University Hospitals of North Midlands NHS Trust

Trust Board (Open)

AGENDA

Meeting held on Wednesday 7th December 2022 at 9.30 am to 12.50 pm
Via MS Teams

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
15 mins	**1.**	Staff Story	Information	Mrs R Vaughan	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 9th November 2022	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
10 mins	**6.**	Chief Executive's Report – November 2022	Information	Mrs T Bullock	Enclosure	
10 mins	**7.**	Accountability and Performance Framework	Approval	Mrs C Cotton	Enclosure	
15 mins	**8.**	Well-Led Self-Assessment	Approval	Mrs C Cotton	Enclosure	
10:25		**HIGH QUALITY**				
10 mins	**9.**	Quality Governance Committee Assurance Report (01-12-22) & Maternity Quality Governance Committee Assurance Report (23-11-22)	Assurance	Prof A Hassell	Enclosure	BAF 1
10 mins	**10.**	Quality Strategy Update	Assurance	Mrs AM Riley	Enclosure	BAF 1
10 mins	**11.**	Q2 Maternity Serious Incident Report	Assurance	Mrs D Brayford	Enclosure	BAF 1
5 mins	**12.**	IPC Board Assurance Framework –November 2022	Assurance	Mrs AM Riley	Enclosure	BAF 1
11:00 – 11:15 COMFORT BREAK						
11:15		**PEOPLE**				
5 mins	**13.**	Transformation and People Committee Assurance Report (30--11-22)	Assurance	Prof G Crowe	Enclosure	BAF 2, 3, 4, 6, 9
10 mins	**14.**	People Strategy	Approval	Mrs R Vaughan	Enclosure	BAF 2, 3
10 mins	**15.**	Workforce Race Equality Standards Report	Approval	Mrs R Vaughan	Enclosure	BAF 2
11:40		**RESOURCES**				
5 mins	**16.**	Performance & Finance Committee Assurance Report (29-11-22)	Assurance	Dr L Griffin	Enclosure	BAF 5, 7, 8
11:45		**RESPONSIVE**				
40 mins	**17.**	Integrated Performance Report – Month 7	Assurance	Mrs AM Riley Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	BAF 1, 2, 3, 5, 8
10 mins	**18.**	UHNM Tier 2 Analysis	Assurance	Mr P Bytheway	Enclosure	BAF 5
12:35	**GOVERNANCE**					
5 mins	**19.**	Board Development Programme Progress Report	Assurance	Mrs C Cotton	Enclosure	
5 mins	**20.**	Calendar of Business 2023/24	Approval	Mrs C Cotton	Enclosure	
12:45	**CLOSING MATTERS**					
5 mins	**21.**	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	22.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 5th December to** Nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:50	**DATE AND TIME OF NEXT MEETING**					
	23.	**Wednesday 4th January 2023, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 9th November 2022 at 9.30 am to 12.45 pm via MS Teams

MINUTES OF MEETING

			Attended	Apologies / Deputy Sent	Apologies

Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
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							Obs.					
Mr P Bytheway	PB	Chief Operating Officer							KT					
Mrs T Bullock	TB	Chief Executive												
Prof G Crowe	GC	Non-Executive Director												
Baroness S Gohir	SG	Non-Executive Director												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Finance Officer												
Dr M Lewis	ML	Medical Director						GH						
Prof K Maddock	KM	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse	SM				SM							
Mrs R Vaughan	RV	Chief People Officer												

Non-Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Ms H Ashley	HA	Director of Strategy												
Prof A Hassell	AH	Associate Non-Executive Director												
Mrs A Freeman	AF	Director of Digital Transformation												
Mrs L Thomson	LT	Director of Communications												
Mrs C Cotton	CC	Associate Director of Corporate Governance					NH							
Professor S Toor	ST	Associate Non-Executive Director												
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI						DR						

In Attendance:		
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mrs S Hill	SH	Patient (item 1)
Ms K Flint	KF	Freedom to Speak Up Guardian (item 13)
Mrs R Pilling	RP	Head of Patient Experience (item 1)

Members of Staff and Public: 3

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Patient Story**	
157/2022	Ms Hill explained that she worked at UHNM before describing her story. She highlighted that a benign lump had been identified in March 2020, however the lump returned and became larger in June 2020 following which she was diagnosed with triple negative breast cancer. She underwent surgery at the Nuffield in July 2020 and commenced chemotherapy in September 2020, whereby she experienced a problem in that the nurse explaining the chemotherapy provided a different explanation to the previous Consultant, therefore she queried this and it was realised that a different patient's profile had been utilised which	

was subsequently rectified. Her chemotherapy finished in January 2021 and a plan for radiotherapy was identified. However, she highlighted that she had received a phone call from the radiotherapy secretary stating the consultant wished to see her; this caused her to become anxious while waiting to be seen as no explanation was provided, although the reason for the request was to suggest having her radiotherapy treatment at Shrewsbury and the Consultant apologised for the anxiousness caused.

Ms Hill highlighted that at the end of her treatment, because this finished at County Hospital she was unable to ring the bell which psychologically had an impact on her, as this is seen as a significant milestone which she was denied. She added that at the end of treatment, she was put onto a self-care pathway which was not explained and other than a 12 month mammogram she found the sudden lack of appointments and interaction difficult, which added to her anxiousness, although she recognised she could contact the breast cancer team at any time using the advice documents provided. A delay in receiving a follow up appointment was highlighted, whereby this was due in September 2021 which she had to chase with the team, and was seen in November 2021. Unfortunately a further lump was identified and following a scan in December 2021 she received a phone call to say that the cancer had returned. She explained that she would have preferred to have received this news face to face. Ms Hill stated that she underwent surgery for a mastectomy in December 2021 and commenced tablet chemotherapy in February 2022 which finished in July 2022. Ms Hill explained some of the difficulties in obtaining her weekly repeat prescription for chemotherapy, as she had to wait for her prescription to be signed off by the oncology pharmacist and she commented that she felt the oncology and breast cancer team worked in silos rather than working together. In addition, following her most recent CT scan, she had to wait three weeks for the results which also added to her anxiousness. Ms Hill concluded that she has since begun working with Macmillan cancer support to improve cancer services for other patients.

Mr Wakefield apologised for the anxiousness caused during Ms Hill's treatment and the delays which occurred. He queried how she was feeling at present and she commented that although she remained anxious and tired she was hoping to return to work shortly and she thanked her manager for the support which had been provided.

Mrs Riley referred to the priority of improving communication with patients going through an oncology pathway and she asked Ms Hill to be involved to which she agreed.

Professor Hassell referred to the separation of the oncology and breast cancer team which required further consideration and he queried how the Trust could improve on the self-care pathway and the sudden stopping of communication at the end of treatment. Ms Hill stated that she felt it would be beneficial to be put in touch with other patients coming to the end of their treatment who could provide each other with support, and perhaps having a professional available to explain some of the things to expect.

Mr Bytheway referred to the wait for the result of CT scan and referred to the monies being invested to appoint additional radiologists with the aim of reducing the wait to one week.

Mr Wakefield thanked Ms Hill for her story and summarised some of the points raised, such as the initial mismatch of her chemotherapy treatment, the phone call asking her to see the Consultant with no explanation of why, the lack of the bell at County Hospital and clarification of the self-care pathway. He suggested that any

	improvements with communication between the oncology and breast cancer team be considered as well as identifying the ways to address the delays with the repeat prescriptions and signposting to areas of support following the end of treatment. It was agreed to provide an update on these areas at a future Quality Governance Committee (QGC) meeting. **The Trust Board noted the patient story.** Ms Hill and Mrs Pilling left the meeting.	**AMR/ML /PB**
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
158/2022	Mr Wakefield welcomed members to the meeting and confirmed that the meeting was quorate.	
3.	**Declarations of Interest**	
159/2022	Mrs Bullock highlighted that she had become a Governor at Newcastle and Stafford Colleges Group.	
4.	**Minutes of the Previous Meeting held 5th October 2022**	
160/2022	The minutes of the meeting held on 5th October were agreed as a true and accurate record. On page 8 it was agreed to include the additional addendum to the minutes: Dr Lewis explained that following the internal review of neonatal mortality consideration had been given to the merits of undertaking an external review. He explained that the report provided to the Board was being reviewed by the Local Maternity and Neonatal Service (LMNS) and the Operational Delivery Network (a regional network providing oversight of the quality standards of delivery). He stated that as part of these reviews, they had been asked to comment on whether the report was appropriate, proportionate and credible and the external scrutiny of the actions being taken would be helpful in identifying any next steps. In addition, the West Midlands NHS Team were completing review of mortality cases in Neonatal Intensive Care Units in the West Midlands, the findings of which should be available at the end of the year. These results would be reviewed via at QGC which would enable comparison between UHNM and other Trust's data, and this data would be considered alongside the outcome of the external evaluations. Dr Lewis explained that these reviews would provide additional assurance and this was felt to be more useful than commissioning a further external review which would take considerable time given the lack of external resource to undertake such reviews, and given the thoroughness of the internal report provided, it was not expected to identify other issues. In addition, given that crude mortality data was only available at present, and given the standardised mortality data would not be available until 2023, an external review was unlikely to add anything to the existing report given there was no access to any additional data. Dr Lewis added that crude mortality for 2022 was in line with other neonatal intensive care units and he stated that the action plan was to be monitored via QGC.	
5.	**Matters Arising from the Post Meeting Action Log**	
161/2022	PTB/550 – it was reiterated that the ICB board papers would be shared with Non-Executive Directors as previously agreed, and the summary of system quarterly performance reviews would continue to be highlighted via the Chief Executives	

	report. PTB/552 – Mr Bytheway stated that updates from the Urgent and Emergency Care Board would be provided via the ICB updates. PTB/567 – Mrs Vaughan highlighted that only anecdotal evidence was available in terms of staff feeling able to progress in their roles and she stated that the main action required managers to feel confident and able to make reasonable adjustments and this remained work in progress.	
6.	**Chief Executive's Report – October 2022**	
162/2022	Mrs Bullock highlighted a number of areas from her report including the work related to standardising clinic letters issued to patients, ongoing challenges with induction of labour, the Care Quality Commission (CQC) unannounced inspection in October, the interviews which were taking place to recruit to the Chief People Officer and the self-certification on elective care, which was to be submitted by 11th November and would be provided to the Trust Board formally in December. She added that in terms of the East Kent report, the Trust was required to consider this in public, and in relation to the four key action areas the response to these would be provided via the usual governance channels. **The Trust Board received and noted the report and approved eREAFs 9886, 9698, 9756 and 9655.**	
HIGH QUALITY		
7.	**Quality Governance Committee Assurance Report (03-11-22)**	
163/2022	Professor Hassell highlighted the following: • The Committee received an annual presentation from legal services which highlighted a concern regarding coroner conclusions, whereby the Trust had received 8 which includes an aspect of neglect in 2022 although there had been a decrease in preventing future deaths conclusions, therefore due to the changes and differences in approach of coroners, the overall number of either conclusion remained comparable • It was noted that the clinical effectiveness group continued to establish its practice and programme of work, which had been delayed and once in place this programme of work had the potential to impact positively on BAF 1 • The provision of divisional reports summarising claims received was welcomed, in order for divisions to learn from these • The Committee were assured of the cardiothoracic surgery review actions • The Committee requested clarification of the definition of definite nosocomial infections given patients were no longer being routinely screened before admission therefore the Trust was unable to definitely confirm whether the patient did not have covid before admission. Mrs Riley confirmed that this had been raised regionally, whereby it was confirmed that no change in definition had been agreed Mr Wakefield queried if the effectiveness of Your Next Patient (YNP) had been considered and Professor Hassell explained that an update had been requested for the next meeting. Mrs Riley added that data was being collated and Mr Bytheway added that meetings were taking place with the Division twice weekly to review Datix incidents as well as triangulating with other information such as complaints.	

	The Trust Board received and noted the assurance report.	
8.	**Winter Plan**	
164/2022	Mr Bytheway highlighted the following: • Considerable improvements had been made when compared to winter 2021, where the Trust was over capacity in critical care and elective operating was not taking place • The assumptions made in the plan in addition to the different way of delivering the bed model due to it being a system wide bed model • The impact of interventions on excess bed demand • The plan aimed to open 76 beds between November and January, 26 more than 2021, although workforce was the main challenge Mr Wakefield thanked Mr Bytheway for the plan and requested assurance of the length of stay reduction, queried what mitigation was in place for strike action and asked whether he was confident in the ability for system partners to take forward their actions. Mr Bytheway referred to the strike action and stated that once notification was received, business continuity plans would be enacted, although high risk areas would be identified where staffing would be maintained. In terms of length of stay reductions he referred to the difficulties with the increase in acuity of patients and stated that the plan was based on average length of stay, guided by medically fit for discharge numbers. In terms of system partners, it was noted that additional capacity had already been brought online, and the situation was more positive in in terms of the ability to escalate, when compared to 2021. Dr Griffin queried the current covid and flu vaccination rates and Mrs Riley stated that covid booster vaccinations stood at 36.5% compared to 34.6% for flu. It was agreed that further assurance was required of the rates for front line staff. Mr Bytheway highlighted that planned updates to the Performance and Finance Committee (PAF) would identify performance against the particular areas in which the Board required sight of, as part of the elective care self-assessment. Mr Wakefield requested that these reports also provide an update on the utilisation of the 130 virtual ward beds. Ms Ashley added that the case for virtual wards was being taken through the governance process. **The Trust Board approved the winter surge and resilience plan.**	
9.	**Care Quality Commission Action Plan & Feedback from Recent Inspection**	
165/2022	Mrs Riley highlighted the following: • Progress had been highlighted against the actions identified following the visit in August 2021 • There had been an increase in problematic actions due to the target dates having slipped and the increased rigour put in place to identify these as amber • A Section 29a notice had been received following the unannounced visit in October 2022, regarding the delay in documentation of mental health interventions • A sense check of all assurance, the frequency of assurance and robustness was being undertaken and this would be reported to QGC in due course. Mr Wakefield queried how some of the actions which had been classed as complete given these were subsequently raised by the CQC as an issue. Mrs	

	Riley stated that actions had been completed but the issue was ensuring these were being consistently applied. Mr Wakefield queried whether this called into question the level of assurance provided to other actions and Mrs Cotton highlighted the work being undertaken to identify additional assurances and assess the adequacy of these. In addition it was noted that an internal audit was planned to be undertaken to review progress against the CQC actions which was due to commence in December and would be reported to the Audit Committee in April 2023. Professor Crowe referred to the assurance which had been relied upon but was not effective and stated that the lessons learnt from this, was that there needed to be an improvement in the control framework which was the work referred to by Mrs Cotton. He reiterated that the external assurance required on the completion of actions would be received via the existing internal audit programme. Mrs Cotton agreed to discuss the assurance map with Professor Crowe in order to highlight the work being undertaken to assess the adequacy of assurance. Mrs Bullock added that the CQC acknowledged the improvements made since the last inspection and noted these were in relation to having the correct policies and assessment documentation in place and were therefore happy that the Trust had taken action in response to the original Section 29a notice, however the ongoing issue with the Section 29a notice was that staff were not completing this on a consistent basis. She stated that the Trust was aware this was an area of risk given the staffing pressures and the inability to staff the wards appropriately and as a consequence, providing clinical care was prioritised over completion of documentation. Professor Hassell stated that it should be recognised that UHNM staff had identified this as a risk to the CQC in that it was not being completed on a regular basis. Mr Wakefield summarised that additional work was to be undertaken to assess the adequacy of assurance provided and the execution of actions going forwards. **The Trust Board received and noted the update.**	**CC**
10.	**IPC Board Assurance Framework –October 2022**	
166/2022	Mrs Riley highlighted that the document had been further updated following receipt of a new national template. Mr Wakefield referred to the reference to including pods within surgery and queried if the space was available for these. Mrs Riley stated that a review was being undertaken to assess what space was available. Ms Bowen referred to the external company used for fit testing of masks and queried whether this was mandated. Mrs Riley stated that this was not mandated but used to provide resilience in the ability to fit test the amount of staff required. **The Trust Board received and noted the document.**	
PEOPLE		
11.	**Transformation and People Committee Assurance Report (02-11-22)**	
167/2022	Professor Crowe highlighted the following:	

	• Good progress had been made on the resolving of less complex cases as well as the strengthening of the freedom to speak up process • An update was provided on the people plan and the Committee noted the slippage on the completion of Personal Development Reviews (PDRs) whereby additional assurance was requested to ensure improvements were being made and sustained • The Committee noted the increased risk in relation to BAF 9 given the challenges within research and innovation and added that the trajectory for improvement seemed vulnerable **The Trust Board received and noted the assurance report.**	
12.	**Equality Diversity and Inclusion (EDI) Strategy**	
168/2022	Mrs Vaughan highlighted the following: • The strategy included seven objectives and had been developed in collaboration with the staff networks and hospital user group • A number of associated actions had been identified, in addition a review of requirements against the RACE code had commenced Mr Wakefield referred to the timing of receiving the different EDI reports and requested that should there be any inconsistencies between the different reports that these should be highlighted given the Committees and the Board were considering these at different times. Dr Griffin queried the work being undertaken with system partners on the EDI agenda and Mrs Vaughan highlighted that as part of work on the RACE code, system partners were involved. **The Trust Board received and approved the strategy.**	
13.	**Q2 Raising Concerns Report**	
169/2022	Mrs Cotton highlighted the following: • A high level summary had been provided for Board consideration and a detailed version had been presented to the Transformation and People Committee (TAP) • An action had been identified for members of the Board to undertake the 'follow up' training available via ESR • A future Board Seminar was being organised to focus on speaking up as well as looking at the associated strategy Ms Bowen referred to the concerns from Imaging and queried what assurance was in place that actions were being taken to address the concerns. Dr Lewis stated that where hotspots had been identified, an Executive Lead had been put forward, in which case he was lead for Imaging. He stated that regular discussions were undertaken with the senior leadership team and an action plan was in place to address the concerns raised. In addition he explained that he was in regular contact with the Freedom to Speak Up Guardian. Professor Maddock commended Mrs Cotton and Ms Flint for the quality of the report and in particular the comprehensiveness of the report provided to TAP. **The Board approved the priorities in the paper and agreed to undertake the required follow up training.**	

RESOURCES		
14.	**Performance & Finance Committee Assurance Report (01-11-22)**	
170/2022	Dr Griffin presented the report and highlighted the following: • The Committee supported and approved a number of investment cases • Concern was raised of the number of retrospective contract awards put forward • Discussion had included a focus on the introduction of YNP **The Trust Board received and noted the assurance report.**	
RESPONSIVE		
15.	**Integrated Performance Report – Month 6**	
171/2022	Mrs Riley highlighted the following in relation to quality and safety: • In terms of the peak in cases of moderate harm and above, this utilised unvalidated data and therefore this may reduce after validation • An improvement had been made in respect of duty of candour • C-difficile cases had increased, and nationally there had been an increase cases. Work with the region was being undertaken to establish what key actions should be focussed on to reduce the number of infections • The definition of nosocomial infections had been checked and the Trust was following the correct procedure and the definition had not changed despite it being recognised that due to patients not being screened for covid on admission, that it was difficult to confirm 'definite' cases Ms Bowen referred to the patient feedback regarding accessing pain relief and queried if this related to particular conditions or more women than men. Mrs Riley stated that no trends had been identified in relation to the conditions, but agreed to confirm whether there was a disproportionate number of women not accessing pain relief. She added this was a priority for improvement given previous patient feedback. Ms Bowen referred to sepsis screening and continued poor compliance and queried the reasons for this. Mrs Riley stated that the main challenges related to emergency portals in particular the Emergency Department (ED) which was due to constant pressures in the Department and pressures on workforce. In addition, challenges had been identified with paediatrics, and members of the team were to be invited to the next QGC meeting to discuss the factors impacting on performance. Mr Bytheway highlighted the following in relation to urgent care: • In terms of taking forward YNP, Executives had continued to be visible by engaging with staff to understand any problems or barriers • During October, 300 hours a week had been saved to ambulance handovers due to the ongoing work being undertaken • ED had been reorganised, including opening of the frailty unit • In terms of the management of risk, huddles were taking place twice a week where risks/incidents were considered, in addition to discussions with the clinical teams so that any required actions could be undertaken in real time. It was noted that no significant incidents had been raised to date in relation to YNP Professor Hassell queried the feedback received from receiving wards in terms of their ability to take patients. Mr Bytheway stated that wards were coping in	

general and the situation was improving, by utilising the additional estate opportunities.

Dr Griffin queried if YNP was the new business as usual or whether it would be utilised to manage periods of stress. Mr Bytheway stated that YNP had enabled an increase in the number of discharges which would drive a new business as usual, although the initiative had initially been utilise to manage and mitigate the level of risk across the system.

Mr Wakefield queried if there were risks to outlying patients and Mr Bytheway stated that the aim was to put patients in appropriate areas i.e. gastroenterology patients on a gastroenterology ward, therefore he expected there to be a limited number of instances where patients were moved into out spaces.

Ms Bowen queried if the patients were aware they were an 'extra' patient and queried feedback to date. Mr Bytheway stated that patients were provided with a letter explaining the position and why we were doing this. Staff also discussed this with them.

Mr Bytheway highlighted the following in relation to cancer performance:

- Since August, there had been a reduction in the backlog and overall the patient tracking list had reduced to 4500
- The backlog was consistently reducing and the Trust was on track with its trajectory
- The main challenge related to the size of the backlog which was 18% compared to 11% to 12% in summer, and this was due to the actions being taken to treat patients more quickly

Mr Wakefield queried if the reasons for the size of the backlog as a percentage, had been highlighted to NHS England, to which Mr Bytheway confirmed.

Mr Bytheway referred to the increase in planned care cancellations on the day and stated that this was due to the covid wave and increase in covid numbers. He added that ultrasound continued to be a challenge for diagnostic performance.

Professor Maddock queried the current position with regard to 104 week waiters and Mr Bytheway stated that this was predicted to have reduced to 5 by the end of November.

Mrs Vaughan highlighted the following in relation to workforce performance:

- Sickness absence remained static overall at 5.19%
- There had been a reduction in covid related absences which was presently at 17%
- Winter wellbeing plan had been identified and promotion of the opportunities for staff to receive support proactively as being undertaken
- PDR performance had been identified as an area of concern and a recovery plan requested; operational pressures in September was sighted as the main challenge
- Some slight improvements had been noted in the turnover and vacancy position and improvements were largely driven by medical staff recruitment
- An updated culture heat map was to be provided to future TAP meeting
- The staff survey was due to close 17th November and the current response rate was just below average
- Staff Awards were to be held on 11th November

Mr Wakefield referred to the internal measures to reduce and monitor agency

	expenditure and queried how this was being managed given the workforce challenges. Mrs Vaughan stated that good progress had made in relation to agency usage despite the ongoing staffing pressures. Mr Oldham highlighted the following in relation to financial performance;: • In month the Trust delivered a £3.3 m surplus against a plan of £3.8 m • Covid costs had reduced in month • The Cost Improvement Programme had been validated at £5.1 m in year and full year impact of £4.4 m against the target of £13.6 m for the year • A forecast had been undertaken which suggested a year end deficit of £9.1 m although mitigations were to be put in place in order to achieve the break even position Mr Wakefield queried the reliability of the mitigations in place for the break even position and Mr Oldham stated that in terms of the break even budget for 2022/23 he was confident of the mitigation to be put in place, however the size of the ask for 2023/24 was expected to be more of a challenge. **The Trust Board received and noted the report.**	
16.	**Emergency Preparedness Annual Assurance Statement and Annual Report**	
172/2022	Mr Bytheway highlighted that the statement had been considered at PAF and a number of areas had been identified as non-compliance due to a change in description, although an associated action plan was in place in order to comply with these in 2023. It was noted that the areas of non-compliance were not expected to be an impact during winter. Dr Griffin added that all Trusts were challenged in meeting all areas of the statement. **The Trust Board noted the statement.**	
GOVERNANCE		
17.	**Audit Committee Assurance Report (04-11-22)**	
173/2022	Professor Crowe highlighted the following: • The latest reports from the Internal Auditors reflected a number with positive assurance • Positive progress had been made on declarations of interests in addition to reducing the number of out of date policies • The External Auditors had been reappointed for a further 3 years • An update had been provided on the national issues which caused a loss of the ledger system and further assurance had been requested that the system is resilient should a further incident occur • A discussion took place on the completion of internal audit actions, and the Committee were assured that processes were in place to ensure these were completed in line with their target date • A number of cases reported by the Local Counter Fraud Specialist were noted, which continued to be managed appropriately • Further action was required on the Board Assurance Framework (BAF) in terms of the impact of identified actions and whether these would be sufficient in reducing the risk score, as well as assessing the achievability of target dates	

	The Trust Board received and noted the assurance report.	
18.	**Q2 Board Assurance Framework**	
174/2022	Mrs Cotton highlighted the following: • The key area of focus for the next quarter, was to establish the trajectory for risk reduction, ensuring a sufficient number of actions were in place to mitigate the risk • Committees had been asked to undertake a deep dive on their BAF risks at a future meeting, so that they can consider the associated trajectory as well as considering the adequacy of the actions identified to meet the trajectory Mr Wakefield welcomed the addition and agreed that additional assurance was required of the appropriateness of the actions identified and assessment of whether these would reduce the risk to the target, within an appropriate and realistic timeframe. Mr Wakefield referred to the financial risk and underlying system deficit and stated that he suspected the risk associated with this should be higher, and asked for this to be considered within the next quarter's report. **The Trust Board approved the Quarter 2 BAF.**	**MO**
CLOSING MATTERS		
19.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
175/2022	Professor Crowe referred to the Freedom to Speak Up Report and the nature of the Executive Summary provided, which was an excellent example of how to write reports and he encouraged this be used as best practice. Mrs Cotton stated that she used this example as a best practice exemplar, when providing her effective report writing training. Professor Crowe referred to workplan and the number of areas where strategies were being brought together separately and he suggested that a further discussion was required in terms of where these strategies could be considered collaboratively. Mr Wakefield agreed and suggested this be considered at a future Board Seminar.	
20.	**Questions from the Public**	
176/2022	Mr Syme referred to the winter plan and queried the need for PwC to be commissioned to undertake system / UHNM capacity analysis. In addition, he referred to the virtual wards initiative and queried how the Trust would report on the efficacy of the initiative especially around quality and safety issues for patients. Mr Bytheway stated that PwC were utilised as this was a system piece of work and due to the lack of capacity in current teams and the need to deliver rapidly. In addition, it helped to get a view of the whole system which could be used in normal operating. Mrs Bullock added that national monies had been provided to ICBs so that additional resource could be put in place to undertake pieces of work where there was not the current capacity to do so and our system had agreed it should be used for this purpose. Mr Bytheway referred to the virtual wards and the national request to create space	

	for step up and step down management of patients. He stated that these were not yet fully recruited to and the Trust was currently considering the quality and safety oversight of these patients. Mr Syme referred to the CQC Section 29a letter and queried what assurance mechanisms were in place to identify such breaches and whether duty of candour had been upheld. Mrs Bullock stated that all of the patients received safe and appropriate care and the delay related to the procedural submission of documentation. Mr Wakefield stated that the Trust Board accepted the seriousness of the situation and confirmed that staffing pressures meant that staff cared for the patients but there had been a delay in completing documentation. He stated that whilst processes were in place, the Trust needed to ensure that staff were able to execute the appropriate documentation in a consistent manner. Mrs Bullock confirmed that no patients were deprived of their liberty and therefore duty of candour did not apply, as the right care was provided to the patients. Mrs Riley added that the CQC stated that staff were working in the best interest of patients and therefore the actions taken were appropriate. She added that no urgent escalations were made on the day of the visit, therefore the treatment and assessment was appropriate for the patients. Mr Syme referred to YNP and queried how the Trust aimed to show the efficacy of the initiative, not only by the 'reduction in Ambulance Handover Delays' but also that YNP as implemented would not cause detriment to inpatients. Mrs Bullock confirmed that every ward had been risk assessed as to whether they could take an additional patient and when introduced, staff were asked to ensure that any incidents as a result of YNP were to be reported via Datix, which was being done and monitored and would be reported to QGC. She stated that there were no incidents reported to date which had led to serious harm, although it was known that there were associated patient experience issues which were being monitored and to date one complaint had been received. She summarised that when considering the risk to patients in hospital, these were far outweighed by the risks to patients in the community having to wait for an ambulance some of whom were coming to significant harm.	
DATE AND TIME OF NEXT MEETING		
21.	**Wednesday 7th December 2022, 9.30 am, via MS Teams**	

Trust Board (Open)

Post meeting action log as at 30 November 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 *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.

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	09/11/2022	09/11/2022	CQC Update included on November's agenda.	B
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	09/11/2022	09/11/2022	CQC Update included on November's agenda.	B
PTB/546	08/06/2022	Integrated Performance Report - Month 1	To take an update to a future QGC meeting regarding measuring the impact on patients who had not received appropriate sepsis screening within the Emergency Department	Ann-Marie Riley	09/11/2022		**Update to be provided**	GB
PTB/548	08/06/2022	Annual Evaluation of Committee Effectiveness & Rules of Procedure	To provide a summary of changes to the Code of Governance at a future Audit Committee	Claire Rylands	02/02/2023		Action not yet due.	GA
PTB/552	06/07/2022	Chief Executives Report - June 2022	To consider how the Board could receive assurance from the system Urgent and Emergency Care Board.	Paul Bytheway	07/09/2022	09/11/2022	Update provided to November's meeting. Mr Bytheway stated that updates from the Urgent and Emergency Care Board would be provided via the ICB updates.	B
PTB/564	05/10/2022	Infection Prevention and Control (IPC) Board Assurance Framework (BAF) – September 2022	To update the next document to include gaps and actions to address the gaps where the risk score had not been achieved. This should include the nosocomial risk and not meeting the cleaning standards	Ann Marie Riley Helen Bucior	09/11/2022	11/11/2022	Complete - provided to November's meeting.	B
PTB/567	05/10/2022	Workforce Disability Equality Standards Report	To seek further information in terms of the reduction in the percentage of staff who believed they were provided with an opportunity for progression / promotion and the reasons behind this.	Ro Vaughan	09/11/2022	09/11/2022	Update provided to November's meeting.	B
PTB/568	09/11/2022	Patient Story	To provide an update on the areas identified as part of the patient story, to a future Quality Governance Committee (QGC) meeting.	Ann Marie Riley Paul Bytheway Matthew Lewis	02/02/2023		Action not yet due	GB
PTB/569	09/11/2022	CQC Action Plan	To discuss the assurance map with Professor Crowe in order to highlight the work being undertaken to assess the adequacy of assurance.	Claire Cotton	31/01/2023		Action not yet due	GB
PTB/570	09/11/2022	Q2 Board Assurance Framework	To consider the risk and impact associated with the underlying system deficit within BAF 8	Mark Oldham Claire Cotton	08/02/2023		Action not yet due	GB

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

November 2022

Part 1: Trust Executive Committee (TEC)

The Trust Executive Committee met virtually on the 23rd November 2022. **Executive Directors** gave the following key updates:

- Work had continued to progress with Community Diagnostic Centres looking at 3 key areas (imaging, endoscopy and physiological measurement) and the progress made in business case developments associated with County Hospital were also highlighted
- Month 6 had delivered a £3.3 m surplus which was less than planned and would provide an underlying issue for 2022/23.
- New protocol had been issued by NHS England with regards to changing financial forecasts whereby if organisations moved from a surplus to a deficit, the Trust entered a 'double lock' process and require sign off through the ICB and if the system moves into a deficit a 'triple lock' would take place, which would require additional sign off of expenditure by regional regulators.
- The autumn statement highlighted that an additional £3.3b would be put into health and the key challenges were expected to relate to inflation and the expectation that growth would be limited.
- Following an unannounced Care Quality Commission inspection the Trust had received a Section 29a for County Hospital regarding consistency of completing mental health assessments and timeliness of documentation. It was noted that a draft report had been received and this was being checked for factual accuracy.
- The Tendable audit process had gone live at County Hospital and training was underway at Royal Stoke before being rolled out. In addition the Care Excellence Framework process was in the process of being refreshed.
- Capital schemes remain an area of focus and the Trust had put forward a bid to support decarbonisation at UHNM although if successful this was to be part funded.
- Capacity for imaging was being expanded and work was being undertaken to ensure the right processes were in place in terms of managing requests
- Standard rates for TIs and locums had been set earlier in the year although it had been noted that some areas had different practices and teams had been reminded that any exceptions required Executive approval
- Angus McGregor had been appointed as Pathology Medical Director for the NMCPS and was due to commence in December
- Deep dive sessions with Epic continued to take place with clinical teams and confirmation had been received from NHSE of the funding to write and develop the associated business case including production of the specification of requirements
- 173 digital advocates had been recruited across the organisation and these were to be reviewed to identify any areas where there were gaps. In addition, the Advocates Network was to launch on 27th March 2023
- Promotion continued in relation to completion of the digital skills assessment, the results of which will inform subsequent training programmes
- Planning continued to take place as a result of planned Industrial action through the RCN. Results of the Unison ballots did not receive the required number for strike action and we await the results from the ballots for the Royal College of Midwives and Chartered Society of Physiotherapists. It was noted that the British Medical Association was due to ballot its members in early January.
- The Trust's Being Kind toolkit had been launched and continued to be promoted which was to be supported by an e-learning package
- The second cohort of delegates had commenced on the High Potential Scheme which included 6 senior leaders from UHNM

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

- Members of staff from each Division had been successful in receiving awards at the Night Full of Stars and new appointments within all Divisions were also highlighted

- Improvements in skin and colorectal two week wait turnaround times were highlighted in addition to theatre utilisation having been benchmarked above the national average
- The level 1 unit on Ward 110 had opened as planned which assisted with vascular cases.
- Challenges with sickness had continued within the majority of Divisions.
- 18 weeks at County Hospital for Trauma and Orthopaedics was due to commence in December which was aimed to improve the position going forwards. In addition, 100% of theatre capacity had returned to Network Services, although the position remained fragile due to the levels of sickness which was impacting on activity.
- Work was being undertaken to step down spinal patients which aimed to be completed by December and Network Services highlighted the ongoing work to increase research activity.
- Children's, Women's and Diagnostics highlighted that 22 midwives had commenced in October which was helping to support the midwifery position.
- Staff engagement activities continued to take place throughout each Division
- The radiology reporting backlog had increased and this risk was to be mitigated in part by the radiology workforce business case. In addition a risk was highlighted in relation to nuclear medicine due to the downtime of a number of reactors, and work was being prioritised accordingly.
- Pressures across the system and the wider area had been identified, particularly in relation to Paediatric Intensive Care activity.
- The successful completion of phase 1 of the Emergency Department reconfiguration was highlighted in addition to improvements within endoscopy and the continued provision of 18 week support
- The first winter ward had been opened and operational pressures and challenges had continued to be experienced.

Part 2: Contract Awards and Approvals

2.1 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 13th October to 12th November, 7 contract awards, which met these criteria, were made, as follows:

- **Provision of Car Park Management at Royal Stoke University Hospital** supplied by APCOA Parking (UK) Ltd, for the period 01.08.2024 – 31.07.2026 with extension options for a further 2 years, at a total cost of £1,729,356.00, approved on 07/10/22
- **Clinical Waste Management Services Contract** supplied by Sharpsmart, for the period 01.10.22 – 30.09.24 at a total cost of £1,707,840.00, providing savings of £8,005.50 negated inflation in year two, approved on 22/09/22
- **Insourcing SHS Theatre Support** supplied by SHS Partners Surgical Ltd, for the period 01.07.22 – 31.03.23, at a total cost of £1,080,000, approved on 22/09/22
- **Histopathology Outsourcing of Laboratory Specimens and Reporting** supplied by Source Bioscience, at a total cost of £1,008,000.00, providing savings of £6,804.00 negated inflation approved on 22/09/22
- **Histopathology Outsourcing** supplied by Histopathology Outsourcing, for the period 01.06.22 – 31.05.23, at a total cost of £827,038.00, providing savings of £11,165.04 negated inflation, approved on 22/09/22
- **Pharmacy Automated Dispensing System Replacement** supplied by Omnicell Ltd, at a total cost of £540,089.00, providing savings of Cost Avoidance £131,448.00 (discount), approved on 20/10/22
- **Provision of External Audit Services** supplied by Grant Thornton UK LLP, at a total cost of £630,000.00, approved on 21/10/22

In addition, the following eREAF was approved at the Performance and Finance Committee on 29th November 2022, and also require Trust Board approval due to the value: Was there just the one, I thought there were 3

Staff Benefits (eREAF 9802)

Contract Value £3,000,000.00 incl. VAT
Duration 01/12/2022 - 30/11/2025
Supplier Vivup

The Trust Board is asked to approve the above eREAF.

2.2 Consultant Appointments – November 2022

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Paediatric Consultant with an interest in Paediatric Emergency Care	Vacancy	Yes	TBC
Consultant Upper GI Surgeon	Vacancy	Yes	01/12/2022
Consultant Thoracic Surgeon	New	Yes	01/12/2022
Consultant Thoracic Surgeon	New	Yes	01/12/2022
Locum Consultant Paediatric Orthopaedic Surgeon	Vacancy	Yes	05/12/2022

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

Post Title	Reason for advertising	Start Date
Consultant Neurosurgeon	Vacancy	01/11/2022
Locum Consultant in Renal Medicine	Maternity	01/11/2022
Locum Consultant Oncologist	Vacancy	01/11/2022
Locum Consultant Orthopaedic Surgeon	Extension	01/11/2022
Consultant Gynae Oncologist	Vacancy	01/11/2022
Locum Consultant Gastroenterologist	Vacancy	07/11/2022
Consultant Histopathologist	Vacancy	07/11/2022
Locum Consultant General Anaesthetist	Retire & Return	08/11/2022
Consultant Histopathologist	Vacancy	07/11/2022
Consultant Microbiologist	Extension	08/11/2022
Consultant Radiologist	Extension	16/11/2022
Locum Consultant in Emergency Medicine	Extension	22/11/2022
Locum Consultant in Emergency Medicine	Extension	22/11/2022

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

Post Title	Closing Date	Note
Locum Plastic Surgeon	New	No Applications
Consultant Microbiologist	Vacancy	No Applicants

2.3 Internal Medical Management Appointments – November 2022

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Joint Local SuppoRTT, LTFT Champion & Doctors Support Lead	New	Yes	01/12/2022
Clinical Lead Oncology	Vacancy	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Clinical Director Trauma	Vacancy	04/11/2022
Lead Medical Examiner	Vacancy	01/11/2022

There were no medical management vacancies that closed without applications / candidates during November 2022:

Part 3: Highlight Report

3.1 Trust Pressures

In the past couple of weeks, the number of patients being treated who have Covid-19 went below 100 for the first time in several months which is positive. Thankfully we have had a mild start to winter, however, we are still experiencing challenges relating to discharging patients and flow through the hospital due to high bed occupancy. We have also seen a 14% increase in ED Attendances than in October, 75% of which have been ambulatory which has inhibited our ability to pull lower acuity majors patients in the area to generate additional ambulance offload capacity. There has also been a 17% increase in ambulances arrivals going straight to a resuscitation cubicle from October to the 27th November demonstrating increased acuity and the necessity for additional patient moves in the Emergency Department in order to decant resuscitation space. We have also seen deterioration in RSUH Medicine of 4 Simple and Timely discharges by 10% and 25% deterioration in complex discharges per day in recent weeks which also impacts on organisational flow. We continue to work with system partners to expedite complex discharges and we are seeing more beds come on line at the Cheadle Hospital, 14 beds initially and phasing up to 40 beds. Work is continuing with the implementation of Your Next Patient which, along with other initiatives such as the opening of the winter ward, were starting to have an impact on flow through the Emergency Departments and hospital although the increase in demand as highlighted above has negated some of this impact. We continue to review internally what we can do differently and to work with our system partners as advised.

Our Medical Director, Dr Matthew Lewis has also led a piece of work to introduce The Standard Process for Referral and Admissions. This is a re-working of the old Internal Professional standards, which had lost impact in recent years. Since the Standard Process was launched in late May, we have seen a change in the discussion between the referring department (ED) and the receiving units (Portals). Going into winter, it is essential that patients are moved swiftly through (or past) ED to be seen by the specialist clinicians in the relevant portals, so we have reinforced the importance of this document. During November, all clinicians will be expected to accept their patients according to the terms agreed in the document, as interpreted by ED; one of the Divisional Medical Directors will be available 24 hours a day to discuss any deviation from this process.

3.2 HSJ Awards

The HSJ Awards continue to be the most esteemed accolade of healthcare service excellence in the UK. I am delighted to be able to report that at the 2022 HSJ Awards our very own Saving Lives with Solar scheme picked up a highly commended in the Towards Net Zero Award for its focus on preventing vulnerable local people from being readmitted to hospital because they are living in cold damp conditions. Well done also to Dr Amit Arora, Consultant Geriatrician who not only leads this scheme with the Estates, Facilities and PFI team but was shortlisted as HSJ Clinical Leader of the Year.

3.3 Visit from Amanda Pritchard, Chief Executive - NHS England

Together with our system partners from the Integrated Care Board, Combined Healthcare, Midlands Partnership Trust and our two Local Authorities we welcomed NHS England Chief Executive Amanda Pritchard to Staffordshire and Stoke-on-Trent on 17th November. It was a great opportunity to discuss our plans and preparations for winter as well as showcase some of the fantastic things we are doing to improve elective recovery and reduce waiting lists.

From what I have been told, Amanda was impressed with our use of robotics for cancer treatment after being given the opportunity to use the Da Vinci robot training simulator as well as observe a tumour removal with our latest Orbeye robot. Both of these have been funded by UHNM Charity. She also visited the site office before stopping in the Emergency Department at Royal Stoke.

3.4 UHNM Awards Celebration 'A Night Full of Stars'

On Friday 11th November we were able to host our annual staff awards A Night Full of Stars. This was the first time since the pandemic we could come together in person to recognise so many of the incredible things our staff do day in and day out for our patients – much of which is above and beyond. We received hundreds of nominations making judging in each category extremely difficult. If you would like to see the winners and nominee films they are on our website.

3.5 UHNM Charity

On Saturday 12th November Wayne and Laura Damant, who run several local businesses, hosted the most spectacular ball for our UHNM Charity. More than 20 local businesses joined hundreds of guests to raise money for the UHNM Charity and I look forward reporting on the total raised in the near future.

3.6 UHNM and PFI Partners Partnership Day 2nd December 2022

We held our first Partnership Day for three years on Friday 2nd December 2022. We pride ourselves at UHNM on the difference we make to our patient and staff experience as a result of the strategic partnerships we enjoy with our PFI private sector partners Sodexo, Siemens, Nasstar and Healthcare Support North Staffs Ltd (Project Co).

We were joined on the day by colleagues from Estates, Facilities and PFI along with representatives from Clinical Divisions and Central Functions. MPFT representatives were also in attendance recognising their PFI at the Haywood Hospital and our joint working in this regard. Board members from each of the partner organisations were in attendance alongside Simon Corben, Director and Head of Profession NHS Estates and Facilities, NHS England and Gareth Jones, Strategic Estates Lead for NHS England and senior representatives from Cabinet Office.

The day, sponsored by our private sector partners, was enjoyable and thought provoking and allowed us to take time out as a team to share knowledge and experience, recognise the enormous contributions of our Estates, Facilities and PFI staff and partners and align our vision and goals for 2023 and beyond.

3.7 Percutaneous Mitral Valve Repair Service

I am pleased to report that NHSE Specialised Commissioners have confirmed that the Trust's bid to provide a Percutaneous Mitral Valve Repair Service (PMVLR) was successful and that UHNM have been commissioned for this service with immediate effect. The addition of PMVRL to our therapeutic armamentarium makes UHNM one of very few UK cardiac centres that are NHSE commissioned to deliver the full range of proven, trans-catheter therapies for adult structural heart disease. This is a great opportunity to offer more patients with life-altering heart disease, a safe and effective treatment option which was previously not available to them, and I thank all colleagues in the Trust who has supported this clinical service development.

Executive Summary

Meeting:	Public Trust Board	**Date:**	7th December 2022
Report Title:	Accountability and Performance Management Framework	**Agenda Item:**	7.
Author:	Claire Cotton, 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**	✓	**Systems & Partners**			
Responsive	✓	**Improving & Innovating**	✓	**Resources**	✓		

Risk Register Mapping

n/a	n/a	n/a

Executive Summary

Situation

The enclosed document is our organisation wide Accountability and Performance Framework. It is structured into 5 core 'parts' covering a broad overview, our corporate governance arrangements, accountabilities, divisional governance arrangements and our performance management framework. It is presented to the Trust Board for approval.

Background

The Well Led Framework sets out clear expectations within its Key Lines of Enquiry (KLOE) around good governance, accountability and performance management. With these expectations in mind, the original version of our Accountability and Performance Framework was developed and approved by the Board in August 2020. Since then, we have continued to evolve and improve, most notably in the continued development of our corporate governance arrangements, our performance management review process (aligned with our Improving Together approach) and our divisional leadership structures. The enclosed, revised version of our Accountability and Performance Framework takes those developments into account.

The Accountability and Performance Framework has been subject to extensive consultation and approval by the Executive Team and has been shared with the Divisions for information ahead of being presented to the Board.

Assessment

As well as some general presentational improvements, there are a number of key changes, as outlined above, which strengthen this revised version, including:

- Our refreshed **Strategic Priorities** (following the work to identify our 'True North' as part of our Improving Together Programme).
- A new section which sets out our accountability for **Equality, Diversion and Inclusion**, our associated governance arrangements and the way in which this forms part of our business. This section has been included following our assessment against the RACE Equality Code.
- The latest version of our **Corporate Governance Structure**, which was reviewed and updated in early 2022 as part of Committee / Executive Group effectiveness reviews. Key changes following this review were around alignment of our operational groups, establishment of a Clinical Effectiveness Group,

strengthened maternity specific governance and a number of changes to our digital governance arrangements.

- Revised **Divisional Accountability** arrangements to reflect the changes made to the divisional leadership structures, setting out 4 tiers of leadership.
- Revised **Divisional Governance Structure** which now also includes a Divisional Workforce / Culture Committee as a minimum expectation and the requirement to have a forum for consideration of Health and Safety matters.
- Complete rewrite of the **Performance Management Framework** to align with the approach now being taken.
- Revised **Divisional Governance Pack** which sets out clearer expectations in particular around annual business cycles. This takes into account findings of relevant Internal Audit Reviews and the Divisional Board Effectiveness Reviews undertaken recently by the Corporate Governance Team.
- Refreshed set of **Key Performance Indicators** which align with those reported within our Integrated Performance Report.

Given the nature of this report, it does not highlight any specific concerns as its purpose is to set out a framework for the organisation. However, the following concern should be noted as it relates to its implementation:

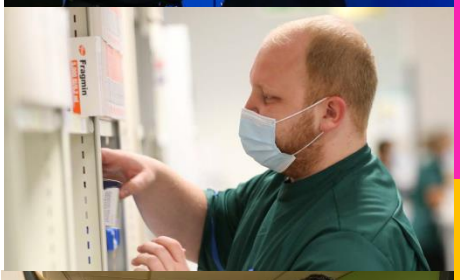
	Areas of Concern / Items for Escalation	Solutions
!	Effectiveness reviews led by the Corporate Governance Team and some key Internal Audit Reviews have identified some gaps within divisions in terms of their adherence / application of the previous Divisional Governance Framework.	The Corporate Governance Team is developing a bespoke package of support for each Division to support the development of their governance arrangements. This will include the application of this framework, which takes into account the findings of effectiveness / Internal Audit Reviews. The Team will work in collaboration with each Division for a period of time; the full scope of this programme is under development and will be agreed with the Executive Team ahead of implementation.

Key Recommendations

The Board is asked to:

- **approve** the revised Accountability and Performance Framework, including the Corporate Governance Structure and
- **note** the programme of corporate support being developed in relation to application of the Divisional Governance Framework

NHS
University Hospitals of North Midlands
NHS Trust



Accountability & Performance Framework

2022 - 2024

Delivering Exceptional Care with Exceptional People

Contents

Part A: Overview

1. Introduction

Good governance is essential to the provision of safe, sustainable and high quality care for patients. Accountability and performance management are core components of our governance framework and enable the Board to fulfil our obligations in the effective management of the organisation.

This Accountability Framework sets out the key enabling structures and processes to support the delivery and achievement of our Vision and strategic objectives, our Annual Plan and our key enabling strategies.

"Accountability typically refers to a relationship involving answerability, an obligation to report, to give an account of actions and 'non-actions'.

This indicates that there is an assumed expectation of the need to report and explain, either in person or in writing."

Kings Fund, 2011

2. Accountability and Responsibility

The main difference between responsibility and accountability is that responsibility can be shared while accountability cannot. Being accountable not only means being responsible for something also ultimately being answerable for your actions.

Individuals are held to account only after a task is done or not done whereas individuals can be responsible before and / or after a task.

- The **accountable person** is the individual who is ultimately answerable for the activity or decision. This includes 'yes' or 'no' authority and 'veto' power. Only one accountable person can be assigned to an action.
- The **responsible person** is the individual/s who actually complete the task. The responsible person is responsible for action / implementation and this responsibility can be shared. The degree of responsibility is determined by the individual with accountability.

3. Well Led Framework

The table below describes how this Accountability Framework will support us to monitor, assure and improve performance against the Well Led Framework:

No.	Well Led Domain	Impact of Accountability Framework
1.	**Is there the leadership capacity and capability to deliver high quality, sustainable care?**	• Accountabilities and responsibilities are clearly defined for individuals and enable effective delegation • Leaders understand the challenges to quality and sustainability • Clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership are understood
2.	**Is there a clear vision and credible strategy to deliver high quality, sustainable care to people and robust plans to deliver?**	• Progress against delivery of the strategy and local plans is monitored and reviewed and there is evidence to show this • The Vision, Values and Strategy has been developed using a structured planning process in collaboration with staff, people who use services and external partners
3.	**Is there a culture of high quality, sustainable care?**	• Action is taken to address behaviour and performance that is inconsistent with the Vision and Values, regardless of seniority • Staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively
4.	**Are there clear responsibilities, roles**	• Effective structures, processes and systems of accountability are in place to

No.	Well Led Domain	Impact of Accountability Framework
	and system of accountability to support good governance and financial management?	support the delivery of the strategy and these are regularly reviewed and improved • Staff at all levels are clear about their roles and they understand what they are accountable for and to whom
5.	**Are there clear and effective processes for managing risks, issues and performance?**	• There are comprehensive assurance systems and performance issues are escalated appropriately through clear structures and processes • There are processes to manage current and future performance. These are reviewed and improved
6.	**Is appropriate and accurate information being effectively processed, challenged and acted upon?**	• There is a holistic understanding of performance, which covers and integrates people's views with information on quality, operations and finances • There are clear and robust service performance measures which are reported and monitored
7.	**Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?**	• There are positive and collaborative relationships with external partners which build a shared understanding of challenges within the system and the needs of the relevant population and to deliver services to meet those needs • There is transparency and openness with all stakeholders about performance
8.	**Are there robust systems and processes for learning, continuous improvement and innovation?**	• Participation in and learning from internal and external reviews – learning is shared effectively and used to make improvements • All staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance – this leads to improvements and innovation

4. Culture of High Performance

As illustrated below, a culture of high performance is defined by continued improvement, leadership development, and empowerment to act, providing clear direction through a credible strategy, objectives / values and ensuring effective systems for appraisal and feedback. There is a strong and established evidence base demonstrating the link between cultures of compassionate and inclusive leadership and stronger organisational performance in terms of patient experience, innovation, finances, staff retention and staff engagement. Our Cultural Improvement Programme focuses on a number of these areas.

Achieving a culture of high performance is dependent upon performance management being an integral part of our organisational environment and is recognised as a positive, not punitive activity. The implementation of this Accountability Framework will support us in delivering our objectives and our strategies and will provide clarity on our expectations.

5. Vision, Values & Strategic Priorities

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 Vision – 'Delivering Exceptional Care with Exceptional People'

Through our organisation wide 'Improving Together' programme, which involves a Trust wide approach to continuous quality improvement, we have reviewed our organisation wide strategic vision and priorities.

Whilst the ambitions outlined within our 2025 Vision remain true, we have simplified our vision statement to provide greater clarity and our refreshed strategic priorities and objectives are aligned to our Improving Together programme.

Our Strategic Priorities and Objectives

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	Working together to improve the health of our population	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.

6. Equality, Diversity and Inclusion

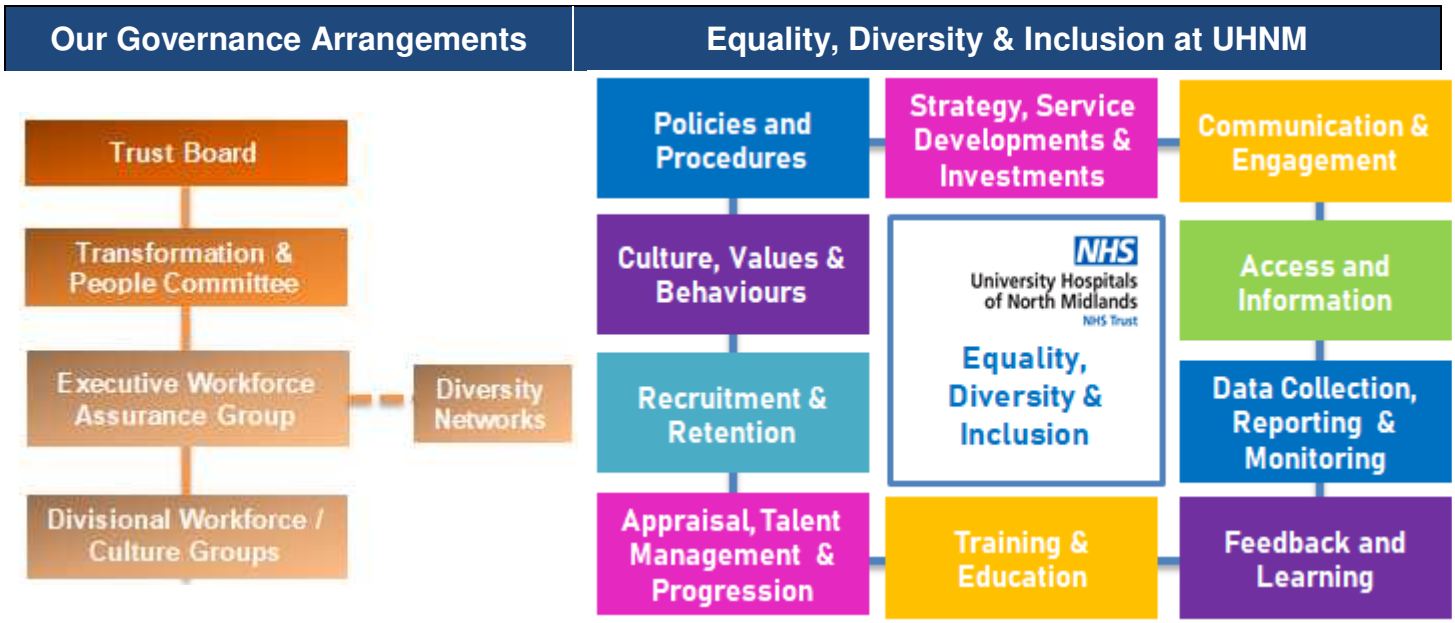
As a major employer and health service provider, we are committed to building an inclusive workforce which is valued and whose diversity reflects the community we serve, enabling us to deliver the best possible health and care services to our patients, carers and communities.

We have a clear policy and a strategy in place which set out our Equality, Diversity and Inclusion expectations for all of our staff, ensuring that equality, diversity and inclusion is integral, not additional, to the way we work.

Equality	Diversity	Inclusion
At its core, equality means fairness or equity. We must ensure that individuals or groups of individuals are not treated less favourably or do not have the same opportunities because of their protected characteristics.	Is recognising, respecting, celebrating and valuing each other's differences. A diverse environment is one with a wide range of backgrounds and mind sets, which allows for an empowered culture of creativity and innovation.	Means creating an environment where everyone feels welcome and valued and confident to be themselves. When all three of these elements are working together, greater impact and change can be achieved.

Accountability for the delivery of our **policy and strategy** rests with the unitary Board. However, our Chief People Officer and our Chief Nurse have specific responsibilities for equality, diversity and inclusion and they are held to account for this. Whilst not mandated, we also have a nominated Non-Executive champion for Equality, Diversity and Inclusion to provide focussed support and challenge. We have also nominated Executive Sponsors for each of our diversity networks, to support them in delivering their objectives.

Whilst we expect that equality, diversity and inclusion features in everything that we do, and we expect oversight, scrutiny and monitoring to take place throughout our governance structure, we do have a defined governance framework for specific elements of this, i.e. scrutiny of our WRES / WDES / RACE Equality Code compliance.



Part B: Corporate Governance

7. Policies and Procedures

There are a number of core governance policies and procedures which have been set by the Board, defining how we operate at an organisational level, in accordance with the regulatory framework. These policies are:

- Standing Orders
- Scheme of Matters Reserved to the Board / Scheme of Delegation
- Standards of Business Conduct
- Standing Financial Instructions
- Risk Management Policy

8. Board Assurance Framework (BAF)

The Board Assurance Framework (BAF) provides a structure and process which enables the Board to focus on the key strategic risks which might compromise the achievement of our Strategic Objectives. We have adopted a '3 lines of defence' approach which highlights the levels of control in place and assurance obtained, both internally and externally, along with clear identification of those accountable for further actions to be taken in order to reduce risk. The Board Assurance Framework is scrutinised by the Board and our Committees on a quarterly basis.

9. Corporate Governance Structure

Our Corporate Governance Structure was refreshed in early 2022 for implementation 2022/23. The structure defines the arrangements through which we monitor and seek assurance, from an operational level through to the Board.

Committees of the Board are chaired by our Non-Executive Directors, who play a key role in holding Executive Directors to account. The chairs of our Committees provide assurance to the Board through a report which identifies:

- Areas of concern / matters to escalate
- Areas of good practice
- Key actions agreed / work underway
- Decisions made

Reporting into our Committees are a series of 'Executive Groups'. These provide the means by which the Executive Team seek action and assurance and report to Committees of the Board in the same way as described above. They have a core set of responsibilities as defined within their Terms of Reference which are focussed around Performance, Risk, Strategy and Governance.

Reporting into our Executive Groups are a series of 'Operational Groups'. These provide operational oversight and ensure delivery against specific priorities and objectives, for example Patient Safety, Data Quality, Learning and Education.

Terms of Reference and Membership are in place for all meetings identified within our structure, which define their objectives and responsibilities. An annual cycle of effectiveness reviews is undertaken to

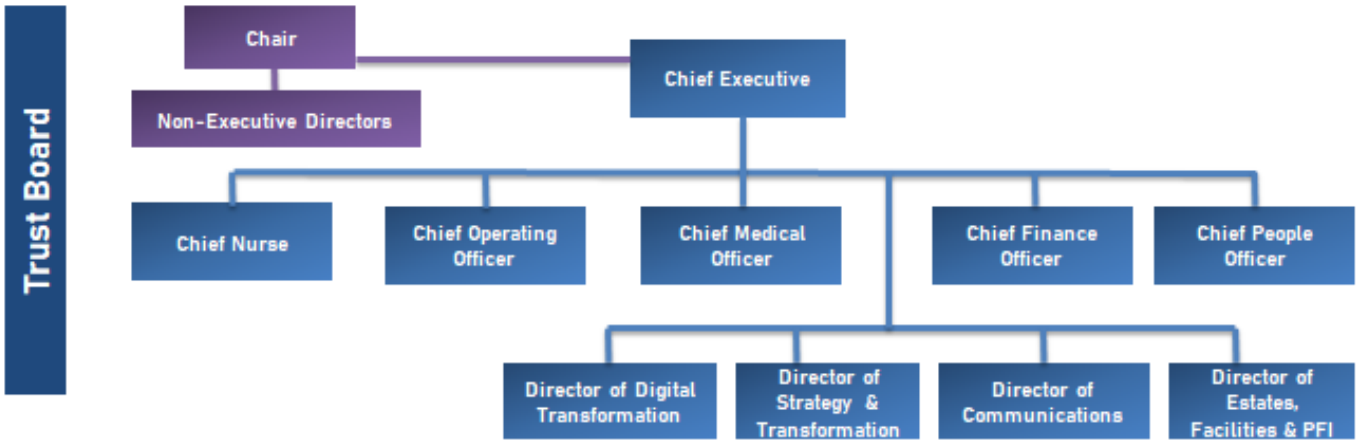
provide opportunity to reflect, learn and continuously improve our governance arrangements and these are also subject to independent scrutiny through our regulators and internal auditors.

The Corporate Governance Structure is illustrated below:

Part C: Accountability

10. Board Accountability

Effective governance requires defined accountabilities, roles and responsibilities and clear ownership. The Board plays a key role in shaping the strategy, vision and purpose of the organisation. They hold the Chief Executive and the Executive Team to account for the delivery of the strategy and ensure value for money. They are also responsible for assuring that risks to the organisation and the public are managed and mitigated effectively. The Board is led by an independent chair and composed of a mixture of both executive and non-executive directors; the Board is a unitary Board who make decisions as a single group, sharing responsibility and liability for all Board decisions, with collective responsibility for the performance of the organisation.



The table below outlines the distinction between Executive and Non-Executive roles of the Board:

	Chair	Chief executive	Non-executive director	Executive director
Formulate Strategy	Ensures board develops vision, strategies and clear objectives to deliver organisational purpose	Leads 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	Holds CE to account for delivery of strategy Ensures board committees that support accountability are properly constituted	Leads the organisation in the delivery of strategy Establishes effective performance management arrangements and controls Acts as Accountable Officer	Holds the executive to account for the delivery of strategy Offers purposeful, constructive scrutiny and challenge Chairs or participates as member of key committees that support accountability	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 board's behaviour and decision making Board culture: Leads and supports a constructive dynamic within the board, enabling contributions from all directors	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	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour Provides a safe point of access to the board for whistle-blowers	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour
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 & clear information to board/ directors (and governors for FTs) are clear to executive	Ensures provision of accurate, timely & clear information to board/ directors (and governors for FTs)	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 key role as an ambassador, and in building strong partnerships with: • Patients and public • Members and governors (FT) • Clinicians and Staff • Key institutional stakeholders • Regulators	Plays key leadership role in effective communication and building strong partnerships with: • Patients and public • Member 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 (FTs)	Leads on engagement with specific internal or external stakeholder groups

9.1 Trust Chair

The Chair is accountable for leading the Board and is responsible for its overall effectiveness in directing the Trust. The Chair is accountable to the Secretary of State, through NHS England, for giving leadership to the Board, ensuring the Trust provides high quality, safe services and value for money within NHS resources. This includes:

- Promoting the highest standards of integrity, probity and corporate governance throughout the organisation and particularly the Board
- Promoting a healthy culture for the organisation so that staff have a safe point of access to the Board for raising concerns
- Demonstrating visible and ethical personal leadership by modelling the highest standards of personal behaviour and ensuring that the Board follows this example
- Leading the Board in establishing effective decision making processes and acting as the guardian of due process
- Making sure the Board understands its own accountability for governing the organisation
- Ensuring the Board Committees that support accountability are properly constituted
- Leading the Board in being accountable

9.2 Non-Executive Directors

Non-Executive Directors have a duty to ensure that the Trust has sufficient control measures in place to be able to effectively manage risk and ensure the governance structure is fit for purpose.

- The Audit Committee, which is a Non-Executive Director Committee, has the delegated responsibility from the Board for ensuring an effective system of integrated governance, risk management and internal control is in place.
- Non-Executive Directors are members of and Chair the Quality Assurance Committee which is a Board sub-committee with overarching responsibility for all aspects of quality governance; the Performance and Finance Committee which is the Board sub-committee with overarching responsibility for financial and operational performance, governance and risk and the Transformation and People Committee which is the Board sub-committee with overarching responsibility for our People and Transformation strategies, performance and risk.

10.3 Chief Executive Officer

The Chief Executive Officer is accountable for:

- Maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding public funds and departmental assets
- Ensuring that the Trust is administered prudently and economically, that resources are applied efficiently and effectively and that there are adequate arrangements in place for the discharge of statutory functions
- Ensuring that there is robust risk management across all organisational, financial and clinical activities

The Chief Executive is accountable to the Board for meeting their objectives and as Accountable Officer, to the Chief Executive of the NHS for the performance of the organisation. The Chief Executive helps create the strategy and vision for the Board and the organisation to modernise and improve services and is responsible for ensuring that the Board's plans and objectives are implemented and that progress towards implementation is regularly reported to the Board using accurate systems of measurement and data management. The Chief Executive also agrees the objectives of the senior executive team and reviews their performance.

10.4 Tier 1 Executive Leadership

Executive Directors are the executive 'arm' of the Board. They meet as a group weekly and have oversight of the efficient and effective management of the Trust by ensuring that there is robust strategic development and operational plans in place to facilitate the achievement of the Trust's objectives and Board decisions. Executive Directors lead the Central Functions / Estates, Facilities & PFI Divisions which comprise a range of centralised services to support the strategic leadership of our clinical divisions.

This includes providing direction and support, monitoring delivery and considering and ensuring action upon risks and mitigations. Specific responsibilities are outlined below:

Executive Director	Responsibility and Accountability
Director of Strategy & Transformation / Deputy CEO	• Leading the development and delivery of the organisation wide strategy, incorporating the Clinical Services Strategy and a coherence annual planning and business development strategy • Co-ordination, production and oversight of the delivery of enabling strategies, business cases and annual plans • Lead executive for system wide working
Chief Nurse	• Quality, including the systems, processes (such as Quality Improvement and Proud to Care Framework) and behaviours by which quality is governed • Contributes to the development and implementation of key objectives to deliver efficient services and effective, high quality patient care and ensure equality, diversity and inclusion • Professional leadership of nurses / midwives and AHPs, provision of professional advice and assurance to the Board, infection prevention and control, public and patient experience, compliance with Care Quality Commission standards • Driving professional accountability in delivering key performance indicators and engendering effective clinical leadership
Chief Finance Officer	• Financial strategy and ensuring effective financial management and control • Providing financial leadership by setting, evaluating and developing organisation wide service and financial frameworks within which operational services can be delivered • Effective operation of the Financial performance, performance reporting and accountability framework
Chief Operating Officer	• Development and implementation of key objectives to deliver services that provide optimum patient care, efficient use of resources and promotion of a culture that is progressive, inclusive and values driven • Providing operational leadership through setting, evaluating and developing effective systems and processes which ensure the smooth running of the organisation and achievement of NHS constitutional targets • Accountability for the management and performance of clinical divisions
Chief Medical Officer	• Quality, including the systems, processes and behaviours by which quality is governed • Contributes to the development and implementation of key objectives to deliver efficient services and effective, high quality patient care and ensure equality, diversity and inclusion • Professional leadership of the medical workforce and for medicines optimisation, including accountability for the Clinical Director of Pharmacy • Driving professional accountability in delivering key performance indicators and engendering effective medical leadership
Chief People Officer	• Leading the development and delivery of strategies relating to all aspects of employment, workforce and organisational development, ensuring these link into other strategies and are aimed at enhancing clinical care and outcomes and ensure equality, diversity and inclusion • Provide workforce advice to the Board, ensuring compliance with all legal and social obligations to employees • Shape and implement the strategic direction of the Trust through the introduction, development and maintenance of human resource practices
Director of Estates, Facilities & PFI	• Leading strategic and operational estate management including development of the estate strategy, management of property, land, building maintenance, space management, energy, utility management, facilities management and the PFI • Leading the PFI, ensuring services are delivered consistent with the contract and collaborative working with PFI partners to optimise value for money • Providing professional advice to the Board on estates, facilities and PFI issues, ensuring compliance with all statutory responsibilities associated with the estate and the PFI
Director of IM&T	• Leading the development of the Digital Transformation strategy and service, providing innovative solutions to improving the efficiency and effectiveness of the Trust's operation • Developing the infrastructure to support the delivery of ICT systems across the Trust • Influence and support the delivery of ICT systems across the Staffordshire STP / ICP • Senior Information Responsible Officer (SIRO) with responsibility for the provision of information
Director of Communications & Charity	• Development and implementation of strategic communications and engagement with all internal and external stakeholders • Development and delivery of a strategy to increase charitable income, aligned to the Clinical Services Strategy, ensuring optimum benefit to patients and staff

11. Divisional Accountability

10.1 Tier 2 Divisional Leadership (Triumvirate):
Divisional Medical Director, Divisional Operations Director and Divisional Nurse Director

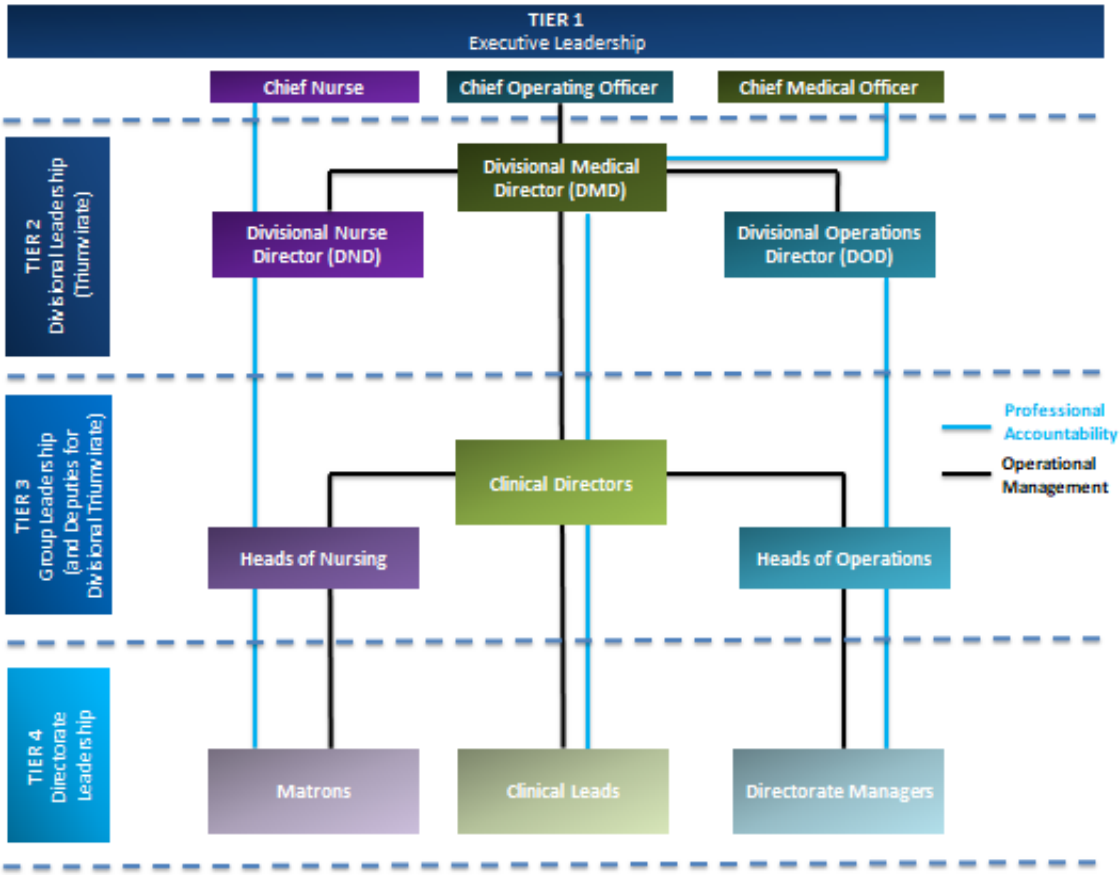
Our Clinical Divisions are managed by clinically led triumvirates comprised of a Divisional Medical Director, Divisional Operations Director and Divisional Nurse Director. These individuals have responsibility and accountability for specific aspects of the Divisional portfolio. The triumvirates are directly accountable to the Chief Operating Officer (through the Divisional Medical Director) although have professional lines of accountability as follows:

- The Divisional Medical Directors are professionally accountable to the Chief Medical Officer
- The Divisional Nurse Directors are professionally accountable to the Chief Nurse

Divisions are held accountable through Performance Management Review Meetings, which are led by the Executive Team. The triumvirate have responsibility for ensuring delivery of agreed organisational policies, objectives and key performance metrics and the governance, oversight and co-ordination of performance within and across all Groups / Directorates. In addition, they are responsible for the development and implementation of robust remedial plans for areas of underperformance and escalating to the Executive Team key areas of risk that may affect delivery of organisational objectives and strategy.

The Divisional Management Team comprises a wider team who are accountable to the Divisional Triumvirate, however, there are individual members of the team who also have professional / managerial accountability to the relevant members of the Executive team as follows:

- Divisional Business Advisor: professionally accountable to the Chief Finance Officer
- People Business Partner: professionally and managerially accountable to the Chief People Officer
- Divisional Informatics Advisor: professionally and managerially accountable to the Chief Finance Officer



[NB: this structure is a broad illustration of accountabilities although there are some differences between each of the Divisions which are set out in their individual structures]

10.2 Tier 3 Group Leadership:

Clinical Directors, Heads of Nursing / Deputy Nurse Directors and Heads of Operations / Deputy Directors of Operations

Supporting our Divisional Triumvirate and overseeing our Directorate Teams is our Group Leadership comprising Clinical Directors, Heads of Nursing and Heads of Operations. These individuals have responsibility and accountability for specific aspects / services within the Divisional portfolio (as well as deputising for Tier 2). They are directly accountable to the Divisional Triumvirate.

- Clinical Directors are operationally and professionally accountable to the Divisional Medical Director
- Heads of Nursing are operationally and professionally accountable to the Divisional Nurse Directors
- Heads of Operations are accountable to the Divisional Operations Director

10.3 Tier 4 Directorate Leadership:

Clinical Leads, Matrons and Directorate Managers

Each of our Directorates is led by a Clinical Lead, Matron and Directorate Manager. They have responsibility for ensuring delivery of agreed organisational policies, objectives and key performance metrics and the governance, oversight and co-ordination of performance within and across their Directorate. In addition, they are responsible for the development and implementation of robust remedial plans for areas of underperformance and escalating to the Divisional Leadership Team key areas of risk that may affect delivery of organisational objectives and strategy.

Clinical Leads and Matrons have designated leadership roles in relation to health and care professionals at a speciality level. They have key responsibilities and accountability for ensuring effective clinical and quality governance and that the values and professional standards are instilled within their workforce. They ensure that their teams are aware of and contribute to the organisation wide ambitions and promote essential standards to be delivered.

Directorates are held accountable through Directorate Performance Management Review Meetings, which are led by the Divisional Triumvirate. The Directorate Leadership Team is accountable for supporting managers / leaders within individual wards and departments, who manage and lead our frontline staff on a day to day basis.

10.4 All Staff

All staff have a responsibility for performance management and improvement, relevant to their role and are supported to identify improvement opportunities and to take action required. Specific and generic roles and responsibilities are outlined within all job descriptions.

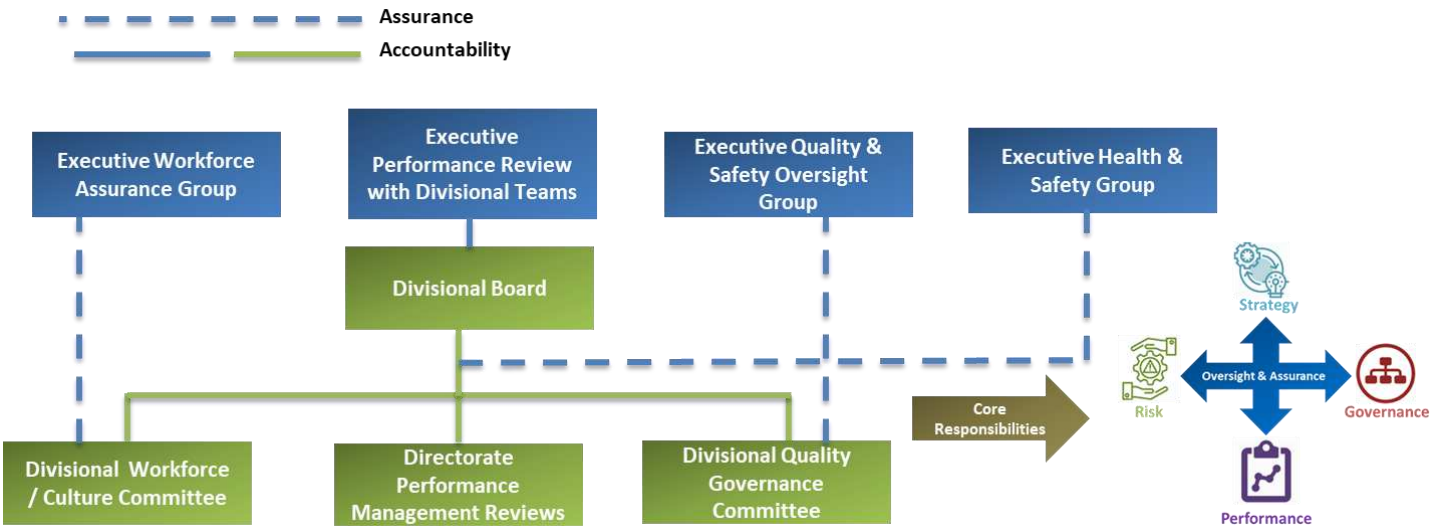
Part D: Divisional Governance

12. Divisional Governance Structure

Divisions are expected to have a clear and cohesive structure in place which sets out the framework within which the performance of the division is governed. Whilst it is recognised that divisional structures need to be tailored to meet the governance needs of each division, as a minimum they must have:

- A clear line of accountability into the Corporate Governance Structure through the Divisional Performance Management Reviews and Executive Groups as appropriate
- A fully constituted Divisional Board comprising the Divisional Management Team, with documented and approved Terms of Reference and Membership, with meetings being held on a monthly basis covering all aspects of divisional strategy, performance, risk and governance, aligned with our Strategic Priorities (a template can be found at appendix 1)
- A Divisional Quality Governance Committee, with documented and agreed Terms of Reference and Membership, directly accountable to the Divisional Board and providing assurance through the Executive Quality and Safety Oversight Group
- A Divisional Workforce / Culture Committee, with documented and agreed Terms of Reference and Membership, directly accountable to the Divisional Board and providing assurance through the Executive Workforce Assurance Group
- A forum within which Health & Safety matters are considered, with assurance being provided through to the Executive Health & Safety Group
- A documented and approved process for the management, escalation and oversight of risk, in accordance with the Risk Management Policy
- Directorate Performance Management Reviews, which align with the Performance Management Framework set out within this document
- Arrangements to ensure consideration of Highlight Reports from relevant Executive Groups to ensure effective flows of information

The minimum structure required is illustrated below:



13. Divisional Board – Core Responsibilities

To ensure consistency across the organisation, each Divisional Board should have a core set of responsibilities which enable the effective oversight and scrutiny of their Division. These are outlined below and are covered within the template Terms of Reference at appendix 1.

Strategy

- Oversee development and implementation of strategy and operational plans at a Divisional level and associated Key Performance Indicators (KPIs), ensuring the adoption of best practice where available
- Develop and oversee implementation of an Annual Plan, aligned with priorities agreed through our Improving Together Programme
- Consult upon and agree any relevant policies, procedures, guidelines, standard operating procedures and protocols and monitor their implementation, where relevant, at a Divisional level

Performance

- Receive assurance on the delivery of strategy and relevant key performance metrics (i.e. driver / watch), ensuring the appropriate allocation of resource
- Monitor the operational systems and processes which ensure competent management within the Division
- Identify, delegate and review relevant actions to improve performance
- Report any exceptions to the Annual Plan, delivery of strategy or areas of underperformance to the Executive Team via the Performance Management Review process

Risk Management

- Where relevant, monitor Root Cause Analysis / trends relating to adverse incidents, ensuring that appropriate action is taken and lessons are learned (this may be delegated to the Divisional Governance Group although the Divisional Board will retain responsibility for oversight)
- Ensure that any risks are managed and reviewed via the Risk Register and in accordance with the Risk Management Policy

Governance

- To review national legislation, guidance and best practice and address local implications of such guidance as appropriate
- Oversee / monitor implementation of actions plans arising from internal / external review, audit, assessment or accreditation
- Undertake an annual self-assessment of effectiveness in order to inform any changes to Terms of Reference and Membership

Part E: Performance Management Framework

14. Performance Management

Performance management is a process of setting goals, monitoring of progress towards delivery and ensuring goals are consistently met in an efficient and effective manner. The goal of performance management is to ensure that all parts of the organisation are optimally working together and taking action in response to actual performance to improve the outcomes for our patients and users.

Performance management requires both good management systems and processes, and an organisational culture that supports and integrates them into the daily work of frontline staff and managers to promote the continuous improvement of services.

14.1 Key Performance Indicators

Performance management is integral to our Corporate Governance Structure. We have agreed a broad range of Key Performance Indicators (KPI's) which form the basis of our performance management framework. These KPI's are aligned to our Strategic Priorities and take into account all NHS constitutional patient access targets and statutory obligations, along with targets we have agreed locally to support the delivery of our overarching 2025 Vision, enabling strategies and to address key areas of risk.

14.2 Statistical Process Control (SPC)

Statistical Process Control (SPC) is an analytical technique that plots data over time, helping us to understand variation in performance, in order to inform decision making and appropriate action planning. We use SPC in our performance reporting to:

- Alert us to a situation that may be deteriorating
- Show if a situation is improving
- Demonstrate how capable a system is of delivering a standard or target
- Show if a process that we depend upon is reliable and in control

We have adopted a model of SPC reporting within our Integrated Performance Report which enables us to draw two main observations of our performance data:

- **Variation:** Are we seeing significant improvement, 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 our 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

14.3 Board / Committee / Executive Oversight, Scrutiny and Accountability

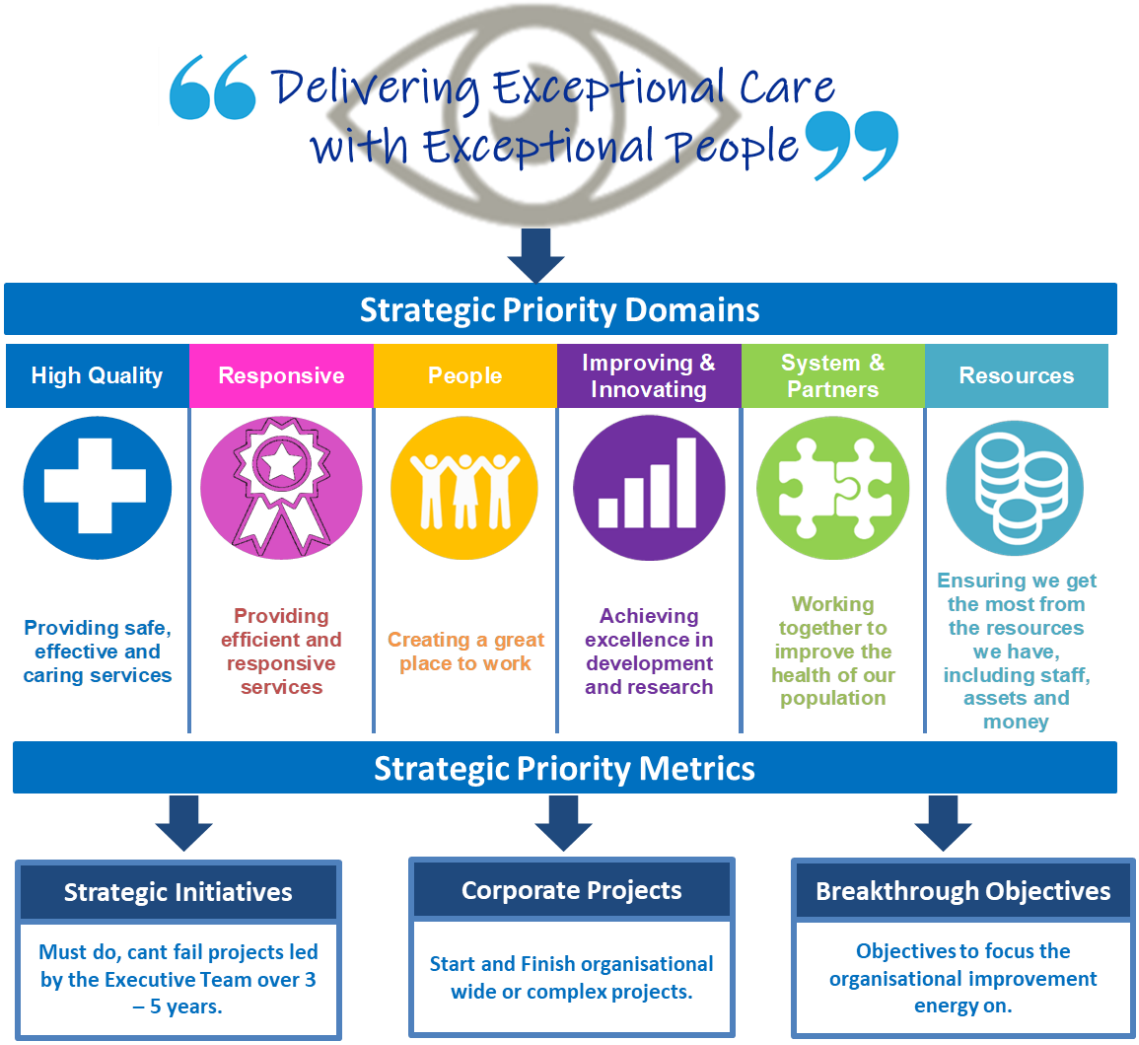
As the **Board** has ultimate responsibility for performance of the organisation, our 'core set' of KPI's are scrutinised and monitored by the Board through the Integrated Performance Report. The Integrated Performance Report is owned by the Executive Directors and is presented to the Board each month. This, along with a selection of other assurance reports agreed by the Board as part of their annual Business Cycle, form the basis upon which Executive Directors are held to account. **The full selection of KPI's included within our Integrated Performance Report to the Board can be found at appendix 2.**

For **Committees** reporting to the Board, we have determined a more granular detail of KPI's which are specific to each element of our strategy (i.e. High Quality, People, Resources, Responsiveness). These are monitored by each of our core Committees and are owned by the lead Executive Director/s and again presented each month for oversight and scrutiny, along with a selection of additional 'assurance reports' which have been agreed by the Board as part of the annual Business Cycle. These reports are scrutinised in the first instance through our **Executive Groups**, according to their Terms of Reference.

14.4 Strategy Deployment Framework

Our Strategy Deployment Framework is the means by which the Board identifies and communicates a focussed set of priorities to ensure that all staff can align with our organisation wide strategy and can understand their contribution to achieving the strategy. The Strategy Deployment Framework focuses on improvement activity and key priorities, identified from data on Trust performance and we have reset our Strategic Priorities and our Objectives as part of this programme.

Aligned to achieving our Vision and Strategic Priorities, a series of Strategic Priority Metrics are identified, performance against which is monitored and delivered through targeted Strategic Initiatives, Breakthrough Objectives and a series of Corporate Projects; this is illustrated below and is set out within our Annual Plan:



14.5 Performance Management Reviews – Divisions / Directorates

Performance Management Reviews between the Divisional Management Team and the Executive Directors are the formal checkpoint at which Divisions are held to account for delivery of the annual plan. The reviews seek to ensure that each Division is balancing patient safety and staff wellbeing with the pressure of financial and operational delivery and the overall sustained health of the Division.

An annual 'focus negotiation' is held between Executive Directors and Divisional Management Team. The purpose of the focus negotiation is to agree 'Driver' and 'Watch' metrics (defined below), which will form the basis of Divisional Performance Management Reviews / Divisional Performance Management Reports, along with a summary of risks being managed by the Division.

Driver Metrics	Areas of performance to be actively worked on to improve, achieve and sustain an identified target.
Watch Metrics	Areas of performance which still require monitoring and reporting and will continue to be addressed through 'Business as Usual (BAU)' but not actively 'problem solved' as a team unless the business rules dictate a change.

The principle of having focus on specific metrics is in recognition of limits to our resource and therefore this ensures that by identifying a smaller number of priorities we can ensure sufficient focus on addressing root causes and implementation of sustainable solutions.

The Divisional Performance Management Reports are a compilation of A3's or 'Countermeasure Summaries' (see section 9.8), aligned to the agreed Driver Metrics. We have agreed 'Business Rules' which are used during the Performance Management Reviews and these determine our expectations in terms of performance management. Using these business rules, a 'mini focus negotiation' takes place to determine whether any Driver Metrics can become Watch Metrics or vice versa.

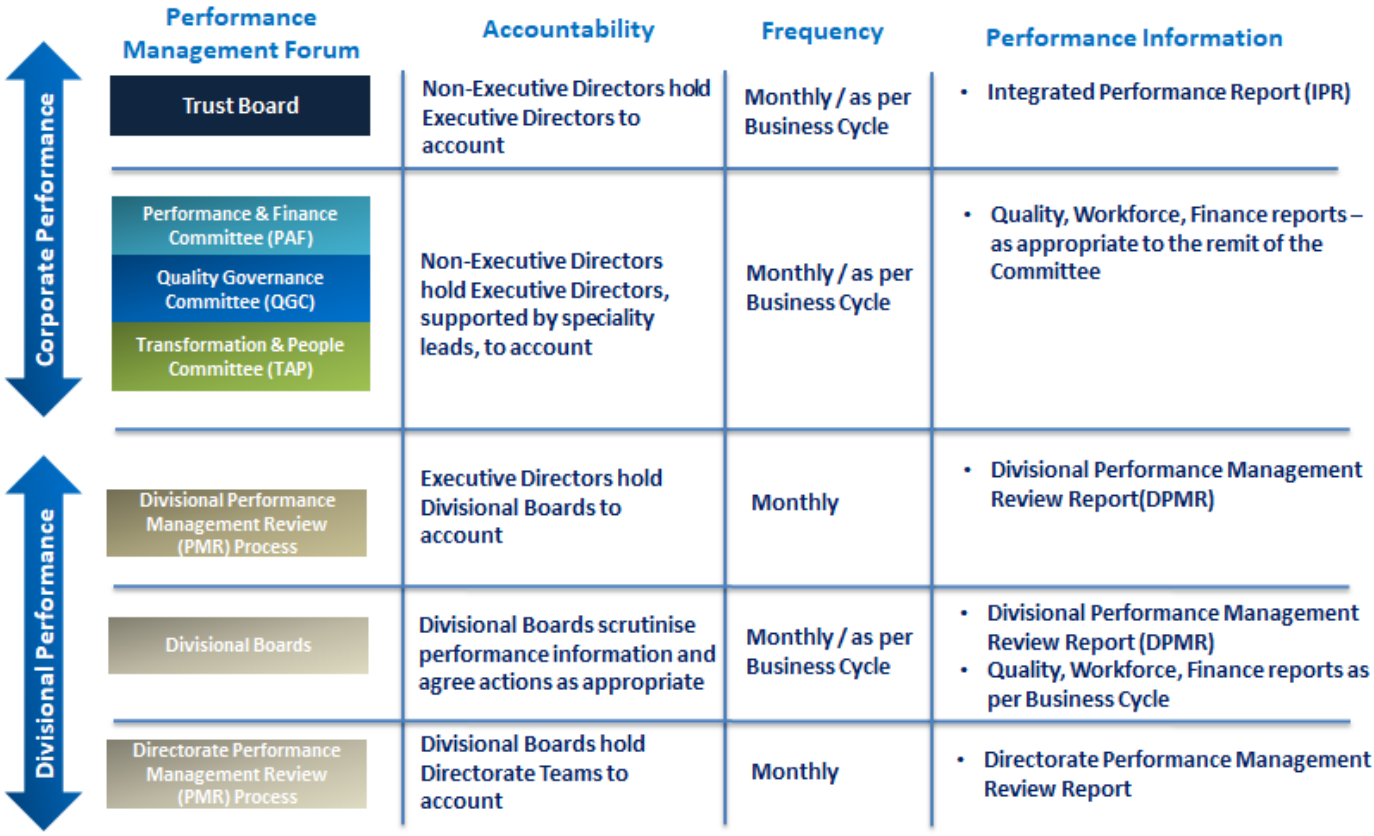
These business rules are described below:

	Rule	Business Rule	In meeting divisional expectation	Rationale	SPC alignment
Driver	Driver is **green** for one reporting period	D1	Celebrate success and move on	Starting to achieve our stretch target (not yet sustained).	Not applicable. Red/ Green classification based on Targets agreed in Focus Negotiation locally for each division. This is because the statistical model will not factor constraints in performance that apply to the situation and so might give "unattainable" targets.
	Driver is **green** for six reporting periods	D6	Standard verbal update and discussion: •Present Countermeasure and lessons learned / insights to share with relevant Divisions •Switch Driver to Watch or keep as Driver with increase target	Achieving our stretch target. Sustained improvement, not a result of natural variation	
	Driver is **red** for 1 reporting periods	D1	Standard verbal update and share top contributing reason, and the amount this contributor impacts the metric	Red means we are not achieving our stretch target. It is therefore the alert which is expected on the Driver metric. We are working to actively improve it in line with our strategic focus	
	Driver is **red** for 2 reporting periods	D2	Produce Countermeasure summary performance report		
	6 drivers are red	D6	Discuss with Exec which countermeasure summary should be prioritised		
Watch	Watch is **green** for reporting period	W1	No action required	Performance is within expected variation or threshold.	SPC chart shows a grey or blue dot
	Watch is **out of control limit** for 1 month	W1	Standard Verbal structure and share top contributing reason and move on (eg. special / significant event)	Red means special cause variation causing adverse performance. Understanding required as to whether adverse performance will be due to a consistent issue or a one off event	SPC chart shows an orange dot Where an SPC chart does not exist red would be where the threshold set is breached for the reporting period
	Watch is **red** for 4 months	W4	Standard verbal update and discussion: 1.Switch to driver metric (replace driver metric into watch) 2.Review thresholds	Four reds mean special cause variation causing adverse performance.	

This arrangement is repeated at a Directorate level, with Divisional Boards holding their Directorates to account for the performance of their Directorate.

The arrangements outlined above are illustrated below.

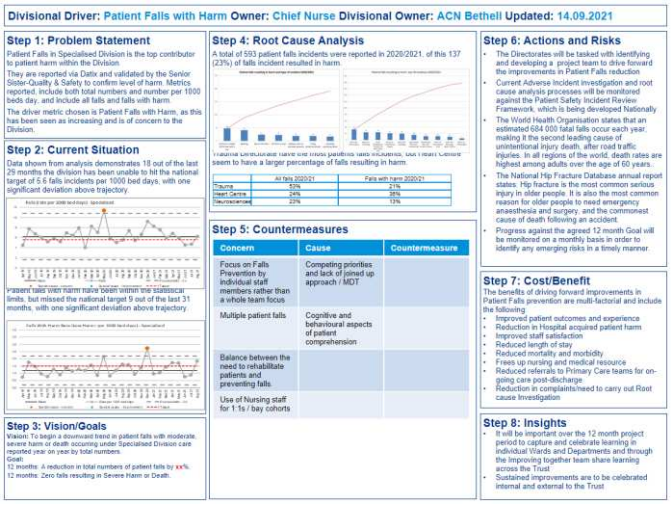
14.6 Overview of Performance Management Framework



14.7 Performance Management from Board to Ward

We use the same tools through from Board to Ward that we have introduced through our Improving Together Programme:

A3
A structured problem solving tool

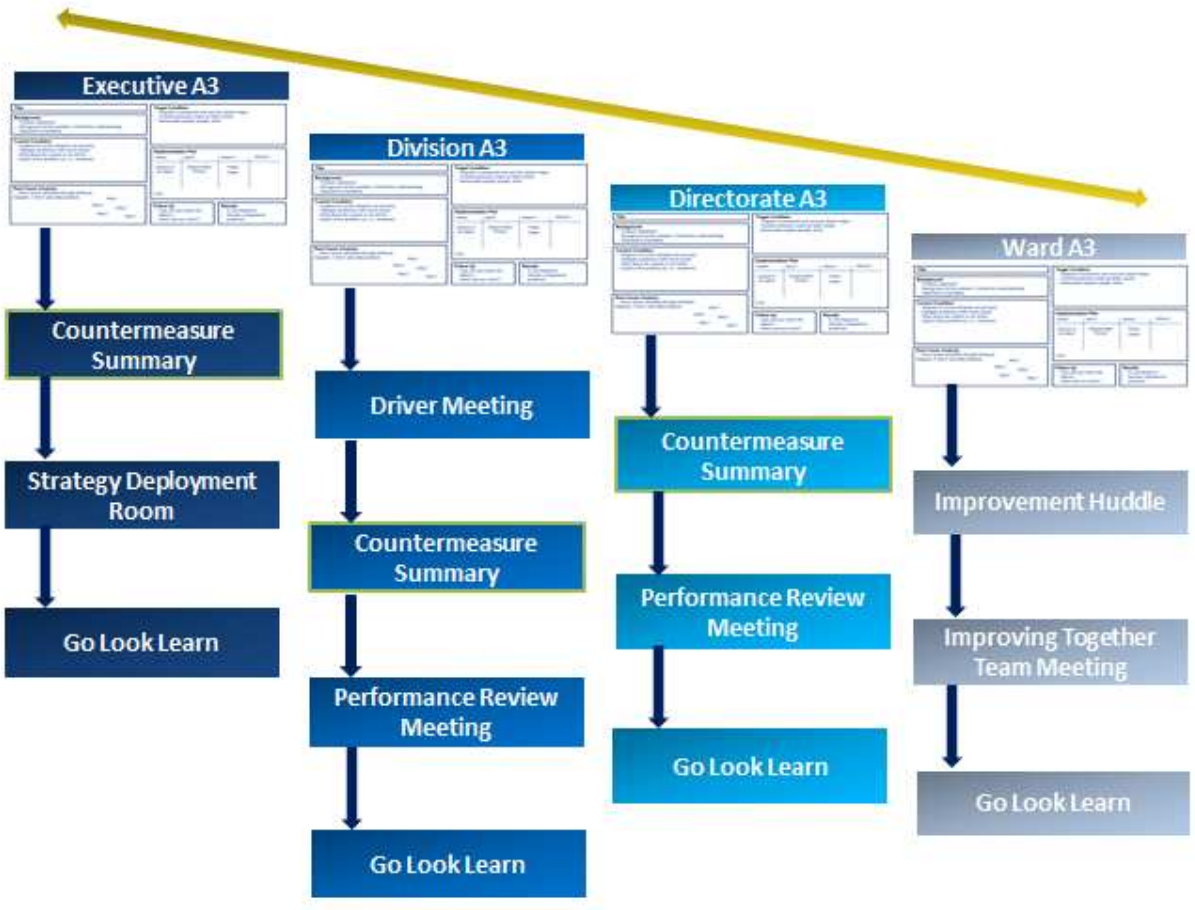


Scorecard
A summary of Driver and Watch Metrics each team has agreed

Driver Metrics

Key Priority Domain	Annual Objective ?	Metric	Target	Jun	Jul	Aug	Sept	Business Rule	Business rule outcome
High Quality		Patient Falls with harm per 1000 bed days	1.5	0.8	0.9	1.8	1.9		
High Quality		Inpatient Sepsis Screening Compliance (contracted)	90.0	81.8	90.9	91.3	80.8		
Responsive		ED 90min referral	50%	44%	49%	51%			
Responsive		RTT >52 Weeks	TBC	1018	1226	1365	1475		
Responsive		Follow Up Backlog over 52 weeks	0	1706	1660	1687	1723		
Responsive		P2 waiting list	TBC	185	250	288	344		
People		Appraisal (PDR)	95%	81.5%	79.3%	82.2%			
People		Staff Vacancies	9% - Oct 21 8.5% - Mar 22	12%	10%	11%			

The nature of these tools means that we can have a golden thread through the organisation that lets everyone in the organisation understand the priorities and how at all levels we are working together to address them. The A3 problem solving tool drives and informs the various activities within teams, at all levels, to deliver collective problem solving (e.g. Improvement Huddles, Driver Meetings and Strategy Deployment Room) and Performance Reporting (Counter measure summaries, Performance Review and Improving Together team meetings) whilst identifying the opportunities to 'go look learn' from the people doing the work.



14.8 Escalation, Oversight, Intervention and Support

The table below sets out the framework that we are working towards in order to ensure a consistent approach to escalation, oversight, intervention and support. This requires corporate teams to ensure the timeliness and accuracy of information to support Divisional Performance Management Reviews. This is aligned to our model of SPC and should be replicated at a Directorate level, by Divisional Boards.

Performance Level	Characteristics of a Division / Directorate at this Level	Oversight Frequency	Intervention to Support Recovery	Support Provided
Low Intensity Support	• Consistent delivery of KPI's across all domains of Quality, Workforce, Operations and Finance • No 'special causes of concerning nature' (variation) or 'variation indicating consistent failing of targets' identified in SPC performance monitoring • Executive Team have confidence in the capacity to respond to and deliver any improvements required	• Executive Performance Management Review Meetings	• Earned autonomy • No interventions likely at this level, standard governance / performance management arrangements will apply.	• Support if required, focussed on development opportunities
Medium Intensity Support	• Delivery issues identified against some KPI's across the domains of Quality, Workforce, Operations and Finance • Variation indicates 'inconsistent passing of targets'	• Executive Performance Management Review Meetings • Oversight of individual performance areas by relevant Executive Lead via monthly Executive Groups.	• Interventions likely to be focussed on supporting improvement in particular areas • Broader intervention may be deployed as deemed appropriate by the Executive Director / Division	• Support focussed on specific improvement issues • Support ***may*** involve any of the points below – dependent upon the nature and level of risk
High Intensity Support	• Consistent indications of 'special causes of concerning nature' or 'consistent falling short of targets' • Likely to require significant support to achieve recovery • Executive team have limited confidence in the capacity/ability to deliver improvement without additional support and challenge	• Executive Performance Management Review Meetings • Oversight of individual performance areas by relevant Executive Lead via monthly Executive Groups with escalation to the relevant Committee as appropriate. • Weekly meetings with the relevant Executive Lead/s as appropriate.	• Development of comprehensive improvement plan, for approval of Executive Team • Intensive oversight arrangements (as deemed appropriate / proportionate) • Potential loss of autonomy • Potential service / capability review	• Support focussed on rapid quality / operational improvement • Lead Executive Director working with the team • Divisional triumvirate coached by Executive counterpart • Partnering with another high performer • Support from corporate functions, i.e. Transformation, Performance, Quality Teams where appropriate • External support / coaching where appropriate

15. Review of this Framework

This Accountability and Performance Framework will be reviewed every two years by the Associate Director of Corporate Governance and will be submitted to the Board for approval and implementation.

Appendix 1:
Divisional Board Template Governance Pack

A) Divisional Board Terms of Reference and Membership Template

Xx Divisional Board
Terms of Reference and Membership
Date

NHS
University Hospitals of North Midlands
NHS Trust

Constitution and Authority

The Trust Executive Team hereby resolves to establish a Divisional Board within each of the Clinical Divisions, to support oversight, scrutiny and assurance at a divisional level in accordance with the Trust's Performance and Accountability Framework.

Membership

- Divisional Medical Director (Chair)
- Divisional Operations Director (Vice Chair)
- Divisional Nurse Director
- Head of Operations / Deputy Operations Director *(details of each per Group)*
- Head of Nursing / Deputy Nurse Director *(details of each per Group)*
- Clinical Directors *(details of each per Group)*
- Directorate Managers *(details of each per Directorate)*
- Matrons *(details of each per Directorate)*
- Divisional Governance and Quality Manager
- Divisional Business Advisor
- People Business Partner

Attendance at Meetings

Other staff members or external experts may be asked to attend by the Chair for all or part of any meeting, as and when appropriate / necessary, particularly when the Group is discussing an issue that is the responsibility of that person.

Substantive members are expected to attend 75% of meetings on an annual basis. This will be monitored through the inclusion of an Attendance Matrix within the minutes of each meeting.

Quorum

A quorum for the Board will be the chair (or vice chair), 50% of Clinical Directors, 50% Matrons and 50% Directorate Managers, from the above list of membership (or their nominated deputies).

Frequency of Meetings

The Board will meet on a monthly basis. However, the Chair may at any time convene additional meetings of the group to consider business that requires urgent attention.

Reporting

The Divisional Board will report to the Executive Team through Performance Management Review meetings and Executive Groups on how it discharges its responsibilities. This will include any matters requiring escalation for information or requiring executive support.

The Board will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Executive Team. This process will be supported by the Corporate Governance Team as required.

The Divisional Board will receive reports from the committees and groups reporting to it, by means of escalation and assurance.

Administrative Support

The Board shall be supported administratively by the Divisional PA, whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair in line with the Business Cycle 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 or provide apologies / nominate a deputy in advance
- Taking the minutes for approval at the next meeting
- Keeping a record of matters arising and action points to be carried forward between meetings through use of the Post Meeting Action Log

Duties

The primary aim of the Divisional Board is to ensure scrutiny, assurance and delivery of all objectives / targets, to monitor, control and escalate risks as appropriate and develop and oversee implementation of strategies and plans for all services within the Division.

The Divisional Board will consider all items in accordance with the Business Cycle, which will inform the monthly agenda.

Strategy

- Oversee development and implementation of strategy and operational plans at a Divisional level and associated Key Performance Indicators (KPIs), ensuring the adoption of best practice where available
- Develop and oversee implementation of an Annual Plan, aligned with priorities agreed through our Improving Together Programme
- Consult upon and agree any relevant policies, procedures, guidelines, standard operating procedures and protocols and monitor their implementation, where relevant, at a Divisional level

Performance

- Receive assurance on the delivery of strategy and relevant key performance metrics (i.e. driver / watch), ensuring the appropriate allocation of resource
- Monitor the operational systems and processes which ensure competent management within the Division
- Identify, delegate and review relevant actions to improve performance
- Report any exceptions to the Annual Plan, delivery of strategy or areas of underperformance to the Executive Team via the Performance Management Review process

Risk Management

- Where relevant, monitor Root Cause Analysis / trends relating to adverse incidents, ensuring that appropriate action is taken and lessons are learned (this may be delegated to the Divisional Governance Group although the Divisional Board will retain responsibility for oversight)
- Ensure that any risks are managed and reviewed via the Risk Register and in accordance with the Risk Management Policy

Governance

- To review national legislation, guidance and best practice and address local implications of such guidance as appropriate
- Oversee / monitor implementation of actions plans arising from internal / external review, audit, assessment or accreditation

- Undertake an annual self-assessment of effectiveness in order to inform any changes to Terms of Reference and Membership

Relationship with Executive Groups

The Group has a key relationship with all Executive Groups as defined within the approved Corporate Governance Structure.

Approval and Review

These Terms of Reference were approved on xx and will be reviewed on xx.

Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers

Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Governance												
Directorate Highlight Reports	●	●	●	●	●	●	●	●	●	●	●	●
Risk Register	●	●	●	●	●	●	●	●	●	●	●	●
Risk Management Audit Findings												
Policies for Consultation	●	●	●	●	●	●	●	●	●	●	●	●
Annual Plan	●											
Annual Effectiveness Review						●						
Terms of Reference and Membership						●						
6 Monthly Fraud Update						●						
High Quality												
Divisional Quality Group Highlight Report (to include external accreditations / inspections)	●	●	●	●	●	●	●	●	●	●	●	●
Executive Quality & Safety Oversight Group Highlight Report	●	●	●	●	●	●	●	●	●	●	●	●
Executive Clinical Effectiveness Group Highlight Report	●			●			●			●		
Divisional Quality Report (including driver / watch metrics)	●	●	●	●	●	●	●	●	●	●	●	●
People												
Divisional Workforce / Culture Group Highlight Report	●	●	●	●	●	●	●	●	●	●	●	●
Executive Workforce Assurance Group Highlight Report	●	●	●	●	●	●	●	●	●	●	●	●
Executive Health & Safety Oversight Group Highlight Report	●	●	●	●	●	●	●	●	●	●	●	●
6 Monthly Equality, Diversity and						●						●

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Inclusion Report												
Divisional Workforce Report (including driver / watch metrics)	●	●	●	●	●	●	●	●	●	●	●	●
Resources												
Divisional Finance Report (to include SFI breaches and salary overpayments)	●	●	●	●	●	●	●	●	●	●	●	●
Executive Business Intelligence Group Highlight Report			●			●			●			●
Executive Digital Data Security and Protection Group Highlight Report	●	●	●	●	●	●	●	●	●	●	●	●
Business Cases / Reviews	As necessary											
Responsive												
Operational Performance Report (including driver / watch metrics)	●	●	●	●	●	●	●	●	●	●	●	●
Improving and Innovating												
Executive Research & Innovation Group Highlight Report		●			●			●			●	
Improving and Innovating												
Executive Strategy & Transformation Group Highlight Report		●			●			●			●	

B) Divisional Board Agenda Template

University Hospitals of North Midlands NHS Trust

Xx Divisional Board

AGENDA

Meeting held on xx 20xx at xx am to xx pm
Venue, Site or via Microsoft Teams

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 2022	Approval		Enclosure
	4.	Matters Arising via the Post Meeting Action Log	Assurance		Enclosure
	GOVERNANCE				
	5.	Xx Directorate Highlight Report (date)			
	6.	Xx Directorate Highlight Report (date)			
	7.	Risk Register – including risks scoring 8 and above			
		HIGH QUALITY			
	x.	Divisional Quality Group Highlight Report (date)	Assurance		Enclosure
	x.	Divisional Quality Report (including driver / watch metrics)	Assurance		Enclosure
	x.	Executive Quality & Safety Oversight Group Highlight Report (date)	Information		Enclosure
	x.	Executive Clinical Effectiveness Group Highlight Report (date)	Information		Enclosure
	x.				
		PEOPLE			
	x.	Divisional Workforce & Culture Group Highlight Report (date)	Assurance		Enclosure
	x.	Divisional Workforce Report	Assurance		Enclosure
	x.	Executive Workforce Assurance Group Highlight Report (date)	Information		Enclosure
	x.	Executive Health & Safety Oversight Group Highlight Report (date)	Information		Enclosure
		RESOURCES			
	x.	Divisional Finance Report	Assurance		Enclosure
	x.	Business Cases (ad hoc)	Approval		Enclosure
	x.	Executive Business Intelligence Group Highlight Report (date)	Information		Enclosure
	x.	Executive Digital Data Security and Protection Group (date)	Information		Enclosure
		RESPONSIVE			
	x.	Divisional Operational Performance Report	Assurance		Enclosure
		IMPROVING AND INNOVATING			
	x.	Executive Research & Innovation Group Highlight Report (date)	Information		Enclosure
		SYSTEMS AND PARTNERS			
	x.	Executive Strategy & Transformation Group Highlight Report (date)			
	CLOSING MATTERS				
		Review of Meeting Effectiveness			Verbal
		Agreement of Items for Escalation to Executive Groups			
		Any Other Business			
	DATE AND TIME OF NEXT MEETING				

C) Divisional Board Minutes Template

University Hospitals of North Midlands NHS Trust

Xx Divisional Board

Meeting held on xx 2019 at xx to xx
Venue, Site or via Microsoft Teams

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	

D) Divisional Board Annual Effectiveness Evaluation Template

Annual Effectiveness Evaluation

Divisional Board:	
Chair:	
Accountable to:	**Executive Team**
Date of Effectiveness Review:	

Processes

To be completed by the Chair on an annual basis (with the assistance of the Corporate Governance Team if required), and presented to Executive Team.

Area / Question	Yes	No	Comments/Action
Composition, establishment and duties			
Are items for escalation agreed at each meeting and escalated accordingly?			
Are meeting papers distributed in sufficient time for members to give them due consideration?			
Has the Divisional Board been quorate for each meeting this year?			

Committee Effectiveness

To be completed by each member of the Divisional Board for to submission to the Chair.

What works well?
What doesn't work well?
Suggestions for Improvement:

Appendix 2:
Performance Management Framework (KPI's) – Integrated Performance Report

Exec Lead	Driver / Watch	Metric (KPI)	Target
	HIGH QUALITY		
CNO		Patient Safety Incidents	n/a
CNO		Patient Safety Incidents per 1000 bed days	50.70
CNO		Patient Safety Incidents per 1000 bed days with no harm	n/a
CNO		Patient Safety Incidents per 1000 bed days with low harm	n/a
CNO		Patient Safety Incidents per 1000 bed days reported as Near Miss	n/a
CNO		Patient Safety Incidents with Moderate Harm +	n/a
CNO		Patient Safety Incidents with Moderate Harm + per 1000 bed days	
CNO		Harm Free Care (new harms)	95%
CNO		Patient Falls per 1000 bed days	5.6
CNO		Patient Falls with harm per 1000 bed days	1.5
CNO/CMO		Medication Incidents per 1000 bed days	6
CNO/CMO		Medication Incidents % with moderate harm or above	0.50%
CNO/CMO		Patient Medication Incidents per 1000 bed days	6
CNO/CMO		Patient Medication Incidents % with moderate harm or above	0.50%
CNO		Serious Incidents reported per month	0
CNO		Serious Incidents Rate per 1000 bed days	0
CNO		Never Events reported per month	0
CNO		Duty of Candour – verbal	100%
CNO		Duty of Candour – written	100%
CNO		Total Pressure Ulcers developed in UHNM care	n/a
CNO		Total Pressure Ulcers developed in UHNM care per 1000 bed days	n/a
CNO		Total Pressure Ulcers developed under UHNM care lapses in care	12
CNO		Total Pressure Ulcers developed under UHNM care lapses in care per 1000 bed days	0.5
CNO		Category 2 Pressure Ulcers with lapses in care	8
CNO		Category 3 Pressure Ulcers with lapses in care	4
CNO		Category 4 Pressure Ulcers with lapses in care	0
CNO		Unstageable Pressure Ulcers with lapses in care	0
CNO		Friends and Family Test – ED	85%
CNO		Friends and Family Test – Inpatient	95%
CNO		Friends and Family Test – Maternity	95%
CNO		Written Complaints per 10,000 spells	35
CMO		Rolling 12 month HSMR	100
CMO		Rolling 12 month SHMI	100
CNO/CMO		Nosocomial Covid-19 Deaths (positive sample 15+ days after admission)	n/a
CNO		VTE Risk Assessment Compliance	95%
CNO		Reported C Difficile Cases per month	8
CNO		Avoidable MRSA Bacteraemia cases per month	0
CNO		Hospital Acquired E Coli Bacteraemia Cases per month	8
CNO		Nosocomial Definite Hospital Acquired Covid Cases	0
CNO		Sepsis Screening Compliance (contracted)	90%
CNO		IVAB within 1 hour (contracted)	90%
CNO		Children Sepsis Screening Compliance (all)	90%
CNO		Children IVAB within 1 hour (all)	90%
CNO		Emergency Portals Sepsis Screening Compliance (contracted)	90%
CNO		Maternity Sepsis Screening (all)	90%
CNO		Maternity IVAB within 1 hour (all)	90%
	RESPONSIVE		
	URGENT CARE		
COO		ED wait to be seen	60
COO		Patients staying 12+ hours in ED	0
COO		Initial assessment within 15 minutes (total type 1)	85%
COO		Ambulance handover greater than 60 minutes	0
COO		Type 1 non-admitted average minutes	180
COO		Pre-noon discharge %	25%
COO		Simple discharges	n/a
COO		Bed occupancy	92%

COO		ED mean speciality referral to discharge time	90
COO		% emergency admissions to same day emergency care wards	30%
COO		Type 1 mean time in department	180
	ELECTIVE CARE		
COO		Cancer 2ww first seen 93rd percentile (excluding breast)	14
COO		Cancer 62 day treated 85th percentile	62
COO		Cancer 2ww first seen 93rd percentile (breast)	14
COO		Cancer 2ww first seen 93rd percentile (colorectal)	14
COO		Cancer 2ww first seen 93rd percentile (skin)	14
COO		Cancer 2ww first seen 93rd percentile (breast symptom)	14
COO		Cancer 2ww referrals first seen within the month	n/a
COO		Cancer 62 day backlog	200
COO		Cancer treated over 62 days	n/a
COO		Cancer 28 day faster pathway 62 day	75%
	PLANNED CARE		
COO		Elective inpatients – actual numbers	Variable
COO		Elective day case – actual numbers	Variable
COO		Number of elective operations	Variable
COO		Weekly 4 hour sessions	Variable
COO		UoR cancelled operations at last minute	Variable
COO		Outpatients new – actual numbers	Variable
COO		Outpatients follow up – actual numbers	Variable
COO		52+ weeks actual and trajectory	Variable
COO		78+ weeks actual and trajectory	0
COO		104+ weeks actual and trajectory	0
COO		Diagnostic activity	Variable
	CONSTITUTIONAL STANDARDS		
COO		ED 4 hour wait performance	95%
COO		12 hour trolley waits	0
COO		Cancer Rapid Access (2 week wait)	93%
COO		Cancer 62 day GP referral	85%
COO		Cancer 62 day screening	90%
COO		Cancer 31 day first treatment	96%
COO		RTT incomplete performance	92%
COO		RTT 52+ week waits	0
COO		Diagnostics	99%
COO		DNA rate	7%
COO		Cancelled operations	150
COO		Theatre utilisation	85%
COO		Same day emergency care	30%
COO		Super stranded patients	183
COO		Delayed Transfers of Care	3.5%
COO		Discharges before midday	25%
COO		Emergency readmission rate	8%
COO		Ambulance handover delays in excess of 60 minutes	0
	PEOPLE		
CPO		Staff Sickness	3.4%
CPO		Staff Turnover	11%
CPO		Statutory and Mandatory Training Rate	95%
CPO		Appraisal (PDR) Rate	95%
CPO		Agency Cost	n/a
CPO		Staff Engagement	n/a
	RESOURCES		
CFO		Trust Income	Variable
CFO		Expenditure: Pay	Variable
CFO		Expenditure: Non-Pay	Variable
CFO		Day case / elective activity	Variable
CFO		Non elective activity	Variable
CFO		Outpatients 1st	Variable
CFO		Outpatients follow up	Variable

Executive Summary

Meeting:	Trust Board	**Date:**	7th December 2022
Report Title:	Well Led Framework – 2022 Self-Assessment	**Agenda Item:**	8.
Author:	Claire Cotton, 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	✓	Systems & Partners	✓		
Responsive		Improving & Innovating	✓	Resources	✓		

Risk Register Mapping

BAF 1	Delivering Positive Patient Outcomes	**Ext 16**
BAF 2	Leadership, Culture and Delivery of Values	**High 12**
BAF 4	System Working	**High 9**
BAF 9	Research and Innovation	**Ext 15**

Executive Summary

Situation

This report provides an updated self-assessment against the Well Led Framework. It is structured around the 8 Key Lines of Enquiry (KLOE) and identifies 'what good looks like', 'prompts' for consideration along with an assurance framework which identifies the key controls and assurances in place which have informed our 2022 assurance ratings. Improvement opportunities have also been identified for each KLOE. It is presented to the Trust Board for assurance and approval.

Background

The NHS Well Led Framework is focussed on integrated quality, operational and financial governance and the characteristics of good organisations in terms of leadership culture, system working and quality improvement. It mirrors the Well Led Framework used by the Care Quality Commission (CQC) in their assessment process. The NHS Improvement guidance on Well Led (2017) encourages providers to have an externally facilitated review against the Well Led Framework at least every three years; a thorough review was undertaken in September 2019 and as part of our locally agreed corporate governance framework, a self-assessment is undertaken each year in between the externally facilitated reviews.

Prior to being presented to the Board, a review of the previous 2021 self-assessment was undertaken by Executive Leads followed by an Executive Workshop held on 18th October, where the findings of the most recent CQC Well Led Inspection were also taken into account. The outputs of this work have informed the enclosed self-assessment for 2022 (for ease of reference, updates are shown in **green text**).

Assessment

Previous assessments have used the 'assurance rating' categories used by our Internal Auditors although for this 2022 assessment we have used the categories used by the Care Quality Commission. However, these can be broadly aligned for comparative purposes (i.e. 'partial assurance' being comparable with 'requires improvement' and 'significant assurance' being comparable with 'good').

Based on this approach, the overall conclusions to be drawn from our 2022 self-assessment are that:

- Whilst we have identified significant developments over the past year, our assessment is that **we have remained the same in terms of our assurance rating in 7/8 of the KLOE's** as we recognise that there are still further improvements to be made.
- We have **improved from 'Partial Assurance' to 'Good' in 1/8 KLOE's**; this is in relation to the work that has

been undertaken to develop our overarching Strategic Priorities and enabling strategies (which was recognised by the CQC).

- A large proportion of the newer developments identified relate to our **Cultural Improvement Programme**, which remains relatively new and will take some time to embed and generate improved cultural outcomes.
- Progress has been made against a number of the improvement opportunities identified within our 2021 assessment with some now complete or 'Business as Usual'. However, in undertaking the assessment we have **identified further improvement opportunities**, which we will track through our governance structure.

The following table summarises the areas of concern (delayed actions), derived from our improvement plan, along with the solutions to address these:

	Areas of Concern / Items for Escalation	Solutions
!	Whilst we have established a Clinical Effectiveness Group, our structures and resource require some strengthening.	The Medical Director is preparing a paper to identify the risks associated with the Clinical Effectiveness portfolio and the potential solutions to address this.
!	Mobilisation of the Business Intelligence Strategy, ensuring: • Divisional ownership of data • A single point of information • Real time data input	Whilst the Business Intelligence Strategy has been developed and agreed, to date the Executive Business Intelligence Group has needed to focus on more operational matters. However, a plan is being developed to shift its focus to oversight and delivery of the strategy.
!	Development of our Engagement Strategy encompassing patients, public and key stakeholders has been delayed.	Whilst a Stakeholder Map and Stakeholder Reference Group have been developed, a full strategy is yet to be developed; this will be undertaken by the Chief Nurse and Director of Communications.

In addition to the steps outlined above, we will be focussing on the following improvement opportunities over the coming year:

- **KLOE 1:** Undertake a Board Effectiveness Evaluation, delivery of our Culture Improvement Programme and to review our structure and resources to support Clinical Effectiveness.
- **KLOE 2:** To review our 2025Vision and to finalise our Estates and People Strategy, embed Patient Safety Learning Standards into practice and to develop a Strategy for Vulnerable People.
- **KLOE 3:** To embed our Be Kind Behaviour Framework and Civility and Respect Programme and to embed the Equality, Diversity and Inclusion Strategy.
- **KLOE 4/5:** To improve our Divisional Governance arrangements / effectiveness including risk management.
- **KLOE 6:** To develop data definitions and a greater depth of analysis of our data aligned with our work on delivering the Business Intelligence Strategy.
- **KLOE 7**: To ensure that the patient's voice is heard and taken into account more broadly, through development and delivery of our Engagement Strategy.
- **KLOE 8:** Continued roll out of our Improving Together Programme.

Finally, in accordance with the NHS Improvement Guidance (2017), during 2023 we will be required to commission an external Developmental Well Led Review. However, it should be noted that the Care Quality Commission are in the process of launching their revised standards which will replace the current KLOE's. At this stage it is unclear as to whether NHSE will revise the Well Led Framework within a similar timeframe. This situation will continue to be monitored in order to determine a proposed approach for assessment during 2023, for consideration by the Board; this may include an assessment to be undertaken as part of our Internal Audit Programme.

Key Recommendations

- The Board is asked to approve the Well Led Self-Assessment for 2022, including the matters of concern and improvement opportunities identified.
- To note that a proposal for external assessment against the Well Led Framework during 2023 will be developed, once the national position between NHS England and the CQC is made clear. Consideration may be given to our Internal Audit Programme.

NHS
University Hospitals of North Midlands
NHS Trust

Well Led Framework

2022 Self-Assessment

Delivering Exceptional Care with Exceptional People

1. Introduction

The NHS Well Framework has a strong focus on **integrated quality, operational and financial governance** and includes a framework of Key Lines of Enquiry (KLOE's) and the characteristics of good organisations. It mirrors the Well Led Framework used by the Care Quality Commission in their assessment of organisations. It provides **content on leadership culture, system-working and quality improvement** and is structured around the following:

1 Is there the **leadership capacity and capability** to deliver high quality, sustainable care?	2 Is there a clear **vision** and credible **strategy** to deliver high quality, sustainable care to people, and robust plans to deliver?	3 Is there a **culture** of high quality, sustainable care?
4 Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?	**Are services well led?**	5 Are there clear and effective processes for managing **risks**, issues and **performance**?
6 Is appropriate and accurate **information** being effectively processed, challenged and acted on?	7 Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services?	8 Are there robust systems and processes for **learning**, continuous **improvement** and **innovation**?

We undertake an annual self-assessment against the Well Led Framework, so that we can identify the arrangements we have in place and where we need to develop further.

For our 2022 self-assessment, we have adopted the criteria used by the CQC in in their assessment process, in place of the Internal Audit assurance ratings we have used in previous years.

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding

In our action planning, we use the following as indicators of our position, these has been used within our opportunities for improvement which are identified throughout this self-assessment.

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

2. Summary Self-Assessment 2020 / 2021

The following provides a high level summary of our self-assessment for 2022 in comparison to previous years. Whilst we have changed our self-assessment rating, this is broadly comparable to the ratings used in previous years and so an indication of whether we have remained the same or improved is also given.

No.	Requirement	Exec Lead	2019/2020 Assurance Rating	NHSIE Developmental Review Sept	2021 Assurance Rating	2022 Assurance Rating	Change
W1	Is there the leadership capacity and capability to delivery high quality, sustainable care?	Chief Nurse / Medical Director	Significant Assurance with Minor Improvement Opportunities	Significant Assurance with Minor Improvement Opportunities	Significant Assurance with Minor Improvement Opportunities	Good	→
W2	Is there a clear vision and a credible strategy to deliver high quality sustainable care to people and robust plans	Director of Strategy & Transformation	Partial Assurance with Improvements Required	Partial Assurance with Improvements Required	Partial Assurance with Improvements Required	Good	↑
W3	Is there a culture of high quality, sustainable care?	Chief People Officer	Significant Assurance with Minor Improvement Opportunities	Significant Assurance with Minor Improvement Opportunities	Partial Assurance with Improvements Required	Requires Improvement	→
W4	Are there clear roles and responsibilities and systems of accountability to support good governance and management?	Chief Executive	Significant Assurance with Minor Improvement Opportunities	Partial Assurance with Improvements Required	Significant Assurance with Minor Improvement Opportunities	Good	→
W5	Are ther clear and effective processes for managing risks, issues and performance?	Chief Finance Officer	Significant Assurance with Minor Improvement Opportunities	Partial Assurance with Improvements Required	Significant Assurance with Minor Improvement Opportunities	Good	→
W6	Is appropriate and accurate information being effectively processed, challenged and acted upon?	Chief Finance Officer	Partial Assurance with Improvements Required	Partial Assurance with Improvements Required	Partial Assurance with Improvements Required	Requires Improvement	→
W7	Are the people who use services, the public, staff and external partners engaged and involvd to support high quality, sustainable services?	Chief Nurse and Director of Communications	Partial Assurance with Improvements Required	Partial Assurance with Improvements Required	Partial Assurance with Improvements Required	Requires Improvement	→
W8	Are there robust systems and processes for learning, continuous improvement and innovation?	Director of Strategy & Transformation	Partial Assurance with Improvements Required	Partial Assurance with Improvements Required	Partial Assurance with Improvements Required	Requires Improvement	→

3. Self-Assessment 2022

W1:	Is there the leadership capacity and capability to deliver high quality, sustainable care?	2022 Assurance Rating
		Good

Lead Director / s:	Chief People Officer	**Supported by:**	Chief Nurse / Medical Director
Lead Committee:	Transformation and People Committee	**Executive Group:**	Executive Workforce Assurance Group

What does 'Good' look like?

- **Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed**
- **The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and takes action to address them**
- **Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, development, deployment and support processes and succession planning**
- **Leaders at every level are visible and approachable**

Prompts

1.1	**Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?**
1.2	**Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them?**
1.3	**Are leaders visible and approachable?**
1.4	**Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership and is there a leadership strategy or development programme, which includes succession planning?**

Assurance Framework

Key Controls in Place

- Robust, competitive and market tested appointments process, covering values and behaviours, in place and undertaken for all Executive Director appointments – now all substantive positions in place
- Adherence to NHSI appointments process for Non-Executive Director appointments
- Appraisal and personal development plans (PDP) in place for all Executive Directors and Non-Executive Directors aligned to Trust Policy / NHSI Framework
- Human Resources Policies / Procedures for Recruitment and Selection
- Board Development Programme in place for 2022/23
- Time to Talk sessions led by the Chief Executive
- People Strategy **and delivery plan** with identified objectives for 2022/23
- Succession Planning for Executive / Senior Managers in place
- Clear responsibilities outlined for each Executive Portfolio
- Talent Management Programme in place
- Code of Conduct for Board Members (as part of Rules

Key Sources of Assurance

- **Personal Files:** All Executive Director positions filled substantively – recruitment information available in all files. Reappointment of Non-Executive Directors undertaken through NHSIE– appointment letters held.
- **Annual Audit of Fit and Proper Persons process (May 2021)** taken to Nomination and Remuneration Committee has demonstrated compliance with declaration requirements, with no concerns identified.
- **Appraisal Documentation and PDP:** Process undertaken during 20/21 for all Executive Directors / Non-Executive Directors with agreed objectives / PDP, including role of 'Corporate Director'.
- **Staff Survey Findings 2021: the staff engagement rate was 6.7, just below the acute Trust average score of 6.8.**
- **Board Assurance Framework 21/22:** Updated by Executive Team and reviewed by Committees / Board each quarter, demonstrating the key strategic risks identified and actions being taken to address

of Procedure) updated and approved May 2022
- Quality Account sets out key challenges associated with quality along with priorities for improvement
- Annual review of Non-Executive Director Skills, Knowledge and Experience
- Improving Together Programme
- Culture Diagnostic
- Leaders are approachable and visible through: Time to Talk, Walkabouts, UHNM Live Sessions
- Support for managers to be visible with staff in the virtual working environment – 20-2-1 sessions
- Development of a visible, supportive and compassionate coaching culture through internal coaching offer and membership of the West Midlands coaching collaborative
- Senior leaders presence and participation at Connects Leadership programme events which includes attending and also leading key sessions
- Working with regional partners to develop solutions on Talent Management and Succession Planning as a system **such as scope for growth, the new nation al programme which is aimed at staff having positive and regular career focussed conversations with their line manager. There is also a system wide High Potential Scheme in place.**
- Fortnightly UHNM Live discussion, Q&A with staff
- Executive back to the floor sessions / shifts
- Executive Development Programme commenced as part of Improving Together
- **Enhanced Divisional Leadership Structure now in place**
- **A3 Positive and Inclusive Culture now BAU as part of Strategy Deployment Room**
- **Chief Nurse and Director of Midwifery Fellowship Programmes**
- **Professional Nurse Advocate Programme**
- **Legacy Mentors for 12 months being introduced**
- **Strategic AHP Lead role being supported for 12 months**
- **Leadership Development Programmes accessible from entry level to senior leadership. They embed positive behavioural expectations in line with our Values, the NHS People Promise, Our Leadership Way and are co-creating UHNM's behavioural framework.**
- **Enable, our programme aimed at middle management has been designed to develop caring, compassionate and inclusive leaders in the organisation. We aim to take over 1000 leaders through this programme over the next two years.**
- **Silver Connects is an open programme aimed at developing all staff in skills required to be compassionate and inclusive leaders.**
- **System Connects is a cohorted programme for senior leaders working across the system.**
- **Our Clinical Leadership and Management Fundamentals programme targets all Clinical Directors and Clinical Leads and runs twice a year to develop their people management skills to ensure they focus on collaborative, compassionate and inclusive leadership.**
- **We provide our FY1/FY2 doctors with a range of**

them
- **NED Annual Review:** Paper to Nomination and Remuneration Committee
- **Evaluation of Connects Programme:** demonstrates that feedback has been universally positive to date
- **Connects Programme:** content endorsed by Staffordshire University
- **2021/21 Leadership Training Uptake:** 531 staff members attended training sessions; this increases to 888 when adding activity up to the end of July 21
- **Culture Heat Map:** Quarterly Heat Map to TAP demonstrating position against key cultural indicators

leadership master classes to introduce the skills and gain knowledge they need • Welcome sessions for newly appointed consultants • RESPOND, a bespoke model and training package to equip staff with the necessary skills and confidence to undertake wellbeing conversations has been embedded into our leadership offering • Executive and Senior Leadership Development Programme • New ENABLE programme for all line managers • New Well Being Walkabouts with Board members • Cultural Improvement Programme	

How our Improving Together Programme Supports this KLOE	
Prompt	**Improving Together Programme**
1.1	**Part of the Improving Together Programme is the 12 month leadership development programme, focussing on the Operational Excellence principles provided by the Shingo Institution. These are principles, tools and capabilities that drive structured problem solving and coaching.**
1.3	**Part of the Leadership Behaviours work stream is teaching the Execs around 'walkabouts' and how to build leader standard work to find time to engage with the organisation more consistently around key routines, such as attending frontline improvement huddles.**

Improvement Opportunities				
No.	**Improvement Opportunities**	**Exec Lead**	**Status Update - 2022 Priorities for Development**	**BRAG**
W1.1	**Board Effectiveness Evalation**	ADCG	Evauluation undertaken during 2021. Further evaluation to be completed 2022/2023.	
W1.2	**A3 – Positive and Inclusive Culture**	CPO	Completed and BAU as part of Strategy Deployment Room.	
W1.3	**Development of Executive and Senior Development Programme**	CPO	Programme underway	
W1.4	**Implementation of revised Divisional Structure and Leadership roles**	COO	Structure now in place.	
W1.5	**Delivery of Culture Improvement Programme**	CPO	Programme developed and underway including Leadership Development.	
W1.6	**Strengthen structures and resource for Clinical Effectiveness.**	MD	Group established although resource to support implementation is limited.	

W2:	Is there a clear vision and credible strategy to deliver high quality sustainable care to people, and robust plans to deliver?	2022 Assurance Rating
		Good

Lead Director / s:	Director of Strategy & Transformation	**Supported by:**	Chief Nurse and Medical Director
Lead Committee:	Transformation & People Committee	**Executive Group:**	Executive Strategy & Transformation Group

What does 'Good' look like?

- **There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well defined objectives that are achievable and relevant.**
- **The strategy is aligned to local plans in the wider health economy and social care economy and services are planned to meet the needs of the relevant population.**
- **Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.**
- **The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners.**
- **Progress against delivery of the strategy and local plans is monitored and reviewed and there is evidence of this. Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors are understood and an action plan is in place.**

Prompts

2.1	**Is there a clear vision and set of values, with quality and sustainability as the top priorities?**
2.2	**Is there a robust, realistic strategy for achieving the priorities and delivering good quality, sustainable care?**
2.3	**Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services and external partners?**
2.4	**Do staff know and understand what the vision, values and strategy are, and their role in achieving them?**
2.5	**Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?**
2.6	**Is progress against delivery of the strategy and local plans monitored and reviewed and is there evidence to show this?**

Assurance Framework

Key Controls in Place

- Clinical Service Line Review undertaken, informed development of our Clinical Strategy
- Values and Behaviours Framework in place; PDR process has been aligned to this
- Values Recognition Scheme in place
- Leadership Development Programme includes development around our Vision, Values and Strategic Objectives
- Executive Groups established as part of revised Corporate Governance Structure – all with a core responsibility for oversight of Strategy Development and Implementation
- Strategy and Transformation Group established as part of revised Corporate Governance Structure
- Strategic Priorities updated as part of Improving Together Programme
- UHNM Strategic Framework (1 page infograph)
- Revised Plan on a Page with refreshed Strategic

Key Sources of Assurance

- **2025 Vision (Strategy):** Updated and approved by the Board in 2017 – includes Vision and Values along with 5 Strategic Objectives (covering quality and sustainability) which were developed through consultation with key stakeholders.
- **Improving Together Programme:** Business case approved by Board and regulators; implementation commenced May 2021 (postponed from 2020 due to Covid)
- **Executive Summaries:** All papers considered within our Corporate Governance Structure include mapping to our Strategic Objectives, including positive / negative impact. This covers business plans, assurance reports, performance reports etc.
- **Integrated Performance Report (IPR):** Considered by the Board and the Finance and Performance Committee each month – refreshed in year to ensure clear alignment with our Strategic Objectives.

Priorities • Values based questions are used in staff interviews • Trust clinical strategy incorporates ICS priorities and development plan along with local authority 'obsessions' • The Trust strategy is underpinned by a number of enabling strategies, e.g. quality, people, digital, finance, R&I, Estates • System Strategy and narrative – 5 year plan • **Quality Strategy approved** • **Digital Strategy approved** • **Refreshed Research and Innovation Strategy approved** • **Development of Centre for Research and Education Excellence (CenREE)** • **Business continuity plans which enable staffing for safe and effective care during critical incidents or events** • **Improving Together Programme and Strategy Deployment Framework** • **Executive Routines – weekly meeting to review progress against priorities** • **Integrated Annual Business Planning Cycle aligned with business planning process** • **Annual Plan, aligned with Strategic Priorities** • **Revised Performance Review process, aligned with our Strategic Priorities** • **Equality, Diversity and Inclusion Strategy** • **ARCHUS Review** • **Clinical Strategy** • **County Clinical Strategy Group** • **CEO is a member of the new ICB** • **CEO is system Lead for Provider Collaboration** • **Key Executives leading or involved in the 9 system work streams and 7 system priorities** • **UHNM led on system bed modelling** • **ICB business case for system patient records** • **Charity project for loneliness** • **System Finance Strategy** • **System wide Occupational Health contract** • **System wide Health & Wellbeing Board** • **System Risk Management Strategy**	• **Executive Groups Governance Pack:** Approved during 2020 as part of the revised Corporate Governance Structure defines core responsibilities for oversight of Strategy Development and Implementation • **Equality and Diversity Strategy:** Approved by the Board with regular reporting from the Equality and Diversity Lead to the Transformation and People Committee and to the Board. • **Improving Together Assurance Map:** Identifies the mechanisms through which our Improving Together priorities are overseen through our governance structure

How our Improving Together Programme Supports this KLOE

Prompt	Improving Together Programme
2.3	**The Strategy Deployment work stream has involved the Execs defining their "True North" metrics, along with the transformational programmes, projects and operational improvement themes. The whole approach is based on structured problem solving and the use of data to validate actions. The purpose is to cascade the True North to all levels of the Trust in a meaningful way. This means the focused negotiations with Divisions to get alignment on the goals, and helping frontline teams identify the metrics that most resonate with their challenges to focus their improvement efforts on. This demonstrates the collaboration with staff, and in time, service users can engage in the improvement routines too.**

Improvement Opportunities

No.	Improvement Opportunities	Exec Lead	Status Update - 2022 Priorities for Development	BRAG
W2.1	**Review / revision of 2025 Vision**	DST	Strategic Priorities reviewed as part of Improving Togegher Programme, Strategic Framework developed. Full	

			document to be updated.	
W2.2	**Approval of Clinical Strategy**	DST	Completed and approved.	
W2.3	**Development of Patient Safety Strategy (Quality Strategy)**	CNO	Completed and approved.	
W2.4	**Review / revision of other enabling strategies**	Various	R&I Strategy approved, Digital Strategy approved. Estates Strategy under review and People Strategy nearing completion.	
W2.5	**Patient Safety Learning Standards to be embedded into practice.**	CNO	To complete corporate level self-assessment during 2022.	
W2.6	**Development of Strategy for Vulnerable People.**	CNO	To be commenced during 2022/23.	
W2.7	**Review of Care Excellence Framework Accreditation Programme.**	CNO	Review undertaken and refreshed approach being utilised – findings shared with Quality Governance Committee.	

	W3:	Is there a culture of high quality, sustainable care?	2022 Assurance Rating
			Requires Improvement

Lead Director / s:	Chief People Officer	**Supported by:**	
Lead Committee:	Transformation & People Committee	**Executive Group:**	Workforce Assurance Group

What does 'Good' look like?

- Leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services. Behaviour and performance inconsistent with the vision and values are acted on regardless of seniority.
- Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (excluding external whistle blowers) are supported. Concerns are investigated sensitively and confidentially and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.
- There are processes for providing all staff at every level with the development they need, including high quality appraisal and career development conversations.
- Leaders model and encourage compassionate, inclusive and supportive relationships among staff so they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing.
- Equality and diversity are actively promoted to the causes of any workforce inequality and are identified and action taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.
- There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility is shared.

Prompts

3.1	Do staff feel supported, respected and valued?
3.2	Is the culture centred on the needs and experiences of people who use services?
3.3	Do staff feel positive and proud to work in the organization?
3.4	Is action taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority?
3.5	Does the culture encourage openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution and is appropriate learning and action taken as a result of concerns raised?
3.6	Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?
3.7	Is there a strong emphasis on safety and wellbeing of staff?
3.8	Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?
3.9	Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?

Assurance Framework

Key Controls in Place	Key Sources of Assurance
• Equality and Diversity Policy / Strategy and Lead in place • Raising Concerns Policy in place • Freedom to Speak Up Policy • Freedom to Speak Up Guardian with Associate	• **WRES Data and Analysis:** Presented to the Board on an annual basis. • **WDES Data and Analysis** • **Gender Pay Gap Analysis** • **Disciplinary Report:** Presented to the

Guardians in place
- Employee Support Advisors are in place **as a confidential peer resource for staff to access with concerns about civility, bullying and harassment**
- Values Recognition Scheme **gives staff, patients and relatives an opportunity to nominate or staff for recognition, demonstrating positive behaviours of living our organisational values**
- People Strategy **and annual delivery plan**
- Senior Independent Director / NED FTSU Lead
- Complaints Policy in place
- Appraisal and PDP Policy in place **for annual PDR's which focus discussions around performance in role behaviours, ambition, aspiration, inclusion and wellbeing**
- **Career development conversations have been made available**
- **Coaching and mentoring can be accessed via the West Midlands Coaching and Mentoring Pool**
- Duty of Candour Policy
- Pulse Check Process
- Just and Learning processes embedded into Trust policies and practices
- Staff Survey used to develop tailored engagement plans
- Improving Together Programme
- Culture and Leadership Programme
- **Reciprocal** Mentorship Programme
- Staff Networks in place (i.e. LGBT+, Disability and Long Term Conditions, Ethnic Diversity) **with Executive Sponsors in place and 2 days per month allocated for Network Chairs**
- **Cultural Calendar of diversity and inclusion events**
- Equality Impact Assessment process
- Learning and Education Strategy
- Development using Apprenticeships
- HR Policies and Procedures (Disciplinary, grievances, Professional Standards, **Resolution Policy** etc.)
- Independent reviews, i.e. Brap, commissioned where necessary
- Diverse Recruitment Plans
- Collaborative working on EDI at a system level with joint training offerings
- Visible, accessible Executive Dignity at Work Policy
- **Cultural Improvement Programme: a number of focussed interventions on culture, behaviour, civility and respect and EDI to ensure UHNM is a great place to work**
- **Resolution Policy and Training Programme**
- **Trust and local induction and on boarding**
- **Speaking Up training**
- **Being Kind compact and Resolution Toolkit; setting out expectations of behaviour in line with our organisational values**
- **Email and meeting etiquette**
- **Wellbeing Plan**
- **A range of wellbeing initiatives and support routes, bespoke training and workshops**
- **Carers passport**
- **Staff Good Causes dedicated funding to support staff wellbeing needs**
- **Staff Support and Counselling Service**

Transformation and People Committee, demonstrates in a confidential manner that actions are taken to address behaviour and performance issues.
- **Raising Concerns / FTSU Reports:** Reports to the Board on a quarterly basis demonstrate volumes / types of concerns raised and action taken, in accordance with Trust Policy.
- **Staff Survey Findings:** Demonstrate that improvements in Health and Wellbeing and Safe Environment – Bullying and Harrassment; Staff Morale was highlighted as a concern in the context of the global pandemic; staff recommend the Trust as a place to work and as a place to receive care had improved
- **Improving Together Programme:** Business case approved by Board and regulators; implementation commenced May 2021 which is focussed on sustained quality improvement, staff engagement and culture change.
- **Gender Pay Gap Report**
- **Apprenticeship Levy Utilisation**
- **Brap / Roger Kline Report into culture:** Completed and shared widely.

• System Wide Staff Psychological Wellbeing Hub • Wellbeing Champions representing all Divisions • Leadership development programmes are accessible for every level of leadership from entry level to senior leadership to embed positive behaviours. • Enable, our programme aimed at middle managers has been designed to develop caring, compassionate and inclusive leaders in the organisation. We aim to take over 1000 leaders through this programme over the next two years. • Improving Together QI Programme • Enhanced Clinical Effectiveness Programme • Electronic Prescribing • Real Time Vitals • CIP / Business Case QIA process • Career development conversations have been made available • Coaching and mentoring can be accessed via the West Midlands Coaching and Mentoring Pool • Cultural Improvement Programme • EDI to ensure UHNM is a great place to work	

How our Improving Together Programme Supports this KLOE	
Prompt	**Improving Together Programme**
3.6	**Whilst not yet in place, the infrastructure within the Improving Together programme will be across all levels and all disciplines in the hospital. The goal is to drive a coaching approach in leaders and provide a way of developing all staff to use approaches for performance management and improvement on a daily basis.**

Improvement Opportunities				
No.	**Improvement Opportunities**	**Exec Lead**	**Status Update - 2022 Priorities for Development**	**BRAG**
W3.1	**Conclusion of Brap / Roger Kline Review and development of plans / programme to address any issues**	CEO	Report concluded and published. Improvement Programme developed, approved and being delivered.	
W3.2	**Relaunch of Just and Learning Culture Tools with a focus on Restorative Practice**	CPO	Tools relaunched.	
W3.3	**Further embed Be Kind Behavior framework and civility and respect programme.**	CPO	Programme developed with timescales as part of Cultural Improvement Programme.	
W3.4	**Embed EDI Strategy into divisions, including introductoin of EDI divisional scorecard and EDI objectives.**	CPO	Strategy developed, delivery plan to be finalised.	

W4:	Are there clear roles, responsibilities and systems of accountability to support good governance and management?	2022 Assurance Rating
		Good

Lead Director / s:	Chief Executive	**Supported by:**	Associate Director of Corporate Governance, Chief Finance Officer and Chief Operating Officer
Lead Committee:	Audit Committee / Board	**Executive Group:**	n/a

What does 'Good' look like?

- **Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.**
- **The board and other levels of governance in the organisation function effectively and interact with each other appropriately.**
- **Staff are clear on their roles and accountabilities.**

Prompts

4.1	**Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?**
4.2	**Do all levels of governance and management function effectively and interact with each other appropriately?**
4.3	**Are staff at all levels clear about their roles and do they understand what they are accountable for and to whom?**
4.4	**Are arrangements with partners and third party providers governed and managed effectively to encourage appropriate interaction and promote co-ordinated, person centred care?**
4.5	**Are there robust arrangements to make sure that hospital managers discharge their specific powers and duties according to the provisions of the Mental Health Act 1983?**

Assurance Framework

Key Controls in Place	Key Sources of Assurance
• **Accountability and Performance Framework (updated August 2022) Highlight Reports now used throughout governance structure** • **Highlight Reports now used throughout governance structure** • **Revised Divisional structure in place** • **Revised Performance Management arrangements in place aligned with Improving Together** • **Integrated Annual Planning Cycle agreed** • **Effective Report Writing Training programme** • Board Assurance Framework 2022/23 • Corporate Governance Structure • Updated Rules of Procedure incorporating Code of Conduct for Board Members • Scheme of Delegation • Trust Policies and Procedures • Executive Groups Governance Pack (Terms of Reference and Membership) • Annual Effectiveness Review process for Committees / Executive Groups • Standards of Business Conduct Policy • Strategy and Transformation Group established with responsibility for oversight of strategic partnerships	• **2020 Internal Audit Review of Executive Governance Structure:** Concluded with Significant Assurance and Minor Improvement Opportunities, demonstrating the effectiveness of the revised governance arrangements • **Corporate Governance Report to Audit Committee:** sets out Declarations of Interest / Gifts and Hospitality – 100% compliance achieve for 2020/21 declarations • **Committee Effectiveness Review Report:** submitted to Trust Board June 2022 outlined feedback which was overall positive and actions identified to address areas for improvement. • **RAG rated business cycles:** considered at each meeting to enable monitoring of compliance / challenge of items deferred • **Divisional Board Effectiveness Review: assessing adherence to the Accountability Framework**

• Effective process in place for reporting through governance structure – 'Highlight Report' including items for escalation and positive assurances • Externally we have SLAs and contracts to manage partnership arrangements • Covid Governance arrangements • Focussed negotiation process as part of Improving Together • **Enhanced Divisional restructure, revised Job Descriptions which clarify roles, responsibilities and accountabilities** • **Senior Leadership Development** • **Revised Performance Review process** • **AD Corporate Governance on System Governance Group** • **New Clinical Effectiveness & Medical Workforce Group** • **Revised Charity and Digital Governance arrangements** • **Revised Accountability Framework** • **Digital Technology Assessment Criteria** • **Leading Medical Examiner process – also in Primary Care**	

How our Improving Together Programme Supports this KLOE	
Prompt	**Improving Together Programme**
4.1	**The infrastructure being developed brings principles such as reporting rules, process confirmation, root cause problem solving and standard work to operational practices, with the intention of driving consistency in systems and corrective improvement action where issues are identified. Status Exchange Conversations will drive proactive planning in a way that links Execs down to frontline teams. These conversations are rooted in the same domains as the strategy (the true north) making strategic intent a daily tactical conversation.**

Improvement Opportunities				
No.	**Improvement Opportunities**	**Exec Lead**	**Status Update - 2022 Priorities for Development**	**BRAG**
W4.1	**Review of our Accountability Framework aligned to our revised Divisional Structures and Performance Management Review process**	ADCG	Updated Accountability Framework completed; for Board approval September 2022.	
W4.2	**Further development of 'operational' elements of our Corprorate Governance Structure**	ADCG	Competed – updated structure approved by the Board in April 2022. Effectiveness Reviews of all Executive Groups undertaken.	
W4.3	**Development of Divisional Governance arrangements / effectiveness.**	COO / ADCG	Effectiveness Review undertaken – action plans under development.	

	W5:	Are there clear and effective processes for managing risks, issues and performance?	2022 Assurance Rating
			Good

Lead Director / s:	Chief Finance Officer	**Supported by:**	Associate Director of Corporate Governance, Chief Operating Officer, Director of Strategy & Transformation
Lead Committee:	Performance and Finance Committee	**Executive Group:**	

What does 'Good' look like?

- **There is an effective and comprehensive process to identify, understand, monitor and address current and future risks.**
- **Financial pressures are managed so that they do not compromise the quality of care. Services developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood.**
- **The organisation has the processes to manage current and future performance.**
- **Performance issues are escalated to the appropriate committees and the board through clear structure and processes.**
- **Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns.**

Prompts

5.1	**Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?**
5.2	**Are there processes to manage current and future performance? Are these regularly reviewed and improved?**
5.3	**Is there a systematic programme of clinical and internal audit to monitor quality, operational and financial processes and systems to identify where action should be taken?**
5.4	**Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?**
5.5	**Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?**
5.6	**When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?**

Assurance Framework

Key Controls in Place	Key Sources of Assurance
• Risk Management Policy in place incorporating Board approved Risk Appetite Statement • Risk Management Training programme • Introduction of responsibility for oversight of risk through Executive Groups • Divisional Risk Management SOPs in place • Board Assurance Framework • Integrated Performance Report to the Board • Highlight Reports to the Board / Committees and Executive Groups covering 'key risks to escalate' • Care Excellence Framework used to triangulate assurance of quality in clinical areas • Accountability and Performance Management Framework	• **Risk Management Audits:** undertaken quarterly to assess compliance with the Risk Management Policy with specific feedback reports to Divisions to aid improvements. • **Training records / feedback for Risk Management Training:** maintained centrally, with overall positive feedback. • **Annual Governance Statement 21/22:** approved by Audit Committee and Trust Board including key risks aligned to the Board Assurance Framework • **Clinical Audit Programme 21/22:** approved by Quality Governance Committee setting out audits of assurance against local priorities and national audit requirements • **Internal Audit of BAF and Risk Management:**

• System Winter Plan to mitigate risk of seasonal pressures, where appropriate partners from outside of the system are included, e.g. adult critical care escalation with SATH • Annual Internal Audit Programme agreed • Regular one to one meetings between key individuals and Executive leads • QIA process • **System Governance Network** • **Performance Management Review process now aligned to Improving Together Programme** • **Risk Reporting forms part of Performance Review Process** • **Operational Risks now better linked to Board Assurance Framework** • **Revised Performance Pack for Divisions** • **Revised 'alarm bell' risk report presented and considered at all Executive Groups** • **Revised Accountability and Performance Management Framework**	concluded with 'substantial assurance' for four consecutive years. • **Assurance Map – Improving Together:** Maps the governance and assurance against key metrics within the Improving Together Programme, agreed by Transformation and People Committee

How our Improving Together Programme Supports this KLOE	
Prompt	**Improving Together Programme**
5.3	**Part of the Divisional management system is to define the business rules that will govern the performance review meetings, ensuring management by exception and data driven focus. This system is fed by the management system deployed to frontline teams (again – early days of deployment, but the Divisions are agreeing their focus areas and business rules at the moment, which will support performance issue escalation). Divisions use structured problem solving templates to proactively report on the actions taken in relation to performance issues. This has already started.**

Improvement Opportunities				
No.	**Improvement Opportunities**	**Exec Lead**	**Status Update - 2022 Priorities for Development**	**BRAG**
W5.1	**Further development of risk management reporting to drive our agenda and to ensure effectiveness of our process, i.e. ensuring that risk management drives reduction in risk**	ADCG	New approach to reporting with the use of alarm bells now embedded into Executive Groups and Performance Reviews. Substantial Assurance given at latest Internal Audit and local audits are seeing continued improvement in quality of risk assessments.	
W5.2	**Risk Management Strategy**	ADCG	Combined with Risk Management Policy.	
W5.3	**Implementation of revised Performance Management Framework (driver / watch metrics)**	CFO	New Performance Management approach in place as BAU.	
W5.4	**Continue to improve risk management within Divisions.**	ADCG	This will form part of the divisional governance improvement programme.	

	W6:	Is appropriate and accurate information being effectively processed, challenged and acted on?	2022 Assurance Rating
			Requires Improvement

Lead Director / s:	Chief Finance Officer	**Supported by:**	
Lead Committee:	Transformation & People Committee	**Executive Group:**	Executive Business Intelligence Group

What does 'Good' look like?

- **Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Staff receive helpful data on a daily basis which supports them to adjust and improve performance as necessary.**
- **Integrated reporting supports effective decision making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people, with quality, operational and financial information.**
- **Performance information is used to hold management and staff to account.**
- **The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.**
- **Information technology systems are used effectively to monitor and improve the quality of care.**
- **Data or notifications are consistently submitted to external organisations as required.**
- **There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.**

Prompts

6.1	**Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?**
6.2	**Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information and challenge it appropriately?**
6.3	**Are there clear and robust service performance measures, which are reported and monitored?**
6.4	**Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, timely and relevant? What action is taken when issues are identified?**
6.5	**Are information technology systems used effectively to monitor and improve the quality of care?**
6.6	**Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?**
6.7	**Are there robust arrangements (including appropriate internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?**

Assurance Framework

Key Controls in Place	Key Sources of Assurance
• Accountability and Performance Management Framework • Annual Business Cycles for Board / Committee / Executive Groups covering a range of performance reports against quality / finance / operations / workforce • Business Intelligence Strategy • Executive Business Intelligence Group • Data Quality Strategy • Executive Data Security and Protection Group • Data Security and Protection Strategy and Framework • Committee Assurance Reports which focus on risks / positive assurances / key actions and decisions • Datix system used for Adverse Incidents, Complaints and Claims • Effective Report Writing Training Programme (including	• **Data Quality Audits** • **Internal Audit – Data, Security and Protection Toolkit:** • **Data Security Incident Investigations:** findings and lessons learned are reported to the Data Security and Protection Group • **Data Quality Kite Marks:** data used for reporting is subject to data quality Kite Mark assurance process to demonstrate its robustness and validity • **Care Quality Commission Insight Report:** regular interpretation and analysis undertaken with findings reported routinely to Quality Governance Committee • **Model Hospital Benchmarking** • **GIRFT Reviews and Reports**

reference to SPC use and SBAR summaries) • Improving Together Programme – 'A3's undertaken to identify key metrics for measurement and improvement • Review of external, national reports to extract learning • Review of Model Hospital, GIRFT, Right Care to understand variation and opportunities for improving • Information asset owners are trained and identified for IT systems • Electronic observations in use to help monitor patients conditions – excludes ED, Paediatrics and Maternity • **New Divisional Analysts** • **New capacity and demand model being rolled out** • **Data Quality Group with divisional engagement** • **New Head of Performance and Information** • **Health inequality data going to Board (ethnicity & deprivation)** • **Use of SPC to drive discussion** • **Public View allows benchmark data** • **Digital Strategy – looking to re-procure and consolidate digital systems as an ICB** • **Performance Review Process revised and aligned with Improving Together** • **Revised Performance Packs for Divisions used at Performance Management Reviews** • **Assurance Mapping now included within Board Assurance Framework** • **Other Assurance Maps produced, i.e. Improving Together, Culture, Maternity and Mental Health**	• **National and Regional benchmark reports** • **DPIAs:** undertaken on all IT / digital contracts to ensure data is processed correctly • **HIMSS assessment:** undertaken to understand any gaps in systems to help improve quality and safety of care • **Assurance Map now included in Board Assurance Framework**

How our Improving Together Programme Supports this KLOE	
Prompt	**Improving Together Programme**
6.1	**The Trust North is a balanced scorecard, across all domains of performance and this is replicated at all levels of the Trust through the management system scorecards. Each team runs performance review huddles to proactively measure their progress.**

Improvement Opportunities				
No.	**Improvement Opportunities**	**Exec Lead**	**Status Update - 2022 Priorities for Development**	**BRAG**
W6.1	**Ensuring divisional ownership of data**	CFO		
W6.2	**Development of a 'single point of information'**	CFO		
W6.3	**Switch to real time data input**	CFO		
W6.4	**Mobilisation of the Business Intelligence Strategy**	CFO		
W6.5	**Finalisation of our Assurance Map**	ADCG	Assurance maps produced for specific areas, i.e. maternity, culture. Assurance Map now included within Board Assurance Framework.	
W6.6	**Data Quality Team to undertake work on data definitions.**	CFO	To be delivered the the Executive Business Intelligence Group.	
W6.7	**Information Team to provide greater depth of analysis of data.**	CFO	To be delivered the the Executive Business Intelligence Group.	

	W7:	Are the people who use services, the public, staff and external partners engaged and involved to support high quality, sustainable services?	2022 Assurance Rating
			Requires Improvement

Lead Director / s:	Chief Nurse and Director of Communications	**Supported by:**	
Lead Committee:	Quality Governance Committee	**Executive Group:**	

What does 'Good' look like?

- **A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture.**
- **The service proactively manages and involves all staff (including those with protected equality characteristics) and ensures that the voices of staff are heard and acted on to shape services and culture.**
- **The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.**

Prompts

7.1	**Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?**
7.2	**Are people who use services, those close to them and their representatives actively engaged and involved in decision making to shape services and culture? Does this include people in a range of equality groups?**
7.3	**Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with protected equality characteristics?**
7.4	**Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population and to deliver services to meet those needs?**
7.5	**Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?**

Assurance Framework

Key Controls in Place	Key Sources of Assurance
• Monday Message, UHNM Bulletins and Covid Updates issued on a weekly basis to maintain staff engagement • Time to Talk sessions with the Chief Executive • Regular UHNM Live Facebook sessions with rotating attendance from Executive Directors • Patient and Public Engagement Strategy in place • Communication Strategy in place • Hospital User Group in place **with representation from both Health Watch organisations** • Values Recognition Scheme • Improving Together Programme • Culture and Leadership Programme • Reverse Mentorship Programme • Staff Networks in place (i.e. LGBT+, Disability and Long Term Conditions, Ethnic Diversity) • Equality Impact Assessment Process • Equality and Diversity Policy • Engagement with external partners including horizontal partnerships with other Trusts and within the ICS • Provider Collaborative, active engagement with the ICS / ICP / Health and Care Senate	• **Patient Stories to Trust Board:** a story is presented to the Board each month, which can be used to triangulate assurance with meeting papers and to identify areas for improvement • **Quarterly Patient Experience Report:** presented to Quality Governance Committee to demonstrate improvements made as a result of patient feedback • **Inpatient Survey Findings:** • **Staff Survey Findings:** in 2020, 45/7% of staff said they were involved in decisions on changes affecting their work areas (47% in 2019) • **Pulse Survey Findings** • **Equality, Diversity and Inclusion Reports** • **WRES Findings** • **WDES Findings** • **Gender Pay Gap Reporting**

• **Part of the system wide People and Communities Assembly giving access to key groups and influencers and an opportunity to share key developments at the Trust** • **Working with the system wide People's Panel to gain insight and feedback through surveys** • **Utilising the system-wide Intelligence Observatory to improve the range and depth of community engagement** • Regular meetings with local MPs • CEO meetings with public groups, e.g. Parkinson's Society • Annual public engagement on Quality Account • Stakeholder meetings with population to engage on service changes • Significant use of social media to inform and engage public • Positive relationships with media, regular press releases, TV and radio interviews to increase awareness and engage public • Live radio Q&A between CEO and public • System wide shadow NHS Board and ICP, also well-established Place Based Partnership Boards within Staffordshire and Stoke-on-Trent and UHNM have regular attendance • System wide Executive Forum which CEO regularly attends • Twice weekly system wide CEO informal catch up meetings • System Finance, Performance and Strategy meeting • UHNM CEO leading Provider Collaborative system work • **Equality Diversity and Inclusion Strategy** • **Members of the local Chamber of Commerce** • **CEO is ICB member** • **CEO Lead on Provider Collaborative** • **Use system patient and public forums** • **Executive Team engaged and leading on key ICS work streams / priorities** • **Numerous clinical networks - Pathology Network, Imaging, Renal, Trauma, Adult Critical Care, Cancer Network, MCHFT, SaTH** • **System wide approach to Occupational Health** • **SHREWD – System performance data** • **Wellbeing Walks - wellbeing of staff**	

Improvement Opportunities				
No.	**Improvement Opportunities**	**Exec Lead**	**Status Update - 2022 Priorities for Development**	**BRAG**
W7.1	**Development of our Engagement Strategy encompassing patients, public and key stakeholders**	DOC / CNO	Stakeholder map developed as part of Strategy Development Toolkit along with Stakeholder Reference Group.	
W7.2	**Approval of Equality, Diversity and Inclusion Strategy**	CPO	Strategy approved through governance structure.	
W7.3	**Further work to be undertaken on ensuring that the patient's voice is heard and taken into account more broadly.**	DOC / CNO	To be undertaken as part of the strategy development.	

	W8:	Are there robust systems and processes for learning, continuous improvement and innovation?	2022 Assurance Rating
			Requires Improvement

Lead Director / s:	Chief Nurse and Director of Strategy & Transformation	**Supported by:**	
Lead Committee:	Transformation and People Committee	**Executive Group:**	

What does 'Good' look like?

- **There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.**
- **There is knowledge of improvement methods and the skills to use them at all levels of the organisation.**
- **The service makes effective use of internal and external reviews, and learning is shared effectively and used to make improvements.**
- **Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.**
- **There are organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems and ways of sharing improvement work.**

Prompts

8.1	**In what ways do leaders and staff strive for continuous learning improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?**
8.2	**Are there standardised improvement tools and methods, and do staff have the skills to use them?**
8.3	**How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?**
8.4	**Do all staff regularly take time out together to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?**
8.5	**Are there systems in place to support improvement and innovation work including objectives and rewards for staff, data systems and processes for evaluating and sharing the results of improvement work?**

Assurance Framework

Key Controls in Place	Key Sources of Assurance
• Improving Together Programme with time out and training on improvement tools, methods and standard ways of working • **Updated Research and Innovation Strategy approved by the Board** • Participation in recognised accreditation schemes, i.e. breastfeeding friendly, menopause • Active involvement in GIRFT programmes • Learning from Deaths (mortality review process) in place • Internal Audit Programme in place • Clinical Audit Programme in place • Root Cause Analysis investigation process to identify lessons learned • Complaints investigation process to identify lessons learned • Staff Awards • Chief Executive Award • Daisy Award • Action Plans against Regulation 28 letters from the	• **Internal Audit Progress Reports to Audit Committee:** • **Quarterly Research Strategy Updates:** demonstrating progress against the Strategy to the Transformation and People Committee • **GIRFT Updates:** demonstrates progress made with recommendations arising from GIRFT reviews • **Quarterly Compliance and Effectiveness Reports:** demonstrate progress made with the Clinical Audit Programme and national audit participation • **Quarterly Mortality Report:** demonstrates latest HSMR/SHMI data along with findings of mortality reviews (and associated performance) • **Education Provider Progress Reports on learners:** for example staff on apprenticeships

Coroner • Submissions to external award schemes, e.g. HPMA / HSJ • Learning, Education and Community Engagement Five Year Strategy and Delivery Plans • Apprenticeship Levy target supports the development of our staff from both clinical and non-clinical • Learning Performance Indicators including National Education Training Survey • Trustwide Learning and Education Group meets quarterly and is responsible for the learning and education agenda • Adverse Incident Reporting Policy and Procedures • Risk Management Panel • Chief Nurse / Medical Director Bulletin on shared learning from incidents • Non-elective Improvement Programme Board • Trust Executive Committee • **Development and introduction of CenREE** • **Trust Board Seminars for strategy and development** • **Executive Director Away Days** • **Learning from national external investigations and reviews through gap analysis and development of action plans – monitored through Trust governance processes** • **Introduction of 'Shared Governance'** • **Establishment of Clinical Effectiveness Group**	

How our Improving Together Programme Supports this KLOE	
Prompt	**Improving Together Programme**
8.1	**This is the long term impact of the Improving Together Programme, building the infrastructure to develop a learning / improvement culture by developing capabilities and routines in the Trust. Lean training for the Centre of Excellence is externally accredited by the LCS.**
8.4	**Each frontline team will run daily improvement huddles, the divisions / specialities will run either weekly or fortnightly huddles to bring teams working on common problems together or coordinate efforts and share best practice.**

Improvement Opportunities				
No.	**Improvement Opportunities**	**Exec Lead**	**Status Update - 2022 Priorities for Development**	**BRAG**
W8.1	Trust wide roll out of Improving Together Programme	CNO	Underway with regular progress reports to Transformation and People Committee.	
W8.2	Refresh of Research and Innovation Strategy	MD	Strategy revised and approved by the Board.	

Quality Governance Committee Chair's Highlight Report to Board

1st December 2022

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• 54 incidents had been reported since the commencement of Your Next Patient, although there were no reports of patient harm and this information continued to be reviewed in terms of themes/trends. In addition, 3 formal complaints had been received • The risk regarding the supply chain of medicines continued to be highlighted, whereby the situation had deteriorated recently resulting in a number of critical medicines having been subject to supply chain issues. In addition, the risks regarding the sustainability of pharmacy staffing and the actions being taken were highlighted • The serious incident report highlighted that 40 Serious Incidents had been closed following discussion with the ICB although there remained 48 RCAs awaited by the ICB for review, reflecting the delays in completion of RCAs due to operational pressures. It was noted that the majority of serious incidents were related to patient falls. • The quality and safety report highlighted the continued reporting of never events and a deterioration in family and friends test recommendations, which was considered to be due to long waits etc. In addition the impact of Your Next Patient was being considered in terms of whether this had resulted in an increase in pressure ulcers and further clarity regarding this had been requested • Historically the Trust has not reported breaches in single sex accommodation for some time although critical care breaches were due to commence being reported, which would affect figures going forwards • The resuscitation annual report highlighted the increasing year on year demands within the team, whereby the increasing requirements for advanced resuscitation courses were also highlighted. The significant gaps identified within the report were recognised and options for addressing would be considered with the medical director.	• To include a metric within the next neonatal action plan report regarding the number of nursing staff starting and leaving so that this could be monitored • To consider the way in which the proforma for determining clinical harm endured by long waiters (RTT) could be expanded, to consider pain experienced by the patients. In addition, to consider how the long wait had impacted on personal circumstances • To confirm whether the risk associated with resuscitation had been included within the risk register • To provide an update on the actions required to address the risk associated with resuscitation training at the Committee in March 2023 • To bring the nutrition and hydration harm ambition to the next meeting
✓ Positive Assurances to Provide	**Decisions Made**
• The research update highlighted the positive progress made in taking forward a Sponsored Clinical Trial of Investigational Medicinal Product within paediatrics. In addition, the team was ahead of schedule in implementing the actions associated with the governance aims of the Research Strategy • An update was provided on the progress made in taking forward the actions associated with the Neonatal Mortality Action Plan. Because of staff illness, there had been delays in reviewing the escalation policy which was due to be consulted on during January 2023. • A number of risks associated with medicines optimisation were highlighted although changes in pharmacy staffing in the cancer centre had reduced the associated risk and the completion of the new Lloyds dispensing space had also resulted in the closure of the associated risk. Positive assurance had been received from the external radio pharmacy audit and results of national benchmarking had demonstrated an improvement in reporting of medication incidents although these remained below the national benchmark • A demonstration was provided on the Tendable System a digital auditing solution which had started to be rolled out throughout the Trust • The Safer Mobility Ambition was outlined to members, which had been developed with a number of stakeholders which focussed on improving safer and functional mobility as well as preventing deconditioning	• The Committee considered the assessment made into the appropriate review process to determine instances of actual harm for long wait patients and it was agreed to review all patients with completed pathways in addition to risk stratification of patients on incomplete pathways, based on clinical presentation, although this would be agreed with Divisions to ensure the benefit from the reviews outweighed the overall effort.

Comments on the Effectiveness of the Meeting

- The Committee welcomed the discussion held and the variety of items provided on the agenda. Members felt the discussion went well given the action to take items as read.

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Research and Innovation Update	BAF 1	9607 4 16504 9	✓	Assurance	7.	Tendable System Update	BAF 1	16	✓	Presentation
2.	Medicines Optimisation Report Quarter 2 2022-23	BAF 1	NEW 20 25050 12	✓ !	Assurance	9.	Safer Mobility Ambition	BAF 1	16	✓	Enclosure
3.	Neonatal Mortality Action Plan	BAF 1	16	✓	Assurance	10.	Long Wait Harm Reviews	BAF 1	16	-	Enclosure
4.	Your Next Patient	BAF 1	16	!	Assurance	11.	Resuscitation Annual Report			!	Enclosure
5.	Serious Incident Report Q2 2022/23	BAF 1	9783 12	!	Assurance	12.	Quality & Safety Oversight Group Assurance Report	BAF 1	16	!	Enclosure
6.	Quality & Safety Report – Month 7 22/23	BAF 1	16	!	Assurance	13.					

3. 2022 / 23 Attendance Matrix

No.	Name	Job Title	A	M	M	J	J	A	S	O	N	D	J	F
1.	Prof A Hassell	Associate Non-Executive Director (Chair)				Chair								
2.	Ms S Belfield	Non-Executive Director												
3.	Mr P Bytheway	Chief Operating Officer												
4.	Ms S Gohir	Associate Non-Executive Director												
5.	Dr K Maddock	Non-Executive Director												
6.	Mr J Maxwell	Head of Quality, Safety & Compliance												
7.	Dr M Lewis	Medical Director							GH					
8.	Mrs AM Riley	Chief Nurse	SM		SM									
9.	Mrs C Cotton	Associate Director of Corporate Governance	NH		NH	NH			NH	NH	NH			
10.	Ms S Toor	Associate Non-Executive Director												
11.	Mrs R Vaughan	Chief People Officer												

Attended | **Apologies & Deputy Sent** | **Apologies**

Maternity Quality Governance Committee Chair's Highlight Report to Board

23rd November 2022

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	• Improvements for antenatal and newborn screening were to focus on the timeliness of sickle cell and thalassemia screening, completion of outcomes on the S4N system and improved compliance to meet the threshold for barcode standards • Three new serious incidents were reported during the quarter, 2 of which were reported to Healthcare Safety Investigation Branch (HSIB) and 1 investigated by local Root Cause Analysis. Assurance was sought and provided on a number of actions arising from previous investigations, which had been completed. • The main challenges associated with Saving Babies Lives related to CO monitoring at 36 weeks although this had improved and was being monitored on a weekly basis • There continued to be low uptake in the completion of friends and family test and a texting service was being considered, in addition to the use of volunteers to encourage completion as well as the questions being asked by the Maternity Voice Partnership • The number of midwifery red flags remained a challenge, with escalation continuing to take place with community midwives. It was expected that by February the impact of the new midwives should result in a reduction of red flags, and the work being undertaken on induction of labours should reducing these further • It was noted that 96% of women on the delivery suite had moderate or high risk pregnancies, which therefore contributed to the stress and pressures being experienced by the maternity team • The challenges associated with the ability to recruit to the final number of midwifery staff were highlighted, and that this may take up to 12 months. A specific recruitment campaign was being planned as well as looking at the offer available for staff such as development, flexibility and career progression opportunities. It was noted that the externally funded maternity fixed term posts were subject to a separate business case which would be resubmitted in 2023	• To discuss the regional work on health inequalities with the maternity team to ensure consistency of approach • To provide the results of the audit of babies born under the 3rd centile and >37+6 weeks' gestation at a future meeting • To invite the Chair of the Maternity Voices Partnership to a future meeting • To determine the national reporting figures for maternity friends and family test • To provide a summary of the number of staff recruited, the outstanding number to be recruited which had received approval and the number to be recruited pending approval. In addition, to articulate the total number of midwives providing services pre covid compared to present • To share the presentation of the Vitality leadership programme with members • To share the outcome of the rapid quality review meeting with the Committee in due course
✓	**Positive Assurances to Provide**	**Decisions Made**
	• An update was provided by a newly qualified midwife who described the Preceptorship package in place which helped to support her and others to settle into their role whilst recognising the ongoing actions being taken as a region to standardise the approach to setting supernumerary times for future cohorts • Improvements were noted within the antenatal and newborn screening programme in particular maintaining levels at pre-pandemic levels and 100% compliance with infectious diseases screening. The Perinatal Mortality Report demonstrated that the Trust was fully compliant with CNST safety action 1 in terms of reviewing deaths in a timely manner and although the stillbirth rate had slightly increased this remained below the national average. • The Saving Babies Lives update highlighted the appointment of a tobacco lead and improvements made in the recording of smoking status. 100% of women with reduced fetal movements had received computerised monitoring and no women had been offered an induction of labour prior to 39 weeks for reduced fetal movements alone. The Committee welcomed the improvement in CTG training which had increased to 76% and was on trajectory to improve to 90% by December • The maternity dashboard highlighted improvements to fetal monitoring training and morbidity measures remained below the national average • The maternity workforce update confirmed that 22 newly qualified nurses had been added to establishment and a further business case was to be considered by the Performance and Finance Committee for the final 18 midwives and if approved it was hoped to commence recruitment of these by January	• No decisions were required to be made

Comments on the Effectiveness of the Meeting
• The importance of having a separate meeting was noted, given the items would not have been given sufficient airtime if discussed during the usual Quality Governance Committee meeting. Members welcomed the clear and easy to read reports.

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Midwife Story	BAF 1		Assurance	6.	Maternity Family Experience Report	BAF 1		Assurance
2.	Antenatal & Newborn Screening Programmes Annual Report 2021/22			Assurance	7.	Maternity Dashboard – Q2 22/23	BAF 1	13420, 11518, 13419, 15993, 16432	Assurance
3.	Maternity New Serious Incident (SI) Report Q2 22/23	BAF 1	15593, 13419, 23361	Assurance	8.	Midwifery Workforce	BAF 1/3		Assurance
4.	Perinatal Mortality Report Q2 22/23	BAF 1		Assurance	9.	Maternity Quality & Safety Oversight Group Assurance Report	BAF 1		Assurance
5.	Saving Babies Lives Care Bundle	BAF 1		Assurance	10.	Letter from NHS E, Reading the Signals East Kent Report	BAF 1		Assurance

3. 2022 / 23 Attendance Matrix

			Attended	Deputy Sent	Apologies Received	
Members:			**May**	**August**	**November**	**February**
Baroness S Gohir	SG	Non-Executive Director (Chair)	SB			
Mr P Bytheway	PB	Chief Operating Officer				
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				
Mrs C Cotton	CC	Associate Director of Corporate Governance		NH	NH	
Mrs R Vaughan	RV	Chief People Officer				

Executive Summary

Meeting:	Trust Board	**Date:**	7 December 2022
Report Title:	Quality Strategy Update	**Agenda Item:**	10.
Author:	Ann Marie Riley, Chief Nurse		
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

BAF1	*Various – linked to BAF 1 Delivering Positive Patient Outcomes*	*Extreme (16)*

Executive Summary

Situation

Our collective intent is to deliver 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.

Our new Quality Strategy, which was launched in June 2022, 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.

Background

Our Quality Strategy sets out four key priorities that have been co-created with our staff, patients and their carers which are underpinned by the latest evidence and research available.

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	• Safe • Effective	• Clinical effectiveness • Safety	• Prevent people from dying prematurely	• High quality • People • Improving and innovating
To deliver consistently safe and reliable care	• Safe • Effective • Caring • Responsive	• Safety • Clinical effectiveness	• Treat and caring for people in a safe environment and protect from avoidable harm	• High quality • Systems and partners
To prevent avoidable delay in patient assessment, treatment and discharge	• Safe • Effective • Responsive	• Safety • Patient experience	• Enhance quality of life for people with long term conditions	• 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	• Safe • Effective • Caring • Responsive	• Patient experience • Safety	• Ensuring people have a positive experience of care	• High quality • Improving and innovating

Assessment

The attached presentation highlights progress against Year One actions since the strategy was launched in May 2022. Key highlights to note:

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

- Establishment review completed for inpatient ward areas (with exception of the Children's Hospital) and theatres; working with finance to align budgets to rosters. Birthrate Plus assessment completed
- Corporate nursing managing healthcare support worker recruitment since May – vacancies reduced from 136.55wte (w/e 8 May 2022) to 33.36wte (w/e 2 October 2022)
- International nurse and midwifery recruitment continues to progress well. Bid being developed for a further cohort of 50wte to be recruited before April 2023
- NHSEI nursing and midwifery retention self-assessment tool completed in partnership with organisational development team
- Improving Together training continues in line with trajectory
- Chief Nurse has completed the Getting to Equity programme as planned. Currently also sponsoring two nurses external to the Trust from that programme and also a UHNM member of staff from the Research team to undertake the Developing Aspirant Ethnic Minority Nursing and Midwifery Leaders Programme

Priority Two: To deliver consistently safe and reliable care

- Nutrition and Hydration Ambition launched, Safe Mobility Ambition and Maintaining Continence Function Ambition in development with plan to launch in October 2022
- Digital Clinical Excellence audits via Tendable App ready to launch. Will commence at County in October 2022. Training for RSUH has commenced
- Clinical Excellence Framework (CEF) in the process of being refreshed with clear metrics required to achieve for Gold and Platinum ratings
- New post 'Lead for Vulnerable People' developed and recruitment in progress to oversee learning disabilities, mental health, autism, dementia and safeguarding across nursing, midwifery and children and young people
- Timely Observations now a Divisional driver metric and performance now presented to Quality Governance Committee
- Jamie Maxwell leading Patient Safety Learning Standards assessment – standards now received and in year 1 we will review corporate level data. We are also currently scoping opportunity to develop standards across our system - we will be the first system in the country to do this if agreed
- CeNREE: new structure in place; number of research awards secured; Alison Cooke now a Member of the CNO Research Transformation Leaders Network; UHNM now a member of the CoDH Clinical

Academic Roles Implementation Network (CARIN); research collaboration opportunities in development (Keele University/Staffs University/John Hopkins); Lead AHP role to be funded for 12 months –currently developing the job description

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

- Acute Patient Flow Group has identified five specialities where we have opportunity to reduce bed days
- Deep dive to review impact of ambulance holding and long waits in ED on skin integrity completed
- Clinical Effectiveness Group now established and work ongoing to develop and deliver annual Divisional Clinical Effectiveness Work Plans
- Red to Green dashboard developed

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

- We have developed a suite of annual patient priorities based on patient/carer feedback

Key Recommendations

The Trust Board is asked to note the transformation work achieved to date and support the transformational aspects of the Quality Strategy moving forward

Together Compassion Safe Improving

NHS
University Hospitals of North Midlands
NHS Trust

UHNM Quality Strategy

2022-2025

Improving Together: High Quality, Responsive, People, Improving & Innovating, Systems & Partners, Resources

Together Compassion Safe Improving

PROUD TO CARE

Quality Strategy 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.

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

Key initiatives	Year one objectives	Progress
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	All electronic roster ward based areas to have an establishment review factoring in acuity, environment and finance All theatres across the Trust to be included in the establishment review	Completed end August 2022
	Birthrate Plus assessment	Completed and business case presented to Execs 13 Sept with agreement in principle for phase 2 of the case
	All budgets aligned to the electronic roster	Reconciliation underway
Minimise the number of vacancies across all staff groups	Corporate nursing team to manage the recruitment of Band 2 and 3 healthcare assistants	In place
	Corporate nursing team to manage the recruitment of newly qualified registered nurses	In place
	To complete retention self assessment tool and develop appropriate action plan	Completed end August 2022
To roll out Improving Together as our organisational continuous improvement approach	To have trained the first 20 wards in the Operational Improvement System (OIS)	Training to be completed by Mar 2023
	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	Training to be completed by Mar 2023
	To have introduced the OIS across the full value stream of Elective Surgery at County site	Training to be completed by Mar 2023

Priority 2:To deliver consistently safe and reliable care

Key initiatives	Year one objectives	Progress
Develop a suite of harm free care ambitions that will set out clear improvement priorities	Develop suite of harm free care ambitions and deliver year one milestones	Nutrition and Hydration Ambition launched August 2022 Safe Mobility Ambition and Maintaining Continence Ambition in development (launch planned Q4). Working collaboratively with John Hopkins Hospital re mobility goals ePMA project progressing as planned
Implement a Trust Wide digital audit programme to measure the quality of care delivered to our patients	Implement digital Clinical Excellence Audit (CEA) programme	Rollout schedule agreed – launch commenced at County in September 2022, phased training planned for RSUH
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	Discussion with IT has taken place –in hold as a corporate project In progress -collaborating with NUH and Bradford to support peer benchmarking In progress as above –to be completed by end Q4
Work in collaboration with Patient Safety Learning (PSL) to complete Safety Assessment at UHNM	Complete assessment tool and develop year one action plan	Toolkit now available –UHNM first organisation to obtain the standards pack. Corporate self assessment will be the aim for year 1 and this commences September 2022 Opportunity to be first in the country to work with PSL to co-develop standards for use across ICS
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	28 NMAHPs currently receiving support from CeNREE (from AC/KL) Structure clear –incorporating research, education, lead AHP, lead ACP, Chief Nurse Fellowship Scheme and Legacy Mentors

Priority 2:To deliver consistently safe and reliable care (cont'd)

Key initiatives	Year one objectives	Progress
	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	Two successful prestigious NIHR PCAF awards (£108,000) One successful Cystic Fibrosis Trust fellowship award One successful North Staffs Medical Institute Award (£8000) One successful WM CRN Personal Development Award Stepping Stone Award to UHNM staff member (£5000) Successful research symposium Internship Invitations as external speaker (AC) Member of CNO Research Transformation Leaders Network (AC) UHNM now a member of the CoDH Clinical Academic Roles Implementation Network (CARIN) Research collaborations emerging (John Hopkins, Keele and Staffs Universities) Processes under review for research and CPD

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

Key initiatives	Year one objectives	Progress
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 In collaboration with system partners to develop Excellence in Discharge programme	Completed Lead identified, work to commence in partnership with MPFT (date TBC) WS2 - 5 specialities identified to achieve optimal bed days in line with peers –reduction in bed day opportunity in brackets • Respiratory (1122) • Gastro (1187.2) • T+O (970.5) • Vascular (122.5) • Gynae (235.4)
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 UHNM to take over the front door assessment of patients from Vocare	Completed

Priority 4 :To ensure that our patients have access to services and/or treatments that meets their needs and delivers positive outcomes and experiences

Key initiatives	Year one objectives	Progress
Strengthen our patient/public voice and ensure we maximise opportunities for co-production across our improvement portfolio	Develop co-produced annual patient priorities based on patient/carer feedback	Priorities identified. Work underway to support co-production of countermeasures Scoping ability to develop a patient partnership model Working with Communication Team to produce a Patient and Public Involvement and Engagement Strategy

Executive Summary

Meeting:	Trust Board	**Date:**	7th December 2022
Report Title:	Maternity New Serious Incident (SI) Report Quarter 2 (1st July – 30th September 2022)	**Agenda Item:**	11.
Author:	Donna Brayford, Deputy Director of Midwifery - Governance		
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**	✓	Improving Together		
Responsive	✓	**Improving & Innovating**	✓	**Resources**	✓			

Risk Register Mapping

15593	*Maternity Assessment Unit Triage*	*High (10)*
13419	*Midwifery Safe Staffing*	*High (12)*
23361	*Number of open adverse incidents and root cause analysis investigations*	*High (12)*

Executive Summary

Situation

This report provides a summary of the numbers and types of serious incidents reported by Maternity during Quarter 2 (2022). As of the end of Q2, maternity have 14 ongoing serious incidents (including new incidents).

Investigation in progress: 7 serious incidents (5 local Root Cause Analysis, 2 Healthcare Safety Investigation Branch Investigations, 0 Perinatal Mortality Review Tools).

Investigations completed/awaiting to be presented and closed by Risk Management Panel and ICB SI Group: 7 incidents.

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 Q2 - 3 new serious incidents were reported:

July	2022	1 incident
August	2022	1 incident
September	2022	1 incident

Category of Incidents:

2 Healthcare Safety Investigation Branch (HSIB) investigation.
1 new incident to be investigated by local Root Cause Analysis (RCA).
0 new incident investigated by the Perinatal Mortality Review Tool (PMRT).

Immediate Actions:

- Rapid review of the case identified that outdated WHO pre-operative checklists were in circulation within the maternity unit. All Managers advised to ensure that outdated checklists are removed from clinical areas. WHO checklist question to be reviewed to include time.
- New neonatal resuscitation record implemented.

Areas of concern/escalation:

There is a delay in the investigation of SI incidents due to current unit activity and staffing levels.

Key Recommendations

The Trust Board is asked to receive and note the report. In addition, the Board is asked to note that future reports will include a timeline of the actions completed (Ockenden Final Report states all actions following a serious incident should be completed with in 6 months). The maternity team will also provide assurance of how system changes have been successfully embedded in practise. The data displaying the ethnicity of the mothers involved in serious incidents now considers the local population breakdown so then can clearly identify trends of racial inequality.

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.

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.
- **Tocolysis -** medications used to suppress premature labour.

Contents

1. New Serious Incidents

Maternity have reported 3 serious incidents during Q2 (2022), July (n= 1), August (n = 1) and September (n = 1). 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 description	Immediate Actions	Outcome	Expected date at ICB SI Review Group
2022/21120	280800	• Early Neonatal Death. • No immediate care issues identified.	• Verbal and Written DOC. • HSIB referral and investigation. • Staff debrief and support implemented.	• Neonatal Death	Stop the clock
2022/19278	279197	• There appears to have been a missed opportunity to commence therapeutic cooling on a baby that met the therapeutic cooling critieria.	• Verbal and written DOC completed. • HSIB Investigation. • NHS Resolutions informed. • Implementation of new neonatal resuscitation record.	• Baby discharged home.	Stop the Clock
2022/16520	276797	• Potential unnecessary Emergency Caesarean section performed.	• Verbal and Written DOC. • Local RCA commenced. • Rapid review of the case identified that outdated WHO pre-operative checklists were in circulation within the maternity unit. All Managers advised to ensure that outdated checklists are removed from clinical areas. • WHO checklist to be revised to include time of USS.	• Well Mum and Baby	26.10.22

2. Current Serious Incidents in progress

Maternity have 7 ongoing serious incidents (including new incidents).
Investigation in progress: (5 local RCA, 2 HSIB, 0 PMRT).

SI ID	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at CCG meeting
2022/5507 RCA Investigation in progress	265355	• Eye abnormality appears not to have been identified at the NIPE examination.	• RCA investigation commenced. • Plan to consider introduction of annual competancies for staff undertaking NIPE examinations.	•The baby is receiving ongoing monitoring.	June 22 To be presented to the directorate in December.
2021/24638 RCA Investigation in progress	259191	• Maternal Death, post-partum, Covid positive	• Verbal and written DOC completed • Safety netting advice to include increased risk factors such as ethnic minority and increased BMI.	• Local RCA in progress.	March 2022 To be presented to the directorate in December.
2022/2564 RCA Investigation in progress	264052	• Term Intrapartum Stillbirth • Deviation from ASQUAM guideline for screening and investigation of the small for gestational age fetus.	• 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.	• PMRT Completed. Local RCA investigation in progress.	4.5.22 To be presented to the directorate in December.
2022/12601 RCA Investigation in progress	274130	• Drug error	• Joint Obstetric/Haematology Clinic agreed to document all management plans on K2 Maternity Electronic records. • Obstetric VTE Guidelines for immediate review inline with RCOG. • Training session to be prepared for Junior medical staff. • Shared learning with Emergency Department.	• Acute pulmonary embolism.	13.9.22 To be presented to the directorate in December.

Investigations completed/awaiting to be presented and closed by Risk Management Panel and CCG SI Group: 7 incidents.

SI ID/ Date on STEIS	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at ICB meeting
2021/16264 HSIB	250418	• Neonatal Death.	• HSIB referral completed. • Verbal and written Duty of Candour completed • Immediate staff de-brief performed. • No further immediate safety actions identified.	• HSIB investigation completed. • UHNM PMRT review completed. Score allocated C+B+A	Awaiting Closure by ICB.
2022/ 2860	259586	• Post-partum care following an ante-natal Stillbirth. • PMRT Completed – care of the mother following the death of her baby was scored a 'C (care thay may have made a difference to the outcome).	• 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.	• PMRT review completed. • Local RCA investigation Completed	Awaiting to be presented to RMP 9.12.22
2022/5764	256167	• Neonatal death	• 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 the UHNM in utero transfer process.	• Round table meeting held to discuss UHNM process for in utero transfer • A post natal review appointment has been arranged for the parents	Awaiting closure by ICB.
2022/12612	267616	• Neonatal Death. • Triage Telephone call to the Maternity Assessment Unit (MAU) prior to admission answered by a Midwife, incorrect advice given to mother.	• Verbal and Written DOC completed. • Professional Midwifery Advocate to support Midwife in restorative supervision. • To implement a teaching session 'Reducing Preterm Birth' related to	• Neonatal Death	13.9.22 Awaiting to present to RMP.

SI ID/ Date on STEIS	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at ICB meeting
			prediction and prevention of preterm labour as outlined in Saving Babies' Lives Care Bundle. All staff to be emailed to access eLearning for healthcare module.		
2022/14402	270536	• Neonatal Death at another provider • Missed opportunity on MAU to perform full booking history with an interpreter. • Missed opportunity to admit the mother on first admission to MAU. • Delay in fetal medicine ultrasound.	• Multidisciplinary team meeting planned to clearly identify actions • Memo sent to all staff re-iterating that all staff must use interpreters for mothers who do not speak/understand English. • All ward managers asked to check correct information available for translation services and displayed. • To discuss daily at safety huddle	• Neonatal Death	30.9.22 Awaiting to present to RMP.
2021/23088 HSIB investigation in progress	257852	• Healthcare Safety Investigation Branch (HSIB) Referral. • Maternal Death.	• 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.	• HSIB Report completed. • Presented at Coroner's Inquest. • Permission given by family to share mother's story for learning.	Awaiting Closure by ICB.

SI ID/ Date on STEIS	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome	Expected date at ICB meeting
			• Implementation of standard COVID documentation template for vaccination discussion at each contact.		
2022/12317	272993	• Ante - partum Stillbirth. • Breach in triage assessment.	• Verbal and written DOC completed. • The MAU Manager has reiterated to all staff the importance of activating the escalation process when the unit is experiencing high levels of activity. • Recruitment of 5.7 WTE telephone triage midwives is now completed.	• Antepartum stillbirth.	9.9.22 Awaiting approval by RMP 9.12.22

3. Serious Incidents closed during Q2 – Learning and Actions

2021/19762 Neonatal Death						
No	**Learning identified**	**Action**	**Action status**	**Responsible**	**Date for completion / update**	**Completed date & evidence**
1	The mother was de-escalated to the Ante-natal Ward from Delivery Suite without consultant review.	a) Delivery Suite Staffing Guideline amended to include 'All mothers whose care is de-escalated from delivery suite to the Ante – natal Care should be seen by the Consultant Obstetrician on – call'. b) Follow up audit to be completed in 6 months to ensure practise is embedded.	a) Complete b) To be completed	a)Clinical Director b)Directorate Auditor	23.6.22 January 2023	a)23.6.22
2.	The Consultant was not present on the delivery suite ward round.	a)Delivery Suite Staffing Guideline to be amended to include – mandatory consultant led ward round to be completed twice daily at 9 am and 8:30 pm. b)Monthly Audit to be completed of Consultant Presence to provide assurance of guideline.	a) Complete b) Monthly	a) 30 June 2022 b)To be completed monthly		a) 30.5.22 **b**) Monthly
3.	The midwives report they were unaware of the concerns.	a)Implement advocate tool for mothers during inpatient stay or receiving care in the community. b) To audit and evaluate use of advocate tool for mothers in 6 months	a)Complete b)To be completed	a) PMA and Maternity a) PMA/MVP	Monthly	November 2022
4.	Escalation tool for Staff	a)UHNM to be part of Pilot for improving clinical escalation – Each Baby Counts Project b)Implementation of PACE – assertiveness tool as part of the project.	Commences November 2022	a)Consultant Obstetrician b)DDOM	November 2022	

2021/19485 **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.** **Joint learning implemented with ED/ GP**						
No	**Learning identified**	**Action**	**Action status**	**Responsible**	**Date for completion/ update**	**Completed date & evidence**
1	Audit of women identified who have received ondansetron in the first trimester of pregnancy	a) DOC letter sent to all affected women. Anomaly scan offered to all women under 20 week's gestation. Follow up of all women post-delivery to ensure that babies not born with affected palates. No further cases identified b)Audit findings to be shared with ED and GP. c)Follow up audit to ensure learning embedded in practise.	a)Completed b)Completed c)Completed			a)October 2021 b)March 2022 c)January 2023
2	ED identified as the location with the highest number of incidents.	Omnicell dispensing system alert to ensure pregnancy and ondansetron alert is activated.	Completed			May 2022

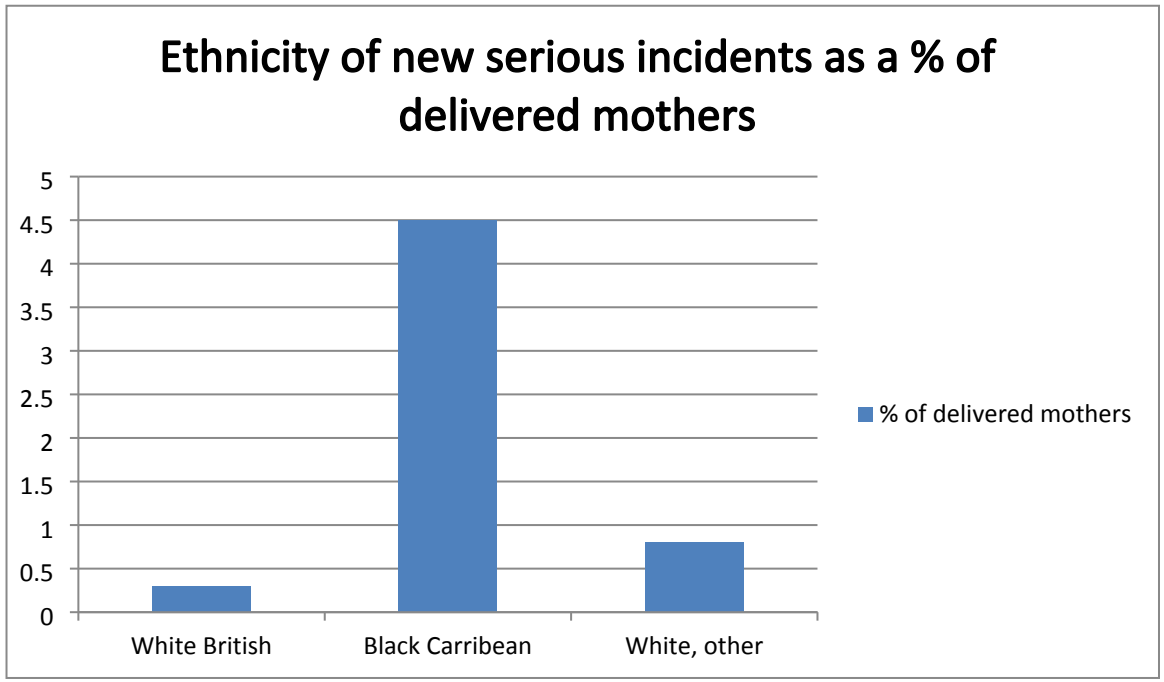
2022/5591 Baby dropped on the postnatal ward.						
No	**Learning identified**	**Action**	**Action status**	**Responsible**	**Date for completion / update**	**Completed date & evidence**
1	Deep Dive Audit completed to identify themes from all babies dropped over the last 2 years.	a)Dropped Baby Risk assessment developed and implemented. b)To repeat audit in 12 months.	a)Complete b)To be completed	a)DDOM/ Ward Manager. b)Clinical Educator		a)Complete June 2022 b)Planned for June 2023
2.	Debrief not completed following incident	Implement STOP 5 Hot Debrief Tool	Complete	DDOM		September 2022

4. Current HSIB Cases

2 Current HSIB cases ongoing

5. Serious Incidents 1st October 2021- 30th September 2022- classed by ethnicity.

This information will be used to inform future actions.



University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board	**Date:**	7th December 2022
Report Title:	Infection Prevention Board Assurance Framework	**Agenda Item:**	12
Author:	Helen Bucior, Infection Prevention Lead Nurse		
Executive Lead:	Mrs Ann-Marie Riley, Chief Nurse/DIPC		

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

BAF 1	Delivering Positive Patient Outcomes	**Ext 16**

Executive Summary

Situation
To update the Board on the self-assessment compliance with NHS England Infection Prevention and Control Board Assurance Framework version (BAF) V1.11

Background
The UKHSA guidance was archived at the end of April 2022. The proposal is that the National Infection Prevention Manual combined with this version of the Board Assurance Framework will support this transition

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 has in place and action and interventions required.

Highlighted in yellow are gaps in assurance or controls

Assessment/risks
- FFP3 resilience principles review – paper submitted to November IPCC
- Cleaning standards work continues
- Assurance for isolation of clinically immunocompromised in ED and general wards
- Mask fit staff to two or more models of UK made FFP3 masks
- Transfer of FFP3 mask fit testing document from Health roster to ESR
- UHNM has a IP Q+A manual which is available on Trust desk top for easy access

Progress
- External company continues to assist with mask fit testing
- Estates and IP are exploring air scrubber technology

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.

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Infection Prevention and Control Board Assurance Framework

November 2022

Delivering Exceptional Care with Exceptional People

Summary Board Assurance Framework

Ref / Page	Requirement / Objective	Risk Score					
		Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Change
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	Low 3			↓
BAF 2 Page 8	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Mod 6	Mod 6	Mod 6			→
BAF 3 Page 14	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Mod 6	Mod 6	Low 3			↓
BAF 4 Page 17	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			→
BAF 5 Page 20	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			→
BAF 6 Page 25	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	Low 3			→
BAF 7 Page 27	Provide or secure adequate isolation facilities.	Low 3	Low 3	Low 3			→
BAF 8 Page 29	Secure adequate access to laboratory support as appropriate	Low 3	Low 3	Low 3			→
BAF 9 Page 32	Have and adhere to policies for the individual's care and provider organisations that will help to prevent and control infections	Low 3	Low 3	Low 3			→
BAF 10 Page 34	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	Low 3	Low	Mod 6			↓

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:	3	2	1			There are a number of controls in place. UHNM Risk assessment are in place where deviation from regional COVID guidelines and testing recommendations	Likelihood:	1	End of Quarter 4
Consequence:	3	3	3				Consequence:	3	
Risk Level:	9	6	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:				
1.1	Systems and processes are in place to ensure that: • A respiratory plan incorporating respiratory seasonal viruses that includes: ○ Point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services ○ Segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g. clinically	• UHNM use PCR testing for patients suspected to have respiratory infection - Laboratory24 hour service • A number of rapid PCR is result is available when required • Triage system in place in ED , use of single rooms with doors for those suspected or confirmed respiratory infection • On arrival to ED patients are immediately identified either asymptomatic for COVID -19 symptoms and infection prevention precautions applied. • ED navigator in place • Aerosol generating procedures in single rooms with doors closed • Major's resuscitation area for all patients	• COVID outbreak • DATIX • Monitoring COVID patient numbers at UHNM for any increase in cases • Monitoring the number of COVID outbreaks for any increase • 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	• Although rapid PCT testing option in place for situations where a rapid results would benefit , trust re visit POCT options • Assurance from Emergency portal and wards re isolation of the clinically vulnerable

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	immunocompromised. ○ A surge/escalation plan to manage increasing patient/staff infections.	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. • Patients are asked to wear face covering/mask • Extremely vulnerable patient placement in COVID ward round guidance and IP Q+A manual • COVID screening guidance includes COVID screening for the immunocompromised • Incident Control Centre (ICC) • Major incident plan • Surge plan • Weekly clinical Group • Tactical group structure in place, meetings currently paused. COO stands up group when required. • COVID Gold command , decisions /assurance report to Trust Board via CEO/COO • Daily COVID report , inpatient status, COVID related staff absences • Demographic and Health responsive staff	and benefits, and programme 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. • 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  COVID19RRGOVERNANCE NOV20v1.pptx measures	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	○ A multidisciplinary team approach is adopted with hospital leadership, operational teams, estates & facilities, IP teams and clinical and non-clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan. • Organisational /employers risk assessments in the context of managing infectious agents are: ○ Based on the measures as prioritised in the hierarchy of controls. ○ Applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ○ Communicated to staff. ○ Further reassessed where there is a change or new risk identified e.g. changes to local prevalence.	risk assessment -COVID risk assessments • Isolation of suspected or Confirmed infectious patients • Advised window opening for a minimum of 10 minutes per hour • Cleaning of work station remains/cleaning of the environment • Down time for areas undertaking AGP's  ventilation-air-changes-per-hour-2021-06 • COVID 19 prevalence rates discussed at weekly clinical group although difficult due to no community testing and screening as per low prevalence guidelines. • Updates are via UKHSA • Maintain routine wearing of face masks in all clinical areas and corridors. • FFP3 masks when caring for confirmed or highly suspected COVID 19 patients and AGP's with patients with infection transmitted by the respiratory route or unknown infectious status • Patient mask wearing where tolerated by patient • Corporate and local risk assessments • Risk assessment policy and template • Risk assessment through COVID governance	• Audit programme • Datix /inappropriate transfers • 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**
• The completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems. • 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 the infectious agents. • Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons. • Resources are in place to monitor and measure adherence to the NIPCM (national infection prevention and control manual). This must include all care areas and all staff (permanent, flexible, agency and external contractors). • The application of IP practices within the NIPCM is monitored. • The IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level. • The Trust Board has oversight of incidents/outbreaks and associated action plans	• COVID care plan • Transfer policy • IP Q+A manual • Audit programme • Matrons walk round • Agenda item Trust Board • National definition of outbreak in place • Outbreak meetings • Outbreak areas included in daily tactical information • Definite Nosocomial COVID 19 numbers are included in Quality performance report • Nosocomial Death review process		• Patients moved on occasions to manage operational pressures and release available capacity

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	• The Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.	• A number of mask models are available, however, further work is required to ensure staff are fitted on 2 models of FFP3 masks – see criteria 10	• Staff training records • Procurement – mask usage	

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 3 Progress Report	BRAG
1	1.1	Segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g. clinically immunocompromised	Matrons/IP	February 2023	November 2022 – to explore gaining assurance around segregation of clinically immunocompromised from emergency portals and wards	
2	1.1	To revisit POCT testing options	Laboratory	February 2023	November 2022 – Although rapid PCR option in place for situations where rapid response is required, to revisit PCOT options and reliability. It is vital that the tests are POCT are accurate.	
3	1.1	Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons.	DIPC	February 2023	Patients moved on occasions to manage operational pressures and release available capacity. Cases discussed with DIPC /IP Team. Risk assessment in place to mix COVID contacts with similar dates. To revisit risk assessment  Risk Assessment COVID IPC reducing	

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	2	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 4 2022
Consequence:	3	3	3				Consequence:	3	
Risk Level:	6	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	Systems and processes are in place to ensure that: • 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. • The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room • Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment. • Enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained. • Manufacturers' guidance and recommended product	• Currently The Royal PFI Operating to 2002 standards • Currently Royal retained and county Operating to 2007 standards • A multi-disciplinary Cleaning Standards Group established to work through the implications of the new standards and identify the actions needed to achieve compliance and any resource requirements • SOP and cleaning method statements for cleaning teams • High level disinfectant , Virusolve and Tristel in place and used for all decontamination cleans	• 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	• Implementation of National Standards of cleanliness 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

	'contact time' is followed for all cleaning/disinfectant solutions/products.
	
	• For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in:
	  ○ patient isolation rooms
	  ○ cohort areas
	  ○ donning & doffing areas – if applicable
	  ○ 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley
		• Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual available on all Trust desk top
		• Process in place for clinical areas with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans
		• 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
		• Responsibility framework
		• Who cleans what posters
		• IP Q+A manual - bed cleaning posters
		• IP Q+A manual - decontamination
		• Use of Medical Device/equipment policy MDM02
		• Terminal clean process
		
		• Audit process
			reviewed by joint CPM / Sodexo/EFP group and action plan completed if needed.
			
			• 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
			
			• Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %.
			
			• IP unannounced	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
rails. ○ where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea and/or vomiting. • The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness • A terminal clean of inpatient rooms is carried out: ○ when the patient is no longer considered infectious ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). ○ following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). • Reusable non-invasive care equipment is decontaminated: ○ between each use ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment. • Compliance with regular cleaning regimes is	• IP Q+A manual - decontamination • Use of Medical Device/equipment policy MDM02	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 between scheduled / barrier cleans. • 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. • IP audits held locally by divisions • Datix reports/adverse incident reports • IP Audits • Clinical cleaning schedule records	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	monitored including that of reusable patient care equipment.			
2.2	• Ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/ • Ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible. • where possible air is diluted by natural ventilation by opening windows and doors where appropriate	• 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 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	• 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.	• Work in progress to explore technology

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		ventilation-air-changes-per-hour-2021-06 • 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 • Most wards have mechanical ventilation in core areas and natural ventilation in bays e.g. window opening • Estates and IP are exploring air scrubber technology • IP and Estates are compiling a list of high risk area and current air changes. This work will then extend to other general inpatient areas.		

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 3 Progress Report	BRAG
2	2.1	Review of cleaning standards	Divisions Facilities/ACN	12/11/2021 31/12/2021 End of quarter 1 2022	July 2022 Discussion and agreement with NHSEI the dismantling of beds to the level undertaken during the CPE would be considered during planned deep cleans/ ward refurbishments and continue with standard and terminal clean process as usual.	
	2.1	Plan for implementation of National Standards of cleanliness 2021	Facilities/Estates PFI	Quarter 4 22/23	A multi-disciplinary Cleaning Standards Group established earlier this year ,including representatives from retained estate, CPM, Sodexo and Infection Prevention to work through	

					the implications of the new standards and identify the actions needed to achieve compliance and any resource requirements. Options analysis paper submitted against the 2021 standards. The Trust are pursuing option 2 which is the implementation of the National Standards of Cleanliness 2021 and the business case is awaiting formal approval On review of all options it has been noted that Option 2 will align all operational processes to allow us to achieve full compliance with the 2021 standards and comparison of cleaning standards will be easy to track via the prescribed star rating system. There will be defined responsibility for cleaning across all disciplines with consistency of approach across the Royal and County sites. There is a need for further work to conclude in respect of quantifying the Nursing elements	
	2.2	To explore alternative technologies to enhance ventilation in bays that have natural ventilation	Infection Prevention Team/Estates	January 2023	IP and Estates are compiling a list of high risk areas and current air changes for these areas. This work will then extend to include other general inpatient areas and current air changes. IP and estates are exploring new technology to improve air quality e.g. UV light technology	

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	2	1			Antimicrobial prescribing is reviewed by ward pharmacy teams on each drug chart review. The AMS team also undertakes targeted ward rounds in clinical areas where the monitoring of antimicrobial consumption indicates areas may need additional support. The AMS team are contactable by clinicians requesting advice re: optimising antimicrobial therapy and this may include escalation to duty Consultant microbiologist if necessary	Likelihood:	1	End of Quarter 1 2023
Consequence:	3	3	3				Consequence:	3	
Risk Level:	6	6	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:				

3.1	• arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated
	• NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented – Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use
	• the use of antimicrobials is managed and monitored:
	  • to optimise patient outcomes
	  • to minimise inappropriate prescribing
	  • to ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus are followed
	• contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including:
	  • total antimicrobial prescribing;
		• Regular, planned Antimicrobial stewardship (AMS) ward rounds
		• Formal lead is the Lead Consultant Microbiologist supported by the Advanced Pharmacist Practitioner- ID & Antimicrobials
		• Trust antimicrobial guidelines available 24/7 via intranet and mobile device App
		• Antimicrobial action plan in place
		• Clostridium-*difficile* Period of increased incidence and outbreaks are reviewed by member of AMS team and actions generated cascaded to ward teams
		• Regional and National networking
			• 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 /	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	• broad-spectrum prescribing; • intravenous route prescribing; adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources • • Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors).	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 • Regular meetings held between commissioners, Trust leads and AMS team to monitor compliance with contractual reporting requirements. CQUIN compliance reported to IPCC • Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM • Reintroduction of point prevalence audits as the Trust comes out of pandemic pressures. Results will be made available to divisional teams and support provided by AMS team to optimise prescribing of antimicrobials.	advice enabled via regional and national networks for challenging cases where additional expert advice around optimal choice of antimicrobials is needed • Trust and commissioners require timely reporting on compliance with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews generating action plans for ward teams. •	

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 3 Progress Report**	**BRAG**
1						

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	1	1			There is a substantial amount of information available to provide to patients this requires continuous update as national guidelines change	Likelihood:	1	
Consequence:	3	3	3				Consequence:	3	
Risk Level:	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:			
4.1 Systems and processes are in place to ensure that: • IP advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use • Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • National principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. national guidance on visiting patients in a care setting is implemented. • Patients being accompanied in urgent and	• Posters and signage in place • Mask available at hospital entrance • Information available on Trust internet site • 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 not have to be the same two visitors. • UHNM visiting information	• 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**
	emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice. • Restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives.	public internet site  Visiting at UHNM internet site.docx • Outbreak management • Discussed at outbreak meeting		
4.2	• There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment.	• Posters and signage in place • Mask available at hospital entrance • Visitor to wear mask unless except • At UHNM FFP3 is recommended for all contact with COVID or high suspected COVID patient	• Monitored by clinical areas • PALS complaints/feedback from service users • Outbreak meetings	
4.3	• If visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE. • Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a	• PPE available • Clinical area to advise visitor • Support from IP Team and Consultant Microbiologist when required	• Monitored by clinical areas • PALS complaints/feedback from service users • Outbreak meetings • 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**
	risk assessment may be undertaken, and mitigations put in place to support visiting. • Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.	• Information available on COVID intranet page • Advice from IP Team and Consultant Microbiologist Infection Prevention triage desk which provides advice and support to clinical areas		
4.4	• Implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	• Resources reviewed • Implementation of a number of controls e.g. staff well being	• Audits • Staff feedback • PAL/complaints - feedback	

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 3 Progress Report**	**BRAG**

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									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1			Arrangements are in place to ensure the screening of patients in line for National guidance. – COVID testing in periods of low prevalence. To continue to reinforce COVID screening protocol.	Likelihood:	1	
Consequence:	3	3	3				Consequence:	3	
Risk Level:	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	Systems and processes are in place to ensure that: • all patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients). • Signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM).	• **COVID Testing** C1662_covid-testing -in-periods-of-low-pre • Routine asymptomatic testing in a number of setting will pause 31st August 2022 • High – risk patient identified for COVID19 MAB and antiviral treatment - PCR • Admission to high risk area at UHNM(Haematology, oncology, real wards Critical care, ward 222, SSCU and PICU) • Symptomatic patients for clinical diagnostic pathway	• 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
		• Symptomatic or immunococompromised patients who are admitted as an emergency or maternity care • Symptomatic or immunocompromised elective care patients prior to acute day case/overnight pre-admission • Transfer into or within hospital for immunocompromised patients • Discharge patients to care home/hospices • Outbreak testing in healthcare settings  uhnm-guidance-on-testing-and-re-testing  elective-and-planned-admission-covid-19-f  emergency-and-non-elective-admissions-c • • Signage in place - instruction for patients if they have symptoms of infection • Screening questions ED		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
5.2	• The infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement • Triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated. • Patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated. • Patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite). • Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available.	• Transfer policy • COVID screening for patients discharged to Nursing /Care homes • Process in place for screening and cohorting COVID contacts exposed during inpatient stay • COVID contact areas reviewed daily by the IP team • 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 • ED triage • IP Q-A manual – isolation of patient if infection is suspected or confirmed	• COVID 19 -Themes report to IPCC • COVID screening spot check audits • Datix • Outbreak investigation • Inappropriate patient moves reported via Datix. Daily process Discuss at outbreak meetings as necessary • COVID electronic Contact tag to electronic records applied by IP Team • COVID electronic record tag on place • Electronic tag/alert for other infections e.g. Cdiff/MRSA in place	• Assurance that transfer policy is followed and hand over received

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• COVID 19 screening and step down guidance • Screening for other resistant organisms is included in the IP Q+A manual • Facemasks available for patients and encourage if appropriate and tolerated		
5.3	• Patients at risk of severe outcomes of infection receive protective IP measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation	• Single rooms recommended for patients who are at severe risk from COVID 19 - included in IP Q+A manual • COVID 19 care plan	• Outbreak investigation • COVID themes report • Complaints • Datix	
5.4	• The use of facemasks/face coverings should be determined following a local risk assessment. • Patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy.	• Patient are encourage to wear mask – leaflet in place • Mask stations in place • OPD process for patients who display symptoms	• Spot check audits	
5.5	• Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection	• Staff Covid /flu vaccination hub in place • Vaccination information available on the Trust intranet • Team Prevent have system in place staff vaccination programme other than flu and COVID	• Staff vaccination uptake reported	
5.6	• Two or more infection cases linked in time, place and person trigger an	• Outbreak process in place	• Outbreak investigation • COVID 19 -Themes report 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
	incident/outbreak investigation and are reported via reporting structures.		IPCC	

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 3 Progress Report	BRAG
1	5.2	Assurance that transfer policy is followed and hand over received	DIPC/Quality Lead	February 2023	To gain assurance that transfer policy is followed and hand over received. Datix process already in place which allows the receiving ward to log any incidents	

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									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1			Information and communication/controls are in place to ensure staff are aware of their responsibilities spot audits continue.	Likelihood:	1	
Consequence:	3	3	3				Consequence:	3	
Risk Level:	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	Systems and processes are in place to ensure that: • IP education is provided in line with national guidance/recommendations for all staff commensurate with their duties. • Training in IPC measures is provided to all staff, including: the correct use of PPE	• Trust induction and mandatory training • IP Q+A manual • COVID 19 intranet page • PPE posters • Donning and Doffing posters, videos and PHE available on Covid-19 section of Trust intranet • Matron walk rounds	• Audits • Unannounced IP checks	
6.2	• All staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM); • Adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to	• Trust induction and mandatory training • IP Q+A manual • PPE posters • IP assurance visits • Matrons visits to clinical areas • UHNM recommend staff use of for highly suspected or confirmed COVID 19 patients	• Audits • Unannounced IP checks • Mandatory training compliance records	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	mitigate any identified risk • Gloves and aprons 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. • Hand hygiene is performed: o before touching a patient. o before clean or aseptic procedures. o after body fluid exposure risk. o after touching a patient; and o after touching a patient's immediate surroundings. o 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 (NIPCM	• FFP3 mask /hood • Eye protection • Gloves • Apron(gown for AGP • IP Q+A manual – five moments for hand hygiene posters and education • Hand washing technique depicted on soap dispensers • Social distance posters displayed throughout the Trust Alcohol gel availability at the point of care • Hand dryers are not available within clinical areas	• Audits • Datix • Hand hygiene audits • Unannounced visits • Audits • Building/clinical space design guidance	
6.3	• Staff understand the requirements for uniform laundering where this is not provided for onsite.	• Laundering of own uniform - information available on Trust Intranet page	• Monitor for any updates in National guideline • Datix/adverse incident	

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 3 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)		Target Date
Likelihood:	1	1	1			Single rooms are available throughout the Trust , however there is a need to explore increasing single room availability (pods).	Likelihood:	1	
Consequence:	3	3	3				Consequence:	3	
Risk Level:	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	Systems and processes are in place to ensure: • That clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (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.	• IP Q+A manual • COVID poster • Mask stations	• IP Spot checks • Assurance obtained for monitoring of inpatient compliance with wearing face masks via Matrons daily walk round	• To gain further assurance re patient mask wearing and documentation if unable to wear a mask
7.2	• Patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM. • Patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent.	• IP Q+A manual • PPE chapter • Infection Prevention triage desk which provides advice and support to clinical areas	• Audit • Spot checks • Datix • Outbreak/incidents	• Work in progress to assess the need for more single room availability to facilitate patient flow and surgical pathway

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
7.3	• Standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings • Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	• IP Q+A manual • PPE chapter	• Audit • Spot checks • Datix • Outbreak/incidents	

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 3 Progress Report	BRAG
7	7.1	The compliance of facemask wearing for patients with respiratory viruses is monitored (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.	DIPC/Matrons	End of January 2023	To gain further assurance re patient mask wearing and documentation if unable to wear a mask	
7	7.2	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 October 2022	May 2022 Request made to analyst to map/predict isolation need. August 2022 single room capacity modelling being added to the acute patient flow work stream' Surgical Division are exploring the use of PODS in a number of wards	

8. Secure adequate access to laboratory support as appropriate.

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	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.	Likelihood:	1	
Consequence:	3	3	3				Consequence:	3	
Risk Level:	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	There are systems and processes in place to ensure: • Laboratory testing for infectious illnesses is undertaken by competent and trained individuals.	• Testing takes place in the pathology Laboratory • How to take a COVID screen information available on Trust intranet. This has been updated in November 2020 • 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.	• Laboratory accreditation	
8.2	• Patient testing for infectious agents is undertaken promptly and in line with national guidance.	• IP Q+A Manual • COVID screening information Trust intranet • COVID Testing and step down guidance • Occupational Health Service in place	• Occupational Health monitoring • 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
	• Staff testing protocols are in place for the required health checks, immunisations and clearance • There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • Inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise	• Turnaround times included in tactical slides • Screening guidelines • IP Q+A Manual	• Outbreak investigation • Datix	
8.3	COVID-19 Specific • Patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk) • For testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	• High – risk patient identified for COVID19 MAB and antiviral treatment - PCR • Admission to high risk area at UHNM(Haematology, oncology, real wards Critical care, ward 222, SSCU and PICU) • Symptomatic patients for clinical diagnostic pathway • Symptomatic or immunococompromised patients who are admitted as an emergency or maternity care • Symptomatic or immunocompromised elective care patients prior to acute day case/overnight pre-	• Reviewed as part of outbreak investigation • Spot checks/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
		admission • Transfer into or within hospital for immunocompromised patients • Discharge patients to care home/hospices • Outbreak testing in healthcare settings  uhnm-guidance-on-testing-and-re-testing •  elective-and-planned-admission-covid-19-f •  emergency-and-non-elective-admissions-c • Process in place for staff COVID testing screening via empactis system		

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 3 Progress Report	BRAG

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			There is a range of information, procedures, and pathways available along with mechanism to monitor.	Likelihood:	1	
Consequence:	3	3	3				Consequence:	3	
Risk Level:	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	Systems and processes are in place to ensure that • Resources are in place to implement, measure and monitor adherence to good IP and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • staff are supported in adhering to all IPC and AMS policies.	• 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	• IP audit programme • Audits undertaken by clinical areas • CEF audits • Proud to care booklet audits • AMS audits	
	• Policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	• Included in IP Q+A manual	• Outbreak investigation • 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
9.2	• All clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM	• Waste policy in place • Waste and stream included in IP mandatory training • Waste and Linen included in IP Q+A Manual	• Audits and spot checks • 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 • This includes: • 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 disposed of correctly by the disposer. • Carry out external waste audits of waste contractors used by the Trust.	
9.3	• PPE stock is appropriately stored and accessible to staff when required as per NIPCM	• Procurement and stores hold supplies of PPE • PPE at clinical level stores in store rooms • Donning and doffing stations at entrance to wards	• PPE availability agenda item on Tactical Group meeting • Audits • 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 3 Progress Report	BRAG

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	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	2		There are clear control in place for management of occupational needs of staff through team prevent to date Monitoring of adhere to PPE requirements continues. Work in progress to further improve develop a long term, sustainable fit testing to ensure staff are fit tested to at least two masks and records entered onto ESR	Likelihood:	1	
Consequence:	3	3	3			Consequence:	3	
Risk Level:	3	3	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:				
10.1	Systems and processes are in place to ensure that: • Staff seek advice when required from their occupational health • bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff	• Occupational Health Provision in place at UHNM		
10.2	• Staff understand and are adequately trained in safe systems of working commensurate with their duties.	• Induction and Mandatory Training • At UHNM FFP3 recommended for all contact with COVID19 confirmed or suspected	• Induction and Mandatory Training compliance records • Audits	
10.3	• A fit testing programme is in place for those who may need to wear respiratory protection.	• Mask fit strategy in place • List of mask fit testers within a clinical areas available on the intranet. • Ashfields external mask fitters assisting currently with testing	• Mask fit training records • List of mask fit testers	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		programme. The support from external trained tester via supply chain is until March 2023 which would leave a gap in support provision after this date if support is not extended		
10.4	• Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: • lead on the implementation of systems to monitor for illness and absence. • facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice. • lead on the implementation of systems to monitor staff illness, absence and vaccination. • encourage staff vaccine uptake.	• Team Prevent contract and service in place	• Outbreak • Datix /adverse incident review	
10.5	• Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM.	• COVID 19 advice available on Trust intranet • Team Prevent Service/advice and follow up • Advice from Consultant Microbiologist	• Audit	
10.6	• A risk assessment is carried out for health and social care staff including	• All managers carry our risk assessment	• Risk assessment and temporary risk mitigation	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19. ○ 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 into these categories should follow the same deployment advice as permanent staff. A risk assessment is required for health and social care staff at high	• Process available on the COVID 19 Trust intranet page • Linked to Empactis	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 via empactis	
10.7	• Testing policies are in place locally as advised by occupational health/public health.	• Staff testing as per National guidance • Information available on Trust intranet • COVID communications	• Outbreak investigation	
10.8	• NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	• Process in place • Information available on Trust intranet	• Outbreak investigation • 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
10.9	• staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance and a record of this training is maintained by the staff member and held centrally/ESR records. • Staff who carry out fit test training are trained and competent to do so. • Fit testing is repeated each time a different FFP3 model is used. • All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood.	• Certificate of testing issued to staff Member • Electronic record currently held locally and on Health Roster • In house train the tester/cascade trainers programme place • Support from external mask fit testers in place Ashfields • A number of mask fit testers have been trained to use the portacount machine using an external company/trainer and results uploaded onto ESR • Air powered hoods and reusable P3 mask available for those that have failed on FFP3 mask • IP Q+A Manual details mask fitting • SOP's in place • Initial priority to ensure staff that are required to wear are FFP3 masks are fit tested. • Further work is required to ensure staff are fitted to use at least two different models of masks	• Mask fitting is currently recorded Health Roster records • Test certificate also retained in staff personal folders	• Further work is required to record training on ESR. Currently FFP3 mask fit is recorded on Health roster and ESR for some staff • Further work is required to ensure staff are fitted to use at least two different models of masks to ensure FFP3 resilience

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	• That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions • Members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • 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. • 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.	• Air powered system hoods and SOP • In situations when staff member fails FFP3 mask fitting. Alternative models available and air powered system. • Discussion should be held in personal folders • Mask fitting certificate to be held in personal folder • Currently added to health roster but further work required to transfer to ESR		
10.10	• Staff who have symptoms of infection or test positive for an infectious agent should	• All managers carry our risk assessment	• Via emapactis • Staff queries' through	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	have adequate information and support to aid their recovery and return to work.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms • Flow charts or staff returning to work available on COVID 19 section of intranet	workforce bureau or team prevent	

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 3 Progress Report	BRAG
10	10.9	**FFP3 resilience principles**. Currently Health roster is used to record mask fit testing. Capturing the data on ESR will allow the information to transfer with the staff member if they transfer between Trusts.	**IP**	January 2023	October 2022 Delivery Manager – National FFP3 Fit Test Team has made contact with UHNM to arrange meeting/support to discuss FFP3 resilience principles and transfer of mask fit data to the ESR system	
10	10.9	**FFP3 Resilience principles** FFP3 users should be tested on two different models of masks (ideally 3)	**IP**	**Quarter 2 2023**	October 2022 - The focus has been to ensure all staff that require FFP3 masks are fitted. Work to ensure staff are fitted to 2 models of FFP3 masks will required working through to establish resources required. IP have appointed a band 3 for a 6 month period to help with fit testing. FFP3 resilience principles paper going to next November IPCC	

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.

Transformation and People Committee Chair's Highlight Report to Board

30th November 2022

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee queried the IT project which was most at risk and it was noted that this related to the Laboratory Management Information System due to staff availability given the team had been supporting the Trust during the pandemic • Escalations from the Digital and Data Security and Protection Group highlighted the ongoing measures to mitigate the risk associated with cyber-attack whilst recognising that this had not reduced the risk score. In addition, data security training compliance continued to be challenged which was expected to impact on the Data Security Toolkit • Learning from the Virginia Mason model, Catalysis CEO forum and NHS partnership highlighted that the success of Improving Together was dependent on the programme being led by the Executive and a key gap was that other UK sites led the programme via an Executive Steering Group and this was being considered • Learning and education activity had continued to take place during 2021/22 and challenges were identified whereby additional supervision of existing trainees was required, consideration of the time required by supervisors when considering operational demand and lack of space for face to face training. • There had been a general deterioration in some of the metrics associated with the Workforce Race Equality Standard (WRES), particularly in relation to bullying, harassment and discrimination and equal opportunities for career development. The Committee considered how BAME staff could be encouraged to apply for higher banded roles in order to reduce the gap of staff in roles Band 6 and above • Month 7 workforce performance continued to report high sickness absence although this had reduced in November as a result of reducing covid absences, and when compared to peers, the Trust had the second highest absence reporting rate and learning from others was being identified.	• To further build upon the Transformation Programme update in respect of the progress being made to take forward transformation in support of the Trust's strategic planning framework • To provide the Population Health and Wellbeing Strategy to a future meeting • To link in with the Learning, Education and Widening Participation team with respect of the digital skills gap identified via the Digital Advocates Network so that this can inform future training offerings • Assurance to be provided to Performance and Finance Committee in respect of clinical coding • To explore the opportunities for further developing apprenticeships within IM&T and the wider Trust • To explore the way in which BAME clinical leadership was reported in the WRES report going forwards • To incorporate the impact on staff following the introduction of Your Next Patient within existing reporting to the Committee going forwards • To expand on future discussions with regards to the cultural heat map when considering future quarterly Cultural Improvement Programme updates
✓ Positive Assurances to Provide	**Decisions Made**
• The Transformation Programme update highlighted the ongoing work being undertaken by Executives to review their A3s which supported the Strategic Priorities. It was expected that this work would subsequently generate additional countermeasures which would be the focus of future transformation projects • The update from the Strategy and Transformation group highlighted progress with delivery against the strategic planning cycle which had been integrated into business cycles for respective groups • The digital strategy update highlighted that although funding had not been secured for all projects, significant progress had been made and central funds were being utilised where possible, this included funding to write the EPR business case on behalf of the system • The System Transformation and Service Change Programme update highlighted that the business case for the Community Diagnostic Centres was to be submitted to NHSE by February 2023 • Learning and education reported a positive increase in requests for information in relation to apprenticeships particularly in the area of healthcare scientists, and although the apprenticeship target had not been achieved in 2021/22 the position had improved for 20223/23. In addition the Trust had won Employer of the Year for Apprenticeships.	• The Committee supported the next steps identified as a result of the learning in relation to the Improving Together Programme • The Committee approved the actions identified in relation to the Workforce Race Equality Standard.

- An update was provided on the Cultural Improvement Programme which demonstrated progress against the actions identified
- The Committee welcomed the support being provided to Divisions in respect of setting expectations of the standard business to be covered by Divisional Workforce / Cultural Groups

Comments on the Effectiveness of the Meeting

- The Committee welcomed the discussion on strategy, delivering the strategic intent and the discussion on transformation and linkages between digital and improving together. Assurance was received and challenged on learning and education as well as the WRES metrics and a helpful discussion was held in terms of the way in which challenges would be addressed.
- The Committee thanked Mrs Vaughan for her work, dedication and professionalism provided to the Trust and wished her well for her retirement.

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Transformation Programme Update			✓	Assurance	8.	Learning, Education and Widening Participation Annual Report 2021/22			✓ !	Assurance
2.	Executive Strategy & Transformation Group Assurance Report	BAF 4	9	✓	Assurance	9.	Workforce Race Equality Standard (WRES) Report - 2022	BAF 2	12	!	Assurance
3.	Digital Strategy Update	BAF 6	12	✓ !	Assurance	10.	Your Next Patient	BAF 1	16	-	Assurance
4.	Executive Digital and Data Security & Protection Group Assurance Report (16-11-22)	BAF 6	12	!	Assurance	11.	Workforce Report – M7 2022/23	BAF 2/3	12 16	✓ !	Assurance
5.	Improving Together Highlight Report			-	Assurance	12.	Cultural Improvement Programme Highlight Report Q2	BAF 2	12	✓	Assurance
6.	Implications of Learning from Catalysis CEO Forum & NHS/Virginia Mason Review for Continuous Improvement at UHNM			!	Assurance	13.	Executive Workforce Assurance Report (18-11-22)	BAF 2/3	12 16	✓	Assurance
7.	Transformation and Service Change Programmes	BAF 4	9	✓	Assurance	14.	Executive Health & Safety Group Assurance Report (17-11-22)			-	Assurance

3. 2022 / 23 Attendance Matrix

No.	Name	Job Title	A	M	J	J	A	S	O	N	D	J	F	M
1.	Prof G Crowe	Non-Executive Director												
2.	Ms H Ashley	Director of Strategy												
3.	Ms S Toor	Associate Non-Executive Director												
4.	Mrs T Bullock	Chief Executive												
5.	Mr P Bytheway	Chief Operating Officer												
6.	Dr L Griffin	Non-Executive Director												
7.	Mrs S Gohir	Non-Executive Director												
8.	Dr K Maddock	Non-Executive Director												
9.	Mrs AM Riley	Chief Nurse												
10.	Mrs C Cotton	Associate Director of Corporate Governance					NH			NH				
11.	Mrs R Vaughan	Chief People Officer												

Attended | Apologies & Deputy Sent | Apologies

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board	**Date:**	7th December 2022
Report Title:	People Strategy	**Agenda Item:**	14.
Author:	Jane Haire, Deputy Chief People Officer		
Executive Lead:	Ro Vaughan, Chief People 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

BAF 3	If we are unable to achieve a sustainable workforce, then we may not have staff with the right skills in the right place at the right time, resulting in an adverse impact on staff wellbeing, recruitment and retention, increasing premium costs and potentially compromising the quality of care for our patients	*Ext 16*
BAF 2	If we are unable to live our values and improve the culture of the organisation to make UHNM a place where all staff are treated with respect and have the opportunity to build a fulfilling career, then staff may experience unacceptable behaviours and a climate of bullying, harassment and inequality, resulting in an adverse impact on staff wellbeing, recruitment, retention and performance, ultimately reducing the quality of care experienced by patients.	*High 12*

Executive Summary

Situation

- The Trust People Strategy currently in place covers the period 2018 – 202.
- A refresh of the People Strategy was planned for 2020 but this was paused pending the work on the national people plan and the national review of the future of HR and OD.
- The timing of the refresh of the People Strategy has also been impacted by the Covid-19 pandemic.
- The work on the revised People Strategy takes into account the Trust priorities, the system priorities and the national direction in line with the recent national reviews and national long term plans.

Background

- A new People Strategy has been developed for the period 2022 – 2025 and is a key enabling strategy that supports the delivery of our Trust Strategy and 2025 Vision.
- Our Trust vision sets a clear direction for the organisation to become a world-class centre of clinical and academic achievement and care. One in which our people all work together with a common purpose to ensure patients receive the highest standard of care in which best people want to work. Simply put this means we want to **'Deliver Exceptional Care with Exceptional People'**.
- For our people who work here that means we want our organisation to be **A Great Place to Work**, where our people feel that they belong and thrive and grow in a culture that is empowering, kind and respectful.
- In developing our People Strategy, we have engaged with our Staff Networks, Divisional leaders, Board members, people experts and trade union partners. We have used the feedback from the annual NHS Staff Survey, the monthly staff surveys and other reviews to inform and shape our direction of travel and to build our work plan.

- The new People Strategy uses the foundations of national people promises and builds upon these with a focus on helping to deliver more people, working differently in a compassionate and inclusive culture.

Assessment

- Our ambition is that this Trust should be a **Great Place to Work**, where we are able to provide the best possible care for all our patients and their family members, by ensuring that we have enough staff with the right skills, working together as a team to common goals and aims.
- Through the feedback we have received we have set a three year work plan under for key domains.

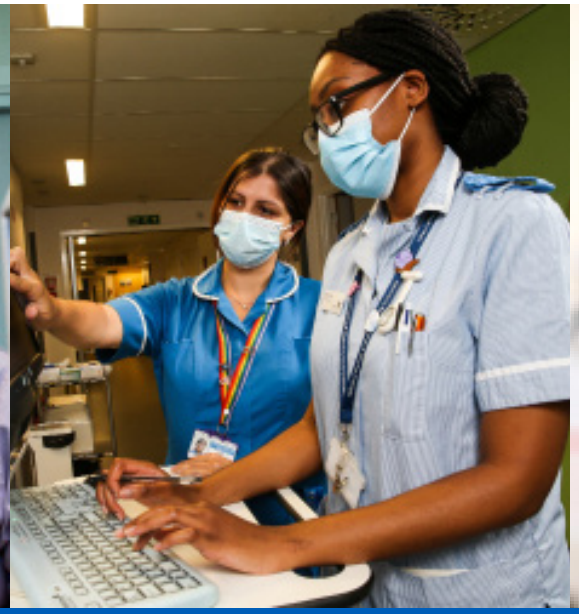
    - **We will look after our people** by supporting our people to be healthy and well, both physically and psychologically, and when unwell ensuring they are supported.
    - **We will create a sense of belonging** where we are kind and respectful to each other by creating a positive and inclusive culture which is reinforced through our Being Kind programme of work and our cultural improvement programme.
    - **We will grow and develop our workforce for the future** by attracting, recruiting and retaining our people. We will plan ahead to anticipate and meet the changes in patient needs and demand for our services within the constraints we face.
    - **We will develop our people practices and systems** by promoting and using new technologies and equipping our people with digital awareness and skills.

- The three-year work plan will evolve over the life of the People Strategy as the context and system around us and we have developed a comprehensive set of metrics that will help us to understand if our activities are making the required impact in the right areas.
- We will continue to consolidate and embed our activities where they are adding value, or be agile in our approach to changing direction when there is evidence to do so.

Key Recommendations

- The Trust Board is asked to approve the People Strategy. Once approved this will be communicated widely to our stakeholders and will be supported on a “plan on a page” as a summary version to support with the messaging.

NHS
University Hospitals of North Midlands
NHS Trust



UHNM People Strategy

Making UHNM a Great Place to Work

2022-2025

Contents

Message from our Chief Executive Officer

Our People Strategy is one of a number of strategies that help us to achieve our organisation strategy and vision for the future. It has been developed following your feedback through the national NHS Staff Survey, the Staff Voice survey, the work of the Culture Team and the Culture Survey (2022) and feedback from listening events. All of this insight has helped us to really understand what makes a great place to work for you all.

We want our colleagues to be happy, healthy and supported, so that they can in turn, support the wellbeing of the people and patients in their care. We must and will ensure our colleagues are treated fairly and everyone is recognised for the contribution they make. We will also use this opportunity to ensure our workforce is reflective of our diverse population through developing an inclusive culture where diversity is welcomed.

In developing our People Strategy, we have taken account of the national direction through the National People Plan and National People Promise and brought this together with our organisation and local system knowledge. From this we have developed our three-year road-map and put simply, our ambition is to create a great place to work here at the University Hospitals of North Midlands NHS Trust.

Through our People Strategy and supporting delivery plans we aim to improve the experience of all our people. We know that it is imperative that we act right now as we work together to meet the demands we are facing as we recover from the Covid-19 waves. We are ready and committed to embrace new ways of working in teams, services and across organisations and sectors, aided by innovation and new technology. We recognise that there is a need to support you to develop your careers and there will be opportunities to develop existing roles, build new and advanced roles, skills and capabilities in areas that we have not done so before. Our aim is to offer you a flexible and rewarding career, development and professional satisfaction in a place where you feel you belong.

We hope that our People Strategy sets out our ambitions and aims to anyone considering applying for our vacancies, undertaking work experience or apprenticeships with us or undertaking studies that may lead you to us in due course – you are part of our future and we welcome you. We understand that you want fulfilling and rewarding careers, that you want to work within a compassionate and inclusive culture, where you are valued for your contribution and you can be yourself.

My promise to you is to put our people at the heart of everything we do in pursuit of outstanding patient care. Our golden thread will be our Trust values and compassionate and inclusive people services working together with you all to achieve our ambitions.

By improving together in a kind, positive and inclusive way we really will make a difference - everyday in everything that we do.

Tracy Bullock
Chief Executive

How we have developed this strategy?

In developing our People Strategy, we have engaged with our Staff Networks, Divisional leaders, Board members, people experts and trade union partners. We have used the feedback from the annual NHS Staff Survey, the monthly staff surveys and other reviews to inform and shape our direction of travel and to build our delivery plan. We have used a wealth of national and local system level resources to develop our People Strategy.

We have really listened to what our people have told us and developed our key priorities for action in response to this. We will continue to listen throughout the life of this strategy, ensuring that all of our people have a voice that counts in order to effect positive change. We will continue to promote our vision, our priorities and our plans. We will do this through a wide range of different formats and communication channels. In particular, we will use staff stories to share experiences that have influenced our aims, ambitions and plans.

About us

169,882 (2021/22)
A&E Attendances

6,180 (2021/22)
Births

11,081 (2021/22)
Elective Admissions

111,918 (2021/22)
Non-elective Admissions

80,621 (2021/22)
Day Case Admissions

751,236 (2021/22)
Adult Outpatient Attendance

88, 296 (2021/22)
Children's Outpatient Attendances

84,647 (2021/22)
Antenatal Clinic Attendances

Our Vision

Our Trust vision sets a clear direction for the organisation to become a world-class centre of clinical and academic achievement and care. One in which our people all work together with a common purpose to ensure patients receive the highest standard of care in which best people want to work. Simply put this means we want to 'Deliver Exceptional Care with Exceptional People'.

For our people who work here that means we want UHNM to be ***A Great Place to Work***, where our people feel that they belong and thrive and grow in a culture that is empowering, kind and respectful.

Our people

We have a diverse workforce of almost 11,500 employed staff and 1,800 bank staff working in many different types of roles, and together with volunteers, colleagues in social care and carers, we have a huge impact on our population. We must know and understand the shape of our workforce if we are to successfully monitor and revise plans that result in the right workforce at the right time, enabling and empowering the workforce to work to the 'top of their licence' or scope of practice. This means releasing capacity at every level possible to deliver within areas of expertise, while maintaining flexibility to respond to changes as they arise.

Our volunteers are very important to assisting / supporting our staff and patients in all areas across the Trust. We will support our volunteers with training, development and opportunities to help move them into permanent roles, if they wish, and we will recognise their time, efforts and their career aspirations .

A workforce made up of 96 Nationalities

37% of the workforce work part-time

23% BAME representation

75% female workforce

409 volunteers

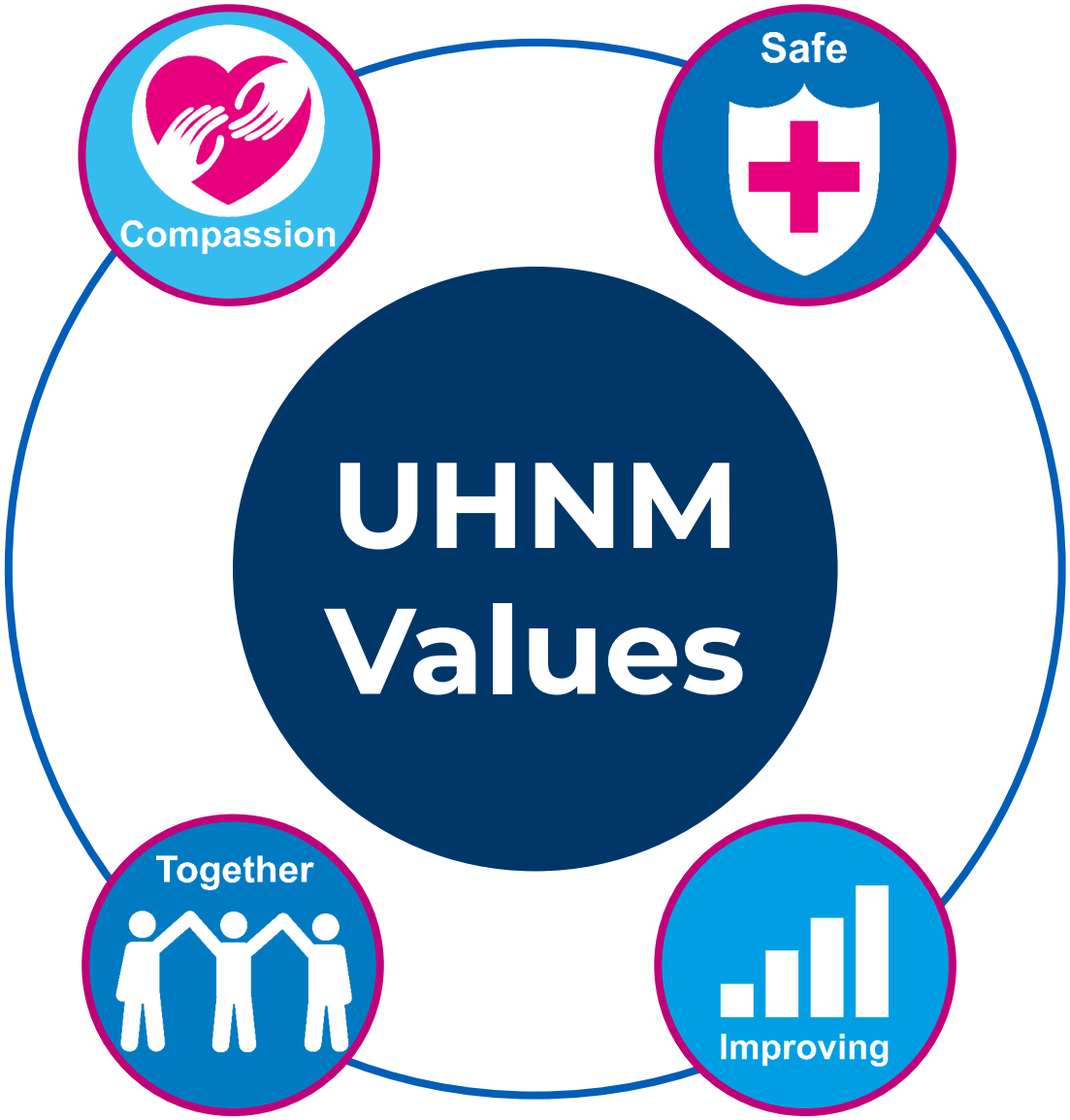
3% of the workforce with a declared disability

89.5% of workforce on a permanent contract

As at 1/9/2022 - Based on Permanent and FTC Status.

Our Values

Our Trust values are designed to be at the heart of everything we do. We promote a compassionate and inclusive culture through our values, which identifies the attitude and behavioural expectations of our people. During 2022 we launched our Being Kind Programme through a series of toolkits and guides. These are a key part of our journey to develop a kind and respectful organisation.



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.

Prioritising our People

Our People Strategy is a key enabling strategy that supports the delivery of our Trust Strategy and 2025 Vision.

Over recent years we have embarked upon a new way of working – our 'Improving Together' Programme. This is a Trust-wide approach to quality improvement and as part of our improvement journey there has been a review of our Trust Strategy, Vision and Priorities. Whilst many of the ambitions within our 2025 Vision remain true, we have simplified our vision and our priorities to provide greater clarity for all of our people and to support their understanding of how we all can contribute to achieving our overall strategy.

In doing this, we have strengthened our focus on our people with a key component being 'Creating a Great Place to Work'. We have agreed objectives, metrics and projects to support us to deliver on this strategic priority.

Our People Strategy is aligned to our other enabling strategies and takes into consideration the following:

- Service transformation, both internally and across our system which offers opportunity to undertake new ways of working and opportunity for professional and personal development.
- Changes to delivery of services and our model of care.
- Best practice quality improvement approaches where people are encouraged to take part in quality improvement and use a series of tools and techniques to enable change.
- On-going development of our estate, both within our hospitals and within the community in order to ensure that capacity is fit for purpose in delivering our model of care.
- Adoption of new technology and innovation, including digital and artificial intelligence, that spans both hospital and community settings. Our people will need to adopt new technology and work differently to maximise the opportunities that change presents.
- Our ambition to undertake world-class health services supported by education, research and innovation in collaboration with regional partners.
- Our financial regime and the opportunity and constraints that this presents.

Influencing Factors

STRENGTHS

- University Teaching Hospital and a Major Trauma Centre
- Outstanding for Care (CQC) and Good for Well-Led (CQC)
- Skilled workforce base
- High quality student placements
- Strong apprenticeship offer
- Excellent leadership development offers
- Values led organisation

WEAKNESSES

- Workforce supply challenges
- High vacancy rates in some staff groups
- Ageing workforce
- Increasing turnover rates
- Staff survey results are below average
- Our culture is not where we want it to be

THREATS

- The ambitions of our strategy may not be achieved due to financial pressures, vacancies and staffing levels
- High competition locally and nationally for NHS workforce
- Agile working opportunities available across the UK
- Changing expectations of the future workforce
- Continuing economic pressures
- Impact of global changes

OPPORTUNITIES

- Further strengthen partnerships with further and higher education institutions
- Work with system partners on our people activities
- Enhance career options for local population through apprenticeship offers
- Embrace digital innovation and transformation
- Develop our leaders in line with national recommendations
- Focus on whole population health through health and wellbeing partnerships

Culture and Inclusion

We are working hard to achieve a more inclusive workplace where people are encouraged to be themselves and deliver their best at work. We are determined to build a workforce that is more representative of our local communities. We know that by achieving this, we are best placed to deliver our objective of delivering fair, inclusive and accessible services for all.

We are proud of the wide diversity of our 11,500 employed staff and 1,800 bank staff and want everyone to feel valued and that they belong. We have included and engaged with members of the Trust's staff network groups and other key stakeholders in developing this Strategy.

The People Strategy is inextricably linked to our Equality, Diversity and Inclusion (EDI) Strategy which has a key focus on promoting equality of opportunity, ensuring the inclusion of our people and valuing the diversity of our people and of our potential future workforce, particularly those in local communities.

Over recent years we have taken forward significant pieces of work to develop equality, diversity and inclusion across our services and workforce and we will continue to develop these. More recently we have a great opportunity to support our future workforce through the national levelling up strategy which focuses on boosting careers for young people to improve employment opportunities.

Good quality data enables us to identify priorities and measure our effectiveness. We recognise that the data collection of protected characteristics for our people needs to be improved in order for us to fully understand our workforce.

Developing our workforce

Workforce planning underpins our People Strategy and delivery plans. Workforce planning is the process of identifying the people and skills we need now, and in the future, to deliver our services.

Over the next 10 years, health and care will change significantly. The national direction of travel involves increasing care in the community; redesigning and reducing pressure on emergency hospital services; more personalised care; digitally enabled primary and outpatient care; and a focus on population health and reducing health inequalities. ***The NHS Long Term Plan*** also identifies areas where earlier diagnosis, new and integrated models of care, and better use of technology offer the potential to significantly improve population health and patient care. Within our organisation and the wider health and care system, we will develop our workforce, in terms of the skills and roles, will need to evolve to keep pace with these changes.

The NHS has a shortage of key workers for many roles, and in Staffordshire and Stoke on Trent Integrated Care System, we have some hard to fill workforce groups. As such, it's very important, that we understand and balance our workforce needs against the workforce that is available. Where we have gaps, we will work with our service leads to identify solutions. This will include working with clinical leaders to look at the potential to deliver services in a different way or with a different mix of skills/roles.

Workforce supply is affected by a range of factors, those that are within our control, those that are within our influence and those that are outside our control. We need to use workforce planning models and tools that help us to set out the right numbers of staff with the right skills, knowledge and values in the right places. The NHS has a shortage of key workers for many roles, and in Staffordshire and Stoke on Trent Integrated Care System, we have some hard to fill workforce groups. As such, it's very important, that we understand and balance our workforce needs against the workforce that is available. Where we have gaps, we will work with our service leads to identify solutions. This will include working with clinical leaders to look at the potential to deliver services in a different way or with a different mix of skills/roles.

We will ensure that our learning and education opportunities meet the needs of the organisation and the wider Health System and that delivery of our training and development activities is flexible, adaptable and reflective of the world that we live in. We will continue to promote the good reputation of the Career and Skills Academy, working with partner organisations to explore funding opportunities and ways to deliver learning and development across Staffordshire.

We will work with the Medical School to ensure our structures, systems and processes for medical education at post graduate and undergraduate level align with clinical directorates in order to attract and retain medical staff, and deliver world class training and education to the doctors of today and the future. We will create a virtual Academy to encourage innovation, and service improvement bringing together multidisciplinary teams and making best use of shared resources and infrastructure.

Alignment to system plans

The Staffordshire and Stoke on Trent integrated care system (ICS) was formally established on 1 April 2021 and there is a clear focus on building a culture of one workforce across the system.

As system partners we recognise the contribution all of our people across health and social care and the significant difference that all their roles make to our patients and service users.

We are clear that by working together as partners we can help improve the employment experience of all our people. The aim of the system people plan is to support the creation of “One Workforce” which will deliver the Staffordshire and Stoke on Trent vision of making Staffordshire and Stoke on Trent the healthiest place to live and work. Through collaborating and joint working we can create new opportunities for roles and careers across the whole system.

Our People Strategy Aims, Ambitions and Plans

We aim to become a leading healthcare organisation, with a positive, compassionate and inclusive culture, enabling our people to deliver the highest standard of care. We will strive to improve the experience of our patients by ensuring our people are appropriately trained, equipped, supported and performing to their best. We will work to improve our culture, supporting our people with the development they need and we will do this by working collaboratively across the local, regional and national health systems to achieve our aims. Underpinning this we believe that our people should demonstrate always our core values and behaviours in all that they do.

We fully endorse the NHS People Promise as a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone. Our People Strategy uses the foundations of these promises and builds upon these with a focus on helping to deliver more people, working differently in a compassionate and inclusive culture. Our People Strategy will be delivered as a series of interconnected programmes and activities, set across four major domains and through our governance and assurance frameworks. We will assess if these are creating a positive impact through a regular review of our workforce information and metrics. We will continue to consolidate and embed our activities where they are adding value, or be agile in our approach to changing direction when there is evidence to do so.

We will look after our people by supporting our people to be healthy and well, both physically and psychologically, and when unwell ensuring they are supported.

We will grow and develop our workforce for the future by attracting, recruiting and retaining our people. We will plan ahead to anticipate and meet the changes in patient needs and demand for our services within the constraints we face.

We will create a sense of belonging where we are kind and respectful to each other by creating a positive and inclusive culture which is reinforced through our Being Kind programme of work and our cultural improvement programme. We will support our staff to be the best they can be by building a psychologically safe, positive, compassionate and inclusive culture where our people are free from discrimination and diversity is celebrated.

We will develop our people practices and systems by promoting and using new technologies and equipping our people with digital awareness and skills.

Our Three-Year Delivery Plan

Our ambition is that this Trust should be a Great Place to Work, where we are able to provide the best possible care for all our patients and their family members, by ensuring that we have enough staff with the right skills, working together as a team to common goals and aims. Through the feedback we have received we have set out the following work plan under for key domains. Our three-year plan will evolve over the life of our People Strategy as the context and system around us and we have developed a comprehensive set of metrics that will help us to understand if our activities are making the required impact in the right areas.

What we will do and how we will do this – Year 1 2022/23

Domain 1: We will look after our people

- We will continue to provide our people with enhanced levels of health and wellbeing support through our wellbeing plan
- We will promote wellbeing conversations using our RESPOND model
- We will increase employee involvement and participation in health and wellbeing activities, promoting physical wellbeing and healthy lifestyle, maximising the expertise and resources available

Domain 2: We will create a sense of belonging where we are kind and respectful to each other

- We will launch our Equality, Diversity and Inclusion Strategy and associated delivery plan
- We will launch our programme of work linked to the RACE Equality Code
- We will develop the profile of our staff networks to maximise their contribution in creating a fair and inclusive culture
- We will roll-out further the 4 step Restorative Just and Learning Model
- We will expand the Freedom to Speak Up Ambassador Service
- We will launch our Being Kind Campaign including our set of expected behaviours of all our people
- We will launch our Resolution Policy and supporting guides
- We will strengthen our selection processes with a focus on increasing the diversity of our workforce

Domain 3: We will grow and develop our workforce for the future

- We will commence rollout of our ENABLE leadership programme
- We will promote the development of our leaders through our coaching network
- We will support our people to maintain compliance with statutory and mandatory training, CPD and core competencies
- We will produce an organisational level workforce plan to identify key workforce supply opportunities
- We will commence development of divisional workforce plans
- We will increase the scale and breadth of apprenticeships on offer
- We will establish new and innovative roles to help better meet the needs of our patients
- We will continue to seek new workforce through international recruitment routes

Domain 4: We will develop our people practices and systems

- We will streamline our recruitment processes to improve the time to hire
- We will work as system partners on the development of robotic solutions to streamline recruitment
- We will launch the “Step into UHNM” digital work experience programme

What we will do and how we will do this: Year 2 – 2023/2024

Domain 1: We will look after our people

- We will implement a network of trained workplace wellbeing champions and embed the Board-level Wellbeing Guardian role.
- We will communicate widely all of our support networks such as Employee Support Advisors, Guardians and Disability Champions
- We will launch a system wide occupational health service
- We will continue to support the wellbeing of our staff through our comprehensive wellbeing plan and financial wellbeing

Domain 2: We will create a sense of belonging where we are kind and respectful to each other

- We will deliver our commitments set out in the Race Code and Equality Diversity and Inclusion Strategy
- We will create team improvement tools that support respectful and open conversations
- We will develop team timeout resources to support team development and effective working
- We will continue to embed our Being Kind tools including our set of expected behaviours of all our people supported by our leadership programmes
- We will develop and support our people from under-represented groups into leadership roles including reciprocal mentoring
- We will promote widely our employment offer/package

Domain 3: We will grow and develop our workforce for the future

- We will develop and implement our retention plan
- We will review all our leadership course for alignment to our culture change programme activities
- We will deliver a clinical leaders/clinical directors leadership programme including mentoring and coaching
- We will implement talent management approaches to underpin staff training/development/appraisals
- We will work with our system to partners to develop joint roles / rotational posts
- We will strengthen partnerships with education providers on learner placements support including T-Levels
- We will continue to strengthen links with our Armed Forces through the Armed Forces Covenant Gold Award

Domain 4: We will develop our people practices and systems

- We will launch the digital staff passport for doctors
- We will develop our use of business intelligence data tools
- We will launch a digital benefits portal
- We will review our people systems to identify areas of streamlining / automation
- We will review the job evaluation processes for efficiency
- We will undertake an assessment our digital skills using the Higher Education England Digital Skills Self-Assessment Tool
- We will develop our approach to service improvement through the work of our Quality Improvement Academy

What we will do and how we will do this – Year 3 2024/25

Domain 1: We will look after our people

- We will strengthen flexible working opportunities through focused campaigns and change initiatives at departmental level
- We will continue to focus on improving our staff rest facility areas
- We will continue to support the wellbeing of our staff through our comprehensive wellbeing plan

Domain 2: We will create a sense of belonging where we are kind and respectful to each other

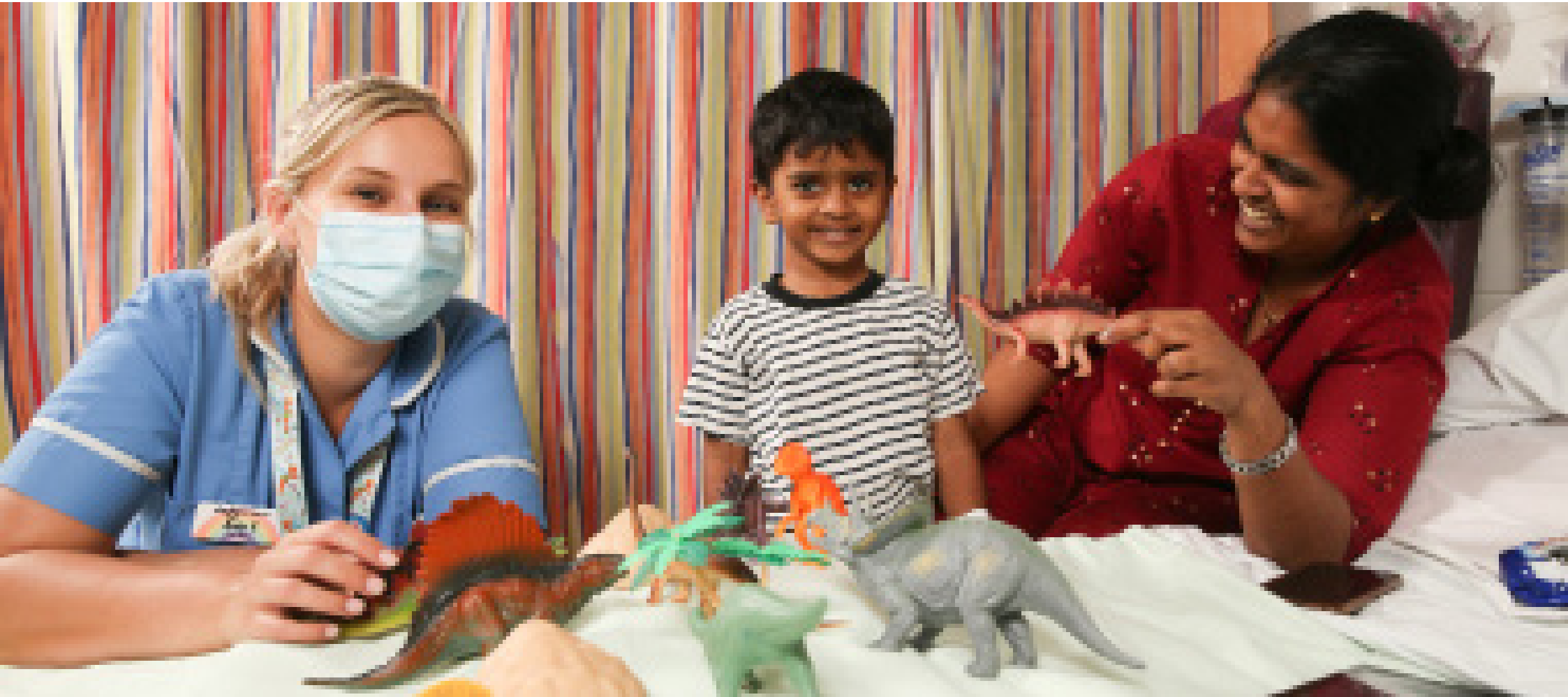
- We will widen career pathways for disadvantaged groups using interventions including reciprocal mentoring
- We will strengthen mechanisms to demonstrate tangible recognition and appreciation so building a sense of value, pride and belonging in our team
- We will increase our employee knowledge and confidence in raising concerns

Domain 3: We will grow and develop our workforce for the future

- We will continue to deliver on our retention plan
- We will develop and launch a succession planning framework linked to our talent management programme
- We will scale up new roles to tackle key staff shortages
- We will increase the pipeline for local school and college leavers to access healthcare careers maximising the apprenticeship levy

Domain 4: We will develop our people practices and systems

- We will embed further remote working opportunities through digital transformation
- We will review, adapt and amend our processes in line with national ESR guidance
- We will continue to develop our people systems in order to streamline our processes
- We will continue to help improve digital skills through our digital advocate network
- We will continue to provide teams with the time, tools and skills for service improvements through our Quality Improvement Academy



Measuring our progress

Effective performance measurement and monitoring will help us to identify our strengths and weaknesses and areas for improvement and action. The measures outlined in our People Strategy have been mapped to our key domains and will be regularly reported through our governance structures with the use of reporting tools such as Business Intelligence/Cultural Heat Maps.

Performance Measure	Strategic Domain				2022/23 Baseline	2025 Ambition
	1	2	3	4		
Sickness absence rates (Absence FTE %)	●				6.28%	3.39%
Turnover (headcount %)	●				11.6%	10%
National Staff Survey Ratings: Staff engagement score	●				6.7	7.0
National Staff Survey Ratings: Positive action on health and wellbeing	●				51.3% Strongly Agree/Agree	60% Strongly Agree/Agree
National Staff Survey Ratings: Diversity and equality		●			8.0	8.8
National Staff Survey Ratings: We are safe and healthy (sub-theme score health and safety climate)		●			5.2	6.0 or above
Enable Leadership Course Participation Rate		●			22% attendance	>85% attendance
National Staff Survey Ratings: We have a voice that counts		●			6.5	7.3 or above
Appraisal Rates			●		79.8%	95%
Vacancy Rates			●		12.01%	<10%
Number of apprenticeships			●		188	>300
Compliance with statutory and mandatory training			●		94%	95%
Recruitment time to hire				●	79 days	59 days
Access to digital work experience (Step into UHNM)				●	450 participants	800 participants

Strategy Oversight

Delivery of the People Strategy will be overseen by the People Directorate. In accordance with the Trust's governance arrangements, strategy updates will be provided to the Transformation and People Committee and also directly to the Trust Board. The Committee has overall Corporate Oversight and Accountability for the People Strategy.

The annual delivery of the People Strategy is translated into an annual people delivery plan approved and overseen by the Transformation and People Committee with quarterly reports provided to our Executive Workforce Assurance Group. The People Strategy is informed by the Workforce Race Equality Scheme, Workforce Disability Equality Scheme, Gender Pay Reporting, and Annual Staff Survey reporting.

Identification of risks to the delivery of the strategy is an ongoing process and is completed by the People Senior Management Team. Risks are assessed for their impact and likelihood using the Trust's Risk Scoring Matrix. Where necessary, risks will be escalated to the Executive Workforce Assurance Group and/or Transformation and People Committee, where they will be subject to a greater level of oversight.

Resources Required

The approach to ensuring we Create a Great Place to Work is a collective responsibility with our leaders, managers, trade union partners, employees, staff partners and supporting teams. More specifically, the delivery of the activities set out in our delivery plan will be through our People Directorate resources. In addition, the Trust has a well-established community of diversity staff forums (The Ethnic Diversity, LGBT+ and Disability & Long-Term Conditions staff networks) which help to shape the strategic direction and delivery plans to ensure that the actions that we take are meaningful and have impact.

Within the People Directorate we have a strong team of subject matter experts and highly skilled people professionals coming from a wide range of clinical, non-clinical, public sector and private sector backgrounds.

Our colleagues from across the People Directorate will work with our wider group of system people professionals through the sharing of best practice, collaborative programmes and/or integrated service delivery models. By scaling up in this way we believe that we can offer more to our staff within the organisation and across the wider integrated health and care system.

Equality Impact Assessment

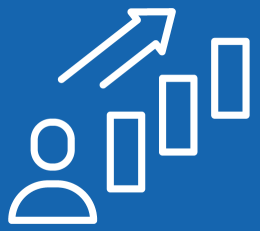
All public bodies have a statutory duty to set out arrangements to assess and consult on how their policies and functions impact on equality. At UHNM this has been applied to assessments on all our policies, guidelines and practices that impact on protected characteristics.

We have a well-established pathway for the approval of procedural documents and policies which include the review of Equality Impact Assessments and Action Plans (where applicable). A Quality Impact Assessment similarly reviews impacts of significant changes to services we provide.

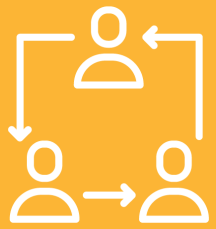
Communicating Our People Strategy

Over the life of our People Strategy, we will continue to promote our vision, our priorities and our plans. We will do this through a wide range of different formats and communication channels. In particular, we will use staff stories to share experiences that have influenced our priorities.

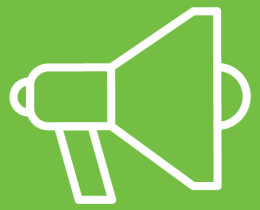
We will promote the strategy and initiatives to our leaders and managers by embedding this into leaderships offerings



We will promote our strategy externally through our Integrated Care System



We will engage the support of our staff networks, staff representatives and ambassadors to help carry the message



We will promote our strategy to our patients, service users and our future workforce through our People Campaigns and the Trust Website

We will use all our internal communication channels to reach our colleagues

Working together to deliver our People Strategy

Making our Trust a great place to work requires a collective effort from us all and we will only achieve our ambitions by working together and improving together. The success of the delivery of our strategy will be through the inputs and efforts of our leaders across the whole Trust.
We invite everyone to get involved in the delivery of our People Strategy so that our collective efforts can help us achieve our ambitions. There are a number of ways that you can get involved:

- By working as compassionate and supportive team members and team leaders where we live the values every day and embody the being kind approach
- By joining local staff networks where these are of interest to you whether that be LGBTQ+, BAME and Disability Staff Networks or special interest wellbeing support groups (such as our Menopause Group)
- By working with our Armed Forces community
- By engaging with our trade union and staff representatives to help us hear your voice
- By completing the annual staff survey and local staff voice surveys to help us gather insights and take action on what matters to you.
- By becoming local leads for key activities such as health and safety representatives, Employee Support Advisors, Wellbeing Champions
- By speaking up about any concerns you have
- By helping to improve our culture by taking positive action against poor behaviour

Hearing your feedback is important to us. If you would like to give any feedback on our people strategy please email myemployeerelations@uhnm.nhs.uk

Executive Summary

Meeting:	Trust Board	**Date:**	7th December 2022
Report Title:	Workforce Race Equality Standard (WRES) Report - 2022	**Agenda Item:**	15
Author:	OD, Culture & Inclusion Business Partner - EDI		
Executive Lead:	Chief People 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

BAF 2	Leadership, Culture and Delivery of Trust Values	*12*

Executive Summary

Situation

As set out in the NHS People Plan, respect; equality and inclusion are central to changing culture and are at the heart of the NHS. The Workforce Race Equality Standard (WRES), mandated through the NHS Contract is a set of 9 measures (metrics) that enable NHS organisations to compare the workplace and career experiences of Black, Asian and Minority Ethnic (BAME) staff compared to their white colleagues, using the information to develop and publish an action plan to address inequalities. Year on year comparison enables NHS organisations to demonstrate progress against the indicators of race equality.

Background

The national evidence shows that Black, Asian and Minority Ethnic (BAME) staff in the NHS are less well represented at senior levels, have measurably worse day to day experiences of life in NHS organisations, and have more obstacles to progressing in their careers.

The COVID-19 pandemic has put in the spotlight the disadvantage experienced by staff with protected characteristics and it is evident that there has been a national worsening of the experience of BAME colleagues compared to white staff, particularly around discrimination from seniors and a sense of equal opportunity.

The Workforce Race Equality Standard (WRES) aims to enable NHS Trusts to understand what they need to do to improve workforce race equality and to embed the WRES within their organisations.

Assessment

This year's WRES results show that UHNM, as with other NHS organisations across England has seen a general deterioration in the experiences of BAME colleagues, which is reflected in the WRES metrics detailed in this report. Whether this national and local deterioration in metrics can be attributed to Covid-19 is yet to be fully understood. In summary, five of our data indicators have improved on the previous year, whilst four have deteriorated. The metrics that have deteriorated are related to experience of bullying, harassment or discrimination and belief in equal opportunity for career development.

It is positive that we can see that our workforce continues to increase in diversity, but this is not reflected in improved performance against our Model Employer target, indicating that BAME staff continue to face barriers to progression into senior roles.

As an organisation our equality and inclusion workforce priorities for 2022-2025 are:

Priority 1: To listen to, understand and learn from the experience of all staff
Priority 2: To respect and value all colleagues and their contribution and have a strategic focus on dignity and respect
Priority 3: To develop a culture of inclusive and compassionate leadership
Priority 4: To ensure that people are recruited, trained and promoted according to their abilities and in the proportions one would expect for the populations represented

Note on Terminology: The terms Black, Asian and Minority Ethnic (BAME) and ethnically diverse will be used throughout this report to describe colleagues from a non-white background.

Key Recommendations:

This report has been presented to Executive Workforce Assurance Group and Transformation & People Committee. Trust Board is requested to consider this WRES Report and the actions we intend to take to close the gaps in career and workplace experience between our BAME staff and the overall workforce at UHNM during 2022-23.

University Hospitals of North Midlands NHS Trust

Workforce Race Equality Standard (WRES)
2022 Report

1. Introduction

The NHS was established on the principles of social justice and equity, but evidence tells us that the treatment of our colleagues from Black, Asian and Minority Ethnic (BAME) groups can fall short. Inequalities in any form are at odds with the values of the NHS and we know that the fair treatment of our staff is directly linked to better clinical outcomes and better experience of care for our patients.

The national evidence from each WRES report over the years has shown that BAME staff are less well represented at senior levels, have measurably worse day to day experiences of life in NHS organisations, and have more obstacles to progressing in their careers.

The COVID-19 pandemic has put in the spotlight the disadvantage experienced by staff with protected characteristics and it is evident that there has been a national worsening of the experience of BAME colleagues compared to white staff, particularly around discrimination from seniors and a sense of equal opportunity.

The key national findings from the 2021 WRES analysis found:

+3.3%
22.4% (309,532) of staff working in NHS Trusts and CCGs in England were from a BAME background. This is an increase from 19.1% in 2018

X1.14
BAME staff were 1.14 times more likely to enter the formal disciplinary process compared to white staff. This is an improvement on 2019 (1.22)

X1.61
White applicants were 1.61 times more likely to be appointed from shortlisting than BAME applicants. There's been year on year fluctuation but no overall improvement in the past 56 years

+48.3%
The total number of BAME staff at Very Senior Manager (VSM) pay band has increased by 48.3% from 201 in 2018 to 298 in 2021

16.7%
16.7% of BAME staff had personally experienced discrimination at work from a manager, team leader or other colleague in 2020, the highest since 2015 (14%)

12.6%
12.6% of board members in NHS trusts were from a BAME background. An improvement from 10.0% in 2020

The WRES has been designed to deliver tangible and lasting improvements in race inclusion. NHS providers are expected to show progress against a number of indicators of workforce equality. The WRES is intended to provide a platform and direction to encourage and help NHS organisations to:

- Reduce the differences in the treatment and experience between BAME and white staff in the NHS
- Compare not only their progress in reducing the gaps in treatment and experience but to make comparisons with similar organisations about the overall level of such progress over time
- Identify and take necessary remedial action on the causes of ethnic disparities in the metric outcomes

The WRES is mandated annually as part of the NHS Standard Contract. NHS Organisations are required to publish their data and action plan on their public facing website.

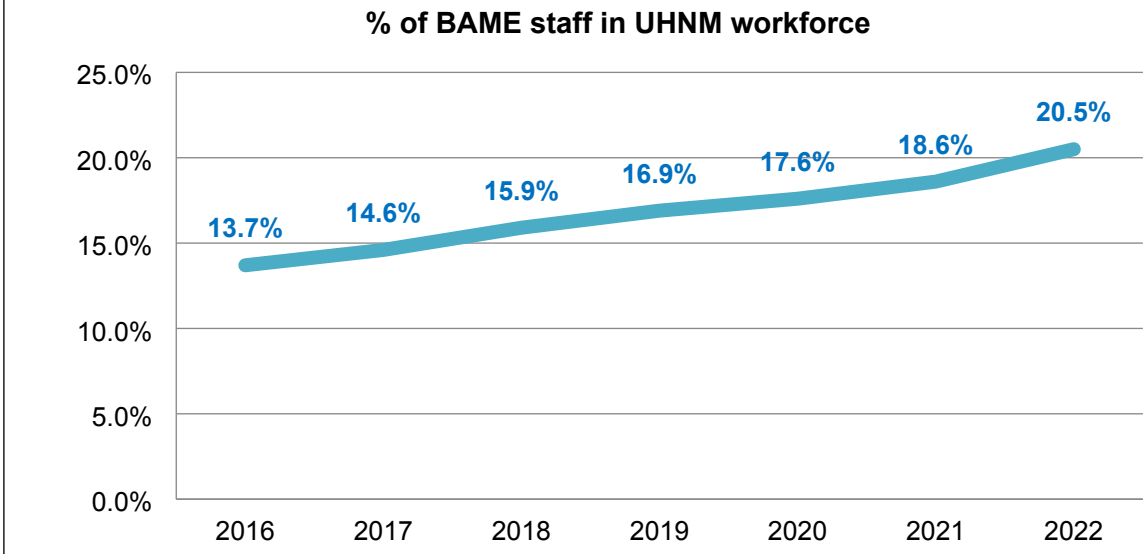
2. WRES Metrics and UHNM Performance

A detailed analysis of the UHNM WRES Metrics and trend analysis is attached as Appendix 1 and includes comparison of our performance against benchmarking data where this is available from either the 2021 NHS Staff Survey, or the 2021 National WRES data analysis report. A summary of our 2022 WRES Metrics is outlined below.

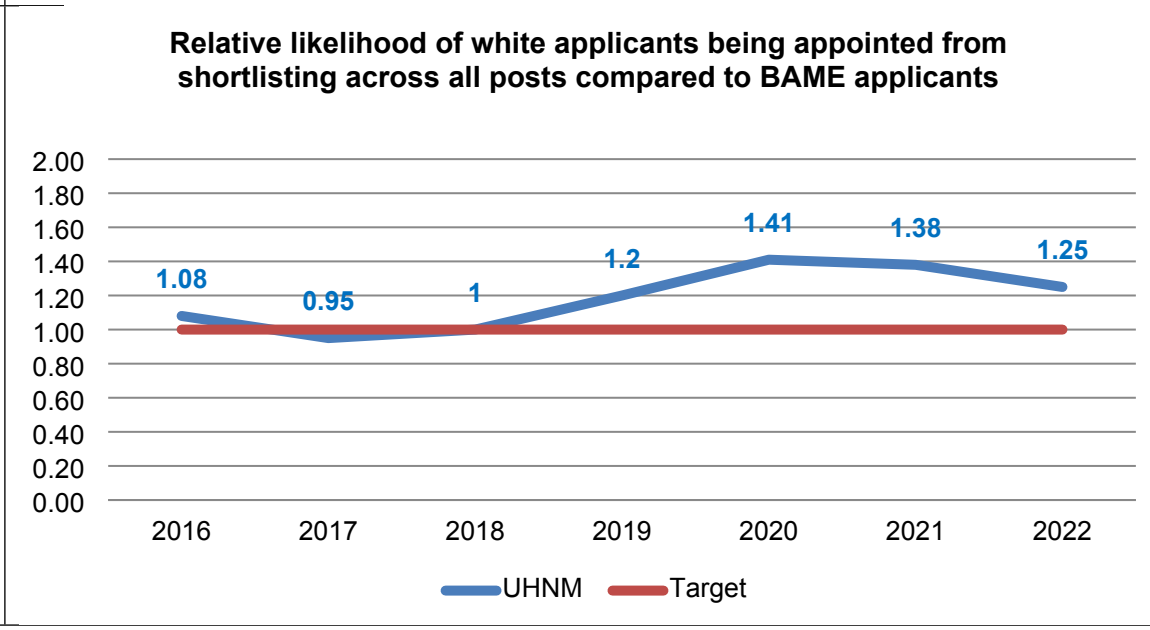
Note: data for Metrics 2, 3 and 4 is auto calculated using the WRES data submission report to produce a relative likelihood score. A relative likelihood of 1.00 indicates that there is no difference between BAME and white staff. For example, for Metric 2, a result above 1.00 indicates that white staff have an increased likelihood of being appointed from shortlisting compared to BAME staff and for Metric 3 a result above 1.00 would indicate that BAME staff are more likely to enter the formal disciplinary process than white staff.

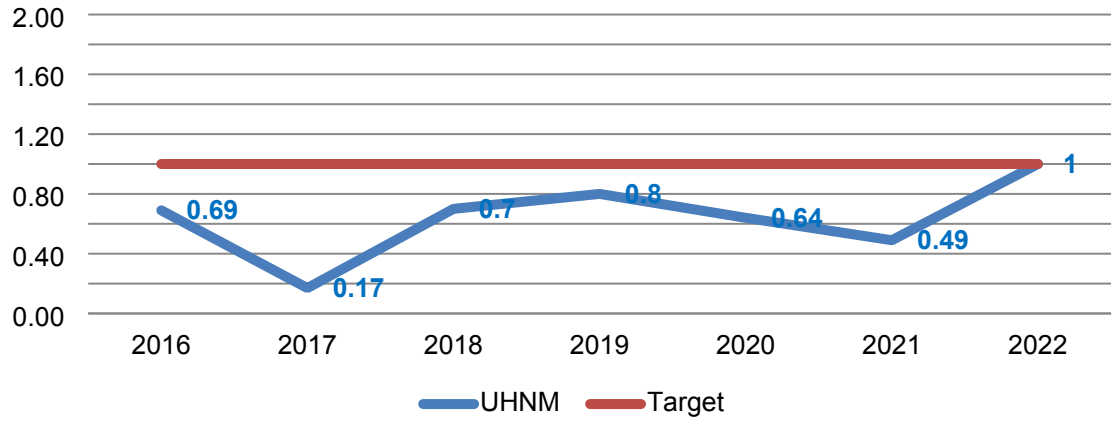
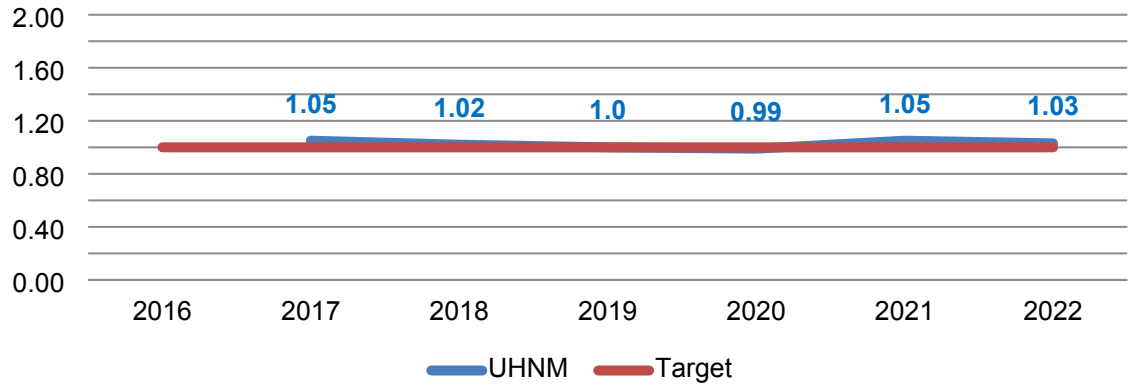
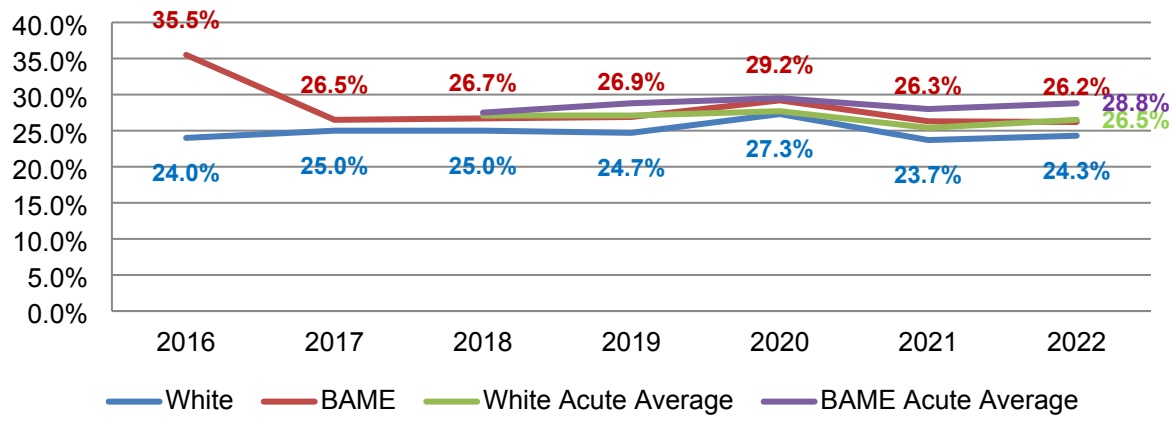
WRES Metrics Trend

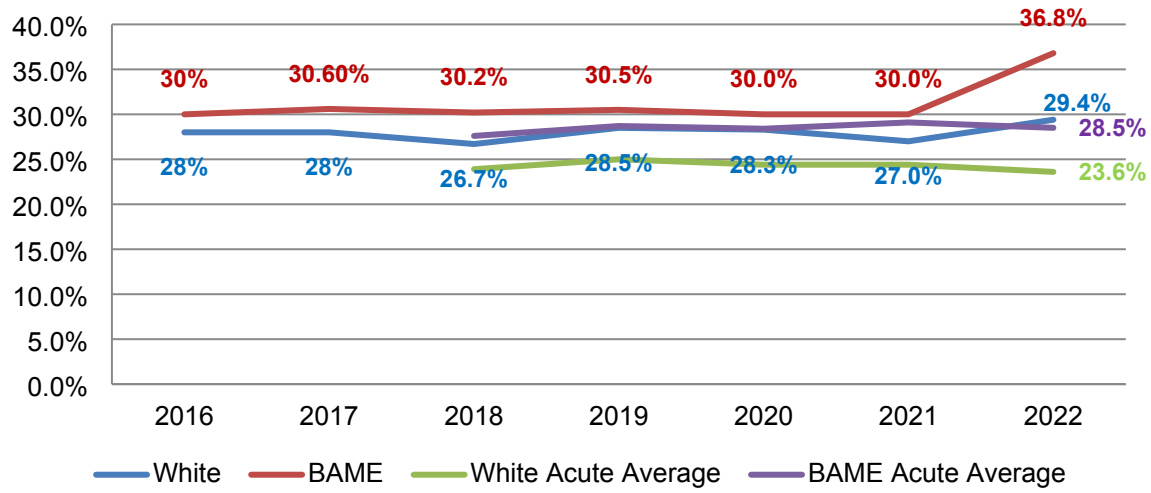
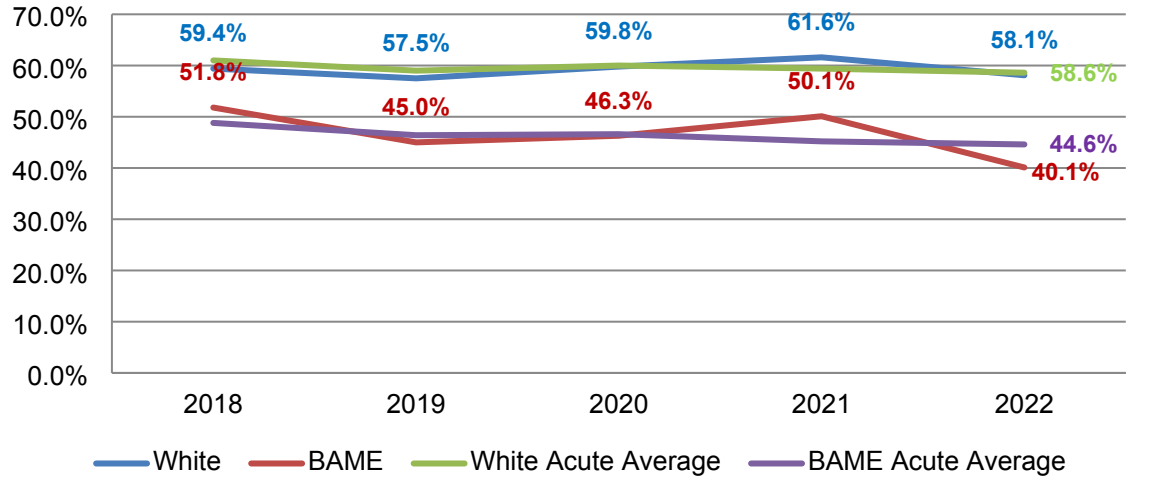
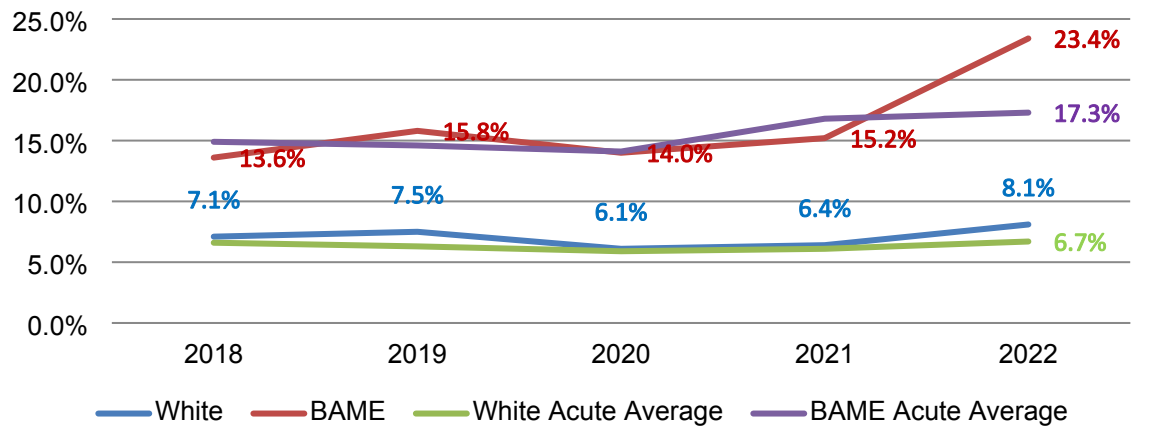
Metric 1



Metric 2



3	**Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff** 
4	**Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BAME staff** 
5	**Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months** 

6	**Percentage of BAME staff experiencing harassment, bullying or abuse from staff in the last 12 months** 
7	**Percentage of BAME staff believing that the Trust provides equal opportunities for career progression or promotion** 
8	**Percentage of BAME staff experiencing discrimination at work from a manager, team leader or other colleagues in the last 12 months** 
9	Percentage difference between the organisations' board voting membership and its overall workforce	-15%

3. Race Equality Actions Undertaken in 2021/22

During 2021/22, we have undertaken the following actions to deliver against our equality, diversity and inclusion WRES priorities, and responding to the findings of the BRAP and Roger Kline cultural review, which includes the creation of our Culture Improvement Plan:

Priority 1: To listen to, understand and learn from the experience of all staff

- Worked with our Staff Networks to create our new Equality, Diversity and Inclusion Strategy
- Approved the Ethnic Diversity Staff Network Charter
- Held a Board Seminar to hear directly from our Staff Networks
- Regular meetings between the Ethnic Diversity Staff Network Chair and Executive Sponsors
- Cultural Review held meetings with staff network members to hear their workplace experiences

Priority 2: To respect and value all colleagues and their contribution and have a strategic focus on dignity and respect

- Worked with our staff networks in the creation of our Being Kind behaviour Compact and supporting guidance and our new Resolution Policy
- Our Ethnic Diversity Staff Network created Zero Tolerance of racism, abuse and harassment posters which have been displayed in all public areas, launched during National Race Equality Week
- Increased Freedom To Speak Up Guardian resource
- Launched mandatory speaking up training for all staff
- Promoted the important role of BAME Allies through our UHNM animation 'how to be an effective ally'
- Raised the profile of race equality and workplace inclusivity through our annual calendar of diversity and inclusion campaigns and engagement activities such as Black History Month, South Asian Heritage Month and Show Racism the Red Card

Priority 3: To develop a culture of inclusive and compassionate leadership

- The UHNM 'Belonging in the NHS' Inclusivity Masterclass has been extended to Silver, Gold and Platinum Connects Leadership Programmes. The Silver masterclass is available on a monthly basis and has been enhanced with activities about micro-aggressions and unconscious bias
- Launched the ENABLE compassionate leadership programme for all line managers, which has inclusion running through the heart of its content
- Race Equality Board Development Seminar held in September 2021 with our Staff Network Chairs
- Winter and Summer system wide Inclusion School sessions for all leaders to gain a greater understanding of key concepts of inclusion
- Our WRES Expert and Sponsor participated in the WRES Expert Advancement Programme

Priority 4: To ensure that people are recruited, trained and promoted according to their abilities and in the proportions one would expect for the populations represented

- Revised and updated the equality & inclusion in recruitment e-learning package
- Enhanced our Values Based Recruitment pool of questions to include a greater scope of EDI related questions
- Commenced cohort 4 of our system wide positive action Staffordshire Stepping Up (renamed New Futures) programme and put forward UHNM nominations to the Midlands Developing Aspirant Nursing & Midwifery Leadership programme
- Continued with the tailored race equality support given to the overseas nursing programme
- Created divisional level Race Disparity Ratio information

4. Conclusions

While there is year on year increases in the diversity of our workforce, their experiences, particularly regarding behaviours and discrimination from other colleagues and managers have deteriorated sharply and remain a key challenge for the organisation, actions to address these challenges are the focus of our Culture Improvement Plan.

We are committed to ensuring that our BAME staff are involved in shaping our equality, diversity and inclusion work and have opportunities to influence our activities to improve race equality at UHNM. We do this by working collaboratively with our Ethnic Diversity Staff Network and through a range of workforce engagement activities, for example survey's and awareness events in addition to the National Staff Survey. We know that by working in partnership with our staff that we can develop workplace cultures where everyone feels they belong, and that enables all of our employees to thrive.

Our WRES Action Plan is based on the commitments of the NHS People Plan, Midlands Workforce Race, Equality and Inclusion Strategy, our UHNM EDI Strategy for 2022-2025 and from listening to the voices of our staff, either directly from our Ethnic Diversity Network, or Staff Voice feedback or arising from the Cultural Review. To maximise meaningful action we are working collaboratively as a system to drive systemic change particularly in the recruitment and progression of BAME colleagues.

At the time of writing, UHNM is participating in The Race Code assessment process, which will lead to the creation of a Race Code Action Plan, which will be implemented and monitored alongside our WRES Action Plan that accompanies this report. The assessment reviews the accountability and governance of the organisation in relation to its commitment and work programmes regarding race equality. The Race Code does not create new obligations but provides a set of standards based on existing laws, codes and best practice through an accountability framework and quality mark. Each provider organisation in the Staffordshire and Stoke on Trent ICS is participating in the Race Code Assessment.

We are also aware that the NHSEI Workforce Race Equality Standard (WRES) team is developing a five-year race equality strategy, to establish a standard for advancing race equality, eliminating discrimination, and fostering good relations for staff and workers across organisations, operations and services. The strategy is due for publication imminently, and will also shape our actions in this important agenda.

Our UHNM equality and inclusion workforce priorities, as identified in our EDI Strategy for 2022-2025 are:

Priority 1: To listen to, understand and learn from the experience of all staff
Priority 2: To respect and value all colleagues and their contribution and have a strategic focus on dignity and respect
Priority 3: To develop a culture of inclusive and compassionate leadership
Priority 4: To ensure that people are recruited, trained and promoted according to their abilities and in the proportions one would expect for the populations represented

Progress against these priorities will be measured by improved scores in the 2023 WRES submission, 2022 and 2023 Staff Survey results and the monitoring of other relevant metrics including regular engagement with our BAME workforce. Progress against this Action Plan will be monitored at the Executive Workforce Assurance Group and Trust Transformation and People Committee.

UHNM WRES Action Plan 2022 – 2023

WRES Metric	Action	Time-scale	KPI	Progress Rating
Percentage of BAME staff in each of the AfC Bands 1 – 9 or medical and dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	• Establishment of an Inclusive Recruitment Task & Finish Group reporting to Executive Workforce Assurance Group • Deep dive into our workforce and recruitment data and work with divisions to develop actions to address areas where ethnic diversity is under represented • Embedding of the Inclusive Leadership Development Strategy • Continue to progress the system and UHNM actions in relation to the 6 High Impact actions identified to close the ethnicity gap in recruitment and promotion outcomes from the Midlands Race Equality and Inclusion Strategy • Creation of divisional Race Disparity Ratio and EDI dashboards to enable local progress monitoring	Q3 Q3 In place Q3	% of BAME staff in pay bands and professional groups/ Model Employer/ Race Disparity Ratio	GA
Relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants	• Establish an Inclusive Recruitment Task and Finish Group, as above • Update recruitment training and monitoring of recruitment panel competence • Introduce an effective audit process of adherence to diverse interview panels and practice	Q3 Q4 Q4	Race Disparity Ratio Model Employer Within 0.8-1.25 WRES Metric 2	GB
Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	• Introduction of the resolution panel meeting as a decision making group when considering dispute resolution and potential referral to disciplinary processes • Just and Learning checklist to be completed before any progression to disciplinary processes	Q2 In place	Within 0.8 – 1.25 WRES Metric 3	B
Relative likelihood of white staff accessing non-mandatory training and (CPD) compared to BAME staff	• Update the talent management process to ensure greater prioritisation of diversity in talent, by introducing a self-nomination route, and assessment centres as a precursor for Gold and Platinum Connects programmes • Continue to promote leadership development opportunities through the Ethnic Diversity Network and Leaders Network (e.g. New Futures and High Potential Scheme) • Promote access to coaching and career conversations available through the system wide pool of diverse coaches • Continue to monitor the diversity of participants in UHNM non mandatory learning and development recorded on ESR	In place	Improved Staff Survey performance at least matching acute sector average on q15 - Does your organisation act fairly with regard to career progression/ promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	B

WRES Metric	Action	Time-scale	KPI	Progress Rating
Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	• Ethnic Diversity Staff Network to work with the Trust Security Lead updating conflict resolution training in line with BMA guidance and ensure all staff are aware of the Trust's position on racist and other abusive behaviours aimed at our staff	Q4	Improved Staff Survey performance at least matching acute sector average on q14a - In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	GB
Percentage of BAME staff experiencing harassment, bullying or abuse from staff in the last 12 months	• Implement the actions within the Trust Culture Improvement Plan • Launch of our new Resolution Policy, Toolkit, Being Kind Compact and associated guides and all staff Being Kind in Action e-learning • Bespoke interventions in hot spot areas • Increase the number of internal mediators with a further cohort of training • Introduction of the 'Feedback Skills and Resolution Skills' Masterclass • Review and update the EDI training provided in our statutory and mandatory training programme • Specific awareness initiatives about microaggressions and harmful banter	Q2 Q1 Q3 Q3 Q4 Q4	Improved Staff Survey performance at least matching acute sector average on q14b&c - In the last 12 months how many times have you personally experience harassment, bullying or abuse at work from managers or other colleagues?	GA
Percentage of BAME staff believing that the Trust provides equal opportunities for career progression or promotion	• Embedding of the Inclusive Leadership Development Strategy • Revise the Performance & Development Review to encompass a more strength based development and forward looking annual appraisal • Promote access to career conversations and coaching • Race Disparity Ratio by directorate	In place Q3 Q3	RDR / Model Employer Targets met Improved Staff Survey performance at least matching acute sector average on q15 - Does your organisation act fairly with regard to career progression/ promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	GA

WRES Metric	Action	Time-scale	KPI	Progress Rating
Percentage of BAME staff experiencing discrimination at work from a manager, team leader or other colleagues in the last 12 months	• All line managers to attend the ENABLE leadership programme • Monthly sessions of Silver Programme Our NHS People inclusivity masterclass • Introduction of a Medical Leadership Programme • Launch of Resolution Policy, Toolkit, Being Kind Compact and associated guides and all staff e-learning • Raise awareness through the diversity events calendar of the Trusts commitment to zero tolerance of discrimination, including Show Racism the Red Card Events and individual responsibility of Allyship • Launch Cohort 2 of the UHNM Reciprocal Mentoring Programme with organisational leaders • Build audit of VBR recruitment question compliance into the recruitment audit process	In place Q2 Q3 On-going Q3 Q4	ENABLE attendance rates Improved Staff Survey performance at least matching acute sector average on q16b - In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?	B GA GB
Percentage difference between the organisations' board voting membership and its overall workforce	• Celebrate the additional ethnic diversity of the Board, welcomed through the appointment of a new non-executive director • Cohort 2 of the Reciprocal Mentorship Programme with members of our Ethnic Diversity Staff and our Trust Board • Continue with strong board leadership internally and externally on race inclusion and engagement with UHNM Staff Diversity Networks • Ensuring diversity in our governance and decision making spaces in line with our Accountability Framework	Q4 Q3 On-going Q4	Board ethnic diversity representation matches that of the organisation – 20.5%	GA

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.

Appendix 1 – UHNM WRES 2022 Metric Analysis

Further detail is provided below on each of the WRES metrics, including comparisons of our performance against benchmarking data where this is available from either the 2021 NHS Staff Survey, or the 2021 National WRES data analysis report, which was published in April 2022.

Four of the WRES indicators are drawn from the national NHS Staff Survey. The response rate for the 2021 staff survey was 43%. 15.1% of these responses were from BAME respondents.

Metric 1: Representation of BAME staff in each of the Agenda for Change (AfC) Bands 1 – 9, or Medical and Dental subgroups and Very Senior Manager (including executive Board members) compared with the percentage of staff in the overall workforce

96.7% of the workforce has disclosed their ethnicity, and the percentage of BAME staff in our total workforce has increased from 18.6% in 2021 to 20.5% at 31st March 2022:

Ethnic Group	% of Total Workforce
White	76.2%
BAME	20.5%
Not Stated/Null	3.3%
Total	**100%**

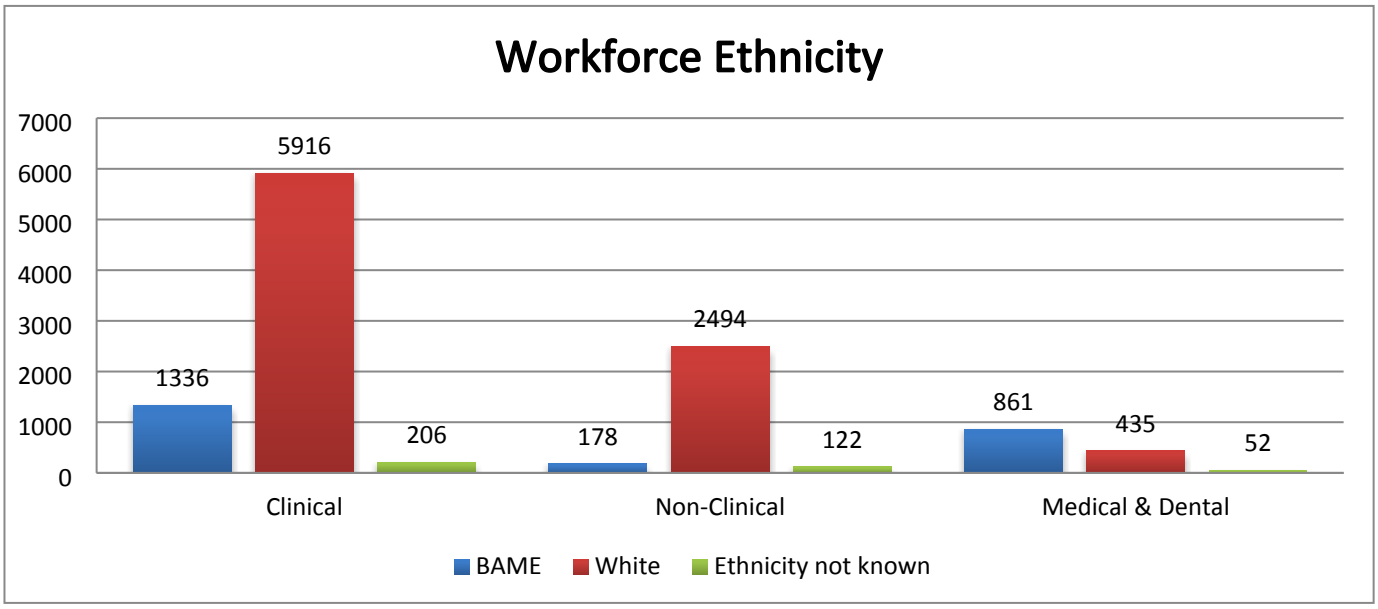
The ethnicity data is not yet available from the 2021 Census. Our latest figures compare favourably with BAME representation within our local communities, as recorded in the 2011 Census, which indicated that across Staffordshire 6.4% of the population is from a Black and Minority Ethnic background. The BAME population of Stoke on Trent is 13.4%, and Staffordshire & Stoke on Trent together being 8.1%. The latest available data for BAME staff representation working in the Midlands NHS is 21.6% (April 2021).

The following table and graphs demonstrate BAME representation across Agenda for Change (AfC) pay bands and Medical and Dental workforce:

WRES Metric		2019	2020	2021	2022	Movement
Percentage of BAME staff in each of the AfC Bands 1 – 9 or medical and dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	Under Band 1: Band 1: Band 2: Band 3: Band 4: Band 5: Band 6: Band 7: Band 8a: Band 8b: Band 8c: Band 8d: Band 9: VSM: Medical & Dental	0.0% 20.4% 9.9% 4.8% 10.4% 23.8% 10.5% 4.0% 5.9% 2.4% 6.5% 0.0% 0.0% 0.0% 55.6%	11.1% 5.0% 11.6% 5.2% 10.7% 24.4% 11.0% 4.8% 6.4% 2.3% 6.5% 0.0% 0.0% 0.0% 58.4%	6.1% 5.1% 11.9% 5.1% 11.9% 26.2% 12.4% 4.3% 6.9% 4.3% 6.1% 0.0% 8.3% 0.0% 60.8%	18.9% 3.2% 13.3% 5.9% 10.2% 30.7% 13.7% 5.8% 6.5% 5.1% 5.3% 0.0% 0.0% 0.0% 63.6%	↕ ↑ ↕ ↑ ↑ ↕ ↕ ↔ ↓ ↔ ↑

At UHNM BAME staff are significantly better represented in clinical roles compared to non-clinical roles:

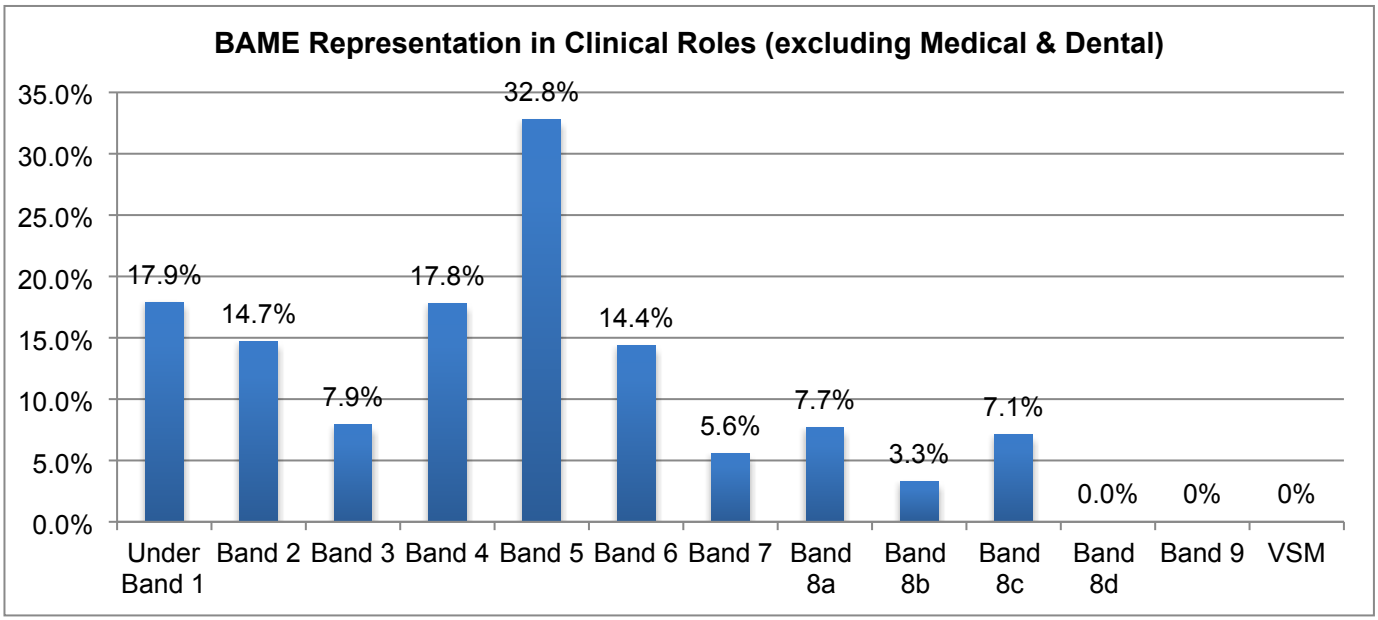
	Non-Clinical Roles	Clinical Roles	Medical & Dental
BAME Representation in UHNM Workforce:	6.4%	17.9%	63.9%



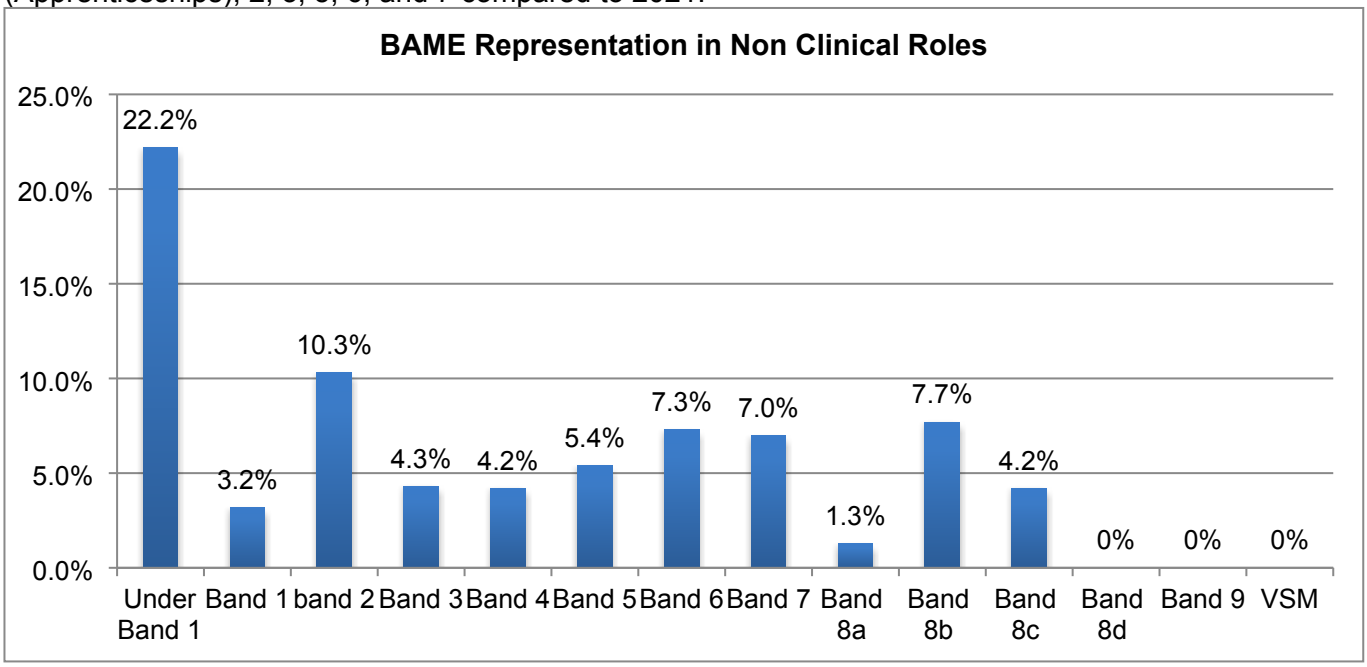
BAME representation has increased across all roles, with Medical and Dental increasing by 3.1%; Clinical roles increasing by 1.9% and representation in clinical increasing by 1.0% compared to 2021.

BAME representation within the Agenda for Change professional groups at UHNM:

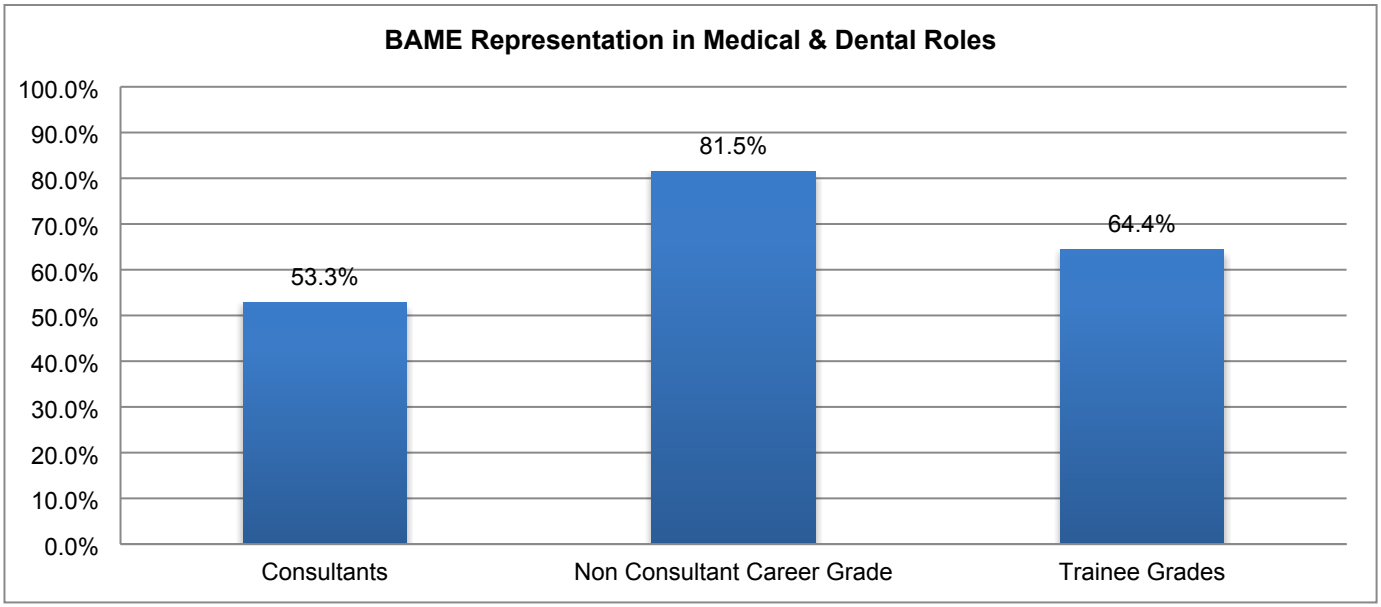
	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Health-care Scientists	Nursing and Midwifery Registered
BAME %	10.5%	14.7%	4.8%	10.0%	15.0%	8.9%	23.8%



There have been notable increases in BAME representation in Clinical Bands Under Band 1 (Apprenticeships), 2, 3, 5, 6, and 7 compared to 2021.



BAME representation in non-clinical roles has remained consistent, but below the ethnicity profile within the local population of Staffordshire and Stoke on Trent in the majority of pay bands.



BAME representation has increased across in our medical and dental workforce, a year on year increase since we began reporting the WRES.

'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS', forms part of a strategy within the overarching WRES to deliver assurance that the composition of leadership not only includes the best range of talent, skill sets and experience available to us, but that it also broadly reflects those who work in our organisation. Our staff should look at their leaders and see themselves represented.

The following table shows the 10-year trajectory for the UHNM workforce to reach equality by 2028 for Agenda for Change Bands 8a to VSM. The numbers show the required staff in post for each year:

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Band 8a	17	21	24	28	31	35	38	42	45	49	52
Band 8b	3	4	5	6	7	9	10	11	12	13	14
Band 8c	2	2	3	3	3	4	4	4	5	5	5
Band 8d	0	0	1	1	1	2	2	2	3	3	3
Band 9	0	0	0	1	1	1	1	1	1	2	2
VSM	0	0	0	1	1	1	1	1	1	2	2

The table below demonstrates the UHNM BAME staff in post as at 31st March 2022 and is compared to the 2022 trajectory for the Trust:

	2018 actual	2019 actual	2020 actual	2021 actual	2022 actual	2022 ambition	Gap
Band 8a	17	20	22	26	25	31	-6
Band 8b	3	2	2	4	5	7	-2
Band 8c	2	2	2	2	2	3	-1
Band 8d	0	0	0	0	0	1	-1
Band 9	0	0	0	1	0	1	-1
VSM	0	0	0	0	0	1	-1

This indicates continued progress in increasing representation in senior positions, but recognises that more work is needed to achieve our aspirations of BAME representation that matches our organisational make-up across all pay bands.

Race Disparity Ratio

The Race Disparity Ratio, introduced in June 2021, is the difference in the proportion of BAME staff at various Agenda for Change bands in the Trust compared to the proportion of white staff at those bands. It is presented at three tiers:

- Bands 5 and below ('lower')
- Bands 6 and 7 ('middle')
- Bands 8a and above ('upper')

The Race Disparity Ratio is underpinned by the principle that once recruited into an organisation progression/promotion chances should be equally accessible to everyone – an issue that is highlighted as problematic by WRES data.

UHNM Race Disparity Ratio	Progress	2022	2021	2020
Disparity ratio – lower to middle	↓	1.62	1.63	1.72
Disparity ratio – middle to upper	↑	2.14	1.74	1.83
Disparity ratio – lower to upper	↑	3.46	2.82	3.14

The Race Disparity Ratio does not include medical and dental staff. The Race Disparity Ratio looks at the probability of White staff being promoted from lower Bands to Bands 8 and 9 and VSM compared to BAME colleagues and these are the implications of our data:

- Lower to Middle tier progression: White staff are 1.62 times more likely to progress through our organisation than BAME staff
- Middle to Upper tier progression: White staff are 2.14 times more likely to progress through our organisation than BAME staff

- Lower to Upper tier progression: White staff are 3.46 times more likely to progress through our organisation than BAME staff

The chart below demonstrates ethnicity representation in clinical and non-clinical Agenda for Change roles, and demonstrates that BAME representation is increasing in the lower and middle tiers, representation has decreased in the upper tier compared to last year. (Figures for 2021 in brackets):

AfC Bandings	White - 2022	BAME - 2022	Unknown - 2022
1 to 5	79.6% (81.2%)	16.8% (14.9%)	3.6% (3.8%)
6 and 7	86.3% (87.5%)	11.3% (9.9%)	2.5% (2.6%)
Band 8a+	92.6% (92.6%)	5.8% (6.1%)	1.6% (1.3%)
Grand Total	**82.0% (83.4%)**	**14.8% (13.2%)**	**3.2% (3.4%)**

We can analyse the race disparity ratio by non-clinical and clinical staff, and this demonstrates that there has been progress in non-clinical roles, but deterioration in the RDR for clinical roles.

UHNM Non Clinical Staff Race Disparity Ratio	Progress	2022	2021
Disparity ratio – lower to middle	↓	0.93	1.05
Disparity ratio – middle to upper	↑	2.50	2.27
Disparity ratio – lower to upper	↓	2.34	2.38

UHNM Clinical Staff Race Disparity Ratio	Progress	2022	2021
Disparity ratio – lower to middle	↑	2.13	2.09
Disparity ratio – middle to upper	↑	1.86	1.46
Disparity ratio – lower to upper	↑	3.95	3.05

Metric 2: The relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants

This indicator, which is extracted from our TRAC recruitment system, indicates that across all recruitment, BAME applicants are less likely to be appointed from shortlisting than white staff with a metric of **1.25**. A metric of 1.0 would indicate no difference between BAME and white applicants.

A review of the TRAC System indicates that for the 12 month period 1st April 2021 – 31st March 2022 demonstrated:

Ethnic Group	Applicants Shortlisted	Applicants appointed	% of applicants appointed from shortlisting	% of Total Appointed
White	3035	599	19.7%	59.7%
BAME	1433	225	15.7%	22.4%
Not Stated	288	179	62.2%	17.8%
Total	**4,756**	**1,003**	**-**	**100%**

(As per WRES guidance, this data excludes Deanery and bank appointments)

This indicates that BAME percentage of total appointments made during the year is similar to our BAME representation within the Trust (20.5%). This metric has improved compared to the previous year, which was 1.38. Data indicates that our performance is better than the average for this indicator.

2022 UHNM Result	2021 UHNM Result	ICS Result	Midlands Result	National Result
1.25	1.38	1.34	1.57	1.61

Metric 3: The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff

To be a model employer, the NHS needs to be an inclusive employer with a diverse workforce at all levels. However, staff also need to feel fully engaged and supported within the workplace. This indicator is based on data from a two year rolling average of the current year and the previous year of entry into our formal disciplinary process as recorded on the HR Case Tracker. The data indicates that our BAME staff are not disproportionally represented in entry to the formal disciplinary process, but are equally likely to, and within the non-adverse range of 0.8 – 1.25 (as measured by the WRES).

2022 UHNM Result	2021 UHNM Result	ICS Result	Midlands Result	National Result
1.0	0.49	0.72	1.09	1.14

Metric 4: Relative likelihood of white staff accessing non-mandatory training and career progression and development (CPD) compared to BAME staff

This indicator measures the relative likelihood of white staff accessing non-mandatory training (recorded on ESR) compared to BAME staff. Our data indicates that White staff are slightly more likely to access non mandatory training and CPD, and has slightly improved compared to the previous year.

2022 UHNM Result	2021 UHNM Result	ICS Result	Midlands Result	National Result
1.03	1.05	0.69	1.04	1.14

Metric 5: Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

This indicator is taken from the 2021 NHS Staff Survey, and shows that 26.2% of the 665 BAME staff who responded to the survey reported experiencing harassment bullying or abuse from patients, relatives or the public in the last 12 months, compared with 26.3% the previous year. Our data is better than the acute sector average and national results for both White and BAME staff on this indicator:

Staff Group	2021 UHNM Result	2021 Staff Survey Acute Sector Average	2021 National Result	2020 UHNM Result	ICS Result	Midlands Result
BAME	26.2%	28.8%	29.2%	26.3%	27.4%	26.8%
White	24.3%	26.5%	27.0%	23.7%	24.4%	25.8%

Metric 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

This indicator measures the percentage of BAME staff reporting experience of harassment, bullying or abuse from other staff in the 2021 NHS Staff Survey in comparison with the organisation as a whole.

The data tells us that there has been deterioration of 6.8% in the percentage of BAME staff reporting experience of harassment, bullying or abuse from other staff compared to last year. White staff experience has also deteriorated by 2.4%. The UHNM data is worse than the acute sector average and national results.

Staff Group	2021 UHNM Result	2021 Staff Survey Acute Sector Average	2021 National Result	2020 UHNM Result	ICS Result	Midlands Result
BAME	36.8%	28.5%	27.6%	30.0%	27.7%	28.5%

White	29.4%	23.6%	22.5%	27.0%	21.9%	22.8%

Metric 7: Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion

This indicator is taken from the 2021 NHS Staff Survey, and a change in how this metric is calculated was made for this survey. We had seen year on year improvement on this indicator over the past 5 years. However, the percentage of our BAME staff that believe that the Trust provides equal opportunities for career progression or promotion deteriorated in 2021 and is worse than the acute sector average and national results.

Staff Group	2021 UHNM Result	2021 Staff Survey Acute Sector Average	2021 National Result	2020 UHNM Result	ICS Result	Midlands Result
BAME	40.1%	44.6%	44.4%	78.2%	77.8%	69.5%
White	58.1%	58.6%	58.7%	87.8%	90.0%	87.8%

Metric 8: Percentage of staff experiencing discrimination at work from a manager, team leader or other colleagues

This indicator is taken from the 2021 NHS Staff Survey, and demonstrates staff experience of discrimination in the workplace from a manager, team leader or other colleagues. Our data shows a significant increase (deterioration) to 23.4% of BAME staff reporting experience of discrimination, compared to 15.2% the previous year. Our data for BAME and white staff is worse than the acute sector average and national results.

Staff Group	2021 UHNM Result	2021 Staff Survey Acute Sector Average	2021 National Result	2020 UHNM Result	2020 ICS Result	2020 Midlands Result
BAME	23.4%	17.3%	17.0%	15.2%	16.0%	16.9%
White	8.1%	6.7%	6.8%	6.4%	5.4%	5.9%

Metric 9: The percentage difference between the organisations board voting membership and its overall workforce

Boards are expected to broadly representative of their workforce. One member of our board is from an ethnically diverse background and the percentage difference between board membership and our BAME workforce is now - 15%.

Performance and Finance Committee Chair's Highlight Report to Board

29th November 2022

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• In terms of urgent care performance, work remained ongoing with the focus on reducing ambulance holds which continued to be challenged. An increase in attendances, additional patients within resus, escalation of critical care and increase in acuity were highlighted as additional challenges which was compounded with inconsistencies with the number of simple discharges • There continued to be a shortfall in the identification of cost improvements, of £4.4 m and this was being considered alongside planning for 2023/24	• To discuss the work being done with regards to improving discharges at December's meeting • To discuss the progress made with theatre improvement programme at the meeting in January • To articulate the reasons for cancellations within future performance reports • To articulate the strategy for Community Diagnostic Centres in January • To clarify the costs associated within the Radiology Workforce business case with regards to outsourcing reduction and improvements to the run rate • To expedite the broader strategy for Imaging and to discuss this at a future meeting
✓ Positive Assurances to Provide	**Decisions Made**
• The Trust continued to remain in Tier 2 with regards to elective care although conversations had commenced with regards to moving out this in the near future. Assurance was provided in terms of the revised trajectory for reducing the 62 day backlog, whereby performance was reducing in line with the trajectory. In addition, the number of 104 patients had continued to reduce and work was ongoing with Divisions to reduce the number of 78 week waits in line with the target for elimination by March 2023. • The Committee welcomed the update from Pharmacy in terms of the procurement of medicines and noted the associated risks with the medical supply chain which continued to be challenged • There had been a small deterioration in the financial position for month 7 although this was expected, and it was noted that the system continued to forecast a break-even position	• The Committee approved the Tier 2 elective care self-certification • The Committee approved the following business cases; BC-0511 for the purchase of a Modular Building to support Enhanced Primary Care and Out of Hours Primary Care Services, BC-0494 Radiology Workforce, BC-0484 Bowel Cancer Screening Programme Age Extension to 56 and 58 year olds, and BC-0502 Maternity Safe Staffing • The Committee approved the following eREAFs 10056, 10150 and 9802
Comments on the Effectiveness of the Meeting	
• The Committee welcomed the focussed discussion on operational performance and agreed to have standing updates at future meetings with regards to the progress made in reducing ambulance waits	

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Performance Report – Month 7 2022/23	BAF 5	16	! ✓	Assurance	6.	BC-0484 NSBCSP Age Extension 56 and 58 year olds Year 2 Business Case	-		-	Approval
2.	UHNM Tier 2 Analysis	BAF 5	16	✓	Assurance	7.	BC-0502 Maternity Safe Staffing in line with Birthrate Plus® Business Case	BAF 1/3	13419 20 24135 20 23834 20 16432 16 11518 15	-	Approval
3.	Planned Care Improvement Board Highlight Report (17-11-22)	BAF 5	16	-	Assurance	8.	Pharmacy Directorate Procurement and Supplies Report M1- 6 2022-23	BAF 8	25050 12 24181 12	✓	Assurance
4.	BC-0511 Purchase of Modular Building to provide Enhanced Primary Care and Out of Hours Primary Care Services at UHNM	BAF 5	16	-	Approval	9.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (PO) Expenditure	-		-	Approval
5.	BC0494 Imaging Services – Radiology Workforce Business Case	BAF 1/3	16	-	Approval	10.	Finance Report – Month 7 2022/23	BAF 8	9	✓	Assurance

3. 2022 / 23 Attendance Matrix

		Attended							Apologies & Deputy Sent				Apologies	
Members:		A	M	J	J	A	S	O	N	D	J	F	M	M
Dr L Griffin (Chair)	Non-Executive Director													
Mr P Akid	Non-Executive Director	Chair												
Ms H Ashley	Director of Strategy													
Ms T Bowen	Non-Executive Director													
Mrs T Bullock	Chief Executive													
Mr P Bytheway	Chief Operating Officer						KT/OW	KT						
Mr M Oldham	Chief Finance Officer													
Mrs S Preston	Strategic Director of Finance													
Miss C Rylands	Associate Director of Corporate Governance			NH	NH	NH	NH		NH					
Mr J Tringham	Director of Operational Finance													

Executive Summary

Meeting:	Trust Board	**Date:**	7th December 2022
Report Title:	Integrated Performance Report, Month 7 2022/23	**Agenda Item:**	17.
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & Safety; Operational Performance: Warren Shaw, Strategic Director of Performance & Information; Matt Hadfield, 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

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

Key messages

The Trust achieved the following standards in October 2022:

- Friend & Family (Inpatients) 95.7% and exceeds 95% target.
- Harm Free achieved 95% target rate
- 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 October 2022.
- Sepsis Screening compliance in Emergency Portals achieved the target 90%.

The Trust did not achieve the set standards for:
- Friend & Family Test for A&E improved to 64.1% but remains below 85% target.
- Friend & Family (Maternity) achieved 50% and below 95% target.
- Falls rate was 5.8 per 1000 bed days against target rate of 5.7 for October 2022
- There were 17 Pressure ulcers including Deep Tissue Injury identified with lapses in care during October 2022.
- 1 Never Event – relating to misplaced NG Tube
- 91% verbal Duty of Candour compliance recorded in Datix
- 44% compliance with Trust's Duty of Candour 10 working day letter performance following formal verbal notification and under review for completion and upload of letter on Datix
- Timely Observations remain below the 90% target at 62.9% during October 2022
- C Diff YTD figures above trajectory with 12 against a target of 8.
- E. Coli Bacteraemia cases below trajectory with 10 in October compared to target of 16.
- Inpatients Sepsis Screening remains below 90% target rate at 81%.
- Inpatient Sepsis IVAB within 1 hour achieved 84.2% and below 90% target rate
- Children's Sepsis Screening compliance reduced to 77.8% and remains below the 90% target.
- Emergency Portals Sepsis IVAB in 1 hour 66.7% and is below the 90% target for audited patients
- Maternity Sepsis Screening compliance improved to 83.3% against 90% target

During October 2022, the following quality highlights are to be noted:
- The rate of complaints per 10,000 spells is 24.54 and is below the target of 35 and within normal variation. Majority of complaints in October 2022 relate to clinical treatment.
- Total number of Patient Safety Incidents increased in month (1888) and the rate per 1000 bed days has also increased at 46.8
- Total incidents with moderate harm or above and the rate of these incidents are above normal variation levels.
- Rate of falls reported that have resulted in harm to patients currently at 1.2 per 1000 bed days in October 2022. The rate of patient falls with harm continues to be within the control limits and normal variation but is below the mean rate and is statistically significantly below the mean for 7 months indicating improvement in reducing harm from falls.
- Medication related incidents rate per 1000 bed days is 5.3 and patient related 4.5 which are higher 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 a increase during October 2022
- Hospital Associated Thrombosis is within normal variation and at mean level.
- Increased numbers of Definite Hospital Onset / Nosocomial COVID-19 cases reported in October 2022 with 80 in total.
- 8 COVID-19 deaths 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). It is noted that national COVID screening guidance changed 14/09/2022. Patients are now only swabbed on admission if being admitted to high risk area, or immunocompromised or symptomatic for COVID. Otherwise patients are now not routinely screened.
- 14 Serious Incidents reported during October 2022.

All data used in this report is as recorded on 8th November 2022 and figures may change following further review/investigation/update

Operational Performance

Emergency Care
- October has been an extremely challenging month for the Non-Elective Improvement Programme with a number of key metrics deteriorating, the most notable of which were ambulance handover delays over an hour as well as the new Urgent & Emergency Care standard of patients spending over 12 hours in the ED. This is predominantly due to increasing IP restrictions, reduced hospital flow, and is in line with

challenges across the region.

- Despite occupancy and departmental congestion, performance maintained across several metrics on our non-admitted pathways, including SDEC utilisation, mean non-admitted time in the ED, and wait to be seen. This is a result of continued efforts to protect our ability to turnaround patients where ever possible through initiative such as the ED Workforce Business Case and EhPC development.
- Your Next Patient continues to embed and has seen positive results. The most significant of which has been the shifting of approximately 50% of patient moves that were previously occurring in the evening and night, now shifting to the morning and early afternoon. This has the dual benefit of relieving pressure off night time staff and reducing the number of extreme ambulance handover delays over six and eight hours. Further work is ongoing to translate this improvement to delays over one hour.
- The Front Door Reconfiguration is nearing completion with final movement expected in January. This has created more departmental ambulatory space which will be supported by the recent implementation of new workforce models at the front door. These moves have also allowed for more efficient placement of wards downstream, further improving efficiency of existing estates. Examples of this include the co-location of our Frailty Unit with the ED, the Specialty Decision Unit integration with two specialty base wards, and the bringing together of all Child Health clinical areas.

Cancer

- Most recent submitted Cancer Waiting Times position is September 22 which was 49.1% for 62 day performance, an improvement of 1.3% above prediction. Octobers predicted position is for 46.7%; however this is expected to improve during month end close.. This improvement is expected due to the intensive recovery work underway across cancer pathways and diagnostics.
- In August the PTL was over 6000 – this has now reduced by 2089 patients to 3911 in total as at 20/11/22. The PTL has reduced consistently for the past 13 weeks
- The 62 day target is expected to continue an improvement trajectory as additional capacity is put into colorectal by insourcing. Skin have effective recovery plans to reduce their backlog.
- In October the backlog of patients has seen a significant reduction from 1041 at the end of August to 894 at the end of September and 887 at the end of October.
- The incremental decrease of the Skin and Colorectal backlogs have been modelled up to the end of March 2023 where the new trajectory meets the initial trajectory submitted in 22/23 operational plans. Both specialties have enacted recovery plans and are ahead of the new trajectories to reduce the number of patients waiting beyond 62 days on the pathway.
- Skin have implemented recovery plans which has seen implementation of telederm and builds both triage and excision capacity.
- The 28 Day Faster Diagnosis position is currently 58.8% for October, an increase on the September performance of 46%. This standard will be a focus of an Improving together project covering all pathways.
- Cancer will form a workstream as part of the Planned Care governance structure – this will initially focus on our challenged pathways of Skin and Colorectal, alongside 2WW and FDS more generally.
- The Trust remains in Tier 2 for cancer performance with weekly meetings with the Regional NHSE team.

Planned Care

- Day Case and Elective Activity delivered 78% and 80% respectively for October 22 against the national ask of 110%/108%.
- Theatre transformation has been added as an additional workstream under Planned Care and begins with a focus on the 6-4-2 booking process with support from the regional theatres team.
- The focus has moved to 78 week waiters with an Annual Plan to reduce them to below 300 patients by March 2023. The major change will be managing the non-admitted (Outpatient) patients to ensure they get a decision to treat or discharge well before March so any treatment can be carried out to meet the 78 week standard. Slide 29 demonstrates we are ahead of trajectory with 737 patients 78+ in September.

RTT

- The overall Referral To Treatment (RTT) Waiting has slightly decreased from 77,985 in September to 77,546 in October.
- The number of patients > 52 weeks continues to increase – from 4377 in August, 4,569 in September

and 5328 in October.

- At the end of October the numbers of >104 patients was 23. A decrease of 33 from the end of September (albeit different patients). The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity, there is considerable work now on the Trusts route to zero for 104 week waiting patients, with challenges around complex pathways, patient choice and fitness for treatment.
- The Trust remains in Tier 2 for 104> performance with weekly meetings with the Regional NHSE team.

Diagnostics

- Overall DM01 performance was 66%, an improvement on last months 64%.
- Within DM01, the greatest proportions of > 6 week waits are within Non-obstetric ultrasound and endoscopy. Both ultrasound and endoscopies positions are related to an increase in demand alongside workforce shortfalls
- Full DM01 recovery plan agreed which sees the Trust achieving 6ww by end March 2023 in line with national requirement; this will be monitored through the planned care group.
- Activity across key modalities up against previous month activity. Incentive schemes starting to improve activity (non-obs ultrasound notably)
- The Improving Together A3 Diagnostic paper has been drafted and presented to Planned Care Group. This will focus on both DM01 and wider diagnostic planned patients for recovery.

Workforce

Key messages

- Our two main areas of focus continue to be on addressing staff availability in relation to high absence rates and turnover.
- Sickness absence rates have increased slightly month on month, although covid related absence during in early November was showing 5.6% decrease in open absences at the same time the previous month. Work on management of sickness absence continues along with support for staff wellbeing.
- The 12m Turnover rate at October 2022 reduced to 10.75% which now sits below the trust target of 11%. However, the overall vacancy rate is sitting at 11.82% meaning recruitment activity remains high as teams work to support additional recruitment business cases and winter plans.
- Sickness levels remain high and above target with a 1% increase at 6.2% in month. With Chest and respiratory (which includes Covid) as the top absence reason at 25.6%, closely followed by Anxiety and Stress at 23.0%. The 12 month cumulative rate marginally increased to 6.29% (6.26% at September 2022).
- Covid related absence by 6 November 2022 covid-related absences stood at 101, which was 16% of the 622 open absences. This is 5.6% decrease on same time the previous month. The UHNM Flu and Covid-19 vaccination programme continues to be promoted for staff to book appointments.
- Internal measures to monitor reduction is agency expenditure continue. Divisional targets for agency ceilings have been calculated. Divisional progress for discussion at the December Executive Workforce Assurance Group.
- The appraisal (PDR) rate remained static at 76.4%. Divisions indicated this was due to continuing operational pressures, but are looking at options on improving performance such as targeting highest areas of noncompliance, arranging proxy access to enable completed PDRs to be entered on to ESR.
- We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory. All Divisions have been asked to provide trajectories for improvement and realistic target performance for the financial year end.
- A cultural heat map has been developed using key indicators of culture. The indicators have been cross referenced with the cultural improvement plan to ensure that most aspects of improvement are being measured and the People Strategy includes these indicators to ensure long term consistency. An electronic form of the cultural heat map is being developed to support regular reporting and in the meantime a version of the heat map has been included in the performance report for the Transformation and People Committee.
- The Resolution Policy is now live. Webinar based training sessions on the policy have run during October and feedback has been extremely positive.

- A training plan for roll-out of “Being Kind” training across UHNM has been developed and this will include roll-out of an e-learning package (procured from A Kinder Life) which brings together the Resolution policy and Being Kind elements. Consideration is being given to mandating this training.
- The National Staff Survey 2022 has been extended to run through to the 25 November. A final push via Trust communication and reminders being sent out via the supplier is taking place. At the time of writing, the Trust response rate is below average for acute Trusts.
- A small working group has commenced work looking at the implementation of the recommendations in the Race Code following a recent assessment of the Trust against the standards.
- Improvement plans have also been requested for some aspects of essential to role training and this will be further discussed at the Transformation and People Committee.
- In relation to industrial action we are waiting for the outcome of ballots and are working with our EPRR team to plan for any potential action.

Finance

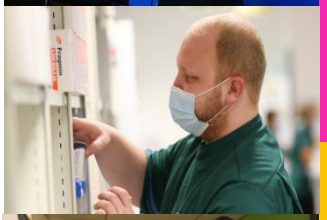
Key elements of the financial performance year to date are:

- Year to date the Trust has delivered an actual surplus of £2.1m against a planned surplus of £4.3m; this is primarily driven by underperformance against the Trust’s in year CIP target.
- The Trust incurred £0.7m of costs relating to COVID-19 in month; with £0.5m of this being chargeable for COVID-19 testing costs. The Trust has overspent by £2.7m against its original in envelope allocation due to the in envelope funding allocation ceasing after Month 2.
- To date the trust has validated £6.0m CIP savings in year; these schemes have a full year impact of £4.4m, which presents a considerable variance to the Trust’s recurrent target of £13.6m which was identified as a key risk in the Trust’s financial plan submission.
- Capital expenditure in Month 7 is £17.9m which is £4.4m behind the plan of £22.3m. Of the expenditure to date £8.3m is the pre-committed repayment of the PFI and IFRS16 lease liabilities.
- The cash balance at Month 7 is £91.1m, which is £13.7m higher than plan. Cash received is above plan due to Capacity and Virtual Ward income received from the ICB.
- The Trust carried out a forecast for the year based on the actual position at Month 7; this forecast suggested a year end deficit of £9.1m before any additional mitigations were applied with the key driver being under delivery against the CIP target.

Key Recommendations

The Trust Board is requested to note the performance against previously agreed trajectories.

NHS
University Hospitals of North Midlands
NHS Trust



Integrated Performance Report

Month 7 2022/23

Delivering Exceptional Care with Exceptional People

Contents

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

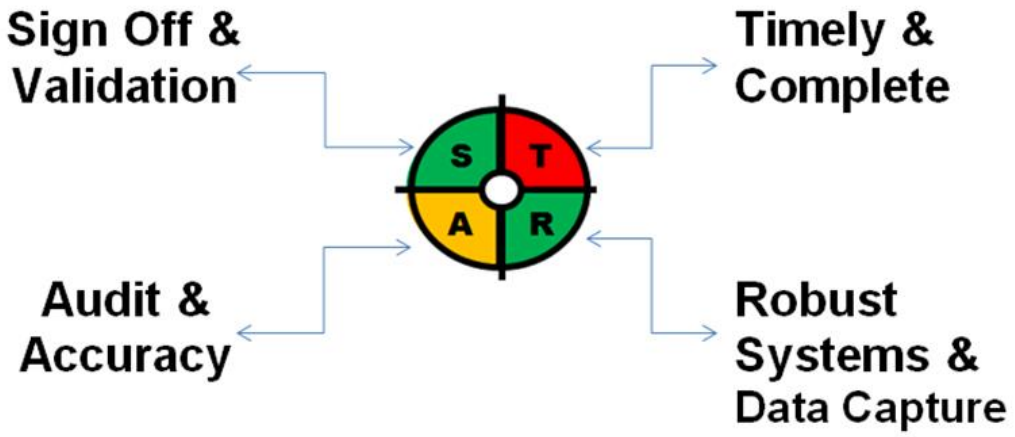
Assurance - how assured of consistently meeting the target can we be?

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**

NHS
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NHS Trust

Quality

Caring and Safety

2025 Vision "Provide safe, effective, caring and responsive services"

Quality Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

The Trust achieved the following standards in October 2022:

- Friend & Family (Inpatients) 95.7% and exceeds 95% target.
- Harm Free achieved 95% target rate
- 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 October 2022.
- Sepsis Screening compliance in Emergency Portals achieved the target 90%.

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E improved to 64.1% but remains below 85% target.
- Friend & Family (Maternity) achieved 50% and below 95% target.
- Falls rate was 5.8 per 1000 bed days against target rate of 5.7 for September 2022
- There were 17 Pressure ulcers including Deep Tissue Injury identified with lapses in care during August 2022.
- 1 Never Event – relating to misplaced NG Tube
- 91% verbal Duty of Candour compliance recorded in Datix
- 44% compliance with Duty of Candour 10 working day letter performance following formal verbal notification and under review for completion and upload of letter on Datix
- C Diff YTD figures above trajectory with 12 against a target of 8.
- E. Coli Bacteraemia cases below trajectory with 10 in October compared to target of 16.
- Inpatients Sepsis Screening remains below 90% target rate at 81%.
- Inpatient Sepsis IVAB within 1 hour achieved 84.2% and below 90% target rate
- Children's Sepsis Screening compliance reduced to 77.8% and remains below the 90% target.
- Emergency Portals Sepsis IVAB in 1 hour 66.7% and is below the 90% target for audited patients
- Maternity Sepsis Screening compliance improved to 83.3% against 90% target

During October 2022, the following quality highlights are to be noted:

- The rate of complaints per 10,000 spells is 24.54 and is below the target of 35 and within normal variation. Majority of complaints in October 2022 relate to clinical treatment.
- Total number of Patient Safety Incidents increased in month (1888) and the rate per 1000 bed days has also increased at 46.8
- Total incidents with moderate harm or above and the rate of these incidents are above normal variation levels.
- Rate of falls reported that have resulted in harm to patients currently at 1.2 per 1000 bed days in October 2022. The rate of patient falls with harm continues to be within the control limits and normal variation but is below the mean rate and is statistically significantly below the mean for 7 months indicating improvement in reducing harm from falls.
- Medication related incidents rate per 1000 bed days is 5.3 and patient related 4.5 which are higher 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 a increase during October 2022
- Hospital Associated Thrombosis is within normal variation and at mean level.
- Increased numbers of Definite Hospital Onset / Nosocomial COVID-19 cases reported in October 2022 with 80 in total.
- 8 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 during October 2022.

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1625	1888	H	
Patient Safety Incidents per 1000 bed days	50.70	42.49	46.80		?
Patient Safety Incidents per 1000 bed days with no harm	N/A	20.74	25.73	L	
Patient Safety Incidents per 1000 bed days with low harm	N/A	12.47	12.17		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.17	2.17		
Patient Safety Incidents with moderate harm +	N/A	44	50	H	
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	1.15	1.24	H	
Harm Free Care (New Harms)	95%	96.1%	96.2%		?
NRLS risk of potential under reporting (CQC Insights)	1.0	0.79	0.89		?
Patient Falls per 1000 bed days	5.6	5.7	5.8		
Patient Falls with harm per 1000 bed days	1.5	1.3	1.4		?
Medication Incidents per 1000 bed days	6	4.7	5.1		?
Medication Incidents % with moderate harm or above	0.50%	1.13%	1.02%		?
Patient Medication Incidents per 1000 bed days	6	3.9	3.9		F
Patient Medication Incidents % with moderate harm or above	0.50%	1.37%	1.32%		?

Metric	Target	Previous	Latest	Variation	Assurance
Serious Incidents reported per month	0	10	14		F
Serious Incidents Rate per 1000 bed days	0	0.26	0.35		F
Never Events reported per month	0	0	1	H	?
Duty of Candour - Verbal/Formal Notification	100%	96%	91%		?
Duty of Candour - Written	100%		44.0%	L	?
All Pressure ulcers developed under UHNM Care	TBC	51	49		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.53	1.65		
All Pressure ulcers developed under UHNM Care lapses in care	12	12	17		?
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.3	0.39		?
Category 2 Pressure Ulcers with lapses in Care	8	1	2		?
Category 3 Pressure Ulcers with lapse in care	4	0	0		?
Deep Tissue Injury with lapses in care	0	5	9		
Unstageable Pressure Ulcers with lapses in care	0	2	1		?

Delivering Exceptional Care with Exceptional People

Quality Dashboard

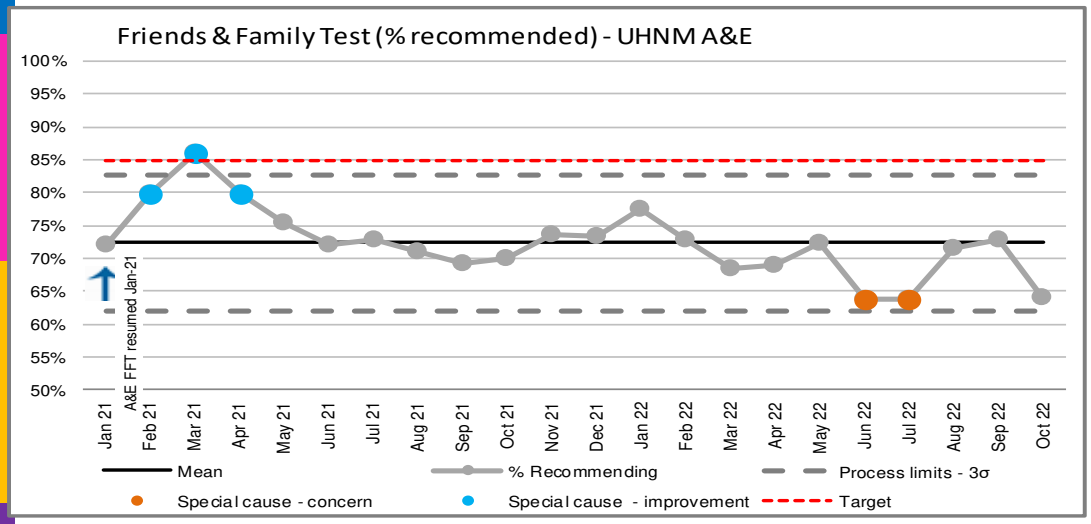
NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	72.9%	64.1%	L	F
Friends & Family Test - Inpatient	95%	99.0%	98.0%		P
Friends & Family Test - Maternity	95%	100%	100.0%		
Written Complaints per 10,000 spells	21.11	19.12	23.24		?
Complaints received by the CQC (feb 21 - Jan 22)	N/A	49	76		
Rolling 12 Month HSMR (3 month time lag)	100	98.44	94.77		P
Rolling 12 Month SHMI (4 month time lag)	100	103.22	105.20	H	?
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	3	8		
VTE Risk Assessment Compliance	95%	99.6%	98.9%		
Reported C Diff Cases per month	8	12	12		?
Avoidable MRSA Bacteraemia Cases per month	0	0	0		?
HAI E. Coli Bacteraemia Cases per month	8	13	18		?
Nosocomial "Definite" HAI COVID Cases - UHNM	0	34	80	H	

Metric	Target	Previous	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	87.2%	81.0%		?
Inpatient IVAB within 1hr (Contracted)	90%	96%	84.2%	L	P
Children Sepsis Screening Compliance (All)	90%	85%	77.8%	L	?
Children IVAB within 1hr (All)	90%	0%	N/A	H	P
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	94%	90.0%		?
Emergency Portals IVAB within 1 hr (Contracted)	90%	82%	65.6%	L	?
Maternity Sepsis Screening (All)	90%	50%	83.3%	H	F
Maternity IVAB within 1 hr (All)	90%	50%	N/A	H	F

Delivering Exceptional Care with Exceptional People

Friends & Family Test (FFT) – A&E



Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
85%	71.4%	72.9%	64.1%

Background

The % of patients who would recommend the service to friends and family if they needed similar care or treatment

What do the results tell us?

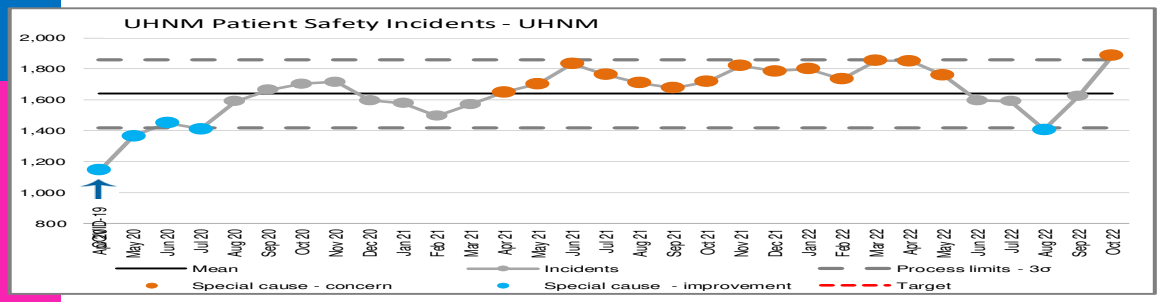
- The satisfaction rate for ED remains below our internal target at 64.1% for October 2022, and is a decrease of previous months. The Trust received 1056 responses which is a slight decrease on the previous month with a 11% response rate for both sites. The Trust's overall satisfaction rate is only significantly lower than the national average of 76% (Sept 22 NHS England).
- Feedback from patient experience of using 111First and the kiosks is being monitored. 27% of respondents in October 22 used 111First prior to attending ED, which remains static. Satisfaction score of patients using 111First was 58% for October 22 which is a decrease on the previous month and is lower than the overall satisfaction rate for ED attendees.

Actions :

- Themes from patient feedback remain the same and are around wait times, staff attitude and access to pain relief.
- Volunteer in ED supporting with refreshment rounds is also going hand out paper copies of the survey.
- Patient Experience team have now met with the ED team to reinstate their Patient Experience Group meetings
- New posters have been designed to encourage more feedback around the use of the 111 Kiosks in ED.

Reported Patient Safety Incidents

University Hospitals of North Midlands NHS Trust

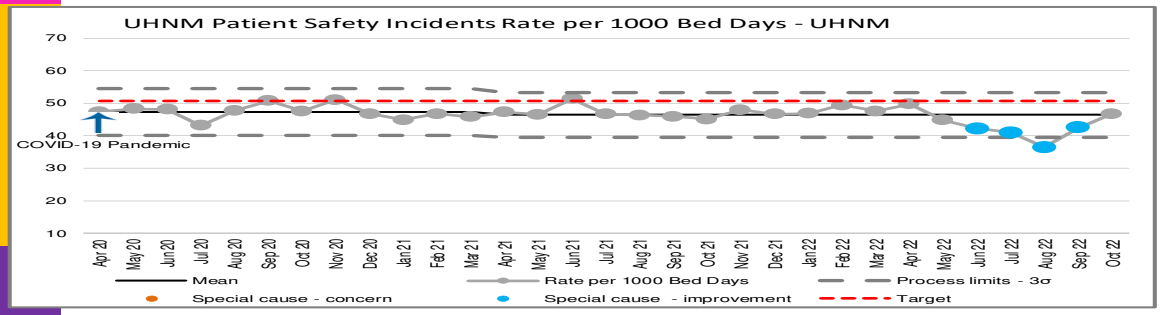


Variation	Assurance
H	

Target	Aug 22	Sep 22	Oct 22
N/A	1407	1625	1888

Background

Total Reported patient safety incidents



Variation	Assurance
	?

NRLS Mean	Aug 22	Sep 22	Oct 22
50.70	36.48	42.49	46.80

What is the data telling us:

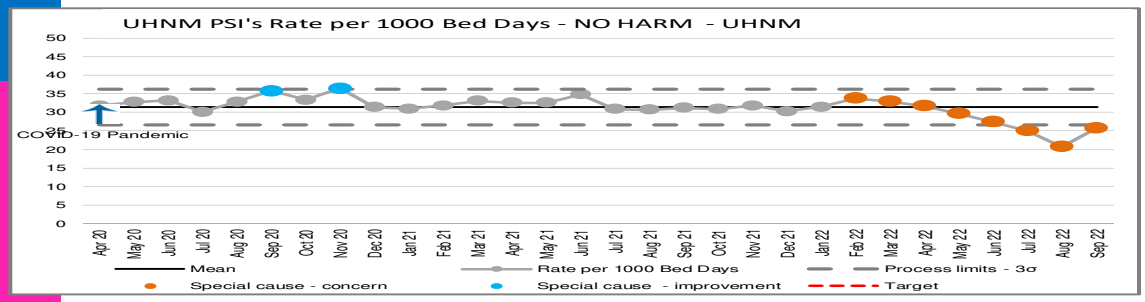
The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The October 2022 total is above the mean total since COVID-19 started. However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total 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 Falls, Medication, Patient Flow and Clinical Assessment related incidents. There has been no significant changes in these categories compared to previous months.

The rate of reported PSIs per 1000 bed days has decreased recently and although increased in October remains below long term mean rate.

Reported Patient Safety Incidents with No / Low Harm or Near Misses per 1000 bed days

NHS University Hospitals of North Midlands NHS Trust

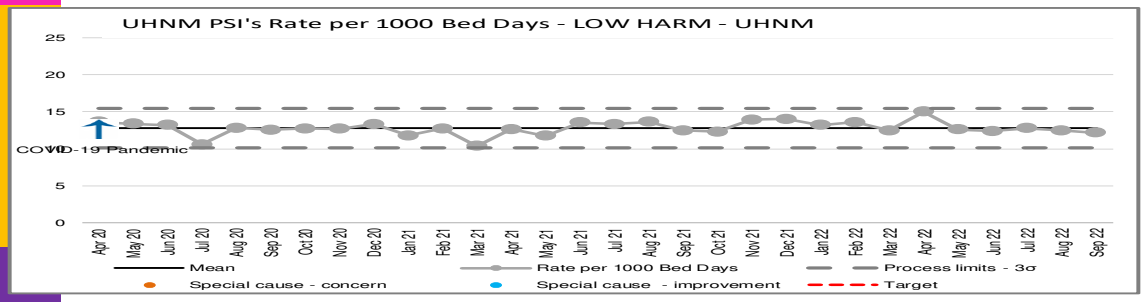


Variation	Assurance

Target	Jul 22	Aug 22	Sep 22
N/A	25.08	20.74	25.73

Background

The rate of Patient safety Incidents per 1000 bed days that are reported as resulting in No Harm to the affected patient.

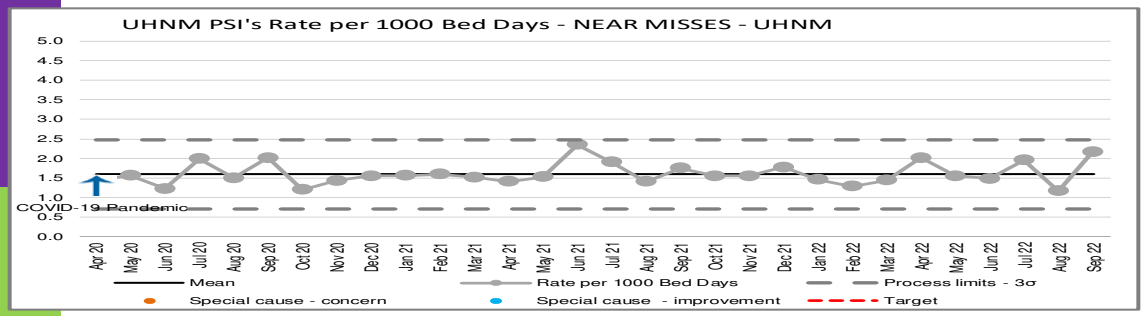


Variation	Assurance

Target	Jul 22	Aug 22	Sep 22
N/A	12.80	12.47	12.17

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	Jul 22	Aug 22	Sep 22
N/A	1.96	1.17	2.17

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 low harm or near misses are showing consistent trends and within normal variation. The no harm incidents have seen reductions in last 8 months that are outside of normal variation. These are no clear reasons for change in no harm except for increase in rate of near misses.

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

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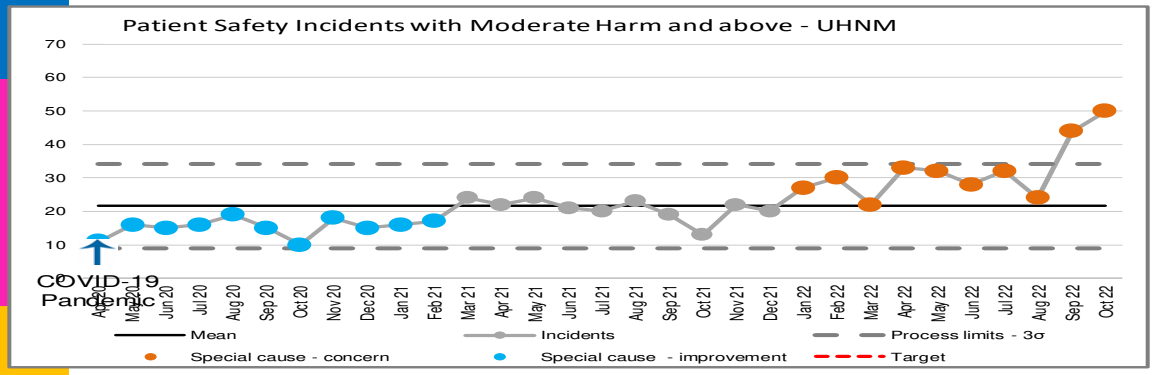
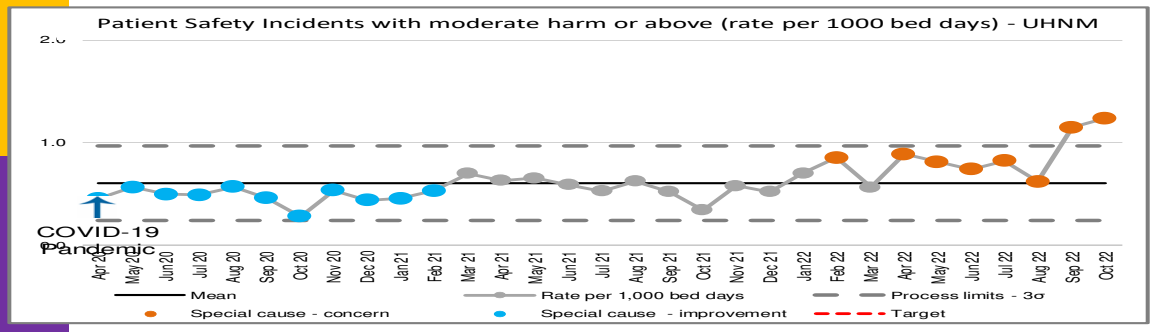


Variation	Assurance
	

Target	Aug 22	Sep 22	Oct 22
N/A	24	44	50

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance
	

Target	Aug 22	Sep 22	Oct 22
N/A	0.62	1.15	1.24

What is the data telling us:

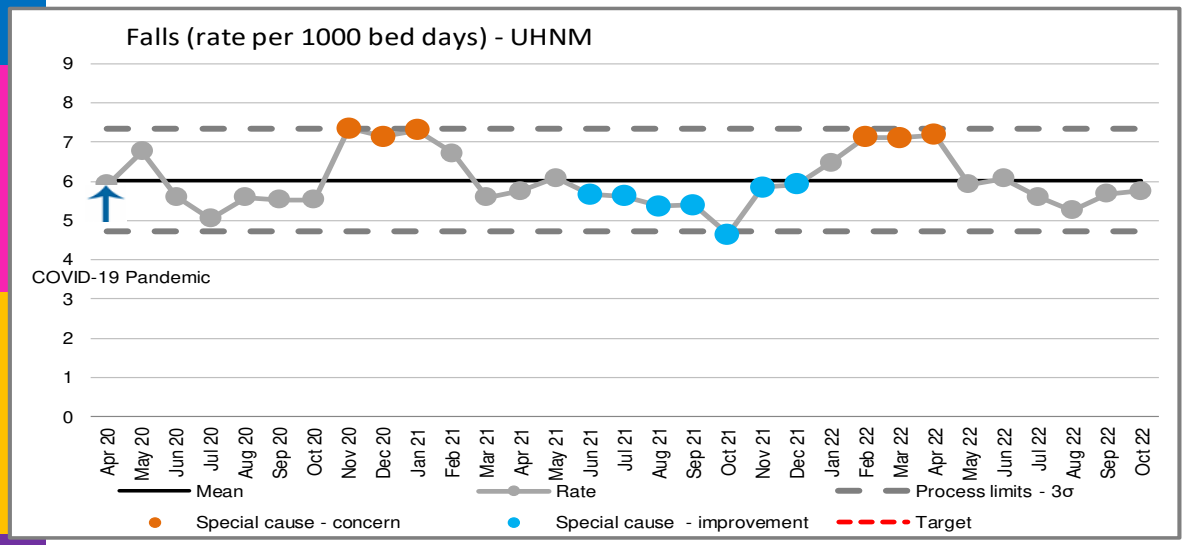
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is above the upper process control limit. The previous 5 months were around the mean rate hence the higher variation indicator. The monthly total may be amended following investigation of the incidents and level of harm reviewed and confirmed. October 2022 total increased from reported 44 to 50 following data refresh for October reporting.

The reason for the increased totals are linked to patient related falls and also Pressure Ulcer related incidents.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with 8 Falls, 6 Treatment/procedure, 5 Pressure Ulcer (hospital acquired), 5 Clinical assessment, 4 Patient Flow.

Patient Falls Rate per 1000 bed days

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
N/A	5.3	5.7	5.8

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

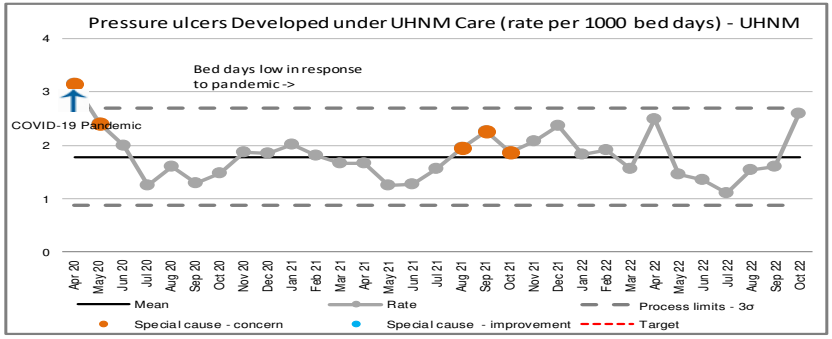
The Trust's rate of reported patient falls per 1000 bed days was within the normal range in October.

The areas reporting the highest numbers of falls in October 2022 were:
Royal Stoke ED – 21 falls, Royal Stoke AMU – 21 falls, Short Stay Unit– 12 falls, Royal Ward 113 - 9 falls,

Recent actions taken to reduce impact and risk of patient related falls include:

- Audits continue to take place on the TOP 5 reporting areas and those areas where SI's occur. Reasons why patients fall are multi faceted and therefore aspects of the audits are changed to ensure that one area of falls improvement can be acknowledged at a time. Audits over the last month has focussed on completion of the 6 CIT and 4AT assessments.
- Falls refresher training and new nursing assistant training has taken place.
- Patient admissions at the County site have been audited to understand if the relevant falls documentation has been undertaken. Also ensuring that the patient has been provided with the appropriate mobility aid when required and that a physiotherapy referral has been made.
- A presentation has been delivered to the new doctors on AMU regarding aspects of patient falls and how they can help to support the reduction in these.

Pressure Ulcers developed under care of UHNM per 1000 bed days

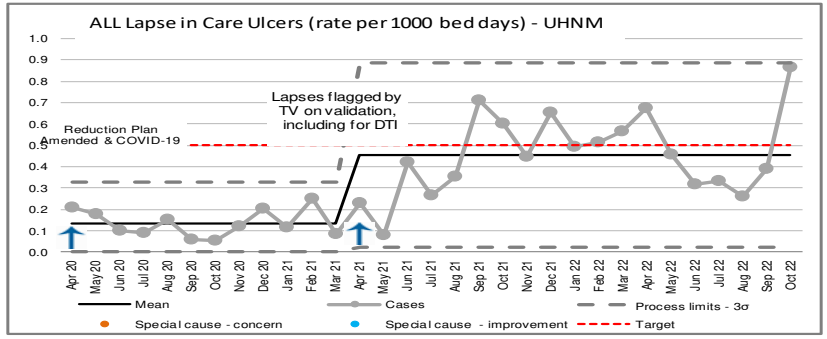


Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
N/A	1.53	1.59	2.60

Background

Rate of Deep Tissue injuries and Category 2-4 and Unstageable pressure ulcers which developed under the care of UHNM



Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
0.5	0.26	0.39	0.87

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 remains within expected limits, which suggests the high number reported for October may be partially due to high activity. Similarly the rate of ulcers with lapses in care is just below the upper expected limit for October.

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.

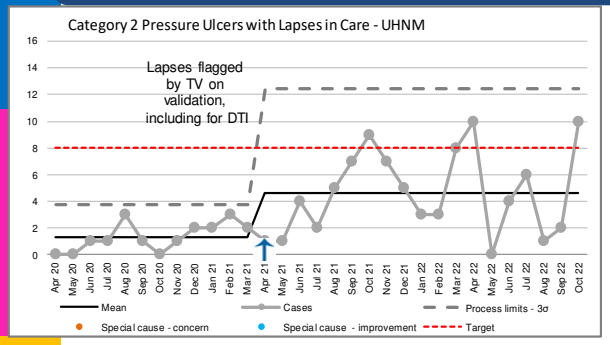
Pressure Ulcer prevention is an annual objective and a key driver metric as part of the Trust's Improving Together programme.

Actions

- A Stop The Pressure conference for stop the pressure day has been postponed due to poor uptake. A stop the pressure day within the Trust is planned for the 16th November with the Quality Nurses and PUP Champions (56 new pressure ulcer prevention champions (PUP) have been signed up),
- Training continues for PUP champions, nursing assistants and on ED statutory and mandatory training days. Champion training is offered for lower limb, continence and surgical champions. Categorisation training dates have now been confirmed into next year. Training has now been provided to registered nurses and nursing assistants through nurse bank.
- ESR training request made for prevention, awaiting confirmation
- Education to be arranged for the implementation of Purpose
- Training video has been made for care of catheters after an increase in urethral damage, along with the catheter life chart being updated and plans to re-launch
- Tendable is now in its testing phase and pressure ulcer prevention questions have been included.
- We continue to discourage the use off loose bundles as we are finding that evidence is missing due to misfiling. Wards ordering loose bundle are being visited and offered support
- PDNs are being utilised to support with cascading of information to teams.

Pressure Ulcers with lapses in care

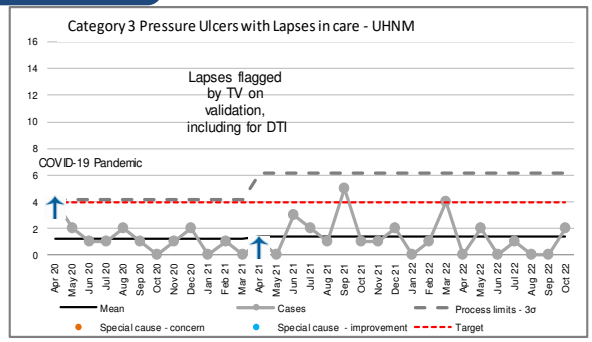
University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
8	1	2	10

Background

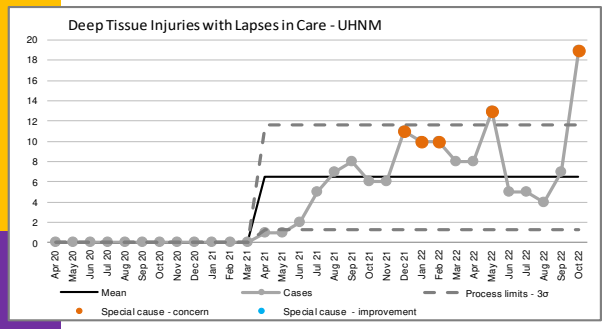


Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
4	0	0	2

Background

Category 3 pressure ulcers which developed under the care of UHNM with lapses in care associated

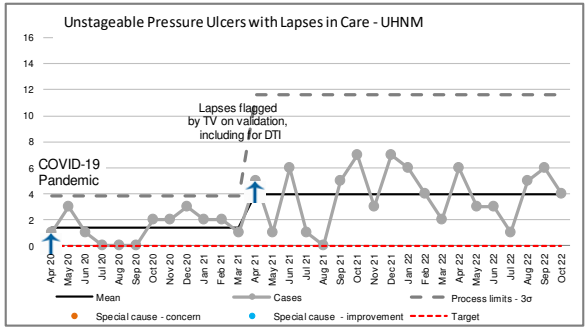


Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
N/A	4	7	19

Background

Deep Tissue Injuries which developed under the care of UHNM with lapses of care associated



Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
0	5	6	4

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 were management of repositioning.

In addition 2 urethral splits with lapses were identified in October 2022

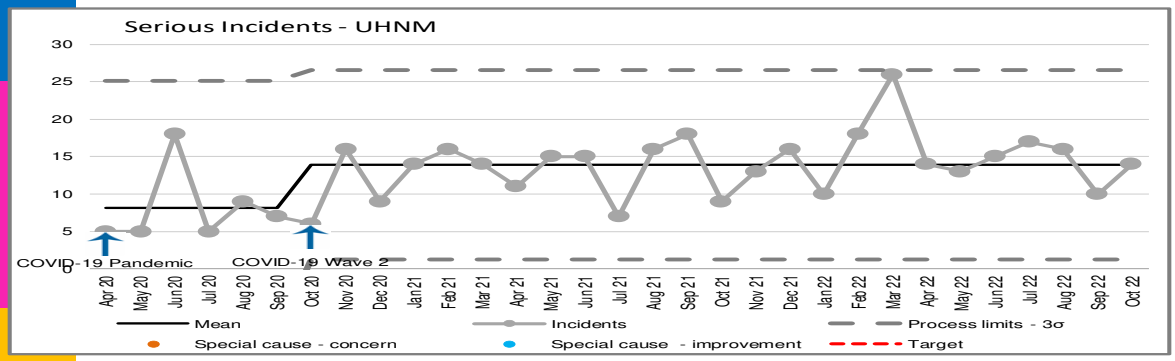
.

Root Cause(s) of damage - Lapses - Oct 2022	Total
Management of repositioning	20
Management of heel offloading	12
Management of device	2
Management of non-concordance	1

Actions:

- Plans are now in place for the continuation of RCA panels as pressures continue. Bespoke panels to be arranged to support areas of multiple reporting
- High reporting wards will be sent notification, with audits and action plans to be implemented to support improvement
- Wards are invited to RCA panels to focus on improvements and learning, to focus on the lapse identified. Support is being offered to wards along with assurance visits following panels. Wards are being asked for feedback on the RCA process for adjustments and/or improvements to be made
- Pressure Ulcer Prevention (PUP) Champions training dates have commenced, along with other training from the TV team

Serious Incidents per month

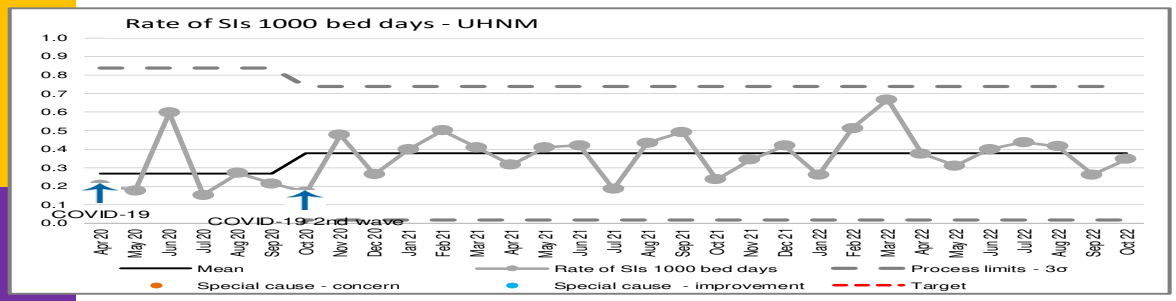


Variation	Assurance
	F

Threshold	Aug 22	Sep 22	Oct 22
0	16	10	14

Background

The number of reported Serious Incidents per month



Variation	Assurance
	F

Target	Aug 22	Sep 22	Oct 22
0	0.41	0.26	0.35

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 remains under review to develop trajectory for reducing serious incidents across UHNM. October 2022* saw 14 incidents reported:

9 Falls related incidents

2 Surgical/Invasive procedure related

1 Maternity/Obstetric incident (mother & baby only)

1 Treatment delay

1 Adverse Media

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 October 2022 is 0.35 and is lower than the long term mean of 0.4 since COVID-19 started in December 2020.

**Reported on STEIS as SI in October 2022, the date of the incident may not be October 2022.*

Serious Incidents Summary

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Summary of new Maternity Serious Incidents

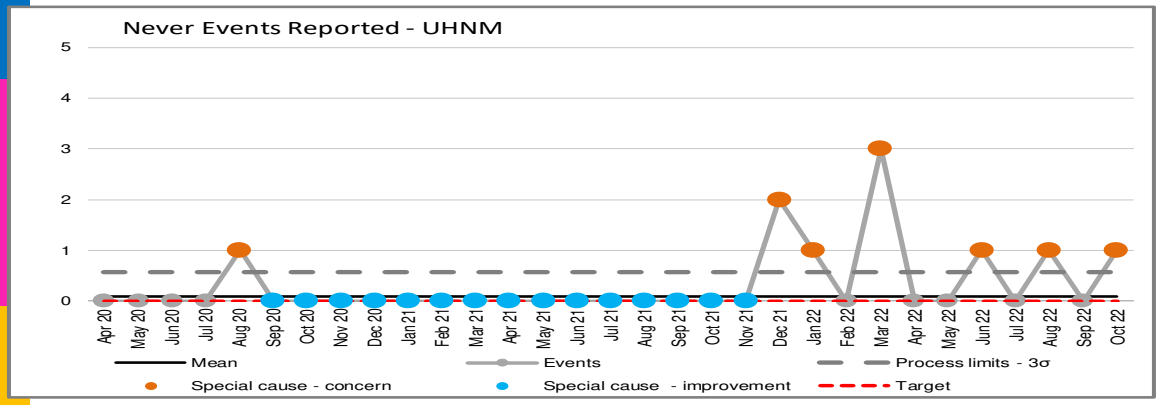
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during October 2022. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary of numbers and categories.

All Serious Incidents will continue to be are 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 was 1 Maternity related Serious Incidents reported on STEIS during October 2022

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:
2022/21120	White - British	Maternity/Obstetric incident (mother & baby)	29/12/2022	Presented at the Maternity Assessment Unit (MAU) at 41+3 weeks gestation with first episode of reduced fetal movements (RFM's). And delivered via Emergency Caesarean section. Baby was intubated and transferred to the neonatal unit for Therapeutic hypothermia (cooling). Baby passed away 6 days post delivery

Never Events



Variation	Assurance
	

Target	Aug 22	Sep 22	Oct 22
0	1	0	1

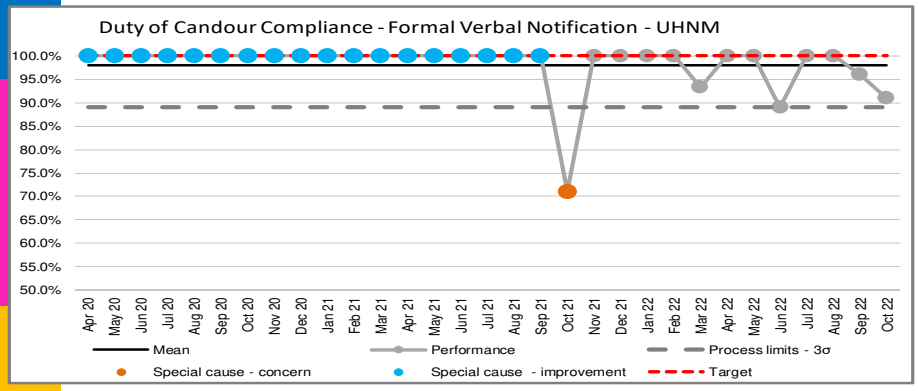
Background

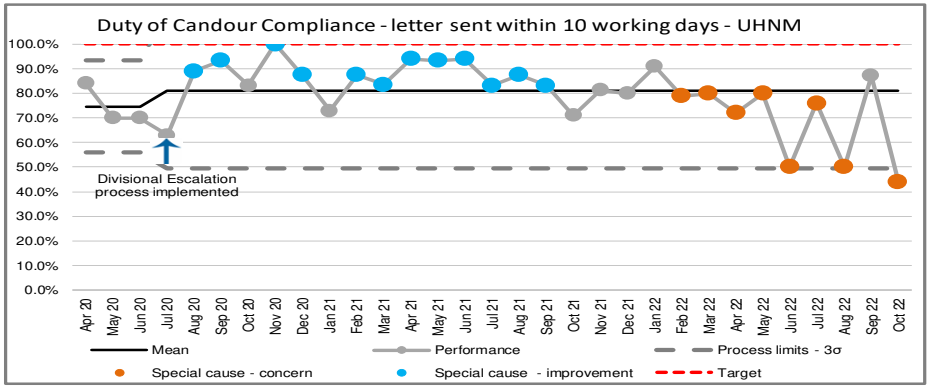
Defined as Serious Incidents that are wholly preventable, as strong systemic protective barriers should be in place

There has been 1 reported Never Event in October 2022. The target is to have 0 Never Events.

Log No.	STEIS Category	Never Event Category	Description	Target Completion date
202/23091	Surgical / Invasive Procedure incident	Misplaced NG Tube	NG Tube placed at 64cm and aspirate gained on 17/10/2022. Feed commenced with no concerns. 22/10/2022 at 22:15 unable to aspirate NG Tube and chest x ray requested and stopped using NG Tube	24/01/2023

Duty of Candour Compliance





Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
100%	100.0%	96.0%	91.0%

Background

The percentage of duty of candour incidents reported per month with verbal notification recorded/undertaken

Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
100%	50.0%	87.3%	44.0%

Background

The percentage of notification letters sent out within 10 working day target

What is the data telling us:

During October there were 34 incidents reported and identified that have formally triggered the Duty of Candour. 91% 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 October 2022 is 44% as 14th November 2022 including those letters that are still within timescale. Outstanding letters / information uploaded to Datix has been escalated with individual wards/departments and via Directorate/Divisional structures.

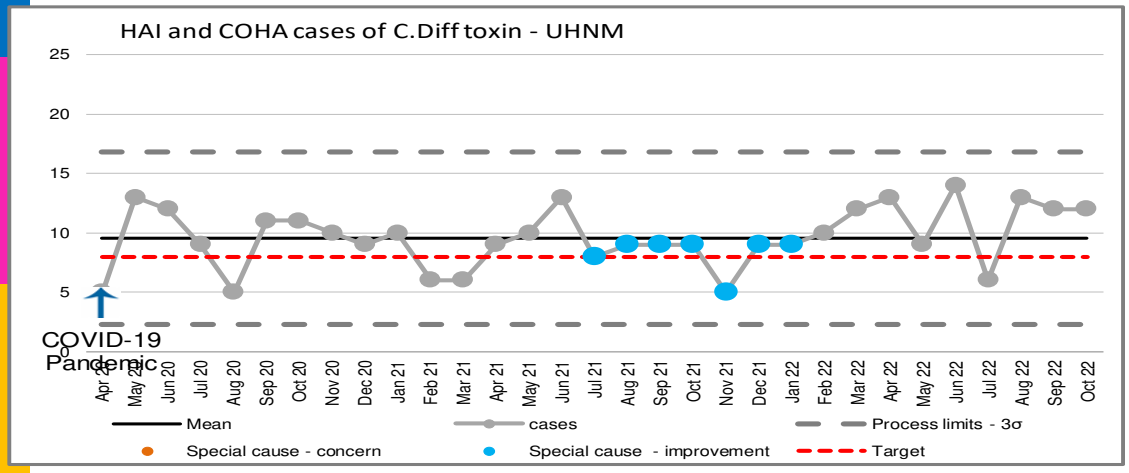
Actions taken:

Escalations on outstanding letters are provided to relevant directorates and divisions via the Divisional Quality & Safety 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.

Awareness sessions and support are being arranged to confirm with clinicians roles and responsibilities for recording and following up on verbal discussions with formal notification letters.

Reported C Diff Cases per month



Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
8	13	12	12

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

Number of C Diff cases cases are within SPC limits and normal variation .

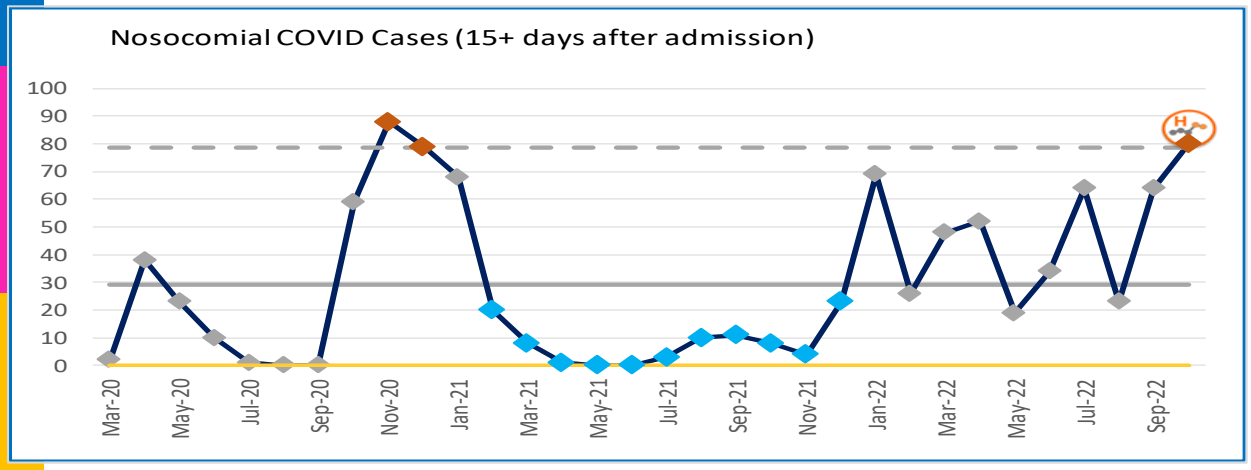
There have been 12 reported C diff cases in October with 5 being Hospital Associated Infection (HAI) cases and 7 COHA cases.

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 have been reported however in one of the specimens CDiff was not grown by the testing centre so it is not 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 and forms part of a multi-disciplinary review
- Routine ribotyping of samples continues

HAI Nosocomial COVID Cases per Month



What do these results tell us?

- Increase in cases throughout October 2022 with 80 definite Healthcare Acquired COVID -19 cases.
- Monthly total is within normal variation and follows national profile for increasing cases within the community during October 2022
- COVID screening guidance changed 14/09/2022. Patients only swabbed on admission if being admitted to high risk area, immunocompromised or symptomatic for COVID. Otherwise patients are now not routinely screened.

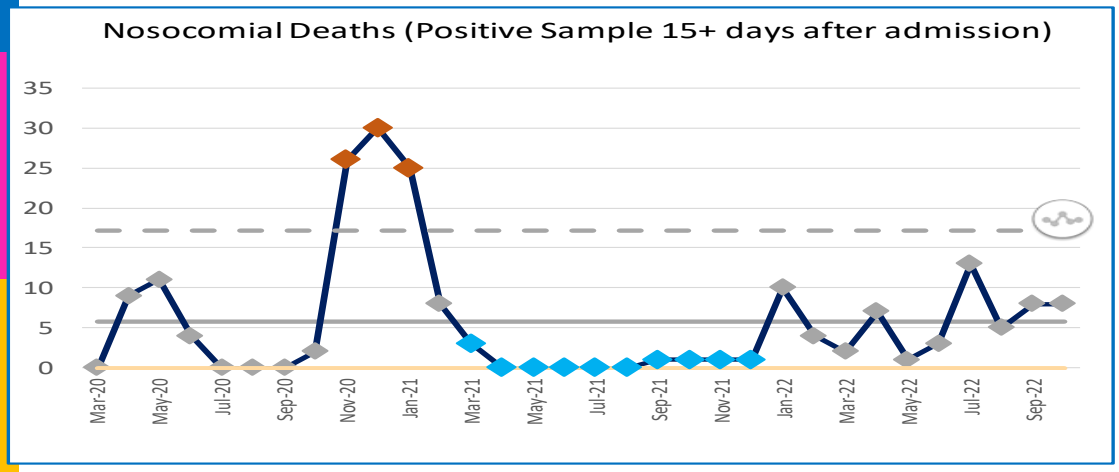
Actions :

- UHNM COVID screening changed in line with National guidance 14th September.
- No routine asymptomatic admission screening for COVID
- Screening for symptomatic, admission to high risk areas and immunocompromised patients
- In addition close patient contacts of a COVID case are also screened and patients who develop symptoms during their hospital stay
- 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
May-22	18484	14	19
Jun-22	18380	34	34
Jul-22	17983	45	64
Aug-22	18247	16	24
Sep-22	18279	58	64
Oct-22	18374	81	80

Nosocomial COVID-19 Deaths per month (with 1st positive result 15 days or more after admission)

University Hospitals of North Midlands NHS Trust



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.

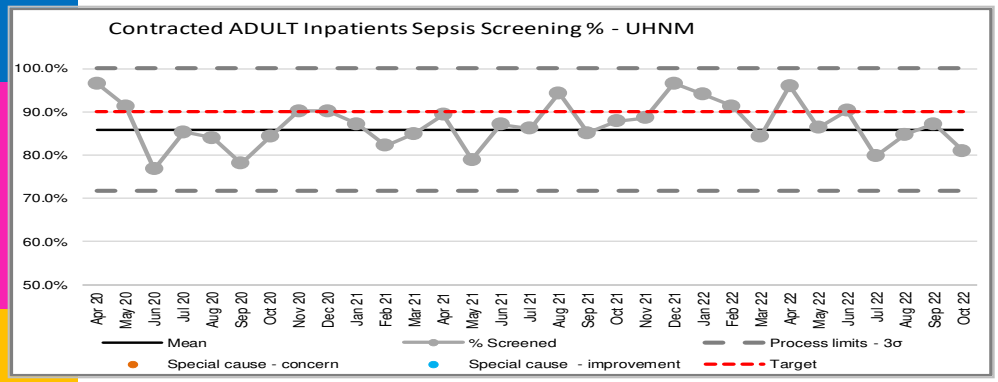
- 8 recorded definite hospital onset COVID-19 deaths in October 2022
- Total 181 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since 1st March 2020 up to 31st October2022
- 45 Definite Hospital acquired COVID-19 deaths during 2022/23 YTD
- The mean number of deaths per month since March 2020 is 6.

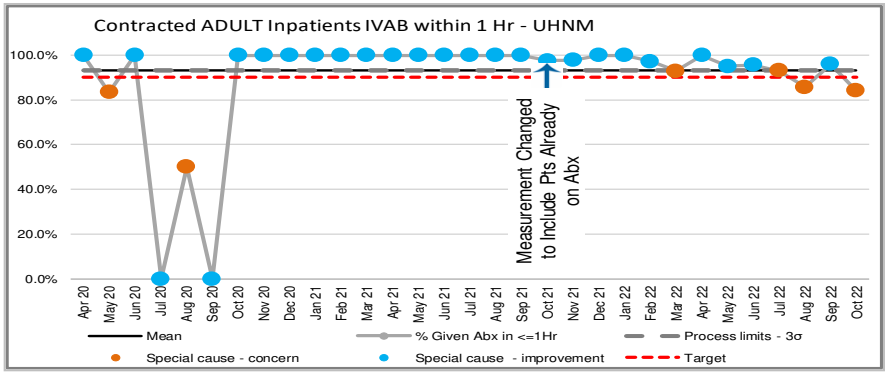
Actions :

Nosocomial COVID-19 deaths are continuing to be reviewed via the COVID Nosocomial Review Panel and updated report is due to be presented to Mortality Review Group identifying the outcome of the case reviews assessing the aspects of COVID-19 management of the patients in November 2022.

Sepsis Screening Compliance (Inpatients Contract)

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
90%	84.7%	87.2%	81.0%

Background

The percentage of adult Inpatients identified during monthly spot check audits with Sepsis Screening undertaken for Sepsis Contract

Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
90%	85.7%	96.0%	84.2%

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:

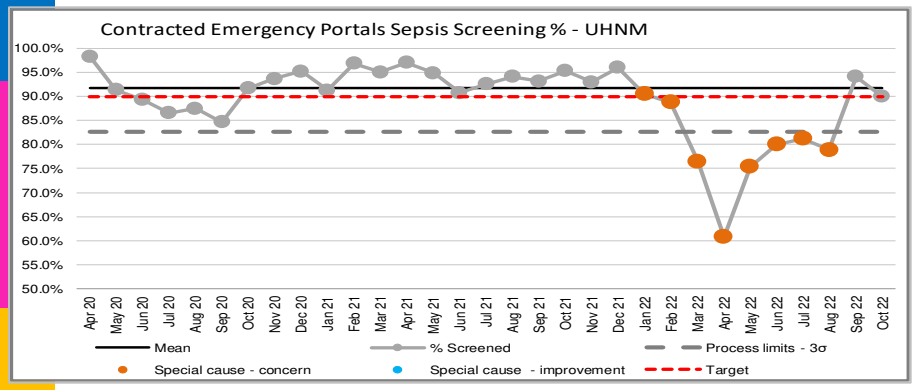
Inpatient areas failed to achieve the screening target in October 2022. There were 121 cases audited with 23 missed screening from different ward areas.
IVAB within 60 minutes was below the required 90% target rate. Out of 121 cases audited, 84 cases were identified as red flags sepsis with 46 cases have alternative diagnosis and 38 cases were true red flags. Out of 38 true red flags cases, 30 were already on IVAB treatment, 5 delayed treatment in which given above two hours.

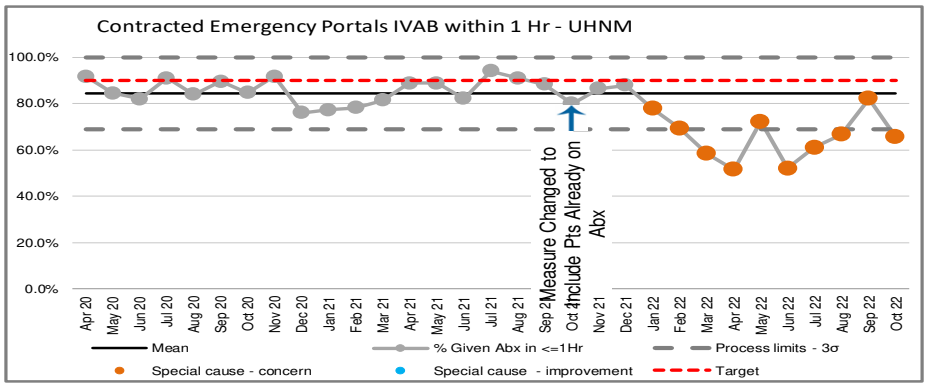
Actions:

- The Sepsis team have continued to focus on providing ward based sepsis drop in session/kiosks on targeted clinical areas and division: on-going
- 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: on-going
- Continued focus and support provided to all divisions to maintain and sustain compliance: on-going
- The Sepsis Team continue to raise awareness of importance of sepsis screening by being involved in HCA, students and new nursing staff induction programmes
- The Sepsis team will continue to promote sepsis awareness in both sites and will prioritise areas to visit with the clinical lead consultant

Sepsis Screening Compliance (Emergency Portals Contract)

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
90%	79%	94%	90%

Background

The percentage of audited Emergency Portal patients receiving sepsis screening for Sepsis Contract purposes

Variation	Assurance

Target	Aug 22	Sep 22	Oct 22
90%	67%	82%	66%

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 has met the target for October 2022. There were 50 cases audited with 5 missed screening in total from 6 of the emergency portals.

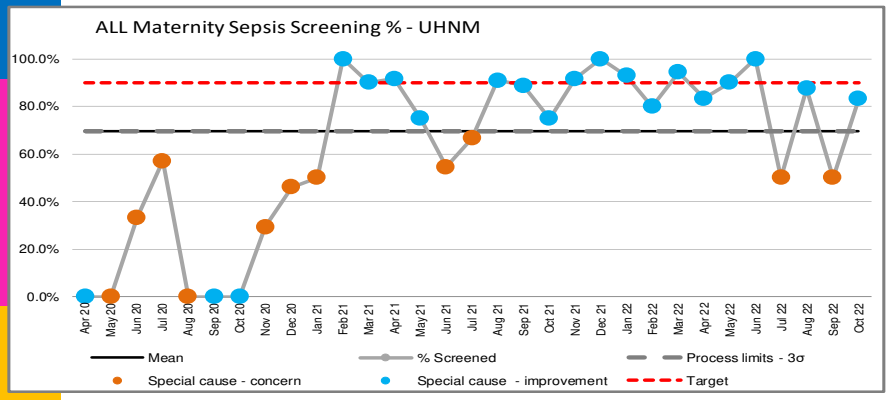
The performance for IVAB within 1hr below target rate in October 2022 is at 66%. Out of 50 cases, there were 39 red flags sepsis in which the 12 cases already on IVAB, 32 cases were newly identified sepsis and 7 cases have alternative diagnosis. There were 11 delayed IVAB with 5 cases delayed within 2 hours and 6 cases above 2 hours. Delayed IVAB within 1 hour is mainly contributed by both ED Royal Stoke and County.

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 and missed screens. Issue with holding ambulances remain a 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

University Hospitals of North Midlands NHS Trust

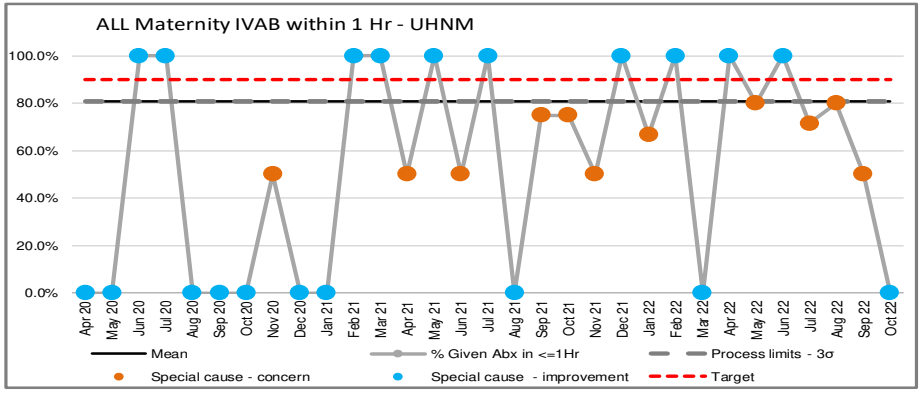


Variation	Assurance
H	F

Target	Aug 22	Sep 22	Oct 22
90%	87.5%	50.0%	83.3%

Background

The percentage of ALL Maternity patients identified during monthly spot check audits receiving sepsis screening.



Variation	Assurance
H	F

Target	Aug 22	Sep 22	Oct 22
90%	80%	50%	N/A

Background

The percentage of ALL Maternity patients from sepsis audit sample receiving IVAB within 1 hour

What is the data telling us:

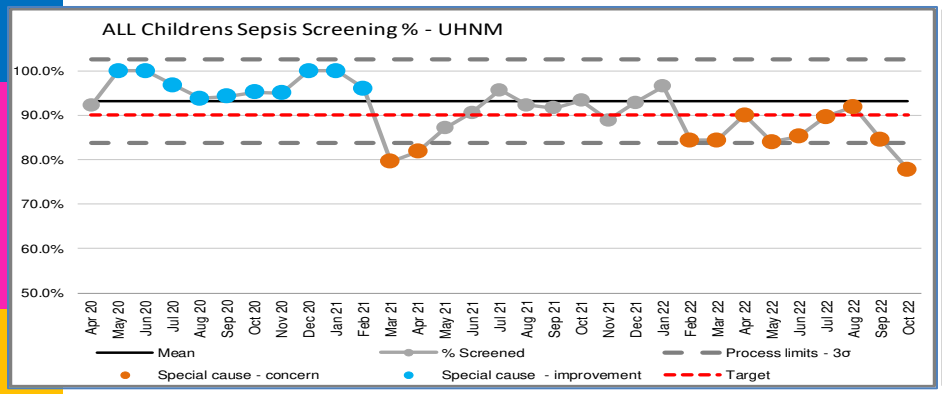
Maternity audits show improvement in screening compliance and IVAB within 1 hour is reported as not applicable as no red flag sepsis trigger during October 2022 randomise audits . This compliance score is based on a very small number, however a regular spot checks audit is being conducted monthly.

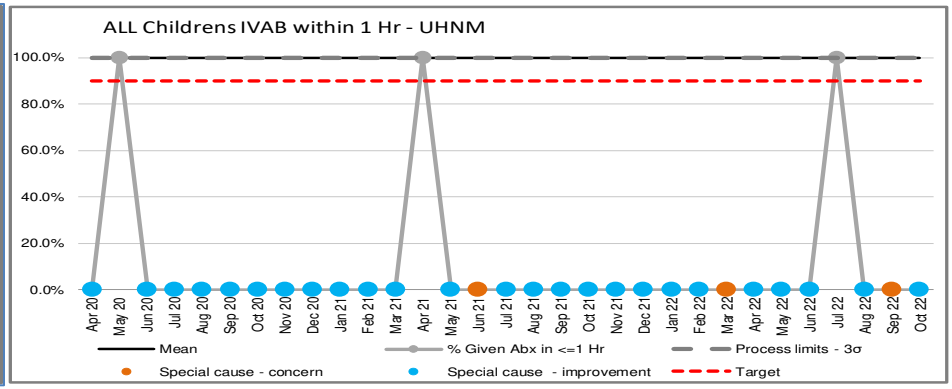
Actions:

- Maternity have already developed and awaiting finalisation of their antibiotic PGD: on-going
- Maternity educator is supporting the sepsis team by conducting independent / in-depth sepsis audits in the whole Maternity department , staff who had missed the screening documentation will be given constructive feedback and offered support/ training: on-going
- 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: on-going
- Plan of delivering sepsis awareness in each clinical areas in September-October with the support of the clinical educator

Sepsis Screening Compliance ALL Children

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
L	?

Target	Aug 22	Sep 22	Oct 22
90%	91.9%	84.6%	77.8%

Background

The percentage of ALL Children identified during monthly spot check audits with Sepsis Screening undertaken

Variation	Assurance
H	P

Target	Aug 22	Sep 22	Oct 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 but lower than target of 90%. Still seen small numbers of children trigger with PEWS > 5 & above in Inpatients areas. 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).

There were only a total of 9 cases audited for emergency portals with 2 missed screening. No red flag identified from the randomise audits. None was identified trigger with PEWS 5> in Inpatients areas during audits.

Actions:

- The Sepsis Team will continue to deliver sepsis drop in session (ward base training) as well as providing sepsis Induction session for newly qualified staff
- 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"

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Emergency Care

- Focus continued in October with respect to the Non-Elective Improvement Plan and the three core elements to support the Ambulance Handover Improvement Plan. Your Next Patient (YNP) continues in operation with twice weekly Executive chaired review meetings. The data shows that this initiative is supporting a reduction in the tail of the longer ambulance handover delays over eight and six hours, despite an increase in those over one hour. The Frailty Decision Unit continues in operation and is staffed to allow the maximum of 8 patients to be turned around by an integrated MDT at the front door. The ED Reconfiguration (Workstream 1) is nearing completion and EhPC moved into the modular building outside at the end of October.

- October saw a slight increase again in Type 1 attendances from 12000 to 13000 and with this performance against KPI's declined further which can also be attributed to poor egress from ED due to increasing COVID numbers resulting in numerous bed restrictions, closed wards, and increasing staff sickness.

    - Four Hour performance marginally reduced to 65% for October.
    - 12 hour trolley waits in the department increased from 700 to 1000 in October.
    - WTBS in the ED slightly increased from 100 to 101 minutes.
    - Ambulance handovers remain a challenge with those over 60 minutes rising from 1002 to 1443.

Cancer

- Trust overall 2WW Performance predicted to land at 78% in October – increasing from 46% in September, as a result of schemes such as the Lower GI Community Referral hub and Community Teledermatology pathways being successfully implemented. Breast symptomatic (where cancer is not suspected) is expected to 100% achieve in October.
- Another record high number of clock stops against the 14 day standard were recorded in October, demonstrating the additional activity being delivered at UHNM in order to meet high 2WW demand and recover the PTL position. A total of 3803 clock stops.
- The 62 Day Standard is predicted to land at 44% in October. This is an un-validated and incomplete position that is expected to change as pathology confirms or excludes cancer for treated patients. Contributing factors include capacity, with robust plans in place to tackle the most challenged specialties (Skin & LGI) over the next quarter.
- The 31 Day Standard is predicted to land at 87% for October and the 31 day Subsequent Anti Cancer Drugs standard is expected to achieve 100% in August.
- The 28 Day Faster Diagnosis Standard is predicted to land at 55% in October.
- Suspected Breast Cancer and Lower GI are now booking 2WW referrals within 7 days, for first appointments – an improvement since last month.
- Skin & Colorectal are the biggest contributors to 62 and 104 day backlogs – focus through intensive exec support and a recovery framework is being used to enact plans and monitor progress closely.
- The backlog has reduced since last month and total PTLs in Skin and LGI has significantly reduced.

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Planned Care

The focus of activities for Planned Care has been as follows:

- Day Case activity and Elective Activity have both shown a decrease from 89% and 82% in September to 78% and 80%respectively. This is still some way from the national ask of 110%/108%. This is against a backdrop of increase cancelations. There is a real focus on the reintroduction of 6-4-2 with support from the regional theatres team.
- The focus has moved to 78 week waiters with an Annual Plan to reduce them to below 300 patients by March 2023. The major change will be managing the non-admitted (Outpatient) patients to ensure they get a decision to treat or discharge well before March so any treatment can be carried out to meet the 78 week standard.

RTT

- The overall Referral To Treatment (RTT) Waiting has slightly decreased from 77,985 in September to 77,546 in October.
- The number of patients > 52 weeks continues to increase – from 4377 in August, 4,569 in September and 5328 in October.
- At the end of October the numbers of >104 patients was 23. A decrease of 33 from the end of September (albeit different patients). The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity, there is considerable work now on the Trusts route to zero for 104 week waiting patients, with challenges around complex pathways, patient choice and fitness for treatment.

Diagnostics

As at w/e 13/11/22:

- CT – delivering 128% BAU, 1,952 patients seen in week
- MR – delivering 108% BAU, 827 patients seen in week
- Ultrasound – delivering 102% BAU, 1,227 patients seen in week
- Echocardiography - delivering 112% BAU, 344 patients seen in week

Histology position :

Urgent (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day **19**, with 80% of cases reported by Day **10**

Radiology reporting backlog:

- High risk relating to 'routine / non cancer reporting' due to reporting capacity and delays in diagnosis RISK register no 25512 score 16

Improving Together A3 presented at Planned Care group

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Section 1: Urgent Care

Headline Metrics

Urgent Care – monthly *(context)*

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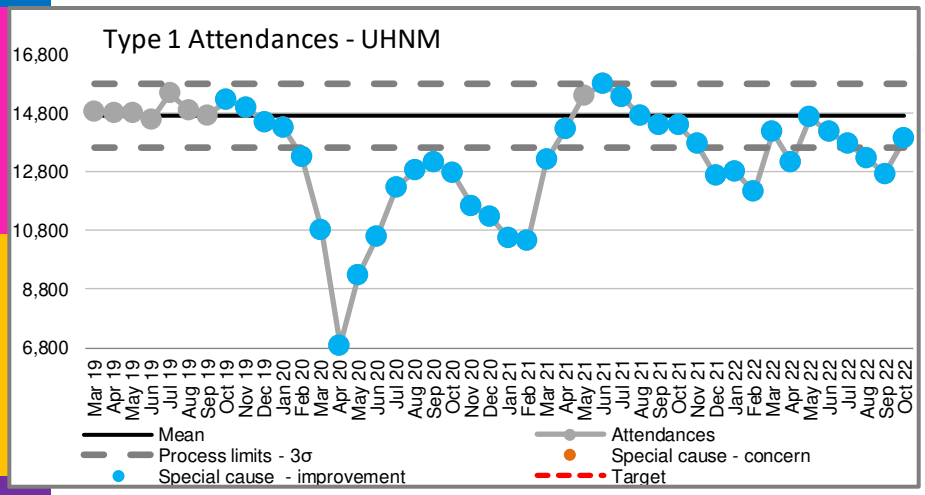
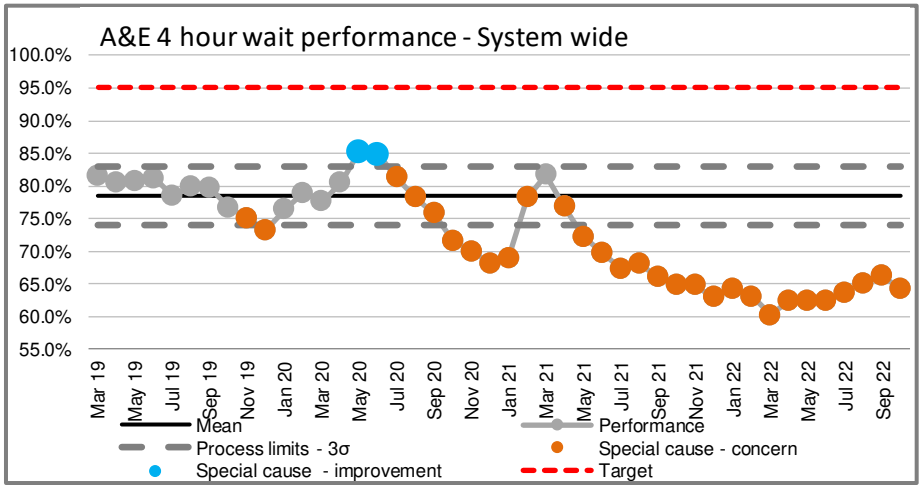
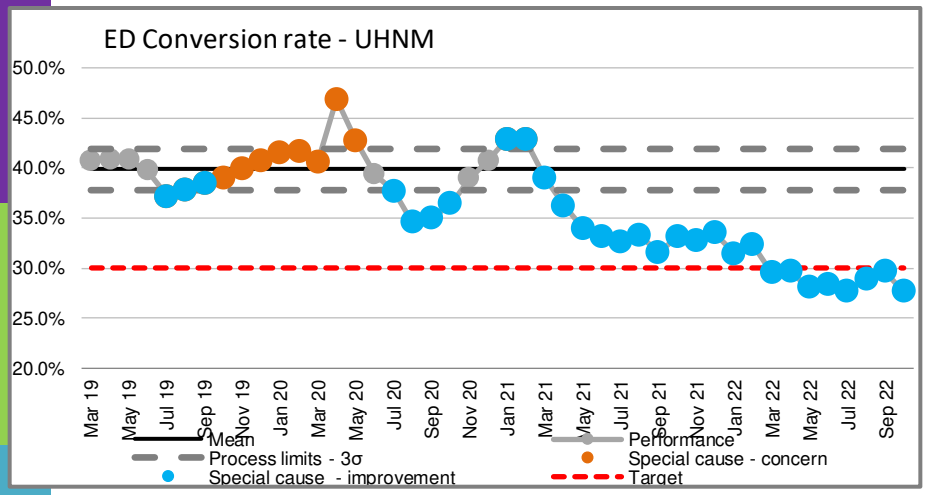
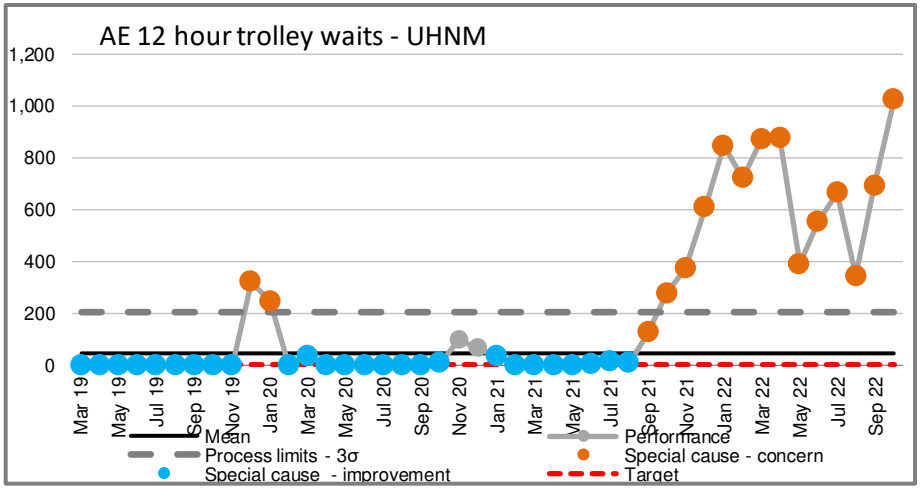
NHS Trust









Delivering Exceptional Care with Exceptional People

WTBS & 12 Hour in department

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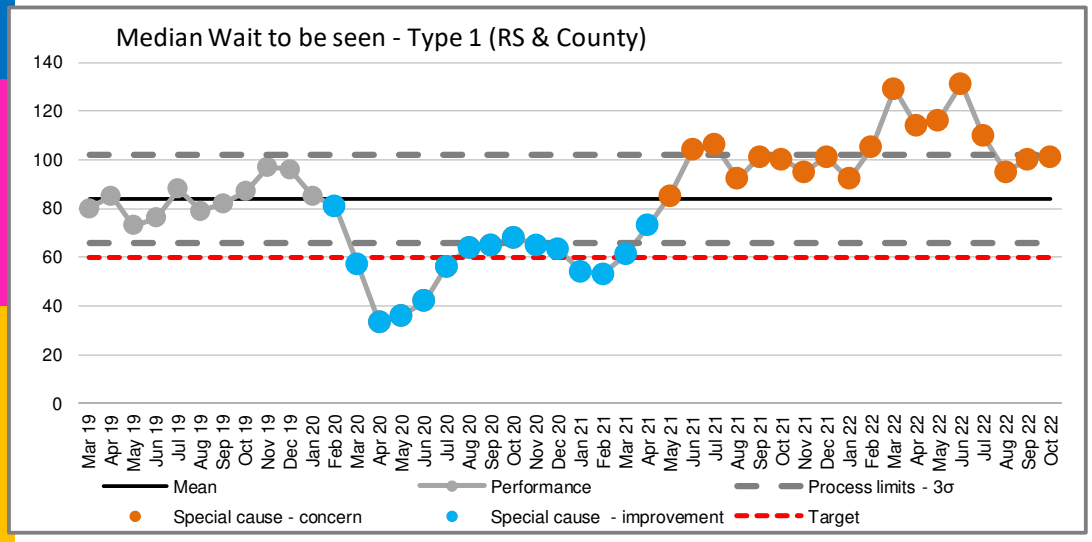
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
H	F

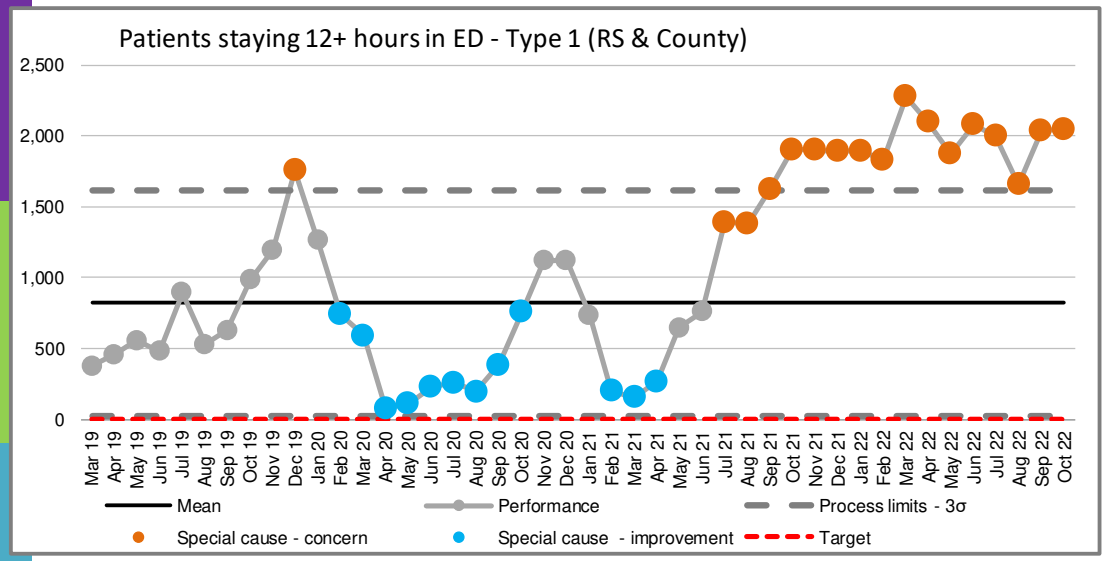
Target	Aug 22	Sep 22	Oct 22
60	95	100	101

Background

The average (median) time in minutes for a patient to be first seen

What is the data telling us?

Median wait to be seen remains above the pre pandemic average and relatively consistent over the last three months.



Variation	Assurance
H	F

Target	Aug 22	Sep 22	Oct 22
0	1659	2035	2052

Background

The number of patients admitted,transferred or discharged over 12 hours after arrival at A&E

What is the data telling us?

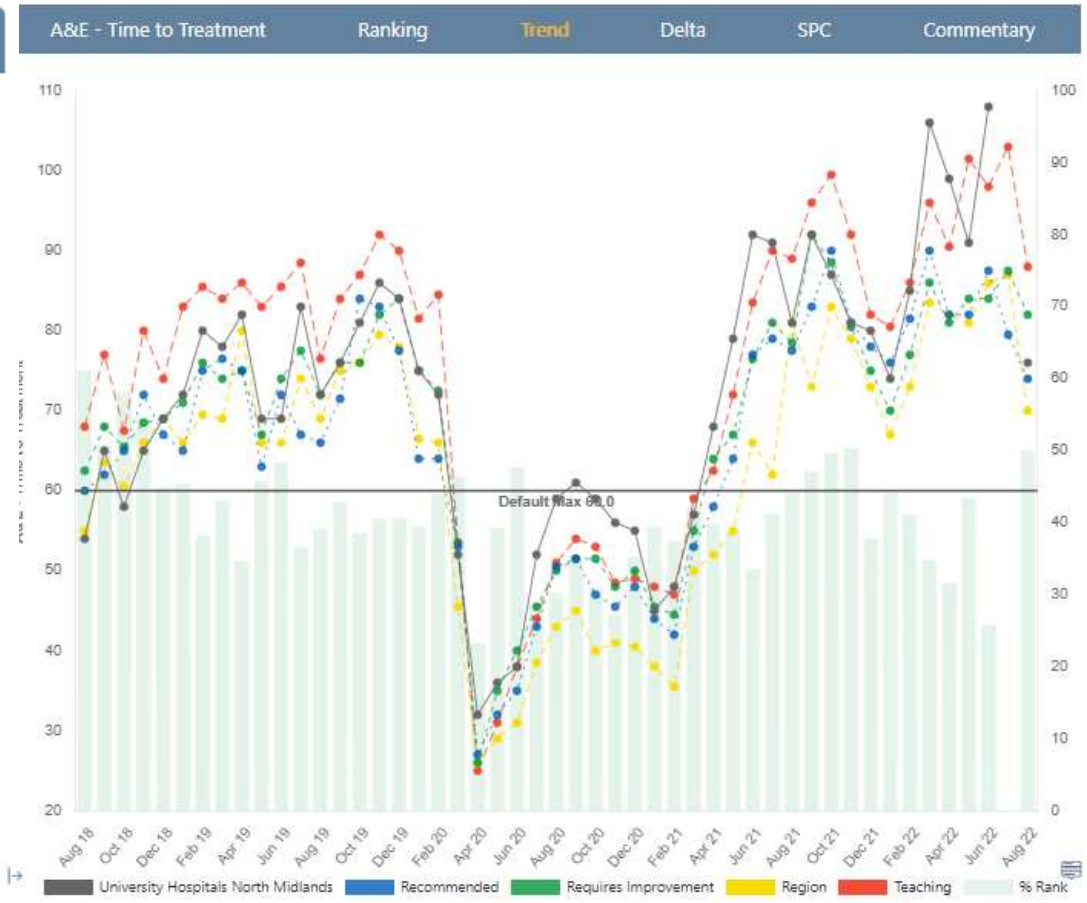
The number of patients waiting over 12 hours has increased significantly over the last 12 months. With 13 points sitting above the upper control limit

Urgent Care – Time to Treatment

University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target	SPC	
A&E - 4 Hour Standard	Sep 22	95.00%	66.2%	34
A&E - 4 Hour Standard (Type 1)	Sep 22	95.0%	46.2%	11
A&E - 4 Hour Standard (Type 2 ...	Sep 22	95.0%	97.2%	32
A&E - Conversion Rate	Sep 22	25.0%	23.0%	26
A&E - DTA to Admission >12 H...	Sep 22	0.0%	14.4%	31
A&E - DTA to Admission >12 H...	Sep 22	0.0	695.0	9
A&E - DTA to Admission >4 Ho...	Sep 22	10.00%	34.1%	57
A&E - Left Without Being Seen	Aug 22	5.00%	0.0%	100
A&E - Reattendance Rate	Aug 22	5.0%	10.1%	13
A&E - Time to Initial Assessment	Aug 22	15.0	8.0	67
A&E - Time to Treatment	Aug 22	60.0	76.0	50
A&E - Total Time in A&E	Aug 22	160.0	180.0	58
A&E - Total Time in A&E (Admit...	Aug 22	180.0	-	-
A&E - Total Time in A&E (Non-...	Aug 22	140.0	180.0	45



- Time to treatment pre pandemic was in line with peers
- More recently UHNM has seen an increase and is currently above peer.

Urgent Care – DTA waits over 12 hours

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Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
A&E - 4 Hour Standard	Sep 22	95.00%	66.2%	L	34
A&E - 4 Hour Standard (Type 1)	Sep 22	95.0%	46.2%	L	11
A&E - 4 Hour Standard (Type 2 ...	Sep 22	95.0%	97.2%	L	32
A&E - Conversion Rate	Sep 22	25.0%	23.0%	L	26
A&E - DTA to Admission >12 H...	Sep 22	0.0%	14.4%	H	31
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A&E - DTA to Admission >4 Ho...	Sep 22	10.00%	34.1%	H	57
A&E - Left Without Being Seen	Aug 22	5.00%	0.0%	C	100
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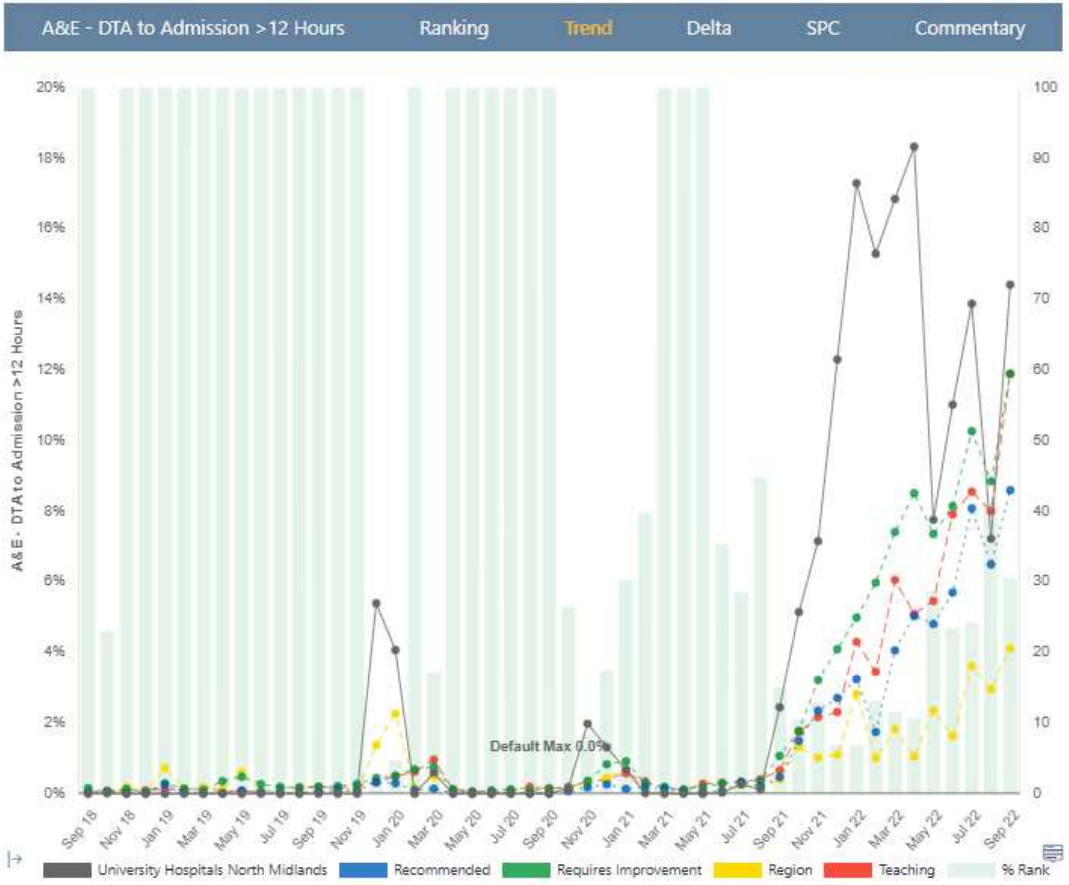
A&E - Time to Initial Assessment	Aug 22	15.0	8.0	C	67
A&E - Time to Treatment	Aug 22	60.0	76.0	H	50
A&E - Total Time in A&E	Aug 22	160.0	180.0	H	58
A&E - Total Time in A&E (Admit...	Aug 22	180.0	-	C	-
A&E - Total Time in A&E (Non-...	Aug 22	140.0	180.0	H	45



- The percentage of patients waiting over 12 hours from the point of DTA has been much higher than peers since September 21, however August 22 saw an improvement taking UHNM back closer to peer.

Section 1: Urgent Care

Workstream 1; Acute Front Door

Time To Triage, Ambulance Handover, & Non admitted average time

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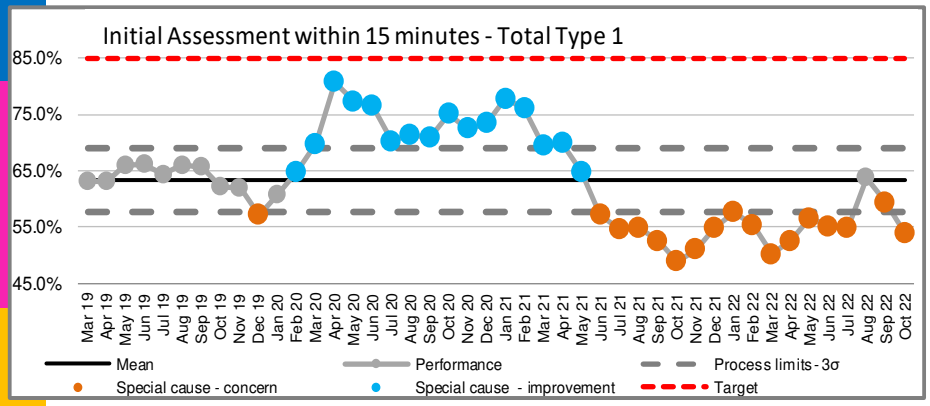


Variation	Assurance
L	F

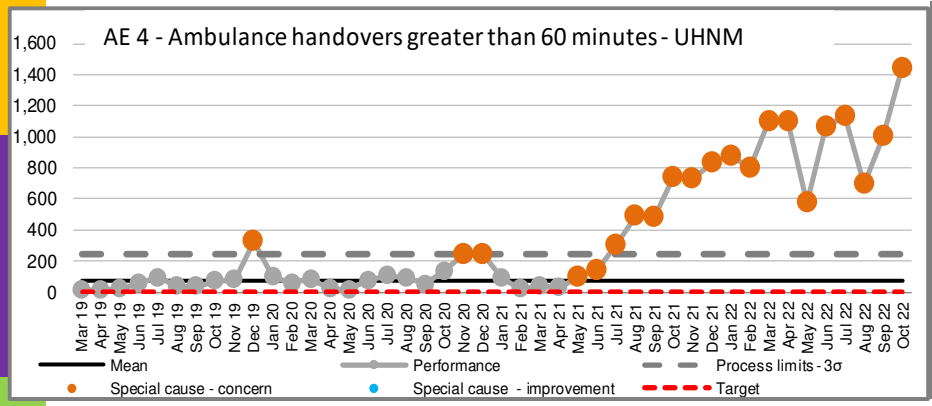
Target	Aug 22	Sep 22	Oct 22
85%	63.7%	59.4%	54.0%

Background

The Percentage of patients attending Type 1 A&E, triaged within 15 minutes of arrival

What is the Data telling us?

Performance remains below the 1920 lower control limit at 54%. This is back at the level seen at the beginning of last summer.



Variation	Assurance
H	?

Target	Aug 22	Sep 22	Oct 22
0	694	1002	1443

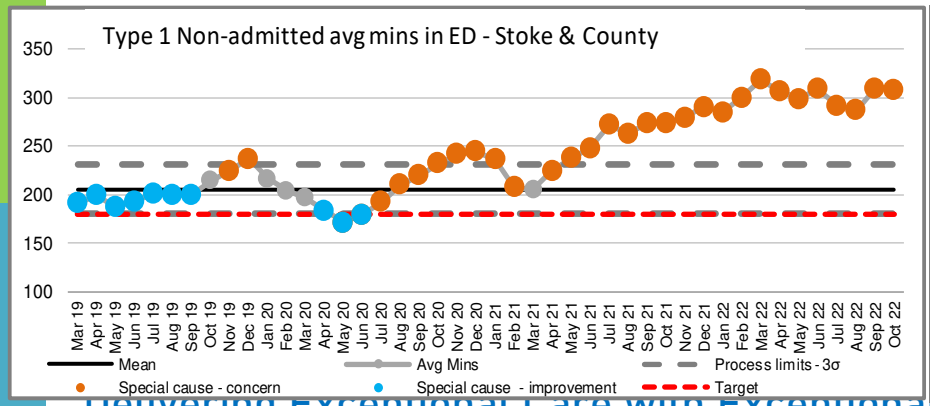
Background

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 16 months with these data points sitting outside of the upper control limits of 201920.

Last month increased by 44% compared to previous month.



Variation	Assurance
H	?

Target	Aug 22	Sep 22	Oct 22
180	287	309	308

Background

The mean time spent in A&E department for patients not admitted to an inpatient bed

What is the Data telling us?

Mean time in department has been increasing since March 2021. The last 18 month data points have been outside of the upper control limits set using 2019/20.

Time To Triage, Ambulance Handover, & Treatment

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Summary

- Ambulance handovers remain a challenge with 60 minute delay instances increasing to 1443 in October from 1002 in September. However, following the embedding and development of YNP the longer 10 and 8 hour waits for ambulances have reduced.
- The average time in department for non-admitted patients remains static to that of September's 307 minutes at 308 minutes for October. This is indicative of the work done to improve non-admitted performance at the front door.
- EhPC performance continues to support the improvement of wider KPI by consistently achieving 100% daily performance against the Four Hour standard. EhPC also hit over 70 patients on two days in October for the first time.

Actions

- The ED Reconfiguration is almost complete with EhPC now relocated in the modular building. There is a business case to be presented to Executives in November outlining options to purchase this building.
- EhPC now located in modular build outside the ED. It is proposed that Vocare relocate alongside EhPC from the CDC building commencing January 2023. This will support greater cross service working and increase deflection of primary care attendances to UHNM.
- With the ED Reconfiguration nearing completion Workstream 1 will resume BAU working with a focus on Triage, Ambulance Handovers, Workforce Planning, EhPC, and Ambulatory/Minors Performance.

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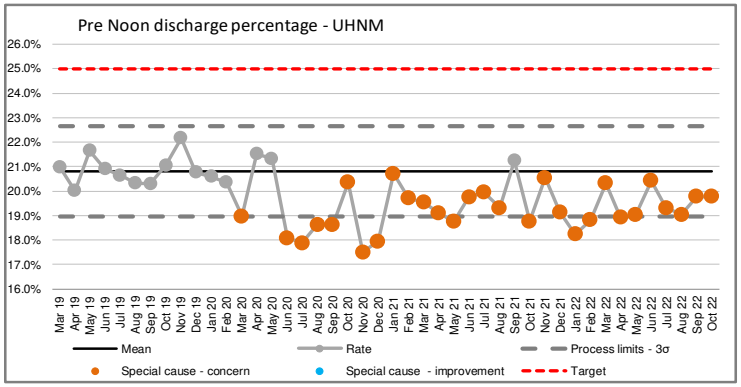
Section 1: Urgent Care

Workstream 2; Acute Patient Flow

Pre-Noon, Simple & Timely, & Occupancy



Variation	Assurance
L	F

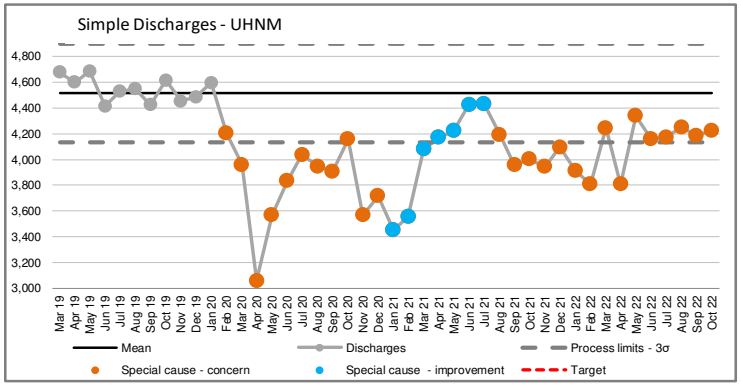
Target	Aug 22	Sep 22	Oct 22
25%	19.0%	19.8%	19.8%

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 13 months triggering the cause for concern SPC rule.



Variation	Assurance
L	

Target	Aug 22	Sep 22	Oct 22
N/A	4253	4185	4226

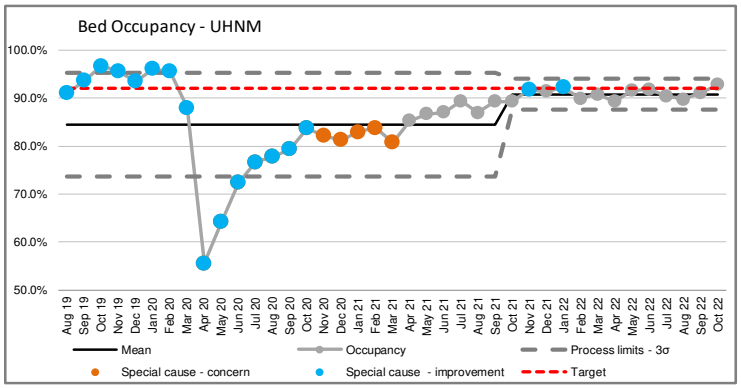
Background

Patients discharged without complex needs

What is the data telling us?

Simple & timely discharges are below pre pandemic levels.

For the last 5 months have been fairly consistent marginally within the lower control limit of 4190.



Variation	Assurance
	?

Target	Aug 22	Sep 22	Oct 22
92%	89.7%	91.1%	92.8%

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 8 months to September have been fairly consistent averaging 91%. October rose to 92.8%, above the target of 92%.

Pre-Noon, Simple & Timely, & Occupancy

University Hospitals of North Midlands NHS Trust

Summary

- Pre-noon discharges again remained static in October with a repeat performance of 19.8%, this is within the 19% - 20% range observed during the past approximately year and a half.
- The number of Simple & Timely discharges improved slightly from 4185 in September to 4226 in October. This has remained largely static for the past five months.
- While there has been a further marginal decline from 91.1% in September to 92.8% in October overall bed occupancy has continued to remain at a relatively static level since September 2021.

Actions

- YNP continues to embed with the final SOP approved. This includes an updated schedule for use in Medicine which describes in Gantt chart format the moves expected by hour of day. Twice weekly communications have been established which include a KPI dashboard to ensure visibility of the net positive impact this initiative has brought. One example of this is moving approximately 50% of late patient moves to the morning and early afternoon. Next steps include the planned roll out to other Divisions including County Hospital.
- Divisional Step Change projects have now commenced in all Divisions except for Surgery where further data analysis has been required to ensure staff engagement and assurance of the opportunity available. While these improvement projects are in their early phases KPI reporting will begin in October with a view to share lessons learned and rollout further early in 2023.

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Section 1: Urgent Care

Workstream 3; Delivering UEC Standards

CRPT+1, SDEC Utilisation, & Mean Time In ED

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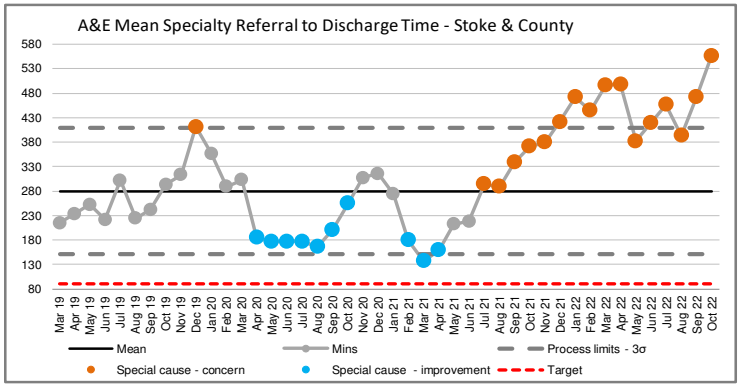


Variation	Assurance
H	F

Target	Aug 22	Sep 22	Oct 22
90	393	473	556

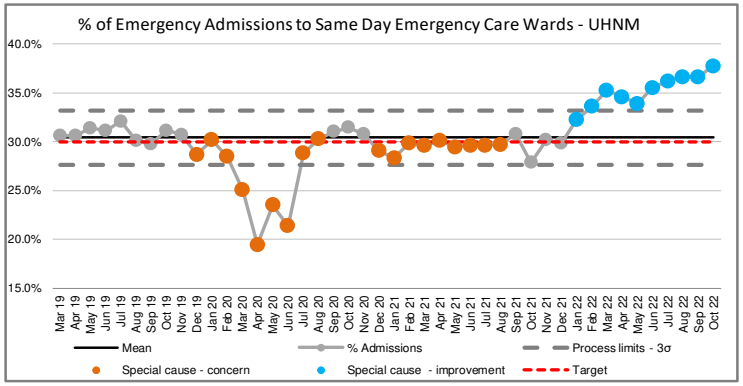
Background

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.

October was the highest seen since recording at 556 minutes.



Variation	Assurance
H	?

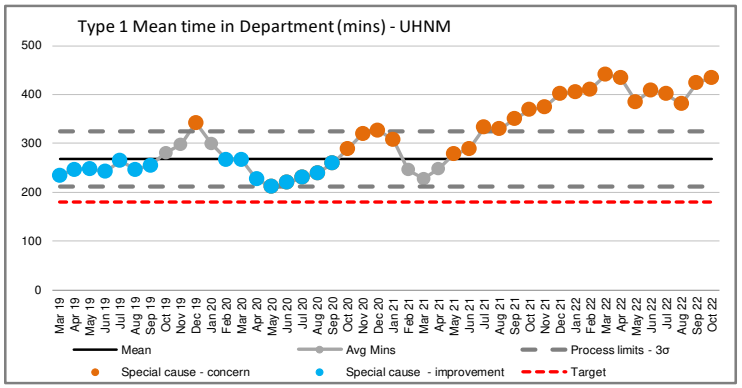
Target	Aug 22	Sep 22	Oct 22
30%	36.6%	36.6%	37.7%

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 above the upper control limits for the last 9 months, with October reaching 37.7%.



Variation	Assurance
H	F

Target	Aug 22	Sep 22	Oct 22
180	380	424	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 14 data points sitting above the control limits.

CRTP+1, SDEC Utilisation, & Mean Time In ED

NHS University Hospitals of North Midlands NHS Trust

Summary

- The average time from specialty referral to discharge grew again in October to a record high of 556 minutes from 473 minutes in September. This deterioration is in line with a number of accompanying metrics which describe an overall reduction in admitted patient hospital flow.
- SDEC utilisation continues to rise further in October reaching another record of 37.7% from 36.6% in September. This continued increase is as a result of improvements in ED navigation and direct GP referrals embedded in line with the IPS becoming more widely utilised and accepted.
- The mean time in department for all patients increased again from 424 minutes in September to 435 in October. Given non-admitted performance has remained static month on month this deterioration can be seen to be driven by admitted pathways and departmental congestion.

Actions

- Workstream 3 now has all three Task & Finish Group meetings in place focussing on Navigation, Portals, and a third quality focussed group forming the newly refreshed governance structure.
- To further embed the new IPS in which all appropriate referred patients go directly to specialty portals a rota has been established for two weeks in November with Divisional Medical Directors contactable directly where failure to adhere to IPS occurs.
- There has also been a debrief meeting scheduled following the two week Medical Director escalation process to ensure live capture of issues and that appropriate actions are implemented.
- Further work is underway with NHS 111 around deflection opportunities within the streaming and redirection tool to compliment recent improvements in internal navigation.

Section 2: ELECTIVE CARE

Cancer – Headline metrics

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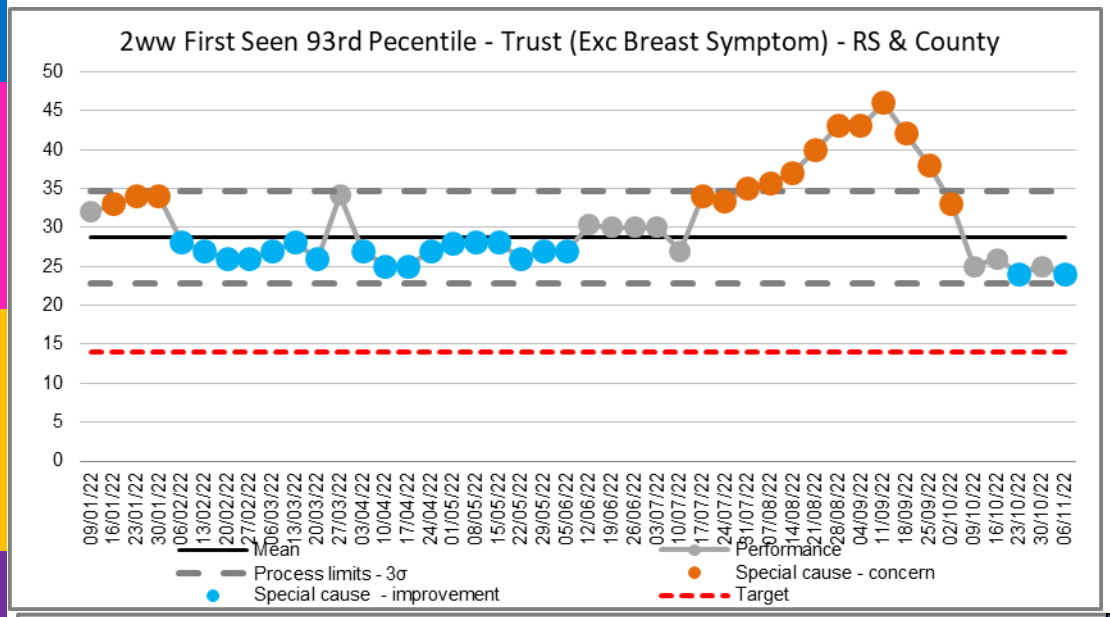


Variation	Assurance
L	F

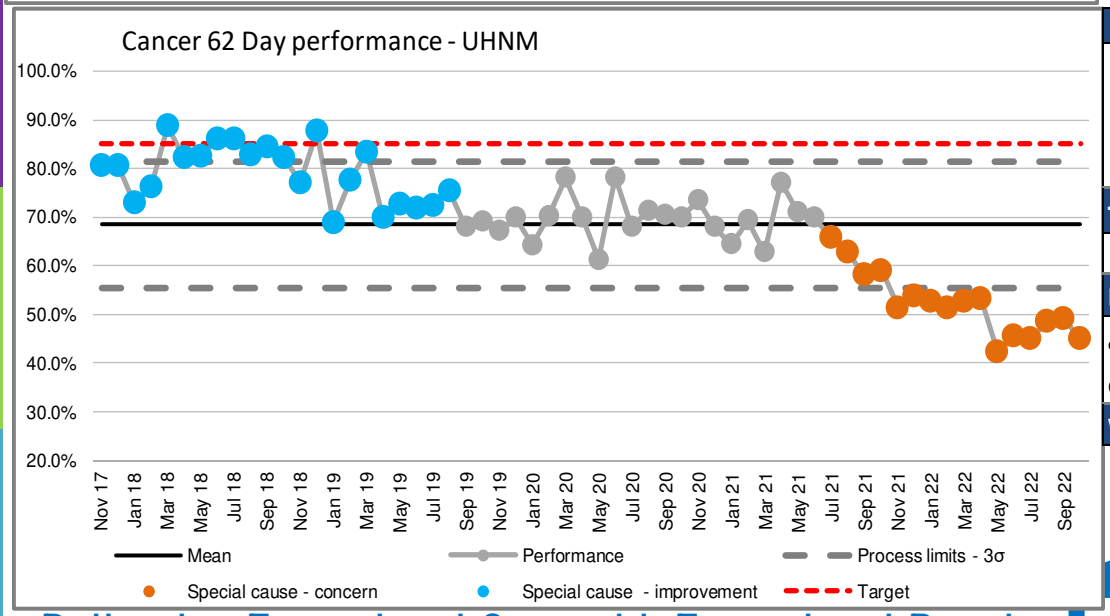
Target	23/10/2022	30/10/2022	06/11/2022
14	24	25	24

Background

The standard is for 93% of patients to be seen within 14 days. This SPC demonstrates within which day 93% of patients were seen on across all tumour sites.

What is the data telling us?

Trust wide – all suspected cancer 2WW referrals. Excluding Breast symptomatic referrals where cancer is not suspected.
93 % of patients first seen for the last week in October had a 14 day clock stop within day 25 of the pathway.



Variation	Assurance
L	F

Target	Aug 22	Sep 22	Oct 22
85%	48.7%	49.1%	44.9%

Background

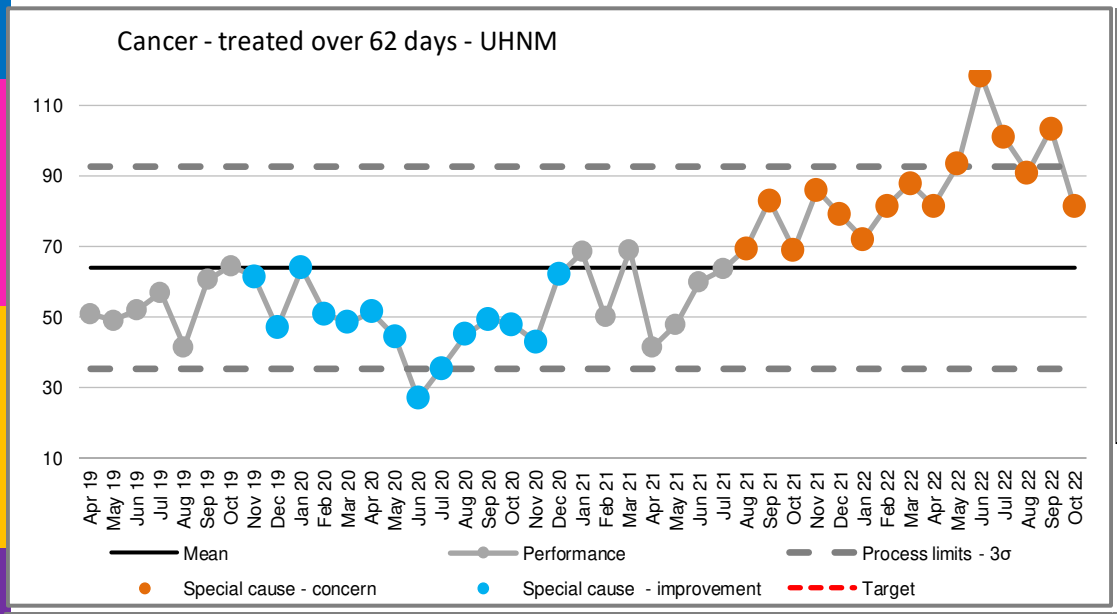
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

Performance significantly challenged and below standard for the past 12 months with a steep decline in May and predicted at for 44% for October – position still to be validated

Cancer - Headline metrics

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	

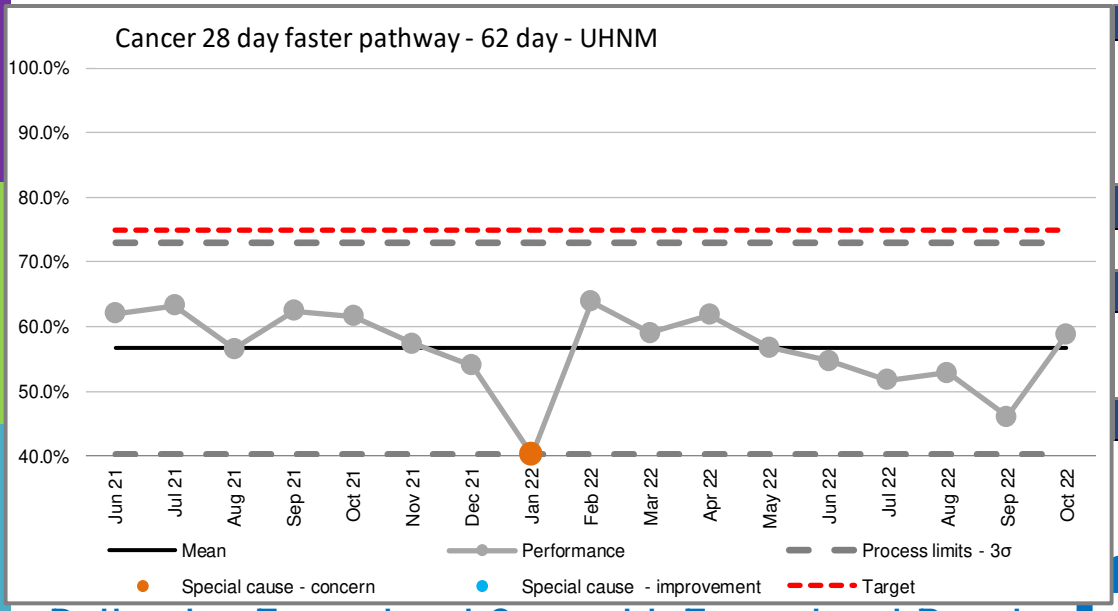
Target	Aug 22	Sep 22	Oct 22
N/A	91.0	103.5	81.5

Background

The number of patients treated over 62 days

What is the data telling us?

Demonstrates total volume of patients who have been treated beyond day 62 is a cause for concern and has been rising over the past 12 months, although there is significant improvements demonstrated in August and further in October.



Variation	Assurance
	F

Target	Aug 22	Sep 22	Oct 22
75%	52.9%	46.0%	58.8%

Background

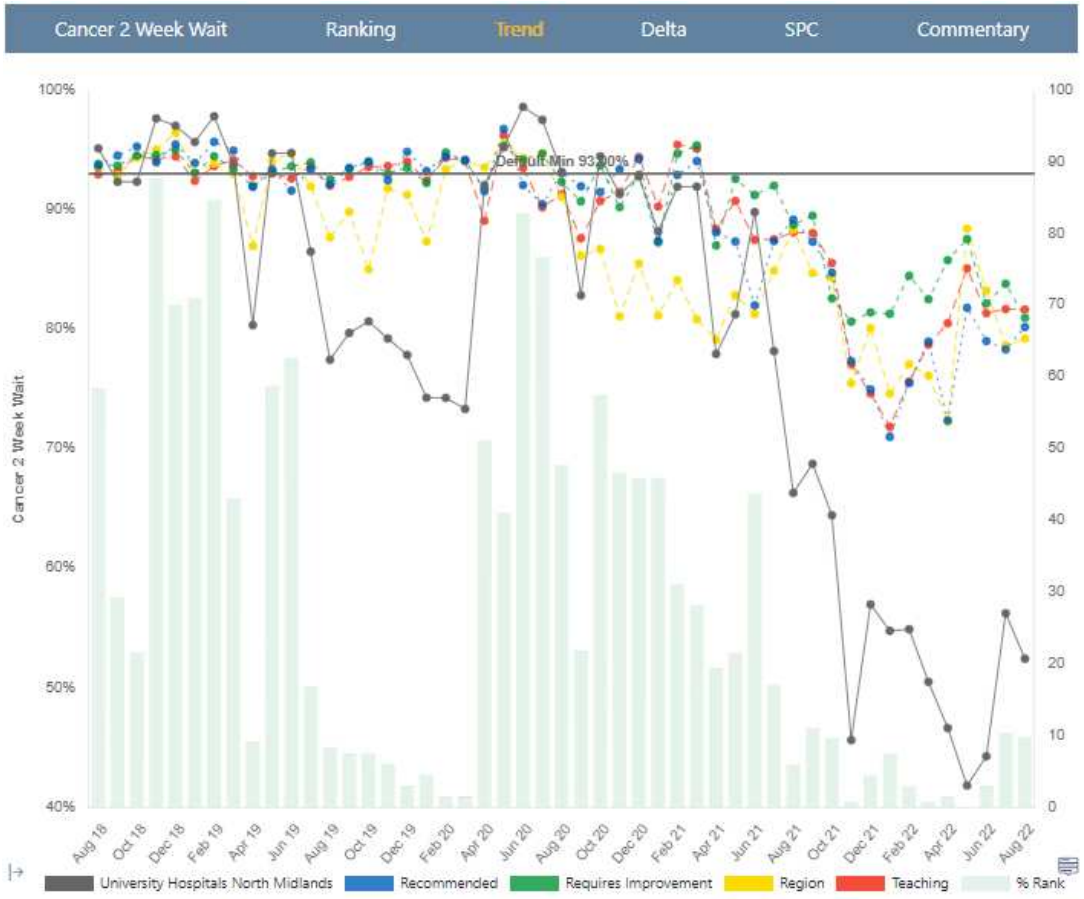
Performance of confirmation or exclusion of cancer communicated with patients within the 28 day timeframe.

What is the data telling us?

The FDS performance remains stable with pockets of good practice. E.g. Breast, Lung and Upper GI all achieve the standard. October position is yet to be finalise d and is predicted to land around 55%

Cancer – benchmarked

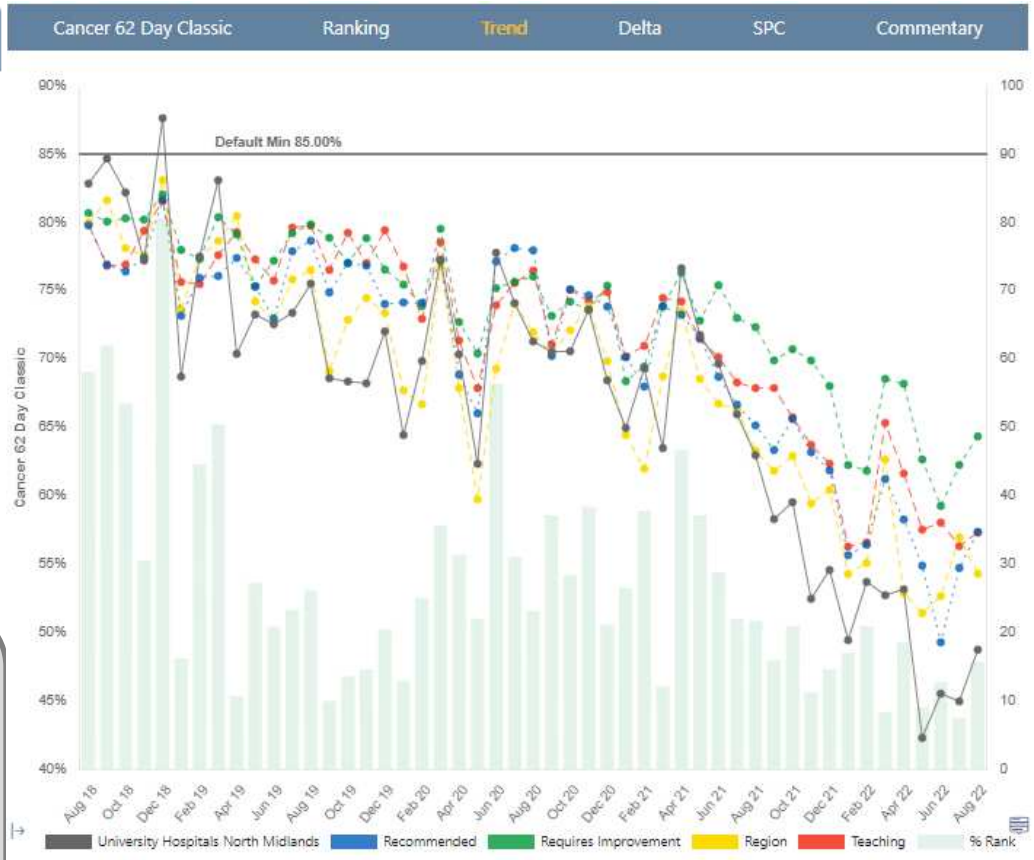
Key Performance Indicator	Period	Target		SPC	
Cancer 2 Week Wait	Aug 22	93.00%	52.4%	L	10
Cancer 2 Week Wait Breast Sym...	Aug 22	93.0%	95.2%	C	74
Cancer 31 Day First Treatment	Aug 22	96.00%	90.1%	L	25
Cancer 31 Day Subsequent Trea...	Aug 22	96.0%	89.3%	L	28
Cancer 62 Day All Sources	Aug 22	85.00%	60.2%	L	27
Cancer 62 Day Consultant Upgr...	Aug 22	85.0%	77.5%	L	52
Cancer 62 Day Screening	Aug 22	90.0%	71.8%	L	55
Cancer Sub Treat Drugs	Aug 22	96.0%	97.2%	C	21
Cancer Sub Treat Radiotherapy	Aug 22	96.0%	92.2%	C	38



- UHNM have seen 14 day performance deteriorate at a greater scale than it's peers since July 2021.
- August 2022 saw a slight dip after a much improved position in July. UHNM are still in the lowest quartile but have seen it's rank improve from worst to 10.

Cancer - Benchmarked

Key Performance Indicator	Period	Target		SPC	
Breast Cancer	Aug 22	85.00%	60.0%		20
Cancer 62 Day Classic	Aug 22	85.00%	48.7%		16
Lower Gastrointestinal Cancer	Aug 22	85.00%	19.0%		12
Lung Cancer	Aug 22	85.00%	25.0%		15
Other Cancer	Aug 22	85.00%	39.8%		21
Skin Cancer	Aug 22	85.00%	45.2%		6
Urological Cancer	Aug 22	85.00%	68.6%		68



- Deterioration has been seen across all peer groups over the last 12 months with UHNM seeing this more dramatically from August 2021
- Improvements have been made since May 22, however UHNM remain in the lowest quartile for the 62 day performance.

Cancer

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Cancer - 28 Day Faster Diagnosis	Aug 22	75.0%	52.9%		6
FDS Brain Tumours	Aug 22	75.0%	-		-
FDS Breast Cancer	Aug 22	75.0%	91.6%		44
FDS Breast Symptoms	Aug 22	75.0%	84.0%		22
FDS Children's Cancer	Aug 22	75.0%	50.0%		4
FDS Gynaecological Cancer	Aug 22	75.0%	52.8%		31
FDS Haematological Malignanci...	Aug 22	75.0%	33.3%		23
FDS Head & Neck Cancer	Aug 22	75.0%	61.6%		16
FDS Lower Gastrointestinal Can...	Aug 22	75.0%	12.8%		4
FDS Lung Cancer	Aug 22	75.0%	93.5%		93
FDS Missing or Invalid	Aug 22	75.0%	-		-
FDS Other Cancer	Aug 22	75.0%	-		-
FDS Sarcoma	Aug 22	75.0%	100%		100
FDS Skin Cancer	Aug 22	75.0%	40.6%		4
FDS Testicular Cancer	Aug 22	75.0%	85.2%		50
FDS Upper Gastrointestinal Can...	Aug 22	75.0%	81.8%		85
FDS Urological Malignancies	Aug 22	75.0%	41.5%		19

- The 28 Day Faster Diagnosis position for all peers saw a drop in August compared to July, where as UHNM saw an improvement.
- UHNM remains in the lowest quartile nationally

Cancer Trajectories

University Hospitals of North Midlands NHS Trust

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 snap-shot PTL position	579	632	639	815	1041	894	887					

National planning guidance 22/ 23 set out the ambition to return the number of patients waiting over 62 days on the live PTL to the levels seen pre-pandemic. The PTL Backlog trajectory for UHNM is set out above; the actuals shown above are a snap shot in time of the PTL position. This is for the week ending last full week of the month per PAF report.

For the month of October 2022, the backlog position was 887 - this includes patients with a decision to treat and a future treatment date scheduled. The majority of the backlog is attributable to Skin and Colorectal. High proportion of patients waiting over 62 days in both tumour sites have future scheduled treatment dates.

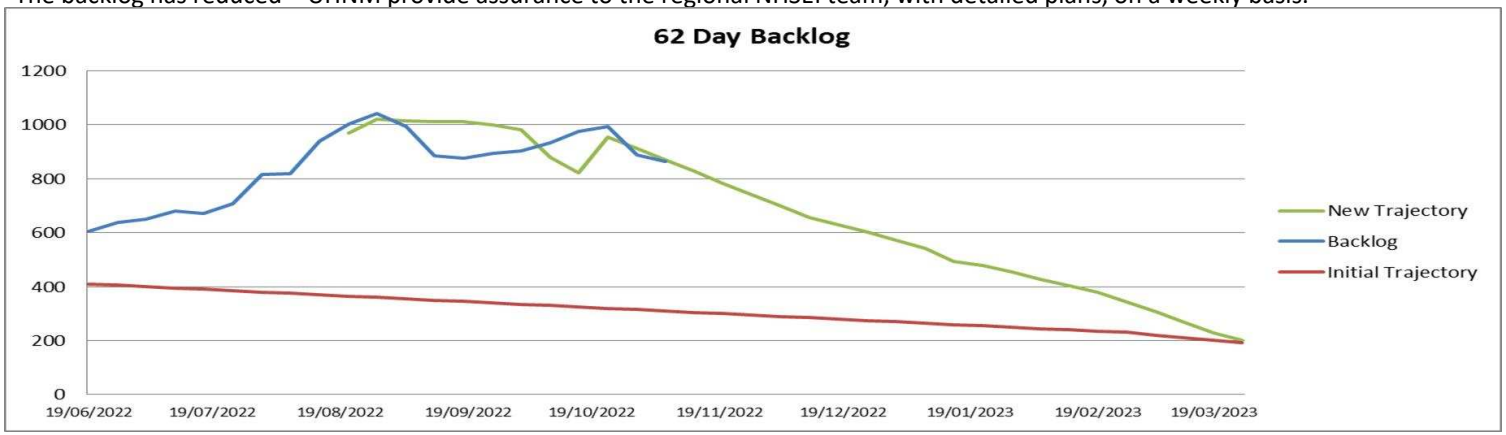
There are multiple contributing factors include delays to pathology reports, urology robotic surgery capacity, complex pathways, increasing element of patient choice and outstanding clinical reviews.

All Divisions are focusing on the backlog and discharge patients where appropriate. Pathway plans are detailed overleaf – there is a concentration on the first appointments and diagnostics and including Oncology. All diagnostic modalities have submitted plans for a reduction in waiting times which includes additional staffing, insourcing and outsourcing and building additional capacity through CDC's. Intensive exec level support is being provided to Skin and Colorectal pathways, which are the main drivers for the backlog position.

Cancer

Actions

- The backlog has reduced – UHNM provide assurance to the regional NHSEI team, with detailed plans, on a weekly basis.



- The incremental decrease of the Skin and Colorectal backlogs have been modelled up to 05/02/23, where the new trajectory meets the initial trajectory submitted in 22/23 operational plans. Both specialties have enacted recovery plans and reducing the number of patients waiting beyond 62 days on the pathway.
- The day by which 93% of patient receive a 2WW 14 day Clock Stop on the LGI pathway has reduced by over 45 days since September – to a current position of within 3 days.
- Breast continue to achieve the 14 day standard and have reduced the overall PTL.
- Over the past 4 weeks the block backlog in Pathology has reduced, supporting overall PTL recovery.
- UHNM is still recording a high number of first treatments, demonstrating increased activity which supports PTL reduction.
- The overall PTL has reduced for the 12th week – and is down to levels seen 6 months ago. In August the PTL was over 6000 – this has now reduced by around 1600 patients to **4410 in total**.

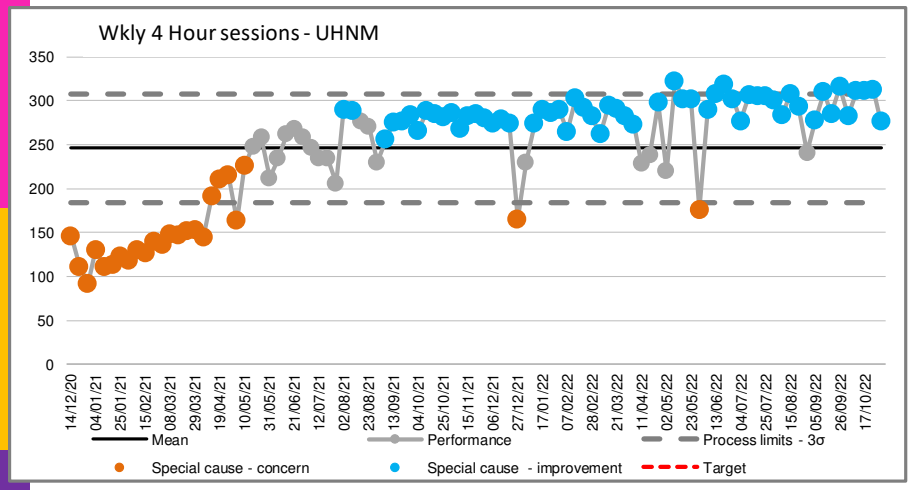
Lower GI:

- Community Referral Hub – managed by the choice and referral centre, continues to be successful. This helps manage and optimise demand, by ensuring only complete referrals which include mandatory pre-requisite investigations and clinical information are submitted to the trust. This will enable clinicians to triage straight to test and risk stratify patients into appropriate capacity. **Next steps** are to implement guidance received in Tier 1 &2 letters to systems – advising that FIT negative patients (some exclusions apply) should not be referred on a 2WW pathway. Plans at a system level are progressing.

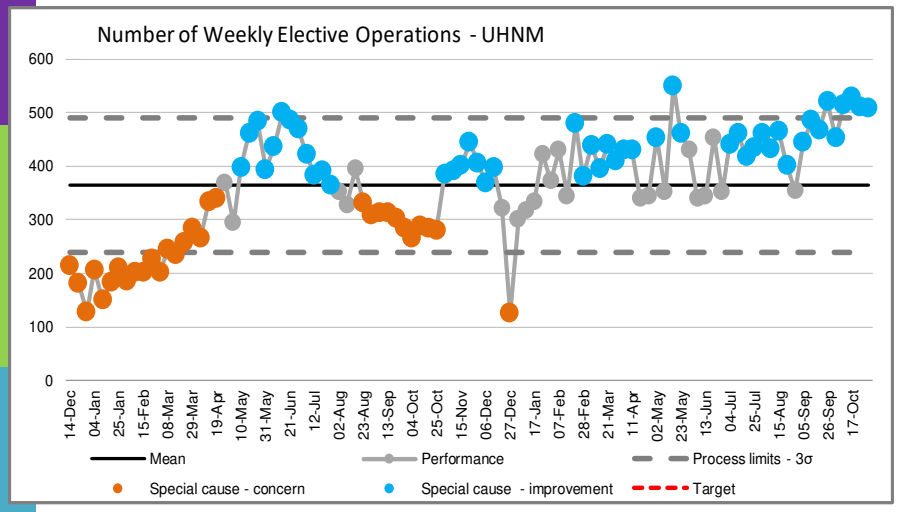
Skin:

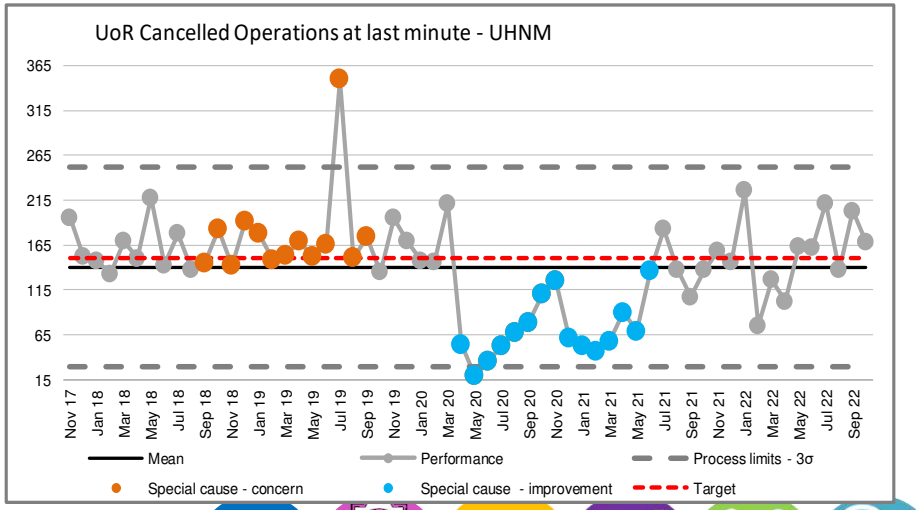
- Primary Care Teledermatology continues to be successful, made live in October. Additional capacity schemes are on-going. Next steps to contract with further external providers to increase activity and reduce wait times. West Midlands Cancer Alliance continue to support with fixed term revenue and a substantive business case is being drafted that ensures sustainability for the service moving forward.

Planned care – *Inpatient Activity*



The number of weekly elective operations have been on an upward trajectory over the last 12 months. This coincides with the increases in the number of weekly 4 hour sessions which is now remaining constant. This has however reduced from 95% to 82% in elective operating. This is being managed through Planned Care to increase this, with the reintroduction of 6-4-2 processes, the Regional theatres lead is also supporting the organisation and will be visiting to assure this process.
The number of patients cancelled on the day continues to fluctuate.





Planned care - *Inpatients*

University Hospitals of North Midlands NHS Trust

Elective inpatients Summary

- Day Case and Elective Activity delivered 78% and 80% respectively for October 22 against the national ask of 110%/108%.
- There is a real focus on 104w cases, many of whom were complex and required whole/half lists. As this number is being driven down the focus is moving to our 78week+ patients.
- At the end of October the numbers of > 104 weeks was 23. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity.
- Insourcing arrangements at weekends continue and have been bolstered to provide more weekend capacity in T&O this started in Feb.
- Nuffield have agreed to take all T&O patients at risk of breaching 78 weeks by end of March who are clinically suitable
- 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

Actions

- External validation support completed end of October, with final report expected by mid November detailing themes and issues.
- 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 complete. Phase 2 underway – RTT Bitesize training now available to divisions., focused on key areas requiring improvement.
- 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 breaching 104 weeks by end of month, combined with forecasting for October and onwards
- Long wait focus moved to patients due to breach 104 weeks in Q3, with plans to eliminate 78 weeks by end of March 2023. Key enablers are ring fencing of beds for Orthopaedics as RSUH, modular theatre at County and improvement in theatre utilisation and booking.
- Increased focus on non-admitted patients and increasing outpatient & diagnostic capacity, improving utilisation and business processes to move patients to a decision to admit.
- Roll-out of Palantir's Foundry platform underway, with working group to be up and running by end of November.

Planned care – *RTT Trajectories*

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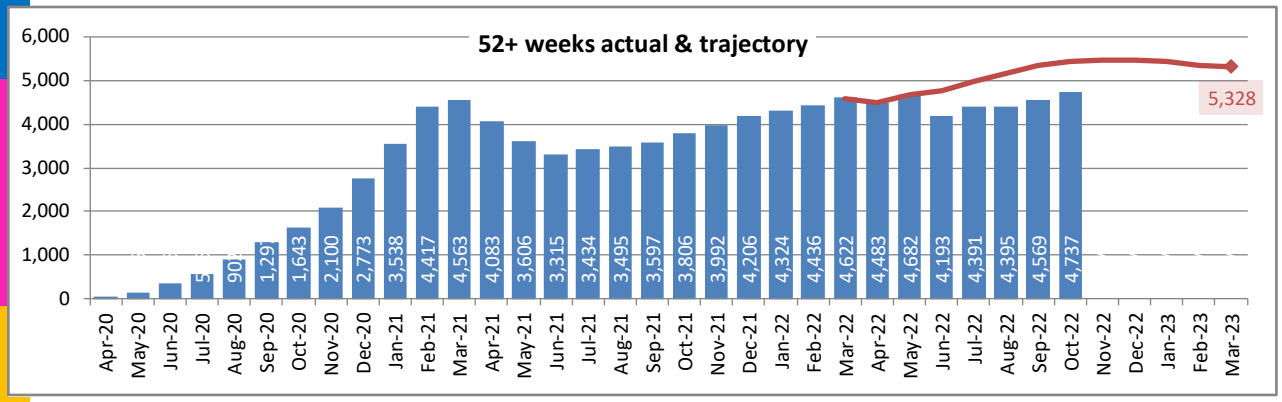
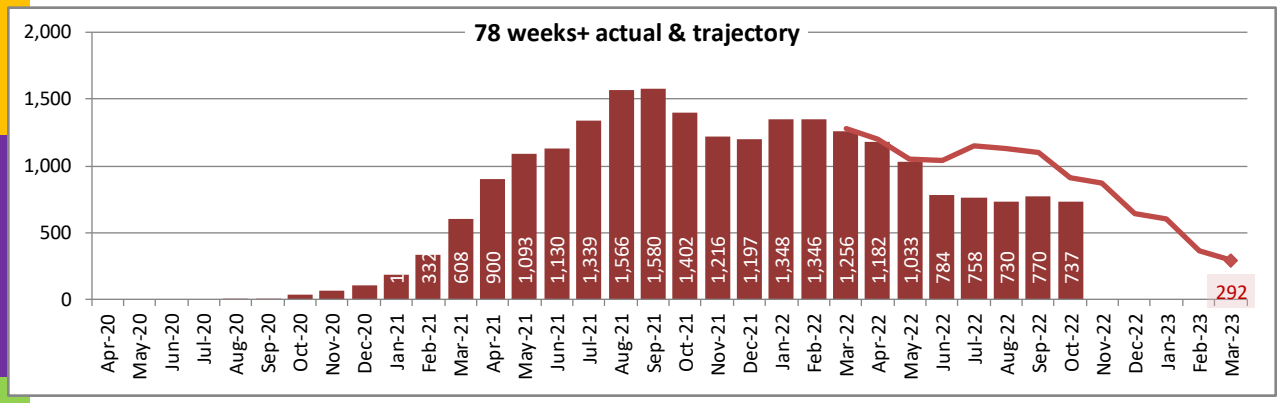
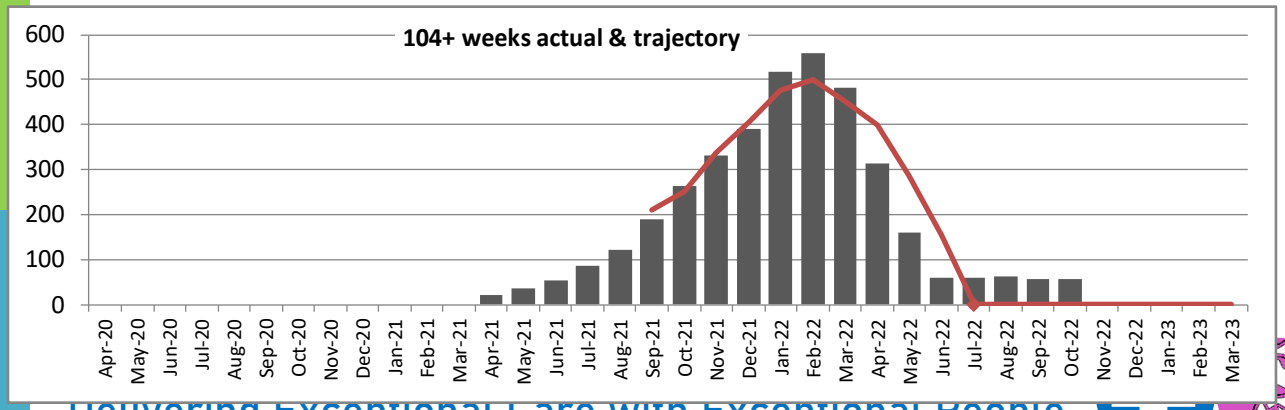


52 Week Waits have been gradually growing since June 21.



78 Week Waits have been reducing for the last 6 months, however last month saw the first increase since January.

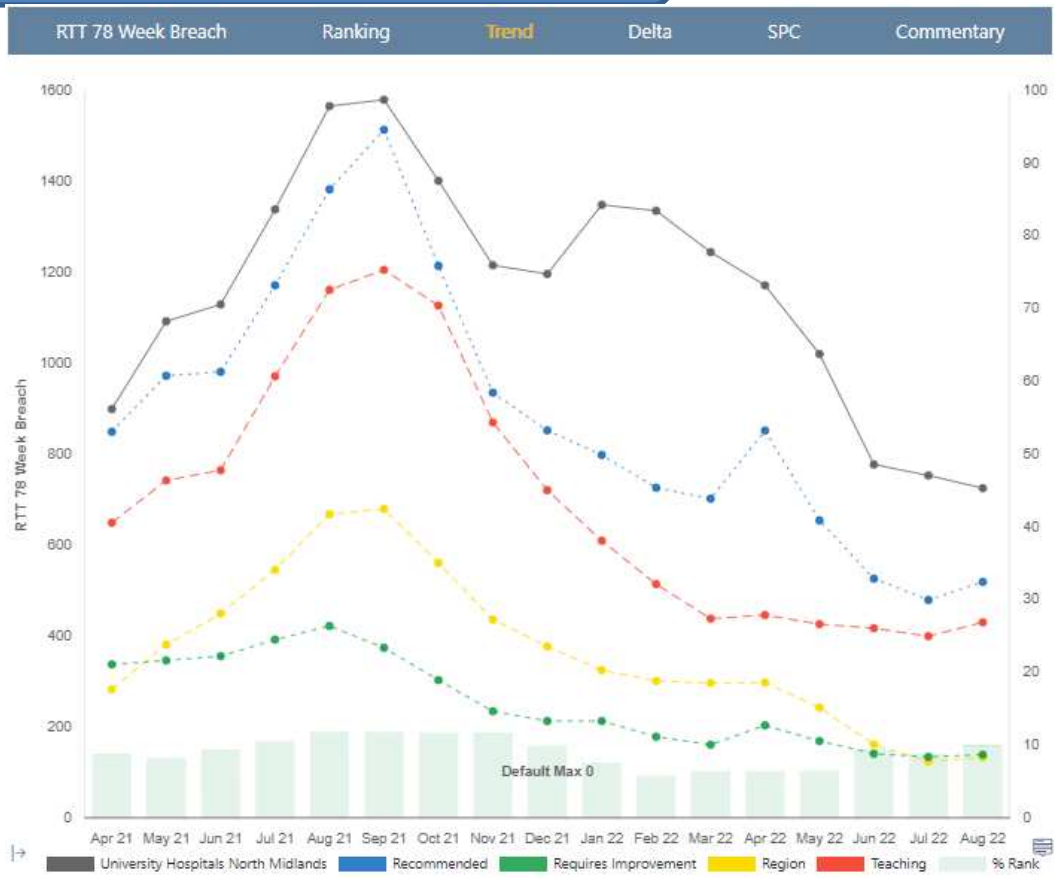


104 Week Waits have been continually decreasing since early March. Number now static at 55. this is made up of patient choice, patients presenting unwell or complex pathways.

RTT - Benchmarked

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
RTT 104 Week Breach	Aug 22	0	64	C	5
RTT 52 Week Breach	Aug 22	0	4,378	H	14
RTT 78 Week Breach	Aug 22	0	726	L	10
RTT 95th Percentile Admitted W...	Aug 22	18.0	81.7	H	11
RTT 95th Percentile Non-Admitt...	Aug 22	18.0	50.7	H	26
RTT Admitted Treatment Within...	Aug 22	90.0%	55.0%	L	29
RTT Average (Median) Admitte...	Aug 22	9.0	15.0	H	30
RTT Average (Median) Non-Ad...	Aug 22	5.0	7.5	H	57
RTT Average Wait for Incomplete	Aug 22	7.00	16.3	H	14
RTT Incomplete 92nd Percentile	Aug 22	-	47.2	H	23
RTT Incomplete Pathways With ...	Aug 22	25.0%	14.9%	L	45
RTT Non-Admitted Treatment ...	Aug 22	95.0%	72.2%	L	43
RTT Total Clock Starts	Aug 22	-	14,460	C	81
RTT Total Clock Stops	Aug 22	-	12,721	C	85
RTT Total Incompletes	Aug 22	-	76,697	H	11



- 78 Week waits are seeing a reducing trend across all peer groups
- All peer groups saw a slight increase in August compared to July, however UHNM continued with the reducing trend.
- UHNM remain in the lowest quartile

Planned care

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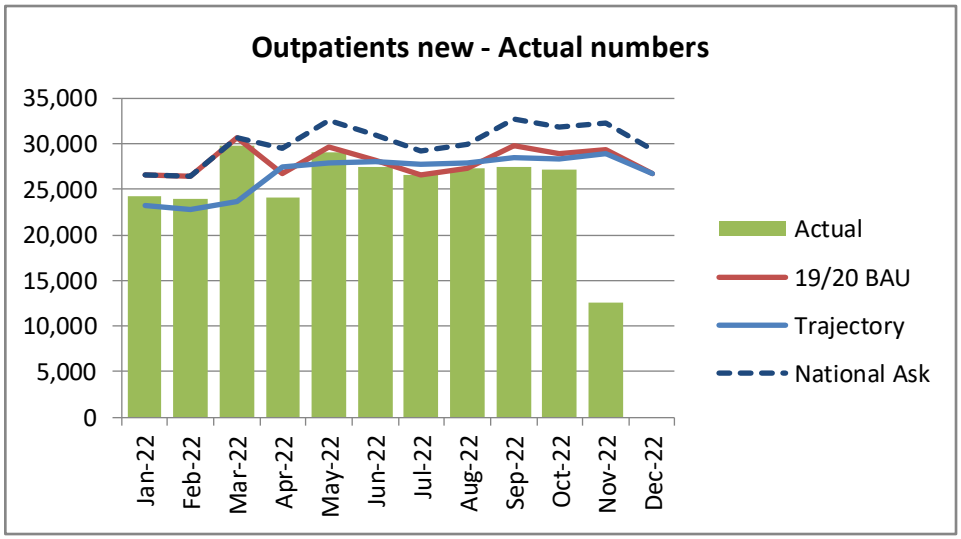
Summary

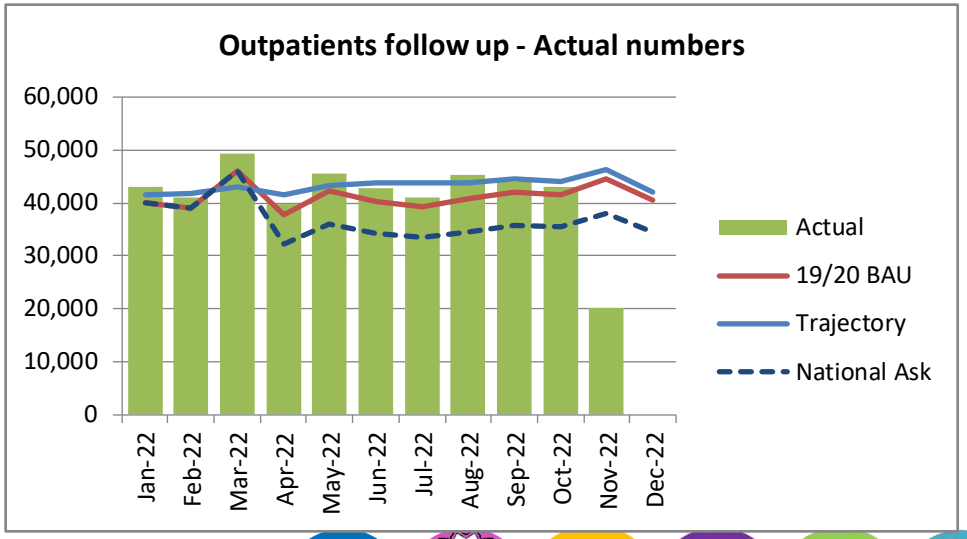
- 52+ week patients increased in October to 4,698
- 78+ patients have been gradually reducing, but has reached a plateau in September – trust is still on trajectory to eliminate 78 weeks waits by end of March 2023, with several key enablers and risks around staffing issues, covid waves and winter pressures.
- Positive 104+ week position at month end with only those complex patients where this is not possible or if patients have chosen to wait now waiting to be treated.
- The overall Referral To Treatment (RTT) Waiting list has started to show signs of stabilisation. April was 76,023, May 75,858, June 75,538 , July 77,242 and August 76,838, September 77,985, October 77,546. However, this is likely to increase again over winter.

RTT

- Validation has increased with extra resource. This will provide an accurate picture of the resource required in the medium term to reduce the list. The number of patients > 18 weeks has decreased to a level of 36,126 (36,565 in August) The increase in total waiting list size is due to increased referrals/clock starts, as well as reduced throughput.
- At the end of October the numbers of > 104 weeks was 24 - a decrease from 314 in April. All patients in this cohort are either there due to patient choice, or complexity of pathway. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance has seen a slight increase at 53.41%. (53.11% August)
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.

Planned care – *Outpatient activity & RTT*





Planned care – *Outpatients*

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Actions

- OP Cell Programme Structure & TOR updated for 22/23 to reflect Elective Recovery Planning Guidance.
- **Work stream 1 Outpatient Service Delivery & Performance**
  - 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 on-going input into Trust training considerations (systems & processes) & links to DQ group. Utilisation focus; bookings, DNAs & cancellations, targets to be set following Session Code flags review.
- **Work stream 2 Outpatient Transformation**
  - **Enhanced Advice & Guidance** ICS Referral Optimisation Steering Group set up (now termed Demand Management Steering Group), A3 drafted to define the programme of work (will include Colorectal/Gastro system wide working group). Following a review of the A&G data requirements the system submission has been amended to include additional RAS data for a T&O service at MPFT. This has impacted the ICS utilisation significantly showing a performance in September of 30% vs 16% target. Further data validation continues for post referral advice @ UHNM, whilst focus for providers expected to shift to pre-referral advice & diverted requests.
  - **PIFU**; divisional % PIFU Targets and trajectory to meet 5% in March 2023. PIFU Divisional Challenge with COO July 11th. Ahead of plan on rollout volume, PIFU captured for >25 specialties (Oct 4.1% vs 2.7% plan). Benchmarking vs national median Sep 2022- UHNM: 21st out of 143 providers (4.1% vs 1.7%). Scoping Robotic Process Automation with UHNM BI for PIFU Discharge letters, request submitted. Exploring post-procedure PIFU opportunities to support pathway work, scoping exercise with T&O. Alternatives for estimating waiting list / appt benefits are being modelled.
  - **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; PKB config working groups - reps invited to OP Cell for updates / discussion. Director of Digital Transformation attended OP Cell in October to share Digital Vision.
  - **SMS via Netcall to Waiting List**. From successful trial in derm & plastics to backlog pts, Partial Booking module purchased for similar approach with other specialties. Used to contact New Waiting List pts (>38wks) during Super September. 44% response rate, with 3% of those receiving an SMS (51 from 1684) no longer requiring an appointment. Plan to rollout for follow ups in top 14 backlog specs from Nov to Feb (commenced Oct).
  - **Virtual Clinic reviews** enabled 432 clock stops from 1693 pathways validated. NHSE identified UHNM as a potential national case study for this approach during feedback at regional network.

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.

Diagnostic Activity

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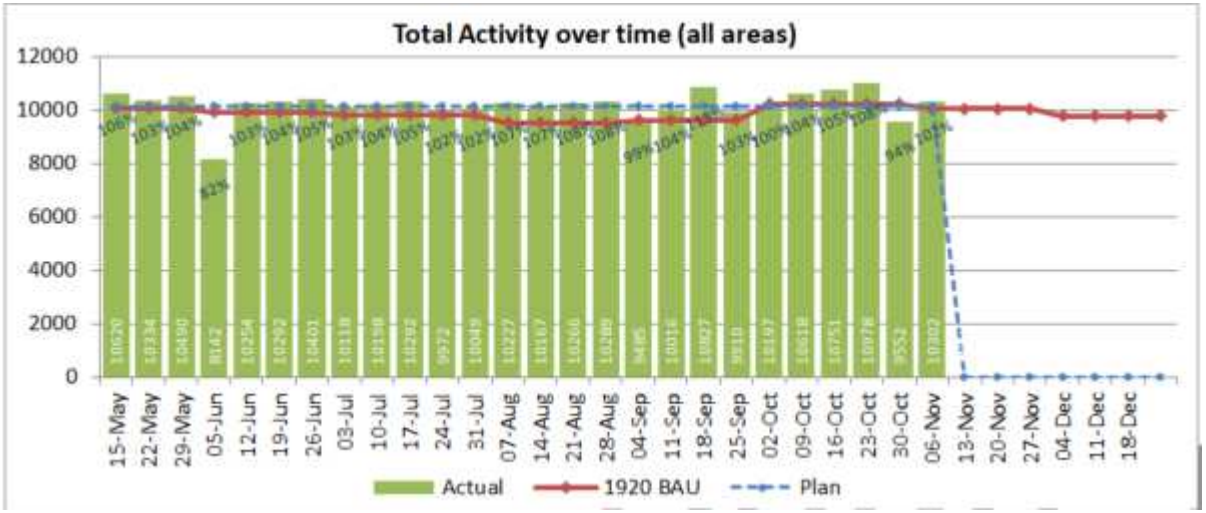
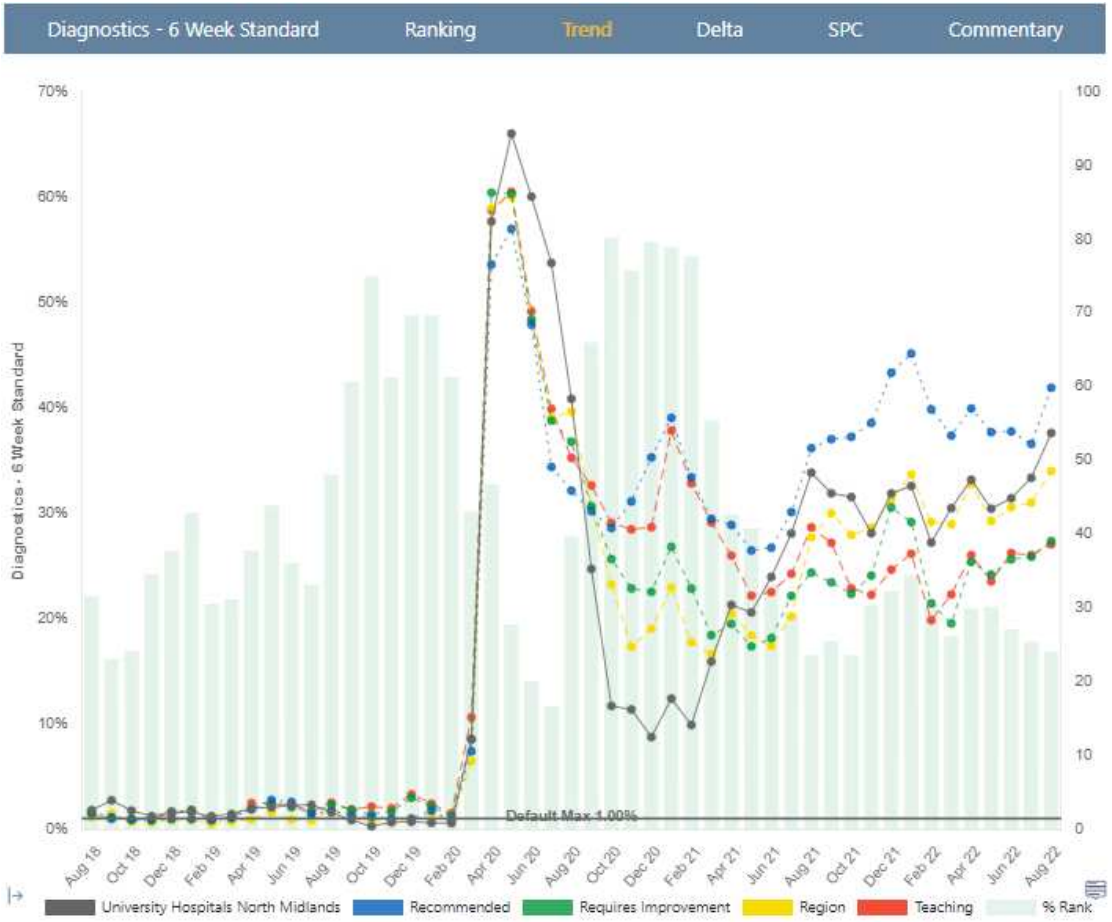
		Aug-22			Sep-22				Unvalidated Figures Currently Oct-22			
Area	DM01 Test	6+	%	Activity	Total WL	6+	%	Activity	Total WL	6+	%	Activity
Imaging	Magnetic Resonance Imaging	949	80.4%	3,780	4,832	694	85.6%	3,564	4,634	774	83.3%	3,666
	Computed Tomography	9	99.7%	8,473	3,292	1	100.0%	8,200	4,141	12	99.7%	8,292
	Non-obstetric ultrasound	7,046	40.6%	4,266	11,446	6,562	42.7%	5,451	11,224	6,171	45.0%	5,343
	Barium Enema							0				
	DEXA Scan											
Physiological Measurement	Audiology - Audiology Assessments	0	100.0%	381	253	6	97.6%	324	307	24	92.2%	283
	Cardiology - echocardiography	635	71.8%	1,325	2,358	654	72.3%	1,242	2,330	698	70.0%	1,295
	Cardiology - electrophysiology	0		7	0	0		2	0	0		2
	Neurophysiology - peripheral neurophy	0	100.0%	308	343	0	100.0%	212	307	0	100.0%	267
	Respiratory physiology - sleep studies	129	79.8%	254	718	180	74.9%	242	558	126	77.4%	282
	Urodynamics - pressures & flows	0		1	0	0		1	0	0		
Endoscopy	Colonoscopy	306	53.4%	327	850	342	59.8%	328	933	417	55.3%	295
	Flexi sigmoidoscopy	159	55.8%	91	522	177	66.1%	71	553	236	57.3%	78
	Cystoscopy	9	93.5%	195	142	12	91.5%	214	135	6	95.6%	223
	Gastroscopy	250	65.1%	733	778	313	59.8%	689	810	429	47.0%	592
	Totals	9,492	62%	20,141	25,534	8,941	65%	20,540	25,932	8,893	66%	20,618



Diagnostics - benchmarked

Key Performance Indicator	Period	Target		SPC	
Audiology	Aug 22	1.00%	0.0%		100
Colonoscopy	Aug 22	1.00%	46.6%		26
Computed Tomography	Aug 22	1.00%	0.3%		80
Cystoscopy	Aug 22	1.00%	6.5%		73
DM01 Waiting <13 Weeks	Aug 22	100.00%	88.4%		35
Diagnostics - 6 Week Standard	Aug 22	1.00%	37.6%		24
Diagnostics - 6 Week Standard ...	Aug 22	99.00%	62.4%		24
Echocardiography	Aug 22	1.00%	28.2%		56
Electrophysiology	Aug 22	1.00%	-		-
Flexi Sigmoidoscopy	Aug 22	1.00%	44.2%		26
Gastroscopy	Aug 22	1.00%	35.0%		34
Magnetic Resonance Imaging	Aug 22	1.00%	19.6%		35
Neurophysiology	Aug 22	1.00%	0.0%		100
Non-obstetric Ultrasound	Aug 22	1.00%	59.4%		1
Sleep Studies	Aug 22	1.00%	20.2%		53
Urodynamics	Aug 22	1.00%	-		-



- Performance at UHNM is better than "Recommended" peers and inline with region
- UHNM have seen a similar trend to it's peer groups however the initial deterioration seen March to June 2021 was more severe causing the national rank to reduce.

Planned care - *Diagnostics*

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Diagnostics Summary

As at w/e 13/11/22:

- CT – delivering 128% BAU, 1,952 patients seen in week
- MR – delivering 108% BAU, 827 patients seen in week
- Ultrasound – delivering 102% BAU, 1,227 patients seen in week
- Echocardiography - delivering 112% BAU, 344 patients seen in week

Histology position :

Urgent (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day **19**, with 80% of cases reported by Day **10**

Accelerated (include all Cancer Resections): 95% reported at Day **36,** with 80% of cases reported by Day **25**

Routine (all Specimens not in above categories): 95% reported at Day **46,** 80% of cases reported by Day 36

Actions

Top 6 contributors for DM01 performance have developed recovery plans, and have been requested to refresh these plans in line with National timescales for recovery (March 23). To be monitored once complete by Planned Care Group.

DM01 performance 65.89% (17,038) 34.11% (8,821) breaches 6 weeks +

Top Contributors – in order of highest breach %

1.	Non-Obstetric Ultrasound (40.6%)	6171 breaches of 11,224 patients
2.	MRI	774 breaches of 4,634 patients
3.	Colonoscopy (53.4%)	417 breaches of 933 patients
4.	Flexi Sigmoidoscopy (55.8%)	236 breaches of 553 patients
5.	Gastroscopy (65.1%)	429 breaches of 810 patients
6.	Echocardiography (71.8%)	651 breaches of 2,283 patients

- **Radiology reporting backlogs;** Outsourcing maximised, full reporting capacity and demand completed. Business case progressing through Trust executive approval process, 6 radiologists applications ready to interview, TI's for cancer backlog agreed.
- High risk relating to 'routine / non cancer reporting' due to reporting capacity and delays in diagnosis (RISK register no 25512)
- Current no of radiology reports in the backlog is: c15,000
- Risk re Imaging reports for 2 week wait internal TAT failure Risk Register no – 23410 score 12
- Risk re GI Imaging reports Risk Register no 23647 - score 12
- **Non – obs Ultrasound capacity for routine patients** New outsourced provider procured & reflected in boost in activity. Trajectory to meet DM01 by March '23
- **Endoscopy;** Fluctuating cancer referral demand against lack of scopist availability

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	10.40%	9.04%	8.83%	7.31%	7.69%	11.81%	12.65%	10.24%	14.05%	7.50%	0.49%
Weeks Waited- 78-104	14.75%	12.57%	9.69%	8.12%	7.16%	9.34%	10.38%	8.38%	13.09%	4.89%	1.66%
Weeks Waited- 52-77	13.21%	12.23%	10.15%	8.60%	7.14%	11.35%	10.62%	9.54%	11.19%	5.03%	0.95%
Weeks Waited- Under 52	13.59%	11.70%	10.03%	9.01%	7.46%	10.31%	10.87%	8.97%	11.45%	5.40%	1.19%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	11.27%	9.89%	9.02%	8.67%	7.85%	11.23%	11.60%	10.12%	12.89%	6.54%	0.92%
Weeks Waited- 78-104	13.17%	10.51%	10.00%	9.38%	7.83%	10.29%	10.12%	9.77%	11.91%	6.01%	1.02%
Weeks Waited- 52-77	13.24%	11.13%	9.79%	9.28%	7.65%	10.75%	10.48%	8.67%	11.41%	6.54%	1.06%
Weeks Waited- Under 52	13.52%	11.48%	10.11%	8.97%	7.53%	10.57%	10.50%	8.98%	11.25%	5.94%	1.14%

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	0.24%	0.38%	0.08%	0.32%	0.38%	0.65%	0.03%	0.05%	0.19%	0.38%	0.46%	0.24%	0.05%	0.03%	93.31%	0.38%	0.65%	1.87%	0.30%
Weeks Waited- 78-104	0.26%	0.70%	0.09%	0.61%	0.17%	1.48%	0.09%	0.35%	#N/A	0.17%	1.13%	0.09%	#N/A	0.09%	89.53%	0.17%	1.66%	1.48%	1.92%
Weeks Waited- 52-77	0.25%	0.47%	0.19%	0.57%	0.54%	1.07%	0.19%	0.16%	0.19%	0.63%	1.45%	0.13%	0.13%	0.09%	88.08%	0.19%	2.12%	1.58%	#N/A
Weeks Waited- Under 52	0.43%	0.62%	0.21%	0.63%	0.62%	1.14%	0.11%	0.19%	0.14%	0.50%	1.54%	0.28%	0.14%	0.20%	84.64%	0.29%	2.87%	2.51%	2.92%

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	0.27%	0.44%	0.21%	0.54%	0.44%	0.80%	0.12%	0.23%	0.09%	0.53%	1.29%	0.20%	0.13%	0.11%	88.02%	0.34%	2.68%	2.15%	1.40%
Weeks Waited- 78-104	0.32%	0.69%	0.11%	0.65%	0.54%	1.26%	0.08%	0.22%	0.05%	0.38%	1.91%	0.32%	0.17%	0.12%	86.20%	0.29%	2.40%	2.15%	2.14%
Weeks Waited- 52-77	0.39%	0.60%	0.18%	0.64%	0.55%	1.11%	0.18%	0.15%	0.18%	0.60%	1.72%	0.31%	0.13%	0.23%	85.25%	0.26%	2.83%	2.31%	2.39%
Weeks Waited- Under 52	0.45%	0.66%	0.20%	0.62%	0.58%	1.26%	0.14%	0.17%	0.15%	0.58%	1.80%	0.32%	0.17%	0.24%	82.84%	0.29%	3.27%	2.82%	#N/A

APPENDIX 1

Operational Performance

Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	Percentage of Ambulance Handovers within 15 minutes	0%	44.60%			
	Ambulance handovers greater than 60 minutes	0	1443			
	Time to Initial Assessment - percentage within 15 minutes	85%	53.97%			
	Average (mean) time in Department - non-admitted patients	180	308			
	Average (mean) time in Department - admitted patients	180	435			
	Clinically Ready to Proceed	90	556			
	12 Hour Trolley Waits	0	1028			
	Patients spending more than 12 hours in A&E	0	2052			
	Median Wait to be seen - Type 1	60	101			
	Bed Occupancy	92%	92.76%			
Cancer Care	Cancer 28 day faster pathway	75%	58.79%			
	Cancer 62 GP ref	85%	44.93%			
	Cancer 62 day Screening	90%	72.41%			
	31 day First Treatment	96%	89.06%			
	2WW First Seen (exc Breast Symptom)	93%	77.88%			

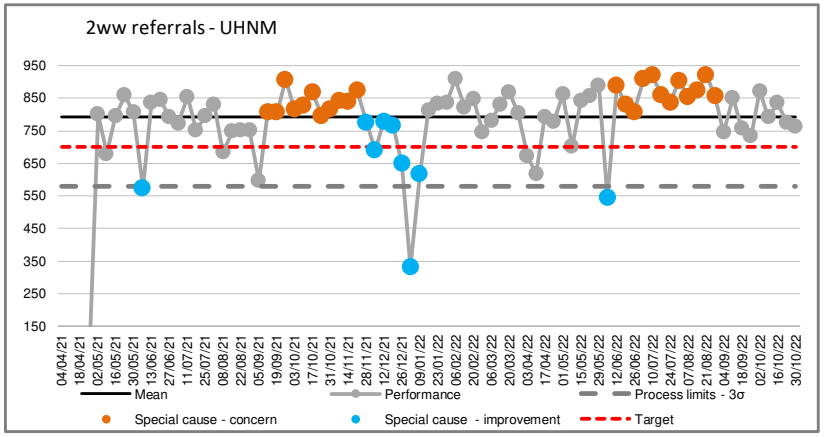
	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	8.0%			
	Cancelled Ops	150	168			
	Theatre Utilisation	85%	78.5%			
Inpatient / Discharge	Same Day Emergency Care	30%	38%			
	Super Stranded	183	201			
	MFFD	100	128			
	Discharges before Midday	25%	19.8%			
	Emergency Readmission rate	8%	9.5%			
Elective waits	RTT incomplete performance	92%	53.51%			
	RTT 52+ week waits	0	4737			
	Diagnostics	99%	64.95%			

Cancer – 62 Day

Target	Aug 22	Sep 22	Oct 22
700	836	775	763

Background

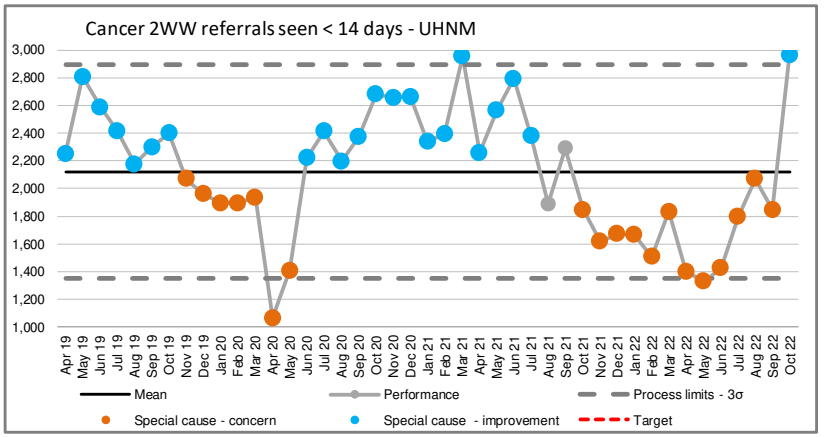
The number of patients referred on a cancer 2ww pathway.



Target	Aug 22	Sep 22	Oct 22
N/A	2071.0	1847.0	2965.0

Background

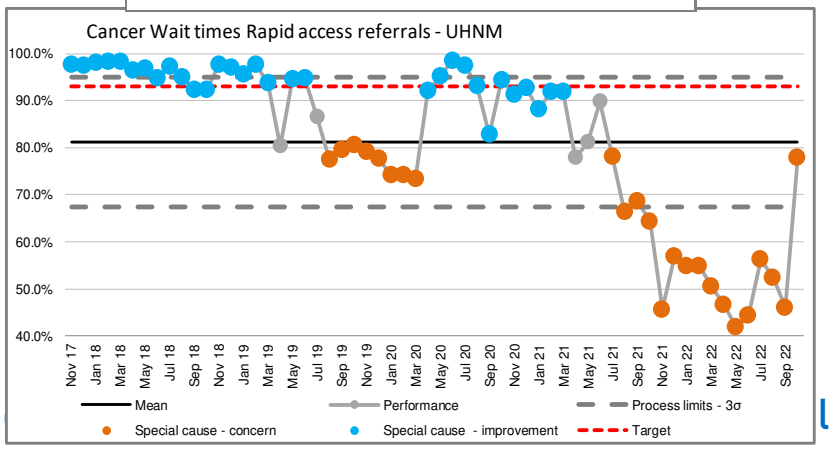
The percentage of patients waiting over 18 weeks for treatment since their referral.



Target	Aug 22	Sep 22	Oct 22
93%	52.4%	46.1%	77.9%

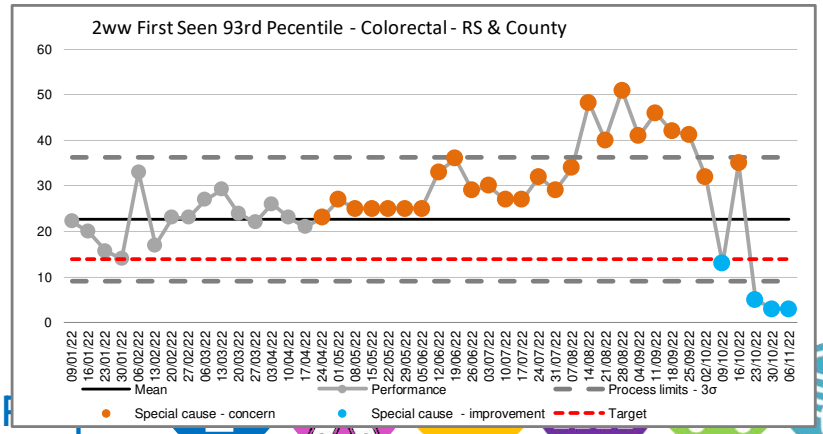
Background

% patients referred on a cancer 2ww seen by a specialist within 2 weeks of referral from GP



Variation	Assurance
L	?

Target	Oct 22	Oct 22	Nov 22
14	5	3	3



Referral To Treatment

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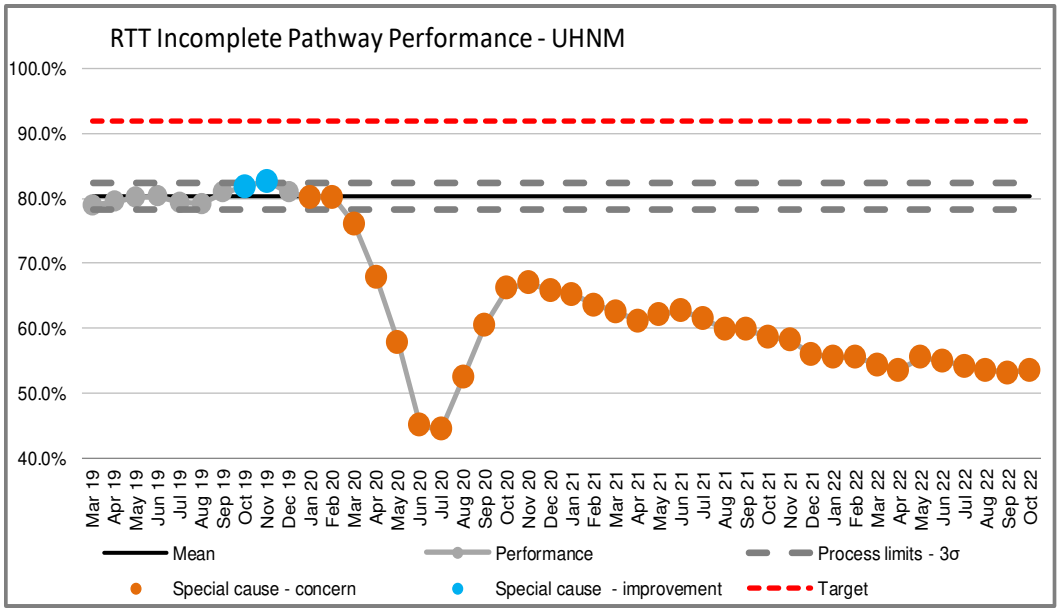
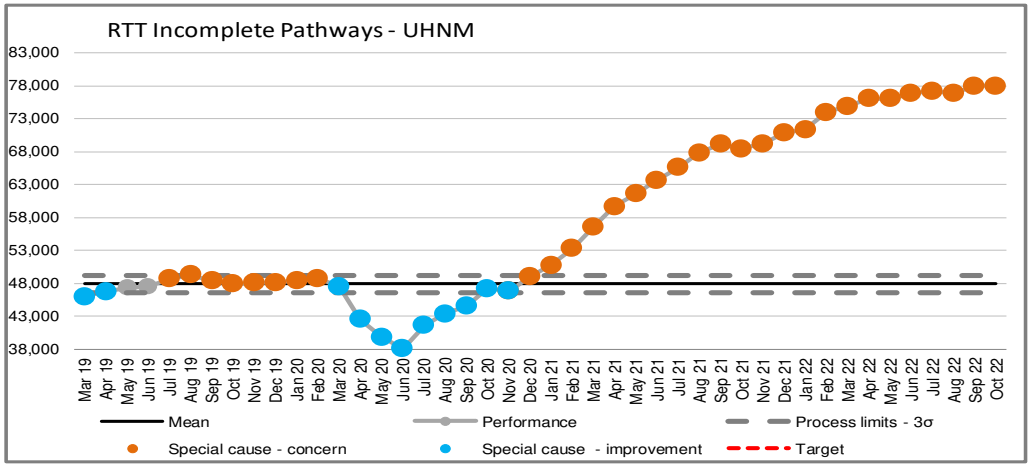
NHS Trust





Variation	Assurance
L	F

Target	Aug 22	Sep 22	Oct 22
92%	53.5%	53.1%	53.5%

Background

The percentage of patients waiting less than 18 weeks for treatment.

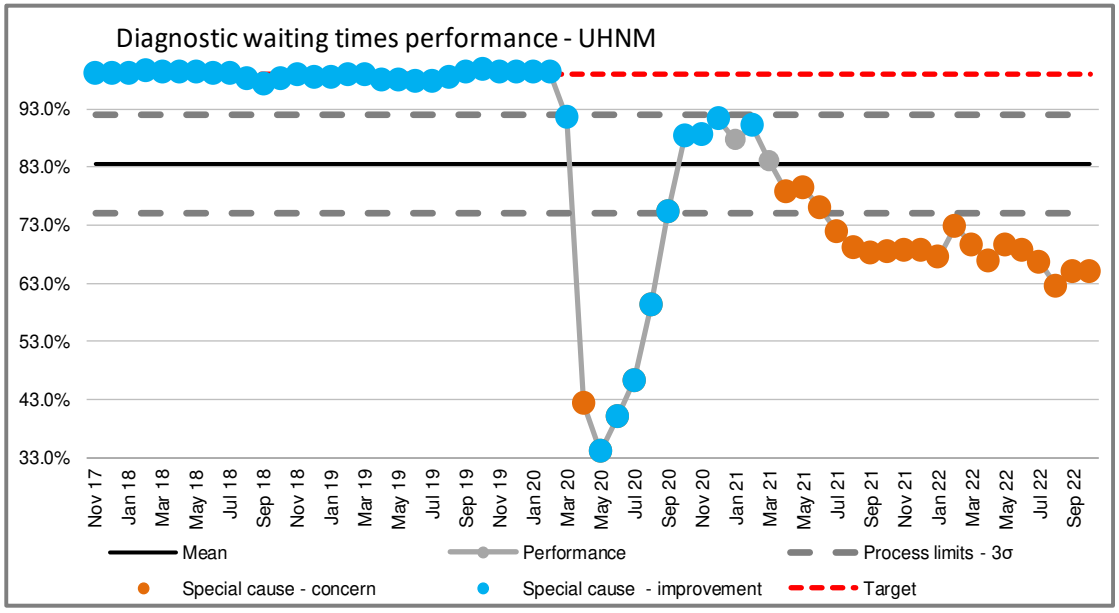
What is the data telling us?

Steady decline in performance since the pandemic began.

Delivering Exceptional Care with Exceptional People

Diagnostic Standards

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
	

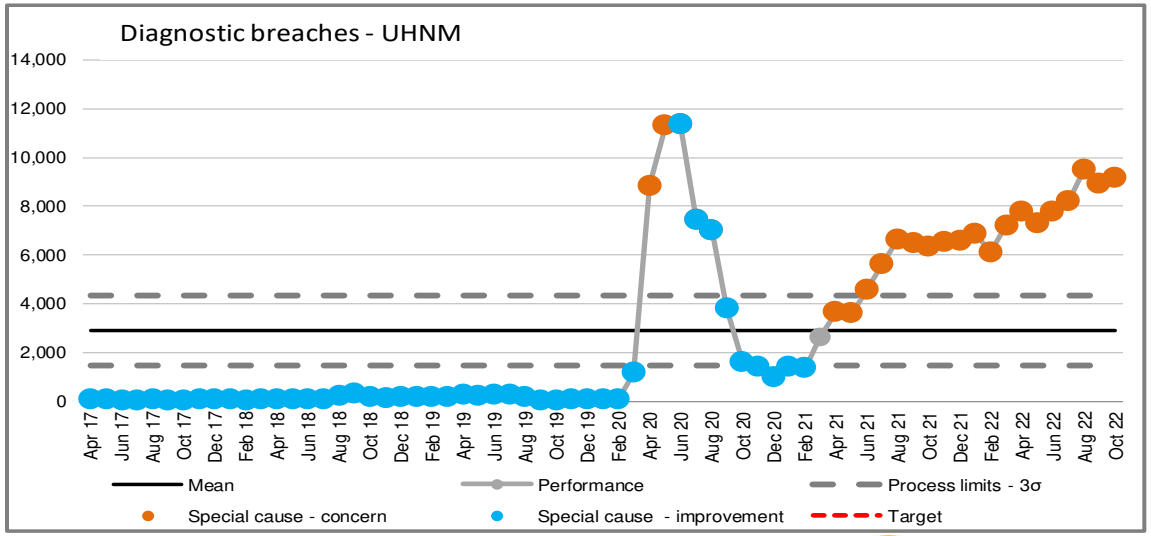
Target	Aug 22	Sep 22	Oct 22
99%	62.4%	65.0%	65.0%

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

University Hospitals of North Midlands NHS Trust

2025 Vision "Achieve excellence in employment, education, development and Research"

Delivering Exceptional Care with Exceptional People

Workforce Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key messages

The Trust's People Strategy 2022-2025 sets identifies the workforce priorities required to support delivery of the Trust's strategic ambitions, vision and objectives whilst demonstrating our values in all that we do. To deliver this four key domains of focus have been identified within the strategy.

- We will look after our people
- We will create a sense of belonging
- We will grow and develop our workforce for the future
- We will develop our people practices and systems

Overall, the level of workforce risk remains at ext16 due to the cultural issues highlighted in our culture review and the impact of increased covid-related absences on sickness levels and workforce availability. There are measures in place to mitigate risks including a recruitment pipeline.

The Cultural Improvement Plan has been updated following a monthly review of progress.

- A cultural heat map has been developed using key indicators of culture. The indicators have been cross referenced with the cultural improvement plan to ensure that most aspects of improvement are being measured and the People Strategy includes these indicators to ensure long term consistency. An electronic form of the cultural heat map is being developed to support regular reporting and in the meantime a version of the heat map has been included in the performance report for the Transformation and People Committee.
- The Resolution Policy is now live. Webinar based training sessions on the policy have run during October and feedback has been extremely positive.
- A training plan for roll-out of "Being Kind" training across UHNM has been developed and this will include roll-out of an e-learning package (procured from A Kinder Life) which brings together the Resolution policy and Being Kind elements. Consideration is being given to mandating this training.

The National Staff Survey 2022 has been extended to run through to the 25 November. A final push via Trust communication and reminders being sent out via the supplier is taking place. At the time of writing, the Trust response rate is below average for acute Trusts.

A small working group has commenced work looking at the implementation of the recommendations in the Race Code following a recent assessment of the Trust against the standards.

Sickness levels remain high and above target with a 1% increase at 6.2% in month. With Chest and respiratory (which includes Covid) as the top absence reason at 25.6%, closely followed by Anxiety and Stress at 23.0%. The 12 month cumulative rate marginally increased to 6.29% (6.26% at September 2022). Covid related absence by 6 November 2022 covid-related absences stood at 101, which was 16% of the 622 open absences. This is 5.6% decrease on same time the previous month. The UHNM Flu and Covid-19 vaccination programme continues to be promoted for staff to book appointments.

For PDRs, divisions continue to report that due to increasing operational pressures, management time has been reduced and alongside reported high levels of sickness absence and vacancies. This has meant that managers have been unable to undertake PDR's in a timely manner and/or that staff are not available to complete. All Divisions have been asked to provide trajectories for improvement and realistic target performance for the financial year end.

Improvement plans have also been requested for some aspects of essential to role training and this will be further discussed at the Transformation and People Committee.

Workforce Dashboard

NHS
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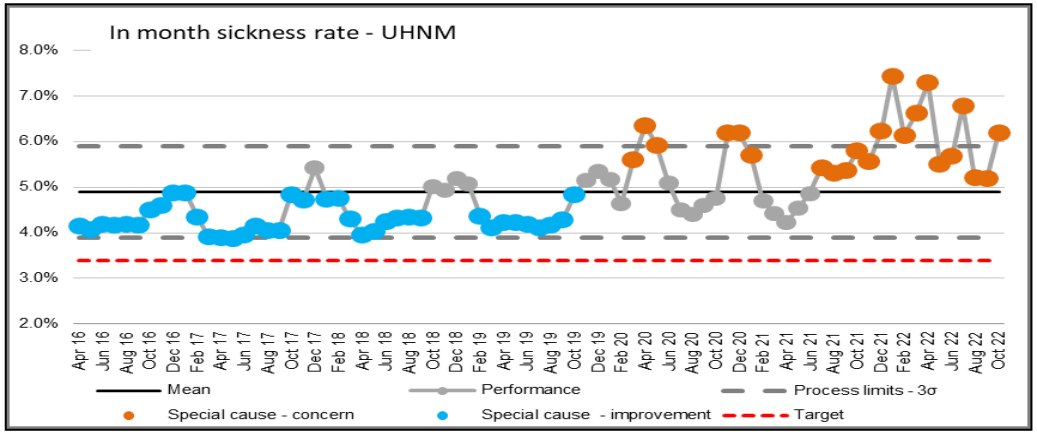
NHS Trust

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	6.20%		
Staff Turnover	11%	10.75%		
Statutory and Mandatory Training rate	95%	92.28%		
Appraisal rate	95%	76.36%		
Agency Cost	N/A	3.25%		

Sickness Absence

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
H	F

Target	Aug 22	Sep 22	Oct 22
3.4%	5.2%	5.2%	6.2%

Background

Percentage of days lost to staff sickness

What is the data telling us?

Sickness rate is consistently above the target of 3.4%.

Summary

(12m cumulative Absence FTE %)

Org L2	Divisional Trajectory - March 2023	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Trajectory
205 Central Functions	3.39%	3.80%	3.83%	3.89%	4.13%	4.13%	4.11%	4.19%	4.21%	4.20%	3.74%	↓
205 Women's, Children's & Clinical Support Services	5.25%	5.20%	5.29%	5.53%	5.88%	5.94%	5.97%	6.03%	6.07%	6.25%	6.35%	↑
205 Estates, Facilities and PFI Division	5.25%	5.13%	5.26%	5.56%	5.81%	5.75%	5.76%	5.85%	5.98%	6.04%	6.20%	↑
205 Medicine and Urgent Care	5.25%	6.01%	6.14%	6.33%	6.56%	6.64%	6.67%	6.76%	6.82%	6.85%	6.94%	↑
205 Division of Network Services	5.25%	4.64%	4.78%	4.96%	5.32%	5.47%	5.69%	5.89%	5.81%	5.78%	5.73%	↓
205 Division of Surgery, Theatres and Critical Care	4.50%	6.46%	6.57%	6.75%	7.02%	7.18%	7.30%	7.45%	7.39%	7.31%	7.30%	↓
205 North Midlands & Cheshire Pathology Service (NMCPS)	5.25%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	5.57%	↔

For M7, Sickness levels remain high and above target with a 1% increase at 6.2% in month. With Chest and respiratory (which includes Covid) as the top absence reason at 25.6%, closely followed by Anxiety and Stress at 23.0%. The 12 month cumulative rate marginally increased to 6.29% (6.26% at September 2022).

Divisional trajectories for achieving a reduction in Sickness Absence can be seen in the table above. 50% of Divisions have seen an increase in sickness again the previous month. The biggest decrease was within central functions going from 4.20% to 3.74%.

By November 2022 covid-related absences stood at 101, which was 16% of the 622 open absences. This is 5.6% decrease on same time the previous month.

Actions

The focus remains on managing areas of high sickness, and continued daily monitoring of sickness absence rates, including COVID related absence:

Medicine division are daily monitoring numbers of overdue absences with targeted intervention. Looking to complete targeted Empactis training in areas with the lowest compliance.

Surgery Division have under taken a deeper dive into their sickness data and have implemented a cycle of improvements. including manager 1:1 training, bite sized sessions, review of management time and support and weekly sickness driver meetings.

Women's Children's and Clinical Support Division are continuing to provide update sessions for managers on sickness absence management. Alongside a new action to complete a deep dive into specific areas with high levels of sickness.

Appraisal (PDR)

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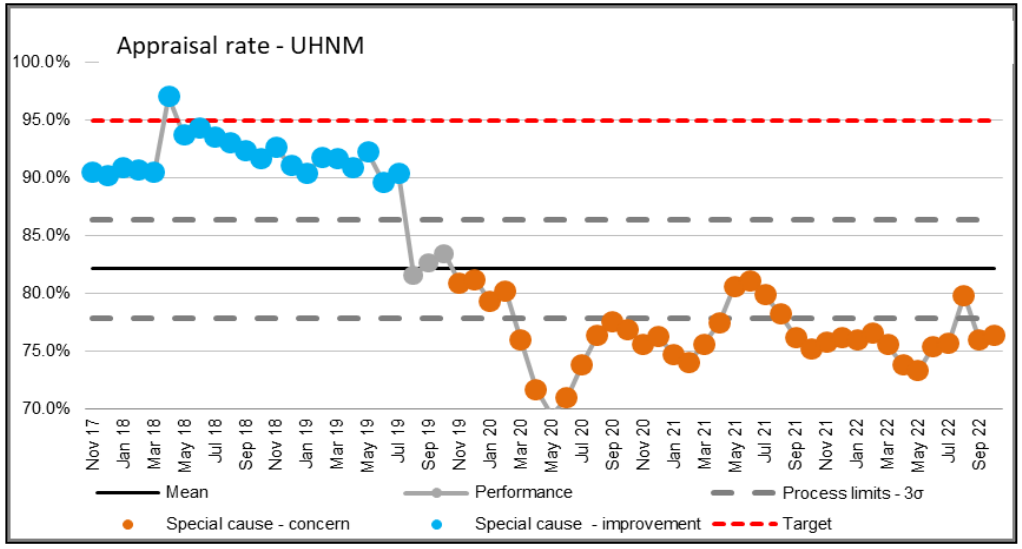
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
L	F

Target	Aug 22	Sep 22	Oct 22
95.0%	79.8%	76.0%	76.4%

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 31 October 2022, the PDR Rate remained static at 76.4% (76.0% at 30 September 2022).

Divisions continue to report that due to increasing operational pressures, management time has been reduced and alongside reported high levels of sickness absence and vacancies. This has meant that managers have been unable to undertake PDR's in a timely manner and/or that staff are not available to complete PDRs.

It has been highlighted in some divisions that PDRs have taken place but have not been uploaded onto ESR.

Actions

The focus on ensuring completion of PDRs is continuing with:

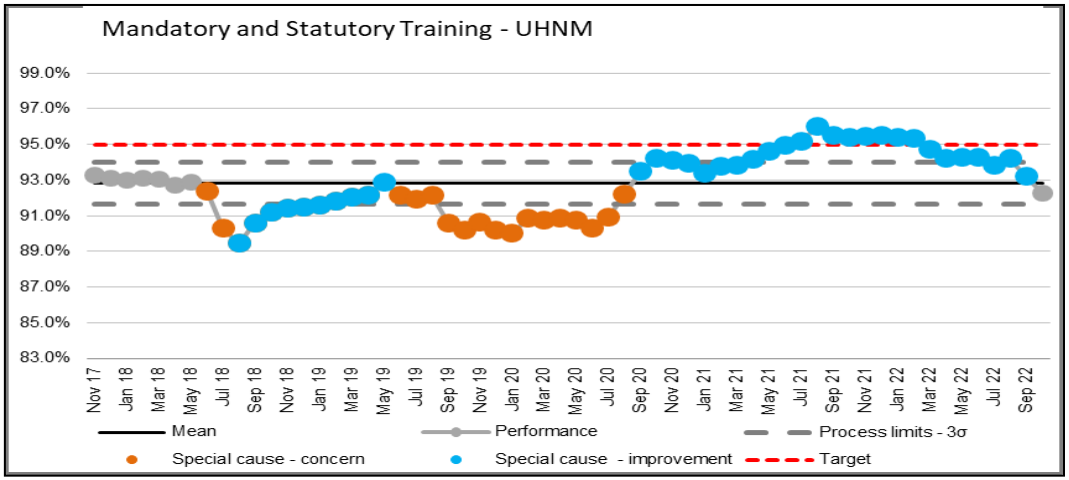
Surgery are re-issuing How to guides to managers and asking all areas to review current compliance and update reasons for non completion.

In Network Division a PDR trajectory has specifically been devised for highest contributing area for non compliance.

Women's Children's and Clinical Support Division are having staff engagement plans being brought to DWAG to be reviewed on a quarterly basis.

Divisions are arranging for proxy access to be setup as a support mechanism for uploading completed PDRs on ESR.

Statutory and Mandatory Training



Variation	Assurance
	F

Target	Aug 22	Sep 22	Oct 22
95.0%	94.2%	93.2%	92.3%

Background

Training compliance

What is the data telling us?

At 92.3%, the Statutory and Mandatory Training rate is just below the Trust target for the core training modules

Summary

The Statutory and Mandatory training rate at 31 October 22 was 92.3% (93.2% at 30 September 22). 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|	10805	10805	9981	92.37%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10805	10805	9995	92.50%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10805	10805	10089	93.37%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10805	10805	9979	92.36%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10805	10805	10044	92.96%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10805	10805	9904	91.66%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10805	10805	9304	86.11%
NHS|CSTF|Information Governance and Data Security - 1	10805	10805	9362	86.65%

Actions

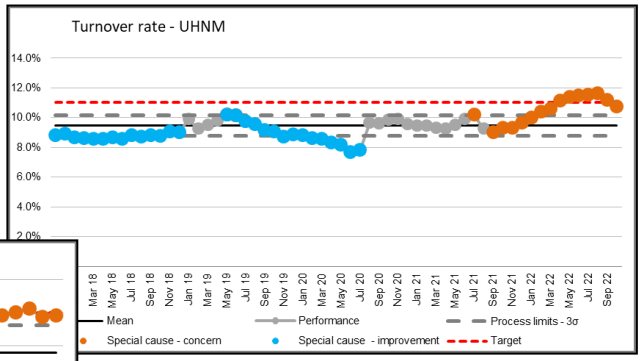
We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

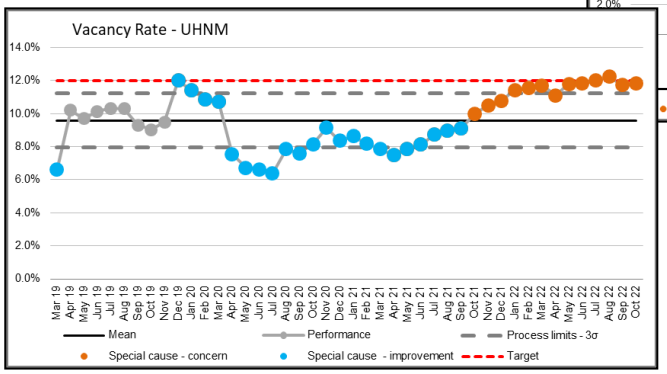
Compliance is monitored and raised via the Divisional performance review process.

Workforce Turnover

NHS
University Hospitals of North Midlands
NHS Trust

The SPC chart shows the rolling 12m cumulative turnover rate.





Variation	Assurance
	

Target	Aug 22	Sep 22	Oct 22
11.0%	11.6%	11.2%	10.8%

Background

Turnover rate

What is the data telling us?

The turnover rate for October 2022 has decreased and fallen below the trust target of 11%.

Vacancy rate has increase slightly from the previous month and sits at 11.7%

The overall Trust vacancy rate calculated as Budgeted Establishment. 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.

Summary

The 12m Turnover rate at October 2022 reduced to 10.75% which now sits below the trust target of 11%. The summary of vacancies by staff groupings highlight a small increase in the vacancy rate over the previous month.

Vacancies at 31-10-22	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,502.43	1,308.37	194.06	12.92%	12.44%
Registered Nursing	3,461.88	2,947.62	514.26	14.86%	14.64%
All other Staff Groups	6,524.90	5,874.77	650.13	9.96%	10.03%
Total	11,489.21	10,130.76	1,358.45	11.82%	11.72%

Although staff in post increased in October 2022 by 127.67 FTE, budgeted establishment also increased by 157.89 fte, which increased the vacancy fte by 30.22 fte overall [*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 31/10/22]

Actions

Divisional targets for agency ceilings have been set out and put forward for Divisional representatives to accept. Divisional progress for discussion at the December Executive Workforce Assurance Group.

Business case is currently going through approval for medical and recruitment resource to meet the demands of recruitment activity.

Recruitment team are about to launch direct twitter and Facebook recruitment via the trac system to gain a wider reach of audience. General recruitment team have introduced a new welcome message to all new hires.

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key elements of the financial performance year to date are:

- Year to date the Trust has delivered an actual surplus of £2.1m against a planned surplus of £4.3m; this is primarily driven by underperformance against the Trust's in year CIP target.
- The Trust incurred £0.7m of costs relating to COVID-19 in month; with £0.5m of this being chargeable for COVID-19 testing costs. The Trust has overspent by £2.7m against its original in envelope allocation due to the in envelope funding allocation ceasing after Month 2.
- To date the trust has validated £6.0m CIP savings in year; these schemes have a full year impact of £4.4m, which presents a considerable variance to the Trust's recurrent target of £13.6m which was identified as a key risk in the Trust's financial plan submission.
- Capital expenditure in Month 7 is £17.9m which is £4.4m behind the plan of £22.3m. Of the expenditure to date £8.3m is the pre-committed repayment of the PFI and IFRS16 lease liabilities.
- The cash balance at Month 7 is £91.1m, which is £13.7m higher than plan. Cash received is above plan due to Capacity and Virtual Ward income received from the ICB.
- The Trust carried out a forecast for the year based on the actual position at Month 7; this forecast suggested a year end deficit of £9.1m before any additional mitigations were applied with the key driver being under delivery against the CIP target.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	80.1		
	Expenditure - Pay	variable	49.6		
	Expenditure - Non Pay	variable	30.4		
Activity	Daycase/Elective Activity	variable	8,348		
	Non Elective Activity	variable	9,680		
	Outpatients 1st	variable	26,655		
	Outpatients Follow Up	variable	41,830		

Income & Expenditure

Income & Expenditure Summary Month 07 2022/23	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	914.8	75.8	76.2	0.5	530.4	530.7	0.3
Other Operating Income	86.2	7.2	8.0	0.8	50.3	52.9	2.6
Total Income	1,001.0	82.9	84.2	1.3	580.8	583.6	2.8
Pay Expenditure	(608.2)	(49.7)	(49.6)	0.0	(347.5)	(337.4)	10.1
Non Pay Expenditure	(332.4)	(27.2)	(30.4)	(3.3)	(193.7)	(209.9)	(16.1)
Total Operational Costs	(940.6)	(76.8)	(80.1)	(3.2)	(541.2)	(547.3)	(6.1)
EBITDA	60.3	6.1	4.1	(2.0)	39.5	36.3	(3.2)
Depreciation & Amortisation	(33.6)	(2.8)	(2.8)	0.0	(19.6)	(19.6)	0.0
Interest Receivable	0.3	0.0	0.2	0.1	0.2	0.6	0.5
PDC	(8.9)	(0.7)	(0.7)	(0.0)	(5.2)	(5.2)	(0.0)
Finance Cost	(18.1)	(2.0)	(2.0)	0.0	(10.6)	(10.5)	0.0
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Surplus / (Deficit)	0.0	0.6	(1.2)	(1.8)	4.3	1.8	(2.6)
DHSC PPE adjustment	0.0	0.0	0.0	0.0	0.0	0.3	0.3
Total	0.0	0.6	(1.2)	(1.8)	4.3	2.1	(2.2)

The main variances for the year to date are:

- Income from patient activities is £0.3m behind plan due to the continued NHSE contract gap; this gap is offset by additional income in respect of pass through devices and drugs for which corresponding additional costs have been noted with non-pay.
- Other operating income has over performed year to date and this is primarily driven by additional educational and training income and additional income from the North Midlands and Cheshire Pathology Alliance. Pay is underspent year to date by £10.1m which is primarily driven by the £3.1m release of the premium element of the annual leave accrual in Month 3. The remaining variance is driven by underspends across registered nursing and NHS Infrastructure. Within the year to date budget is £2.2m non-recurrent CIP of which the nursing and NHS Infrastructure elements have delivered.
- Non-pay is overspent year to date by £16.1m. Non-delivery of recurrent CIP continues to impact the position (see Section 3 below) by £5.0m, there remains a cost pressure due to the lack of COVID-19 in envelope funding past Month 3 and both drugs and devices to continue to spend above plan (for which we have noted additional income above).

Capital Spend

Capital Expenditure as at Month 7 2022/23 £m	2022/23 Forecast Revised/ plan M07	In Month			Year to Date		
	Actual	Plan	Actual	Variance	Plan	Actual	Variance
PFI lease liability repayment	(10.5)	(0.9)	(0.9)	-	(6.2)	(6.2)	-
Repayment of IFRS16 leases	(3.7)	(0.3)	(0.3)	-	(2.2)	(2.2)	-
Pre-committed items	(14.3)	(1.2)	(1.2)	-	(8.3)	(8.3)	-
PFI lifecycle and equipment replacement (MES/PACS)	(3.5)	(0.2)	(0.2)	(0.0)	(1.9)	(1.2)	0.6
PFI enabling cost	(0.2)	-	-	-	-	(0.0)	(0.0)
PFI related costs	(3.7)	(0.2)	(0.2)	(0.0)	(1.9)	(1.2)	0.6
Wave 4b Funding - Lower Trent Wards	(5.1)	(1.2)	(0.8)	0.4	(2.7)	(2.3)	0.4
Project STAR multi-storey car park	(6.8)	(0.3)	(0.3)	0.0	(1.1)	(1.1)	0.0
TIF 2 PDC (CTS Phase 1)	(4.6)	(0.2)	(0.0)	0.1	(0.2)	(0.0)	0.1
TIF 2 PDC (Inpatient Wards)	(0.4)	-	-	-	-	-	-
TIF 2 PDC ('FM' Build)	(0.3)	-	-	-	-	-	-
TIF 2 PDC (CTS Phase 2)	-	-	-	-	-	-	-
Emergency Department (restatement costs)	-	-	-	-	-	-	-
Home reporting breast care - PDC	(0.2)	-	-	-	(0.0)	(0.0)	-
MRI acceleration upgrades	(0.2)	-	-	-	-	-	-
Endoscopy equipment and works - PDC ICB allocation	(0.7)	-	-	-	-	-	-
CT9 enabling and equipment - PDC	(1.2)	-	-	-	-	-	-
Frontline digitalisation equipment - PDC	(0.5)	-	-	-	-	-	-
EPR Business Case development - PDC	(0.7)	-	-	-	-	-	-
Schemes funded by PDC and Trust funding	(20.7)	(1.6)	(1.2)	0.5	(4.0)	(3.5)	0.5
LIMS (Laboratory Information Management System)	(0.5)	(0.0)	-	0.0	(0.2)	(0.2)	0.1
EPMA (Electronic Prescribing)	(0.6)	(0.0)	(0.0)	0.0	(0.2)	(0.2)	0.0
CT7 enabling works (BC 415)	(1.1)	(0.6)	(0.0)	0.5	(1.1)	(0.1)	1.0
Patient Portal roll out costs (BC 462)	(0.5)	(0.0)	(0.0)	0.0	(0.1)	(0.0)	0.0
Pharmacy Dispensary	(0.3)	-	-	-	(0.3)	(0.3)	-
Anaesthetic medical records (Nasstar) (BC 444)	(0.2)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Home reporting implementation costs (BC 453)	(0.1)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
Market testing refresh - CRIS/PACS/MRI	-	-	-	-	-	-	-
New Scanner CT 8	(1.4)	-	-	-	-	-	-
ED ambulance offload - enabling ward moves	(0.7)	(0.4)	(0.4)	(0.0)	(0.4)	(0.4)	(0.0)
Schemes with costs in more than 1 financial year	(5.4)	(1.1)	(0.5)	0.6	(2.4)	(1.3)	1.1
2022/23 schemes	(15.1)	(1.2)	(0.3)	0.9	(5.2)	(3.2)	2.1
IFRS 16 New Vehicles lease	(0.1)	-	-	-	-	-	-
IFRS 16 County Theatres TIF1 (IFRS16)	(2.1)	-	-	-	-	-	-
IFRS16 lease additions (incremental impact of IFRS16)	(0.7)	-	-	-	-	-	-
Lease liability re-measurement	(0.1)	-	-	-	(0.1)	-	0.1
IFRS16 funded schemes	(3.0)	-	-	-	(0.1)	-	0.1
Donated/Charitable funds expenditure	(4.6)	(0.0)	(0.0)	-	(0.3)	(0.3)	-
Charity funded expenditure	(4.6)	(0.0)	(0.0)	-	(0.3)	(0.3)	-
Overall capital expenditure	(66.7)	(5.3)	(3.4)	2.0	(22.3)	(17.9)	4.4

Key variances at Month 7 are:

- PFI lifecycle and equipment replacement is £0.6m behind plan at Month 7 due to no refresh of the MES or PACS equipment having taken place to date. The element of the PFI unitary payment relating to this is accounted for as a pre-payment therefore this does not represent a slippage in the capital programme in respect of capital financing, however additions of £0.6m to the PPE balance in respect of this replacement were expected at Month 7.
- The Lower Trent ward scheme is £0.4m behind plan at Month 7 due to contractor delays and the opening of the new ward is expected to slip by 4 weeks in to January 2023. As part of the Winter Plan ward 80/81 will be retained in the West Building and additional equipment required for the new Trent ward has been included in the capital plan.
- The enabling works for CT7 are behind plan at Month 7, the completion of the scheme and installation of the equipment has slipped to January 2023 due to delays relating to lender approval, which has now been received.

Balance sheet

Balance sheet as at Month 7	31/03/2022	31/10/2022			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	576.4	574.5	567.6	(6.9)	Note 1
Right of Use Assets	-	17.8	17.5	(0.4)	
Intangible Assets	20.7	17.8	17.4	(0.4)	
Trade and other Receivables	1.4	1.4	1.4	0.0	
Total Non Current Assets	598.6	611.5	603.9	(7.6)	
Inventories	16.3	15.8	16.0	0.2	
Trade and other Receivables	41.6	39.8	42.3	2.6	Note 2
Cash and Cash Equivalents	87.6	77.3	91.0	13.8	Note 3
Total Current Assets	145.5	132.8	149.3	16.5	
Trade and other payables	(116.6)	(105.9)	(115.9)	(10.0)	Note 4
Borrowings	(10.7)	(13.6)	(13.5)	0.1	
Provisions	(2.5)	(2.5)	(3.2)	(0.7)	Note 5
Total Current Liabilities	(129.8)	(122.0)	(132.6)	(10.6)	
Borrowings	(257.8)	(260.7)	(261.2)	(0.5)	
Provisions	(3.9)	(3.9)	(3.8)	0.1	
Total Non Current Liabilities	(261.6)	(264.6)	(264.9)	(0.3)	
Total Assets Employed	352.6	357.7	355.7	(2.1)	
Financed By:				-	
Public Dividend Capital	648.2	648.2	648.2	0.0	
Retained Earnings	(437.0)	(431.9)	(433.9)	(2.1)	Note 6
Revaluation Reserve	141.4	141.4	141.4	-	
Total Taxpayers Equity	352.6	357.7	355.7	(2.1)	

Note 1. Variance to plan reflects slippage of £4.4m in capital expenditure in the revised capital plan year to date. The remaining variance is due to the timing of PFI equipment replacement as part of the managed equipment scheme which is funded through the PFI unitary payment in 2021/22.

Note 2. Variance to plan is mainly due to accrued income in relation to the Pathology Network for pay recharges above the SLA baseline for Month 1 to 7. Receivables are also higher than plan due to the increase in PFI prepayments relating to the PFI equipment replacement described above.

Note 3. The variance is due to higher than planned cash receipts of £9.2m, mainly due to additional cash received from Stoke-on-Trent and Staffordshire ICB in relation to capacity funding and virtual wards and also from Health Education England. This is partly offset by payments being £4.2m lower than plan.

Note 4. Payables are £10m higher than plan due to a number of reasons:

- Deferred income is higher than plan as a result of cash received from Staffordshire and Stoke on Trent ICB relating to a number of schemes. The deferred income balance also includes significant balances relating to Health Education England training, digital pathology and high cost devices.
- General payables are higher than plan year to date and continues to reflect the impact of the unavailability of the efinancials system during August.
- Payables are also higher than plan and reflect a significant value of invoices outstanding with NHS Supply Chain at the end of Month 7. The invoices are relating to the provision of high cost devices which need to be verified before payment can be made.

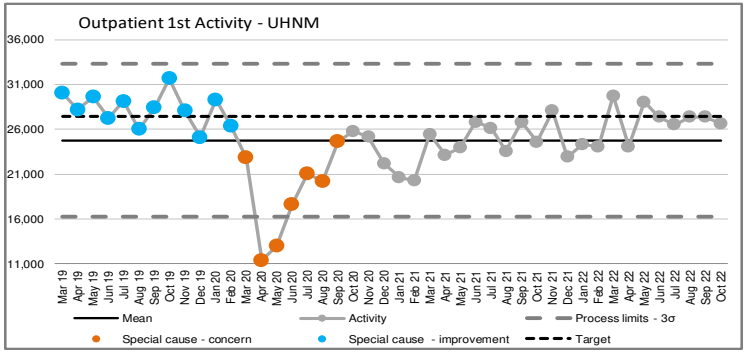
Note 5. Provisions are £0.7m higher than plan due to new provisions arising in 2022/23. A case has arisen which relates to a staffing issue and which has a total potential cost to the Trust of £0.2m. A £0.6m provision is also required for a potential fine from the Care Quality Commission (CQC) relating to an on-going investigation.

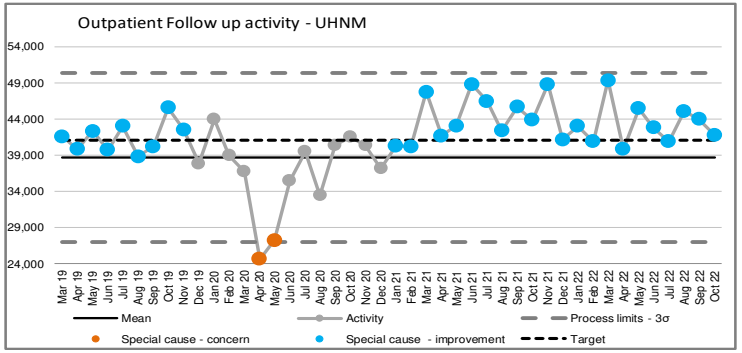
Note 6. Retained earnings show a £2.1m variance from plan and reflect the income and expenditure position at Month 7. This variance reflects the surplus/deficit position as would be reported in the Statement of Comprehensive Income within the Trusts annual accounts. Financial performance shows a variance of £2.3m from plan; financial performance excludes the impact of donated income, depreciation and DHSC consumables and to Month 7 these items show a variance of £0.2m to plan.

Activity

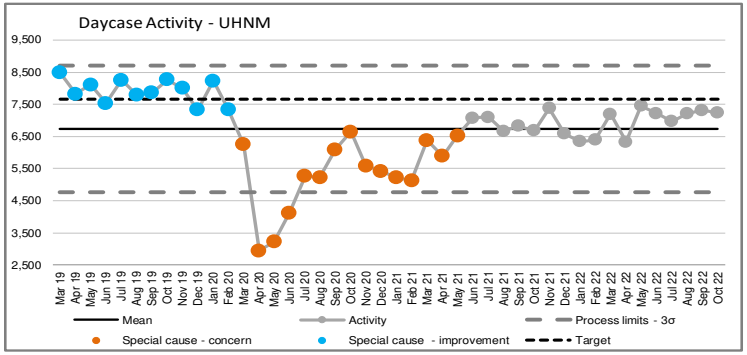
NHS University Hospitals of North Midlands NHS Trust

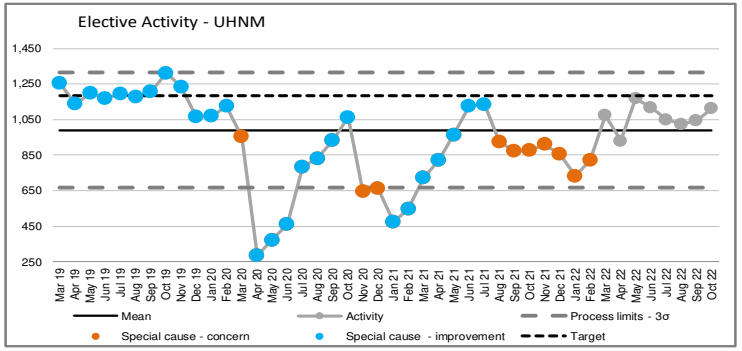
Planned care Outpatient



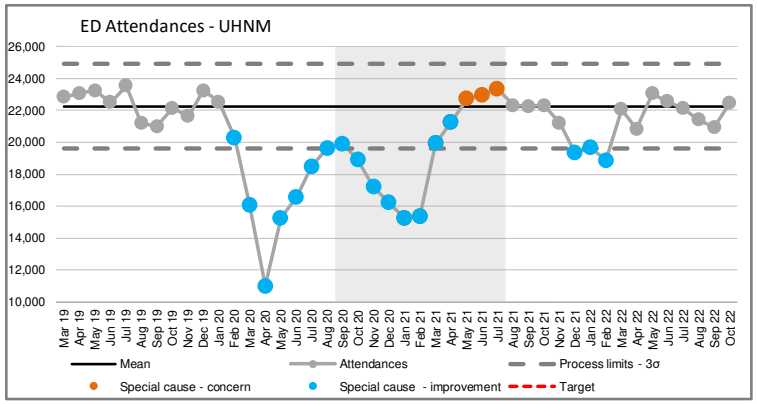


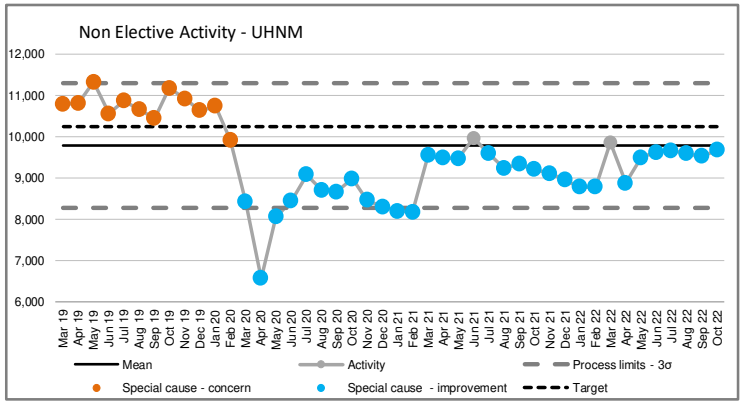
Planned care Inpatient





Urgent Care





Delivering Exceptional Care with Exceptional People

Executive Summary

Meeting:	Trust Board	**Date:**	7th December 2022
Report Title:	UHNM Tier 2 analysis	**Agenda Item:**	18.
Author:	Katy Thorpe – Deputy Chief Operating Officer		
Executive Lead:	*Paul Bytheway – Chief Operating Officer*		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

Executive Summary

Situation

- On the 25th October 2022, all Trust's with tier 1 or 2 oversight by NHS England for Elective recovery received a letter 'Next steps on elective care for Tier One and Tier Two providers'.
- This outlined the priorities for recovery of elective and cancer care.
- Each provider had to undertake a self-certification against the outlined priorities by 11th November 2022.

Background

- University Hospitals North Midlands is currently a tier 2 provider. This began with a focus on patients waiting 104 weeks +, in June this was extended to patients waiting over 78 weeks and cancer performance.
- Since this system was put in place UHNM have been meeting with the NHS England regional team on a weekly basis to assess performance, and since 3rd October daily calls in regard to our 104+ RTT cohort.

Assessment

- UHNM is currently undertaking all elements required in the letter
- Each indicator mentioned is tracked either through PAF or the weekly briefing
- The detail of this is covered through weekly assurance dashboards and meetings
- Not all indicators meet the requirements outlined in the letter

Key Recommendations

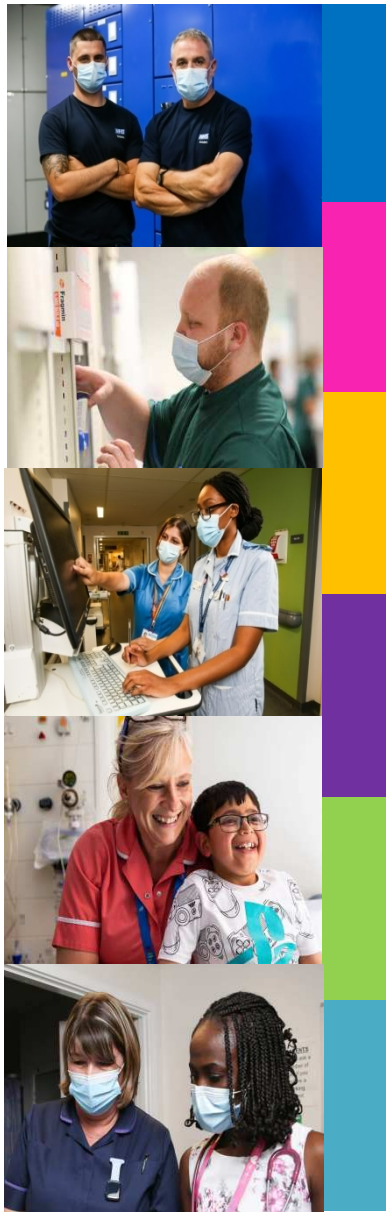
- As part of the letter self-certification is required for the following items:
  - A lead Exec has responsibility for elective and cancer performance and recovery.
  - Relevant committees receive appropriate reports
  - Agreed plan for 78ww and 62 day trajectories
  - Report received on Lower GI, Skin and Prostate pathways
  - Pursuing outpatient transformation
  - Received reports on Super September and Validation
  - Received assurance on clinical prioritisation and reviewed cancer turnaround times
  - Discussed theatre productivity at every Trust Board
  - Reviewed Model Health System theatre productivity
  - Confirmed SRO for theatre productivity
  - Ensured diagnostic utilisation
- This was approved, signed and returned on the 11th November. A copy of this letter is attached to the report.

University Hospitals of North Midlands NHS Trust

Tier Two Elective Care Analysis

Response to letter received 25/10/22

(data updated 30/11/22)



Delivering Exceptional Care with Exceptional People

Overview

UHNM at Tier 2

University Hospitals of North Midlands NHS Trust

University Hospitals North Midlands is currently a tier 2 provider. This began with a focus on patients waiting 104 weeks +, in June this was extended to patients waiting over 78 weeks and cancer performance.

The table below describes the tier two system the Trust has been operating within as described in June. The only amendment which has taken place is that the regional reporting calls take place weekly.

Tiers 1 & 2:

Increased managed or facilitated support in relation to 78 week cohort risk position and cancer 62-day backlog:

- Support to understand risk position and identify highest impact actions to address it (e.g. which specialties are most affected, how can this be managed)
- Support from other providers and systems with more capacity (e.g. via mutual aid) for cancer and 78w patients, in terms of:
  - Supporting patients who choose to be seen elsewhere
  - Access to remote consultation capacity in other providers
  - Access to remote diagnostic capacity from other systems
- Support to implement changes to improve visibility of RTT status/ waiting time / cancer waiting times across the system
- Access to national experts and support around establishing good practice management ("back to basics") each of the proposed national big bets:
  - optimising use of NHS and independent sector capacity
  - diagnostics
  - outpatient transformation and non-admitted pathways
  - surgical pathways
  - patient choice

Tier 1 – National oversight	**Tier 2 – Regional oversight**
Most challenged trusts in terms of potential 78 week cohort and delivery to date - Likely fortnightly meetings between national team(s) and trust CEO, COO, with associated reporting, with cancer team in attendance if trust is in/near Top 20 for cancer - Possible periodic calls between ministers and trust CEO - National support to develop and deliver a tailored 78 week waits plan - On-site support from national experts as required - Baseline assessment of trust performance to include cancer	*Slightly less challenged, but still at risk of having patients breach 78 weeks by April 2023* - Likely fortnightly reporting to regional team on progress and risk position, with cancer team in attendance if trust is in/near Top 20 for cancer - Regional support to develop a tailored 78 week waits plan

Planned Care Improvement Programme

University Hospitals of North Midlands NHS Trust

- The Trust has a Planned Care Board in place which monitors both performance and improvement programmes in line with the 'plan on a page' shown on slide 4.
- When this was put in place it was designed to capture both the National asks on recovery at the time, and local programmes of work where issues had been identified for improvement.
- This structure sits alongside the Weekly Briefing performance pack, the Tier 2 data pack for NHSE and a detailed weekly assurance data pack which is reviewed weekly through a planned care assurance meeting.

Planned Care Improvement Programme

NHS
University Hospitals of North Midlands
NHS Trust

	Diagnostics	Cancer	Theatres	Outpatients	Patient Access
Focus Areas	• Delivery plan for DM01 improvement • Re define the diagnostic work streams with a focus on each diagnostic area • Workforce Planning	• 28 day FDS • Pathway level scrutiny for Colorectal and Skin • 2WW backlogs • Over 62 day patients waiting	• Define the theatre transformation programme • Ensure 6-4-2 • Elective hub development • GIRFT standards review • Pre assessment process	• PIFU • Referral optimisation (A&G) • Virtual • Super September	• Define work stream to include standardisation of process, adherence to the patient access policy, training and data quality
Top actions	• Increase booking and slots in readiness for October following OP focus in Sept • Endoscopy productivity review • Radiology reporting turnaround times • Insourcing provider of US • Improve histology turnaround times	• Analysis of UHNM pathways as compared to best practice and outline associate work streams • Action plan for Skin • Action plan for colorectal • Review administration delay patients	• Launch 'right procedure, right place' • Analysis of list allocation, list usage and waiting list size • Launch tool for waiting list prioritisation support via Graphnet • Review 6-4-2	• Increase booking of new patients • Roll out text contact for 78+ waiting patients • Ensure utilisation is monitored • Increased communications with Patients • GP engagement	• Outpatient system training refresher • Patient access policy revision • Patient access policy refresh training
Weekly Assurance • Weekly meeting with the Operational Directors • Looks across all planned performance metrics • Looks for assurance and work plans against 'off track' items • Metric will include:	• Diagnostic performance at DM01 level • Pathology turnaround times	• 2ww • 2ww – breast symptomatic • First treatment • Sub anti-cancer drug • Sub radiotherapy • Sub surgery • 62 day traditional • 62 day – breast symptomatic • 31 day rare cancer • Screening • Upgrades • 28 day FDS	• In session utilisation • Session utilisation • Late starts • Cancelations on the day • activity	• Utilisation • DNA • Unrecorded outcomes • PIFU % • A&G turnaround times and utilisation • % use of virtual clinics	• Incomplete • RTT • New/FU WL • Backlogs - FU, +104 and +78

Next Steps on Elective Care for Tier One and Two Providers

University Hospitals of North Midlands NHS Trust

NHS England has outlined the next steps and expectations in a letter dated 25th October 2022.

In this there are six areas of focus:

1. Excellence in the fundamentals of waiting list management
2. Validation
3. Appropriate surgical and diagnostic prioritisation
4. Cancer pathway re-design for lower GI, skin and prostate
5. Outpatient transformation
6. Surgical and theatre productivity

This pack outlines the Trust position against each of the 6 items.

1. Excellence in the Fundamentals of Waiting List Management

Elective Access

University Hospitals of North Midlands NHS Trust

Access Policy

- The most recent version of UHNM's Patient Access Policy was released May 2021. It contains updates to national rules and processes regarding Covid-19, and complies with the NHS England Model Access Policy.
- It details the Royal College of Surgeon's Clinical Prioritisation codes and how to apply them, as well a suite of Standard Operating Procedures to support elective care.
- It is due for review May 2023, but an addendum will be added to reflect the changes to the national RTT rules around patient choice and active monitoring.

All patients waiting over 104 weeks and the 78 week cohort are reviewed and progressed on a weekly basis through a series of PTL meetings.

The data is tracked on a weekly basis, both through the tier 2 meeting with region and is contained within the Trusts weekly performance briefing.

1. Elective Access cont.

University Hospitals of North Midlands NHS Trust

- The 104 week position is tracked by individual patient
- The Trust is currently working on a route to zero which is supported by Mutual aid, outsourcing and insourcing funded through ERF monies.
- The situation as at 24.11.22 is stated below.

*Select **System** and **Providers** from below dropdowns*	Forecasted end of 104+ November Cohort						Forecasted end of 104+ December Cohort					
	Number of pts within the 104+ October cohort who despite current mitigation will **not** have been seen by the end of November						Number of pts within the 104+ October cohort who despite current mitigation will **not** have been seen by the end of December					
SSOT ICB	Complex **(Pathway)**	Complex **(Unwell)**	Complex **(Covid)**	Capacity	Choice **(P6)**	Choice **(Local)**	Complex **(Pathway)**	Complex **(Unwell)**	Complex **(Covid)**	Capacity	Choice **(P6)**	Choice **(Local)**
University Hospitals of North Midlands NHST	9	1			2	2					1	
Nuffield North Staffs					1							
Ramsay Healthcare												
System Total	9	1	0	0	3	2	0	0	0	0	1	0

1. Elective Access cont.

University Hospitals of North Midlands NHS Trust

- The 78 week position is tracked looking at both admitted and non-admitted pathways with the aim to eliminate non-admitted pathways earlier than the end of the financial year to allow time for admitted pathways to be booked.
- Both are currently in a reducing position, however the non-admitted element is off plan although the Trust is on track for its submitted position.
- The region is reporting that UHNM are ahead of others in the region and there is a recognised risk around an admitted shortfall which will be supported through IS and mutual aid.

78+ ww Actuals: **All patients that are currently waiting over 78 weeks.**

Provider	78+ ww actuals				
	Previous week	w/e 20/11/22	Last 4 weeks trend	End of month plan	Variance
University Hospitals of North Midlands	717	710	↓	872	-162
All Acute Trusts	**717**	**710**	↓	**872**	**-162**
BEACON PARK HOSPITAL	11	6	↓	#N/A	#N/A
NUFFIELD HEALTH, NORTH STAFFORDSHIRE HOSPITAL	2	5	→	#N/A	#N/A
ROWLEY HALL HOSPITAL	6	8	→	#N/A	#N/A
All ISP	**19**	**19**	↓	**#N/A**	**#N/A**

78+ ww cohort by end of March 2023: **All patients that could be waiting over 78 weeks by 31 March 2023 if not seen**

Provider	78+ ww cohort by 31 March 2023			
	Previous week	w/e 20/11/22	Change from previous week	Weekly removals required to clear cohort
University Hospitals of North Midlands	3,242	3,050	-192 ↓	-176
All Acute Trusts	**3,242**	**3,050**	**-192** ↓	**-176**
BEACON PARK HOSPITAL	57	48	-9 ↓	-3
NUFFIELD HEALTH, NORTH STAFFORDSHIRE HOSPITAL	8	59	51 ↑	0
ROWLEY HALL HOSPITAL	52	47	-5 ↓	-3
All ISP	**117**	**154**	**37** ↑	**-6**

1. Excellence in the Fundamentals of Waiting List Management

Cancer Services

University Hospitals of North Midlands NHS Trust

The NHS has delivered a massive reduction in patients waiting two years and is also now steadily reducing the number of people waiting more than 18 months and 62 days:

- At UHNM the backlog has reduced by 176 patients from a high of 1041 in Aug, to 865 currently.
- The overall PTL has reduced for the 11th week – and is now down to levels seen 6 months ago. In August the PTL was over 6000 – this has reduced by around 1600 patients to 4410 in total.
- Improvements have mainly been in the Skin PTL – which was at 2259 in Aug and has reduced by 948 patients to 1311 currently.

UHNM ensures operational management and oversight of the PTL. The PTL is tracked every week by a dedicated team of Cancer Patient Pathway Co-ordinators, with 'Next Step' recorded for each patient, and robust escalation in place. It is presented weekly to the DCOO & COO.

UHNM align with best practice and current CWT guidance. Using national directives, such as Best Practice Timed Pathways and Monitoring Datasets:

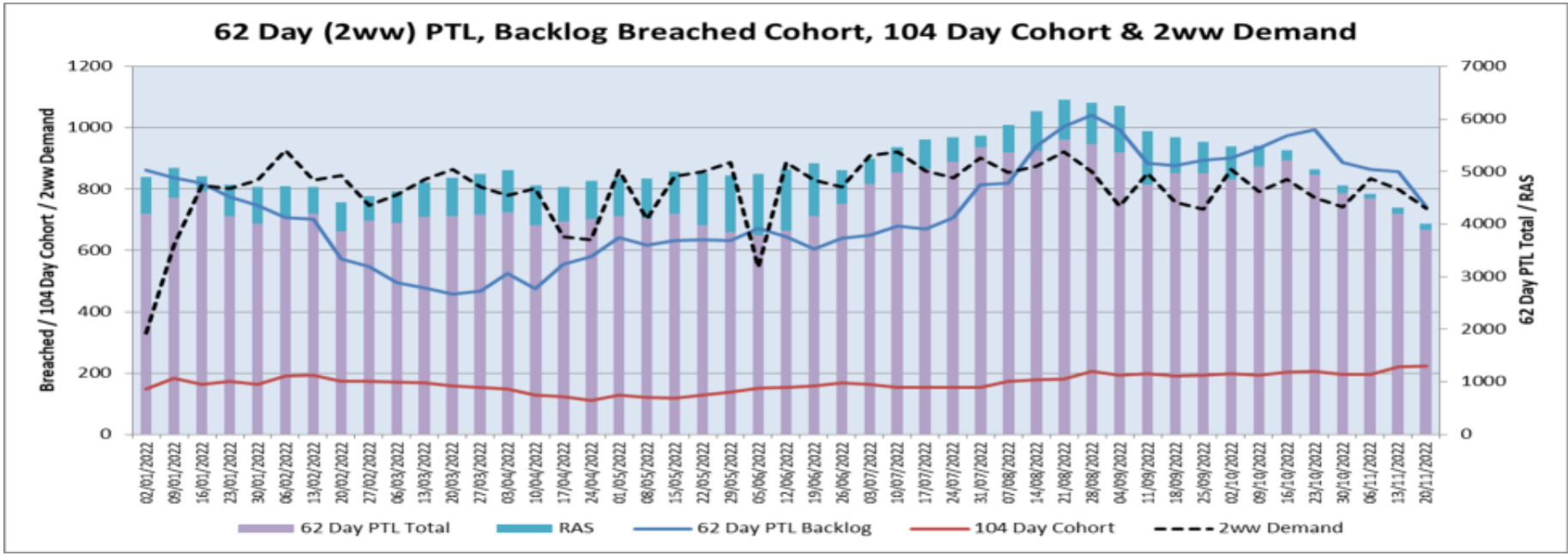
The data is tracked on a weekly basis, both through the tier 2 meeting with region and is contained within the Trusts weekly performance briefing.

1. Cancer Services Cont.

University Hospitals of North Midlands NHS Trust

At UHNM, 82% of the backlog is mainly made up of Skin and Lower GI. Only 6% of the backlog is attributable to Urology, which is considerably better than national proportions.

- Service Development Funding made available through the West Midlands Cancer Alliance has funded a number of additional capacity schemes within Colorectal and Skin which has contributed to recovery.
- Diagnostic turn around times have supported the overall improved PTL position.
- This is tracked and reported on weekly



The black dotted line: 2WW demand
The blue line: 2WW 62 day backlog
The red line: 104+ backlog
The overall bar: PTL total volume
The turquoise: PTS on ERS in a 'RAS' to be appointed

2. Validation

University Hospitals of North Midlands NHS Trust

There are three phases for the validation of waiting lists:

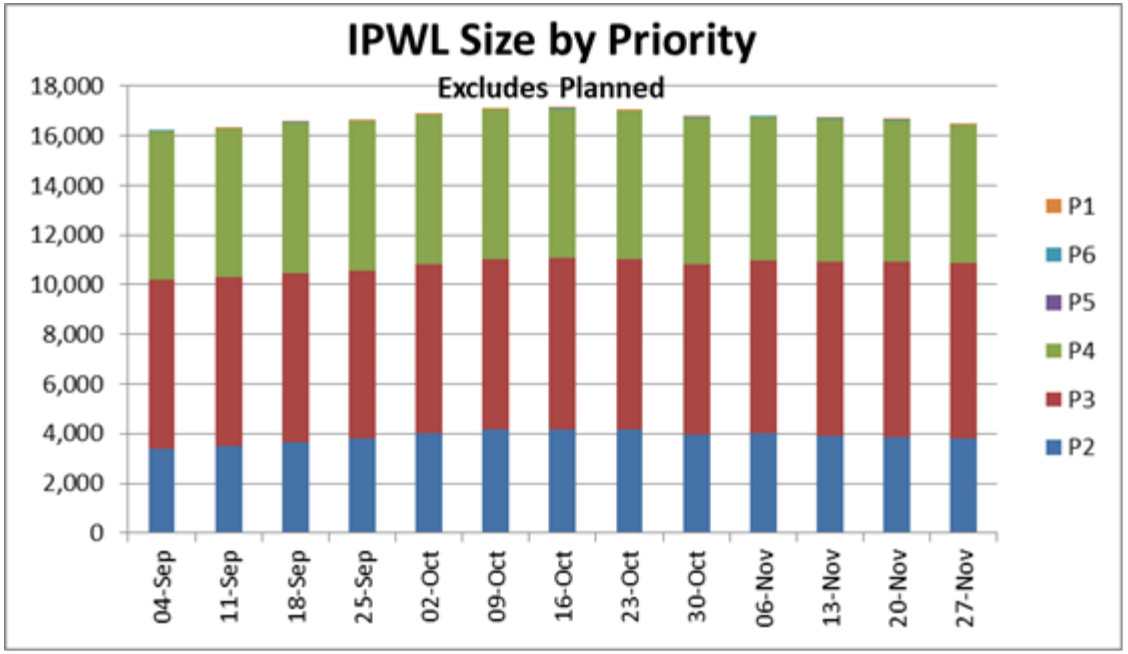
- By 23rd December: any patient waiting over 52 weeks on an RTT pathway who has not been validated in the previous 12 weeks must be contacted. The Trust has completed the necessary validation and demonstrated this to the National Team via submission
- By 24th Feb 2023: any patient waiting over 26 weeks on an RTT pathway who has not been validated in the previous 12 weeks must be contacted. There are currently 36,553 incomplete validations in this cohort. This is in addition to the monthly statutory return of c.5,700 per month. We currently have 55% of the necessary capacity to meet this requirement with a shortfall of 132 validation/day, an additional 3 additional validators are being recruited to the team to meet this expectation.
- By 28th April 2023: Any patient on an RTT pathway who has not been validated in the previous 12 weeks must be contacted. This is a currently undefined number dependant on progress on point 2 and waiting list size.

3. Appropriate Surgical and Diagnostic Prioritisation

University Hospitals of North Midlands NHS Trust

The surgical waiting list is systematically prioritised by P code as seen in the table to the right.

Surgical teams prioritise booking of P2 and cancer patients and this is tracked on a weekly basis.

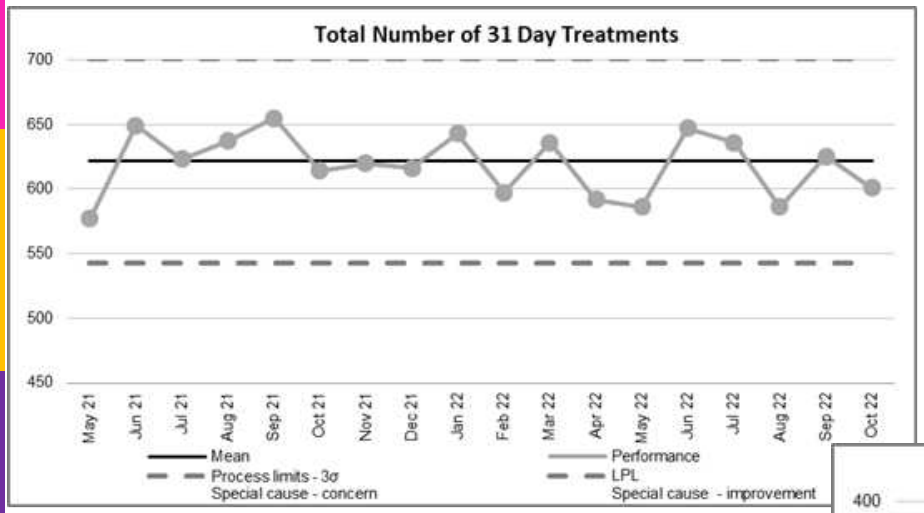


CDC's

UHNM is working on a strategy for CDCs with a business case to follow, draft is due to be completed in December and the case is due to be seen in PAF in Januarys meeting.

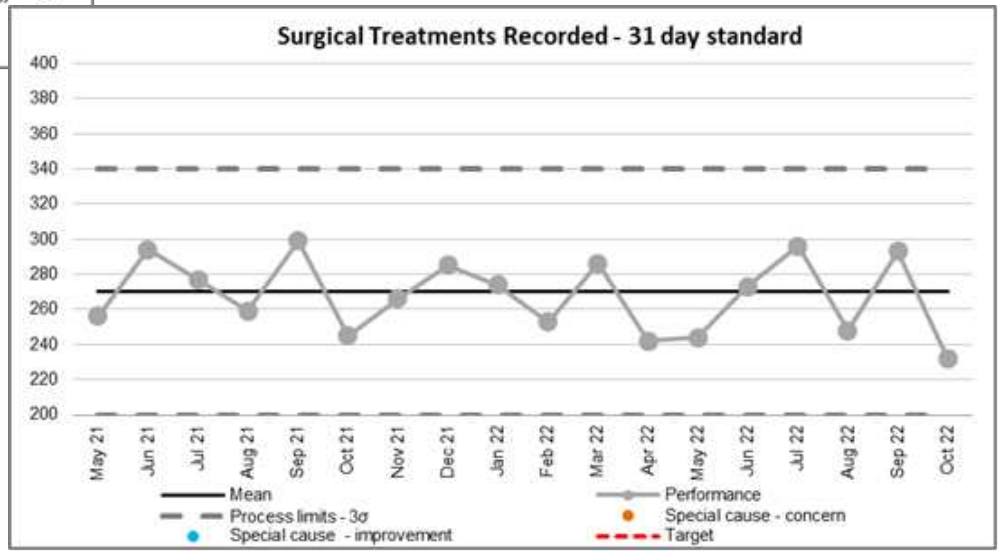
3. Appropriate Surgical and Diagnostic Prioritisation Cancer – 31 day standard

University Hospitals of North Midlands NHS Trust



Volumes of surgical treatments have natural fluctuations and includes patients with diagnosed cancer only (i.e. Excluding any skin excisions which turned out not to be cancer)

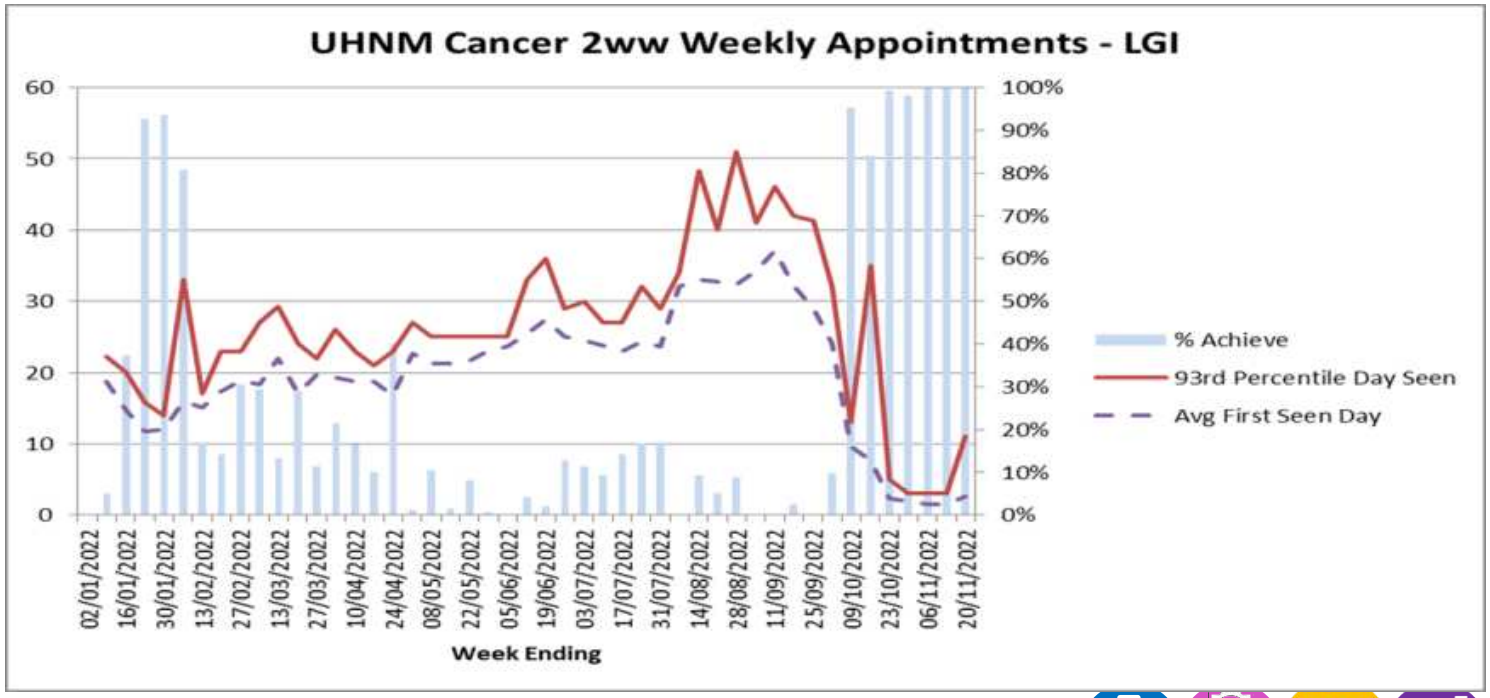
It is predicted an increase in volume will be demonstrated in November data as a number of additional surgical capacity schemes were enacted.



4. Cancer Pathway Re-design Lower GI

University Hospitals of North Midlands NHS Trust

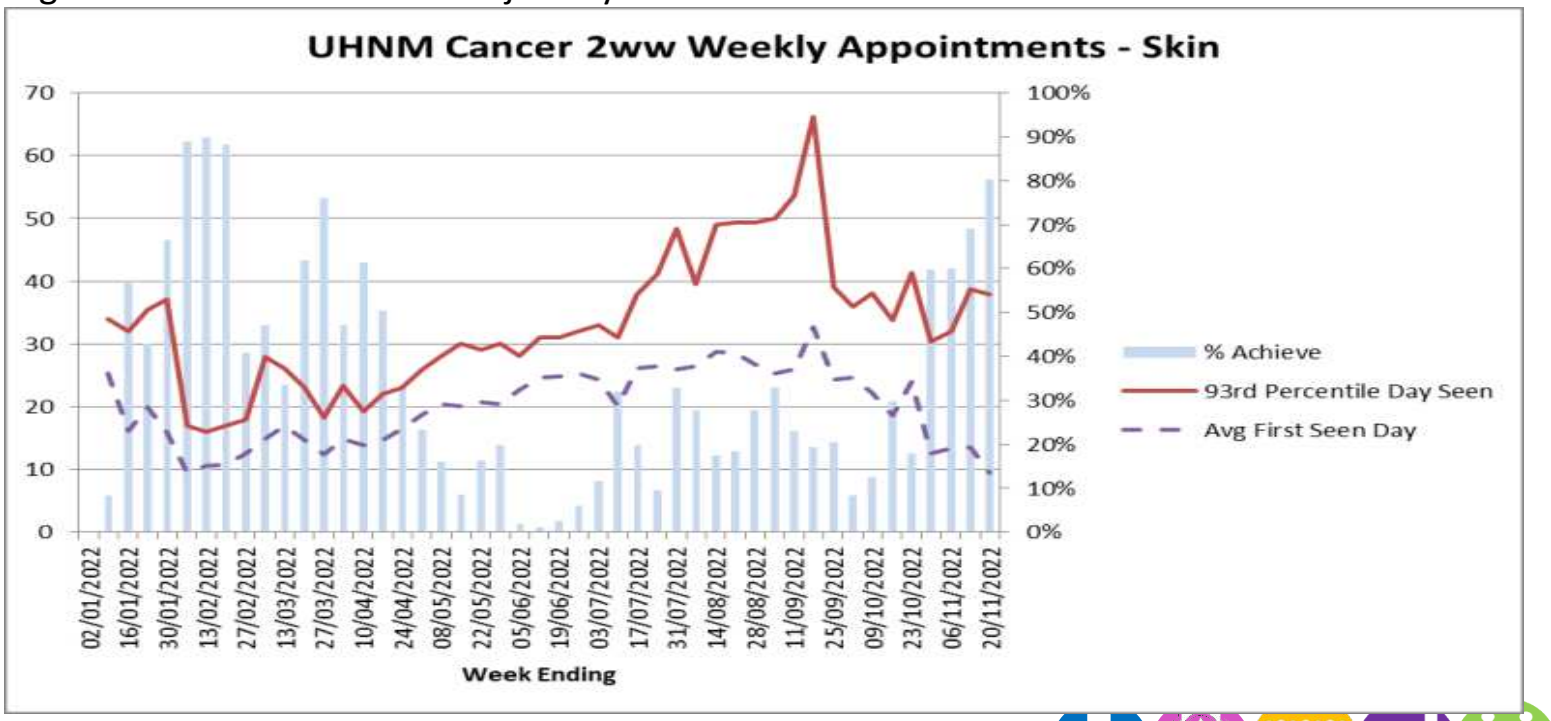
- The day by which 93% of patient receive a 2WW 14 day Clock Stop on the LGI pathway has reduced to a current position of within 11 days.
- In mid September the LGI PTL volume was over 2500, the PTL has reduced by over 1200 patients over the past 13 weeks and is currently at 1288, with a backlog of 290.
- Recovery has been supported by the LGI Community Referral Hub – which optimises referrals to include all mandatory dataset including FIT results, which allows faster triage and directs patients straight to the right test.
- The ICS is supporting implementation of BSG guidance which advises that FIT negative patients (with normal bloods and no other clinical concerns) should NOT be referred on the 2WW pathway.



4. Cancer Pathway Re-design Skin

University Hospitals of North Midlands NHS Trust

- 40% of patients within the Skin backlog have a next event as treatment scheduled, compared with 20% in Oct.
- 3% of the current backlog are waiting a treatment date compared to 31% in October
- The day by which 93% of patient receive a 2WW 14 day Clock Stop has reduced by over 30 days to a current position of within 38 days. This is due to the backlog of patients waiting who were booking in to November however significant improvements are expected in December.
- Currently, there are only 4 patients booked as a breach in December, due to patient choice. Skin is predicted to achieve 14 day in December.
- The Skin PTL has reduced by over 1144 patients over the past 13 weeks and is currently at 1115 with a backlog of 306 – which is within trajectory



4. Cancer Pathway Re-design Prostate

University Hospitals of North Midlands NHS Trust

- Best Practice Timed Pathway Prostate – Full implementation of the Prostate BPTP has been achieved at UHNM, with the correct sequence of events monitored by a dedicated CNS team.
- While the pathway has been implemented we currently do not meet the timescales required of the pathway.
- UHNM is also progressing local anaesthetic transperineal biopsy (LATP) with a nominated nurse providing training to other trusts within the region, after sign off from Guy's & St Thomas' – training centre.
- The WMCA have convened a group of analysts from across the region, to assess data collection against timed milestones of BPTPs.
- This will allow evaluation of performance against each step, to target improvement efforts.
- UHNM Senior Cancer Data Analyst is informing the piece of work and leading development with the Head of West Midlands Cancer Alliance.

5. Outpatient Transformation

University Hospitals of North Midlands NHS Trust

UHNM has an Outpatient work stream under the planned care board which focuses on all of the following:

- PIFU
- Advice & Guidance
- Reduction in FU
- Reducing DNAs
- Virtual appointments

Each of these is monitored through either the weekly briefing or the assurance dashboard.

The Trust also participated successfully in ‘Super September’ which focused on outpatient schemes. This saw successful increase in PIFU numbers, increase validation, communication with patients waiting and additional clinics. UHNM are being taken forward as a national case study due to the success of the schemes implemented.

6. Surgical and Theatre Productivity

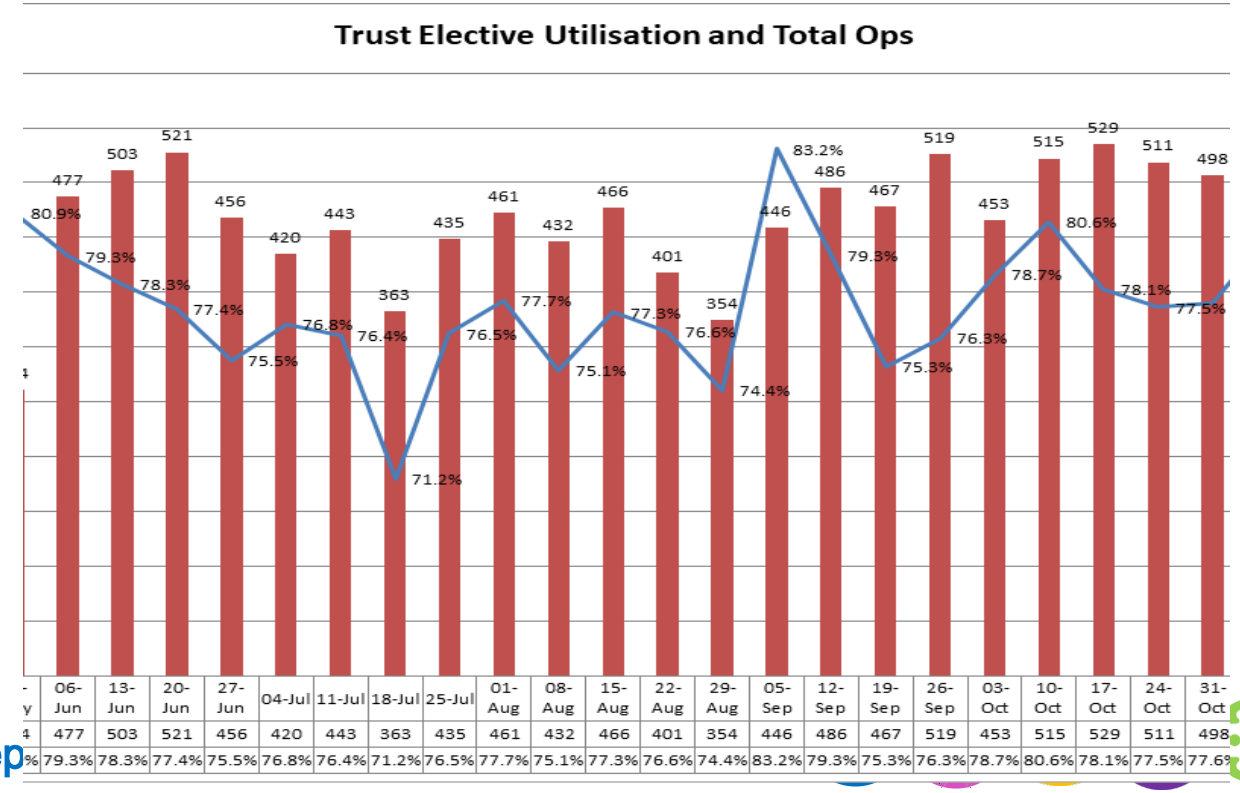
University Hospitals of North Midlands NHS Trust

There are seven requirements outlined in the letter:

1. Confirmation of oversight arrangements for theatre productivity.
   - UHNM has confirmed COO, DCOO and DMD as SROs for this oversight
2. Theatre utilisation requirement for 85%
   - This is tracked on a

   weekly basis and while

   the requirement is not currently achieved there is an Improving Together (Trust QI programme) piece of work under the planned care board which looks to address this.



6. Surgical and Theatre Productivity

University Hospitals of North Midlands NHS Trust

3. Elective surgery should be day case by default, delivering day case rates across all surgery of 85%
   - This is not currently achieved, but tracked and reported monthly to Performance & Finance Committee (PAF). This will also now be added into the weekly briefing.
4. Maximise Right Procedure, Right Place
   - UHNM has signed up to be a pilot for this model of working and is currently working with regional colleagues and the skin team to put this in place.
5. Adopt best practice pre & peri-operative medicine
   - There is a performing together A3 looking at preams.

6. Surgical and Theatre Productivity

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NHS Trust

6. Optimise the booking and scheduling process
   - Theatres have re-instated the theatre optimisation meetings which challenge directorates on their booking profiles at 6/4/2 weeks. This process is being tested by the Regional theatre lead to provide assurance of process and efficiency.
7. Not performing interventions identified as 'must not do' on EBI lists 1 and 2 unless applying for specific criteria.
   - This is in line with the ICB policy 'Commissioning Policy, Excluded and Restricted Procedures; V 2.0' which was issued 8th July 2022.
   - The Trust follows the ICB blueteq process for requesting permission and this is tracked in the system. A process will now be put in place to correlate procedures undertaken and approvals granted.

Conclusion

University Hospitals of North Midlands NHS Trust

- UHNM is currently undertaking all elements required in the letter
- Each indicator mentioned is tracked either through PAF or the weekly briefing
- The detail of this is covered through weekly assurance dashboards and meetings
- Not all indicators meet the requirements outlined in the letter

Recommendation

University Hospitals of North Midlands NHS Trust

As part of the letter self certification is required for the following items:

1. Has a lead Exec with responsibility for elective and cancer performance and recovery.
2. Relevant committees receive appropriate reports
3. Agreed plan for 78ww and 62 day trajectories
4. Has received report on Lower GI, Skin and Prostate pathways
5. Is pursuing outpatient transformation
6. Has received reports on Super September
7. Has received reports on validation
8. Has received assurance on clinical prioritisation and reviewed cancer turnaround times
9. Discussed theatre productivity at every Trust Board
10. Review Model Health System theatre productivity
11. Confirmed SRO for theatre productivity
12. Ensured diagnostic utilisation

The recommendation is that the self certification is approved, with this report being made available to the relevant committees and the amendments to reporting data as per the following slide be made to ensure oversight of items through the correct operational Groups.

Reporting

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Category	Metric	Current Dataset/Report
	RTT 78 WW performance against trajectory	Weekly Briefing - RTT Page.
	62 day cancer performance against trajectory	62 day performance in Weekly Briefing, but no trajectory or PAF which shows a target, trajectory to be added
VALIDATION	By 23/12/22 - Any patient waiting over 52 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted	Tracked via central submission
	By 2/02/23 - Any patient waiting over 26 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted	
	By 28/04/23 - Any patient waiting over 12 weeks on an RTT pathway (at 20 April 2023) who has not been validated* in the previous 12 weeks should be contacted	
SURGICAL & DIAGNOSTIC PRIORITISATION	62 Day Suspected Cancer patients waiting for a diagnostic test. For each Tumour group diagnostic test maximum timeframes need to be adhered to. Max is 10 days referral to report. Review of turnaround times.	Diagnostics - Backlog size of PTL is shared in weekly tier 2 meetings. Benchmarking data in PAF. Trajectory not available for Activity/WL across all DM01 modalities but is beign added to the diagnostic cell report.
	31 day Cancer standard (DTA to Treatment)	PAF
CANCER PATHWAY REDESIGN	Lower GI, Skin and Prostate cancer report of structure and performance	Reported through cancer data set
OUTPATIENT TRANSFORMATION	25% reduction in outpatient follow up appts by March 2023.	OPFU Backlog Volume is in Weekly Briefing
	PIFU	Add to weekly briefing
	16 Specialist advice requests per 100 1st OP appts	A&G through OP cell report
	DNA rate reductions	Assurance dashboard
	25%+ OP appts via video/Telephone	Trust level in Weekly Briefing
	New/FU ratios	OP Cell report
	Monitor performance and benchmarking	PAF/IPR refreshed quarterly
SURGICAL & THEATRE	Theatre Utilisation >85%	Assurance dashboard mid November and added back into Weekly Briefing
	Daycase rates of all surgery of >85%	Data is in Weekly Briefing, not displayed to view this - to ammend
	Booking at 6/4/2	Available, to be added to the assurance pack and weekly brief
	Surgical prioritisation	Available, to be added to the assurance pack
	Remove simple surgical procedures out of theatres into rooms.	This is a national programme UHNM have signed up to
APPENDIX	Super September report	

To: NHS Trust and Foundation Trust chief executives and chairs

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

25 October 2022

Dear colleague,

Next steps on elective care for Tier One and Tier Two providers

On 18 October, NHS England wrote to the NHS outlining further plans to boost capacity and resilience for services over the coming challenging winter period. This letter now sets out immediate next steps for tier one and tier two of the elective recovery programme to ensure that our phase two objectives around 78 week waiters and 62 day cancer waits are met.

The NHS has delivered a massive reduction in patients waiting two years and is also now steadily reducing the number of people waiting more than 18 months and 62 days respectively. Activity levels compared to pre-pandemic are increasing but we can still do more. There is no one silver bullet, but through a combination of getting the basics right and data-led management and innovation, particularly on outpatient and diagnostic activity, we firmly believe that we can continue to make genuine progress.

We realise that there are a lot of asks on providers and that each of you will know best your local circumstances and what works well. However, through each wave of Covid over the past two years, hospitals have got better and better at protecting elective and cancer care. There are significant learnings from individual organisations across the country that can make a huge difference if adopted collectively. That is why we are now asking all colleagues to step up efforts on all of the measures outlined below. With this in mind, we ask that you complete the Board self certification, (see appendix A) to allow us to support you where you are having the greatest challenges. The fundamentals that we have, collectively, proven to work are:

Excellence in the Fundamentals of Waiting List Management

Ensuring operational management and oversight of routine elective and cancer waiting lists aligns with best practice as outlined/directed within the national programme and current Cancer Waiting Times guidance. All patients past 62 days for cancer and 78

weeks for wider elective care should be reviewed and the actions required to progress them to the next step in their pathway prioritised.

Validation

The validation and review of patients on a non-admitted waiting list is important for the appropriate use of outpatient capacity and to provide clean visible waiting lists to ensure timely and orderly access to care. There are three phases to validating waiting lists that providers are required to undertake routinely – technical, administration and clinical and, following on from guidance sent out on 16 August available here, we expect providers to meet this timeline:

a) By 23rd December 2022
   Any patient waiting over 52 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted

b) By 24th February 2023
   Any patient waiting over 26 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted

c) By 28th April 2023
   Any patient waiting over 12 weeks on an RTT pathway (at 20 April 2023) who has not been validated* in the previous 12 weeks should be contacted

Appropriate surgical and diagnostic prioritisation

We know that 85% of patients waiting longer than 62 days from their referral for urgent suspected cancer are waiting for a diagnostic test. For cancer in particular, the significant demand for additional diagnostic capacity means that Trusts need to adhere to the maximum timeframes for diagnostic tests within each tumour-specific Best Practice Timed Pathway, but should at all times have a maximum backstop timeframe of 10 days from referral to report. Trusts should undertake a comprehensive review of current turnaround times and what further prioritisation of cancer over more routine diagnostics would be required to meet this backstop requirement.

Trusts should ensure that existing community diagnostic centres (CDCs) capacity is fully utilised by ringfencing it for new, additional, backlog reducing activity, and working with their wider ICS partners to use a single PTLs across the system. Trusts should work across their systems to accelerate local approval of business cases CDCs, additional acute imaging and endoscopy capacity; and expedite delivery of those investments once approved, and should continue to explore partnerships with the independent sector to draw on or build additional diagnostic capacity.

Surgical prioritisation should continue to follow the guidance set out in the letter of 25 July, providing ringfenced elective capacity for cancer patients (particularly P3 and P4 urology and breast patients) and 78ww patients. Performance against the 31 day standard from decision to treat to treatment should be used to assess whether the first of these objectives is being met.

Cancer pathway re-design for Lower GI, Skin and Prostate

There are three pathways making up two-thirds of the patients waiting >62 days and where increases over the past year have been the largest: Lower GI, Skin and Urology. Service Development Funding was made available to your local Cancer Alliance to support implementation of these changes and additional non-recurrent revenue funding has also been made available nationally.

Lower GI: Full Implementation of FIT in the 2ww pathway

As set out in the joint guidance on FIT issued by the British Society of Gastroenterology and Association of Coloproctology of Great Britain and Ireland (ACPGBI), and reinforced in this letter, most patients with suspected colorectal cancer symptoms but a FIT of fHb <10 µg Hb/g, a normal full blood count, and no ongoing clinical concerns should not be referred on a LGI urgent cancer pathway. Where referred, teams should not automatically offer endoscopic investigation but consider alternative, non two week wait, pathways as set out in the letter.

Full implementation of teledermatology in the suspected skin cancer pathway

All Trusts should work with their ICS to implement teledermatology and digital referral platforms to optimise suspected skin cancer pathways and reduce unnecessary hospital attendances to tackle the backlog and meet increasing demand. NHS England's guidance on the implementation of teledermatology pathways is endorsed by the British Association of Dermatologists and supports a Best Practice Timed Pathway for skin cancer which has been published this week.

Implementation will require provision for dermoscopic images to be taken for Urgent Suspected Cancer Skin cancers. This could be delivered by primary care, a separately contracted service delivered by primary care, in a community image taking hub setting, or by medical illustration departments in secondary care. Capacity must be in place for daily dermatologist triage of images, as either additional activity or as part of existing job plans. Following triage, the consultant or a member of their team should communicate with the patient (via telephone, video or face-to-face consultation) and be booked directly for surgery and receive appropriate preoperative advice and counselling if required.

Full implementation of the Best Practice Timed Pathway for prostate cancer
All provider Trusts should implement the national 28-day Best Practice Timed Pathway for prostate cancer, centred on the use of multiparametric MRI (mpMRI) before biopsy. Using pre-biopsy mpMRI means patients can be triaged towards a biopsy so at least 25% can avoid it, over 90% of significant cancers can be diagnosed on imaging and fewer insignificant cancers are diagnosed. Use of local anaesthetic transperineal biopsy where clinically indicated provides increased accuracy and reduced risk of infection, without the resource intensity of procedures done under general anaesthetic.

Implementation will require all patients to be booked in for both mpMRI and biopsy at the point of triage, with triage taking place no later than 3 days from the date the referral is received. Ring-fenced mpMRI slots should be in place – weekly demand analysis from radiology requesting systems should be used to inform the level at which this is set, with frequency of mpMRI slots sufficient to support delivery of timely biopsy. Maximum use of local anaesthetic transperineal prostate biopsy should also be ensured, with general anaesthetic biopsy used only where clinically indicated or for patient preference. Pre-biopsy mpMRI and biopsy procedures should take place no later than 9 days from the date the referral is received.

Outpatient transformation
Outpatients make up around 80% of the total waiting list and it is crucial that, over the winter period, providers continue to keep a strong operational focus on providing these services. Providers are asked to continue their work to deliver a 25% reduction in outpatient follow up appointments by March 2023.

a) As part of this, trusts are asked to continue the expansion of patient initiated follow up (PIFU) to all major outpatient specialties, especially increasing the volume of PIFU activity in specialties where it is now well established.
b) Continue to deliver at least 16 specialist advice requests per 100 first outpatient appointments. Providers are asked to focus efforts on pre-referral advice models.
c) Further initiatives to support outpatient follow-up (OPFU) reduction should also include improved and standardised discharge procedures and more effective administrative processes – including focusing on reducing DNAs in outpatient settings
d) In order to enable a personalised approach for outpatients and where it is clinically appropriate to do so, outpatient appointments should continue to be delivered via video and telephone, at a rate of 25% of all outpatient appointments. Remote consultation guidance and implementation materials can be found on NHS Futures here.

Surgical and theatre productivity

It is essential that we make best use of available surgical capacity, to drive productivity improvements and protect elective activity through winter. As such we expect providers to:

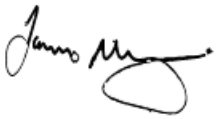
a) Review the senior responsible officer(s) (SROs) and oversight arrangements in relation to theatre productivity and strengthen these if necessary. Ideally, it should consist of a senior manager working 'shoulder-to-shoulder' with a senior clinician – to succeed we need both groups working together.
b) Drive up theatre utilisation to 85%, underpinned by the cases per list standards set out within the GIRFT high volume low complexity (HVLC) programme.
c) Make elective surgery daycase by default, delivering daycase rates across all surgery of 85%, and helping to free up valuable inpatient beds for complex work.
d) Maximise Right procedure right place, taking simple surgical procedures out of theatre into procedure rooms, eg hand surgery, cyctoscopy, hysteroscopy
e) Adopt best practice pre & peri-operative medicine pathways to reduce issues of under booking of lists, on the day cancellations, and pro-longed length of stay, as well as providing better care for patients.
f) Optimise the booking & scheduling processes, ensuring that patients are ready for surgery prior to being offered a surgery date, with an embedded data driven, clinically led approach.
g) Not performing those interventions identified as 'must not do' on EBI lists 1 and 2 and following the stated process for those List 1 and 2 interventions that should only be performed after applying the specific criteria.

Board Self-certification

As part of the above priorities, we are asking each provider to undertake a Board self certification process and have it signed off by Trust Chairs and CEOs by November 11, 2022. If you are unable to complete the self certification process then please could you discuss next steps with your Regional team. The details of this self certification can be found at Appendix A.

Thank you for all of your continued hard work in addressing what are two critical priorities for the NHS over the winter period. Please share this letter with your Board, key clinical and operational teams and relevant committees, and do email england.electiveopsanddelivery@nhs.net should you have any questions.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Dame Cally Palmer
National Cancer Director
NHS England

Elective Recovery Self certification **Appendix A**

The Chair and CEO are asked to confirm that the Board:

a) Has a lead Executive Director(s) with specific responsibility for elective and cancer services performance and recovery.

b) That the Board and its relevant committees (F&P, Safety and Quality etc) receive regular reports on elective, diagnostic and cancer performance, progress against plans and performance relative to other organisations both locally and nationally.

c) Has an agreed plan to deliver the required 78ww and 62 day trajectories for elective and cancer recovery, and understands the risks to delivery, and is clear on what support is required from other organisations.

d) Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.

e) Is pursuing the opportunities, and monitoring the impacts, presented by Outpatient transformation and how this could accelerate their improvement, alongside GIRFT and other productivity, performance and benchmarking data and opportunities.

f) Have received a report on Super September and have reviewed the impact of this initiative for their Organisation.

g) Have received reports on validation, its impact and has a validation plan in line with expectations in this letter.

h) Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.

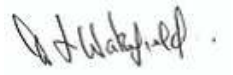
i) Discuss theatre productivity at every trust board; we suggest with the support of a non-executive director to act as a sponsor.

j) Routinely review Model Health System theatre productivity data, as well as other key information such as day-case rates across trusts.

k) Confirm your SROs for theatre productivity.

l) Ensure that your diagnostic services reach at least the minimum optimal utilisation standards set by NHS England.

Signed by CEO  Date: 11/11/2022

Signed by Chair  Date: 11/11/2022

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th December 2022
Report Title:	Update on Board Development Programme	**Agenda Item:**	19..
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**	✓	**Systems & Partners**	✓			
Responsive	✓	**Improving & Innovating**	✓	**Resources**	✓			

Executive Summary

Situation

This paper is to provide the Board with an overview on progress against the topics identified to be delivered within the 2022/23 Board Seminar Programme.

Background

The Board Development Programme was approved by the Board in May 2022. This comprised variety of business and developmental topics including 'must dos', emerging developments and operational/strategic challenges, aligned to our Strategic Priorities.

Assessment

A review of the Board Development Programme has been undertaken and the attached demonstrates the topics which have been covered as planned, deferred or added. The main changes to the programme are as follows:

- The session on Digital / EPR was brought forward to September from October, to enable the EPIC demonstration be provided to Board members
- The session on culture was expanded and moved to take place in October during the Trust Board Time Out
- Inclusion of an additional topic at the Trust Board Time Out in October, on Population Health and Wellbeing
- The session on Freedom to Speak Up has been moved from the Trust Board Time Out, to January
- The session on the well led framework has been moved from November to December's Open Board meeting
- Inclusion of a session on the Annual Plan/Enabling Strategies/Focussed Confirmation in March 2023, as per the integrated business planning cycle of business
- The topics of System/Provider Collaborative Joint Meetings, 'Integration' White Paper & Place and Clinical Research Network/CENREE are to be carried forward to the 2023/24 programme

Key Recommendations

The Board is asked to note the updated Board Development Programme and to note the timing of the remaining sessions, highlighting where any changes are required and whether any additional items should be included.

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Board Development Programme 2022/23

November 2022

Strategic Priority	Topic	Development (D) or Business (B)	Purpose / Outcome	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
				1st	11th		13th	3rd	14th	11th/ 12th	9th		11th		15th
High Quality	Ockenden Update	B	Understanding of current progress with Ockenden recommendations, areas of challenge and variation												
Improving & Innovating	Research Strategy	D & B	Understanding progress of implementation of the Strategy and future opportunities for research and innovation												
High Quality Responsive Resources	Operational Delivery, Elective Waits & 22/23 Financial Landscape	B	Consideration of the challenges associated with use of the Independent Sector, changes to infection prevention guidance and impact of covid related costs.												
Systems & Partners	System Plan & Delivery 2022/23	B	Understanding and agreement of the core elements of the System Plan submission, including key risks			NEDS Mtg									
Resources	Estates Strategy	B	Refresh of the Estates Strategy, Archus review and Development Control Plan												
Systems & Partners	County Hospital Strategy	B	Overview of the strategy for transformation of the County Hospital site												
High Quality	Safeguarding	B	'New agency approach' to Safeguarding – Adult and Children's Safeguarding					Closed Board							
Resources	Digital Strategy – EPR	D & B	Consideration of the electronic patient record and implementing the digital strategy												
Improving & Innovating	Improving Together	D	Understanding of programme progress to date, key risks, Board / Committee assurance and next steps.												
People	People Strategy – Culture	D	Consideration of the refreshed People Strategy, the launch of the Being Kind Compact and the Trust's Enable Programme												

Strategic Priority	Topic	Development (D) or Business (B)	Purpose / Outcome	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
				1st	11th		13th	3rd	14th	11th/ 12th	9th		11th		15th
Resources	Estates Strategy – Sustainability	B	Progress with net carbon zero and implementing the estates strategy												
Systems & Partners	Population Health & Wellbeing	B	To highlight the work undertaken to date in relation to the approach to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population												
Improving & Innovating	Well Led Assessment	B	To self-assess against the Well Led Framework, identifying any gaps to be addressed									Open Board			
People	Freedom to Speak Up	D & B	Self-assessment and Trust Board training												
Improving & Innovating	Strategic Risks – BAF	B	Agreement of the Strategic Risks for the Board Assurance Framework (BAF) for 2022/23.												
Resources	Annual Plan / Enabling Strategies / Focussed Confirmation	B	Scope to be defined												
To be carried forward to the 2023/24 programme															
Systems & Partners	System / Provider Collaborative Joint Meetings	D & B	Purpose and scope and date to be defined												
Systems & Partners	'Integration' White Paper & Place	D & B	Understanding the progress to date and any key issues/implications												
Improving & Innovating	Clinical Research Network & CENREE	B	Purpose and scope to be defined												

Key:

	Complete
	Planned

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th December 2022
Report Title:	Calendar of Business 2023/24	**Agenda Item:**	20.
Author:	Nicola Hassall, Deputy Associate Director of Corporate Governance		
Executive Lead:	All		

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	✓		

Executive Summary

Situation and Background

The Trust Calendar of Business includes dates for all Board, Committee and Executive Group meetings. Dates have been set based on the 2022/23 cycle, and considered to ensure reports are able to be considered at respective Executive Groups and Committees prior to submission to the Trust Board.

Assessment

The Calendar of Business for 2023/24 follows the similar sequencing of meetings as per 2022/23, although a number of changes have been made to ensure meetings whereby the Divisional Triumvirate attend, are held on either a Tuesday or Thursday, this has resulted in the following changes:

- Charity Committee moved to a Tuesday instead of Friday
- Executive Business Intelligence Group moved from a Tuesday to a Friday
- Executive Infrastructure Group moved from a Friday to a Tuesday
- Executive Clinical Effectiveness Group moved from a Tuesday to a Thursday, in addition the frequency of the meeting has increased
- Executive Quality and Safety Oversight Group moved from a Monday to a Tuesday
- Executive Digital, Data Security and Protection Group moved from a Wednesday to a Thursday
- Executive Health and Safety Group moved from a Thursday to a Tuesday
- Executive Workforce Assurance Group moved from a Friday to a Thursday
- Inclusion of Non-Elective and Planned Care Improvement Groups

It should be noted that although the scheduling of Committee meetings follow the same pattern as for 2022/23, in December meetings are held earlier due to the Bank Holiday and Christmas periods, therefore some information may not be available for these meetings.

Key Recommendations:

The Trust Board is asked to **approve** the Calendar of Business for 2023/24

Calendar of Business 2023 / 2024

NHS University Hospitals of North Midlands NHS Trust

	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun
April	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30							
M12 Reporting					PTB		BH			BH	EIG	EST	EWAG	EBI				NEIG		PRM					PAF	TAP	QGC											
					CTB						EHSG	ERI	CEG					PRC		PRN					CC		AC											
											QSOG		DSP					PRS		PCIG																	
May			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31				
M1 Reporting			BH		PTB					MQSOG		TBS						EHSG	NRC	EWAG					NEIG	MQGC	PRM				BH	PAF	TAP				
					CTB													QSOG		DSP					PRC		PRN											
					CT																				PRS		PCIG											
June						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
M2 Reporting						QGC						PTB						EIG	EST	EWAG	EBI				NEIG		PRM					PAF	TAP	QGC			
												CTB						EHSG	ERI	CEG	AC*				PRC		PRN					CC					
																		QSOG		DSP					PRS		PCIG										
July	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31						
M3 Reporting					PTB						EHSG	TBS	EWAG					NEIG	NRC	PRM					PAF	TAP	QGC										
					CTB						QSOG		DSP					PRC		PRN							AC											
																		PRS		PCIG																	
August				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
M4 Reporting					PTB					MQSOG								EIG	EST	EWAG	EBI				NEIG	MQGC	PRM				BH	PAF	TAP	QGC			
					CTB													EHSG	ERI	CEG					PRC		PRN					CC					
																		QSOG		DSP					PRS		PCIG										
September																																					
M5 Reporting																																					
October																																					
M6 Reporting																																					
November																																					
M7 Reporting																																					
December																																					
M8 Reporting																																					
January																																					
M9 Reporting																																					
February																																					
M10 Reporting																																					
March																																					
M11 Reporting																																					

COLOUR KEY		TIME
Public Trust Board	PTB	9:30 - 12.30 pm
Closed Trust Board	CTB	1.00 - 2.00 pm
Trust Board Seminar	TBS	9.00 - 1.00 pm
Trust Board Time Out	BTO	9.00 - 4.30 pm
Annual General Meeting	AGM	1.00 - 3.00 pm
Performance and Finance Committee	PAF	9.00 - 11.30 am
Executive Infrastructure Group	EIG	9.30 am - 11.00 am
Executive Business Intelligence Group	EBI	9.00 - 10.30 am
Non-Elective Improvement Group	NEIG	8.00 - 9.00 am
Planned Care Improvement Group	PCIG	4.00 - 5.00 pm
Audit Committee	AC	12.30 - 3.00 pm
Corporate Trustee	CT	2.30 - 3.30 pm
Charity Committee	CC	12.30 - 2.00 pm
Quality Governance Committee	QGC	9.00 - 11.30 am
Maternity Quality Governance Committee	MQGC	9.30 - 11.30 am
Executive Quality and Safety Oversight Group	QSOG	2.00 pm - 4.00 pm
Executive Maternity Quality and Safety Oversight Group	MQSOG	2.00 pm - 4.00 pm
Executive Clinical Effectiveness Group	CEG	12.30 pm - 2.00 pm
Nomination & Remuneration Committee	NRC	10.00 am - 11.30 am
Transformation and People Committee	TAP	9.00 - 11.30 am
Executive Data Security and Protection Group	DSP	2.30 - 4.00 pm
Executive Health and Safety Group	EHSG	11.30 - 1.00 pm
Executive Research & Innovation Group	ERI	11.00 am - 12.30 pm
Executive Workforce Assurance Group	EWAG	9.00 - 11.00 am
Executive Strategy and Transformation Group	EST	9.00 - 10.30 am
Performance Management Reviews	PR	C 9.30 - 11.30 am S 12.30 - 2.30 pm M 9.00 - 11.00 am N 11.30 - 1.30 pm
Staffordshire School Holidays		

Trust Board

2022/23 BUSINESS CYCLE

KEY TO RAG STATUS	
Paper rescheduled for future meeting	
Paper rescheduled for next meeting	
Paper taken to meeting as scheduled	

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		6	4	8	6	3	7	5	9	7	11	8	8	
HIGH QUALITY														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse					Staff		Staff		Staff				
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Quality Strategy Update	Chief Nurse													
Clinical Strategy	Director of Strategy													To be provided to TAP before being brought to Board
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse						→							
Quality Account	Chief Nurse													
7 Day Services Board Assurance Report	Medical Director													
NHS Resolution Maternity Incentive Scheme	Chief Nurse													
Maternity Serious Incident Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													TBC
Infection Prevention Board Assurance Framework	Chief Nurse													
RESPONSIVE														
Integrated Performance Report	Various	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
PEOPLE														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Chief People Officer													
People Strategy Update	Chief People Officer													
Revalidation	Medical Director													
Workforce Disability Equality Report	Chief People Officer													
Workforce Race Equality Standards Report	Chief People Officer													
Staff Survey Report	Chief People Officer													
Raising Concerns Report	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
IMPROVING AND INNOVATING														
Research Strategy	Medical Director				→									Taken to TAP in April. Final version to be presented to Board in September (due to annual leave during August)
SYSTEM AND PARTNERS														
System Working Update	Chief Executive / Director of Strategy													
RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy		N/A											
Digital Strategy Update	Director of Digital Transformation													
Going Concern	Chief Finance Officer													Taken to Audit Committee
Estates Strategy Update	Director of Estates, Facilities & PFI													Date to be confirmed
Annual Plan	Director of Strategy													
Board Approval of Financial Plan	Chief Finance Officer													

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		6	4	8	6	3	7	5	9	7	11	8	8	
Activity and Narrative Plans	Director of Strategy													
Final Plan Sign Off - Narrative/Workforce/Activity/Finance														
Capital Programme 2022/23	Chief Finance Officer													Taken to PAF
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance													
Audit Committee Assurance Report	Associate Director of Corporate Governance													
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
Accountability Framework	Associate Director of Corporate Governance													
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance													
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance													
G6 Self-Certification	Chief Executive													
FT4 Self-Certification	Chief Executive													
Board Development Programme	Associate Director of Corporate Governance													Deferred from Nov. due to number of items on the agenda
Well-Led Self Assessment	Associate Director of Corporate Governance													