Trust Board (Open)

Meeting held on Wednesday 4th May 2022 at 9.30 am to 12.30 pm via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	1.	Patient Story	Information	Mrs AM Riley	Verbal	
5 mins	2.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 6th April 2022	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	6.	Chief Executive's Report – April 2022	Information	Mrs T Bullock	Enclosure	
10:15	**STRATEGY**					
10 mins	7.	Digital Strategy	Approval	Mrs A Freeman	Enclosure	**BAF 7**
10:25	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	8.	Quality Governance Committee Assurance Report (28-04-22)	Assurance	Ms S Belfield	Enclosure	**BAF 1**
5 mins	9.	IPC Board Assurance Framework –April 2022	Assurance	Mrs AM Riley	Enclosure	**BAF 1**
10 mins	10.	Ockenden Final Report – 15 Immediate and Essential Actions Gap Analysis	Assurance	Mrs AM Riley	Enclosure	**BAF 1**
10:45	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	11.	Transformation and People Committee Assurance Report (27-04-22)	Assurance	Prof G Crowe	Enclosure	**BAF 1, 2, 3, 4 5**
10:50 – 11:00: COMFORT BREAK						
11:00	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	12.	Performance & Finance Committee Assurance Report (26-04-22)	Assurance	Mr P Akid	Enclosure	**BAF 6, 7, 8 & 9**
11:05	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
40 mins	13.	Integrated Performance Report – Month 12	Assurance	Mrs AM Riley Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	**BAF 1, 2, 3, 6 & 9**
11:45	**GOVERNANCE**					
5 mins	14.	Audit Committee Assurance Report (29-04-22)	Assurance	Prof G Crowe	Enclosure	
10 mins	15.	Speaking Up Report – Q4	Assurance	Miss C Rylands	Enclosure	
10 mins	16.	Board Assurance Framework – Q4	Approval	Miss C Rylands	Enclosure	
5 mins	17.	Revised Corporate Governance Structure	Approval	Miss C Rylands	Enclosure	
5 mins	18.	G6 & FT4 Self-Certification	Approval	Mrs T Bullock	Enclosure	
12:20	**CLOSING MATTERS**					
5 mins	19.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	20.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 3rd May to nicola.hassall@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
12:25	**DATE AND TIME OF NEXT MEETING**					
	21.	**Wednesday 8th June 2022, 9.30 am via Microsoft Teams**				

PROUD TO CARE

Trust Board (Open)

Meeting held on Wednesday 6th April 2022, 9.30 am to 12.45 pm
Via Microsoft 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												
Mr P Bytheway	PB	Chief Operating Officer												
Mrs T Bullock	TB	Chief Executive												
Prof G Crowe	GC	Non-Executive Director												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Financial Officer												
Dr M Lewis	ML	Medical Director												
Prof K Maddock	KM	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse	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												
Mrs S Gohir	SG	Associate Non-Executive Director												
Prof A Hassell	AH	Associate Non-Executive Director												
Mrs A Freeman	AF	Director of Digital Transformation												
Mrs L Thomson	LT	Director of Communications												
Miss C Rylands	CR	Associate Director of Corporate Governance												
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI												

In Attendance:	
Mr I Bentley	Patient (Item 1)
Mrs D Brayford	Quality and Risk Manager – Obstetrics & Gynaecology (item 10)
Mrs N Hassall	Deputy Associate Director of Corporate Governance (minutes)
Mrs S Jamieson	Head of Midwifery (item 10)
Dr A Jegannathen	Consultant Oncologist (item 1)
Mr S Malton	Deputy Chief Nurse (representing Mrs Riley)
Mrs R Pilling	Head of Patient Experience (item 1)

Members of Staff and Public via MS Teams: 6

No.	Agenda Item	Action
1.	**Patient Story**	
048/2022	Mrs Bentley described her story which related to being diagnosed with breast cancer in 2018 and her subsequent treatment. She explained that after being diagnosed in April 2018, she had a mastectomy and subsequently participated in a clinical trial and received courses of chemotherapy and radiotherapy. She explained that she experienced initial difficulties with her oncologist, following which she requested to see a different oncologist and explained the difficulties	

	she experienced with Tamoxifen, before describing the way in which she had researched the benefits of a plant based diet. She added that in 2019 she made a complaint to the Trust in respect of neutropenic patients attending ED which she felt was well handled and she was made aware of the actions taken as a result. She explained that she had subsequently become involved in various patient experience activities within the Trust. Mr Wakefield referred to Mrs Bentley's initial experience whereby she had tried to obtain a lot of information following diagnosis and he queried what the Trust could have done to provide additional information. Mrs Bentley explained that the power of practitioners needed to be recognised whilst developing a relationship of mutuality with patients. Dr Griffin welcomed the holistic approach to health and wellbeing described by Mrs Bentley and thanked her for work on patient advocacy. Ms Bowen referred to the initial issue with Mrs Bentley's oncologist whereby a comment was made about her arthritis and she queried if any learning was shared regarding this. Mrs Bentley explained that it was difficult to change consultants and she was unsure if that experience had been shared with the initial consultant. Mr Wakefield apologised for the initial reaction from the oncologist regarding her arthritis and for the link and issues with Tamoxifen not being identified and he also welcomed the collaborative working between Mrs Bentley and Dr Jegannathen. **The Trust Board noted the patient story.** Mrs Bentley, Dr Jegannathen and Mrs Pilling left the meeting.	
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
049/2022	Mr Wakefield welcomed members of the Board and observers to the meeting. It was confirmed that the meeting was quorate.	
3.	**Declarations of Interest**	
050/2022	Dr Griffin's standing declaration regarding his involvement in the Nottingham Maternity review as noted as were other standing declarations were noted.	
4.	**Minutes of the Previous Meeting held 9th March 2022**	
051/2022	The minutes of the meeting from 9th March 2022 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
052/2022	PTB/509 – It was noted that this would be considered by the Transformation and People Committee (TAP) in April. PTB/515 – It was noted that demographic information of those patients who had been sectioned would be reported going forwards in the quarterly report.	
6.	**Chief Executive's Report – March 2022**	

053/2022	Ms Ashley highlighted a number of areas from the report. Mr Bytheway provided an update in relation to current operational pressures and cases of Covid. He explained that there were over 260 covid patients in the organisation, which was the highest number experienced for some months. It was noted that whilst the work undertaken in February and March to reset the organisation and reduce occupancy was successful, the capacity created had been replaced with additional covid patients. He stated that the Trust had continued with as much operating as possible although there continued to be challenges with staff sickness. It was highlighted that the Trust had moved into an internal incident structure for the next 10 days which was focussing on 3 particular areas. Professor Hassell referred to the national messaging regarding lateral flow testing which he felt was confusing and queried the situation for the Trust. Mr Bytheway stated that the Trust had considered the new guidance and so far no problems with lateral flow tests had been experienced. He added that the patient testing regime was being considered and no changes were to be made until it was clear which part of the patient pathway needed to change. Ms Ashley stated that all Trusts were working through the implications of the testing guidance and she suggested an update be provided to the Quality Governance Committee (QGC) regarding any risks or concerns as a result of the new guidance. Mr Wakefield referred to the reference to the virtual reality session and queried how widespread this was used. Mrs Thomson stated that the Trust was one of the first to utilise the technology, as part of a pilot and she explained there were plans in place to roll this out further. Dr Griffin commented on Dr Karen Juggins receiving the Royal College of Surgeons Coyler Gold Medal for her work with the Keep Stoke Smiling campaign and Professor Crowe added his thanks to the charity for the support provided to this prevention agenda. Mr Wakefield referred to the 'integration' White Paper and changes to the configuration of Place to provide better alignment with the local authority, and queried the implications and impact on the Trust. Ms Ashley agreed to brief the Board on this at a future seminar. The new 'integration' White Paper has been published which has been discussed by our shadow Integrated Care Board. This will change the configuration of Place within Staffordshire and Stoke-on-Trent. Further details will be shared on this as progress is made at system level. **The Trust Board noted the report and approved the following eREAFs 8974, 8939, 8788 and 9054.**	**AMR/SM** **HA**
7.	**Clinical Strategy**	
054/2022	Ms Ashley highlighted the way in which the clinical strategy had been developed, noting the delays as a result of Covid which in particular affected the completion of the service line reviews. It was noted that the strategy had been widely consulted upon. Ms Gohir referred to the women's health section and queried if gynaecology waiting lists should be referred to. Ms Ashley stated that whilst this was not explicitly referenced, the associated developments for County Hospital aimed to	

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	reduce these waiting lists by developing services at County Hospital for those affected. Dr Griffin queried the next steps and queried how this linked to the overall corporate strategy. It was noted that the reference to the system priorities remained in draft, whilst the system firmed these up. Mr Akid queried if the strategy had been costed in terms of overall affordability and Ms Ashley highlighted that the delivery plans associated with the strategy would identify the costs. Ms Bowen referred to some grammatical errors within the objectives and queried if the strategy should include more detail with regards to digital systems. Ms Ashley stated that whilst the strategy referred to other enabling strategies, the overall ambition to improve digital systems would be referenced more fully within the Digital Strategy. Professor Crowe stated that TAP would monitor the delivery of the strategy every 6 months and queried whether a Board development session was required in terms of considering the different areas of strategic intent referred to in the various strategies, which would enable the Board to consider the various priorities and consider what investment was required. Ms Ashley agreed that once the enabling strategies had been refreshed, these would be reviewed going forwards at the same point to enable the Board to consider these as a whole. **The Trust Board approved the Clinical Strategy and agreed to receive further updates on progress at TAP.**	**HA**
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
8.	**Quality Governance Committee Assurance Report (24-03-22)**	
055/2022	Ms Belfield highlighted the following from the report: • The Committee considered analysis regarding neonatal emergency readmissions and noted the outcome of the internal reviews which were progressing for cardiothoracic surgery • Concerns of staffing levels were raised due to the impact of covid and ongoing challenges associated with recruitment were highlighted **The Trust Board received and noted the assurance report.**	
9.	**IPC Board Assurance Framework (BAF) – March 2022**	
056/2022	Mr Malton highlighted that the changes to the national guidance would be incorporated into a future document and it was expected that this would affect 5 areas of the BAF Mr Wakefield referred to the changes to social distancing and whether this would be beneficial given the rising number of cases. Mr Bytheway stated that a reduction in social distancing had been enacted, as a result to the change in national guidance although risk assessments would continue to be undertaken where clinicians were worried about the potential impact on vulnerable patients. Mr Wakefield stated that given the rise in nosocomial infections, whether this was	

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	due to a reduction in social distancing and Mr Bytheway stated that this was difficult to establish, given lack of restrictions elsewhere and therefore infections could have been picked up in community. It was noted that whilst social distancing had been removed, masks were continuing to be worn. **The Trust Board received and noted the report.**	
10.	**UHNM Ockenden and Kirkup Update / Action Plan & Maternity Services Workforce Establishment**	
057/2022	Mrs Brayford and Mrs Jamieson joined the meeting. Dr Lewis referred to the recently received Ockenden report which highlighted concerns in relation to the quality and uniformity of care and missed opportunities to learn from patients and staff, culminating in a number of immediate recommendations stipulated for all Trusts. It was noted that a separate Trust Board Development session had been held on 1st April which focussed on the Ockenden recommendations and progress made to date. Mrs Jamieson highlighted the following: • Progress against the first set of actions had been reported to the region. In addition the workforce plan had been provided to the Board which articulated the vision for transformational posts associated with maternity services and this was separate to the clinical midwifery establishment • It was noted that following the most recent Ockenden report, further gap analysis would be undertaken on the recommendations and an update would be provided to the Trust Board in May Mrs Brayford highlighted the following: • A second self-assessment had been undertaken which demonstrated 99% compliance and the outstanding action related to the establishment of a Standard Operating Procedure to cascade information through the ICS structure • The Kirkup recommendations and actions had been revisited, with the outstanding actions relating to higher education courses for postnatal clinician and the refresh of the midwifery retention strategy Professor Hassell commented that whilst important for all Trusts, the number and complexity of guidance from different agencies in relation to maternity care was difficult to navigate and queried whether this could be brought together to include some prioritisation. He queried whether representations could be made nationally for this and Mrs Jamieson agreed to consider this further. Mrs Jamieson added that the Ockenden report brings together a number of drivers and the actions related to ongoing work in other workstreams. Dr Griffin referred to the importance for Boards to seek assurance not just reassurance in this area and felt that the reports provided where comprehensive in providing that assurance. He also stated that the Ockenden review referred to a lack of compassion and kindness and this required further consideration. Mr Wakefield stated that given the number of actions in place and the staffing problems, that the Board needed to continuously request assurance of maternity safety. Mrs Jamieson referred to Dr Griffin's point in that compassion and kindness needed to be demonstrated by leaders and added that an external survey was to be undertaken in order to establish the current culture in place. She added that in terms of safety and the mitigation in place, she was assured	

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	that whilst there were some shortages of staff, mitigation was in place to reduce the risk and she felt able to raise any concerns with Executives as required. Miss Rylands referred to the work undertaken to strengthen current oversight and scrutiny of this agenda and stated that given the large and vast amount of publications/recommendations she had started to develop a maternity assurance map which would be provided to QGC in due course, in order to demonstrate where assurance is provided. Ms Ashley stated that the report highlighted wider lessons which go beyond maternity services and these were being reflected on by Mrs Riley and Mr Malton. **The Trust Board received and noted the update in relation to the Ockenden and Kirkup recommendations and endorsed the development of business case for staffing.** Mrs Brayford and Mrs Jamieson left the meeting.	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH		
11.	**Transformation and People Committee Assurance Report (23-03-22)**	
058/2022	Professor Crowe highlighted the following from the report: • The Committee considered the additional transformation posts required in maternity and supported the development of the business case • An update in relation to workforce planning was provided and the Committee was to receive a detailed establishment review in due course • An update was provided on Improving Together and it was noted that some staff had been promoted from the team which would negatively impact on the resources available and would affect ongoing momentum of the programme • The Committee considered the staff survey results, whereby 7 themes were below the national average and this highlighted the challenges with staff engagement and morale Ms Bowen referred to covid related sickness absence which had increased and queried the mitigation in place. Mr Bytheway stated that staffing remained the biggest challenge in maintaining flow through the hospital and stated that at least 2 registrants were in place on every ward but this required movement of staff to do so, which subsequently impacts on staff engagement and morale. **The Trust Board received and noted the assurance report.**	
12.	**brap Review**	
059/2022	Mr Wakefield referred to the review which had been commissioned by the Board following the survey undertaken by MSC and BAPIO. He stated that Roger Kline and brap undertook the review and made for difficult reading, highlighting unacceptable behaviours, demonstrating that this culture had persisted for many years. He stated that the Culture Review Committee would continue to monitor progress in relation to the actions taken as a result of the review as part of the Board's commitment to addressing the issues raised and he added that the full report would be made public via the Website. Dr Lewis provided a presentation and highlighted the following: • The approach to the review included meetings held with staff to obtain	

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	background knowledge, considered the results from the 2020 staff survey, any member of staff was invited to talk to brap and Roger Kline whereby 34 staff and 61% from a BME background were spoken to, an online survey which was completed by over 3500 staff, focussed discussions with a further 39 staff and interviews held with senior leaders • 1 in 10 respondents indicated they were currently experiencing bullying/harassment, affecting 1 in 5 doctors/dentists • 1 in 5 respondents highlighted a culture of bullying in their team • 1 in 5 respondents highlighted being subject to bullying/harassment from a manager in the previous 24 months, and half of doctors attributed this to their ethnicity • 1 in 5 respondents highlighted being subject to bullying/harassment from colleagues in the previous 24 months, affecting 1 in 3 doctors • Bullying/harassment from patients affected 1 in 4 doctors in the past 24 months and 1 in 3 nurses. It was noted that staff were more inclined to report natures of bullying/harassment when received from members of the public • The nature and contributors of bullying/harassment was identified • In terms of organisational culture, the Executive Team were aware of the need to promote an inclusive culture and the work on values recognition was welcomed whilst recognising underlying tensions and long-standing unresolved conflicts and grievances • Many staff described an unacceptable climate of bullying, harassment and inequality, which impacted on staff wellbeing, recruitment, retention and performance • Although the Trust was not an outlier, the Trust was keen to take action the first of which would be to share the results with staff Mr Wakefield summarised that the review had identified behavioural difficulties in the organisation which were re unacceptable and the Trust Board would not tolerate it. Dr Griffin thanked Roger Kline and brap for the review and welcomed the publication of the report. Professor Crowe stated that whilst it made for difficult reading, it was not something which would be taken lightly and he queried when the actions associated with the report would be identified. Dr Lewis stated that staff needed to take stock of the information and reflect on the responses and stated that the actions would be considered further by the Culture Review Group. He added that some immediate actions had been taken in particular focussing on reducing the formality of raising concerns when relating to bullying and harassment. Dr Lewis added his thanks to the staff who had taken part in the review. Mrs Vaughan referred to the engagement with the staff networks and staff side representatives regarding the results of the report. **The Trust Board received and noted the report.**	
13.	**Staff Survey Results**	
060/2022	Mrs Vaughan highlighted the following: • The responses had been reviewed against the 7 key themes in the national People Promise in addition to considering staff engagement and morale and this change made it difficult to compare with previous results • The survey was carried out between September and December 2021 which	

	was at the same time as the brap and Care Quality Commission surveys, with an overall response rate of 43% which was lower than the national average of 46% • There had been a national decline in performance across all areas of the people promise • The results in comparison with previous years and in particular the areas which had declined were highlighted • The actions required to be taken as a result of the survey would be considered alongside action planning for the brap survey so that the responses were not taken in isolation Mr Wakefield summarised that the results were disappointing results especially when taking into account the brap survey, which highlighted a lot of work which was required in this area. He stated that the action plan resulting from the survey would be considered by TAP and suggested that this be considered at a future Board Seminar to reflect on the approach being taken to move towards improving staff engagement scores. **The Trust Board received and noted the report.**	**RV**
ENSURE EFFICIENT USE OF RESOURCES		
14.	**Performance & Finance Committee Assurance Report (22-03-22)**	
061/2022	Dr Griffin highlighted the following from the report: • The Committee considered the emerging digital strategy and increasing risk to cyber security • Continuing operational challenges were highlighted • The Committee noted the deficit position for the system financial plan and the narrative system plan had been shared with Committee members for information Mr Wakefield highlighted that systems had been asked to deliver a break even position which was at odds to the deficit position which had been initially submitted. **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
15.	**Integrated Performance Report – Month 11**	
062/2022	Mr Malton took the paper as read but highlighted the following: • There had been a rise in friends and family figures which was positive and the patient experience group continued to support further developments in relation to this • There had been a spike in the number of incidents with moderate harm, although further validation of these incidents was being undertaken and all instances would be subject to be reviewed by the serious incident process • The number of falls resulting in moderate harm had increased and a deep dive had been undertaken which identified these were predominantly in the Emergency Department, and steps had been taken to improve visibility of patients in the Department • Pressure ulcers deep dive had been undertaken which identified an initial correlation with staffing numbers this was to be considered further by QGC	

Mr Wakefield referred to the removal of doors in the Emergency Department to improve visibility and queried whether this was counter intuitive given the reasons for putting these in place. Mr Malton explained that whilst the doors had been put in place to address issues with covid and privacy and dignity, following a risk assessment only 6 doors had been removed.

Mr Bytheway highlighted the following in relation to urgent care:

- There had continued to be challenges with performance, with a high number of DTAs in the Department and impact on ambulance holds
- A test of change was in place regarding the new way of streaming enhanced primary care which was to go live from 1st May
- The main challenge related to ambulance handovers and the position was not improving; a number of changes had been enacted to improve the position which included the cohorting of patients
- The number of medically fit for discharge (MFFD) patients had reduced from 200 to 100 in February resulting in a small improvement in performance during March although this had subsequently deteriorated due to the increase in MFFD numbers and impact of covid
- The Trust was continually in discussion with the region and the ambulance service of what could be done differently to support the ambulance service, this included the immediate handover policy which was in place

Mr Wakefield queried when an improvement in performance was expected and Mr Bytheway stated that whilst there was a slight improvement in March, while there remained challenges with MFFDs, covid numbers and reduced occupancy, improvements in performance would be difficult.

Mr Akid referred to the previous investment in workforce for the Emergency Department and he queried if these staff had commenced and when the investment would make a difference in performance. Mr Bytheway stated that a tiered rota was to be implemented but this was not yet ready to be put in place. He stated that he was not expecting an improvement to be seen until at least the middle of May and Dr Lewis added that the regional team were aware of the current pressures and as such discharge and admission criteria was being reviewed.

Mr Bytheway highlighted the following in relation to cancer performance:

- Breast, skin and upper GI continued to be the main specialties with challenged performance
- 62 day performance and 104 day performance had started to improve
- The significant number of referrals and workforce challenges continued to be the main limitations

Dr Griffin queried colorectal cancer performance and Mr Bytheway stated that the Clinical Nurse Specialist team had had a number of staff leave but bringing in FIT testing was helping to manage cases proactively.

Mr Bytheway referred to RTT and diagnostics performance and highlighted that the follow up backlog continued to be reviewed on a monthly basis and the Specialised Division were using a Consultant team to review the follow up backlog. In addition, nearly all teams were working towards introducing patient initiated follow up (PIFU). In terms of theatre performance, there had been an increase in the number of elective sessions and treatments and utilisation was at 400 per week and operating had not significantly dropped which was positive.
Mr Wakefield referred to the trajectory of zero 104 weeks waits by the end of quarter 1 and whether this continued to be achievable. Mr Bytheway stated that

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	although the elective orthopaedic ward was not being utilised, due to the increase in covid and MFFD cases, orthopaedic daycases had continued, and the Trust remained on track to achieve zero at the end of June. Mrs Vaughan highlighted the following in relation to workforce performance: • Ongoing sickness absence and increasing levels of covid related absence were highlighted, which continued to fluctuate, with current covid related absence standing at 45% of overall absence Mr Wakefield requested clarification of the isolation requirements for staff and Mrs Vaughan stated that staff were still required to undertake lateral flow testing and any positive cases required staff to isolate. Mr Oldham highlighted the following in relation to financial performance: • The Trust had a positive position of £5.2 m surplus although this had reduced from the previous month • The Trust was expecting to achieve its forecast or be slightly better than plan • Covid costs had reduced slightly from the previous month • £23.9 m of capital had been spent, which was £1.1 m behind plan. A lot of work had been undertaken to catch up and the Trust was on track to utilise the resources for the full year **The Trust Board received and noted the performance report.**	
CLOSING MATTERS		
16.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
063/2022	No further comments were raised.	
17.	**Questions from the Public**	
064/2022	Mr Syme referred to ambulance handover delays and performance in February 2022 whereby there were 1251 ambulances handovers delays exceeding 1 hour and up to 29th March, 3000 lost hours due to delays. He referred to the Trust having the lowest conveyance rates in the West Midlands and queried the original trajectories to reduce delays and by what date. In addition he queried if plans from other Trusts who were performing better, such as Walsall and University Hospital Coventry and Warwick had been reviewed. Mr Bytheway stated that the trajectories had been reviewed and despite various actions being taken a reduction had not been noted. He stated that the system were considering the extraordinary actions available to be taken to improve performance and agreed to provide a further to Mr Syme outside of the meeting. Mr Syme referred to ambulance delays and the impact on patients attending with possible stroke, hearts attack or fractured neck of femur (FNOF), given the importance of early treatment for these presentations. Dr Lewis explained that both heart and stroke patients required time sensitive treatments and data was recorded in terms of delays in addition to monitoring incidents via the mortality and morbidity meetings. He stated that whilst he was not able to answer the question specifically, data would continue to be collected to establish any impact on patient outcomes. He stated that in terms of FNOF patients, this was less time sensitive but agreed to consider any associated	**PB**

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	incidents in relation to these patients.	
DATE AND TIME OF NEXT MEETING		
17.	Wednesday 4th May 2022, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at 28 April 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/509	09/02/2022	Bi-Annual Nurse Staffing Review Update	To provide feedback to the Transformation and People Committee (TAP) on net numbers of nursing recruitment, how the position related to previous years, including turnover rates for nurses.	Ann Marie Riley	30/04/2022	27/04/2022	Paper included on April's TAP agenda.	B
PTB/510	09/02/2022	Integrated Performance Report - Month 9	To provide the Quality Governance Committee with further information in relation to deep tissue pressure ulcers	Ann Marie Riley	28/04/2022	28/04/2022	Pressure ulcer review paper included on April's QGC agenda.	B
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	04/05/2022		**Update to be provided.**	GB
PTB/514	09/03/2022	CQC Action Plan	To update the action plan and expand on the points raised in terms of measures of implementation and delivery and provide future updates on a quarterly basis.	Scott Malton Ann Marie Riley	08/06/2022		Action not yet due.	GB
PTB/515	09/03/2022	CQC Action Plan	To consider how demographic information within mental health needs risk assessments could be reported on going forwards.	Scott Malton Ann Marie Riley	06/04/2022	06/04/2022	It was noted that demographic information of those patients who had been sectioned would be reported going forwards in the quarterly report.	B
PTB/516	09/03/2022	Maternity Serious Incident Report – Quarter 3	To amend future reports to analyse ethnicity over a 12 month period.	Sarah Jamieson	08/06/2022		Action not yet due.	GB
PTB/517	09/03/2022	Maternity Serious Incident Report – Quarter 3	To amend future reports to include anticipated timescales to complete investigations in addition to identifying any particular learning points regarding emerging themes.	Sarah Jamieson	08/06/2022		Action not yet due.	GB
PTB/520	09/03/2022	Integrated Performance Report - Month 10	To provide an update to QGC in relation to the harm reviews undertaken for those patients waiting longer than planned, in terms of establishing any impact on their outcomes.	Ann Marie Riley	28/04/2022	28/04/2022	Harm review paper included on April's QGC agenda.	B
PTB/521	09/03/2022	Integrated Performance Report - Month 10	To provide a summary of the key trajectories to be achieved in the next few months in addition to identifying any particular vulnerabilities / challenges and discuss at PAF.	Paul Bytheway	31/05/2022		Action not yet due.	GB
PTB/522	09/03/2022	Integrated Performance Report - Month 10	To provide an update to PAF in terms of the assumptions associated with improving ED performance, the trajectory for improvement and associated timescales.	Paul Bytheway Jen Freer	31/05/2022		Target date moved from April. Delayed due to the need to understand the step change impact of a new stream in ED 'EhPC' implementation on non-admitted performance, triage performance and over all wait time in ED to then have a starting point for our recovery trajectory. EhPC goes live on May 1st and update to be provided to PaF in May.	GB
PTB/524	06/04/2022	Chief Executives Report	To provide an update to QGC on the implications and risks associated with the new patient covid testing guidance	Ann-Marie Riley Scott Malton	30/05/2022		Action not yet due.	GB
PTB/525	06/04/2022	Chief Executives Report	To provide a future Board Seminar on the integrated White Paper, enabling strategies and brap/staff survey action planning.	Claire Rylands	04/05/2022	07/04/2022	Complete - incorporated into the 2022/23 Board Development Programme.	B
PTB/526	06/04/2022	Integrated Performance Report - Month 11	To provide an update to Ian Syme regarding the ambulance holds trajectories and actions being taken.	Paul Bytheway	04/05/2022	28/04/2022	Meeting arranged for 28th April	B

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met virtually on the 20th April 2022. The meeting was a shortened meeting and focussed on the brap report. The following points were highlighted:

- A presentation highlighting the key findings from the report was provided to Divisions in addition to highlighting the key actions which were underway and were being planned.
- The need to challenge inappropriate behaviours was highlighted which included the need to empower staff to call out inappropriate behaviour
- The issue of grievances being formalised too often was raised, and the actions being taken to make the process quicker, in addition to resetting the Trust's approach to focus on early and informal resolution of issues were highlighted
- The need to increase diversity of Associate Freedom to Speak Up Guardians was raised, and it was noted that an ongoing recruitment campaign was underway to appoint additional associates
- Divisional staff welcomed the report and stated that as a result they felt more able to discuss cultural differences

Part 2: Chief Executive's Highlight Report

1. Contract Awards and Approvals

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

- **Extension of contract to Transfer patients for Bariatric Surgery to Private provider** supplied by Transform Hospital Group for the period 01/04/22 - 31/03/23, at a total cost of £790,000.00, approved on 06/04/22
- **Supporting Elective Orthopaedic Operating at RSUH** supplied by 18 Week Support for 3 months, at a total cost of £515,255.00, approved on 06/04/22
- **Patient Knows Best Patient Portal (NHSIE funded)** supplied by Patient Knows Best, at a total cost of £792,000.00, approved on 28/03/22
- **RS/1577/CAP – Grindley Hill Multi-story Car Park** supplied by IHP Vinci Construction, at a total cost of £518,914.61, approved on 24/03/22
- **Maintenance of Siemens X-ray Equipment** supplied by Siemens Healthcare, for the period 01/04/22 - 31/03/27, at a total cost of £3,036,704.00, providing savings of £13,459.00, approved on 06/04/22
- **Services of Junior Doctors via Health Education England** supplied by HEE, for the period 01/04/22 - 31/03/23, at a total cost of £4,259,482.00, approved on 06/04/22
- **Nursing Master Vendor Contract** supplied by Medacs, for the period 01/04/22 - 30/09/22, at a total cost of £1,200,000.00, providing savings of £24,000.00, approved on 06/04/22
- **Neurosurgery Consumables** supplied by various, for the period 01/03/22 - 28/03/23, at a total cost of £659,435.48, providing savings of £3,253.69, approved on 24/03/22
- **Outsourcing of Radiology Reporting** supplied by Medica Reporting, for the period 01/04/22 - 31/03/23, at a total cost of £2,000,000.00, approved on 06/04/22
- **Franking machine postage charges for 2022/2023** supplied by Pitney Bowes, for the period 01/04/22 - 31/03/23, at a total cost of £670,000.00, approved on 24/03/22
- **SHARPSMART (CLINICAL WASTE SHARPS)** supplied by Sharpsmart Ltd, for the period 04/02/22 - 03/02/24, at a total cost of £976,388.49, providing savings of £8,135.00, approved on 24/03/22

In addition, the following eREAFs were approved by the Performance and Finance (PAF) Committee in April and require Board approval due to their value:

Cytotoxic Dose Banded - Chemo, Immunotherapy and Monoclonal Medicines. (eREAF 9199)

Contract Value £3,036,079.00 incl. VAT
Duration 01/04/22 - 30/06/22
Supplier Baxter and Qualasept
Savings - Negated Inflation saving £81,974.14 incl VAT

Heart Valves Mechanical and Tissue (eREAF 9133)

Contract Value £2,045,150.40 incl. VAT
Duration 01/06/22 - 31/05/24 (including a 2 year option to extend)
Supplier Various
Savings - £11,497.67 Incl VAT

Pacemakers Devices and Loop Recorders (eREAF 9004)

Contract Value £1,200,000.00 incl. VAT
Duration 01/05/22 - 31/12/22
Supplier Various
Savings - Negated Inflation saving of £4,000 Incl VAT

The Trust Board are asked to approve the above eREAFs.

2. Consultant Appointments – April 2022

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Community Paediatrician	Vacancy	Yes	TBC
Locum Consultant General Surgeon - Upper GI (HPB) Surgery	Vacancy	Yes	TBC
Specialist Doctor in Clinical Oncology	Vacancy	Yes	01/06/2022
Locum Consultant in Renal Medicine	New	Yes	03/08/2022
Locum Consultant in Renal Medicine	New	Yes	03/08/2022

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

Post Title	Reason for advertising	Start Date
Specialist Doctor in Elderly Care	Vacancy	01/04/2022
Locum Stroke Consultant	Extension	01/04/2022
Locum Consultant Neurologist	Extension	01/04/2022
Locum Consultant obstetrician and Gynaecologist	Extension	01/04/2022
Locum Consultant Orthopaedic Surgeon	Vacancy	04/04/2022
Locum ENT Consultant	New	19/04/2022
Consultant Obstetrician	Extension	11/04/2022
General Paediatric Consultant	Vacancy	25/04/2022
Consultant Gynae Oncology	Extension	27/04/2022

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

Post Title	Closing Date	Note
Consultant Neurologist	04/04/2022	No Suitable Applicants
Locum Consultant Intensivist	03/04/2022	No suitable applicants
Consultant Intensivist	10/04/2022	No Applications
Locum Consultant in Emergency Medicine	24/04/2022	No suitable applications
Consultant Microbiologist	24/04/2022	No applications
Consultant Clinical Oncologist – Head & Neck, Thyroid and UGI	24/04/2022	No applications
Consultant Clinical Oncologist - Lung and Urology	24/04/2022	No applications

3. Internal Medical Management Appointments – April 2022

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Clinical Lead Emergency Medicine	Vacancy	Yes	07/04/2022
NICU Clinical Lead	Vacancy	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Clinical Lead Emergency Medicine	Vacancy	07/04/2022

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

Post Title	Closing Date	Note
n/a	n/a	n/a

4. Covid 19 and Trust Pressures

We have had some particularly challenging weeks during April as we continued to see very high volumes of sick patients attend our emergency departments and very high volumes of Covid-19 positive patients in our beds, although very few Covid-19 positive patients have required critical care. The impact of this new Covid-19 surge and the emergency care pressures was felt across the whole system and in response, a system critical incident was called as we headed into the Bank Holiday weekend. There were several factors which were being experienced by all healthcare partners but one of the most prominent for us all was staff sickness – which at UHNM half was related to Covid-19.

There were a number of actions that we had already taken to address patients waiting longer in our Emergency Department than any of us would want and this included moving one additional patient to each ward at Royal Stoke. We also booked additional medical shifts and had discussions with our partners around the support they could offer.

The above actions and effort by all meant that we were able to maintain safety through what was a very busy four day Bank Holiday weekend over Easter.

5. Integrated Care System (ICS) Board

The ICS Board held a meeting in public on 21st April 2022, where a number of items were considered; to summarise:

- A presentation about the vision for the Children's Integrated Care System Board to improve the health, care and wellbeing of Children and Young People
- Declaration of an ICS critical incident as a result of severe pressures on services across the system
- Community Rapid Intervention Service (CRIS) and West Midlands Ambulance Service (WMAS) working together to reduce patients waiting for an ambulance response with a shared IT platform
- Closure of some care homes to admissions due to workforce sickness and infection prevention requirements – impacting on the delivery of elective recovery programmes
- Multi Agency Discharge Events (MADE) being undertaken to bring a system wide focus to discharge
- ICS work stream updates including System Development Plan, Ready to Operate statements and Scheme of Delegation
- Appointment of four Executive Directors to the ICB (Paul Brown, Chief Finance Officer designate, Dr Paul Edmonson-Jones, Chief Medical Officer designate, Sally Young, Director of Corporate Governance designate and Heather Johnstone, Interim Chief Nursing & Therapies Officer designate)
- Development of an Organisation Development Plan
- Work being undertaken with regard to Place arrangements following publication of the Integration White Paper
- Staffordshire and Stoke on Trent Staff Wellbeing Week 25th April to 1st May 2022
- Development of the ICS Green Plan which builds on the NHS Trust Green Plans submitted in January
- The Voluntary Sector Alliance which aims to increase health equity in community based approaches
- An update on system Performance and Finance, Operational Planning 22/23 and System Quality and Safety

6. Single Health Resilience Early Warning Database (SHREWD)

On 11th April, to help support some of our system wide issues, our colleagues at the ICS launched an exciting digital platform which displays all urgent care data from the emergency care pathway across all partners. It is hoped that the SHREWD database will help us better manage our system pressures across Staffordshire and Stoke-on-Trent. The launch includes demonstration sessions and I am certainly looking forward to mine.

7. Culture and Bullying and Harassment Report

Last month we published the brap and Roger Kline Report which looked at the culture in our organisation. As well as making this available publicly we have made this available to all of our staff and we are asking all teams to discuss how the findings make them feel and to share ideas on how we can collectively address the issues it highlights. We will be developing a collective response to this, co-designed with our staff to ensure UHNM is a great place to work for everybody.

8. Freedom to Speak Up Guardian's Office

In April, our Freedom to Speak Up Guardian's Office, previously within our Human Resources Department, moved over to our Corporate Governance Department and Kerry Flint commenced her new role as Freedom to Speak Up Guardian on 4th April.

We have now launched an internal advert seeking expressions of interest for a number of volunteers to undertake the role of Associate Freedom to Speak Up Guardians, to support our Speaking Up activities and to help staff raise issues and concerns.

9. Ramadan

During the month we saw the start of Ramadan and took the opportunity to wish all of our Muslim colleagues a happy and healthy month. We made information available via our Intranet to all of our staff on how best to support colleagues during this time.

10. Enable – Managers Leadership Programme

We are delighted to have launched our new training programme for managers called 'Enable'. The programme has been designed by our People and Organisational Development team and looks to specifically embed appreciative enquiry and compassionate and inclusive leadership. We will be encouraging as many managers as possible to attend this programme and it is an expectation that anyone wishing to become a future UHNM manager will undertake this programme as a pre-requisite.

11. Da Vinci Xi Ecosystem

During the month we took delivery of the latest new generation da Vinci Xi ecosystem, replacing our first da Vinci Si robot, which was funded by our charity over seven years ago. The robot's dual console system supports the training for surgeons and trainee surgeons both internal and external in advanced surgical techniques. The latest £2 million robot was also funded through our charity and the team did not waste any time with the first patient benefitting from the minimally invasive surgery on the first day of its arrival!

12. NEW2 Health & Care System Recruitment Open Days

During the first two weeks of May there will be a series of events which are free to attendees, with some roles being showcased not requiring applicants to have any specific experience. There are a variety of health and care roles to learn about and discuss with managers, recruitment teams and employees on the days.

Together Compassion Safe Improving
PROUD TO CARE

Executive Summary

Meeting:	Public Trust Board	Date:	4th May 2022
Report Title:	Digital Strategy	Agenda Item:	7
Author:	Amy Freeman – Director of Digital Transformation		
Executive Lead:	Amy Freeman – Director of Digital Transformation		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

22938	Log4j Vulnerability	Ext 15
9036	Vulnerability to Cyber Attack	Ext 15
21784	Confidentiality, Integrity and Availability of Trust Information	High 12
22949	IM&T Contract Management	High 12
23759	Inappropriate clinical decisions due to large number of digital systems in place	High 12
9897	Insecure Information on Desktop PCs	High 12
23258	IT Leighton Hospital	High 12
22094	Lack of devices for windows 7 replacement project	High 12
10278	M2 pin error issues	High 12
23753	Network failure due to multiple service providers	High 12
23752	Patients receive incorrect medicines due to manual medication processes	High 12
12536	Replacement of data centre and infrastructure	High 12
17542	Restoration & Recovery - IT remote working, support and vulnerabilities	High 12
8849	Staff using unsecured and unlicenced personal phones for work email	High 12
23755	System failure due to lack of Information Technology Infrastructure Library (ITIL)	High 12

Executive Summary

The attached digital strategy sets out a digital journey between now and the end of 2024. The digital strategy is aligned to the Trusts key priorities; High Quality, Responsive, People, Improving & Innovating, System & Partners and Resources. The digital strategy also enables the Trusts Clinical Strategy, People Plan, Estates Strategy, Research and Innovation Strategy and Divisional Plans.

The digital strategy considers improvements in clinical digital services, foundation IT services (getting the basics right), professionalisation of digital and clinical digital staff, the digital skills of staff, data insights and innovation, working closely with system partners and business and communication services and as such is a holistic strategy considering people, processes and technology.

The digital strategy looks at the current complex technical landscape at UHNM with over 400 systems deployed across the Trust, a number managed by the central IM&T team and a number managed locally by divisions. It champions both the consolidation and simplification of systems but also a standard approach to system administration and support regardless of who supports the system. The document also poses the question of when to build on existing systems, when to purchase new systems, when to purchase and when to develop our own IT systems.

The digital strategy considers and responds to the national and regional digital agenda including white papers, strategies, mandates and guidance.

The digital strategy debates the digital governance arrangements with a proposed move from reporting to the Performance and Finance Committee to the Transformation and People Committee (TAP) as success will be highly dependent on business transformation, people development and culture. In addition the digital strategy looks to mitigate or minimise the digital risks identified on the Trusts risk register.

The digital strategy details the approach to investment and how business cases will be produced for the planned investments and where possible opportunity to apply for external funding will be sought. The strategy does however ask for recurrent funds to invest in:-

- Chief Nurse Information Officer and Divisional Digital Nurses of £91,357
- Additional Business Intelligence professionals enabling clinical and business insights to support clinical service development, day to day management and clinical modelling of £117,294
- Establishment of business relationship managers for the Trusts divisions to improve the relationship and service between IM&T and divisions of £154,230
- Training and continuous professional development for digital and digital clinicians to support professionalisation of £11,000.

Total recurrent investment requested of £373,881.

The digital strategy aims to tackle equality, diversity and inclusion both in terms of using data to support identifying and driving out health inequality but also ensuring digitally enabled services do not create a 2 tier health service and meet disability standards such as Web Content Accessibility Guidelines (WCAG) 2 Level AAA. It also details a commitment to ensure equality and diversity impact assessments are completed for all digital investments to ensure the technology does not disadvantage any protected groups. We will also look to use technology to help improve health services for protected groups through the use of technology such as screen readers and systems which support a number of languages.

The strategy details the delivery plan, the communication approach and how the progress of the strategy will be monitored.

Input has been sought for the digital strategy from:-

- Divisional Boards
- TEC
- Junior Doctors Forum
- Digital and Data Security and Protection Group

Key Recommendations

The Trust Board is asked to approve the digital strategy and agree for business cases to be developed when required (in relation to the recurrent £373,881).

The Trust Board is asked to note the proposed governance arrangements for the Digital and Data Security and Protection Group to report to TAP which will be reflected on the updated Corporate Governance Structure.

Digital Strategy

2022 - 2025

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1. Introduction

Our vision at University Hospitals of North Midlands (UHNM) is to deliver exceptional care with exceptional people and it has never been more important to enable this vision with supportive digital and data insight services. The delivery of digital technology and data driven insights can make a significant impact on patient outcomes through supporting service and pathway redesign, clinical decision support, enabling patient self-management, self-service, and increased productivity.

Study Paper for 2nd Lunchtime Seminar for Administrative Staff to be held at 12.30.p.m. on Thursday, 23rd May, 1968, in the H.M.C. Boardroom.

1. Introduction. In many ways the introduction of a computer into an organisation is a similar process to that involving any other new bit of complicated and expensive equipment. The need has to be ascertained by careful study by outside experts; their report has to be scrutinised carefully by management; and if approval is given a plan for introducing the equipment is needed, and a new type of staff have to be employed to work it. When it comes, some people already in post will have to learn how to use it, and its usefulness will have to be evaluated. This process has been followed for a new Maternity hospital, and will be followed again for a new path. lab., training school, and Surgical Block. It is most unlikely that the outside experts will offer to give a course of lectures on how these might work; will ask for many meetings with medical staff to persude them to use the new tools or ask for their advice in how they are introduced; will assent to and will even start discussions which say that administrators will have to have a new, long, cool look at their jobs. Is the reason for this that computer study teams are normally megalomaniacs? or just that North Staffs has been unlucky in the team it has got? Or is it in fact the case that there are special aspects of a computer project which have wider implications than most other new bits of equipment?

2. The Computer as Information Machine. There is so far no validated evidence about magalomania among systems consultants. There is, however, a fair amount of evidence to show that computer schemes in other contexts have succeeded in meeting their objectives, only if management at all levels has been fully informed about the implications, and staff are ready to do their jobs in new ways. This is particularly so where the attempt has been to establish so-called 'Management Information Systems'. That this should be so becomes apparent as soon as the computer is seen as an information machine, which potentially makes the information resources of the organisation available to be used in a way that has never been possible before. The use of a new memory, thousands of times faster, but in many ways less flexible, than the brain-and-paper systems it replaces, is clearly something which is likely to affect all levels of management, once the premise is granted that managers exercise control and make decisions largely through information which is fed to them (or which they labour to prepare), about how their department has gone on in the past, and what it is likely to be asked to do in the future. We can examine the premise if need be.

UHNM have a pedigree and heritage in leading the way in digital technology as evidenced by a copy of the original Study Paper into the implementation of a new computer system. In 1968 UHNM trail blazed work in the area of health care computer systems being one of the first hospitals in the country to do so. This was followed in the Millennium with the development of the Clinical Information System (CIS) which was one of the first portals specifically for clinical use in England to display clinical data from a range of best of breed systems in a single place. iPortal is the latest incarnation of the CIS and delivers not only a clinical portal but a clinical workspace where data is not just viewed but created. This strategy aims to challenge the organisation to celebrate and respect its digital roots and embrace digital in our pathways and processes.

When responding to the Covid19 pandemic, one of the most impactful tools at our disposal was digital and data. Digital services allowed us to enable staff to work effectively from home, book vaccination appointments and convert face to face appointments to video and telephone consultations to name but a few. Data, facts and analytics enabled us to provide meaningful insights about the health emergency we were managing. Data was essential to our day-to-day response including the management of nosocomial infections and planning Covid19 vaccinations. This strategy aims to build on the digital advancements seen during the Covid19 pandemic and seek out wider opportunities we have in relation to digital and data insights to improve safety, quality and service efficiency.

This digital strategy aims to set out how UHNM will use digital and data insights to enable the delivery of exceptional care including how we develop our exceptional people to be digitally confident. The strategy is grounded in delivering good foundation services for staff and patients in recognition that these core services are the building blocks for our digital ambitions.

As the Integrated Care System (ICS) of Staffordshire matures the development of system wide services and pathways will increase, this strategy will consider how digital services may need to adapt to enable greater cross organisational, frictionless working for the benefits of our patients.

2. Background

The Digital Transformation Strategy 2019 – 2023 set out a range of digital projects which together would improve the digital maturity of the Trust resulting in improved safety, quality and efficiency. A year after the Digital Transformation Strategy was approved Covid19 hit, some projects were accelerated because they supported the Trusts response to Covid19 such as remote consultations and virtual wards, however, some planned projects have been subject to delay as the digital team and clinical stakeholders were understandably reprioritised to develop a range of solutions in response to the pandemic.

The Covid19 pandemic has accelerated the adoption of technology and the demand for digital solutions from clinicians at UHNM has significantly increased and the digital service needs to respond to and build on this enthusiasm ensuring we are investing in the right tools for the job in a strategic and co-ordinated way.

As we adapt to live with Covid-19 we need to consider how we can eradicate the significant waiting lists caused by the pandemic. With big waiting lists and broadly the same numbers of staff to support our patients, we may need to look at reimagining how we can provide the right interventions to the right patients in the most time efficient way. Opportunities to reimagine the clinical pathways enabled by digital services from referral or admission to discharge should be considered which may include a wider use of video consultations, virtual clinics, additional virtual wards, pre-clinic questionnaires, straight to diagnostics, digital preams, post-operative digital guides, patient initiated follow up and self-care support.

With workforce gaps set to be with us for a while yet seeking out ways to make life easier for busy teams would be beneficial. Whilst there is no silver bullet for efficiency the digital teams must be challenged to make life easier. This could include connecting monitoring devices to the electronic observations system to improve accuracy and reduce the need for manual entry, speeding up computer log in times, reducing the number of systems that need to be checked, proactive support services reducing the need for clinicians to log support calls and eradicating dual keying for example. In other words we need to simplify.

At the last count the Trust identified 456 systems in use (clinical systems, enabling services systems and infrastructure systems) this complex array of systems results in confusion, systems contain overlapping capabilities, data is in silos and we don't have one system that tells our patients story. This strategy aims to consolidate the systems and tools we have and answer the key question about the direction of travel for our clinical systems. When do we expand on what we have, replace what we have, when to build systems and when to buy them with the focus on simplification and consolidation.

In 2021 the Trust has developed a clinical strategy which details that the future model of care will include a material shift from hospital care to a whole system approach, with care integrated across providers and locations. Many of the services will be provided in a community or home setting and pathways will be joined up, both in terms of information and care delivery. This hospital without walls approach will require clinical digital systems to be available anytime, anywhere and potentially by people outside of UHNM. Consideration will also need to be given to remote patient monitoring, patient system access and communication tools whilst keeping security and data protection at the forefront of our plans.

During 2021 the system landscape has changed with the establishment of the ICS and with the Integrated Care Board (ICB) coming into legal effect in 2022. Greater clarity over the form, function and responsibility of the ICBs is now available and UHNM are recognised as a key system partner. We recognise our responsibility to work closely with system partners and deliver digital systems and tools which may span the traditional boundaries of our hospital walls. UHNMs participation in the One Health and Care Record (Staffordshire Integrated Care Record) is an example of joint digital working but we will need to do more.

3. Context – where are we now?

Foundation IT

Over the last 2 years the Trust have invested in improving the IT infrastructure ready for the increased adoption of technology. This has included replacing out of date end user computers, data centre storage, single sign on technology to reduce the need for clinicians to remember multiple passwords and the implementation of cyber security solutions. This has been a very welcome investment and has started to make a difference to staff. During the Covid19 pandemic a large number of laptop devices were deployed to aid agile working and the virtual private network (VPN) solution was upgraded to support the increased number of staff working remotely. As more and more workflows turn digital we will need to ensure there is sufficient end user computers available on the wards and in the clinics for staff to use. Likewise as more services are delivered closer to the patients home the need to ensure our remote access services have the capacity to perform well will be critical.

The increased use of digital technology has resulted in an impact on the network which is provided by 2 suppliers.

- Nasstar who provide the network service at the Royal Stoke site through the Trusts private finance initiative (PFI) which is supported by the Estates and Facilities Directorate
- Premier Technical Services Group Ltd (PTSG) who provide the network service at County Hospital which is supported by IM&T.

This disjointed service provision does not currently meet the growing and changing needs of the Trust and is proposed to be addressed in this strategy.

Clinical Systems

The last 3 years has seen a real acceleration in the use and demand on technology. The current digital clinical system model deployed at the Trust is best of breed. Best of breed is described as "The best system in its referenced niche or category. Although it often performs specialised functions better than an integrated system, this type of system is limited to its specialty area only." These systems are connected together (where possible) through an integration engine and data is displayed through an in house developed clinical portal. This is a complex model and can result in some elements of the clinical record only being visible in standalone systems. This silo clinical data is a clinical risk.

There are 456 known IT solutions in use across the Trust some of which are supported by IM&T and others supported locally by divisional teams. Not all systems provide data to the Trusts data warehouse or Clinical Portal (iPortal) which can result in a disjointed record and limited data for reporting and analytic purposes. The way in which divisionally managed clinical systems are supported and maintained differ across the divisions and this results in a varied end user experience and limited system management assurance.

UHNM benefit from an in-house software development team. This skilled team are able to build web based applications to a specification of requirements to support changes to clinical and operational workflows. This benefits the Trust where commercial off the shelf products are not available or where our clinical system providers are unable to support the required changes within an acceptable or timely manner. Whist this self-build approach adds significant value it can also add risk especially when the team is small and as such the decision to build over buy needs to be a conscious decision.

The Trusts main electronic patient record (EPR) is supplied by System C. The following capabilities are deployed across the Trust:-

- CareFlow Patient Administration System (PAS)
- CareFlow Business Intelligence
- CareFlow Order Communications & Results Reporting

- CareFlow Emergency Department
- CareFlow Vitals
- Bluespier Theatres

The Trust also has the following projects in flight:

- CareFlow Connect (clinical communication tool) – live in pilot mode only
- CareFlow Medicines Management (including First Databank's Multilex drug database)
- PDS – the Trust has licensing to enable Patient Demographic Service (PDS)/CP-IS deployment
- Discharge summary, using CareFlow Clinical Narrative

The Trust does not currently use the following System C solutions:

- CareFlow Vitals Maternity and Paediatric modules
- Patient Flow (bed management)
- CareFlow Clinical Narrative (clinical noting)
- CareFlow Care Planning
- CareFlow Clinical Workspace

A number of the systems not in use at UHNM compete with our in-house developed solutions iPortal and Ward Information System (WIS). The benefits of these in-house solutions should be assessed against the benefits of adopting the CareFlow alternatives.

The contract with our current EPR supplier ends in September 2022, to replace this system it is a 4 year process (18 months to produce the required strategic outline case, outline business case, competitive procurement and full business case) and 24 months to implement a Trust wide solution. An extension with our current supplier will be secured and the opportunity will be taken to test the market for one of the options below.

Option	Name	Description
Option A	Best of breed EPR	Each element is sourced from the supplier shown to provide the best capability and value for money for that required functionality
Option B	Best of Suite EPR	A core set of functionality is sourced from a single supplier where these elements are naturally integrated. This core is as large as practicable. Outside of the core systems are procured on a best capability and value for money basis but ensuring they interface tightly with the core EPR
Option C	Single Integrated EPR (Wall to Wall)	The complete range of required functionality is sourced from a single supplier who will provide a fully integrated EPR

This market testing will lead us to answer the question of should we enhance what we have, replace what we have, build systems ourselves or buy commercially available solutions.

The Trust is in the middle of replacing its laboratory information management system (LIMS) which should be finished in the autumn of 2022.

Medical Devices

The Trust deploys a large number of medical devices, as technology advances the line between medical devices and digital clinical systems starts to blur. The integration of medical devices and in particular the data feed from the device into the patient record stored in the digital clinical system can deliver improved decision making, self-care opportunities and improved safety.

It will be important that as new medical devices are procured this interoperability is considered so the benefits can be exploited. A closer working relationship between Clinical Technology and IM&T will be required going forward to ensure compatibility and security of the devices.

Business Systems

The workforce, procurement, estate management, quality management (incident and risk) and finance systems are operated, supported and trained by the relevant responsible department. The digital workflows vary from department to department. This is an area to further exploit digital opportunities to eradicate paper based processes, manual workflows and repetitive transactional activities. For example in the area of Theatre Stock Management.

Support Arrangements

As the dependency on digital services continues to increase we need solid and resilient infrastructure to be available to enable new digital initiatives and a move away from paper. Delivering highly available IT is just as much about the people, processes and maintenance schedules as it is about the technology. The Trust uses elements of Information Technology Infrastructure Library (ITIL) which is a globally recognised best practice methodology for IT service management. We need to embrace the changes that have come with ITIL V4 and implement elements not currently deployed such as event management, problem management, knowledge management and release management processes. This will help move the support service from a reactive user contact driven support service to a proactive maintenance service. To do this we need to equip our support teams with the skills and knowledge to deliver proactive services. A skills and development framework is required to ensure staff have the skills and experience to move to event and maintenance driven service.

Digital systems outside of IM&T need to be managed to the same standard as those managed by the IM&T team and as such the development of a support framework will set out the business change, support, maintenance and management standards that need to be met.

People & Culture

The IM&T department employs 123 digital, data and records staff covering the following disciplines

- Data protection and security
- Health records (digital and paper)
- Clinical system training
- Clinical system support
- IT operations
- IT service desk
- Programme management and business change
- System development
- Business intelligence
- System integration
- Desktop services
- Telecommunications (inc switchboard)

Historically access to professional training for our digital and data professionals has been limited. The formal recognition and professionalisation of our digital staff will improve the quality of our service and support the recruitment, retention and grow our own skills agenda.

UHNM benefits from a highly engaged Chief Clinical Information Officer (CCIO) who is supported by Divisional Chief Clinical Information Officers (DCCIO), these clinicians are the eyes and ears of their division. Our nursing, midwifery and allied health professional (AHP) colleagues do not benefit from the same level clinical digital representation and we look to address this in this strategy.

The digital confidence and capabilities of staff varies but is yet to be base lined. Formal training is available for the main clinical systems in use across the Trust, however, divisionally managed systems are not subject to formal training. Basic computer confidence and training on Microsoft Windows and Microsoft Office products are not available. The development of digital skills feels like an opportunity and a necessity for the Trust. Only with improved digital confidence will we foster a digital first culture

where people are thinking about how technology can help them resolve a problem they face. We are quite some distance away from digital first thinking.

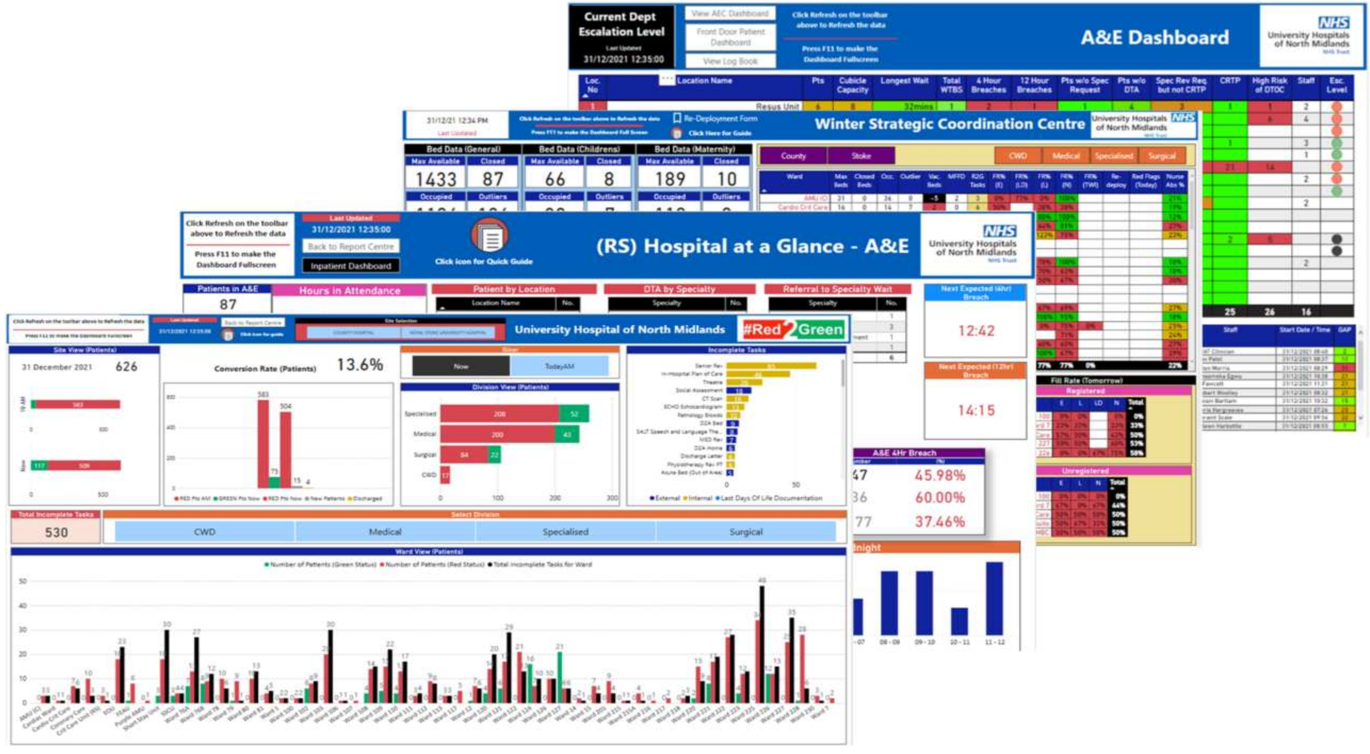
Data and Insights

The Trust benefits from a clinical data warehouse which contains information from the following systems:-

- CareFlow PAS
- CareFlow Emergency Department
- CareFlow Order Comms and Results Reporting
- CRIS
- Bluespier Theatres
- Red to Green
- WIS
- iPortal
- K2 Maternity
- Picanet
- Badger
- Netcall Friends and Family
- Medisec
- Audibase Audiology Feeds

However, a significant amount of data required by operational, clinical and management teams is collated manually due to the inconsistent use of clinical systems and unavailability of real-time clinical noting. The move to real-time recording would unlock significant potential in the use of data to drive automated workflow, decision making and clinical alerts for example bed management. This will be a significant cultural change.

There is an opportunity for improved data analytics and insights if other clinical system data was to be available in the data warehouse. In addition if we added data from other Trust business systems such as incidents, risks, workforce and finance it would allow the triangulation of data to enable improved insights to support better decision making. This would allow us to move to a self-service reporting model where staff could look for information when they needed it and slice the data to suit their needs. This is dependent on the individual being able to trust the data they see in the dashboards and that is depending on a shift to real-time use of our clinical systems by all.



Analysis Approach

The digital strategy has been informed using 2 analysis frameworks. A Strengths, Weaknesses, Opportunities and Threat (SWOT) analysis which allowed critical reflection of the current digital capabilities in the Trust. A Political Economic, Social, Technological, Legal and Environmental (PESTLE) analysis which enabled the consideration of wider factors which may impact the organisation and the plans.

SWOT Analysis

Strengths	Weaknesses
• Dedicated Workforce • Skilled Digital Workforce • In House Development Capability • Medical Digital Leadership • Improving Foundation Capabilities	• Single Points of Failure (people) • Limited Training and Education Opportunities • Limited Nurse/Midwife/AHP Digital Leadership • Limited Operational Engagement • Inconsistently managed departmental solutions • Inconsistent network service provision • Slow log in times • Reactive support service with a large support call backlog • High number of systems in use leading to silo data and multiple user credentials.
Opportunities	**Threats**
• Cloud • Artificial Intelligence • Robotic Process Automation • Exploit Existing Technology • Genomics • Increased focus on business systems • Move to proactive support services • Regional Digital Approach	• Regional Digital Approach • National Change of Direction • Limited Funding • Cyber Security

PESTLE Analysis

Political	Economic	Social
• ICB • ICP • Placed Based Partnerships • Provider Collaborations • Primary Care Networks • NHSX • NHSD • NHSI/E • CQC	• Annually Set Budgets • Third Party Price Rises • Digital Workforce Gap 32,000 by 2030	• Patient Demand • Patient Digital Capabilities • Patient Self Care Compliance • Low average reading age in Stoke on Trent • 20% most deprived unitary authorities in England • Higher than average citizens with long-term sickness • Below national and regional average hourly pay
Technological	**Environmental**	**Legal/Regulatory**
• Rate of Technical Change • Cyber Security • Artificial Intelligence • Robotic Automation • Technology Obsoleteness • Build or Buy • Data Science	• Net Carbon Neutral • Waste from Electrical and Electronic Equipment Regulations • Protection from Natural Disasters (Flood) • Cooling Data Centres as outside temperatures rise	• GDPR • Data Protection Act • ICO • Information Standards Notices • DCB 1596 • DCB 0160/0129 • Cyber Essentials • Data Security and Protection Toolkit

4. How we have developed this strategy

The development of this strategy started with a review of the Trusts current strategies and where the delivery of these strategies could be enabled and enhanced by technology. The strategy has been developed with our CCIO and DCCIOs and has been reviewed through the Trusts digital governance structure.

A review of our current digital capabilities has also been undertaken. 2 frameworks were assessed;

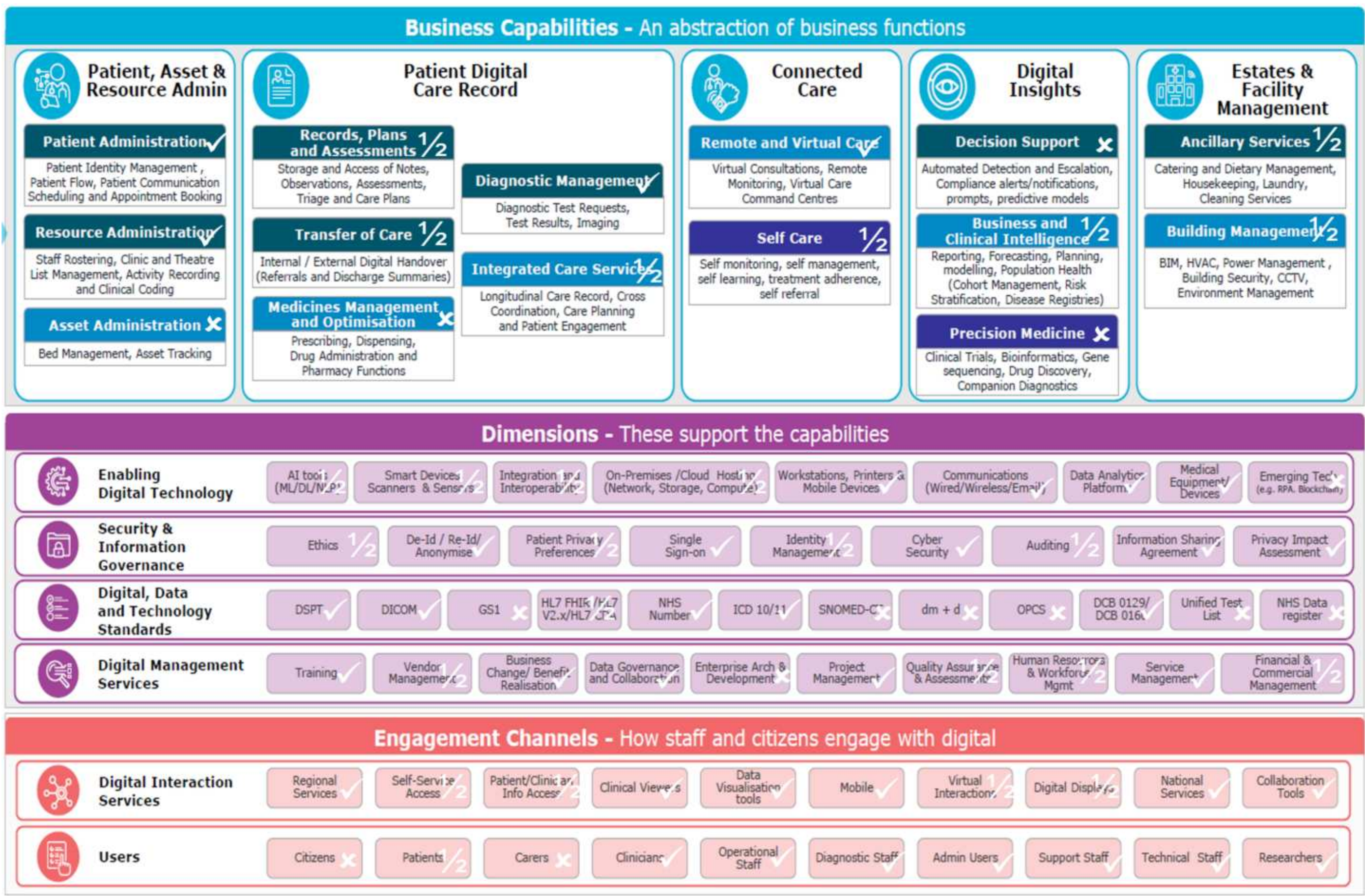
HIMSS - EMRAM
The Electronic Medical Record Adoption Model, EMRAM - is a unique evaluation model, which analyses the maturity of IT environments in hospitals and enables benchmarking during the implementation of Digital Clinical System (DCS) technology. The model identifies the level of DCS capabilities ranging from limited ancillary department systems through to a full paperless DCS environment. This review included a self-assessment exercise in which we self-assessed at 1.8 and an on-site independent assessment which was scored 2 out of a possible 7.

Stage	Clinical Documentation	EMR/CDR	IT Security	Closed Loop Administration
Stage achievement	0	6	0	0
Percent achievement	27%	100%	88%	6%
Stage 6	0%	100%	92%	6%
Stage 5	5%	N/A	100%	N/A
Stage 4	60%	100%	100%	N/A
Stage 3	0%	N/A	100%	N/A
Stage 2	N/A	100%	100%	N/A
Stage 1	N/A	100%	N/A	N/A

NHSX What Good Looks Like Framework
The What Good Looks Like (WGLL) framework is a model that looks at the required digital capabilities across 7 domains. Well Led, Ensure Smart Foundations, Safe Practice, Support People, Improve Care, Healthy Populations, Empower Citizens. It builds on established good practice to provide clear guidance for health and care leaders to digitise, connect and transform services safely and securely. This will improve the outcomes, experience and safety of our citizens. The UHNM average score for the framework is 1.6 out of a possible 5, more details are available in the diagram below.

These reviews enabled the Trust to prioritise investments and monitor progress in a structured way.

NHS Digital Hospital Blueprint
In 2021 NHSX released the digital hospital blueprint. This document sets out a Blueprint for Digital Innovation in digitally advanced hospitals. The blueprint capabilities have been assessed and mapped, ✓ = UHNM have the capability, × = UHNM do not have the capability, ½ = UHNM have some capabilities but not all.



Items in green are classed as foundation capabilities, items in light blue are transformational capabilities and items in dark blue/purple are innovative capabilities. It is proposed that initiatives are prioritised in that order.

Finally we have taken in to account the SWOT and PESTLE analysis looking at how we can build on our strengths, mitigate our threats and exploit our opportunities.

5. Where do we want to get to?

The vision for the digital service is

"Delivering Exceptional Care with Exceptional People enabled by Exceptional Digital Services".

We want to:-

Enable High Quality care through the delivery of a mature clinical digital system capable of:-

- Contributing to delivering exceptional care with exceptional people by putting digital solutions and data insight into the hands of front-line staff and patients to support clinical decision making, increasing clinical safety, process automation and improving clinical outcomes.
- Reducing medication errors with electronic prescribing and medicines administration.
- Reducing the clinical risk of our clinicians not being able to see the whole clinical record, by having all clinical documentation held digitally and being accessible in one place. Consideration will be given to how this is best delivered; enhance or replace, build or buy.
- Ensuring important clinical tasks are not missed through the implementation of clinical task management and clinical communications.
- Supporting improved data quality through championing real time digital record keeping and producing data quality insights.
- Reaching HIMSS EMRAM level 5 in 3 years which will deliver all capabilities from 0 to 5 detailed in the diagram below.

STAGE	HIMSS Analytics EMRAM EMR Adoption Model Cumulative Capabilities
7	Complete EMR: external HIE, data analytics, governance, disaster recovery, privacy and security
6	Technology enabled medication, blood products, and human milk administration; risk reporting
➤ 5	Physician documentation using structured templates; full CDS; intrusion/device protection
4	CPOE; CDS (clinical protocols); Nursing and allied health documentation; basic business continuity
3	Nursing and allied health documentation; eMAR; role-based security
✓ 2	CDR; Internal interoperability; basic security
✓ 1	Ancillaries - Lab, Rad, Pharmacy, PACS for DICOM & Non-DICOM - All Installed
✓ 0	All Three Ancillaries Not Installed

Be Responsive through ensuring our staff can access our digital systems with modern devices which are underpinned by excellent support services:-

- Developing a proactive event and maintenance driven service reducing the need for front line staff to log support calls.
- Reducing the number of network services providers and simplifying the network to improve performance and reduce downtime.
- Increasing the availability of end user computer devices selected by ward staff to best suit their requirements. Proactively support these devices by moving to a proactive maintenance model. Ensuring these devices are refreshed regularly to ensure good performance.
- Minimising the downtime of clinical systems caused due to cyber security threats by operating effective cyber security processes, monitoring and maintenance.
- Ensuring the performance of our systems through ensuring new products and services meet our architectural principals.
- Reducing the time staff spend logging into our systems and services by doing a deep dive on log in times.
- Offering maximum flexibility to our staff by using cloud services to deliver key systems over the internet available on most devices.
- Developing a support framework for systems supported outside of IM&T to ensure they are appropriately and robustly managed including business change.

Improve and Innovate through delivering data insights to clinical and operational staff. Using data to support the prioritisation and monitoring of improvement initiatives:-

- Enabling confident clinical and business decision making through the availability of rich data intelligence.
- Increasing the systems that feed the data warehouse to allow for more data to be available for analysis. This will allow data to be triangulated for improved insight for example performance data with staff data with incident data.
- Enabling more staff to have access to tools and validated data so they can dig into their own data to find insights.
- Adopting an agile development method to give end users early visibility of solutions and dashboards.
- Engaging actively with the Trusts Research and Innovation agenda ensuring any digital innovations are safe, secure and appropriately supported.

Work with Systems and Partners to do the initiatives that make sense to do together, together. Enable integrated pathways with integrated technology and data:-

- Enabling hospitals without walls to support integrated care. As Acute and specialist Trust we will look to enable care being delivered closer to the patient's homes and the local community, breaking down barriers between care settings for an improved patient experience. A 'virtual first' model prioritising remote care will help to manage service demand, optimise triage and be more convenient for some patients.
- Increasing the clinical information that is available in the One Health and Care System to increase its value to clinicians.
- Providing data to enable system level dashboards and data insights to support planning and prioritisation.
- Ensuring solutions meet NHS interoperability standards to enable integration both now and in the future.
- Considering participating in shared services where this maintains or improves quality without increasing the cost to the system or Trust.
- Working as a system on enabling a single co-ordinated offer of digital channels for citizens across the system and roll out remote monitoring technologies to help citizens manage their care at home.

- Contributing to the system plan for embedding population health management capabilities and ensuring these are supported by the necessary data and digital infrastructure, such as linked data and digital interventions

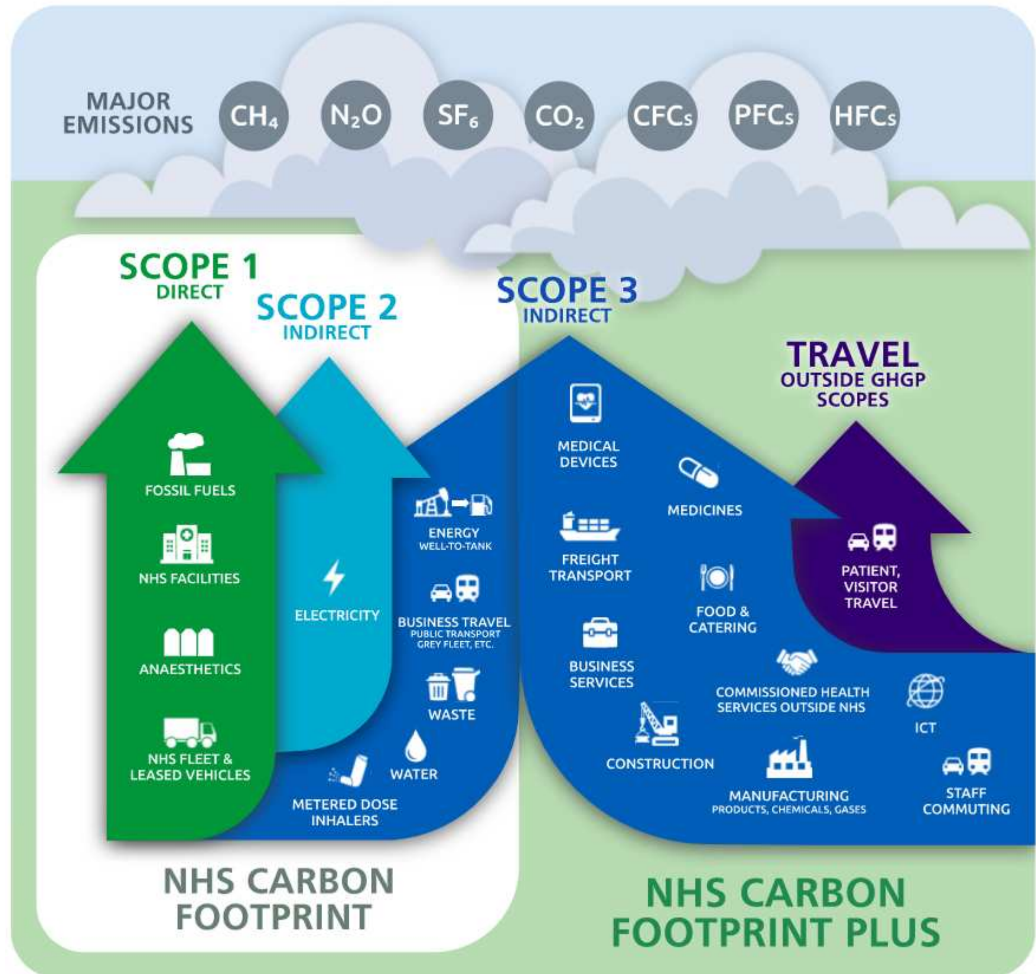
Empower People both patients and staff to make the most to the technology available and to confidently get involved in the future of digital healthcare:-

- Fostering a digitally confident workforce through effective learning, development and inspiring digital clinical leadership. This will include the establishment of technical communities of interest where staff can share hints, tips, ideas and learning.
- Giving our nurses, midwives and AHPs a loud digital voice allowing them to shape the future of digital clinical systems.
- Providing the training and support for staff to use technology to the fullest.
- Recognising the various professions within digital and ensure staff have the opportunity to professionally develop with recognised qualifications and professional body membership, making most of the apprenticeship levy.
- Promoting a culture of digital innovation encouraging all staff to consider digital solutions to clinical problems. Promoting the use of the Improving Together A3 Improvement Tool to really understand the problem or opportunity for improvement and consider if digital solutions could be effective countermeasures.
- Developing a grow our own skills programme of digital staff in anticipation of the digital workforce gap of 32000 staff by 2030.
- Digitally empower patients with a range of instinctive and informative digital tools and services, promote self-care and active engagement with healthcare services reducing the number of times they need to visit our hospital locations to receive care.
- Offering all patients the option of video consultations for appointments that do not require the clinician to undertake a physical examination.
- Giving patients access to their care record, letters, appointments, care plans, condition specific information, surveys, polls and questionnaires.
- Researching existing citizen digital training services available in Staffordshire and work with communications to develop a micro site which details the opportunities. Also ensure front line staff are able to signpost patients to digital skills services to improve their digital confidence and increase the likely hood of them engaging in digital health services. Work with the ICS to support a system approach to citizen digital skills.
- Evaluating our quality impact assessment process to ensure it is effective in evaluating the digital exclusion of patients and undertake a quality impact assessment for all innovations and systems to ensure digitally excluded patients do not receive a reduced service as a result.

Make the most of our Resources through optimising business and communication systems to improve efficiency:-

- Improving business efficiency through reimagining current paper driven or silo processes, simplifying or automating processes.
- Improving clinical communication efficiency through the replacement of non-critical pager services with a fit for purpose communication solution.
- Enabling the ability to take and make Trust phone calls from any location and on many devices (mobile, computer, tablet).
- Developing learning and improvement through developing communities of interest to share good practice, lessons learned and support using digital tools to enable these communities to share in both real time and asynchronously.
- Establishing a programme management solution to enable the visibility and prioritisation of projects across the Trust ensuring they are aligned to the Trusts key priority domains.
- Improving communication across the Trust by giving all staff Office 365 which includes email, Microsoft Teams, Viva (employee experience and engagement platform), Forms, SharePoint online, OneDrive allowing maximum flexibility to staff.
- Reducing stock wastage through the implementation of a Theatre Stock Management Solution

- Contributing to delivering a net zero NHS through improved sourcing, improved compute management e.g. cloud and tools to reduce staff, patient and visitor travel.



Trusts Strategic Initiatives

We want to enable the Trusts Strategic Initiatives with the required digital capabilities.

Positive and inclusive culture will be supported by:-

- Delivering digital tools and services allow staff to work more efficiently and effectively from any location to support agile working.
- Viva (employee experience and engagement platform) as part of Office 365. Microsoft Viva brings together communications, knowledge, learning, resources, and insights into an integrated experience that empowers people and teams to be their best, from anywhere.
- Ensuring digital solutions are evaluated from a quality impact assessment to mitigate against digital exclusion.
- Ensuring technologies such as Artificial Intelligence and Machine Learning are analysed to be assured the solutions are not subject to data, analytical or societal bias.

Improving Together will be supported by:-

- Delivering a programme management solution to enable the visibility and prioritisation of projects across the Trust ensuring they are aligned to the Trusts key priority domains.
- Improving data warehouse services to increase the data available for reporting and analytics to support the Improving Together programme.

- Working with the Improving Together team to support the digitisation of elements of the Improving Together standard work for example looking at a digital strategy deployment room and digital quality improvement boards.

Elective Recovery:-

- Delivering a patient portal to support the elective pathway which would include; patient letters (appointments, discharge, clinical), appointments (calendar, cancellations and rebooking), condition specific libraries of content (videos, leaflets, guides, exercise sheets), patient surveys, polls, questionnaires and clinical forms such as Preams, patient and speciality communication (chat, picture sharing, video sharing), PIFU workflow, care plans and emergency care plans, patient added information such as weight, cigarettes smoked, alcohol consumption, pain levels, blood sugars etc.
- Working with the programme to identify any dashboard or reporting requirements to support elective recovery.
- Working with the programme to identify any digital solutions to support elective recovery.

Waits and Flows:-

- Delivering a clinical system and data insights to enable visibility of the pathway and any bottle necks.
- Delivering data insights that allow the detailed analysis of medically fit for discharge patient journeys and right to reside data.
- Evaluating the current multidisciplinary approach to complex discharges and identify if these could be improved with enhanced digital solutions and data insight.

System Alignment:-

- See System and Partners section

6. How we will get there

This strategy will be delivered as a series of interdependent and interlinked programmes and projects managed by the digital programme office. Projects will be delivered adopting either the Prince2 project management methodology or Agile Project Management (APM) whichever is proportionate and appropriate for each project.

Each project will have a defined project organisation/structure and governance arrangements established which will direct the project and ensure delivery. These projects will report into the IT Programmes Operational Group and up to the Executive Digital and Data Security and Protection Group.

Where projects are new and investment is significant, complex or contentious a business case will be produced in line with the Trusts standing financial instructions. The business case will be processed for approval in line with the standing financial instructions and is a gateway to ensure the initiative is clearly defined and benefits and costs are understood.

Where projects are aligned to the ICS, digital joint governance, reporting and delivery work streams will be established to ensure alignment and skills sharing.

Essential to the delivery of this strategy is the effective engagement of clinicians as well as operational leaders. Clinical engagement is essential if Digital and Data Insight projects and changes are to be seen as enablers to clinical and service improvements. Large projects will benefit from the creation of stakeholder engagement groups and Clinicians and Business Leaders will:-

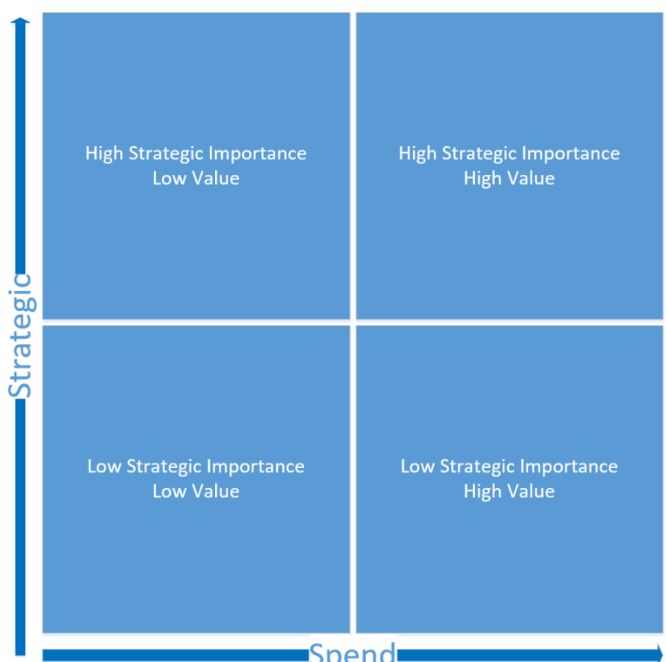
- Drive the design and introduction of new technology and clinical systems

- Become responsible for the ownership of systems, and
- Be held accountable for the realisation of benefits associated with the implementation of clinical and business systems.

Clinicians are the public face of the organisation. They have considerable experience of the NHS. This gives them a wealth of knowledge about the strengths and weaknesses of Trust systems and processes, and also puts them in a good position to determine what will work. They should have a clear understanding of how developments in Digital and Data Insights could help improve the quality of care and patient safety. We will build upon relationships with the professional groups who are affected by the large projects as these will be responsible for, and deliver, much towards the success of this strategy.

The clinical voice will be heard and their views will be incorporated in the case for change, and in articulating clinical, business and patient benefits.

An integral part of the delivery of the strategy will be our relationships with our supplier partners. In 2021 the Trust Executives agreed a new IT Commercial Manager post for the Trust. This post aims to improve our relationships and drive value with our suppliers. The post holder will map our current suppliers to the matrix below and set up supplier management processes and routines for each quadrant and the suppliers will be engaged in line with the routines.



The IT Commercial Manager will also ensure that suppliers have effective contracts and are procured through a competitive procurement process.

This focus on supplier relationships will enable us to drive value and quality of our digital services.

UHNM have over 450 systems in use (as identified during the Log4J cyber security incident), these standalone silo systems can result in increased risk in the following areas:-

- Incomplete clinical record due to silo solutions not feeding the Trusts clinical portal, digital clinical system, patient held record and ICS wide population health management system.
- Duplicate clinical system functionality due to local purchasing decisions.
- Increase in Cyber Security vulnerabilities which if exploited could result in IT services being unable to staff and patients resulting in the cancellation of clinical activity.
- Increased complexity for clinical staff, multiple systems to use and update which can lead to information being missed.

A number of these systems deliver similar or competing features and all require support, maintenance and upgrades. The strategy aims to reduce the number of systems in use through improved system introduction governance on the back of the nationally mandated digital technology assessment criteria (DTAC).

7. Alignment to our Trust Strategy

This digital strategy is directly aligned to the Trust Strategy and the connections to the vision, values, key priority domains and Trust Strategic Initiatives have been drawn out in the document.

The illustration below provides an overview of how the enabling projects align to the Trusts key priority domains.

Influences

Trust
- Trust Strategy
- Clinical Strategy
- People Plan
- Divisional Plans
- Improving Together
- Estates Strategy
- Research and Innovation Strategy

ICS/Regional
- Together We're Better
- Staffordshire and Stoke on Trent Digital Strategy
- MPFT Digital Strategy
- Combined Healthcare Digital Strategy

National
- NHSX What Good Looks Like
- NHSX Data saves lives: reshaping health and social care with data
- NHSX Digital Hospitals Blue Print
- NHS People Plan
- The future of NHS human resources and organisational development
- Harnessing the information revolution
- Making IT Work
- The future of healthcare: our vision for digital, data and technology in health and care
- Digital transformation in the NHS
- Delivering a net zero NHS
- Joining up care for people, places and populations

Digital Strategy on a Page

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

Resources Business & Comms
- Office 365
- Viva (communication and engagement)
- Microsoft Teams & Telephone Integration
- Pager Replacement
- Programme Management Solution
- Paper Process Replacement
- Workforce System Enhancement and Integration
- Net Zero Carbon Footprint

High Quality Clinical Services
- HIMSS Level 5
- Nurse & AHP Documentation
- Medical Documentation
- Electronic Prescribing
- Scans & Image Viewing
- Task Management & Clinical Comms
- EPR Procurement Planning
- Improved End User Experience
- Laboratory Management Information System
- Digital Pathology

System & Partners
- One Health and Care System Enhancements
- System Dashboards and Intelligence
- Technology to support integrated pathways
- West Midlands Imaging Network
- North Midlands and Cheshire Pathology Network
- Cancer Alliance

Responsive Foundation IT
- Network Service Improvements
- End User Computer Availability
- Ongoing Refresh Programme
- Exploiting Cloud
- Proactive Support Model
- Log in Performance
- Cyber Security Services
- Architectural Principals & Standards
- Virtual Desktop

Improving and Innovating Data Insights
- Data Warehouse Refresh
- Increased Data Feeds
- Power BI – Cloud
- Clinical Insights
- Business Insights
- Agile Development Adoption
- Digital Research and Innovation

People
- Establishing the Office of CCIO & CNIO
- Digital Confidence Programme
- Digital Team Professionalisation
- IT System Management Standards
- Digital Workforce Gap
- Patient and Carers Portal
- Patient Digital Letters
- Patient Self-care
- Patient Virtual Interactions
- Patient and Carers Digital Skills
- Patient and Carers Digital Exclusion

Vision:
Delivering Exceptional Care with Exceptional People enabled by Exceptional Digital Services

7.1 Alignment to our Key Enabling Strategies

The digital strategy directly underpins the Trusts other enabling strategies providing the technology, innovation and data insights to support the delivery of the vision.

Delivering high quality clinical system services and HIMSS EMRAM level 5 digital clinical systems supports both the Clinical Strategy and Quality Strategy.

Delivering responsive foundation IT and support services supports the Estate Strategy and People Strategy.

Delivering the range of projects under the people key priority domain focused on both patients and staff supports the People Strategy and Clinical Strategy.

Delivering improved data insights and innovation as detailed in the improving and innovating key domain supports the Quality Strategy, Clinical Strategy, People Strategy and Research and Innovation Strategy.

Delivering initiatives outlined in the system and partners key priority domain supports the Clinical Strategy as we look to move to a hospital without walls approach to care.

Delivering the improved communication tools and paper free business processes as detailed in the resources key priority domain supports the People Strategy and Finance Strategy.

8. Alignment to System Plans

As the Integrated Care System (ICS) of Staffordshire matures the development of system wide services and pathways will increase, this strategy will consider how digital services may need to adapt to enable greater cross organisational, frictionless working for the benefits of our patients.

To date UHNM have participated in:-

- Providing data to the One Health and Care record which is an integrated care record for people living in Staffordshire and Stoke on Trent.
- Providing the digital solutions for the Community Rapid Intervention Service which is leading to a reduction in Emergency Department attendances.
- Shrewd system dashboard.

Further joint work will be required as more integrated pathways are developed.

In June 2021 the Integrated Care Systems: design framework was published by NHS England and NHS Improvement which sets out in the section on data and digital standards and requirements, the obligations and expectations of digital and data. As an Acute provider we will need to support and collaborate with our ICS digital colleagues to enable these standards and expectations.

9. Alignment to National Policy and Plans

Strategy has its origins in a number of Government policy initiatives and NHSx papers, as now described.

- Data Saves Lives: Reshaping Health and Social Care with Data - June 2021
- What Good Looks Like (WGLL) Framework - August 2021
- Future of human resources and organisational development report - November 2021
- The NHS Long Term Plan – August 2019
- Integrated Care Systems: design framework – June 2021
- Digital Technology Assessment Criteria (DTAC)
- NHS England - Cyber Security Programme
- Delivering a net zero NHS
- Joining up care for people, places and populations – February 2022

Data Saves Lives: Reshaping Health and Social Care with Data

This NHSx strategy sets out 7 goals to improving care through the exploitation of data.

- Bringing people closer to their data
- Giving health and care professionals the data they need to provide the best possible care
- Supporting local and national decision makers with data
- Improving data for adult social care
- Empowering researchers with the data they need to develop life-saving treatments, models of care and insights
- Helping colleagues develop the right technical infrastructure
- Helping developers and innovators to improve health and care

As an acute and specialist Trust there are a number of areas where we can support this NHSx strategy and these have been included in this Strategy including the delivery of patient portal technology, enhanced data warehouse and analytics services, enforcement of interoperability standards and improvements in the transfer of care documentation.

NHS Number

Consistent use of the NHS Number as the **medical records identifier** across COVID services.

Patients will be asked their NHS Number and be guided to finding it if they are unable to state it.

Structured Data Store

A **structured data store** for all **clinical events**. This will be populated by COVID-19 services and **made available via open APIs** for other digital services to consume. Patients will **access via NHS app and NHS.uk**

Improved Patient Experience

COVID-19 services will **use NHS Login** to improve the experience and avoid having to constantly enter the same personal info. It will be backed by **My NHS Account** with patient details, access to health services, booking/ changing appointments, vaccination status, health records and personalised wellness services

Consistent Digital Communications

Patients will be able to **update their contact details electronically** with the change feeding into all national IT systems. Further work is required to change addresses as the process for this is defined in the GMS Regulations.

Consistent Staff Identity

Establish a **single staff identity system** converging the range of systems in place currently. This would reduce delays in onboarding staff, the administrative costs and the cyber and fraud risk due to a unified audit log.

Sharing Data

Agree on the approach to **data architecture** for the system to accommodate the range of organisations interested in COVID-19 data; ensuring a strategic approach to data analytics and having a single version of the truth.

What Good Looks Like Framework

The 'What Good Looks Like' framework was published to build on good practice and to provide guidance for the safe and secure digitisation of health and care services in support of the Long Term Plan aspirations.

The WGLL has been included by NHSE/I in both the ICS design framework and the NHS Operational Planning and Contracting Guidance, reflecting the expectation that the standards in the WGLL framework will be used to accelerate digital and data transformation across the NHS.

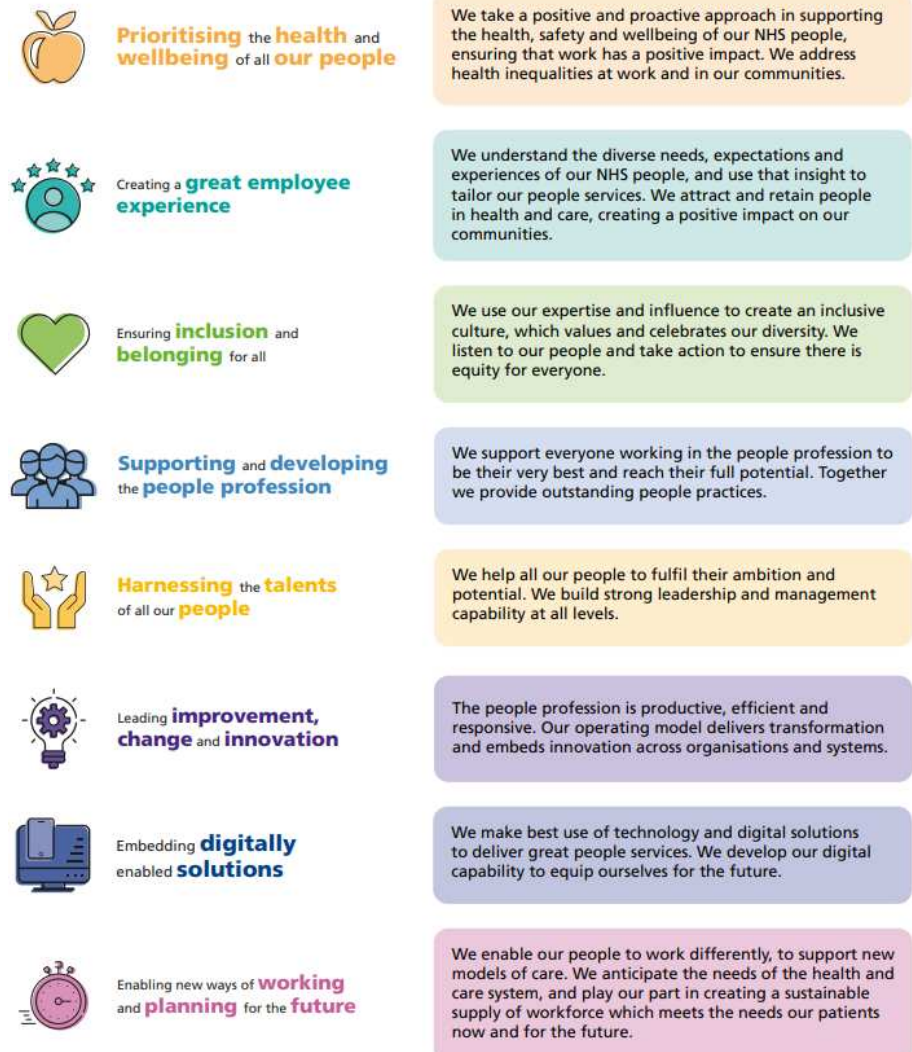
The WGLL framework has 7 success measures:

- Well led
- Ensure smart foundations
- Safe practice
- Support people
- Empower citizens
- Improve care
- Healthy populations

Future of human resources and organisational development report

The Future of human resources and organisational development report details how the NHS of 2030 will be fundamentally different from the service we work in today – as set out in the NHS Long Term Plan. The world of work is changing at a pace never imagined, with growing evidence of links between staff wellbeing, care quality and retention. This is evolving alongside digital technologies, automating tasks, remote working and new advances based on artificial intelligence. Meanwhile, existing ways of working, models of care and organisational boundaries are being transformed, as the NHS adapts to the changing needs and expectations of our population.

It sets out 8 strategic themes many of which can be enabled or enhanced by the use of technology. The report also details the need to support people in the development of their skills including digital skills.



The NHS Long Term Plan

Chapter Five of the NHS Long Term Plan sets out a wide-ranging programme to upgrade technology and digitally enabled care across the NHS. These investments enable many of the wider service changes set out in the NHS Long Term Plan. Over the next ten years they will result in an NHS where digital access to services is widespread. Where patients and their carers can better manage their health and condition. Where clinicians can access and interact with patient records and care plans wherever they are, with ready access to decision support and AI, and without the administrative hassle of today. Where predictive techniques support local Integrated Care Systems to plan and optimise care for their populations. And where secure linked clinical, genomic and other data support new medical breakthroughs and consistent quality of care.

Practical priorities will drive NHS digital transformation

- **Create straightforward digital access to NHS services, and help patients and their carers manage their health.**
- **Ensure that clinicians can access and interact with patient records and care plans wherever they are.**
- **Use decision support and artificial intelligence (AI) to help clinicians in applying best practice, eliminate unwarranted variation across the whole pathway of care, and support patients in managing their health and condition.**
- **Use predictive techniques to support local health systems to plan care for populations.**
- **Use intuitive tools to capture data as a by-product of care in ways that empower clinicians and reduce the administrative burden.**
- **Protect patients' privacy and give them control over their medical record.**
- **Link clinical, genomic and other data to support the development of new treatments to improve the NHS, making data captured for care available for clinical research, and publish, as open data, aggregate metrics about NHS performance and services.**
- **Ensure NHS systems and NHS data are secure through implementation of security, monitoring systems and staff education.**
- **Mandate and rigorously enforce technology standards (as described in The Future of Healthcare) to ensure data is interoperable and accessible.**
- **Encourage a world leading health IT industry in England with a supportive environment for software developers and innovators.**

Integrated Care Systems: design framework

The Integrated Care Systems: design framework proposes that systems will need to have smart digital and data foundations in place. The System will need to locally determine the right way to develop these capabilities and to ensure they are available at system and place level, and across provider collaboratives. Specifically, ICS NHS bodies are expected to:-

- Have a renewed digital and data transformation plan that is embedded within the ICS NHS body plan and details the roadmap to achieve 'What Good Looks Like'; and enables a cross system approach to transformation, so that changes to models of care and service redesign involve digital and data experts working with partners from all relevant sectors.
- Have clear accountability for digital and data, with a named SRO with the appropriate expertise, (registered professional or with equivalent experience), underpinned by governance arrangements that have clear oversight and responsibility for digital and data standards and requirements for the ICS and enabling partner organisation programmes and services.
- Invest in levelling-up and consolidation of infrastructure, linked to the future ICS reference target architecture and data model, adopting a simplified cloud-first infrastructure that provides agility and frictionless cross-site working experience for the workforce. 48 | Integrated Care Systems: design framework
- Implement a shared care record, that allows information to follow the patient and flow across the ICS to ensure that clinical and care decisions are made with the fullest of information.
- Ensure adherence by constituent partners to standards and processes that allow for interoperability across the ICS, and alignment to forthcoming national guidance.

- Enable a single co-ordinated offer of digital channels for citizens across the system and roll out remote monitoring technologies to help citizens manage their care at home.
- Cultivate a cross-system intelligence function to support operational and strategic conversations, as well as building platforms to enable better clinical decisions. This will require ICSs to have linked data, accessible by a shared analytical resource that can work on crosssystem priorities.
- Agree a plan for embedding population health management capabilities and ensuring these are supported by the necessary data and digital infrastructure, such as linked data and digital interventions.

DTAC

DTAC is the new national baseline criteria for digital health technologies entering into the NHS and social care.

The DTAC is designed to be used by healthcare organisations to assess suppliers at the point of procurement or as part of a due diligence process. The DTAC will ensure products meet our standards in: clinical safety, data protection, cyber security, interoperability and accessibility. The DTAC brings together legislation and recognised good practice into one place, helping the system to assess products quickly and consistently and the Trust must consider the legislative requirements in any build. This will result in a change of policy whereby all digital purchases are approved by IM&T.

NHS England – Cyber Programme

The project is working with colleagues in NHS Digital and NHS Improvement to ensure that Trusts are aware of their accountabilities and responsibilities and undertake cyber security actions, including:-

- Completing independent assessments organised through NHS Digital.
- Ensure the outcome of cyber security assessments are acted upon, to mitigate risks
- Ensure that Critical alerts are actioned within 14 days.
- Ensure that organisations subscribe to NHS Digital CareCERT Collect, act on advisories when they are issued, and submit remediation plans.

Delivering a net zero NHS

The national target as set out in Delivering a net zero NHS released in October 2020 is to be the world's first net zero national health service. 2 targets have been set:-

- For the emissions the NHS control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
- For the emissions the NHS can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

Digital has a role to play in reaching this target in ensuring the devices we deploy and support are carbon efficient, infrastructure is delivered to enable agile working, tools are deployed to enable the reduction in travel such as video conferencing, processes are reinvented to be paperlite or paperless, remote monitoring applications support a reduction in hospital visits.

Joining up care for people, places and populations

The national vision is to have a core minimum digital capability across all Trusts to enable transformed models of care.

Digital tools should be deployed to empower people to look after their health and take greater control of their own care, offering flexibility and support through the NHS App and NHS.uk, remote monitoring and digital health apps. The vision is to have a shared care records for all citizens by 2024 that provide a single, functional health and care record which citizens, caregivers and care teams can all safely access.

Digital transformation should be supported by formally recognising the Digital Data and Technology profession within the NHS Agenda for Change and including basic digital, data and technology skills in the training of all health and care staff.

Support all health and care staff to be confident when recommending digital interventions to patients and individuals using services, based on what we know works and what people want to access.

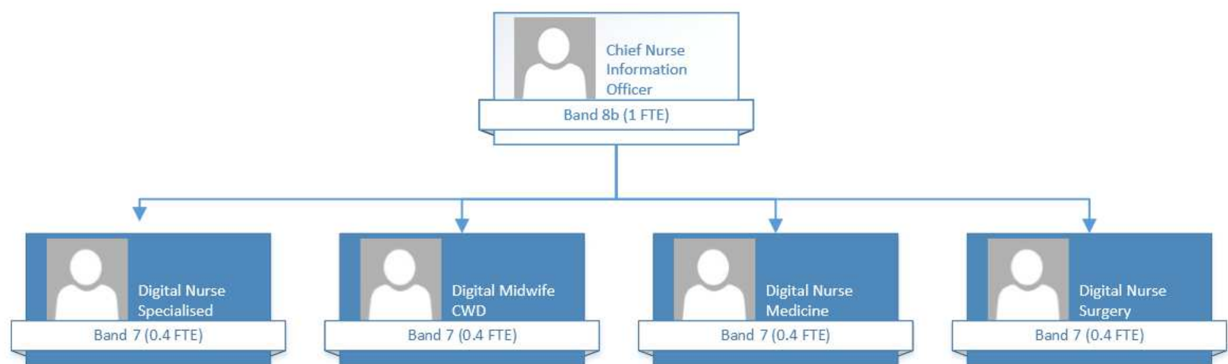
Support place-based organisations, Integrated Care Systems (ICSs) will develop digital investment plans for bringing all organisations to the same level of digital maturity. These plans will outline how ICSs will ensure data flows seamlessly across all care settings and use tech to transform care so that it is person-centred and proactive at place level.

10. Resources Required

As detailed in section 6 - How will we get there, it is intended that each initiative or project will be supported by a business case. This business case will identify any additional resources required for the delivery and on-going operating of the new service. The business case will consider infrastructure, software, equipment, training and people when evaluating the resources alongside the benefits and return on investment.

In addition to the project specific business cases there is an on-going requirement for some business as usual investment this is detailed below.

Clinical Leadership
We require experienced clinical leadership representing nurses, midwives and allied health professionals. The structure below provides further detail.



The cost of this on-going structure will be £144,944 per annum. £53,587 of the required funding is available through the nursing teaching fund but the remaining £91,357 which will be a recurrent pressure.

Business Intelligence Team
In the past 6 months we have really seen the benefit of good data insights for planning, assurance and decision making. This has been proven with the development of the Trusts Winter Coordination Centre Dashboard. The team would be able to create and support additional dashboards to support decision making and planning if it had more capacity. Whilst a business case will be produced for an increased data warehouse with data feeds from more systems, if the team were increased by 2 straight away we would be able to support clinicians and operational managers with relevant and supporting dashboards without delay. The recurrent cost of this would be £117,294.

Business Relationship Managers
IM&T staff are keen to support the divisions with all things digital, from getting the most out of existing systems or from supporting digital investments when an idea is first thought of. This will allow us to look and see if we already have the capabilities in our existing systems or in use across other divisions, if we need to purchase something we look at solutions the technical and security requirements are baked in, if

solutions don't exist that we build solutions that fit in our technical environment and are supportable. We also would like to support divisions develop their digital innovation plan and support the consolidation of solutions. To support this we would like 3 digital business relationship managers (BRM) at band 7. These BRMs will work closely with the division, the DCCIO and DCNIO to understand their services and build relationships work up digital plans, co-ordinate bids for digital projects, help with the development of business cases, contract renewals and specifications. The recurrent cost of this would be £154,230.

Technical Training

To get the most out of technology we need to know how to set it up and support it well. The IM&T teams do not routinely benefit from industry standard technical training in the systems they support. It is important that we change this so they can offer the best possible solutions to the organisation. It is planned that a programme of Microsoft training is made available to our service desk, desktop, operations, BI and development teams allowing them to exploit the Trusts investment. To make this affordable we are working with a supplier who can offer Microsoft this as a series of apprenticeships. Whilst we will need to allow time for staff to undertake their training it is expected that we will see the benefits quickly in terms of improved support and solutions. The apprenticeships will be funded from the apprenticeship levy.

Digital Clinical Leadership Training

It is important that our clinical digital leaders embark on personal development in the arena of digital health. There are a number of digital leadership events during the year that will contribute to clinicians continuing professional development (CPD) in the area of digital. The cost of these events is £550 per person. The estimated total cost of this CPD will be a maximum of £11,000.

11. How we will measure our success

As detailed in section 6 - How will we get there, it is intended that each initiative or project will be supported by a business case. This business case will identify KPIs and detailed benefits realisation plans and measures for each project or initiative. These KPIs will be managed by the project and reported to the Executives through business case update reports.

As the plans come together we will see our:-

- HIMSS EMRAM score increase from 2 to 5.
- WGLL score increase from 1.6 to 5.
- number of foundation services as detailed in the NHSX Digital Hospital Model be 100% compliant.
- KLAS score improvement (we will receive the base line for this from NHSX in early 2022).
- number of silo systems reduce from 456 to under 400.
- spend on paper and print will reduce by 15%
- number of systems feeding into the data warehouse increase by 20%.
- clinicians will not need to log into as many independent systems seeing a reduction of 15%.

Most importantly the quality and safety of our care will improve. We will see a reduction in our medication incidents; reduction in hospital acquired acute kidney injury and increased time to care. We will see our patients engaging in their own care through technology and only coming to the hospital where their intervention requires it.

It is anticipated that conversations will switch from:-

Workforce

Now	To Be
I have to wait ages for a computer to become available.	I can always find a working computer to work on.
It takes ages to log into a computer so sometimes I don't bother.	I can log in to a computer in less than 30 seconds.
I have to log into loads of different systems to see all the clinical information about my patient.	I can see the clinical information I need about a patient to help me make safe decisions.
Our paper processes waste time and are not good for the environment.	I can complete electronic forms for processes which is quicker and more visible.
I update the computer at the end of my shift.	I can effectively keep contemporaneous clinical records allowing real time information to benefit my colleagues and kick off other workflows automatically.
I have to duplicate information into different systems which is very frustrating.	I can update the system once and the data flows to where it needs to be.
I have to print off a digital image, scan it in and attach it to the patient record.	Images are all stored in PACS regardless of type so I know where they are all.
I don't have time to log a support call for the broken kit we have.	Computer equipment just works.
I have passwords coming out of my ears.	I can use the same password or my smartcard to get into systems.
I don't have access to information or data to enable me to do my job better.	I have access to dashboards and data that help me make decisions.
I can't believe I am recording annual leave on a sheet of paper in the year 2022.	I can request and have my annual leave approved electronically and the days taken/left are automatically calculated.
I can't read the prescription or doctor's signature.	Prescriptions are electronic and clear.
My phone, laptop, tablet, iPod does not always connect to the network everywhere in the hospital.	I am always connected when in the hospital.
My patients don't always turn up for their appointments.	My patients receive appointment information, reminders, pre appointment questions and condition specific information which results in them turning up for their appointment.
I am not very good with a computer.	I am confident to use a computer and recognise it is a key tool to do my job.
I have a desk phone, VOIP phone, Teams, pager, WIFI phone, mobile phone and Vocera - Aghhhhhh	I have one number for people to reach me!
Don't come to work at UHNM the IT is not good.	Come and work at UHNM the technology is an enabler of exceptional care.

Patients and Carers

Now	To Be
I have lost my appointment letter and need to ring the hospital to find out when my appointment is.	I have my appointment details on my patient held record. I also received a reminder for my appointment a couple of days before the appointment.
I want to talk to my clinician or clinical service and struggle to get through on the telephone.	I can send my clinician or clinical service a secure message to ask my question.
I have to run the telephone gauntlet to get my test results.	I can see my test results on my patient held record.
I get anxious before my visit to the hospital because I have a difficult journey and when I get there the appointment did not require a physical examination.	I can attend my appointment by video from the comfort of my own home.
I am asked a lot of questions at my appointment some of which I cannot remember the answer. If I had known I would have brought the information with me.	I can complete a pre-appointment questionnaire at home and find the information I need to complete it properly.
I feel like I have to tell my medical history to every clinician I meet, it is very tiring.	I can show clinicians my medical record on my patient held app or they can look it up on the One Health One Care portal.
I wish I could see the letters that are sent to my GP about me.	I can see all letters on my patient held record.
I get confused when I am given lots of advice at an	Advice and videos about my condition are available on

appointment and my son lives down south so is unable to come with me to my appointment.	the patient held record and I can share it with my Son so he can help me with my self-care.
I get confused when I am given lots of advice at an appointment and my son lives down south so is unable to come with me to my appointment.	My son can join me over video for the appointment, he reminds me of the advice I am given to help me with my self-care.

12. How we will monitor our progress

This strategy sets out a range of projects and programmes that will deliver a range benefits to the business. Business priorities and technology advancements can change quickly and as such this Digital Strategy will be a living document that will be subject to formal change control.

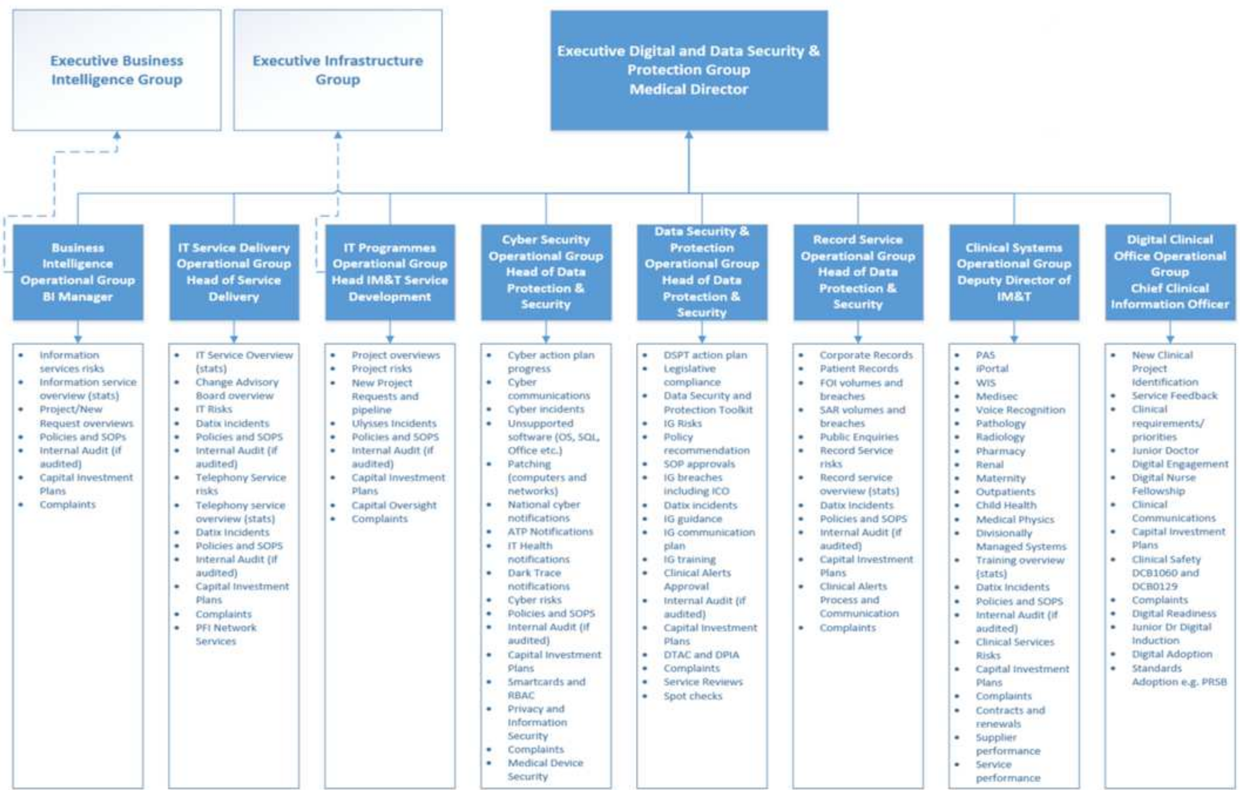
Governance arrangements in the form of Executive Digital and Data Security and Protection Group will hold IM&T Services to account for the execution of the strategy. This executive level group will be charged with steering, governing and performance managing the Digital Projects in order to achieve the targets, objectives and benefits set out in the strategy through the IT Programmes Operational Group.

It is proposed that because the Digital Strategy will require significant business transformation and people development the Executive Digital and Data Security and Protection Group report through the Transformation and People Committee (TAP) to the Trust Board with clear terms of reference.

IT User Groups will be established for specific IT systems/services or initiatives for example the Careflow Medicines Management Steering Group.

The success of the Digital strategy and on-going long term digital journey will require on-going continuous improvement, this will require clinical stewardship from a mature clinical informatics capability. An Office of the CCIO (OCCIO) will be established to directly support the clinically led, digitally enabled vision. The OCCIO will be chaired by the CCIO. The group will provide clinical informaticians a framework to develop and drive clinical development of new digital clinical systems. In addition the OCCIO will enhance skills of staff and deliver new opportunities to wider their experience. This group will build on and add to the existing clinical informatics workforce which currently exists in Pharmacy, Pathology, Radiology and Maternity. Wrapping a structure, support and process framework around the clinical informaticians will allow them to lead our digital journey.

The digital governance structure is shown below.



Currently the Executive Digital and Data Security and Protection Group reports to the Executive Infrastructure Group and then onwards to Performance and Finance Committee. The success of digital strategy will be highly dependent on our staff, transformation of our services and our culture. This digital strategy recommends that the Executive Digital and Data Security and Protection Group reports to the Transformation and People Committee. All business cases would continue to be presented at the Performance and Finance Committee as per the Trusts Standing Financial Instructions.

Risk Management

The delivery of projects in this Digital Strategy is critical as it is a key enabler to deliver our Service Developments, on-going clinical systems development, ICS and Trust plans.

IM&T follows the Trust's processes for the management of its risks. Components of this strategy will be managed in accordance with Trust's risk management practice, risks will be reviewed and managed at the relevant operational groups. A departmental risk register is in place which provides the description of risk, impact, probability, overall risk score, details of risk control, actions planned, action progress, impact, probability, residual risk, lead officer and lead director. A risk and issues log is also maintained at project level as per our project management methodologies.

Risks scored above the corporate threshold are escalated in to the corporate risk process which will help asses any wider dependencies particularly where the risk may impact the delivery of key health service improvements.

The departments current risk profile is shown in the table below:-

Current Risk Rating	Number of Risks
Extreme (15)	2
High (10)	2
High (12)	8
High (8)	2
High (9)	2
Moderate (4)	3
Moderate (5)	1
Moderate (6)	5
Grand Total	25

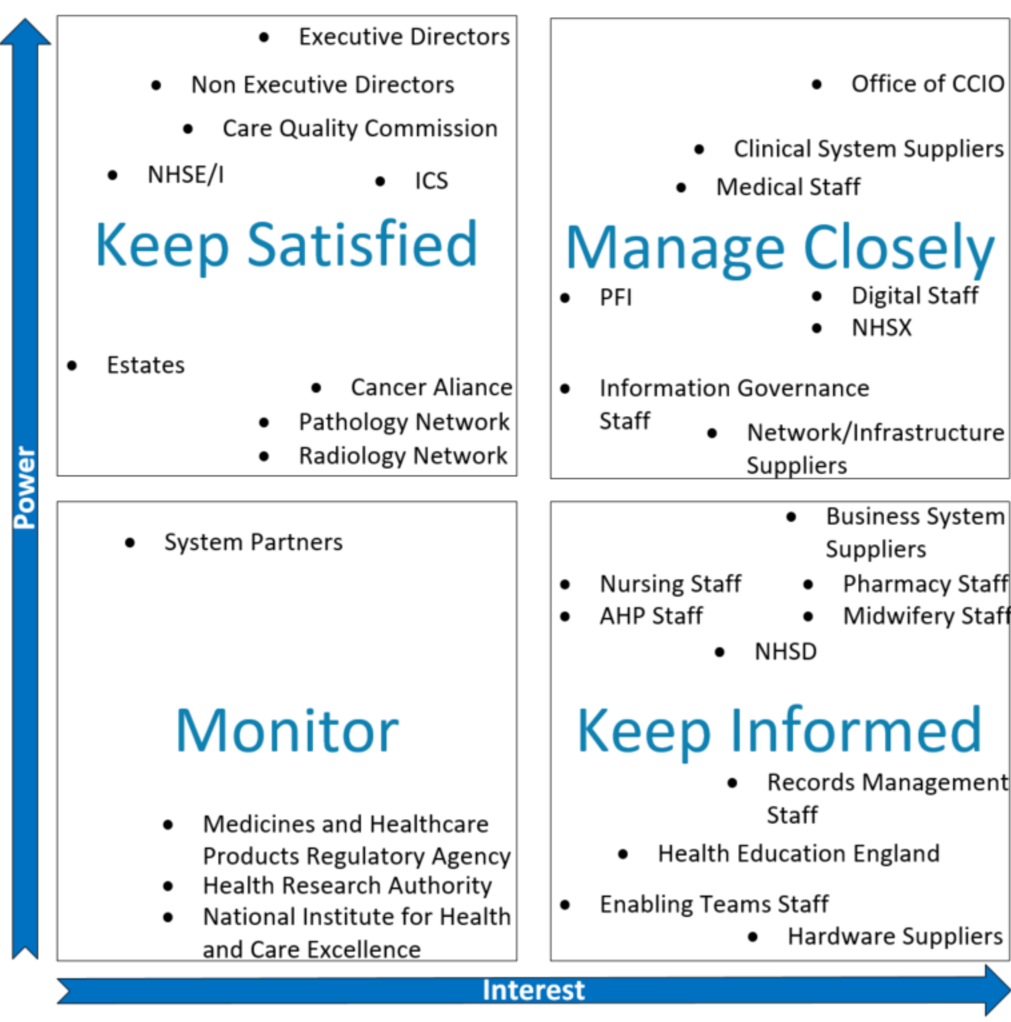
The 2 current extreme risks are:-

ID	Title	If (Cause)	Then (Event)	Resulting In (Effect)	Controls	Assurances	Risk level (initial)	Risk level (current)
22938	Log4j Vulnerability	the appropriate technical controls are not put in place to patch this vulnerability	a threat actor can infiltrate and have full access to all of the trust systems	loss of systems manipulation of systems for ransom inability to access systems to support patient care business interruption/ disruption as appointments are cancelled potential manipulation of data within systems leading to data quality issues reputational damage as inappropriate technical controls were not in place	firewall blocking list of suppliers with contact made to ensure they patch the vulnerability software tools in use to identify if servers have vulnerability which will link back to the supplier to patch the vulnerability	perimeter control by the firewall to block this vulnerability 259 suppliers(as at 15.12.2021): 153 contacted with 83 responses 104 suppliers to be contacted	Extreme (20)	Extreme (15)
9036	Vulnerability to Cyber Attack	If the organisations infrastructure and clinical systems not not adequately protected from either a targeted or indirect attack	Then this would compromise the operation and delivery of care within the hospital	Resulting in a loss of IT systems for potentially a prolonged period, and potential cancellation of some services, as well as reputational damage, increased backlog of patients and operations and potential fines of upto 4% of trust budget by NHS England if a cyber 'even' causes impact to the operating of the hospital.	Intercept-X (anti ransomware) in place to protect against wannacry type attacks. Server and PC patching process Implementation of next generation firewalls technology DarkTrace is a machine learning based cyber security technology which monitors network traffic and actively blocks malicious activity Annual external Penetration Testing Governance Pack developed for DSP with Cyber Lead membership Windows 10 build incorporating national cyber security centre baseline recommendations	External Auditing from NHS Digitial and other internal/external assessments. Cyber Action Plan Incident reporting Penetration test report - actions of which are incorporated into the cyber plan DSP toolkit self assessment Bitsight cyber rating report IT Health dashboard monitoring	Extreme (15)	Extreme (15)

Both of which are directly improved as a result of delivering this strategy.

13. How we will communicate this strategy

The development of the communications strategy commenced with evaluating stakeholders and creating a stakeholder map shown below. For each group of stakeholders different communication and engagement approaches will be required.



The strategy will be communicated using a number of communication mediums including but not limited to:

- Twitter
- Facebook (UHNM staff page)
- Publish the strategy on the Trusts website
- UHNM Live
- Presentations at Digital Governance Meetings
- suppliers and meetings with strategic suppliers
- Project specific workshops
- Monday Message
- Time to Talk
- Presentation at the ICS Digital Group
- Email to NHSD, NHSx and System Partners
- Email to third party

The full strategy, strategy on a page and summary version will be made available to stakeholders.

14. How we will ensure equality, diversity and inclusion

The implementation of digital health services requires explicit consideration to equality, diversity and inclusion. We deliver care to patients who are unique and we must ensure that the services we offer can cater for those unique needs. We will respect patient's digital capabilities and ensure we do not create barriers to receiving or engaging in their care and where possible use technology to support overcoming some of the barriers that exist today. For example electronic letter delivery can enable those with reading difficulties to use screen readers and patient held records solutions could be available in a wide range of languages.

We will design services based upon patient's digital preferences for example always offering video consultations for clinics that do not require a physical examination but also offer a more traditional option if that is preferred. We will seek to assure ourselves that any new technology deployed is inclusive including considering how those with protected characteristics might be impacted. Web based solutions will meet the Web Content Accessibility Guidelines (WCAG) 2 Level AAA Conformance. In addition we will assure ourselves that suppliers who provide systems which are artificially intelligent or undertake machine learning have taken steps to mitigate against the risk of data bias, societal bias and algorithmic bias in their solution.

For those motivated to use digital health services but lack the confidence we will sign post to appropriate learning and support services.

Each project business case will undertake an equality impact assessment which will assure the Trust that consideration has been given to equality, diversity and inclusion.

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

Our responsibilities to equality and inclusion do not end at the considerations given to the digital systems we are implementing and the digitally enabled care pathways we are developing. We can improve equality and inclusion through increasing the data feeds the Trust provides to the population health management system of the integrated care system. This additional data will allow richer population health intelligence which in turn will support more inclusive care planning.

15. Plan on a Page

Digital Strategy on a Page

16. Strategic Delivery Plan

The strategic delivery plan is wholly dependent on funding being available. The planned approach is to have business cases produced and approved subject to funding, and as funding becomes available either nationally, regionally or internally the priority cases most closely aligned with the funding aims will be selected. Due to the funding arrangements the plan will need to be fluid with the exception of a number of agreed and currently funded programmes or programmes which are not dependant on additional funding, the list below details all the projects the funding position and when ideally we would like the work to commence.

Initiative	Funding	Project Start	Improving Together	Risk Reference	Rough Order of Magnitude (ROM) Cost Capital/One Off	Rough Order of Magnitude (ROM) Recurrent
EPR Procurement Planning	Not Funded	2022	High Quality	22949 / 17505 / 22201	150,000	
LIMS	Business Case Agreed	2022	High Quality		Funds Agreed	
On-going Refresh Programme	Not Funded	2022	Responsive	14092 / 22201		825,000
Proactive Support Model	No Additional Funds Required	2022	Responsive	9145	No Additional Funds Required	
Log In Performance	Not Funded	2022	Responsive		100,000	
Cyber Security Services	NHSE/I Funding	2022	Responsive	21784 / 23538 / 9897 / 8852 / 22938 / 17542 / 8849 / 9036 / 22201	No Additional Funds Required	
Digital Team Professionalisation	Apprenticeship Levy	2022	People	8846	No Additional Funds Required	
Digital Workforce Gap (Grow our own)	Apprenticeship Levy	2022	People	8846 / 9144	No Additional Funds Required	
Patient & Carers Portal	NHSE/I Funding	2022	People		250,000	144000
Patient Digital Letters	NHSE/I Funding	2022	People		No Additional Funds Required	
Patient Self Care	NHSE/I Funding	2022	People		No Additional Funds Required	
Patient Surveys and Questionnaires	NHSE/I Funding	2022	People		No Additional Funds Required	
Patient Virtual Interactions (PIFU)	NHSE/I Funding	2022	People		No Additional Funds Required	
Digital Research and Innovation	Not Funded	2022	Improving and Innovating		250,000	
System Dashboards and Intelligence	System Funded	2022	System and Partners		No Additional Funds Required	
Office 365	Business Case Agreed	2022	Resources	20689 / 8849	Funds Agreed	
Microsoft Teams & Telephone Integration	Not Funded	2022	Resources	17542		100,000
Programme Management Solution	Not Funded	2022	Resources		30,000	50,000
HIMSS EMRAM Level 3	Not Funded	2023	High Quality	9144 / 22201	20,000	
Nurse & AHP Documentation	Not Funded	2023	High Quality		<<add inpatient digitisation cost>>	
Electronic Prescribing & Medication Administration	Business Case Agreed	2023	High Quality		Funds Agreed	
Improved End User Experience	Not Funded	2023	High Quality	10278		30,000
Digital Pathology	NHSE/I Funding	2023	High Quality		No Additional Funds Required	
Network Service Improvements	Not Funded	2023	Responsive		2,000,000	1,400,000
End User Computer Availability	NHSE/I Funding	2023	Responsive	22094	No Additional Funds Required	
Exploit Cloud	Not Funded	2023	Responsive	13760 / 12536 / 22235	200,000	250,000
Architectural Principals & Standards	No Additional Funds Required	2023	Responsive	10387	No Additional Funds Required	
Virtual Desktop Assessment	Not Funded	2023	Responsive	9897 / 22094 / 17542	50,000	25,000
Office of the CCIO & CNIO	Not Funded	2023	People			<<add updated costs>>
Digital Confidence Programme	Partially Funded	2023	People			80,000
IT System Management Standards	Not Funded	2023	People		60,000	
Patient & Carers Digital Skills	Not Funded	2023	People		45,000	
Patient & Carers Digital Exclusion	Not Funded	2023	People		-	
Data Warehouse Refresh	Not Funded	2023	Improving and Innovating		500,000	100,000
Increased Data Feeds	Not Funded	2023	Improving and Innovating		150,000	50,000
PowerBi - Cloud	Not Funded	2023	Improving and Innovating	22235		48,000
Clinical Insights	Not Funded	2023	Improving and Innovating		-	
Agile Development Approach	Not Funded	2023	Improving and Innovating		20,000	
One Health & Care System Enhancements	Not Funded	2023	System and Partners		20,000	10,000
Viva	Business Case Agreed	2023	Resources		70,000	
Paper Process Replacement	Not Funded	2023	Resources		-	
Workforce System Enhancement and Integration	Not Funded	2023	Resources		80,000	45,000
HIMSS EMRAM Level 5	Not Funded	2024	High Quality	9144 / 22201	60,000	
Medical Documentation	Not Funded	2024	High Quality		100,000	
Business Insights	Not Funded	2024	Improving and Innovating		40,000	
Technology to Support Integrated Pathways	Not Funded	2024	System and Partners		No Additional Funds Required	
Pager Replacement	Not Funded	2024	Resources		700,000	300,000
Theatre Stock Management System	Not Funded	2024	Resources		500,000	120,000
Net Zero Carbon Footprint	Not Funded	2024	Resources		45,000	
Scans & Image Viewing	Not Funded	2025	High Quality		400,000	100,000
Task Management and Clinical Communications	Not Funded	2025	High Quality		300,000	80,000
West Midlands Imaging Network	Not Funded	On-going	System and Partners		No Additional Funds Required	
North Midlands & Cheshire Pathology Network	Not Funded	On-going	System and Partners		No Additional Funds Required	
Cancer Alliance	Not Funded	On-going	System and Partners		No Additional Funds Required	
					Total	Total
					6,140,000	3,757,000

Quality Governance Committee Chair's Highlight Report to Board

28th April 2022

NHS
University Hospitals of North Midlands
NHS Trust

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee noted 1 hospital acquired MRSA case had been reported in the quarter with 7 being reported in total during the year. 112 c-diff cases were reported in the year which was above the trajectory of 93. • In relation to the Infection Prevention BAF and managing covid patients safely, it was noted that it was accepted to defer from national guidance and utilise a risk assessed approach, particularly in relation to covid contact patients. Due to this there had been an increase in risk score associated with BAF1 whilst the impact of these changes were being monitored. • Whilst mortality performance demonstrated that HSMR and SHMI values continued to be better than or within expected ranges and UHNM compared well to peer and national average results for the 12 month rolling HSMR and SHMI, the Committee noted the ongoing challenges in respect of completing mortality reviews and structured judgement reviews, in areas particularly affected by Covid and staff shortages, with actions being taken by the Mortality Review Group to support the improvement in completion. • The report into the deep dive undertaken to establish the reasons for the increase in pressure ulcers related to deep tissue injuries was provided, which identified contributing factors associated with patients waiting in ambulances as well as challenges with nurse staffing delaying the management of heel offloading. The recommendations from the review were to be incorporated into a Pressure Ulcer Prevention Improvement Plan. • The M12 quality and safety report highlighted the continued challenges in respect of emergency portal management of sepsis and provision of antibiotics within an hour with targeted actions being taken with the Emergency Department. The Committee also noted that 3 never events had also occurred during the quarter. • The Health and Safety Group highlighted a theme from numerous reports whereby there had been an increase in incidents relating to verbal and physical aggression from patients, which was a particular concern given the recent brap and staff survey results and the security management team were considering associated campaigns.	• To provide a further update at a future meeting in relation to sepsis screening performance • To articulate the process and approach taken to CuSUM alerts within the next mortality report • To consider the thematic review into never events at the next meeting • To confirm the criteria associated with determining performance when completing VTE Risk Assessments on admission • To expand upon associated links to the risk register on future BAF reports, including links to ambulance delays. In addition to consider target risk scores for risks identified for Q1, in particular any reductions in consequence and whether these would be achievable. . • Comments to be provided on the draft 2021/22 Quality Account
✓ Positive Assurances to Provide	**Decisions Made**
• A presentation was provided by the Director of Midwifery which highlighted a number of areas which were being progressed, and key highlights included the Midwifery Triage Service which was now fully staffed 24/7, an update on progress in relation to induction of labour and the ongoing utilisation of the Maternity Voices Partnership • The Committee considered current compliance in relation to the 15 immediate and essential actions of the final Ockenden report which highlighted the actions which had already been completed, those in progress and those which would be delayed in completion • An update was provided on the ongoing work to identify any harm attributed to patients as a result of long waits and the process was to be further developed to identify potential harm or detrimental impact in addition to triangulation with complaints data • The Q4 Board Assurance Framework identified a change in risk score in relation to BAF 3 – Sustainable Workforce, which had reduced to a 16 following discussion and consideration at the Performance and Finance and Transformation and People Committees.	• The Committee agreed with the proposal to close the HSE/CQC Action Plan given the change in guidance and the removal of social distancing and noted that remaining risk assessments would be managed via business as usual

Comments on the Effectiveness of the Meeting
• The Committee commended the Director of Midwifery on the quality of information presented

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Director of Midwifery Presentation	BAF 1 & 3	-	Information	8.	52 Week Breach Assurance Report	BAF 1		Assurance
2.	Ockenden Final Report	BAF 1	16432, 13419	Assurance	9.	M12 Quality & Safety Report	BAF 1		Assurance
3.	HSE / CQC Action Plan Closure	BAF 1	17654	Approval	10.	Q4 Board Assurance Framework	-		Approval
4.	Q4 Infection Prevention Report	BAF 1		Assurance	11.	Executive Health & Safety Group Assurance Report	-		Assurance
5.	Q4 Infection Prevention BAF	BAF 1		Information	12.	Quality & Safety Oversight Group Assurance Report	BAF 1		Assurance
6.	Mortality Summary Report	BAF 1		Assurance	13.	Draft Quality Account	BAF 1		Approval
7.	Pressure Ulcer Review	BAF 1		Assurance					

3. 2022 / 23 Attendance Matrix

Attended | Deputy Sent | Apologies Received

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

Executive Summary

Meeting:	Public Trust Board	Date:	4th May 2022
Report Title:	Infection Prevention Board Assurance Framework	Agenda Item:	9
Author:	Helen Bucior, Infection Prevention Lead Nurse Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC		
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

Identified throughout the document.

Executive Summary:

Situation

To update the Committee on the self-assessment compliance framework with Public Health England and other COVID-19 related infection prevention guidance. This will enable the Trust to identify any areas of risk and show corrective actions taken in response. The framework is structured around the 10 existing 10 criteria set out in the code of practice on the prevention and control of infection which links directly to the Health and Social Care Act 2008.

Background

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

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

Assessment/risks

- Not moving patients until 2 negative COVID screens achieved. For asymptomatic patients this is not always possible and therefore remains on the action plan. COVID themes paper on IPCC agenda
- Recording mask fit testing is in place for area that use Health rostering system. Compliance and mask fit failure rate to be monitored by the Divisions - this remains on the action plan
- None conformities for decontamination of bed that are returned for repair remains and difficulty with dismantling of electronic beds at ward level remains an actions and will be included in the cleaning collaborative work
- West building estates/building long standing issues including number of non -compliant hand wash sinks
- Risk assessment undertaken to support deviating from national guidance. This approach has been supported by a recent document (Midlands Regional IPC principles) released by NHSE/I
- Visiting for patients has been increased to 2 visitors for each patient per day.
- Reverting to Pre-pandemic spacing in outpatients and clinics where appropriate

Progress

- Following NHSEi 10th December – Trust moved back to AMBER. Internal risk rating for both criteria 1 and 2 reduced to reflect this
- External company continues to assist with mask fit testing
- Ward are currently receiving reminder calls to prompt COVID screening
- Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools and methodologies to work through the actions needed to respond to the cleaning issues in West Building highlighted during the CPE Outbreak
- West Building estates non complaint hand wash sinks replacement work is in progress

Key Recommendations:

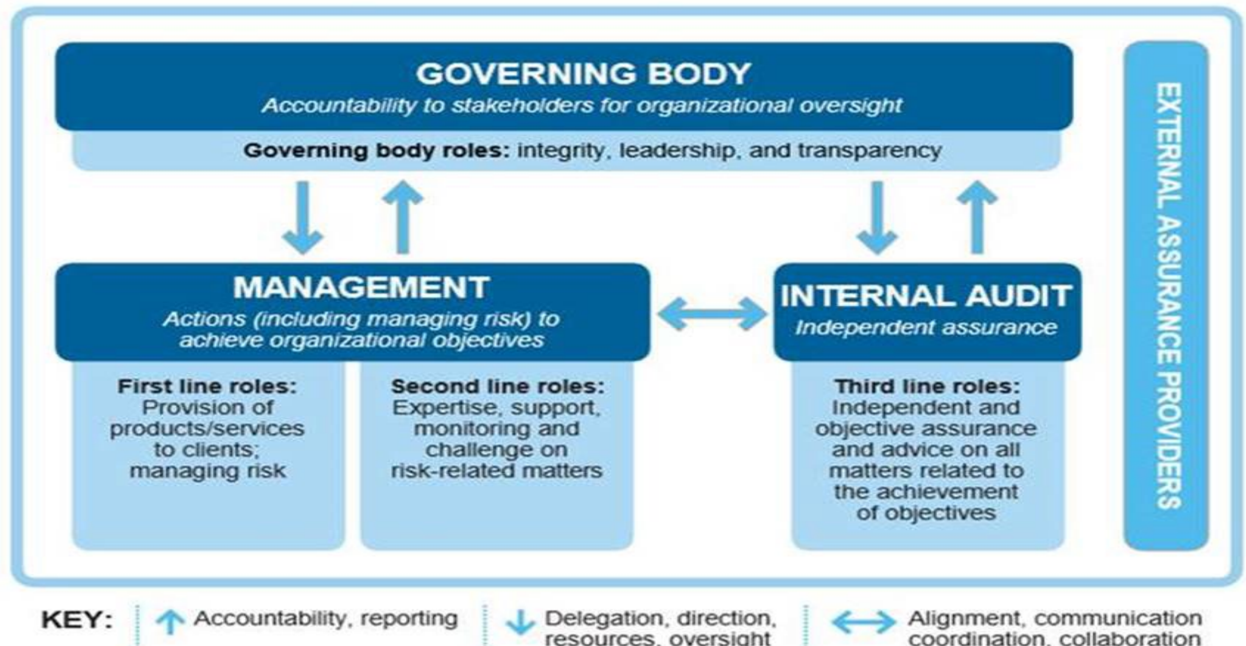
The Trust Board is asked to note the document for information, and note the ongoing work to strengthen the assurance framework going forward.

Infection Prevention and Control Board Assurance Framework

March 2022

Summary Board Assurance Framework

Ref / Page	Requirement / Objective	Risk Score					
		Q4	Q1	Q2	Q3	Q4	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.	Mod 6	Mod 6	Mod 6	Mod 6	High 9	↑
BAF 2 Page 19	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Mod 6	Low 3	Low 3	Mod 6	Mod 6	→
BAF 3 Page 29	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	High 9	Mod 6	Mod 6	Mod 6	Mod 6	→
BAF 4 Page 32	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care, in a timely fashion.	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 5 Page35	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 6 Page41	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Mod 6	Mod 6	Low 3	Low 3	Low 3	→
BAF 7 Page 47	Provide or secure adequate isolation facilities.	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 8 Page 50	Secure adequate access to laboratory support as appropriate.	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 9 Page 54	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections.	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 10 Page 57	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Low 3	Low 3	Low 3	Low 3	Low 3	→



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

1st line of defence, processes guidelines, training
2nd line of defence, Datix, root cause analysis, audits, COVID themes
3rd line of defence, external visits NSHEi , PHE, CCG attendance at outbreak meetings and IPCC

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
1.1	Systems and processes are in place ensure: Update V 1.8 A respiratory season/winter plan is in place: that includes • point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services to enable appropriate segregations of cases depending on the pathogen • Plan for and manage increasing case numbers where they occur. • a multidisciplinary team approach is adopted with hospital leadership, estates	• All emergency patients are screened on decision to admit and set intervals of stay as per protocol. • Elective screening protocol in place • UHNM have access to rapid PCR testing circumstances that require a rapid result to facilitate placement • Elective screening protocol in place • EPRR forum • UHNM Major Incident response and recovery plan • Super serge identified and reviewed QIA completed for each area	• From June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme • Theme report to IPCC • Pre AMS check COVID -19 screening results, if patient arrives in green area with no COVID screen a Datix is raised.	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
& facilities, IP Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan • Risk assessments are carried out in all areas by a competent person with the skills, knowledge and experience to be able to recognise the hazards associated with respiratory infectious agents • Local risk assessments are based on the measure as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff • The documented risk assessment includes: • A review of the effectiveness of the ventilation in the area • Operational capacity • Prevalence of infections/variants concern in the local area • Triaging and SARS-CoV-2 testing is undertaken for all patients either at the pointe of admission or soon as possible/practical following admission across all pathways;	• Multidisciplinary team approach • Exec sign off • Nominated ventilation lead to liaise with IP • Risk assessment follow Hierarchy of controls • QIA process • Daily Tactical meetings • March 2022 UHNM Risk assessment completed. • Social distancing reverted back to pre-pandemic spacing, except in staff rooms/restaurant where masks are removed. Distancing to remain at 2 metres • Mixing contact (negative) patients with non-contact (negative) patients when the Trust is on escalation level 4 with significant numbers of ambulances holding unable to offload, a significant number of specialties being held within the emergency portals and 90 or more medically fit	• Datix • OB meetings	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
		for discharge patients are being held at the Trust. • Non-contact patients selection criteria for admission to a contact ward • Reduce contact classification period from 10 days to 7 days if patient remains symptomatic and negative COVID screen on day 6 after exposure Risk Assessment COVID IPC reducing 20220401 Midlands Regional IPC principl • Regional COVID guidance received from NHSEi • Work with LRF to obtain community rates • IP attends the weekly Staffordshire and Stoke on Trent , Test, Trace and Outbreak Management Group • On arrival in ED patients are immediately identified either asymptomatic for COVID -19 and apply infection prevention		

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
Update V 1.8 • When an unacceptable risk of transmission remains following the risk assessment, consideration to the	precautions. • ED navigator in place • Colour coded areas in ED to set out COVID and Non COVID areas. This was revised in September 2020 to mirror inpatient zoning. Purple ED with blue single rooms and respiratory assessment unit • Aerosol generating procedures in single rooms with doors closed • ED navigator records patient temperature and asked COVID screening questions. Patient then directed to either remain in purple or blue single room • ED pathways and SOP • When ambulance identify suspected COVID patients are received in respiratory assessment Unit ED • All patients screened for COVID -19 when decision made to admit • Maternity pathway in place • Elective Pre Amms Plan to swab • Patients72 hours pre admission SOP in place • Radiology /interventional flow chart • Children's unplanned admission. ED Navigator asked COVID questions then child directed to either RED of Green Areas. • All children, symptomatic or asymptomatic are swabbed in child health. This is recorded within their		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	extended use of respiratory RPE for patient care in specific situations should be given	medical records, placed onto the nursing and medical handover so that we are made of the results and whether we need to chase if not received within a timely manner. The patient flow reports to the Child Health tactical meeting every morning how many children have been swabbed result and any outstanding • All children swabbed are placed into a sideward upon receiving their result are either kept within a side ward or moved to a bay if the swab is negative. • Screening for patients on systematic anticancer treatment and radiotherapy • Out patient flow chart in place • Thermal imaging cameras in some areas of the hospital • Iportal alert in place for COVID positive patients • Extremely vulnerable patient placement added into new COVID ward round guidelines (October 2020) PDF covid-19-care-plan-jan-22.pdf PDF 4th-february-2021-covid-ward-round-guic • Doors fitted to resus areas in both ED's		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
		• Discussed at Clinical group. Paper prepared by Deputy Medical Director which received exec approval w/c 26 July 2021 • August 2021 Introduction of FFP3 masks for all contact/ within 2 metres of COVID positive patients. The use of FFP3 masks for aerosol generating procedures remains in place • UKHSA issued updated guidance 17th January 2022 re FFP3 or equivalent for staff when with confirmed or suspected patients / organisms spread through the airborne route		
1.2	Patients with possible or confirmed Covid-19 are not moved unless this is essential to their care or reduces the risk of transmission. There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative Update V 1.8. Ensure that patients are not transferred unnecessarily between care areas unless; there is a change in their infectious status, clinical need, or availability of services. That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable	• All patients admitted to the Trust are screened for COVID -19 • All patients that test negative are rescreened on days 4, 6, 14 and weekly • Critical care plan with step down decision tree • COVID-19 Divisional pathways • Step down guidance available on COVID 19 intranet page • Barrier and Terminal clean process in place • IP PHE guidance • Isolation guidance IP Q+A manual • COVID Q+A available on Trust intranet • COVID 19 outbreak meetings • Patient COVID -19 discharge information	• Unannounced visits for clinical areas with clusters or HAI cases of COVID-19 • Review of HCAI COVID cases by IP Team/RCA • Datix /adverse incidence reports for inappropriate transfers	• NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	letter for patient who are discharged but contact of a positive case		
1.3	Compliance with the national guidance around discharge or transfer of Covid-19 positive patients.	• Infection prevention step down guidance available on Trust intranet • All patients who are either positive or contacts of positives are advised to complete self –isolation if discharged or transferred within that time frame • All patients are screened 48 hours prior to transfer to care homes • New UHNM ward round guidance October 2020. This also included placement of the extremely vulnerable patient • COVID ward round guidance updated as new treatment or evidence emerges. Guidance updates are discussed at the weekly clinical COVID group guidance-on-screening-and-testing-for-co 4th-february-2021-covid-ward-round-guic	• Datix/adverse incidence reports	
1.4	**All staff (clinical and non-clinical)** are trained in putting on and removing PPE, know what PPE they should wear for each setting and context and have access to the PPE that protects them for the appropriate setting and context as per national guidance. Linked NHSIE Key Action 3: Staff wear the right	• Key FFP3 mask fit trainers in place in clinical areas • PPE posters and information available on the Trust COVID -19 page. This provides the what, where and when guide for PPE • Infection Prevention Questions and Answers Manual include donning and	• Daily stock level of PPE distributed via email and agenda item for discussion at COVID-19 tactical group • IP complete spot check of PPE use if cluster/OB trigger • Records of Donning and	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
level of PPE when in clinical settings, including use of face masks in non-clinical settings. Linked Key Infection Prevention points – COVID 19 vaccination sites Monitoring of IP practices, ensuring resources are in place to enable compliance with IP practice of staff adherence to hand hygiene? • Staff adherence to hand hygiene • Patients, visitors and staff are able to maintain 2 metre social and physical distancing in all patient care areas, unless staff are providing clinical/personal care and wearing appropriate PPE • Staff social distancing across the workplace • Staff adherence to wearing of fluid resistant surgical face masks a) clinical b) non clinical setting Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting The role of PPE guardians/safety champions to embed and encourage best practice has been considered	doffing information. • Areas and situations that require high level PPE are agreed at clinical and tactical • Aerosol generating procedures (AGP's) which require high level PPE agreed at clinical and tactical group • COVID -19 Clinical Group reviews any proposed changes in PPE from the clinical areas • Link to Public Health England donning and doffing posters and videos available on Trust intranet • Chief Nurse PPE video • Extended opening hours supplies Department • Risk assessment for work process or task analysis completed by Health and Safety • Estates in house teams and contractors • are issued with SOP for working in clinical and non- clinical areas • PHE announced from 11th June 2020 all staff to wear mask in both clinical and non-clinical health care setting • Matrons walk rounds • Specialised division summarised BAF and circulated to matrons • ACN's to discuss peer review of areas • Poster displayed in entrances and along corridors reinforcing the use of masks social distancing and one way systems • Catch it , bin in, kill it posters in ED waiting	Doffing training for staff trained by IP • A number of Clinical areas have submitted PPE donning an doffing records to the IP team • Donning and Doffing training also held locally in clinical areas • Cascade training records held locally by Divisions • Sodexo and Domestic service training records • IP unannounced assurance visits • Review of UHNM vaccination areas against key infection prevention points COVID -19 • Hand hygiene audits • FFP3 testing records can be added as a skill to Health roster.	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace Update V 1.8 Resources are in place to implement and measures adherence to good IP practice. This must include all care areas and all staff (permanent , agency and external contractors) The application of IP practices within this guidance is monitored e.g. • Hand hygiene • PPE donning and doffing training • Cleaning and decontamination Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone. The Trust in not reliant on a particular mask type and ensure that a range of predominantly UK mask FFP3 masks are available to users as required	rooms • Lessons learnt poster Lessons learnt - Non Clinical June 2021.pdf Lessons learnt - Clinical June 2021.pdf unannounced-ip-visit-template-2020-11.p non-clinical-assurance-visit-checklist-2020 • QIA process for occasions when risk assess that the 2 metres can be reduced SOP beds social distance Jan 2022.do • • PPE available • Mask fit testers throughout the Trust • PPE videos and posters available • IP Q+A manual • QIA/risk assessments • Trust Ventilation authorising engineer (AE) is the lead author of SVHP guidance around COVID. AE attends the Trust Ventilation safety group and has a fixed agenda item for any updates and changes to guidance and legislation.		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Organisational/employers risk assessment in the context of managing seasonal respiratory infectious agents are • based on the measures as prioritised in the hierarchy of controls including evaluation of the ventilation in the area, operational capacity, and prevalence of the infection/new variant of concern in the local areas • Applied in order and include elimination , substitution , engineering , administration and PPE/RP • Communicated to staff Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	• The Trust has a list of available models of FFP3 masks to use. A number of staff are trained on 2 types of masks but this work is on-going as the priority it to ensure all staff who require FFP3 are tested on a suitable model first then tested on an alternative model	• Local FFP3 records held by the division • Health roster FFP3 records	
1.5	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at -19 clinical groups which was held originally twice weekly, reduced to weekly and now increased back to twice weekly due to surge of COVID.	• Clinical Group meeting action log held by emergency planning	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Purpose of the Clinical Group - The Group receive clinical guidance and society guidance which is reviewed and if agreed used to advise clinical teams after approval at Exec COVID -19 meeting which is held twice monthly. • The clinical group initially weekly , now stepped down to Bi weekly • Tactical group – The tactical Group held daily. April 2021 now stepped down. The Group decide and agreed tactical actions Makes recommendations to Gold command • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates • IP provide daily support calls to the clinical areas		
1.6	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	• Incidence Control Centre (ICC) Governance • Clinical Group, Divisional cells, Workforce Bureau, Recovery cells subgroup feed in to tactical group. • COVID Gold command , decisions /Assurance reported to Trust Board Via CEO Report/COO	• Meeting Action log held by emergency planning • Trust Executive Group Gold command – Overall decision making and escalation • Tactical, Operational Delivery Group - The delivery of the objectives and benefits, and programme communications COVID 19	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			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 measures COVID19RRGOVERNANCE NOV20v1.pptx	
1.7	Risks are reflected in risk registers and the Board Assurance Framework where	• Risk register and governance process • Datix incidents	• IP risks are agenda item at Infection Prevention and	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
appropriate. • Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. • Trust Board has oversight of on going outbreaks and actions plans • The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases • Linked NHSIE Key Action 9: Local Systems must assure themselves, with commissioners that a Trust's infection prevention and control interventions are optimal, the Board Assurance Framework is complete and agreed action plans are being delivered. • There are check and challenge	• Board assurance document standing agenda item Trust board and IPCC. • TOR • Outbreak IImarch submissions are copied to Chief Nurse/DIPC and exec Team • Outbreak areas are included in daily tactical meeting • Outbreak areas included in Gold update slides • Outbreak meetings attended by CCG and PHE • Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report • Nosocomial death review process • Visiting /walk round of areas by executive/senor leadership team SOP bed removal due to social distancir	Control committee (IPCC) • Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report • Nosocomial death review process – paper to Quality and Governance Committee 20th January 2021 • COVID themes report to IPCC • RCA process for all probable and definite COVID 19	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	opportunities by the executive/senior leadership teams in both clinical and non-clinical areas			
1.8	Robust IPC risk assessment processes and practices are in place for non Covid-19 infections and pathogens.	• IP questions and answers manual • Section in IP questions and answer manual 2.1 priority of isolation for different infections and organisms • Sepsis pathway in place • Infection Risk assessment in proud to care booklets and admission documentation • C.diff care pathway • IP included in mandatory training • Pre Amms IP Screening • Birmingham paused ribotyping service for C.DIFF due to COVID-19. During periods of increased incidence ribotyping is useful to establish person to person transmission, Leeds Hospital are now undertaking this service • Proud to care booklets revised an reinstated August/September 2020 • Revised pathways to include actions for extremely vulnerable patients who are admitted into the Trust • Advantages and disadvantages to reinstating MRSA screening as per UHNM policy undertaken and recommenced May 2021	• MRSA screening compliance • Monthly Sepsis Compliance audits. Screening compliance for sepsis and time to antibiotics for Red flag patients • IP audits • Infection Prevention Health care associated infection report, including submitted to monthly to Quality and Safety. • Submission of Infection figures to Public Health England. Clostridium difficile, MRSA blood stream infections (bacteraemia) and Gram Negative blood stream infections • Seasonal influenza reporting • Audit programme for proud to care booklets • CPE colonisation outbreak team closed the outbreak on 14th December 2021 following NHSEi whereby only minor points picked up	

Control and Assurance Framework					
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			at the inspection and the Trust was moved back to AMBER	

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

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
2.1	Designated nursing/medical teams with appropriate training are assigned to care for and treat patients in Covid-19 isolation or cohort areas.	• Higher risk areas with own teams • Zoning of hospital in place with cleaning teams • UHNM clinical guidance available on the intranet • Trust COVID -19 clinical group established to discuss and agree clinical pathways • Nice Guidance and National Clinical Guidance COVID-19 available on the Trust intranet • Links to PHE guidance on assessing COVID-19 cases available on Trust intranet page • Education videos clinical and non - clinical videos on Trust intranet • Process and designated staff for ED	• Clinical Group action log • PPE training records which are held locally	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		to ensure cleans are completed timely		
2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to Covid-19 isolation or cohort areas. Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	• SOP and cleaning method statements for cleaning teams • PPE education for cleaning teams • Initial meetings held with facilities/estates to discuss and plan COVID-19 requirements IP agenda item • Representatives from the division are attending the daily tactical meetings, and an E,F & PFI daily meeting is taking place which includes our partners • Discussed at March Matrons meeting. To ensure terminal cleans are signed off by the Nurse in Charge	• Clinical teams sign off any terminal cleans requested to say that clean has been completed to the agreed standard. • Spot check assurance audits completed by cleaning supervisors/managers during COVID • Cleanliness complaints or concerns are addressed by completing cleanliness audit walkabouts with clinical teams, and CPM / domestic supervisors • PPE and FFP3 mask fit training records with are held by cleaning services • GREAT training record cards are held centrally by Sodexo for all individual domestics • Key trainers record • Notes from Sodexo Performance Monthly meeting , Sodexo Operational meeting , Divisional IP Meeting and facilities/estates meeting	• Learning from CPE outbreak. We have recognised areas we can strengthen our assurance process on standards of cleanliness
2.3	Decontamination and terminal decontamination of	• SOP for terminal and barrier cleans	• C4C audits reinstated July	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	isolation rooms or cohort areas is carried out in line with PHE and other national guidance. Update V 1.8 A terminal clean /deep clean of inpatient rooms is carried out: • Following resolutions of symptoms and removal of precautions • When vacated following discharge or transfer (this includes removal and disposal /or laundering of all curtains and bed screens) • Following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air changes within the room)	in place and was reviewed in February 21. • High level disinfectant , Virusolve and Tristel in place and used for all decontamination cleans • Dedicated terminal clean teams introduced during the 2/3 wave of COVID for ED, AMU/AMRA/FEAU as well as Lyme Building where main ITU beds are located to ensure that quick , effective decontamination of potentially infected areas could be completed 24/7. • Terminal cleans are requested via IP Team • Terminal clean process included in IP Q+A manual	2020 these results are fed into IPCC • Completion of random 10% rooms each week by cleaning supervisors/managers to ensure that all rooms are cleaned to the agreed cleaning standards – Any rooms that are found to be below standard are rectified immediately. • Terminal clean electronic request log • Patient survey feedback is reviewed by joint CPM / Sodexo/EFP group and action plan completed if needed. • IP assurance visits and audits	
2.4	Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance. A minimal of twice daily cleaning of • Patients isolation rooms • Cohort areas • Donning and doffing areas • Frequently touched surfaces e.g. door/toilet	• Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual • Process in place for clinical areas with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans • Feedback from NHSI provided to cleaning teams and action plan	• Barrier clean request electronic log held by Sodexo and circulated following any updates / removal of barrier cleans to Sodexo and Trust staff including IP Team. • IP spot checks for clinical areas with clusters of COVID -19 or HAI cases of COVID -	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls (Source, Timeframe and Outcome)**	**Gaps in Control or Assurance**
	handles, patient call bells over bed tables and bed rails. Where there may be higher environmental contamination rates including • Toilets/commodes particularly if patient has diarrhoea Update V 1.8 Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas	Action Plan Following NHS England NHS Im devised NHSI action plan June 21.docx • Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual	19 • Disinfectant check completed during IP spot checks • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans. • November 2021 Implementation of IPS audit • C4C audit programme in place	
2.5	Attention to the cleaning of toilets / bathrooms, as Covid-19 has frequently been found to contaminate surface in these areas.	• Cleaning schedules in place • Barrier cleans (increased cleaning frequency) process in place which includes sanitary ware and other frequent touch points • Barrier cleans also requested for other infections /period of increased incidence /outbreaks e.g. C.diff , Norovirus	• Cleaning schedules are displayed on each ward • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans.	
2.6	Update V 1.8 Where patients with respiratory infection are cared for: Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution	• Virusolve and Tristel high level disinfectant used as routine for cleaning/disinfecting environment and non invasive equipment • Virusolve wipes also used during height of pandemic	• Evidence from manufacture that these disinfectants are effective against COVID -19 • Evidence of Virusolve weekly strength checks , held locally at ward	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.		/department level • IP checks that disinfectant is available during spot checks	
2.7	Manufacturer's guidance and recommended product 'contact time' must be followed for all cleaning / disinfectant solutions / products.	• Contact times detailed in SOP and cleaning methods statements • Included in mandatory training • Included in IP Q+A • Disinfectant used routinely	• Monthly on-going training is completed with all domestic staff to ensure that core competencies such as cleaning effectively with chemicals is trained out on a frequent basis. • Where outbreaks are identified, regular staff who clean in this area have competency checks to ensure that they are following GREAT card training • Spot checks completed by CPM includes observation of cleaning techniques by the domestic staff.	
2.8	As per national guidance: • 'Frequently touched' surfaces, e.g. door / toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions and bodily fluid. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should	• Cleaning of frequently touch points included in Barrier clean process • Offices and back offices also supplied with disinfectant wipes to keep work stations clean. • Non- invasive medical equipment must be decontaminated after each use. IP Q+A manual	• IP checks • Barrier clean request log • Terminal clean request log • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	be cleaned at least twice daily. • Rooms / areas where PPE is removed must be decontaminated, timed to coincide with periods immediate after PPE removal by groups of staff (at least twice a day). Linked NHSIE Key Action 1: All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.		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.	
2.9	Linen from possible and confirmed Covid-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken.	• Included in IP questions and answers manual • Linen posters depicting correct linen bag displayed in clinical areas and linen waste holds • Red alginate bags available for infected linen in the clinical areas • Infected linen route	• IP quarterly audits , undertaken by own areas, audits held locally by divisions and requested to also send to harmfreecare email • Datix reports/adverse incidents • IPS audits undertaken by the IP Team	
2.10	Single use items are used where possible and according to single use policy.	• IP question and answers manual • Medical device policy • SOP for Visor decontamination in time of shortage	• IP audits held locally by divisions and requested to also send to harmfreecare email	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance. Update V 1.8 Resuable non –invasive care equipment is decontaminated: ○ Between each use ○ After blood and/or body fluid contamination ○ At regular predefined interval as part of an equipment cleaning protocol ○ Before inspection, service or repair equipment Update V 1.8 Compliance with regular cleaning regimes is monitored including that of reusable equipment	• IP question and answers manual covers decontamination • Air powered hoods – SOP in place which includes decontamination process for the device • Re usable FFP3 Masks – Sundstrom/ GVS Elipse. SOP's in place which includes the decontamination process • Medical device policy • Availability of high level disinfectant in clinical areas • Sterile services process • Datix process • Bed Storage Group looking at non conformities for beds that require repair • Clinical cleaning schedules • Domestic cleaning schedules • Cleaning of electronic beds part of collaborative cleaning	• IP audits held locally by divisions • Datix reports/adverse incident reports • IP assurance visits	• Decontamination of beds returned for repair process non conformities • Electronic beds – difficult dismantle the bed base mechanism to allow for effective cleaning –this issue has been raised regionally by NHSI
2.12	Update V 1.8 As part of heirachy of controls assessment : ventilation systems, particularly in, patient care areas (natural or mechanical) meets national recommendations for the minimum of air changes refer to specific guidance In patients care health building note 04-01 Adult in patient facilities	• 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	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying out an annual audit for system compliance.	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations authorised engineer A systematic review of the ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways Where possible air is diluted by natural ventilation by opening windows and doors were appropriate Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission. Where a clinical space has a very low air changes and it is not possible to increase dilution effectively , alternative technologies are considered with estates/ventilation group When considering screens/partitions in reception /waiting areas , consult with estates/facilitates teams , to ensure that air flow is not affected, and cleaning schedules are in place Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air Where possible ventilation is maximised by opening	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 PDF 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 • January 2022 Estates and IP are exploring the use of air scrubber machine to try on ward in West Building • Review of areas that request Perspex screens to check need and requirement for		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	windows where possible to assist the dilution of air.	cleaning/ventilation not affected		
2.13	Update V 1.8 The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. Update V 1.8 The organisation had systems and processes in place to identify and communicate changes in the functionality of area/rooms Update V 1.8 Ensure cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment Monitor adherence environmental decontamination with actions in place to mitigate any identified risk Monitor adherence to the decontamination of shared equipment	• Cleaning standards meetings in place, review of National standards • Cleaning collaborative improvement project now underway • Regular walkabouts of all non-clinical areas are completed, and any actions found are either emailed through to helpdesk to be logged as jobs to be completed or are noted by Sodexo at time of audit – follow-up visits are completed to ensure all jobs have been completed • Quarterly Environmental Audits are completed of all clinical areas by an independent auditor plus input from nursing, cleaning and estates to review environmental standards – reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %.	• Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %. • C4C report presented at IPCC	Cleanliness assurance processes around

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	2.4	West Building long standing Estates issues. Reactive work	Divisions Facilities and Estates	05/11/2021 30/11/2021 End of quarter 1 2022	On going review of CPE colonisation in West Building. Long standing estates issues in West Building including a number of non- compliant hand wash sinks. Reactive estates works list identified. Long term plan to be agreed. November 2021 Capital funding agreed and allocated c £150k for the replacement of 75 non-compliant wash hand basins including associated IPS panels within the West Building Wards and FEAU. February 2022 Sink replacement in progress	In progress
7	2.13	Cleaning issues both nursing and cleaning responsibilities highlighted during CPE outbreak west Buildings. Strengthen assurance process on standards of cleanliness	Divisions Facilities/ACN	12/11/2021 31/12/2021 End of quarter 1 2022	October 2021 Terminal cleans in progress Review sign off process November 2021 03/11/2021 terminal clean west building completed Terminal clean briefing sheet designed Terminal clean of all West using steam and HPV Terminal Clean of FEAU and ward 122 using steam and HPV completed 06/11/2021 Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools and methodologies to work through the actions needed to respond to the cleaning issues in West Building highlighted during the CPE Outbreak. March 2022 Collaborative work continues	In progress

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
3.1	Arrangements around antimicrobial stewardship are maintained. Update V 1.8 Previous antimicrobial history is considered The use of antimicrobials is managed an monitored: Update V 1.8 • To reduce inappropriate prescribing • To ensure patients with infections are treated promptly with correct antibiotic	• Regular, planned Antimicrobial stewardship (AMS) ward rounds • Trust antimicrobial guidelines available 24/7 via intranet and mobile device App • Antimicrobial action plan in place • Clostridium *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 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	• Same day escalation to microbiologist, if concerns. Outcome recorded on I portal • Metric available around the number of times App accessed by UHNM staff • Compliance with guidelines and other AMS metrics reported to Infection prevention and control Committee (IPCC) • Meeting minutes reviewed and actions followed up • Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl. PHE) thought leaders members	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• All national CQUINS currently suspended by NHSE / PHE • Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM	• 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. On hold during COVID19 due to redeployment of duties • The pharmacy team undertook a trust-wide point prevalence audit using a new electronic data capture tool. Results will be reviewed during January and shared with ACN's and Microbiologist.	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight. Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director and the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. Linked to NHSIE Key Action 10: Local systems must review system performance and data, offer peer support and take steps to intervene as required.	• Quarterly point prevalence audits maintained by AMS team at UHNM despite many regional Trusts not undertaking any more. These have restarted in December 2020 as held during COVID-19. Results online. • Results from all AMS audits and targeted ward reviews are reported at the Antimicrobial Stewardship Group and minutes seen by IPCC • CQUIN submissions completed in timely manner and generate action plans for AMS and ward teams to	• Whilst only a snap-shot audit the Trust value the output from these audits. Work is underway Q1 and Q2 20/21 to review potential change in data collection to optimise impact. • IPCC scrutinise results. Divisions held to account for areas of poor performance. Audit outputs will be used as basis of feedback on performance to individual clinical areas going forward. • Trust CQUIN contracts manager holds regular track and update meetings to challenge progress	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Update V 1.8 Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens	follow up concerns each quarter. Currently suspended.	vs AMS CQUINS, Currently suspended.	

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	1	1	There is a substantial amount of information available to provide to patients this requires continuous update as national guidelines change	Likelihood:	1	End of Q3 – Achieved in Q4
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	3	3	3	3	3		Risk Level:	3	

Control and Assurance Framework

	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
4.1	Implementation of national guidance on visiting patients in a care setting. Update V 1.8 Visits from patients relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients , staff and visitors There is clearly displayed , written information available to prompt patients, visitor and staff to comply with hand washing, wearing of facemask /face coverings and physical distancing Restrictive visiting may be considered appropriate during outbreaks within inpatient areas. This is an	• To help protect patients and staff from Covid-19, the NHS suspended all visiting to hospitals. This national suspension has now been lifted and visiting is to be introduced in some areas of our hospitals, subject to certain conditions. From Monday 17 August 2020 visiting will be phased in across some areas and will be allowed in the West Building at Royal Stoke and in Wards 7, 12, 15 at County Hospital. All visiting will have to be pre-booked and relatives will be provided with the correct information and contact details to book in advance. Visitors will be	• 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**
	organisational decision following a risk assessment Update V 1.8 If visitors are attending a care areas with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be a FRSM. Update V 1.8 Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reason (e.g. parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. Update V 1.8 Visitors are not present during AGPs on infectious patient unless they are considered essential following a risk assessment e.g. care/parent/guardian.	instructed to wear face masks and other PPE if they are providing bedside care. We will continue to monitor prevalence and changes in visiting restrictions will be reinstated with immediate effect should it be necessary • The only exceptional circumstances where on visitor , an immediate family member or carer will be permitted to visited are listed below- • The patient is in last days of life- palliative care guidance available on Trust intranet • The birthing partners are able to attend all scans and antenatal appointments induction of labour and post natal appointments • The parent or appropriate adult visiting their child • Other ways of keeping in touch with loved ones e.g. phone calls , video calls are available • EOL visiting guidance in place • Guidance to accommodate visitor if appropriate and necessary to assist a patients communication and/or to meet their health, emotional , religious or spiritual need • A familiar care/parent or guardian/support/personal assistant		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
		• Children both parents /guardian where the family bubble can be maintained • March 2021 Visiting guidance inpatient during COVID 19 pandemic: principles discussed at Clinical Group and tactical • Visiting COVID-19 information available on UHNM internet page • August 2021 Input from Matron for Mental Health & Learning Disability re leaflets. Minor changes required. • 26TH December 2021 visiting restriction re introduced due to Omnicron • PPE information provided to visitors • March 2022 – Visitors increased to 2 per patient		
4.2	Areas in which suspected or confirmed Covid-19 patients are being treated are clearly marked with appropriate signage and have restricted access.	• ED colour coded areas are identified by signs • Navigator manned ED entrance • Hospital zoning in place	• Daily Site report for county details COVID and NON COVID capacity	
4.3	Information and guidance on Covid-19 is available on all trust websites with easy read versions.	• COVID 19 section on intranet with information including posters and videos	• COVID-19 page updated on a regular basis	
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed Covid-19 patient needs to be moved.	• Transfer policy C24 in place and reference to Covid included • IP COVID step down process in place	• Datix process	
4.5	Implementation of the Supporting excellence in infection prevention and control behaviours toolkit	• UHNM developed material, posters • Hierarchy of controls video use on		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	has been considered	COVID 19 intranet page • UHNM wellbeing support and information		

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	1	1	Whilst arrangements are in place ensure the screening of all patients. To continue to reinforce COVID screening protocol and monitor compliance. Surveillance of omicron cases within UHNM is in place.	Likelihood:	1	End of Q4 – achieved
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	3	3	3	3	3		Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
5.1	Update V 1.8 Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival Update V 1.8 Infection status of the patient is communicated to the receiving organization,	• ED navigator records patient temperature and asked screening questions. Patient then directed to relevant coloured area • All patients who are admitted are screened for COVID 19 • Work completed to install doors to resus areas in both ED's • December 2021 – review of green resus doors and use of area	• June 2020 IP team review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme . COVID 19 -Themes report to IPCC	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed Covid-19 symptoms and to segregate them from non Covid-19 cases to minimise the risk of cross-infection as per national guidance. Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases. Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid-19 Staff are aware of agreed template for triage questions to ask Update V 1.8 Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible Screening for COVID -19 is undertaken prior to attendance wherever possible to enable early	• Posters in place for visitors re respiratory instructions • Clinical letter/ pre op screening in place to identify /enable early recognition of respiratory symptoms • Hospital zoning/pathways • COVID 19 care pathway • Screening protocol in place	• ED pathways including transfer of COVID positive patient from County to Royal Hospital • COVID screening spot check audits	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	recognition and to clinically assess patients prior to any patients attending a healthcare environment Patients with respiratory symptoms are assessed in segregated areas, ideally a single room, and away from other patients pending their test result. There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved			
5.2	Mask usage is emphasized for suspected individuals. Face coverings are used by all outpatients and visitors Update V 1.8 Facemask are worn by staff and patients in all health care facilitates Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care Update V 1.8 Patients with suspected or confirmed respiratory infection are provided with a surgical face mask (Type II or Type IIR) to be	• Use of mask for patients included in IP COVID -19 • question and answers manual • All staff and visitors to wear masks from Monday15th June2020 • ED navigator provide masks to individual in ED • Mask stations at hospital entrances • Covid-19 bulletin dated 12th June 2020 • 28th August updated guidance from PHE recommends in patients to also wear surgical masks if tolerated and does not compromise care • IP Assurance visits • Senior walk rounds of clinical areas • Matrons daily visits • Patient who are clinically extremely vulnerable should remain in a single room	• Hospital entrances Mask dispensers and hand gel available • Datix /incidents • COVID-19 themes report to IPCC	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	worn in multi-bedded bays and communal areas if this can be tolerated. Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so) and is not detrimental to their physical or mental needs Individuals who are clinically extremely vulnerable form COVID 19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room Update V 1.8 Patients at risk of severe outcomes of respiratory infection receive protective IP measures depending in their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation and risk for their families and carers accompanying them for treatments /procedures must be considered	for the duration of their hospital stay • Patient are encourage to wear mask – leaflet in place 8th-march-2021-covid-ward-round-guidan covid-19-care-plan-jan-22.pdf • Trust internet and social media provide information re the need for wearing of face masks whilst in /visiting hospital • Included in COVID 19 care pathway • IP Q+A isolation manual		
5.3	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. Linked NHSIE Key Action 6: Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients	• Colour coded areas in ED to separate patients, barriers in place. • Screens in place at main ED receptions • Colour coded routes identified in ED • Social distancing risk assessment in place • Perspex screens agreed through R+R process for other reception area	• Division/area social distancing risk assessments	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	must be considered and wards are effectively ventilated. Update V 1.8 Patient visitors , and staff can maintain 1 metre or greater social and physical distancing in all patient care areas: ideally segregation should be spate spaces , but there is potential to use screens e.g. to protect reception staff	• Social distance barriers in place at main reception areas • Chief Nurse/DIPC visited clinical areas to review social distancing within bays. A number of beds have been removed throughout the Trust. • January 2022 – 2 metre rule maintained. Risk assessments completed and signed off by DIPC for ward areas need to use closed beds due to social distancing • January 2022 - Risk assessments to be revisited for Out- patient /imaging area that need to reduce distance to 1 metre – this work is in progress • March 2022- Social distancing removed to pre pandemic		
5.4	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible.	• Process for isolation symptom patient in place • Process for cohorting of contacts • Contacting patients who have been discharged from hospital then later found to be a close contact of a COVID-19 positive case , patient to be informed by the clinical area and self- isolation advice provided as per national guidance • https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions. • Patient who tested negative on admission and remain an inpatient are retested for COVID days 4 and 6, day 14 then weekly • Spot check audits • Assurance obtained for monitoring of inpatient compliance with wearing face masks via Matrons	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			daily walk round	
5.5	Patients with suspected Covid-19 are tested promptly. There is evidence of compliance with routine testing protocols in line with key actions	• All patients who require overnight stay are screened on admission and patients who develop symptoms – UHNM screening guidance in place • December 2021 – surveillance of Omicron cases in place to monitor number of inpatients with the variant	• Adverse incident monitor /Datix	
5.6	Patients who test negative but display or go on to develop symptoms of Covid-19 are segregated and promptly re-tested and contacts traced. Isolation , testing an instigation of contact tracing is achieved for all patients with new onset symptoms , until proven negative	• Screening protocol in place which includes rescreening /re testing. Pathways in place for positive COVID 19 patients • Iportal alert and April 2021 contact alert in place iportal/medway • The IP team have been applying a Covid-19 contact alert within the ICNET system since November 2020 and this continues. • Inpatient contacts are cohorted • COVID 19 positive patients are cared for on blue wards or single rooms or COVID 19 cohort areas on critical care unit	• Datix process • IP reviews	
5.7	Patients who attend for routine appointments and who display symptoms of Covid-19 are managed appropriately. Update V 1.8 Where treatment is not urgent consider delaying this unit resolution of symptoms providing this does not impact negatively on patient outcomes	• Restoration and Recovery plans • Thermal temperature located in a number outpatient areas – with SOP if patient triggers. Script in place for scheduling outpatient/ investigations • Mask or face coverings for patients attending appointments from Monday 15th June 2020 • Process at PREAMMS if patient positive for COVID	• Datix process	

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
6.1	Update V 1.8 Appropriate infection prevention education is provided for staff, patients and visitors All staff (clinical and non-clinical) have appropriate training, in line with the latest PHE and other guidance, to ensure their personal safety and working environment is safe. Patient pathways and staff flow are separated to minimise contact between pathways. E.g. this could include provisions of spate entrances/exits or use of one way system , clear signage and restricted access to communal areas,	• PPE discussed at tactical group • Training videos available • FFP3 mask fit key trainers • Donning and Doffing posters, videos and PHE available on Covid-19 section of Trust intranet • Posters in corridors - keep to the left • One way signs in place along corridors	• Tactical group action log • Divisional training records • Mandatory training records	
6.2	All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it. Update V 1.8	• PPE and standard precautions part of the infection prevention Questions and Answers manual.	• Training records • IP spot checks of PPE on wards and Departments undertaken	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Training in IP measures is provided to all staff, including : the correct use of PPE including an intial face fit test/and fit check each time when wearing a filters face piece (FFP3) respirator and the correct technique of putting on and removing (donning/diffing) PPE safely. Gloves are worn when exposure to blood and/or other body fluids , non intact skin or mucous membranes is anticipated or in line with SICP's and TBP's	• FFP3 train the trainer programme in place • Trust mask fit strategy • SOP and training for reusable FFP3 masks • SOP and training for use of air powered hoods • Critical care - Elipse FFP3 reusable introduced • PPE posters are available in the COVID -19 section of trust intranet page		
6.3	A record of staff training is maintained.	Mask fit strategy in place	• Training records originally held locally by the Clinical areas • Records held on L drive for those trained by the infection prevention team • April 2021,Option now available to enter FFP3 training onto Health Rostering this captures the model of mask and date trained • Test certificate must continue to be filed in personal folder and this is reiterated to mask fit tester. November 2021 wider spot checks commenced IP • Health and Safety leading on portacount mask fit business	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			case which has the potential to enhance mask fit training records further as this system is capable of collected data which can be uploaded	
6.4	Appropriate arrangements are in place so that any reuse of PPE is in line with the CAS Alert is properly monitored and managed.	• SOP in place for reuse of visors • SOP in place for use of air powered filters systems plus key trainers • SOP in place for the care of reusable FFP3 masks (Sundstrom))	• SOP 's available on Trust intranet • Training logs held divisionally for air powered systems • IP training log for air powered systems key trainers and distribution of reusable FFP3 masks (Sundstrum)	
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken.	• PPE standard agenda at COVID Tactical meeting • Datix process • Midlands Region Incident Coordination Centre PPE Supply Cell	• Tactical group action log • Datix process • Incidents reported by procurement to centre PPE supply Cell	
6.6	Adherence to the PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	• PPE Audits • PPE volume use discussed at tactical COVID-19 Group	• Spot audits completed by IP team	
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions. Linked NHSIE Key Action 1: Staff consistently practices good hand hygiene.	• Hand hygiene requirements set out in the infection prevention Questions and Answers manual • Poster for hand hygiene technique displayed at hand wash sinks and stickers on hand soap and alcohol dispensers • Alcohol gel availability at the point of care	• Monthly hand hygiene audits completed by the clinical areas • Infection Prevention hand hygiene audit programme. Overview of results fed into infection Prevention committee • Independent hand hygiene audits completed by IP Senior Health Care	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
6.8	Hygiene facilities (IP measures) and messaging are available for all • Hand hygiene facilities including instructional posters • Good respiratory hygiene measures • Staff maintain physical distancing of 1 metre or greater wherever possible in the workplace unless wearing PPE as part of direct care • Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • Frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas • Staff regularly undertake hand hygiene and observe standard infection prevention precautions • Guidance on hand hygiene, including drying	• Hand washing technique depicted on soap dispensers • Social distance posters displayed throughout the Trust • IP assurance visits • Matrons visits to clinical areas Recommendation that physical distancing should be at least 1 metre, increasing whenever feasible to2 metres across all health and care settings. • Car sharing question forms part of OB investigation process • Communications reminding staff re car sharing • IP Q+A decontamination section • COVID Q+A • Wearing of mask posters displayed throughout the Trust • Advise and videos' on the Trust internet page	• Hand hygiene audits • Spot checks in the clinical area • IP assurance visits • Cleanliness audits • IP environmental audits • Quarterly audits conducted and held by the clinical areas • Hand hygiene audits	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	should be clearly displayed in all public toilet areas as well as staff areas	• Hand hygiene posters /stickers on dispenser display in public toilets		
6.8	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	• Paper Towels are available for hand drying in the Clinical areas	• IP audits to check availability	
6.9	Staff understand the requirements for uniform laundering where this is not provided on site.	• Instruction for staff laundering available on the Trust COVID -19 section of intranet • Dissolvable bags to transport uniforms home available for staff • Communications /daily bulletin to remind staff not to travel to and from work in uniforms	• Clinical areas to monitor • Reports of member of public reporting sighting of staff in uniform	
6.10	All staff understand the symptoms of Covid-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms (even if experiencing mild symptoms) Update V 1.8 To monitor compliance and reporting for asymptomatic staff testing	• For any new absences employee should open and close their usual absence via Empactis system • Symptom Advice available on Trust intranet • Communications updated to reflect changing national guidance • Staff report Lateral flow testing via the national route only	• Cluster /outbreak investigations	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
6.11	All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	• Communication /documents • Reminders on COVID bulletins Trust intranet • Staff Lateral flow testing • Communications updated to reflect changing national guidance	• Cluster /outbreak investigations	
6.12	A rapid and continued response through on- going surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patient/individuals)	• ICNET surveillance system • Reports • Trust wide daily COVID Dashboard/report • COVID -19 Tactical daily • briefing	• COVID Dashboard • COVID -19 Tactical daily briefing • COVID 19 Gold update slides	
6.13	Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	• ICNet surveillance system • Reports • RCA's are required for all Probable and Definite HAI Covid-19 cases	• Theme report IPCC • RCA review	
6.15	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	• ICNet surveillance system • Daily COVID reports of cases	• Outbreak investigation • Outbreak minutes	

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

7. Provide or secure adequate isolation facilities

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
Systems and processes are in place to ensure:				
7.1	Patients with possible or Covid-19 are isolated in appropriate facilities or designated areas where appropriate. Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas Update V 1.8 That clear advice is provided , and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs	• Hospital zoning in place • Recovery and Restoration plans for the Trust – • December 2020 –another increased wave of COVID 19 • COVID prevalence considered when zones identified • Purple wards • Blue COVID wards identified at both sites created during second wave • Green wards for planned screened elective patients • Recovery and Restoration plans • Ward round guidance available on COVID 19 intranet page • Patient are offered and encouraged to wear masks – stickers have been developed to record if patients are unable to	• June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify themes which are presented at IPCC . • Themes report to IPCC • Inappropriate patient moves reported via Datix. Daily process Discuss at outbreak meetings as necessary	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		wear masks		
7.2	Patients with suspected or confirmed COVID -19 are isolated in appropriate facilities or designated areas where appropriate; Areas used to cohort patients with possible or confirmed Covid-19 are compliant with the environmental requirements set out in the current PPE national guidance. Update V 1.8 On -going regular assessment of physical distancing an bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical requirements) Separation ins space and /or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in receptions areas and avoid mixing of infectious and non-infectious patient Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where treatment cannot be deferred, their care is provided from services able to operate in a way which minimises the risk of spread of virus to other patients/individuals Standard infection prevention precautions (SPIC's) are used at the point of care for patient who have been	• Areas agreed at COVID-19 tactical Group • Restoration and Recovery plans • QIA process • Hospital zoning in place • Pre Amms process • IP Q+A isolation section	• Action log and papers submitted to COVID-19 tactical and Clinical Group	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	screened , triaged and tested and have a negative result The principles of SICPs and TBPs continued to be applied when caring for the deceased	• PPE posters • COVID 19 information available Trust intranet • IP Q+A manual		
7.3	Patients with resistant / alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	• Infection Prevention Questions and Answers Manual includes alert organisms/resistant organism • Support to Clinical areas via Infection Prevention triage desk • Site team processes • Clostridium *difficile* report • Patients received from London to critical care unit – screening policy for resistant organisms in place	• RCA process for Clostridium *difficile* • CDI report for January Quality and Safety Committee and IPCC • Outbreak investigations • MRSA bacteramia investigations • Datix reports	

8 Secure adequate access to laboratory support as appropriate.

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

Control and Assurance Framework

	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
8.1	Testing is undertaken by competent and trained individuals. • Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• How to take a COVID screen information available on Trust intranet. This has been updated in November 2020 • Swabbing training package in place and swabbing Champions identified • Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited. • Turnaround times included in tactical slides	• Review of practice when patient tests positive after initial negative results	
8.2	Patient and staff Covid-19 testing is undertaken promptly and in line with PHE and other national guidance. Linked NHSIE Key Action 7: Staff Testing:	• All patients that require an overnight stay are screened for COVID-19 on admission or pre admission if planned/elective surgery	• Empactis reporting • Team Prevent systems • Datix/adverse incidence reporting • Cluster /outbreak investigation	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls (Source, Timeframe and Outcome)**	**Gaps in Control or Assurance**
a) Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing. b) If your Trust has a high nosocomial infection rate you should undertake additional targeted testing of all NHS Staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back. That all emergency patients are tested for COVID -19 and other respiratory infections appropriate on admission Linked to NHSIE Key Action 8: Patient Testing: a) All patients must be tested at emergency admission, whether or not they have symptoms. b) Those with symptoms of Covid-19 must be retested at the point symptoms arise after admission. c) Those who test negative upon admission must have a second test 3 days after admission and a third test 5 – 7 days post admission. Letter 6th April NHS October 2020 the region implemented requirement for screening on day 13 d) All patients must be tested 48 hours prior	• Screening process in place for elective surgery and some procedures e.g. upper endoscopy • Process in place for staff screening via empactis system and Team Prevent • Patients who test negative are retested 4, day 6 and day 14 and weekly • Patient who develop COVID symptoms are tested • Staff screening instigated in outbreak areas • November 2020 - Lateral flow device staff screening to be implemented to allow twice weekly. Staff are asked to submit results via text. Jan 2021 Recent communications on COVID bulletin to remind staff to submit results • Questions and answers available on the COVID 19 page Trust intranet re lateral flow including actions to take for reporting both a negative or positive result • All patient discharged to care setting as screened 48 hours prior to transfer/discharge • Designated care setting in	procedures • Report received by Deputy Chief Nurse on a daily basis with list of patients that are due for re screen. Clinical areas then contacted and prompt to re screen. Day 14 and weekly screening in place.	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
to discharge directly to a care home (unless they have tested positive within the previous 90 days) and must only be discharged when the test result is available and communicated to receiving organisation prior to discharge. Care home patients testing positive can only be discharged to CQC designated facilities. Care homes must not accept discharged patients unless they have that persons test result and can safely care for them. e) Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission.	place for positive patients requiring care facilities on discharge – Trentham Park • 11th May 2021 introduction of day 14 screen and also weekly screen for negative patients • From 29th April 2021 a team from HR are supporting the IP Team by contacting the clinical area to advise when screens are due • In addition to the above from 11th May 2021 inpatients who have not tested covid 19 positive within the previous 90 days are to be rescreened on day 14 and then weekly		
There is regular monitoring and reporting that identified cases have been tested and reported I line with the testing protocols (correctly recorded data)	• Reviewed as part of outbreak investigation • Matrons and ACN'S aware of retesting requirement		
Staff testing protocols are in place	• Not required currently but kept under review		
• That sites with high nosocomial rates should consider testing COVID negative patients daily.	• Patients are tested as part or outbreak investigation		
	• Designated home identified- Trentham Park		
• That those being discharged to a care facility			

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation. Update V 1.8 There is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patient who are fully vaccinated, asymptomatic, and not a contact of cases suspected/confirmed cases of COVID-19 within the last 10days. Instead these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance	• UHNM continue with PCR testing pre operatively but are exploring using lateral flow tests for day case surgery and other surgery , except those patients requiring critical care post op		
8.3	Screening for other potential infections takes place.	• Screening policy in place, included in the Infection Prevention Questions and Answers Manual • MRSA Screening recommenced in May 2021	• MRSA screening compliance • Prompt to Protect audits completed by IP • Spot check for CPE screening	

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
9.1	Update V 1.8 The application of IP practices and monitored and that resources are in place to implement and measures adherence to good IP practice. This must include all care areas and all staff (permanent , agency and external contractors) Staff are supported in adhering to all IPC policies, including those for other alert organisms. Update V 1.8 Safe spaces for staff break areas/changing facilities are provided	• IP included in mandatory update • Infection Prevention Questions and Answers manual with ICON on every desk top for ease of use • Infection Prevention triage desk which provides advice and support to clinical areas • • Rest pods are in place • Additional rest areas in place • List of changing areas available on the Trust intranet	• IP audit programme • Audits undertaken by clinical areas • CEF audits recommenced Sept 2020 • Proud to care booklet audits recommenced Sept 2020 • Compliance with correct mask wearing and Doctors complaint with Bare Below the Elbow monitored via senior walk rounds of clinical areas	
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively	• Notifications from NHS to Chief nurse/CEO	• Clinical Group meeting action log held by emergency planning	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	communicated to staff.	• IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at COVID clinical group which is held twice weekly • Daily tactical group • Incident control room established where changes are reported through • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates		
9.3	All clinical waste and linen/laundry related to confirmed or possible Covid-19 cases is handled, stored and managed in accordance with current national guidance.	• Waste policy in place • Waste stream included in IP mandatory training	The Trust has a Duty of Care to ensure the safe and proper management of waste materials from the point of generation to their final disposal (Cradle to Grave). This includes: • Ensuring the waste is stored safely. • Ensuring the waste is only transferred to an authorised carrier and disposer of the waste. • Transferring a written description of the waste • Using the permitted site code on all documentation. • Ensuring that the waste is	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			disposed of correctly by the disposer. • Carry out external waste audits of waste contractors used by the Trust.	
9.4	PPE stock is appropriately stored and accessible to staff who require it.	• Procurement and stores hold supplies of PPE • Stores extended opening hours • PPE at clinical level stores in store rooms • Donning and doffing stations at entrance to wards	• PPE availability agenda item on Tactical Group meeting	

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

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

Control and Assurance Framework

	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
10.1	Update V 1.8 Staff seek advice when required from their Occupational l Health department/GP or employer as per their local policy Update V 1.8 Bank, agency and locum staff follow the same deployment advice as permanent staff Update V 1.8 Staff who are fully vaccinated against COVID-10 and are a close contact of a case of COVID-19 are able to return to work without the need to self isolate \9 see staff isolation : approach following updated government guidance)	• All managers carry our risk assessment • Process available on the COVID 19 Trust intranet page • BAME risk assessment • Young persons risk assessment • Pregnant workers risk assessment • Risk assessment to identify vulnerable workers • Isolation tool available for staff on Trust intranet • UHNM follow National guidance	• Risk assessment and temporary risk mitigation will be reported to the workforce bureau. To protect confidentiality individual risk assessments will not be requested as these should be kept in the employees personal file • Managers required to complete , review and update risk assessments for vulnerable persons	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
Update V 1.8 Staff understand and are adequately trained in safe systems of working including donning and doffing of PPE Staff in 'at risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported. That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff Update V 1.8 A risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be a high risk of complications from respiratory infection such as influenza and severe illness from COVID -19 ○ A discussion is had with employees who are in the at-risk groups: including those who are pregnant and specific ethnic minority groups; ○ That advice is available to all health and social care staff, including specific advice to those at risk from complications ○ Bank, Agency and locum staff who fall onto these categories should follow the same deployment advice as permanent staff	• PPE donning and doffing videos available on the intranet • PPE posters • IP Q+A manual • Staff risk assessment process already in place at UHNM • Staff risk assessment information available on the Trust intranet page	• IP assurance visits	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff			
10.2	Staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally Staff who carryout fit testing training are trained and competent to do so All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used A record of the fit test and result is given to and kept by the trainee and centrally within the organisation For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods 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	• Mask fit strategy in place • Mask fit education pack • SOP for reusable face masks and respiratory hoods in place • PHE guidance followed for the use of RPE • PPE poster available on the intranet • Training records held locally • Fit testers throughout the Trust • Complete and issue Qualitative Face Fit Test Certificate • Divisions hold records • Option now available on Health roster to capture mask fit testing • SOP for reusable face masks and respiratory hoods in place	• Training records for reusable masks • Training records held locally • FFP3 testing records now available on Health Rostering to record mask type and date and divisional mask fit compliance % monitored	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal 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 Update V 1.8 A fit testing programme is in place for those who may need to wear respiratory protection Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection prevention precautions, including PPE and outlined in national guidance	• For staff groups that use Heather roster FFP3 mask fit testing details can be added as a skill to this system. • Fit testing in place • PPE requirement applicable to all staff , no exemptions for those who have recovered or received vaccination		
10.3	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the crossover of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance.	• Restore and Restorations plans	• Incidence process/Datix	
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible,	• Social distancing tool kit available on COVID 19 intranet page	• Social distance monitor walk round introduced Friday 5th June	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	particularly if not wearing a facemask and in non-clinical areas. Health and care settings are COVID 19 secure workplaces as far as practical, that is that any work place risks are mitigated maximally for everyone Linked NHSIE Key Action 2: Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.	• Site circulation maps • Keep your distance posters • COVID-19 secure declaration • Social distancing risk assessment guidance for managers presentation 5th June2020 • Meeting room rules • Face masks for all staff commenced 15th June • Visitor face covering • COVID secure risk assessment process in place • November 2020 – Car sharing instructions added to COVID Bulletin	• Social distance department risk assessments • COVID-19 secure declarations	
10.5	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas.	• Social distancing tool kit • Staff encouraged to keep to 2 metre rule during breaks • Purpose build rooms for staff breaks in progress	• Social distance monitor walk rounds • Social distance posters identify how many people allowed at one time in each room	
10.6	Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms.	• Team prevent monitoring process • Work force bureau	
10.7	Staff who test positive have adequate information and support to aid their recovery and return to work. Update V 1.8 Where there has been a breach in infection prevention procedures staff are reviewed by Occupational Health , who will	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms. • Empactis line will first ask – is the absence related to coronavirus. To which the employee must say yes or no • Once the absence is reported to the employees manger via email, the	• Via emapactis • Staff queries' through workforce bureau or team prevent	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	• Lead on the implementation of system to monitor for illness and absence • Facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the health care workforce • Lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19	manager will categorise the absence type specified in the flow chart. • Team prevent complete COVID 19 staff screening • Areas where transmission has occurred are discussed at clinical group and relevant staff screening under an ILOG number is agreed. • Flow charts of staff returning to work available on COVID 19 section of intranet		

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

Executive Summary

Meeting:	Public Trust Board	Date:	4th May 2022
Report Title:	Ockenden Final Report – 15 Immediate and Essential Actions Gap Analysis	Agenda Item:	10.
Author:	Donna Brayford, Quality and Risk Manager / Sarah Jamieson, Director of Midwifery		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

16432	*Covid 19 and Compliance with CNST Maternity Safety Actions*	*Extreme (15)*
13419	*Midwifery Safe Staffing*	*Extreme (16)*

Executive Summary

Situation

The Ockenden – Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March. This report provides an overview and action plan for the UHNM Maternity Services response to the 15 immediate and essential actions and is accompanied by the gap analysis and action plan, the report itself and the final report letter. It is a requirement that *'The Ockenden report should be taken to your next public Board meeting and be shared with all relevant staff'.*

There are more than 60 local actions for learning specific to the Shrewsbury and Telford Hospital NHS Trust. In order to provide additional assurance and ensure that lessons are learned and that any service improvements are driven forward as quickly as possible, UHNM will carry out a gap analysis against all of these recommendations and it is proposed that these are presented to Board in July 2022.

Background

In June 2017 the then Secretary of State for Health and Social Care commissioned a review into maternity services at the Shrewsbury and Telford Hospital NHS Trust following concerns raised by bereaved families where babies or mothers had died or suffered serious harm whilst receiving care at that Trust. In December 2020 the Ockenden review reported its initial findings following 250 clinical reviews, which contained seven Immediate and Essential Actions ('IEAs') for all providers to take to assess the quality and safety of maternity services at local NHS providers, which encourages providers to increase partnership working through Local Maternity and Neonatal Systems ('LMNSs'), ensuring patient feedback is acted upon, and that risk assessments are undertaken at each contact throughout the maternity pathway.

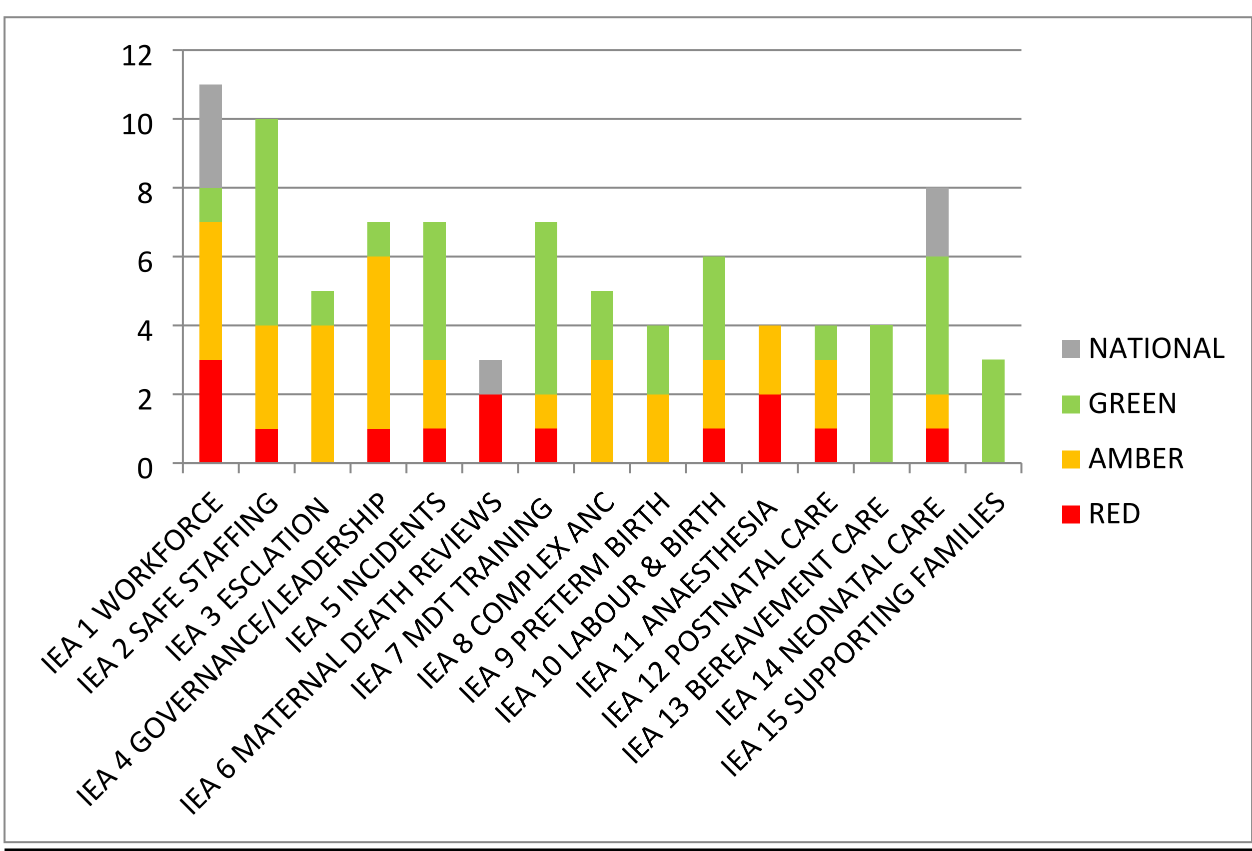
This final report states that the Board has a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening at our organisation / within our local system. The final report letter

strongly recommends that everyone reads the report, regardless of their role. After reviewing the report, we should take action to mitigate any risks identified and develop robust plans against areas where our services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

Assessment

UHNM current compliance against the Immediate and Essential Actions of the Ockenden Final report are :



The ongoing assurance of compliance and sustainability of improvement will be supported by Regional Chief Midwives and their teams. These processes will include quality assurance visits the first of which for UHNM maternity is planned for the 5th May 2022. Members of the national team may periodically choose to join regional visits/engage with the assurance processes.

Key Recommendations

To receive this report as assurance of progress towards achieving compliance with Ockenden – the Final Report.

Official
Publication approval reference: B1523

Skipton House
80 London Road
London
SE1 6LH

1 April 2022

To:
- NHS Trust and Foundation Trust:
    - Chief Executives
    - Chairs
    - Chief Nurses
    - Chief Midwives
    - Medical Directors
- ICS leads and Chairs
- LMNS/LMS leads
- CCG Accountable Officers

CC:
- Regional chief nurses
- Regional chief midwives
- Regional medical directors
- Regional obstetricians

Dear colleagues

OCKENDEN – Final report

The Ockenden – Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March.

Donna Ockenden and her team have set out the terrible failings suffered by families at what should have been the most special time of their lives. We are deeply sorry for the loss and the heartbreak they have had to endure.

This report must act as an immediate call to action for all commissioners and providers of maternity and neonatal services who need to ensure lessons are rapidly learned and service improvements for women, babies, and their families are driven forward as quickly as possible.

NHS England and NHS Improvement are working with the Department of Health and Social Care to implement the 15 Immediate & Essential Actions (IEAs) and every trust, ICS and LMS/LMNS Board must consider and then act on the report's findings.

We have announced significant investment to kick-start transformation of maternity services with investment of £127 million over the next two years, on top of the £95 million annual increase that was started last year. This will fund further workforce expansion, leadership development, capital to increase neonatal cot capacity, additional support to LMS/LMNS and retention support. We will set out further information in the coming weeks.

Your Board has a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening at your organisation / within your local system. The Ockenden report should be taken to your next public Board meeting and be shared

with all relevant staff – we strongly recommend everyone reads it, regardless of their role. After reviewing the report, you should take action to mitigate any risks identified and develop robust plans against areas where your services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up. We expect every trust board to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events. A dedicated maternity listening event should take place in the coming months. We will soon publish a revised national policy and guidance on speaking up.

Staff in maternity services may need additional health and wellbeing support. Please signpost colleagues to local support services or national support for our people.

The report highlights the importance of listening to women and their families. Action needs to be taken locally to ensure women have the necessary information and support to make informed, personalised and safe decisions about their care.

It includes a specific action on continuity of carer: *'All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.' (*IEA 2, Safe Staffing page 164)

In line with the maternity transformation programme, trusts have already been asked to submit their MCoC plans by 15 June 2022. In doing so, they must take into account this IEA in ensuring that safe midwifery staffing plans are in place. Trusts should therefore immediately assess their staffing position and make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Boards must also assure themselves that any recent reviews of maternity and neonatal services have been fully considered, actions taken, and necessary assurance of implementation is in place.

We expect there will be further recommendations for maternity and neonatal services to consider later this year given other reviews underway. We are committed to consolidating actions to ensure a coherent national delivery plan.

However, there can be no delay in implementing local action that can save lives and improve the care women and their families are receiving now.

In the 25 January 2022 letter we asked you to set out at a Public Board your organisation's progress against the seven IEAs in the interim Ockenden report before the end of March 2022. Your position should be discussed with your LMS and ICS and reported to regional teams by 15 April 2022. We will be publishing a detailed breakdown of these returns and compliance by Trust with the first Ockenden IEAs at NHSE/I public Board in May. Your trust also needs to provide reliable data to the regular provider workforce return, with executive level oversight.

For organisations without maternity and neonatal services, this report must still be considered, and the valuable lessons digested.

We know you will be as determined as we are to ensure the NHS now makes the changes that will prevent other families suffering such devastating pain and loss.

Yours sincerely

Amanda Pritchard	**Ruth May**	**Professor Stephen Powis**
NHS Chief Executive	Chief Nursing Officer	National Medical Director

1: WORKFORCE PLANNING AND SUSTAINABILITY		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action – financing a safe maternity workforce The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	1.1The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.		1.1 National Action	https://www.england.nhs.uk/2022/03/nhs-announces-127m-maternity-boost-for-patients-and-families/	1.1 NHS England	Awaiting further information
	1.2 Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements		1.2 Birth Plus Plus review	Birth Rate Plus full review agreed and funded by the LMNS. Birth Rate Plus review in progress	1.2 Director of Midwifery	31.5.22
	1.3 Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.		1.3 Recalculation of current calculated uplift	6.4.22 Email request to action leads sent	1.3 Human Resouces and ESR Team. Obstetrics Education and Training Leads.	30.4.22
	1.4 The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.		1.4 National Action		1.4 NHSE, RCOG, RCM, RCPCH.	
Essential action – training We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	1.5 All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.		1.5 Gap analysis against the RCM 2017 Statement to be performed	Robust Preceptorship programme in place Steering group commenced to review current programme - lead clinical educator, Recruitment and Retention Midwife, Student Midwife Facilitator and Mentor, Inpatient and Outpatient Matron	1.5 Lead recruitment and Retention Midwife/ Lead Midwife Clinical Educator	30.4.22
	1.6 All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.		1.6 All NQMs with less than one year in post re-allocated to hospital inpatient setting	5.4.22 Immediate action completed.	1.6 Inpatient and Outpatient Matron	5.4.22

	1.7 All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.		1.7 All labour ward co-ordinators to attend fully funded and nationally recognised course	Currently, 14 Band 7 co-ordinators who have not completed a nationally recognised course	1.7 Inpatient Matron/ Lead Midwife for Education and Development/ Clinical Educator	31.3.23
	1.8 All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.		1.8 Develop orientation package		1.8 Inpatient Matron/ Delivery Suite Co-ordinator/ Lead Midwife for Education and Development/ Clinical Educator	31.7.22
	1.9 All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.		1.9 One HDU trained Midwife to be allocated to each shift 24/7	Core Team completed higher Education Level module in Critical Care of the Deteriorating Woman	1.9 Inpatient Matron/ Delivery Suite Manager	30.4.22
	1.10 All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.		1.10 Develop a strategy to support a succession - planning programme, to include a gap analysis of all leadership and management roles		1.10 Director of Midwifery/ Organisational and Development Department	30.9.22
	1.11 The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.		National Action		1.11 NHS England	

2: SAFE STAFFING		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
? **Essential action** All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	2.1 When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.	Amber	2.1 Daily Sitrep to be additionally shared with Clinical Director, Obstetric Clinical Lead, Medical Director and Patient Safety Champion	Currently, daily Sitrep shared with Directorate Manager, Chief Nurse, Inpatatient and Outpatient Matron, Quality and Risk Manager	Senior Midwifery Leadership Team	30.4.22
	2.2 In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.	Green		Separate Consultant Rota for Obstetrics and Gynaecology	Clinical Director/ Directorate Manager	
	2.3 All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	Green		Job description and Person Specification for labour ward co-ordinator inplace.	Inpatient Matron	
	2.4 All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.	Green		All MCoC at UHNM has been suspended since March 2020	Director of Midwifery	
	2.5 The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction.	Green		MCoC will be withheld until robust evidence available	Director of Midwifery	
	2.6 The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.	Green		All job plans have protected 1 x SPA protected time per week for continuous professional development. This is sufficient time for all training requirements. Annual job plan review and signed off	Clinical Director/ Directorate Manager	
	2.7 All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	Green		Band 7 1.0 WTE Lead Midwife Clinical Educator in post / Band 6 1.0 WTE Midwife Clinical educator advertised 2 x Lead Midwife for Education and Development	Director of Midwifery	
	2.8 Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	Red	2.8 Newly appointed Band 7/8 to be allocated a named and experienced mentor	Oupatient Band 7 allocated named Mentor	Director of Midwifery	From Immediate Effect

	2.9 All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.		2.9 To include a description of pathways within the maternity strategy	Terms of Reference for Safety Huddle, Obstetric Risk Meeting, Perinatal Case Review, HSIB Quarterly Meeting, Directorate Business and Performance include Outpatient Representation. Weekly Rotation into Inpatient Placement Emergency Clinical Skills - inpatient and Outpatient.		31.12. 22
	2.10 All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.		2.10 Gap analysis to be performed against 'RCOG Guidance on the engagement of long term locums in maternity care in NHS England'		Directorate Manager	31.7.22

3: ESCALATION AND ACCOUNTABILITY		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Staff must be able to escalate concerns if necessary. There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	3.1 All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.		3.1 Develop a conflict of clinical opinion policy	Jump Escalation Poster in place for conflict of clinical opinion Trust recognised assertiveness Tool currently being explored	Clinical Director/ Quality and Risk Manager	31.7.22
	3.2 When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.			Internal Trainee Competency Dashboard completed and shared with all Consultants. Locum Trainee competency process to be reviewed.		
	3.3 Trusts should aim to increase resident consultant obstetrician presence where this is achievable.		3.3 Clinical Director and Directorate Manager to review increasing consultant presence	Currently, consultant Obstetricians are present Monday - Friday 9:00 - 22:00 / Saturday - Sunday 9:00 - 17:00 There is a current review of consultant presence.	Clinical Director/ Directorate Manager	31.7.22
	3.4 There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.		3.4 Current guideline in place, to be reviewed in line with RCOG recommendations		Clinical Director	30.7.22
	3.5 There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.			Documented in UHNM Escalation Policy	Director of Midwifery	

4: CLINICAL GOVERNANCE - LEADERSHIP		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	4.1 Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.		4.1 To finalise the assurance map		Clinical Director/ Director of Midwifery/ Clinical Director/ Chief Nurse	30.4.22
	4.2 All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.		4.2 National Maternity Self-Assessment Tool to be completed		Director of Midwifery/ Clinical Director/ Directorate Manager/Quality and Risk Manager	31.5.22
	4.3 Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.		4.3 Appoint a patient safety specialist	Clinical Director, Associate Chief Nurse for Quality and Compliance, Deputy Medical Director, DOM nominated. Plan	Director of Midwifery/ Clinical Director/ Directorate Manager	30.6.22
	4.4 All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.			Consultant Obstetric Consultant lead allocated 1 per session per week. Lead Fetal Monitoring Obstetrician allocated 1 session per week. Lead Consultant Guideline allocated 1 session per week. Perinatal consultant Review allocated 1 session per week.		
	4.5 All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		4.5 To organise training in causal analysis and family engagement	Quality and Risk Manager/ 2 x Lead Midwife for Education and Development attended 5 days human factors	Quality and Risk Manager	31.8.22
	4.6 All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.		4.6 Consultant Midwife for Public Agenda to be appointed midwifery co-lead	Consultant Obstetric Co-Lead in post	Consultant Midwife	30.5.22
	4.7 All maternity services must ensure they have midwifery and obstetric co-leads for audits.		4.7 Midwifery Co-Lead to be appointed	Consultant Co-Lead and Directorate Auditor in post		30.5.22

5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATION AND COMPLAINTS		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	5.1 All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.			Head of Patient Safety and Compliance approves all investigations prior to sharing with family		
	5.2 Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.			Lessons from clincal incidents included in manadatory emergency drills, fetal monitoring study days and CTG Masterclass		
	5.3 Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.			Audit documented as part of incident action plan		
	5.4 Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.		5.4 Timeline to be added to new Maternity Risk Management Strategy		Quality and Risk Manager	31.5.22
	5.5 All trusts must ensure that complaints which meet SI threshold must be investigated as such.		5.5 To review complaints process jointly with Complaints Department		Quality and Risk Manager / Divisional Governance Lead/ Complaints and Patient Experience Department	31.5.22
	5.6 All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.		5.6.1 Maternity Services to work with MVP in reviewing complaints response processes 5.6.2 MVP to attend UHNM Training Session		MVP/ PMA/ Complaints Services	31.6.22
	5.7 Complaints themes and trends must be monitored by the maternity governance team.			Patient Experience Report completed by Professional Midwifery Advocate which is presented through the governance Process including Public Trust Board		

6: LEARNING FROM MATERNAL DEATHS		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings..	6.1 NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death		National Action			
	6.2 This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.		6.2 Development of Joint Review Panel/ investigation		Clinical Director/ Quality and Risk Manger/ Divisional Governance Lead	31.6.22
	6.3 Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.		6.3 Learning will be implemented within 6 months		Clinical Director/ Quality and Risk Manger/ Divisional Governance Lead	31.6.22

7: MULTIDISCIPLINARY TRAINING		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	7.1 All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.			Mandatory MDT Training/ MDT Attendance at Maternity Forum, weekly Obstetric Risk Meeting, Directorate Business and Performance Meeting, Perinatal Mortality review meetings	Lead Midwife for Education and Development/ Lead Clinical Educator	
	7.2 Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.			SBAR part of yearly mandatory training day and yearly fetal monitoring day		
	7.3 All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.		7.3 Human factors training to include psychological safety and upholding safety. Learning to be agreed by the LMNS		Lead Midwife for Development and Education/ Lead Midwife for Retention and Recruitment/ Consultant Obstetrician Training Lead	31.8.22
	7.4 There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.			Currently paused due to staffing pressures, to be recommenced September 2022. Weekly live drills in all inpatient areas in place.		
	7.5 There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.			2 x 1.0 WTE PMA 1 x 1.0 WTE Retention and Recruitment Midwife UHNM well-being Hub and counselling services		

	7.6 Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.			Fetal monitoring Day, CTG Masterclass, and k2 CTG Competency Package in place. Currently paused due to staffing pressures, to be recommenced September 2022		
	7.7 Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.		7.7.1 All clinicians to complete yearly K2 CTG competency and yearly Obstetric Emergency Drills Day . Added to Directorate Risk Register		Clinical Director/ Director of Midwifery/ Fetal Monitoring Midwifery and Consultant Lead	31.7.22

8: COMPLEX ANTENATAL CARE		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance. Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy.	8.1 Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.		8.1 To review current service for women with pre-existing medical disorders	Pre-Conceptual Care available for women with Type 1 diabetes.	Outpatient Matron	31.7.22
	8.2 Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.			Dedicated clinic and specialist midwives in post	Outpatient Matron	
	8.3 NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.		8.3 To perform gap analysis against NICE Diabetes and Pregnanacy Guidance 2020	Diabetic Specialist Midwife/ Nurses, Consultant Lead Joint Diabetic and Endocrine Clinic	Diabetic Specialist Midwife	30.6.22
	8.4 When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.		8.4 To perform audit to provide assurance against recommendation		Clinical Auditor	31.7.22
	8.5 Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).			Joint Renal / Obstetric Specialist Clinic in place		

9: PRETERM BIRTH		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	9.1 Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.			New Pre - term Birth - Prediction, Prevention and Mangement Guideline implemented , counselling by senior clinicinas included		
	9.2 Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.		9.2 To review Electronic Fetal Monitoring Guideline/ Pre-Term Birth - Prediction, Prevention and Management Guideline in line with recommendation		Fetal Monitoring Lead	31.5.22
	9.3 Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.			Preventing Pre-Term Birth Guideline (2022)	Consultant Neonatologist	
	9.4 There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.		9.4 Formal audit to be implemented as part of rolling audit programme	Informal audit currently in place	Directorate Lead Auditor	30.7.22

10: LABOUR AND BIRTH		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	10.1 All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made.			Inpatient Risk Assessment at each contact implemented. SOP insitu. Electronic records template implemented.	Inpatient Matron	
	10.2 Midwifery-led units must complete yearly operational risk assessments.		10.2 Operational Risk assessment to be completed		Deputy Director of Midwifery / County Matron	30.7.22
	10.3 Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.			Live Skills Drills Programme in place, included as part of TNA.		
	10.4 It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.		10.4 To review process for updating women weekly of changing transfer times	Transfer Time discussion part of Homebirth Risk Assessment performed at 36 weeks gestation.	Outpatient Matron	30.5.22
	10.5 Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.		10.5 To develop a pathway for induction of labour including if IOL delay occurs	SOP in place - 'Delay or deferral for Planned Induction of Labour'	Inpatient Matron	30.7.22
	10.6 Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.			Centralised monitoring in place		

11: OBSTETRIC ANAESTHESIA		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	11.1 Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.		11.1 To develop pathway for outpatient postnatal anaesthetic follow up		Directorate Manager/ Outpatient Matron/ Anaesthetic Clinical Director	31.8.22
	11.2 Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.		11.2 To complete audit of maternity electronic records for assurance of action		Directorate Auditor	31.6.22
	11.3 All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC.		11.3 Audit record of documentation to be completed		Obstetric Clinical Lead Anaesthetist	31.7.22
	11.4 Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance. Obstetric anaesthesia staffing guidance to include: *- The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.* *- The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.* *- The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.* *- Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.*		11.4 To perform benchmark against current electronic maternity records		Obstetric Clinical Lead Anaesthetist	31.7.22

12: POSTNATAL CARE		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times.	12.1 All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward.		12.1 To add consultant review of postnatal readmissions on a non - maternity ward to Postnatal Care Guideline/ Care of the Unwell Woman	All post-natal readmissions are reviewed by consultant Obstetrician Reviewed as part of Quality Performance Report	Consultant Midwife for Public Health	31.6.22
	12.2 Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.		12.2 To add action to Post-natal Care Guideline / Care of the Unwell Woman to ensure robust process		Consultant Midwife for Public Health	31.6.22
	12.3 Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.			All postnatal readmissions are medically reviewed on immediate admission. Monitored as part of Quarterly Quality Performance Report	Quality and Risk Manager	
	12.4 Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.		12.4.1 Birth Rate Plus to be completed, 6 monthly staffing paper to be presented to Trust Board and LMNS to include staffing levels on the postnatal ward	Birth Rate Plus in progress	Director of Midwifery	31.10.22

13: BEREAVEMENT CARE		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services**.**	13.1 Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.			There are identified midwives who are trained to provide care in line with National Bereavement Care Guideline 24/7	Inpatient Matron	
	13.2 All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.			Consultant Obsterician and identified midwives who have received consent training	Clinical Director/ Inpatient Matron	
	13.3 All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.			All families offered post-natal counselling appointment with Consultant Obstetrician, Consultant Neonatologist, Bereavement Midwife, Governance Midwife	Bereavement Midwife/ Quality and Risk Manager	
	13.4 Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.			Local UHNM Guideline in line with National Bereavement Care Pathway	Bereavement Midwife/ Quality and Risk Manager	

14: NEONATAL CARE		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	14.1 Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.			West Midlands Neonatal Operationall Delivery Network (ODN)		
	14.2 Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.			Clinical Director for Neonatology/ West Midlands ODN Network		
	14.3 Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.			Clinical Director for Neonatology/ West Midlands ODN Network		
	14.4 Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.		External Action			
	14.5 Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.		External Action	West Midlands ODN Network		
	14.6 Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required			Neonatal Nurse Matron/ Consultant Neonatologist		30.6.22

	14.7 Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.			Consultant Neonatologist Lead for Resuscitation		
	14.8 Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.			Neonatal Nurses numbers not in line with British Association of Perinatal Medicine (BAPM) Guidelines, Business Case approved to increase establishment.		30.10.22

15: SUPPORTING FAMILIES		RAG STATUS	ACTIONS	COMMENTS	PERSON RESPONSIBLE	DATE
Essential action Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision. Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care.	15.1 There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.			Designated Maternity Mental Health Nurse and Midwife UHNM Care Pathway - includes access to RAID Team, crisis team, Mother and Baby unit with designated psychiatrist, direct access to Trauma Service. Outreach Clinic currently being explored, this will be led by the Specialist Psychiatrist based in Ante-Natal Clinic.	Outpatient Matron	
	15.2 Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.			Birth Afterthoughts Service, Mother and Baby Unit and Trauma Service available for direct referral without formal mental health diagnosis.	Outpatient Matron	
	15.3 Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.			Specialist Roles appointed - Mental Health Nurse with specialist background in Perinatal Mental Health, Specialist Psychiatrist	Outpatient Matron	

Transformation and People Committee Chair's Highlight Report to Trust Board

27th April 2022

1. Highlight Report

Matters of Concern or Key Risks to Escalate

- Quality Improvement Academy (QIA) staffing is fragile due to recent leavers and whilst steps are being taken to address this, it remains a risk to the **Improving Together Programme**
- **WRES / WDES** indicators are taken from the national staff survey and in line with that, both at UHNM and nationally have deteriorated across the board, in particular in relation to the experience of discrimination and equal opportunities
- Some concern expressed around 'initiative overload', the use of language and the need to ensure that programmes of work associated with the culture of the organisation are aligned and co-ordinated with programmes such as **Improving Together Programme and Leadership Development etc**
- Concerns raised with regard to the **disciplinary procedure**, in particular the time taken to reach resolution – a review of this is currently underway
- Concerns raised regarding the level of **vacancy rates** within the organisation – a further in depth review of these areas is being undertaken to seek assurance on actions being taken to maintain service delivery
- HEE undertook an exploratory visit to the **Obstetrics and Gynaecology Department** in response to 10 red flags being raised as part of the 2021 GMC Survey – however, findings were positive (see below)

Major Actions Commissioned / Work Underway

- Further work to be undertaken to ensure alignment between the **Research Strategy** and the Clinical Strategy
- Further discussion regarding the **Research Strategy**, including benchmarking, AHP activity and risks / resources to be discussed at the Trust Board Seminar
- **Improving Together Roadmap** for the next two years is under development and this will come back to the Committee, including reference to the resources needed in order to deliver the programme
- Development of the **Equality, Delivery and Inclusion Strategy** is underway and is currently out for consultation and will be brought back to the Committee for approval
- Further work to be undertaken on the **Freedom to Speak up Report** to include trend analysis, outcomes / experience of those who report issues and learning. A more detailed report will be provided to TAP with a shortened version for the Board
- A review of **disciplinary processes** is underway and the plan to address the challenges identified in terms of time being taken will be brought back to the Committee
- **Staffing Report** on Allied Health Professionals to be developed and presented to the Executive Workforce Assurance Group
- A review of the monthly **Workforce Report** is to be undertaken to ensure that it provides assurance on work being undertaken around key areas of risk identified
- A deeper discussion on the objectives set out within the **People Plan** at the meeting in June, with a view to transfer of oversight of the brap response from Culture Review Committee at an appropriate point
- Review of workforce related **risk register**, specifically in relation to risks associated with culture / bullying and harassment

Positive Assurances to Provide

- Launch of **CENREE** within the Research and Innovation Department which provides the infrastructure to help staff develop and lead research
- Appointments process well underway within the **Improving Together** team with interviews being held 27th April
- Very successful test of change took place within the West Building as part of the **Improving Together Programme** around discharge of our most vulnerable patients. The changes were successful and will be rolled out to the remainder of the West Building / Medicine

Decisions Made

- Approved the **Research Strategy** subject to the further alignment noted
- Approval of the **People Plan 2022/23** which has been mapped to the national People Plan and Integrated Care System Priorities
- A further review of the risk score associated with Sustainable Workforce on the **Board Assurance Framework** should be undertaken

- **Enable Leadership Programme** now being launched
- **Disability Champions** established which will see introduction of buddy roles along with signposting to support such as the Tailored Adjustment Plan
- **A Great Place to Work** project being undertaken which engages staff in sharing the top 3 things that matter to them and review progress against any improvements – this has been piloted within the Organisational Development Department
- A range of activities undertaken by the new **Freedom to Speak up Guardian** including visibility walkabouts, promotional materials, commencement of appointments process for Associate Freedom to Speak Up Guardians and arrangement of listening events for Maternity following recommendations of the Ockenden Review
- Exploratory visit into **Obstetrics and Gynaecology** was reassuring for Health Education England and no major concerns were identified

Comments on the Effectiveness of the Meeting

- Consideration to be given as to a face to face meeting at some point in the future
- Audit Committee to be alerted to concerns around the disciplinary process, gaps in divisional reporting and strategic workforce planning and the development of this
- How the organisation is going to be assured, including external in relation to discriminatory issues – these may form part of the Internal Audit Plan

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	R&I Strategy	-	n/a	Approval	10.	BRAP Report and National Staff Survey 2021- Interim corporate actions	BAF 2/3	n/a	Assurance
2.	Improving Together Highlight Report	-	n/a	Assurance	11.	Future of HR and OD Update	-	n/a	Information
3.	Quarterly Workforce Equality, Diversity and Inclusion Report	BAF 2	n/a	Assurance	12.	HEEWM Exploratory Visit to Obs & Gynae	BAF 1/2/3	n/a	Assurance
4.	Speaking Up Report – Quarter 4 and annual report 2021-22	BAF 2	n/a	Assurance	13.	Q4 Board Assurance Framework	-	n/a	Approval
5.	Formal Disciplinary Activity Q4 2021/22	-	n/a	Assurance	14.	Executive Strategy & Transformation Group Assurance Report	BAF 4/5	n/a	Assurance
6.	Nursing Vacancies	BAF 1/3	n/a	Assurance	15.	Executive Research & Innovation Group Assurance Report	-	n/a	Assurance
7.	National Education Training Survey Results (NETS) - Nursing & Midwifery	BAF 3	n/a	Assurance	16.	Executive Workforce Assurance Group Assurance Report	BAF 1/2/3	n/a	Assurance
8.	M12 Workforce Performance Report	BAF 2/3	n/a	Assurance	17.	Integrated Care System Board Partner Briefing – April 2022	BAF 4 / 5	n/a	Information
9.	People Plan 2022/23	BAF 2/3	n/a	Assurance					

3. 2022 / 23 Attendance Matrix

Attended	Apologies & Deputy Sent	Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Prof G Crowe	GC	Non-Executive Director (Chair)												
Ms H Ashley	HA	Director of Strategy and Transformation												
Ms S Belfield	SB	Non-Executive Director												
Mrs T Bowen	TBo	Non-Executive Director												
Mrs T Bullock	TB	Chief Executive												
Mr P Bytheway	PB	Chief Operating Officer												
Dr L Griffin	LG	Non-Executive Director												
Mrs S Gohir	SG	Associate Non-Executive Director												
Dr K Maddock	KM	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse												
Miss C Rylands	CR	Associate Director of Corporate Governance												
Mrs R Vaughan	RV	Chief People Officer												

Performance and Finance Committee Chair's Highlight Report to Board

26th April 2022

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Concern expressed through the Executive Digital Data Security and Protection Group around the management of **infrastructure related risks**; the Group would be maintaining a close review on this • There are a number of investments needed to enable delivery of the **Digital Strategy** for which funding was yet to be identified • Cultural change needed in order to embed a 'Digital First' approach in line with the **Digital Strategy** • Some of the timeframes for actions within the **Board Assurance Framework** had now passed; it was noted that this was due to them being aligned to the end of the financial year although this would be revisited in the Q1 report • Concern expressed around the revised risk score within the **Board Assurance Framework** for Sustainable Workforce (in particular within specific areas, i.e. maternity) as it was suggested that this might now be too low – this will be discussed with the Transformation and People Committee • High numbers of Covid, occupancy and ambulance holds have created significant levels of pressure, particularly during the lead up to Easter • **Cancer performance** remains challenged with capacity within the Breast Team being significantly reduced, plans are on place to improve this • **Diagnostics** performance is not currently seeing the planned levels of activity in order to deliver the improvements needed although actions are underway to improve this	• Significant programme of work being undertaken at a system level in relation to **Frailty** with a wider offer in the community which links to the service being provided at UHNM – the Committee requested that a more comprehensive, system wide strategy is presented to the Board or a Seminar in the future. • Action to be included with regard to the development and delivery of the County Hospital Strategy within the **Board Assurance Framework**
✓ Positive Assurances to Provide	**Decisions Made**
• The **Respiratory Post Covid Follow Up Service** is in line with national BTS guidance for long Covid care • The **Frailty at the Front Door** service is to expedite the journey of frail older patients who present at the Emergency Department so that they can been seen in more appropriate environments with 'Home First' as being a key essential; a business case review demonstrated that whilst not all KPI's had been delivered, there had been a change in the landscape and therefore the strategic direction of the Frailty Service. • A **Chief Nursing Information Officer** was due to be appointed • The **Digital Strategy** had been aligned to the Improving Together Domains and was well written, having been through an extensive consultation process with buy in from all Divisions • Reduction in Covid numbers, medically fit for discharge patients now starting to be seen, although both still remain high • Cancer activity is increasing and the waiting list backlog is being reduced although there is much more work to be done. • At month 12 the **financial position** demonstrated a surplus of £3.6m was delivered against a planned deficit of £1.8m resulting in a favourable variance of £3.6m against the full year plan – primarily driven by non-recurrent additional Covid allocation of £3.2m.	Approval of Business Cases: • BC 0436 to support additional nursing resource required to continue to operate the **Specialised Decisions Unit (SDU)**, expanding from 8 to 14 beds based on ward 210 (previously funded from recurrent winter monies) • BC 0470 for the **Extension of Respiratory Post Covid Follow Up Service** for a further 12 months Approval of **Contract Awards:** • Cytotoxic Dose Banded - Chemo, Immunotherapy and Monoclonal Medicines. (eREAF 9199) • Corporate Travel Management (eREAF 9169) • Heart Valves Mechanical and Tissue (eREAF 9133) • Vehicle Fleet Hire Contract (eREAF 9056) • Pacemakers Devices and Loop Recorders (eREAF 9004) • Insourcing of Neurology Services to be provided by Elective Services Ltd (eREAF 9217) • Grindley Hill Multi-Storey Car Park (eREAF 9241) • Approval of the **Digital Strategy** which was regarded as a model of best practice for

	strategy development in terms of content, approach and ambition • Approval of the **Financial Plan for 2022/23**

Comments on the Effectiveness of the Meeting

- Agreed that whilst an extraordinary meeting for business cases was beneficial, this was not expected to become the 'norm'

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Business Case: BC-0436 Specialised Decisions Unit (SDU)	**BAF 6**	21099/ 21706	Approval	7.	Log4J Progress Update	**BAF 7**	22938, 9036	Assurance
2.	Business Case: BC-0470 Extension of Respiratory Post Covid Follow Up Service	-	23843	Approval	8.	Executive Infrastructure Group Assurance Report	**BAF 8**	n/a	Assurance
3.	Business Case Review: BC-0266 Frailty at the Front Door	-	n/a	Assurance	9.	Q4 Board Assurance Framework	-	*Various*	Approval
4.	Authorisation of New Contract Awards and Contract Extensions	-	n/a	Approval	10.	Month 12 Performance Report – 2021/22	**BAF 1/6**	Various	Assurance
5.	Executive Digital and Data Security & Protection Group Assurance Report	**BAF 7**	n/a	Assurance	11.	Month 12 Finance Report 2021/22	**BAF 9**	n/a	Assurance
6.	Digital Strategy	**BAF 7**	*Various*	Approval	12.	Financial & Capital Plan 2022/23	**BAF 9**	n/a	Approval

3. 2022 / 23 Attendance Matrix

Legend: Attended | Apologies & Deputy Sent | Apologies

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

Executive Summary

Meeting:	Public Trust Board	Date:	4th May 2022
Report Title:	Integrated Performance Report, month 12 2021/22	Agenda Item:	13.
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & safety; Operational Performance: Warren Shaw, Associate Director of Performance & Information; Matt Hadfield, Deputy Associate Director of Performance & Information. Workforce: Claire Soper, Assistant Director of Human Resources; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse / Paul Bytheway: Chief Operating Officer / Ro Vaughan: Chief People Officer / Mark Oldham: Chief Finance Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

Executive Summary

Situation

The attached Integrated Performance Report details the performance and achievements against a set of key indicators developed by the Department of Health and Social Care. The framework provides an overview of how the Trust is performing against the following four domains and the impacts on the strategic objectives:

1. Quality of Care - safety, caring and Effectiveness
2. Operational Performance
3. Organisational Health
4. Finance and use of resources

Assessment

Quality & Safety

The Trust achieved the following standards in March 2022:

- Friend & Family (Inpatients) improved to 99.3% and exceeds 95% target.
- Harm Free exceeded 95% target rate with 95.2%
- Trust rolling 12 month HSMR continues to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 99.5% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- C Diff YTD figures below trajectory with 0 against a target of 8.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during March 2022.
- Inpatient Sepsis IVAB within 1 hour achieved 92.9% and exceeded 90% target rate
- Maternity Sepsis Screening compliance 94.4% against 90% target

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E has decreased to 68.5% and below 85% target.
- Friend & Family (Maternity) decreased to 60% and below 95% target.
- Falls rate was 7.1 per 1000 bed days
- 3 Never Events reported
- There were 23 Pressure ulcers including Deep Tissue Injury identified with lapses in care during March 2022.
- 93% (12 cases) Duty of Candour 10 working day letter performance following formal verbal notification. 14 of 15 have patients have received written notification but 1 case is waiting update.
- Inpatients Sepsis Screening 84.4% below 90% target rate
- Children's Sepsis Screening compliance 84.4% and below the 90% target.
- Sepsis screening compliance in Emergency Portals below the target 90% with 76%.
- Emergency Portals Sepsis IVAB in 1 hour 58% and is below the 90% target for audited patients

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

- The rate of complaints per 10,000 spells is 33.48 and is slightly below the target of 35 and within normal variation. Majority of complaints in March 2022 relate to clinical treatment.
- Total number of Patient Safety Incidents increased in month (1821) but the rate per 1000 bed days has decreased at 46.75 and both measures are within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents above normal variation levels and incidents are under review to identify issues/themes but within normal variation and seen reductions from February 2022.
- Decrease in total reported incidents relating to staffing shortages and lack of appropriate staff on wards/departments during January 2022. 60 in total although 31 were coded as patient related, the remaining 29 were reported as staff related incidents.
- Rate of falls reported that have resulted in harm to patients currently at 1.5 per 1000 bed days in March 2022. The rate of patient falls with harm continues to be within the control limits and normal variation but is above the mean rate which indicates there may be improvement in reducing harm from falls.
- Medication related incidents rate per 1000 bed days is 4.4 and patient related 3.8 which are decreases compared to previous month but similar to 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 decrease during March 2022 along with a similar decrease in number with lapses in care compared to previous months.
- 48 Definite Hospital Onset / Nosocomial COVID-19 cases reported in February 2022.
- 4 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).
- 26 Serious Incidents reported March 2022.

<u>**Operational Performance**</u>

Emergency Care

- Attendances increased dramatically in March back up to levels seen in Oct 21. High numbers of DTA's were held in ED overnight due to bed based acuity, high numbers of MFFD with all escalation capacity being open and utilised and infection issues compounding flow. There was also a need to flex capacity into COVID capacity.
- Ambulance handover delays over 60 minutes were high and was a worsening picture against previous months and the decline in 15 minute handovers dropped to 20%. Instances of surge evidenced for WMAS attends which provides challenges for triage, especially when stand by patients have to be managed on clinical need.
- Time to initial assessment meant the position was reduced further on last month to 46%
- Time to Treatment in ED increased in March and was at 140 minutes.

Cancer

- Most recent submitted Cancer Waiting Times position is February 2022. Suspected Breast Cancer, Lung and Upper GI have all achieved the 28Day FDS standard for February.
- Provisional March indicates achievement of 31 day sub radiotherapy and 31 day rare cancers standards.
- The overall 2WW 14 day position for March 22 is predicted to achieve in the region of 50%.
- The 28 Day Faster Diagnosis position is currently at 63% with the majority of breaches in Colorectal

and Skin.

- The overall 62 day position for March 22 is currently at 41%. This is an incomplete and un-validated position that is expected to change as histology confirms a cancer or non-cancer diagnosis for patients treated. There is also a growing volume of unreported pathways due to outstanding histology affecting the position.
- There are currently 474 patients in the 2WW backlog. A reduction since last month

Planned Care

- Day Case and Elective Activity delivered 93% and 83% respectively for March 22 against the national ask of 95%, a significant improvement on February's position for Day Case (87%) and Electives (73%).
- In month Planned Care Cell focuses on elective recovery based on 10 high impact changes in accordance with the elective plan.
- Theatre plan for Q1 2022/23 gives 104% of 19/20 capacity. "Book-a-thon" launched to ensure theatre utilisation is improved, and to date as many long waiters and P2s as possible.
- County theatre due to open 11th April.

RTT

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For March the indicative number of Incomplete pathways has risen to 74,984 (February 73,360).
- The number of patients > 18 weeks has risen to a level of 33,665 (February 32,831).
- The numbers of 52 week waits in February has increased slightly with an un-validated total of 4,603 (February 4,461) this figure is below the trajectory.
- At the end of March the numbers of > 104 weeks was 494, a decrease of 40 on January.

Diagnostics

- For DM01 (15 nationally identified Dx tests) the validated position for total waiting list has increased in March from 22,529 to 24,004. The Non-obstetric ultrasound waiting list increased slightly from 9,394 to 9550. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance is at 71%.
- Within DM01, the greatest proportions of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls, a number of actions are in place. Non obstetric ultrasound performance remains a Driver Metric for CWD and has specific focus for improvement, albeit this is related to workforce retention, recruitment and innovative ways to train and recruit. Further outsourcing of non-obstetric ultrasound scanning is continuing to be explored.
- DM01 performance excluding non obs ultrasound would be c84%.

<u>Workforce</u>

Key messages

- The strategic focus of our People Plan remains on supporting recruitment, staff wellbeing and absence management.
- The sustainable workforce risk remains high because there is still an impact of covid surges on sickness levels and workforce availability, although there are plans in place to mitigate risks and additional recruitment is taking place. Divisions report increased staffing challenges due to operational pressures and the opening of additional capacity, combined with high sickness rates and vacancy levels.

Sickness

- The in-month sickness rate was 6.62% for March 22 (6.14% in February). The 12 month cumulative rate increased to 5.73% (5.54% at 28/02/22).
- Covid-related absence increased throughout March 2022 and started to decline again from 3rd April.
- The focus remains on areas with high sickness levels, with actions including:
  - Assurance meetings taking place in the Divisions, focussing on the top 10 long term and top 10 frequent absences.
  - Continued daily monitoring of sickness absences, specifically all COVID related absence and stress related absence.
  - Joint focused absence huddles for Medicine and Surgery taking place with the HR Director and Divisional Representatives

- Divisions have set trajectories for achieving a reduction in Sickness Absence (subject to Covid Pandemic spikes, Winter Pressures and staffing deficiencies) with a year-end target of around 5.5%, which will be monitored via the Improving Together Programme

Appraisals

- The final outturn for the 12m ending 31st March 2022 was 75.55%

Statutory and Mandatory Training

- The Statutory and Mandatory training rate at 31st March 2022 was 94.73% (95.34% at 28th Feb 2022). This compliance rate is for the 6 'Core for All' subjects only
- We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

Vacancies

- The overall Trust vacancy rate was 11.71% as a result of a small uplift in budgeted establishment (12.36 fte), and a decrease in staff in post (7.55 fte). Bank and Agency covered 76% of the vacancy position and there was 1154.30 FTE activity in the recruitment pipeline

Finance

Key messages

- The Trust has delivered an actual surplus of £3.6m in month against an in month planned deficit of £1.8m and a full year surplus of £8.7m resulting in a favourable variance of £3.6m against the full year plan. This surplus above plan is primarily driving by an additional non-recurrent COVID allocation received in Month 12 of £3.2m.
- Adjustments have been made within the Month 12 position (within both income and non-pay) in respect of the DHSC PPE which has been issued throughout the year, the additional employer's pension contribution of 6.3% (within both income and pay) and the prior year annual leave accrual has been re-calculated in line with the current balance of annual leave outstanding.
- A full year forecast was undertaken at Month 9 and reviewed at Month 11 which presented a £5.2m surplus. At Month 11 the Trust reported the expected forecast position was in excess of the original forecast figure of £5.2m due to the expected receipt of TIF ITU funding of £1.3m in Month 12. At year end the Trust has reported a full year surplus position of £8.7m which is primarily driven by the additional non-recurrent COVID allocation received in Month 12 as excluding this income stream, the Trust has delivered the original forecast position with the additional TIF ITU funding being offset by the annual leave accrual being in line with last year's accrual rather than a previously forecast £2m reduction.
- The Trust incurred £1.3m of costs relating to COVID-19 in month which is an increase of £0.4m compared with Month 11's figure. This remains within the Trust's YTD fixed allocation with £0.8m being chargeable on top of this allocation for COVID-19 testing costs.
- Capital expenditure for the year is £42.7m which is £0.2m behind the plan
- The cash balance at Month 12 is £87.6m which is £7.2m lower than plan, the main reason being lower than forecast is final ERF payment of £5.1m will be made in 2022/23

Key Recommendations

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

Integrated Performance Report

Month 12 2021/22

Quality | Operational | Workforce | Finance

Contents

Section		Page
1	Introduction to SPC and DQAI	3
2	Quality	5
3	Operational Performance	17
4	Workforce	52
5	Finance	58

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?

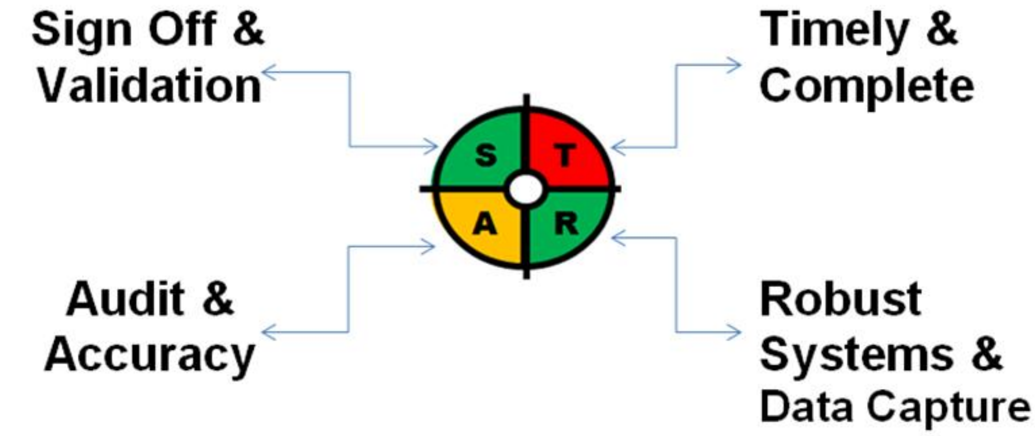
The below key and icons are used to describe what the data is telling us;

Variation			Assurance		
	H L	H L	?	P	F
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

Quality | Operational | Workforce | Finance

A note on Data Quality

- Data Quality Assurance Indicators (DQAI) are used in this report to help give context and assurance as to the reliability and quality of the data being used.
- The STAR Indicator provides assurance around the processes used to provide the data for the metrics reported on.
- The four Data Quality domains are each assessed and assurance levels for each are indicated by RAG status.



Explaining each domain

Domain	Assurance sought
S - Sign Off and Validation	Is there a named accountable executive, who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency with executive officer oversight?
T - Timely & Complete	Is the data available and up to date at the time of submission or publication. Are all the elements of required information present in the designated data source and no elements need to be changed at a later date?
A - Audit & Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur (Annual / One Off)? Are accuracy checks built into collection and reporting processes?
R - Robust Systems & Data Capture	Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?

RAG rating key

Green	Good level of Assurance for the domain
Amber	Reasonable Assurance – with an action plan to move into Good
Red	Limited or No Assurance for the domain - with an action plan to move into Good

Quality

Caring and Safety

2025 Vision “Provide safe, effective, caring and responsive services”

Quality | Operational | Workforce | Finance

Quality Spotlight Report

Key messages

The Trust achieved the following standards in March 2022:

- Friend & Family (Inpatients) improved to 99.3% and exceeds 95% target.
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Quality Dashboard

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1821		
Patient Safety Incidents per 1000 bed days	N/A	46.75		
Patient Safety Incidents per 1000 bed days with no harm	N/A	32.66		
Patient Safety Incidents per 1000 bed days with low harm	N/A	11.86		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.64		
Patient Safety Incidents with moderate harm +	N/A	21		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.54		
Harm Free Care (New Harms)	95%	95.2%		
Patient Falls per 1000 bed days	5.6	7.1		
Patient Falls with harm per 1000 bed days	1.5	1.5		
Medication Incidents per 1000 bed days	6	4.4		
Medication Incidents % with moderate harm or above	0.50%	1.56%		
Patient Medication Incidents per 1000 bed days	6	3.8		
Patient Medication Incidents % with moderate harm or above	0.50%	0.00%		

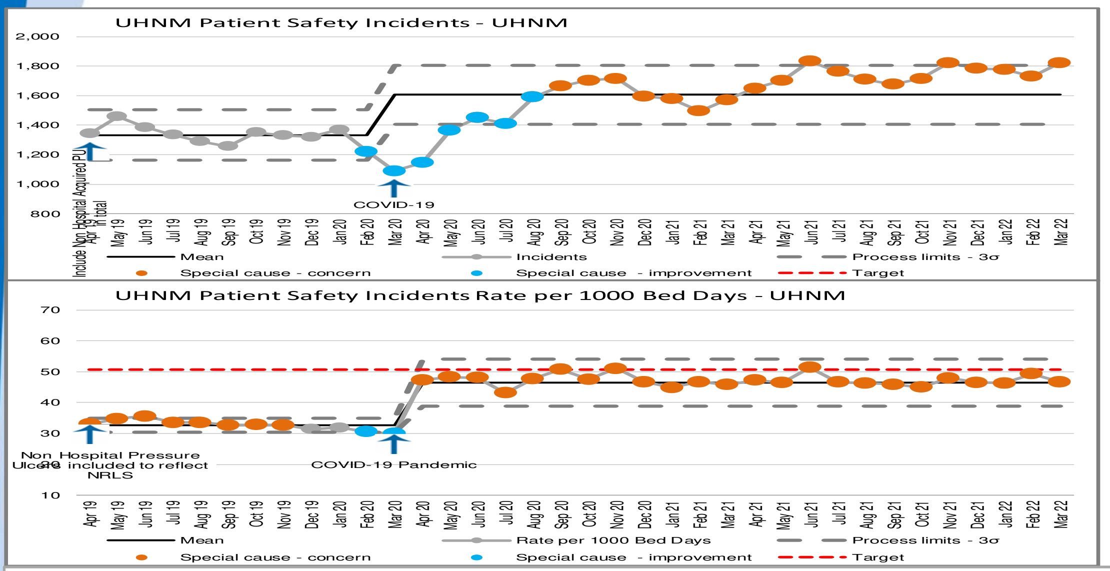
Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	0	26		
Serious Incidents Rate per 1000 bed days	0	0.51		
Never Events reported per month	0	3		
Duty of Candour - Verbal/Formal Notification	100%	100%		
Duty of Candour - Written	100%	79.0%		
All Pressure ulcers developed under UHNM Care	TBC	68		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.93		
All Pressure ulcers developed under UHNM Care lapses in care	12	21		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.65		
Category 2 Pressure Ulcers with lapses in Care	8	6		
Category 3 Pressure Ulcers with lapse in care	4	1		
Deep Tissue Injury with lapses in care	0	13		
Unstageable Pressure Ulcers with lapses in care	0	4		

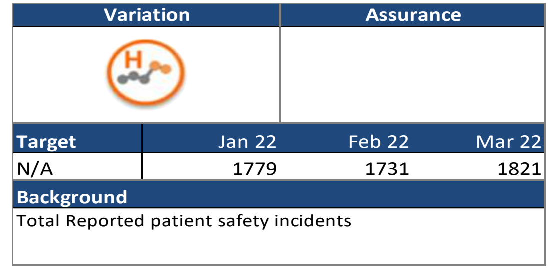
Quality Dashboard

Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	72.9%		
Friends & Family Test - Inpatient	95%	99.3%		
Friends & Family Test - Maternity	95%	100.0%		
Written Complaints per 10,000 spells	21.11	35.63		
Rolling 12 Month HSMR (3 month time lag)	100	97.33		
Rolling 12 Month SHMI (4 month time lag)	100	101.79		
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	4		
VTE Risk Assessment Compliance	95%	0.0%		
Reported C Diff Cases per month	8	12		
Avoidable MRSA Bacteraemia Cases per month	0	0		
HAI E. Coli Bacteraemia Cases per month	8	10		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	48		

Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	84.4%		
Inpatient IVAB within 1hr (Contracted)	90%	92.9%		
Children Sepsis Screening Compliance (All)	90%	84.4%		
Children IVAB within 1hr (All)	90%	0.0%		
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	76.5%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	58.3%		
Maternity Sepsis Screening (All)	90%	94.4%		
Maternity IVAB within 1 hr (All)	90%	N/A		

Reported Patient Safety Incidents





Variation		Assurance	
Target	Jan 22	Feb 22	Mar 22
N/A	1779	1731	1821
Background			
Total Reported patient safety incidents			

Variation		Assurance	
NRLS Mean	Jan 22	Feb 22	Mar 22
50.70	46.29	49.34	46.75

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The March 2022 total remains above the mean total since COVID-19 started. However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

The largest categories for reported PSIs excluding Non Hospital acquired Pressure Ulcers are:

- Patient related Slip/Trip/Fall - 278 (250)
- Clinical assessment (Including diagnosis, images and lab tests) – 85 (84)
- Patient flow incl. access, discharge & transfer - 110 (107)
- Documentation – 34 (46)
- Pressure Ulcers (Hospital acquired) – 70 (78)

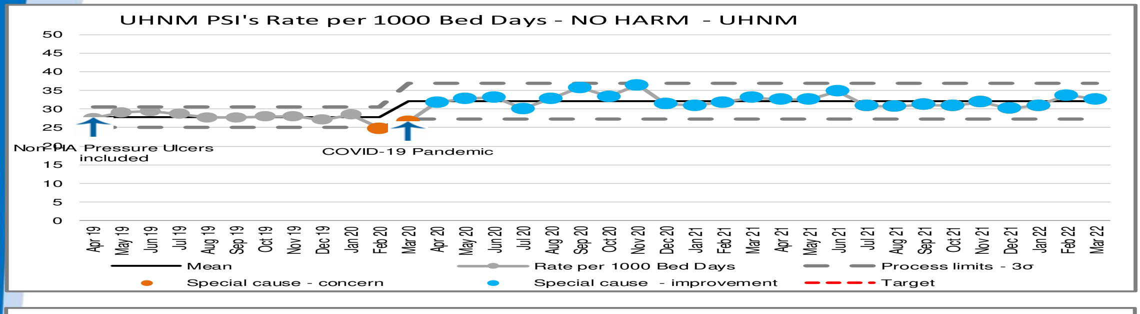
Treatment/Procedure - 61 (58)
Medication incidents - 149 (150)
Infection Prevention – 54 (39)
Staffing – 28 (31)

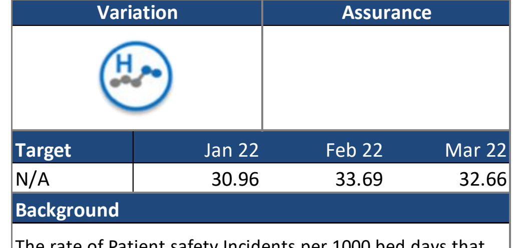
There has been increase in the number of staffing related incidents submitted during March 2022 with 85 (55 in February, 60 in January, 74 in December, 60 in November and 61 in October) incidents reported. 28 of these were under patient related and the remaining 43 were reported as staff related and 14 Trust related. All of these incidents were relating to lack of suitable trained staff. Individual incidents may relate to lack of different staff groups and during February 2022 the following were reported:

63 (48 in February, 49 in January 2022 and 69 in December 2021) – insufficient professional healthcare staff
13 (2 in February, 13 in January 2022 and 7 in December 2021) – insufficient non professional healthcare staff (6 of these were reported at County Hospital Ward 1)
9 (6 in February, 9 in January 2022 and 6 in December 2021) – insufficient support staff

The rate of reported PSIs per 1000 bed days has remained relatively stable following the change at the start of COVID-19 pandemic but is currently below the NRLS Mean rate

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

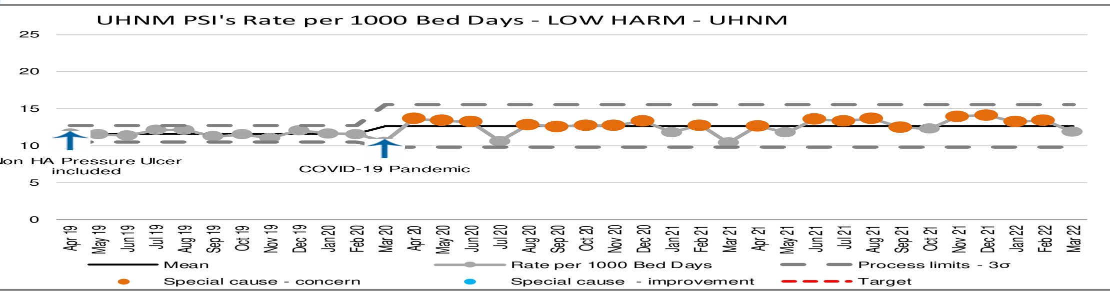


Variation	Assurance
	

Target	Jan 22	Feb 22	Mar 22
N/A	30.96	33.69	32.66

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	Jan 22	Feb 22	Mar 22
N/A	13.19	13.43	11.86

Background

The rate of Patient safety Incidents per 1000 bed days that are reported as resulting in LOW Harm to the patient.

UHNM PSI's Rate per 1000 Bed Days - NEAR MISSES - UHNM

Non HA Pressure Ulcer included

COVID-19 Pandemic

Mean | Rate per 1000 Bed Days | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

Variation	Assurance

Target	Jan 22	Feb 22	Mar 22
N/A	1.48	1.28	1.64

Background

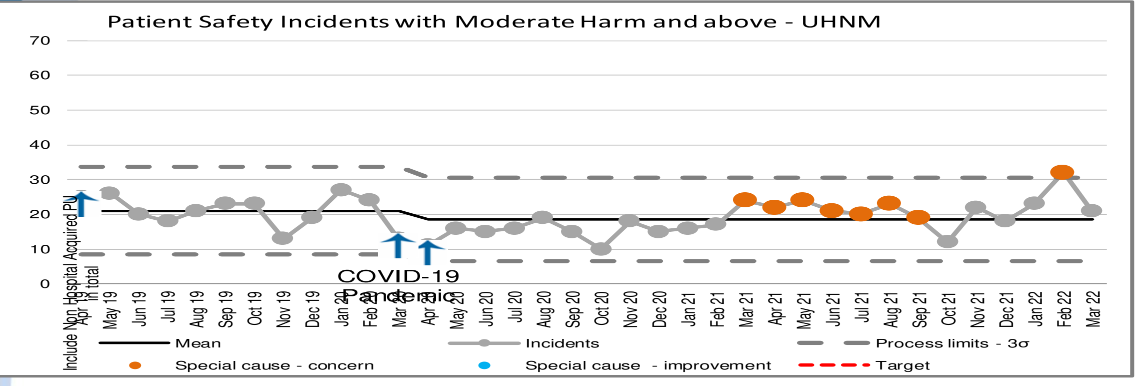
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

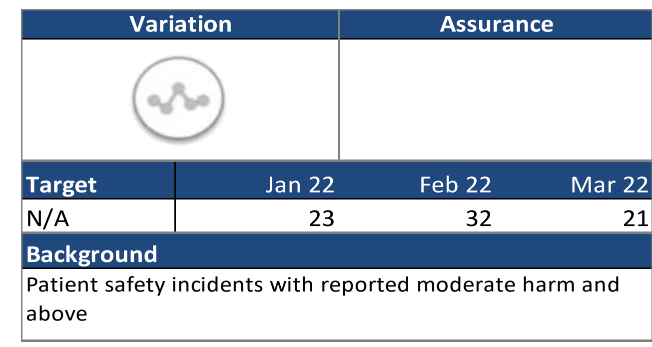
What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with no harm or low harm are showing consistent trends. Although Low harm has seen increase in recent months the rate is still within normal variations and around the long term mean for no harm, low harm and near miss incidents.

The reporting of all incidents and near misses should continue to be encouraged so that mitigating actions and learning can be identified via these incidents to further improve the quality of care and services provided and reduce risk of serious harm.

Reported Patient Safety Incidents with Moderate Harm or above





Variation	Assurance

Target	Jan 22	Feb 22	Mar 22
N/A	23	32	21

Background

Patient safety incidents with reported moderate harm and above

Patient Safety Incidents with harm (rate per 1000 bed days) - UHNM

Non Hospital Pressure Ulcers included to reflect NRLS

COVID-19 Pandemic

Mean · Rate per 1,000 bed days · Process limits - 3σ · Special cause - concern · Special cause - improvement · Target

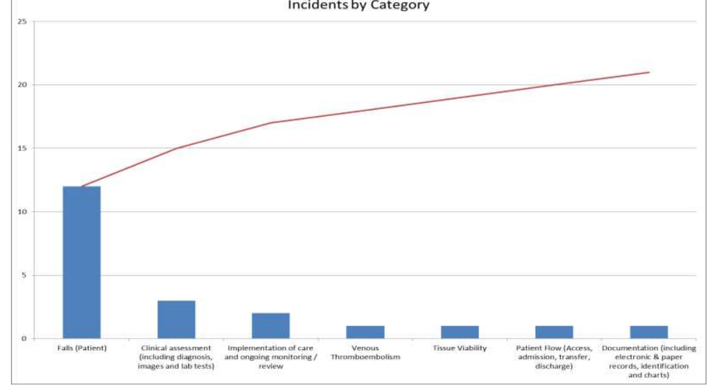
Variation	Assurance

Target	Jan 22	Feb 22	Mar 22
N/A	0.60	0.91	0.54

What is the data telling us:

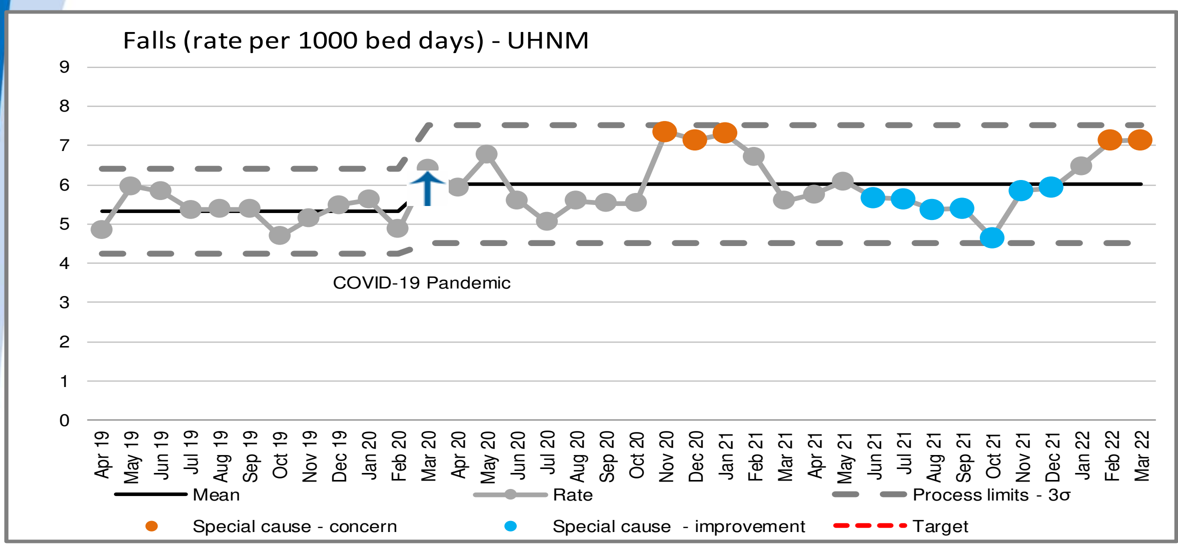
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within outside variation and with monthly special cause noted. The monthly total may be amended following investigation of the incidents and level of harm reviewed and confirmed.

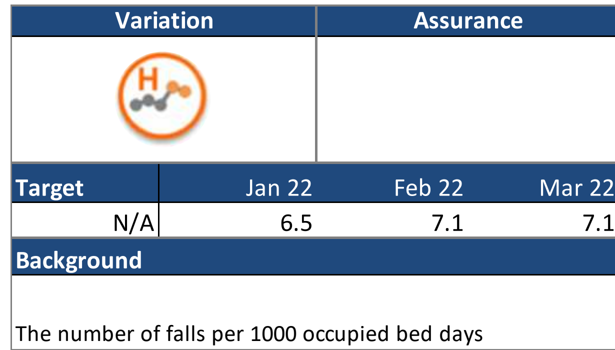
The top category of incidents resulting in moderate harm reflect the largest reporting categories with 12 Falls, 3 clinical assessment, 2 implementation of care, being top 3 categories.
National Comparison taken from latest CQC Insight Report is that 26.1% of reported patient safety incidents to NRLS resulted in harm. UHNM latest results are 22.8%



Quality | Operational | Workforce | Finance

Patient Falls Rate per 1000 bed days





Variation	Assurance

Target	Jan 22	Feb 22	Mar 22
N/A	6.5	7.1	7.1

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 remains within the control limits and normal variation although past 2months are near to the upper control limit

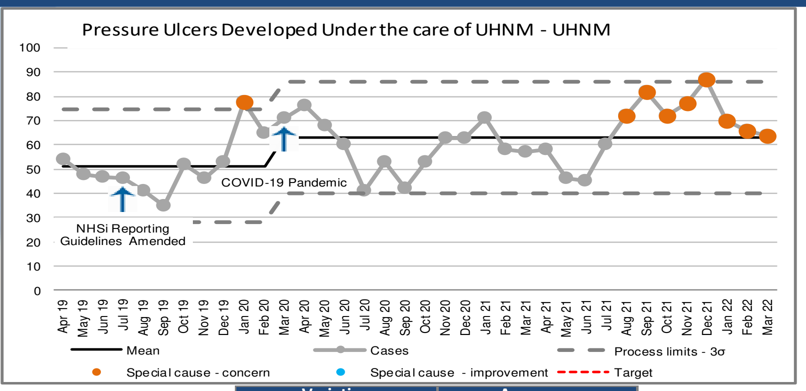
The areas reporting the highest numbers of falls in March 2022 were:

Royal Stoke ED- 32 falls   Royal Stoke AMU – 18 falls   Royal Ward 228 – 13 falls   County Hospital AMU – 11 falls

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

- Meetings are continuing with the ECC falls group, they are currently focussing on a different aspect of falls each week and are revamping their training presentations.
- 6 of the doors in ECC red majors have been removed, this provides betted observation of the patient.
- Documentation regarding falls has been observed by the falls champion on AMU and the Q&S team to identify common themes and improvements.
- Ward 228 have a patient that has fallen 7 times. Documentation and preventative measures are compliant. None of the 13 falls for ward 228 have caused a patient harm.
- New falls champion and refresher dates have been advertised in May at the County Site. Further dates will be made at the Royal Stoke site when room availability has been secured.

Total Pressure Ulcers developed under care of UHNM

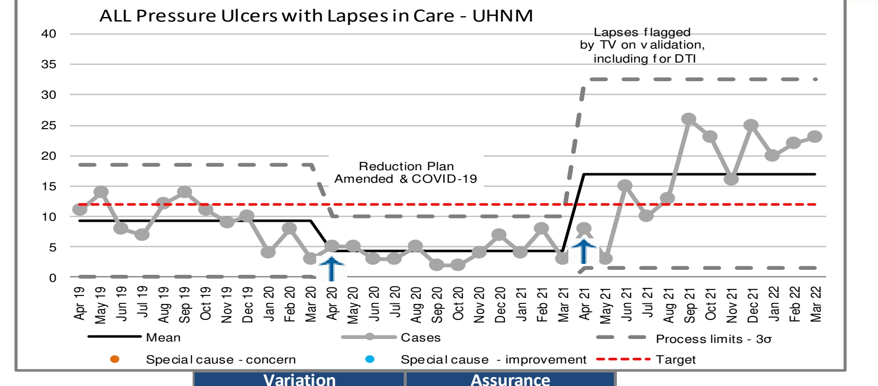


Variation	Assurance

Target	Jan 22	Feb 22	Mar 22
N/A	70	66	64

Background

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



Variation	Assurance

Target	Jan 22	Feb 22	Mar 22
12	20	22	23

Background

ALL pressure ulcers which developed whilst under the care of UHNM with lapses in care identified

The number of pressure ulcers reported as developed under UHNM care has been above average for 8 consecutive months, which may indicate a significant change. The tables below show breakdowns of the pressure ulcers reported last month.

Category	Total (Mar 2022)
DTI	24
Category 2	26
Category 3	7
Category 4	0
Unstageable	7
Total	**64**

Top Body Locations	Total (Mar 2022)
Heel	12
Sacrum	4
Buttock	4

The number of DTI's reported as developed under UHNM care has also been above average for 8 consecutive months. Numbers within other categories are stable.

The number of pressure ulcers reported as developing under the care of UHNM, where lapses in care have been identified, has been significantly higher than in previous years, but there does not currently appear to be a further increasing trend.

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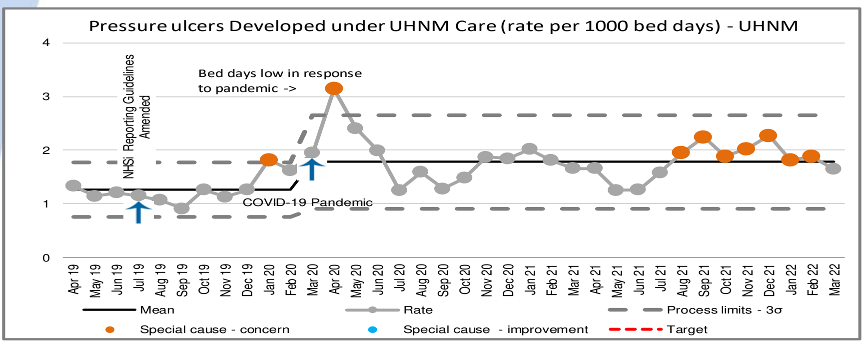
Pressure Ulcers developed under care of UHNM per 1000 bed days

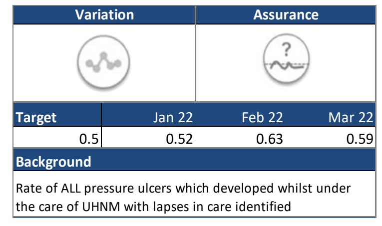


ALL Lapse in Care Ulcers (rate per 1000 bed days) - UHNM

Reduction Plan Amended & COVID-19

Mean — Cases — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Variation		Assurance	
Target	**Jan 22**	**Feb 22**	**Mar 22**
N/A	1.82	1.88	1.64
Background			
Rate of Deep Tissue injuries and Category 2-4 and Unstageable pressure ulcers which developed under the care of UHNM			



Variation		Assurance	
Target	**Jan 22**	**Feb 22**	**Mar 22**
0.5	0.52	0.63	0.59
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 is showing signs of returning to normal variation, after 7 consecutive months above the average. The rate of ulcers with lapses in care has been significantly higher than in previous years, but there does not currently appear to be a further increasing trend.

Acuity for ward areas is taken into account in line with lapses in care.

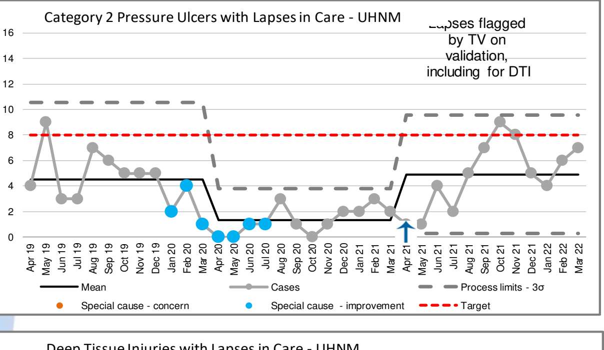
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.

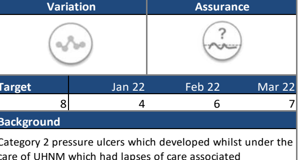
Pressure Ulcer prevention is an annual objective and a key driver metric as part of the Trust's Improving Together programme.

Actions

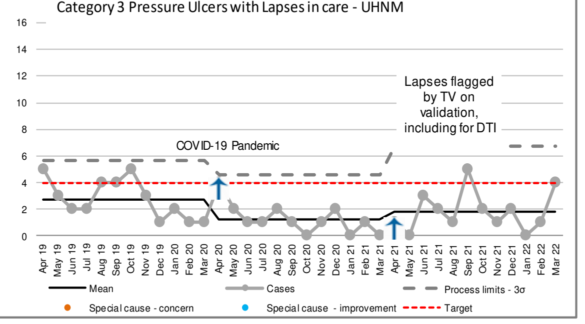
- Documentation is under constant review to reduce identified lapses, aSSKINg bundle has recently been amended to address panel themes
- Pressure Ulcer Prevention (PUP) education is now delivered on multiple platforms including the Nursing Assistant, adaptation nurse and Preceptorship induction programme , new starters in ED and child health, Mandatory ED training and ward champions . Education and support can also be requested as required.
- Communication is provided by SSR for Q&S to multiple reporting wards to highlight learning needs and support formulation of the action panel ahead of RCA panel.
- Following RCA panel assurance is sought from clinical areas by SSR for Q&S, spot audits are completed during the visit.
- Seating audits are being completed across the trust and a proposal for new chairs has been submitted for the Royal Stoke site. Care of the elderly received their new chairs with funds supported by PHE. The County site have also been audited identifying poor pressure relief within the cushion. Action to be taken.
- Review of surfaces in ED to enhance Pressure ulcer prevention, 15 Stryker trollies with high quality pressure relieving mattresses have been purchased. ED will be ordering repose companions for all surfaces. An Ambulance assessment tool has been devised to implement early intervention of PUP however support is still being sought from WMAS.

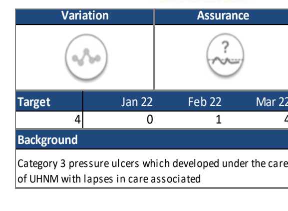
Pressure Ulcers with lapses in care



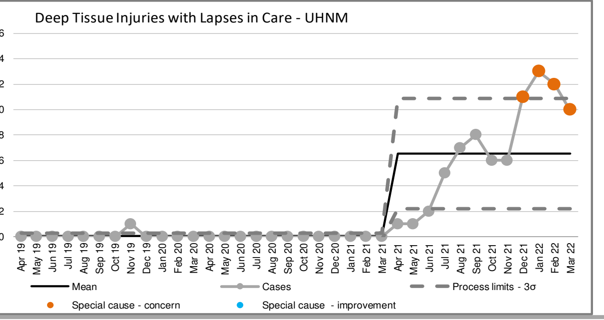


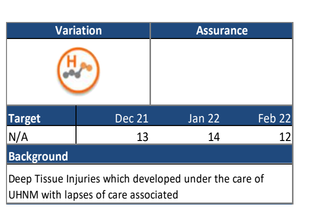
Variation		Assurance	
Target	Jan 22	Feb 22	Mar 22
8	4	6	7
Background			
Category 2 pressure ulcers which developed whilst under the care of UHNM which had lapses of care associated			



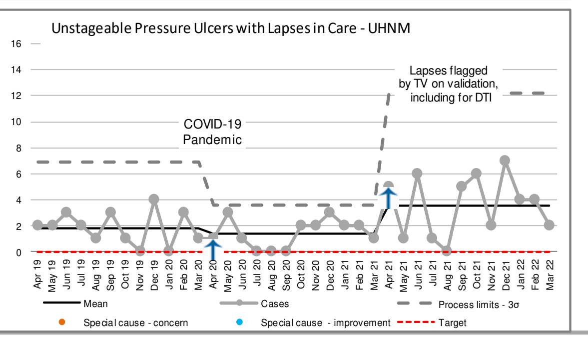


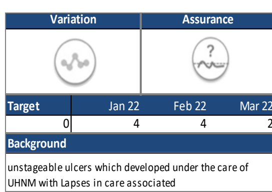
Variation		Assurance	
Target	Jan 22	Feb 22	Mar 22
4	0	1	4
Background			
Category 3 pressure ulcers which developed under the care of UHNM with lapses in care associated			





Variation		Assurance	
Target	Dec 21	Jan 22	Feb 22
N/A	13	14	12
Background			
Deep Tissue Injuries which developed under the care of UHNM with lapses of care associated			





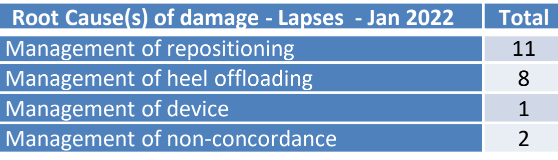
Variation		Assurance	
Target	Jan 22	Feb 22	Mar 22
0	4	4	2
Background			
unstageable ulcers which developed under the care of UHNM with Lapses in care associated			

What is the data telling us:

Deep Tissue Injuries are noted with potential special cause variation and Deep Dive into these DTIs is currently ongoing with the Tissue Viability team and will report the outcome of the review at March 2022 Quality Governance Committee. This analysis is being undertaken to assess the potential causes for increased pressure ulcers with lapses in care and whether this is result of the current operational pressures across the Trust and potentiallinks with long waits in Emergency Department and/or on ambulances.

As shown in the table below, common lapses identified are management of repositioning and heel offloading .

Locations with more than 1 lapse in January 2022 were:
Ward 221 (3), Ward 126 (2), Emergency Care Centre (2), (County) Ward 15 (2), (County) Ward 14 (2)

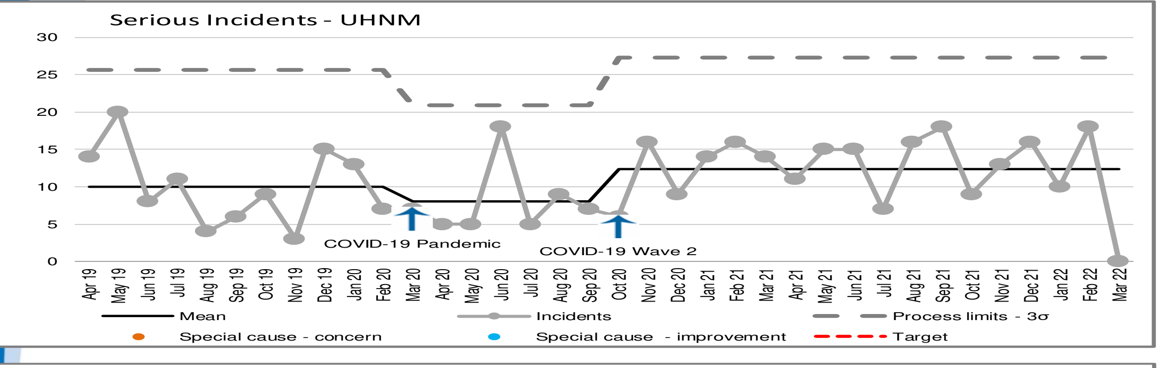


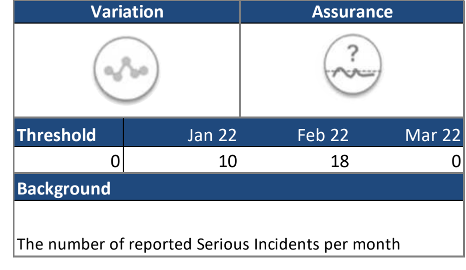
Root Cause(s) of damage - Lapses - Jan 2022	Total
Management of repositioning	11
Management of heel offloading	8
Management of device	1
Management of non-concordance	2

Actions:

- High reporting wards will be sent notification, with Hot Debriefs taking place on the wards
- Education continues on high reporting areas from TV Team and Corporate team
- Pressure Ulcer Prevention (PUP) Champions training is in process planning for next year and focuses on learning from incidents.
- Engage house keepers to support wards with ensuring adequate equipment is available for heel offloading.
- Learning form RCA's educational guide has been shared with staff.

Serious Incidents per month





Variation	Assurance		
Threshold	Jan 22	Feb 22	Mar 22
0	10	18	0
Background			
The number of reported Serious Incidents per month			

Rate of SIs 1000 bed days - UHNM

1.0 0.9 0.8 0.7 0.6 0.5 0.4 0.3 0.2 0.1 0.0

COVID-19 COVID-19 2nd wave

Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22

Mean — Rate of SIs 1000 bed days — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Variation	Assurance		
Target	Jan 22	Feb 22	Mar 22
0	0.26	0.51	0.00
Background			
The rate of Serious Incidents Reported per 1000 bed days			

What is the data telling us:

Monthly variation is within normal limits. Target has been set at 0 for serious incidents but this is under review to develop trajectory for reducing serious incidents across UHNM. March 2022* saw 26 incidents reported with 22 at RSUH and 4 at County Hospital:

- 12 Falls related incidents
- 4 Treatment delay
- 2 Diagnostic related
- 1 Maternity related (mother & baby only)
- 1 Maternity related (baby only)
- 3 Surgical/invasive procedure related incidents
- 1 Medical device/equipment related
- 1 sub optimal care of deteriorating patient
- 1 Accident / Collision related

The rate of SIs per 1000 bed days has varied consistently within confidence limits indicating normal variation and there has not been any significant trend, however March 2022 has seen increase towards the upper confidence limit and above the long term mean.

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

Serious Incidents Summary

Summary of new Maternity Serious Incidents

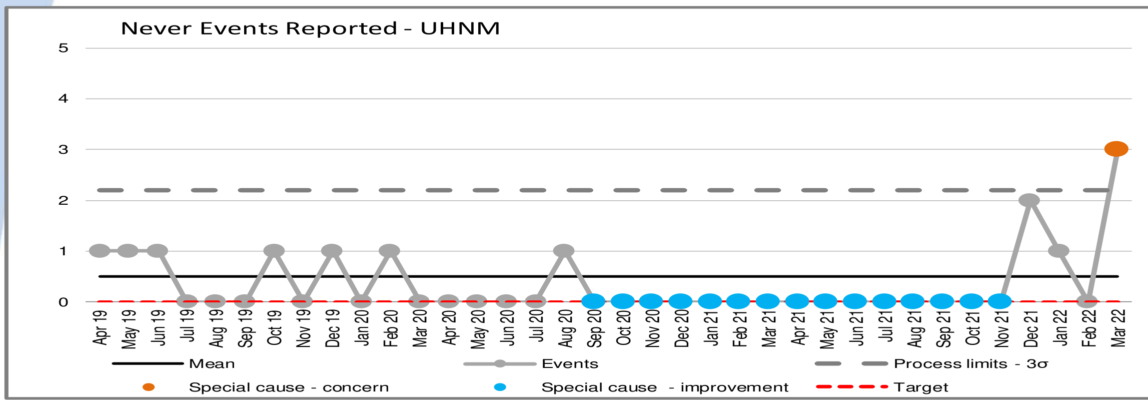
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during March 2022. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

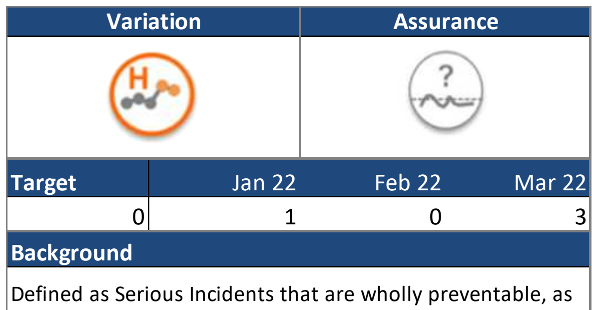
All Serious Incidents will continue to be are reported and investigated and the final Root Cause Analysis presented at Divisional meetings and Risk Management Panel for review and agreement prior to sharing with CCGs for closure.

There were 2 Maternity related Serious Incidents reported on STEIS during March 2022

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:
2022/5507	White - British	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	15-Jun-22	Baby seen in the eye clinic. She was born at UHNM and had incomplete closure of the right eye leaving her right cornea unprotected. Mother's photos reviewed - appears to be present at birth, not detected on completion of the NIPE. She is now being treated for dryness of the right cornea.
2022/5764	Not Stated	Maternity/Obstetric incident meeting SI criteria: mother & baby (this include foetus, neonate and infant)	20-Jun-22	Neonatal Death at 30 weeks gestation. Perinatal Mortality Review Tool received from an external provider. Ante – natal Care provided by UHNM scored as a 'C' by the external hospital review group, care issues identified that may have made a difference to the outcome.

Never Events





Variation	Assurance		
Target	Jan 22	Feb 22	Mar 22
0	1	0	3

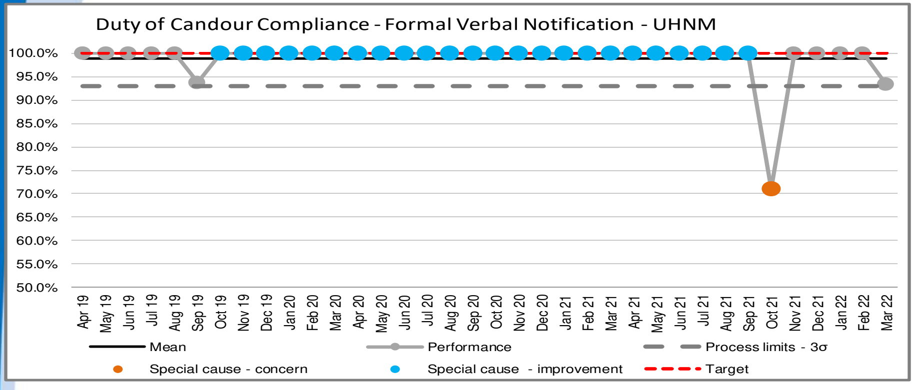
Background

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

There has been 3 reported in March 2022 and 6 in total for year to date 2021/22. The target is to have 0 Never Events.

Log No.	STEIS Category	Never Event Category	Description	Target Completion date
2022/5020	Surgical invasive procedure	Incorrect implant / prosthesis	Following injury to right humerus, operative fixation undertaken and used reconstruction plate rather than intended LCP plate. Noted that plate had slight bend and treated conservatively. 6 weeks post procedure x ray confirmed break to bilateral aspect of the plate. Underwent further operation to repair the failed plate. • Reconstruction plates have been removed from the operation sets and are now being stored separately. • Learning alert issued to all relevant staff within Theatres and Trauma & Orthopaedic Directorate	09/06/2022
2022/5023	Surgical invasive procedure	Wrong site surgery	Patient underwent excision for multiple mole biopsies. Patient later reported that incorrect lesion had been removed from shoulder/back area. Correct lesion removed at follow up appointment • All staff advised to look at clinical photographs (if available) prior to procedure being carried out • Laptop available in second minor op room so that patient is in the same room when clinical photographs are being viewed • Patient to point to area that is to be removed, mirrors to be used if this is on the back. Especially important if no photographs available. If any doubt on location, referring Dr to be consulted. If this is not possible, surgery to be rescheduled.	09/06/2022
2020/5030	Surgical invasive procedure	Incorrect implant / prosthesis	A closed ante grade intramedullary nailing of left femur performed with no intra operative issues. After the procedure had been performed, it was identified that a different sized locking bolts used. Reviewed by Consultant Surgeon and discussed with patient that no impact on outcome and patient was fully weight bearing and mobilizing 2 days post surgery.	09/06/2022

Duty of Candour Compliance

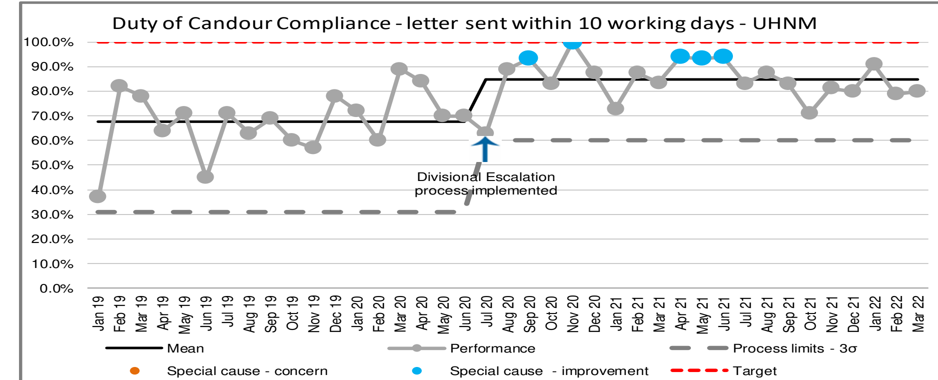


Variation	Assurance

Target	Jan 22	Feb 22	Mar 22
100%	100.0%	100.0%	93.3%

Background

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



Variation	Assurance

Target	Jan 22	Feb 22	Mar 22
100%	90.9%	79.0%	80.0%

Background

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

What is the data telling us:

During March there were 15incidents reported and identified that have formally triggered the Duty of Candour. All 14 of these cases (93.3%) have recorded that the patient/relatives been formally notified of the incident in Datix, the final incident is awaiting update on Datix that duty of candour has been completed.

Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during March 2022 is 80%.

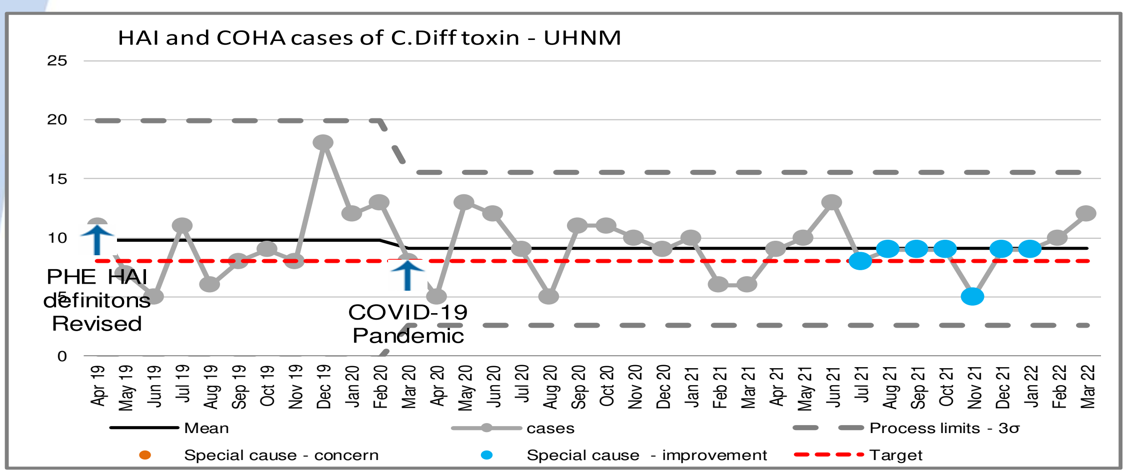
There are 2 cases that did not received the letter within 10 days but have subsequently been circulated to patients/relatives and there is 1 case still awaiting update on Datix.

Actions taken:

The Divisions have escalated performance within their governance and performance forums and follow up with clinicians is being taken to ensure that letters are provided within the timeframe. Escalations on outstanding letters are provided to relevant directorates and divisions via the Divisional Governance & Quality Managers and these are provided once identified and Duty of Candour required and where there has been no response prior to the deadline date. Additional support is being provided in writing the letters for clinician review and signature.

Compliance is included in Divisional reports for discussion and action.

Reported C Diff Cases per month



Variation	Assurance

Target	Jan 22	Feb 22	Mar 22
8	9	10	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 March with 8 being Hospital Associated Infection (HAI) cases and 4 COHA cases.

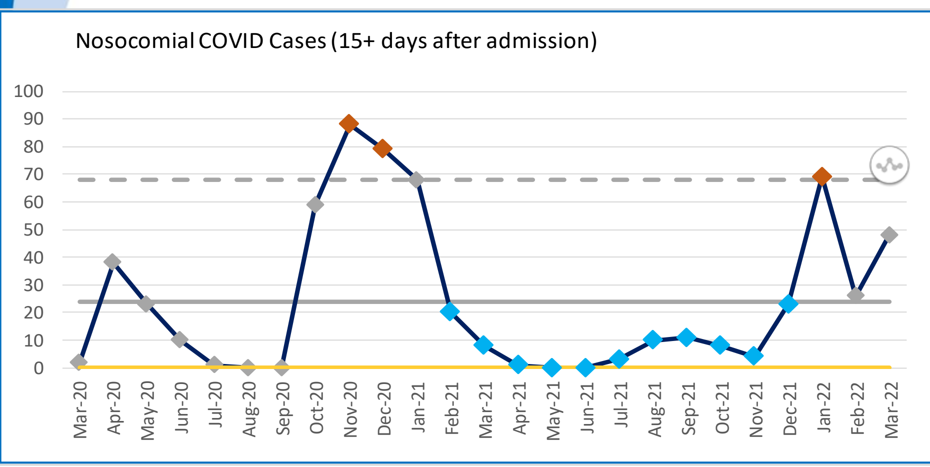
HAI: cases that are detected in the hospital three or more days after admission (day 1 is the day of admission)

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 have been no clinical areas that have had more than one Clostridium *difficile* case in a 28 day period.

Actions:

- Continue surveillance for HAI C diff with continued immediate implementation of control measures to prevent transmission
- In all cases control measures are instigated immediately
- Each in-patient is reviewed by the C *difficile* nurse at least 3 times a week, and forms part of a multi-disciplinary review.
- Routine ribotyping of samples is now being undertaken at Leeds hospital. This will help determine if cases can be linked
- A Clostridium *difficile* Task and Finish Group in place



	Community COVID-19 rate per 100,000 population (as at month end)				UHNM		
	England	W Mids	Staffs	Stoke	Total Admissions	COVID cases	
						Prob	Def
Oct 20	232.1	273.7	352.2	373.3	17006	63	59
Nov 20	152.2	188.0	206.0	350.3	14956	109	88
Dec 20	526.0	404.1	370.2	318.7	14701	107	79
Jan 21	283.0	328.0	296.0	239.5	14255	128	68
Feb 21	86.60	113.2	104.6	125.2	14101	31	20
Mar 21	56.0	61.6	56.2	76.8	17105	12	8
Apr 21	24.1	23.6	17.7	35.1	16554	3	1
May-21	49.0	36	27.9	18.3	17273	0	0
Jun-21	100.4	76.9	62.4	93.6	18527	0	0
Jul-21	290.1	273.5	242.9	223.3	18168	4	3
Aug-21	310.8	321.7	360.5	375.6	17160	14	10
Sep-21	355.3	414.0	512.2	423.3	17327	11	10
Oct-21	484.9	468.8	569.7	532.7	17055	8	8
Nov-21	476.1	400.2	455.2	492.2	17700	4	4
Dec-21	1591.6	1461.3	1574.0	1298.4	16688	13	23
Jan-22	904.4	856.7	824.5	1044.7	16109	67	69
Feb-22					16278	39	26
Mar-22					18518	71	48

What do these results tell us?

- Increase in cases throughout March 2022 with 48 definite Healthcare Acquired COVID -19 cases.
- March has seen increase in Probable and definite Hospital Onset COVID
- Monthly total is within normal variation

Actions :

- All Emergency patients continue to be screened for COVID 19 on admission to UHNM, screening programme in place for planned surgery/procedures.
- All inpatients who have received a negative COVID 19 screen continue to have a repeat COVID 19 screen on day 4 , 6 and then weekly
- COVID 19 themes report provided to IPCC
- UHNM Guidance on Testing and re-testing for COVID 19 plus step down of suspected/positive cases
- Isolate suspected patients on identification of symptoms
- Process for patients identified as a contact with positive patients
- Process in place for outbreak management and reporting

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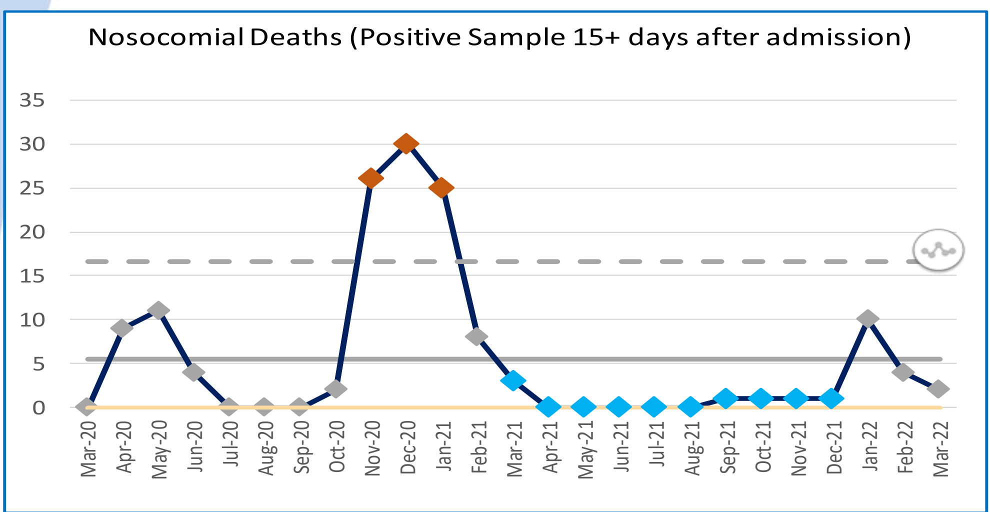
Nosocomial COVID-19 Deaths per month (with 1st positive result 15 days or more after admission)



What do these results tell us?

Increase in monthly total but within normal variation limits

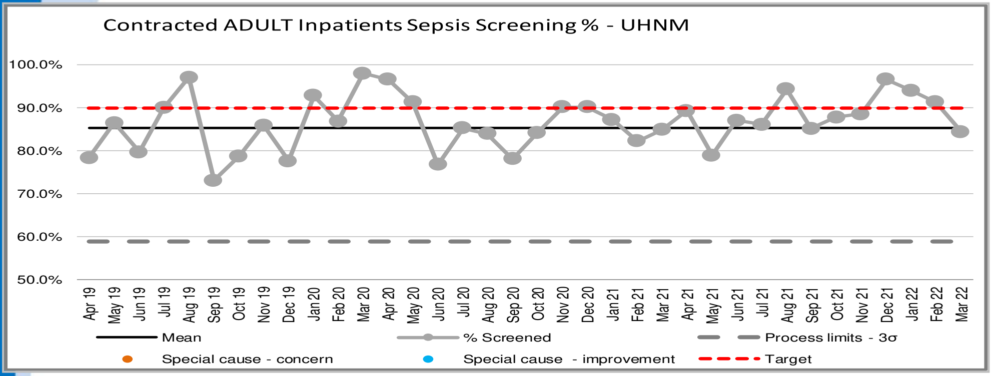
The criteria for the Definite Hospital acquired/Nosocomial COVID-19 is that the patient had **first positive** COVID-19 swab result 15 days or more following admission to UHNM.

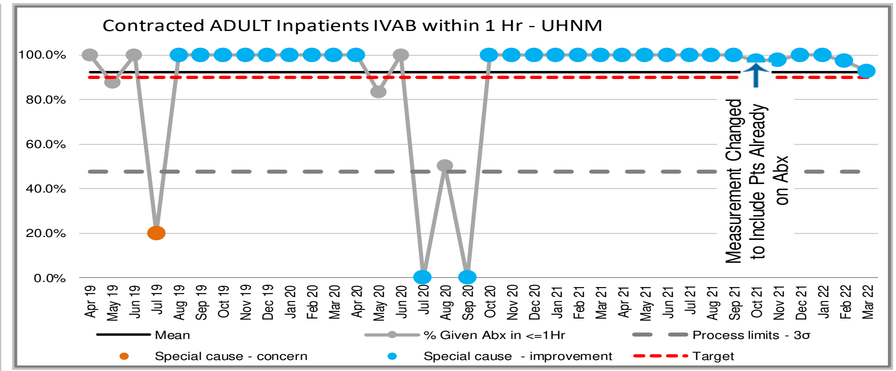
- 2 recorded definite hospital onset COVID-19 deaths in March 2022
- Total 136 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since 1st March 2020 up to 31st March 2022
- 20 Definite Hospital acquired COVID-19 deaths during 2021/2022
- The mean number of deaths per month since March 2020 is 6.

Actions :

All definite Nosocomial COVID-19 deaths up to and including December 2021 have bee reviewed and report has been submitted to the Mortality Review Group identifying the outcome of the case reviews assessing the aspects of COVID-19 management of the patients. Reviews for any further deaths will be undertaken and outcomes compared to the reviews already completed.

Sepsis Screening Compliance (Inpatients Contract)





Variation	Assurance		
Target	**Jan 22**	**Feb 22**	**Mar 22**
90%	94.0%	91.3%	84.4%

Background

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

Variation	Assurance		
Target	**Jan 22**	**Feb 22**	**Mar 22**
90%	100.0%	97.2%	92.9%

Background

The percentage of adult inpatients identified during monthly spot check audits receiving IV Antibiotics within 1 hour for Sepsis Contract

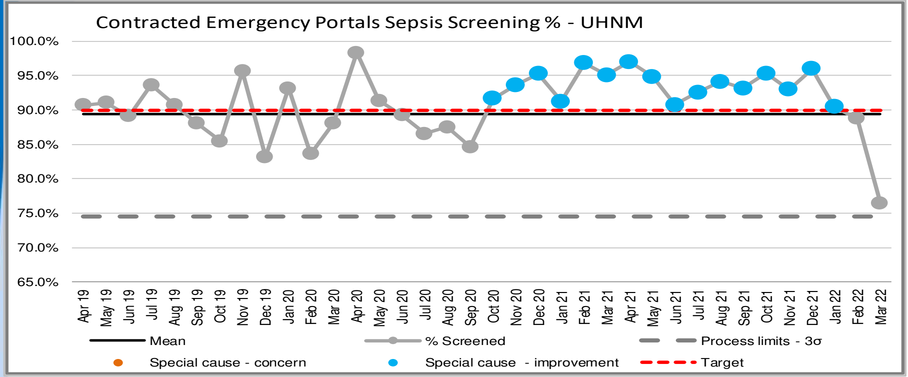
What is the data telling us:

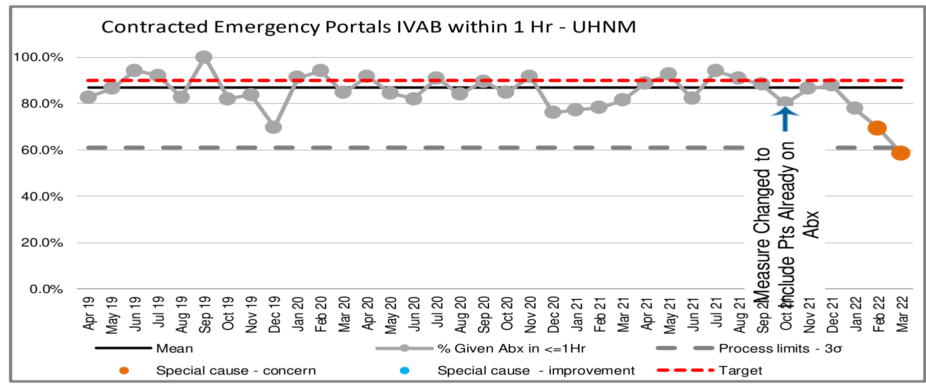
Inpatient areas missed the screening target in March however variation is within normal ranges.
IVAB within 60 minutes is also above target rate with consistently high results.

Actions:

- The sepsis team have continued to provide sepsis re-enforcement, kiosks, visiting ward areas to update clinical staff and promote awareness around sepsis: on-going
- The Sepsis team regularly identify areas of poor compliance and prioritise those areas for more focused re-enforcement and sepsis kiosks each month; on-going
- The Sepsis team continued to work closely with the VitalPac team in order to address issues around staff access and sepsis vitals reporting; on-going
- The Sepsis team offered both delivering out of hours training (7 am) to capture late & night staff as well as early shift staff: on-going
- Continued focus and support provided to all divisions to maintain and sustain compliance: on-going
- The Sepsis Team will continue to create awareness by being involved for HCA and Students induction programmes, this will also include new nursing staff: on-going
- Involvement in the development of the Sepsis Dashboard report by supporting and working closely with the Business Intelligence team (testing & reviewing): on-going

Sepsis Screening Compliance (Emergency Portals Contract)





Variation	Assurance		
Target	**Jan 22**	**Feb 22**	**Mar 22**
90%	90%	89%	76%

Background

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

Variation	Assurance		
Target	**Jan 22**	**Feb 22**	**Mar 22**
90%	78%	69%	58%

Background

The percentage of Emergency Portals patients from sepsis audit receiving IVAB within 1 hour for Sepsis Contract purposes

What is the data telling us:

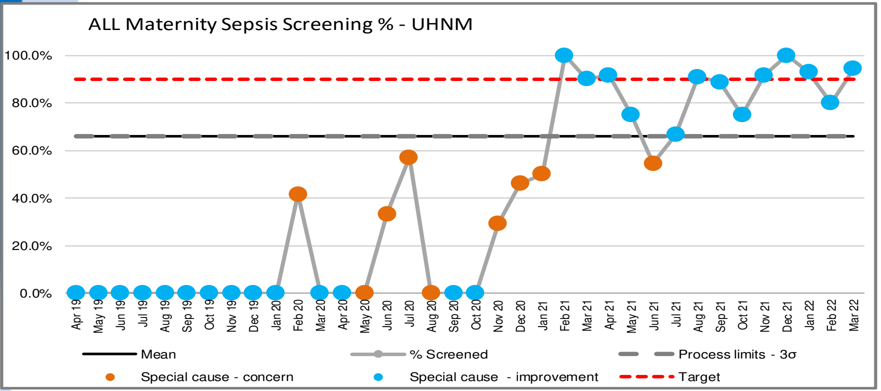
Adult Emergency Portals screening below target for March 2022. Prior to February 2022 there had been consistent achievement of target performance above the target rate..

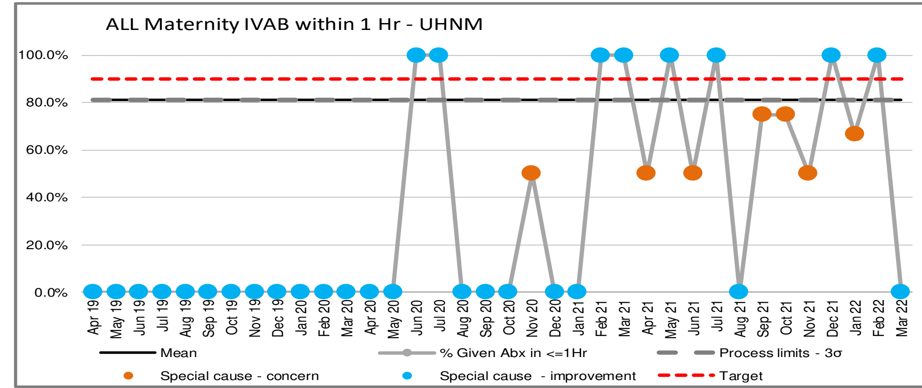
The performance for IVAB within 1hr below target rate for March.

Actions:

- The Sepsis team continue to closely monitor the compliance by visiting the A&E regularly and offering department based sepsis reinforcement when staffing and acuity allows. During February and March 2022 the Emergency portals saw increased activity and attendances.
- The Sepsis Team is working collaboratively with the A&E Quality nurses, senior staff and A&E Sepsis clinical lead for providing solutions to late IVAB incidents and robust actions put in place. The late IVAB have been addressed through escalation and training for individual staff involved: on-going
- To continue with sepsis awareness by providing sepsis kiosks when necessary, this will give staff opportunity to discuss and ask questions about sepsis and patient management

Sepsis Screening Compliance ALL Maternity

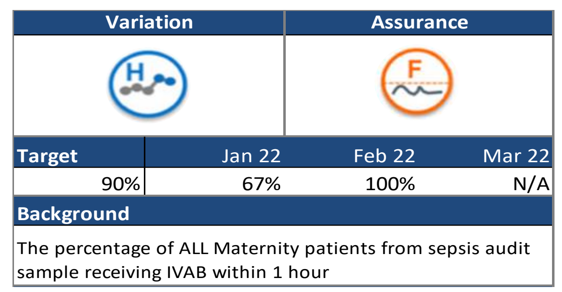




Variation	Assurance		
H	F		
Target	Jan 22	Feb 22	Mar 22
90%	92.9%	80.0%	94.4%

Background

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



Variation	Assurance		
H	F		
Target	Jan 22	Feb 22	Mar 22
90%	67%	100%	N/A

Background

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

What is the data telling us:

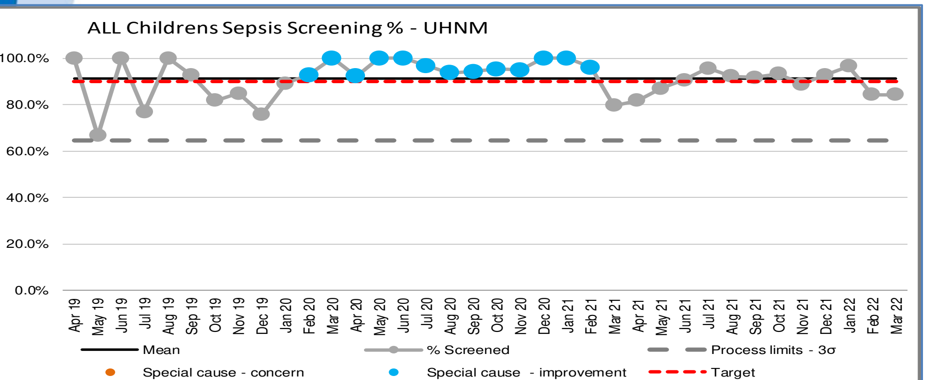
Maternity Inpatients and Emergency portal (MAU) audits show significant improvement in screening compliance above the mean rate with a return to above target performance with 94.4% in March

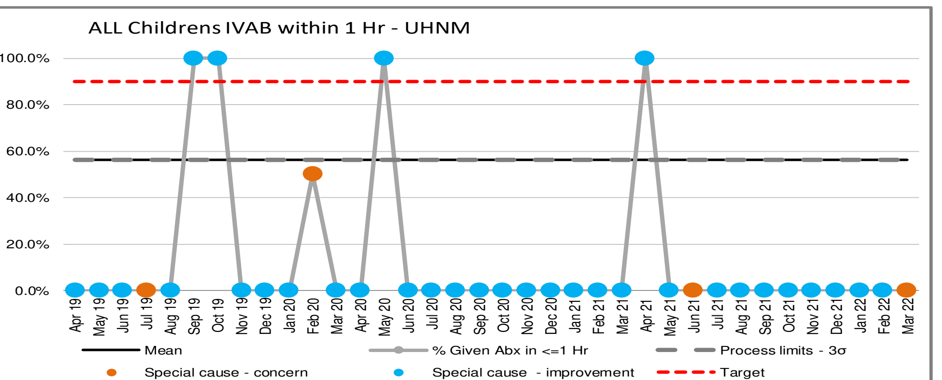
There were no red flag sepsis patients identified in the March audits hence the result of N/A for antibiotics within an hour.

Actions:

- The Maternity Senior team and clinical staff have continued to work collaboratively with the sepsis team to ensure patient safety; on-going
- The Sepsis team will continue to audit Maternity comprehensively to ensure maintenance of high standard of sepsis practice and compliance: on-going
- Maternity educator is supporting the sepsis team by conducting independent sepsis audits in the whole Maternity department with good effect: on-going
- The plan of delivering Maternity 5 hour sepsis CPD champion training remain in the pipeline for future collaborative work has been temporarily put on-hold due to current operational pressures and critical incident situation

Sepsis Screening Compliance ALL Children



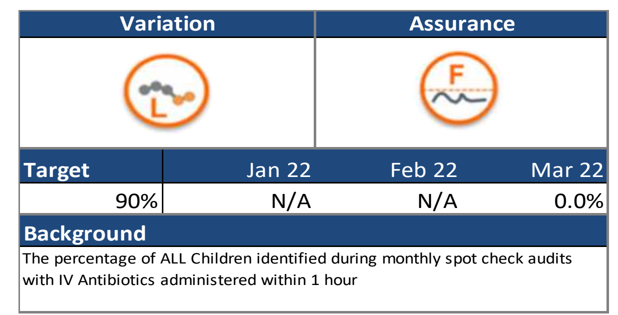


Variation	Assurance

Target	Jan 22	Feb 22	Mar 22
90%	96.6%	84.4%	84.4%

Background

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



Target	Jan 22	Feb 22	Mar 22
90%	N/A	N/A	0.0%

Background

The percentage of ALL Children identified during monthly spot check audits with IV Antibiotics administered within 1 hour

What is the data telling us:

Children's Services show normal variation for Sepsis Screening and have previously achieved the target rate but not consistently achieving the 90% rate.

Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks).

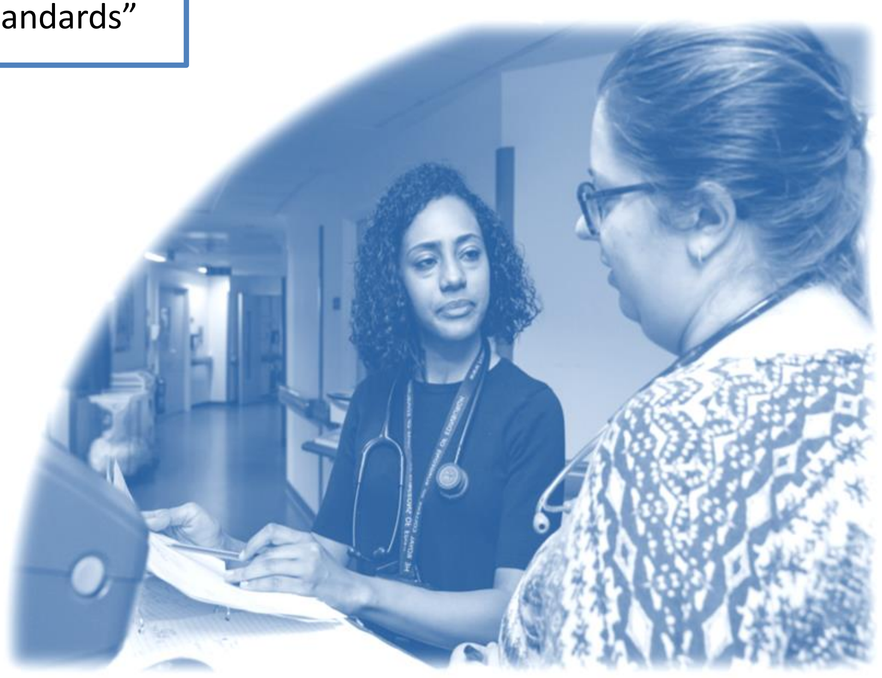
Actions:

- The Sepsis Team continue to deliver re-enforcement and kiosks to specific areas when falls in compliance are identified: on-going
- The Sepsis Team have adjusted the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective
- 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 due to current situation

Quality | Operational | Workforce | Finance

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"



Quality | Operational | Workforce | Finance

Spotlight Report from Chief Operating Officer

Emergency Care

- Attendances increased dramatically in March back up to levels seen in Oct 21. High numbers of DTA's were held in ED overnight due to bed based acuity, high numbers of MFFD with all escalation capacity being open and utilised and infection issues compounding flow. There was also a need to flex capacity into COVID capacity.
- Ambulance handover delays over 60 minutes were high and was a worsening picture against previous months and the decline in 15 minute handovers dropped to 20%. Instances of surge evidenced for WMAS attends which provides challenges for triage, especially when stand by patients have to be managed on clinical need.
- Time to initial assessment meant the position was reduced further on last month to 46%
- Time to Treatment in ED increased in March and was at 140 minutes.

Cancer

- Most recent submitted Cancer Waiting Times position is February 2022. Suspected Breast Cancer, Lung and Upper GI have all achieved the 28Day FDS standard for February.
- Provisional March indicates achievement of 31 day sub radiotherapy and 31 day rare cancers standards.
- The Trust continues to conduct a very high number of 1st appointments, with around 3649 patients being seen in March.
- The overall 2WW 14 day position for March 22 is predicted to achieve in the region of 50%.
- The 28 Day Faster Diagnosis position is currently at 63% with the majority of breaches in Colorectal and Skin. System challenge for Q4 to secure primary care traction on the FIT pathway given the direct link to improved performance potential. Decision to bring UHNM in line with best practice pathway (sequential FIT model) was flagged at the regional T&F group 11.03.22. Decision to shift to sequential model from 01.05.22 communicated at exec level. Primary care are prioritising recall and safety net mechanisms to support.
- The overall 62 day position for March 22 is currently at 41%. This is an incomplete and un-validated position that is expected to change as histology confirms a cancer or non cancer diagnosis for patients treated. There is also a growing volume of unreported pathways due to outstanding histology affecting the position.
- There are currently 474 patients in the 2WW backlog. A reduction since last month. Of the 2WW patients who have breached, 145 patients are in Colorectal and 115 are in Skin.
- The 104+ backlog is slowly reducing, currently circa 100. Divisions have been asked to focus on this cohort and discharge patients where appropriate – e.g. where there are patients waiting over 104 days with an outstanding clinical review. 29% of the 104+ backlog is within Colorectal and 27% is with Skin.

Spotlight Report from Chief Operating Officer

Planned Care

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

- Day Case and Elective Activity delivered 93% and 83% respectively for March 22 against the national ask of 95%, a significant improvement on February's position for Day Case (87%) and Electives (73%).
- In month Planned Care Cell focus on elective recovery based on 10 high impact changes in accordance with the elective plan.
- Theatre plan for Q1 2022/23 gives 104% of 19/20 capacity. "Bookathon" launched to ensure theatre utilisation is improved, and to date as many long waiters and P2s as possible.
- County theatre due to open 11th April.

RTT

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For March the indicative number of Incomplete pathways has risen to 74,984 (February 73,360).
- The number of patients > 18 weeks has risen to a level of 33,665 (February 32,831).
- The numbers of 52 week waits in February has increased slightly with a un-validated total of 4,603 (February 4,461) this figure is below the trajectory.
- At the end of March the numbers of > 104 weeks was 494, an decrease of 40 on January. The Planned Care group is monitoring progress against treatment plans for these patients with escalations to Divisional ADs and CDs when required. Projected number of 104 week breaches at end of April is 383, but this will improve with the anticipated increased booking throughout April.
- Performance has slightly decreased throughout March at provisional 54.9% (February 55.7%).
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.

Diagnostics

- For DM01 (15 nationally identified Dx tests) the validated position for total waiting list has increased in March from 22,529 to 24,004. The Non-obstetric ultrasound waiting list increased slightly from 9,394 to 9550. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance is at 71%.
- Within DM01, the greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls, a number of actions are in place. Non obstetric ultrasound performance remains a Driver Metric for CWD and has specific focus for improvement, albeit this is related to workforce retention, recruitment and innovative ways to train and recruit. Further outsourcing of non-obstetric ultrasound scanning is continuing to be explored.
- DM01 performance excluding non obs ultrasound would be c84%.
- Histology turnaround times remain a high risk; there is an action plan in place and the position is improving. Cancer related histology is being treated urgently and all cancer related escalations are being prioritised.

Section 1: NON ELECTIVE IMPROVEMENT

Urgent Care – Attendances and 4 hour performance

Type 1 Attendances - UHNM

16,800
14,800
12,800
10,800
8,800
6,800

Nov 17, Dec 17, Jan 18, Feb 18, Mar 18, Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean | Attendances | Process limits - 3σ
Special cause - concern | Special cause - improvement | Target

Type 1 performance (RS & County) - UHNM

100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%

Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean | Performance | Process limits - 3σ
Special cause - concern | Special cause - improvement | Target

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Urgent Care – In Month Performance Summary

Attendances; Total type 1 attendances increased in March 2021 and where back up to levels seen in Autumn 2021. seen pre Xmas 2021.

Triage; Initial assessment within 15 minutes decreased in March from 53.8% from 46%%. Performance is influenced most where there are surges of over 30 attendances within the hour, particularly in the evening. This can be where staff shortages, particularly decision makers has been a challenge. The department are aiming to stop the decline in triage time with re-deployment of staff in the department at the time and are looking at tiered rotas in line with RCEM guidance. A business case addressing workforce challenges was approved in early October and staff are being recruited to as per the planning timescale in that case, a separate paper was presented at PAF this month to share the current position against the funding, a further update will be due back to PAF in May 2022.

Ambulance; The percentage of ambulance handovers within 15mins at RSUH site declined in March 20% Handover delays over 60 minutes also slightly increased. However longer delays occurred during peak ambulance arrival times in early evening, when multiple Crews arrive on site in succession. A Go, Look, Learn of evaluation and learning took place and a brief report was circulated. During march the cohorting of up to 4 WMAS crews has taken place to reduce ambulance holds in times of surge, however the pressure remains across both WMAS and UHNM with the current demand on services. Work to reconcile WMAS performance data and UHNM PIN out routines continues to ensure accurate reporting of ambulance turnaround times.

Long waits; The number of patients in the department for > 12 hours saw a slight growth in line with increased attendances and long waits in the department across both admitted and non admitted pathways.

Admissions; The number of patients attending and admitted with Covid-19 Rose through March with bed demand reaching 225 at the end of March. 1+ LoS spell are at around 92% of 1920 BAU. Discharges pre-noon remained much the same as previous months but the re start week did show improving metrics around earlier moves for all specialties until the workforce and bed capacity constraints and increased covid demand started to impact.

4 hour Performance; In March the 4 hour performance (total type 1) declined to 40%

Improvement Overview and Focus

- Patient safety and delivering quality care are of the utmost importance to UHNM.
- The most valuable possession for the patient is their time.
- UHNM will improve quality and performance by **reducing ED waiting times** for assessment, treatment, home or onward admission to portal/bed base.

Acute Front Door

STREAMING & DEFLECTION REDESIGN:

- UHNM Enhanced Primary Care Model
- Clinical Navigation / 111 First / Kiosk Deflection
- Rapid Assessment & Treatment (RATs) Stream
- SIFT / Ambulatory Majors management model

COMPLEX TRIAGE:

- Go Look Learn - 15 min triage standard review
- Go Look Learn - Ambulance handover processes

MEASURED BY

- Numbers streamed to primary care / UCC
- KIOSK Activity
- Number of patients navigated direct to Portal
- Ambulance Handover times
- Proportion of patients triaged in 15mins

Acute Front Door

WORKFORCE REVIEW & RECRUITMENT:

- Tier structured workforce 24/7
- Shift Skill Mix management – training rqs
- Specialty E-referral & CRTP
- CDU feasibility study

MEASURED BY

- Proportion of Pts seen in 1hr
- Overnight WTBS
- Non admitted breaches
- CRTP

Ward based Principles

REDUCING CONGESTION:

- Right sizing and maintaining Portal Capacity
- EDD led flow management in Medicine
- LOS reviews and stranded reduction

MEASURED BY

- 12Hr Breaches
- Total time in department
- SDEC
- Spells >1 day LOS

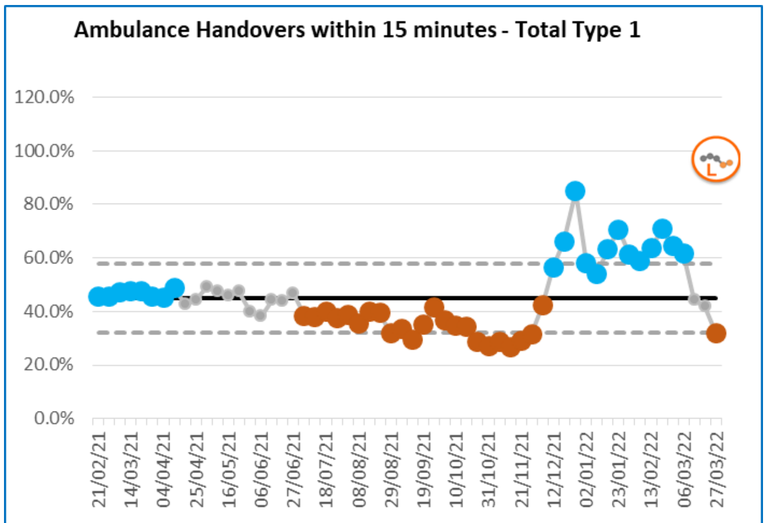
Quality | Operational | Workforce | Finance

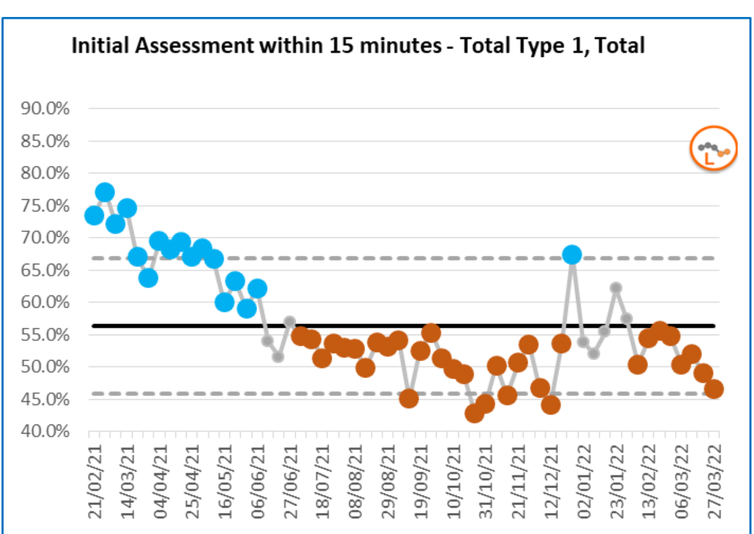
TIME FOCUSED METRICS / UEC Standard

Front Door - Attendance Management

RECENT AND IMMINENT ACTIONS

- Test of change from Navigator at the front door fully embedded which continues to support redirection to alternative places of care including portals (if attending with GP letter) and primary care services from December. Increases seen in patients being deflected to UCC and reductions in those needing to go for triage assessment.
- 'RED' GP reinstated and capacity increased - daily monitoring of referrals demonstrates that Vocare are currently seeing on average 23 Children (increase from 17) and 31 adults per day (decrease from 38).
- Use of GP referral hub and consultant connect to prevent GP walk in directed to ED
- Regular social media campaigns to highlight alternative services on offer in the community and use of 111First
- 111 Kiosks - early review of the data available indicates that only 4% of patients are being redirected to alternative pathways





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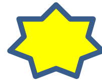
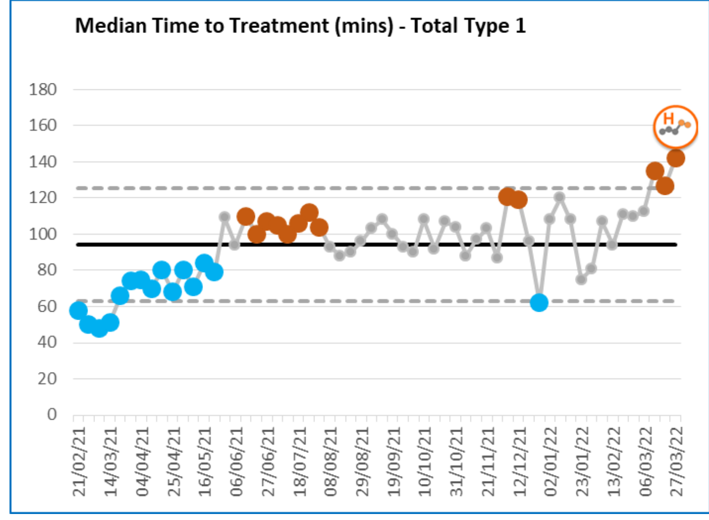
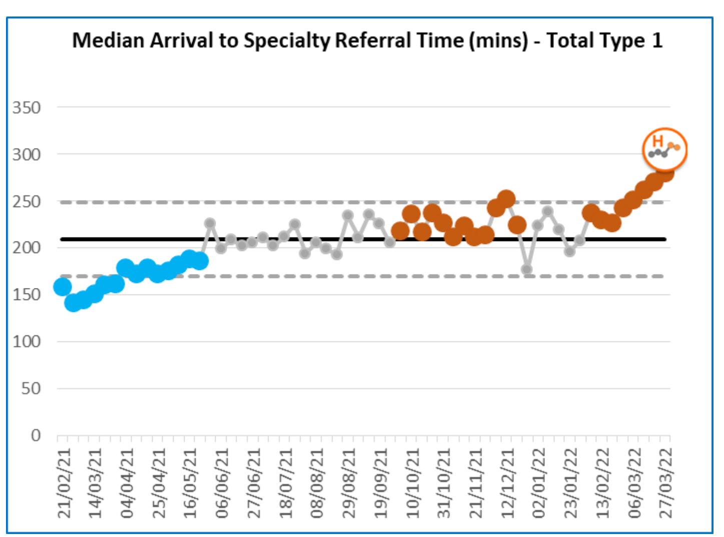
Front Door - Prompt Decisions

RECENT AND IMMINENT ACTIONS

- ED Medical Workforce business case, initial review paper went to PAF February 2022, further update due in May 22
- Engage senior clinicians. Re-set department structures and revise rotas, commenced Nov 21 – further work being planned
- Medical rota alignment to the new Tier's recommended by RCEM is underway
- A&E internal improvements including roles and responsibilities, huddles and rounding to improve grip, supported by visible improvement and escalation dashboards
- Ambulance cohort area (x4) implemented



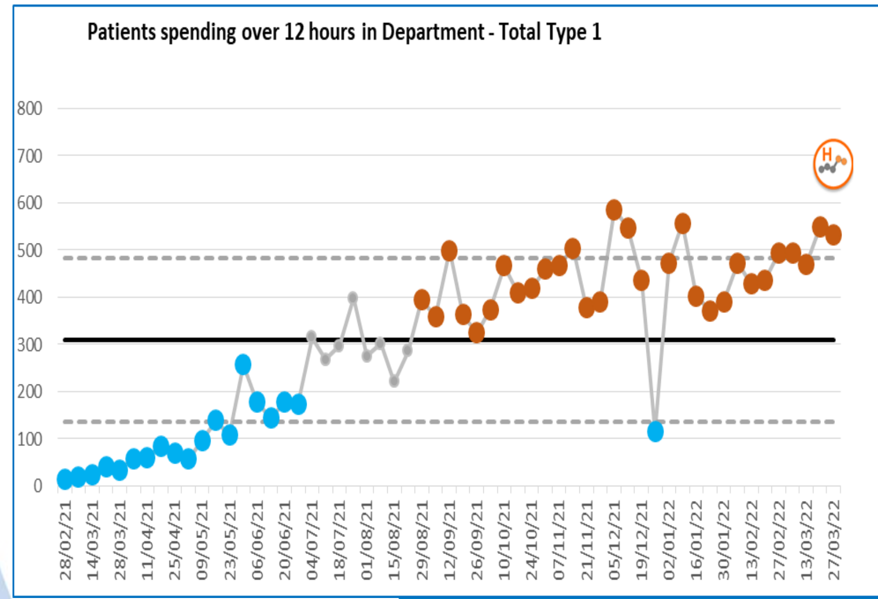


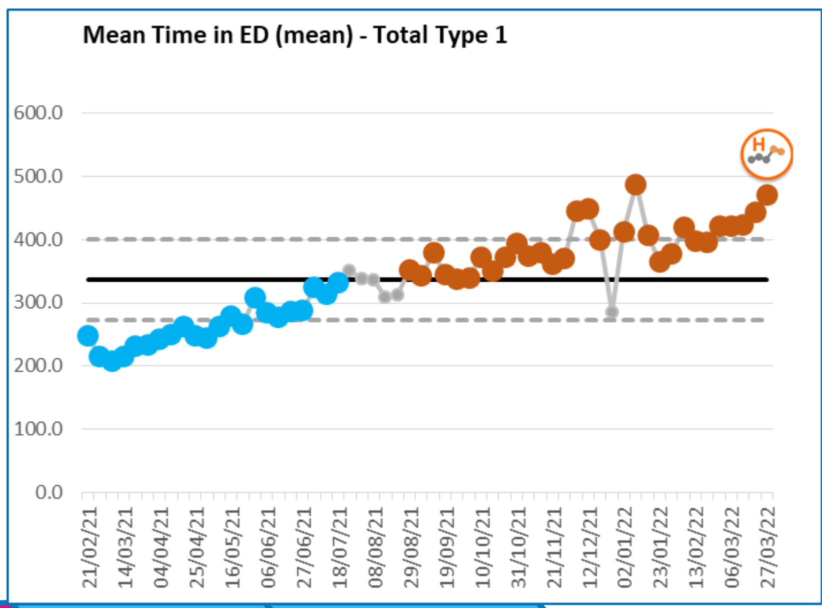


Ward based Principles - Early Egress for Admissions

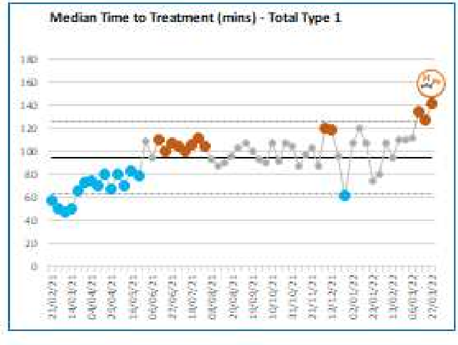
RECENT AND IMMINENT ACTIONS

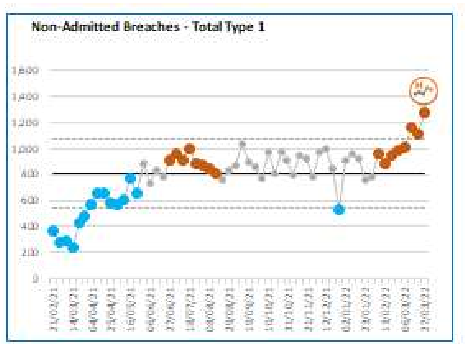
- Medicine division piloting new approach to EDD management to define true capacity/demand at start of the day and to drive behaviours at ward level
- Daily touch points with IPC and Red to Green Meetings in place to aid flow
- Application of MFFD and possible transition to Medically Optimised for Transfer (MOFT) to be reviewed and wards instructed on use
- Continued LOS work on stranded patients – great success seen in 21+ day waits.
- Reset week enacted in March – information on aims provided to tactical and outcomes demonstrated in terms of earlier discharges for all divisions .

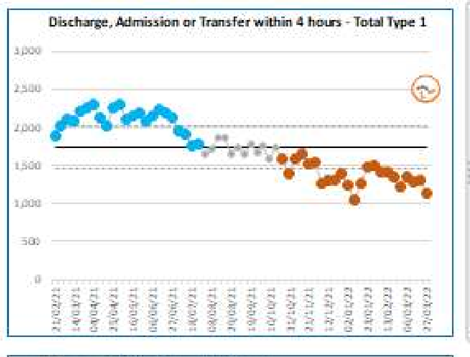


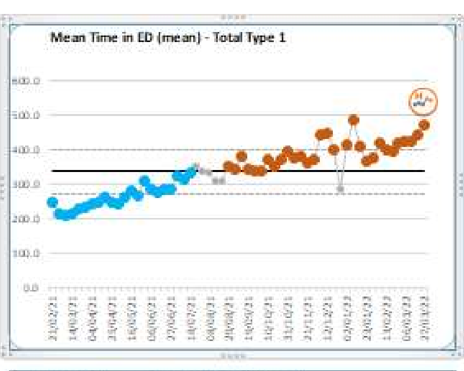


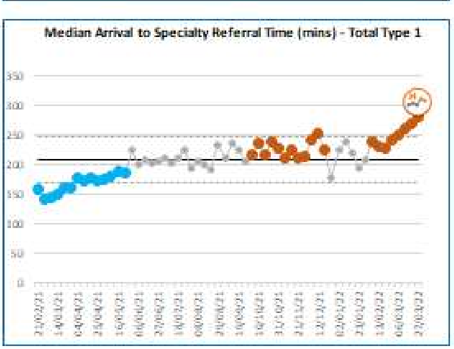
Front door

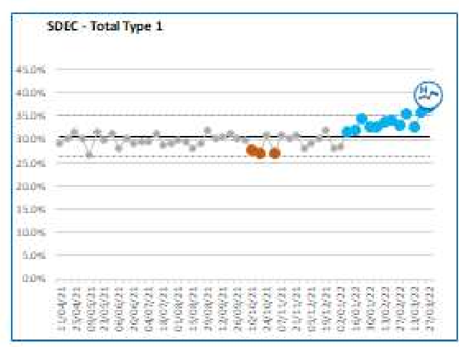


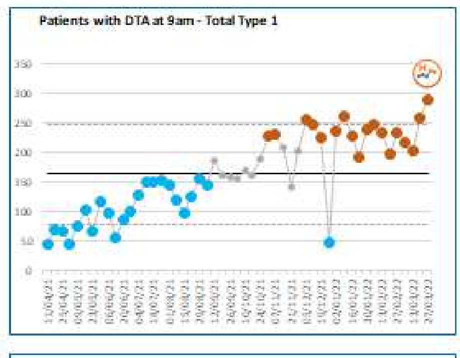


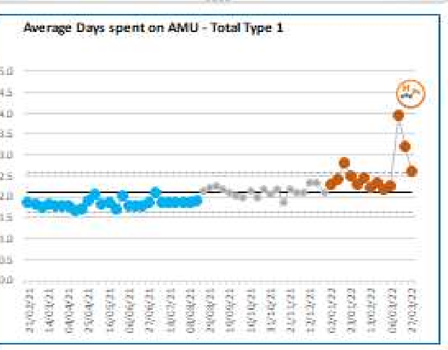


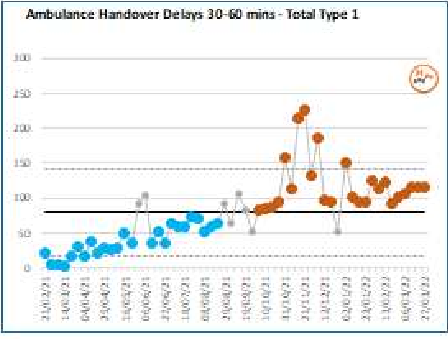


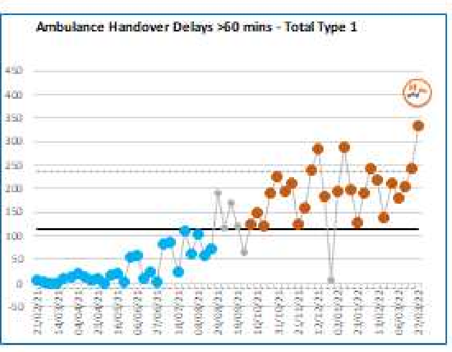


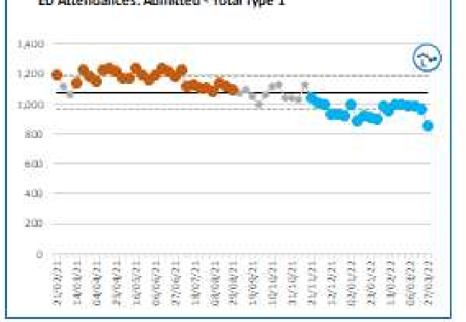


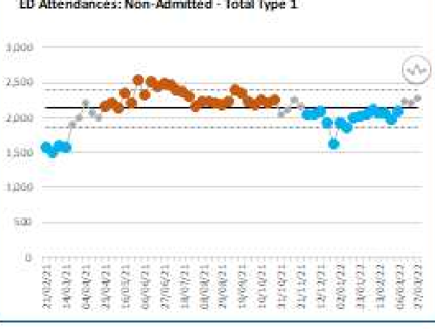








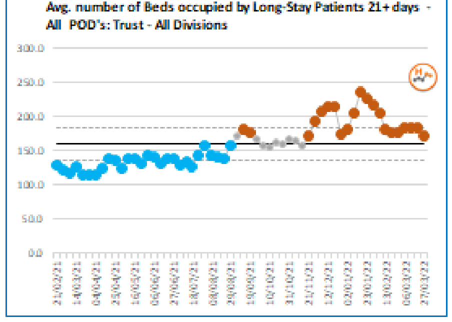


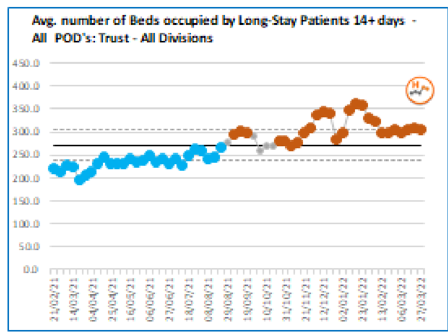


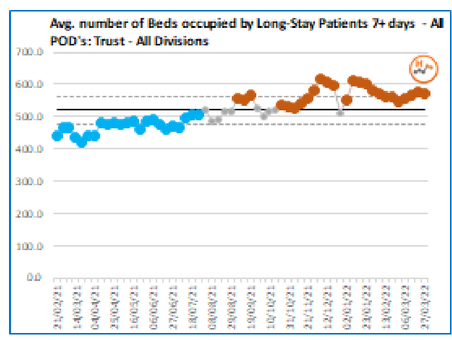
Together Compassion Safe Improving

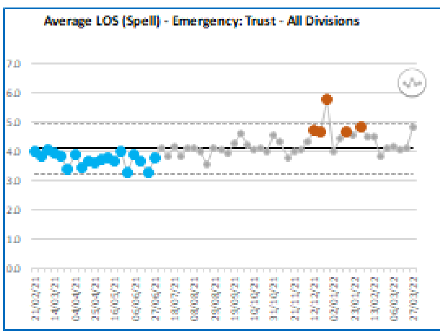
Quality | Operational | Workforce | Finance

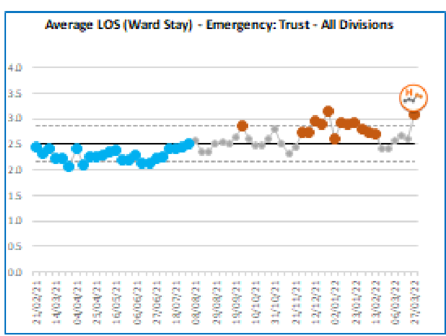
Flow

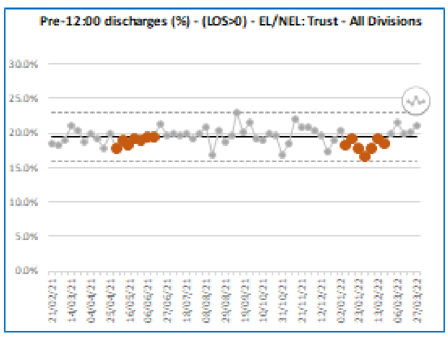


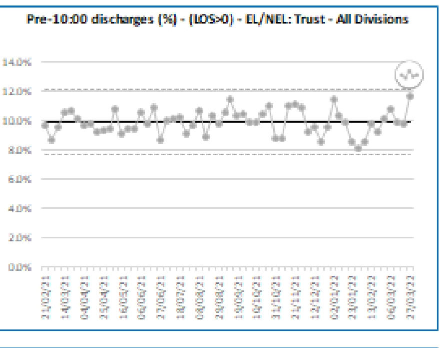


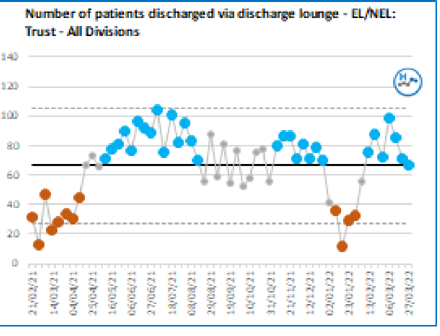


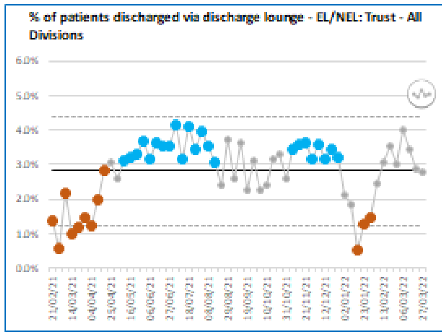


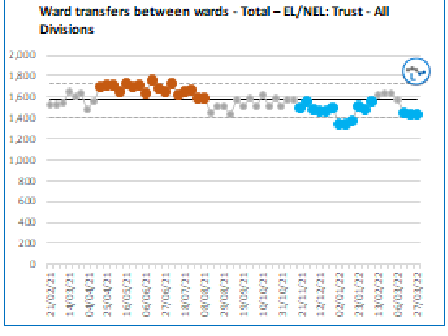


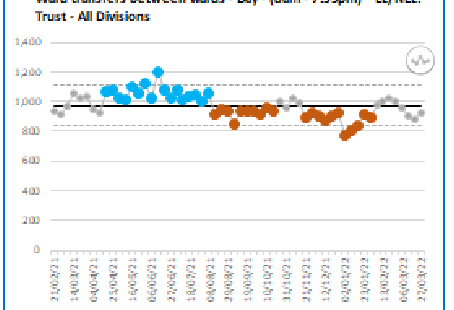


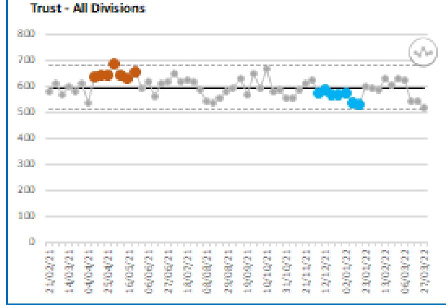












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Section 2: ELECTIVE CARE

Challenges:

- Themes of increasing cancellations due to rising COVID prevalence – e.g. patients not eligible for surgery or diagnostic investigations resulting in cancelled lists and increasing admin burden on depleted teams to rebook.
- Delays to Oncology due to vacancies. The division is recruiting. Current wait for some patients is 5+ weeks.
- Histology turn around times are suboptimal although have improved from previous month. Escalation timeframe remains at 19 days.
- Treatment capacity for Urology – low risk patients are being clinically prioritised.

Actions:

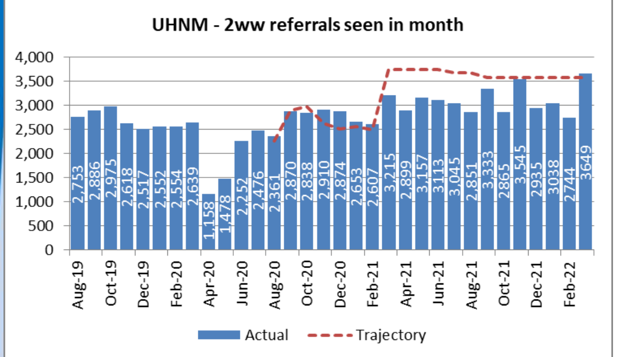
- In March, 2WW CT reporting turn around times improved to an average of 3 days between scan taken and scan reported.
- Endoscopy have reduced the volume of patients waiting for 2WW appointments. Netcall has been reinstated to reduce number of DNAs and improve efficiency. The team have also improved the position on patients being dated within 7 days.
- The first few patients have now been received from the Galleri Trail – a blood test that returns a signal if there is indication there may be cancer present, which will trigger secondary care investigation. Patients and are being progressed through the usual pathways with cancer services liaising with appropriate specialties to expedite diagnostics.
- The consultation on the clinical review of cancer standards is open – proposal for removing the 14 day standard to be replaced by the 28 day standard – and other changes including amalgamating the 31 day standards. Cancer services working to understand the impact on performance although timescales for implementation are to be confirmed from the national cancer team.
- The ICS Transformation Delivery Unit (TDU) met to discuss system actions and priorities for cancer recovery. Primarily – FIT, Breast Pain Clinics, GP initiated Telederm, the TDU function of the ICS will support pathway transformation across primary / secondary / community organisations to improve services and recover cancer performance with a focus on 28 day FDS compliance.
- The decision and timescales of the shift to FIT was communicated at the System FIT Task & Finish Group and also with the ICS TDU. From the dates below, referrals will be managed as follows:
    - 1.4.22 – return with advice any referral if a FIT isn't requested
    - 1.5.22 – return with advice any referral if FIT result isn't available on referral
- The first Breast Pain clinic was successfully delivered on 08.04.22. These clinics deliver care closer to home for patients with non urgent breast symptoms. The opportunity to recover cancer performance depends on the commissioning intentions following the pilot – e.g. whether secondary care specialists will continue to deliver the service in another setting or whether existing community clinicians will be up-skilled.

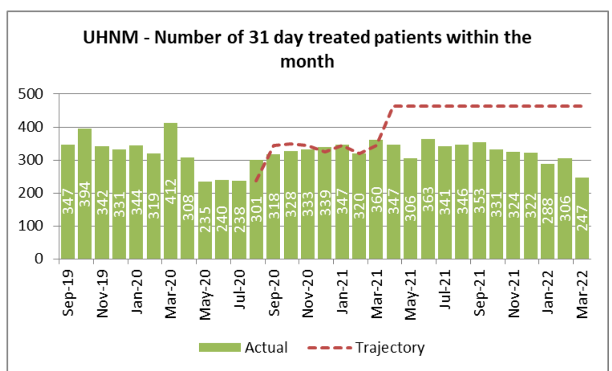
Cancer

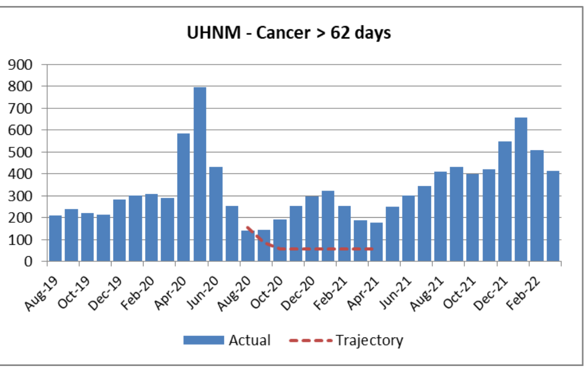
- Trajectories have been agreed and are being tracked against the actual positions. Most recent nationally published data is for January.
- January and February are predicted to have a high proportion of breaches as the trust has been impacted in the Omicron wave. It is predicted that as this backlog of patients waiting is cleared that performance against the 62 day standard will improve from March 22.
- Risks to cancer recovery are diagnostic and treatment capacity within the trust. Particularly in Pathology, where turn around times are being impacted by workforce challenges. Treatment capacity impacted by non elective demand and workforce shortages.
- Key assumptions in the H2 plan were that cancer pathway transformation activities were accelerated at pace, i.e. implementation of best practice pathways in LGI to include FIT results in all LGI 2WW referrals as soon as possible. Other schemes presented at a system cancer summit align to cancer priorities and aim to prevent cancer, or support the shift in stage at which cancer is diagnosed, release consultant capacity that will support a reduction in the backlog of patients waiting and support the workforce through enhancements to facilitate 28 Day FDS.

Trust			Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
14 Day Standard 93% *(suspected cancer, excluding breast symptom)*	TRAJECTORY	First Seen	3745	3745	3745	3666	3666	3566	3566	3566	3566	3566	3566	3566
		Breaches	809	769	699	961	901	641	481	366	306	246	186	166
		Performance	78.3%	79.4%	81.3%	73.7%	75.4%	82.0%	86.5%	89.7%	91.4%	93.1%	94.7%	95.3%
	ACTUALS	First Seen	2899	3157	3113	3045	2851	3333	2865	3545	2967	3038	2744	3649
		Breaches	640	593	318	665	961	1042	1019	1927	1264	1373	1238	1793
		Performance	77.9%	81.2%	89.7%	78.1%	66.2%	68.7%	64.4%	45.6%	57.3%	54.8%	54.8%	50.8%
		Variation	-0.4%	1.8%	8.4%	4.4%	-9.2%	-13.3%	-22.1%	-44.1%	-34.1%	-38.3%	-39.9%	-44.5%
		Regional (Midlands)	81.7%	85.0%	81.1%	83.4%	84.0%	81.4%	79.9%	73.5%	74.8%	69.1%		
		National	85.4%	87.5%	84.9%	85.6%	84.7%	84.1%	81.3%	77.4%	78.6%	74.9%		
31 Day First Treatment Standard 96%	TRAJECTORY	Treatment	463	463	463	463	463	463	463	463	463	463	463	463
		Breaches	49	46	43	38	34	29	25	23	22	20	19	18
		Performance	89.4%	90.0%	90.7%	91.7%	92.6%	93.7%	94.6%	95.0%	95.2%	95.6%	95.8%	96.1%
	ACTUALS	Treatment	347	306	363	341	346	353	331	324	322	288	306	247
		Breaches	23	19	22	22	29	46	42	46	22	34	33	21
		Performance	93.3%	93.7%	93.9%	93.5%	91.6%	86.9%	87.3%	85.8%	93.1%	88.1%	89.2%	91.4%
		Variation	3.9%	3.7%	3.2%	1.8%	-1.0%	-6.9%	-7.4%	-9.3%	-2.1%	-7.6%	-6.7%	-4.7%
		Regional (Midlands)	91.9%	92.5%	91.9%	91.9%	90.2%	88.7%	90.2%	89.7%	90.3%	85.5%		
		National	94.2%	95.1%	94.6%	94.7%	93.7%	92.6%	93.5%	93.0%	93.4%	89.6%		
62 Day (2ww) Standard 85%	TRAJECTORY	Treatment	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0
		Breaches	75.5	71.5	67.5	62.5	59.5	57.5	50.0	44.0	38.0	32.0	32.0	32.0
		Performance	69.3%	70.9%	72.5%	74.5%	75.8%	76.6%	79.6%	82.1%	84.5%	86.9%	86.9%	86.9%
	ACTUALS	Treatment	181.0	166.5	198.0	186.5	187.5	199.0	168.0	178.0	172.5	152.5	168.5	135.5
		Breaches	42.0	48.5	59.0	64.0	69.5	84.0	70.0	87.0	81.0	73.0	82.5	76.5
		Performance	76.7%	70.8%	70.2%	65.6%	62.9%	57.7%	58.3%	51.1%	53.0%	52.1%	51.0%	43.5%
		Variation	7.4%	-0.1%	-2.3%	-8.9%	-12.9%	-18.9%	-21.3%	-31.0%	-31.5%	-34.8%	-35.9%	-43.4%
		Regional (Midlands)	69.9%	66.4%	66.4%	63.3%	61.6%	58.3%	57.3%	56.9%	57.1%	50.3%		
		National	75.4%	73.0%	73.3%	72.1%	70.7%	68.0%	67.8%	67.5%	67.0%	61.8%		

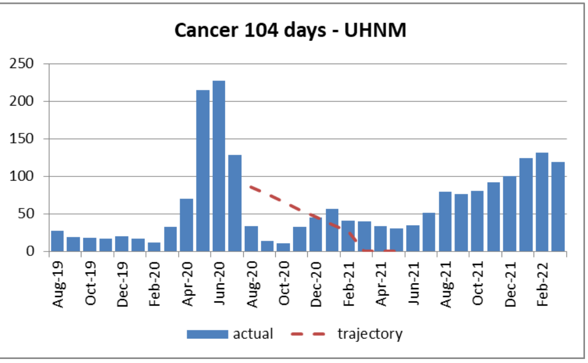
Cancer







Provisional March	Target	Trust Actual	Clock Stops	Breaches	Breaches Over	Needed Treatments
TWW Standard	93%	50.8%	3650	1797	1542	22022
TWW Breast Symptomatic	93%	3.3%	91	88	82	1167
31 Day First	96%	90.4%	198	19	12	278
31 Day Subsequent Anti Cancer Drugs (inc Chemo)	98%	100.0%	23	0	Achieved!	Achieved!
31 Day Subsequent Surgery	94%	85.2%	27	4	3	40
31 Day Subsequent Radiotherapy	94%	100.0%	29	0	Achieved!	Achieved!
62 Day Standard	85%	41.6%	115.5	67.5	51	335.5
Rare Cancers - 31 Day RTT pathway	85%	-	0	0	1	1
62 Day Screening	90%	73.3%	15	4	3	26
28 Day FDS Standard	75%	63.4%	2135	781	248	990
62 Day Consultant Upgrade	93%	74.1%	54	14	11	147
Closed Pathways > 104 Day			27.5			



Reduced volume of 104+ and 62+ waits in March. Pre-validated position shows a high number of 2WW 1st OPAs conducted – 3649, although treatment capacity has been impacted by workforce redeployment to support Covid surge based on workforce attrition of front line services. Clinicians asked to focus on cancer pathway review > 62 days and focus on 104 day decisions and outcomes to reduce these volumes and ensure appropriate clinical validation of next step pathways.

Planned care - *Inpatients*

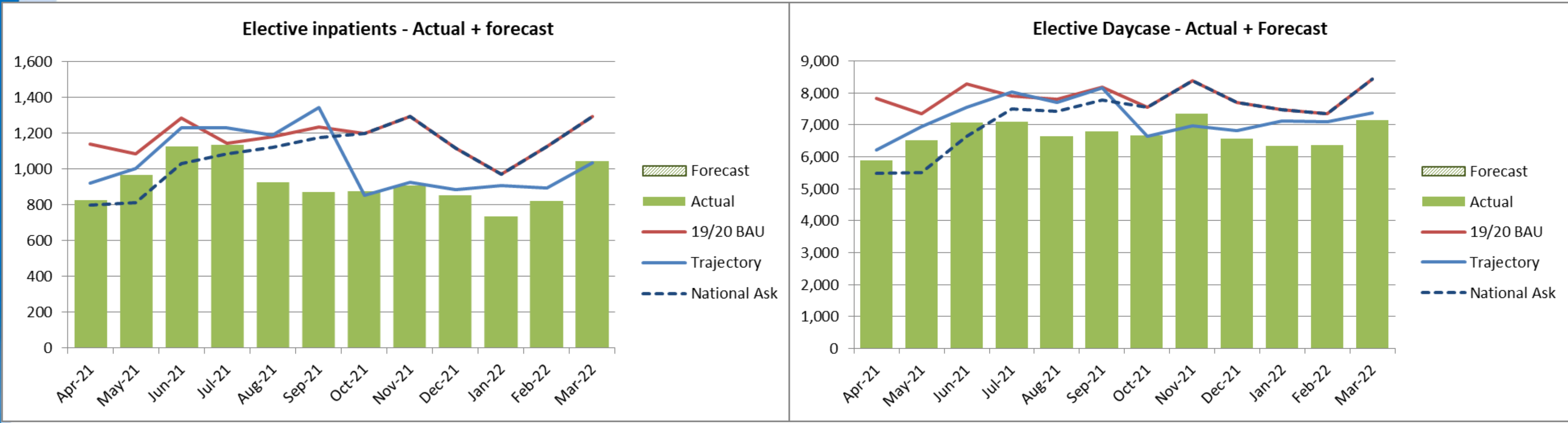
Elective inpatients Summary

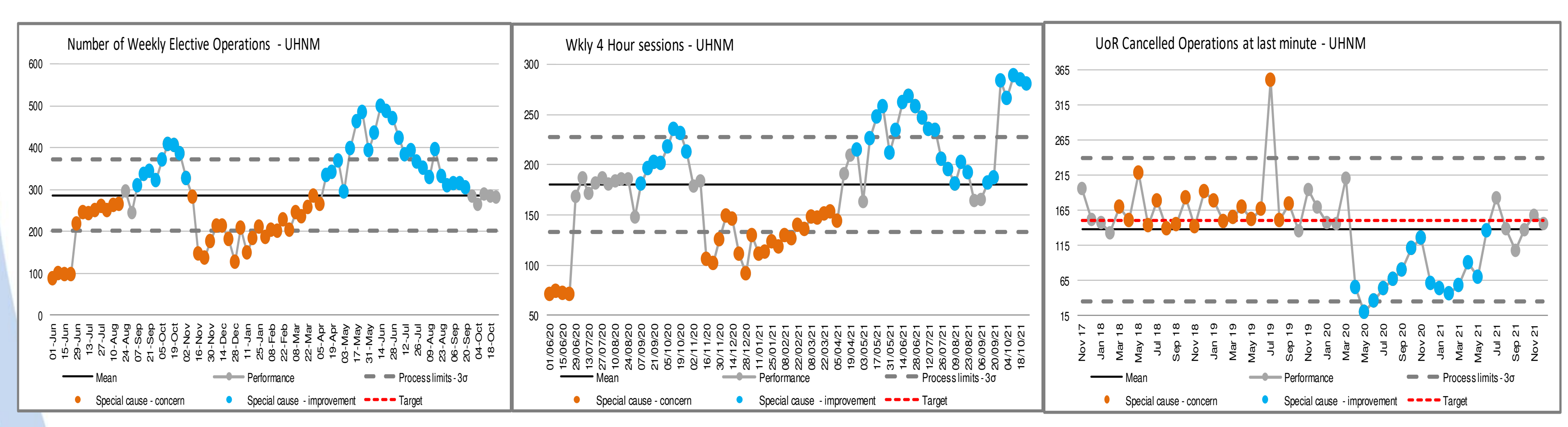
- For March the total inpatient actuals against BAU was 93%, and improvement on February (86%) Insourcing arrangements at week ends continue and have been bolstered to provide more weekend capacity in T&O started Feb.
- CCG offer of Spire for additional capacity and patients going via CCG Choose and Book Service.
- Contracting arrangements for 2022/23 confirmed – extension of existing IPT contracts for Ramsay & Nuffield.
- Improvement in return of discharge summaries for subcontracted patients. All patients referred under ICF contracts expected to be completed end of May 2022.

Actions

- External validation support commenced 21st March, focusing on long waiters, themes and trends.
- Demand scoping for 22/23 IS complete & shared with CCGs. Final numbers for capacity agreed.
- New electronic process for managing patients transfers to IS live and working.
- 'Validation summit' planned to bring Corporate Team, DQ & Information teams together with divisional representation to scope out root causes and define strategy for improvement. Booked for April 28th.
- Training continues on RTT for new staff and where post validation has found incorrect actioning of pathway for staff to be retrained. Extra training capacity sought to provide clinician & refresher training, as well as "at elbow" bespoke training & support for groups of staff. Band 5 to be recruited to support.

Planned care – *Inpatient Activity*





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Planned care - *Outpatients*

Summary

- For March (as at 03/04), the total outpatient actuals against BAU for outpatients was 100%. This is higher in follow ups than new (94% New, 104% follow up).
- For outpatient appointments (appointment type) the Trust delivered **71.4%** F2F and **28.6%** non F2F(Telephone & Video). For new appointment types F2F was **75%** & non F2F **25%** & follow ups F2F **69.4%** & non F2f **30.6%**
- OP Cell A3 work has helped to define current overall waiting list position by category; vs pre covid increase of 15,000 (6.5%) to 250,000, and increase in those >52 weeks (vs Review Date) by 7,800 (200%) to c.12,000 (half of increase attributable to use of Review Date). As at 03/04/2022, total WL has increased further to 271,000. Recent increases in the waiting list attributed to 2 categories; New (Non-18 weeks) & Follow Up (Non-18 weeks).
- Reduction from 11,631 (end of June) to 10,010 (25th July) in >52 week patients (14%). Further reduction to 9,184 as at 5th September (21% vs end of June). Up to 10,737 as at 3rd April; has been at a similar level for last 13 weeks.

RTT

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For March the indicative number of Incomplete pathways has risen to 74,984 (February 73,360).
- The number of patients > 18 weeks has risen to a level of 33,665 (February 32,831).
- The numbers of 52 week waits in March has increased with a provisional 4,603 (February 4,461) this figure is however below the trajectory.
- At the end of March the numbers of > 104 weeks reported were 494. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance has slightly decreased at 54.9%
- Work plans around long wait patient validation and treatment tracking are in progress

Planned care - *Outpatients*

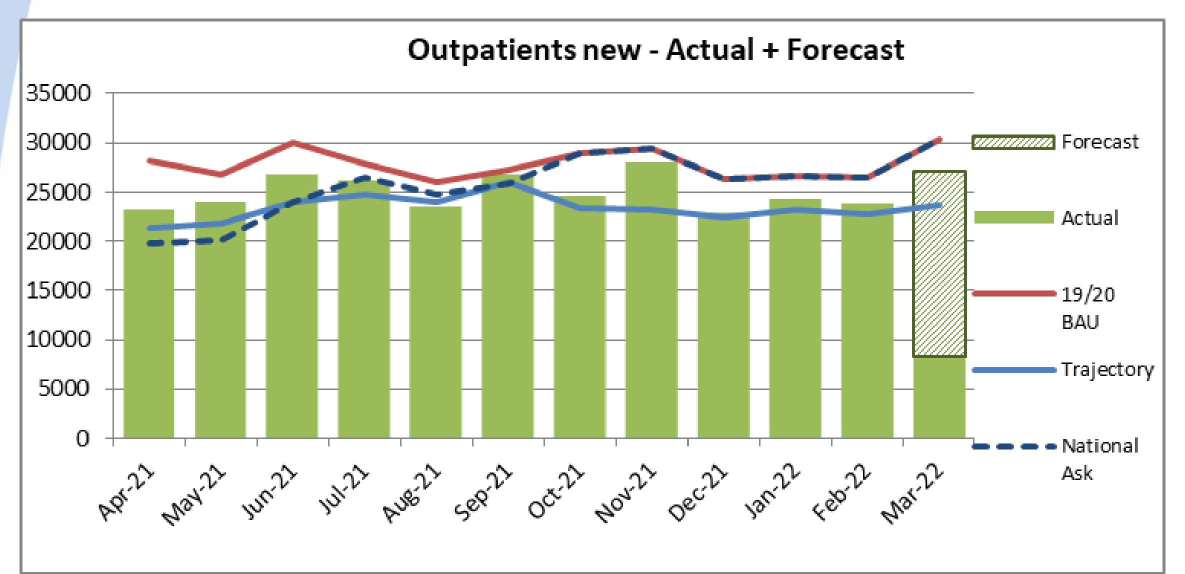
Actions

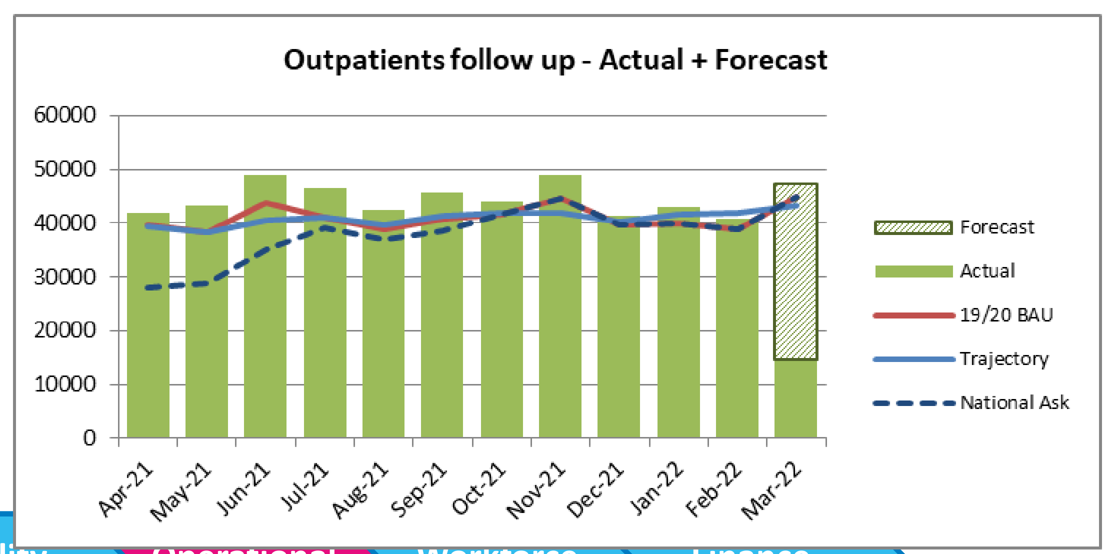
- **Divisional Waiting List Management** with a focus on validation, data quality and >52 weeks patients.
  - Outpatient Reviews - templates completed for March for New Waits (104+/78/52/18 wks), plus follow up backlog, PIFU, EAG & Non Face to Face. Long waiters in New Non-18 week category identified as issue; to be taken to DQ group, to clarify and align recording & reporting requirements.
  - OP Waiting List reporting now includes 78 & 104+ wk band in line with 22/23 Elective Care Guidance.
  - 1m+ plans approved (March 2022) based on risk assessments, supports FTF activity increase where required; CAFs to be submitted to ensure managed.
  - SMS via Netcall targeting follow up backlog patients trialled successfully in dermatology and plastics. Of the 919 patients acknowledging the message, 17% wished to be discharged back to their GP. Netcall Partial Booking module purchased in March will facilitate similar approach for other specialties.
- **Outpatient Service Delivery & Performance** workstream - delivering vs. plans for Partial Booking Rollout, Netcall Rollout, CAF Issues Action Plan, and OP Clinic Process vs. Maturity model. Review Date training prioritised; DQ Alert circulated & Quick Reference Guides created, plus floor walking support. Wider training plan being developed with Ongoing input into Trust training considerations (systems & processes), and links to DQ group.
- **Enhanced Advice & Guidance** sub workstream (linking with system).
  - Task & Finish Groups for Urology, Neurology, Respiratory and Gastro taking actions forward to increase A&G, develop pathways FAQs.
  - Work underway to directly contact 21 GP practices not using A&G, and further 32 practices with a high volume of referrals and less than 12% A&G usage.
  - Revised Steering Group with wider System partners arranged for April 26th.
- **PIFU sub-workstream** rolling out vs plan.
  - Regular meetings with live specialties (T&O went live in March, agreement in principle with Therapies); meetings with ENT, gynaecology, T&O & Therapies to discuss specific pathways & work through checklist. Benchmarking used to identify target areas and inform rollout phasing for 2022/23.
  - Actions around Discharge to PIFU approach to support wider rollout **went live March 2022**, as per focus advice from meeting with NHSE contact. Additional Careflow outcome now added, other amendments planned.
  - PIFU Survey ready to be sent to clinicians across UHNM to raise awareness and further identify existing and potential PIFU pathways.
- **Submissions to Elective Recovery Fund** in place for A&G & PIFU. Consultant Connect data is included and confirmed, but recent query around Community RAS data inclusion, and discussions ongoing with NHSE supported by Information Services.
- **Virtual Care 25%;** SUS submission 'fix' implemented from Nov 2021 (with BI); longer term, alignment of clinic booking and media type outcomes. Launch of a new teledermatology service; skin cancer wait times decreased from 28 days to an average of 10 days in February.
- **Elective Recovery 2022/23**; narrative plans submitted in February for EAG (16% target), PIFU (5% target) & Virtual Care (25% target).
- **Patient Portal**; support provided to identify potential OP benefits, following demos from suppliers to a wide UHNM audience & patients.

Risks:

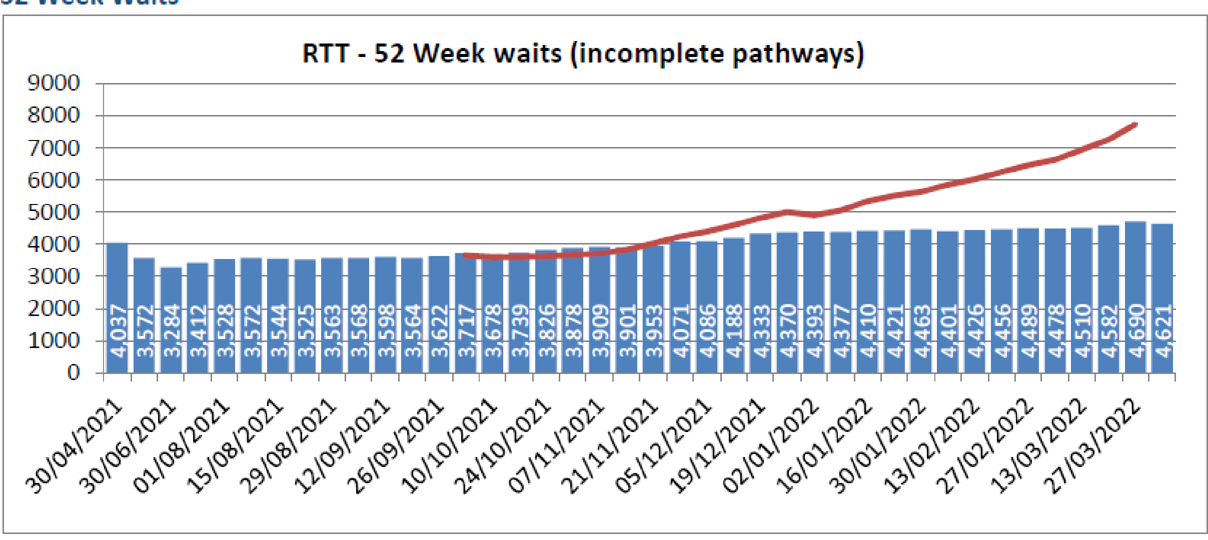
- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, on Divisional Risk Registers.
- PIFU H2 end target of 2% of all outpatient activity moved or discharged to PIFU. Whilst achieving rollout to initial specialties in low volumes, shortfall projected against this target (nationally an issue). Actions identified to extend rollout and close the gap as outlined above, moving towards 5% March 2023 target including all 'major' outpatient specialties. Meeting held in Feb with NHSE; advised to focus on capturing Discharge to PIFU.

Planned care – *Outpatient activity & RTT*





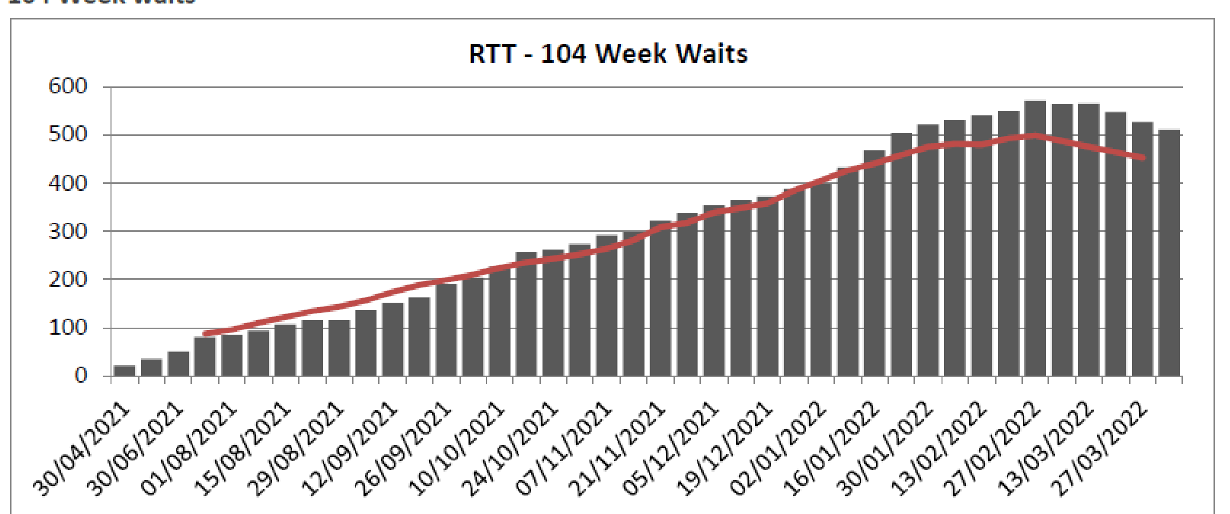
52 Week Waits



52 Week Waits showed a small increase over winter, but are starting to increase again.

The Trust is currently ahead of trajectory and expecting to finish well ahead of trajectory.

104 Week waits



104 Week Waits have been continually decreasing throughout March. The trust is off-trajectory to clear all 104 week waits by end of Q1, but action plans are in place to return to trajectory but there are significant volumes of patients into Q2 aligned with the 2 year Phase 1 R&R demand which will be a challenge. Most challenged specialties are T&O and Colorectal and these fit the nationally profiled capacity constraints.

Diagnostic Activity

Plan | Activity | Avg Activity - Last 52 Weeks | Waiting List Size (start of week)

Activity Counts | Waiting List Size | Week Ending

Summary

- For DM01 (15 nationally identified Dx tests) the validated position for total waiting list has increased in March from 22529 to 24,004. The Non-obstetric ultrasound waiting list increased slightly from 9,394 to 9550. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance is at 71%.
- Within DM01, the greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls, a number of actions are in place. Non obstetric ultrasound performance remains a Driver Metric for CWD and has specific focus for improvement, albeit this is related to workforce retention, recruitment and innovative ways to train and recruit. Further outsourcing of non-obstetric ultrasound scanning is continuing to be explored.
- DM01 performance excluding non obs ultrasound would be c84%.

- Histology turnaround times remain a high risk; there is an action plan in place and the position is improving. Cancer related histology is being treated urgently and all cancer related escalations are being prioritised
- Capacity and Demand work has been completed within Imaging relating directly to Consultant Radiologist and SpR capacity.
- Histology and Endoscopy remain high risk areas both have plans for improvement.
- Plain film is also an area with a high volume of waiters, predominantly due to staffing shortages and covid social distancing guidance which have now been removed

Diagnostic Activity

Issue: Histology
Histology have high pressures on current capacity; consultant reporting capacity, laboratory capacity, admin support. Expected increase in recovery requirement and cancer related demand

Mitigation:
- Significant Increase in Sendaway work to outsourced providers
- Request from SaTH for laboratory and reporting support
- SOS to other pathology networks for outsourced capacity – declined to date
- Quality Summit with network trusts taken place and action plan in place
- 2 histopathologists recruited in Jan / 4 histopathologists planned to be recruited in April and May for start between April and Oct
- Incentivised payments agreed for laboratory staff (to clear block backlog) and to consultants to increase available reporting sessions
- Sickness absence management in line with sickness absence policy
- Fortnightly updates to member Trusts, clinicians
- Cancer Services meetings in place weekly with member Trusts to ensure all cancer escalations are completed

Impact:
- Increase in Clinical risk
- Turnaround times not to required standard for some specialties for Cancer and non-cancer / Delays in results available for MDT and / or patient treatment
- Increase in outsourcing and locum costs
- Increase in reported errors

Timescale:
Extreme measures to be taken to reduce backlog as soon as possible
Trajectory in place (currently ahead of plan). May Target in place

Non obstetric ultrasound - capacity is insufficient to reduce the waiting list backlog any further

Impact:
Increase in waiting times and backlog for non urgent scans / Inability to meet DM01 standards
Increased stress for current staff, Poor patient experience

Mitigation:
Approval of funding for temporary Independent Sector Capacity – now in place – scanning c 900 patients per month
Continuing to try to source locum sonographers
Reviewing workforce plans and AFC banding in line with other Trusts / Extension of bank rates for sonographers

Endoscopy backlog - This is reducing and the teams have deployed capacity to significantly reduce backlogs and support urgent/cancer pathways and stabilise the elective pathways.

Impact:
- Delayed diagnosis / Treatment / DM01 performance standard not met / Outpatient Waiting list growth

Mitigation:
- Use of the Independent sector has been prioritised for P3 classification patients where suitable (DM01) to date 680 pts have been transferred to beacon park but remain on UHNM list as TCI dates not yet known.
- Session Utilisation at RSH and County to maximise throughput to support DM01 movement and day case lists at the week ends continue to deliver circa 165 cases each week.

APPENDIX 1

Operational Performance

Quality Operati

Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	60.20%	L	F	
	12 Hour Trolley waits	0	372	H	?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	47.18%	L	?	STAR
	Cancer 62 GP ref	85%	48.25%	L	?	
	Cancer 62 day Screening	90%	61.90%	common cause	?	
	31 day First Treatment	96%	85.26%	L	?	
Elective waits	RTT incomplete performance	92%	54.32%	L	F	
	RTT 52+ week waits	0	4622	H	F	
	Diagnostics	99%	67.40%	L	F	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.3%	common cause	?	
	Cancelled Ops	150	146	common cause	?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	30.1%	H	?	
	Super Stranded	183	205	H	P	
	DToC	3.5%	3.40%	common cause	?	
	Discharges before Midday	30%	20.2%	common cause	F	
	Emergency Readmission rate	8%	11.8%	L	F	
	Ambulance Handover delays in excess of 60 minutes	10	800	H	F	

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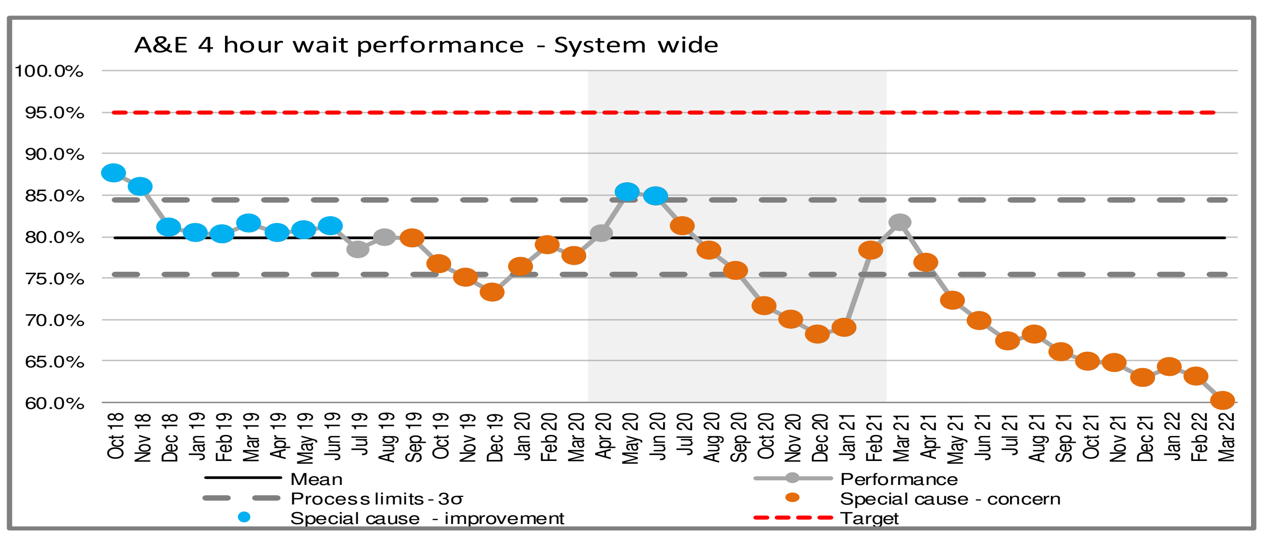
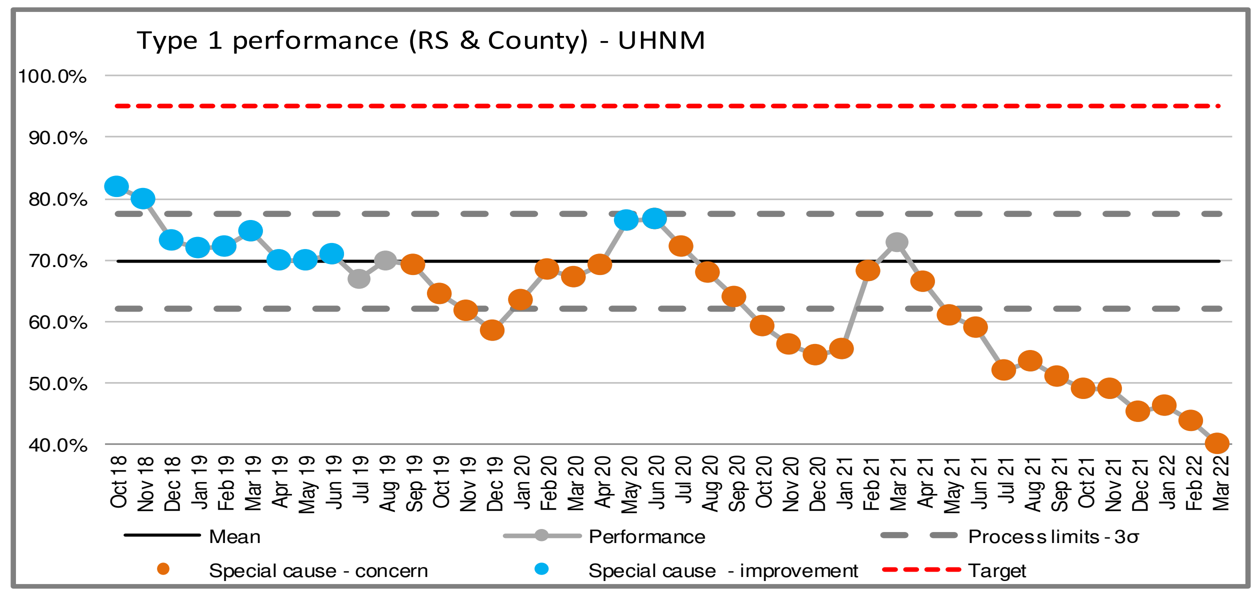
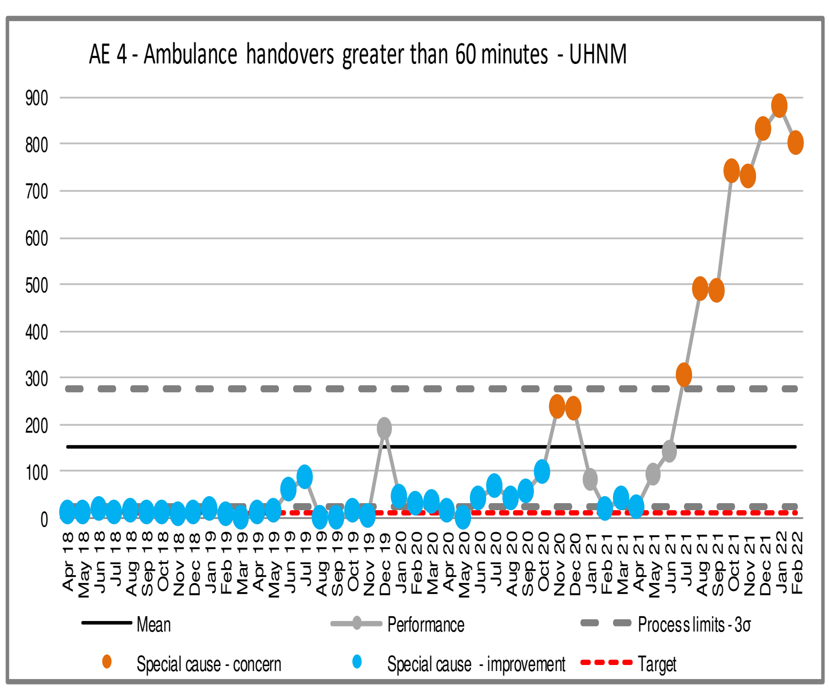
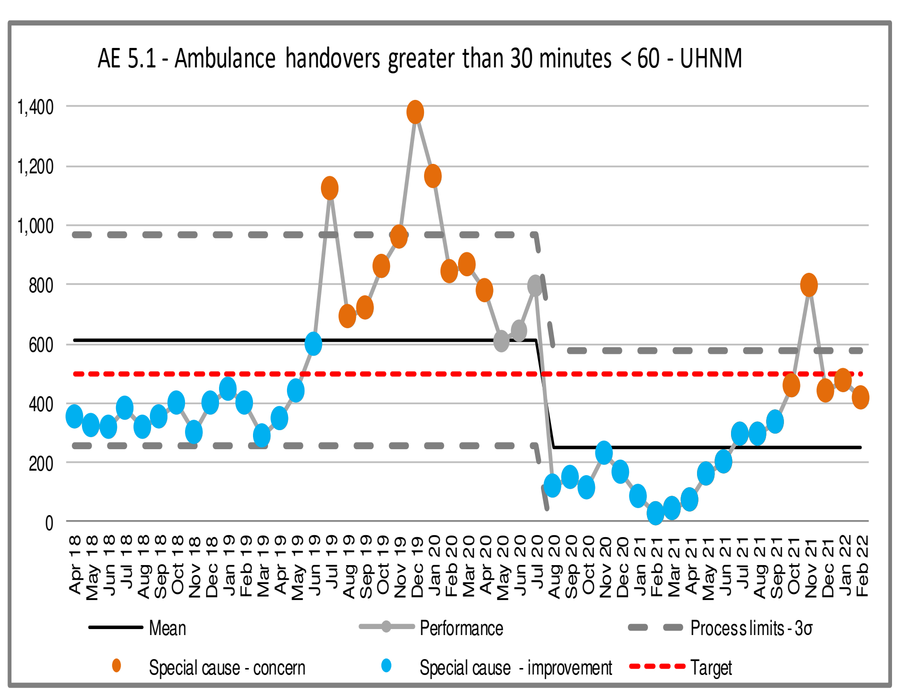
URGENT CARE – 4 hour access performance





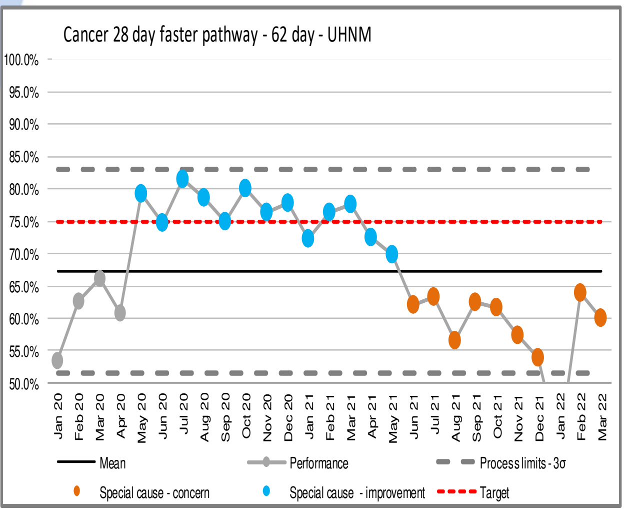
URGENT CARE – 4 hour access – ambulance handovers

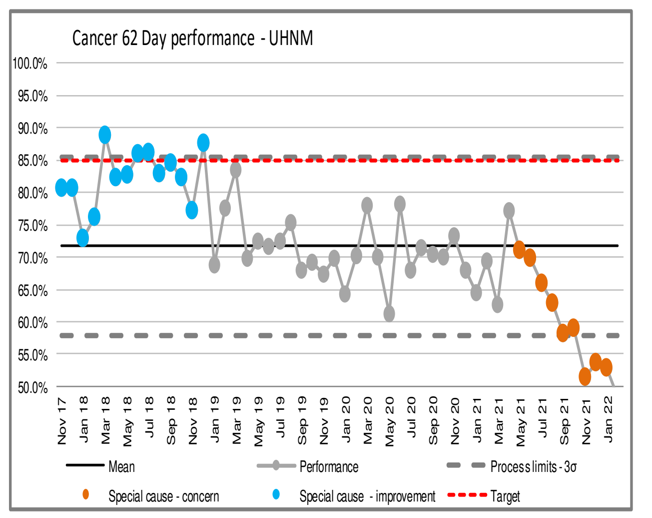




From August – internal validation of > 30 minutes

Cancer – 62 Day





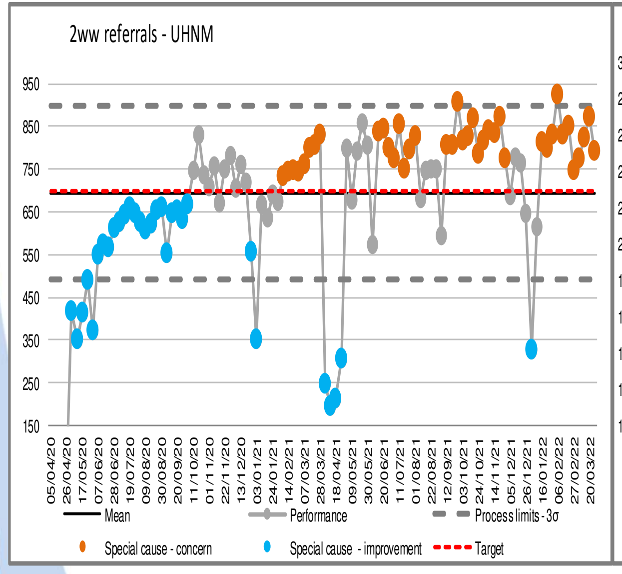
Variation			Assurance
Target	Dec 21	Jan 22	Feb 22
85%	53.7%	52.8%	48.3%

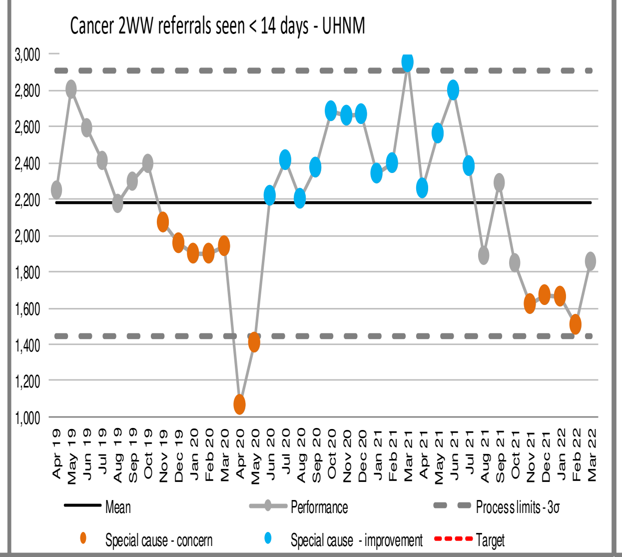
Background

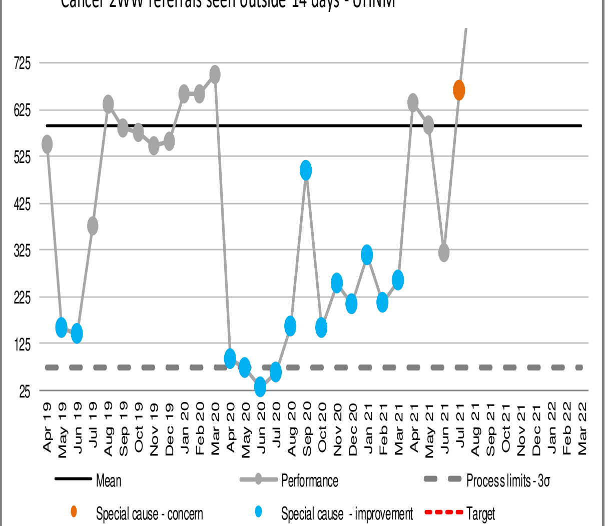
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

Apart from three occasions the standard has been below the mean since Sept-19.

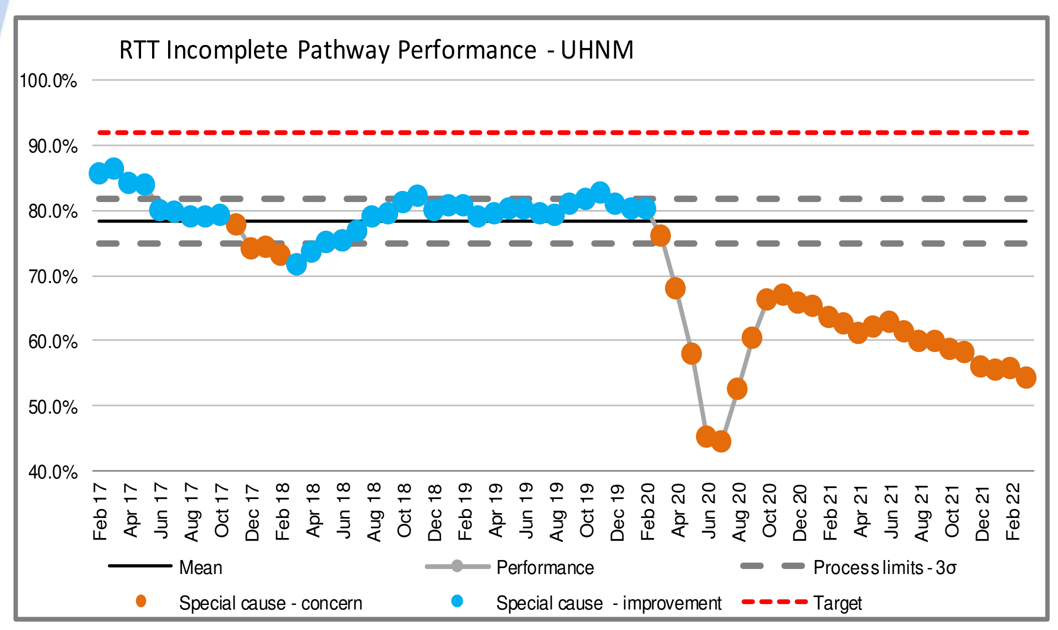






Quality | Operational | Workforce | Finance

Referral To Treatment



Variation	Assurance

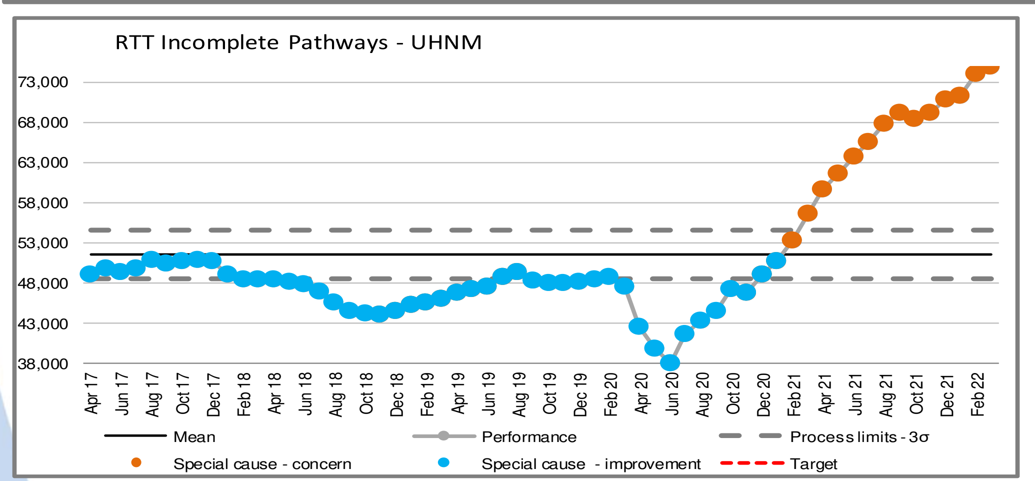
Target	Jan 22	Feb 22	Mar 22
92%	55.5%	55.6%	54.3%

Background

The percentage of patients waiting less than 18 weeks for treatment.

What is the data telling us?

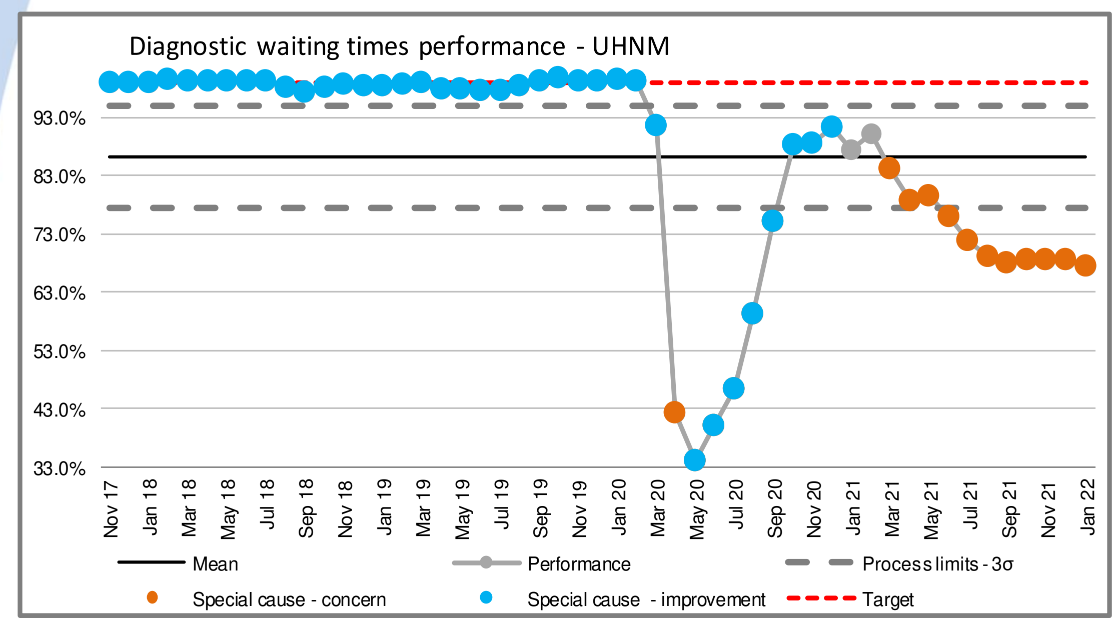
Steady decline in performance since the pandemic began.

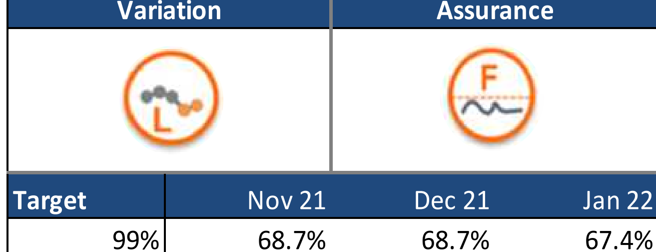


Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Diagnostic Standards





Variation	Assurance

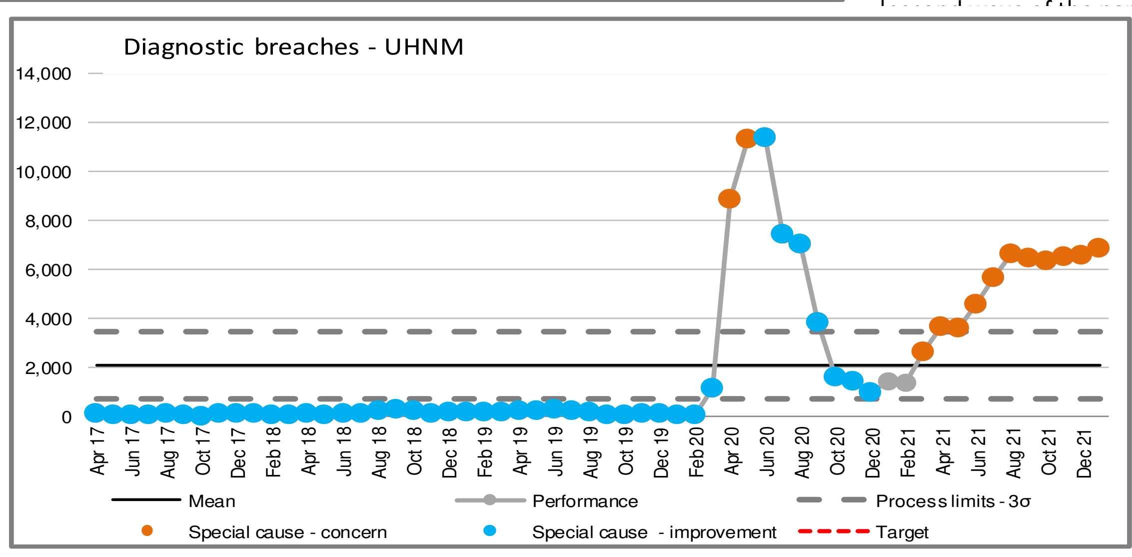
Target	Nov 21	Dec 21	Jan 22
99%	68.7%	68.7%	67.4%

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



Workforce

2025 Vision	"Achieve excellence in employment, education, development and Research"

Workforce Spotlight Report

Key messages

The strategic focus of our People Plan remains on supporting recruitment, staff wellbeing and absence management.

The sustainable workforce risk remains high because there is still an impact of covid surges on sickness levels and workforce availability, although there are plans in place to mitigate risks and additional recruitment is taking place. Divisions report increased staffing challenges due to operational pressures and the opening of additional capacity, combined with high sickness rates and vacancy levels.

Sickness

The in-month sickness rate was 6.62% for March 22 (6.14% in February). The 12 month cumulative rate increased to 5.73% (5.54% at 28/02/22).

Covid-related absence increased throughout March 2022 and started to decline again from 3rd April.

The focus remains on areas with high sickness levels, with actions including:

- Assurance meetings taking place in the Divisions, focussing on the top 10 long term and top 10 frequent absences .
- Continued daily monitoring of sickness absences, specifically all COVID related absence and stress related absence.
- Joint focused absence huddles for Medicine and Surgery taking place with the HR Director and Divisional Representatives

Divisions have set trajectories for achieving a reduction in Sickness Absence (subject to Covid Pandemic spikes, Winter Pressures and staffing deficiencies) with a year end target of around 5.5%, which will be monitored via the Improving Together Programme

Appraisals

The final outturn for the 12m ending 31st March 2022 was 75.55%

Statutory and Mandatory Training

The Statutory and Mandatory training rate at 31st March 2022 was 94.73% (95.34% at 28th Feb 2022). This compliance rate is for the 6 ‘Core for All’ subjects only

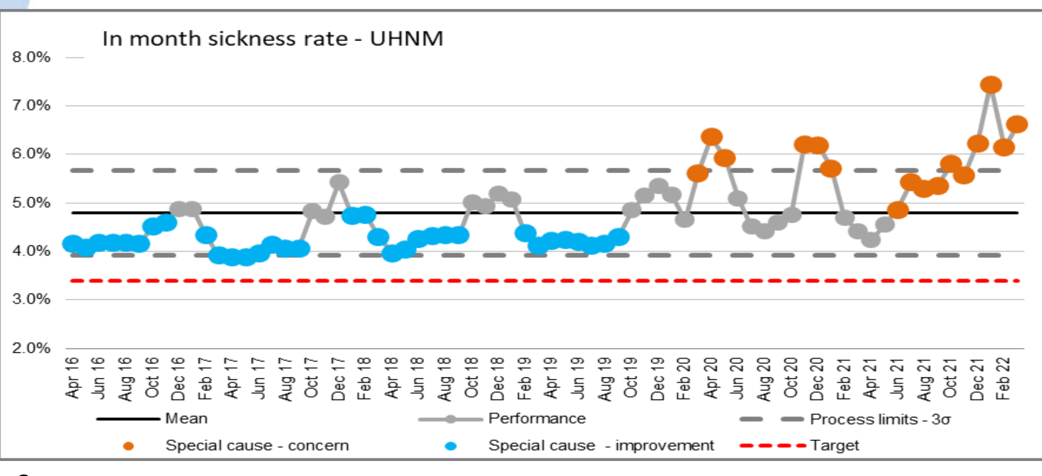
We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

Vacancies

The overall Trust vacancy rate was 11.71% as a result of a small uplift in budgeted establishment (12.36 fte), and a decrease in staff in post (7.55 fte). Bank and Agency covered 76% of the vacancy position and there was 1154.30 FTE activity in the recruitment pipeline

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	6.62%		
Staff Turnover	11%	10.59%		
Statutory and Mandatory Training rate	95%	94.73%		
Appraisal rate	95%	75.55%		
Agency Cost	N/A	2.59%		



Variation		Assurance	
Target	**Jan 22**	**Feb 22**	**Mar 22**
3.4%	7.4%	6.1%	6.6%

Background

Percentage of days lost to staff sickness

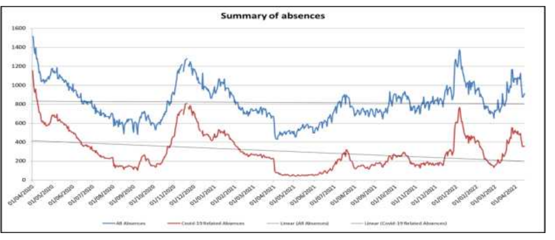
What is the data telling us?

Sickness rate is consistently above the target of 3.4%. The special cause variation from April 2020 is a result of covid-19.

Summary

The in-month sickness rate was 6.62% for March 22 (6.14% in February). The 12 month cumulative rate increased to 5.73% (5.54% at 28/02/22).

Covid-related absence increased throughout March 2022 and started to decline again from 3rd April. As of 14th April 2022, covid-related open absences* numbered 362 which was 39.56% of all absences [*includes absences resulting from adhering to isolation requirements]



To manage staff availability the Workforce Bureau is operating as virtual bureau, in conjunction with Nursing and Medical Bureaus, to manage staff deployment as and when necessary. Daily Sitreps on staff absence continue to be produced, informing the tactical Covid Dashboard and decisions on the redeployment of staff

Deep dives into reasons for stress related absence are undertaken to help target actions for support. The covid self-isolation tool continues to be updated as government guidance changes and communications with staff continue.

Actions

Assurance meetings are taking place in the Divisions, focussing on the top 10 long term and top 10 frequent absences by specialty.

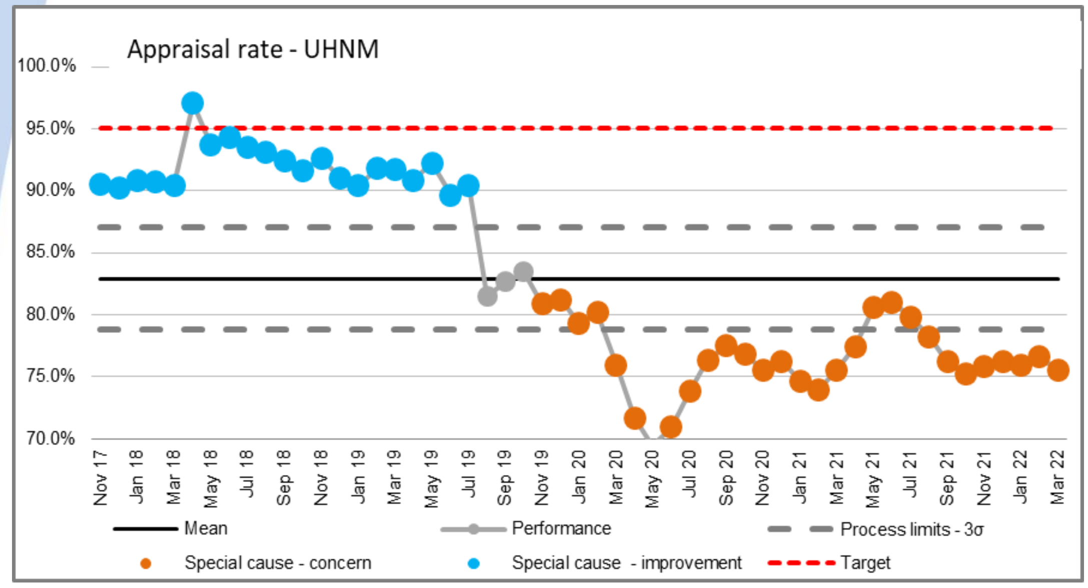
There is continued daily monitoring of sickness absence rates, including COVID related absence

Joint focused absence huddles for Medicine and Surgery take place with HR

There is improved access to Empactis, targeted training and monitoring of compliance with Empactis requirements

Divisions have set trajectories for achieving a reduction in Sickness Absence (subject to Covid Pandemic spikes, Winter Pressures and staffing deficiencies) with a year end target of around 5.5%, which will be monitored via the Improving Together Programme

Appraisal (PDR)



Variation	Assurance

Target	Jan 22	Feb 22	Mar 22
95.0%	75.9%	76.6%	75.6%

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

Completion of PDRs was suspended during January 2022, while the Trust was at Critical Incident level.

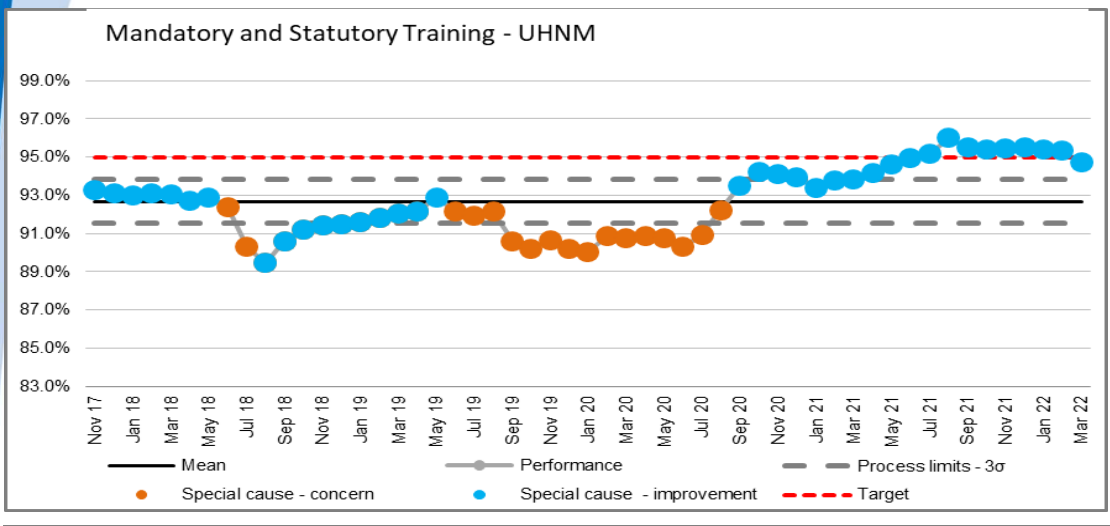
February saw an upturn in the Non-Medical PDR compliance rate to 76.58% (corrected from the previously reported 79.08% at 28th February 2022).

The final outturn for the 12m ending 31st March 2022 was 75.55%

Actions

Requirements for undertaking quality PDRs with staff will be a feature of the comprehensive ‘Enable Middle Management’ programme which will be delivered to 616 managers during 2022/2023.

Statutory and Mandatory Training



Variation	Assurance

Target	Jan 22	Feb 22	Mar 22
95.0%	95.4%	95.3%	94.7%

Background

Training compliance

What is the data telling us?

At 94.73%, the Statutory and Mandatory Training rate just below the Trust target for the core training modules

Summary

The Statutory and Mandatory training rate at 31st March 2022 was 94.73% (95.34% at 28th Feb 2022). This compliance rate is for the 6 'Core for All' subjects only

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10619	10619	10044	94.59%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10619	10619	10085	94.97%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10619	10619	10072	94.85%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10619	10619	10061	94.75%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10619	10619	10076	94.89%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10619	10619	10016	94.32%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10619	10619	9159	86.25%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10619	10619	9413	88.64%

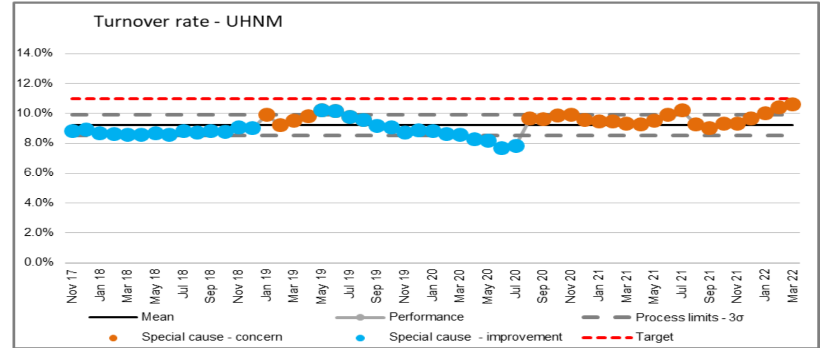
Actions

We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

Compliance is monitored and raised via the Divisional performance review process.

Workforce Turnover

The SPC chart shows the rolling 12m cumulative turnover rate.



Variation	Assurance

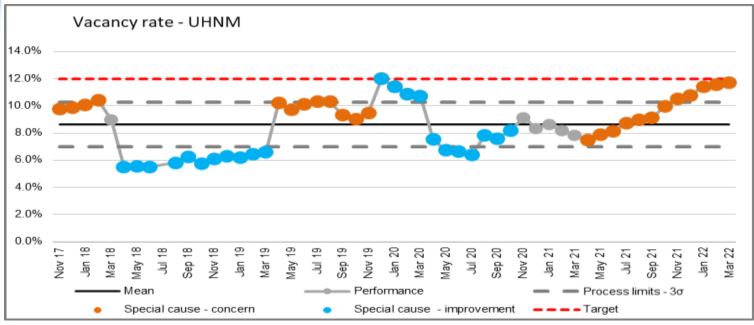
Target	Jan 22	Feb 22	Mar 22
11.0%	10.0%	10.4%	10.6%

Background

Turnover rate

What is the data telling us?

The special cause variation in the Turnover rate from August 2020 was due to Student Nurses, who had supported throughout the first wave of covid-19, returning to University. The 12m rolling turnover rate remains below the target 11%



The overall Trust vacancy rate is calculated as Budgeted Establishment less staff in post. The vacancy rate is influenced by an increase in budgeted establishment to account for the Winter Workforce Plan as well as approved business cases

Actions

The Trust is working to accelerate recruitment plans where possible, including for healthcare support workers.

A business case has been approved for international recruitment of 100 Nurses in 2022/23

Summary

The 12m Turnover rate was 10.59% (10.4% at 28/02/22).
Staff in post decreased in March 2022 by 7.55 fte*, and budgeted establishment increased by 12.36 fte. This resulted in an overall increase in the vacancy position by 19.91 fte

Vacancies at 31-March 22	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,468.85	1,277.55	191.30	13.02%	13.39%
Registered Nursing	3372.95	2935.78	437.17	12.96%	12.82%
All other Staff Groups	6435.56	5743.30	692.26	10.76%	10.46%
Total	11,277.36	9,956.63	1,320.73	11.71%	11.55%

In month, Bank and Agency fte was 1008.90, which covered 76.39% of this vacancy position.
There was 1154.30 FTE in the recruitment pipeline
Other mitigations against the vacancy position include offering Additional PA's; extended / increased hours; On call payments and overtime.

Finance

2025 Vision	"Ensure efficient use of resources"

Quality › Operational › Workforce › **Finance**

Finance Spotlight Report

Key messages

- The Trust has delivered an actual surplus of £3.6m in month against an in month planned deficit of £1.8m and a full year surplus of £8.7m resulting in a favourable variance of £3.6m against the full year plan. This surplus above plan is primarily driving by an additional non-recurrent COVID allocation received in Month 12 of £3.2m.
- Adjustments have been made within the Month 12 position (within both income and non-pay) in respect of the DHSC PPE which has been issued throughout the year, the additional employer's pension contribution of 6.3% (within both income and pay) and the prior year annual leave accrual has been re-calculated in line with the current balance of annual leave outstanding.
- A full year forecast was undertaken at Month 9 and reviewed at Month 11 which presented a £5.2m surplus. At Month 11 the Trust reported the expected forecast position was in excess of the original forecast figure of £5.2m due to the expected receipt of TIF ITU funding of £1.3m in Month 12. At year end the Trust has reported a full year surplus position of £8.7m which is primarily driven by the additional non-recurrent COVID allocation received in Month 12 as excluding this income stream, the Trust has delivered the original forecast position with the additional TIF ITU funding being offset by the annual leave accrual being in line with last year's accrual rather than a previously forecast £2m reduction.
- The Trust incurred £1.3m of costs relating to COVID-19 in month which is an increase of £0.4m compared with Month 11's figure. This remains within the Trust's YTD fixed allocation with £0.8m being chargeable on top of this allocation for COVID-19 testing costs.
- Capital expenditure for the year is £42.7m which is £0.2m behind the plan
- The cash balance at Month 12 is £87.6m which is £7.2m lower than plan, the main reason being lower than forecast is final ERF payment of £5.1m will be made in 2022/23

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	80.1		
	Expenditure - Pay	variable	44.0	H	?
	Expenditure - Non Pay	variable	28.5		P
Activity	Daycase/Elective Activity	variable	7,469	L	?
	Non Elective Activity	variable	9,323	L	?
	Outpatients 1st	variable	22,911	L	?
	Outpatients Follow Up	variable	41,262		?

Income & Expenditure

Income & Expenditure Summary Month 12 2021/22	Annual Budget £m	In Month Budget £m	In Month Actual £m	In Month Variance £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Variance £m
Income From Patient Activities	890.9	93.5	98.8	5.3	890.9	882.0	(8.9)
Other Operating Income	89.8	7.8	11.1	3.3	89.8	93.6	3.7
Total Income	980.7	101.3	109.9	8.6	980.7	975.5	(5.2)
Pay Expenditure	(584.1)	(70.8)	(67.7)	3.1	(584.1)	(569.0)	15.1
Non Pay Expenditure	(337.9)	(27.9)	(33.0)	(5.1)	(337.9)	(342.9)	(5.0)
Total Operational Costs	(922.0)	(98.7)	(100.8)	(2.1)	(922.0)	(911.9)	10.1
EBITDA	58.7	2.6	9.2	6.6	58.7	63.6	5.0
Depreciation & Amortisation	(29.9)	(2.5)	(2.9)	(0.5)	(29.9)	(30.6)	(0.7)
Interest Receivable	0.1	0.0	0.0	0.0	0.1	0.0	(0.1)
PDC	(7.6)	(0.6)	(1.3)	(0.6)	(7.6)	(8.3)	(0.6)
Finance Cost	(16.1)	(1.3)	(1.5)	(0.1)	(16.1)	(16.2)	(0.1)
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Surplus / (Deficit)	5.1	(1.8)	3.6	5.4	5.1	8.7	3.6
Financial Recovery Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	5.1	(1.8)	3.6	5.4	5.1	8.7	3.6

The main variances in month are:

- Income from patient activities has over performed in month primarily due to an additional non-recurrent COVID-19 allocation of £3.2m and receipt of TIF ITU funding amounting to £1.3m.
- Both income from patient activities and pay are high in month due to the fully funded NHSIE adjustment in respect of the increase in employer pension contributions (£22.2m income and £22.2m pay impact); a budget adjustment has been made in respect of this within both categories.
- Other operating income has over performed in month and this is primarily driven by additional income to compensate for the DHSC issued PPE for the 21/22 financial year of £2.4m. This is on top of COVID out of envelope income received above plan of £0.3m (see section 2c below) and additional income in respect of the HEE contract of £0.3m due to an updated contract being received in Month 12.
- Pay is underspent in month by £3.1m which is primarily driven by underspends across registered nursing (see Winter detail below) and non-recurrent funding underutilised in month for the System Elective Recovery fund and the System Workforce Funding.

Capital Spend

Capital Expenditure as at Month 12 2021/22 £m	Revised 2021/22 Plan	2021/22 year end forecast	In Month			Year to Date		
	Plan	Actual	Budget	Actual	Variance	Forecast	Actual	Variance
PFI & finance lease liability repayment	(9.2)	(9.2)	(0.8)	(0.8)	-	(9.2)	(9.2)	-
Pre-committed items	(9.2)	(9.2)	(0.8)	(0.8)	-	(9.2)	(9.2)	-
PFI lifecycle and equipment replacement	(5.3)	(5.3)	(3.5)	(3.5)	-	(5.3)	(5.3)	-
PFI enabling cost	(0.8)	-	-	-	-	-	-	-
PFI related costs	(6.1)	(5.3)	(3.5)	(3.5)	-	(5.3)	(5.3)	
RI demolition	(0.9)	(1.2)	(0.1)	(0.1)	(0.1)	(1.2)	(1.3)	(0.1)
Project STAR multi-storey car park	(1.2)	(1.4)	(0.3)	(0.5)	(0.2)	(1.4)	(1.5)	(0.0)
Thornburrow decant office accommodation	(1.9)	(2.0)	-	-	-	(2.0)	(2.0)	0.0
Wave 4b Funding - Lower Trent Wards	(2.2)	(2.2)	-	(0.4)	(0.4)	(2.2)	(2.2)	0.0
CT7 scanner enabling cost	(1.2)	(0.1)	(0.1)	(0.1)	-	(0.1)	(0.1)	-
STP diagnostic Funding and Cancer funding CT7	(1.0)	(1.0)	(1.0)	(1.0)	-	(1.0)	(1.0)	-
PDC funding - elective recovery (CTS/theatre/CC) TI	(1.8)	-	-	-	-	-	-	-
PDC funding Cyber Security/Home working TIF	(0.3)	(0.1)	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0
PDC funding - Unified Tech funding	(1.6)	(1.4)	(1.4)	(1.5)	(0.0)	(1.4)	(1.5)	(0.0)
PDC funding - Digital Maternity Tech funding	(0.3)	(0.1)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)
PDC funding - Imaging Academy	(0.5)	(0.5)	(0.5)	(0.3)	0.1	(0.5)	(0.3)	0.1
PDC funding - Radiology digital	(0.5)	(0.5)	(0.5)	(0.5)	-	(0.5)	(0.5)	-
PDC funding - Pathology digital diagnostics	(0.2)	(0.2)	(0.2)	(0.2)	0.0	(0.2)	(0.2)	0.0
PDC funding - LIMS	(0.4)	(0.4)	(0.4)	(0.4)	-	(0.4)	(0.4)	-
PDC funding - Patient Portal	(2.0)	(0.8)	(0.8)	(0.8)	-	(0.8)	(0.8)	-
PDC funding - Cyber security	(0.3)	(0.3)	(0.3)	(0.3)	-	(0.3)	(0.3)	-
Schemes funded by PDC and Trust funding	(16.2)	(12.2)	(5.7)	(6.2)	(0.6)	(12.2)	(12.1)	0.0
LIMS (Laboratory Information Management System	(0.6)	(0.5)	-	-	-	(0.5)	(0.5)	0.0
EPMA (Electronic Prescribing)	(0.5)	(0.4)	(0.1)	(0.0)	0.1	(0.4)	(0.4)	-
Completion of RSUH ED doors	(0.2)	(0.2)	-	-	-	(0.2)	(0.2)	-
Pathology integration	(0.3)	(0.3)	(0.2)	(0.2)	-	(0.3)	(0.3)	0.0
Medical devices fleet replacement	(0.7)	(0.6)	(0.6)	(0.6)	-	(0.6)	(0.6)	-
Schemes with costs in more than 1 financial year	(2.3)	(2.0)	(0.9)	(0.8)	0.1	(2.0)	(2.0)	0.1
2021/22 schemes	(14.2)	(15.7)	(7.4)	(8.0)	(0.6)	(15.7)	(15.6)	0.1
Funds to be allocated to schemes	-	-	-	-	-	-	-	-
Donated/Charitable funds expenditure	(3.0)	(3.0)	(2.3)	(2.3)	-	(3.0)	(3.0)	-
Charity funded expenditure	(3.0)	(3.0)	(2.3)	(2.3)	-	(3.0)	(3.0)	-
Overall capital expenditure	(51.0)	(47.4)	(20.4)	(21.5)	(1.1)	(47.4)	(47.2)	0.2

Overall capital expenditure in the year is £47.2m against a forecast of £47.4m, an underspend of £0.2m. The main variances are explained below.

- The PDC funded imaging academy scheme was under spent by £0.15m at the year end due to delays in delivery of a number of items of equipment, these items will be included in the 22/23 capital plan.
- The anaesthetic medical records scheme was under spent by £0.12m due to delays in the installation of the Nastar link, this expenditure will be incurred in 2022/23.
- Expenditure of £3.0m has been incurred on donated or granted schemes in 2021/22, the main items being the surgical robot £1.5m and the Neurosurgery Orbeye £0.5m which have both been funded by the Denise Coates Foundation.
- The year end expenditure of £47.4 is £3.6m lower than the plan of £51.0m. The Trust is fully utilising the system capital allocation. The variance from plan is due to the Trust not utilising £3.6m of PDC funding in 2021/22. Of this £1.8m is in relation to the TIF schemes for critical care, County CTS and theatres. There is no agreement to be able to carry forward the TIF funding to 2022/23, however the Trust has been awarded future TIF funding for the County hospital site.
- A further £1.1m variance relates to the PDC funded patient portal, £2m of funding was allocated to the Trust in mid-February prior to costs being known. Actual expenditure was £0.8m in 2021/22 and future years capital costs will be included in the 2022/23 capital plan. The remaining £0.7m is over a number of the other PDC schemes e.g. Digital Maternity Tech funding.

Balance sheet

Balance sheet as at Month 12	31/03/2021	31/03/2022			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	531.2	574.6	578.3	3.7	Note 1
Intangible Assets	22.8	18.2	18.8	0.6	
Other Non Current Assets	-	-	-	-	
Trade and other Receivables	0.5	0.5	1.4	1.0	Note 2
Total Non Current Assets	554.5	593.2	598.6	5.4	
Inventories	15.0	17.0	16.2	(0.8)	Note 3
Trade and other Receivables	47.4	34.3	45.0	10.6	Note 4
Cash and Cash Equivalents	55.8	94.8	87.6	(7.2)	Note 5
Total Current Assets	118.2	146.1	148.8	2.7	
Trade and other payables	(98.5)	(119.1)	(119.8)	(0.6)	
Borrowings	(8.3)	(11.0)	(11.1)	(0.1)	
Provisions	(3.6)	(2.5)	(2.5)	(0.0)	
Total Current Liabilities	(110.4)	(132.7)	(133.4)	(0.8)	
Borrowings	(268.5)	(256.8)	(257.4)	(0.6)	Note 7
Provisions	(2.2)	(2.1)	(3.8)	(1.7)	Note 6
Total Non Current Liabilities	(270.7)	(258.9)	(261.2)	(2.3)	
Total Assets Employed	291.5	347.7	352.7	5.0	
Financed By:				-	
Public Dividend Capital	637.9	649.4	648.2	(1.2)	Note 8
Retained Earnings	(465.3)	(460.3)	(437.7)	22.7	Note 9
Revaluation Reserve	118.9	158.7	142.2	(16.5)	Note 10
Total Taxpayers Equity	291.5	347.7	352.7	5.0	

Variances to the plan at Month 12 are explained below:

1. The plan did include an estimated £39m increase in land and building asset values following receipt of the draft valuation. However the plan did not include donated capital expenditure of £3m in month 12 as the timing of completion of schemes was not certain.
2. This variance reflects the increase in the provision liabilities arising from the 2019/20 clinicians' pensions compensation scheme.
3. The reduction in the inventory balance is due to a review of the accounting treatment of items included previously in the ventilators inventory count.
4. The main reasons for the variance are;
   - NHS accruals are £3.2m higher than plan and reflect the system Covid top up redistribution from local commissioners that will be paid in May 2022.
   - Non NHS prepayments are £4.1m higher than plan and reflect the payment of 2022/23 business rates in late March 2022 for the Royal Stoke and County Hospital.

1. Cash is £7.2m lower than plan and reflects lower cash received of £3.8m mainly due to the final Elective Recovery Fund cash balance will not be received until 2022/23. Payments are £3.8m higher than plan and reflect the payment of 2022/23 business rates in late March 2022.
2. Provisions are £1.7m higher than plan and reflect an increase in the provision liabilities arising from the 2019/20 clinicians' pensions compensation scheme of £1m.
3. Borrowing is £0.6m higher than plan and reflects the addition to the finance lease liability in relation to the Digital Pathology capital scheme which was in place prior to 31 March 2022.
4. Public Dividend Capital is £1.2m lower than plan. The variance reflects the lower than planned cash drawdown in relation to the Patient Portal capital scheme due to the overall cost and phasing of the scheme being lower than first anticipated.
5. Retained earnings show a variance of £22.7m from plan. Of this variance £6.4m which reflects the revenue variance from plan at the year end and the impact of donated income and expenditure of £2.6m. The remaining £16.3m variance is due to the reversal of previous impairments charged to revenue as a result of the asset revaluations at 31 March 2022 as covered in the PPE narrative above.
6. The revaluation reserve is £16.5m lower than plan at the year end. The plan included an estimated increase of £39m in land and building asset valuations following the receipt of the draft valuation report. However £16.3m of the increases in asset valuation are classified as the reversal of an impairment previously charged to revenue and are therefore reversed see retained earnings explanation above.

Expenditure - Pay and Non Pay

Pay Summary Month 12 2021/22	Annual Budget £m	In Month Budget £m	In Month Actual £m	In Month Variance £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Variance £m
Medical	(176.6)	(21.0)	(19.9)	1.1	(176.6)	(174.2)	2.4
Registered Nursing	(169.9)	(21.0)	(17.8)	3.2	(169.9)	(161.3)	8.6
Scientific Therapeutic & Technical	(71.0)	(8.6)	(7.6)	1.0	(71.0)	(68.0)	3.0
Support to Clinical	(78.8)	(9.5)	(8.4)	1.1	(78.8)	(77.0)	1.8
NHS Infrastructure Support	(87.8)	(10.7)	(14.1)	(3.4)	(87.8)	(88.4)	(0.6)
Total Pay	(584.1)	(70.8)	(67.7)	3.1	(584.1)	(569.0)	15.1

Pay –Key variances

- Within the above budget for Month 12 is £1.6m of reserves which have not been spent (split across numerous expenditure headings) with the main elements being £0.4m for the non-recurrent investment reserve primarily relating to System Elective recovery, £0.4m in respect of Specialised Commissioners and £0.3m against the System Workforce Funding.
- The underspend on registered nursing remains in line with the prior year trend as a result of the number of vacancies across the trust. Within the Month 12 budget there is £0.7m of underutilised budget in reserves (part of the £1.6m noted above) and within the Month 12 actual were total premium costs (bank and agency) of £2.1m covering existing workforce vacancies and absences.

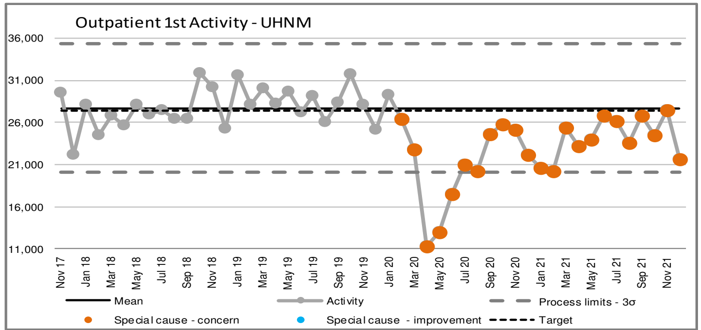
Non Pay Summary Month 12 2021/22	Annual Budget £m	In Month Budget £m	In Month Actual £m	In Month Variance £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Variance £m
Tariff Excluded Drugs Expenditure	(79.8)	(6.6)	(7.8)	(1.2)	(79.8)	(84.1)	(4.3)
Other Drugs	(24.4)	(2.0)	(2.2)	(0.2)	(24.4)	(24.4)	(0.0)
Supplies & Services - Clinical	(88.7)	(7.7)	(12.4)	(4.7)	(88.7)	(94.5)	(5.8)
Supplies & Services - General	(7.2)	(0.8)	(1.0)	(0.2)	(7.2)	(8.2)	(1.0)
Purchase of Healthcare from other Bodies	(24.8)	(2.0)	(1.2)	0.9	(24.8)	(21.5)	3.3
Consultancy Costs	(1.9)	(0.1)	(0.2)	(0.1)	(1.9)	(2.0)	(0.1)
Clinical Negligence	(25.4)	(1.3)	(1.1)	0.2	(25.4)	(25.2)	0.2
Premises	(32.5)	(2.9)	(3.8)	(0.9)	(32.5)	(34.4)	(1.9)
PFI Operating Costs	(35.5)	(3.0)	(1.8)	1.3	(35.5)	(34.3)	1.2
Other	(17.7)	(1.4)	(1.5)	(0.1)	(17.7)	(14.4)	3.3
Total Non Pay	(337.9)	(27.9)	(33.0)	(5.1)	(337.9)	(342.9)	(5.0)

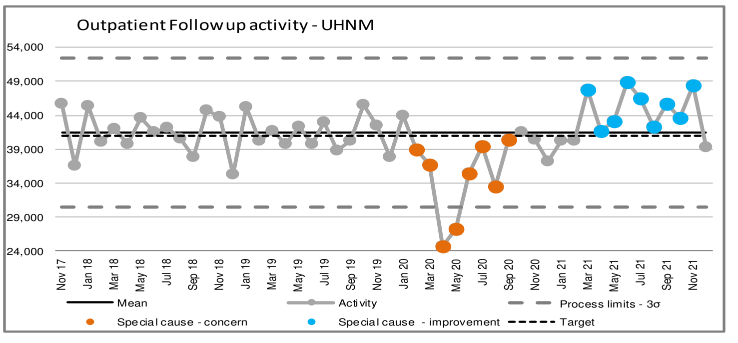
Non Pay key variances:

- An adjustment in respect of the centrally distributed PPE stock by the DHSC of £2.1m has been made within supplies and services – clinical to account for full year issues. The overspend on supplies and services – clinical (aside from the PPE adjustment) is driven by £0.6m additional non-recurrent revenue spend which was approved by the Executive Team earlier in the calendar year, £0.9m write off of ventilators previously classified as stock and £0.5m over spend on high cost pass through devices in month against which we have received additional income.
- Purchase of Healthcare from other Bodies is reporting a variance of £0.9m as a result of both an underspend against the IS contract (£0.2m) and an adjustment against Community Health Partnerships accrued expenditure due to a detailed reconciliation being undertaken.
- Premises costs are overspent in month by £0.9m which is solely driven by additional non-recurrent revenue spend which was approved by the Executive Team earlier in the calendar year.
- PFI operating costs are underspent in month by £1.3m driven by the release of accruals which have been identified as no longer required following a review of the PFI MES model in M12. These accruals relate to mammography units (£0.3m); MES price differences (£0.4m); and de-scoped items (£0.5m)

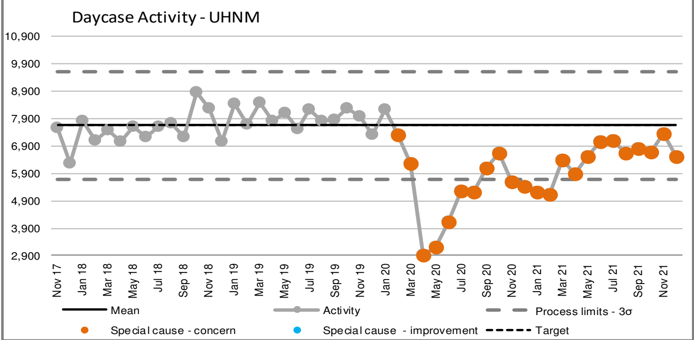
Activity

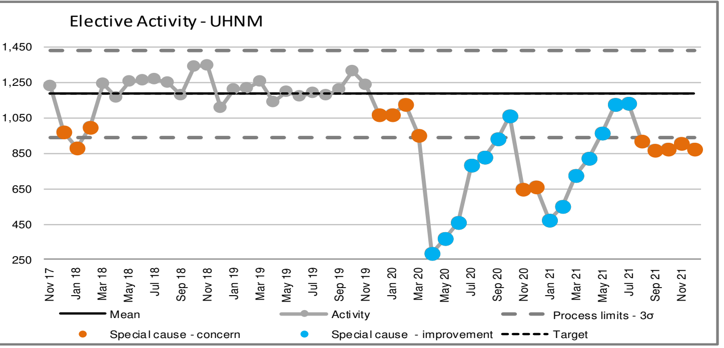
Planned care Outpatient



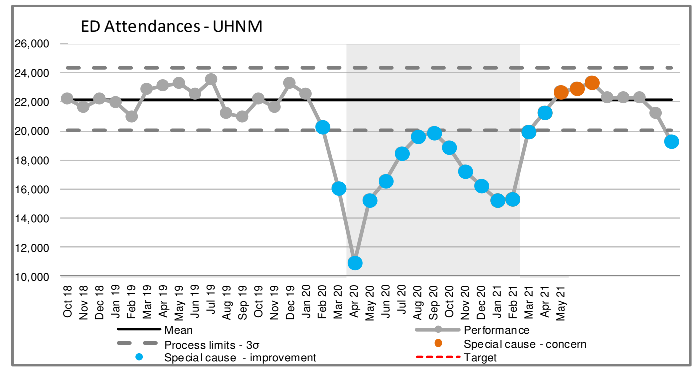


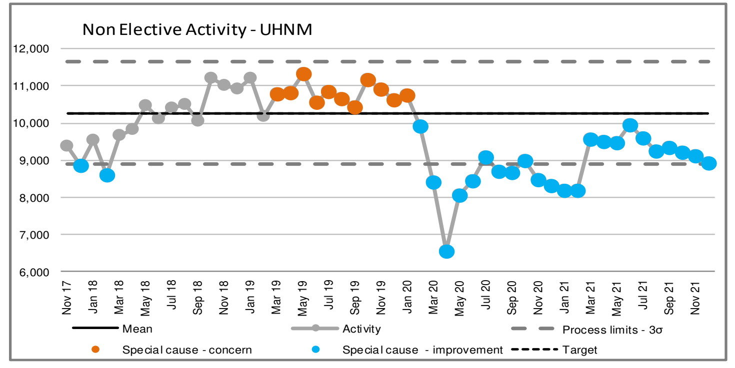
Planned care Inpatient



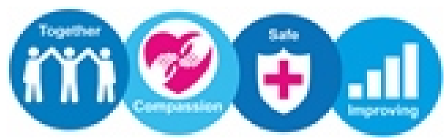


Urgent Care





Quality | Operational | Workforce | Finance



Audit Committee Chair's Highlight Report to Trust Board

29th April 2022

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee considered whether the internal audit plan should incorporate an additional review to explore the completion of the actions identified in response to the brap and staff survey. It was noted that the Executive had considered what support might be required in due course in terms of validating and stress testing the actions taken and this would be considered further by the Board. • An increase in overpayments related to late receipt of termination and change forms in addition to job planning adjustments was highlighted and this was to be considered with divisional teams via performance reviews	• To consider the scope and timing of further internal audit reviews into maternity given the publication of the full Ockenden report • To determine if any of the outstanding policies are critical and require a more urgent review • To clarify the nature of the donation/grant received during the quarter • To expand on the information provided in terms of the declarations of interest process and how this can inform the Trust in managing potential conflicts
Positive Assurances to Provide	**Decisions Made**
• The Committee received 6 finalised internal audit reports, all of which received positive opinions. These included substantial assurance in relation to IT Cyber Security Governance and Risk Management Framework and Board Assurance Framework, good progress in relation to the Ockenden Response Follow Up and reasonable progress in relation to E-Rostering Follow Up, Capital Programme and IT Asset Management Review • The Committee received the Head of Internal Audit Opinion for 2021/22 which concluded positively that the Trust had an adequate and effective framework for risk management, governance and internal control. • The Committee received an update in terms of Internal Audit Recommendations and agreed the movements to target dates were reasonable • The Committee considered the updated position in relation to received declaration of interests and the response rate of 90%. • The External Audit Plan for 2021/22 was noted, as was the proposed audit approach which identified materiality to be £11 m an increase of £1 m from the previous year with a continued focus on accruals in addition to the updated disclosures required within the Annual Report in relation to the Trust's fair pay multiple • The proposed rating for the Counter Fraud Functional Standard Return was noted as an overall rating of green • The total losses and special payments made during the financial year equated to £629,776 • 5 single tender waivers were noted during the quarter in addition to 92 SFI breaches relating to raising of late purchase orders • The Committee welcomed the enhanced transparency in relation to the 2021/22 annual leave provision and the approach taken	• The Committee approved the Internal Audit Plan 2022/23 – 2024/25 • The Committee approved the Quarter 4 Board Assurance Framework • The Committee approved the Counter Fraud Workplan for 22/23 • The Committee approved that the financial accounts for 2021/22 should be prepared on a going concern basis

Comments on the Effectiveness of the Meeting
• The Committee welcomed the discussion held.

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Internal Audit Progress Report	BAF 7, 1, 3, 8, 9	-	Assurance	8.	Draft Quality Account	BAF 1	Various	Approval
2.	Internal Audit Annual Report & Opinion	-	-	Assurance	9.	External Audit Plan & Progress Report	BAF 9	-	Assurance
3.	Approval of Internal Audit Plan 22/23	-	-	Approval	10.	LCFS Annual Report 2021/22	-	-	Approval
4.	Internal Audit Recommendation Tracker	-	-	Assurance	11.	Losses and Special Payments Q4 2021/22	BAF 9	-	Assurance
5.	Corporate Governance Report	-	-	Assurance	12.	SFI Breaches and Single Tender Waivers Q4 2021/22	BAF 9	-	Assurance
6.	Board Assurance Framework Q4	ALL	Various	Approval	13.	Going Concern Assessment & Annual Leave Provision	BAF 9	-	Approval
7.	Issues for Escalation from Committees	-	-	Assurance	14.	Draft Accounts	BAF 9	-	Assurance

3. 2022 / 23 Attendance Matrix

Key: Attended | Apologies & Deputy Sent | Apologies

Members:		A	M	J	J	A	S	O	N	D	J	F	M
Prof G Crowe	Non-Executive Director (Chair)	Attended											
Mr P Akid	Non-Executive Director	Attended											
Ms S Belfield	Non-Executive Director	Attended											
Mrs T Bowen	Non-Executive Director	Attended											
Other Attendees:													
Ms N Coombe	External Audit – Grant Thornton	Apologies											
Mr G Patterson	External Audit – Grant Thornton	Attended											
Mr M Gennard	Internal Audit - RSM	Attended											
Mr A Hussain	Internal Audit - RSM	Attended											
Ms S Coster	LCFS - RSM	Attended											
Mrs N Hassall	Deputy Associate Director of Corporate Governance	Attended											
Mr M Oldham	Chief Finance Officer	Attended											
Mrs S Preston	Strategic Director of Finance	Attended											
Miss C Rylands	Associate Director of Corporate Governance	Attended											

Executive Summary

Meeting:	Public Trust Board	Date:	4th May 2022
Report Title:	Speaking Up Report Q4/ Annual Report 2021-22	Agenda Item:	15.
Author:	Workforce Equality & Inclusion Lead		
Executive Lead:	Chief People Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF 1	*Delivering Positive Patient Outcomes*	*20*
BAF 2	*Leadership, Culture and Delivery of Trust Values*	*12*

Executive Summary

Situation - when things go wrong we need to make sure that lessons are learnt and improvements are made. If we think something might go wrong, it's important we feel able to speak up so that potential harm is avoided. Even when things are going well, but could be made even better we should feel able to say something and should expect that what we say is listened to and used as an opportunity for improvement. Speaking Up is about all of these things.

Background - this quarterly Speaking Up Report provides an update to Trust Board on progress in relation to developing our speaking up culture, relevant national speaking up guidance published, and a summary of concerns raised at UHNM for the Quarter 4 period of January – April 2022 and a summary of the full year data for 2021-22.

Assessment – during the quarter 21 speaking up contacts were received. 20 concerns were recorded on the speaking up tracker, which includes concerns raised with the Freedom to Speak Up Guardians and those raised to the Chief Executive's Office, within a division, or via CQC/other routes that have then been notified to the FTSU Guardian for inclusion on the speaking up tracker. One contact was made to our Employee Support Advisors, and is included in our reportable speaking up data.

Key Recommendations

Trust Board is asked to note:

- The speaking up data and themes raised during Quarter 4 2021-22
- The speaking up themes and trends raised during the year 2021-22
- The actions proposed to further encourage and promote a culture of speaking up at UHNM.

Speaking Up
Quarter 4 2021-22

1. Introduction

This Quarter 21 speaking up contacts have been made via the UHNM speaking up routes, which include 20 concerns recorded on the speaking up tracker which records issues raised with the Freedom to Speak Up Guardians; the Chief Executive's Office; within a division or via CQC/other routes that have then been notified to the FTSU Guardian for inclusion on the speaking up tracker. One contact has also been made to our Employee Support Advisors, who act as speaking up champions across the Trust.

2. National Guardians Office (NGO) Update

NGO Senior Leader Training

The final module of the Freedom to Speak Up E-learning 'Follow Up' will be launched on 12th April. This module is designed for leaders at all levels to help foster a speaking up culture in their organisations. Developed for senior leaders throughout healthcare - including executive and non-executive directors, lay members and governors – this module aims to promote a consistent and effective Freedom to Speak Up culture across the system which enables workers to speak up and be confident they will be listened to and action taken.

It is proposed that the training form part of a board development session, where the Speaking Up Board Self Review Tool is also considered.

Freedom to Speak Up Guardian Survey

The annual Freedom to Speak Up Guardian Survey has been published. The survey shows the experience of guardians amid the continued pressure of the pandemic on the healthcare sector. While the majority of guardians who responded were positive about the speaking up culture in their organisation, there are warning signs that more action is needed. The proportion of guardians who reported a positive speaking up culture in their organisation has dropped, in line with the national NHS Staff Survey results. The survey can be accessed here .

The results of the latest Freedom to Speak Up Guardian survey correlate with the findings of the 2021 national NHS Staff Survey. The proportion of staff who say they feel safe to speak up about anything which concerns them in their organisation has fallen by more than three percentage points to 62%. The proportion of staff who disagreed with the question was 14.5% (up from 13.3% in 2020). Only half of respondents (49.8%) were confident that their organisation would address their concern (q21f).

The NGO has indicated that it will be updating its website with information and resources on measuring the effectiveness of Freedom to Speak Up. This will include how staff survey data can provide insights into an organisation's speaking up culture.

Ockenden Report

Donna Ockenden's Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust was published in March 2022. The report highlights the consequences of a culture where workers are fearful of the consequences if they speak up. The full report can be read here. The midwifery service at UHNM has already taken steps to encourage a speaking up culture and to ensure staff are aware of all the routes available to raise concerns and where to access support.

Case Review Gap Analysis Tool

The NGO has collated together recommendations from the nine case review reports which have been published and grouped them thematically. To help with gap analysis, the NGO has created a tool, published in December 2021 which Freedom to Speak Up Guardians and others responsible for speaking up in their organisations can use to review arrangements and develop plans and actions for improvement. Using this and other guidance published by the NGO as a self-review tool, organisations can identify and improve gaps in their speaking up arrangements.

The tool will be used by the FTSU Guardian team and Executive and Non-Executive Leads for Speaking Up to further enhance speaking up arrangements at UHNM. The gap analysis has been populated and will be finalised with agreed action dates for completion by the wider FTSU team before being shared more widely.

3. Supporting a Speaking Up Culture

UHNM Speaking Up Culture – 2021 Staff Survey

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

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

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

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

UHNM All Staff Speaking Up Training Update

The new UHNM mandatory speaking up e-learning was launched during October's Speak Up Month and is based on the resources released by the NGO and Health Education England. The Speak Up, Listen Up training gives all staff an understanding of the importance of speaking up and how to speak up, whilst the listen up elements equip line managers with the skills to respond effectively when issues are raised to them. At the time of writing, 1,706 UHNM staff have undertaken the training.

These packages are also pre-requisite training for the UHNM Gateway to Management programme.

Work is also underway to overhaul the current equality, diversity and inclusion / civility and respect / speaking up corporate induction package.

Speaking Up Policy - Update

The Speaking Up Policy HR30 has been ratified and now states that reporters of concerns and issues will have input into the terms of reference for any investigation that is to be undertaken. This is in response to an NGO Case Review recommendation.

Work in Confidence System

A paper has been produced on the options appraisal for purchasing the Work in Confidence reporting system, which is to be considered by the Trust Executive Team during April 2022.

Lead Freedom to Speak Up Guardian Recruitment

Kerry Flint has been successfully recruited to the full time Lead Freedom to Speak Up Guardian position, and commenced on 4th April 2022. Kerry is undertaking a comprehensive induction, including attending the annual NGO Conference and completing the NGO Guardian training, in addition to a full handover from the outgoing guardian, who is now focussing attention on equality, diversity and inclusion and civility and respect.

Employee Support Advisors

A revised role description for the Employee Support Advisor voluntary role has been co-developed with a small group of ESA's taking into account the NGO guidance on speaking up champions. The role refocuses the ESA role in supporting colleagues experiencing incivility, disrespect, bullying and harassment and processes to resolve these incidents informally. ESA's will continue to be champions of a healthy speaking up culture and to signpost to FTSU Guardians where required. Once the role has been finalised, a recruitment campaign will be held to increase the numbers, diversity and location of ESA's. Contacts to our ESA's will continue to be noted within the Speaking Up Quarterly reports but will not be included in data reported to the National Guardians Office.

4. Quarterly Speaking Up Cases – Quarter 4 – January – March 2022

The following information reflects speaking up contacts that have been recorded on the **Speaking Up Tracker.** Contacts are recorded in accordance with guidance from the National Guardians Office. Contacts are themed in line with categories issued to NHS Trusts by the NGO. The following information is presented so that patterns emerge over time, whilst being mindful about the need for confidentiality. The data is intended to draw attention to particular issues, patterns of activity or themes:

Month	No. of contacts in the Quarter	Of which were raised anonymously	Of Which are Closed	Reports of detriment/ victimisation as a result of speaking up
January	10	0	6	0
February	4	0	1	0
March	6	0	1	0
Total	**20**	**0**	**8**	**0**

No cases were reported anonymously, but one was raised via CQC and the identity of the reporter not shared with the organisation. A signal of a healthy speaking up culture is that staff feel able to raise issues and concerns openly, as opposed to anonymously.

Theme	Number
Attitudes and behaviours	11
Equipment and maintenance	0
Staffing levels	1
Policies, procedures and processes	5
Quality and safety	0

Patient experience	0
Performance capability	1
Service Changes	0
Other	2
Total	**20**

Summary of speaking up contacts recorded on the Speaking Up Tracker during Quarter 4 January - March 2022:

No.	Theme	Summary	Status
1.	Attitudes & Behaviours	Guidance sought from FTSUG from individual that concerns have been raised against	Support and guidance through process provided. Signposted to emotional wellbeing support. Closed.
2.	Attitudes & Behaviours	Letter of concern submitted to CEO office about behaviours in a team. Reporter has left the organisation	Division undertaken fact finding and programme of work established with the team. Closed.
3.	Policies, processes & procedures	FTSUG contacted after reporter concerned about work undertaken by colleague outside of uhnm employment and social media	Supported to raise issues with line manager. Appropriate action taken. Closed.
4.	Attitudes & Behaviours	Speaking up fact find review undertaken and feedback provided to reporters. One reporter concerned that support and restorative practice actions had not occurred.	Supported to raise with line manager. Actions have now been fully implemented. Closed.
5.	Attitudes & Behaviours	Reporter raised concerns with FTSUG about working relationship with new line manager.	Supported to take personal action and to seek support from next level manager. Active.
6.	Attitudes & Behaviours	Reporter raised issues with CQC about behaviours, discrimination in a team and that other colleagues have raised issues but not acted upon	Initial fact find discovered no record of issues referenced to having been raised with trade unions or other speak up routes. One reporter has been supported previously to raise concerns with Divisional leader and action plan in place monitored by Division. FTSUG held follow up conversation and was advised that situation has improved but that some issues remain. This has been escalated to the division.
7.	Other	Reporter requested meeting with FTSUG	FTSUG supporting team members and further meeting arranged – Active.
8.	Policies, Processes & Procedures	Reporter concerned about the management of their disability, application of sickness policy and attitude of line manager	FTSUG supported reporter to raise issues with next level line manager. HR support in place and supportive return to work package in place. Guidance provided to line manager. Closed.
9.	Attitudes & Behaviours	Reporter previously supported by FTSUG re made contact due to resurgence of behaviours experienced.	Reporter selected to leave the organisation and not pursue issues. FTSUG provided confidential feedback to division - Closed.
10.	Attitudes & Behaviours	Reporter raised issues about covid vaccination and micro management. Supported by FTSUG to raise issues to next level manager.	Meeting held and dignity at work process underway – active.
11.	Staffing Levels	Anonymous concerns raised about junior medical staffing levels at County Hospital.	Escalated to Associate Medical Director, additional information sought, FTSUG sought confidential meeting with anonymous reporters. Educational lead encouraged staff to speak out at doctor's forum so that

No.	Theme	Summary	Status
			issues can be addressed.
12.	Policies, Processes & Procedures	Reporter raised issues about recruitment process followed in department.	Clarity provided on process followed. Further questions raised – meeting to take place to discuss further – Active.
13.	Attitudes & Behaviours	Reporter raised issues previously and informal resolution attempted. This has failed and reporter wished to escalate their concerns.	Meeting held with head of department and options discussed – Active.
14.	Policies, Processes & Procedures	Reporter concerned about the management of their disability, application of sickness policy and attitudes of colleagues and manager	Independent manager appointed to undertake a fact find review - Active
15.	Attitudes & Behaviours	Reporter raised issues about 'gas lighting' and other negative behaviours.	FTSUG supported reporter (with immediate line manager) to raise issues with next level manager. Plan in place, supportive emotional support instigated, and occupational health support in place. Active.
16.	Attitudes & Behaviours	Reporter raised issues of hostile working environment, and other colleagues feeling similarly.	Personal action with support of FTSUG to be taken, review situation in one month with FTSUG – Active.
17.	Other	Request to meet with FTSUG	Meeting being arranged – Active
18.	Capability & Performance	Concerns raised about individual welfare	Escalated to division and HR. Supportive package in place. Feedback provided to reporter. Closed.
19.	Attitudes & Behaviours	Meeting requested with FTSUG to discuss behaviours	Meeting arranged – Active.
20.	Policies, Processes & Procedures	Reporter concerned about the management of their disability	FTSUG supported with options – informal grievance submitted and meeting held with next level manager supported by Trade Union representative – Active.

Open Speaking Up Cases from Previous Quarters

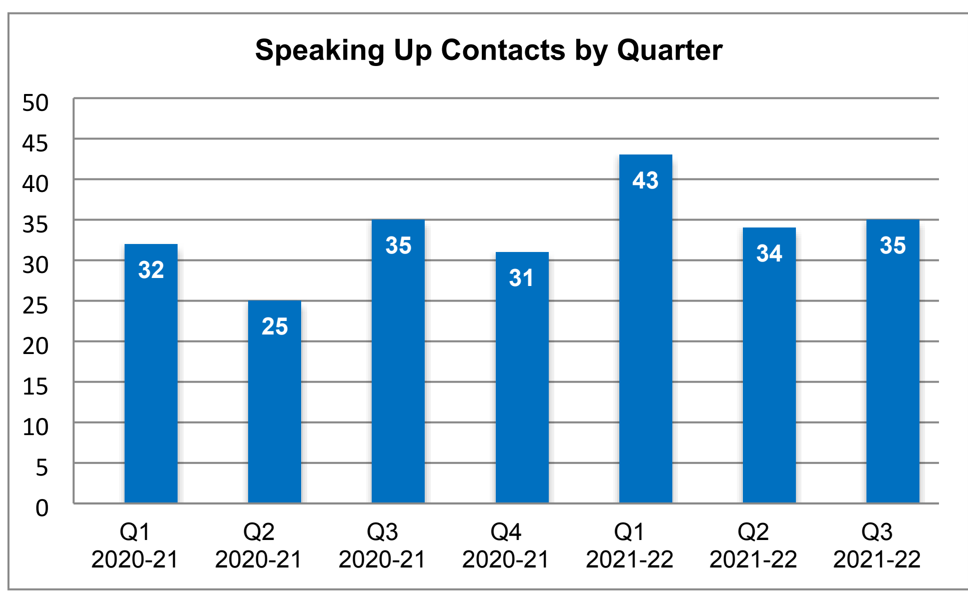
Theme	Summary	Month Case Raised	Status
Quality & Safety	Concerns raised with Medical Director about quality and safety, workload, communication and behaviours.	September 2021	Additional related concerns received. Quality Summit established to review and take forward actions to address concerns.
Quality & Safety	Further issues raised regarding clinical practice and behaviours in work area.	December 2021	Fact finding and grievance processes currently active.

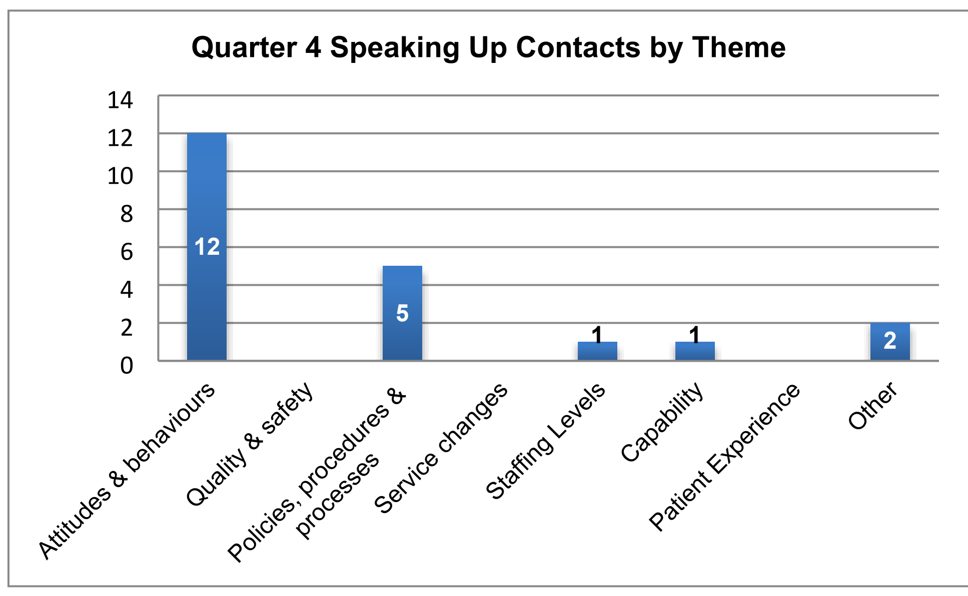
Issues Raised with our Employee Support Advisors

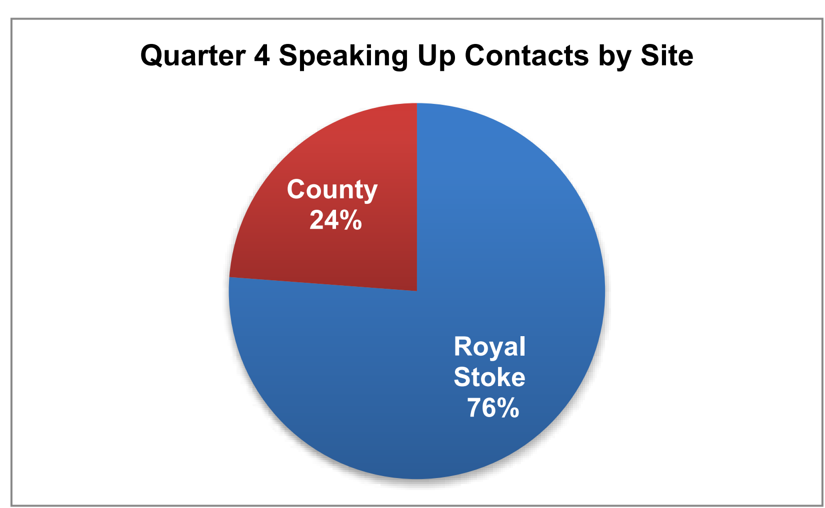
The NGO requests on a quarterly basis the number of issues raised through freedom to speak up channels (i.e. Freedom to Speak Up Guardians and champions). Our Employee Support Advisors act as speaking up champions and therefore their activity is included in NGO data submissions. During the quarter our ESA's have received 1 contact relating to the following themes:

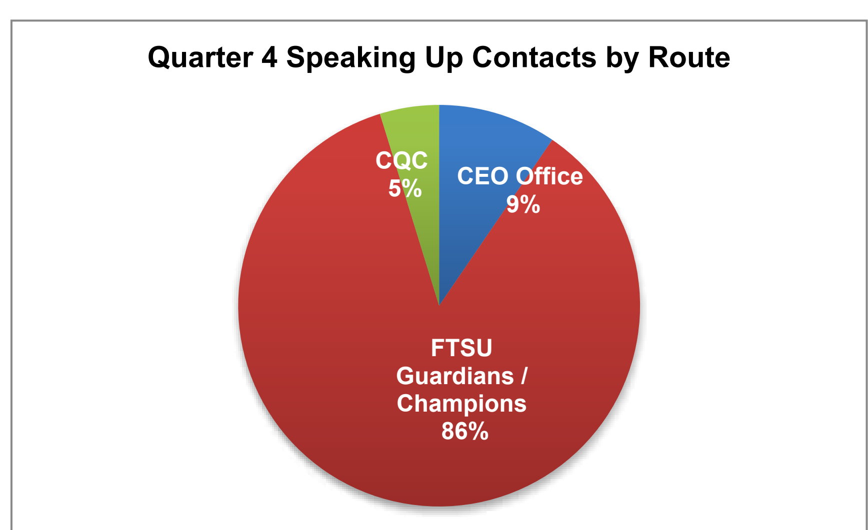
Theme	Number
Attitudes and behaviours	1
Equipment and maintenance	0
Staffing levels	0
Policies, procedures and processes	0
Quality and safety	0
Patient experience	0
Performance capability	0
Service Changes	0
Performance capability	0
Total	**1**

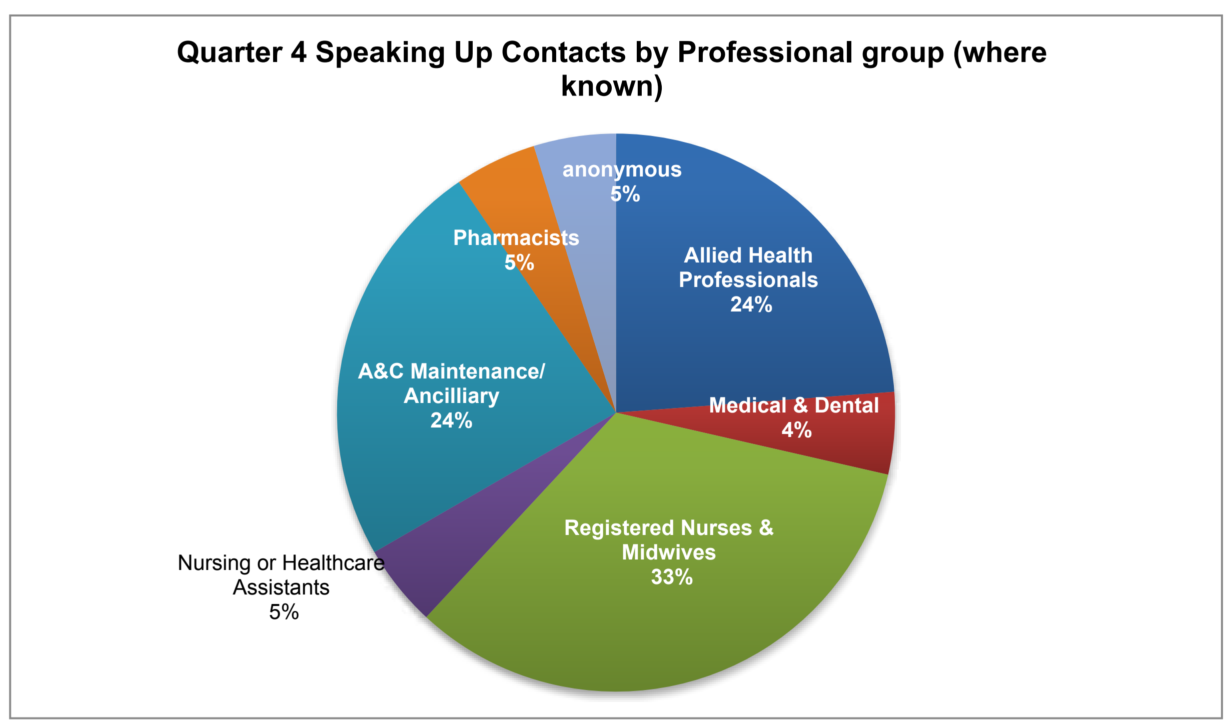
Quarter 4 Data Summary of All Speaking Up Contacts:

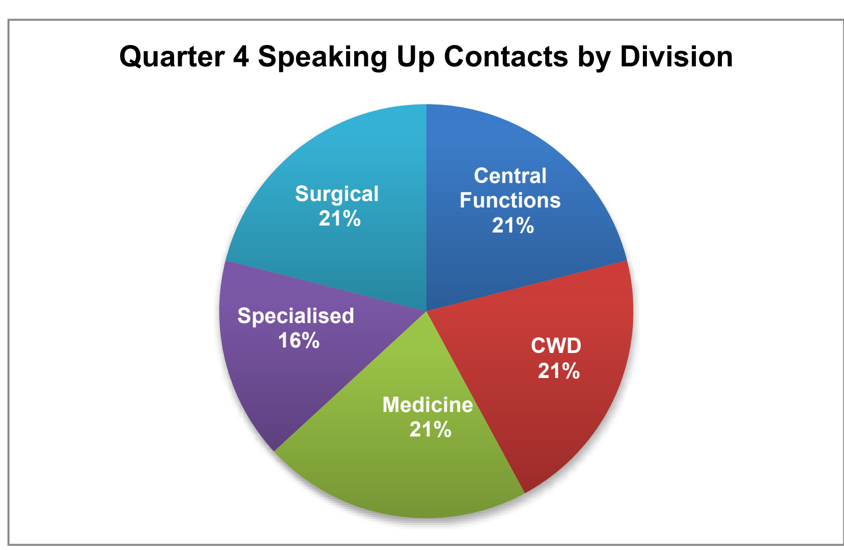


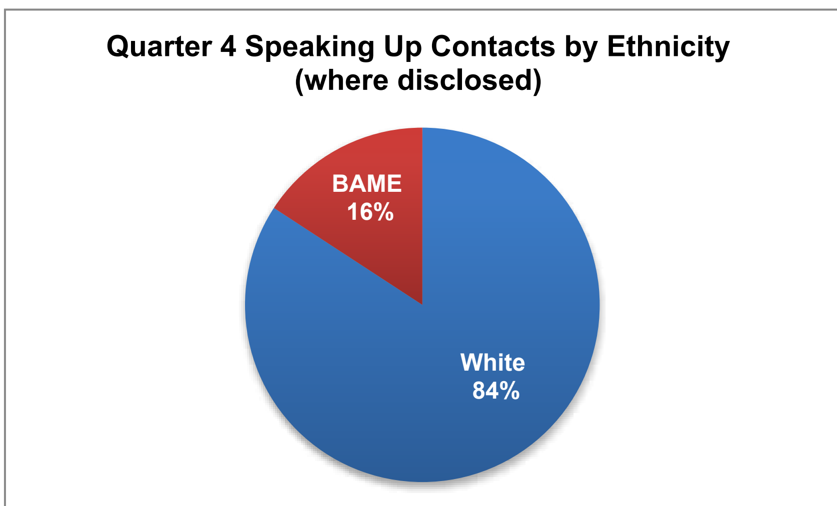



Quarter 4 Speaking Up Contacts by Site
County
24%
Royal
Stoke
76%


Quarter 4 Speaking Up Contacts by Route
CQC
5%
CEO Office
9%
FTSU
Guardians /
Champions
86%


Quarter 4 Speaking Up Contacts by Professional group (where known)
anonymous
5%
Pharmacists
5%
Allied Health
Professionals
24%
A&C Maintenance/
Ancilliary
24%
Medical & Dental
4%
Registered Nurses &
Midwives
33%
Nursing or Healthcare
Assistants
5%





5. Recommendations

Trust Board is asked to note the activity and actions relating to speaking up undertaken in the Quarter 4 of 2021-22, and the focus going forward over the next quarter, which will be:

- Arrange a board development session to cover the Follow Up NGO speaking up training, and to review the updated Speaking Up Self Review Tool and UHNM Speaking Up Strategy.
- Re-advertise for voluntary Freedom to Speak Up Guardian roles to increase numbers and diversity within the FTSU team.
- Consider the findings and recommendations from the BRAP Report in relation to the speaking up culture and provision within the organisation.
- Progress actions relating to the Work in Confidence System

Appendix 1: Freedom to Speak Up Annual Report and Data Summary 2021-22

The following information provides a high level summary of activities undertaken during the year to support a speaking up culture and analysis of the speaking up contact data received during 2021-22.

Actions taken in 2021/22 to develop a speaking up culture at UHNM:

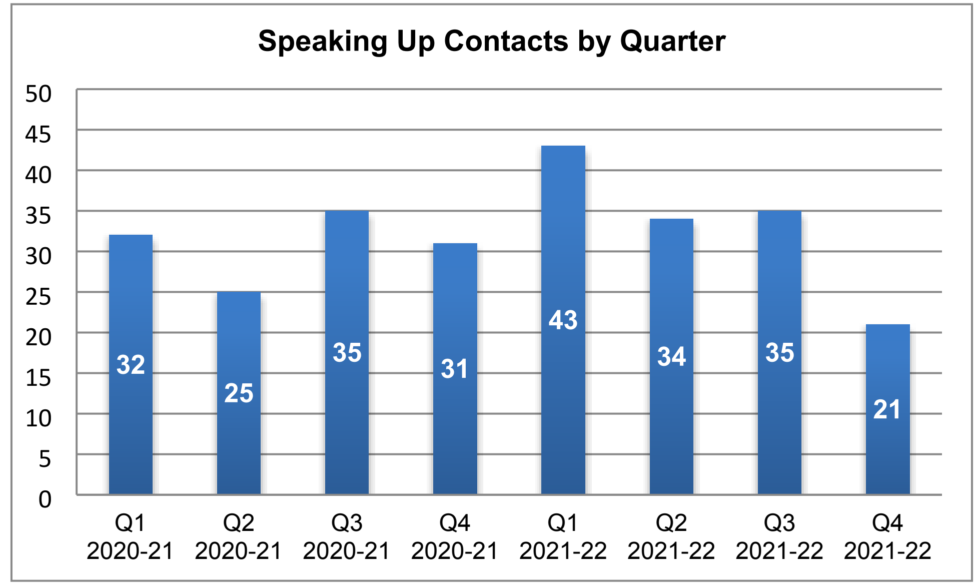
- Introduced Speak Up and Listen Up training into our statutory and mandatory training programmes for all staff. The training was launched during October's 2021 Speak Up Month and is based on the resources released by the NGO and Health Education England. The Speak Up, Listen Up training will give all staff an understanding of the importance of speaking up and how to speak up, whilst the listen up elements equip line managers with the skills to respond effectively when issues are raised to them and to create a speaking up culture in their teams.
- Completed the actions from the 2020 Internal Audit review into our speaking up arrangements undertaken by KPMG. The Audit had provided an assessment of 'significant assurance with minor improvement opportunities'.
- Launched 'Staff Voice'. The Staff Voice survey has been developed internally as a method of receiving more frequent feedback from staff than offered by the annual National Staff Survey, and is an additional route for staff to voice their experiences in the organisation. The survey was launched on 1st of June 2021, and runs for the first 10 days of each month. It is completely anonymous.
- Increased FTSU Guardian resource, with the recruitment of a full time Guardian, Kerry Flint in February 2022, who commenced in role on 4th April 2022.
- Our Speaking Up Index score improved year on year (although this indicator will not continue beyond 2021):

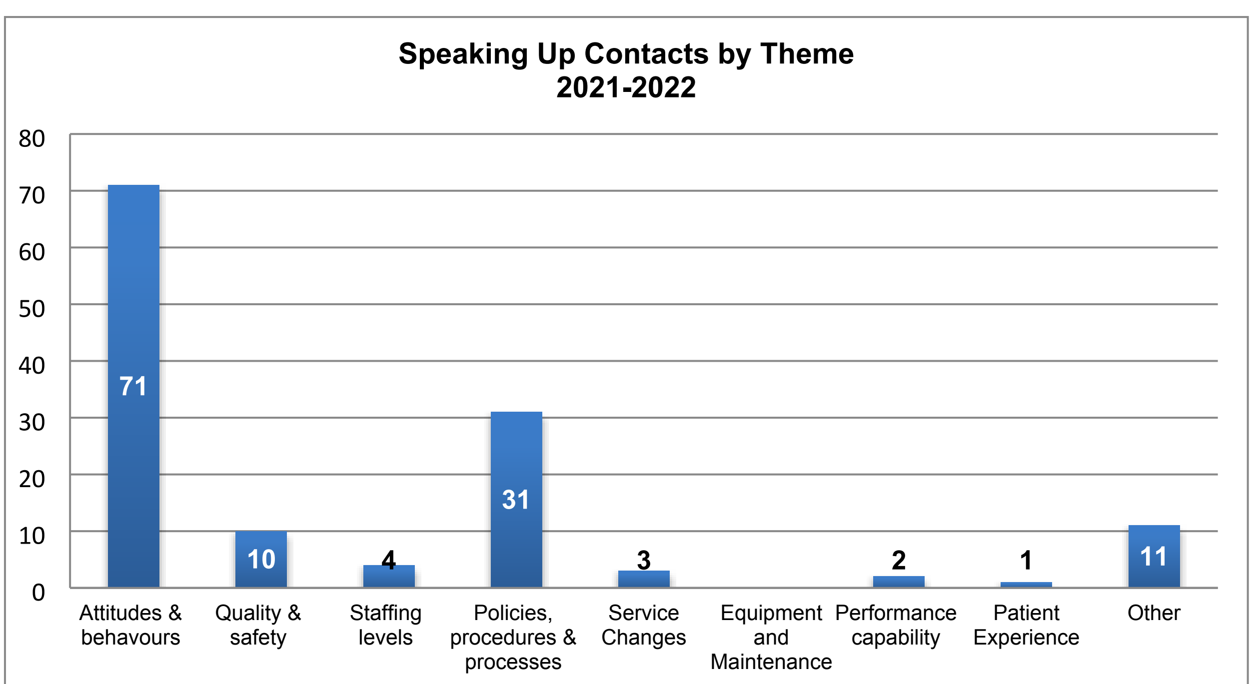
Year	UHNM Index Score
2021	76.8%
2020	75.5%
2019	74%

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

Summary of 2021-22 Speaking Up Contacts

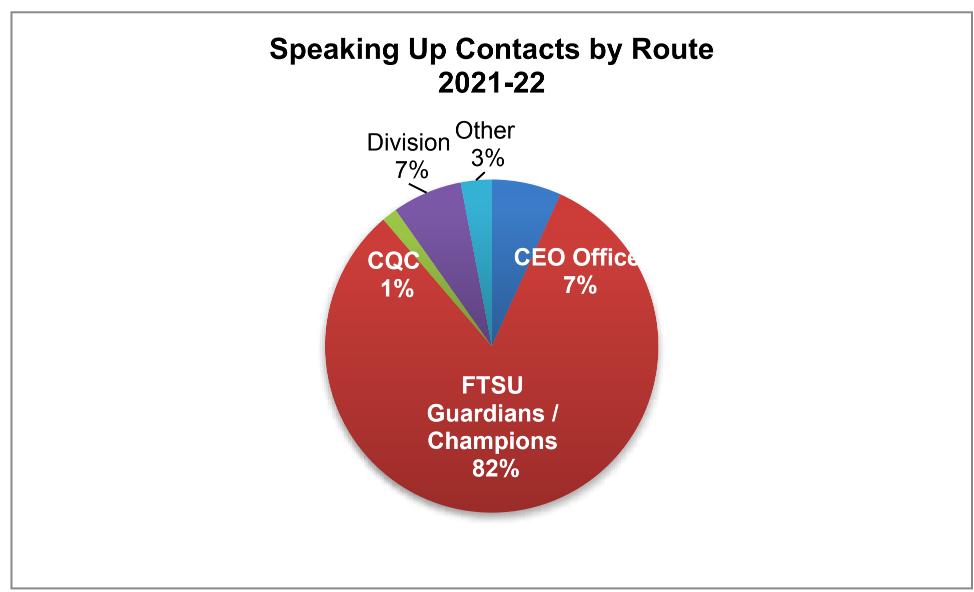
133 speaking up contacts were made in the year, by over 140 individuals. This represents a year on year increase since we began recording this data.



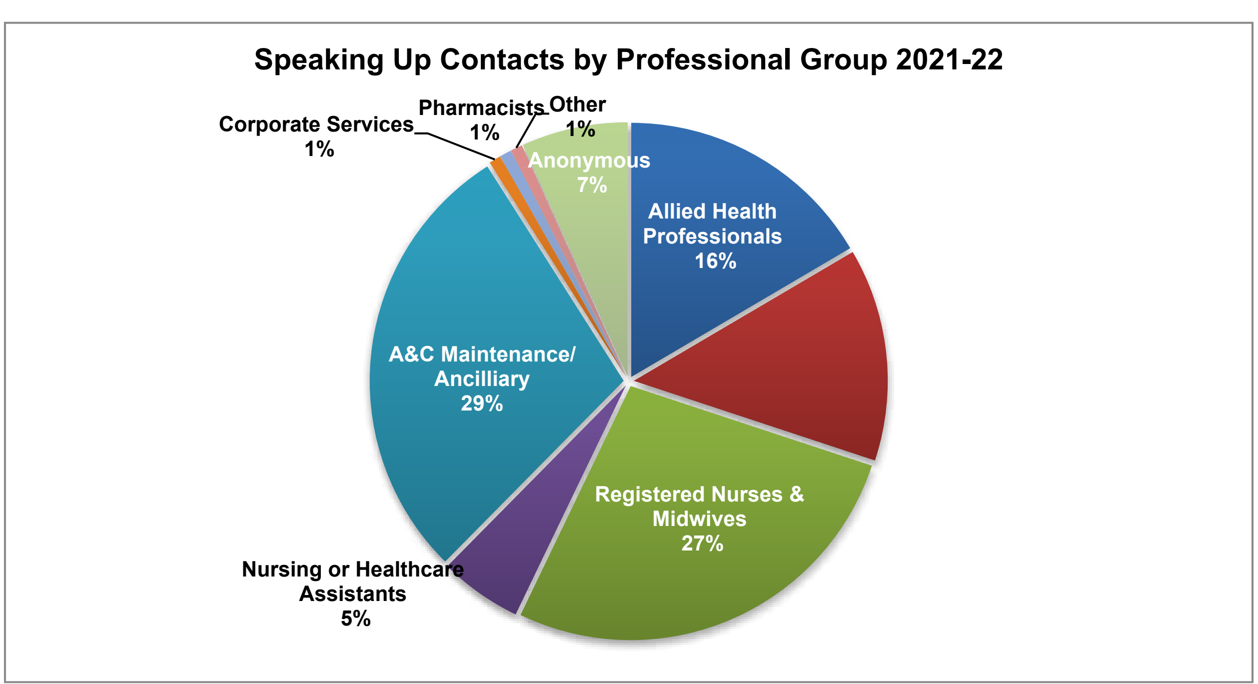


Attitudes and behaviours remains the highest reported theme, as in previous years and this is mirrored by the national speaking up data.

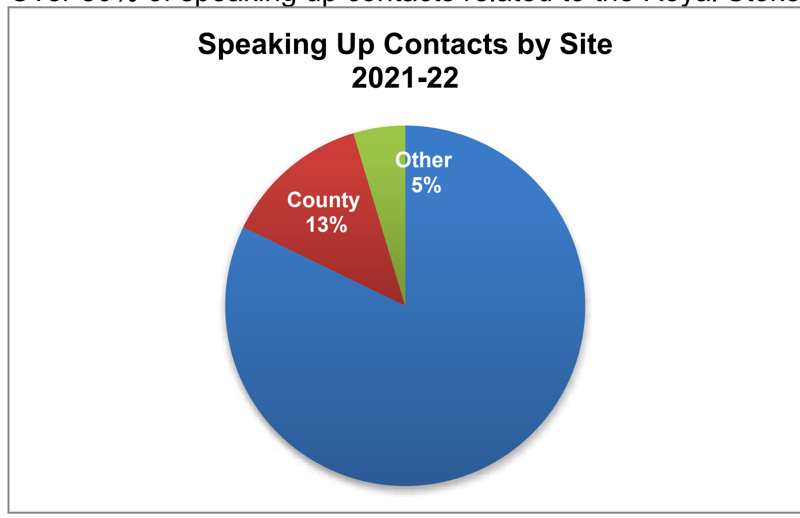
Data indicates that the overwhelming majority of issues are raised via Freedom to Speak Up Guardians/Champions. Our Speaking Up training encourages workers to raise issues with their line managers wherever possible, and therefore many issues may be resolved without the need to escalate using speaking up routes:



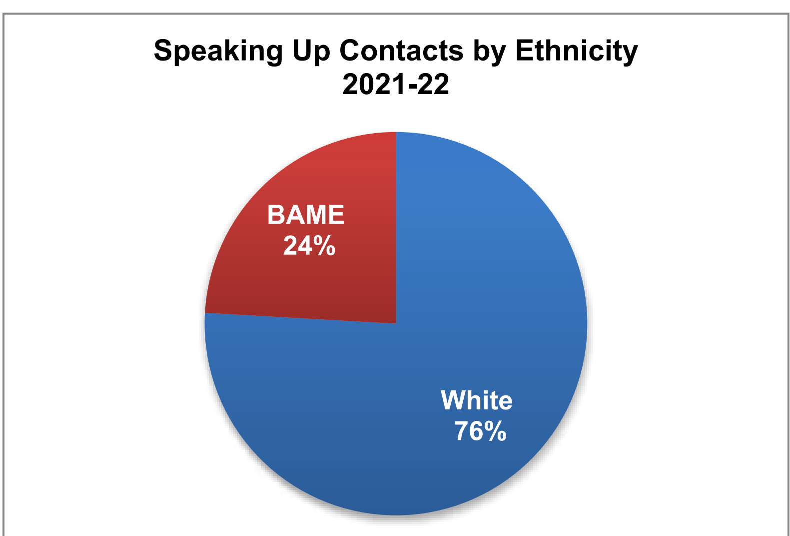
The data demonstrates that Administrative and Clerical/Maintenance/Ancillary groups are the largest staff group to raise issues, followed by registered Nurses and Midwives, Allied Health Professionals and Medical and Dental staff.



Over 80% of speaking up contacts related to the Royal Stoke University site:



Analysis of speaking up contacts demonstrates that where ethnicity has been disclosed, that contacts are representative of the ethnicity of the UHNM workforce, with 24% of contacts being from a Black, Asian and Minority Ethnic background, compared to 19% of the total workforce.



Executive Summary

Meeting:	Trust Board (Open)	Date:	4th May 2022
Report Title:	Quarter 4 Board Assurance Framework	Agenda Item:	16.
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	*Various*		

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

The Board Assurance Framework (BAF) provides a structure and process to enable the Board to focus on the key risks might compromise the achievement of our Strategic Priorities. The BAF has been updated for Quarter 4 21/22 and was presented to the Committees of the Board during April for scrutiny and approval.

Background

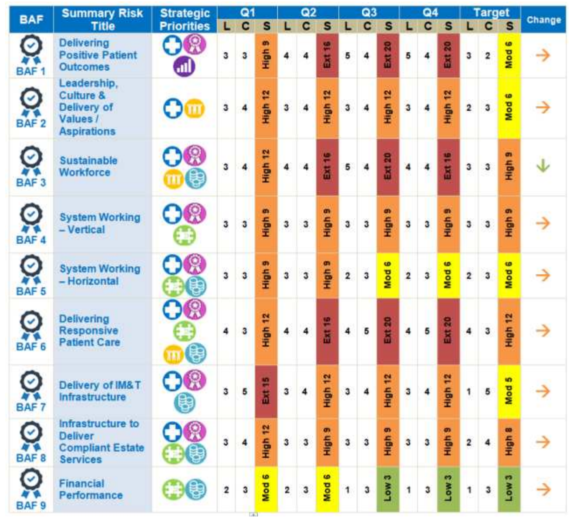
The Strategic Risks identified within the BAF were refreshed by the Executive Team and endorsed by the Board at the start of 21/22. As part of our Risk Management Improvement Programme, the BAF is continuously refined in order to ensure that it meets the needs of the Board. This is tested by our Internal Auditors on an annual basis and the findings of their review form the basis of our ongoing improvement programme.

Assessment

There were significant changes to the BAF at Quarter 3 in relation to the addition of an Assurance Map, which captures actual sources of assurance received by Committees; this is now embedded into the process for review of the BAF.

The image here provides a summary of the BAF at Quarter 4. The key change is that BAF 3 – Sustainable Workforce has reduced in score following the Secretary of State announcement on 31st January 2022 that the legislation requiring mandatory vaccination of front line health care workers was to be reconsidered.

The Strategic Risk Heat Map identifies our Strategic Priorities for 'High Quality' and 'Responsive' are currently under the most significant threat to achievement.



BAF	Summary Risk Title	Strategic Priorities	Q1 L	Q1 C	Q1 S	Q2 L	Q2 C	Q2 S	Q3 L	Q3 C	Q3 S	Q4 L	Q4 C	Q4 S	Target L	Target C	Target S	Change
BAF 1	Delivering Positive Patient Outcomes		3	3	High 9	4	4	Ext 16	5	4	Ext 20	5	4	Ext 20	3	2	Mod 6	→
BAF 2	Leadership, Culture & Delivery of Values / Aspirations		3	4	High 12	3	4	High 12	3	4	High 12	3	4	High 12	2	3	Mod 6	→
BAF 3	Sustainable Workforce		3	4	High 12	4	4	Ext 16	5	4	Ext 20	4	4	Ext 16	3	3	High 9	↓
BAF 4	System Working – Vertical		3	3	High 9	3	3	High 9	3	3	High 9	3	3	High 9	3	3	High 9	→
BAF 5	System Working – Horizontal		3	3	High 9	3	3	High 9	2	3	Mod 6	2	3	Mod 6	2	3	Mod 6	→
BAF 6	Delivering Responsive Patient Care		4	3	High 12	4	4	Ext 16	4	5	Ext 20	4	5	Ext 20	4	3	High 12	→
BAF 7	Delivery of IM&T Infrastructure		3	5	Ext 15	3	4	High 12	3	4	High 12	3	4	High 12	1	5	Mod 5	→
BAF 8	Infrastructure to Deliver Compliant Estate Services		3	4	High 12	3	3	High 9	3	3	High 9	3	3	High 9	2	4	High 8	→
BAF 9	Financial Performance		2	3	Mod 6	2	3	Mod 6	1	3	Low 3	1	3	Low 3	1	3	Low 3	→

Key Recommendations:

- The Trust Board is asked to consider the Quarter 4 BAF and confirm whether it is satisfied that the risk scores are an accurate representation of our current position, and whether there is sufficient action being taken to mitigate these risks.
- The Trust Board is asked to approve the Q4 BAF

Board Assurance Framework (BAF)

Quarter 4 2021/22

1. Introduction

Situation

The Board Assurance Framework (BAF) provides a structure and process that enables a focus for the Board on the key risks which might compromise the achievement of the organisation's Strategic Objectives. The BAF maps out the key controls which are in place to support delivery of those objectives and to mitigate risk and provide a framework of assurance which the Board can draw upon when considering the effectiveness of those controls. These controls and assurances have been set out in line with the '3 lines of defence' model (appendix 1), aiding the identification of areas of weakness.

Background

The Strategic Risks contained within the 2021/22 BAF were agreed initially by the Executive Team and then endorsed by the Board at a development session ahead of the start of the new financial year. These strategic risks were a refinement of those agreed for the 2020/21 BAF, given the significant overhaul undertaken in early 2020 just ahead of the Covid-19 pandemic.

Assessment

Significant work has been undertaken to improve the format and function of BAF and our risk management processes over recent years and this has resulted in three consecutive annual reviews undertaken by our Internal Auditors concluding with a rating of 'Significant Assurance with Minor Improvement Opportunities'. These findings have contributed to the positive and improved overall Head of Internal Audit Opinion for 2020/21 of 'Significant Assurance with Minor Improvement Opportunities'. A programme of risk management improvement remains an ongoing focus for the organisation and this will continue throughout the course of 2021/22. However, we continue to improve the format and function of the BAF and will do this on an ongoing basis in order to optimise its effectiveness.

At Quarter 1, we took into account recommendations made by our most recent Internal Audit Review, including an indicators of whether the risks identified are 'internally or externally driven'. We also included the Risk Appetite Matrix (appendix 2) as a reference point; this is used to determine the target levels of risk.

Key Changes to the BAF at Quarter 4

1) Key changes since the Quarter 3 BAF was presented have been displayed in blue text.

2) When updating the BAF for Quarter 4, further consideration has been given to the scoring of risk. Whilst no risks have increased in score, 1 risk has decreased in risk score with the remainder staying the same. Our most significant risks are as follows:

- BAF 1 – Delivering Positive Patient Outcomes
- BAF 6 – Delivery Responsive Patient Care

Further information is captured within the BAF in the 'rationale for risk score' sections.

Key to 'BRAG' Ratings

BAF Action Plans – Key to Progress Ratings		
	On Track	Improvement on trajectory, either: GA – 'On track – not yet completed' or GB 'On track – not yet started'
	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement, e.g. milestones breached
	Delayed	Off track / trajectory / milestone breached. Recovery plan required.

3. Summary Board Assurance Framework

BAF	Summary Risk Title	Strategic Priorities	Q1			Q2			Q3			Q4			Target			Change
			L	C	S	L	C	S	L	C	S	L	C	S	L	C	S	
BAF 1	Delivering Positive Patient Outcomes		3	3	High 9	4	4	Ext 16	5	4	Ext 20	5	4	Ext 20	3	2	Mod 6	→
BAF 2	Leadership, Culture & Delivery of Values / Aspirations		3	4	High 12	3	4	High 12	3	4	High 12	3	4	High 12	2	3	Mod 6	→
BAF 3	Sustainable Workforce		3	4	High 12	4	4	Ext 16	5	4	Ext 20	4	4	Ext 16	3	3	High 9	↓
BAF 4	System Working – Vertical		3	3	High 9	3	3	High 9	3	3	High 9	3	3	High 9	3	3	High 9	→
BAF 5	System Working – Horizontal		3	3	High 9	3	3	High 9	2	3	Mod 6	2	3	Mod 6	2	3	Mod 6	→
BAF 6	Delivering Responsive Patient Care		4	3	High 12	4	4	Ext 16	4	5	Ext 20	4	5	Ext 20	4	3	High 12	→
BAF 7	Delivery of IM&T Infrastructure		3	5	Ext 15	3	4	High 12	3	4	High 12	3	4	High 12	1	5	Mod 5	→
BAF 8	Infrastructure to Deliver Compliant Estate Services		3	4	High 12	3	3	High 9	3	3	High 9	3	3	High 9	2	4	High 8	→
BAF 9	Financial Performance		2	3	Mod 6	2	3	Mod 6	1	3	Low 3	1	3	Low 3	1	3	Low 3	→

L Likelihood C Consequence S Score

Strategic Priorities

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

4. Strategic Risk Heat Map

BAF		Summary Risk Title	Strategic Priorities
	BAF 1	Delivering Positive Patient Outcomes	
	BAF 2	Leadership, Culture & Delivery of Values / Aspirations	
	BAF 3	Sustainable Workforce	
	BAF 4	System Working – Vertical	
	BAF 5	System Working – Horizontal	
	BAF 6	Delivering Responsive Patient Care	
	BAF 7	Delivery of IM&T Infrastructure	
	BAF 8	Infrastructure to Deliver Compliant Estate Services	
	BAF 9	Financial Performance	

What does the Strategic Risk Heat Map tell us?

The Strategic Risk Heat Map is designed to identify the level of threat posed to our Strategic Priorities. It demonstrates the following:

- **'High Quality'** is the most threatened of our strategic priorities, with 8 out of 9 strategic risks posing a threat to it, 2 of which are scored at Extreme 20.
- **'Responsive'** is the second most threatened of our strategic priorities, with 7 out of 9 strategic risks posing a threat to it, again 2 of which are scored at Extreme 20.
- **'System and Partners'** is the third most threatened of our strategic priorities, with 5 out of 9 strategic risks posing a threat, however only one of those risks (BAF 6), is classed as Extreme 20.

5. Board Assurance Framework 2021 / 22

	BAF 1:	Delivering Positive Patient Outcomes	Internally Driven	✓
			Externally Driven	

Risk Description

Cause		Event		Effect
If we are unable to achieve agreed safe staffing requirements for nursing, medical and AHPs		**Then** we may not be able to provide harm free care including the inability to reduce the number of nosocomial infections, pressure ulcers, falls and VTE		**Resulting in** avoidable patient harm, higher than expected mortality and poor patient experience and satisfaction.
Lead Director / s:	Chief Nurse and Medical Director		**Supported by:**	Chief Operating Officer
Lead Committee/s:	Quality Governance Committee / Transformation & People Committee		**Executive Group:**	Quality and Safety Oversight Group

Strategic Objectives and Risk Register

Impact on Strategic Objectives:	High Quality	✓	Improving and Innovating	✓
	Responsive	✓	Systems and Partners	
	People		Resources	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	4	5	5	Likelihood:	3	31/03/2022
Consequence:	3	4	4	4	Consequence:	2	
Risk Level:	High 9	Ext 16	Ext 20	Ext 20	Risk Level:	Mod 6	
Rationale for Risk Level:	We entered another wave of Covid in quarter 4 which increased staff sickness across the Trust, combined with winter pressures. These pressures, coupled with vacancies have placed significant pressure upon the existing workforce.						

Links to Risk Register				
	ID 21433 Adult Critical Care Consultant Workforce	Ext 20	**ID 11294** NMCPS Pathology Histology Medical Reporting Capacity	Ext 16
	ID 18093 Nurse Staffing in NNU	Ext 16	**ID 13419** Midwifery Safe Staffing	Ext 16
	ID 22651 Transitional Care Service	Ext 15	**ID 18842** Junior Medical Rota Child Health Gaps	Ext 16
	ID 11518 Midwifery Continuity of Carer Model	Ext 15	**ID 21721** Nuclear Medicine Physics Workforce	Ext 15
	ID 16432 Compliance with CNST Maternity Safety Actions	Ext 15	**ID 8451** Trauma Directorate Nursing Workforce	High 12
	ID 21706 Safer Care Nursing Availability – Specialised Decision Unit	High 12	**ID 21634/21660** Staff Absences Related to Covid at RSUH & County	High 12
	ID 8615 Radiotherapy Radiographer Staffing Levels	High 12	**ID 21867** Non-Compliance with Antenatal Ultrasound	High 12
	ID 21661 Child Health Nursing Workforce	High 12		

Position Statement

What progress has been made during the last quarter?

Continued with twice daily escalation staffing meetings, led by senior nursing staff which have been successful in mitigating workforce risk where possible. Overseas nursing recruitment processes continue with further recruitment being seen during the quarter.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence

- Daily nurse staffing meetings to identify requirements and appropriate escalation of gaps and required support
- Safer Staffing Tool completion twice daily by Ward staff
- Local processes in place for medical and AHP staff to assess requirements and establishments
- International Recruitment commenced and approval for c.70 nurses.
- Development of Site Safety Dashboard
- Development of Safe Staffing hub (8.00 am – 8.00 pm 7 days a week)
- Quality Impact Assessments undertaken for change in services regarding additional capacity areas and

	changes in establishments • Senior leadership team in place for each ward and department, with overarching accountability for delivering quality and minimising hospital acquired harm • Falls Champion role in each Ward/Department. • Tissue Viability Link Nurses in each Ward/Department • Corporate Quality & Safety Team co-ordinate Improvement Programmes for Pressure Ulcers, Falls and VTE • Specific governance arrangements in place for Maternity Services, including compliance with CNST requirements. • Infection Prevention Team co-ordinate Improvement Programmes for infections, including Sepsis and Nosocomial COVID-19 infections • Training Programmes in place for all key harms • Patient experience team in place • Crude Mortality rates - monitoring and notification from Medical Examiner • Monthly Directorate Mortality and Morbidity meetings (M&M) are held to review deaths and discuss cases.
2nd Line of Defence	• 6th monthly nurse staffing establishment reviews to ensure established nursing numbers match acuity • Birth rate plus staffing assessment for midwifery services • Validation of pressure ulcers undertaken by Corporate Tissue Viability Team • Validation of infections undertaken by Infection Prevention/Microbiology Teams • Datix and Root Cause Analysis (RCA) training available to ensure accurate reporting and investigation of patient harm. Bespoke sessions arranged within Divisions. • Root Cause Analysis (RCA) Scrutiny Panels in place for Serious Incidents, Pressure Ulcers, Patient Falls, Venous Thromboembolism (VTE) and Infections • Agreed reduction trajectories in place for each patient harm • Collaborative working in place with CCG representatives regarding harm reduction • Care Excellence Framework in place, with an identified schedule of annual visits to each Ward/Department, or more frequently if indicated • COVID-19 deaths have been included in the Trust's SJR process to allow for review of care provided to patients and identify any potential areas for improvement/learning • Mortality Review Panel for Definite Nosocomial COVID-19 deaths established by Deputy Medical Director to identify learning and good practice. Review commenced to identify ward status for inclusion in mortality reviews. • Nosocomial COVID-19 Infections will be subject to RCA and reported to the Infection Prevention Committee • A strengthened clinical governance framework including revised Terms of Reference for the Quality and Safety Oversight Group (QSOG) and Quality Governance Committee (QGC) remains in place • 'High Quality' identified as a Key Priority Domain for the UHNM Improving Together Programme • 52 week / 104 day Harm Review Panel process in place with CCG representation • Agreed policies and procedures for the management of patients with mental health conditions and / or Mental Health Act including Standard Operating Procedure for Use of Ligature Knives and Trust Wide Corporate Ligature Risk Assessment • Policies and Procedures for the Management and care of patients with mental health conditions reviewed and actions completed and responded to in relation to the CQC Section 29a notice
3rd Line of Defence	• Registered and regulated by CQC • Process in place with Commissioners to undertake Clinical Quality Review Meetings (CQRM) • 6 nominated Patient Safety Specialists participating with development programme by NHSI as part of national NHS Patient Safety Strategy. Induction / Training • NHSEI scrutiny of COVID-19 cases/Nosocomial infections/Trust implementation of Social distancing, Patient/Staff screening and PPE Guidance

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)					
1st Line (Divisional)		**2nd Line (Corporate)**		**3rd Line (External)**	
Q3 Saving Babies Lives Care Bundle	✓	Month 9, 10, 11 Quality and Safety Reports	!✓	CQC Inspection Report	!✓
Q3 Maternity Serious Incident Report	!	Q3 Serious Incident Report	!	CQC Insights Report	✓
Q3 Maternity Dashboard	✓	Q3 Infection Prevention Report	✓	18 weeks Referral to Treatment Deep Dive Review	!
Q3 Perinatal Mortality Review Tool	✓	Q2 Mortality Report (including Covid Mortality Benchmarking)	✓		
Q3 Maternity Family Experience Report	✓	Q3 Patient Experience Report	!✓		
Midwifery Workforce	!	Q3 IPC Board Assurance Framework	✓		
Pressure Ulcers and Lessons Learned	✓	Nursing and Midwifery Staffing and Quality Report	!		
Ockenden and Kirkup Update & Action Plan	✓	CQC Action Plan	✓		
Covid 19 Nosocomial Mortality	!	Workforce Assurance Report	!		

Review Update					
BC-0448 Overseas Nursing	✓	Improving Together Highlight Report	!✓		
Maternity Services Workforce Establishment to Deliver Assurance of Maternity Safety	!				
BC-0446 Additional Pharmacy Staffing Resource and Input to the Adult Cancer Care	✓				
BC-0441 Expansion of GI (Colorectal & Upper GI) Emergency General Surgery Business Case	✓				
ED Medical Workforce Update	✓				
Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)					
Annual Medical Examiners Report	✓	2020/21 Annual Quality Account	✓	CQC Inspection Update	✓!
Clostridium Difficile Update		Bi-Annual Mental Health and Learning Disability Update	✓	NHS Resolution Maternity Incentive Scheme	✓
Pressure Ulcer Prevention RCA Update	✓	Bi-annual Nursing Establishment Review	!	IPC Board Assurance Framework Internal Audit	✓
Neonatal Workforce CNST	!	Perfect Ward Update	✓	Ockenden Review Internal Audit	✓
Midwifery Workforce Review	!	Emergency Department Assurance Report	✓!	NHSE Visit to West Building – Update	✓
Q2 Maternity Services Self-assessment BAF	✓	Ockenden Report: Assessment and Assurance Framework / Action Plan	✓		
Sepsis Review	✓				
County Serious Incident Update	!				
Emergency Department Medical Workforce Business Case	✓				
Anaesthetic Workforce Business Case	✓				
AMU Nursing Workforce Business Case	✓				
Adult Critical Care Expansion	✓				
NIV CCU Ward 222 Nursing Establishment Business Case	✓				

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Establishment review to be completed which will align acuity with workforce
- Business case to secure additional midwifes in line with Birth Rate Plus to be progressed through business planning process and recruitment
- Recruitment against Emergency Department Business Case to be completed

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Meeting to be held with Regional NHS Team regards to reducing MFFD patients,	Medical Director	31/01/2022	Medical Directors attended regional meetings to support the Trust's MFFD position. Regular discussions ongoing with consultant colleagues with regard to appropriate discharge plans.	B
2.	Update to be provided to the Regional Risk Group regarding actions being taken for admission avoidance and monitoring of 7 key actions.	Chief Nurse	31/01/2022	Chief Nurse attended the System Clinical Risk Group to provide regular update on actions taken.	B
3.	To implement Perfect Ward audit system and app	Chief Nurse	31/07/2022	Perfect Ward project has been approved and shared with Executives and NEDs. Project Plan under development. Timeframe extended due to technical compatibility issue which is being worked through with IM&T.	GA
4.	To develop Trust Patient Safety Incident Review Plan (PSIRP) and engagement of Patient Safety Partners to support review and patient	Chief Nurse & Medical Director	30/06/2022	National PSIRF guidance has been updated following COVID-19 with amended dates and learning from early adopters. This is under review and inclusion in UHNM PSIRP.	GA

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
	involvement in Trust quality meetings.			National timescale is to implement in 2023	
5.	Establishment Review to be completed to align acuity with workforce.	Chief Nurse	30/06/2022	Establishment review underway.	GA
6.	Recruitment of midwives in line with Business Case and Birth Rate Plus.	Chief Nurse	30/09/2022	Trust Board Seminar discussed current gap and action to be taken. Agreement in principle to proceed with recruitment pending completion and approval of business case.	GA
7.	Recruitment against Emergency Department Business Case to be completed.	Chief Nurse	30/07/2022	Consultant posts appointed to, awaiting visas / recruitment checks to conclude. Nursing recruitment ongoing, monitored monthly through Division.	GA

BAF 2:	Leadership, Culture and Delivery of Values / Aspirations	Internally Driven	✓
		Externally Driven	

Risk Description

Cause	Event	Effect
If we are unable to ensure the leadership culture reflects our values and aspirations	**Then** a negative cultural environment could be established	**Resulting in** an adverse impact on patient care, staff disengagement and ineffective performance.

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

Strategic Objectives and Risk Register

Impact on Strategic Objectives:	High Quality	✓	Improving and Innovating	
	Responsive		Systems and Partners	
	People	✓	Resources	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	3	**Likelihood:**	3	31/03/2022
Consequence:	4	4	4	4	**Consequence:**	2	
Risk Level:	High 12	High 12	High 12	High 12	**Risk Level:**	Mod 6	

Rationale for Risk Level:

- The National view of the 2021 Staff Survey presents a picture that NHS Staff perception is of increasing workloads with less resource available and increasing time pressures. More staff report experiencing burnout and nationally, 46.8% of staff experienced stress – 8% higher than in 2017. There was an overall decline in staff perceptions that care of patients/service users is a top priority and in standards of care. There was also an overall decline in staff willing to recommend organisations as places to work and in diversity and equality indicators. Locally, the Trust scored lower than national average against all 7 themes, as well as staff engagement and morale.
- The results of the BRAP work are also linked to the Staff Survey outcomes as regards issues raised and actions planned. Both reports indicate a number of issues need to be addressed and the key focus for action will be to address behaviours, generally across the Trust and specifically in staff groups and hotspot areas. This is because adverse staff behaviours increase the risk to the Trust's culture, values and aspirations, impacting on patient care, increasing staff disengagement and affecting performance as well as having an adverse effect on our ability to recruit and retain staff.
- Based on the National Staff Survey, a methodology to calculate a more frequent staff engagement rate has been implemented using the results of the Staff Voice Survey. The February 2022 staff voice results had indicated an upturn in the local staff engagement factors, although the engagement rate returned to pre-February levels in March 2022
- Leadership and management development offers continue to be promoted.
- Sickness levels remain high as a result of the latest surge on Covid-related absences. Wellbeing Plans are in place with our Occupational Health and Staff Support and Counselling Providers contributing to the range of offers
- The key risk and challenge likely to prevent successful delivery of activities aimed at improving organisational culture and behaviours and maximising the potential of our people to improve patient outcomes is that operational pressures, the impact of Covid and other winter pressures, prevents staff from being released to undertake the training and development necessary to improve organisational culture.

Links to Risk Register: None identified

Position Statement

What progress has been made during the last quarter?

Staff Engagement

- At 6.7, the staff engagement score reduced slightly, as did the score for the benchmark group overall. The Trust continues to remain just below the acute trust average score
- The BRAP results are linked to the Staff Survey outcomes as regards issues raised and actions planned. Both reports indicate a number of issues need to be addressed and the key focus for action will be to address behaviours, generally across the Trust and specifically in staff groups and hotspot areas. This is because adverse staff behaviours increase the risk to the Trust's culture, values and aspirations, impacting on patient care, increasing staff disengagement and affecting performance as well as having an adverse effect on our ability to recruit and retain staff.
- Based on the National Staff Survey, a methodology to calculate a more frequent staff engagement rate has been implemented

using the results of the local Staff Voice Survey. The February 2022 staff voice results had indicated an upturn in the local staff engagement factors, although the engagement rate returned to pre-February levels in March 2022

- The Staff Survey findings have been shared with the Divisions who are reviewing the information as it impacts on their areas so that they can implement tailored interventions that are appropriate and are aligned to the corporate priorities for staff engagement and the wider corporate agenda under the '*Improving Together*' programme. Divisions will produce local, tailored communications and action plans to address the issues their staff say are important to them. Via the Executive Workforce Assurance Group, we will hold conversations with Divisions to gain their ideas and thoughts on improving staff and team engagement overall, and hold the Divisions accountable for delivering on their action plans.
- The Improving Together programme is being used as the means to drive an improvement in staff engagement. The aim is for the staff engagement rate to be better that national average by the 2022 Staff Survey, and to ensure the Trust is placed in the top 20% of Acute Trusts by 2023

Staff experience

- Trust scored lower than national average against all 7 themes of the 2021 NHS Staff Survey, as well as lower than overages on staff engagement and morale
- On Staff morale, the benchmark group results declined compared to 2020 and the Trust's score also declined in line with that trend. At 5.6, the Trust's score remains just below the acute trust average of 5.7, as it did in 2020
- A Civility and Respect Task and Finish Group is established to progress a Resolution Policy, Behaviour Framework and Compassionate Leadership

Staff Wellbeing

Throughout 2021/22, we have continued to implement wellbeing offers and review and update the Wellbeing Plan. In Q4, enhancements included:

- Ensuring Menopause in the work place is on the wellbeing agenda
- Providing the Wellbeing Wagon for staff wellbeing, engagement and charity events
- Addressing Junior doctors wellbeing
- Developing the Carers passport for Executive approval in April 2022
- Schwartz Rounds funded for another 2 years
- RESPOND, a 7-step model for wellbeing conversations, has been accredited
- The UHNM Admin & Clerical conference focussed on staff wellbeing

An additional Wellbeing day was provided to all staff in 2020/21 and has been offered again in 2021/22 in recognition of everyone's hard work and commitment during these challenging years

Key Controls Framework – 3 Lines of Defence	
1st Line of Defence	• Divisional Staff Engagement Plans set out the tailored actions to improve staff experience • Improving Together programme – Staff engagement A3 is developed
2nd Line of Defence	• Staff Voice pulse check survey implemented from June 2021 • People Strategy and supporting HR Delivery Plan, with performance reported to Transformation and People Committee. The HR Delivery Plan has been updated to take account of the actions required to support the NHS People Plan and ensure alignment of objectives • Partnership working with the STP is in place to introduce a range of Recruitment and Retention initiatives • The Trust has set targets for staff engagement rates; sickness and turnover. Actual performance is monitored on against target.
3rd Line of Defence	• National Quarterly Pulse Survey was implemented from July 2021 • The 2021 National Staff Survey results have been analysed and corporate improvement activities set out and reported to Board. Divisions are also reviewing the Staff Survey information as it impacts on their areas so that they can implement tailored interventions, communications and action plans to address the issues their staff say are important to them. Performance monitoring will be carried out via the Executive Workforce Assurance Group. • The Trust Wellbeing Plan and wellbeing offer have been refreshed and updated. • The Brap Survey has been completed and the results shared with the Board in April 2021. • Our Gender Pay Gap report shows the difference in the average earnings between all men and women employed at UHNM and the actions we are taking to further reduce the gender pay gap. • The Stonewall Equality Index is a benchmarking tool for employers to measure their progress on LGBT+ inclusion in the workplace. Participating organisations are required to demonstrate their work in eight areas of employment policy and practice. Alongside this, employees are also given the opportunity to complete an anonymous survey around their experiences of diversity and inclusion at work. UHNM took part in this index last year and out of 403 organisations taking part we came in 252nd place. We last took part in 2019 and scored in 325th place. This improvement shows that we are making headway in our work for LGBT+ and equality. • The RESPOND 7 step model for wellbeing conversations has been accredited.

Assurance Map					
Committee Assurances (assurances received by the Committee/s during this quarter)					
1st Line (Divisional)		**2nd Line (Corporate)**		**3rd Line (External)**	
		Q3 Organisational Development / Culture Update	✓	CQC Inspection Report	!✓
		M9,10,11 Workforce Performance Report	!✓	2021 NHS Annual Staff Survey	!
		Q3 Formal Disciplinary Activity	!		
		Equality, Diversity and Inclusion Progress Report	✓		
		Q3 Speaking Up Report	✓		

		Workforce Assurance Report	!		
		Q3 Guardian of Safe Working	✓		
		Revalidation and Appraisal Report	!		
		Succession Planning and Talent Management	✓		
		Gender Pay Gap Report	!		
		National Education and Training Survey	✓		
		Improving Together Highlight Report	!✓		
Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)					
		People Plan Annual Report	✓!	Staff Survey Report	✓!
		Human Resources Delivery Plan	✓		
		Learning, Education and Widening Participation Progress Report	✓		
		Health & Wellbeing Plan Progress Report	✓		
		Workforce Disability Equality Standard	!		
		Workforce Race Equality Standard	!		

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Up-skill managers to adopt a motivational and inspiring leadership style
- Improve and evidence the positive action taken on health and wellbeing (Staff Survey)
- Improve equality and diversity, staff morale and a culture of safety (Staff Survey)
- Improve Leadership and Management Development and Visibility (Staff Survey)
- Improve Staff Engagement (Staff Survey)

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Resume the Trust-wide cultural analysis	Chief People Officer	31/03/2022	We will be taking forward the findings from the Trust Culture and Leadership Diagnostic Programme, building on the experiences of staff during Covid, to develop a Trust wide OD programme. The Delivery plan will go to the TAP Committee in April 2022.	A
2.	Implement a UHNM plan relating to the launch of the "Leadership Compact" document within the NHS People Plan	Chief People Officer	30/06/2022	The leadership behavioural framework which will be co-created with our leaders as part of the Middle Management Programme development process. We are supporting the Improving Together Programme and Quality Academy with those aspects linked to leadership behaviours and cultural change.	A
3.	Leadership and Management Development offer: Internal and External offer focus on managers across the Trust to ensure a competency level is embedded	Chief People Officer	31/03/2022	We continue to deliver the Connects Programme, an established intervention which nurtures and supports leadership development for colleagues selected to attend for future career development The Connects programme has been developed into a system-wide programme.	B
4.	Work with members of the Quality Improvement Academy to deliver "Improving Together to Deliver Exceptional Care" and lead on those aspects linked to leadership behaviours and cultural change	Chief People Officer	31/03/2023	The Positive & Inclusive Culture A3 has been developed, where the driver metric is the staff engagement rate.	GA
5.	Produce an action plan to address the findings of the BRAP Survey	Chief People Officer	31/05/2022	The Brap Survey has closed and the findings were reported in April to the Board. Development of the Action Plan is now underway.	GA
6.	To provide a current measure, the Staff Voice Survey should be adjusted to include a	Chief People Officer	31/03/2022	A methodology is in place, based on the National Staff Survey methodology, to produce a local staff engagement score from the monthly Staff Voice Survey.	B

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
	local staff engagement indicator				
7.	Implement the next quarterly People Pulse Survey	Chief People Officer	31/03/2022	The quarterly People Pulse Survey opened in January 2022 for staff to share their views about their working experience. The responses will be used to shape a range of support, both locally and nationally.	**B**
8.	Deliver the comprehensive Enable Middle Management programme, which is aimed at upskilling managers to adopting a motivational and inspiring leadership style.	Chief People Officer	31/03/2023	We will deliver the comprehensive 'Enable Middle Management' programme for 616 managers in 2022/23.	**GA**

	BAF 3:	Sustainable Workforce	Internally Driven	✓
			Externally Driven	✓

Risk Description

Cause	Event	Effect
If we are unable to sustain our workforce at the required levels, taking into account the impact of Covid on staff resilience and retention,	**Then** we may not have staff with the right skills in the right place at the right time,	**Resulting in** adverse impact on patient outcomes, increase in premium costs, staff disengagement and inability to take forward continuous improvement and innovation.

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

Strategic Objectives and Risk Register

Impact on Strategic Objectives:				
	High Quality	✓	Improving and Innovating	
	Responsive	✓	Systems and Partners	
	People	✓	Resources	✓

Improving Together

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	4	5	4	Likelihood:	3	31/03/2022
Consequence:	4	4	4	4	Consequence:	3	
Risk Level:	High 12	Ext 16	Ext 20	Ex6 16	Risk Level:	High 9	

Rationale for Risk Level:

The level of risk has been reduced following the Secretary of State announcement on 31st January 2022 that the legislation requiring mandatory vaccination of front line health care workers was to be reconsidered. The Government's decision is subject to Parliamentary process and will require further consultation and a vote to be passed into legislation. As a result, the Trust has stood down the Task and Finish Group responsible for implementing the legislation. However, the Trust does continue to encourage staff to get vaccinated.

The risk remains high as, although there are good plans in place to mitigate risks and additional recruitment is taking place, there is still an impact of Covid surges on sickness levels and workforce availability.

- Divisions report increased staffing challenges due to operational pressures and the opening of additional capacity, combined with high sickness rates and vacancy levels
- Sickness levels remain high and continue to be monitored on a daily basis, with operational contingency plans in place.
- Redeployment of staff is being managed via the Medical, Nursing and workforce bureaus and processes are in place to escalate requests for support to the wider System should the need arise.

To mitigate these risks and challenges further, the process for assuring workforce availability will be reviewed through the Improving Together programme in 2022/23. This will cover sickness absence, vacancies and retention in particular.

The Transformation and Performance Committee receives regular updates on workforce numbers, vacancies and staff absences.

Links to Risk Register (>12)

Risk	Level	Risk	Level
ID 21433 Adult Critical Care Consultant Workforce	Ext 20	**ID 21481** Breast Radiologist Workforce	Ext 20
ID 18093 Nurse Staffing in NNU	Ext 16	**ID 11294** NMCPS Pathology Histology Medical Reporting Capacity	Ext 16
ID 21595 Microbiology Workforce	Ext 16	**ID 13419** Midwifery Safe Staffing	Ext 16
ID 22651 Transitional Care Service	Ext 15	**ID 18842** Junior Medical Rota Child Health Gaps	Ext 16
ID 21883 Children's Assessment Unit Staffing	Ext 16	**ID 20809** NMCPS Histology Admin Capacity	Ext 16
ID 23024 B5 Radiographer Workforce	Ext 16	**ID 21721** Nuclear Medicine Physics Workforce	Ext 15
ID 11518 Midwifery Continuity of Carer Model	Ext 15	**ID 16432** Compliance with CNST Maternity Safety Actions	Ext 15
ID 11002 Consultant Medical Staff Recruitment CWD	High 12	**ID 21867** Non-Compliance with Antenatal Ultrasound	High 12
ID 21719 Medicine Safety Officer Vacancy	High 12	**ID 20626** Phlebotomy Staffing Levels	High 12

	ID 8451 Trauma Directorate Nursing Workforce	High 12	**ID 21706** Safer Care Nursing Availability – Specialised Decision Unit	High 12
	ID 8615 Radiotherapy Radiographer Staffing Levels	High 12	**ID 21634/21660** Staff Absences Related to Covid at RSUH & County	High 12
	ID 21661 Child Health Nursing Workforce	High 12		

Position Statement

What progress has been made during the last quarter?

- The first draft of the Trust Workforce Plan, part of the overall Operational Plan, has been submitted. This will undergo confirm and challenge as well as triangulation with Finance and Activity Plans, before the final submission at the end of April 2022.
- The Trust has stood down the Task and Finish Group responsible for implementing the mandatory vaccination legislation. However, the Trust does continue to encourage staff to get vaccinated.
- The Workforce Bureau has been stood down but continues to operate as a virtual bureau
- The 2021 National Staff Survey results have been analysed and corporate improvement activities reported to Board

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• Workforce planning process ensures alignment with activity and financial plans • Actions to improve staff experience are detailed in Divisional Staff Engagement Plans • Ongoing recruitment processes • Rotas and rota coordinators management of roster processes • Medical rotas are reviewed, vacant shifts covered where possible from doctor bank and agency, adverts out for Trust grades where applicable. Locums are used / recruited to fill gaps where necessary • Directorate and divisional management teams monitor staffing levels • Chief Nurse staffing reviews • The UHNM Staff Voice is a monthly staff survey designed to help understand key issues important to staff about wellbeing, making improvements to where they work and the way they provide patient care. This survey also provides a local measure of staff engagement. **Digital Agenda:** The draft People Digital Strategy for the NHS was released in September 2021 and sets out draft commitments for the next 3 years. The Digital Agenda is a system-led work programme initially covering the roll out of a Digital Staff Passport to hold staff 'verified employment and training credentials'.
2nd Line of Defence	• The Trust's People Strategy is supported by an HR Delivery Plan, with improvement activities cascaded via Divisional People Plans. The HR Delivery Plan is currently being updated for 2022/23 priorities and actions. • The system led workforce demand and supply process remains in place and will continue to manage redeployment of staff where required, as well as system wide recruitment initiatives. The Trust continues to progress its own recruitment plans as well. • Processes are in place to request mutual aid from across the System if required • The Workforce Bureau is now operating as a virtual bureau. • Staffing for the Winter plan is out to advert and / or in process of being recruited to • Established Banks are in place – including Nursing, Medics and other staff groups • Business cases approved to address staffing in ED, Anaesthetics and Critical Care and other hotspots are being recruited to • Weekly meetings take place with Medical Staffing to review rotas, gaps and progress against recruitment • General recruitment drives are on-going and there is an element of head hunting via informal networks • Golden Handshakes and handcuffs can be used for new starters **Digital Agenda:** The Trust has volunteered to participate in a trial of the digital staff passport. This will involve identifying doctors training who are due to rotate in the Spring/Summer of 2022. As confirmation of acceptance on to the pilot has not yet been received, no actions are arising at this time.

3rd Line of Defence	• The workforce planning process ensures alignment of workforce with activity and financial plans. The first draft submission of the Workforce Plan, which forms part of the overall Operational Plan for 2022/23, was submitted for triangulation, confirm and challenge and will be revised accordingly for the final submission on 22nd April 2022.
	• Covid related plans remain in place, including:
	  ○ The *COVID-19 Staff Shortage Contingency Arrangements*, a sub-plan to the Trust's Business Continuity Plan which details the processes that will be put in place within the operational settings of each Division to manage a disruption of service delivery as a result of staff shortages and is supplemented by the Disruptive Incident Staffing Plan and Operational Workforce Plan.
	  ○ Internal redeployment and volunteer process are place to offer support to areas of need
	  ○ Partnership working within the STP continues with system wide processes for mutual aid and redeployment of staff where possible.
	• The 2021 National Staff Survey results have been analysed and corporate improvement activities set out and reported to Board. Divisions are also reviewing the Staff Survey information as it impacts on their areas so that they can implement tailored interventions, communications and action plans to address the issues their staff say are important to them. Performance monitoring will be carried out via the Executive

	Workforce Assurance Group. • The National quarterly 'People Pulse survey has been implemented from July 2021 • Workforce risks are reported via Datix and are monitored to ensure Divisional action and review. • Divisions report increased staffing challenges due to operational pressures and the opening of additional capacity, combined with high sickness rates and vacancy levels • Quarterly vacancy benchmarking data, available via NHS Digital

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)					
1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
Maternity Services Workforce Establishment to Deliver Assurance of Maternity Safety	!	Q2 Nurse Vacancy Progress Report		CQC Inspection Report	!✓
BC-0448 Overseas Nursing	✓	M9, 10, 11 Workforce Performance Report	✓!	2021 NHS Annual Staff Survey	!
BC-0446 Additional Pharmacy Staffing Resource and Input to the Adult Cancer Care	✓	Workforce Assurance Report	!	Covid 19 Pandemic – Business Continuity Planning Framework	✓
BC-0441 Expansion of GI (Colorectal & Upper GI) Emergency General Surgery Business Case	✓	Improving Together Highlight Report	!✓		
ED Medical Workforce Update	✓	Nursing and Midwifery Staffing and Quality Report	!		
		Q3 Guardian of Safe Working	✓		
		Workforce Plan	!		
		National Education and Training Survey	✓		
Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)					
Midwifery Workforce Review	!	People Plan Annual Report	✓!	Staff Survey Report	✓!
Neonatal Workforce CNST	!	Human Resources Delivery Plan	✓	STP/ICS Workforce Development Fund Annual Report for 2020/21	✓
Emergency Department Medical Workforce Business Case	✓	Bi-annual Nursing Establishment Review	!	E-rostering Internal Audit	!
Anaesthetic Workforce Business Case	✓	Winter Plan	✓!	Job Planning Internal Audit	✓
AMU Nursing Workforce	✓	Apprenticeship Levy Progress Report	!		
Adult Critical Care Expansion	✓	Learning, Education and Widening Participation Progress Report	✓		
NIV CCU Ward 222 Nursing Establishment Business Case	✓	Outline Content of the Strategic Workforce Plan	✓		

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Development of Divisional People Plans and Workforce Plans for 2022/23, aligned to the corporate agenda
- Review of processes to assess workforce availability, covering sickness absence, vacancies and retention
- On-going development of workforce supply and recruitment processes to address future workforce supply issues

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Provide support and development to line managers to enable them to develop their approach to management which includes leading agile workers.	Chief People Officer	31/03/2022	To support the Staff Survey improvement activity: Improving Leadership and Management Development and Visibility • The Leadership and Management Development programme has recommenced and will continue throughout 2022/23 • Management development sessions have been offered around managing/leading agile teams • An Agile Working Policy has been put in place Based on the National Staff Survey, a more frequent staff engagement rate is in place using the results of the local Staff Voice Survey.	B

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarterly Progress Report**	**BRAG**
2.	Implement the legislation requiring all patient-facing health and social care workers in England have been double-vaccinated from 1st April 2022.	Chief People Officer	31/03/2022	Work on the mandatory vaccination requirements have been paused given the Secretary of State announcement on 31st January 2022 that the legislative requirement was being reconsidered. The Government's decision is subject to Parliamentary process and will require further consultation and a vote to be passed into legislation. The Trust will continue to encourage and support as many staff as possible to get vaccinated	**B**
3.	Manage deployment of staff to support areas with high absences as a result of sickness and the omicron variant	Chief People Officer	31/01/2022	The Workforce Bureau works with Nursing and Medical Bureaus to manage staff deployment where necessary The Trust produces Daily Sitreps on staff absence. This feeds into the tactical Covid Dashboard and informs decisions on redeployment of staff Three of the clinical divisions have identified sickness as a driver metric under the Improving Together programme and are undertaking deep dives into reasons for stress related absence to help target actions for support.	**B**
4.	Develop an A3 under the Improving Together Programme for 2022/23 covering sickness absence, vacancies and retention.	Chief People Officer	31/03/2023	Development of the A3 is underway.	**GA**
5.	Work with divisional teams to support the development of their People Plans.	Chief People Officer	31/03/2023	Approach is to be developed.	**GA**
6.	Align the Trust's workforce plan with capacity plans developing a local toolkit for use by management teams.	Chief People Officer	31/03/2023	Approach is to be developed.	**GA**
7.	Lead on local, national and international recruitment campaigns to address workforce supply issues, ensuring that the Trust's recruitment materials, processes and practices are effective and efficient and promote the benefits of working at UHMM.	Chief People Officer	31/03/2023	Business case for international recruitment of nurses has been approved.	**GA**

BAF 4: System Working - Vertical

Internally Driven	
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we are unable to effectively collaborate with key stakeholders as part of the Integrated Care system,	**Then** we may not be able to provide health services which meet the needs of the system population	**Resulting in** fragmented, poor quality, inefficient and ineffective services

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

Strategic Objectives and Risk Register

Impact on Strategic Objectives:				
	High Quality	✓	Improving and Innovating	
	Responsive	✓	Systems and Partners	✓
	People		Resources	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	3	Likelihood:	2	31/03/2022
Consequence:	3	3	3	3	Consequence:	3	
Risk Level:	High 9	High 9	High 9	High 9	Risk Level:	Mod 6	
Rationale for Risk Level:	With the introduction of the Integration White Paper and the implications for Place across Staffordshire and Stoke on Trent, there remains further work for providers to undertake as part of both Provider Collaborative and delivery of services at a locality level.						
Links to Risk Register	None identified						

Position Statement

What progress has been made during the last quarter?

Workshop undertaken to develop priorities for Provider Collaboration, Terms of Reference for Provider Collaborative Board developed and agreed. Clinical Networks continue to develop including Pathology, Imaging and Adult Critical Care.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence

- ICS Shadow Board in place
- ICS Development Plan in place, approved by NHSE/I, with workstream and leads in place
- ICS Interim Chief Executive in post
- System wide Executive Forum
- System Performance, Finance & Strategy Group
- System workforce group
- System quality group being re-established
- Three system Place Based Partnerships
- Provider Collaborative Workstream now on line led by UHNM CEO
- Self-Assessment completed
- Back Office Workstream in place
- UHNM Chair, Chief Executive & Director of Strategy are members of relevant system groups / meetings
- CFO/COO & DoS are members of Finance, Strategy & Operations system group
- MD member of system wide Clinical Senate
- System working discussed weekly at UHNM Executive Meetings

2nd Line of Defence

- Transformation and Delivery Unit (TDU) in place
- ICS Workstreams underway but require review
- ICS Development Plan in place and approved by NHSE/I
- Three Places developed with OD programme in place
- CCG merger approved
- Design Framework under review / discussion

3rd Line of Defence

- ICS designation plan approved by NHSIE
- System Quarterly Performance Review Meetings (outcomes shared with the Board

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)					
1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		Strategy and Transformation Group Highlight Report	✓	18 weeks Referral to Treatment Deep Dive Review	!
		System Working Update	✓!		
Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)					
				Quarterly System Performance Review Meeting	

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Paper being taken to the ICB at the end of April to gain support for future Place configuration and implications for commissioning and healthcare provision.

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Develop an Integrated Strategy for Health and Social Care	ICS Chief Executive	During 22/23	Approach to development of strategy as well as Five Year Plan agreed by ICS.	**GA**
2.	Place to develop a clear, agreed, strategic approach to population health management.	ICS Chief Executive	System Action – Timeframe to be confirmed	Action Learning Sets now in place at both ICS and Place level with priorities being established and relevant stakeholders engaged.	**GA**
3.	Update on ICS workstreams to be provided to future Transformation and People Committee.	Director of Strategy	31/03/2022	Complete and now incorporated as part of Business Cycle.	**B**
4.	Implementation of new Place arrangements and locality infrastructure.	ICS Chief Executive	30/06/2022	Paper being taken to the ICB at the end of April 2022.	**GA**

BAF 5: System Working - Horizontal

Internally Driven	
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we do not effectively collaborate with other providers and commissioners (both within and out with the ICS)	**Then** some specialist services may become unsustainable and the opportunities to achieve economies of scale within clinical support functions could be lost	**Resulting in** unsustainable, fragmented, poor quality, inefficient and ineffective services that are not VFM.

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

Strategic Objectives and Risk Register

Impact on Strategic Objectives:				
	High Quality	✓	Improving and Innovating	
	Responsive	✓	Systems and Partners	✓
	People		Resources	✓

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	2	2	Likelihood:	2	31/03/2022
Consequence:	3	3	3	3	Consequence:	3	
Risk Level:	High 9	High 9	Mod 6	Mod 6	Risk Level:	Mod 6	
Rationale for Risk Level:	There remains a lack of formal contracting / partnership arrangements in place to support some of the emerging risks and issues with neighbouring trusts, resulting in ad hoc and unsustainable solutions being put in place.						
Links to Risk Register	None identified						

Position Statement

What progress has been made during the last quarter?

Little progress has been made during the last quarter due to operational pressures across all organisations.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• Designated Lead for UHNM - Director of Strategy • Exec to Exec meetings - formalised with SaTH • Director of Strategy represents Trust on Spec Com discussions in respect of network development for Midlands • UHNM CEO leading system Provider Collaborative and self-assessment undertaken • Strategies for each Trust to be reviewed to ensure that strategic developments between UHNM / MCHFT and UHNM / SATH are taken into account • Restoration and Recovery Plans robust and delivering • Plan for inaugural Provider Collaborative meeting for April 2022 • Membership and Terms of Reference agreed for Provider Collaborative Board
2nd Line of Defence	• Transformation & People Committee • Strategy and Transformation Group established to oversee Strategic Partnerships • Informal Exec to Exec discussions to be re-established post COVID with SaTH • Chief Executive is part of the NHS Midlands Clinical Strategy Group which is largely related to specialist services and has agreed to be part of a Task and Finish Group in respect of specialist cancer services. Therefore ensuring UHNM is contributing to and influencing developments. • Chief Executive and Director of Strategy part of Midlands and West Midlands Provider Collaborative Networks
3rd Line of Defence	• N8 Pathology collaborative completed successfully • West Midlands Imaging Network now in place

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)					
1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		Strategy and Transformation Group Highlight Report	✓		
		System Working Update	✓		
		ICS Transformation Update	✓		
		Clinical Strategy	✓		
Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)					

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Whilst the target risk score has been achieved, there remains a gap in formalising the contracting / partnership arrangements with neighbouring trusts

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Develop formal governance for a collaborative programme with SaTH.	Director of Strategy	30/06/2022	Discussions remain ongoing.	GA
2.	Refresh / development and agreement of UHNM Trust wide Strategy.	Director of Strategy	31/03/2022	Clinical Strategy signed off, enabling strategies at various stages of development. Strategic Priorities / objectives agreed as part of Improving Together Programme.	B
3.	Provider Collaborative stocktake to be completed Presented to Performance, Strategy and Finance Group, Exec Forum ICS Board. Variation and population health data to be collated and work streams to be decided	Chief Executive	31/03/2022	Stocktake completed. Workstreams to be decided at April meeting.	A
4.	Update on ICS work streams to be provided to future Transformation and People Committee	Director of Strategy	February / March 2022	Completed and added to business cycle going forward.	B

BAF 6: Delivering Responsive Patient Care

Internally Driven	✓
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we are unable to create sufficient capacity to deal with the increased accumulating backlog of patients as a result of Covid	**Then** we may be unable to treat patients in a timely manner	**Resulting in** potential patient harm and inability to recover services following the pandemic.

Lead Director / s:	Chief Operating Officer	**Supported by:**	Chief Nurse and Medical Director
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Operational Delivery Group

Strategic Objectives and Risk Register

Impact on Strategic Objectives:				
	High Quality	✓	Improving and Innovating	
	Responsive	✓	Systems and Partners	✓
	People	✓	Resources	✓

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4	4	4	**Likelihood:**	4	31/03/2022
Consequence:	3	4	5	5	**Consequence:**	3	
Risk Level:	High 12	Ext 16	Ext 20	Ext 20	**Risk Level:**	High 12	

Rationale for Risk Level: **Based on the continuing high occupancy across our organisation, due to increase in Covid demand and the need for the appropriate segregation of multiple pathways. Challenges exist in our ability to freely move patients around our hospital and provide timely care.**

Links to Risk Register

Risk	Level	Risk	Level
ID 10342 Delivery of constitutional cancer quality standards	Ext 20	**ID 21101** Waiting Times	Ext 16
ID 18664 Gynaecology 52 Week Wait Patient Numbers	High 12	**ID 9910** Patients waiting extreme time periods for follow up appointments	High 12
ID 15788 Delivery of RTT Performance - Diagnostic Capacity Covid	High 12	**ID 20739** Endoscopy planned patients waiting list	High 12

Position Statement

What progress has been made during the last quarter?

During Quarter 4 we have agreed a number of business cases to provide additional theatre capacity across the UHNM estate footprint. In particular preparing the County Site to become a planned care hub which will allow for operating on day case 23 hour and long wait patients, i.e. seventh theatre business case – additional insourcing business case; enhanced endoscopy delivery. During Quarter 4 we have seen increase in the number of elective operative procedures taking place and work is now in place to further sustain these. We have also sustained long term locums into permanent positions for both our spinal and trauma services.

In relation to urgent and emergency care, the ED staffing business case has now been 80% recruited to which will stabilise the ED workforce and further supporting our urgent care pathways we have agreed a number of business cases to improve flow through our emergency general surgery, neurology by enhancing our medical and nursing teams, we have also provided additional funding to manage the increase in our emergency surgical demand by increasing the amount of dedicated theatre space required to treat these patients in a timely way.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence

- Regular review through the Planned Care Cell of our theatre timetable that supports all of the planned care pathways
- Weekly cancer and elective care PTL meetings undertaken by Deputy COO and Heads of Service / Directorate Management Teams

2nd Line of Defence

- Enhanced monitoring of our long wait patients and weekly oversight through COO led meeting
- Revised contract with Independent Sector to transfer a higher volume of patients to ensure timely treatment and reduced waiting list to enable focus on more complex P2 patient clearance Commissioning of In-sourcing provision to increase workforce cover to reduce loss of theatre capacity and enable traction on list continuity.
- Alternate week deep dives with COO, Clinical Director, Cancer Services and Heads of Service in both Planned Care and Cancer Care to understand current risks and support solutions
- CEO led Non-Elective Improvement Programme

3rd Line of Defence	• System wide Urgent Care Board remains in place with specific actions to reset during March • System wide ambulance handover improvement plan initiated

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)					
1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
BC-0437 Secondary Care Dental Services NHSE Funded Restoration and Recovery	✓	M9, 10, 11 Operational Performance Report	✓!		
BC-0442 Urology Nephrectomy Demand	✓	Operational Delivery Group Highlight Report	✓ !		
Enhanced Primary Care (EhPC) in Emergency Department	✓				
ED Medical Workforce Update	✓				
BC-0465 Elective Recovery of T&O Services	✓				
BC-0466 Neurology External Support	✓				
BC-0468 Theatre Timetable Recovery & Investment Plan	✓				
BC-0469 Transfer of Bariatric Surgery to the Private Sector	✓				
BC-0472 Endoscopy Recovery Funding	✓				
Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)					
Planned Care Safety Briefing / Cancer Services Gap Analysis	✓	Winter Plan	✓!		
Paediatric Surge Planning	!	H2 Operational Plan	✓!		
Colorectal Cancer Pathway Business Case	✓				
Extension of Mobile MRI Rental Business Case	✓				
Endoscopy Insourced Service Business Case	✓				
CT7 Business Case	✓				
7TH Theatre at County Hospital Business Case	✓				
Adult Critical Care Expansion Business Case	✓				
Emergency Department Medical Workforce Business Case	✓				
Sustainability of Spinal Services Business Case	✓				

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- **High occupancy** – unable to reduce our occupancy to facilitate planned and urgent care pathways
- Unreliable simple discharge delivery that supports flow through the organisation
- High MFFD as a % of bed occupancy
- Available theatre / diagnostic capacity to allow patients to move through their cancer and planned care pathways in a timely way

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Increase capacity of UHNM footprint through the development of County Hospital as an elective care centre	Chief Operating Officer	31/03/2022	Increased capacity delivered through additional theatre resources now available.	B+
2.	Implement the critical care business case which supports an increase in capacity and staffing which allows the protection of our theatre teams	Chief Operating Officer	30/09/2022	Phase 1 implemented, demand and capacity for Winter 22/23 and beyond ongoing.	GA
3.	Review of theatre timetable for Q4 to maximise throughput of patients	Chief Operating Officer	31/03/2022	Review of Theatre Timetable completed.	
4.	Monitor the long wait position for the those patients waiting over 52 and 104	Chief Operating	30/06/2022	Governance process in place to eliminate 104 by the end of June	GA

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarterly Progress Report**	**BRAG**
	weeks as part of performance management	Officer		2022. Risk remains around high tip ins quarter 2.	
5.	Implement business case that supports elective recovery through Q4 including the development of County as an elective hub ready for the delivery in Q1	Chief Operating Officer	31/03/2022	See action point 8.	A
6.	Implement business cases that support non-elective programme of work ready for the new urgent care standards	Chief Operating Officer	31/03/2022	Delay in delivery due to Q4 operational pressures.	A
7.	Review independent sector contract as part of annual planning 2022/23	Chief Operating Officer	31/03/2022	In progress and delivered as part of annual planning cycle.	GA
8.	During 22/23 using TIF funding, embed and deliver an additional day case / 23 hour capacity at County Hospital.	Chief Operating Officer	31/12/2022	Business case agreed, procurement underway.	GA
9.	Working with our PWC system partners, implement the recommendations supporting elective recovery.	Chief Operating Officer	30/09/2022	Awaiting final report.	GA

BAF 7: Delivery of IM&T Infrastructure

Internally Driven	✓
Externally Driven	

Risk Description

Cause	Event	Effect
If our infrastructure and clinical systems are not sufficient or adequately protected	**Then** this could compromise connectivity and access to key critical patient information **services such as clinical decision support**	**Resulting in** compromised patient care (including patient delays, cancellation of services, **clinical harm**), reputational damage and potential fines.

Lead Director / s:	Director of Digital Transformation	**Supported by:**	Medical Director and Chief Finance Officer
Lead Committee:	Performance & Finance Committee	**Executive Group:**	Executive Data Security & Protection Group

Strategic Objectives and Risk Register

Impact on Strategic Objectives:				
	High Quality	✓	Improving and Innovating	
	Responsive	✓	Systems and Partners	
	People		Resources	✓

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	3	Likelihood:	1	31/03/2022
Consequence:	5	4	4	4	Consequence:	5	
Risk Level:	Ext 15	High 12	High 12	High 12	Risk Level:	Mod 5	

Rationale for Risk Level:	Digital Health Technology, if effectively deployed and highly available is able to improve patient safety through clinical decision support, alerts and monitoring. Failure to adopt this technology could result in harm that would have been avoidable. Likewise when the technology is adopted if it is unavailable for a sustained period of time our patients could be impacted by harm that would otherwise been avoidable.

Links to Risk Register (>12)				
	ID 22938 Log4j Vulnerability	Ext 15	**ID 22094** Lack of devices for windows 7 replacement project	High 12
	ID 21784 Confidentiality, Integrity and Availability of Trust Information	High 12		

Position Statement

What progress has been made during the last quarter?

The Digital Strategy has been drafted and presented to Trust Executive Committee, Junior Doctors Forum, Specialised Divisoinal Board, EID and the Data Security and Protection Group.

Funding has been received and invested in:

- a clinical portal – PKB which will help patients engage in their care
- front line end user devices for wards and clinics
- backup software and firewall security solutions helping us improve the availability of information systems

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• Investment already made in enhanced Cyber Tools and defence (Intercept-X) to protect against 'wannacry' type attacks. • Server and PC patching in place and enhanced network firewalls and other network perimeter controls. • Deployment of Microsoft Advanced threat detection to improve cyber defences • Implementation of Darktrace to detect and respond to subtle, stealth attacks inside the network — in real time. • IT Health dashboard implemented to provide real-time visibility and overview of the network and systems, identifying any potential cyber security issues that warrant attention and assurance on the cyber security environment • Implementation of ORDR at County Hospital to monitor network activity of medical devices and Internet of Things (IoT) devices • Implementation of National Cyber Security Centre recommendations on passwords
2nd Line of Defence	• Raised staff awareness and understanding of cyber security through education and communication • NHS Digital accredited awareness training provided to Board members • NHS Digital Cyber essentials best practice being progressed • IM&T Programme Board in place • New Digital and Data, Security & Protection Group in place • Cyber action plan in place

	• Dedicated Cyber defence lead role and cyber defence technician appointed • Cyber security services contracted from I3Secure
3rd Line of Defence	• Annual external Penetration Testing has been undertaken and a remediation plan developed • External assessment to undertake IT health check and gauge the Trust's position to apply for cyber essentials accreditation • HIMSS EMRAM assessment completed – HIMSS 2 • What Good Looks Like assessment completed – 1.8 out of 5 • Annual DSPT toolkit submission. Current rating is *standards not fully met (plan agreed)*

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)					
1st Line (Divisional)		**2nd Line (Corporate)**		**3rd Line (External)**	
BC-0443 Darktrace Renewal Business Case	✓	Q3 Data Security and Protection Update	!		
Log4J Progress Update	✓	IM&T Strategy Progress Report	✓		
BC-0460 Unified Tech Fund Supporting Core Digital Capabilities and Infrastructure	✓	Executive Infrastructure Group Assurance Report	!		
BC-0449 Speech Recognition & Digital Dictation	✓	Executive Digital & Data Security & Protection Assurance Report	!		
BC-0462 Patient Portal	✓	Digital Strategy Progress Report	✓		
Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)					
Bring Your Own Device Scheme and Associated Safeguards	✓			Network Security Internal Audit Report	✓
				Data Security and Protection Toolkit Internal Audit Report	✓
				General IT Controls Internal Audit	✓

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Approved Digital Strategy
- Office 365 migration
- Nurse and AHP documentation
- Electronic prescribing and medicines administration
- Electronic patient record strategic outline case
- Network services strategic outline case
- Backup and firewall implementation
- iPortal rewrite onto a supported platform
- WIS rewrite onto a supported platform
- Recruit to the Commercial Manager post
- Recruit to the Technical Architect post
- Recruit to the Chief Nurse Information Officer post
- Implement laboratory management information system
- Implement digital pathology

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Deployment of Windows 10 with improved in built security and based on National Cyber Security Centre and Microsoft best practice	Director of Digital Transformation	31/06/2022	50 Windows 7 devices left to replace.	GA
2.	Continue work towards the toolkit Cyber Essentials and ISO27001 compliance and integration of network segregation.	Director of Digital Transformation	31/05/2022	Solutions for firewalls and backups in place; awaiting implementation. Support from i3Secure for cyber resource ongoing with recruitment in progress for Trust Cyber Leads. Awaiting technical changes by Nasstar to enable the network segmentation.	GA
3.	O365 Implementation.	Director of Digital Transformation	30/07/2022	Project kick-off with technical supplier formalising arrangements and identifying project plan and key milestones.	GA
4.	Digital Strategy approval and recruitment into additional strategic roles	Director of Digital Transformation	30/07/2022	Digital Strategy presented to many forums across the Trust. Business case to be written to request support for resources to deliver strategy	GA

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarterly Progress Report**	**BRAG**
	and agreed programme of works.			and sustain the chance.	
5.	Procurement of network service.	Director of Digital Transformation	30/06/2023	SOC to Performance and Finance Committee 26/04/22 with expected transition / implementation of single supplier by June 2023.	**GA**
6.	iPortal and WIS rewrite.	Director of Digital Transformation	31/03/2023	Technical lead in place and WIS re-write well underway due to go live in July following additional change requests. iPortal to follow.	**GA**

BAF 8: Infrastructure to Deliver Compliant Estate Services

Internally Driven	✓
Externally Driven	

Risk Description

Cause	Event	Effect
If we are unable to sufficiently invest and develop our retained clinical and non-clinical estate	**Then** we may be unable to provide services in a fit for purpose healthcare environment	**Resulting in** the inability to provide high quality services in a safe, secure and compliant environment

Lead Director / s:	Director of Estates, Facilities and PFI	**Supported by:**	Director of Digital Transformation and Chief Finance Officer
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Infrastructure Group

Strategic Objectives and Risk Register

Impact on Strategic Objectives:				
	High Quality	✓	Improving and Innovating	
	Responsive	✓	Systems and Partners	✓
	People		Resources	✓

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	3	**Likelihood:**	2	31/03/2022
Consequence:	4	3	3	**3**	**Consequence:**	4	
Risk Level:	**High 12**	**High 9**	**High 9**	**High 9**	**Risk Level:**	**High 8**	

Rationale for Risk Level:

- Project STAR (Demolition) – buildings remain (EF&PFI, Windsor House, Main Entrance) and car parks
- Estate condition – compressed programme, to mitigate access issues due to high levels of bed occupation / activity. Backlog schemes being delivered consistent with capital programme.
- Estate configuration / utilisation / optimisation / adjacencies – Independent review of County completed and commenced review of Royal Stoke. Findings will be used to inform the Estate Strategy
- West Building – physical estates works progressed to improve compliance, alongside refresh of service standards and monitoring arrangements to ensure cleaning standards improved and sustained
- Sustainability / Net Zero Carbon (NZC) – gap analysis currently underway to understand compliance against the requirements of the NHS Standard Contract and Greener NHS Delivery Plans. This is informing the development of new UHNM Green Plan 2022-25 (replacing the Sustainable Development Plan) and associated capital investment required to ensure delivery.

Links to Risk Register (>12)				
	ID 20315 Interventional Room 5 does not meet Ventilation Building Regulations	**High 12**	**ID 21742** Utility room availability in Children's ED	**High 12**

Position Statement

What progress has been made during the last quarter?

- Project STAR – completed public / key stakeholder consultation; demolition progressing well. Meetings held with Grindley Hill Court residents; progressed activities to support submission of planning application for new car park on 17/01/22, consistent with programme.
- Estate condition – significant works completed against backlog maintenance; statutory maintenance and progression of capital schemes (including Lower Trent) all of which support in reducing risks associated with the condition of the estate.
- Estate Strategy / Clinical Strategy – independent review of estate at County and Royal Stoke to inform refreshed Estates Strategy.
- Sodexo Market Testing Business Case – secured approvals of business case and progressing legal / commercial agreements to support lender approval.
- West Building – re-inspection of West Building by NHSIE, very positive feedback received on transformation achieved.
- Sustainability / Net Zero Carbon (NZC) – very first draft of UHNM Green Plan has been released for consultation and the Sustainability Team continue to support delivery of the ICS Green Plan
- Sustainability / NZC – Works underway to deliver estates schemes to support progress towards NZC targets, i.e. decarbonisation, backlog, flow modelling, LED lighting, EV charging and RTPI screens in bus shelters

Key Controls Framework – 3 Lines of Defence

1st Line of Defence

- Infirmary Site (Project STAR) – Approved Business Case.
- Estate Condition: Planned Preventive Maintenance; competent estates staff/ Authorised Persons; KPI's monitored through CEF/ Environmental Audits
- Maintenance Operational Board; Operational policies; Service Specifications PFI, 7 Facet Survey.
- Fire Safety/ Security Policies; Protocols; Guidelines; patrolling; CCTV; FRA's in place.
- Sustainable Development Steering Group (biannual) and the development of the UHNM Green Plan 2022-25 (aligned to the national Greener NHS Programme and NZC agenda)

2nd Line of Defence	• Infirmary Site (Project STAR): NHSEI provided capital to deliver business case • Estate Condition - Capital bids prioritised against Estate 7 Facet Findings and approved at CIG. • Estate Strategy – Clinical Strategy and independent review used to inform refreshed Estate Strategy. • Fire/Security: 'On the spot' fire improvement notices, Fire Safety KPIs & ad-hoc audits/inspections • LSMS close working with local Police and visibility on site
3rd Line of Defence	• NHSEI review on Project STAR, Lower Trent project, Market Testing Business Case & West Building • PFI Statutory maintenance programme • Regulatory inspection/validation programmes including: CQC, PLACE, PAM and ERIC • External audits including Fire and Police Service and external audit i.e. KPMG • Authorising Engineers Audits of building services and associated maintenance regimes. • Participation in National Programme (SSRM) hosted by Cabinet Office & HM Treasury • National Audits – ¼ Green NHS Data Collections, Annual Fleet Data Collection; *upcoming National Waste and Food Data Collections

Assurance Map					
Committee Assurances (assurances received by the Committee/s during this quarter)					
1st Line (Divisional)		**2nd Line (Corporate)**		**3rd Line (External)**	
		Executive Infrastructure Group Assurance Report	!		
Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)					
PLACE Inspection Findings & Action Plan	✓	Multi Story Car Park Business Case	✓		
		Capital Programme 2021/22	✓!		
		Fire Annual Report	✓		
		Security Annual Report	✓		
		Update on Car Parking Strategy	✓		
		Project STAR Update			

Gaps in Control or Assurance
What are the gaps to be addressed in order to achieve the target risk score?
• Project STAR; capital schemes, 2021/22 statutory maintenance and West Building – continue to progress consistent with agreed programmes

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	RI Site demolition	Director of E,F & PFI	01/03/2024	Phases 1 – 4 completed, Phase 5 underway and on programme. Remaining legacy buildings on site until full sale of site.	GA
2.	Car parking solution	Director of E, F&PFI	31/05/2022	Secure planning approval and vacant possession of site to allow construction to commence.	GA
3.	RI/COPD - Release land for land sale	Director of E,F& PFI	2024/2025	Will be released upon completion of construction and new car park at GHC.	GA
4.	Lower Trent Business Case	Director of E,F&PFI	31/01/2023	Conclude decant and complete refurbishment consistent with revised programme.	GA
5.	Sodexo Market Testing BC	Director of E,F&PFI	31/07/2022	Formalise variation of PFI (Deed of Variation) with Project Co, Sodexo and PFI Funders.	GA
6.	Estate condition	Director of E,F&PFI	31/03/2023	Delivery statutory maintenance & capital schemes in accordance with programmes.	GA
7.	Strategic Supplier Programme	Director of E,F & PFI	31/07/2022	Refresh current programme and identify additional schemes for delivery 2023.	GA
8.	Estates Workforce Reviews	Director of E,F & PFI	31/05/2022	Capital team review completed and focus now on operations skill mix review	GA
9.	Cleaning Collaborative	Director of E,F & PFI	31/05/2022	Sustain improvements seen in West Building and progress all agreed activities to plan.	GA
10.	Net Carbon Zero	Director of E,F & PFI	31/03/2025	Gap analysis underway to understand compliance against the requirements of the NHS Standard Contract and Greener NHS Delivery Plans. This is informing the development of the new UHNM Green Plan 2022-25.	GA

BAF 9: Financial Performance

Internally Driven	✓
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we, or system partners, are unable to operate within available resources	**Then** the system financial plan for 2021/22 may not be delivered	**Resulting in** increasing Cost Improvement Programmes, and a lack of ability to invest in the development of future services

Lead Director / s:	Chief Finance Officer	**Supported by:**	Chief Operating Officer
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Infrastructure Group

Strategic Objectives and Risk Register

Impact on Strategic Objectives:				
	High Quality		Improving and Innovating	
	Responsive		Systems and Partners	✓
	People		Resources	✓

Improving Together

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	1	1	Likelihood:	1	31/03/2022
Consequence:	3	3	3	3	Consequence:	3	
Risk Level:	Mod 6	Mod 6	Low 3	Low 3	Risk Level:	Low 3	
Rationale for Risk Level:	Financial Plan for the year delivered with surplus at Month 11 at £5.2m and forecast on track to sustain.						
Links to Risk Register	N/A						

Position Statement

What progress has been made during the last quarter?

Strong financial performance maintained. Support to system through £10m reduction in income to allow CCG to increase investment through the Better Care Fund to support ongoing performance and reduce pressure into 2022/23.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• Performance Management meetings in place with Divisions • Financial codes and procedures • Restoration and recovery group scrutiny • Exec Team approval of additional investment up to £250k • STP Finance Director meeting established to consider system position • Ongoing discussions with NHSIE on underlying position to inform improvement trajectories
2nd Line of Defence	• Finance report in place to performance and Finance Committee with associated scrutiny; enhanced to include run rate performance and analysis of additional COVID related expenditure • Standing Financial Instruction
3rd Line of Defence	• Consideration of Internal audit programme to reflect changing risks on COVID • STP Capital Programme in place in Line with Capital Resource Limit (CRL) • External audit programme in place • NHSE/I allocations confirmed

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		M9, 10, 11 Finance Report	✓	Payroll Review	✓
		Budget Setting Framework 2022/23	✓	Key Financial Systems Review	✓
		Financial Plan Update 2022/23	✓		
		Capital Planning Update 2022/23	✓		
		System Plan Submission	!		
Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)					
		Budget Setting 2021/22	✓	NHS System Oversight Framework Segmentation	!

		H1 Financial Plan	✓		
		H2 Financial Plan	✓		
		Investment Assurance Report	!		

Gaps in Control or Assurance

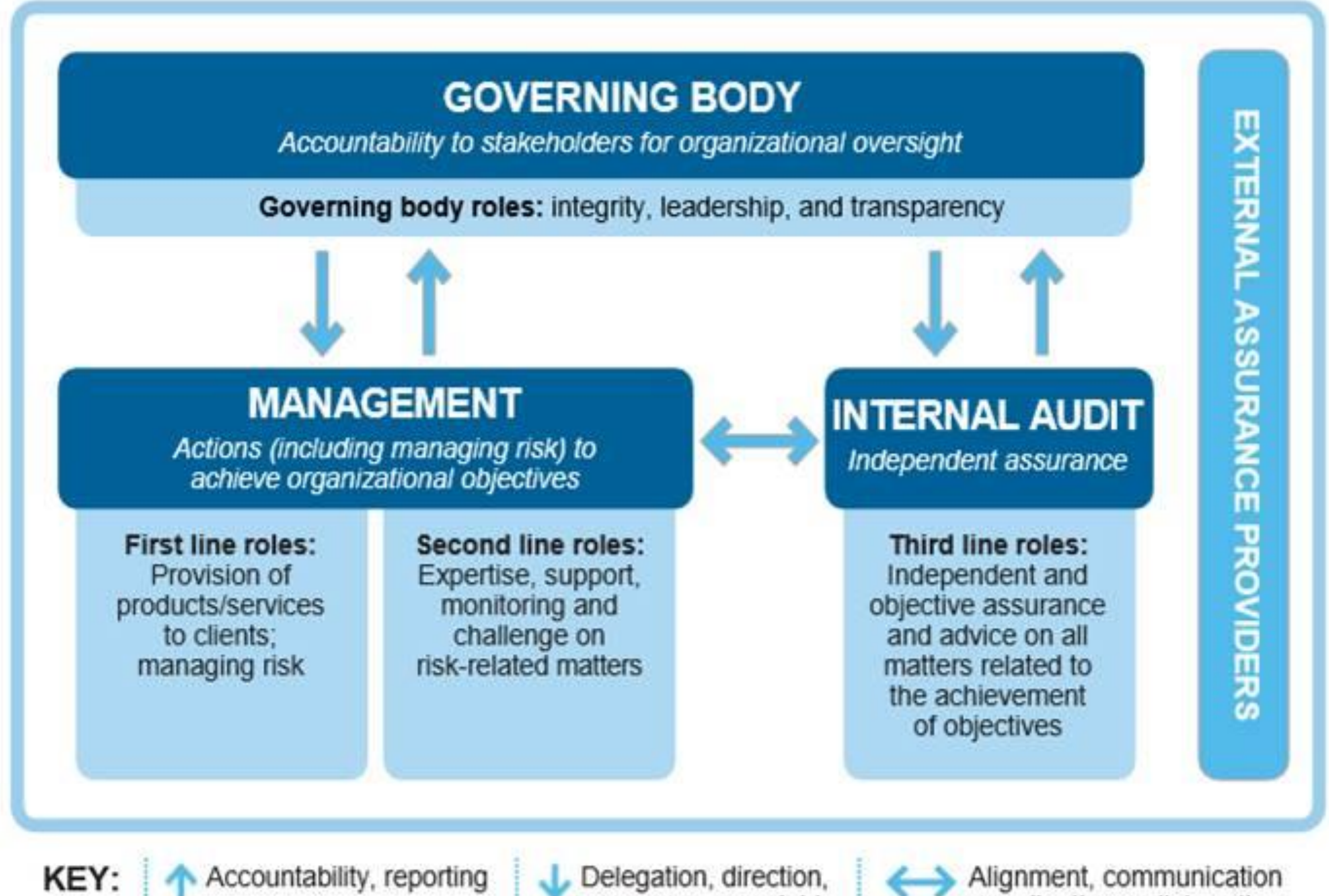
What are the gaps to be addressed in order to achieve the target risk score?

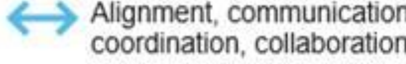
Moving forward underlying deficit as a system is £133m with a £48m in year deficit of which UHNM represents £9.2m. Plans include unified CIPs of circa £7m. In year non-recurrent flexibility available to support but underlying position will need addressing going forward into 2022/23.

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	To develop CIP plans for 2022/23	Chief Finance Officer	31/03/2022	Corporate plans in place for circa £7m with a remaining £7m within Divisions to be identified. Targets have been communicated and in the process of being embedded into the Improving Together performance framework.	GA

Appendix 1: Three Lines of Defence





Appendix 2: Risk Appetite Matrix

Sub Category of Risk		Risk Appetite	Risk Score Tolerance
Impact on Quality	Patient Safety (e.g. patient harm, infection control, pressure sores, learning lessons)	Cautious	Mod 4 – Mod 6
	Effectiveness (e.g. outcomes, delays, cancellations or operational targets and performance)	Open	High 8 – High 12
	Service User and Carer Experience and the ability to manage quality (e.g. complaints, audit, surveys, clinical governance and internal systems)	Open	High 8 – High 12
Impact on Regulation & Compliance	Statutory Regulation and Requirements (e.g. Information Commissioner, Care Quality Commission, Health and Safety Executive, Professional Regulatory Bodies such as General Medical Council, Nursing & Midwifery Council, external certifications such as JAG and ISO).	Cautious	Mod 4 – Mod 6
	National Guidance and Best Practice (e.g. National Institute for Health and Care Excellence, GIRFT)	Open	High 8 – High 12
Impact on Reputation	Day to day activity (e.g. standards of conduct, ethics and professionalism and delivery of services)	Cautious	Mod 4 – Mod 6
	Risk as a result of protecting and improving the safety of patients	Seek	Ext 15 – Ext 25
Impact on Workforce	Staff recruitment (e.g. compliance with regulations such as visa requirements, Equal Opportunities and Diversity, that ensure staff are recruited fairly and competent to deliver services)	Cautious	Mod 4 – Mod 6
	Employment practice	Cautious	Mod 4 – Mod 6
	Staff retention (e.g. attractiveness of Trust as an employer of choice)	Open	High 8 – High 12
Impact on Infrastructure	Estates Infrastructure	Cautious	Mod 4 – Mod 6
	Security (e.g. access and permissions to systems and networks)	Cautious	Mod 4 – Mod 6
	Control of Assets (e.g. purchase, movement and disposal of ICT equipment)	Cautious	Mod 4 – Mod 6
	Business continuity (e.g. cyber-attack, maintenance of networks, alternative solutions)	Cautious	Mod 4 – Mod 6
	Data (e.g. integrity, availability, confidentiality and security, unintended release)	Cautious	Mod 4 – Mod 6
Impact on Finance & Efficiency	Value for money and sustainability (including cost saving)	Cautious	Mod 4 – Mod 6
	Standing Financial Instructions (SFI's) and financial control	Cautious	Mod 4 – Mod 6
	Fraud and negligent conduct	Minimal	Low 1 – Low 3
	Contracting	Seek	Ext 15 – Ext 25
Impact on Partnerships / Collaboration	Partnerships	Open	High 8 – High 12
Impact on Innovation	Innovation (e.g. new ways of working, new products, new and realigned services, new models of staffing and realignment of services, international recruitment, new ICT systems and improvements)	Seek	Ext 15 – Ext 25
	Financial Innovation (e.g. new ways of working, new products, new and realigned services)	Open	High 8 – High 12

LEVELS OF RISK APPETITE	
Avoid **Risk Score Tolerance 0**	We are not prepared to accept any risk.
Minimal **Risk Score Tolerance 1 – 3**	We accept that risks will not be able to be eliminated, therefore these should be reduced to the lowest levels, with ultra-safe delivery options, recognising that these may have little or no potential for reward/return.
Cautious **Risk Score Tolerance 4 – 6**	We are willing to accept some low levels of risk, while maintaining overall performance of safe delivery options, recognising that these may have restricted potential for reward/return.
Open **Risk Score Tolerance 8 – 12**	We are willing to accept all potential delivery options, recognising that these may provide an acceptable level of reward.
Seek **Risk Score Tolerance 15 - 25**	We are eager to be innovative, choosing options with the potential to offer higher business rewards.

Executive Summary

Meeting:	Public Trust Board	Date:	4th May 2022
Report Title:	Corporate Governance Structure (April 2022)	Agenda Item:	17.
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	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	*No risk identified on the Risk Register.*	*n/a*

Executive Summary

Situation

The enclosed organisation chart sets out the Corporate Governance Structure of the organisation, including the Board, its Committees, Executive Groups and Operational Groups. Since its initial development in 2020, the structure is reviewed on an annual basis and is being presented to the Board for approval.

Background

Following the NHSIE Well Led Developmental Review undertaken in 2019, an extensive programme of work has been undertaken to improve the organisation's corporate governance arrangements. This included a redesign of our Corporate Governance Structure and saw the introduction of the Transformation and People Committee, along with a series of Executive Groups.

Whilst now embedded, the structure has continued to be developed over time, ensuring clear alignment with our Strategic Priorities and taking into account the findings of our Annual Effectiveness Review process. Our Internal Auditors reviewed the effectiveness of our Executive Groups during their 2020/21 audit programme and concluded their review with **Significant Assurance with Minor Improvement Opportunities.** These groups have continued to evolve since that review.

In addition, the Care Quality Commission Inspection undertaken during 2021, with regard to the 'Well Led' element, saw an improved rating from **Requires Improvement** to **Good**, with particular reference within their findings to the corporate governance arrangements, specifically:

✓	'The board and other levels of governance in the organisation functioned effectively and interacted with each other appropriately'.
✓	'There were governance processes in place to identify issues which enabled the board to know where the risks are and take action to make improvements which should deliver sustainable change'.

Assessment

The most recent review of the Corporate Governance Structure has been discussed and agreed with the Executive Team and its effectiveness will continue to be reviewed. A number of changes have been made during this most recent review, these are summarised as follows:

No.	Change		Rationale
1.		Establishment of specific Quality Governance Committee / Executive Quality & Safety Oversight Groups for **Maternity Services**.	To provide an enhanced focus on maternity, including Ockenden findings / actions.
2.		Establishment of **Executive Clinical Effectiveness Group.**	Introduced by the Medical Director, to bring an enhanced focus and structure on clinical effectiveness matters.
3.		Refreshed **Clinical Ethics Advisory Group**, reporting into the Executive Clinical Effectiveness Group.	Whilst a Clinical Ethics Advisory Group has been in place for some time, its reporting lines and focus have been updated and realigned.
4.		Uplift of the **Medical Gases Steering Group** from a 'below the line' working group to having a direct report into the Executive Quality & Safety Oversight Group.	To enhance oversight and opportunity for escalation.
5.		Revised structure for **Digital / Data Security & Protection.**	A streamlining of the digital governance structure was undertaken by the Director of Digital Transformation during 2021 and supported by the Executive Team.
6.		Transfer of **Digital Governance Structure** over to the Transformation and People Committee.	Given the focus on digital transformation and the introduction of a new enabling strategy for Digital Transformation.
7.		Inclusion of the **Culture Review Committee** and the **Executive Culture Review Group**	Established as part of the Brap / Roger Kline review and response – these are Task and Finish and will be removed once absorbed into business as usual.
8.		Transfer of **Executive Health & Safety Group** from Quality Governance Committee to Transformation and People Committee.	Following the January 2022 publication looking at NED roles, better alignment with the wellbeing agenda and in recognition that the majority of Health and Safety related matters are focussed on staff.
9.		Establishment of **Medical Workforce Group** reporting into Executive Workforce Assurance Group.	Established by the Medical Director to scrutinise / seek assurance on matters relating to medical workforce planning.
10.		Establishment of **County Hospital Group** reporting into the Executive Strategy & Transformation Group.	Programme group established to oversee the County Hospital Programme.
11.		Inclusion of **Children's Hospital Strategy Group** within the structure, reporting into Executive Strategy and Transformation Group.	This was not previously reporting into an Executive Group.

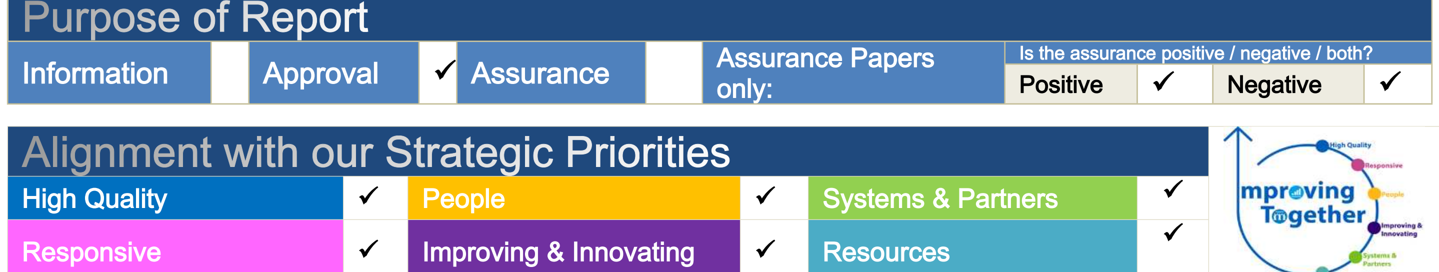
Key Recommendations

The Board is asked to **approve** the revised Corporate Governance Structure, whilst noting that in-year changes *may* be made if required – these will be notified to the Board accordingly.

Corporate Governance Structure
NHS
University Hospitals of North Midlands
NHS Trust
Corporate Trustee
Trust Board
Performance & Finance Committee (PAF)
Audit Committee
Charity Committee
Quality Governance Committee (QGC)
Maternity QGC
Culture Review Committee (T&F)
Nomination & Remuneration Committee (NRC)
Transformation & People Committee (TAP)
Performance Management Review (PMR) Process
Assurance
Executive Business Intelligence Group
Executive Infrastructure Group
Executive Operational Delivery Group
Planned Care Improvement Board
Non-Elective Improvement Board
Maternity QSOG
Executive Quality & Safety Oversight Group
Executive Clinical Effectiveness Group
Executive Digital and Data Security and Protection Group
Executive Culture Review Group (T&F)
Executive Health & Safety Group
Executive Research & Innovation Group
Executive Workforce Assurance Group
Executive Strategy and Transformation Group
Data Quality Assurance Group
Estates Divisional Board
Medical Equipment Group
Capital Investment Group
EPRR Group
CT PEG Group
Patient Safety Group
Patient Experience Group
Risk Management Panel
Safeguarding Group
Medicines Optimisation & Safety Group
Infection Prevention & Control Group
Mental Health / LD / Autism / Dementia Group
Medical Gases Steering Group
Clinical Ethics Advisory Group
Business Intelligence Operational Group*
IT Programme Operational Group
IT Service Delivery Operational Group
Cyber Security Operational Group
Data Security & Protection Operational Group
Record Service Operational Group
Clinical Systems Operational Group
Digital Clinical Office Operational Group
Fire Safety Group
Radiation Protection Group
Divisional Estates, Facilities & PFI Health & Safety Group
Quality Assurance Steering Group
Clinical Oversight Group
Learning & Development Group
Professional Standards & Conduct Group
Medical Education Group
Medical Workforce Group
Transformation Programme Sub Groups
County Hospital Group
Children's Hospital Strategy Group
Operational
*Business Intelligence Operational Group also has a dual report to the Executive Business Intelligence Group
Strategic Priorities
Improving Together
High Quality
Responsive
People
Improving & Innovating
Systems & Partners
Resources
Divisional Boards / Divisional Governance Structures
Day to Day / BAU Working Groups (not part of governance structure)
Together
Compassion
Safe
Improving
Updated April 2022

Executive Summary

Meeting:	Public Trust Board	Date:	4th May 2022
Report Title:	G6 and FT4 Annual Declaration	Agenda Item:	18.
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		



Purpose of Report

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

Alignment with our Strategic Priorities

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

Executive Summary:

Situation

NHS Trusts are required to self-certify that they meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements.

The enclosed FT4 and G6 declaration fulfils the self-certification obligation for 2021/22 and is presented for approval of the Board.

Background

Although NHS Trusts are exempt from needing the provider licence, directions from the Secretary of State require NHSIE to ensure that NHS Trusts comply with conditions equivalent to the licence as it deems appropriate.

The enclosed submission includes updated narrative for each section of the declaration.

Assessment

The Trust Board at its Board Seminar on 16th March considered the attached and agreed to continue to provide a response of not confirmed for FT4 (No. 4) as although financial performance has improved, there remain major risks in relation to long waiting lists, an underlying deficit and system with a deficit, in addition to an outstanding Section 31 Notice. In addition it was agreed to provide a response of not confirmed for the G6 declaration due to the same issues.

Key Recommendations:

The Board is asked to formally consider and confirm the Trust's self-certification.

PROUD TO CARE

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | 2021/22

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board's corporate governance framework is set out within the Rules of Procedure, which is reviewed and approved by the Board. This is supported by a number of key policies, for example, Standing Orders, Scheme of Delegation, Standing Financial Instructions, Risk Management Policy and Standards of Business Conduct. Key risks are recorded on the organisation wide risk register in accordance with Trust policy and key strategic risks are reviewed and monitored by the Board and its Committees. During 2021/22, the Trust has continued to implement its strengthend Corporate Governance Structure, including further embedding the Executive Groups, reporting through to Committees, with alignment to the organisations strategic objectives.	OK
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	A process is in place to ensure that any guidance on good corporate governance issued by regulators, and other national arms lengh bodies, is considered by the Executive Directors. Each week, guidance is shared with relevant Executive and Operational Leads for consideration and action.	OK
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	As referred to above, the Rules of Procedure set out the Board and Committee structures, responsibilities and reporting lines, along with an independent review being undertaken in year, which led to subsequent changes which were approved by the Board. The Rules of Procedure includes business cycles for the Board and its Committees, which identifies the reporting required by Executive Directors. Each Committee of the Board provides an exception based highlight report, to the Board at each meeting which is presented by the Non-Executive Chair. These reports provide a 2 page summary of items to escalate, key actions, positive assurance and decisions made, along with a summary agenda and attendance matrix. This reporting arrangement has also continued in year, for executive groups reporting into Committees. Clear reporting lines and accountabilities are in place, and these form part of a number of Trust-wide policies and procedures, set out in (1) above.	OK
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Not confirmed	Although financial performance has improved, there remain major risks in relation to long waiting lists and backlogs associated with elective and cancer recovery, the need to demonstrate sustainable improvements in urgent care performance, an underlying deficit and system with a deficit, in addition to an outstanding Section 31 Notice.	OK

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Chief Nurse and Medical Director jointly hold executive leadership for quality, both of whom are voting members of the Board. In addition, the 2025Vision sets out our key objectives, including the provision of safe, effective, caring and responsive services. This strategic objective is measured via a number of critical success factors covering CQC ratings, reductions in harm arising from falls and pressure ulcers, maintaining mortality rates, infection control measures and PLACE inspection performance. We have a Quality Impact Assessment process in place which provides assurance that the quality of care is not compromised for any financial planning decisions taken. The Annual Business Cycles for the Trust Board and the Quality Governance Committee provide a framework for reporting on all aspects of quality and this includes regular Patient Experience Reports and our Annual Quality Account, which demonstrate the mechanisms by which information from stakeholders and patients on the quality of our services, is taken into account. The Board has continued to enhance its processes for patient engagement through the scheduling of Patient Stories at each Public Board.	OK
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	An ongoing process is in place to ensure compliance with the Fit and Proper Persons Test, with work undertaken in year to review and strengthen the processes in place. Appointments have been made in year to recruit to the positions of Non-Executive Director, and Medical Director.	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature ____________________ **Signature** ____________________

Name David Wakefield, Chairman **Name** Tracy Bullock, Chief Executive

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A Although financial performance has improved, there remain major risks in relation to long waiting lists, an underlying deficit and system with a deficit, in addition to an outstanding Section 31 notice. OK

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates: **2021/22** — Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Not confirmed — Please complete the explanatory information in cell E36

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Please Respond

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Please Respond

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

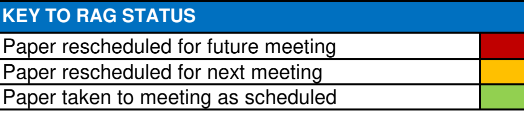
Signature		**Signature**	
Name	David Wakefield	**Name**	Tracy Bullock
Capacity	Chairman	**Capacity**	Chief Executive
Date	04 May 2022	**Date**	04 May 2022

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Although financial performance has improved, there remain major risks in relation to long waiting lists and backlogs associated with elective and cancer recovery, the need to demonstrate sustainable improvements in urgent care performance, an underlying deficit and system with a deficit, in addition to an outstanding Section 31 Notice.

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 6	May 4	Jun 8	Jul 6	Aug 3	Sep 7	Oct 5	Nov 9	Dec 7	Jan 11	Feb 8	Mar 8	Notes
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse													
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Quality Strategy Update	Chief Nurse													
Clinical Strategy	Director of Strategy													
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
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													TBC
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													
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS STANDARDS														
Integrated Performance Report	Various	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH														
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													
Research Strategy	Medical Director													
Staff Survey Report	Chief People Officer													
LEAD STRATEGIC CHANGE WITHIN STAFFORDSHIRE AND BEYOND														
System Working Update	Chief Executive / Director of Strategy													
ENSURE EFFICIENT USE OF 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													TBC
Going Concern	Chief Finance Officer													
Estates Strategy Update	Director of Estates, Facilities & PFI													TBC
Annual Plan	Chief Finance Officer													
Capital Programme 2022/23	Chief Finance Officer													
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		

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	
Raising Concerns Report	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
Accountability Framework	Associate Director of Corporate Governance													TBC
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													