AGENDA BOARD OF DIRECTORS

DATE AND TIME: 10:00am, 28th September 2018
VENUE: Boardroom, Glebe House, Kettering General Hospital

<table>
<thead>
<tr>
<th>TIME</th>
<th>ITEM</th>
<th>SUBJECT</th>
<th>ACTION</th>
<th>LEAD</th>
<th>ENCLOSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.00</td>
<td>Patient Story</td>
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</tbody>
</table>

1. OPENING ADMINISTRATION

| 10.30 | 1.1 | Apologies for Absence | - | - | (verbal) |
| 1.2 | Declarations of Interest | - | Chairman | (verbal) |
| 1.3 | Minutes from previous meeting of 6 July 2018 | Approval | Chairman | (attached) |
| 1.4 | Action Log | Review | Chairman | (attached) |

| 10.35 | 1.5 | Chair’s Update | Note | Chairman | (verbal) |
| 1.6 | Chief Executive’s Update | Note | Chief Executive | (verbal) |

2. STRATEGY

| 11.00 | 2.1 | Board Governance Implementation Proposals | Approval | Director of Governance | (attached) |
| 11.15 | 2.2 | 2018/2020 KGH Strategy | Approval | Director of Strategy | (attached) |
| 11.30 | 2.3 | Transformation Update | Note | Director of Finance | (attached) |
| 11.45 | 2.4 | Digital Roadmap Strategy | Approval | Chief Executive | (attached) |

3. OPERATIONAL

| 12.00 | 3.1 | Integrated Governance Report | Approval | Committee Chairs | (attached) |
| 12.10 | 3.2 | Quality Improvement Plan | Note | Director of Nursing and Quality | (attached) |
| 12.20 | 3.3 | Board Assurance Framework and Corporate Risk Register | Approval | Director of Governance | (attached) |
| 12.30 | 3.4 | GMC Survey Results | Note | Medical Director | (attached) |
| 12.45 | 3.5 | Learning from Mortality and Morbidity Annual Report | Note | Medical Director | (attached) |
4. RESOLUTION TO EXCLUDE THE PRESS AND PUBLIC

The Board is asked to approve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.

5. DATE & TIME OF NEXT MEETING

- 10:00am
- Friday 30th November 2018
- Boardroom, Glebe House
MINUTES OF THE BOARD OF DIRECTORS MEETING HELD AT 10:00AM ON THE 6TH JULY 2018, BOARDROOM, GLEBE HOUSE

PRESENT: Mr A Burns - Chairman
         Mr S Weldon - Chief Executive
         Ms L Hackshall - Director of Nursing & Quality
         Ms N Briggs - Director of Finance
         Ms E Doyle - Interim Chief Operating Officer
         Prof. A Chilton - Medical Director
         Mr P Harris-Bridge - Non-Executive Director
         Mrs J Gray - Non-Executive Director
         Mr B Chopra - Non-Executive Director
         Dr L Llewellyn - Non-Executive Director
         Mr T Shipman - Non-Executive Director
         Mr D Venkatasamy - Non-Executive Director

IN ATTENDANCE: Mrs S Hills - Healthwatch
                Ms D Burnett - Acting Committee Secretary

NOMINATED GOVERNOR: Mr S Lake - Lead Governor

OBSERVERS: Mr R Apps, Ms S Holden, Ms E Hannah, Mr R Cook, and Mrs G Chapman

1. OPENING ADMINISTRATION

   The Chairman welcomed Dr Lise Llewellyn and Mr Damien Venkatasamy, new Non-Executive Directors to the meeting.

1.1 APOLOGIES FOR ABSENCE

   Apologies for absence were received from Mr M Smith, Director of Human Resources & OD, Ms L Hanna, Non-Executive Director, Prof. C Welsh, Non-Executive Director and Ms P Grimmett, Director of Strategy and Partnerships.

1.2 Declarations of interest

   There were no declarations of interest relevant to the items on the agenda.

1.3 Minutes from the Extraordinary Board meeting on 24th May 2018

   The minutes of the Extraordinary Board meeting were approved as a true and accurate record.

1.4 Minutes from the previous meeting on 1st June 2018

   The minutes of the Board of Directors meeting were approved as a true and accurate record subject to a minor amendment.
1.5 **Action Log**

The action log was received and the progress and assurances noted.

2. **ORGANISATIONAL STRUCTURE**

2.1 **Board Governance Proposal**

Mr Weldon introduced the proposal for new board governance arrangements and highlighted the strengths to the Board of moving to a revised model of working including:

- Enabling the development in a *long term* strategy
- Formal Board on a bi-monthly basis alternated with Board Development sessions to allow the Board planned time to factor in its long term strategy.
- Review of the role of Board Sub-Committee meetings
- Good corporate governance: alignment to the NHSi regulatory cycle.

The Board discussed the proposed governance arrangements and key points from the discussion included:

- A requirement for the underpinning infrastructure to be in place to support clinical development including the availability of timely information
- The need to take account of the role of the Council of Governors in new governance arrangements.
- To ensure the governance arrangements reflected engagement in the STP
- To ensure the Board Assurance Framework and the Corporate Risk Register are reflected in all elements of the updated proposals.

Board members welcomed the opportunity for a refresh of the balance and rhythm of the Board and of the prospect of a focus on the strategy and culture, and agreed it was the right process to go forward.

**DECISION:** *The Board APPROVED the Board Governance Paper for further development with a trial set of proposals to be presented at the 28th September 2018 meeting.*

3. **RESOLUTION TO EXCLUDE THE PRESS AND PUBLIC**

The Board approved that members of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.

4. **DATE AND TIME OF NEXT MEETING**

- 10.00am
- 28th September 2018
- Boardroom, Glebe House
## Board of Directors Part 1 Action Log -September

<table>
<thead>
<tr>
<th>MINUTE REF</th>
<th>SUBJECT</th>
<th>ACTION REQUIRED</th>
<th>OWNER</th>
<th>DATE RAISED</th>
<th>DATE DUE</th>
<th>PROGRESS/COMMENT/ ASSURANCE</th>
<th>ACTION STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>KPIs - Integrated Governance Report</td>
<td>The draft new key performance indicators to be included within the integrated governance report would be presented to the Board of Directors in April.</td>
<td>Chief Operating Officer</td>
<td>02 March 2018</td>
<td>28 September 2018</td>
<td>The first Integrated Governance Reports had now been completed and shared with Board Sub-Committees and included the new key performance indicators.</td>
<td>ACTION COMPLETED</td>
</tr>
<tr>
<td>1.5</td>
<td>Director of Nursing and Quality Report</td>
<td>To circulate a visits programme for the Board to review</td>
<td>Director of Integrated Governance</td>
<td>04 May 2018</td>
<td>28 September 2018</td>
<td>The programme of Quality Visits had been completed and shared with Executives and Governors and continued to be progressed.</td>
<td>ACTION COMPLETED</td>
</tr>
</tbody>
</table>
Executive Summary

A proposal for refreshing and updating the Board Governance structure for Kettering General Hospital NHS Foundation Trust (KGH) was discussed at the July 2018 Board of Directors and agreed in principle. This paper takes forward those proposals and sets out the process to embed the key changes throughout the remainder of 2018/19.

A review that tested the current arrangements against best practice from across the NHS was commissioned. This was to respond to the recommendations of the earlier reviews, including by NHS Improvement in May 2017 and by PwC in August 2017, that identified the need to strengthen governance arrangements. A set of proposed recommendations were approved in principle at 6 July 2018 Board meeting, subject to comments being addressed.

A paper setting out the proposals in more detail was drafted. This was sent out to all Governors, Non-Executive Directors, and Executive Directors for comment in July 2018. Overall the comments received were supportive of the paper and in favour of the changes. There were no comments that require material changes to the proposed approach.

The Board Governance Implementation Proposals takes forward changes in the following areas:

- The Board of Directors and committee Terms of Reference
- Interactions and links between Board, committees and Council of Governors
- Schedule and frequency of meetings
- Tools, templates and processes

Non-Executive Chairs and Executive Leads for the Board and its committees have been identified. The following principles are core to the new arrangements:

- Chairs and Executive Leads should work collaboratively to develop forward-looking work plans and agendas
- The Executive Group Meeting (EGM) is to provide a gateway for approval of Board papers.
A full review of these arrangements, and the learnings from them, will be carried out by Audit Committee in April 2019. A review of the initial cycle of meetings to assess whether incremental changes need to be made.

The Board of Directors is recommended to approve the Board Governance Implementation proposals.

Reason for Consideration
The Board of Directors previously considered the proposed recommendations at the July 2018 meeting. These were approved subject to comments being addressed and implementation proposals being developed.

This paper is the response to these points and sets out the timelines and approach for the changes to Board Governance in the organisation. It is therefore appropriate that the Board of Directors has the opportunity to review, discuss and approve the more detailed proposals and their implementation plans.

Paper Previous Consideration
Initial proposals and recommendations:
- EGM: 26 June 2018
- Board of Directors: 6 July 2018

Board Governance Implementation Proposals:
- EGM: 24 July 2018
- Board Development Session: 7 September 2018
- EGM: 18 September 2018

Strategic Objectives
The Board Governance proposals are an enabler for delivery of all four strategic objectives:
- To provide high quality care to individuals, communities and the population we serve
- To be a strong and effective partner in the wider health and social care community
- To maintain a fulfilling developmental working environment for our staff
- To be a clinically and financially sustainable organisation.

Financial Implications
It is not anticipated that there will be any financial implications as a result of this paper.

Risks
The Board Governance Implementation proposals set out how risks will be managed, reported and monitored in the organisation, and how business will be organised around these.
This includes using the Corporate Risk Register (CRR) and Board Assurance Framework (BAF) as a route through which business is conducted.

Should the proposals not be implemented, there is a risk that risk oversight within the organisation does not move to the required level.

**Equality impact**

An equality impact assessment has not been undertaken.
Meeting | Board of Directors  
---|---  
Agenda Item | 2.1  
Paper Title | Board Governance Implementation Proposals  
Date | 28 September 2018  
Author | Richard Apps, Director of Integrated Governance  

**Situation**

A proposal for refreshing and updating the Board Governance structure for Kettering General Hospital NHS Foundation Trust (KGH) was discussed at the July 2018 Board of Directors and agreed in principle. This paper is intended to take forward those proposals and sets out the process to embed the key changes throughout the remainder of 2018.

Following agreement to the initial proposals into a paper describing the processes in more detail and implementation plans was commissioned. This was sent to Governors, Non-Executive Directors, and Executive Directors for comment in July. Comments received from this review were used to inform an updated draft of the proposals. The revised schedule of meetings and governance processes has been tested during September to ensure that they will work in practice, and before they are adopted formally. This has allowed for refinement where required.

The Board of Directors is now asked to approve the implementation of the Board Governance proposals in full. This will be subject to an initial review of effectiveness after the initial running of the process, and full review eight months after adoption.

**Background**

Governance arrangements at KGH have been subject to a number of reviews and iterations. NHS Improvement carried out a targeted review in May 2017 (shortly after the Trust had been placed into special measures), and PwC carried out a review in August 2017. Both reviews considered a range of governance elements and made a series of recommendations to strengthen the organisation’s governance. These were taken forward through a Trust-wide action plan to implement required changes.

One action was to test the structure of the Board and its committees and set out clear lines of delegation. To enable this a review of the KGH Board and committees was commissioned. In order to respond to the recommendations of the earlier reviews this set out to test the current governance arrangements against best practice from across the NHS. It benchmarked against practices at both comparative and ‘outstanding’ Trusts, whilst also considering the principles and ideals in the NHS Leadership Academy’s guidance *The Healthy NHS Board*[^1^][^2^]. Initial proposals and recommendations emerging from this review were agreed in principle by the Board of Directors in principle in July 2018.

[^1^]: The Healthy NHS Board: A review of guidance and research evidence’, February 2010  
[^2^]: The Healthy NHS Board 2013 - Principles for Good Governance’, May 2013
A condition of this agreement was that more detailed plans were developed, along with an implementation plan. Following further work and engagement with stakeholders, a paper was drafted. This was sent out to all Governors, Non-Executive Directors, and Executive Directors in July for their comment. A summary of feedback received, with analysis of respondents, is shown in the table below:

| Comments received from | • Two Non-Executive Directors  
|                        | • One Executive Director  
|                        | • Two Governors  
|                        | • Acting Committee Secretary  |

| Overview of comments | Overall the comments were supportive of the paper and in favour of the changes. There were no comments that require material changes to the proposed approach. There were four key themes coming through the comments that have been incorporated into the latest version (see below). |

| Key themes to be incorporated into the final version | • Updates to the responsibilities of Board committees (where required) are being discussed with the Executive Lead and Chair of the committee, to allow for changes to be made and agreed at the next committee meeting.  
|                                                     | • Where required, changes to membership of committees are being discussed and agreed with Executive Leads and Chairs of committees in order to be incorporated into the next versions of the TOR.  
|                                                     | • The updated version of the paper addresses the concerns raised regarding the administrative requirements, including clarifying the responsibilities of Executive leads and Chairs in preparing papers.  
|                                                     | • The updated version of the paper clarifies the process of risk management and brings it in line with the risk management review. |

An update was provided to the Board Development Session on 7 September 2018, where there was a further opportunity for comment. No further material comments were received at this session.

**Assessment**

Key changes that the proposal take forwards:

1. **Board and committee Terms of Reference**
   - Board and committees to have clarity on purpose and role.
   - Delegated authority from Board to enable committees to make decisions to effectively oversee delivery of operations and strategy.
   - Each committee to have clear accountability of standing agenda items.
Interactions and links between Board, committees and Council of Governors

- Executive Group Meeting (EGM) to provide a gateway for approval of Board papers.
- EGM to hold central role of reviewing and approving the Integrated Governance Report. Approved Integrated Governance Report to provide strategic and operational context to each committee.
- Integrated Governance Report to be the formal route for committees to report and escalate to the Board.
- EGM to hold central role in reviewing BAF and CRR and highlighting to committees where review is required of specific risks. Committees to provide necessary updates on risk to Audit committee, and Audit committee to have oversight of Board Assurance Framework.
- Audit committee to carry out review of governance arrangements for Board and committees 8 months following implementation of changes.
- Two joint meetings to be scheduled per year between the Governors and the Board to provide discussion between Governors and the Board outside of formal Board meetings.
- Governors will continue to attend committee meeting and the Board as participating observers.

Schedule and frequency of meetings

- Board meetings to be on the last working day of the month, alternating between formal Board and Board Development Session.
- Organisational Development Committee to move to bi-monthly meetings.
- Committee meeting schedule designed to allow for review of previous months data and reporting of the data to Board in the same month.

Tools, templates and processes

- Standardised templates for agendas, minutes, actions and reports.
- Processes set out to support administrative requirements of meetings.

Non-Executive and Executive leads for each committee have been identified as part of the review. This operationalises the proposals and ensures that there are clear arrangements that will enable the Board of Directors and its committees to conduct their business. The expectation is that the committee Chair and the Executive Director Lead will work collaboratively to agree work plans and set agendas for meetings. As set out in the table above, it is the expectation that all Board papers (and, by extension, relevant committee papers) will have previously been reviewed at an EGM meeting.

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Chair (Non-Executive Director)</th>
<th>Executive Director Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Directors</td>
<td>Alan Burns, Chair</td>
<td>Simon Weldon, Chief Executive</td>
</tr>
<tr>
<td>Quality &amp; Safety</td>
<td>Professor Christopher Welsh</td>
<td>Leanne Hackshall, Director of Nursing and Quality</td>
</tr>
<tr>
<td>Organisational</td>
<td>Janet Gray</td>
<td>Mark Smith, Director</td>
</tr>
</tbody>
</table>
The Council of Governors and Executive Group Meetings are not included in the table above, as these are not committees of the Board of Directors. They are therefore subject to different leadership arrangements.

The proposed new arrangements are being tested throughout September to ensure that they are fit-for-purpose and to identify any required refinements. At this stage a ‘lessons learnt’ report will be developed which will include refinements to the process. This will be submitted to EGM for consideration.

Although not a formal part of KGH’s Board Governance, the paper also describes the relationship between the Board of Director’s oversight of the organisation and the regulatory (NHS Improvement) oversight. This is primarily through the Progress Review Meetings (PRMs) and Quarterly Oversight Meetings (QRMs) and delivered through the Integrated Governance Report.

A full review of these arrangements, and the learnings from them, will be carried out by Audit Committee in April 2019. The Chief Executive and Director of Integrated Governance will undertake a review of the initial cycle of meetings to assess whether incremental changes need to be made.

**Recommendation**

The Board of Directors is recommended to approve the Board Governance Implementation proposals.
Board Governance Implementation Proposal

September 2018
V02c DRAFT FOR DISCUSSION
Document History

Revision History

Date of this revision: 13 September 2018

Date of next revision: Following Board review on 28 September 2018

<table>
<thead>
<tr>
<th>Revision date</th>
<th>Summary of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 July 2018</td>
<td>Initial document draft created</td>
</tr>
<tr>
<td>31 July 2018</td>
<td>First draft circulated for review and comment</td>
</tr>
<tr>
<td>1 August 2018</td>
<td>Updated draft to take account of reviewer comments; addition of information on NHS Improvement Performance Review Meeting and Quarterly Review Meeting</td>
</tr>
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Distribution

This document has been distributed to:

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<th>Name</th>
<th>Title/Organisation</th>
<th>Date of Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Governors, Non-Executive Directors and Executive Directors</td>
<td>Kettering General Hospital NHS Foundation Trust</td>
<td>31 July 2018</td>
</tr>
<tr>
<td>Board of Directors</td>
<td>Kettering General Hospital NHS Foundation Trust</td>
<td>21 September 2018</td>
</tr>
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1 Executive summary

A proposal for refreshing and updating the Board Governance structure for Kettering General Hospital NHS Foundation Trust (KGH) was discussed at the July 2018 Board of Directors and agreed in principle. This paper is intended to take forward those proposals. It sets out the process to embed the key changes throughout the remainder of 2018. It is also intended as a guide to support members of the Board and its committees in an ongoing manner.

The key changes proposed to the KGH governance covered throughout this paper are set out in the table below:

<table>
<thead>
<tr>
<th>Area</th>
<th>Proposed changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board and committee Terms of Reference</td>
<td>• Board and committees to adopt the principles and structures proposed in <em>The Healthy NHS Board</em> İ.</td>
</tr>
<tr>
<td></td>
<td>• Delegated authority from Board to enable committees to make decisions to effectively oversee delivery of operations and strategy (this is described in Section 4.2)</td>
</tr>
<tr>
<td></td>
<td>• Each committee to have a unitary purpose with standing agenda items that flow from this.</td>
</tr>
<tr>
<td>Interactions and links between Board, committees and Council of Governors</td>
<td>• Executive Group Meeting (EGM) to provide a gateway for approval of Board papers.</td>
</tr>
<tr>
<td></td>
<td>• EGM to hold central role of reviewing and approving the executive summary of the Integrated Governance Report. The approved report will provide the strategic and operational context to each committee.</td>
</tr>
<tr>
<td></td>
<td>• EGM to play a central role through reviewing the BAF prior to committee meetings and highlighting where a specific risk requires review from a committee.</td>
</tr>
<tr>
<td></td>
<td>• Committee’s to review and provide assurance on the specific risks relevant to that committee to provide updates on those risks to the Audit Committee, which has oversight of BAF.</td>
</tr>
<tr>
<td></td>
<td>• Audit committee to carry out a review of governance arrangements for Board and committees eight months following implementation of changes.</td>
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<tr>
<td></td>
<td>• Two joint meetings to be scheduled per year between the Governors and the Board enabling discussion outside of formal Board meetings.</td>
</tr>
<tr>
<td></td>
<td>• Governor representatives to sit on committees as ‘participating observers’, though without voting rights.</td>
</tr>
</tbody>
</table>

1 *The Healthy NHS Board 2013 - Principles for Good Governance*, May 2013
<table>
<thead>
<tr>
<th>Area</th>
<th>Proposed changes</th>
</tr>
</thead>
</table>
| **Schedule and frequency of meetings** | • Board meetings to be on the last working day of the month, alternating between formal Board and Board Development Session.  
• Workforce Development Committee to be renamed as the ‘Organisational Development Committee’, and to move to bi-monthly meetings.  
• Committee meeting schedule designed to allow for review of previous months data and reporting of the data to Board in the same month.                                                                                                                                                                                                 |
| **Tools, templates and processes** | • Workplan for the year and agendas to be agreed between Non-Executive committee Chair and nominated Executive lead for each committee.  
• Refreshed datasets and key indicators to be designed for each committee.  
• Standardised templates for agendas, minutes, actions and reports.  
• Processes set out to support administrative requirements of meetings.                                                                                                                                                                                                                                           |

Updated schedules of meetings have been developed to enable implementation of the proposals. Refreshed Terms of Reference (ToR) for the Board and its Committees are included as an appendix to this paper. Templates have also been developed to support revised reporting to the Board and its Committees and drive greater standardisation. These are also included in the appendix to this paper.
2 Introduction to key changes to Board governance

Section synopsis
- This section sets out the background to the proposed changes to Board Governance for Kettering General Hospital NHS Foundation Trust (KGH), which are based on best practice and comparator Trusts.
- The proposals clarify the purpose and aims of the Board and its committees, setting out their structure and focus.
- This paper sets out the systematic mechanism that will allow for communication of key information between the committees, and details of the linkages between the Board, committees, and Council of Governors to ensure effective governance.

A set of proposals to refresh and update the Board Governance of Kettering General Hospital NHS Foundation Trust (KGH) was discussed at the July 2018 Board of Director’s Meeting and agreed in principle. The proposals support the Board in fully achieving its role in building patient, public and stakeholder confidence in the high-quality care the organisation provides. This paper takes forward the proposals and sets out key changes to be made. It outlines the support that will be provided to embed changes. Finally, it acts as a guide to the Board and its committees to provide ongoing high-quality, effective governance to KGH.

The key changes are centred around the structure and focus of the Board and committees. This includes how they interact together, the schedule and frequency of meetings, and consistency of processes, tools and reports. Taken together, this represents a refresh of existing governance arrangements that have served KGH well, rather than an entire revision. Changes are required, though, as the context within which the organisation is operating has changed and the role of the Board evolves.

The proposals detailed within this paper have been developed based on both best practice guidance as well as a benchmarking exercise. The principles and ideas set out in the NHS Leadership Academy’s guidance ‘The Healthy NHS Board’ remains the most relevant source of best practice guidance and is summarised in this paper. This has been combined with other guidance to inform the development of the key changes identified. The findings of a benchmarking exercise of KGH against both ‘comparator’ and ‘outstanding’ Trusts has also been incorporated. This will ensure that a set of effective, efficient governance arrangements are implemented.

The key changes proposed are described in more detail, and these build on the paper presented at the July 2018 Board of Director’s meeting. The proposals clarify the purpose and aims of the Board and its committees, setting out their structure and focus. Terms of Reference (ToR) for the Board and each of the committees have been reviewed to ensure each has clarity of role, purpose and accountability of standing agenda items. The ToR also ensure that the committees have sufficient delegated authority from the Board to make the

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2 Stakeholders for the Trust include, but are not limited to: Members, Governors, staff, system partners and regulators

3 The Healthy NHS Board: A review of guidance and research evidence, February 2010

4 The Healthy NHS Board 2013 - Principles for Good Governance, May 2013
necessary decisions to effectively oversee delivery of their scope. This will ensure that items are only escalated as and when Board decision-making and direction is required.

The **systematic mechanism** that will allow for communication of key information between the committees is set out in this paper. Details of the **linkages between the Board, committees, and Council of Governors** to ensure effective governance are also included. Specifically, The EGM will act as a ‘gateway’ for Board papers to be approved before they are circulated the Executive Group Meeting (EGM) which includes reviewing and approving the executive summary of the Integrated Governance Report. This report will be used to share strategic and operational context across committees. EGM will also review the Board Assurance Framework (BAF) prior to committee meetings and highlighting where specific risks require review by committees. Each committee will report relevant updates to Audit Committee, which has oversight of the BAF and will in turn report on the BAF to the Board.

An updated **schedule for meetings** has been developed, which is aligned to regulator requirements and the Trusts business cycle. These determine a frequency that makes best use of Executive and Non-Executive Director time in governing the organisation.

Finally, guidance is provided in the form of **practical processes, tools and templates** that will support implementation and administration for Board governance. These are intended to not only support the Trust Board Secretary, but also to ensure there is clarity and consistency in understanding of roles, accountabilities and expectations of outcomes across the Board and its committees. These set clear expectations of the memberships of Boards and its committees, which in turn will ensure an increase in the effectiveness of the governance arrangements.

This paper will be a ‘living document’, that will necessarily evolve over time. In particular, revisions may be made following the planned review of the governance changes that is scheduled eight months following implementation. At this stage, processes and practices will have been tested and optimisations may be identified. Despite this, it is intended that the core principals outlined in this paper will remain in place as long as suitable and serving the needs of KGH, the Board and its committees, and ultimately the Trust’s stakeholders including the patients that it serves.
3 Best practice guidance for NHS Board governance

Section synopsis
- This section provides a summary of the best practice guidance, including *The Healthy NHS Board*, which sets out the role of a Board of an NHS Foundation Trust and the structure and form of its committee
- A summary of the benchmarking exercise against ‘comparator’ and ‘outstanding’ Trusts is provided, which showed that policies and processes at KGH were broadly in line with other organisations
- This section is included for information and forms the basis of the changes that are described in more detail in the previous and following sections.

3.1 NHS guidance on the role of the Board
As outlined by *The Healthy NHS Board*\(^5\), the Board must use effective governance to build patient, public and stakeholder confidence that their health and healthcare is effectively overseen and provided. This fundamental accountability to the public and stakeholders is delivered by building confidence:

- In the quality and safety of health services.
- That resources are invested in a way that delivers optimal health outcomes.
- In the accessibility and responsiveness of health services.
- That patients and the public can help to shape health services to meet their needs.
- That public money is spent in a way that is fair, efficient, effective and economic.\(^6\)

In order to achieve this purpose, the Board must effectively carry out all three of its key roles:

<table>
<thead>
<tr>
<th>Role</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formulate Strategy</td>
<td>- To ensure that the strategy is demonstrably shaped and owned by the board, with active consultation and engagement in its development with staff, patients, Governors, members and other stakeholders, and takes into account the organisations responsibility as part of the wider health economy.</td>
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<tr>
<td></td>
<td>- To ensure the strategy has a compelling vision for the future, underpinned with clear strategic objectives and accompanied by a clear statement of the organisations purpose, values and behaviours.</td>
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<td></td>
<td>- To have an explicit approach to strategic decision making; where decisions are aligned to strategic direction, there is agreed delegation, and agreement about which decisions require Governor and or external approval.</td>
</tr>
</tbody>
</table>

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\(^5\) The Healthy NHS Board: A review of guidance and research evidence, February 2010
\(^6\) The Healthy NHS Board 2013 - Principles for Good Governance, May 2013
Role | Definition
--- | ---
**Ensure Accountability** | • To hold the organisation to account for its performance in the delivery of strategy. The board must be assured through the review of reliable sources of information (as opposed to reassured through others).
• To ensure and be assured that the organisation operates effectively and with openness, transparency and candour. The board must ensure that a clear assurance and escalation framework is in place.
• To seek assurance that the systems of control are robust and reliable and are in line with the Boards risk appetite (quality governance, financial stewardship, risk management, legality, decision making, information governance etc.)

**Shape Culture** | • To shape a healthy culture for the board and the organisation reflecting the NHS values, as defined in the NHS Constitution and supporting delivery of the strategy.
• Exemplify and model to support the embedding of the culture. The board needs to be seen as the champion of the values in the way it operates and behaves.

### 3.2 NHS guidance on the role of the Board committees

Board committees are created to enable greater effectiveness of the Board and to support the discharge of its duties. While the formal powers of the organisation are vested in the Board, the NHS Code of Accountability allows the Board to delegate some elements of its business to Board committees and the Executive. Committees responsible for audit and remuneration are a requirement of all Boards to enable accountability.

Other, non-required, committees of the Board must ensure:

• The function or functions of the committee are not those that should be carried out by the whole Board, or by the Executive.
• They are contributing to improved clarity of role and alignment between other committees and the Board itself.

Board committees should all have a Non-Executive Chair and checks and balances need to be maintained in committee membership.

### 3.3 Benchmarking against other Trusts

A review of best practice across ‘comparator’ and ‘outstanding’ Trusts was carried out. This was used along with the NHS guidance to determine the most effective Board governance arrangements for KGH.

This exercise involved analysing key information on the governance arrangements from seven Trusts that were comparative to KGH (the ‘comparator’ Trusts) and five that are rated as ‘outstanding’ by the Care Quality Commission (CQC). Major findings of this exercise included:

• Seven of the Trusts held Board meetings on a bi-monthly or on a less frequent basis.
- Performance data reported at Board meetings for the majority of the Trusts reviewed was for the previous month/s; holding meetings in the last week of the month appeared to be an effective method for timely reporting of data.
- With respect to the structure of Board committees, each Trust reviewed had a Board committee that focused on: Audit; Remuneration; Quality; and Performance and/or Finance.
- The majority of the comparative Trusts additionally had committees that focused on workforce and charitable funds.

The outputs of this analysis has supported the development of refreshed governance arrangements for KGH. These are based not only best practice available to the NHS more widely, but also practical implementation for comparator and outstanding Trusts.
## 4 Board and Committee overview

### Section synopsis
- The updated governance structure sets out the revised frequency of some meetings.
- This section sets out the detail of the Board and its committees, and any changes that arise to these. The delegation to committees is as follows:

<table>
<thead>
<tr>
<th>Committee</th>
<th>Delegated authority from Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality and Safety</td>
<td>To make the necessary decisions to enable the delivery of the Quality Strategy, through:</td>
</tr>
<tr>
<td></td>
<td>- Ensuring the Quality Strategy is delivered through the six Quality Pledges.</td>
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<td>- Ensuring the organisation is striving to provide high-quality care to individuals, communities and the population it serves. This includes consideration of events that impact on patient safety, and the learnings that can be drawn from these.</td>
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<td>- Overseeing the delivery of the Quality Improvement Plan and ensuring a culture of continuous improvement is embedded throughout the organisation.</td>
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<tr>
<td>Organisational Development</td>
<td>To make the necessary decisions to oversee the delivery of the Organisational Development strategy across the Trust, through:</td>
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<tr>
<td></td>
<td>- Ensuring delivery of the organisational development strategy through its eight objectives</td>
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<td></td>
<td>- Ensuring the CARE values are embedded across the organisation.</td>
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<td></td>
<td>- Ensuring the organisation is compliant with statutory requirements.</td>
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<tr>
<td>Audit</td>
<td>To be an independent source of assurance to the Board on the effective stewardship of the organisation, through:</td>
</tr>
</tbody>
</table>
|                                  | - Seeking assurance on the adequacy and effective operation of the organisation’s overall governance and internal control system, including:  
  risk management, and 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. |
|                                  | - Responsibility for carrying out reviews on the effectiveness of the other Board committees.                                                                                                                                       |
|                                  | - Ownership of the Board Assurance Framework, and to report on this to Board. Other Board committees are responsible for providing the Audit Committee with updates on this.                                                                 |
| Performance, Finance & Resources | To make the necessary decisions to oversee the delivery of the transformation agenda in order to secure the financial sustainability of the organisation, whilst delivering resilient, high quality services for patients, through: |
|                                  | - Ensuring that the underlying plans to deliver transformation are robust and realistic.                                                                                                                                             |
|                                  | - Ensuring that investments and capital expenditure support delivery of the overall strategy.                                                                                                                                       |
### Nominations & Remuneration
To agree the remuneration arrangements for Executive Directors.

To recommend to the Board of Directors the process for the selection, appointment, termination, compensation and benefits of Executive Directors.

To monitors and evaluates the performance of the Executive Directors subject to the advice of the Chief Executive. It may obtain legal, remuneration and other advice as and when required.

### Charitable Funds
To manage the funds of the Charity in line with the overall objectives of the Charity, through:
- Using the funds to help improve the lives of patients, their families, visitors and staff at KGH.
- Overseeing activities in two main areas, fund-raising activities and investments.
- Ensuring that the financial arrangements of the charity are kept separate from those of the overall Trust.

### Executive Group Meeting
To manage the day-to-day business of the organisation, where this does not fall within the remit of the other committees outlined above.

In practice, this is defined by the portfolios of each of the Executives, which are defined and agreed through the Board and its committees.

- The linkage between the Board and its committees, as well as other statutory bodies such as the Council of Governors is described. To fulfil its commitments the Board will delegate powers to committees, as set out above. Committees will report back to the Board frequently. The Council of Governors holds the Board to account on performance.
- To reflect the changes to frequency of some meetings, an overall updated schedule of meetings has been produced which includes dates for the year ahead.
- The major milestones in meeting preparation are set out, these show at what stage agendas should be agreed, papers commissioned and circulated, and minutes produced.
4.1 Governance structure

- **Trust Board**
  - Chair: Alan Burns
  - Frequency: Bi-monthly – Formal meeting in public
  - Frequency: Bi-monthly – Board development session in private

- **Organisational Development Committee**
  - Chair: Janet Gray
  - Frequency: Bi-monthly

- **Performance, Finance & Resources Committee**
  - Chair: Phil Harris-Bridge
  - Frequency: Monthly

- **Quality & Safety Committee**
  - Chair: Chris Welsh
  - Frequency: Monthly

- **Audit Committee**
  - Chair: Trevor Shipman
  - Frequency: Quarterly

- **Nominations & Remuneration Committee**
  - Chair: Alan Burns
  - Frequency: Meetings as required

- **Charitable Funds Committee**
  - Chair: TBD
  - Frequency: Quarterly

- **Executive Group Meeting**
  - Chair: Simon Weldon
  - Frequency: Bi-weekly
4.2 Key features of the Board and its committees

Board
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 formal powers of the organisation are vested in the Board. The Board is chaired by the Trust Chairman, a Non-Executive Director.

The Board delegates authority to Board committees to discharge its duties effectively; these committees escalate items to the Board where Board decision-making and direction is required. The Board also delegates authority to the Executive to enable the organisation’s business to be delivered effectively.

The formal Trust Board meets in public bi-monthly. A private Board Development Session takes place bi-monthly, on alternate months to the formal Board. The Board Development Session provides dedicated time for the Board to focus in depth on matters relating to strategy and culture.

The Board is accountable to the Council of Governors, who attend Board meetings but in order to fulfil their role in holding the Board to account cannot be members of the Board. This is described in more detail below.

Quality and Safety Committee
The Quality and Safety Committee has delegated authority from the Trust Board to make the necessary decisions to enable the delivery of the Quality Strategy. This includes ensuring the Quality Strategy is delivered through the six Quality Pledges. The committee is also responsible for ensuring that the organisation is striving to provide high-quality care to individuals, communities and the population it serves. This includes consideration of events that impact on patient safety, and the learnings that can be drawn from these.

As part of this remit, the committee oversees the delivery of the Quality Improvement Plan and is responsible for ensuring a culture of continuous improvement is embedded throughout the organisation.

The committee will escalate items to the Board where Board decision-making and direction is required.

The Quality and Safety Committee meets on a monthly basis.

Organisational Development Committee
The Organisational Development Committee has delegated authority from the Trust Board to make the necessary decisions to oversee delivery and provide assurance on all aspects of Organisational Development. The committee will ensure delivery of the organisational development strategy through its eight objectives and that the CARE values are embedded across the organisation. It is also responsible for ensuring the organisation is compliant with statutory requirements.

The Organisational Development Committee will enable delivery of the Trust vision for high-quality patient care from a workforce and organisational development perspective. This will include ensuring that patients are treated, looked after and cared for by a skilled, informed,
engaged, motivated, trained, developed and recognised workforce. This workforce should also be committed to the Trust’s CARE values, strategy and objectives. The committee will oversee the development, implementation and review of plans within each Division that ensure workforce skills, numbers and deployment are safe, efficient and effective. Finally, the committee will aim to increase staff engagement through providing assurance that the workforce is led, managed and motivated in accordance with workforce management policies, processes and values that reflect best practice.

The committee will escalate items to the Board, where Board decision-making and direction is required.

The Organisational Development committee meets on a bi-monthly basis, in the same month as the Trust Board.

**Audit Committee**

The Audit Committee is an independent source of assurance to the Board on the effective stewardship of the organisation and, in turn, is empowered to seek assurance on the adequacy and effective operation of the organisation’s overall governance and internal control system. The Audit Committee is established in accordance with Standing Orders (and as set out in the Audit Code for NHS Foundation Trusts and the Code of Governance issued by NHSI).

The committee has oversight of the adequacy and effective operation of the organisation’s overall governance and internal control system. This includes risk management, and 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.

The committee has ownership of the Board Assurance Framework and will request for the other Board committees to review and make updates to their respective risks when required. The Audit Committee will report on the Board Assurance Framework to the Board.

In addition, the committee is responsible for carrying out reviews on the effectiveness of the other Board committees.

The Audit Committee meets on a quarterly basis, with more frequent meetings when required.

**Performance, Finance & Resources Committee**

The Performance, Finance and Resources Committee has delegated authority from the Board to make the necessary decisions to oversee the implementation of the long-term strategy through effective transformation. This should secure the financial sustainability of the organisation, whilst delivering resilient, high quality services for patients.

The committee should oversee, and provide assurance that, the transformation agenda is being successfully delivered. This should include assurance that the underlying plans to deliver transformation are robust and realistic. The committee will ensure that investments and capital expenditure support delivery of the overall strategy. It will also ensure that operational and financial performance is in line with agreed plans, driving service improvements, and achieving the financial objectives of the Trust.
The committee will escalate items to the Board, where Board decision-making and direction is required. The committee also has authority to report to regulators as required.

The Performance, Finance and Resources Committee meets on a monthly basis.

Nominations and Remuneration Committee
The Nominations and Remuneration Committee has delegated authority from the Trust Board to agree the remuneration arrangements for Executive Directors. The committee recommends to the Board of Directors the process for the selection, appointment, termination, compensation and benefits of Executive Directors. In common with the Audit Committee, a remuneration committee is a requirement of the NHSI Code of Governance.

In addition, it monitors and evaluates the performance of the Executive Directors subject to the advice of the Chief Executive. It may obtain legal, remuneration and other advice as and when required.

The Nominations and Remuneration Committee meets at least once per year, and more frequently when required.

Charitable Funds Committee
The Charitable Funds Committee has delegated authority from the Trust Board to manage the funds of the Charity in line with the overall objectives of the Charity. These funds should be used to help improve the lives of patients, their families, visitors and staff at KGH. The committee oversees activities in two main areas, fund-raising activities and investments. The committee also ensures that the financial arrangements of the charity are kept separate from those of the overall Trust.

The Committee will report to the Board of Directors via its minutes and will highlight key issues and risks in the accompanying verbal report from the Chair. The committee will escalate items to the Board, where Board decision-making and direction is required. The committee may seek professional advice (for example in relation to investments) where appropriate.

The Charitable Funds Committee meets at least four times per year.

Note: An annex to this paper sets out Non-executive Director alignment to committees of the Board

Executive Group Meeting
The Executive has delegated authority from the Trust Board to manage the day-to-day business of the organisation, where this does not fall within the remit of the other committees outlined above. In practice, this is defined by the portfolios of each of the Executives, which are defined and agreed through the Board and its committees.

The Executive Leadership Team provides assurance to the Board of Directors on all aspects of setting and delivering the Trusts strategy and key programmes of work. It oversees and monitors the financial performance of the Trust and ensures appropriate integration and liaison between individual clinical services, clinical and corporate functions and strategic and operational matters.
The Executive Group Meeting (EGM) is attended by the Executive Leadership Team and monitors and provides high level oversight of the financial and operational domains of the Trust. The EGM is the gateway for Board paper review and approval. In particular, it will review and sign off the executive summary of the Integrated Governance Report. This will be distributed to each Board committee to ensure consistency of information and basis of decision-making.

Note that on occasions where the schedule of meetings does not allow for this, the Informal Executive Meeting will provide this function. The EGM will also provide a central function in reviewing the Corporate Risk Register (CRR) and Board Assurance Framework (BAF) and highlighting where a specific risk requires review from a committee.

The EGM meets on a fortnightly basis.

**Council of Governors**
The Trust Board (otherwise the Board of Directors) is accountable to the Council of Governors. The Council of Governors monitors the overall performance of the Trust. In addition, the Council has a wider role to ensure that the local community members and staff have a greater say in how services are developed and delivered. All NHS Foundation Trusts have a Council of Governors as a condition of their licence.

Governors act in the best interests of the Trust and must adhere to its values and code of conduct. The role of the Council is strategic and advisory and not operational. Governors should acknowledge the overall responsibility of the Trust Board for the day-to-day management of the Trust.

The Council of Governors meets four times a year. The Governor Overview Group, which assists the Council to hold Non-Executive Directors to account for the financial standing and overall performance, meets eight times per year. The Lead Governors attends the Trust Board as a non-voting member and other Governors are welcome to observe Board meetings. In order to hold the Trust Board to account it is key for Governors not to be involved in Board decision making and only attend Board meetings or parts of Board meetings held in public. Furthermore, a nominated Governor is invited to attend Board committee meetings as an observer.

### 4.3 Interactions and links between the Board, its committees and Governors

**Board and committees**
The formal Trust Board must ensure it fulfils all three elements of its role (these elements are: formulate strategy, ensure accountability, and shape culture). In order to do this, as outlined in the previous section, the Board will delegate elements of its remit focused on delivery to the committees.

In doing this, the Board will:
- Set out clear accountability for delivery of specific work areas.
- Empower committees to take the necessary decisions to deliver the Board and Trust long-term strategy.
• Only require the escalation of items to the Board when Board direction and decision-making is required.

Each committee will be responsible for producing an annual report that outlines the business conducted during the relevant period. This will be provided to the Audit Committee (in the timeframe requested by the Audit Committee), who will in turn report in aggregate to the Board.

Between committees
The principal of delegation of authority to committees is that each will then have a unitary role. However, it is inevitable that there will be both information that is required for multiple committees (for example the Integrated Governance Report), and that there are some areas that will be within the remit of multiple committees.

To enable each committee to maintain a unitary role and undertake the work that forms part of the delegated authority, the following principles have been developed:

• The executive summary of the Integrated Governance Report, signed off by the EGM, will be used to share the strategic and operational context across committees. This will be combined with a detailed section prepared for each committee and will be the first substantial item on the agenda for each committee, ensuring a common view of core information as the basis for decision-making and oversight.
• EGM will review the BAF prior to committee meetings and will highlight where a specific risk requires review from a committee. Each Board committee will review and provide assurance on the specific risks relevant to that committee and provide updates on those risks to the Audit Committee. The Audit Committee has oversight of the BAF and provides assurance on the robustness of risk processes to the Board.
• The Chair and Executive lead of each committee will complete the final page of each section of the Integrated Governance Report which forms the committee report to Board, detailing major decisions made and escalations to Board. The Board Secretary will compile each of the completed four parts following committee meetings to finalise the full Integrated Governance Report for Board.
• Finally, by exception where required, committee chairs can call for a Committee in Common to discuss specific items of relevance to two or more groups.

These principles have been designed to ensure that the balance between minimising duplication and maintaining visibility of work across committees. Support will be made available to committees (as detailed in the relevant Terms of Reference included as an appendix to this paper) to enable commitments to be met.

Between Board, committees and Governors
The Council of Governors plays a crucial role in ensuring that the Board operates in an effective manner and, as described above, the Board is accountable to the Council of Governors. As the Council of Governors monitors performance of the Trust, a close degree of cooperation between the Council and the Board is required. In order for Governors to discharge their roles effectively they must also understand the how the Trust provides oversight and assurance of its performance.

To enable the Council of Governors to discharge its responsibilities. The following principles have been developed:
A nominated Governor is invited to attend each committee as an observer, as stated in the terms of reference (see appendix).

Two meetings per year will take place between the Governors and the Board (in addition to the formal Boards), allowing for semi-structured ‘away time’ to focus on strategic topics.

Governors Oversight Group will meet with Non-Executive Directors, as described above, in addition to these meetings.

These principles are designed to enable Governors to discharge their responsibilities, without being overly onerous. They also recognise the strategic and advisory roles that Governors hold and the more operational nature of the Board and its committees.

4.4 NHS Improvement regular meetings

NHS Improvement (NHSI) is the Trust’s regulator and issues the licence to provide services with associated conditions. NHS Improvement provides oversight on Trust performance (clinical, operational and financial). Performance is reported from the Board to NHS Improvement primarily via two means: the Progress Review Meeting (monthly), and the Quarterly Review Meeting (quarterly). Though these do not form a part of the Trust’s governance structure, they are statutory meetings and the Trust governance processes will produce the inputs into these meetings. A governance flow chart is shown in the diagram below:

**Progress Review Meeting**

The Progress Review Meeting (PRM) is held on a monthly basis and is based on an agenda developed by NHSI. It is attended by the Executive team and one Non-Executive Director. The meeting provides an update across three areas: quality, operations and finance. Performance data from the preceding month, that has been reviewed and signed off by the Board and its committees inform the meeting. By exception workforce items are also discussed. Actions are set and updated on a monthly basis.
NHSI may also request updates in other relevant areas that will enable them to maintain oversight of Trust performance. These items would be considered by EGM prior to presentation at the PRM.

**Quarterly Review Meeting**

The Quarterly Review Meeting (QRM) is held on a quarterly basis and is based around a standing agenda. This focuses on: quality, operations, finance and workforce. Where possible, the QRM seeks to use Board papers as an input to the meeting, which would pass through the governance processes described in this paper.

Where NHSI also requests updates to enable them to maintain oversight of Trust performance, in common with the PRM approach, these items would be considered by EGM prior to presentation at the QRM.
4.5 Schedule of meetings
The diagram below sets out the proposed schedule of meetings for the Board and its committees for any given financial year, as outlined in respective Terms of Reference (see appendix). The schedule maps to the business cycle, ensuring the Board and its committees are able to meet their regulatory commitments.
A detailed schedule for the Board and its committees from September 2018 to December 2019 is included below.

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Formal Board</th>
<th>Board Development Session</th>
<th>Executive Group Meeting</th>
<th>Organisational Development Committee</th>
<th>Quality &amp; Safety Committee</th>
<th>Performance, Finance &amp; Resources Committee</th>
<th>Audit Committee</th>
<th>Nominations &amp; Remuneration Committee</th>
<th>Charitable Funds Committee</th>
<th>Council of Governors</th>
<th>Joint Council &amp; Board Meeting</th>
<th>Annual Members Meeting</th>
<th>Governor Overview Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Start time</td>
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Note: The table includes the start times and dates for each meeting, including month and day. The meetings are scheduled from September 2018 to December 2019.
The below diagram sets out the detailed schedule for a given working month, working backwards from the last day where the Formal Board or Board Development session would be held.

<table>
<thead>
<tr>
<th>Working days countdown to the end of the month</th>
</tr>
</thead>
<tbody>
<tr>
<td>-21</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>Formal Board / Board Development Session</td>
</tr>
<tr>
<td>EGM</td>
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<tr>
<td>ODC</td>
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<tr>
<td>QSC</td>
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<tr>
<td>PFR</td>
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</tbody>
</table>

This confirms that all agendas will be finalised by the first working day of the month. All papers are then be distributed no later than five working days before respective meetings. However, exceptional data item(s) may be circulated up to three days before the meeting, with agreement from the relevant Chair. This also requires that a given committee’s meeting should take place a minimum of six working days before the Board. This will allow time for report(s) to be compiled ahead of Board paper distribution.
5 Process guidance and ways of working

Section synopsis

- To enable successful implementation of the changes described in the previous section a set of revised processes have been developed. These build on the current process that have enabled the governance arrangements, which have served the Trust well.
- These processes are the governance 'standard operating procedures' (SOP) for the Trust. This covers agenda setting, paper production, creating minutes and recording actions, reports from committees to the Board, the integrated governance report, annual reports, and sets out how arrangements will be reviewed.
- Templates to support the revised processes are included as an appendix to this paper.

5.1 Agendas

The revised Terms of Reference (ToR) for the Board and its committees (see appendix) clearly set out the purpose and ambition, authority and standing agenda themes for each meeting. These are specifically designed to ensure that, collectively, they allow the Board to discharge its responsibilities.

Agendas should be built from the standing agenda themes in respective meeting’s ToRs. Other items not in the standing agenda themes can be added to the agenda, but only where they support delivery of the purpose and ambition of the meeting set out in the ToRs. All meeting agendas should be tested to ensure that this principle is met. In doing so, meetings should be focused around the ToRs.

The standard agenda template (see appendix) should be used for the Board and its committees. The template purposefully includes a timings column. This is to ensure that appropriate focus is given to respective items on the agenda (this allows for more significant items to be assigned more time for discussion). It should be noted that a greater focus on strategic and forward-looking items was a key change across the majority of the committees as part of the last ToRs refresh. Again, this should be factored into the development of Board and committee agendas.

The Board Secretary shall be responsible for providing support to the respective Chair and Executive Director in creating agendas. All agendas should be finalised and distributed to members by the first working day of the month in which the meeting is taking place (as per the schedule in the previous section). Maintaining this discipline will ensure that high quality papers can be prepared for meetings and relevant governance and business processes are followed. The process for preparing papers is described below.

5.2 Preparing papers

Papers support the Board and its committees to effectively discharge their responsibilities. They also provide one part of the record of the discussions that happen at each meeting, and some are made available to the public. Given the importance of papers to the running of
each meeting, the process for preparing papers has been revised to provide greater standardisation whilst reducing the burden on the organisation.

All papers should include the cover page template (see appendix). At a glance the cover page will clearly convey what action the meeting is being asked to take, why the meeting is being asked to consider the item (i.e. how it relates to its purpose and ambition) and where the item has been previously considered. The cover page template should run to no more than two sheets of A4 paper in total.

Papers should be no longer than four pages of A4 in length, excluding cover page. This succinctness is important as it reduces the burden of developing papers, as well as ensuring that all attendees for a given meeting are able to read all papers in advance and adequately prepare. The exceptions to this rule are:

- where statutory documentation (for example the Trust’s annual report and accounts) is sent to the Board or a committee for sign off
- where a statutory item is necessarily produced in another format (for example the mortality dashboard) is sent to the Board or a committee for sign off.
- for committees only: where a longer report has been commissioned by the committee to make a delegated decision; this does not apply to the Board.

In these cases, a summary should also be produced for consideration.

Papers should all be prepared using the situation, background, assessment and recommendation (SBAR) communication tool. SBAR is an easy to use, structured form of communication that enables information to be transferred accurately between individuals. SBAR consists of standardised prompt questions in four sections to support staff in sharing concise and focused information. The standard paper template (see appendix) will support the preparation of papers using the SBAR approach. This should be used for the Board and its committees.

Where necessary appendices can be added to supplement the paper, but these should be tailored to contain the precise information that is required by the meeting in question. Where appendices are added, papers should still adhere to the principle of being no longer than four pages of A4 in total (excluding cover page).

The Board Secretary shall be responsible for providing support to the Chair (and Executive Director) in collating papers. All papers should be distributed to members a minimum of five working days in advance of meetings, unless otherwise agreed with the Chair (as per the schedule in the previous section). Where possible papers should be submitted to the relevant committee for consideration prior to being submitted to Board.

5.3 Minutes of meetings and records of actions

It is important that accurate and robust minutes and actions are recorded from each meeting. These not only guide the work programmes of the Board and its committees, they also provide an ‘audit trail’ of discussions and agreements. In common with the preparation of papers, the process for capturing minutes and actions from meetings has been revised to ensure greater consistency.
In order to ensure draft minutes can be completed in a timely manner, with minimal delay between meeting decisions and actions being undertaken, a minutes and actions template has been developed (see appendix). Specifically, the template is intended to support the Chair record key decisions from the meeting in real time. Using the template across the Board and its committees will ensure that a common approach minutes and actions is employed, increasing accessibility. This approach will balance accuracy with reducing the burden on the organisation.

The Board Secretary shall be responsible for providing support to the Chair (and Executive Director) in preparing draft minutes. Draft minutes should be distributed to members no later than five working days after meetings, ahead of formal sign off at the following meeting.

5.4 Integrated Governance Report

When any given item is considered by a committee, the broader context in which the organisation is operating must be considered. For example, when considering operational performance as part of Performance, Finance & Resources, it is necessary to consider the workforce challenges (as discussed in the Organisational Development Committee) and clinical challenges (as discussed in Quality & Safety Committee). The Integrated Governance Report contains a set of core operational information that supports informed decision-making at committee level, and that all are working from a common basis. A template has been produced for the Integrated Governance Report (see appendix), that builds on prior versions.

The report is formed of a narrative executive summary which sets out the strategic, operational, quality, financial and workforce context of the organisation, supported by high level metrics. Each narrative section will be prepared by the Director of Strategy, Chief Operating Officer, Director of Nursing and Quality, Director of Finance and the Director of Human Resources & Organisational Development respectively. In addition to each of the five updates, an overarching executive summary will be provided by the Chief Executive that describes the overall strategic and operational context for the organisation.

Each respective Executive lead will also prepare a more detailed section on operations, quality, finance and workforce. These will be formed of: a data driven dashboard; exception reporting; informal intelligence; and comparator benchmarking. These sections are aligned to the organisation’s four strategic objectives.

The executive summary and the detailed sections should be agreed at the Executive Group Meeting proceeding a cycle of committee meetings. Each committee will then review the executive summary and the detailed sections relevant to the respective committee (for example quality will be reviewed by the Quality and Safety committee) as the first substantial item on the agenda for each of the committees. Other information not directly relevant to the committee’s business will be available for reference, but will not be discussed.

The Head of Performance shall be responsible for providing support to the Chief Executive and respective Executive Directors to prepare their relevant sections, and the overall report. A template for the Integrated Governance Report has been included in the appendix.

During each of the committee meetings major decisions made and required escalations to Board will be documented to form the final page of each section of the Integrated Governance Report. It will be the responsibility of the Chair of each of the committees and
the Executive lead to complete this section. It is advised that the Chair and Executive lead hold a meeting to discuss and finalise this section immediately following the committee meeting. This section of the Integrated Governance Report forms the report from the committee to the Board.

Each of the completed sections will be combined by the Trust Board Secretary to form the full Integrated Governance Report to Board. Each committee should provide their updated sections of the Integrated Governance Report to the Board Secretary ahead of the formal Board meeting. These should be provided no later than five working days before the Board, allowing them to be included in formally distributed papers.

This Integrated Governance Report enables the broader context to be considered whenever a paper is presented to the Board or its committees. It will also support the identification of impacts in one area from underperformance or decisions in another. In addition, it will more rapidly allow cross cutting issues to be identified and resolved. As stated in the section above, the Integrated Governance Report is a tool that will be used to link the committees and the Board.

5.5 Annual reports and from committees
Following the conclusion of the annual business planning cycle, each committee and the Board are asked to confirm their purpose and ambition for the year and set out a clear work programme to support delivery. These should be ratified through the Board for committees, and through the Council of Governors for the Board\(^7\).

At the end of the financial year, each committee is required to produce a formal annual report that is submitted to the Audit Committee in the timeframe requested by the Audit Committee. The report should clearly set out achievements against the agreed purpose, ambition and work programme. Where a specific element has not been achieved, the underlying reasons should be recorded together with lessons learned and mitigating actions. A template for annual reports from committees has been included in the appendix. In common with other reports and papers, the annual report should be no longer than four pages of A4 in length; the annual report should be accompanied by a cover page as this will allow for the capturing of any financial or risk implications clearly.

The Audit Committee is then responsible for drawing themes from across the reports, embedding these into process for the following year. Individual annual reports from committees will support the construction of the Trusts overall annual report; this is also overseen by the Audit Committee.

5.6 Regularly reviewing and improving governance
Regular and ongoing reviews are critical to embedding continuous improvement in governance. This paper sets out a number of practical steps that allow the Trust to initially implement improvements agreed at its July 2018 Board.

\(^7\) Note: The Council of Governors has a strategic and advisory role; in practice this means that they will be able to provide comment on the Board work programme as opposed to formal ratification. This does not affect the Council’s ability to hold the Board to account for the performance of the Trust.
Following implementation Chairs are asked to formally seek feedback from members at the end of each meeting, either verbally or in writing. Iterative changes to meetings in response to the feedback will support and enable continuous improvement.

Wholesale changes should be reserved for more formal review. In the first instance it is planned that eight months after implementation a review of the effectiveness of the changes will be undertaken through the Audit Committee. Recommendations emanating from this review will be reported for consideration of the Board.

Thereafter, the formal annual report process will form the basis from which reviews and major changes to governance arrangements will be undertaken. As outlined in respective terms of reference, these will be updated annually as part of the process. There is not an expectation that ToRs will be subject to change; in practice this should be reserved for where there is a significant change in the operating environment of the organisation (for example regulatory action, or a major change in Government policy).
6 Appendix

6.1 Terms of Reference

6.1.1 Board

BOARD OF DIRECTORS

TERMS OF REFERENCE

1. PURPOSE

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

2. AUTHORITY

The powers of the Trust are to be exercisable by the Board of Directors on its behalf. Any of those powers may be delegated to a committee of Directors or to an Executive Director.

The Chairman of the Trust or, in his absence, the Vice Chairman is to preside at meetings of the Board of Directors and will have a casting vote.

The Board of Directors, in consultation with the Council, will adopt Standing Orders covering the proceedings and business of its meetings to include the values and standards of conduct for the Trust and staff in accordance with NHS values (Nolan Principles).

3. MEMBERSHIP AND ATTENDANCE

<table>
<thead>
<tr>
<th>Chair of Committee</th>
<th>A Non-Executive Chairman</th>
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<tbody>
<tr>
<td>Members</td>
<td>Minimum of 5 and maximum of 7 Non-Executive, with Non-Executive Directors always in the majority</td>
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<td>Minimum of 5 and maximum of 7 Executive Directors, to comprise of:</td>
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<td></td>
<td>Chief Executive (and accounting officer)</td>
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<td></td>
<td>Finance Director</td>
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<td>Medical Director a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984)</td>
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<td></td>
<td>Director of Nursing</td>
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<td></td>
<td>Chief Operating Officer</td>
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<td>Director of Human Resources &amp; Organisational Development</td>
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<td></td>
<td>Director of Integrated Governance</td>
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<tr>
<td>Attendees</td>
<td>Trust Board Secretary</td>
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<td></td>
<td>Lead Governor</td>
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</table>

3.1. All members participate in the full Board meeting. The Lead Governor attends part one of the formal Board meeting and other Governors are welcome to observe part one of the Trust Board meeting. Governors only attend meetings and parts of meetings that are held in public.

4. MEETINGS AND QUORUM

At least one third of the whole number of the Directors appointed, (including at least two non-executive Directors and two voting Executive Directors).
Meetings shall be held bi-monthly in public with alternative bi-monthly Board Development Sessions. Formal Board meetings are formed of two parts, part one is held in public and part two is used to discuss confidential business, for which the Board is asked to approve that representatives of the press and other members of the public are excluded from.

There will be an open meeting in September for members and the public when the Board of Directors will present the Annual Report and Accounts to the Council.

5. SUPPORT ARRANGEMENTS

5.1 The Trust Board Secretary shall be responsible for providing support to the Chairman and to the Board. Agendas for forthcoming meetings will be agreed with the Committee Chair and nominated Executive Director on the first working day of the month, and papers will be distributed to members one week in advance of the meeting. Papers will be approved at EGM prior to being distributed, or by exception papers may be taken to the Informal Executive Meeting if EGM is not held in the week prior to the Board.

6. DECLARATION OF INTERESTS

6.1 All members must declare any actual or potential conflicts of interest relevant to the work of the Board.

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

1 Define the direction of the Trust, setting policy and strategy regarding future development, having regard to the views of the Council.

2 Manage the day to day operation of the Trust, ensuring that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery and governance arrangements.

3 Monitor progress and achievements against regulatory requirements and approved plans and objectives, ensuring the effective management of the Trust by maintaining the appropriate balance of skills and experience.

4 Ensure compliance with the Trust's Terms of Authorisation and all obligations lawfully imposed upon the Trust by the Independent Regulator and any other statutory body or agency.

5 Ensure appropriate arrangements are in place to manage and support the Council and information needs are agreed.

6 Address workforce issues, workforce planning and people development.

7 Develop partnership working and patient and public involvement, clarifying how the public interests of patients and the local community will be represented, including the approach for addressing the overlap/interface between Governors and any local consultative forums in place.

8 Ensure exception reporting procedures are in place to ensure any risks that
could materially impact compliance are reported to Monitor and potential compliance failures are remedied.

9 Ensure submission of all mandatory returns, the Trust's annual report and accounts and forward plans, and appropriate action is taken on issues raised from assessments, in order to present a balanced and understandable assessment for all public statements and reports to regulators and inspectors, as well as information to be presented by statutory requirements.

10 Ensure the Trust's constitution is reviewed as necessary in line with Monitor guidance.

11 Ensure adequate systems and processes are maintained to measure and monitor the Board's own performance and that of its committees and planned and progressive refreshing of the Board of Directors.

12 Annual evaluation of individual directors to ensure contributions remain effective and commitment to the role is demonstrated.

13 Maintain formal and transparent arrangements for considering how financial reporting and internal control principles are applied and for maintaining an appropriate relationship with the Trust's auditors.

14 Maintain a sound system of internal control to safeguard public and private investment, the Trust's assets, patient safety and service quality and review at least annually.

15 Ensure the Trust's membership strategy is implemented in line with Monitor's requirements.

16 Ensure a public document is available setting out the policy to consult and involve members, patients and local community, ensuring satisfactory dialogue with members, patients and the local community takes place including description of the kind of issues on which they will be consulted.

17 Ensure co-operation with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy (maintaining a schedule of specific third-party bodies) and periodically review effectiveness of processes/relationships.

18 Ensure suitable delegation of powers and responsibilities to committees of the Board and the Trust Executive to enable the effective and efficient discharging of Board responsibilities. Delegation must pay regard to the duties outlined above.

8. STANDING AGENDA THEMES

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<tbody>
<tr>
<td>1</td>
<td>Trust Strategy</td>
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<td>2</td>
<td>Culture</td>
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<tr>
<td>3</td>
<td>Accountability (Including Board Assurance Framework and Corporate Risk Register)</td>
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<tr>
<td>4</td>
<td>Escalations and data from committees</td>
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9. REPORTING

9.1 Reports to the Board:
• Committee reports (from Quality and Safety, Performance, Finance and Resource, Organisational Development, Audit, Remuneration and Nominations)
• Board Assurance Framework (BAF)
• Corporate risk register
• Integrated Governance Report

10. PROCESS FOR MONITORING EFFECTIVENESS OF THE BOARD

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

10.2 The effectiveness of the Board will be reviewed as part of the wider review of the full Board governance process. This review will be carried out by the Audit Committee eight months following implementation of the new process.

10.3 Annually, the Trust must produce an Annual Report and Accounts. This includes an assessment of the effectiveness of the Board and information on compliance, with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings.

10.4 The Trust Board Secretary will assess agenda items to ensure they comply with the Board’s responsibilities. The secretary will monitor the frequency of the Board meetings and the attendance records to ensure attendance figures are complied with.

10.5 Terms of reference are to be reviewed at least annually.

11. REVIEW

11.1 Review date: July 2018
11.2 Next Review May 2019
6.1.2 Quality & Safety Committee

DRAFT QUALITY AND SAFETY COMMITTEE
TERMS OF REFERENCE

1. PURPOSE
1.1 The committee is responsible for overseeing the delivery of the Quality Strategy through:

- Ensuring the objectives underpinning the six Quality Pledges are delivered.
- Ensuring the organisation is striving to provide high quality care to individuals, communities and the population it serves.
- Overseeing the delivery of the Quality Improvement Plan and embedding a culture of continuous improvement.

2. AUTHORITY
2.1 The Quality and Safety Committee is empowered to make the necessary decisions to deliver the quality strategy across the organisation.

2.2 The Committee is charged with providing assurance to the Board and is authorised to investigate any activity within its Terms of Reference.

2.3 The Committee is required to escalate items to the Board, where Board direction and decision making is required.

3. MEMBERSHIP AND ATTENDANCE

<table>
<thead>
<tr>
<th>Chair of Committee</th>
<th>Chris Welsh</th>
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<tbody>
<tr>
<td>Members</td>
<td>Three Non-Executive Directors (including Chair)</td>
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<tr>
<td></td>
<td>Director of Integrated Governance</td>
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<td></td>
<td>Chief Executive</td>
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<td></td>
<td>Director of Nursing and Quality</td>
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<td></td>
<td>Medical Director</td>
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<td></td>
<td>Chief Operating Officer</td>
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<tr>
<td>Attendees</td>
<td>Chief of Divisions (3)</td>
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<td></td>
<td>Deputy Director of Nursing and Quality</td>
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<tr>
<td></td>
<td>Deputy Medical Director</td>
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<td>Deputy Director of Integrated Governance</td>
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<td>Deputy Chief Operating Officer</td>
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</table>
Notes on membership and attendance:

3.1 The committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate. The Chairman, Chief Executive or other executive director may be invited to attend any meeting of the Committee, particularly when the Committee is discussing areas of the Trust’s operation that are the responsibility of that director. The nominated Governor will attend the meeting as an observer.

4. MEETINGS AND QUORUM

4.1 The quorum shall be at least two Non-Executive Directors and one Executive Director.

4.2 Meetings of the committee will take place monthly, scheduled to support the business cycle of the Trust and the effectiveness of the Board.

5. SUPPORT ARRANGEMENTS

5.1 The Trust Board Secretary 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 nominated Executive Director and papers will be distributed to members one week in advance of the meeting, with exceptional data to be added at least 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, summarising 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 relevant to the work of the Committee, which shall be recorded in the Minutes accordingly.

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

7. DUTIES
7.1 To oversee the effectiveness of the clinical systems developed and implemented by the Quality Governance Steering Group to ensure they maintain compliance with the Care Quality Commission’ Fundamental Standards of quality & safety. This is carried out through:

- A high level overview through the Integrated Governance Report.
- A deep dive into one practice or service item from the Quality Strategy, Quality Improvement Plan or Integrated Governance Report (items to be discussed on a rolling basis).

7.2 To have oversight of the delivery of the Quality Improvement Plan, through:

- Oversight of the implementation of the plan
- Acting as a point of escalation for risks to delivery and supporting mitigations
- Ensuring the right resources are made available for successful delivery

7.3 To ensure that processes are in place to ensure the escalation of risks from local and clinical unit risk registers to the corporate risk registers and that required updates are made to the Board Assurance Framework (through the Audit Committee).

7.4 To support the development and implementation of the Trust’s Quality Strategy and Quality Pledges.

7.5 Oversee an effective system for safety within the Trust, with particular focus on; patient safety, including a consideration of the Quality Impact Assessment of Cost Improvement Programmes, staff safety and wider health & safety requirements.

7.6 Oversee an effective system for delivering a high-quality experience for all its patients and service users, including carers, with particular focus on involvement and engagement for the purposes of learning and making improvement.

8. STANDING AGENDA ITEMS

<table>
<thead>
<tr>
<th></th>
<th>Reduce avoidable harm and mortality</th>
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<tbody>
<tr>
<td></td>
<td>Integrated Governance Report</td>
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<tr>
<td>2.</td>
<td>Putting patients first</td>
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<td></td>
<td>Quality Strategy</td>
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<td>3.</td>
<td>Develop culture of continuous improvement and safety</td>
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<td></td>
<td>Quality Improvement Plan</td>
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<td>4.</td>
<td>Deep dive into challenges from items 2 or 3</td>
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<td>5.</td>
<td>Risk &amp; Board Assurance Framework</td>
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<td>6.</td>
<td>Routine reporting</td>
</tr>
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</table>

9. REPORTING
9.1 To Board:

The committee is directly accountable to the Board of Directors. The Chair of the Committee shall prepare a summary report to the Board detailing:

- Decisions taken.
- Items that require Board assurance.
- Items that need to be escalated to the Board for direction or decision making.

9.2 To Audit Committee:

The Chairman will report any specific issues on the risk register to the Audit Committee.

9.3 Reports to the Quality and Safety Committee:

- Integrated Governance Report
- QIP report

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 during the period of Board governance review.

10.2 The effectiveness of the committee will be reviewed as part of the wider review of the full Board governance process. This review will be carried out by the Audit Committee 8 months following implementation of the new process.

10.3 The Committee will produce an annual report on the actions taken by the Committee to comply with its Terms of Reference. The annual report will include information about compliance with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings. The annual report will also include information about the reporting arrangements into the Committee from any other Committee or Sub-committee. The secretary will assess agenda items to ensure they comply with the Committee’s responsibilities. The secretary will monitor the frequency of the Committee meetings and the attendance records to ensure attendance figures are complied with. Terms of reference to be reviewed at least annually.

Review date: August 2018
Next Review May 2019
DRAFT ORGANISATIONAL DEVELOPMENT COMMITTEE
TERMS OF REFERENCE

1. PURPOSE AND AMBITION

1.1 Purpose:
The committee is responsible for delivering and providing assurance on all aspects of Organisational Development through:
- Delivery of the organisational development strategy through its eight objectives
- Ensuring the organisation is compliant with statutory requirements
- Embedding the CARE values across the organisation
The committee duly escalate items to the Board, seeking their direction and decision making as required.

1.2 Ambition:
Patients receive high quality care in line with the Trust vision because:
They are treated, looked after and cared for by a skilled, informed, engaged, motivated, trained, developed and recognised workforce, committed to the Trust’s CARE values, strategy and objectives.
Plans are developed, implemented and continuously reviewed within each Division – owned by the Division – that ensure workforce skills, numbers and deployment are safe, efficient and effective.
Staff are more engaged because:
The workforce is led, managed and motivated in accordance with workforce management policies, processes and values that reflect best practise.

2. AUTHORITY

2.1 The Organisational Development Committee is empowered to make the necessary decisions to oversee the delivery of the Organisational Development strategy across the Trust. The committee is charged with providing assurance to the Board and is authorised to investigate any activity within its Terms of Reference. The committee is required to escalate items to the Board, where Board direction and decision making is required. The committee has authority to review information and report to regulators as required.

2.2 A key relationship for this group will be to the Local Workforce Advisory Board (LWAB) members of the committee are represented on the LWAB and therefore communication should be maintained through this route.

2.3 The committee will be accountable for the Diversity and Inclusion Steering Group.
3. MEMBERSHIP AND ATTENDANCE

<table>
<thead>
<tr>
<th>Chair of Committee</th>
<th>Janet Gray</th>
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<tbody>
<tr>
<td><strong>Members</strong></td>
<td></td>
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<tr>
<td>Three Non-Executive Directors (one is the Chair of the committee)</td>
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<tr>
<td>Director of Human Resources &amp; Organisational Development</td>
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<tr>
<td>Director of Nursing &amp; Quality</td>
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<tr>
<td>Chief Operating Officer</td>
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<td><strong>Attendees</strong></td>
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<tr>
<td>Director of Medical Education</td>
<td></td>
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<tr>
<td>Deputy Director of Human Resources &amp; Organisational Development</td>
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<tr>
<td>Deputy Director of Nursing &amp; Quality</td>
<td></td>
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<tr>
<td>Deputy Medical Director</td>
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<tr>
<td>Deputy Chief Operating Officer</td>
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<tr>
<td>Head of Financial Management or Finance Business Partner</td>
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<tr>
<td>Head of Learning &amp; Education</td>
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<tr>
<td>Trade Union representation</td>
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<tr>
<td>Nominated Governor</td>
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<tr>
<td>Others by invitation to discuss pertinent issues/topics</td>
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</table>

Notes on membership and attendance:

3.1 The committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate. The Chairman, Chief Executive or other executive director may be invited to attend any meeting of the Committee, particularly when the Committee is discussing areas of the Trust’s operation that are the responsibility of that director. The nominated Governor will attend the meeting as an observer.

4. MEETINGS AND QUORUM

4.1 A quorum of the Group shall be two Non-Executive Directors one of whom will Chair the meeting, the Director of Human Resources & Organisational Development*, Director of Nursing & Quality*, Chief Operating Officer* and Deputy Medical Director* Posts marked with * can send their deputy however a minimum of two Executive Directors must be in attendance. Any attendees must be at a suitably senior level and briefed sufficiently to enable them to make decisions and participate in discussions. On a request basis, the committee will invite other senior staff to attend the meeting to provide a learning opportunity.

4.2 Meetings shall be held on a bi-monthly basis.
5. SUPPORT ARRANGEMENTS

5.1 The Trust Board Secretary 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 nominated Executive Director and papers will be distributed to members one week in advance of the meeting, with exceptional data to be added at least 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, summarising 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 relevant to the work of the Committee, which shall be recorded in the Minutes accordingly.

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

7. DUTIES

7.1 To be assured that various strategies, including the Organisational Development Strategy, Organisational Development Plan and Leadership and Development Plan are fit for purpose and are being effectively implemented and reviewed.

7.2 Delivering an organisational development plan that aligns with the Trust’s Strategy and the Northamptonshire Health and Social Care Board.

7.3 Monitor the organisational development plan and organisational development strategy implementation and progress in realising the plans, especially the reductions in the direct cost to the Trust of temporary (agency) staff.

7.4 To agree and support the organisational development planning and organisational development processes each year, working towards this being a continuous process over the year.

7.5 Discuss and review potential solutions to workforce demand – such as new roles, new ways of working, redefining roles, 7 day working.

7.6 To understand the workforce requirements in delivering against both local and national priorities in the context of supply and wider demographics and be assured that appropriate structures, processes and education is in place so we have the right staff, with the right skills in the right place and reviewed.

7.7 Be assured that the people management processes are in place and are being followed.
7.8 To be assured that there are mechanisms in place to deliver effective staff engagement and to regularly review staff feedback, including through, but not limited to, the annual staff survey.

7.9 To structure the Committee agenda to ensure that the Trust CARE values are incorporated into the business of the committee ensuring a workforce is in place in order to be assured the Trust is well led.

7.10 Risk assess the organisational development interventions to direct the Committee’s activities and feed into the Corporate Risk Register – reviewing Trust objectives. Provide any required updates to the Board Assurance Framework, relevant to the work of the committee, to the Audit Committee.

8. STANDING AGENDA THEMES

| 1. | Accountability | Integrated Governance Report |
| 2. | Compassionate | Organisational Development Strategy Implementation |
| 3 | Engaging | Embedding CARE Values |
| 4 | Respectful | Workforce Compliance & Operational Performance (including: MAST, pre-employment checks, revalidation, pay reports) |
| 5 | (Every other meeting) | Risk and Board Assurance Framework |

9. REPORTING

Reports to Board:

9.1 The Organisational Development Committee will formally report on a bi-monthly basis to the Board of Directors with a summary report and minutes.

9.2 Organisational Development Strategy, including staff survey results (every other Board).

Reports to Organisational Development Committee:

9.3 The committee will receive reports at each meeting on the progress for delivering the Trust organisational development plans and other agreed actions, by exception. There will also be a regular update from the Learning & Education Group and a quarterly progress report in relation to Diversity and Inclusion within the Trust.

9.4 To receive reports from the Learning & Education Group and ensure their work plan aligns with, and is integrated with, the wider Organisational Development Strategy.
9.6 The Staff Health & Wellbeing Group will also formally report to the Organisational Development Committee on a quarterly basis for assurance purposes, however for operational decisions, the Group would escalate to the Operational Management Committee.

10. PROCESS FOR MONITORING EFFECTIVENESS OF THE COMMITTEE

10.1 The Chair of the committee will seek feedback from all attendees on the effectiveness of committee meetings following each meeting during the period of Board governance review.

10.2 The effectiveness of the committee will be reviewed as part of the wider review of the full Board governance process. This review will be carried out by the Audit Committee 8 months following implementation of the new process.

10.3 To produce an annual report each year, following the organisational development planning cycle, to give assurance to the Audit Committee that a workforce plan is in place that is aligned with, and support, delivery of the Trust’s Strategy.

11. REVIEW

Review date: August 2018
Next Review May 2019
6.1.4 Audit Committee

DRAFT 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 NHSi), a Non-Executive Director Audit Committee has to 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.

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

2.2 The committee has authority to investigate any activity within its duty and has complete freedom of access to the Trust's records, documentation and employees (this authority does not extend to confidential patient information).

2.3 It may seek information or explanation it requires from the 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.

3. MEMBERSHIP AND ATTENDANCE

<table>
<thead>
<tr>
<th>Chair of Committee</th>
<th>Trevor Shipman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members</td>
<td>Three Non-Executive Directors</td>
</tr>
<tr>
<td>Attendees</td>
<td></td>
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<tr>
<td>-----------------------------------------------</td>
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<tr>
<td>Representative of the Trust’s Internal Auditors</td>
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<tr>
<td>Representative of Local Counter Fraud Service</td>
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<tr>
<td>Representative of External Auditors</td>
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<tr>
<td>Chairman of the Trust</td>
<td></td>
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<tr>
<td>Director of Finance or representative</td>
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<tr>
<td>Director of Integrated Governance</td>
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<tr>
<td>Nominated Governor</td>
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<tr>
<td>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</td>
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</tbody>
</table>

Notes on membership and attendance:

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 be the Chair of the Quality and Safety Committee. One of the Non-Executive Directors shall chair the Committee.

3.2 A nominated Governor is invited to attend each meeting. The Chair of the Council of Governors must be present when the Audit Committee signs off accounts.

3.3 A quorum of the Committee shall be two members.

4. MEETINGS AND QUORUM

4.1 Meetings of the Committee shall be chaired by one of the Non-Executive Director members, with the other acting as deputy in his 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.

4.3 Excepting for reasons of sickness, or unavoidable leave it is an expectation that committee members will attend meetings. Annual Leave should, where possible, be planned around meetings. Deputies are not accepted.

4.4 To be quorate, for the purposes of decision making, one non-executive and one executive member are required to be present. 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.

5. SUPPORT ARRANGEMENTS

5.1 The Trust Board Secretary 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 nominated Executive Director and papers will be distributed to members one week in advance of the meeting, with exceptional data to be added at least 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, summarising 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 relevant to the work of the Committee, which shall be recorded in the Minutes accordingly.

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

7. DUTIES

The duties and responsibilities of the Committee are as follows:

7.1 Internal Audit

7.1.1 It is the responsibility of the Director of Finance 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 and 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.

7.3 Local Counter Fraud Service

7.3.1 To receive reports from counter fraud, specifically open fraud case reporting and fraud prevention activities.

7.4 Governance and Assurance

7.4.1 The Audit Committee has responsibility for overseeing the Trust’s governance and assurance process and for reviewing, prior to submission to the Board, the Annual Accounts and the Annual Governance Statement.

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

(f) Schedules of losses and compensations

(g) Schedules of debtors/creditors balances over 3 months and £5,000 and explanations/ action plans

(h) Schedules of waivers of purchasing authorities approved each quarter

(i) Schedules of maverick transactions made 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.

(k) The Board’s self-certification process in relation to the Annual Plan before its submission to NHSi to ensure the Board is assured that systems and processes are in place to deliver the Annual Plan and to review the self-assessment on a six-monthly basis.

7.4.3 The Committee will review the annual reports to the Board of Directors from the Quality and Safety, Performance, Finance and Resources, Nominations and Remuneration, Organisational Development and Charitable Funds Committees.

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 next full 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 governance.

7.5 Board Assurance Framework

7.5.1 The Audit Committee holds the ownership of the Board Assurance Framework and the other Board committees will report updates related to their committees to the Audit Committee.

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.
  ▪ Review the annual financial statements for both the Trust’s Final Accounts and the Charitable Funds, before submission to the Board of Directors for approval.
  ▪ Review and approve the Trust accounting policies each year.

7.7 Key Trust Documents

7.7.1 Review any proposed changes to Standing Orders and Standing Financial Instructions for approval by the Board.

8. STANDING AGENDA ITEMS

1. Integrated Governance Report
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 Chairman, as applicable.

9.3 The Committee will submit the Board Assurance Framework to the Board on a bi-monthly basis.

9.4 An annual report of the activities of the Committee shall be presented to the Board of Directors.

Reporting to Audit Committee:

9.5 Updated Board Assurance Framework from other Board Committees.

9.6 Corporate Risk Register.

9.7 Annual Financial Statements.

9.8 Annual Governance Framework.

9.9 Annual Reports from the other Board Committees.

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 during the period of Board governance review.

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

10.3 The Committee will review its terms of reference annually.
10.4 The Committee shall carry out an annual self-assessment in relation to its own performance.

11. REVIEW
Review date: August 2018
Next Review May 2019
PERFORMANCE, FINANCE & RESOURCES COMMITTEE
TERMS OF REFERENCE

1. PURPOSE AND AMBITION

1.1 The Performance, Finance & Resources Committee is responsible for overseeing and providing assurance that:

- The Trust’s transformation agenda is being successfully delivered.
- Investments and capital expenditure are supporting delivery of the overall strategy.
- Operational and financial performance is: in line with agreed plans; driving service improvements; and achieving the financial objectives of the Trust.

1.2 The ambition is to deliver the trusts long term strategy, through effective clinically led transformation that secures the financial sustainability of the organisation, whilst delivering resilient, high quality services for patients.

2. AUTHORITY

2.1 The Performance, Finance and Resources Committee is empowered to make the necessary decisions to oversee the implementation of transformation across the trust, in line with the long term strategy. Agreed authority limits for the Committee are in the standing financial instructions for the Trust. Where these are breached the committee must make a recommendation to the Board, who have the authority to make decisions at any level.

2.2 The work of the committee will also cover all aspects of financial performance, operational performance and efficient use of resources against strategic and operational (in year) plans. The committee has authority to report to regulators as required.

2.3 The committee is required to escalate any item to the Board, where Board direction or decision making is required.

2.4 The Performance, Finance & Resources Committee in its workings will be required to adhere to the Constitution of Kettering General Hospital NHS Foundation Trust, the Provider License Conditions and Code of Governance issued by the Independent Regulator for NHS Foundation Trusts.

2.5 The Committee is authorised to obtain independent professional advice as it considers necessary in accordance with these Terms of Reference.

2.6 The committee is charged with providing assurance to the Board and is authorised to investigate any activity within its Terms of Reference, providing scrutiny and challenge where required.
3. **MEMBERSHIP**

<table>
<thead>
<tr>
<th>Chair of Committee</th>
<th>Phil Harris-Bridge</th>
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<tbody>
<tr>
<td><strong>Members</strong></td>
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<tr>
<td>Two Non-Executive Directors (one is the Chair of the committee)</td>
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<tr>
<td>Chief Operating Officer</td>
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<td>Chief Information Officer <em>when appointed</em></td>
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<td>Director of Finance</td>
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<td><strong>Attendees</strong></td>
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<td>Director of Estates <em>when Estates is a formal agenda item</em></td>
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<tr>
<td>Director of IT <em>when IT is a formal agenda item</em></td>
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<tr>
<td>Deputy Chief Operating Officer</td>
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<td>Deputy Director of Finance</td>
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<td>Director of Strategy</td>
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<td>Heads of Divisions (one per division)</td>
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<td>Nominated Governor</td>
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3.1 The Committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate. The Chairman, Chief Executive or other Executive Director may be invited to attend any meeting of the Committee, particularly when the Committee is discussing areas of the Trust’s operation that are the responsibility of that director. The nominated Governor will attend the meeting as an observer.

4. **MEETINGS AND QUORUM**

4.1 Meetings of the Committee shall be chaired by one of the Non-Executive Director members, with the other 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 monthly basis. Responsibility for calling meetings of the Committee shall rest with the Committee Chair. The meetings will not take more than 2 hours and will dedicate equal focus to strategy, culture and ensuring accountability.

4.3 Excepting for reasons of sickness, or unavoidable leave it is an expectation that committee members will attend meetings. Annual Leave should, where possible, be planned around meetings. Deputies are not accepted.
4.4 To be quorate, for the purposes of decision making, one non-executive and one executive member are required to be present. 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.

5 SUPPORT ARRANGEMENTS

5.1 The Trust Board Secretary 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 nominated Executive Director and papers will be distributed to members one week in advance of the meeting, with exceptional data to be added at least 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, summarising 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 relevant to the work of the Committee, which shall be recorded in the Minutes accordingly.

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

7. DUTIES

7.1 TRANSFORMATION

- To oversee the implementation of transformation across the Trust, enabling delivery of its long term strategy.
- To oversee the implementation of national transformation plans within divisions, including GIRFT, Model Hospital, and Carter.
- To monitor strategic priorities including review of Assurance Framework, as appropriate regarding the risks aligned to the Committee.

7.2 INVESTMENTS & CAPITAL

- To oversee investment and capital expenditure across the trust, supporting delivery of transformation to deliver the long term strategy.
• To make new decisions on investments and capital when within the authority of the committee. To make recommendations for Board decisions when outside of the authority of the committee.
• To monitor the performance of the investment of cash or capital expenditure by scheme against plan. To take decisions to support recovery where underperformance is experienced.

7.3 BOARD ASSURANCE FRAMEWORK (BAF) & STRATEGIC RISKS
• To review the status of the top-level strategic risks owned by the Committee by reviewing the actions being taken to mitigate risks.
• To ensure that the gaps in control and gaps in assurance for strategic risks are reported appropriately to the Committee by the Lead Executive.
• To ensure the Executive highlight any urgent red rated operational risks to the Committee.

7.4 BUSINESS PLANNING AND MONITORING
• The committee will be responsible for signing off the Trusts annual plan, ensuring that it supports delivery of the long term strategy (covering transformation, performance and finance). This will be ratified with the Board of Directors prior to submission to NHS Improvement.
• To oversee implementation of the annual plan, monitoring and reviewing progress against plan, taking decisions to recover areas of underperformance, providing assurance to the Board and escalating as required.
• Undertake such reviews as the Board of Directors may require to give it assurance on any particular matter relating to operational, resources and financial performance.
• To implement, monitor and review the Committee work programme in line with the priorities within the annual plan and the Trust’s Board Assurance Framework.

7.5 PERFORMANCE (in addition to business planning and monitoring)
• To seek assurance that performance management principles and processes are embedded throughout the Trust in order to drive improvement in service delivery.
• To annually review the Trust Performance Management Strategy.
• To ensure that the Board of Directors is fully briefed on emerging performance management requirements, taking into account local and national policy.

7.6 FINANCE (in addition to business planning and monitoring)
• The Committee will review the basis for the reforecasts to ensure that quarterly monitoring submitted to NHS Improvement is in line with the updated plan.
• The Committee shall carry out a high-level review of the content and presentation of financial reports, as appropriate to its needs.
• The Committee shall periodically review the long-term cash flow projection for the Trust and report as appropriate to the Board of Directors.
7.7 RESOURCES

Estates

- To receive recommendations regarding capital spend from the Capital Investment Group, via the Operational Management Group.
- To receive the annual capital plan for onward submission for approval by the Board of Directors.
- To receive reporting on large capital projects (>£500k) progress against planned timescales.
- Consider capital scheme benefits realisation reports for schemes above £500k in value.

Information & Communications Technology

- To monitor the implementation of the IT/Systems Strategy
- Review project plans and monitor implementation of major ICT and Information/Reporting Projects.
- Monitor the delivery of benefits from ICT and Information/Reporting implementations.

8. STANDING AGENDA THEMES

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<table>
<thead>
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<tbody>
<tr>
<td>1.</td>
<td>Integrated Governance Report</td>
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<tr>
<td>2.</td>
<td>Transformation</td>
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<tr>
<td>3.</td>
<td>Investments and Capital</td>
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<td>4.</td>
<td>Risks and BAF</td>
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<tr>
<td>5.</td>
<td>Operational Performance and Finance</td>
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<tr>
<td>6.</td>
<td>Estates and IT (every other meeting – each to be discussed once per quarter)</td>
</tr>
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9. REPORTING

Reporting to Board:

9.1 The Performance, Finance & Resources Committee shall formally report to the Board of Directors on a monthly basis providing a summary performance report, detailing exceptions from expected performance.

Reporting to Audit Committee:

9.2 The Committee shall provide an annual report to the Audit Committee by 31 May each year, summarising the work as key issues covered by the Committee to gain assurance on the adequacy of the financial planning, physical resource and infrastructure put in place by the Trust to meet the objectives of the annual plan.
Reporting to Performance, Resources and Finance Committee:

9.3 The committee shall receive an Integrated Governance Report from the Executive Group Meeting.

9.4 The Committee shall receive reports from the relevant Executive Director in accordance with the annual work programme.

10. PROCESS FOR MONITORING EFFECTIVENESS OF THE COMMITTEE

10.1 The Chair of the committee will seek feedback from all attendees on the effectiveness of committee meetings following each meeting during the period of Board governance review.

10.2 The effectiveness of the committee will be reviewed as part of the wider review of the full Board governance process. This review will be carried out by the Audit Committee 8 months following implementation of the new process.

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

11. REVIEW

Review date: August 2018
Next Review May 2019
6.1.6 Nominations and Remuneration Committee

NOMINATIONS AND REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

1.1 The Committee’s role is to recommend to the Board of Directors the process for the selection, appointment, termination, compensation and benefits of Executive Directors.

1.2 The Committee will monitor and evaluate the performance of the Executive Directors subject to the advice of the Chief Executive.

2. AUTHORITY

2.1 The Board of Directors delegates authority to the Committee to agree the remuneration arrangements for Executive Directors. The remuneration for Non-Executive Directors is determined by the Council of Governors via its Appointments and Remuneration sub Group.

2.2 The Committee may obtain legal, remuneration and other advice as and when required and may appoint and secure the attendance of at meetings external remuneration and other consultants and advisers as it deems appropriate.

3. MEMBERSHIP AND ATTENDANCE

<table>
<thead>
<tr>
<th>Chair of Committee</th>
<th>Alan Burns</th>
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</thead>
<tbody>
<tr>
<td>Members</td>
<td>All Non-Executive Directors</td>
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<tr>
<td></td>
<td>Three other Board members (Non-Executive Directors)</td>
</tr>
<tr>
<td>Attendees</td>
<td>Chief Executive</td>
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</table>

Director of Human Resources and Organisational Development will attend the Committee as required to provide advice on matters related to its role including benchmarking data, reward practice, external regulation impacting on appointment, compensation, benefit and termination.

Trust Board Secretary, as required.

3.1 The Chief Executive and Director of Human Resources and Organisational Development shall be excluded from discussions related to their own remuneration.
4. **MEETINGS AND QUORUM**

4.1 There will be a minimum of 1 meeting held each year.

4.2 A quorum of the Committee shall be 3 members including the Chair.

4.3 Meetings may be convened more frequently when vacancies arise or at the discretion of the Chair.

5. **SUPPORT ARRANGEMENTS**

5.1 The Trust Board Secretary 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 nominated Executive Director and papers will be distributed to members one week in advance of the meeting.

6. **DECLARATION OF INTERESTS**

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

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

7. **DUTIES AND RESPONSIBILITIES**

The duties and responsibilities of the Committee are as follows:

7.1 **Conditions of Service**

7.1.1 The Committee has responsibility for the review and approval of additional non pay benefits, contracts of employment and severance packages.

7.1.2 The Committee shall receive reports from the Chief Executive with regard to the performance of Executive Directors.

7.1.3 The Committee will receive reports relating to national and local market factors including benchmarking of pay and may request reports relating to senior management posts to ensure the consistent application of the Trust’s equality obligations.

7.2 **Appointments**

7.2.1 The Committee will advise the Council of Governors Appointments and Remuneration Committee on the appropriate composition of the Board of Directors as vacancies arise.
7.2.2 The Committee will make recommendations to the Council of Governors Appointments and Remuneration Committee concerning the appointment of the Chief Executive.

8. REPORTING

8.1 The Committee will ensure that the Trust’s Annual Report and Accounts include a report on the remuneration arrangements for Executive Directors.

8.2 An annual report on the activities of the Committee shall be presented to the Audit Committee.

9. REVIEW

Review date: August 2018
Next Review May 2019
6.1.7 Charitable Funds Committee

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

The overall objective of the Charity is;

“to apply the income and at their discretion as far as may be permissible, the capital, for any charitable purpose or purposes relating to the National Health Service and mainly for services provided by Kettering General Hospital NHS (Foundation) Trust”

(Source, Charitable deed KGH NHST GCF)

Our public facing website states that:

“The KGH Charity Fund has been set up to help improve the lives of patients, their families, visitors and staff at the Kettering General Hospital. By raising funds we aim to enhance and improve patient care and facilities and go the extra mile for local health care.”

2. AUTHORITY

2.1 The Charitable Funds Committee is accountable to the Board of Directors from whom it receives delegated authority.

2.2 The Committee will report to the Board of Directors via its minutes and will highlight key issues and risks in the accompanying verbal report from the Chair.

2.3 The Exec and Non Exec directors of the Trust (The Board of Directors) are held to be trustees of all charitable funds held in KGH Charitable Trust name and are responsible for financial probity of the funds.

2.4 The Charitable Funds Committee (the Committee) will ensure that spending of charitable funds within its portfolio of responsibility are utilised in accordance with its terms of delegated authority as approved by the Board of Directors.

3. MEMBERSHIP AND ATTENDANCE

<table>
<thead>
<tr>
<th>Chair of Committee</th>
<th>TBD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members</td>
<td>Three Non-Executive Directors (one is the Chair of the committee)</td>
</tr>
<tr>
<td></td>
<td>Three other Board members (Executive or Non-Executive Directors)</td>
</tr>
</tbody>
</table>
### Attendees

| Head of Financial Services, Head of Communications, Fundraising Manager, Patient Experience Manager and up to four Fund Managers (These officers of the Trust do not have voting rights but are expected to provide advice to the Committee as appropriate). |
| Nominated Governor |
| Trust Board Secretary, as required. |

Notes on membership and attendance:

3.1 The committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate. The Chairman, Chief Executive or other executive director may be invited to attend any meeting of the Committee, particularly when the Committee is discussing areas of the Trust’s operation that are the responsibility of that director. The nominated Governor will attend the meeting as an observer.

4. **MEETINGS AND QUORUM**

4.1 A quorum of the Committee shall be three members.

4.2 There will be a minimum of four meetings held each year.

4.2 The Board of Directors or the Chairman of the Committee may convene special meetings.

5. **SUPPORT ARRANGEMENTS**

5.1 The Trust Board Secretary 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 nominated Executive Director and papers will be distributed to members one week in advance of the meeting. Meeting papers will also be available to other members of the Board for information.

6. **DECLARATION OF INTERESTS**

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

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

The Trustees have responsibility to manage the funds in line with the overall objective of the Charity and so that these are used to **help improve the lives of patients, their families, visitors and staff at the Kettering General Hospital**.

The duties and responsibilities of the Committee are therefore as follows:

7.1 GOVERNANCE AND ASSURANCE

- To apply the charitable funds in accordance with the budget, priorities and spending criteria determined by the Trust as trustee and in accordance with the relevant legislation.

- To actively encourage the spending of Charitable Funds for their intended purpose and to ensure that funds are not carried forward from year to year without good reason (i.e. a specific and agreed item of equipment/capital scheme)

- To ensure that the Trust policies and procedures for charitable funds investments are followed and including annual review of the Trust’s Investment and Reserves Policy.

- To ensure compliance with the Charities Act 2011 and investments comply with the Trustee Act 2000

- To monitor the Trust’s Scheme of Delegation.

- To receive at least bi-annually reports from the Director of Finance related to their delegated authority to administer and manage the charitable funds on behalf of the Committee.

7.2 FUND RAISING ACTIVITY

- To monitor the progress of any major fundraising appeals and activities to support the charity.

- To provide guidelines in respect of donations, legacies and bequests.

7.3 INVESTMENTS

- To be responsible for the day-to-day management of the investments of the charitable funds in accordance with the investment strategy set down from time to time by the trustee.

- To obtain appropriate professional advice to support its investment activities.

- To appoint an investment manager (if agreed as required by the Committee) to advise it on investment matters and may delegate day-to-day management of some or all of the investments to that investment manager.
To ensure that the amount to be invested or redeemed from the sale of investment shall have regard to the requirements for immediate and future expenditure commitments.

To establish and maintain an approved list of counter parties for investment activities.

To operate an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose, to the Board of Directors, the basis for applying accrued income to individual funds in line with charity law and Charity Commissioner guidance.

To regularly review investments to see if other opportunities or investment managers offer a better return.

7.4 GENERAL

To ensure that the banking arrangements for the charitable funds are kept entirely distinct from the Trust’s NHS other funds.

To ensure that separate current and deposit accounts should be minimised consistent with meeting expenditure obligations.

8. STANDING AGENDA

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Fundraising Activities/Income received over the previous quarter</td>
</tr>
<tr>
<td>2</td>
<td>Financial report – balances held by the Charitable Fund</td>
</tr>
<tr>
<td>3</td>
<td>Request for expenditure</td>
</tr>
</tbody>
</table>

9. REPORTING

9.1 To provide an annual report to the Audit Committee by the end of each financial year of the work and key issues covered by the Committee.

9.2 The Committee is responsible for the urgent escalation of any identified issues to the Board of Directors, via the Chairman, as applicable.

9.3 The Committee will review and approve the Charitable Fund Annual Report and Accounts.

10. PROCESS FOR MONITORING EFFECTIVENESS OF THE COMMITTEE

10.1 The Chair of the committee will seek feedback from all attendees on the effectiveness of committee meetings following each meeting during the period of Board governance review.
10.2 The effectiveness of the committee will be reviewed as part of the wider review of the full Board governance process. This review will be carried out by the Audit Committee eight months following implementation of the new process.

11. REVIEW
Review date: August 2018
Next Review May 2019
EXECUTIVE GROUP MEETING
TERMS OF REFERENCE

1. PURPOSE
1.1 The Executive Group Meeting provides the Board with assurance concerning all aspects of setting and delivering the strategic direction of the Trust and its associated clinical strategies. It monitors and has high level oversight of the financial and operational domains of the Trust. The group is the gateway to the Board.

2. AUTHORITY
2.1 The Executive Leadership Team through the Chief Executive provides assurance to the Board of Directors with assurance concerning all aspects of setting and delivering the Trust’s strategy and key programmes of work.

3. MEMBERSHIP AND ATTENDANCE

<table>
<thead>
<tr>
<th>Chair of Committee</th>
<th>Chief Executive</th>
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</thead>
<tbody>
<tr>
<td>Members</td>
<td></td>
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<tr>
<td></td>
<td>Chief Operating Officer</td>
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<tr>
<td></td>
<td>Director of Finance</td>
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<tr>
<td></td>
<td>Medical Director</td>
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<td></td>
<td>Director of Nursing</td>
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<td></td>
<td>Director of HR &amp; OD</td>
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<td></td>
<td>Director of Integrated Governance</td>
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<tr>
<td></td>
<td>Director of Corporate Services</td>
</tr>
<tr>
<td></td>
<td>Chief of Divisions (x3)</td>
</tr>
<tr>
<td></td>
<td>Director of Medical Education</td>
</tr>
<tr>
<td>Attendance</td>
<td>The Committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate</td>
</tr>
</tbody>
</table>

4. MEETINGS AND QUORUM
4.1 Quorum shall be at least two Executive Directors and one Chief of Division
4.2 Meetings will be held on a fortnightly basis
5. SUPPORT ARRANGEMENTS

The Trust Board Secretary 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 papers will be distributed to members one week in advance of the meeting. Meeting papers will also be available to other members of the Board for information.

6. DECLARATION OF INTERESTS

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

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

7. DUTIES

7.1 Monitor and have high level oversight of the financial and operational performance of the Trust

7.2 Ensure the alignment of the Trust’s strategy with the strategy of the STP and National Strategies

7.3 Ensure that there is appropriate integration and liaison between individual clinical services, between clinical and corporate functions and between strategic and operational matters, within the Trust and with external partners.

7.4 Develop, agree and monitor implementation of plans to improve the efficiency, effectiveness and quality of the Trust’s services.

7.5 Support individual Executive Directors to deliver their delegated responsibilities by providing a forum for exchange of information, mutual support, and resolution of issues and achievement of agreement.

7.6 Assure the Board that key risks and issues are being managed and mitigated in an appropriate way.

7.7 Act as the ‘gateway’ for items and papers that have been prepared for Board consideration; come to agreement on any revisions required to items or papers, and approve items or papers prior to Board consideration.

8. STANDING AGENDA THEMES
1. Integrated Governance Report
2. Board Assurance Framework (BAF)
3. Corporate risk register
4. Items / papers for Board consideration

9. REPORTING

9.1 To Board: The Executive Group Meeting shall report to the Board via the Chief Executive update report.

9.2 To EGM: The EGM will receive reports from Executive Directors, or from representatives from within their portfolios, relevant to the business of the committee.

10. PROCESS FOR MONITORING EFFECTIVENESS OF THE COMMITTEE

10.1 The Chair of the committee will seek feedback from all attendees on the effectiveness of committee meetings following each meeting during the period of Board governance review.

10.2 The effectiveness of the committee will be reviewed as part of the wider review of the full Board governance process. This review will be carried out by the Audit Committee eight months following implementation of the new process.

11. REVIEW

Review date: August 2018
Next Review May 2019
6.1.9 Council of Governors

COUNCIL OF GOVERNORS
TERMS OF REFERENCE

1. PURPOSE

In accordance with Paragraph 13 of the Constitution, the Trust has a Council of Governors who are elected by members of the Trust or appointed by partner organisations.

The purpose of the Council of Governors is to:

- Hold the Board of Directors to account for the performance of the Trust
- Represent the interests of members and nominated partner stakeholders.

(Note: The Council of Governors is derived from the National Health Service Act 2006; and the Health and Social Care Act 2012; Monitor’s NHS Foundation Trust Code of Governance. These terms of reference should be read in conjunction with these source documents.)

2. AUTHORITY

Statutory

- To approve the policies and procedures for the appointment, re-appointment, removal, appraisal and remuneration of the Chairman of the Board of Directors and Non-Executive Directors on the recommendation of the Council of Governors’ Appointment & Remuneration Group.

- To approve the appointment or re-appointment of the Chairman and Non-Executive Directors of the Board of Directors on the recommendation of the Council of Governors’ Appointment & Remuneration Group and having taken into account the views of the Board of Directors on the qualifications, skills and experience required for each position as Non-Executive Director.

- To approve the removal of the Chairman or a Non-Executive Director of the Board of Directors on the recommendation of the Council of Governors Appointment & Remuneration Group, providing that the Council of Governors has first exhausted all other means of resolving the matter at issue in accordance with the Code of Governance.
• To approve the remuneration, allowances and other terms of office on appointment and any changes thereafter for the Chairman and Non-Executive Directors of the Board of Directors on the recommendation of the Council of Governors Appointment & Remuneration Group.

• To approve the appointment of the Chief Executive recommended by the Non-Executive Directors.

• To approve the criteria for appointing, reappointing the Auditor on the recommendation of the Audit Committee.

• To receive the Annual Accounts, any report of the Auditor on the Annual Accounts and the Annual Report, including the Quality Report.

• To receive and consider updates on the Trust’s strategic direction and act as a critical friend in providing feedback to the Board of Directors in development of strategic plans.

• To hold the non-executive directors, individually and collectively, to account for the performance of the Board of Directors.

• To represent the interests of the members of the trust as a whole and the interests of the public.

• To approve “significant transactions”.

• To approve an application by the trust to enter into a merger, acquisition, separation or dissolution.

• To decide whether the trust’s non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions.

• To approve amendments to the Trust’s Constitution.

3. MEMBERSHIP AND ATTENDANCE

<table>
<thead>
<tr>
<th>Chair of Committee</th>
<th>A Non-Executive Chairman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members</td>
<td>4 Elected Staff Governors</td>
</tr>
<tr>
<td></td>
<td>13 Public Governors</td>
</tr>
<tr>
<td></td>
<td>3 Kettering</td>
</tr>
<tr>
<td></td>
<td>3 Corby</td>
</tr>
<tr>
<td></td>
<td>3 East Northamptonshire &amp; Bedford</td>
</tr>
<tr>
<td></td>
<td>3 Wellingborough</td>
</tr>
<tr>
<td></td>
<td>1 Rest of UK</td>
</tr>
</tbody>
</table>
8 Appointed Governors

1 University of Northampton
1 University of Leicester
1 Northamptonshire County Council
3 Voluntary Sector Representatives
1 Corby Clinical Commissioning Group
1 Healthwatch

Attendees

Trust Board Secretary
Members of the public

4. MEETINGS AND QUORUM

4.1 There will be formal meetings in public at least 4 times each year and in addition there will be an Annual Members meeting for members and the public when the Board of Directors will present the Annual Report and Accounts to the Council.

4.2 8 Governors will be a quorum.

4.3 Excepting for reasons of sickness, or unavoidable leave it is an expectation that Governors attend a minimum of three Council meetings per year.

4.4 The Chairman of the NHS Foundation Trust will chair the Council of Governors.

4.5 The Vice-Chairman/Senior Independent Director will deputise for the Chairman when necessary.

4.6 The Council will invite the Chief Executive to attend meetings and other Executive and Non Executive Directors as appropriate.

4.7 Governors will be elected to serve on Board/committees as the “Nominated Governor”. In addition a Deputy Nominated Governor will be elected. Both nominees to attend the committee meetings.

5. SUPPORT ARRANGEMENTS

5.1 The Trust Board Secretary shall be responsible for providing support to the Chairman and to the Council. Agendas for forthcoming meetings will be agreed with the Committee Chair and Lead Governor on the first working day of the month, and papers will be distributed to members one week in advance of the meeting.
6. **DECLARATION OF INTERESTS**

6.1 All members must declare any actual or potential conflicts of interest relevant to the work of the Council.

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

7. **DUTIES**

7.1 **General**

- To act at all times in the best interests of the Trust and in accordance with the Terms of Authorisation, the Constitution and the Governors Code of Conduct.
- To promote the achievement of the Trust's objectives within the Terms of Authorisation and of its Principal Purpose as set out in the Constitution.
- The role of the Council is strategic and advisory and **not operational**. Governors should acknowledge the overall responsibility of the Board of Directors for the day to day management of the NHS Foundation Trust. The powers of the Council may not be used to veto the decisions of the Board of Directors.

7.2 **Advisory Role:**

- Provide views on how the Foundation Trust can shape services to meet the needs of the members and the wider community, representing the interests of members and partner organisations in the governance of the Trust.
- Governors will regularly feedback information about the Trust, its vision and its performance to the constituencies or the stakeholder organisations that either elected or appointed them.

7.3 **Guardianship:**

- Act as guardian of NHS Principles and values and ensure the Trust operates in a way that fits its statement of purpose and complies with the Terms of Authorisation.
- Identify ways that Governors can obtain and present members' views.
- Establish policy for engagement with Board of Directors on:
  - How Governors will undertake their roles
  - How concerns around performance of the Board are to be addressed
  - How the Council is consulted on the development of forward plans and significant changes to delivery of business plan
  - Challenge the Board of Directors about concerns and risks identified by the Council.

7.4 **Governance:**
Meet sufficiently regularly to discharge duties and invite Chief Executive/Executive Directors/ Non Executive Directors as appropriate

Ensure a clear and fair policy is in place for removal of any Governor that consistently and unjustifiably fails to attend meetings, has a conflict of interest or fails to discharge his/her responsibilities

8. COUNCIL SUB GROUPS
The Council will have a:

- Overview Group. 8 meetings per year
- Appointment & Remuneration Group

Task & Finish Groups may be established to address specific issues.

9. STANDING AGENDA THEMES

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Northamptonshire Health and Social Care Board</td>
</tr>
<tr>
<td>2.</td>
<td>Reports from Board Committees</td>
</tr>
</tbody>
</table>

10. REPORTING

10.1 The Council of Governors reports to the membership of the Trust.

10.2 The Council of Governors meets in public and the agenda, papers and minutes for all the meetings will be posted on the website.

10.3 A report on the work of the Council of Governors shall be given at the Annual Members’ meeting.

11. ACCOUNTABLE TO
The Council of Governors represents the interests of, and is accountable to, the membership of the Trust.

12. PROCESS FOR MONITORING EFFECTIVENESS OF THE COUNCIL
12.1 The Chair of the Council will seek feedback on the effectiveness of meetings following each meeting during the period of Board governance review.

12.2 The effectiveness of the Council will be reviewed as part of the wider review of the full Board governance process. This review will be carried out by the Audit Committee eight months following implementation of the new process.

12.3 Terms of reference are to be reviewed at least annually.

13. REVIEW

13.1 Review date:
13.2 Next Review
6.2 Templates
Templates are provided to support the processes that are described above in section 5. These should be extracted and used to support preparation for the Board and its committees set out in this paper. These are subject to iterative revision, based on the feedback arrangements described throughout this document.

6.2.1 Agenda template
Please note: the below template has been completed for the Quality and Safety committee as a working example. When using the template this information should be removed and replaced with the relevant committee information.

---

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Quality and Safety Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>XX/XX/XXXX, XX:XX – XX:XX</td>
</tr>
<tr>
<td>Location</td>
<td>[Full address]</td>
</tr>
</tbody>
</table>

**Purpose and Ambition**
The committee is responsible for overseeing the delivery of the Quality Strategy through:
- Ensuring it is delivered through the 6 Quality Pledges.
- Ensuring the organisation is striving to provide high quality care to individuals, communities and the population it serves.
- Overseeing the delivery of the Quality Improvement Plan and embedding a culture of continuous improvement.

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Lead</th>
<th>Timing</th>
<th>Paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Apologies for absence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Minutes of the previous meeting</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>Action log</td>
<td></td>
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</tr>
<tr>
<td>4</td>
<td>Reducing avoidable harm and mortality</td>
<td>Integrated Governance Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Putting patients first</td>
<td>Quality Strategy</td>
<td></td>
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<tr>
<td>6</td>
<td>Developing a culture of continuous improvement and safety</td>
<td>Quality Improvement Plan</td>
<td></td>
<td></td>
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<tr>
<td>7</td>
<td>Deep dive into items 3 and 4</td>
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<tr>
<td>8</td>
<td>Risk and Board Assurance Framework</td>
<td>BAF and CRR</td>
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<tr>
<td>9</td>
<td>Items for escalation to Board</td>
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<tr>
<td>10</td>
<td>Feedback from Non-Executive Director Meetings/Nominated Governor</td>
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</tr>
<tr>
<td>11</td>
<td>Any other business</td>
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<tr>
<td>12</td>
<td>Assessment of meeting</td>
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<tr>
<td>13</td>
<td>Date and time of next meeting</td>
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</tbody>
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6.2.2 Paper template

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<table>
<thead>
<tr>
<th>Meeting</th>
<th>Board / Committee / Council of Governors’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>X,X</td>
</tr>
<tr>
<td>Paper Title</td>
<td>[Title]</td>
</tr>
</tbody>
</table>
Kettering General Hospital NHS Foundation Trust

Date: XX/XX/XXXX
Author: [Name], [Title]

Situation
Please detail the situation of this paper, this should include:
- What has prompted the development of this paper?
- What are the key complications or challenges that require discussion?
- What has changed?

Background
Please detail the background to the recommendations in this paper, this should include:
- What was the situation before the challenge or change became apparent?
- What has already been tried?
- What is the optimal outcome or output?

Assessment
Provide an assessment of the situation and background and identify the preferred outcome, this should include:
- What are the potential, specific, actions that could be taken?
- What are the clinical, operational and financial implications of these actions?
- What are the risks of action or inaction, and how is this mitigated?

Recommendation
Please make a recommendation for the action required to achieve the preferred outcome, this should include:
- Outline of the recommended course of action, referencing how this will deliver the desired outcome
- What are the immediate next steps?
- What are the dependencies on other projects, programmes or areas?

Appendix
This can be used for any additional information that supports the previous sections but does not necessarily fit within a single box. Note: Appendices count towards the overall paper length.

Note: Papers must not exceed four pages of A4 in total

6.2.3 Cover page template

Meeting: Board / Committee / Council of Governors’
Agenda Item: X.X
Paper Title: [Add title here]
Date: XX/XX/XXXX
Author: [Name], [Title]

This paper is for: [Delete as appropriate]
☐ Action ☐ Discussion ☐ Note ☐ Information

Executive Summary
S Situation
B Background
Kettering General Hospital NHS Foundation Trust

A  Assessment
R  Recommendation

Reason for Consideration
Rationale for the Board / Committee consideration of the paper being presented

Paper Previous Consideration
List of any other Committees that have previously considered this paper (or a version of it)

Strategic Objectives
Identify the strategic objectives that the paper impacts upon

Financial Implications
Summarise the financial implication of the paper, if any

Risks
Summarise any risks that arise from this paper, including the impact of non-implementation of recommendations

Equality impact
Summarise the findings of any equality impact assessments that have been undertaken

Note: This cover sheet must not exceed two pages of A4 in total

6.2.4 Minutes and actions template

Meeting  Board / Committee / Council of Governors
Date  XX/XX/XXXX, XX:XX – XX:XX
Location  [Full address]

Purpose and Ambition
To be added for the relevant meeting from Terms of Reference

Attendance  Name and Title
Present  Name, Title
In Attendance  Name, Title
Apologies  Name, Title

Meeting Action Log

<table>
<thead>
<tr>
<th>No</th>
<th>Action</th>
<th>Owner</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Action</td>
<td>Owner</td>
<td>Due Date</td>
</tr>
<tr>
<td>2</td>
<td>Action</td>
<td>Owner</td>
<td>Due Date</td>
</tr>
</tbody>
</table>

Minutes

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Discussion</th>
<th>Action (Owner)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Action notes of discussion</td>
<td>Capturing of actions (and owner) for adding to log above</td>
</tr>
</tbody>
</table>

Decision:
<table>
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<tr>
<th></th>
<th>Note of any decision taken</th>
<th>Capturing of actions (and owner) for adding to log above</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Action notes of discussion</td>
<td></td>
</tr>
<tr>
<td><strong>Decision:</strong></td>
<td>Note of any decision taken</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Next Meeting**

<table>
<thead>
<tr>
<th>Date</th>
<th>XX/XX/XXXX, XX:XX – XX:XX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>[Full address]</td>
</tr>
</tbody>
</table>

**6.2.5 Annual report template**

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Name</td>
</tr>
</tbody>
</table>

**Purpose and Ambition**

To be added for the relevant meeting from Terms of Reference

**Membership**

<table>
<thead>
<tr>
<th>Name, Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name, Title</td>
</tr>
<tr>
<td>Name, Title</td>
</tr>
</tbody>
</table>

**Chair’s summary**

Narrative Executive Summary to be provided by the Committee Chair, outlining major successes and challenges for the committee over the past year; should reference the plans for the year ahead, and how these have been influenced by the current year

**Progress of standing agenda items**

<table>
<thead>
<tr>
<th>Standing Agenda Item</th>
<th>Year-end position</th>
<th>Plans for next year</th>
</tr>
</thead>
<tbody>
<tr>
<td>From Terms of Reference</td>
<td>Summary of progress made against standing agenda items, in relation to committee purpose</td>
<td>Plans for following year for standing agenda item, related to committee purpose</td>
</tr>
<tr>
<td>From Terms of Reference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>From Terms of Reference</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Business items completed**

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Decision / Outcome</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Summary description of the business item completed</td>
<td>Confirmation of the decision taken, or outcome achieved</td>
<td>Date of decision / outcome</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Business items not completed during year

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Reason for non-completion</th>
<th>Date at which it was agreed item could not be completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Summary description of the business item NOT completed</td>
<td>Summary of the factors that meant the business item could not be completed, and mitigations employed</td>
<td>Date</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Plan for next year

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Summary description of the business item and the intention behind inclusion in the annual plan of work</td>
<td>Date by which discussion or a decision is due</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Sign off

<table>
<thead>
<tr>
<th>Date</th>
<th>XX/XX/XXXX</th>
</tr>
</thead>
</table>

Note: This report should be no longer than four pages in length

6.2.6 Integrated governance report template
## Executive Summary

### Overall strategic performance by the Chief Executive
- Performance against strategic objectives
- Summary of external factors and policy drivers that may impact Trust

### Overall Trust performance summary provided by the Chief Executive
- Overall performance against strategic and operational objectives

<table>
<thead>
<tr>
<th>To provide high quality care to individuals, communities and the population we serve – <strong>Quality</strong></th>
<th>To be a strong and effective partner in the wider health and social care community – <strong>Operations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Executive summary provided by the Director of Nursing and Quality</td>
<td></td>
</tr>
<tr>
<td>• Updates against both strategic and operational objectives</td>
<td>• Executive summary provided by the Chief Operating Officer</td>
</tr>
<tr>
<td></td>
<td>• Updates against both strategic and operational objectives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To maintain a fulfilling and developmental working environment for our staff – <strong>Workforce</strong></th>
<th>To be a clinical and financially sustainable organisation – <strong>Finance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Executive summary provided by the Director of HR and OD</td>
<td></td>
</tr>
<tr>
<td>• Updates against both strategic and operational objectives</td>
<td>• Executive summary provided by the Director of Finance</td>
</tr>
<tr>
<td></td>
<td>• Updates against both strategic and operational objectives</td>
</tr>
</tbody>
</table>
Quality dashboard
Measures to include:
- C. Diff. / MRSA scores
- IPaC audits
- NHS Thermometer scores
- Falls
- Complaints and complaints performance
- Never events and SIs
- Duty of candour
- SHMI
**Exception reporting**

- *Summary of areas where delivery was not in line with plan to deliver strategic objectives*

**Informal intelligence**

- *Summary or invalidated and / or informal intelligence relevant to the delivery of the strategic objective*

**Comparator information**

- *Report to be designed to be run from CHKS / Dr Foster / GIRFT reporting, showing quality measures compared against relevant Trusts (Examples from Frimley below)*
### Quality and Safety Committee

**Report to Board**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Description and summary discussion</th>
<th>Decision</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Description of item and summary of discussion</td>
<td>Decision made by committee, including unanimity</td>
<td>Review date of item / decision</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Items escalated for Board discussion/ decision making

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Description and summary discussion</th>
<th>Reason for escalation</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Description of item and summary of discussion</td>
<td>Rationale for escalating, including why the committee was unable to discuss or decide</td>
<td>Date by which discussion or a decision is due</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To be a strong and effective partner in the wider health and social care community – Operations

Operational dashboard
Measures to include:
- A&E performance (incl. ambulance handover)
- RTT performance
- Cancer target performance
- Diagnostics rates
- Cancellations
- DTOC
<table>
<thead>
<tr>
<th>Exception reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of areas where delivery was not in line with plan to deliver strategic objectives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Informal intelligence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary or invalidated and / or informal intelligence relevant to the delivery of the strategic objective</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comparator information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report to be designed to be run from CHKS / Dr Foster / UNIFY reporting, showing operational measures compared against relevant Trusts (Examples from Frimley below)</td>
</tr>
<tr>
<td>Agenda Item</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

**Items escalated for Board discussion/ decision making**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Description and summary discussion</th>
<th>Reason for escalation</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>Rationale for escalating, including why the committee was unable to discuss or decide</td>
<td>Date by which discussion or a decision is due</td>
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<td></td>
<td></td>
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<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To be a clinical and financially sustainable organisation – Finance

Finance dashboard
Measures to include:
- I&E (by POD)
- EBITDA
- Capital spend
- CIP achieved
- CIP trajectory
- Agency spend
### Exception reporting

- **Summary of areas where delivery was not in line with plan to deliver strategic objectives**

### Informal intelligence

- **Summary or invalidated and / or informal intelligence relevant to the delivery of the strategic objective**

### Comparator information

- **Comparison of KGH finances with national and regional averages, where available**
- **Overview of the regional financial performance, from STP reporting plus relevant comparison where possible**
## Major decisions log

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Description and summary discussion</th>
<th>Decision</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Description of item and summary of discussion</td>
<td>Decision made by committee, including unanimity</td>
<td>Review date of item / decision</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

## Items escalated for Board discussion/ decision making

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Description and summary discussion</th>
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<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Description of item and summary of discussion</td>
<td>Rationale for escalating, including why the committee was unable to discuss or decide</td>
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<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To maintain a fulfilling and developmental working environment for our staff – Workforce

Workforce dashboard
Measures to include:
- Vacancy rate
- Turnover rate
- Sickness rate
- Appraisals
- Safe staffing mix (day and night)
- MaST
- Agency / bank rates
### Exception reporting
- *Summary of areas where delivery was not in line with plan to deliver strategic objectives*

### Informal intelligence
- *Summary or invalidated and/or informal intelligence relevant to the delivery of the strategic objective*

### Comparator information
- *Comparison of workforce metrics against nationally reported metrics, i.e. sickness rates, turnover, agency usage (cap breaches)*
  
  *(Examples from Frimley below)*
## Organisational Development Committee Report to Board

<table>
<thead>
<tr>
<th>Major decisions log</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agenda Item</strong></td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

## Items escalated for Board discussion/ decision making

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Description and summary discussion</th>
<th>Reason for escalation</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Description of item and summary of discussion</td>
<td>Rationale for escalating, including why the committee was unable to discuss or decide</td>
<td>Date by which discussion or a decision is due</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex 1

Non-executive Directors play a crucial role as part of any effective Board. Specifically, they bring independence, external perspectives and skills to everything that the Board does. They also hold the Executive to account for delivery, offering constructive scrutiny and challenge, whilst providing visible leadership that supports the development of a healthy culture.

Chairing or participating as a member of a committee of the Board is a critical mechanism through which Non-executive Directors manage accountability. In addition, Non-executives may also be asked to engage and provide specific skills, experience and insight into targeted initiatives, where significant change or risk is being managed within the Trust. Together may present unmanageable time demands on Non-executives, especially when arranged with short notice. Equally, there are many examples across Trusts where some Non-executives are overly relied upon and, as a result, the full breadth and depth of the team is not utilised.

Further to the refreshed governance proposals and the recent appointment of new Non-executives it is important to ensure that there is clarity around role with respect to committees. The below schematic has been developed to ensure that there is balanced use of Non-executive Director time across committees, with skills and experience best matched to each:

<table>
<thead>
<tr>
<th>Committee</th>
<th>Chair</th>
<th>Second</th>
<th>Bench</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance, Finance &amp; Resources</td>
<td>Phil Harris-Bridge</td>
<td>Damien Venkatasamy</td>
<td>Lizzie Hanna</td>
</tr>
<tr>
<td>Quality &amp; Safety</td>
<td>Christopher Welsh</td>
<td>Lise Llewellyn</td>
<td>Janet Gray</td>
</tr>
<tr>
<td>Organisational Development</td>
<td>Janet Gray</td>
<td>Trevor Shipman</td>
<td>Phil Harris-Bridge</td>
</tr>
<tr>
<td>Audit</td>
<td>Trevor Shipman</td>
<td>Lise Llewellyn</td>
<td>Lizzie Hanna</td>
</tr>
<tr>
<td>Charitable Funds</td>
<td>Janet Gray</td>
<td>Lizzie Hanna</td>
<td>-</td>
</tr>
</tbody>
</table>

As outlined in the governance proposals, there is a single Non-executive Chair for each committee. Respective Chairs are responsible for preparing and presenting reports from their committees to the Council of Governors (note - fuller responsibilities for each Chair are set out in respective Terms of Reference). A second Non-executive is also aligned to each committee and should be aware and able to discharge the Chair’s responsibilities if needed (e.g. due to short term sickness). Further resilience is added to arrangements through the use of the ‘bench’. Named Non-executives on the bench are asked to attend committees where either the Chair or second are unable to attend.
Where Non-executives’ skills, experience and insight into targeted initiatives is required, Executives are asked to plan this well in advance, providing due notice.

The Trust also hosts a placement from the NExT Director Scheme, this aims to find and support the next generation of talented people from black, Asian and minority ethnic (BAME) communities to become non-executive directors in the NHS. As part of this programme, Bailey Chopra shadows and is mentored by our experienced NEDs and attends Trust Board and Committees in a non-voting capacity.
Executive Summary

S Kettering General Hospital (KGH) has undertaken a process of engagement with staff, patient representatives, governors and the Board to develop the updated short to medium term strategy for the organisation.

This has been developed iteratively using multiple engagement initiatives with the overall objective of ensuring that everyone in the organisation has had the opportunity to contribute and influence the development of the short to medium term strategy.

B The CQC’s Well-led key line of enquiry two (KLOE 2) assesses whether an organisation has a clear vision and credible strategy. KGH’s current position against this KLOE was assessed as an area of weakness at the Board Development Session on 6 July 2018.

To progress development of the short to medium term strategy, an extensive programme of work has taken place with a wide range of stakeholders, ensuring that the Trusts CARE values and long term strategic objectives remain at the core.

22 June – Launch of the strategy design at a workshop with senior clinical and managerial staff. This led to identification of their key themes that need to be included in a short-medium term strategy. Further workshops with the executive team, Heads of Departments and Heads of Divisions took place during June and early July to agree a first draft.

Week of 16 July – Launch of the engagement and first draft to the organisation, through Leadership Brief and CEO weekly email. Varied methods of engagement were then employed to allow for everyone in the organisation to have the opportunity to contribute and influence the development of the strategy wheel. Through this process feedback was successfully gathered from over 500 stakeholders from across the organisation.

6 September – Engagement with progress and staff feedback discussed at the Board Development session.
### A

The feedback gathered was analysed to identify core themes along with identifying which objectives needed amending or removing. The short to medium term strategy presented to Board incorporates the feedback received from all stakeholders. Furthermore, the feedback has informed proposed ideas for a new structure to present the strategy.

**Next Steps:**

i. Professional graphic support is employed to develop the content into a one-page document for staff that is easy to read, accessible and portable. Draft to be presented to the Executive Management Group on 2 October 2018.

ii. A further staff engagement plan will be put in place during October 2018 that will align individual’s roles to appropriate elements of the strategy. This will aim to ensure each member of staff understands and can feel a valued part of ‘the whole team’ in helping the trust deliver its ambitions.

iii. The agreed document will be launched at patient and voluntary groups, and communicated externally to the organisation, to build wider engagement and understanding of the key medium terms strategic objectives of the Trust.

### R

The Board of Directors is recommended to approve the content of the short to medium term strategy included in the paper, and note that further steps to design the presentation and engage with our staff and patients further.

---

**Reason for Consideration**

Oversight of the Trust’s strategy is a core function of the Board of Directors. This paper sets out the process of engagement that has led to the development of the updated short to medium term strategy. The Board of Directors is the most appropriate forum for sign off of the short to medium term strategy.

**Paper Previous Consideration**

- EGM: 18 September 2018
- Board Development Session: 7 September 2018

**Strategic Objectives**

The four core long term strategic objectives are central to the updated short to medium term strategy.

**Financial Implications**

The financial implications from the recommendations in this paper would include the cost of external graphic design support. These are expected to be minimal and processes will be adhered to procure this support at the best value for money.

**Risks**

Having a robust and realistic short term strategy with well-defined objectives that are achievable and relevant is a critical component of the Trusts overall strategy, therefore without agreement on the short to medium term strategy the overall strategy for the Trust cannot be developed.
Furthermore, there is a risk that without the short to medium term strategy, the critical areas of work which have been identified as vital to the Trusts success over the next couple of years will not be a given adequate focus consistently across the Trust.

The development of the short to medium term strategy involved a structured planning process in collaboration with stakeholders from across the Trust. There is a risk that failure to take forward the product of this process will result in stakeholders not fully supporting or understanding the strategy and will likely result in poor engagement from stakeholders with future initiatives.

**Equality impact**

An equality impact assessment will be carried out for the short to medium term strategy once approved.
Situation

Kettering General Hospital (KGH) has undertaken a process of engagement with staff, patient representatives, governors and the Board to develop a short to medium term strategy for the organisation.

This was developed iteratively using a range of engagement initiatives. These had an overall objective of ensuring that everyone in the organisation had the opportunity to contribute and influence the development of the strategy. A final version that incorporates the feedback received throughout this process is presented to the Board to review and approval.

Following Board approval, the short to medium term strategy will be finalised for dissemination to the organisation and public. In addition, an engagement plan will be developed which will ensure each member of the organisation understands how their individual role aligns to the strategy and the part they will play in delivering it.

Background

The CQC’s Well-led key line of enquiry two (KLOE 2) assesses whether an organisation has a clear vision and credible strategy. KGH’s current position against this KLOE was assessed as an area of weakness at the Board Development Session on 6 July 2018. To address this a Task and Finish Group was established, with involvement from both Non-Executive and Executive Directors, to progress the development of both the short to medium term strategy and the long term strategy for the organisation.

To develop the short to medium term strategy a series of workshops were held with senior leaders throughout June and July to review the previous KGH strategy wheel. The intention of this review was twofold: firstly, to ensure the CARE values and the existing high level strategic objectives for the Trust remained relevant. Secondly, the short to medium term objectives were reviewed and refreshed with the Trust’s key priorities though to March 2020.

The wider organisation was then asked to test and refine the objectives included in the draft updated wheel (see Annex 1), developed through the senior leader workshops. Stakeholders were asked to: provide overall feedback; state which objectives they thought were most important to the organisation; identify objectives they would amend or remove; and suggest any objectives they would like to add. Staff and stakeholder engagement in designing the Trusts strategy is a key
To allow everyone in the organisation the opportunity to contribute and influence the development of the strategy wheel, a number of engagement methods were employed. These included: meetings and events that incorporated every level of staff within each division and corporate function; drop in sessions led by Executive Directors, held at different times throughout the week and at weekends; an online survey that could be accessed through K-Net, the organisation’s intranet; and posters in a number of key staff areas. Communication through multiple methods supported this engagement. Examples of the engagement methods are provided in Annex 2.

Through this wide-reaching engagement, feedback was gathered from over 500 stakeholders from across the organisation. This covered every level of staff from each of the divisions and corporate functions, as well as Governors. Following the engagement from across the organisation in August, initial updates were made to the strategy wheel. This updated version was then shared with the Board and patient engagement groups for further feedback.

In parallel to the development of the short to medium term strategy, the development of the long term strategy has progressed through two workstreams. The first of these is reviewing the long term clinical sustainability of services. This will consider how the current and future clinical sustainability of the Trust interlinks with the detailed financial sustainability review and how it will support the Trust in committing to a long term strategy that will deliver its strategic objectives.

The second workstream is a joint piece of work with Northampton General Hospital, which is exploring solutions for how the two organisations can work collaboratively to provide integrated services, bringing the hospitals closer together, while maintaining individual sovereignty. A planned review will focus on exploring what the best ‘form’ of collaboration for clinical and financial sustainability of both organisations is. Progress against both of these workstreams will be presented to the Board in November 2018.

### Assessment

The feedback gathered has been analysed to identify core themes from the responses to all of the questions asked. These are outlined in the table below. The objective identification labels (e.g. ‘Y6’), relate to the labels assigned for the purpose of providing feedback against each of the draft objectives, as shown in the full ‘strategy wheel’ diagram (see Annex 3).

<table>
<thead>
<tr>
<th>Key themes</th>
<th>High level summary points</th>
<th>Actions taken as a result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language</td>
<td>• Wording is focussed towards management</td>
<td>• Language reviewed for all objectives throughout wheel</td>
</tr>
<tr>
<td></td>
<td>• Abbreviations not understood</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• “Language to be suitable for the public at large”</td>
<td></td>
</tr>
<tr>
<td>Structure</td>
<td>• Complicated and difficult to absorb so many</td>
<td>• Proposal for new</td>
</tr>
</tbody>
</table>
elements
• The wheels and the timeframe are not clear
• “If we are on a journey, why are we going in circles?”
structure is included as part of Annex A

Methods of engagement/communication
• Not enough emphasis on communication throughout objectives
• Need to improve communication across the Trust
• “Better communication in every area”
• New objective Y6 is focussed on communication

Staff health and well being
• Not enough emphasis on staff health and wellbeing, specific areas include:
  • Staff facilities/ rest areas
  • Access to food/drinks 24/7
  • Car parking
  • “Provide adequate area for staff breaks and facilities... [provide] hot food on site”
• Staff health and wellbeing addressed in new objective Y4

Leadership and accountability
• Staff culture and morale
• To firm up ownership of objectives
• “individuals to be held to account”
• Leadership more explicitly addressed in new objective Y5

The analysis, shown in Chart 1 below, also identified the objectives that were thought to be most important to the organisation and those that required amendment or removal. The horizontal axis refers to the labelling of the objectives in the strategy wheel diagram (see Annex 3). The vertical axis numbers refer to the amount of times the objective was included in the feedback response.

Chart 1. Outcome of feedback for objectives identified as most important and those that required amendment or removal.

<table>
<thead>
<tr>
<th>Amend/ Remove feedback</th>
<th>#</th>
<th>Original objective</th>
<th>Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4</td>
<td></td>
<td>Work in partnership with NGH to develop an effective acute unified model of care</td>
<td>19 comments, feedback split between suggestions to: remove; merge with G5; and to give more emphasis to other partnerships.</td>
</tr>
<tr>
<td>G3</td>
<td></td>
<td>Ensure no patient spends more time in our hospital than they need to</td>
<td>18 comments, feedback split between suggestions to: merge with G6 (length of stay); and ensure the wording did not suggest a focus away from patient care.</td>
</tr>
</tbody>
</table>
Continually challenge our own practice around length of stay and empower and educate patient in self care

Clinically and digitally transform our organisation

Develop as a centre of excellence by embedding a culture of continuous improvement

Implement GIRFT (Get it Right First Time) across the hospital, putting evidenced based practice at the heart of what we do

14 comments, the feedback was split between suggestions to: merge with G3 or G4; and improve wording/grammar.

14 comments, the feedback was split between suggestions to: provide a more specific objective on IT facilities; and clarify what the objective meant.

13 comments, the feedback was split between suggestions to: merge with Y6, Y4 & Y3; and cut down on the words to simplify.

13 comments; majority focussed on insufficient clarity on ‘GIRFT’.

The feedback received from the engagement across the organisation has been incorporated into the final version of the strategy wheel, see Annex 3. From the feedback received it became apparent that the current presentation of the short to medium term strategy as a wheel was not easy to understand to all people. Therefore, proposed ideas for alternative structures to present the short to medium term strategy have been developed, see Annex 4. Examples of strategy presentation from other Trusts are presented in Annex 5. The Trust will continue to develop presentational format options in the next few weeks, and will ultimately be developed into a one pager using professional graphic design support.

The next stage of development will include an engagement plan that will ensure every stakeholder understands how their individual role aligns to the strategy and the part they will play in ensuring delivery. The engagement plan also focus on how patients will be engaged with the final short to medium term strategy.

Recommendation

The Board is recommended to approve the content of the current version of the short to medium term strategy, which has been developed with extensive engagement from across the organisation.

Following approval from the Board, it is recommended that the short to medium term strategy is finalised with professional support for dissemination to the organisation and public.
Annexes for Short to Medium term strategy paper
Annex 1: Draft wheel developed for feedback from the organisation

To provide safe high quality CARE to our communities – Our Vision

To embed clinical leadership as the way we run as an organisation
To embed and develop our quality improvement journey to outstanding
To right size the hospital making best use of our bed base and outpatient facilities
To positively promote and engage with users of our services
To ensure our leaders are embedded in the development and vision of the health and care partnership
To learn from patient experience, embedding changes into our routine practices
To use the quality strategy to ensure staff are able to do the best they can for all our patients

To ensure no patient spends more time in our hospital than they need to
To be a strong and effective partner in the wider health and social care community
To be an advocate for the health and care partnership, recognising the contribution we make
To be a clinical and financially sustainable organisation
To continually challenging our own practice around length of stay and empower and educate patient in self care
To work with partners to develop integrated pathways that support patients to be cared for locally and regionally
To maintain a fulfilling and developmental working environment for our staff
To agree the long term clinical strategy for our organisation
To ensure no patient spends more time in our hospital than they need to
To ensure all our staff have a current appraisal, with a clear development programme to promote leadership within the organisation
To develop as a centre of excellence by embedding a culture of continuous improvement
To further develop the frail and elderly service
To work with partners to develop integrated pathways that support patients to be cared for locally and regionally
To work in partnership with NGH to develop an effective acute unified model of care
To implement GIRFT across the hospital, putting evidenced based practice at the heart of what we do
To deliver the capital plan, focussing on improving the patient experience
To deliver our operational plan and our constitutional commitments to patients
To clinically and digitally transform our organisation
To provide high quality care to individuals, communities and the population we serve

To drive service based innovation and development through devolution
To further develop as a centre of excellence for training and education with particular focus on workforce
To positively promote and engage with users of our services
To work in partnership with NGH to develop an effective acute unified model of care
To implement GIRFT across the hospital, putting evidenced based practice at the heart of what we do
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To provide high quality care to individuals, communities and the population we serve

P1: To provide high quality care to individuals, communities and the population we serve
P2: To use the quality strategy to ensure staff are able to do the best they can for all our patients
P3: To learn from patient experience, embedding changes into our routine practices
P4: To drive service based innovation and development through devolution
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P6: To right size the hospital making best use of our bed base and outpatient facilities
P7: To positively promote and engage with users of our services

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G6: To continually challenging our own practice around length of stay and empower and educate patient in self care
G7: To further develop the frail and elderly service

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B2: To agree the long term clinical strategy for our organisation
B3: To clinically and digitally transform our organisation
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B5: To deliver our operational plan and our constitutional commitments to patients
B6: To deliver the capital plan, focussing on improving the patient experience
B7: To implement GIRFT across the hospital, putting evidenced based practice at the heart of what we do

Y1: To maintain a fulfilling and developmental working environment for our staff
Y2: To embed clinical leadership as the way we run as an organisation
Y3: To implement our organisational development strategy to engage more fully and deeply with our staff and patients
Y4: Improve staff engagement Trust wide through responding to the issues identified in the staff survey
Y5: Ensure all our staff have a current appraisal, with a clear development programme to promote leadership within the organisation
Y6: To further develop as a centre of excellence for training and education with particular focus on workforce
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P7: To positively promote and engage with users of our services
Annex 2: Examples of engagement initiatives

1. Leadership sponsored events in respective divisions/ corporate functions
2. Drop in session with Executive Directors
3. Online survey on K-Net on ‘Our Future’ K-Net page
4. Posters in The Zone and other key staff areas
Annex 3: Updated wheel

**Short term operational objectives**
- B7: Implement national efficiency models, putting evidenced based practice at the heart of what we do
- B6: Agree our digital strategy and implementation plan
- B5: Make best use of our financial resources to improve patient experience
- B4: Deliver our operational plan and our commitments to patients

**Medium term strategic objectives**
- B3: Clinically and digitally transform our organisation
- B1: Be a clinical and financially sustainable organisation
- B2: Agree the long term clinical strategy for our organisation

**Long term strategic objectives**
- G4: Ensure our leaders are embedded in the development and vision of the health and care partnership
- G5: Work with partners to develop an effective acute unified model of care
- G6: Continually challenge our own practice around length of stay
- G7: Work with partners to develop integrated pathways that support patients out of hospital care

**Medium term strategic objectives**
- P4: Drive service based innovation and development
- P2: Use the quality strategy to ensure staff are able to do the best they can for all our patients
- P3: Positively promote and engage with patients

**Long term strategic objectives**
- P1: Provide high quality care to individuals, communities and the population we serve

**Medium term operational objectives**
- P5: Embed and develop our quality improvement journey to outstanding
- P6: Ensure the hospital is making the best use of its facilities to meet patient needs
- P7: Learn from patient experience, embedding changes into our routine practices

**Short term operational objectives**
- P1: Maintain a fulfilling and developmental working environment for our staff
- P2: Embed clinical leadership as the way we run as an organisation
- P3: Implement our organisational development strategy to engage more fully and deeply with our staff and patients
- P4: Promote and support leadership development at all levels of the organisation
- P5: Improve the way we communicate with each other to develop a common voice
- P6: Develop as a centre of excellence for training and education with a culture of continuous improvement

**Long term operational objectives**
- Y1: Ensure our staff always feel valued through improving engagement and supporting staff health and well being
- Y2: Ensure patients are discharged when safe to do so and in a timely manner
- Y3: Be an advocate for the health and care partnership, recognising the contribution we make
- Y4: Be a strong and effective partner in the wider health and social care community
- Y5: Ensure our leaders are embedded in the development and vision of the health and care partnership
- Y6: Continually challenge our own practice around length of stay
- Y7: Work with partners to develop integrated pathways that support patients out of hospital care

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**To provide safe high quality CARE to our communities – Our Vision**

Kettering General Hospital
NHS Foundation Trust

Strategy Wheel v5
Our aim is be an outstanding District General Hospital
We will provide safe, high quality CARE to our communities through delivering our objectives

**Long term strategic objectives**
- Be a strong and effective partner in the wider health and social care community
- Maintain a fulfilling and developmental working environment for our staff

**Medium term strategic objectives**
- Be a clinical and financially sustainable organisation
- Positively promote and engage with patients
- Ensure patients are discharged when safe to do so and in a timely manner
- Embed clinical leadership as the way we run as an organisation
- Implement our organisational development strategy to engage more fully and deeply with our staff and patients

**Short term operational objectives**
- Clinically and digitally transform our organisation
- Agree the long term clinical strategy for our organisation
- Drive service based innovation and development
- Ensure the hospital is making the best use of its facilities to meet patient needs
- Ensure our leaders are embedded in the development and vision of the health and care partnership
- Continually challenge our own practice around length of stay
- Develop as a centre of excellence for training and education with a culture of continuous improvement
- Ensure our staff always feel valued through improving engagement and supporting staff health and well being
- Promote and support leadership development at all levels of the organisation
- Improve the way we communicate with each other to develop a common voice
- Implement national efficiency models, putting evidenced based practice at the heart of what we do
- Deliver our operational plan and our commitments to patients
- Agree our digital strategy and implementation plan
- Make best use of our financial resources to improve patient experience

**Annex 4: Proposed idea for updated structure (a)**
<table>
<thead>
<tr>
<th>Long term strategic objectives</th>
<th>Medium term strategic objectives</th>
<th>Short term operational objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide high quality care to individuals, communities and the population we serve</td>
<td>Use the quality strategy to ensure staff are able to do the best they can for all our patients</td>
<td>Embed and develop our quality improvement journey to outstanding</td>
</tr>
<tr>
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<td></td>
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</tr>
</tbody>
</table>

Our aim is to be an outstanding District General Hospital

We will provide safe, high quality CARE to our communities through delivering our objectives
Annex 5: Examples of strategy presentation from other Trusts

DELIVERING OUR STRATEGY
FOR YOU, WITH YOU

Here are some examples of how we are already delivering our strategy.

Our vision:
To be a leading provider of outstanding, compassionate care

BUILD
GROW
INNOVATE
DEVELOP
QUALITY

OUR STRATEGY IN ACTION
We call our strategy DIGIQ and for the last few years it has been delivered under these five key themes. They help us decide and plan the work we do across the Trust and activity we will support. Some teams have already responded to the overall Trust plan by developing their own local business plans. Describing what DIGIQ means for them and their local priorities:

Thanks to the dedication and hard work of our staff and all supporting us to grow and develop we have many great things and look forward to working together to make a difference for you, with you.

01604 682682
@ nhft.nhs.uk

Microsoft Teams

One vision, three priorities & seven ambitions
We have an agreed clear vision, focused priorities and ambitions. They will underpin our work with staff, patients and colleagues in primary and community care to improve the quality and safety of existing services and accelerate the introduction of new joined-up preventative and integrated services in the community.

One Vision
TO DELIVER THE BEST QUALITY AND SAFEST CARE FOR OUR COMMUNITY

Three Priorities
Deliver for today | Invest in quality, staff and clinical leadership | Build a joined-up future

Seven Ambitions
1 Deliver personal care | 2 Deliver safe care | 3 Deliver joined-up care | 4 Support a healthy start | 5 Support a healthy life | 6 Support ageing well | 7 Support all our staff

Kettering General Hospital
NHS Foundation Trust
Executive Summary

S Kettering General Hospital is required and has previously committed to delivering a minimum of £14.4m Cost Improvement Plan (CIP). This is a key element of delivering the Trusts overall financial plan, and as one of the elements of the overarching plan entirely under the Trusts control, it provides an insight into the level of grip the Trust has over its financial and operational management.

This paper sets out the progress the Trust has made in identifying and working up schemes to deliver the £14.4m by year end. It also explains the improvements to the governance arrangements which surround the process of CIP and transformation.

B In early 2018 Trust Board of Directors approved a Financial Sustainability Plan which included various recommendations to strengthen the governance around the Trusts approach to CIP scheme delivery.

In April 2018, Trust Board approved a financial plan recommended by Executive Group Meeting (EGM), which included £14.4m of CIP delivery. £4.8m of this value was identified as transactional schemes with agreed monthly forecasts for the year.

It was agreed that the remaining value would be transformational schemes, delivering recurrent efficiencies to improve the overall efficiency of how the Trust delivers its services. Q1 was set aside to work up these transformational schemes in more detail, with financial delivery starting from Q2 onwards.

A As at M5 the Trust is forecasting a total of £15.5m of financial efficiency schemes. This surpasses the £14.4m target by £1.1m. This breaks down as:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>£7.7m</td>
</tr>
<tr>
<td>Med</td>
<td>£4.4m</td>
</tr>
<tr>
<td>High</td>
<td>£3.4m</td>
</tr>
<tr>
<td>Total</td>
<td>£15.5m</td>
</tr>
</tbody>
</table>

Variance to target £1.1m

There is a further £2.5m identified as a stretch target on the current schemes, bringing the stretch total to £18m. This stretch is associated with delivering the planned clinical efficiencies early and work is ongoing to do this.
£12m of the current £15.5m (14.5m of the stretch) are recurrent efficiencies which will improve the Trust long-term bottom line.

£5.7m of the schemes are transactional and £9.8m are transformational.

The Trust Board of Directors is asked to note the contents of the report and the progress being made against delivering the £14.4m CIP target, as a key part of the overarching financial plan.

**Reason for Consideration**
The Trust Board requires oversight and assurance against the transformation plan.

**Paper Previous Consideration**
EGM 180918

**Strategic Objectives**
Being a financially and clinically sustainable organisation is one of the four key strategic objectives of the Trust. Delivering our agreed financial plan and recurrent clinical and financial efficiencies directly contributes to this.

**Financial Implications**
The paper sets out how the Trust is progressing in delivering against its £14.4m CIP and transformation target.

**Risks**
Risks against delivery are highlighted by the schemes which compromise of the red rated schemes in the paper.

Risks and mitigations are managed on a scheme by scheme level through the approved governance structure.

**Equality impact**
Equality impact assessments are undertaken on a scheme by scheme level.
Situation
Kettering General Hospital is required and has previously committed to delivering a minimum of £14.4m Cost Improvement Plan (CIP). Delivering this level of savings is a key component of delivering the Trusts overarching financial plan and provides an insight into the level of grip the Trust has over its financial and operational management.

This paper sets out the progress the trust has made in identifying and working up schemes to deliver the £14.4m by year end. It also explains the improvements to the governance arrangements which surround the process of CIP and transformation.

Background
In early 2018 Trust Board Directors approved a Financial Sustainability Plan which included various recommendations to strengthen the governance around the Trust’s approach to CIP scheme delivery. An extract is shown in the image below:

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>Priority</th>
<th>By when</th>
<th>Implementation risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMO</td>
<td>Re-establish the reporting rhythm between PMO and Trust Management Committee (bi-weekly) and Performance Finance &amp; Resource (monthly);</td>
<td>High</td>
<td>1 month</td>
<td>Medium</td>
</tr>
<tr>
<td>PMO</td>
<td>Establish a clearly defined gateway process to map out how CIP should be developed and each appropriate approval stages and defined authority / responsibilities required at each stage.</td>
<td>High</td>
<td>1 month</td>
<td>Medium</td>
</tr>
<tr>
<td>PMO</td>
<td>Ensure that CIP plans are aligned with the Trust's strategic plan. This should be part of a gateway approval process and clearly documented in project initiation documents</td>
<td>High</td>
<td>1-2 months</td>
<td>Medium</td>
</tr>
<tr>
<td>PMO</td>
<td>Set up a de minimum amount for workbooks/PIF and document details of each CIP schemes above the de minimum amount (e.g. nature of the schemes, KPIs, milestones, risks and mitigations, etc.) for FY18/19 and going forward.</td>
<td>High</td>
<td>Ongoing</td>
<td>Low</td>
</tr>
<tr>
<td>PMO</td>
<td>Establish the part year effect and full year effect of each CIP scheme within the CIP tracker.</td>
<td>High</td>
<td>1 month</td>
<td>Low</td>
</tr>
<tr>
<td>PMO</td>
<td>Document the terms of reference.</td>
<td>Medium</td>
<td>2 months</td>
<td>Low</td>
</tr>
</tbody>
</table>

In April 2018, Trust Board approved a financial plan recommended by Executive Group Meeting (EGM), which included £14.4m of CIP delivery. £4.8m of this value was identified as transactional schemes with agreed monthly forecasts for the year.

It was agreed that the remaining value would be transformational schemes, delivering recurrent efficiencies to improve the overall efficiency of how the Trust delivers its services. Q1 was set aside to work up these transformational schemes in more detail, with financial delivery starting from Q2 onwards.
Assessment

Governance
The Trust has put in place a series of improvements to governance and documentation around its identification of CIP and transformation schemes, risk management, quality assurance and programme tracking. All recommendations in the financial sustainability report have been addressed.

Delivery Structure
The Trust has put in place three principle delivery routes to monitor progress, risk and benefits realisation for all schemes.

1. Model Hospital and Getting it Right First Time (GIRFT)
Focussing on using national benchmarking efficiency tools, to highlight where we might focus efforts to improve the effectiveness and efficiency with which we deliver care for patients. Clinical Leads for particular services work with the transformation team to identify opportunities for improving their services; Ophthalmology, Trauma & Orthopaedics (T&O) and Cardiology now have agreed improvement plans in place which are set to deliver improvements in operational effectiveness and financial benefits. Urology, Ear, Nose and Throat (ENT), and General Medicine are currently in the process of exploring their opportunities.

2. Carter Enablers
Lord Carter of Coles report into NHS Efficiencies focussed attention on the opportunities for improvement in Information Management & Technology (IM&T), Estates, Procurement and Back Office Services. This group has now identified £1m of opportunity for 18/19 (increasing for 19/20) and is moving these from level 3 to benefits realisation in level 4.

3. Invest and Return
To improve the speed of decision making where a capital or revenue investment is required, in order to deliver larger financial efficiencies. Investments have already been approved to enable a number of transformational schemes to take place.

Alongside these, are two separate initiatives aimed at encouraging, supporting and delivering innovation at the front line.

I. Radical Devolution is exploring the concept of how moving financial, workforce and other traditionally centrally held functions to a clinical service, could drive innovation in service delivery. A more detailed proposal for how this could work alongside organisational corporate commitments and management of risks will be forthcoming.

II. Dragons Den event is being held on 11 October. Staff and teams from across the organisation are invited to submit their ideas for improving patient care, safety or operational efficiency, with a change to receive funding of up to £100k to implement their idea.

Total Forecast Plan
As planned, the Transformation, Operational (including Clinical staff) and Finance teams spent Q1 identifying transformational schemes that would deliver recurrent Trust efficiencies of a minimum of £10.4m.
A number of schemes have now been agreed and the detailed steps to ensure delivery of tangible benefits with milestones are in place.

The total forecast is now £15.5m year end, surpassing the target of £14.4m.

The following graph shows the risk rating against the £15.5m of schemes.

Low risk (Green) £7.7m  
Med Risk (Amber) £4.4m  
High (Red) £3.4m

Schemes move from red to amber when fully approved and costed delivery plans are in place. A green rating indicates that planned delivery has started and is on track.

A breakdown of Divisional and Corporate initial targets that were agreed, alongside M5 forecast is shown in the following table.
**Risks and Mitigations**

Risks to delivery are managed on a scheme by scheme level, in the appropriate governance process as highlighted above. Each Division and specialty continue to develop contingencies to each scheme and new ideas to mitigate against any under delivery.

The Trust has also identified a number of transformational schemes with 18/19 values less than the full FYE opportunity which has been identified. Together they represent an additional stretch target of £2.5m and increase the total stretch target to £18m. These schemes have weekly meetings in place to drive faster delivery in 18/19 and realise more of the full year value.

**Recurrent/Non-Recurrent**

Over £12m of the forecast is on recurrent schemes which will deliver long lasting efficiencies to the way the Trust delivers its services.

**M5 Actual Position**

The following table shows YTD performance of the current schemes against the agreed plan.

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Year to Date</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan £000s</td>
<td>Actual £000s</td>
</tr>
<tr>
<td>Transactional Schemes</td>
<td>£1,103</td>
<td>£1,748</td>
</tr>
<tr>
<td>Transformational Schemes</td>
<td>£1,338</td>
<td>£1,446</td>
</tr>
<tr>
<td>Growth</td>
<td>£828</td>
<td>£546</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>£3,270</strong></td>
<td><strong>£3,740</strong></td>
</tr>
</tbody>
</table>
**Recommendation**

Next steps are to:

1. Move delivery of the detailed plans on Ophthalmology, T&O and Cardiology from amber level 3 into level 4 green - benefits realisation.
2. Work up detailed delivery plans on all red rated schemes and move them to level 3 (amber).
3. Hold Dragons den and agree innovation ideas for further development
4. Work up Radical Devolution proposal

Trust Board is asked to note the report.
The Five Year Forward View makes a commitment that, by 2020, there would be “fully interoperable electronic health records so that patient’s records are paperless”. This was supported by a Government commitment in Personalised Health and Care 2020 that “all patient and care records will be digital, interoperable and real-time by 2020”.

Digital transformation was highlighted as a key strategic priority by our staff when developing the Trust’s emerging short to medium term strategy.

The Trust has now developed our digital vision to 2020. This vision is underpinned by five strategic objectives and brings together existing and new digital change programmes into a single Digital Roadmap to 2020.

A new digital roadmap transformation programme will need to be launched to deliver the change across the Trust. A critical arm of the Digital Roadmap is the implementation of a fully electronic patient record (EPR). Selecting a new EPR partner is an essential precondition for the roadmap to be delivered.

At the Board Development Session on 6 July 2018, the current position in relation to IT and information was assessed as an area that requires improvement. To address this a Task and Finish Group was established with the involvement of two NEDs (Phil Harris-Bridge and Damien Venkatasamy).

The Task and Finish Group worked with the IT and Information teams at an away day in August to create a digital vision, set of strategic objectives and Digital Roadmap to 2020. These together with considerations for mobilising a digital transformation programme are now being shared with the Board.

Our vision for 2020 is to deliver digital services that:
• empower patients, putting them at the centre of their care,
• enable our passionate staff to provide the best possible services and achieve world class health outcomes,
• utilise data and information across the trust and with strategic partners.
The vision is underpinned by five strategic objectives that will be delivered through a series of projects, between now and 2020, that are plotted on the Digital Roadmap. Whilst some of these projects are already being delivered, others are new and require scoping. Accordingly, a programme definition phase is now proposed.

As outlined above selecting an EPR partner is a key enabler for the programme. The Board is asked to approve a market testing exercise that will run from October 2018 to February 2019.

The Board is asked to:

- Approve the vision and digital roadmap to 2020
- Approve the process to select a new electronic patient record partner
- Approve the definition phase of the digital roadmap programme

Reason for Consideration

In July the organisation’s current position in relation to IT and information was assessed as an area that requires improvement by the Board. The Board is now asked to approve a vision, digital roadmap and definition phase of a transformation programme that seeks to address the required improvement areas.

In addition, the selection of a new EPR partner is likely to be one of the most significant procurement decisions made by the organisation in the next five years. Accordingly, the Board is asked to approve the selection process prior to kick off.

Paper Previous Consideration

- EGM: 18 September 2018
- PFR: 21 September 2018

Strategic Objectives

Digital transformation was highlighted as a key strategic priority by our staff when developing the emerging short to medium term strategy for the organisation. The Digital Roadmap is a key enabler to deliver of our overall strategy.

Financial Implications

Given the ambition of the roadmap there is a likely need for additional financial investment in IT. At this stage these costs are not yet fully developed. The programme definition phase will provide the costs and benefits of the programme.

Risks

Implementation of the digital roadmap is critical to enabling the future clinical and digital transformation of the organisation. Without it the broader trust strategy is not deliverable. It is also the vehicle through which the Trust will be able to meet regional STP and national expectations around being paperless by 2020.

Equality impact

No equality impact assessments that have been undertaken as part of this work
Meeting | Board of Directors  
---|---  
Agenda Item | 2.4  
Paper Title | Digital Roadmap  
Date | 28 September 2018  
Author | Vicki Arnold, Director of IT  
| Ajay Verma, Clinical Chief Information Officer  
| Adrian Ierina, Clinical Chief Information Officer  
| Andy Frost, Head of Performance  
| Mark Gregson, Deputy Director of IT  

**Situation**

The Five Year Forward View makes a commitment that, by 2020, there would be “fully interoperable electronic health records so that patient’s records are paperless”. This was supported by a Government commitment in Personalised Health and Care 2020 that “all patient and care records will be digital, interoperable and real-time by 2020”.

Digital transformation was highlighted as a key strategic priority by our staff when developing the emerging short to medium term strategy for the organisation.

At an away day in August the IT and Information teams came together with the CEO, two NEDs and the CCIOs to develop our digital vision to 2020. This vision is underpinned by five strategic objectives and brings together existing and new digital change programmes into a single Digital Roadmap to 2020. A final version of the Digital Roadmap is presented to the Board to review and approve.

A new digital roadmap transformation programme will need to be launched to deliver the change across the Trust. The Board is asked to approve a six week programme definition phase. This phase will ensure each project within the programme is fully scoped, with defined costs and benefits. A full programme initiation document will then be submitted to the Board for approval November 2018.

A critical arm of the Digital Roadmap is the implementation of a fully electronic patient record (EPR). The Trust’s current main EPR, System C’s Medway, is due for contract renewal in May 2019. Selecting a new EPR partner is an essential precondition for the majority of the other elements of the digital roadmap to be delivered. The Board is asked to approve a process to select a new electronic patient record partner by February 2019.

**Background**

At the Board Development Session on 6th July 2018, the organisation’s current position in relation to IT and information was assessed as an area that requires improvement. To address this a Task and Finish Group was established with the involvement of two NEDs (Phil Harris-Bridge and Damien Venkatasamy). The group drove the development of an IT and Information strategy that delivers
against national and regional STP requirements, whilst enabling the right clinical and digital transformation at KGH.

The first iteration of an emerging digital vision and Digital Roadmap to 2020 were tested with the IT and Information teams at an away day in August 2018. The session was facilitated by the CEO, the two nominated NEDs, the Director of IT and the Head of Performance. The away day was an opportunity to be bold, unbounded, and forward looking. During the day workshop style sessions were held around the following areas:

- The overall Trust short to medium term strategy
- Strengths, weaknesses, opportunities and threats to IT and information
- The emerging digital vision, strategic objectives and Digital Roadmap to 2020
- NED reflections on digital transformation, together with Q&A.

Feedback and outputs from the away day were then used to create an updated digital vision, set of strategic objectives and Digital Roadmap to 2020. These together with considerations for mobilising a digital transformation programme are now being shared with the Board.

Alongside the above activity, work has been underway to develop a process to support the selection of an EPR partner. An EPR provides a digital view of clinical information to coordinate patient care and document the point at which it was delivered. It is typically delivered through departmental or service based modules. When modules are fully integrated across a trust or health system, an EPR can provide an enterprise view of the patient. This provides a full view of a patient, and their history of care, irrespective of the setting in which the care was delivered within the system. These integrated records can then be used to support operations, finance and reporting in a joined up way. A fully integrated EPR can be achieved through either; the creation of a bespoke best of breed system, integrating multiple EPR modules; or through the implementation of a single supplier integrated solution.

KGH currently has an EPR across some services, with System C as its main supplier. Other systems are provided by alternative providers, and are integrated with System C through a custom engine. Some services still remain paper based. The contract with System C, is due for renewal in May 2019.

The Trust is seeking to implement a fully integrated clinical record that enables delivery of its broader digital roadmap and clinical transformation plan by 2020. In order to enable this, a long term agreement and partnership with one or more electronic clinical record suppliers is needed. A formal process to design our requirements, evaluate the market and select supplier(s) is now needed. Importantly, as part of any future decision the costs of changing supplier needs to be considered. This includes a slowdown in the pace pace of digital transformation, additional implementation and transition costs, as well as potentially significant data quality challenges. A proposed process for selecting a new partner is now being shared with the Board for approval.
### Assessment

The digital vision for 2020 for Board approval is set out below:

**Our vision for 2020 is to deliver digital services that:**

- **empower patients, putting them at the centre of their care,**
- **enable our passionate staff to provide the best possible services and achieve world class health outcomes,**
- **utilise data and information in an collaborative way across the trust and with strategic partners.**

This vision is important for patients as it delivers the infrastructure that enables seamless care across pathways, preventing delays and putting them at the centre of their care with access to, and control over their own electronic health records.

The vision is important to our staff because it enables them to focus on clinical duties, reducing time spent on paper-based administrative tasks. It also allows us to optimise data driven decision making through improved information and analytics.

The vision also enables delivery of the Trust’s short to medium term strategy, including facilitating greater integration with system partners.

The vision is underpinned by five strategic objectives:

- **By 2018,** strengthening partnerships, through shared solutions and expertise that enable our staff to deliver high quality care.
- **By 2019,** developing our digital infrastructure to ensure it is secure, reliable, responsive and resilient to our business needs.
- **By 2019,** providing trusted information that enables our staff to make information-led decisions regarding the best care they can provide.
- **By 2020,** delivering a fully integrated electronic clinical record where routine processes are digitised enabling staff to focus on clinical duties.
- **By 2020,** delivering joined up digital services that empower patients, puts them at the centre of their care, to help them make informed decisions.

Each strategic objective will be delivered through a series of projects, between now and 2020, that are plotted on the Digital Roadmap (see annex). The Roadmap forms the basis of the transformation programme that will now need to be mobilised across the Trust. Some of the projects that form part of the programme are already underway. For example the radiology order communications project is on track to deliver by the end of September 2018, meaning that all requests will be received electronically from then onwards. However, there are a number of other projects that are yet to be defined. For others, the selection of an EPR partner is an essential precondition to the project commencing. For example, the electronic prescribing project cannot proceed until an EPR partner is selected. A programme definition phase is now proposed in order to:

- To scope and define each component project within the programme
- To map dependencies across the projects, setting out an overall delivery plan to 2020
To set out the costs and benefits of the programme, accounting for both capital and recurrent values (financial and otherwise)

To define the capacity and capability requirements to support delivery of the programme

At the end of the programme definition phase a full programme initiation document will be submitted to the Board for approval in November 2018.

As outlined above selecting an EPR partner is a key enabler for the programme. The Board is asked to approve a market testing exercise that will run from October 2018 to February 2019, concluding before the existing supplier requires contract termination or extension confirmation. Importantly, the process will be clinically led and managerially supported.

The first step in the process is to produce a robust specification, through a multi-disciplinary team (CCIOs, Divisional Directors, finance, operations and information). The second step will be to use the specification to test the market, seeking requests for information from a suite of suppliers. These will then be evaluated by a moderation panel, who will determine whether there is a clear preferred supplier (where a direct award can be made) or whether there are two or more potentially preferred suppliers (where a mini-competition will be run). The process has been approved by procurement, and will utilise the London Procurement Partnership Clinical Digital Information System (LPP CDIS) framework.

The annex includes a fuller paper setting out the:
- Situation and background
- Our digital vision and strategic objectives
- Our Digital Roadmap and the IT transformation portfolio
- Enablers to support delivery success

**Recommendation**

The Board is asked to:
- Approve the vision and digital roadmap to 2020
- Approve the process to select a new electronic patient record partner
- Approve the definition phase of the digital roadmap transformation programme

**Annex Reference**

*Our Digital Roadmap - Proposal for Board approval v3.0*
Digital Roadmap

Proposal for Board approval

28 September 2018
Executive Summary

• A clear vision and credible strategy is vital for the Trust to deliver high-quality sustainable care to the individuals, communities and populations we serve. Three parallel pieces of work are being carried out across the Trust to define our strategy: short to medium term strategy (now to March 2020), long term strategy (now to March 2023), and full strategy.

• Digital transformation was highlighted as a key strategic priority by our staff when developing the emerging short to medium term strategy for the organisation.

• At an away day in August the IT and Information teams came together with the CEO and two of our NEDs to develop our digital vision to 2020. This vision is underpinned by five strategic objectives and brings together existing and new digital change programmes into a single digital roadmap to 2020.

• A new digital roadmap transformation programme will need to be launched to deliver the change across the Trust.

• A key enabler for the programme is the implementation of a fully integrated electronic patient record (EPR). The current EPR contract expires in May 2019. Whilst a process to select a long term partner is run, the interim decision to extend the current contract by twelve months has been taken.

• The Board is asked to:
  • Approve the vision and digital roadmap to 2020
  • Approve the process to select a long term electronic patient record partner
  • Approve a definition phase of the digital roadmap transformation programme
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National policy and STP context guide and inform the Trust’s digital direction

The Five Year Forward View (published in October 2014) and Personalised Heath & Care 2020 (published in November 2014) both state the need to **deliver better clinical outcomes through the use of technology, systems and data** (see appendix)

Through the Sustainability and Transformation Partnership programme, **Northamptonshire** has established the Heath & Care Programme through which digital initiatives are being delivered (county wide WiFi for staff, shared care records, improvements in business intelligence reporting) (see appendix for Northamptonshire digital roadmap).

The **national and countywide requirements are reflected in the revised Trust’s Digital Roadmap.** A number of digital initiatives already underway with others planned over the next two years.
Our latest self assessment against the Digital Maturity Framework shows that there are key areas where there is more we need to do to move further, faster.

- The diagram below shows our most recent Digital Maturity Assessment (DMA) from October 2017 (red line) compared to the national average (blue line).
- Whilst the Trust has made significant progress over the last year to improve its self assessment DMA score, it is still behind the national average in three core areas.
Understanding the components of the Digital Maturity Assessment

The digital maturity assessment presents 179 questions in total, split over three themes each with sub sections. Areas with the most significant gap to national (marked in amber) are priorities within the new KGH Digital Roadmap:

**Readiness**
(30 questions)

*The extent to which we are able to plan and deploy*

- Strategic Alignment
- Leadership
- Resourcing
- Governance
- Information Governance

**Capabilities**
(134 questions)

*The extent to which we are able to support the delivery of care*

- Records, Assessments and Plans
  - Transfers of Care
  - Orders and Results Management
  - Medicines Management & Optimisation
- Decision Support

**Infrastructure**
(15 questions)

*The extent to which the underlying infrastructure is in place to support these capabilities*

- Enabling Infrastructure

Examples challenges on slide 7
Examples challenges on slide 8
Examples challenges on slide 9
Current challenges and opportunities in records, assessments and plans

- The majority of records across the Trust are paper based. This presents a number of challenges including: accuracy and consistency, delays in processing activity, knock on impacts on patients and clinic schedules etc.
- There is no single central repository that provides a consolidated and consistent view of the patient across the Trust. Records can be manually retrieved, however, the process is labour intensive and introduces delays in care.
- The Trust will need to implement a full electronic patient record in order to meet the national objective to be paperless by 2020.
Current challenges and opportunities in decision support

- 36% of all medication paperwork has an element that is either incomplete or inaccurate. This is higher than the national average (28%). This presents risk and introduces delays in discharge.

- An Electronic Prescribing and Medicines Administration (ePMA) system would not only offer the opportunity to address such problems, but create the opportunity to improve processes through the use of new management data and the establishment of an audit trail.
Current challenges and opportunities in enabling infrastructure

- The effective use of **electronic systems relies upon an enabling infrastructure** that allows staff access regardless of physical location. At present, the **Wi-Fi network is patchy**, with a programme to update by December 2018. In addition, a number of **clinics are run jointly across the county**. A **reciprocal Wi-Fi programme**, as part of the Local Digital Roadmap, is now being run to March 2019.

- A lot of time is wasted by logging into the different systems that clinicians need to use. **Streamlining access to clinical systems and patient records** through the use of a single Sign-On solution can help to release that time back to patient care, **saving minutes per patient**.

- At present, our Medway PAS system is not connected to the **national Personal Demographics Service (PDS)** meaning that incomplete or inaccurate demographics may be recorded locally. PDS is the national electronic database of NHS patient details such as name, address, date of birth and NHS Number (known as demographic information), **enabling a patient to be readily identified by healthcare staff quickly and accurately**.
IT and information are critical functions, central to the Trust’s success. Over recent years there have been great examples of improvements in each of these areas.

**Key recent achievements**

- **Improving our Collaborative working**
  - EMRAD enabled 5 KGH Radiologists to remotely report on CT, MRI and PF
  - Appointment of 2 x Chief Clinical Information Officers in Jan 2018

- **Putting in place secure, reliable, responsive, resilient infrastructure**
  - No known ransomware infections after WannaCry cyber attack in May 17
  - Trust’s core IT infrastructure migrated successfully into new data centre in Mar 18

- **Ensuring our information systems are fit for purpose**
  - The upgrade to Medway PAS to v4.8 took place in Nov 17
  - The Radiology Order Communications project went live for GPs in Nov 17 and internally in Mar 18
However, as we look at our current IT and information functions, it is clear that there are threats and weaknesses we must address whilst seizing opportunities.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tr>
<td>We’re passionate about what we do</td>
<td>We don’t prioritise well</td>
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<tr>
<td>We’re a great team and work together well</td>
<td>We don’t identify and track benefits</td>
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<tr>
<td>We do what we do well</td>
<td>We don’t optimise the systems we deploy with the divisions</td>
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<tr>
<td>We’re flexible and accommodating</td>
<td>Struggle to do BAU and Transformation at the same time</td>
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<td>We support where we’re needed</td>
<td>Data isn’t centralised, and there is a lack of ownership</td>
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<table>
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<tr>
<th>Opportunities</th>
<th>Threats</th>
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<td>We’re small enough to be nimble</td>
<td>We don’t have enough cash to deliver the projects</td>
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<tr>
<td>Optimising systems is a quick win without cost</td>
<td>We don’t have the skills and capacity needed</td>
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<td>Better identification of benefits and lessons learned</td>
<td>Decisions are made on flawed data</td>
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<td>Patients want to see improved ability to access their records</td>
<td>We have a siloed mentality</td>
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<td>We could build bridges with the divisions</td>
<td>We don’t deal well with unexpected workload</td>
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<tr>
<td>Developing and improving our data warehouse</td>
<td>We don’t recruit as well as we could</td>
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Digital transformation was highlighted as a key strategic priority by our staff when developing the emerging medium term strategy for the Trust

- Through August we have been engaging with our staff to develop our medium term strategy to 2020. Digital transformation was a consistently recurrent theme in engagement events, with recognition that it is a critical enabler to delivery of many other strategic priorities.
- We now need a clear vision and digital roadmap that steers transformation in information and IT through a managed portfolio of defined programmes and projects.
Our vision for 2020 is to deliver digital services that;

- empower patients, putting them at the centre of their care,
- enable our passionate staff to provide the best possible services and achieve world class health outcomes,
- utilise data and information in a collaborative way across the trust and with strategic partners.
**Our vision is underpinned by five strategic objectives**

<table>
<thead>
<tr>
<th>Our vision</th>
<th>Why is the vision important?</th>
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<tr>
<td>Our vision for 2020 is to deliver digital services that; empower patients,</td>
<td>To deliver the <strong>infrastructure that enables seamless care for patients</strong> across pathways,</td>
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<td>putting them at the centre of their care, enable our passionate staff to</td>
<td>preventing delays and putting patients at the centre of their care with access to, and</td>
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<td>provide the best possible services and achieve world class health outcomes,</td>
<td>control over their own electronic health records.</td>
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<td>utilise data and information in an collaborative way across the trust and</td>
<td>To enable staff to focus on clinical duties, reducing time spent on paper-based administrative tasks. To optimise data driven decision making through improved information and analytics.</td>
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<td>with strategic partners.</td>
<td>To enable delivery of the Trust’s long term strategy and transformation plans, including facilitating greater integration with system partners as well as recurrent resource savings across the organisation.</td>
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**Strategic objectives to deliver our vision**

- **By 2018, strengthening partnerships, through shared solutions and expertise that enable our staff to deliver high quality care**
- **By 2019, developing our digital infrastructure to ensure it is secure, reliable, responsive and resilient to our business needs.**
- **By 2019, providing trusted information that enables our staff to make information-led decisions regarding the best care they can provide.**
- **By 2020, delivering a fully integrated electronic clinical record where routine processes are digitised enabling staff to focus on clinical duties.**
- **By 2020, delivering joined up digital services that empower patients, puts them at the centre of their care, to help them make informed decisions.**
At the away day the teams identified how the Trust would feel for patients, staff, and IT when the strategic objectives were delivered

Patients will be able to:

- Access a version of their clinical records through an online account
- Use an interactive service to access care through a medium of their choosing
- Be treated and seen without any paper being used to capture or record their medical records

Staff will be able to:

- Make informed decisions and measure the impact of their decisions on the Trust
- Understand the next steps in the patient journey, and anticipate what patients will need next
- Use AI and machine learning to diagnose patients

IT will be able to:

- Respond to and resolve the Trust’s issues 24/7
- Work alongside the divisions through a structure that allows more collaborative working
- Focus on the key projects within the Trust, that will deliver the most value to staff and patients
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Our Digital Roadmap sets out our IT and information transformation to 2020

Delivering a fully integrated electronic clinical record where routine processes are digitised enabling staff to focus on clinical duties.

Developing our digital infrastructure to ensure it is secure, reliable, responsive and resilient to our business needs.

Delivering digital services that empower patients, puts them at the centre of their care, to help them make informed decisions.

Providing trusted information to enable our staff to make information-led decisions ensuring they can provide the best care possible.

Strengthening collaboration and strategic partnerships, sharing solutions, expertise and lessons learned to enable transformation.

* This is a key dependency for the successful delivery of a fully integrated electronic clinical record.
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There are three key enablers to support delivery success:

1. Selecting an **electronic patient record** partner

2. Developing the **right capability and capacity** in IT and information

3. Designing the right **programme and change model** to ensure appropriate control over delivery of the portfolio
There are a range of approaches available to achieve a fully integrated electronic clinical record

- An Electronic Patient Record (EPR) provides a **digital view of clinical information** to coordinate patient care and document the point at which it was delivered.
- An EPR is **typically delivered through departmental or service based modules**.
- When **modules are fully integrated** across a trust or health system, an EPR can provide an enterprise view of the patient. This provides a **full view of a patient**, and their **history of care**, irrespective of the setting in which the care was delivered within the system. These integrated records can then be used to **support operations, finance and reporting in a joined up way**.
- A **fully integrated EPR can be achieved through either; the creation of a bespoke best of breed system**, integrating multiple EPR modules; or through the **implementation of a single supplier integrated solution**.

### Best of breed solution
- Ability to integrate existing trusted and accepted systems.
- Readily supports incremental addition of functions but may take longer to implement.
- Taking an incremental approach leads to a more gradual impact on business.
- Cost savings take longer to be realised but upfront costs tend to be lower.
- Inconsistent design and slower performance in moving from one system to another.

### Single supplier integrated solution
- Necessary to ‘rip and replace’ all existing systems.
- Entirely new system to be learned, meaning a steep learning curve, and re-training of staff.
- Rapid provision of a complete electronic system enabling fast pace of change.
- High upfront costs but benefits are realised more quickly.
- Consistent look and better performance.
KGH’s current EPR is partially integrated, with System C its biggest provider. However, some services remain paper based and do not use an EPR.

- KGH currently has an **EPR across some services**, with **System C as its main supplier**. Other systems are provided by **alternative providers**, and are integrated with System C through a **custom engine**. **Some services still remain paper based**.
- The contract with System C, is due for **renewal in May 2019** although there is an option to extend for 12, 24 or 36 months.

---

**Key**
- Module in use at KGH - provided by System C
- Module in use at KGH - other provider (non System C)
There is now an opportunity to consider what a fully integrated EPR may look like for KGH

The Trust is seeking to implement a fully integrated EPR in line with the 2020 plan. In order to enable this, the additional modules not currently provided through an EPR need to be considered.

Key
- Module in use at KGH - provided by System C
- Module in use at KGH - other provider (non System C)
- Module not in use at KGH – System C and other provider options
When moving from one supplier to another it is typical for a trust to incur a number of transitional costs. These need to be considered carefully as part of any supplier selection decision. Illustrative examples of transition costs for KGH are set out below:

| Impact on pace on change | Full re-procurement will likely take a minimum of four additional months.  
|                          | Implementation of the system will then likely take a further twelve months.  
|                          | Other dependent projects will also likely be delayed, meaning the 2020 roadmap is not deliverable. |
| Implementation costs     | IT implementation costs, with c17 staff needed from IT for: Systems – configuration, testing, IT Infrastructure, IT security, IT Training, information reporting, data quality  
|                          | Clinical implementation costs, with c20 staff needed for: divisional facilitation, UAT, training etc.  
|                          | Management costs, with dedicated procurement, finance and project management support. |
| Data quality costs        | Based on previous implementations, post implementation data quality challenges are common, often resulting in operational challenges and validation programmes, with potential for clinical harm. |
A process to select an EPR partner by February 2019 has been approved by procurement

The below process uses established frameworks and has been approved by procurement:

- **Multi-disciplinary team** (CCIOs, Divisional Directors, finance, operations and information).
- Design and agree **functional and non-functional requirements**.
- Produce **single specification** approved by procurement.
- The trust currently has **limited data and information about suppliers** offers.
- Other organisations have not readily shared their information.
- Accordingly an **RFI process** will seek to collect **written information about the capabilities of various suppliers.**
- **Information responses assessed** against pre-agreed criteria.
- **Independent scoring** prior to **group moderation**.
- Where there is a **clear preferred supplier** move to **direct award**.
- Where the **top two or more suppliers have scores within 10%** of one another move to **mini competition**.
- **Direct award** including query response period and evaluation. Estimated to take 2 months to complete.
- **Mini competition** including query response period, supplier event, evaluation and presentations. Estimated to take 5 months to complete.

*There are two core frameworks which could be used for the procurement process (LPP CDIS or SBS – Healthcare Clinical Information Systems)*
Critical success factors to selecting an EPR partner include:

**Clinical Leadership:**
- It is critical that the process is *clinically led* and *managerially supported*.
- Specifically, *clinicians* should be at the heart of all activities in the process, from *specification design and market testing*, to *evaluation and decision making*.
- Whilst the two CCIOs will lead clinical engagement, a broader range of clinical stakeholders will provide input throughout the process.

**Robust Specification:**
- A clear technical specification sets out *how the future system will function*. It *defines the scope* or *boundaries of the system*, *removes ambiguity* around functionality and *lists assumptions* upon which the design is based.
- It is important to *take the required time to develop a robust specification upfront*, ensuring all other steps and decisions in the process are fed off this.

**Proactive Management:**
- Selecting an *EPR partner* is a prerequisite for many other elements of the digital roadmap to be delivered. Accordingly, there is a need to *proactively manage the process, minimising delays* and delivering to the agreed timeline.
- Specifically, *dedicated programme management and procurement time* will be required to facilitate the process.
At the IT and information away day it was clear that the team needs to develop its transformation capability and capacity alongside its BAU activity.

- At the IT and information August away day the room was split into groups of five. Each group was asked to identify key enablers for success required to deliver the digital roadmap's strategic objectives.

- Every single one of the five groups identified capacity and capability within the IT and Information as a key enabler.

- Other key areas included collaborative working across the Trust, and LHE, allowing greater access to self help, and a clear vision and strategy that the Trust maintains.

<table>
<thead>
<tr>
<th>Number of groups (out of five) that identified each enabler at the IT away day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right capacity and capability to deliver</td>
</tr>
<tr>
<td>Collaborative working (across the Trust and the LHE)</td>
</tr>
<tr>
<td>Enabling through self help (both staff and patients)</td>
</tr>
<tr>
<td>Clear vision and strategy that we stick to</td>
</tr>
<tr>
<td>Wi-Fi (stable and faster)</td>
</tr>
<tr>
<td>Single data warehouse</td>
</tr>
</tbody>
</table>
Initial capacity and capability gaps have been identified across IT and information.

<table>
<thead>
<tr>
<th>Area</th>
<th>Additional Capability and/or Capacity Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IT</strong></td>
<td>• EPR System Support capability and capacity (within IT and across the Trust)</td>
</tr>
<tr>
<td></td>
<td>• Programme/project management, including benefits realisation capability and capacity</td>
</tr>
<tr>
<td></td>
<td>• Supplier and contract management capability and capacity</td>
</tr>
<tr>
<td></td>
<td>• Cyber Security capability and capacity (within IT and across the Trust)</td>
</tr>
<tr>
<td></td>
<td>• Microsoft Windows10 capability</td>
</tr>
<tr>
<td></td>
<td>• Best Practice Service Management (ITIL) capability and capacity</td>
</tr>
<tr>
<td><strong>Information</strong></td>
<td>• Information integration capability and capacity</td>
</tr>
<tr>
<td></td>
<td>• Data analytics and programming capability and capacity</td>
</tr>
<tr>
<td></td>
<td>• Information access administration and training capacity across the organisation</td>
</tr>
<tr>
<td></td>
<td>• Microsoft Office training capacity</td>
</tr>
</tbody>
</table>
Model Hospital demonstrates that there is an opportunity to increase our capacity and capacity through rebalancing pay and non pay costs.

**Pay Costs**

- 25% of Trusts with the lowest values
- Your Trust
- Selected peers
- 25% of Trusts with the highest values

When benchmarked against peers our pay costs are significantly lower than average, and below the median across the country.

**Overall Costs**

However, our non-pay costs are significantly higher than the benchmark, swinging our total costs to higher than the median (for our selected peers). This suggests that there may be a false economy in place.

Historically, we have only had the capacity and capability in place to run and maintain our essential IT and information services, with limited focus on transformation.

We have been unable to focus on effective supplier and contract management.

There is an opportunity to invest in additional capacity and capability (in pay costs) to better manage contracts and transformation (non pay costs).
We are implementing robust governance to manage transformation delivery

The existing Digital Hospital Steering Group will be refreshed, and chaired by the CEO, with NED, CCIO and Divisional Chief membership. The group will provide executive oversight to the programme.

A new Programme Board will allow oversight and management of programmes.

The authority responsible for the final design of solutions, such that clinical practice can use the system to realise the expected benefits.

The group ensures two way engagement and communications are in place, to ensure the vision and design are effectively understood.
Portfolio, programme and project management layers to secure delivery

- A new Digital Roadmap Programme Management Office will manage project implementation, reporting into the Programme Board.
- Each project will be delivered through a combination of IT Delivery and business change expertise.

The PMO will oversee all digital roadmap projects, managing dependencies, risks and issues, escalating to the Programme Board as required. They will be responsible for delivering outcomes that realise agreed benefits.

Each project will be delivered through a combination of IT and business (operations and clinical staff) expertise. Projects will be responsible for delivery of agreed outputs within set cost and time parameters set across the programme.

*Four projects are included for illustrative purposes. It is expected that more projects will concurrently be operating across the programme.
<table>
<thead>
<tr>
<th>#</th>
<th>Item</th>
<th>Slide</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Situation and background</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Assessment</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Our digital vision and strategic objectives</td>
<td>12</td>
</tr>
<tr>
<td>2.2</td>
<td>Our Digital Roadmap and the IT transformation portfolio</td>
<td>17</td>
</tr>
<tr>
<td>2.3</td>
<td>Enablers to support delivery success</td>
<td>19</td>
</tr>
<tr>
<td>3</td>
<td>Recommendation and next steps</td>
<td>32</td>
</tr>
</tbody>
</table>
Digital roadmap programme programme definition phase

Objectives of the phase

- **To scope and define each component project** within the programme
- **To map dependencies** across the projects, setting out an **overall delivery plan to 2020**
- **To set out the costs and benefits of the programme**, accounting for both capital and recurrent values (financial and otherwise)
- **To define the capacity and capability requirements** to support delivery of the programme

Approach and timeline

<table>
<thead>
<tr>
<th>WK 1</th>
<th>WK 2</th>
<th>WK 3</th>
<th>WK 4</th>
<th>WK 5</th>
<th>WK 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Weekly Steering Group</td>
<td>Weekly Steering Group</td>
<td>Weekly Steering Group</td>
<td>Weekly Steering Group</td>
<td>Weekly Steering Group</td>
</tr>
<tr>
<td>Programme definition</td>
<td>Design Programme Structure</td>
<td>Define Programme Approach to RAIDS, Benefits &amp; Dependencies</td>
<td>Design Governance and Reporting</td>
<td>Define Programme Plan and Costing</td>
<td>Create PID</td>
</tr>
<tr>
<td>Project definition</td>
<td>Create Catalogue for Existing Projects</td>
<td>Create Catalogue for New Projects</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Integrated Governance Report

Date: 28 September 2018

Reporting Period: August 2018
## Executive Summary

<table>
<thead>
<tr>
<th>Overall Trust performance summary provided by the Chief Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To provide high quality care to individuals, communities and the population we serve – Quality</strong></td>
</tr>
<tr>
<td>- Metrics aligned to Quality Strategy Pledges</td>
</tr>
<tr>
<td>- Improved/sustained performance in a number of key quality metrics with the Trust continuing to report no cases of MRSA bacteraemia</td>
</tr>
<tr>
<td>- Challenges with performance in Clostridium Difficile, Complaints management and response times to the completion of serious incident reports; the latter due to complexity in nature of the cases and joint investigations with other Trusts. Education, training and support in place and a review of complaints to be commissioned</td>
</tr>
<tr>
<td>- Concerns remain regarding patients with challenging behaviours and reports of violence against staff. A summit with countywide partners is arranged for 15 October</td>
</tr>
<tr>
<td><strong>To be a strong and effective partner in the wider health and social care community – Operations</strong></td>
</tr>
<tr>
<td>- Performance has been stronger this month across all metrics excluding Referral to Treatment (RTT) standards. RTT performance is impacting upon strategic, operational and financial objectives for the Trust. Divisions are implementing action plans to improve RTT performance and treat patients in a timely manner.</td>
</tr>
<tr>
<td>- KGH is working with health system partners to implement UEC system priorities including intermediate care and NASS pathway changes, this will support winter planning for the Trust.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To maintain a fulfilling and developmental working environment for our staff – Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The Trust vacancy rate is escalating given the challenges to recruit based on national shortages and additional posts added to establishment, whilst the risk is mitigated by the use of temporary staff this is having an impact on our financial position</td>
</tr>
<tr>
<td>- The Trust Mandatory and Statutory training reporting has changed to incorporate additional subjects, whilst compliance is meeting the target overall some subjects and staff groups remain a concern with additional initiatives in place to address this in line with the Trust Quality Improvement Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To be a clinical and financially sustainable organisation – Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The key challenge YTD is the medical pay overspends totalling £2.0m which is driving the YTD deficit of £1.7m. In addition the Medical income shortfall (A&amp;E £0.1m and ACU £0.5m) is a concern driven by inaccurate coding in A&amp;E and reduced activity in Ambulatory Care. These risks and others will have the following impact on the Trust outturn position and require a specific set of mitigations.</td>
</tr>
<tr>
<td>- £3.9m medical pay</td>
</tr>
<tr>
<td>- £1.5m A&amp;E and ACU activity</td>
</tr>
<tr>
<td>- £1.3m Cost of KGH at Home</td>
</tr>
<tr>
<td>- £0.1m system support</td>
</tr>
</tbody>
</table>
To provide high quality care to individuals, communities and the population we serve – Quality

Quality dashboard

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Month</th>
<th>Trajectory</th>
<th>Actual</th>
<th>Trajectory</th>
<th>Actual</th>
<th>Trajectory</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac arrests outside of A&amp;E / Cath Lab per 1,000 bed days</td>
<td>&lt; 0.69</td>
<td>Aug-18</td>
<td>&lt; 0.69</td>
<td>0.58</td>
<td>&lt; 0.69</td>
<td>0.53</td>
<td>&lt; 0.69</td>
<td>0.5</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>&lt; 2</td>
<td>Aug-18</td>
<td>3</td>
<td>&lt; 6</td>
<td>8</td>
<td>&lt; 10</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Complaints acknowledged within the regulated 3 days</td>
<td>100%</td>
<td>Aug-18</td>
<td>87%</td>
<td>100%</td>
<td>77%</td>
<td>100%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Complaints response performance (working days)</td>
<td>&lt;= 35</td>
<td>Aug-18</td>
<td>98</td>
<td>&lt;= 35</td>
<td>92</td>
<td>&lt;= 35</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>Dementia Screening</td>
<td>&gt; 90%</td>
<td>Aug-18</td>
<td>&gt; 90%</td>
<td>&gt; 90%</td>
<td>&gt; 90%</td>
<td>&gt; 90%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Falls with moderate harm and above per 1,000 bed days</td>
<td>&lt; 0.18</td>
<td>Aug-18</td>
<td>0.17</td>
<td>&lt; 0.18</td>
<td>0.145</td>
<td>&lt; 0.18</td>
<td>0.14</td>
<td></td>
</tr>
<tr>
<td>Friends and Family Test - Inpatients recommending</td>
<td>&gt;=95%</td>
<td>Aug-18</td>
<td>97%</td>
<td>&gt;=95%</td>
<td>97%</td>
<td>&gt;=95%</td>
<td>97%</td>
<td></td>
</tr>
<tr>
<td>Hand hygiene - standard compliance</td>
<td>&gt;=95%</td>
<td>Aug-18</td>
<td>99%</td>
<td>&gt;=95%</td>
<td>99%</td>
<td>&gt;=95%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>Mortality rate (HSMR) relative risk rating</td>
<td>100</td>
<td>06/17 - 05/18</td>
<td>100</td>
<td>106.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA</td>
<td>Nil</td>
<td>Aug-18</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Never Events reported in month</td>
<td>Nil</td>
<td>Aug-18</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Pressure Tissue Damage Grade 3 avoidable 1,500 bed days 1 month retrospectively</td>
<td>&lt; 0.06</td>
<td>Jul-18</td>
<td>&lt; 0.06</td>
<td>0</td>
<td>&lt; 0.06</td>
<td>0</td>
<td>&lt; 0.06</td>
<td>0.05</td>
</tr>
<tr>
<td>Serious Incidents externally reported</td>
<td>Nil</td>
<td>Aug-18</td>
<td>2</td>
<td>4</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious Incidents signed off and submitted within timescale</td>
<td>&gt; 95%</td>
<td>Aug-18</td>
<td>Not applicable</td>
<td>&gt; 95%</td>
<td>0%</td>
<td>&gt; 95%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>SHMI rate</td>
<td>100</td>
<td>01/17 - 12/17</td>
<td>100</td>
<td>110.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Exception reporting

- Work is ongoing to support timely and effective complaints resolution, particularly for complex complaints investigation and response. The reporting of ‘average’ response timescales is impacted by some complex complaints within divisions. Resources to manage complaints are under review and a recovery plan commenced, including commissioning an external review of the complaints pathway.
- Inpatients FFT recommendations remain consistently high, however with low rates of returns. Electronic devices are being installed across the Trust to replace paper systems.
- C.Diff toxin cases continue to be variable throughout the year to date. The IPaC team continue to monitor and work with staff on the ward to improve practice.

Comparator information

- Compared with other similar and local Trusts inpatients FFT recommendations remain consistently high, above three out of four comparable Trusts and higher than the England average.
- However, rates of returns are lower than three of the four comparator Trusts and below the national average.
## Major decisions log – to note

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Description and summary discussion</th>
<th>Decision</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Management of patients with challenging behaviours.</td>
<td>A clear process for managing patients with extremely challenging behaviour is required, including joint working with other organisations.</td>
<td>October 2018</td>
</tr>
<tr>
<td>2</td>
<td>Following the implementation of a new 35 day standard for dealing with complaints, a number of issues resulting in delays have been identified within the complaints process. A review is about to undertaken.</td>
<td>Until resolved this will pose a reputational risk to the Trust.</td>
<td>End of November 2018</td>
</tr>
<tr>
<td>3</td>
<td>NHSI have issued revised guidance concerning the reporting of pressure ulcers. The significant changes will require a major education programme within the Trust and will result in new reporting data sets.</td>
<td>The challenges to implementation by end of December 2018 are identified as a major challenge.</td>
<td>December 2018</td>
</tr>
<tr>
<td>4.</td>
<td>The changes in Northamptonshire County Council with the development of two unitary authorities may have a significant impact on the Trust as their policies and procedures may not be aligned.</td>
<td>To ensure that changes within NCC are monitored with regard to any impact on safeguarding in the Trust.</td>
<td>December 2018</td>
</tr>
</tbody>
</table>
### Operational dashboard

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Month</th>
<th>Current month Trajectory</th>
<th>Actual</th>
<th>Current Quarter Trajectory</th>
<th>Actual</th>
<th>Year to date Trajectory</th>
<th>Actual</th>
<th>Trend since April 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum waiting time of 4 hours in A&amp;E from arrival to admission, transfer or discharge (Trust level performance against plan)</td>
<td>95%</td>
<td>Aug-18</td>
<td>85.5%</td>
<td>89.3%</td>
<td>85.9%</td>
<td>83.4%</td>
<td>86.3%</td>
<td>84.0%</td>
<td>➢</td>
</tr>
<tr>
<td>Maximum waiting time of 4 hours in A&amp;E from arrival to admission, transfer or discharge (Acute Footprint area) PSF target 90%</td>
<td>90%</td>
<td>Aug-18</td>
<td>93.9%</td>
<td>90.6%</td>
<td>90.6%</td>
<td>91.1%</td>
<td>➢</td>
<td></td>
<td>➢</td>
</tr>
<tr>
<td>RTT waiting times - Non admitted within 18 weeks</td>
<td>95%</td>
<td>Aug-18</td>
<td>80.2%</td>
<td>80.5%</td>
<td>78.9%</td>
<td></td>
<td>➢</td>
<td></td>
<td>➢</td>
</tr>
<tr>
<td>RTT waiting times - admitted within 18 weeks</td>
<td>90%</td>
<td>Aug-18</td>
<td>64.1%</td>
<td>65.0%</td>
<td>60.7%</td>
<td></td>
<td>➢</td>
<td></td>
<td>➢</td>
</tr>
<tr>
<td>RTT waiting times - Incomplete within 18 weeks</td>
<td>92%</td>
<td>Aug-18</td>
<td>83.8%</td>
<td>79.0%</td>
<td>➢</td>
<td></td>
<td>➢</td>
<td></td>
<td>➢</td>
</tr>
<tr>
<td>2 week from urgent GP referral to 1st OPA</td>
<td>93%</td>
<td>Aug-18</td>
<td>93%</td>
<td>97.3%</td>
<td>93%</td>
<td>96.1%</td>
<td>93%</td>
<td>95.7%</td>
<td>➢</td>
</tr>
<tr>
<td>2 week from referral to date first seen - symptomatic breast patients</td>
<td>93%</td>
<td>Aug-18</td>
<td>93%</td>
<td>100.0%</td>
<td>93%</td>
<td>97.8%</td>
<td>93%</td>
<td>98.7%</td>
<td>➢</td>
</tr>
<tr>
<td>31 day for second or subsequent treatment - surgery</td>
<td>94%</td>
<td>Aug-18</td>
<td>94%</td>
<td>100.0%</td>
<td>94%</td>
<td>100.0%</td>
<td>94%</td>
<td>100.0%</td>
<td>➢</td>
</tr>
<tr>
<td>31 day for second or subsequent treatment - anti cancer drug treatments</td>
<td>98%</td>
<td>Aug-18</td>
<td>98%</td>
<td>100.0%</td>
<td>98%</td>
<td>100.0%</td>
<td>98%</td>
<td>100.0%</td>
<td>➢</td>
</tr>
<tr>
<td>31 days from diagnosis to treatment for all cancers</td>
<td>96%</td>
<td>Aug-18</td>
<td>96%</td>
<td>97.1%</td>
<td>96%</td>
<td>97.9%</td>
<td>96%</td>
<td>98.4%</td>
<td>➢</td>
</tr>
<tr>
<td>62 day for first treatment from urgent GP referral to treatment: all cancers</td>
<td>85%</td>
<td>Aug-18</td>
<td>85%</td>
<td>85.1%</td>
<td>85%</td>
<td>88.2%</td>
<td>85%</td>
<td>84.2%</td>
<td>➢</td>
</tr>
<tr>
<td>62 day for first treatment from consultant screening service referral: all cancers</td>
<td>90%</td>
<td>Aug-18</td>
<td>90%</td>
<td>100.0%</td>
<td>90%</td>
<td>100.0%</td>
<td>90%</td>
<td>96.6%</td>
<td>➢</td>
</tr>
<tr>
<td>Diagnostic waiting times, % of patients not seen w ithin 6 weeks of referral</td>
<td>1%</td>
<td>Aug-18</td>
<td>1%</td>
<td>0.6%</td>
<td>1%</td>
<td>0.7%</td>
<td>1%</td>
<td>0.8%</td>
<td>➢</td>
</tr>
<tr>
<td>% of elective activity cancelled by the hospital on or before the day of admission</td>
<td>0.8%</td>
<td>Aug-18</td>
<td>0.8%</td>
<td>0.6%</td>
<td>0.8%</td>
<td>0.4%</td>
<td>0.8%</td>
<td>0.4%</td>
<td>➢</td>
</tr>
<tr>
<td>3.5% Delayed Transfers of Care, % of the Trusts beds occupied by patients who's care should be being managed else where</td>
<td>3.5%</td>
<td>Aug-18</td>
<td>3.5%</td>
<td>5.9%</td>
<td>3.5%</td>
<td>6.3%</td>
<td>3.5%</td>
<td>5.6%</td>
<td>➢</td>
</tr>
<tr>
<td>Stranded patients, average patients in hospital w ith a length of stay of 7 days +</td>
<td>328</td>
<td>Aug-18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>➢</td>
</tr>
<tr>
<td>Long Stay patients, average patients in hospital w ith a length of stay of 21 days +</td>
<td>167</td>
<td>Aug-18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>➢</td>
</tr>
<tr>
<td>Ambulance handovers in excess of 1 hour (Black Breaches)</td>
<td>Nil</td>
<td>Aug-18</td>
<td>9</td>
<td>94</td>
<td>285</td>
<td></td>
<td></td>
<td></td>
<td>➢</td>
</tr>
</tbody>
</table>
Comparator information

- Compared nationally A&E performance at KGH is both below target and marginally below the national average for August.
- Cancer performance is amongst the best nationally, exceeding both the national average and target.
- RTT performance remains a challenge, with KGH amongst the poorest performers nationally; below both target and national average.

Exception reporting

- The Trust has seen an improvement in its performance against the A&E waiting time standard for the month of August, over achieving against its planned trajectory. This has been achieved through focus on super stranded patient reduction including implementation of long stay Wednesday. Increased and more consistent levels of discharges from medical wards and reducing outlier. This has supported a reduction in bed occupancy from 100.3% in July to 96.1% in August allowing more consistent flow from A&E and reducing A&E 4 hour breaches.
- The Trust continues to maintain its delivery of the cancer waiting times standards and anticipates delivering these going forward in Quarter 2.
- 18 week referral to treatment (RTT), ambulance hand over and delayed transfer of care standards continues to be the areas where the Trust is most challenged, plans however are in place to address each of this including:
  - Additional internal capacity to reduce RTT waiting list volumes and times.
  - Working with EMAS to improve hand over times and
  - Health system plans to reduce the level of patients that no longer need to be in a hospital beds (delayed transfers of care)
## Major decisions log – to note

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Description and summary discussion</th>
<th>Decision</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Annual Report of the Major Incident Group. Externally validated by NHSE with positive outcome.</td>
<td>Unanimous Approval</td>
<td>Calendar Q2.2019</td>
</tr>
</tbody>
</table>

## Items for Boards attention

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Description and summary discussion</th>
<th>Rationale for Board attention</th>
<th>Expected Committee Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4.1 Operational Performance Summary Report. A&amp;E Performance – sustainability and consequent ability to achieve performance improvement trajectory in coming months.</td>
<td>Committee unable to achieve assurance that internal and system improvement initiatives once agreed/implemented will achieve trajectory and a sustainable EC service through Winter.</td>
<td>October 2018</td>
</tr>
<tr>
<td>2</td>
<td>4.1 Operational Performance Summary Report. RTT Performance – gap between actual and trajectory performance is widening with performance stalled at &lt;80%.</td>
<td>Performance improvement progress has stalled and Committee unable to achieve assurance that performance improvement to achieve trajectory will be delivered.</td>
<td>October 2018</td>
</tr>
<tr>
<td>3</td>
<td>4.1 Operational Performance Summary Report. Radiology Performance and Recovery.</td>
<td>Congratulations to the team: - cleared the significant historical PF reporting backlog - re-established a clear balance between demand and supply capacity to prevent re-occurrence</td>
<td></td>
</tr>
</tbody>
</table>
To be a clinical and financially sustainable organisation – Finance

### Finance dashboard

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Status</th>
<th>Trust</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normalised Net Surplus / (Deficit)</td>
<td>Net income and expenditure</td>
<td></td>
<td></td>
<td>The deficit in-month is £2.8m, year to date performance is £1.7m adverse variance to plan. The key drivers are overspends in medical pay partially offset by reduction in depreciation due to a review of asset life.</td>
</tr>
<tr>
<td>Agency Spend</td>
<td>Agency spend against plan</td>
<td></td>
<td></td>
<td>Agency spend is £0.2m overspent in month.</td>
</tr>
<tr>
<td>QIPP Saving</td>
<td>Savings against the QIPP Savings plan. This includes both cost and income generation schemes</td>
<td></td>
<td></td>
<td>CIP delivery in month is £0.6m under plan due to KPMG review of asset life resulting in a reduction in depreciation.</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>Cumulative expenditure against the capital plan</td>
<td></td>
<td></td>
<td>Total expenditure in August is an underspend of £0.5m against the Trusts revised capital plan. The Trust is forecasting a £14.3m capital spend programme.</td>
</tr>
<tr>
<td>Cash</td>
<td>Cash held</td>
<td></td>
<td></td>
<td>The cash position is £4.3m versus a plan of £1.2m.</td>
</tr>
</tbody>
</table>
### Exception reporting

- The key challenge YTD is the medical pay overspends totalling £2.0m which is driving the YTD deficit of £1.7m. In addition the Medical income shortfall (A&E £0.1m and ACU £0.5m) is a concern driven by inaccurate coding in A&E and reduced activity in Ambulatory Care. These risks and others will have the following impact on the Trust outturn position and require a specific set of mitigations.
  - £3.9m medical pay
  - £1.5m A&E and ACU activity
  - £1.3m Cost of KGH at Home
  - £0.1m system support

- These risks will be mitigated by the following actions that will form part of the in year financial delivery plan with tracked actions and Executive level reporting:
  - CIP Stretch £1.8m
  - Income opportunities £1.7m
  - WLI's £0.5m
  - Contingency release £2.3m (winter and planning contingencies)
  - 20 bed reduction at Claremont £0.5m
  - Medical Pay £TBC

- These actions will ensure delivery of Q2 and Q3 position but still leave the remaining £9.6m planning gap that the Trust is working with system partners to bridge. The discussions at present have the potential to realise £3.3m for KGH to support its financial position.

- Key achievements:
  - Reassessment of fixed asset life resulting in £0.9m benefit year to date.
  - Continued over performance in Orthopaedic activity £1m YTD
  - Over-performance against CIP plans YTD £0.4m

### Comparator information

N/A
## Performance Finance & Resources Committee: Finance Report to Board

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Description and summary discussion</th>
<th>Decision</th>
<th>Expected Committee Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Replacement Cath Labs Business Case</td>
<td>The PF&amp; R Committee APPROVED the business case.</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>LIMS Business Case (1 NED declared interest and withdrew from discussion and approval vote)</td>
<td>The PF&amp;R Committee APPROVED the business case.</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>7.2 IT Strategy Refresh – Digital Roadmap Excellent summary of direction and priorities for the Trust’s digital development journey. This is the starting position for more detailed work to generate the strategy plan based on resource commitment (£s and expertise/skills) and outcomes delivery plan.</td>
<td>Unanimous Approval</td>
<td>Nov. 2018 PF&amp;R</td>
</tr>
</tbody>
</table>

### Items for the Boards attention

<table>
<thead>
<tr>
<th>Agenda Item</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8.1 Delivering the 18/19 Finance Plan Detailed plan for delivery of the Trust’s Finance Plan for 2018/19 has been developed and is being implemented.</td>
<td>The Committee perceived the recovery plan to contain significant risk to delivery, even though elements of contributory performance (eg, CIPs) are performing well. PF&amp;R need to see and review progress of the recovery initiatives to be assured of delivery to mitigate the risk.</td>
<td>October 2018</td>
</tr>
<tr>
<td>2</td>
<td>7.3 IT Disaster Recovery Update. Number of areas of capability remain to be scheduled for failure/failover testing. Power supply arrangements for secondary/failover data centre need to be confirmed/established.</td>
<td>Further risk mitigation required</td>
<td>TBA – Activity Plan to be confirmed</td>
</tr>
<tr>
<td></td>
<td>7.2 Critical Board decision in Q1.2019 on EPR system as the foundation underpinning the Trust’s digital roadmap for the next 5 to 10 years. Both “stay” and “change” decisions will have significant +ve and -ve implications, also decision impacts many other key system/change developments.</td>
<td>Schedule preparation for the decision into Board agenda early in Q1. Active NED engagement in the process to aid assurance confidence.</td>
<td>January 2019</td>
</tr>
</tbody>
</table>
To maintain a fulfilling and developmental working environment for our staff – Workforce

Workforce dashboard

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Month</th>
<th>Current month Trajectory</th>
<th>Current Quarter Trajectory</th>
<th>Year to date Trajectory</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacancy</td>
<td>7%</td>
<td>Aug-18</td>
<td>14.72%</td>
<td>13.75%</td>
<td>13.45%</td>
<td></td>
</tr>
<tr>
<td>Turnover</td>
<td>11%</td>
<td>Aug-18</td>
<td>11.15%</td>
<td>10.05%</td>
<td>11.18%</td>
<td></td>
</tr>
<tr>
<td>Sickness Absence</td>
<td>4%</td>
<td>Aug-18</td>
<td>4.31%</td>
<td>4.43%</td>
<td>4.25%</td>
<td></td>
</tr>
<tr>
<td>Appraisals</td>
<td>85%</td>
<td>Aug-18</td>
<td>79.3%</td>
<td>77.6%</td>
<td>80.5%</td>
<td></td>
</tr>
<tr>
<td>Statutory and Mandatory Training</td>
<td>85%</td>
<td>Aug-18</td>
<td>85.0%</td>
<td>84.5%</td>
<td>88.3%</td>
<td></td>
</tr>
<tr>
<td>Safe Staffing Matrix - Nursing and Care staff (Day)</td>
<td>100%</td>
<td>Aug-18</td>
<td>91.2%</td>
<td>91.6%</td>
<td>92.2%</td>
<td></td>
</tr>
<tr>
<td>Safe Staffing Matrix - Nursing and Care staff (Night)</td>
<td>100%</td>
<td>Aug-18</td>
<td>100.0%</td>
<td>100.2%</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>
Exception reporting

Vacancy (%) increased from 12.78% (M4) to 14.72% (M5) against our 7% target; the Trust had more leavers in Mth 5 than starters (net 10 wte) and an increase of 75 wte in budgeted establishment. This increase of posts is not vacant posts but additional pay cost within the Medicine Division, which will be removed in Month 6 therefore the underlying vacancy rate position is 13.1%. The recruitment team are currently processing 243.77 offers, 191.57 adverts, and with a further 35.01 posts being prepared for advert. The total activity figure is therefore 470.35, this is less than the 602.88 (minus 75wte) budgeted vacancies, however there are a number of larger recruitment campaigns being undertaken including an open day on the 15th September 2018. There are also plans being put into place with regards to education and development of our trainee Nursing Associate and Assistant Practitioner roles.

Sickness (%) has increased to 4.31% as a result of increased long term sickness absence. The Trust has engaged in a staff health and wellbeing programme of improvement with NHSi whereby a Health and Wellbeing Plan has been developed and submitted, with actions being progressed to support our staff including the new Employee Assistance programme which was launched in August.

Turnover (%) is at 11.15%. The appraisal position is 79.3% an improvement from the decline in Mth 4. Following the agreement of the national pay award the Trust review of the appraisal policy and process has commenced. Statutory & Mandatory Training (%) is at 85% with specific departments and staff groups receiving additional focus via actions in the Trust Quality Improvement Plan.

Comparator information

N/A
### Organisational Development Committee
**Report to Board**

**Date of meeting:** 19th September 2018

#### Major decisions log

<table>
<thead>
<tr>
<th>Agenda Item</th>
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<th>Decision</th>
<th>Expected Committee Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The Trust Workforce Race Equality Standard information was present to the committee</td>
<td>The committee approved the document on behalf of the Board. The document will now be placed on the Trust website</td>
<td>September 2019</td>
</tr>
</tbody>
</table>

#### Items escalated for Board discussion/ decision making

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Description and summary discussion</th>
<th>Reason for escalation</th>
<th>Expected Committee Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The committee reviewed the Trust safe staffing position and were concerned with regards to the support and number of additional staff required to care for patients whereby an Acute Hospital setting was not the most appropriate place for patients for different care needs</td>
<td>The committee are raising this issue to bring to the Boards attention the high number of patients with challenging behaviours the Trust provides care for. The Director of Nursing is holding a summit to discuss this issue further with system partners on the 15th October.</td>
<td>The next report to the committee will be on the 22nd November 2018</td>
</tr>
<tr>
<td>2</td>
<td>The committee received a paper with regards to Statutory and Mandatory training within the Trust, including the new reporting arrangements. Whilst some areas and staff groups remain a challenge there is a clear grip on this issue.</td>
<td>The committee are raising this item to the Board given the assurance received with regards to the Statutory and Mandatory training position, particularly given the previous challenges in this area</td>
<td>The next report to the committee will be on the 22nd November 2018</td>
</tr>
</tbody>
</table>
Executive Summary

S  The Quality Improvement Plan (QIP) sets out the actions being taken to deliver quality improvements and tracks the progress in delivery of these. To date, the focus has been on the Must Do actions that the CQC identified in the 2017 inspection. There has been significant progress made, with the latest reporting showing that 51% (49 out of 97) of actions are now either signed off or complete (and pending sign off) and that delivery is on track with our planned trajectory.

There are two component issues identified as ‘off track’:
- Compliance with DNACPR forms and Mental Capacity Assessments
- Scheduling of the Outpatients estates work

These component actions are being actively tracked through the QIP governance and recovery plans are in place or are being implemented.

B  The QIP PMO tracks resolution of Must Do and Should Do actions, embed a culture of continuous improvement, and establish the approach to collection of evidence to support assertions of improvement. The QIP was refreshed using the SBAR structure, and root causes and component issues identified. Divisional QIP Task Force meetings have been established to ensure appropriate ownership of issue resolution, including Executive sponsors. The focus of these to date has been primarily on the Must Do actions identified by the CQC in the 2017 inspection. Given the good progress made against these, the focus has now broadened to the Should Do actions.

To ensure sustainable improvement a number of Quality Assurance Visits and Audits are being undertaken. These are the route through which the Board of Directors is given assurance that the progress that is being reported through the QIP is evident throughout the Trust. These are supplemented by regular interaction with regulators (CQC and NHS Improvement) and the establishment of the Shared Learning Group. This is provided an opportunity to discuss best practice collectively across the Divisions as well as look at areas of challenge across the Trust.

A  Good progress is being made towards completing and signing off the actions identified in the QIP. At the end of cycle 6, only 17 actions are identified as having ‘some issues’ and two are off track (detailed above). The trajectory indicates that there are a relatively large number of actions due to complete by the end of September. In addition to the actions that are due to complete imminently, there are also some that will be tracked over a longer timeframe:
- Actions that involve major estates works
- Actions where actions have been implemented but the impact has not been as expected
- Trust-wide challenges.

The QIP PMO will continue to provide additional support to the corporate teams to identify actions and evidence required to address the outstanding component issues. Over the coming weeks a review of the progress in each Division and the effectiveness of the current Divisional QIP Task Force reporting process will be undertaken. This is in the context of the good progress made.

Immediate next steps and areas of focus are:
- Evidence collection, including obtaining evidence from corporate teams, quality control and preparation for the Provider Information Request;
- Sharing best practice, including the Quality Improvement Shared Learning Group and support to CQC and NHSI relationship meetings; and
- Transitioning improvement from ‘extraordinary’ to business as usual, including assurance of ongoing monitoring mechanisms.

The Board is recommended to note the contents of this report and the progress made in the respect of completing and signing off the actions within the QIP. The Board is asked to continue its sponsorship of the programme SRO and approach to quality improvement. The Board is further recommended to continue engagement with Quality Assurance Visits to assess whether the improvements are evident throughout the Trust.

**Reason for Consideration**
To update the Board of Directors on progress with the Quality Improvement Plan, and to ask the Board to champion the Trust’s ongoing quality improvement journey.

**Paper Previous Consideration**
- EGM 18 September

**Strategic Objectives**
To provide high quality care to the patients and communities that we serve.

**Financial Implications**
Failing to deliver improved care and systems could result in increased claims and/or penalties.

**Risks**
Recorded where relevant in Divisional Risk Registers and BAF.

**Equality impact**
An equality impact assessment has not been undertaken for the quality improvement plan. Within each service area EI is assessed for policies.
The Quality Improvement Plan (QIP) sets out the actions being taken to deliver quality improvements and tracks the progress in delivery of these. To date, the focus has been on the Must Do actions that the Care Quality Commission (CQC) identified in the 2017 inspection.

Since the previous update to the Board on the QIP (June 2018), there has been significant progress made. QIP reporting shows that 51% (49 out of 97) of actions are now either signed off or complete (and pending sign off). Following support to Divisions to accelerate progress, the latest reporting cycle also shows progress is on track against the planned trajectory, shown in the chart below. Note that this relates to identified component actions as opposed to Must Do actions (there is a further explanation of this in the Background section).

The Should Do actions are now also being tracked through the QIP. These have been incorporated into reporting for all Divisions in the latest reporting cycle.

There have now been six complete reporting cycles for QIP. Each cycle showing good progress with both completion of actions and sign off of evidence since the previous cycle. The progress through the reporting cycles is shown in the chart below, and the table below sets out the dates of the reporting cycles.
Note: The reporting methodology changed following Cycle 1, therefore this data is not directly comparable

The above chart shows the continual progress of Must Do actions since the start of cycle 1 in June 2018.

There has also been a noticeable shift in attitudes and behaviours towards quality improvement, with many staff taking a more active role in improvements for their service.

There are two component issues identified as ‘off track’:
- Compliance with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and Mental Capacity Assessments
- Scheduling of the Outpatients estates work

These component actions are being actively tracked through the QIP governance and recovery plans are in place or are being developed (i.e. the Outpatients estates work is being tracked through capital projects). Where required, these are subject to internal escalation.

Background

Since the last Board update on QIP (June 2018) substantial work has been completed to refresh the approach towards improvement. The QIP Programme Management Office (PMO) tracks resolution of actions identified as Must Do and Should Do actions, embed a culture of continuous improvement, and establish the approach to collection of evidence to support assertions of improvement.

Additional capacity has been secured to enable:
- The provision of support to Divisions to implement improvements (for example supporting a service to project manage iterative and tactical changes).
- An increased level of assurance (for example through the establishment of divisional Task Forces, detailed below).
- The coordination of different improvement initiatives (for example the outputs from the Patient-Led Assessments of the Care Environment (PLACE) audits and their inclusion in the QIP).

This approach has been underpinned by a refresh of the QIP using a Situation, Background, Assessment, Recommendation (SBAR) approach. This is clinically-
recognised and enabled the root causes of issues identified for resolution by Divisions and corporate functions. It also identifies the required evidence of improvement. In practice this means that a single Must Do actions identified by the CQC will have multiple root causes identified and in turn a set of component actions to address this.

Divisional QIP Task Force meetings have been established to ensure appropriate ownership of issue resolution, including Executive sponsors. They track the progress towards action completion and are the forum at which actions are ‘signed off’ once the threshold of evidence is reached. Importantly, challenges and blocks to progress are identified and discussed. Divisional QIP Task Force meetings are held on a fortnightly basis and are attended by the Divisional Leadership and Executive Sponsors.

The focus of the QIP and the Divisional QIP Task Force meetings to date has been primarily on the Must Do actions identified by the CQC in the 2017 inspection. Given the good progress made against these, the focus has now broadened to the Should Do actions.

To ensure sustainable improvement Quality Assurance Visits and Audits are being undertaken. These are the route through which the Board of Directors is given assurance that the progress that is being reported through the QIP is evident throughout the Trust. Non-Executive Directors, Governors, Executive Team and external bodies such as the Clinical Commissioning Group (CCG) and HealthWatch are involved in the Quality Visits. This ensures that they are objective and beneficial to the departments. They allow risks or issues to be effectively escalated and provide support with unblocking challenges as required.

There has been ongoing dialogue on improvement with CQC through the regular Relationship Management meetings, and with NHSI through Progress Review Meetings. These meetings provide the Trust and individual services with an opportunity to demonstrate key achievements and areas of improvement throughout the year, rather than just through the formal inspection. These meetings with the regulators have allowed the Divisions to take a step back and reflect on the quality improvement journey they are undertaking.

This has been supplemented internally by the establishment of the Shared Learning Group (SLG). The first meeting was held on 30 August 18 (chaired by the Chief Executive) and provided an opportunity to discuss best practice collectively across the Divisions as well as look at areas of challenge across the Trust.
Good progress is being made towards completing and signing off the actions identified in the QIP. The Trust is currently on track with delivery against the refreshed trajectory for completion of Must Do actions (see chart in Situation section). The trajectory indicates that there are a relatively large number of actions due to complete by the end of September 2018. These actions are being tracked through the QIP PMO and Divisional QIP Task Force meeting process, and where these are identified as having ‘some issues’ or are ‘off track’ then remedial actions and plans are identified. At the end of cycle six, only 17 actions are identified as having ‘some issues’ and two are off track.

In addition to the actions that are due to complete imminently, there are also some that will be tracked over a longer timeframe. These include:

- Actions that involve major estates works: such as proposed changes that will see the Frank Radcliffe Fracture Clinic relocated to increase space in the Emergency Department (ED). Detailed plans have been developed for these schemes and they are being tracked as capital projects.
- Actions which have been implemented but the impact has not been as expected: such as 15 minute observations in ED. Although these have not had the expected impact, alternative approaches have been developed and are being iteratively tested to establish those with the highest impact.
- Trust-wide challenges: such as medical staff training compliance; where a greater level of consultation and testing is being undertaken to establish an effective approach to improvement.

For all of the above actions the QIP PMO will continue to track progress and provide targeted support where required. The QIP PMO will also continue to provide additional support to the corporate teams to identify actions and evidence required to address the outstanding component issues. Any ongoing challenges requiring escalation will be discussed at EGM, and if necessary reported to Quality and Safety Committee.

Over the coming weeks, a review of the progress in each Division, and the effectiveness of the current Divisional QIP Task Force reporting process will be undertaken. Where significant progress has been made with the Must Do and Should Do actions and the documentation evidencing this progress, alternative uses of the meeting will be explored. This may include the QIP PMO working with Divisions to assess the quality of the service against CQC service specifications. This will help to build up a broader picture of the improvements that have been made. It will also allow the service to identify further improvements beyond those identified by CQC in the last inspection. This process will be supported by the ongoing quality assurance visits and audits and the Business As Usual (BAU) monitoring mechanisms that are already in place within the Trust.

Immediate next steps and areas of focus are:

- Evidence collection, including obtaining evidence from corporate teams, quality control and preparation for the Provider Information Request;
- Sharing best practice, including the Quality Improvement Shared Learning Group and support to CQC and NHSI relationship meetings; and
- Transitioning improvement from ‘extraordinary’ to BAU, including assurance of ongoing monitoring mechanisms.
<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Board is recommended to note the contents of this report and the progress made in the respect of completing and signing off the actions within the QIP. The Board is asked to continue its sponsorship of the programme SRO and approach to quality improvement.</td>
</tr>
<tr>
<td>The Board is further recommended to continue engagement with Quality Assurance Visits to assess whether the improvements are evident throughout the Trust.</td>
</tr>
</tbody>
</table>
Quality Improvement Plan Update

Prepared for Board of Directors, 28 September 2018
Following accelerated support the latest reporting cycle shows that we are on track with our planned trajectory, with 51% completed and/or signed off

- To date, the **focus has been on the Must Do actions** that the CQC identified in the 2017 inspection. The Should Do actions are now also being reviewed in the QIP Task Force meetings and have been incorporated into reporting for all Divisions in the latest reporting cycle.

- There have been six complete reporting cycles for QIP, with each cycle showing good progress with both **completion of actions and sign off of evidence** since the previous cycle.

- There has also been a **noticeable shift in attitudes and behaviours towards quality improvement**, with many staff taking a more active role in improvements for their ward / department; reported through the NHSi review of ED and CCG review of maternity.

- The latest QIP dashboard for Cycle 6 (reported to EGM on 17 September) shows 51% (49 out of 97) of Must Do component issues are either complete or signed off.

- It has been confirmed that we will have a **new Lead CQC Inspector** (Jo Naylor-Smith) for the next inspection. The Executive Team have provided Jo with a full briefing on QIP and Well Led.
### Executive Summary

**S** 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 & performance in risk management. The Trust must demonstrate that systems and processes of risk management are effective and that staff at all levels have the skills and knowledge to use them effectively.

**B** The 2017 Well-led Review identified that improvements were required in Risk Management from ward to board. During August 2018 a wholesale review of risk management systems was undertaken, this encompassed:

- refreshing our understanding of the Board Assurance Framework and the Corporate Risk Register, and how these are governed within the Trust
- Refreshing and providing clarity on risk management, risk escalation and assurance flows
- Use of a generic risk register template that is user friendly and identifies assurance as well as controls
- Using the developing Trust Strategy to assess strategic risks to delivery of our strategic and operational objectives
- Ensuring executive ownership of BAF risks

**A** EGM agreed the risk register template for the BAF and CRR in August 2018, enabling:

- Improved description of risks and the consequences;
- Definition of the current controls in place and identification of gaps in controls;
- Description of what assurances exist on controls and identification of gaps in assurances;
- Further planned actions to reduce the level of risk.

The Risk Management Strategy will be updated in order to support:

- A training framework aligned to the Organisational Development Strategy to enable staff to understand, assess and manage risks (including risk registers and the revised format);
- Accountability within Divisions for risk registers;
- Oversight and assurance mechanisms within the governance committee structure for risks linked to specific domains (eg quality, finance, performance)
- ‘Ward to Board’ line of sight of risks and risk escalation route;
- A reviewed Terms of Reference of the Risk Management Steering Group, with a focus on clinical engagement/operational management of risks and how risks are managed and escalated from Ward to Board.
The Board is asked to:
- Approve the BAF and CRR Purpose and Governance definitions
- Approve the ward to board risk flow and escalation framework
- Approve the BAF risks as presented at the annex

**Reason for Consideration**
Under the Well-led domain, to agree a framework for risk management systems and processes.

**Paper Previous Consideration**

**Strategic Objectives**
All

**Financial Implications**
Failing to ensure risk management processes and systems are robust could result in financial loss for the Trust.

**Risks**
The risk to the Trust is that the current risk management processes and systems are not robust and aligned to best practice.

**Equality impact**
None identified.
Meeting | Board of Directors  
---|---  
Agenda Item | 3.3  
Paper Title | Development of Risk Management strategy and Board Assurance Framework (BAF)  
Date | 28 September 2018  
Author | Richard Apps, Director of Integrated Governance  

### Situation

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 & performance in risk management. The Trust must demonstrate that systems and processes of risk management are effective and that staff at all levels have the skills and knowledge to use them effectively.

Evidence of effective risk management can be described as the proactive identification of risk that is reported openly and quickly and where there is ownership of actions at the appropriate level within the organisation.

### Background

During August 2018 a wholesale review of risk management systems was undertaken, this encompassed:

- **Setting out the overarching process for managing risk, to be incorporated into the Risk Management Strategy, including:**
  - Detailing the purpose and the governance of the Board Assurance Framework and the Corporate Risk Register.
  - Providing an overview of the flow of risks from ward to Board, detailing the necessary review points at each stage.
  - Providing guidance on using the risk register template to ensure consistency, including: the description of risk; management of risk; and assurance of risk.

- **Re-developing the Corporate Risk Register and the Board Assurance Framework:**
  - Revising the template to be used for all risk registers to ensure clarity and consistency of use.
  - Reviewing and refining the current risks in the Corporate Risk Register.
  - Grouping current Board Assurance Framework risks to the developing strategic objectives to ensure the risks included are the right risks and to identify potential gaps.
  - Working with executive risk owners to ensure the current risks in the CRR and BAF are the right risks and are recorded accurately.
Assessment

The reframed purpose and governance of the Board Assurance Framework and Corporate Risk Register is set out below

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Board Assurance Framework</strong></td>
<td><strong>Corporate Risk Register</strong></td>
</tr>
<tr>
<td>• The Board Assurance Framework (BAF) brings together in one place all of the relevant information on the risks to the Trust’s <em>strategic</em> objectives. It is an essential tool providing board assurance over the key controls in place that manage the risks to the achievement of strategic objectives.</td>
<td>• The Audit Committee has oversight of the BAF and provides assurance on the robustness of risk processes to the Board. Each Board committee will review and provide assurance on the specific risks relevant to that committee and provide updates on those risks to the Audit Committee. EGM will play a central role through reviewing the BAF prior to committee meetings and highlighting where a specific risk requires review from a committee.</td>
</tr>
<tr>
<td>• The BAF is informed by the Corporate Risk Register and other risk registers, as well as considering further external risks to delivering the Trust’s strategic objectives.</td>
<td>• The BAF is reported at each formal Board for assurance.</td>
</tr>
</tbody>
</table>

The Corporate Risk Register (CRR) brings together all significant risks from across the organisation which impact the delivery of the Trust’s operational activities. It is used to help ensure appropriate action is taken to effectively manage each risk.

- The CRR is informed by Divisional and local risk registers, as well as considering risks across the organisation to the Trust’s operational objectives.

- When the decision is made to escalate a risk to the CRR at a Divisional governance meeting, it is first escalated to the relevant Executive owner to make an assessment on whether it should be included in the CRR. The CRR is reviewed by the Risk Management Steering Group, which monitor and review the risks ensuring that appropriate assessment, management and ownership of risks is taking place in all risk registers up to and including the CRR.

- To provide Board assurance on the Trust’s significant operational risks, as with the BAF, the Audit Committee has oversight of the CRR, with each committee reviewing and providing assurance on specific risks relevant to that committee. EGM will play the central role of reviewing the CRR prior to committee meetings and highlighting where a specific risk requires review from a committee.

The Risk Management Strategy details the governance structure on risk management including risk appetite, the methodology of assessing risks, accountability (individuals, committees and the Board), reporting cycles and assurance mechanisms. The Risk Management Strategy will be further reviewed during October 2018 in order to support:
• A training framework aligned to the Organisational Development Strategy to enable staff to understand, assess and manage risks (including risk registers and the revised format);
• Accountability within Divisions for risk registers;
• Oversight and assurance mechanisms within the governance committee structure for risks linked to specific domains (eg quality, finance, performance)
• ‘Ward to Board’ line of sight of risks and risk escalation route;
• A reviewed Terms of Reference of the Risk Management Steering Group, with a focus on clinical engagement/operational management of risks and how risks are managed and escalated from Ward to Board in line with the updated risk assurance and escalation framework below:

EGM agreed a revised risk register template for the BAF and CRR in August 2018, this was further shared with the Board at the September Board Development session. The revised risk register report enables:

• Improved description of risks and the consequences;
• Definition of the current controls in place and identification of gaps in controls;
• Description of what assurances exist on controls and identification of gaps in assurances;
• Further planned actions to reduce the level of risk.

The BAF was then reviewed, taking into account previous BAF risks alongside alignment of the strategic and operational objectives as at 5 September 2018.
The above template for the BAF and CRR will be utilised for all risk registers. This will support staff to consistently describe and score risks and how to identify what further actions are required.

The BAF itself has been constructed following risk assessments undertaken by the Executive Team informed by the revised strategic objectives:

**Strategic Objectives**

- To provide high quality care to individuals, communities and the population we serve.
- To be a strong and effective partner in the wider health and social care community.
- To maintain a fulfilling and developmental working environment for our staff.
- To be a clinically and financially sustainable organisation.

The refreshed BAF details nine strategic risks informed by consideration of the strategic objectives (Appendix 1).

The BAF will be reviewed by executive risk owners on a monthly basis.

**Recommendation**

The Board is asked to:
- Approve the BAF and CRR Purpose and Governance definitions
- Approve the ward to board risk flow and escalation framework
- Approve the BAF risks as presented at the annex

**Annex Reference**

Board Assurance Framework (BAF)
### Board Assurance Framework
As at 19th September 2018

<table>
<thead>
<tr>
<th>Ref</th>
<th>Summary Description</th>
<th>Current Risk Level (Sept 2018)</th>
<th>Target Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To provide high quality care to individuals, communities and the population we serve</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAF001</td>
<td>The long term strategy is at risk without appropriate alignment to and engagement with clinical staff with the potential impact on the quality of care.</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>BAF002</td>
<td>Reduced patient and staff experience through failure to deliver the quality strategy ambitions.</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>BAF003</td>
<td>Dilution and division of patient care as a result of opening unplanned escalation areas at times of high bed occupancy and activity.</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td><strong>To maintain a fulfilling and developmental working environment for our staff</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAF004</td>
<td>Negative patient experience impact from failure to improve staff morale, staff recruitment and retention.</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>BAF005</td>
<td>Impact on quality of care and safety through failure to have the right people with appropriate training and capacity to deliver services.</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td><strong>To be a strong and effective partner in the wider health and social care community</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAF006</td>
<td>Impact on patient care, experience and length of stay as a result of failure to effectively collaborate with our Acute partners in the Health Care Partnership.</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td><strong>To be a clinically and financially sustainable organisation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAF007</td>
<td>The Trust needs to develop an Estates Development Control Plan (DCP) to compliment the work it is doing on its long term clinical strategy. This would also include immediate priorities for action.</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>BAF008</td>
<td>The financial delivery plan for 2018/19 is at risk if productivity and cost control actions are not implemented. Failure to deliver the plan would impact patient care and constitutional commitments.</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>BAF009</td>
<td>Failure to deliver the digital strategy would impact the quality and effectiveness of clinical care. It would also have consequences on income.</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Risk ID</td>
<td>Description</td>
<td>Current Controls</td>
<td>Gaps in Controls</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>BAF001</td>
<td>The long term strategy is at risk without appropriate alignment to and engagement with clinical staff with the potential impact on the quality of care.</td>
<td>Transformation planning. Recruitment of Chief posts. Involvement of Divisional leadership in executive governance and reporting. Trust strategy and engagement. Improved governance processes and reporting to Quality &amp; Safety Committee (Q&amp;SG)</td>
<td>Establishment of an internal regulatory system.</td>
</tr>
<tr>
<td>BAF003</td>
<td>Dilution and division of patient care as a result of opening unplanned escalation areas at times of high bed occupancy and activity.</td>
<td>Emergency Care Intensive Support Team (ECIST). MADE events. NCC/Commissioner engagement. External consultants/capacity management in place both internal and external. ED Operational Policy. ED escalation policy. Operational escalation policy.</td>
<td>Establishment of 'right size' working model. Continued significant numbers of stranded and super-stranded patients.</td>
</tr>
<tr>
<td>Risk ID</td>
<td>Description</td>
<td>Current Controls</td>
<td>Gaps in Controls</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>BAF005</td>
<td>Impact on quality of care and safety through failure to have the right people with appropriate training and capacity to deliver services.</td>
<td>Organisational Development Strategy. Recruitment campaigns. Skill mixing and staff modelling. Use of temporary workforce. Mandatory &amp; Role specific training. Core competency framework for professional groups. CPD for professional groups.</td>
<td>Uptake of e-learning. Availability of staff to complete training. Preparedness for education commissioning changes.</td>
</tr>
<tr>
<td>BAF006</td>
<td>Impact on patient care, experience and length of stay as a result of failure to effectively collaborate with our Acute partners in the Health Care Partnership. Potential for Clinical teams having unmanageable workloads and failure to manage/discharge stranded and super-stranded patients also impacted by failure to strengthen partnerships/ collaboration via Health and Care Partnership.</td>
<td>Internal capacity and flow management in place. Capacity and Clinical Ops teams in place. Internal and emergency care recovery care plan delivered through transformation and recovery programme. Activity projections informing bed modelling and business planning. MADE events. ECIP Concordat. SAFER and red to green initiatives in place. Long stay Wednesday checking individual patient plans and a focus on stranded and super stranded patients.</td>
<td>Right sizing hospital. For stranded and super-stranded patients - adequate provision for pathways and health and care monitoring. Agreement on future collaborative models with Northampton General Hospital (NGH)</td>
</tr>
<tr>
<td>Risk ID</td>
<td>Description</td>
<td>Current Controls</td>
<td>Gaps in Controls</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>BAF007</td>
<td>The Trust needs to develop an Estates Development Control Plan (DCP) to compliment the work it is doing on its long term clinical strategy. This would also include immediate priorities for action.</td>
<td>Lack of Trust autonomy on capital planning and access to funding. Lack of complete register for medical devices under £5k. Estate Development Control Plan.</td>
<td>3</td>
</tr>
<tr>
<td>BAF009</td>
<td>Failure to deliver the digital strategy would impact the quality and effectiveness of clinical care. It would also have consequences on income.</td>
<td>Capacity to deliver the strategy. Core governance and delivery architecture.</td>
<td>4</td>
</tr>
</tbody>
</table>
### Executive Summary

**S** GMC NTS Outlier (Red and Green Flags) Response for Program groups submitted to HEE

**B** GMC National Training Survey 2018 has provided feedback on Program groups (e.g. F1, F2, CT, ST) and on specialty (e.g. Cardiology, Surgery).

**A** Education Leads have provided feedback on outlier response. Initial meetings have discussed the trainee response in detail. Education lead has agreed to work a team to improve quality of education and training. MEC meeting on 19 March 2018 will hold discussion to formalise action plan for each specialty. Medical Education Department will assess the progress each quarter.

**R** Board to note the progress made.

### Reason for Consideration

KGH is an affiliated teaching hospital aspiring to be an Associated Teaching Hospital. KGH receives over £6.5 million education fund each year. KGH need to ensure an optimal balance between service and training, and to ensure delivery of high quality of training. HEE has continued to show confidence in KGH and has continued to increase the number of trainees especially in Emergency Medicine.

### Paper Previous Consideration

EGM, WDC, MEC- Results of GMC NTS Survey 2018

### Strategic Objectives

To provide high quality care to patients by ensuring high quality training

### Financial Implications

Poor trainee experience can result in withdrawal of trainees with loss of education funds.

### Risks

Loss of educational income, reputation and staff satisfaction, patient safety

### Equality impact

Neutral
<table>
<thead>
<tr>
<th>Meeting</th>
<th>Board of Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>3.4</td>
</tr>
<tr>
<td>Paper Title</td>
<td>GMC Survey Results</td>
</tr>
<tr>
<td>Date</td>
<td>28 September 2018</td>
</tr>
<tr>
<td>Author</td>
<td>Director of Medical Education</td>
</tr>
</tbody>
</table>

**Situation**

GMC NTS Outlier (Red and Green Flags) Response for Program groups submitted to HEE

**Background**

GMC National Training Survey 2018 has provided feedback on Program groups (e.g. F1, F2, CT, ST) and on specialty (e.g. Cardiology, Surgery).

**Assessment**

Education Leads have provided feedback on outlier response. Initial meetings have discussed the trainee response in detail. Education lead has agreed to work a team to improve quality of education and training. MEC meeting on 19 March 2018 held discussion to formalise action plan for each specialty. Medical Education Department will assess the progress each quarter.

**Recommendation**

Board to note the progress made.
GMC 2018 National Trainees and Trainers Survey

Summary:
Each year GMC carries out Trainees and Trainers survey between March and May, the findings are published towards the end of academic year (July), results shared widely and are available freely on GMC website. Patient safety/ bullying/ undermining concerns are shared immediately during the survey and Trust has to submit a response.

Overall, the KGH scores/trends have continued to improve and there is potential for significant further improvement. Closer collaboration between clinical and executive teams at KGH would remain pivotal in enhancing the support for trainers and trainees, enhancing training environment and improving patient safety.

What are the results nationally:
- Over 70,000 trainees and trainers took part in the national training surveys.
- This year, new questions were added to the surveys to help better understand the extent of burnout amongst doctors in training and trainers.

The results are stark, as stated in the GMC initial findings report.

Long and intense working hours, heavy workloads and the challenges of frontline medical practice are affecting doctors’ training experience and their personal wellbeing.
- Nearly a quarter of doctors in training and just over a fifth of trainers told us they’re burnt out because of their work.
- Almost a third of trainees said that they are often or always exhausted at the thought of another shift. And well over a half of trainees, and just under a half of trainers, reported that they often or always feel worn out at the end of their working day.
- A fifth of doctors in training and trainers told us they feel short of sleep when at work.
- Two in five trainees and two thirds of trainers rated the intensity of their work as very heavy or heavy; and nearly half of trainees reported that they work beyond their rostered hours on a daily or weekly basis.
- And around a third of doctors in training and trainers said that training opportunities are lost to rota gaps.

However, the majority of trainees remain satisfied with their overall educational experience; which is testament to the dedication and hard work of those that train them.

GMC Training environments report states that medical training cannot continue to rely on the good will of senior doctors.

GMC Promoting excellence standards state that trainees must be educated in high quality, safe and effective environments, where trainers are also well supported in their roles.
What are the results for KGH?
Of the 18 indicators assessed in the Trainees survey (n>120), we achieved scores within the national average for all except one i.e. Educational Supervision was a negative outlier (indicated in red).

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Satisfaction</td>
<td>73.01</td>
</tr>
<tr>
<td>Clinical Supervision</td>
<td>86.91</td>
</tr>
<tr>
<td>Clinical Supervision out of hours</td>
<td>83.39</td>
</tr>
<tr>
<td>Reporting systems</td>
<td>70.93</td>
</tr>
<tr>
<td>Work Load</td>
<td>47.03</td>
</tr>
<tr>
<td>Teamwork</td>
<td>68.41</td>
</tr>
<tr>
<td>Handover</td>
<td>62.52</td>
</tr>
<tr>
<td>Supportive environment</td>
<td>68.84</td>
</tr>
<tr>
<td>Induction</td>
<td>71.76</td>
</tr>
<tr>
<td>Adequate Experience</td>
<td>76.08</td>
</tr>
<tr>
<td>Curriculum Coverage</td>
<td>73.13</td>
</tr>
<tr>
<td>Educational Governance</td>
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</tr>
<tr>
<td>Educational Supervision</td>
<td>79.15</td>
</tr>
<tr>
<td>Feedback</td>
<td>70.40</td>
</tr>
<tr>
<td>Local Teaching</td>
<td>68.00</td>
</tr>
<tr>
<td>Regional Teaching</td>
<td>72.18</td>
</tr>
<tr>
<td>Study Leave</td>
<td>47.45</td>
</tr>
<tr>
<td>Rota Design</td>
<td>51.00</td>
</tr>
</tbody>
</table>

What are the reason for low ‘Educational Supervision’ scores?
GMC asked 4 questions to assess quality of educational supervision and responses were:
1. In your current post, do you have a training/learning agreement with your educational supervisor which sets out your respective responsibilities? (Yes 80%, No 10%, Don’t know 10%).
   To what extent do you agree or disagree with the following statements?
2. If I had any concerns in this post (personal or educational) I would know who to approach to talk to in confidence. (Strongly agree 33%, agree 58%, Neither agree or disagree 5%, Disagree 4%)
3. My educational supervisor is easily accessible should I need to contact them. (Strongly agree 37%, agree 49%, Neither agree or disagree 9%, Disagree 4%, strongly disagree 1%)
4. The level of contact from my educational supervisor is appropriate for my training needs. (Strongly agree 34%, agree 49%, Neither agree or disagree 11%, Disagree 4%, strongly disagree 2%)

Nearly one-third trainees strongly agreed, half agreed but 10-20% trainees disagreed with these statements. I personally feel we can overcome this by meeting the trainees more frequently (rather than meeting them for mandatory beginning and end of 4-month placement meetings, we should also aim to meet them at the recommended mid placement meeting at 2 months) and enquire if any concern has remained unaddressed. More frequent meetings would particularly benefit those trainees who were struggling to settle or make progress.
How does the overall Trust feedback compare to last 3 years?
In 2015 we had three, in 2016 four, 2017 two and this year we have one negative outlier (denoted in red). Compared to last year, scores have improved in 14 items, declined in 2 items though remaining within national average, and declined significantly in one item to be a negative outlier.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Satisfaction</td>
<td>76.13</td>
<td>79.25</td>
<td>76.00</td>
<td>76.81</td>
<td>75.54</td>
<td>71.43</td>
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<td>Clinical Supervision out of hours</td>
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<td></td>
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<td>Reporting systems</td>
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<td>68.45</td>
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<tr>
<td>Work Load</td>
<td>46.99</td>
<td>42.72</td>
<td>49.43</td>
<td>43.33</td>
<td>36.32</td>
<td>42.64</td>
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<td>Teamwork</td>
<td></td>
<td></td>
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<td>68.05</td>
<td>68.41</td>
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<td></td>
<td>+0.36</td>
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<td>Handover</td>
<td>55.42</td>
<td>62.36</td>
<td>69.53</td>
<td>70.52</td>
<td>68.37</td>
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<td>Supportive environment</td>
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<td></td>
<td></td>
<td>72.70</td>
<td>68.77</td>
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<td>Induction</td>
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<td>Adequate Experience</td>
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<td>79.69</td>
<td>78.68</td>
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<td>76.56</td>
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<td>Curriculum Coverage</td>
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<td>70.67</td>
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<td>68.54</td>
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<td>Local Teaching</td>
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<td>Regional Teaching</td>
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<td>65.99</td>
<td>65.90</td>
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<td>65.82</td>
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</tr>
<tr>
<td>Study Leave</td>
<td>65.06</td>
<td>58.94</td>
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<td>49.23</td>
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<tr>
<td>Rota Design</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>51.00</td>
<td></td>
</tr>
</tbody>
</table>

**Legend for colour coding in GMC Survey**
- **Dark Green**: An above outlier
- **Light Green**: Within the upper Quartile but not an above outlier
- **White**: Average, within the interquartile range
- **Red**: A Below outlier
- **Pink**: Within the lower quartile but not a below outlier
- **Grey**: less than 3 responses
- **Yellow**: no response
**KGH Specialty Posts 2018**

All trainee grades (Foundation, Core and Specialist Trainees) within each specialty gave feedback. Analysis of data in rows provides feedback on strengths and weaknesses of each specialty. Analysis of the data in vertical columns gives us an indication of issues that run across different specialties.

<table>
<thead>
<tr>
<th>Post Specialty</th>
<th>Overall Satisfaction</th>
<th>Clinical Supervision</th>
<th>Clinical Supervision out of hours</th>
<th>Reporting systems</th>
<th>Work Load</th>
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Analysing the data in vertical ‘Columns’ demonstrates domains that are of concern across specialties e.g. ‘Clinical supervision out of hours’ shows pink flags in a number of Medical Specialties, Paeds and T&O. These specialties need to review the on-call rota/staffing/consultant supervision. Similarly, there are red flags for ‘Team work’ in General surgery and Paeds, and red flags for ‘Induction’ in Cardiology and Paeds.
Analysing the data across the ‘Rows’ demonstrates the performance of each specialty areas. Cardiology, General Surgery, Paeds and Geriatrics show large numbers of red and pink flags.

Consultants/Leads/Managers in each specialty need to carefully evaluate their strengths and weaknesses and work towards addressing them.
Specialties with red and pink flags must improve the training environment for the benefit of trainees/trainers/patients.

**KGH Program Groups 2018**

Each training Grade e.g. F1, F2, GP or CT has given a feedback. ST trainees’ feedback is indicated just by the name of Program.

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F1 trainees, ACCS (Acute Care Common Stem) Core Trainees and Surgery Core trainees. GP trainees also gave good feedback despite high workload. Emergency Medicine got a green flag for regional teaching but red for local teaching, their trainers have repeatedly complained that teaching sessions were cancelled by the Trust during capacity pressures. F2, Core Medical, and ST in Geriatrics/Paeds/Anaesthesia reported a number of red and pink flags.

**KGH Trainer Survey**
Response rate of Consultant Trainer was higher in survey than most other organisations and generally better feedback compared to peers.

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Analysis of feedback from different specialties suggest that ‘Time for Training’ is the most common concern among the trainers despite a good feedback on ‘Resources for Training’.

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Board of Directors 28 September 2018 – GMC Survey Results
Trainer Specialty | Response Rate | Overall Satisfaction | Work Load | Handover | Supportive environment | Curriculum Coverage | Educational Governance | Time for training | Rota Design | Resources for trainers | Support for trainers | Trainer Development |
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**HEE EM feedback**
Acting post graduate Dean has written to the Trust with their initial observations as below and requested action plans for red flags and examples of good practice (green flags) to share with other organisations.

**KGH Green Flags**

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### Executive Summary

**S** Each Trust must produce an annual summary report of the actions that it has taken to learn from patient deaths over the previous year. Throughout 2017/18 Kettering General Hospital (KGH) has implemented a range of initiatives that have improved the way in which patient deaths are reviewed, analysed and the learnings shared. This report summarises progress made over the year.

**B** Learning from Deaths Annual Report - Concerns about Patient Safety and Mortality rates has intensified recently after high-profile investigations into NHS hospitals and a recent CQC report into the way NHS trusts review and investigate deaths of patients in England.

KGH undertook reviews of: 50% of all adult in-patient deaths; Dr Foster alerts / outliers; unexpected deaths/ or those escalated via Serious Incident Review Group (SIRG); deaths where there are concerns from Next of kin/ PALs; and all learning disability deaths.

It was agreed that all deaths relating to maternity, perinatal and Paediatric deaths will be reviewed following national guidelines (MBRRACE, SUDI and Paediatric pathways).

**Governance structure:** Mortality reviews, analysis, dashboard and annual report are discussed and considered in Patient Safety Advisory group (under title of Mortality surveillance) , Quality Governance Steering Group and received by Quality and Safety Committee on behalf of Trust Board (illustrated in page 2 of Quarter 4 dashboard).

**A** KGH has developed a mortality dashboard that informs all reviews, and includes not only Mortality review data, but also include Dr Foster analysis and top five learning themes and actions around learning themes. The overall approach has been recognised by NHS Improvement as a national exemplar.

**Quarter 4 dashboard:** 52% of deaths were reviewed in 2017-18

In quarter 4 the top five learning themes were:
- Documentation, including the capturing of co-morbidities, could be improved
| Use of DNACPR could be completed earlier in the patient pathway |
| Earlier consideration of ceiling treatment including Advanced care plan needs improvement |
| Clinical diagnostic issues where results are not reviewed in a timely fashion |
| Notable that sepsis learning theme has improved cross the organisation, and no longer appeared in the top five learning themes |
| A new screening tool incorporates positive feedback to clinical teams and this has commenced with April data |

The Board is asked to note the report and the significant progress that has been made over the year.

The following challenges are also noted:
- Sustaining interest and enthusiasm amongst reviewers - New reviewers are currently being recruited
- Implementing Medical Examiner model to suit KGH needs - Plans and proposal to go to Patient Safety Advisory Group in 6 months
- Embedding learning in every specialty and begin to see improved quality of care - this is on-going and specialties are asked to present learning in joint forums
- Make reviews and analyses completely electronic - will need to be aligned with Trust digital strategy
- Identification of alternative estates for Mortality Room - in hand with Director of Estates

All above issues are discussed, actions put in place and monitored at PSAG.

**Reason for Consideration**

The Mortality Report (Learning from Deaths and Mortality Reviews Annual Report 2017/18) and Learning from deaths dashboard is a statutory item for Board consideration.

**Paper Previous Consideration**
- Quality and Safety Committee: 19 September 2018

**Strategic Objectives**

This report relates to the following strategic objectives:
- To provide high quality care to individuals, communities and the population we serve
- To be a strong and effective partner in the wider health and social care community

**Financial Implications**
There are no material financial implications as a direct result of the content of this report.

Although there may be income opportunities associated with some themes included within it (i.e. effective coding or comorbidities), this is beyond the scope of the report.

**Risks**

There are risks associated with not following guidelines and the Trust processes for sharing learnings from patient deaths. This may lead to avoidable patient harm.

**Equality impact**

An equality impact assessment has not been completed for this report.
**Document History**

**Revision History**

Date of this revision: 14 September 2018

Date of next revision: N/A

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**Distribution**

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**Authors**

Report authors:

Professor Andrew Chilton
Dr Manjula Natarajan
Mr Hayden Barker
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1 Introduction by KGHFT Medical Director – Professor Andrew Chilton

Illness is a defining moment in our lives and brings with it great challenge at vulnerable times for patients and families. Deeply etched memories of the care provided are formed which families carry with them.

When death is the outcome, expected or not, it amplifies this effect and reshapes families and carers perspectives and experience.

The dead have no voice; however, we can provide this function by being open, transparent and willing to learn the lessons that emerge from their clinical journey.

In providing this function and making it tangible and real we have adopted and improved upon the process of learning from deaths.

This has been achieved through the efforts of the mortality reviewers led by Dr Natarajan our deputy medical director.

In this learning we have seen the clinical care reviewed, understood, evaluated and presented to the organisation in themed modules to provide opportunity for learning, sharing of best practice, education and improvement in the care we deliver.

This has been achieved through a systematic approach of using validated screening tools and where required structured judgement reviews.

The report sets out the fundamental work performed, emergent themes and organisational learning shared.

The report looks back but also reflects the future direction of travel and ambition demonstrating the power of the review captured in well thought out informative dashboards.

It is important we recognise the contribution of the reviewers as they are fundamental to the process and I want to thank them personally for their professionalism and enthusiasm in making this possible. I want to recognise Dr Natarajan’s major contribution in leading and delivering this.

I have personally benefited from my involvement in the panel discussion of complex cases and know I am a better clinician for this. I would urge engagement and involvement in this process as it is deeply rewarding.

Professor Andrew Chilton
2 Background

Concerns about Patient Safety and Mortality rates has intensified recently after high-profile investigations into NHS hospitals and a recent CQC report into the way NHS trusts review and investigate deaths of patients in England.

Research suggests that preventable deaths due to problems in care only make up around 3-4% of deaths and there is a lack of association between Hospital wide Standardised Mortality Ratios (HSMR) and avoidable deaths

The Secretary of State for Health commissioned a report into the understanding of UK death, which found the following:

- Sometimes not treated with kindness, respect and sensitivity; can feel their involvement is tokenistic; and often question the independence of the reports
- The NHS does not prioritise learning from deaths and misses countless opportunities to learn and improve as a result
- There is no single framework which sets out how local NHS organisations should identify, analyse and learn from deaths of patients in their care or who have recently been in their care

This report made a number of recommendations to which the Trust is responding and this policy sets out that response in the form of a procedural document on which mortality review Trust wide will now be based. These recommendations are:

- Publish evidence based methodology for reviewing deaths across the organisation, using initially a screening tool, followed by nationally validated Review methodology (Example- PRISM, Structured Judgement Reviews) for second reviews.
- Collect a range of specified information on deaths that were thought more likely than not due to problems in health care and serious incidents, and consider what lessons need to be learned on a regular basis
- Establish robust Governance framework around Review of deaths, learning and reporting as Serious Incidents
- Publish that information quarterly to Trust Board
- Publish evidence of learning and action- To speciality Morbidity and Mortality Meetings and Patient safety Lessons Learned Forums.
- Feed local dashboard information to commissioners via Patient Safety Lessons learnt forum quarterly.
- Identify Board-level leaders, both Executive and Non-Executive as Patient Safety Director to take responsibility for this agenda.
- Ensure that investigations of any deaths that may be the result of problems in care are more thorough and involve families and carers
- Particular priority to be given to identifying patients with a significant mental health problem of a learning disability to make sure their care responds to their particular needs; and that particular trouble is taken over any mortality investigations to ensure wrong assumptions are not made about the inevitability of death.
Ensure that the NHS reviews and learns from all deaths of people with learning disabilities, in all settings. The Learning Disabilities Mortality Review Programme (to commence county-wide from September 2017) will provide support to both families and local NHS areas to enable reporting and independent, standardised review of all learning disability deaths between the ages of 4 to 74.

These recommendations were detailed in further guidance published in March 2017 by National Quality Board (NQB).

2.1 Kettering General Hospital Milestones (timeline)
Outlined in the NQB Guidance published in March 2017, Trusts were given a number of national requirements/targets to meet within a 12 month period. Figure 1 below outlines each of those objectives and the dates in which Kettering General Hospital achieved each.

![Figure 1: Timeline for Mortality Review Process at KGH](image)

2.2 Scope for Mortality Reviews
KGH is a district General Hospital, with approximately 1,100-1,200 adult in-patient deaths every year. Scope of this guidance for KGH includes reviewing the following:

- 50% of all adult in-patient deaths
- Dr Foster alerts/ outliers
- Unexpected deaths/ or those escalated via Serious Incident Review Group (SIRG)
- Deaths where there are concerns from Next of kin/ PALs
- All learning disability deaths
It was agreed that all deaths relating to maternity, perinatal and Paediatric deaths will be reviewed following national guidelines (MBRRACE, SUDI and Paediatric pathways).

Patient involvement: KGH bereavement booklet includes a paragraph which declares that the organisation will review deaths and share learning and investigation with family where the care was thought to be less than acceptable standard and likely to have affected the outcome.

2.3 Methodology for reviews

2.3.1 Mortality Review Room
The Mortality Review Room was sourced in May 2017 and is a central location that houses all the deceased notes which require a mortality review. The room has restricted access and adequate space for group / panel discussions to take place.

\[ \text{FIGURE 2 MORTALITY REVIEW ROOM} \]

2.3.2 Mortality Screening Tool
The Mortality Screening tool is the Trust screening proforma for reviewing deceased notes and asks Mortality reviewers to make a judgement on whether the case requires a more in-depth review (Structured judgment review – Section 3.C). The screening tool is a working document and we have recently changed how we grade cases, from Likert score (6 – 1) to Overall assessment of Care (Overall Very Poor Care – Excellent Care). The Governance structure in section 4 of this report outlines the process for each of the screening tool outcomes. All learning points identified are themed are feedback to individual Specialty Mortality and Morbidity (M&M) meetings and also shared with all Specialties via the Patient Safety Lessons Learnt Forum (PSLLF).

50% of all adult in patient deaths during April 2017 – March 2018 were reviewed using the mortality screening tool (available from: http://www.kgh.nhs.uk/EasysiteWeb/getresource.axd?AssetID=16647&type=Full&servicetype=Attachment). A collaborative review between the Medical Director, Deputy Medical Director and Mortality Review Team was undertaken and a revised tool is now in use for deaths occurring in April 2018 – March 2019 (Appendix 1).

2.3.3 Structured Judgement review (SJR)
Structured Judgement Review (SJR) is the Nationally implemented in-depth review tool, published by the National Mortality Case Record Review (NMCRR). During 2017/18, all
mortality screening tools which scored a Likert 4 -1 and/or patients who were deemed as receiving Poor/Very Poor Care were subject to an SJR.

In 2017, NMCRR adapted the SJR tool and removed the ‘Avoidability’ section of the tool however, Kettering General Hospital have found this an integral part of the Governance process and allows for clear escalation to the Serious Incident Review Group (SIRG) and has therefore been retained in the latest version (as part of the policy, available from: http://www.kgh.nhs.uk/EasysiteWeb/getresource.axd?AssetID=16647&type=Full&servicetype=Attachment).

2.3.4 Panel discussion
A multi-disciplinary panel discussion is held when an SJR has one of the following outcomes:

- Likert 4 (Possibly avoidable but not very likely (less than 50:50))
- Likert 3 (Probably avoidable (more than 50:50))
- Likert 2 (Strong evidence of avoidability)
- Likert 1 (Definitely avoidable)

The panel team consists of consultant mortality reviewers, sepsis lead nurse, End of Life lead nurse, the Deputy Medical Director and/or Medical Director and the Mortality Review Manager and Assistant. For specific cases, other clinical members of staff are invited to discuss complex cases such as VTE lead nurse, Haematologist consultant and Respiratory consultant.

All panel discussion meetings are structured around an initial overview of the case, any problems in healthcare identified and a conclusion (including final Likert score and learning points identified by the group). If a case is still deemed to be a Likert 3 or <3, this is then escalated to SIRG for further scrutiny and is then declared as: Local level action (learning points to specialty M&M and PSLLF), Internal Investigation or Externally reportable Serious Incident (Duty of Candour is then commenced for the two latter options).

Panel discussions are very objective and discussed in depth with the experts around the table for complex cases.

2.3.5 Central Mortality Database
A comprehensive Mortality Database is kept in a secure shared drive and contains a clear audit trail for every case reviewed, from screening tool to SIRG outcome and Specialty M&M inclusion. The database is split into Quarters 1 – 4 and keeps an up-to-date record of every review undertaken. This is maintained by the Mortality Review Manager and Assistant and contains hyperlinks to each stage of the review (screening / SJR / panel discussion / specialty M&M presentation / final investigation report).

A separate column for Doctor Foster Alerts (Sepsis and Senility for example) is updated regularly to ensure these cases are monitored closely and can be filtered to allow for quick data and learning theme analysis.

2.3.6 Database maintained by individual Specialty Mortality and Morbidity (M&M) Teams
The Care of the Elderly Specialty M&M team have a rolling database which keeps track of every patient death which occurred within their specialties ward areas. This is updated in
real time on a monthly basis during the Geriatrics M&M and contains discussion points and whether or not the death was expected or unexpected. This format is being discussed with other Specialty M&M's across the Trust and will potentially implemented across more departments during 2018/19 financial year.

2.4 Governance (Structure / Policy)
Mortality Surveillance Group (MSG) is part of existing Patient Safety Advisory Group (PSAG). The primary role of the MSG is to provide assurance and problem sense to the Trust Board of Directors on learning from deaths as per National Quality Board guidance. Mortality indicator statistics do not in themselves constitute evidence regarding the standard of care delivered, but do require consideration when concerns are raised. The group will review data on patient deaths, including results and learning generated by local mortality review, and considers and implements strategies to improve care and reduce avoidable mortality.

Mortality Review Group under PSAG chaired by Medical Director / Deputy MD will meet monthly to discuss complex cases and agree on outcomes as a panel and the designated Non-Executive Director will be involved with this group. Serious Incident Review Group (SIRG) will have delegated responsibility.

PSAG will have the following as standing agenda items every month as a minimum:

Reported by the Deputy Medical Director as dashboard

- Total number of deaths for the quarter
- Number of reviews completed using screening tool, and number of deep second reviews done using SJR
- Breakdown of patient groups as per Section 7.2, Figure 2 (per quarter)
- Detail on themes identified and recommendations for action
- Details of Themes converted to QI projects and assessment of impact on practice
- Details of any mortality alerts and response

Quality Governance Steering Group (QGSG) (monthly) will receive exception reports from PSAG on Mortality issues.

Quality and Safety Committee (Previously Integrated Governance Committee) which is a sub-committee of Trust Board will receive monthly dashboard report similar to PSAG.

A Non-executive Director was appointed in June 2017, who subsequently left the organisation. Our newly appointed Non-executive Director since June 2018 is Dr Chris Welsh.

The Quality and Safety Committee will receive the Mortality surveillance dashboard. This data will include the total number of the Trust's inpatient deaths and those deaths that the Trust has subjected to mortality review. Of these deaths subjected to review, the Trust will provide estimates of how many deaths were judged more likely than not to have been due to problems in care. The Committee will also receive from quarter 3 narrative on QI initiatives and assessment of impact of the actions.
Regulations will require that the data providers publish be summarised in Quality Accounts from June 2018, including evidence of learning and action as a result of this information and an assessment of the impact of actions that a Trust has taken. This will be included in future Quality Report. This was published in our recent Quality Account.

### 2.5 Resources

#### 2.5.1 Business case

A business case was submitted and approved early in 2017 to comply with requirements set out in National Quality Board for trust requirements for mortality reviews.

Business case included resources for Mortality Lead, Mortality Reviewers, Manager and administrative support

#### 2.5.2 Mortality Lead and Recruiting reviewers

Deputy Medical Director is Mortality Lead for the Trust, overseeing reviews, drawing learning themes and attending M&M meetings to ensure learning is embedded in each specialty.
Strategic communication at Regional and Regulatory levels is done by MDD and Deputy MD.

A Mortality Reviewer recruitment identified key clinicians and specialist nursing staff (Sepsis and End of Life) to join the Mortality Review Team. Each clinician is provided with a job description which outlines the reviewer’s role and responsibilities and agreed protected time to conduct reviews, as part of job planning.

As of September 2018, there are ten Consultant reviewers from the following Specialties: Anaesthetics, ITU, Orthopaedics, General Surgery, Older Adults / Geriatrics, Respiratory, Cardiology, Gastroenterology, and Nephrology. Further recruitment for an Acute Medicine physician is ongoing.

2.5.3 Mortality Manager & Mortality Assistant (Mortality Review Team)
A newly created full-time Mortality Manager post was appointed to in March 2018. The appointed individual provides support to the Medical Director and Deputy Medical Director as well as the Mortality Reviewers for all Mortality related work, including support for specialty M&M and quality improvement work.

The Mortality Assistant post was appointed to in July 2018. The appointed individual is an essential administrative role for the Mortality Team and also an integral part of the Co-morbidity capturing Quality Improvement project. They capture and analyse data three times per week and liaise with key members of the project fortnightly to ensure consistent improvement is sustained.

2.5.4 Plans for the future (Medical examiner)
Following recent national guidance on implementation of Medical Examiners by April 2019, we are currently in the process of understanding implications for KGH and way forward.
3 Learning from death and the mortality dashboard
KGH approach to the dashboard is to present not only Mortality review data, but also include DR Foster analysis and top five learning themes and actions around learning themes.

During a recent Countywide M&M lessons learnt forum, Matt Fogarty (Deputy Patient safety Director for NHS Improvement) was present. The Medical Director and Deputy Medical Director discussed the monthly and quarterly dashboard with NHSI who was impressed with the presentation and in particular, the transparency and concise sharing of learning themes identified via the Learning from Deaths Process. The dashboard has been shared with NHSI since and are being used as an exemplar for other Trusts across the country. An example of the July 2018 dashboard, which contains an overview of quarterly learning themes, is available in Appendix 2.

3.1 July Mortality Review Dashboard
Below are the overall figures from the Learning from Deaths review for 2017/18 (April 2017 – March 2018, see Appendix 2):

- Total Adult inpatient deaths in Kettering General Hospital: 1,236
- Total Number of Adult inpatient deaths reviewed using the Mortality screening tool: 641 (52%)
- Total Number of Adult inpatient deaths which required a SJR: 49
- Total Number of Adult inpatient deaths escalated to SIRG:8
- Total number of Adult inpatient deaths declared as an Internal Investigation / Externally Reportable Serious Incident: 5
- All Learning disability deaths were reviewed and found to have no lapses in care. One case was presented in PS lessons learnt forum.

The top five learning themes are shown in the table below:

<table>
<thead>
<tr>
<th>Quarter Four learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>57-60% of the case note reviews revealed that patients received good care during their last episode of care, and that there were no additional learning points</td>
</tr>
<tr>
<td>Top 5 themes:</td>
</tr>
<tr>
<td>o Documentation, including the capturing of co-morbidities, could be improved</td>
</tr>
<tr>
<td>o Use of DNACPR could be completed earlier in the patient pathway</td>
</tr>
<tr>
<td>o Earlier consideration of ceiling treatment including Advanced care plan needs improvement</td>
</tr>
<tr>
<td>o Clinical diagnostic issues where results are not reviewed in a timely fashion</td>
</tr>
<tr>
<td>o Notable that sepsis learning theme has improved cross the organisation, and no longer appeared in the top five learning themes</td>
</tr>
</tbody>
</table>

**Table 1 Top learning themes from Quarter 4**
Figure 3 describes the methodology through which KGH shares learning from deaths:

### Figure 4 Learning dissemination from Mortality Reviews

#### 3.2 Learning from deaths

Focus over the first year was to set up a standardised process for reviewing adult in-patient deaths. Second priority was to standardise M&M meetings and ensure learning from each of the reviews is discussed in the meetings ultimately leading to better patient experience and improved quality of care. We have continued to disseminate learning trust-wide and county wide through lessons learnt forum.

**Achievement one: M&M meetings**

A shared electronic folder was created for each specialty and reviews with learning points. Deputy MD and Mortality Manager have attended most Specialty M&M meetings to support and improve process around learning from deaths. The journey of improvement is evident in most specialties where reviewer’s recommendations are discussed, debated and learning points embedded within specialty. These meetings are attended by all grades of Doctors, and in some specialities, attended by ward sisters and matrons.

**Achievement two: Patient Safety Lessons Learnt Forum (PSLLF)**

Chaired and moderated by Medical Director/ Deputy MD, this is one of our key success story over the past 4 years to disseminate trust-wide learning. Key focus for every presenter is
analysing a serious incident/ Never Event/ Mortality review and sharing lessons learned with the wider organisation. This meeting provides an un-biased, transparent supportive platform and environment for Consultants to discuss and learn from incidents. Audience is multi-disciplinary and has had very good feedback over the years from all grades of Doctors and nursing staff. PSLLF takes place every 6 weeks and also has Non-executive Directors, Executive Directors and Commissioners (for never events and County-wide M7M) attending the meeting. County wide M&M takes place every 4-6 months, where Northampton General Hospital, Northamptonshire Healthcare Foundation Trust and KGH come together over an afternoon to share methodology process around mortality reviews and also share lessons learnt from joint investigations across organisations. A recent county-wide M&M in June 2018 was attended by Dr Matt Fogarty (invited guest, Deputy Director of Patient Safety, NHSI). Dr Fogarty was highly appreciative of the joint working and sharing lessons across the county.

3.3 Quality Improvement projects
Quality Improvement projects include improvement in Sepsis pathway and Comorbidity capturing is currently underway. The Sepsis Quality Improvement work has been ongoing for over 12 months, in which time the Mortality Reviews have seen a large reduction in the number of Sepsis related learning points. Discussions at Patient Safety Lessons Learnt Forum around Sepsis have been frequent with updates from Amy Wride, Sepsis Nurse Practitioner, and Dr Phil Watt (ITU consultant), Clinical Lead for Sepsis CQUIN and Sepsis Improvement.
Comorbidity capturing was reviewed as a result of a rising HSMR and Dr Foster alerts. Following multiple meetings and trend analysis with the Trust’s Dr Foster representative, a lower comorbidity capture rate than the national average was deemed a key contributing factor. Since July 2018, regular meetings with the Doctors Administrative Assistants (task orientated administrative staff, based in key ward areas) were initiated. Methods of improvement were discussed, and the first area of focus was the urgent care escalation wards (Clifford and Middleton Assessment Unit).

Following regular involvement with the Doctors administrative assistant and data collected three times per week on Clifford and MAU, an improvement in capturing is materialising and clinical staff are starting to transition to a newly introduced comorbidity sheet, which allows clinical staff to quickly tick key comorbidities for in-patients during first Consultant episode (FCE). This in turn, allows the coding team to accurately capture a full list of patients’ comorbidities within one central piece of documentation.

3.3.1 Training (in-house + external meetings)
Senior Reviewers have undertaken SJR training conducted by Royal College of Physicians NMCRR group in 2017. This has subsequently been rolled out to the remaining reviewers in-house, and refresher training is due to take place regionally in September 2018.

There is an induction and shadowing process identified for new comers and has had very good feedback.

3.4 Dr Foster metrics and alerts
Dr Foster metrics and alerts are reviewed on a monthly basis at PSAG. The results are reviewed and analysed, and learning themes disseminated as per Mortality Review Process. Alerts reviewed, analysed and feedback provided to CQC and NHSI during 2017/18 is:

- Senility and organic mental health disorders
- Septicaemia

Analysis for the above alerts was done through notes review and coding analysis. This concluded that there were no avoidable deaths, but that comorbidity capture and initial diagnosis could be improved, see summary in Figure 6 below.
3.5 Coding team
Coding team and analysis of coding forms an integral part of the PSAG. A Trust-wide coding improvement plan, to improve the depth of coding, is currently in place.

3.6 Changing culture
Mortality reviewers are heavily engaged and keen to standardise and improve process week on week. Panel discussion brings together experts from various specialties to then form a
consensus opinion on complex cases. Each Specialty is engaged in standardising M&M process and beginning to learn from reviews and embed lesson learnt

Ultimate driver for change in culture and improving quality of care needs to start at the ward level and we have seen the improvements over the last few months, where positive feedback is now disseminated to clinical teams.

4 Future challenges

- Sustaining interest and enthusiasm amongst reviewers
- Implementing ME model to suit KGH needs
- Embedding learning in every specialty and begin to see improved quality of care
- Make reviews and analyses completely electronic
- Identification of alternative estates for Mortality Room
References

CQC Learning, candour and accountability- A review of the way NHS trusts review and investigate the deaths of patients in England, DECEMBER 2016.


Royal College of Physicians - National Mortality Case Record Review (NMCRR) programme resources. https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrn-programme-resources
Annex 1: Draft Screening Tool for Adult Inpatient Deaths between April 2018 – March 2019

[Diagram of the screening tool with fields for patient information, mortality screening criteria, and decision-making process for referral or further screening.]
## Outcome of Screening Assessment:

<table>
<thead>
<tr>
<th>#</th>
<th>Level of Care</th>
<th>Tick</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Likely to have affected the outcome</td>
<td>X</td>
<td>Escalate to SJR</td>
</tr>
<tr>
<td>1b</td>
<td>Overall Very Poor Care</td>
<td>X</td>
<td>Learning Points to be detailed below and escalated to specialty M&amp;M</td>
</tr>
<tr>
<td>2a</td>
<td>Likely to have affected the outcome</td>
<td>X</td>
<td>Escalate to SJR</td>
</tr>
<tr>
<td>2b</td>
<td>Overall Poor Care</td>
<td>X</td>
<td>Learning Points to be detailed below and escalated to specialty M&amp;M</td>
</tr>
<tr>
<td>3</td>
<td>Adequate Care</td>
<td></td>
<td>Learning Points to be detailed below and escalated to specialty M&amp;M (Include Positive Feedback to Teams)</td>
</tr>
<tr>
<td>4</td>
<td>Good Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Excellent Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Learning Point(s) / Positive Feedback

<table>
<thead>
<tr>
<th>Name of Department M&amp;M</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Time Taken to Complete Screening Review: ________________ minutes
Annex 2: Learning from Deaths Dashboard

Table 1: Monthly Dashboard – July 2018

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Number of Adult In-patient Deaths</th>
<th>Number Reviewed using Screening Tool</th>
<th>Number Reviewed by Specialty Team</th>
<th>Total Avoidable Deaths</th>
<th>Number Declared as SI</th>
<th>Number Reviewed using SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>87</td>
<td>33</td>
<td>16 (17%)</td>
<td>0</td>
<td>0</td>
<td>0/4</td>
</tr>
<tr>
<td>May</td>
<td>110</td>
<td>46</td>
<td>18 (16%)</td>
<td>0</td>
<td>0</td>
<td>0/2</td>
</tr>
<tr>
<td>June</td>
<td>90</td>
<td>50</td>
<td>16 (16%)</td>
<td>0</td>
<td>1</td>
<td>Internal SI (L1)</td>
</tr>
<tr>
<td>July</td>
<td>78</td>
<td>41</td>
<td>11 (14%)</td>
<td>0</td>
<td>1</td>
<td>NLT at SI (L4)</td>
</tr>
<tr>
<td>August</td>
<td>91</td>
<td>45</td>
<td>15 (16%)</td>
<td>0</td>
<td>1</td>
<td>External SI (L2)</td>
</tr>
<tr>
<td>September</td>
<td>104</td>
<td>55</td>
<td>15 (15%)</td>
<td>0</td>
<td>1</td>
<td>Internal SI (L3)</td>
</tr>
<tr>
<td>October</td>
<td>90</td>
<td>40</td>
<td>47 (10%)</td>
<td>0</td>
<td>2</td>
<td>Internal SI (L2)</td>
</tr>
<tr>
<td>November</td>
<td>106</td>
<td>52</td>
<td>55 (19%)</td>
<td>0</td>
<td>0</td>
<td>0/4</td>
</tr>
<tr>
<td>December</td>
<td>122</td>
<td>50</td>
<td>50 (20%)</td>
<td>0</td>
<td>1</td>
<td>Internal SI (L4)</td>
</tr>
<tr>
<td>January</td>
<td>120</td>
<td>57</td>
<td>52 (21%)</td>
<td>0</td>
<td>0</td>
<td>0/4</td>
</tr>
<tr>
<td>February</td>
<td>83</td>
<td>44</td>
<td>44 (13%)</td>
<td>0</td>
<td>1</td>
<td>Internal SI (L3)</td>
</tr>
<tr>
<td>March</td>
<td>126</td>
<td>59</td>
<td>18 (12%)</td>
<td>0</td>
<td>0</td>
<td>0/5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1236</td>
<td>608</td>
<td>641 (52%)</td>
<td>0</td>
<td>8</td>
<td>5/49</td>
</tr>
</tbody>
</table>

April 2017-March 2018 there was a total of 1236 adult in-patient deaths over the year. 52% of these deaths were reviewed using a screening tool (total), and structured review form (SIU) when deeper review was required.

9.6% of the deaths were reviewed using SIU, and 46.9% were referred to Serious Incident Review Group (SIRG) for further consideration. One case was a level 1 review, which was declared as an External Serious Incident. The final investigation confirmed that death was unavoidable. There were no available (level 1) deaths during last year.

All learning disability deaths were reviewed using the same tool.

Quality assurance of reviews and reviewers: validation of reviewers was looked at using agreement between screening tool and SIU panel discussion.

- Figure 1: There was complete agreement between screening tool and SIU in 94% of the cases.
- Figure 2: 81% of the screening tool scores were downgraded (score 3 or 4/5 for example after SIU and panel discussions) where they required discussion at M&Ms and share learning.
- Figure 3: 4% (10 cases) were upgraded (score 1 or 2 for example), which required M&M discussion and shared learning and presentation to the learning disability lead forum. These were downgraded by one level (Figure 2).
- Figure 4: Of those downgraded, 25% were downgraded by one level, 25% by 2 levels, and 12% of cases by 3 levels (made by SIU and panel).

Availability of death judgement score (DCS SIU)
- Score 0 – Definite survival
- Score 1 – Strong evidence, high viability
- Score 2 – Possibly available (more than 20%)
- Score 3 – Possibly available but not very likely (less than 20%)
- Score 4 – Eighty evidence of availability
- Score 5 – Definitely not available
<table>
<thead>
<tr>
<th>Table 3: Learning Themes Q1 - Q4 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quarter 1 - 2017/18</strong></td>
</tr>
<tr>
<td>Good care, no learning points</td>
</tr>
<tr>
<td>35% of reviews had no learning points</td>
</tr>
<tr>
<td>Improve Documentation</td>
</tr>
<tr>
<td>8% of reports had poor documentation</td>
</tr>
<tr>
<td>Earlier use of DNA/CPR / End</td>
</tr>
<tr>
<td>10% of cases were attributed to</td>
</tr>
<tr>
<td>community</td>
</tr>
<tr>
<td>Safety: Ward staff training sessions</td>
</tr>
<tr>
<td>4% of cases identified</td>
</tr>
<tr>
<td><strong>Quarter 2 - 2017/18</strong></td>
</tr>
<tr>
<td>Good care, no learning points</td>
</tr>
<tr>
<td>65% of reviews had no learning points</td>
</tr>
<tr>
<td>Improve Documentation</td>
</tr>
<tr>
<td>16% of reports had poor documentation</td>
</tr>
<tr>
<td>Earlier use of DNA/CPR / End</td>
</tr>
<tr>
<td>10% of cases were attributed to</td>
</tr>
<tr>
<td>community</td>
</tr>
<tr>
<td>Safety: Ward staff training sessions</td>
</tr>
<tr>
<td>6% of cases identified</td>
</tr>
<tr>
<td><strong>Quarter 3 - 2017/18</strong></td>
</tr>
<tr>
<td>Good care, no learning points</td>
</tr>
<tr>
<td>56% of reviews had no learning points</td>
</tr>
<tr>
<td>Improve Documentation</td>
</tr>
<tr>
<td>20% of reports had poor documentation</td>
</tr>
<tr>
<td>Earlier use of DNA/CPR / End</td>
</tr>
<tr>
<td>10% of cases were attributed to</td>
</tr>
<tr>
<td>community</td>
</tr>
<tr>
<td>Safety: Ward staff training sessions</td>
</tr>
<tr>
<td>4% of cases identified</td>
</tr>
<tr>
<td><strong>Quarter 4 - 2017/18</strong></td>
</tr>
<tr>
<td>Good care, no learning points</td>
</tr>
<tr>
<td>54% of reviews had no learning points</td>
</tr>
<tr>
<td>Improve Documentation</td>
</tr>
<tr>
<td>10% of reports had poor documentation</td>
</tr>
<tr>
<td>Earlier use of DNA/CPR / End</td>
</tr>
<tr>
<td>0% of cases were attributed to</td>
</tr>
<tr>
<td>community</td>
</tr>
<tr>
<td>Safety: Ward staff training sessions</td>
</tr>
<tr>
<td>6% of cases identified</td>
</tr>
</tbody>
</table>

**Actions:**
- Specialty M&M: robust documented M&M in place and attended by Deputy MD and Mortality Manager to reinforce learning themes. Actions from meetings are captured in shared drives and reviewed every quarter by the team.
  - Improve documentation: Specialty M&M are addressing with all clinicians.
  - Clinical diagnostic issues: All cases are reviewed with admitting teams, sheet introduced in clinical notes and M&M needs to improve capture. Will be reviewed quarterly.
  - Clinical diagnostic issues: All cases are reviewed with admitting teams, sheet introduced in clinical notes and M&M needs to improve capture. Will be reviewed quarterly.
  - Clinical diagnostic issues: All cases are reviewed with admitting teams, sheet introduced in clinical notes and M&M needs to improve capture. Will be reviewed quarterly.

**Notable changes:**
- Safety: ward staff training has improved across the organization, and no longer features in the top 3 learning themes.
### Table 4: Or Factor Metrics –滚动月

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HMRR (rolling 12m average)</td>
<td>107.9 'higher than expected'</td>
<td>108.4 'higher than expected'</td>
<td>108.3 'as expected'</td>
<td>107.4 'higher than expected'</td>
</tr>
<tr>
<td>Alerts</td>
<td>Other flow disease and urinary tract infections</td>
<td>Other lower disease, urinary tract infections and acute genitourinary disease</td>
<td>Skin and subcutaneous tissue infections, other lower disease and urinary tract infections</td>
<td>Skin and subcutaneous tissue infections and urinary tract infections</td>
</tr>
<tr>
<td>Crude rate (DNN)</td>
<td>3.4% vs peer group rate of 3.6%</td>
<td>3.4% vs peer group rate of 3.6%</td>
<td>3.3% vs peer group rate of 3.6%</td>
<td>3.4% vs peer group rate of 3.6%</td>
</tr>
<tr>
<td>Relative Care coding (%)</td>
<td>1.0% vs national 4.0%</td>
<td>3.3% vs national 4.0%</td>
<td>3.3% vs national 4.0%</td>
<td>3.3% vs national 4.0%</td>
</tr>
<tr>
<td>Admission co- mortality scoring (%)</td>
<td>Score of 0.48% vs national 51.8%</td>
<td>Score of 0.48% vs national 51.8%</td>
<td>Score of 0.48% vs national 51.8%</td>
<td>Score of 0.48% vs national 51.8%</td>
</tr>
<tr>
<td>Upper Quartile Co-morbidity</td>
<td>51.5% vs national 26.2% vs national 25.6% vs national 25%</td>
<td>26.2% vs national 25.6% vs national 25%</td>
<td>26.2% vs national 25.6% vs national 25%</td>
<td>26.2% vs national 25%</td>
</tr>
<tr>
<td>SWIFT</td>
<td>100.4 'higher than expected'</td>
<td>105.3 'as expected'</td>
<td>100.4 'as expected'</td>
<td>104.9 'as expected'</td>
</tr>
</tbody>
</table>

### Table 3: Or Factor Reports – Outcomes of Reviews

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Items</th>
<th>Obs vs expected</th>
<th>Non-home reviewed</th>
<th>Outstand deaths</th>
<th>Learning Poles / Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017</td>
<td>Vascular &amp; Plastic</td>
<td>Insufficient evidence</td>
<td>-</td>
<td>0</td>
<td>To Specialty MAM and PRU / CDC Response provided for both items</td>
</tr>
<tr>
<td>April 17 – March 18</td>
<td>Other Urology Disease</td>
<td>82 vs 44</td>
<td>10</td>
<td>0</td>
<td>To Specialty MAM meetings</td>
</tr>
<tr>
<td>March 17 – February 18</td>
<td>Urology Urology</td>
<td>15 vs 7</td>
<td>5</td>
<td>0</td>
<td>To Specialty MAM meetings</td>
</tr>
<tr>
<td>April 17 – March 18</td>
<td>Vascular &amp; Plastic</td>
<td>24 vs 13</td>
<td>5</td>
<td>0</td>
<td>To Specialty MAM meetings</td>
</tr>
<tr>
<td>February 17 – January 18</td>
<td>Vascular &amp; Plastic</td>
<td>43 vs 32</td>
<td>15</td>
<td>0</td>
<td>To Specialty MAM meetings</td>
</tr>
</tbody>
</table>

**Abbreviations:**
- RCP SR – Royal College of Physicians methodology based Structured Judgement Review
- LD – Learning Disability team
- MAM – Morbidity and Mortality meetings
- PRU – Patient Safety, Learning & Actions Review Forum