



Trust Board (Open)

Meeting held on Wednesday 8th June 2022 at 9.30 am to 12.30 pm
 via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	PROCEDURAL ITEMS					
20 mins	1.	Patient Story	Information	Mrs AM Riley	Verbal	
5 mins	2.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 4 th May 2022	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	6.	Chief Executive's Report – May 2022	Information	Mrs T Bullock	Enclosure	
10:15	STRATEGY					
10 mins	7.	Quality Strategy 2022-25	Approval	Mrs AM Riley	Enclosure	BAF 1
10 mins	8.	People Plan Annual Report 2021/22	Assurance	Mrs R Vaughan	Enclosure	BAF 2, 3
10 mins	9.	Annual Plan 2022/23	Approval	Ms H Ashley	Enclosure	
10:45	PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES					
5 mins	10.	Quality Governance Committee Assurance Report (01-06-22)	Assurance	Ms S Belfield	Enclosure	BAF 1
5 mins	11.	IPC Board Assurance Framework – May 2022	Assurance	Mrs AM Riley	Enclosure	BAF 1
10:55 – 11:05:	COMFORT BREAK					
10 mins	12.	2021/22 Quality Account	Approval	Mrs AM Riley	Enclosure	BAF 1
10 mins	13.	Maternity Serious Incident Report	Assurance	Mrs AM Riley	Enclosure	BAF 1
11:25	ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH					
5 mins	14.	Transformation and People Committee Assurance Report (31-05-22)	Assurance	Dr L Griffin	Enclosure	BAF 1, 2, 3, 4 5
11:30	ENSURE EFFICIENT USE OF RESOURCES					
5 mins	15.	Performance & Finance Committee Assurance Report (31-05-22)	Assurance	Dr L Griffin	Enclosure	BAF 6, 7, 8 & 9
11:35	ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS					
40 mins	16.	Integrated Performance Report – Month 1	Assurance	Mrs AM Riley Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	BAF 1, 2, 3, 6 & 9
12:15	GOVERNANCE					
5 mins	17.	Annual Evaluation of Committee Effectiveness & Rules of Procedure	Approval	Miss C Rylands	Enclosure	
5 mins	18.	Enhancing Board Oversight: A new approach to non-executive champion roles - Gap and Assurance Analysis	Approval	Miss C Rylands	Enclosure	
12:25	CLOSING MATTERS					
5 mins	19.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	20.	Questions from the Public Please submit questions in relation to the agenda, by 9.00 am 6th June to nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:30	DATE AND TIME OF NEXT MEETING					
	21.	Wednesday 6th July 2022, 9.30 am via Microsoft Teams				



Trust Board (Open)

Meeting held on Wednesday 4th May 2022, 9.30 am to 12.20 pm
Via Microsoft Teams

MINUTES OF MEETING

			Attended	Apologies / Deputy Sent	Apologies										
			A	M	J	J	J	A	O	N	D	J	F	M	
Voting Members:															
Mr D Wakefield	DW	Chairman (Chair)													
Mr P Akid	PA	Non-Executive Director													
Ms S Belfield	SB	Non-Executive Director													
Mrs T Bowen	TBo	Non-Executive Director													
Mr P Bytheway	PB	Chief Operating Officer													
Mrs T Bullock	TB	Chief Executive													
Prof G Crowe	GC	Non-Executive Director													
Dr L Griffin	LG	Non-Executive Director													
Mr M Oldham	MO	Chief Financial Officer													
Dr M Lewis	ML	Medical Director													
Prof K Maddock	KM	Non-Executive Director													
Mrs AM Riley	AR	Chief Nurse													
Mrs R Vaughan	RV	Chief People Officer													

			A	M	J	J	J	A	O	N	D	J	F	M
Non-Voting Members:														
Ms H Ashley	HA	Director of Strategy												
Mrs S Gohir	SG	Associate Non-Executive Director												
Prof A Hassell	AH	Associate Non-Executive Director												
Mrs A Freeman	AF	Director of Digital Transformation												
Mrs L Thomson	LT	Director of Communications												
Miss C Rylands	CR	Associate Director of Corporate Governance												
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI												

In Attendance:	
Miss K Flint	Freedom to Speak Up Guardian (item 15)
Mrs N Hassall	Deputy Associate Director of Corporate Governance (minutes)
Mrs C Jarrett	Patient Representative (item 1)
Mrs S Jamieson	Head of Midwifery (item 10)
Mrs R Pilling	Head of Patient Experience (item 1)

Members of Staff and Public via MS Teams: 5

No.	Agenda Item	Action
1.	Patient Story	
<i>065/2022</i>	<p>Mrs Pilling introduced Mrs Jarrett, and explained that it was Deaf Awareness Week and the story related to her experience of being treated at the Trust over 6 years ago and as a result her subsequent engagement with the Trust and role as a volunteer and in particular what she had experienced whilst having a hearing impairment.</p> <p>Mrs Jarrett recalled her story and explained that she was hearing impaired, which resulted from having had a severe ear infection. She explained that she had been</p>	

	<p>treated via ENT and described some delays in being seen. She described the effects on patients suffering with hearing impairments and the additional issues which had arisen during the pandemic, in terms of mask wearing. She stated that as a result of her complaint, which was investigated and addressed, she had since become involved in the Hospital User Group and Patient Information Group. She also highlighted her involvement in training her dog as Pets as Therapy (PaT). Mrs Jarrett described some of the experiences she had encountered while visiting other patients in hospital with her dog, such as patients at the end of life or with cognitive impairment and she noted some very moving and emotional effects of patients having access to PaT.</p> <p>Mr Wakefield thanked Mrs Jarrett for her story and referred to the initial delays in being seen by ENT and apologised for the waits incurred.</p> <p>Ms Bowen queried if a group was in place to coordinate other volunteers within the Trust with PaT dogs and Mrs Jarrett explained that she was aware of one other volunteer with a dog at Stoke and another at County Hospital and Mrs Pilling explained that dog therapy provision was looking to be expanded.</p> <p>Professor Maddock queried how often Mrs Jarrett encountered medical and nursing students, in terms of making them aware of the impact of hearing loss and Mrs Jarrett stated that she had previously been involved in talking to students with regards to deaf awareness, although this had stopped due to Covid.</p> <p>The Board thanked Mrs Jarrett for providing her tremendous story in addition to her ongoing involvement in volunteering.</p> <p>The Trust Board noted the story.</p> <p>Mrs Pilling and Mrs Jarrett left the meeting.</p>	
2.	Chair's Welcome, Apologies & Confirmation of Quoracy	
<i>066/2022</i>	Mr Wakefield welcomed members of the Board and observers to the meeting. It was confirmed that the meeting was quorate.	
3.	Declarations of Interest	
<i>067/2022</i>	The standing declarations were noted.	
4.	Minutes of the Previous Meeting held 6th April 2022	
<i>068/2022</i>	The minutes of the meeting from 6 th April 2022 were approved as an accurate record.	
5.	Matters Arising from the Post Meeting Action Log	
<i>069/2022</i>	PTB/513 – it was noted that including metrics associated with the action plan were being considered for inclusion in the performance report and a further update would be provided at the next meeting.	
6.	Chief Executive's Report – April 2022	
<i>070/2022</i>	Mrs Bullock highlighted a number of areas from her report.	

	<p>Mr Wakefield queried the impact of not being able to fill the 2 intensivists posts. Dr Lewis noted that it was a priority to recruit to the substantive appointments but agreed that the challenges being experienced were creating a risk but this was currently being managed.</p> <p>Ms Gohir queried if vacancies could remain open for longer when no applications were received. Mrs Bullock stated that vacancies were sometimes left open but also efforts were made to time the adverts so that these were being advertised when staff were due to finish their training posts for example.</p> <p>Ms Gohir queried the impact of the additional Bank Holiday for the Jubilee and Mrs Bullock stated that the preparations for the Bank Holiday would be the same as other holidays, however the Trust seemed to cope better over Bank Holiday periods demonstrating that sufficient planning was in place.</p> <p>Ms Bowen queried whether the Children's Integrated Care Board would impact on the Trust's Children's Strategy to which Mrs Bullock explained that it would not have an impact.</p> <p>Professor Maddock referred to the recruitment to Associate Freedom to Speak Up Guardians and queried the progress being made in recruiting. Miss Rylands explained that 18 expressions of interest had been received to date, from variety of professions and stated that the closing date was in the next couple of weeks.</p> <p>The Trust Board noted the report and approved eREAFs 9199, 9133 and 9004.</p>	
7.	Digital Strategy	
071/2022	<p>Mrs Freeman highlighted the key areas of the strategy and the way in which it had been co-produced with staff and aligned to the Trusts key strategic priorities.</p> <p>Mr Akid welcomed the strategy and stated that the Performance and Finance (PAF) Committee had suggested it be used as a good practice strategy going forwards.</p> <p>Ms Gohir queried if enough resource was in place to deliver the strategy and queried how equality was to be considered when introducing new systems. Mrs Freeman stated that there was not enough capacity in place to deliver the strategy, but she expected business cases to be produced as initiatives were being taken forward. She added that equality impact assessments would be undertaken for each initiative as part of the business case process in addition to working with suppliers to ensure their algorithms did not introduce bias.</p> <p>Ms Bowen referred to the risks identified and whether it was anticipated that the strategy would reduce the associated risk on the Board Assurance Framework (BAF). Mrs Freeman agreed that delivering the strategy should reduce the risk score on the BAF, in particular the decision to implement Patient Portal and other improvements for cyber security.</p> <p>Professor Hassell queried how realistic the strategy was in terms of achievability. Mrs Freeman stated that it would be difficult to achieve and the biggest concern was the cultural aspect of enabling and enthusing staff to think about digital transformation, which linked to the importance of introducing the Chief Nursing Information Officer role in addition to the Chief Clinical Information Officer.</p>	

	<p>Dr Griffin referred to the ambition to inter-relate with system issues and queried how the strategy would incorporate working with Provider Collaboratives. Mrs Freeman stated that part of this involved the Integrated Care Board Digital Group looking at complimentary services which could be used as a system i.e. security operations centre.</p> <p>Professor Maddock referred to the use of pure data and the associated challenges with this. Mrs Freeman stated that when looking at how conditions were managed, trends would be considered alongside the different outcomes based on differences in society and the data would be used to drive insight which could subsequently change clinical practice.</p> <p>Professor Crowe referred to the resources required and queried whether the element of partnering with other organisations should be focussed on, in order to deliver the improvements at pace. He also queried whether the clinical strategy was strongly defined in terms of informing choice and prioritisation. Mrs Freeman stated that the strategy had been mapped through to the Improving Together which therefore linked to the clinical strategy and stated that working with other organisations was taken forward, where it was logical to do so.</p> <p>The Trust Board approved the digital strategy and agreed for business cases to be developed as required (in relation to the recurrent £373,881 investment).</p> <p>The Trust Board noted the proposed governance arrangements for the Digital and Data Security and Protection Group to report to Transformation and People (TAP) Committee which had been reflected on the updated Corporate Governance Structure.</p>	
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PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES

8.	Quality Governance Committee Assurance Report (28-04-22)	
072/2022	<p>Ms Belfield highlighted the following from the report:</p> <ul style="list-style-type: none"> • The Committee welcomed the input and assurance provided by Mrs Jamieson in terms of maternity services • A deep dive into pressure ulcers had been undertaken and the work had identified certain interdependencies which required better ways of working with partners • In terms of sepsis performance, the Committee noted that appointments had been made to the sepsis team and a further update was to be provided on the actions being taken to improve performance • 3 never events had been identified a further update was to be provided to the meeting on the associated thematic review <p>Professor Hassell referred to completion of the death reviews and stated that the areas with higher numbers of outstanding reviews were the areas affected the most by covid and he queried if any additional support could be provided to those areas. Dr Lewis agreed, stating that additional support was being considered but expertise was required from the staff in those areas. Dr Lewis agreed to provide a timeline to address and complete the reviews to the Quality Governance Committee (QGC) identifying key learning points.</p> <p>The Trust Board received and noted the assurance report.</p>	ML

9.	IPC Board Assurance Framework (BAF) – April 2022	
073/2022	<p>Mrs Riley referred to BAF 1 and the ongoing work being undertaken with NHSIE Regional Infection Prevention leads, whereby risk based decisions were being made where the Trust was going outside of national guidance, in addition to this being considered and agreed at the internal clinical group and tactical group. It was noted that the risk score associated with BAF 1 therefore had increased. Mrs Riley added that new guidance was to be incorporated into the BAF in the next iteration.</p> <p>Mr Wakefield queried whether the changes impacted on BAF 7 in terms of isolation facilities and Mrs Riley stated that this had not negatively impacted on the patients being chosen to isolate.</p> <p>Mr Wakefield queried if zoning remained in place and Mrs Riley stated that those suspected of covid and other infections continued to be isolated.</p> <p>The Trust Board received and noted the report.</p>	
10.	Ockenden Final Report – 15 Immediate and Essential Actions Gap Analysis	
074/2022	<p>Mrs Jamieson presented the gap analysis undertaken following the publication of the final Ockenden report. The 15 immediate and essential actions were highlighted in addition to the immediate responses which had been taken.</p> <p>Ms Gohir referred to a number of publications which were due to be released in relation to maternity services and black and ethnic minorities which would be beneficial to be reviewed and incorporated into the overarching action plan.</p> <p>Dr Griffin welcomed the early decision to pause continuity of carer planning at the beginning of Covid, given the recommendations from Ockenden. He referred to the action in relation to telephone advice for neonatal resuscitation and whether this was progressing. Mrs Jamieson stated that conversations were being held with the neonatal team in relation to this and agreed to expand on the update in relation to this action in the next report.</p> <p>Mr Wakefield summarised that the Board had been asked to assure themselves of progress being made to adhere to the 4 pillars and he welcomed the honesty provided in completing the gap analysis. He stated that whilst the Board were assured, there remained actions to be taken and these would continue to be monitored.</p> <p>The Trust Board received the report as assurance of the progress being made towards achieving compliance with Ockenden – the Final Report.</p>	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH		
11.	Transformation and People Committee Assurance Report (27-04-22)	
075/2022	<p>Professor Crowe highlighted the following from the report:</p> <ul style="list-style-type: none"> • Positive assurance was provided in relation to the CENREE research and innovation group for Nursing and Midwifery and Allied Health Professionals • The Improving Together team highlighted challenges in their resource but good progress continued to be made 	

	<ul style="list-style-type: none"> The Committee approved the Research Strategy and People Plan 2022/23 Some concerns were raised with regards to the different initiatives in place and needing to ensure coordination between these <p>The Trust Board received and noted the assurance report.</p>	
ENSURE EFFICIENT USE OF RESOURCES		
12.	Performance & Finance Committee Assurance Report (26-04-22)	
<i>076/2022</i>	<p>Mr Akid highlighted the following from the report:</p> <ul style="list-style-type: none"> The Committee noted the further investment required in terms of the Digital Strategy and the cultural change required to embed a digital first approach It was noted that a number of the timeframes associated with actions within the BAF had passed and this was due to them being aligned with the end of the financial year which was to be reviewed for quarter 1. In addition it was agreed to reconsider the risk score for BAF 3 Positive assurances and major actions raised during the meeting were also highlighted <p>The Trust Board received and noted the assurance report.</p>	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
13.	Integrated Performance Report – Month 12	
<i>077/2022</i>	<p>Mrs Riley took the paper as read but highlighted that work was continuing to be undertaken to identify the actions required to improve sepsis screening</p> <p>Mr Wakefield referred to pressure ulcer performance and queried the reasons for the worsening trend. Mrs Riley referred to the deep dive into deep tissue injury ulcers and noted that delays to transferring patients had been identified as a concern and further information was to be provided to QGC in terms of what had been identified and the actions being taken to minimise harm.</p> <p>Ms Bowen queried the reason for the increase in patient falls and referred to medication incidents and whether any movement was anticipated on incidents reducing prior to the introduction of EPMA. Mrs Riley stated that in terms of patient falls, concerns had been raised in the Emergency Department regarding the visibility of patients and as such 6 doors had been removed which had improved visibility and the number of falls continued to be monitored to establish any impact. She added that the Trust was an outlier in terms of medication incidents and this remained a work in progress, Mrs Freeman added that when EPMA was introduced, she expected there to be an increase in incidents before it reduced.</p> <p>Ms Gohir referred to pressure ulcers and queried if the same patients could be counted twice and also queried the age profile. Mrs Riley stated that it would depend on the specialty and agreed to provide further analysis to QGC.</p> <p>Professor Maddock referred to the 3 never events and queried the assurance being provided on these. Mrs Riley explained that each incident was being investigated and a thematic review was being undertaken which would be considered at QGC. It was noted that the patients did not come to harm as a result of the never events.</p>	AMR

Mr Bytheway highlighted the following in relation to urgent care performance:

- The work undertaken to prepare for the Easter period had resulted in reduced pressure on the front door which had since been sustained
- Performance had started to increase due to the Emergency Department workforce coming online, an increase in the number of senior decision makers and Junior Doctors and sickness absence starting to reduce

Mr Wakefield referred to current performance and queried the reason for the enhanced primary care service being busy but not the out of hours GP service. Mr Bytheway stated that this was being worked through with the CCG and there should be an increase in the number of patients being redirected.

Professor Hassell referred to the challenges at County Hospital ED Performance and queried how these differed to that of Royal Stoke. Mr Bytheway stated that the challenges were the same in terms of workforce, number of medically fit for discharge patients and flow but the additional challenge was space as this was restricted at County Hospital. In addition due to having smaller numbers of staff, any reductions in staffing had a greater impact.

Mr Wakefield requested an update on the current position with ambulance holds and Mr Bytheway stated that these were reducing and space was being created to move patients more easily.

Dr Griffin queried whether the enhanced primary care service had commenced as planned and Mr Bytheway confirmed that this had commenced, some initial issues had been identified but it was moving in the right direction.

Mr Bytheway highlighted the following in relation to cancer performance:

- 62 and 104 day waits were reducing, demonstrating that activity was increasing
- There remained significant two week wait challenges within the breast team due to lack of medical resource in order to keep on top of demand
- The 7th theatre had come online and more work was being done to reduce the endoscopy backlog

Mr Wakefield referred to the reduced performance in the breast team and the size of the risk. Mr Bytheway stated that the workforce was not sufficient to treat the number of patients in a timely manner therefore locum cover was being utilised in addition to increasing the number of radiographers.

Dr Griffin referred to challenges in colorectal, skin cancer and histology and queried the plans in place to improve performance. Mr Bytheway stated that histology remained the biggest area of concern in terms of getting results back due to workforce issues and the inability to meet demand.

Dr Lewis referred to the number of outstanding 'blocks' which had fallen demonstrating some improvement in turnaround times for cancer and histology cases. He added that interviews were also due to take place for Histopathology Consultants.

Mr Bytheway highlighted the following in relation to planned care performance:

- Performance was above trajectory for inpatients and just below for daycase patients
- The number of 4 hour sessions in theatres had increased in addition to the number of patients being seen in theatres

Ms Bowen referred to the validation summit and queried how quickly this would provide a positive impact. Mr Bytheway stated that the summit reaffirmed the rules and added that a further update was to be provided to PAF.

Professor Maddock referred to the three charts on page 44 of the pack whereby the data seemed to stop in November, and Mr Bytheway agreed to review and update these.

PB

Mr Wakefield referred to the target of reducing 104 week waits to zero by June and queried how this was progressing. Mr Bytheway stated that this was to be considered by the Board Seminar, but highlighted that the number continued to reduce and performance was ahead of trajectory. He stated that the challenged areas were spinal and colorectal which reflected similar national challenges, although the reopening of the elective orthopaedic ward had helped.

Ms Bowen queried whether waiting list data was to be published by ethnicity and Mr Bytheway stated that this was being considered and Ms Ashley added that it was being considered as to how the data could be presented in a form that was meaningful to the public, and that this would be considered when reporting on April's data. Mrs Bullock stated that once the national ask of ethnicity and deprivation were reported the Trust would consider how data was to be presented in terms of other protected characteristics to give a fully rounded view.

Mr Bytheway stated that in terms of diagnostics performance, there had not been an increase in performance for Non Obstetric Ultrasound and the Trust had agreed funding to use private providers to improve performance, due to the ongoing challenges associated with workforce.

Mrs Vaughan highlighted the following in relation to workforce performance:

- Sickness absence remained the main area of concern although there had been an improvement in covid related absences which was presently 20% of all absences and had reduced from 39% at the time of the report
- Appraisal rates remained static at 75% and core for all statutory and mandatory training performance was holding at the required levels

Ms Bowen referred to the workforce dashboard and given recruitment was such an issue queried whether recruitment metrics should be included. RV stated that recruitment activity was monitored i.e. length of time to recruit and she agreed to provide further information to TAP.

RV

Professor Hassell referred to the changes in national guidance for staff covid testing and queried the current position. Mrs Vaughan stated that the guidance remained in place for patient facing NHS staff and staff were expected to continue with testing, using the free tests available from the national website.

Mr Oldham highlighted the following in relation to financial performance:

- The Trust ended in a strong position of an £8.7 m surplus against an anticipated £5.1 m surplus
- The increase had been driven by end of year adjustment regarding covid costs
- A late allocation had been received for critical care which had been offset by the annual leave accrual
- The system overall delivered a surplus
- The capital programme was challenged by receipt of late allocations but the allocations had been spent with the exception of £200,000
- The cash position ended lower than forecast but a payment for the Elective

	<p>Recovery Fund was expected to be paid in April</p> <p>Mr Wakefield thanked Mr Oldham and the finance team on behalf of the Board in delivering the positive year end position.</p> <p>The Trust Board received and noted the performance report.</p>	
GOVERNANCE		
14.	Audit Committee Assurance Report (29-04-22)	
<i>078/2022</i>	<p>Professor Crowe highlighted the following:</p> <ul style="list-style-type: none"> • The Committee welcomed the progress made with the Internal Audit programme, and reports received had been assessed as substantial assurance or good progress which was positive and underpinned the expected positive year end opinion from the Head of Internal Audit • The Committee considered the possibility of requiring an additional review into the implementation of Ockenden recommendations which would be considered in due course <p>Professor Crowe thanked Mr Oldham and Miss Rylands and their respective teams for the continued contributions and reports provided to the Committee.</p> <p>The Committee noted the assurance report.</p>	
15.	Speaking Up Report –Q4	
<i>079/2022</i>	<p>Miss Rylands took the report as read and highlighted the following:</p> <ul style="list-style-type: none"> • Miss Flint had commenced in post as the new Freedom to Speak Up Guardian • As the position had been increased into a full time post, this was enabling more proactive work to be undertaken resulting in additional contacts being made • Advertisement and recruitment to Associate Freedom to Speak Up Guardians had continued • Changes were to be made to the next quarterly report, incorporating additional detail within the report to TAP to enrich the discussion and an Executive Summary which would be considered by the Board <p>Professor Hassell welcomed the move of the Guardian to Corporate Governance and the separation from Human Resources. He referred to the Associate Guardians and whether they had any protected time. Miss Rylands stated that 1 to 2 days a month had been suggested, which would require support from their line manager. In addition, discussions had been held in terms of providing additional support to individuals for their training, including the national training but also coaching skills and courageous conversations.</p> <p>Professor Hassell queried whether there was opportunity to reflect on outcomes of investigations and identifying when things had gone wrong and practice changed as a result. Miss Rylands stated that a feedback process was in place and this was to be incorporated into future reports. Miss Flint added that she was exploring the opportunity for staff to share information from their experience of raising concerns.</p>	

	<p>Mr Wakefield welcomed the increase in support for the role and welcomed the input and initial actions taken by Miss Flint in her role in promoting a culture of speaking up at UHNM.</p> <p>The Trust Board received and noted the speaking up data and themes raised during Quarter 4 2021-22 and the themes and trends raised during the year. The Trust Board noted the proposed actions being taken to further encourage and promote a culture of speaking up at UHNM.</p>	
16.	Board Assurance Framework – Q4	
<i>080/2022</i>	<p>Miss Rylands highlighted that the document had been considered by the Committees during April and discussion had been held in terms of the reduction in risk score for BAF 3 - sustainable workforce. Subsequently the risk score had been increased to Extreme 16. She stated that new risks were to be reported on from Q1.</p> <p>Dr Griffin referred to the links to the risk register and the risk around critical care workforce and queried if could be considered at Committee level, this was agreed.</p> <p>The Trust Board approved the Board Assurance Framework for Quarter 4.</p>	
17.	Revised Corporate Governance Structure	
<i>081/2022</i>	<p>Miss Rylands highlighted the key changes made to the structure, which included the move for the Health and Safety and the Digital and Data Security and Protection Groups to report into TAP. It was noted that the structure would continue to be reviewed and updated as required.</p> <p>Mr Wakefield stated that once the Culture Review Committee had agreed it had fulfilled its duties, any remaining business would be reported to TAP.</p> <p>The Trust Board approved the revised Corporate Governance Structure.</p>	
18.	G6 & FT4 Self-Certification	
<i>082/2022</i>	<p>Miss Rylands highlighted that the self-certifications reflected the discussion held at a previous Board Seminar in March and was being brought to the Board for final approval. It was noted 2 elements of the self-certification could not be confirmed, which was the same as the previous year.</p> <p>The Trust Board agreed with the Trust’s self-certification in that FT4 (No. 4) and G6 were not confirmed.</p>	
CLOSING MATTERS		
19.	Review of Meeting Effectiveness and Business Cycle Forward Look	
<i>083/2022</i>	No further comments were made.	
20.	Questions from the Public	
<i>084/2022</i>	Mr Syme referred to the Digital Strategy and requested clarification as to how the	

	<p>Strategy would affect the role of the Trusts Caldicott Guardian and whether enhanced support was required to ensure the Trusts Caldicott Guardian can fully fulfil their duties.</p> <p>Mrs Freeman highlighted that she hoped that the strategy would result in the reduction of systems being used across the Trust which should provide a positive impact on the role of Caldicott Guardian, as there would be less systems to be overseen. She stated that it was an ambitious agenda but the roles of Chief Clinical Information Officer and Chief Nursing Information Office would assist in providing oversight. Dr Lewis added that if any additional workload pressures were identified these would be considered in due course.</p> <p>Mr Syme referred to the Ockenden update and in particular the labour and birth action. He referred to the midwife led unit at County Hospital and queried what operational risk assessments had been undertaken for the Midwife Led Unit (MLU) at County Hospital since it became operational and what had been learned and actioned from those assessments.</p> <p>Mrs Riley stated that whilst the MLU at County Hospital had been suspended, yearly risk assessments had been undertaken, but due to the short turnaround of the document it had been scored as red as the actual copy was not available at the time, therefore this was now green. She added that regular quality impact assessments were also undertaken and provided to the local maternity network service. Mrs Riley agreed to confirm that risk assessments had been undertaken for the previous years and to confirm any learning.</p>	AMR
DATE AND TIME OF NEXT MEETING		
21.	Wednesday 8 th June 2022, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at 01 June 2022

CURRENT PROGRESS RATING		
B	Complete / Business as Usual	Completed: Improvement / action delivered with sustainability assured.
GA / GB	On Track	Improvement on trajectory either: A. On track – not yet completed <i>or</i> B. On track – not yet started
A	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
R	Delayed	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/513	09/03/2022	CQC Action Plan	To consider and establish a way of highlighting the performance metrics associated with the action plan going forwards within the IPR	Scott Malton Ann Marie Riley	08/06/2022		Metrics associated with the action plan are being considered for inclusion in the performance report and a further update would be provided at the next meeting.	GB
PTB/514	09/03/2022	CQC Action Plan	To update the action plan and expand on the points raised in terms of measures of implementation and delivery and provide future updates on a quarterly basis.	Scott Malton Ann Marie Riley	30/06/2022		Action plan to be considered by CQC Assurance Group, followed by Quality Governance Committee in June, and Board in July.	GA
PTB/516	09/03/2022	Maternity Serious Incident Report – Quarter 3	To amend future reports to analyse ethnicity over a 12 month period.	Ann Marie Riley Sarah Jamieson	08/06/2022	01/06/2022	Included in Q4 report	B
PTB/517	09/03/2022	Maternity Serious Incident Report – Quarter 3	To amend future reports to include anticipated timescales to complete investigations in addition to identifying any particular learning points regarding emerging themes.	Ann Marie Riley Sarah Jamieson	08/06/2022	01/06/2022	Included in Q4 report	B
PTB/521	09/03/2022	Integrated Performance Report - Month 10	To provide a summary of the key trajectories to be achieved in the next few months in addition to identifying any particular vulnerabilities / challenges and discuss at PAF.	Paul Bytheway	31/05/2022		Update to be provided	GB
PTB/522	09/03/2022	Integrated Performance Report - Month 10	To provide an update to PAF in terms of the assumptions associated with improving ED performance, the trajectory for improvement and associated timescales.	Paul Bytheway Jen Freer	31/05/2022		Update to be provided	GB
PTB/524	06/04/2022	Chief Executives Report	To provide an update to QGC on the implications and risks associated with the new patient covid testing guidance	Ann-Marie Riley Scott Malton	30/06/2022		New guidance implemented beginning of May 2022. Update to be provided to June's QGC.	GA
PTB/527	04/05/2022	Quality Governance Committee Assurance Report (28-04-22)	To provide a timeline to address and complete the outstanding mortality reviews to the Quality Governance Committee (QGC) identifying key learning points.	Matthew Lewis	30/06/2022		Action not yet due.	GB
PTB/528	04/05/2022	Integrated Performance Report – Month 12	To provide additional analysis of pressure ulcers to QGC including age profile.	Ann Marie Riley	30/06/2022		Action not yet due.	GB
PTB/529	04/05/2022	Integrated Performance Report – Month 12	To update the three charts on page 44 of the pack to include most recent data	Paul Bytheway	08/06/2022	01/06/2022	Complete.	B
PTB/530	04/05/2022	Integrated Performance Report – Month 12	To provide information on key recruitment metrics to the TAP.	Ro Vaughan	30/06/2022		Action not yet due.	GB
PTB/531	04/05/2022	Questions from the Public	To confirm that risk assessments had been undertaken for the MLU for previous years and to confirm any learning.	Ann-Marie Riley	30/06/2022		Action not yet due.	GB



Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met virtually on the 25th May 2022.

The first part of the meeting was led by Matthew Lewis, Medical Director, where he presented a revised Standard Process for Referral and Admission of Patients. This document was an update to our existing Internal Professional Standards document and makes clear the responsibility of clinical leaders for decision making and management of flows of our patients throughout the organisation, therefore moving the focus of clinical activity and risk from our Emergency Department. The document had been widely consulted upon prior to being presented to the Committee and was therefore approved. The document will be communicated widely throughout the organisation for implementation commencing 29th May at 9:00am.

Divisions then took the opportunity to highlight any key matters requiring escalation, the following points were noted:

- Surgical Division sought support from the Procurement Team with regard to services for bariatric patients.
- Specialised Division confirmed that they had now resumed elective operations at County Ward 112.

Finally Executive Directors gave the following key updates:

- Leaders were urged to support the new 'Enable' Programme for middle managers
- Staff were thanked for their hard work and response to the incident associated with our network recently
- A process to review alternative video appointment technology had commenced with a series of demonstrations being held; clinicians were invited to join these
- Staff were thanked for their feedback in relation to the Culture Review and leaders urged to continue with these conversations and continue to provide further feedback
- Adverts had been publicised for leadership posts to support the County Hospital Programme
- Thanks were given for all of the work undertaken on 104 week waits which had seen a considerable improvement from over 400 at the end of March to the under 30 expected at the end of June
- Work on a new clinical excellence audit programme had been undertaken with a new system due to be launched over the coming weeks, which would digitalise the previous Clinical Excellence Framework (CEF)
- Acknowledgement of inflation rises and financial hardship being experienced with an expectation that the situation with regard to finance would become more challenging as Covid money comes to an end, cost improvement programmes to be given a new emphasis and national communicated planned around caps in payment; a package of support was being developed for staff in terms of financial hardship

Part 2: Chief Executive's Highlight Report

1. Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. Since 12th April to 11th May, 7 contract awards, which met this criteria, were made, as follows:

- **Gridley Hill Multi Storey Car Park** supplied by IHP Vinci, at a total cost of £565,655.54, approved on 26/04/22
- **Insourcing of Neurology Services** supplied by elective services, for the period 31/03/22 – 30/09/22, at a total cost of £600,000.00, approved on 26/04/22
- **Cytotoxic Dose Banded** supplied by various, for the period 01/04/22 - 30/06/22, at a total cost of £3,036,079.00, providing savings of £81,974.14, approved on 09/05/22
- **Corporate Travel Management** supplied by Corporate Travel Management, for the period 01/05/22 - 30/04/26, at a total cost of £720,000.00, providing savings of £929.28, approved on 26/04/22
- **Heart Valves Mechanical and Tissue** supplied by various, for the period 01/06/22 - 31/05/24, at a total cost of £2,045,150.40, providing savings of £11,497.67, approved on 26/04/22
- **Vehicle Fleet Hire Contract** supplied by Fleetcare, for the period 01/11/22 - 31/10/26, at a total cost of £795,535.68, providing savings of £1,865.00, approved on 26/04/22
- **Pacemakers Devices and Loop Recorders** supplied by various, for the period 01/05/22 - 31/12/22, at a total cost of £1,200,000.00, providing savings of £4,000.00, approved on 09/05/22

In addition, the following eREAFs has been retrospectively approved via an Extraordinary Non-Executive Directors meeting on 13th May, due to the approval and service being time critical:

Trent Wave 4b - New 26 Bed Ward (eREAF 9349) - Information

Contract Value £4,470,598.31 incl. VAT
 Duration Capital purchase
 Supplier Vinci Construction Ltd

2. Consultant Appointments – May 2022

The following table provides a summary of medical staff interviews which have taken place during May 2022:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Spinal Surgeon	New	Yes	01/06/2022
Locum Consultant Intensivist x 2	Vacancy	Yes	TBC
Specialist Doctor in Clinical / Medical Oncology	Vacancy	Yes	TBC
Consultant Histopathologist x 4	Vacancy	Yes	TBC
Locum Consultant Cardiothoracic Anaesthetist	New	No	N/A

The following table provides a summary of medical staff who have joined the Trust during May 2022:

Post Title	Reason for advertising	Start Date
Consultant Plastic Surgeon	Retire & Return	01/05/2022
Acting up Consultant in Respiratory	Vacancy	02/05/2022
Locum Consultant General Anaesthetist	Maternity	02/05/2022
Locum Medical and/or Surgical Retina Consultant Ophthalmologist	Vacancy	09/05/2022
Specialist Grade	Retire & Return	16/05/2022
Consultant Orthopaedic Surgeon	Retire & Return	16/05/2022
Locum Oral Max Surgeon	New	16/05/2022
Locum Consultant Radiology with interest in Thoracic/Lymphoma Imaging	New	16/05/2022

The following table provides a summary of medical vacancies which closed without applications / candidates during May 2022:

Post Title	Closing Date	Note
None to report.		

3. Internal Medical Management Appointments – May 2022

The following table provides a summary of Medical Management interviews which have taken place during May 2022:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Surgical Division Clinical Governance Lead	Vacancy	Yes	07/04/2022

The following table provides a summary of Medical Management who have joined the Trust during May 2022:

Post Title	Reason for advertising	Start Date
Not applicable.		

The following table provides a summary of medical vacancies which closed without applications / candidates during May 2022:

Post Title	Closing Date	Note
Clinical Lead - Respiratory Medicine	25/05/2022	Closed with no applications.

4. Covid 19 and Trust Pressures



Following an initial reduction in Covid numbers being seen at the beginning of the month, it appears to have plateaued towards the end although has remained at a significantly higher level than we hoped for. As a result we have remained busy with high bed occupancy affecting capacity for urgent care and elective care. Despite this, elective activity is increasing over time and we are now seeing many days where we are at pre pandemic levels. As such, we are making inroads with our waiting lists which is no mean feat given the pressures we are all still under and I am very proud of all staff who have been involved in delivering this for our patients.

5. System Wellbeing Week



A virtual wellbeing week organised by our partners in the Integrated Care System took place, providing participants with the opportunity to celebrate how far we have come, to reflect and to recuperate. The week had a fully packed agenda of high quality speakers and workshops and was really well received by those who attended.

6. Quarterly System Review Meeting



I joined system colleagues on 12th May for our quarterly System Review Meeting with our regulators at NHS England and Improvement. These reviews are focussed on current areas of pressure across the system and to discuss our key challenges. It was recognised that the recent surge of Covid and the staff absences as a result had been a particularly challenging time for us but that we had managed this very well. Detailed discussions took place in relation to our Elective / Cancer and Diagnostics performance, Urgent and Emergency Care performance, financial performance, Mental Health and Learning Disabilities, Maternity Services, Workforce and Integrated Care System Development.

A number of areas of positive progress were noted, in relation to:

- Integrated Care System (ICS) transition, including appointments made
- Management of the Omicron surge with acknowledgement of the huge pressures and significant activity being undertaken
- Being the only system in the Midlands to achieve all metrics for Covid Vaccinations
- Achievement of the Learning Disabilities and Autism trajectory target
- The People Hub, reservist work and Equality, Diversity and Inclusion, despite vacancy challenges
- Being seen as a 'High Performer' from a CQC perspective in relation to Mental Health

Our key challenges were also highlighted, these being:

- High numbers of patients waiting over 78 weeks with forecasted non-achievement of target, whilst recognising the focus had been 104 weeks and that work to determine the 78 week position was just starting
- Our system plan showing non-achievement of the 104 target by the end of 2022/23 with risks to the delivery of zero 104 weeks by the end of June. However, they acknowledged the position submitted was work in progress and that we are now planning to achieve this and at the time of the meeting were ahead of plan
- Sustained Urgent and Emergency pressures and significant risks around ambulance handover delays
- System financial deficit of £28.6m

As a result of the discussion, a number of actions were agreed and will be followed up at our next review:

- Resubmission of activity figures for Elective / Cancer and Diagnostics and to explore all possible options for achieving 78 weeks, including the identification of key risks
- Agreeing additional support from the national team with regard to Urgent and Emergency Care and providing an update on the outputs of our 'reset week' including lessons learnt and further actions
- Report on progress and milestones with our business cases to secure additional funding for digital, diagnostics and TIF 2
- To provide a progress report on Continuity of Care implementation, including timescales and actions

7 Refugee Nurses



I had the opportunity to meet and greet our new refugee nurses from Lebanon. This group of six nurses are very experienced in their native countries and arrived in the UK last month. Following a four week induction in Liverpool they are now settling into Stoke and have now begun their UHNM journey. I was delighted that we were selected as one of only a small number of Trusts to offer such placements and I am honoured to be able to offer them security in a job and a place to settle and it was wonderful to welcome them in person. I am looking forward to hearing about their progress over the coming months.

On a similar subject I was delighted to present my Chief Executive's Award to the nurse education team, who have supported 91 nurses from across the globe, ensuring that they can be successfully employed with us. This team not only focus on ensuring our international colleagues can work successfully in our NHS but a significant proportion of their time is spent supporting them to settle into their new social environment. This has resulted in UHNM being able to retain the vast majority of the international nurses recruited. This award was most definitely well deserved

8. Emergency Department



We launched the latest of our transformation initiatives in the Emergency Department at Royal Stoke to help improve waiting times and treat people quicker. We have now taken over the Urgent Care Centre (UCC) service which was previously provided by Vocare. The new service is called the Enhanced Primary Care (EhPC) stream which means patients are effectively directed to the most appropriate clinician or assessment portal on arrival or on referral from assessment in the community. This service is now receiving 50-60 patients a day which is a significant increase on those see under the previous service which in turn will help to ease the pressure in ED

9. Single Health Resilience Early Warning Database (SHREWD)



Another key development in managing the best patient experience and reduced waits through our hospitals and the wider system was the launch of a new digital platform called the Single Health Resilience Early Warning Database (SHREWD). The tool displays urgent care data in one easily accessible dial view, providing a real time overview of pressures across Staffordshire and Stoke-on-Trent and will support all system partners involved in managing the emergency care pathway.

10. Dying Matters Awareness Week



Our Palliative Care Team hosted a number of podcasts during Dying Matters Awareness Week, which was a great chance to get others talking and to share stories. We have also launched the new Purple Bow and individualised care bundles for last days of life.

11. Staff Engagement and Culture



We have taken the opportunity during May to hold a series of conversations with our staff to reflect on the recent review of our culture which was shared with the Board in April. The purpose of these sessions is to reflect and to seek ideas from our staff on how improvements can be made and we've had some really positive discussions and suggestions coming forward as a result. We will be reporting to the Culture Review Committee on how these plans are starting to shape up and will be continuing to engage, share and learn throughout the organisation.

12. Imaging Accreditation



Following a thorough four day onsite inspection, the Imaging Directorate has been recommended to maintain its external Quality Standards in Imaging (QSI / UKAS) accreditation which is a fantastic achievement especially during a very tough couple of years. The whole imaging team have worked tirelessly throughout the year to both maintain and improve quality standards, which is reflected in this accreditation.

13. Employer of the Year for Higher Apprenticeships



We were delighted to have been awarded as winners for the Employer of the Year Awards at Staffordshire University this month. Katie Berger, our Pathology Education Lead accepted the award on behalf of our Education Team – it is fantastic to see that all of the hard work put into our apprenticeships has been recognised in this way.

14. Histopathology Appointments



We have previously reported on workforce issues within our Histopathology department and the impact this is having on specimen reporting. I am therefore delighted that in May, we offered substantive consultant posts to four Histopathologists, all of who had been trained in our unit at Royal Stoke. The backlog has improved significantly over the last few months and these new appointments will help us to deal with the backlog completely and manage the day to day workload pressures in the department by providing more rapid reporting of biopsy specimens. These appointments are a tremendous testament to the training offered at UHNM, and a great example of how we develop the consultants of the future.

15. Network Issues



On the 18 May the Trust suffered network issues which significantly impacted on some phones and digital systems. In summary:

The Trust is two thirds through a programme of changes which have been taking place over the last 3 months, so far with no unintended impact. A planned change took place on the 18 May which involved an upgrade to move the data centre from the old network to the new network. Significant testing had taken place prior to the change with no issues experienced and a roll back plan was in place to address any unintended consequences should they occur.

On recognising a problem, the roll back plan was initiated but was unsuccessful. A local fix was unable to be undertaken by Nasstar so the problem was escalated to CISCO as a priority 1 call. The network and voice services were restored by 2.30 pm in a phased way as reloading took place.

A meeting of all partners took place on the 20 May to commence the RCA and a full paper will be brought through our governance arrangements in the usual way once we have had the opportunity to review the RCA.

16. Next Steps on Transitioning from Covid Response to Recovery



On 19th May, we received a letter from our regulators at NHS England and Improvement, setting out the next steps in transitioning from Covid response to recovery. Whilst the letter did not set any additional expectations or priorities on local systems beyond those already set out in national operational planning guidance, it made clear an expectation of Integrated Care Systems for immediate focus on the following priorities:

- **Delivering timely urgent and emergency care discharge;** addressing ongoing challenges across the urgent care pathway through improved discharge planning with discharges at weekends matching those on weekdays, while working in partnership to address wider system capacity challenges.
- **Providing more routine elective and cancer tests and treatments;** continuing progress already seen towards the target of July 2022 around elective care and treatment and people diagnosed with cancer having treatment within 62 days of GP referral.
- **Improving patient experience;** full implementation of updated Infection Prevention and Control guidance including national principles on hospital visiting and.

The letter also gave commitment to reducing the burden of additional national reporting where possible to do so and highlighted the immediate task of empowerment, partnership and innovation seen during the pandemic response being built upon, ensuring that lessons are learned to reform services for the future.

The letter has been shared with our Tactical Group for review and enactment.

17. National Healthcare Estates and Facilities Day 15th June 2022



The professional associations representing the majority of estates and facilities staff across UK healthcare have jointly created a national day to celebrate the essential work of all estates and facilities staff. The day, which is the first of its kind, will be held on Wednesday, 15th June 2022 and the third Wednesday of June every year thereafter. UHNM will be joining other Trusts across the County in promoting the day and celebrating the achievements of our staff within our Estates, Facilities and PFI Division and recognising the vital importance that each and every one of them play in providing safe, effective and caring services to our patients and a great place to work for our staff.





Executive Summary

Meeting:	Trust Board	Date:	8 th June 2022
Report Title:	Quality Strategy 2022-2025	Agenda Item:	7.
Author:	Ann-Marie Riley, Chief Nurse / Scott Malton, Deputy Chief Nurse		
Executive Lead:	<i>Ann-Marie Riley, Chief Nurse</i>		

Purpose of Report

Information	Approval	x Assurance	Assurance Papers only:	Is the assurance positive / negative / both?		
				Positive	x	Negative

Alignment with our Strategic Priorities

High Quality	x	People	Systems & Partners
Responsive		Improving & Innovating	Resources



Risk Register Mapping

<i>BAF1</i>	<i>Delivering Positive Patient Outcomes</i>	Extreme (20)
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Executive Summary

Our collective intent is to be a world-class centre of clinical and academic excellence, where staff work collaboratively to ensure patients receive the highest standards of care and the best people want to come to UHNM to learn, work and research delivering exceptional care with exceptional people.

We are proud of the achievements we have made on our journey to being a world-class centre of clinical and academic excellence having achieved 'Outstanding' for Caring in our most recent Care Quality Commission (CQC) inspection during 2021. However, our journey is far from over. Our new Quality Strategy sets out four key priorities that have been co-created with our staff, patients and their carers and we have utilised the latest evidence and research available to underpin our four key priorities.

- To develop consistently positive practice environments recognising our staff are safety critical
- To deliver consistently safe and reliable care.
- To prevent avoidable delay in patient assessment, treatment and discharge.
- To ensure that our patients have access to services that meets their needs and delivers positive outcomes and experiences.

This three year Quality Strategy puts patients and the communities we serve at the centre of our journey to world-class excellence ensuring that the care we provide is person centred and meets the needs of our population.

The Strategy has been aligned to organisational, regional and national priorities to ensure a joined up seamless approach to delivering our key objectives. Our Quality Improvement programme Improving Together is our key enabler to ensuring delivery of this strategy and clear milestones have been developed to ensure delivery can be robustly monitored.

Key Recommendations

- *For Board to approve the quality strategy*



UHNMM Quality Strategy

2022-2025

Contents

3	Foreword	29	Alignment to our Trust Strategy
4-5	Introduction & our values	30	Alignment to System Plans
6-7	Improving together	31	Resources Required
8-10	Context - where are we now?	32	How we will measure our success
11-13	How have we developed this strategy?	33	How we will monitor our progress
14	SWOT Analysis	34	How we will communicate this strategy
15-28	How we will get there: Priority 1, 2 & 3	35-36	How we will ensure equality, diversity and inclusion & plan on a page

Foreword



It is a such pleasure to welcome you to our Quality Strategy and share our key priorities to further support delivery of safe, high quality care over the next three years.

Each and every member of UHNM has a part to play in helping us realise the benefits of this strategy and deliver a positive impact on patient outcomes, and patient and staff experience.

The pandemic in particular has highlighted how brilliantly our teams work together to respond to challenges, lead innovation and develop patient centred, outcome focused pathways and services.

You will see that our Quality Strategy has a golden thread of collaboration and partnership, where our teams, healthcare partners and our population work together to make a positive difference for the people who use our services.

Ann-Marie Riley
Chief Nurse

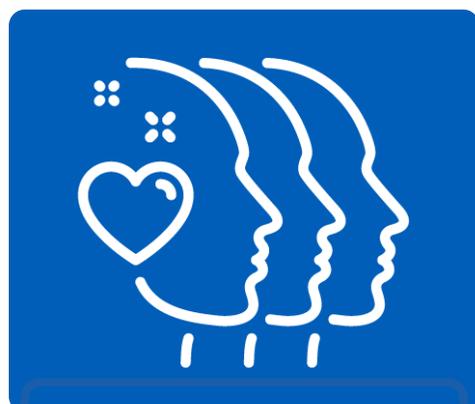
Matthew Lewis
Medical Director

Paul Bytheway
Chief Operating Officer

1. Introduction

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We are proud of the achievements we have made on our journey to being a world-class centre of clinical and academic excellence having achieved 'Outstanding' for Caring in our most recent Care Quality Commission (CQC) inspection during 2021. However, our journey is far from over. Our new Quality Strategy sets out four key priorities that have been co-created with our staff, patients and their carers and we have utilised the latest evidence and research available to underpin our four key priorities.



1. To develop consistently positive practice environments recognising our staff are safety critical.



2. To deliver consistently safe and reliable care.



3. To prevent avoidable delay in patient assessment, treatment and discharge.

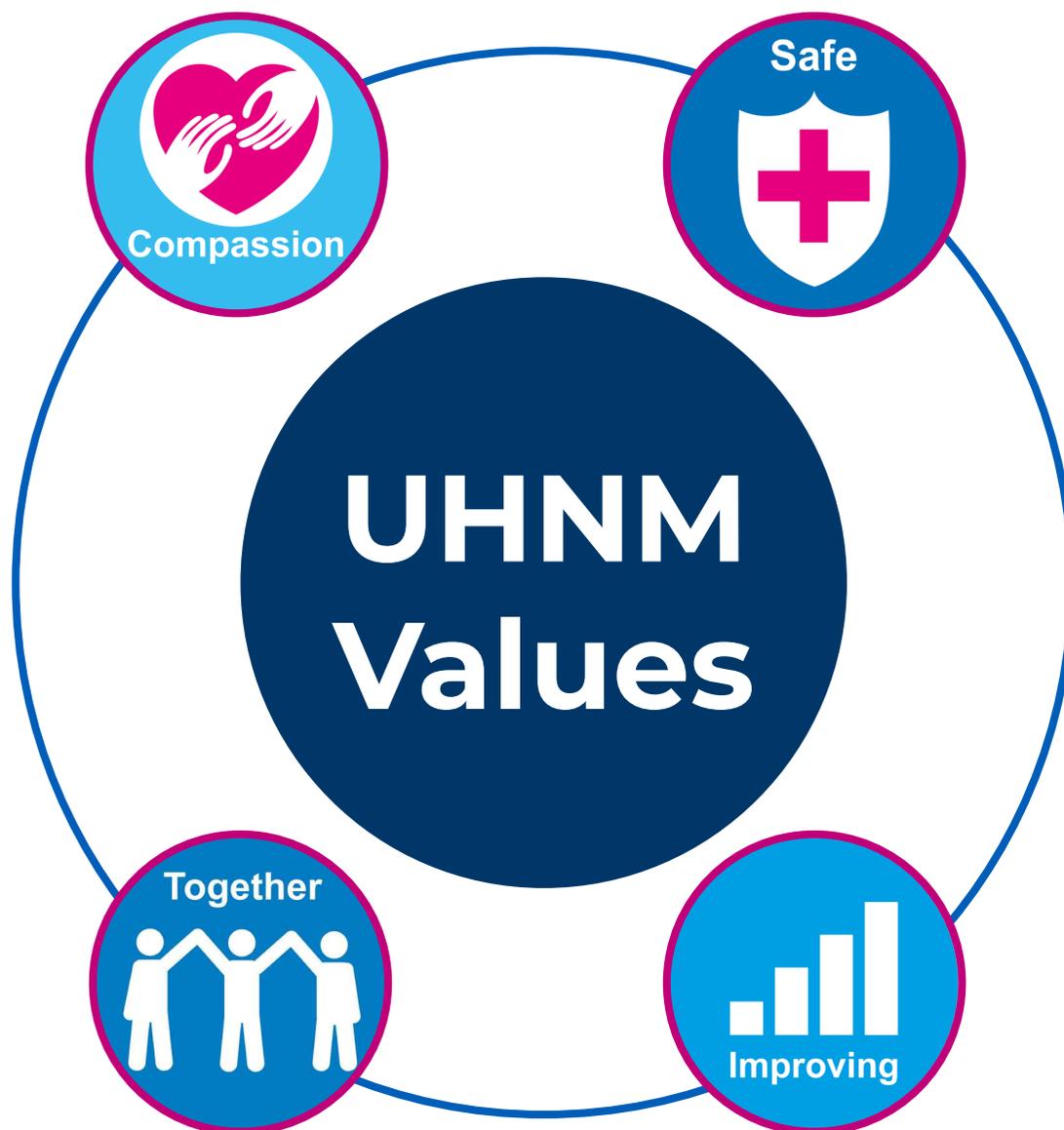


4. To ensure that our patients have access to services that meets their needs and delivers positive outcomes and experiences.

To support us in the delivery of our four key priorities we will continue to deliver our service improvement programme 'Improving Together' which builds on our organisation wide ambition of continuous improvement. Our Trust Values of 'Together', 'Compassion', 'Safe' and 'Improving' will remain at the core of all we do.

This three year Quality Strategy puts patients and the communities we serve at the centre of our journey to world-class excellence ensuring that the care we provide is person centred and meets the needs of our population.

Our Values



Together

We are a Team – I will be considerate, help others to achieve our goals and support others to make positive changes

We are Appreciative – I will acknowledge and thank people for their efforts and contributions

We are Inclusive – I will be open and honest, welcome people's views and opinions and involve people in the decisions that affect them

Compassion

We are Supportive – I will be empathetic and reassuring. I will support and encourage people when they need it

We are Respectful – I will treat people fairly, with respect and dignity, protect their privacy and help them to feel comfortable

We are Friendly – I will be welcoming and approachable. I will make eye contact, say hello and introduce myself

Safe

We Communicate Well – I will explain clearly, share relevant and timely information and keep people updated

We are Organised – I will plan ahead, manage my time well and be prompt in what I do

We Speak Up – I will contribute to ensuring health and constructive feedback for all so we can feel safe to challenge inappropriate care and behaviour and promote our values

Improving

We Listen – I will welcome people's views and ideas, invite people to ask questions and share their opinions and respond to what I hear

We Learn – I will share best practice, celebrate good performance and support others to use their skills, learn and grow

We Take Responsibility – I will have a positive attitude, act and encourage people to take the initiative and make improvements

2. Background

University Hospitals of North Midlands NHS Trust which spans over two sites, known as Royal Stoke University Hospital (RSUH) and County Hospital, works to deliver our '2025 Vision'. The Vision set a clear direction for the organisation to become a world-class centre of clinical care and academic achievement. The Vision outlined our strategic intentions for our clinical services and set the framework within which our staff would all work together with a common purpose to ensure patients receive the highest standard of care and to be the place in which the best people would want to work.

The Trust is implementing a continuous quality improvement methodology as the new way of working at UHNM – this is known as Improving Together. This is a LEAN based approach to cultural change, recognising that staff who deliver care know what needs to be done to make it better each day.

The Improving Together programme has supported the refresh of the Trust Strategy, creating six Strategic Priority Domains which help align the improvement energy of the organisation by focussing on what matters most and cascading these priorities in a meaningful way across the organisation. The Quality Improvement Academy, as the delivery team for Improving Together, will continue to train colleagues on the new Operational Improvement System, which is the new tools and routines that will enable our staff to do a little every day to improve the care we give to our patients and the environment within which we work. The fundamentals of this approach are to encourage structured, collaborative problem solving (known as A3 thinking) and supporting standardisation of processes to encourage predictability of delivery and outcomes and as a baseline from which we can improve.

The Trust has established its new strategic planning framework, with six Strategic priority domains

This Quality Strategy is directly linked to the Trust's Strategic Priority objective of High Quality and will enable the achievement of this strategic priority through continuous improvement and our Improving Together programme.

High Quality

Providing safe, effective and caring services

1

Response

Providing efficient and responsive services

2

People

Creating a great place to work

3

Improving and Innovating

Achieving excellence in development and research

4

Systems and Partners

Leading strategic change within Staffordshire and beyond

5

Resources

Ensuring we get the most from the resources we have, including staff, assets and money

6

3. Context - where are we now?

National context

The NHS Long Term Plan (2019) sets out a clear ambition for quality in the NHS by encouraging high quality of care for all across all of health, public health and social care.

A single definition of quality for the NHS was first set out in High Quality Care for All in (2008) and has since been embraced by staff throughout the NHS and enshrined in legislation through the Health and Social Care Act (2012). This definition sets out three dimensions to quality, all three of which must be present in order to provide a high quality service.

- Clinical effectiveness-quality care is care which is delivered according to the best available evidence
- Safety-quality care is care which is delivered so as to avoid all avoidable harm and risk to patient safety
- Patient experience-quality care is care which looks to give the individual as positive an experience as possible

The Health and Social Care Act (2012) also defines success in terms of the outcomes which are achieved for patients and service users. The NHS Outcomes Framework (2022) sets out the national outcomes that all providers of NHS-funded care should contribute towards. These outcomes span five domains:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

The quality of care we provide to our patients is regulated by the Care Quality Commission (CQC) who can take enforcement action if our standards fall below those set out by the Commission in their Guidance about compliance: Essential standards of quality and safety (2018).

Our Quality Strategy 2022-2025 sets out to build on the Trust's previous quality strategies and brings into focus four key priorities so that we achieve local, regional and national standards regarding quality of care to ensure regulatory compliance and patient satisfaction.

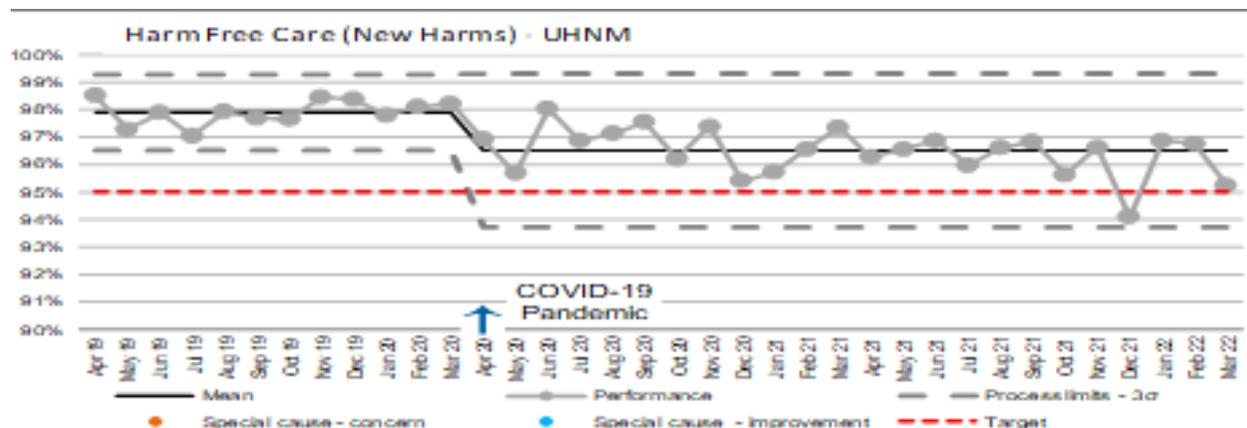
The Quality Strategy 2022-2025 four key priorities are aligned to the national quality agenda, the Health and Social Act (2012), the National Outcomes Framework (2022), the CQC key Lines of Enquiry (KLOEs) and UHNMs Strategic Priority Objectives (see figure 1).

Figure 1: Quality priorities aligned to national, regulatory and UHNM strategic objectives

Quality Strategy Priorities 2022-2025	The CQC - Key Lines of Enquiry (2018)	The Health and Social Care Act (2012)	The National Outcomes Framework (2022)	UHNM Strategic Objective Priorities
To develop consistent positive practice environments recognising out staff are safety critical	<ul style="list-style-type: none"> • Safe • Effective 	<ul style="list-style-type: none"> • Clinical effectiveness • Safety 	<ul style="list-style-type: none"> • Prevent people from dying prematurely 	<ul style="list-style-type: none"> • High quality • People • Improving and innovating
To deliver consistently safe and reliable care	<ul style="list-style-type: none"> • Safe • Effective • Caring • Responsive 	<ul style="list-style-type: none"> • Safety • Clinical effectiveness 	<ul style="list-style-type: none"> • Treat and caring for people in a safe environment and protect from avoidable harm 	<ul style="list-style-type: none"> • High quality • Systems and partners
To prevent avoidable delay in patient assessment, treatment and discharge	<ul style="list-style-type: none"> • Safe • Effective • Responsive 	<ul style="list-style-type: none"> • Safety • Patient experience 	<ul style="list-style-type: none"> • Enhance quality of life for people with long term conditions 	<ul style="list-style-type: none"> • Responsive • High quality • Systems and partners
To ensure that our patients have access to services and/or treatments that meets their needs and delivers positive outcomes and experiences	<ul style="list-style-type: none"> • Safe • Effective • Caring • Responsive 	<ul style="list-style-type: none"> • Patient experience • Safety 	<ul style="list-style-type: none"> • Ensuring people have a positive experience of care 	<ul style="list-style-type: none"> • High quality • Improving and innovating

We have made good progress at UHNM in delivering high quality, safe services. We continually exceed the target in the national Harm Free Care survey. The national target for this survey is 95% and we consistently are above that threshold (see figure 2).

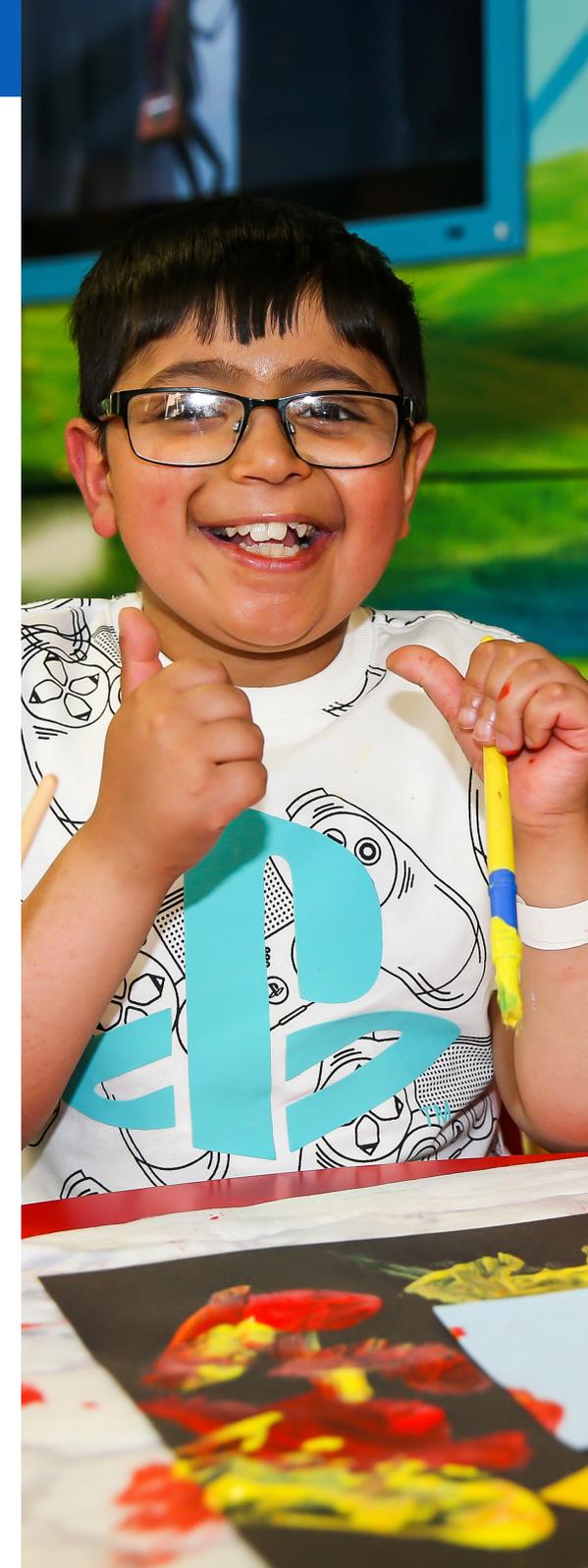
Figure 2: Harm free care score (2019-2022)



However, we recognise that we have more work to do. This is evident by our current CQC inspection results which demonstrate our progress but also highlights areas that require improvement (see figure 3).

Figure 3: UHNM CQC rating following inspection August 2021

Domain	June 2019 Ratings	August 2021 Ratings	Visual Rating
Are services safe?	Requires Improvement	Requires Improvement	Yellow Circle
Are services effective?	Requires Improvement	Requires Improvement	Yellow Circle
Are services caring?	Good	Outstanding	Green Star
Are services responsive?	Requires Improvement	Requires Improvement	Yellow Circle
Are services well led?	Requires Improvement	Good	Green Circle
Overall	Requires Improvement	Requires Improvement	Yellow Circle



The Quality Strategy 2022-2025 is being launched at a challenging time for the NHS given the national context of the COVID-19 pandemic which severely restricted access to services for many of our patients. As we move into the recovery phase, learn to live with COVID-19, and restore all our services to optimal levels, it has never been more important that quality and safety are at the forefront of all we do. As an organisation, supported by our continual improvement programme and our dedicated teams, we have never been more ready to face this challenge.

4. How we have developed this strategy

The Quality Strategy 2022-2025 has been developed with involvement from staff, service users and carers/relatives. A literature review was undertaken to ascertain current best practice in terms of quality in an acute setting. A thematic review of the Trust's harm data and incidents was undertaken in order for us to be confident that our priorities capture the true essence of the challenges identified and that our key initiatives have identified metrics that make it clear what we are aiming for and when we have achieved our goals. Using the tools and principles available to us from Improving Together we have undertaken the 'A3' process on each of the four priorities.

Four clear priorities emerged from the literature and these were reflected during consultation with our staff, patients and relatives/carers.

Priority one: To develop consistently positive practice environments recognising our staff are safety critical

There is a plethora of national and international evidence describing the complex interdependent relationship between staffing and its effect on various factors including timeliness and completeness of care delivery, patient safety, and patient and staff experience. Nationally, however, it is evident that recruiting, supporting continued professional development and retaining staff is a key challenge across all healthcare providers. We aim to be the regional employer of choice and will continue to introduce innovative ways to recruit, develop and retain our workforce.

Our colleagues are valuable assets and we will strive to ensure everyone is able to have a positive experience at work as we recognise how key this is to supporting individual and team well-being, and how interlinked staff experience is to our ability to consistently deliver safe, high quality care.



Evidence shows that patient satisfaction is highest in NHS organisations that have high employee engagement and more engaged employees have been linked to better outcomes for patients and service users.

An empowered work environment enhances positive outcomes for both our colleagues and those who use our services. We will support our teams to have the time, skills and resources they need to make the improvements they feel are necessary to improve patient outcomes and patient and staff experience.

Priority two: To deliver consistently safe and reliable care

‘Patient safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS’ definition of quality in healthcare, alongside effectiveness and patient experience’ (The NHS Patient Safety Strategy 2019).

In line with national ambitions we will work to continually improve the reliability and effectiveness of our clinical systems and processes to positively impact our overall patient safety culture and system. Evidence shows that clinically research-active hospitals have better patient care outcomes. We will deliver a programme of work to further develop a research culture across UHNM, offering increasing numbers of colleagues the opportunity to be involved in research activity and publication.

Clinical effectiveness is defined as ‘the application of the best knowledge, derived from research, clinical experience, and patient preferences to achieve optimum processes and outcomes of care for patients. The process involves a framework of informing, changing, and monitoring practice.’ (Promoting Clinical Effectiveness, NHS Executive 1996). Our Clinical Effectiveness Group was started in 2022 to develop divisional strategies that reflect issues raised through complaints, audits, incidents, risks, national best practice, research, innovation and quality improvement programmes.

We will continue to make effective use of data to reduce unwarranted variation and support continual improvement. We will learn when things go wrong and, where appropriate, will ensure that learning is shared across our system partners to maximise opportunities to improve safety for our populations. We will develop a range of harm free care related ambitions to define and standardise care against best practice and improve reliability in these areas.



Priority three: To prevent avoidable delay in patient assessment, treatment and discharge

Our population is facing the on-going impact of the COVID-19 pandemic via delays in access to care both from an elective and non-elective perspective, delays which could lead to avoidable stresses and harm. We will continue to work tirelessly to review our systems, processes and pathways so we can ensure patients receive the care they need with the least delay possible.

For any patients subject to delays we will continue to proactively assess their care needs to minimise the potential for harm to occur.

We aim to maximise technological and digital solutions to support improved clinical pathways, improved outcomes and deliver opportunities to release clinical time to care.

Priority four: To ensure that our patients have access to services and/or treatments that meet their needs and delivers positive outcomes and experiences

The overall experience and safety of our patients is just as important out of hospital as it is when they are an inpatient with us. We will work collaboratively across the system to understand improvement opportunities for those across our population who are at the highest risk of adverse outcomes.

We recognise the importance of developing an equal partnership between our staff, patients and the wider population we serve and will strive to understand what matters most to those who use our services. We will increasingly work in partnership with our patients and public, co-producing solutions to improve their outcomes and experience.

We will develop annual patient priorities, based on patient and carer feedback so we can continually learn from and improve the patient experience.



SWOT (strengths, weaknesses, opportunities and threats) Analysis

In order to support the implementation of the Quality Strategy, a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis has been undertaken to ensure that all aspects of strategy delivery are taken into consideration.

Strengths

- Outstanding for Caring (CQC)
- CeNREE to support staff development and research vision
- Improving Together QI programme
- Quality Team
- Safe Medications Officer
- Safe Devices Officer
- Care Excellence Framework
- External Accreditations

Weaknesses

- Limited staff with project management experience
- Large focus politically on operational delivery which may overshadow other projects
- Tired workforce following working through the pandemic
- ICS board new with governance arrangements still being decided

Opportunities

- Staff development
- New roles and secondment opportunities
- Improving the quality of services
- Engaging patients, relatives, and carers
- Digital innovation
- Divisional realignment to the strategy will support future developments

Threats

- Divisional realignment and Management of Change
- ICB maturity to support collaboration and innovation across pathways
- New wave of COVID-19 may set back our plans and milestones
- Staff availability across patient pathways

5. How we will get there

The Quality Strategy 2022-2025 will focus on four key priorities. Each of these priorities has a number of initiatives that are set against milestones so the progress against each of the priorities can clearly be measured.

Priority one: To develop consistently positive practice environments recognising our staff are safety critical.

Key Initiatives	Year 1: 2022 (Milestones)	Year 2: 2023 (Milestones)	Year 3: 2024-25 (Milestones)	Key Metrics
<p>To develop our establishment review process to include all nursing, midwifery, allied healthcare professionals and registered pharmacy professionals across ward and non-ward based areas</p>	<p>All electronic roster ward based areas to have an establishment review factoring in acuity, environment and finance</p> <p>All budgets aligned to the electronic roster</p> <p>All theatres across the Trust to be included in the establishment review</p> <p>Birthrate Plus assessment</p>	<p>All outpatient areas to be included in the establishment review</p>	<p>All allied healthcare professionals services to have undertaken their first establishment review</p>	<p>100% compliance with the business cycle of the establishment review process</p> <p>100% of all budgets aligned with the electronic rosters</p>

Minimise the number of vacancies across all staff groups

To establish a robust process to monitor nurse, midwife, allied healthcare professionals and registered pharmacy professional vacancies across UHNM

Corporate nursing team to manage the recruitment of Band 2 and 3 healthcare assistants

Corporate nursing team to manage the recruitment of newly qualified registered nurses

To complete retention self assessment tool and develop appropriate action plan

To continue with overseas recruitment plan

Zero healthcare support workers vacancies

2% reduction in registered nurse turnover

Model hospital upper quartile performance for registered nurse turnover

2% reduction in registered nurse turnover

Nursing vacancy factor to be within agreed tolerance of 7-9% by year three

Midwifery vacancy factor to be within agreed tolerance of 7-9% by year three

Allied health professional vacancy factor to be within agreed tolerance of 7-9% by year three

Medic and non-clinical staff vacancy factor to be within agreed tolerance

To roll out Improving Together as our organisational continuous improvement approach

To have trained the first 20 wards in the Operational Improvement System (OIS)

To have all divisions and directorate leadership teams trained and delivering the Improving Together programme as business as usual – sustaining the improvement work through the organisation

To have introduced the OIS across the full value stream of Elective Surgery at County Hospital

To have 80% of County Hospital working within the Improving Together team, making Improving Together business as usual on that site

To have 28 ward areas working to Improving Together

To complete the delivery of Improving Together to County Hospital

To have trained 40 (63%) of ward teams with Improving Together

NB Trajectory of completion Improving Together training to all ward areas is April 2026

Metrics used locally in divisions and agreed as part of the 'A3' process

Delivery of the Trust's strategic objectives

To improve our staff survey results

Support year one actions aligned to Positive and Inclusive Culture A3

Support year two actions aligned to Positive and Inclusive Culture A3

Support year three actions aligned to Positive and Inclusive Culture A3

To be in the top 20% of Trust's by 2024

Local staff surveys

National staff survey - to be in the top 20% of Trust's by 2024

Develop a culture of inclusion and belonging

National tool kit on civility and implemented

Chief Nurse to have completed the Getting to Equity programme and be an active sponsor

Overseas nurses, midwives, allied healthcare professionals and registered pharmacy professionals forum established to celebrate the diversity of our workforce

Civility and Respect training programme implemented

Chief Nurse fellow programme established

Just Culture principles embedded at all levels of the organisation

Workforce race equality standard data improvements seen in senior (band 8a upward) posts

Improved staff survey results

Reduction in formal grievances

Priority Two: To deliver consistently safe and reliable care

Key Initiatives	Year 1: 2022 (Milestones)	Year 2: 2023 (Milestones)	Year 3: 2024-25 (Milestones)	Key Metrics
<p>Develop a suite of harm free care ambitions that will set out clear improvement priorities</p>	<p>Develop suite of harm free care ambitions and deliver year one milestones for:</p> <ul style="list-style-type: none"> Optimal nutrition and hydration Optimal skin integrity Optimal continence function Safe and timely medication administration Plan for electronic prescribing and medicines administration launch Assessment and treatment of to prevent venous thromboembolism Prevention of nosocomial infection Safe mobility 	<p>Develop suite of harm free care ambitions and deliver year 2 milestones for:</p> <ul style="list-style-type: none"> Optimal nutrition and hydration Optimal skin integrity Optimal continence function Safe and timely medication administration Assessment and treatment of to prevent venous thromboembolism Prevention of nosocomial infection Safe mobility Continue to grow our electronic prescribing and medicines administration technology 	<p>Develop suite of harm free care ambitions and deliver year three milestones for:</p> <ul style="list-style-type: none"> Optimal nutrition and hydration Optimal skin integrity Optimal continence function Safe and timely medication administration Assessment and treatment of to prevent venous thromboembolism Prevention of nosocomial infection Safe mobility Continue to grow our electronic prescribing and medicines administration technology 	<p>On-going improvement in Clinical Excellence Audit (CEA) programme quality indicators</p>

Implement a Trust Wide digital audit programme to measure the quality of care delivered to our patients

Implement digital Clinical Excellence Audit (CEA) programme

Annual review of audit questions aligned to current best practice

Annual review of audit questions aligned to current best practice

On-going improvement in Clinical Excellence Audit (CEA) programme quality indicators

Review the Clinical Excellence Accreditation Framework (CEF) to reflect the priorities within this strategy

Develop ward to Board quality and safety dashboard

Develop Clinical Excellence Support framework

Refresh criteria for each level of accreditation

All wards to have commenced the new accreditation framework

Collaborate with other organisations to create a regional/national data set of nursing, midwifery and allied health profession sensitive indicators that could be subject to peer benchmarking

Establish a research base for future research linked with Centre for NMAHP Research and Education Excellence and the Chief Nursing Officer research strategy

Continual assessment and improvements linked to Improving Together

Clinical Excellence Audit (CEA) data within agreed range for accreditation

Ensure that safeguarding of our most vulnerable patients is central to all we do.

Staff should be knowledgeable in safe guarding processes to ensure that patients are protected when abuse is suspected/disclosed

Chaperone policy to be updated and disseminated across the Trust

Meet S29a requirements in relation to care of patients requiring mental health support

Recruit to safeguarding lead post

Review of safeguarding training to ensure best practice

Collaborate with system partners to scope options for implementation of Liberty Protection Safeguards requirements

Full review of our safeguarding, mental health, learning disability and autism services across UHNM

Increase safeguarding training compliance for all our staff by 20%

Maintain safeguarding training compliance at 85% or above

Statutory and mandatory safeguarding training compliance figures 85% in each division

To ensure the timely undertaking of patient observations (BP, Resp, Pulse, O2 and Temp) and appropriate escalations and actions

Develop ward to board quality and safety dashboard

Set clear performance metrics in relation to timely observations

Performance data to be reported to the Quality and Safety oversight Group and Quality Governance Committee

In year increase in wards/department meeting required performance in relation to timely observations

All wards and departments meet required performance in relation to timely observations

90% of clinical observations consistently completed on time

Patient Safety Incident Response Framework (PSIRF)

All internal processes to have been reviewed with regards to governance and the PSIRF agenda

In-patient falls PSIRF process established with the Integrated Care System

Business case for PSIRF lead agreed

Agreed responses for all incident responses across the integrated care system

Thematic reviews system in place and established.

PSIRF completely rolled out across the organisation

Work in collaboration with Patient Safety Learning to complete Safety Assessment at UHNM

Complete assessment tool and develop year one action plan

Deliver in year actions

Deliver in year actions

Completion of all actions and positive assessment by patient safety lead

Develop a Centre of Research and Innovation Excellence (CeNREE) which includes a human factors faculty

Complete job plans for all staff with research in their job description, to provide protected time for nursing, midwifery and allied health professions led research

Provide opportunities to all nursing, midwifery and allied health professional staff to engage in research

Establish rapid review team to answer urgent clinical care questions

Competitive continuing professional development funding application process to ensure best applicants and topics aligned with Trust priorities

Robust research process and research and innovation structure, which includes clear governance and safety standard operating procedures

Develop clinical academic job descriptions for agenda for change Bands 5-8

Clinical Academic Career pathway in place agenda for change Band 5-8 to develop excellence in NMAHP research in multiple professional disciplines

All staff to have opportunities to engage with research at some level

Increase dissemination of research to local, national and international audiences

Increase collaborations for multi-centre research

Increase successful NMAHP academic grant and fellowship applications

Increase publications as lead author to disseminate research to local, national and international audiences including high impact factor journals

Lead collaborations for multi-centre research

Year on year increase in number of staff leading or participating in research activity/ publications

<p>Deliver Clinical Effectiveness Group objectives</p>	<p>Develop and deliver annual Divisional Clinical Effectiveness Work Plan</p>	<p>Develop and deliver annual Divisional Clinical Effectiveness Work Plan</p>	<p>Develop and deliver annual Divisional Clinical Effectiveness Work Plan</p>	<p>Clinical audit data get it right first time performance Adherence to national institute of clinical excellence guidance Model Hospital benchmarking data</p>
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Priority Three: To prevent avoidable delay in patient assessment, treatment and discharge

Key Initiatives	Year 1: 2022 (Milestones)	Year 2: 2023 (Milestones)	Year 3: 2024-25 (Milestones)	Key Metrics
<p>We will better understand the potential/actual harm caused through not achieving the constitutional standards across non elective and elective pathways</p>	<p>Deep dive review considering impact of ambulance holding and long waits in ED on skin integrity</p> <p>Reassess our harm review process for our long wait patients to ensure all aspects of harm are considered as part of the review process</p>	<p>Deliver in year harm review deep dive schedule</p>	<p>Deliver in year harm review deep dive schedule</p>	<p>Harm incidence</p>

To reduce steps and procedures that do not add value to patients and service users outcomes or experience

Red to Green dashboard to be developed

Red to Green process being utilised across all adult in patient areas at UHNM

In collaboration with system partners to develop Excellence in Discharge programme

Regular forum established for our Discharge facilitators across all our in-patient wards to ensure learning is far reaching

Establish a patient forum on the discharge process working closely with Healthwatch to refine our discharge processes

Create and deliver a formal patient discharge training programme that upskills our staff to ensure timely and accurate discharge plans

Improvement in patient survey results relating to the discharge process

Healthwatch assessment of our discharge processes

Red to Green key performance indicators within agreed limits for all in-patient wards

All ward based staff who are part of the discharge process to have access to the training programme

Focus on improvement initiatives on the transition between services to reduce the amount of time patients and service users are waiting to access the next steps of their pathway

Criteria led discharge across all specialties at UHNM

Reassess our admission process for mental health patients who require admitting to the acute provider with a physical condition.

When patients are medically fit for discharge there are no delays by UHNM in referring the patient on to community services

Strong partnership with our in-patient mental health assessment team with clear defined key performance indicators and robust monitoring of the service to ensure it continues to meet the needs of our patients in a timely way

All patients who are discharged from hospital will receive a timely and accurate discharge letter

Staffing model which allows nurses, midwives and to work across traditionally set organisational boundaries

Transitional services that are nurse, midwife and allied healthcare professional led.

The delivery of the Integrated Care System five year plan objectives

Fewer long term health condition patients being admitted to acute hospital beds

Wherever possible we will avoid in-patient care so that patients are can be assessed, investigated and treated in (or from) their own homes

Increase capacity of virtual wards

Collaborate with partners to support delivery of the Integrated Care System five year plan

UHNM to take over the front door assessment of patients from Vocare

Collaborate with partners to support delivery of the Integrated Care System five year plan

Develop nurse, midwifery and allied healthcare professional led pathways for patients to support care closer to home

Reassess ability to deliver continuity of carer service for maternity

Staffing model which allows nurses, midwives and allied healthcare professionals to work across traditionally set organisational boundaries.

Transitional services that are nurse, midwife and allied healthcare professional led

The delivery of the Integrated Care System five year plan objectives

Fewer long term health condition patients being admitted to acute hospital beds

Priority Three: To prevent avoidable delay in patient assessment, treatment and discharge

Key Initiatives	Year 1: 2022 (Milestones)	Year 2: 2023 (Milestones)	Year 3: 2024-25 (Milestones)	Key Metrics
<p>Strengthen our patient/public voice and ensure we maximise opportunities for co-production across our improvement portfolio</p>	<p>Co-produce and publish our carers strategy</p> <p>Recommence Friends and Family Test audits across the organisation</p> <p>Convene an active patient and public involvement group for research</p> <p>Develop co-produced annual patient priorities based on patient/carer feedback</p>	<p>Develop patient partnership chair role</p> <p>Develop patient partnership group with representation across each Division</p> <p>In year increase in co-production initiatives</p>	<p>In year increase in co-production initiatives</p>	<p>Patients participating in patient safety investigations</p> <p>Meeting all eight of the dementia care standards</p> <p>All patient safety quality improvement projects to have patient representation on the project groups</p> <p>All research projects to have patient and public involvement from design to dissemination</p> <p>Number of co-production initiatives</p>

To ensure if someone has cause to raise a complaint that the process is simple, timely and effective answering the concern raised in a format that all our service users can understand

Best practice timings for complaint turnaround

Scope potential for increased patient involvement in the investigation process of complaints and incidents

Appoint to the head of complaints role substantively

Develop electronic complaints system

New innovative ways explored to ensure our patients voices are heard using different technologies

Substantive Head of Complaints role appointed

All written complaints response within nationally recommended times scales

6. Alignment to our Trust Strategy

The Quality Strategy is aligned to our Trust Strategy. The Trust has six priority objectives (High Quality, Responsive, People, Improving and Innovating, Systems and Partners and Resource). The Quality Strategy is aligned to the Trust Priority Objective of High Quality. The Quality Strategy is an enabling strategy and will ensure the delivery of the priority objective of High Quality.

In the section 3-Context, where are we now, the table in figure one clearly highlights which elements of the Quality Strategy align with the Trust's Strategy.



7. Alignment to system plans

This strategy compliments the wider system commitment to improving health outcomes for its residents including focus on collaboration to develop of seamless pathways, the principles of care closer to home and empowering patients to support their own health and wellbeing.

Next steps ICS development

System performance and finance

1. Improve outcomes in population health and healthcare
2. Tackling inequalities in outcomes, experience and access
3. Enhancing productivity and value for money
4. Helping the NHS support broader social and economic development



1. Recovery



2. System savings

Additional priorities



3. Frailty



4. Health inequalities

8. Resources required

As detailed in section 5 – ‘How will we get there’, several key initiatives have been identified which are required in order for the Quality Strategy to progress and be delivered. A number of these initiatives will be delivered using existing structures within the corporate and bed based divisions and will not require additional funding in order for us to realise the quality gains. Some aspects of the funding required has already been secured and the work has commenced. However, it is recognised that business cases will be required for two of the initiatives. The table below outlines the resources required and identifies the funding stream.

Resource Required	Cost 2022	Cost 2023	Cost 2024-25	Funding stream
Perfect Ward- digital auditing system	£ 74,790	£ 74,790	£ 74,790	Funding secured
Patient safety learning programme (in association with Helen Hughes –CEO Patient Safety Learning)	£6750	£5000	£5000	Funding Secured
Patient Safety Incident Response Framework (PSIRF) lead Band 8a	£ 55,000 including on costs (recurrently)	£ 55,000 including on costs (recurrently)	£ 55,000 including on costs (recurrently)	Business Case Required
Timely care project lead Band 8a secondment (1 year)	£27,500 (part year effect including on costs)	£27,500 (part year effect including on costs)	N/A	Business case required
Excellence in discharge matron (6 month secondment) Band 8a	£27,500 (including on costs)	N/A	N/A	Include in winter planning assumption
Chief Nurse Fellowships	20 per year (max 2 days per month back-fill costs)	20 per year (max 2 days per month backfill costs)	20 per year (max 2 days per month backfill costs)	Continuing professional development allocation

Business cases resulting from establishment reviews will be submitted for consideration as required.

9. How we will measure our success

The metrics on how we will measure our success are clearly laid out in the tables in section 5- how will we get there. Each table has a section that is labelled key metrics. The items listed in this column are the mechanisms in which we will measure our success.

Where possible we have aligned these methods of measuring with national standards. In some cases, we are designing and implementing new systems and processes which means that the data capturing method does not yet exist. Perfect ward is a good example of this. Once this electronic auditing system has been rolled out it will give us a unique opportunity to measure aspects of care and quality that we have not had the ability to do, in real time, before. This ability to have oversight of all our clinical areas electronically will enhance the quality of our services and the timeliness of our responses.



10. How we will monitor our progress

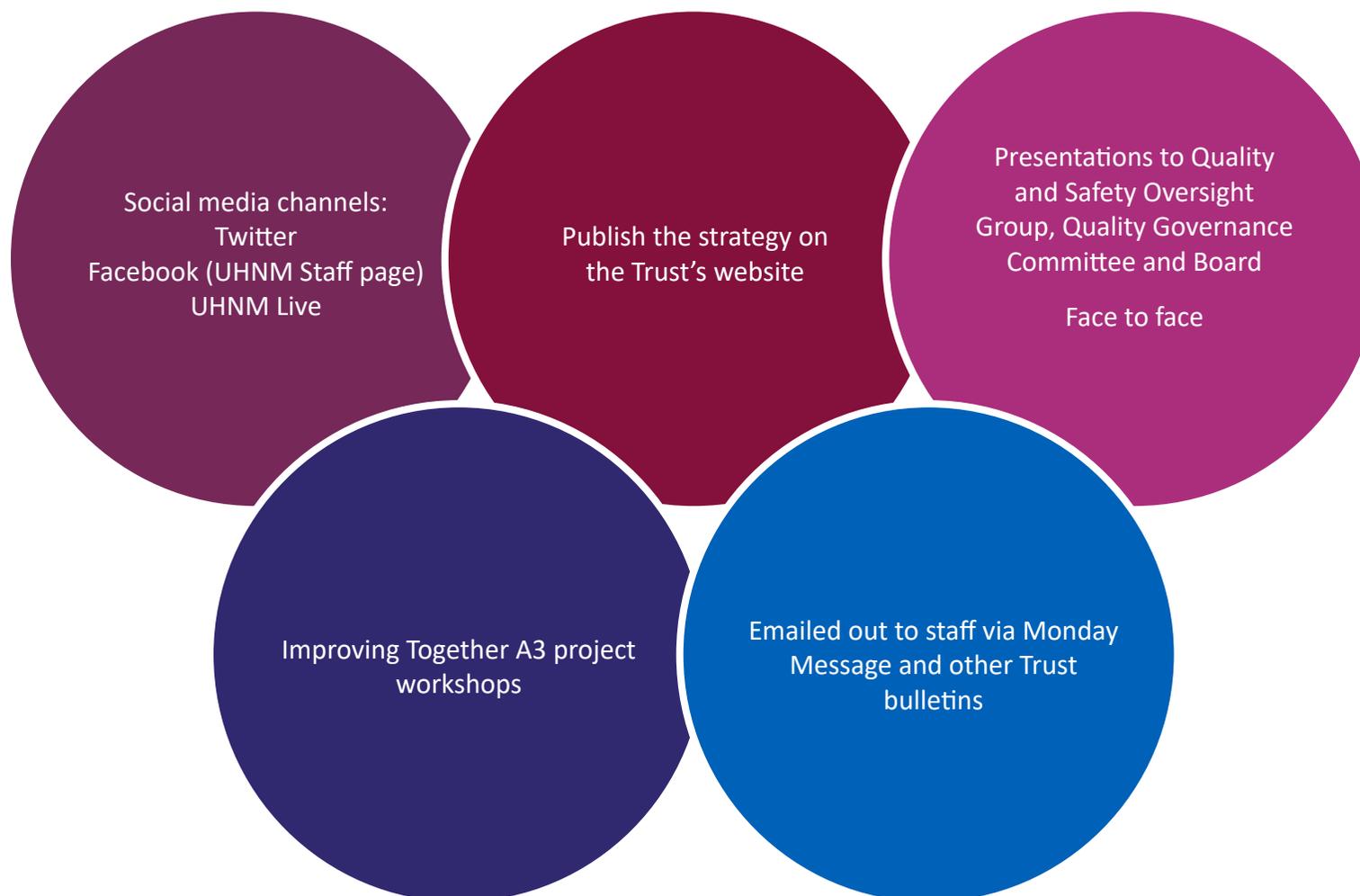
The Quality Strategy will report progress against the milestones through already existing governance structures and meetings that are held at the Trust. Once a quarter each division will be expected to produce a highlight report stating the progress made against each of the four key priorities.

The Quality Strategy Reporting Structure



11. How we will communicate this strategy

A board communications strategy will be deployed to ensure that all our staff, patients and relatives/careers have access to the strategy. A series of posters for each of the key priority will be developed so they can easily be displayed across the organisation. The strategy will be communicated using a number of communication mediums including but not limited to:



12. How we will ensure equality, diversity and inclusion

It is essential that equality, diversity, and inclusion is considered at every level when implementing the Quality Strategy. The four key priorities and the initiatives that enable the achievement of the key priorities are based on the principles of equality and inclusion.

The Trust will seek to treat all people equally and fairly. This includes those seeking and using the services, employees and potential employees. No-one will receive less favourable treatment on the grounds of sex/gender (including Trans People), disability, marital status, race/colour/ethnicity/nationally, sexual orientation, age, social status, their trade union activities, religion/beliefs or caring responsibilities nor will they be disadvantaged by conditions or requirements which cannot be shown to be justifiable. All staff, whether part time, full-time, temporary, job share or volunteer; service users and partners will be treated fairly and with dignity and respect.

Quality Impact Assessments will be carried out to ensure that the initiatives deployed in the Quality Strategy are inclusive and that staff, patients and relatives/carers are not disadvantaged by the new ways of working.



Plan on a page

Enablers

Trust

- Trust Strategy
- Clinical Strategy
- People Plan
- Improving Together
- Estates Strategy
- Medicines Optimisation Strategy
- Digital Strategy
- Finance Strategy
- Research and Innovation Strategy
- CeNREE

Integrated Care System/ Regional

- Together We're Better
- ICS 5yr strategy
- ICS leadership strategy
- ICS Governance meeting

National

- The Health and Social Care Act (2012)
- The National Outcomes Framework (2022)
- The CQC- Key lines of Enquiry (2018)
- The National Quality Board
- HEE Quality and Improvement Outcomes framework

Resource

- To reduce waste by delivering exceptional high quality care
- To seek opportunities to release time to care

System and Partners

- Patient Safety Incident Response Framework (PSIRF)
- System wide approach to shared learning

Improvement and Innovation

- Improving Together to drive Quality Improvement
- Develop and establish CeNREE
- Connect and collaborate with international colleagues on Research projects

High Quality

- To develop consistently positive practice environments recognising our staff are safety critical
- To deliver consistently safe and reliable care
- To prevent avoidable delay in patient assessment, treatment and discharge
- To ensure that our patients have access to services that meets their needs and delivers positive outcomes and experiences

Responsive

- Reduce steps and procedures that do not add value
- Reduce delays using Red to Green process for in-patients
- Wherever possible avoid In-patient care so patients can be assessed, investigated and treated in (or from) their own home

People

- Establishment reviews for Nurse, Midwife, AHPs and registered pharmacy professional
- Minimise the number of vacancies across all staff group
- To provide training and development opportunities for staff across the Trust
- Diversity and Inclusion at the heart of all we do





Executive Summary

Meeting:	Trust Board	Date:	8 th June 2022
Report Title:	People Plan Annual Report 2021/22	Agenda Item:	8.
Author:	Claire Soper, Head of HR Governance and Workforce Information		
Executive Lead:	Ro Vaughan, Chief People Officer		

Purpose of Report			
Information	Approval	Assurance	Assurance Papers only: <input checked="" type="checkbox"/>
			Is the assurance positive / negative / both?
			Positive <input checked="" type="checkbox"/> Negative <input type="checkbox"/>

Alignment with our Strategic Priorities			
High Quality	People	Systems & Partners	Resources
Responsive	Improving & Innovating		
		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>



Risk Register Mapping		
BAF 2	If we are unable to ensure the leadership culture reflects our values and aspirations, then a negative cultural environments could be established, resulting in an adverse impact on patient care, staff disengagement and ineffective performance	High 12
BAF 3	If we are unable to sustain our workforce at the required levels, taking into account the impact of Covid on staff resilience and retention, then we may not have staff with the right skills in the right place at the right time, resulting in adverse impact on patient outcomes, increase in premium costs, staff disengagement and inability to take forward continuous improvement and innovation	Ext 16

Executive Summary:

Situation
 With the release of the NHS People Plan in July 2020, the Trust's People Strategy and supporting HR Delivery Plan were reviewed and updated to ensure alignment of objectives.

Background
 The national NHS People Plan and the People promise were launched on 30 July 2020 setting out specific commitments around four key areas:

- Looking after our people
- Belonging in the NHS
- New ways of working and delivering care
- Growing for the future

Assessment
 This report sets out the specific commitments of the NHS People Plan and how each is supported by this Trust's Plan, with an update on work carried out during 2021/22, as well as setting out future work plans and key indicators.

The main focus in 2021/22 remained on mitigating workforce risks associated with the covid-19 pandemic. This included ensuring and improving staff health and wellbeing as well as reinstating delivery of our leadership development offers. However, the impact of the covid pandemic, and the significant additional work that the pandemic caused, are reflected in the key performance indicators.

Our priority for 2022/23 will be to promote a compassionate culture through our values, which identify the attitude and behavioural expectations of our staff with inclusivity at the heart of our values. These values

are threaded through the 2022/23 People Plan priorities.

This report was submitted to Transformation and People Committee on 31st May 2022

Recommendations

Trust Board is asked to note the progress made under the Trust People Strategy



UHNM People Plan Annual Report 2021/22

19 May 2022

1. Introduction

The national NHS People Plan and People Promise, launched on 30 July 2020, sets out what colleagues can expect from their leaders and from each other in terms of specific commitments around four key areas and the People Promise

- **Looking after our people** particularly the actions we must all take to keep our people safe, healthy and well – both physically and psychologically.
- **Belonging in the NHS** highlighting the support and action needed to create an organisational culture where everyone feels they belong.
- **New ways of working and delivering care** emphasising that we need to make effective use of the full range of our people’s skills and experience to deliver the best possible patient care.
- **Growing for the future** particularly the need to build on renewed interest in NHS careers, to expand and develop our workforce, as well as taking steps to retain colleagues for longer.

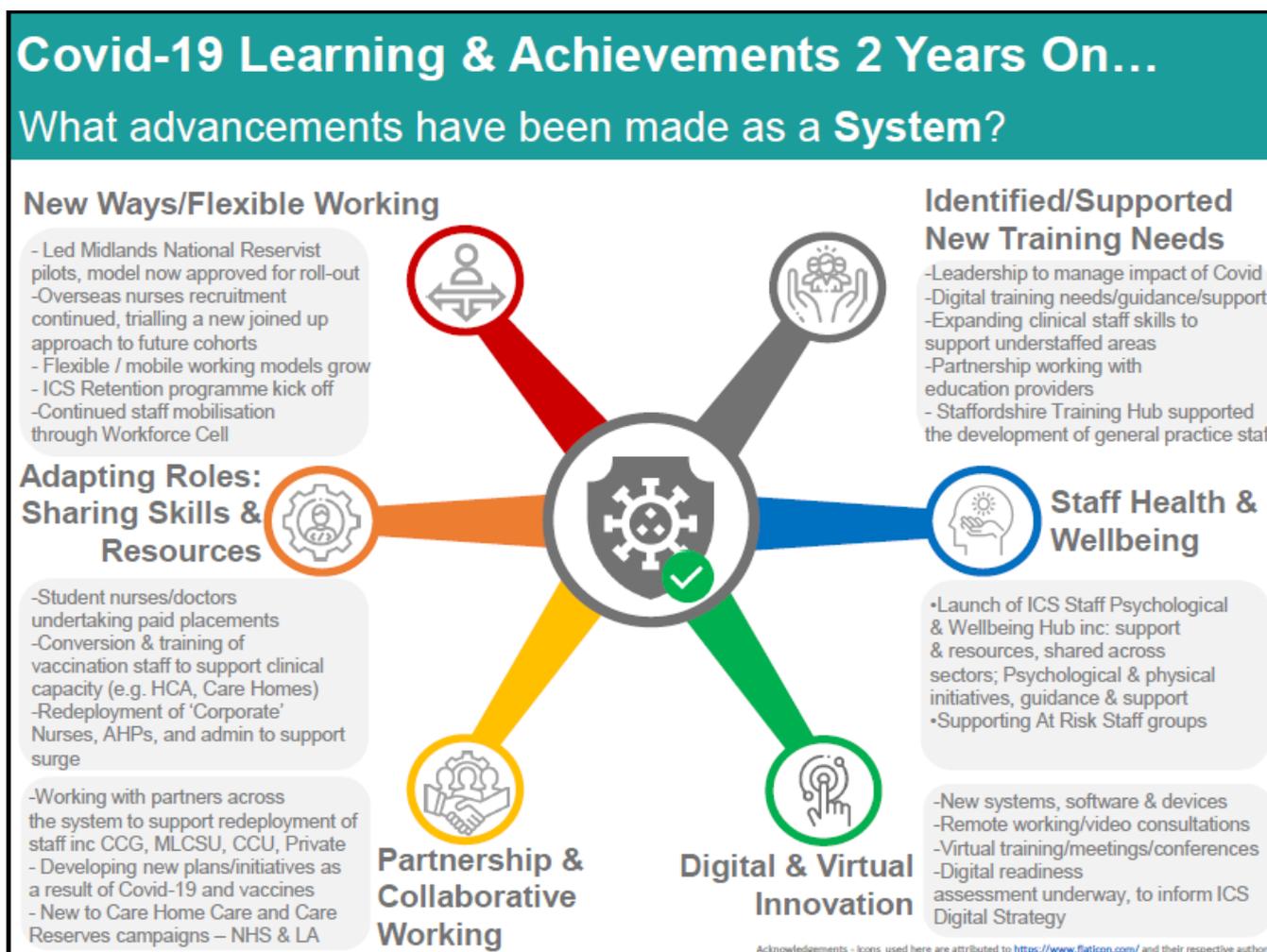
The aim is to make the **NHS People Promise** a reality for all so that the NHS will become the best place to work for all by 2024 – where we are part of one team that brings out the very best in each other.



In November 2021, NHS England published the “The future of NHS human resources and organisational development” which outlined the ten-year strategy for the human resources (HR) and organisational development (OD) services in the NHS. As a result, the People Strategy has been refreshed, and aligns to national plans. The People Strategy is supported by an annual Delivery Plan, with improvement activities cascaded via Divisional People Plans. The annual Delivery Plan is a key piece of assurance contributing towards the mitigation of workforce risks identified in the Board Assurance Framework.

2. Working Collaboratively as a System

The diagram below highlights some of the learning and achievements delivered collaboratively as a system since the outbreak of covid-19



We continue to work collaboratively with system partners on a number of projects including:

- A Retention Project on corporate level outputs and specific support to the Pathology Directorate
- Launching the ICS collaborative tender for Occupational Health Services with new contract go live 1st April 2023
- Responding to the Midlands Race Equality & Inclusion Strategy with the development of our 6 High Impact Recruitment Actions.
- System wide senior leadership cultural education programme 'Comfortable Being Uncomfortable with Race & Difference) and we delivered a development session as part of the 100 Day EDI Challenge Project
- System Connects was launched in July with 120 delegates including 40 from North Staffs Combined Healthcare Trust.
- The Staffordshire and Stoke system wellbeing week 'Together we're better: recognise, reflect, and reconnect' designed with system leads and run 'virtually' in 25th April 2022.

3. People Plan Annual Report 2021/22

The following narrative presents the People Plan Annual Report, highlighting some of the work carried out during 2021/22 and planned future aspirations.

Assurance against the HR Delivery Plan is provided to Transformation and People Committee and performance is reported against key performance indicators

3.1 Supporting the NHS People Plan Objective: Growing for the Future

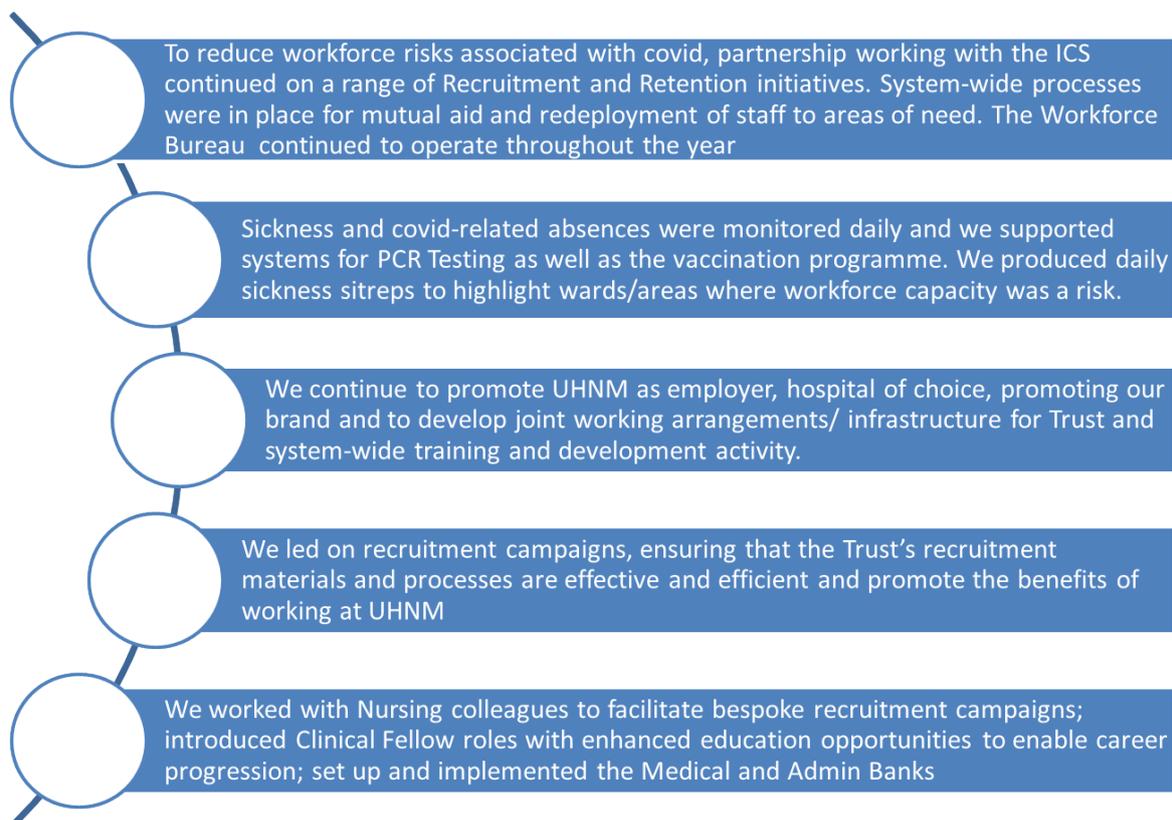
UHNM People Plan Objective

Planning the workforce to support the recruitment of the right people, in the right numbers at the right time to deliver safe, high quality patient care.

Summary

The focus during 2021/22 continued to be on managing the workforce implications of covid-19.

The Workforce Bureau managed and mitigated workforce risks associated with the covid-19 pandemic, operating as a “virtual workforce bureau” at times, with a lead HR practitioner coordinating workload.



Throughout December and January, significant resources were diverted to implement the regulations requiring mandatory vaccination of front line health care workers, which was later withdrawn. As a result, the Trust stood down the Task and Finish Group responsible for implementing the legislation. However, the Trust does continue to encourage staff to get vaccinated.

Outcomes

- At 31st March 2022, the vacancy rate was 11.71%, equivalent to 1320.71 FTE. In March 2022, Bank and Agency fte was 1008.90, which covered 76.39% of this vacancy position and there was 1154.30 FTE in the recruitment pipeline
- Turnover rates for 2021/22 were within target
- Agency costs as a percentage of pay costs in 2021/22 were comparable to the previous year

We're making strides with....

Nursing

Advanced Clinical Practitioners offering a broader range of health professionals to develop to master's level.
Expanding the international nurse recruitment programme and piloting International midwifery recruitment
Apprentice Nursing Assistants (ANA's), Trainee Nursing Associates (TNA's) and Pre-Registration Nursing Apprenticeships, creating an important opportunity for learning and career development.
Supporting nursing assistants who have previously gained a nursing registration in another country to achieve NMC registration in England.

Medical Staff

A new medical workforce group has been established to have oversight of the medical workforce risks and mitigation plans

Pharmacists

Development of 'Consultant Ready Pharmacists' and continuing to explore and develop senior pharmacists in line with Advanced Clinical Pharmacist framework for clinical and therapeutic leads
Introducing a Step programme for cancer pharmacists to develop clinical skills bridging the band 7 to 8a role into clinical specialists and independent prescribers.
Putting career escalation measure in place for Pharmacy Technicians and the support worker workforce

Future Workforce

Putting a support package in place to recruit trades apprentices at level 2/3 and provide opportunities for school leavers to take up an apprenticeship with college release
Working with Staffordshire University on Higher Apprenticeship Theatre foundation degree in acute care and Higher Apprenticeship Nurse Practitioners foundation degree in acute care. And for 2021/22, the Trust was awarded the Staffordshire University 'Employer of the Year for Higher Apprenticeships' award
Developing programmes which support attraction of our future workforce supply:
- Step into Medicine – which offers our foundation doctors the opportunity to talk about their step into medicine / UHNM. The aim is for the first talk to be launched in May.
- Step into UHNM – this will comprise a number of films which will be used as part of the step into UHNM webinar sessions with Q&As. The aim is to market our careers locally and increase our market awareness

Key Activities for 2022/23 include....



3.2 Supporting the NHS People Plan Objective: Belonging in the NHS

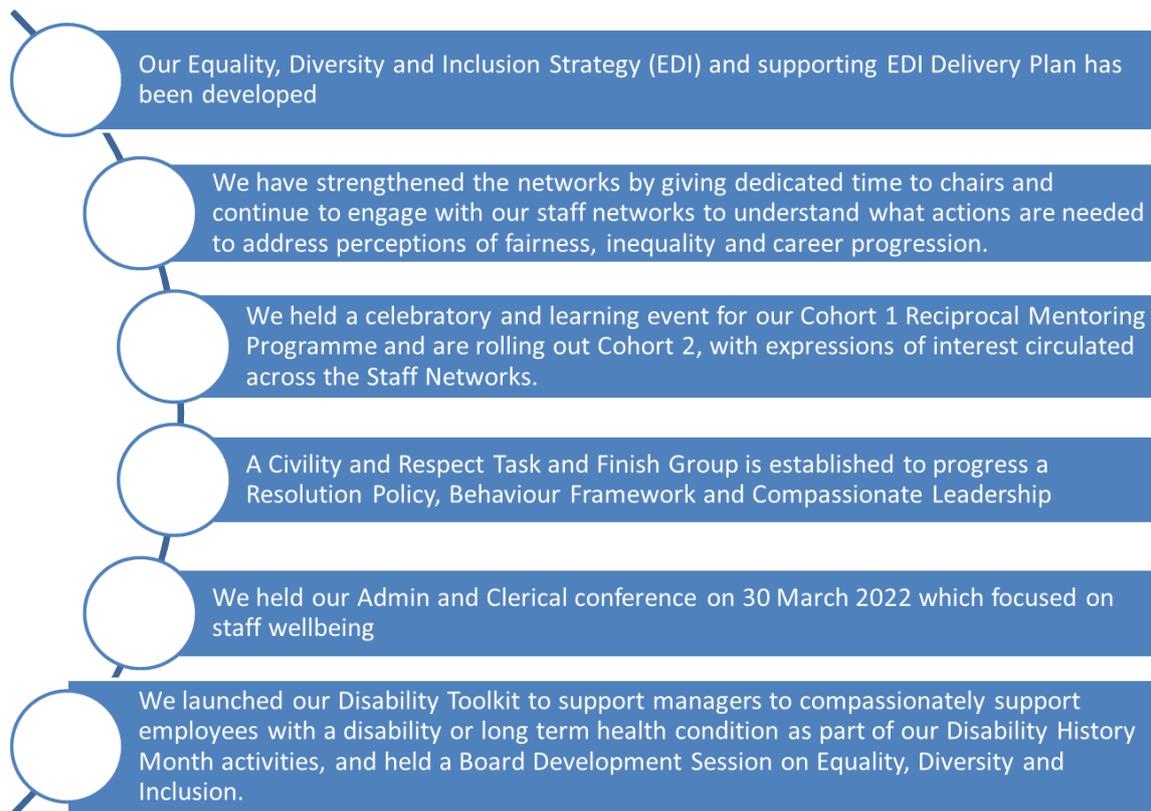
UHNM People Plan Objective

Developing the organisation to deliver the Trust's vision and values

Summary

Our priority for 2021/22 was to further build our inclusive workforce, where all our staff feel valued and whose diversity reflects the community we serve. Our work has focused on developing a culture that celebrates diversity and where our staff are informed and educated about equality and inclusion to become inclusive leaders and allies to colleagues from protected groups.

Key activities included institutionalizing diverse recruitment panels; increasing the diversity of delegates on our internal leadership development programmes; and providing support for line managers to enable the compassionate management of staff with disabilities and long term health conditions.



Many other events, webinars and sessions were provided including Managing and leading virtual teams; Summer Inclusion Schools on micro-aggression, unconscious bias, and understanding privilege & the power of allyship; events throughout October to mark Black History Month; compassionate management of staff with disabilities; webinar to mark International Women’s Day; LGBT+ podcasts as part of LGBT+ History Month and we marked International Day for the Elimination of Racial Discrimination with the launch of new Respect posters developed by our Ethnic Diversity Staff Network.

The Trust monitors how effectively we address any gaps in the treatment and experience of our BAME and Disabled workforce through the Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) and reports annually on our Gender Pay Gap.

We re-launched the Connects leadership programmes in July 2021 and have continued to support and offer management and leadership development through our internal and external offer, to ensure UHNM leaders and managers have the skills to carry out their roles effectively and to support their personal and professional development. 11 staff still achieved their Silver Connects Award, and another 97 staff are working towards their Silver Award. 14 staff achieved the Gold Connects Awards and 21 achieved the Platinum Connects Award.

The Trust also joined the West Midlands coaching collaboration which provides increased access to coaching for UHNM managers and staff from either UHNM trained coaches or coaches from one of the 37 member organisations within the region.

In August 2021, the Trust commissioned brap and Roger Kline to conduct a review into the culture and bullying and harassment at UHNM. Addressing the findings of this review, which were reported in April 2022, will be the focus for 2022/23.

Outcomes

Nationally there was an overall down-turn in staff survey results, across all questions and UHHNM results followed this trajectory, scoring lower than national average against all 7 themes of the annual NHS Staff Survey.

At 6.7, the staff engagement score reduced slightly, as did the score for the benchmark group. The Trust continues to remain just below the acute trust average score.

At points during 2021/22, the requirement to complete appraisals (PDRs) was suspended while the Trust was at Critical Incident level and times during covid. The final outturn for the 12m ending 31st March 2022 for Non-Medical PDR compliance was 75.55%.

We're making strides with....

We continue to strengthen our staff networks promoting the EDI agenda and, once approved, our EDI Strategy for the next 3 years will be launched alongside a further New Futures BAME development programme across the system.

Supporting the "Improving Together" process and our Quality Improvement Academy and leading on those aspects linked to staff engagement, leadership behaviours and cultural change

Key Activities for 2022/23 include....



3.3 Supporting the NHS People Plan Objective: Looking after our People

UHNM People Plan Objective

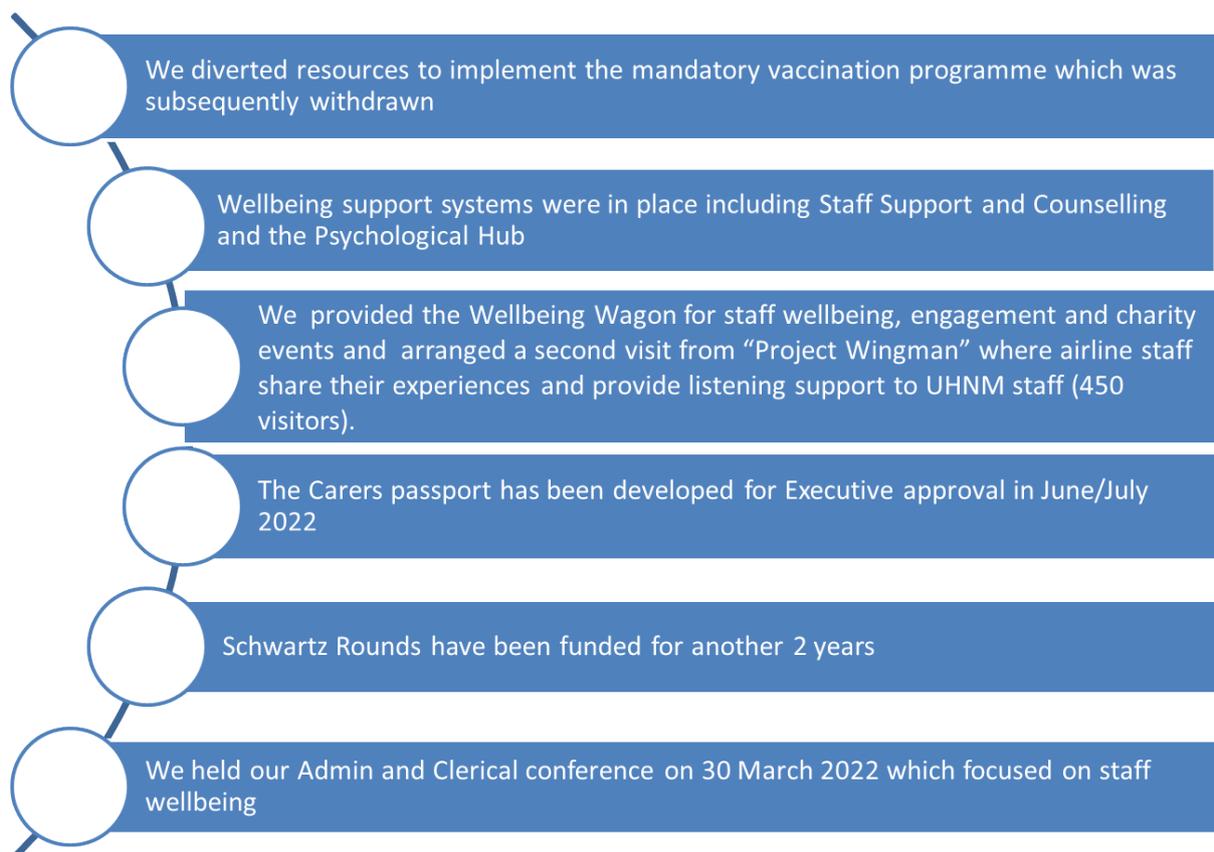
- **Enhancing Staff Experience through improvements to Staff Wellbeing, Reward and Recognition**
- **Improving Learning, Education and Widening Participation to continually enhance opportunities for staff to progress their careers and further develop their skills to be at the leading edge of healthcare provision**

Summary

Our staff have been through one of the most challenging periods; preparing for and managing Covid-19 at its various peaks. The main impacts on our staff have been their concerns for their on-going health and wellbeing – living and working during a pandemic – and their on-going resilience. Our workforce has demonstrated its ability and resilience in meeting increasing demands at times of high sickness and recurrent covid ‘peaks’.

We have a Trust-wide staff engagement plan in place, which incorporates our wellbeing initiatives as part of our offer for improving staff experience.

Throughout the pandemic, we increased wellbeing activities and offerings. We led on staff testing, worked with Occupational Health to resolve issues associated with covid 19, and worked with the corporate nursing and Infection Prevention and Control teams to support staff vaccination programmes



We have continued to support and offer management and leadership development through our internal and external offer, to ensure UHNM leaders and managers have the skills to carry out their roles effectively and also that their personal and professional development is supported

Our Learning and Education strategy aims to develop and enable learning and education across the Trust

and system wide, working closely with our partners in generating and securing innovative models of learning and education delivery across Staffordshire and beyond

Outcomes

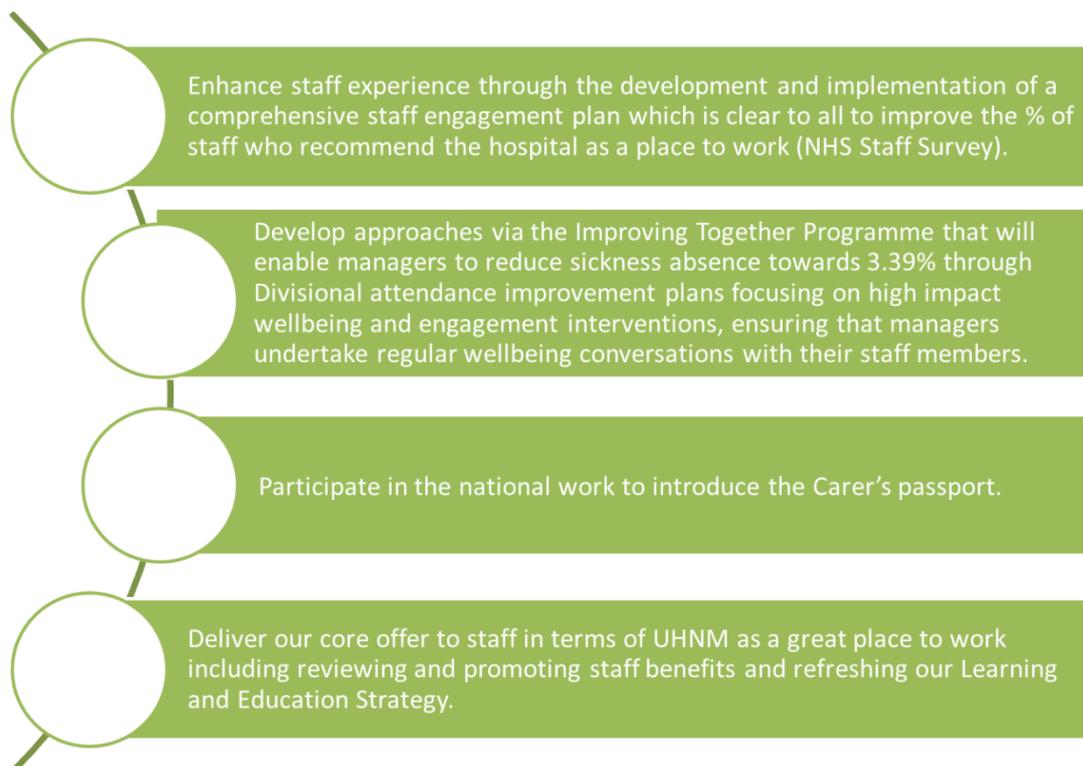
- The 12 month cumulative Sickness rate was 5.73% which was outside of target. In the main, this was a result of spikes in covid-related throughout 2021/22.
- At 94.73%, the Statutory and Mandatory Training compliance rate fell just short of the 95% target.

We're making strides with....

Continuing to deliver against our wellbeing and engagement plans

- We launched the system-wide online Psychological Hub and continue to work in partnership with Team Prevent to provide dedicated workshops to staff experiencing "long Covid". Our RESPOND wellbeing conversation tool has been delivered to around 284 members of staff. We have provided Stress First aid training sessions; Listening & Debriefing sessions and Suicide Prevention training. We also established a specific Winter Wellbeing plan with a focus on fundamentals (food and water).
- Other staff support mechanisms in place include an active and engaged Menopause group; Schwartz rounds; workshops delivered by Combined Healthcare including "Beating Burnout, Fighting Fatigue"
- Funded by NHS charities monies, the UHNM "Wellbeing Wagon" was introduced to provide a dedicated space to engage with staff across both sites

Key Activities for 2022/23 include....



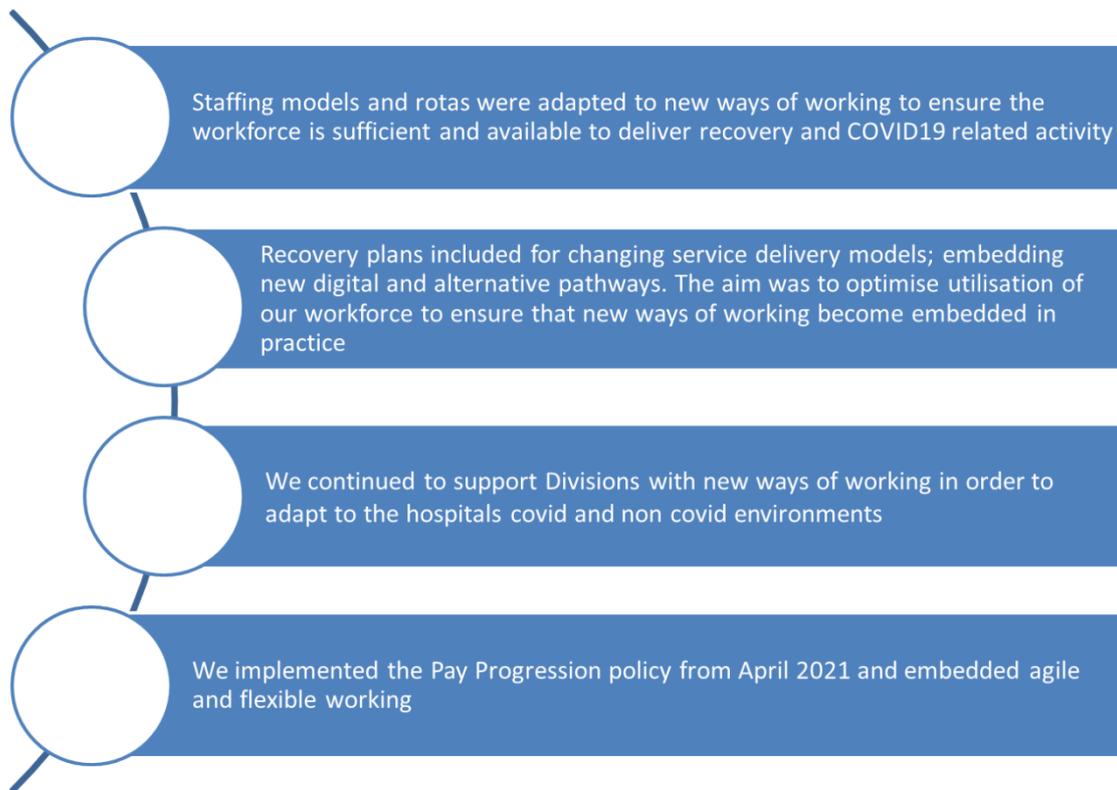
3.4 Supporting the NHS People Plan Objective: New Ways of Working and Delivering Care

UHNM People Plan Objective

New ways of Working

Summary

Plans were developed for restoration and recovery to shape the “new normal”; to capitalise on new ways of working and transformation; to reduce the risk of an increase in staff absence levels, and to reduce the risk of poor staff engagement.



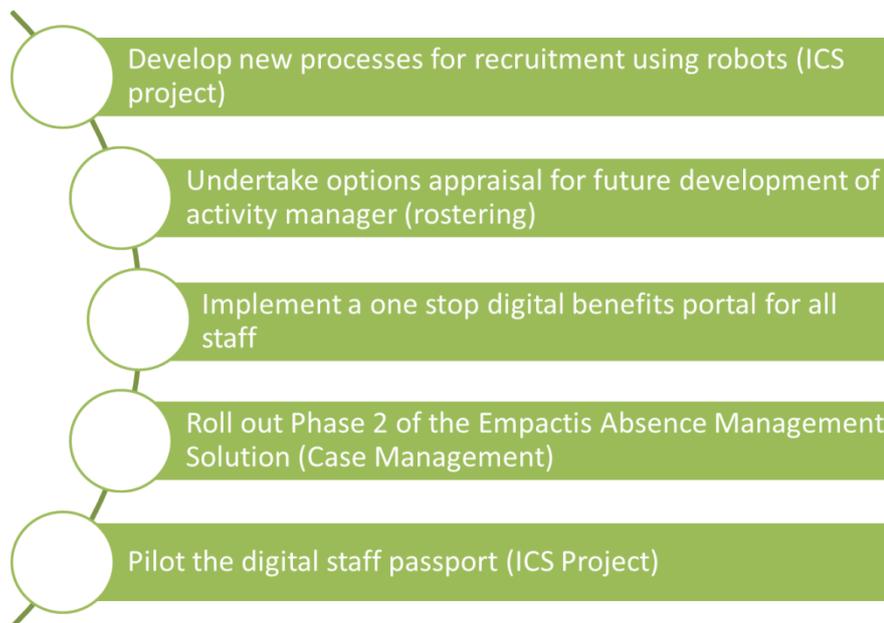
Outcomes

Staff have been able to work in an agile and flexible way, building on the changes introduced during the height of the pandemic

We're making strides with....

- Developing a cohort of Career Ambassadors to promote health and care roles
- Delivering a Step Change Improvement Project in Recruitment
- Undertaking a DBS validation scoping exercise

Key Activities for 2022/23 include....



3.5 Performance against Key Metrics

The pace at which change has been delivered in many areas was impacted by the covid pandemic as the priority was for staff to work clinically and in patient facing areas. Sickness absence as a key metric has been severely impacted by covid throughout year 2 of the pandemic.

Significant HR and other corporate resources had to be diverted over the winter period to implement the mandatory vaccination programme, which was subsequently withdrawn. This impacted on delivery plans.

Nationally, there was an overall down-turn in staff survey results across all questions and UHHNM results follow this trajectory.

The key performance metrics set out in the HR Delivery plan are:

Metric	Performance at 31 st March 2022
1. To maintain actual substantive staffing levels within a tolerance level of +/-5% of that planned	Substantive Staff variance as % of plan was +4.26% above plan
2. The Trust Apprenticeship target is 200	The number of Apprenticeship starts between April 21 and March 22 were 169. This figure is for both new and existing staff. Performance was impacted by Covid – for UHNM staff the priority has been service recovery, and for education providers, their focus was on delivery to their students.
3. Improve the percentage of staff saying that they are satisfied with the extent to which their organisation values their work from 44.6% to 47% by 31 st March 2022	The 2021 Staff Survey showed that 36.7% of staff were satisfied with the extent to which the organisation values their work (44.6% in 2020) <i>The national average for acute trusts reduced from 47.0% to 40.7%</i>
4. Absence due to work related stress is reduced from 26%% of total sickness	Absence due to work related stress was 27.4% for the 12m ending 31 March 2022

Metric	Performance at 31 st March 2022
absence at 28/02/21 to 20% by March 2023	
5. To improve staff perception that the organisation takes positive action on health and wellbeing to better than National average	Staff perception that the organisation takes positive action on health and wellbeing was 51.3%. The national average was 56.4% <i>*Historic trend data is not available as the response options changed for the 2021 Staff Survey</i>
6. To improve Staff recommendation of the organisation as a place to work from 64.3% to better than National average (66.9% in 2020) by 31st March 2022 (as evidenced in the NHS Staff Survey)	Staff recommendation of the Trust as a place to work declined from 64.3% to 54.6% <i>The national average for acute trusts reduced from 67% to 58.4%</i>
7. To meet absence management call back & Return to Work compliance targets in more than 80% of episodes by 31st March 2022	The combined compliance rate for March 2022 was 39% (up from 37% at March 2021). Performance improved, although the target was not met
8. The % of staff saying their immediate manager takes a positive interest in their health and safety is improved from 65.6% to 76.9% by March 2023	This question has been removed from the NHS Staff Survey

4 Recommendations

Trust Board is asked to note the progress made towards under the Trust People Strategy



Executive Summary

Meeting:	Trust Board	Date:	8 th June 2022
Report Title:	Annual Plan 22-23	Agenda Item:	9.
Author:	Claire Rylands , Helen Ashley		
Executive Lead:	Helen Ashley, Director of Strategy & Transformation		

Purpose of Report			
Information	Approval	✓ Assurance	Assurance Papers only:
			Is the assurance positive / negative / both?
			Positive
			Negative

Alignment with our Strategic Priorities			
High Quality	✓	People	✓
Responsive	✓	Improving & Innovating	✓
		Systems & Partners	✓
		Resources	✓



Risk Register Mapping

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Executive Summary

As part of the Improving Together Programme, the Executive have taken time to review the Trusts Strategic Priorities and the programmes of work that are in place to support their delivery.

The attached Annual Plan seeks to draw together the Strategic priorities that are in place to support the delivery of the Trusts Vision as well as a number of breakthrough objectives and Strategic Initiatives, the plan also sets out how these are aligned to the Board Assurance Framework and NHS Priorities.

For 23/24 the process of review of priorities and initiatives will start much earlier in the year, annual Board engagement will be sought as part of that process as described in the Annual Business Planning cycle

Key Recommendations

The Trust Board is asked to note and approve the Annual Plan



University Hospitals
of North Midlands
NHS Trust

Annual Plan

2022/2023

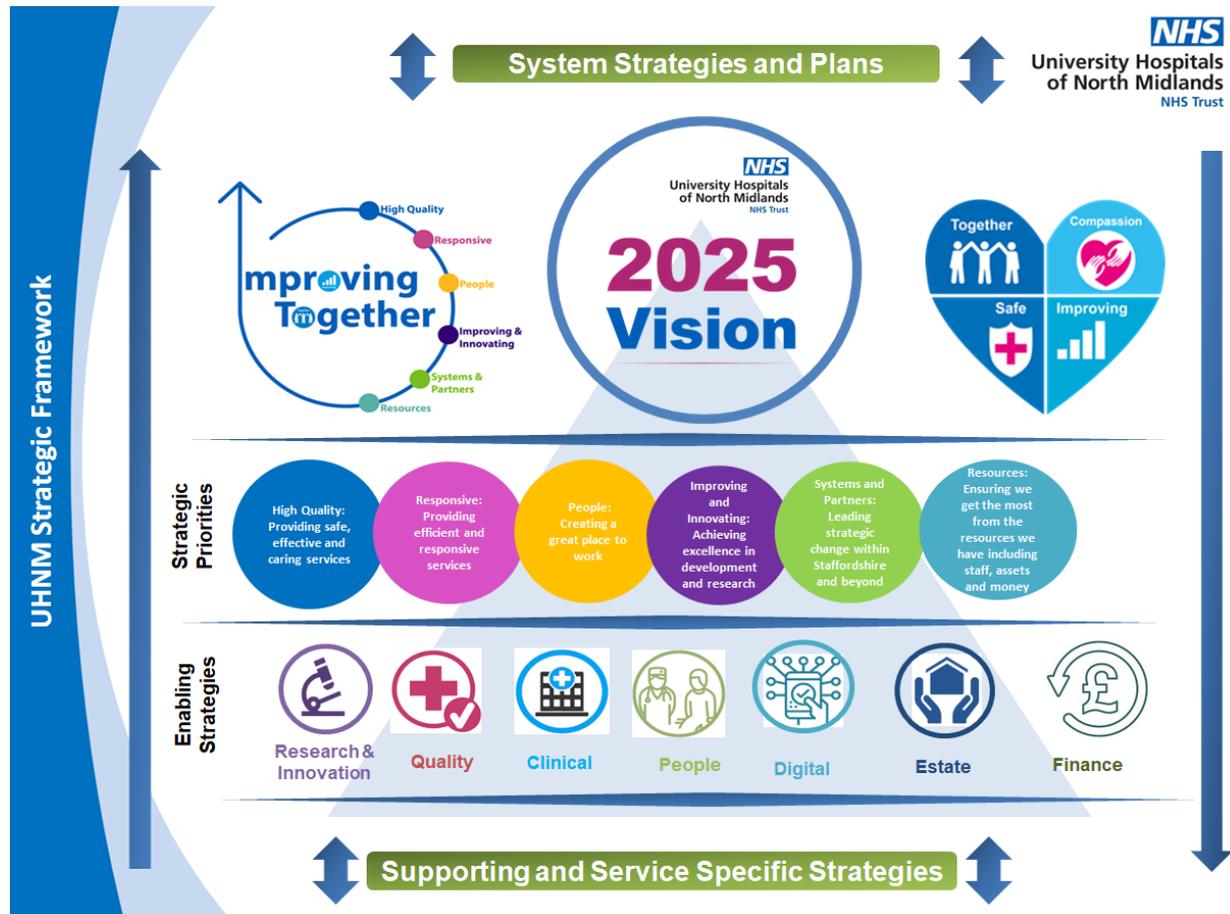


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Introduction

This **Annual Plan 2022/23** sets out our intentions for the coming year. The Plan is aligned to our Strategic Framework (as shown below).



Our current strategy is our **2025 Vision**, which was initially developed in 2014 following our integration with Mid Staffordshire Hospital. Whilst much of this remains relevant, we recognise that times have moved forward and despite Covid-19 setting us back somewhat in terms of refreshing our strategy, we are doing this through the *strategy deployment* element of our **Improving Together Programme**. The **strategy deployment framework** focuses on improvement activity on key priorities, identified from data on Trust performance and we have reset our Strategic Priorities and our Objectives as part of this programme. The Improving Together programme has a number of additional components to support this:



- The establishment of a **Quality Improvement Academy** team to build greater capacity and support for all of our staff to use established quality improvement methodologies and lead change
- Developing our **Executive Team as 'Lean'** leaders with behaviours and skills that will cascade through the organisation, supporting all staff to lead quality improvement at whatever level and role they perform
- Introduction of an **Operational Improvement System** – a new set of skills, routines and behaviours which enables all staff to contribute to small changes each day that will improve the care we provide to our patients

We are a large, modern Trust in Staffordshire, **providing care in state of the art facilities**. We provide a full range of general hospital services for approximately 1.1 million people locally in Staffordshire, South Cheshire and Shropshire. We employ around 11, 000 members of staff and we provide specialised services for a population of around 3 million, including neighbouring counties and North Wales.

We are one of the largest hospitals in the West Midlands and have one of the **busiest Emergency Departments** in the Country, with an average of around 14,000 patients attending each month across both of our sites. Many emergency patients are brought to us from a wide area by both helicopter and ambulance because of our **Major Trauma Centre status**; as we are the specialist centre for the North Midlands and North Wales.

As a University Hospital, we work very closely with our partners at Keele and Staffordshire University and we are particularly proud of our **Medical School**, which has an excellent reputation. We also have strong links with our local schools and colleges. As a major teaching trust, we hold a large portfolio of commercial research, which provides us with an additional source of income. **Our research profile** enables us to attract and retain high quality staff.

Our **specialised services** include cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care, paediatric intensive care, trauma, respiratory conditions, spinal surgery, upper gastro-intestinal surgery, complex orthopaedic surgery and laparoscopic surgery.

We play a key role within the **Staffordshire and Stoke-on-Trent Integrated Care System (ICS)**, which has partnership working at it's very core as we work closely together to transform the way health care is delivered for the benefit of our population. This includes leadership and participation in partnership boards which bring together health, social care, independent and voluntary sector organisations across Staffordshire.

We look to **involve our service users** in everything we do, from providing feedback about the services we provide, to helping to share our priorities. This work is co-ordinated by our dedicated Patient Experience Team.

Risks to Delivery

Through our annual review of the **Board Assurance Framework (BAF) for 2022/23**, we have identified a number of strategic risks which might compromise our ability to delivery our Plan. These risks will be monitored through our Board and Committees and are summarised below:

Strategic Priority Domains		
	High Quality	Providing safe, effective and caring services
	Response	Providing efficient and responsive services
	People	Creating a great place to work
	Improving & Innovating	Achieving excellence in development and research
	Systems and Partners	Improving the health of our population by working with partners
	Resources	Ensuring we get the most from the resources we have, including staff, assets and money

Summary Board Assurance Framework 2022/23		
No.	Summary of Risk Description	Impact on Strategic Priorities
BAF 1	Delivering Positive Patient Outcomes	
BAF 2	Living our Values	
BAF 3	Achieving a Sustainable Workforce	
BAF 4	System Working	
BAF 5	Delivering Responsive Patient Care	
BAF 6	Delivery of IM&T Infrastructure	
BAF 7	Infrastructure to Deliver Compliant Estate Services	
BAF 8	Financial Sustainability	
BAF 9	Ability to Deliver the Clinical Strategy	
BAF 10	Ability to Enhance Participation in Research and Innovation	

System Working

As an **Integrated Care System Board**, all partners have held a series of development workshops to redefine who we are and set our priorities for the future, through this, all partners have committed to a single purpose statement and **four core priorities for 2022/23**, demonstrating that we are one system and that we have strong clinical and professional leadership to these priorities. Each priority has a senior responsible officer, including Chief Executives from local authorities and the NHS.



National NHS Priorities

In 2022/23 the NHS will continue to focus on restoring services, meeting new care demands and reducing the care backlog that are a direct consequence of the pandemic through:

- Accelerating plans to grow the substantive workforce and working differently whilst keeping a focus on the health, wellbeing and safety of staff.
- Using what we have learnt through the pandemic to rapidly and consistently adopt new models of care that exploit the full potential of digital technologies.
- Working in partnership as systems to make the most effective use of the resources available across acute, community, primary and social care settings, to get above pre-pandemic levels of productivity as the context allows.
- Using the additional funding government has made available to us to increase our capacity and invest in buildings and equipment to support staff to deliver safe, effective and efficient care.

We have taken the national [NHS priorities](#) into account when developing our Strategic Priorities and have mapped them accordingly:

NHS Priorities and Mapping to our Strategic Priority Domains		
	Invest in our workforce	
	Respond to Covid-19 more effectively	
	Delivery significantly more elective care to take the elective backlog	
	Improve the responsiveness of urgent and emergency care (UEC)	
	Improve timely access to primary care	
	Improve mental health services for people	
	Continue to develop our approach to population health management	
	Exploit the potential of digital technologies to transform	
	Make the most effective use of our resources	
	Establish ICB's and collaborative system working	

As summary of more detailed system requirements to deliver these Ten National Priorities can be found at appendix 1.

Improving Together

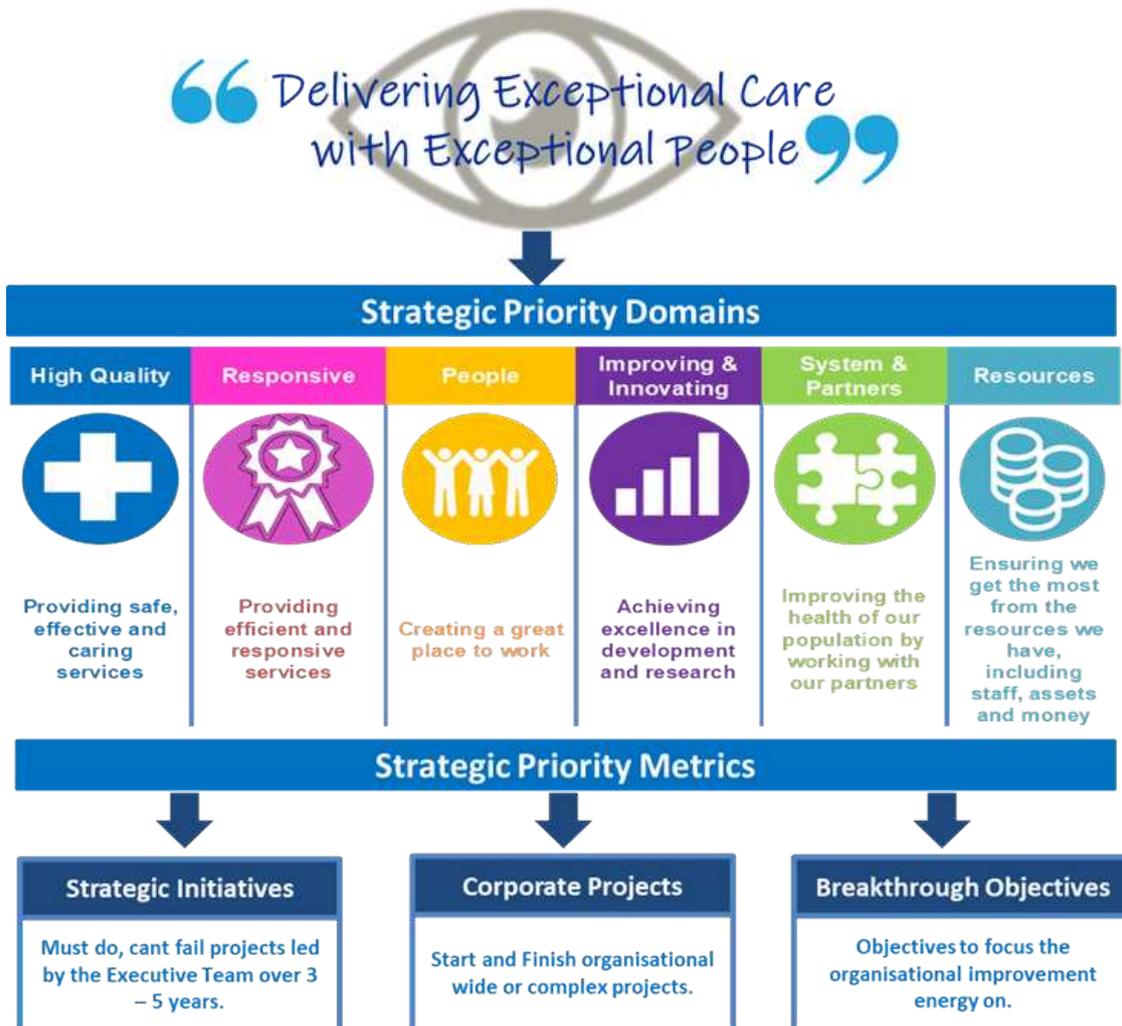
2022/23 will be the second year of our Trust-wide organisational development programme, Improving Together. **Improving Together** will build capacity and capability for improvement at all levels in the Trust, and ensure that we define, align and cascade goals across the organisation that will drive improvement efforts.

As part of the Improving Together approach to strategic alignment and continuous improvement and organisational learning, there are four focus areas (**breakthrough objectives**), related to our strategic priorities, have been identified through a structured problem solving methodology. The four areas are

- High Quality - Timely capture of clinical observations
- Responsive – Clinically Ready to proceed (from the Emergency Department)
- Responsive - Elective Recovery
- People – Availability

The breakthrough objectives are shared with frontline teams - wards and departments, who will choose initially one breakthrough objective driver metric to focus on, increasing over time to multiple driver metrics. Teams will use Improving Together methodology – structured problem solving and improvement huddles – to improve their performance. Visitors to wards and departments which have completed their training will have the opportunity to join staff in the daily huddle meetings, contribute to improvement ideas and view the driver metric work on the local performance boards.

The diagram below sets out our Strategic Planning Framework and how we have developed Strategic Initiatives, Corporate Projects and Breakthrough Objectives to support the delivery of our Strategic Priority Metrics for 2022/23:



2022/23 Priorities

Developed through the processes outlined above, and taking into account the context in which we work, this section sets out our **priorities for 2022/23**. We will be developing our 'A3's' for each of these areas to understand where the root cause of non-achievement lies and the biggest contributors. From those A3's we will identify a number of 'countermeasures' which may require a step change and therefore require a Corporate Project to be initiated in order to achieve.

 High Quality	
Strategic Priority Domain	Providing safe, effective and caring services
Strategic Priority Metrics	Increase in Harm Free Care Improving Patient Experience
Breakthrough Objectives	Timely capture of clinical observations
Strategic Initiatives	Improving Together Programme County Hospital Programme Digital Transformation Programme

 Responsive	
Strategic Priority Domain	Providing efficient and responsive services
Strategic Priority Metrics	Reducing waits in ED Eliminating 104 week waits 28 Day Faster Diagnostic Standard
Breakthrough Objectives	Clinically Ready To Proceed Elective Recovery – eliminating 78 week waits
Strategic Initiatives	County Hospital Programme

 People	
Strategic Priority Domain	Creating a great place to work
Strategic Priority Metrics	Improved Staff Engagement
Breakthrough Objectives	Improved Staff Availability
Strategic Initiatives	Positive and Inclusive Culture Programme Improving Together Programme

 Improving & Innovating	
Strategic Priority Metrics	Achieving excellence in development and research
Breakthrough Objectives	Increased number of Trial participants CQC KLOE Improvements
Strategic Initiatives	Improving Together Programme County Hospital Programme

 System & Partners	
Strategic Priority Domain	Improving the health of our population by working with partners
Strategic Priority Metrics	<i>*Linked to index of multiple deprivation</i>
Strategic Initiatives	Provider Collaboration

 Resources	
Strategic Priority Domain	Ensuring we get the most from our resources (staff, money and assets)
Strategic Priority Metrics	Income and Expenditure Position
Strategic Initiatives	County Hospital Programme

Divisional Priorities

Through a process of 'focussed negotiation', each clinical division has agreed their priority metrics, these priorities were originally developed in the Autumn of 2021 with the intention of them being in place for the next 18 months. Consideration may need to be given to whether or not some of the priorities need to be refined before the end of 22/23. These are referred to as 'Driver Metrics' (although we have a number of additional metrics referred to as 'Watch Metrics'). Driver Metrics for each Division are summarised below:

Surgical Division		
Strategic Priority Domain	Metric	Target
High Quality	Pressure Ulcers per 1000 bed days	0
High Quality	Inpatient Sepsis Screening compliance	90%
Responsive	P2 Waiting List	<1000
Responsive	RTT >52 weeks	<1500
Responsive	Cancer 2ww	<14 days
People	Sickness Absence	5.5%
People	Appraisal (PDR)	70%
Medical Division		
Strategic Priority Domain	Metric	Target
High Quality	Patient Falls per 1000 bed days	5.6
Responsive	Utilisation (Endoscopy)	85%
Responsive	Performance – RTT <52 weeks	40
Responsive	Performance – Follow Up Backlog	12,000
Responsive	Cancer 2ww standard	93%
Responsive	15 minutes to triage	25
Responsive	Time seen by Emergency Department	60
Responsive	Stranded patients	200
People	Sickness Absence	5.25%
Resources	Consultant headcount to plan	-
Resources	Other Medical headcount to plan	-
Specialised Division		
Strategic Priority Domain	Metric	Target
High Quality	Patient Falls per 1000 bed days	1.5
High Quality	Inpatient Sepsis Screening compliance (contracted)	90%
Responsive	CRTP: < 60 mins / < 12 mins	TBC
Responsive	RTT > 52 weeks	TBC
Responsive	Follow up Backlog > 52 weeks	0
Responsive	P2 Waiting List	TBC
People	Appraisal	95%
People	Staff Vacancies (nursing)	TBC
Children, Womens and Diagnostics Division		
Strategic Priority Domain	Metric	Target
High Quality	Sepsis screening compliance	100%
High Quality	IVAB within on 1 hour	100%
High Quality	Maternity CNST compliance – smoking cessation	80%
Responsive	Histopathology cancer 7 day turnaround time	80%
Responsive	Cancer related CT scans currently outstanding	70%
Responsive	Gynaecology 52 week waits	0
Responsive	Non obstetric ultrasound performance (6 weeks +)	0
People	Appraisal	95%
People	Return to Work overdue	0 (95%)
People	Vacancies	-

Corporate Priorities

People

- **Growing for the future** – by attracting, recruiting and retain a workforce for the future.
- **Belonging in UHNM** – by supporting our staff to be the best they can and by building a psychologically safe and inclusive culture where staff are free from discrimination and diversity is celebrated.
- **Looking after our people** - by ensuring our people are healthy and well both physically and psychologically and when unwell are supported.
- **New Ways of Working** – by developing our approach to the development of our workforce through education, training and leadership using technology to maximise learning opportunities.

Digital

- The implementation of **Patient Knows Best** which is a Patient Held Record allowing patients to receive letters, test results, appointments and online assessments and surveys as well as the patient being able to add other helpful health information.
- Completion of the implementation **Laboratory Management Information System** allowing all N8 Pathology Network services to run on a single modern solution.
- Complete the migration of email and collaboration services to **Office 365** giving staff access to Email, Teams, OneDrive, SharePoint Online, Planner, Viva and Forms.
- Establishing the Office of the to include a **Chief Nurse Information Officers** and Digital Nurses, Midwives and Allied Health Professionals.
- Continue with the implementation of **Electronic Prescribing and medicines administration** to improve patient safety.

Estates

- **Project Star** – will see significant improvements to staff car parking solution and allow the disposal of land previously used by the hospital to support regeneration of the City.
- **Lower Trent**– will see the delivery of a ward template within the Trent building, with key adjacencies to clinical services, supporting capacity/flow challenges.
- **ICS Green Plan**– aligned to our Trust Green Plan the ICS Green Plan sets out our carbon reduction initiatives that are already underway and plans for the subsequent three years as we progress towards net carbon zero.
- **PFI** – Continue to work with PFI partners on delivering value release initiatives as part of our Supplier Relationship Management Programme, delivered in conjunction with Cabinet Office.
- EFP Strategies/Services – to respond to changing national guidance and to exploit potential of digital and other technologies to improve efficiency and effectiveness.

Finance and Business Intelligence

- **Business Intelligence strategy** – will see significant improvements in understanding Capacity and demand linking in workforce activity and finance alongside operational requirements.
- **Divisional support**– embed Divisional analysts to support the evidence based approach to decision making and performance management.
- **Deliver the Capital plan**– ensure that investment funds are fully utilised delivering benefits to improved IT, medical equipment and building infrastructure.
- **Deliver system wide Financial objectives** – To work collectively to deliver on the annual financial plan at a system and organisational level.

Schedule of Investments

Through our Business Planning process, we have identified a number of developments which have been prioritised for investment, to support delivery of our Annual Plan and longer term Strategic Priorities. The investments we have scheduled for 2022/23 Elective Recovery Funding (ERF) are summarised below:

Strategic Priorities	Investment Description (subject to approvals and prioritisation process)
Children's, Women's and Diagnostics	
	Extension of Portering provision for CT4: Imaging Main Hub until Sept 22
	Extension of 'CT in a box': Temporary 7th CT scanner to support the agreed Lung Cancer Screening programme activity prior to permanent installation
	Health Harmonie and weekend ultrasound lists: Outsourcing and weekend staffing to deliver recovery
	Locum radiographers plain film: 4 locum radiographers would be located at RSUH (x2), County (x1) and in the Community x-ray services (x1)
	Temp MRI Mobile and staffing: MRI HIRE and temp staffing to support recovery
	Gynaecology: DC/EL to Rowley hall 20 patients per month
Medicine	
	Covid Follow up (12mth non-recurrent): Request for 12 month non-recurrent resources to support respiratory Covid inpatient follow up and diagnostics. Costs included reflect medicine costs only and is subject to further evidence/benefits from supportive services for resources previously funded
	Endoscopy staffing (12mth non-recurrent): Request for 12month non-recurrent continuation of resources from 2021/22 together with additional project manager and pre-assessment nurse. Insufficient capacity within endoscopy service to maintain the current admin/pre-assessment/TNE service demands without this resource. RDC funding secured and the costs included here reflect remaining posts
	General Medicine Outpatient Recovery: Recovery of follow up backlog waiting times. Requests funding for additional TIs and a clinical fellow for Nephrology to support with the reduction of the number of patients overdue their follow up appt.
	Respiratory Outpatient Recovery: Requested funding will cover the costs of additional TI payments to support with the reduction of the new patients waiting list as well as reducing the number of patients overdue their follow up appt. To support with recovery of data quality errors that inflate the waiting list position a B3 administrator/validator is also requested.
	Gastroenterology Outpatient Recovery: Service currently offers a 40ww to new outpatient appt. There are also a significant number of patients requiring a follow up appt. Requested funding will cover additional TI payments and also request funding for a B3 administrator/validator.
	Endoscopy Recovery (12mth): In order to address the back log of patients, to support the recovery of the endoscopy service and reduce diagnostic wait times, the Service requests funding for additional resources for 12mths
Surgery	
	Extended transfer of patients to Private Healthcare - Bariatric Surgery: Burcot
	Theatre Timetable recovery & investment plan – SHS: Phase 1 - 12 Week extension - mitigating risks from on-going sickness absence / Phase 2 - 40 Week extension - secure opportunities for further increased activity
	Ward 8 at County: Extend capacity nights and weekends
	ENT Locum
	PFI refurbishment condensing from 8 to 4 weeks
	Plastics: Middle Grade Locum
	Ophthalmology: ANP to free up Consultant
Specialised	
	Neurology External Support: Elective Services
	Elective Recovery of T&O Services: 18 Week Source (3 month)
Corporate	
	Modular theatre county: c. £3.4m FYE - starting in Nov, c £1.4m in 22/23.
	County CTS/County Hospital Elective Hub
	Validators: waiting list
	Planned Care - Support to IS/External sourcing: Band 6 and Band 4 resource for 12 months to support the IS contracts and to keep sourcing external opportunities to increase elective capacity.
	Cancer: 18 weeks outsource Breast, 18 week outsource Breast Ultrasound weekends



Appendix 1 – NHS System Requirements



A: Invest in our workforce

- Improve retention by delivering the NHS People Promise to improve the experience of our staff.
- Continue to support the health and wellbeing of our staff.
- Improve attendance by addressing the root causes of non COVID-related sickness absence.
- Improve the Black, Asian and minority ethnic disparity ratio.
- Implement plans to promote equality across all protected characteristics.
- Accelerate the introduction of new roles, such as anaesthetic associates, and expand advanced clinical practitioners
- Develop the workforce required to deliver multidisciplinary care closer to home
- Ensure the highest level of attainment set out by the 'meaningful use standards' for e-job planning and e-rostering is met to optimise the capacity of the current workforce
- Establish, or become part of, volunteer services such as the NHS cadets and NHS reservists.
- Expand international recruitment through ongoing ethical recruitment of high quality nurses and midwives
- Leverage the role of NHS organisations as anchor institutions/networks to widen participation and create training and employment opportunities
- Make the most effective use of temporary staffing
- Ensure training of postgraduate doctors continues, with adequate time in the job plans of supervisors to maintain education and training pipelines
- Ensure sufficient clinical placement capacity to enable students to qualify and register as close to their initial expected date as possible.



B: Respond to Covid-19 ever more effectively

- Increase the number of patients referred to post-COVID services and seen within six weeks of referral
- Decrease the number of patients waiting longer than 15 weeks, to enable their timely placement on the appropriate management or rehabilitation pathway.



C: Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards

C1: Maximise elective activity and reduce long waits, taking full advantage of opportunities to transform the delivery of services

- Eliminate waits of over 104 weeks as a priority
- Reduce waits of over 78 weeks and conduct three-monthly reviews for this cohort of patients
- Develop plans that support an overall reduction in 52-week waits where possible
- Accelerate the progress already made towards a more personalised approach to follow-up care in hospitals or clinics, reducing outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023
- Plan how the redeployment of the released capacity (including staff) is used to increase elective clock-stops or reduce clock-starts proactively.
- Demonstrate how capital proposals support a material quantified increase in elective activity
- Rapidly draw up delivery plans across elective inpatient, outpatient and diagnostic services for adults and children for April 2022 to March 2023.

C2: Complete recovery and improve performance against cancer waiting times standards

- Return the number of people waiting for longer than 62 days to the level in February 2020
- Meet the increased level of referrals and treatment required to reduce the shortfall in number of first treatments.
- Priority actions should centre on ensuring there is sufficient diagnostic and treatment capacity to meet recovering levels of demand, with a particular focus on the three cancers making up two-thirds of the national backlog (lower GI, prostate and skin).
- Improve performance against all cancer standards, with a focus on the 62-day urgent referral to first treatment standard, the 28-day faster diagnosis standard and the 31-day decision-to-treat to first treatment standard
- Make progress against the ambition in the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower, including timely presentation and effective primary care pathways, faster diagnosis and targeted case finding and surveillance.
- Ensure fully operational and sustainable patient stratified follow-up (PSFU) pathways for breast, prostate, colorectal and one other cancer by the end of the first quarter of 2022/23.
- For systems participating in colon capsule endoscopy and cytosponge projects, deliver agreed levels of activity
- Increase the recruitment and retention of clinical nurse specialists, cancer support workers and pathway navigators, and promote take up of clinical training opportunities for the cancer workforce.

C3: Diagnostics

- Increase diagnostic activity to a minimum of 120% of pre-pandemic levels across 2022/23
- Develop investment plans that lay the foundations for further expansion of capacity through CDCs in 2023/24 and 2024/25.
- Increase the number of endoscopy rooms, levelling up to a guide level of 3.5 rooms per 100,000 population over 50 years of age.
- Invest in CT capacity to support expansion the Target Lung Health Checks programme from 2023/24, with target coverage to be agreed between Cancer Alliances and the National Cancer Programme team.
- Develop additional digitally connected imaging capacity and ensure that acute sites have a minimum of two CT scanners
- Procure new breast screening units to deliver the 36-month cycle.

C4: Deliver improvements in maternity care

- Local maternity systems (LMSs) to continue to work with providers to implement local plans to deliver Better Births



D: Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity

D) Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity

D1: Urgent and emergency care

- Reduce 12-hour waits in EDs towards zero and no more than 2%
- Improve against all Ambulance Response Standards
- Minimise handover delays between ambulance and hospital, allowing crews to get back on the road and contribute to achieving the ambulance response standards.
- Ensure stability of services and have planned contingency in advance of next winter.
- Increase capacity within NHS 111 to ensure the service is the credible first option for patients, enabling their referral to the most appropriate care setting.
- Expanding urgent treatment centre (UTC) provision and increasingly moving to a model where UTCs act as the front door of ED, to enable emergency medicine specialists to focus on higher acuity need within the ED.

D2: Transform and build community services capacity to deliver more care at home and improve hospital discharge

- Comprehensive development of virtual wards towards a national ambition of 40–50 virtual wards per 100,000 population.

Urgent community response

- Maintain full geographic rollout and continue to grow services to reach more people extending operating hours where demand necessitates and at a minimum operating 8am to 8pm, 7 days a week
- Improve outcomes through reaching patients in crisis in under 2 hours where clinically appropriate.
- Increase the number of referrals from all key routes, with a focus on UEC, 111 and 999, and increase care contacts
- Improve capacity in post urgent community response services to support flow and patient outcomes including avoiding deterioration into crisis again or unnecessary admission
- Ensure workforce plans support increasing capacity and development of skills and competencies in line with service development
- Improve data quality and completeness in the Community Services Dataset (CSDS) as this will be the key method to monitor outcomes, system performance and capacity growth

Anticipatory care

- ICSs should design, plan for and commission Anticipatory Care (AC) for their system. Systems need to work with health and care providers to develop a plan for delivering AC from 2023/24 by Q3 2022, in line with forthcoming national operating model for AC.

Enhanced Health in Care Homes

- Ensure consistent and comprehensive coverage of Enhanced Health in Care Homes in line with the national framework.

Community service waiting lists

- Develop a trajectory for reducing their community service waiting lists
- Significantly reduce the number of patients waiting for community services
- Prioritise patients on waiting lists
- Consider transforming service pathways and models to improve effectiveness and productivity.

Hospital discharge

Work together with local authorities and partners, including hospices and care homes, to release the maximum

number of beds, as a minimum this should be equivalent to half of current delayed discharges. Systems should seek to sustain the improvement in delayed discharges in 2022/23 working with local authority partners and supported by the Better Care Fund and the investment in virtual wards.

Digital

- Identify digital priorities to support the delivery of out-of-hospital models of care through the development of system digital investment plans, ensuring community health services providers are supported to develop robust digital strategies to support improvements in care delivery
- Ensure providers of community health services, including ICS-commissioned independent providers, can access the Local Care Shared Record as a priority in 2022/23, to enable urgent care response and virtual wards
- Deliver radical improvements in quality and availability against national data requirements and clinical standards, including the priority areas of urgent care response and musculoskeletal (MSK).

NHS E: Improve timely access to primary care

- Support PCNs to have in place their share of the 20,500 FTE PCN roles by the end of 2022/23
- Expand the number of GPs towards the 6,000 FTE target, with consistent local delivery of national GP recruitment and retention initiatives.

NHS F: Improve mental health services and services for people with a learning disability and / or autistic people

F1: Expand and improve mental health services

- Continue to expand and improve their mental health crisis care provision for all ages.
- Ensure admissions are intervention-focused, therapeutic and supported by a multidisciplinary team, utilising the expansion of mental health provider collaboratives across the whole mental health pathway where systems plan such developments.
- Continue the expansion and transformation of mental health services, as set out in the NHS Mental Health Implementation Plan 2019/20–2023/24, to improve the quality of mental healthcare across all ages.
- Continue to grow and expand specialist care and treatment for infants, children and young people.
- Subject to confirmation, encourage participation in the first phase of the national Quality Improvement programme to support implementation of the Mental Health Act reforms.

F2: Meet the needs of people with a learning disability and autistic people

- Increase the rate of annual health checks for people aged 14 and over on a GP learning disability register towards the 75% ambition in 2023/24.
- Continue to improve the accuracy of GP learning disability registers.
- Maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability and/or who are autistic, consistent with the ambition set out in the NHS Long Term Plan, and to develop community services to support admission avoidance and timely discharge.
- Build on the investment made in 2021/22 to develop a range of care and diagnostic services for autistic people delivered by multidisciplinary teams.
- Implement the actions coming out of Learning Disability Mortality Reviews (LeDeRs), including following deaths of people who are autistic, to tackle the inequalities experienced by people.

NHS G: Continue to develop our approach to population health management, prevent ill-health and address health inequalities

- Support the rollout of tobacco dependence treatment services in all inpatient and maternity settings.
- Improve uptake of lifestyle services, the Diabetes Prevention Programme, Low Calorie Diets, the new Digital Weight Management Programme and digitally supported self-management services.
- Restore diagnosis, monitoring and management of hypertension, atrial fibrillation and high cholesterol and diabetes, as well as asthma and COPD registers and spirometry checks for adults and children, to pre-pandemic levels.
- Progress against the NHS Long Term Plan high impact actions to support respiratory, stroke and cardiac care, implementing new models of care and rehabilitation.
- Reduce antibiotic use in primary and secondary care through early identification and treatment of bacterial infections and support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary.
- Renew focus on reducing inequalities in access to and outcomes from NHS public health screening and immunisation services
- Continue to adopt culturally competent approaches to increasing vaccination uptake in groups that have a lower than overall average uptake as of March 2022
- Continue to deliver on the personalised care commitments set out in the NHS Long Term Plan.

NHS H: Exploit the potential of digital technologies to transform the delivery of care and patient outcomes

- Include provisions for robust cyber security across the system.
- Reflect ambitions to consolidate purchasing and deployment of digital capabilities

- Set out the steps being taken locally to support digital inclusion
- Consider how digital services can support the NHS Net Zero Agenda.
- By March 2023, all systems within a Shared Care Record collaborative can exchange information across the whole collaborative, with a view to national exchange by March 2024.
- Local authorities with social service responsibilities within their footprint are connected to their local Shared Care Record solution by March 2023, and that all social care providers can connect within six months of them having an operational digital social care record system
- Suppliers comply with interoperability standards as these are finalised by April 2022
- General practice promotes the NHS App and NHS.UK to reach 60% adult registration by March 2023
- Plans are developed to support skilling up the workforce to maximise the opportunities of digital solutions.

NHS I: Make the most effective use of our resources

I1: Use of resources

- Fully restore core services and make significant in-roads into the elective backlog and NHS Long Term Plan commitments.
- Develop plans that deliver the necessary exit run-rate position to support delivery of future requirements.

I2: Financial framework

The 2022/23 financial and contracting arrangements are summarised as:

- A glidepath from current system revenue envelopes to fair share allocations. ICB revenue allocations will be based on current system funding envelopes, which continue to include the funding previously provided to support financial sustainability.
- Increased clarity and certainty over capital allocations, with multi-year operational capital allocations set at ICB level, building on the approach taken in the last two years, and greater transparency over the allocation of national capital programmes.
- A collective local accountability and responsibility for delivering system and ICB financial balance. Each ICB and its partner trusts will have a financial objective to deliver a financially balanced system, namely a duty on breakeven.
- A return to signed contracts and local ownership for payment flows under simplified rules.
- A commitment to support systems to tackle the elective backlog and deliver the NHS Long Term Plan. Additional revenue and capital funding will be provided to systems to support elective recovery, with access to additional revenue where systems exceed target levels.
- A continued focus on integration of services to support the transition for future delegations.

NHS J: Establish ICBs and collaborative system working

- CCG leaders and designated ICB leaders should continue with preparations for the closure of CCGs and the establishment of ICBs, working toward the new target date of 1 July 2022.
- ICB designate chairs and chief executives should continue to progress recruitment to their designate leadership teams, adjusting their timelines as necessary while managing immediate operational demands.

Maternity Quality Governance Committee Chair's Highlight Report to Board

25th May 2022



University Hospitals
of North Midlands
NHS Trust

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	<ul style="list-style-type: none"> During Q4 there were 7 new serious incidents reported within Maternity of which 5 are being investigated through local Root Cause Analysis and 2 using the Perinatal Mortality Tool There has been a delay in the investigation of serious incidents within Maternity due to unit activity and staffing levels; additional resource has been sought to enhance governance / investigation processes and a revised timescale has been agreed in terms of completion of outstanding investigations Face to face training for staff within Maternity was suspended during Covid, therefore an online training package was launched although pressures with staffing had made this challenging and so the packages were broken down into four monthly topics for staff to complete 11 perinatal mortality cases presented to the Directorate within Quarter 4 of which 2 were reported as Serious Incidents Ward 206 identified as a concern in terms of staffing where mitigations are often needed in order to ensure safe staffing levels are in place Tight timescale of January 2023 for completion of the NHS Resolution submission, which will need to be taken through internal governance processes initially Challenges were noted in implementing Uterine Artery Doppler Scanning and further work was to be undertaken to determine how this would be employed. 	<ul style="list-style-type: none"> Audits in relation to Ockenden recommendations will be presented to the Committee as separate items in order to provide greater depth of assurance Smaller team of investigators for maternity related incidents being established to ensure consistency in the quality of Root Cause Analysis; investigator will be responsible for follow up on actions arising from the investigation A number of actions have been introduced following an audit of incidents associated with falls within maternity; a risk assessment process is in place and actions to support mothers at risk are agreed on an individualised basis Targeted approach to key individuals on fetal monitoring within Maternity being undertaken Work is underway to redesign the Maternity Dashboard utilising analytical resource now within the Department A variety of plans are underway to support the retention and recruitment programme in place, including international recruitment with 5 candidates secured, direct support offer with NHSIE and business case development New NHS Resolution Maternity Incentive Scheme standards have been launched; there are some key changes in relation to the standards which are being worked through in readiness for a submission in January
✓	Positive Assurances to Provide	Decisions Made
	<ul style="list-style-type: none"> Compliance with Saving Babies Lives is on track with the majority of indicators, with plans in place to improve compliance in areas which are below target A comprehensive Training Plan is now in place with face to face due to recommence in September 2022 There has been a change in requirement in terms of reporting on Caesarean Sections which is reflected within the Maternity Dashboard Confirmation of funding for a further year has been given in relation to cessation of smoking Home Birth service has been reinstated With regard to Perinatal Mortality Reviews and CNST Safety Actions, 100% compliance had been achieved in 4 / 4 indicators 	<ul style="list-style-type: none"> There were no specific items requiring decision
Comments on the Effectiveness of the Meeting		
<ul style="list-style-type: none"> Agreed that it would be helpful to include Neonatal metrics and assurance; these will be factored into the business cycle Agreed that having a separate meeting for Maternity was a very positive move and members felt assured that sufficient coverage was being provided Agreed that the meeting was now incorporated into the Corporate Governance Structure and was not an 'extraordinary meeting' 		



2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Maternity New Serious Incident (SI) Report Summary Quarter 4 21/22	BAF 1	15593, 13419, 23361	Assurance	4.	Q4 2021/22 Perinatal Mortality Report	BAF 1		Assurance
2.	Saving Babies Lives Care Bundle (SBLCB) Quarter 4 <ul style="list-style-type: none"> Maternity Training Report Quarter 4 1st January 2022 - 31st March 2022 Three Year Training Plan and Trajectory for Maternity Services(2021-2024) 	BAF 1	16432, 24037, 13419	Assurance	5.	Midwifery Workforce Report	BAF 1 & 3		Assurance
3.	Maternity Dashboard – Quarter 4 21/22	BAF 1	13420, 11518, 13419, 15993, 16432	Assurance	6.	NHS Resolution Maternity Incentive Scheme			Assurance

3. 2022 / 23 Attendance Matrix

Members:	Attended			Deputy Sent			Apologies Received						
	A	M	M	J	J	A	S	O	N	D	J	F	M
Ms S Belfield SB Non-Executive Director (Chair)													
Mr P Bytheway PB Chief Operating Officer													
Ms S Gohir SG Associate Non-Executive Director													
Prof A Hassell AH Associate Non-Executive Director													
Dr K Maddock KM Non-Executive Director													
Mr J Maxwell JM Head of Quality, Safety & Compliance													
Dr M Lewis ML Medical Director													
Mrs AM Riley AM Chief Nurse						SM							
Miss C Rylands CR Associate Director of Corporate Governance						NH							
Mrs R Vaughan RV Chief People Officer													

Quality Governance Committee Chair's Highlight Report to Board

1st June 2022



University Hospitals
of North Midlands
NHS Trust

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	<ul style="list-style-type: none"> 54 serious incidents were reported during quarter 4, 30 of which related to falls. The numbers of serious incidents closed during the quarter were noted, with 88 serious incidents remaining open. The Committee challenged the timeline associated with closing the incidents and it was noted that an improvement was expected to be seen in the next 2 months. In terms of quality and safety for April 2022, the actions taken to issue outstanding duty of candour letters were noted. Sepsis screening compliance in emergency portals was raised given this had reduced significantly in month and further training was being undertaken with the team as well as reviewing the current process via 'go, look, learn'. The spike in pressure ulcers was queried although it was noted that the data was unvalidated and therefore could reduce slightly 	<ul style="list-style-type: none"> To provide an update in relation to clarifying the actions associated with serious incident case 2021/13358 To provide assurance in future serious incident reports on closed serious incidents, the actions taken and evidence that these had been completed To provide absolute numbers when presenting data in future quality and safety reports, in addition to the percentages To provide an update in relation to the outcome of the NHSIE Ockenden review from 5th May To clarify the actions being taken to improve reporting of complaints and associated ethnicity
✓	Positive Assurances to Provide	Decisions Made
	<ul style="list-style-type: none"> The Committee considered the outcome of the never events review, the majority of which related to surgical type never events, although 40% did not take place within a theatre environment. The Committee queried whether the safer surgery checklist was embedded within the Trust given the type of incidents reported, and it was noted that observational audits continued to be undertaken to assess the culture and establish areas for improvement. It was confirmed that in terms of the national definition of what should be reported as a never event, the more generic 'type' of events related surgical incidents whereas other never events were more specific and therefore did not have as many reported The Committee noted that although not contractually required to undertake local CQUINs, 5 selected schemes would be undertaken in addition to the required 3 specialised services schemes The Committee welcomed the committee effectiveness review which had mostly positive comments, noting that 2 actions for improvement had been identified. 	<ul style="list-style-type: none"> The Committee approved the Quality Strategy 2022-25 The Committee approved the Quality Account 2021/22 The Committee approved the revised Terms of Reference which were to be incorporated into the Rules of Procedure
Comments on the Effectiveness of the Meeting		
	<ul style="list-style-type: none"> The Committee welcomed the discussion held and thanked Ms Belfield for her time as Chair of the Committee, given that the meeting would be her last before the end of her term as Non-Executive Director. 	



2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Quality Strategy	BAF 1		Approval	6.	Extraordinary Maternity Quality & Safety Oversight Group Assurance Report	BAF 1		Assurance
2.	Q4 Serious Incident Report	BAF 1		Assurance	7.	Quality & Safety Oversight Group Assurance Report	BAF 1		Assurance
3.	Never Events Review	BAF 1		Assurance	8.	Draft Quality Account	BAF 1		Approval
4.	M1 Quality and Safety Report	BAF 1		Assurance	9.	Committee Effectiveness Review			Approval
5.	Commissioning for Quality and Innovation (CQUIN) scheme for 2022/23			Assurance					

3. 2022 / 23 Attendance Matrix

Members:	Attended			Deputy Sent					Apologies Received				
	A	M	M	J	J	A	S	O	N	D	J	F	M
Ms S Belfield SB Non-Executive Director (Chair)													
Mr P Bytheway PB Chief Operating Officer													
Ms S Gohir SG Associate Non-Executive Director													
Prof A Hassell AH Associate Non-Executive Director													
Dr K Maddock KM Non-Executive Director													
Mr J Maxwell JM Head of Quality, Safety & Compliance													
Dr M Lewis ML Medical Director													
Mrs AM Riley AM Chief Nurse	SM												
Miss C Rylands CR Associate Director of Corporate Governance	NH												
Mrs R Vaughan RV Chief People Officer													



Executive Summary

Meeting:	Trust Board	Date:	8 th June 2022
Report Title:	Infection Prevention Board Assurance Framework	Agenda Item:	11.
Author:	Helen Bucior, Infection Prevention Lead Nurse		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

Information	Approval	Assurance	x	Assurance Papers only:	Is the assurance positive / negative / both?
					Positive x Negative

Alignment with our Strategic Priorities

High Quality	x	People		Systems & Partners	
Responsive		Improving & Innovating		Resources	



Risk Register Mapping

BAF1	Delivering Positive Patient Outcomes	Extreme (20)
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Executive Summary:

Situation

To update the Committee on the self-assessment compliance with UKHSA and NHSEi regional COVID guidance

Background

Understanding of COVID-19 has developed and is still evolving. Public Health England and related guidance on required Infection Prevention measures has been published, updated and refined to reflect the learning. This continuous self-assessment process will ensure organisations can respond in an evidence based way to maintain the safety and patients, services users and staff.

Each criteria had been risk scored and target risk level identified with date for completed. Although work is in progress, the self-assessment sets out what actions, processes and monitoring the Trust already has in place for COVID-19.

The previous version of the IPC BAF is attached and shaded grey

Assessment/risks

- None conformities for decontamination of bed that are returned for repair remains and difficulty with dismantling of electronic beds at ward level remains an actions and will be included in the cleaning collaborative work
- Risk assessment undertaken to support deviating from national guidance. This approach has been supported by a recent document (Midlands Regional IPC principles) released by NHSE/I
- Visiting for patients has been increased to 2 visitors for each patient 2-4 pm, 6-8 pm. The 2 visits for the majority of cases do not need to be the same visitors

Progress

- External company continues to assist with mask fit testing
- Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools and methodologies continues to review cleaning standards
- Estates and IP are exploring the use of air scrubber technology
- May 2022 UV air system on trial ward 225

Key Recommendations:

Trust Board are asked to note the document for information, and note the on-going work to strengthen the assurance framework going forward.

Infection Prevention and Control Board Assurance Framework

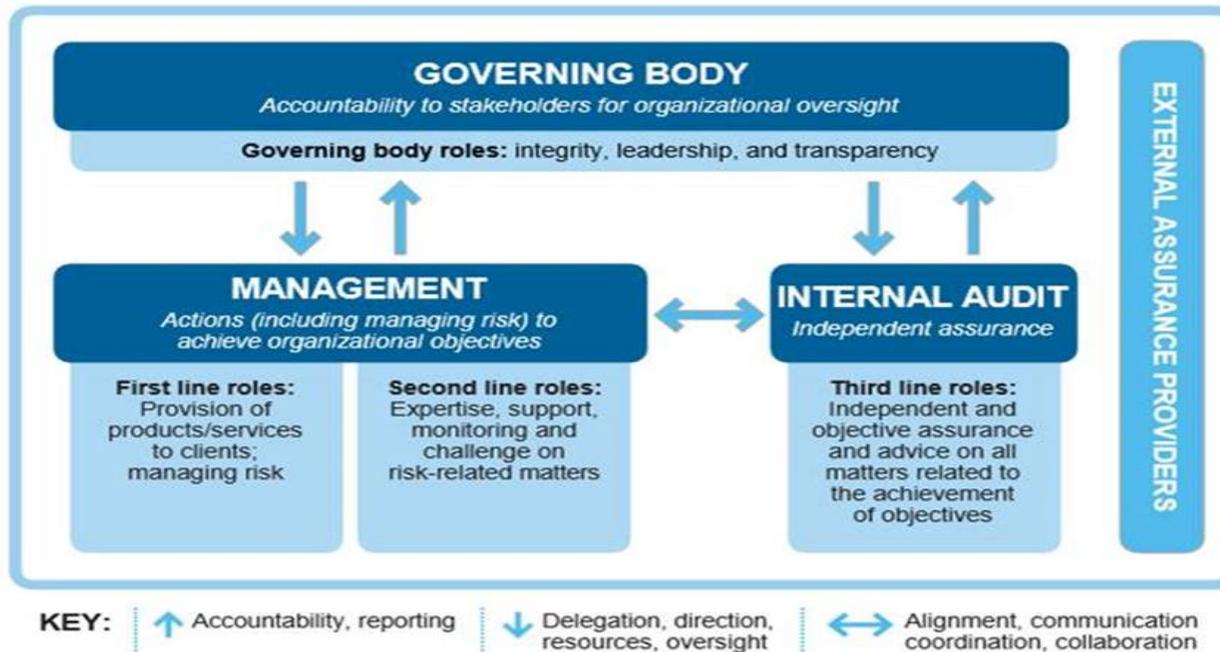
May 2022



Summary Board Assurance Framework

Ref / Page	Requirement / Objective	Risk Score					Change
		Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	
BAF 1 Page 4	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.	High 9	Mod 6				↓
BAF 2 Page 19	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Mod 6	Mod 6				→
BAF 3 Page 29	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Mod 6	Mod 6				→
BAF 4 Page 32	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care, in a timely fashion.	Low 3	Low 3				→
BAF 5 Page 35	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Low 3	Low 3				→
BAF 6 Page 41	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Low 3	Low 3				→
BAF 7 Page 47	Provide or secure adequate isolation facilities.	Low 3	Low 3				→

The IIA's Three Lines Model



IP draws on controls and assurances on three levels, aligned to the above model. Examples of these includes

1st line of defence, processes guidelines, training

2nd line of defence, Datix, root cause analysis, audits, COVID themes

3rd line of defence, external visits NSHEi, PHE, CCG attendance at outbreak meetings and IPCC

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.

Risk Scoring							Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Quarter	Q4	Q1	Q2	Q3	Q4	Likelihood:		Consequence:	Risk Level:	
Likelihood:	3					There are a number of controls in place. UHNM Risk assessment are in place where deviation from regional guidelines and testing recommendations	Likelihood:	1	End of Quarter 3	
Consequence:	3						Consequence:	3		
Risk Level:	9						Risk Level:	3		

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
1.1	<p>Intervention and principles physical distancing</p> <p>Emergency department Maintain at least 1 metre with areas for post testing and triaged respiratory infection</p> <p>For confirmed negative patients return to pre COVID -19 pandemic distancing</p>	 <p>20220401 Midlands Regional IPC principles</p> <ul style="list-style-type: none"> On arrival in ED patients are immediately identified either asymptomatic for COVID -19 symptoms and infection prevention precautions applied. ED navigator in place Colour coded areas in ED to set out COVID and Non COVID areas in place Aerosol generating procedures in single rooms with doors closed Major's resuscitation area for all 	<ul style="list-style-type: none"> Datix OB meetings Monitoring COVID patient numbers at UHNM for any increase in cases Monitoring the number of COVID outbreaks for any increase 	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
<p>Inpatient Settings</p> <p>Revert to pre COVID 19 pandemic bed spacing in all inpatient areas - ensure move to comply with all appropriate HTMs/HBNs if not currently the case</p> <p>Non clinical areas</p> <p>Options:</p> <ol style="list-style-type: none"> 1. Revert to pre COVID 19 pandemic 	<p>patients requiring this level of medical care. This area consists of single rooms with sliding doors and neutral pressure ventilation. Signage in place to set out level of PPE required for each room depending on infectious status of patient.</p> <ul style="list-style-type: none"> • Patients are asked to wear face covering/mask • UHNM risk assessment in place • Social distancing no returned to pre-pandemic spacing, a number of wards had beds removed to comply with 2 metre social distance rule • Emergency admission COVID PCR screening in place • Pre OP - Elective admission screening in place , lateral flow 72 hours pre admission and day of admission • Pre Op - PCR testing in place for patients that require critical care post operatively • Encourage patients to wear masks • Staff to continue mask wearing • Social distancing returned to pre-pandemic spacing in non- clinical 		

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<p>desk/chair spacing OR</p> <p>2. Maintain physical distancing and allow staff to remove masks</p> <p>The mitigation for removing physical distance consists of</p> <ul style="list-style-type: none"> • For removing the physical distancing constraints is keep masks/face covering • Remove masks and keep physical distance • Where the physical distancing constraints remain in place mask use is down to individual preference however, where masks are not worn everyone must have access to masks to wear if circumstances change (for example additional people come into the room) • Consideration to ventilation of these areas should be taken into account when making decisions. • Compliance and risk assessments should be documented 	<p>areas with the exception of staff rooms/restaurant/eating areas where masks are required to be removed. Distancing to remain at 2 metres in these areas</p> <ul style="list-style-type: none"> • Masks must be worn when walking around the building/hospital and when accessing shared spaces such as toilets and kitchen areas where occupancy is unable to be controlled • Advised window opening for a minimum of 10 minutes per hour • Cleaning of work station remains 		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
1.2	<p>Patient safety and governance</p> <ul style="list-style-type: none"> There should be systems in place to identify those harmed through acquiring COVID 19 in health care settings, or where harm had occurred through COVID -19 related interventions and report through existing organisational patient safety and organisational learning mechanisms Outbreak reporting Local deviation <p>As in previous versions of the national IPC guidance, organisations may choose to adopt practices that differ from these regional principles or nations guidance.</p>	<ul style="list-style-type: none"> Reporting of hospital onset COVID 19 infection in place COVID 19 definite and probable mortality reviews SI framework National definition of outbreak in place Outbreak report Outbreak meetings UHNM outbreak closure time is 7 days after the last positive case - then ward monitored for the next 28 days Staff to undertake daily lateral flow testing for 7 days from the date of outbreak declared UHNM risk assessments in place Screening options paper presented and option agreed with execs 22nd April 2022 -To continue PCR testing on day 1 and day 4 – emergency admissions. Day 6 , 14 and weekly no longer in place. To continue PCR testing if patient develops COVID symptoms or in outbreak situation 	<ul style="list-style-type: none"> COVID outbreak DATIX Monitoring COVID patient numbers at UHNM for any increase in cases Monitoring the number of COVID outbreaks for any increase 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		 Risk Assessment COVID IPC reducing <ul style="list-style-type: none"> • Staff to continue with twice weekly lateral flow testing – UHNM positivity rates monitored • Flow chart in place with actions to take if test is positive – return to work guidance • Flow chart in place for staff who test negative by are symptomatic request a PCR test • Consultant Microbiologist monitors admission screening positivity rates 		
1.3	<ul style="list-style-type: none"> • Testing of asymptomatic staff in non- outbreak settings <p>Options 1</p> <p>1 Clinical staff to continue to test using LFT twice weekly</p> <p>2 As community prevalence decrease consider stepping down routine asymptomatic testing in some or all clinical areas</p>	<ul style="list-style-type: none"> • Flow chart in place with actions to take if test is positive – return to work guidance • Flow chart in place for staff who test negative by are symptomatic request a PCR test • Consultant Microbiologist monitors admission screening positivity rates 	<ul style="list-style-type: none"> • Datix • OB meetings • Monitoring COVID patient numbers at UHNM for any increase in cases • Monitoring the number of COVID outbreaks for any increase 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	National Infection Prevention Manual released <ul style="list-style-type: none"> Changes in list of Aerosol Generating Procedures (AGP) 	<ul style="list-style-type: none"> Clinical Group to review and advise on revised APG list 	<ul style="list-style-type: none"> Audit OB monitoring Datix 	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1						

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Risk Scoring						Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Quarter	Q4	Q1	Q2	Q3	Q4		Likelihood:	Consequence:	Risk Level:
Likelihood:	2					Whilst cleaning procedures are in place to ensure the appropriate management of premises further work is in progress re cleaning standards and role and responsibilities	Likelihood:	1	End of Quarter 1 2022
Consequence:	3						Consequence:	3	
Risk Level:	6						Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
2.1	<p>Intervention and Principles - Environmental Cleaning</p> <p>In all clinical areas with asymptomatic patients, staff or visitor the 2021 National Standards of Cleanliness should apply</p> <ul style="list-style-type: none"> Respiratory - Enhanced environmental decontamination should be undertaken in clinical areas where respiratory transmission based precautions are practice Outbreak –Enhanced environmental cleaning, touch point cleaning minimum 2 hourly Designated nursing/medical teams with appropriate training are assigned to care for 	<ul style="list-style-type: none"> National standards of cleanliness in place – options analysis paper submitted against the 2021 standards SOP and cleaning method statements for cleaning teams High level disinfectant, Virusolve and Tristel in place and used for all decontamination cleans Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual Process in place for clinical areas with clusters and HAI cases of COVID -19 requiring increased 	<ul style="list-style-type: none"> CEF audits C4C audits Audits and assurance visits by IP Ward audits Spot check assurance audits completed by cleaning supervisors/managers Cleanliness complaints or concerns are addressed by completing cleanliness audit walkabouts with clinical teams, and CPM / domestic supervisors Patient survey feedback is reviewed by joint CPM / Sodexo/EFP group and 	<ul style="list-style-type: none"> Decontamination of beds returned for repair process non conformities Learning from CPE outbreak. We have recognised areas we can strengthen our assurance process on standards of cleanliness

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	and treat patients in Covid-19 isolation or cohort areas.	cleaning and /or terminal cleans <ul style="list-style-type: none"> • Cleaning schedules in place • Barrier cleans (increased cleaning frequency) process in place which includes sanitary ware and other frequent touch points • Process and designated staff for ED to ensure cleans are completed timely 	action plan completed if needed. <ul style="list-style-type: none"> • Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %. • C4C report presented at IPCC • GREAT training record cards are held centrally by Sodexo for all individual domestics • Key trainers record • Notes from Sodexo Performance Monthly meeting , Sodexo Operational meeting , Divisional IP Meeting and facilities/estates meeting 	
2.2	Ventilation <ul style="list-style-type: none"> • As part of heirachy of controls assessment : ventilation systems, particularly in, patient 	<ul style="list-style-type: none"> • UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for 	<ul style="list-style-type: none"> • Estates have planned programme of maintenance • The Authorising Engineer 	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
<p>care areas (natural or mechanical) meets national recommendations for the minimum of air changes refer to specific guidance, In patients care health building note 04-01 Adult in-patient facilities</p> <ul style="list-style-type: none"> The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations authorised engineer A systematic review of the ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways Where possible air is diluted by natural ventilation by opening windows and doors were appropriate Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission. Where a clinical space has a very low air changes and it is not possible to increase dilution effectively , alternative technologies are considered with estates/ventilation group Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air 	<p>Healthcare Society in order to provide assurance to the Trust Board on the safe operation and reduction in risk of infection transmission through ventilation systems. TOR written</p> <ul style="list-style-type: none"> The Trust also appointed external authoring Engineers. This is in line with the NHS estates best practise and guidance from Health Technical Memorandum (HTM) namely 03/01 Specialised Ventilation for Healthcare Premises. Trust Estates Ventilation Aps attended week long Specialized ventilation in health care at Leeds University – Much of this content contact relates to airborne respiratory infections Lessons learnt poster which encourage regular opening of windows to allow fresh air  <p>ventilation-air-changes-per-hour-2021-06</p> <ul style="list-style-type: none"> IP and estates have worked with areas know to be undertaking aerosol generating procedures and completed the fallow times IP have nominated point of contact re ventilation advise 	<p>Ventilation will provide external independent specialist advice and support as well as carrying out an annual audit for system compliance.</p>	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		<ul style="list-style-type: none"> • Most wards have mechanical ventilation in core areas and natural ventilation in bays (window opening) • January 2022 Estates and IP are exploring the use of air scrubber technology • May 2022 UV air system on trial ward 225 		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 1 Progress Report	BRAG
2	2.1	Review of cleaning standards	Divisions Facilities/ACN	12/11/2021 31/12/2021 End of quarter 1 2022	<u>November 2021</u> Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools and methodologies to work through the actions needed to respond to the cleaning issues that were highlighted during the CPE Outbreak. <u>March 2022</u> Collaborative work continues	In progress
	2.2	To explore alternative technologies to enhance ventilation in bays that have natural ventilation	Infection Prevention Team/Estates	End of Quarter 2 2022	<u>May 2022</u> UV Light air technology on trial ward 225	

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Risk Scoring								
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)	Target Date
Likelihood:	2					Whilst there are controls and assurances place some of the finding of the antimicrobial audits demonstrate area of non-compliance therefore further control are to be identified and implemented in order to reduce the level of risk	Likelihood:	2
Consequence:	3						Consequence:	3
Risk Level:	6						Risk Level:	6
								End of Quarter 1 2021

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:			
3.1 Arrangements around antimicrobial stewardship are maintained. Update V 1.8 Previous antimicrobial history is considered The use of antimicrobials is managed an monitored: Update V 1.8 <ul style="list-style-type: none"> To reduce inappropriate prescribing To ensure patients with infections are treated promptly with correct antibiotic 	<ul style="list-style-type: none"> Regular, planned Antimicrobial stewardship (AMS) ward rounds Trust antimicrobial guidelines available 24/7 via intranet and mobile device App Antimicrobial action plan in place Clostridium <i>difficile</i> Period of increased incidence and outbreaks are reviewed by member of AMS team and actions generated cascaded to ward teams Regional and National networking to ensure AMS activities are optimal Formal regional meetings and informal national network activities AMS CQUIN further mandates key AMS principles to be adhered to All national CQUINS currently suspended by NHSE / PHE 	<ul style="list-style-type: none"> Same day escalation to microbiologist, if concerns. Outcome recorded on I portal Metric available around the number of times App accessed by UHNM staff Compliance with guidelines and other AMS metrics reported to Infection prevention and control Committee (IPCC) Meeting minutes reviewed and actions followed up Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl. PHE) thought leaders members Trust and commissioners require timely reporting on compliance 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		<ul style="list-style-type: none"> Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM 	<ul style="list-style-type: none"> with AMS CQUIN targets. Wards showing deviation from targets are followed up by targeted AMS team ward reviews generating action plans for ward teams. On hold during COVID19 due to redeployment of duties The pharmacy team undertook a trust-wide point prevalence audit using a new electronic data capture tool. Results will be reviewed during January and shared with ACN's and Microbiologist. 	
3.2	<p>Mandatory reporting requirements are adhered to and boards continue to maintain oversight.</p> <p>Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director and the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available.</p> <p>Linked to NHSIE Key Action 10: Local systems must review system performance and data, offer peer support and take steps to intervene as required.</p> <p>Update V 1.8</p>	<ul style="list-style-type: none"> Quarterly point prevalence audits maintained by AMS team at UHNM despite many regional Trusts not undertaking any more. These have restarted in December 2020 as held during COVID-19. Results online. Results from all AMS audits and targeted ward reviews are reported at the Antimicrobial Stewardship Group and minutes seen by IPCC CQUIN submissions completed in timely manner and generate action plans for AMS and ward teams to follow up concerns each quarter. Currently suspended. 	<ul style="list-style-type: none"> Whilst only a snap-shot audit the Trust value the output from these audits. Work is underway Q1 and Q2 20/21 to review potential change in data collection to optimise impact. IPCC scrutinise results. Divisions held to account for areas of poor performance. Audit outputs will be used as basis of feedback on performance to individual clinical areas going forward. Trust CQUIN contracts manager holds regular track and update meetings to challenge progress vs AMS CQUINS, Currently suspended. 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care, in a timely fashion.

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)	Target Date	
Likelihood:	1					There is a substantial amount of information available to provide to patients this requires continuous update as national guidelines change	Likelihood:	1	End of Q3
Consequence:	3						Consequence:	3	–
Risk Level:	3						Risk Level:	3	Achieved in Q4

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
4.1	Continues use of Fluid resistant Surgical Masks in all patient facing and non –clinical setting (unless clinically exempt)	<ul style="list-style-type: none"> Posters and signage in place Mask available at hospital entrance 	<ul style="list-style-type: none"> Monitored by clinical areas PALS complaints/feedback from service users Outbreak meetings 	
4.2	Patient visiting	<ul style="list-style-type: none"> 30th May visiting updated .The majority of inpatients are permitted to have two visitors, between 2pm and 4pm and again between 6pm and 8pm. In the majority of cases these do <u>not</u> have to be the same two visitors. 	<ul style="list-style-type: none"> Monitoring of number of Outbreak 	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Risk Scoring							Target Risk Level (Risk Appetite)	Target Date
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level		
Likelihood:	1					Whilst arrangements are in place ensure the screening of all patients. To continue to reinforce COVID screening protocol and work towards lateral flow testing for those patients that remain an inpatient	Likelihood: 1	
Consequence:	3						Consequence: 3	
Risk Level:	3						Risk Level: 3	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:			
5.1 Testing <ul style="list-style-type: none"> All NHS patients in a hospital setting requiring a test by a clinical to support clinical decisions during their care and treatment pathway should be offered a PCR test as part of their usual diagnostic pathway Testing for asymptomatic in patients on day 3 and days 5-7 of their stay should now be undertaken by lateral flow device LFD 	<ul style="list-style-type: none"> CR testing in place for all emergency inpatient admissions and symptomatic patients PCR continues on day 1 and day 4 of inpatient stay, Risk assessment completed ,no day 6 screen, 14 or weekly. In addition PCR testing for patient who have or develop COVID 19 symptoms No system in place for inpatient lateral flow testing (POCT) and recording of results on electronic system 	<ul style="list-style-type: none"> COVID 19 -Themes report to IPCC COVID screening spot check audits Datix Outbreak investigation 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		<p>to allow for surveillance of cases and alert when possible or definite outbreak</p> <ul style="list-style-type: none"> • PCR remains for outbreak screening, both patients and staff <p>UHNM isolation period remains at 10 days - no POCT in place to release patients earlier</p> <ul style="list-style-type: none"> • Planned elective admissions are now tested using lateral flow 72 hours prior to admission and on the day of admission • PCR testing for patients discharged to nursing/care home 		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 1 Progress Report	BRAG
5	5.1	Introduction of lateral flow testing for day 4 and 6 of inpatient stay	Deputy Chief Nurse	End of July	<u>April 2022</u> Lateral flow testing introduced for elective cases. Meeting held to discuss the use of lateral flow (POCT) for patients who remain an in- patient. Challenge to ensure results are recorded electronically and feed into electronic system to enable reporting and to ensure the Infection Prevention Team are aware of positive cases and outbreak to enable outbreak actions to be instigated. In addition time and staff required to ensure compliance with POCT rules- explore swabbing team.	On- going

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of their responsibilities in the process of preventing and controlling infection.

Risk Scoring							Target Risk Level (Risk Appetite)	Target Date	
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level			
Likelihood:	1					Information and communication/controls are in place to ensure staff are aware of their responsibilities spot audits continue.	Likelihood:	1	End of Quarter 2 2021
Consequence:	3						Consequence:	3	
Risk Level:	3						Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
6.1	<p>Intervention and Principles PPE</p> <ul style="list-style-type: none"> Non Respiratory - for symptomatic patients staff should follow standard infection control precautions Respiratory - for caring for patients with respiratory symptoms direct contact staff should take respiratory transmission based precautions <p>Consider the use of FFP3 for prolonged contact with positive symptomatic patients , especially in areas where ventilation is not complaint with ventilations standards</p>	<ul style="list-style-type: none"> Infection Prevention Questions and Answers manual, chapter Q1 standard precautions PPE posters are available in the COVID -19 section of trust intranet page UHNM recommend staff use of for highly suspected or confirmed COVID 19 patients <ul style="list-style-type: none"> FFP3 mask /hood Eye protection Gloves Apron(gown for AGP) 	<ul style="list-style-type: none"> Divisional FFP3 training records Mandatory training records Assurance visits/spot checks Ward audits 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 1 Progress Report	BRAG
6						

7. Provide or secure adequate isolation facilities

						Risk Scoring			
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level		Target Risk Level (Risk Appetite)	
Likelihood:	1					Isolation facilities are available and hospital zoning currently in place, however there is a need to explore increasing single room availability (pods).		Likelihood:	1
Consequence:	3							Consequence:	3
Risk Level:	3							Risk Level:	3

Control and Assurance Framework

Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
7.1	<p>Intervention and principles – Contact Isolation (assuming the patients area asymptomatic and have agreeing with the Trust testing protocol and have recent negative test)</p> <ul style="list-style-type: none"> 10-day isolation from time of last positive contact 7-day isolation from time of last positive contact 5- day isolation from time of last positive contact Retain contacts on same clinical area with separate toilet and bathroom facilities to other patients Patients with possible or Covid-19 are isolated in appropriate facilities or designated areas where appropriate. 	<ul style="list-style-type: none"> UHNM risk assessment with Exec sign off Considered related to risk within the organisation and system UHNM have reduced patient COVID contact classification period from 10 days to 7 days if patient remains asymptomatic and tests negative PCR COVID screen on day 6 after exposure then contact isolation can discontinue 	<ul style="list-style-type: none"> If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions. Contact tag to electronic records applied by IP Team Spot check audits Assurance obtained for monitoring of inpatient compliance with wearing face masks via Matrons daily walk round June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify themes which are presented 	<p>Work in progress to assess the need for more single room availability to facilitate patient flow and surgical pathway</p>

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Restricted access between pathways if possible,	<ul style="list-style-type: none"> COVID contacts are cohorted with similar isolation periods to reduce risk Where possible cohort nursing staff to provide care for the contact and the negative or positive patients separately PPE changed when moving between cohorts Clinical equipment where possible designed to cohort and decontaminated after use <p>UHNM risk assessment</p> <ul style="list-style-type: none"> Mixing contact (negative) patients with non-contact (negative) patients when the Trust is on escalation level 4 with significant numbers of ambulances holding unable to offload, a significant number of specialties being held within the emergency portals and 90 or more medically fit for discharge patients are being held at the Trust. Non-contact patients selection criteria for admission to a contact ward - this is contained in the risk assessment 	<p>at IPCC .</p> <ul style="list-style-type: none"> Themes report to IPCC Inappropriate patient moves reported via Datix. Daily process Discuss at outbreak meetings as necessary 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 1 Progress Report	BRAG
7	7.1	To assess the need for further single room isolation facilities (PODS) to facilitate COVID patients remaining on their original ward, facilitate flow and surgical pathway	DIPC	End of June 2022	<u>May 2022 Request</u> made to analyst to map/predict isolation need.	

CURRENT PROGRESS RATING		
B	Complete / Business as Usual	Completed: Improvement / action delivered with sustainability assured.
GA / GB	On Track	Improvement on trajectory either: A. On track – not yet completed or B. On track – not yet started
A	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
R	Delayed	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Infection Prevention and Control Board Assurance Framework

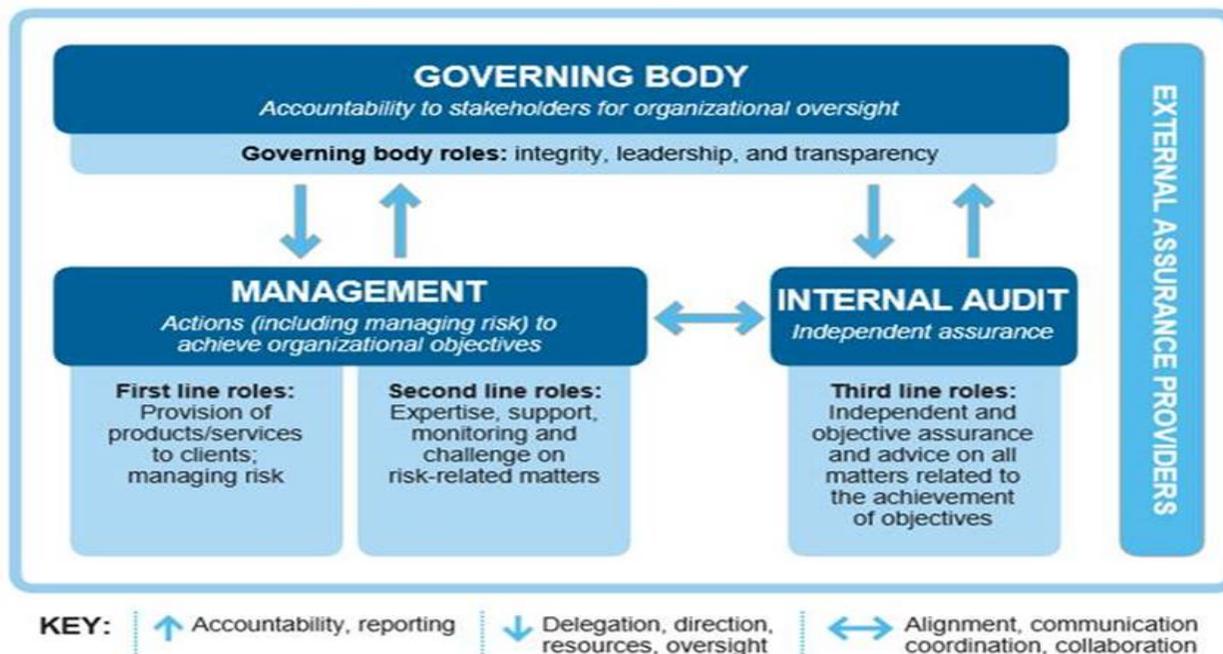
March 2022



Summary Board Assurance Framework

Ref / Page	Requirement / Objective	Risk Score					Change
		Q4	Q1	Q2	Q3	Q4	
BAF 1 Page 4	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.	Mod 6	Mod 6	Mod 6	Mod 6	High 9	↑
BAF 2 Page 19	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Mod 6	Low 3	Low 3	Mod 6	Mod 6	↓(end of quarter 3)
BAF 3 Page 29	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	High 9	Mod 6	Mod 6	Mod 6	Mod 6	→
BAF 4 Page 32	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care, in a timely fashion.	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 5 Page 35	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 6 Page 41	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Mod 6	Mod 6	Low 3	Low 3	Low 3	→
BAF 7 Page 47	Provide or secure adequate isolation facilities.	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 8 Page 50	Secure adequate access to laboratory support as appropriate.	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 9 Page 54	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections.	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 10 Page 57	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Low 3	Low 3	Low 3	Low 3	Low 3	→

The IIA's Three Lines Model



IP draws on controls and assurances on three levels, aligned to the above model. Examples of these includes

1st line of defence, processes guidelines, training

2nd line of defence, Datix, root cause analysis, audits, COVID themes

3rd line of defence, external visits NSHEi , PHE, CCG attendance at outbreak meetings and IPCC

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.

						Risk Scoring			
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	2	2	3	There are a number of controls in place, however evidence of assurance monitoring has demonstrated some gaps which will be addressed through the action plan CPE colonisation OB/ NHSEi visited rated Trust as RED on the NHSEI matrix from mid- September to Mid-December and therefore we increased the risk rate to 16, this risk has now reduced and NHSEi and has moved the Trust back to AMBER. End of quarter 3 position risk reduced to 6. Quarter 4 risk increased due to COVID Contact mixing	Likelihood:	1	End of Quarter 3
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	6	6	6	6	9		Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
1.1	<p>Systems and processes are in place ensure:</p> <p>Update V 1.8 A respiratory season/winter plan is in place: that includes</p> <ul style="list-style-type: none"> point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services to enable appropriate segregations of cases depending on the pathogen Plan for and manage increasing case numbers where they occur. a multidisciplinary team approach is adopted with hospital leadership, estates 	<ul style="list-style-type: none"> All emergency patients are screened on decision to admit and set intervals of stay as per protocol. Elective screening protocol in place UHNM have access to rapid PCR testing circumstances that require a rapid result to facilitate placement Elective screening protocol in place EPRR forum UHNM Major Incident response and recovery plan Super serge identified and reviewed QIA completed for each area 	<ul style="list-style-type: none"> From June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme Theme report to IPCC Pre AMS check COVID -19 screening results, if patient arrives in green area with no COVID screen a Datix is raised. 	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<p>& facilities, IP Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan</p> <ul style="list-style-type: none"> Risk assessments are carried out in all areas by a competent person with the skills, knowledge and experience to be able to recognise the hazards associated with respiratory infectious agents <ul style="list-style-type: none"> Local risk assessments are based on the measure as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff The documented risk assessment includes: <ul style="list-style-type: none"> A review of the effectiveness of the ventilation in the area Operational capacity Prevalence of infections/variants concern in the local area Triaging and SARS-CoV-2 testing is undertaken for all patients either at the point of admission or soon as possible/practical following admission across all pathways; 	<ul style="list-style-type: none"> Multidisciplinary team approach Exec sign off Nominated ventilation lead to liaise with IP Risk assessment follow Hierarchy of controls QIA process Daily Tactical meetings March 2022 UHNM Risk assessment completed. Social distancing reverted back to pre-pandemic spacing, except in staff rooms/restaurant where masks are removed. Distancing to remain at 2 metres Mixing contact (negative) patients with non-contact (negative) patients when the Trust is on escalation level 4 with significant numbers of ambulances holding unable to offload, a significant number of specialties being held within the emergency portals and 90 or more medically fit 	<ul style="list-style-type: none"> Datix OB meetings 	

Control and Assurance Framework

Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<p>for discharge patients are being held at the Trust.</p> <ul style="list-style-type: none"> • Non-contact patients selection criteria for admission to a contact ward • Reduce patient COVID contact classification period from 10 days to 7 days if patient remains symptomatic and negative COVID screen on day 6 after exposure <p> Risk Assessment COVID IPC reducing</p> <p> 20220401 Midlands Regional IPC principles</p> <ul style="list-style-type: none"> • Regional COVID guidance received from NHSEi • Work with LRF to obtain community rates • IP attends the weekly Staffordshire and Stoke on Trent , Test, Trace and Outbreak Management Group • On arrival in ED patients are immediately identified either asymptomatic for COVID 		

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
<p>Update V 1.8</p> <ul style="list-style-type: none"> When an unacceptable risk of transmission remains following the risk assessment, consideration to the 		<p>-19 and apply infection prevention precautions.</p> <ul style="list-style-type: none"> ED navigator in place Colour coded areas in ED to set out COVID and Non COVID areas. This was revised in September 2020 to mirror inpatient zoning. Purple ED with blue single rooms and respiratory assessment unit Aerosol generating procedures in single rooms with doors closed ED navigator records patient temperature and asked COVID screening questions. Patient then directed to either remain in purple or blue single room ED pathways and SOP When ambulance identify suspected COVID patients are received in respiratory assessment Unit ED All patients screened for COVID -19 when decision made to admit Maternity pathway in place Elective Pre Amms Plan to swab Patients 72 hours pre admission SOP in place Radiology /interventional flow chart Children's unplanned admission. ED Navigator asked COVID questions then child directed to either RED of Green Areas. All children, symptomatic or asymptomatic are swabbed in child 		

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<p>extended use of respiratory RPE for patient care in specific situations should be given</p>	<p>health. This is recorded within their medical records, placed onto the nursing and medical handover so that we are made of the results and whether we need to chase if not received within a timely manner. The patient flow reports to the Child Health tactical meeting every morning how many children have been swabbed result and any outstanding</p> <ul style="list-style-type: none"> • All children swabbed are placed into a sideward upon receiving their result are either kept within a side ward or moved to a bay if the swab is negative. • Screening for patients on systematic anticancer treatment and radiotherapy • Out patient flow chart in place • Thermal imaging cameras in some areas of the hospital • Iportal alert in place for COVID positive patients • Extremely vulnerable patient placement added into new COVID ward round guidelines (October 2020) <div style="display: flex; justify-content: center; gap: 20px;"> <div style="text-align: center;">  covid-19-care-plan-jan-22.pdf </div> <div style="text-align: center;">  4th-february-2021-covid-ward-round-guidelines.pdf </div> </div> <ul style="list-style-type: none"> • Doors fitted to resus areas in both ED's 		

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		<ul style="list-style-type: none"> Discussed at Clinical group. Paper prepared by Deputy Medical Director which received exec approval w/c 26 July 2021 August 2021 Introduction of FFP3 masks for all contact/ within 2 metres of COVID positive patients. The use of FFP3 masks for aerosol generating procedures remains in place UKHSA issued updated guidance 17th January 2022 re FFP3 or equivalent for staff when with confirmed or suspected patients / organisms spread through the airborne route 		
1.2	<p>Patients with possible or confirmed Covid-19 are not moved unless this is essential to their care or reduces the risk of transmission.</p> <p>There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative</p> <p>Update V 1.8. Ensure that patients are not transferred unnecessarily between care areas unless; there is a change in their infectious status, clinical need, or availability of services.</p> <p>That on occasions when it is necessary to</p>	<ul style="list-style-type: none"> All patients admitted to the Trust are screened for COVID -19 All patients that test negative are rescreened on days 4, 6, 14 and weekly Critical care plan with step down decision tree COVID-19 Divisional pathways Step down guidance available on COVID 19 intranet page Barrier and Terminal clean process in place IP PHE guidance Isolation guidance IP Q+A manual COVID Q+A available on Trust intranet COVID 19 outbreak meetings 	<ul style="list-style-type: none"> Unannounced visits for clinical areas with clusters or HAI cases of COVID-19 Review of HCAI COVID cases by IP Team/RCA Datix /adverse incidence reports for inappropriate transfers 	<ul style="list-style-type: none"> NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	<ul style="list-style-type: none"> • Patient COVID -19 discharge information letter for patient who are discharged but contact of a positive case 		
1.3	Compliance with the national guidance around discharge or transfer of Covid-19 positive patients.	<ul style="list-style-type: none"> • Infection prevention step down guidance available on Trust intranet • All patients who are either positive or contacts of positives are advised to complete self –isolation if discharged or transferred within that time frame • All patients are screened 48 hours prior to transfer to care homes • New UHNM ward round guidance October 2020. This also included placement of the extremely vulnerable patient • COVID ward round guidance updated as new treatment or evidence emerges. Guidance updates are discussed at the weekly clinical COVID group <div style="text-align: center;">   </div> <p>guidance-on-screeni 4th-february-2021-c ng-and-testing-for-coovid-ward-round-guic</p>	<ul style="list-style-type: none"> • Datix/adverse incidence reports 	
1.4	All staff (clinical and non-clinical) are trained in putting on and removing PPE, know what PPE they should wear for each setting and context and have access to the PPE that protects them for the appropriate setting and context as per national guidance .	<ul style="list-style-type: none"> • Key FFP3 mask fit trainers in place in clinical areas • PPE posters and information available on the Trust COVID -19 page. This provides the what, where and when guide for PPE • Infection Prevention Questions and 	<ul style="list-style-type: none"> • Daily stock level of PPE distributed via email and agenda item for discussion at COVID-19 tactical group • IP complete spot check of PPE use if cluster/OB trigger 	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
<p>Linked NHSIE Key Action 3: Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings.</p> <p>Linked Key Infection Prevention points – COVID 19 vaccination sites</p> <p>Monitoring of IP practices, ensuring resources are in place to enable compliance with IP practice of staff adherence to hand hygiene?</p> <ul style="list-style-type: none"> • Staff adherence to hand hygiene • Patients, visitors and staff are able to maintain 2 metre social and physical distancing in all patient care areas, unless staff are providing clinical/personal care and wearing appropriate PPE • Staff social distancing across the workplace • Staff adherence to wearing of fluid resistant surgical face masks <ul style="list-style-type: none"> a) clinical b) non clinical setting <p>Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting</p> <p>The role of PPE guardians/safety champions to embed and encourage best practice has been</p>	<p>Answers Manual include donning and doffing information.</p> <ul style="list-style-type: none"> • Areas and situations that require high level PPE are agreed at clinical and tactical • Aerosol generating procedures (AGP's) which require high level PPE agreed at clinical and tactical group • COVID -19 Clinical Group reviews any proposed changes in PPE from the clinical areas • Link to Public Health England donning and doffing posters and videos available on Trust intranet • Chief Nurse PPE video • Extended opening hours supplies Department • Risk assessment for work process or task analysis completed by Health and Safety • Estates in house teams and contractors are issued with SOP for working in clinical and non- clinical areas • PHE announced from 11th June 2020 all staff to wear mask in both clinical and non-clinical health care setting • Matrons walk rounds • Specialised division summarised BAF and circulated to matrons • ACN's to discuss peer review of areas • Poster displayed in entrances and along corridors reinforcing the use of masks social distancing and one way systems 	<ul style="list-style-type: none"> • Records of Donning and Doffing training for staff trained by IP • A number of Clinical areas have submitted PPE donning an doffing records to the IP team • Donning and Doffing training also held locally in clinical areas • Cascade training records held locally by Divisions • Sodexo and Domestic service training records • IP unannounced assurance visits • Review of UHNM vaccination areas against key infection prevention points COVID -19 • Hand hygiene audits • FFP3 testing records can be added as a skill to Health roster. 	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
<p>considered</p> <p>There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace</p> <p>Update V 1.8</p> <p>Resources are in place to implement and measures adherence to good IP practice. This must include all care areas and all staff (permanent , agency and external contractors)</p> <p>The application of IP practices within this guidance is monitored e.g.</p> <ul style="list-style-type: none"> • Hand hygiene • PPE donning and doffing training • Cleaning and decontamination <p>Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.</p> <p>The Trust in not reliant on a particular mask type and ensure that a range of predominantly UK mask FFP3 masks are</p>	<ul style="list-style-type: none"> • Catch it , bin in, kill it posters in ED waiting rooms • Lessons learnt poster <ul style="list-style-type: none">   Lessons learnt - Non Clinical June 2021.pdf Lessons learnt - Clinical June 2021.pdf   unannounced-ip-visit non-clinical-assurance-template-2020-11.pre-visit-checklist-2020 • QIA process for occasions when risk assess that the 2 metres can be reduced <ul style="list-style-type: none">  SOP beds social distance Jan 2022.do • PPE available • Mask fit testers throughout the Trust • PPE videos and posters available • IP Q+A manual • QIA/risk assessments • Trust Ventilation authorising engineer (AE) is the lead author of SVHP guidance around COVID. AE attends the Trust Ventilation safety group and has a fixed agenda item for any updates and changes 		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<p>available to users as required</p> <p>Organisational/employers risk assessment in the context of managing seasonal respiratory infectious agents are</p> <ul style="list-style-type: none"> based on the measures as prioritised in the hierarchy of controls including evaluation of the ventilation in the area, operational capacity, and prevalence of the infection/new variant of concern in the local areas Applied in order and include elimination , substitution , engineering , administration and PPE/ RP Communicated to staff <p>Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.</p>	<p>to guidance and legislation.</p> <ul style="list-style-type: none"> The Trust has a list of available models of FFP3 masks to use. A number of staff are trained on 2 types of masks but this work is on-going as the priority it to ensure all staff who require FFP3 are tested on a suitable model first then tested on an alternative model 	<ul style="list-style-type: none"> Local FFP3 records held by the division Health roster FFP3 records 	
1.5	<p>National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way.</p>	<ul style="list-style-type: none"> Notifications from NHS to Chief nurse/CEO IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates Changes raised at -19 clinical groups which was held originally twice weekly, reduced to weekly and now increased back to twice weekly due to surge of 	<ul style="list-style-type: none"> Clinical Group meeting action log held by emergency planning 	

Control and Assurance Framework				
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		<p>COVID.</p> <ul style="list-style-type: none"> • Purpose of the Clinical Group - The Group receive clinical guidance and society guidance which is reviewed and if agreed used to advise clinical teams after approval at Exec COVID -19 meeting which is held twice monthly. • The clinical group initially weekly , now stepped down to Bi weekly • Tactical group – The tactical Group held daily. April 2021 now stepped down. The Group decide and agreed tactical actions Makes recommendations to Gold command • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates • IP provide daily support calls to the clinical areas 		
1.6	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	<ul style="list-style-type: none"> • Incidence Control Centre (ICC) Governance • Clinical Group, Divisional cells, Workforce Bureau, Recovery cells subgroup feed in to tactical group. • COVID Gold command , decisions /Assurance reported to Trust Board Via CEO Report/COO 	<ul style="list-style-type: none"> • Meeting Action log held by emergency planning • Trust Executive Group Gold command – Overall decision making and escalation • Tactical, Operational Delivery Group - The delivery of the objectives and benefits, and programme 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			<p>communications COVID 19 response and R&R. Co - ordination of resources. Escalation forum for linked Groups and Cells ensuring that the interdependencies are effectively managed, including system. Makes recommendations to Gold Command for key decisions.</p> <ul style="list-style-type: none"> • Clinical steering Group – Coordinate clinical decision – making to underpin continual service delivery and COVID 19 related care • Workforce Group – Lead the plan and priorities for our people recovery. Health and Wellbeing. Agree significant pipeline changes in working practices. Agree the impact if change made during COVID and priorities to support recovery • Divisional Groups – Agree infection Prevention <p> COVID19RRGOVERNANCE NOV20v1.pptx measures</p>	
1.7	Risks are reflected in risk registers and the	<ul style="list-style-type: none"> • Risk register and governance process 	<ul style="list-style-type: none"> • IP risks are agenda item at 	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
<p>Board Assurance Framework where appropriate.</p> <ul style="list-style-type: none"> Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. Trust Board has oversight of on going outbreaks and actions plans The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases Linked NHSIE Key Action 9: Local Systems must assure themselves, with commissioners that a Trust’s infection prevention and control interventions are optimal, the Board Assurance Framework is complete and agreed action plans are being delivered. 	<ul style="list-style-type: none"> Datix incidents Board assurance document standing agenda item Trust board and IPCC. TOR Outbreak Ilmarch submissions are copied to Chief Nurse/DIPC and exec Team Outbreak areas are included in daily tactical meeting Outbreak areas included in Gold update slides Outbreak meetings attended by CCG and PHE Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report Nosocomial death review process Visiting /walk round of areas by executive/senor leadership team <p> SOP bed removal due to social distancir</p>	<p>Infection Prevention and Control committee (IPCC)</p> <ul style="list-style-type: none"> Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report Nosocomial death review process – paper to Quality and Governance Committee 20th January 2021 COVID themes report to IPCC RCA process for all probable and definite COVID 19 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<ul style="list-style-type: none"> There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas 			
1.8	Robust IPC risk assessment processes and practices are in place for non Covid-19 infections and pathogens.	<ul style="list-style-type: none"> IP questions and answers manual Section in IP questions and answer manual 2.1 priority of isolation for different infections and organisms Sepsis pathway in place Infection Risk assessment in proud to care booklets and admission documentation C.diff care pathway IP included in mandatory training Pre Amms IP Screening Birmingham paused ribotyping service for C.DIFF due to COVID-19. During periods of increased incidence ribotyping is useful to establish person to person transmission, Leeds Hospital are now undertaking this service Proud to care booklets revised and reinstated August/September 2020 Revised pathways to include actions for extremely vulnerable patients who are admitted into the Trust Advantages and disadvantages to reinstating MRSA screening as per UHNM policy undertaken and recommenced May 2021 	<ul style="list-style-type: none"> MRSA screening compliance Monthly Sepsis Compliance audits. Screening compliance for sepsis and time to antibiotics for Red flag patients IP audits Infection Prevention Health care associated infection report, including submitted to monthly to Quality and Safety. Submission of Infection figures to Public Health England. Clostridium difficile, MRSA blood stream infections (bacteraemia) and Gram Negative blood stream infections Seasonal influenza reporting Audit programme for proud to care booklets CPE colonisation outbreak team closed the outbreak on 14th December 2021 following NHSEi whereby 	

Control and Assurance Framework				
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			only minor points picked up at the inspection and the Trust was moved back to AMBER	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
3	1.2	NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified	Microbiologist/ ACN's	31/05/2020 31/08/2021 29/10/2021 31/12/2021 28/02/2022 03/04/2022 03/05/2022	<p>Testing and re testing, Interpretation of swabs and step down of IP precaution process in place at UHNM. Suspected or positive patients are moved on clinical need/assessment and in line with UHNM step down process. For patients who test negative on admission re screening is undertaken.</p> <p>17th November NHSI guidance recommended that the second test is taken on day 3 after admission and day 5 after admission. Implementation of the new guidance is in place and a manual prompt is provided to the clinical areas. (Days 4 and 6 admission day counted as day 1). Waiting for 2 negatives swabs before moving for patients that are not COVID suspected does not always occur.</p> <p><u>September 2021</u> A COVID themes review paper is presented at IPCC bi monthly and is an agenda item. Investigation of themes and discussions at COVID outbreak meetings provide an opportunity to review not always achieving this standard and whether this has an impact on potential transmission or outbreak. A number of specialised ward strive to isolate admissions into a single room until COVID results are known.</p> <p><u>November & December 2021</u> action continues to remain under surveillance</p> <p><u>March 2022</u> action continues to remain under surveillance</p>	Action under surveillance

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

						Risk Scoring				
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date	
Likelihood:	2	1	1	2	2		Whilst cleaning procedures are in place to ensure the appropriate management of premises further work is required around cleaning responsibilities and revision of assurance processes in relation to cleanliness. The risk for this criteria was raised to 12 from Mid -September to Mid- December 2021. Due to enhanced surveillance around the cleaning process and more assurance the risk has been reduced to 6.	Likelihood:	1	End of Quarter 1 2022
Consequence:	3	3	3	3	3			Consequence:	3	
Risk Level:	6	3	3	6	6			Risk Level:	3	

Control and Assurance Framework

Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
2.1	Designated nursing/medical teams with appropriate training are assigned to care for and treat patients in Covid-19 isolation or cohort areas.	<ul style="list-style-type: none"> Higher risk areas with own teams Zoning of hospital in place with cleaning teams UHNM clinical guidance available on the intranet Trust COVID -19 clinical group established to discuss and agree clinical pathways Nice Guidance and National Clinical Guidance COVID-19 available on the Trust intranet Links to PHE guidance on assessing COVID-19 cases available on Trust intranet page Education videos clinical and non - clinical videos on Trust intranet Process and designated staff for ED to ensure cleans are completed 	<ul style="list-style-type: none"> Clinical Group action log PPE training records which are held locally 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
2.2	<p>Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to Covid-19 isolation or cohort areas.</p> <p>Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management</p>	<p>timely</p> <ul style="list-style-type: none"> SOP and cleaning method statements for cleaning teams PPE education for cleaning teams Initial meetings held with facilities/estates to discuss and plan COVID-19 requirements IP agenda item Representatives from the division are attending the daily tactical meetings, and an E,F & PFI daily meeting is taking place which includes our partners Discussed at March Matrons meeting. To ensure terminal cleans are signed off by the Nurse in Charge 	<ul style="list-style-type: none"> Clinical teams sign off any terminal cleans requested to say that clean has been completed to the agreed standard. Spot check assurance audits completed by cleaning supervisors/managers during COVID Cleanliness complaints or concerns are addressed by completing cleanliness audit walkabouts with clinical teams, and CPM / domestic supervisors PPE and FFP3 mask fit training records with are held by cleaning services GREAT training record cards are held centrally by Sodexo for all individual domestics Key trainers record Notes from Sodexo Performance Monthly meeting , Sodexo Operational meeting , Divisional IP Meeting and facilities/estates meeting 	<ul style="list-style-type: none"> Learning from CPE outbreak. We have recognised areas we can strengthen our assurance process on standards of cleanliness
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line	<ul style="list-style-type: none"> SOP for terminal and barrier cleans in place and was reviewed in 	<ul style="list-style-type: none"> C4C audits reinstated July 2020 these results are fed 	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<p>with PHE and other national guidance.</p> <p>Update V 1.8</p> <p>A terminal clean /deep clean of inpatient rooms is carried out:</p> <ul style="list-style-type: none"> • Following resolutions of symptoms and removal of precautions • When vacated following discharge or transfer (this includes removal and disposal /or laundering of all curtains and bed screens) • Following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air changes within the room) 	<p>February 21.</p> <ul style="list-style-type: none"> • High level disinfectant , Virusolve and Tristel in place and used for all decontamination cleans • Dedicated terminal clean teams introduced during the 2/3 wave of COVID for ED, AMU/AMRA/FEAU as well as Lyme Building where main ITU beds are located to ensure that quick , effective decontamination of potentially infected areas could be completed 24/7. • Terminal cleans are requested via IP Team • Terminal clean process included in IP Q+A manual 	<p>into IPCC</p> <ul style="list-style-type: none"> • Completion of random 10% rooms each week by cleaning supervisors/managers to ensure that all rooms are cleaned to the agreed cleaning standards – Any rooms that are found to be below standard are rectified immediately. • Terminal clean electronic request log • Patient survey feedback is reviewed by joint CPM / Sodexo/EFP group and action plan completed if needed. • IP assurance visits and audits 	
2.4	<p>Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.</p> <p>A minimal of twice daily cleaning of</p> <ul style="list-style-type: none"> • Patients isolation rooms • Cohort areas • Donning and doffing areas • Frequently touched surfaces e.g. door/toilet handles, patient call bells over bed tables and 	<ul style="list-style-type: none"> • Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual • Process in place for clinical areas with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans • Feedback from NHSI provided to cleaning teams and action plan 	<ul style="list-style-type: none"> • Barrier clean request electronic log held by Sodexo and circulated following any updates / removal of barrier cleans to Sodexo and Trust staff including IP Team. • IP spot checks for clinical areas with clusters of COVID -19 or HAI cases of COVID - 19 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<p>bed rails.</p> <p>Where there may be higher environmental contamination rates including</p> <ul style="list-style-type: none"> Toilets/commodos particularly if patient has diarrhoea <p>Update V 1.8</p> <p>Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas</p>	<p>devised</p> <p> Action Plan Following NHS England NHS Im</p> <p> NHSI action plan June 21.docx</p> <ul style="list-style-type: none"> Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual 	<ul style="list-style-type: none"> Disinfectant check completed during IP spot checks Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans. November 2021 Implementation of IPS audit C4C audit programme in place 	
2.5	<p>Attention to the cleaning of toilets / bathrooms, as Covid-19 has frequently been found to contaminate surface in these areas.</p>	<ul style="list-style-type: none"> Cleaning schedules in place Barrier cleans (increased cleaning frequency) process in place which includes sanitary ware and other frequent touch points Barrier cleans also requested for other infections /period of increased incidence /outbreaks e.g. C.diff , Norovirus 	<ul style="list-style-type: none"> Cleaning schedules are displayed on each ward Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans. 	
2.6	<p>Update V 1.8</p> <p>Where patients with respiratory infection are cared for: Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution</p>	<ul style="list-style-type: none"> Virusolve and Tristel high level disinfectant used as routine for cleaning/disinfecting environment and non invasive equipment Virusolve wipes also used during height of pandemic 	<ul style="list-style-type: none"> Evidence from manufacture that these disinfectants are effective against COVID -19 Evidence of Virusolve weekly strength checks , held locally at ward 	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	at a minimum strength of 1,000ppm available chlorine, as per national guidance . If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.		/department level <ul style="list-style-type: none"> IP checks that disinfectant is available during spot checks 	
2.7	Manufacturer’s guidance and recommended product ‘contact time’ must be followed for all cleaning / disinfectant solutions / products.	<ul style="list-style-type: none"> Contact times detailed in SOP and cleaning methods statements Included in mandatory training Included in IP Q+A Disinfectant used routinely 	<ul style="list-style-type: none"> Monthly on-going training is completed with all domestic staff to ensure that core competencies such as cleaning effectively with chemicals is trained out on a frequent basis. Where outbreaks are identified, regular staff who clean in this area have competency checks to ensure that they are following GREAT card training Spot checks completed by CPM includes observation of cleaning techniques by the domestic staff. 	
2.8	As per national guidance: <ul style="list-style-type: none"> ‘Frequently touched’ surfaces, e.g. door / toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions and bodily fluid. Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should 	<ul style="list-style-type: none"> Cleaning of frequently touch points included in Barrier clean process Offices and back offices also supplied with disinfectant wipes to keep work stations clean. Non- invasive medical equipment must be decontaminated after each use. IP Q+A manual 	<ul style="list-style-type: none"> IP checks Barrier clean request log Terminal clean request log Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated 	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<p>be cleaned at least twice daily.</p> <ul style="list-style-type: none"> Rooms / areas where PPE is removed must be decontaminated, timed to coincide with periods immediate after PPE removal by groups of staff (at least twice a day). <p>Linked NHSIE Key Action 1: All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.</p>		<p>between scheduled / barrier cleans.</p> <ul style="list-style-type: none"> Non-clinical areas are cleaned at regular frequencies through the day especially sanitary ware, and if additional cleans are required between scheduled cleaning, these can be requested via the helpdesk. 	
2.9	<p>Linen from possible and confirmed Covid-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken.</p>	<ul style="list-style-type: none"> Included in IP questions and answers manual Linen posters depicting correct linen bag displayed in clinical areas and linen waste holds Red alginate bags available for infected linen in the clinical areas Infected linen route 	<ul style="list-style-type: none"> IP quarterly audits , undertaken by own areas, audits held locally by divisions and requested to also send to harmfreecare email Datix reports/adverse incidents IPS audits undertaken by the IP Team 	
2.10	<p>Single use items are used where possible and according to single use policy.</p>	<ul style="list-style-type: none"> IP question and answers manual Medical device policy SOP for Visor decontamination in time of shortage 	<ul style="list-style-type: none"> IP audits held locally by divisions and requested to also send to harmfreecare email 	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
2.11	<p>Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance.</p> <p>Update V 1.8</p> <p>Resuable non –invasive care equipment is decontaminated:</p> <ul style="list-style-type: none"> ○ Between each use ○ After blood and/or body fluid contamination ○ At regular predefined interval as part of an equipment cleaning protocol ○ Before inspection, service or repair equipment <p>Update V 1.8</p> <p>Compliance with regular cleaning regimes is monitored including that of reusable equipment</p>	<ul style="list-style-type: none"> • IP question and answers manual covers decontamination • Air powered hoods – SOP in place which includes decontamination process for the device • Re usable FFP3 Masks – Sundstrom/ GVS Elipse. SOP’s in place which includes the decontamination process • Medical device policy • Availability of high level disinfectant in clinical areas • Sterile services process • Datix process • Bed Storage Group looking at non conformities for beds that require repair • Clinical cleaning schedules • Domestic cleaning schedules • Cleaning of electronic beds part of collaborative cleaning 	<ul style="list-style-type: none"> • IP audits held locally by divisions • Datix reports/adverse incident reports • IP assurance visits 	<ul style="list-style-type: none"> • Decontamination of beds returned for repair process non conformities • Electronic beds – difficult dismantle the bed base mechanism to allow for effective cleaning –this issue has been raised regionally by NHSI
2.12	<p>Update V 1.8</p> <p>As part of heirachy of controls assessment : ventilation systems, particularly in, patient care areas (natural or mechanical) meets national recommendations for the minimum of air changes refer to specific guidance</p> <p>In patients care health building note 04-01 Adult in patient facilities</p>	<ul style="list-style-type: none"> • UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust Board on the safe operation and reduction in risk of infection transmission through ventilation systems. TOR written • The Trust also appointed external 	<ul style="list-style-type: none"> • Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying out an annual audit for system compliance. 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
<p>The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations authorised engineer</p> <p>A systematic review of the ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways</p> <p>Where possible air is diluted by natural ventilation by opening windows and doors were appropriate</p> <p>Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission.</p> <p>Where a clinical space has a very low air changes and it is not possible to increase dilution effectively , alternative technologies are considered with estates/ventilation group</p> <p>When considering screens/partitions in reception /waiting areas , consult with estates/facilitates teams , to ensure that air flow is not affected, and cleaning schedules are in place</p> <p>Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air</p> <p>Where possible ventilation is maximised by opening</p>		<p>authoring Engineers. This is in line with the NHS estates best practise and guidance from Health Technical Memorandum (HTM) namely 03/01 Specialised Ventilation for Healthcare Premises.</p> <ul style="list-style-type: none"> Trust Estates Ventilation Aps attended week long Specialized ventilation in health care at Leeds University – Much of this content contact relates to airborne respiratory infections Lessons learnt poster which encourage regular opening of windows to allow fresh air  <p>ventilation-air-changes-per-hour-2021-06</p> <ul style="list-style-type: none"> IP and estates have worked with areas know to be undertaking aerosol generating procedures and completed the fallow times IP have nominated point of contact re ventilation advise January 2022 Estates and IP are exploring the use of air scrubber machine to try on ward in West Building Review of areas that request Perspex screens to check need and requirement for 		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
2.13	<p>windows where possible to assist the dilution of air.</p> <p>Update V 1.8 The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.</p> <p>Update V 1.8 The organisation had systems and processes in place to identify and communicate changes in the functionality of area/rooms</p> <p>Update V 1.8 Ensure cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment</p> <p>Monitor adherence environmental decontamination with actions in place to mitigate any identified risk</p> <p>Monitor adherence to the decontamination of shared equipment</p>	<p>cleaning/ventilation not affected</p> <ul style="list-style-type: none"> • Cleaning standards meetings in place, review of National standards • Cleaning collaborative improvement project now underway • Regular walkabouts of all non-clinical areas are completed, and any actions found are either emailed through to helpdesk to be logged as jobs to be completed or are noted by Sodexo at time of audit – follow-up visits are completed to ensure all jobs have been completed • Quarterly Environmental Audits are completed of all clinical areas by an independent auditor plus input from nursing, cleaning and estates to review environmental standards – reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %. 	<ul style="list-style-type: none"> • Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %. • C4C report presented at IPCC 	<p>Cleanliness assurance processes around</p>

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
6	2.4	West Building long standing Estates issues. Reactive work	Divisions Facilities and Estates	05/11/2021 30/11/2021 End of quarter 1 2022	On going review of CPE colonisation in West Building. Long standing estates issues in West Building including a number of non-compliant hand wash sinks. Reactive estates works list identified. Long term plan to be agreed. <u>November 2021</u> Capital funding agreed and allocated c £150k for the replacement of 75 non-compliant wash hand basins including associated IPS panels within the West Building Wards and FEAU. <u>February 2022</u> Sink replacement in progress	In progress
7	2.13	Cleaning issues both nursing and cleaning responsibilities highlighted during CPE outbreak west Buildings. Strengthen assurance process on standards of cleanliness	Divisions Facilities/ACN	12/11/2021 31/12/2021 End of quarter 1 2022	<u>October 2021</u> Terminal cleans in progress Review sign off process <u>November 2021</u> 03/11/2021 terminal clean west building completed Terminal clean briefing sheet designed Terminal clean of all West using steam and HPV Terminal Clean of FEAU and ward 122 using steam and HPV completed 06/11/2021 Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools and methodologies to work through the actions needed to respond to the cleaning issues in West Building highlighted during the CPE Outbreak. <u>March 2022</u> Collaborative work continues	In progress

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	2	2	2	2	Whilst there are controls and assurances place some of the finding of the antimicrobial audits demonstrate area of non-compliance therefore further control are to be identified and implemented in order to reduce the level of risk	Likelihood:	2	End of Quarter 1 2021
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	9	6	6	6	6		Risk Level:	6	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
3.1	<p>Arrangements around antimicrobial stewardship are maintained. Update V 1.8 Previous antimicrobial history is considered</p> <p>The use of antimicrobials is managed an monitored: Update V 1.8</p> <ul style="list-style-type: none"> To reduce inappropriate prescribing To ensure patients with infections are treated promptly with correct antibiotic 	<ul style="list-style-type: none"> Regular, planned Antimicrobial stewardship (AMS) ward rounds Trust antimicrobial guidelines available 24/7 via intranet and mobile device App Antimicrobial action plan in place Clostridium <i>difficile</i> Period of increased incidence and outbreaks are reviewed by member of AMS team and actions generated cascaded to ward teams Regional and National networking to ensure AMS activities are optimal Formal regional meetings and informal national network activities AMS CQUIN further mandates key AMS principles to be adhered to All national CQUINS currently suspended by NHSE / PHE 	<ul style="list-style-type: none"> Same day escalation to microbiologist, if concerns. Outcome recorded on I portal Metric available around the number of times App accessed by UHNM staff Compliance with guidelines and other AMS metrics reported to Infection prevention and control Committee (IPCC) Meeting minutes reviewed and actions followed up Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl. PHE) thought leaders members Trust and commissioners require timely reporting on compliance 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		<ul style="list-style-type: none"> Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM 	<ul style="list-style-type: none"> with AMS CQUIN targets. Wards showing deviation from targets are followed up by targeted AMS team ward reviews generating action plans for ward teams. On hold during COVID19 due to redeployment of duties The pharmacy team undertook a trust-wide point prevalence audit using a new electronic data capture tool. Results will be reviewed during January and shared with ACN's and Microbiologist. 	
3.2	<p>Mandatory reporting requirements are adhered to and boards continue to maintain oversight.</p> <p>Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director and the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available.</p> <p>Linked to NHSIE Key Action 10: Local systems must review system performance and data, offer peer support and take steps to intervene as required.</p> <p>Update V 1.8</p>	<ul style="list-style-type: none"> Quarterly point prevalence audits maintained by AMS team at UHNM despite many regional Trusts not undertaking any more. These have restarted in December 2020 as held during COVID-19. Results online. Results from all AMS audits and targeted ward reviews are reported at the Antimicrobial Stewardship Group and minutes seen by IPCC CQUIN submissions completed in timely manner and generate action plans for AMS and ward teams to follow up concerns each quarter. Currently suspended. 	<ul style="list-style-type: none"> Whilst only a snap-shot audit the Trust value the output from these audits. Work is underway Q1 and Q2 20/21 to review potential change in data collection to optimise impact. IPCC scrutinise results. Divisions held to account for areas of poor performance. Audit outputs will be used as basis of feedback on performance to individual clinical areas going forward. Trust CQUIN contracts manager holds regular track and update meetings to challenge progress vs AMS CQUINS, Currently suspended. 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care, in a timely fashion.

						Risk Scoring			
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level There is a substantial amount of information available to provide to patients this requires continuous update as national guidelines change	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	1		Likelihood:	1	End of Q3
Consequence:	3	3	3	3	3		Consequence:	3	–
Risk Level:	3	3	3	3	3		Risk Level:	3	Achieved in Q4

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
4.1	<p>Implementation of national guidance on visiting patients in a care setting.</p> <p>Update V 1.8 Visits from patients relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients , staff and visitors</p> <p>There is clearly displayed , written information available to prompt patients, visitor and staff to comply with hand washing, wearing of facemask /face coverings and physical distancing</p> <p>Restrictive visiting may be considered appropriate during outbreaks within inpatient areas. This is an organisational decision following a risk assessment</p>	<ul style="list-style-type: none"> To help protect patients and staff from Covid-19, the NHS suspended all visiting to hospitals. This national suspension has now been lifted and visiting is to be introduced in some areas of our hospitals, subject to certain conditions. From Monday 17 August 2020 visiting will be phased in across some areas and will be allowed in the West Building at Royal Stoke and in Wards 7, 12, 15 at County Hospital. All visiting will have to be pre-booked and relatives will be provided with the correct information and contact details to book in advance. Visitors will be instructed to wear face masks and other PPE if they are providing 	<ul style="list-style-type: none"> Monitored by clinical areas PALS complaints/feedback from service users Outbreak meetings 	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
<p>Update V 1.8</p> <p>If visitors are attending a care areas with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be a FRSM.</p> <p>Update V 1.8</p> <p>Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reason (e.g. parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.</p> <p>Update V 1.8</p> <p>Visitors are not present during AGPs on infectious patient unless they are considered essential following a risk assessment e.g. care/parent/guardian.</p>	<p>bedside care. We will continue to monitor prevalence and changes in visiting restrictions will be reinstated with immediate effect should it be necessary</p> <ul style="list-style-type: none"> • The only exceptional circumstances where on visitor , an immediate family member or carer will be permitted to visited are listed below- • The patient is in last days of life-palliative care guidance available on Trust intranet • The birthing partners are able to attend all scans and antenatal appointments induction of labour and post natal appointments • The parent or appropriate adult visiting their child • Other ways of keeping in touch with loved ones e.g. phone calls , video calls are available • EOL visiting guidance in place • Guidance to accommodate visitor if appropriate and necessary to assist a patients communication and/or to meet their health, emotional , religious or spiritual need • A familiar care/parent or guardian/support/personal assistant • Children both parents /guardian where the family bubble can be 		

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		<p>maintained</p> <ul style="list-style-type: none"> • <u>March 2021</u> Visiting guidance inpatient during COVID 19 pandemic: principles discussed at Clinical Group and tactical • <u>Visiting COVID-19</u> information available on UHNM internet page • <u>August 2021</u> Input from Matron for Mental Health & Learning Disability re leaflets. Minor changes required. • <u>26TH December 2021</u> visiting restriction re introduced due to Omnicron • PPE information provided to visitors • March 2022 – Visitors increased to 2 per patient 		
4.2	Areas in which suspected or confirmed Covid-19 patients are being treated are clearly marked with appropriate signage and have restricted access.	<ul style="list-style-type: none"> • ED colour coded areas are identified by signs • Navigator manned ED entrance • Hospital zoning in place 	<ul style="list-style-type: none"> • Daily Site report for county details COVID and NON COVID capacity 	
4.3	Information and guidance on Covid-19 is available on all trust websites with easy read versions.	<ul style="list-style-type: none"> • COVID 19 section on intranet with information including posters and videos 	<ul style="list-style-type: none"> • COVID-19 page updated on a regular basis 	
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed Covid-19 patient needs to be moved.	<ul style="list-style-type: none"> • Transfer policy C24 in place and reference to Covid included • IP COVID step down process in place 	<ul style="list-style-type: none"> • Datix process 	
4.5	Implementation of the Supporting excellence in infection prevention and control behaviours toolkit has been considered	<ul style="list-style-type: none"> • UHNM developed material, posters • Hierarchy of controls video use on COVID 19 intranet page • UHNM wellbeing support and info 		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Risk Scoring						Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Quarter	Q4	Q1	Q2	Q3	Q4		Likelihood:		
Likelihood:	1	1	1	1	1	Whilst arrangements are in place ensure the screening of all patients. To continue to reinforce COVID screening protocol and monitor compliance. Surveillance of omicron cases within UHNM is in place.	Likelihood:	1	End of Q4 – achieved
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	3	3	3	3	3		Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
5.1	<p>Update V 1.8 Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival</p> <p>Update V 1.8 Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred</p> <p>Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed Covid-19 symptoms and to segregate them from non Covid-19 cases to</p>	<ul style="list-style-type: none"> ED navigator records patient temperature and asked screening questions. Patient then directed to relevant coloured area All patients who are admitted are screened for COVID 19 Work completed to install doors to resus areas in both ED's December 2021 – review of green resus doors and use of area Posters in place for visitors re respiratory instructions Clinical letter/ pre op screening in place to identify /enable early recognition of respiratory symptoms 	<ul style="list-style-type: none"> June 2020 IP team review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme . COVID 19 -Themes report to IPCC ED pathways including transfer of COVID positive patient from County to Royal Hospital COVID screening spot check audits 	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
<p>minimise the risk of cross-infection as per national guidance.</p> <p>Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.</p> <p>Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid-19</p> <p>Staff are aware of agreed template for triage questions to ask</p> <p>Update V 1.8 Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible</p> <p>Screening for COVID -19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patients attending a healthcare environment</p> <p>Patients with respiratory symptoms are assessed in segregated areas, ideally a single room, and away from other patients pending their test result.</p>	<ul style="list-style-type: none"> • Hospital zoning/pathways • COVID 19 care pathway • Screening protocol in place 		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<p>There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved</p>			
5.2	<p>Mask usage is emphasized for suspected individuals. Face coverings are used by all outpatients and visitors Update V 1.8</p> <p>Facemask are worn by staff and patients in all health care facilities</p> <p>Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care Update V 1.8</p> <p>Patients with suspected or confirmed respiratory infection are provided with a surgical face mask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.</p> <p>Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so) and is not detrimental to their physical or mental</p>	<ul style="list-style-type: none"> • Use of mask for patients included in IP COVID -19 • question and answers manual • All staff and visitors to wear masks from Monday 15th June 2020 • ED navigator provide masks to individual in ED • Mask stations at hospital entrances • Covid-19 bulletin dated 12th June 2020 • 28th August updated guidance from PHE recommends in patients to also wear surgical masks if tolerated and does not compromise care • IP Assurance visits • Senior walk rounds of clinical areas • Matrons daily visits • Patient who are clinically extremely vulnerable should remain in a single room for the duration of their hospital stay • Patient are encourage to wear mask – leaflet in place <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  8th-march-2021-covid-ward-round-guidan </div> <div style="text-align: center;">  covid-19-care-plan-jan-22.pdf </div> </div>	<ul style="list-style-type: none"> • Hospital entrances Mask dispensers and hand gel available • Datix /incidents • COVID-19 themes report to IPCC 	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<p>needs</p> <p>Individuals who are clinically extremely vulnerable from COVID 19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room</p> <p>Update V 1.8</p> <p>Patients at risk of severe outcomes of respiratory infection receive protective IP measures depending in their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation and risk for their families and carers accompanying them for treatments /procedures must be considered</p>	<ul style="list-style-type: none"> Trust internet and social media provide information re the need for wearing of face masks whilst in /visiting hospital Included in COVID 19 care pathway IP Q+A isolation manual 		
5.3	<p>Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.</p> <p>Linked NHSIE Key Action 6: Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients must be considered and wards are effectively ventilated.</p> <p>Update V 1.8</p> <p>Patient visitors , and staff can maintain 1 metre or greater social and physical distancing in all patient care areas: ideally segregation should be spate spaces , but there is potential</p>	<ul style="list-style-type: none"> Colour coded areas in ED to separate patients, barriers in place. Screens in place at main ED receptions Colour coded routes identified in ED Social distancing risk assessment in place Perspex screens agreed through R+R process for other reception area Social distance barriers in place at main reception areas Chief Nurse/DIPC visited clinical areas to review social distancing within bays. A number of beds have been removed throughout the Trust. January 2022 – 2 metre rule maintained. Risk assessments completed and signed off by 	<ul style="list-style-type: none"> Division/area social distancing risk assessments 	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	to use screens e.g. to protect reception staff	<p>DIPC for ward areas need to use closed beds due to social distancing</p> <ul style="list-style-type: none"> January 2022 - Risk assessments to be revisited for Out- patient /imaging area that need to reduce distance to 1 metre – this work is in progress March 2022- Social distancing removed to pre pandemic 		
5.4	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible.	<ul style="list-style-type: none"> Process for isolation symptom patient in place Process for cohorting of contacts Contacting patients who have been discharged from hospital then later found to be a close contact of a COVID-19 positive case , patient to be informed by the clinical area and self- isolation advice provided as per national guidance https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection 	<ul style="list-style-type: none"> If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions. Patient who tested negative on admission and remain an inpatient are retested for COVID days 4 and 6, day 14 then weekly Spot check audits Assurance obtained for monitoring of inpatient compliance with wearing face masks via Matrons daily walk round 	
5.5	Patients with suspected Covid-19 are tested promptly. There is evidence of compliance with routine testing protocols in line with key actions	<ul style="list-style-type: none"> All patients who require overnight stay are screened on admission and patients who develop symptoms – UHNM screening guidance in place December 2021 – surveillance of Omicron cases in place to monitor number of inpatients with the variant 	<ul style="list-style-type: none"> Adverse incident monitor /Datix 	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
5.6	<p>Patients who test negative but display or go on to develop symptoms of Covid-19 are segregated and promptly re-tested and contacts traced.</p> <p>Isolation , testing an instigation of contact tracing is achieved for all patients with new onset symptoms , until proven negative</p>	<ul style="list-style-type: none"> • Screening protocol in place which includes rescreening /re testing. Pathways in place for positive COVID 19 patients • Iportal alert and April 2021 contact alert in place iportal/medway • The IP team have been applying a Covid-19 contact alert within the ICNET system since November 2020 and this continues. • Inpatient contacts are cohorted • COVID 19 positive patients are cared for on blue wards or single rooms or COVID 19 cohort areas on critical care unit 	<ul style="list-style-type: none"> • Datix process • IP reviews 	
5.7	<p>Patients who attend for routine appointments and who display symptoms of Covid-19 are managed appropriately.</p> <p>Update V 1.8</p> <p>Where treatment is not urgent consider delaying this unit resolution of symptoms providing this does not impact negatively on patient outcomes</p>	<ul style="list-style-type: none"> • Restoration and Recovery plans • Thermal temperature located in a number outpatient areas – with SOP if patient triggers. Script in place for scheduling outpatient/ investigations • Mask or face coverings for patients attending appointments from Monday 15th June 2020 • Process at PREAMMS if patient positive for COVID 	<ul style="list-style-type: none"> • Datix process 	

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

						Risk Scoring			
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level Whilst information and communication/controls are in place to ensure staff are aware of their responsibilities spot audits continue. Work in progress to further improve retention of FFP3 mask fit training records	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	1	1	1		Likelihood:	1	End of Quarter 2 2021
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	6	6	3	3	3		Risk Level:	3	

Control and Assurance Framework

Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
6.1	<p>Update V 1.8 Appropriate infection prevention education is provided for staff, patients and visitors</p> <p>All staff (clinical and non-clinical) have appropriate training, in line with the latest PHE and other guidance, to ensure their personal safety and working environment is safe.</p> <p>Patient pathways and staff flow are separated to minimise contact between pathways. E.g. this could include provisions of spate entrances/exits or use of one way system , clear signage and restricted access to communal areas,</p>	<ul style="list-style-type: none"> PPE discussed at tactical group Training videos available FFP3 mask fit key trainers Donning and Doffing posters, videos and PHE available on Covid-19 section of Trust intranet Posters in corridors - keep to the left One way signs in place along corridors 	<ul style="list-style-type: none"> Tactical group action log Divisional training records Mandatory training records 	
6.2	<p>All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it.</p> <p>Update V 1.8 Training in IP measures is provided to all staff,</p>	<ul style="list-style-type: none"> PPE and standard precautions part of the infection prevention Questions and Answers manual. FFP3 train the trainer 	<ul style="list-style-type: none"> Training records IP spot checks of PPE on wards and Departments undertaken 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<p>including : the correct use of PPE including an initial face fit test/and fit check each time when wearing a filters face piece (FFP3) respirator and the correct technique of putting on and removing (donning/doffing) PPE safely.</p> <p>Gloves are worn when exposure to blood and/or other body fluids , non intact skin or mucous membranes is anticipated or in line with SICP's and TBP's</p>	<p>programme in place</p> <ul style="list-style-type: none"> Trust mask fit strategy SOP and training for reusable FFP3 masks SOP and training for use of air powered hoods Critical care - Elipse FFP3 reusable introduced PPE posters are available in the COVID -19 section of trust intranet page 		
6.3	A record of staff training is maintained.	Mask fit strategy in place	<ul style="list-style-type: none"> Training records originally held locally by the Clinical areas Records held on L drive for those trained by the infection prevention team April 2021, Option now available to enter FFP3 training onto Health Rostering this captures the model of mask and date trained Test certificate must continue to be filed in personal folder and this is reiterated to mask fit tester. November 2021 wider spot checks commenced IP Health and Safety leading on portacount mask fit business case which has the potential to 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			enhance mask fit training records further as this system is capable of collected data which can be uploaded	
6.4	Appropriate arrangements are in place so that any reuse of PPE is in line with the CAS Alert is properly monitored and managed.	<ul style="list-style-type: none"> SOP in place for reuse of visors SOP in place for use of air powered filters systems plus key trainers SOP in place for the care of reusable FFP3 masks (Sundstrom)) 	<ul style="list-style-type: none"> SOP 's available on Trust intranet Training logs held divisionally for air powered systems IP training log for air powered systems key trainers and distribution of reusable FFP3 masks (Sundstrom) 	
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken.	<ul style="list-style-type: none"> PPE standard agenda at COVID Tactical meeting Datix process Midlands Region Incident Coordination Centre PPE Supply Cell 	<ul style="list-style-type: none"> Tactical group action log Datix process Incidents reported by procurement to centre PPE supply Cell 	
6.6	Adherence to the PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	<ul style="list-style-type: none"> PPE Audits PPE volume use discussed at tactical COVID-19 Group 	<ul style="list-style-type: none"> Spot audits completed by IP team 	
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions. Linked NHSIE Key Action 1: Staff consistently practices good hand hygiene.	<ul style="list-style-type: none"> Hand hygiene requirements set out in the infection prevention Questions and Answers manual Poster for hand hygiene technique displayed at hand wash sinks and stickers on hand soap and alcohol dispensers Alcohol gel availability at the point of care 	<ul style="list-style-type: none"> Monthly hand hygiene audits completed by the clinical areas Infection Prevention hand hygiene audit programme. Overview of results fed into infection Prevention committee Independent hand hygiene audits completed by IP Senior Health Care 	
6.8	Hygiene facilities (IP measures) and messaging are		<ul style="list-style-type: none"> Hand hygiene audits 	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
<p>available for all</p> <ul style="list-style-type: none"> • Hand hygiene facilities including instructional posters • Good respiratory hygiene measures • Staff maintain physical distancing of 1 metre or greater wherever possible in the workplace unless wearing PPE as part of direct care • Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • Frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas • Staff regularly undertake hand hygiene and observe standard infection prevention precautions • Guidance on hand hygiene, including drying should be clearly displayed in all public toilet 	<ul style="list-style-type: none"> • Hand washing technique depicted on soap dispensers • Social distance posters displayed throughout the Trust • IP assurance visits • Matrons visits to clinical areas <p>Recommendation that physical distancing should be at least 1 metre, increasing whenever feasible to 2 metres across all health and care settings.</p> <ul style="list-style-type: none"> • Car sharing question forms part of OB investigation process • Communications reminding staff re car sharing • IP Q+A decontamination section • COVID Q+A • Wearing of mask posters displayed throughout the Trust • Advise and videos' on the Trust internet page • Hand hygiene posters /stickers 	<ul style="list-style-type: none"> • Spot checks in the clinical area • IP assurance visits • Cleanliness audits • IP environmental audits • Quarterly audits conducted and held by the clinical areas • Hand hygiene audits 	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	areas as well as staff areas	on dispenser display in public toilets		
6.8	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	<ul style="list-style-type: none"> Paper Towels are available for hand drying in the Clinical areas 	<ul style="list-style-type: none"> IP audits to check availability 	
6.9	Staff understand the requirements for uniform laundering where this is not provided on site.	<ul style="list-style-type: none"> Instruction for staff laundering available on the Trust COVID - 19 section of intranet Dissolvable bags to transport uniforms home available for staff Communications /daily bulletin to remind staff not to travel to and from work in uniforms 	<ul style="list-style-type: none"> Clinical areas to monitor Reports of member of public reporting sighting of staff in uniform 	
6.10	All staff understand the symptoms of Covid-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms (even if experiencing mild symptoms) Update V 1.8 To monitor compliance and reporting for asymptomatic staff testing	<ul style="list-style-type: none"> For any new absences employee should open and close their usual absence via Empactis system Symptom Advice available on Trust intranet Communications updated to reflect changing national guidance Staff report Lateral flow testing via the national route only 	<ul style="list-style-type: none"> Cluster /outbreak investigations 	
6.11	All staff understand the symptoms of COVID-19	<ul style="list-style-type: none"> Communication /documents 	<ul style="list-style-type: none"> Cluster /outbreak investigations 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	<ul style="list-style-type: none"> Reminders on COVID bulletins Trust intranet Staff Lateral flow testing Communications updated to reflect changing national guidance 		
6.12	A rapid and continued response through on- going surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patient/individuals)	<ul style="list-style-type: none"> ICNET surveillance system Reports Trust wide daily COVID Dashboard/report COVID -19 Tactical daily briefing 	<ul style="list-style-type: none"> COVID Dashboard COVID -19 Tactical daily briefing COVID 19 Gold update slides 	
6.13	Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	<ul style="list-style-type: none"> ICNet surveillance system Reports RCA's are required for all Probable and Definite HAI Covid-19 cases 	<ul style="list-style-type: none"> Theme report IPCC RCA review 	
6.15	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	<ul style="list-style-type: none"> ICNet surveillance system Daily COVID reports of cases 	<ul style="list-style-type: none"> Outbreak investigation Outbreak minutes 	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
2	6.3	Monitoring FFP3 mask fit compliance %	Divisions	31/09/2021	To monitor the mask fit compliance % for own division using available records – Health Roster	On- going

7. Provide or secure adequate isolation facilities

						Risk Scoring				
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date	
Likelihood:	1	1	1	1	1		Isolation facilities are available and hospital zoning in place.	Likelihood:	1	Q4 20/21– achieved
Consequence:	3	3	3	3	3			Consequence:	3	
Risk Level:	3	3	3	3	3			Risk Level:	3	

Control and Assurance Framework

Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
7.1	<p>Patients with possible or Covid-19 are isolated in appropriate facilities or designated areas where appropriate.</p> <p>Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff</p> <p>Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas</p> <p>Update V 1.8 That clear advice is provided , and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs</p>	<ul style="list-style-type: none"> Hospital zoning in place Recovery and Restoration plans for the Trust – December 2020 –another increased wave of COVID 19 COVID prevalence considered when zones identified Purple wards Blue COVID wards identified at both sites created during second wave Green wards for planned screened elective patients Recovery and Restoration plans Ward round guidance available on COVID 19 intranet page Patient are offered and encouraged to wear masks – stickers have been developed to record if patients are unable to 	<ul style="list-style-type: none"> June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify themes which are presented at IPCC . Themes report to IPCC Inappropriate patient moves reported via Datix. Daily process Discuss at outbreak meetings as necessary 	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
7.2	<p>Patients with suspected or confirmed COVID -19 are isolated in appropriate facilities or designated areas where appropriate;</p> <p>Areas used to cohort patients with possible or confirmed Covid-19 are compliant with the environmental requirements set out in the current PPE national guidance.</p> <p>Update V 1.8 On -going regular assessment of physical distancing an bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical requirements)</p> <p>Separation ins space and /or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in receptions areas and avoid mixing of infectious and non-infectious patient</p> <p>Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where treatment cannot be deferred, their care is provided from services able to operate in a way which minimises the risk of spread of virus to other patients/individuals</p> <p>Standard infection prevention precautions (SPIC's) are used at the point of care for patient who have been</p>	<p>wear masks</p> <ul style="list-style-type: none"> • Areas agreed at COVID-19 tactical Group • Restoration and Recovery plans <ul style="list-style-type: none"> • QIA process <ul style="list-style-type: none"> • Hospital zoning in place • Pre Amms process • IP Q+A isolation section 	<ul style="list-style-type: none"> • Action log and papers submitted to COVID-19 tactical and Clinical Group 	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<p>screened , triaged and tested and have a negative result</p> <p>The principles of SICPs and TBPs continued to be applied when caring for the deceased</p>	<ul style="list-style-type: none"> • PPE posters • COVID 19 information available Trust intranet • IP Q+A manual 		
7.3	<p>Patients with resistant / alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.</p>	<ul style="list-style-type: none"> • Infection Prevention Questions and Answers Manual includes alert organisms/resistant organism • Support to Clinical areas via Infection Prevention triage desk • Site team processes • Clostridium <i>difficile</i> report • Patients received from London to critical care unit – screening policy for resistant organisms in place 	<ul style="list-style-type: none"> • RCA process for Clostridium <i>difficile</i> • CDI report for January Quality and Safety Committee and IPCC • Outbreak investigations • MRSA bacteraemia investigations • Datix reports 	

8 Secure adequate access to laboratory support as appropriate.

Risk Scoring						Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Quarter	Q4	Q1	Q3	Q3	Q4		Likelihood:		
Likelihood:	1	1	1	1	1	Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited. Work continues to improve COVID-19 screening compliance as per screening protocol.	Likelihood:	1	Q4 20/21– target achieved
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	3	3	3	3	3		Risk Level:	3	

Control and Assurance Framework

Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
8.1	<p>Testing is undertaken by competent and trained individuals.</p> <ul style="list-style-type: none"> Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available 	<ul style="list-style-type: none"> How to take a COVID screen information available on Trust intranet. This has been updated in November 2020 Swabbing training package in place and swabbing Champions identified Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited. Turnaround times included in tactical slides 	<ul style="list-style-type: none"> Review of practice when patient tests positive after initial negative results 	
8.2	<p>Patient and staff Covid-19 testing is undertaken promptly and in line with PHE and other national guidance.</p> <p>Linked NHSIE Key Action 7: Staff Testing:</p>	<ul style="list-style-type: none"> All patients that require an overnight stay are screened for COVID-19 on admission or pre admission if planned/elective surgery 	<ul style="list-style-type: none"> Empactis reporting Team Prevent systems Datix/adverse incidence reporting Cluster /outbreak investigation 	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
<p>a) Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing.</p> <p>b) If your Trust has a high nosocomial infection rate you should undertake additional targeted testing of all NHS Staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back.</p> <p>That all emergency patients are tested for COVID -19 and other respiratory infections appropriate on admission</p> <p>Linked to NHSIE Key Action 8: Patient Testing:</p> <p>a) All patients must be tested at emergency admission, whether or not they have symptoms.</p> <p>b) Those with symptoms of Covid-19 must be retested at the point symptoms arise after admission.</p> <p>c) Those who test negative upon admission must have a second test 3 days after admission and a third test 5 – 7 days post admission. Letter 6th April NHS October 2020 the region implemented requirement for screening on day 13</p> <p>d) All patients must be tested 48 hours prior</p>	<ul style="list-style-type: none"> • Screening process in place for elective surgery and some procedures e.g. upper endoscopy • Process in place for staff screening via empactis system and Team Prevent • Patients who test negative are retested 4, day 6 and day 14 and weekly • Patient who develop COVID symptoms are tested • Staff screening instigated in outbreak areas • November 2020 - Lateral flow device staff screening to be implemented to allow twice weekly. Staff are asked to submit results via text. Jan 2021 Recent communications on COVID bulletin to remind staff to submit results • Questions and answers available on the COVID 19 page Trust intranet re lateral flow including actions to take for reporting both a negative or positive result • All patient discharged to care setting as screened 48 hours prior to transfer/discharge • Designated care setting in 	<p>procedures</p> <ul style="list-style-type: none"> • Report received by Deputy Chief Nurse on a daily basis with list of patients that are due for re screen. Clinical areas then contacted and prompt to re screen. Day 14 and weekly screening in place. 	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
<p>to discharge directly to a care home (unless they have tested positive within the previous 90 days) and must only be discharged when the test result is available and communicated to receiving organisation prior to discharge. Care home patients testing positive can only be discharged to CQC designated facilities. Care homes must not accept discharged patients unless they have that persons test result and can safely care for them.</p> <p>e) Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission.</p> <p>There is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)</p> <p>Staff testing protocols are in place</p> <ul style="list-style-type: none"> • That sites with high nosocomial rates should consider testing COVID negative patients daily. • That those being discharged to a care facility 	<p>place for positive patients requiring care facilities on discharge – Trentham Park</p> <ul style="list-style-type: none"> • 11th May 2021 introduction of day 14 screen and also weekly screen for negative patients • From 29th April 2021 a team from HR are supporting the IP Team by contacting the clinical area to advise when screens are due • In addition to the above from 11th May 2021 inpatients who have not tested covid 19 positive within the previous 90 days are to be rescreened on day 14 and then weekly • Reviewed as part of outbreak investigation • Matrons and ACN’S aware of retesting requirement • Not required currently but kept under review • Patients are tested as part of outbreak investigation • Designated home identified- Trentham Park 		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<p>within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.</p> <p>Update V 1.8</p> <p>There is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patient who are fully vaccinated, asymptomatic, and not a contact of cases suspected/confirmed cases of COVID-19 within the last 10days. Instead these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance</p>	<ul style="list-style-type: none"> • UHNM continue with PCR testing pre operatively but are exploring using lateral flow tests for day case surgery and other surgery , except those patients requiring critical care post op 		
8.3	<p>Screening for other potential infections takes place.</p>	<ul style="list-style-type: none"> • Screening policy in place, included in the Infection Prevention Questions and Answers Manual • MRSA Screening recommenced in May 2021 	<ul style="list-style-type: none"> • MRSA screening compliance • Prompt to Protect audits completed by IP • Spot check for CPE screening 	

9. Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections.

						Risk Scoring				
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date	
Likelihood:	1	1	1	1	1		There is a range of information, procedures, and pathways available along with mechanism to monitor.	Likelihood:	1	Q4 20/21 – target achieved
Consequence:	3	3	3	3	3			Consequence:	3	
Risk Level:	3	3	3	3	3			Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
9.1	<p>Update V 1.8</p> <p>The application of IP practices and monitored and that resources are in place to implement and measures adherence to good IP practice. This must include all care areas and all staff (permanent , agency and external contractors)</p> <p>Staff are supported in adhering to all IPC policies, including those for other alert organisms.</p> <p>Update V 1.8</p> <p>Safe spaces for staff break areas/changing facilities are provided</p>	<ul style="list-style-type: none"> • IP included in mandatory update • Infection Prevention Questions and Answers manual with ICON on every desk top for ease of use • Infection Prevention triage desk which provides advice and support to clinical areas • • Rest pods are in place • Additional rest areas in place • List of changing areas available on the Trust intranet 	<ul style="list-style-type: none"> • IP audit programme • Audits undertaken by clinical areas • CEF audits recommenced Sept 2020 • Proud to care booklet audits recommenced Sept 2020 • Compliance with correct mask wearing and Doctors complaint with Bare Below the Elbow monitored via senior walk rounds of clinical areas 	
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively	<ul style="list-style-type: none"> • Notifications from NHS to Chief nurse/CEO 	<ul style="list-style-type: none"> • Clinical Group meeting action log held by emergency planning 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	communicated to staff.	<ul style="list-style-type: none"> • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at COVID clinical group which is held twice weekly • Daily tactical group • Incident control room established where changes are reported through • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates 		
9.3	All clinical waste and linen/laundry related to confirmed or possible Covid-19 cases is handled, stored and managed in accordance with current national guidance .	<ul style="list-style-type: none"> • Waste policy in place • Waste stream included in IP mandatory training 	<p>The Trust has a Duty of Care to ensure the safe and proper management of waste materials from the point of generation to their final disposal (Cradle to Grave). This includes:</p> <ul style="list-style-type: none"> • Ensuring the waste is stored safely. • Ensuring the waste is only transferred to an authorised carrier and disposer of the waste. • Transferring a written description of the waste • Using the permitted site code on all documentation. • Ensuring that the waste is 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			disposed of correctly by the disposer. <ul style="list-style-type: none"> Carry out external waste audits of waste contractors used by the Trust. 	
9.4	PPE stock is appropriately stored and accessible to staff who require it.	<ul style="list-style-type: none"> Procurement and stores hold supplies of PPE Stores extended opening hours PPE at clinical level stores in store rooms Donning and doffing stations at entrance to wards 	<ul style="list-style-type: none"> PPE availability agenda item on Tactical Group meeting 	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

						Risk Scoring				
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level		Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	1	There are clear control in place for management of occupational needs of staff through team prevent to date		Likelihood:	1	End of quarter 2 2021
Consequence:	3	3	3	3	3			Likelihood:	3	
Risk Level:	3	3	3	3	3	Monitoring of adhere to social distancing and PPE continues. Work in progress to further improve retention of FFP3 mask fit training records		Risk Level:	3	

Control and Assurance Framework

Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
10.1	<p>Update V 1.8</p> <p>Staff seek advice when required from their Occupational Health department/GP or employer as per their local policy</p> <p>Update V 1.8</p> <p>Bank, agency and locum staff follow the same deployment advice as permanent staff</p> <p>Update V 1.8</p> <p>Staff who are fully vaccinated against COVID-10 and are a close contact of a case of COVID-19 are able to return to work without the need to self isolate \9 see staff isolation : approach following updated government guidance)</p> <p>Update V 1.8</p>	<ul style="list-style-type: none"> All managers carry our risk assessment Process available on the COVID 19 Trust intranet page BAME risk assessment Young persons risk assessment Pregnant workers risk assessment Risk assessment to identify vulnerable workers Isolation tool available for staff on Trust intranet UHNM follow National guidance 	<ul style="list-style-type: none"> Risk assessment and temporary risk mitigation will be reported to the workforce bureau. To protect confidentiality individual risk assessments will not be requested as these should be kept in the employees personal file Managers required to complete , review and update risk assessments for vulnerable persons 	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
<p>Staff understand and are adequately trained in safe systems of working including donning and doffing of PPE</p> <p>Staff in 'at risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported.</p> <p>That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff</p> <p>Update V 1.8 A risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be a high risk of complications from respiratory infection such as influenza and severe illness from COVID -19</p> <ul style="list-style-type: none"> ○ A discussion is had with employees who are in the at-risk groups: including those who are pregnant and specific ethnic minority groups; ○ That advice is available to all health and social care staff, including specific advice to those at risk from complications ○ Bank, Agency and locum staff who fall onto these categories should follow the same deployment advice as permanent staff ○ A risk assessment is required for health and social care staff at high risk of 	<ul style="list-style-type: none"> ● PPE donning and doffing videos available on the intranet ● PPE posters ● IP Q+A manual ● Staff risk assessment process already in place at UHNM ● Staff risk assessment information available on the Trust intranet page 	<ul style="list-style-type: none"> ● IP assurance visits 	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
10.2	<p>complications, including pregnant staff</p> <p>Staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally</p> <p>Staff who carryout fit testing training are trained and competent to do so</p> <p>All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used</p> <p>A record of the fit test and result is given to and kept by the trainee and centrally within the organisation</p> <p>For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods</p> <p>A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health</p> <p>Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-</p>	<ul style="list-style-type: none"> Mask fit strategy in place Mask fit education pack SOP for reusable face masks and respiratory hoods in place PHE guidance followed for the use of RPE PPE poster available on the intranet Training records held locally Fit testers throughout the Trust Complete and issue Qualitative Face Fit Test Certificate Divisions hold records Option now available on Health roster to capture mask fit testing SOP for reusable face masks and respiratory hoods in place 	<ul style="list-style-type: none"> Training records for reusable masks Training records held locally FFP3 testing records now available on Health Rostering to record mask type and date and divisional mask fit compliance % monitored 	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
<p>usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal</p> <p>Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board</p> <p>Update V 1.8</p> <p>A fit testing programme is in place for those who may need to wear respiratory protection</p> <p>Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection prevention precautions, including PPE and outlined in national guidance</p>	<ul style="list-style-type: none"> For staff groups that use Heather roster FFP3 mask fit testing details can be added as a skill to this system. Fit testing in place PPE requirement applicable to all staff , no exemptions for those who have recovered or received vaccination 		
10.3	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the crossover of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance .	<ul style="list-style-type: none"> Restore and Restorations plans Incidence process/Datix 	
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas.	<ul style="list-style-type: none"> Social distancing tool kit available on COVID 19 intranet page Site circulation maps Keep your distance posters Social distance monitor walk round introduced Friday 5th June Social distance department risk assessments 	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<p>Health and care settings are COVID 19 secure workplaces as far as practical, that is that any work place risks are mitigated maximally for everyone</p> <p>Linked NHSIE Key Action 2: Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.</p>	<ul style="list-style-type: none"> • COVID-19 secure declaration • Social distancing risk assessment guidance for managers presentation 5th June2020 • Meeting room rules • Face masks for all staff commenced 15th June • Visitor face covering • COVID secure risk assessment process in place • November 2020 – Car sharing instructions added to COVID Bulletin 	<ul style="list-style-type: none"> • COVID-19 secure declarations 	
10.5	<p>Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas.</p>	<ul style="list-style-type: none"> • Social distancing tool kit • Staff encouraged to keep to 2 metre rule during breaks • Purpose build rooms for staff breaks in progress 	<ul style="list-style-type: none"> • Social distance monitor walk rounds • Social distance posters identify how many people allowed at one time in each room 	
10.6	<p>Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.</p>	<ul style="list-style-type: none"> • Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms. 	<ul style="list-style-type: none"> • Team prevent monitoring process • Work force bureau 	
10.7	<p>Staff who test positive have adequate information and support to aid their recovery and return to work.</p> <p>Update V 1.8</p> <p>Where there has been a breach in infection prevention procedures staff are reviewed by Occupational Health , who will</p> <ul style="list-style-type: none"> • Lead on the implementation of system 	<ul style="list-style-type: none"> • Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms. • Empactis line will first ask – is the absence related to coronavirus. To which the employee must say yes or no • Once the absence is reported to the employees manger via email, the manager will categorise the absence type specified in the flow 	<ul style="list-style-type: none"> • Via emapactis • Staff queries’ through workforce bureau or team prevent 	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	<ul style="list-style-type: none"> to monitor for illness and absence Facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the health care workforce Lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 	<ul style="list-style-type: none"> chart. Team prevent complete COVID 19 staff screening Areas where transmission has occurred are discussed at clinical group and relevant staff screening under an ILOG number is agreed. Flow charts of staff returning to work available on COVID 19 section of intranet 		

CURRENT PROGRESS RATING		
B	Complete / Business as Usual	Completed: Improvement / action delivered with sustainability assured.
GA / GB	On Track	Improvement on trajectory either: A. On track – not yet completed or B. On track – not yet started
A	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
R	Delayed	Off track / trajectory – milestone / timescales breached. Recovery plan required.



Executive Summary

Meeting:	Trust Board	Date:	8 th June 2022
Report Title:	Draft Quality Account	Agenda Item:	12
Author:	Head of Quality, Safety & Compliance		
Executive Lead:	Chief Nurse		

Purpose of Report

Information	Approval	X Assurance	X Assurance Papers only:	Is the assurance positive / negative / both?			
				Positive	X	Negative	X

Alignment with our Strategic Priorities

High Quality	X	People		Systems & Partners	
Responsive		Improving & Innovating		Resources	



Risk Register Mapping

BAF1	Various – linked to BAF 1 Delivering Positive Patient Outcomes	Extreme (20)
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Executive Summary

Situation

The attached is the latest draft of the Trust’s annual Quality Account. The account summarises activity during 2021/2022. The content of the Quality Account is defined by the Quality Accounts letter 2019/20 issued by NHS Improvement and the NHS Quality Accounts Guidance which continues to apply. Noted NHS providers are no longer expected to obtain assurance from their external auditor on their Quality Account for 2020/21.

The Quality Account has been shared at Trust Quality Governance Committee and Audit Committee and with external stakeholders for completion and return of the final Stakeholder comments from Clinical Commissioning Groups, Overview & Scrutiny Committees of both Stoke-on-Trent City Council and Staffordshire County Council and Healthwatch by 30/05/2022. The final account including the stakeholder comments will be published by 30th June 2022 following approval at the Trust Board meeting on 8th June 2022.

Background

Part A of the Quality Account provides summary of Strategic Objectives, Quality Priorities and Objectives for 2021/2022 and how these will be measured and monitored, participation in clinical audit programmes, clinical research participation, data quality results and Information Governance Toolkit attainment levels.

Our overall goal is to support our staff to get it right first time, every time for our patients.

The identified priorities for 2022/2023 are:

- To continue to improve safe care and treatment to patients
- To improve staff engagement and well being following COVID-19 pandemic
- To improve patient experience

Part B of the account reviews the Trust’s Quality Performance for 2021/2022 against the priorities that were identified last year. These include both local and national results and how the indicators compare against the initial targets that had been set at the start of 2020/21.

Part C is currently awaiting completion as the stakeholder comments and will not be ready for inclusion until after 30th June 2022.

Assessment

The Quality Account for 2021/2022 meets the statutory and regulatory requirements and includes all the required information. There are some outstanding data that will require updating but at time of the final draft being published are not yet available via national sources.

There has been good engagement in the completion of the variation sections from identified leads and the draft has been shared for external stakeholder comment.

Key Recommendations

The Trust Board is asked to:

- To note and approve the draft version of the latest Quality Account 2021/2022 along with the quality priorities for 2022/2023 and links to existing Trust aims and objectives which has been previously agreed at QGC and Audit Committee in April 2022 and QSOG May 2022.
- To note that the Quality Account will be updated to include remaining stakeholder comments once received



Quality Account

2021 / 2022



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Part A: Statement on Quality



OVERVIEW

1. Introduction to UHNM

Welcome to the Quality Account for the University Hospitals of North Midlands NHS Trust (UHNM) for 2021/22. As we review the last 12 months and consider our priorities for the year ahead, we reflect on the continuing impact the COVID-19 pandemic has had on our hospitals, our staff and our patients.

During the last year we did all we could to continue care for all our patients, including transferring planned surgery and treatments to other providers and private hospitals less impacted by COVID-19; transforming our outpatient appointments into telephone and video consultations and introducing a family support service to help provide essential communication between families and patients while visiting restrictions were in place. Despite the challenges we have faced, we have made great progress in improving our services for our patients and local communities, while making every effort to keep them safe and receive the best possible experience.

Our staff have continued to adapt and show resilience under extreme pressure and acted with compassion and professionalism and were acknowledged with an Outstanding rating in The Care domain during the most recent CQC inspection during 2021. It is hoped this report serves as an open and honest account of where we have moved forward both as a result of and despite the pandemic and where we still have further improvements to make.

We are committed to providing safe, high quality care to our communities and we continue to focus on delivering quality improvement in all we do.

University Hospitals of North Midlands NHS Trust was formed in November 2014 following the integration of University Hospital of North Staffordshire NHS Trust and Mid Staffordshire NHS Foundation Trust. We have two hospitals, Royal Stoke University Hospital and County Hospital, and we are very proud of both.

We are a large, modern Trust in Staffordshire, providing services in state of the art facilities. We

provide a full range of general hospital services for approximately 900,000 people locally in Staffordshire, South Cheshire and Shropshire. We employ around 11,000 members of staff and we provide specialised services for a population of three million, including neighbouring counties and North Wales.

We are one of the largest hospitals in the West Midlands and have one of the busiest Emergency Departments in the country, with an average of nearly 15,000 patients attending each month across both of our sites. Many emergency patients are brought to us from a wide area by both helicopter and land ambulance because of our Major Trauma Centre status; as we are the specialist centre for the North Midlands and North Wales.

As a University Hospital, we work very closely with our partners at Keele and Staffordshire University and we are particularly proud of our medical school, which has an excellent reputation. We also have strong links with local schools and colleges. As a major teaching Trust, we hold a large portfolio of commercial research, which provides us with a source of income. Our research profile also enables us to attract and retain high quality staff.

Our specialised services include cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care, paediatric intensive care, trauma, respiratory conditions, spinal surgery, upper gastro-intestinal surgery, complex orthopaedic surgery and laparoscopic surgery.

We are a key player in the Staffordshire Sustainability and Transformation Partnership (STP) / Integrated Care System (ICS) and take an active part in the planning and discussions. The health economy plan remains focused on minimising admissions to and discharging as soon as possible from the major acute site at Royal Stoke University's Hospital (RSUH), with as much care as possible being delivered in community settings or at County Hospital (CH).

We benefit from being able to attract and retain high quality staff. In order to do this we need to continue to maintain and expand our tertiary capabilities to service the populations of the north west Midlands, Derbyshire, Wales, south Manchester and the northern suburbs of Birmingham.

Postgraduate Medical Education has strong links with both Keele and Staffordshire Universities. All our trainees are allocated from Health Education England, West Midlands. We are looking at a possible expansion in our Foundation doctors and are working with directorates to look at opportunities.

We moved foundation training online and developed a virtual learning environment that was rolled out in July 2021. The Extended Reality Laboratory (Sim suite) at County Hospital is being used more and more by the whole Multi Disciplinary Team. Funding was obtained to upgrade the technology infrastructure at the Post Graduate Medical Centre, County Hospital.

Royal Stoke University Hospital



The County Hospital (Stafford)



Nursing and Midwifery continue to maintain strong links with Keele and Staffordshires Universities supporting the development of Registered Nurses in addition to Nursing Associates and the provision of a wide range of post registration courses. In house developments has seen the development of a '*Skills Escalator*' enabling our staff to undertake career progression though apprenticeships both at unregistered and registered levels as part of our *Grow Our Own Strategy*.

DRAFT

2. Statement on Quality

We are proud to say that University Hospital of North Midlands NHS Trust continues to show commitment of our staff to improve the quality, safety and experience of patients in our care. We will continue to achieve this by our staff understanding their role and empowering and equipping them towards delivering excellence every day resulting in improved patient outcomes, staff morale, productivity and efficiency.

COVID-19 has continued to dominate 2021/22 as it did in 2020/21, however, throughout the year we also continued to transform the way we deliver services and we have been overwhelmed with the professionalism, flexibility and positive attitudes from our staff.

The period covered by this Quality Account is from 1 April 2021 through to 31 March 2022 and once again the year has been dominated by the impact of and our response to the Covid-19 pandemic.

Our Trust has experienced several surges and peaks in the number of patients it is treating with Covid-19 while also managing high levels of staff absence due to isolation rules. We would like to express, on behalf of the Trust Board, our deep and sincere gratitude to colleagues working across our hospitals for their unwavering commitment and dedication to tackle head-on the unprecedented challenges they faced in safely treating and caring for, all the patients admitted to our hospitals during this time.

So many staff have and continue to worked tirelessly, under immense pressure and within the tightest of timescales and there is much to be proud of, for example:

- Colleagues redeployed into unfamiliar clinical areas driven by their desire to support those clinical teams at the forefront of Covid-19
- Urgent elective and cancer services continued to be delivered, supported by some additional capacity and facilities from the independent sector.
- Outpatient appointments were delivered virtually – by telephone or video – enabling the Trust to keep people safe whilst continuing to deliver their essential care.

During the last 12 months we have moved from the response to Covid -19 into managing the disease and our dedicated staff have continued to play a pivotal role and focus attention on our operational reset and recovery of elective and planned care. It is widely acknowledged that waiting lists have grown as a consequence of Covid -19 and many patients are waiting far longer than we would ever want them to but our teams are working hard to increase our theatre capacity and ensure that patients are accessing outpatient clinics.

Whilst the pandemic has absolutely dominated the year, there has been a considerable amount of other work happening and during the year we celebrated the CQC awarded us the rating of Outstanding for Caring following our inspection. This was a significant achievement and recognised the high quality care and compassion delivered by our staff during a pandemic. As we look to the future we will focus efforts to improve further and achieve a rating of 'Outstanding' overall.

Our staff are our greatest asset and we have continued to provide packages of support and offers of wellbeing provision as well as develop our teams by rolling out our Quality Improvement Programme to empower and support all staff and departments to changes – no matter how small - to deliver better services and play a vital role in building healthier, happier, fairer lives for the people we serve – our patients, our staff, our local communities.

We are also grateful to our partners within the Staffordshire and Stoke-on-Trent system and beyond for their support throughout the year and look forward to working closer with them as part of the ICS as it is established.

Looking ahead to 2023/24 we will continue to address our biggest challenges around capacity and demand with focus on Urgent and Emergency Care across both our sites and our recovery process so we can deliver safe quality care to those who need it the most.

We made good progress against our quality and safety priorities identified in last year's account, including:

- 20% reduction in Category 3 Hospital Acquired Pressure Ulcers with 'lapses in care' in 2021/22 compared to 2020/21 totals
- Sepsis screening for Inpatients and Intravenous Antibiotics (IVAB) in 1 hour have seen improvements during 2021/22.
- Exceeding the 95% National Target for Harm Free Care (New Harms)
- Reduction in rate of reported patient falls in 2021/22 compared to 2020/21
- UHNM continues to compare well against peers during 2021/22 and remains within expected ranges for both HSMR and SHMI mortality indicators
- Improvement in VTE risk assessment compliance with average 99.3% in 2021/22
- Reduced rate of formal complaints received as we increased activity during 2021/22 from 2020/21
- Our Speaking Up Index score as part of Staff Survey has improved year on year

We are proud of our achievements, however we recognise that there are also areas where we need to make further improvement, for example:

- Emergency Department 4 hour target performance
- Continued improvement in Sepsis screening compliance and pathway
- To reduce harm from falls
- To reduce Hospital acquired Category 2 pressure ulcers and Deep Tissue Injuries with lapses in care

It has been an incredibly challenging year for all of us but it is also one that has made us very proud to be Chairman and Chief Executive of UHNM. Undoubtedly there will be further challenges ahead for us throughout 2022/23 and beyond but given we have seen what our UHNM family can do in extremis we are more than ever more confident that together, we will come through and we look forward to seeing how the 'new NHS' evolves. We hope you enjoy reading this Quality Account.

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 and 2013 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Account (which incorporate the above legal requirements).

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

David Wakefield
Chairman

Tracy Bullock
Chief Executive Officer

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2.2 Strategic Objectives

Our ‘2025 Vision’ was developed to set a clear direction for the Organisation to become a world class centre of clinical and academic achievement and care. One in which our staff all work together with a common purpose to ensure patients receive the highest standard of care and the place in which the best people want to work.

To achieve the 2025 Vision we must respond to the changing requirements of the NHS as they emerge and operate in ever more challenging times. This means that we have to think further than the here and now and continue to look beyond the boundaries of our organization for inspiration. Our involvement in the STP is crucial in enabling us to move towards our vision and to become a sustainable provider of healthcare services.

Our Strategic Objectives

Our Vision is underpinned by 6 key Strategic Priorities (SO):

High Quality	Responsive	People	Improving & Innovating	System & Partners	Resources
 <p>Providing safe, effective and caring services</p>	 <p>Providing efficient and responsive services</p>	 <p>Empowering, developing and supporting for effective performance</p>	 <p>Achieving excellence in development and research</p>	 <p>Leading strategic change within Staffordshire and beyond</p>	 <p>Ensuring we get the most from the resources we have, including staff, assets and money</p>

Our Values

We continue to encourage a compassionate culture through our values, which identify the attitude and behavioural expectations of our staff.



	<ul style="list-style-type: none"> • We are a team • We are appreciative • We are inclusive
	<ul style="list-style-type: none"> • We are supportive • We are respectful • We are friendly
	<ul style="list-style-type: none"> • We communicate well • We are organised • We speak up
	<ul style="list-style-type: none"> • We listen • We learn • We take responsibility

Our full 2025 Vision is available via our website: www.uhnm.nhs.uk.

Priorities for Improvement

3.1 Our Quality Priorities and Objectives for 2022/23

Our core vision continues to be a leading centre in healthcare, driven by excellence in patient experience, research, teaching and education. Our overall ambition is to become one of the top University Teaching Hospitals in the UK by 2025.

We want everyone who works at UHNM to share this vision and place quality at the heart of everything we do by embracing and demonstrating the following Trust values of Compassion, Safety, Improving and Together. The Trust is supporting this vision through a number of initiatives



Improving Together

In 2021/22, through the implementation of the Improving Together programme, the Trust established its new strategic planning framework, with 6 Strategic Priority Domains (a clear and certain direction for our work) being shared with teams across the Trust.

Strategic Priority Domains		
	High Quality	Providing safe, effective and caring services
	Response	Providing efficient and responsive services
	People	Creating a great place to work
	Improving & Innovating	Achieving excellence in development and research
	Systems and Partners	Leading strategic change within Staffordshire and beyond
	Resources	Ensuring we get the most from the resources we have, including staff, assets and money

These domains allow all members of UHNM staff to **ALIGN** their work with the priorities of the organisation. The metrics associated with these domains allow the Trust to understand if its delivering the services to the required standard for its patients and help to identify where improvements can be made.

During this year the first teams were trained in the new tools and routines associated with the Improving Together approach **ENABLING** continuous improvement to become part of the everyday work of the Trust. The first two waves of training have up-skilled 532 members of staff including the ward teams from wards 230, 202, 227, 109, 102 and AMU County, AMU Stoke, PACU and SAU and the Divisional and Directorate Triumverates (Clinical Chairs/Leads, ACNs/Matrons and ADs/DMs). These teams have had 5 months of training and coaching in the new skills and are now embedding them into practice. In addition a further 221 staff have received one off training in the new tools and routines, enabling them to support the teams on each wave.

Through new style conversations with the Executive Team, called Focus Negotiations, the Divisional team have been able to agree their priority areas for improvement and to focus their improvement energy on the issues that will have the biggest impact for our patients and the monthly meetings with the Executive team to discuss progress against these priorities are now focussed, rich discussions on addressing the problems the Trust faces.

The training and focus has led to improvements in many areas of practice, eg with individual wards reducing the number of falls or pressure ulcers in their areas, discharges happening earlier in the day, discharge letters being completed in a timely manner, care for deteriorating patients being improved. In addition through all the challenges of working in healthcare through the COVID-19 pandemic, staff have been able to identify things that are within their control to **IMPROVE** and are using their new tools to support their day to day work.

As we move into 2022/23, the Quality Improvement Academy is expanding its scope and pace of roll out, by working collaboratively with the Transformation team. Together they will deliver an integrated approach to continuous improvement at the County Hospital site, whilst continuing to train both frontline and corporate teams at Royal Stoke.



Prioritising our quality improvement areas

We have continued our focus on quality aligned to our Strategic Objectives and 2025Vision.

Our aim is to provide safe, clean and effective person-centred care to every patient, every time. To achieve this we recognise that we must continue to:

- Build stronger clinical leadership
- Provide valid, reliable and meaningful information as a basis for measurement and improvement
- Build greater capacity and capability of our staff to interpret the information and implement sustainable change.

Our Overall Goal for 2022/23 is:

To support our staff to get it right first time every time for our patients

Aims

To continue to improve harm free care and treatment to patients

How will we do this:

- Improve sepsis treatment and recognition of deteriorating patients
- To evaluate and reduce long waiters following the COVID-19 pandemic
- To support the Recovery & Restoration Plan across the health economy
- Ensure that services follow appropriate infection prevention guidance and continue to be COVID-19 secure
- Aim to reduce patient falls resulting in low harm or above by a further 5% from 2020/2021 baseline
- Aim to reduce total numbers of Category 2 to 4 Pressure Ulcers, unstageable pressure ulcers and deep tissue injuries developed under UHNM care by 10% from 2020/2021 baseline.
- Evaluate and introduce new technologies and techniques for treating patients.
- Improve the number of reported medication errors and associated training in medication safety
- Delivering the Improving Together Programme

Measure this through:

- Quality Performance Report
- Harm Free Care
- Serious Incidents analysis
- Legal claims
- Mortality reviews and outcomes
- Getting It Right First Time (GIRFT) Reviews and analysis
- Clinical Audits
- Wards Performance Boards as part of Delivering Exceptional Care

To improve staff engagement and well being following COVID-19 pandemic

How will we do this:

- To support the introduction of the Trust's Wellbeing Programme and activities that focus on staff wellbeing and empowerment
- Ensure that staff are working within COVID-19 secure environments and support provided to staff
- Support staff and services in providing care in 'new ways' following COVID-19
- Promote mental health wellbeing and support
- Delivering the Improving Together Programme
- Introduction of Shared Governance

Measure this through:

- Staff survey
- Pulse Check
- Staff Voice
- Chief Executive Briefings
- Freedom to Speak up report

To improve patient experience

How will we do this:

- Utilise patient and visitor feedback
- Seek wider engagement with 'harder to reach' patient groups
- Review patients experiences during COVID-19 and identify positive changes to adapt service provisions
- Review the different ways that patient experience and views are gathered and acted upon within UHNM
- To formalize patient engagement in patient safety programmes

Measure this through:

- Inpatient and Outpatient survey
- Complaints & PALS themes
- Patient Stories

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3.2 How we have performed against Quality KPIs during 2021/22

Quality Indicator	Previous Period		Current Period	
	January 2020 – December 2020		January 2021 – December 2021	
The value of the Summary Hospital level Mortality Indicator (SHMI)	1.03 (Band 2)		1.02 (Band2)	
The percentage of deaths with palliative care coded at either diagnosis and/or specialty level	2.3%			
Patient Reported Outcome Measures scores* (National Average)	Participation Rate 2019/20	Participation Rate 2019/20	Participation Rate 2020/21	Adjusted Health Gain 2020/21
☑ Groin hernia surgery	-	-	-	-
☑ Varicose Vein Surgery	-	-	-	-
☑ Hip Replacement Primary Surgery	57.2% (65.5%)	57.2% (65.5%)		0
☑ Knee Replacement Primary Surgery	54.1% (63.5%)	54.1% (63.5%)		
*EQ-5D scores finalised data release				
Percentage of patients aged				
☑ 0 to 15; and	No new data publication available from NHS Digital portal		No new data publication available from NHS Digital portal	
☑ 16 and over				
Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from hospital				
The Trust's responsiveness to the personal needs of its patients	2020/21 Survey TBC TBC		2021/22 Survey TBC TBC	
Percentage of staff employed by the Trust who would recommend the trust as a provider of care to their friends and family (Agree / Strongly Agree)	2020 76% (England Average Acute Trusts 73%)		2021 TBC	
Percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (Acute Trusts) (National Average)	2019/20 Q1 93.79% (95.56%) Q2 93.99% (95.47%) Q3 93.29% (95.33%) Q4 TBC % (TBC%)		2020/21 No new data publication available from NHS Digital portal	
The rate per 100,000 bed days of Clostridium Difficile infection reported within the Trust amongst patients aged two or over (Trust apportioned)	2019/20 39.8 (England Average 29.7)		2020/21 TBC	
The number and rate of patient safety incidents reported within the trust - Acute trusts (non specialist)	9368 (Oct 2019 – March 2020) 40.2 per 1000 bed days			
The number and rate of such patient safety incidents that resulted in severe harm or death— acute (non specialist)	22 (Oct 2019 – March 2020) 0.1		Oct 2020 – March 2021	

Commissioning for Quality and Innovation (CQUIN) Indicators for 2021/22

During 2021/22, due to the national NHS response to the COVID-19 pandemic the funding for all acute Trusts changed to a block payment which included funding for CQUINs.

As a result of this there were no national or local CQUINs which were required to be agreed or to be achieved during 2021/22. Therefore UHNM were automatically paid for CQUINs at 100% even though there were no indicators set to be achieved.

DRAFT

4. Patient Story

I recently had the misfortune of incurring a freakish and bizarre accident which resulted in my transfer via helicopter and my admission to UHNM for emergency operations and then transferred on to Ward 227 Acute Rehab Trauma Unit (ARTU). Having had a relatively healthy and injury-free life, my views on the NHS system were, at best, ok and adequate. That was until I was under the good auspices of the ARTU.

The compassion, dedication, cleanliness, professionalism and duty of care provided by all the staff I personally encounters (and witnessed as being administered to other patients) was far beyond my expectations. I was retained on ARTU for two full weeks while I recovered from major surgery and rehabilitated back to an acceptable state for discharge.

From the Anaesthetists and Surgeons, the daily doctors rounds with their cheerful and pleasant bed-side manner; the positive reassurances and encouragement from the Physiotherapists; the unlimited and dedicated care from the nurses and the assistance from all the other staff has been second to none.

I could not sing the hospital staffs praises high enough and wish to convey my sincere thanks and deepest gratitude to for the care provided.

I write to express my gratitude to the team who ensured the safe delivery of my daughter, Poppy, at the Royal Stoke Maternity Unit. I went into labour and was admitted to the Royal Stoke Maternity Unit. Whilst there, I was under the care of the midwives Donna and Jade who, whilst not with me for long as their shift ended in the early morning, supported me, and my husband Alex through the difficult contractions with professionalism and good humour.

Lindsay, the midwife who took over my care and stayed with me until Poppy was born, was nothing short of a superstar. She monitored Poppy's heart rate

forensically, and made me feel completely at ease throughout. She was always calm, professional and I believe a wonderful testament to the Royal Stoke Maternity team.

Unbeknown to anyone at this stage, Poppy was 'face up' (I am sure there is a medical term for this but I am unsure of what it is!) and as such was proving difficult to 'push' out. Due to Lindsay's close monitoring of Poppy's heart rate, it became clear that Poppy was becoming distressed, and was experiencing bradycardia. Responding quickly and calmly, the emergency lever was pulled, and within seconds, a team of professionals entered the room. Each person in the room, despite the situation, introduced themselves warmly, which helped greatly as it became clear that we would be moving to theatre for a trial of forceps.

Each stage of the process, which resulted in an emergency c section, although fast-moving, was explained to me and my husband. Due to the clear communication between the consultants and other staff (I am sad to say that I have only the names Gigi and Mark, but there were many others) there was no doubt in my mind that I was receiving the very best care from the very best team, something which I am exceptionally grateful for.

Importantly, I felt such kindness and care from the team - almost as though I was a family member. This is something I will always remember. I feel that the professionals who were working that day are a testament to the very best that the NHS offers its patients, and I, my husband and our family are so grateful for each member of the team that day. I would be so grateful if you could pass on my sincere thanks.

5. Statement of Assurances

5.1 Review of Services

Care Quality Commission

The Trust was last inspected on 24th and 25th August 2021 and the inspection followed the new regime for inspection. The CQC carried out a short notice-announced inspection of the following acute services provided by the trust and inspected two core services due to concerns about the quality and safety of services. These were:

- Urgent and emergency care at the Royal Stoke University Hospital.
- Medicine at the Royal Stoke University Hospital.

The CQC also carried out two focused inspections as part of the continual checks on the safety and quality of healthcare services. These were:

- Medicine at County Hospital. This was a focused inspection on the safe, effective and well-led key questions.
- Surgery at County Hospital. This was a focused inspection of safe and well-led key questions.

The final report was published on 21st December 2021. The overall rating for the Trust stayed the same. The CQC rated UHNM overall as **requires improvement**. The CQC rated the reviewed services as follows:

- Medicine at County Hospital – Requires Improvement
- Surgery at County Hospital – Good
- Urgent and Emergency Care at Royal Stoke University Hospital – Requires Improvement
- Medicine at Royal Stoke University Hospital – Good

Some services previously rated requires improvement were not inspected because the latest inspection was focused only on services where there were concerns or had not inspected for some time. The CQC continue monitoring the progress of improvements to the services and will re-inspect them as appropriate. Services previously rated as requires improvement and not inspected this time include:

- Urgent and emergency care at County Hospital.
- Outpatients at County Hospital and the Royal Stoke University Hospital.

Whilst the CQC rated the Trust overall as Requires Improvement, we did see improvements in two of domains

- Caring improved from Good to Outstanding
- Well Led improved from Requires Improvement to Good

The table below shows the rating by the 5 key domains and compares results to the 2019 inspections:

Domain	June 2019 Ratings	August 2021 Ratings	
Are services safe?	Requires Improvement	Requires Improvement	●
Are services effective?	Requires Improvement	Requires Improvement	●
Are services caring?	Good	Outstanding	★
Are services responsive?	Requires Improvement	Requires Improvement	●
Are services well led?	Requires Improvement	Good	●
Overall	Requires Improvement	Requires Improvement	●

Section 29A Warning Notice

Following the inspection, the CQC served a Warning Notice under Section 29A of the Health and Social Care Act 2008. This warning notice served to notify the trust that the Care Quality Commission had formed the view that the quality of health care provided in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital and the risk management of patients with mental health needs medicine at County Hospital required significant improvement.

Section 31 Notices

On 19th June 2019 the Trust were served notice under Section 31 of the Health and Social Care Act 2008, imposing specific conditions in relation to the Emergency Department at Royal Stoke and Medical Care (compliance with Mental Health Act Code of Practice) at Royal Stoke.

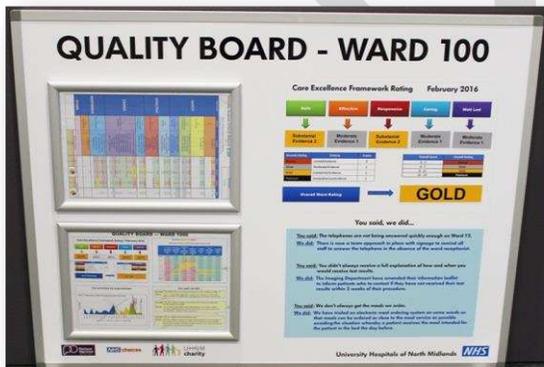
A weekly report was developed, which set out the specific detail of conditions imposed along with an Assurance Framework that detailed the immediate actions taken in response along with monitoring arrangements, ongoing assurance mechanisms and supporting evidence available.

In September 2020, the CQC removed the conditions in relation to the Mental Health Act code of practice but the conditions relating to the Emergency Department remained in place because:

- The Trust had not yet achieved 95% compliance with assessing patients within 15 minutes of arrival in emergency department at Royal Stoke University Hospital.
- Audits undertaken did not provide the CQC with full assurance of the systems in place to ensure that patients are assessed within 15 minutes of attending the department by suitably qualified and trained staff in line with national guidance.
- CQC were not assured that the action the Trust were taking was enough to assure the inspectors that the system is implemented and effective.

In response to the letter received, the weekly report was amended and enhanced in order to provide the CQC with additional assurance. Since January 2022, the CQC have accommodated monthly reporting and a further application is being prepared by the Trust to remove the conditions.

Care Excellence Framework



The Care Excellence Framework (CEF) is a unique, integrated tool of measurement, clinical observations, patient and staff interviews, benchmarking and improvement. It reflects CQC standards and provides assurance around the CQC domains of:

- Safety
- Effectiveness
- Responsive
- Caring
- Well led



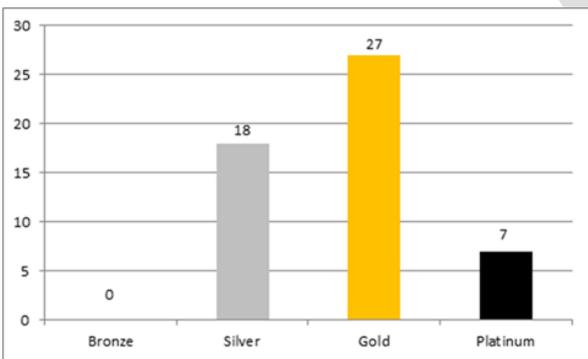
The CEF is delivered in a supportive style fostering a culture of learning, sharing and improving, and reward and recognition for achievement. Each domain consists of clinical observations, documentation reviews, patient interviews and feedback from staff forums.

The framework provides an award system for each domain and an overall award for the ward/department based on evidence. The awards range through bronze, silver, gold and platinum and are displayed in each clinical area. The clinical area is supported to develop and deliver a bespoke improvement plan and spread good practice. Areas with a bronze award are supported to make improvements by the Quality and Safety team and areas rated platinum are encouraged to share their good practices.

During 2020/21 COVID19 pandemic the planned CEF reviews were suspended but safety reviews were conducted to provide assurance about the standards of care delivered to our patients. The planned CEF programme recommenced in April 2021, however visits were not completed in September/October which affected Q2/Q3. Since then visits have continued despite the challenges COVID 19 has continued to present.

Wards and departments from all divisions have been visited. Visits from Q4 are awaiting validation but below is a summary of published awards from 2021/2022.

Published CEF Awards 2021/2022



Ward 111 – Platinum CEF award July 2021



PLACE Inspection

PLACE inspections in 2021 were cancelled nationally again due to the COVID 19 pandemic challenges within NHS premises. However, Trusts were encouraged to complete a PLACE-Lite inspection where possible. Due to the Covid19 challenges at UHNM at that time it was agreed that a PLACE-Lite inspection would be undertaken in Spring 2022 which, to date has not yet commenced. It is planned for this to be completed before the Autumn 2022 when PLACE inspections usually occur.



5.2 Participation in Clinical Audit

Clinical Audit is an evaluation of the quality of care provided against agreed standards and is a key component of quality improvement. The aim of any Clinical Audit is to provide assurance and to identify improvement opportunities. The Trust has an agreed yearly programme of Clinical Audits which includes:

- National audit where Specialties/Directorates are asked to be involved
- Corporate and Divisional audits
- Local audits which clinical teams and specialties determine and reflect their local priorities and interests

As part of the Clinical Audit Policy any clinical audit carried out within the Trust should be registered with the Trust's Clinical Audit Team, the team has a database which monitors the progress.

The National Clinical Audits and NCEPOD enquiries that the Trust participated in, and for which data collection was completed during 2021/22 alongside the number of cases submitted, are referred to in the tables below:

A process is in place to ensure that leads are identified for all the relevant National Audits and NCEPOD. The lead will be responsible for ensuring full participation in the audit.

National Confidential Enquiries

Following receipt of the reports, we undertake review of the recommendations and implement an improvement plan.

NCEPOD Study	UHNM Registered	Status
NCEPOD: Transition from Child Health Services to Adult Care	Yes	Data Collection
NCEPOD: Community Acquired Pneumonia	Yes	Not due to begin until Spring 2022
NCEPOD: Crohns Disease	Yes	Planning Data sent
NCEPOD: Epileptic seizures	Yes	Data Collection

All published reports are received by the Trust and reviewed locally. A steering group is convened for each enquiry and local action plans are developed where necessary to ensure all relevant recommendations from NCEPOD are implemented. Implementation of the action plans is monitored centrally at the Trust's NICE and External Publications Implementation Group, chaired by the Associate Medical Director (Governance, Safety and Compliance), to ensure full completion.

5.3 National Clinical Audits

These audits indicate our level of compliance with national standards and provide us with benchmark information on to which to compare practice. The results of the audits inform the development of local action plans to improve patient care.

National Clinical Audit National Audit	UHNM Registered	% of cases Submitted
Case Mix Programme - Intensive Care National Audit & Research Centre (ICNARC)	Yes	100%
Chronic Kidney Disease Registry (Previously known as UK Renal Registry)	Yes	100%
Cleft Registry and Audit Network (CRANE) Continuous data collection	Yes	100%
Elective Surgery (National PROMs Programme)	Yes	100%
Emergency Medicine QIP: Pain in Children (care in Emergency Departments)	Yes	100%
Emergency Medicine QIP: Severe Sepsis and Septic Shock (care in Emergency Department)	Yes	100%
Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls	Yes	100%
Falls and Fragility Fracture Audit Programme: National Hip Fracture Database	Yes	100%
Falls and Fragility Fracture Audit Programme: The Fracture Liaison Service Audit	Yes	100%
Inflammatory Bowel Disease Audit (IBD)	Yes	100%
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	100%
MBRRACE-UK: Maternal Mortality Surveillance	Yes	100%
MBRRACE-UK: Perinatal Confidential Enquiries	Yes	100%
MBRRACE-UK: Perinatal Mortality Surveillance	Yes	100%
National Adult Diabetes Audit: National Diabetes Core Audit	Yes	100%
National Adult Diabetes Audit: National Pregnancy in Diabetes Audit	Yes	100%
National Adult Diabetes Audit: National Diabetes Footcare Audit	Yes	100%
National Adult Diabetes Audit: National Inpatient Diabetes Audit	Yes	100%
National Asthma and COPD Audit Programme: Adult Asthma Secondary Care	Yes	100%
National Asthma and COPD Audit Programme: COPD Secondary Care	Yes	100%
National Asthma and COPD Audit Programme: Paediatric Asthma	Yes	100%
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Cardiovascular Disease Prevention	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia	Yes	100%
National Audit of Seizures and Epilepsy in Children and Young People	Yes	100%
National Cardiac Arrest Audit	No	-

National Cardiac Audit Programme: Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Cardiac Audit Programme: National Adult Cardiac Surgery Audit	Yes	100%
National Cardiac Audit Programme: National Audit of Cardiac Rhythm Management Devices and Ablation	Yes	100%
National Cardiac Audit Programme: National Audit of Percutaneous Coronary Interventions	Yes	100%
National Cardiac Audit Programme: National Congenital Heart Disease Audit (NCHDA)	Yes	100%
National Cardiac Audit Programme: National Heart Failure Audit (NHFA)	Yes	100%
National Child Mortality Database (NCMD)	Yes	100%
National Comparative Audit of Blood Transfusion: Audit of Blood Transfusion Against NICE Guidelines	Yes	100%
National Comparative Audit of Blood Transfusion: Audit of the Perioperative Management of Anaemia in Children Undergoing Elective Surgery	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Gastro-Intestinal Cancer Audit Programme: Bowel Cancer Audit	Yes	100%
National Gastro-Intestinal Cancer Audit Programme: Oesophago-Gastric Cancer Audit	Yes	100%
National Joint Registry	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Perinatal Mortality Review	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Vascular Registry	Yes	100%
Neurosurgical National Audit programme	Yes	100%
Paediatric Intensive Care Audit Network (PICANet)	Yes	100%
Respiratory Audits: National Outpatient Management of Pulmonary Embolism	Yes	100%
Respiratory Audits: National Smoking Cessation 2021 Audit	Yes	100%
Sentinel Stroke National Audit programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine Benchmarking Audit	Yes	100%
Transurethral Resection and Single Instillation mitomycin C Evaluation in Bladder Cancer Treatment	Yes	100%
Trauma Audit & Research Network (TARN)	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%

Urology Audits: Cytoreductive Radical Nephrectomy Audit	Yes	100%
Urology Audits: Management of the Lower Ureter in Nephroureterectomy Audit	Yes	100%

Corporate and Local Clinical Audits

A total of 79 clinical audit projects were completed by Clinical Audit Staff and a further 336 clinician led audit projects were registered during 2021/22. These audits help us to ensure that we are using the most up to date practices and identify areas where we can make further improvements. An example of improvements made in response to the audit results is:

Re-Audit of Inpatient Falls

Action	Co-ordinator	Status of Action
<i>In order to disseminate the results to the relevant teams and raise awareness of the improvements to be made:</i>		
The results were shared with all Falls Champions / Quality Nurses and Matrons	Audit Lead	Complete
The audit results were added to the Falls Champions training template and updates	Audit Lead	Complete
The findings were presented to the Falls Steering Group / Divisional Governance meetings/ Quality and Safety Oversight Group and the Associate Chief Nurse meeting	Audit Lead	Complete
An update was added to the Falls presentation at the Quality Governance Committee	Audit Lead	Complete
<i>In order to ensure lying and standing blood pressure is completed for all patients at risk of falling or over the age of 65 years:</i>		
The Care Excellence Framework will continue to monitor compliance. Areas of none compliance will be highlighted via the bespoke Ward action plan	Audit Lead	Ongoing
<i>In order to ensure each patient is assessed and subsequently managed due to their falls risk:</i>		
A review of all falls documentation was undertaken to ensure that it was relevant, fit for purpose and reflected national guidance	Audit Lead	Complete
Additional questions have been added to the monthly falls audit to provide on-going assurance around the full completion of all falls documentation	Audit Lead	Complete
<i>In order to ensure the falls proforma is completed in full:</i>		
A process for sharing outcome letters with Consultants following RCA panel for serious incidents has been introduced. It is anticipated that this will help to highlight areas for improvement in completion of post falls proforma and completion of actions	Audit Lead	Complete
Continue to work with the medical teams to ensure timely post fall reviews and acknowledgement of falls prevention actions in the blue section of the Post Falls Proforma.	Audit Lead	Ongoing

5.4 Participation in Clinical Research

UHNM participates in clinical trials across the healthcare sector from novel interventions and drugs to device innovations which aim to improve quality of life and outcomes for our patients. Research Practitioners and Midwives work alongside clinical teams and support services to identify and consent potential research participants, discussing trials with patients and providing care throughout the studies. During the pandemic UHNM has been contributing to the delivery of national Urgent Public Health Studies in response to COVID-19. The trials have provided important information on the epidemiology of the virus as well as potential treatment options for those affected by COVID-19

There are several other key reasons why UHNM should participate in research. Being research active:

- is associated with better clinical outcomes

- brings a range of finance benefits, including savings on medicines and staff time
- improves UHNM's reputation
- enhances recruitment & retention of high quality staff
- improves staff knowledge & skills
- is key to our academic partnerships
- enhances patient experience

Furthermore, the Care Quality Commission (CQC) are increasingly recognising the value of research and it has been identified that research active organisations fare better in CQC inspections. A key development has been the recent agreement by CQC to include, for the first time, a question about research opportunities offered to patients in the CQC Annual Survey of Inpatient Experience.

Strategic Aims

1. Culture: To develop a Trust-wide culture of research and innovation.
2. Capacity: To grow the Trust's capacity to support research and innovation.
3. Finance: To develop a robust, sustainable and transparent financial model for research and innovation.
4. Governance: To support and enhance research and innovation through provision of a robust governance framework.

Research and Innovation highlights from 2021/2022

- UHNM were part of the NIHR Annual Financial Review 2020/21. 5 areas were reviewed; UHNM were given a final rating of Very Good in all areas, the highest rating for the review. Details below.

Focus Area	Self-Score	Final Rating	Comment
Financial Controls	Very Good	Very Good	Job planning policy is in place; use of specific cost centres for grants and job codes for projects and preparation of financial reports based on extract from the ledgers.
Financial Systems	Very Good	Very Good	Very Effective finance system (ABS) is used and has all the features of a good system.
Financial Management	Good	Very Good	Very good bid writing SOP and costing tool used by the academic development team; very good policy on subcontracting; SOP on subcontracting guides the process, in addition to collaboration agreements; the award close process is good.
Risk Management	Good	Very Good	Good audit report for 202, with no concerns.
Governance Arrangements	Good	Very Good	Good structure with SMT involvement in project oversight; very robust monitoring regime that is supported by monitoring SOPs; HR processes are well documented; a clear process for publication.

- The trust has successfully recruited over 2000 participants to research studies over the past 12 months.
- We were on of the top 3 recruiting sites in the country for REMAP-CAP, this intensive care based study, looks at patients with Community Acquired Pneumonia and identifies the effect of a range of interventions to improve outcome
- We have successfully opened and recruited 250 participants to the SIREN study, which looked at whether prior infection of SARS-CoV2 protects against future infection of the same virus.
- We have concluded successful recruitment to the COVAC-IC study in less than 1 year. This study looks at the immune response to COVID-19 vaccines in immunocompromised patients with haematological disorders and the data currently being analysed.
- Awarded: Dr Fran Gilchrist Research for patient benefit grant application £259,446. 'Comparison of Lower Airway Sampling Strategies In Children with Protracted Bacterial Bronchitis (CLASSIC PBB)'
- COVAR-MS a UHNM sponsored trial developed by Dr Seema Kalra was funded by commercial partner Biogen Ltd. Recruitment has now started for the study; An observational study to evaluate immune response to COVID-19 vaccines, infections and immune treatments in people with multiple sclerosis.
- We are sponsoring a medical device trial led by one of our UHNM Paediatric consultants in collaboration with an international company. The trial which will look at performance and adherence in children and young people whilst using asthma devices.
- We continued to support the management and evaluation of the £1.2m Innovate UK Heart Failure Test Bed which uses digital technology to improve early detection of deteriorating health in heart failure.
- A small grant of £14,000 was awarded by the North Staffordshire Medical Institute (NSMI) to a UHNM Dietician with support from the academic team. This pilot/feasibility study will look at whether using coloured crockery with older people improves their dietary intake.
- The trust has also been awarded funding for three other NSMI grants which are in the fields of Pathology, Radiography and Pediatrics.
- UHNM has implemented the use of RED-CAP, which is a system that enables better data management and also enables virtual consenting of patients taking part in research.
- OPTIMA (optimal personalised treatment of early breast cancer using multi-parameter analysis) UHNM remain the top recruiter for this study of the 1 trusts taking part in the trial.
- TUDCA- (Testing the safety and effect of tauroursodeoxycholic acid (TUDCA) on disease progression.). The final patient has been recruited into the TUDCA trial. This means that UHNM will be the 2nd biggest in the UK recruiter with only Sheffield (a major MND research centre) recruiting more.
- REMAP CAP (Randomised, Embedded, Multi-Factorial, adaptive platform for community-acquired pneumonia) We recruited the 169th patient into the REMAP CAP trial in critical care; this put Royal Stoke as the second top recruiting site nationally.
- OPTIMAS – (OPTimal TIMing of Anticoagulation after acute ischaemic Stroke: a randomised controlled trial (OPTIMAS Trial) 4 patients were recruited to the OPTIMAS trial in September putting us joint-second place for the month of September. A tremendous effort by the Stroke team.
- A joint statistician has been appointed between the trust and Staffordshire University. This will help strengthen the quality of the research that is conducted by UHNM as sponsor and help develop further projects.

5.5 Data Quality

The Data Quality Strategic Plans and Data Quality Assurance Group continued to provide strategic and operational assurance to the Executive Business Intelligence Group, led by the Chief Financial Officer, throughout 2021/22. The corporate Data Quality team has continued to provide assurance throughout the last year to support the improvement of Data Quality and the provision of excellent services to patients and other customers.

- The DQ team continued to support UHNM staff, answering and resolving thousands of queries and helping to support teams undertaking unfamiliar roles in the Trust's response to the COVID-19 pandemic.
- Support for IT projects was also continued with testing, validation and systems expertise provided by the team.
- The Divisional Data Quality Groups have been re-established, with representation from all directorates in attendance. These groups fulfill an important role in the Data Quality Assurance Framework.
- The Action Plan supporting the DQ Strategy has been developed and is continually monitored and updated.
- The terms of reference for the DQ Assurance group have been updated to reflect DQ obligations to the Data Security & Protection Assurance Framework.
- The Data Quality Assurance Indicator has been partially implemented for the Integrated Performance Report discussed at Trust Board level.

2021/22 has been another productive year for the data quality team and we aim to build on this throughout 2022/23, supporting the strategic aims of the Trust.

5.6 NHS Number & General Medical Practice Code Validity

University Hospitals of North Midlands NHS Trust submitted records to the Secondary Uses System (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. This is a single source of comprehensive data which enables a range of reporting and analysis in the UK. The figures below are for the period April 2021 to January 2022 which reflects a marginal improvement in NHS Number. The percentage of UHNM records in the published data which included the patient's valid **NHS number** was:

- 99.9% for admitted patient care; national performance is 99.6%
- 99.9% for outpatient care; national performance is 99.7%
- 99.2% for accident & emergency care; national performance is 95.4%

Valid **General Medical Practice Code** performance is:

- 100% for admitted patient care; national performance is 99.7%
- 100% for outpatient care; national performance is 99.6%
- 100% for accident & emergency care; national performance is 98.8%

Trust performance for GMP Code remains higher than the national average.

5.7 Clinical Coding Accuracy Rate

The annual internal Data Security & Protection Toolkit (DSPT) clinical coding audit took place during 2021/22, achieving an overall 'mandatory' rating in all areas of the audit and 'advisory' in 2 of the 4 areas audited. Percentage accuracy has improved significantly in one of the four areas since last year (Primary Procedures). All recommendations from the 2020/21 audit have been actioned. The Trust's Clinical Coding auditors carried out this year's audit.

The internal Staff Audit Programme continues for all coding staff. The audit process has been revised and updated for 2022/23.

The Trust has a qualified Clinical Coding Trainer who has established a 2 year training programme for trainee coders and in-house workshops for existing staff. In addition, they provide all mandatory national training, ensuring all coders are compliant with training requirements.

U-codes (no associated income due to missing information) have remained low throughout 2021/22, reporting a monthly average of 3.3%, a slight reduction from 2020/21.

5.8 Data, Security & Protection (DSP) Toolkit Attainment Levels

The Data, Security and Protection Toolkit is a self-assessment, seeking assurance all standards supporting the integrity, confidentiality and availability of information have been achieved. The toolkit continues to evolve by incorporating best practice guidance; thereby ensuring continuous improvement in the Trust's DSP posture.

The COVID pandemic required a revision of the yearly submission dates from 31st March 2021 to 30th June 2021 in recognition of the pressures NHS Trusts were facing. The Trust submitted its final assessment declaring all standards had been achieved except for one. An improvement plan was developed and approved by NHS Digital with confirmation all actions will be implemented by December 2021. The Trust's initial rating of 'standards not fully met (plan agreed)' was updated to 'standards fully met' in January 2022 following implementation of the action plan.

This year NHS Digital has confirmed the submission date will be 30th June 2022. To support the Trust with its assessment an internal audit review has been scheduled for May 2022, the findings of which will be reported to the newly formed Executive Digital and DSP Group. Areas for improvement will be monitored via an improvement plan with monthly reporting to the Executive Digital and DSP Group. As in previous years, if the Trust does not achieve all standards, the Trust's rating will be classified as 'Standards not fully met (plan agreed)' and an improvement plan will be submitted to NHS Digital, for their approval. The Executive Digital and DSP Group will continue to seek assurance on the Trust's DSP toolkit position, thereby providing assurance to the Trust Board, via the Performance and Finance Committee.

5.9 Seven Day Services

The seven day services standards were established to ensure that patients admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. Ten clinical standards for seven day services in hospitals were developed and four of these subsequently identified as priorities on the basis of their impact on patient outcomes.

These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

The importance of ensuring that patients receive the same level of high quality care every day is reflected in the inclusion of these standards in the NHS Standard Contract. The Care Quality Commission's (CQC) current hospital inspection regime features 7DS under the effective key question.

In response to UHNM's consistent compliance with the standards, an assurance framework was developed which moved away from large scale audits to an overview of performance supported by a more focused review process. A further revision of Guidance in February 2022 simplified the expectations around the Board Assurance Framework and gave additional examples of evidence that can be used to support this. Our existing framework is fully aligned to the new guidance. We continue to undertake targeted specialty level audits supported by performance data, local delegations of authority under standard 8, and evidence of appropriate staffing levels. UHNM continues to meet the 4 high priority standards; improvement work is focused around process and clinical record keeping and assurance of agreed local practice in respect of further demonstration of compliance with standards 8.

Part B: Review of Quality Performance

6. Quality Priorities 2020/21

In 2020/21, in partnership with our stakeholders we identified 3 specific priorities to focus on:

- To continue to improve safe care and treatment to patients
- To improve staff engagement and well being following COVID-19 pandemic
- To improve patient experience

Details of our performance against these priorities are provided in the following pages.





Priority 1: To continue to improve safe care and treatment to patients

Quality, safety and patient experience remains our number 1 priority and our strategy confirms our relentless commitment to the elimination of error, to systematic promotion of safety, embracing wholeheartedly learning from our mistakes and those of others, changing our clinical services to improve the outcomes for patients and the delivery of excellent clinical results.

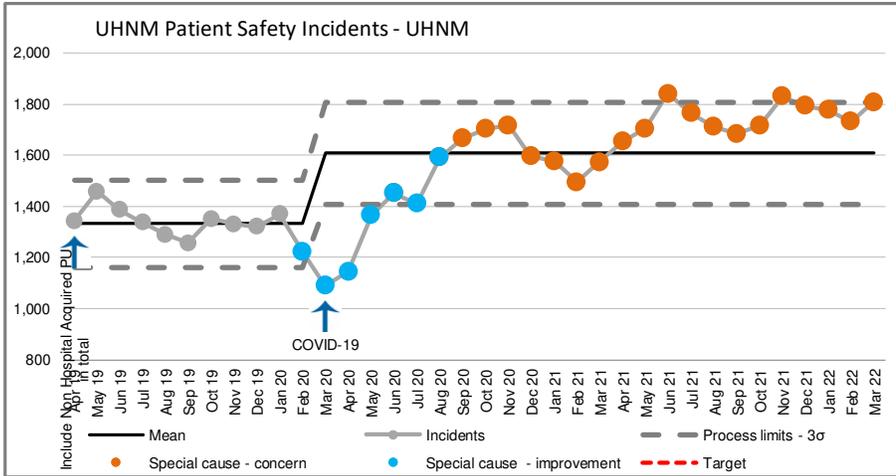
We said we would achieve this by

- Improve sepsis treatment and recognition of deteriorating patients
- To evaluate and reduce long waiters following the COVID-19 pandemic
- To support the Recovery & Restoration Plan across the health economy
- Ensure that services follow appropriate infection prevention guidance and continue to be COVID-19 secure
- Aim to reduce patient falls resulting in low harm or above by a further 5% from 2020/2021 baseline
- Aim to reduce total numbers of Category 2 to 4 Pressure Ulcers, unstageable pressure ulcers and deep tissue injuries developed under UHNM care by 10% from 2020/2021 baseline.
- Evaluate and introduce new technologies and techniques for treating patients.
- Improve the number of reported medication errors and associated training in medication safety
- Delivering the Improving Together Programme

Performance against this priority and its aims has been monitored during 2021/22 using a range of key indicators. The following section provides a summary of the performance for these indicators and what these results mean for our patients.

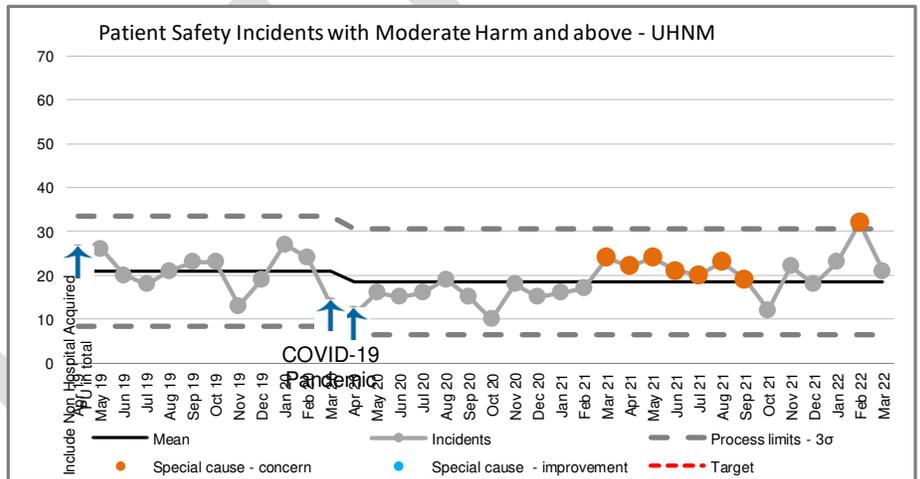
Patient Safety Incidents

We continue to aim to reduce harm to our patients. A key indicator of this is the number of patient safety incidents* reported and the rate per 1000 bed days and the number and rate of patient safety incidents with moderate harm or above. The charts below illustrate the monthly totals for these indicators.



15% increase in total reported Patient Safety Incidents from 2020/21 to 2021/2022. Increased reporting is an indication of an open and improved reporting culture

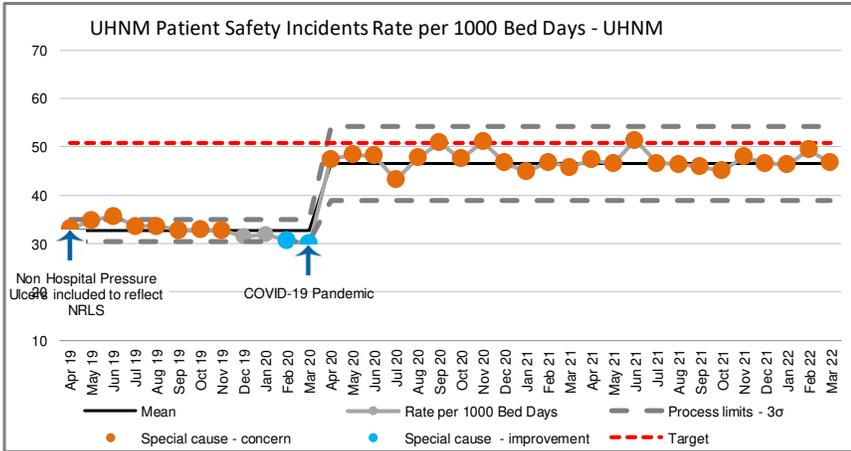
33.8% increase in total reported Patient Safety Incidents with harm 2020/2021 to 2021/2022



Total reported patient safety incidents have increased during 2021/2022 compared to 2020/2021 as the Trust has continued to promote positive reporting of adverse incidents. The rate of reported incidents has however remained relatively stable with a slight reduction in 2021/2022 with a rate of 47.2 patient safety incidents per 1000 bed days compared to 47.4 in 2020/2021.

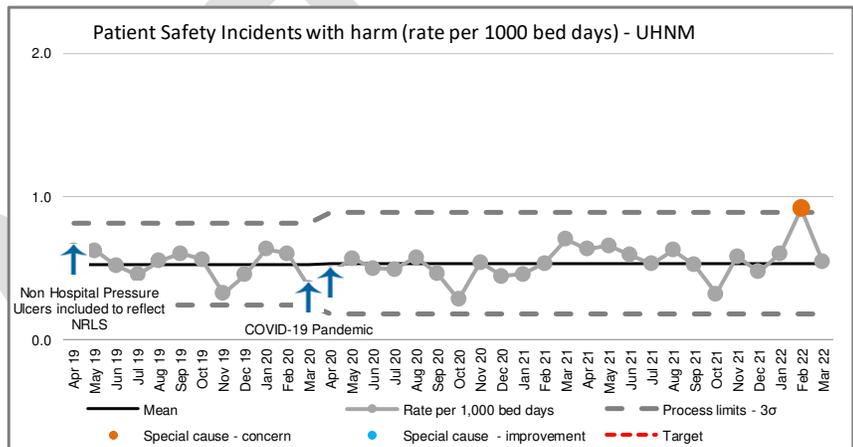
However, whilst there have been increased numbers of patient safety incidents reported as resulting on moderate harm or above during 2021/2022 the rate of patient safety incidents resulting in moderate harm or above is the same in 2021/2022 as 2020/2021 at 0.5 incidents per 1000 bed days. The increase in total numbers is partly explained by the increase in hospital activity during 2021/2022 compared to 2020/2021 as the Trust, and the country, moved out of the COVID-19 pandemic and more hospital services were reopened.

This is important as the increased reporting of patient safety incidents are related to low or no harm. Reporting of low and no harm incidents is indicator of positive reporting culture and staff awareness of need and benefits of reporting incidents to see improvements and reductions in the level of harm.



0.2% decrease in rate of reported Patient Safety Incidents per 1000 bed days from 2020/21 to 2021/22

Rate of reported Patient Safety Incidents with moderate harm per 1000 bed days in 2021/22 has same mean rate (0.5) as 2020/21



6 reported Never Event during 2021/22

Never Events

UHNM has introduced strong systems to allow for the reporting of adverse incidents to ensure lessons are learnt whenever possible. During 2021/22, we have reported 6 Never Events which compares to 1 reported in 2020/21. The following provides a summary of the reported Never Events (month reported as Never Event on STEIS) together with any identified learning following the completion of the incident review to prevent recurrence.

2021/25043 Retained foreign object post procedure (December 2021)

Identified that after initial checking that a small swab was unaccounted for following further checks within Theatres. X ray confirmed swab retained and consent obtained to remove retained swab via local anaesthetic.

- Trust policy C07 amended to ensure that an additional count is undertaken between the Scrub Practitioner and another Theatre Practitioner following completion of the procedure but prior to disposal of the remaining swabs/suture needles.
- All members of the multidisciplinary team have been made aware of the amendments to policy C07.
- Harm free care alert has been circulated to ensure learning from this incident is shared.
- New Theatre Induction training package being developed (April 2022) by Theatre Practice Development Team for new staff to raise awareness of relevant policies and standards.

2021/25872 Wrong site Surgery (December 2021)

The patient attended Central Treatment Suite and a punch biopsy on the right anterior nostril was performed which contravened what the patient was listed for on the operating list. Following the procedure the patient highlighted that the incorrect lesion had been removed.

- Where more than one lesion is present, clinical photography or use of the Consultant Connect App must be undertaken during the consultation which can then be used as reference with the patient on the day of the procedure during the consent process.
- The LocSSIP safety checklist has been amended to include an additional step whereby the patient is asked to confirm the surgical site marking prior to the procedure
- A stop moment must occur prior to commencement of the procedure to ensure that consent, procedure, side and side are checked against the theatre list and verbally confirmed by the Operating Surgeon and patient (if procedure occurring under local anaesthetic).
- Observational audits to be undertaken to provide assurance that staff are adhering to the revised processes

2022/1446 Retained foreign object post procedure (January 2022)

Following operation to stabilize spiral fracture to distal tibia and fibula, post operative x rays were undertaken to check fixation and incidental finding of the x ray noted that there was a radio opaque filament of thread evident. Clinical decision to leave the sterile material and no infection. Patient informed of the incident and plan to monitor wound for infection. The root cause for this incident is that the drill had contact with the swab during the procedure which caused the radiopaque thread to be retained within the surgical wound.

- Issue with retained thread and fraying swabs have been reported to the MHRA and awaiting feedback

2022/5020 Incorrect Implant/Prosthesis (March 2022)

Following injury to right humerus, operative fixation undertaken and used reconstruction plate rather than intended LCP plate. Noted that plate had slight bend and treated conservatively. 6 weeks post procedure x ray confirmed break to bilateral aspect of the plate. Underwent further operation to repair the failed plate.

- Reconstruction plates have been removed from the operation sets and are now being stored separately.
- Learning alert issued to all relevant staff within Theatres and Trauma & Orthopaedic Directorate

2022/5023 Wrong site surgery (March 2022)

Patient underwent excision for multiple mole biopsies. Patient later reported that incorrect lesion had been removed from shoulder/back area. Correct lesion removed at follow up appointment

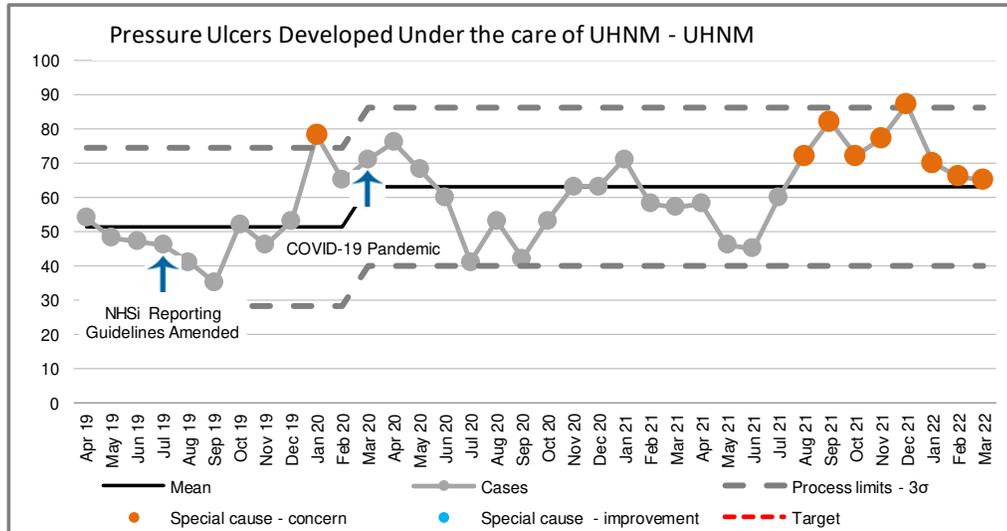
- All staff advised to look at clinical photographs (if available) prior to procedure being carried out
- Laptop available in second minor op room so that patient is in the same room when clinical photographs are being viewed
- Patient to point to area that is to be removed, mirrors to be used if this is on the back. Especially important if no photographs available. If any doubt on location, referring Dr to be consulted. If this is not possible, surgery to be rescheduled.

2022/5030 Wrong implant/prosthesis (March 2022)

A closed ante grade intramedullary nailing of left femur performed with no intra operative issues. After the procedure had been performed, it was identified that a different sized locking bolts used. Reviewed by Consultant Surgeon and discussed with patient that no impact on outcome and patient was fully weight bearing and mobilizing 2 days post surgery.

Pressure Ulcers developed under UHNM Care

We have seen an increase in Pressure Ulcers developed whilst under the care of UHNM. During 2021/22 there were 800 reported pressure ulcers developed at UHNM compared to 705 in 2020/21. This equates to 13% rise in identified pressure ulcers.

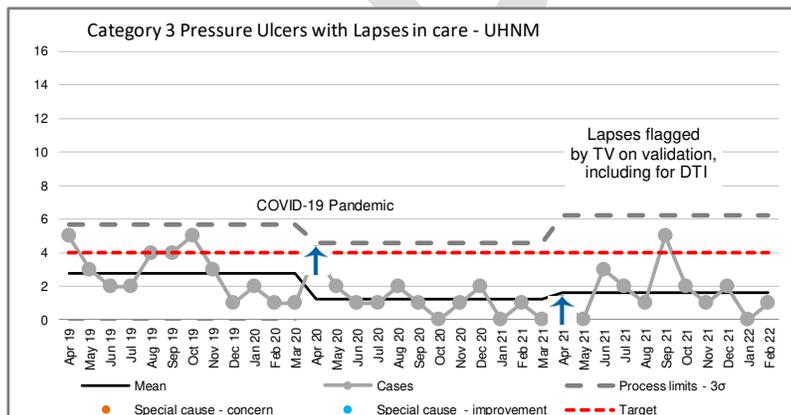
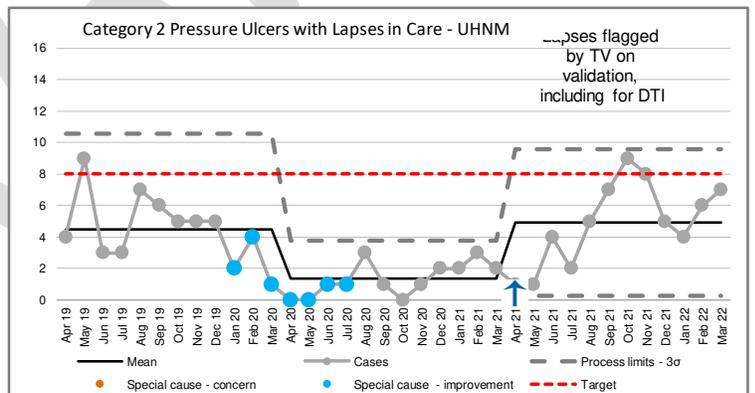


13% increase in reported Pressure Ulcers Developed whilst under care of UHNM

0 Category 4 Hospital Acquired Pressure Ulcer with lapse in care identified during 2021/22

However, there have been reductions in different Categories of Pressure Ulcers which have had lapses in care identified during 2021/22. Whilst there have been increases in Category 2 there are reductions in Category 3 and Category 4.

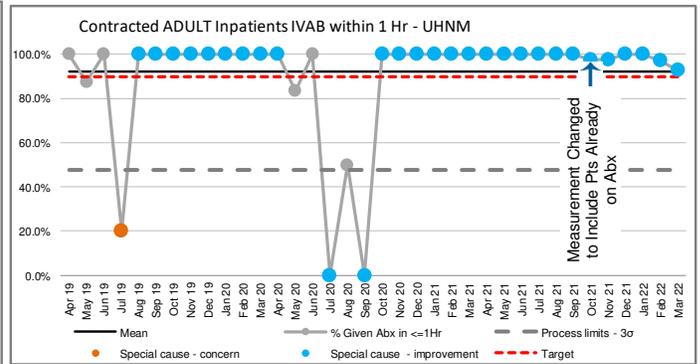
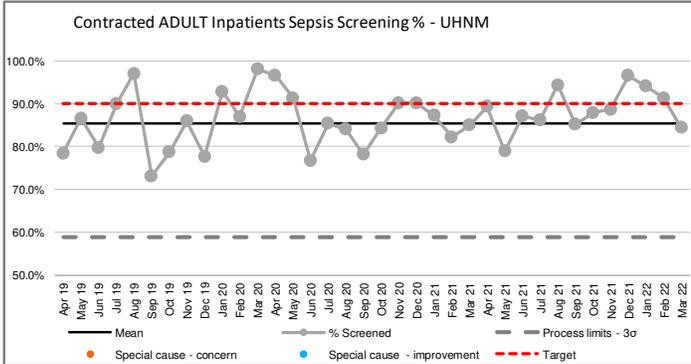
59 Category 2 Pressure Ulcers with 'lapses in care' in 2021/22 increased compared to 16 in 2020/21



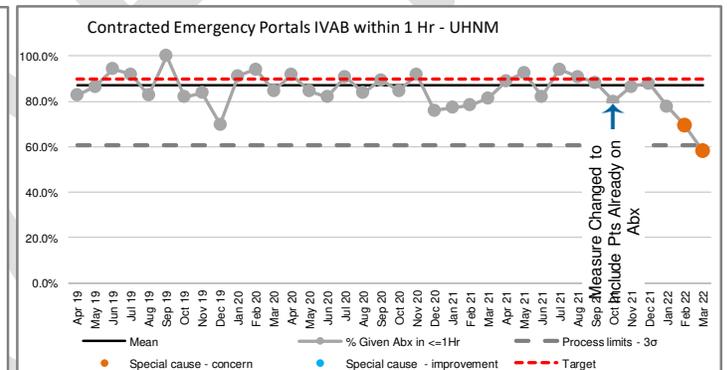
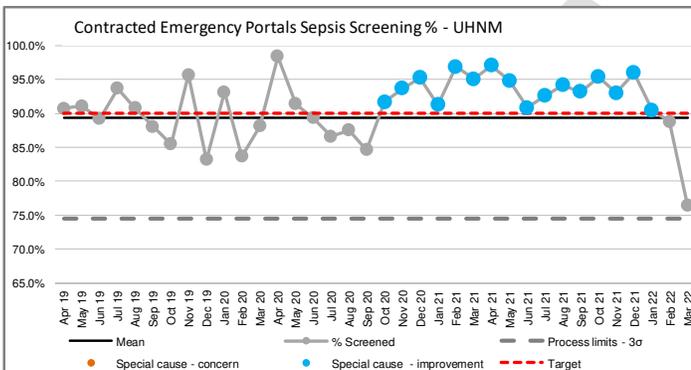
Further 20% reduction in Category 3 Pressure Ulcers with 'lapses in care' in 2021/22 compared to 2020/21 following 63% reduction in 202/21 from 1919/20

Sepsis Recognition and Treatment

Inpatient areas have seen improvements in both screening and Intravenous Antibiotics (IVAB) in 1 hour during 2021/22. Sepsis screening improved from 85.9% in 2020/21 to 87.85%. Likewise the IVAB in 1 hour has improved from 93.3% to 99.1% Speaking Up Index score has improved year on year



Emergency Portals have seen improvements in screening but reductions in IVAB in 1 hour during 2020/21. Sepsis screening increased from 91.8% in 2020/21 to 92.35%. However, the IVAB in 1 hour has increased from 84.3% to 84.65%.

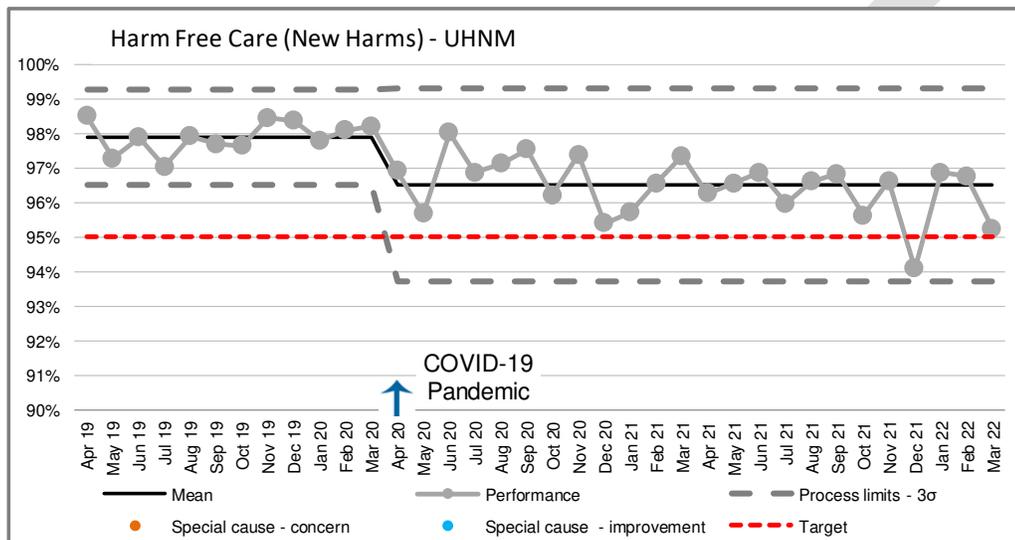


The UHNM Sepsis Team has continued to support and raise awareness to all levels of clinical/medical staff in emergency portals and in-patient areas at both sites to continue to embed the sepsis pathway and improve sepsis screening and antibiotic timeliness.

Harm Free Care (New Harms)

The national target for Harm Free Care (New Harms) is 95% and UHNM have exceeded this target during 2021/22 with average rate of 96.2% (refer to chart below). The results are gathered during the monthly Safety Thermometer assessments where all UHNM Inpatients are reviewed on 1 day of the month to assess whether they have experienced harm from a fall, pressure ulcer, pulmonary embolism/deep vein thrombosis or catheter associated urinary tract infection during their current inpatient admission. These results are reported nationally on monthly basis.

The mean rate for 2021/22 has varied and there have been decreases compared to 2020/21 (96.7%) but the Trust has continued to exceed the national target despite the continued challenges the organization has faced during the second year of COVID-19 pandemic.



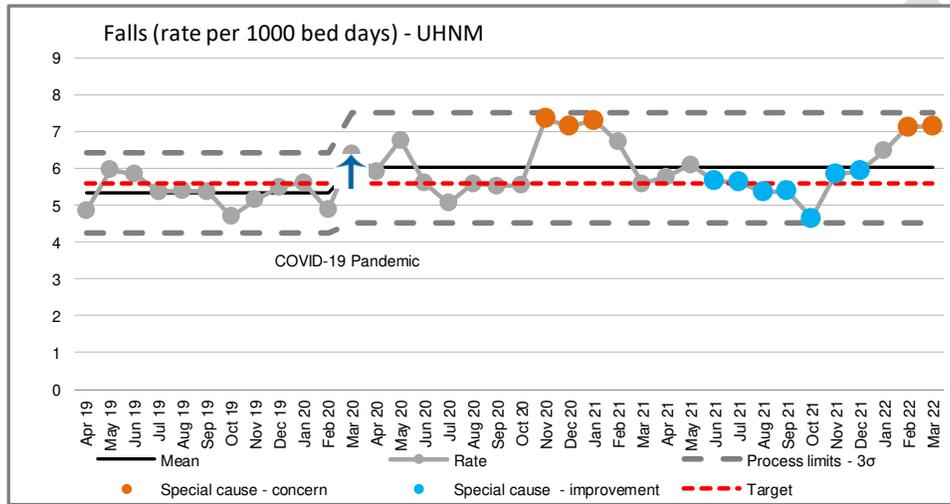
Exceeding the 95% National Target for Harm Free Care (New Harms) throughout 2021/22

Average Rate 96.2%

Patient Falls

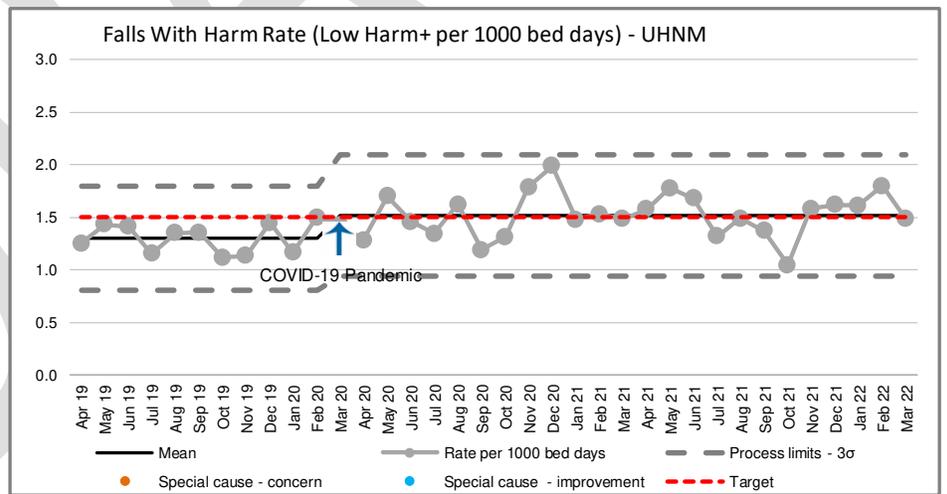
Patient Falls have increased in total numbers in 2021/22 compared to 2020/21 with 2637 and 2388 respectively. This equates to 10.4% reduction. In order to be able to account for changes in activity the Trust uses the patient falls rate per 1000 bed days. During 2021/22 the overall rate was 5.9 compared to 6.2 in 2020/21 and 5.4 in 2019/20. During COVID-19 pandemic there have continued to be challenges and during 2021/22 there has been increases in activity compared to 2020/21 but activity levels are below pre COVID-19 pandemic levels.

The Royal College of Physicians national average for acute NHS Trusts from previous national audit report is 5.6 falls per 1000 bed days.



4.8% decrease in rate of reported patient falls in 2021/22 compared to 2020/21.

0.6% increase in rate of harm to patients as result of falls per 1000 bed days in 2021/221 with 1.53 compared to 1.52 in 202/21

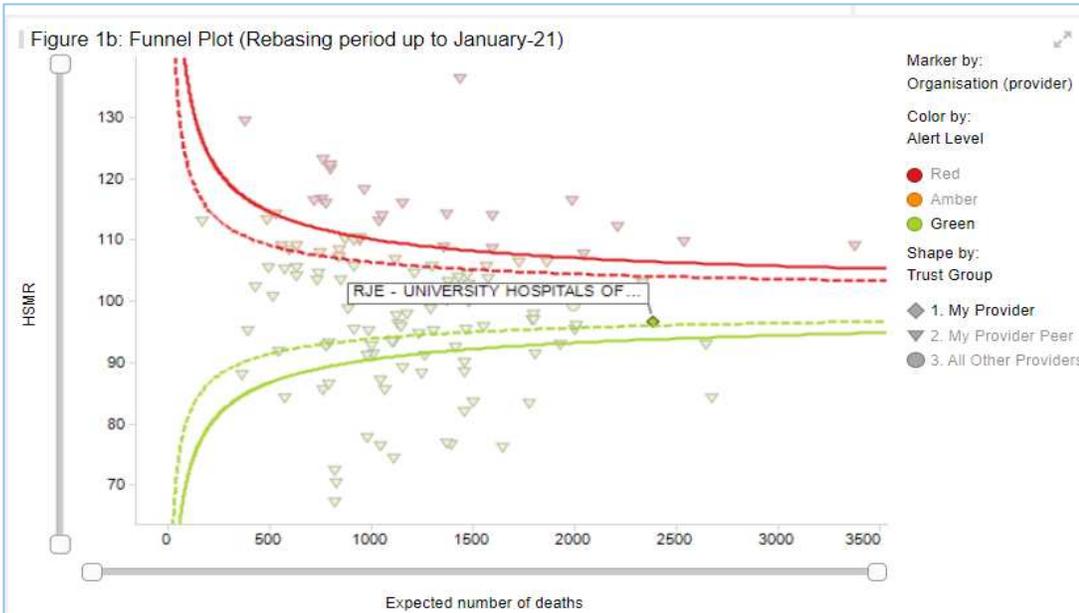


There have been increases in both the total numbers and rate of patient falls that have resulted in harm. This is important as the aim was to reduce harm from falls by 10% whilst encouraging incidents to be reported.

Total falls with harm have increased by 6%, with 680 in 2021/22 compared to 587 in 2020/21 and 631 in 2019/20. This has also seen the rate of falls with harm increase by 0.6%.

Mortality

Our mortality rate with the current 12 month rolling HSMR score (Feb 2021 – Jan 2022) is 96.60. This means that UHNM’s number of in hospital deaths is less than the expected range based on the type of patients that have been treated. This compares to 96.93 for 2020/21.



UHNM continues to compare well against peers during 2020/21 and is better than expected based on standardized casemix

To calculate mortality we use a system called Hospital Standardised Mortality ratio (HSMR). HSMR is a system which compares a hospital’s actual number of deaths with their predicted number of deaths. The prediction calculation takes account of factors such as the age and sex of patients, their diagnosis, whether the admission was planned or an emergency. If the Trust has a HSMR of 100, this means that the number of patients who died is exactly as predicted. If the HSMR is above 100 this means that more people died than would be expected, a HSMR below 100 means that fewer than expected died.

The Summary Hospital-level Mortality Indicator (SHMI) is a measure of mortality, developed by the Department of Health, like HSMR this measure compares actual number of deaths with our predicted number of deaths.

Like HSMR the prediction takes into account factors such as age and sex of patients and their diagnosis. The current SHMI value for the Trust is 1.03 (as expected). This is a rolling 12 month measure and covers the period January 2021 – December 2021. The value for 2020/21 was 1.07.

Why are the two measure different?

Although similar the measures are not exactly the same, one of the reasons that the SHMI is different is because unlike HSMR it looks at patients who die within 30 days of leaving hospital.

Learning from Deaths Mortality Reviews

During 2021/22, we continued to use our online Mortality Review Proforma to allow in hospital deaths to be electronically reported following review of the patient death and included the outcomes of these reviews within Mortality Summary Report presented at the Trust's Quality Governance Committee and reported to the Trust Board.

Of 3444 inpatient deaths during 2021/22 (Apr 21 to Mar 22) 2115 patients have been reviewed (61%)

Overall number of reviews submitted during 2021/22 to date is 2785

These reviews required reviewing clinicians to assess the care provided prior to death using the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) A-E categories. In addition, from December 2017, we adopted a more detailed review proforma based on the Royal College of Physicians Structured Joint Review form.

During April 2021 – March 2022¹, the Trust have completed 2115 online proformas for hospital deaths recorded during 2021/22 (61%). Each one of these deaths is assessed to classify the level of care the patient received (some reviews completed by the Nosocomial COVID-19 panel require the scoring to be confirmed by the parent specialty). The overall number of mortality reviews submitted during 2020/21 is 2785. Completion of the reviews has been impacted by COVID-19 pandemic and during 2021/22 there will be further reviews undertaken of hospital onset COVID-19 related deaths.

It should be noted that the mortality reviews are currently ongoing and these figures relate to deaths in 2021/22 that have also had completed reviews submitted by 3rd May 2022. There are deaths that are still being reviewed as part of the Trust's local Mortality & Morbidity Review meetings but whilst the deaths may have occurred in 2021/22 the reviews will be completed in 2022/23.

	2021/22 Total		Q1		Q2		Q3		Q4 ²	
Total Number of Deaths in reporting period	3444		682		870		987		905	
Total Number of Deaths in reporting period reviewed (% of total deaths)	2115	61%	548	80%	607	70%	600	61%	360	40%
Total Number of reviewed deaths with suboptimal care identified – NCEPOD grade E (% of reviews)	0	0%	0	0%	0	0%	0	0%	0	0%

* The Royal College of Physicians removed the scoring system on preventability following a national pilot. UHNM continue to use the NCEPOD classification system:

- A: Good practice - a standard that you accept for yourself
- B: Room for improvement - regarding clinical care
- C: Room for improvement - regarding organisational care
- D: Room for improvement - regarding clinical & organisational care
- E: Less than satisfactory - several aspect of all of the above

A summary of the learning identified from the completed mortality reviews is provided below and does not just relate to those deaths where suboptimal care has been identified. The learning relates to where improvements can be made but did not directly contribute to a patient's death.

¹ As at 03/05/2022

² As at time of updating the list of inpatient deaths ran up to March 2022 deaths.

The following provides a summary of issues identified during the Structured Judgement Review process that could be improved (for SJRs submitted during 2021/22 where overall scores were for very poor, poor or adequate care and/or where problems in care identified):

- Delays in CT scans impacting patient care
- Inappropriate patient transfers impacting on patient care
- Importance of communication with families around DNAR and End of Life Care; including timely discussion of these with the patient when it's recognized that they're approaching end of life, timely uploading of these into medical records and ensuring relatives are given time to make decisions and establishing ceilings of care for patients
- Importance of completing key documentation in timely and accurate way, including updating and signing of care records, medication charts and scoring tools, fluid balance charts, Cause of Death and discharge summaries
- Importance of consulting senior colleagues if unsure regarding appropriate treatment of patient
- Importance of timely monitoring and review of patients manner and for escalation to senior clinicians for review where appropriate especially re fluid balance, hypoglycemia and during dialysis
- Medication issues including accuracy of prescription calculations (taking into account patient's weight), appropriate management of anticoagulation during chemotherapy, and consideration of switching to alternative routes of administration, timeliness of administration and review of medication (especially antibiotics and anticoagulants) and the timeliness of prescribing
- Should always ensure full history is checked when clerking patients to inform care
- Importance of access to imaging to inform care and timeliness of reviewing imaging reports
- Timeliness of carrying out blood tests to inform care
- Timeliness of drain insertions

Hospital Acquired Infections

The Trust continues to strive to reduce the number of avoidable hospital associated infections. Two of the key infection associated indicators that are used are Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C Diff). During 2021/22, we have seen slight increases in like for like numbers compared to 2020/21 for Clostridium Difficile.

Indicator	2020/21 Target	2020/21	2021/22
To reduce C Difficile infections	96	107	112
To reduce MRSA infections (Trust apportioned)	0	4	7



Priority 2:

To improve staff engagement and well being following COVID-19 pandemic

We said we would do this by:

- To support the introduction of the Trust's Wellbeing Programme and activities that focus on staff wellbeing and empowerment
- Ensure that staff are working within COVID-19 secure environments and support provided to staff
- Support staff and services in providing care in 'new ways' following COVID-19
- Promote mental health wellbeing and support
- Delivering the Improving Together Programme
- Introduction of Shared Governance

Performance against this priority and its aims has been monitored during 2020/21. The following section provides a summary of the performance for these indicators and what these results mean for our patients.

Freedom to Speak Up

The Trust has continued to promote our speaking up routes and support available from our Freedom to Speak Up Guardians. Our Lead Freedom to Speak Up Guardian provides quarterly reports to the Transformation and People Committee and Trust Board on speaking up themes raised and actions taken.

Actions taken in 2021/22:

- Introduced Speak Up and Listen Up training into our statutory and mandatory training programmes for all staff. The training was launched during October's 2021 Speak Up Month and is based on the resources released by the NGO and Health Education England. The Speak Up, Listen Up training will give all staff and understanding of the importance of speaking up and how to speak up, whilst the listen up elements equip line managers with the skills to respond effectively when issues are raised to them and to create a speaking up culture in their teams.
- Completed the actions from the 2020 Internal Audit review into our speaking up arrangements undertaken by KPMG. The Audit had provided an assessment of 'significant assurance with minor improvement opportunities'.
- Launched 'Staff Voice'. The Staff Voice survey has been developed internally as a method of receiving more frequent feedback from staff than offered by the annual National Staff Survey, and is an additional route for staff to voice their experiences in the organisation. The survey was launched on 1st of June 2021, and runs for the first 10 days of each month. It is completely anonymous.
- Increased FTSU Guardian resource, with the recruitment of a full time Guardian in February 2022

Our Speaking Up Index score has improved year on year (although this indicator will not continue beyond 2021):

Year	UHNM Index Score
2021	76.8%
2020	75.5%
2019	74%

A new question was introduced to the 2020 NHS Staff Survey specifically relating to a speaking up culture. Our 2021 data shows a deteriorated position, however this is also reflected across the average for acute trusts which also fell by over 5 percentage points:

Question	Average for Acute Trusts	UHNM 2021 Result	UHNM 2020 Result
I feel safe to speak up about anything that concerns me in this organisation	60.7%	58.5%	63.6%

An additional new question was introduced to the 2021 NHS Staff Survey to complement this question, being:

Question	Average for Acute Trusts	UHNM 2021 Result
If I spoke up about something that concerned me I am confident my organisation would address my concern	47.9%	45.7%

- During 2021/22 over 140 individuals raised issues through our speaking up routes, another year on year increase
- Our Speaking Up Policy is reviewed annually and was updated during 2021 to include a recommendation from an NGO case review, to state that reporters of concerns are involved in the development of terms of reference for speaking up fact find investigations
- Refreshed our Speaking Up page on the Intranet to highlight the routes available to raise issues quickly and constructively
- Promoted safe speaking up channels available to those staff whose voices are not so often heard through engaging with our Staff Voice Networks and we monitor the demographic details of speaking up contacts to ensure that they are representative of our workforce
- The Trusts Lead Freedom To Speak Up (FTSU) Guardian, supported by two voluntary FTSU Guardian roles and a network of Employee Support Advisors who are representative of our workforce in terms of ethnicity and other protected characteristics
- The FTSU Guardians have ready access to senior leaders and others to enable rapid escalation of issues, maintaining confidentiality as appropriate
- The Trust has named Executive and Non-Executive Leads for speaking up
- Enhanced our Disciplinary Policy to include the 4 Step Restorative Practice model, to complement the Just and Learning Culture approach
- Ensured that learning from National Guardian Office case reviews are implemented within the organisation

2021 NHS Staff Survey – The National Context and Trust Outcomes

The 2021 NHS Staff Survey was carried out between September and December 2021 and the Trust response rate was 43% (44% in 2020).

The Annual NHS Staff Survey was open to all staff and 4749 took part (4699 in 2020). The national average for the benchmark group (acute and acute & community trusts) is 46%. It should be noted that the published Staff Survey report is based on a sample population of 1250, regardless of the number of staff surveyed. Also, data in the national results is weighted to reflect the distribution of staff according to staff group.

The key focus of actions will be to address behaviours, possibly targeted as specific groups or hotspots. We will be developing a resolution policy on how to address issues via an informal footing, but within a specific framework. Issues around behaviours are linked to the two corporate risks and also impact on recruitment and retention.

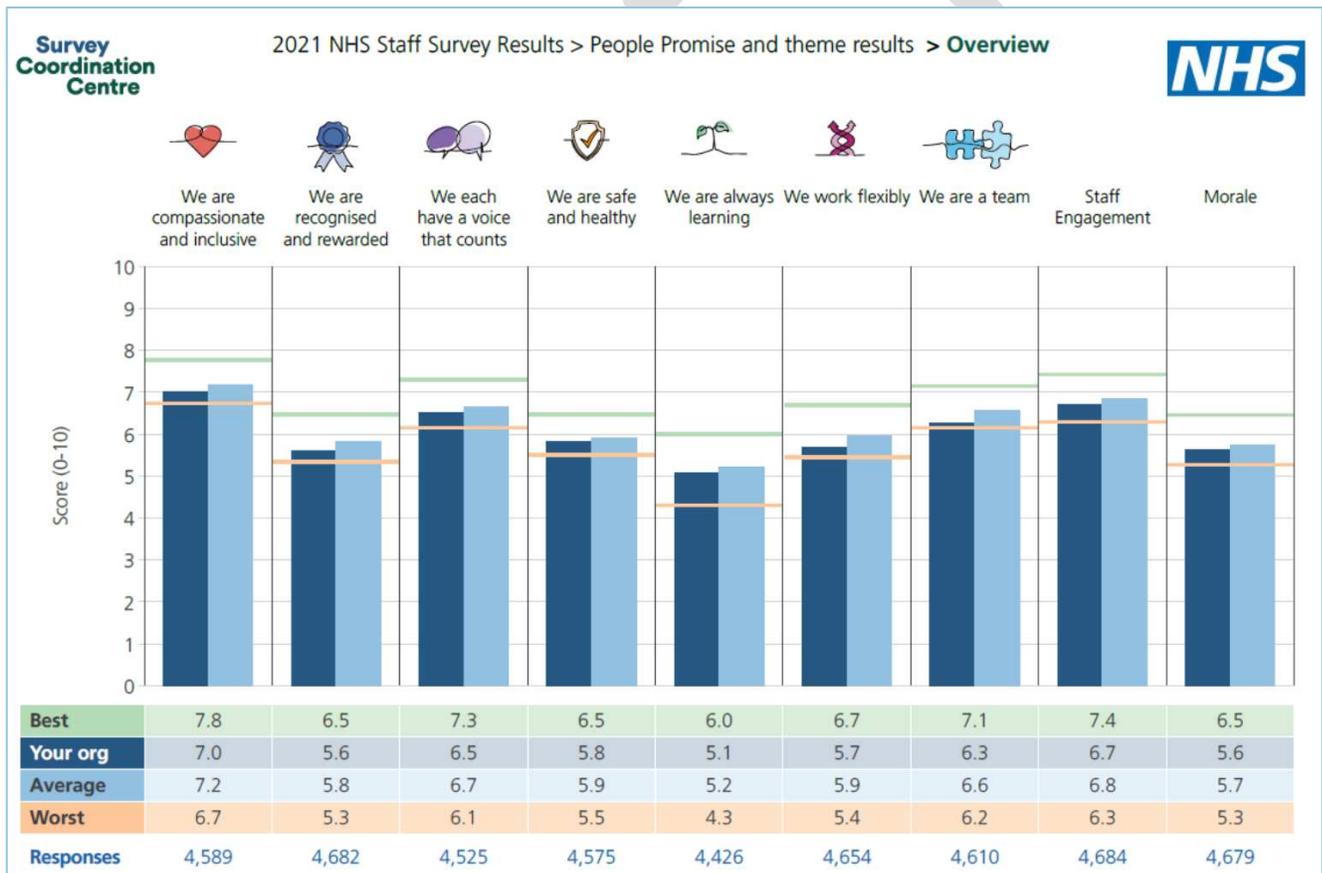
For 2021, the results of the NHS Staff Survey are now measured against these seven People Promise elements and against the two themes ‘Staff Engagement’ and ‘Morale’ which have been reported in previous years. However, this does mean that historic trend data is not available for many of the questions asked in the Survey

- Against the 7 People Promise themes, this Trust scored lower than national average on each theme.
- At 6.7, the staff engagement score reduced slightly in line with an overall reduction in the benchmark group results. The Trust remains just below the acute trust average of 6.8 and this position is unchanged from the previous year.
- Staff morale also reduced in line with an overall reduction in the benchmark group results. At 5.6, the Trust’s score remains just below the acute trust average of 5.7 and this position is also unchanged from the previous year.

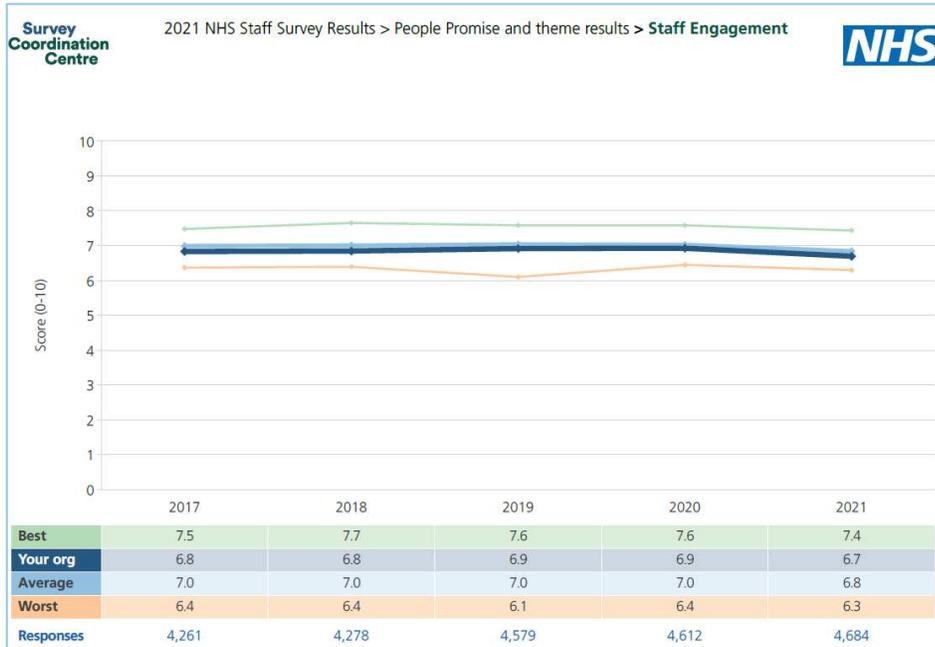
Although the results are below average, the trajectory has followed the benchmark group

The following table presents an overview of the 7 themes, staff engagement and morale scores and compares this Trust’s results to the national average for our benchmarking groups, and indicating the scores of the best and worst performing acute trusts.

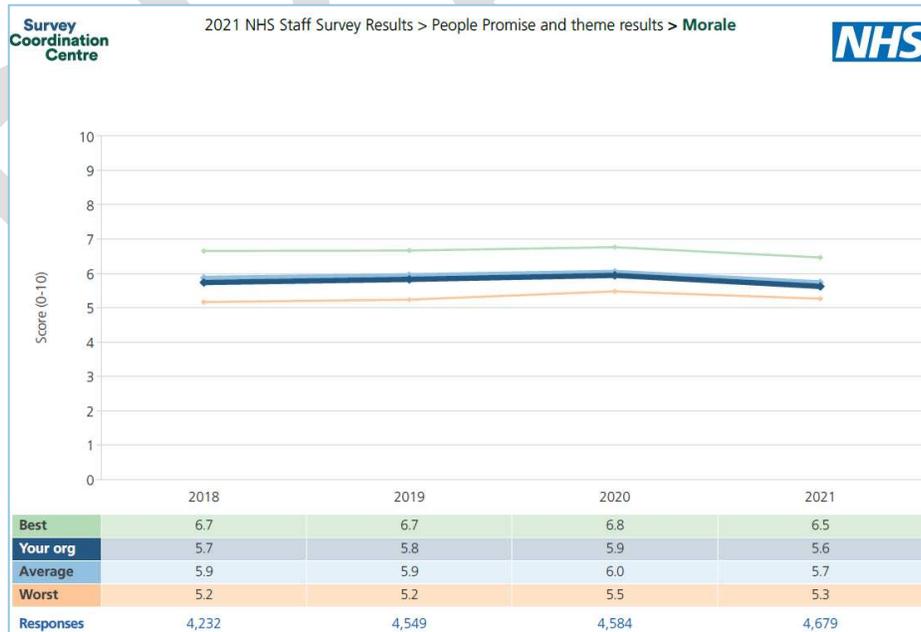
This Trust scored lower than national average against all 7 themes, as well as staff engagement and morale.



Staff engagement – At 6.7, the staff engagement score reduced slightly, as did the score for the benchmark group overall. The Trust continues to remain just below the acute trust average score.



Staff morale – Overall, the benchmark group results reduced compared to 2020 and the Trust’s score also experienced a reduction in line with that trend. At 5.6, the Trust’s score remains just below the acute trust average of 5.7, as it did in 2020.



The local Staff Voice survey indicates there can be inconsistency in how staff feel:



This is demonstrated in more detail by the factors which comprise the local staff engagement rate



Adverse staff behaviours increase the risk to the Trust’s culture, values and aspirations, impacting on patient care, increasing staff disengagement and affecting performance as well as having an adverse effect on our ability to recruit and retain staff.

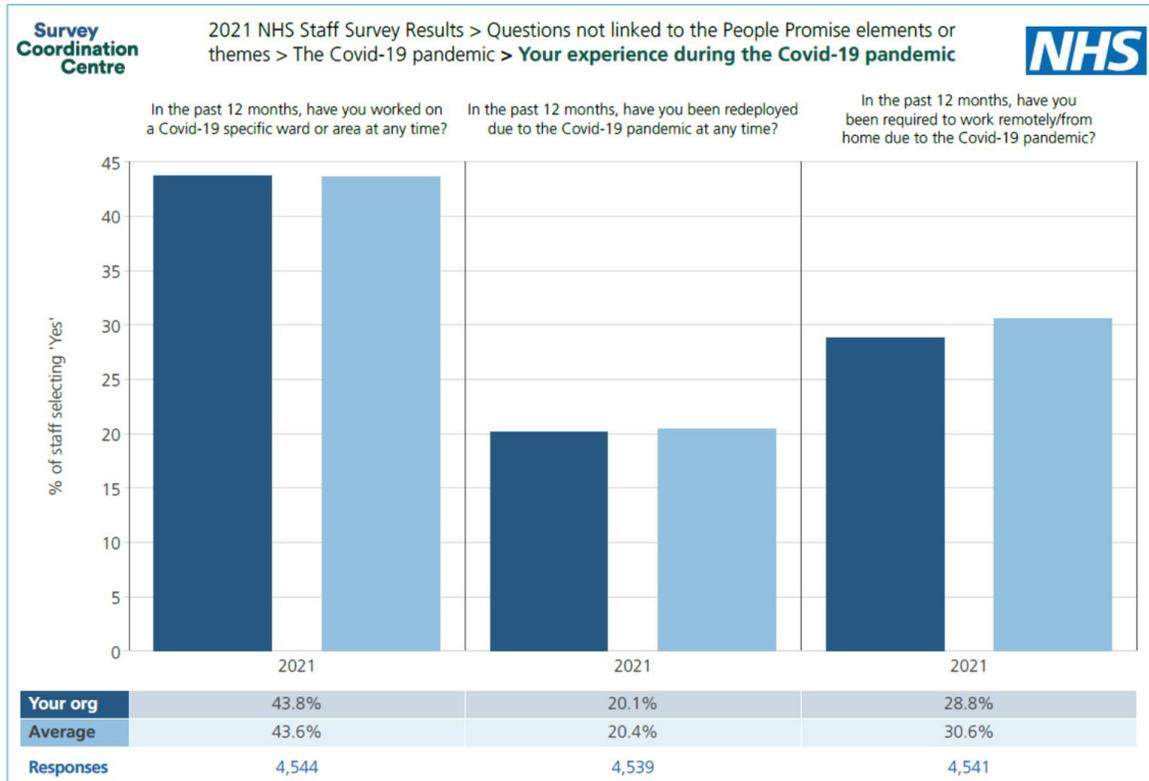
Staff experience during Covid-19

In the 2021 Staff Survey, staff were asked 3 questions relating to their experience during the Covid-19 pandemic:

- a) In the past 12 months, have you worked on a Covid-19 specific ward or area at any time?

- b) In the past 12 months, have you been redeployed due to the Covid-19 pandemic at any time?
- c) In the past 12 months, have you been required to work remotely/from home due to the Covid-19 pandemic?

There was little distinction between the Trust results and the average for the benchmark group, except that, when compared to the benchmark group, slightly fewer Trust staff said they had been required to work from home due to the pandemic



Next Steps

The improvement activities follow on from the 2019 and 2020 Staff Surveys, when we set out the key areas of corporate focus planned for 2020/21. The pace at which change has been delivered in many areas has been impacted by the Covid pandemic and the need for staff to work clinically and in patient facing areas. Key developments such as the Enable programme and other important leadership activities have understandably stalled whilst the focus has been on supporting the operational delivery of services and patient care and staff wellbeing.

We did not achieve the goal of being above average in terms of Staff Engagement by the 2021 Survey, although the aspiration to be in the top 20% of Trusts by 2023 remains



Priority 3: To improve patient experience

We said we would do this by:

- Utilise patient and visitor feedback
- Seek wider engagement with 'harder to reach' patient groups
- Review patients experiences during COVID-19 and identify positive changes to adapt service provisions
- Review the different ways that patient experience and views are gathered and acted upon within UHNM

Performance against this priority and its aims has been monitored during 2020/21. The following section provides a summary of the performance for these indicators and what these results mean for our patients

University Hospitals of North Midlands aspires to achieve a culture where the voice of our patients, their carers and families is at the heart of all that we do and we believe that patients can be equal partners in creating positive changes through identifying where barriers and challenges exist in our systems.

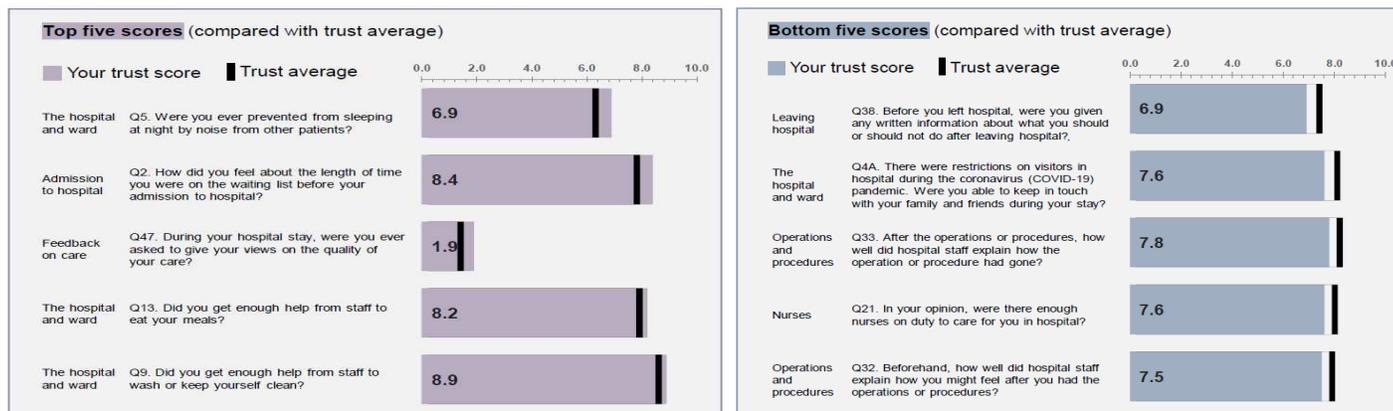
The Trust has also worked in partnership with stakeholders on quality improvement activities including:

- Hospital User Group (HUG) – has continued their monthly virtual meetings during the COVID 19 pandemic
- Raising the profile of our Patient Leaders to increase involvement in projects across the Trust
- Healthwatch – our close relationship with Healthwatch is maintained through their membership of the HUG. Healthwatch have been invaluable for collecting and sharing feedback from our patients during the pandemic
- Complaint Peer Review Workshops – on hold due to the pandemic
- Patient Information Ratification Group has continued to meet virtually throughout the pandemic.
- Assist, dDeaflinks and Capita have continued to provide interpretation services throughout the pandemic. The majority of foreign language interpretation now takes place via video or telephone with good effect.
- Learning Disability Service User Group has continued to meet virtually.
- The Sustainable Transformation Programme has worked with UHNM, MPFT, CCG, WMAS and UHDB to introduce "111First" and "111First Kiosks" to direct patients to the most appropriate service and admission into emergency portals as appropriate.
- UHNM membership of the CCG Community & Engagement Group to provide consistent messaging to the general public and seldom heard groups throughout Staffordshire
- Membership of the Carers Partnership Board to support delivery of the Stoke on Trent Carers Strategy 2021-25 and the development of the UHNM Carer's strategy.
- Working with MPFT, Combined Health and the CCG to agree a consistent approach and Peer review of local Equality Delivery System objectives

Annual Inpatient Survey

The 2020 Inpatient Survey results were published in October 2021. 1250 patients who were in hospital in October and November 2020 were invited to participate in the survey and we had a 42% response rate. We scored somewhat better than expected in comparison to all other trusts in 1 question and about the same as expected in 44 questions. There were no questions where we performed worse than expected compared to all other Trusts.

UHNM top and bottom 5 scores compared with Trust average.



The way we communicate with our patients continues to have a significant effect on their overall experience of our Trust. We know we need to improve the way we share information to support patients to feel more involved in decisions that affect their care and treatment.

Improvement initiatives include:

- The re-launch of the “It’s OK to ask” campaign: to encourage patients to ask the questions about their care and treatment that matter to them. This campaign has been extended in the community to prepare patients for their GP consultation and hospital visit; to and support in Shared Decision Making.
- New on-line Communication Training has been developed and is available to all staff via our e-learning platform.
- Health Literacy training has been adapted and has now moved to online as an e-learning package, as well as bespoke training to individual areas.
- Redesign of patient information leaflets to promote patient awareness and development of an electronic Patient Information library to support staff to have easy access to patient information leaflets.
- The development of electronic “Accessibility & Communication Alerts” which can be added to patient records to ensure staff are aware of patients with any communication support needs.
- Measurement of the effectiveness of initiatives with patient surveys to inform the Clinical Excellence Framework audit programme.
- Triangulation of quality and safety data to identify themes.
- Proactive recruitment of volunteers to assist with the improvement of service delivery and the patient experience.
- Working towards NHS Rainbow Badge Accreditation to demonstrate our commitment to improving our LGBTQ+ inclusivity.

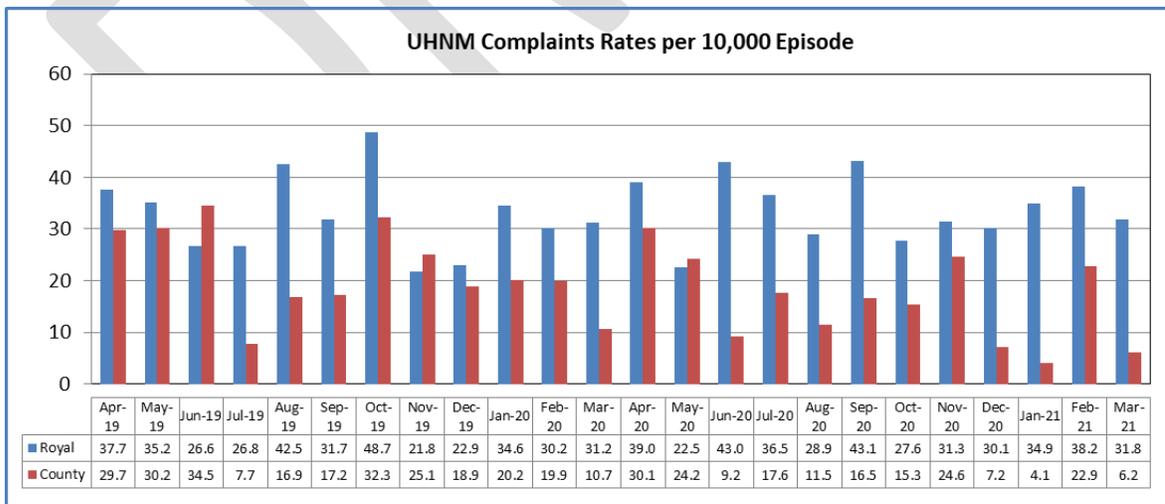
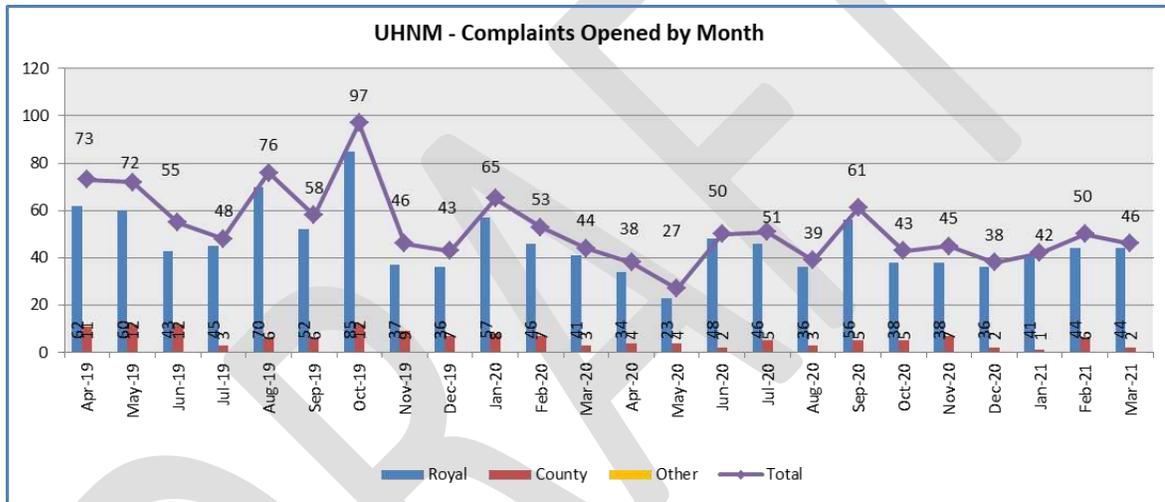
Complaints

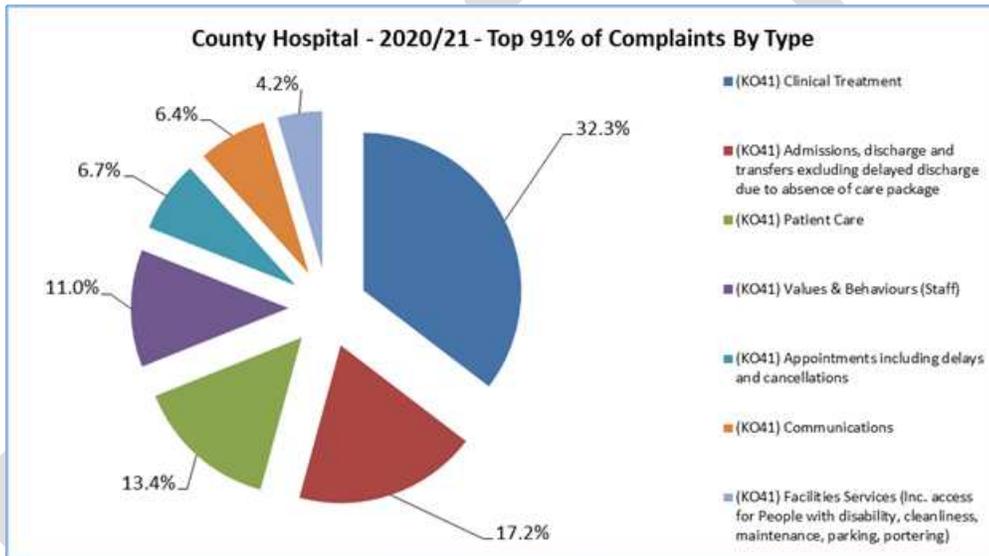
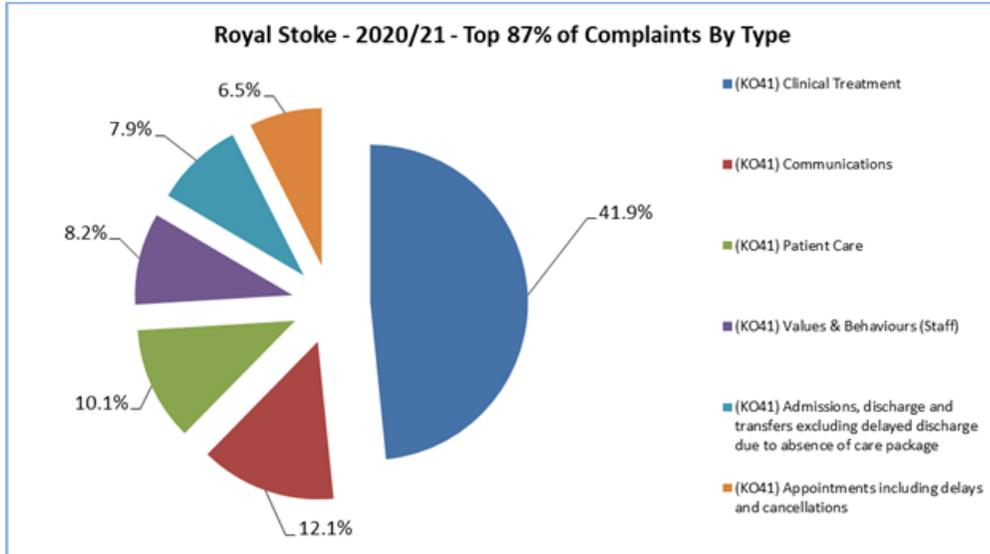
The total number of complaints opened at Royal Stoke University Hospital during 2021/22 is xx which is xx% lower than the previous 3 year average of xx.

The total number of complaints opened at County Hospital was xx in 2021/22, which is xx% lower than the previous 3 year average of xx.

During 2021/22, the Complaints Team have achieved the following:

- Continued effective working with the PALS Team to resolve complaints informally where possible.
- On-going review of the current process to facilitate an improvement in the timeliness of responses from receipt of complaint to final response.
- A set of Golden rules has been agreed and implemented to improve consistency and quality of responses.
- Complaints closed during 2021/22 had been open for an average of xx days compared to the previous 3 year average of 50 days.





Ethnicity of Complainant	%
Not stated	55.65%
White - British	41.10%
White - other white	0.68%
Pakistani	0.68%
(blank)	0.34%
Other mixed	0.34%
Other Asian	0.34%
Bangladeshi	0.17%
Chinese	0.17%
Black African	0.17%
Indian	0.17%
Mixed white and black African	0.17%
Grand Total	100.00%

Learning from Complaints

One of the most important aspects of the complaints process for the Trust is to learn lessons and make changes to enhance the experience for our patients, carers and relatives. The section below describes some of the improvements made as a direct result of complaint investigations.

You said: Patient has a large tumour on her oesophagus which has gone unnoticed/treated for 18 months and family feel that all the signs were missed.

We Did: The vetting process has changed and all 2 week wait UGI referrals. These are now sent straight to OGD, thus avoiding any delay

You said: Patient needed to start chemo tablets but when came to collect these at County Pharmacy they were not ready.

We Did: To contact pharmacy via generic email if immediate dispensing is required as the note in the chemotherapy prescribing system may not be seen as there is no prompt on the printed prescription that additional delivery instructions have been added. When informed via email or verbally if a pre-assessment is not required, dispensing will be expedited

You said: You were not happy that your personal information was read aloud whilst checking into the Pre-Ams clinic despite you protesting to the receptionist.

We Did: Reviewed and immediately amended the booking in process following this incident. Patient details are now checked by nursing assistants when the patient is in the clinic room. All reception staff are to complete in-house training in relation to data protection and patient confidentiality

You said: You did not understand what was being told to you at your Neurology appointment.

We Did: In future the Consultant will check whether what is being said is understood and if further clarification is required. An insight has also been gained from colleagues with regards to communication and has been informed that when he talks too quickly, what is being said is not always understood. He is now very conscious and delivers information in a slow and precise manner.

You said: You had an overdose of contrast dye when attending for a scan.

We Did: The Radiology Team will endeavour to improve communication between themselves and the referring clinical teams in complex cases. This will be achieved based on internal e-mail in the first instance and this could then be highlighted in MDT discussion. Direct telephone contact to the next available person would be made if there is no response from e-mail after 48 hours. The Radiology Department is starting to put in further comments after the MDT, which would help other staff directly or not directly involved in the MDT discussion.

You said: You were very unhappy with the lack of support you were offered following the loss of your baby.

We Did: The gap in service in regards to bereavement support for families who suffered the loss of their baby on the NICU following delivery has now been addressed. The Maternity Centre has now increased the hours that the Bereavement Midwives are available and extended the Maternity Bereavement services to include families from the NICU.

Part C: Statements from our key stakeholders



DRAFT



Staffordshire & Stoke-on-Trent Clinical Commissioning Groups (CCGs) are pleased to comment on this Quality Account 2021/2022.

DRAFT



City of
Stoke-on-Trent

DRAFT



Executive Summary

Meeting:	Trust Board	Date:	8 th June 2022
Report Title:	Maternity New Serious Incident (SI) Report Summary Quarter 4 (1 st January – 31 st March 2022)	Agenda Item:	13.
Author:	Donna Brayford, Quality & Risk Manager; Sharon Bailey, Lead Midwife for Education and Development		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

Information	✓	Approval		Assurance	✓	Assurance Papers only:	Is the assurance positive / negative / both?			
							Positive	✓	Negative	✓

Alignment with our Strategic Priorities

High Quality	✓	People		Systems & Partners	
Responsive	✓	Improving & Innovating	✓	Resources	



Risk Register Mapping

15593	Maternity Assessment Unit Triage	Extreme (15)
13419	Midwifery Safe Staffing	Extreme (16)
23361	Number of open adverse incidents and root cause analysis investigations	Extreme (20)

Executive Summary

Situation

This report provides a summary of the numbers and types of Serious Incidents reported by Maternity during Quarter 4 (2021/22). As of 12.04.22 maternity have 17 ongoing serious incidents (including new incidents).

Investigation in progress: 13 serious incidents (8 local Root Cause Analysis, 2 Healthcare Safety Investigation Branch Investigations, 3 Perinatal Mortality Review Tools)

Investigations completed/awaiting to be presented and closed by Risk Management Panel and CCG SI Group: 4 incidents

A Serious Incident report is presented to the Directorate and CWD Division monthly. The Ockenden Final Report states all serious incident actions must be completed within 6 months.

Background

Following the publication of the Ockenden review, Trust Boards are to have specific sight of Maternity Serious Incidents on a quarterly basis.

Assessment

In Q4 - 7 new serious incidents were reported:



- January 2022 1 incident (Case subsequently requested to be de-escalated)
- February 2022 4 serious incidents
- March 2022 2 serious incidents

Category of Incidents:

- 0 Healthcare Safety Investigation Branch (HSIB) investigation (1 case rejected by HSIB)
- 5 new incidents to be investigated by local Root Cause Analysis (RCA).
- 2 new incident investigated by the Perinatal Mortality Review Tool (PMRT).

Immediate Actions:

- The Maternity Assessment Unit (MAU) has reviewed the triage process to comply with Birmingham Symptom-specific Obstetric Triage System (BSOTS) recommendations. The Maternity Clinical Auditor has completed an audit of triage breach times to explore themes and develop a further action plan.
- Extraordinary meeting planned to review if current MAU actions from previous incidents to assess if improvements have occurred with the triage assessment process.
- A falls risk assessment is completed for all women who arrive onto the postnatal areas following delivery and new mothers are advised of the risks factors associated with dropped babies. An assessment checklist for dropped babies will shortly be added to the K2 electronic records. The Trust Falls Lead attended the unit to inspect the post natal area to identify any further potential preventative actions. An audit is to be undertaken to identify any themes from reported dropped babies in previous 2 years.
- As follow on from an external PMRT review a round table meeting has been arranged to review the UHNM process for intra - utero transfers to external trusts.
- The ASQUAM guideline for screening and investigation of the small for gestational age fetus and growth restriction to be reviewed.
- To consider the introduction of an annual competency assessment for Newborn and Infant Physical Examination (NIPE) assessors.
- Clinical Midwife Educator to promote use of Rotational Thromboelastometry (ROTEM) at daily Delivery Suite Safety Huddle.
- All Serious Incident Actions must be completed within 6 months of the incident (Ockenden Final Report)

Areas of concern/escalation:

There is a delay in the investigation of SI incidents due to current unit activity and staffing levels.

There was a significant delay in the processing of SI Case no 2021/3974 due to the RCA lead experiencing a long term episode of sickness. The investigation was transferred to a member of the governance team to complete. The investigation required significant addition and amendments which resulted in the delay. The investigation has been completed and was presented at the Risk Management Panel (RMP) on 07.04.22 and is awaiting approval by the CCG SI Review Group.

Key Recommendations

The Board are asked to accept and receive assurance of this report

Maternity New Serious Incident Reporting Process – for information.

The Maternity Team strive to declare Serious Incidents as soon as possible. The Quality and Risk Team are informed of the incident by Datix, a clinician or mother's concern or on completion of an investigation such as a Perinatal Mortality Review Tool (PMRT). The Clinical Director (CD) and Head of Midwifery (HOM) are immediately informed. The incident is discussed at the weekly Multi-disciplinary Obstetric Risk meeting to establish facts and ensure all immediate actions are implemented. A 72 hour brief is prepared and once approved by the HOM and CD is then escalated to the Divisional Team for approval by the Divisional Associate Chief Nurse and Divisional Governance Lead. The Serious Incident will be disclosed as soon as possible to the woman and her family.

HSIB Investigations and SI Reporting.

There has been recent discussions regarding reporting all maternity cases that are reported to Health Safety Investigation Bureau (HSIB) for investigation as Serious Incidents. There does appear to be some variation in practice across the country. Some Trusts are reporting all cases as Serious Incidents and some are reporting retrospectively following the HSIB investigation and patient safety recommendations. We have historically reported retrospectively following receipt of HSIB investigation reports. However, HSIB can take up to 12 months to complete an investigation which means a significant delay in Serious Incident reporting. Therefore, following correspondence from the Medical Director and Chief Nurse, as of 25/11/20 the decision was made to Serious Incident report and then de-escalate afterwards if appropriate.

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3. Current Serious Incidents in progres	11
4. Serious Incidents closed during Q4 – Learning and Actions.....	19
5. Current HSIB Cases.....	25



1. Definitions

Antepartum haemorrhage - defined as bleeding from the genital tract during pregnancy.

Cardiotocograph (CTG) - is used during pregnancy to monitor fetal heart rate and uterine contractions.

Cooling Therapies are described as:

Passive – turning off heating equipment and removing covering from the baby.

Active – placing the baby on a temperature controlled cooling mattress or using a temperature controlled cooling cap.

Therapeutic - is a procedure where the infant is cooled to between 33 and 34 degrees Celsius, with the aim of preventing further brain injury following a hypoxic (lack of oxygen) injury. Hypothermia is usually induced by cooling the whole body with a blanket or mattress.

Hypoxic ischaemic encephalopathy (HIE) - is a type of newborn brain damage caused by oxygen deprivation and limited blood flow.

Low cord pH – may indicate a baby has suffered a significant hypoxic incident before birth.

Perinatal Mortality Review Tool (PMRT) - Systematic, multidisciplinary review of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.



2. New Serious Incidents

Maternity have reported 7 Serious Incidents during Q4 (2022), January (n=1), February (=4) and March (= 2). Table 1 gives a brief description of the incident and immediate actions taken. It has been agreed by the Directorate, Division and Trust Board that all HSIB investigations will be reported as Serious Incidents and then de-escalated if required.

Table 1 - Brief description of new serious incidents and immediate action taken.

SI ID	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG SI Review Group
2022/2864 RCA Investigation in progress	261961 Jan 2022	<ul style="list-style-type: none"> Unexpected term admission to Royal Stoke Neonatal Unit for therapeutic hypothermia – (cooling) following a spontaneous normal vaginal delivery of male infant at 39 weeks gestation. An initial review of the care provided by the maternity team was conducted on 05.01.22 at the Obstetric Risk Meeting and it was concluded that all ante-natal management was correct and no immediate recommendations identified. The Root Cause is unclear at present. 	<ul style="list-style-type: none"> Verbal and written Duty of Candour completed. Parents consented to HSIB investigation. Subsequent MRI was normal, therefore does no longer fit criteria for HSIB. Local RCA in progress. 	<ul style="list-style-type: none"> Baby discharged home on day 9. MRI showed no signs of HIE. The case was rejected by HSIB as HIE was not detected on MRI scan. 	De-escalation requested on 16.03.22 and 11.04.22, no longer fits serious incident criteria.

SI ID	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG meeting
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SI ID	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG meeting
2022/2564 RCA Investigation in progress	264052 February 2022	<ul style="list-style-type: none"> Intrapartum Stillbirth, 38 weeks and 6 days Deviation from ASQUAM guideline for screening and investigation of the small for gestational age fetus. 	<ul style="list-style-type: none"> Verbal and written Duty of Candour completed. Rapid Review completed. ASQUAM guideline for screening and investigation of the small for gestational age fetus and growth restriction to be reviewed. The case met the criteria for HSIB investigation. The parents opted for a local Root Cause Analysis investigation. On-going bereavement care and support provided by the UHNM Bereavement Specialist Midwives. 	<ul style="list-style-type: none"> Local RCA investigation in progress. Case will also be reviewed via the PMRT process. 	4.5.22 RCA in progress
2022/ 2860 RCA Investigation in progress	259638 February 2022	<ul style="list-style-type: none"> Ante-natal Stillbirth at 23 weeks and 3 days, following delivery the mother experienced a massive post-partum haemorrhage(5000mls)and subsequently required a uterine hysterectomy. PMRT Completed – care of the mother following the death of her baby was scored a ‘C (care that may have made a difference to the outcome) 	<ul style="list-style-type: none"> A written duty of candour letter was sent to the parents advising of serious incident reporting. Clinical Midwife Educator to promote use of ROTEM at daily Delivery Suite Safety Huddle. 	<ul style="list-style-type: none"> PMRT review completed. Local RCA investigation in progress. 	9.5.22 Delay in investigation process due to RCA Leads being required to support clinical activity.

SI ID	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG meeting
2022/2568 PMRT review completed	261253 February 2022	<ul style="list-style-type: none"> • Ante – natal stillbirth at 30 weeks and 3 days. • There was a delay in triage of the mother on admission to the Maternity Assessment Unit 	<ul style="list-style-type: none"> • A written duty of candour letter was provided to the parents advising of SI investigation. • Maternity team to immediately review triage guideline to bring in line with the BSOTS system recommendations. • Maternity Clinical Auditor requested to review all Datix for triage breaches to explore themes and develop a further action plan. • Extraordinary meeting planned to review if current MAU actions from previous incidents to improve triage breaches need expediting. 	<ul style="list-style-type: none"> • 3.0 WTE midwives have been employed to manage Maternity Assessment Unit triage telephone calls therefore reducing the number of tasks to be performed by the midwife on MAU. • Maternity triage face to face assessments brought in line with BSOTS requirements. • Ongoing local audit of maternity triage assessment times 	4.5.22 PMRT review completed. To be presented at at the Directorate meeting on 22.04.22(March meeting cancelled)
2022/5764 PMRT review completed	256167 February 2022	<ul style="list-style-type: none"> • Neonatal death at 30 weeks gestation at an external Trust following in utero transfer from UHNM. • The PMRT review was completed by the external trust that scored the UHNM 	<ul style="list-style-type: none"> • The UHNM PMRT team completed a second review of UHNM antenatal care and confirmed their view that the antenatal care should remain as a score of B. However, areas for improvement were identified with 	<ul style="list-style-type: none"> • Round table meeting arranged to discuss UHNM process for in utero transfer 	20.06.22 PMRT review complete, to be presented at the Directorate meeting on 22.04.22 (March

SI ID	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG meeting
		ante natal care as C (care which may have made a difference to the outcome) due to an inappropriate in utero transfer and communication issues surrounding the transfer. The UHNM team PMRT review group had scored the antenatal care as B.	<p>the UHNM in utero transfer process.</p> <ul style="list-style-type: none"> A round table meeting was planned to immediately review and revise the intra utero transfer process. To reschedule round table meeting as previous cancelled due to staffing pressures. 	<ul style="list-style-type: none"> A post natal review appointment has been arranged for the parents 	meeting cancelled)
2022/5591 RCA Investigation in progress	267414 March 2022	<ul style="list-style-type: none"> Baby dropped from mother's arms on the postnatal ward. The baby incurred a left parietal fracture of the skull 	<ul style="list-style-type: none"> Rapid Review completed. Trust Falls Lead attended the postnatal area to inspect the area to identify any further potential preventative actions. An audit to be performed into all cases of dropped babies reported in previous 2 years to identify any relevant themes 	<ul style="list-style-type: none"> Baby receiving ongoing neonatal care and monitoring 	17.03.22 Delay in investigation process due to RCA Leads being required to support clinical commitments
2022/5507 RCA Investigation in progress	265355 March 2022	<ul style="list-style-type: none"> A child attended an ophthalmology appointment at seven months of age. During the consultation, the child was found to have incomplete closure of the right eye which resulted in the cornea being 	<ul style="list-style-type: none"> Treatment was provided to treat dryness of the cornea and a plan was made to review the baby again in 6 weeks. RCA investigation commenced. Plan to consider introduction of annual competencies for staff undertaking NIPE examinations. 	<ul style="list-style-type: none"> The baby is receiving ongoing monitoring by the ophthalmology service. 	16.06.22 Delay in investigation process due to RCA Leads being required to support clinical

SI ID	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG meeting
		<p>unprotected .</p> <ul style="list-style-type: none"> • The child's mother produced photographs following birth which indicate poor eyelid closure in the right eye. • The abnormality appears not to have been identified at the NIPE examination. 			commitments.

3. Current Serious Incidents in progress

Maternity have 17 ongoing serious incidents (including new incidents).
Investigation in progress: (11 local RCA, 3 HSIB, 3 PMRT).

SI ID	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG meeting
2021/19762 September 2021 PMRT Review complete .	254486 September 2021	<ul style="list-style-type: none"> Neonatal Death at 30 weeks and 6 days gestation. Parents have requested a coroner's inquest due to their concerns around care provided on the antenatal ward prior to baby's delivery. Local media reporting. 	<ul style="list-style-type: none"> Staff support arranged from the Professional Midwifery Advocate. Coroner's inquest to be held. External Consultant Obstetrician present at review as a lead reviewer to give parents reassurance of openness and transparency. Verbal and written DOC completed. 	<ul style="list-style-type: none"> Mother and family continue to be supported by the bereavement team. Date for coroners inquest confirmed. 	17.12.21 PMRT complete. Local RCA to be completed and both PMRT and RCA to be presented at RMP on 15.05.22
2021/19485 RCA investigation inprogress	251596 Sept 2020	<ul style="list-style-type: none"> Term baby born with Cleft Lip and Palate. Unable to locate record of discussion of risk of Ondansetron when administered to mother at less than 12 weeks gestation. Medicines and Healthcare products Regulatory Agency (MHRA) update states 'Ondansetron: small increased risk of oral clefts following use in the first 12 weeks of pregnancy'. Recommendation: if the clinical 	<ul style="list-style-type: none"> Memo sent to all medical staff to remind medical staff to counsel women appropriately. Spot case audit on women who have received ondansetron – 5 cases identified in ED. Immediate joint learning implemented with ED. Verbal and written Duty of Candour completed. Local Root Cause in progress. Joint RCA with pharmacy. Delay in reporting as incident report triggered by GP complaint during the 	<ul style="list-style-type: none"> Baby and family continue to receive support from Birmingham Cleft Lip and Palate team and UHNM paediatric gastroenterology. 	15.12.21 RCA delayed due to conflicting governance commitments . Awaiting further input from pharmacy directorate. Estimated to be completed May 22

SI ID	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG meeting
		decision is to offer Ondansetron in pregnancy, women must be counselled on the potential benefits and risk of use, both to her and to her unborn baby and the final decision should be made jointly.	<p>post-natal period.</p> <ul style="list-style-type: none"> Adverse drug reaction reported to MHRA. 		
2021/23088 HSIB investigation in progress	257852 November 2021	<ul style="list-style-type: none"> Healthcare Safety Investigation Branch (HSIB) Referral. Maternal Death, 24 days post-partum following an emergency caesarean section at 40 weeks and 2 days gestation. Covid positive. Raised Body Mass Index Coroner's Inquest Not received Covid vaccination. 	<ul style="list-style-type: none"> Written DOC to Next of Kin completed. Development of Covid Surveillance Pathway for pregnant women who are covid positive including development of Covid 19 Triage Tool for pregnant or postnatal women (up to 6 weeks) Implementation of Covid Care Plan in Obstetrics, updated inline with Coronavirus (COVID-19) infection and pregnancy (V14.3) New standard implemented - A Consultant Obstetrician should review all pregnant and recently pregnant women with suspected or confirmed COVID-19 who are in hospital at least daily Implementation of standard COVID documentation template for vaccination discussion at each contact. 	<ul style="list-style-type: none"> Awaiting HSIB report Staff support arranged. 	8.2.22 Awaiting completion of HSIB investigation

SI ID	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG meeting
2021/24638 RCA Investigation in progress	259191 November 2021	<ul style="list-style-type: none"> Maternal Death, 61 days post-partum, Covid positive Raised Body Mass Index Black, Carribean Not received Covid vaccination 	<ul style="list-style-type: none"> Verbal and written DOC completed Safety netting advice to include increased risk factors such as ethnic minority and increased BMI. 	<ul style="list-style-type: none"> Local RCA in progress. 	28.2.21 RCA delayed due to conflicting governance and operational commitments.
2021/16264 HSIB Investigation in progress	250418 July 2021 HSIB	<ul style="list-style-type: none"> Early Neonatal Death. Cord Prolapse at home. Deteriorating maternal condition on admission to Maternity, transferred to intensive care. 	<ul style="list-style-type: none"> HSIB referral completed. Verbal and written Duty of Candour completed Immediate staff de-brief performed. Staff support arranged. Staff de-brief offered to ambulance crew. No further immediate safety actions identified. 	<ul style="list-style-type: none"> Mum well, discharged home. HSIB investigation in progress, awaiting report. UHNM PMRT review completed . Score allocated B+B+A 	05.10.21 Awaiting completion of HSIB investigation
2021/6701 RCA investigation in progress	239973 February 2021	<ul style="list-style-type: none"> Acute collapse following major maternal haemorrhage. 17+4 weeks pregnant with twins, Findings of a ruptured rudimentary horn of the uterus (a uterine abnormality). Both fetus's in the abdomen. Ultrasound scans did not 	<ul style="list-style-type: none"> Potentially two opportunities to identify issue and instigate different management plan. Local RCA ongoing. 	<ul style="list-style-type: none"> Seen at 6 weeks post – operatively, and mum is recovering well. Debrief given. RCA presented at RMP on 	23.6.21 RCA complete and presented at RMP on 7.4.22 Due to be be represented on 28.06.22.

SI ID	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG meeting
		diagnose that the pregnancy had implanted in a rudimentary uterine horn.		08.04.22 . and rescheduled for 28.06.22	Delay due to RCA Leads working clinically to support the workforce.

Investigations completed/awaiting to be presented and closed by Risk Management Panel and CCG SI Group: 4 incidents.

SI ID/ Date on STEIS	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG meeting
2021/16483 July 2021 RCA investigation completed	248229 June 2021	<ul style="list-style-type: none"> • Inappropriate induction at 34 and 6 days. • Mother received a caesarean section and spinal anaesthesia. • Baby delivered at 35 weeks and required admission to the neonatal unit. • Potential impact upon subsequent labour for the mother. 	<ul style="list-style-type: none"> • Individual practitioner met with educational supervisor. • Verbal and written Duty of Candour completed. • Local Root Cause Analysis in progress. 	<ul style="list-style-type: none"> • Mother and Baby well. • Awaiting outcome of investigation. • Presented at Risk management panel on 29.03.22 Awaiting closure by the SI review group 	30.10.21 Presented at RMP on 29.3.22

SI ID/ Date on STEIS	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG meeting
2021/3974 RCA investigation completed	237628 January 2021	<ul style="list-style-type: none"> Sudden unexpected post-natal neonatal collapse at 25 minutes of age. Baby was intubated and transferred to the neonatal unit. Active cooling was commenced on admission to the neonatal unit. 	<ul style="list-style-type: none"> HSIB referral rejected as MRI reported to be normal, local RCA ongoing. Immediate action - the neonatal team were not crash bleeped following the neonatal collapse. MDT decision that clinical staff should crash bleep the neonatal team for any sudden unexpected postnatal collapse of a newborn baby. Memo sent to all areas. Local RCA completed –waiting to be presented at directorate. 	<ul style="list-style-type: none"> Baby is well, feeding on demand, with normal reflexes on her last examination. To be reviewed again in 3 months then if remains well will be discharged by the neonatology team. Presented at RMP on 08.04 22 . Awaiting closure by SI group. 	19.05.21 Presented at RMP on 4.4.22 .
2021/9749 HSIB investigation completed	243402 April 2021	<ul style="list-style-type: none"> Baby required transfer to the neonatal unit and required active cooling. Forceps delivery following a prolonged fetal bradycardia possibly due to placental abruption. 	<ul style="list-style-type: none"> Case reported to HSIB for investigation Support provided to the family. Draft HSIB report received by the trust to be reviewed for factual accuracy and shared with staff for approval. 	<ul style="list-style-type: none"> MRI report revealed no convincing abnormality to suggest HIE or structural changes to explain seizures. Baby was discharged home 	2.8.21 HSIB investigation completed. Presented at RMP on 29.3.22 HSIB Triangulation meeting arranged for 25.05.22

SI ID/ Date on STEIS	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG meeting
				with mum at 24 days of age. Baby continues to receive anti convulsants. Plan to repeat MRI if seizures persist. Presented at RMP on 29.03.22 HSIB triangulation meeting arranged for 26.05.22	
2021/3124 RCA Investigation Completed	218366 March 2020	<ul style="list-style-type: none"> • A category 1 caesarean section at 37 weeks and 6 days for a pathological cardiotocograph (CTG); a pathological CTG is a CTG with 1 abnormal feature or 2 non reassuring features. • Baby needed transferring to the neonatal unit and required active cooling. • Retrospective Incident. 	<ul style="list-style-type: none"> • This is an obstetric emergency which was managed in accordance with guidance from the maternity team. • Retrospective Serious Incident, a brief overview took place at the time of the incident but it was not formally investigated. COVID-19 escalations were being discussed apace at the time 	<ul style="list-style-type: none"> • Baby continues to be care of the paediatric team. • Some motor reflex delay noted, parents report abnormal jerky movements. • Baby currently waiting for a further MRI and 	07.05.21 Presented at RMP on 22.02.22

SI ID/ Date on STEIS	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG meeting
			<p>and the Directorate also experienced a maternal death in the unit at a similar time point which could account for why the incident was overlooked at the time. Recognised through failsafe audit that an RCA required. Sincere apologies given to parents for delay.</p> <ul style="list-style-type: none"> • Parents given option to request a HSIB investigation in view of late formal investigation, declined. • No immediate actions. RCA ongoing. 	<p>follow up. Presented at RMP meeting on 22.02.22</p>	

4. Serious Incidents closed during Q4 – Learning and Actions

2021/19478

Datix ID 252148

- Ante partum Stillbirth at 31 weeks and 4 days gestation.
- Delay in triage on admission to Maternity Assessment Unit (MAU).

No	Learning identified	Action	Action status	Responsible	Date for completion/ update	Completed date & evidence
1	All telephone calls to maternity triage to be answered by a Registered Midwife	1.1 Employment of designated telephone triage Midwives	1.1 3 WTE midwives recruited to enable a 24 hour telephone triage service. To re-advertise for further 2.4 WTE.	Director of Midwifery	30.04.22	30.4.22
		1.2 Audit of triage telephone calls being answered by a Registered Midwife to be completed 3 months from implementation of new telephone triage midwife.	Date planned to commence	Directorate Clinical Auditor	30.06.22	
2.	An initial triage assessment to be completed within 30 minutes on all women	Completion of the Birth Rate Plus assessment to ascertain the correct midwifery staffing ratio on the Maternity Assessment Unit.	In progress	Director of Midwifery	30.03.22	

	attending the UHNM maternity Assessment Unit					
3	Triage Breach implemented as a trigger for the escalation process	Midwifery Staff to inform flo-co ordinator if triage times are breached so they can implement the escalation process.	Complete	MAU Manager	1.7.22	Completed 31.7.21
4	Triage process to be completed in a shorter time in line with BSOTS, recommended time 15 minutes	To re-train MAU staff to perform triage in line with BSOTS Guidance.	Complete	MAU Manager		Complete February 2022
5	<u>Incidental Finding</u> Woman's blood pressure was not managed in line with guidance	5.1 Following discussion at the Consultant meeting further guidance on BP management to be shared with obstetric staff 5.2 Memo to midwifery staff re BP management 5.3 Repeat audit to be complete to ensure compliance with current Hypertension Guideline	5.1/5.2/ 5.3 Complete	Consultant Obstetrician Head of Midwifery. Directorate Clinical Auditor		5.1/5.2 Complete Jan 2022 5.3 Complete March 2021
6	<u>Incidental Finding</u> All pregnant women to undergo carbon monoxide screening during pregnancy.	Audit of compliance with carbon monoxide screening completed 4 times yearly as part of SBLCB Compliance.		SBLCB Lead Midwife		Complete. Performed quarterly. Action plan received and monitored by

						Directorate and Division Quarterly.
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202123613
Datix ID 248261



Neonatal Death at 25+6 corrected gestation.

- a) Triage Telephone call to the Maternity Assessment Unit (MAU) answered by ward clerk, incorrect advice given to mother.
b) Delay in re-commencing Iv antibiotics when developed signs of necrotising enterocolitis (NEC).

No	Learning identified	Action	Action status	Responsible	Date for completion/ update	Completed date & evidence
1	The triage telephone call to the Maternity Assessment Unit was not managed appropriately. The telephone call to triage was taken by a ward clerk and advice gained from a midwife. The advice was incorrect and admission to MAU should have been advised.	<p>1.1 MAU triage risk register has been increased, divisional and executive team aware that the current staffing establishment does not allow the telephone triage call to be answered by a midwife 24/7.</p> <p>1.2 Employment of designated telephone triage Midwives</p>	<p>1.1 Complete</p> <p>1.2 Complete</p>	<p>1.1 Director of Midwife</p> <p>1.2 MAU Manager</p>	<p>1.1 30.9.21</p> <p>1.2 Initial employment of 3.0 WTE</p>	<p>1.1 Completed 14.9.21.</p> <p>1.2 3.0 WTE phone triage midwives recruited, 2 currently in post, 2 to start in 8 weeks. To re advertise for further 2.4 WTE phone triage midwife.</p>
2	The use of carbon monoxide screening was paused during the Covid 19 pandemic. Carbon monoxide monitoring was reintroduced 1.3.21.	On-going discussions between Saving Babies Lives Midwife and the Outpatient Matron to address barriers to compliance. Review of equipment to ensure all areas/staff have the monitors/consumables and the training to competently perform CO monitoring. Compliance reports shared weekly with team leaders, Outpatient Matron and		Saving Babies Lives Midwife and Outpatient Matron	31.12.21	Complete And Ongoing quarterly audit with action plan

	<p>Improvement is needed with compliance.</p>	<p>HOM/Consultant midwife. 15.10.21 36.4% compliance. Consideration to start reintroduction of face to face booking appointments.</p>				<p>monitoring performed, shared with Directorate, Division, Trust Board and LMNS</p>
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3	There is no evidence in the notes that the mother was asked about domestic abuse at booking.	<p>3.1 Raise awareness with Maternity staff of the importance of asking the routine enquiry at every opportunity through Learning from Incident Newsletter</p> <p>3.2 Audit of routine enquiry for domestic abuse.</p>		<p>3.1 Lead Midwife for Education and Development</p> <p>3.2 Directorate Clinical Auditor</p>	<p>3.1 31.01.22</p> <p>3.2 31.03.22</p>	<p>3.1 Complete</p> <p>3.2 Completed Plan for reaudit quarterly.</p>
4	The tocolysis medication was not administered in line with current UHNM guidance. There was a delay in the administration of the 3rd dose of Nifedipine. A 4th dose was administered which is not reflected in current local guidance	<p>4.1 Management of preterm birth to be included on mandatory training (skills drills day 3).</p> <p>4.2 Individual feedback to clinicians.</p>		<p>4.1 Saving Babies Lives Midwife.</p> <p>4.2 Professional Midwifery Advocate</p>	<p>4.1 31.12.21</p> <p>4.2 31.12.21</p>	<p>4.1 Training currently paused</p> <p>4.2 Completed</p>

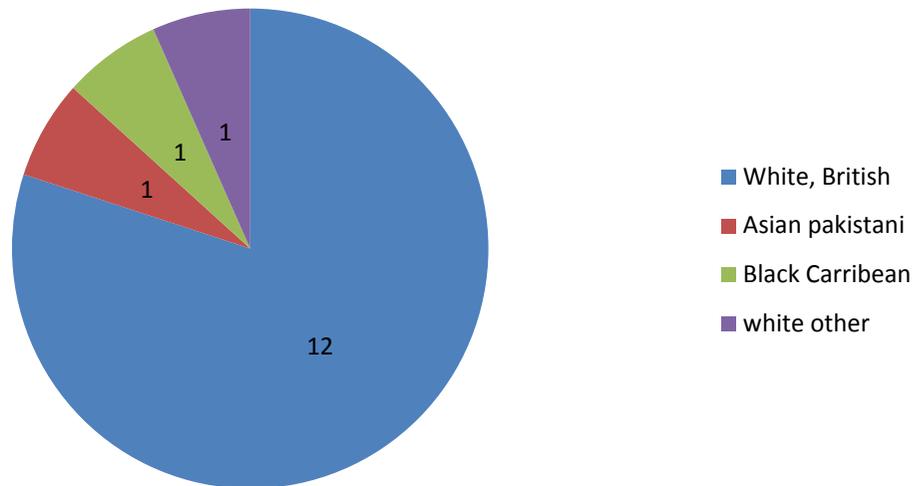
5. Current HSIB Cases

2 Current HSIB cases ongoing

6. Serious Incidents April 2021-March 2022- classed by ethnicity

This information will be used to inform future actions.

Ethnicity of mothers whose care was reported as a serious incident





Transformation and People Committee Chair's Highlight Report to Trust Board

31st May 2022

1. Highlight Report

!	Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
	<ul style="list-style-type: none"> Quality Improvement Academy Staffing remains fragile and has impacted upon Improving Together training capacity although mitigations are in place; core managers training has dipped below trajectory and Boot Camps have been scheduled Board Development session for Improving Together Programme is yet to be confirmed for Non-Executive Directors Activity in relation to apprenticeships and absence management have been impacted upon significantly as a result of Covid although there are plans to bring these back on track Disappointing results from the Staff Survey which have previously been reported to the Board; some concern also expressed around the uptake to the Staff Voice Survey although there are plans in place to improve uptake through the Staff Engagement Lead PDR performance during M1 has continued to decline; there are plans in place to improve the position but this requires considerable focus – quality PDR's is built into ENABLE programme Resuscitation Training remains an area of concern which is being looked into by the Chief Nurse and Medical Director April sickness absence was the highest to date although is expected to improve in May and there continue to be challenges with the recruitment process which is creating additional pressure 30 exception reports issued to the Guardian of Safe Working during Q4; 3 of which identified safety concern associated with Covid related absence – some concerns expressed around engagement in this process A particular concern had been raised through staff discussions around the use of Whatsapp out of hours 	<ul style="list-style-type: none"> Some further refinement to be made to the Annual Plan including consideration as to whether investment into staffing within Maternity Services should be included A refreshed roll-out plan for the Improving Together Programme has been developed which includes an 18 month forward view Further assurance requested around the engagement of senior leaders in the Improving Together Programme; consideration to be given as to how the methodology can be embedded into the existing Leadership Development Programme Annual People Plan sets out a range of activities which will be delivered throughout the course of 22/23 Discussion to take place outside of the meeting around how the Committee plans its activities throughout the course of the year given the scale of its business cycle
✓	Positive Assurances to Provide	Decisions Made
	<ul style="list-style-type: none"> Improving Together work with ward 102 is beginning to demonstrate progress as they recover from the Omicron Covid wave; AMU will begin to improve as the process is refreshed with them through Wave 3 of the programme Existing programmes associated with Organisational Development are progressing well and have been refreshed to take into account the findings of the recent Culture Review; this includes the ENABLE Programme for Middle Managers which is fully booked for the first 6 months following outstanding feedback, the Clinical Leadership Programme which launches in June and the Civility & Respect Programme which commences 27th June Staff are continuing to access formal support services such as Staff Support and Counselling and the System online Psychological Hub facilities; a number of financial wellbeing initiatives have also been included to the Wellbeing Plan Divisions had reported through the Health & Safety Group that there were starting to feel relief from the pressures of Covid and able to resume 'business as usual' 	<ul style="list-style-type: none"> Approval of Annual Plan (subject to some minor changes) which draws together priorities agreed through the Improving Together Programme; this is predominantly aimed at being a communication document for the organisation – will be presented to the Board for approval in June Approval of the Terms of Reference and Membership of the Committee
Comments on the Effectiveness of the Meeting		
<ul style="list-style-type: none"> Consideration to be given going forward as to how the Committee gives sufficient focus to the Transformation side of its responsibilities 		

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Annual Plan 2022-23	Various	Various	Approval	9.	Executive Workforce Assurance Group Highlight Report	BAF 2 / 3	n/a	Assurance
2.	Improving Together Highlight Report		n/a	Assurance	10.	Committee Effectiveness Review		n/a	Assurance
3.	People Plan Annual Report 2021/22	BAF 2 / 3	Ext 16 High 12	Assurance	11.	Staffordshire and Stoke on Trent ICS Development Plan / Newsletter	BAF 4	n/a	Assurance
4.	Organisational Development and Culture Update	BAF 2	High 12	Assurance	12.	Review of Effectiveness and Attendance		n/a	Information
5.	Health & Wellbeing Plan Progress Report	BAF 3	n/a	Assurance	13.	Review of Business Cycle		n/a	Assurance
6.	M1 Workforce Performance Report	BAF 2 / 3	Ext 16 High 12	Assurance	14.	Items for Escalation		n/a	Assurance
7.	Guardian of Safe Working Report Q4 21/22	BAF 1 / 3	n/a	Assurance	15.	Items for Audit Committee		n/a	Assurance
8.	Executive Health & Safety Group Highlight Report	BAF 3	n/a	Assurance				n/a	Information

3. 2022 / 23 Attendance Matrix

				Attended		Apologies & Deputy Sent					Apologies				
Members:				A	M	J	J	A	S	O	N	D	J	F	M
Prof G Crowe	GC	Non-Executive Director (Chair)													
Ms H Ashley	HA	Director of Strategy and Transformation													
Ms S Belfield	SB	Non-Executive Director													
Mrs T Bullock	TB	Chief Executive													
Mr P Bytheway	PB	Chief Operating Officer													
Dr L Griffin	LG	Non-Executive Director													
Mrs S Gohir	SG	Associate Non-Executive Director													
Dr K Maddock	KM	Non-Executive Director													
Mrs AM Riley	AR	Chief Nurse													
Miss C Rylands	CR	Associate Director of Corporate Governance													
Mrs R Vaughan	RV	Chief People Officer													

Performance and Finance Committee Chair's Highlight Report to Board

31st May 2022



University Hospitals
of North Midlands
NHS Trust

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	<ul style="list-style-type: none"> Implementation of the new Internal Professional Standards is likely to highlight deficiencies within specialities which will need to be addressed Diagnostics in MRI and Ultrasound remain an area of concern; a plan is in place for MRI although a plan for Ultrasound is yet to be determined Pathology turnaround times remains an area of concern with infrastructure issues cited as a particular area of concern Main risk associated with the expansion of County Elective Capacity is around theatre staffing; recruitment plans underway with the main mitigation being an insourcing model in order to support staffing Concern expressed around contract awards / extensions for Endoscopy and Imaging Contrast Media being retrospective; this was being raised with the Divisions through Performance Management Reviews In month the Trust delivered an actual deficit of £1.4m against an in month planned surplus of £0.6m; total capital expenditure incurred of £3.3m which is £0.2m behind plan and cash is £10.3m behind plan although this variance was largely due to Health Education Training income which was expected to be received Construction industry has become more and more unstable with fixed price costs being held for much shorter periods and manufacturing lead-in periods increasing as businesses hold less stock and manufacture more to order. This instability was exasperated by higher than usual national fuel prices and global raw material price increases associated with conflict in the Ukraine. Measures to mitigate this risk were supported by the Committee 	<ul style="list-style-type: none"> Three work streams of the Non-elective Improvement Group will continue to implement change and drive improvements focused around workforce at the front door, transformation to implement the new standards and occupancy to ensure patient flow Plan on a Page for non-elective improvement activity to be further developed with a view to sharing with the Trust Board Further stretching of trajectories for non-elective care to be considered Discussion between chairs of PAF and QGC to take place with regard to quality indicators for Urgent Care Detailed discussion regarding Planned Care (including Cancer) to take place at the next meeting A change to the way in which 2 week cancer waits are reported is being planned Operational Delivery Group is being reviewed to focus on the of the Elective / Non-Elective Improvement Boards Procurement of external support for development of business case associated with network and communications market testing to commence – business case back to PAF in August Revised financial plan as a system is to be submitted on 20th June
✓	Positive Assurances to Provide	Decisions Made
	<ul style="list-style-type: none"> Since November 2021 admissions via ED have decreased by 125 per week. Non-admitted demand remained stable and the number of patients seeing the Navigator only in ED rose to >200 Standard Working Practices for Referral and Admission has been approved by the Trust Executive Committee and enacted as of 30th May 2022 Cases through theatre are now back to 'business as usual' pre-pandemic levels and the 7th theatre is up and running at County Hospital Business case review process has continued and is now in a much better position than reported 12 months ago – intention is to reach the target of 0 reviews outstanding 	<p>Approval of New Contract Award and Contract Extensions:</p> <ul style="list-style-type: none"> Subcontract Award for Endoscopy Diagnostic Services (eREAF 9266) Supply of Imaging Contrast Media (2022/23 Extension) (eREAF 9140) Trent Wave 4b – New 26 Bed Ward (eREAF 9349) Information <p>Approval of Business Cases:</p> <ul style="list-style-type: none"> BC 0479 Expansion of County Elective Capacity BC 0397 Network and Communications Strategic Outline Case Request for Funding – MRI Scanner <ul style="list-style-type: none"> Approval of Terms of Reference and Membership following the Effectiveness Review; this will be submitted to the Board as part of the Rules of Procedure



Comments on the Effectiveness of the Meeting

- Positive meeting, in particular the work around non-elective improvement plans – very pleased with the report; could have given 1 hour and also very helpful to have the team members to present
- Ability to handle business cases more quickly than usual given that they were taken as read
- Agreement to be reached as to how much time is dedicated to Planned Care at the next meeting

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Month 1 Performance Report 2022/23: • Review of Urgent Care	BAF 1 / 6	Ext 20	Assurance	8.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (PO) Expenditure		n/a	Assurance
2.	Operational Delivery Group Highlight Report	BAF 1 / 6	Various	Assurance	9.	Committee Effectiveness Review		n/a	Approval
3.	Planned Care Cell Highlight Report	BAF 1 / 6	Various	Assurance	10.	Month 1 Finance Report 2022/23	BAF 9	Low 3	Assurance
4.	BC-0479 Expansion of County Elective Capacity	BAF 6	Ext 16 / 20	Approval	11.	Capital Programme Inflation Pressures		n/a	Assurance
5.	BC-0397 Network and Communications Strategic Outline Case	BAF 7	High 12	Assurance	12.	Non Elective Improvement Board Minutes	BAF 1 / 6	n/a	Information
6.	Request for Funding – MRI Mobile Scanner	BAF 6	n/a	Approval	13.	Review of Meeting Effectiveness and Attendance		n/a	Information
7.	Business Case Review Schedule		n/a	Assurance	14.	Review of Business Cycle		n/a	Information

3. 2022 / 23 Attendance Matrix

		Attended		Apologies & Deputy Sent					Apologies					
		A	M	J	J	A	S	O	N	D	J	F	M	M
Members:														
Mr P Akid (Chair)	Non-Executive Director													
Ms H Ashley	Director of Strategy													
Ms T Bowen	Non-Executive Director													
Mrs T Bullock	Chief Executive													
Mr P Bytheway	Chief Operating Officer													
Dr L Griffin (Chair)	Non-Executive Director													
Mr M Oldham	Chief Finance Officer													
Mrs S Preston	Strategic Director of Finance													
Miss C Rylands	Associate Director of Corporate Governance													
Mr J Tringham	Director of Operational Finance													



Executive Summary

Meeting:	Trust Board	Date:	8 th June 2022
Report Title:	Integrated Performance Report, Month 1 2022/23	Agenda Item:	16.
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & safety; Operational Performance: Warren Shaw, Associate Director of Performance & Information; Matt Hadfield, Deputy Associate Director of Performance & Information. Workforce: Claire Soper, Assistant Director of Human Resources; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse Paul Bytheway: Chief Operating Officer Ro Vaughan: Chief People Officer Mark Oldham: Chief Finance Officer		

Purpose of Report

Information	Approval	Assurance	✓	Assurance Papers only:	Is the assurance positive / negative / both?			
					Positive	✓	Negative	✓

Alignment with our Strategic Priorities

High Quality	✓	People		Systems & Partners	
Responsive	✓	Improving & Innovating	✓	Resources	✓



Risk Register Mapping

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Executive Summary

Situation

The attached Integrated Performance Report details the performance and achievements against a set of key indicators developed by the Department of Health and Social Care. The framework provides an overview of how the Trust is performing against the following four domains and the impacts on the strategic objectives:

1. Quality of Care - safety, caring and Effectiveness
2. Operational Performance
3. Organisational Health
4. Finance and use of resources

Assessment

Quality & Safety

The Trust achieved the following standards in April 2022:

- Friend & Family (Inpatients) 99.1% and exceeds 95% target.
- Harm Free exceeded 95% target rate with 96.3%
- 100% verbal Duty of Candour compliance
- 0 Never Events reported
- Trust rolling 12 month HSMR continues to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 99.3% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during April 2022.

- Inpatients Sepsis Screening 96% above 90% target rate
- Inpatient Sepsis IVAB within 1 hour achieved 100% and exceeded 90% target rate
- Children's Sepsis Screening compliance 90% and achieved the 90% target.

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E 69.1% and below 85% target.
- Friend & Family (Maternity) decreased to 60% and below 95% target.
- Falls rate was 7.2 per 1000 bed days
- There were 21 Pressure ulcers including Deep Tissue Injury identified with lapses in care during April 2022.
- 72% (5 out of 7 cases) Duty of Candour 10 working day letter performance following formal verbal notification. 6 patients have received written notification but 1 case is waiting update.
- C Diff YTD figures below trajectory with 13 against a target of 8.
- Sepsis Screening compliance in Emergency Portals below the target 90% with 60.8%.
- Maternity Sepsis Screening compliance 83.3% against 90% target
- Emergency Portals Sepsis IVAB in 1 hour 50% and is below the 90% target for audited patients

During April 2022, the following quality highlights are to be noted:

- The rate of complaints per 10,000 spells is 24.27 and is slightly below the target of 35 and within normal variation. Majority of complaints in April 2022 relate to clinical treatment.
- Total number of Patient Safety Incidents increased in month (1822) but the rate per 1000 bed days has increased at 48.95 and both measures are within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents above normal variation levels and incidents are under review to identify issues/themes but within normal variation.
- Increase in total reported incidents relating to staffing shortages and lack of appropriate staff on wards/departments during March 2022. 81 in total although 33 were coded as patient related, the remaining 48 were reported as staff related incidents.
- Rate of falls reported that have resulted in harm to patients currently at 1.3 per 1000 bed days in April 2022. The rate of patient falls with harm continues to be within the control limits and normal variation but is above the mean rate which indicates there may be improvement in reducing harm from falls.
- Medication related incidents rate per 1000 bed days is 4.4 and patient related 3.6 which are similar to previous month and mean rates. The monthly variation is within the normal expected variation and consistent with Trust mean rates.
- Pressure Ulcers per 1000 bed days developed under UHNM care has seen an increase during April 2022
- 52 Definite Hospital Onset / Nosocomial COVID-19 cases reported in February 2022.
- 7 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths of first positive result 15 days or more after admission to hospital).
- 14 Serious Incidents reported April 2022.

Operational Performance

Emergency Care

- April saw a decline in Type 1 attendances at 13130 versus 14162 in March. In line with this reduction ambulance attends also fell from 4852 to 4489. The conversion rate remained at 29%.
- 4 hour performance rose slightly to 62.5% which could be attributed to the above reduction in attendances.
- The 12 hour delays in the department remained static overall across March and April. However, it is important to note that April was a month characterised by two distinct phases. While both pre noon discharges and simple and timely discharges fell against March, and early April suffered poor performance as a result, the Easter bank holiday was the beginning of a welcome turning point and began a trend in overall reduction of 12 hour and 60 minute ambulance handover delays. We have seen this performance improvement sustain into May.
- 12 hour and 60 minute ambulance handover delays are critical patient safety metrics and were key factors in the reduction to EMS Level 2, which occurred for the first time since the COVID-19 pandemic began.

Cancer

- Most recent submitted Cancer Waiting Times position is March 22.
- Levels of suspected cancer patients first seen at UHNM in March was at 121% of the volume seen pre-

pandemic – a greater recovery compared with the national position of 116%

- In March 22, the proportion of patients waiting over the key standard, 62 days to treatment, was 11% which 2% better than the regional average and work on the early parts of the pathway continue to reduce this by improvement to the 14 day standard from 55 days in January to 35 in April
- Provisional April 22 data indicates achievement of 31 day sub radiotherapy and 31 day rare cancers standards.
- The 14 day position for April 22 is predicted to achieve in the region of 46%. However the trust recorded less 14 day breaches than the previous month.
- The 28 Day Faster Diagnosis position is currently at 61% with the majority of breaches currently recorded in Colorectal (420), Breast (194) and Skin (112).
- The 62 day position for April 22 is currently at 46%. This is an incomplete and un-validated position that is expected to change as histology confirms a cancer or non-cancer diagnosis for patients treated. There is also a growing volume of unreported pathways due to outstanding histology affecting the position.
- There are currently 631 patients in the 2WW backlog. Of the 2WW patients who have breached, 214 patients are in Colorectal and 161 are in Skin.
- The 104+ backlog remains steady, currently circa 100. Divisions have been asked to focus on this cohort and discharge patients where appropriate – e.g. where there are patients waiting over 104 days with an outstanding clinical review. 21% of the 104+ backlog is within Colorectal and 24% is with Skin.

Planned Care

The focus of activities for Planned Care has been as follows:

- Day Case and Elective Activity delivered 85% and 84.5% respectively for April 22 against the national ask of 110%, a significant improvement on March's position for Day Case (83%) and Electives (81%).
- A combined site focus on Theatres, by booking ahead, ensuring all lists are fully used and only for the most urgent and longest waiting patients is being enabled by a revitalised "6-5-4" weekly meeting which will continue to increase theatre throughput past 1920 levels
- In month Planned Care Cell focused on elective recovery based on 10 high impact changes in accordance with the elective plan.
- Theatre plan for Q1 2022/23 gives 104% of 19/20 capacity. "Bookathon" launched to ensure theatre utilisation is improved, and to date as many long waiters and P2s as possible. County theatre reopened 11th April – all 7 theatres now online.

RTT

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For April the indicative number of Incomplete pathways has risen to 76,023 (March 74,984).
- The number of patients > 18 weeks has risen to a level of 35,345 (March 33,665)
- The numbers of 52 week waits in April has decreased with a total of 4,483 compared to 4,603 in March.
- At the end of April the numbers of > 104 weeks was 314 a decrease from 494 in March The Planned Care group is monitoring progress against treatment plans for these patients. The reduction in 104 week patients has reduced the patients likely to breach 104 weeks from to around 40 in May with patient by patient focus on reducing that number further, as well as minimising the cancellations might not be bookable again until July.
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.

Diagnostics

- For DM01 (15 nationally identified Dx tests) the validated position for total waiting list has decreased in April from 24,004 to 23,502. The Non-obstetric ultrasound waiting list increased slightly from 9,550 to 9,631. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance is at 66.86%.
- Within DM01, the greatest proportions of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls, a number of actions are in place. Non obstetric ultrasound performance remains a Driver Metric for CWD and has specific focus for improvement, albeit this is related to workforce retention, recruitment and innovative ways to train and recruit. Further outsourcing of non-obstetric ultrasound scanning is continuing to be explored.
- DM01 performance excluding non obs ultrasound would be 78%. Non-DM01 diagnostics are being reviewed against the standard concentrating on the Cancer and the RTT delays to ensure that robust plans and trajectories are put in place to reduce delays.

- Histology turnaround times remain a high risk; there is an action plan in place and the position is improving. Cancer related histology is being treated urgently and all cancer related escalations are being prioritised.

Workforce

Key messages

- The strategic focus of our People Plan remains on supporting recruitment, staff wellbeing and absence management.
- The sustainable workforce risk remains high because there is still an impact of covid surges on sickness levels and workforce availability, although there are plans in place to mitigate risks and additional recruitment is taking place. Operational pressures, high sickness rates and vacancy levels contribute to the staffing challenges.

Sickness –

- The in-month sickness rate was 7.29% in April 22 (6.62% in March). The 12 month cumulative rate increased to 6.02% (5.73% at 31/03/22).
- Covid-related absence increased throughout March 2022 and started to decline again from 3rd April. As of 25 May 2022, covid-related open absences* numbered 81 which was 12% of all open absences [**includes absences resulting from adhering to isolation requirements*]
- There is continued daily monitoring of sickness absences, specifically all COVID related absence and stress related absence and a Divisional focus on long term and frequent absences, supported by absence huddles with HR

Appraisals –

- At 30 April 2022, the PDR Rate continued to decline to 73.78%, down from 75.55% at 31 March 2022
- Focused discussions have been taking place with Divisions to gain assurance on plans to achieve an improvement in the numbers of appraisals being scheduled for completion

Statutory and Mandatory Training –

- The Statutory and Mandatory training rate at 30 April 2022 was 94.25% (94.73% at 31 March 2022). This compliance rate is for the 6 'Core for All' subjects only
- We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

Vacancies –

- The overall vacancy rate was 11.10% at 30 April 2022 (11.71% at 31 March 2022), equivalent to 1237.21 FTE. Staff in post decreased in April 2022 by 51.70fte and budgeted establishment reduced by 135.22fte as establishment associated with escalation wards was removed. The decrease in budgeted establishment had the effect of reducing the vacancy position by 83.53 fte.
- In month, Bank and Agency fte was 933.81, which covered 75.48% of this vacancy position and there was 1076.70 FTE in the recruitment pipeline.
- Overall the target **average time to hire** (from vacancy creation to checks complete) is 60 days and although this average is achieved, there are aspects of recruitment, such as pre-employment, which currently exceed the local performance target (17days of the overall 60 day target).

Finance

Key messages

- The late timing for the final financial plans and the impact of finalising the accounts for 2021/22 has led to a slimmer closedown for the Month 1 accounts consequently this report focuses on the key issues and risks. It is difficult to reach conclusions on the outlook for the year based on 1 month of data but it

appears as if pay expenditure and income are performing in line with expectations and non-pay is slightly above where we would expect it to be.

- This report presents the financial performance of the Trust for April (Month 1). Key elements of the financial performance are:
- In month the Trust delivered an actual deficit of £1.4m against an in month planned surplus of £0.6m. This adverse variance to plan is primarily driven by non-delivery of CIP in month in the region of £1m and under recovery of income driven by underperformance of ERF and Specialised Commissioning; these issues were identified as key risks in our financial plan submission.
- The Trust incurred £1.2m of costs relating to COVID-19 in month which is a decrease of £0.1m compared with Month 12's figure with £0.4m being chargeable on top of this allocation for COVID-19 testing costs.
- Capital planned expenditure for 2022/23 as reported to Performance and Finance Committee in April 2022 is £69.8m. In Month 1 total expenditure has been incurred of £3.3m which is £0.2m behind plan. The majority of the expenditure in Month 1 is the pre-committed repayment of the PFI and IFRS16 lease liabilities.
- The cash balance at Month 1 is £74.3m, which is £10.3m lower than plan. The main year to date variances from plan are driven by Health Education Training income being lower than plan and general payables being in excess of plan.

Key Recommendations

The Trust Board is requested to note the performance against previously agreed trajectories.

Integrated Performance Report

Month 1 2022/23



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A note on SPC

The following report uses statistical process control (SPC) methods to draw two main observations of performance data;

Variation - are we seeing significant improvement, significant decline or no significant change

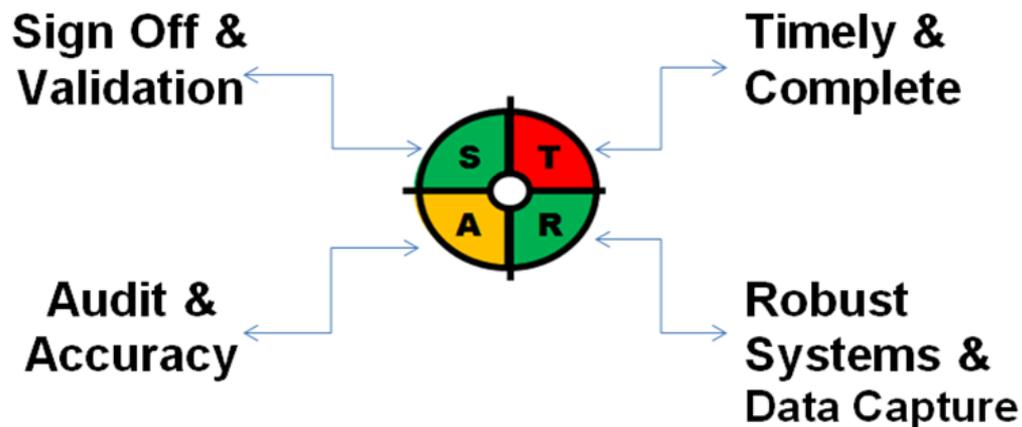
Assurance - how assured of consistently meeting the target can we be?

The below key and icons are used to describe what the data is telling us;

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

A note on Data Quality

- Data Quality Assurance Indicators (DQAI) are used in this report to help give context and assurance as to the reliability and quality of the data being used.
- The STAR Indicator provides assurance around the processes used to provide the data for the metrics reported on.
- The four Data Quality domains are each assessed and assurance levels for each are indicated by RAG status.



Explaining each domain

Domain	Assurance sought
S - Sign Off and Validation	Is there a named accountable executive, who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency with executive officer oversight?
T - Timely & Complete	Is the data available and up to date at the time of submission or publication. Are all the elements of required information present in the designated data source and no elements need to be changed at a later date?
A - Audit & Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur (Annual / One Off)? Are accuracy checks built into collection and reporting processes?
R - Robust Systems & Data Capture	Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?

RAG rating key

Green	Good level of Assurance for the domain
Amber	Reasonable Assurance – with an action plan to move into Good
Red	Limited or No Assurance for the domain - with an action plan to move into Good

Quality

Caring and Safety

**2025
Vision**

“Provide safe, effective, caring and responsive services”



Key messages

The Trust achieved the following standards in April 2022:

- Friend & Family (Inpatients) 99.1% and exceeds 95% target.
- Harm Free exceeded 95% target rate with 96.3%
- 100% verbal Duty of Candour compliance
- 0 Never Events reported
- Trust rolling 12 month HSMR continue to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 99.3% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during April 2022.
- Inpatients Sepsis Screening 96% above 90% target rate
- Inpatient Sepsis IVAB within 1 hour achieved 100% and exceeded 90% target rate
- Children's Sepsis Screening compliance 90% and achieved the 90% target.

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E 69.1% and below 85% target.
- Friend & Family (Maternity) decreased to 60% and below 95% target.
- Falls rate was 7.2 per 1000 bed days
- There were 21 Pressure ulcers including Deep Tissue Injury identified with lapses in care during April 2022.
- 72% (5 out of 7 cases) Duty of Candour 10 working day letter performance following formal verbal notification. 6 patients have received written notification but 1 case is waiting update.
- C Diff YTD figures below trajectory with 13 against a target of 8.
- Sepsis Screening compliance in Emergency Portals below the target 90% with 60.8%.
- Maternity Sepsis Screening compliance 83.3% against 90% target
- Emergency Portals Sepsis IVAB in 1 hour 50% and is below the 90% target for audited patients

During April 2022, the following quality highlights are to be noted:

- The rate of complaints per 10,000 spells is 24.27 and is slightly below the target of 35 and within normal variation. Majority of complaints in April 2022 relate to clinical treatment.
- Total number of Patient Safety Incidents increased in month (1822) but the rate per 1000 bed days has increased at 48.95 and both measures are within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents above normal variation levels and incidents are under review to identify issues/themes but within normal variation.
- Increase in total reported incidents relating to staffing shortages and lack of appropriate staff on wards/departments during March 2022. 81 in total although 33 were coded as patient related, the remaining 48 were reported as staff related incidents.
- Rate of falls reported that have resulted in harm to patients currently at 1.3 per 1000 bed days in April 2022. The rate of patient falls with harm continues to be within the control limits and normal variation but is above the mean rate which indicates there may be improvement in reducing harm from falls.
- Medication related incidents rate per 1000 bed days is 4.4 and patient related 3.6 which are similar to previous month and mean rates. The monthly variation is within the normal expected variation and consistent with Trust mean rates.
- Pressure Ulcers per 1000 bed days developed under UHNM care has seen an increase during April 2022
- 52 Definite Hospital Onset / Nosocomial COVID-19 cases reported in February 2022.
- 7 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths of first positive result 15 days or more after admission to hospital).
- 14 Serious Incidents reported April 2022.



Quality Dashboard

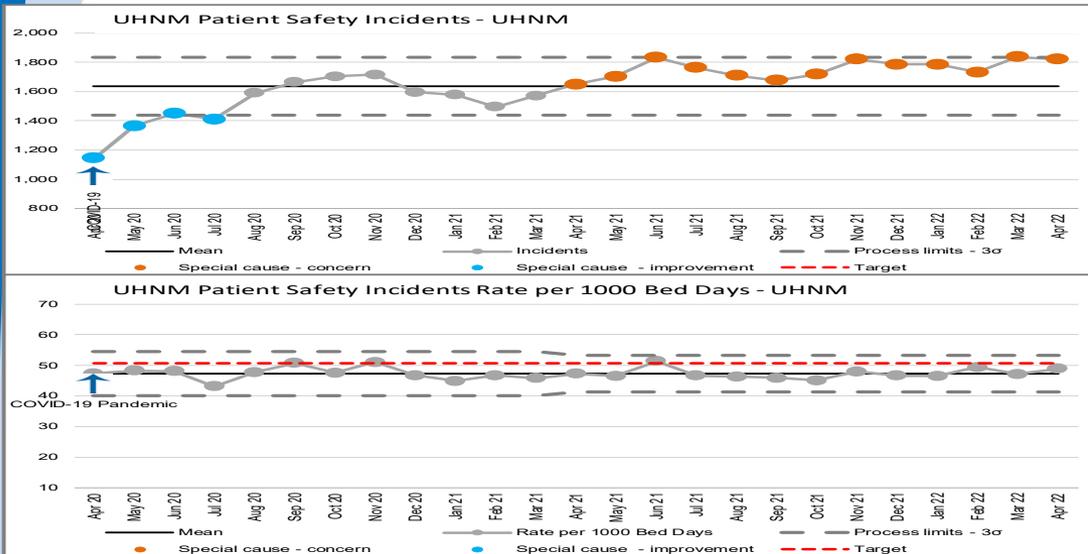
Metric	Target	Latest	Variation	Assurance	Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1822			Serious Incidents reported per month	0	14		
Patient Safety Incidents per 1000 bed days	N/A	48.95			Serious Incidents Rate per 1000 bed days	0	0.38		
Patient Safety Incidents per 1000 bed days with no harm	N/A	31.35							
Patient Safety Incidents per 1000 bed days with low harm	N/A	14.70			Never Events reported per month	0	0		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.96							
Patient Safety Incidents with moderate harm +	N/A	32			Duty of Candour - Verbal/Formal Notification	100%	100%		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.86			Duty of Candour - Written	100%	72.0%		
Harm Free Care (New Harms)	95%	96.3%							
					All Pressure ulcers developed under UHNM Care	TBC	90		
Patient Falls per 1000 bed days	5.6	7.2			All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	2.42		
Patient Falls with harm per 1000 bed days	1.5	1.3			All Pressure ulcers developed under UHNM Care lapses in care	12	24		
					All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.64		
Medication Incidents per 1000 bed days	6	4.4			Category 2 Pressure Ulcers with lapses in Care	8	10		
Medication Incidents % with moderate harm or above	0.50%	1.83%			Category 3 Pressure Ulcers with lapse in care	4	0		
Patient Medication Incidents per 1000 bed days	6	3.9			Deep Tissue Injury with lapses in care	0	8		
Patient Medication Incidents % with moderate harm or above	0.50%	2.05%			Unstageable Pressure Ulcers with lapses in care	0	6		

Quality Dashboard

Metric	Target	Latest	Variation	Assurance	Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	69.1%			Inpatient Sepsis Screening Compliance (Contracted)	90%	96.0%		
Friends & Family Test - Inpatient	95%	99.1%			Inpatient IVAB within 1hr (Contracted)	90%	100.0%		
Friends & Family Test - Maternity	95%	60.0%			Children Sepsis Screening Compliance (All)	90%	90.0%		
Written Complaints per 10,000 spells	21.11	24.27			Children IVAB within 1hr (All)	90%	N/A		
					Emergency Portals Sepsis Screening Compliance (Contracted)	90%	60.8%		
Rolling 12 Month HSMR (3 month time lag)	100	96.60			Emergency Portals IVAB within 1 hr (Contracted)	90%	50.0%		
Rolling 12 Month SHMI (4 month time lag)	100	102.97			Maternity Sepsis Screening (All)	90%	83.3%		
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	7			Maternity IVAB within 1 hr (All)	90%	100.0%		
VTE Risk Assessment Compliance	95%	99.3%							
Reported C Diff Cases per month	8	13							
Avoidable MRSA Bacteraemia Cases per month	0	0							
HAI E. Coli Bacteraemia Cases per month	8	9							
Nosocomial "Definite" HAI COVID Cases - UHNM	0	52							



Reported Patient Safety Incidents



Variation		Assurance			
		Target	Feb 22	Mar 22	Apr 22
		N/A	1733	1837	1822
Background					
Total Reported patient safety incidents					

Variation		Assurance		
50.70		49.40	47.16	48.95

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The April 2022 total remains above the mean total since COVID-19 started. However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

The largest categories for reported PSIs excluding Non Hospital acquired Pressure Ulcers are:

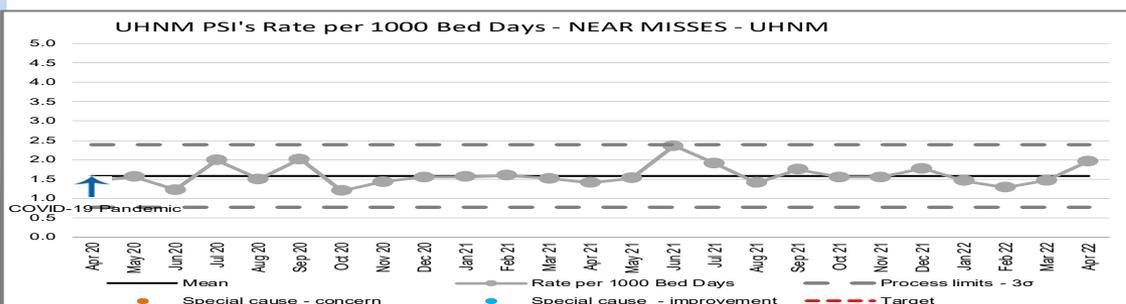
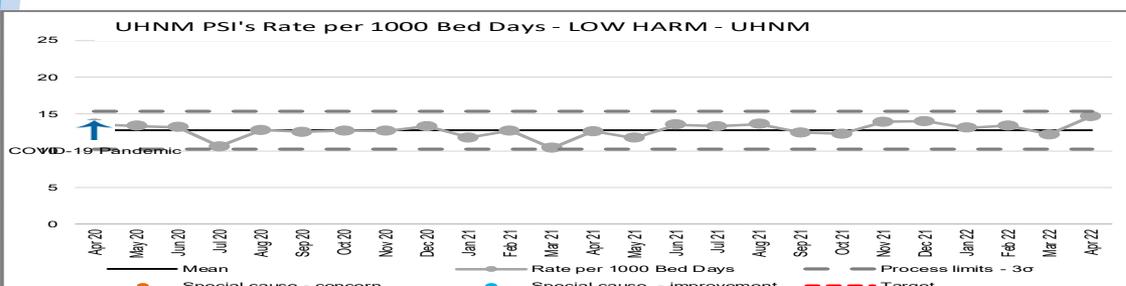
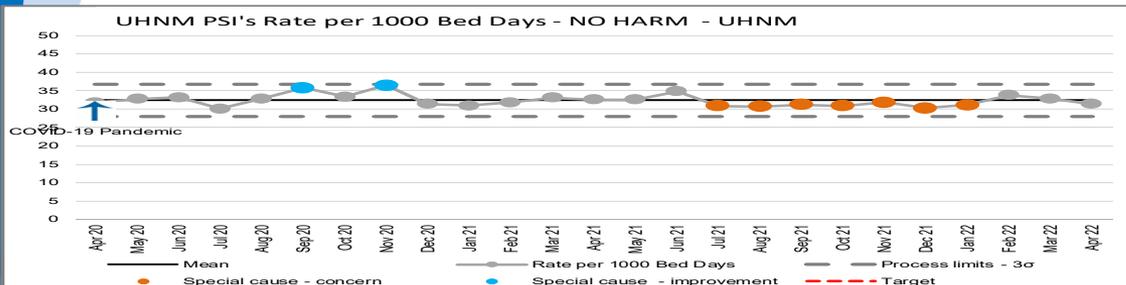
- Patient related Slip/Trip/Fall - 267 (278)
- Clinical assessment (Including diagnosis, images and lab tests) – 84 (85)
- Patient flow incl. access, discharge & transfer - 129 (110)
- Documentation – 52 (34)
- Pressure Ulcers (Hospital acquired) – 106 (70)
- Treatment/Procedure - 56 (61)
- Medication incidents - 148 (149)
- Infection Prevention – 39 (54)
- Staffing – 33 (28)
- Maternity Triggers - 58

There has been increase in the number of staffing related incidents submitted during April 2022 with 81 (85 in March, 55 in February, 60 in January, 74 in December, 60 in November and 61 in October) incidents reported. 33 of these were under patient related, 43 were reported as staff related and 5 Trust related. All of these incidents were relating to lack of suitable trained staff. Individual incidents may relate to lack of different staff groups and during April 2022 the following were reported:

- 77 (63 in March, 48 in February, 49 in January 2022 and 69 in December 2021) – insufficient professional healthcare staff
- 9 (13 in March, 2 in February, 13 in January 2022 and 7 in December 2021) – insufficient non professional healthcare staff
- 7 (9 in March, 6 in February, 9 in January 2022 and 6 in December 2021) – insufficient support staff

The rate of reported PSIs per 1000 bed days has remained relatively stable following the change at the start of COVID-19 pandemic but is currently below the NRLS Mean rate

Reported Patient Safety Incidents with No / Low Harm or Near Misses per 1000 bed days



Variation		Assurance		
Target	Feb 22	Mar 22	Apr 22	
N/A	33.81	32.89	31.35	
Background				
The rate of Patient safety Incidents per 1000 bed days that are reported as resulting in No Harm to the affected patient.				

Variation		Assurance		
Target	Feb 22	Mar 22	Apr 22	
N/A	13.43	12.22	14.70	
Background				
The rate of Patient safety Incidents per 1000 bed days that are reported as resulting in LOW Harm to the patient.				

Variation		Assurance		
Target	Feb 22	Mar 22	Apr 22	
N/A	1.28	1.46	1.96	
Background				
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS				

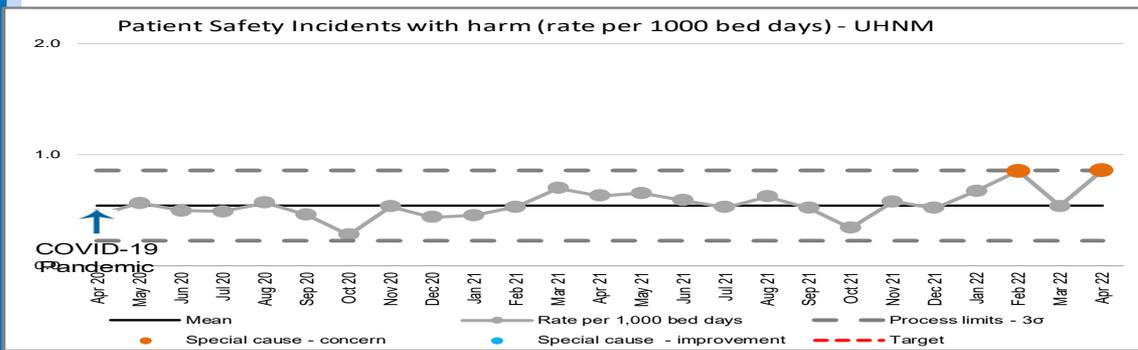
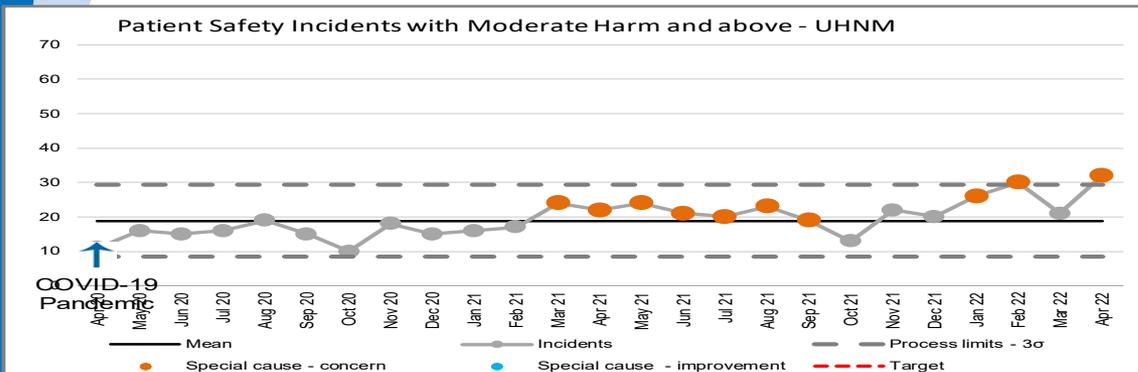
What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with no harm or low harm are showing consistent trends. Although Low harm has seen increase in recent months the rate is still within normal variations and around the long term mean for no harm, low harm and near miss incidents.

The reporting of all incidents and near misses should continue to be encouraged so that mitigating actions and learning can be identified via these incidents to further improve the quality of care and services provided and reduce risk of serious harm.



Reported Patient Safety Incidents with Moderate Harm or above



What is the data telling us:

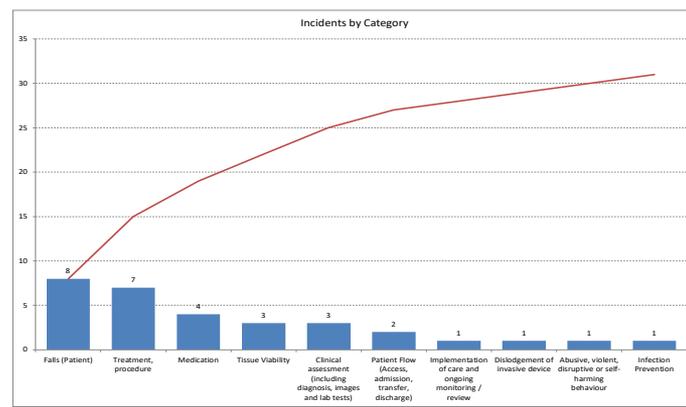
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within outside variation and with monthly special cause noted. The monthly total may be amended following investigation of the incidents and level of harm reviewed and confirmed.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with 8 Falls, 7 Treatment related, 4 medication being top 3 categories.

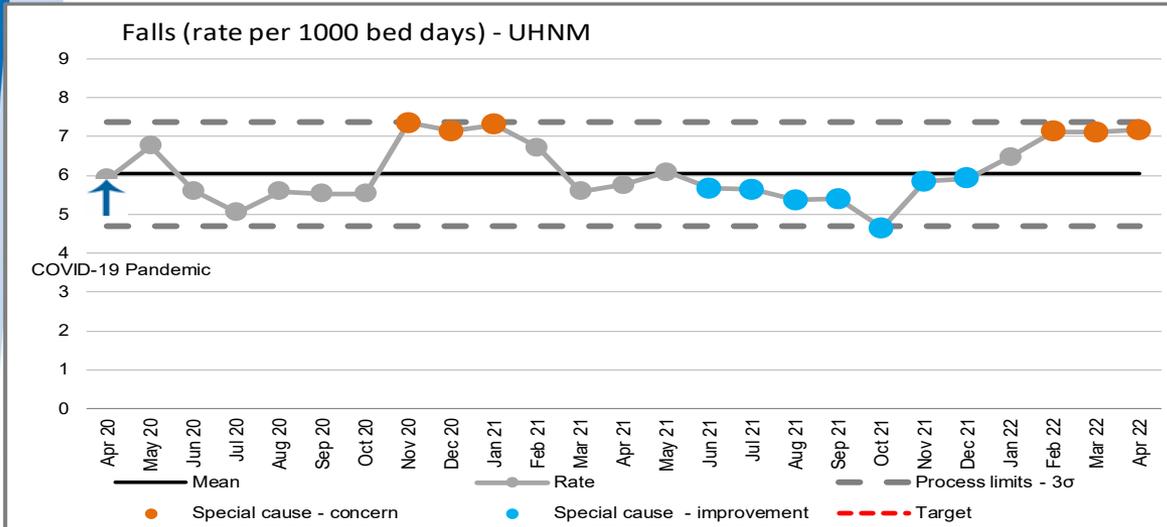
National Comparison taken from latest CQC Insight Report is that 26.1% of reported patient safety incidents to NRLS resulted in harm. UHNM latest results are 22.8%.

Variation		Assurance		
Target		Feb 22	Mar 22	Apr 22
N/A		30	21	32
Background				
Patient safety incidents with reported moderate harm and above				

Variation		Assurance		
Target		Feb 22	Mar 22	Apr 22
N/A		0.86	0.54	0.86



Patient Falls Rate per 1000 bed days



Variation		Assurance		
Target		Feb 22	Mar 22	Apr 22
N/A		7.1	7.1	7.2
Background				
The number of falls per 1000 occupied bed days				

What is the data telling us:

The Trust's rate of reported patient falls per 1000 bed days has been near to the upper control limit for the past 3 months which indicates potentially significant change.

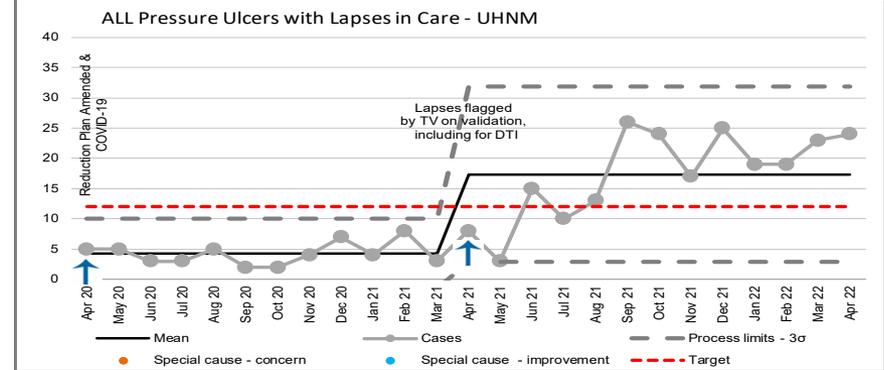
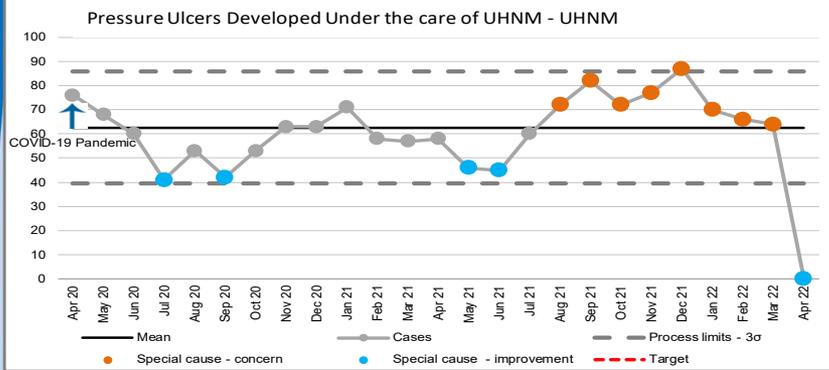
The areas reporting the highest numbers of falls in April 2022 were:

Royal Stoke ED- 25 falls Royal Stoke AMU – 18 falls Royal Ward 225 – 13 falls

Recent actions taken to reduce impact and risk of patient related falls include:

- A Falls Champion Refresher date has taken place and staff will be attending the presentation for the new falls champions day this month.
- 10 of the doors in ECC red majors are due to be removed in the next 4 months and replaced with clear doors.
- The Top 5 falling wards have had audits carried out on the risk assessments of falls. This information gathered has been cascaded to the wards.
- Further audits are continuing to ensure that preventative measures are in place to mitigate the risk that has been identified.
- County Hospital are completing an audit to ensure all new patients that utilise a mobility aid at home are provided with a mobility aid on admission to the hospital, that a physiotherapy referral has been requested and that the mobility aid denotes the correct banding.

Total Pressure Ulcers developed under care of UHNM



Variation		Assurance	
Target	Feb 22	Mar 22	Apr 22
N/A	66	64	0
Background			
Number of Deep Tissue injuries and Category 2-4 and Unstageable pressure ulcers which developed under the care of UHNM			

Variation		Assurance	
Target	Feb 22	Mar 22	Apr 22
12	19	23	24
Background			
ALL pressure ulcers which developed whilst under the care of UHNM with lapses in care identified			

The number of pressure ulcers reported as developed under UHNM care has been above average for 8 of the past 9 months, which may indicate a significant change. The tables below show breakdowns of the pressure ulcers reported last month.

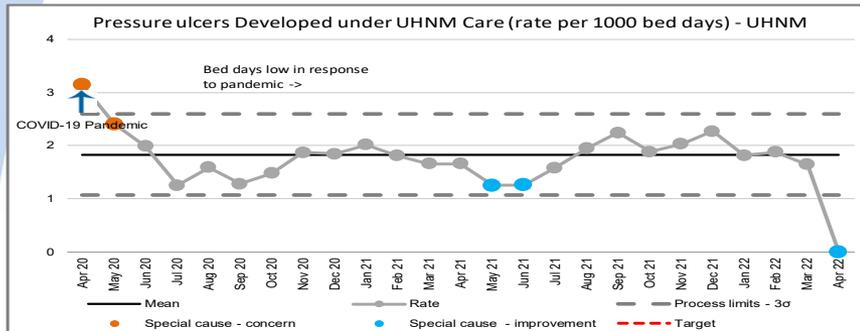
Category	Total (Apr 2022)
DTI	34
Category 2	42
Category 3	2
Category 4	0
Unstageable	14
Total	92

Top Body Locations	Total (Apr 2022)
Heel	22
Buttock	22
Sacrum	13

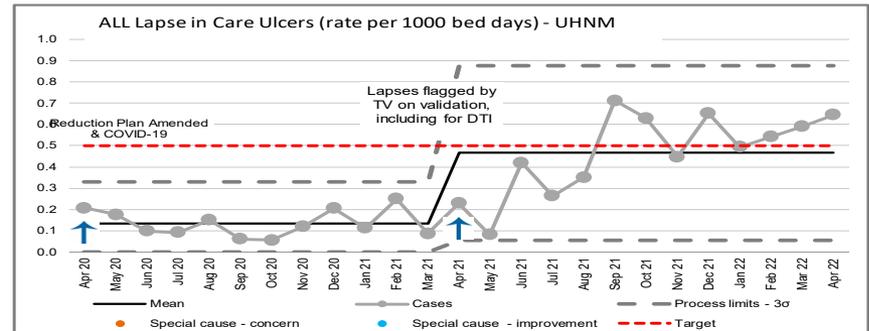
The number of DTI's reported as developed under UHNM care has been above average for 9 consecutive months, and the number of Category 2's reported in April was significantly above the 2 year monthly average of 26. Numbers within other categories are stable.

The number of pressure ulcers reported as developing under the care of UHNM, where lapses in care have been identified, has been significantly higher than in previous years, but there does not currently appear to be a further increasing trend.

Pressure Ulcers developed under care of UHNM per 1000 bed days



Variation		Assurance		
Target		Feb 22	Mar 22	Apr 22
	N/A	1.88	1.64	0.00
Background				
Rate of Deep Tissue injuries and Category 2-4 and Unstageable pressure ulcers which developed under the care of UHNM				



Variation		Assurance		
Target		Feb 22	Mar 22	Apr 22
	0.5	0.54	0.59	0.64
Background				
Rate of ALL pressure ulcers which developed whilst under the care of UHNM with lapses in care identified				

What the data is telling us

The rate of pressures ulcers reported as developed under UHNM care appears stable, showing only expected variation. The rate of ulcers with lapses in care has been significantly higher than in previous years, but there does not currently appear to be a further statistically significant increasing trend.

Acuity for ward areas is taken into account in line with lapses in care.

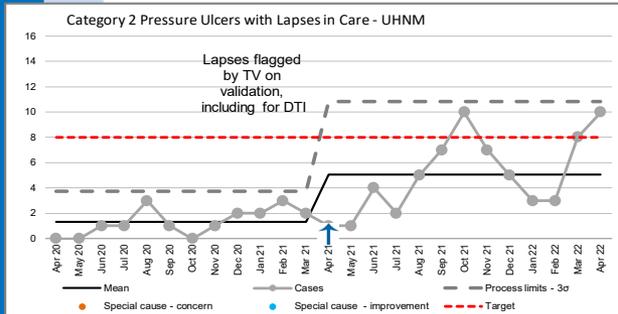
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.

Pressure Ulcer prevention is an annual objective and a key driver metric as part of the Trust's Improving Together programme.

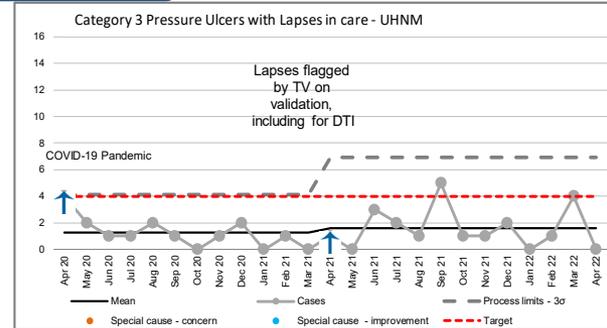
Actions

- Multiple areas are reviewing documentation and will be presented at Steering group
- Pressure Ulcer Prevention (PUP) education is now delivered on multiple platforms including the Nursing Assistant, adaptation nurse and Preceptorship induction programme , new starters in ED and child health, Mandatory ED training and ward PUP champions has been re-launched to cascade information. Education and support can also be requested as required.
- Communication is provided by SSR for Q&S to multiple reporting wards to highlight learning needs and support formulation of the action panel ahead of RCA panel.
- Following RCA panel assurance is sought from clinical areas by SSR for Q&S, spot audits are completed during the visit.
- RCA process is under constant review for improvement and to support ward in learning
- Review of surfaces in ED to enhance Pressure ulcer prevention, 15 Stryker trollies with high quality pressure relieving mattresses have been purchased. ED repose companions have arrived and staff will receive training by end of May. An Ambulance assessment tool has been devised to implement early intervention of PUP however support is still being sought from WMAS.

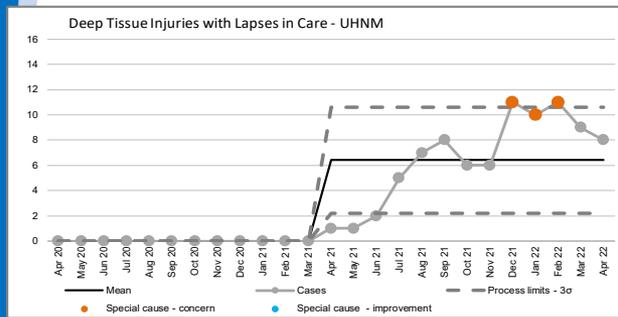
Pressure Ulcers with lapses in care



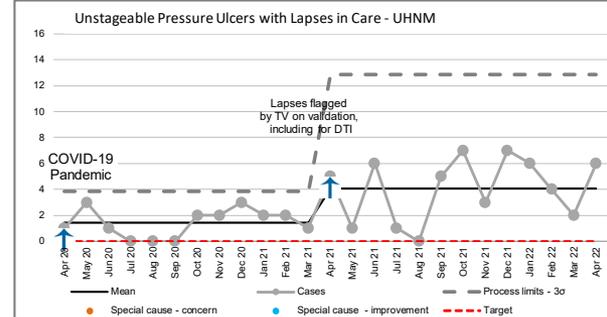
Variation	Assurance			
Target	Feb 22	Mar 22	Apr 22	
	8	3	8	10
Background				
Category 2 pressure ulcers which developed whilst under the care of UHNM which had lapses of care associated				



Variation	Assurance			
Target	Feb 22	Mar 22	Apr 22	
	4	1	4	0
Background				
Category 3 pressure ulcers which developed under the care of UHNM with lapses in care associated				



Variation	Assurance			
Target	Feb 22	Mar 22	Apr 22	
	N/A	11	9	8
Background				
Deep Tissue Injuries which developed under the care of UHNM with lapses of care associated				



Variation	Assurance			
Target	Feb 22	Mar 22	Apr 22	
	0	4	2	6
Background				
unstageable ulcers which developed under the care of UHNM with lapses in care associated				

What is the data telling us:

The number of pressure ulcers reported as developing under UHNM care with identified lapses in care is showing only normal variation in each of the categories .
As shown in the table below, the most common lapses identified was management of repositioning.

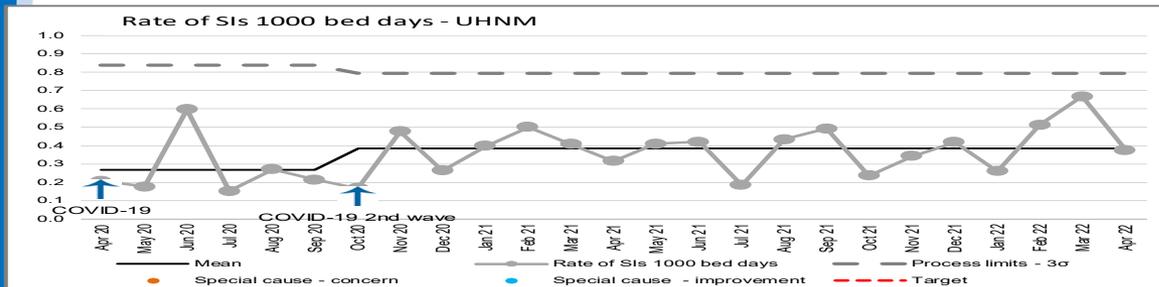
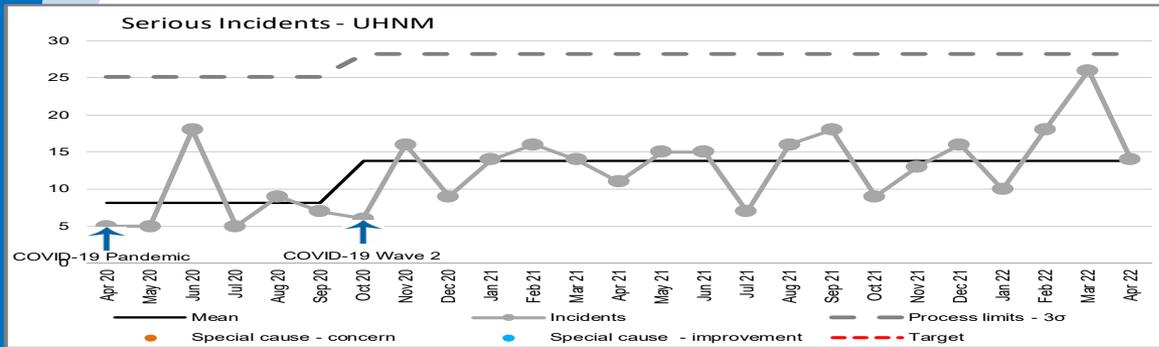
Locations with more than 1 lapse in April 2022 were: **AMU (Stoke) (5), ED (Stoke) (3), Ward 106/107 (2), Ward 227 (2)**

Root Cause(s) of damage - Lapses - Apr 2022	Total
Management of repositioning	15
Management of heel offloading	4
Management of device	4

Actions:

- High reporting wards will be sent notification, with Hot Debriefs taking place on the wards
- Education continues to be offered on high reporting areas
- Pressure Ulcer Prevention (PUP) Champions training dates have commenced, along with other training from the TV team
- Heel offloading campaign to take place at the end of May
- Tendable audit questions completed which will support with RCA learning and 5 key questions which link into common RCA themes will be added to CEF

Serious Incidents per month



Variation	Assurance		
Threshold	Feb 22	Mar 22	Apr 22
	0	18	26
Background			
The number of reported Serious Incidents per month			

Variation	Assurance		
Target	Feb 22	Mar 22	Apr 22
	0	0.51	0.67
Background			
The rate of Serious Incidents Reported per 1000 bed days			

What is the data telling us:

Monthly variation is within normal limits. Target has been set at 0 for serious incidents but this is under review to develop trajectory for reducing serious incidents across UHNM. April 2022* saw 14 incidents reported with 12 at RSUH and 2 at County Hospital (both falls):

- 10 Falls related incidents
- 2 Medication related
- 2 Diagnostic related

The rate of SIs per 1000 bed days has varied consistently within confidence limits indicating normal variation and there has not been any significant trends. The current rate of SIs per 1000 bed days for April 2022 is 0.38 and is above the long term mean of 0.36 since COVID-19 started in December 2020.

*Reported on STEIS as SI in April 2022, the date of the incident may not be April 2022.

Serious Incidents Summary

Summary of new Maternity Serious Incidents

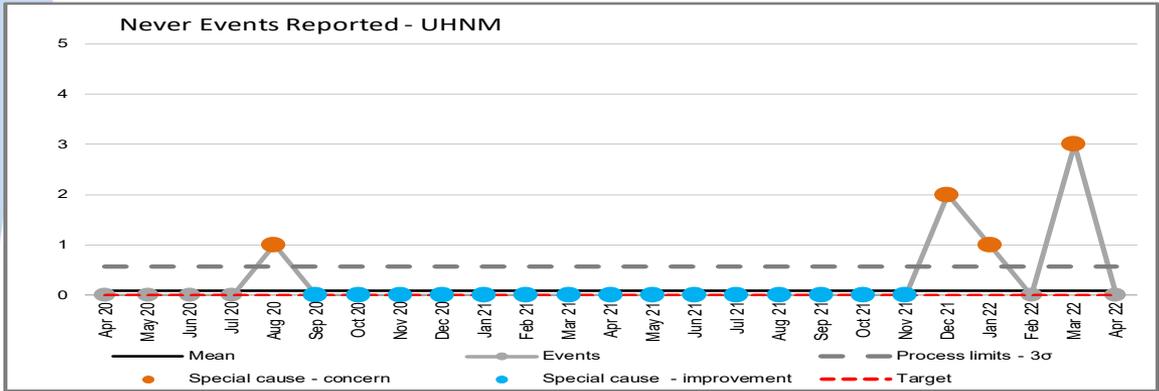
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during March 2022. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary of numbers and categories.

All Serious Incidents will continue to be reported and investigated and the final Root Cause Analysis presented at Divisional meetings and Risk Management Panel for review and agreement prior to sharing with CCGs for closure.

There were 0 Maternity related Serious Incidents reported on STEIS during April 2022

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:

Never Events

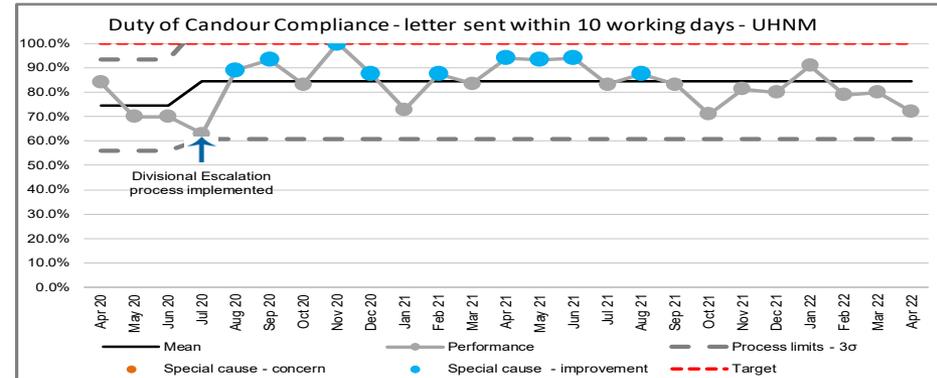
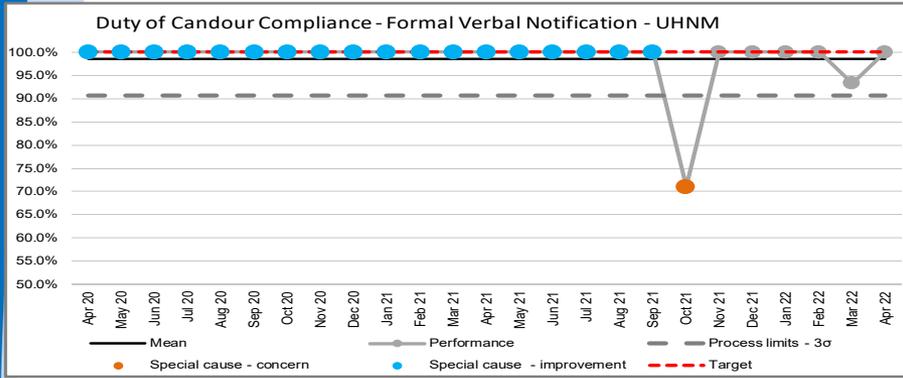


Variation		Assurance					
Target	0	Feb 22	0	Mar 22	3	Apr 22	0
Background							
Defined as Serious Incidents that are wholly preventable, as strong systemic protective barriers should be in place							

There has been 0 reported in April 2022 and 6 in total for 2021/22. The target is to have 0 Never Events.

Log No.	STEIS Category	Never Event Category	Description	Target Completion date

Duty of Candour Compliance



Variation		Assurance		
Target	Feb 22	Mar 22	Apr 22	
100%	100.0%	93.3%	100.0%	
Background				
The percentage of duty of candour incidents reported per month with verbal notification recorded/undertaken				

Variation		Assurance		
Target	Feb 22	Mar 22	Apr 22	
100%	79.0%	80.0%	72.0%	
Background				
The percentage of notification letters sent out within 10 working day target				

What is the data telling us:

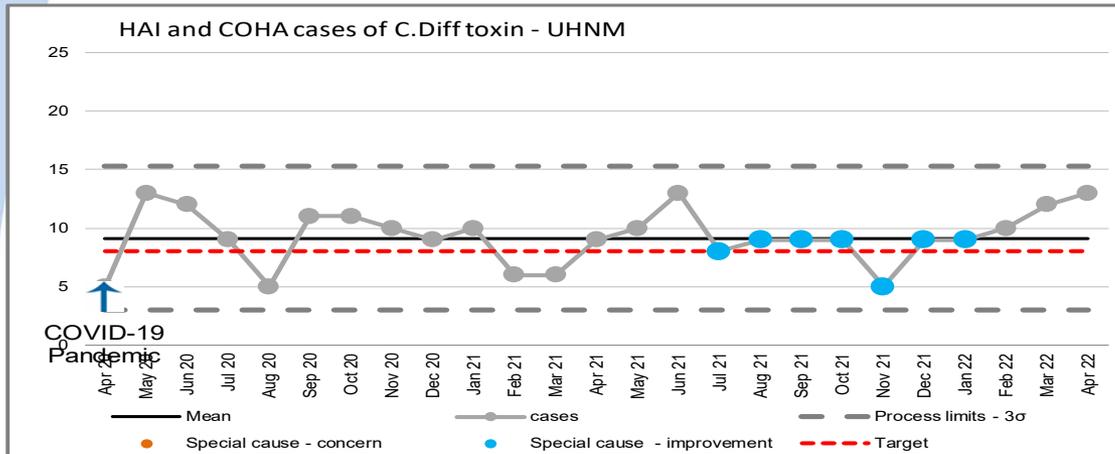
During April there were 7 incidents reported and identified that have formally triggered the Duty of Candour. All 7 of these cases (100%) have recorded that the patient/relatives been formally notified of the incident in Datix. Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during April 2022 is 72%. There is 1 case that did not received the letter within 10 days but have subsequently been circulated to patients/relatives and there is 1 case still awaiting update on Datix.

Actions taken:

The Divisions have escalated performance within their governance and performance forums and follow up with clinicians is being taken to ensure tat letters are provided within the timeframe. Escalations on outstanding letters are provided to relevant directorates and divisions via the Divisional Governance & Quality Managers and these are provided once identified and Duty of Candour required and where there has been no response prior to the deadline date. Compliance is included in Divisional reports for discussion and action.



Reported C Diff Cases per month



Variation		Assurance		
Target		Feb 22	Mar 22	Apr 22
8		10	12	13
Background				
Number of HAI + COHA cases reported by month				

What do these results tell us?

Number of C Diff cases are within SPC limits and normal variation .

There have been 13 reported C diff cases in April with 10 being Hospital Associated Infection (HAI) cases and 3 COHA cases.

HAI: cases that are detected in the hospital three or more days after admission (day 1 is the day of admission)

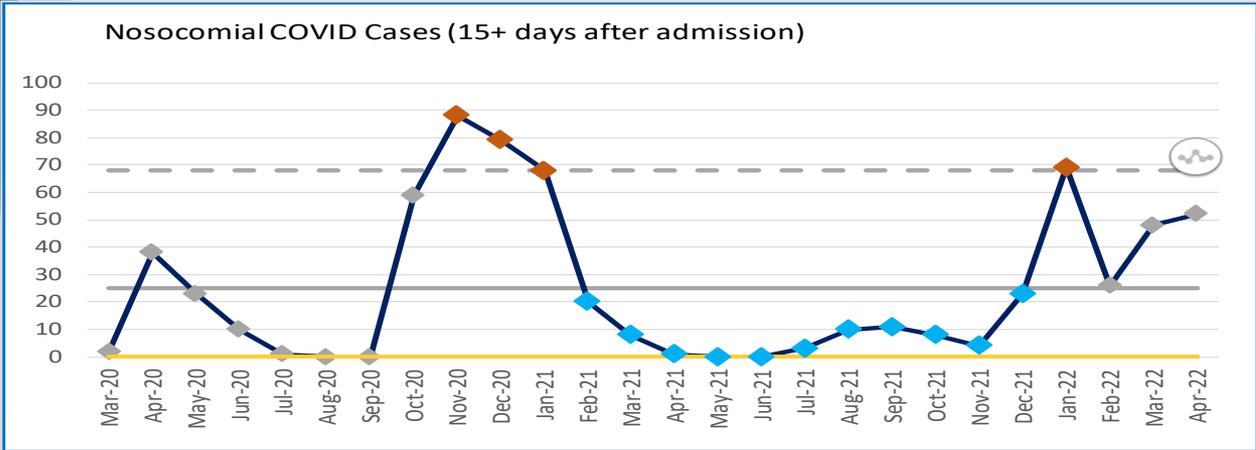
COHA: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks

There has been one clinical area that has had more than one Clostridium *difficile* case in a 28 day period. Ribotyping results are still outstanding so it is not yet possible to determine whether patient to patient transmission has occurred.

Actions:

- Continue surveillance for HAI C diff with continued immediate implementation of control measures to prevent transmission
- In all cases control measures are instigated immediately
- Each in-patient is reviewed by the C *difficile* nurse at least 3 times a week, and forms part of a multi-disciplinary review.
- Routine ribotyping of samples is now being undertaken at Leeds hospital. This will help determine if cases can be linked
- A Clostridium *difficile* task and finish Group in progress

HAI Nosocomial COVID Cases per Month



What do these results tell us?

- Increase in cases throughout April 2022 with 51 definite Healthcare Acquired COVID -19 cases.
- April has seen increase in Probable and definite Hospital Onset COVID
- Monthly total is within normal variation

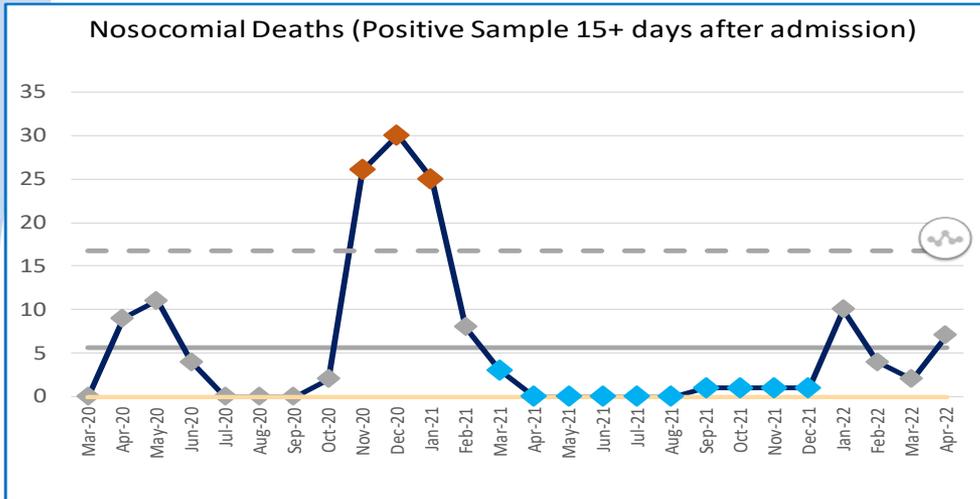
Actions :

- All Emergency patients continue to be screened for COVID 19 on admission to UHNM, screening programme in place for planned surgery/procedures.
- All inpatients who have received a negative COVID 19 screen continue to have a repeat COVID 19 screen on day 4 , 6 and then weekly
- COVID 19 themes report provided to IPCC
- UHNM Guidance on Testing and re-testing for COVID 19 plus step down of suspected/positive cases
- Isolate suspected patients on identification of symptoms
- Process for patients identified as a contact with positive patients
- Process in place for outbreak management and reporting

	UHNM		
	Total Admissions	COVID cases	
		Prob	Def
Oct 20	17006	63	59
Nov 20	14956	109	88
Dec 20	14701	107	79
Jan 21	14255	128	68
Feb 21	14101	31	20
Mar 21	17105	12	8
Apr 21	16554	3	1
May-21	17273	0	0
Jun-21	18527	0	0
Jul-21	18168	4	3
Aug-21	17160	14	10
Sep-21	17327	11	10
Oct-21	17055	8	8
Nov-21	17700	4	4
Dec-21	16688	13	23
Jan-22	16109	67	69
Feb-22	16278	39	26
Mar-22	18518	71	48
Apr-22	16538	72	52



Nosocomial COVID-19 Deaths per month (with 1st positive result 15 days or more after admission)



What do these results tell us?

Increase in monthly total but within normal variation limits

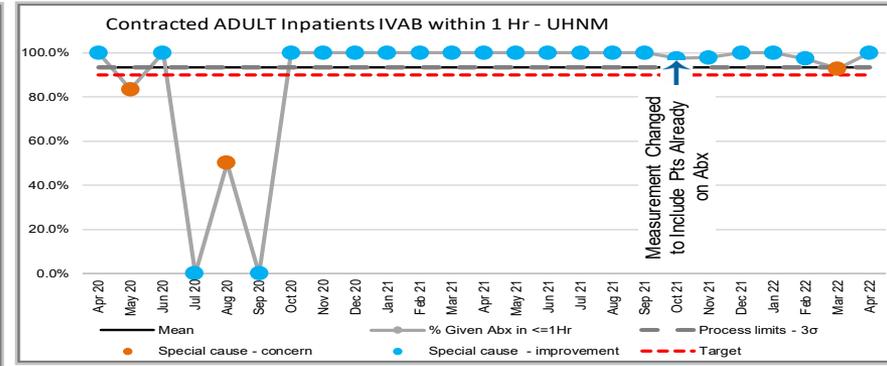
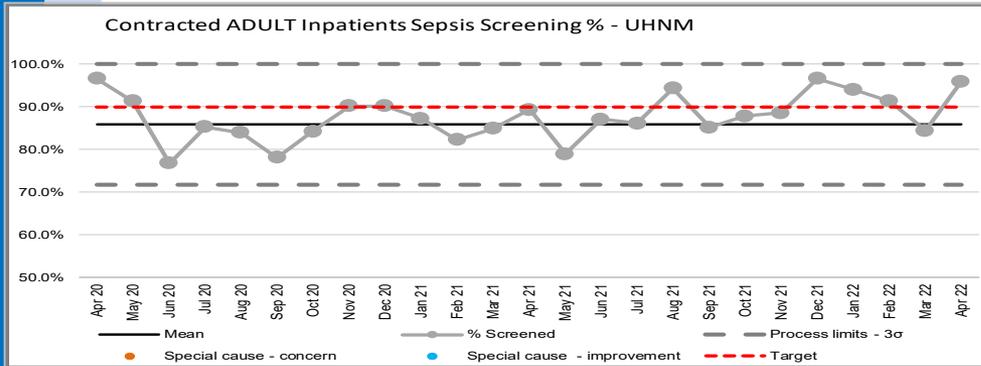
The criteria for the Definite Hospital acquired/Nosocomial COVID-19 is that the patient had **first positive** COVID-19 swab result 15 days or more following admission to UHNM.

- 7 recorded definite hospital onset COVID-19 deaths in April 2022
- Total 143 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since 1st March 2020 up to 30th April 2022
- 20 Definite Hospital acquired COVID-19 deaths during 2021/2022
- The mean number of deaths per month since March 2020 is 6.

Actions :

All definite Nosocomial COVID-19 deaths up to March 2022 have been reviewed and report has been submitted to the Mortality Review Group identifying the outcome of the case reviews assessing the aspects of COVID-19 management of the patients. Reviews for any further deaths will be undertaken and outcomes compared to the reviews already completed.

Sepsis Screening Compliance (Inpatients Contract)



Variation		Assurance		
Target	Feb 22	Mar 22	Apr 22	
90%	91.3%	84.4%	96.0%	
Background				
The percentage of adult Inpatients identified during monthly spot check audits with Sepsis Screening undertaken for Sepsis Contract				

Variation		Assurance		
Target	Feb 22	Mar 22	Apr 22	
90%	97.2%	92.9%	100.0%	
Background				
The percentage of adult inpatients identified during monthly spot check audits receiving IV Antibiotics within 1 hour for Sepsis Contract				

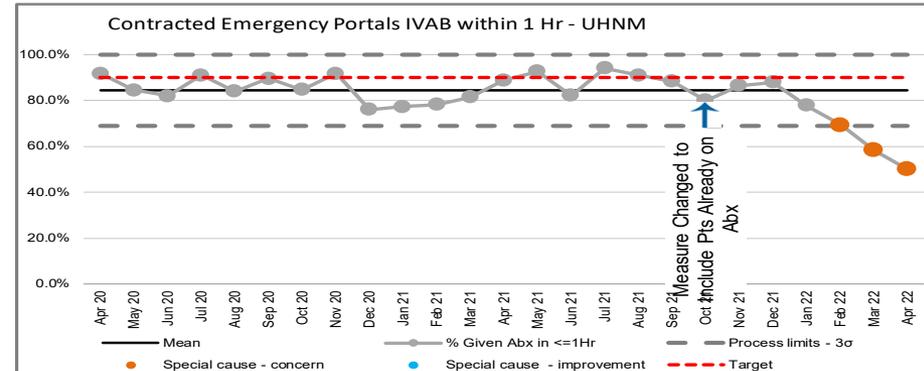
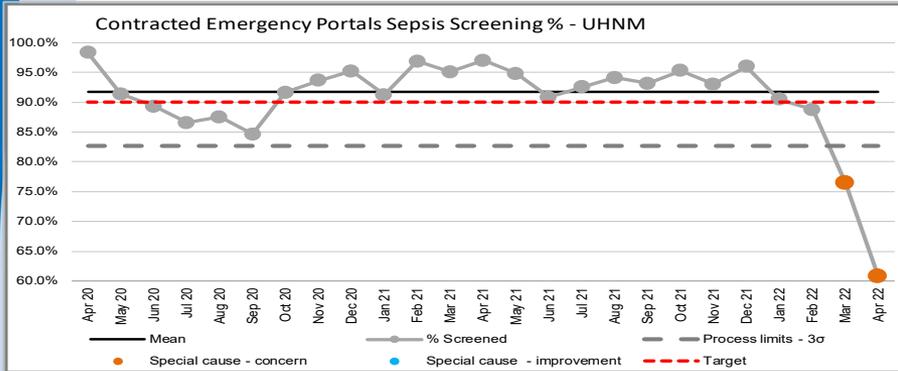
What is the data telling us:

Inpatient areas achieved the screening target in April 2022 however variation is within normal ranges. IVAB within 60 minutes is also above target rate with consistently high results.

Actions:

- The Sepsis team have continued to focus on providing ward based sepsis session/kiosks on targeted clinical areas
- The Sepsis team regularly identify areas of poor compliance and prioritise those areas for more focused sepsis re-enforcement: on-going
- The Sepsis team continued to work closely with the VitalPac team in order to address issues in timely manner and work in sepsis vitals upgrade is on-going
- Continued focus and support provided to all divisions to maintain and sustain compliance: on-going
- The Sepsis Team will continue to create awareness by being involved for HCA, students and new nursing staff induction programmes: on-going

Sepsis Screening Compliance (Emergency Portals Contract)



Variation		Assurance		
Target	Feb 22	Mar 22	Apr 22	
90%	89%	76%	61%	
Background				
The percentage of audited Emergency Portal patients receiving sepsis screening for Sepsis Contract purposes				

Variation		Assurance		
Target	Feb 22	Mar 22	Apr 22	
90%	69%	58%	50%	
Background				
The percentage of Emergency Portals patients from sepsis audit receiving IVAB within 1 hour for Sepsis Contract purposes				

What is the data telling us:

Adult Emergency Portals screening below target for April 2022. Prior to February 2022 there had been consistent achievement of target performance above the target rate.

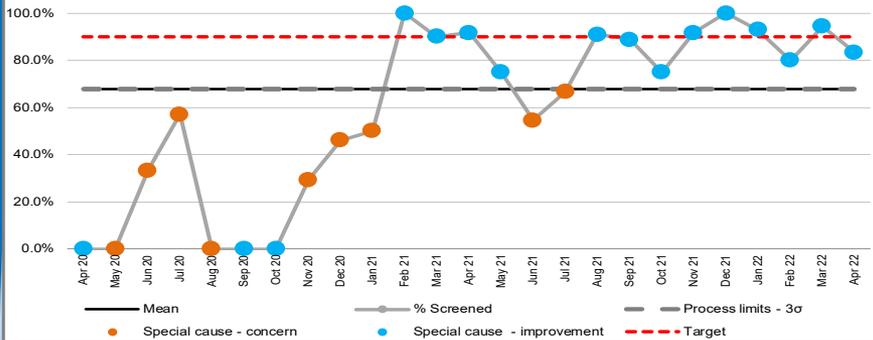
The performance for IVAB within 1hr below target rate in April 2022 at 50%

Actions:

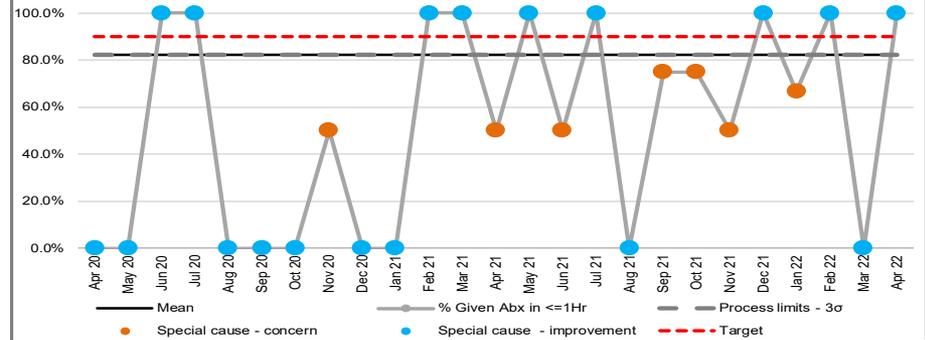
- The Sepsis team continued to closely monitor compliance by visiting and auditing A&E regularly. Provide sepsis session when staffing and acuity allows: on-going
- The Sepsis team is working collaboratively with the A&E Quality nurses, sepsis champions, senior team and A&E sepsis clinical lead to provide support with late IVAB incidents. The screening documentation and late IVAB have been addressed through escalation however, on-going plan to resolve issue with holding ambulances remain the challenge .
- Face to face A&E sepsis induction for new nursing staff, nursing assistant and medical staff will recommence once capacity pressure/flow improve in the department
- Regular meeting with A&E senior team reinstated to review current robust actions in place

Sepsis Screening Compliance ALL Maternity

ALL Maternity Sepsis Screening % - UHNM



ALL Maternity IVAB within 1 Hr - UHNM



Variation		Assurance		
Target	90%	Feb 22	Mar 22	Apr 22
	80.0%	94.4%	83.3%	
Background				
The percentage of ALL Maternity patients identified during monthly spot check audits receiving sepsis screening.				

Variation		Assurance		
Target	90%	Feb 22	Mar 22	Apr 22
	100%	N/A	100%	
Background				
The percentage of ALL Maternity patients from sepsis audit sample receiving IVAB within 1 hour				

What is the data telling us:

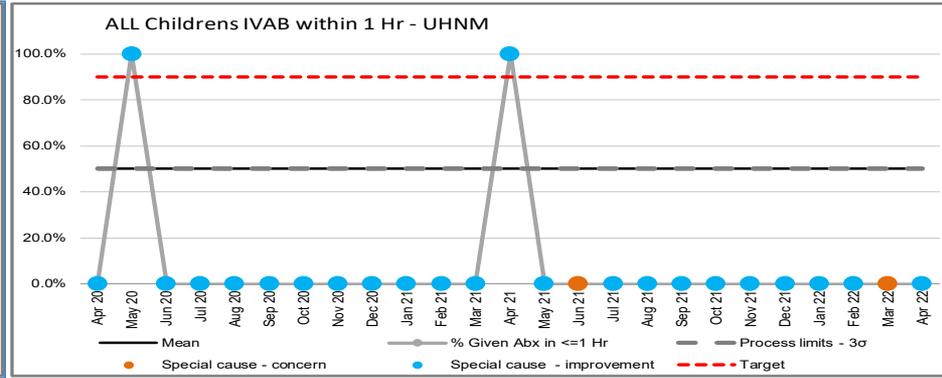
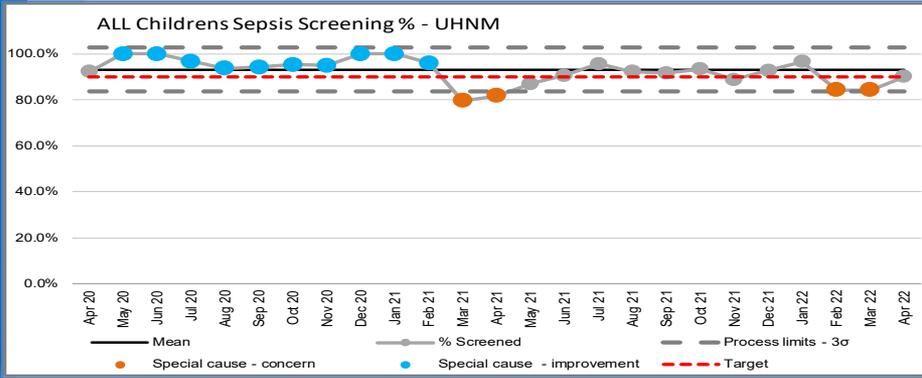
Maternity Inpatients and Emergency portal (MAU) audits show significant improvement in screening compliance above the mean rate with a return to above target performance with 83.3% in April

100% of the red flag sepsis patients identified in the April 2022 audits achieved IV antibiotics within an hour.

Actions:

- The Maternity Senior team and clinical staff have continued to work collaboratively with the sepsis team to ensure patient safety: on-going
- The Sepsis team will continue to audit comprehensively to ensure maintenance of high standard of sepsis practice and compliance: on-going
- Maternity educator is supporting the sepsis team by conducting independent sepsis audits in the whole Maternity department with good effect: on-going
- PGD for sepsis led by Maternity educator/team is underway and this will be supported by the sepsis team, micro consultant, pharmacist and sepsis clinical lead
- Future plan for Maternity 5 hour sepsis CPD champion training remain in the pipeline however, has been temporarily put on-hold due to current operational pressures

Sepsis Screening Compliance ALL Children



Variation		Assurance		
Target	Feb 22	Mar 22	Apr 22	
90%	84.4%	84.4%	90.0%	
Background				
The percentage of ALL Children identified during monthly spot check audits with Sepsis Screening undertaken				

Variation		Assurance		
Target	Feb 22	Mar 22	Apr 22	
90%	N/A	0.0%	N/A	
Background				
The percentage of ALL Children identified during monthly spot check audits with IV Antibiotics administered within 1 hour				

What is the data telling us:

Children's Services show normal variation for Sepsis Screening and have previously achieved the target rate but not consistently achieving the 90% rate. Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks).

Actions:

- The Sepsis Team will continue to deliver re-enforcement and kiosks to specific areas when falls in compliance are identified: on-going
- The Sepsis Team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective; on-going
- Plan of collaborative work with Children education lead and aiming to deliver 3-5 hour Sepsis CPD champion training and ward based sessions: on- hold but plan to reinstate in the next few months

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"



Planned Care

The focus of activities for Planned Care has been as follows:

- Day Case and Elective Activity delivered 85% and 84.5% respectively for April 22 against the national ask of 110%, a significant improvement on March's position for Day Case (83%) and Electives (81%).
- A combined site focus on Theatres, by booking ahead, ensuring all lists are fully used and only for the most urgent and longest waiting patients is being enabled by a revitalised "6-5-4" weekly meeting which will continue to increase theatre throughput past 1920 levels
- In month Planned Care Cell focus on elective recovery based on 10 high impact changes in accordance with the elective plan.
- Theatre plan for Q1 2022/23 gives 104% of 19/20 capacity. "Bookathon" launched to ensure theatre utilisation is improved, and to date as many long waiters and P2s as possible. County theatre re-opened 11th April – all 7 theatres now online.

RTT

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For April the indicative number of Incomplete pathways has risen to 76,023 (March 74,984).
- The number of patients > 18 weeks has risen to a level of 35,345 (March 33,665)
- The numbers of 52 week waits in April has decreased with a total of 4,483 compared to 4,603 in March.
- At the end of April the numbers of > 104 weeks was 314 a decrease from 494 in March The Planned Care group is monitoring progress against treatment plans for these patients. The reduction in 104 week patients has reduced the patients likely to breach 104 weeks from to around 40 in May with patient by patient focus on reducing that number further, as well as minimising the cancellations might not be bookable again until July.
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.

Diagnostics

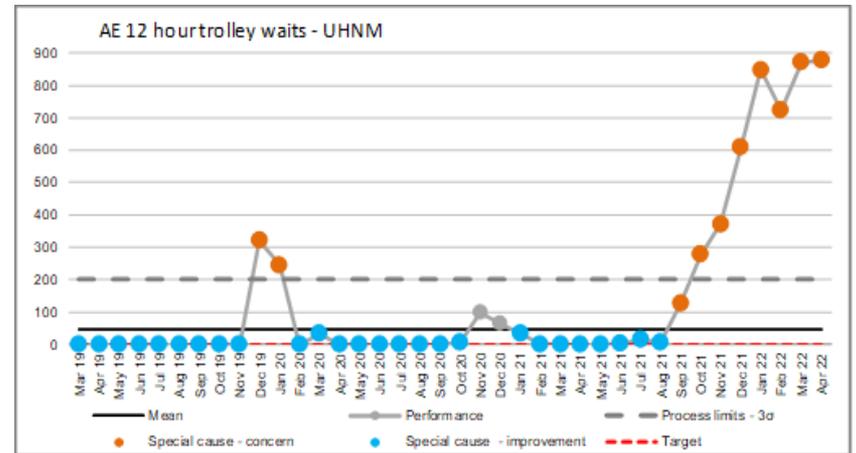
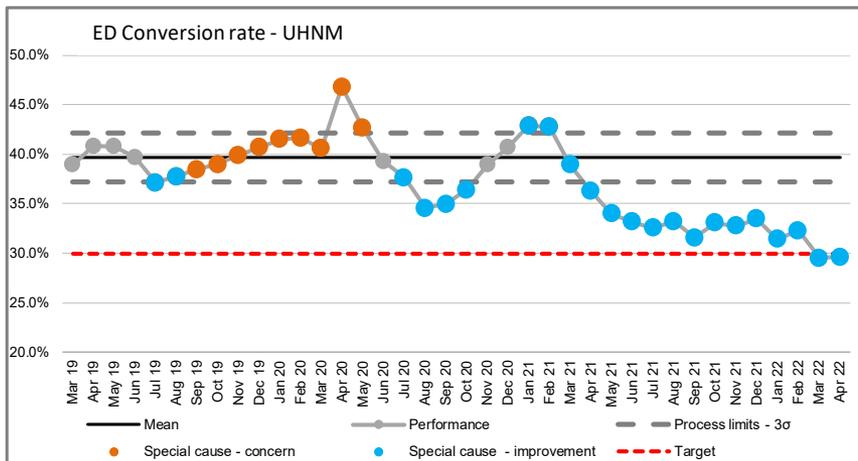
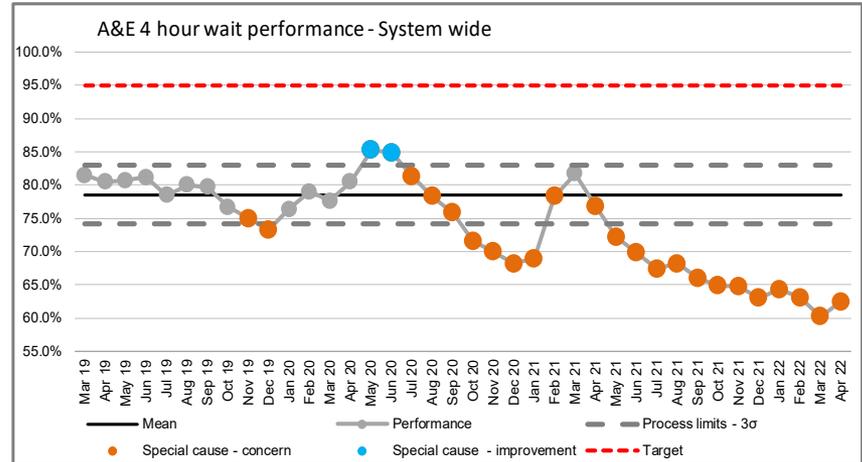
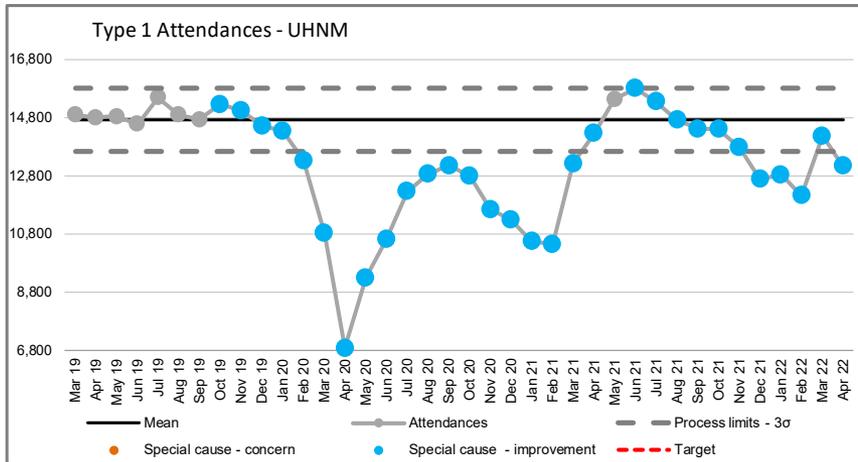
- For DM01 (15 nationally identified Dx tests) the validated position for total waiting list has decreased in April from 24,004 to 23,502. The Non-obstetric ultrasound waiting list increased slightly from 9,550 to 9,631. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance is at 66.86%.
- Within DM01, the greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls, a number of actions are in place. Non obstetric ultrasound performance remains a Driver Metric for CWD and has specific focus for improvement, albeit this is related to workforce retention, recruitment and innovative ways to train and recruit. Further outsourcing of non-obstetric ultrasound scanning is continuing to be explored.
- DM01 performance excluding non obs ultrasound would be 78%. Non-DM01 diagnostics are being reviewed against the standard concentrating on the Cancer and the RTT delays to ensure that robust plans and trajectories are put in place to reduce delays.
- Histology turnaround times remain a high risk; there is an action plan in place and the position is improving. Cancer related histology is being treated urgently and all cancer related escalations are being prioritised.

Section 1: Urgent Care

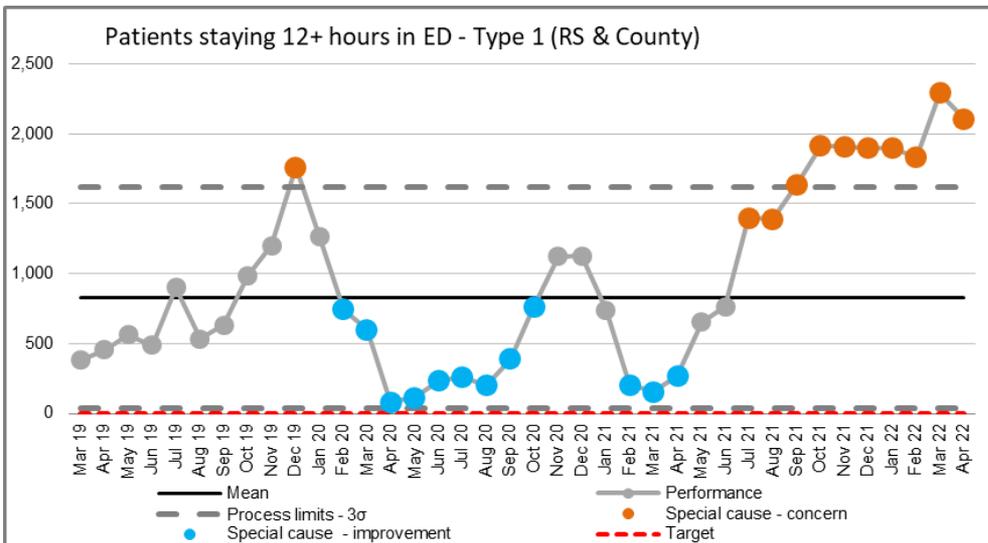
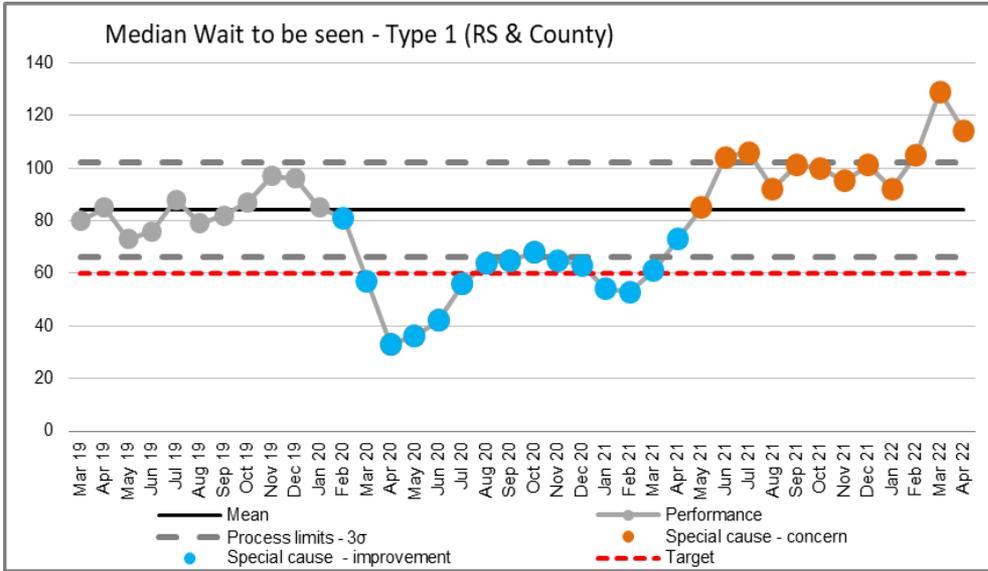
Headline Metrics



Urgent Care – monthly (context)



WTBS & 12 Hour in department



Variation		Assurance		
Target	60	Feb 22	Mar 22	Apr 22
		105	129	114
Background				
The average (median) time in minutes for a patient to be first seen				
What is the data telling us?				
Wait to be seen has increased over the last 12 months with the last 3 months being above the upper control limit				

Variation		Assurance		
Target	0	Feb 22	Mar 22	Apr 22
		1832	2292	2106
Background				
The number of patients admitted, transferred or discharged after waiting over 12 hours from their arrival				
What is the data telling us?				
The number of patients waiting over 12 hours has increased significantly over the last 12 months. With 8 points sitting above the upper control limit				

4 Hour Performance & 12 Hour Trolley Waits

Summary

- Renewed focus on the three workstreams of the Non-Elective Improvement Programme (including the implementation of SHREWD), increased senior operational oversight following the appointment of the new Interim Deputy Chief Operating Officer – Delivery and Interim Head of Operations – Site, and the exiting of winter pressures began to improve performance in critical areas in the final weeks of April.
- Overall 4 hour performance rose against the March position slightly at 62.5%, County performance improved in Month compared to March.
- The 7 day average for 12 hour DTA fell from a peak mid month of 36.3 per day to 18.9 per day by the final day of Saturday representing an almost 50% reduction in the 7 day rolling average. Likewise, just one day in the final week of April saw 60 minute ambulance handover delays exceed to previous median.

Actions

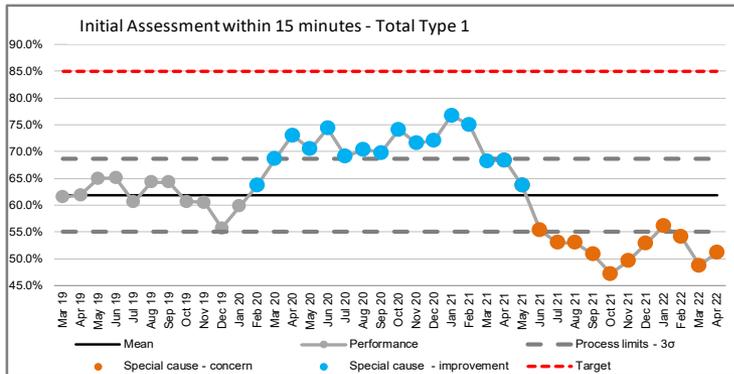
- Reset week planned for 16/05/2022 with aims of improved flow in the medical bed base to support reduction in long waits in ED post DTA, with improved timeliness of bed allocation and movement.
- County Operational Performance Task & Finish Group to be set up to review data and agree robust actions to deliver 4 hour performance at County site
- Ambulatory Task & Finish group established to review ways of working, medical leadership and to set an improvement trajectory for non-admitted performance – including establishment and development of the enhanced Primary Care (EhPC) stream
- Review of estate and layout of ED post social distancing to ensure best distribution of workforce and space for efficiency.
- CMO to implement a refreshed Standardised Process for Referral and Admission following engagement with senior clinicians and operational leaders.

Section 1: Urgent Care

Workstream 1; Acute Front Door

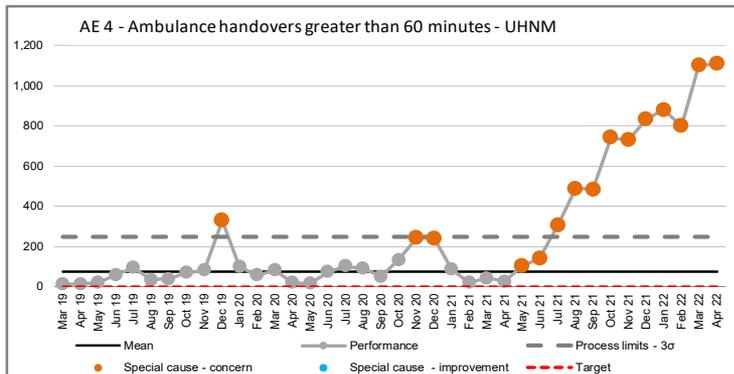


Time To Triage, Ambulance Handover, & Non admitted average time



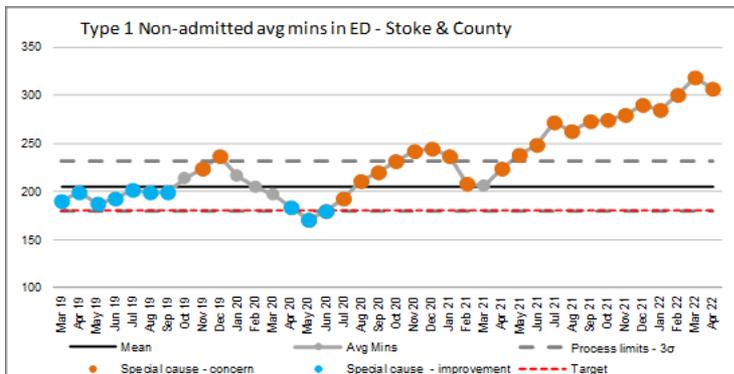
Variation		Assurance		
Target	85%	Feb 22	Mar 22	Apr 22
	54.1%	48.8%	51.1%	
Background				
the Percentage of patients attending Type 1 A&E, triaged within 15 minutes of arrival				
What is the data telling us?				

Performance remains relatively static for the past year and below the lower control limit. This is however against the context of high numbers ambulance holds and departmental congestion as a result of occupancy.



Variation		Assurance		
Target	0	Feb 22	Mar 22	Apr 22
	800	1100	1109	
Background				
The number of ambulance handovers greater than 60 mins				
What is the data telling us?				

Handover delays over 1 hour have risen dramatically over the last 12 months with the last 10 data points sitting outside of the control limits of 2019/20



Variation		Assurance		
Target	180	Feb 22	Mar 22	Apr 22
	300	318	307	
Background				
The mean time (in minutes) spent in the A&E department for patients that are not admitted to an inpatient bed				
What is the data telling us?				

Mean time in department has been increasing since March 2021. The last 12 month data points have been outside of the control limits set using 2019/20

Time To Triage, Ambulance Handover, & Treatment

Summary

- Time to initial assessment had improved in month and the recently appointed Triage Nurses will have supported in this 3% improvement as that can be evidenced when splitting out the RSUH and County data. This has been supported by improvements in Navigation and the maintenance of the Navigator as a position that cannot be pulled to cover other areas of the department.
- This improvement in triage represents the maintenance of safety in the Emergency Department despite ambulance handover delays and congestion as the result of high occupancy.
- Ambulance handovers remain a challenge in the early April for both WMAS and UHNM. To mitigate this risk cohort area for up to 5 patients to wait with 1 crew was introduced to ensure patient safety in the community. There have however, been significant improvements in the final weeks of April (~50% reduction in the rolling 7 day average number of 12 hour breaches from the middle of April to the end).

Actions

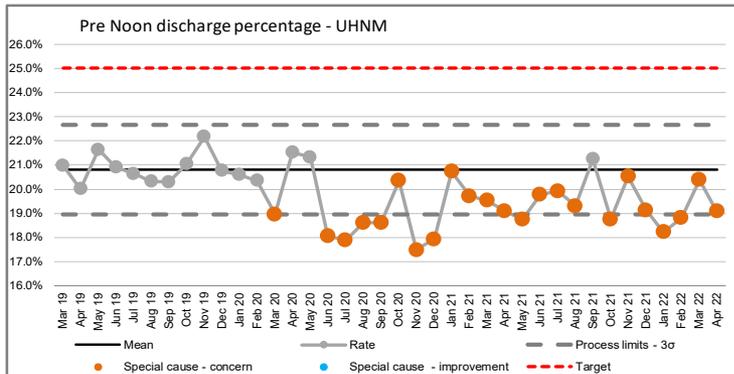
- Reset week planned for 16/05/2022 with aims of improved flow in the medical bed base to support reduction in long waits in ED post DTA, with improved timeliness of bed allocation and movement.
- The ownership of the Enhanced Primary Care Service moving to UHNM from 01st May will support deflection of appropriate primary care patients to EhPC, with the aim of getting the patient to the right place first time and avoiding unnecessary triage for these patients.
- WMAS HALO support to continue until end May with Winter funding to support cohort and crews
- ED and WMAS now have bi weekly operational level meetings
- Go, Look, Learn of handover process completed and shared with COO and Deputy COO, to discuss recommendations for handover improvements with WMAS colleagues

Section 1: Urgent Care

Workstream 2; Acute Patient Flow

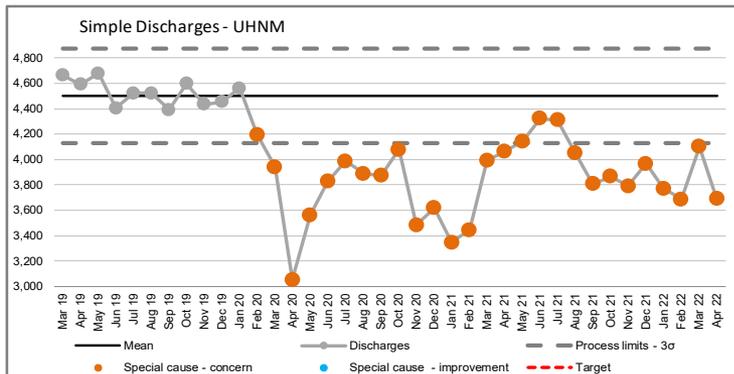


Pre-Noon, Simple & Timely, & Occupancy



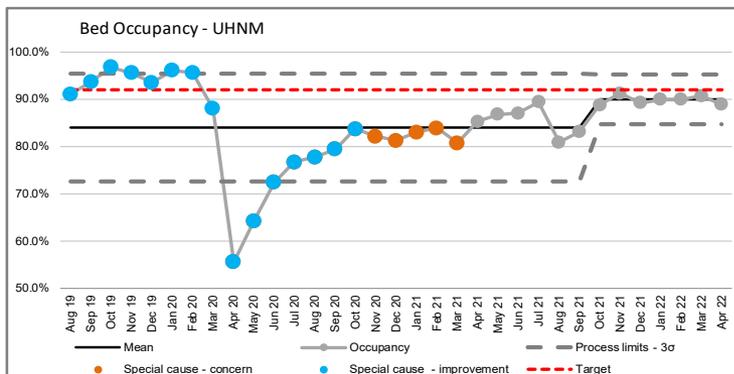
Variation		Assurance		
Target		Feb 22	Mar 22	Apr 22
25%		18.8%	20.4%	19.1%
Background				
The percentage of discharges complete before 12 noon.				
What is the data telling us?				

Pre noon discharges have been below the 1920 mean for the last 7 months triggering the cause for concern SPC rule.



Variation		Assurance		
Target		Feb 22	Mar 22	Apr 22
N/A		3688	4102	3691
Background				
Patients discharged without complex needs				
What is the data telling us?				

Simple & timely discharges are below pre pandemic levels and have moved in line with bed demand



Variation		Assurance		
Target		Feb 22	Mar 22	Apr 22
92%		89.9%	90.6%	88.9%
Background				
The percentage of general and acute beds occupied overnight at UHNM				
What is the data telling us?				

COVID had a significant impact on bed occupancy however the last 7 months have been fairly consistent averaging 89%.

Summary

- There has been a renewed group focus areas to support improvement opportunities identified. These are criteria led discharge, managing outliers, virtual wards, WIS board data, bed management tool on-going development, and complex discharges.
- Step Change Project – West Building (focussed on discharges that fail to go ahead on the day planned) is progressing well. EDD -2 and EDD - 1 MDT actions clear and reinforced at Board rounds. Focus on TTO, discharge letters and TOC processes is seeing sustained improvement.
- New ward to board Red to Green dashboard has been developed. Divisions are reporting increased use of status exchange methodology during red to green meetings which once embedded, will help drive pre noon, simple and timely, and even complex discharges. This will in turn result in reduced occupancy.

Actions

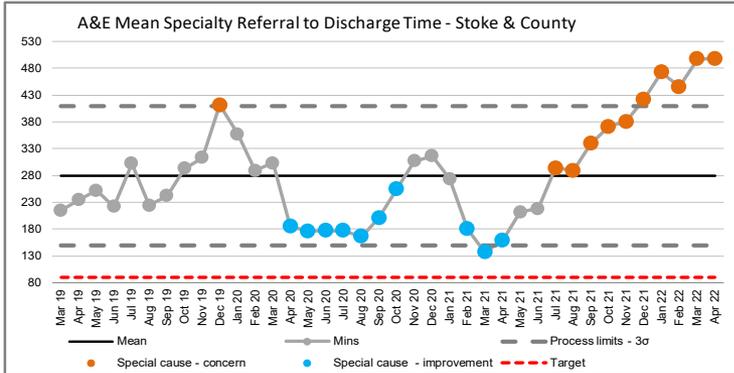
- Plan to share Step Change Project learning across medical Division planned by the end of Summer 22.
- All Divisions scoping Criteria Led Discharge (CLD) opportunities . CLD can now be captured via WIS board for those areas now trialling CLD
- Electronic referrals for EAU from ED / AMU to support flow.
- Discharge Lounge to actively pull by receiving data of definite discharges to ward 120 overnight or to lounge by 10am.
- Medicine restart week – reviewing EDD's.
- Cardiology virtual ward discussion planned to be updated in the report for next month.

Section 1: Urgent Care

Workstream 3; Delivering UEC Standards

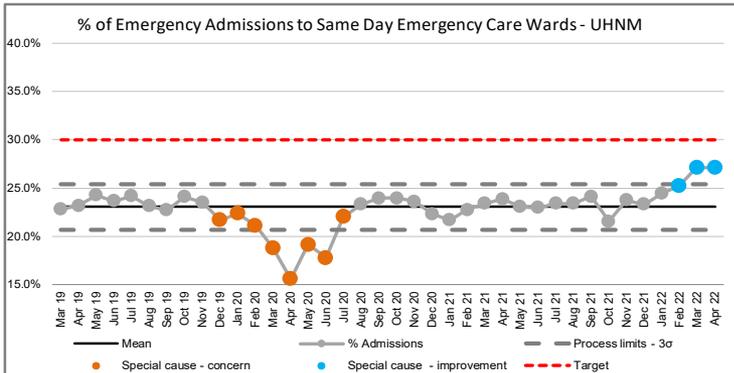


CRPT+1, SDEC Utilisation, & Mean Time In ED



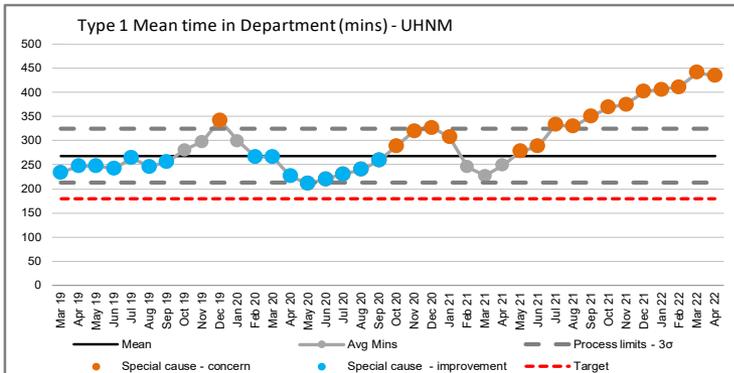
Variation		Assurance		
Target	90	Feb 22	Mar 22	Apr 22
	90	445	497	498
Background				
The average time from the ED referral to a specialty to discharge from the ED				
What is the data telling us?				

The average time from referral to discharge has increased since March 2021 with the last 5 data points sitting above the upper control limit.



Variation		Assurance		
Target	30%	Feb 22	Mar 22	Apr 22
	30%	25.2%	27.1%	27.1%
Background				
% of emergency admissions that are admitted to the Trust's SDEC wards, and discharged within 24 hours				
What is the data telling us?				

The Trust has been consistently inline with pre pandemic proportions of patients going through SDEC with the last 3 months seeing a significant increase up to 27% in April.



Variation		Assurance		
Target	180	Feb 22	Mar 22	Apr 22
	180	411	441	435
Background				
The mean time (in minutes) spent in the A&E department				
What is the data telling us?				

Total time in department has been increasing since March 2021 with the last 8 data points sitting above the control limits.

CRPT+1, SDEC Utilisation, & Mean Time In ED

Summary

- It has been pleasing to see SDEC numbers rise to levels not seen pre pandemic.
- It is disappointing that the proxy measure for CRPT+1 and mean time in the Emergency Department have maintained their high levels. It is expected that improvements seen at the front door, including the introduction of the Nurse Navigator role and EHPC service will precipitate improvements as they continue to embed and develop from next month and beyond.
- The focus from actions being developed in the workstream is to move towards tangible delivery of the new UEC standards.

Actions

- Workstream 3 structure being redesigned in line with the development of the corporate projects and A3 development.
- Workstream leads being appointed and task and finish groups re-focused with the aim of driving the improvements to reduce 12 hour waits in ED and increase of patients moving from ED when CRTP has been applied.
- Review of the AE to Ward dashboard with Acute clinical/ ward colleagues with the aim of the dashboard “Go live date” in June
- SAU digitisation meeting being planned in May 2022 (will support SAU having e-referrals from ED and live view of surgical patients awaiting care in ED)

Section 2: ELECTIVE CARE



Challenges:

- Overall PTL inflation due to COVID prevalence – e.g. patients having diagnostics or TCIs rebooked, extending pathways.
- Expected Breast surgery capacity challenges, as consultant body impacted by Covid and planned / unplanned leave.
- Pathology pressures on-going – weekly PTL meeting instated with service leads, dedicated to escalating cancer pathway patients outstanding pathology results.
- Treatment capacity for Urology – low risk patients are being clinically prioritised to wait longer, impacting the 104+ day position.
- Delays to Oncology due to workforce pressures. The division has recruited to 1 post with an expected start date of 01/06 however some vacancies remain unfilled.

Actions:

- Cancer site specific draft trajectories were endorsed by divisions at the Assurance Meeting. This includes the backlog, 104+ and 28 Day FDS metrics. The trajectories describe incremental improvements towards achieving the planning guidance aims; to return the number of patients waiting over 62 days to levels seen pre-pandemic, and to confirm or exclude cancer within 28 days for 75% of patients referred on a suspected cancer pathway.
- Breast recovery actions are being worked through. 18 week mobilisation meetings are underway to deliver extra capacity that will recover the backlog of patients waiting for 1st OPA. Trajectories and demand models are being drafted by cancer services analysts.
- The cancer services team has begun a new workstream to support FDS delivery: Tracking pathways against best practice timed milestones to understand pinch points, which can be supported using SCR. National webinar attended to understand best practice data collection, with a gap analysis underway to show what it will take to achieve the new way of tracking.
- The new FDS Framework has been conveyed through the assurance meeting, for an awareness of cancer priorities. Investment against worked up schemes that fulfil faster diagnosis aims will be granted through the cancer alliance and divisions have been asked to work up proposals ready to bid when funding is announced.
- Patients continue to be received and progressed from the Galleri Trail – a blood test that returns a signal if there is indication there may be cancer present, which will trigger secondary care investigation.
- The sequential FIT model go live date has been paused to allow for further system wide discussion, and pathways continue to be managed as follows: Return with advice any referral if a FIT isn't requested.
- The first Breast Pain clinic was successfully delivered on 08.04.22. These clinics deliver care closer to home for patients with non urgent breast symptoms. The opportunity to recover cancer performance depends on the commissioning intentions following the pilot – e.g. whether secondary care specialists will continue to deliver the service in another setting or whether existing community clinicians will be up-skilled.

Cancer Trajectories

Provider Level				April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	E.B.32	Count	The number of cancer 62-day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non-site specific symptoms											
				462	440	420	400	380	360	340	320	300	280	250	191
			UHNM Average Actual	533											

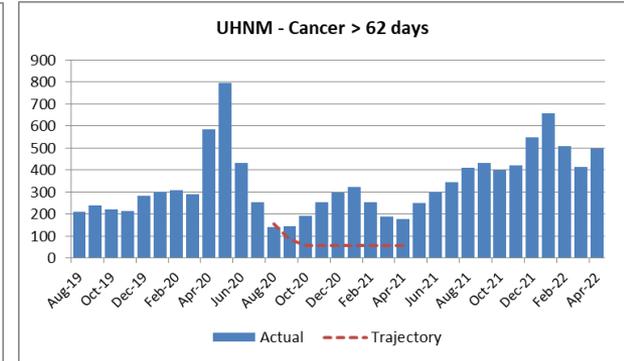
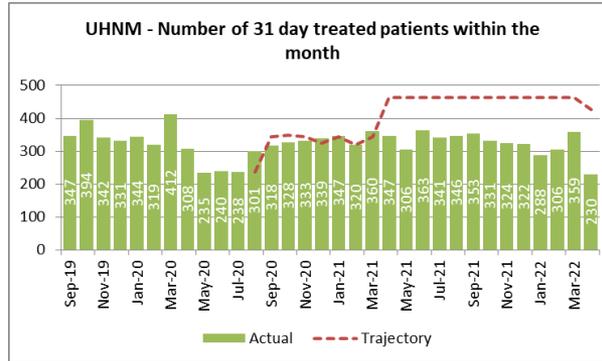
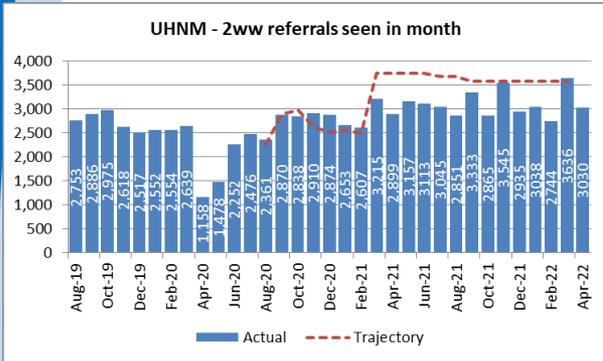
In March22, the proportion of patients waiting over 62 days on the GP referred suspected cancer PTL was at 11%, which is less than the regional position of 13%.

National planning guidance 22/ 23 set out the ambition to return the number of patients waiting over 62 days to the levels seen pre-pandemic. The trajectory for UHNM is set out above. For the month of April 2022, the average backlog position was 533 – this includes patients with a decision to treat and a future treatment date scheduled, however this is still 71 patients larger than the aim.

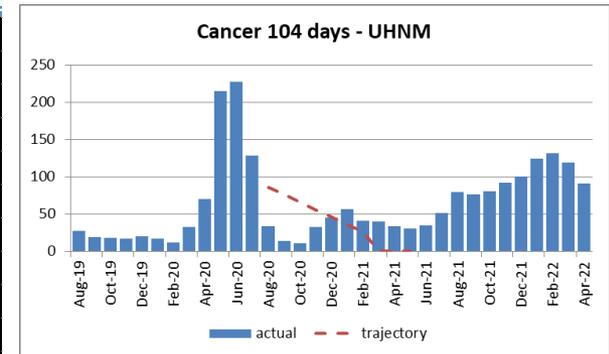
Of the 2WW patients who have breached, 202 patients are in Colorectal and 153 are in Skin. The number of patients waiting over 104 days is 121. Of these, 29 are on a Colorectal pathway – 24%, 25 are on a Skin pathway – 21%. There are 40 patients waiting over 104 days with a diagnosis of cancer. Of those, 10 are in Urology, 8 are in Breast and 5 in H&N.

Contributing factors include delays to pathology reports, urology robotic surgery due to capacity, complex pathways, increasing element of patient choice and outstanding clinical reviews. Divisions have been asked to focus on the backlog and discharge patients where appropriate – e.g. patients waiting over 104 days with an outstanding clinical review.





Provisional April	Target	Trust Act	Clock Stop	Breaches	Breaches Over	Needed Treatment
TWW Standard	93%	46.2%	3021	1624	1413	20180
TWW Breast Symptomatic	93%	15.9%	63	53	49	695
31 Day First	96%	90.1%	262	26	16	388
31 Day Subsequent Anti Cancer Drug	98%	100.0%	31	0	Achieved!	Achieved!
31 Day Subsequent Surgery	94%	73.5%	34	9	7	117
31 Day Subsequent Radiotherapy	94%	96.3%	82	3	Achieved!	Achieved!
62 Day Standard	85%	46.2%	150.5	81	59	390.5
Rare Cancers - 31 Day RTT pathway	85%		0	0	1	1
62 Day Screening	90%	52.6%	19	9	8	72
28 Day FDS Standard	75%	61.9%	2260	860	296	1181
62 Day Consultant Upgrade	93%	77.1%	70	16	12	159
Closed Pathways > 104 Day			33.5			



Planned care - *Inpatients*

Elective inpatients Summary

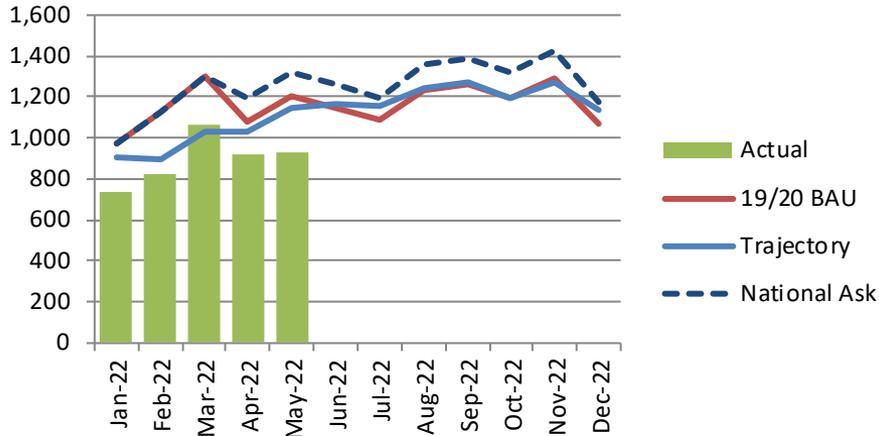
- Day Case and Elective Activity delivered 85% and 84.5% respectively for April 22 against the national ask of 110%, an improvement on March's position for Day Case (83%) and Electives (81%).
- Insourcing arrangements at week ends continue and have been bolstered to provide more weekend capacity in T&O started Feb.
- Contracting arrangements for 2022/23 confirmed – extension of existing IPT contracts for Ramsay & Nuffield.
- Improvement in return of discharge summaries for subcontracted patients. All patients referred under ICF contracts expected to be completed end of June 2022.
- County and Royal Stoke Theatres have re-implemented a “6-5-4” weekly operational meeting to ensure a higher proportion of available lists are fully used and to move capacity to the specialties most needing it. This also tracks and ensures bookings so that patients and staff are given more notice so cancellations and non-attendances can be driven down
- The reduction in 104 week patients has reduced the patients likely to breach 104 weeks from 400 in January to around 40 in May with patient by patient focus on reducing that number further, as well as minimising the cancellations might not be bookable again until July
- July 104 week patients are on track to be completed by mid-July as the focus moves to no 78 week waiting patients by March 2023

Actions

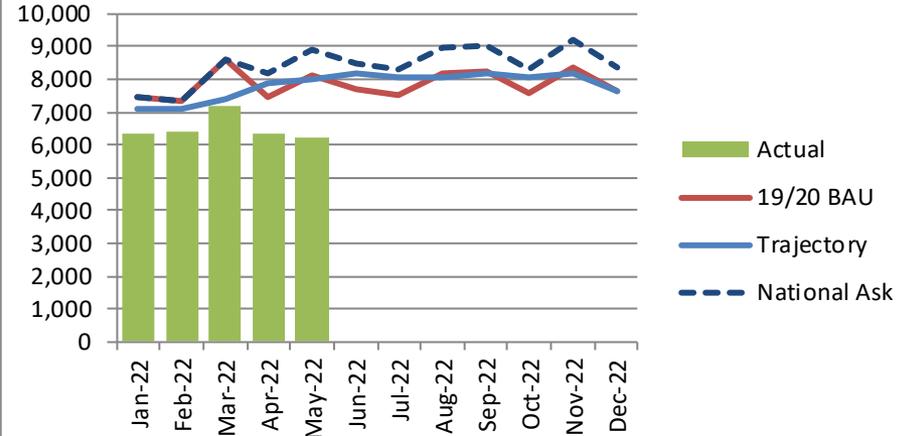
- External validation support commenced 21st March, focusing on long waiters, themes and trends.
- Demand scoping for 22/23 IS complete & shared with CCGs. Final numbers for capacity agreed.
- New electronic process for managing patients transfers to IS live and working.
- Trust wide revamp of validation & training underway, focusing on tracking long waiters, exposing and addressing bottlenecks in pathways. Phase 1 to deep dive training needs analysis.
- Active reporting focus on ensuring the right patients (urgent and longest waiters) are the patients booked into all available capacity so that the limited resource available continues to be used for the right patients by clinical need
- Patient by patient monitoring by each specialty and by the corporate team on the small number of patients at risk of the end-June deadline for 104 weeks

Planned care – Inpatient Activity

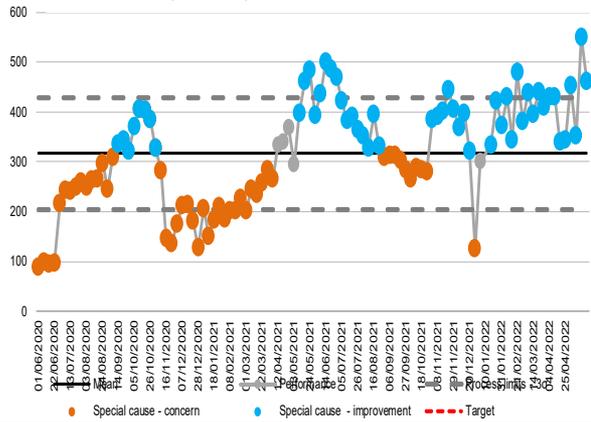
Elective inpatients - Actual numbers



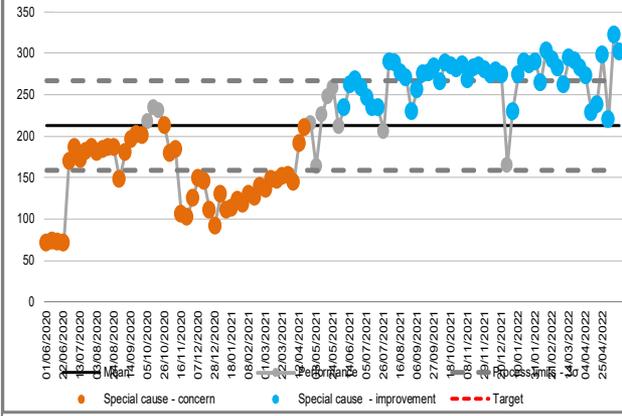
Elective Daycase - Actual numbers



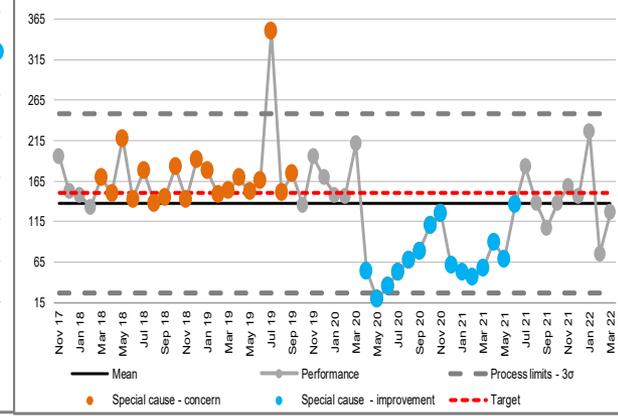
Number of Weekly Elective Operations - UHNM



Wkly 4 Hour sessions - UHNM



UoR Cancelled Operations at last minute - UHNM



Summary

- For April the total outpatient actuals against BAU for outpatients was 98%. This is higher in follow ups than new (89% New, 104% follow up).
- OP Cell A3 work has helped to define current overall waiting list position by category; vs pre covid increase of 15,000 (6.5%) to 250,000, and increase in those >52 weeks (vs Review Date) by 7,800 (200%) to c.12,000 (half of increase attributable to use of Review Date). As at 01/05/2022, total WL has increased further to 274K. Recent increases in the waiting list attributed to 2 main categories; New (18 weeks) & Follow Up (Backlog).
- Reduction from 11,631 (end of June) to 10,010 (25th July) in >52 week patients (14%). Further reduction to 9,184 as at 5th September (21% vs end of June). Up to 11,827 as at 1st May; increase of 1.1K vs previous month. 9 specialties responsible for 80% of increase, Divisions have fed back at OP Cell on associated actions.
- Outpatient transformation workstreams aim to tackle the growth in referrals to enable and support primary, community and secondary care to widen the scope and capacity to care for the patients they can most appropriately help

RTT

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For April the indicative number of Incomplete pathways has risen to 76,023 (March 74,984). A validation effort is increasing with extra recruitment to provide a more concrete picture of the clinical and administration resource required in the medium term to start reducing the list
- The number of patients > 18 weeks has risen to a level of 35,345 (March 33,665)
- The numbers of 52 week waits in April has decreased with a total of 4,483 compared to 4,603 in March.
- At the end of April the numbers of > 104 weeks was 314 a decrease from 494 in March The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance has slightly decreased throughout April at provisional 53.51% (March 54.9%).
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.

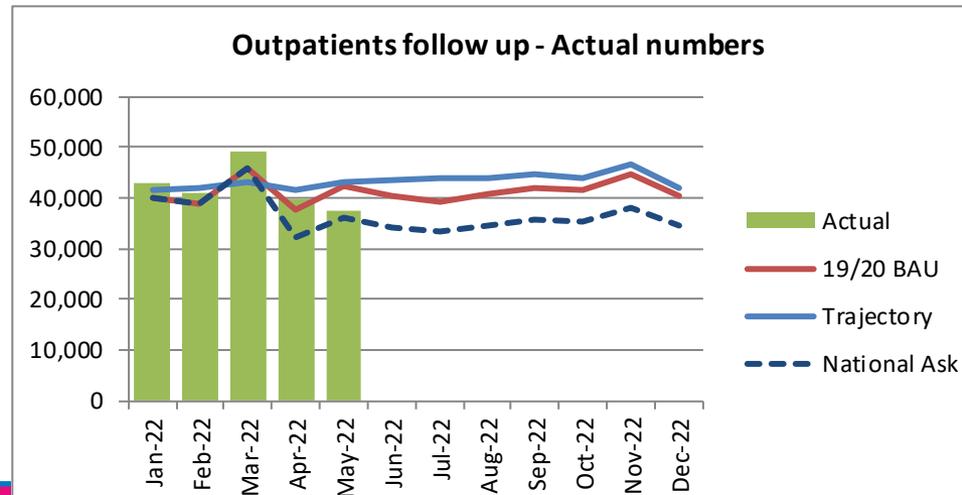
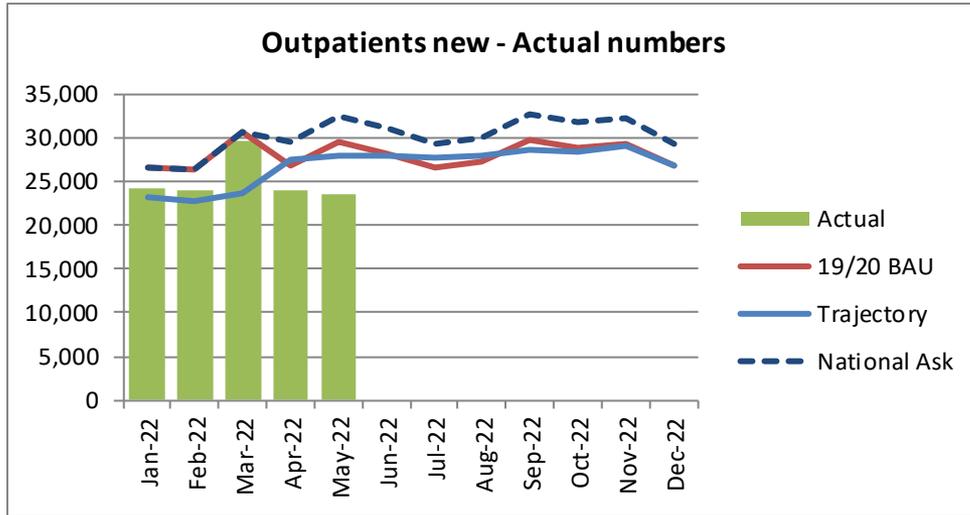
Actions

- OP Cell Programme Structure & TOR updated for 22/23 to reflect Elective Recovery Planning Guidance
- **Workstream 3 Outpatient Waiting List Management & Reporting**
 - Outpatient Reviews - templates completed for March for New Waits (104+/78/52/18 wks), plus follow up backlog, PIFU, EAG & Non Face to Face. Long waiters in New Non-18 week category identified as issue. Clarifying & aligning recording & reporting requirements, seeking advice around specific cohorts from Elective Access Lead & Information Services.
 - Waiting List Validation plan being pulled together, to be shared for Divisional signoff.
 - 1m+ plans approved (March '22) from risk assessments, supports FTF activity increase where required; CAFs to be submitted to ensure managed.
 - SMS via Netcall targeting follow up backlog patients trialled successfully in derm & plastics. Netcall Partial Booking module purchased to facilitate similar approach for other specialties; urology & gastro first. Specialty/Outpatient process described, Rollout Plan being drafted.
- **Workstream 1 Outpatient Service Delivery & Performance**
 - Workstream delivering vs. plans for Partial Booking Rollout, Netcall Rollout, CAF Issues Action Plan, and OP Clinic Process vs. Maturity model. Review Date training prioritised; DQ Alert circulated & Quick Reference Guides created. Wider training plan being developed with ongoing input into Trust training considerations (systems & processes), and links to DQ group.
- **Workstream 2 Outpatient Transformation**
 - **Enhanced Advice & Guidance** sub workstream (linking with system).
 - Task & Finish Groups for Urology, Neurology, Respiratory and Gastro taking actions forward to increase A&G, develop pathways FAQs.
 - Revised Steering Group with wider System partners held April 26th.
 - **PIFU sub-workstream** rolling out vs plan, divisional PIFU Targets for 22/23 agreed with Divisions.
 - Infrastructure;** Review TOR for PIFU Implementation Group, progress Discharge to PIFU & Move to PIFU framework; iportal, Careflow, SOP, reporting, Review EHIA
 - Specialty Rollout** Extending rollout in existing specialties, for example Sleep, IBD, T&O. On track for rollout to ENT & Sleep in May, meetings held/to be scheduled with gastro, gynaecology, midwifery, child health, urology, ophthalmology. Review Outcomes report with divisions & specialties to identify PIFU opportunities. Clinician Survey –collate and act on results, follow up as necessary.
 - **Submissions to Elective Recovery Fund** in place for A&G & PIFU. EAG Consultant Connect data is included and confirmed, plus including post referral advice agreed.
 - **Elective Recovery 2022/23;** plans submitted for EAG (16% target), PIFU (5% target) & Virtual Care (25% target). EAG System submission challenged; further discussion at next System partner meeting.
 - **Virtual Care 25%;** SUS submission 'fix' implemented from Nov 2021 (with BI); longer term, alignment of clinic booking and media type outcomes.
 - **Patient Portal;** support provided to identify potential OP benefits, following demos from suppliers to a wide UHNM audience & patients.

Risks

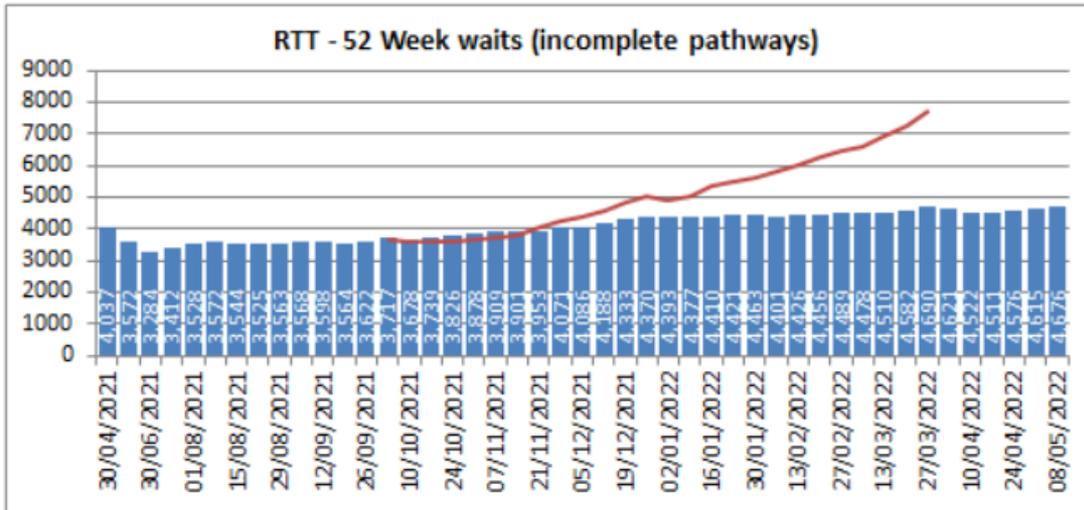
- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, on Divisional Risk Registers.
- Clinical Validation requirement; risk of achieving vs resources available.

Planned care – Outpatient activity & RTT



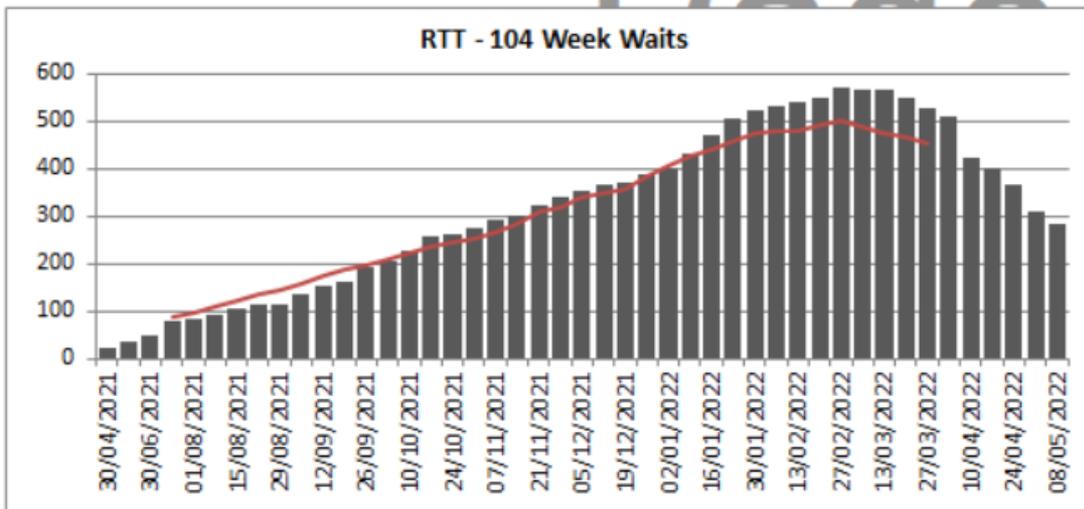
Planned care – RTT Trajectories

52 Week Waits



52 Week Waits showed a small increase over winter

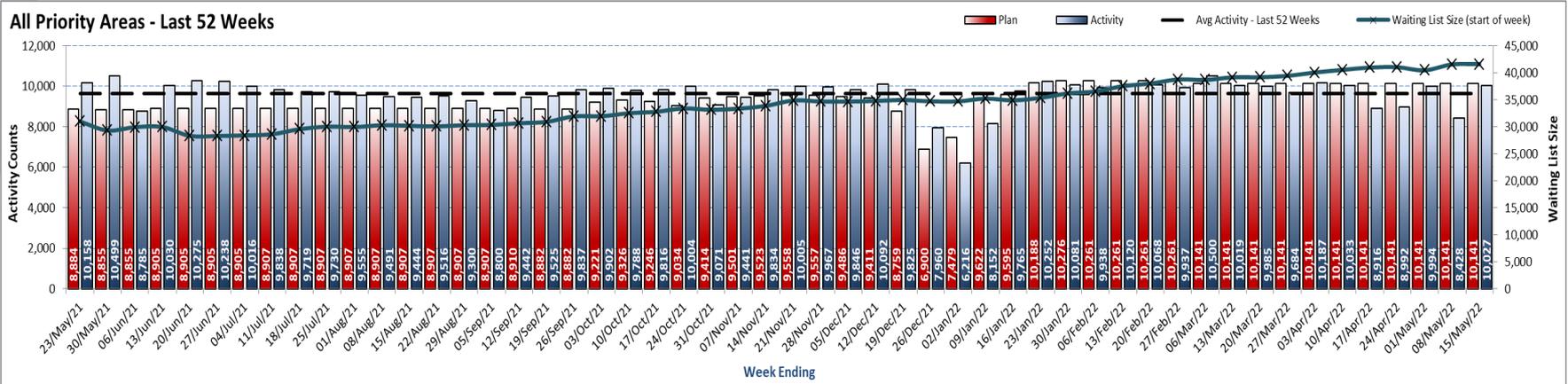
104 Week waits



104 Week Waits have been continually decreasing throughout March and April. Most challenged specialties are T&O and Colorectal.

Diagnostic Activity

All Priority Areas - Last 52 Weeks



Summary

- For DM01 (15 nationally identified Dx tests) the validated position for total waiting list has decreased in April from 24,004 to 23,502. The Non-obstetric ultrasound waiting list increased slightly from 9,550 to 9,631. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance is at 66.86%.
- Within DM01, the greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls, a number of actions are in place. Non obstetric ultrasound performance remains a Driver Metric for CWD and has specific focus for improvement, albeit this is related to workforce retention, recruitment and innovative ways to train and recruit. Further outsourcing of non-obstetric ultrasound scanning is continuing to be explored.
- DM01 performance excluding non obs ultrasound would be 78%.
- Histology turnaround times remain a high risk; there is an action plan in place and the position is improving. Cancer related histology is being treated urgently and all cancer related escalations are being prioritised.
- Capacity and Demand work has been completed within Imaging relating directly to Consultant Radiologist and SpR capacity.
- Histology and Endoscopy remain high risk areas both have plans for improvement.
- Plain film is also an area with a high volume of waiters, predominantly due to staffing shortages and covid social distancing guidance which have now been removed



Diagnostic Activity

What is going well?	<p>UHNM Imaging Directorate has been recommended to maintain its external Quality Standards in Imaging (QSI / UKAS) accreditation. This is following a thorough 4-day on-site inspection this week with 8 visiting assessors reviewing and assessing the full scope of Imaging services across all hospital sites.</p> <p>UHNM imaging department is fully compliant with the EMRAM Stage 6 standards.</p> <p>NHS E/I have set up a regional support team for Pathology – UHNM actively involved.</p>
Concerns	<ul style="list-style-type: none"> • Workforce recruitment & retention for Pathology; National success stories / Best practice studies for sharing • Supernumerary posts funded for pathology i.e. staff backfill for release to university • National view of Endoscopy Patient Access; support for how to manage patients that DNA appointments
Diagnostic recovery risks & issues	<p>Pathology; Recruitment & retention of staff</p> <p>Endoscopy; Fluctuating cancer referral demand against lack of scopist availability</p> <p>Imaging; Ultrasound capacity for routine patients</p>
Mitigation plan	<p>Histopathology Recovery Plan in place and working through critical actions, with clear milestones for delivery reflected</p>
Top 3 workforce challenges	<ol style="list-style-type: none"> 1. Pathology workforce vacancies 2. Endoscopy Scopist locum 3. Pathology workforce retention
Digital Update	<p>Regional West Midland Digital Pathology September 2022 launch</p>
Top 3 Imaging Challenges	<ol style="list-style-type: none"> 1. Retention of reporting staff 2. Reporting turnaround 3. Capacity - Ultrasound
Top 3 Endoscopy Challenges	<ol style="list-style-type: none"> 1. Capacity; Scopist availability; 1 locum secured but no CVs through for 2nd locum; annual leave / training lists affect capacity 2. Patient compliance; DNAs / Patient last minute cancellations; Netcall reminds patients, and patients are confirming, but are still not attending. Corporate performance team are looking at changing access policy to support but not a quick fix 3. Fluctuating demand; cancer 150 / wk. on average (last week increased to 181)
Top 3 Pathology Challenges	<ol style="list-style-type: none"> 1. Workforce vacancies & retention of staff at all levels 2. Turnaround of Histopathology results – action plan in place 3. Number of projects currently live across the Pathology network

Inpatient and Outpatient Decile & Ethnicity

“In line with NHS Planning Guidance the Trust must ensure board papers are published that include an analysis of waiting times disaggregated by ethnicity and deprivation” The Trust has only recently had the capability to analyse this information and will therefore spend the coming months seeking to understand what the data and take action to positively impact upon unwarranted variation

Inpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
	Weeks Waited- >104	9.99%	8.82%	8.49%	7.88%	7.92%	12.11%	12.53%	10.44%	13.28%	7.97%
Weeks Waited- 78-104	15.13%	10.78%	10.86%	8.22%	7.14%	10.24%	11.48%	7.45%	12.65%	4.73%	1.32%
Weeks Waited- 52-77	15.18%	12.00%	9.99%	8.86%	7.62%	11.01%	10.17%	7.45%	11.54%	4.91%	1.27%
Weeks Waited- Under 52	13.38%	11.87%	9.69%	8.79%	7.51%	10.72%	10.78%	9.10%	11.45%	5.65%	1.04%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
	Weeks Waited- >104	11.36%	10.43%	8.91%	8.85%	8.03%	11.24%	11.53%	10.16%	12.67%	6.07%
Weeks Waited- 78-104	12.91%	9.98%	9.62%	8.84%	7.27%	11.14%	11.45%	9.65%	11.86%	6.02%	1.27%
Weeks Waited- 52-77	13.35%	11.09%	10.18%	9.17%	7.45%	10.86%	10.57%	9.23%	11.66%	5.53%	0.91%
Weeks Waited- Under 52	13.63%	11.61%	10.10%	9.04%	7.46%	10.49%	10.50%	8.92%	11.25%	5.99%	1.00%

Inpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
	Weeks Waited- >104	0.19%	0.38%	0.09%	0.24%	0.38%	0.59%	0.00%	0.05%	0.19%	0.35%	0.47%	0.19%	0.02%	0.05%	93.70%	0.33%	0.73%	1.86%
Weeks Waited- 78-104	0.62%	0.78%	0.16%	0.54%	0.23%	0.78%	0.00%	0.16%	0.16%	0.47%	1.24%	0.47%	0.23%	0.16%	88.21%	0.16%	1.78%	1.78%	2.09%
Weeks Waited- 52-77	0.21%	0.71%	0.21%	0.78%	0.67%	1.91%	0.14%	0.32%	0.04%	0.32%	1.27%	0.25%	0.04%	0.28%	85.95%	0.07%	2.08%	1.66%	3.11%
Weeks Waited- Under 52	0.40%	0.65%	0.15%	0.60%	0.55%	1.05%	0.09%	0.15%	0.12%	0.41%	1.49%	0.24%	0.15%	0.14%	85.39%	0.32%	2.70%	2.54%	2.88%

Outpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
	Weeks Waited- >104	0.30%	0.50%	0.19%	0.41%	0.50%	0.77%	0.14%	0.21%	0.10%	0.66%	1.13%	0.32%	0.15%	0.15%	87.96%	0.28%	2.85%	2.31%
Weeks Waited- 78-104	0.46%	0.45%	0.24%	0.53%	0.36%	0.98%	0.21%	0.12%	0.14%	0.34%	1.37%	0.27%	0.15%	0.15%	87.50%	0.33%	2.67%	1.90%	1.82%
Weeks Waited- 52-77	0.27%	0.71%	0.16%	0.66%	0.56%	1.06%	0.11%	0.23%	0.10%	0.42%	2.02%	0.34%	0.19%	0.23%	85.03%	0.26%	2.74%	2.40%	2.50%
Weeks Waited- Under 52	0.42%	0.64%	0.20%	0.62%	0.55%	1.22%	0.13%	0.17%	0.16%	0.57%	1.80%	0.32%	0.15%	0.23%	83.25%	0.28%	3.22%	2.72%	3.31%

APPENDIX 1

Operational Performance

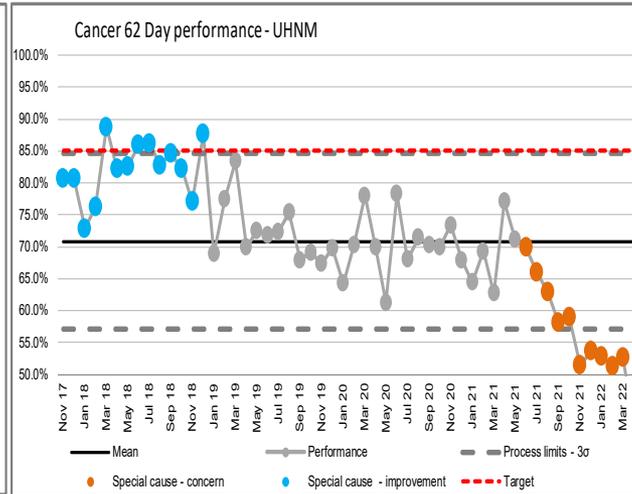
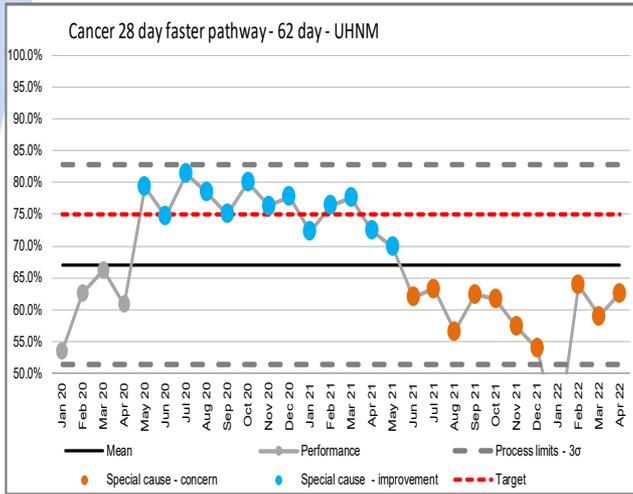


Constitutional standards

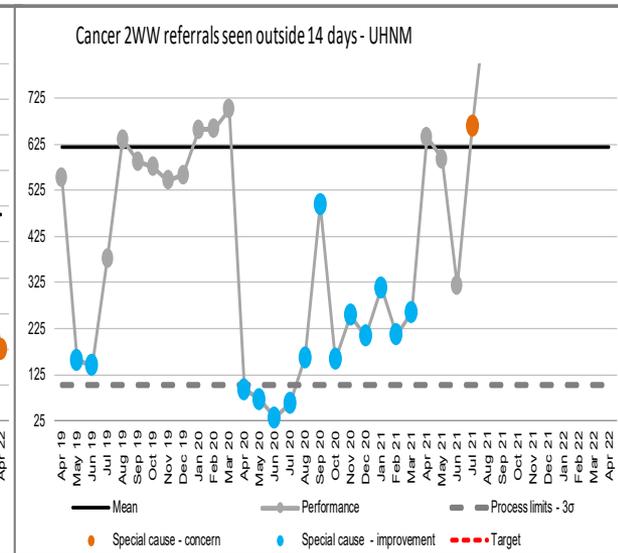
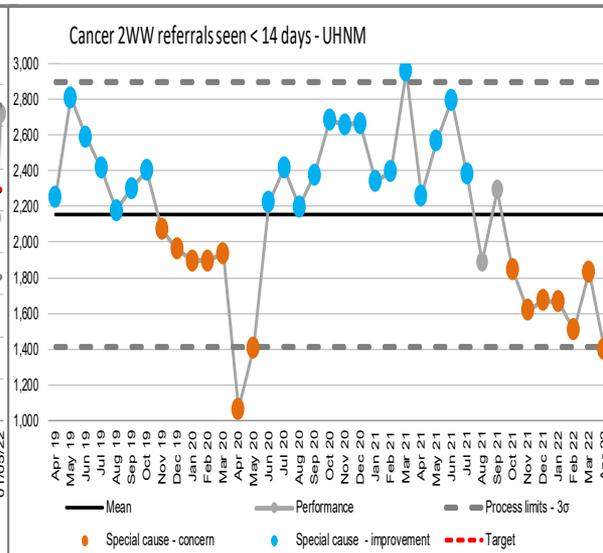
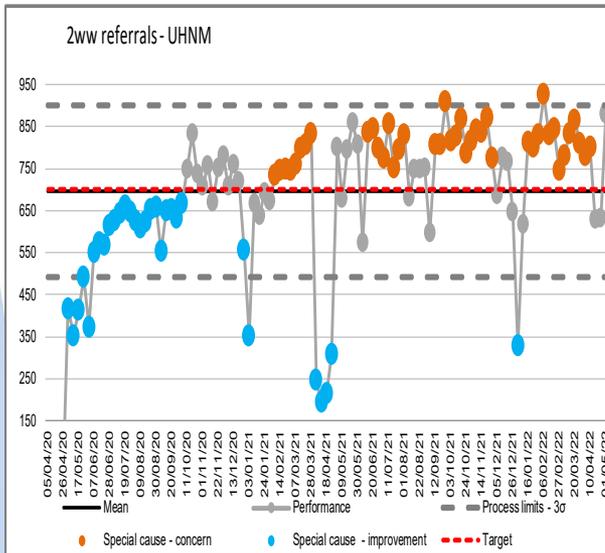
	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	62.50%			
	12 Hour Trolley waits	0	878			
Cancer Care	Cancer Rapid Access (2 week wait)	93%	46.24%			
	Cancer 62 GP ref	85%	42.55%			
	Cancer 62 day Screening	90%	52.94%			
	31 day First Treatment	96%	89.57%			
Elective waits	RTT incomplete performance	92%	53.51%			
	RTT 52+ week waits	0	4483			
	Diagnostics	99%	66.86%			

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.3%			
	Cancelled Ops	150	126			
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	30.1%			
	Super Stranded	183	197			
	DToC	3.5%	5.20%			
	Discharges before Midday	25%	19.1%			
	Emergency Readmission rate	8%	10.2%			
	Ambulance Handover delays in excess of 60 minutes	0	1109			

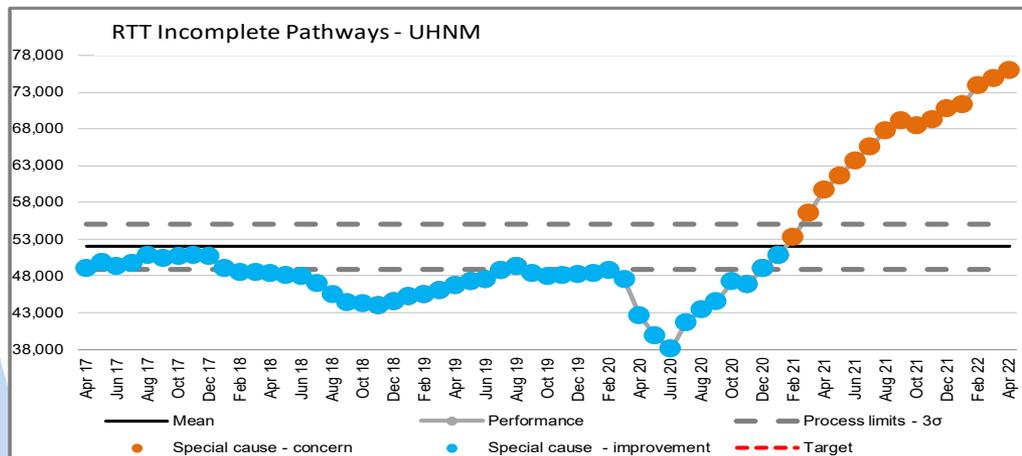
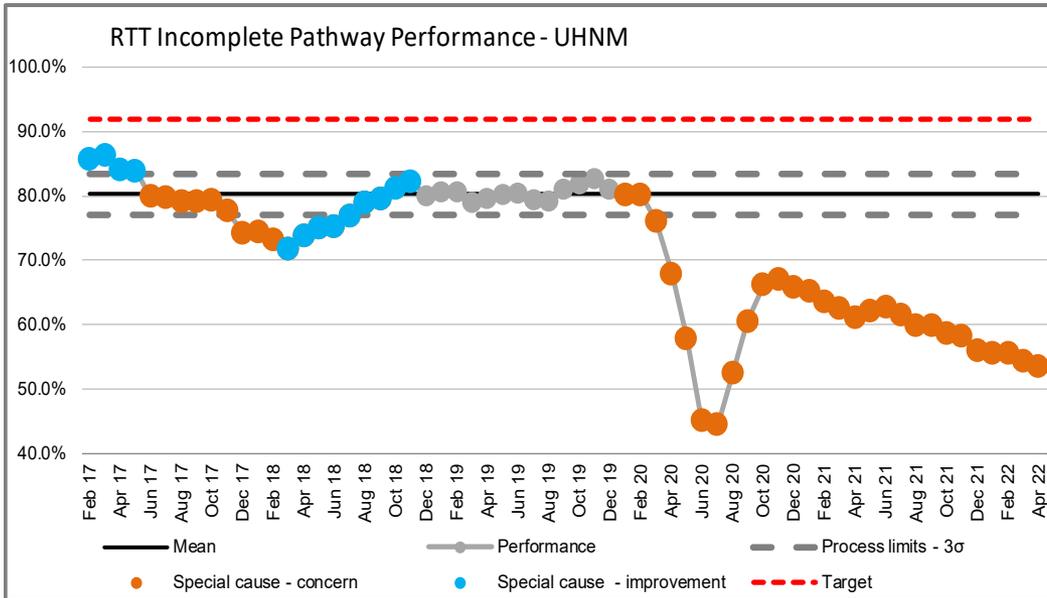
Cancer – 62 Day



Variation		Assurance					
Target	85%	Feb 22	51.3%	Mar 22	52.7%	Apr 22	42.6%
Background							
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer							
What is the data telling us?							
Apart from three occasions the standard has been below the mean since Sept-19.							

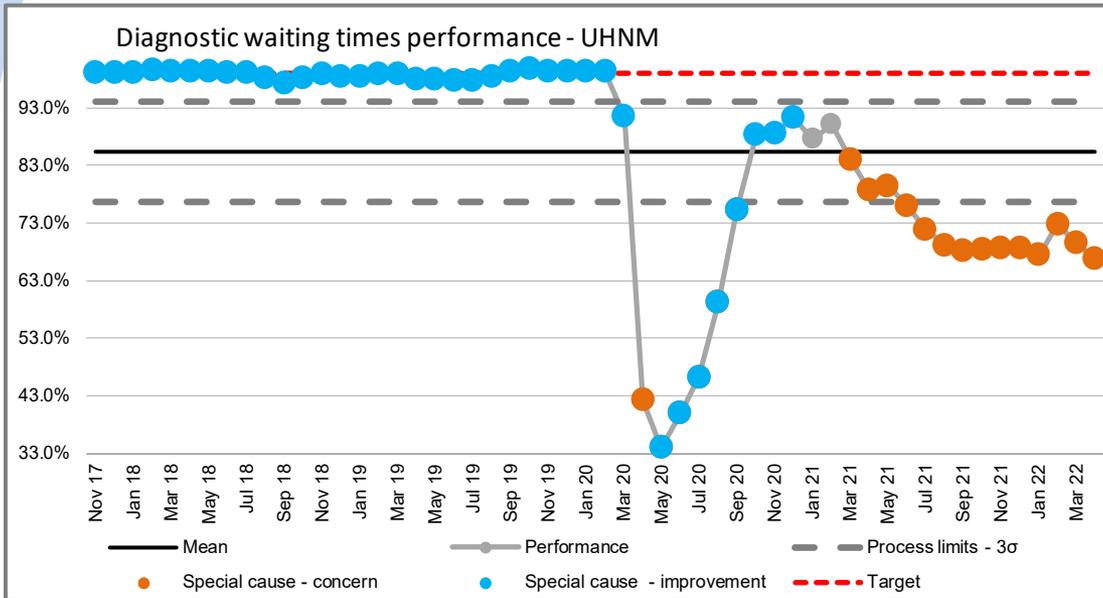


Referral To Treatment



Variation		Assurance		
Target	Feb 22	Mar 22	Apr 22	
92%	55.6%	54.3%	53.5%	
Background				
The percentage of patients waiting less than 18 weeks for treatment.				
What is the data telling us?				
Steady decline in performance since the pandemic began.				

Diagnostic Standards



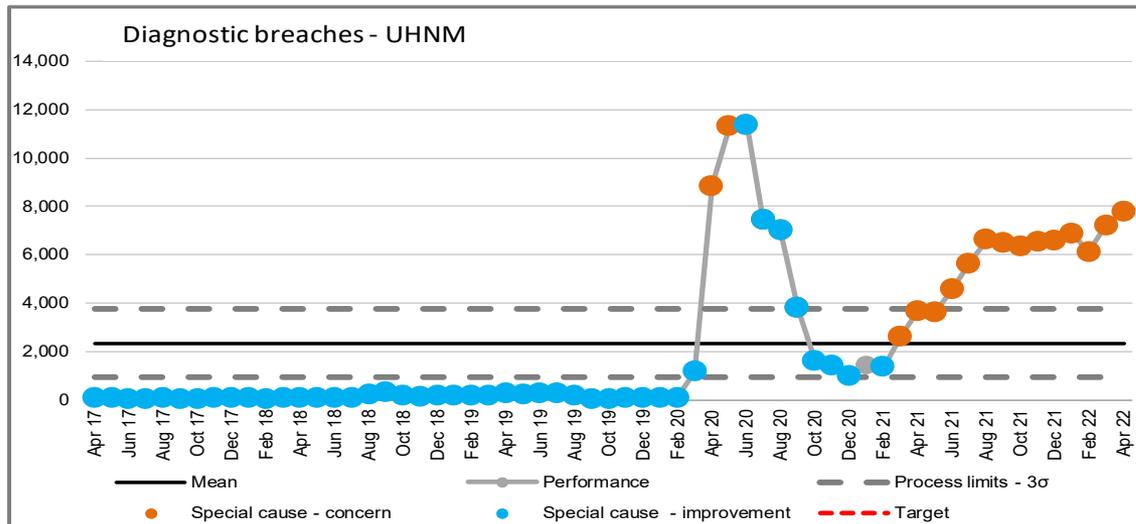
Variation		Assurance		
Target	Feb 22	Mar 22	Apr 22	
99%	72.8%	69.5%	66.9%	

Background

The percentage of patients waiting less than 6 weeks for the diagnostic test.

What is the data telling us?

The diagnostic performance has shown normal variation up until March 2020. Special cause variation occurred from March (COVID-19). Recovery has been evident until the second wave of the pandemic



Workforce

2025 Vision “Achieve excellence in employment, education, development and Research”



Workforce Spotlight Report

Key messages

The strategic focus of our People Plan remains on supporting recruitment, staff wellbeing and absence management.

The sustainable workforce risk remains high because there is still an impact of covid surges on sickness levels and workforce availability, although there are plans in place to mitigate risks and additional recruitment is taking place. Operational pressures, high sickness rates and vacancy levels contribute to the staffing challenges.

Sickness - The in-month sickness rate was 7.29% in April 22 (6.62% in March). The 12 month cumulative rate increased to 6.02% (5.73% at 31/03/22).

Covid-related absence increased throughout March 2022 and started to decline again from 3rd April. As of 25 May 2022, covid-related open absences* numbered 81 which was 12% of all open absences [**includes absences resulting from adhering to isolation requirements*]

There is continued daily monitoring of sickness absences, specifically all COVID related absence and stress related absence and a Divisional focus on long term and frequent absences, supported by absence huddles with HR

Appraisals - At 30 April 2022, the PDR Rate continued to decline to 73.78%, down from 75.55% at 31 March 2022

Focused discussions have been taking place with Divisions to gain assurance on plans to achieve an improvement in the numbers of appraisals being scheduled for completion

Statutory and Mandatory Training - The Statutory and Mandatory training rate at 30 April 2022 was 94.25% (94.73% at 31 March 2022). This compliance rate is for the 6 'Core for All' subjects only

We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

Vacancies - The overall vacancy rate was 11.10% at 30 April 2022 (11.71% at 31 March 2022), equivalent to 1237.21 FTE. Staff in post decreased in April 2022 by 51.70fte and budgeted establishment reduced by 135.22fte as establishment associated with escalation wards was removed. The decrease in budgeted establishment had the effect of reducing the vacancy position by 83.53 fte.

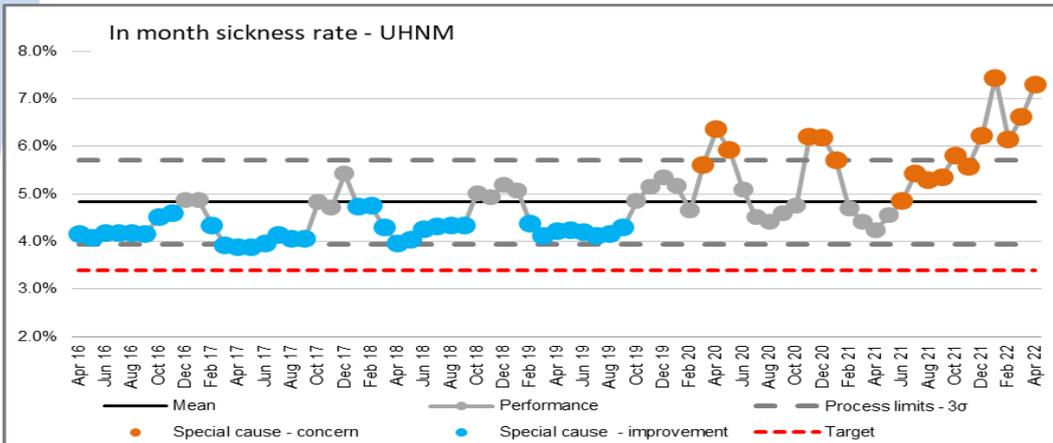
In month, Bank and Agency fte was 933.81, which covered 75.48% of this vacancy position and there was 1076.70 FTE in the recruitment pipeline.

Overall the target **average time to hire** (from vacancy creation to checks complete) is 60 days and although this average is achieved, there are aspects of recruitment, such as pre-employment, which currently exceed the local performance target (17days of the overall 60 day target).

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	7.29%		
Staff Turnover	11%	11.12%		
Statutory and Mandatory Training rate	95%	94.25%		
Appraisal rate	95%	73.78%		
Agency Cost	N/A	3.30%		

Sickness Absence



Variation		Assurance		
Target	3.4%	Feb 22	Mar 22	Apr 22
		6.1%	6.6%	7.3%
Background				
Percentage of days lost to staff sickness				
What is the data telling us?				
Sickness rate is consistently above the target of 3.4%. The special cause variation from April 2020 is a result of covid-19.				

Summary

The in-month sickness rate was 7.29% in April 22 (6.62% in March). The 12 month cumulative rate increased to 6.02% (5.73% at 31/03/22).

Covid-related absence increased peaked in March 2022 and started to decline slowly from 3rd April. As of 25 May 2022, covid-related open absences* numbered 81 which was 12% of all open absences [*includes absences resulting from adhering to isolation requirements]

Divisions have set trajectories for achieving a reduction in Sickness Absence (subject to Covid Pandemic spikes, Winter Pressures and staffing deficiencies) with a year-end target of around 5.5%, which will be monitored via the Improving Together Programme (Staff Availability Objective). Performance at M1 was as follows:

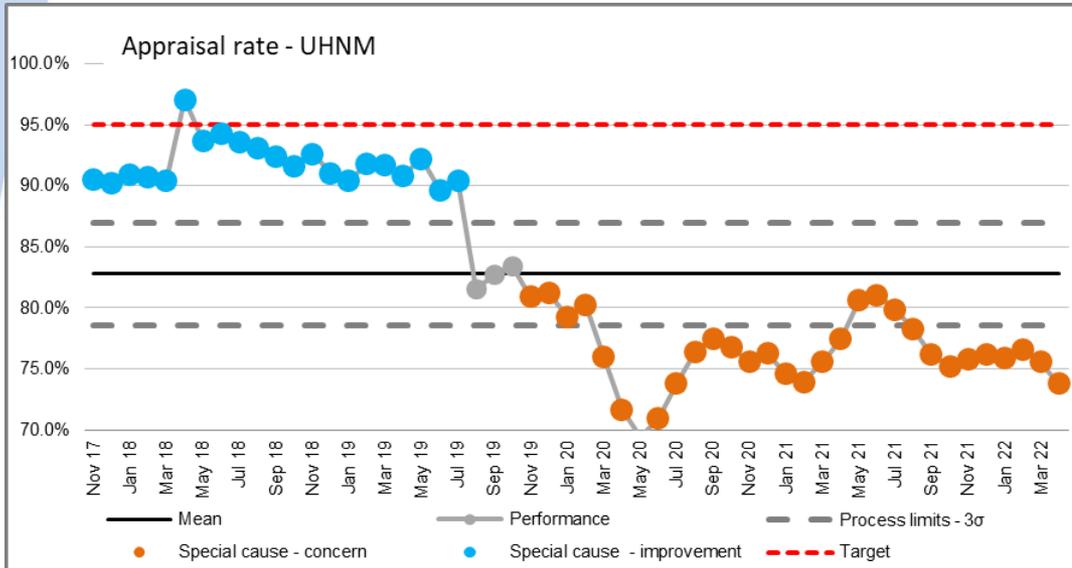
(12m cumulative Absence FTE %)

Org L2	Divisional Trajectory - by March 2023	Jan-22	Feb-22	Mar-22	Apr-22	Change on previous month
205 Central Functions	3.39%	3.80%	3.83%	3.89%	4.13%	↑
205 Children's, Women's & Diagnostics	5.25%	5.20%	5.29%	5.53%	5.88%	↑
205 Estates, Facilities and PFI Division	5.25%	5.13%	5.26%	5.56%	5.81%	↑
205 Medicine Division	5.25%	6.01%	6.14%	6.33%	6.56%	↑
205 Specialised Division	5.25%	4.64%	4.78%	4.96%	5.32%	↑
205 Surgical Division	4.50%	6.46%	6.57%	6.75%	7.02%	↑

Actions

- Assurance meetings have taken place in the Divisions, focussing on the top 10 long term and top 10 frequent absences by speciality.
- There is continued daily monitoring of sickness absence rates, including COVID related absence
- Joint focused absence huddles for Medicine and Surgery take place with HR
- Access to Empactis has been improved and targeted training provided. Compliance with Empactis requirements is monitored.

Appraisal (PDR)



Variation	Assurance

Target	Feb 22	Mar 22	Apr 22
95.0%	76.6%	75.6%	73.8%

Background
Percentage of Staff who have had a documented appraisal within the last 12 months.

What is the data telling us?
The appraisal rate is consistently below the target of 95%.
Note: Completion of PDRs was suspended during covid-19 unless there was capacity to complete them.

Summary

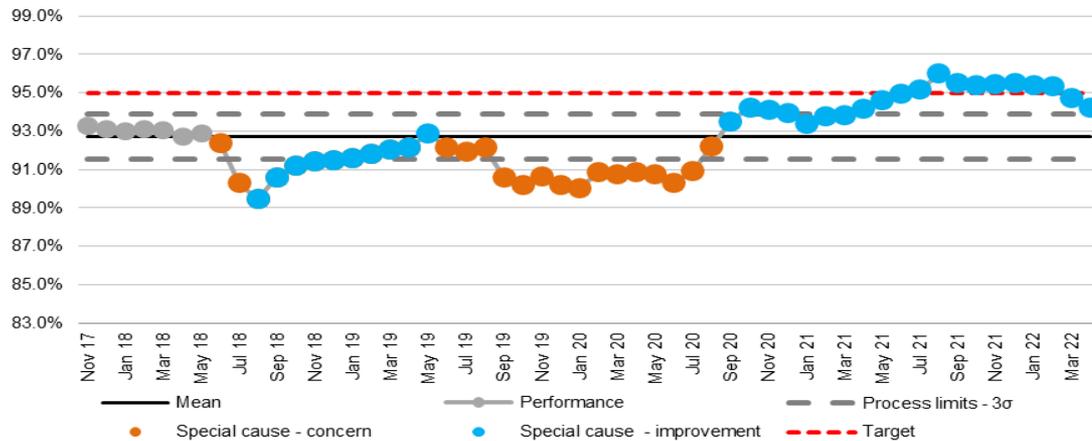
At 30 April 2022, the PDR Rate continued to decline to 73.78%, down from 75.55% at 31 March 2022

Actions

Requirements for undertaking quality PDRs with staff will be a feature of the comprehensive 'Enable Middle Management' programme which will be delivered to 616 managers during 2022/2023. Focused discussions have been taking place with Divisions to gain assurance on plans to achieve an improvement in the numbers of appraisals being scheduled for completion

Statutory and Mandatory Training

Mandatory and Statutory Training - UHNM



Variation		Assurance		
Target	Feb 22	Mar 22	Apr 22	
95.0%	95.3%	94.7%	94.3%	
Background				
Training compliance				
What is the data telling us?				
At 94.73%, the Statutory and Mandatory Training rate just below the Trust target for the core training modules				

Summary

The Statutory and Mandatory training rate at 30 April 2022 was 94.25% (94.73% at 31 March 2022). This compliance rate is for the 6 'Core for All' subjects only

Competence Name	Assignment Count	Required	Achieved	Compliance %
205 MAND Security Awareness - 3 Years	10878	10878	10256	94.28%
NHS CSTF Equality, Diversity and Human Rights - 3 Years	10878	10878	10266	94.37%
NHS CSTF Health, Safety and Welfare - 3 Years	10878	10878	10287	94.57%
NHS CSTF Infection Prevention and Control - Level 1 - 3 Years	10878	10878	10264	94.36%
NHS CSTF Safeguarding Adults - Level 1 - 3 Years	10878	10878	10287	94.57%
NHS CSTF Safeguarding Children (Version 2) - Level 1 - 3 Years	10878	10878	10154	93.34%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS CSTF Fire Safety - 1 Year	10863	10863	9269	85.33%
NHS CSTF Information Governance and Data Security - 1 Year	10863	10863	9502	87.47%

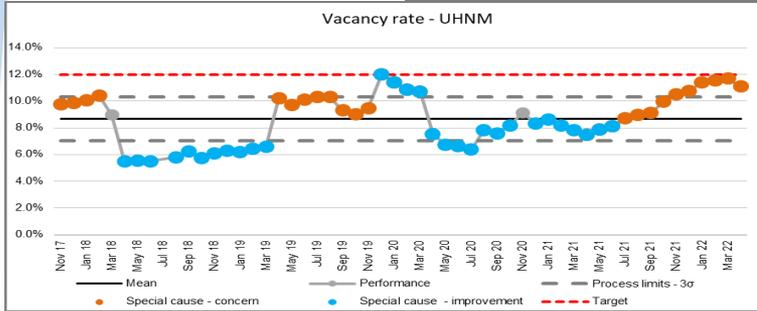
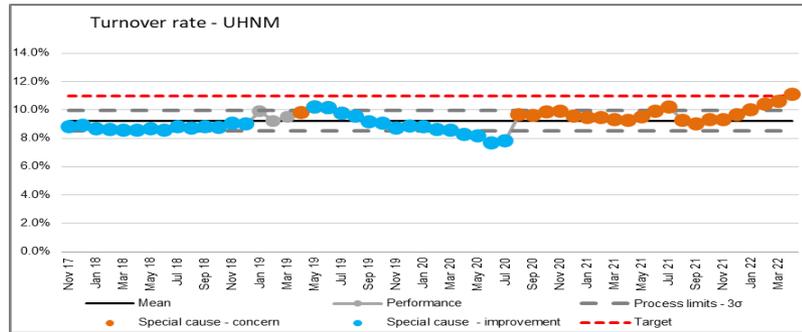
Actions

We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

Compliance is monitored and raised via the Divisional performance review process.

Workforce Turnover

The SPC chart shows the rolling 12m cumulative turnover rate.



The overall Trust vacancy rate calculated as Budgeted Establishment less staff in post, reduced to 11.1% from 11.71% The vacancy rate is influenced by changes to budgeted establishment for Winter Workforce Plan and approved business cases, as well as changes to staff in post.

Variation	Assurance

Target	Feb 22	Mar 22	Apr 22
11.0%	10.4%	10.6%	11.1%

Background
Turnover rate

What is the data telling us?

The special cause variation in the Turnover rate from August 2020 was due to Student Nurses, who had supported throughout the first wave of covid-19, returning to University. The 12m rolling turnover rate remains below the target 11%

Actions

Six International nurses joined UHNM as part of an NHS pilot scheme to recruit medically trained refugees. All six qualified as nurses in their home country and are resuming their nursing careers in the UK.

The Recruitment service is currently working through a full process review to identify process improvements of the on-boarding stage using the Improving Together methodology and the development of a Step Change project. Action taken to date is process mapping of activities undertaken within recruitment with revision of standard operating procedures.

Summary

The 12m Turnover rate was 11.12% (10.59% at 31/03/22). Staff in post decreased in April 2022 by 51.70 fte*. Budgeted establishment reduced by 135.22 fte as establishment associated with escalation wards was removed. The decrease in budgeted establishment had the effect of reducing the vacancy position by 83.53 fte

In month, Bank and Agency fte was 933.81, which covered 75.48% of this vacancy position

There was 1076.70 FTE in the recruitment pipeline. Other mitigations against the vacancy position include offering Additional PA's; extended / increased hours; On call payments and overtime.

Overall the target **average time to hire** (from vacancy creation to checks complete) is 60 days and although this average is achieved, there are aspects of recruitment, such as pre-employment, which currently exceed the local performance target (17days of the overall 60 day target).

	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Vacancies at 30-04 22					
Medical and Dental	1,471.42	1,277.77	193.65	13.16%	13.02%
Registered Nursing	3316.01	2911.41	404.60	12.20%	12.96%
All other Staff Groups	6354.71	5715.76	638.95	10.05%	10.76%
Total	11,142.14	9,904.93	1,237.21	11.10%	11.71%



Finance

**2025
Vision**

“Ensure efficient use of resources”



Finance Spotlight Report

The late timing for the final financial plans and the impact of finalising the accounts for 2021/22 has led to a slimmer closedown for the Month 1 accounts consequently this report focuses on the key issues and risks. It is difficult to reach conclusions on the outlook for the year based on 1 month of data but it appears as if pay expenditure and income are performing in line with expectations and non-pay is slightly above where we would expect it to be.

This report presents the financial performance of the Trust for April (Month 1). Key elements of the financial performance are:

- In month the Trust delivered an actual deficit of £1.4m against an in month planned surplus of £0.6m. This adverse variance to plan is primarily driven by non-delivery of CIP in month in the region of £1m and under recovery of income driven by underperformance of ERF and Specialised Commissioning; these issues were identified as key risks in our financial plan submission.
- The Trust incurred £1.2m of costs relating to COVID-19 in month which is a decrease of £0.1m compared with Month 12's figure with £0.4m being chargeable on top of this allocation for COVID-19 testing costs.
- Capital planned expenditure for 2022/23 as reported to Performance and Finance Committee in April 2022 is £69.8m. In Month 1 total expenditure has been incurred of £3.3m which is £0.2m behind plan. The majority of the expenditure in Month 1 is the pre-committed repayment of the PFI and IFRS16 lease liabilities.
- The cash balance at Month 1 is £74.3m, which is £10.3m lower than plan. The main year to date variances from plan are driven by Health Education Training income being lower than plan and general payables being in excess of plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	80.1		
	Expenditure - Pay	variable	67.7		
	Expenditure - Non Pay	variable	33.0		
Activity	Daycase/Elective Activity	variable	7,184		
	Non Elective Activity	variable	8,921		
	Outpatients 1st	variable	22,954		
	Outpatients Follow Up	variable	37,569		

Income & Expenditure

Income & Expenditure Summary Month 01 2022/23	Annual Budget £m	In Month		
		Budget £m	Actual £m	Variance £m
Income From Patient Activities	883.1	73.1	72.9	(0.2)
Other Operating Income	80.3	6.7	6.8	0.1
Total Income	963.3	79.8	79.6	(0.2)
Pay Expenditure	(578.6)	(47.7)	(46.9)	0.7
Non Pay Expenditure	(330.0)	(26.6)	(29.2)	(2.5)
Total Operational Costs	(908.6)	(74.3)	(76.1)	(1.8)
EBITDA	54.7	5.5	3.6	(2.0)
Depreciation & Amortisation	(33.6)	(2.8)	(2.8)	(0.0)
Interest Receivable	0.3	0.0	0.0	0.0
PDC	(8.9)	(0.7)	(0.7)	(0.0)
Finance Cost	(17.1)	(1.4)	(1.4)	(0.0)
Other Gains or Losses	0.0	0.0	0.0	0.0
Surplus / (Deficit)	(4.6)	0.6	(1.4)	(2.0)

The main variances in month are:

- Income from patient activities has underperformed in month primarily due to reduced income from NHSE Specialised commissioners against plan (£0.5m) and an under achievement against the plan for the Elective Recovery Fund (£0.4m). This has been offset by an over achievement against plan of £0.5m for pass through drugs / devices for which corresponding spend is also reflected in the non-pay position.
- Pay is underspent in month by £0.7m which is primarily driven by underspends across registered nursing and NHS Infrastructure. Although the run rate is higher than that noted in 2021/22 this is driven by the additional NI uplift (1.25%) and the pay award (2%) which has been confirmed for some staff groups and accrued for the remainder of the staff groups where the award has yet to be announced.
- Non-pay is overspent in month by £2.5m; primarily driven by non-delivery of recurrent CIP of approximately £1m. In month both drugs and devices have overspent against the plan by £0.5m and premises by £0.2m both of which we have received additional income to offset this spend; with the premises spend being offset by Cancer Transformation income.

Capital Spend

Capital Expenditure as at Month 1 2022/23 £m	2022/23 Plan April PAF	In Month			Year to Date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
PFI lease liability repayment	(10.5)	(0.9)	(0.9)	-	(0.9)	(0.9)	-
Repayment of IFRS16 leases	(3.7)	(1.9)	(1.9)	-	(1.9)	(1.9)	-
Pre-committed items	(14.3)	(2.7)	(2.7)	-	(2.7)	(2.7)	-
PFI lifecycle and equipment replacement	(3.5)	(0.2)	(0.2)	-	(0.2)	(0.2)	-
PFI enabling cost	(0.3)	-	-	-	-	-	-
PFI related costs	(3.8)	(0.2)	(0.2)	-	(0.2)	(0.2)	-
Wave 4b Funding - Lower Trent Wards	(4.9)	(0.1)	(0.0)	0.0	(0.1)	(0.0)	0.0
Project STAR multi-storey car park	(14.8)	(0.0)	-	0.0	(0.0)	-	0.0
PDC TIF2 County elective hub	(3.9)	-	-	-	-	-	-
Emergency Department (restatement costs)	(0.2)	-	-	-	-	-	-
Schemes funded by PDC and Trust funding	(23.7)	(0.1)	(0.0)	0.1	(0.1)	(0.0)	0.1
LIMS (Laboratory Information Management System)	(0.3)	-	-	-	-	-	-
EPMA (Electronic Prescribing)	(0.6)	-	(0.0)	(0.0)	-	(0.0)	(0.0)
Medical devices fleet replacement	(0.8)	-	-	-	-	-	-
CT7 enabling works (BC 415)	(1.1)	-	-	-	-	-	-
Patient Portal roll out costs (BC 462)	(0.5)	-	-	-	-	-	-
Pharmacy Dispensary	(0.3)	(0.2)	(0.2)	-	(0.2)	(0.2)	-
Anaesthetic medical records (Nasstar) (BC 444)	(0.1)	-	-	-	-	-	-
Home reporting implementation costs (BC 453)	(0.1)	-	-	-	-	-	-
Schemes with costs in more than 1 financial year	(3.9)	(0.2)	(0.2)	(0.0)	(0.2)	(0.2)	(0.0)
2022/23 schemes	(17.2)	(0.3)	(0.1)	0.2	(0.3)	(0.1)	0.2
IFRS 16 New Vehicles lease	(0.1)	-	-	-	-	-	-
IFRS 16 County Theatres TIF1 (IFRS16)	(1.8)	-	-	-	-	-	-
Lease liability re-measurement	(0.1)	-	-	-	-	-	-
IFRS16 funded schemes	(2.1)	-	-	-	-	-	-
Donated/Charitable funds expenditure	(4.7)	-	-	-	-	-	-
Charity funded expenditure	(4.7)	-	-	-	-	-	-
Overall capital expenditure	(69.8)	(3.5)	(3.3)	0.2	(3.5)	(3.3)	0.2

In Month 1 total expenditure of £3.3m is £0.2m behind plan. The majority of the expenditure in Month 1 is the pre-committed repayment of the PFI and IFRS16 lease liabilities.

The only other significant areas of expenditure are on the continuation of the scheme to increase the area of the pharmacy dispensary and the completion of schemes that were committed in 2021/22. Work will continue to ensure that schemes with pre-commitments from 2021/22 are completed as soon as possible in 2022/23.

As shown in the table above £7.2m of the capital funding is still to be allocated by us to specific schemes. There are already significant pressures against this funding including the capital impact of business cases that are expected to progress and also from the expected impact of inflation on projects that have already been agreed.

In addition a risk has been identified by NHSIE in relation to the granting of £11m Capital Resource Limit (CRL) in relation to the Grindley Hill car park scheme. The £11m cost of this scheme will be funded in cash terms from the Trust's own cash reserves although we will still require a CRL allocation to cover the capital expenditure. Further discussions with NHSIE are scheduled to take place soon and an update will be provided at the meeting.

Balance sheet

Balance sheet as at Month 1	31/03/2022	30/04/2022			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	576.4	571.8	571.3	(0.5)	
Right of Use Assets	-	19.3	19.3	(0.0)	
Intangible Assets	20.7	20.3	19.9	(0.4)	
Trade and other Receivables	1.4	1.4	1.4	-	
Total Non Current Assets	598.6	612.8	611.9	(0.9)	
Inventories	16.3	16.3	16.5	0.2	
Trade and other Receivables	41.6	41.6	42.2	0.6	
Cash and Cash Equivalents	87.6	84.6	74.3	(10.3)	Note 1
Total Current Assets	145.5	142.5	133.0	(9.5)	
Trade and other payables	(116.6)	(111.5)	(104.4)	7.1	Note 2
Borrowings	(10.7)	(13.1)	(13.0)	0.1	
Provisions	(2.5)	(2.5)	(2.5)	(0.0)	
Total Current Liabilities	(129.8)	(127.1)	(120.0)	7.2	
Borrowings	(257.8)	(269.4)	(268.1)	1.3	Note 3
Provisions	(3.9)	(3.9)	(3.8)	0.0	
Total Non Current Liabilities	(261.6)	(273.3)	(271.9)	1.3	
Total Assets Employed	352.6	354.9	353.1	(1.9)	
Financed By:				-	
Public Dividend Capital	648.2	648.2	648.2	-	
Retained Earnings	(437.0)	(434.6)	(436.6)	(2.0)	Note 4
Revaluation Reserve	141.4	141.4	141.4	(0.0)	
Total Taxpayers Equity	352.6	354.9	352.9	(2.0)	

Variances to the plan at the year-end are explained below:

Note 1. Cash is £10.3m lower than plan at Month 1. This is primarily due to £6.9m of cash that was not received as expected from Health Education England relating to Q1 training income. This is expected to be received in Month 2. The remaining variance is due to higher than forecast general payments.

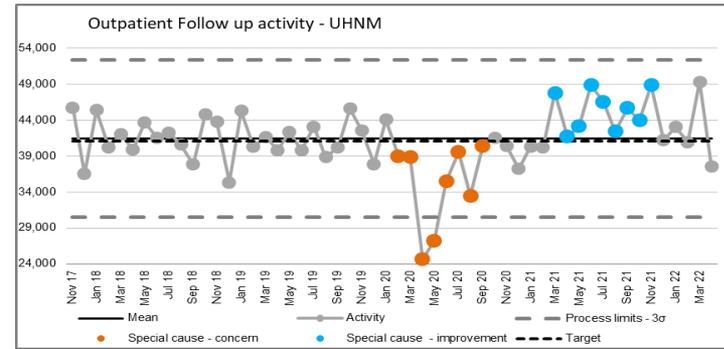
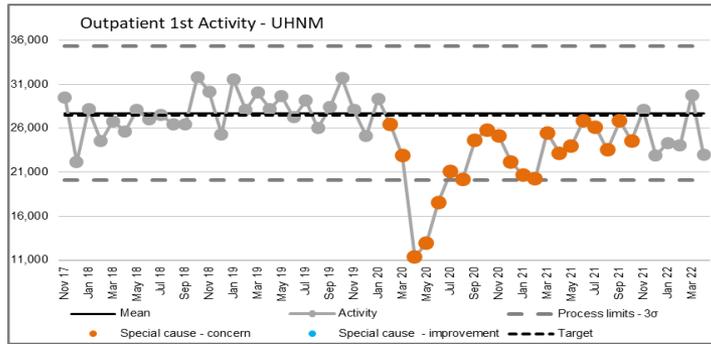
Note 2. Payables are £7.1m lower than plan. The plan value includes an expected £4.6m increase in deferred income in respect of the Q1 Health Education England training income referred to in note 1. The remaining variance is due to lower than forecast accruals at the end of Month 1 resulting from the higher level of general payments made in month.

Note 3. Borrowings are £1.3m lower than plan and reflect the actual IFRS16 lease liabilities outstanding. The plan figures represent the estimated liability submitted to NHSIE in January 2022. However the final assessment of applicable leases and calculation of their values has resulted in a lower lease liability at the transition date of the 1st April.

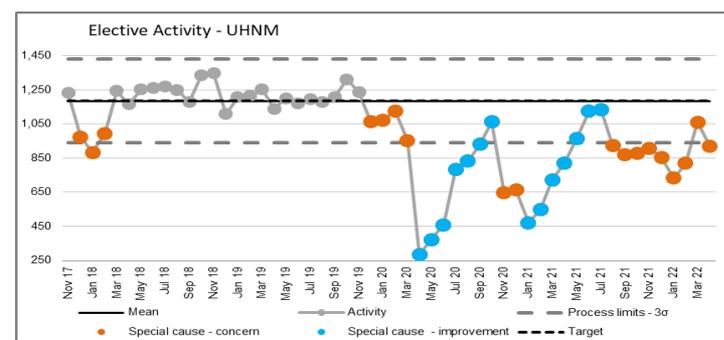
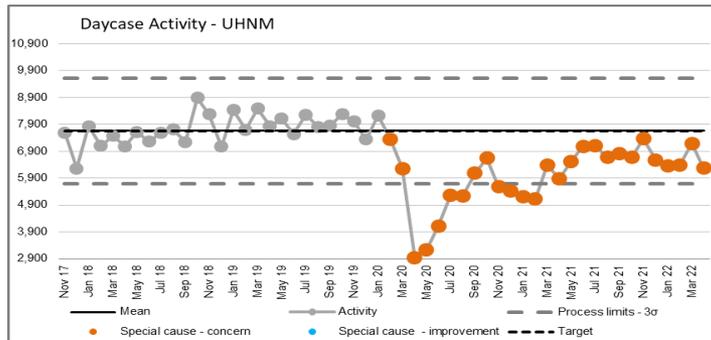
Note 4. Retained earnings show a £2m variance from plan and reflect the revenue position at month 1.

Activity

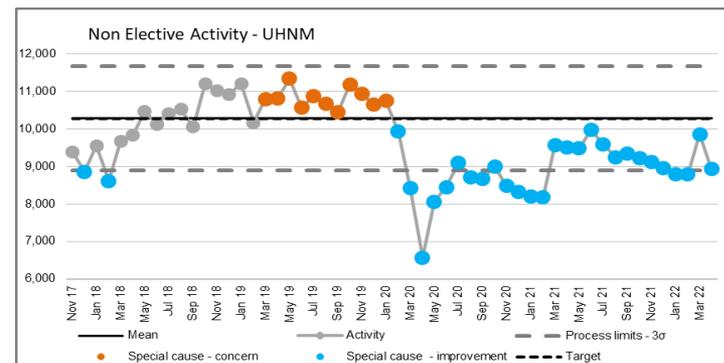
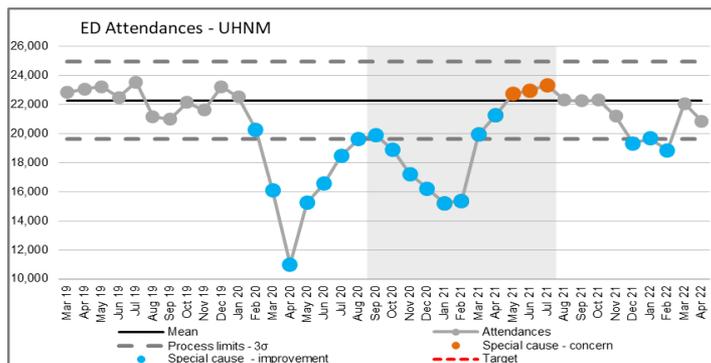
Planned care
Outpatient



Planned care
Inpatient



Urgent Care





Executive Summary

Meeting:	Public Trust Board	Date:	8 th June 2022
Report Title:	Committee Effectiveness and Revised Rules of Procedure	Agenda Item:	17.
Author:	Deputy Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

Purpose of Report			
Information	Approval	✓ Assurance	Assurance Papers only:
			Is the assurance positive / negative / both?
			Positive ✓ Negative ✓

Alignment with our Strategic Priorities			
High Quality	✓	People	✓
Responsive	✓	Improving & Innovating	✓
		Systems & Partners	✓
		Resources	✓



Executive Summary:

Situation

In line with best practice, each Committee of the Trust Board annually reflects on their own performance and effectiveness. The review comprises of three parts; committee effectiveness comprising feedback from the Chair and Committee members, an annual summary of the key areas of work and achievements against the Terms of Reference and business cycle and revision of the Committee Governance Pack, taking into account any issues raised by the effectiveness review and annual report.

Background

Reviews for each Committee have been undertaken and either presented to respective Committees (or having taken Chairs action), which included the approval of revised Terms of Reference for each Committee, taking into account the actions arising from the effectiveness reviews.

Assessment

Members and regular attendees of the various Board Committees were asked to complete a self-assessment questionnaire regarding the effectiveness of the Committees during 2021/22. In addition, a Committee Process checklist was completed by each Chair of the Committee.

The results of the process indicate a broad consensus that all Board Committees have been effective in the discharge of their duties and this is further supported by the content of the Committee Annual Reports. The above processes identified a number of actions to be taken forward to further enhance effectiveness and these are detailed within the report.

Revised Rules of Procedure 2022/23

Following the review of Committee Governance Packs and their approval by respective Committees, the Rules of Procedure for 2022/23 has been revised. No major changes have been made to the Rules of Procedure and only minor changes have been made to the Terms of Reference, mainly in relation to the business cycles for each Committee.

Key Recommendations:

The Trust Board is asked to note:

- the outcomes of the self-assessment process.
- that annual reports for each Committee have been considered by the respective Committees.
- that revised Committee Governance Packs have been approved by each Committee, and incorporated within the Rules of Procedure for 2022/23

The Trust Board is asked to approve the revised Rules of Procedure for 2022/23, incorporating the Trust Board Business Cycle and Committee Governance Packs.



Review of Board Committee Effectiveness 2021/22

June 2022

1. Introduction

As part of the Trust's governance arrangements, and as set out within the Trust's Rules of Procedure, members and regular attendees of Board Committees were asked to complete a self-assessment questionnaire regarding the effectiveness of the Committees during 2021/22.

The questionnaires were based upon good practice guidance which requires Boards to review the effectiveness of their Committees on an annual basis.

In addition, an annual report for each Committee was prepared which summarised the purpose of the Committee, membership and attendance, key issues covered and actions taken.

The outcomes of these reports have been considered by each Committee in addition to their revised Committee Governance Packs (which include terms of reference, business cycles and standard agendas).

2. UHNM Board Committees

Five formal Board Committees have been established and were in operation during 2021/22. In addition, a task and finish Culture Review Committee was established in June 2021; the effectiveness of this Committee will be established via a case closure report once the Committee has considered its Terms of Reference to have been fulfilled.

2.1 Nominations and Remuneration Committee

The Committee:

(a) Advises the Trust Board about appropriate remuneration and terms of service for the Executive Directors (i.e. Trust Board voting and no-voting members), the Chief Executive and posts assigned to the Very Senior Manager framework. This includes:

- (i) All aspects of salary (including any performance-related elements/bonuses)
- (ii) Provisions for other benefits, including pensions and cars
- (iii) Arrangements for termination of employment and other contractual terms

(b) Monitors and evaluates the performance of individual Directors (with the advice of the Chief Executive)

(c) Advises on and oversees appropriate contractual arrangements for Executive Directors, and when required, consider issues relating to remuneration, terms of service and performance issues for senior management staff

The Committee Chairman shall make recommendations to the Trust Board regarding the Composition of the Trust Board to ensure there are robust processes in place to review the role and performance of Non-Executive Directors and the Chairman, and to advise the Chairman regarding the filling of Non-Executive Vacancies.

The Committee is also responsible for reviewing and advising the Trust Board on the appointment process for Non-Executive Directors.

2.2 Audit Committee

The Audit Committee supports the Trust Board in their responsibilities for issues of Integrated Governance, Risk Management and Internal Control, by reviewing the comprehensiveness of internal and external assurances in meeting the Trust Board and Accounting Officer's needs, in addition to reviewing the reliability and integrity of these assurances.

2.3 Quality Governance Committee

The Quality Governance Committee assures the Trust Board of the organisation's performance against quality and research objectives. This assurance is secured through the Assurance Framework, the Corporate Risk Register and the audit plans, which focus on the quality and research objectives of the Trust.

2.4 Performance and Finance Committee

The Performance and Finance Committee oversees all aspects of the Trust's financial, workforce and performance management arrangements, and provides robust assurance in these areas to the Trust Board. The Trust Board continues to have primary responsibility for the financial, organisational development and business performance of the Trust and all Trust Board Directors will continue to be accountable in this respect.

2.5 Transformation and People Committee

The Committee assures the Trust Board in relation to the strategic impact of the Transformation Programmes and People and Organisational Development Strategy on the delivery of the Trust's strategic objectives.

3. Committee Attendance

The average attendance of Committee members for 2021/22 was as follows:

Committee	Average Attendance of Members (%)						
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Nominations and Remuneration Committee	76.0%	83%	89%	87%	73%	71%	85%
Audit Committee	80.0%	83%	93%	77%	83%	87%	90%
Quality Governance Committee	82.5%	86%	85%	79%	84%	83%	80%
Performance and Finance Committee	71.0%	95%	83%	85%	82%	83%	87%
Transformation and People Committee	N/A	N/A	N/A	N/A	94%	82%	80.5%

Attendance matrices for each Committee can be found in the individual Committee Annual Reports.

4. Responses from Committee Self-Assessment Questionnaires

Each Committee member (and regular attendee where required) were asked to complete a Committee Effectiveness questionnaire. The questionnaires were based upon good practice guidance which requires Boards to review the effectiveness of their Committees on an annual basis and included a number of questions covering the practice and conduct of the Committees. In addition a Committee Processes questionnaire was completed by the Deputy Associate Director of Corporate Governance on behalf of the Chair of the Committee.

A summary of the responses received against the questions posed in the questionnaires is listed below:

Committee	Positive Response						
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Nominations and Remuneration Committee	75%	97%	92%	92%	Not undertaken	99%	98%
Audit Committee	77%	85%	94%	88%	86%	98%	96%
Quality Governance Committee	96%	98%	92%	91%	93%	98%	92.5%
Performance and Finance Committee	84%	N/A	86%	82%	96%	99%	94%
Transformation and People Committee	N/A	N/A	N/A	N/A	90%	100%	98%

- Negative statements made in relation to each of the Committees (including any associated comments and agreed actions) are listed below.

Question	Response	Comments	Actions Agreed
Nominations and Remuneration Committee			
The Committee has set itself a series of objectives for the year	1 respondent disagreed	Not sure that a series of objectives have been set but neither am I sure that such objectives are required	<ul style="list-style-type: none"> In terms of redundancy cases, Divisional Teams to consider payback periods and ensure these are not excessive, before being presented to the Committee
The quality of papers received allows members to perform their roles effectively		No comments were made	
Audit Committee			
Decisions and actions are implemented in line with the timescale set down	1 respondent disagreed	Some challenges in meeting timescales on audit recommendations due to focus on pandemic response and restoration and recovery.	<ul style="list-style-type: none"> No actions identified
Quality Governance Committee			
Membership and attendance enables the group/committee to cover all aspects of its terms of reference	1 respondent disagreed	On occasion we have struggled because the right people aren't around the table	<ul style="list-style-type: none"> Additional meetings have been incorporated into the 2022/23 calendar of business for specific meetings focussed on maternity related items, thus reducing the size of the agenda for some meetings Corporate Governance Team to continue to provide Meeting Etiquette guidance to report authors in terms of effective Executive Summaries
Performance and Finance Committee			
The group/committee environment enables people to express their views, doubts and opinions	1 respondent disagreed	Views and opinions are not sought from Executive Directors only Non-Executives	<ul style="list-style-type: none"> When reviewing the items scheduled on the business cycle, members are to consider and confirm any changes required to the level of detail contained within the reports at that point, to ensure this is incorporated from the beginning
Decisions and actions are implemented in line with the timescale set down	1 respondent disagreed	Some delays in assurance on business case implementation needs further improvements	

Question	Response	Comments	Actions Agreed
Debate is allowed to flow, and conclusions reached without being cut short or stifled	1 respondent disagreed	Not a criticism given operating environment recently but size of agenda and timeliness of papers leaves reduced time for debate and challenge on a consistent basis	<p>of the year and does not subsequently require changing</p> <ul style="list-style-type: none"> To continue to implement the revised business case review process In order to aid deeper discussion of items, if more than two business cases are scheduled for approval, consideration will be given as to the benefit of holding a shorter extraordinary Committee meeting to discuss these separately In order to manage the size of the agenda and keep items to time, the Chair is to remind presenters during the meeting, that their papers should be taken as read, and instead, 2 to 3 key highlights should be provided. In addition, the Corporate Governance Team will continue to provide authors with the Meeting Etiquette guidance on presenting papers
Each agenda item is 'closed off' appropriately so that the group/committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored	1 respondent disagreed	No comment provided	
Group/committee meetings are chaired effectively	1 respondent disagreed	No comment provided	
The Chair is visible within the Trust and is considered approachable	1 respondent disagreed	Visibility of Chair impacted by Covid	
The Chair allows debate to flow freely and does not assert his/her own views too strongly	1 respondent disagreed	No comment provided	
Transformation and People Committee			
No negative comments were made.			<ul style="list-style-type: none"> Corporate Governance Team to continue to provide Meeting Etiquette guidance to report authors in terms of effective Executive Summaries

5. Conclusion

The output of the Committee effectiveness reviews and Committee annual reports have been considered by Committees, and actions have been agreed by each Committee. Terms of Reference have also been updated, and take into consideration any changes required for 2022/23 and these are included within the revised Rules of Procedure.

6. Key Recommendations

The Trust Board is asked to note:

- the outcomes of the self-assessment process.
- that annual reports for each Committee have been considered by the respective Committees.
- that revised Terms of Reference have been approved by each Committee, and incorporated within the Rules of Procedure for 2022/23



Rules of Procedure

May 2022

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About University Hospitals of North Midlands NHS Trust

What we do....

University Hospitals of North Midlands NHS Trust was formed in November 2014 following the integration of University Hospital of North Staffordshire NHS Trust and Mid Staffordshire NHS Foundation Trust. We have two hospitals, Royal Stoke University Hospital and County Hospital.

We are a large, modern Trust in Staffordshire, providing services in state of the art facilities. We provide a full range of general hospital services for approximately 1.1m people locally in Staffordshire, South Cheshire and Shropshire. We employ around 11,000 members of staff and we provide specialised services for a population of around 3m, including neighbouring counties and North Wales.

We are one of the largest hospitals in the West Midlands and have one of the busiest Emergency Departments in the country, with an average of around 14,000 patients attending each month across both of our sites. Many emergency patients are brought to us from a wide area by both helicopter and land ambulance because of our Major Trauma Centre status; as we are the specialist centre for the North Midlands and North Wales.

As a University Hospital, we work very closely with our partners at Keele and Staffordshire University and we are particularly proud of our Medical School, which has an excellent reputation. We also have strong links with local schools and colleges. As a major teaching Trust, we hold a large portfolio of commercial research, which provides us with a source of income. Our research profile also enables us to attract and retain high quality staff.

Our specialised services include cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care, paediatric intensive care, trauma, respiratory conditions, spinal surgery, upper gastro-intestinal surgery, complex orthopaedic surgery and laparoscopic surgery.

We play a key role within the Staffordshire and Stoke-on-Trent Integrated Care System (ICS), which has partnership working at its very core as we work closely together to transform the way health care is delivered for the benefit of our population. This includes leadership and participation in partnership boards which bring together health, social care, independent and voluntary sector organisations across Staffordshire.

We look to involve our service users in everything we do, from providing feedback about the services we provide, to helping to share our priorities. This work is co-ordinated by our dedicated Patient Experience Team.

Our 2025 Vision

Our 2025 Vision was developed to set a clear direction for the organisation to become a world class centre of clinical and academic achievement and care. One in which our staff all work together with a common purpose to ensure the highest standard of care and the place in which the best people want to work.

To achieve the 2025 Vision we must respond to the changing requirements of the NHS as they emerge and operate in ever more challenging times. This means that we have to think further than the here and now and continue to look beyond the boundaries of our organisation for inspiration. Our involvement in the Integrated Care System is crucial in enabling us to move towards our Vision and to become a sustainable provider of healthcare services.



Our Strategic Priorities

Through our organisation wide 'Improving Together' programme, which is a Trust wide approach to quality improvement, we have reviewed our organisation wide strategic vision and priorities.

High Quality	Responsive	People	Improving & Innovating	System & Partners	Resources
					
Providing safe, effective and caring services	Providing efficient and responsive services	Creating a great place to work	Achieving excellence in development and research	Leading strategic change within Staffordshire and beyond	Ensuring we get the most from the resources we have, including staff, assets and money

Our Values

We continue to encourage a compassionate culture through our values, which identify the attitude and behavioural expectations of our staff.



1. Introduction

The University Hospitals of North Midlands NHS Trust (the Trust) is a statutory body which came into existence on 4th November 1992 under The North Staffordshire Hospital NHS Trust (Establishment) Order 1992 No 2559 (the Establishment Order). On the 1st April 2003, via order No 792, the name of the hospital was changed to the University Hospital of North Staffordshire NHS Trust. On 1st November 2014, the name of the hospital was changed to the University Hospitals of North Midlands NHS Trust.

- NHS Trusts are governed by statute, mainly the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 (the 2006 Act) and the National Health Service Act 1977 (the 1977 Act and together with the 2006 Act, the NHS Acts).
- The functions of the Trust are conferred by this legislation.
- The Trust also has statutory powers to fund projects jointly planned with local authorities, voluntary organisations and other bodies.
- The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.
- The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

All generalised reference within these Rules of Procedure to the male gender should read as equally applicable to the female gender and vice versa.

2. Definitions

Accountable Officer	The NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.
Associate Member	A person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.
Board	The Chair, Executive Directors and Non-Executive Directors of the Trust collectively as a body.
Budget	Resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust. The budget should, where appropriate, also be supported by budgets relating to workforce and workload.
Budget Administrator	Employee with delegated authority from a Budget Manager (to a limit of £5,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Manager	Employee with delegated authority from a Budget Holder (to a limit of £25,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Holder	Director or employee with delegated authority from the Chief Executive (to a limit of £50,000 inclusive of VAT) to manage finances (income and expenditure) for a specific area of the organisation
Chair of the Trust	Is the person appointed by the Secretary of State for Health and Social Care to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression ‘the Chair of the Trust’ shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.
Chief Executive	The chief accountable officer of the Trust.



Commissioning	The process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
Committee	Means a committee or sub-committee created and appointed by the Trust.
Committee members	Means persons formally appointed by the Board to sit on or to chair specific committees.
Contracting and Procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Employee (Officer)	Employee of the Trust or any other person holding a paid appointment or office with the Trust.
Executive Director (Officer Member)	An officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Funds held on trust	Those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the NHS Act 2006, as amended. Such funds may or may not be charitable.
He/she or his/her	Where this term appears this term is to be taken as referring to the post holder and is interchangeable as the gender of that post holder changes
Member	Executive Director or non-Executive Director of the Board as the context permits.
Membership, Procedure and Administration Arrangements Regulations	NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.
Non-Executive Director (Non-Officer Member)	A member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.
Scheme of Reservation and Delegation of Powers	Document which sets out the powers reserved by the Trust Board, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures.
Senior Independent Director (SID)	A non-executive director available to raise concerns whereby contact through the normal channels of Chair, Chief Executive, Executive Director or Associate Director of Corporate Governance has failed to resolve.
SO's	Standing Orders.
Standing Financial Instructions (SFIs)	Document detailing the financial responsibilities, policies and procedures adopted by the Trust.
Trust	University Hospitals of North Midlands NHS Trust.
Vice Chair	The Non-executive Director appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

3. Governance

The role of the Board is to set strategy, lead the organisation, oversee operations and to be accountable to stakeholders in an open and effective manner. Good governance provides the key to effective leadership, meaningful challenge, accountability and responsibility. Corporate governance is the system by which companies and other Board led organisations are directed and controlled. The Board is separate from the day to day operational management, which is the responsibility of the Executive Directors and the management structure they lead.

As described in NHS Improvement's Well-led Framework, NHS Trusts are operating in challenging environments characterised by the increasingly complex needs of an ageing population, growing emphasis on working with local system partners to create innovative solutions to longstanding sustainability problems,



workforce shortages and the slowing growth in the NHS budget. Trust Boards need to ensure that their oversight of care, quality, operations and finance is robust in the face of uncertain future income, potential new models of care and resource constraints. Good governance is essential if they are to continue providing safe, sustainable and high quality care for patients.

NHS Trusts should conduct their affairs effectively and, in so doing, build patient, public and stakeholder confidence that they are providing high quality sustainable care. NHS Trust Boards are responsible for all aspects of performance and governance of the organisation.

4. Statutory Framework

The University Hospitals of North Midlands (UHNM) Board consists of:

- The Chair of the Trust appointed by NHS Improvement (NHSI) on behalf of the Secretary of State
- 6 Non-Executive Directors
- 6 Executive Directors including the Chief Executive and the Chief Finance Officer

The principal place of business of the Trust is the Royal Stoke University Hospital, Newcastle Road, Stoke-on-Trent, Staffordshire, ST4 6QG. The Trust also provides services at the County Hospital, Weston Road, Stafford, ST16 3SA.

An organisational chart of the Trust Board members and the Trust Boards Committee Structure can be found at appendices 1 and 2.

5. The Board and Exercise of Statutory Powers

The Board shares responsibility for:

- Ensuring that high standards of corporate governance are observed and encouraging high standards of propriety
- Establishing the strategic direction and priorities of UHNM
- The effective and efficient delivery of UHNM's plans and functions
- Promoting quality in UHNM's activities and services
- Monitoring performance against agreed objectives and targets
- Ensuring that Board members personally and corporately observe the seven principles of public life set out by the Committee on Standards in Public Life.

The Board has collective responsibility for the decisions made by it. Members of the Board shall be subject to the Code of Conduct set out in appendix 3.

Any member of the Board who significantly or persistently fails to adhere to these Rules of Procedure may be judged as failing to carry out the duties of their office and will be managed in accordance with current Trust Policy.

6. Meetings and Proceedings of the Board

6.1 Meetings of the Board

- Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine and as set out within the annual Calendar of Business.
- The Board may invite any person to attend all or part of a Board meeting.
- Meetings will either be held virtually, via MS Teams, or at various locations within Royal Stoke University Hospital or County Hospital, as required.
- Members of the Board are expected to attend not less than 8 Board meetings (whether formal meetings or seminars) in any 12 month period.



6.2 Admission of the Public and Press

- The Board will operate in an open and transparent fashion, except where confidentiality requirements are concerned.
- The chair will give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and members of the press, subject to the provisions of the Public Bodies (Admission to Meetings) Act 1960, such as to ensure that the Board's business may be conducted without interruption or disruption. The Board may resolve to exclude the public and conduct its business in private, whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business being transacted or for other special reasons stated in the resolution.
- Members of the public and press are not admitted to meetings of committees or sub-committees except by specific invitation.

Business proposed to be transacted when the press and public have been excluded from a meeting

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, shall be confidential to the members of the Board.

Directors or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

Use of mechanical or electrical equipment for recording or transmission of meetings

The Trust does not permit the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Board. Such permission shall be granted only upon resolution of the Chair and Chief Executive, in advance of the meeting.

6.3 Board Meeting Agenda and Papers

In normal circumstances, the agenda will be sent to members 5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in emergency. For meetings held in public, the agenda and supporting papers shall be published via the Trust website www.uhnm.nhs.uk at least three working days before the meeting.

The order of business at Board meetings shall follow the agenda issued for that meeting unless otherwise directed by the Chair, at whose discretion, or at the request of another member of the Board, the order may be altered at any stage. The agenda will be primarily based upon the Business Cycle approved by the Board (appendix 4).

Papers may only be tabled at a meeting of the Board with the permission of the Chair.

No other business other than that on the agenda will be taken except where the Chair considers the item should be discussed.

Members of the Board should treat those papers identified as private and confidential and not discuss them with persons other than Board members or employees unless this is agreed with the Chair. If so discussed, members of the Board should ensure that those with whom they have consulted are made aware of, and respect, the need for confidentiality.

Members must take care not to leave Board papers identified as private unattended or where others may obtain access to them.

6.4 Extraordinary Meetings of the Board

In the event of urgency the Chair may determine to hold a meeting to be known as an extraordinary meeting at such time as he/she may determine.

6.5 Power to Call Meetings of the Board

Where, in the opinion of the Chair, an urgent matter has arisen, the Chair may call a meeting of the Board at any time.

Where two or more members of the Board submit a signed request for a meeting to the chair, the chair shall, as soon as practicable but no later than seven calendar days from the date the request was submitted, arrange for the meeting to be held within 28 calendar days from the date the request was submitted.

6.6 Chairing of Meetings

The procedure at meetings shall be determined by the Chair presiding at the meeting. The Chair shall, if present, preside at all meetings of the Board. In the absence of the Chair, the Vice-Chair will preside.

In the absence of both the Chair and the Vice-Chair, a Non-Executive Director chosen by the other members will preside.

6.7 Procedure at Meetings of the Board

The Chair or person presiding over the meeting of the Board will:

- Preserve order and ensure that all members of the Board have sufficient opportunity to express their views on all matters under discussion
- Determine all matters of order, competency and relevancy
- Determine in which order those present should speak
- Determine whether or not a vote is required and how it is carried out

Written comments on agenda items submitted by any member of the Board who is not present when a particular agenda item is discussed may be circulated to those members of the Board who are present at the meeting and read out at the appropriate point in the meeting.

Decisions of the Board will normally be made by consensus rather than by formal vote. Failing consensus, decisions will be reached by means of a vote when:

- the person presiding over the meeting feels that there is a body of opinion among members of the board at the meeting who disagree with a proposal or have expressed reservations about it and no clear consensus has emerged; or
- when a member of the Board who is present requests a vote to be taken; or
- any other circumstances in which the person presiding at the meeting considers that a vote should be taken.

Voting will take place as follows:

- Where a decision of the Board requires a vote it shall be determined by a majority of the votes of the members of the Board present and voting on the question. The person presiding at the meeting shall declare whether or not a resolution has been carried or otherwise. In the case of an equal vote, the person presiding (i.e. the Chair of the meeting shall have a second, and casting vote).
- At the discretion of the Chair, all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.
- If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).
- In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.
- A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.
- A manager attending the Trust Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of

the Executive Director. The status of Executive Directors when attending a meeting shall be recorded in the minutes.

No resolution of the Board will be passed if it is unanimously opposed by all of the Executive Directors present or by all of the Non-Executive Directors present.

The minutes of the meeting will record only the numerical results of a vote showing the numbers for and against the proposal and noting any abstentions. The minutes shall be conclusive evidence of the outcome. Votes will not normally be attributed to any individual member of the Board but any member may require that their particular vote be recorded, provided that he/she asks the secretary immediately after the item has concluded.

The Board may agree to defer a decision on an agenda item so that it can be provided with additional information or for any other reason. The decision to defer together with the reasons for doing so will be recorded in the minutes of the meeting together with the proposed time for returning the matter to the Board for its consideration.

The Board may decide to delegate decisions on agenda items to the Chair. Any decision to do so shall be recorded in the minutes of the meeting.

Where in the opinion of the Chair, and considering advice from the Chief Executive, or any other Executive Director, significant operational or other matters require approval by the Board between formal meetings, papers will be circulated by the secretary for approval by correspondence. Any matter capable of being passed by the Board at a meeting may instead be passed by written confirmation given by a majority of the members of the Board with the Chair having the power to cast a second casting vote.

Only exceptionally, where the process to reach a decision would not benefit from discussion in a meeting at which members views would inform debate or, if the issue is time critical will a Board decision be reached without a formal meeting.

6.8 Quorum of the Board

No business shall be transacted at a meeting unless at least six Directors with voting rights (including at least two Executive Directors and three Non-Executive Directors) are in attendance. Attendance of the Chair, shall count as one of the Non-Executive Directors.

An individual in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

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

Participation will usually be in person, but in exceptional circumstances members of the Board may participate by telephone or video-conferencing facility and be deemed to be present and constitute part of the board for that meeting.

When a Board meeting:

- Is not quorate within half an hour from the time appointed for the meeting or;
- Becomes inquorate during the course of the meeting;

the meeting shall either be adjourned to such time, place and date as may be determined by the members present or shall continue as an informal meeting at which no decisions may be taken.

6.9 Minutes of the Board

The minutes of the proceedings of a meeting along with a Post Meeting Action Log shall be drawn up and submitted for agreement at the next ensuing meeting where their approval will be recorded.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate (for example matters arising).

The record of the minutes shall include:

- The names of:
 - Every member of the Board present at the meeting
 - Any other person present
 - Any apologies tendered by an absent member of the Board
- The withdrawal from a meeting of any member on account of a conflict of interest and;
- Any declaration of interest

Minutes of any meeting of the Board will record key points of discussion. Where personnel, finance or other restricted matters are discussed, the minutes will describe the substance of the discussion in general terms.

Once agreed, the minutes will be published via the Trust website www.uhnm.nhs.uk.

6.10 Emergency Powers

The functions exercised by the Board may, in an emergency, be exercised by the Chair after having consulted the Chief Executive.

The exercise of such powers by the Chair must be reported to the next formal meeting of the Board in public session for ratification. The reasons for why an emergency decision was required must be clearly stated.

6.11 Delegation of Powers

The Board remains accountable for all of UHNM's functions, even those delegated to Committees, the Chair, Chief Executive, Executive Directors or employees, and will require information about the exercise of delegated functions to enable it to maintain a monitoring role.

The list of matters reserved for decision by the Board does not however preclude other matters being referred to the Board for decision. All powers delegated by the Board can be reassumed should the need arise and the Board reserves the right to deal with any matters previously delegated. The Board may also revoke or vary such delegation.

The Board delegates to each Committee the discharge of those functions that fall within their respective terms of reference other than any matters reserved to the Board.

The Chief Executive shall prepare a scheme of delegation (Trust Policy F02 Scheme of Delegation and appendix 6 of this document), identifying which functions he/she shall perform personally and which functions have been delegated to Committees and individual employees.

All powers delegated by the Chief Executive can be reassumed by them should the need arise.

Powers are delegated to the Committees and individual employees on the understanding that they will not exercise delegated powers in a matter which in their understanding is likely to be cause for public concern or which might have an effect on the reputation of the Trust.

The exercise of all delegated powers is on the basis that appropriate expert advice will be sought as necessary and that any costs involved can be met within the authorised budget.

The Corporate Governance Team shall keep a record of the powers, authorities and discretions delegated by the Board.

In the absence of an employee to whom powers have been delegated, those powers shall be exercised by the relevant Executive Director unless alternative arrangements have been approved by the Board. If the Chair is absent the powers delegated to him may be exercised by the Vice Chair in relation to the Board and the Chief Executive after taking advice as appropriate from the Board and Executive Directors.

6.12 Role of Accountable Officer and Standing Financial Instructions

The Chief Executive acts as the Accountable Officer. As Accountable Officer, she/he is responsible for ensuring that the public funds for which she/he is personally responsible are properly safeguarded and that functions are used effectively, efficiently and economically.

The standing financial instructions, (Trust Policy F01 Standing Financial Instructions), detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that financial transactions are carried out in accordance with the law and government in order to achieve probity, accuracy, economy, efficiency and effectiveness. They provide a framework of procedures and rules for employees to follow.

All proposed expenditure above £1 million must be formally approved by the Trust Board.

6.13 Personal Conflicts of Interest

If a member of the Board or a Committee member knowingly has any interest or duty which is material and relevant, or the possibility of such an interest or duty, whether direct or indirect and whether pecuniary or not, that in the opinion of a fair minded and informed observer would suggest a real possibility of bias in any matter that it brought up for consideration at a meeting of the Board or any Committee, he/she shall disclose the nature of the interest or duty at the meeting. The declaration of interest or duty may be made at the meeting or at the start of the discussion of the item to which it relates or in advance in writing to the Corporate Governance Team. If an interest or duty has been declared in advance of the meeting, this will be made known by the Chair of the meeting prior to the discussion of the relevant agenda item. In the event of the person not appreciating at the beginning of the discussion that an interest or duty exists, he/she should declare an interest as soon as he/she becomes aware of it.

If a member of the Board or a Committee has acted in accordance with the provisions above and has fully explained the nature of their interest or duty, the members of the Board or Committee present will decide unanimously whether and to what extent that person should participate in the discussion and determination of the issue and this will be recorded in the minutes and the extent to which the person concerned had access to any written papers on the matter. If it is decided that he/she should leave the meeting, the Chair may first allow them to make a statement on the item under discussion.

Where the chair of the meeting has a relevant interest then he/she must advise the Board or the Committee accordingly, and with their agreement and subject to the extent decided, participate in the discussion and the determination of the issue. This will be recorded in the minutes and the extent to which he/she had access to any written papers on the matter. If it is decided that the Chair should leave the meeting because of a conflict of interest, another member will be asked to chair the discussion of the relevant agenda item in accordance with the procedure set out above.

Employees who are not members of the Board or Committee, but who are in attendance at a meeting of the Board or a Committee should declare interests in accordance with the same procedures as for those who are members. Where the chair of a meeting rules that a potential conflict of interest exists, any employee so concerned should take no part in the discussion of the matter and may be asked to leave by the meeting chair.

A member of the Board, Committee or employee shall be subject to the arrangements for dealing with conflicts of interests as set out in the Trust Policy G16 Standards of Business Conduct.

6.14 Allowances for Non-Executive Members of the Board

Non-Executive members of the Board are entitled to seek reimbursement of reasonable expenses incurred in the exercise of duties in accordance with Trust Policy.

7. Meetings and Proceedings of Committees

Where no specific provisions are specified for Committees, these are the same as the principles and provisions for the Board, as set out above. Where there is any inconsistency between the said provisions and any provisions in the Terms of Reference for any Committee, the latter shall prevail.

Committee Governance Packs for each of the Committees, which include Terms of Reference and Membership, Business Cycles, Agenda and Reporting Templates and Self-Assessment Tools can be found at appendices 7 – 13.

7.1 Appointment of Committees

- The Board may establish a Committee for any purpose within its functions and shall determine the powers and functions of any such Committee.
- The Board shall appoint members of the Committees.
- The Board shall appoint, for every Committee, a Chair who shall be a member of the Board, unless there is a specific requirement that the Chief Executive, as Accounting Officer, should be chair.
- The Board shall keep under review, the structure and scope of activities of each Committee.
- The Board shall set out the Terms of Reference for each Committee (see appendices 7 – 13).
- The Board may at any time amend the Terms of Reference of any Committee.

7.2 Meetings of a Committee

A Committee shall hold meetings at such regular intervals as may be determined by the members of the Committee. The Committee shall determine the time and place of the meetings to be held.

7.3 Extraordinary Meetings of a Committee

In the event of urgency, the Committee chair may determine to hold an extraordinary meeting at such time and place as he/she may determine.

7.4 Attendance at Committee Meetings

A member of the Board may attend and speak with the permission of the chair of the Committee at any meeting of a Committee.

A member of the Board who is not a member of the Committee shall not vote on any matter before the Committee. However, should a formal member of the Committee be unable to attend a specific meeting, a suitably senior Deputy may attend, with the full delegated authority of the substantive member and where appropriate, they will be counted in terms of quoracy.

7.5 Chairing of Committee Meetings

The procedure at meetings shall be determined by the Committee chair presiding at the meeting.

The Committee chair shall, if present, preside at all meetings. In the absence of the Committee chair, a non-executive Board member, who is also a member of the Committee, or a Board member nominated by the Committee chair shall preside.

7.6 Quorum of Committees

The quorum for a Committee meeting shall generally consist of one half of the total membership of the Committee of which at least one non-executive member of the Board is present, unless stated otherwise within their Terms of Reference.

7.7 Minutes of Committees

A member of the Executive Suite shall act as Secretary to Committees or nominate a deputy. The Secretary shall record the minutes of every meeting of the Committee or nominate a deputy. The record of minutes shall be submitted to the Committee at its next meeting for agreement, confirmation or otherwise.

Minutes of all Committee meetings will be accessible to all Board members via the Corporate Governance Team.

7.8 Committee Reporting to the Board

The Corporate Governance Team will prepare a report following each Committee meeting, on behalf of the Committee chair, for presentation to the next Board meeting. This will include a section highlighting key points, and referral of items as appropriate as well as any recommendations to the Board.

Each Committee, led by the Chair, will undertake an annual effectiveness evaluation against their Terms of Reference and Membership. An evaluation template for each Committee can be found within their respective 'Governance Pack'. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

7.9 Prohibition on Delegation of a Committee's Function

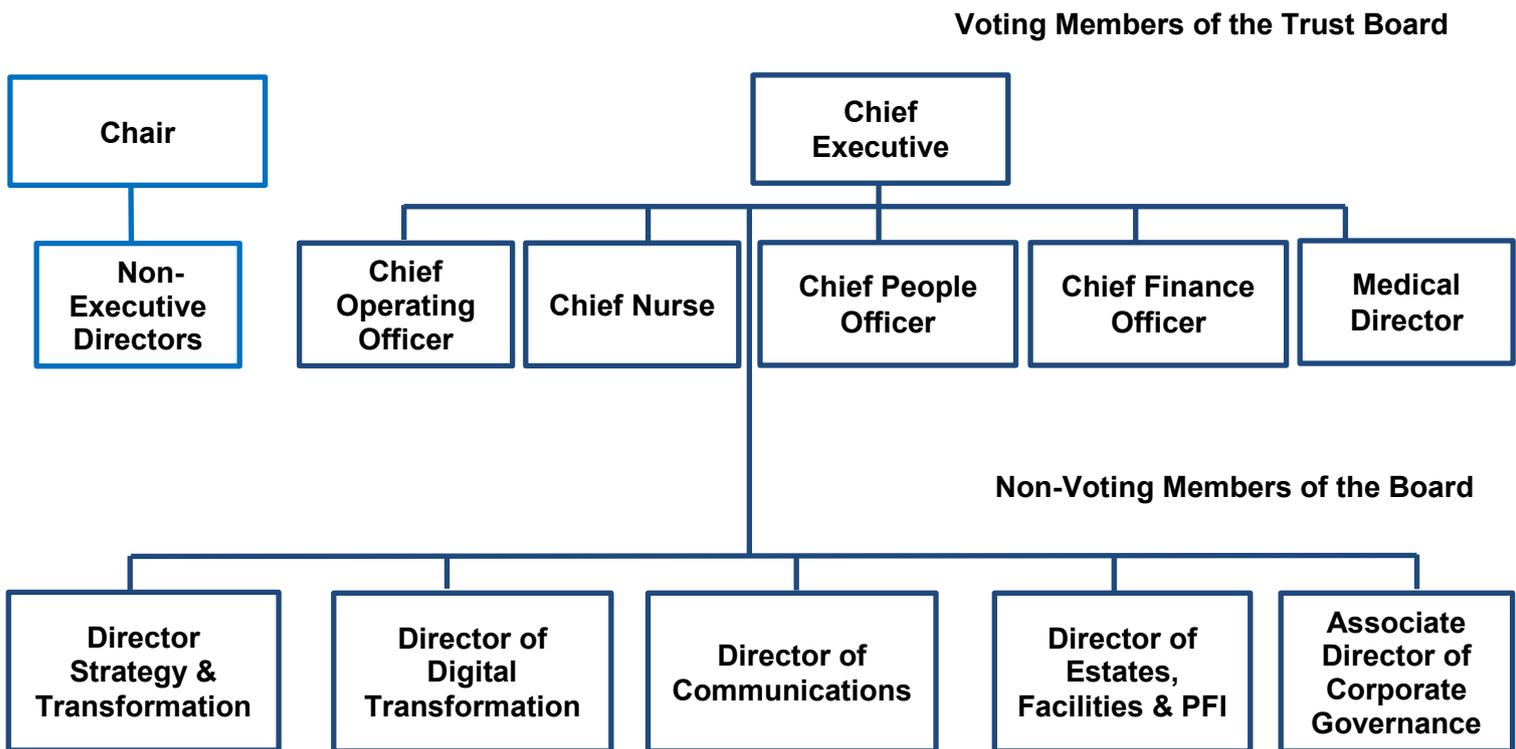
A Committee shall not delegate its functions to any other group established by the Committee or to any other person unless authorised by the Board in the Committee's Terms of Reference.

8. Other Documents Relevant to these Rules of Procedure

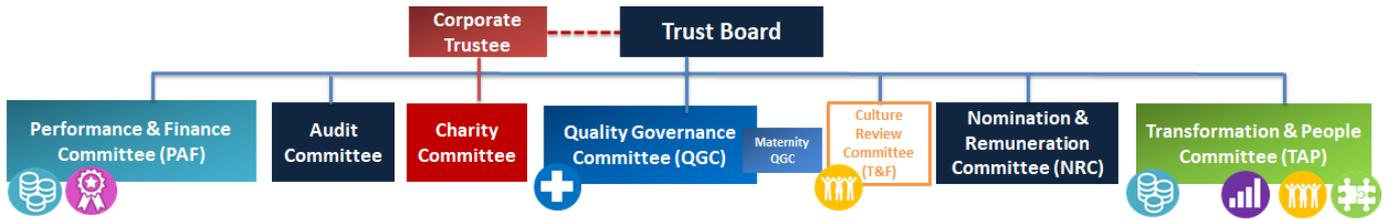
The following documents should be read in conjunction with the Rules of Procedure:

- F01 Standing Financial Instructions
- F02 Scheme of Delegation
- G19 Standing Orders
- G16 Standards of Business Conduct
- Trust Values, Behaviours and Standards Framework

Appendix 1 – Trust Board Organisation Chart



Appendix 2 – Trust Board and Committee Organisation Chart



Appendix 3 - Code of Conduct for Board Members

UHNM Trust Board: Code of Conduct

To justify the trust placed in me by patients, service users and the public, I will abide by these standards at all times when at the service of the NHS.

I understand that care, compassion and respect for others are central to quality in healthcare; and that the purpose of the NHS is to improve the health and wellbeing of patients and service users, supporting them to keep mentally and physically well, to get better when they are ill and when they cannot fully recover, to stay as well as they can to the end of their lives.

I understand that I must act in the interests of patients, service users and the community I serve, and that I must uphold the law and be fair and honest in my dealings.

1. Introduction

All members of NHS Boards are expected to work to the highest personal and professional standards and should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities.

This Code of Conduct has been developed in line with a range of existing standards relevant to the healthcare sector. The standards set out within this Code are consistent with the Nolan Principles on Public Life and with existing regulatory frameworks applying to professionals and senior managers working in the NHS.

In addition, the Code of Conduct should be read alongside the Trusts Values, Behaviours and Standards Framework.

2. Purpose

Senior leadership roles can frequently require individuals to address dilemmas in difficult decisions. Their decisions must balance the potentially conflicting but legitimate needs of individuals, communities, the healthcare system and taxpayers.

- Part 1 of this Code of Conduct is designed to provide a framework to guide judgment in these circumstances, through a consistent application of values and principles.
- Part 2 sets out a modern etiquette for Board members, including behavioural expectations, to help ensure that Board meetings are effective and focused.
- Part 3 provides an outline of the individual and collective roles and responsibilities of Board members.

3. Part 1: Standards For Board Members

All Board members should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities, such as the differences in role of executive and non-executive Board members. To justify the trust that has been placed in them by patients and the public they must adhere to these standards of personal behaviour, technical competence and business practice.

3.1 Personal Behaviours

In the treatment of patients and service users, their families and their carers, the community, colleagues and staff, and in the design and delivery of services for which they are responsible, Board members must commit to:

- The values of the **NHS Constitution** in the treatment of staff, patients and their families and carers and the community, and in the design and delivery of services for which they are responsible.
- Promoting **equality and diversity** in the treatment of staff, patients and their families and carers, and the community, and in the design and delivery of services for which they are responsible.
- Promoting **human rights** in the treatment of staff, patients, their families and carers, and the community, and in the design of services for which they are responsible.
- The **duty of candour** to ensure that 'patients/their families are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and supported to deal with the consequences'. This applies to patient safety incidents that occur during care provided and that result in moderate harm, severe harm or death. This also applies to suspected incidents which have yet to be confirmed, where the suspected result is moderate harm, severe harm or death.
- The requirements as set out by the Care Quality Commission in relation to the **Fit and Proper Persons Test**.

Board members must apply the following principles in their work and relationship with others:

Responsibility	I will be fully accountable for my work and the decisions that I make, for the work and decisions of the Board, including delegated responsibilities, and for the staff and services for which I am responsible.
Honesty	I will act with honesty in all my actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence my decisions as a Board member
Openness	I will be open about the reasoning, reasons and processes underpinning my actions, transactions, communications, behaviours and decision-making and about any conflicts of interest
Respect	I will treat patients and service users, their families and carers, the community, colleagues and staff with dignity and respect at all times
Professionalism	I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a Board member and that I reflect on and identify any gaps in my knowledge and skills, and will participate constructively in appraisal of myself and others. I will adhere to any professional or other codes by which I am bound
Leadership	I will lead by example in upholding and promoting these Standards, and use them to create a culture in which their values can be adopted by all.
Integrity	I will act consistently and fairly by applying these values in all my actions, transactions, communications, behaviours and decision-making, and always raise concerns if I see harmful behaviour or misconduct by others.

3.2 Technical Competence

For themselves and the organisation, Board members must seek:

- To make sound decisions individually and collectively
- Excellence in the safety and quality of care, patient experience and the accessibility of services
- Long term financial stability and best value for the benefit of patients, service users and the community.

This will be done through:

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**PROUD
TO
CARE**

- Always putting the safety of patients and service users, the quality of care and patient experience first, enabling colleagues to do the same.
- Demonstrating the skills, competencies and judgment necessary to fulfil their role and by engaging in training, learning and continuing professional development.
- Having a clear understanding of the business and financial aspects of the organisations work and of the business, financial and legal contexts in which it operates
- Making best use of expertise and that of colleagues while working within the limits of their own competence and knowledge.
- Understanding their role and powers, the legal, regulatory and accountability frameworks and guidance within which they operate and the boundaries between the executive and non-executive.
- Working collaboratively and constructively with others, contributing to discussions, challenging decisions and raising concerns effectively.
- Publicly upholding all decisions taken by the Board under due process for as long as they are a member of the Board.
- Thinking strategically and developmentally.
- Seeking and using evidence as the basis for decisions and actions.
- Understanding the health needs of the population served.
- Reflecting on personal, Board and organisational performance and how their behaviour affects those around them; and supporting colleagues to do the same.
- Looking for the impact of decisions on the services provided, on the people who use them and on staff.
- Listening to patients and service users, their families and carers, the community, colleagues and staff and making sure people are involved in decisions that affect them.
- Communicating clearly, consistently and honestly with patients and service users, their families and carers, the community, colleagues and staff, ensuring that messages have been understood.
- Respecting patients' rights to consent, privacy and confidentiality and access to information, as enshrined in data protection and freedom of information law and guidance.

3.3 Business Practices

For themselves and for the organisation, Board members must seek:

- To ensure the organisation is fit to service its patients and service users, and the community.
- To be fair, transparent, measured and thorough in decision making and in the management of public money.
- To be ready to be held publicly to account for the organisations decisions and for its use of public money.

This will be done through:

- Declaring any personal, professional or financial interests and ensure that they do not interfere with actions, transactions, communications, behaviours or decision making, removing themselves from decision making when they might be perceived to do so.
- Taking responsibility for ensuring that any harmful behaviour, misconduct or systems weaknesses are addressed and learnt from, and taking action to raise any such concerns identified.
- Ensuring that effective complaints and whistleblowing procedures are in place and in use.
- Condemning any practices that could inhibit the reporting of concerns by members of the public, staff or Board members about standards of care or conduct.
- Ensuring that patients and service users and their families have clear and accessible information about the choices available to them so that they can make their own decisions.
- Being open about the evidence, reasoning and reasons behind decisions about budget, resource and contract allocation.
- Seeking assurance that the organisations financial, operational and risk management frameworks are sound, effective and properly used and that the values in these standards are put into action in the design and delivery of services.
- Ensuring that the organisations contractual and commercial relationships are honest, legal, regularly monitored and compliant with best practice in the management of public money.
- Working in partnership and co-operating with local and national bodies to support the delivery of safe, high quality care.
- Ensuring that the organisations dealings are made public, unless there is a justifiable and properly documented reason for doing so.



4. Part 2: Board Meetings - Etiquette

The Trust Board is the predominant mechanism by which strategy is agreed, performance monitored and executive actions held to account on behalf of stakeholders. It is therefore essential that the Board conducts meetings with a view to optimising the use of the time and intellectual capital of members.

As such, the Board needs to focus on the purpose of the meeting, and all the elements that can contribute to an effective discussion, including the way members interact and work together to ensure sound decision-making.

An effective Board develops and promotes its collective vision of the Trust's purpose, culture, values and the behaviours it wishes to promote in conducting its business. In particular it:

- Provides direction for management;
- Demonstrates ethical leadership, displaying and promoting behaviours consistent with the culture and values it has defined for the organisation;
- Makes well-informed and high-quality decisions based on a clear line of sight into the business.

Ensuring robust and appropriate challenge depends on a number of factors being in place: the right information in the right format in advance of the meeting; an appropriate setting; length of the meeting; good Chairmanship; appropriate Boardroom behaviours and the encouragement of a culture where challenge is accepted.

If Board members are not fully engaged throughout the duration of a Board meeting, and behaviours are poor, decision-making will be impaired. It may be possible that Board papers are failing to engage members, consequently not stimulating directors to ask questions and challenge assumptions behind recommendations.

4.1 Before the Meeting

- Provide papers 5 days in advance of the meeting, to allow these to be circulated to members; late papers will only be allowed following discussion with the Chief Executive/Chair.
- Having received the Board papers before the meeting, read the agenda, and any supporting papers ahead of the meeting and prepare questions to be raised at the appropriate time, or think of suggestions to resolve problems.
- Be clear on the decision that is being asked for.
- Request further information ahead of the meeting or seek clarification from the Corporate Governance Team or report author (including highlighting typographical and other errors not of material consequence), where appropriate.
- Submit apologies, and where appropriate arrange for a deputy to attend (ensuring they are well-briefed).
- Arrive for the meeting on time, stay for its duration, and ensure regular attendance at all meetings.
- If you have to leave before the end of the meeting, inform the Chair beforehand. However, this should be avoided whenever possible.

4.2 During the Meeting

- Declare any potential or real conflicts of interest with regard to any matter on the agenda.
- If using an electronic device to make notes during the meeting of discussions and decisions made, it is advisable to inform fellow Board members of your intention and gain the permission of the Chair.
- Unless there are specific reasons for doing so, no part of the meeting should be visually or audio recorded. If such recording is agreed the Chair must inform the meeting beforehand.

4.3 Focussing on the Agenda

- Stay focused on agenda items.
- Dedicate attention to the purpose of the meeting and refrain from performing other duties at the same time.

- Turn off mobile phones/electronic communications device. When an electronic device must be kept on, turn to silent/vibrate. Should individuals need to answer an urgent call; attendees should be forewarned that an urgent call is expected and permission of the Chair to keep the electronic device on must be sought.
- Refrain from private conversations with others at the meeting (whether spoken or written), and the passing of notes.

4.4 Contributing to the Discussion

- If appropriate, attract the Chair's attention when wishing to contribute to the discussion, and wait until the Chair indicates that you may speak so as to avoid interrupting a fellow Board member. Direct comments and discussion through the chair.
- When invited to speak by the Chair, do so clearly, concisely and at a volume that all attendees can hear (especially the minute-taker), without shouting. Avoid the use of jargon and acronyms.
- Throughout the meeting be respectful of the role of the chair in encouraging debate, summarising discussion and clarifying decisions made.
- Be constructive and professional in imparting an opinion or information.
- Listen attentively and respectfully to others, making notes of any points to raise when an opportunity to respond arises; do not interrupt when others are speaking.
- Ensure body language demonstrates participation and engagement in the meeting.
- Challenge inappropriate behaviour/language from other Board members at the time via the chair or after the meeting if more convenient.
- Treat attendees fairly and consistently, even if there is disagreement with another's point of view.
- Challenge and provide critique constructively, and ensure that any challenges are proportionate and based on fact. Challenge the issue being discussed, not the personality of other individuals taking part in the discussion.
- Seek clarification or amplification when necessary.

4.5 Unitary Board

- Board members should know and understand their role at the meeting and the need for the Board to act as a corporate body (i.e. not to pursue self-interest or the interest of another body).
- Board members should not act territorially/personally, and should remember the need to contribute to the corporate nature of the Board.
- Regard and welcome challenge as a test of the robustness of papers and arguments presented.
- Do not cause offence or take offence, accept the diversity of opinions and views presented.

4.6 Accountability

- Seek professional guidance/clarification from the Chair during the meeting (or Associate Director of Corporate Affairs outside the meeting) wherever there may be any concern about a particular course of action.
- Keep confidential matters confidential.

4.7 After the meeting

- Participate and contribute to any post-meeting review with a view to making future meetings more effective
- A summary of actions agreed will be produced and circulated by the Corporate Governance Team within 1 day of the meeting. Board members must read the action summary and complete any relevant tasks and report back appropriately on their completion in a timely manner. A central log of all actions agreed by the Board will be maintained by the Corporate Governance Team.
- Draft minutes will be produced within one working week after the meeting. These should be read with a view to clarifying matters and sending amendments to the Corporate Governance Team at the earliest opportunity. This should help to reduce the time taken approving the minutes at the next Board meeting.
- Observe the confidentiality and sensitivity of matters discussed at the meeting and ensure that all papers, both electronic and paper copies are stored safely.

- Remember that decisions were taken collectively by the Board and therefore that responsibility remains collective too.

Where there is evidence that the Board etiquette policy has been breached, the chair, with guidance from the Corporate Governance Team, will recommend the necessary action to be taken.

Any meeting to discuss breaches of Board etiquette will take place with the presence of the member accused of inappropriate behaviour, in accordance with the Board's code of conduct, where applicable.

Board behaviour and performance, collectively and individually, should be reviewed as part of an annual Board evaluation process.

All Board members share corporate responsibility for:

- formulating strategy
- ensuring accountability
- shaping culture
- ensuring the Board operates as effectively as possible

5.1 Chair and Chief Executive

The Chair and Chief Executive have complimentary roles in Board leadership. These are defined in more detail within the 'Memorandum of Understanding between the Chair and Chief Executive'. In essence, these two roles are:

- The **Chair** leads the Board and ensures the effectiveness of the Board (and Council of Governors once Foundation Trust status is achieved)
- The **Chief Executive** leads the executive and the organisation

5.2 Roles of Board Members

There are distinct roles for different members of the Board. These are set out in the following table:

	Chair	Chief Executive	Non-Executive Director	Executive Director
Formulate Strategy	Ensures Board develops vision and clear objectives to deliver organisational purpose	Leads vision, strategy development process	Brings independence, external skills and perspectives and challenge to strategy development	Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant)
Ensure Accountability	<p>Holds CEO to account for delivery of strategy</p> <p>Ensures that Board committees that support accountability are properly constituted</p>	<p>Leads the organisation in the delivery of strategy</p> <p>Establishes effective performance management arrangements and controls</p> <p>Acts as Accountable Officer</p>	<p>Holds the executive to account for the delivery of the strategy</p> <p>Offers purposeful, constructive scrutiny and challenge</p> <p>Chairs or participates as member of key committees that support accountability</p>	Leads implementation of strategy within functional areas
Shape Culture	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected and modelled in their own and in the Boards behaviour and decision making	Provides visible leadership in developing a positive culture for the organisation and ensures that this is reflected in their own and the executive's behaviour and decision making	<p>Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour</p> <p>Provides a safe point of access to the</p>	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour

	Chair	Chief Executive	Non-Executive Director	Executive Director
	Board culture: Leads and supports a constructive dynamic within the Board, enabling contributions from all directors		Board for whistle blowers	
Context	Ensures all Board members are well briefed on external context	Ensures all Board members are well briefed on external context		
Intelligence	Ensures requirements for accurate, timely and clear information to Board / directors are clear to executive	Ensures provision of accurate, timely and clear information to Board / directors	Satisfies themselves of the integrity of financial and quality intelligence	Takes principal responsibility for providing accurate, timely and clear information to the Board
Engagement	Plays a key role as an ambassador, and in building strong partnerships with: <ul style="list-style-type: none"> • Patients and public • Members and governors (FT) • Clinicians and staff • Key institutional stakeholders • Regulators 	Plays a key leadership role effective communication and building strong partnerships with: <ul style="list-style-type: none"> • Patients and public • Members and governors (FT) • Clinicians and staff • Key institutional stakeholders • Regulators 	Ensures Board acts in best interests of the public Senior independent director is available to members and governors if there are unresolved concerns	Leads on engagement with specific internal or external stakeholder groups

6. Monitoring Compliance with the Code of Conduct

Overall Board behaviour and performance, collectively and individually, will be reviewed as part of an annual Board evaluation process.

Individual performance against this Code of Conduct will be assessed as part of the appraisal discussion with the Chief Executive Officer / Chair as appropriate.

7. References

- ICSA: Specimen Board Meeting Etiquette, February 2012
- Cabinet Office: Code of Conduct for Board Members of Public Bodies, June 2011
- CHRE: Standards for members of Boards and governing bodies in England, (draft for consultation), January 2012
- Professional Standards Authority: Standards for members of NHS Boards and Clinical Commissioning Group governing bodies in England
- National Leadership Council: The Healthy NHS Board, Principles for Good Governance, February 2010

Appendix 4 – Trust Board Business Cycle 2022/23

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	6	4	8	6	3	7	5	9	7	11	8	8
HIGH QUALITY												
Chief Executives Report												
Patient Story												
Quality Governance Committee Assurance Report												
Quality Strategy Update												
Clinical Strategy												
Emergency Preparedness Annual Assurance Statement and Annual Report												
Care Quality Commission Action Plan												
Bi Annual Nurse Staffing Assurance Report												
Quality Account												
7 Day Services Board Assurance Report												
NHS Resolution Maternity Incentive Scheme												
Maternity Serious Incident Report												
Winter Plan												
PLACE Inspection Findings and Action Plan												
Infection Prevention Board Assurance Framework												
RESPONSIVE												
Integrated Performance Report	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10
PEOPLE												
Transformation and People Committee Assurance Report												
Gender Pay Gap Report												
People Strategy Update												
Revalidation												
Workforce Disability Equality Report												
Workforce Race Equality Standards Report												
Staff Survey Report												
IMPROVING AND INNOVATING												
Research Strategy												
SYSTEM AND PARTNERS												



Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	6	4	8	6	3	7	5	9	7	11	8	8
System Working Update												
RESOURCES												
Performance and Finance Committee Assurance Report												
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above												
Digital Strategy Update												
Going Concern												
Estates Strategy Update												
Annual Plan												
Capital Programme 2022/23												
GOVERNANCE												
Nomination and Remuneration Committee Assurance Report												
Audit Committee Assurance Report												
Board Assurance Framework		Q4			Q1			Q2			Q3	
Raising Concerns Report		Q4			Q1			Q2			Q3	
Accountability Framework												
Annual Evaluation of the Board and its Committees												
Annual Review of the Rules of Procedure												
G6 Self-Certification												
FT4 Self-Certification												
Board Development Programme												



Appendix 5 – Annual Effectiveness Evaluations

NB. Separate checklists are in place for the Audit Committee.

Name of Committee:	
Chair:	
Date of Effectiveness Review:	

Processes

To be completed by the Chair with the assistance of the Corporate Governance Team if required, and presented to the relevant Board Committee.

Area / Question	Yes	No	Comments
Composition, establishment and duties			
Does the Committee have written terms of reference and have they been approved by the Trust Board?			
Are the terms of reference reviewed annually?			
Are committee members independent of the management team?			
Are the outcomes of each meeting reported to the Corporate Trustee?			
Does the committee prepare an annual report on its work and performance?			
Has the committee established a plan of matters to be dealt with across the year?			
Are committee papers distributed in sufficient time for members to give them due consideration?			
Has the committee been quorate for each meeting this year?			
Compliance with the law and regulations governing the NHS			
Does the committee review assurance and regulatory compliance reporting processes?			

Committee Effectiveness

To be completed by each member of the Group for to submission to the Chair.

Statement	Please tick (✓) one box for each question					Comments/ action
	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer	
Theme 1 – Committee Focus						
The committee has set itself a series of objectives for the year						
The committee has made a conscious decision about the information it would like to receive						
Committee members contribute regularly to the issues discussed						
The committee is aware of the key sources of assurance and who provides them						
Theme 2 – Committee Team Working						
The committee has the right balance of experience, knowledge and skills to fulfil its role						



Statement	Please tick (✓) one box for each question					Comments/ action
	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer	
The committee ensures that the relevant Executive Director attends meetings to enable it to understand the reports and information it receives						
The committee is fully briefed on key risks and any gaps in control						
The committee environment enables people to express their views, doubts and opinions						
Members hold their assurance providers to account for late or missing assurances						
Decisions and actions are implemented in line with the timescale set down						
Theme 3 – Committee Effectiveness						
The quality of committee papers received allows committee members to perform their roles effectively						
Members provide real and genuine challenge – they do not just seek clarification and/or reassurance						
The committee challenges management and other assurance providers to gain a clear understanding of their findings						
Debate is allowed to flow, and conclusions reached without being cut short or stifled						
Each agenda item is 'closed off' appropriately so that the committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored						
At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well or not so well						
The committee provides a written summary report of its meetings to the Trust Board including items for escalation						
The Trust Board challenges and understands the reporting from the Committee						
Theme 4 – Committee Engagement						
Membership and attendance at the committee enables the committee to cover all aspects of its terms of reference						
Theme 5 – Committee Leadership						
The committee chair has a positive impact on the performance of the committee						
Committee meetings are chaired effectively						
The committee chair is visible within the Trust and is considered approachable						
The committee chair allows debate to flow freely and does not assert his/her own views too strongly						
The committee chair provides clear and concise information to the Trust Board on committee activities and gaps in control						

Appendix 6 – Annual Governance Report Template

Introduction

The xxx Committee is established under Board delegation with approved terms of reference that reflects best practice available nationally. The Committee consists of xx Non-Executive Directors, has met on xx occasions throughout xx and has discharged its responsibilities. An outcome summary of each meeting of the Committee is formally reported to the Public Trust Board via the Committee Chair. The report has highlighted key points of discussion, challenge, decisions made, referral of items as appropriate and recommendations to the Board.

During the year, the Committee comprised of the following membership:

- xx

Other individuals such as the xx have been invited to attend the Committee during xx, for all or part of meetings at the request of the Committee Chair.

Key Areas of Work and Achievements against the Terms of Reference

During the year the Committee has monitored the progress made in delivering the business cycle, as can be seen below:

Compliance with the key responsibilities is evidenced by the actions identified in the following sections:

- xxx

Review of the Effectiveness and Impact of the Committee

The Committee has been active during the year in discharging its responsibilities and has undertaken a self-assessment of its effectiveness.

Emerging Issues and Objectives for xxx

- xxx

Attendance Matrix

All the meetings of the Committee held during xx were quorate.

	Attended	Apologies Given – Deputy sent	Apologies Given	Not in Post								
Members:												
	A	M	J	J	A	S	O	N	D	J	F	M

The average attendance of members (or deputies) at the Committee was xx%.

Conclusion

The Committee is of the opinion that this annual report is reflects the work of Committee during xx and that the Committee has reviewed xxx. In addition there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.



Appendix 7 – Agenda Template



University Hospitals
of North Midlands
NHS Trust

Title of Committee

Meeting held on xx at xx am to xx pm
Trust Boardroom, Springfield, Royal Stoke

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format
PROCEDURAL ITEMS					
	1.	Chair's Welcome, Apologies and Quoracy	Information		Verbal
	2.	Declarations of Interest	Assurance		Verbal
	3.	Minutes of the Meeting held xx xx	Approval		Enclosure
	4.	Matters Arising via the Post Meeting Action Log	Assurance		Enclosure
	xx				
	5.				
	6.				
	7.				
	xx				
	8.				
	9.				
	10.				
	xx				
	11.				
	12.				
	13.				
GOVERNANCE					
	14.				
	15.				
	16.				
CLOSING MATTERS					
	17.	Review of Meeting Effectiveness and Business Cycle Forward Look			
	18.	Agreement of Items for Highlight Report including Items for Escalation to Trust Board			
DATE AND TIME OF NEXT MEETING					



Appendix 8 – Minutes Template



University Hospitals
of North Midlands
NHS Trust

Title of Committee

Meeting held on xx at xx to xx
Trust Boardroom, Springfield, Royal Stoke

MINUTES OF MEETING

Members: A M J J A S O N D J F M

- xxx
- xxx
- xxx
- xxx
- xxx
- xxx

In Attendance:

xxx	xx	Personal Assistant (minutes)
xxx	xx	xxx
xxx	xx	xxx

No.	Agenda Item	Action
1.	Chair's Welcome, Apologies and Confirmation of Quoracy	
2.	Title	
	xx	
3.	Title	
	xx	
4.	Title	
	xx	
5.	Date and Time of Next Meeting	
	Date / Date / Time / Venue	



Audit Committee

Committee Governance Pack

April 2022

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Membership

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members. One of the members will be appointed as Chair of the Committee by the Board and the Chair of the organisation shall not be a member of the Committee. In addition, other Non-Executives are invited to attend as required.

Attendance at Meetings

The Chief Finance Officer and appropriate internal and external audit representatives shall normally attend meetings. At least once a year, the Committee should meet privately with the external and internal auditors.

The local counter fraud specialist will attend a minimum of two committee meetings a year.

The Chief Executive should be invited to attend and should discuss at least annually with the Committee the process for assurance that supports the Annual Governance Statement. He or she should also attend when the Committee considers the draft annual report and accounts. All other Executive Directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The Corporate Governance team shall provide appropriate support to the Chair and Committee members.

Quorum

A quorum shall be two non-executive members.

Frequency of Meetings

The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of five meetings per annum at appropriate times in the reporting year and audit cycle is proposed. The External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

Reporting

The Committee shall report to the Board on how it discharges its responsibilities.

The minutes of the Committee meetings shall be formally recorded and made available to all members of the Committee.

The Corporate Governance Office will submit a report following each Committee meeting, on behalf of the Committee Chair, for presentation at the next Open Trust Board. The report will summarise the decisions made as well as highlighting any items for escalation.

The Committee, led by the Chair, will undertake an annual effectiveness evaluation against their Terms of Reference and Membership. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness of and how embedded risk management is in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows compliance with regulatory requirements
- The robustness of the processes behind the quality accounts.

The annual report will describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The Committee's duties/responsibilities can be categorised as follows:

Integrated Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated 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.

In particular the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

- The policies and procedures for all work related to fraud and corruption as required by NHS Counter Fraud Authority.

In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (Quality Governance Committee, Performance and Finance Committee and Transformation and People Committee) so that it understands processes and linkages.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate assurance to the Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the internal audit service and the costs involved
- Review and approval of the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Consideration of the major findings of internal audit work (and managements response) and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal annual and carrying out an annual review.

External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Ensure that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by the Department of Health's arms-length bodies or regulators / inspectors (for example, the Care Quality Commission, NHS Improvement etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies etc.).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. In particular this will include the Quality Assurance Committee and Finance and Efficiency Committee in terms of risk management.

Relationship with other Committees:

As a Committee of the Trust Board, it is important that the Committee minimises areas of overlap. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:

- Issues around clinical risk management including receiving assurance from the clinical audit function will be considered at the Quality Governance Committee
- The effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensuring that any such concerns are investigated proportionately and independently, will be considered at the Transformation and People Committee.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS requirements of the Government Functional Standard 013 Counter Fraud and shall review the outcomes of work in these areas.

The Committee will refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority.

Management

The Committee shall request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letters of representation.
- Qualitative aspects of financial reporting.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
29 TH April 2022	12.45 pm – 3.00 pm	Via MS Teams	22 nd April 2022
17 th June 2022	10.15 am – 12.00 pm	Via MS Teams	10 th June 2022
28 th July 2022	12.45 pm – 3.00 pm	Via MS Teams	21 st July 2022
4 th November 2022	12.45 pm – 3.00 pm	Via MS Teams	28 th October 2022
2 nd February 2023	12.45 pm – 3.00 pm	Via MS Teams	26 th January 2023

C. Annual Business Cycle

Title of Paper	Apr	Jun	Jul	Oct	Jan
	29	17	28	04-Nov	02-Feb
Private Internal and External Audit Discussions					
Board Assurance Framework	Q4		Q1	Q2	Q3
Annual Governance Statement					
Annual Report					
Committee Effectiveness					
Internal Audit Recommendation Tracker					
Quality Account					
Review of the Risk Management System					
Issues for Escalation from PAF, TAP, QGC					
Analytical Review and Draft Accounts					
Losses and Special Payments and Stock Write Offs					
Going Concern					
Audited Accounts and Financial Statements					
Single Tender Waiver / SFI					
Annual Accounts Timetable					
Assurance from Third Party Providers					
Internal Audit Progress Reports					
Internal Audit Annual Report and Opinion					
Approval of Internal Audit Plan					
Effectiveness of Internal Audit					
External Audit Plan					
External Audit Progress Report					
Audit Findings Report and Letter of Representation					
Auditor's Annual Report					
Quality Account External Audit Report					
Effectiveness of External Audit					
Informing the Audit Risk Assessment					
Counter Fraud Annual Plan					
Trust's Assessment against the NHS CFA GFS					
Counter Fraud Annual Report					
Counter Fraud Progress Report					
Effectiveness of LCFS					
Annual Clinical Audit Plan					

Nominations and Remuneration Committee

Committee Governance Pack

April 2022

A. Terms of Reference

Constitution and Authority

The Trust Board hereby resolves to establish a Committee of the Board to be known as the Nominations and Remuneration Committee (the Committee). The Committee has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by the Trust Board to take action in respect of any activities within its Terms of Reference. The Committee is authorised by the Trust Board to obtain, at the Trust's expense, outside legal or other professional advice on any matters within its terms of reference.

Membership

The Committee shall comprise at least three members, all of whom shall be Non-Executive Directors. The Chair of the Trust Board may also serve on the Committee.

- Mr David Wakefield, Chairman (Chair)
- Mr Peter Akid, Non-Executive Director
- Ms Sonia Belfield, Non-Executive Director
- Professor Gary Crowe, Non-Executive Director
- Professor Andrew Hassell, Non-Executive Director
- Dr Leigh Griffin, Non-Executive Director

Appointments to the Committee are made by the Trust Board and shall be for a period of up to three years, which may be extended for further periods of up to three years. At such time when the Committee is required to consider matters in relation to the Chair i.e. consideration of successor, the Senior Independent Director will be invited to Chair the meeting.

Attendance at Meetings

Only members of the Committee have the right to attend committee meetings. However, other individuals, such as the Chief Executive and other advisers may be invited to attend all or part of any meeting as and when appropriate.

It is expected that the following members of staff will regularly attend Committee meetings in an advisory capacity:

- Chief People Officer. The Chief People Officer will be excluded from meetings when their own remuneration is being considered.
- Associate Director of Corporate Governance. The Associate Director of Corporate Governance will provide administrative support to the Committee and advise on points of governance.

Quorum

The quorum necessary for the transaction of business shall be two members.

Frequency of Meetings

The Committee shall meet at least four times a year, and otherwise as required.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Associate Director of Corporate Governance, whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Maintaining records of members' appointments and renewal dates
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

Remuneration

- To agree the remuneration and terms of service arrangements for Executive Directors (i.e. Board voting and non-voting members), the Chief Executive and posts assigned to the Very Senior Manager framework.
- To oversee the contractual arrangements for Executive Directors and, when required, consider issues relating to remuneration, terms of service and performance issues for Very Senior Managers.
- To review additional non-pay benefits.
- To review severance packages which fall outside the standard provisions of the Contract of Employment*
- As appropriate, the Audit Committee will provide a Value for Money (VfM) view on severance packages as per the agreed thresholds set by NHS Improvement.
- To ensure that the Annual Report includes a report on the remuneration arrangements for Executive Directors and the Chief Executive, including those who have joined or left the Trust during the financial year.
- Receive assurance as to off-payroll and interim Board payments

* Severance Packages approval levels

Severance packages which fall outside the standard provisions of the Contract of Employment must be calculated using standard guidelines. Any proposal to make payments outside of the current guidelines are subject to the approval of HM Treasury, via NHS Improvement (NHSI).

Redundancy Payments

The Committee must consider/approve any redundancy payments which are £10,000 or above. Any payments

below these thresholds can be agreed by the Chief Executive / Chief Finance Officer/ Chief People Officer outside of the meeting with notification being made to the next meeting of the Committee.

Tribunal Settlements

The Committee must consider / approve tribunal settlements which are £10,000 or above. Any payments below this threshold can be agreed by the Chief Executive, Chief People Officer and Chief Finance Officer outside of the meeting with notification being made to the next meeting of the Committee. In circumstances where a decision regarding a settlement of £10,000 or above is urgent, a decision can be made through discussion with the Chairman. Again this would need to be reported to the next meeting of the Committee.

Nominations

- The appointment of the Chief Executive is the responsibility of the Chairman. This process will be supported by NHS Improvement. The Chairman shall assemble an appropriate panel with relevant expertise and experience in respect of the appointments process.
- To regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) required of Non-Executive Directors of the Board, and make recommendations to the Board with regards to any changes.
- To consider and make recommendations to the Trust's Board on any proposals to changes in the structure of the Board and any proposals to increase or decrease the number of voting Executive Directors and/or Non- Executive Directors. The Trust Board should approve such changes.
- When a decision is taken to change the structure of the Board and/or a vacancy arises on the Trust Board, the Committee may seek advice from the Chief People Officer with regard to the recruitment process to be adopted.
- Before an appointment is made by the Board, the Committee will evaluate the balance of skills, knowledge, experience and diversity on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment.
- To give full consideration to succession planning for all Board Members in the course of its work, taking into account the challenges and opportunities facing the organisation, and the skills and expertise needed on the Board in the future.
- To monitor and evaluate the performance of the individual Directors (with the advice of the Chief Executive).
- To develop, monitor and seek feedback on a process for the evaluation of performance and contribution on the part of the Chairman and Non-Executive Directors.
- To consider the person specification when Non-Executive vacancies arise.
- Prior to the appointment of a Non-Executive Director, the proposed appointee should be required to disclose any other interests that may result in a conflict of interest and be required to report any further interests that could result in a conflict of interest.
- To annually review the time required for Non-Executive Directors. Performance evaluation should be used to assess whether the Non-Executive Directors are spending enough time to fulfil their duties.
- To consider the re-appointment of any Non-Executive Directors at the conclusion of their specified term of office having given due regard to their performance and ability to continue to contribute to the Board in the light of the knowledge, skills and experience required
- To keep up to date and fully informed about strategic issues and commercial changes affecting the Trust and the environment in which it operates.
- To review the results of the Board performance evaluation process that relate to the composition of the Board.
- Receive the annual declaration of the Chair in respect of the Board Members complying with the Fit and Proper Persons regulation and receive evidence based assurance that all newly appointed executive directors including the Chief Executive are deemed Fit and Proper.
- Approve any remedial action plan to address non-compliance with the Fit and Proper Persons regulation.
- Approval of membership of Board Committees as appropriate, in consultation with the chairpersons of those Committees

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
11 TH May 2022	1.30 pm – 3.00 pm	MS Teams	4 th May 2022
13 th July 2022	1.30 pm – 3.00 pm	MS Teams	6 th July 2022
14 th September 2022	1.30 pm – 3.00 pm	MS Teams	7 TH September 2022
11 th January 2023	1.30 pm – 3.00 pm	MS Teams	4 th January 2023
15 th March 2023	1.30 pm – 3.00 pm	MS Teams	8 th March 2023

C. Annual Business Cycle

Title of Paper	May	Jul	Sep	Jan	Mar
	11	13	14	11	15
Redundancy Payments £10,000 and above					
Remuneration and terms of service for Executive Directors and Chief Executive					
Remuneration Section of Annual Report					
Off-payroll and interim Board payments					
Pension Restructuring Payment Scheme Review					
Changes to the Composition of the Trust Board					
Non-Executive Director Performance Reviews					
Non-Executive Director Succession Planning					
Review of Time Required for Non-Executive Directors					
Executive / Non-Executive Appointments					
Succession Planning					
Executive Director Performance Reviews					
Fit and Proper Persons Declarations					
Committee Effectiveness					

Quality Governance Committee

Committee Governance Pack

April 2022

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Quality Governance Committee (the Committee). The Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee has no executive powers, other than those specified in these Terms of Reference or otherwise by the Trust Board in its Scheme of Delegation. The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

Membership

- Non-Executive Directors x3
- Medical Director
- Chief Nurse
- Chief Operating Officer
- Chief People Officer
- Head of Quality Safety & Compliance
- Associate Director of Corporate Governance

Attendance at Meetings

Other Directors may be asked to attend by the Committee Chair.

Other individuals such as, but not restricted to, representatives of clinical governance, audit and risk, internal and external audit may be invited to attend all or part of any meeting as and when appropriate and necessary.

Members are required to attend at least 10 out of 12 meetings per year.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and one Executive Director of the Board.

Frequency of Meetings

The Committee shall meet on a monthly basis, in addition an extraordinary meeting will be held each quarter to solely consider items regarding maternity safety.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The purpose of the Committee is to assure the Trust Board of the organisation's performance against quality and research objectives. This assurance is secured through the Assurance Framework, the Corporate Risk Register and the audit plans, which focus on the quality and research objectives of the Trust.

The primary duties of the Committee are as follows:

- To provide assurance to the Trust Board, of the level, adequacy and maintenance of integrated governance, risk management and internal control across quality and research governance activities.
- In respect of this committee, quality is defined as made up of three elements patient safety, clinical best practice and patient experience.

Responsibility for Risk Management

The Committee shall consider the Trust's strategic risks of a clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:

- Current and target risk scores
- Impact that the risk has on strategic objectives
- Potential consequences of the risk
- Impact that the risk has on achieving Care Quality Commission standards
- Impact of operational risks on the risk
- Potential or actual origins that have led to the risk
- How the risk is controlled and reported
- The assurance mechanisms for the risk
- Gaps in controls or negative assurances for the risk
- The actions and timescales for mitigating the risk

The relevant Executive Director responsible for managing each respective strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.

Safe

- Using the assurance framework, the Committee will review the risk and adequacy of assurance of patient safety (the avoidance, prevention and improvement of adverse outcomes). Ensuring that internal

and external assurances of patient safety are regularly reviewed and the strength of assurances evaluated.

- Receive assurance that external reports on patient safety that have an impact on acute care have been reviewed, considered and any learning adopted. This will include national inquiries; quality reports; safety alerts; Department of Health and Social Care reviews; NHS Improvement; and professional bodies with the responsibility for the performance of staff, (Royal Colleges, accreditation bodies etc)
- Review the risks and adequacy of assurance that statutory and mandatory training requirements are being met.

Effective (Patient Outcomes)

- Review the risks and adequacy of assurance of compliance with the CQC relevant Outcomes
- Review the assurance that the clinical audit programme is aligned with the key strategic and operational risks.
- Review the risks and adequacy of assurance of staff engagement in annual objectives improving patient safety, clinical best practice and patient experience.

Caring

- Review risks and the adequacy of assurance of patient experience, via review of the action plans to address the outcomes of patient surveys; patient experience tracker results; complaints and comments; patient stories; external reports such as CQC; Healthwatch; Overview and Scrutiny Committees etc.

Research Governance

- Review the risks and adequacy of assurance that research activity across the Trust is delivered within the national regulatory requirements and that research and innovation activity is driving improvement.

Other Assurance Functions

- Review the risks and assurances to compliance with the CQC registration requirements.
- Review the process and methodology for production of the quality account ensuring that it meets the Trust legal obligations and duties.
- Review any investigations of activities which are within its terms of reference.
- Review the findings of other significant governance and risk reports, both internal and external to the organisation, and shall consider any implications for the governance of the Trust.
- Monitor operational management and implementation of policies to ensure internal control and assurance of quality and research governance.
- Review details of the number and concerns raised on a quarterly basis
- To maintain oversight of the potential impact on quality arising from financial pressures, the Committee will review quarterly QIA reports

Management

- The Committee shall request and review reports and positive assurances from directors and managers on the overall accuracy of information in respect of governance, risk management and internal control.
- The Committee may also request specific reports from individual functions within the Trust as they may be appropriate to the overall arrangements set out above.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
28 th April 2022	09:00 am – 11:30 am	MS Teams	21 st April 2022
25 th May 2022*	02.00 pm – 4.30 pm	MS Teams	18 th May 2022
1 st June 2022	09:00 am – 11:30 am	MS Teams	25 th May 2022
30 th June 2022	09:00 am – 11:30 am	MS Teams	23 rd June 2022
28 th July 2022	09:00 am – 11:30 am	MS Teams	21 st July 2022
24 th August 2022 *	10.30 am – 12.30 pm	MS Teams	17 th August 2022
1 st September 2022	09:00 am – 11:30 am	MS Teams	25 th August 2022
29 th September 2022	09:00 am – 11:30 am	MS Teams	22 nd September 2022
3 rd November 2022	09:00 am – 11:30 am	MS Teams	27 th October 2022
23 rd November 2022*	1.00 pm – 3.00 pm	MS Teams	16 th November 2022
1 st December 2022	09:00 am – 11:30 am	MS Teams	24 th November 2022
22 nd December 2022	09:00 am – 11:30 am	MS Teams	15 th December 2022
2 nd February 2023	09:00 am – 11:30 am	MS Teams	26 th January 2023
22 nd February 2023*	10.30 am – 12.30 pm	MS Teams	15 th February 2023
2 nd March 2023	09:00 am – 11:30 am	MS Teams	23 rd February 2023
30 th March 2023	09:00 am – 11:30 am	MS Teams	23 rd March 2023

* Extraordinary meetings to consider maternity related items only

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	28	01-Jun	30	28	01-Sep	29	03-Nov	01-Dec	22	02-Feb	02-Mar	30
Quality Strategy												
Quality & Safety Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Nursing and Midwifery Staffing and Quality Report / Staffing Assurance Framework												
Serious / Adverse Incident Report		Q4			Q1			Q2			Q3	
Infection Prevention Report	Q4			Q1			Q2			Q3		
Infection Prevention, Vaccination & Sepsis Team Annual Report												
Mortality Report												
Health and Safety Annual Report												
HSE Gap Analysis												
Sharps Regulatory Compliance												
Medical Examiner Update												
Readmissions Update												
Resuscitation Annual Report												
Fire Annual Report												
Annual Security Report												
Antenatal & Newborn Screening Programmes Annual Report 2019/20												
Quarterly Maternity Dashboard		Q4			Q1			Q2			Q3	
Maternity Serious Incident Report					Q1							
Maternity Family Experience Report												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	28	01-Jun	30	28	01-Sep	29	03-Nov	01-Dec	22	02-Feb	02-Mar	30
Ockenden Report Update												
Saving Babies Lives Care Bundle												
Perinatal Mortality Report		Q4			Q1			Q2			Q3	
NHS Resolution Maternity Incentive Scheme												
Midwifery Workforce Paper												
Maternity Services Self-assessment Board Assurance Framework												
Midwifery Continuity of Care Update and Action Plan												
Compliance and Effectiveness Report		Q4			Q1			Q2			Q3	
Care Quality Commission Inspection Update												
Research and Innovation Update												
Get It Right First Time Update												
Annual Clinical Audit Plan												
Medicines Optimisation												
Organ Donation and Transplantation												
PLACE Inspection Findings and Action Plan												
7 Day Services Board Assurance Report												
End of Life Annual Report												
Patient Experience Report												
Mental Health and Learning Disability Annual Report												
Safeguarding Children Annual Report												
Safeguarding Adults Annual Report												
CQC Insight Report												
Litigation Report												
Quality Account												
Board Assurance Framework	Q4			Q1			Q2			Q3		
Infection Prevention Board Assurance Framework	Q4			Q1			Q2			Q3		
Assurance Report from Quality and Safety Oversight Group												
Assurance Report from Clinical Effectiveness Group												
Committee Effectiveness												
Executive Groups Effectiveness Reviews / Terms of Reference												
Quality Impact Assessment Report												



Performance & Finance Committee

Committee Governance Pack

April 2022

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Performance and Finance Committee (the Committee). The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference or otherwise by the Board in its Scheme of Delegation.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or without the Trust as it considers necessary.

Membership

- Non-Executive Directors x3
- Chief Executive
- Chief Finance Officer
- Chief Operating Officer
- Director of Strategy and Transformation
- Operational and Strategic Directors of Finance
- Associate Director of Corporate Governance

Attendance at Meetings

Other Directors may be asked to attend by the Committee Chair. Other individuals may be invited to attend all or part of any meeting as and when appropriate and necessary.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and two Executive Directors of the Board.

Frequency of Meetings

The Committee shall meet on a monthly basis.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust Board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

On behalf of Trust Board, the prime purpose of the Committee is to oversee progress in the delivery of financial and operational performance, receiving assurance from Executive Directors.

The Committee will also:

- Consider financial and operational strategies, prior to submission to Trust Board for approval
- Approve business cases in accordance with delegated authority from Trust Board, in accordance with the Scheme of Delegation
- Review progress against the delivery of business plans
- Oversee financial and operational related strategic risks, and their mitigation plans, through the Board Assurance Framework on a quarterly basis
- Escalation of matters to Trust Board as agreed by the Committee.

The duties of the Committee are as follows:

Financial and Operational Performance

- To consider and monitor progress against delivery of the Trust's Financial Plan
- To monitor delivery of the Trust's cost improvement programme
- To oversee and evaluate the development of the Trust's financial and operational performance to deliver the objectives as set out in the Annual Plan and to ensure delivery of the statutory financial and NHS Constitutional targets
- To ensure that the Trust has in place a comprehensive financial and operational performance management control framework
- To review the proposed annual financial plans for revenue and capital, working capital and cash management

Approval of Business Cases and Business Development

- To agree the Trust's Capital Programme for submission to the Trust Board
- To oversee, scrutinise and approve within delegated limits as specified by the Scheme of Delegation the investment appraisal of capital and revenue business cases

Contract and Income Monitoring

- To scrutinise the development of the Trust's contractual regime including contract portfolios and contracting processes
- To identify and scrutinise the systems to provide early warnings of potential risks and opportunities in the implementation of the contractual framework of the Trust

- To identify, monitor, prioritise and mitigate risks to in relation to the implementation of the model contract and the relationship between activity, income and costs
- To ensure the Trust Board is advised of any significant variation in activity and its impact on income and costs
- To review the systems in place to ensure compliance with the contract terms

Treasury Management

- To monitor cash, liquidity and working capital
- To approve relevant benchmarks for monitoring investment performance
- To review and monitor investment performance

Relationship with the Audit Committee

As a Committee of Trust Board, it is important that the Committee minimises areas of overlap with the Audit Committee. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:

- Audit – External and Internal
- Approval of Annual Report and Accounts
- Approval of Standing Financial Instructions and Scheme of Delegation
- Local Counter Fraud Specialist work
- Local Security Management Specialist work

Relationship with the Transformation and People Committee

As a Committee of Trust Board, it is important that the Committee minimises areas of overlap with other Committees. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:

- To oversee and evaluate the development of the Trust's workforce performance to deliver the objectives as set out in the Annual Plan
- To ensure that the Trust has in place a comprehensive workforce performance management control framework
- To ensure that any workforce implications of financial plans are thoroughly considered and taken into account
- To ensure that current and future workforce issues and developments are fully reflected in business and financial plans and forecasts
- To ensure the Trust is continually reviewing current ways of working and developing new ways of working that are designed to encourage staff to maximise their effectiveness in delivering the Annual Plan
- To review the impact of human resources and organisational development strategies and plans on business performance and associated targets

Responsibility for Risk Management

The Committee shall consider the Trust's strategic risks of a non-clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:

- Current and target risk scores
- Impact that the risk has on strategic objectives
- Controls and assurances in place for each risk
- The actions and timescales for closing gaps in controls and assurances and mitigating the risk

The relevant Executive Director responsible for each strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
26 th April 2022	9.00 am – 12.00 pm	MS Teams	19 th April 2022
31 st May 2022	9.00 am – 12.00 pm	MS Teams	24 th May 2022
28 th June 2022	9.00 am – 12.00 pm	MS Teams	21 st June 2022
26 th July 2022	9.00 am – 12.00 pm	MS Teams	19 th July 2022
30 th August 2022	9.00 am – 12.00 pm	MS Teams	23 rd August 2022
27 th September 2022	9.00 am – 12.00 pm	MS Teams	20 th September 2022
1 st November 2022	9.00 am – 12.00 pm	MS Teams	25 th October 2022
29 th November 2022	9.00 am – 12.00 pm	MS Teams	22 nd November 2022
20 th December 2022	9.00 am – 12.00 pm	MS Teams	13 th December 2022
31 st January 2023	9.00 am – 12.00 pm	MS Teams	24 th January 2023
28 th February 2023	9.00 am – 12.00 pm	MS Teams	21 st February 2023
28 th March 2023	9.00 am – 12.00 pm	MS Teams	21 st March 2023

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	26	31	28	26	30	27	1	29	20	31	28	28
Finance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
CIP Report		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Budget Setting Framework 2023/24												
Annual Plan 2022/23												
Capital Programme												
Operational Performance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Winter Plan												
Digital Strategy Progress Report												
Business Cases between £500,001 to £1,000,000												
Authorisation of Contract Awards												
Board Assurance Framework	Q4			Q1			Q2			Q3		
Committee Effectiveness												
Supplies and Procurement Report												
Emergency Preparedness Annual Assurance Statement and Annual Report												
Annual Audit into Overseas Visitors Policy Compliance												
Assurance Report from Executive Infrastructure Group												
Assurance Report from Executive Business												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	26	31	28	26	30	27	1	29	20	31	28	28
Intelligence Group												
Assurance Report from Operational Delivery Group												
Assurance Report from Non-Elective Improvement Group												
Assurance Report from Planned Care Group												
Executive Groups Effectiveness Reviews / Terms of Reference												
Business Case Review Schedule												



Transformation and People Committee

Committee Governance Pack

April 2022

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Transformation and People Committee (the Committee).

The Committee is a non-executive committee of the Trust Board and has powers to ensure that the Board is able to act in accordance with legislation, compliance or direction requirements inclusive of workforce legislation and to be fully appraised of the strategic impact of the Transformation Programmes and People and Organisational Development Strategy on the delivery of the Trust's strategic objectives.

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

Membership

- Non-Executive Directors x 4 (one designated chair and one designated deputy chair)
- Chief People Officer
- Chief Executive
- Chief Operating Officer
- Chief Nurse
- Medical Director
- Director of Strategy
- Associate Director of Corporate Governance

Attendance at Meetings

Other Directors may be asked to attend by the Committee Chair.

Regular Attendees

Other individuals such as, but not restricted to the following may be invited to attend all or part of any meeting as and when appropriate and necessary:

- Chief Finance Officer
- Deputy Director of Human Resources
- Assistant Director of Organisational Development
- Assistant Director of Human Resources Governance
- Assistant Director of Learning and Education
- Associate Director for Medical Education
- Guardian of Safe Working
- Freedom to Speak Up Guardian

Members are required to attend at least 10 out of 12 meetings per year. Regular attenders are expected to maintain a good standard of attendance and should attend meetings at least once per quarter.

If by exception members are unable to attend they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends they must be able to fully participate in the meeting but will have no voting rights).

Attendees who are deputising for members and/or regular attenders must be properly briefed by the person they are deputising for, on the content of the meeting and the item they are presenting.

The Trust's Chairman shall not be a member of the Committee but is authorised to observe any meetings of the Committee.

The Committee may also invite other senior officers of the Trust and other specialist advisors (internal or external) to present papers on an ad-hoc basis. Such attendees will hold no voting rights.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and two Executive Directors of the Board.

Frequency of Meetings

The Committee shall meet on a monthly basis.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team on behalf of the Chair for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The Committee is responsible for ensuring that strategic transformation and people matters are considered and planned into Trust Strategy and service delivery and shall include the following duties:

Workforce and Organisational Development

- To ensure direction and priorities for the development of workforce strategies, including approval of the People and Organisational Development Strategy, Learning and Education Strategy and Workforce plan.
- To monitor the progress and effectiveness of workforce strategies against corporate strategy, organisational values and workforce experience, as measured by key workforce performance indicators.
- To approve new Workforce / OD projects and practices, paying particular attention to the impact on patient experience, quality, efficiency, equality and diversity and workforce.
- To receive assurance that workforce policies are regularly reviewed and updated as required and in line with current legislation.
- To monitor progress associated with Workforce recommendations arising from audits and the Audit Committee.
- To approve the development, implementation and evaluation of Leadership and Management Development, Talent Management & Succession Planning, Wellbeing Plans and Apprenticeship and Widening participation activity.
- To review and analyse the experiences of our staff and how we involve and engage with them to support successful and sustainable organisation and cultural change;
- To take an overview of the equality, diversity and inclusion policy and achievement of goals.
- To receive and consider the Quarterly Guardian of Safe Working Hours report on behalf of the Board.
- To receive and consider the Quarterly Speaking Up Report on behalf of the Board
- To consider clinical workforce transformation issues.
- To review and approve mandated workforce reporting returns including workforce equality, revalidation and Safe Staffing reports.
- To provide assurance to the Board that the Trust is compliant with relevant HR legislation and best practice.
- To ensure that the workforce implications of financial plans are thoroughly considered and taken into account
- To ensure that current and future workforce issues and developments are fully reflected in business and financial plans and forecasts
- To ensure the Trust is continually reviewing current ways of working and developing new ways of working that are designed to encourage staff to maximise their effectiveness in delivering the Annual Plan
- To review the impact of human resources and organisational development strategies and plans on business performance and associated targets

Transformation

- To ensure direction and priorities for internal and external system wide transformation, including partnership working, aligns with both the Trust's overall strategy and future developments and with the developing Integrated Care System Strategy.
- To scrutinise strategic transformation performance indicators on behalf of the Board, reporting to the Board via the integrated performance report to highlight good practice and outline areas for improvement on an exception basis.
- To ensure transformation interdependencies and risks are properly accounted for as part of the Trust's overall transformation programme of work and to remove obstacles to successful delivery.
- To ensure key enablers are properly considered as part of the implementation of transformation programmes (e.g. Information Management & Technology and Organisational Development).
- To monitor progress associated with Transformation recommendations arising from audits and the audit committee.
- To receive assurance delivery reports of transformation schemes (inclusive of progress and delivery).
- To scrutinise, challenge and develop workforce and transformation performance indicators on behalf of the Board, reporting to the Board via the integrated performance report as required.
- Horizon scanning for new developments and benchmarking to ensure practice is always in line with national / regional development
- Ensuring that ensuring new technologies / advances in digitalisation are embraced and considered along with service developments
- Ensuring alignment of research and education to service developments



General Committee Duties

- To prepare an Annual Report for the Board each year to review the Committee’s work in discharging its duties against its Terms of Reference. The report will cover the previous financial reporting period.
- To ensure that the work of the committee liaises and consults with the divisions of the Trust in achieving the objectives of the Annual Work Plan and/or Strategy
- To identify any risks which may prevent the achievement of the Annual Work Plan and ensure that these are assessed and placed on the Trust’s Risk Register/Board Assurance Framework as appropriate.
- To report any exceptions to the Annual Work Plan or Strategy to the Board.
- Review and approve the Annual Report, Annual Work Plan and Terms of Reference of any Groups that have a direct report to the Committee.

Responsibility for Risk Management

The Committee shall consider the Trust’s strategic risks of a non-clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:

- Current and target risk scores
- Impact that the risk has on strategic objectives
- Controls and assurances in place for each risk
- The actions and timescales for closing gaps in controls and assurances and mitigating the risk

The relevant Executive Director responsible for each strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.

Relationship with Other Committees

The Committee will have a key relationship with other Committees of the Board, in particular:

- Quality Governance Committee
- Performance and Finance Committee

Matters for consideration / referral to other Committees of the Board will be done so via the Committee Assurance Reporting mechanism.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
27 th April 2022	09:00 am – 11:30 am	MS Teams	20 th April 2022
31 st May 2022	09:00 am – 11:30 am	MS Teams	24 th May 2022
29 th June 2022	09:00 am – 11:30 am	MS Teams	22 nd June 2022
27 th July 2022	09:00 am – 11:30 am	MS Teams	20 th July 2022
31 st August 2022	09:00 am – 11:30 am	MS Teams	24 th August 2022
28 th September 2022	09:00 am – 11:30 am	MS Teams	21 st September 2022
2 nd November 2022	09:00 am – 11:30 am	MS Teams	26 th October 2022
30 th November 2022	09:00 am – 11:30 am	MS Teams	23 rd November 2022
21 st December 2022	09:00 am – 11:30 am	MS Teams	14 th December 2022
1 st February 2023	09:00 am – 11:30 am	MS Teams	25 th January 2023
1 st March 2023	09:00 am – 11:30 am	MS Teams	22 nd February 2023
29 th March 2023	09:00 am – 11:30 am	MS Teams	22 nd March 2023

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	27	31	29	27	31	28	2 Nov	30	21	01- Feb	01- Mar	29
Workforce Performance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
People Strategy Update												
HR Delivery Plan												
Strategic Workforce Plan												
Organisational Development/Culture Update												
Talent and Succession Planning Update												
Health & Wellbeing Plan Progress Report												
Learning, Education and Widening Participation Progress Report												
Apprenticeship Levy Progress Report												
Workforce Race Equality Standard												
Workforce Disability Equality Standard												
Equality, Diversity & Inclusion Progress Report												
Gender Pay Gap Report												
Staff Survey Report												
Revalidation Report												
Nursing and Midwifery Staffing and Quality Report												
Nursing Establishment Review												
Formal Disciplinary Activity / Imperial Policy Action Plan	Q4			Q1			Q2			Q3		
Speaking Up Report	Q4			Q1			Q2			Q3		
Guardian of Safe Working Report		Q4			Q1			Q2			Q3	
Annual Plan												
National Student Survey & Action Plan												
National Education and Training Survey Results												
Postgraduate Medical and Dental Education Report												
Undergraduate Medical School Report												
Transformation Programme Update												
Improving Together Highlight Report												
Research and Innovation Strategy												
ICS Transformation Update												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	27	31	29	27	31	28	2 Nov	30	21	01-Feb	01-Mar	29
Clinical Strategy 2021-2026												
Board Assurance Framework	Q4			Q1			Q2			Q3		
Committee Effectiveness												
Assurance Report from Executive Research and Innovation Group												
Assurance Report from Workforce Assurance Group												
Assurance Report from Executive Strategy and Transformation Group												
Assurance Report from the Executive Health and Safety Group												
Assurance Report from the Executive Digital and Data Security Group												
Executive Groups Effectiveness Reviews / Terms of Reference												





Executive Summary

Meeting:	Trust Board	Date:	8 th June 2022
Report Title:	Enhancing Board Oversight: A new approach to non-executive champion roles Gap and Assurance Analysis	Agenda Item:	18.
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

Purpose of Report			
Information	Approval	Assurance	Assurance Papers only:
	✓	✓	Is the assurance positive / negative / both?
			Positive ✓ Negative

Alignment with our Strategic Priorities			
High Quality	✓	People	✓
Responsive	✓	Improving & Innovating	✓
		Systems & Partners	✓
		Resources	✓



Risk Register Mapping	
n/a	No risks identified

Executive Summary

Situation
 NHS England and Improvement (NHSEI) have undertaken a review of non-executive director champion roles. The review has concluded that of the 18 roles identified, 5 of these should be retained and the remaining 13 should be discharged through existing Committee arrangements.

A gap and assurance analysis assessment has been undertaken to identify our current position against the recommended guidance and to propose a number of actions which will strengthen our arrangements in line with best practice. This was considered by the Executive Team at their meeting held on 21st December initially.

Background
 The NHSIE review found that the increasing number of NED champion roles has made it difficult for Trusts to discharge them all effectively and that some roles had been in place for a decade without review.

Assessment
 The assessment has found that whilst our existing assurance arrangements are broadly in line with the recommended practice, there are a number of areas where action could be taken. Some actions have already taken place since receipt of this guidance including identification of NED lead for Security, transfer of reporting from Health & Safety into Transformation and People Committee, process for MHPS cases set out, agreement of handover of Maternity Champion NED role and inclusion of resuscitation reporting and violence prevention and reduction reporting added to Committee Business Cycles. Further recommended actions are regarded as being easy to resolve and can be done through the Corporate Governance Office within a reasonably short timeframe.

- ## Key Recommendations
- To consider the assessment and to determine whether this is an accurate reflection of assurance arrangements
 - To approve the actions identified within section 6 of this report.



Enhancing Board Oversight: A new approach to non-executive champion roles

Gap and Assurance Analysis

May 2022

1. Introduction

In December 2021, NHS England and Improvement published guidance on a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some non-executive director (NED) champion roles, through committee structures.

Whilst it is recognised that the guidance is recommended rather than mandatory, a gap and assurance analysis has been undertaken to evaluate the Trust's position and to identify areas where assurance could be strengthened and therefore better aligned to this new guidance.

2. Background

Over a number of years now, there have been a range of issues which at various times have required additional board level focus to respond to and learn from high-profile failings in care or leadership. This has resulted in numerous reviews and reports establishing a requirement for trust boards to designate NED champions for specific issues to deliver change, spanning quality, finance and workforce.

A national review was undertaken which identified that the number of NED champion roles was making it difficult for organisations to discharge them all effectively, particularly with a limited number of NEDs. It also found that a number of these roles had been in place for over a decade without review.

Therefore, the review looked at the reasons for establishing such roles (some are statutory), and taking into account the principle of a unitary trust board, it was concluded that a number of these roles could best deliver progress through existing committee structures as opposed to an individual role.

3. Key Findings of the Review

There were 18 roles which formed part of this review and it was concluded that of these roles:

- 5 should be retained as NED champion roles (of which two are statutory)
- 13 should transition to a new approach in terms of Committee oversight as opposed to individual

The roles which were identified as needing to be retained are as follows:

Roles to be Retained		
Role	Type of Role	Legal Basis
Maternity Board Safety Champion	Assurance	Recommended
Wellbeing Guardian	Assurance	Recommended
Freedom to Speak Up Champion	Functional	Recommended
Doctors Disciplinary Champion / Independent Member	Functional	Statutory
Security Management Champion	Assurance	Statutory

The remaining roles, recommended to transition to the new approach are set out in the diagram below:

Roles to Transition to New Approach				
Hip Fracture, Falls and Dementia	Learning from Deaths	Safety and Risk	Palliative and End of Life Care	Health and Safety
Children and Young People	Resuscitation	Cyber Security	Emergency Preparedness	Safeguarding
	Counter Fraud	Procurement	Security – Violence and Aggression	

4. Recommendations for Implementation and Support

The review recommended a number of steps for organisations to take, to support the effective implementation of this new approach:

- Review of current roles against the revised approach
- Alignment of roles to Committee structures (whilst recognising this may vary dependent upon individual organisational governance structures)
- Outlining reporting structures and inclusion within relevant business cycles
- Updating Terms of Reference (where appropriate)

5. Responding to the Review and Recommendations

In response to the review and its recommendations, a gaps and assurance analysis has been undertaken. The aim of this analysis was to identify the following:

- Current arrangements, including nominated Non-Executive / Executive Leads, responsible committees and assurance arrangements identified within business cycles
- Whether current arrangements are in line with (or exceed) the recommended approach, are partially in line with the recommended approach or are not in place / not in line with the recommended approach
- Any further actions needed to strengthen assurance arrangements or to bring in line with the recommended approach

The full assessment can be found at appendix 1 of this report. The following provides a summary of the assessment:

Roles to be Retained			
Role	NED Lead	Assurance Assessment	Action Proposed
Maternity Board Safety Champion	Sonia Belfield / (Shai Gohir)		n/a
Wellbeing Guardian	Leigh Griffin		n/a
Freedom to Speak Up Champion	Andy Hassell		n/a
Doctors Disciplinary Champion / Independent Member	Various		n/a
Security Management Champion	Gary Crowe		n/a

Roles to be Transition to New Approach			
Role	Exec Lead	Assurance Assessment	Action Proposed
Hip Fractures, Falls and Dementia	Chief Nurse		n/a
			Action 1
Palliative and End of Life Care	Chief Nurse		Action 2
Resuscitation	Medical Director		n/a
Learning from Deaths	Medical Director		n/a
Health & Safety	Chief Executive		n/a
Safeguarding	Chief Nurse		n/a
			n/a
Safety and Risk	Chief Nurse		n/a
Children and Young People	Medical Director		Action 3
Counter Fraud	Chief Finance Officer		n/a
Emergency Preparedness	Chief Operating Officer		n/a
			Action 4
Procurement	Chief Finance Officer		n/a
			n/a
			n/a
Cyber Security	Director of Digital Transformation		n/a
			n/a
Security Management – Violence and Aggression	Director of Estates, Facilities & PFI		n/a
			n/a
			n/a

Key to Assurance Assessment:	Assurance arrangements are not in place / arrangements are not in line with the recommended practice
	Assurance arrangements are in place which partially meet the recommended practice
	Assurance arrangements are in line with or exceed the recommended practice

6. Recommendations

To enhance our existing assurance arrangements and bring in line with recommended practice, a number of actions were identified:

Recommended Actions	Progress
Action 1: Quality Governance Structure to be reviewed to ensure appropriate oversight of Dementia	Business cycle to be considered.
Action 2: Consider NED attendance at the End of Life Steering Group (or alternative, perhaps just once per year).	Requires further consideration.
Action 3: Reporting on Children and Young People's services to be included on appropriate Committee agendas	To be included as and when appropriate.
Action 4: Consideration to be given to the role of Committee Chairs / Audit Committee in ensuring triangulation of EPRR, Security Management and Health and Safety	To be undertaken as part of Chair's reporting into Audit Committee.

Gap and Assurance Analysis

Key to Assurance Assessment:	Assurance arrangements are not in place / arrangements are not in line with the recommended practice
	Assurance arrangements are in place which partially meet the recommended practice
	Assurance arrangements are in line with or exceed the recommended practice

1. Retained NED Champion Roles

Retained NED Role:	Maternity Board Safety Champion (Recommended)
Designated NED Champion:	Sonia Belfield (Chair of Quality Governance Committee) (to be taken over by Shai Gohir)
Assurance Assessment:	Assurance arrangements are in line with or exceed the recommended practice
Assurance Committee:	Quality Governance Committee
Relevant Resources:	<ul style="list-style-type: none"> • Morcambe Bay Investigation (2015) • Safer Care 2016 • Ockenden Review (2020) • NRS Maternity Incentive Scheme Safety Actions
<p>The Champion should act as a conduit between staff, frontline safety champions, service users, local maternity system leads, the regional chief midwife and lead obstetrician and the Trust Board to understand, communicate and champion learning, challenges and successes.</p> <p>The named champion could be the chair of the quality and safety committee and the requirements of the role could be discharged through the appropriate committee, provided Trusts ensure that the clinical director and director of midwifery are integral to these committee meetings. NEDs should use appreciative inquiry approaches and the Maternity Self-Assessment Tool to provide assurance to the Board that the best quality maternity care is being provided by their Trust.</p>	
Current Board Assurance Arrangements	Actions to Strengthen Assurance / Transition to Guidance
<ul style="list-style-type: none"> • Designated NED Champion in place (with handover of role identified) • Quarterly Reporting to Trust Board on maternity related Serious Incidents • Dedicated Maternity Quality & Safety Oversight Group and Quality Governance Committee agreed as part of revised Corporate Governance Structure • Quality Governance Committee Highlight Report to Trust Board • Regular cycle of reporting to the Quality Governance Committee by the Director of Midwifery on a range of maternity related reports including Safer Care Bundle, Ockenden Review, Perinatal Mortality Reviews, Continuity of Carer Standards, Maternity Incentive Scheme Safety Actions, Saving Babies Lives Care Bundle, Maternity Family Experience Report, Maternity Self-Assessment Tool, Maternity Dashboard • Ockenden Review included on Internal Audit Programme and recommendation tracking via Audit Committee • Maternity Assurance Matrix 	<p>No further actions required. Agreement reached for Shai Gohir to take over the role of Maternity Safety Champion.</p>

Retained NED Role:	Wellbeing Guardian (Recommended)
Designated NED Champion:	Leigh Griffin
Assurance Assessment:	Assurance arrangements are in line with or exceed the recommended practice
Assurance Committee:	Transformation and People Committee
Relevant Resources:	<ul style="list-style-type: none"> • NHS Staff and Learners' Mental Wellbeing Commission 2019 • We are the NHS People Plan for 2020-21 – action for us all • Guardian Community website
<p>The NED should challenge their Trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision. The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the Board, the requirement for the wellbeing guardian to fulfill this role is expected to reduce over time.</p>	
Current Board Assurance Arrangements	
<ul style="list-style-type: none"> • Designated NED Champion in place • Staff Health and Wellbeing Progress Report to Transformation and People Committee every 6 months • Transformation and People Committee Highlight Report to Trust Board • Staff Survey Findings Reported to the Trust Board and the Transformation and People Committee • Executive Workforce Assurance Group report to Transformation and People Committee bi-monthly 	Actions to Strengthen Assurance / Transition to Guidance
	No actions required.

Retained NED Role:	Doctors Disciplinary NED Champion / Independent Member (Statutory)
Designated NED Champion:	As nominated by the Chair
Assurance Assessment:	Assurance arrangements are in place which partially meet the recommended practice
Assurance Committee:	Transformation and People Committee
Relevant Resources:	<ul style="list-style-type: none"> • Maintaining High Professional Standards in the modern NHS: A Framework for the initial handling of Concerns about Doctors and Dentists in the NHS • Directions on Disciplinary Procedures 2005
<p>Requirement for chairs to designate a NED member as the 'designated member' to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case.</p>	
Current Assurance Arrangements	
<ul style="list-style-type: none"> • Quarterly Report on Employment Cases to the Transformation and People Committee • Verbal Report on Medical Suspensions to the Closed Trust Board • Designated NED assigned to each case, as determined by the Chair 	Actions to Strengthen Assurance / Transition to Guidance
	No actions required. Paper on MHPS presented to the Board outlining arrangements; this included identification of a Designated NED to each case.

Retained NED Role:	Freedom to Speak Up (FTSU) Champion (Recommended)
Designated NED Champion:	Andrew Hassell
Assurance Assessment:	Assurance arrangements are in line with or exceed the recommended practice
Assurance Committee:	Transformation and People Committee
Relevant Resources:	<ul style="list-style-type: none"> Robert Francis Freedom to Speak Up Report (2015) FTSU supplementary information

All NHS Trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation. The role of the NED champion is separate to that of the guardian. The NED Champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and like them could act as a conduit through which information is shared between staff and the Board. All NEDs should be expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why.

Current Board Assurance Arrangements	Actions to Strengthen Assurance / Transition to Guidance
<ul style="list-style-type: none"> Designated NED Champion in place Regular meetings between the NED Champion and the Freedom to Speak Up Champion Quarterly FTSU Report to the Trust Board Quarterly FTSU Report to the Transformation and People Committee Transformation and People Committee Highlight Reports to the Trust Board 	No actions required.

Retained NED Role:	Security Management NED Champion (Statutory)
Designated NED Champion:	Gary Crowe
Assurance Assessment:	Assurance arrangements are in line with or exceed the recommended practice
Assurance Committee:	Quality Governance Committee (requires further consideration)
Relevant Resources:	<ul style="list-style-type: none"> Directions to NHS Bodies on Security Management Measures 2004

Statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at Board level. Security management covers a wide remit including counter fraud, violence and aggression and security management of assets and estates. Whilst promotion of security management in its broadest sense should be discharged through the designated NED, relevant committees may wish to oversee specific functions related to counter fraud and violence / aggression. Boards should make their own local arrangements for the strategic oversight of security assets and estates.

Current Assurance Arrangements	Actions to Strengthen Assurance / Transition to Guidance
<ul style="list-style-type: none"> NED Lead identified for Counter Fraud – this has been extended to cover the role of Security Management, by the Chair of TP Reports on Counter Fraud presented to the Audit Committee each month Fraud Risk Assessment undertaken by LCMS and signed off by Chair of Audit Committee Security / violence / aggression related incidents reported to Quality Governance Committee Transfer of Health and Safety Executive Group to Transformation and People Committee as part of revised Corporate Governance Structure 	No further actions required – Security Lead and transfer over to Transformation and People Committee completed and nominated lead identified.

2. Issues that can be overseen through Committee structures

Quality Governance Committee				
Assurance Requirements	Executive Lead	Current Assurance Arrangements	Assurance Assessment	Actions to Strengthen Assurance / Transition to Guidance
1. Hip Fractures, Falls and Dementia				
<p>1.1</p> <p>All Trusts and health boards should have a director with responsibility for falls and the 'National Audit of Inpatient Falls Audit (NAIF) Report 2020' recommends a patient safety group which is overseen by a member of the Executive and Non-Executive Team.</p> <p>This could be fulfilled by an executive rather than a NED, provided there is committee and board oversight of safety, prevention and risk management and use of data to gauge the effectiveness of practice.</p>	Chief Nurse	<p>Assurance on Falls and Dementia considered through:</p> <ul style="list-style-type: none"> • Patient Safety Group currently chaired by Deputy Medical Director • Quality & Safety Oversight Group chaired by Chief Nurse • Quality Governance Committee chaired by Non-Executive Director 	<p>Assurance arrangements are in place which are in line with or exceed the recommended practice</p>	<p>No further action.</p>
<p>1.2</p> <p>Hip fractures and other serious harms resulting from inpatient falls can be linked to dementia. The board should consider the benefits of joint oversight and strategic planning across both agendas and implement where appropriate. Sufficient senior level support to enable systemic change is needed, including effecting change in partner external organisations and allocated resources as needed.</p>	Chief Nurse			
<p>1.3</p> <p>The Quality Governance Committee may wish to ensure that the Executive Lead for Dementia attends the Committee and they also attend the Dementia Steering Group, reporting issues into the Quality Committee.</p>	Chief Nurse	<ul style="list-style-type: none"> • Chief Nurse is a member of the Quality Governance Committee • Dementia Steering Group in place (attended by senior representative of Chief Nurse) 	<p>Assurance arrangements are in place which partially meet the recommended practice</p>	<p>Action 1: Quality Governance Structure to be reviewed / refined (to ensure appropriate oversight of Dementia)</p>
2. Palliative and End of Life Care (PEoLC)				
<p>2.1</p> <p>Board level oversight can be well supported through the Quality Governance Committee, with reporting to the Board. The work of the Committee might include:</p>	Chief Nurse	<ul style="list-style-type: none"> • End of Life Steering Group in place • End of Life Care Annual Report presented to Quality 	<p>Assurance arrangements are in place which partially</p>	<p>Action 2: Consider NED attendance at the End of Life Steering Group (or</p>

Quality Governance Committee					
Assurance Requirements	Executive Lead	Current Assurance Arrangements	Assurance Assessment	Actions to Strengthen Assurance / Transition to Guidance	
<ul style="list-style-type: none"> NED attendance from the Quality Committee at the PEOLC Group Ensuring the Board is aware of standards of care in PEOLC Reviewing PEOLC complaints to see where improvements could be made 		Governance Committee <ul style="list-style-type: none"> End of Life complaints are considered as part of Patient Experience Report to Quality Governance Committee (quarterly) 	meet the recommended practice	alternative even if just once a year)	
3. Resuscitation					
3.1	The Quality Committee may wish to discharge the NED designated role rather than an individual NED, and include this on the Committee work plan, ensuring sign off from the Board.	Medical Director	<ul style="list-style-type: none"> Resuscitation Group in place which currently reports to the Patient Safety Group (which reports to the Quality and Safety Oversight Group) Annual reporting on Resuscitation on Quality Governance Committee Business Cycle 	Assurance arrangements are in place which are in line with or exceed the recommended practice	No further action.
4. Learning from Deaths					
4.1	<p>The Quality Committee should understand the Learning from Deaths Review process, champion quality improvement that leads to actions to improve patient safety and assure published in formation on the organisations achievements and challenges.</p> <p>Implementing the Learning from Deaths Framework: Key requirements for Trust Boards includes some useful questions that NEDs may wish to ask in relation to these responsibilities.</p>	Medical Director	<ul style="list-style-type: none"> Mortality Review Group in place Mortality Report to the Quality Governance Committee which includes Learning from Deaths 	Assurance arrangements are in place which are in line with or exceed the recommended practice	No further action
5. Health and Safety					
5.1	Committee members should have a sound understanding of the risks, the systems in place for managing them, an appreciation of the causes of any failures and an understanding of the legal	Chief Executive <i>(via AD Corporate)</i>	<ul style="list-style-type: none"> Executive Health & Safety Group in place Monthly Executive Health & Safety Group Highlight 	Assurance arrangements are in place which are in line	No further action

Quality Governance Committee				
Assurance Requirements	Executive Lead	Current Assurance Arrangements	Assurance Assessment	Actions to Strengthen Assurance / Transition to Guidance
<p>responsibilities of employers and individual directors for ensuring the health and safety of workers and others affected by work activities.</p> <p>They should be familiar with the Trust's Health and Safety Policy, which should be an integral part of the organisations culture, values and standards and assure themselves that this is being followed.</p>	<i>Governance)</i>	<p>Reports to Transformation & People Committee (including risks)</p> <ul style="list-style-type: none"> Annual Work Plan agreed by Executive Group and Committee Bi-annual Health & Safety Report to Committee 	with or exceed the recommended practice	
6. Safeguarding				
<p>6.1</p> <p>This role could be discharged through a Committee but in ensuring appropriate scrutiny of the Trust's safeguarding performance, all Board members should have level 1 core competencies in safeguarding and must know the common presenting features of abuse and neglect and the context in which it presents to healthcare staff.</p>	Chief Nurse	<ul style="list-style-type: none"> All Board members are required to have level 1 training in safeguarding 	Assurance arrangements are in place which are in line with or exceed the recommended practice	No further action.
<p>6.2</p> <p>In addition, board members should understand the statutory role of the board in safeguarding including partnership arrangements, policies, risks and performance indicators; staff roles and responsibilities in safeguarding and the expectations of regulatory bodies in safeguarding.</p> <p>The CQC Well Led Framework does not reference a safeguarding NED, rather it notes that the inspection team should speak to any senior member of the organisation with safeguarding responsibility.</p>	Chief Nurse	<ul style="list-style-type: none"> Quality Governance Committee has oversight of Safeguarding through Annual Safeguarding Children and Adults Annual Reports Positive feedback from the recent CQC Inspection in relation to Safeguarding 	Assurance arrangements are in place which are in line with or exceed the recommended practice	No further action.
7. Safety and Risk				
<p>7.1</p> <p>CQC Well Led framework refers to interviewing a sample of NEDs with the NED for safety and risk being a priority. This refers generally to a NED that would have suitable oversight rather than a specific NED – i.e. Chair of Quality / Audit Committee.</p>	Chief Nurse	<ul style="list-style-type: none"> NED membership on Quality Governance Committee (including 2 x clinicians) / Audit Committee with oversight and scrutiny of 	Arrangements are in place which are in line with or exceed the	No further action.

Quality Governance Committee					
Assurance Requirements		Executive Lead	Current Assurance Arrangements	Assurance Assessment	Actions to Strengthen Assurance / Transition to Guidance
	However, should Trusts wish to do so, allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice.		safety	recommended practice	
8. Lead for Children and Young People					
8.1	<p>Rather than a specific NED, generally a NED should have suitable oversight, such as the Chair of Quality.</p> <p>However, should Trusts wish to do so, allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice.</p>	Medical Director	<ul style="list-style-type: none"> Children's Hospital Strategy in place 	Assurance arrangements are in place which partially meet the recommended practice	Action 3: Ensure that there is reporting on Children and Young people services on the appropriate Committee agenda

Audit Committee				
Assurance Requirements	Executive Lead	Current Assurance Arrangements	Assurance Assessment	Actions to Strengthen Assurance / Transition to Guidance
9. Counter Fraud				
<p>9.1 This could be an executive and is not intended to be a NED role – there is no longer a statutory requirement to designate a NED champion.</p> <p>Audit Committee chair (and members) may wish to review the Local Counter Fraud Specialists (LCFS) final reports and consider any necessary improvements to controls, along with any recommendations obtained within reports following the Counter Fraud Authority’s engagement through its quality assurance programme.</p>	Chief Finance Officer	<ul style="list-style-type: none"> Regular reports from the LCFS are provided to the Audit Committee. 	Arrangements are in place which are in line with or exceed the recommended practice	No action required.
10. Emergency Preparedness				
<p>10.1 The independence that NEDs bring is essential to being able to hold the Accountable Emergency Officer to account, but responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met. EPRR should be included on appropriate Committee plans and EPRR Board reports, including EPRR annual assurance.</p>	Chief Operating Officer	<ul style="list-style-type: none"> Emergency Preparedness Annual Assurance Statement and Annual Report taken to Performance and Finance Committee EPRR part of Executive Infrastructure Group Business Cycle Highlight Reports from Executive Infrastructure Group to Performance and Finance Committee 	Arrangements are in place which are in line with or exceed the recommended practice	No action required.
<p>10.2 Given the synergies between EPRR, security management and health and safety, triangulation between those areas through the Board and Committees will be essential.</p>	Chief Operating Officer, Director of Estates and Facilities, Chief Executive	<ul style="list-style-type: none"> Currently, security management and health and safety report into Executive Health & Safety Group and then through Transformation and People Committee EPRR reports through Executive Infrastructure Group and Performance and Finance Committee 	Assurance arrangements are in place which partially meet the recommended practice	Action 4: Consideration to be given as to the role of Committee Chairs / Audit Committee in ensuring triangulation of these three areas

Performance and Committee					
Assurance Requirements		Executive Lead	Current Assurance Arrangements	Assurance Assessment	Actions to Strengthen Assurance / Transition to Guidance
11. Procurement					
11.1	The Performance and Finance Committee should help raise awareness of commercial matters at Board and director levels and facilitate discussions that identify benefits to procurement activity and strategic development.	Chief Finance Officer	<ul style="list-style-type: none"> Supplies and Procurement Report presented to Finance and Procurement Committee on a quarterly basis 	Arrangements are in place which are in line with or exceed the recommended practice	No further action.
11.2	The committee would need to understand the scope of procurement, the priorities at national and ICS level and the challenges of delivering change.	Chief Finance Officer	<ul style="list-style-type: none"> As above 	Arrangements are in place which are in line with or exceed the recommended practice	No further action.
11.3	The Audit Committee should regularly review procurement.	Chief Finance Officer	<ul style="list-style-type: none"> Regular reporting on Single Tender Waivers / compliance with Standing Financial Instructions to Audit Committee 	Arrangements are in place which are in line with or exceed the recommended practice	No further action.
12. Cyber Security					
12.1	Board leadership is seen as essential to the success of this agenda so Trusts may decide it is more appropriate for this function to be discharged by the Board than a Committee. NEDs should provide check and challenge, ensuring information has been considered in all decisions and that this can be evidenced.	Director of Digital Transformation	<ul style="list-style-type: none"> IM&T Strategy Progress report presented bi-annually to the Performance and Finance Committee and the Board Assurance on Cyber Security (via Data Security and Protection Toolkit) to Audit Committee Executive Digital and Security and Protection Group 	Arrangements are in place which are in line with or exceed the recommended practice	No further action

Performance and Committee					
Assurance Requirements		Executive Lead	Current Assurance Arrangements	Assurance Assessment	Actions to Strengthen Assurance / Transition to Guidance
12.2	Each Trust should have a Senior Information Risk Officer (SIRO), who would usually be an Executive, although Trusts can appoint a NED to this role should they wish to.	Director of Digital Transformation	<ul style="list-style-type: none"> Director of Digital Transformation designated as SIRO 	Arrangements are in place which are in line with or exceed the recommended practice	No further action.
12.3	The SIRO should ensure on behalf of the Board that the 10 minimum Cyber Security Standards are followed through their organisation.	Director of Digital Transformation	<ul style="list-style-type: none"> Done through the Executive Data Security and Protection Group which reports to Performance and Finance Committee Annual Internal Audit report to Audit Committee 	Arrangements are in place which are in line with or exceed the recommended practice	No further action.
12.4	The board / committee should regularly review Cyber Security Risks, ensuring appropriate mitigation, and that regular maintenance of critical systems and equipment takes place, while minimising impact on clinical services during system downtime. This should include: <ul style="list-style-type: none"> Removal of unsupported systems from Trust networks Timely patching of systems and prompt action on high severity alerts when they are issued Ensuring robust and immutable backups are in place 	Director of Digital Transformation	<ul style="list-style-type: none"> IT infrastructure included on Board Assurance Framework which is reported to the Board Quarterly Risk register in place which is reported to the Executive Infrastructure Group and the Performance and Finance Committee 	Arrangements are in place which are in line with or exceed the recommended practice	No further action.
12.5	Boards should undertake annual cyber awareness training, in addition to the mandatory and statutory information governance training that individual Board members are required to complete.	Director of Digital Transformation	<ul style="list-style-type: none"> Forms part of the Board Development Programme 	Arrangements are in place which are in line with or exceed the recommended practice	No further action.

Transformation and People Committee					
Assurance Requirements		Executive Lead	Current Assurance Arrangements	Assurance Assessment	Actions to Strengthen Assurance / Transition to Guidance
13. Security Management – Violence and Aggression					
13.1	Develop a violence prevention and reduction strategy that has been endorsed by the Board , underpinned by relevant legislation, ensuring the strategy is monitored and reviewed regularly to be decided by the Board.	Director of Estates, Facilities & PFI	<ul style="list-style-type: none"> Strategy developed and approved by the Executive Health & Safety Group – agreed for Committee approval 	Assurance arrangements are in place which partially meet the recommended practice	No further action.
13.2	Inequality and disparity in the experience of any staff groups, including those with protected characteristics, has been addressed and clearly referenced in an equality impact assessment which has been made available to all stakeholders .	Director of Human Resources	<ul style="list-style-type: none"> Equality, Diversity and Inclusion report presented quarterly to the Transformation and People Committee Executive Culture Review Group focusing on this as part of Culture Review Data being captured as part of Integrated Performance Report 	Assurance arrangements are in place which partially meet the recommended practice	No further action.
13.3	A senior management review is undertaken twice a year and as required or requested, to evaluate and assess the Violence Prevention and Reduction Programme, the findings of which are shared with the Board . The Workforce / People Committee may wish to align this with wider wellbeing work being undertaken by the Committee , particularly in relation to wellbeing support after violence.	Director of Estates, Facilities & PFI Director of Human Resources	<ul style="list-style-type: none"> Regular reporting to the Executive Health & Safety Group Highlight Report from Executive Health & Safety Group to the Board Wellbeing Plan approved by the Transformation and People Committee Annual Report on Violence Prevention and Reduction to Transformation & People Committee 	Arrangements are in place which are in line with or exceed the recommended practice	No further action.

