter of concern provided the request to do so is a collective one by the majority of Non-Executive Directors.

### 2.7 Schedule of Matters Reserved to the Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised by The Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and should be read in conjunction with the Constitution. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

### 2.8 Lead Roles for Board Members

The Chair will ensure that the designation of Lead roles or appointments of Board members as required by NHS England or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

## 3 MEETINGS OF THE TRUST

### 3.1 Calling meetings

(1) Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

(2) The Chair of the Trust may call a meeting of the Board at any time.

(3) One third or more voting members of the Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

### 3.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be ~~delivered~~ communicated to every Board member, ~~or sent by post to the usual place of residence of each Board member~~, so as to be available to members at least seven days before the meeting. Failure to serve such a notice on any member shall not affect the validity of a meeting.

(2) Notwithstanding the above requirement for notice, the Chair may waive notice on written receipt of the agreement of at least two-thirds of voting Directors (Executive and Non-Executive Directors taken together) but to include a minimum of two voting Executive Directors and two Non-Executive Directors.

(3) In the case of a meeting called by Board members in default of the Chair calling the meeting, the notice shall be signed by those members.

(4) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

(5) A Board member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 14 days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

### 3.3 Agenda and Supporting Papers

The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted.

The Agenda and supporting papers will be sent to members seven days before the meeting With the Chair's agreement, additional papers may be issued ~~rs, whenever possible, shall accompany the agenda, but will certainly be despatched~~ no later than three ~~working~~ days before the meeting, ~~save in emergency.~~

### 3.4 Petitions

Where a petition has been received by the Trust, the Chair shall include the petition as an Item for the agenda of the next meeting.

### 3.5 Notice of Motion

(1) Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

(2) The notice shall be delivered at least 10 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

### 3.6 Emergency Motions

Subject to the agreement of the Chair, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

### 3.7 Motions: Procedure at and during a Meeting

i) **Who may propose?**

A motion may be proposed by the Chair of the meeting or any voting member present. It must also be seconded by another voting member.

ii) **Contents of motions**

The Chair may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Board of Directors;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

ii) The Chair, having regard to the advice of the Company Secretary, may reject a Motion if it:

(a) is not about a matter for which the Trust has a responsibility;

(b) is defamatory, frivolous or offensive;

(c) requires the disclosure of confidential or exempt information;

(d) Would, if carried, commit the Board to a course or courses of action contrary to agreed procedures or outside its authority to act.

iii) **Amendments to motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

iv) **Rights of reply to motions**

**a) Amendments**

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

**b) Substantive/original motion**

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

v) **Withdrawing a motion**

A motion, or an amendment to a motion, may be withdrawn.

vi) **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that a member/Director be not further heard;

In those cases where the motion is either that the meeting proceeds to the “next business’”or “that the question be now put” in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

**38 Motion to Rescind a Resolution**

(1) Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Board of Directors of Directors may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

(2) When any such motion has been dealt with by the Board of Directors it shall not be
competent for any director/member other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

**39 Chair of Meeting**

(1) At any meeting of the Board of Directors the Chair, if present, shall preside. If the
Chair is absent from the meeting, the Deputy Chair (if the Board has appointed one), if present, shall preside.

(2) If the Chair and Deputy Chair are absent, such Non-Executive Director as the Board members present shall choose shall preside.

**3.10 Chair's Ruling**

The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

**3.11 Quorum**

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and voting members (including at least one Executive Directors and at least two ~~one~~ Non-Executive Directors) are present.

(ii) A non-voting executive or non-executive director or an officer in attendance for an Executive director (Officer Member) but without formal acting up status does not count towards the quorum.

(iii) If after 15 minutes from the time appointed for a meeting of the Board of Directors to take place no quorum is present, then there shall be no meeting. Likewise, if during a meeting the Chair, after counting the number of directors present, declares that there is no quorum, the meeting shall stand adjourned to a time arranged by the Chair or to the next ordinary meeting of the Board of Directors.

(iv) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

**3.12 Voting**

(i) Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a

meeting shall be determined by a majority of the votes of members present and voting on the question.

(ii) Each Director and Non-Executive Director shall be entitled to exercise one vote. For the avoidance of doubt, in the event of equality of votes, the Chair shall always have a casting vote.

(iii) At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

(iv) If at least one third of the Board members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

(v) If a Board member so requests, their vote shall be recorded by name.

(vi) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

(vii) An officer who has been appointed formally by the Board to act up as an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director. An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

**3.13 Suspension of Standing Orders**

(i) Except where this would contravene any statutory provision or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least two Non-Executive Directors and at least two Executive Directors) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Board of Directors's minutes.

(ii) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and members of the Trust.

(iii) The Audit Committee shall review every decision to suspend Standing Orders.

**3.14 Variation and Amendment of Standing Orders**

These Standing Orders shall not be varied except in the following circumstances:

- upon a notice of motion under Standing Order 3.5;
- upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;
- that two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive Directors vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision.

Direction made by the Independent Regulator of NHS Foundation Trusts and is approved by the Independent Regulator.

**3.15 Record of Attendance**

The names of the Chair and Directors/members present at the meeting shall be recorded.

### 3.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ordinary meeting.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

### 3.17 Admission of Public and the Press

**3.17.1** The public and representatives of the press shall be entitled to attend all formal meetings of the Trust (Board) but shall be required to withdraw upon the Trust (Board) resolving in accordance with the following:

> *"A body may, by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted….." (Section 1(2) Public Bodies (Admission to Meetings) Act 1960)*

**3.17.2** The Chair shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

> *"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public" (utilising the power given in section 1(8) Public Bodies (Admission to Meetings) Act 1960)*

**3.17.3** Nothing in these Standing Orders shall require the Trust (Board) to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board.

## 4 APPOINTMENT OF COMMITTEES AND SUB COMMITTEES

### 41 Appointment of Committees

The Board shall determine the membership and terms of reference of committees and sub-committees and shall if it requires, receiving and considering reports of such committees.

### 4.2 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term "Chair" is to be read as a reference to the Chair of other committee as the context permits, and the term "member" is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

### 4.3 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide. . Such terms of reference should be read in conjunction with the Constitution.

### 4.4 Delegation of Powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.

### 4.5 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees that it has formally constituted. Where the Board determines that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. Those appointed would be entitled to the payment of travelling and other allowances.

### 4.6 Appointments for Statutory Functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions laid down by the Board of Directors.

### 4.7Committees Established by the Board of Directors

The committees and sub-committees established by the Board are:

### 4.7.1 Audit Committee

In line with the requirements of the 2006 Act , an Audit Committee will be established and constituted to provide the Board of Directors with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations applicable to the Trust. The Terms of Reference will be approved by the Board of Directors and reviewed on a periodic basis.

The Code of Governance for NHS Providers recommends a minimum of three Non-Executive Directors be appointed, unless the Board decides otherwise and the Terms of Authorisation require that at least one must have recent and relevant financial experience.

### 4.7.2 Remuneration and Appointments Committee

A Remuneration and Appointments Committee will be established and constituted.

The committee shall be comprised exclusively of a minimum of 3 Non-Executive Directors.

The Remuneration and Appointments Committee will have delegated responsibility for setting remuneration and terms of service for the Chief Executive and other Executive Directors. including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

**~~(iii)~~** arrangements for termination of employment and other contractual terms. **~~4.7.3~~**

**~~Charitable Funds Committee~~**

~~(iv) In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Trust Board will establish a Trust and Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities~~

~~Commission.~~

~~(v) The provisions of this Standing Order must be read in conjunction with~~

~~Standing Order 2.8 and Standing Financial Instructions.~~

### 4.7.3 Other Committees

The Board may also establish such other committees as required to discharge the Trust's responsibilities.

## 4.8 Confidentiality

A member of the Board or a committee of the Board shall not disclose a matter dealt with by, or brought before, the Board/committee without its permission or until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

A Director of the Trust or a member of a committee shall not disclose any matter dealt with by, the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

# 5 ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

## 5.1 Delegation of Functions to Committees and Directors

The Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee or sub-committee appointed by virtue of Standing Order 4, or by

an individual Director, in each case subject to such restrictions and conditions as the Trust thinks fit.

## 5.2 Emergency Powers and Urgent Decisions

The powers, which the Board has reserved, to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be notified and recorded to the next formal meeting of the Board of Directors.

## 5.3 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.

## 5.4 Delegation to Officers

**5.4.1** Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust.

**5.4.2** All powers delegated by the Chief Executive can be re-assumed by them should the need arise. As Accounting Officer, the Chief Executive is accountable through NHS England to Parliament for the funds entrusted to the Trust.

**5.4.3** The Chief Executive shall prepare a Scheme of Delegation identifying their proposals, which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board.

**5.4.4** Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of any Executive Director to provide information and advise the Board in accordance with statutory requirements. Outside these statutory requirements the role of the Director of Finance shall be accountable to the Chief Executive for operational matters.

**5.4.5** Powers are delegated to Directors and officers on the understanding that they will exercise powers in a matter which, in their judgement, is not likely to be a cause for public concern.

**5.4.6** The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

**5.4.7** In the absence of a Director or officer to whom powers have been delegated those powers shall be exercised by that Director or officer's superior unless alternative arrangements have been ~~approved by the Board~~ notified in writing by the director concerned. If the Chief Executive is absent powers delegated to them may be exercised by his/her appointed deputy ~~Chairman~~ after taking appropriate advice from the Finance Director

**5.5Schedule of Matters Reserved to the Trust and Scheme of Delegation of Powers.** The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers should be read in conjunction with the Constitution.

**5.6 Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions**

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the Audit Committee, and to the Board at the next available opportunity ~~for action or ratification.~~ All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

## 6 OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

### 6.1 Policy Statements: General Principles

The Board of Directors will from time to time agree and approve Policy Statements/ Procedures, which will apply to all, or specific groups of staff employed by Kettering General Hospital NHS Foundation Trust. Delegated authority to approve such Policies and Procedures will be set out in the Trust's Scheme of Delegation.

### 6.2 Specific Policy Statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Conflicts of Interest Policy for Kettering General Hospital NHS Foundation Trust staff;
- the staff Disciplinary and Appeals Procedures adopted by the Trust both of which should be read in conjunction with Standing Orders.

### 6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Board of Directors in accordance with the Financial Regulations should be read in conjunction with the Constitution.

### 6.4 Specific Guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000;
- Equality Act 2010.

## 7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS / DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

### 7.1 Declaration of Interests

#### 7.1.1 Requirements for Declaring Interests and Applicability to Board Members

The regulatory framework requires Board of Directors Members to declare interests, which are relevant and material to the Board of Directors Secretary. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

#### 7.1.2 Interests which are Relevant and Material

(i) Interests which should be regarded as "relevant and material" are:

a) Directorships, including Non Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

d) A position of authority in a charity or voluntary organisation in the field of health and social care;

e) Any connection with a voluntary or other organisation contracting for NHS services;

f) Research funding/grants that may be received by an individual or their department;

g) Interests in pooled funds that are under separate management.

(ii) Any member of the Board of Directors who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

### 7.1.3 Advice on Interests

**If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Trust Board Secretary.**

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

### 7.1.4 Recording of Interests in Board of Directors Minutes

At the time Board members' interests are declared, they should be recorded in the Board of Directors minutes.

Any changes in interests should be declared at the next Board of Directors meeting following the change occurring and recorded in the minutes of that meeting.

### 7.1.5 Publication of Declared Interests ~~in Annual Report~~

Board members' directorships of companies likely or possibly seeking to do business with the NHS will be published on the Trust's website. The information should be kept up to date for inclusion in succeeding annual reports.

### 7.1.6 Conflicts of Interest Which Arise During the Course of a Meeting

During the course of a Board of Directors meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision (See overlap with SO 7.3)

## 72 Register of Interests

**7.2.1** The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2), which have been declared by both Executive and Non-Executive Board of Directors members.

**7.2.2** These details will be kept up to date by means of an ~~annual~~ ongoing review of the Register in which any changes to interests declared ~~during the preceding twelve months~~ will be incorporated upon notification to the Trust Board Secretary.

**7.2.3** The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

## 7.3 Exclusion of Chair and Members in Proceedings on Account of Pecuniary Interest

### 7.3.1 Definition of Terms Used in Interpreting 'Pecuniary' Interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

**(i)** **"spouse"** shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

**(ii)** **"contract"** shall include any proposed contract or other course of dealing.

**(iii)** **"Pecuniary interest"** Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if: -

a) they, or their nominee, are a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

b) they or a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(iv) **Exception to Pecuniary Interests.** A person shall not be regarded as having a pecuniary interest in any contract if: -

a) neither they or any person connected with him/her has any beneficial interest in the securities of a company of which they or such person appears as a member, or

b) any interest that they or any person connected with them may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or

c) those securities of any company in which they (or any person connected with them) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

**7.3.2 Exclusion in Proceedings of the Board of Directors**

(i) Subject to the following provisions of this Standing Order, if the Chair or a member of the Board of Directors has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(ii) The Board may, subject to such conditions as it may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed. Such action shall have the support of at least two-thirds of the Directors (including two Executive and two Non-Executive Directors).

(iii) The Board of Directors may exclude the Chair or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which they have a pecuniary interest is under consideration.

(iv) Any remuneration, compensation or allowance payable to the Chair or a member by virtue of paragraph 11 of Schedules 3 & 4 to the National Health Service Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(v) This Standing Order applies to a committee or sub-committee as it applies to the Trust.

## 8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

### 8.1 Custody of Seal

The common seal of the Trust shall be kept by the Chief Executive or a nominated manager by him/her in a secure place.

### 8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed on the order of the Board of Directors in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

### 8.3 Register of Sealing

The Chief Executive shall keep a register in which they, or another manager of the Trust authorised by them, shall enter a record of the sealing of every document.

### 8.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

## 9. **Resolution of Disputes with the Council of Governors –** See Section 10 to Annex 4 above

## 10. NOTIFICATION OF NHS ENGLAND AND COUNCIL OF GOVERNORS

The Board shall notify NHS England and the Council of Governors of any major changes in the circumstances of the Trust which have made or could lead to a substantial change to its financial well being, healthcare delivery performance, or reputation and standing or which might otherwise affect the Trust's compliance with the terms of its Authorisation.

## 11. BOARD PERFORMANCE

The Chair, with the assistance of the Trust Secretary, shall lead, at least annually, a performance assessment process for the Board. This process should act as the basis for determining individual and collective professional development programmes for Directors.

## ANNEX 6

## FURTHER PROVISIONS - ELIGIBILITY TO BE A MEMBER

### 1. Eligibility to be a Member

A person may not become a Member of the Trust, and if already a Member will immediately cease to do so, if they:

**1.1** Are under sixteen years of age;

**1.2** Are, or have been subject to a sex offender order; or has been convicted of any offence against children;

**1.3** resign on notice to the Trust BoardBoard of Directors Secretary,

**1.4** Cease to be entitled under this Constitution to be a Member of any of the constituencies,

**1.5** Are expelled under this Constitution,

**1.6** Appear to the Trust Board Secretary that they no longer wish to be a Member and after enquiries made, in accordance with a process approved by the Council of Governors, they fail to confirm that they wish to continue to be a Member of the Trust.

**1.7** They are identified as a vexatious complainant as described in the Trust's Policy and Procedure for the Management of Complaints

### 2. Expulsion of a Member

A Member (including nominated Members) may be expelled by a resolution of the Council of Governors. The following procedure is to be adopted.

**2.1** Any Member may complain to the Trust Board Secretary that another Member has acted in a way detrimental to the interests of the Trust.

**2.2** If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each Member's point of view is heard and may either:

(a) dismiss the complaint and take no further action; or
(b) arrange for a resolution to expel the Member complained of to be considered at the next meeting of the Council of Governors

**2.3** If a resolution to expel a Member is to be considered at a meeting of the Council of Members, details of the complaint must be sent to the Member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

**2.4** At the Meeting, the Council of Governors will consider oral and written evidence produced in support of the complaint and any oral and written evidence submitted for or on behalf of the Member about whom complaint has been made.

**2.5** If the Member complained of fails to attend the meeting without due cause the meeting

may proceed in their absence.

**2.6** A person expelled from Membership will cease to be a Member upon the declaration by the Chair of the meeting that the resolution to expel them is carried.

**2.7** No person who has been expelled from Membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the Members of the Council of Governors present and voting at a meeting of the Council.

## ANNEX 7 - STANDARDS OF BUSINESS CONDUCT

Both the Council of Governors and the Board of Directors will operate a Code of Conduct. This will ensure high standards of probity and responsibility and will make it clear how potential conflicts of interests are dealt with. Kettering General Hospital NHS Foundation Trust has adopted the Nolan Principles of Public Life set out at paragraph 11 of this Appendix.

### 1. Policy

**1.1** Staff must comply with the Managing Conflicts of Interest policy . The following provisions should be read in conjunction with this document.

### 2 Standards of Business Conduct

#### 2.1 Trust Policy and National Guidance

All Trust staff and members of must comply with the Trust's Standards of Business Conduct/Management of Conflict of Interests Policy, the Code of Governance for NHS Providers (2023) and any other best practice advice or guidance issued by the Regulator.

#### 2.2 Interest of Directors and Employees in Contracts

i) Any Director or employee who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them has any pecuniary interest, direct or indirect, shall declare their interest by giving notice in writing of such fact to the Chief Executive or the Board of Directors Secretary as soon as practicable.
ii) A Director or employee should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.
iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.
iv) Directors must behave in accordance with the seven Nolan principles of behaviour in Public Life: which are detailed in Annex 7 to the Trust's Constitution – Standards of Business Conduct, and must comply, upon appointment and throughout their Terms of Office, with the requirements of the Trust's Fit and Proper Person Policy.

#### 2.3 Canvassing of, and Recommendations in Relation to Appointments

i) Canvassing of Directors or Governors of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.
ii) Directors, employees and Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

#### 2.4 Relatives of Directors, Governors or Employees

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any Director, Governor or employee of the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.
ii) Every Director, Governor and employee of the Trust shall disclose to the Chief

Executive/Chief People Officer any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive/Chief People Officer to report any such disclosure made and determine any appropriate actions required in response..

iii) On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board of Directors whether they are related to any other member or holder of any office under the Trust.

iv) Where the relationship to a member of the Trust is disclosed, ~~the Standing Order headed 'Disability of Chairman and members in proceedings on account of pecuniary interest' (SO 7)~~ the provisions of Board Standing Order 7 (above) shall apply.

**3 The Board of Directors and Council of Governors will:**

a) abide by the Seven Principles of Public Life (Nolan), which are:

**Selflessness** – Holders of public office should take decisions solely in terms of the public interest. They should not do so to gain financial or other material benefits for themselves, their family or their friends.

**Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

**Objectivity** – In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

**Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

**Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

**Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

**Leadership** – Holders of public office should promote and support these principles by leadership and example.

b) Actively support the vision and aims of Kettering General Hospital in developing as a successful NHSFT;

c) Act in the best interests of the Trust at all times:

d) Contribute to the work of the Council of Governors and the Board of Directors in order for it to fulfil its role as defined in the Trust's Constitution;

e) Recognise that the Council of Governors exercises collective decision-making on behalf of all patients, Members, local public and staff;

f) Not expect any privileges from being a Council Member, Director or Officer of the Trust;

g) Recognise that the Council of Governors has no managerial role within Kettering General Hospital NHS Foundation Trust;

h) Value and respect Council Member and Director colleagues and all members of staff;

i) Respect the confidentiality of information received in individual roles;

j) For Council Members to attend meetings of the Council of Governors and development days, on a regular basis, in order to carry out their role;

k) Directors, Council Members and Officers of the Trust are to conduct themselves in a manner that reflects positively on Kettering General Hospital NHS Foundation Trust, acting as an ambassador for the Trust;

l) Directors and Council Members will comply with the Constitution;

m) Directors and Council Members will respect the confidentiality of individual patients;

n) Directors, Council Members and Officers of the Trust will not knowingly make or permit, any untrue or misleading statement relating to their own duties or the functions of Kettering General Hospital NHS Foundation Trust;

o) Directors, Council Members and Officers of the Trust shall discuss all communication with the media with the Communications Manager or Board of Directors Secretary prior to contact;

p) Directors, Council Members and Officers of the Trust will support and assist the Accounting Officer of Kettering General Hospital NHS Foundation Trust in his/her responsibility to answer to the regulator, commissioners and the public for the performance of the Trust.

**6.** In addition, Governors, ~~in undertaking the role of Council Members of this NHS Foundation Trust~~ shall sign a declaration stating that they have read, understood and agreed to comply with the Kettering General Hospital NHS Trust Foundation Trust's Code of Conduct for Council Governors, agreeing also to inform the Trust Board Secretary if at any time, they become unable to comply with the Code or any part of the Code.

~~**6.1** If they are a member of any trade union, political party or other organisation, and if so, that they recognise that they must declare this fact and that they will not be representing those organisations (or the views of those organisations) but will be representing the constituency (public and staff) that elected them;~~

~~**6.2** That they seek to ensure that fellow Council Members are valued as colleagues and that their views are both respected and considered;~~

~~**6.3** They accept responsibility for their own actions;~~

~~**6.4** They show commitment to working as a team member by working with all colleagues in the NHS and wider community;~~

~~**6.5** They seek to ensure that the Membership of the constituency or partner organisation they represent is properly informed and given the opportunity to influence services;~~

~~**6.6** They seek to ensure that no one is discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin;~~

~~**6.7** They will agree to have a Disclosure and Barring Service check.~~

**KETTERING GENERAL HOSPITAL PROCEDURE FOR THE REMOVAL OF A GOVERNOR FROM OFFICE**

*1. Constitutional provisions*

Article 19.2.12 of the Trust's Constitution provides that 'A person…if already holding such office (of Governor) will immediately cease to do so if:

'They are removed from the Council of Governors, following an approved procedure, by a resolution approved by 75% of the remaining Council Members present and voting at a General Meeting on the grounds that:

(a) They have committed a serious breach of the Trust's Code of Conduct (enclosed as an appendix to this document), or
(b) They have acted in a manner detrimental to the interests of the Trust, or
(c) They have failed to discharge their responsibilities as a Council Member.'

*2. Procedure*

2.1 Requests for the removal of a Governor from the Council of Governors under Section 19.2.12 of the Trust's Constitution should be submitted in writing to the Trust Board Secretary, including reasons and supporting evidence. Complaints may be submitted from any source. The Trust Board Secretary shall bring the matter to the attention of the Trust Chair, who shall determine whether to proceed with the complaint, formally or informally. If the Chair decides a complaint shall be dealt with informally, the Chair will discuss it with the Governor and if appropriate, offer advice or support to the Governor to avoid any further breaches of the Governors' Code of Conduct or the Trust Constitution. This will be documented in writing to the Governor and kept on file for a period of 12 months. The complaint shall not be taken further under this procedure, unless the Chair subsequently determines that the complaint is more serious than first thought and should be dealt with as follows below.

2.2 If the Trust Chair decides that the complaint should be dealt with formally they, or another individual appointed by them, shall then carry out a preliminary review of the case lasting, in normal circumstances, no longer than one month, and determine (in writing) one of the following courses of action:

(i) If this review concludes that there is no case to answer, the matter shall go no further and no formal resolution to remove the individual may be proposed.
(ii) If this review concludes that there is or may be a case to answer, the subject of the allegation shall be notified and invited to give their account of the matter, following which full investigation into the matter, by the Trust Chair or their nominated investigating representative, shall take place.

2.3 Where full investigation is deemed to be required in accordance with section 2.2(ii) above, it should be completed as soon as practicable, and ideally within six weeks of the date of notification. If, following investigation, it is concluded that there is no case to answer, the matter shall go no further and no resolution to remove the Governor shall be proposed. If the investigation concludes that there is or may be a case to answer, the investigator shall notify the Governor of that fact and of their recommendations (if any). The proposal to remove the Reviewer shall be put to a meeting of the Council of Governors to be held not sooner than 28 days from the date on which the Investigator notifies the Governor subject to the allegation that, in their opinion there is or may be a case to answer.

2.4 The Governor subject to the allegation shall have the right to prepare a written response to be sent to the Members of the Council of Governors no later than seven days in advance of the meeting. At the meeting itself, the Governor shall have the right to address the Council of Governors in relation to the proposal for their removal but shall not be entitled to attend the rest

of the meeting or to witness the proposal, the deliberations of the Council of Governors or their subsequent vote on the matter. The Governor shall have the right to be accompanied.

2.5 The Motion to remove the Governor from the Council shall require the approval of at least three quarters of the Members of the Council, present and voting.

2.6 In determining the matter, the Council shall be entitled to agree, by simple majority of Governors present and voting, sanctions other than removal from office which may include (but are not limited to) a written warning or restrictions on the Governor's ability to claim expenses or participate in specific aspects of Trust business.

2.7 The Governor shall be notified of the Council's decision by the Trust Board Secretary, in writing, within two working days of the decision. The Governor has the right to appeal any sanction issued. An appeal must be raised in writing under one or more of the following grounds:

- Identified flaws in the investigation or hearing process
- Additional information that they believe would affect the outcome which was not available at the time of the hearing
- Failure of the Council of Governors to consider all the information raised
- Overly harsh sanction imposed

2.8 An appeal must be lodged within five working days of receipt of the outcome letter to the Trust Board Secretary. The Governor should state in full their grounds of appeal. The Trust Board Secretary will arrange for an appeal hearing to take place within 21 days of receipt of the appeal letter. In the event that no appeal is lodged, any sanction will take effect seven days following the conclusion of the appeal deadline.

2.9 A Non-Executive Director, normally the Vice Chair, will be appointed to chair the appeal hearing alongside a panel comprising another member of the Board of Directors and a Governor from another Foundation Trust. The Trust Chair, and any individuals appointed by them to carry out previous investigations or involved in the case in any way, shall be precluded from panel membership.

2.10 It is the responsibility of the Governor to state their case for appeal. The Panel will have available to them the original hearing information and any further information submitted by the Governor in advance of the appeal hearing.

2.11 The Panel shall be requested to make a recommendation on whether the appeal is upheld or dismissed. Its recommendation may be given on the day or may be deferred for further consideration in which case the Governor will receive written notification within seven days of the hearing with the details of the decision reached. Following notification to the Governor, the Panel's recommendations will be formally submitted to the Council of Governors for determination, at a meeting to be held within a further 14 days of notification to the Governor. The Council will be invited to confirm or amend its previous decision, and must have regard to the recommendations of the Appeal Panel in doing so.

2.12 The Council's subsequent determination is final and there is no further internal right of appeal. Any Council decision to remove the Governor from the Council will take effect seven days following notification of Panel outcomes. The complainant will be notified in writing of the completion of the process.

[ADD LOGO]

# KGH SIGNIFICANT TRANSACTIONS POLICY AND PROCEDURE

| | |
|---|---|
| **VERSION NUMBER** | **002** |
| **KEY CHANGES FROM PREVIOUS VERSION** | **Fixed definitions of Significant Transactions removed to facilitate more flexible determinations on a case by case basis.** |
| **AUTHOR** | **Trust Board Secretary** |
| **CONSULTATION GROUPS** | **Consultation Review Working Group** |
| **IMPLEMENTATION DATE** | ***June 2024*** |
| **AMENDMENT DATE(S)** | - |
| **LAST REVIEW DATE** | **June 2024** |
| **NEXT REVIEW DATE** | **June 2027** |
| **APPROVAL BY COUNCIL OF GOVERNORS** | *6 June 2024* |
| **APPROVAL BY BOARD OF DIRECTORS** | *5 June 2024* |


**Summary**

The Significant Transactions Policy sets out how the Trust will ensure that it carries out formal processes in relation to significant transactions and adheres to relevant legislative and regulatory frameworks. This process includes the identification of potential transactions, assessment of whether a transaction is 'significant', internal and external due diligence processes, reporting to NHS England and approval of a transaction.

The Policy makes sure that all staff and the Council of Governors understand their obligations and responsibilities in relation to Significant Transactions. It also makes sure that the Council of Governors receive adequate training and an appropriate level of information in order to them to discharge their responsibilities.


**Policy requirement (see Section 2)**

Requirements include:

- All transactions that may be classed as significant must be assessed against a range of monetary and non-monetary criteria to determine whether they are significant. This must be reviewed by the Chief Finance Officer and considered by the Council of Governors.
- Internal due diligence processes must be carried out on all significant transactions. Some transactions may also require reporting to NHS England or external due diligence, which must be assessed on a case-by-case basis.

The Council of Governors has a statutory responsibility to approve the transaction through considering whether the Board of Directors has been thorough and comprehensive in reaching its proposal and has appropriately obtained and considered the interests of members and the public as part of the decision-making process.

## 1: Introduction

### 1.1 Rationale:

Entering into significant transactions may be necessary to contribute to the delivery of our vision and strategic objectives.

NHS Foundation Trusts (FT) have specific responsibilities as set out in legislative and regulatory frameworks around the assessment and approval of significant transactions. In particular:

- The NHS Act 2006, as amended by the Health and Social Care Act 2012, requires a Foundation Trust to seek the approval of its Council of Governors if it proposes to enter into a significant transaction.
- NHS England has published guidance to help support Trusts including FTs undertaking statutory transactions to ensure that such proposed transactions are the right solutions to the issues they wish to address and that the intended benefits will be delivered.
- The NHSE Guidance entitled “Assuring and supporting complex change Statutory transactions, including mergers and acquisitions” published October 2022 on based on the provisions of the Health and Care Act 2022 and supersedes previous such guidance that had been issued by NHS England.
- NHSE in its guidance insists that **“all transaction proposals will need to have patient and population benefits at their core and be underpinned by detailed plans for delivering those benefits”**.

The Health and Care Act 2022 contains a number of provisions relevant to this guidance which include: -

- transfer of legal powers in relation to transaction approval from Monitor and the Trust Development Authority to NHS England.
- introduction of statutory transfer schemes between trusts (new section 69A of the NHS Act 2006).
- clarification of the FT dissolution power.
- requirement for the Secretary of State for Health and Social Care to approve all transactions, including those only involving foundation trusts.
- exemption of transactions between trusts from review by the Competition and Markets Authority (CMA).

The Trust’s Constitution does not currently contain any descriptions or definition of the term ‘significant transaction’ for the purposes of section 51A of the 2006 Act (Significant Transactions), therefore the Board of Directors and Council of Governors will decide each case on its merit and in line with process outlined in this policy.

The Significant Transactions Policy will ensure that:

- A defined process is in place for identifying transactions and determining whether or not a transaction is deemed to be classed as significant;
- Robust due diligence processes are in place for assessing a significant transaction and evaluating risks;
- The Board of Directors and the Council of Governors have assurance that a robust and consistent approach is in place to ensure that sound business decisions are made based on a full impact and risk assessment;

- A clear process in in place setting out what information Governors will be given, at what point in the process Governors will be asked to approve the transaction, and how the views of members will be sought, and stakeholders kept informed.
- Appropriate approvals of the significant transaction are obtained in line with legislation and guidance;
- Significant transactions are reported to NHS England, in line with requirements; and
- All staff involved in significant transactions are aware of the process and their roles and responsibilities.

**1.2 Scope**:

This policy will apply to all transactions that could be classed as significant.

The following transactions will **always** be significant:

1. Joint ventures.
2. Mergers and acquisitions.
3. Dissolutions and separations.

This Policy will be followed by all staff who are involved in such a transaction e.g. through due diligence or gathering of evidence, as well as getting approval from the Board of Directors and the Council of Governors. Responsibilities are set out in Section 4.

Each transaction must be assessed on a case-by-case basis as to whether it is deemed to be significant or not. This process is set out in detail in Section 3.3. Assessment will take into account the following criteria:

Please note:

(1) This list is not exhaustive and other criteria may be assessed relevant to the nature of the transaction
(2) The criteria are not intended to be set as pass/fail criteria i.e. if one fails, it means the transaction is significant. Instead a balanced view will be taken of the results across all of the criteria and level of risk/exposure present.

**Monetary criteria**

What is the value of the transaction in relation to:

- Income: does the annual income attributable to the assets or contract associated with the transaction, divided by the income of the trust exceeds 10% (Income Test)?
- Assets: Do the gross assets subject to the transaction divided by the gross assets of the Trust exceed 10%?
- Capital: the gross capital or consideration associated with the transaction divided by the total capital of the trust following completion, or the effects on the total capital of the trust resulting from a transaction, exceeds 10%?

Whether it involves a volatile income e.g. Payment by Results?

Is it a loss making contract or acquisition?

Will there be significant financial penalties for non-performance?

Will there be significant liabilities e.g. redundancies from TUPE?

Will it increase the Trust's debt levels?

**Non-monetary criteria**

Is the transaction departing significantly from Trust strategy ?

Does it lead to a change in function or form e.g. commissioning?

Does it involve significant reputational risk?

Will it involve separate reporting to NHSE?

Does it involve a new CQC registration?

Will non-NHS income be increased by more than 5%?

Will it have a significant adverse impact on existing services?

Does it have an adverse impact on equality?

### 1.3 Out of Scope

The Council of Governors' discreet statutory role in contributing to the development of the Trust's annual plans and strategic development is out of scope of this procedure and guidance.

### 1.4 Principles

NHS organisations are increasingly planning transactions to bring increased opportunities to achieve strategic objectives, reorganise or respond to changes in the financial climate or local health economy. This is driven by a wider strategy of innovation and growth, as well as efforts to address clinical and financial issues that might affect patient care.

Significant transactions are generally complex and carry a detail of risk, and therefore will be subject to high scrutiny, transparency and follow due process.

It is important that entering into a significant transaction does not damage either our reputation, sustainability or reduce our ability to deliver our existing business.

Legislation sets out specific responsibilities and approvals necessary for our Council of Governors to be assured that the Board of Directors has carried out robust processes to assess a significant transaction and has considered the views of members and other stakeholders.

## 2: Procedure

### 2.1 Identifying and confirming a significant transaction

The Chief Finance Officer will identify any potential significant transactions arising from the Trust's business planning and corporate governance processes and frameworks, taking into account the criteria set out above and consulting the Integrated Leadership Team as appropriate, arising from the Trust's annual business planning processes.

The Chief Finance Officer will notify the Chief Executive, Trust Chair and Lead Governor within 14 days of a significant transaction being identified so it can be quickly established if there are any concerns which may prevent the Council of Governors approving the transaction. The Council of Governors shall receive a written report setting out details of the transaction, at its next scheduled meeting or, where the matter is urgent, at an Extraordinary meeting convened for the purpose. The report shall set out:

- Background to the transaction – either through a written report or a presentation. This will include a clear explanation of what the transaction is and the potential impact for the Trust.
- Assessment against significant transaction criteria.
- Recommended conclusion as to whether a transaction is deemed to be significant or not.

If the Council of Governors disagree with the assessment of whether or not a transaction is significant, they need to state the reasons and a meeting held with the Lead Governor, Chief Executive, Chief Finance Officer and Trust Chair to resolve the issue. In the event that agreement cannot be reached, the decision of the Chief Executive and Chief Finance Officer shall be final.

Where a transaction fits within **NHS England's** thresholds of a material or a significant transaction, this must be reported to them as early in the assessment stage as possible, and their processes for self-certification or detailed review followed.

### 2.2 Engagement in Project Delivery

The Council of Governors have a role to play throughout the process and this policy sets out a summary of their responsibilities, including when they will expect to be involved and what information they will expect to receive.

Approval of the transaction by the Council of Governors should be scheduled in the business, project or programme plan for the transaction, and Stakeholder

engagement plans reviewed as required to ensure that the Council of Governors is fully informed prior to a decision being sought.

The Council of Governors must be consulted on a case-by-case basis about the process that should be followed to enable them to be involved and informed in order to approve the transaction. This will take into account the nature, complexity, impact and risk of the transaction. Involvement could involve one or more of the following:

- The nominated Lead Governor .
- A working group of the Council of Governors who would meet to look at the proposal and process in more detail.
- Attendance at Board of Directors meetings where the transaction is considered.
- Update reports on the process and due diligence to formal Council of Governor meetings.

By 'approval' this means the Council of Governors need to satisfy themselves that the board of directors has been thorough and comprehensive in reaching its proposal and appropriately obtained and considered the interests of members and the public as part of the decision making process.

**2.3 Approval of significant transactions**

**2.3.1 Board of Directors** – the Board of Directors is responsible for making the formal decision whether to proceed with the transaction, subject to Council of Governors' approval. Once Council of Governors approval has been received, the transaction can go ahead.

2.3.2 **Council of Governors** – Governors need to satisfy themselves that the Board of Directors has followed and comprehensive processes in developing its proposals and has appropriately obtained and considered the interests of members, the public and other key stakeholders as part of the decision-making process.

They must be assured that a due process has been followed, that the Board has sought and obtained assurance regarding risk and has taken account of the implications of not approving the transaction. The Council can disagree with the merits of a particular decision of the board on a transaction, but still give its consent because due diligence has been followed and assurance received.

To withhold its consent, the council of governors would need to establish that appropriate due diligence was either not undertaken or properly factored into decision-making. They should consider the implications of withholding consent in terms of the key risks the transaction was designed to address.

2.3.3 The Council of Governors will need to receive adequate information from the Board of Directors to enable them to make their decision to approve the transaction. The nature of this information will vary depending on the specific nature of the transaction. Examples of information that the Council of Governors may require to give them the assurances they need are set out in Appendix 2.

2.3.4 Provided reasonable assurance is obtained, governors should not unreasonably withhold their consent for a proposal to go ahead.

2.3.5 This approval will be obtained at a formal Council of Governors meeting, which depending on the nature of the transaction may be a private meeting.

2.3.6 If the Council of Governors raise a concern about the process or the due diligence

which prevents them from approving the transaction, then this concern will be addressed by the Chief Executive, Chief Finance Officer and lead Executive Director for the proposal, and taken back to Board of Directors for approval.

**2.3.7** f the Council of Governors does not approve the transaction, the Trust Board Secretary will record the rationale in the Minutes. In such circumstances, The Trust Board Secretary will report the rationale to the Board of Directors and the resolution process will be followed as provided in Section 10.3 of The Council of Governors Standing Orders, set out in the Constitution.

2.3.8 In accordance with the NHS Act 2012:

For statutory transactions (i.e. mergers, acquisitions, separations or dissolutions) more than half of the members of the **full** Council of Governors must approve the application. This means more than half of the total number of governors, not just those in attendance at the meeting where the decision is taken.

For other transactions more than half of the members of the full Council of Governors **voting** need to approve the Trust entering into any significant transaction**.** This means more than half of the governors who are in attendance at the meeting and who vote at that meeting.

**3. Reporting to NHS England (NHSE)**

3.1 If a transaction represents 10%+ of assets, income or capital, it is reportable to NHSE, however, all statutory transactions are reportable to NHS England, regardless of their size. The NHSE guidance “Assuring and supporting complex change Statutory transactions, including mergers and acquisitions”, must be consulted as the transaction may be subject to either Board Certification or a Detailed Review depending on its nature or whether it meets certain monetary thresholds or risk factors set out in the guidance.

3.2 NHSE has the statutory powers to support, review and approve transactions. The legislation dictates that NHSE can only grant an application for a merger, acquisition, dissolution or separation where they are satisfied that trusts have taken the necessary steps to prepare for the transaction, and where the grant is also approved by the Secretary of State.

3.3 However, the SoS`s approval is not required for FT dissolutions. For other transactions, NHSE will seek the support of the Secretary of State on trusts’ behalf, but trusts may be required to provide supporting information further to FBC submissions, in response to SoS requests.

3.4 NHSE encourage early ‘informal’ engagement when the transaction is being strategically assessed so that they can provide support, advice and consider whether the proposed transaction would meet their thresholds or need reviewing by the Competitions and Markets Authority.

3.5 Transactions defined by NHSE as “material” will require Board of Directors to make a Self-Certification

3.6 Transactions defined by NHSE as “significant” will be subject to a detailed review and approval by NHSE. This will consider four dimensions of strategy, transaction execution, quality and finance. The review will result in a transaction risk rating of red, amber or green. Transactions should only be proceeded with if the risk rating is green or amber.

**4. Training**

4.1 Related training will be provided to members of the Council of Governors (CoG) or Board of Directors once every three years and/or whenever the CoG or Board of Directors has witnessed significant renewal (i.e. at least 30% of new members have joined) as training will enable either of these bodies to fulfil their duties. Such training will also be provided to senior managers, especially those who may be involved in leading their service during a significant transaction or to create awareness and may be delivered by staff from the Trust or Internal/External Audit and may include:

- Training and refresher training of the Significant Transactions Policy.
- Training on specific types of transaction such as merger and acquisitions.
- Financial analysis training.
- Training on how to interpret a due diligence report.

**5. Communication with members**

Once a final decision has been taken on the proposed significant transaction and it is no longer deemed as confidential, the Council of Governors will communicate the transaction to the Trust's members and the public. The Trust will assist the Governors in doing this. The method of communication will be agreed for each transaction and could include the Trust's website, an advertised drop-in session or a newsletter.

6. **Post transaction**

A review will be carried out one year post the significant transaction taking place to assess its reputational, financial, quality and operational impact against the original plans. This will be coordinated by the Chief Finance Officer and reported to the Board of Directors and the Council of Governors.

**6: Reference documents**

Constitution

*[NHSE Guidance]*

**7: Monitoring** :

| Element to be monitored | Lead | Tool | Frequency | Reporting Bodies |
|---|---|---|---|---|
| Audit of implementation of this policy with regards significant transactions. | Chief Finance Officer | Surveys & Desktop Review of application of Policy. | At the end of the year if a significant transaction had taken place. | Board / Council |

**8. Appendices**:

Appendix 1 Equality Impact Assessment.
Appendix 2 Sources of assurance for Council of Governors

[ADD LOGO]

**Appendix 1**

| Equality Impact Assessment (EIA) – Assessment of draft revised policy | | | |
|---|---|---|---|
| 1.Division | Corporate | 2. Department | Corporate Governance |
| 3. Person(s) completing this form | Richard May, Group Company Secretary | 4. Contact Information | 07814 078217, Richard.may1@nhs.net |
| 5. Others involved | Constitution Review Working Group<br>Director of Corporate and Legal Affairs<br>Chief Finance Officer | 6. Date of this assessment | 26 April 2024 |
| 7. What is being assessed (please tick) | New Policy: **No** ☐<br>Existing Policy **Yes** ☐<br>New Service / Function ☐<br>Review Service / Function ☐ | 8. Implementation/ effective date | *June 2024* |
| 9. Name of Policy | Significant Transactions | | |
| 10. What are the aims / objectives of policy this service? | The Significant Transactions Policy sets out how the Trust will ensure that it carries out formal processes in relation to significant transactions and adheres to relevant legislative and regulatory frameworks. This process includes the identification of potential transactions, assessment of whether a transaction is 'significant', internal and external due diligence processes, reporting to NHS England and approval of a transaction.<br><br>The Policy makes sure that all staff and the Council of Governors understand their obligations and responsibilities in relation to Significant Transactions. It also makes sure that the Council of Governors receive adequate training and an appropriate level of information in order to them to discharge their responsibilities. | | |
| 11. Who will be impacted by policy / service (please tick) | Patients **INDIRECT** ☐<br>Carers **INDIRECT** ☐<br>Public **INDIRECT** ☐ | 11a. If staff are impacted, how many individuals / Which Groups of Staff are likely to be affected? | As specified in the policy, principally the Council of Governors, Chief Finance Officer and Trust Board Secretary. |

| | | | | |
|---|---|---|---|---|
| | Staff **INDIRECT** ☐<br>Governors **DIRECT** ☐ | | | |
| 12. Who has been involved in the policy / service development (please tick) | Patients ☐<br>Carers ☐<br>Public ☐<br><br>Staff ☐<br>Other YES ☐ | | 12a. If yes, who have you involved and how have they been involved | Policy developed by the Constitution Review Working Group comprising the Trust Vice-Chairs and four Governors, supported by the Trust Board Secretary. Consultation on the draft subsequently undertaken with the Chief Finance Officer, Director of Corporate and Legal Affairs and Major Programmes Team |
| 13. What further consultation method(s), if any, are you proposing? | None | | 14. How are any changes / amendments to the policy / service to be communicated? | Approval by the Board and Council at June 2024 meetings and subsequent publication on the Trust's website as an addendum to the Constitution. |
| 15. Impacts on Protected Equality Characteristics | Policy is about a process to be followed to ensure the Trust complies with legislative and regulatory guidance in relation to any significant transactions carried out. The policy does not directly impact staff, service users or stakeholders in terms of protected characteristics. | | | |

**Appendix 2 Sources of Assurance for Council of Governors**

The precise nature of the information to be reported by the Board of Directors to the Council of Governors will vary depending on the specific nature of the significant transaction, but is likely to comprise some or all of the information below:

| **Evidence that the Board of Directors has:** | **Potential sources of assurance** |
|---|---|
| Carried out an appropriate level of financial and market due diligence relating to the proposed transaction. | Tender due diligence checklist.<br>Internal audit review of significant risks highlighted during tender process for which mitigations are not possible.<br>Certification that price covers cost and includes margin from Chief Finance Officer |
| Considered the implications of the proposed transaction on the Trust's risk assessment and risk ratings, having taken full account of reasonable downside sensitivities. | Certification from Chief Finance Officer.<br>Board and Council reports. |
| Conducted appropriate inquiry about the probity of any partners involved in the transaction, taking into accounts the nature of the services provided and likely reputational risk. | Partner due diligence checklist.<br>Board and Council reports. |
| Conducted an appropriate assessment of the nature of services being undertaken as a result of the transaction and any implications for reputational risk arising from these. | Certification that service is deliverable and non impacting from Chief Operating Officer.<br>Equality impact assessment.<br>Internal audit review of significant risks highlighted during tender process for which mitigations are not possible. |
| Received appropriate external advice from independent professional advisors with relevant experience and qualifications (if required). | Executive Summary from External Advisors Report and Audit Committee reports. |

[ADD LOGO]

| **Evidence that the Board of Directors has:** | **Potential sources of assurance (not an exhaustive list)** |
|---|---|
| Taken into account the best practice advice in the guidance published by NHSE or commented by exception where this is not the case. | Statement from the Board of Directors. |
| Resolved any accounting issues relating to the transaction and its proposed treatment. | Certification from the Chief Finance Officer.<br>Board and Council reports. |
| Address any legal issues associated with the transfer of staff (if relevant). | Board and Council reports. |
| Complied with any consultation requirements. | Summary of consultation process and feedback. |
| Established the organisational and management capacity and skills to deliver the planned benefits of the proposed transaction. | Board and Council reports. |
| Involved senior clinicians at the appropriate level in the decision-making process and received confirmation from them that there are no material clinical concerns in proceeding with the transaction, including consideration of the subsequent configuration of clinical services. | Confirmation from Clinical Senate. |
| In the case of a contract of a specified period, ensured appropriate legal protection in relation to staff, including on termination of the contract. | Board and Council reports. |
| Ensured relevant commercial risks are understood. | Board and Council reports. |

| **Evidence that the Board of Directors has:** | **Potential sources of assurance (not an exhaustive list)** |
|---|---|
| Prepared a post transaction integration plan. | Board and Council reports. |
| Prepared plans for applying appropriate quality governance arrangements. | Quality impact assessment.<br>Certification that a quality service can be delivered with compliance with regulatory standards from Executive Director of Nursing and the Medical Director.<br>Board and Council reports. |

# Cover sheet

| | |
|---|---|
| Meeting | Boards of Directors of Northampton General Hospital NHS Trust (NGH) and Kettering General Hospital NHS Foundation Trust (KGH) meeting together in Public |
| Date | 5th June 2024 |
| Agenda item | 10 |

| | |
|---|---|
| Title | Board Assurance Framework (BAF) |
| Presenter | Richard Apps, Director of Corporate and Legal Affairs |
| Author | Debbie Spowart, Head of Risk |

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

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

| Reason for consideration | Previous consideration |
|---|---|
| To provide assurance of relationship between the Group Board Assurance Framework (BAF) and the Corporate significant risks at both Kettering General and Northampton General Hospitals. | Previously considered by committees in common during May 2024. |

## Report

This report provides oversight of the Group Board Assurance Framework at 17th May 2024 and the relationship between the strategic risks on the Group BAF and the significant risks contained on the Corporate Risk Registers at both Kettering General (KGH) and Northampton General Hospitals (NGH) that potentially impact on the BAFs strategic risks.

Risk Management is both a statutory requirement and an indispensable element of good management and is a fundamental part of the total approach to quality, corporate and clinical governance and is essential to the Trusts abilities to discharge its functions as a partner in the local health & social care community, as a provider of health services to the public and an employer of significant numbers of staff.

To ensure best practice in good governance, and to reach an outstanding rating under the CQC

well-led domain, the Trust must demonstrate delivery of best practice and performance in risk management.

Each assigned BAF monitoring committee received the Group BAF in May 2024 alongside the associated significant corporate risks from each hospital.

Following Executive reviews, the following changes were made:

- UHN01 - New and updated further planned actions added across all controls. Updated assurances across all controls. The People Committee has requested that the risk appetite for this risk be changed to 'low', reflecting the imperative that the aims and objectives are achieved to ensure our ability to attract, recruit, develop and retain colleagues thus able to deploy the right people to the right role at the right time.
- UHN02 – Updates across all assurances and further planned actions.
- UHN03 – Updated further planned actions (control 1 and 2) and updated assurances from achieved actions on progress against objectives (line 3).
- UHN04 – Completion of planned action on control 1 and 2 and addition of new further planned actions.
- UHN05 – Completion of action for 6 Facet Survey at KGH. New action added for equivalent at NGH and extension to action date (control 5).
- UHN06 – Updates across all assurances and further planned actions.
- UHN07 - Updates across all assurances and further planned actions.
- UHN08 – Updates across all assurances and further planned actions. Current risks score changed.

Appendix A details the group BAF and Appendix B details the alignment of significant corporate risks at both KGH and NGH @ 17th May 2024.

In line with good governance, deep dives of BAF Risks UHN04, UHN05 and UHN07 were completed in May 2024.

## Appendices

Appendix A – UHN Group BAF @ 29/05/2024

Appendix B – Alignment of significant corporate risks at both KGH and NGH @ 17/05/2024

## Risk and assurance

As set out in the report.

## Financial Impact

Financial risks are detailed within the BAF

## Legal implications/regulatory requirements

Duty to identify and manage risks / CQC Well-Led

## 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) |

# Group Board Assurance Framework

## 29th May 2024

University Hospitals of Northamptonshire NHS Group

| Ref | Group Priority | Scrutinising Committee | Risk Title | Initial Risk Level (July 2022) | Current Risk Level (May 2024) | Movement (from Initial) | Residual Risk Level | Risk Appetite | Summary Updates |
|---|---|---|---|---|---|---|---|---|---|
| **UHN01** | People | Group People Committees in Common | Challenges in our ability to attract, recruit, develop and retain colleagues means we are unable to deploy the right people to the right role at the right time resulting in potential detriment to patient care. | **16** | **16** | → | **12** | **Moderate** | New and updated further planned actions added across all controls.<br><br>Updated assurances across all controls |
| **UHN02** | Quality | Quality Safety Committee in Common | Failure to deliver the UHN Clinical Strategy and clinical collaboration may result in some areas of clinical and financial unsustainability | **12** | **16** | ↑ | **8** | **Low** | Updates across all assurances and further planned actions |
| **UHN03** | Patient | Quality Safety Committee in Common | Failure to deliver the group Nursing, Midwifery and Allied Health Processionals (NMAHP) Strategy may result in inequity of clinical voice, failure to become a truly clinically led organisation and centre of excellence for patient care | **12** | **12** | → | **8** | **Low** | Updated further planned actions (control 1 and 2) and updated assurances from achieved actions on progress against objectives (line 3) |
| **UHN04** | Systems and Partnership | Quality Safety Committee in Common<br><br>Finance and Investments Committee in Common | Failure of the Integrated Care Board (ICB) to deliver transformed care will result in an impact on the quality of service provided across the Group | **16** | **16** | → | **12** | **High** | Completion of planned action on control 1 and 2 and addition of new further planned actions |
| **UHN05** | Sustainability | Finance and Investments Committee in Common | Risk of failing estate buildings and infrastructure due to age and suitability and, failure to deliver Group strategic estates plans, may prevent delivery of key Group strategies, eg Clinical Strategy | **12** | **12** | → | **6** | **High** | Completion of action for 6 Facet Survey at KGH. New action added for equivalent at NGH.<br><br>Extension to action date (control 5) |
| **UHN06** | Quality | Quality Safety Committee in Common | Failure to deliver the long-term Group Academic Strategy may result in University Hospitals Northamptonshire's (UHN) ability to attract high calibre staff and research and education ambitions. Recognition of impact on financial income to the Group | **12** | **12** | → | **4** | **Low** | Updates across all assurances and further planned actions |
| **UHN07** | Quality | Quality Safety Committee in Common | Failure to deliver the Group Digital Strategy may result in our staff and patients not having the tools or information they need to deliver, and receive safe, high quality patient care. | **16** | **16** | → | **16** | **High** | Updates across all assurances and further planned actions |
| **UHN08** | Sustainability | Finance and Investments Committee in Common | Failure to deliver a Group Medium Term Financial Plan results in an inability to deliver Trust, Group and system objectives. | **16** | **16** | ↓ | **16** | **High** | Updates across all assurances and further planned actions<br><br>Risk level changed following agreement at F&IC in May 2024 |

| Principal Risk No: | UHN01 | Risk Title: | Challenges in our ability to attract, recruit, develop and retain colleagues means we are unable to deploy the right people to the right role at the right time resulting in potential detriment to patient care. |
|---|---|---|---|
| | | Materialising in [any/several] of the following circumstances: | The Group People Committee will determine circumstances in which it considers the risk to have materialised, having regard to key qualitative and quantitative evidence including:<br>(1) Sustained declines in Staff and People Pulse Survey key indicators in respect of response rates, discrimination and advocacy<br>(2) Key metrics relating to sickness absence, turnover, vacancies and statutory and mandatory training/appraisal completions in special cause variation for at least three consecutive reporting periods<br>(3)Key metrics relating to safe staffing in special cause variation for at least three consecutive periods<br>(4)Customer experience performance/concerns referred from quality committees<br>(5) Cumulative qualitative and anecdotal evidence identified in the course of business-as-usual activities e.g. Non-Executive site visits/presentations to Committee/regular communication mechanisms.<br>(6)Corporate Risks (below) materialise. |

| Date Risk Opened: | April 2021 | Risk Classification: | Operational / Infrastructure | Risk Owner: | Group Chief People Officer | Scrutinising Committee: | People Committees in common |
|---|---|---|---|---|---|---|---|

| Corporate Risk Register Links: | | | |
|---|---|---|---|
| NGH CRR: | NGH46 - Detrimental staff wellbeing and mental health including self-harm and suicide (Current risk score 20)<br>NGH47 - HCSW Retention (Current risk score 16)<br>NGH49 - Staff Morale (Current risk score 16) | KGH CRR: | KCRR017 - Organisational challenge in relation to staffing with the potential to impact negatively on patient experience and outcomes (Current risk score 16)<br>KCRR069 – Management of V&A incidents to staff and impact on staff well-being (Current risk score 15) |

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

| | Current Controls | Plan Delivery Assurance/ Group IGRs (Internal / External) | Control Gaps | Assurance Gaps | Further planned actions to mitigate gaps | Action Owner | Due date |
|---|---|---|---|---|---|---|---|
| 1 | Dedicated to Excellence Strategy – Culture and Leadership and Management programme ip programme and | National Staff Survey staff engagement and morale scores reviewed by People Committee (Internal)<br>Anti- racism plan (Internal)<br>New strategic EDI lead commenced in post Sept 2023 (Internal)<br>Executive sponsors in place for all UHN staff networks (internal)<br>Anti-racism statement co-produced with staff and approved at People Committee and adopted by UHN (Internal)<br>UHN Head of OD & Inclusion in post (internal) | Action plan to be built based on 2023 Staff Survey results.<br>Anti-racism education for HR team to support high level of cultural competence. | Rethinking Racism education programme dates confirmed for June, July & September. Communications package not fully developed | UHN Group staff survey action plan being developed and launched under Team UHN campaign<br>Formal Tackling Racism Strategy documents and communication to be developed.<br>Communications package to be developed for Rethinking Racism education programme.<br>Delivery of Rethinking Racism education programme during June, July & September | Culture Lead<br>Head of OD & ED&I<br>Head of OD & ED&I<br>EDI Lead | 30.06.2024<br>31.05.2024<br>31.05.2024<br>30.09.2024 |
| | | National Staff Survey staff engagement and morale scores reported to People Committee (Internal)<br>New UHN appraisal pilot in place (internal)<br>Appraisal completion rates reported to People Committee (Internal)<br>Numbers completing leadership training reported to People Committee (Internal) | UHN appraisal process and integrated system not tested.<br>Availability of staff makes it difficult to release colleagues to attend training | | Pilot new non-medical appraisal process and create service specification for system.<br>Leadership and Management programme to be further developed in line with 2024 staff survey priorities ensuring content is aligned to our D2E values | Culture Lead / Head of People Development<br>Head of People Development | 30.06.2024<br>31.08.2024 |

| | Current Controls | Plan Delivery Assurance/ Group IGRs (Internal / External) | Control Gaps | Assurance Gaps | Further planned actions to mitigate gaps | Action Owner | Due date |
|---|---|---|---|---|---|---|---|
| 2 | Attraction and Resourcing Strategy, including international recruitment and Agency Transformation Programme | Vacancy rates, Turnover rates, Time to Hire reported to People Committee (Internal) | Challenges recruiting nurses due to supply of trained nurses in UK | | Recruitment and onboarding workstream delivery plans to be delivered with regular updates to People Committee | Head of People Planning/Process | 31.03.2025 |
| | | | Lack of technology to improve Time to Hire (TTH) | | Introduction of RPA technology to improve TTH and onboarding | Head of People Planning/Process | 30.09.2024 |
| | | Standardised Group Enhanced Rate process and criteria (Internal) | | | | | |
| | | Audit of recruitment processes reported to Audit Committee according to schedule (Internal) | | | | | |
| | | Single temporary staffing team NGH (Internal) | | | | | |
| | | National Staff Survey morale score reported to People Committee (Internal) | | | | | |
| | | | No UHN corporate induction | | Harmonised Group approach to Corporate Induction | Head of People Planning/Process | 30.06.2024 |
| | | | Process improvement in reductions in Time to Hire leading to reduced attrition. | | Develop process improvements in recruitment to reduce time to hire for financial efficiency and agency reduction. | Head of People Planning/Process | 30.08.2024 |
| | | Agency spend (WTE, % paybill, above cap and off framework) reported to Finance and Performance Committee and People Committee and ICB Financial Recovery Board (Internal / External) | Creation of new Collaborative Bank | | Implement collaborative bank early adopter trial. Rescoped to HCA. Dependent on aligning onboarding. | Senior Transformation lead. | 30.06.2024 |
| | | | Single UHN Workforce Attraction point of contact | | Development of Group Recruitment Microsite | Head of People Planning/Process | 31.10.2024 |
| | | | Single UHN approach to International Doctor Recruitment and Pastoral Programme and supportive and consistent on-boarding process for International medical recruits | | Develop Group Induction Pack for International Medical Graduates and pastoral programme | Head of People Planning/Process | 31.03.2025 |
| | | | Ability to attract and retain and engage Jnr/middle grade doctors | | Develop and implement improving working lives for Jnr Doctors national programme | Head of People Planning/Process | 31.03.2025 |
| | | | Full utilisation of ESR for benefit of managers and in readiness of newly procured national system | | Develop ESR and Manager Self Service | Head of People Planning/Process | 31.03.2025 |
| | | Finalised costed efficiency plans at KGH and NGH (Internal) | | | | | |
| | | Delivered 2023 recruitment campaign for internationally educated nurses (NGH target 40) (Internal) | | | | | |
| | | Delivered NGH Temporary staffing hub (Internal) | | | | | |
| | | Recruitment and onboarding transformation scoping stage complete and workstreams developed. (Internal) | | | | | |
| | | DBS recheck process commenced in NGH (Internal) | Aligned approach to DBS recheck programme | | Deliver aligned DBS process and renewal system across the Group | Head of Planning and Process | 30.09.2024 |
| 3 | Retention Strategy, including Health and Wellbeing and Recognition | Vacancy & Turnover rates, Absence rates reported to People Committee (Internal) | | | | | |
| | | UHN Aligned medical bank rate card (Internal) | | | | | |
| | | UHN alignment of HCA career pathway (internal) | | | | | |
| | | Exit interview analysis reported to People Committee (Internal) | | | Delivery of UHN stay conversation tool kit | Senior HR Business Partner | 30.08.2024 |
| | | National Staff Survey engagement and morale scores reported to People Committee (Internal) | Restructure and alignment of the UHN staff support offers. | . | Deliver aligned Single Point of Access model, Trauma incident support and staff psychological wellbeing service across UHN. | Head of HWB | 30.09.2024 |
| | | Opened Our Space at NGH & New restaurant facility at KGH (internal) | Care Café @KGH requires funding | | Secure ongoing funding source for Care Cafe. | Head of HWB | 01.06.2024 |
| | | Implementation of Just Culture principles with HR, Union and management teams with introductory workshops been run at both sites (Internal) | | | | | |
| | | Greater consistency in approach to restorative justice across UHN evidenced in similar case load in both Trusts (Internal) | | | | | |

| Current Controls | | Plan Delivery Assurance/ Group IGRs (Internal / External) | Control Gaps | Assurance Gaps | Further planned actions to mitigate gaps | Action Owner | Due date |
|---|---|---|---|---|---|---|---|
| 4 | Learning and Development Strategy | Statutory and mandatory training completion rates (MAST) and Appraisal completion rates reported to People Committee (Internal) | Appraisal process not yet tested | | New UHN appraisal process to be tested and reviewed<br><br>National induction and National mandatory training alignment (internal) | Culture Lead<br><br>Head of L&D | 30.07.2024<br><br>31.12.2024 |
| | | Training audit (internal) | | People oversight | Outcomes of training audit to People Committee | Head of L&D | 31.03.2025 |
| 5 | Clinical Strategy including detailed speciality strategies and workforce plans | Oversight of strategy documents to Group Transformation Committee (Internal)<br><br>Workplan of prioritised policies for alignment agreed to be achieved by April 2025 (Internal) | Prioritised timebound plan to deliver clinical collaboration (including enabling functions)<br><br>Potential gap in resource to meet the requirements of the plan<br><br>People Policies not fully aligned | Development of People structure to support group model/collaborative working to be finalised once re-set of UHN model is clear | Deliver next stage of UHN People Team Structure<br><br>Work toward achieving workplan of prioritised aligned UHN policies | Chief People Officer<br><br>Senior HR Business Partner | 31.12.2024<br><br>31.03.2025 |
| 6 | Safe Staffing Strategy | Safe staff metrics including Roster publication performance reported to People Committee (Internal)<br><br>Compassionate rostering programme (KGH) (Internal)<br><br>Self-rostering pilot (NGH) (Internal)<br><br>Agile working Audit (NGH) (Internal)<br><br>Reviewing self-rostering pilot at NGH given additional work required for eRostering team around set up and administration (Internal)<br><br>UHN Agile working policy ratified | Industrial relations climate/strikes | | HCA Band 2/3 claim for back pay to be determined<br><br>Mitigation plans in place for junior doctor strikes | Deputy CPO<br><br>CPO | 30.09.24<br><br>On going |
| 7 | Volunteering strategy | Number of volunteer hours/month reported to People Committee (Internal)<br><br>Volunteer to career programme launched January 2024 (Internal) | Further opportunity to develop new pathways from Volunteer to career (V2C)<br><br>Volunteer profile should reflect our communities – attraction and recruitment activities need to facilitate diverse volunteer profile.<br><br>Additional transport options needed for KGH to support patients/carers with mobility needs to move within the building.<br><br>Identified role for volunteers to support patients on admission to improve patient experience<br><br>No on-going funding for schools outreach worker | | Continue to support school outreach work on more limited basis<br><br>Develop internal transport provision for patients and extend successful trials to KGH<br><br>Trial admissions piece of work with identified wards to ensure workstream supports patients on admission<br><br>Develop proposals for second phase of Volunteer to Career programme | Head of Volunteer Services | 30.09.2024<br><br>30.09.2024<br><br>30.09.2024<br><br>30.09.2024 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Principal Risk No:** | **UHN02** | **Risk Title:** | Failure to deliver the UHN Clinical Strategy and clinical collaboration may result in some areas of clinical and financial unsustainability | | | | | |
| | | **Materialising in any/several of the following circumstances:** | Fragmented and inefficient service delivery<br>Service cessation or interruption of service provision for fragile services<br>Sub-optimal outcomes and patient experience<br>Negatively impacting staff retention, recruitment and morale | | | | | |
| **Date Risk Opened:** | April 2021 | **Risk Classification:** | Quality, Operational, Infrastructure, Financial | **Risk Owner:** | Medical Directors | **Scrutinising Committee:** | Quality Safety Committee in common | |
| **Corporate Risk Register Links:** | | | | | | | | |
| **NGH CRR:** | NGH88 - Failure to Meet National Cancer Waiting Times Standards (Current risk score 16)<br>NGH885 - Loss of PIFU data leading to loss of patient care and unquantifiable harm (Current risk score 16) | **KGH CRR:** | KCRR049 - If Radiology imaging is not completed within 6 weeks of referral the Diagnostic target will be breached (Current risk score 16)<br>KCRR065 – Safe delivery of T&O Spinal Surgery (Current Risk score 15) | | | | | |

| Initial Risk Score | | Current Risk Score | | Residual Risk Score | | Risk Appetite |
|---|---|---|---|---|---|---|
| 12 (High) | | 20 (Significant) | | 8 (High) | | Low |
| **Consequence** | **Likelihood** | **Consequence** | **Likelihood** | **Consequence** | **Likelihood** | **Group Priority** |
| 4 | 3 | 4 | 5 | 4 | 2 | Quality |

| | Current Controls | Plan Delivery Assurance/ Group IGRs (Internal / External) | Control Gaps | Assurance Gaps | Further planned actions to mitigate gaps | Action Owner | Due date |
|---|---|---|---|---|---|---|---|
| 1 | The Clinical Strategy oversight through UHN ILT and the Clinical Quality and Safety Committee (Axis 1)<br>and the UHN / UHL partnership board (Axis 2) | UHN Board governance updates (Quality, Finance, Transformation) (Internal)<br><br>ILT updates and assurance (Internal)<br><br>External reviews (Neonatal) (External)<br><br>Agreement of 11 workstreams at partnership board April 2024 (Internal) | Resource constraints – clinical and project resource (Industrial action, Financial deficit.<br><br>Ability to influence systemwide patient pathway changes | | Review of enabling clinical capacity to affect change.<br><br>Progress pathway reviews across system UEC and across Axis 2 | Medical Directors, Chief Operating Officers<br><br>Medical Directors, Chief Operating Officers | 31.12.2024<br><br>31.12.2024 |
| 2 | Detailed plan for subsequent phase of work that will focus on the integration of specific services – Review of Target Operating Models | Schedule of service strategy developments (Group) (Internal)<br><br>Oversight monitoring through Asana Project Software (Group) (Internal)<br><br>Standing clinical collaboration updates to Clinical Quality Safety and Performance Committees (Group) (Internal) | Resource Gaps Resource constraints – clinical and project resource | | Progress the review of all services against Target Operating Model<br>Review of enabling clinical capacity to affect change | Chief Operating Officers, Medical Directors | 31.05.2024 |

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|---|---|---|---|---|---|---|---|---|
| **Principal Risk No:** | **UHN03** | **Risk Title:** | Failure to deliver the group Nursing, Midwifery and Allied Health Processionals (NMAHP) Strategy may result in inequity of clinical voice, failure to become a truly clinically led organisation and centre of excellence for patient care | | | | | |
| | | **Materialising in any/several of the following circumstances:** | N,M,AHP reduced engagement with patient centred initiatives focused on improving safety and quality of care<br>N,M,AHP reduced engagement with professional projects that enhance our working environment and improve morale<br>N,M,AHP are not offered, engage or attend development, training and education opportunities<br>NGH is not able to demonstrate Pathway to Excellence compliance for re-designation | | | | | |
| **Date Risk Opened:** | April 2021 | **Risk Classification:** | Quality, Operational, Infrastructure | **Risk Owner:** | Directors of Nursing and Midwifery | **Scrutinising Committee:** | Quality Safety Committee in common | |
| **Corporate Risk Register Links:** | | | | | | | | |
| **NGH CRR:** | NGH39 - Risk of lack of adherence to good safeguarding practices in the trust (current risks score 16)<br>NGH42 - Risk that patients in NGH will suffer harm from falling (Current risk score 15)<br>NGH74 - Risk of harm to patients from physical and psychological deconditioning (current risks score 16)<br>NGH307 - There is a risk of an adverse event as a result of incorrect CTG interpretation (current risk score 15)<br>NGH562 - Risk that children & pregnant women at risk may not be identified due to insufficient skill & availability within Safeguarding (Current risks score 20)<br>NGH686 – There is a further risk regarding women leaving Community appointments without their next appointment being booked.<br>NGH752 - Not Sharing the New Born NHS Number at Birth with Social Care<br>NGH885 - Loss of PIFU data leading to loss of patient care and unquantifiable harm (Current risk score 16) | | | **KGH CRR:** | | | | |

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

| | Current Controls | Plan Delivery Assurance/ Group IGRs (Internal / External) | Control Gaps | Assurance Gaps | Further planned actions to mitigate gaps | Action Owner | Due date |
|---|---|---|---|---|---|---|---|
| 1 | NGH and KGH have a shared Nursing, Midwifery & AHP professional strategy (IGNITE) monitored via hospital Nursing and Midwifery Boards/Nurse Executive Meeting.<br><br>Aligned reporting and monitoring across the Group. | NGH completed and achieved Pathway to Excellence re-accreditation (June 23) (Internal)<br><br>KGH commenced @Quality Framework' implementation (internal)<br><br>All focused works streams have updated year 3 plan and commenced to refresh metrics moving into year 3 or strategy (Internal) | Current strategy is in its final year, new strategy is being developed across UHN and will be required for September 2024 | Both the Pathways and Quality Frameworks have similar pillars and will be allow for comparative measurements in most areas and be tracked within the IGR | The strategy progress and relevance against National agendas will be monitored and updated on a Quarterly basis as needed- no further mitigations needed | CNO's | 30. 09.2024 |
| 2 | There is a Director of Nursing and Midwifery and a Deputy who have jointly led the development of the NMAHP strategy at NGH and KGH. | The NMAHP is linked to our People, Academic and Clinical Strategies (Internal) Ignite strategy oversight at NMHAP (Internal)<br><br>Establishment of a quarterly joint NMAHP Board (Internal)<br><br>Established quarterly strategy review groups (Group) (internal.<br><br>Joined KGH and NGH strategy teams meetings (internal) | Joined NMAHP boards have not been established due to both organisations currently drafting the new strategy under new frameworks. | Frameworks in both organisations are robust and tested (Pathways/Quality Framework) and mostly comparative. | Continue to give final close down metrics and ensure all learning is carried into the New 2024 UHN strategy | CNO's | 30. 09.2024 |
| 3 | Workstream leads and working groups identified to define progress against objectives. | Each Trust has a Strategy Group Meeting where each Workstream Lead provides an update on progress (internal)<br><br>Established quarterly strategy review groups (Group) (internal)<br><br>Progress against metrics is presented by NGH and KGH to People and Quality Committee in Common | Achievement of year 3 metrics and oversight by CNO's. | Metrics agreed for year 3 and being measured not yet presented to Committees in Common. | New strategy to involve UHN oversight group rather than site based | CNO's | 31.12.2024 |

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|---|---|---|---|---|---|---|---|
| 4 | Reporting structure agreed to the joint Collaborative Programme Committee | Reports to joint Collaboration Programme Committee (CPC), Group People Committee (internal)<br><br>IGR now with agreed metrics and benchmarks (internal)<br><br>Report individually to NMB (NGH) and CPAG (internal) | | | | | |
| 5 | KGH Strategy / Pathway Lead proactively managing the implementation of the IGNITE strategy.<br><br>Secured funding to commence P2E journey (KGH) | Named KGH lead for IGNITE and in due course P2E (internal) | | | | | |
| 6 | Dedicated communication programme to support the implementation of IGNITE (NGH and KGH) | Strategy celebrated through International Nurses Day, Midwives Day & AHP Day 2022 (Group) (internal) | | | | | |

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|---|---|---|---|---|---|---|---|---|
| **Principal Risk No:** | **UHN04** | **Risk Title:** | Failure of the Integrated Care System (ICS) to deliver transformed care will result in an impact on the quality of service provided across the Group | | | | | |
| | | **Materialising in any/several of the following circumstances:** | Risk to delivering locally for our patients the core aims of Integrated Care Systems to; 1. Improve outcomes in population health and healthcare. 2. Tackle inequalities in outcomes, experience and access.3. Enhance productivity and value for money 4. Help the NHS support broader social and economic development. | | | | | |
| **Date Risk Opened:** | June 2022 | **Risk Classification:** | Quality<br>Finance | **Risk Owner:** | Director of Strategy and Strategic Estate | **Scrutinising Committee:** | Quality Safety Committee in common<br>Finance and Investments Committee in Common | |
| **Corporate Risk Register Links:** | | | | | | | | |
| **NGH CRR:** | NGH 424 - Risk of reduced patient safety when demand exceeds capacity (Current risk score 15) | | | **KGH CRR:** | KCRR011 - Continued extreme pressure on capacity and reported incidents of low nursing levels and delayed discharges creates the risk of creates the risk of poor quality of care and patient safety, combined with staff well-being. (current risks core 20) | | | |

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

| | **Current Controls** | **Plan Delivery Assurance/ Group IGRs (Internal / External)** | **Control Gaps** | **Assurance Gaps** | **Further planned actions to mitigate gaps** | **Action Owner** | **Due date** |
|---|---|---|---|---|---|---|---|
| 1 | The development and delivery of the Northamptonshire Integrated Care System (ICS) to include the Northamptonshire Integrated Care Board and the Northamptonshire Integrated Care Partnership | UHN Chair and GCEO representation at the Integrated Care Partnership and the Integrated Care Board (internal/ external)<br>Integrated Care Partnership 10-year Strategy and Outcomes Framework (external)<br>Alignment of the Health and Wellbeing Boards (North and West) strategies and ICB 5-year plan to the ICP 10-year strategy (external)<br>ICB Strategy and planning group established to deliver ON THE 5 year forward plan as per national guidance (internal / external)<br>Group engagement with NEDS on existing ICB architecture (internal) | Alignment of ICB plan with the Integrated Care Partnership strategy, Health and Wellbeing Boards strategies, operational planning requirements and UHN Group strategies and planning | Level of focus on system resilience and working as a system to ensure delivery of collaborative working to deliver the strategies and supporting operational plans.<br>Assurance to delivery of system delivery plans | Further strengthening of the System Urgent and Emergency and discharge planning to Be Plans developed- delivery to be led at Place for North and West<br>Mapping of all partnership strategies and plans into a clear framework and resetting of governance workstreams | COOs<br>DoS | 31.12.2023<br>31.03.2025 |
| 2 | Implementation of the ICS operating model to deliver good quality care, financial balance and improved outcomes.<br>UHN leadership system, workstreams to develop Collaboratives, Place, Clinical Model, and enablers e.g., Digital, People, Estates, Finance with supporting delivery plans | Collaborative Boards developing prioritised delivery plans ((Internal / External);<br>• MHLDA<br>• Elective Care<br>• CYP<br>Establishment of Place Delivery Boards, Local Area Partnerships to deliver improved outcomes in population health and healthcare (Internal / External)<br>Population Health Board (Internal / External)<br>System Clinical Leads Board (Internal / External)<br>System Quality Board (Internal / External)<br>System Boards for enablers(Internal / External);<br>• Estates<br>• People<br>• Digital<br>Urgent and Emergency Care system Board and Planning (Internal / External) | Connection of decision making across the ICB to include Place and Collaboratives<br>UHN Place based approach and strategies | Assurance to delivery of system delivery plans for collaboratives and Place | Prioritisation of delivery and Out of Hospital, discharge, UEC strategy and Plans (to replace iCAN) priorities across the collaboratives and Place | COOs | 31.03.2024 |

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| **Principal Risk No:** | **UHN05** | **Risk Title:** | Risk of failing estate buildings and infrastructure due to age and suitability and, failure to deliver Group strategic estates plans, may prevent delivery of key Group strategies, eg Clinical Strategy. | | | | | |
| | | **Materialising in any/several of the following circumstances:** | May result in care delivery from poor clinical environments, cost inefficiencies, health and safety incidents, accidents and statutory non-compliance attributable to some degree to substandard existing estate, and lost opportunities for integrated care delivery at place, resulting in serious safety incidents causing injury or death, fines, prosecution and associated reputational damage. | | | | | |
| **Date Risk Opened:** | 01 April 2022 | **Risk Classification:** | Quality<br>Finance<br>Infrastructure | **Risk Owner:** | Director of Strategy and Strategic Estate<br>Director of Operational Estates | **Scrutinising Committee:** | Finance and Investments Committee in Common | |

**Corporate Risk Register Links:**

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|---|---|---|---|
| **NGH CRR:** | NGH259 - Risk of exposure to asbestos fibre from lack of management to exposure (Current risk score 15)<br>NGH 262 - Risk of asbestos related diseases from exposure to asbestos fibre (Current risk score 20)<br>NGH 265 - Heating and hot water infrastructure (Current risk score 16)<br>NGH 270 - Risk of failure to meet national standards of cleaning (Current risk score 16)<br>NGH 301 – Risk of failure of gas interlock system (Current risk score 15)<br>NGH 258 - Risk of incorrect disposal of clinical waste at source (Current risk score 15) | **KGH CRR:** | KCRR015 - No sustainable capacity for urgent care (Current risk score 20)<br>KCRR026 - Risk of loss of power or reduced power to site if the main high voltage incoming switchgear fails (Current risk score 15)<br>KCRR030 - Loss of heating and hot water failures and interruptions to some or all areas of the trust due to age of boiler system (Current risk score 16)<br>KCRR059 - Risk to patient safety and quality of care due to the current layout of LNU as there is a lack of visibility of all babies and the lack of continuous supervision of these babies (Current risk score 16)<br>KCRR036 - Recognition that due to the age of the Trusts estate not all wards or services have suitable environments to be able to provide a high-quality service from. (Current risk score 16)<br>KCRR040 - Recognition that due to the age of the some of the medical and diagnostic equipment, maintenance and replacement parts are no longer available (Current risk score 15)<br>KCRR045 - A significant increase in headcount coupled with reduced useable office accommodation puts at risk operational and clinical efficacy and compliance with workplace occupational health and safety regulations (Current risk score 16)<br>KCRR055 - Recognition that areas of Trust could fall into darkness due to aged lighting that is no longer available (Current risk score 15)<br>KCRR070 - Impact on delivery of services during inspection of RAAC found to be present in Rockingham Wing (Current risk score 15) |

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

| | Current Controls | Plan Delivery Assurance/ Group IGRs (Internal / External) | Control Gaps | Assurance Gaps | Further planned actions to mitigate gaps | Action Owner | Due date |
|---|---|---|---|---|---|---|---|
| 1 | Completed and approved Group Clinical Strategy will define the clinical requirements of both sites for the future. | UHN now has a Strategic Development Committee in place (Internal)<br>Clinical service strategy focus and implementation plan (internal) | Scope of Clinical collaboration | | Complete target operating model<br>Complete NGH Master Plan<br>Developmental Control Plan (NGH) | DofS&SE | 31.11.2023<br>30.08.2024<br>31.12.2024 |
| 2 | Kettering Hospital now have a full Development Control Plan for the whole site, forming part of the HIP2 and other programmes.<br>Northampton Hospital have a site masterplan.<br>OBC has been submitted<br>NGH Masterplan funding | Kettering HIP2 SOC has been submitted and a Local Development Order has been signed with Kettering Planning Authority (Internal / External)<br>Board oversight of KGH outline business case (internal) | NGH do not have an up to date Development Control Plan | | NGH Development Control Plan to commence | DofS&SE | 31.08.2024 |

| | Current Controls | Plan Delivery Assurance/ Group IGRs (Internal / External) | Control Gaps | Assurance Gaps | Further planned actions to mitigate gaps | Action Owner | Due date |
|---|---|---|---|---|---|---|---|
| 3 | These foundations will come together to start to form the Group Strategic Estates Plan. | | | The Group requires a joint Strategic Estates Plan that supports delivery of the Group Clinical Strategy | Group Strategic Estates Plan to be commissioned in Autumn 2021 following completion of the Group Clinical Strategy. | DofS&SE | 31.08.2024 |
| 4 | A System Estates Board is in place across the ICS with all Health and Care partners. | | | The System Estates Strategy is not strategic and needs further development<br><br>System wide view of all provider / partner strategic estate need / plans | **L**ed by ICB to develop an infrastructure plan | | **TBC** |
| 5 | All key estates infrastructure elements have independent AE (authorising engineers) appointed, annual audits and action plans in place; technical and trust meetings in place. | Monthly estates assurance report for each hospital is presented at the Finance CiC (internal)<br><br>Technical meetings in place to review progress against audit plans (internal) | | | Review of technical meetings effectiveness | DofE&F KGH and NGH | 01.06.2024 |
| 6 | Business continuity plans and infrastructure resilience/back up systems are in place | Estates infrastructure is regularly tested (internal)<br><br>Risk rated capital backlog plans in place (internal)<br><br>Estates strategies for each site (internal) | Infrastructure is aging and estates capital plans are insufficient to replace all equipment | assurance for Estates infrastructure BCP to be included in estates assurance reporting, with input from EPRR leads | Annual review of Business Continuity Plans | EPRR Leads | 31.03.2024 |
| 7 | Estates backlog capital programme | Trust capital committees (internal)<br><br>KGH 6 Facet Survey (internal) | | NGH 6 Facet survey due for renewal 24/25 | Tender for completion of a full site 6 facet survey for NGH | DofE NGH | 01.01.2025 |

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| **Principal Risk No:** | **UHN06** | **Risk Title:** | Failure to deliver the long-term Group Academic Strategy may result in inability to attract high calibre staff and deliver on our research and education ambitions. | | | | | | |
| | | **Materialising in any/several of the following circumstances:** | Sustainability of 5-year project<br>Impact on financial income to the Group<br>Impact on patient outcomes and experience<br>Lack of progress with our academic partnerships and collaborations with local universities, with potential to impact on University status | | | | | | |
| **Date Risk Opened:** | April 2021 | **Risk Classification:** | Quality<br>Finance | **Risk Owner:** | Medical Directors and Director of Strategy | **Scrutinising Committee:** | Quality Safety Committee in common | | |
| **Corporate Risk Register Links:** | | | | | | | | | |
| **NGH CRR:** | | | | **KGH CRR** | KCRR017 - Organisational challenge in relation to staffing with the potential to impact negatively on patient experience and outcomes (Current risk score 20) | | | | |

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

| | Current Controls | Plan Delivery Assurance/ Group IGRs (Internal / External) | Control Gaps | Assurance Gaps | Further planned actions to mitigate gaps | Action Owner | Due date |
|---|---|---|---|---|---|---|---|
| 1. | Academic and Research Strategy oversight through UHN ILT and the Clinical Quality and Safety Committee (Axis 1)<br>and the UHN / UHL partnership board (Axis 2) | UHN Board governance updates (Quality, Finance, Transformation) (Internal)<br><br>ILT updates and assurance (Internal)<br><br>External reviews (Neonatal) (External)<br><br>Agreement of 11 workstreams at partnership board April 2024 (internal) | Resource constraints – clinical and project resource (Industrial action, Financial deficit<br><br>Ability to influence systemwide recruitment of patients into research. | | Review of enabling clinical capacity to affect change.<br><br>Progress standardisation of academic and research governance, operational structures, recruitment key joint posts and expansion of opportunities for cross organisational trials | Medical Directors<br><br>Chief Nursing Officers | 31.12.2024<br><br>31.12.2024 |

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|---|---|---|---|---|---|---|---|---|
| **Principal Risk No:** | **UHN07** | **Risk Title:** | Failure to deliver the Group Digital Strategy may result in our staff and patients not having the tools or information they need to deliver, and receive safe, high quality patient care. | | | | | |
| | | **Materialising in any/several of the following circumstances:** | - Patients are not in control of, or kept well informed of, their care so we fall behind standards and expectations of patients<br>- Clinicians do not have the access to full, accurate and timely patient information when they need it, leading to a negative impact on patient care decisions - and therefore outcomes<br>- Staff (clinical and non clinical) do not have the tools, (or the tools are not based on a secure and reliable supporting digital infrastructure), to perform their roles effectively, resulting in poor productivity, poorer outcomes for patients, and a block on their ability to collaborate easily and well, within UHN and also more widely.<br>- Managers and clinicians do not have relevant, accurate, consistent and reliable data readily available in a useful form, to make timely informed decisions, leading to greater operational challenges for UHN, and poorer patient outcomes as result. | | | | | |
| **Date Risk Opened:** | Apr 21<br>Revised April 23 | **Risk Classification:** | Quality, infrastructure, finance | **Risk Owner:** | Group Chief Digital Information Officer | **Scrutinising Committee:** | Quality and Safety Committee | |

**Corporate Risk Register Links:**

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|---|---|---|
| NGH 93 - Clin Apps - No Electronic Prescribing and Medicine Administration System (EPMA) (Current risk score 16)<br>NGH 114 - TECH - threat to our IT systems and / or infrastructure from a cyber or malware attack resulting in a loss of service or data (Current risk score 15) | **KGH CRR:** | KCRR038 - Loss of the current Intranet service and experience a loss of data contained therein. (Current risk score 16)<br>KCRR009 - Threat to IT systems from Cyber security and malware attacks (Current risk score 16) |

| **Initial Risk Score** | | **Current Risk Score** | | **Residual Risk Score** | | **Risk Appetite** |
|---|---|---|---|---|---|---|
| 16 (Extreme) | | 16 (Extreme) | | 16 (extreme) | | High |
| **Consequence** | **Likelihood** | **Consequence** | **Likelihood** | **Consequence** | **Likelihood** | **Group Priority** |
| 4 | 4 | 4 | 4 | 4 | 4 | Sustainability |

| | Current Controls | Plan Delivery Assurance/ Group IGRs (Internal / External) | Control Gaps | Assurance Gaps | Further planned actions to mitigate gaps | Action Owner | Due date |
|---|---|---|---|---|---|---|---|
| 1 | Digital Transformation governance structure to monitor and support project delivery against plan | Digital Transformation governance structure including programme boards (EPR; digital transformation, infrastructure boards; health intelligence transformation; robotic process automation and communication and engagement group) with accompanying reports (internal)<br><br>UHN Digital Forward View summarising plan and priorities for the year ahead – agreed by ILT (internal)<br><br>Regular updates to ILT on digital delivery and any UHN decisions needed (e.g. on re-prioritisation of the plan as needs arise) (internal)<br><br>UHN attendance at ICS digital and data board to help tie UHN and ICS ambitions together and also secure support from wider ICS colleagues where required (Internal)<br><br>TIAA audit (reasonable assurance report)(Internal)<br><br>ICS Digital Director involvement and ICS involvement with digital strategy (external) | Sub-committee to cover digital delivery to feed into Board Committee<br><br>ICS Digital Strategy oversight group to link in all CIOs from Northamptonshire (upward group from ICS digital and data board)<br><br>Review required of where Robotic Process Automation group feeds into Committee structure | Benefits reporting to showcase impact of digital transformation, and ensure lessons learnt (and then communicate this back to our colleagues)<br><br>Ongoing clarity on digital ambitions and priorities of the ICS, and timescales of key projects they are leading on.<br><br>Confirmation UHN health intelligence service will be able to meet needs of UHN after the conclusion of the data warehouse/ health intelligence transformation programme | Digital Delivery Group to be set up as sub-committee of Quality Committee<br><br>Quality Committee to receive upward reports from Digital Delivery Group<br><br>Benefit reporting to incorporate into Digital Delivery Group<br><br>ICB Digital Director to feed into Digital Delivery Group<br><br>Attendance of UHN CDIO at ICS Digital Strategy Group<br><br>Robotic Process Automation oversight group to feed into Digital Delivery Group and Finance Committee – include performance reporting and organisational form<br><br>Attendance at KGH, NGH governance forums to communicate, engage and assure on delivery – HLT (when set up) and Divisional meetings<br><br>Reporting into Performance Committee:<br>1) To give overview of health intelligence transformation programme<br>2) Update on health intelligence form/ service offering | CDIO<br><br>CDIO<br><br>Head of DT&I<br><br>ICB DD<br><br>CDIO<br><br>CDIO/ Dir of Gov/ CFO<br><br>CDIO<br><br>CDIO<br><br>CDIO | 30.06.2024<br><br>30.06.2024<br><br>31.08.2024<br><br>31.08.2024<br><br>31.05.2024<br><br>31.07.2024<br><br>31.07.2024<br><br>30.06.2024<br><br>31.10.2024 |

| | Current Controls | Plan Delivery Assurance/ Group IGRs (Internal / External) | Control Gaps | Assurance Gaps | Further planned actions to mitigate gaps | Action Owner | Due date |
|---|---|---|---|---|---|---|---|
| 2 | Operational governance structure (meetings/committees) to review and oversee the performance of the 'business as usual' parts of the Digital Division's work (e.g. financial control & risk management, and performance of ICT areas such as security, systems performance, upgrades, hardware management, etc)) | Digital Operational Meeting oversees with reports feeding in from Data Security and Protection Group, risk, finance as well as oversight of operational KPIs and incident management | Digital Operational Meeting to feed into sub-committee structure | | Digital Delivery Group to be set up as sub-committee of Quality Committee | CDIO | 30.06.2024 |
| 3 | Prioritisation governance process (including representatives from a diverse range of staff) to oversee digital transformation prioritisation. | Regular updates to ILT on digital delivery and any UHN decisions needed regarding re-prioritisation of the plan as needs arise)<br><br>Operation of key forums from Digital which feed into prioritisation process including the Clinical Design Authority (main forum for clinical and operational input into digital transformation agenda) and Technical Design Authority (main forum for checking ideas are technically feasible for consideration) authority groups. | Visibility of prioritisation changes to Board Committee | Require continual review of priorities – will need assurance the dynamism of process will be ongoing.<br><br>Clinical Design Authority needs regular attendance and engagement from clinical colleagues<br><br>Historic backlog of work remains across digital – although prioritisation exercise encompassed all, given volume the review of relevancy of these requests needs to be conducted and backlog reduced | Digital Delivery Group to give visibility to Quality Committee on prioritisation changes<br><br>Review clinical design authority attendance ensuring representation from clinical leaders to steer prioritisation recommendations for ILT<br><br>Review and consolidation required of historic backlog | CDIO<br><br>CCIO<br><br>Head of DT&I | 31.07.2024<br><br>30.09.2024<br><br>30.09.2024 |
| 4 | Structured communication and engagement activities with clinical and operational leadership on the digital agenda including: | UHN Digital Communications and Engagement Group with communication and engagement plan<br><br>UHN Digital Champion network<br><br>UHN Digital academy to oversee digital training and support and digital competency<br><br>Digital UHN branding | UHN Digital Communications and Engagement Group to feed into sub-Committee structure | Need to include targets or assess how we will measure improvements in staff and patient engagement<br><br>Greater evidence of user-led design<br><br>Greater evidence of patient engagement<br><br>Build on UHN digital branding for UHN digital vision (e.g. ehospital) | Digital Delivery Group to be established with upward report from Digital Coms and Engagement Group – then upward report into Quality Committee<br><br>Evidence of service designer within digital driving user-led approach<br><br>Regular attendance at patient engagement forums (internal and ICS)<br><br>Work with Communication Team on branding | CDIO<br><br>Head of DT&I<br><br>CCIO<br><br>CCIO | 30.06.2024<br><br>30.11.2024<br><br>31.10.2024<br><br>30.09.2024 |
| 5 | Plan to have the resource (digital, clinical and operational) required to ensure capability and capacity required to deliver | Restructure of digital teams into UHN team for greater flexibility and wider skill set to draw upon<br><br>Reporting through digital programme groups on resource requirements/ engagement | Vacancy controls and financial constraints resulting in vacancy gaps | Resource dependency to be highlighted as critical factor through programme reporting structure to give assurance necessary capability/ capacity is in place for key priority work, and to understand risks and specific areas of pressure.<br><br>Unknown future industrial action which may impact ability for digital change to be enacted across UHN | Recruit into key vacancies (e.g. Dep CDIO and Head of Health Intelligence)<br><br>Upward reporting on resource risk to come through upward reporting structure to Digital Delivery Group and then Quality Committee as required | CDIO<br><br>CDIO | 30.09.2024<br><br>31.07.2024 |
| 6 | Supplier management process to manage relationships with key digital suppliers and key contracts, to ensure confidence in their ability to deliver and manage any risks. | Contractual meetings between Digital SLT and account managers of suppliers (internal)<br><br>Reporting through digital programme groups on supplier delivery<br><br>Regular Exec meetings with KGH EPR supplier<br><br>East Midlands Acute Partners group set up to jointly manage/ mitigate NGH EPR supplier risk | NGH EPR governance (post-investment sign off) | NGH Exec EPR supplier meeting<br><br>Visibility of supplier support issues/ risks across UHN Execs | Regular NGH Exec EPR supplier meeting<br><br>Refine EPR governance (KGH and NGH) to ensure visibility of supplier support across UHN Execs<br><br>Upward reporting on supplier risk to come through upward reporting structure to Digital Delivery Group and then Quality Committee as required<br><br>Regular attendance at East Midlands Acute Partners EPR group | CDIO/ MD<br><br>Head of DT&I/ CDIO<br><br>CDIO<br><br>CDIO | 31.08.2024<br><br>30.06.2024<br><br>31.07.2024<br><br>31.10.2024 |
| 7 | Strategy/ approach to seek out nationally funded programmes of work (e.g. EPR) to ensure necessary funding to deliver as much of our strategic ambitions as possible, as soon as possible | CDIO / ICB Digital Director/ NHFT CDIO collaboration – regular meetings to determine national funding options<br><br>CDIO interaction with National CDIO forums and NHS England | | Opportunity/ horizon scanning – implementation of Digital Commercial Manager to support this activity | Recruit into Digital Commercial Manager position<br><br>UHN/ UHL CDIO to be appointed to work more closely with NHS England and capitalise opportunities for funding across all organisations | Head of DT&I<br><br>UHN/ UHL CDIO | 30.09.2024<br><br>30.09.2024 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Principal Risk No:** | **UHN08** | **Risk Title:** | Failure to deliver improvement in underlying revenue finances and develop a path out of financial deficit to breakeven over the medium term: | | | | | |
| | | **Materialising in any/several of the following circumstances:** | The Finance and Investment Committee will advise the Trust Boards on financial performance:<br>- Financial run rate deteriorating<br>- Efficiency delivery not meeting targets<br>- Cost assumptions including inflation materialising at high levels than planned<br>- Industrial actions creating unplanned and unfunded costs<br>- Medium term financial plan development is not underpinned by clinical and operational strategy.<br>- Capacity, consistency and accountability leads to different approaches in each Trust | | | | | |
| **Date Risk Opened:** | April 2021/ review May 24 | **Risk Classification:** | Financial<br>Operational | **Risk Owner:** | Chief Finance Officer | **Scrutinising Committee:** | Finance & Investment Committee | |
| **Corporate Risk Register Links:** | | | | | | | | |
| **NGH CRR:** | NGH 35 - Failure in having financial control measures to deliver the 23-24 Financial Plan and return to medium term financial balance (Current risk score 20)<br>NGH 38 - The Trust may not have sufficient capital for Capital requirements or may not be able to maximise its capital spend (Current risk score 15) | | | **KGH CRR:** | KCRR056 - Failure in having financial control measures to deliver the 22-23 Financial Plan and return to medium term financial balance (Current risk score 20) | | | |

| Initial Risk Score | | Current Risk Score | | Residual Risk Score | | Risk Appetite |
|---|---|---|---|---|---|---|
| 16 (Extreme) | | 16 (Significant) | | 6 (moderate) | | High |
| **Consequence** | **Likelihood** | **Consequence** | **Likelihood** | **Consequence** | **Likelihood** | **Group Priority** |
| 4 | 4 | 3 | 4 | 3 | 2 | Sustainability |

| | Current Controls | Plan Delivery Assurance/ Group IGRs (Internal / External) | Control Gaps | Assurance Gaps | Further planned actions to mitigate gaps | Action Owner | Due date |
|---|---|---|---|---|---|---|---|
| 1 | Budgets | • Documented, understood and signed off budgets by budget managers<br>• Alignment of bottom up evidenced based budgets with top down high level budget<br>• Agreed risk and contingency approach aligned to Board risk appetite | Capacity gap on budget consistency due to both Deputy CFO absent on long term sickness since October 2023 and identified differences in budget setting approaches | Documented sign off by all Budget Managers | Hospital Directors of Operational Finance working together to support consistency.<br>NHS IMAS support to capacity | Hospital Director of Operational Finance | June 2024 |
| 2 | Affordability / Accountability | • Equal focus is given to funding (affordability) of investments as determining the costs<br>• Have defined goals and priorities to support budget setting<br>• Involve stakeholders effectively in the budget process sharing analysis, risks, and working to understand choices<br>• Establish clear roles and responsibilities | Culture of investigating funding options and focus on affordability<br>Evaluate budget setting process to consider achievements and challenges<br>Focus on benefits realisation | Ensure all financial controls are operating efficiently and effectively.<br>Business cases focus on benefits and affordability | Lessons learnt on 23/24 financial performance where CIP was fully delivered and reset control total met.<br>Improve the culture, profile and ownership of finances across both Trusts | Chief Financial Officer | June 2024 |
| 3 | Reporting / Risk Appetite / Planning / Performance Management | • Reporting, Provide accessible online reporting replacing fixed emailed reports.<br>• Risk appetite / risk and contingency planning. Alongside budget setting develop and agree an approach to risk and contingency.<br>• Planning. Financial planning is one element of effective public financial management along with budget preparation, performance management and stakeholder reporting.<br>• Performance Management | Static reporting and access to financial information is lacking<br>Workforce has grown and risk of breaching agency cap and establishment | Methodology and governance is in place to support effective use of staffing, reduce variation and deployment.<br>Performance management operates without a documented and understood framework with differential approaches | Streamline and simplify finance transactions and eliminate immaterial transactions<br>Develop finance dashboards to support access and drill down for budget managers<br>Consider performance management frameworks and approach to ensure finance supports efficient operational performance and workforce deployment. | Interim Deputy CFO | August 2024 |
| 4 | Culture / Choices / Control | • Finance's partnership role in businesses will "shift upstream" from budgeting and reporting to scenario planning and advanced forecasting.<br>• Exploit the technology, including through automation to eliminate manual tasks within finance<br>• Streamline intergroup transactions and recharges | Single set of Standing Financial Instructions across UHN<br>Capacity in Financial Management teams with a high level of turnover<br>High number of procurement waivers and non-compliance | Budget management training and support effectiveness to be reviewed<br>Corporate teams within Finance Directorate to considered against optimised arrangements across UHL /UHN | Remove unnecessary recharges<br>Complete Financial Services restructure<br>Eliminate breaches of SFIs<br>Review and set direction for Senior Finance Structure | Chief Financial Officer | September 2024 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | • Complete the financial services restructure following pre-consultation engagement.<br>• Eliminate breaches of SFIs in relation to procurement, locally described as Maverick and Waivers, avoid direct awards and drive value through clear documented outcome based specifications.<br>• Develop senior finance team capacity and support professional development including considering One NHS Finance resources<br>• Support identification of organisational choices | Senior Finance team structure does not promote accountability and ownership across UHN<br>Framework for tough choices to be developed | | Develop continuous improvement approach for finance, procurement and contracting | | |

**Corporate Risks Aligned to BAF risks @ May 2024**

| BAF Link | Risk ID (BAF/CRR) |
|---|---|
| UHN001<br>(Group People Plan) | KCRR017 - Organisational challenge in relation to staffing with the potential to impact negatively on patient experience and outcomes (Current risk score 16)<br>KCRR069 – Management of V&A incidents to staff and impact on staff well-being (Current risk score 15) |
| | NGH46 - Detrimental staff wellbeing and mental health including self harm and suicide (Current risk score 20)<br>NGH47 - HCSW Retention (Current risk score 16)<br>NGH49 - Staff Morale (Current risk score 16) |
| UNH002<br>(Clinical Strategy) | KCRR065 – Safe delivery of T&O Spinal Surgery (Current Risk score 15) |
| | NGH88 - Failure to Meet National Cancer Waiting Times Standards (Current risk score 16)<br>NGH885 - Loss of PIFU data leading to loss of patient care and unquantifiable harm (Current risk score 16) |
| UHN003<br>(Group Nursing, Midwifery and Allied health Professionals strategy) | |
| | NGH39 - Risk of lack of adherence to good safeguarding practices in the trust (current risks score 16)<br>NGH42 - Risk that patients in NGH will suffer harm from falling (Current risk score 15)<br>NGH74 - Risk of harm to patients from physical and psychological deconditioning (current risks score 16)<br>NGH307 - There is a risk of an adverse event as a result of incorrect CTG interpretation (current risk score 15)<br>NGH562 - Risk that children & pregnant women at risk may not be identified due to insufficient skill & availability within Safeguarding (Current risks score 20)<br>NGH686 – There is a further risk regarding women leaving Community appointments without their next appointment being booked.<br>NGH752 - Not Sharing the New Born NHS Number at Birth with Social Care<br>NGH885 - Loss of PIFU data leading to loss of patient care and unquantifiable harm (Current risk score 16) |
| UHN004<br>(Integrated Care Board) | KCRR011 - Continued extreme pressure on capacity and reported incidents of low nursing levels and delayed discharges creates the risk of creates the risk of poor quality of care and patient safety, combined with staff well-being. (current risks core 20) |
| | NGH 424 - Risk of reduced patient safety when demand exceeds capacity (Current risk score 20) |
| UHN005<br>(Group Strategic Estates Programme) | KCRR015 - No sustainable capacity for urgent care (Current risk score 20)<br>KCRR026 - Risk of loss of power or reduced power to site if the main high voltage incoming switchgear fails (Current risk score 15)<br>KCRR030 - Loss of heating and hot water failures and interruptions to some or all areas of the trust due to age of boiler system (Current risk score 16)<br>KCRR059 - Risk to patient safety and quality of care due to the current layout of LNU as there is a lack of visibility of all babies and the lack of continuous supervision of these babies (Current risk score 16)<br>KCRR036 - Recognition that due to the age of the Trusts estate not all wards or services have suitable environments to be able to provide a high-quality service from. (Current risk score 16)<br>KCRR040 - Recognition that due to the age of the some of the medical and diagnostic equipment, maintenance and replacement parts are no longer available (Current risk score 15)<br>KCRR045 - A significant increase in headcount coupled with reduced useable office accommodation puts at risk operational and clinical efficacy and compliance with workplace occupational health and safety regulations (Current risk score 16)<br>KCRR055 - Recognition that areas of Trust could fall into darkness due to aged lighting that is no longer available (Current risk score 15)<br>KCRR070 - Impact on delivery of services during inspection of RAAC found to be present in Rockingham Wing (Current risk score 15) |
| | NGH259 - Risk of exposure to asbestos fibre from lack of management to exposure (Current risk score 15)<br>NGH 262 - Risk of asbestos related diseases from exposure to asbestos fibre (Current risk score 20)<br>NGH 265 - Heating and hot water infrastructure (Current risk score 16)<br>NGH 270 - Risk of failure to meet national standards of cleaning (Current risk score 16)<br>NGH 301 – Risk of failure of gas interlock system (Current risk score 15)<br>NGH 258 - Risk of incorrect disposal of clinical waste at source (Current risk score 15) |
| UHN006<br>(Group Academic Strategy) | KCRR017 - Organisational challenge in relation to staffing with the potential to impact negatively on patient experience and outcomes (Current risk score 20) |
| | |

| BAF Link | Risk ID (BAF/CRR) |
|---|---|
| UHN007<br>(Digital Strategy) | KCRR038 - Loss of the current Intranet service and experience a loss of data contained therein. (Current risk score 16)<br>KCRR009 - Threat to IT systems from Cyber security and malware attacks (Current risk score 16) |
| | NGH 93 - Clin Apps - No Electronic Prescribing and Medicine Administration System (EPMA) (Current risk score 16)<br>NGH 114 - TECH - threat to our IT systems and / or infrastructure from a cyber or malware attack resulting in a loss of service or data (Current risk score 15) |
| UHN008<br>(Group Medium Term Financial Plan) | KCRR056 - Failure in having financial control measures to deliver the 22-23 Financial Plan and return to medium term financial balance (Current risk score 20) |
| | NGH 35 - Failure in having financial control measures to deliver the 22-23 Financial Plan and return to medium term financial balance (Current risk score 20)<br>NGH 38 - The Trust may not have sufficient capital for Capital requirements or may not be able to maximise its capital spend (Current risk score 15) |

# Cover sheet

| | |
|---|---|
| Meeting | Boards of Directors of Northampton General Hospital NHS Trust (NGH) and Kettering General Hospital NHS Foundation Trust (KGH) meeting together |
| Date | 5 June 2024 |
| Agenda item | 11 |

| | |
|---|---|
| Title | Fit and Proper Persons Annual Declarations (FPP) |
| Presenter | John MacDonald, Trusts' Chair |
| Author | Richard May, Interim Group Company Secretary |

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

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

| Reason for consideration | Previous consideration |
|---|---|
| For the Boards of Directors to accept the Chair's assurance that all Board Members continue to meet the Fit & Proper Persons requirements | None |

## Executive Summary

Board members have submitted yearly declarations satisfying Care Quality Commission (CQC) Regulations for the Trust to be able to demonstrate that all Directors are of good character and meet the CQC's Fit and Proper Persons Regulation. Completed Declaration Forms are retained by the Trust Board Secretary.

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

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

Outputs from Board members' annual appraisals form part of the FPP requirements, and will be reported as follows:

- Chair and Non-Executive Directors to the Council of Governors on 6 June 2024 (KGH only), and to NHS England (UHN)
- The Chief Executive and Executive Directors to the Remuneration and Appointments Committee in July 2024.

All appraisals have taken place, or are scheduled to take place, by no later than 30 June 2024.

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

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

In accordance with the requirements set out in revised guidance, issued by NHS England in August 2023, the Chair and Senior Independent Directors will be requested to submit a declaration of compliance to NHS England by 30 June 2024.

**RECOMMENDATION -** The Boards are asked to accept the assurance that all Members continue to meet the Fit & Proper Persons requirements.

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

# Cover sheet

| | |
|---|---|
| Meeting | Boards of Directors of Northampton General Hospital NHS Trust (NGH) and Kettering General Hospital NHS Foundation Trust (KGH) meeting together in Public |
| Date | 5 June 2024 |
| Agenda item | 12 |

| | |
|---|---|
| Title | Annual reviews of Audit Committees' Terms of Reference |
| Presenter | Richard Apps, Director of Corporate and Legal Affairs |
| Author | Richard May, UHN Company Secretary |

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

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

| Reason for consideration | Previous consideration |
|---|---|
| The Committees' Terms of Reference require these to be reviewed annually, and any changes approved by Boards. | Recommendation to increase Membership to four Members per Committee approved by Boards of Directors on 9 April 2024.<br><br>Audit Committees reviewed Terms of Reference at 29 April 2024 meetings |

## Executive Summary

The Audit Committees, at their meetings on 29 April 2024, reviewed their Terms of Reference and **RECOMMENDED TO THE BOARDS OF DIRECTORS** the adoption of revised Terms of Reference as set out in the **Appendices.**

The following specific matters are brought to the Boards' attention:

*Membership*

The Boards of Directors resolved, at the 9 April 2024 meeting, to increase the membership of each Committee to four Non-Executive Directors (including the Committee Chair). The Committees request that the Boards revisit this decision given constraints arising from Non-Executive Directors' overall workload and Healthcare Financial Management Association (HFMA) recommended best practice, and reduce the number of members per committee to three. The Committees also questioned the appropriateness of the Trust Vice-Chairs being members of the Committee in the context of the restriction of the Trust Chairs being members.

Subject to determination of this issue, Boards are requested to confirm committees' membership, currently:

*KGH:* Alice Cooper (Chair), Jill Houghton, Andrew Moore and Trevor Shipman

*NGH:* Elena Lokteva (Chair), Jill Houghton, Rachel Parker and Caroline Stevens

*Withdrawal of delegated authority to approve the annual reports and accounts*

The Committees are recommending that their delegated authority to approve the annual reports and accounts be relinquished for reservation to Boards of Directors. Subject to approval of this change, additional Board meetings will be required to make the necessary approvals of the 2023-24 reports and accounts; these are provisionally scheduled to take place on 26-27 June 2024.

*Other changes*

Other changes reflect updates to governance structures, including role and Committee titles, terminology (removing reference to 'maverick' transactions) and added reference to the emerging collaboration with the University Hospitals of Leicester NHS Trust (UHL). The requirement for the Chief Executive to attend the committees to present the internal audit plans and annual accounts has also been removed – these matters are the responsibility of the Chief Finance Officer.

| Appendices |
| --- |
| Revised draft Terms of Reference: KGH (Appendix A) and NGH (Appendix B) |
| Risk and assurance |
| The Committees retains ownership of the Board Assurance Framework as specified in the appendices. |
| Financial Impact |
| No direct implications relating to this report and recommendations. |
| Legal implications/regulatory requirements |

| |
|---|
| The Terms of Reference continue to reflect the Audit Committees' statutory and Constitutional duties in respect of the Trusts' governance and systems of internal control. |
| Equality Impact Assessment |
| Neutral |

# AUDIT COMMITTEE
# TERMS OF REFERENCE

## 1. PURPOSE

1.1 In accordance with Standing Orders (and as set out in the Audit Code for NHS Foundation Trusts and the Code of Governance issued by NHS England), an Audit Committee will be established.

1.2 The committee has oversight of the adequacy and effective operation of the organisation's overall governance and internal control system, including:

- Risk management
- Financial, operational and compliance controls (including systems for clinical audit)

The committee reviews and reports on these along with the related assurances that underpin the delivery of the organisation's objectives contained within the Assurance Framework.

1.3 The committee provides independent oversight of the adequacy and effective operation of collaboration~~the group model~~ with the Northampton General Hospital NHS Trust (NGH), whilst working closely with the NGH Audit Committee to deliver the benefits from the alignment of work plans, oversight activities and shared learning.

## 2. AUTHORITY

2.1 The Audit Committee is empowered to seek assurance on the adequacy and effective operation of the organisation's overall governance and internal control system, including the activities of the University Hospitals of Northamptonshire Group.

2.2 In addition to any statutory authority the committee has delegated authority from the Board of Directors as set out in the Trust's Scheme of Delegation. The committee has delegated authority to investigate any activity within its duty and has complete freedom of access to the Trust's records, documentation and employees, subject to compliance with Trust's Information Governance Policies and statutory responsibilities with regard to data protection.

2.3 It may seek any information or explanation it requires from Trust employees who are requested to co-operate with any requests made by the committee.

2.4 The committee is an independent source of assurance to the Board on the effective stewardship of the organisation.

2.5 The Internal and External Auditors are to have access to the Chair of the Audit Committee if required to raise issues of concern.

2.6 The Committee is authorised to access external legal and professional advice if required and for this to be funded by the Trust.

## 3. MEMBERSHIP AND ATTENDANCE

| | |
|---|---|
| **Chair of Committee** | A Non-Executive Director |
| **Members** | Three Non-Executive Directors including the Committee Chair |
| **Attendees** | Representatives of the Trust's Internal Auditors |
| | Representatives of Local Counter Fraud (Anti-Crime) Service |
| | Representatives of External Auditors |
| | Representative(s) of the NGH Audit Committee |
| | Group Chief Finance Officer or representative |
| | Hospital Finance Director and/or representatives |
| | Director of ~~Integrated Governance~~Corporate and Legal Affairs and/or representatives |
| | Nominated Governor and Deputy |
| | Other Directors and Trust staff attendance will be at specific invitation of the committee, particularly when the committee is discussing an issue which is their area of responsibility<br><br>Representatives of external Bodies/Agencies providing assurance to the Trust e.g. NHS Counter-Fraud Authority (NHSCFA) |
| | The Chief Executive shall attend to present the Annual Report and Governance Statement, ~~internal audit plan and the annual accounts~~. |

3.1 The Board of Directors will appoint three Non-Executive Directors to be the members of the Audit Committee. At least one of the three must be suitably financially qualified and one shall where possible be a member of the ~~Group~~ Clinical Quality and~~,~~ Safety ~~and Performance~~ Committee. One of the Non-Executive Directors shall chair the Committee. The Trust Chair shall not be a member of the Committee.

3.2 A Governor, nominated by the Council of Governors, is entitled~~invited~~ to ~~attend~~observe each meeting.

## 4. MEETINGS AND QUORUM

4.1 Meetings of the Committee shall be chaired by one of the Non-Executive Director members, with another Non-Executive Director acting as deputy in his/her absence.

4.2 Meetings of the Committee shall take place at the frequency and timing necessary to enable discharge of its responsibilities and the Committee will routinely meet on a quarterly basis. Responsibility for calling meetings of the Committee shall rest with the Committee Chair. Unless in exceptional circumstances, meeting schedules shall be aligned with the NGH Audit Committee.

4.3 Excepting for reasons of sickness, or unavoidable leave it is an expectation that committee members will attend meetings. Annual Leave by attendees should, where possible, be planned around meetings. With the Chair's agreement, Non-Executive Directors may appoint deputies to attend meetings in their absence.

4.4 A quorum of the Committee shall be two Non-Executive members. Committees may take place without a quorum at the discretion of the chair but decisions cannot be taken.

4.5 Decisions of the Committee shall be determined by a majority of the votes of the Members present and voting. The Member presiding as Chair shall have a casting vote in the event of equality of voting.

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

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

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

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

## 5. SUPPORT ARRANGEMENTS

5.1 The Director of ~~Integrated Governance~~Corporate and Legal Affairs shall be responsible for providing support to the Chair and to the Committee. Agenda~~s~~ for forthcoming meetings will be agreed with the Committee Chair and ~~Group~~ Chief Finance Officer and papers will be distributed to members one week in advance of the meeting, with any outstanding reports to be added no later than three days in advance of the meeting. Meeting papers will also be available to other members of the Board for information.

5.2 The Committee will establish an annual work programme, setting out those items that it expects to consider at forthcoming meetings.

## 6. DECLARATION OF INTERESTS

6.1 All members must declare any actual or potential conflicts of interest arising from items of Committee business, which shall be recorded in the Minutes accordingly.

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

## 7. DUTIES

The duties and responsibilities of the Committee are as follows:

7.1 Internal Audit

7.1.1 It is the responsibility of the ~~Group~~ Chief Finance Officer to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

7.1.2 To review the Internal Audit programme, consider the major findings of Internal Audit investigations and the management's response and ensure coordination between the Internal and External Auditors.

7.1.3 To ensure that the Internal Audit function is adequately resourced, has appropriate standing within the Trust and fulfils its function efficiently and effectively.

7.2 External Audit

7.2.1 To make recommendations to the Council of Governors, and following their approval, to the Board of Directors, regarding the appointment, reappointment, termination of appointment and fees of the External Auditor.

7.2.2 To ensure that the External Auditor remains independent in its relationship and dealings with the Trust.

7.2.3 To review the annual audit programme and to discuss with the External Auditor, before the annual audit commences, the nature and scope of the audit.

7.2.4 To review External Audit reports, including value for money reports and the Annual Governance Statement, together with management response.

7.2.5 To consider where the External Auditors might appropriately undertake investigative and advisory work.

7.2.6 To assess the quality of External Audit work on an annual basis.

7.2.7 To ensure there is a policy on accessing non-audit advice from the External Auditors

7.3 Local Counter Fraud Service

7.3.1 To receive reports from counter fraud, specifically open fraud case reporting and fraud prevention activities.

7.3.2 To receive and agree the annual plan for fraud awareness and review

7.3.3 To ensure the organisation has appropriate policies with regard to Fraud, Bribery and Corruption as required by NHSCFA

7.3.4 To ensure the Trust is meeting the NHSCFA quality assurance standards

7.4 Governance and Assurance

7.4.1 The Audit Committee has responsibility for overseeing the Trust's governance and assurance process and for recommending the approval of~~ing~~ the Annual Report including the Annual Accounts and the Annual Governance Statement, to the Board of Directors.

7.4.2 In particular, the Committee shall independently monitor and review:

(a) The internal and external audit services

(b) Financial information systems, the integrity of the financial statements and significant financial reporting judgements

(c) The establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives

(d) Treasury management policy

(e) Compliance with Standing Orders and Standing Financial Instructions, reviewing decisions to suspend Standing Orders and recommending changes to the Board of Directors.

(f) Schedules of losses and compensations

(g) Schedules of payroll debt and aged debt

(h) Schedules of approved waivers of purchasing authorities ~~approved each quarter~~

(i) Schedules of ~~maverick~~ transactions ~~made~~approved without appropriate authority ~~approved each quarter~~

(j) Issues that should be referred to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

7.4.3 The Committee will review ~~annual reports~~self-evaluations undertaken by ~~from~~ Board Committees and escalate items to the Board of Directors as required.

7.4.4 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee

wishes to raise, the Chair of the Audit Committee should bring the matter to the attention of the Board of Directors at the Board's next meeting ~~of the Board of Directors~~.

7.4.5 The Committee will review and investigate any matter at the request of the Board of Directors.

7.4.6 The Committee will routinely review the effectiveness of Board and Trust-wide governance, as part of which it will seek assurance around the development, implementation and monitoring of the Integrated Care System (ICS).

7.4.7 The committee shall work with the ~~Group~~ Clinical Quality and~~,~~ Safety ~~and Performance~~ Committee to ensure the Trust's systems and processes with regard to Clinical Audit are adequate and reflect the risks in the Trust

7.4.8 The Committee shall ensure that the systems and processes the Trust has in place enable the Whistle-blowing Policy to be effective and accessible

7.5 Board Assurance Framework (BAF)

7.5.1 The Audit Committee shares ownership of the Group Board Assurance Framework with the NGH Audit Committee, and the other Board committees will report updates related to their committees to the Audit Committees.

7.5.2 The Committee is to ensure that the Board Committees have sufficient support to fulfil this role

7.5.3 The Committee will ensure regular review and challenge regarding the contents of the BAF

7.6 Financial Reporting and Performance.

7.6.1 The Committee will:

- Liaise with the all Board Committees to ensure that weaknesses in control exposed by that Committee are investigated.
- Recommend to Board ~~Approve~~ the annual financial statement for the Trust's Final Accounts for approval
- Review and approve the Trust accounting policies each year.

7.7 Key Trust Documents

7.7.1 Review any proposed changes to the Scheme of Delegation, Standing Orders and Standing Financial Instructions for approval by the Board.

7.8 University Hospitals of Northamptonshire Group / University Hospitals of Leicester (UHL) collaboration

7.8.1 The Committee will review the effectiveness of Board and Trust-wide governance, as part of which it will seek assurance around the development, implementation and monitoring of Group Model Governance arrangements with Northampton General Hospital and collaboration with UHL. In fulfilling this role, the Committee shall assure itself in respect of the effectiveness of the arrangements as they relate to the delivery of strategic~~Group~~ objectives whilst maintaining the KGH systems of internal control, and provide assurance to the Board of Directors as required and requested.

7.9 In order to ensure an integrated approach and carry out the above duties effectively, the Committee will have effective relationships with all Board committees so that it understands processes and linkages and seeks assurance on their work.

7.10 The Committee may request specific reports from individual functions within the organisation in pursuance of its duties.

## 8. STANDING AGENDA ITEMS

| | |
|---|---|
| 1. | Internal Audit Reports |
| 2. | External Audit Reports |
| 3. | Counter Fraud Reports |
| 4. | Financial Governance |
| 5. | Group Board Assurance Framework |
| 6. | Items to escalate to the Board of Directors |

## 9. REPORTING

Reporting to Board:

9.1 The Committee will submit a report, from the Chair, ~~that will accompany the minutes of the Audit Committee meeting~~ to highlight recommendations that may need formal Board approval.

9.2 The Committee is responsible for the urgent escalation of any identified issues to the Board of Directors, via the Chair, as part of the Integrated Governance Report.

Reporting to Audit Committee:

9.3 The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility, though the Committee may not delegate powers to a sub-committee unless expressly authorised by the Board of Directors.

The terms of reference, including the reporting procedures of any sub-committees must be approved by the committee and regularly reviewed.

## 10. PROCESS FOR MONITORING EFFECTIVENESS OF THE COMMITTEE

10.1 The Chair of the committee will seek feedback on the effectiveness of committee meetings following each meeting.

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

10.3 The Committee will review its terms of reference annually, and recommend any changes for Board approval.

## 11. REVIEW

Reviewed: April 202~~3~~4 (Audit Committee)
Approved: ~~October~~June 202~~3~~4 (Board of Directors)
Next Review date: April 2025~~October 2024~~

# AUDIT COMMITTEE
# TERMS OF REFERENCE

## 1. PURPOSE

1.1 In accordance with Standing Orders (and as set out in the ~~Audit Code for NHS Foundation Trusts and the~~ Code of Governance for NHS Provider trusts issued by NHS England), an Audit Committee will be established.

1.2.1 The Committee provides assurance to the Board that effective risk management, internal control and governance processes are maintained and that the Trust's activities comply with the law, guidance and codes of conduct governing the NHS. The committee provides a formal independent mechanism for ensuring a co-ordinated approach for achieving sound financial and managerial control.[1]

1.3 The committee provides independent oversight of the adequacy and effective operation of ~~the group model~~collaboration with the Kettering General Hospital NHS Foundation Trust (KGH), whilst working closely with the KGH Audit Committee to deliver the benefits from the alignment of work plans, oversight activities and shared learning.

## 2. AUTHORITY

2.1 The Audit Committee is empowered to seek assurance on the adequacy and effective operation of the organisation's overall governance and internal control system, including the activities of the University Hospitals of Northamptonshire Group.

2.2 In addition to any statutory authority the committee has delegated authority from the Board of Directors as set out in the Trust's Scheme of Delegation. The committee has delegated authority to investigate any activity within its duty and has complete freedom of access to the Trust's records, documentation and employees, subject to compliance with Trust's Information Governance Policies and statutory responsibilities with regard to data protection.

2.3 It may seek any information or explanation it requires from Trust employees who are requested to co-operate with any requests made by the committee.

2.4 The committee is an independent source of assurance to the Board on the effective stewardship of the organisation.

[1] Extract from NGH Scheme of Delegation

2.5 The Internal and External Auditors are to have access to the Chair of The Audit Committee if required to raise issues of concern

2.6 The Committee is authorised to access external legal and professional advice if required and for this to be funded by the Trust.

## 3. MEMBERSHIP AND ATTENDANCE

| | |
|---|---|
| **Chair of Committee** | A Non-Executive Director |
| **Members** | Three Non-Executive Directors including the Committee Chair |
| **Attendees** | Representative of the Trust's Internal Auditors |
| | Representative of Local Counter Fraud (Anti-Crime) Service |
| | Representative of External Auditors |
| | Representative of the KGH Audit Committee |
| | ~~Group~~ Chief Finance Officer and/or representatives |
| | Hospital Finance Director and/or representatives |
| | Director of ~~Integrated Governance~~Corporate and Legal Affairs or representative |
| | Trust Board Secretary or representative |
| | Other Directors and Trust staff attendance will be at specific invitation of the committee, particularly when the committee is discussing an issue which is their area of responsibility<br><br>Representatives of external Bodies/Agencies providing assurance to the Trust eg NHS Counter Fraud Authority (NHSCFA) |
| | The Chief Executive shall attend to present the Annual Report and Governance Statement~~, internal audit plan and the annual accounts~~. |

3.1 The Board of Directors will appoint three Non-Executive Directors to be the members of the Audit Committee. At least one of the three must be suitably financially qualified and one shall where possible be a member of the ~~Group~~ Clinical ~~Quality~~ and~~,~~ Safety ~~and Performance~~ Committee. One of the Non-Executive Directors shall chair the Committee. The Trust Chair shall not be a member of the Committee.

## 4. MEETINGS AND QUORUM

4.1 Meetings of the Committee shall be chaired by one of the Non-Executive Director members, with another Non-Executive Director acting as deputy in his/her absence.

4.2 Meetings of the Committee shall take place at the frequency and timing necessary to enable discharge of its responsibilities and the Committee will routinely meet on a quarterly basis. Responsibility for calling meetings of the Committee shall rest with the Committee Chair. Unless in exceptional circumstances, meeting schedules shall be aligned with the KGH Audit Committee.

4.3 Excepting for reasons of sickness, or unavoidable leave it is an expectation that committee members will attend meetings. Attendees' Annual Leave should, where possible, be planned around meetings. With the Chair's agreement, Non-Executive Directors may appoint deputies to attend meetings in their absence.

4.4 A quorum of the Committee shall be two Non-Executive members. Committees may take place without a quorum at the discretion of the chair but decisions cannot be taken.

4.5 Decisions of the Committee shall be determined by a majority of the votes of the Members present and voting. The Member presiding as Chairman shall have a casting vote in the event of equality of voting.

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

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

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

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

## 5. SUPPORT ARRANGEMENTS

5.1 The Director of ~~Integrated Governance~~Corporate and Legal Affairs shall be responsible for providing support to the Chairman and to the Committee. Agendas for forthcoming meetings will be agreed with the Committee Chair and Group Chief Finance Officer and papers will be distributed to members one week in advance of the meeting, with any outstanding reports to be added no later than three days in advance of the meeting. Meeting papers will also be available to other members of the Board for information.

5.2 The Committee will establish an annual work programme, setting out those items that it expects to consider at forthcoming meetings.

## 6. DECLARATION OF INTERESTS

6.1 All members must declare any actual or potential conflicts of interest arising from items of Committee business, which shall be recorded in the Minutes accordingly.

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

## 7. DUTIES

The duties and responsibilities of the Committee are as follows:

7.1 Internal Audit

7.1.1 It is the responsibility of the ~~Group~~ Chief Finance Officer to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

7.1.2 To review the Internal Audit programme, consider the major findings of Internal Audit investigations and the management's response and ensure coordination between the Internal and External Auditors.

7.1.3 To ensure that the Internal Audit function is adequately resourced, has appropriate standing within the Trust and fulfils its function efficiently and effectively.

7.2 External Audit

7.2.1 To consider the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the Board when appropriate).

7.2.2 To ensure that the External Auditor remains independent in its relationship and dealings with the Trust.

7.2.3 To review the annual audit programme and to discuss with the External Auditor, before the annual audit commences, the nature and scope of the audit.

7.2.4 To review External Audit reports, including value for money reports and the Annual Governance Statement, together with management response.

7.2.5 To consider where the External Auditors might appropriately undertake investigative and advisory work.

7.2.6 To assess the quality of External Audit work on an annual basis.

7.2.7 To ensure there is a policy on accessing non-audit advice from the External Auditors

7.3 Local Counter Fraud Service

7.3.1 To receive reports from counter fraud, specifically open fraud case reporting and fraud prevention activities.

7.3.2 To receive and agree the annual plan for fraud awareness and review

7.3.3 To ensure the organisation has appropriate policies with regard to Fraud, Bribery and Corruption as required by NHSCFA

7.3.4 To ensure the Trust is meeting the NHSCFA quality assurance standards

7.4 Governance and Assurance

7.4.1 The Audit Committee has responsibility for overseeing the Trust's governance and assurance process and for recommending the approval of~~ing~~ the Annual Report including the Annual Accounts and the Annual Governance Statement, to the Board of Directors.

7.4.2 In particular, the Committee shall independently monitor and review:

(a) The internal and external audit services

(b) Financial information systems, the integrity of the financial statements and significant financial reporting judgements

(c) The establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives

(d) Treasury management policy

(e) Compliance with Standing Orders and Standing Financial Instructions, reviewing decisions to suspend Standing Orders and considering draft revisions prior to submission to the Board

(f) Schedules of losses and compensations

(g) Schedules of debtors/creditors balances

(h) Schedules of approved waivers of purchasing authorities ~~approved each quarter~~

(i) Schedules of ~~maverick~~ transactions ~~made~~approved without appropriate authority ~~approved each quarter~~

(j) Schedules of salary overpayments

7.4.3 The Committee will review ~~annual reports from~~self-evaluations undertaken by Board Committees and escalate items to the Board of Directors as required.

7.4.4 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should bring the matter to the attention of the Board of Directors at the Board's next ~~-~~meeting ~~of the Board of Directors~~.

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| | |
|---|---|
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## 11. REVIEW

Reviewed: ~~September 2023~~April 2024 (Committee)
Approved: June 2024~~October 2023~~ (Board of Directors)
Next Review date: ~~October 2024~~April 2025